Gloucestershire Child Death Review

NHS
Gloucestershire
Clinical Commissioning Group

Gloucestershire
COUNTY COUNCIL

CDOP Annual Report 2020-2021

December 2021

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. 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. It has been written during the unprecedented times of a global pandemic. Despite this, the panel has endeavoured to meet remotely and give due consideration to each and every child and their family and carers so that any lessons learned are captured and disseminated to the relevant individuals or agencies involved.

There is a wide association of committed professionals across the county who continue to approach the work of CDOP in a manner that ensures it is a success. In my role as Chair I would like to take the opportunity in my foreword to thank these professionals for their continued diligence and hard work in contributing to the CDOP process and, ultimately, assisting in the production of this report.

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 forms (Reporting Form) and 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.

The Gloucestershire Partnership would like to thank the Child Death team at Bristol University for their support and administration of the child death process over many years. Following the introduction of

eCDOP the Gloucestershire Partnership elected to provide all Child Death support locally and engaged QES directly to provide the service. As expected there has been a lot of learning incorporating this part of the process into the review team's current roles. There was, and still is, a lot of work to be done to ensure the system is being used to its capacity to benefit the team and to provide Gloucestershire Partners the expected continual high standards for the benefit of the children and families of our County.

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. The 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.

This year there has been a delay in the production of the report due to the lack of familiarity with systems and an administration vacancy in the GSCP business unit. The aim for the future is that this report will be produced in a timelier manner and more scrutiny will occur with 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 within 24 hours of prognosis.

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).

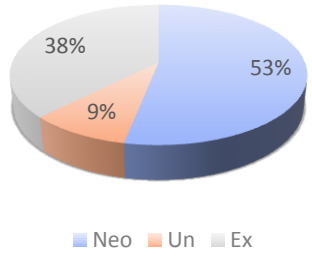
Notification and case management

Throughout the twelve months this report covers (April 2020 – March 2021) Gloucestershire were notified of the death of 32 children who were resident in the county. Through this report data is set out for the year 2020-2021 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.

2018-19	2019-20	2020-2021
23	30	32

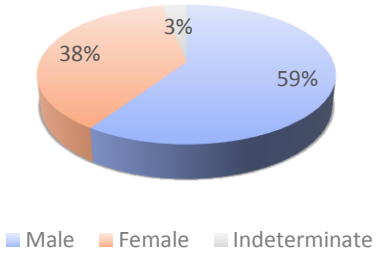
The 32 cases are shown in the charts below by Classification, Age, Sex and ethnicity with the three years figures in the tables.

Classification



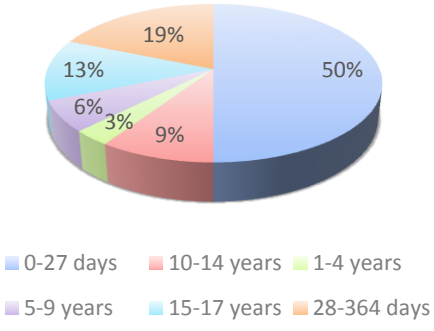
	2018-19	2019-20	2020-21
Expected	9%	33%	38%
Unexpected	39%	33%	9%
Neonatal	52%	33%	53%

Gender



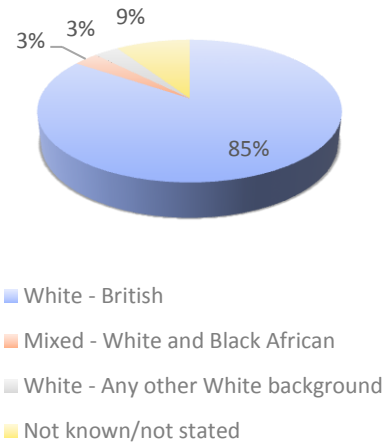
	2018-19	2019-20	2020-21
Male	52%	60%	59%
Female	42%	40%	38%
Indeterminate	0	0	3%

