

Oxfordshire Child Death Overview Process

Annual Report for 2018/19

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1.0 Introduction from the CDOP Chair

The annual report of the Oxfordshire Child Death Overview Process (CDOP) sets out the CDOP work carried out during 2018-2019. The report discusses activity, functions, processes and analysis. It reviews the recommendations from the year 2018-2019 and makes recommendations for 2019-2020.

Deaths in children are always very distressing for parents, carers and clinical staff. Developing an overview of the confirmed causes of childhood deaths can lead in some instances to effective action in preventing future deaths. In accordance with the statutory guidance, we review deaths of all children resident in Oxfordshire, identifying themes, modifiable factors and any issues that may affect the safety and welfare of children. In particular, we aim to develop a more detailed understanding of the causes of death and where appropriate, take forward recommendations made by the panel to influence strategic changes and practice.

In 2018 'Working Together to Safeguard Children' was updated. This introduced significant changes to Local Safeguarding Boards and to the Child Death Review Process. This process is now governed by the Department of Health, reflecting the fact that 80% of all child deaths have a medical cause. How Oxfordshire is responding to these changes is discussed within this report.

The CDOP is made up of representatives from the agencies that make up the Oxfordshire Safeguarding Children Board membership. The representation from agencies and professionals is consistently good. I am grateful for the commitment of all those who are involved in this process attending panel meetings and contributing to the analysis of cases.

There is continued commitment to ensure effective communication and good working relationships. Across all agencies, the panel critically reviews and seeks to identify any local issues and learning. It is through this scrutiny and constructive challenge that we will continue to jointly work to improve services for children across Oxfordshire.

Sula Wiltshire,
CDOP Chair
Director of Quality and Lead Nurse
Oxfordshire Clinical Commissioning Group

2.0 Background

The statutory requirement to establish a panel that would review every child death in their local area has been in place since 2006 (section 14 (2) of the Children Act 2004)¹. These regulations were further developed in Working Together to Safeguard Children (2018)².

The specific functions as laid down in the statutory guidance are as follows:

- Review the available information of deaths of all children up to the age of 18 years. This includes the deaths of infants less than 28 days, including those born before viability, but not those who are stillborn or are terminated pregnancies within the law
- Collecting, collating and reporting on a national agreed data set for each child who has died
- Meeting regularly to review and evaluate data collected, identifying lessons to be learnt and raising any issues for concern
- Monitoring the response of professionals to the unexpected death of a child and the effectiveness of services
- Referring to the chair of the OSCB any case where there may be grounds for a serious case review
- Monitoring the support services offered to bereaved parents/families,
- Identifying any public health issues and considering, with Public Health, how best to address these and their implications for provision of services and training

The Oxfordshire CDOP is committed to the process of systematically reviewing all children's deaths, ensuring the child death review process is grounded in respect for the rights of children and their families, and focused where possible on preventing future child deaths.

The CDOP membership comprises of representatives from key partner agencies, from the OSCB membership and the Coroner's office, to provide expertise on a wide range of issues pertinent to children's services. The panel includes a lay member, who has provided a vital perspective to the panel's discussions, although this post is currently vacant. Relevant professionals can be co-opted to assist when appropriate. Attendance at the meeting over the past year has been good.

The CDOP this year has reviewed between 3 and 8 cases at each meeting, completing the statutory Form C for each case, identifying modifiable factors and categorising each death. A full list of CDOP members can be seen in Appendix 2.

¹ http://www.legislation.gov.uk/ukpga/2004/31/pdfs/ukpga_20040031_en.pdf

² https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

3.0 CDOP Process

The administration of the Oxfordshire CDOP is hosted by Oxfordshire Clinical Commissioning Group (OCCG) and is chaired by the Director of Quality and Lead Nurse from the OCCG. The Designated Doctor for Child Death is a Consultant Paediatrician at the Oxford University Hospitals NHS Foundation Trust and is commissioned by the OCCG to undertake this role.

