OSCB Oxfordshire Safeguarding Children Board

NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Child Death Overview Process

Annual Report for 2019/20

OSCB Oxfordshire Safeguarding Children Board

NHS Oxfordshire Clinical Commissioning Group

Oxfordshire Child Death Overview Process

Annual Report for 2019/2020

Introduction from the Director of Quality & Nursing

The annual report of the Oxfordshire Child Death Overview Process (CDOP) sets out the CDOP work carried out during 2019-2020. The report discusses activity, functions, processes and analysis. It reviews the recommendations from the year 2019-2020 and makes recommendations for 2020-2021.

Deaths in children are always very distressing for parents, carers and clinical staff. Reviewing the confirmed causes of childhood deaths can lead to effective action in preventing future deaths, which is at the core of the process. In accordance with the statutory guidance, the sub group reviews 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 subgroup to influence strategic changes and practice.

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.

Whilst it falls outside of the scope of this report, it would be remiss not to mention the unprecedented challenge the COVID-19 pandemic is presenting to us all. I am pleased that children seem to be much less severely affected but, in line with national guidance, we have adapted our processes to ensure that all child deaths are reported within 48 hours. The process is also gathering additional information to ensure that all information that may be related to the direct or non-direct impact of COVID -19 is captured. This will be fully analysed in next year's report.

Sula Wiltshire,
CDOP Chair
Director of Quality & Nursing
Oxfordshire Clinical Commissioning Group

1.0 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 updated in Working Together to Safeguard Children (2018)[2]. Oxfordshire CDOP merged with Buckinghamshire CDOP in April 2019 to comply with the requirement 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 year[1].

The Oxfordshire Child Death Overview Panel (CDOP) is a subgroup of the Oxfordshire Safeguarding Children's Board. It reports monthly via the Case Review and Governance Group, and annually to the Oxfordshire Safeguarding Children's Board.

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 administration of the Oxfordshire CDOP is hosted by Oxfordshire Clinical Commissioning Group (OCCG) and is chaired by the Director of Quality & Nursing from the OCCG. The Designated Doctor for Child Death is a Consultant Paediatrician at the Oxford University Hospitals NHS Foundation Trust (OUHFT) and is commissioned by the OCCG to undertake this role. Oxfordshire follow the national process and use the electronic system eCDOP to facilitate this.

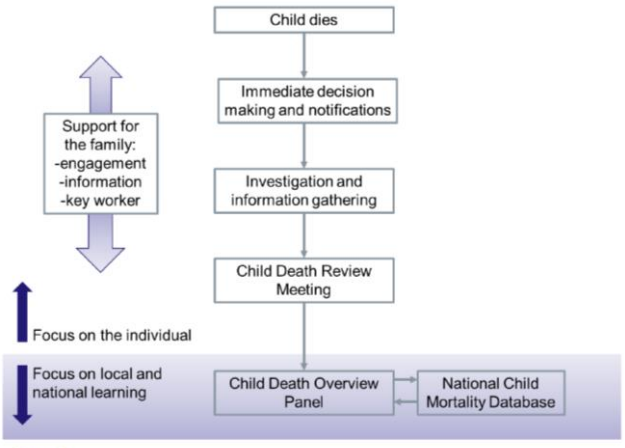


Figure 3

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 subgroup's discussions. Attendance at

[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

the meeting over the past year has been good. A full list of CDOP members can be seen in Appendix 1.

2.0 CDOP Activity 2019/2020

In 2019/20 the Oxfordshire and Buckinghamshire CDOP system received 111 notifications. 30 of these were for children who lived in Oxfordshire, 24 were from Buckinghamshire. The remaining 57 were for children from other geographical areas, who died in Oxfordshire at either the regional hospital or regional children's hospice. These notifications were passed to their local teams to manage. The majority were from Wiltshire or Berkshire. Data of this notification and reviews can be found in Appendix 2.

The Oxfordshire CDOP panel met on four separate occasions in 2019-2020 to review child deaths. The deaths of 27 children whose usual residence was in Oxfordshire were reviewed These reviews included deaths that occurred in the year 2019-2020 and reviews that occurred before this year, but had been carried over, due to alternative investigations which prevented completion of the CDOP process earlier.

