



LOCAL SAFEGUARDING
CHILDREN BOARD
NORTHAMPTONSHIRE

Local Safeguarding Children Board Northamptonshire

Child Death Review Annual Report

April 1st 2010 – March 31st 2011

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Introduction

The Local Safeguarding Children Board Northamptonshire (LSCBN) established the Child Death Review process in April 2008. This was done to fulfil the recommendations of the Kennedy Report (2004), provisions of the Children Act 2004 and Working Together to Safeguard Children (2010) that the deaths of all children up to the age of 18 years be reviewed by the Local Safeguarding Children Board.

Child Death Review Process

The child death review process consists of a rapid response following sudden and unexpected deaths (defined as death that was not considered as a significant possibility in the preceding 24 hours) and a later review of all childhood deaths by the Child Death Review (CDR) Committee.

The rapid response follows the protocol published by the LSCBN which is based upon statutory guidance contained within Working Together to Safeguard Children (2010) as well as guidance published by the Department for Children Schools and Families (now part of the Department for Education).

The rapid response details arrangements for the transfer of the child's body to the local A+E department with early joint management of the death by police and paediatric services including early contact with social services teams to discover if there had been involvement with the family. As soon as practical on that or the next working day the responsible police officer contacts the lead paediatrician for child death review in order to agree next steps in the response. This will include a decision on a joint home visit involving the police and lead paediatrician, a review of known information and agreement on the timing of an initial professionals meeting. Not all sudden and unexpected deaths will result in an initial professionals meeting if early review of the case suggests it is unlikely to add significantly to case management (this is most usually in cases such as road traffic accidents or deaths from recognised severe infections – information about these deaths will be reviewed as part of the work of the CDR committee – below).

The initial professionals meeting is typically held on the third day after the death and includes representatives of all agencies working with the child and family or involved in the management of the death. This meeting reviews all of the available information about the case and the record of the meeting is used to inform both the Coroner and pathologist if a post mortem is taking place. As part of the agenda of all initial meetings a decision is made as to whether the death should be referred for consideration of a Serious Case Review or any other review.

A final professionals meeting is held for all deaths for which an initial professionals meeting was held and all professionals attending the first meeting are again invited. The meeting reviews the final post-mortem report

and any other new information before analysing the death using a protocol issued by the Department for Education. This analysis is passed to the CDR Committee in order to inform the final analysis carried out by that group.

The review process is overseen by the Child Death Review (CDR) Committee. The committee is chaired by Teresa DeVito from Services for Children, Young People and Families.

The CDR Committee includes representatives of Northamptonshire County Council (Children and Young People's Service), NHS Northamptonshire, Northamptonshire Police, Northamptonshire Fire and Rescue, East Midlands Ambulance Service, Kettering General Hospital Foundation NHS Trust and Northampton General Hospital NHS Trust.

The CDR Committee reviews the death of every child in Northamptonshire using information gathered from agencies working the child and family through use of the Department for Education data collection forms. This information is summarised for the Committee and presented by the lead paediatrician together with the completed analysis from the final professionals meeting where appropriate. The CDR committee considers each death and conducts an analysis of the death using the Department for Education analysis proforma.

The CDR Committee has met on 4 occasions in 2010-11. The final meeting of 2010-11 was postponed due to an OFSTED inspection and was held very early in 2011-12.

Resources for Child Death Review Process

In 2008 the Government announced additional funding over the period 2008/09 to 2010/11 for Local Authorities and Primary Care Trust to support the new statutory child death review processes.

Within Northamptonshire, the Local Authority funds of £73,000 support the Child Death overview panel and costs of a co-ordinator employed for 27.5 hrs per week, who co-ordinates the work of the child death review team.

Funding to the PCT of £95,000 was provided to support health professionals delivering their statutory roles. The funding in 2010/11 was used for:

- 5 designated sessions of a Consultant Paediatrician to advise on and lead the delivery of the child death review process (£58,992)
- the immediate response for unexpected deaths through paediatricians that provide 24hr immediate response within hospitals for unexpected deaths through their baseline contract.

Future resourcing

The PCT has not received any funding for 2011/12 for the Child Death Review process though statutory duties remain.

