Pan-Dorset Safeguarding Children Partnership

PAN-DORSET SAFEGUARDING CHILDREN PARTNERSHIP

PAN DORSET CHILD DEATH OVERVIEW PANEL (CDOP)

Annual Report to the Pan-Dorset SCP from 1st April 2020 to 31 March 2021

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 2020/21 in relation to the Child Death Overview Panel (CDOP).

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 (BCP)
- Somerset County Council
- Dorset Council
- Somerset Clinical Commissioning Group
- Dorset Clinical Commissioning Group

The chairing arrangements changed in April 2020. Previously, the panel was chaired by a Somerset Representative and Dorset/BCP vice-chaired, this has now rotated.

In addition, all four Doctors for child death are now part of the panel (instead of 2 previously). This was following review of the first year in which one representative from each county attended. This decision was made to increase professional scrutiny and support peer review during panel discussions.

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 each geographical footprint in Dorset and Somerset.

- ✓ 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 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 this annual reporting period we experienced Covid-19. Even though no Dorset/Somerset child death cases were reported due to Covid-19, adaptations were made to panel working:

Covid-19 adaptations have been implemented. All panel meetings were converted from face to face to virtual meetings using Microsoft Teams. IT resources were also utilised in supporting the adaptation of Local Child Death Review Meetings with all agencies outside of hospital settings also able to join meetings using this software.

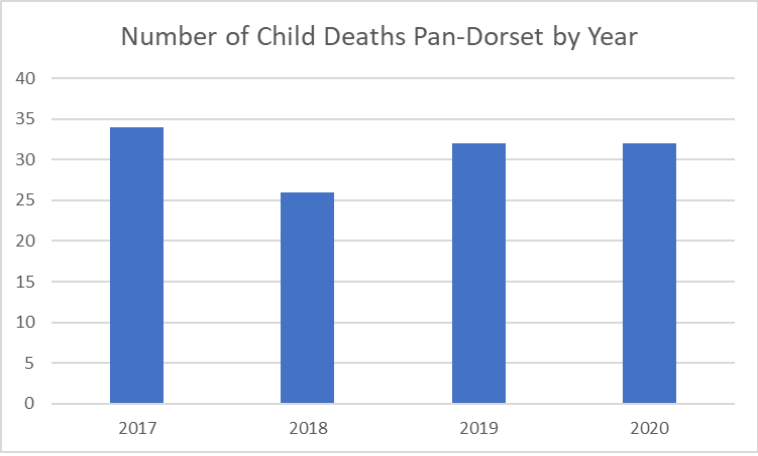
The CDOP panel has met 5 times (6 were scheduled but 1 meeting was cancelled due to postponed inquests as a result of Covid) and reviewed 25 Pan-Dorset deaths (13 Dorset and 12 BCP) and 16 Somerset cases averaging 8 cases a panel. This is in line with the most recent published national CDOP data for 2018-19.

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 2020/21 CDOP identified modifiable factors in 10 of the 25 (40%) of Pan-Dorset deaths, which is above the national average of 30% in the most recent published CDOP data for 2018-2019. This is likely due to the combination of a robust panel and smaller numbers of cases in the sample size.

In 2020/21, Dorset identified the factors highlighted in yellow:

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

Child Deaths – Numbers (01.04.19 to 31.03.20)
The Child Death Overview Panel (CDOP) has been notified of a total of 32 deaths during this twelve-month period, which is the same number as in 2019-2020.

