Somerset Safeguarding Children Partnership

Somerset Council

NHS Somerset

Pan-Dorset Safeguarding Children Partnership

Dorset Council

BCP Council

Dorset Police

NHS Dorset Clinical Commissioning Group

PAN DORSET AND SOMERSET CHILD DEATH OVERVIEW PANEL (CDOP)

Annual Report from 1 April 2023 – 31 March 2024

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Introduction

The purpose of this report is to provide Child Death Review partners and members of the Pan-Dorset and Somerset Safeguarding Children Partnerships with an update for the last twelve-month period during 2023/24 in relation to the work of the Child Death Overview Panel (CDOP).

The Child Death Review partners for the Child Death Overview Panel geography are:

- Bournemouth, Christchurch, and Poole Council (hereafter referred to as BCP)
- Somerset Council
- Dorset Council
- NHS Somerset ICB
- NHS Dorset ICB

A Child Death Review is conducted for all children aged 0-17 when a death is reported. Information is gathered from professionals who knew the child, and families are supported to ensure their voices are heard. A comprehensive review meeting is held to identify and implement any early learning. After this meeting and the conclusion of any parallel investigations, the case is anonymised and presented to the Dorset and Somerset Child Death Overview Panel.

Child Death Overview Panels

Every death of a child is a tragedy which has a wide impact on family, friends and the community. The panel's task is to learn from the circumstances of every death and to:

- Identify any changes which can be made that might help prevent further deaths.
- Share the learning regionally and nationally, with other agencies involved in the process.
- Identify evolving trends to explore with the aim to prevent further deaths.
- Identify learning and service improvements that will ensure families are well supported.

The review process is not about allocating blame but is about learning lessons to prevent deaths in the future.

All CDOP Members have a responsibility for sharing learning from panel discussions.

The purpose of a review is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified.

The panel continues to consist of members from Dorset and Somerset, focused on meeting statutory requirements in relation to Child Death Reviews (CDRs). This is in accordance with Working Together to Safeguard Children and Child Death Statutory and Operational Guidance. The panel is currently chaired by a Somerset representative with a Dorset representative vice-chairing.

The Child Death Overview Panel (CDOP) core members are:

- Designated Doctors for child death (2 attending for each county),
- Social Care representatives (3 Local / Unitary Authority representatives 1 for each local authority area),
- Police Force representatives (1 each from Dorset and Avon and Somerset)
- NHS Dorset ICB / Somerset ICB Designated Nurses Safeguarding Children
- Public Health representative
- NHS Dorset ICB / Somerset ICB Primary Care representative
- Nursing representative
- Midwifery representative for Neonatal cases
- Obstetric representative for Neonatal cases

The Panel's Shared Purpose

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

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

CDOP Data

The CDOP panel has met 4 times in 2023/24 and reviewed 27 deaths: 22 Pan-Dorset deaths (10 Dorset and 12 BCP) and 5 Somerset deaths.

