

Pan-Dorset Safeguarding Children Partnership



**DORSET
POLICE**



PAN DORSET CHILD DEATH OVERVIEW PANEL (CDOP)
Annual Report to the Pan-Dorset SCP from 1st April 2021 to
31 March 2022





**DORSET
POLICE**



PAN DORSET CHILD DEATH OVERVIEW PANEL (CDOP)

Annual Report to the Pan-Dorset SCP from 1st April 2021 to 31 March 2022

Introduction

The purpose of this report is to provide members of the Pan-Dorset SCP with an update for the last twelve-month period during 2021/22 in relation to the Child Death Overview Panel (CDOP). This report is for the information of partnership members and is not for wider circulation. The Report will be shared with our CDOP Partners, Somerset, as they will have already received the data and discussed at CDOP panels.

Child Death Reviews Panels

The panel continues to consist of Dorset and Somerset, focused on meeting the Government requirements of Working Together 2018.

The Child Death Overview Panel (CDOP) members are:

- Bournemouth, Christchurch, and Poole Council.
- Somerset County Council.
- Dorset Council.
- Somerset Clinical Commissioning Group.
- Dorset Clinical Commissioning Group (now NHS Dorset Integrated Care Board).

The panel is currently chaired by a Dorset representative with Somerset vice-chairing. This will continue until 2023 when it will rotate. We have changed the meeting structure to include all four Doctors for child death as part of each panel as this has provided increased scrutiny and peer review during discussions as well as support.

The Panel's Shared Purpose

Our shared purpose is to provide high standard child death reviews and to ensure maximum impact of learning, which is shared in line with agreed governance structures within both counties.

- ✓ We will work together to professionally scrutinise every child death within Dorset and Somerset.
- ✓ We will ensure the voice of the family is heard in the reviews, key learning is shared, and recommendations made in line with local policy.
- ✓ We will also feed into national networks to share data and help identify potential themes which can only be identified at scale.

During the annual reporting period Covid-19 restrictions were initially in place and the previously implemented virtual panels using Microsoft Teams software continued. The last panel of this period reconvened face to face (albeit adhering to Covid-19 precautions), which was greeted with unanimous support. The panel reflected on virtual working benefits included:

- Reduced travel.
- Increased ease for participants to dial in for individual cases.

Negatives included:

- Isolation and lack of face-to-face support following difficult cases.
- Working from home with family distractions making it difficult to compartmentalise cases.
- Difficulty in picking up nonverbal cues in virtual meetings.
- Regular IT issues causing inefficiency.

Learning: As a panel we will incorporate remote participation for those attending for a single case to aid convenience going forward. We are also confident we have an effective method that works if required in the future. There were frustrations however around NHS estates guidance that delayed the reconvening of face-to-face Child Death Panels at a time there were no restrictions for the general public.

CDOP Data

The CDOP panel has met 6 times and reviewed 27 deaths: 26 Pan-Dorset deaths and 1 Out of County death. (14 Dorset, 12 BCP and 1 OOC). In 10 (37%) of these cases there were modifiable factors identified. In addition, the panel reviewed 22 Somerset deaths, 9 of which had modifiable factors identified. This compared to last year's figures where 25 Dorset cases were reviewed, and modifiable factors were identified in 40% of cases. 16 Somerset cases were also reviewed. This is slightly higher than the most recent published national CDOP data for 2019-20, which gives a national average of 34% of cases identifying modifiable factors. This could either be because of the holistic nature of the

panel membership and experience within or natural variation caused by small numbers being reviewed. We will be monitoring long term data for this going forward.

The panel also reviewed LeDeR Cases. A LeDeR review is required for children over the age of 4 years who died with a diagnosed learning disability. The focus of LeDeR is to improve services, reduce inequalities in health and to reduce premature death. For these cases, a LeDeR representative from Dorset CCG is invited to attend the Local Child Death Review Meetings and the Child Death Overview Panel meeting to facilitate collaborative working.

