Gateshead local safeguarding children board

Sunderland Safeguarding Children Board

South Tyneside Safeguarding Children Board

South of Tyne
Child Death Overview Panel
2016-2017
Annual report

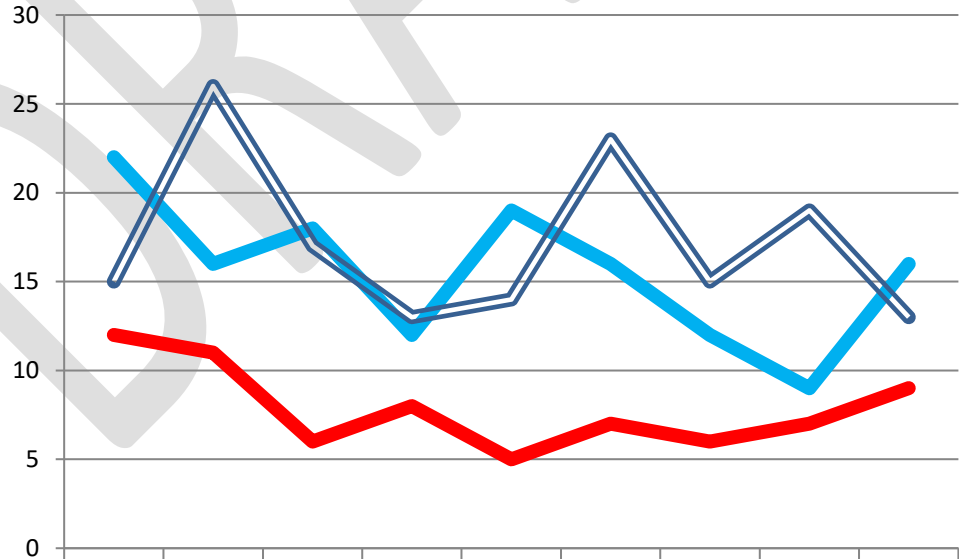
Contents

1. Introduction

The South of Tyne Child Death Overview Panel (CDOP) has undertaken its role to review the death of every child aged under 18 resident in Sunderland, Gateshead and South Tyneside on behalf of the Local Safeguarding Children Boards since April 2008. Its functions are laid out in Working Together to Safeguard Children 2015. The CDOP works to a national methodology which enables it to clarify the cause and circumstances of each child death, and hence identify whether there were modifiable factors which may have contributed to the death to ensure other siblings and the wider public are protected from similar circumstances. The process also monitors the availability of resources to support bereaved parents.

2. Number of Deaths

The South of Tyne CDOP was notified of the death of 38 children during 2016-2017, this is a slight increase on the previous two years. Year on year variation in notifications is to be expected in relatively rare events such as child deaths, small variations each year can appear to represent a big difference. In 2016-2017 there were 16 deaths in Gateshead, 13 in Sunderland and 9 in South Tyneside. These comprised of 8 expected deaths of children with known life limiting medical conditions, 17 neonatal deaths and 12 deaths that were unexpected.



	08-09	09-10	10-11	11-12	12-13	13-14	14-15	15-16	16-17
South Tyneside	12	11	6	8	5	7	6	7	9
Gateshead	22	16	18	12	19	16	12	9	16
Sunderland	15	26	17	13	14	23	15	19	13

Notifications by Local Authority of Residence

3. Number of Completed Reviews

In 2016-2017 the SoT CDOP completed the reviews of 38 deaths; this continues a pattern of increased number of completed reviews over recent years. Regionally there was also a small increase in the number of completed reviews in 2016-2017, however national data showed a decrease in the number of completed reviews.

Completed Reviews	2014-2015	2015-2016	2016-2017
SoT	33	35	38
North East	157	151	157
England	3515	3665	3575

Completed Reviews Reported to Department for Education

There were 6 CDOP meetings scheduled in 2016-2017, but one meeting was cancelled as it was not quorate. Department for Education figures for 2016-2017 state that 6 meetings was the average for CDOPs across England. The SoT CDOP averaged 8 completed reviews per meeting which is higher than the reported national average for 2016-2017.

