Herefordshire Safeguarding Children Board

Child Death Overview Panel

Annual Report

1st April 2015 - 31st March 2016

Introduction

Every child death is a tragedy for the child's parents, family and the community and represents suffering and unfulfilled promises. Understanding the circumstances which caused that child's death is one way to make sense of the death and may help to prevent other childhood deaths, poor health outcomes, injury or disability for other children

This has been the seventh year of operation for the Herefordshire Child Death Overview Panel, which was set up in 2008. **Chapter 5 of Working Together to Safeguard Children 2015** requires all local authorities have arrangements in place to review the deaths of all children from their area in order that:

- Information is collected and analysed about each death with a view to identifying:

    A) any case giving rise to the need for a review
    B) Any matters of concern affecting the safety and welfare of children in the area of the authority; and
    C) Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area;

- Procedures can be put in place for ensuring that there is a co-ordinated response by the Authority, their Board partners and other relevant persons to an unexpected death.

The HSCB is working closely with both regional and national partners to understand the causes of child deaths in the West Midlands and to consider how we can best safeguard and promote the health and welfare of all Herefordshire children.

Membership of the Child Death Overview Panel

This is a multi-agency panel with representatives from the following agencies:-

- Consultant, Public Health, Herefordshire Council (Chair)
- SUDIC Paediatrician, Herefordshire CCG (CDR Chair)
- Service Manager, Safeguarding, Review and Quality Assurance, Children's Wellbeing Directorate
- Designated Nurse Safeguarding Children, Herefordshire CCG
- HSCB Lead Learning & Development Officer (CDOP Co-ordinator)
- West Mercia Police
- Designated Doctor, Herefordshire CCG
- A&E Consultant, Herefordshire Wye Valley Trust
- Herefordshire Coroner's Officer
- Head of Midwifery and Nursing, Wye Valley Trust

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How we measure child death

The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate of the cause of death (and therefore is not the responsibility of the CDOP).

A child death review is completed for every child that dies in England and includes:

a. Collecting and analysing information about each death with a view to identifying:

   i. Any matters of concern affecting the safety and welfare of children in the area of the authority including any case giving rise to the need for a review.
   ii. Any general public health or safety concerns arising from deaths of such children.

b. Putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

   Most child deaths do not lead to a serious case review. A serious case review is initiated where abuse or neglect of a child is known or suspected; and

c. Either:
   i. The child has died.
   ii. The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child's welfare.

In reviewing the death of each child, the CDOP is to consider modifiable factors, for example, in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level. The CDOP submits aggregated findings from all child deaths and informs local strategic planning, including the local Joint Strategic Needs Assessment (JSNA), on how to best safeguard and promote the welfare of children in the area. Each CDOP is required to prepare an annual report of relevant information for the LSCB.

Child Death Overview Panel Meetings

CDOP meetings took place at regular intervals throughout the year. In addition the child death review panel group met on a monthly basis to ensure comprehensive timely investigating and reporting of deaths to enable prompt presentation at CDOP. Where appropriate, extraordinary meetings were held to consider additional information. Increased involvement of children's social care was felt necessary and resulted in one such extraordinary meeting. This meeting produced significant additional information to assist CDOP recommendations. With the increased involvement of children's social care during the year it became apparent that they made a positive contribution to the consideration surrounding the family and to CDOP.

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Statistical Information for 2015/2016

