Child Death Overview Panel
Southwest Peninsula

Child Death Response & Review Service
Southwest Peninsula

First Annual Public Report
April 2022 - March 2023

Foreword

Year 2022-2023

The ripple effect of a child's death, either expected or unexpected is far reaching; families, friends and communities are deeply affected by such a loss; lives are forever changed.

Information and data gathered by the Child Death Review Process enables Child Death Overview Panels (CDOPs) to make recommendations and identify learning to our Partners and the wider audience on a national level through the National Child Mortality Database.

This report brings together the work of our Child Death Review and Response Team which gathers the information from notification stage through to the final Child Death Overview Panel.

The report identifies patterns across groups of child death occurrences for preventative action. By influencing system change through partnership working, we continually strive to reduce avoidable child deaths in the Peninsula.

We must continue to build and develop our ability to fully utilise the intelligence that the child death reviews yield.

Our Team has worked hard to educate and involve our partner agencies in Child Death Reviews - ensuring families voices are heard to enable the final review to be as robust as possible. We continue to strive for the understanding and willingness of agencies to contribute fully to each review thus ensuring data is as complete as possible.

Our hope, as always, is that this report influences thinking and practice in a way that enables us to act to protect children from avoidable deaths and improve families' bereavement experience following the sad death of their child.

We wish to thank everyone that has contributed to this year's report, with particular thanks to our Panel Members whose hard work makes it possible for the CDOP to fulfil its functions.

"Every person involved in Child Death Review is acutely aware that the learning gained from this process is a gift, a gift entrusted to us by the families who have endured the worst loss.

We therefore have a responsibility to share that learning with those who can influence change and improve the public health messages received by families. Sharing the learning ensures that the voice of those children is still being heard and continue to help prevent future child deaths."

Nicky Hughes, Service Manager CDOP

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Introduction

The Child Death Review Process applies to all infants, children and young people under the age of 18 years. The purpose of the process is to try to ascertain why children die and put in place interventions to protect other children and prevent future deaths wherever possible.

In 2018 the Government Department responsible for the Child Death Review process moved from the Department of Education to the Department of Health and Social Care; and the statutory responsibility to deliver the process moved from Safeguarding Children Partnership Boards to 'The Partners'. The Partners are Local Authorities and Integrated Care Boards.

Statutory Guidance was published in 2018 ensuring the process is robust and standardised throughout England: Child death review: statutory and operational guidance (England) - GOV.UK (www.gov.uk)

Underpinned by Working Together Chapter 6:

Working together to safeguard children - GOV.UK (www.gov.uk)

The Child Death Overview Panel is a collaborative, multi-agency approach, working to ensure that any learning from the death of a child is captured, disseminated and implemented across the many organisations who have involvement in the health, wellbeing and safety of children, not just locally but across the country. To do this, we review information including reports and investigations that have been compiled around the death of a child, and bring together these reports to see if there are any trends or themes which help us to identify interventions that might reduce the risk of a child dying in the future. Although our role is to be analytical, we are all very aware that behind the reports that we review is a tragic loss, one which has impacted family, friends, communities and often the health and care professionals involved also.

The Southwest Peninsula CDOP covers the Local Authority areas of Cornwall & Isles of Scilly, Devon, Plymouth and Torbay.

The collation and sharing of all learning from Child Death Reviews and the CDOP is managed by the National Child Mortality Database (NCMD) which has been operational since 1st April 2019.

The NCMD gathers information on all children who die across England with the aim to learn lessons that could lead to changes to reduce child mortality

The Mission of CDOP

The prevention of accidents involving children

The understanding of patterns of childhood death

Improvement in interagency practice in this very sensitive area

Education of the public and of professionals working with children

Membership

The Southwest Peninsula Child Death Overview Panel (SWP CDOP) aim to meet 11 times per year with the majority of meetings dedicated to specific thematic topics, for example; neonatal deaths, sudden unexpected deaths of infants, road traffic incidents or suicide.

