Northern Lincolnshire

Child Death Review Annual Report

2019/20

Contents

Foreword by DPH

This is the first Annual Report which is governed by the Child Death Review Partners Executive Group. It covers a period of significant change for the child death review process with responsibility for the oversight of child deaths in a locality transferring from multi-agency safeguarding arrangements to health services. New guidance published by the government in 2018 was required to be implemented by September 2019. To achieve this, we have seen the coming together of statutory partners to provide assurance that the process is being carried out effectively and the development of new roles to oversee the delivery of the child death review process. This year has been a steep learning curve for all of those involved and we have made good progress. We have developed a robust framework to support the development of the new process, we have established mature relationships between the key partners which allow for debate and challenge and we have a vision for how the process needs to work in the future to facilitate a good child death review process. The following report will explain the new guidance, how it has been implemented locally, it will review the child deaths which have been heard at CDOP during 2019/20, explore progress over the past twelve months and look at what the CDR partners want to achieve during the next year.

I would like to thank the data analysts from North and North East Lincolnshire Councils who have supported the production of this report and the Child Death Managers and Administrators for their contribution to the report and their ongoing work to ensure a robust child death process takes place.

Introduction

Child Death Overview Panels (CDOPs) have been in place since April 2008. Their role, outlined in Working Together 2018 is to review all deaths of children up to the age of 18 years, excluding stillbirths (where a health professional was in attendance) and planned terminations.

The death of a child is a devastating loss that profoundly affects all who were involved in caring for the child in any capacity. The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families. The intention of the review is not about allocating blame but to enable them to understand what happened to their child and know that lessons will be learned to prevent future child deaths.

The statutory guidance recommends that the local child death arrangements cover a child population such that they typically review at least 60 deaths per year. On average Northern Lincolnshire reviews c. 25 deaths per year. To ensure compliance with the recommendation for 60 deaths, Northern Lincolnshire partners are working with Hull, East Riding of Yorkshire, York and North Yorkshire Child Death Review partners. The localities are working together to

- share learning,
- identify themes and trends
- align processes and procedures to support analysis and comparison
- undertake thematic reviews.

The statutory CDR Partners working with Northern Lincolnshire across the region have signed a 'Letter of Understanding', which underpins the partnership work.

The Northern Lincolnshire CDOP continues to collate information on all child deaths that sadly occur in this area. Information is fed from the electronic data collecting system, eCDOP, directly to the National Child Mortality Database (NCMD) for National Learning. The NCMD is an NHS funded project, delivered by the University of Bristol, that gathers information on all children who die across England. The combined findings from all child deaths informs local strategic planning, including the joint strategic needs assessment, on how to best to promote positive outcomes for children in this area. This annual report will assist in ensuring that learning from the CDOP is shared with local Children's and Community focussed partners in Northern Lincolnshire.

CDOP Members and Panel Meetings

CDOPs are made up of people with professional expertise from a range of organisations.

Panel member	Title and Organisation	Role on CDOP[1]
Steve Pintus	Director of Health and Wellbeing, North East Lincolnshire Council	Chair and Senior Public Health Professional
Julie Forrest	Child Death Review Manager, North Lincolnshire Council	
Cathy Thompson	Child Death Review Manager, North East Lincolnshire Council	
Kelly Crow	Child Death Review Administrator, North Lincolnshire Council	
Anna Cramer	Child Death Review Administrator, North East Lincolnshire Council	
Dr. Ahmed Mohammed	Northern Lincolnshire and Goole NHS Foundation Trust.	Designated Doctor for Child Deaths
Julie Wilburn	Designated Nurse, North East Lincolnshire CCG	Designated Doctor or Nurse for Safeguarding Children
Sarah Glossop	Head of Safeguarding, North Lincolnshire CCG	Designated Doctor or Nurse for Safeguarding Children
Marcia Pathak	Named GP, North East Lincolnshire CCG	Primary Care Representative
Elisabeth Alton	Named GP, North Lincolnshire CCG	Primary Care Representative
Philip Booker	Detective Chief Inspector, Humberside Police	Police
Charlene Sykes	Service Manager, North Lincolnshire Council	Children's Social Care
Sarah Blanchard	Service Manager, North East Lincolnshire Council	Children's Social Care
Darren Chaplin	Head of Access and Inclusion, North Lincolnshire Council	Education Services
Ruth Illman	Principal Educational Psychologist, North Lincolnshire Council	Education Services
Nathan Heath	Group Manager, Access and Inclusion Service, North East Lincolnshire Council	Education Services
Eleni Triantafyllou	Principal Educational Psychologist, North East Lincolnshire Council	Education Services
Karen Higgins	St Andrew's Hospice, North East Lincolnshire	Hospice Representative
Awaiting Appointment- Lay Member for NLCCG Governing Body		*Lay Representative*