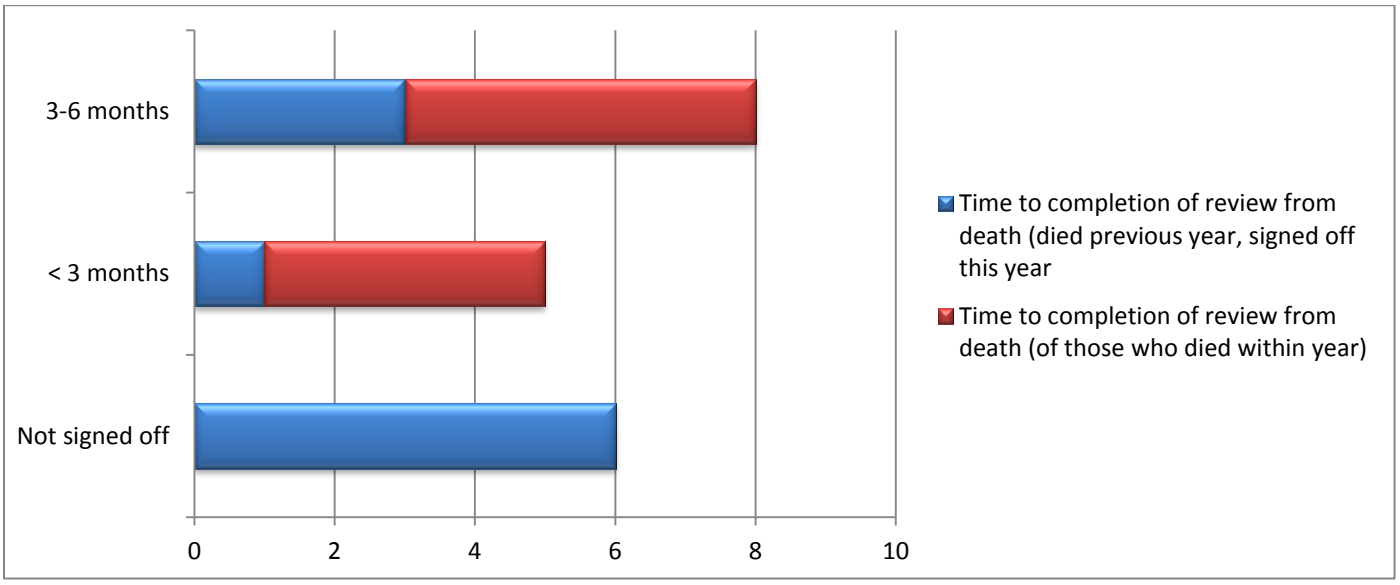
Child Deaths in Review Period

There were 14 deaths within the review period of which eight have been signed off by CDOP, two with modifiable factors. Six are still awaiting sign off and will form part of next year's Annual Report.

One death from the year 2013/14 was signed off within this review period. This death was the subject of a Serious Case Review, hence the delay. Four deaths from the period 2014 -2015 underwent sign off at CDOP within this year. Of the six from the current year that are awaiting sign off, two await post-mortem (and possibly inquest). Eight deaths which occurred in 2015/16 were successfully signed off within the six month timescale.

Deaths signed off at CDOP Between 01 April 2015 and 31 March 2015	
Number of Child Deaths which occurred between 01 April 2013 and 31 March 2014 where the review was completed between 01 April 2015 and March 2016	1
Number of Child Deaths which occurred between 01 April 2014 and 31 March 2015 where the review was completed between 01 April 2015 and March 2016	4
Number of Child Deaths which occurred between 01 April 2015 and 31 March 2016 where the review was completed between 01 April 2015 and March 2016	8
Total Deaths signed off by CDOP within reporting period	**13**

Time to completion of review from death



The majority of deaths are signed off with the statutory 6 month period. Delays are associated with prolonged investigation (RCA, Post Mortem,Inquest,etc) but also persistent delay with returns of Form B's. This is being addressed.

