Herefordshire Safeguarding Children Board

Child Death Overview Panel

Annual Report

1st April 2016 - 31st March 2017

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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 eighth 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

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 whose parents reside 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 quarterly 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 and discussion at CDOP.

Statistical Information for 2016/2017

Child Deaths in Review Period

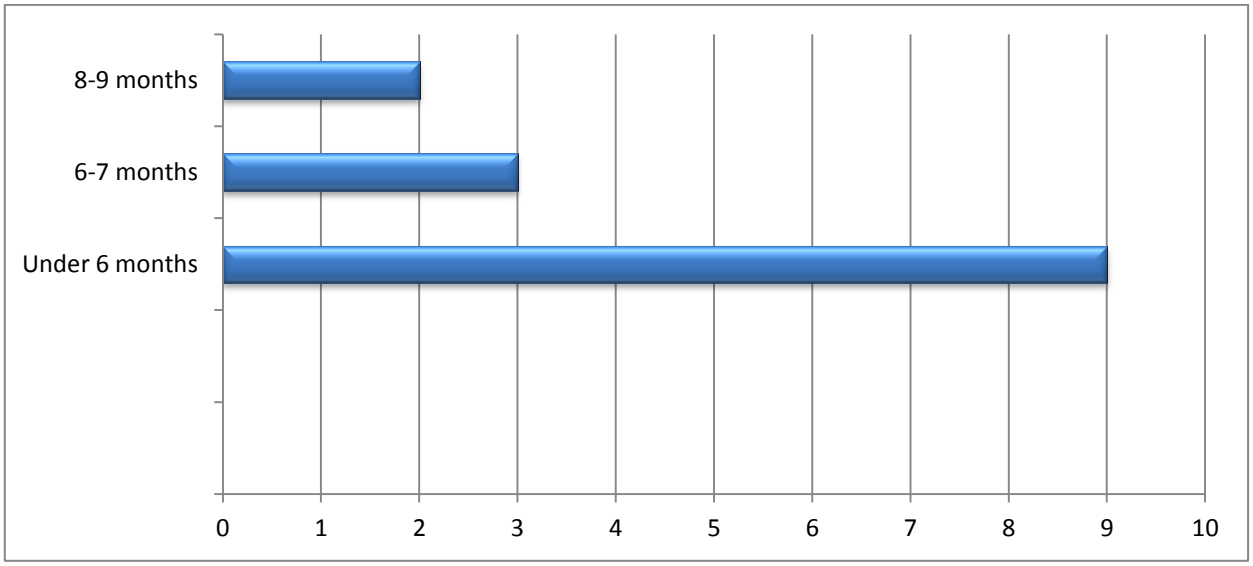
A total of eleven deaths occurred within the review period, April 2016 – March 2017, three of which are still awaiting completion of review.

There were fourteen deaths signed off at the CDOP meetings within this review period, these are the focus of the Annual Return to the DfE for Herefordshire and will also be the focus of this CDOP Annual Report.