Age at death



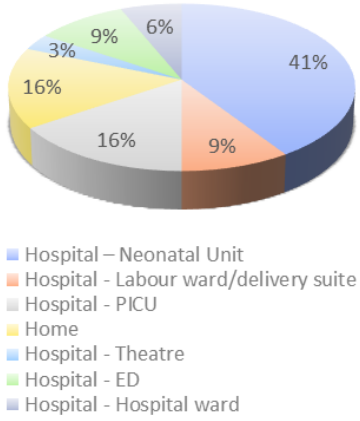
	2018-19	2019-20	2020-2021
0-27 days	40%	34%	50%
28-364 days	40%	17%	19%
1-4 years	8%	23%	3%
5-9 years	4%	13%	6%
10-14 years	4%	3%	9%
15-17 years	4%	10%	13%

Ethnicity



	2018-19	2019-20	2020-21
White – British	66%	64%	85%
Mixed - White and Black African	4%	0	3%
Mixed – White and Black Caribbean	0	3%	0
White - Any other white background	26%	7%	3%
Other ethnic group	0	3%	0
Not known/not stated	4%	23%	9%

Location of Death



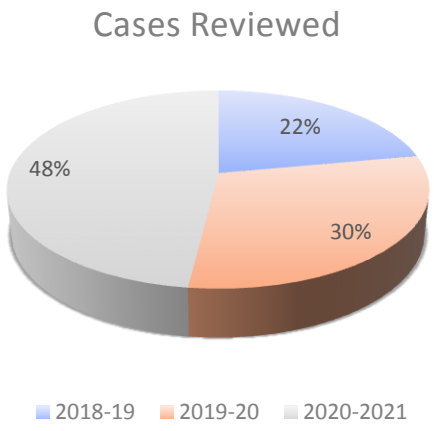
	2018-19	2019-20	2020-21
Hospital - Neonatal Unit	35%	26%	41%
Hospital - Labour Ward/Delivery Suite	13%	3%	9%
Hospital -PICU	13%	7%	16%
Hospital – Theatre	-	-	3%
Hospital – Emergency Department	13%	10%	9%
Hospital – Ward	-	17%	6%
Hospice	4%	17%	-
Home	22%	13%	16%
Other – public place	-	7%	-

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 and will review options in the future when a safe and secure return to the workplace is an option for all involved and alternative attendance options made, where necessary, for those that are unable to attend in person.

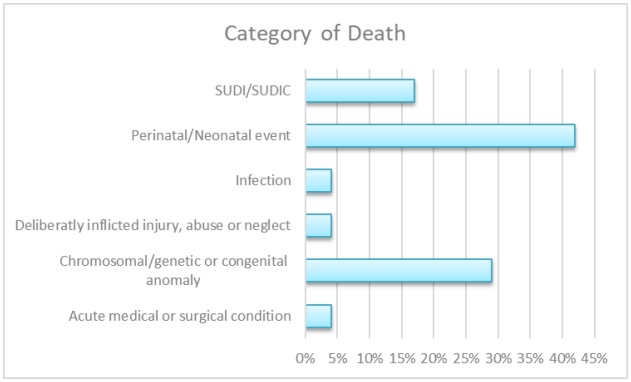
Summary statistics

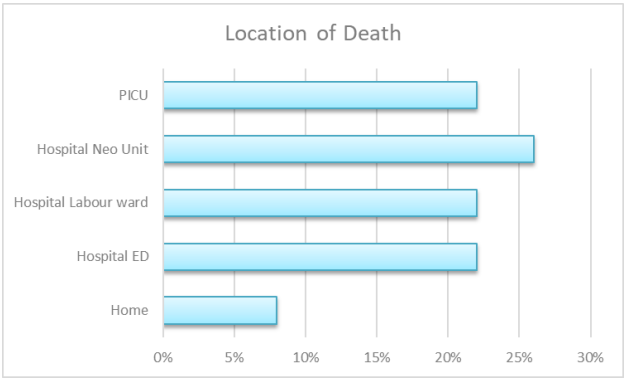
- The majority of child deaths are neonatal deaths accounting for 53% of the total child deaths in 2020-2021
- 69% of deaths occurred within the first year of life
- Deaths from external causes, which includes deliberately inflicted abuse or neglect, trauma and external factors or self- inflicted harm and suicide are rare. They account for 19 (12%) of deaths.