	No Of CDOP Meetings	Average No. of Cases Completed
SoT	5	8
England Average	6	6

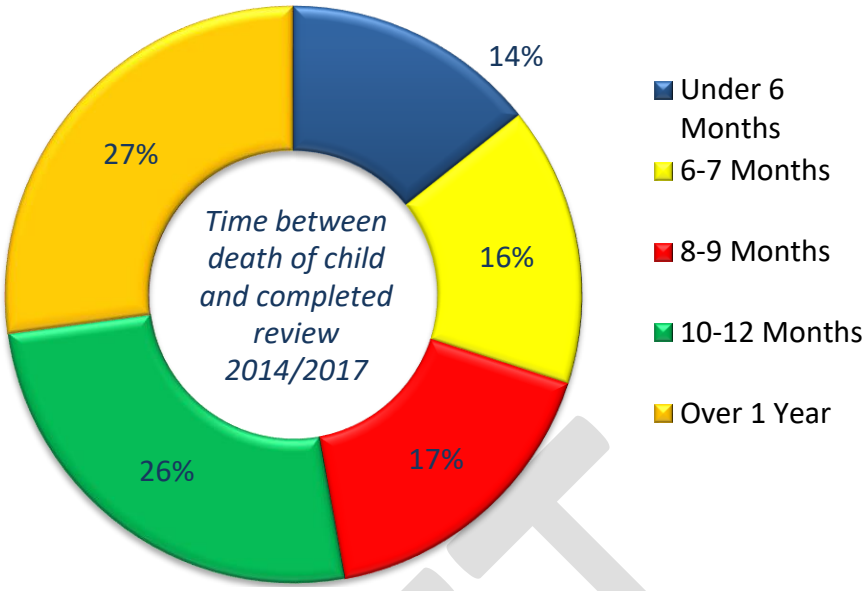
Number of Panel Meetings Held/Number of Reviews Completed

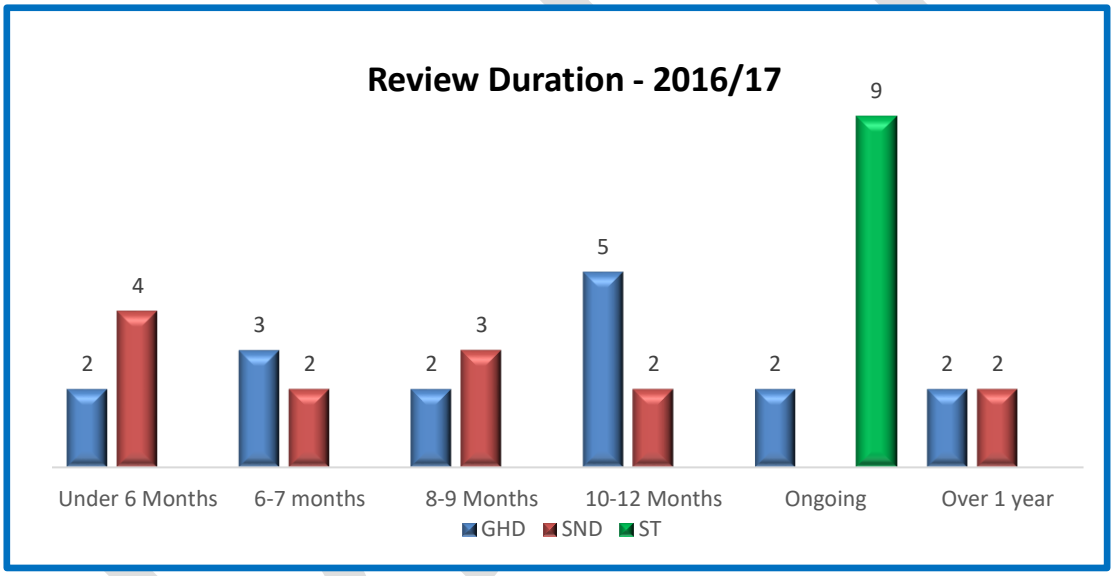
4. Duration of Reviews (2014 – 2017)

73% of reviews of deaths completed between 2014 and 2017 have been concluded within 12 months of the death. Nationally 76% of reviews were completed within 12 months of the death in 2016-2017.

