

The Child Death Review Process for North Yorkshire and York

Second Annual Report

2009-2010



Welcome

Welcome to the second annual report of The Child Death Review Process for North Yorkshire and York.

As Chair of The Child Death Overview Panel for North Yorkshire and York, I would like to welcome you to our second annual report, which covers our activity for the year April 2009 to the end of March 2010.

Child death review processes became mandatory in April 2008. Our panel is responsible for overseeing the establishment by local agencies of effective processes for Rapid Response by key professionals to unexpected deaths, and for reviewing information on all child deaths that occur in the areas of the two Local Safeguarding Children Boards (LSCB'S) in North Yorkshire and York. One LSCB covers the area of North Yorkshire County Council, and the other covers the area of City of York Council. The panel is ultimately accountable to the two LSCB Chairs.

The purpose of the panel, and the child death review processes that support the panel's work, is to learn any lessons and identify preventable factors at both national and local level, so that local and/or national action can then be taken to reduce the number of child deaths in the future.

In this year's report, attention is again drawn to the need to promote parental awareness of "Safe Sleeping" for babies and infants. In addition, a number of other issues are identified, as described in section 9 of the report, with recommendations for action set out in section 10.



Phil Kirby
Associate Director of Public Health,
North Yorkshire and York PCT (Chairperson)

Introduction

Chapter 7 of Working Together to Safeguard Children (2010) requires all local authorities to have arrangements in place to review the deaths of all the children from within that area. It sets out two distinct but interrelated processes:

- Coordinated actions by professionals following the unexpected death of a child (known as “Rapid Response”), and
- The Child Death Overview Panel – providing analysis of each death anonymously so that lessons may be learned to safeguard other children in future.

This report outlines progress made in each of these multi-agency processes noting what was achieved in 2009/10 and what further work is needed in this coming year. It collates the data that has been collected by the Child Death Overview Panel (referred to as the Panel) and highlights a small number of themes.

As well as aiming to improve the multi-agency response to the death of individual children, the overarching principle is that where there are any lessons to be learned from a child’s death, or from a recurring issue in relation to more than one death, appropriate action is taken and messages are cascaded to those who can make a difference in the future. This report therefore presents the key Panel recommendations and some of the actions that are required to implement them. A more detailed list of recommendations is contained in the companion CDOP Action Plan (2009/10).

Child death reviews are a confidential process and it is important that the identities of any of the children or their families cannot be known. All reports that go to Panel have been anonymised and Panel members remain unaware of the names of any of the children in the reports. Information then in this report is presented in such a way as identities are not revealed.

From summer 2010 there will be a mechanism for the views of parents and families to be fed into the Panel review process, although the Panel will continue to consider all cases anonymously. This move is welcomed by the LSCBs and will only add to the quality of analysis and lessons that can be learned from these tragic deaths.

Working Together to Safeguard Children was revised in April 2010 and amendments were made to the section that contains detailed guidance about the child death processes (Chapter 7). However as this report looks back over the period 2009/10, the definitions and processes in this report will refer to the original guidance set out in 2006. The difference in real terms is small and we will address the changes later in this report.

What happens when a child dies?

There are two interrelated strands to the process: The Rapid Response and the Child Death Overview Panel (CDOP).

The Rapid Response

The Rapid Response process is only relevant to those deaths that are “unexpected”, with an unexpected death being defined as;

“the death of a child (birth to 18 years, excluding babies still born), which was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death”.

Between 1st April 2009 and 31st March 2010 there were 19 deaths in our area that were unexpected, of which twelve were suitable for a Rapid Response process. The Panel agreed that the deaths of very premature babies, whilst meeting the formal definition of “unexpected”, were best managed by health services and did not warrant a full multi-agency approach of the Rapid Response. This accounts for the disparity in the numbers.

The Coroners were involved in all of the 12 cases appropriate for Rapid Response and in most there was initial information sharing coordinated by the Police and the Acute Trust Paediatrician for Sudden Unexpected Death in Infancy and Childhood (known as the SUDIC Paediatrician). Initial Case Discussions were held for many, but not all, of these deaths, bringing together other agencies with knowledge of the child and their family.