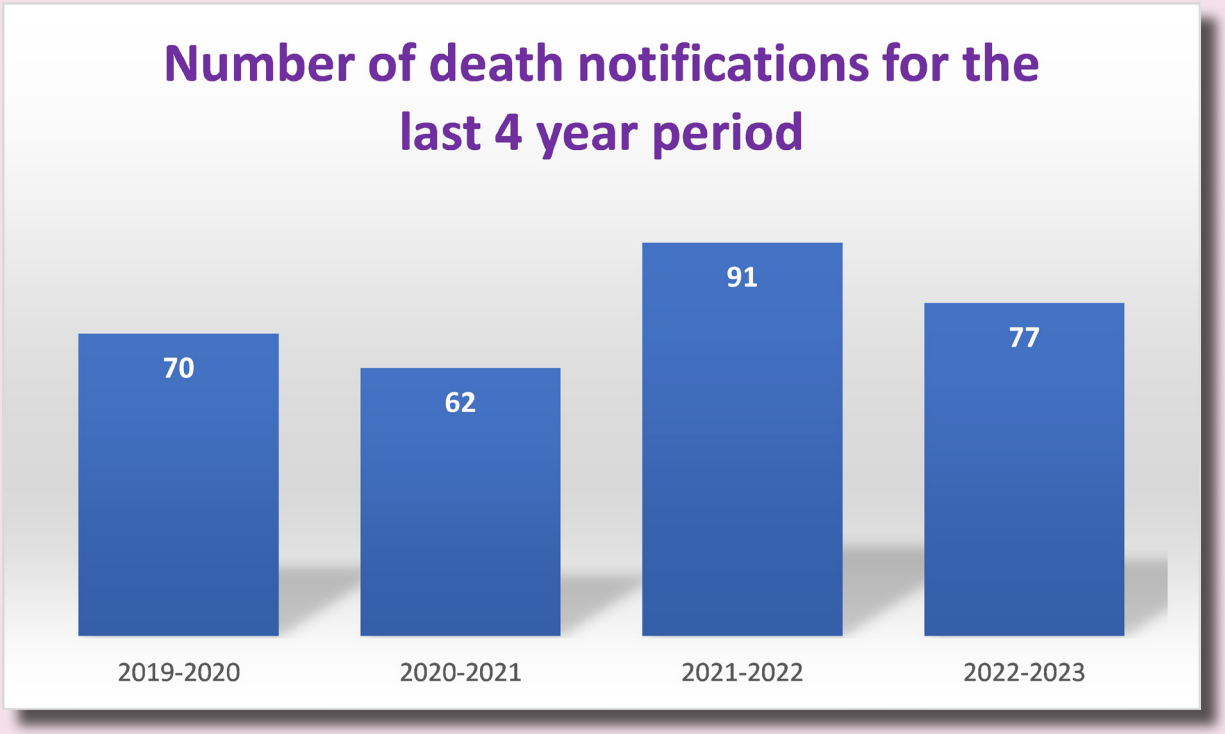
Themed meetings assist in identifying themes and support greater learning.

SWP CDOP comprises of senior representatives from key partner agencies who together have expertise in a wide range of services regarding children's health and wellbeing. The membership of Child Death Overview Panels are made up of (but not limited to):

- Chair of the Panel – Director of Public Health
- Designated Doctor for CDOP
- Child Death Review & Response Service Manager
- Designated/Named Nurse for Safeguarding Children
- Safeguarding Children's Partnerships
- Police
- Obstetrics
- Midwifery
- Paediatrics
- Neonatology
- Social Care
- Paramedics/Transport Services
- Education

Other senior professionals are invited on a case by case basis.

Notification of Child Deaths to SWP CDOP



There were 77 deaths of children resident within the Southwest Peninsula notified year 2022/2023. A small number of additional deaths were notified to SWP CDOP of children not normally resident here.

