CDOP Annual Report 2022-2023

Gloucestershire Child Death Review

NHS Gloucestershire

Gloucestershire County Council

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, we are indebted to the professionals involved in the Gloucestershire CDOP process who continue to work tirelessly to ensure this learning is captured, disseminated and implemented in their various organisations. Every death that is discussed is emotionally difficult, but this is important work, and it would not be possible without the commitment of those involved. We are fortunate to have close links in Gloucestershire between the Child Death Review team and the Gloucestershire Safeguarding Children Partnership, in particular the GSCP Business Unit, who provide the administrative work that goes on behind the scenes to ensure all the meetings that are required are accurate and comprehensive.

As we move from 2022/2023 year into 2023/2024 year there are challenges that the CDOP will need to address in terms of designated positions within our local health trusts, along with a need to review the administrative function to assure the Child Death Review Partners of the capacity to undertake both the work of the CDOP in the short and medium term but into the future.

Finally, the Gloucestershire CDOP would like to recognise the tireless work of the recently retired Dr Imelda Bennet and thank her for her leadership as a core member of the Gloucestershire CDOP since 2007 as the Designated Doctor for Gloucestershire.

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 usually within 24 hours of the 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 four 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 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).

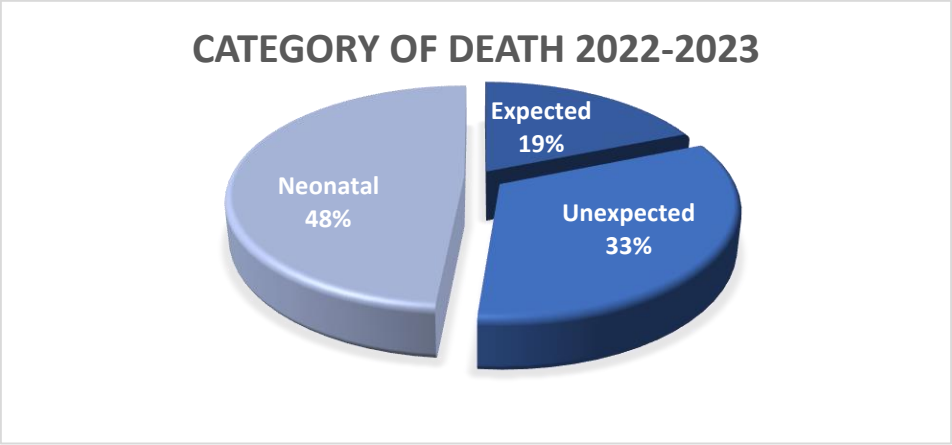
Notification and Case Management

Throughout the twelve months this report covers (April 2022 – March 2023), Gloucestershire were notified of the death of 43 children who were resident in the county. Through this report, data is set out for the year 2022-2023 with 4 year summary data under each section for comparison year on year. The table below shows notification figures for the last four years. It is recognised that historically there are variations of these numbers with Gloucestershire having figures previously as low as 19 and highest at 44.

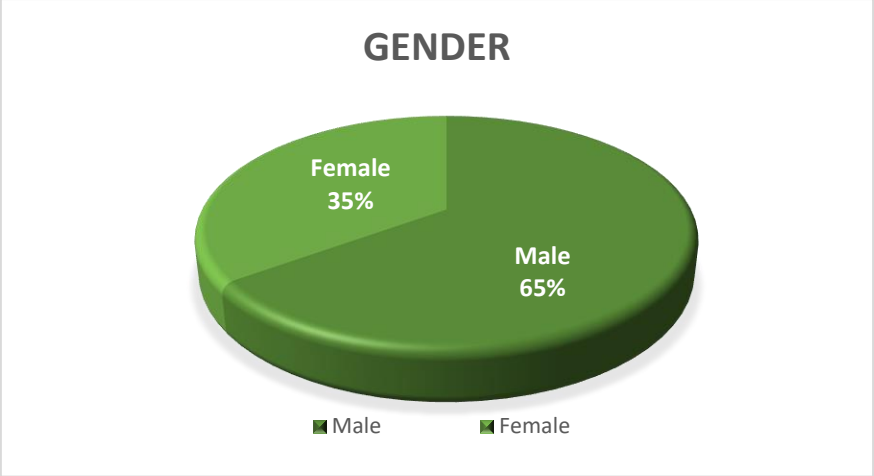
2019-20	2020-2021	2021-2022	2022-2023
30	32	37	43