Modifiability

CDOP is required to assess the preventability of each death by considering whether there were factors which may have contributed to the death of the child and if so, whether these could be “modified” to reduce the risk of future child deaths. During 2021/22 CDOP identified modifiable factors in 10 of the 27 (37%) Pan-Dorset deaths reviewed. This is in comparison with the most recently published Southwest figure, which sits at 32% modifiability and 34% nationally.

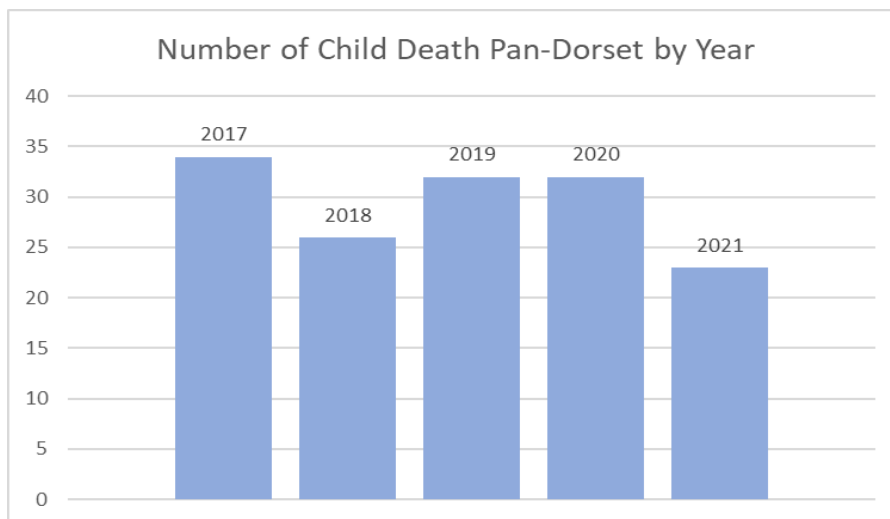
In 2021/22, out of a list of modifiable factors outlined below, Dorset identified the factors highlighted in yellow, with the number of times identified in brackets. Where appropriate, panel members were given actions to highlight certain modifiable factors for learning within agencies.

1. Smoking by a parent or carer (6)
2. Quality of service delivery (1)
3. Unsafe sleeping arrangements (3)
4. Substance and/or alcohol misuse by a parent or carer
5. Maternal health problems (2)
6. Maternal obesity during pregnancy (1)
7. Challenges with access to services (1)
8. Poor communication and information sharing (1)
9. Domestic abuse
10. Poor home environment
11. Consanguinity (parents are known blood relatives to each other)
12. Mental health condition in a parent or carer
13. Inappropriate supervision of children / babies (1)

Child Deaths – Notifications (01.04.21 to 31.03.22)

Child Death Overview Panel (CDOP) has been notified of a total of 23 deaths of Pan Dorset residents during this twelve-month period, in addition to 4 notifications of Out of County children, resident elsewhere who died within our area – these deaths will be

reviewed and recorded by their home LA's. The 23 notifications of Pan Dorset children is the smallest number of deaths recorded since CDOP was introduced in 2008.

