Gloucestershire Child Death Review

NHS Gloucestershire

Gloucestershire County Council

CDOP Annual Report 2021-2022

Date 21-22 (SDT)

Contents

Introduction from CDOP Chair

Although a rare event in our society, the death of a child is a heart-breaking loss that deeply affects the friends and family of the child involved. Behind every child's death there is the tragedy of a grieving family, friends and community and we will always aim to keep the family and children at the centre of what we do. As a society it is essential that we learn from these tragic deaths, identify any modifiable factors and implement better ways of working to help prevent similar deaths in the future. This report outlines the number and pattern of those deaths across the county of Gloucestershire and highlights the work of the panel in the last year.

The Gloucestershire CDOP is a collaborative effort, multi-agency membership is robust and meetings are inclusive. As ever, I am indebted to the professionals involved in our CDOP process who continue to work tirelessly to ensure this learning is captured, disseminated and implemented in their various organisations. This learning will have a positive impact on the safety, health and wellbeing of children and young people in the county as well as being promoted regionally and nationally when appropriate. Every death that is discussed is emotionally difficult, but this is important work and it would not be possible without the passion and commitment of those involved, many of whom have been panel members for a number of years. I would also like to take this opportunity to recognise the administrative work that goes on behind the scenes to ensure the meetings that are held every two months are accurate and comprehensive along with projects that take place outside of the panel meetings that aim to make our county a safer place.

Scott Riddell, Centre Manager, Gloucestershire Coroner's Court & Acting Chair of Gloucestershire CDOP.

Useful Links

Gloucestershire Child Death Protocol
https://www.gscb.org.uk/media/2107585/child-death-review-protocol-for-gloucestershire-2021-v4-june-2021.pdf

Gloucestershire Safeguarding Practice Review Process
https://www.gloucestershire.gov.uk/media/2106570/gscp-safeguarding-practice-review-process-april-2021-v11.pdf

SUDI/SUDIC Guidelines
https://www.rcpath.org/uploads/assets/874ae50e-c754-4933-995a804e0ef728a4/Sudden-unexpected-death-in-infancy-and-childhood-2e.pdf

Background to the Child Death Review Process

Child death review partners are local authorities and any clinical commissioning groups for the local area as set out in the Children Act 2004 as amended by the Children and Social Work Act 2017. The statutory responsibilities for child death review partners are set out in Chapter 5 of Working Together to Safeguard Children (2018) outlining the processes to be followed when a child dies. In addition to this, Child Death Review Statutory and Operational Guidance published in October 2018 is followed for all deaths occurring after 1st April 2019.

Under current guidance, CDR Partners are required to establish a procedure to conduct a co-ordinated multi-agency response where the death of any child under 18 years of age meets the following criteria.

- is or could be due to external causes
- is sudden and there is no immediately apparent cause (including SUDI/C)
- occurs in custody, or where the child was detained under the Mental Health Act
- where the initial circumstances raise any suspicions that the death may not have been natural; or
- in the case of a stillbirth where no healthcare professional was in attendance.

In Gloucestershire a joint police, social care and health initial safeguarding discussion occurs at the time of death between police, social care, health and the Coroner's Officer. A formal initial case discussion is undertaken for unexpected deaths within 24 hours of death (or the next working day). This involves statutory agencies, the Coroner's Officer and all professionals involved with the child and family.

CDR Partners are also required to establish a Child Death Overview Panel (CDOP). The two are separate processes but are closely linked. The process ensures early notification and prompt investigation of any death that meets the criteria listed above. The CDOP process ensures that every child's death is comprehensively reviewed, and lessons learnt so that action can be taken to prevent future deaths where possible. The CDOP reports to the Gloucester Safeguarding Children Partnership Management Group.

The Child Death Review Process

A child's death is anonymously reviewed by CDOP after a range of standard information has been collected using statutory forms and the case has been discussed by professionals involved in the child's life at a child death review meeting, known locally as a final case discussion (FCD) meeting. Following the FCD meeting, a detailed compilation of data from the statutory Reporting Form, outcomes of the FCD meeting (Analysis Form) and medical reports including post mortems is produced and anonymised by the Child Death Review Team in Gloucestershire for presentation to CDOP. Data is collected using the eCDOP case management tool to ensure compliance with information governance and data security regulations and to ensure an automatic upload of information to the National Child Mortality Database (NCMD) as has been required since 1st April 2019. The CDOP reviews each case with the aim of identifying modifiable factors and highlights any learning identified. The CDOP aims to identify those factors in the course of a child's life, and leading to the child's death, which might have directly led to the child's death or increased their vulnerability, and which might have been amenable to modification. It also makes recommendations which may prevent similar deaths occurring in the future. However, it may also make recommendations related to service improvement, where changes in practice could lead to improved experiences for children and young people at the end of life or during the course of their treatment.

