Gloucestershire Child Death Overview Panel (CDOP)

Annual Report for Child Death Reviews Gloucestershire Safeguarding Children Executive (GSCE)

1st April 2015 – 31st March 2020

November 2020

Contents

1. Introduction

We are fortunate that a child death is a rare event in our society, however, each death represents a tragedy for the family and the purpose of the Child Death Review process (CDR) is to identify potentially modifiable factors[1] which may prevent future deaths from occurring. The CDR process is also able to identify local and regional trends to inform the work of Commissioners, Providers and other relevant organisations. For example, in the case of children with life-limiting conditions, the CDR process is able to consider whether these children were in receipt of appropriate care during their life and had access to appropriate support services at the end of life. Where the CDR process identifies learning, this is fed back to the relevant agencies by the Child Death Overview Panel on behalf of the Child Death Review Partners (CDR Partners) in Gloucestershire who are the NHS Gloucestershire Clinical Commissioning Group and Gloucestershire County Council.

At the beginning of the CDR process in 2008, the Gloucestershire Child Death Overview Panel (CDOP) was established in line with guidance set out in *Working Together to Safeguard Children*. This CDOP continues to review the deaths of all children resident in this area. Some of these deaths may occur outside of the region and these are also reviewed by this panel.

2. Background to the Child Death Review Process

Chapter 5 of "Working Together to Safeguard Children" (2018) outlines the processes to be followed when a child dies. In addition to this, Child Death Review Statutory and Operational Guidance was published in October 2018 and 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 called a "Joint 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.

The full process for a Joint Agency Response is set out in the SUDI/C Guidelines which can be accessed here:
https://www.rcpath.org/uploads/assets/874ae50e-c754-4933-995a804e0ef728a4/Sudden-unexpected-death-in-infancy-and-childhood-2e.pdf

In Gloucestershire a joint police, social care and health rota is staffed during office hours (Monday to Friday 9am to 5pm) to provide this response. Outside of these hours an initial safeguarding discussion occurs at the time of death between police, social care, health and the Coroner's Officer. On the next working day, a formal initial case discussion is undertaken. 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 Joint Agency Response process ensures early

[1] A modifiable death is defined as one where there are factors which may have contributed to the death which, by means of nationally or locally achievable interventions, could be modified to reduce the risks of future child deaths.

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.

3. The Child Death Review Process

A child's death is 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) is produced and anonymised by the Child Death Enquiries Office at the University of Bristol 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.

4. 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 University of Bristol through the Child Death Enquiries Office. Information collected at the point of notification of death is entered onto the eCDOP case management tool. 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. The annual report includes five years of aggregate 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.

5. Notifications of child deaths

5.1 Summary Data (2015 – 2020)

This section summarises all the deaths notified to the Child Death Enquiries Office between 1st April 2015 and 31st March 2020, of children resident in the Gloucestershire area. This data is drawn from Access notification and eCDOP databases.

5.2 Analysis of notifications by year (2015-2020)

During the period 2015-2020, 139 child deaths were notified. Year on year variation in notifications is to be expected (as shown in Table 1) and with rare events such as a child death, small variations can appear to represent a big difference. However, because the number of notifications for one area of residence are so small the most likely explanation for any patterns is random year-on year variation.

Table 1: Numbers of deaths notified by year 2015 to 2020 in Gloucestershire

	Number of child deaths notified					
	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	Total
Gloucestershire	19	36	31	23	30	139