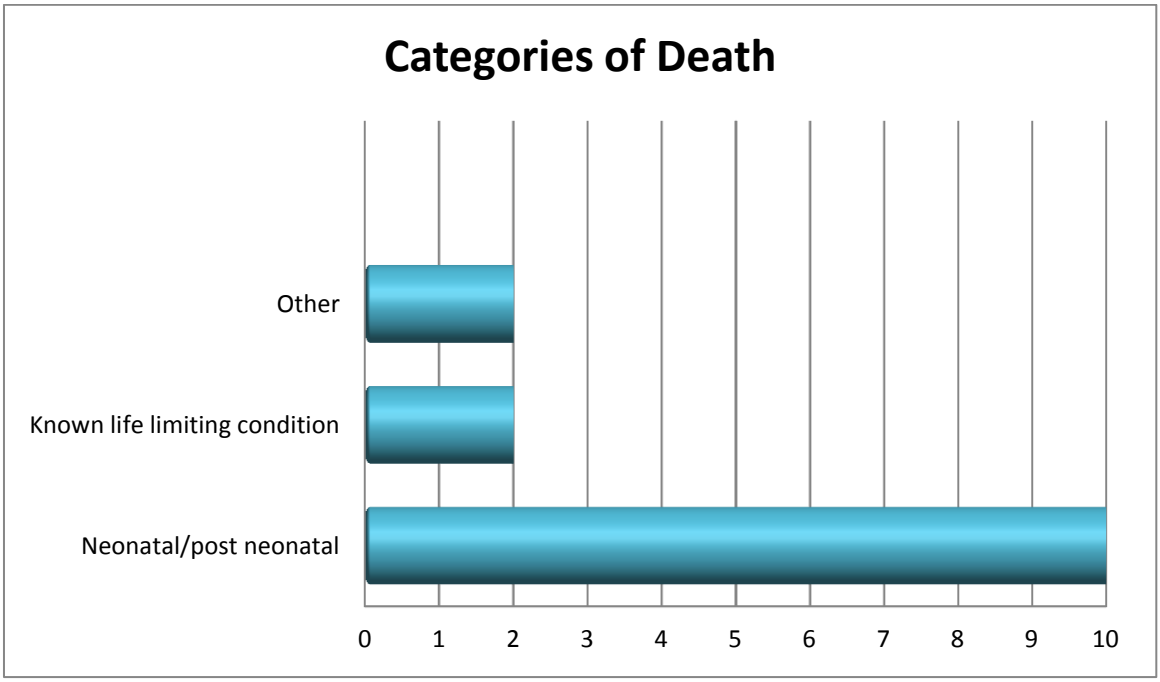
Six deaths from the period 2015 -2016 underwent sign off at CDOP within this year. Of the three from the current year that are awaiting sign off, two await post-mortem results (and possibly inquest). Eight deaths which occurred in 2016/17 were successfully signed off within the six month timescale.

Deaths signed off at CDOP Between 01 April 2016 and 31 March 2017	
Number of Child Deaths which occurred between 01 April 2015 and 31 March 2016 where the review was completed between 01 April 2016 and March 2017	6
Number of Child Deaths which occurred between 01 April 2016 and 31 March 2017 where the review was completed between 01 April 2016 and March 2017	8
Total Deaths signed off by CDOP within reporting period	**14**

