**Somerset Child Death Review Arrangements**

**Annual Report 2021-22**

**November 2022**

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1. **Introduction**

* 1. This annual report on the joint Child Death Review arrangements for Somerset and Dorset covers April 2021 – March 2022. This is a public report which sets out the work of the local Child Death Review partners in Somerset in association with the joint Pan Dorset and Somerset Child Death Review process.
	2. In September 2022, the Memorandum of Understanding (MoU) and the Terms of Reference (ToR) for the joint Pan Dorset and Somerset Child Death Overview Panel (CDOP) were reviewed and agreed by all the Child Death Review partners in Somerset and Dorset.
	3. For further information on the role and function of the Somerset Child Death Review process see: [**http://sscb.safeguardingsomerset.org.uk/working-with-children/child-death-review**](http://sscb.safeguardingsomerset.org.uk/working-with-children/child-death-review)

# Number of Child Death Notifications in 2021-22

2.1 During 2021-22 there were 19 deaths of children resident in Somerset:

2.2The majority of deaths were infant deaths; with 60% of deaths involving a child 0-27 days old. See table below for breakdown of ages of child deaths in Somerset:

**3.0 Number of Child Death Reviews completed in 2021-22**

3.1 In 2021-22 22 child deaths were reviewed and the majority of those deaths occurred in 2020. A small number of child deaths reviewed were from 2018 (1), 2019 (5) and 2021 (2). On average child deaths are reviewed within 12 to 13 months, but there are multiple factors that can impact on the length of time it takes to review a child’s death. The Covid 19 pandemic did not impact on the number of cases reviewed, as the joint Child Death Overview Panels moved quickly to virtual and continued to run as normal. See table below for breakdown of age of children subject to a child death review in 2021-22.

3.2 Further breakdown of the categories of child deaths reviewed is outlined in the table below, in accordance with categories provided by the National Child Mortality Database.

**4.0 Unexpected Deaths**

4.1 An unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility, for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.

4.2 It is no longer a requirement to 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 Joint Agency Response. 37% of Somerset Child Deaths reviewed in 2021-22 were unexpected.

**5.0 Modifiable factors related to Somerset Child Deaths**

5.1 The Pan Dorset and Somerset Child Death Overview Panel (CDOP) considers modifiable factors; intrinsic to the child or related to the family environment, parenting capacity or service provision, and considers what action could be taken locally and what action could be taken at a regional or national level. These are factors, where if such actions could be taken, the risk of future child deaths could be reduced.

5.2 41% (9) of Somerset child deaths reviewed during 2021-22 identified modifiable factors. Examples of potentially modifiable factors identified at the CDOP from Somerset child death cases reviewed during 2021-22 are:

* Smoking by mothers in pregnancy
* High BMI of mothers during pregnancy
* Smoking in the household
* Unsafe sleeping arrangements

**6.0 Safeguarding Children Cases**

6.1 In circumstances where a child has died, and abuse or neglect is known or suspected, at any point during the Child Death Review process professionals should notify the safeguarding children partners whose responsibility it is to determine whether the case meets criteria for a Local Child Safeguarding Practice Review (CSPR) or a Rapid Review.

6.2 One of the cases reviewed this year was subject to a Local Child Safeguarding Practice Review (LCSPR). Learning from the [LCSPR](https://sscb.safeguardingsomerset.org.uk/working-with-children/child-safeguarding-practice-reviews/#details-2-0) which was published in August 2021 under the pseudonym Charlie included:

* Recognise and consider the impact of domestic abuse on babies/children.
* Identify the needs of a child/family.
* Develop a clear plan of service provision/intervention in accordance with the Effective Support for Children and Families framework.
* Reflect on the needs of a child/family.

The Child Death Review process did not identify any additional learning.

**7.0 Learning from the Child Deaths reviewed in 2021-22**

7.1 The number of deaths reviewed is small which makes statistical analysis difficult. However, some learning has been identified from Somerset child death reviews, which included:

* Unsafe sleeping, in particular co-sleeping is an ongoing factor, despite evidence that health professionals have clearly delivered the message. Work is being undertaken locally and nationally to explore why advice is not always acted upon, particularly with fathers and other family members who may be caring for children. Unsafe sleeping also occurs when families are out of routine. Need to ensure consistency of information given to families from different agencies.
* The issue of smoking in pregnancy is also an ongoing factor.
* We have identified good practice in palliative care pathways and evidence of improvements that have been made in advanced care planning.
* High risk individuals and their ability to access flu vaccinations when an inpatient.
* Supporting the transition of vulnerable individuals with learning disabilities through the use of communication passports.

7.2 Learning from Somerset Child Death Reviews is disseminated through Governance meetings. In addition, learning identified from Dorset Child Death Reviews identified through the joint Pan Dorset and Somerset Child Death Overview Panel is also shared with Child Death Review partners across Somerset.

**8.0 Actions taken as a result of the Child Deaths reviewed in 2021-22**

8.1 This report does not detail actions taken related to specific children or individual practitioners, to preserve confidentiality. This report describes actions taken to address system issues which will improve outcomes for children and reduce the risk of child deaths in future. Actions undertaken as a result of child deaths reviewed in 2021-22 included:

* Raising awareness of sharing information with professionals regarding expectant fathers.
* Consideration now being given to offering high risk patients flu vaccinations before they are discharged from acute settings.
* Assurance sought from Acute settings that they are routinely using communication passports for children with learning disabilities.

**9. National Child Mortality Database (NCMD)**

9.1 The Pan Dorset and Somerset CDOP (Child Death Overview Panel) fulfil its statutory responsibility to submit Child Death Review data through the eCDOP case management system.

**10.** **LeDeR and Somerset Child Death Review arrangements**

10.1 The Learning Disabilities Mortality Review (LeDeR) programme describes a review process for the deaths of people aged 4 years and over with learning disabilities in England. It is important to specifically recognise and record if a child or young person has learning disabilities, irrespective of any other diagnoses or syndromes that are recognised. For further information: <https://leder.nhs.uk/about>

10.2 There have been three child death cases reviewed in 2021-22 that involved the local LeDeR team.

## 11. Conclusion

 We are pleased that the number of child deaths in Somerset are declining. Whilst small numbers of child deaths make it difficult for themes to be identified Child Death Review partners are clear of the importance to learn lessons even from single cases. Further work will be undertaken in 2022-23 in relation to aligning the Joint Agency Review process across Somerset.