Health and Wellbeing Board

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Child Death Overview Panel (CDOP) Annual Report

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Role and Purpose of CDOP

- *Child death review: Statutory and Operational Guidance: Oct 2018 – compliant.*
- Legal responsibility to ensure that the deaths of children normally resident in their area are reviewed.
- Analyse and identify matters relating to the death that are relevant to the welfare of children or to public health and safety and whether action is required.
- To consider modifiable factors which may prevent future deaths from occurring.
- Must enable local and national learning using standardised approaches.(national templates)

Role and Purpose of CDOP (cont)

- To notify the Medical Examiner (once introduced) and the doctor who certified the cause of death.
- To provide data to NHS Digital and then, once established, to the National Child Mortality Database.
- To produce an annual report on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process.
- To contribute to local, regional and national initiatives to improve learning from child death reviews.
- including, where appropriate, approved research carried out within the requirements of data protection.

CDOP Membership

- Public Health (chair as independent of key providers).
- Designated Doctor for Child Death.
- Social Services.
- Police.
- Designated Doctor and Nurse for Safeguarding.
- Health visiting/school nursing.
- Primary Care – GP.
- Nursing and/or midwifery.
- Lay representation (for thematic review meetings).
- Other professionals that CDRPs consider should be involved (Education, mental health provider, NEAS etc).

CDOP Annual Report (2018/19)

A joint Child Death Overview Panel (CDOP) is in place for Durham and Darlington, reporting to both children's safeguarding partnerships.

24 children in Durham and 4 in Darlington died during 2018/19.

There were 39 child death reviews considered by CDOP in 2018/19 (time period 2015 – 2019).

Of the 39 cases reviewed there were modifiable factors in four deaths:
Smoking in the home and smoking during pregnancy.

Timeline for Reviews

- 2 completed within 6 months.
- 28 completed within 6-12 months.
- 10 completed which were over 12 months old.

Categories of Death

- The majority of deaths relate to perinatal/neonatal deaths and life limiting conditions.
- 69% of deaths are of children under one year old.
- 74% are male deaths.
- Majority of deaths occurred at hospital (67%).

Contributory factors:

- Childs needs: 18 health factors which were sufficient to explain death.
- Family / environment: smoking during pregnancy, parental substance misuse, child's mental health, co – sleeping
- Service provision: access to health care and prior surgical intervention

Key Issues from Child Death Reviews 2018/19

Babies with life limiting conditions

- Ensure relevant teams within tertiary services, district and community health services are involved in discharge planning and health care plans to ensure the family receive support during the antenatal and postnatal period.
- There is a regional neonatal care comfort bundle checklist available that would improve communication across all health sectors.

Accidental deaths

- As part of primary care and routine visits by the health visiting service reinforcement messages of safety outdoors and indoors should be given.
- Improved communication and risk management of the use of paracetamol – public health to coordinate a public awareness programme.

Children with chronic medical conditions

- There was a failure to recognise a critical and acute illness in a child with an underlying chronic and complex condition. In terms of learning, consideration should be given to implementing the difficulty airway society extubation guidelines. There was also a delay in the child receiving oxygen therapy prior to admission to hospital and assurances have been sought from the CCG in terms of issues identified for primary care and ambulance services.

Neonatal deaths

- Similar themes have been previously identified from an external review of maternity services. In terms of paediatric input in the management of a high risk mother and delivery of her baby. Need to undertake a regional thematic review of neonatal deaths.

Good Practice

- Actions have been undertaken in the management of high risk mothers and delivery in terms of prompt transfer times to tertiary centres and subsequent interventions.
- 0 – 19 service have identified staff to take part in public health commissioned bereavement support training. This was following discussion at CDOP about how siblings and peers are better supported following the death of a sibling or friend.
- The rapid response team continue to be an essential support incredibly valued by families and partners.

Developments During 2018/19 – Roll into 2019/20

- Training on child death review process.
- Bereavement support training.
- Discussion with Tees CDOP about the establishment of twice a year joint thematic review sessions.

- Commencement of the information sharing agreements with PHE and the four (now three) CDOPs to undertake regional thematic reviews:
  - Suicide and self harm
  - Sudden and unexpected deaths in infancy
  - Trauma deaths
  - Neonatal deaths