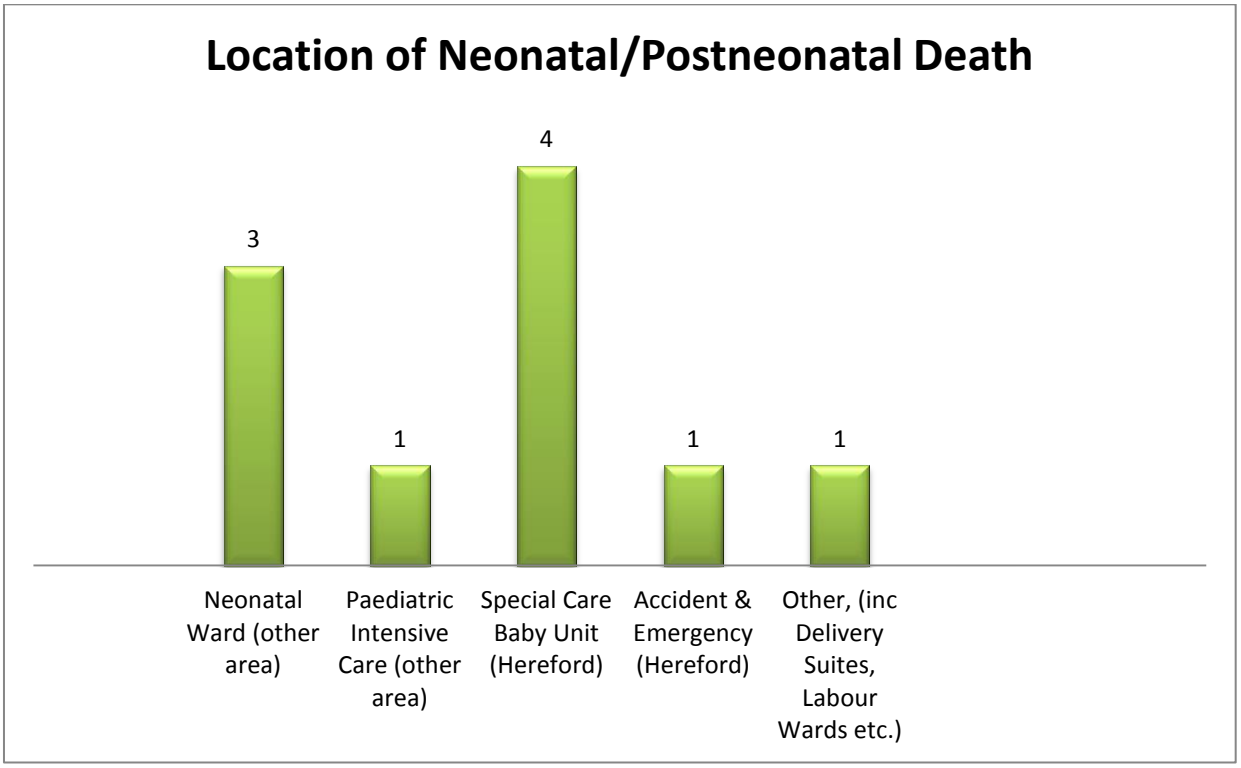
Time to completion of review from death

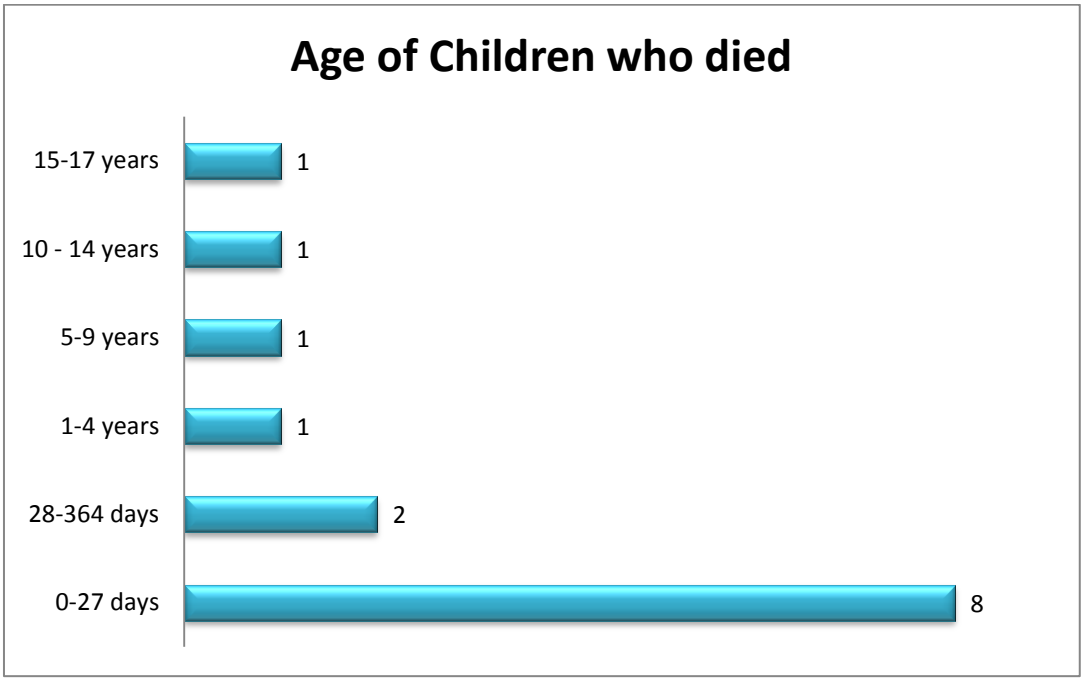


The majority of deaths were signed off within the statutory 6 month period. Delays are associated with prolonged investigation (RCA, Post Mortem, Inquest, etc) but there have also been delays with returns of Form B's. This was highlighted as an issue in last year's Annual Report, and whilst we have seen an improvement, this will remain an area of further work.