CDOP Panel Membership as at 31.03.2020

[1] As specified within CDR Statutory guidance. Some roles/ functions are identified within the statutory guidance, but no additional detail is provided in respect of their specific role on the CDOP

CDOP Process

Background

The government commissioned Wood Report published in May 2016, recommended that Child Death Reviews should continue to be hosted within local multi-agency arrangements but CDOPs should be hosted within the NHS. Furthermore, it recommended that ownership of the arrangements for supporting CDOPs should move from the Department for Education to the Department of Health and Social Care. These recommendations were accepted by Government in May 2016. Changes were enacted in the Children and Social Work Act 2017, with the Government publishing Child Death Review Statutory and Operational Guidance in October 2018.

There were several significant changes that were implemented by 29th September 2019.

The key changes to the child death review process are detailed below:

The **shift in responsibility** for the CDOP from Local Safeguarding Children Boards (LSCBs) to local Child Death Review Partners (CDRP) required collaboration between Local Authorities and Clinical Commissioning Groups (CCG's) within a determined geographical footprint to hold joint responsibility for the child death review process.

The **merger of existing CDOP's** to ensure that CDRP represent a geographical footprint that enables the review of a minimum of 60 deaths each year for thematic learning to take place.

The requirement to perform a **Joint Agency Response –** on-call health professional, police investigator, duty social worker, if a child's death: is or could be due to external causes; is sudden and there is no immediately apparent cause (including SUDI/C); occurs in custody, or where the child was detained under the Mental Health Act; where the initial circumstances raise any suspicions that the death may not have been natural; or in the case of a stillbirth where no healthcare professional was in attendance.