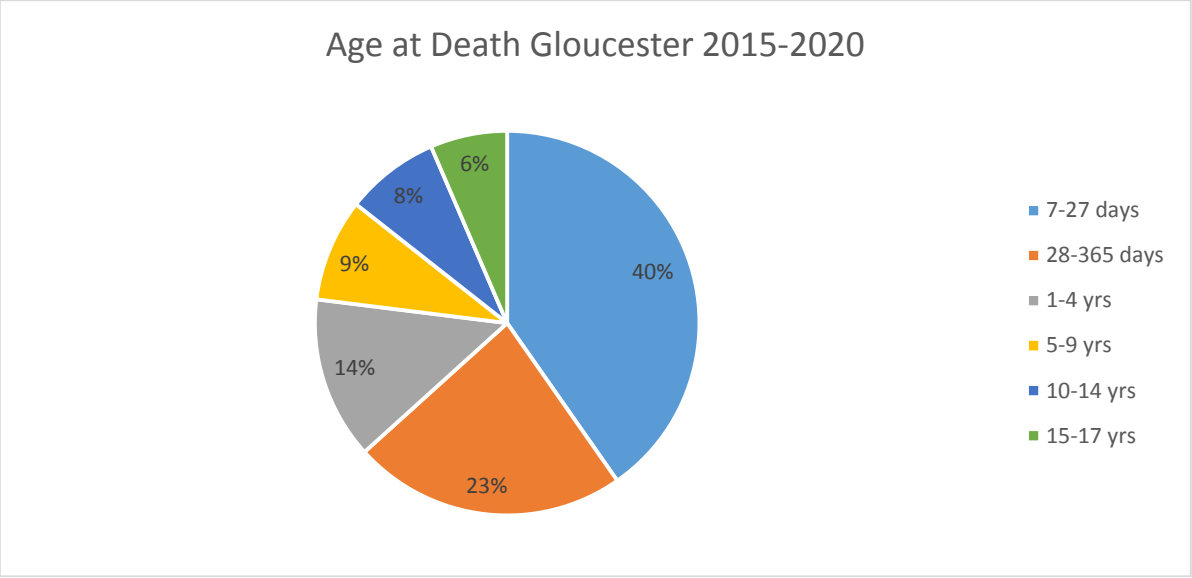
5.3 Duration of reviews

There is an inevitable time-lag between notification of a child's death and discussion at CDOP**.** There are various factors that contribute to this: the return of Reporting Forms from professionals, the completion of the final post mortem report by the pathologist and receipt of the final report from the FCD meeting. On occasion when the outcome of a Coroner's inquest is awaited, there may be a delay of over a year before a case might be brought before CDOP. The undertaking of a criminal investigation or a Serious Case Review will also affect when a case is discussed at Panel. See Appendix A for a full breakdown of duration of reviews by year.

5.4 Age at death

Using five year data, the greatest proportion of notifications 56 (40%) were received for babies dying in the neonatal period (under one month of age). This figure increases by 32 (63%) when all deaths under one year are included, this is just above national observations (61%)[2].

Figure 1: Notifications by Age, 2015 – 2020



5.5 Location of death – where child was confirmed deceased

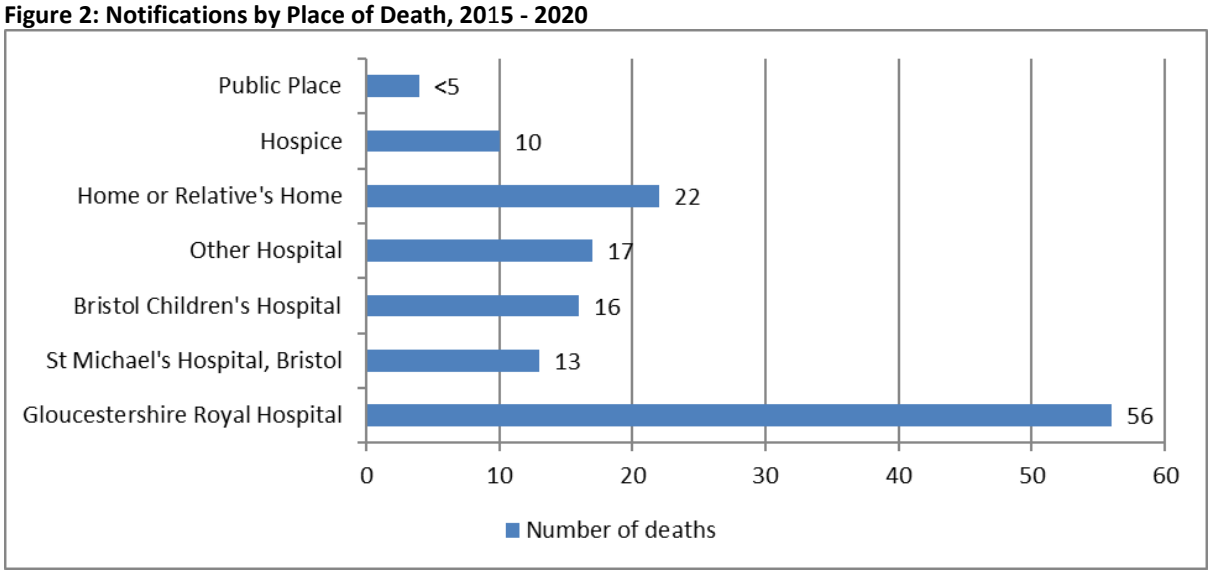
This data records where the child actually died. Many children resident in Gloucestershire may be transferred to tertiary hospitals in other regions for treatment. A number of these children go on to die in those locations as can be seen in Figure 2 below. The figures in this section represent the total number of deaths at each location during the five year period. A total of 102 deaths (74%) occurred in a hospital setting, 22 at home (16%) and 10 (7%) of deaths occurred in a hospice.

