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Improving the Practice of Child Death Overview Panels – a paediatric perspective

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Abstract

Objective: In England every death in childhood is reviewed by a local multi-disciplinary Child Death Overview Panel (CDOP) with the intention of understanding causation and implementing interventions to reduce future deaths. This study aimed to establish how well panels work from the perspective of the paediatricians involved; to ascertain whether they deliver good value and identify areas for improvement.

Design: A questionnaire was sent to every CDOP paediatrician in the country (n=93). Questions focused on the quality of CDOP case discussions as well as examples of effective and significant recommendations. Responses were analysed using simple quantitative and qualitative methods.

Results: 84/93 (90%) of the paediatricians responded. Amongst respondents, 60 (71%) believe investment in CDOPs is offering good value; 73 (87%) feel that case discussions are rigorous and consistent and over 90% believe that the correct issues are emerging from discussions. However responders noted many areas for improvement: 40 (48%) suggested devolving the discussion of specialist deaths (e.g. neonates) to hospital-based review meetings or holding themed meetings with invited specialists; 11 (13%) suggested filtering out cases where learning is unlikely before full CDOP meetings and 13 (15%) called for national integration and analysis of data.

Conclusions: In this time of economic austerity it is vital that the CDOPs add value to the invested resources. Although CDOP paediatricians feel that panels are working well there is scope for improvement through enhancing relationships with commissioning bodies, aggregate review and analysis of CDOP data at a national level and consideration of specialist and/or network review of certain categories of deaths such as cardiac surgery, oncology and neonates.

INTRODUCTION

Since April 2008 Local Safeguarding Children Boards (LSCBs) in England have been given the statutory responsibility for child death review processes. The relevant legislation is enshrined within the Children Act 2004[1] and applies to all people under the age of 18 years. The processes to be followed when a child dies are outlined within Working Together to Safeguard Children 2006.[2] This document outlines two inter-related processes; a 'Rapid Response' where a group of professionals come together for the purpose of thoroughly evaluating the cause of death of an individual child, when the death of that child is *unexpected*, and a 'Child Death Overview Panel' (CDOP) that comes together to undertake an overview of *all* child deaths under the age of 18 years in a defined geographical area[3]. Child Death Overview Panels involve lead professionals from multiple agencies and are represented from health by the Designated Paediatrician for Unexpected Deaths. The overall purpose of the child death review processes is to understand how and why children die and then implement interventions to prevent future deaths.[2]

At the time of implementation there was little published evidence for the benefit of CDOPs although there was an intuitive consensus that a rigorous review would enable a more proactive approach to reducing child mortality[4]. This study examines the value of CDOPs from the perspective of the paediatricians who sit on these panels and addresses three questions:

1. How well are CDOPs working in practice?
2. Do paediatricians feel they are delivering good value?
3. Can CDOP practice be improved?

It was decided to survey the Designated Paediatricians because they are involved and/or have oversight of all types of deaths, whereas other members of the overview panel (for example police, social workers) are only involved in a small proportion cases.

METHODS

A questionnaire was designed and piloted with three CDOP paediatricians and then redrafted following their feedback. The final online survey (Appendix A) was sent via the Designated Doctor of every LSCB to the CDOP paediatrician (n=93). The survey was sent out three times and CDOP co-ordinators were contacted to remind the non-responders.

In addition to seeking data and examples of significant recommendations, the questionnaire focused on the following areas:

- Whether discussions are focused on the deaths where learning is likely to influence future practice.
- Whether the right issues are emerging from discussions.
- Whether analysis is rigorous and consistent.
- How much influence CDOPs bring to bear upon commissioners and other agencies.
- Suggestions to make panels more effective.
- Elements of the CDOP process that might be discontinued or devolved.
- How CDOP paediatricians regard the overall value of the process.

Responses were analysed using simple descriptive statistics and qualitative methods for free comments. Since several issues for improving the CDOP process recurred throughout the survey the data is presented thematically by integrating all relevant responses. Ethical approval was received from the University of Bristol Ethics Committee.

RESULTS

Eighty-four out of a total 93 CDOP paediatricians answered the survey (response rate 90%). No information is available about non-responders but examination of response by location

did not reveal any obvious geographical bias. Fifteen respondents did not complete every question.

1. Panel demographics and paediatrician time commitment

The total population (aged 18 or younger) covered by each CDOP ranges from 27,000 to 1,200,000 (median 130,000) and 30% of panels contain a tertiary paediatric centre in their area. Over the preceding 2 year period, respondents reported between 8 and 360 deaths in their area (median 100). Seventy-four respondents (88%) reported that their panel reviewed all deaths, 6 respondents (7%) reviewed only unexpected deaths and 3 (4%) reviewed all deaths except neonatal deaths. 45% of panels meet every two months, 26% meet quarterly and 29% meet every 4-6 weeks. The total time allocated to this work in CDOP paediatricians' job plans varied from 0 hours (18% of all CDOP paediatricians) to 34.6 hours per month (median 4 hours). The time actually spent on the work varied from 4 to 36 hours per month (median 8.5) - this work being divided into preparation (median 4; range 1-32), attending meetings (median 2.5; 1-10), and subsequent actions (median 2; 0.5-10).

