



**Coventry, Solihull & Warwickshire Safeguarding Children  
Boards**

# **CHILD DEATH REVIEW PROCESS**

## **ANNUAL REPORT**

**2008 - 2009**

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## **Introduction**

As the Chair of the Sub-Regional Child Death Overview Panel I am delighted to introduce this first Annual Report for the Child Death Review Process.

The preparations to ensure we had processes in place for 1 April 2008 began in 2007 with the appointment of a Development Officer, Celia East, who was instrumental together with partner agencies, in setting up the policies and procedures.

We recognised that in order to maximise learning, and to inform local strategic planning on how best to safeguard and promote the welfare of children in our area, a sub-regional approach between Coventry, Solihull and Warwickshire LSCB was the way forward. This innovative approach enabled local safeguarding boards to maintain their own local Child Death Review panel, whilst sharing the same processes and procedures, serviced by a central establishment responsible for the co-ordination and administration of all activity. The benefits of this approach ensured consistency across the sub-region, data shared at a higher level at the sub-regional Overview Panel and shared costs.

The first six months of data identified a trend in young children dying from Sudden Infant Death Syndrome (SIDS) and in March 2009 the Child Death Overview Panel endorsed the sub-regional SIDS Preventative (Safe Sleeping) Campaign.

Setting up an entirely new process has been both exciting and challenging and I would like to thank all partner agencies for their commitment in developing the process and for their ongoing contribution throughout the first year.

Chris Hallett  
Head of Service  
Children in Need Division

## **1 Background**

- 1.1 Chapter 7 Working Together to Safeguard Children 2006 and Regulation 6, Local Safeguarding Children Board (LSCB) Regulations 2005, set out the procedures to be followed when reviewing child deaths.
- 1.2 There are two interrelated processes for reviewing child deaths:
- (i) a rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death
  - (ii) an overview of all child deaths under 18 years who normally reside in the LSCB, undertaken by a Child Death Overview Panel, accountable to the LSCB Chair
- 1.3 The function of the Child Death Overview Panel is to :
- (a) Collect and analyse information about each death with a view to identifying:
    - (i) any case giving rise to the need for a serious case review
    - (ii) any matters of concern affecting the safety and welfare of children in the LSCB area, and
    - (iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the LSCB area
  - (b) Put in place procedures for ensuring there is a co-ordinated response by the local authority, their Board partners and other relevant persons to an unexpected death

## **2 Sub-Regional Approach – Coventry, Solihull and Warwickshire**

- 2.1 Chapter 7 of Working Together gives provision for LSCBs to share Child Death Overview Panels, depending on the size of population served. It was agreed that Coventry, Solihull and Warwickshire LSCB would each maintain their own local panel and share a strategic sub-regional Child Death Overview Panel responsible for collating data from the three LSCB areas.
- 2.2 There were identifiable benefits by adopting a hybrid approach in that detailed reviews would be conducted locally by managers who had a good understanding of local policy and feeding aggregated sub-regional data into the strategic overview panel would identify themes, learning opportunities and strategic planning on how best to safeguard and promote the welfare of children across the three LSCB areas.
- 2.3 It was also agreed that the three local panels would share the same processes and procedures, co-ordinated by a Manager with administrative support, and with each LSCB contributing to the cost.
- 2.4 A Project Manager was appointed to progress the work plan, supported by a multi agency CDRP Working Group and CDRP Steering Group, the latter becoming the strategic Sub-Regional Child Death Overview Panel.
- 2.5 It was agreed that local panels would convene every two months and the sub-regional panel, every six months.

### **3 Work undertaken during 2008 – 2009**

#### **3.1 Rapid Response Process**

The Sudden and Unexpected Death in Infants (SUDI) Protocol provides guidance and procedures to all agencies involved in the rapid response process. The SUDI protocol has been in force across the sub-region for some time with good working practices established in investigating unexpected deaths in infants. In light of Chapter 7 coming into effect, the SUDI protocol has been expanded to incorporate procedures in the investigation of sudden and unexpected deaths of children up to 18 years of age and has been renamed the Sudden and Unexpected Death in Children (SUDC) Protocol

- 3.1.1 Multi-agency training on the SUDC Protocol was delivered across the sub-region to practitioners and managers which was well received. The protocol has been tested in a small number of deaths of older children with varying success. It is inevitable that there will be teething problems with any new procedures but lessons have been learned for the future.

#### **3.2 Processes**

The first five months of this reporting year were dedicated to formalising notification and information gathering processes and setting up local panels by identifying panel members and providing appropriate training. Local panels commenced in September 2008 after sufficient information had been gathered on deaths notified from 01 April 2008 onwards.