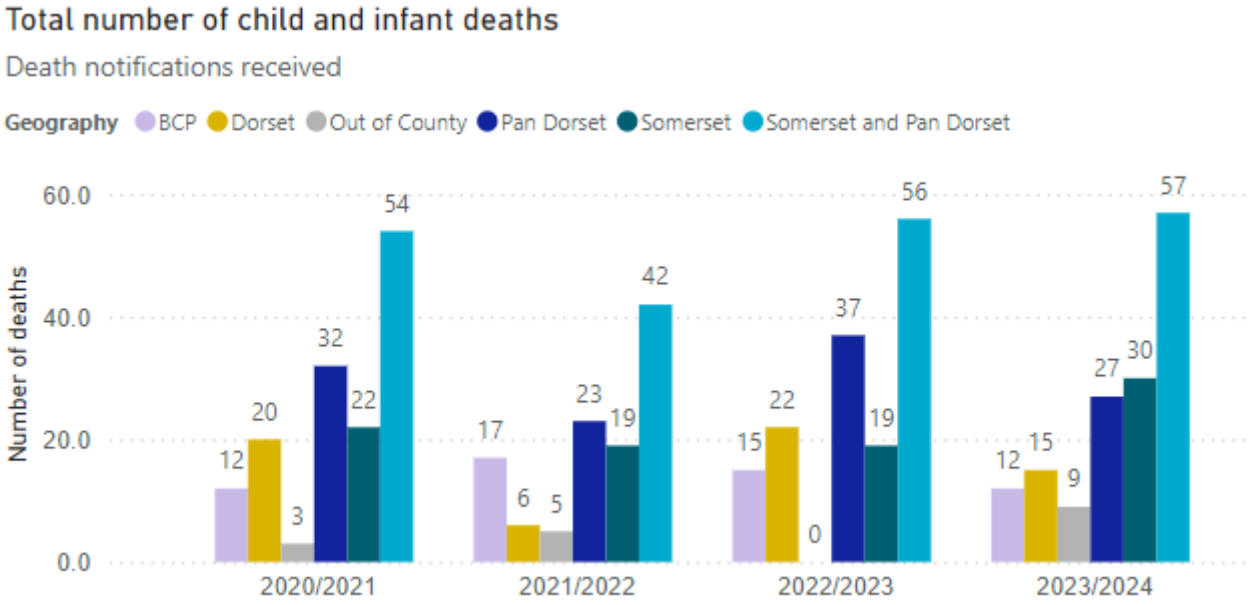
In 14 of these 27 cases (52%) there were modifiable factors identified. This compared to last year's figures where 59 cases were reviewed, and modifiable factors were identified in 54.2% of cases.

To compile this CDOP annual report we have used a new Business Intelligence (BI) tool that has been developed by Public Health in Somerset to compare our own Pan Somerset and Dorset CDOP data down to local authority level. Where possible we have presented data in the same format that the NCMD publish their annual report and quarterly data at CDOP and ICB geographies.

Child and Infant Death – Notifications (01.04.23 to 31.03.24)

The Pan Dorset and Somerset Child Death Overview Panel (CDOP) has been notified of a total of 57 child and infant deaths. 27 deaths of Pan Dorset (Dorset and Bournemouth, Christchurch & Poole) residents and 30 deaths of Somerset residents during this twelve-month period. In addition, there were 9 notifications of Out of County children, resident elsewhere who died within our areas – these deaths will be reviewed and recorded by their home Local Authority. The below graph demonstrates the break down of notified death per local authority. The number of notified deaths in 2020/2021 and 2021/2022 were lower than the historic averages likely due to the noted impacts of the covid-19 pandemic lockdown and isolation measures. This year's numbers and 2022/2023 are back in line with historic expected numbers. Historically our death rates have been below the national averages.

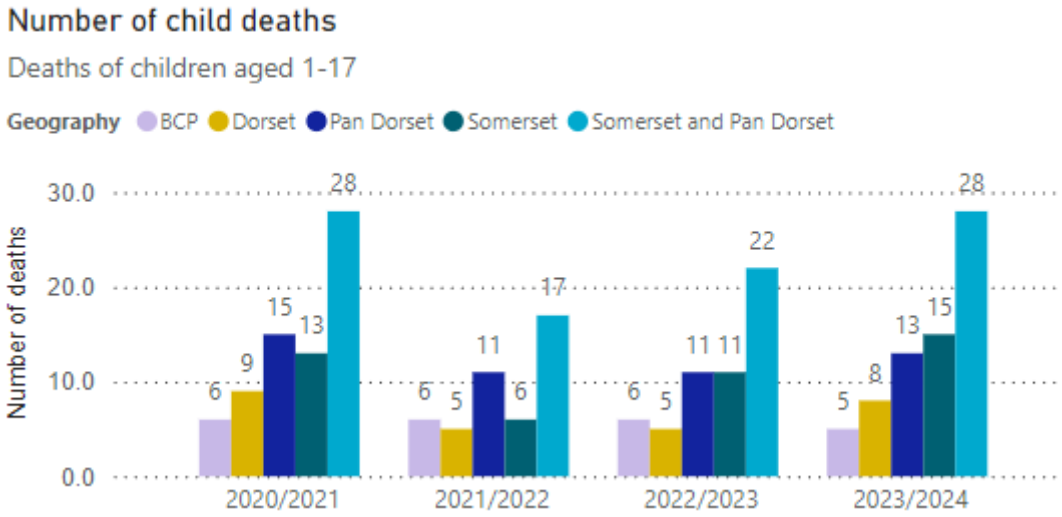
Figure1:



Number of Child Death Notifications

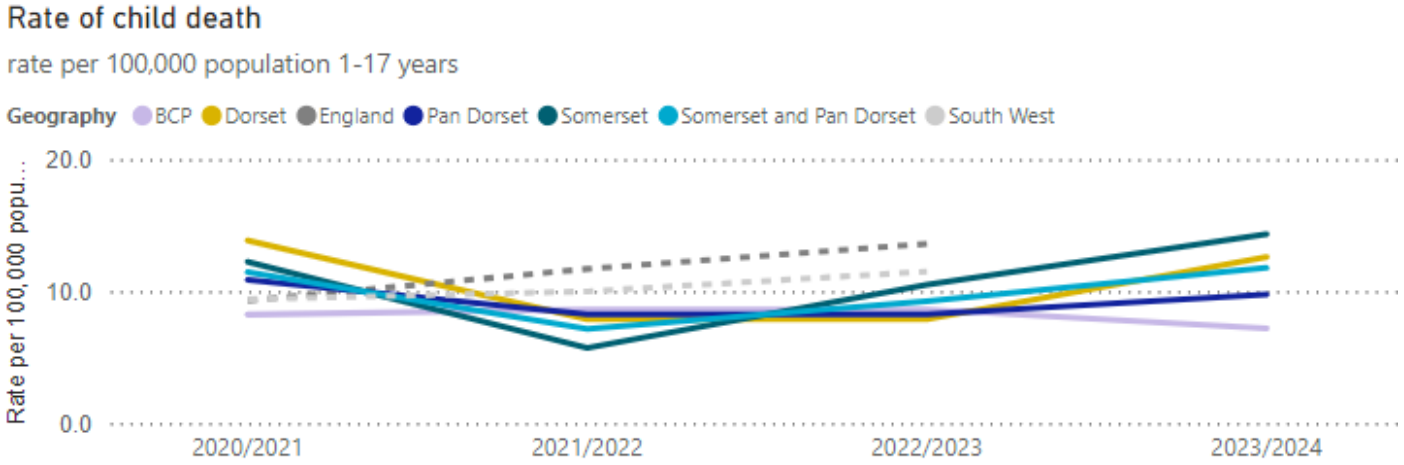
The graph below shows child deaths (deaths in Children aged 1-17) by local authority, year on year. Over the last 5 years, child deaths across Somerset and Pan Dorset were at their lowest in 2021-22 (17 child (age 1-17) deaths) and highest in in 2023-2024 (28 child (age 1-17) deaths).

Figure 2:



There is no specific reason for this and whilst there has been an increasing trend in recent years, rates in 2023/2024 are comparable to those seen in 2020/21. This increasing trend will be monitored closely over the coming years and how it compares regionally and nationally. The below chart demonstrates CDOP footprint down to Local Authority area comparison against most recent national and regional data.