Child deaths are reviewed using multi-agency procedures based on the statutory process. Notification of a death leads to one of two pathways being followed.

If the child dies unexpectedly, an early response is required by practitioners working with the family. This is to ensure:

- efficient multi-agency information sharing
- identify immediate risks and needs
- initiate bereavement support for the child's family and affected communities and
- collate knowledge of the family and circumstances on behalf of the Coroner.

The early response meeting will consider whether a recommendation for consideration of a Serious Case Review should be made by the Case Review Assurance and Governance (CRAG) subgroup of OSCB.

A multiagency review is carried out by the Child Death Overview Panel, once all related investigations have been completed, and documentation has been collected. After each panel meeting, a summary of findings is shared with CRAG.

In situations when the child's death is anticipated or expected, support and identification of family needs and potential community issues should have been addressed in the palliative care planning processes. Information and evidence is collated for review by the overview panel without a professional's rapid response meeting.

3.1 Working Together to Safeguard Children 2018 changes

The revised statutory guidance, published in July 2018, recommends that the geographical and population 'footprint' of child death review partners should cover a child population, such that they typically review at least 60 child deaths per year¹. This footprint should take into account networks of NHS care, and agency and organisational boundaries, in order to reflect the integrated care and social networks of the local area. As such, Oxfordshire (approximately 40 deaths per year), and Buckinghamshire (35 deaths per year) have agreed to merge their CDOP panels from April 1st 2019.

The guidance also recommends that every child death (not just unexpected deaths) will have a Child Death Review Meeting. The detail of how these meetings are designed and run can be agreed locally and Oxfordshire agencies have agreed to

build on existing meetings (such as mortality and morbidity meetings) rather than introduce an additional layer.

It has been agreed that Oxfordshire and Buckinghamshire will continue to convene a multi-agency panel for their own area. These will review the deaths of all children normally resident in that area, and also where appropriate, the deaths of non-resident children. Local actions to modifiable factors identified will be actioned in a timely manner. Additional scrutiny will be provided by the Designated Doctor, and/or a member of the CDOP coordination team attending the panel in the other area. This will enable 'sign off' of the 'child death analysis form' (formally Form C).

Oxfordshire and Buckinghamshire will then hold joint themed panels three times a year. These meetings will involve senior professionals who have had no involvement in the cases under discussion and who can identify thematic system changes, in order to learn lessons for the prevention of future child deaths. The first meeting is being planned for November 2019.

The final change is the introduction of the role of key worker. Supporting and engaging the family who have lost a child is of prime importance throughout the whole child death review process. Recognising the complexity of the process, and the state of total shock that bereavement can bring, the guidance recommends that families should be given a single, named point of contact who they can turn to for information on the processes following their child's death, and who can signpost them to sources of support. It has been agreed that all agencies will commit to providing this role with ongoing work to develop local expectations. Good practice supports this approach to ensure that bereaved families have a single point of contact.

3.2 National Child Death Mortality Database (NCMD)

The National Child Death Mortality Database has been introduced from April 1st 2019. This was largely in response to criticism of CDOP that included a perception that it produced little in the way of national data or initiatives that might help prevent the deaths of children and that there was huge variability in the practice of CDOPs

The database aims to:

- Capture, analyse and disseminate appropriate data and learning from child death reviews
- Drive the quality of child death review at every stage through benchmarking and quality improvement methodology.
- Study and analyse the patterns, causes and associated risk factors of child mortality in England, providing information to target preventative healthcare and to assist in policy decisions.
- Influence national policy
- Provide an evidence based selection of confidential enquiries

- Contribute to improved outcomes for children and improved experiences for families accessing services in the future.

The database will collate data collected by CDOPs via statutory forms and supplementary forms (for those using eCDOP this will happen automatically). This will mean that the system will be able to identify emerging themes at the point of notification. It will then aid production of annual and thematic reports and dissemination of learning and recommendations nationally.

The database has been funded initially for 4 years and commissioned by HQIP on behalf of NHS England.

