Annual Report on the work of the Child Death Overview Panel (CDOP)

2013/2014

Aim To inform the Leicester Local Safeguarding Children Board and the Leicestershire and Rutland Local Safeguarding Children Board on activity, standards, outcomes and statistics in relation to the work of CDOP.

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In consultation with Dr Tim Davies - CDOP Chair

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Glossary

Abbreviation	Explanation
CAIU	Child Abuse Investigation Unit
CDOP	Child Death Overview Panel
CDR	Child Death Review Manager
DI	Detective Inspector
DfE	Department for Education
DS	Detective Sergeant
HM Coroner	Her Majesty's Coroner
LLR	Leicester, Leicestershire and Rutland
LPT FYPC	Leicestershire Partnership Trust Families Young People and Childrens Services
LRI	Leicester Royal Infirmary
LSCB	Local Safeguarding Children's Board
NNU	Neonatal Unit
PED	Paediatric Emergency Department
PMR	Perinatal Mortality Review
SCR	Serious Case Review
SILP	Serious Incident Learning Process
SLA	Service Level Agreement
SUDIC	Sudden Unexpected Death in Childhood
SUI	Serious Untoward Incident
UHL	University Hospital of Leicester
WTE	Whole Time Equivalent

1. Introduction

1.1 The Children Act (2004) places a statutory duty on local authorities in England to set up LSCBs. One of the duties of the LSCB is to ensure a review is undertaken on the deaths of all children who are normally resident within their area.

1.2 The duties undertaken by the LLR CDOP are as outlined in chapter 5 of 'Working Together to Safeguard Children 2013'. The child death overview process has been established within LLR since February 2009. 'Working Together to Safeguard Children 2006' outlined the duties of the LSCB to undertake a review of any child death resident within their area. 'Working Together to Safeguard Children 2013' re-emphasised the need to ensure a process is in place to undertake this work.

1.3 The remit of the child death overview process is to co-ordinate a systematic review of the death of children between 0 and 18 years of age (the review does not include stillbirths).

1.4 The process incorporates two interrelated pathways that allow for expected and unexpected deaths to be reviewed ('Working Together to Safeguard Children 2013' p73). The purpose of which allow for;

"(a) collecting and analysing information about each death with a view to identifying-

-any case giving rise to the need for a review mentioned in Regulation 5(1) (e);

-any matters of concern affecting the safety and welfare of children in the area of the authority; and

-any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area;

(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death." (HM Government, 2010).

1.5 The child death overview process is not an investigation and does not supersede the need for organisations to undertake their own reviews following the death of

a child. It is intended that the child death overview process will incorporate issues identified within the SCR and SILP processes to ensure shared learning.

2. Accountability and Assurance

2.1 LLR CDOP is a sub group of the LSCB and as such is accountable to the Independent Chairs of the respective LSCBs. Accountability is assured in a number of ways:

- Under current arrangements the CDR Manager is an officer of the respective LSCBs. Reports are submitted to the Boards (in consultation with the CDOP Chair) at agreed timescales to provide assurance in relation to the effectiveness of the work of the panel.

- The DfE requires LSCBs to provide annual data in relation to the number of notifications their respective child death overview panels receive. For LLR this data is provided on behalf of the respective LSCBs by the CDR Manager.

- The latest report from the DfE is due for release in July 2014.

- The CDR Manager meets with both LSCB Board Managers to deal with issues arising. For 2014 as part of these meetings the CDR Manager will discuss the quarterly reports that are prepared for panel and the LSCB Board meetings. These reports will provide an overview of current cases that have not yet been concluded at panel and will highlight any areas for immediate action.

- The CDR Manager attends the SCR Subgroups for both Leicester City and Leicestershire and Rutland on a monthly basis to ensure there is early notification of cases and effective sharing of information. Under current arrangements CDOP will not undertake a review until the SCR or SILP process has been completed.
  Note: For all cases that may be subject to a parallel review (e.g. SCR, SILP, SUI or criminal review), the CDR Manager provides a briefing to panel outlining the facts of the case. A monthly update regarding progress will then be made.

- Close links remain with both HM Coroners with jurisdiction within LLR in order to ensure there is an agreed process for mutual sharing of

information. Enabling information to be shared proportionally and appropriately provides a fuller understanding of the factors associated with child deaths.

- During 2013 it was agreed with representatives from the commissioning body for CDOP that the reports compiled and submitted by the named nurses following a home visit would be presented to the commissioners and audited (on a 3 monthly basis). A pilot has been undertaken to assess the feasibility of this.
    - It was identified that some amendments to the audit tool were required. Once these have been incorporated a formal proposal will then be presented to the relevant bodies.