Children resident in Gloucestershire are treated in many different hospitals. This reflects the wide geographical area covered by Gloucestershire and the number of counties in which residents receive healthcare services including Bristol, Oxfordshire, Swindon and Birmingham and their willingness to

[2] https://digital.nhs.uk/data-and-information/publications/statistical/child-death-reviews/2019/content

contribute to the process. This can present particular issues for Gloucestershire CDOP for the timely and complete collation of information for the review of children's deaths due to the wide range of organisations that must be engaged.

Figure 2: Notifications by Place of Death, 2015 - 2020



In Gloucestershire, policy recommends that all collapsed children are brought into hospital. In total 22 (16%) children died at home or at a relative's home in the five year period.

5.6 Gender

There have been more notifications of deaths in boys than in girls as can be seen in the table below. In total 80 (58%) of deaths were male and 59 (42%) were female. This is in line with national trends for childhood deaths which also show slightly higher proportions of deaths registered in England were for male children[3].

Table 2: Numbers of deaths notified between 1st April 2015 and 31st March 2020 by gender

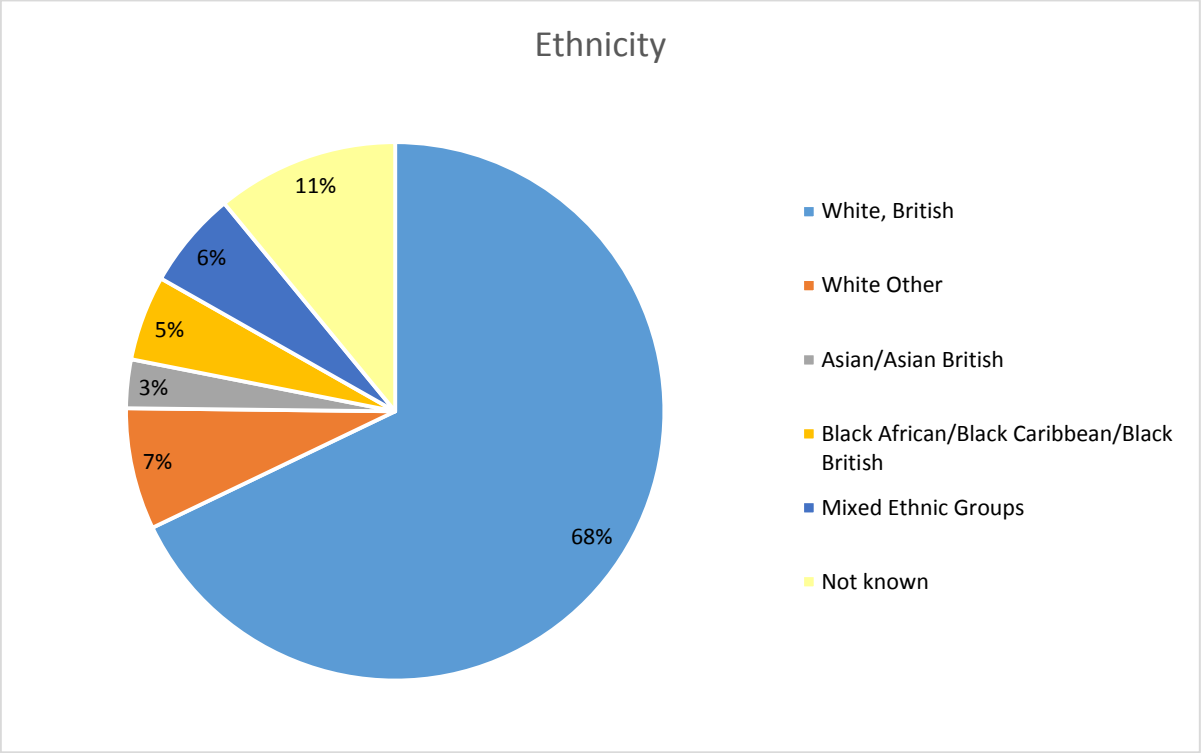
	Male	Female
Gloucestershire	80	59

5.7 Ethnicity

Figure 3 shows that the majority of deaths for Gloucestershire are children of White British ethnic origin. 93 (68%) White British, 10 (7%) White Other, 4 (3%) Asian, 7 (5%) Black African/Black Caribbean/Black British and 8 (6%) Mixed ethnic groups. From the documentation received ethnicity was unknown in 15 (11%) of cases.