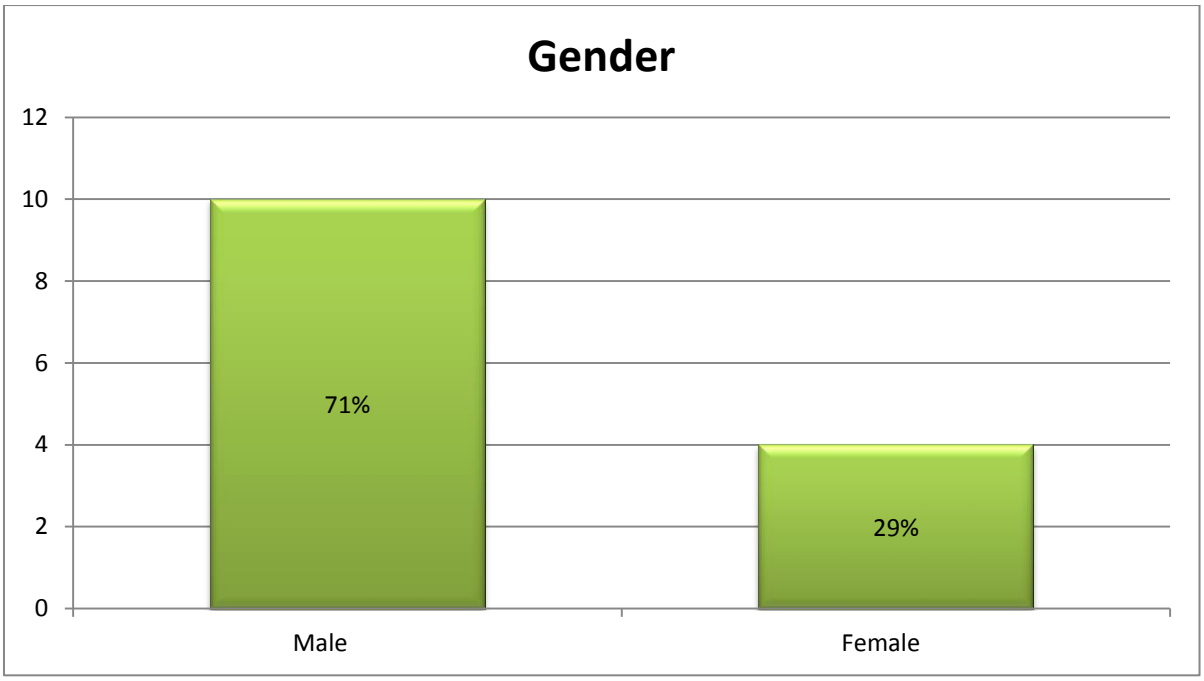
Neonatal/postneonatal deaths remain the most common age of death category. Nationally, in 2016 the neonatal rate increased by 3.7% compared to 2015.