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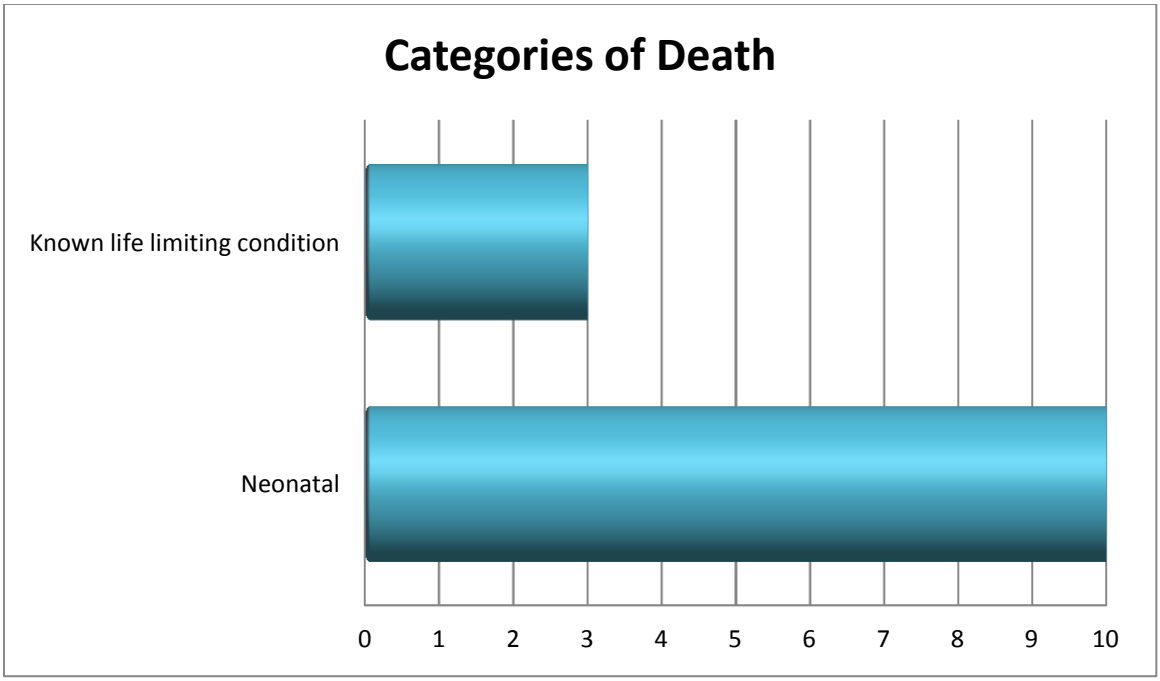
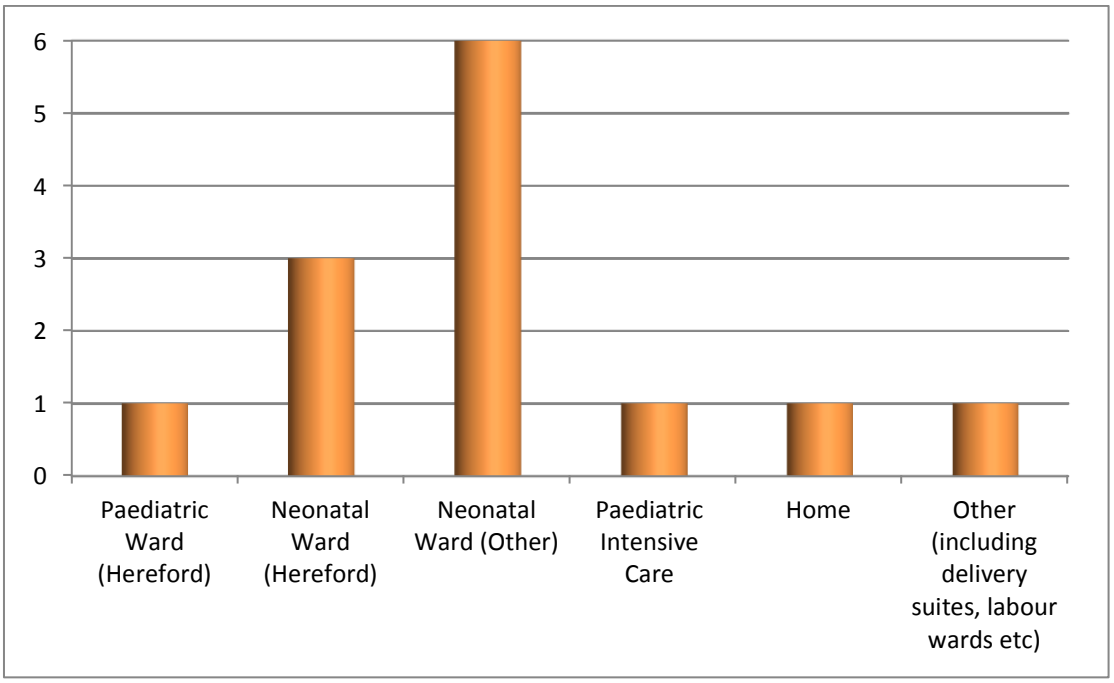


Neonatal deaths remain the most common age of death category. Six of these occurred in Neonatal units outside Herefordshire. A further breakdown is shown in the table below.

