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Coventry, Solihull & Warwickshire Safeguarding Children Boards

CHILD DEATH OVERVIEW PANELS

ANNUAL REPORT

2013 - 2014

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Appendices

1 The focus for 2013-2014 continued very much as in previous years by aiming to review cases in a timely manner, finalise outstanding areas of work, progressing actions arising from reviews and continually reviewing and improving the process as a whole. The added element for this reporting year is the involvement of parents in the process which is covered in more detail in paragraph 15.1.

2 Deaths reviewed by Child Death Overview Panels (CDOPs) during 2013-2014

18 panels were held across the sub-region during 2013-2014 and **78** deaths were reviewed (87 reviewed in 2012-2013). Of the **78** deaths reviewed, **29** (37%) were identified as having modifiable factors, i.e. where there are factors which may have contributed to vulnerability, ill health or death. This figure is slightly higher than the previous year where **23** (26.4%) had modifiable factors. The breakdown for each LSCB is detailed in the table below:

LSCB	Panels held	Deaths Reviewed	Modifiable Factors
Coventry	6	28	10 (36%)
Solihull	4	17	7 (59%)
Warwickshire	8	33	12 (36%)
Total	**18**	**78**	**29 (37%)**

2.1 Of the 6 Coventry panels held, 5 were full CDOPs and one a Fast Track CDOP. Solihull held 4 full CDOPs. Warwickshire held 6 full CDOPs and 2 Fast Tack CDOPs.

3 Recommendations and actions arising from Coventry CDOP during 2013-2014

12 actions arose from deaths reviewed during 2013-2014. The following is a summary of the learning identified from the deaths reviewed:

3.1 Sudden Infant Death Syndrome (SIDS)

Coventry CDOP reviewed 2 deaths from SIDS during 2013-2014. Both had modifiable factors as unsafe sleeping, i.e. co-sleeping was a contributory factor in both and both families were considered to be vulnerable. One death which identified further contributory factors including alcohol consumption, was subject of a Serious Case Review (SCR) and CDOP endorsed the learning and recommendations identified in the SCR. One recommendation from the SCR was to write to the Department for Education and Department of Health to commission research in this area so that a more targeted approach might become national policy in relation to particularly vulnerable families as these are clearly preventable deaths and action is required to remedy this. The CDOP Manager assisted with the letter sent to the Secretary of State, Mr Gove, by providing the LSCB Chair with SIDS data and learning from CDOP reviews, which supported the need for a targeted approach with vulnerable families.

3.1.1 A reply was received from Mr Gove who stated that as part of their work on the national repository of SCRs, the NSPCC published a thematic briefing on learning from the review of cases involving parental substance misuse. This briefing also includes several references to the risks of co-sleeping and a number of recommendations around assessment, professional awareness and skills. Mr Gove stated that his department would continue to maintain an overview of the key messages which are emerging from SCRs for both local agencies and central government.

3.1.2 CDOP commenced a review into a 3rd SIDS death but this was postponed and referred to the Serious Case Review Subgroup for consideration of a Serious Case Review, due to the risk factors identified. A response was subsequently received from the LSCB Chair

outlining why the criteria for an SCR was not met and welcomed any findings from the CDOP review, which will now take place during year 2014-2015.

3.1.3 Further work has been conducted across the sub-region in 2013-2014, in relation to SIDS, focusing on the more vulnerable families. This is outlined in more detail in paragraph 7.5.

3.1.4 CDOP also reviewed the unlawful death of a child which was also subject of a criminal investigation and a Serious Case Review. CDOP endorsed the learning, recommendations and actions arising from the Serious Case Review.

3.2 Modifiable deaths where no actions were identified.
The learning highlighted in paragraph 3.1 relates to deaths where CDOP concluded there were modifiable factors. There were however additional deaths reviewed where modifiable factors were identified but CDOP did not identify any actions. These deaths included:

3.2.1 Neonatal deaths due to prematurity where maternal smoking during pregnancy contributed to premature labour and where the review identified that appropriate referrals were made antenatally to smoking cessation.

3.2.2 Third party or parental misjudgement resulting in accidental deaths, i.e. road traffic collisions and drowning.

3.2.3 Where consanguinity (parents are blood related) was a factor in a chromosomal/genetic condition.

3.3 Learning identified where no modifiable factors were identified
Conversely there was learning and actions identified in reviews where no modifiable factors were identified, in other words, deaths which were not preventable, as follows:

3.3.1 Following on from the work conducted in 2012-2013 to promote the 'Headsmart' project to raise GP's awareness of brain tumour symptoms in children, CDOP reviewed a further death where a child made a number of presentations to a GP prior to diagnosis. Although the outcome for this child would not have changed, a further opportunity was taken to raise the awareness of 'Headsmart and CDOP learning at a Paediatric 'Protected Learning Time' session for GPs.

3.3.2 In the review of a neonate who died at a hospital outside the area, the Health Visitor conducted a home visit, unaware that the baby had died. Notification protocols were ascertained with the hospital concerned and were found to be robust. The delay in communication was due to internal processes and Coventry Child Health was reminded of the urgency to share such information.

3.3.3 In the review of a baby who died from a life limiting condition shortly after birth, the panel considered that Mother should have been on a 'high risk' care pathway due to her previous obstetric history as opposed to a 'low risk' care pathway and this was conveyed to the hospital concerned.

3.3.4 In the review of a premature baby, it was identified that a partogram (a graph used during labour which at a glance identifies changes and deviations from the norm) was not used during labour. This was fed back to the Head of Midwifery at the hospital concerned.

3.3.5. The review of an infant who died suddenly whilst an in-patient from an undiagnosed congenital heart condition was subject of an internal review by a senior Consultant

Paediatrician at the hospital concerned. It was observed that the standard of medical and nursing notes/observation charts were high and as expected the overall clinical responsibility for this child moved from one consultant to another from day to day where in the main handovers were good, however there was some learning identified as follows: (i) a cardiac diagnosis was considered but not re-visited (ii) some x-rays were not reviewed with the radiologists and (iii) some investigations marked urgent were not followed through or not commented on by subsequent Consultants doing the ward round.

3.3.5.1 No actions were identified from the internal review but this case has been discussed internally at the hospital's Quality Improvement and Patient Safety Committee (QIPS) and will also be discussed at a future audit meeting.

3.3.5.2 When this case was reviewed at CDOP an action was identified to enquire if surviving siblings had been investigated for this condition

3.3.6 In a 'Root Cause Analysis' investigation conducted by the hospital concerned following the death of a full term baby from intrapartum hypoxia (lack of oxygen during delivery) one of the recommendations was 'The use of ultrasound scan to confirm the fetal heart in a woman with a raised BMI > 35 and to update the Obesity guideline. Following the review CDOP sought how this would be achieved as there is no facility to conduct ultrasound scanning at certain times of the day. A response was received from the hospital stating the service would be available 24 hours a day.

4 Recommendations and actions arising from Solihull CDOP during 2013-2014

27 actions arose from deaths reviewed during 2013-2014. The following is a summary of the learning identified from the deaths reviewed:

4.1 CDOP reviewed the death of a young person who accidentally asphyxiated by becoming entangled with an object suspended from their bunk bed. This death was also subject to a 'Significant Incident Learning Process' (SILP) review which identified learning and recommendations to Solihull LSCB which the CDOP endorsed.

4.1.1 It was also identified that this was the 4th death in similar circumstances across the sub-region. A recommendation was therefore made to Solihull LSCB that the learning be disseminated to all Early Year practitioners to advise parents and carers of the dangers.

4.1.2 The CDOP learning was also shared with other CDOPs across the country and contact made with the Child Accident Prevention Trust (CAPT) who highlighted the dangers in their monthly newsletter.

4.2 CDOP ascertained that a young driver killed in a road traffic collision was undergoing neurological investigations for vacant episodes at the time but had not been advised against driving as his locum Consultant believed the minimum age for driving in the UK was 18 years. CDOP sought reassurance from the hospital concerned that locums, particularly those coming to work in the UK are conversant with UK laws. CDOP also sought assurance from the hospital concerned that in addition to advice against driving, the advice given should include abstaining from certain sports and operating machinery etc.

4.3 The review of a neonate who required surgery identified that no PICU beds were available at the local specialist hospital and the child was too unstable to transfer to the nearest bed available 100 miles away. Although the unavailability of a PICU bed locally did not contribute to the death, CDOP did highlight this to the local specialist hospital who informed CDOP that a regional review of PICU beds had taken place, the outcome of which will be shared with CDOP when completed.

4.4 In the review of a neonate who died shortly after birth at 21 weeks gestation, contributory factors were identified as maternal smoking during pregnancy and other physical health issues including a raised BMI of 44. CDOP sought reassurance that Mother was referred to smoking cessation and for weight management support.

4.5 In the review of another neonate who died shortly after birth at 29 weeks gestation, it was ascertained that the GP had referred Mother to the Alcohol Service due to her drinking 6 weeks before her pregnancy was confirmed, however this information was not communicated by the GP Practice to the Community Midwifery Services. Although alcohol consumption was not a contributory factor to prematurity (maternal smoking was) CDOP communicated with the GP practice to ensure that processes were in place to ensure that all relevant information is passed on to Midwifery Services.

4.6 *Modifiable deaths where no actions were identified.*
The learning highlighted in paragraphs 4.1 to 4.5 relate to deaths where CDOP concluded there were modifiable factors and actions were identified. There was however a further neonatal death reviewed where excessive alcohol consumption pre-pregnancy and maternal smoking during pregnancy were known links to the medical condition which caused death, however no actions were identified as Mother had been referred to smoking cessation but had declined the service.

4.7 Learning identified where no modifiable factors were identified
Conversely there was learning and actions identified in reviews where no modifiable factors were identified, in other words, deaths which were not preventable, as follows:

4.7.1 In the review of a child who died from a brain tumour, CDOP identified that this child had presented to A&E with frontal band type headaches which were considered to be a migraine. A further presentation to the GP with the same symptoms also concluded migraine. A diagnosis was made following a second visit to A&E. Whilst it was acknowledged that an earlier diagnosis would not have changed the outcome for this child, contact was made with the GP Practice and A&E concerned to ascertain if there were any 'red flag' symptoms present which may have prompted an urgent referral.

4.7.2 An action was also identified to disseminate information to GPs on 'Headsmart' a project aimed at raising the awareness of brain tumour symptoms in children, as was done in Coventry.

4.8 In the review of an infant who died unexpectedly from an undiagnosed heart condition, a number of learning points were identified by the 'Rapid Response' investigation as per the Sudden and Unexpected Death in Children (SUDC) Protocol and the CDOP review namely; swabs taken during a previous hospital admission were mislaid and during resuscitation more than the recommended dose of adrenaline was given. Whilst neither of these factors contributed to this child's death, CDOP enquired from the hospital concerned if both were flagged as incidents, what learning has been identified and if any measures have been put in place to prevent a reoccurrence.

4.8.1 The same review also identified that an infant blood pressure cuff was not available in the ambulance conveying the child to hospital. As before, this did not contribute in any way towards the death but an action was identified to clarify with West Midlands Ambulance Service their policy on infant blood pressure cuffs in ambulances.

4.9 Miscellaneous actions:

4.9.1 A number of actions were identified to ascertain the welfare and on-going support for bereaved siblings.

4.9.2 Specific actions were identified to raise awareness of the requirements of a multi-agency 'Rapid Response' investigation as per the Sudden and Unexpected Deaths in Children (SUDC) Protocol.

4.9.3 A number of actions were identified for specific service providers, either to (ii) request additional information, (ii) seek clarification on local learning and practices put in place or (iii) feedback learning from CDOP reviews.

5 Recommendations and actions arising from Warwickshire CDOP during 2013-2014

33 actions arose from deaths reviewed during 2013-2014. The following is a summary of the learning identified from the deaths reviewed:

5.1 Following the death of a toddler who climbed onto an insecurely fixed fireplace which came away from the wall and fell on the child, links were made with Trading Standards, the Royal Society for the Prevention of Accidents (RoSPA) and the Child Accident Prevention Trust (CAPT) to raise awareness of the importance of having fireplaces and surrounds professionally fitted.

5.2 The review of a death from Sudden Infant Death Syndrome (SIDS) where baby was co-sleeping with Mum on a sofa was referred to Warwickshire LSCB Special Cases Subgroup for consideration of a Serious Case Review after the review ascertained that a number of professionals were involved with Mum, who at the time of death was staying with relatives after being made homeless. The criteria for a Serious Case Review was met and is ongoing.

5.3 In the review of another SIDs death where baby was co-sleeping with Mum, actions were identified to ensure Mum received professionals support due to a history of mental ill health and to look for any research published with regards to the use of anti-depressants and a link with excessive drowsiness or sleepiness (no published research was found).

5.4 The review of a young person who died from a brain tumour identified that 7 presentations were made to a GP and a further 3 with other health professionals in a two week period before diagnostic investigations were conducted. A recommendation was made for all GPs to be made aware of 'Headsmart' a project aimed at raising the awareness of brain tumour symptoms in children and young persons. This was an action already pursued by Coventry CDOP after reviewing deaths in similar circumstances and you will note a similar action arising from Solihull CDOP which demonstrates the effective sub-regional arrangement of sharing learning and actions across the three LSCB areas.

5.5 Another example of where learning has been shared across the sub-region relates to the review of 4 deaths across the sub-region from accidental asphyxiation as a result of children becoming entangled in objects suspended from bunk type beds. A recommendation was made initially by Coventry CDOP in 2012-2013 to disseminate the learning to all Early Years Practitioners to advise parents and carers of the dangers. This was also endorsed by Solihull CDOP when reviewing a similar death, as outlined in paragraph 4.1. As Warwickshire CDOP had reviewed two deaths in previous years a recommendation was made to Warwickshire LSCB to disseminate the learning to all Early Years practitioners.

5.5.1 Contact was also made with the Child Accident Prevention Trust (CAPT) who highlighted the dangers in their monthly newsletter.

5.6 The review of a young person with a complex medical history who died from complications three weeks after undergoing a high risk surgical procedure, identified that

this young person had been discharged from an out of area specialist hospital without a clear structured discharge plan which resulted in (i) poor communication between the hospital and community health service providers (ii) limited direct follow up in the three weeks following the operation, relying on Mum to initiate any further medical contact (iii) no indication as to what advice Mum was given by the discharging hospital.

5.6.1 CDOP wrote to the Clinical Director of the hospital concerned to ascertain what their procedure is with regards to providing structured plans on discharge.

5.6.2 It was noted that the Community Children's Nursing Service (CCNS) were aware of this young person's discharge and feedback was given to the CCNS to advise that if a child is being discharged from hospital into the community and a discharge summary/plan is not received they should be proactive and make contact with the hospital.

5.7 Neonatal deaths:

A number of reviews were conducted where learning was identified. The following cases were all subject of an internal review conducted by the hospital concerned, either by a Root Cause Analysis or at an internal review meeting. The learning and actions identified were shared with CDOP.

5.7.1 Following the review of a premature baby who died within a day of birth from Intra Ventricular Haemorrhages, a Root Cause Analysis identified sub-optimal care following Mum's admission with abdominal pain at 27 weeks gestation. The root cause was due to human error by not assessing the baby's condition accurately, poor documentation with no clear management plan and failing to fully inform the on call consultant. Recommendations made were to (i) Reinforce the importance of accurate documentation through meetings with junior and senior clinicians in both Maternity and Neonatology (ii) Review key policies to provide explicit guidance to staff (iii) Educate staff on communication regarding their interactions with each other and patients (iv) Reinforce the need to involve the most senior available Obstetrician and Neonatologist in the management plan and attend delivery when it is anticipated to be difficult.

5.7.2 CDOP endorsed the learning and actions but requested that in future, action plans include an audit column to outline updates.

5.8 A premature baby transferred to an out of area hospital at 26 weeks gestation subsequently died following an outbreak of Serratia Marcescens Infection (a deadly bacterium) in the intensive care room of the neonatal unit. An internal review and a coronial investigation identified that the infection was spread on the unit by human contact. The hospital concerned identified a number of recommendations to improve hygiene as well as learning on how the infection was controlled. This learning was endorsed by CDOP and a recommendation was made to share the learning with all of our sub-regional Neonatal Units.