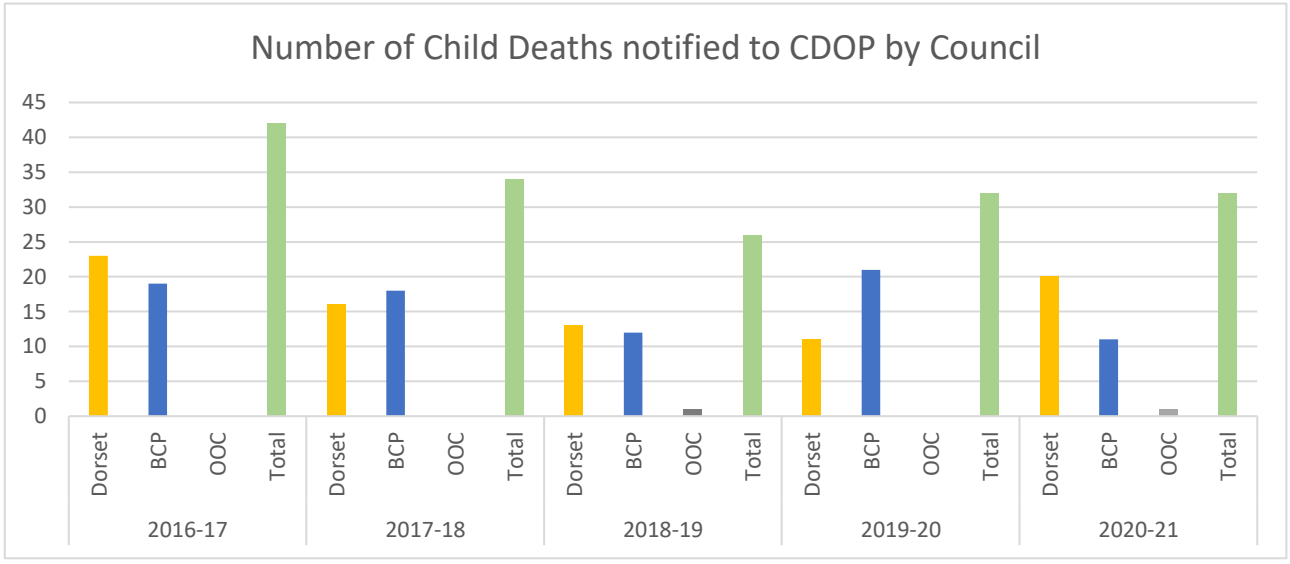


Child Deaths Pan-Dorset

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

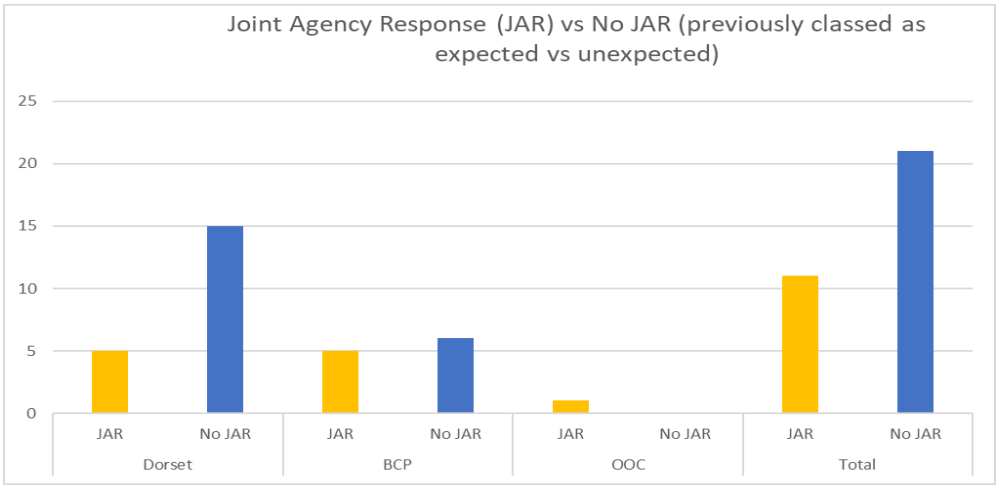
Number of Child Deaths notified to CDOP by Local Authority

The graph below shows child deaths by county, year on year. Over the last 5 years, child deaths were at their lowest in 2018-19 and highest in 2016-17. 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. Last year 20 cases were within the Dorset Local authority, 11 within Bournemouth Christchurch and Poole and 1, out of county.



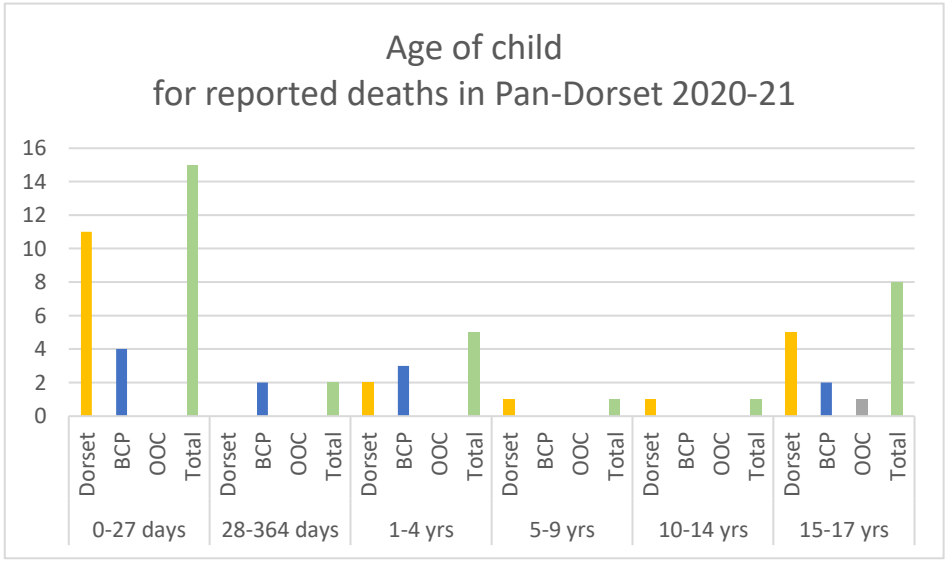
Reported Child Deaths with Joint Agency Responses