The final Rapid Response meeting, known as the Multi-Agency Case Discussion (Phase Three Meeting) happened in only two of the cases. This meeting allows professionals to meet following the final post mortem results to decide what else needs to happen to support the family or investigate the death further and to pick up lessons that may be learned. This meeting feeds back this information to the Coroner and to the CDOP Panel.

The main reason for the limited number of Phase Three Meetings is that there was no local Designated Doctor for Child Deaths until October 2009 when Dr Sally Smith was appointed to that post. Processes are now such that from February 2010 for all child deaths, subject to a Rapid Response, there should be a Phase Three Meeting, the benefits of which we anticipate will be seen in the third Annual Report.

From April 2010 the Rapid Response to each child’s case will be audited using a national proforma. Also from this date also Phase Three meetings will feedback learning points to the parents and families, if they wish this.

The Child Death Overview Panel (CDOP)

The CDOP is a multi-agency panel responsible for reviewing information on all child deaths, expected or unexpected, in North Yorkshire and York.

Who are the members of the child death overview panel?

The CDOP is chaired by Dr Phil Kirby, Associate Director of Public Health, NHS North Yorkshire and York (the PCT). Dr Kirby is a member of the North Yorkshire and City of York LSCBs but is not expected to comply with Board attendance requirements.

CDOP Membership – at 31st March 2010	
Dr Phil Kirby (Chairperson)	Associate Director of Public Health, NY&Y PCT
John Roughton	Group Manager, Children Services, City of York Council – represents City of York Education Service.
Nick O'Brien	General Manager, Children's Social Care, North Yorkshire County Council
Dr Kate Ward	Designated Doctor for Child Protection – North Yorkshire LSCB
Dr Robin Ball	Designated Doctor for Child Protection – City of York LSCB
Dr Sally Smith	Designated Doctor for Child Deaths – NY&Y PCT
Alan Critchlow	Principal Education Social Worker, North Yorkshire Education Service
Vacancy	Representative of Community and Mental Health Services – NY&Y PCT
Joe Cocker	Safeguarding Manager, City of York LSCB
Anne McMorris	Safeguarding Manager, North Yorkshire LSCB
Superintendent Lewis Raw	Head of Major and Specialist Crime, North Yorkshire Police
CDOP Officers	
Liz Carr	Policy Officer, North Yorkshire LSCB
Angela Stringer	CDOP Administrator, North Yorkshire LSCB

Attendance at panel meetings

The attendance of core members since the Panel's inception has been high. Panel members are expected to attend at least three out of every four meetings with the exception of the two Designated Doctors for Child Protection for whom the expectation is that at least one of them will be present at each meeting.

Attendance at CDOP Meetings - Of 7 meetings in 2009-10		
	North Yorkshire	City of York
Chairperson	7	
LSCB Manager	2	3
Social Care	5	5
Education	5	(Represented by CSC)
Police	4	
Designated Doctors for LSCBs	All 7 meetings were covered equally	
PCT	7	
Designated Doctor for Child Deaths	4 (out of 4 possible)	
LSCB Staff	7	

From April 2010 it is required that CDOP maintains and publishes a register of attendance. The LSCBs have job descriptions which all agency representatives are required to follow and which will be monitored through reports to the respective LSCB Executive Groups.

A representative of midwifery services will be sought to join the Panel for 2010-11.

Collecting the data: An Overview

Number of child deaths occurring in 2008/9 and 2009/10

Table One: Number of child deaths		
	Number of notifications of child deaths occurring between 1st April 2008 and 31st March 2009.	Number of notifications of deaths occurring between 1st April 2009 and 31 March 2010
City of York	15	19
North Yorkshire	35	27
	50	46

Table one shows that overall numbers of child deaths were similar between the two years that CDOP has been established. Notifications in North Yorkshire have reduced by 22% and have increased in York by 25%, however with such small figures it is unlikely that this has significance.

Child Deaths in North Yorkshire and York (2001-2005)

Table Two: Number of child deaths in North Yorkshire and York over the five years from 2001 to 2005						
Age band	2001	2002	2003	2004	2005	Total
<28 days	14	13	11	21	24	83
28 days to <1	3	9	7	9	13	41
1-4	12	12	5	7	5	41
5-9	4	4	4	2	0	14
10-14	4	9	3	4	4	24
15-17	9	13	8	7	1	38
Total	46	60	38	50	47	241

Source: ONS annual deaths extract

Table Two shows figures for the five years between 2001-05. During this period, the annual numbers of child deaths lie within a range of 38 to 60, with an average of 48 child deaths per year. It is notable that the figures for 2008/9 and 2009/10 are very similar.