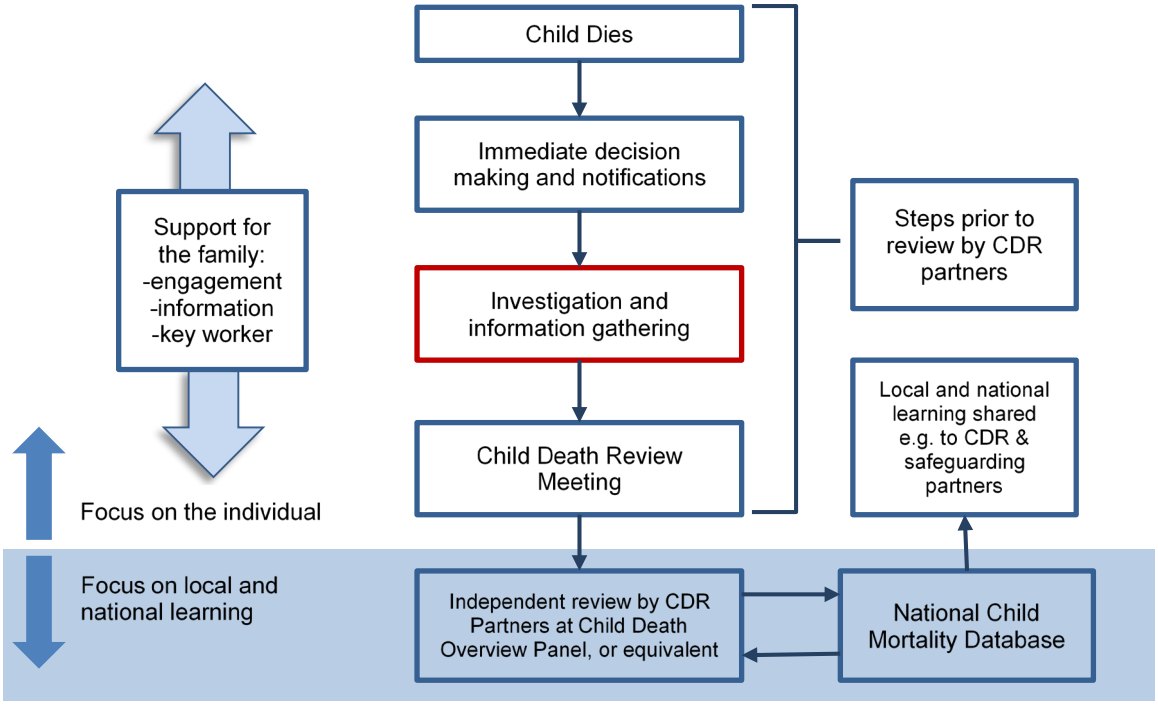
Establishment of local multi-agency Child Death Review Meetings (CDRM)**.** The professionals involved in the child's care and investigation of the death from health services, social care, police, education, and public health will need to be involved with CDRMs to ensure all relevant information regarding the child's life, their family circumstances and the circumstances of the death receive due consideration. The process is designed to capture the expertise and thoughts of all individuals who have interacted with the case to identify changes that could save the lives of children.

Establishment of a **'key worker' role** to act as a single point of contact with the bereaved family for the duration of the death review process. This is separate to bereavement support and will primarily be a signposting role as well as a first point of contact for the family and conduit for them between the review process and the organisations reviewing (and potentially investigating) the child's death.

Submission of data on each child death to the **National Child Mortality Database** (NCMD) CDRMs will need to ensure data is captured systematically and flowed to NCMD.

Child Death Review Process

As of March 2020, the Child Death Overview Panel (CDOP) and Northern Lincolnshire Child Death Review (CDR) Process is shown in the flow-chart below.



Local arrangements for the Child Death Review process are based on the geographical footprint for North Lincolnshire and North East Lincolnshire Local Authority (LA) areas. This footprint corresponds with each LA Clinical Commissioning Groups' (CCG) footprint. Within the LA, the responsibility for ensuring child death reviews are carried out have been delegated to the Directors of Public Health.

This Northern Lincolnshire approach to the Child Death Review arrangements will ensure the appropriate review of the deaths of all Northern Lincolnshire resident children (up to and including those aged 17), and babies born to Northern Lincolnshire resident mothers, whether the child dies in Northern Lincolnshire or outside the area. It will consider the deaths of non-Northern Lincolnshire resident children where learning for Northern Lincolnshire services may be identified and support the learning through Child Death Review arrangements in other localities, where Northern Lincolnshire resident children have died.

The Northern Lincolnshire CDOP met twice during 2019/20.