5.9 The review of a 6 day old full term baby who died from a form of meningitis identified that Mum had telephoned the postnatal ward at the hospital concerned on two occasions voicing concerns. The member of staff who took the second call wasn't aware that Mum had telephoned previously and as a consequence the serious nature wasn't recognised and appropriate advice was not given, which delayed treatment. The Root Cause Analysis identified the following learning: (i) All telephone assessments and advice given should be documented as this will ensure high quality, safe care. (ii) If a person calls for advice on more than one occasion the records of previous telephone calls must be reviewed to ensure that safe and appropriate advice is given.(iii) The hospital's guideline 'Early Onset Neonatal Infection Detection and Management' needs to be ratified and implemented into clinical practice as soon as possible. (iv) The changes made to the

hospital's 'Care of Women in Labour Guideline' needs to be disseminated and implemented into clinical practice as soon as possible. Recommendations made were to: (i) Develop a telephone assessment form for the postnatal ward (ii) Ensure that there is a process in place for the review of previous calls made to the postnatal ward (iii) Complete and disseminate the guidelines referred to.

5.10 A premature baby at 23 weeks and 5 days gestation, born at a local hospital and transferred shortly after birth to an out of area hospital, was reviewed at the local hospital's Critical Incident meeting. One of the learning points related to the use of antenatal steroids. (Steroids are prescribed to Mums likely to have a premature birth to promote the development of baby's lungs together with other benefits). Giving steroids to Mum was considered on her admission and a decision was made not to give them. In retrospect, whilst it was recognised that steroids would only have had a minimal effect, it was felt that Mum should have been given steroids at 23 and 5 days gestation. The internal review also identified that in retrospect Mum should have been transferred 'in-utero' to a hospital with a Neonatal Unit. Current hospital policy stipulated that transfers should not be done before 24 weeks gestation, however in light of this review the hospital's guidelines and care pathway has been amended to reflect this.

5.11 Modifiable deaths where no actions were identified.
The learning highlighted in paragraphs 5.1 to 5.10 relate to deaths where CDOP concluded there were modifiable factors and actions were identified. There were however a further three neonatal deaths reviewed where modifiable factors were attributed to a combination of (i) maternal smoking during pregnancy (ii) use of cannabis during pregnancy and (iii) maternal obesity. No actions were identified as appropriate referrals were made and CDOP acknowledged Warwickshire Public Health's ongoing campaign to reduce maternal smoking.

5.12 Learning identified where no modifiable factors were identified
Conversely there was learning and actions identified in reviews where no modifiable factors were identified, in other words, deaths which were not preventable, as follows:

5.12.1 Following the review of a young person at secondary school who had a known congenital heart disease, CDOP sought to establish the process for involving the School Nursing Service and how medical information was shared after it was ascertained that the School Nursing Service had not been fully involved. An action was identified for the Education Safeguarding Manager to write to all Head Teachers to remind schools to be proactive and link in with the School Nursing Service when a pupil has, or is diagnosed with a medical condition.

5.13 The review of a toddler who died unexpectedly from cardiac failure was admitted on three occasions in the month prior to their death. During admission the possibility of a heart condition was considered but not followed through. A root cause analysis conducted by the hospital concerned identified that there was (i) a delayed recognition of the development of cardiac failure (ii) an incomplete interpretation of an echocardiogram (ECG) conducted on the third admission (iii) a failure to regularly measure blood pressure and include this in the Paediatric Early Warning Score (PEWS - a system used in A&E and acute wards to assess the severity of symptoms according to the score).
(iv) use of single episode notes used on the ward leading to a lack of availability of past clinical records (v) a poor transfer of information across healthcare organisations leading to the over reliance on information from parents (vi) a different Consultant covering the ward each day resulting in a lack of continuity of care.

5.13.1 Some of the recommendations and actions made are as follows: (i) Implement a 'Consultant of the Week' system as part of the service design (ii) Implement a documented 'Consultant to Consultant' handover (iii) Improve the documented discharge processes to involve Parents/Guardians (iv) Improve healthcare records and improve accessibility to them (v) Ensure improved access to echocardiography for inpatients built into service redesign pathways (vi) Regular refreshment of all Paediatrician's ECG interpretation skills (vii) A refreshment of Clinical Staff's understanding of PEWS.

5.13.2 Having reviewed all of the information CDOP conclude that death would not have been preventable but the child's care would have been managed better if a diagnosis had been made sooner.

5.13.3 CDOP also identified that this was a poorly child who was under the care of a number of specialists and had been subject to numerous investigations and it was clearly documented that this child was distressed and in pain whilst in hospital. CDOP made an observation of the importance of taking into consideration a child's wellbeing when being investigated for medical conditions and wished this to be noted in the annual report. CDOP also identified an action that the learning be shared at a future Continuous Professional Development (CPD) meeting attended by Warwickshire Paediatricians.

5.14 In the review of a premature baby born at 23 weeks gestation who died from prematurity and sepsis contracted from Mum, it was known that Mum was taken to hospital by ambulance the day before giving birth, feeling unwell with a high temperature, abdominal pain and reduced fetal movements. Mum was given oral antibiotics and discharged home with a plan to be seen in the antenatal outpatients clinic the following day. Mum however was admitted again the following day via ambulance with pain and a high temperature and went into spontaneous labour. Resuscitation was attempted but due to the poor prognosis treat was withdrawn. This death was reviewed at the hospital's internal Clinical Incident meeting and the learning concluded that Mum should have been admitted following her first presentation to hospital and given intravenous antibiotics. Following the review it was also agreed to increase Consultant presence to 60 hours per week on the labour ward, providing an additional two Consultants. Feedback was also given to clinical and midwifery staff providing care to Mum.

5.14.1 CDOP concluded that this baby's death could not have been prevented but acknowledged the learning identified and actions put in place.

5.15 In the review of a neonate born prematurely at 27 weeks and diagnosed with a number of complex medical conditions following birth, the panel was aware that this baby had been diagnosed antenatally with a medical condition. Mum was referred to a specialist hospital but remained on a low risk Midwifery led care pathway. Although this did not contribute to baby's death, the panel concluded that Mum's risk should have been re-assessed and changed to Consultant led care. This was fed back to the hospital concerned and shared with staff.

5.16 In the review of a neonate born very early at 22 weeks gestation, CDOP noted that Father was used as an interpreter for Mum at the initial pre-booked antenatal appointment and on subsequent occasions. Whilst CDOP acknowledged that this may have to be the case in dynamic situations, the panel was concerned that an interpreter was not used at the first pre-booked appointment which inhibited the midwife booking the pregnancy to ask the routine question around domestic abuse. CDOP therefore wrote to the hospital concerned to clarify they had a policy on the use of interpreters (which they did) and to reinforce compliance with hospital staff.

5.17 In the review of a young person who was a front seat passenger in a stolen vehicle and ejected from the vehicle due to not wearing a seat belt, the panel was aware that this young person had a background of offending and risky behaviour and was known to Warwickshire Youth Justice Service (WYJS) as an active case at the time of death. In view of this WYJS conducted a 'Critical Learning Review' which was shared with CDOP. CDOP was also made aware of the complex family history of this young person as well as the young driver and passenger who survived the collision. The Operations Manager from WYJS and the Police Senior Investigating Officer attended to assist and contribute to the review. CDOP concluded that there were no modifiable factors however actions were identified to (i) ensure support for the family which included contact with the school to ascertain the well-being of surviving siblings and support offered (ii) enquiries to ensure that appropriate referrals and action were made and taken in relation to historical domestic violence (which they were). (iii) The Critical Learning Review also identified some internal learning for Warwickshire Youth Justice Service with regards to their processes and actions identified.

5.17.1 Every review is a holistic review, not just looking into the circumstances relating to death but also encompassing family and environment, parenting capacity, service provision and follow up plans for the family and this particular case demonstrates this, as well as the benefits of inviting professionals involved with the death and/or family to contribute to the review.

5.18 Miscellaneous actions:

5.18.1 A number of actions were identified to make contact with schools to ascertain the welfare and on-going support for bereaved siblings.

5.18.2 Actions were identified to ensure professional support was in place for bereaved parent(s).

5.18.3 Actions were also identified to ensure the safeguarding of siblings and effective communication between professionals.

15.8.4 A number of actions were identified for specific service providers, either to request additional information or feedback learning from reviews.

5.18.5 Warwickshire CDOP has made contact with the NHS Area Team with a view to securing GP representation on the panel, recognising that there is a gap in expertise in this area.

5.18.6 Dialogue is taking place with West Midlands Ambulance Service in relation to transporting deceased children to hospital as opposed to utilising undertakers which has impacted on the timeliness of obtaining necessary samples in some cases.

5.18.7 Specific actions were identified to raise awareness of the requirements of a multi-agency 'Rapid Response' investigation as per the Sudden and Unexpected Deaths in Children (SUDC) Protocol in deaths where the protocol was not followed.

5.18.8 A working group has been agreed to review the Warwickshire Multi Agency Sudden and Unexpected Deaths in Children (SUDC) Protocol.

Generic themes identified in the categories of deaths reviewed during 2013-2014

6 Neonatal deaths

As in the previous year, neonatal deaths were the highest category of deaths reviewed during 2013-2014 accounting for 36% (**31**out of **87**) of the total reviewed. Of the **31** deaths reviewed, modifiable factors were identified in **12** (39%) deaths and no modifiable factors were identified in **19** (61%). This ratio is slightly higher than 2012-2013 (31% modifiable, 69% no modifiable factors). In **9** out of **12** neonatal deaths reviewed where modifiable factors were identified, maternal smoking during pregnancy was identified as a contributory factor to premature labour and subsequent vulnerability of baby. To a lesser extent maternal obesity and maternal alcohol consumption and substance misuse during pregnancy were also contributory factors.

6.1 In the other 3 neonatal deaths reviewed where modifiable factors were identified, contributory factors were suboptimal intra-partum or neonatal care and access to health care as outlined in more detail in paragraphs 3 - 5.

6.2 The findings in 2013-2014 are in complete contrast to the previous year where in 2012-2013 the majority of modifiable factors (9 in 13 of deaths reviewed) related to service provision, compared to 4 out of 13 where modifiable factors attributed to maternal lifestyle.

6.3 We are fortunate as a sub-region to continue to have the complete co-operation of our local hospitals (and out of area hospitals for that matter) in providing their 'Root Cause Analysis' reports and action plans as well as feedback from internal review meetings, which greatly assists the CDOP review.

6.4 With regards to the number of neonatal deaths notified during 2013-2014, there were 43 neonatal deaths notified across the sub-region which is a collective increase of 28% across the region compared to 2012 -2013 (31 in 2013-13 and 43 in 2013-2014). The increases have notably risen in Solihull and Warwickshire.

7 Sudden and Unexpected Deaths

18 deaths were reviewed during 2013 – 2014 across the sub-region; the next highest category to neonatal deaths. **5** of the deaths reviewed occurred in the year 2011-2012 and were all subject of lengthy investigations, i.e. Police, Coronial, Serious Case Review, Significant Incident Learning Process (SILP), or a combination, prior to the CDOP review which accounts for the delay. **8** deaths occurred in 2012-2013 and **5** in 2013- 2014. A breakdown of the type or cause of death is as follows:

5 = Medical cause ascertained (i.e. previously undiagnosed heart condition, meningitis, and septicaemia)
5 = Road Traffic Collision
3 = Accidental death due to external factors (i.e. drowning, accidental asphyxiation and other trauma)
4 = Sudden Infant Death Syndrome
1 = Unlawful killing

7.1 With regards to the deaths from medical causes, all are outlined in paragraphs 3 - 5 as learning was identified from them all irrespective of whether modifiable factors were identified.

7.2 It is worthy of mention that the 3 deaths from a previously undiagnosed heart condition were all subject of ongoing tests, were in-patients in hospital either at the time of death or discharged shortly prior and in two cases a heart condition had been considered

whilst the children were in-patients but not pursued. It is also important to point out that this learning has, or will be, discussed and shared at internal Paediatric Continuous Professional Development meetings by the hospitals concerned.

7.3 Of the 5 deaths reviewed as a result of road traffic collisions, no patterns were identified with regards to location as they occurred in different areas (two outside the West Midlands region) and were a combination of passengers and drivers in a varied age group. That said, non- compliance with wearing seat belts by passengers was a contributory factor in 2 of the deaths.

7.3.1 Since the start of the child death review process in April 2008, CDOPs have reviewed a total of **5** deaths (including the 2 mentioned in 7.3) where the non-wearing of seatbelts was identified as a contributory factor. 4 occurred in the Coventry or Warwickshire area and one out of area. From the discussions at the review, police officers from the Road Fatality Investigation Unit, do routinely enforce the non-wearing of seatbelts and therefore no additional actions have been identified to date.

7.3.2 Two of the deaths from road traffic collisions were caused by collisions from the rear, due to the offending vehicle travelling too fast for the circumstances. In both cases the children that died were sitting in the rear, correctly restrained and in both cases the offending drivers were convicted of causing their deaths by dangerous driving.

7.3.3 CDOP has reviewed a total of **4** deaths caused by rear collisions since April 2008 (including the 2 mentioned in paragraph 7.3.2.) All of them occurred out of the sub-regional area, either on motorways or dual carriageways. It has been difficult for panels to identify any actions to prevent against these collisions but if there is anything positive to be gleaned from these tragic deaths, the offending drivers in all 4 deaths were convicted of causing death by dangerous driving and the dangers highlighted in the media.

7.4 *Rapid Response investigations*

7.4.1 **9** of the 18 unexpected deaths were subject of a multi-agency rapid response investigation under the Sudden and Unexpected Deaths in Children (SUDC) Protocol.

7.4.2 A further **5** (the 5 road traffic collisions) were subject of a police investigation on behalf of the Coroner. In 3 deaths prosecutions for causing death by dangerous driving followed. No prosecutions were pursued in the other two.

7.4.3 Of the remaining 4 deaths, **3** children died whilst either an inpatient or shortly after presentation at A&E. All were subject of an internal review conducted by the hospitals concerned and learning identified, as outlined in paragraphs 3.3.5, 5.9 and 5.13.

7.4.4 The remaining death occurred abroad whilst on a family holiday. Attempts were made to obtain information from the police where death occurred but unfortunately this was not forthcoming. Obtaining information on deaths occurring abroad is problematic and this is highlighted further under ‘Processes’ in paragraph 15.2

7.4.5 The 2012-2013 CDOP Annual Report highlighted a review where a ‘Rapid Response’ investigation was not initiated and an action was identified to raise awareness with the police. Rather than wait for the review which can take several months, any operational issues in relation to the multi-agency SUDC Protocol are now highlighted at the next available panel under ‘Operational Issues’ so that timely action can be initiated. The actions outlined in paragraphs 5.18.6- 5.18.8 relate to operational issues highlighted from deaths in 2013-2014 which are yet to be reviewed.

7.4.6 Further information on what a 'Rapid Response' investigation entails is outlined in Appendix 'D'.

7.5 Sudden Infant Death Syndrome (SIDS)

4 SIDS deaths were reviewed during 2013-2014. An unsafe sleeping environment i.e. co-sleeping with an adult in either an adult bed or on a sofa was identified as a contributory factor in all 4 deaths and in 2, maternal smoking was also a contributory factor.

7.5.1 The 2012-2013 CDOP Annual Report makes reference to work being conducted around implementing a SIDS Risk Assessment Tool which Community Midwives would complete at the first home visit post discharge, conduct a physical check of where baby sleeps (both night and day time sleeps) and agree an action plan with parent(s) if any risks are identified. The Health Visitor will then follow up and any other professionals involved with the family will also be made aware of any risks so that safe sleeping messages can be reinforced.

7.5.2 In November 2013 Solihull Public Health, Children's Health Team, organised a conference to highlight their priorities for 0-5 year olds which includes the prevention of SIDS. The conference was supported by The Lullaby Trust (formerly the Foundation into the Study of Infant Deaths) who gave an excellent presentation on the evidence based research on the risks and characteristics of SIDS. The conference was well attended by a good cross section of health professionals and was well received. It was proposed that Solihull Health Visiting Service would conduct the initial risk assessment at the primary visit and views were sought from delegates. This is still being considered by the Health Visiting Service.