In November 2010, the service specification and job roles of the lead paediatrician and co-ordinator were reviewed and revised to ensure the most effective and efficient use of funding. This was in consultation with the post holders and resulted in revising the job plan to reflect the capacity and activity required for the role.

The revised service specification for 2011/12 maintained funding for 5 sessions for the lead paediatrician but specified 3 of the sessions were designated for the Child death review process. The remaining 2 sessions were to be worked flexibly across child death review and child protection medicals. This recognises the varying pressures within both these areas and enabled a flexible approach to make best use of resources

The outcome of this review was presented to the LSCBN.

Activities and progress

During the year there were no changes to the team and the working pattern continued as in previous years.

The bereavement pack for families has continued to be used widely and positive feedback has been received from parents and families. The pack includes information for parents about the child death review process and invites them to submit comments or questions to be considered within the review. This is in keeping with recommendations in the revised edition of Working Together. The pack is given to parents by relevant professionals and was presented at the LSCBN Conference on 21 May 2010, as an example of innovation and positive practice. Copies can be obtained from the CDR office.

Membership of an East of England network of CDR teams has continued with valuable interchange of views. Additionally we participate in a national electronic network, which allows CDR teams to exchange views and ideas through e-mails. Comments and feedback have been provided to DCSF consultations and to the revision of Working Together.

Following the General Election in May 2010 Department for Children, Schools and Families was absorbed into the Department for Education. This has not changed the reporting requirements or pathways to date.

8 early strategy meetings have been held in which information is exchanged and plans agreed for both the investigation of the death and care of the family.

Additionally we have held 2 final review meetings which have allowed the professionals involved with family to review all available facts about the death, to consider any learning points, both about good practice and areas for improvement and also to agree a clear approach to any outstanding needs of the family. The discussions at these meetings have also informed the CDR Committee in its work. We also held 1 final review meeting for a child who died in late 2009-10 and will be scheduling 5 final review meetings for children who died late in 2010-11 and for whom we are awaiting final post-mortem or other information.

Education sessions have been held by the lead paediatrician for groups of paediatricians, A+E staff and community nurses. The sessions have included both trainees and career grade staff and have been held in Kettering, Northampton and community settings. Agreements are in place to deliver regular sessions to teams in both acute provider trusts. Additionally a meeting has been held with staff from the Police Child Abuse Investigation Unit

Summary of Childhood Deaths

The deaths of 47 children aged less than 18 years of age between 1st April 2010 and 31st March 2011 were notified to the child death review office. Of these deaths, 17 children normally resident in Northamptonshire died outside of the county. The usual reason for deaths occurring out of county was that the child was receiving specialist care (neonatal or paediatric intensive care) that could not be provided in county, 1 child died in an accident whilst on holiday in the UK, this death will be reviewed in the area in which the death occurred.

Age at death 2010 -11 (CEMACH ranges):

Age	Male	Female	Total
0 – 28 days	15	5	20
Under 1 year	8	3	11
1 – 4 years	2	0	2
5 – 15 years	5	5	10
16 – 18 years	3	1	4
	33	14	47