- 3.2.1 In October 2008 a full time Clerical Officer was appointed and in December 2008 the newly appointed Manager for the child death review process took up her post to continue the work of the Project Manager, appointed to set up the initial process. With two new personnel appointed, this was an opportune time to review the process now that it had moved from the training and preparation phase to panels being fully operational.
- 3.2.2 Administrative procedures were reviewed to ensure information gathering was consistent and timely and gaps identified in the process were addressed.
- 3.2.3 A review of all current cases was conducted with actions identified and progressed to get cases ready for panel.
- 3.2.4 A recommendation / action plan database was introduced so that each local panel could track all recommendations and actions arising from panels to ensure ownership and accountability.
- 3.2.5 The process of when neonatal deaths will be reviewed by local panels was clarified.

### **4 Local Panels and recommendations arising from cases reviewed**

- 4.1 11 panels were convened across the sub-region during this reporting period and 24 cases were reviewed. Recommendations identified were:

- 4.1.1 A change in procedures for the Health Visiting Service in contacting families who do not attend appointments for immunisations. (*Coventry*)

- 4.1.2 Heads of Service were notified to ensure effective communication between service providers in cases where children are treated and/or die in another area, as a result of gaps in communication being identified. *(Coventry)*
- 4.1.3 An awareness campaign was recommended to reduce the risks of Sudden Infant Death Syndrome (SIDS) more commonly known as cot death, in light of the number of cases reviewed. *(Coventry)*
- 4.1.4 A recommendation was made to Warwickshire Road Safety Unit for road calming measures on a main road following the death of a child in a road traffic collision. Following a detailed investigation by the Engineers Department a number of street improvements were authorised to improve safety on this road. *(Warwickshire)*

#### **4.2 Sub-Regional Child Death Overview Panel**

Two strategic Sub-Regional Child Death Overview Panels took place in 2008-2009, in November 2008 and March 2009. The panel fully endorsed the SIDS Preventative Campaign and recommended that this be conducted across the sub-region.

#### **4.3 Child Death Review Working Group**

The Working Group consists of Managers and Practitioners involved in the rapid response and child death review process. The remit of the Working Group is to: support the three local panels in terms of administration, management and audit functions; ensure operational co-ordination between the 3 LSCBs and support and monitor the Manager's work plans. Four working group meeting took place throughout 2008-2009

### **5 Work in progress**

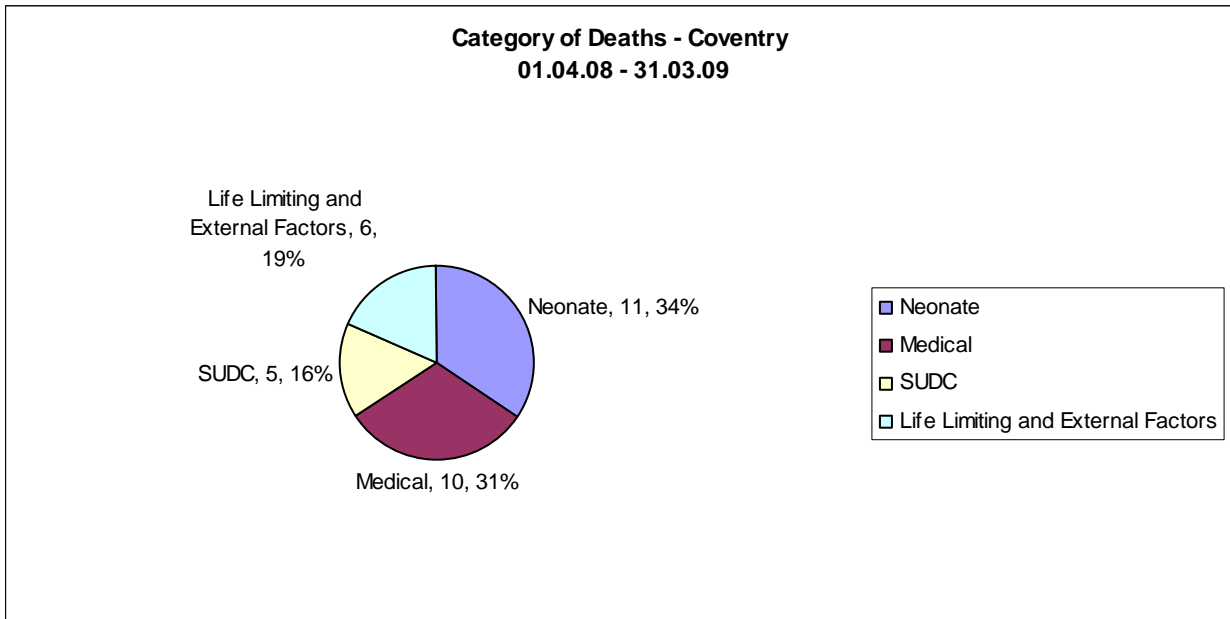
- 5.1 The following areas work will continue throughout 2009-2010:
- 5.2 Ongoing development of the child death processes and raising awareness to continue.
- 5.3 Develop links with Warwickshire Neonatal Units and attend their mortality review meetings.
- 5.4 Develop the on-line electronic system to enhance the timeliness of notifications and the overall information gathering process.
- 5.5. Develop policy with regards to involving bereaved families in the child death review process.
- 5.6 Develop a corporate process for reviewing neonatal deaths across the sub-region.
- 5.7 Continue to monitor and review the work of rapid response teams in line with the SUDC Protocol
- 5.8 Develop a support service for professionals involved in the child death review process.
- 5.9 Arrange a development day for all panel members across the sub-region