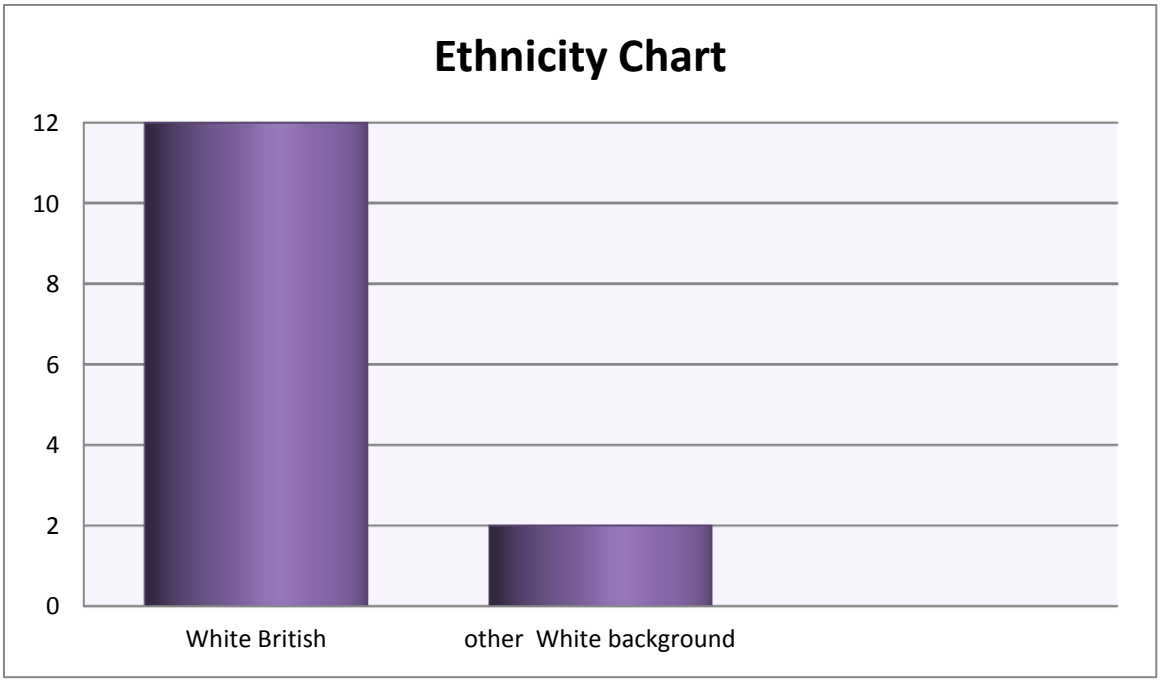


As seen previously for Herefordshire, death in infancy (particularly the neonatal period) remains the most common age of death.

Consistent with previous years, approximately two thirds of reviews completed Nationally were of children who died under the age of one; with 43% for children aged 0-27 days; and a further 21% for children aged between 28 and 364 days at the time of death.



Nationally, Boys' deaths account for over half of the deaths reviewed (56%). The panels in the year ending 31 March 2017 were only slightly more likely to identify modifiable factors in reviews of boys' deaths (28%) than in girls' deaths (27%)



Ethnicity distribution remains predominantly White British, reflecting the Herefordshire population but with 2 deaths being other White British.

Modifiable Factors

Of the deaths considered this year, three were reported as having modifiable factors. These are factors that the panel have decided may have contributed to the death but that local or national actions could have been taken to prevent that death or future deaths.

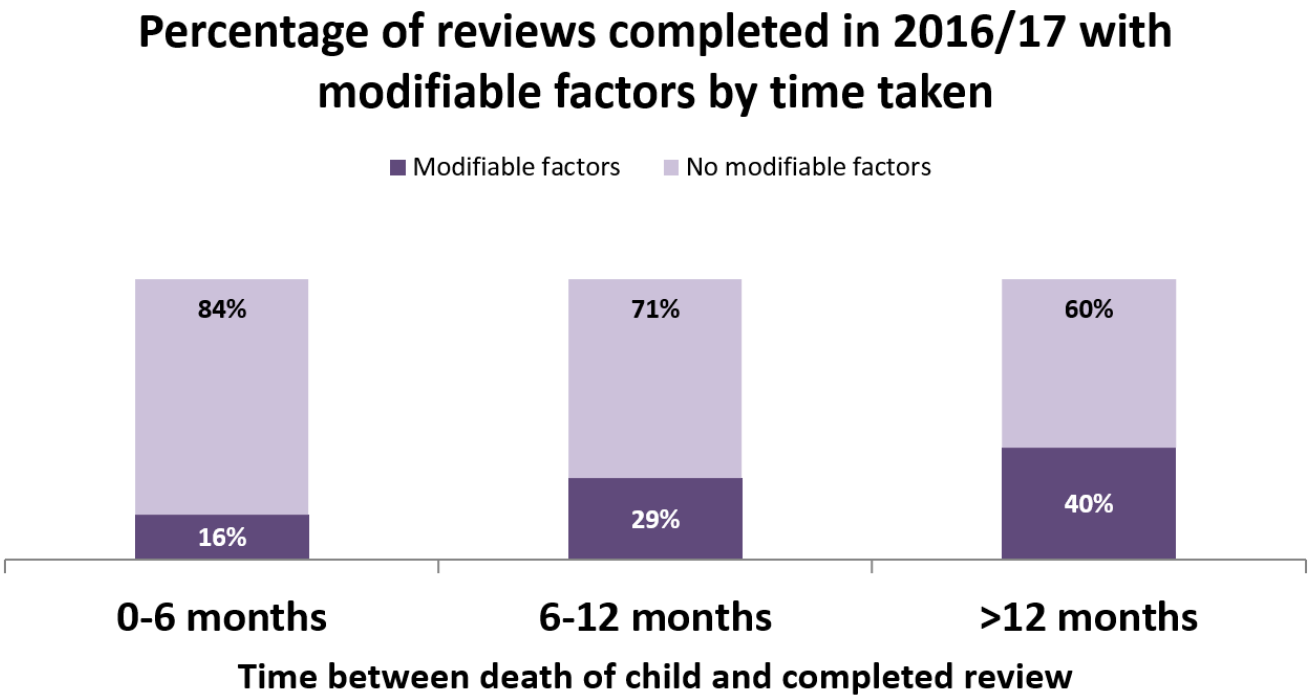
- Ensuring uptake of early ante-natal care was highlighted as a factor in one of the neonatal deaths, along with the promotion of PAUSE. PAUSE works with women who have experienced, or are at risk of, repeat removals of children from their care. It aims to break this cycle and give women the opportunity to develop new skills and responses that can help them create a more positive future. CDOP communicated with Primary Care to alert them to the possibility of a future pregnancy and being pro-active about the management of this.