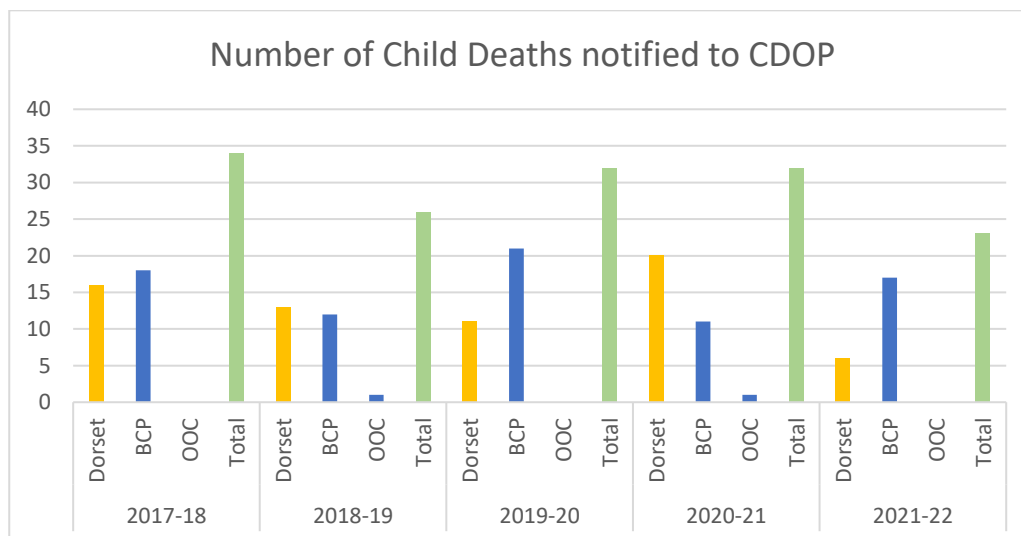


Child Deaths Pan-Dorset:

The current data shows no current trend in child death numbers.

Number of Child Deaths notified to CDOP by Local Authority

The graph below shows child deaths by local authority, year on year. Over the last 5 years, child deaths were at their lowest in 2021-22 and highest in 2017-18. There is no specific reason for this and there is no current increasing or decreasing trend in child death numbers either Pan-Dorset or at Local Authority level.



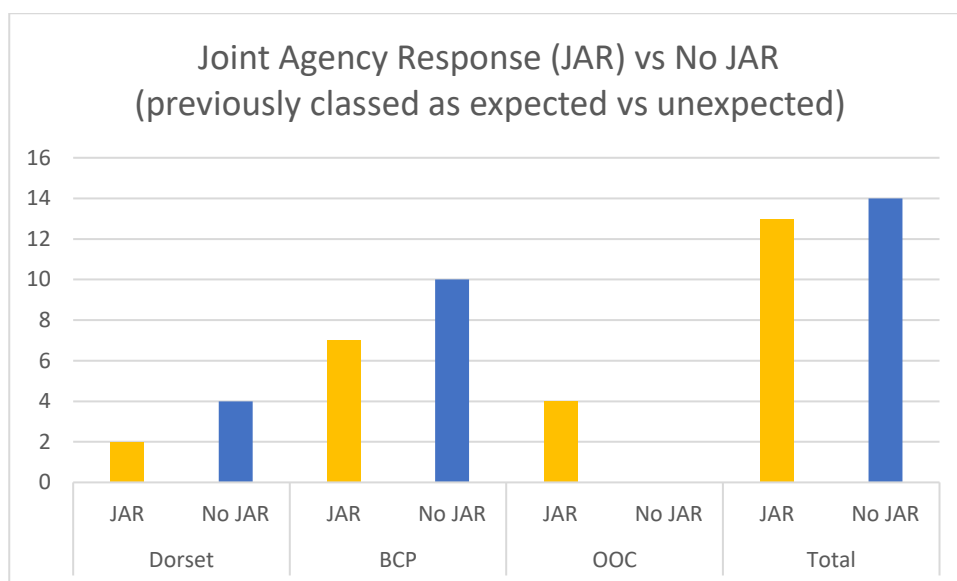
Reported Child Deaths with Joint Agency Responses

The Pan-Dorset total number of deaths (23) is made up of 17 reported in Bournemouth, Christchurch and Poole, 6 in other areas of Dorset. In addition, we were notified of a further 4 deaths from children who died whilst visiting Dorset but who were resident elsewhere (OOC). Out of the 23 deaths, 7 were neonatal. In the previous reporting year 15 neonatal deaths were reported.