## Appendix A

### 6 Coventry

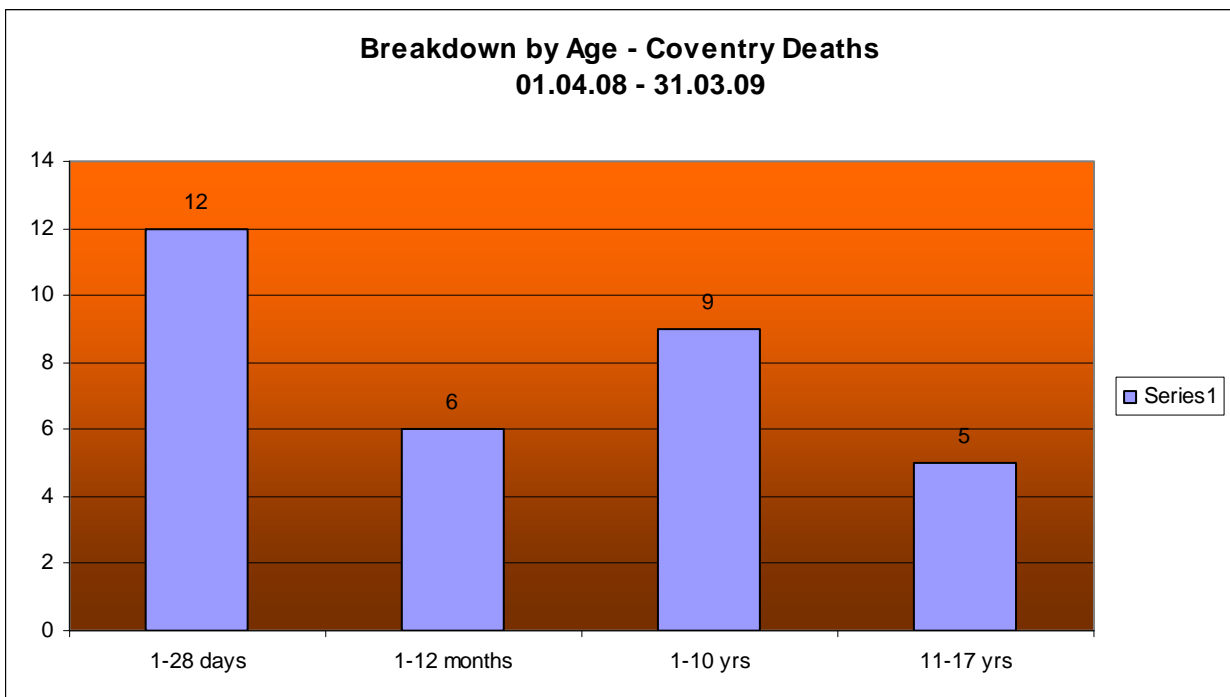
6.1 32 deaths were notified to the Child Death Review Manager during 2008-2009