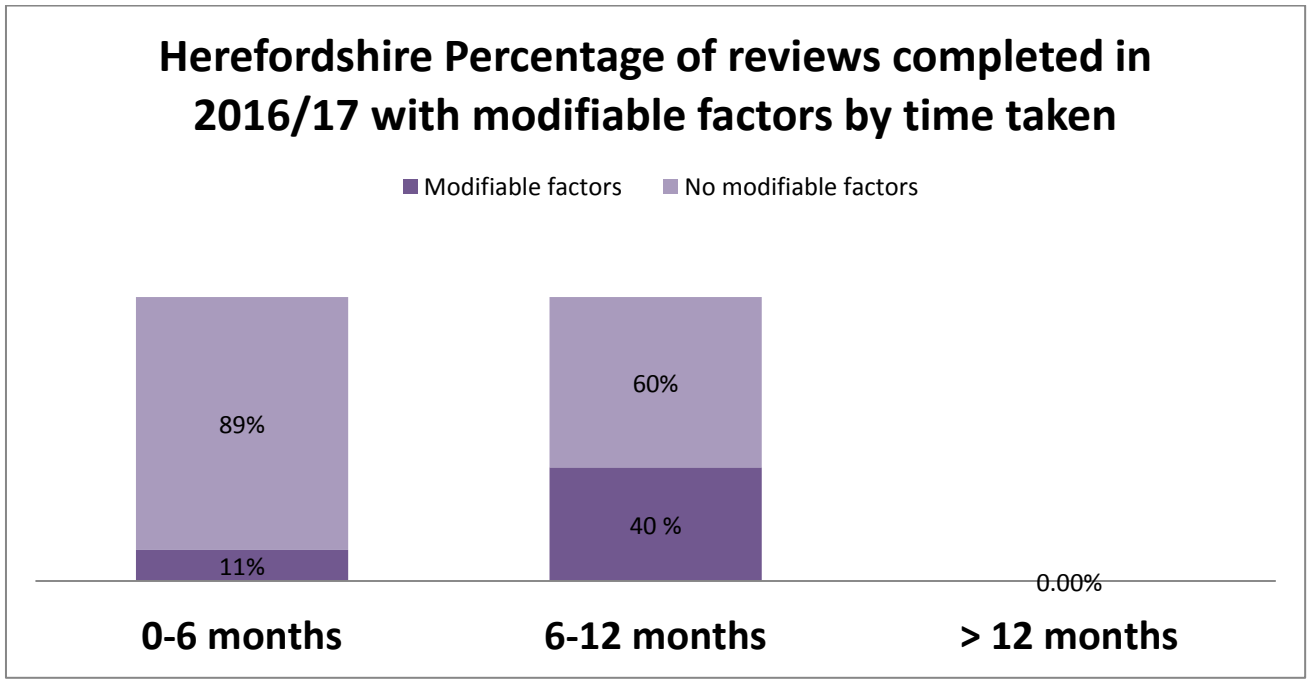
- In respect of undiagnosed breech births, it is essential for all maternity and obstetric staff to review all prior tests to gain information related to patient. An RCA was undertaken and a 10 point plan for triage has now been put into practice. Learning has been disseminated across Obstetric Services through a safety brief and all Risk and Governance meetings, Perinatal and Morbidity and Mortality Meetings.