Production of this report

The CDOP is required to produce an annual report each year outlining the work of the panel and relevant learning from the cases reviewed to inform the priorities of the CDR Partners. This Annual Report is produced using data collected by the Gloucestershire Child Death Review Team. Information collected at the point of notification of death is entered onto the eCDOP case management system. Information collected from statutory forms, FCDs and CDOP reviews is populated onto eCDOP as the case progresses through the Child Death Review process. The eventual CDOP multi-agency dataset is extremely comprehensive. This Annual Report includes three years of data to help reduce year on year variations associated with rare events such as a child death. This allows better identification of longer-term trends or key themes which may not have been as apparent within a single year of data.

Explanation of Category of Death

Unexpected child deaths are defined as the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death. This includes children and young people with disabilities or life limiting illnesses, children and young people who die in road traffic accidents, by drowning etc. and children who are admitted to a hospital ward and subsequently die unexpectedly in hospital.

Expected child deaths are defined as a child with a life limiting condition (Advanced Care Plan usually in place) or in a hospital/hospice and are anticipated to die.

Neonatal deaths are defined as a babies that die within 28 days of birth of any cause or for the purposes of this process a baby who dies that has not left hospital since birth (excluding live born terminations).

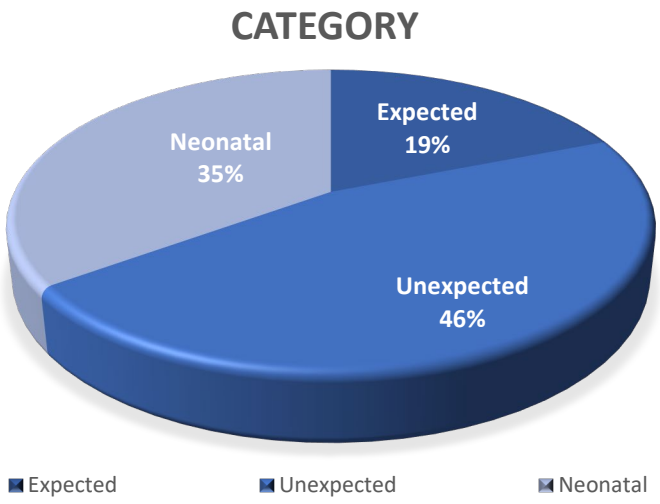
Notification and Case Management

Throughout the twelve months this report covers (April 2021 – March 2022), Gloucestershire were notified of the death of 37 children who were resident in the county. Through this report data is set out for the year 2021-2022 with 3 year summary data under each section for comparison year on year. The table below shows notification figures for the last three years. It is recognised that historically there are variations of these numbers with Gloucestershire having figures as low as 19 and highest at 44.

2019-20	2020-2021	2021-2022
30	32	37

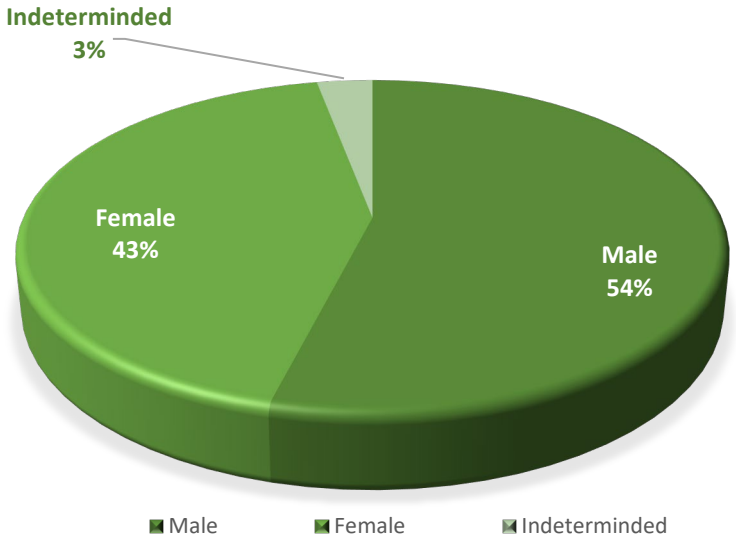
The 37 cases are shown in the charts below by Classification, Age, Sex and Ethnicity with the three years figures in the tables.

Data, Graphs and Charts



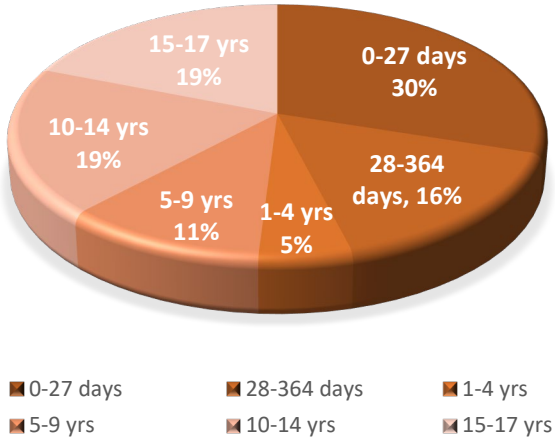
	2019-20	2020-21	2021-22
Expected	33%	38%	19%
Unexpected	33%	9%	46%
Neonatal	33%	53%	35%