7.5.3 In March 2014 the CDOP Manager arranged training for key Midwifery and Health Visiting leads from Coventry and Warwickshire so they could cascade the training within their own services. The training provided them with evidence based research on the risks of SIDS and the key elements of conducting the SIDS risk assessment. Delegates were also given Coventry and Warwickshire SIDS data from 2008- 2013, outlining the most prevalent risks. This was based on a model produced by Rotherham NHS which identifies the 15 most prevalent risks and characteristics of SIDS. Rotherham Public Health kindly transposed our local data onto their model free of charge, which is a useful tool for health professionals when conveying the risks to parent(s). (Data was produced for Coventry and Warwickshire only as Solihull figures are too small). The documents are linked to this report in paragraph 7.5.6

7.5.4 The CDOP Manager has also liaised with the Chair of the West Midlands Parent and Child Health Record (red book) Forum to get a risk assessment form bound into the red book. The CDOP Manager obtained consensus from the West Midlands to develop this and has formed a working group with representatives from the West Midlands region to progress this.

7.5.5 **30** SIDS deaths have been reviewed across the sub-region from 2008-2013 (14 each at Coventry and Warwickshire CDOP and 2 at Solihull CDOP). Of the 30, **27** (90%) were preventable with modifiable factors being identified. It is known that in **17** (57%) of deaths, parent(s) were given clear safe sleeping advice by a health professional which was not followed. That's not to say that advice wasn't given in the other 13 deaths but that it could not be verified by the information provided for the review. In many cases, parent(s) were considered to be vulnerable and/or leading chaotic lifestyles.

7.5.6 The following data highlights the risk factors and characteristics of the 30 SIDS reviewed, as per the Rotherham tool mentioned in paragraph 7.5.3:

- In 25 (83%) co-sleeping or an unsafe sleeping position was a contributory factor
- In 21 (70%) one or both parents smoked (15 were co-sleeping with baby at time of death)
- In 11 (37%) one or both parents had consumed alcohol prior to the death (8 were co-sleeping with baby at the time)
- In 5 (17%) one or both parents had taken an illegal substance prior to the death and in all 5 cases parent(s) were co-sleeping with their baby at the time of death

Characteristics of SIDS:

- In 21 (70%) deaths, parent(s) were living in poverty (unemployed or on low income)
- In 19 (63%) babies were not breastfed
- In 11 (37%) Mother had a history of mental ill health
- In 9 (30%) of deaths, Mothers were young, aged between 16-21 years

The full documents can be viewed by clicking on the following:


Coventry SIDS Data 2008-2013.pdf


Warwickshire SIDS Data 2008-2013.pdf

7.5.7 The above information only relates to the deaths that have been reviewed at CDOP. Further deaths did occur in 2013-2014 (and also in 2014-2015) which have the characteristics of SIDS but are still being investigated. Derbyshire and Stoke who have been conducting risk assessments for some time have seen a reduction in SIDS but it is difficult to quantify if this is wholly or partly due to the risk assessment. That said, the Lullaby Trust recognise this as good practice and are promoting its use across the county. We also know from our own data that safe sleeping messages are clearly not being followed and there is a will across the sub-region to address this.

8 Chromosomal, Genetic and Congenital Anomalies.

20 deaths reviewed during 2013-2014 came under this category. The vast majority were congenital defects identified antenatally or shortly after birth and where death occurred during the neonatal period. Modifiable factors were identified in **4** (20%) deaths, these being consanguinity; sub-optimal post discharge care following complex surgery (as outlined in paragraph 5.6) and two where maternal smoking and/or alcohol consumption during pregnancy were contributory factors. Learning and actions were also identified in deaths categorised as non-modifiable as outlined in paragraphs 3.3.5, 4.8, 5.12.1, 5.13 and 5.15.

9 Malignancy

8 deaths were reviewed during 2013-2014 with **1** identified as having modifiable factors (outlined in paragraph 5.4). In all deaths from malignancy, information is obtained from health practitioners to capture the timeline from early presentation(s) to referral, diagnosis and treatment in order to identify any learning. As outlined in paragraphs 3.3.1 and 4.7.1 learning was identified with regards to the recognition of 'red flag' symptoms of brain tumours and awareness being raised with GPs.

9.1 As in previous years, what has been consistent is the excellent cross-agency working between tertiary hospitals, GPs and community palliative care services in supporting the child/young person and their family during the end of life stage and again, as in previous years, the dedication of the Community Children's Nursing Teams and palliative leads in providing 24 hour care when required.

10 Trauma and other external factors

8 deaths were reviewed during 2013-2014, **5** as a result of road traffic collisions and the remainder were accidental. **5** of the 8 were identified as having modifiable factors which are referred to in paragraphs 3.2.2, 4.1 and 4.2.

11 Serious Case Reviews

Of the **78** deaths reviewed, **3 (**4%) were subject of a serious case review. Two of the deaths occurred in 2011-2012 and one in 2013-2014. One of the deaths is the remaining one reviewed during 2013-2014, referred to in paragraph 3.1.4.

12 Additional information on deaths reviewed where modifiable factors were identified

Of the **29** deaths reviewed during 2013-2014 where modifiable factors were identified, the following information provides a breakdown with regards to age, gender, ethnicity, category of death and place where events leading to death occurred.

12.1 *Age*

15 were 0-27 days, **5** were 28-364 days, **3** were 1-4 years and **3** were 15-17 years. The remainder are not categorised further because the number is too small and individuals might be identifiable.

12.2 *Gender*

15 were male and **14** female.

12.3 *Ethnicity*

23 were White British, **4** were of Asian origin. The remainder were too small a number to categorise.

12.4 *Category of death*

12 were categorised as death from a 'Perinatal/neonatal event', **6** from 'Trauma and other external factors', **4** from Chromosomal, Genetic and Congenital Anomalies and **4** from Sudden unexpected, unexplained death'. The remainder were too small a number to categorise.

12.5 P*lace of event which led to the child's death*

17 were in hospital at the time of death, either in the Neonatal Unit, Paediatric Intensive Care Unit or Delivery Suite. It should be noted that in **14** of these deaths, modifiable factors did not relate to the medical care given but were due to maternal lifestyle choices, i.e. smoking, obesity, drink or drug consumption during pregnancy and mother's physical condition which contributed to premature labour and vulnerability of the child. In the other **3** deaths prior medical intervention was a contributory factor.

12.5.1 Of the remaining deaths, **8** took place at the home address and **4** in a public place.

12.6. At the time of death **2** children were subject of Child Protection Plans. None of the deaths with modifiable factors identified were of asylum status.

13 West Midlands CDOP Region

Dr Ann Aukett the former Clinical Lead for Safeguarding Children NHS West Midlands and Chair of the West Midlands Regional CDOP Forum, produced a 4 year regional annual report covering 2008-2012 which was reported on in this annual report last year. A regional CDOP report for 2012-2013 is being produced by Birmingham Public Health but has not been completed in time for this annual report.

13.1 With the retirement of Dr Aukett and the reorganisation of the NHS, it was assumed that the West Midlands Regional CDOP Forum would be supported by the Maternity and Children's Service of the newly formed West Midlands Strategic Clinical Network. So as not to lose momentum, the CDOP Manager took on the role of Interim Chair and organised two regional meetings during 2013-2014. A business case was presented to the Strategic Clinical Network outlining the remit of the forum, work completed and ongoing work. The CDOP Manager also met with the Clinical Director of the Maternity and Children's Service and with Public Health, England (West Midlands) however a decision is yet to be made with regards to responsibility for the regional forum and who will chair it. This is unfortunate particularly as one of the key findings from a study in 2013 by the National Perinatal Epidemiology Unit, University of Oxford, commissioned by the Department for Education, related to the importance of regional working, as follows: "*There is evidence of beneficial regional sharing and learning between some CDOPs with meetings to exchange knowledge, information and concerns, and develop similar preventive approaches. However, this is not a universal activity. Furthermore, because of the demise of Regional Government Offices (RGOs) and NHS restructuring, organisations, such as RGOs and strategic health authorities, which arranged regional meetings in some areas in the past, no longer exist; regional leadership has yet to re-emerge. Recommendation: 'The continuation in some places and re-establishment in others of regional meetings is essential to facilitate shared learning across CDOPs. Funded national meetings would support one aspect of shared national learning and could be stand alone or form part of the remit of a national database provider.'*

14 National learning from deaths reviewed during 2013-2014

The annual returns on deaths reviewed during 2013-2014 were submitted to the Department for Education in May 2014, as requested. As this year's annual report is being produced earlier than in previous years it does not contain the DfE report. This is usually published by DfE towards the end of July and will be circulated separately when received.

15 Processes

15.1 *Involving families in the child death review process*

A protocol has been produced on how the sub-region will engage with families, which has been endorsed by the three Local Safeguarding Children's Boards. The sub-region has agreed that an appropriate professional will be identified to inform families in person and give them the opportunity of contributing to the review and/or asking any questions. Where a professional is no longer involved with the family, the CDOP Manager will make contact in writing. A sub-regional information leaflet has been produced for families which explains the process and also provides details of support organisations.

15.1.1 The CDOP Manager prepared a briefing note for professionals to assist with this process and met /made contact with key professionals to explain the process and their responsibility. The process was implemented on 1 July 2013 and as of 31 March 2014, the end of the reporting year, **65** families were informed and given leaflets. In **48** deaths (74%), the leaflet was given to the family by a professional known to the family and/or involved in the death. Of the 48, 2 (4%) have provided information to the CDOP review. In the other 17 deaths (26%), a leaflet was sent directly to parent(s) by the CDOP Manager with a covering letter as a professional was no longer involved with the family. Of the 17 deaths, 6 (35%) families have responded. In addition to this, 2 families made contact with the CDOP Manager prior to the start of the process and contributed information.

15.1.2 In all cases where families responded they had concerns and questions they wished to ask. This information was sought from professionals and answers provided to them. Having the perspective of families has added value to the reviews in the following ways:

15.1.3 Additional information has been provided by parents that would not have been known to the panel by gathering information from professionals only. This has resulted in:

(i) More learning being identified with regards to service provision and actions identified as a result

(ii) The panels being made aware of complaints made by parents and other reviews being undertaken, that would not have been readily known without parents' information

(iii) Recommendations have been suggested to the panel, with those more appropriate as national recommendations forwarded to the Department for Education

(iv) Parents' perspective on the rapid response process in unexpected and unexplained deaths and contact with specific agencies, both positive and negative.

15.2 *Deaths occurring abroad:*

To date the sub-region has reviewed 2 deaths where children have died abroad whilst on holiday visiting relatives. In the first death the child and family were under the care of a local paediatrician so information with regards to the circumstances and hospital involved were by obtained by the paediatrician from the family. In the second death, the CDOP Manager only became aware of the death through the media. Contact was made with the Foreign and Commonwealth Office who were not aware of the death and suggested contacting the police directly in the country where the death occurred. This was done twice, with no response. The information provided to the review on the circumstances of death was therefore taken solely from reports in the local and national British media.

15.2.1 From discussions at the West Midlands Regional CDOP forum, this is a problem across the whole region (and no doubt across the country) and extremely frustrating to say the least when the information can be obtained by the media but not by a statutory body. Unfortunately Working Together to Safeguard Children 2013, our statutory guidance, is non-specific, stating 'LSCBs should use sources available, such as professional contacts or the media, to find out about cases when a child who is normally resident in their area dies abroad.'

15.2.2 West Midlands Police informed the Regional CDOP Forum in September 2013 that West Mercia Police were leading on a proposal being put to the Association of Chief Police Officers (ACPO) for the police to be specific points of contact for countries when UK citizens die (contact would be with the police area covering the home address) who would then conduct safeguarding checks and notify all agencies. An update on this proposal has been requested from West Midlands Police

15.3 *Assisted conception:*

Following the review of a neonate conceived by assisted conception, the panel felt they didn't have sufficient information on the rationale used by the fertility service when implanting embryos. It was therefore agreed that where it is known that pregnancy resulted from assisted conception, information will be requested from the fertility service involved as we do for other medical information.

15.4 *Independent neonatologists attending neonatal reviews:*

In 2013 the West Midlands Strategic Clinical Network, Maternity and Children's Service canvassed all CDOPs in the West Midlands region on how they reviewed neonatal deaths. Following a submission of our sub-regional process the CDOP Manager was invited to a meeting with the Clinical Lead, Central Newborn Network as it was ascertained that our sub-regional CDOPs were further ahead in reviewing neonatal deaths than other areas. The Central Newborn Network is keen to be involved in the review of neonatal deaths at CDOPs and is proposing that Consultant Neonatologists attend CDOP reviews away from their host Trust to provide an independent view. It was

suggested that our sub-region could 'pilot' this in the first instance. Whilst we are fortunate that our local Consultant Neonatologists are very objective, they cannot always attend CDOPs so the sub-region welcomes the opportunity of trialling this proposal.

15.5 *Dissemination of CDOP learning to support the Learning and Improvement Framework:* Learning identified at individual CDOPs is routinely shared across the sub-region and actions replicated as illustrated in the learning identified in paragraphs 3 – 5. Where appropriate, learning and recommendations are also shared wider with other CDOPs across the country and this will continue. When actions are identified to share learning the CDOP Manager will follow these through to ensure that the learning has been shared. CDOPs will also ascertain how individual organisations ensure that the learning is disseminated to all professionals.

15.6 *CDOP Membership:*
The new Head of Safeguarding at West Midlands Ambulance Service (WMAS) has offered to become a permanent member of sub-regional CDOPS and attend when cases involving WMAS are being reviewed. This is very welcomed and will further enhance the exchange of information when queries or actions arise in relation to WMAS.

15.7 *Collating information for the child death review process:*
Excellent co-operation in providing information continues across the sub-region and beyond. A detailed covering letter sent to GPs explaining why certain information is required has improved the information received from GPs.

15.8 *Collation of national child death data and national CDOP learning:*
The absence of a national database to collate national child death data and national learning/recommendations was reported in last year's annual report and despite the Department for Education commissioning work in this area and issuing a statement in 2013 that it will be progressed, no update has been received to date. The only indication that this is being progressed was given by the Secretary of State, Mr Gove who alluded to this in his response to Coventry LSCB as outlined in paragraph 3.1, stating; 'The Department of Health is leading on work to establish a database which will enable the collection, analysis, interpretation and reporting at a national level of the data produced by Child Death Overview Panels. We anticipate that this will provide a good basis at national level for considering deaths from specific conditions, including those associated with co-sleeping.'

15.9 The generic form used to record the findings of the review (known as Form C) was reviewed by the Department for Education in 2011, but as reviews and learning have evolved the form is no longer adequate to record all information, particularly around prematurity. There is no 'tick box' to record prematurity and the other boxes do not accurately reflect conditions intrinsic to premature babies. Parents' mental/emotional/ behavioural condition is catered for but not physical conditions, therefore obesity, or other physical conditions contributing to the prematurity and vulnerability of baby have no specific place for recording. The CDOP Manager has fed this back to the Department for Education on three occasions but it appears that there is no one at DfE responsible for driving or changing processes.

16 CDOP Working Group

The CDOP Working Group, formed in 2007 to progress the operational elements of the child death review process met twice during 2013-2014. All on-going work is reflected in the CDOP Manager's work plan, which is monitored by the CDOP Working Group.

17 CDOP Budget

17.1 Expenditure 2013 – 2014

Salaries: CDOP Manager and CDOP Officer.		£59 119
Staff travel		£786
Office costs (stationary, photocopying, phones, IT charges.)		£2894
Printing (Leaflet for parents)		£166
Contribution from Warwickshire	£26 000	
Contribution from Solihull	£13 000	
Contribution from Coventry	£24800	
Total Income	**£63800**	
Total expenditure		**£62965**

18 Sub-Regional data on child deaths notified in 2013 – 2014

18.1 During 2013-2014, **81** deaths were notified to the child death review process across the sub-region, a 20% increase compared to the **65** deaths notified in 2012-2013. The data contained in Appendix 'E' gives a breakdown of deaths reported year on year. The increases have been seen in the following categories:

18.2 *Neonatal deaths*
Both Solihull and Warwickshire have seen an increase in Neonatal deaths compared to 2012-2013. Solihull's have doubled (5 in 2012-2013 and 10 in 2013-2014). Warwickshire has seen a slight increase (13 in 2012-2013 and 19 in 2013-2014). Coventry has remained fairly static (13 in 2012-2013 and 14 in 2013-2014).

18.3 *Sudden and Unexpected Deaths*
Warwickshire has seen an increase in the number of sudden and unexpected deaths, (6 in 2012-2013 and 10 in 2013-2014) the increase has been in deaths from Sudden Infant Death Syndrome (SIDS). Warwickshire were fortunate not to have had any SIDS in the previous 2 years, i.e. 2011-2012 and 2012-2013 but had 3 in 2013-2014. The other slight increase was due to external factors (2 in 2012-2013, a drowning and road traffic collision and 4 in 2013-2014, 3 road traffic collisions and 1 non-accidental injury).