During 2016/2017, 61% of reviews were completed within 12 months.

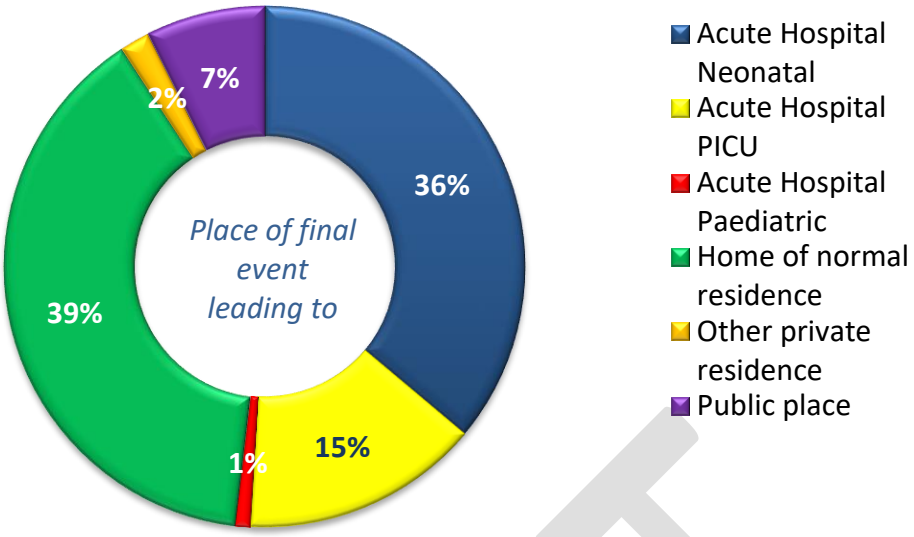
The majority of SoT cases taking over 12 months to review have been subject to parallel processes (inquests, legal proceedings, Serious Case Reviews and internal agency reviews) which have delayed their discussion at CDOP.