4.0 The National picture

The National report has not yet been published.

5.0 Oxfordshire CDOP Activity

5.1 Reported deaths in 2018/19

In 2018-2019, 92 child deaths were reported to the Oxfordshire CDOP. 29 (17 expected and 12 unexpected) of the child deaths reported were of children normally resident in Oxfordshire and 63 of the deaths were of children normally resident in other counties. Oxfordshire has a high number of deaths of children who are not Oxfordshire residents because it hosts the regional hospital and children's hospice. The number of Oxfordshire deaths is significantly less than 17/18 (40). Two of these deaths (both female, aged 4-17 years of age) were of children who also had Learning Disabilities. As such, once the review is completed by CDOP, the information will be shared with the Learning Disabilities Mortality Review (LeDeR) Programme.

The information on each child's death is collected and collated. Information relating to the death of non-Oxfordshire children is passed to the relevant single point of contact for child deaths in the child's normal area of residence. The responsibility for reviewing the death of an out of county child, then falls to the CDOP that covers the area of the child's normal residence. Oxfordshire, in its annual return to the Department for Education, reported on the number of deaths of non-Oxfordshire children who died in Oxfordshire. However, these were not considered at the Oxfordshire panel meetings.

5.2 Reviewed deaths 2018/19

The Oxfordshire CDOP panel met on four separate occasions in 2018-2019 to review child deaths. The deaths of 24 children whose usual residence was in Oxfordshire were reviewed. These reviews included deaths that occurred in the year 2018-2019 and reviews that occurred before 2017-18, but had been carried over, due to alternative investigations which prevented completion of the CDOP process earlier.

Where other processes need to be completed, for example criminal investigations and proceedings, Coroner's investigations, or individual internal agency reviews, there can be a gap of several months between a death and that death being reviewed by the panel. The CDOP panel cannot review the death until all other processes have been completed, as the review would not be comprehensive.

Not all of the child deaths occurring in 2018-19 have been reviewed by the CDOP; 16 cases were carried over to the 2019- 2020 year. In addition, there are 3 cases prior to 2018-19 which have not yet been reviewed, because they are awaiting other investigations to be completed. In all cases carried over, the panel has agreed the delays are outside of their control or jurisdiction.

Outstanding cases are discussed weekly by the CDOP administration team and the Designated Doctor, to ensure that data collection and information sharing is up to date and progressing. Assurance is also sought to confirm any immediate learning and actions are being undertaken by practitioners and organisations. A summary of open cases and parallel processes is presented at each panel meeting, to ensure the panel has clear oversight of the issues causing delays.

The outcomes of panel meetings are twofold: Firstly to identify the classification of death and modifiable factors. Of the deaths reviewed in 2018-2019, 10(42%) were identified as having modifiable factors. Action and activities undertaken in response to identified modifiable factors are detailed in section 6.7. The second part is to identify issues for services or practitioners, identifying any learning that needs to be shared.

Of the child deaths reviewed in 2018-2019, 6 (25%) were identified as the expected deaths of children dying from life limiting conditions. Of the deaths reviewed, 11 (46%) were identified as perinatal or neonatal causes. Support and care for these families was provided.

The content and use of Advance Care Plans (ACPs), and whether or not palliative care was introduced in a timely manner has been monitored specifically as an action from 17/18. This has identified 6 (25%) cases of good palliative care (ACPs in place, timely referrals to palliative care, family enabled to have their child die in the place of their choosing). In 4 (17%) cases organ donation was explicitly discussed with 2 (8%) proceeding to donate organs. There were 4 (17%) cases where issues were raised about palliative care (ACPs not in place or not available to services, timely referrals to palliative care not made, family not enabled to have their child die in the place of their choosing). In addition the quality of bereavement services/ coordinated bereavement plans was analysed. In 6 (25%) cases there was evidence that there was a lack of adequate coordinated bereavement services.

