Health and Wellbeing Board

27 November 2019

Child Death Overview Panel Annual Report

Report of Gill O'Neill, Deputy Director of Public Health, Durham County Council

Electoral division(s) affected:

Countywide

Purpose of the Report

1 The purpose of the report is to present to Health and Wellbeing Board the 2018/19 County Durham and Darlington Child Death Overview Panel (CDOP) Annual Report (Attached at appendix two).

Executive summary

2 This report provides a summary of the CDOP Annual Report.

Recommendation(s)

3 Members of the Health and Wellbeing Board are recommended:

(a) To note the content of the annual report and the developments planned for 2019/20 and beyond.

(b) To note the importance of the work on reducing tobacco dependency in pregnancy as it is a clear modifiable factor in child deaths.

(c) To receive a presentation at the Health and Wellbeing Board on the 27 November 2019.

(d) To consider writing to other chairs of Health and Wellbeing Boards across the North East to endorse the importance of the regional thematic reviews proposed to be undertaken on:

(i) Suicide and self harm;
(ii) Sudden and unexpected deaths in infancy;
(iii) Trauma deaths;
(iv) Neonatal deaths.

Background

4 Over the last 12 months the Child Death Overview Panel (CDOP) has worked to ensure compliance against the Child death review: Statutory and Operational Guidance: Oct 2018. CDOP is a sub group of the Durham Safeguarding Children's Partnership and the Darlington Safeguarding Children's Partnership.

Role of CDOP

5 CDOPs role is as follows:

- It has a legal responsibility to ensure that the deaths of children normally resident in their area are reviewed;
- To 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;
- It must enable local and national learning using standardised approaches (national templates);
- If it identifies any errors of deficiencies in an individual child's registered cause of death it must report them;
- 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.

Membership of CDOP

6 As part of the review to ensure compliance with national guidance the terms of reference for CDOP were refreshed and membership updated. There is consistently good attendance at CDOP and members include:

- 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).

2018/19 Annual report

7 This is the 8th annual report of CDOP and reflects activity from 1 April 2018 – 31 March 2019. Last years report (2017/18) saw 33 child deaths in Durham and 7 in Darlington. Fortunately, numbers remain low for 2018/19 with 24 children in Durham and 4 in Darlington dying during 2018/19.

8 There were 39 child death reviews considered by CDOP in 2018/19 (time period 2015 – 2019). The delays for deaths coming through CDOP are due to other proceedings taking place and cases are not reviewed until a case has completed all other processes such as serious case review, criminal or coronial proceedings.

9 Of the 39 cases reviewed there were modifiable factors in four deaths with two factors identified:

- Smoking in the home and smoking during pregnancy.

Categories of death

10 The majority of deaths relate to perinatal/neonatal deaths and life limiting conditions which is consistent with the national dataset.

11 69% of deaths are of children under one year of age and most are expected deaths.

12 74% are male deaths and the majority of deaths occurred at hospital (67%)

Contributory factors

13 These are factors that have contributed to the death and are not necessarily modifiable in the individual cases cause of death.

14 Childs needs: 18 health factors which were sufficient to explain death.

15 Family / environment: smoking during pregnancy, parental substance misuse, child's mental health, co – sleeping.

16 Service provision: access to health care and prior surgical intervention.

Key Issues to be considered

17 These are areas which CDOP remains interested in ensuring the work is progressed.

Babies with life limiting conditions

18 CDOP needs assurance that 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

19 As part of primary care and routine visits by the health visiting service reinforcement messages of safety outdoors and indoors should be given.

20 Improved communication and risk management of the use of paracetamol which public health are coordinating a public awareness programme involving pharmacies and schools.

Children with chronic medical conditions

21 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

22 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. There is the need to undertake a regional thematic review of neonatal deaths to understand the issues across the integrated care system.

Good Practice

23 CDOP is a very well established process across County Durham and Darlington. It is important to draw out areas of good practice such as:

- 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 2019/20

24 Now the transition has taken place and there is compliance with national guidance there is work to undertake to improve processes and to continue to challenge the system to prevent future child deaths and learning is proactively implemented when there are modifiable factors identified. The 2019/20 developmental areas include:

- Multi agency training on child death review processes;
- Bereavement support training to be delivered to the 0 – 19 staff and a programme of work rolled out across County Durham;
- Discussion with Tees CDOP about the establishment of twice a year joint thematic review sessions. This is to be fully compliant with national guidance which stipulates a CDOP should review 60 deaths a year.
- 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.

Main implications

25 Members of the Health and Wellbeing Board are requested to note that:

- The annual report is a statutory responsibility and highlights the child deaths for the year;
- CDOP is compliant with the new working together guidance and has refreshed the terms of reference and membership;
- There are areas of good practice as highlighted in paragraph 23;
- The developments being progressed will seek to undertake a number of thematic reviews across the north east region to develop a more robust data set which will provide more comprehensive recommendations.

Conclusion

26 The CDOP annual report is a statutory requirement and provides a strategic summary of the child deaths during the year and the outcomes of the child death reviews that have been considered by CDOP.

Background papers

- None

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Appendix 1: Implications

Legal Implications

Durham County Council meets its statutory requirement as a child death review partner by working in line with HM Government Child Death Review Statutory and Operational Guidance, October 2018 and Working Together to Safeguard Children 2018. In addition, working in line with Section 16Q of the Children Act 2004, as amended by the Children and Social Work Act 2017.

Finance

Statutory partners continue to work within financially challenging times. The CDOP requirement is a statutory obligation placed upon the Council to continue to meet. Staffing support is met by the Durham County Council and Durham Safeguarding Children Partnership arrangements.

Consultation

No implications.

Equality and Diversity / Public Sector Equality Duty

No implications.

Climate Change

No implications.

Human Rights

No implications.

Crime and Disorder

Close partnership working exists under the requirements of CDOP. The relevant statutory partners working together to address any requirements in relation to reporting and in the prevention and detection of crime.

Staffing

No direct implications.

Accommodation

No direct implications.

Risk

The risk to child death review partners, (the Council) is minimal due to the statute requirement.

Procurement

No direct implications.