- In respect of an accidental death, research has been undertaken into similar accidental deaths investigated within the regional CDOP's and Police. International studies were also reviewed. Advice and guidance was shared and discussed at CDOP.

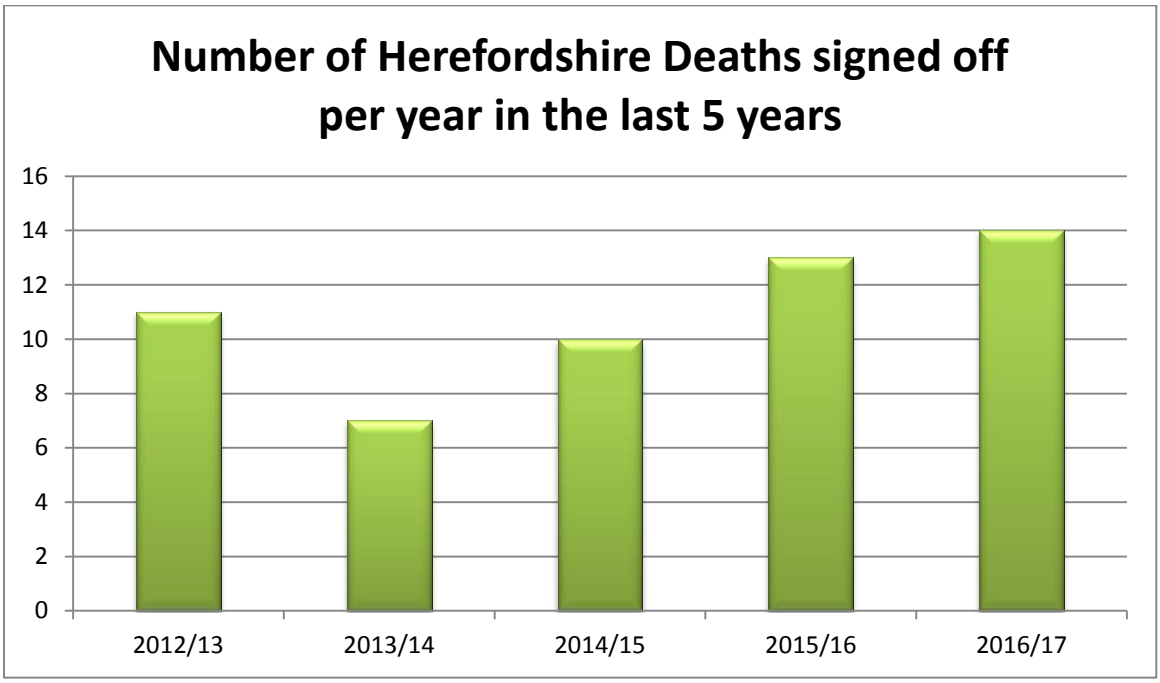
Two rapid responses were undertaken during the year for children who died at home. Neither of these deaths had modifiable factors. Rapid responses were also undertaken for two children who were confirmed dead in hospital but further information from a Rapid Response was needed due to the unexpected nature of the death. One of these deaths was thought to have a modifiable factor. It has been noted that the West Mercia SUDIC Protocol is due for review and this is being undertaken shortly.