There were 2 (8%) suicides reviewed in 2018/19, and one further case that had an open verdict. The 3 young people were aged 13, 14 and 15, 2 male and one female. Only one of these cases had any previously known mental health problems and there were no modifiable factors in any of the cases.

Tables and charts to support the commentary above are included in Appendix 1.

6.0 Modifiable factors

Preventable child deaths can be defined as “those in which modifiable factors may have contributed to the death. These factors are defined as those which by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths².”

The panel considers all the available information and makes a decision as to whether there were any modifiable factors in each case. These include factors in the family, environment, parenting capacity and service provision. Consideration should be made as to what action could be taken at a local, regional or national level to prevent future deaths to improve service provision to children, families and the wider community. When considering modifiable factors the panel is required to make a decision on whether the factors contributed to or caused the death.

In the year 2018-2019, the CDOP panel concluded that in 10 (42%) of cases reviewed there were modifiable factors. The following were identified that contributed to or caused the death.

Modifiable factors identified were:

- Co sleeping (3 cases/ 10%)
 - in each case there were other factors identified (infection) and each family had been given co-sleeping advice
- Smoking (5 cases/ 17%)
 - There was no direct causal link identified
- Housing issues (2 cases/ 7%)
 - Not felt to be contributory but continues to be an indicator of vulnerability
- Infection guidelines/ sepsis guidelines not being followed (3 cases/ 10%)
 - Local guidelines have been updated and additional education put in place

There are a number of established national campaigns around the issues that relate to modifiable factors, where that is the case, no specific recommendations have been made.

It is of note that the modifiable factors recorded remain consistent from year to year.

7.0 Unexpected deaths and early response in Oxfordshire

In collaboration with the Designated Doctor for Child Deaths (in working hours) and Acute Paediatricians (out of hours) the Child Death Team ensures that families are provided with support in the event of a sudden and unexpected child death. They work collaboratively with other organisations including the Coroner’s office, Schools, Youth Projects, Social Care, South Central Ambulance Service, Thames Valley

Police, Oxford University Hospitals NHS Trust, Oxford Health NHS Foundation Trust, Helen and Douglas House Hospice and the child bereavement charity Seesaw, in order to enhance the quality of care provided to all those whose work brings them into contact with bereaved families.

The process ensures that the Child Death Team makes a vital contribution not only to the CDOP review, but to the immediate response provided in the event of an unexpected child death. This difficult and sensitive work provides robust support for families and professionals in the tragic circumstances surrounding a child death.

Currently, families do not attend the early response meeting; however, the role of the Coroner is to keep them fully informed throughout the process. To this end, the notes and actions of the early response meeting are shared with the Coroner and a Coroner's Officer attends the meeting when possible. In 2018-2019, a total of 12 unexpected deaths of Oxfordshire children were reported to the Oxfordshire CDOP and Early Response Coordination team: 7 boys and 5 girls. For all Oxfordshire cases, an early response meeting was held.

All of the families received immediate bereavement care and support from the Oxfordshire Child Death Response Team. This OUH service to support the early response process is being reviewed following the change to National Guidance².

All unexpected out of area cases were referred to the relevant LSCB at the earliest opportunity, with further information provided to the relevant area by the OCCG safeguarding team following discussion and advice from the Designated Doctor for Child Death.

8.0 Designated Doctor's report.

The past year has seen further embedding of the electronic notification and reporting system, enabling timely and consistent reporting to CDOP in all cases of unexpected and predicted deaths. The Joint Agency Response to unexpected deaths in Oxfordshire remains a significant strength, with clear commitment from all partners to early information gathering and robust action plans. This has been particularly effective in a number of deaths that occurred in young people in the 16-18 year age group whose care is provided in areas outside of the Paediatric medical sphere.