GENDER



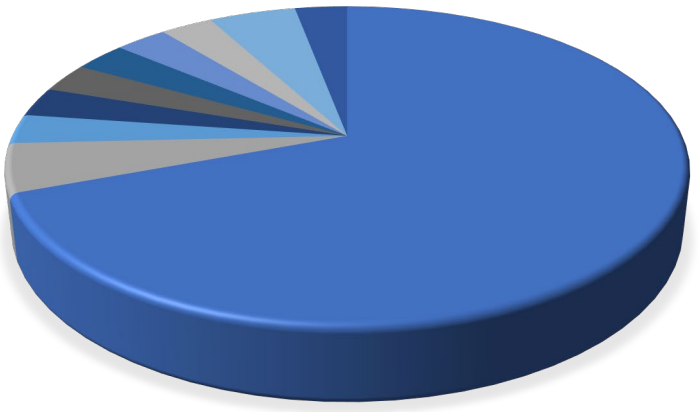
	2019-20	2020-21	2021-22
Male	60%	59%	54%
Female	40%	38%	43%
Indeterminate	0	3%	3%

AGE OF DEATH



	2019-20	2020-21	2021-22
0-27 days	34%	50%	30%
28-364 days	17%	19%	16%
1-4 years	23%	3%	5%
5-9 years	13%	6%	11%
10-14 years	3%	9%	19%
15-17 years	10%	13%	19%

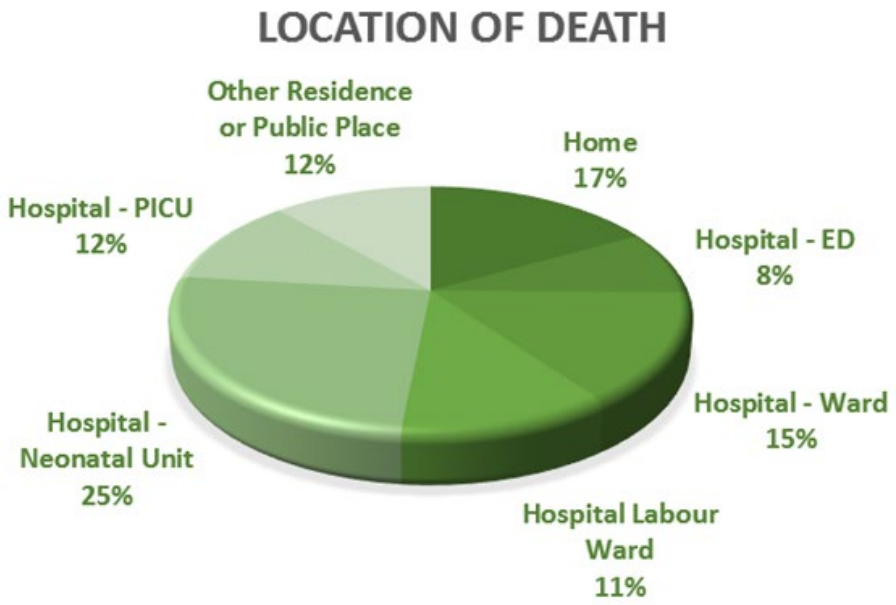
ETHNICITY



Except for White British (70%) the small data figures for all other ethnicities cannot be included in this chart. Please see below for figures.

Recording of ethnicity is now a requirement all cases.

	2019-20	2020-21	2021-22
White – British	64%	85%	70%
White - Any other white background	7%	3%	3%
Mixed - White and Black African	-	3%	-
Mixed – White and Black Caribbean	3%	-	-
Mixed - White and Asian	-	-	3%
Mixed – Any other mixed background	-	-	3%
Black or Black British - Caribbean	-	-	3%
Other ethnic group	3%	-	6%
Asian or Asian British - Any other Asian background	-	-	6%
Asian or Asian British - Indian	-	-	3%
Not known/not stated	23%	9%	3%



	2019-20	2020-21	2021-22
Hospital - Neonatal Unit	26%	41%	24%
Hospital - Labour Ward/Delivery Suite	3%	9%	11%
Hospital -PICU	7%	16%	11%
Hospital – Theatre	-	3%	-
Hospital – Emergency Department	10%	9%	8%
Hospital – Ward	17%	6%	14%
Hospice	17%	-	-
Home	13%	16%	16%
Other Residence or public place	7%	-	16%

Summary statistics

- The majority of child deaths are neonatal deaths accounting for 35% of the total child deaths in 2021-2022
- 46% of all deaths occurred within the first year of life
- 70% of deaths were children from a white British background

CDOP Meetings and Case Reviews

CDOP meetings have continued regularly and virtually. The attendance at these meetings has been more consistent with a greater attendance from members. Gloucester CDOP will continue to run these meeting virtually but will, this year, review options of returning to round the table meetings with the opportunity of a virtual sign in for those that cannot attend in person.