6.2 Categories of death:

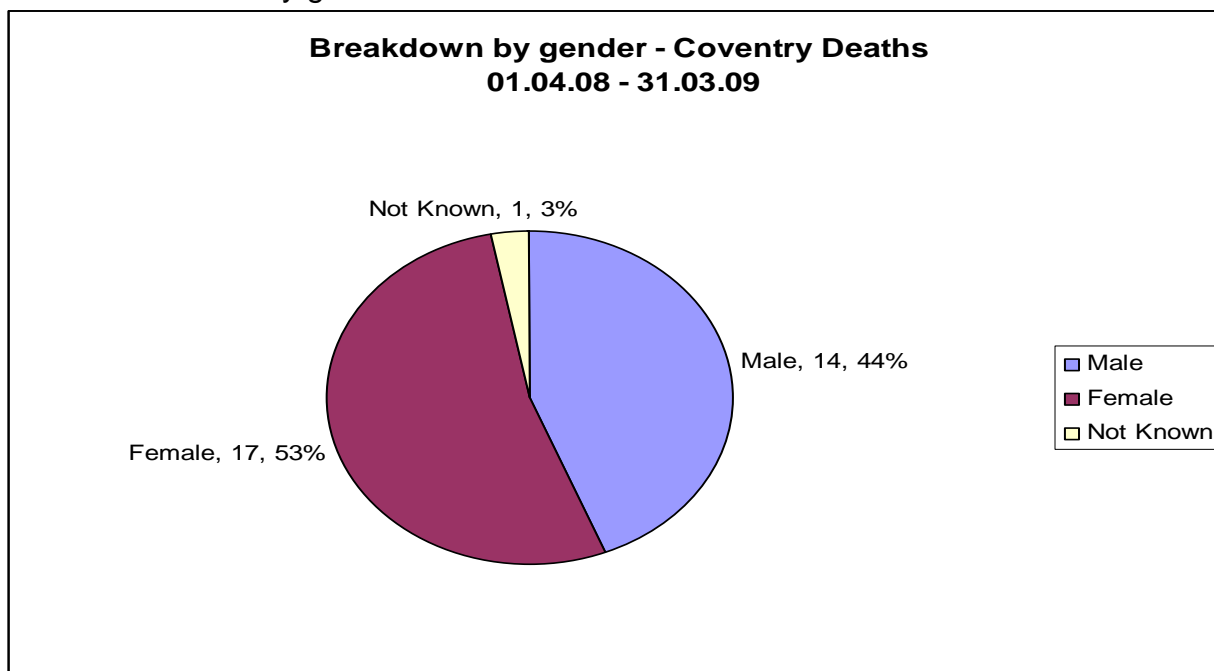


6.3 Deaths due to external causes include road traffic collisions, and accidental deaths.

6.4 Breakdown by age:



## 6.5 Breakdown by gender:



6.6 There is insufficient data to provide a breakdown by ethnicity as the earlier notification forms used did not have the facility to record a child's ethnicity.

## 7 Local Child Death Overview Panel

### 7.1 Members:

John Forde, Consultant in Public Health (Chair)  
Jivan Sembi, Head of Safeguarding  
Dr Supratik Chakraborty, Consultant Paediatrician  
Dr Karen McLachlan, Consultant Paediatrician  
Dr Miriam Wood, GP  
Detective Inspector Chris Hanson, West Midlands Police  
Lesley Cleaver, Paediatric Liaison Nurse, Coventry PCT  
Sue Aucutt, Midwifery Service, University Hospital, Coventry and Warwickshire  
Debbie Carter, North East Neighbourhood Manager, Children's Services  
Sandra Shipton, Education  
Jane Goodyear, Early Years  
Ramona Baretto, Legal Services, Coventry Children's Services  
John Clarke/ Denis Murphy, Fire and Rescue Service

#### Co-opted Member:

Dr Kate Blake, Consultant Neonatologist

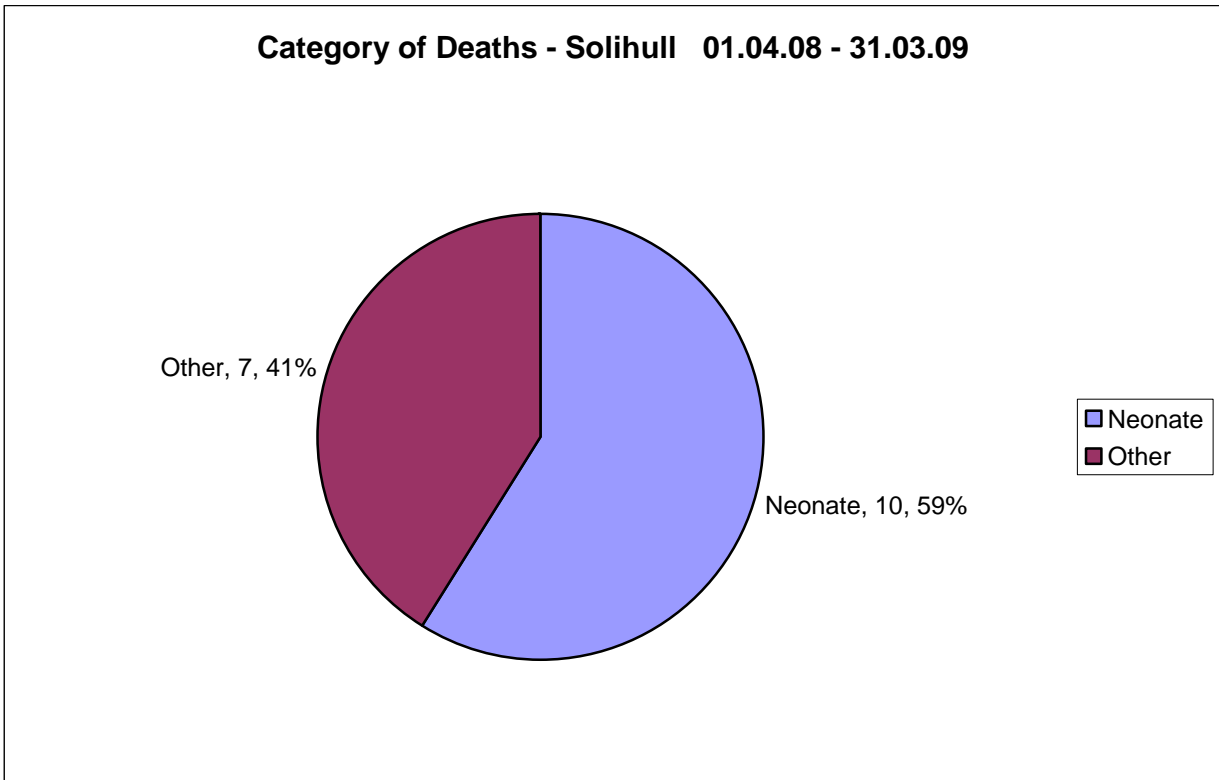
7.2 The panel met 3 times during the latter part of 2008-2009 and reviewed 9 cases.

