
PREVENTING CHILDHOOD DEATHS SUPPLEMENTARY SURVEY 2008

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Introduction

Following completion of the DCSF study 'Preventing Childhood Deaths' (1) a follow up survey of LSCBs was carried out in January - March 2008 to determine progress in implementing the arrangements for rapid response and child death review immediately prior to the scheduled implementation date of April 2008.

Methods

A short questionnaire was sent to all LSCBs in England in January 2008. This questionnaire was identical to that used in October 2006, with the addition of specific questions relating to collaboration with neighbouring authorities, and on appointment of lead paediatricians for unexpected child deaths. Findings from the questionnaire returns were compared with those returned in October 2006. This questionnaire was followed up, with those LSCBs indicating a willingness to participate, with two audits - one relating to the rapid response process and one to the child death overview panels.

Results

Out of a total of 144 questionnaires distributed, 93 were returned, a 64% return rate, compared to 42% in 2006. Results from the two surveys are compared in table 1. Although 100% of those responding reported that they either had, or were developing a joint agency protocol (compared to 84% in 2006), the number with an established and fully operational protocol remained low, with only 17 boards (18%) reporting that their protocol was working well and a further 22 (24%) that it was working in part. Considerable progress has been made however in extending these protocols to cover unexpected deaths in all children (94% compared to 58% in 2006) as opposed to infants only. It is possible that the low reported rate for established protocols was because many areas that already had established protocols for unexpected infant deaths were developing these further to include unexpected deaths in older children. A number of respondents reported specific issues in relation to protocol implementation as free text responses. These included difficulties around getting paediatricians to participate in home visits; one London borough awaiting the development of a London-wide protocol; and issues around funding for paediatricians and other resources.

Table 1: Results of LSCB surveys

| | 2006 Survey N = 60 | 2008 Survey N = 93 |
|--|-------------------------------|-------------------------------|
| Rapid Response | | |
| Joint Agency Protocol Established | 19 (32%) | 27 (29%) |
| Joint Agency Protocol in Development | 31 (52%) | 66 (71%) |
| Joint Agency Protocol shared with neighbouring authorities | - | 69 (74%) |
| Joint Agency Protocol covers all unexpected deaths | 29 (58%) | 87 (94%) |
| Joint Agency Protocol covers infant deaths only | 9 (18%) | 3 (3%) |
| Not specified | 12 (24%) | 3 (3%) |
| Joint Agency Protocol working well | - | 17 (18%) |
| Joint Agency Protocol working in part | - | 22 (24%) |
| Joint Agency Protocol not working | - | 8 (9%) |
| Child Death Overview Panel (CDOP) | | |
| CDOP established | 3 (5%) | 30 (32%) |
| CDOP in development | 36 (60%) | 63 (68%) |
| No CDOP | 21 (35%) | - |
| CDOP covering all child deaths | 17 (44%) | 85 (91%) |
| CDOP covering only unexpected deaths | 6 (15%) | 3 (3%) |
| Collaborating with neighbouring authorities in establishing CDOP | - | 66 (71%) |
| Lead paediatrician in post | 30 (50%) | 63 (68%) |

In contrast to the situation in 2006, all the 93 boards had either developed or were developing a CDOP. In keeping with the requirements of *Working Together*, the majority (85, 91%) of panels were reviewing all child deaths, although it was concerning that 3 reported that they were only reviewing unexpected deaths. Most LSCBs (71%) indicated that they were collaborating with neighbouring authorities in establishing their CDOP.

Rapid Response Results, 2008

Three LSCBs (2 from the W Midlands, 1 from E Anglia) returned rapid response audit forms on a total of 16 unexpected deaths occurring between July and December 2007. The ages of the children varied from one who died at birth, through to 10 years 11 months. The ages, causes of death and progress of the rapid response for

the individual cases are given in Table 2. Six children died of natural causes (including three SIDS), five were deemed accidental, one a homicide, and four were not specified or not known. In five cases concerns of a child protection nature were identified and three cases were referred to the Crown Prosecution Service. One case occurred at an armed forces base in Europe. This case was nevertheless notified to the police and some components of the rapid response, including an initial information sharing meeting and a home visit were completed.

Of the remaining 15 cases, the initial notification came mostly from ambulance control (10 cases), with three from an emergency department and two from paediatricians. All but one case were notified within 24 hours, the majority (67%) within 2 hours.