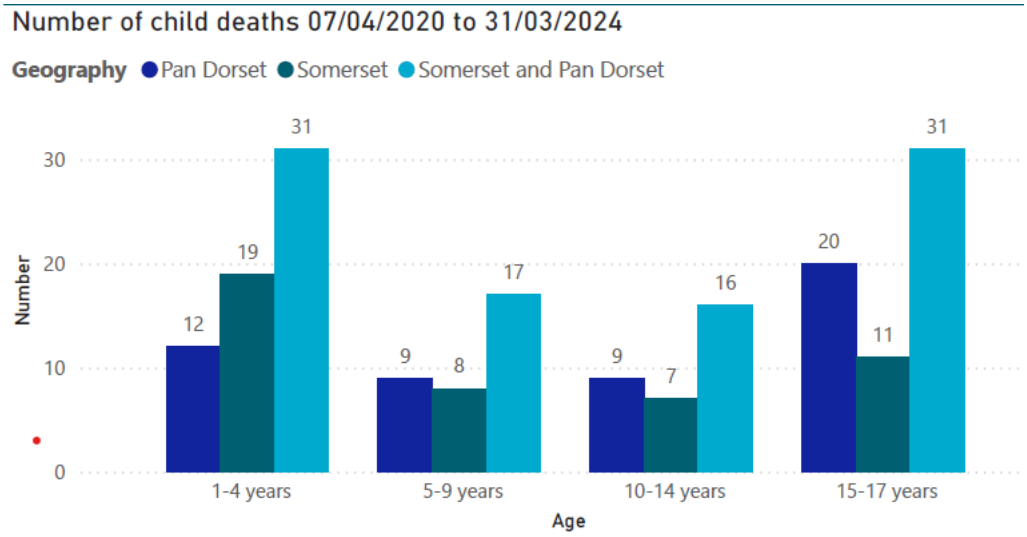
Figure 3:



Combining data for 4 years allows us to examine differences in the rate of death by age group across the CDOP region. The graph below shows the rate of age standardised deaths by age groups for the CDOP region by Local Authority area for the time period 01/04/2020 to 31/03/2024. This is the first

time we have been able to look at the local CDOP data in this way and there is no national or regional data to compare to.

Figure 4:

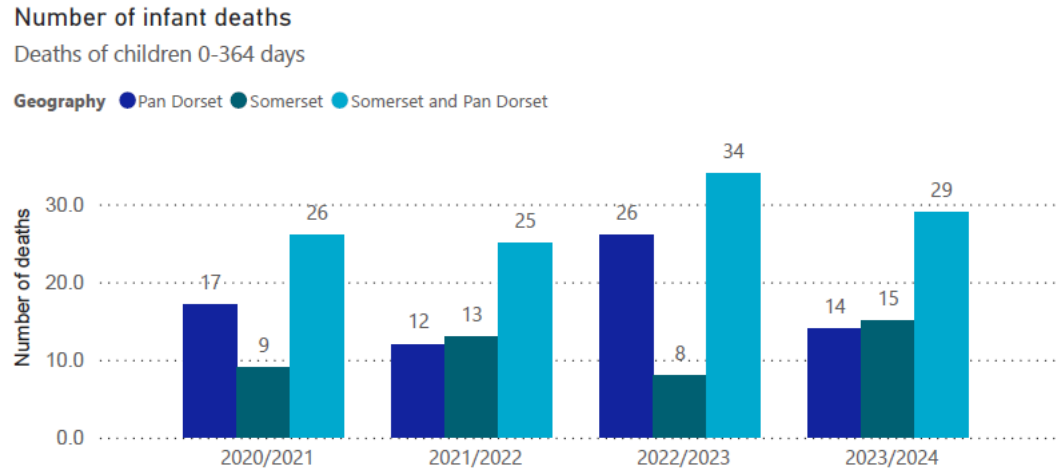


Numbers of child deaths aggregated 2020 to 2024 in those aged 5-9 and 10-14 are relatively consistant across the Somerset and Pan Dorset CDOP region. However, there are more variations in the 1-4 and 15-17 age categories between Somerset and Pan Dorset (NHS Dorset) areas. Somerset has a higher number at 19 in the 1-4 years group whilst Pan Dorset (NHS Dorset) has 12. In the 15-17 years age group Pan Dorset (NHS Dorset) area has almost double the number of deaths (20) compared to the NHS Somerset area (11).

Number of Infant Death Notifications

Figure 5 below shows infant deaths (deaths in children aged 0-364 days) by local authority, year on year. Over the last 5 years, infant deaths across Somerset and Pan Dorset were at their lowest in 2021-22 (22 infant deaths) and highest in in 2022-2023 (34 infant deaths). There is no particular reason identified for this.

Figure 5:



Combining data for 4 years allows us to examine differences in the rate of death by age group across the CDOP region. Figure 7 shows the rate infant death per 1,000 live births for the CDOP region by Local Authority area for the period 01/04/2020 to 31/03/2024.

