Health and Wellbeing Board

11 May 2022

County Durham and Darlington Child Death Overview Panel Annual Report 2020/21

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 the Health and Wellbeing Board the 2020/21 County Durham and Darlington Child Death Overview Panel (CDOP) Annual Report attached at Appendix 2 and to give a brief summary of the main report.

Executive Summary

2 This year's Annual 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 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.

Recommendations

3 The Health and Wellbeing Board is recommended to:

a. Note the content of this report and the associated CDOP Annual Report as assurance it is fulfilling its responsibilities as a sub-group of the DSCP.

Background

4 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.

5 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 Process

6 There are 3 interrelated processes for reviewing child deaths (detail in main report):

i. Joint Agency Response.
ii. Child Death Review Meeting.
iii. Child Death Overview Panel.

7 The purpose of a Child Death 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.

8 The Panel has two distinct elements:

i. ***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.

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

9 There were 18 children in Durham and 11 in Darlington died between 1 April 2020 and 31 March 2021, which was a decrease in 3 from the previous reporting period. Neonatal deaths still account for the highest

proportion (30%), although this is a drop from the previous year of 43%. Significant areas of increase are shown as external event and suicide or self harm.

10 Between April 2020 and March 2021 there were four Child Death Overview Panels in which 43 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.

11 34 child death reviews are ongoing; 18 of which cannot be completed until other proceedings have been concluded.

12 The Child Death Review Statutory & Operational Guidance states that CDOPs should aim to review all children's deaths within six weeks of receiving all information including the results of the Coroner's Inquest. Out of 43 completed reviews, 21% were completed in less than six weeks. This has been compounded following the COVID-19 pandemic throughout 2020-21. A decision was reached that all face to face meetings would be suspended and future Child Death Overview Panel meetings would be held virtually. The Panel considers that this transition has been successful and has not impacted on the quality and discussion at the Panel meetings.

13 Reasons for those taking longer than six months to complete include 18 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.

Analysis of Key Learning

14 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.

15 The following modifiable factors and key learning points identified from the Child Death Reviews completed during 2020/21 have been condensed into the following concise bullet points to maintain the anonymity of the cases discussed:

- Smoking in the household.
- Smoking during pregnancy.
- Management of high risk pregnancies.
- Co-sleeping and parental alcohol and/or substance misuse.

Areas of Good Practice

16 There were a number of cases where it was acknowledged the support and actions taken by professionals involved with a child/young person and their parents/carers was highly commendable and was considered to be over and beyond their roles and responsibilities.

17 The role of the Rapid Response Service continues to be identified as being a highly invaluable resource, evidenced through joint investigations with the Police together with the Joint Agency Response process.

Developments During 2020/21

18 There have been a number of significant developments made during this period, all of which are detailed in the main Annual Report. A few of note are:

- A review of Sudden Unexpected Death in Infancy in families where the children are considered at risk of significant harm;
- ICON – Parental/Carer advisory programme to reduce potential traumatic head injury in infants;
- Vicarious Trauma – awareness raising for practitioners;
- Changes have been made to the CAMHS Front End Service to ensure both young people and their parents/carers' voices are heard during the assessment process.

Developments for 2021/22

19 Some of the ongoing or proposed developments for 2021/22 were as follows:

- Improved coordination of Child Death Thematic Reviews;
- Improve timescales for completion and receipt of Post Mortem Reports;

- Better oversight and control over Child Death Reviews vs Child Safeguarding Practice Reviews (formerly Serious Case Reviews);
- Awareness raising and learning - Co-Sleeping, Parental Smoking and Parental;
- Child Death Overview Panel Development Session considering themes.

Conclusion

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.

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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 implications.

Accommodation

No implications.

Risk

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

Procurement

No implications.

Appendix 2: The Child Death Review Process For County Durham and Darlington Annual Report 2020/21

Attached as a separate document.