3. Panel membership

3.1 CDOP is currently chaired by Dr Tim Davies, Consultant Lead for Screening and Immunisation, employed by Public Health England. The current chairing arrangement is supported by both LSCBs.

3.2 CDOP has a permanent core membership of the appropriate level of seniority, including public health, child health, police and social care. The membership is reviewed on an annual basis to ensure appropriate representation and a record of attendance at panel by organisations is logged. This information is made available to the LSCBs – see appendix 1.

3.3 'Working Together to Safeguard Children 2013' is not prescriptive regarding the composition of panel members. Current membership of the LLR panel was revisited as part of the review of LLR CDOP which was completed mid-2012.

Membership comprises representation from:

- Leicestershire Constabulary Child Abuse Investigation Unit (CAIU)
- Leicester City Council Children and Young Peoples Services (CYPS)
- Leicestershire CYPS
- Rutland CYPS
- Leicestershire Partnership Trust
- University Hospitals of Leicester NHS Trust
- Community Paediatricians
- Designated Paediatrician for Safeguarding
- Consultant Neonatologist
- Designated Nurse for Safeguarding

- Public Health
- Lay Member
- Chair

3.4 The terms of reference along with panel membership were reviewed and signed off (by the Chair) in December 2013.

3.5 CDOP currently meets 6 weekly for 2-3 hours per panel. At the beginning of each meeting panel members are reminded of the need to observe the confidential nature of the meetings.

4. Procedures

Notifications

4.1 Currently all child deaths are reported to the CDR Manager. As the designated person to whom child death notifications are forwarded the CDR Manager's name and e-mail address is held by the DfE, who coordinate a national contact list. A notification can be made to the CDR Manager by any professional involved in the care of the child.

Information Sharing

4.2 As outlined in chapter 5 of 'Working Together to Safeguard Children 2013' registry offices are required to provide a weekly report to CDOP on deaths they are aware of. These reports ensure that information is received (on behalf of the LSCB by the designated professional) no later than 7 days from the date of registration of death. In addition the CDR Manager provides information to HM Coroner for Leicester City and South to allow for cross reference of notifications on a weekly basis. Following discussion, HM Coroner for the County does not wish to receive this.

4.3 The CDR Manager reports to the LSCB all circumstances where abuse has been identified as, or suspected to be, a factor in the death of a child. Where appropriate CDOP will recommend consideration of an SCR.

4.4 For cases undergoing the SCR or SILP process a formal agreement is sought from the respective Chairs of the subgroups to identify when the case can be received and presented to the CDOP panel. A professional from the subgroup will be identified to aid the CDR Manager with the completion of the analysis proforma that panel members receive.

4.5 For cases undergoing the SUI process a single point of contact has been identified (within health) to provide the CDR Manager with information for panel and assurance around progression of actions identified.

4.6 For cases undergoing criminal review there is a single point of contact identified within the Police to provide information to be presented to panel.

The Child Death Review Process

4.7 'Working Together to Safeguard Children 2013' (chapter 5) provide guidance for LSCBs in regard to how child death reviews should be undertaken. For unexpected cases 'Working Together' suggests a timescale of 1-6 months (this is dependent on the availability of post mortem reports). 'Working Together' is not prescriptive in its guidance and local guidelines have therefore been developed to ensure cases are progressed effectively.

4.8 Locally it has been agreed with all partner agencies that:

- Expected cases will be ready for panel within 12 weeks.

- Unexpected cases will be ready for panel within 26 weeks. This time period is guided by the time taken for post mortem results to be made available to the CDR Manager. This is a process which is reflected nationally. The current arrangement of awaiting the results of the post mortem before presenting a case to panel has been agreed within LLR by all panel members.

- All neonatal cases will be reviewed by the PMR Group prior to being heard at the CDOP. To provide congruency between the two processes the CDR Manager attends the PMR meetings. This process was instigated following close liaison with UHL and continues to be supported by panel members as a means of providing a more robust approach to the review of such cases.

- Where possible cases will be 'grouped' together in accordance to circumstances.

5. Sudden Unexpected Death in Childhood (SUDIC) arrangements

5.1 Following local consultation with partners the 'rapid response' process that was referred to within 'Working Together to Safeguard Children 2010' (and remains within 'Working Together 2013') is termed locally as the SUDIC response. This outlines the response that is initiated following the sudden/unexpected death of a child.