Data, Graphs and Charts

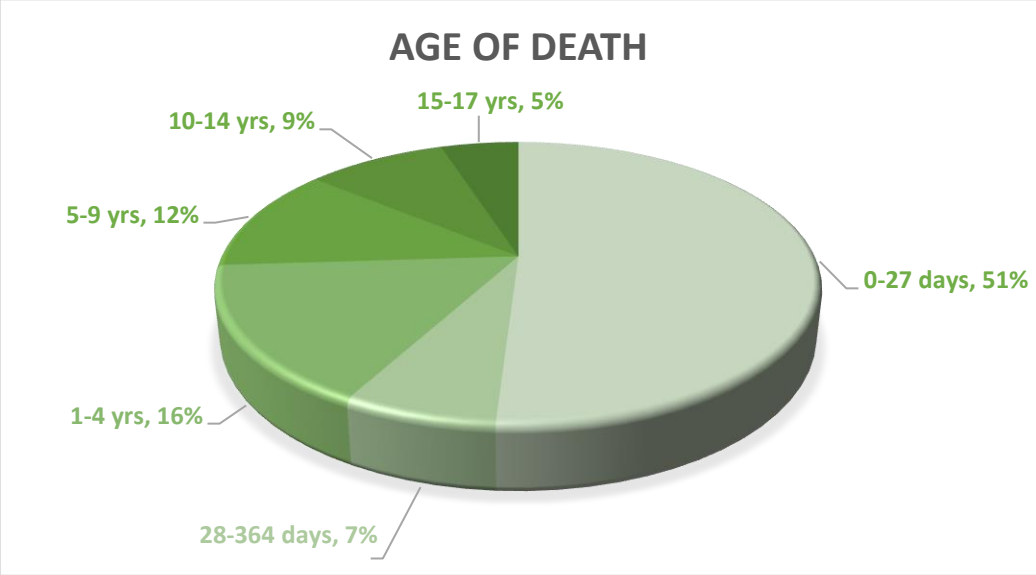
The 43 cases for this year are shown in the charts by category, gender, age, ethnicity and location of death with the four years figures in the tables.



	2019-20	2020-21	2021-22	2022-23
Expected	33%	38%	19%	19%
Unexpected	33%	9%	46%	33%
Neonatal	33%	53%	35%	48%

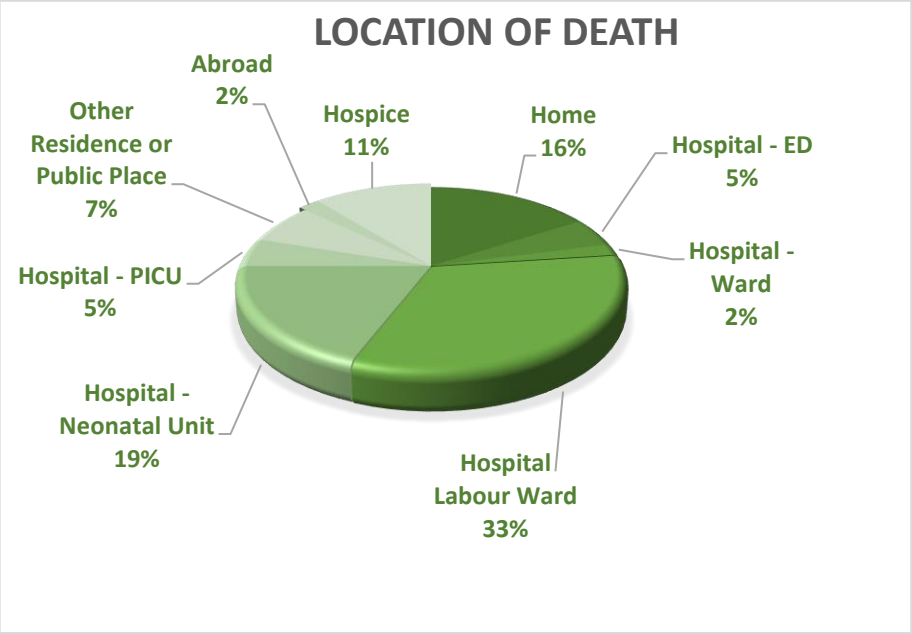


	2019-20	2020-21	2021-22	2022-23
Male	60%	59	54%	65%
Female	40%	38%	43%	35%
Indeterminate	0%	3%	3%	0%