Location of Death



Six deaths occurred on a neonatal ward outside Herefordshire. Those occurring in the local neonatal unit were mostly term babies; four of the thirteen deaths were associated with a congenital problem.

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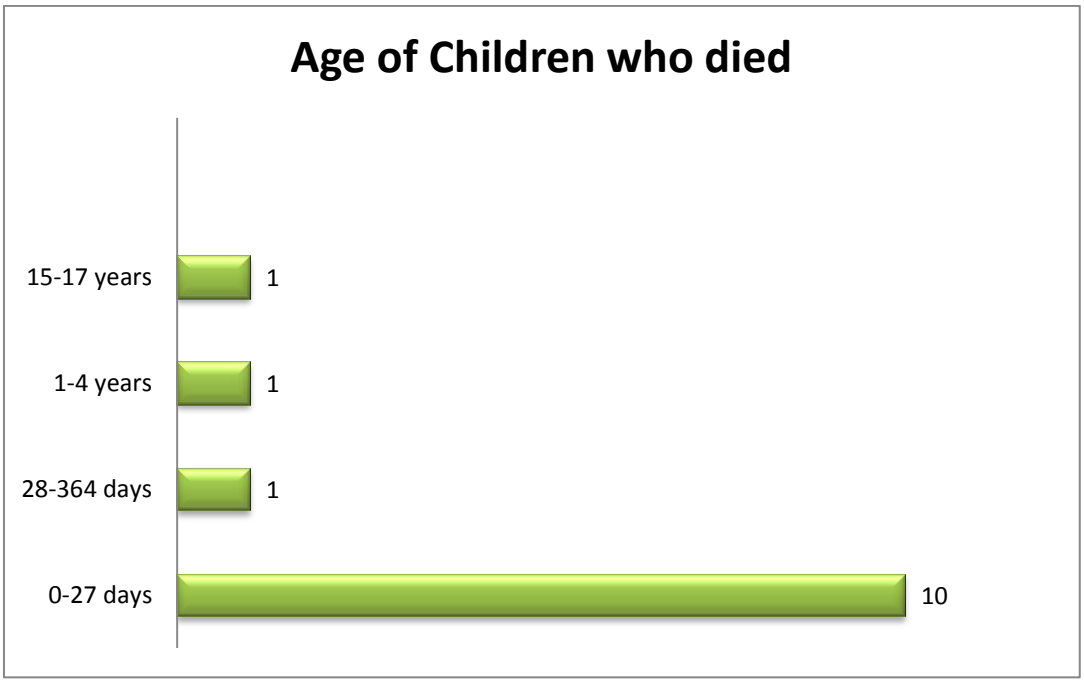
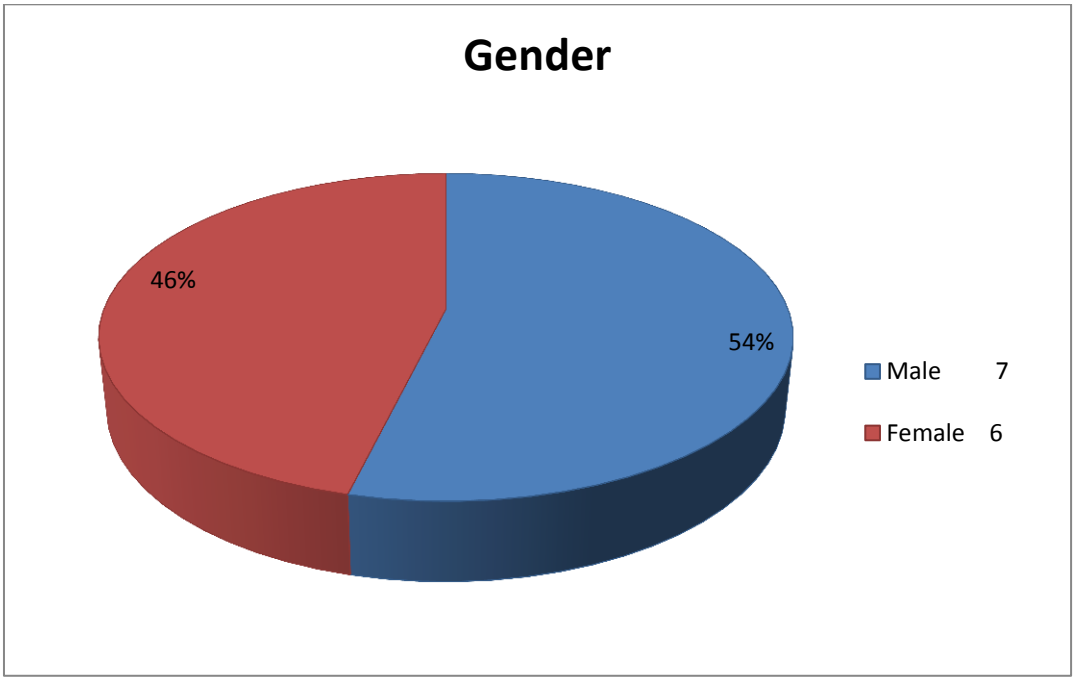