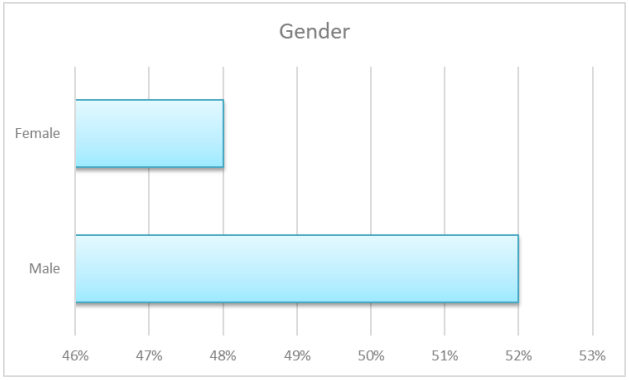


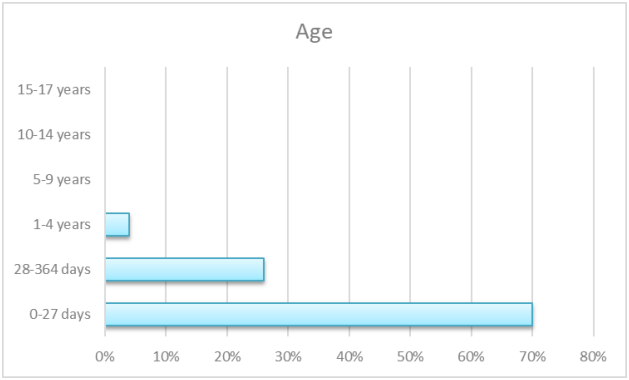
2018-19	2019-20	2020-2021
17	23	37

Completed Cases 2019-2020

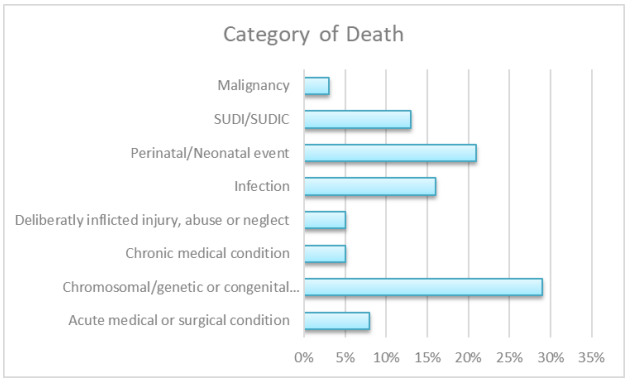


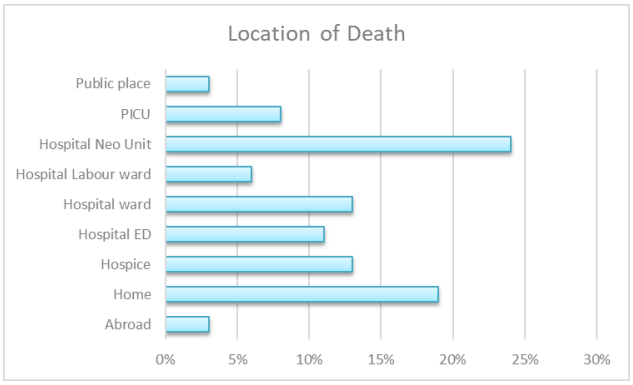


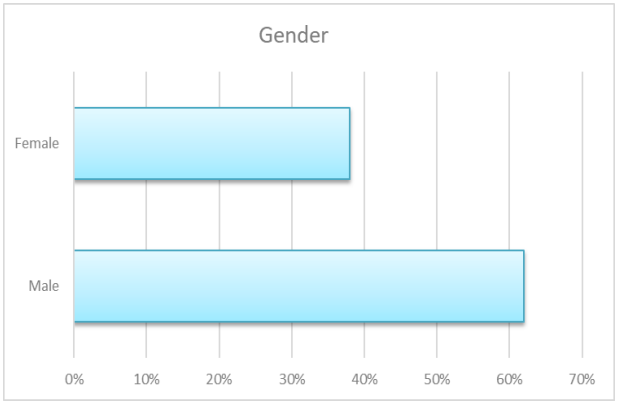


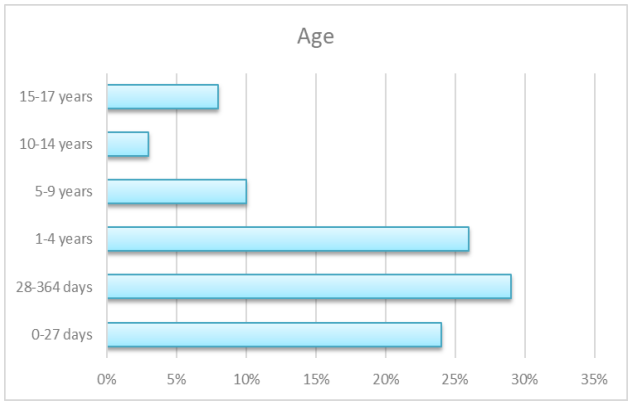


Completed Cases 2020-2021









National Data (National Child Death Mortality Database Second Annual report)

The NCMD produced their second annual report for the year April 2020 to March 2021 based on data provided from cases reviewed at CDOPs in England. It shows the following and Gloucestershire comparative figures are in the brackets:

- 63%(69%) of deaths were less than a year of age and 42%(53%) were less than 28 days
- Where ethnicity recorded (78% of all child deaths), 62% were white British, 19% were Asian/Asian British, 9% Black/Black British and 7% Mixed race though further work required to include all deaths.
- Approximately, there were three times as many deaths for children who were resident in the most deprived neighbourhoods
- Where gestational age at birth known 69% were born prematurely
- Where place of death known, 78% occurred within a hospital trust, 22% outside of hospital

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.

The Team have also fully participated in the National Reviews, NCMD events and conferences to ensure Gloucestershire's Child Death Process are fully compliant and responsive to a changing environment.

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 states 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 will be required.