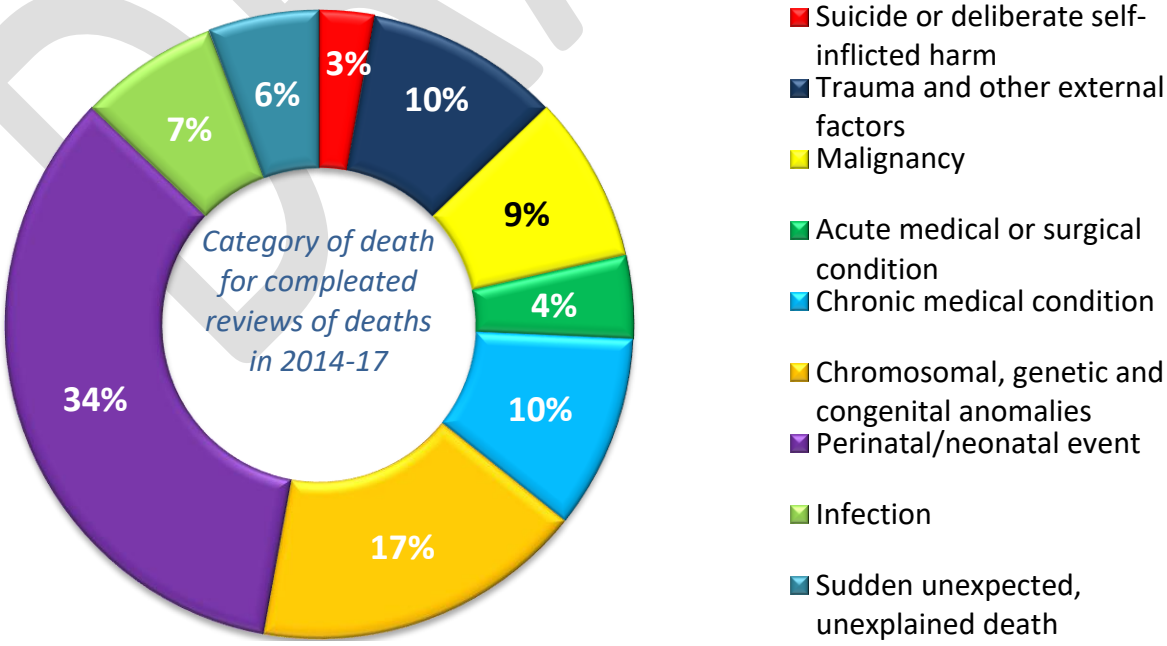


5. Circumstances of Deaths 2014-2017

Places of final event leading to the child deaths seen locally reflects those identified in regional and national findings with the largest proportions of deaths being associated with premature birth and the deaths occurring within the first 28 days of life in a hospital setting and those occurring within the home.

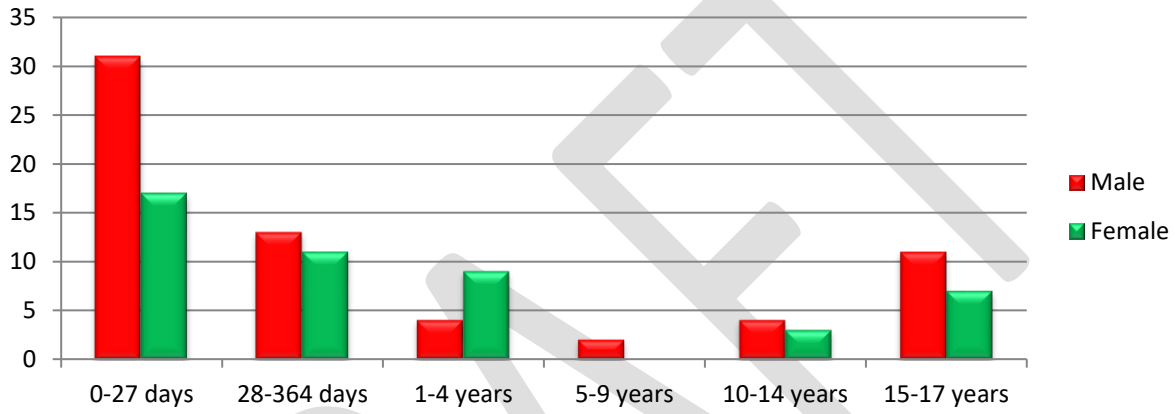


The Child Death Overview Panel is required to categorise each child death using a national standard list of categories. During 2014-2017, 34% of deaths were categorised as perinatal/neonatal events. The second most common cause was chromosomal, genetic or congenital abnormalities, with 17% of the deaths fitting into this category. Sudden unexpected, unexplained deaths (6%) continues a pattern of decreasing reported SoT rates over previous years since a peak of 16% in 2013-2014. It should be noted that the Suicide or deliberate self-inflicted harm category (3%) also includes deaths as a result of alcohol/substance misuse whether accidental or deliberate.

