Northamptonshire Safeguarding Children Board

Child Death Review Sub Group
Annual Report

2016-2017

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Lisa Walsh and Michelle Dominic

Contents

1. Introduction/context/background

This report covers the period from 1st April 2016 to 31st March 2017 and provides information on the total number of child deaths reviewed in Northamptonshire. It also reflects the activity of the Child Death Review (CDR) Sub Group highlighting its successes, current developments, learning and challenges.

The report should also serve as a resource to inform public health measures to promote child health, safety and wellbeing.

2. Statutory and legislative context

Since April 1st 2008, Local Safeguarding Children Boards (LSCBs) in England have had a statutory responsibility for the child death review process. The relevant legislation is contained within the Children Act 2004 and the Child death review process was put in place to fulfil the recommendations of the Kennedy Report (2004).

The processes to be followed are outlined within 'Working Together to Safeguard Children 2015: Chapter 5, Child Death Review Processes.

3. Governance and accountability

The Child Death Review Sub Group is responsible for the reviewing the deaths of any children normally resident in Northamptonshire.

- All deaths in children are reviewed, regardless of the circumstances or where they occur; The purpose of the review is:
- To understand why some children die;
- To identify the cause of death where possible;
- To determine the preventability of the death;
- The identification of modifiable factors is a key function;
- To identify matters of concern affecting the safety and welfare of children;
- To identify wider public health or safety concerns arising from a particular death or pattern of deaths and make recommendations;
- Monitor the support provided to families of children who have died; and
- The Sub Group puts arrangements in place to undertake a co-ordinated agency response to all unexpected deaths of children.

The Child Death Review Sub Group is accountable directly to the Northamptonshire Safeguarding Children Board for its governance and arrangements for assessing its outputs and effectiveness.

4. Child Death Review Processes

The review of child deaths consists of two inter-related processes:

1. A rapid response following sudden and unexpected deaths. This is undertaken by a group of professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child. Any immediate issues which require action by partner agencies and support services such as bereavement care for the families are addressed by this process. The nature of the investigation and arrangements for the post mortem are undertaken at this stage (such as referral for a serious case review and/or a serious incident review). When the post mortem result and cause of death is known, a further review meeting is held. This takes place alongside a joint visit by the lead paediatrician and investigating officer to the family, to discuss the findings of the post mortem and attend to any concerns and issues they may wish to raise.

2. An overview of all child deaths up to the age of 18 years occurring in the NSCB local area is undertaken by the panel. This takes place at the bi-monthly Child Death Review Sub Group meetings. This is a paper exercise based on information available from those who were involved in the care of the child, both before and immediately after the death, and other sources, including, perhaps, the Coroner. This provides a further opportunity for challenge. Following satisfactory discussion, cases are closed at this stage.

N.B - In the reporting, there is usually an overlap of child deaths which occurred in the preceding reporting year, but were concluded as indicated above in the current reporting year. We are required to submit both sets of data in our returns to the DfE.

Definitions adopted by the CDR

A **Child** is defined as anyone who has not yet reached their 18th birthday.

An unexpected death is defined as the death of a child that 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.

Preventable Child deaths are those in which modifiable factors may have contributed to the death. These factors are defined as those which, by nationally or locally achievable interventions, could reduce the risk of future child deaths. The factors include those in the family or environment, parenting capacity or service provision (this includes the input of all partner agencies who are ordinarily involved in the welfare of our children and families) as well as actions that could be taken at a regional or national level.

5. Progress/service/provision

Northamptonshire has a child population of 171,200 children and young people under the age of 19 years. This constitutes approximately 25% of the population of Northamptonshire.

The Child Death Review Sub Group has met bi-monthly for the last year to review child deaths in the county.

- 16 Early Professional meetings following unexpected child deaths were held;
- 14 Final Review Professional meetings were held;
- 8 Joint meetings between the police, lead paediatrician and families to discuss issues arising from the post mortem report were held;
- 56 reviews were completed in the reporting year. 24 from the preceding reporting year were completed. The reason for the delay was as a result of chasing information from deaths which occurred in health settings outside of Northamptonshire;
- 1 case was referred for a further review (such as serious case reviews, serious incident reviews, case mapping exercises and other appropriate formats); and
- 1 multi-agency audit was undertaken.