18.4 Coventry's sudden and unexpected deaths remained static. Solihull saw a reduction in their sudden and unexpected deaths.

18.5 *Life Limiting Conditions*
Warwickshire has seen an increase in the number of deaths from life limiting conditions (2 in 2012-2013 and 9 in 2013-2014) however no inferences can be drawn from this.

18.6 Coventry and Solihull's have remained fairly static.

18.7 A breakdown of all categories year on year is contained in Appendix 'E' and a breakdown of the types of sudden and unexpected deaths year on year is outlined in Appendix 'F'.

18.8 Although these figures have been reported on it must be emphasised that we are dealing with very small numbers and no real inference can be drawn from them.

18.9 Sub-regional deaths by Category 2013-2014 (Total 81)

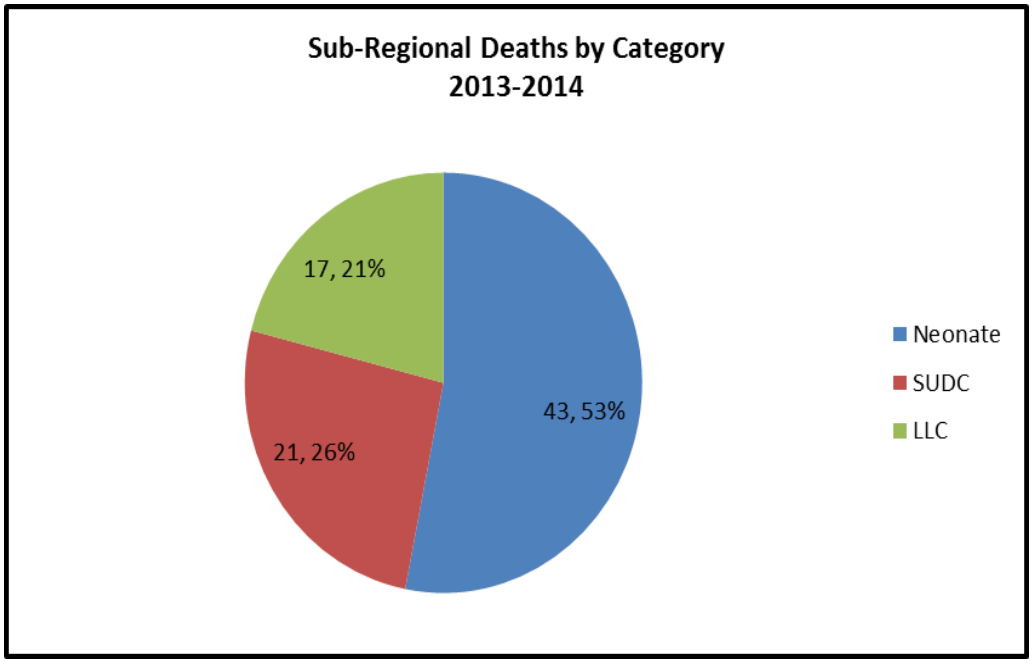
Definitions of the categories used are as follows:

Neonate: 0-28 days of age very often born prematurely and in the vast majority of cases have never left hospital.

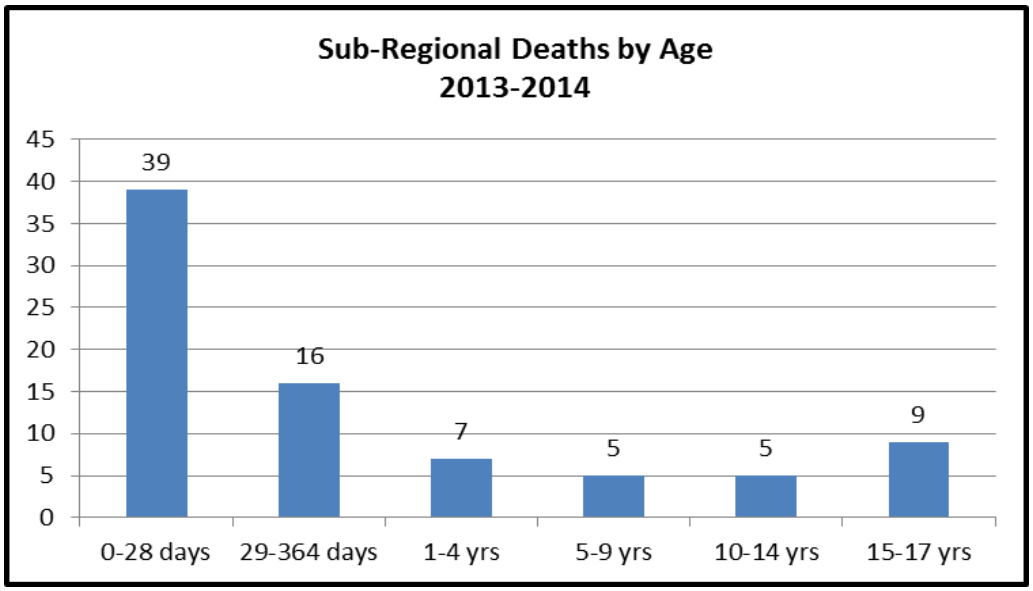
SUDC – Sudden and Unexpected Death requiring an Inquest to establish cause of death and where either a multi-agency 'Rapid Response' investigation under the SUDC Protocol has been conducted or a police investigation.

Medical - An unexpected death but where the cause of death is known and a death certificate is issued, e.g. epilepsy, asthma.

LLC – expected death from a life limiting condition where the cause of death is known and a death certificate is issued.

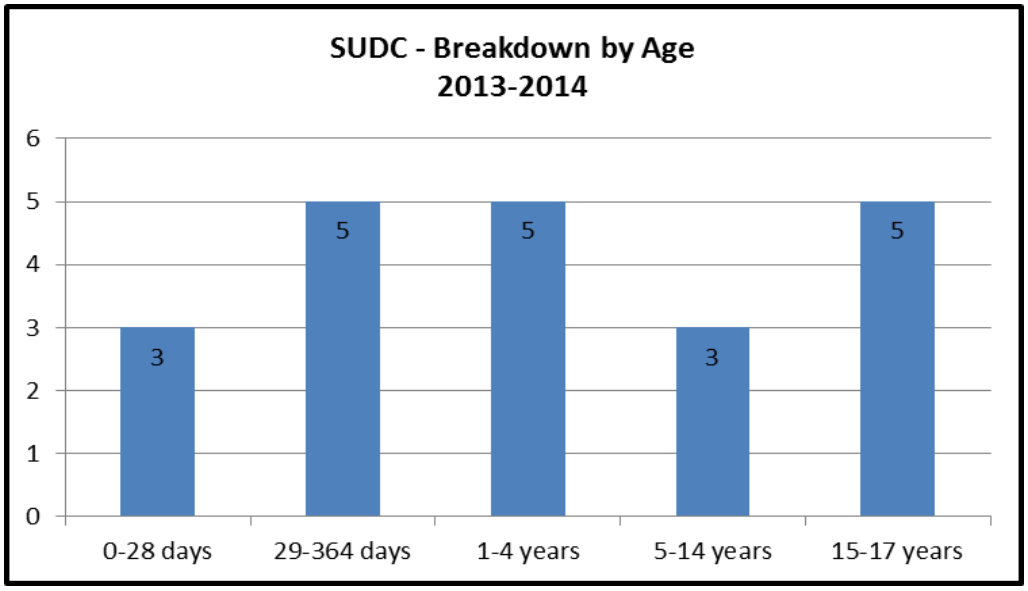


18.10 Sub-regional Deaths by Age 2013-2014 (Total 81)



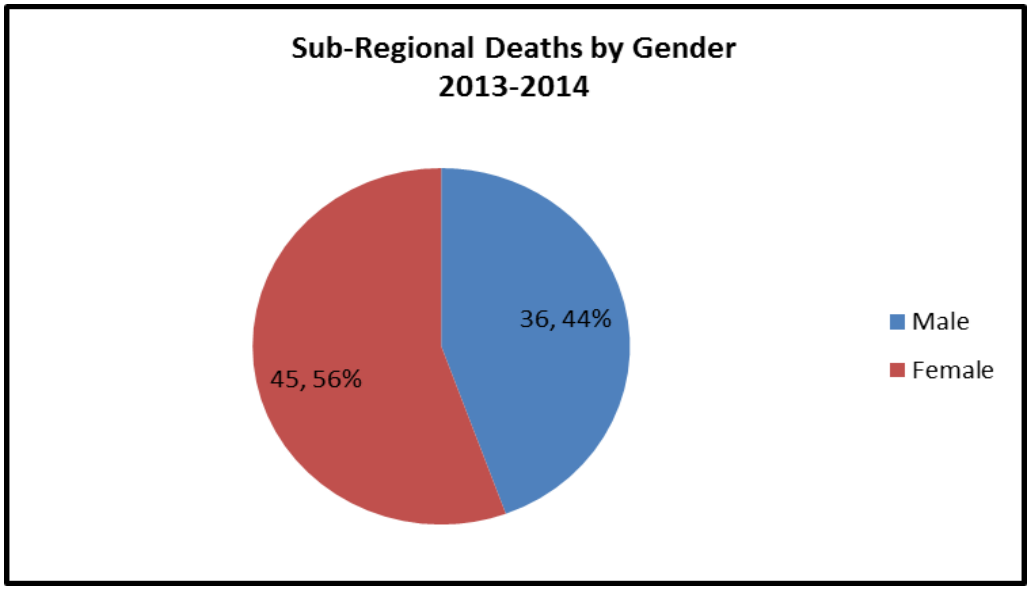
18.11 The breakdown of ages in 2013-2014 mirrors that of 2012-2013 in the first 5 groups. The variance is in the 15-17 year group which is the 3rd highest category in 2013-2014 compared to being joint lowest in 2012-2013 (with the 5-9 year category). The reason for this is that 2 deaths from an unexpected medical condition were aged in this group as were 3 of the young persons who died in road traffic collisions.

18.12 The following chart gives a breakdown by age of the sudden and unexpected deaths notified in 2013-2014. N.B. Not all of have been reviewed.



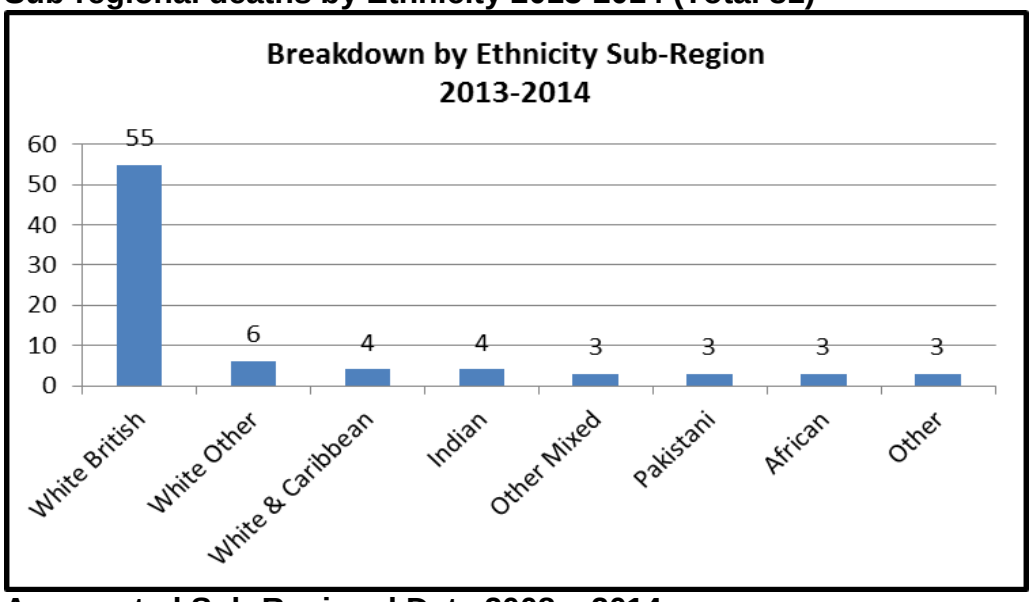
18.13. **0-28 days:** **2** SIDS and **1** medical cause
29 – 364 days: **4** SIDS and **1** medical cause
1-4 years: **3** external (drowning and non-accidental injury) and **2** medical
5-14 years: **2** medical and **1** external (RTC) (5-9 and 10-14 ages combined)
15-17 years: **3** external (RTC) and **2** from medical causes

18.14 Sub-Regional Deaths by Gender 2013-2014 (Total 81)



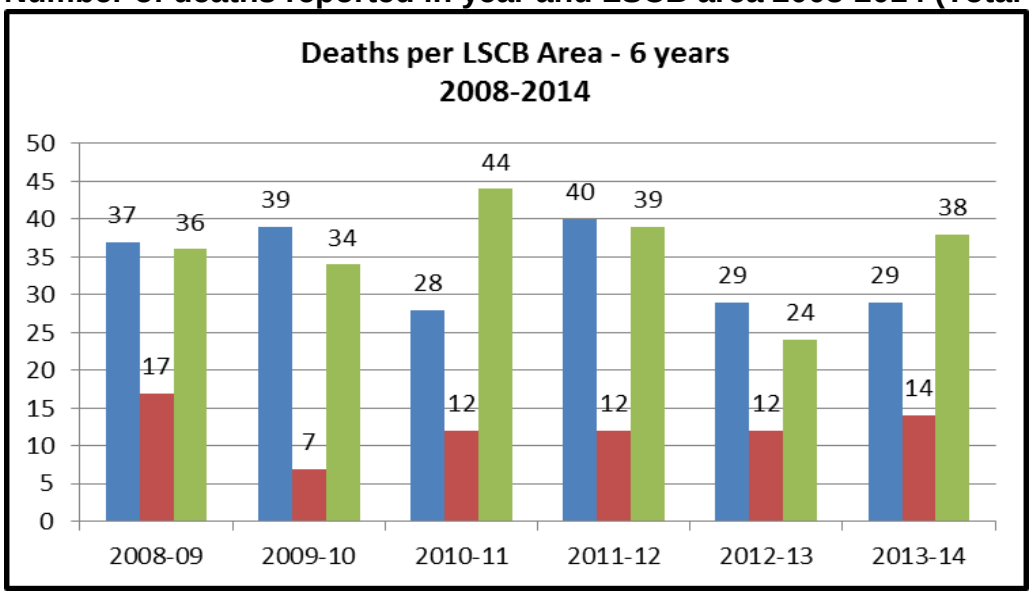
18.15 Regional and national data for 2013-2014 is not yet available however trends in previous years have shown more male than female deaths. Our sub-regional data for this year, 2013-2014, therefore bucks this trend by having more female than male deaths.