About the Child Death Overview Panel meetings...

Whilst there were 46 child deaths for the year 2009/10 in the area, the national data collection is concerned only with those cases that have been reviewed by the Panel within this time scale. In brief;

- Between April 2009 and March 2010 there were seven Panel meetings.
- Thirty-nine cases were reviewed at these seven Panels.
- There were four children's deaths from 2008/9 that at the end of March 2010 have yet to come to Panel. One of these children was subject to Serious Case Review, one awaited an inquest outcome and two were in further investigation processes.
- Of the 46 child deaths reported to CDOP in 2009/10, 23 cases were reviewed at Panels in this year.

About the figures...

It is important to understand the judgements that Panels are required to make about whether or not a child's death may have been prevented.

Firstly, Panels will review each case brought before it to consider:

- Any factors contributing to the death,
- Classification of the death, and
- Lessons to be learnt from the death or from patterns of similar deaths in the area.

A case review form is used to facilitate this discussion. This form remains anonymous with a unique identifier but no identifiable information. For each death the Panel classifies the cause of death, makes a decision as to the preventability of the death, identifies any modifiable factors and considers any recommendations that may be made about actions which could be taken to prevent such deaths in the future.

The criteria provided by the DCSF for Panel to categorise the death are:

- **"Preventable"** = Identifiable failures in the child's direct care by any agency, including parents; organisational, systemic or other indirect failure(s) within one or more agency
- **"Potentially preventable"** = Potentially modifiable factors extrinsic to the child
- **"Not preventable"** = Death caused by intrinsic or extrinsic factors, with no identified modifiable factors

(There is also a facility to state "inadequate information to make a judgement" but this was not required in Panels meeting in either 2008/9 or 2009/10).

Please note that the categories indicate whether or not there are factors that may have prevented the death. They should not imply blame by any individual.

Facts and Figures from 2009 - 2010

Table Three: Category of death for child death reviews completed by CDOP between 1 April 2009 and 31 March 2010

Table Three: Category of death and classification by Panel, 2009/10			
	Number of preventable child deaths recorded under this category of deaths	Number of potentially preventable child deaths recorded under this category of deaths	Number of not preventable child deaths recorded under this category of deaths
Deliberately inflicted injury, abuse or neglect	0	0	0
Suicide or deliberate self-inflicted harm	1	0	0
Trauma and other external factors	1	2	0
Malignancy	0	0	1
Acute medical or surgical condition	0	0	2
Chronic medical condition	0	0	0
Chromosomal, genetic and congenital anomalies	0	1	11
Perinatal/neonatal event	1	2	10
Infection	0	1	2
Sudden unexplained, unexpected death	0	4	0
Unknown category	0	0	0
Total	3	10	26

Table Three indicates clearly that most (64%) of the deaths reviewed were from “chromosomal, genetic and congenital abnormalities” (31%) or were “perinatal or neo-natal events” (33%). Only four of the 25 deaths in these two categories were considered at Panel to be preventable or potentially preventable.

There were four deaths that were categorised as “Sudden unexplained deaths” - all were classified as SIDS (Sudden Unexpected Death in Infancy). This aspect is discussed later in of this report.



Table Four: Events which caused child deaths occurring between 1 April 2009 and 31 March 2010

Table Four: Events which caused child deaths between 2009/10			
	Number of preventable child deaths where this event was known to have occurred	Number of potentially preventable child deaths where this event was known to have occurred	Number of not preventable child deaths where this event was known to have occurred
Neonatal death	0	2	10
Known life-limiting conditions	0	1	11
Sudden unexpected death in infancy (SIDS)	0	4	0
Road traffic accident/collision	0	1	1
Drowning	0	0	0
Fire and burns	0	0	0
Poisoning	0	0	0
Other non-intentional injury/accident/trauma	1	1	0
Substance misuse	1	0	0
Apparent suicide	0	0	0
Apparent homicide	0	0	0
Other	1	1	4
Total	3	10	26

Table Four provides further categorisation of child deaths as requested for national data collection. This shows that the three preventable deaths fell into the categories of “non intentional injury/ accident/trauma”, “substance misuse” and “other”.