Number of child deaths 2016-2017	**51**
Gender	20 Males 31 Females
Ethnicity	35 White British 3 Caucasian 1 Black African 1 Caribbean 1 Indian 1 Latvian 1 White Asian 1 White Polish 7 Not known **
*** Please note the 7 not known are deaths noted where the gestation was unviable*	

The greater number of child deaths in both the expected and unexpected categories occurred in children and babies under the age of one year. A further breakdown shows the higher number in the neonatal age group as a result of prematurity and its associated complications. There are 2 special care baby units in the county and the deaths mainly result from planned withdrawal of care. This trend is in line with the national figures across the country.

There were 14 unexpected deaths in the reporting year. The rapid response process was undertaken in all of these cases.

Modifiable factors were identified in 10 of the deaths reviewed. These included:
- Co sleeping;
- Smoking during pregnancy;
- Support for parents following bereavement;
- Parental substance misuse / alcohol use and; and
- Process for informing birth parents where the child was 'looked after'.

6. Outcomes/performance/successes/achievements

The majority of actions set out in the Sub Group Action Plan; based on the NSCB Business Plan Priorities for 2016-17, have been achieved:
- The members of the Sub Group robustly scrutinise all child deaths reviewed and challenges partner agencies appropriately. This is reflected in the capture of the range of issues which have been identified as contributory to the deaths reviewed;
- There is a good link with other Sub Groups, particularly the Serious Case Review Sub Group;

- Early professionals meetings are very robust in discussing whether a referral should be made for consideration of a type of review under the remit of the SCR Sub Group;
- Learning events are recommended as appropriate, such as case mapping exercises and dissemination of learning to health and education colleagues in various bulletins and presentations;
- Early professionals meetings continue to be very well attended. These have a multi-agency focus where there is robust sharing of information and challenge to partner agencies. An example of which is, one child death raised concerns for how a child's journey was managed and a single agency audit was requested to be undertaken by various health services;
- The Project Officer is part of a national network of Child Death Co-ordinators who learn and share good practice. Alerts are disseminated effectively through this group;
- The Sub Group has requested and received presentations from various services across the partnership to understand their contributions. These include the palliative care lead, psychology team and bereavement care;
- The Sub Group has contributed to regional and national studies to help understand sensitive issues such as suicides in children;
- The Sub Group continues to appropriately refer cases for a consideration of a review to the SCR Sub Group;
- The CDR Sub Group undertakes 6 monthly health checks to review the group's membership, Terms of Reference, strengths, weaknesses, opportunities and threats;
- There has been good, consistent multi agency attendance and commitment throughout the year ensuring robust and informed discussion and challenge when reviewing child deaths;
- The Chair of the Sub Group has remained consistent throughout the year;
- We have been able to have an active vice chair in place which ensures that all scheduled meetings can occur;
- There is strong input from primary care through the attendance and participation of the Named GP for Safeguarding;
- There is a clear governance structure with bi monthly reports and ESG meetings where relevant issues and matters which require escalation and input from the NSCB chair and input from other NSCB Sub Group leads are addressed;
- Following the release of a post mortem report, all families who have requested a copy have had a meeting jointly with the lead Paediatrician and Police in a mutually agreed environment away from the child's home. These has enabled families to ask about and raise issues of importance to them. These issues are captured within the final review meetings and actions monitored; and
- Bereavement support continues to be actively provided both for neonatal and child deaths. Information on specialist culture sensitive neonatal bereavement support has also been provided as indicated.

Specific Examples of Success

1. Following concerns raised by families, the issue of the length of time taken to complete post-mortems was raised with the Coroner by the NSCB Independent NSCB Chair. We understand the delay is largely due to a nationwide shortage of specialist Perinatal Pathologists. We now sensitively include this information at the start of our liaison with families where appropriate to better manage the situation;