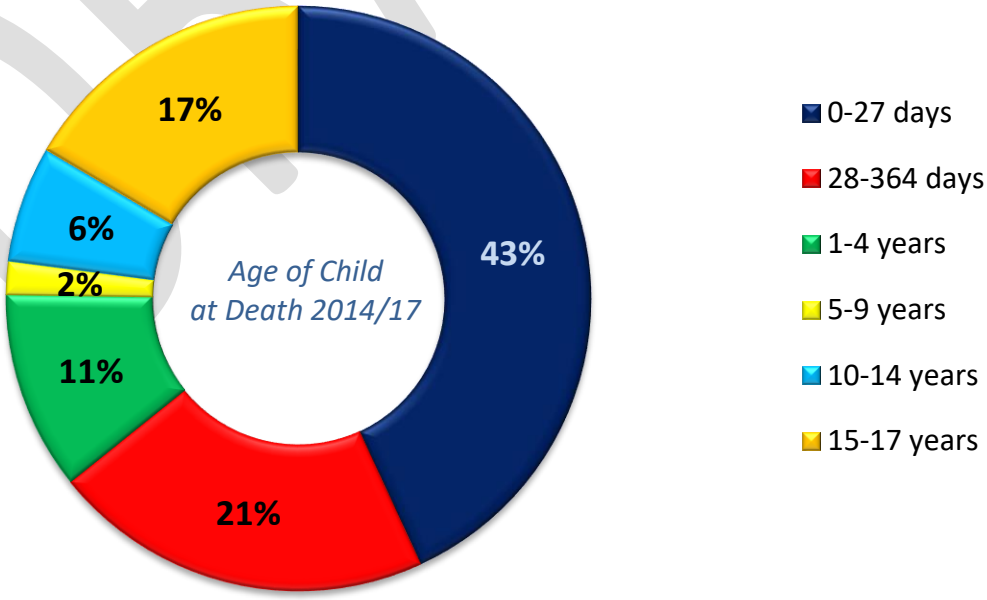


6. Characteristics 2014-2017

Most notifications (43%) were received for babies dying in the neonatal period (0-28 days). The first year of life has the highest risk, with 64% of deaths occurring during this period. Rates then decrease in mid-childhood before peeking again at ages 15-17 with 17% of deaths. It is worth noting that the age bands used do not cover equal periods of childhood e.g. 10-14 years covers a five year period and 15-17 years covers a three year period. There have been more notifications of deaths in boys (58%) than girls (42%). This mirrors national data from the child death review process, with 56% of deaths reviewed occurring in boys nationally in 2016-17. The national data shows that boys are more likely to die at all ages and from all causes.



Age/Gender of Reported Deaths 2014/2017



91% of notifications received by the SoT CDOP in 2014-16 (97% in 2016/17) were for children of White, British origin with the remaining deaths being Asian or Asian, British – Bangladeshi, Arab or Other Asian backgrounds which broadly reflects the ethnicity of the local population.

Due to small numbers, information in this section should be treated with caution.

Child Protection Plans

4% of deaths in 2014/2017 were the subject of a child protection plan at the time of their death. This is slightly higher than the 2% reported in the 2016-2017 national data.

Serious Case Reviews

A SCR was carried out for 3% of the deaths during 2014/2017, which is the same percentage as reported in the 2016/2017 national data. The majority of these reviews were still ongoing as of 31 March 2017.

7. Modifiable Factors

Since 2010 deaths have been classified as "Modifiable Factors Present" or "No Modifiable Factors Present". *Working Together to Safeguard Children* (2010) defines modifiable factors as "one or more factors, in any domain, which 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 child deaths". Due to the small number of deaths reviewed each year there will be some variation at a local level but the percentage of SoT cases with modifiable factors identified reflects those identified at a regional and national level.