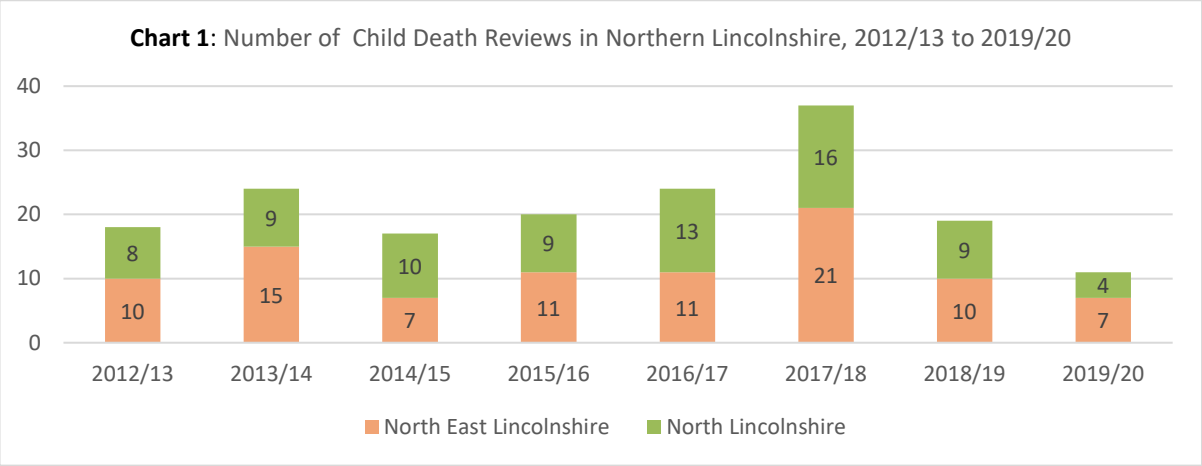
Due to the statutory processes involved in understanding, the circumstances of a child's death there can be a considerable lag between the date of death and the date of the CDOP. The date of death and the date of the concluded review may fall within different financial years.

None of the cases reviewed by Northern Lincolnshire CDOP in 2019/20 were subject to a serious case review.

Child Death Overview Panel

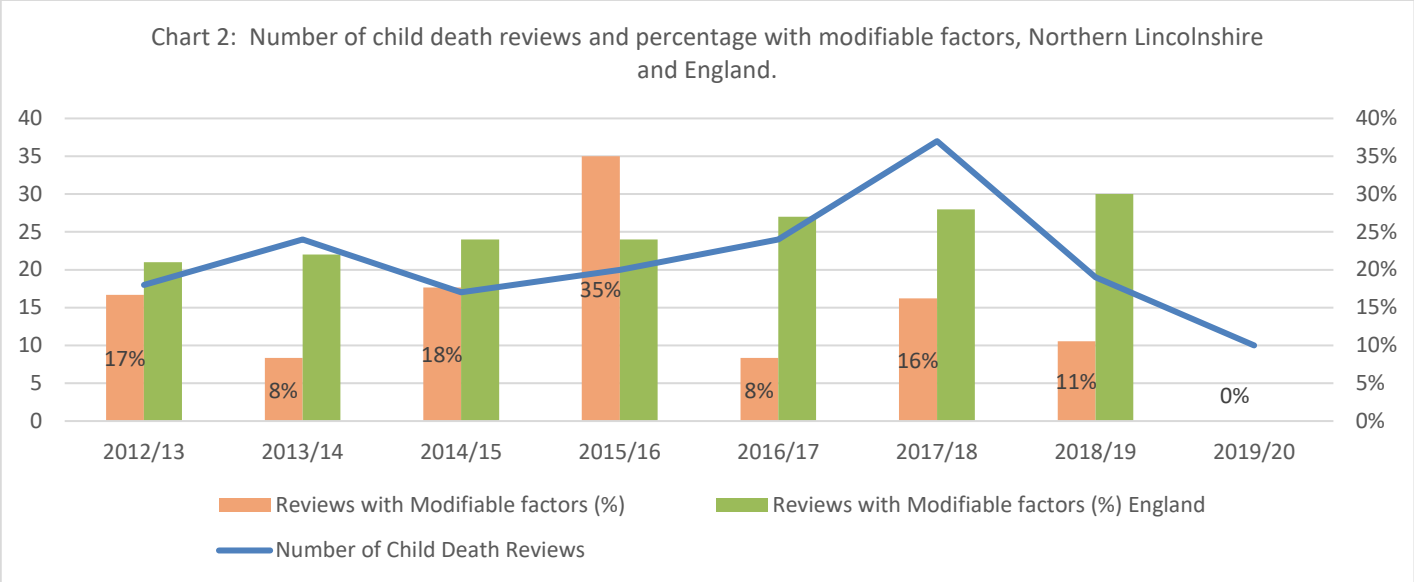
Number of child death reviews

Chart 1 shows the number of child deaths which have been reviewed each year in Northern Lincolnshire since 2012/13. There were 169 child deaths reviewed within this 8-year period.