	2019-20	2020-21	2021-22	2022-23
0-27 days	34%	50%	30%	51%
28-364 days	17%	19%	16%	7%
1-4 years	23%	3%	5%	16%
5-9 years	13%	6%	11%	12%
10-14 years	3%	9%	19%	9%
15-17 years	10%	13%	19%	5%

Ethnicity	2019-20	2020-21	2021-22	2022-23
White – British	64%	85%	70%	78%
White - Any other white background	7%	3%	3%	-
White - Irish	-	-	-	2%
Mixed - White and Black African	-	3%	-	-
Mixed – White and Black Caribbean	3%	-	-	2%
Mixed - White and Asian	-	-	3%	5%
Mixed – Any other mixed background	-	-	3%	2%
Black or Black British - Caribbean	-	-	3%	-
Black or Black British - African	-	-	-	5%
Other ethnic group	3%	-	6%	2%
Asian or Asian British - Any other Asian background	-	-	6%	2%
Asian or Asian British - Bangladeshi	-	-	-	%
Asian or Asian British - Indian	-	-	3%	2%
Not known/not stated	23%	9%	3%	-



Summary Statistics

- 57% of recorded deaths were neonatal
- 58% of all deaths occurred within the first year of life
- 33% of deaths were unexpected
- 19% of deaths were expected
- 76% of deaths were children from a white British background
- 65% of deaths were male, 35% female

	2019-20	2020-21	2021-22	2022-23
Hospital - Neonatal Unit	26%	41%	24%	19%
Hospital - Labour Ward/Delivery Suite	3%	9%	11%	33%
Hospital -PICU	7%	16%	11%	5%
Hospital – Theatre	-	3%	-	%
Hospital – Emergency Department	10%	9%	8%	5%
Hospital – Ward	17%	6%	14%	2%
Hospice	17%	-	-	11%
Home	13%	16%	16%	16%
Abroad	-	-	-	2%
Other Residence or public place	7%	-	16%	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. Gloucestershire 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 that cause of death is 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.

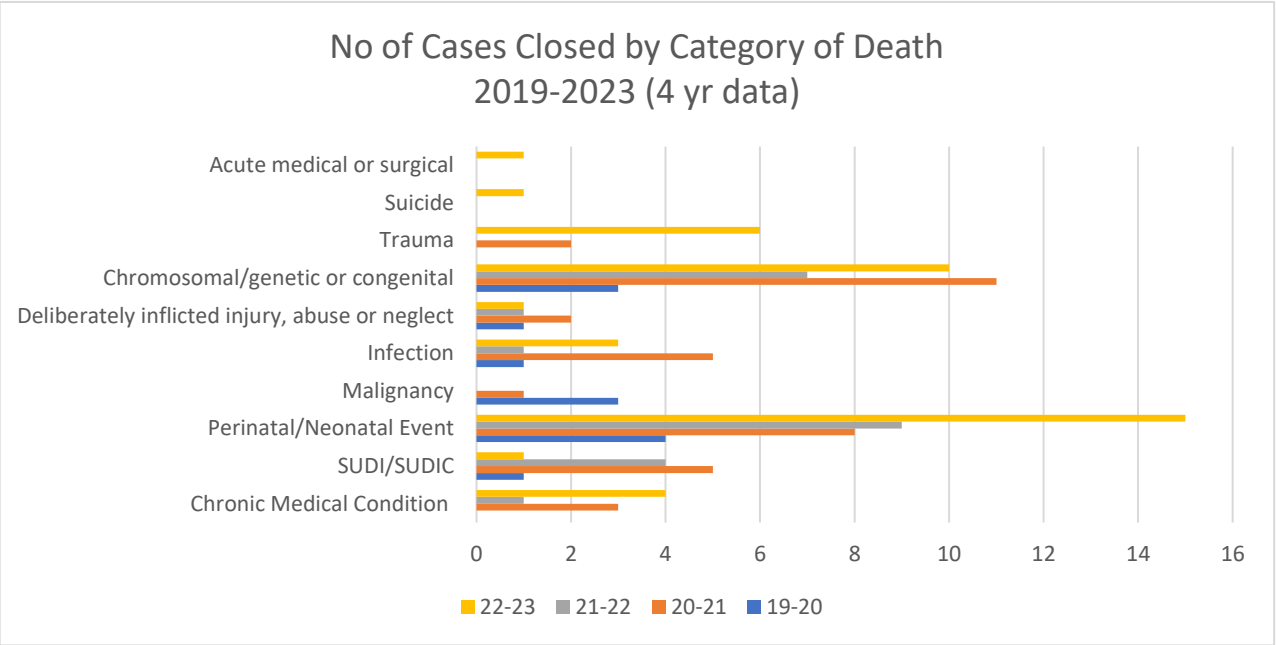
Due to the retirement of Gloucestershire's Designated Doctor for Child Death Reviews, it will no longer be possible to carry out final case reviews or CDOP panel reviews for open cases until the post has been filled. Local paediatricians are available when necessary to provide support to the Child Death Review Team if necessary but, without the allocation of this key professional, Gloucestershire cases cannot be completed or reviewed. It is hoped that this post will be filled in the near future, and it is possible that extra panel meetings will be held to reduce any backlog.