Modifiable %	2014-2015	2015-2016	2016-2017
SoT	24%	17%	26%
North East	28%	18%	25%
England	24%	24%	27%

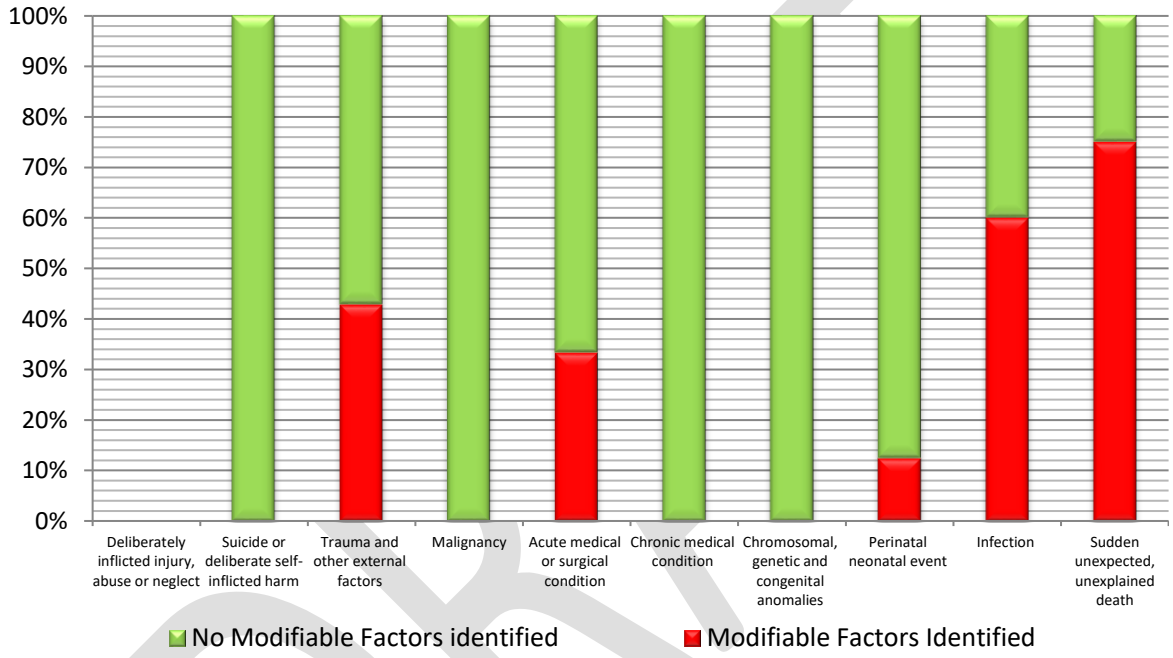
Percentage of Completed Reviews with Modifiable factors Identified

Sudden Unexpected, Unexplained Deaths continue to have the highest percentage of identified modifiable factors identified 74%, with recurring themes of co-sleeping, unsafe sleep environments (sleeping on sofa etc.) and parental consumption of alcohol. These have been subject to previous CDOP interventions, such as the "Give

me room to breathe" campaign, and the promotion of safe sleep information with parents/carers and continue to be a high priority for the CDOP partners.

Infection classification has seen an increase in modifiable factors identified to 60% with the modifiable factors identified relating to the early recognition of symptoms, the need for seeking timely medical intervention and prompt commencement of medication.

While the trauma category had 42% modifiable factors, these were spread across a wide range of ages and causes of death with no identifiable patterns or themes present.



Percentage of Reviews Completed With Modifiable Factors Identified by Category of Death 2014/17

8. Recommendations and Actions from Completed Reviews 2016-2017

- NHS Primary, Secondary and Tertiary care Services at a local and regional level – Single agency action plans have been developed to address issues identified by the Coroner during his inquest into the death of a young person with known asthma from an acute asthma attack. The young person had been diagnosed with asthma many years earlier and had been seen regularly by both secondary and tertiary services.

  The Coroner sent out his regulation request shortly after the inquest. The Coroner has a legal powers and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28 or because the power comes from

regulation 28 of the Coroners (Inquests) Regulations 2013. Subsequently, NHS Primary, Secondary and Tertiary Care examined their involvement and developed an action plan to address the issues which were monitored closely by the local child death review group. The local Hospital identified amongst other learning that they required a Doctor to take the lead on the provision for respiratory services and in early 2016, a Paediatrician commenced the one year's training.