Once all reports have been received for the child and the final Child Death Review has been held the cases are presented to the CDOP Panel anonymously for their review. This ensures that there is a fair audit for each case with actions, lessons learnt and cause of death are agreed against the information provided by agencies that have had involvement during the child's life. As a result, the child deaths reviewed at CDOP have often occurred at least 6 months prior to CDOP panel.

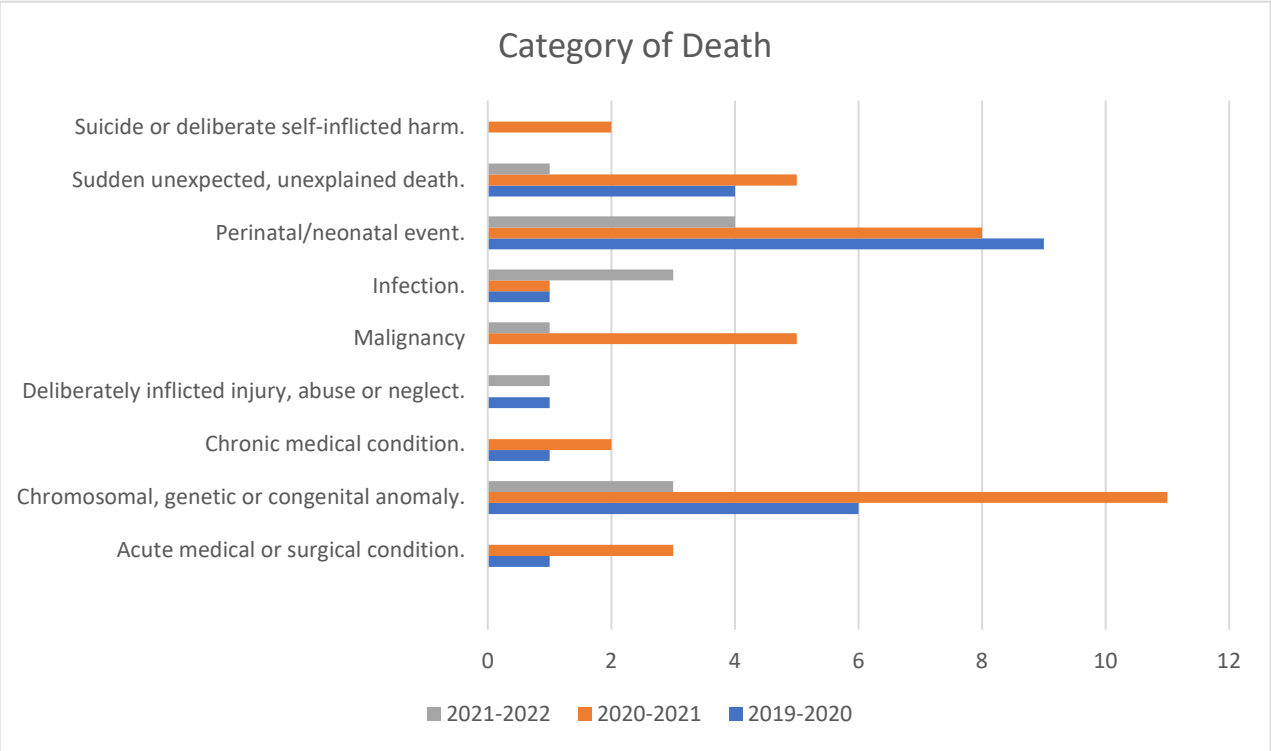
Cases Reviewed 2019-2022

2019-20	2020-2021	2021-2022
23	37	13

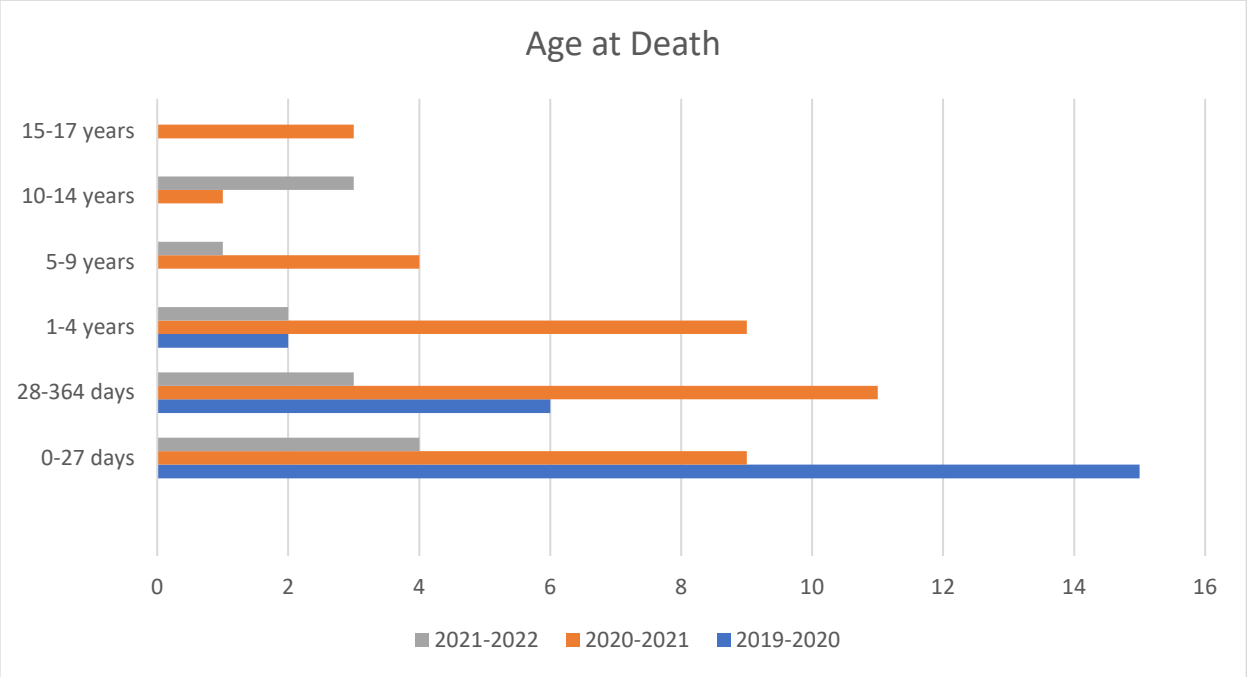
Due to a lack of administrative support for Gloucestershire's eCDOP throughout the year 2021-2022 has meant that the number of reviews was reduced.

