



TELFORD & WREKIN AND SHROPSHIRE'S SAFEGUARDING CHILDREN BOARD

CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT 2008/09

1. Introduction

- 1.1 The Child Death Overview Panel (CDOP) commenced following the directions laid out in Chapter 7 of Working Together to Safeguard Children (WTSC) published in 2006.
- 1.2 This specified the procedures to be followed subsequent to a child death in the LSCB area (s) covered by the Local CDOP.
- 1.3 The joint CDOP for Telford & Wrekin and Shropshire commenced on 1 April 2008 as part of the statutory national response to child deaths triggered by high profile fatal Child Abuse cases and prosecutions of parents following one or more Sudden Unexpected Death(s) in Infancy (SUDI). These highlighted the need for a co-ordinated investigative response to such deaths and for organised protocols in the UK.
- 1.4 The responses to child deaths fall mainly into two categories, a multi-disciplinary Rapid Response to Sudden Unexpected Deaths and an information gathering procedure for all other deaths from birth up to the day before the 18th birthday.
- 1.5 When the report on each death has been compiled, it is presented to the CDOP for review and analysis is made to determine preventable factors, lessons learned or changes which may be needed to improve child survival. The ultimate aim of this work is to decrease the number of child deaths, increase the safety of childcare practices, professional care and the general environment for children.
- 1.6 Alongside the investigation and information gathering procedures is the support required for families through a traumatic life event to ensure that other family members are safe; provide an explanation of the cause of death where possible and to prevent the recurrence of a similar death in the future.
- 1.7 Following a small number of child deaths, suspicious circumstances may come to light which may result in a Serious Case Review or a criminal investigation; in which case these procedures would override the CDOP enquiries until they are complete.



2. Evolution and Membership of the Child Death Overview Panel

- 2.1 The creation of a formal response to SUDIs locally was first discussed in 2004 following the publication of the Kennedy Report and Dr Deborah Bell, Associate Specialist Community Paediatrician, wrote an outline proposal for managing SUDIs in babies less than 12 months of age. This was superseded by the WTSC document which extended the death review procedures throughout childhood and adolescence which very substantially increased the scope and complexity of the whole process.
- 2.2 A multi-disciplinary working party met in 2007 involving the West Mercian Police area (Shropshire, Herefordshire and Worcestershire) and included representatives from Health, Social Care, Police and Coroners and a protocol was agreed for the management of Sudden Unexpected Deaths.
- 2.3 During 2006, a number of pilot studies took place in different areas of the UK under the auspices of the Confidential Enquiry into Maternal & Child Health (CEMACH). Using information from these, Drs Fleming and Sidebotham from Bristol & Warwick Medical Schools developed training courses for professionals expecting to become involved in carrying out child death reviews and national guidelines gradually became available.
- 2.4 From 1 April 2008, Dr Bell was appointed as Named Doctor for the Child Death Reviews working with the Safeguarding Team, headed up by the Designated Nurse for Safeguarding Children and Dr Ganesh, Designated Consultant Paediatrician for Safeguarding. The Child Death Overview Panel Co-ordinator joined the team in mid April. The Panel met bi-monthly from May 2008 with the Designated Nurse as Chair and Designated Consultant Paediatrician as Vice-Chair and included representatives from SaTH Paediatric and Maternity Services, both Local Authority Children's Services, Police, Coroner's Officers, Public Health and Hope House Hospice.