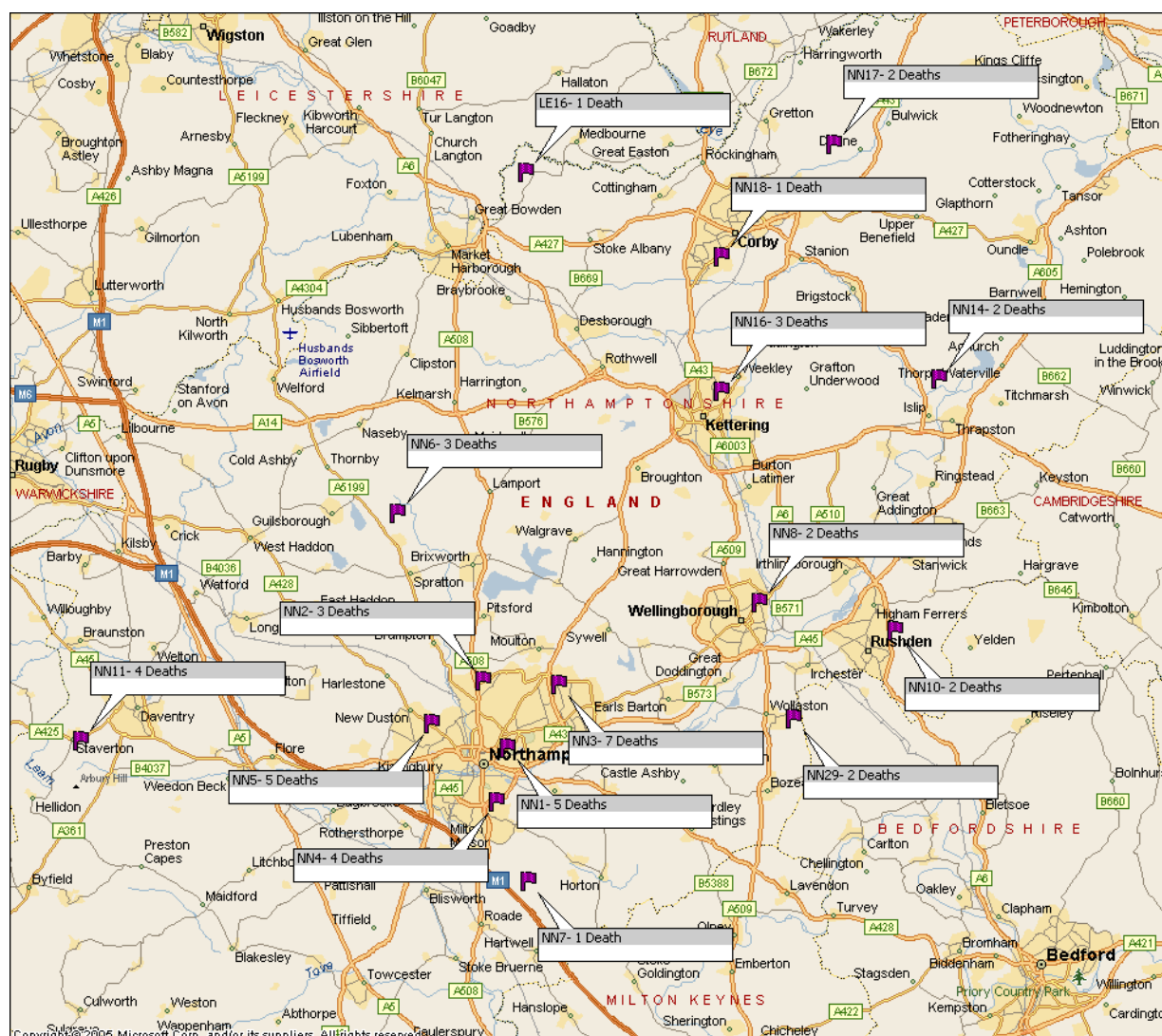
33 of the deaths were males and 14 females (ratio 2.35:1)

The total number of childhood deaths occurring for children normally resident in Northamptonshire in 2010-11 was 47 compared with 51 in 2009-10 and 46 in 2008-09. This is fewer than in previous calendar years:

Childhood deaths (0-17 years) in Northamptonshire

2003	2004	2005	2006	2007
77	81	58	66	68

Deaths have been reported from all postcode districts in the county apart from NN9, NN12 and NN13 as well as one neighbouring county postcode where the child lived in Northamptonshire. No obvious clusters have been observed.



Expected and Unexpected deaths

A death is classified as expected when it is felt to have been a significant possibility during the preceding 24 hours, but not necessarily predicted; an example would be a child with advanced cancer for whom death was

inevitable although the exact timing was not predictable. An unexpected death is classified as one that occurs without having been regarded as a significant possibility within the previous 24 hours an example would be a child dying in a road accident.

16 deaths were felt to be unexpected whilst 31 were felt to be expected. Further analysis of the cause of death and other comments are given for those deaths that have been reviewed by the CDR Committee.

Deaths Reviewed by the CDR Committee

19 deaths from 2010-11 have, so far, been reviewed by the CDR Committee. Additionally 15 deaths from 2009-10 and 1 death from 2008-09 were reviewed during this year. The most common reason for delayed review is the delay before receipt of a final post-mortem report for sudden and unexpected deaths and also some instances of other inquiries such as criminal investigations or examination of sudden untoward incidents. One death from 2008-09 has yet to be reviewed as the serious case review has yet to be published.