Themes raised by these reviews included

- The challenges of large families attending either ED or Helen House immediately after a death,
- Information sharing when a child moves area
- Lack of consensus in professional's views of treatment goals
- Ensuring the voice of the child is heard when planning for the end of life care
- Sudden Unexpected Death in Epilepsy
- Out of hours access to organ donation

Outstanding recommendations are discussed in section 5.

The recommended time scales for completing a review is 6 months, however where there is another statutory review, such as coronial processes, this timescale is not possible. It is encouraging to see that 93% of all cases are reviewed within a year, and that Oxfordshire's average length of time for a review is significantly less than the national average (189 days vs 274). (Appendix 2)

3.0 Implementation of Working Together 2018 changes 19/20

The introduction of the role of key worker has had a positive impact on supporting and engaging the family who have lost a child throughout the whole child death review process. All agencies have supported this, and to date key workers have included GPs, Health Visitors, Community Children's Nurses, Social Workers, Teachers, Doctors and Police. Anecdotal feedback from a small number of families has significantly enriched the learning from several reviews.

Every child death now has an individual a Child Death Review Meeting (CDRM). These are held by the provider organisation where the child died, and as such the majority are held in OUHFT. The learning from these has been invaluable and is carried forward into the analysis form reviewed at the CDOP panel. It has been noted that the level of interagency shared knowledge of the child is rarely done at this level whilst a child is alive and that for some children, particularly those with complex health needs, this would be invaluable.

Action: Designated Doctor to consider how this could be incorporated into practice.

Oxford University Hospital Foundation Trust (OUH) have identified that, as a regional hospital, the impact of convening the majority of the CDRMs has a significant impact on their resources. They have been successful in developing a business case, which has allowed them to employ a child mortality team to support all aspects of the Child Death Review Process for all children who die in OUH.

Oxfordshire and Buckinghamshire have continued to convene a multi-agency panel for their own area. Additional scrutiny has been provided by the Designated Doctor, and/or a member of the CDOP coordination team attending the panel in the other area. This has highlighted a variation in the use of modifiable factors. Guidance on this is expected from the National Child Mortality Team.

Oxfordshire and Buckinghamshire have held two joint themed panels to date, the second of which included the Pan Berkshire CDOP. The theme of the first was infections and the second looked at haem-oncology conditions. Local learning has been shared and applied across the wider system. This has included improving advice about sepsis for parents of children with complex health needs and sharing of information about specialist bereavement services available in the region.

4.0 Updates on CDOP Recommendations from 2018/19

The full action plan can be found in Appendix 3.

There has been good progress in relation to end of life care planning, but the timeliness of the introduction of palliative care remains a challenge. The identification of the benefit of multiagency planning earlier in a child's illness (discussed in section 3) will provide an opportunity to further embed this into practice.

There were a small number of examples of appropriate offers of organ donation, including the facilitation of the first time a young person's heart was transplanted into an adult, but there were also ongoing challenges of accessing the organ donation out of hours, which the Designated Doctor is pursuing.

Action: Designated Doctor to liaise with the tissue donation service regarding out of hours support.

5.0 Recommendations for 2020/2021

i. Designated Doctor to promote multiagency case discussions as standard practice when a child with complex health needs is deteriorating and a holistic, cohesive plan is required. This will enable the voice of the child to be heard, and ensure that professionals reach consensus in end of life planning.
ii. Designated Doctor to liaise with the tissue donation service to ensure that adequate information is available to ensure that access to support out of hours does not prevent tissue donation when this is requested by a family.
iii. Oxfordshire and Buckinghamshire CDOP to hold a joint themed meeting on Sudden Unexpected Death in Epilepsy, to ensure that all knowledge and learning is understood and shared across services.

6.0 Conclusion

The CDOP process within Oxfordshire continues to be supported well by all agencies and organisations.