Where the information was available, the initial history was taken in hospital by a paediatrician in all cases, with the police also in attendance in four cases and an emergency department doctor in one. All children were examined by a paediatrician, together with a police officer in one case and an emergency department doctor in three. Investigations were deemed not to be appropriate in two cases. Of the remainder, eight were carried out fully according to the local protocol. In a small number of cases some difficulties were reported in carrying out investigations: in two cases these were related to deaths occurring out of county, in one case because of the need for a police investigation, and in one case because of religious reasons.

In three cases information was not available about parental care and in one further case (that of the baby who died at birth as a presumed homicide) the aspects of parental care listed were deemed not to be appropriate. In the other cases, most parents were allowed to hold their child (10); were given photographs and/or mementos (9); were offered counselling or religious support (10); were given written information (9) and contact details (11); and were informed about the post mortem examination (11). Fewer (7) were informed about the rapid response process.

An initial information sharing and planning meeting was held in all but one case, mostly (10) within 24 hours. This was followed by a joint agency home visit in 12 (75%) cases, either on the same day (7) or the following day (3). In two cases it was deemed not to be appropriate - one which the police were treating as a crime scene, and another where the child died at sea. In one further case, the police undertook a single agency home visit, but then shared the information and the video with the multi-agency team. The police were involved in all 12 home visits, and a paediatrician in 11 (a general paediatrician in five, a SUDI paediatrician in five and the designated doctor for safeguarding in one). No home visits included representatives of primary care or social care.

An autopsy was carried out in all cases -10 by a paediatric pathologist, one by a forensic pathologist, one joint autopsy and one by a general hospital pathologist. In three cases, details of the pathologist weren't provided. A final case discussion had been held in four cases, all within 2-4 months, and was planned in a further six. All four case discussions were attended by the police, only one by a paediatrician, three by primary care (GP and / or health visitor or midwife), one by a social worker and one by a coroner's officer

Table 2: Rapid Response audit - ages and causes of death

| LSCB | Child's Age | Cause of Death | Initial History and Examination | Investigations | Initial Multi Agency meeting | Joint home visit | Final case discussion |
|-------------|--------------------|---|--|-----------------------|-------------------------------------|-------------------------|------------------------------|
| A | 5 months | Unknown | Yes | Yes | Yes | No | Planned |
| B | 1 year | Natural Causes: Pneumonia (severely disabled child) | Yes | Some | Yes | Yes | NK |
| B | 3 months | SIDS | Yes | Some | Yes | Yes | Yes |
| B | 10 years | Accident: Drowning | Yes | NK | NK | NA | No |
| B | 6 months | SIDS | Yes | NK | Yes | Yes | Yes |
| B | Birth | Homicide | Yes | Yes | Yes | NA | Planned |
| B | 18 days | Natural causes (not specified) | Yes | Yes | Yes | Yes | Yes |
| B | 5 months | Natural causes: CMV infection | Yes | Some | Yes | Yes | No |
| B | 2 months | Accident: Asphyxia (face down on duvet) | NK | NK | Yes | Yes | No |
| B | 1 year | Accident: furniture fell on child | Yes | NA | Yes | No | No |
| B | 3 years | Accident | Yes | NA | Yes | Yes | No |
| C | 1 month | Accident (overlying) | Yes | Yes | Yes | Yes | Yes |
| C | 2 months | SIDS | Yes | Yes | Yes | Yes | Planned |
| C | 3 months | Not specified | Yes | Yes | Yes | Yes | Planned |
| C | 3 days | Not specified | Yes | Yes | Yes | Yes | Planned |
| C | 7 months | Not known | Yes | Yes | Yes | Yes | Planned |

CDOP Audit Results

Based on the questionnaire results, we sent an amended CDOP audit tool to 16 LSCBs who had established CDOPs and were willing to participate in an audit. Only four completed audit tools were returned. Three of these panels had met twice in the preceding six months, and one had met once. Correspondence with some of the other panel chairs indicated that although many panels had been meeting, much of this had been in relation to developing the panel and their processes, and carrying out “trial runs”, rather than actually carrying out full child death reviews.

At those panel meetings audited, Police, Nursing, Public Health, and Children’s Social Care were reportedly present in all panel meetings. Hospital and Community Paediatricians, Education, Primary Care and the Coroner were present at some meetings only, and other ad hoc members, including a Road Safety representative, Adult Social Care, an Administrator and members of the Safeguarding Team were present in at least one of the panels. The number of panel members present varied from seven to ten.

A total of 35 cases were reviewed in the seven panel meetings (Table 3).