Cases Reviewed 2019-2023

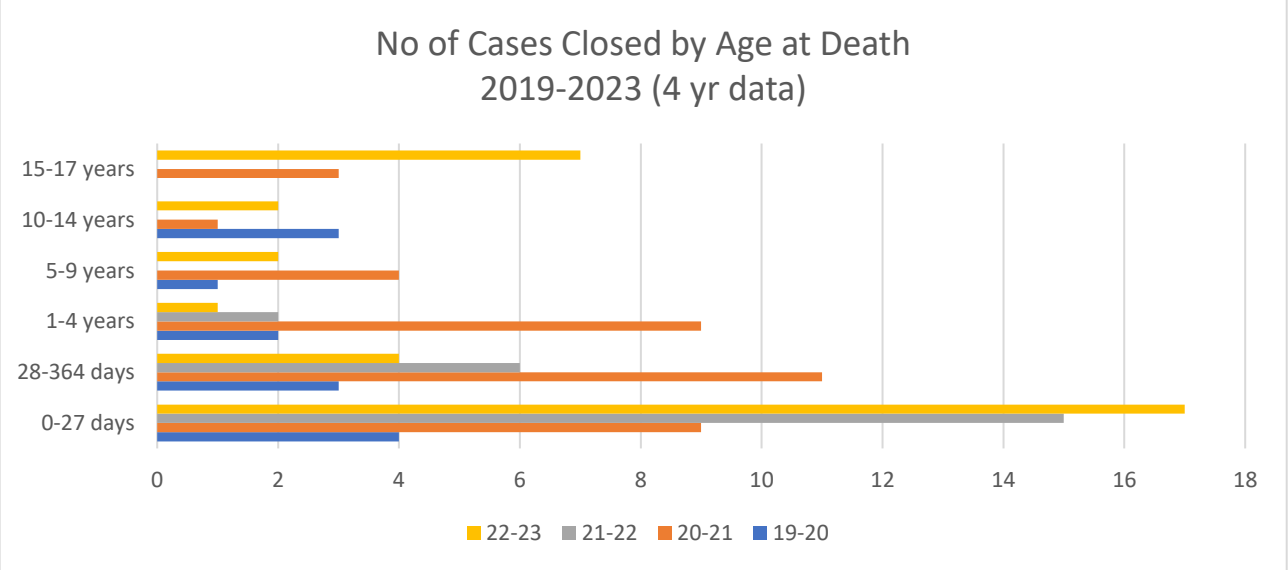
2019-20	2020-2021	2021-2022	2022-23
23	37	13	33