18.16 Sub-regional deaths by Ethnicity 2013-2014 (Total 81)

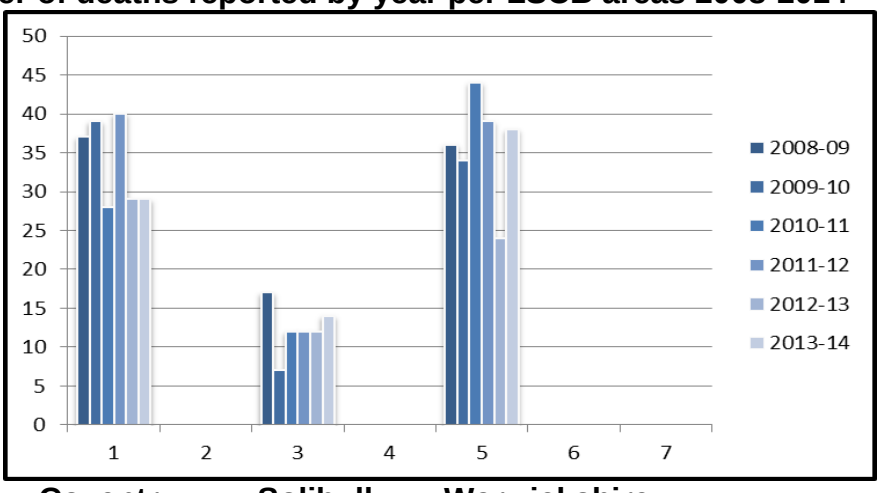


19 Aggregated Sub-Regional Data 2008 – 2014

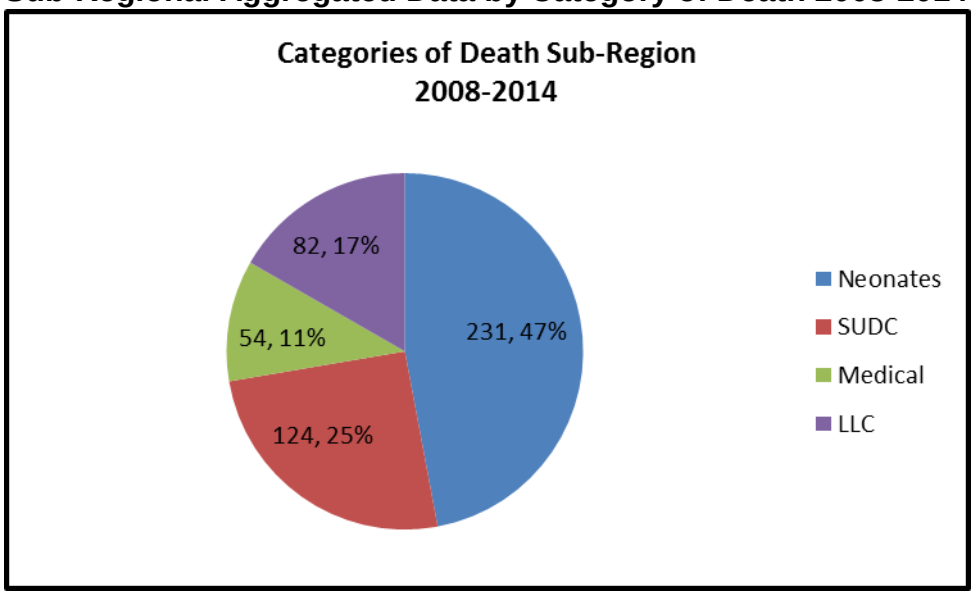
19.1 Number of deaths reported in year and LSCB area 2008-2014 (Total 491)



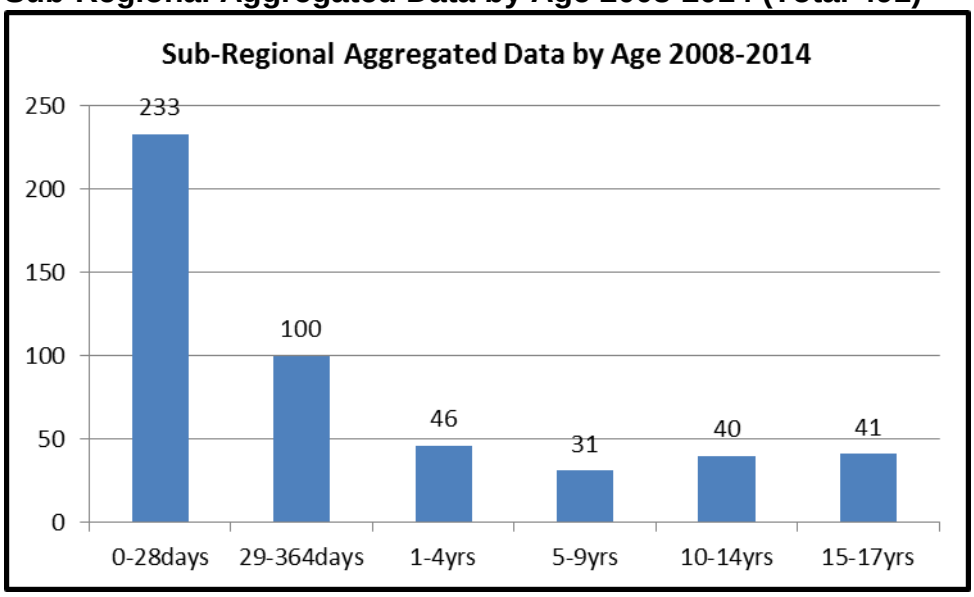
19.2 Number of deaths reported by year per LSCB areas 2008-2014



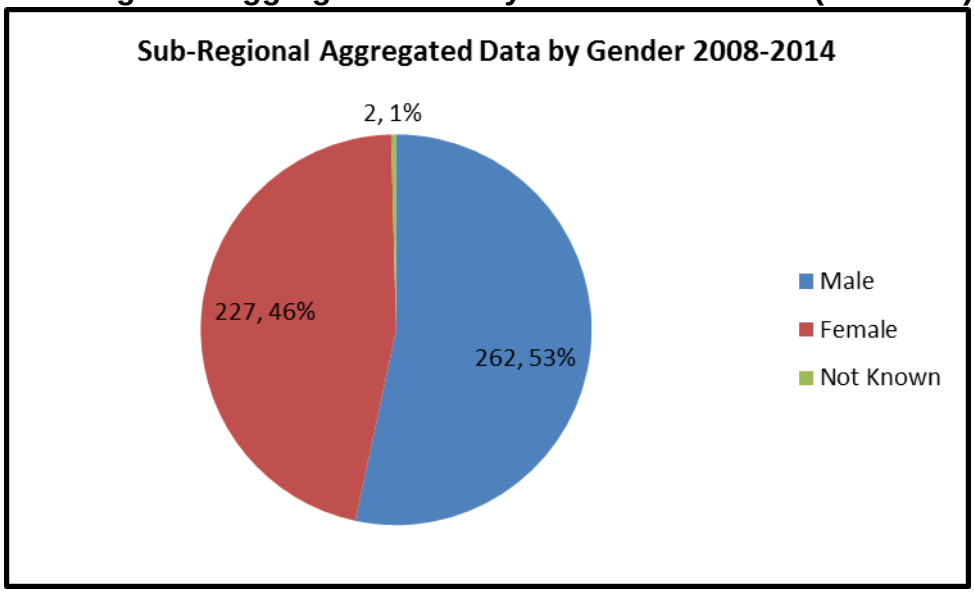
19.3 Sub-Regional Aggregated Data by Category of Death 2008-2014 (Total 491)



19.4 Sub-Regional Aggregated Data by Age 2008-2014 (Total 491)

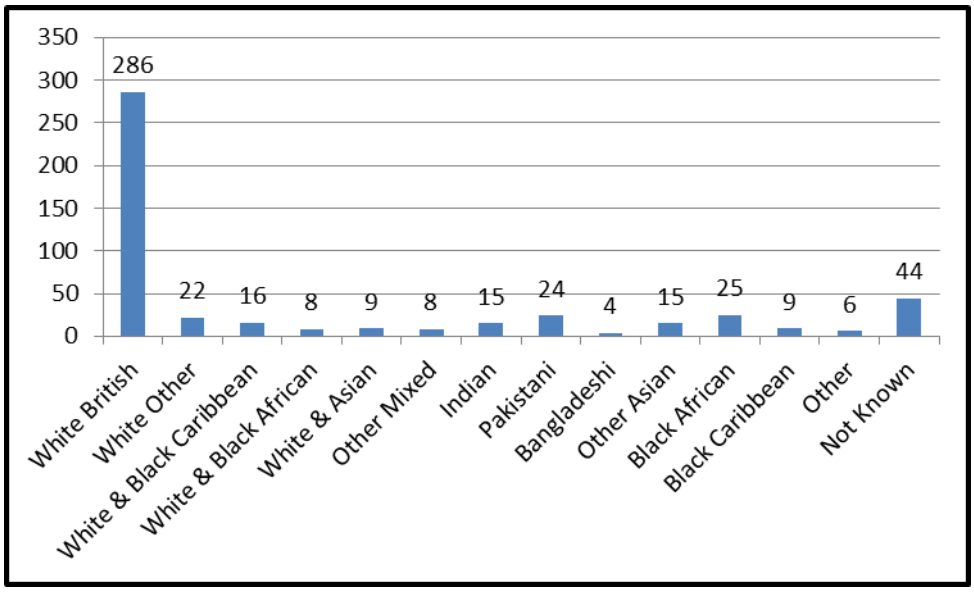


19.5 Sub-Regional Aggregated Data by Gender 2008-2014 (Total 491)



19.5.1 The 2 unknown were extreme premature babies where gender could not be determined.

19.6 Sub-Regional Aggregated Data by Ethnicity 2008-2014 (Total 491)



19.6.1 The 'Not Known' are deaths from 2008-2009 and a few from 2009-2010 when ethnicity was not requested on the national template forms. This changed in early 2009-2010 and ethnicity has been captured since.

Author: **Dara Lloyd**
Child Death Overview Panel Manager for,
Coventry, Solihull and Warwickshire

Appendix 'A'

Coventry Child Death Overview Panel

1 CDOP Members during 2013-2014:

John Forde, Consultant in Public Health (Chair)
Gillian Attree, Named Nurse for Child Protection, UHCW
Dr Supratik Chakraborty, Consultant Paediatrician (Community)
Lesley Cleaver, Support Nurse for Vulnerable Families
Detective Inspector Chris Hanson/ Jayne Gooderidge, West Midlands Police
Sandra Kerr, Manager, Children's Social Care
Nichola Lamb, Named Midwife for Safeguarding, UHCW
Jayne Phelps, Designated Nurse for Child Protection
Amanda Reynolds, Manager, Early Years
Dr Brian Shields, Consultant Paediatrician (Acute Services) UHCW
Dr Miriam Wood, GP

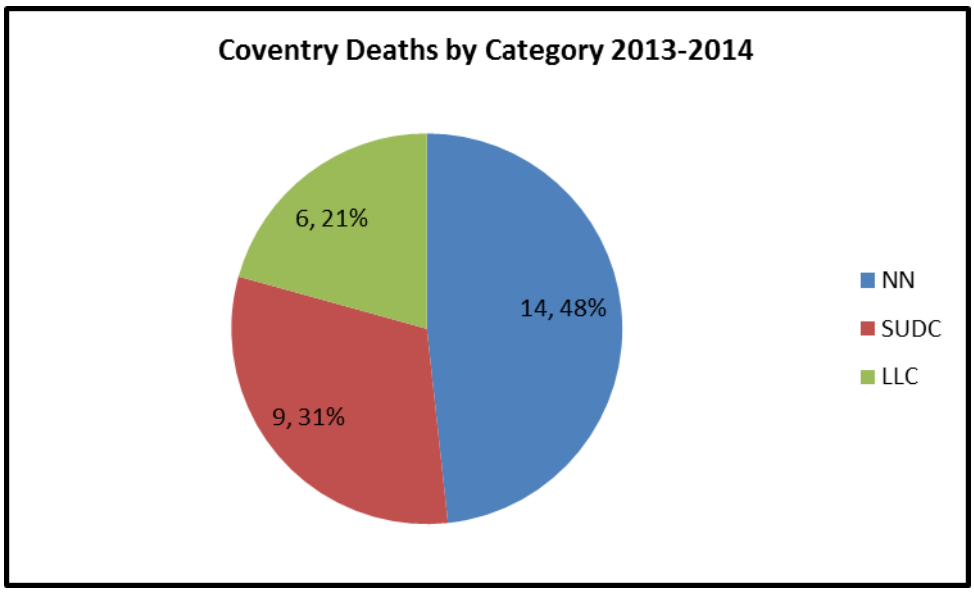
1.1 Co-opted Members:
Dr Kate Blake, Consultant Neonatologist

2 Details of the number of CDOPs held and the number of deaths reviewed is outlined in in paragraph 2 of the annual report. One CDOP meeting was cancelled (August 2013) as there were not enough cases ready to make the meeting viable. A summary of the recommendations and actions arising from Coventry CDOP are outlined in paragraph 3.

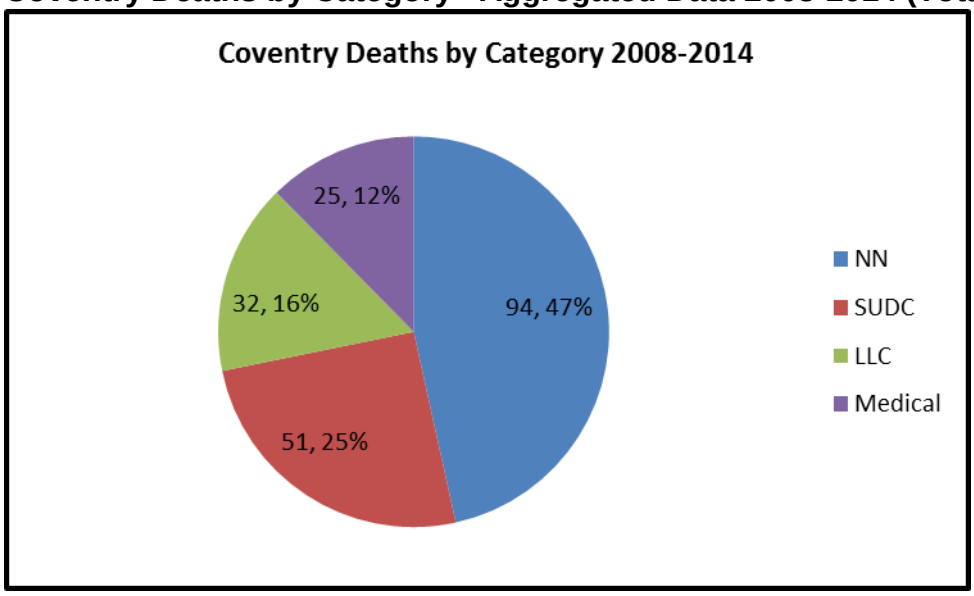
3 **Coventry Child Death Data:**
29 deaths were notified in 2013-2014, the same number as in 2012-2013. Deaths reported year on year since the process began in 2008 are shown in paragraph 19.1.

3.1 Categories that have a total of 2 or less have been merged in accordance with disclosure control guidance issued by the NHS Information Centre for Health and Social Care.

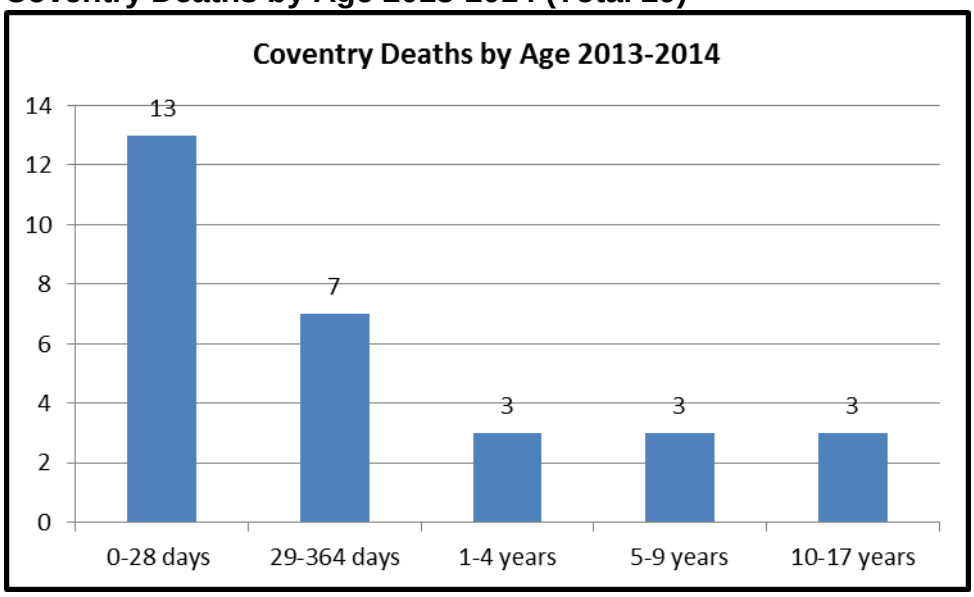
3.2 Coventry Deaths by Category 2013-2014 (Total 29)