- City Hospitals Sunderland NHS Foundation Trust have implemented changes including changes to policies about transfer of patients; Handover proformas; and policies regarding outstanding blood results.

- City Hospitals Sunderland NHS Foundation Trust - Prior to attending high risk deliveries, neonatal team should re-check resuscitaires to make sure it's working properly and the cylinders are full.

- Newcastle Hospitals NHS Foundation Trust - Discuss complex chronic pain cases the Consultant in Pain Management and other colleagues with expertise in non- medical symptom management.

- Newcastle Hospitals NHS Foundation Trust - Always consider all options to support medical treatments.

- Newcastle Hospitals NHS Foundation Trust - Health (especially PICU staff) to understand the need to work as part of a multiagency team if child is a LAC and explain all medical jargon not only to birth parents but also to SW if LA hold parental Responsibility

- Newcastle Hospitals NHS Foundation Trust - Babies at risk NOT to be discharged from hospital in absence of a pre-discharge planning meeting and adequate notice to ensure community support is in place.

- Newcastle Hospitals NHS Foundation Trust - Antibiotics should be given within an hour of the decision to prescribe.

- LSCB's - Consider local means to reinforce means of reducing risk factors associated with SUDI's.

- Gateshead Drug Death Panel - awareness raising with service providers and general public around overdose signs.

9. South of Tyne Child Death Overview Panel Business Plan 2015 – 2017

Objective/Priority		Action(s)	Responsible Person	Timescale	Progress/Outcomes	RAG Rating
1.0	**To ensure the Child Death Process across SoT fulfils its statutory functions in line with Working Together 2015**	Ensure dedicated administrative support is available to support the work of the CDOP and that this role is clearly outlined in a job description with a clear accountability framework with links to the 3 Local Safeguarding Children Boards (LSCBs)	3 LSCB Business Managers Chair CDOP	November 2015 (for 2016-17 arrangements)	CDR Coordinator post agreed till March 2017	Achieved Green
		Ensure the CDOP provides regular reports on activity to each LSCB.	Child Death Review Co-ordinator Chair CDOP	July 2016	LCDRP's have an agreed reporting arrangement to their LSCB Draft CDOP annual report shared July 2016, but not signed off by CDOP till September due to cancellation of meeting	Achieved Green

Objective/Priority		Action(s)	Responsible Person	Timescale	Progress/Outcomes	RAG Rating
		Ensure the CDOP receives regular budget updates	Gateshead Council Corporate Finance Gateshead LSCB Business Manager	September 2015	Budget now a fixed agenda item for each CDOP	Achieved Green
		To maintain effective communication and good working relationships with the Coronial System across SoT	Child Death Review Co-ordinator Chair CDOP Des Drs CDR	April 2016	Coroner's Officers invited to rapid Response meeting Coroners attended Local Sub Group meetings to discuss new SUDI guidance.	Achieved Green
		SoT CDOP Terms of Reference, including chairing arrangements, to be updated and agreed by CDOP Members	LSCB Business Managers	September 2015	TOR agreed at July 2015 meeting	Achieved Green

Objective/Priority		Action(s)	Responsible Person	Timescale	Progress/Outcomes	RAG Rating
2.0	**To collect and collate data on all child deaths in SoT and to evaluate the data on these deaths to identify lessons to be learnt or any issues of concern and ensure learning is disseminated to the public and professionals**	To ensure the notification procedures following child death are timely and ensure relevant personnel are informed	Child Death Review Co-ordinator	September 2015	Robust notification system in place across all 3 areas	Achieved Green
		Monitor out of area deaths to ensure reports/information are provided within timescales	Child Death Review Co-ordinator Chair CDOP LCDRG Chairs	April 2016	Progress of ongoing cases discussed at each LCDRG and CDOP meeting	Achieved Green
		Raise any issues of non-compliance by health providers in the statutory process with commissioners in the CCGs and Area Teams (NHS England)	Chair CDOP Designated Professionals	April 2016	Included in the ST and Sunderland Commissioning Action Plan which is shared at the Strategic Safeguarding Committee Designated Professionals have links to NHS England Quality Surveillance Group via network and Directors of Nursing & Medical Directors	Achieved Green