7.3 13 actions were completed, arising from the cases reviewed and three recommendations were progressed as detailed in paragraph 4.

## 8 Solihull

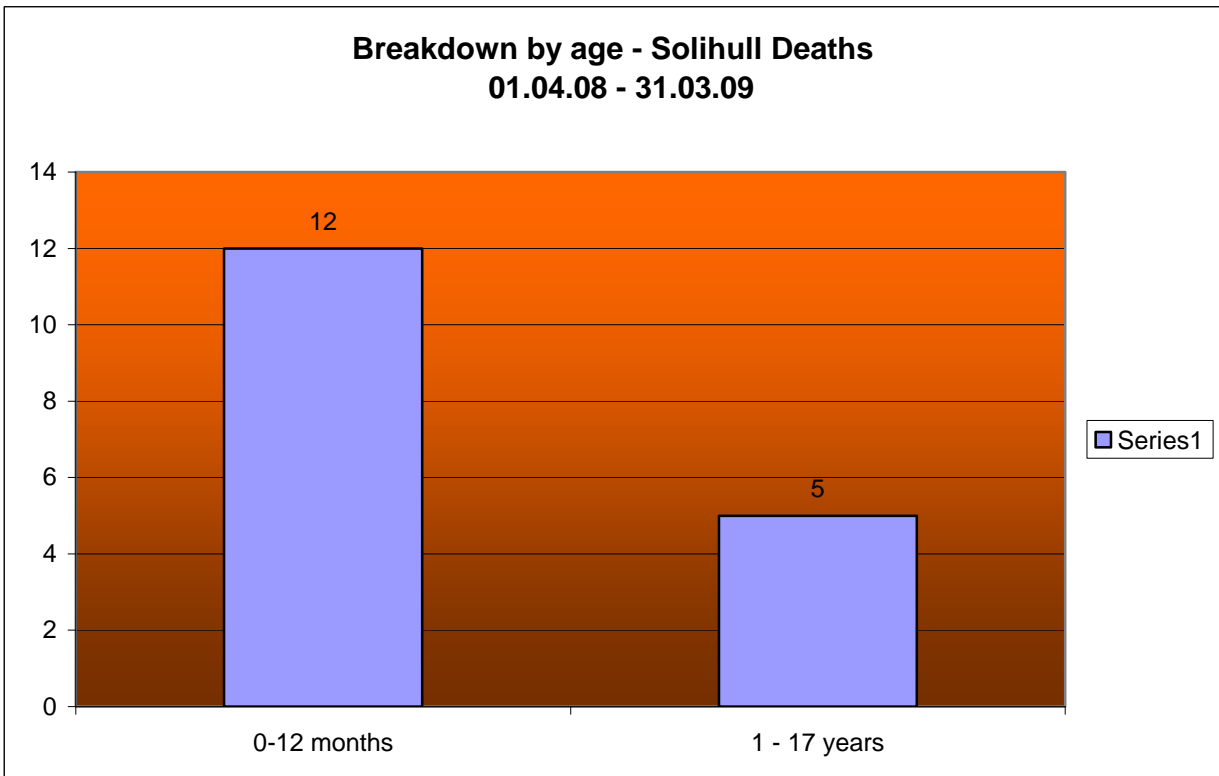
8.1 17 deaths were notified to the Child Death Review Manager during 2008-2009