National Percentage chart





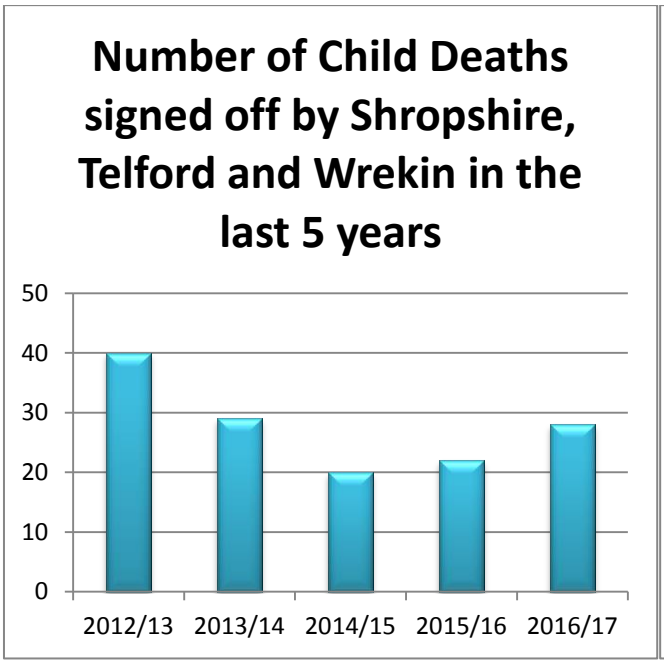
Where modifiable factors are identified, Herefordshire's CDOP achieve sign off in line with the National figures.

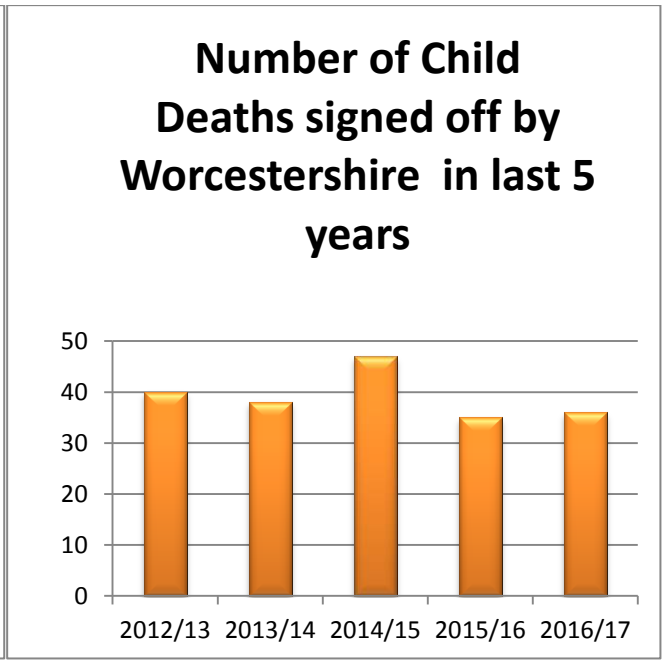


Although the numbers are small, there is a slight increase in CDOP sign offs in Herefordshire for the current year. This is partly due to the fact that 6 of the deaths signed off within this year's CDOP occurred within 2015/16. The numbers are too small to be of statistical significance, and no common themes have been identified.

Nationally, the number of child death reviews has fallen slightly in the most recent year after an increase in the previous year, however, the longer term trend is a gradually decreasing number of reviews.

However, as you will see from our regional neighbours, there has been a slight increase in 2016/17.





Case Reviews

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

Learning Themes

- Neonatal deaths remain the most common age of death category.

Issues Arising

There remains difficulty in obtaining Form B responses in a timely fashion from several agencies (this is a regional difficulty). SUDIC paediatrician and the Chair of CDOP have written and spoken to professionals. A review of the West Mercia Policy may address this issue.

- 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 15/16 Annual report have been implemented.
- 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.

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

In March 2016, The Wood Report was published, a Review of the Role and Functions of Local Safeguarding Children Boards. The Report recognises that over 80% of child deaths have a medical or public health causation, and therefore recommends that ownership of the arrangements for supporting CDOPs should move to the Department of Health. The Report also comments that child deaths should be reviewed over a population size that gives a sufficient number of deaths to be analysed for patterns, themes and trends of deaths, and refers to regionalisation or a national-regional model for CDOPs.

The Government's response to the Wood Report, published in May 2016 stated that "we intend to put in place arrangements to transfer national oversight of CDOPs from the Department for Education to the Department of Health, whilst ensuring that the keen focus on distilling and embedding learning is maintained within the necessary child protection agencies." At this time, we are still awaiting details about how this transfer will take place.