3. Preliminary Review of Child Deaths from April 2008 – March 2009

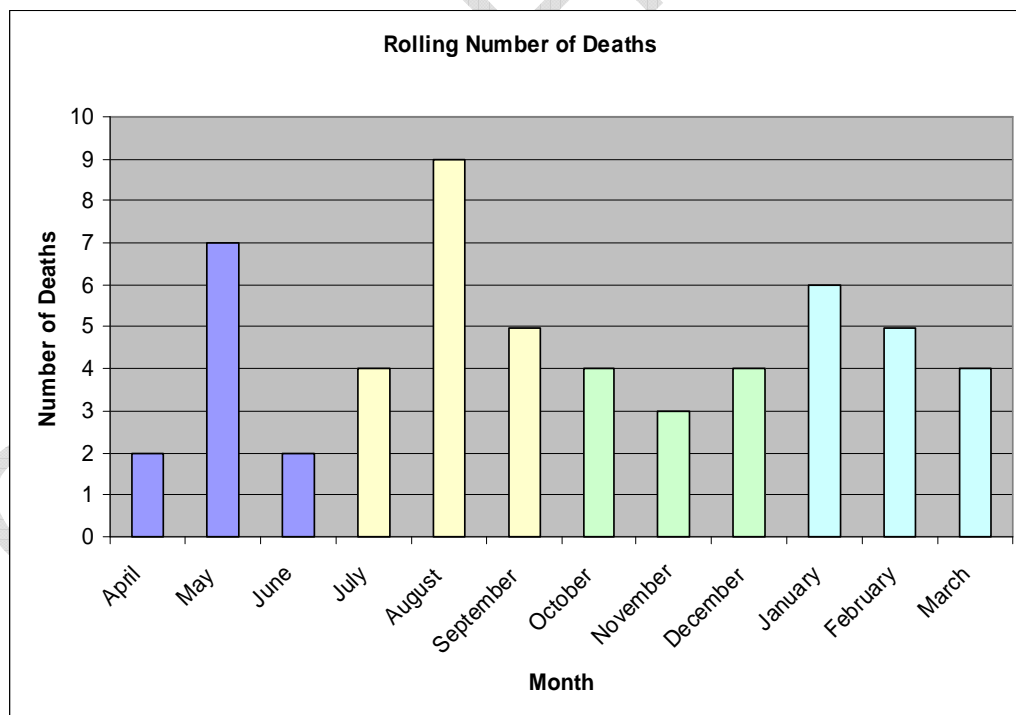
For information it is important to note that this report is incomplete. The reasons for this are as follows:-

- 3.1
 - There is a time lag between a death occurring and the completion of the processes required to produce the final report for the CDOP. Completion of reports is dependent on the timescales of external agencies, e.g. the length of time taken to complete complex medical investigations, Inquests, etc. Full analysis of the deaths during the first year will not, therefore, be available until Autumn 2009.

It has not, therefore, been possible to adhere to pre-determined performance indicators in relation to presenting reports to the CDOP within a time period following a death; although this is done as soon as possible depending on individual circumstances.

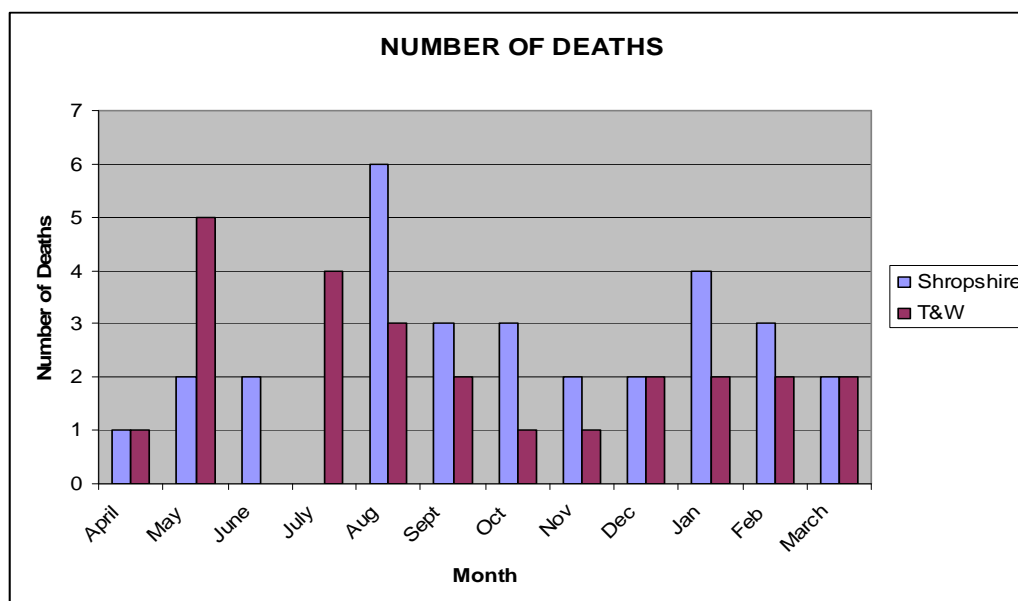
- 3.2 ▪ The capacity of the Named Doctor has meant that the number of sessions available to carry out this work is challenged by other workload commitments. Work is in hand by managers to address this and a successful bid for resources in the PCT local development process will ease pressure in 2009/10.
- 3.3 ▪ The Named Doctor responds to calls for a Rapid Response into Sudden, Unexpected Deaths within weekday working hours only. There is currently no capacity for an out-of-hours team leading to information collecting in some cases being incomplete. (See Appendix B for details)
- 3.4 During the planning stages of the death review processes, the named doctor estimated a possible 40 to 50 deaths per year based on her own statistics collected from 1990 to 2007, approximate mortality figures from Special Care Baby Unit and an estimate of the number of deaths in the 16 to 17 year old age group.
- 3.5 The actual number of deaths during the first year was 55 which show an increase. Most months saw between 3 to 6 deaths but there were a couple of months (May and August) with 7 and 9 deaths respectively and in April and June there were only 2 deaths. There is no obvious reason for this variation other than the natural fluctuation of small numbers.