In accordance with the Office for National Statistics and the NHS Digital guidance relating to the publication of births and death statistics, when a count is equal to or less than 5 (including zero), data must be suppressed. As such, data for this group cannot be reported separately.

Legislation allows for CDR partners to review the deaths of non-resident children within the CDR partners' area of responsibility.

The Statutory guidance states that a; "*pragmatic approach Child Death Review should be taken to such deaths, entailing discussion between the CDOP team in the area where the child is resident and that team in the area where the child died. The primary responsibility for panel discussion should lie with the CDOP where the child has died. However, consideration should also be given to where the most learning can take place*".

Due to the Southwest Peninsula's unique geography, with an expansive coastline and its increase in population size during the holiday seasons SWP CDOP additionally reviews the deaths of some non-resident children, who die within the Southwest Peninsula area, if there is local learning to be identified.

Even though a small number of non-resident children's cases are reviewed each year the SWP CDOP understands the importance of these reviews and the learning that may be gained. The decision to review the case of a non-resident child is made on a case by case basis.

Where the decision is made not to review the case the learning from the resident CDOP is always requested and shared with our Partners.

South West Peninsula Child Death Overview Panel Activity

The amount of cases reviewed by CDOPs in any one year will not match the number of notifications of deaths in the same year. The reviewed deaths may be a mix of deaths from several previous years. This is a consequence of CDOP being the 'final discussion' around the death of a child and therefore we are required to wait until all organisations' serious investigations, multi-agency safeguarding reviews, criminal investigations and possible prosecutions, and finally coronial inquests are complete before the case can be presented to Panel. Very occasionally additional and infrequent reviews such as an Ombudsman Report may be published sometime after a CDOP has reviewed the case.

The number of deaths reviewed by SWP April 2022 - March 2023:

Total number of cases reviewed:

84

Categories reviewed in 2022 - 2023:

1. Deliberately inflicted injury, abuse or neglect	1%
2. Suicide and self harm	11%
3. Trauma	7%
4. Malignancy	12%
5. Acute medical or surgical condition	7%
6. Chronic medical condition	6%
7. Chromosomal, genetic and congenital anomalies	13%
8. Perinatal / neonatal event	28%
9. Infection	8%
10. Sudden unexpected and unexplained	7%

Modifiable Factors Identified

One of the key functions of the Child Death Overview Panels is decide whether a child death is modifiable. Deliberation over cases has demonstrated to the Panel that whilst in some cases it is relatively clear whether the death was modifiable or not, in many cases the decision is not clear cut. The Panel works to the national definition as shown below, but beyond this there are no other nationally directed tests or approaches that would support the reaching of a decision.

The national definition is as follows: ***A death should be categorized as modifiable if: The panel have identified 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***

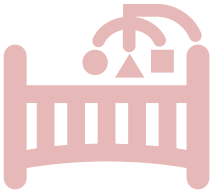
Determining modifiability is *not* about determining whether the death of the case being reviewed was preventable but whether there was a reasonable probability that if the factor in question was modified, by achievable methods, the risk of future child deaths would be reduced.

The SWP CDOP strive to develop a consistent approach to ascertaining modifiability in child death.

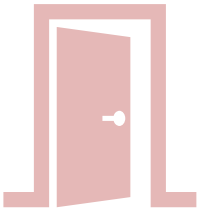
% of cases with modifiable factors (South West Peninsula)	% of cases with modifiable factors (England)
33%	39%

Most Frequent Modifiable Factors Identified

Sleep environment / unsafe sleeping arrangements



Access to appropriate services

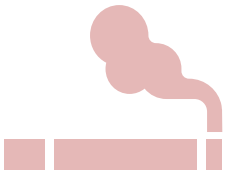


Initiation of treatment / identification of illness

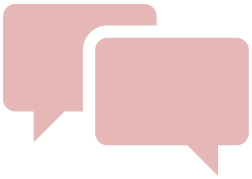
Treatment plan issues

Home safety conditions

Exposure to cigarette smoke during pregnancy and beyond



Communication within or between agencies



Alcohol / substance misuse / use by a parent or carer

Focus on Deprivation

Following the **Risk of Child Death in England linked with Deprivation report** by the National Child Mortality Database our focus section for this years report is on deprivation.