All four deaths from Sudden Unexpected Death in Infancy (SIDS) have been categorised as potentially preventable, with some of the factors identified by Panel leading to changes in public health messages locally.

Table Five: Ages of children and categorisation of their death

Table Five: Ages of children and categorisation of their death			
	Number of preventable deaths	Number of potentially preventable deaths	Number of not preventable deaths
0-27 days	1	3	15
28-364 days	0	4	3
1 year-4 years	1	1	3
5-9 years	0	0	1
10-14 years	0	0	3
15-17 years	1	2	1
Unknown	0	0	0
Total	3	10	26

Table Five reflects that the majority of deaths considered were of children under one year of age (26 deaths, 67%), with 19 (49%) being under one month old. There were 6 deaths of children between one year and ten years (15%) and 7 deaths of young people over ten (18%). This age profile of child deaths is mirrored throughout all child death data nationally.

Table Six: Gender of children

Table Six: Gender of child deaths			
	Number of preventable deaths	Number of potentially preventable deaths	Number of not preventable deaths
Male	2	6	18
Female	1	4	8
Total	3	10	26

Table six shows that there are twice as many deaths of boys (26) as of girls (13), with the difference being significant, especially in deaths that were not preventable. This is reflected nationally with more deaths of boys prematurely and in their first month.

Additionally

- There were no children subject to a Child Protection Plan at the time of their death or previously.
- There were no children subject to statutory orders per se.

Which staff are involved in the process?

Paediatricians: Designated Doctor for Child Deaths and UDIC Paediatricians

Dr Sally Smith, a Consultant Paediatrician at York District Hospital was appointed as the Designated Doctor for Child Deaths in October 2009. This enabled multi-agency case discussions to take place for children who had died unexpectedly, once their final post mortem results were known. This post is pivotal to successful responses to managing children's deaths, bringing key professionals together to review a child's death and see if there are lessons to be learned at that stage.

Early responses to unexpected deaths are coordinated through the five acute hospitals in North Yorkshire and York by Sudden Unexpected Death in Infancy and Childhood (SUDIC) Paediatricians. These lead Paediatricians are:

Dr Ian Cannings – Harrogate Hospital

Dr Robin Ball – York Hospital

Dr Kate Ward – Airedale Hospital

Dr Deiter Dammann/ Dr John James – The Friarage Hospital, Northallerton, and

Dr Udupa Venkatesh – Scarborough Hospital.

Local Authorities

Unfortunately both the CDOP Administrator and Manager posts became vacant in June 2009. Panel processes have been managed since this time by Angela Stringer and Heather Pearce (temporary Administrators) with Liz Carr, LSCB Policy Officer from the North Yorkshire LSCB team office in Northallerton. Following a staffing review, it has been agreed to employ a full time Business Support Officer for CDOP. This post would undertake all the day to day work needed for the Panel with support from the LSCB Policy Officer and Designated Doctor for Child Deaths. Recruitment is underway for this temporary post with central government funding to March 2011.

Primary Care Trust (PCT)

The PCT had originally funded two part-time posts to collect and collate reports to CDOP from their staff. These posts ceased in March 2010 and thanks are extended to Wendy Atkinson who developed these processes within the PCT. There is a review in the PCT of how reports from health professionals will be collected and how health services will be represented on the Panel.

Training for staff involved in the process

Training courses, with supporting materials, were designed by the Department for Children, Schools and Families for staff involved in the processes and Panels. A full days training has been rolled out in May/June 2010 in Scarborough, Harrogate, Northallerton and York and training is being planned for Craven later in this year. These courses have brought together professionals working with Rapid Response to look at systems that are in place and strengthen multi-agency working relationships. The feedback from delegates on these courses has been positive.

Further introductory training was cancelled in 2009/10 as there was no take up of these courses. It is planned for the LSCBs to include this information in events they organise to disseminate lessons learned through Serious Case Reviews and other learning processes.

Budgets

The child death process saw an allocation of grants from the DCSF for three years to March 2011 to the two local authorities for the CDOP functions and to the PCT for the Rapid Response processes. The budgets of North Yorkshire and York LSCBs have been pooled to allow recruitment of staff to administer CDOP.