Table 3: Cases reviewed

| | Number (%) of cases N = 35 |
|-------------------------------------|---|
| Age group | |
| Neonatal | 11 (31) |
| Infant | 8 (23) |
| 1-4 | 4 (11) |
| 5-9 | 2 (6) |
| 10-14 | 4 (11) |
| 15-18 | 6 (17) |
| Cause of Death* | |
| Expected | 9 (23) |
| Unexpected Natural (excluding SIDS) | 17 (44) |
| Sudden Infant Death Syndrome | 0 (0) |
| Accident | 3 (8) |
| Homicide | 1 (3) |
| Suicide | 2 (5) |
| Not established | 6 (15) |
| Near Miss | 1 (3) |

* One site reported a total of 15 cases reviewed, but listed 19 separate causes, the reason for this discrepancy was not clear.

Although this small sample cannot be assumed to be representative, it does give an idea of the sort of profile of deaths being reviewed. The age distribution is in keeping with the overall age distribution for all child deaths obtained from ONS data, and the recorded causes of death similarly show an expected profile, with the notable absence of no cases of sudden infant death syndrome (SIDS). It is possible that these were being recorded by panels as “not established”.

Most panels reviewed between two and four cases per meeting, although one panel listed 15 deaths and another 14 deaths for one meeting. In the latter case, three out of 14 were deferred for a later review, four were ‘follow up’ cases from a previous meeting and seven were new deaths. It was noted that much of the information was incomplete and cases were therefore being brought to the panel on more than one occasion.

Only two panels attempted to determine whether the deaths reviewed were avoidable¹. One reviewed two deaths concluding one was unavoidable and the other was not clear. The other panel classified one of the 15 deaths reviewed as potentially avoidable, but did not give any indication for the other deaths. One case was referred on by a panel for a Serious Case Review, and one other case from a different panel was listed for a more ‘in-depth’ review. No other onward referrals were made. Only two panels listed any recommendations arising from the reviews. Both panels recommended bereavement support for siblings or families. Other recommendations from one of the panels included a request for alternative names to be added to notifications of death, and recommendations to the local child accident support in relation to water safety.

¹ The term ‘avoidable’ had been used in initial versions of the audit tool and analysis proformas. In keeping with the PSA target on preventable deaths, subsequent versions have changed to use the term ‘preventable’. For this audit, the term avoidable was retained.

Discussion and Conclusions

This follow up study of LSCBs has shown considerable progress in developing and implementing child death review procedures between October 2006 and February 2008. Nevertheless, it was clear that, shortly before the scheduled implementation date of 1st April 2008, few LSCBs had fully operational rapid response procedures or child death overview panels. It would appear that both processes were being seen as evolving processes which will continue to develop and will take time to refine and become fully embedded in practice. There appears to have been a positive degree of cooperation between neighbouring authorities, for example in establishing shared protocols for rapid response, or through combined child death overview panels.

Those audits returned demonstrated that the rapid response process can work well, even in relation to deaths of older children, and for one death occurring out of the country. In particular, the initial management in hospital appears to work appropriately with good parental care; and notification, initial information sharing and planning takes place promptly. Joint home visits were carried out in most cases where deemed appropriate. The aspect that appears to be working least well is organising the final local case discussions. In many cases these had not taken place within four months of the death, and those that had taken place appeared to be poorly attended.

At this stage, few child death overview panels had started reviewing deaths, with many still devoting panel meetings to establishing processes, or carrying out trial runs. Of those few that were able to return audits, the process appeared to be working reasonably well. Panels were managing to document the cause of death in most cases. However, panels were obviously struggling with deciding whether or not the deaths were avoidable. Only two panels had attempted to determine avoidability, and that only for three deaths in total. It is likely that further guidance is needed for panels on how to classify this aspect.

The process has shown that the audit tool for the rapid response is usable and fit for purpose. The information provided on the child death overview panels was limited, and this audit tool could be amended to reflect more closely the process that takes place, and to establish standards of good practice. It would be appropriate to repeat an audit on a wider basis now after LSCBs have been given sufficient time to implement the rapid response and child death review processes.

References

1. Sidebotham P, Fox J, Horwath J, Powell C, Perwez S. Preventing Childhood Deaths: An Observational Study of Child Death Overview Panels in England. London: Department for Children, Schools and Families; 2008.

Additional Information

Further information about this research can be obtained from Isabella Craig, 4th Floor, DCSF, Sanctuary Buildings, Great Smith Street, London SW1P 3BT.

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