5.2 All notifications are received by the CDR Manager whose role it is to coordinate the initial SUDIC response. The work of the CDR Manager is supported by the project support officer for the CDOP process. Both posts are 1 WTE.

5.3 As part of the SUDIC response a home visit is considered. Within LLR this function is undertaken by a member of the named nurse safeguarding team (as part of their full time employment). Where possible this visit will coincide with visits that are being undertaken by the police, in an attempt to provide minimal intrusion to the family. The nurses provide cover during office hours (9am – 5pm) Monday to Friday (excluding bank holidays). During 2013 there were a number of changes within the named nurse work force and at present there are 4 nurses providing cover for the rota (this will increase to 5 by mid-summer). Following completion of a secondment, capacity may increase to 6 in September 2014.

5.4 The SUDIC Doctor role is covered by one community paediatrician, who is available to provide medical advice in relation to notifications received, chair any initial meetings to discuss the case and chair the final case discussion. The SUDIC Doctor meets with the CDR Manager on a weekly basis to discuss 'active cases' as well as prior to panel meetings to review the cases to be presented. This arrangement is reviewed as part of the doctor's job plan on an annual basis in order to ensure services are being utilised effectively. Cover by the SUDIC Doctor is currently provided on:

- Monday/Tuesday/Wednesday – AM
- Thursday – PM

5.5 In addition, to aid with the notification process, promote the CDOP process and facilitate the prompt obtaining of information, a specialist nurse (0.5WTE) is located within the UHL Safeguarding Team.

5.6 The Service Level Agreement for CDOP provision within LLR was reviewed in January 2014 and supported the current working arrangements.

6. Data.

6 As referenced in section 2, LLR CDOP submitted data to the DfE in relation to cases **reviewed at panel between** 1st April 2013 and 31st March 2014. The report from the DfE is due for release in July 2014. CDOP has effective data management systems in place to record, analyse and monitor childhood deaths and meet its intended purposes and outcomes, as directed by the DfE. Data analysis is used intelligently to recognise local risks and issues. A project was

undertaken (in 2013) to meet the DfE tender specification to identify the most effective way of utilising the data currently collected. As part of the recommendations included in the report it was noted that a national database should be established to allow for the collation, analysis and interpretation of CDOP data at a national level. To date there has been little progress in achieving a centralised live system for data collection.

A full copy of the report is available from the LLR CDOP office.

6.2 During the time period outlined in the DfE statistical analysis 47 cases were reviewed by LLR CDOP and 8 panel meetings were held. Two of these meetings were used as developmental sessions and six were utilised to review cases.

6.3 Table 1 provides an overview of the classifications of the cases reviewed (categories 1-10 as directed by the DfE)

Table 1

The 47 cases reviewed at panel (in the time period outlined) were categorised as follows;

1 Deliberately inflicted injury, abuse or neglect	7
2 Suicide or deliberate self-harm	0
3 Trauma & other external factors	6
4 Malignancy	5
5 Acute medical or surgical condition	2
6 Chronic medical condition	2
7 Chromosomal genetic & congenital anomalies	10
8 Perinatal/neonatal event	8
9 Infection	6
10 Sudden unexpected unexplained death	1

Positive factors noted as part of the reviews included:

- Relevant professionals receive feedback via quarterly meetings.
- Children and families supported around their choices for end of life care.
- Close liaison with other professionals to ensure on-going bereavement support offered to families including siblings.
- Appropriate referrals being made for genetic counselling for families.
- Interpreting services being utilised effectively.
- CDOP linking into the work being undertaken and progressed by the Joe Humphries Memorial Trust.
    - This includes the CDR Manager speaking at local conferences.
    - CDOP are currently exploring opportunities for increasing public awareness/training with regard to basic life support.

7. Overview of cases notified to CDOP – April 1st 2013 – March 31 2014

7.1 The data referred to in section 2 and 6 relates only to those cases that have undergone a review at panel during the time period outlined, it does not reflect the number of notifications CDOP receives during that time – nor does it outline the work/learning that occurs in preparing cases for panel.

7.2 As previously mentioned LLR CDOP has a duty to ensure there is a review conducted into the death of ALL children 0-18 years (excluding still births), normally resident within LLR.

7.3 Between April 1st 2013 – March 31st 2014 LLR CDOP were notified of 131 notifications. Of these, they were required to undertake a review on 75 (the remainder of numbers relate to those babies born at less than 23 weeks gestation and children who died within the LLR borders but who were not residents of LLR).