An individualised approach to child death will be supported by professionals with an identifiable role at trust level across Oxfordshire. This will ensure compliance with the new national guidelines and augment the early response to predicted child deaths. The focus will be on identification of key workers and greater provision of family support in every case. Added to this is a commitment to more consistent and in-depth local analysis through Child Death Review Meetings in all areas, with improved mechanisms for shared understanding and learning. The regional CDOP process will be enhanced by the provision of more detailed data following these reviews to our own and neighbouring CDOP's. These links are already in place

through as we support the implementation of new national guidance and this is expected to grow in the upcoming year.

9.0 Update on 17/18 recommendations and actions

1. The family and environment section of the CDOP form is inconsistently completed affecting the quality of the report.

OCCG developed a guideline for professionals completing these documents which were shared with all partners in September 2018. This has improved the consistency of data within the reporting forms. In addition the changes to the forms introduced in April 2019 have made some of these fields mandatory rather than optional.

Greater family involvement in review processes is a key focus of the new statutory guidance (see section 3.1).

2. CDOP have identified several cases where there has been a delay in a family being able to view their child's body. All relevant agencies are reviewing and updating their policies. CDOP will receive a report to provide assurance of completion of this action.

OUH and TVP have amended their policies. In addition OUH have increased their facilities for the viewing of bodies and there have not been any further reports of this issue.

3. Temporary housing has been a repeated theme – to date there is no direct link between this and the child's death. CDOP will share this information with the Local Authority and will monitor this trend.

There have been 2 cases where housing was mentioned in 18/19. In neither case was this felt to be a contributory factor.

4. In several reviews in 17/18 the content and use of Advance Care Plans (ACPs) has been discussed. This has shown some variation in practice and knowledge. Actions have been agreed by panel members to review the use of ACPs and this information is now recorded in the mortality and morbidity minutes. A copy of the ACP is uploaded to eCDOP.

Please see 18/19 themes.

10.0 CDOP Recommendations from 2018/19

1. All aspects of end of life care where there is time to plan requires further attention. Although there was some evidence of good joint working there were still a number of areas requiring improvement.
 - a. The content and use of Advance Care Plans (ACPs),
 - b. The introduction or palliative care in a timely manner
 - c. The offering of organ donation

Action: OCCG to continue to monitor trends.

Action: OCCG to share information with the EOL collaborative project.

Action: CDOP to monitor the impact of the role of the key worker

2. 2 suicides and one death with an open verdict deaths of young teenagers, where no modifiable factors were identified, is concerning. It has been identified that suicide in young people is rarely caused by one thing; it usually follows a combination of previous vulnerability and recent events. Important themes for suicide prevention are support for or management of family factors (e.g. mental illness, physical illness, or substance misuse), childhood abuse, bullying, physical health, social isolation, mental ill-health and alcohol or drug misuse^[1].

Action: Oxfordshire Multi-agency Suicide Prevention Group to share a programme to raise awareness of these vulnerabilities to ensure appropriate targeting of services.

3. All provider agencies to focus on the implementation of the introduction of the key worker role. This work will need to include capturing the family view's so that it can be included in the review process. Together with a scoping of the availability and quality of bereavement services and introduction of explicit coordinated bereavement plans.

Action: All provider agencies.

4. The implementation of the changes recommended in Working Together (2018), combining with Buckinghamshire should lead to improved governance of the system. This includes the introduction of themed meetings which will enable analysis of themes from a more meaningful number of cases.

Action: all agencies to embed new processes.

11.0 Conclusion

The CDOP process within Oxfordshire has been supported well by all agencies and organisations. There have been a number of staff changes within the immediate CDOP team, and also within the representatives on the panel. The CDOP processes have also been updated in line with other changes to safeguarding local services and continue to provide effective and timely support to families at the time of their bereavement.

Agreement of the changes need to meet the requirements of the updated Child Death Review Guidelines have involved significant commitment from all agencies but Oxfordshire now has robust transition arrangements in place to meet these.