2. Subjective opinion of CDOP value

Sixty of eighty-four (71%) respondents agreed or strongly agreed that CDOPs offer good value. Seventy-three of eighty-four respondents (87%) felt that the analysis is rigorous and consistent and 92% believe that the correct issues are emerging from discussions and are focussed on deaths where learning is likely to influence future practice. When asked what they believed to be the most important function of CDOP, 25 respondents (30%) cited learning from cases, 24 (29%) cited the identification of modifiable factors and 23 (27%) cited the prevention of future child deaths and/or improving child health.

3. Areas for improvement

Despite this general consensus that CDOPs are working well, respondents noted potential areas for improvement. Respondents were keen to foster approaches that delivered more robust, efficient and productive discussions at panel meetings. The three most consistent themes suggested to improve CDOP efficiency were the devolution of neonatal deaths to perinatal meetings, ensuring that the right professionals attend CDOP, and introducing a clinical review of cases before meetings to allow full CDOP discussion only for those deaths where there were uncertainties or where recommendations are likely to arise.

Neonatal deaths - Despite a statutory obligation to discuss all deaths, 10 panels have already chosen to depart from this approach in pursuit of greater efficiency. Twenty-seven respondents (32%) stated that the discussion of neonatal deaths should be discontinued, devolved or drastically shortened to increase CDOP efficiency. They argued that thorough discussion about neonatal management often requires specialist medical knowledge that is beyond current panel members' competence and that the neonatal discussions rarely yielded new or significant insights not already known within neonatal networks. Some doctors suggested devoting whole meetings to neonatal deaths with a neonatologist present or having the chair, CDOP doctor or a subgroup review all neonatal cases beforehand and only bringing deaths to the panel if learning is likely. One panel has seen the establishment of mortality review committees in local obstetric units and several other respondents suggested devolving the responsibility of neonatal reviews to perinatal meetings within existing neonatal networks.

Triage – Eleven respondents (13%) suggested filtering cases before the full CDOP meeting to avoid discussing deaths where information was lacking or learning unlikely. Forty respondents (48%) questioned whether CDOPs were the best forum for discussion of deaths related to specialist services (e.g. cardiac, oncology) and suggested themed review

meetings with invited specialists or devolving cases for internal review within the speciality (e.g. cancer) networks. At least one CDOP has already adopted specialist themed panels with external expert peer review of cases.

Appropriate CDOP membership – Fifty-one respondents (61%) commented that alterations to panel membership could improve efficiency in line with Chapter 7 of *Working Together* which stipulates that all core members do not necessarily have to be involved in every case discussion[*ibid.*]. The value of co-opting various specialists onto the panel was a recurring theme throughout the survey and 22 respondents (26%) stressed the importance of having the right people around the table. Twelve respondents (14%) emphasised the value of strong links and representation by coroners' officers.

Improving effectiveness - Although 74 respondents (88%) believed CDOP discussions were targeted on issues that will influence future practice, 76 (90%) proposed ways to improve panel effectiveness (see Box 1 for examples). The three main suggested areas were national analysis of data, stronger links with commissioning bodies, and a re-evaluation of CDOPs' primary purpose.

Box 1: What would make CDOPs more effective?

Membership/Chairing

- Improve links with Coroners
- Streamline membership and clarify what each member brings
- Employ a CDOP nurse
- Employ a competent chairperson and retain them for several years

Process

- Fast-track straightforward cases by mini-panel
- Only full CDOP discussion if issues identified

Information sharing

- Electronic sharing of data with non-CDOP agencies e.g. neonatal death review
- Use morbidity and mortality information in forms B and C to maximise available information
- Local Emergency Department to provide data on near misses/accidents

Networking

- Multiagency seminars to network, pool data and share learning

Perinatal Reviews

- Involve a neonatologist for the discussion of neonatal deaths
- Improve links with perinatal mortality meetings to reduce duplication
- Discuss neonatal deaths separately, and only if baby left hospital
- Establish mortality review committee in obstetric units

National analysis of data and learning - Nine respondents (11%) believe that too much CDOP time is spent discussing single issues that may not be epidemiologically significant and that some populations are too small to inform credible conclusions. Thirteen respondents (15%) contended that national collation and analysis of mortality data, lessons learned, and Panel suggestions for evidence-based strategies to prevent future deaths would enhance the overall process. Many examples of CDOP work were given that have the

potential for universal application such as paediatric DVT prophylaxis guidelines, and storing warm baby clothes in ambulances. However, with no national forum to share experiences, lessons and approaches, each panel is left to solve these issues independently.