Modifiable factors

One of the main roles of the CDOP is to determine whether deaths were preventable. Preventable child deaths are defined as those in which modifiable factors may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced.



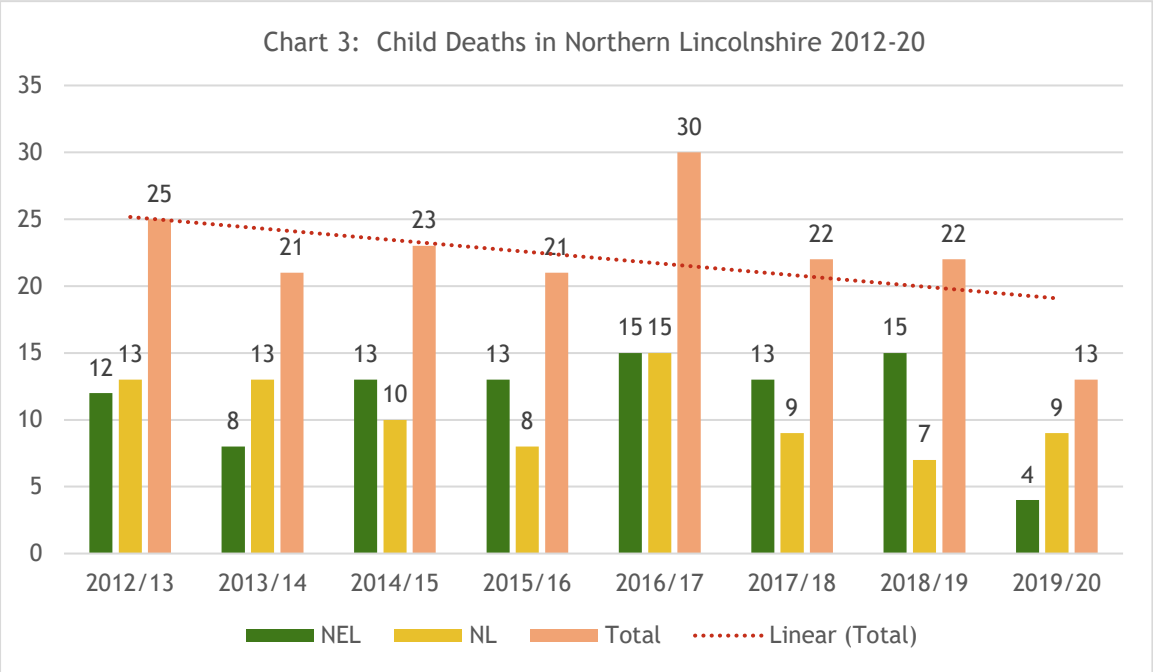
(Source: Child Death Reviews: year ending 31 March 2019 - NHS Digital)

Chart 2 shows that nationally, there seems to be a steadily increasing trend in the percentage of child death reviews assessed as having modifiable factors. Across Northern Lincolnshire the same trend in identifying modifiable factors is not evident. During 2019/20 none of the 10 child death reviews were assessed as having modifiable factors. England figures for 2019/20 not available at time of writing.

Data Analysis

Total number of child deaths

Thirteen children residing in Northern Lincolnshire died in 2019/2020. In comparison to previous years, there has been a reduction in the total number of child deaths across Northern Lincolnshire. The reduction is due to a significant decrease in the number of deaths in North East Lincolnshire; whereas the number of deaths in North Lincolnshire has remained constant with previous years, see chart 3 below:



National Comparator

Latest child mortality rates for the period 2016-2018 (directly standardised rate of death due to all causes, persons aged 1-17) in the table below show North Lincolnshire and North East Lincolnshire are similar to the national benchmark.