3.6



There were 25 deaths from T&W and 30 deaths from Shropshire (which is split into two Coroner's Areas of Mid & North Shropshire and South Shropshire), of which 80% came from the Mid & North Shropshire area. There were, therefore, slightly more deaths than expected in T&W, assuming a 40:60 ratio for the child population.

3.7



Almost 62% of the deaths occurred between birth and 12 months of age which is a very similar ratio to that calculated during the national CEMACH Pilot Studies in 2006 (57%) and the ONS statistics for 2007 (60%). Deaths locally show a 'U Shaped Curve' also found during the CEMACH work which indicates the highest mortality during the first year of life dropping to a low level during childhood and beginning to rise again in later adolescence.

4. Deaths up to 12 months of age

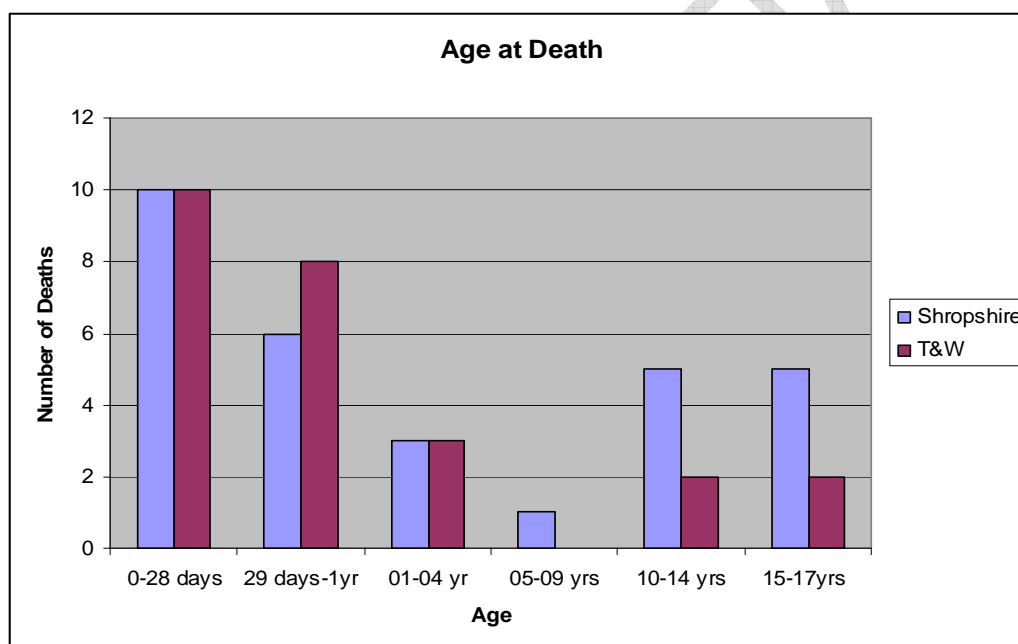
4.1 A similar number of babies died in T&W (18) and Shropshire (16) from all conditions. There were 7 SUDIs but only 3 have been completed in relation to information gathering, Inquests and final Case Discussions. Most showed the well-evidenced pattern of risk factors such as smoking, young parental age and bed-sharing. The families were well known to professionals and had been given Reduce the Risk of SUDI information.