7.4 Until the case has been to panel it is not possible to provide details of categorisations of death (as shown in table 1) – and with unexpected cases CDOP are required to wait until the post mortem has been released to them by HM Coroner before taking the case to panel.

Table 2 – overview of notifications LLR are required to review for April 2013 – March 2014

Age	Total Number	Neonatal	Expected	Unexpected
0-27 days	**30**	28	0	2
28-364 days	**15**	0	9	6
1-4 years	**12**	0	5	7
5-9 years	**3**	0	1	2
10-14 years	**9**	0	7	2
15-18 years	**6**	0	3	3

7.5 As part of the CDOP process information is gathered form professionals/agencies involved with the child and family in order to prepare the case for review. If any areas are identified as requiring action this will be undertaken, CDOP does not wait for the case to reach panel before ensuring learning has been identified and disseminated and any areas of concern have been addressed.

For example;

- Work is underway with partners to review support and information offered to children with life limiting conditions.
- Partners have undertaken work to review the support and resources available to those working with children and young people who may be victims of bullying.
- Work is being progressed regarding public awareness of basic life support and available training.

7.6 Of those cases still requiring review there are a number of factors that will be influential in the timing of them reaching panel;

- CDOP may still be awaiting the PM results (which can take 6 months).
- Some may be subject to parallel reviews (such as SUI or CI) and CDOP will await the outcome of these reviews before completing panel review.

7.7 As part of the assurance around CDOP, the CDR Manager now produces quarterly reports outlining the progression of each case. Within the report details are included on;

- Requested information from professionals that is still outstanding.
- Other processes being undertaken (for e.g. SCR or Coronial review).
- Date case ready for panel and date scheduled for panel.

8 Learning and dissemination arising from the work of CDOP relating to cases that were reviewed between 1st April 2013 and 31st March 2014 as well as cases notified but not yet completed.

8.1 The remit of CDOP panels nationally is to provide an overview of cases and identify learning that seeks to reduce future deaths and as such views the 'wider picture'. It is not the intention of CDOP panels to identify a list of failings or review the cases under the same criteria as that considered during an SCR process. Therefore in the majority of cases it is acknowledged that there will be no recommendations to be made by CDOP. This does not mean that significant work has not been undertaken in assuring that all cases are reviewed appropriately. It is important to note that even in cases where specific recommendations or learning is noted and acted upon, from a statistical viewpoint it is almost impossible (due to the low numbers involved) to demonstrate a direct correlation between action undertaken as a result of a recommendation from CDOP and a decrease in the number of deaths in a particular category year on year.

8.2 As part of the review of all of the cases, the panel monitors the appropriateness of the professionals' responses to each unexpected child death to ensure thorough consideration of how such deaths might be prevented in the future is undertaken. It also monitors the support and assessment of services offered to the families of children who have died.

8.3 Alongside determining if modifiable factors can be identified within a case, CDOP members are also asked to consider if there are additional actions, learning points or recommendations that can be drawn from the review. The panel seeks to help identify and report on any public health issues that may pose risks to children's health or development. In order to ensure learning is identified themed panels are held throughout the year. Cases that have already been reviewed will be brought back to panel alongside new cases with similar contributory factors. As part of this work the CDR Manager along with public health professionals look at current CDOP cases and seek to establish if/how they mirror the national picture. Part of the aim of undertaking themed panels is to allow additional review of cases to be undertaken and provide assurance with regard to any actions/learning identified. Reassuringly in many instances this process demonstrates that no further action is required.

8.4 For the annual report all CDOP members were asked to provide an overview of learning/action that has taken place within their organisation as a result of a CDOP case.

8.5 In order to maintain an audit trail, CDOP members are also required to provide evidence of any such learning (e.g. minutes of meetings, amended guidelines etc). This is then used by the CDOP office to build up a portfolio. Organisations were asked

to provide evidence of learning to be highlighted for the CDOP annual report -the following organisations provided information:

UHL

Emergency Department

- Meeting with HM Coroner to discuss the current processes in place following the death of a child (within ED). This includes improving paperwork to aid professionals to complete the process more effectively.
- Working with partners to seek clarity on the protocols associated with the transportation of children pronounced 'dead at the scene'.
- Undertaking multi agency training events to educate professionals who will be involved in the initial SUDIC process (this involves professionals from partner agencies)
- Development of new guidelines in the department with the regard to the management of children presenting with heamotemasis (vomiting blood.) This has arisen as a result of a case reviewed at panel.
- Close work with the Joe Humphries Memorial Trust and also the Heart Start initiative, resulting in a number of consultants committing to teaching (in their own time) basic life support skills to school children.
- Continued feedback to staff (from the CDR Manager and UHL panel member) on panel findings via the staff team meetings.