3.3 Coventry Deaths by Category– Aggregated Data 2008-2014 (Total 202)

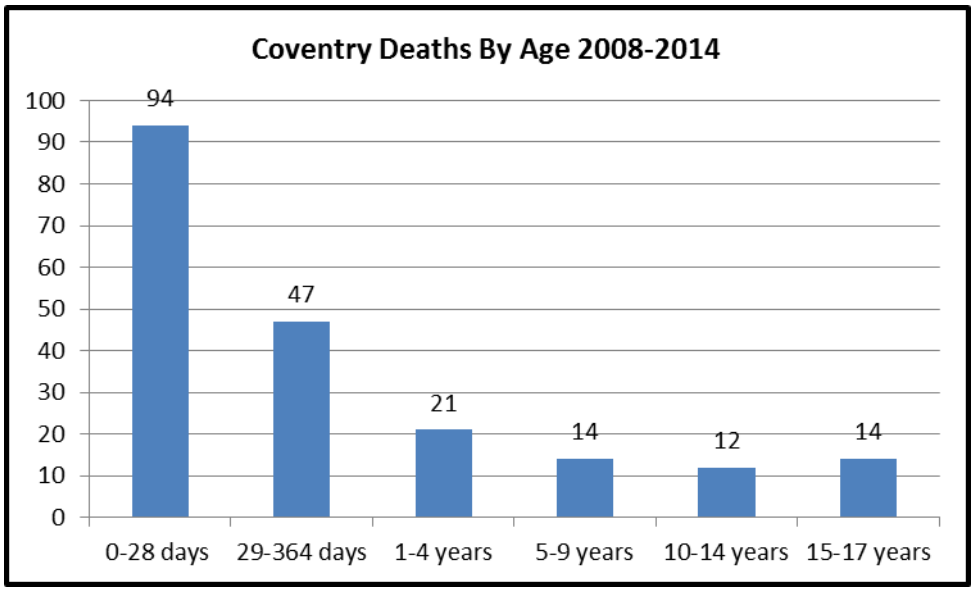


3.4 Coventry Deaths by Age 2013-2014 (Total 29)

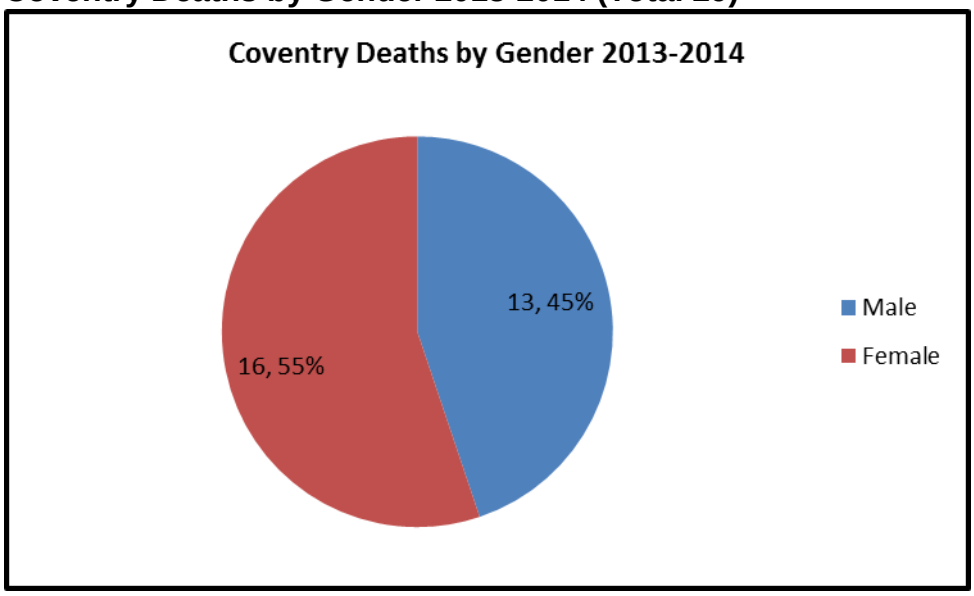


Age groups 10-14 and 15-17 years have been merged due to the low numbers.

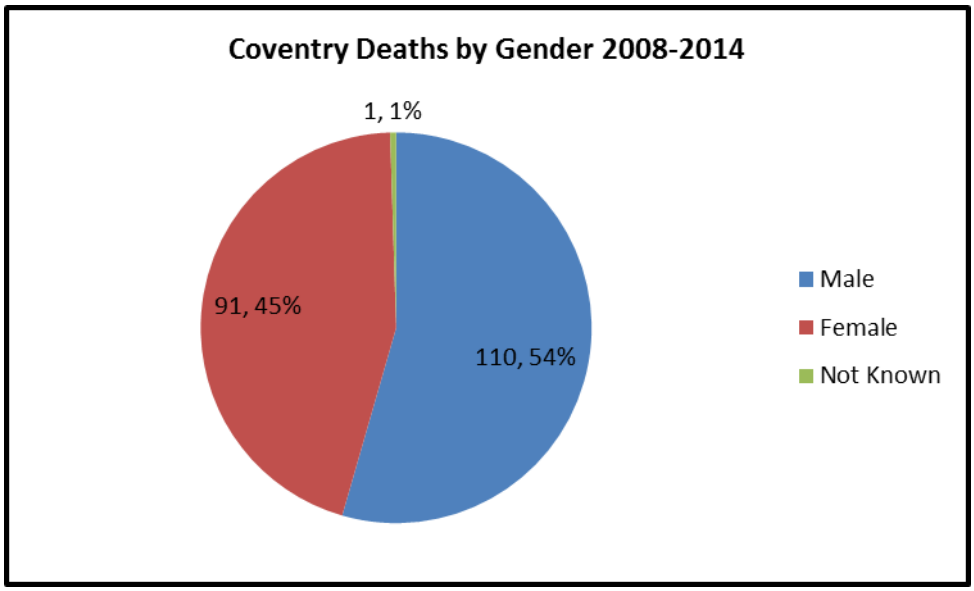
3.5 Coventry Deaths by Age - Aggregated Data 2008-2014 (Total 202)



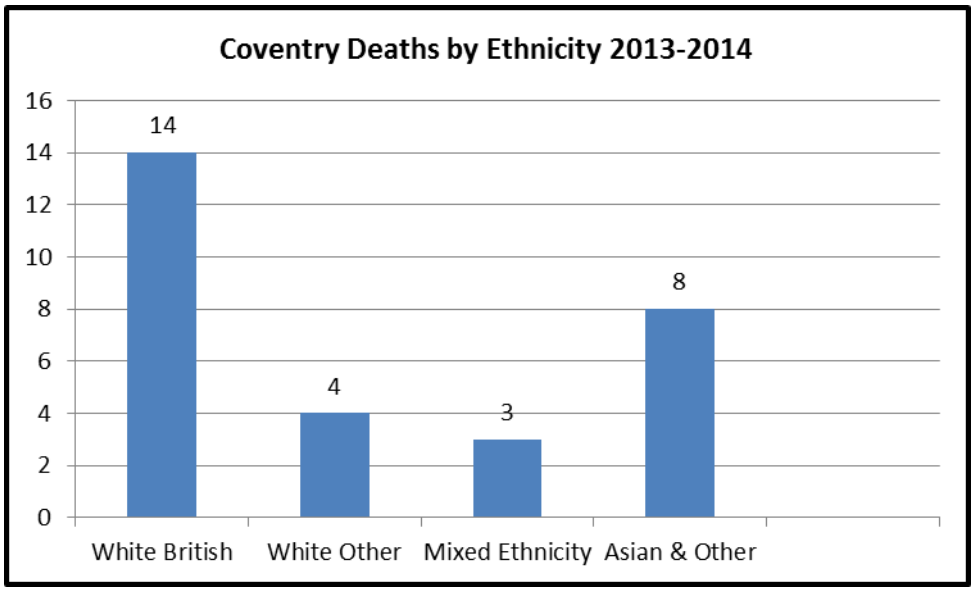
3.6 Coventry Deaths by Gender 2013-2014 (Total 29)



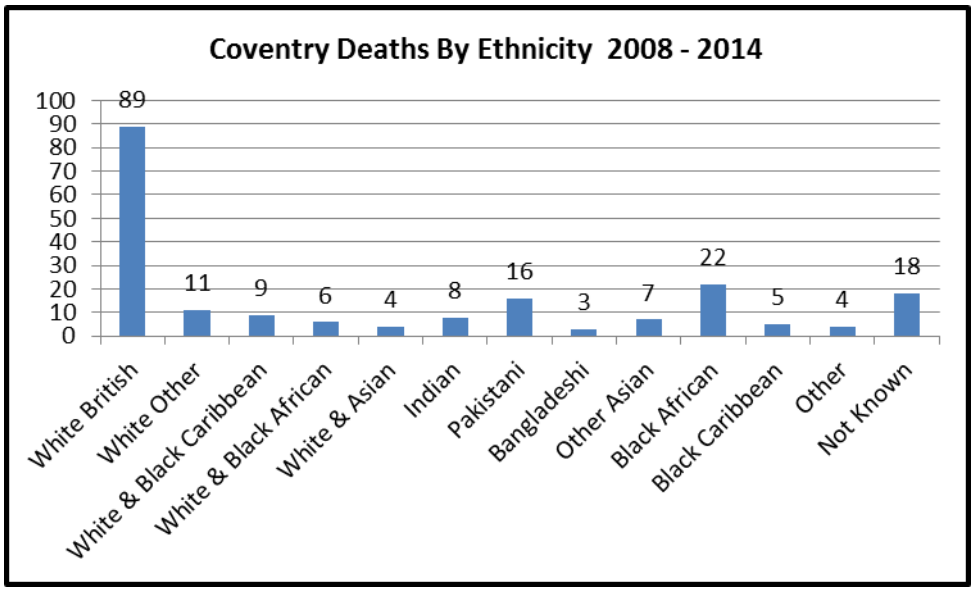
3.7 Coventry Deaths by Gender – Aggregated Data 2008-2014 (Total 202)



3.8 Coventry Deaths by Ethnicity 2013 – 2014 (Total 29)



3.9 Coventry Deaths by Ethnicity – Aggregated Data 2008 – 2014 (Total 202)



4 Summary:

4.1 Neonatal deaths continue to be the highest category as expected.

4.2 The highest age group is 0-28 days which incorporates the neonatal deaths and therefore expected.

4.3 The graph in 3.2 shows 14 neonatal deaths but the graph in 3.4 showing a breakdown of ages shows there were 13 aged 0-28 days. The reason for this is that one neonate lived outside the 28 days but was still categorised as a neonatal death as the child was born prematurely and never left hospital.

4.4 Looking at the 6 year data, 70% of deaths (141 out of 202) occurred within the first year of life. This is also mirrored by Solihull and Warwickshire.

4.5 Coventry has bucked the national and regional trend regarding gender in 2013-2014 but aggregated data for 2008-2014 shows overall more male deaths than female deaths which is in keeping with national and regional trends.

4.6 With regards to ethnicity, children of White British' origin remains the highest category. Children of 'White Other' origin has shown a slight increase since 2011 which may be due to the increase in population from Eastern European countries.

4.7 The 'Not Known' are deaths from 2008-2009 and a few from 2009-2010 when ethnicity was not requested on the national template forms. This changed in early 2009-2010 and ethnicity has been captured since.

Appendix 'B'

Solihull Child Death Overview Panel

1 CDOP Members during 2013-2014:

Ian Mather, Consultant in Public Health (Chair)
Paul Nash, Solihull LSCB (Vice Chair)
Alison Frost, Team Leader, Solihull MBC Legal Services
Detective Inspector Jayne Gooderidge / Jim Foy
Steve Martin, Chief Education Welfare Officer / Mohammed Bham, Principle Education Psychologist
Carol Owen, Midwifery Services, Heartlands Hospital
Eleni Prodromou, Assistant Team Manager, Solihull Children's Social Care
Dr Alan Stanton, Consultant Paediatrician (Community)

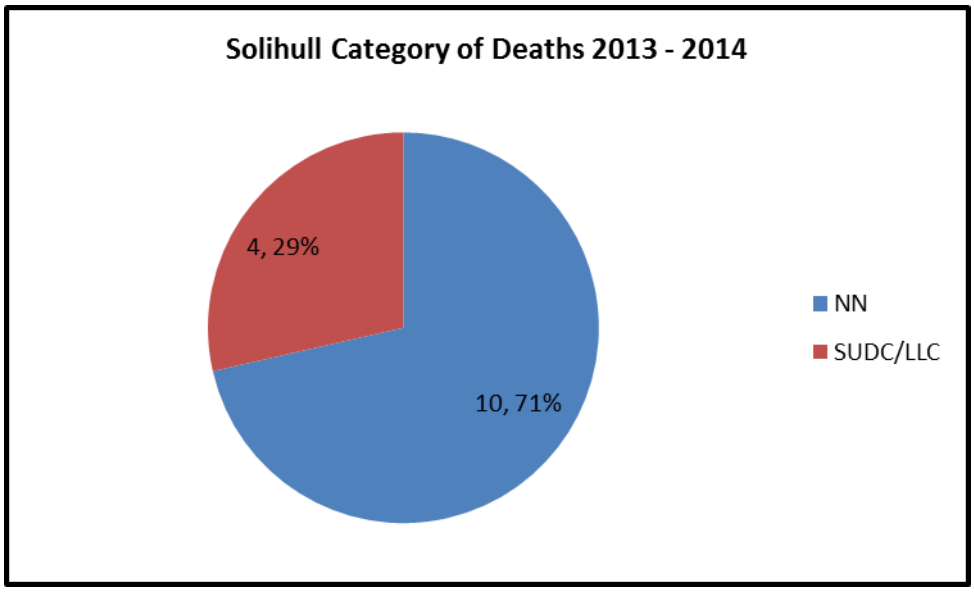
1.1 Co-opted member:
Dr Richard Mupanemunda, Consultant Neonatologist, Heartlands Hospital.

2 Details of the number of CDOPs held and the number of deaths reviewed is outlined in in paragraph 2 of the annual report. To date it has not been necessary to convene a Fast Track CDOP but this will be considered if the numbers demand. A summary of the recommendations and actions arising from Solihull CDOP are outlined in paragraph 4.

3 Solihull Child Death Data
14 deaths were notified in 2013-2014, a small increase on the **12** deaths notified in 2012-2013. Deaths reported year on year since the process began in 2008 are shown in paragraph 19.1.

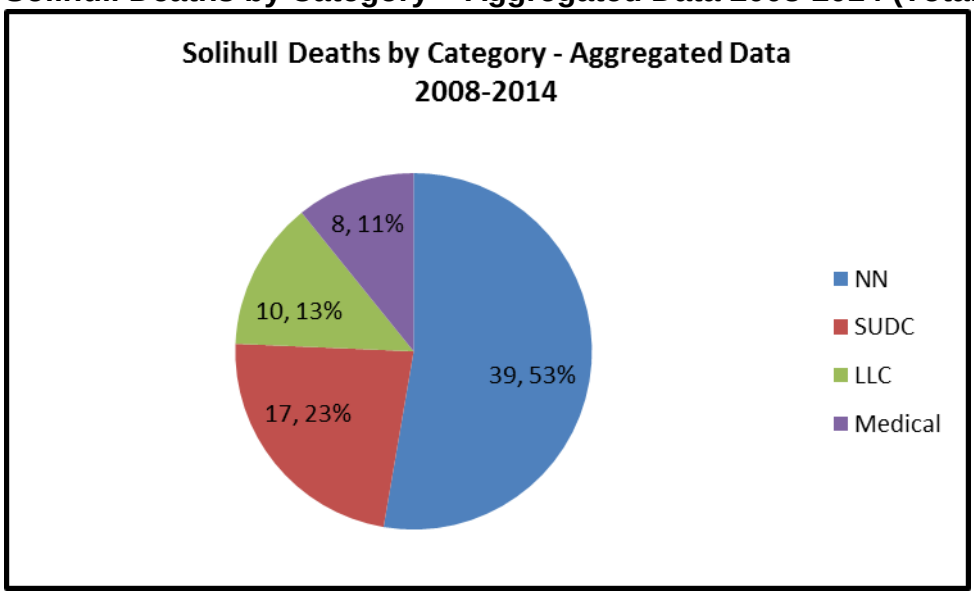
3.1 Categories that have a total of 2 or less have been merged in accordance with disclosure control guidance issued by the NHS Information Centre for Health and Social Care.