The discussion refers to deaths from 2010-11, figures from 2009-10 are provided for comparison.

Age distribution 2010 – 11 (deaths reviewed by CDR):

Age	Expected Deaths	Unexpected Deaths	Number
0 – 28 days	11	0	11
Under 1 year	1	1	2
1 – 5 years	1	0	1
5 – 15 years	2	1	3
16 – 18 years	0	2	2
Total	15	4	19

Age distribution 2009 – 10:

Age	Expected Deaths	Unexpected Deaths	Number
0 – 28 days	26	1	27
Under 1 year	3	3	6
1 – 5 years	3	5	8
5 – 15 years	1	6	7
16 – 18 years	0	1	1
Total	33	16	49

Although 51 children normally resident in Northamptonshire died in 2009-10, 2 of these deaths related to infants delivered as part of a therapeutic termination

who showed signs of life and were therefore registered as live births, in accordance with national guidelines these deaths were not reviewed

The CDR Committee analysed each death in accordance with the process recommended by the DCSF that is itself based on the CEMACH pilot study (Why Children Die, 2008). The process is detailed on the DFE website.

Each death was considered with a judgement made as to whether there were factors contributing to the death from 4 domains. The domains were:

- a) Factors intrinsic to the child (*such as known health needs, behavioural problems etc*).
- b) Factors in the parenting capacity (*ability to provide basic care in a number of areas*).
- c) Factors in family and environment (*family functioning, drug use, community support etc*).
- d) Factors in relation to service delivery.

The factors discussed in the above domains were then used as the basis of a judgement on cause of death against a 10 point categorisation and also for a judgement as to whether the death was preventable or potentially so.

Expected Deaths

<u>Cause of Death</u>	<u>2009-10</u>	<u>2010-11 (to date)</u>
Prematurity (and complications)	22	11
Cardiac	5	0
Neuro-developmental	2	0
Oncology	1	2
Congenital abnormalities	5	2
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Total	35	15

For all of the expected child deaths factors intrinsic to the child provided a complete and sufficient explanation for the death of the child. All of the expected deaths were not felt to have had any modifiable factors apart from one death due to cardiac causes. In this case neonatal screening had failed to detect the significant cardiac abnormality and discussions were held with both paediatric units in the county about measures that could be taken to improve the effectiveness of screening arrangements.

Unexpected Deaths

16 unexpected deaths have occurred, 4 of which have so far been reviewed by the CDR Committee. As mentioned above, in the majority of cases, review has been delayed by the need to await the final post-mortem report, but delay in individual cases has been due to criminal proceedings or other review processes that are still underway. In 2010 -11, 7 unexpected deaths occurred in the final 3 months of the reporting year.

<u>Cause of Death</u>	<u>2009-10</u>	<u>2009-10 (to date)</u>
SUDI / SIDS*	4	0
Infection	5	1
Road accidents	4	1
Cardiac	2	2
Epilepsy	1	0
Accident	0	0
Homicide	0	0
Suicide	0	0
Fire	0	0
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Total	16	4

* SUDI is Sudden and Unexpected Death in Infancy, this includes deaths for which a cause is established and those for whom no cause is found. SIDS is Sudden Infant Death Syndrome and includes only those SUDI deaths for which no cause is established after a detailed post-mortem examination.

For the 4 unexpected deaths analysed so far 2 were due to out of hospital cardiac arrest – one secondary to infection and one during exercise. There were a further 2 deaths due to out of hospital cardiac arrest both occurring during exercise. In none of these cases was there felt to have been a previously detectable cause and it was felt that appropriate first aid and resuscitation attempts had been made.

The death due to epilepsy occurred whilst the child was overseas; unfortunately it has not been possible to obtain any further details.

The death due to a road accident occurred to a young driver and it was felt the modifiable factors related to training and speed were present. Similar issues were identified in those deaths from 2009-10 reviewed during this year.