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

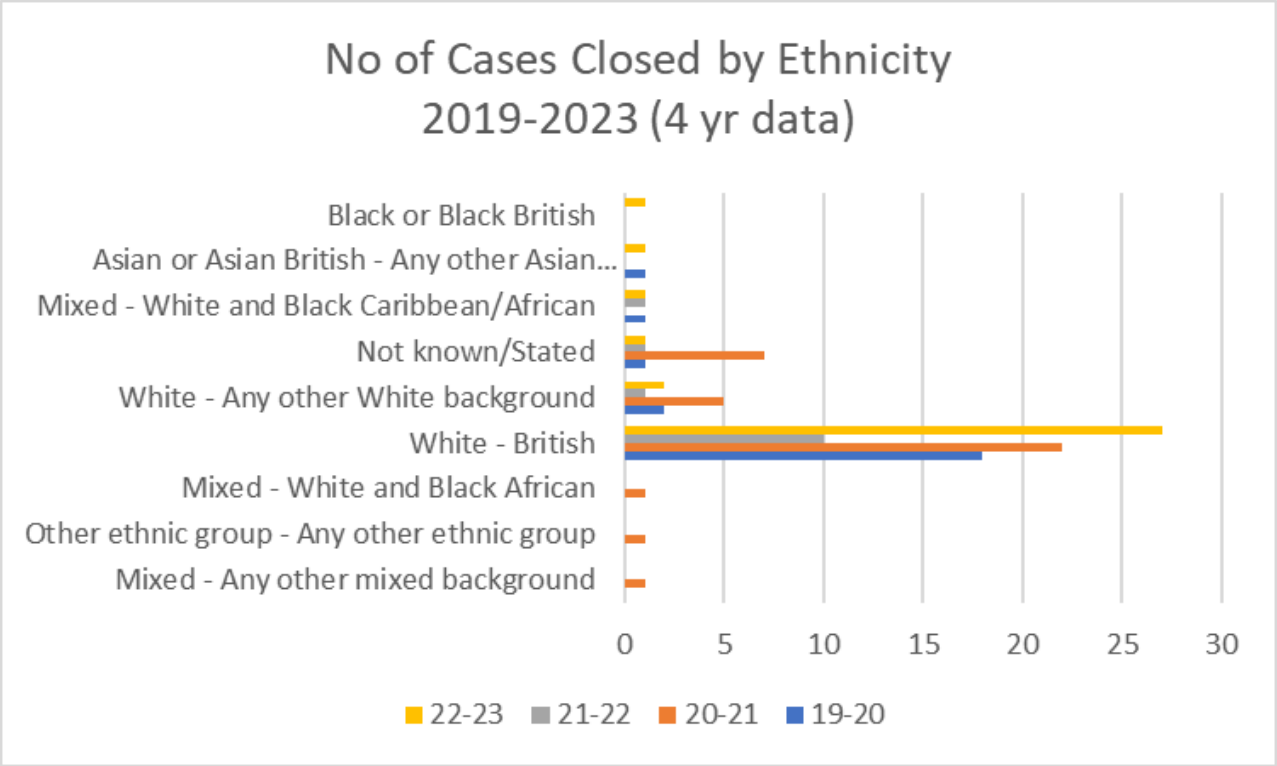
Category of Death



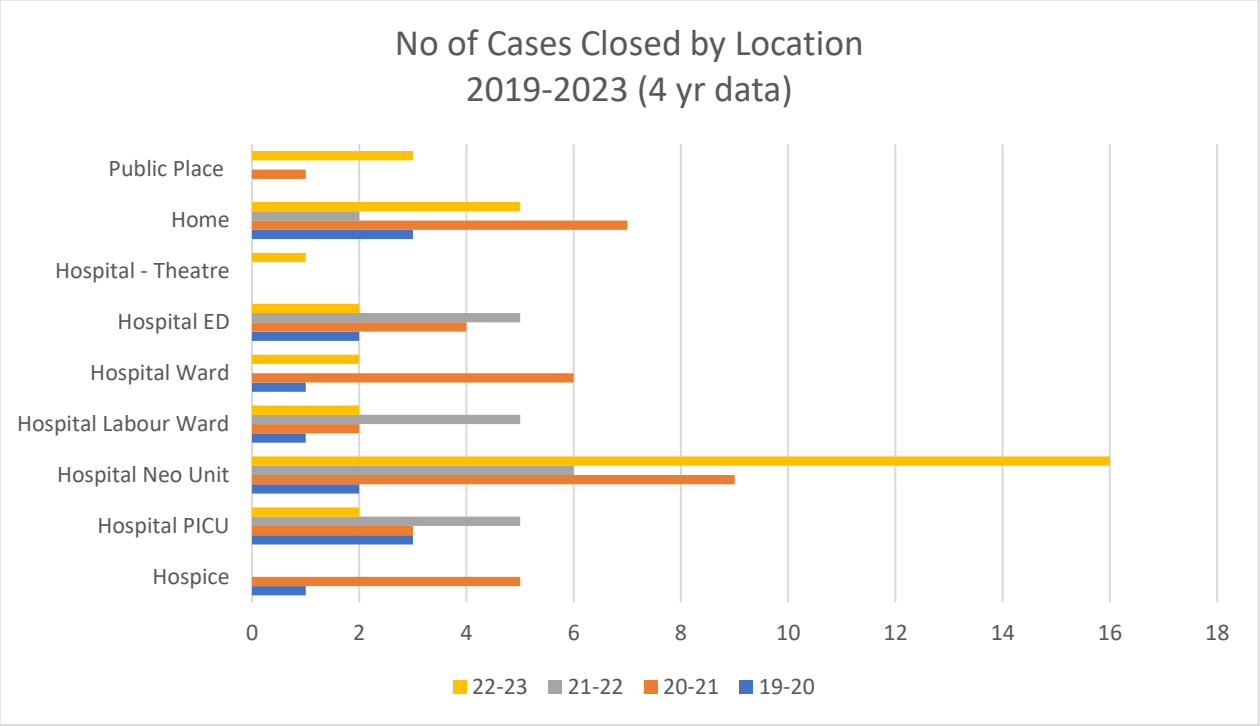
Age of Death



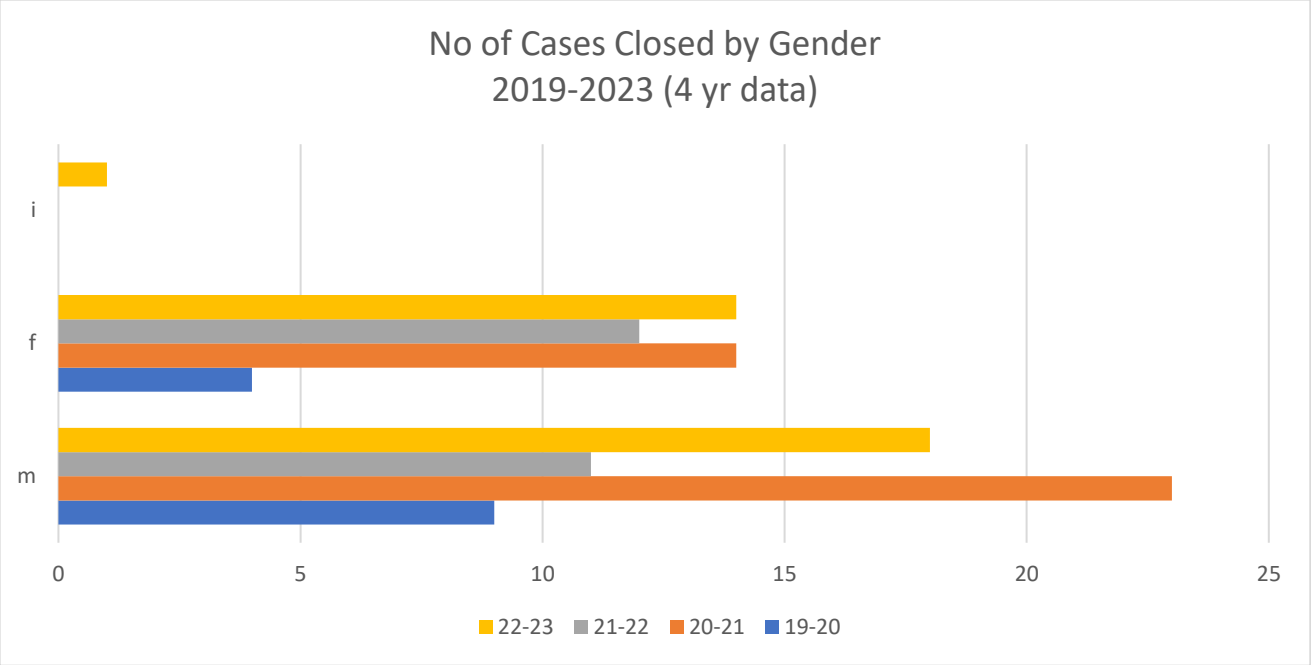
Ethnicity



Location of Death



Gender

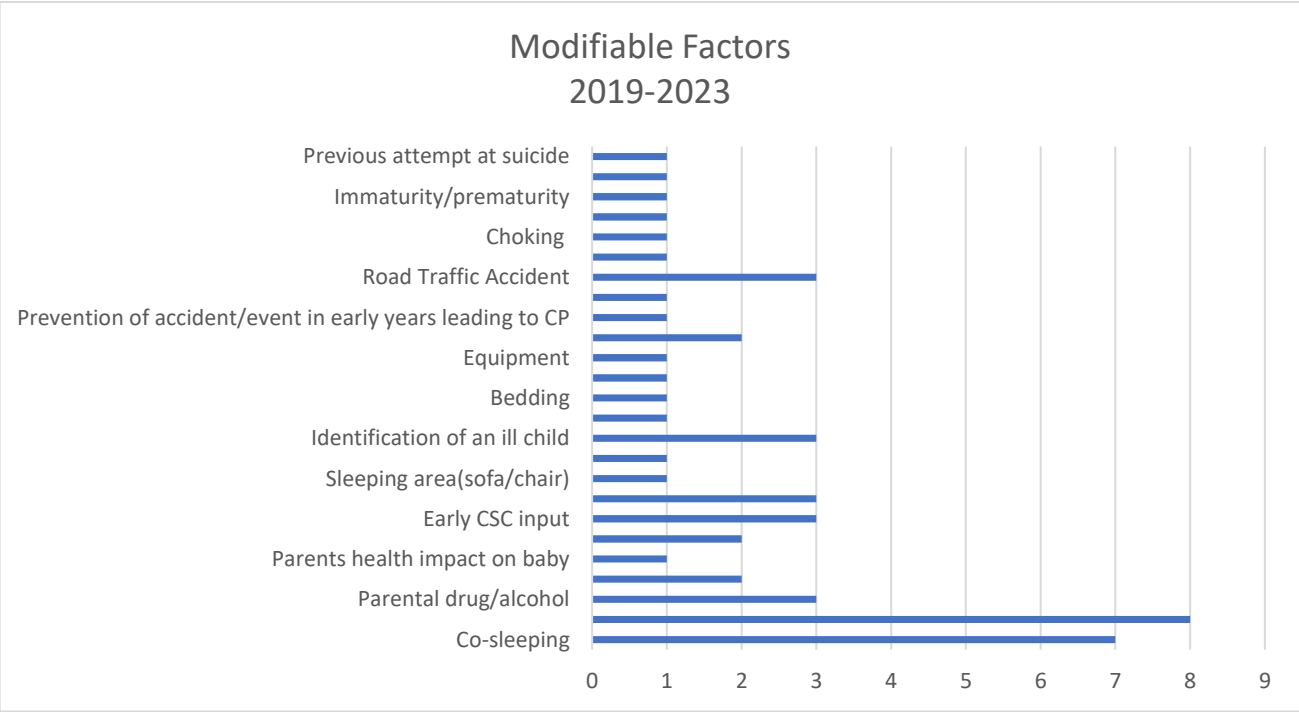


Modifiable Factors Identified During Child Death Reviews 2019-2023

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 106 cases reviewed during 2019-2023, 15 were identified as having modifiable factors . Locally the most recognised factors are 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), lack of neonatal cots, RTC, cosanguinity etc.

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



Unfortunately, for the second year there appears to have been some issues recording the 21-23 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 again this will be fundamental to the work of CDOP going forward.

Deprivation Deciles for children who died April 2019 to March 2023

Work is currently being undertaken in Gloucestershire to produce the Gloucestershire/local demographics for the last four years of child deaths. At the time of producing this report this process is still under review and once data has been gathered will be published as a separate document available on the Child Death pages of our website. Click here

National Data

The NCMD (National Child Mortality Database) produced their second annual report for the year April 2021 to March 2022 in November 2022 based on data provided from cases reviewed at CDOPs in England. At the time of publication of this report the NCMD Report for 2022-2023 has not yet been published.

Data is collected as part of the child death review process, which applies to all children under the age of 18 and is mandatory in England. Child death overview panels have a statutory obligation to collect information from every agency that has had contact with the child and to share this with the NCMD, with the ultimate goal of understanding why children die and making changes to improve and save lives in the future.

Child death overview panels notify the NCMD of each child death within 48 hours, and provide basic information about the child's characteristics and suspected cause of death. As the death is reviewed, this basic information is developed into a comprehensive record of the circumstances of the child's death with input from all professionals who had contact with the child.