The index of multiple deprivation positions each small area in England from most to least deprived calculated on seven different factors:

- income
- employment
- education
- health
- crime
- barriers to housing and services
- living environment

Decile 1 represents the most deprived 10% (or decile) of small areas in England, and Decile 10 represents the least deprived 10%.[1]

Evidence shows that those living in the most deprived areas of England face the worst healthcare inequalities in relation to healthcare access, experience and outcomes.[2]

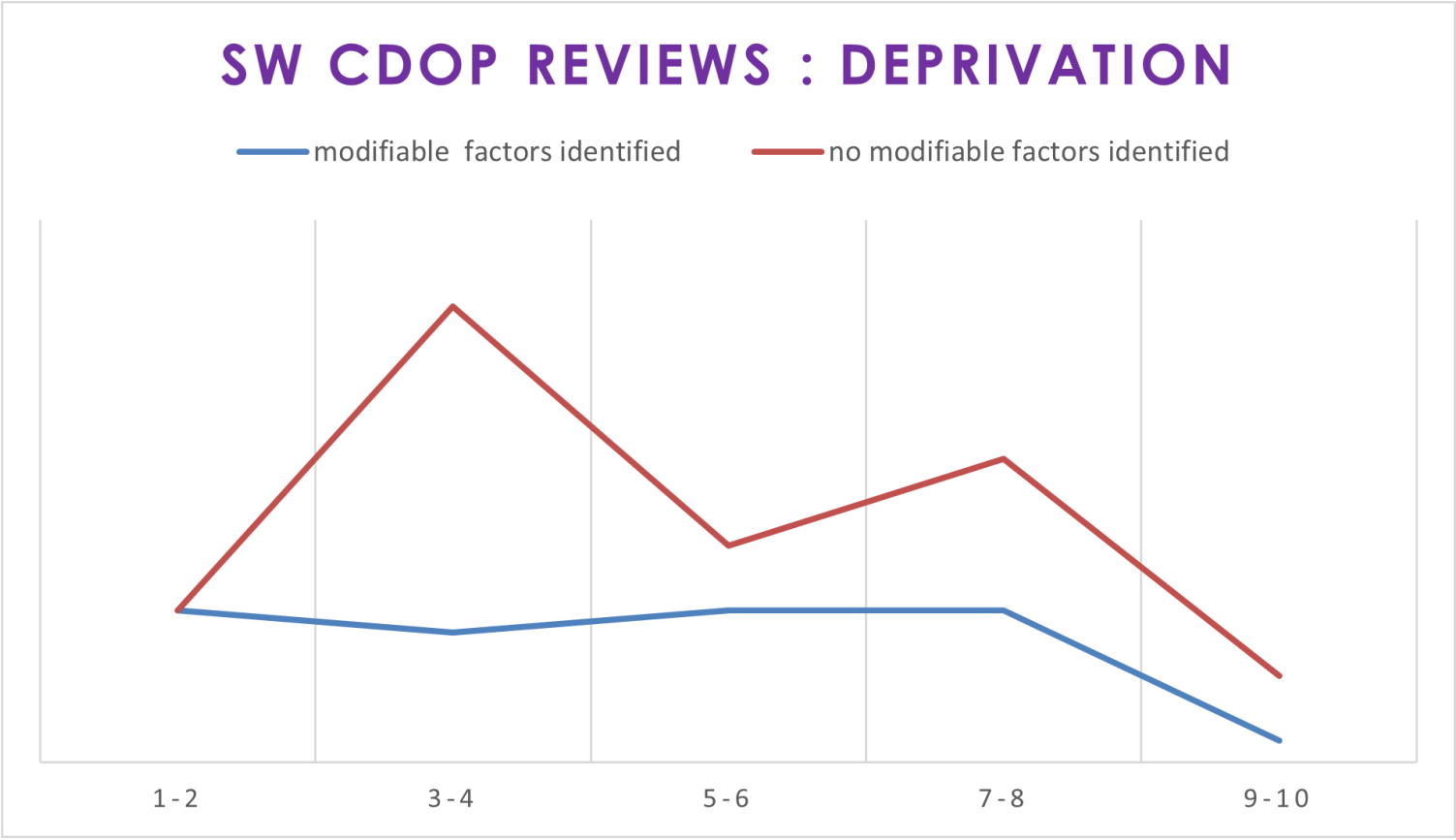
The Risk of Child Death in England linked with Deprivation report by the National Child Mortality Database (commissioned by the Healthcare Quality Improvement Partnership (HQIP)) was based on data for children who died between April 2019 and March 2020 in England. SW CDOP along with other CDOPs contributed to the discussions on the topic of this report. Their report indicated that child mortality increased as deprivation increased.