Analysis of a death in a neighbouring area revealed a number of issues about management of severe acute illness within hospital and in particular issues of monitoring and communication. These issues and subsequent recommendations were shared with the clinical managers of the local paediatric departments by the lead paediatrician and assurances have been received that the relevant recommendations have been implemented locally with an early warning system now in place.

Review of Last Year's Plans

It continues to be the case that few home visits have been performed during this year but the main reason for this is that many of the unexpected deaths occurred in settings or circumstances in which earlier multi-agency discussions agreed that a home visit was unlikely to add to information or bereavement care. All unexpected deaths are discussed with the lead paediatrician as soon as possible and a plan for management is agreed. We have held an increased number of early professionals meetings. There does remain a challenge in providing a timely response to those deaths occurring out of normal working hours.

There has been an active programme of teaching and training delivered to a variety of agencies and staff groups. This has been well received and will be continued.

Information has been provided on a regular basis to the Department for Education. The annual report on child death reviews published by the Department of Education showed that Northamptonshire performs above the national average for time taken for completion of reviews.

With changes in arrangements following the election there have been no further meeting with GOEM / DCSF. The lead paediatrician has attended further training run on child death review and bereavement support for families as well as a day on transitional arrangements in end of life planning run by East Midlands SHA.

Discussion

The child death review process has generally continued to work well within Northamptonshire. Although links with the Registrar for Births and Deaths have been established and for a period notifications were received there has been a recent reduction in information received.

There has again been evidence that end of life planning has worked well for a number of children with known life limiting conditions and this was discussed in a training session for community children's nurses by the lead paediatrician.

We continue to see a pleasingly low number of infants dying suddenly and unexpectedly from unknown causes (SIDS). Preliminary analysis of these deaths continues to show the presence of known risk factors such as parental smoking or possible overheating. Case discussions however have confirmed that these issues are being discussed with mothers by midwives after the birth.

We have seen fewer deaths from road traffic accidents and again no clear pattern within these deaths has been seen either in terms of location or underlying cause; it is therefore difficult to recommend any specific measures.

Deaths from out of hospital cardiac arrest have again been seen in young people at low frequency. No detectable or preventable factors have been found in any of the deaths and no form of screening would have been of benefit. There was evidence of good first aid in a number of these cases and no evidence that access to advanced techniques such as defibrillators would have made any difference to outcome.

One death reviewed was of a child who died after cardiac procedures in Oxford. This death was reviewed as part of the Oxford Cardiac Services Review and this review was discussed by Northamptonshire's Child Death Review Committee. Neither the Oxford review nor our discussions identified any specific issues in the care of the child from Northamptonshire.

Plans for the next year

Feedback on the findings from the CDR process will be given to partners in health and other agencies as will a continued programme of teaching about the process, end of life planning and bereavement services has been planned.

Many of the services contributing to the response to child deaths and the review of the deaths are undergoing significant change. It will be important to disseminate information about changes in individual agency practice that impact upon child death review work and to review procedures across all involved agencies in order to ensure that the high quality of care and rigour demonstrated in the management of child deaths is maintained. This will present challenges as it appears likely that input in the early stages after a child death is likely to be provided by a greater variety of professionals some of whom may not be specialists in this area of work. It is probable that additional training will be provided by the lead paediatrician in order to reduce the impact of these changes.

The work of the CDR committee will be strengthened with the addition of a Consultant in Public Health from May 2011. This is in keeping with the requirements within Working Together to Safeguard Children and will allow more detailed examination of any public health implications of deaths reviewed.

Some nationally organised systems of data collection are being discontinued. In particular the neonatal mortality data previously collected by CMACE has ceased and no alternative arrangements are in place. It is hoped that regional systems will continue to operate and the lead paediatrician will liaise with colleagues in an effort to obtain useful data for Northamptonshire.

The child death review process in Northamptonshire has been reviewed as part of the recent OFSTED inspection. Once this report has been received any recommendations made in respect of the child death review process will be considered and implemented.

Information on child deaths will continue to be reported to the Department for Education on an annual basis or more frequently on request. The data set recorded by the CDR procedures will be amended in accordance with Department for Education requirements as necessary. In this way, the LSCB will provide information as required for Indicator 4 of PSA 13.

Dr Mark Hunter
April 6th 2011.