[3] Department for Education *Child Death Reviews: Year Ending 31 March 2017*, Department for Education, SFR 36/2017, 31st July 2017

Figure 3: Notifications by Ethnic Groups, 2015 - 2020



5.8 Deaths requiring a Joint Agency Response (JAR) (2015-2020)

Since the inception of the child death review process there has been a requirement to perform further investigations for children who die where the cause is unknown. This was previously called a Rapid Response, but the terminology has been changed following the publication of the Child Death Review Statutory and Operational Guidance in 2018 and it is now referred to as a Joint Agency Response (see section 2 above for further information). The JAR is triggered if the death of the child:

- 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.

Prior to 2018, the above criteria were not used, and the trigger for a rapid response was where the death was considered unexpected. The definition of "unexpected" was a death which was not anticipated as a significant possibility 24 hours before the death or, where there was a similarly unexpected collapse or incident leading to or precipitating the events that led to the death.

In the 5 years covered by this report, Table 3 below, shows the number of rapid responses or JARs that have taken place by year.

Table 3: Number of Rapid Responses / Joint Agency Responses

Year	Number of Rapid Responses or Joint Agency responses.
2015-2016	19
2016-2017	36
2017-2018	31
2018-2019	23
2019-2020	11
TOTAL:	120

6. Child Death Overview Panel Review Data

This section summarises the Panel's review decisions for 2015-2020 and its actions for 2019-20. There is an inevitable time-lag between notification of a child's death and discussion at CDOP**.** There are various factors that contribute to this: the return of statutory paperwork by professionals, receipt of the final post-mortem report and receipt of the analysis form from the final case discussion meeting. On occasion when the outcome of a Coroner's inquest is awaited, there may be a delay of over a year before a case might be brought before CDOP. The undertaking of a criminal investigation or a Child Safeguarding Practice Review will also affect when a case is discussed at Panel. In addition, certain children who have been under the care of specialist regional paediatric teams (e.g. cardiology) will be reviewed at a specialist themed CDOP for the region as well as coming to Gloucestershire CDOP for final review, to ensure that the relevant expertise is present when identifying learning from these cases.

For these reasons, the population of children described in Section 6 *Summary Data* may partially overlap but is distinct from the population of children described in this section. This is illustrated in Table 4.

The Gloucestershire CDOP has reviewed 161 deaths between 1st April 2015 and 31st March 2020. Of the 139 deaths notified between 1st April 2015 and 31st March 2020, there are currently 34 that have not yet been reviewed by CDOP. All but 1 child who died before 1st April 2017 have been reviewed by CDOP. See Appendix A for a full breakdown.

34 children waiting to be reviewed in total as opposed to 35 which were outstanding as at the same time last year.

During the 2019/2020 child death review year the Gloucestershire CDOP panel reviewed a total of 23 deaths.

