Health and Wellbeing Board

21 January 2021

Child Death Overview Panel Annual Report

Report of Amanda Healy, 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 2019/20 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 of the raising awareness campaigns to recognise and respond to children showing signs of an acute illness and also the raising awareness through existing campaigns regarding bike safety as these issues were identified as modifiable factors in child deaths reviewed by the Child Death Overview Panel during this period.

(c) To note the work ongoing to develop thematic reviews through a merged CDOP with another CDOP area in the North East region.

Background

4 The Child Death Overview Panel (CDOP) has put in place the necessary changes 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 up to 18 years of age normally resident in their area are reviewed;
- to analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths
- To make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children;
- To notify the Child Safeguarding Practice Revie Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected
- To notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death;
- To input specific data within the National Child Mortality Database;
- To produce an annual report for Child Death Review Partners 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 Deaths;
- Children's Social Care;
- Police;
- Designated Doctor and Designated Nurse for Safeguarding;
- Primary Care (GP and the 0-25 Service);
- Child & Family Health;
- Lay representation (for thematic review meetings);

- Other professionals that CDRPs consider should be involved; (mental health provider, Ambulance Service, etc).

2019/20 Annual report

7 This is the 9th annual report of CDOP and reflects activity from 1 April 2019 – 31 March 2020. Last year's report (2018/19) saw 24 child deaths in Durham and 4 in Darlington. Fortunately, numbers remain low for 2019/20 despite a slight increase with 28 children in Durham and 4 in Darlington dying during 2019/20.

8 There were 20 child death reviews considered by CDOP in 2019/20 (these include previous time periods outside of 2019/20). 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 20 cases reviewed there were modifiable factors in five deaths with seven factors identified:

- Chronic self-management of diabetes;
- Neglect;
- Cumulative risk;
- Co-sleeping;
- Parental cannabis use;
- Parental awareness of sepsis;
- Surgical procedure.

Categories of death

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

11 55% of deaths are of children under one year of age and most are expected deaths.

12 60% are male deaths and the majority of deaths occurred at home (30%)

Key Issues to be considered

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

<u>Raising Awareness regarding Signs & Indicators of Acute Illness in Children</u>

14 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.

Children with Chronic Medical Conditions

15 One 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

16 There is a need to utilise all resources such as existing local initiatives and raising awareness campaigns that target teenagers regarding bike safety.

Neonatal deaths

17 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

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

- The role of the rapid response team continues to be an essential support incredibly valued by families and Child Death Review Partners. It is noteworthy that County Durham and Darlington is the only area in the North East that is fully compliant with Working Together to Safeguarding Children in terms of establishing this service. The rapid response team continues to be an essential support incredibly valued by families and partners;
- The work of the Paediatric Diabetic Team identified in one case;
- 0-25 service have staff trained in bereavement support for children that have been affected by the death of a child;

Developments 2019/20

19 A select number of 0-25 Service practitioners have completed training around bereavement support for children. Following COVID-19 restricts, Harrogate & District NHS Foundation Trust has extended this training provision for all 0-25 Service practitioners;

20 The 019 Service is also working with a charity to develop online bereavement training to supplement the above training provision.

Main implications

21 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 18;
- The developments being progressed will seek to undertake a number of thematic reviews across a wider footprint to develop a more robust data set which will provide more comprehensive recommendations.

Conclusion

22 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.