4.2 One of the unexpected issues regarding the death reviews during the first year has been the number of very premature babies who came within the CDOP remit. Any baby who has even the most fleeting signs of life at birth is registered as a live birth, even below the generally accepted limit of foetal viability of 24 weeks gestation. There is an expectation that all these deaths will be reviewed by CDOP, despite the fact that they are also reviewed by CEMACH which appears to be duplication, especially when deaths are related to obstetric events or extreme prematurity. A decision will need to be made nationally relating to these issues and if CDOP is to continue to review Perinatal deaths, this ought to be done in closer conjunction with the Maternity and Neonatal services who review these deaths via their own Perinatal Mortality meetings. Collecting information regarding these deaths is time consuming and there have been some issues about access to records, although this has improved.

- 4.3 Only one baby died from a primary infectious cause which is encouraging as this age group are vulnerable to sudden, overwhelming infections by organisms such as the meningococcus which was the cause in this instance.
- 4.4 10 babies died of congenital anomalies or syndromes including 4 with the most severe forms of congenital heart disease, 2 with diaphragmatic hernias causing insufficient lung capacity to sustain life and 2 conjoined twins.

5. Deaths from 1 – 17 years

- 5.1 The average annual deaths in the 1 to 16 age group across the whole of Shropshire was 20 during the 1990s and 18 from 2000 to 2007 according to the figures compiled by Dr Bell during that period. There were 19 deaths during 2008/09 plus 2 deaths in 17 year olds and twice as many occurred in Shropshire than in T&W.



- 5.2 There were 5 deaths in each area from congenital anomalies/syndromes or medical causes including 2 associated with malignancies and one Sudden Unexpected Death in Epilepsy in a boy with a very severe epileptic condition.
- 5.3 Shropshire had nine unexpected deaths in this age group comprising four Road Traffic Collisions, four hangings and one murder.
- 5.4 Two car passengers were killed, one or both of whom may not have been wearing a seatbelt. One of the cars was driven at great speed by a young driver who had only just passed his test. Two cyclists were killed, one with learning difficulties. A case discussion to look at all the issues has yet to be held. Neither child was wearing helmets.

5.5 Two young people in T&W also hung themselves, making a total of 6 such incidents over the whole county in the 12 months which is highly unusual as previous such events have tended to happen only once every 2 to 3 years. There is no evidence of any link between the young people involved and at the Inquests of the T&W youngsters; the Coroner concluded that one death was suicide and one accidental. The Inquests for the Shropshire youngsters have not yet taken place.

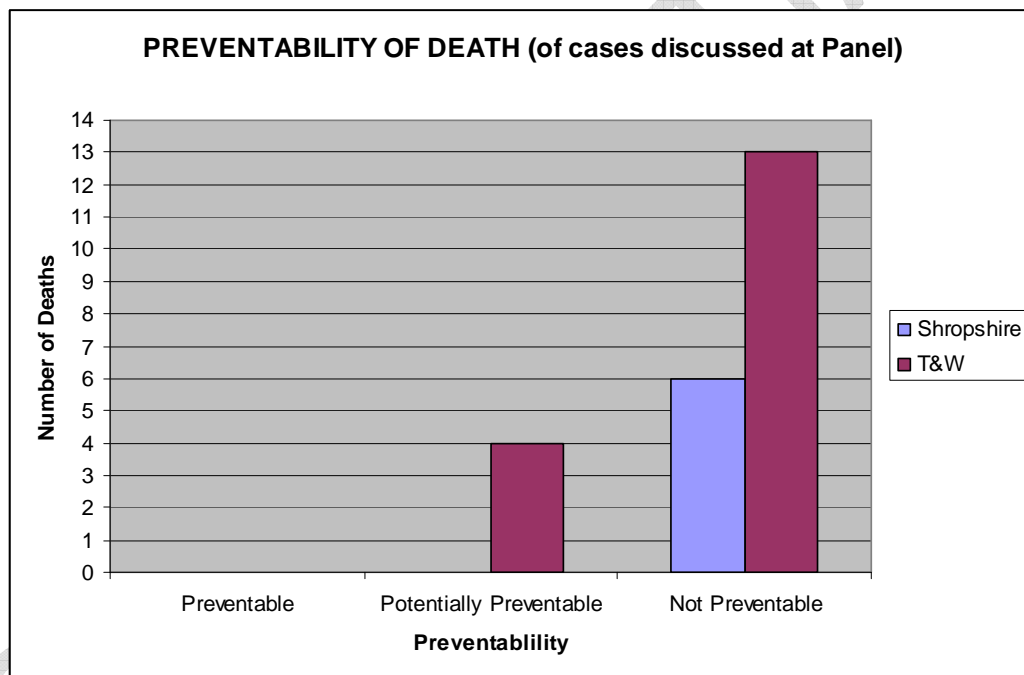
6. Analysis of deaths which have been presented to CDOP

6.1 During the period of 1 April 2008 to 31 March 2009, the Panel discussed and categorised 23 deaths.

0 deaths were classed as Preventable.