As seen previously for Herefordshire, and in line with National figures, death in infancy (particularly the neonatal period) remains the most common age of death.



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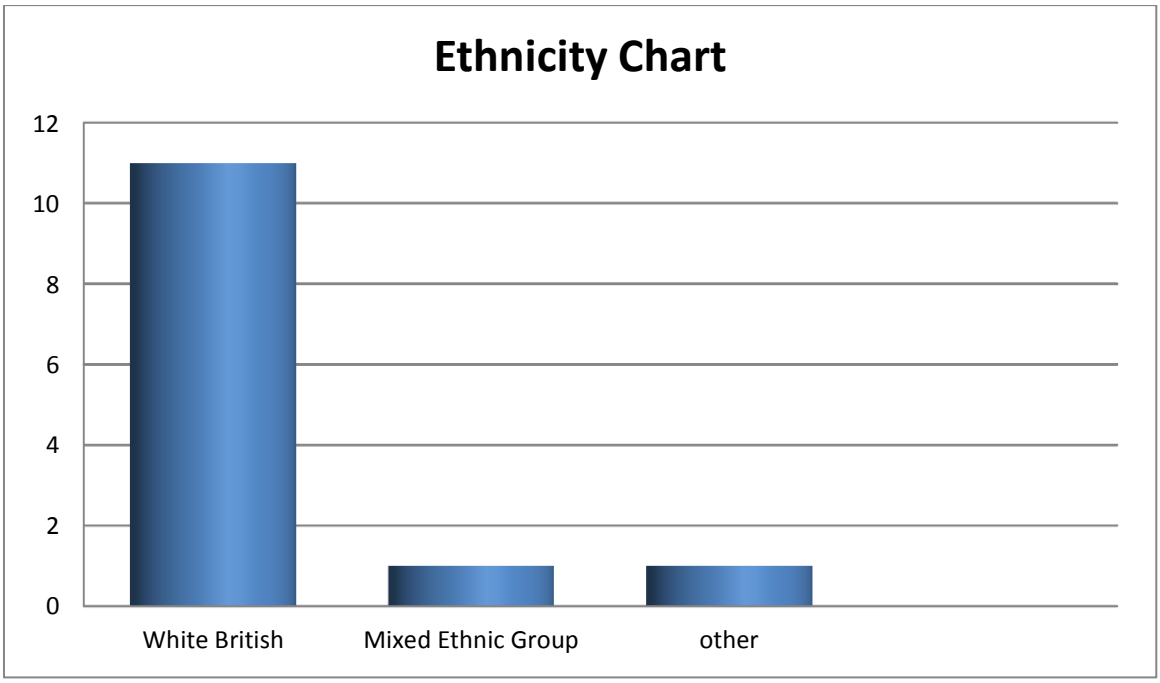

Ethnicity distribution remains predominantly white British, reflecting the Herefordshire population but with almost 2 in 10 deaths being non-white British.