Table 1: Directly standardised rate of death

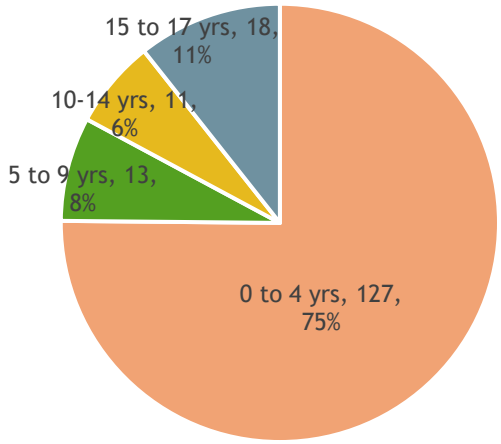
Region	Rate
North Lincolnshire	12.8
North East Lincolnshire	15.6
England	11

Source: Office of National Statistics

Age of child at time of death

In 2019/20, all cases reviewed by Northern Lincolnshire CDOP, except for 1 in North Lincolnshire, were infant deaths. Most reviews were for new-born babies that died during the first 28 days of life, defined as neonatal deaths these accounted for 71% in North East Lincolnshire and 63% in North Lincolnshire. Over an eight-year period, 75% of CDOP reviews involved children under 5 years of age. See chart 4 below:

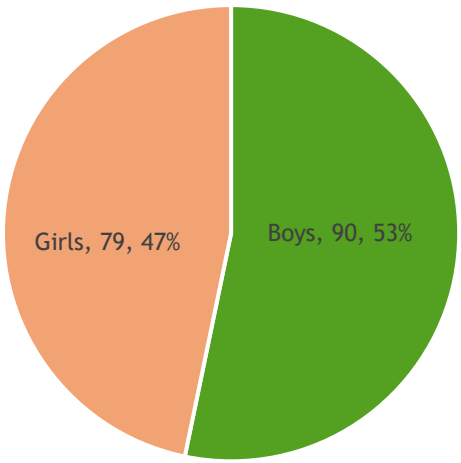
Chart 4: Number of reviewed child deaths by age group, Northern Lincolnshire, 2012/13 to 2019/20.



Gender

In North Lincolnshire, more child death reviews were for girls (55%) whereas in NEL 60% reviewed were boys. See chart 5 below:

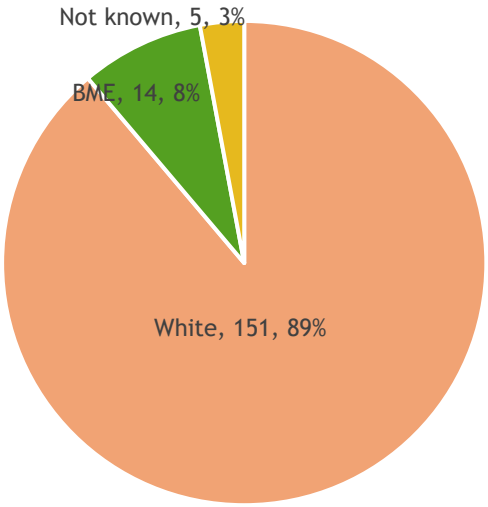
Chart 5: Number and precentage of reviewed child deaths by gender, Northern Lincolnshire, 2012/13 to 2019/20



Ethnicity

Over an eight-year period, 89% of reviews, where the ethnicity was known, were for white British children. See chart 6 below:

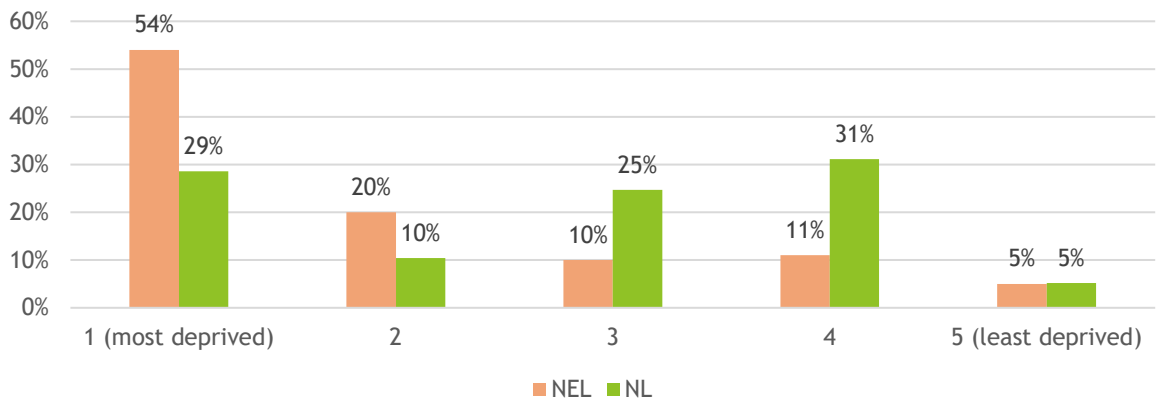
Chart 6: Number and precentage of reviewed child deaths by ethnicity, Northern Lincolnshire, 2012/13 to 2019/20



Deprivation

The Index of Multiple Deprivation is a relative measure of deprivation. According to this indicator, North East Lincolnshire ranks as the 29th most deprived local authority in England, (out of 317), and North Lincolnshire as the 115th most deprived. Chart 7 shows the percentage of child deaths in North and North East Lincolnshire by national deprivation quintile. Quintiles are five equal groups into which England has been divided according to deprivation distribution. There is a strong relationship between deprivation and child deaths. It is particularly evident in North East Lincolnshire where approximately 54% of all deaths are in the most deprived fifth of neighbourhoods.

Chart 7 : Percentage of Child Deaths by Deprivation Quintile of Home Address, Northern Lincolnshire, 2012/13 to 2019/20



Category of death

Since 2010/11 the CDOP has been required to assign each death to one of ten nationally defined categories.

Table 2 shows the number of child death reviews for each category of death for Northern Lincolnshire 2012/2013-2019/2020	North Lincolnshire	North East Lincolnshire	Total
1. Deliberately inflicted injury, abuse, or neglect - This includes numerous physical injuries, which may be related to homicide as well as deaths from war, terrorism or other mass violence. It also includes severe neglect leading to death.	0	2	2
2. Suicide or deliberate self-inflicted harm - This includes any act intentionally to cause one's own death. It will usually apply to adolescents rather than younger children.	5	3	8
3. Trauma and other external factors - This relates to unintentional physical injuries caused by external factors. It does not include any deliberately inflicted injury, abuse, or neglect.	6	3	9
4. Malignancy - This includes cancer and cancer like conditions such as solid tumours, leukaemia & lymphomas, and other malignant proliferative conditions, even if the final event leading to death was infection, haemorrhage etc.	7	8	15
5. Acute medical or surgical condition - A brief sudden onset of illness which resulted in the death of a child.	6	5	11
6. Chronic medical condition – A medical condition which has lasted a long time or was recurrent and resulted in the death of child.	7	7	14
7. Chromosomal, genetic, and congenital anomalies – Medical conditions resulting from anomalies in genes or chromosomes as well as a defect that is present at birth.	13	22	35
8. Perinatal/neonatal event – The death of child as a result of extreme prematurity, adverse outcomes of the birthing process, intrauterine procedure or within the first four weeks of life.	20	23	43
9. Infection – This can be any primary infection (i.e., not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby.	9	8	17
10. Sudden unexpected or unexplained death – This is where pathological diagnosis is either Sudden Infant Death Syndrome (SIDS) or 'unascertained', at any age.	4	11	15

In 2019/20, 60% (6 out of 10) of the child deaths reviewed were neonatal events; 43% (3 out of 7) in NEL and 66% (2 out of 3) in NL. In all of the reviews identified as neonatal events, extreme prematurity was recorded as the cause of death.