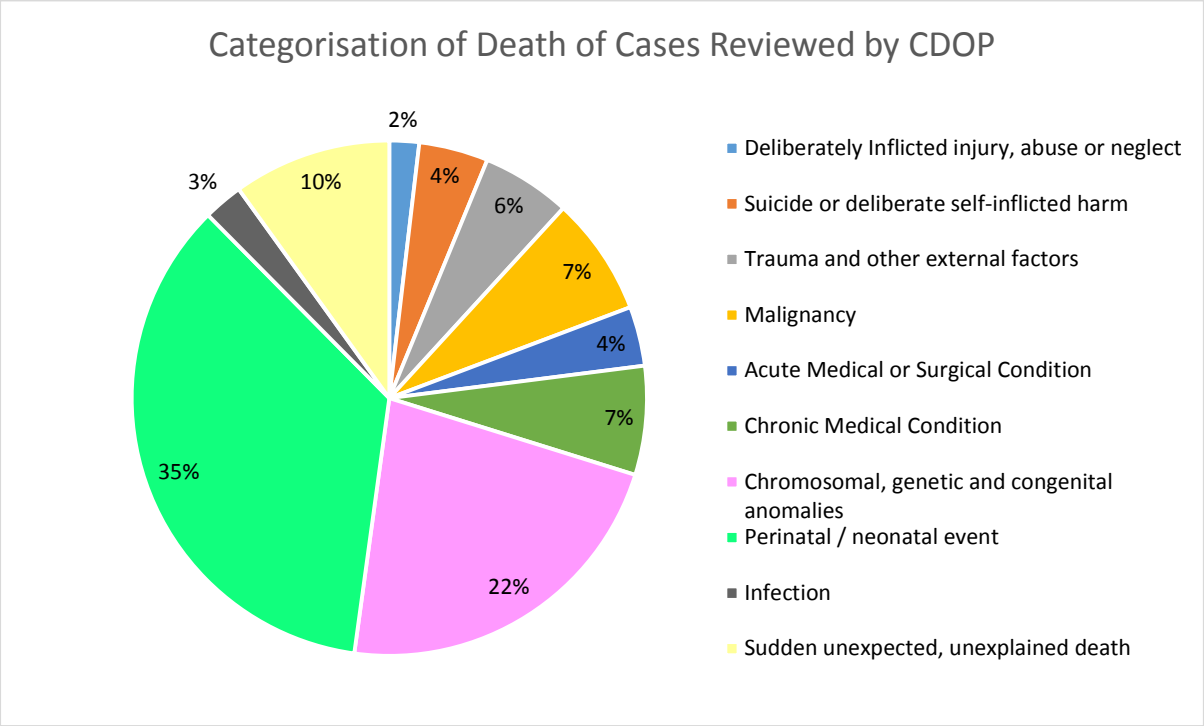
Table 4: Number of child deaths reviewed by CDOP, 2015 - 2020

	2015-16	2016-17	2017-18	2018-19	2019-20	Totals
Gloucestershire	55	38	28	17	23	161

6.1 Categorisation of death for cases reviewed by CDOP

As part of the Child Death Review process, each death reviewed by the panel is categorised by the most likely cause of death based on a set of pre-defined categories. The categorisation of deaths for cases reviewed by the panel over the five year period is shown in Figure 4 below. This shows that the most common categorisation is perinatal/neonatal event 57 (35%) followed by chromosomal, genetic and congenital anomalies 36 (20%). The other categories are much less common.

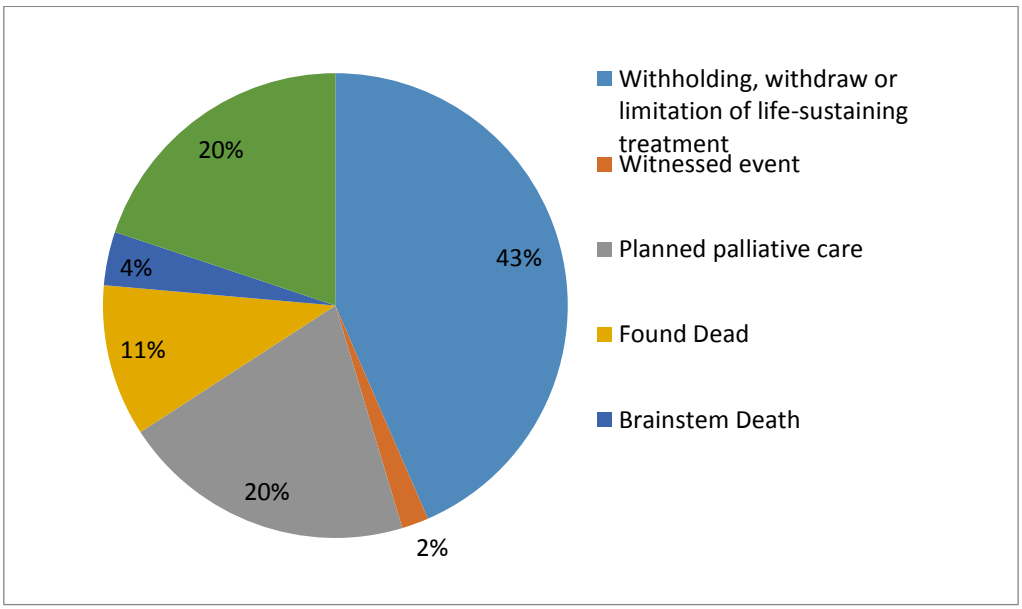
Figure 4: Categorisation of Deaths for Children Reviewed by CDOP, 2015 - 2020



6.2 Mode of death of cases reviewed by CDOP

As can be seen from the pie chart in
Figure 6 below, the most common manner of death for Gloucestershire children is withholding, withdrawing or limitation of life-sustaining treatment 70 (43%). This decision is always made following careful consideration with the child's parents and carers. This is followed by those children who died following planned palliative care 33 (20%) and children who died following unsuccessful cardio-pulmonary resuscitation 32 (20%). Of these cases children who were found dead represents 17 (11%) of cases reviewed.