Links with other CDOPs

CDOPs are linked nationally and regionally in several ways. The Regional CDOP Administrators continue to meet independently in Leeds. There is regular email communication between the different CDOPs and a recent regional training event in bereavement issues for parents. The Regional Government Office has coordinated meetings for CDOP Chairpersons.

Katy Garrett, DCSF has been helpful in supporting any queries re the national processes with staff in Warwickshire continuing to offer training and coordinate national data.

The Child Accident Prevention Trust (CAPT) have held two regional seminars to help CDOPs apply learning to actions. Both have been attended by North Yorkshire and York CDOP staff.

CDOP staff from East Riding have observed a Panel meeting and it is intended that we reciprocate.



Learning Lessons: Key Learning Points

Any recommendations made by CDOP will be directed at interventions that could help prevent future child deaths or improve the safety of children at a local, regional or national level. The Panel does not normally make direct recommendations in respect of individual case management.

Teenagers and learning to take risk

Adolescence is a time when all young people learn about the world they live in and venture out on their own or with their friends. They increasingly make decisions about what to share with those who care for them and when to share it. The handful of teenage deaths in North Yorkshire and York do not lend themselves to any trends.

However Panel members felt it would be helpful to reinforce for those working with young people that teenagers are vulnerable when they are out and about and that they often do not ask for help when it is needed. Boys appeared to be more at risk than girls. Specific issues raised included:

- MP3 players and similar devices may reduce awareness of teenagers to risks of road traffic.
- Health “drop in” Services within schools need to be assessed for their effectiveness and for their capacity within the schools.

Safe Sleeping for babies

The issue of “safe-sleeping” of infants has been prominent in both years that the Panel has been operating, especially when compounded by alcohol, drugs and smoking.

Between the two years from April 2008 to March 2010, there were 9 deaths where the sleeping arrangements for the infants appeared to be an important factor in their deaths. Of these deaths:

- Four were babies and one a toddler sharing the parental bed
- Three babies were asleep either with a parent on a sofa or in a bed made up for them in an easy chair
- Only one of the babies was put to sleep in their own cot at that time

- In seven of the nine families, one or both parents smoked. Most of the parents reported restricting smoking to outdoors or in rooms away from the baby
- Six of the mothers had smoked in pregnancy
- Of the nine babies, three were sleeping whilst in the care of their father and a further three whilst with both parents. Two were in the care of their mothers. Only one of the babies was in their own cot.
- Parents had been drinking in four of the ten cases – albeit reported small quantities in two of the cases
- Housing was a serious issue in three of the cases with families staying in temporary accommodation or with friends
- None of the babies were premature. One infant however was not gaining weight as would be expected.

The Panel felt that the factors noted above were similar to those highlighted nationally for SIDS. Panel noted that fathers were present in eight of the deaths, and that this highlighted the need to consider how effectively the current public health messages about safe sleeping are targeted at fathers.

Smoking and Pregnancy

- The known link between mothers smoking in pregnancy and SIDS appears to be reflected in the analysis of local infant deaths.

Issue of Prematurity

- The issue of prematurity has been raised, including definitions of viability between 21 and 24 weeks. In particular, these deaths are classified as “unexpected” as they could not have been predicted 24 hours in advance, yet the chances of survival are minimal.

Bereavement Services

- Counselling and Bereavement support is available in some areas but it is uncertain how consistently this is available across the whole of North Yorkshire and York and how this is offered to families.

Congenital abnormalities

- Whilst congenital abnormality accounts for a high number of deaths in the area, the Panel found no links between any of the deaths or trends that would warrant further investigation. Each death was quite individual.

Childhood Accidents

- Often a theme in Panels, accidents in North Yorkshire to children are few and far between. Indeed only one of the 39 deaths considered at Panel was caused by a childhood accident. Individual actions were taken by agencies at the time to prevent future such deaths.

Service Issues

- Communication between Neonatal Units out of area and community health staff could improve in some areas.
- Communication between Health Visitors, GP's and Midwives needs to be addressed in some cases.
- In several cases the family would have benefitted from support at a Common Assessment Framework (CAF) level. Agencies could be more aware of the benefits of CAF when Children's Social Care is unable to offer a service.