Once published the National data can be found on the NCMD website click here

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

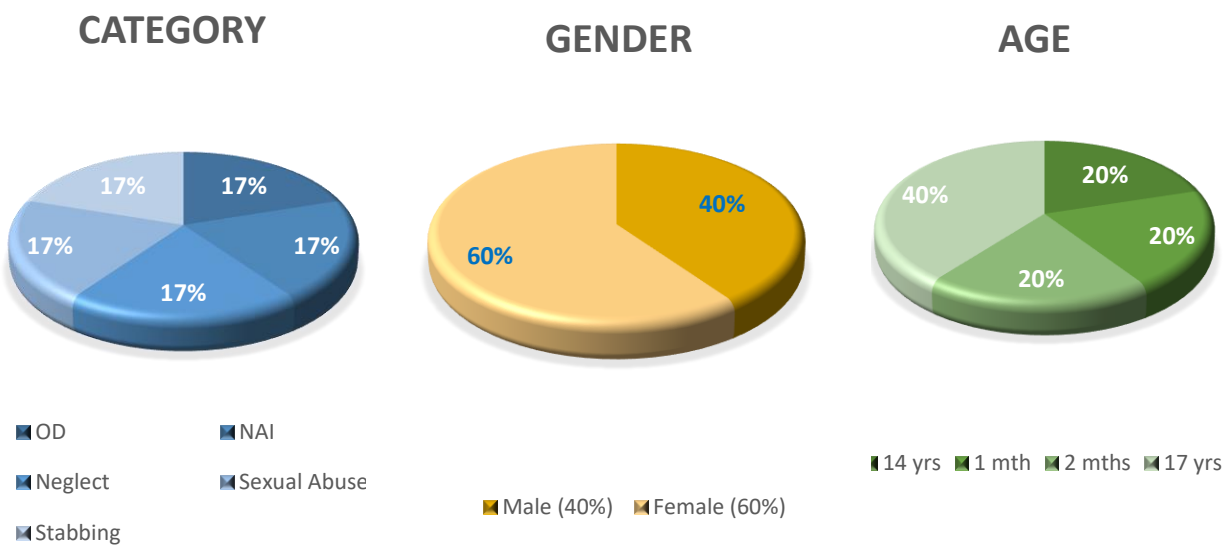
The Child Death Process and Child Death Overview Panels have previously all been undertaken as face to face meetings. As a consequence of Covid-19, all meetings changed to virtual and continue to do so preventing any delays to final case reviews. Gloucestershire continued to adhere to the National guidance during the pandemic when collecting data which included the possibility of Covid infection, previous contact with the child and implications of Covid on services provided to the child and family during those testing times. Meetings remain virtual at this time and this has proven to be an effective approach providing a higher attendance of key professionals at these meetings.

ALTE's (Acute Life Threatening Events)

Gloucestershire has an ALTE process, which links closely across all agencies and mirrors the initial case discussion for child death reviews. During the four year period covered in this report 17 ALTE Reviews were carried out. These covered neglect, stabbing, overdose, NAI, drowning, collapse, attempted suicide and sexual abuse.

Two of the cases reviewed through ALTE this year unfortunately became child death reviews which then followed the due process. These 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 2022-2023

- Continuing the work on Safer Sleeping – Gloucestershire updated their Safer Sleeping guidance in 2021 through a task and finish group. All documentation and learning has been disseminated throughout all agencies. CDOP continue to link with all Safeguarding Partners (GSCP, ICB, GCC and Police) to promote this universally in Gloucestershire.
- The Network Meetings – The lead nurses for child death continue to attend the National Lead Nurse Child Death Network
- Strep A – work was carried out by the Lead nurse to ensure that all MIU's and GPs were following the same guidance for the Strep A outbreak. It was confirmed that the correct guidance was being followed throughout the county. GSCP sent an Alert Newsletter out offering national advice. This was also sent to all schools in Gloucestershire.
- RTCs – CDRT linked in with that Fire Service who were already providing learning/events to raise road safety awareness for young drivers/riders through educational settings.
- New guidance for GPs and their role in child death reviews was received from NCMD was circulated to all Gloucestershire GPs.
- An urgent safety alert was issued by the Office for Product Safety and Standards advising parents to cease using and destroy self-feeding pillows. GSCP sent a newsletter out through the GovDel system as an alert.
- Deaths out of county and country – there have been a number of deaths out of the county and country. Cross border cases prove difficult at the best of times but positive links have been made in these cases
- Cross border CDOP – The Statutory Reviews Coordinator now attend the cross border CDOP meeting held and chaired by Wales/Cheshire.
- The Statutory Review Coordinator will continue to interact with the South Network of Coordinators.

Current Multi-Agency Issues

Lack of Designated Doctor

As mentioned previously in this report Gloucestershire currently do not have a Designated Doctor for Child Death Reviews meaning that final case reviews and CDOP panel reviews cannot be carried out and cases cannot be closed.

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

Again, this 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.
- Easy to Use guides have been produced for
    - 'How to Make a Notification of a Child Death'
    - 'How to Complete a Reporting Form'
    - 'The Child Death Process Explained'.

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, due to the retirement of our Designated Doctor there is no longer anyone medically qualified to carry out these visits. 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. Pediatricians who have been involved with families are available to share this information.

Plans for the year 2023-2024

- 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 but due to lack of capacity it has been agreed that the CDRT will only attend if requested or agenda items are specific to processes.
- 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.
- 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 though there has been a national delay.

- 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 2021-2023 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 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.

Useful Links

Gloucestershire Child Death Protocol
https://www.gloucestershire.gov.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

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