Figure 6: Modes of Death of Cases Reviewed by CDOP, 2015 - 2020



6.3 Factors in the social environment

The presence or absence of factors in the social environment such as mental health issues and drug abuse are routinely collected on the Reporting Forms dataset from professionals who have contact with the families. These are summarised on the Analysis Form dataset at the final case discussion meeting and carefully reviewed by CDOP. They are shown in table 5 below. Please note that these factors are not necessarily considered to be modifiable in every case and may not have been directly contributory to the child's death, rather this data reflects the presence or absence of a factor within the social environment.

Table 5: Factors in the family and environment recorded in cases reviewed by CDOP of children resident in Gloucestershire 2015-2020

Factors in Social Environment	Yes	No	Not known
Smoking by a parent or carer / Smoking by Mum during pregnancy	69 (43%)	83 (52%)	9 (5%)
Alcohol or Substance Misuse by a parent or carer	30 (19%)	117 (72%)	14 (9%)
Domestic violence	37 (23%)	118 (73%)	6 (4%)
Emotional, Behavioural or Mental Health condition in a parent or carer	58 (36%)	92 (57%)	11 (7%)

Table above shows significant factors to include smoking in a parent/carer, emotional, behavioural or mental health condition in a parent/carer and alcohol/substance abuse in a parent/carer.

6.4 Modifiable Factors – Reducing the Risk of Future Deaths

The focus of the Child Death Review process is to assess modifiable factors in each child's death. Modifiable factors are defined as "one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths". Panels can identify modifiable factors in the child's direct care by any agency, including parents, latent, organisational, systemic or other indirect failure(s) within one or more agency. Therefore, a death identified as having modifiable factors may not necessarily be due to a failure of the Local Authority or other agencies to safeguard the child's welfare. An example of a modifiable factor might be a death resulting from a vaccine preventable infection where the vaccine had not been given to the child.

For cases reviewed by CDOP during the five year period, modifiable factors were identified in 45 (30%) of cases. In the majority of cases, (115/161) no modifiable factors were identified. In the case of one child reviewed during the period there was inadequate information on which to make a judgment.

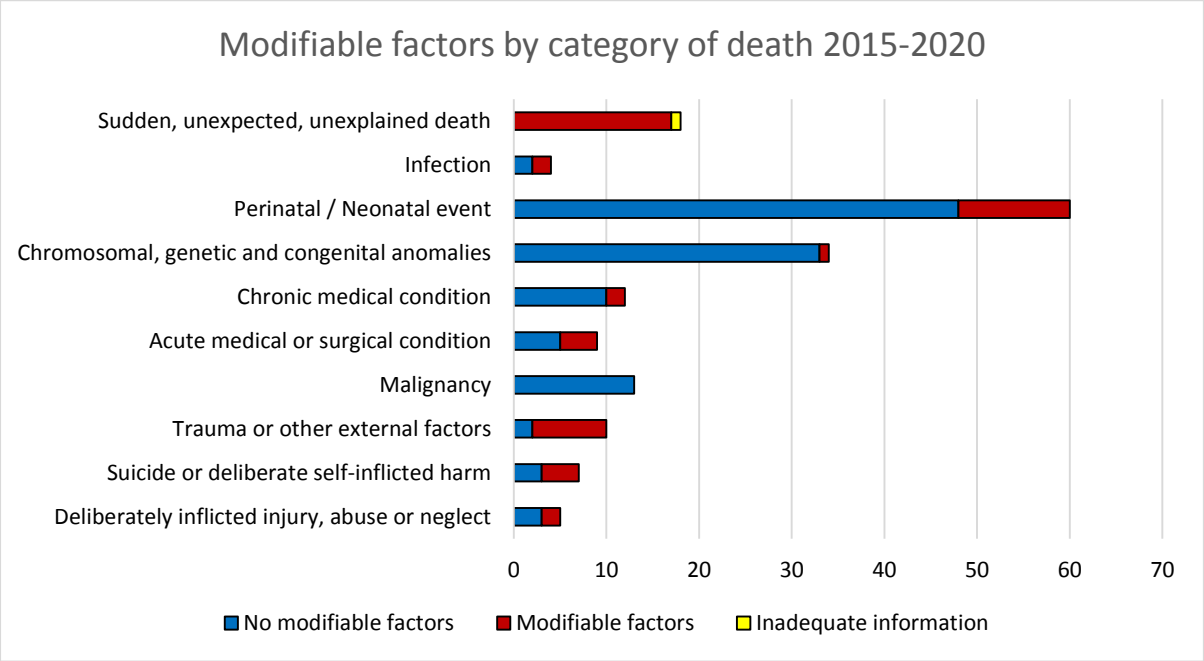
There seems to be a steadily increasing trend nationally in the percentage of child death reviews assessed having modifiable factors from 24% in the year ending 31 March 2015 to 30% in the year ending 31 March 2019[4].