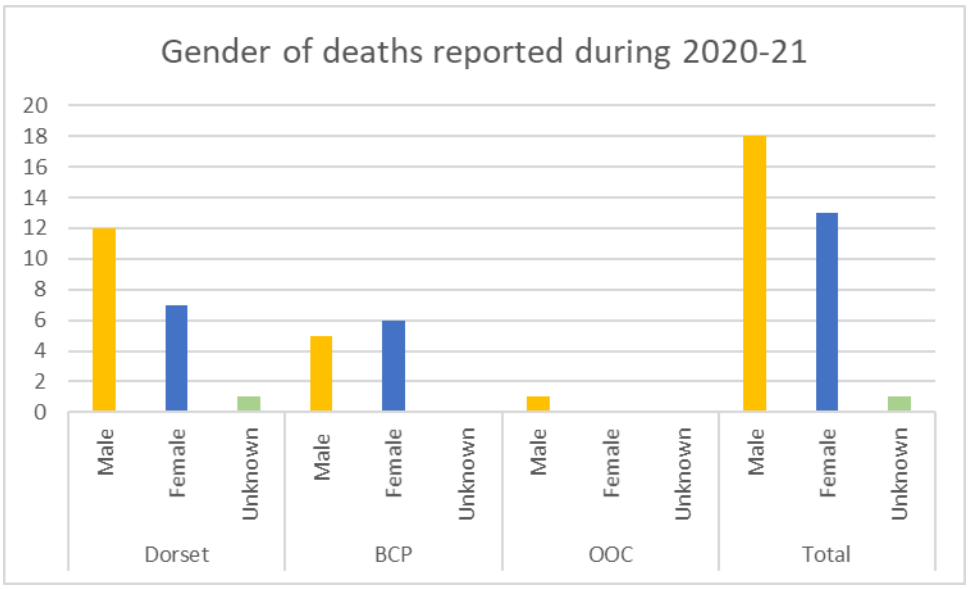
Within Dorset, the majority of deaths have been expected, without the need for a Joint Agency Response. The graph below shows the distribution of these across Local Authority areas and out of county.



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) and for the deaths during 2019/20 there were 13 out of 32 deaths where a Rapid Response was commenced.

The following 2 graphs show further information relating to child death profiling. The highest volume of child deaths falls within the '27 days old and under' category at 47%. This compares to 42% nationally. This is expected as it includes those born with signs of life but often with life limiting conditions or extreme prematurity. The difference in percentage is due to the likely small sample size in Dorset. They also show that there were slightly more male vs female deaths with 56% Male compared to 46% Female. This matches the most recent national statistics published for 2018-2019.





The deaths notified to the Pan Dorset CDOP in 2020-21 occurred in the following settings: Hospital, (27) 84.4%, Home (2) 6.2%, and in a public place (3) 9.4%. The most recent published National CDOP data is for 2018-2019, showing 67% of children died in Hospital, 21% at home and 5% in a public place. The reason for this difference is unknown.

Two of the cases reviewed were LeDeR reviews. A LeDeR review is required for children 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.

The table below categorises the Dorset deaths reviewed by the Pan-Dorset CDOP and more recently Pan-Dorset and Somerset CDOP over the last 5 years. The data trends here are broadly in line with national published data. We have had no Covid-19 related child deaths to date.