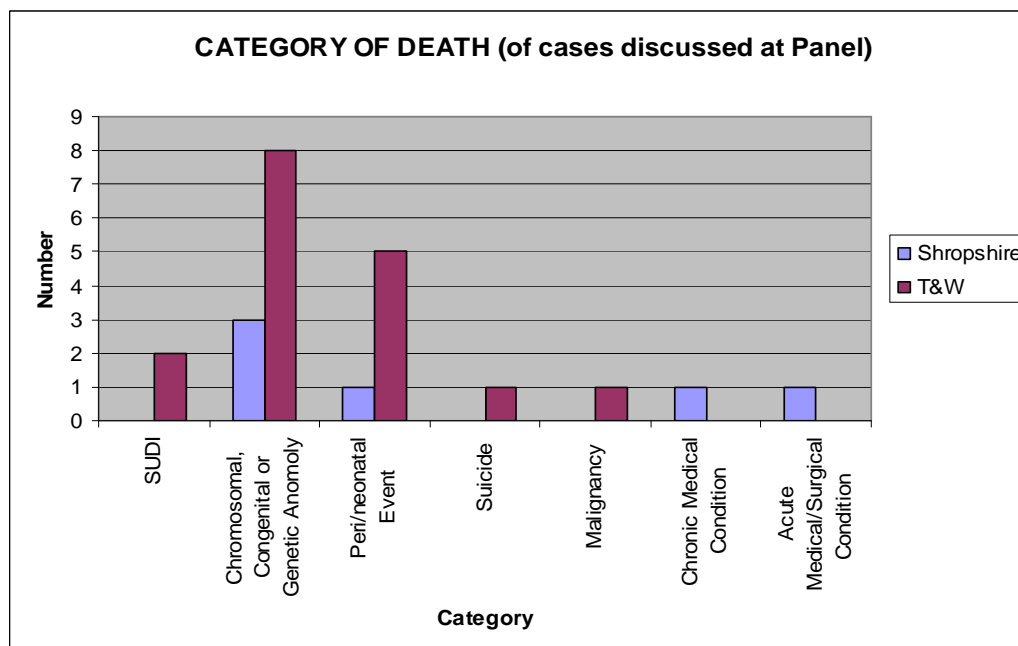
4 deaths were classed as Potentially Preventable.

19 deaths were classed as Not Preventable.



6.2 The CDOP agreed that 4 deaths were potentially preventable. Two were Sudden, Unexpected Deaths in Infancy with multiple risk factors. One was a 15 year old boy who hung himself after expressing suicidal thoughts. One was a baby who died following a complicated birth at 24 weeks gestation where maternal substance abuse may have contributed to the premature labour.

6.3



6.4 Further analysis of deaths will be undertaken when all the deaths during the year have been presented to and considered by the CDOP.

6.5 The length of time this will take will depend on external factors mentioned previously and the capacity of the Co-ordinator and Named Doctor.

7. CDOP Training

7.1 Information in relation to training issues has not been included in this report due to the current unavailability of the Designated and Named Nurse. The PCT is currently reviewing all safeguarding training to ensure quality and volume meet the required standard.

8. CDOP Finance

8.1 Information on financial issues has been included briefly in this report in relation to the increase of funding to support safeguarding and CDOP processes for 09/10.

9. Summary

9.1 There were 55 deaths from 1 April 2008 to 31 March 2009.

9.2 The most vulnerable age group are babies from birth to 12 months of age with a much lower death rate during childhood which starts to rise again in the adolescent years.

9.3 There were slightly more deaths than expected statistically in the T&W area.

Only 23 deaths were presented to the CDOP up to 31 March and of these, all but four were deemed not to have been preventable.