^[1] <http://documents.manchester.ac.uk/display.aspx?DocID=37566>

Appendix 1

Chart 1: Number of deaths in Oxfordshire children reported to CDOP aged 0-18 years, 2006– 2018/19

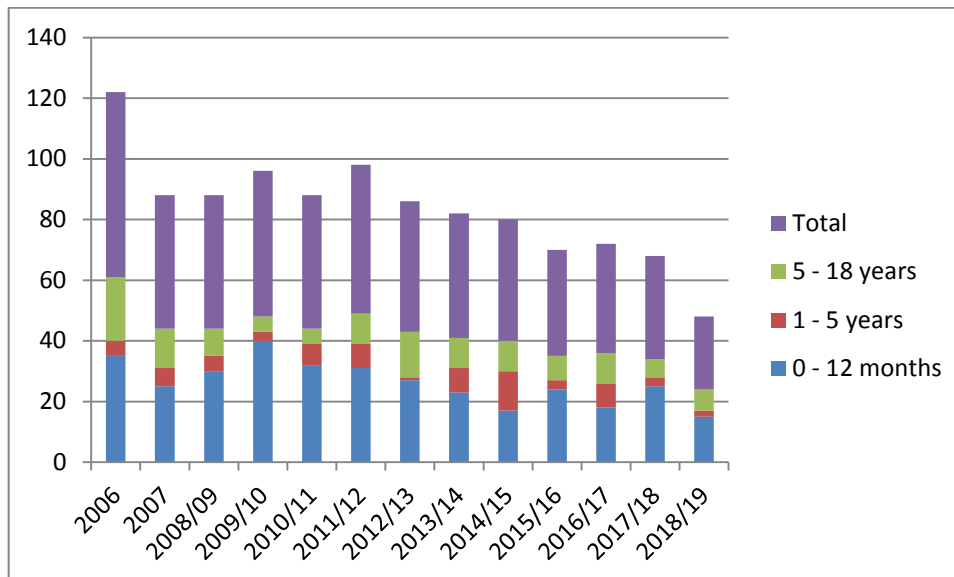


Table 1: Cause of child deaths reported to the Oxfordshire CDOP between 2018/19

| Name | Number of child deaths with modifiable factors recorded under this event | Number of child deaths with no modifiable factors recorded under this event |
|---|--|---|
| Deliberately inflicted injury, abuse or neglect | 0 | 0 |
| Suicide or deliberate self-inflicted harm | 2 | 1 |
| Trauma and other external factors | 0 | 1 |
| Malignancy | 0 | 0 |
| Acute medical or surgical condition | 1 | 1 |
| Chronic medical condition | 1 | 0 |
| Chromosomal, genetic and congenital anomalies | 0 | 7 |
| Perinatal/neonatal event | 4 | 3 |
| Infection | 2 | 0 |
| Sudden unexpected, unexplained death | 1 | 0 |
| Total | 11 | 13 |