Overall 58% of the child deaths reviewed by the SWP CDOP in the year 2023-23 resided in the areas of highest deprivation (1 to 5).

Modifiable Factors	1 and 2	3 and 4	5 and 6	7 and 8	9 and 10
No	12%	38%	18%	25%	7%
Yes	25%	21%	25%	25%	4%

1 Health state life expectancies by national deprivation deciles, England - Office for National Statistics (ons.gov.uk)

2 NHS England » Deprivation



SWP CDOP continue to have concerns that families in rural areas who are in poverty do and will find accessing services, particularly tertiary services, more difficult. This concern has been highlighted to the National Child Mortality Database and we are aware of their important ongoing data collection and analysis into the link between child mortality and deprivation.

Key Learning & Recommendations from Child Deaths

Safe Sleeping Awareness and Advice

- There should be increased awareness of safe sleeping risk factors including sedating medication given to parents who have recently given birth and are co-sleeping with their children. Clear advice from the prescriber to parents and carers taking opiate medication with regards to the fact that co-sleeping is considered to be unsafe whilst taking opiate medication.
- Safe discharges postnatally include the risk assessment of the ability for the parent and/or carers to safely care for the child. Discharging professionals need to understand how the mother can sleep safely with her newborn baby. For example not being able to walk upstairs to a safe sleeping environment, should be considered particularly in cases involving lower caesarean section.
- All those working with families should promote safe sleep messages at every opportunity. It is useful to give this advice in the room where the baby is expected to sleep.
- Out of routine risks should be highlighted in any literature and any discussions around safer sleeping including exemplars such as holidays, babysitters, social care placements.

Risks of Smoking

- National campaigning regarding smoking and links to the increased risk of child death.
- Improvement in the delivery of easily understandable safe sleep messaging to parent/carers regarding the increased risk to a child of co-sleeping with a smoker.
- Consideration is given to whether there are any additional or alternative interventions that might support pregnant people and their household contacts to stop smoking, where the usual smoking cessation advice has not been successful / received positively (likely to be emerging evidence / pilot schemes). That evidence, guidance and good practice around vaping as a form of risk reduction is considered.

Training

- Services need to be mindful that the national report on suicide from National Child Mortality Database suggests all professionals working with children over the age of 10 should receive Suicide Prevention Training.
  https://www.ncmd.info/publications/child-suicide-report/

Availability of Services

- General practice and other providers of urgent primary care should ensure that pregnancy testing is available and accessible. This recommendation is supported by NICE.
- There is a lack of available outreach palliative care service. Integrated palliative care or end of life care at home needs to be formally commissioned.