Objective/Priority	Action(s)	Responsible Person	Timescale	Progress/Outcomes	RAG Rating
				Training continues for all involved in the Child Death Review Process	
	Information is collated and reviewed by CDOP to identify lessons to be learned or any issues of concern:	CDOP/Local CDRG	April 2016	Cases reviewed at local child death groups and CDOP Updates to LSCBs Links well established with local Case Review Sub-committees	Achieved Green
	Give Me Room to Breathe campaign review actions to be implemented	Child Death Review Co-ordinator CDOP Chair	September 2015	GMRTB campaign discontinued as new guidance issued by WHO/UNICEF. All local advice materials and training updated in line with new guidance.	Achieved Green

Objective/Priority		Action(s)	Responsible Person	Timescale	Progress/Outcomes	RAG Rating
		Share learning regionally and nationally via the child death networks and other groups, e.g. local child accident prevention groups	Child Death Review Co-ordinator Designated Doctors CDOP Chair	April 2015	Concerns re Heated Birthing Pools share nationally via PHE Learning points from cases shared via regional Designated Doctors meetings. Information also shared with regional audits (Sepsis Deaths) and national audits (Suicides and LeDeR programme)	Achieved Green
3.0	**To ensure bereaved families receive support and continued care appropriate to their needs and that their views are represented within the Child Death Review Process**	To ensure families are provided with the SoT leaflet on the Child Death Review Process	Designated Doctors Coroner's Officers	September 2015	Rapid response and Case review meetings ensuring that a professional is identified to liaise with family.	Achieved Green
		Designated Paediatrician to inform local case discussion/rapid response of parental views or queries	Designated Doctors	Immediate		Achieved Green

Objective/Priority		Action(s)	Responsible Person	Timescale	Progress/Outcomes	RAG Rating
		Family support protocol to be reviewed and agreed within each locality	LSCB Business Managers Designated Professionals or specialist professionals	April 2016	Agreed at January 2016 CDOP	Achieved Green
		Review service provision for bereaved families and ensure any gap in provision is highlighted to the Clinical Commissioning Groups (CCGs)	CDOP Members Chair CDOP	April 2016	Bereavement support included in all case discussions	Achieved Green
4.0	**To identify and advocate for needed changes in legislation, policy and practice to promote child health and safety and to prevent child deaths**	To influence statutory guidance, policy and practice by responding to consultations and influencing local and national developments from learning across SoT	Chair CDOP	April 2016	Any publications to child death shared SoT CDOP represented at NHS England CDOP stakeholder event	Achieved Green
		To ensure policies and procedures across SoT are reviewed and updated in response to updated guidance or new legislation is this not included in the review of TOR	Chair CDOP Child Death Review Co-ordinator	April 2016	Wood report released, still awaiting new guidance from NHS England. No issues in new SUDI guidance which require	Achieved Green

Objective/Priority		Action(s)	Responsible Person	Timescale	Progress/Outcomes	RAG Rating
					any changes to local procedures	
5.0	**To ensure recommendations from Inspections are responded to in a timely effective manner**	Review arrangements in line with any recommendations from statutory inspections	Chair CDOP	April 2016		Achieved Green

The principles underlying the overview of all child deaths:

- Every child's death is a tragedy
- Learning lessons
- Joint agency working
- Positive action to safeguard and promote the welfare of children

South of Tyne Child Death Overview Panel,

Safeguarding Business Unit,

1st Floor, Civic Centre,

Regent Terrace,

Gateshead,

NE8 1HH

Tel: 0191 433 3547 Fax: 0191 4333950

email: CDOP@Gateshead.GCSX.Gov.UK