3.2 Solihull Deaths by Category 2013-2014 (Total 14)

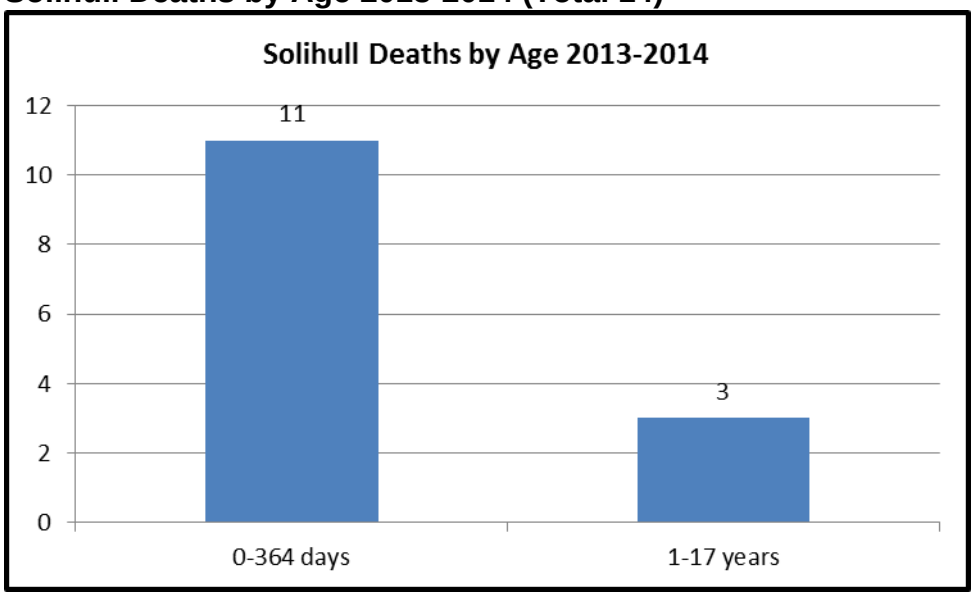


3.2.1 Categories of SUDC and Life Limiting Conditions have been grouped together due to the low numbers.

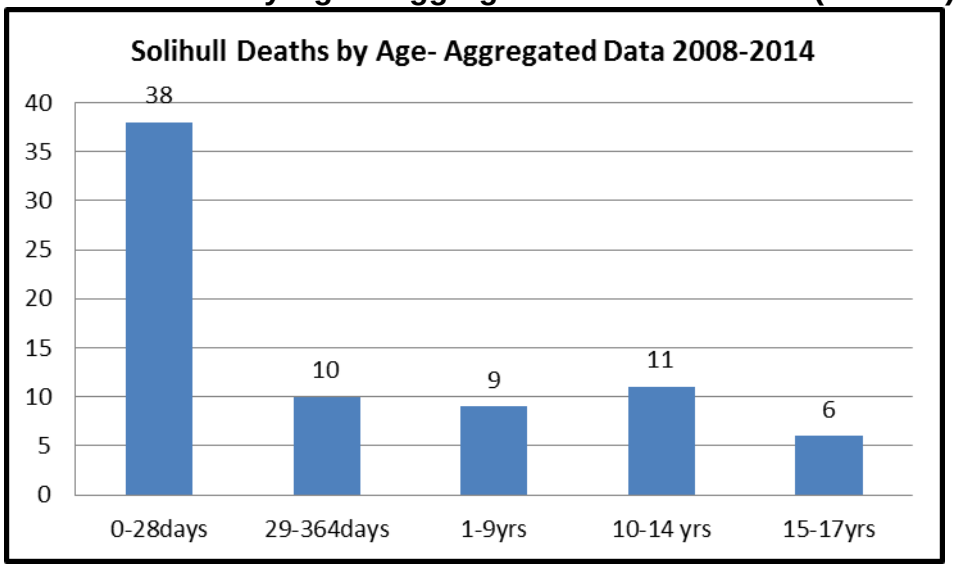
3.3 Solihull Deaths by Category – Aggregated Data 2008-2014 (Total 74)



3.4 Solihull Deaths by Age 2013-2014 (Total 14)

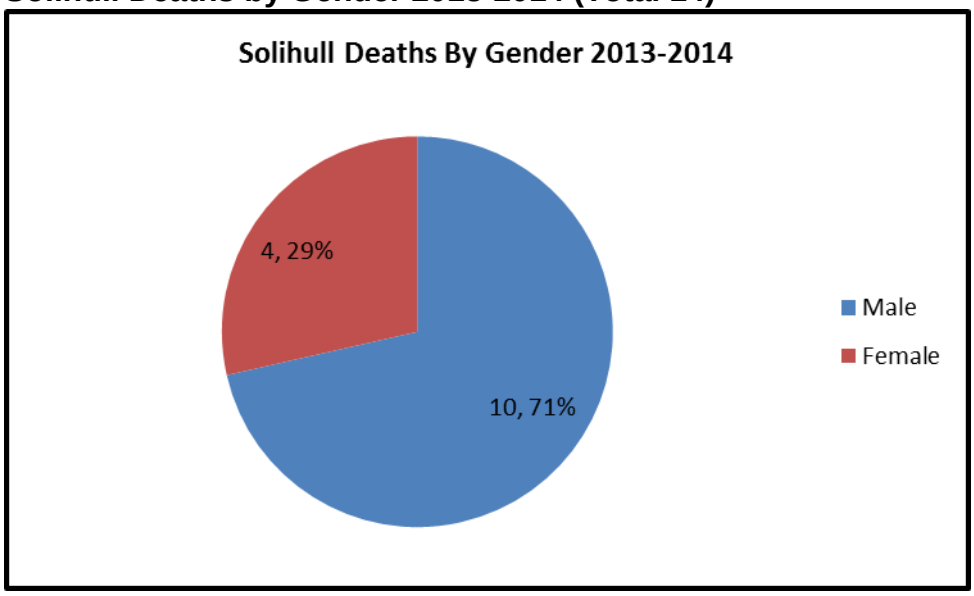


3.5 Solihull Deaths by Age – Aggregated Data 2008-2014 (Total 74)

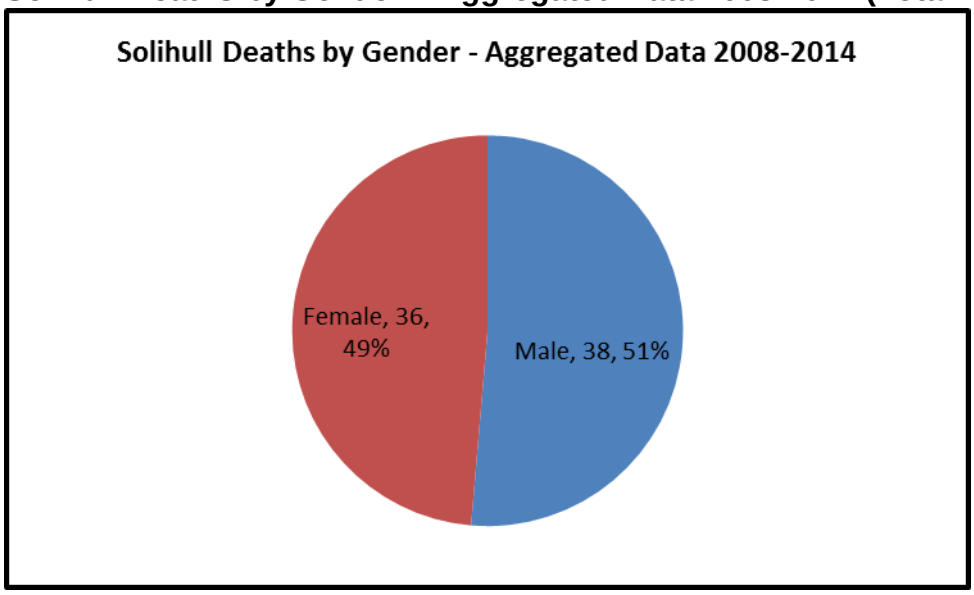


3.5.1 Age groups 1-4 and 5-9 years have been merged due to the low numbers.

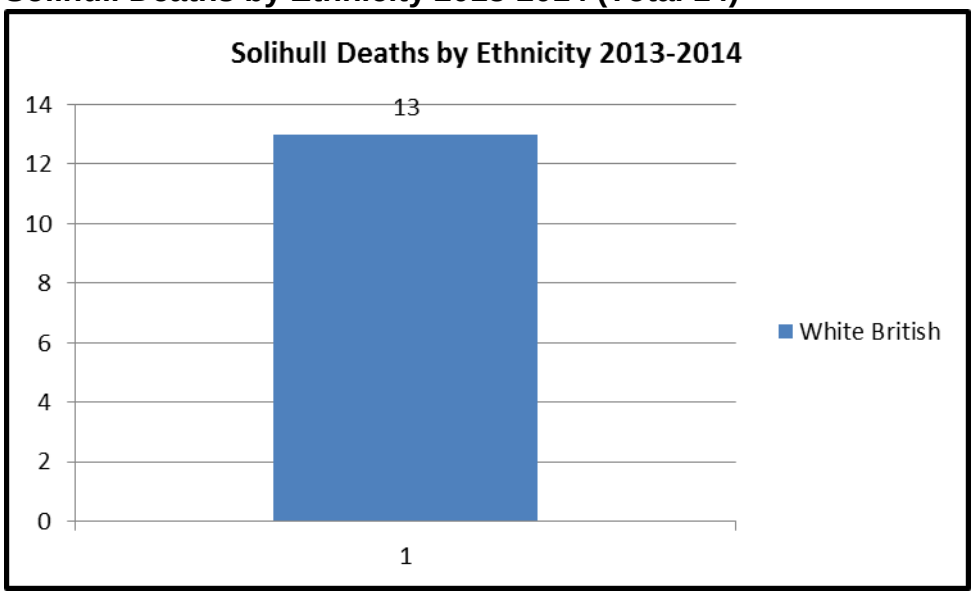
3.6 Solihull Deaths by Gender 2013-2014 (Total 14)



3.7 Solihull Deaths by Gender – Aggregated Data 2008-2014 (Total 74)

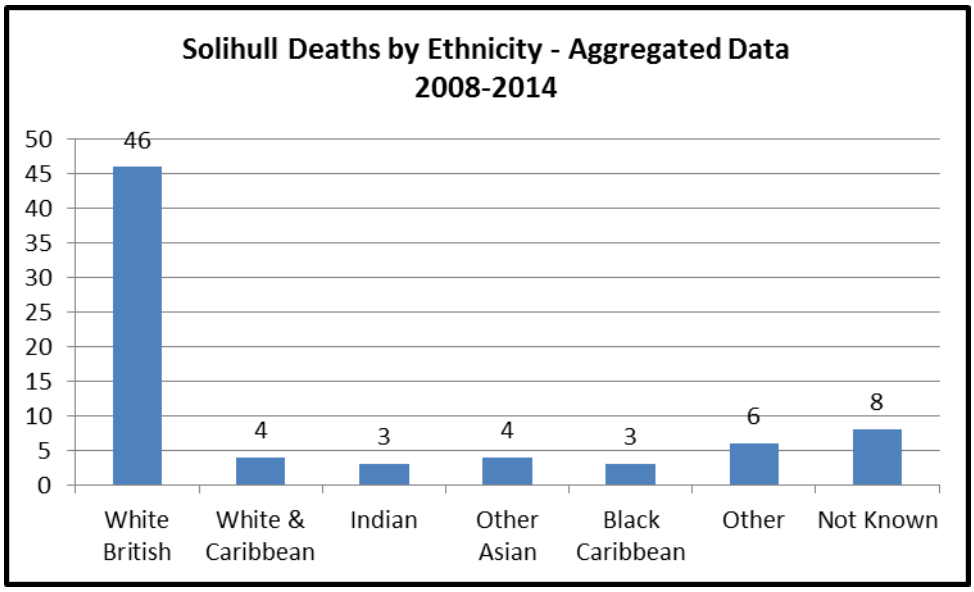


3.8 Solihull Deaths by Ethnicity 2013-2014 (Total 14)



3.8.1 The remaining death cannot be categorised due to its lone number.

3.9 Solihull Deaths by Ethnicity – Aggregated Data 2008-2014 (Total 74)



4 Summary

4.1 Neonatal deaths continue to be the highest category as expected.

4.2 The highest age group is 0-28 days which incorporates the neonatal deaths and therefore expected. Due to the low numbers in the 29-364 day category, these have been merged with the 0-28 day category. The other categories have also been merged together due to the low numbers.

4.3 The 6 year aggregated data gives a better picture. As can be seen, 65% of deaths (48 out of 74) occurred within the first year of life, which is also mirrored by Coventry and Warwickshire.

4.4 Aggregated data on gender bucked the national and regional trend up to 2013 by having more female deaths overall than male. However with 2013-2014 data added, male deaths now slightly outweigh those of females, which is in keeping with national and regional trends.

4.5 With regards to ethnicity, children of White British' origin remains the highest category as it has done over previous years.

4.6 The 'Not Known' are deaths from 2008-2009 when ethnicity was not requested on the national template forms. This changed in early 2009-2010 and ethnicity has been captured since.

Appendix 'C'

Warwickshire Child Death Overview Panel

1 CDOP Members during 2013-2014:

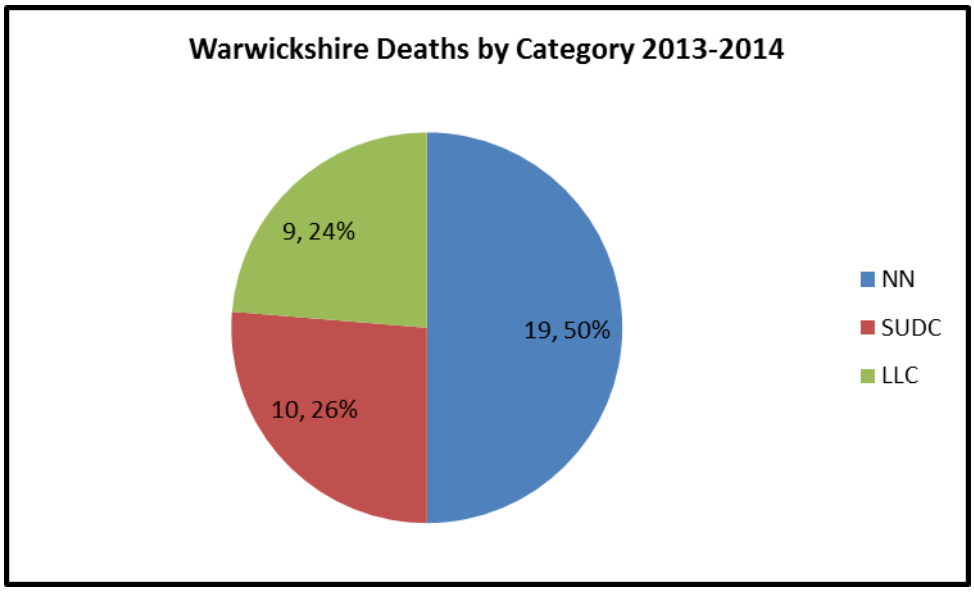
Cornelia Heaney, Development Officer for WSCB (Chair)
Jenny Butlin-Moran, Service Manager, Child Protection
Jackie Channell, Designated Nurse for Child Protection
Cathy Ellis, Consultant in Child Health
Victoria Gould, Young People Legal Services Manager, Warwickshire County Council
Detective Inspector Nigel Jones, Warwickshire Police
Dr Kathryn Millard, Consultant in Public Health
Angela O'Boyle, LSCB Lay Member
Adrian Over, Safeguarding Children's Manager for Education
Janet Pollard, Clinical Governance Midwife, South Warwickshire NHS Foundation Trust
Dr Peter Sidebotham, Consultant Paediatrician (Community)
Linda Watson, Assistant Head for of Children, Young People and Family Service,

2 Details of the number of CDOPs held and the number of deaths reviewed is outlined in in paragraph 2. A summary of recommendations and actions arising from Warwickshire CDOP are outlined in paragraph 5.

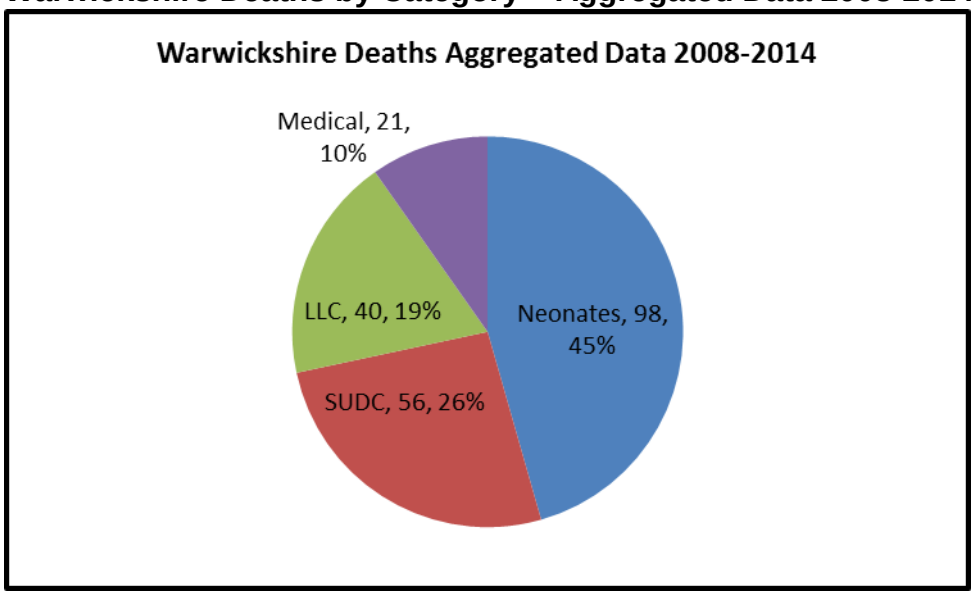
3 **Warwickshire Child Death Data:**
38 deaths were notified in 2013-2014, a 36% increase to the **24** deaths notified in 2012-2013. Deaths reported year on year since the process began in 2008 are shown in paragraph 19.1.