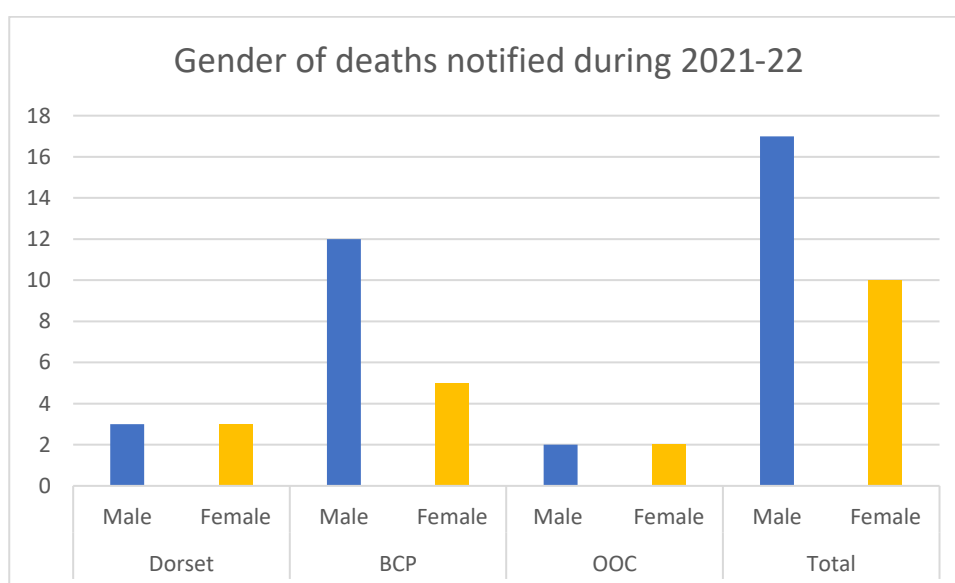
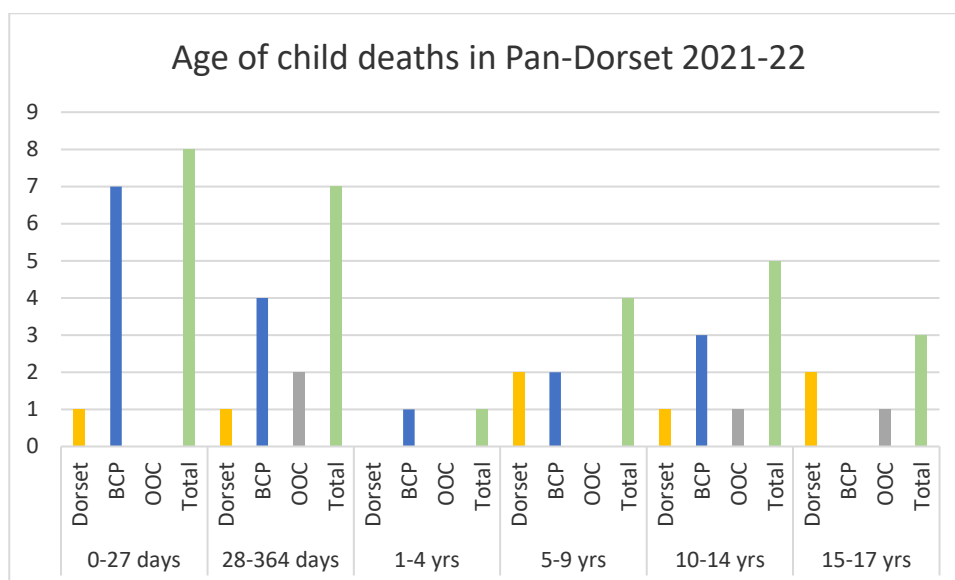
1 of these 23 children was reported as dying with Covid-19. Post-mortem results are awaited to determine whether this will be recorded as the cause of death.

Within Dorset, most deaths were expected and did not need a Joint Agency Response. The graph below shows the distribution of these across Dorset and where a Dorset child has died out of county. The overall total is skewed by the out of county deaths requiring a joint agency response.

NOTE: It is no longer a requirement that we categorise deaths into expected and unexpected cohorts for the national data return. But we are still aware of unexpected deaths as they will initiate a Rapid Response (also known as joint agency response/JAR) and for the deaths during 2021/22 there were 9/23 where one was commenced, in addition to the 4/4 Out of County deaths which also occurred.