Below is the data in respect to Category of Death, Age at Death, Ethnicity, and Location of Death for the cases reviewed at CDOP over the last three year period.

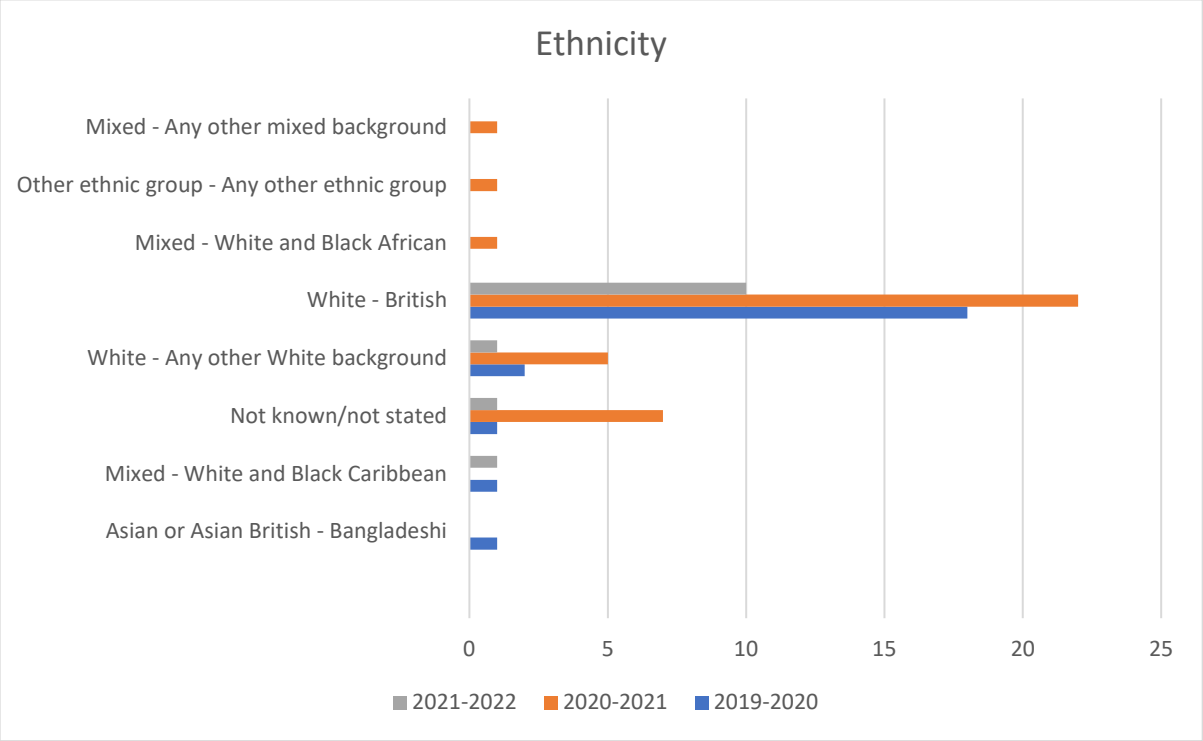
Category of Death



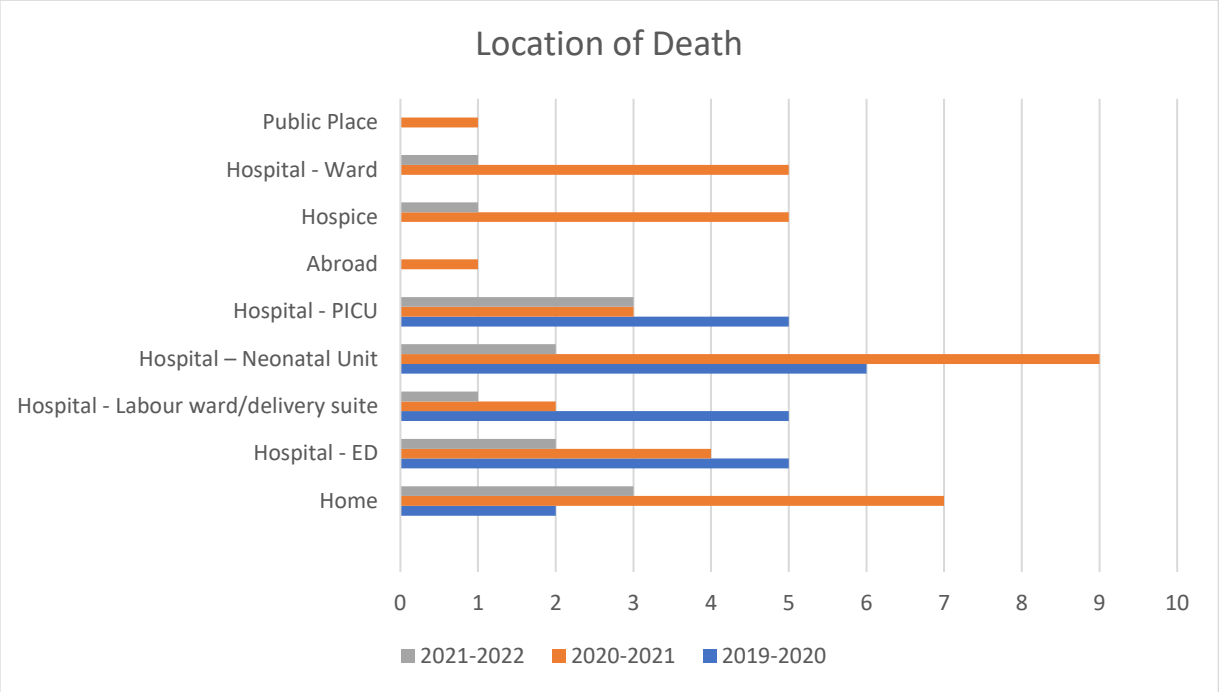
Age of Death



Ethnicity



Location of Death



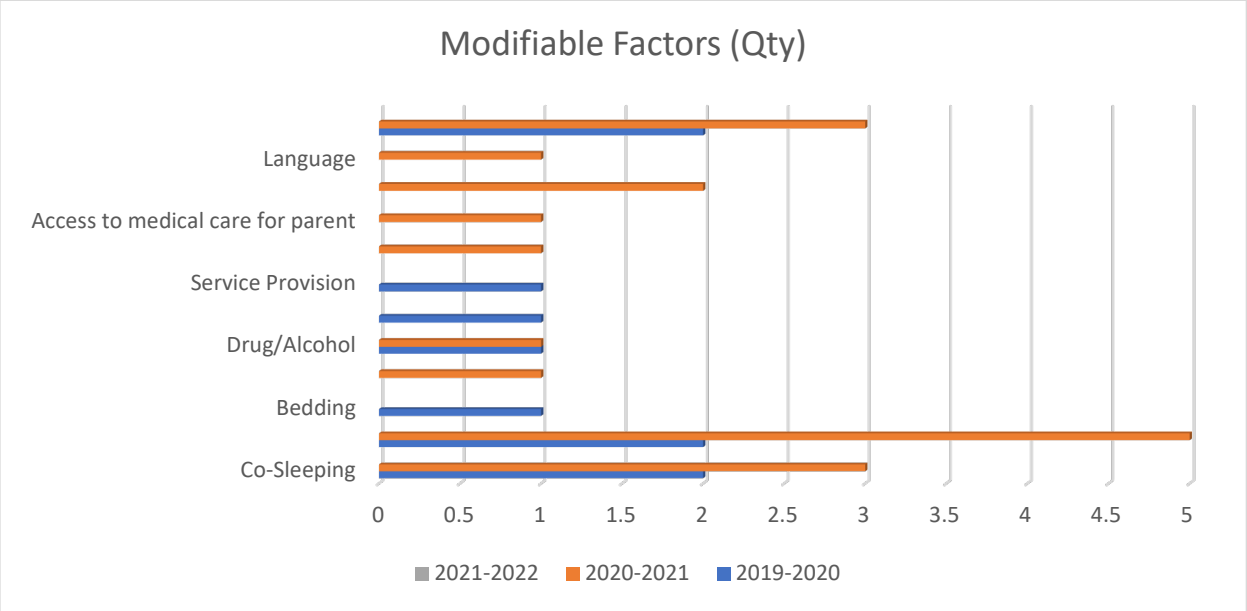
Modifiable Factors Identified During Child Death Reviews 2019-2022

Such modifiable factors are defined as factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths

Of the 73 cases reviewed during 2019-2022, 12 were identified as having modifiable factors . Nationally about 30% of all deaths have identiifed modifiable factors. Locally the most recognised factors related to SUDI and included co-sleeping and parental smoking

For all deaths, Other factors identified included parental drug/alcohol, identification of an ill child/baby, medication, parental health, communications, sleeping area (sofa/chair etc), etc.