8.2 Categories of death:

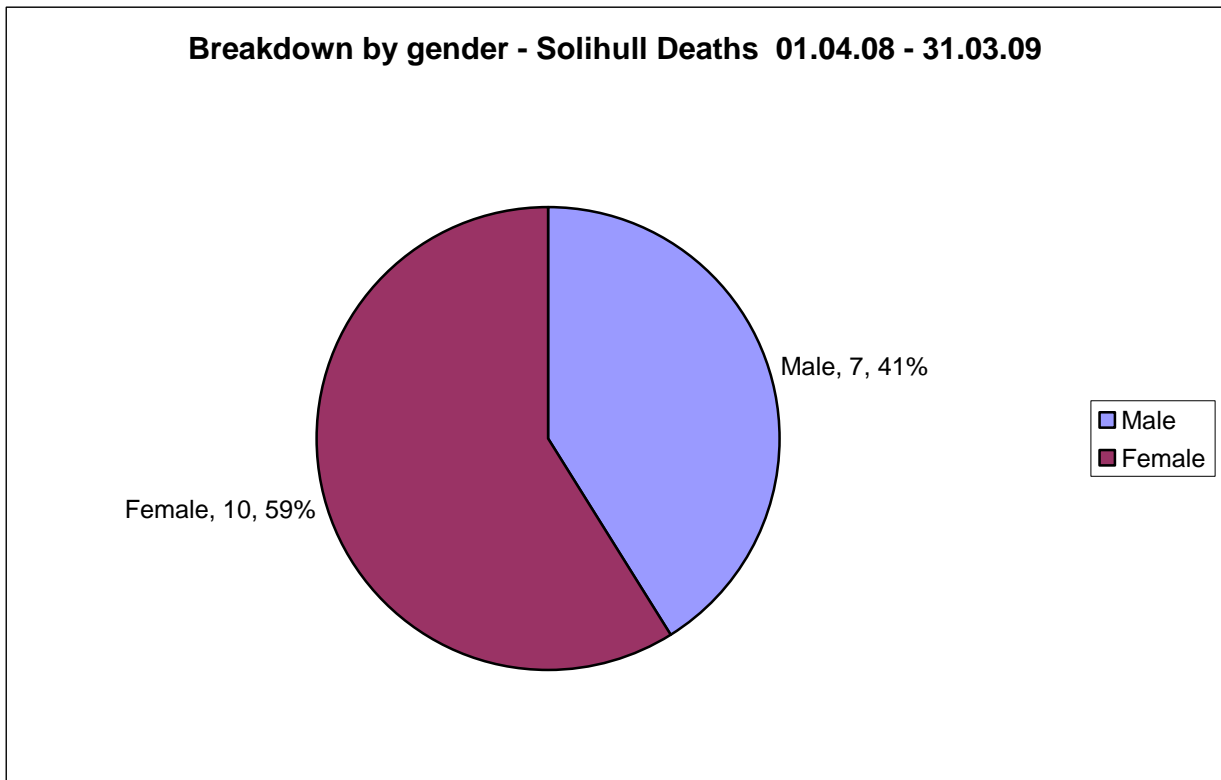


8.3 'Other' includes children who died from medical causes, life limiting conditions, and road traffic collisions.

8.4 Breakdown by age:



## 8.5 Breakdown by gender:



## 9 Local Child Death Overview Panel

### 9.1 Members:

Debbi Davies, Business Manager, LSCB (Chair)  
Dr Alan Stanton, Community Paediatrician  
Carol White, Midwifery Services, Heartlands Hospital  
Kim Probert, Designated Nurse for Safeguarding  
Heather Owen, Named Nurse for Safeguarding  
Detective Inspector Glen Boulton, West Midlands Police  
Ian Mather, Consultant in Public Health  
Steve Martin, Chief Education Welfare Officer  
Eleni Prodromou, Solihull Children's Services  
Paul Nash, Independent Reviewing Officer  
Marj Rogers, Probation