Commissioning – local LSCBs and commissioners are responsible for funding CDOPs and implementing their recommendations. This implies that effective working relationships between CDOPs and these bodies are fundamental to realising CDOP recommendations. Respondents perceived reasonably effective influence with LSCBs, the police and social care, but felt that their influence was limited with local and national commissioning bodies. Thirty-five doctors (42%) reported that their influence with Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) was non-existent or needed improvement. Sixty-two respondents (74%) believed that CDOP carried little influence with Specialist Commissioners; 4 respondents (5%) stated that their recommendations are consistently ignored and 5 respondents (6%) suggested improving links with commissioning bodies to optimise panel effectiveness.

4. Monitoring Outcomes

Only 18 respondents (21%) cited reducing future deaths and improving child health as the *most important* function of CDOP work. Most of the remaining respondents cited various other objectives and functions such as “identifying the role of maltreatment as a factor in child deaths”.

One-hundred and seventy-four different examples of effective, significant and appropriate recommendations were proffered, but less than half of these suggestions related to reducing future deaths. Although some panels reported “hugely influencing local practice”, many complained of lack of influence. Three doctors (4%) called for the entire process to be devolved to other bodies and claimed that the current outcomes do not justify the present investment.

DISCUSSION

When Child Death Overview Panels were introduced in England at a cost of £53 million[5] it was argued that there was neither good evidence nor systems in place to evaluate their effectiveness[6]. This study is the first attempt to examine the value of CDOP from the perspective of the paediatricians involved.

There are marked variations in practice between panels across England. The reported population covered by each panel, time invested by CDOP paediatricians and perceived impact vary considerably. The majority of these doctors subjectively feel that CDOPs are working well and deliver good value. While several panels believe they are significantly changing local practice, others believe they have yet to make a tangible difference to improving child health and reducing future mortality

CDOPs have been responsible for many positive changes in local policy, but they will require further alignment of purpose, practice and policy before significant improvements in child health and death patterns are realised. National collation and analysis of data is vital to ensure that maximum intelligence is derived from the data collected by CDOPs. In the interim period, there should be close collaboration between panels across regions/health care networks in order to share lessons and avoid duplication of work.

While Child Death Review processes are established in many other high-income countries around the world (USA, Australia, New Zealand), there is international variation in how reviews are conducted.[7] In the USA, fetal panels stand alone and there is a focus in many states on 'unexpected deaths'. In Australia, the basis for child death review stems primarily from deaths arising from maltreatment. A collaborative enquiry into what aspects of each system works best would further inform how processes are developed in the UK.

Limitations

The survey did not achieve a 100% response rate and the number of doctors who responded to each question varied. Brevity of the questionnaire limited the amount of detailed information for individual issues raised by respondents. The survey involved CDOP paediatricians, who are likely to be committed to the process, and their views may not represent those of all doctors who are less familiar with the processes. Furthermore, it should be stressed that this study only offers one perspective on a multi-agency process. The data that informed our findings are inevitably from a medical perspective and may not be shared by other panel members.

Conclusions

Although the potential value of CDOPs is recognised by the paediatricians involved, the true benefit of CDOPs has yet to be fully realised. Based on the paediatricians' views, devolving discussion of specialist deaths to hospital-based review meetings or themed meetings with invited specialists would improve efficiency, as would filtering out cases where learning is unlikely and nationally aggregating data. Clarification of what each panel member and agency contributes to the overall CDOP process is also essential.

There is an on-going need for formal national evaluation of the child death review process. This should focus on ways that individual panels can share information to collectively improve generic learning across the process. Future studies should consider other CDOP members' perspectives on this process and seek to quantify the benefit delivered.

Contributorship Statement

Dr Lenton conceived the study and supported Dr Allen in designing the questionnaire, analysing and interpreting data and drafting the initial paper. Dr Fraser and Dr Sidebotham critically revised the work and contributed to re-drafting.

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Competing Interests

None declared

What is already known

- Since 2008 local multi-agency panels have reviewed every child death in England with the aim of reducing future deaths and improving national child health.
- There has been no attempt to assess how panels operate or whether they are reducing deaths.
- Panels consume considerable financial and human resources.

What this study adds

- There is marked variation in the way panels operate, perceive their primary aim and successfully influence local practice.
- Most CDOP doctors feel that panels are delivering good value.
- National collation of data, devolution of specialist deaths to clinical networks, and modifying panel membership may improve Panel effectiveness.

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