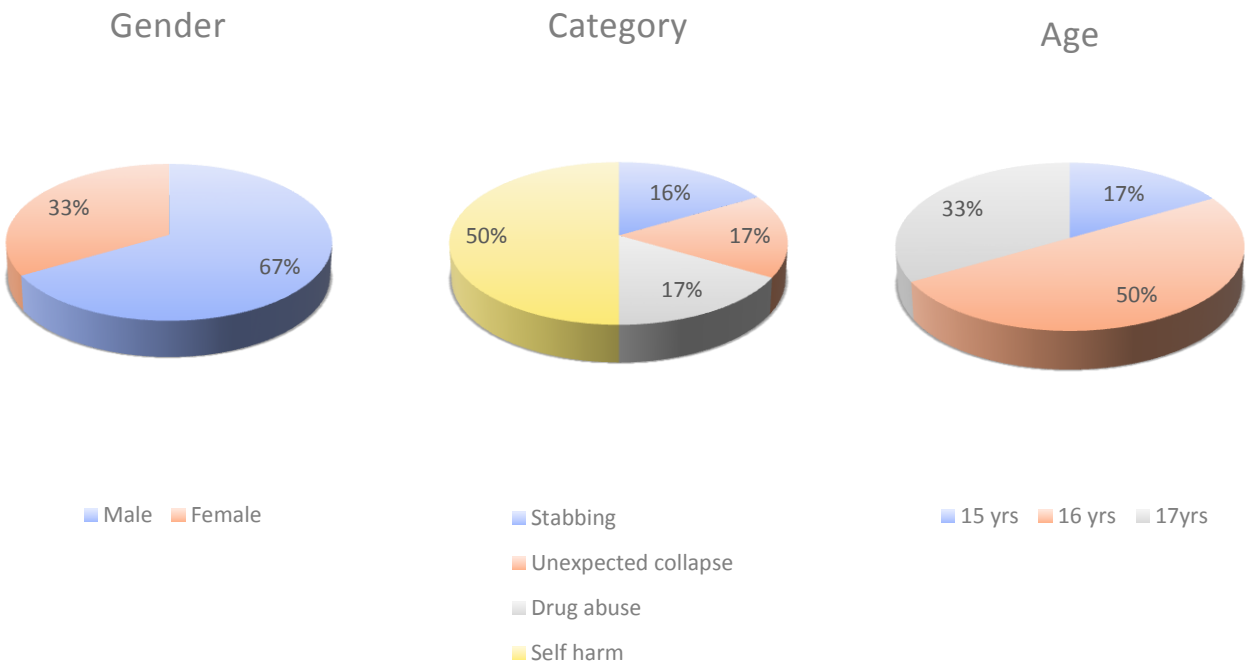
Paediatric Palliative Care Group

The Gloucestershire Child Death Review Team members 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.

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 drug abuse and overdose, hangings, stabbing and a medical collapse (unknown cause).

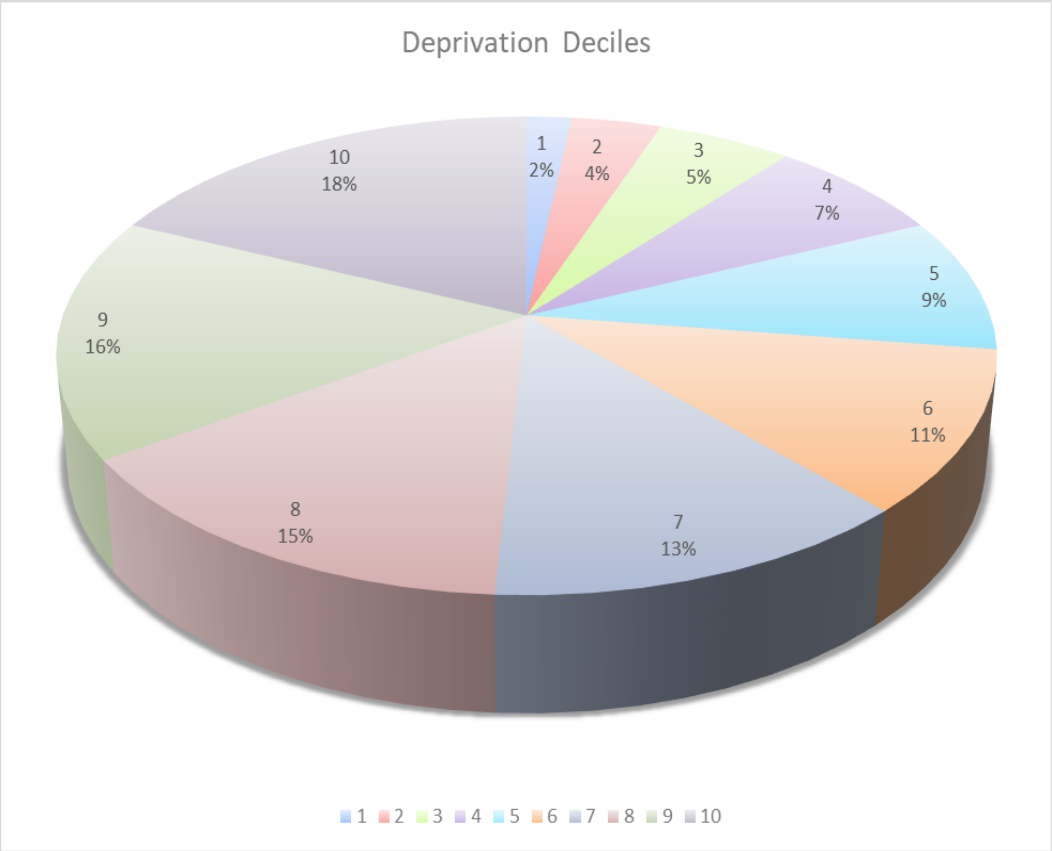
One of the cases reviewed through ALTE unfortunately became a child death and LSCPR which then followed the due process. This case will not be included in the data below.