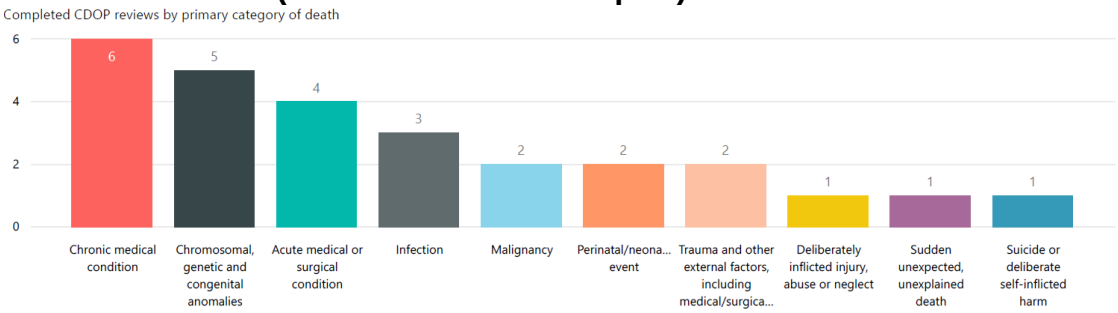
The first year of embedding the changes from Working Together 2018 has gone well. In particular, the system wide approach to providing key workers for all families has meant that this additional role has not been burdensome on any one organisation. Working as one CDOP system with Buckinghamshire has provided an additional layer of scrutiny and wider system learning.