Chart 2: The age and gender of the Oxfordshire child deaths reviewed in 2018/19

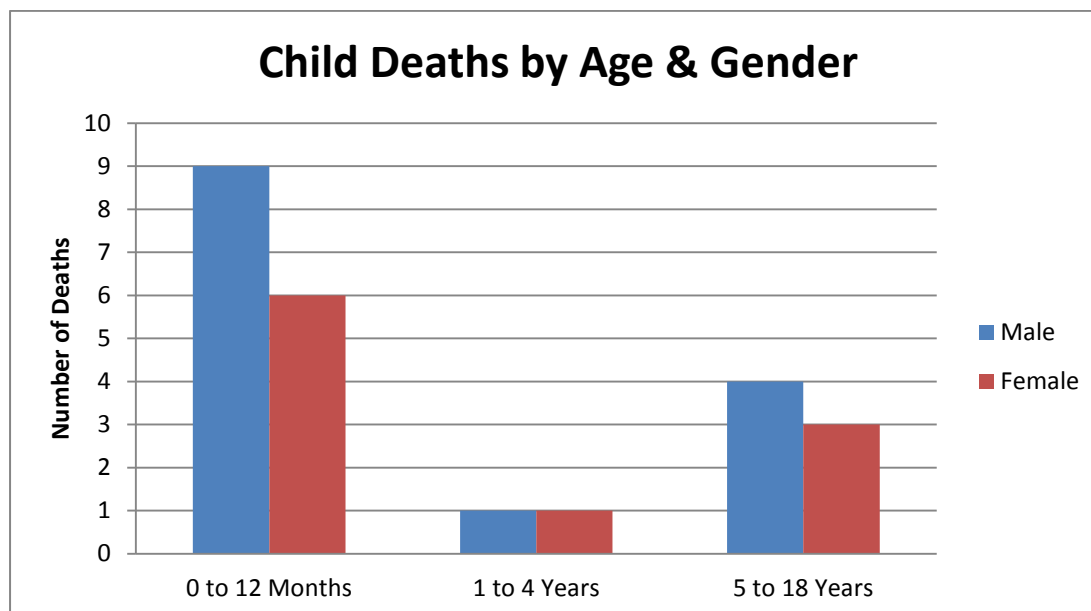


Table 3: Location of fatal event leading to the child's death, as reported to Oxfordshire (CDOP), in 2018/19

| | | Number of child deaths with modifiable factors | Number of child deaths with no modifiable factors |
|--|--------------------------------|--|---|
| Acute Hospital | Emergency Department | 4 | 0 |
| | Paediatric Ward | 1 | 0 |
| | Neonatal Unit | 0 | 0 |
| | Paediatric Intensive Care Unit | 1 | 6 |
| | Labour wards | 1 | 4 |
| Home of normal residence | | 3 | 0 |
| Public place (including roads, railways, parks, restaurants, beaches, etc) | | 1 | 1 |
| Hospice | | 0 | 2 |
| TOTAL | | 11 | 13 |

Appendix 2

CDOP Membership 2018/19

| Name | Position | Agency |
|---------------------------------|--|--|
| Sula Wiltshire | Chair: Director of Quality and Lead Nurse | Oxfordshire Clinical Commissioning Group |
| Dr Alison Shefler | Designated Doctor for Child Deaths Consultant Paediatric Intensive Care, | Oxford University Hospitals NHS Trust |
| Alison Chapman | Designated Nurse & Safeguarding Lead, | Oxfordshire Clinical Commissioning Group |
| Karen Brombley | Deputy Designated Nurse & Safeguarding Lead, | Oxfordshire Clinical Commissioning Group |
| Gaza Vass | Consultant, NNU | Oxford University Hospitals NHS Trust |
| Kay Bishop | Business Manager OSCB | Oxfordshire Safeguarding Children Board |
| Coleen Bowker | Paediatric Pathologist | Oxford University Hospitals NHS Trust |
| Dr Emily Harrop | Paediatric Palliative Care Consultant | Helen & Douglas House Hospice |
| Lisa Lord/Jayne Harrison | Named Nurse Safeguarding | Oxford Health Foundation trust |
| Pauline Burke | CDOP and Safeguarding Officer | Oxfordshire Clinical Commissioning Group |
| Cat d'Angelo | Safeguarding Support Officer and CDOP admin | Oxfordshire Clinical Commissioning Group |
| DI Larry Johnson | DI Police Child Abuse Investigation Unit | Thames Valley Police |
| | Lay Representative | Independent |
| Hazel Cringle | Safeguarding Manager | Oxfordshire County Council |
| Antony Heselton | Head of Safeguarding | South Central Ambulance Service |
| Donna Husband | Commissioning Manager in Public Health | Public Health - OCC |
| Sarah Ledingham | Named GP Safeguarding | Oxfordshire Clinical Commissioning Group |
| Judith Mulligan | Director | See Saw Bereavement Charity |
| Ruth Rees | Coroners Service Manager | Coroner's Office |
| Tracy Toohey | Safeguarding Lead, OUH | Oxford University Hospitals |
| Rosalie Wright | Midwifery Manager | Oxford University Hospitals |

Appendix 3