Communication between Agencies

- There is a need for nationally joined up systems for Social Care to ensure when families move area their history is known to agencies to ensure proper follow up and support.

Working with our Partners

An emerging theme from reviews undertaken this year is the difficulty for emergency services to locate caravans within large parks without co-ordinates.

Panel suggested a recommendation that caravan sites should promote the downloading and use of the 'What3words' app to assist ambulance crews in finding location.

In response to this theme a working group was formed which included representation from the South Western Ambulance Service and Public Health.

The group contacted the British Holiday & Home Parks Association (BH & HPA) with a view to raising this as a discussion point with members. CDOP recommended it would be helpful if the parks could display What3Words and / or encourage visitors to download the App.

In response to that recommendation BH & HPA developed guidance for the 2,000 BH & HPA members who own and operate some 3,000 parks across the UK.

They suggested not only to display the relevant information in caravans, but also to advise their display in, for example, reception and washing-up areas to assist families holidaying in their own tent or caravan.

We thank BH & HPA for their endorsement of our recommendation and commitment to ensuring families are safe and aware of their location when on holiday parks.

Working with Families

The Joint Agency Response Nursing Service for the South West Peninsula is the team of Nurse Practitioners, referred to as JAR Nurses, who provide ongoing support, advice and liaison for families who have experienced a child's unexpected, or unexplained death.

Our response covers children up to their 18th birthday.

The JAR Nurse act as a keyworker for the bereaved family to keep them fully informed of the Child Death Review Process (CDRP) and signpost to local bereavement services.

Continued support for families in the weeks following the death of a child will focus on signposting families to appropriate services to meet individual needs. This will be different for each family.

Quotes from our families

"I find it much easier to talk to you, you seem to understand in a way that other people don't."

Mother to 1 year 4 month old

"You just have a sixth sense, you just know when to message me, I'm not having a great day."

Mother to 5 year 11 month old

"I honestly don't think I could have got through what was happening (for mum) if I hadn't had you to talk to. I do know that I certainly wouldn't be the person I am now if I hadn't had all of the support you provided. Knowing you were around to talk to helped me keep going and support (mum) and I think you are all amazing."

Maternal Grandmother to 4 month old

"We just want to say thank you so much for all your help and support you have given us through this difficult time. We have appreciated all the times you tried to get answers from different colleagues. We miss [our daughter] everyday and we know that she will be so grateful of all the help and phone calls to check in and updating us when you should, thank you again."

Parents and extended family of 5 year 11 month old

"Thank you so much for everything, you've been my guardian angel through all this and it has meant so much having you there."

Sibling of child 17 years

Closing Remarks

It is only by engaging effectively with families and supporting their contribution to and feedback on the Child Death Review Process that we can improve the service for those families we are yet to meet. The key worker for Child Death Review assigned to a family has the responsibility of making the process transparent and accessible, so that families feel informed and their views valued.

The feedback we receive from families allow us to improve services for children and their families. For those children who sadly are expected to die our aim is that the child's journey is tailored holistically to the needs of the child and to that of their family. For those children who die unexpectedly our aim is to walk alongside that family from the point of their bereavement to the conclusion of the coronial investigation, offering support and guidance regarding the child death review process and to signpost families to services that meet their individualised bereavement needs.

The only way we can achieve both aims is through parental engagement in the CDRP. It is hoped that the guidance provided by their keyworker and the support of other professionals who cared for their child both in life and in death will allow parents to feel that they are able to entrust their experiences to the Child Death Overview Panel, to allow that learning to inform the development of new services that meet the needs of children and their families. Sharing the learning ensures that the voice of those children is still being heard and is helping to prevent future child deaths.

We send a heartfelt thank you to the parents who have contributed to the learning from each Child Death Review. This information will be used to improve local public health messaging and added to the information that is gathered nationally in an effort to prevent future child deaths.

Produced by Child Death Response & Review Team

Livewell Southwest