Rapid Response Processes

Rapid Response processes are still developing in our area with agencies sometimes still uncertain about how responses should be made following an unexpected death.

Where there have been difficulties these are largely recognised and individual agencies are then working to improve their services and joint working. CDOP processes have been a good channel for these discussions.

Where face to face agency meetings are held shortly after the child's death, the feedback is that responses are more coordinated in the weeks that follow. This is especially so with older children who may attend school and where the needs of their wider community should be considered.

Similarly where a multi-agency meeting has taken place, agencies have opportunity to debrief and reflect on practices together.

Post Mortem Reports and Inquests

The timeliness of post mortems and post mortem reports has been noted as a key factor in delays in investigations. Sometimes this is due to timing of inquests and release of information by the Coroner but a general shortage of available Paediatric Pathologist input has been noted.

Quality of Reports to CDOP

The quality of reports to CDOP has been variable with many report writers providing limited information. Where agencies who know the child or family well have provided detail over and above that asked for in the national reporting forms, the quality of the Panel analysis has been enhanced. The quality of post mortem reports is commended.

Clarification

Despite the Multi-Agency nature of CDOP, issues sometimes arose that required further clarification, e.g. Services available to new migrants.

Recommendations made by the panel

Recommendations from CDOP are now being followed up through the steering group and an overview of progress is kept by the LSCBs performance groups.

The key recommendations are:

- **Raise awareness of parents to safe sleeping practices with infants.**

In June 2010 for Child Safety Week the PCT with the LSCBs lead a campaign directed at those working with young families to promote safe sleeping. This included press releases, distribution of room thermometers to all new parents, and posters and leaflets to display in doctors surgeries and other places frequented by new parents. Training is to be provided for staff in October 2010 by the Foundation for the Study of Infant Deaths (FSID).

- **Need to raise awareness of teenage boys to seek medical attention/ other help when they have health concerns, e.g. personal health issues or after risky behaviour.**

Practice sheets for teachers and youth workers to be designed and circulated to agencies to bring home these child safety messages.

- **Awareness raise re drug & alcohol issues amongst young people and how this impacts upon those who are parents.**

A young persons drug worker will advise the CDOP in any future drug related deaths of young people and steps will be taken to promote safety messages to young people where friends are taking drugs/alcohol and help is needed.

- **Raise awareness of professionals to the impact of parental substance misuse.**

Practice guidance about parental substance misuse is available on the LSCB websites and is key to the Drug and Alcohol Action Teams' (DAATs) strategies for the area.

- **Raise awareness that whilst younger infants should use car seats for car travel, they should not spend unnecessary time in them.**

This became one of the key messages for Child Safety Week promoted by the LSCBs.

- **Further awareness is needed re the dangers of shaking and rough handling of babies.**

NSPCC publicity on shaken babies remains relevant and will be promoted in work with new parents.

- **Education to young people re dangers on the road whilst listening to music – this is also an issue regionally.**

Safety messages for teenagers to be circulated to youth workers and teachers.

- **All agencies should be aware of need to work alongside those families who do not readily engage with professionals.**

Practice Guidance has been published on the LSCB website for all staff and their first line managers.

- **All front line staff working with families should encourage them to register with a GP.**

Awareness to be promoted via relevant training and line-management mechanisms.

- **Practice Guidance would be helpful for those working with bereaved families to include the needs of a child's siblings for support as well as the parents and wider family.**

Work to be undertaken with hospices and LSCBs to design short, accessible guide for staff.

Forward Planning

And some targets for the next year:

- To bring the views and comments of parents and carers into the case reviews undertaken by the Panel.
- To explore working with the local leisure industry to promote child safety messages.
- To take a child safety road show with key messages to staff working across all parts of North Yorkshire and York.
- To develop practical guidance for staff in respect of supporting bereaved families
- Develop protocols with all of the neighbouring authorities in relation to CDOP and Rapid Response processes.



This report was compiled by the CDOP team.

They can be contacted at:

Room SB 109
South Block
County Hall
Racecourse Lane
Northallerton
North Yorkshire
DL7 8AE

Telephone: (01609) 534446 or (01609) 535182 or (01609) 536909

If you would like this information in another language or format such as Braille, large print or audio, please ask us.

Tel: 01609 532917 E-mail: communications@northyorks.gov.uk