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

Deprivation Deciles for children who died April 2019 to March 2021

Locally we appear to have more deaths in less deprived areas. This may reflect the small numbers and we will continue to review this.



1 = most deprived – 10 most affluent

Gloucestershire CDOP achievements during 2020-2021

- 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 data for all cases has been collated.

- 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

- 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 universal 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

  An advice pack has been produced for professionals which includes –
  1. Red Book Insert –This is a nationally approved insert for the Red Book which is currently not available for Gloucestershire families. It provides documentation for the family and an easy way to start conversations in relation to 'safer sleeping' beginning antenatally with midwifery and continuing into infancy. All professionals will receive a copy of the insert to enable further discussion with families at all contacts with any professional.
  2. SIDS A Brief Guide for Professionals – This was developed to provide some additional information for professionals who are unfamiliar with safer sleep advice.
  3. Frequently Asked Questions – Consulting national websites and partners, a FAQ's sheet has been produced to assist Professionals with the most common questions that families ask.

- Formalising Gloucestershire Hospitals Child Death Response.
  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.

- Commissioning of Skeletal Surveys – This process had been identified as a risk area for child death investigation process. A local agreement has now been achieved between HMCO and Gloucestershire Hospital Trust to facilitate this process.

- Update of relevant procedures and protocols.
  Gloucestershire Protocol for Child Death reviews was fully reviewed this year and continues as a live document to facilitate prompt reflection of any local or national changes to legislation, process or procedure. Our procedures/documentation has been shared with other CDOPs to aid them in delivering the child death process.

- Work with NCMD Quality Improvement Review of Joint Agency Response (JAR)Processes

Gloucestershire Child Death Team have undertaken work with the National Group to help streamline processes for JAR

- Tuberculosis awareness raising
  As a result of an unexpected infant death with TB, a Task & Finish group was established to develop a flowchart to raise awareness of:
- Populations at risk of TB
- Symptoms of concern
- Where to seek advice for children and adults with TB concerns
- Support for vulnerable populations, such as additional support for housing and immigration issues
- How to register with a GP
  This flowchart has been widely distributed in adult and children services

Plans for the year 2021-2022

- Gloucestershire have recruited a Statutory Review Coordinator within GSCP. The role will cover all statutory reviews including child death.

- The Statutory Review Coordinator has successfully applied to become a QES eCDOP Change Champion for the South West region. This will involve testing updates and new functions on eCDOP before they are uploaded to the live systems.

- Statutory Review Coordinator has made contact with the South Network of Coordinators to ensure Gloucestershire processes align with other areas.

- To develop a local Training pack on the Child Death Process for Gloucestershire professionals.

- 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 2021-22 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, identification of a vice chair for the CDOP Panel.

- Develop a work action plan to implement recommendations from NCMD reports due to be published (Child Mortality and Social Deprivation /Suicides)

The Child Death Team would 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.

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