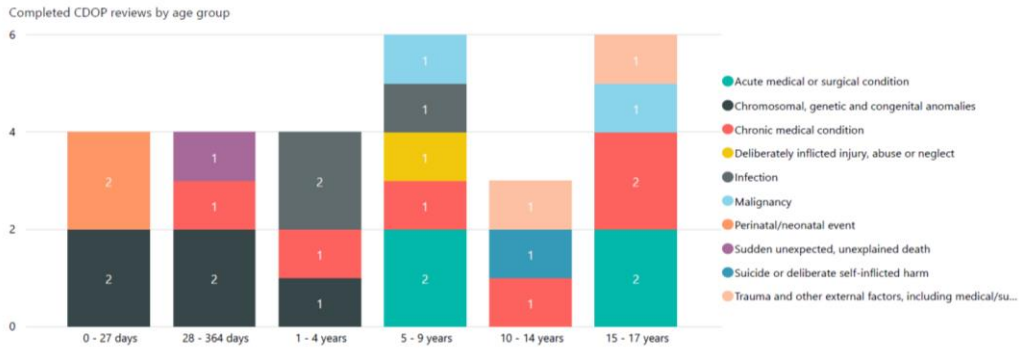
Appendix 1

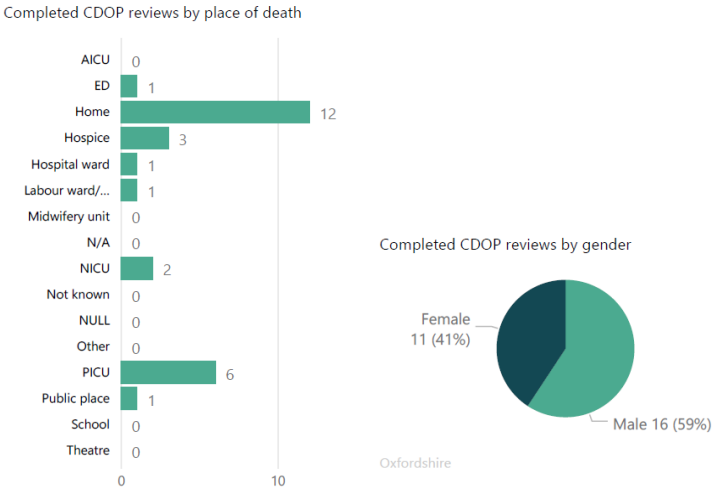
CDOP Membership 2018/19

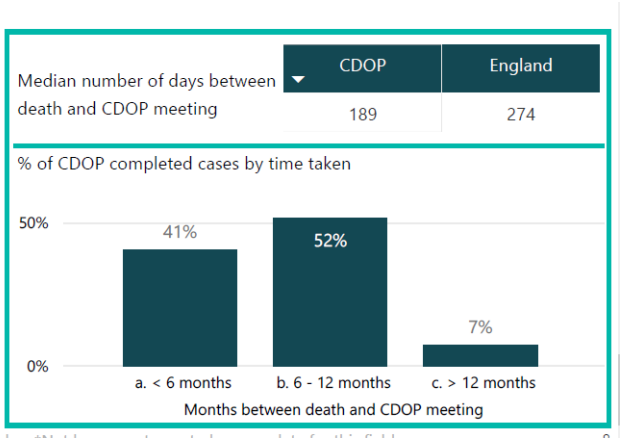
Name	Position	Agency
Sula Wiltshire	Chair: Director of Quality &Nursing	Oxfordshire Clinical Commissioning Group
Dr Alison Shefler	Designated Doctor for Child Deaths Consultant Paediatric Intensive Care,	Oxford University Hospitals NHS Trust
Alison Chapman	Designated Nurse & Safeguarding Lead,	Oxfordshire Clinical Commissioning Group
Karen Brombley	Designated Nurse Looked After Children & Safeguarding in Complex Care	Oxfordshire Clinical Commissioning Group
Gaza Vass	Consultant, NNU	Oxford University Hospitals NHS Trust
Kay Bishop	Business Manager OSCB	Oxfordshire Safeguarding Children Board
Andrea Lambert	Director of Clinical Services	Helen & Douglas House Hospice
Dr Emily Harrop	Paediatric Palliative Care Consultant	Helen & Douglas House Hospice and Oxford University Hospitals NHS Trust
Lisa Lord/Jayne Harrison	Named Nurse Safeguarding	Oxford Health Foundation trust
Pauline Burke	CDOP and Safeguarding Officer	Oxfordshire Clinical Commissioning Group
DI Matt Bick/ DI Pete Scott	DI Police Child Abuse Investigation Unit	Thames Valley Police
Hilary Seal	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
Meriel Raine	Named GP Safeguarding	Oxfordshire Clinical Commissioning Group
Judith Mulligan	Director	See Saw Bereavement Charity
David Freeman	Coroners Service Manager	Coroner's Office
Tracy Toohey	Safeguarding Lead, OUH	Oxford University Hospitals
Rosalie Wright	Midwifery Manager	Oxford University Hospitals

Appendix 2: CDOP data (from NCMD annual report)









Appendix 3: CDOP Annual Report 2018/19 Action Log		
Recommendation	*Action from Annual report* and additional actions from CDOP panel	Update
1. All aspects of end of life care where there is time to plan requires further attention. 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	• *OCCG to continue to monitor trends.* • *OCCG to share information with the EOL collaborative project*. • *CDOP to monitor the impact of the role of the key worker* • Provide regular teaching on use of ACPs at OUH Paediatric Grand Round (EH) *completed* • Provide one off teaching to Social workers on use of ACPs (EH) *completed* • Develop the integration of Specialist Paediatric Palliative Care within OUH (HDH and OUH) *ongoing* • Raise awareness of options for organ donation within ICU settings and HDH (SNODs, AS and EH) *ongoing*	See section main report
2. 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[1].	*Oxfordshire Multi-agency Suicide Prevention Group to share a programme to raise awareness of these vulnerabilities to ensure appropriate targeting of services.*	Oxfordshire continues to monitor suicides in the county in real time in partnership with Thames Valley Police and the Coroner's Office and any themes from individual cases is shared with the system. The self-harm awareness play – 'Under My Skin' was performed again in Oxfordshire Secondary schools during March 2020 before the schools were closed due to COVID-19. The Multi-agency group also published its Suicide and Self-harm Strategy in April 2020 after consultation with residents (Young People and adults) during 2019 https://www.oxfordshire.gov.uk/residents/social-

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

		and-health-care/health-recovery-and-wellbeing/mental-wellbeing
3. a) 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. b) Availability and quality of bereavement services to be scoped c) Introduction of explicit coordinated bereavement plans.	*Providers to ensure a consistent approach to the Implementation of the introduction of CDRMs* • Finalise shared understanding of roles and responsibilities of key worker *completed* • Develop flow chart of identification of key worker *completed* • Provider services to develop a suite of resources to support key workers *completed* • Develop localised guidance on implementation of CDRM *completed* • CDOP coordination team and providers to add CDRMs to existing process *completed*	See section 4 main report
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.	*All agencies to embed new processes.* • Oxon and Bucks CDOP coordination teams to attend the alternate CDOP meeting to ensure consistency of approaches across the patch *completed* • Themed meeting scheduled *completed* • Explore options for themed meetings to include Pan berks CDOP *completed*	See section 4 main report