Figure 5, below, shows the proportion of deaths within each category that were considered to have modifiable factors following review by CDOP. This shows that the categories that represent unexpected deaths (45), e.g. suicide, trauma and other external factors and sudden, unexpected, unexplained death, have the highest proportion of modifiable factors associated with them. This is

[4] https://digital.nhs.uk/data-and-information/publications/statistical/child-death-reviews/2019/content

as expected and is in line with the national picture. Perinatal or neonatal event, malignancy and chromosomal, genetic and congenital anomalies have the lowest proportion of modifiable factors associated with them, this is also in line with the national picture.

Figure 5: Modifiable factors by category of death, 2015-2020



7. Summary statistics, Key Themes, Recommendations and Actions taken

7.1 Summary Statistics

- The majority of child deaths are expected deaths accounting for 99 (64%) of child deaths in the five-year period.
- 57 (40%) of child deaths occurred in the perinatal or neonatal period and 32 (23%) occurred within the first year of life.
- The most common category of death in Gloucestershire is perinatal or neonatal event 57 (35%). This is in line with the national picture.
- 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.
- In the majority of deaths reviewed no modifiable factors were identified. However modifiable factors were identified in 45 (30%) of cases reviewed by the panel during the five-year period. Nationally this figure is 30%.

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

- The Child Death Process and 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 as pre-planned, hence timescales were adhered to. In the acute phase of such a traumatic event, chairing such meetings has been more challenging when trying to support

professionals who have been directly involved with the families, whilst obtaining an objective overview of the situation which led to the death.
In addition, documentation was updated, in line with National requirements to ensure more detailed information was available about the child's death, the possibility of Covid infection or previous contact which might have had an impact on the child.

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

7.3 Key actions and Themes

- Further promotion on Safer Sleeping

  In recognition that babies are still dying as a consequence of co-sleeping with additional risk factors (smoking/drugs/alcohol) further work was undertaken in Gloucestershire to promote a safer sleeping environment.

  A poster was developed and disseminated widely in Gloucestershire promoting factors of safer sleep (**See Appendix 2**). This also was publicised by the Cheltenham Football Team and through partner agencies and Gloucestershire Safeguarding Children Board.

  The Lift the Baby campaign was promoted via partner agencies focusing on providing safe sleep information specifically to fathers.

  Work to continue throughout next year.

- Training of new professionals who may be involved in a child's death.

  It became evident that some Police Officers were not familiar with the approach recommended for the Police when a child dies. This has resulted in the development of a Police Officers Handbook for Child Death – SUDIC Investigation (DI Lucie Smith) and further training within the Force.

  Police have also reviewed their threshold for drug testing of parents/carers when it is considered that drugs may have been a factor in the child's death.

- Better links between SWAST and Police for unexpected collapses in children

  Gloucestershire lead professionals for child death have worked with SWAST to ensure that when a child collapses and requires resuscitation, that the Police are notified immediately. This approach has now been adopted across the South West.

- Maternity Services

  As a result of close working relationships with Maternity Services and the Child Death Review Team incorporating family feedback, outcomes of HSIB and Datix, has identified learning to be embedded.

  Examples

1. The retention of placentas for neonates who have been admitted to NICU or died
2. Ensuring the Obstetric Team are aware of chromosomal or significant PM findings if the neonate has died in a tertiary centre – implication for next pregnancy.
3. Within the South West continuing to raise issues in relation to neonatal bed capacity and transfers of very premature babies.
4. Following a child death in a family, there has been improved early communication between Midwives and Health Visitors for subsequent pregnancies.

This work is ongoing.

- Promoting the role of Key Workers

  In accordance with the guidance Working Together 2018, the Child Death Review Team have prioritised ways in which to obtain family feedback for Child Death Reviews. A Key Worker Information and Support Pack has been developed which has been very positively received by those Key Workers identified.