What have we learned from 2019/2020?

During 2019-20 two CDOP reviews were held. Due to the statutory processes involved in gaining all relevant information about the circumstances of a child's death, there can be a considerable lag between the date of death and the date of the CDOP where the death is reviewed and signed off. The date of death and the date of the concluded review often fall within different financial years.

Within this time, the significant changes to the organisational management of the CDR process and to the eCDOP and the information gathering processes contributed to the time lapse between CDOP's being held. This was further compounded by the restrictions imposed by the Covid-19 crisis.

The four cases that remained open following these two CDOP's will need to be reviewed and reported in next year's figures.

These CDOP meetings were held using the old process. With the new process, all challenges, discussions, and identification of lessons learned will be completed at the CDRM before being taken to the CDOP review.

Lessons Learned

The child death review process is designed to capture the expertise and thoughts of all individuals who have interacted with the case in order to ensure that a robust review of all child deaths. The purpose of the review is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in our area or to public health and safety, and to consider whether action should be taken in relation to matters identified. If the child death review partners find action should be taken by a person or organisation, they must inform them.

Throughout the year 2019/19, seven areas where lessons to be learned were clearly identified by the CDR process. All seven agencies were informed of actions needed and appropriate interventions are in progress to improve services for children and their families.

Progress on implementing Recommendations from 2018/2019

1. An End-of-Life pathway is in development to support families in cases where the baby/child has an assessed life limiting condition and where the need for Hospice intervention is required. Care plans will be put in place at the earliest opportunity. Maternity services, the Paediatric consultant and hospice will work to ensure an advanced care plan is agreed and implemented as soon as possible post-delivery.

2. ECDOP has been used to across Northern Lincolnshire to record meetings and attendees, capture case notes and record outcomes regarding reasons for the death and modifiable factors. There is still learning around the use of ECDOP and there have been some issues which are flagged to QES the system administrator.

3. The Child Death Executive Partners published their plan for the reviewing of child deaths in time in June 2019. An MOU was signed by partners across the Humber Coast and Vale STP to ensure the appropriate number of deaths could be reviewed to ensure lessons learnt and themed reviews can take place.

Future priorities and recommended actions

Recommendations deferred from 2018/19

Due to the changes in the guidance and personnel the following require further progress:

1. To undertake further analysis of the circumstances of premature births and to understand how many of the premature babies and pregnant mothers were cared for in specialist units.
   With the implementation of the new guidance this can be more fully considered through CDOP in 2019/20.
2. To explore the relationship between where the mother lived, and how engaged the mother was with universal services and to consider if there are any recommendations for future service provision.
   With the implementation of the new guidance this can be more fully considered in the Child Death Review Meetings
3. To include the analysis of the Serious Incident Reports/Root Cause Analysis undertaken in respect of child deaths so that CDOP is enabled to comprehensively capture and disseminate learning. This will be an integral part of the new CDR.
   As no cases reviewed in 18/19 had SIs or RCAs this will be followed up in 19/20

New Recommendations for 2019/20

1. All staff who have a responsibility for caring for children are aware of the child death review process through the provision of bespoke training.
2. Families who have been bereaved receive timely and appropriate information regarding the child death review process. Local information should be produced to support families and provide complementary information to 'When a child dies: information for parents and carers'
3. To ensure that the Key Worker role is clearly defined, and the most appropriate professional is identified quickly and has the appropriate knowledge of how to support a bereaved family acting as the conduit between the process and the family.
4. Establish a robust system for capturing feedback from bereaved families as to how they felt the child death review process has been delivered.
5. Assess the effectiveness of the current Child Death Overview Panel arrangements