Neonatal Care

- Feedback from the perinatal mortality review panel to neonatal staff has continued and three sessions were completed in 2013.
- An intra-departmental review of cases where necrotising entero colitis was a significant factor was undertaken in order to ascertain if there were any common themes within the cases. The review did not identify any themes and demonstrated that management of cases was in line with recognised standards of care.

    - During 2014 there is a plan to undertake a similar review of hypoxic ischaemic encephalopathy cases again in order to ascertain if there are any common themes. The findings will be fed back to CDOP.

Shared Learning

Panel members are updated by panel representatives from CYPS on cases that are undergoing review via the SCR and SILP process and early learning is

disseminated. Details of learning/actions identified are held by the LSCB Board office.

Police

There are monthly meetings with the CDR Manager to discuss cases. This provides an opportunity to address any concerns. It also ensures that any issues that have been identified during the joint home visit undertaken by the police and named nurse have been reviewed.

The police continue to support the multi-agency training events that occur to educate professionals who will be involved in the initial SUDIC process (this involves professionals from partner agencies)

Public Health

As a result of a number of cases of infant deaths where modifiable risk factors have been noted, Leicestershire County Public Health have organised a series of infant mortality road-shows in each District bringing together children's centre staff and service providers to highlight the risk factors and promote awareness of the services available to tackle them. The road-shows are running this spring and each District will nominate a 'Health in Infancy Champion' to ensure the lessons learnt are sustainable and built into future partnership working.

9 Awareness raising

This falls within two categories;

- The need to ensure that professionals are aware of the CDOP process and the role they have within it.
- The need to ensure that lessons that are identified during the review of a case are disseminated appropriately and embedded within practice.

In each instance the key is to utilise already established information sharing forums alongside identifying new arenas. The information needs to be relevant and accessible to the professional in order for them to access and retain it. This can take a variety of forms such as presentations, leaflets, newsletters, e–bulletins, discussions within professional forums and attendance at study days. The CDR Manager and the Leaning and Development Officer for the LSCBs meet to review cases and identify appropriate forums for dissemination.

10 Areas for continued action in 2014 -2015

Bereavement support

This continues to be an area for development during the next 12 months. As part of the home visit undertaken, families are asked if the CDR Manager may contact them at a future point (usually 3-4 months later.) The aim of the follow up contact is to provide families with an opportunity to ask any questions and also provides an opportunity to discuss any support the family feel may be of benefit.

Work also continues with professionals from partner agencies to review the current support and information that is provided.

Regional conference

Due to reduced capacity within the CDOP team the event has been postponed and is now scheduled for late 2014 (September/October). Colleagues from across the region will be invited to attend. Those attending will be asked to provide an overview of issues/learning within their CDOP area and also discuss ways of ensuring more collaborative working.

11 Recommendations

1. The LSCBs (and CDOP members) support the hosting and organisation of the regional conference.
2. The LSCBs continue to support (through appropriate forums) the need to develop a national database in order to identify emerging trends and themes.
3. CDOP continues to provide assurance to the LSCB (via agreed reporting schedules) outlining case progression and learning/action identified.
4. CDOP members are supported by their organisations in undertaking and supporting the work of CDOP.

Appendix 1

During 2013/14 CDOP met on 8 occasions, 2 meetings were developmental and 6 were case reviews. Representation at the meetings is shown in table 2 below.

Following review of the CDOP Terms of Reference (in December 2013) it was agreed that from January 2014, a representative from Leicestershire Partnership Trust FYPC and UHL Named Doctor for Safeguarding would be invited to attend CDOP panels.

Table 3

Representation	**Attendance**	
	Developmental Panel (2)	**Case review Panel (6)**
Chair	2	4
Leicester City, Leicestershire Council & Rutland Children and Young Peoples Services (CYPS)	1	6
Leicestershire Partnership Trust FYPC (Invited Jan 2014)	0	2
University Hospitals of Leicester NHS Trust		
Children's Emergency Department Consultant	1	3
Consultant Paediatrician /Neonatologist	1	6
Named Doctor for Safeguarding (invited Jan 2014)	0	1
Consultant Community Paediatrician/co- Chair	0	3
Designated Paediatrician/SUDIC Doctor	2	6
Designated Nurse for Safeguarding	2	5
Public Health	1	4
Lay Member	2	5
Leicestershire Constabulary Child Abuse Investigation Unit (CAIU)	1	5