- Young Persons who die at times of transitioning from Children to Adult Services

  There has been clarification of the Child Death Process by SWAST and Hospital Emergency Department following the demise of a young person who was almost 18 years with a chronic medical condition. Although initially deemed/managed as an adult, was legally still a child. As a result

  1. Adult Epilepsy Service has reviewed their safeguarding policy and actions if a young person in transition between medical services does not attend an appointment. They have adopted the 'was not brought' rather than 'did not attend' approach and attempt to phone the young person at the time of the appointment. If unsuccessful they escalate in accordance with the Escalation Policy.

  2. SWAST and the Emergency Department have redefined the age definition for some of their policies.

- Multi Agency Home Visits

  Guidance currently states that a joint home/scene of collapse visit by Police and Health should be carried out. 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 to be discussed with partners and at CDOP. If this guidance is to be implemented than additional funding will be required.

- Commissioning of After Death Services at Hospice

  Although the Hospice provided support, special bedroom and counselling services for families post the death of their child, this was not formally commissioned and was dependent on charity. Through the Child Death Review Process each child who has used this

service has been highlighted to the Commissioners and the risk identified should this service be withdrawn. As a result, this service is now fully commissioned.

- Paediatric Palliative Care Group

  The Gloucestershire Child Death Review Team members now link into 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.

- Identification of Good Practice

  When the Child Death Review Process identifies good practice, letters are sent to professionals involved and the learning cascaded to teams. This has included –

  1. Early Advanced Care Planning
  2. Early involvement of the Palliative Care Team
  3. Early involvement of Hospice and Community Nursing
  4. Good multi agency communication
  5. Provision of End of Life Care with prescriptions in place

- Updating Procedures and Protocols

  The updating of all procedures in accordance with Working Together 2018 has provided an opportunity for the Child Death Team to review all elements of the process.

  1. Procedures have been updated
  2. Protocol has been reviewed and updated to include child funerals, Covid-19, updated partner agency procedures.
  3. Links with SWAST, Gloucestershire Constabulary and Gloucestershire Children's Social Care reviewed and confirmed.
  4. The role of Health Partner agencies has been updated and clarified
  5. The path of the deceased body and post death investigations has been redefined.
  6. Establishment of closer working with the Coroner's Officers.
  7. Identification of Key Workers

  It was also identified that there was potentially a lot of learning from children who had had an acute life threatening event (ALTE) but may not have died at the time of the event. As a result, Gloucestershire have implemented an ALTE process which links closely across all agencies and mirrors the initial case discussion.

Action Plan for year 2020-2021

The following have been added to the CDOP Action Plan (this will be reviewed on a quarterly basis at CDOP Panel) –

- Ethnicity – aim to ensure every child's ethnicity is identified to ensure if any minority groups are identified.
- Parental Feedback – ensuring every family has been given the opportunity to provide feedback
- Audit – ensuring that all information is available for the FCR

- Continuing the work on Safer Sleeping – The NCMMD are currently undertaking a review of infant deaths. Learning needs to be cascaded throughout Gloucestershire.
- Formalising Gloucestershire Hospitals Child Death Response
- The effects of Covid and Child Death
- Future discussions for CDOP – Themed reviews, the role of local and tertiary reviews, identification of a vice chair for the CDOP Panel.
- Child Safety Week
- Learning from children who have died with Asthma – cascading to schools and primary care.
- Continuing update of procedures and protocols.

Appendix A: Duration of CDOP Reviews by Year (2010-2020)

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Total number of notifications	36	30	43	26	45	19	36	31	23	30
Total number of cases reviewed	24	34	33	34	34	55	38	28	17	24
Years of Review	**Number reviewed**	**Number reviewed**	**Number reviewed**	**Number reviewed**	**Number reviewed**	**Number reviewed**	**Number reviewed**	**Number reviewed**	**Number reviewed**	
2008/09	14	3	3	0						
2009/10	9	16	4	1	1	1				
2010/11	1	15	16	4	0	0				
2011/12		0	10	15	5	0				
2012/13			0	14	25	4				
2013/14				0	3	23				
2014/15					0	27	17	0	1	
2015/16						0	17	2	0	
2016/17							4	17	10	
2017/18								9	6	
2018/19									0	0
2019/20									24	0

- NB: All but 1 child who died before 1st April 2017 have been reviewed by CDOP (this is due to HMCO re-opening the case)
- NB: The above details the number of cases awaiting review by CDOP, all cases except those of children who died in the last 6 months have already undergone a final case discussion meeting