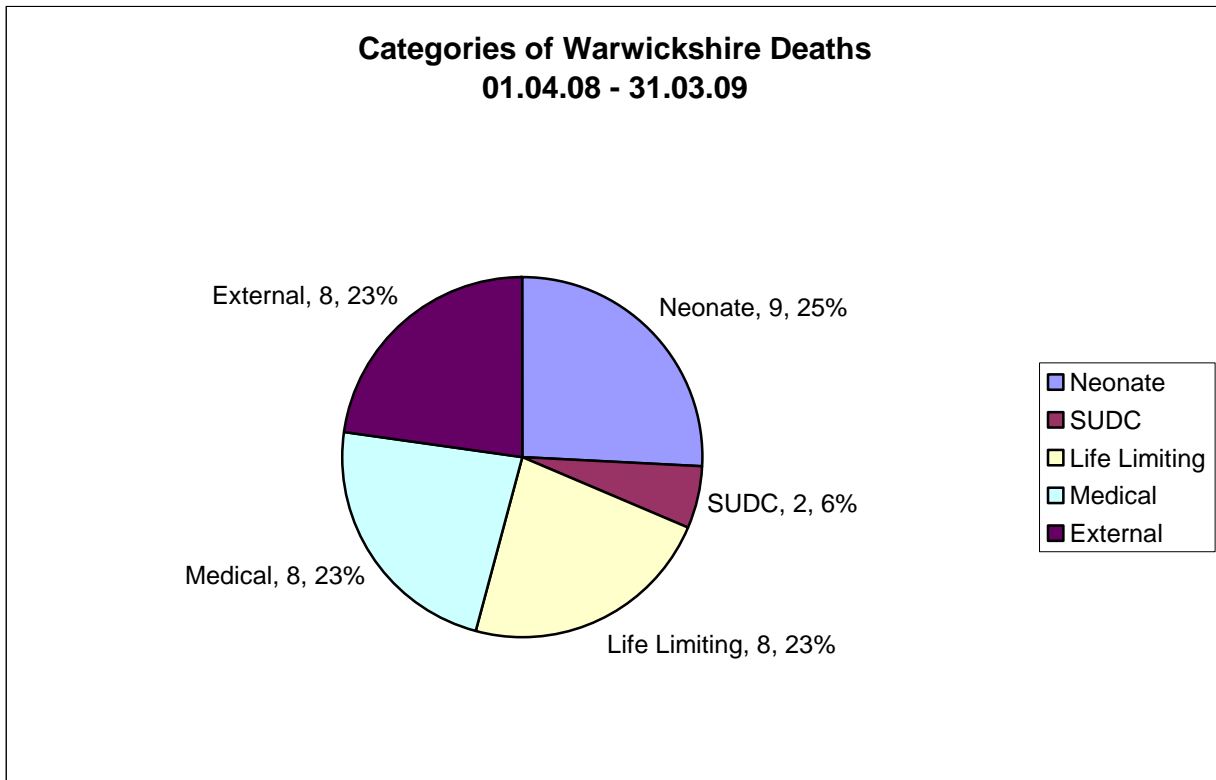
9.2 Solihull's local panel met twice in the latter part of 2008-2009 and reviewed 4 cases. 2 were completed and 2 were deferred to obtain further information.

9.3 11 actions were completed. No recommendations were made during this reporting period.

## 10 Warwickshire

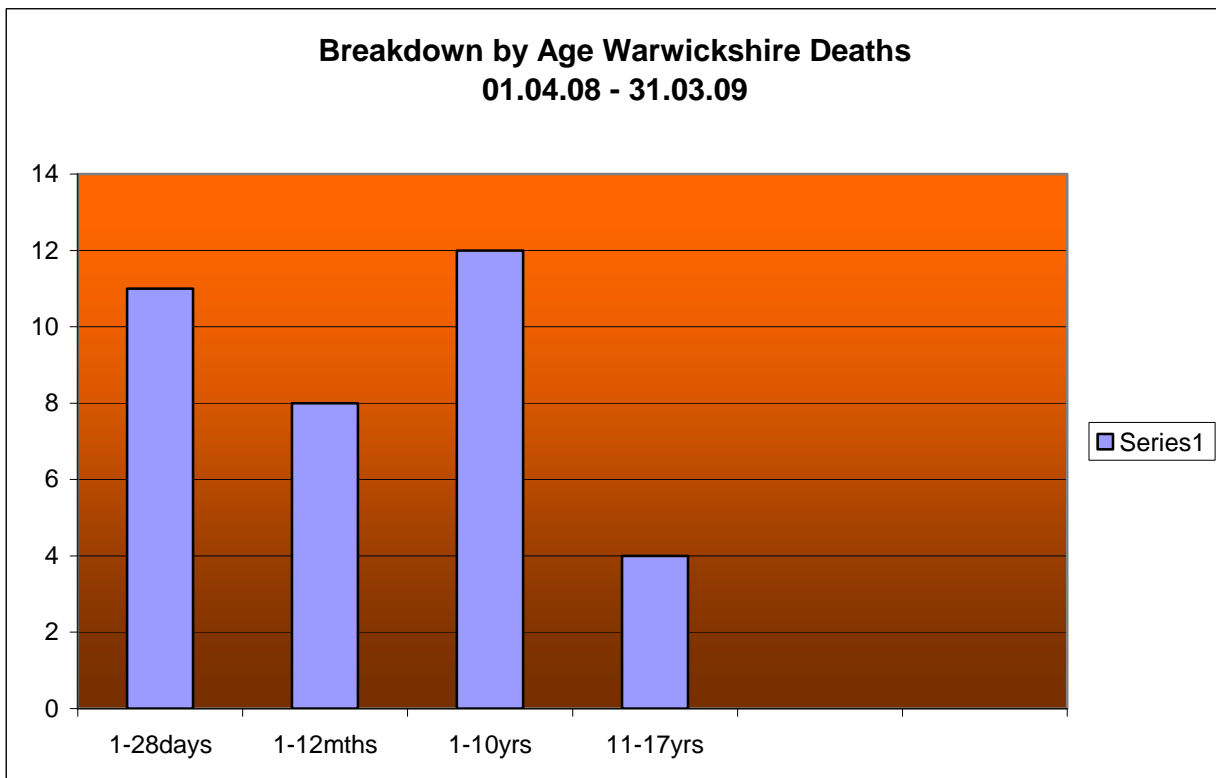
10.1 35 deaths were notified to the Child Death Review Manager during 2008-2009