Category	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**Total**
1. Deliberately inflicted injury, abuse or neglect	0	2	0	0	0	**2**
2. Suicide or deliberate self-inflicted harm	3	4	1	0	5	**13**
3. Trauma and other external factors, including medical/surgical complications/error	6	1	7	6	0	**20**
4. Malignancy	6	5	4	1	1	**17**
5. Acute medical or surgical condition	1	1	2	7	0	**11**
6. Chronic medical condition	2	0	0	0	1	**3**
7. Chromosomal, genetic and congenital anomalies	5	11	10	4	9	**39**
8. Perinatal/neonatal event	6	12	9	7	6	**40**
9. Infection	4	1	0	4	3	**12**
10. Sudden unexpected, unexplained death	5	1	2	0	0	**8**
Total number of deaths reviewed by CDOP	**38**	**38**	**35**	**29**	**25**	**165**

Analysis of Child Death themes

Suicide – Between April 2020 and March 2021, the CDOP reviewed 5 deaths which were categorised as 'suicide or self-inflicted deliberate harm.' Hanging was found to be the method in 3 of these 5 cases, along with ingestion of an elicit substance and injuries caused by collision with a train. During this year the Dorset Suicide Prevention Strategy and Implementation Plan was drafted and has since been finalised. Learning from one of these cases was also fed into the South-West Designated Nurse CLA network. 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.

SUDI – During this CDOP year, we have been notified of 2 SUDI deaths, this is in addition to the 5 from last year which are still open pending inquests and other external processes, these deaths are

therefore not represented in the above table, as they are yet to be reviewed by the CDOP. A specialist SUDI cohort is planned for November 2021 to review these deaths as a group, enabling comparisons to be drawn. Health visiting will be invited to attend this panel.

Learning and Outcomes

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

Case 1 Suicide / Self-inflicted harm CDOP discussion identified potential concerns where children within private school settings may not have the same challenge if concerns are raised compared to state schools. It was recognised that within the private setting school counsellors often don't work in a multi-agency arrangement, and the relationship with parents means it can be harder for private schools to challenge.	This Case led to the recommendation to explore potential barriers. There is ongoing work between the CCG and LA's around how private schools work with CSC and other agencies. The CCG will link with Education safeguarding leads and BCP MASH lead in order to pursue this barrier.
Case 2 – Suicide / Self-inflicted harm It had been identified that there was a developing theme in recent local suicide cases, where friends were made aware of a young person's mental state or intentions but didn't share this information with anyone.	Following this case, BCP have carried out work to create the 'pack of positivity'; cards to help identify mental health concerns earlier within schools. These are resources produced by young people for young people, supported by the Mental Health in Schools team. It also includes a Teacher's pack. This work will be highlighted in the PDSCP newsletter and is being shared with schools and other key partners.
Case 3 – Infection Prior to this case there was no formal pathway to ensure babies were assessed where a new mother presented with an infection requiring admission. This case also led to a Coroners Regulation 28 notice being issued, requesting a national change.	As a result of this case, there has been a 'Think Mum, think baby' campaign and a revised sepsis pathway has now been introduced. This has been shared across local Hospital Trusts and Primary Care. The case will be presented at the CDOP Learning Event in November 2021.
Case 4 – Infection	As a result of this case, the CCG have linked with health visiting and midwifery to

Mother sought advice on Facebook rather than through contacting a health professional or using a peer reviewed website such as 'Healthier Together' The recommendation was to explore how to reach all families and gain improved access to reliable health information.	highlight the Wessex Healthier Together website. There is also planned work to ensure that reputable sources such as Wessex Healthier Together are highlighted if a health-related internet search occurs.

Other Outcomes

- New link with maternity patient safety group, a representative from the CCG is now invited to join all neonatal panels.
- New agreed scoring – after raising the question with the NCMD, it has been confirmed nationally that a death at any age in childhood, should be recorded as a neonatal event, wherever the child had an underlying condition caused by complications at birth e.g., cerebral palsy. This will ensure consistent scoring and recording going forward
- It has been noted that in a high number of deaths which occurred due to extreme prematurity, maternal smoking / smoking in the home / maternal obesity were present. This has been fed back to the NCMD who will seek to include this data set within the mandatory questions collected nationally for all deaths. This will enable further analysis of this link.

Future Developments

- The CDOP learning event has been re-scheduled to 4th November 2021 to improve attendance, the aim of the event is to share recent learning from CDOP across a multi-agency audience, raising awareness of learning from local cases and discussing the changes that have been implemented as a result.
- Embedding the CDOP learnings pathways through new 'place-based' multi-agency learning into the Pan-Dorset SCP Learning Hubs.
- Review of the CDOP Terms of Reference has now been completed and agreed.

Prepared by: Rachel Thorpe **Pan Dorset SCP Manager** Date **Oct 2021**
Sam Abdollahian: **CDOP Chair**

National Date referenced from : https://digital.nhs.uk/data-and-information/publications/statistical/child-death-reviews/2019/