2. Following the collapse and death of a child from a cardiac condition at School, a piece of work was undertaken to establish the location of de-fibrillators in the county and challenge schools to ensure their pupil data is kept up-to-date. The family of the child undertook a campaign to raise the funds which has led to all primary schools in the county being provided with defibrillators;
3. The Safe Sleep campaign was re-launched in early 2017 following the campaign which took place in 2016. This followed 5 unexpected child deaths from December 2014-May 2015 which all involved co-sleeping as a contributory factor. Individual examples by colleagues across the partnership have evidenced the leaflet is being well used and has encouraged in depth discussions with parents. In spite of joint work by Midwives, Health Visitors and Family Nurse Practitioners in reinforcing this advice (evidenced by written documentation in the health records), co sleeping continues to be a factor in child deaths in the county;
4. A task and finish group was convened to ensure that, following the death of any child, rapid communication across all agencies takes place to advise of the incident and to ensure databases are updated and services such as school bus services are terminated. This is particularly relevant when a child dies out of county or when a child has additional needs which necessitated the involvement of a range of services;
5. The Sub Group highlighted the issue of bereavement support for the siblings and near relatives of children who have died. As part of the review process, we actively identify the siblings and ensure that the School Nurses or family liaison team from the siblings schools are involved in providing support;
6. There has been good interagency working following the death of a child which occurred whilst on holiday in another county. The early professionals meeting was convened via a conference call and in a timely manner after the event. This meant that relevant issues for the family were already being addressed by the time of their return to the county;
7. Following the death of a young person from a drowning incident abroad, there were concerted efforts by the team to obtain the relevant information and ensure the siblings and peers were supported. It highlighted the difficulties encountered when there is a death abroad and in particular when interment has taken place abroad;
8. Following a recurrent issue of water related deaths in the county, representatives from the county's Fire and Rescue service visit schools annually to discuss water safety and talk about the dangers of entering cold water to rescue pets and people. A leaflet endorsed by the NSCB was developed for this purpose;
9. Following the death of a young person who contracted a rare infection following contact with animals at an animal sanctuary, a learning review took place and a recommendation was made for information to be provided to families who visit such establishments to raise awareness of this risk;
10. The Sub Group have experienced the emotional impact that undertaking this work can have on the team and it is impossible to be removed from it. In addition to receiving assurance that we have access to opportunities to debrief and be counselled if required, 'chat ' and 'down-time' have been included at the end of the meetings to allow Sub Group members and participants to support each other;
11. As part of the rapid response process following the death of a baby, enquiries revealed the possibility of safeguarding concerns relating to a sibling. This highlighted why it is important for a strategy meeting to be convened proactively when there are unexpected child deaths. This is now the standard practice;

12. Following child deaths relating to infections over a three month period which had caused alarm in the community, there was timely sharing of information and co-ordinated working with our Public Health and Primary Care colleagues to communicate with families and undertake the measures recommended by Public Health;
13. Continues to monitor and review its performance by a regular health check; and
14. The Sub Group's Action Plan was refreshed in line with the recommendations from the recent Ofsted Review and Business Plan. The Sub Group maintains and monitors a running log of good practice and improved practice as a direct result of reviewing child deaths.

7. Challenges/issues/developments/opportunities

Current Developments

- GP Safeguarding Forums – Continue to disseminate learning to the Safeguarding GP forum on learning from child deaths;
- NSCB Newsletter – The bi-monthly newsletter includes information and learning from relevant child deaths when appropriate and as required. Whilst distribution is across the partnership, the newsletter is also disseminated to other professionals such as dentists, child minders and pharmacists;
- Dissemination of information to colleagues in Education - through bulletins;
- Task and finish groups where indicated continue to be important learning and information sharing opportunities; and
- Deep dives into thematic issues continue to be undertaken.

Challenges

- Quality of information – In some instances, particularly when children have died in health institutions outside the county, the provision of information to inform the review process has taken a long time. This impacts on the Sub Group's ability to complete the case reviews in a timely manner. The Sub Group works together to overcome these challenges by the appropriate Sub Group member contacting their equivalents in the other county to gain the required detail; and

- Work load and emotional impact - Northamptonshire remains an outlier with regards to the number of child deaths which occur. This impacts on the capacity available to undertake all the elements of the review process. The team members have also experienced the emotional impact of work in this area, particularly when we have had a number of deaths occurring close together.

8. Next Steps/plans/priorities/actions

- The Sub Group's performance will continue to be monitored and reviewed on a quarterly basis by means of a Chairs report to the Executive Support Group; and

- The Sub Group's Action Plan will be refreshed and monitored in line with recommendations following the review of the NSCB's business priorities.