10.2 Categories of deaths:

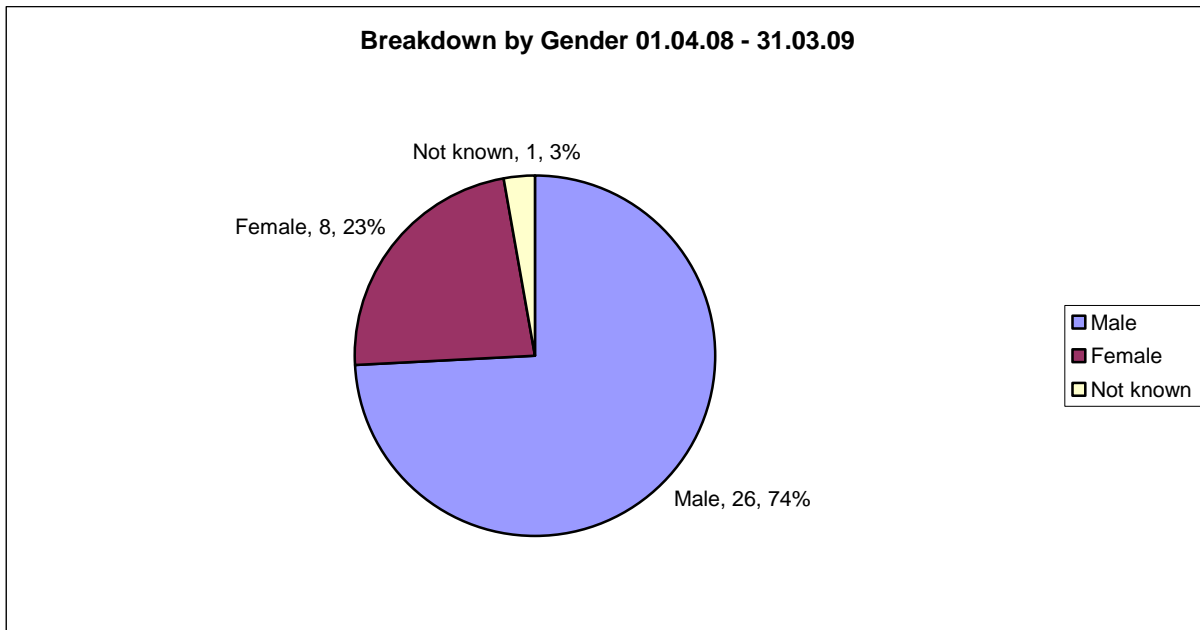


10.3 Deaths due to external causes include road traffic collisions, drowning, and accidental deaths.

10.4 Breakdown by age:



## 10.5 Breakdown by gender:



10.6 There is insufficient data to provide a breakdown by ethnicity as the earlier notification forms used did not have the facility to record a child's ethnicity.

## 11 Local Child Death Overview Panel

### 11.1 Members:

Dr Vic Tuck, Development Manager, Warwickshire LSCB (Chair)  
Phil Sawbridge, Assistant Head of Service - Safeguarding Children, Quality Assurance and Service Development  
Dr Peter Sidebotham, Consultant Paediatrician  
Victoria Gould, Young People Legal Services Manager  
Detective Inspector Nigel Jones, Warwickshire Police  
Marie Holden, Locality Manager, Warwickshire PCT  
Kathryn Millard, Locum Consultant in Public Health  
John Sullivan, Education Safeguarding Manager  
Andy Wade, Assistant Chief Officer, Probation

11.2 Warwickshire's local panel met 6 times in 2008-2009 and reviewed 13 cases.

11.3 9 actions were completed, arising from the cases reviewed and one key recommendation was made, detailed in paragraph 4.

**Dara Lloyd**  
**Manager – Child Death Review Process**