The aim for the future is to attempt to correlate cause of death and modifiable factors.



- Unfortunately, there appears to have been some issues recording the 21-22 data and modifiable factors have not been highlighted in eCDOP. The Gloucestershire Child Death Review Team recommend these cases are revisited to enable modifable factors to be identified on eCDOP as this will be fundamental to the work of CDOP going forward.

Deprivation Deciles for children who died April 2021 to March 2022

The NCMD published their annual report in November 2021 in which they correlated deprivation factors with cause of death and modifiable factors.

Work is currently being undertaken in Gloucestershire Public Health to produce the Gloucestershire/local demographics for the last three years of child deaths. Unfortunately, this is currently not fully completed and will be shared as a separate paper when available.

National Data

The NCMD (National Child Mortality Database) produced their second annual report for the year April 2020 to March 2021 in November 2021 based on data provided from cases reviewed at CDOPs in England. At the time of publication of this report the NCMD Report for 2021-2022 has not yet been published.

The effects of Covid-19 on the Child Death Review Process

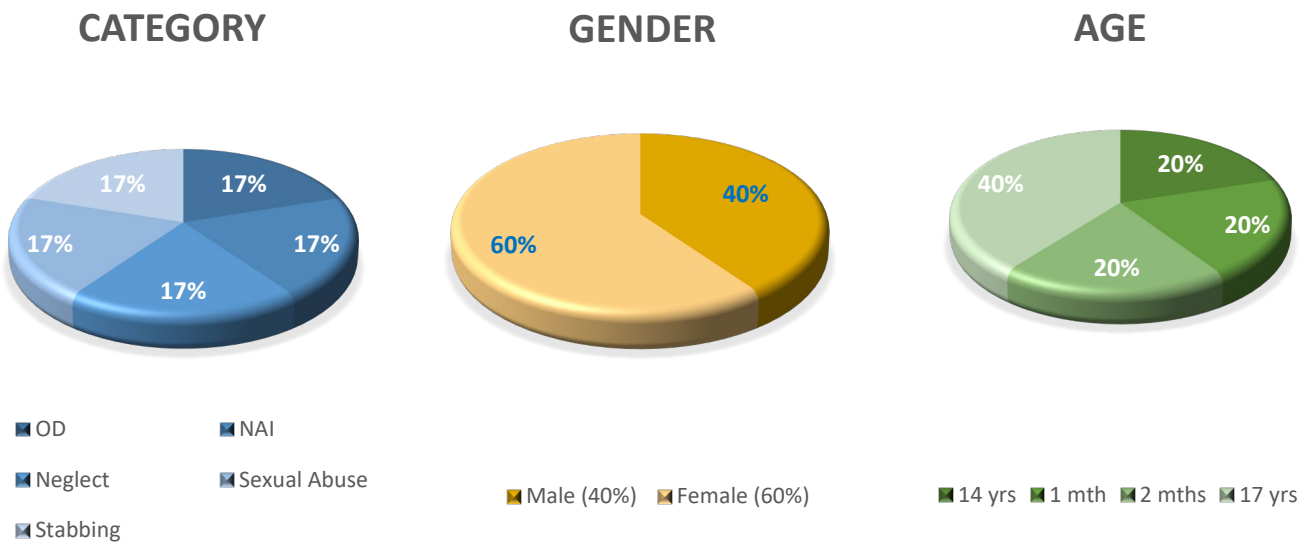
The Child Death Process and Child Death Overview Panels have previously all been undertaken as face to face meetings. As a consequence of Covid-19, all meetings changed to virtual and have continued to do so preventing any delays to final case reviews. Gloucestershire continue to adhere to the National guidance when collecting data which includes the possibility of Covid infection, previous contact with the child and implications of Covid on services provided to the child and family during these testing times.

ALTE's (Acute Life Threatening Events)

Gloucestershire have implemented an ALTE process which links closely across all agencies and mirrors the initial case discussion for child death reviews. During the period covered in this report 6 ALTE Reviews were carried out. These covered neglect, stabbing, overdose, NAI and sexual abuse.

One of the cases reviewed through ALTE unfortunately became a child death which then followed the due process. This case will not be included in the data below.

For more information on the ALTE process and its links with Local Child Safeguarding Practice Reviews (LCSPR) click here



Gloucestershire's CDOP Achievements During 2021-2022

Additional achievements last year were hindered by Covid, lack of admin staff and the additional time to implement eCDOP.

- Improving the recording of Ethnicity – Every child's ethnicity should be identified to ensure if any minority groups are over-represented in child deaths.
  This has been highlighted to all agencies and there was a 97% success rate for 20-21 which is a considerable improvement from previous years.