The following 2 graphs show further information relating to child death profiling. The highest volume of child deaths are in the 0-27 day-old category. This is expected as it includes those born with signs of life but often with life limiting conditions or extreme prematurity. They also show that there were more male vs female deaths. This reflects the 2020-21 national gender picture. This year we have an increased proportion of deaths in the 28–365-day subgroup. This is caused by the unusual proportion of 5 currently unexplained deaths in the past year 2, likely SUDI and 3 unexplained. Local reviews have not occurred yet for these deaths as post-mortem reports are still awaited. Any themes that come out of these will be reported as they evolve. These deaths also increased the proportion of JARs held compared to non JARs. Last year there were 13 JARS from 32 deaths compared to this year's 13 from 27.



Please note this table includes notification of 4 deaths in Dorset of non-resident children.

The Pan Dorset deaths of resident children notified to CDOP in 2021-22 occurred in the following settings: Hospital, (13) Home (8) and in a public place (2). The distribution is reflected similarly in the most recently published national statistics for place of death.

The table below shows the categories of death, reviewed by CDOP, of Dorset children and out of area children over the last 5 years. There was an increase in SUDI deaths being reviewed last year which was raised as a concern and the safeguarding partnership had been informed as appropriate messages were being given to parents but not being followed. These deaths occurred in both 2019-2020 (3) and 2020-2021 (2) showing no increasing trends over time but a delay in coroners process due to Covid-19 led to all the cases being finalised for discussion this year.

Categorisation of Dorset cases reviewed by the Pan-Dorset CDOP in the last 5 years:

Category	2017/18	2018/19	2019/20	2020/21	2021/22	Total
1. Deliberately inflicted injury, abuse, or neglect.	2	0	0	0	0	2
2. Suicide or deliberate self-inflicted harm.	4	1	0	5	2	12
3. Trauma and other external factors, including medical/surgical complications/error.	1	7	6	0	2	16
4. Malignancy.	5	4	1	1	5	16
5. Acute medical or surgical condition.	1	2	7	0	0	10
6. Chronic medical condition.	0	0	0	1	1	2
7. Chromosomal, genetic, and congenital anomalies.	11	10	4	9	1	35
8. Perinatal/neonatal event.	12	9	7	6	9	43
9. Infection.	1	0	4	3	2	10
10. Sudden unexpected, unexplained death.	1	2	0	0	5	8
Total number of deaths reviewed by CDOP	38	35	29	25	27	154

Analysis of Child Death Themes

Suicide: Between April 2021 and March 2022, the CDOP reviewed 2 deaths which were categorised as ‘suicide or self-inflicted deliberate harm.’ Modes of death included seizure activity following possible ingestion of sodium azide and hanging. The CDOP have linked with the Suicide Surveillance Group to raise and monitor the use of sodium azide following concern that it is readily available given that it has a legitimate use.

For each of these reviews, the CDOP has sought specialist psychiatrist input from CAMHS and multi-agency work has been carried out immediately after each death under the Rapid Response process to identify peers and siblings, ensuring that they are supported and not also at risk of dying by suicide, Implementing the suicide contagion protocol devised following CDOP review last year.

SUDI: During this CDOP year, we have reviewed 5 SUDI deaths (date of death occurred prior to 2021-2022), a specialist SUDI cohort was held in November 2021 to review these deaths as a group, enabling comparisons to be drawn. Health visiting were invited to attend this panel, themes and recommendations identified by the panel were shared in writing to the safeguarding children’s partnership.

Learning and Outcomes

Below is a selection of some of the recommendations, actions in progress or outcomes of cases discussed this year:

Case 1 – SUDI: CDOP held a SUDI cohort in November 2021, the panel reviewed 4 cases where a theme was found; Families were aware of the safe sleeping message but were choosing not to follow it. The message needs to be reinforced and updated, to include the message of always needing 'clear, safe space around the baby'.	Joint Action – The panel wrote to the PDSCP's MAQPAG recommending that multi agency work should be undertaken. There is a planned Safe Sleeping campaign...
Case 2 – Maternal Diabetes: The panel reviewed the case of a baby, born to a diabetic mother. As part of this review, the Designated Doctor met with the diabetes Consultant to discuss and review management during the pregnancy. As a result of review the maternity pathway for diabetic women has been amended.	Diabetes specialists now provide a weekly clinic rather than fortnightly. A recent review of another infant death where diabetes was a factor noted that the new arrangements had been very successful in substantially improving the mother's diabetes control.
Case 3 - Primary Care Cough Advice: The panel reviewed the case of a 2-year-old boy who had been diagnosed with T-cell ALL following multiple presentations to GP in the 4 months prior to diagnosis with recurrent viral infections. As a result of the review, recently published guidance was shared with GP surgeries.	The cough protocol was sent to both GP safeguarding leads and added to the GP bulletin to highlight the recently published guidance with the aim of avoiding such a delay in referral in any future case.
Case 4 - Empyema, Citrobacter braakii infection: The panel reviewed the case of a 10-day old baby who had been prescribed antibiotics post birth due to mother suffering fevers and suspected sepsis, though neither culture did identify Group B Streptococcus. Baby collapsed in a public place at 10 days of age and subsequent PM investigations revealed Empyema, Citrobacter braakii infection. As a result of this review, one of the trusts was tasked with exploring what information is given to parents regarding identifying future risks associated with sepsis post discharge. CDOP also fed back that they endorsed the review of labour line and securing funding for the service. There was also exploration of smoking cessation advice post birth and how parents are educated about the risks of smoking in the home.	As a result of the review, Poole NICU are currently considering adopting the use of the Lullaby Trust's 'baby check' leaflet. CDOP's support of securing permanent funding for labour line was shared the Maternity Hub is now live, allowing nonclinical calls to be diverted and clinical calls to be answered in a more timely way. Health visiting teams have also shared assurances that postnatal smoking advice is consistently offered and explained in relation to SUDI risks, offering referrals to Live Well Dorset for smoke stop support.
Case 5 – Somerset Suicide: The panel reviewed the Somerset case of a 17-year-old girl, believed to have died by suicide. She	Following this review, Dorset shared 2 resources with Somerset teams for implementation into their

was found in her bedroom, during a covid isolation period, having had no known mental health concerns. She had been indirectly exposed to suicide, some 3 months prior to her death and was in her 1st year of college. Following this review, Dorset shared their suicide contagion protocol with Somerset, in addition to 'Dorset's open door to all.'

workstreams. This is a demonstration of a good use of shared resources following the panel's merge.

Other Outcomes

- It has been noted that in a high number of deaths which occurred due to extreme prematurity, maternal obesity was present. We have fed this back to the NCMD who have, in April 2022, changed the national forms to include mother's BMI as specific data field, enabling nation-wide data collation which will facilitate further analysis of this link.
- On 4th November 2021, a CDOP Learning Event took place, invites were sent to a multi-agency audience. The event covered the following:
 - Learning from Local Suicides.
 - 'Think Mum, Think Baby' – local Sepsis learning and updated pathway.
 - Sudden Unexpected Death in Infancy, an overview of the report published by The Child Safeguarding Practice Review Panel.
 - Dorset Police protocols following a Sudden Unexpected Death.
 - The Role of the Lead Nurse in dealing with SUDIs within a DGH.
- The CDOP learning event feedback was sought retrospectively. The feedback was unanimously positive, with consistent requests for future similar events. Pan Dorset CDOP will now plan another Learning Event for later in the year, continuing to raise awareness of learning from local cases and discussing the changes that have been implemented as a result.

Future Developments

- Embed the CDOP learnings pathways through new 'place-based' multi-agency learning into the Pan-Dorset SCP via Dorset Council MAQPAG and BCP Scrutiny and Quality Assurance Committee.
- Since the introduction of the NCMD (National Child Mortality Database), themes and trends should be highlighted and reviewed by their data analysts. Pan Dorset CDOP however will independently complete a 5-year audit of local Modifiable Factors to check for any patterns or trends which will not be highlighted by the national team.

Prepared By:

Emma Porter, CDOP Co-ordinator, and Dr Sam Abdollahian, CDOP Chair.

Date: 20/08/2022.