This year, three deaths were identified as significant and subsequently Root Cause Analyses (RCA) were undertaken. The first death occurred in hospital where the child suffered from congenital heart disease; the second an 'accidental' hanging; where there was an enquiry into the leadership of the resuscitation team in A&E; the third following a breech delivery where the baby died. The latter two have yet to be signed off at CDOP. The former involved the availability of a cardiac bed at Birmingham Children's Hospital, however the main cause of death was agreed to have been as a result of the underlying poor condition of the baby rather than delayed transfer.

Two rapid responses were undertaken during the year. Audit forms were submitted to the LSCB Business Unit. A positive comment was made by visiting DCI whilst attending a death. They observed that the local team has a smooth, well organized, rapid response process.

There is a large body of data, currently inaccessible for interrogation nationally, or for local CDOPs to make comparisons with their peers. NHS England is funding the development of a specification for a national system to allow the collection, analysis, interpretation and benchmarked reporting at a national and local level, of the data produced locally by CDOPs.

Case Reviews

There were no Serious Case Review referrals made from CDOP during the year.

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Learning Themes

- Evidence of Advance Care plans being used to support parents and family at the time of the child's death.
- Neonatal deaths remain the most common age of death category.
- Support for families. One death highlighted the need for continuity for the family. A meeting of professionals was held following the death to discuss how best to manage the transition between inpatient care and the team involved and the wish to have end of life care at home. An advance care plan was in place for this child.
- One death was a result of an unusual cause of death - Cowpox. This unusual occurrence occurred in an immunocompromised child who had had chronic health issues and had undergone 3 separate renal transplants.
- Group B strep sepsis **-** a death associated with the group B streptococcus occurred during the year. This highlighted the continued concern over the screening for this condition which was discussed amongst panel members. The condition currently has a high national profile to reduce neonatal morbidity and morbidity - the condition is now being moved forward by BLISS, a national perinatal charity. A new method of testing for this infection during pregnancy is available privately. There is still ongoing debate and review by NICE and the Department of Health regarding the added value and cost benefit for the screening.
- The neonatal transport team from the SWMNN visited in response to one death. They highlighted deficiencies in the local process of management. They also clarified the role and responsibility of the NTS when undertaking a transfer. This was discussed at CDOP, addressed with NTS and is being taken forward by the NTS / SWMNN as a discussion point.
- One death highlighted the need to escalate information and raise awareness for all agencies who may potentially become involved in future pregnancies, particularly in a vulnerable woman. The action was in the form of a letter to the GP to highlighting the vulnerability and to promptly sharing information.

Issues Arising

Again difficulty in obtaining Form B responses in a timely fashion from several agencies. SUDIC paediatrician and the Chair of CDOP have written and spoken to professionals. The CDOP has considered the learning from this and have recommended the following:

- Professionals are made aware of their role through the development of a pathway which is on the LSCB website
- A good practice guide and sample is posted on the web to assist with understanding
- The Director of Children Services, as the accountable officer has been alerted to take the appropriate action.

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- A communication item on the CDOP agenda to agree dissemination of learning, with responsibility for this to the HSCB Communications Sub Group.
- Mortality in general is currently high on WVT profile – in addition to CDOP/CDR in-hospital deaths are undergoing internal review.

Achievements

- Membership of the CDOP continues as a stable core group.
- All recommendations and actions from the 14/15 Annual report have been implemented.
- Local and national (Bliss 2016) feedback has recommended improved engagement with families. Locally the NHS team have evidenced development an end of life individualised care plan and pathway to ensure seamless service between acute services and home.
- Form B submissions by local paediatricians was noted to be of high quality.
- DfE annual return was submitted in a timely fashion.
- Neonatal deaths continue to be considered and discussed in open multi-professional forum with feedback to the CDOP.
- Hospital Intranet details for the CDOP team and the death management documentation has been updated.
- MBRRACE reporting is 100% for WVT.

Conclusion

CDOP and CDR continues as a positive process for Herefordshire with active multi agency involvement in meetings however there is still difficulty in obtaining form B responses which will continue to be addressed.

The 13 deaths detailed in this report were signed off for annual submission to DfE. Still no trends are identifiable due to small numbers.

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