- 9.4 Further analysis will be done into the 55 deaths when all the cases have been completed and presented to the CDOP. The reasons for the delay are outlined in Appendices A and B.
- 9.5 The learning points which have been highlighted by the CDOP so far are as follows:
- 9.6
- The mortality rate for babies born extremely early is still high, despite excellent neonatal facilities locally. It is not always clear why premature labour happens however, smoking and substance abuse during pregnancy can contribute to placental problems which can then threaten the pregnancy.
- 9.7
- Recognition of babies who have a higher risk of SUDI is important. Health Professionals should continue to emphasise risk reduction measures and continue to target high risk families for enhanced support.
- 9.8
- Parents continue to need advice about how to recognise and respond to signs of serious illness in young babies.
- 9.9.1
- There are inconsistencies when seriously ill 16 and 17 year olds present for hospital care in relation to their admission to Paediatric or Adult units.
- 9.9.2
- Road Safety advice needs to be targeted at older children and adolescents in relation to cyclists wearing helmets and car passengers wearing seatbelts. Newly qualified drivers need to understand the potential consequences of driving at high speed and passengers should be encouraged to put pressure on them to slow down if they are driving dangerously.
- 9.9.3
- The question remains whether or not nationally reported suicide clusters are influencing the actions of disturbed young people and how to respond to this worrying trend locally. The press have a role to play here and the local media have been asked not to specify how young people have died in these circumstances but social networking sites spread this information very quickly so it is difficult to suppress the details for long.

**Report compiled by Dr Deborah Bell
Associate Specialist Community Paediatrician**

1 June 2009



TELFORD & WREKIN AND SHROPSHIRE'S SAFEGUARDING CHILDREN BOARD

CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT 2008/09

Appendix A

Capacity Issues

Cases are prepared for CDOP by the Named Doctor for Child Death Reviews and the CDOP Co-ordinator. During the early months of the work, many policies and procedures have been developed and links made with various professionals who are involved when a child dies. The CDOP Co-ordinator was initially allocated 25% of a full-time post for the CDOP work however; it soon became evident that this was not sufficient. In recognition of this, the PCT has secured funding from 09/10 to increase the CDOP post to full-time in order to address the increasing requirements of the role. The current job description and person specification for the role is under review and a temporary CDOP coordinator is in place to support this process.

Dr Bell, Named Doctor, was allocated 2 sessions per week for the CDOP work and then 3 sessions per week from April 2008. As the number of deaths rose over the next few months, this has proved challenging in the time allocated. The sessions increased to 5 per week from November 2008 to February 2009 which eased the pressure. Since February 2009 the named doctor has only had capacity for 2-3 sessions per week to carry out the CDOP work. This has led to an increasing length of time to prepare reports for CDOP.

There remains a challenge for the named doctor to balance other Paediatric workload within the paediatric team. This is being considered by senior managers within the PCT and specifically the medical manager. Furthermore, a permanent desk at 30 West Road would contribute to more efficient use of the time available.



TELFORD & WREKIN AND SHROPSHIRE'S SAFEGUARDING CHILDREN BOARD

CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT 2008/09

Appendix B

RAPID RESPONSE

In relation to the Rapid Response to Sudden Unexpected deaths, Dr Bell is effectively 'on-call' from 9 am to 5 pm during working hours and has been called on approximately 8 occasions, mainly following infant deaths, to meet families, carry out home visits and liaise with Police, Coroner's Officers and the Paediatric pathologists in Birmingham. Dr Bell will do evening visits if required in most instances when a death occurs during the working day.

The ability to respond immediately to such events requires the person 'on-call' to have a sufficiently flexible programme and to be trained to be able to quickly determine the level of response required. The large area of the whole of Shropshire covered is a considerable challenge and Rapid Responses have taken place in locations covered by both the T&W and Shropshire Safeguarding Boards. The Police and Coroner's Officers have welcomed the new arrangements and professionals from all over the county are getting used to the requirement to rapidly notify the CDOP Co-ordinator when a death occurs.

Dr Ganesh is working on plans to extend the Rapid Response team to cover weekends and holidays. From April 2010, cover will also be needed on Thursdays and Fridays. The extended Rapid Response team is likely to consist of Paediatricians and other experienced health professionals and all who volunteer for this role will need to be trained and remunerated for being 'on-call' and for responses they are required to carry out.