- Encourage better Parental Feedback – Every family should be given the opportunity to provide feedback as to the care of their child during life and the impact of their child's death. For every new case a Keyworker is identified to support the family and provide a point of contact for the family or any professional involved in the case. Close to the time of the final case discussion the key worker contacts parents for any feedback they wish to give to the panel/professionals involved in their child's life/death to facilitate learning for any future cases. Work continues in this area and the plan is to audit its implementation in the future.

- Continuing the work on Safer Sleeping – The NCMD are currently undertaking a review of infant deaths. Learning needs to be cascaded throughout Gloucestershire. Gloucestershire have updated their Safer Sleeping guidance through a task and finish group. All documentation and learning has been disseminated throughout all agencies and again promoted for Child Safety Week. CDOP linked with all Safeguarding Partners (GSCP, GHC, GCC and Police) to promote this universally in Gloucestershire. Relevant documents are now in the process of being uploaded on all key partners intranets in order that all agencies use common language when communicating with parents and carers

- The Network Meetings – The lead nurses for child death now attend the National Lead Nurse Child Death Network

- Gloucestershire Hospitals have identified a dedicated Paediatrician as Child Death Lead for the Trust and who is working closely with the Child Death Review Team. This has helped improve the response of Hospital staff, supported those involved in a child death and facilitated communication of learning to the child death team and to hospital staff.

- The Statutory Review Coordinator will continue to hold the role of QES eCDOP Change Champion for the Southwest region. This will involve testing updates and new functions on eCDOP before they are uploaded to the live systems.

- Statutory Review Coordinator will continue to interact with the South Network of Coordinators to ensure Gloucestershire processes align with other areas.

- Due to Covid a lot of previous links were lost and we have now revisited links with the LeDeR Review and they now are a member of the CDOP Panel.

- eCDOP – Has now been embedded in practice and has become a more useful tool enabling more efficient use of data with lots of potential for the future.

Current Multi-Agency Issues:

Training for Professionals who may be involved in a child's death

Throughout the year there have been a number of requests for training on the child death review process. Due to the number of changes in the administration of the child death process in Gloucestershire, it is the intention of the team to formalise a training package to include: Notification, Reporting Forms and explaining the process itself by way of presentations and webinars.

The Child Death Review team always respond to individual requests for assistance in completing Notification and Reporting forms.

Multi Agency Home Visits

Guidance currently recommends that there should be a joint home/scene of collapse visit by Police and health. In Gloucestershire, at present, the only Health professional trained to attend these visits is the Designated Doctor for Child Death Reviews. Gloucestershire Police have received additional training for these visits but there is still a lack of availability for Health to attend. This matter is regularly discussed with Partners and at CDOP. If this guidance is to be implemented then additional funding and training will be required to ensure health professionals are able to fulfil this role.

Post Mortem Reports

Further work is still required to redefine the process for the sharing of Post Mortem reports with families and professionals.

Plans for the year 2022-2023

- To continue to develop a local Training Pack on the Child Death Process for Gloucestershire professionals.
- Paediatric Palliative Care Group - To continue to link with the Paediatric Palliative Care Group meetings. These meetings cover palliative care, end of life processes, hospice involvement, training and processes, as well as individual case reviews. Both the Child Death Review Team and the Paediatric Palliative Care Group find the involvement beneficial to both groups.
- Continue to maintain Protocol/Website to reflects current local and National guidance for professionals and families
- Audit – to ensure all information is available for the FCR. For each case completed in 2022-23 there will be an audit to identify any agencies/documents/reports that were not made available to the review. This will be monitored and any inconsistencies will be addressed.
- Future discussions for CDOP. Themed reviews, the role of local and tertiary reviews.
- Develop a work action plan to implement recommendations from NCMD reports due to be published (Child Mortality and Social Deprivation /Suicides.
- The role of the Medical Examiners - The Government have proposed extending the role of the Medical Examiners to become an integral part of all death reviews. Work is currently underway in Gloucestershire to facilitate this process.

- Data analysis of deprivation data related to cause of death needs to be interrogated in more detail and correlated with any recorded modifiable issues, if we are to identify any local trends and compare to National data.

- The Gloucestershire Child Death Review Team recommend the cases from 2021-2022 are revisited to enable modifable factors to be identified on eCDOP as this will be fundamental to the work of CDOP going forward.

- CDOP to determine the future presentation of data for the annual report.

The Child Death Team and CDOP would like to thank the Lead Nurse for Child Death during this period for all her input and dedication to the Child Death Process and the CDOP Panel over the past few years. We wish her every happiness in her retirement. Our thanks also to The Lead CAMHS Consultant Psychiatrist and CDOP panel representative for her support and experience during complex child reviews and her contribution to the panel.

The Child Death Team and CDOP would like to welcome our two new Lead Nurses for the Child Death Process and our new Business Administrator who has joined the GSCP Business Unit for her support to the Child Death Processes and Panel.

The Child Death Team would also like to thank all the Professionals who have worked closely with us over the past year and have facilitated this process and enabled us to share and implement our learning. We look forward to next year and further development of our multi-agency plans.

Gloucestershire Child Death Review

NHS
Gloucestershire
Clinical Commissioning Group

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COUNTY COUNCIL