3.1 Categories that have a total of 2 or less have been merged in accordance with disclosure control guidance issued by the NHS Information Centre for Health and Social Care.

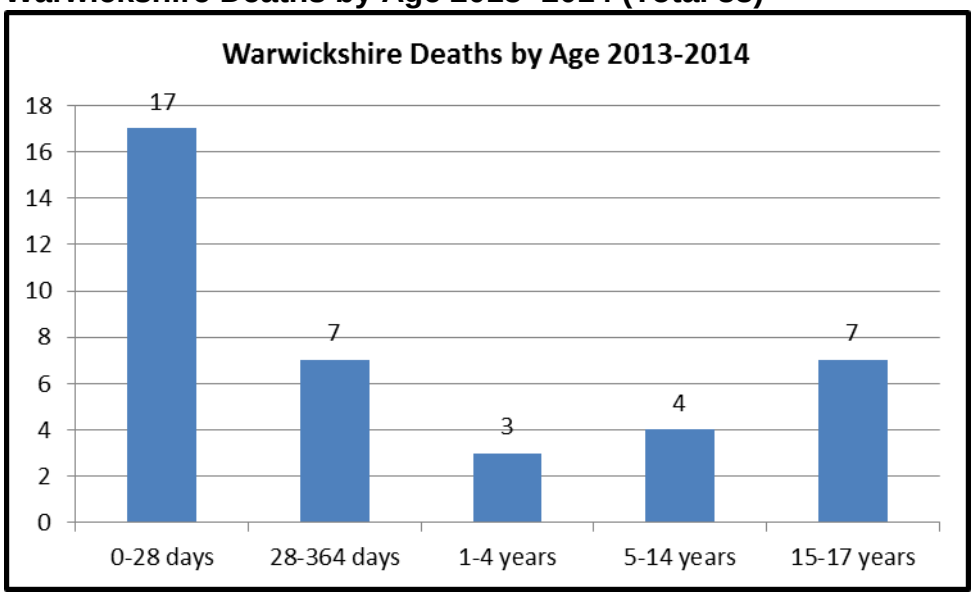
3.2 Warwickshire Deaths by Category 2013-2014 (Total 38)



3.3 Warwickshire Deaths by Category – Aggregated Data 2008-2014 (Total 215)

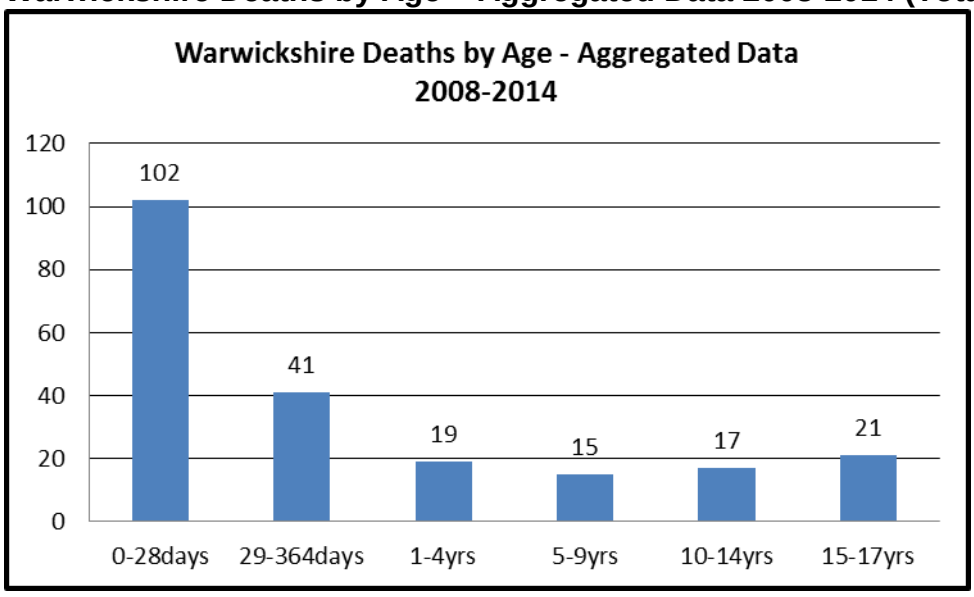


3.4 Warwickshire Deaths by Age 2013 -2014 (Total 38)

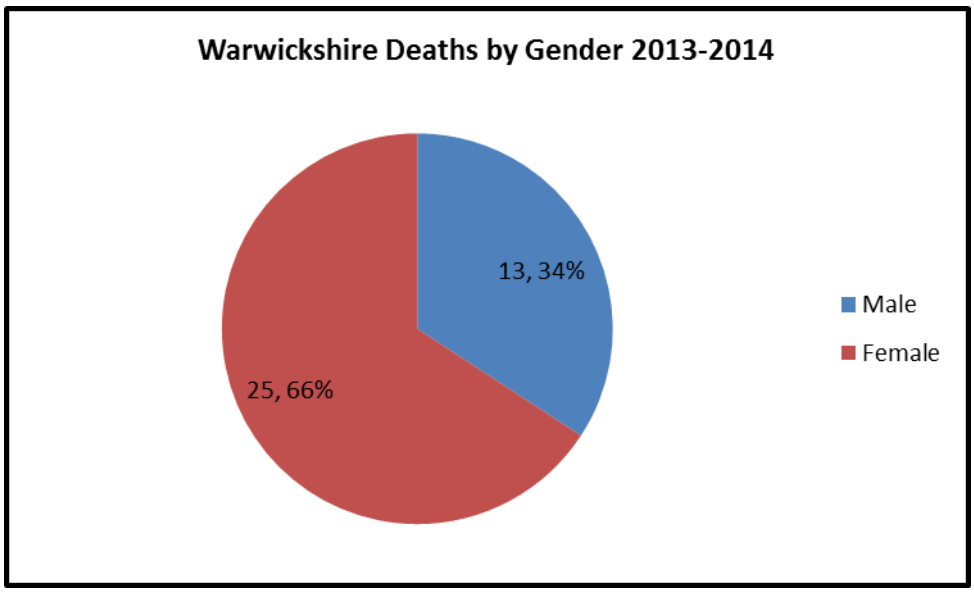


3.4.1 Age groups 5-9 and 10-14 years have been merged due to the low numbers.

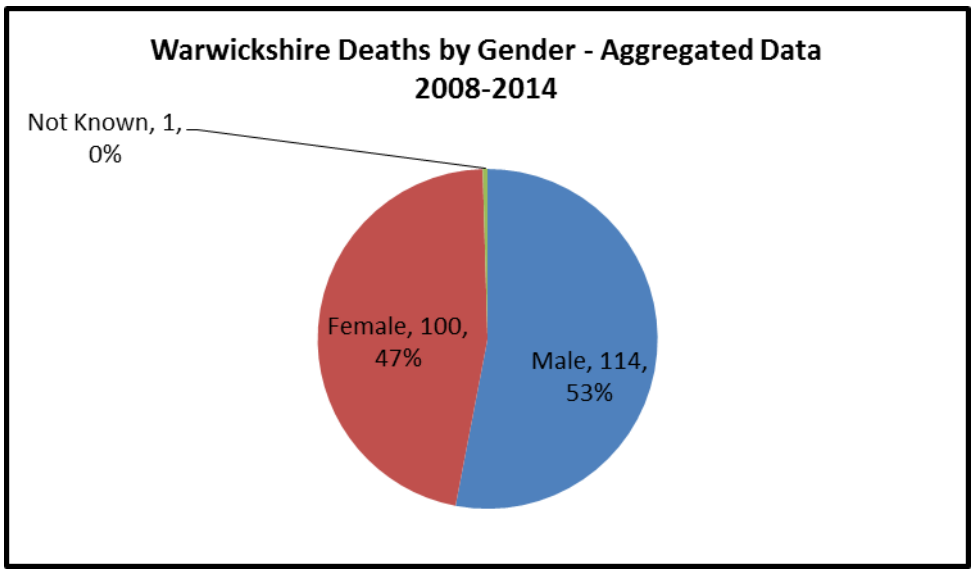
3.5 Warwickshire Deaths by Age – Aggregated Data 2008-2014 (Total 215)



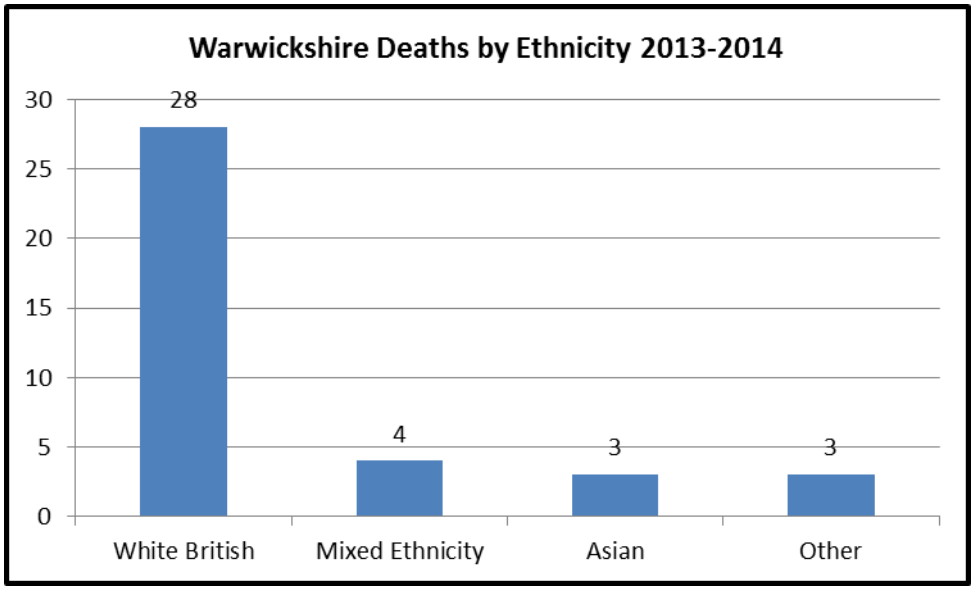
3.6 Warwickshire Deaths by Gender 2013-2014 (Total 38)



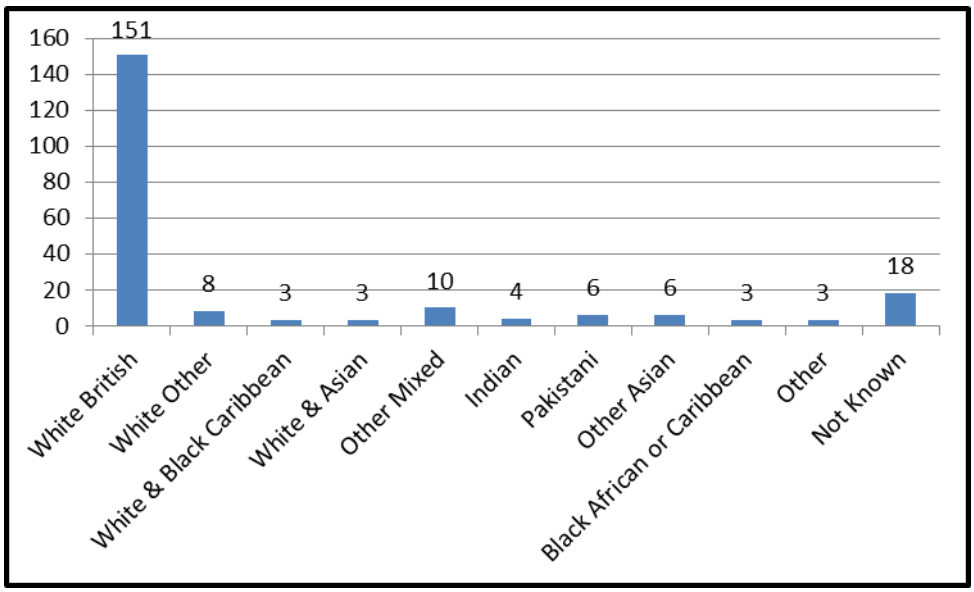
3.7 Warwickshire Deaths by Gender – Aggregated Data 2008-2014 (Total 215)



3.8 Warwickshire Deaths by Ethnicity 2013-2014 (Total 38)



3.9 Warwickshire Deaths by Ethnicity – Aggregated Data 2008-2014 (Total 215)



4 Summary

4.1 Neonatal deaths continue to be the highest category as expected.

4.2 The highest age group is 0-28 days which incorporates the neonatal deaths and therefore expected.

4.3 The graph in 3.2 shows 19 neonatal deaths but the graph in 3.4 showing a breakdown of ages shows there were 17 deaths aged 0-28 days. The reason for this is that 2 neonates lived beyond 28 days but were still categorised as neonatal deaths as they were born prematurely and never left hospital.

4.4. The aggregated data for ages shows that 67% of deaths (143 out of 215) occurred within the first year of life. This is also mirrored by Coventry and Solihull.

4.5 The proportion of male and female deaths in 2013-2014 bucked the national trend as more females died in 2013-2014 than male. The aggregated data however is in keeping with the national trend of more male then female deaths.

4.6 With regards to ethnicity, children of White British' origin remains the highest category as it has done over previous years.

4.7 The 'Not Known' are deaths from 2008-2009 when ethnicity was not requested on the national template forms. This changed in early 2009-2010 and ethnicity has been captured since.

Appendix 'D'

Rapid Response Investigation – Sudden Unexpected Death in Children Protocol

Chapter 5 of Working Together to Safeguard Children 2013, defines the unexpected death of an infant or child (less than 18 years old) as a death:

- Which was not anticipated as a significant possibility for example, 24 hours before the death; or

- Where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death

Response to Unexpected Deaths

All Local Safeguarding Children's Boards are expected to have procedures in place to ensure there is a co-ordinated multiagency response to unexpected deaths. Where a death is sudden, unexpected and unexplained a 'rapid response' investigation will be instigated, as follows:

a) The immediate history taking, examination of the child and investigations will be carried out and support provided to the family.
b) The designated paediatrician will notify the Coroner, Police Senior Investigating Officer, Children's Social Care and immediate information sharing will take place.
c) A home visit will take place within 24 hours, by the Police and a health professional, i.e. a Paediatrician or specialist nurse to visit the scene of death; obtain a more detailed history; explain the process to parents/families and facilitate support to the family.
d) A post- mortem examination will take place.
e) An initial multi-agency information and planning meeting will take place chaired by the designated paediatrician, after the initial post-mortem results are known. This can take place verbally over the telephone if there are no concerns.
f) A final multi-agency case discussion meeting will be convened and chaired by the designated paediatrician when all of the information has been obtained, including the final post mortem report. All agencies known to the child and/or involved in the rapid response investigation are invited. At this meeting any contributing factors will be identified and on-going support for the family. The minutes of this meeting will be provided to H.M. Coroner prior to the Inquest (if being held) and to the Child Death Overview Panel.
g) A meeting will be arranged with the parents to; discuss the cause of death and any contributing factors, identify and facilitate any on-going needs and advise re tissue retention. The professional(s) identified to meet with the family is agreed at the final case discussion meeting and is usually the designated paediatrician. If the family decline a meeting, the findings will be conveyed by letter by the designated paediatrician.
h) An Inquest may be held by the Coroner but changes to the Coroner's Rules states that the Coroner does not have to hold an Inquest if death from natural causes has been ascertained.

West Midlands and Warwickshire have both produced a 'Best Practice Multi-Agency Protocol for Sudden Unexpected Deaths of Infants and Children under 18 years of age' (SUDC Protocol)