Figure 7:

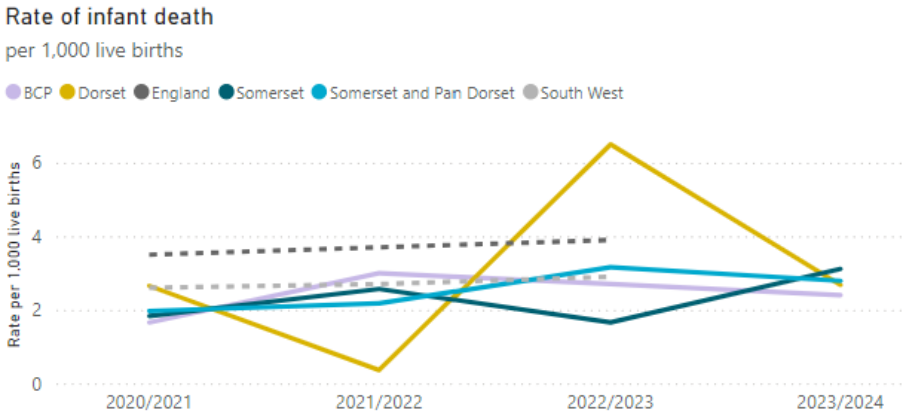


Figure 8 below illustrates rates of infant deaths are greatest in the neonatal period (0-27 days) 1.7 per 1,000 live births (n=77) across the CDOP region. Rates are fairly consistent across the different local authorities with slight variations likely due to the small numbers of deaths.

Figure 8:

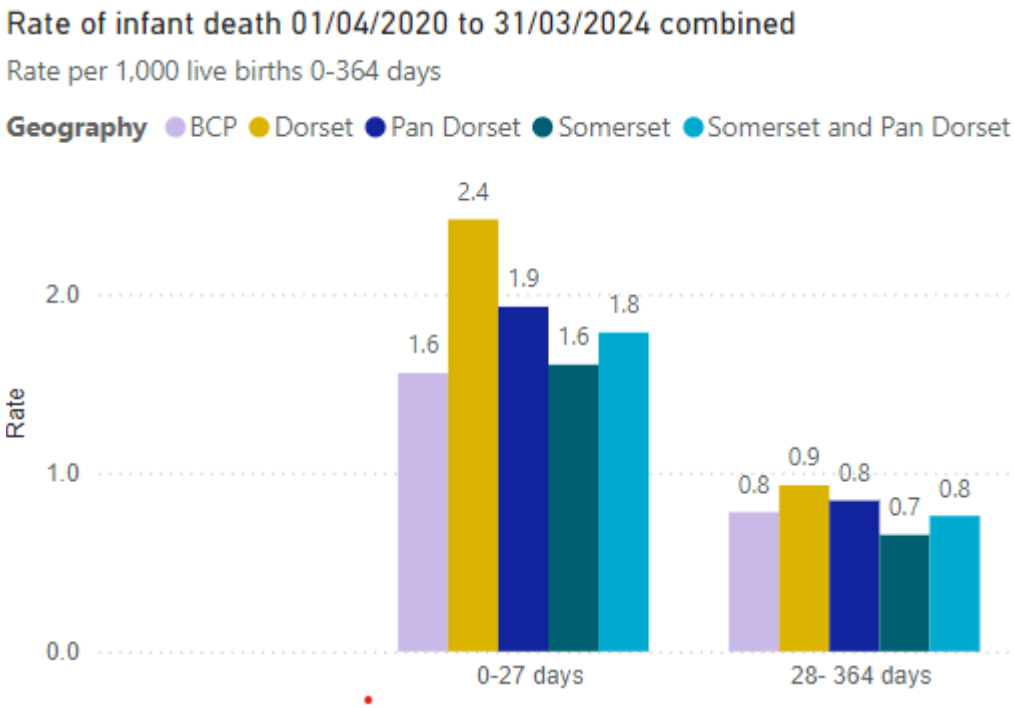
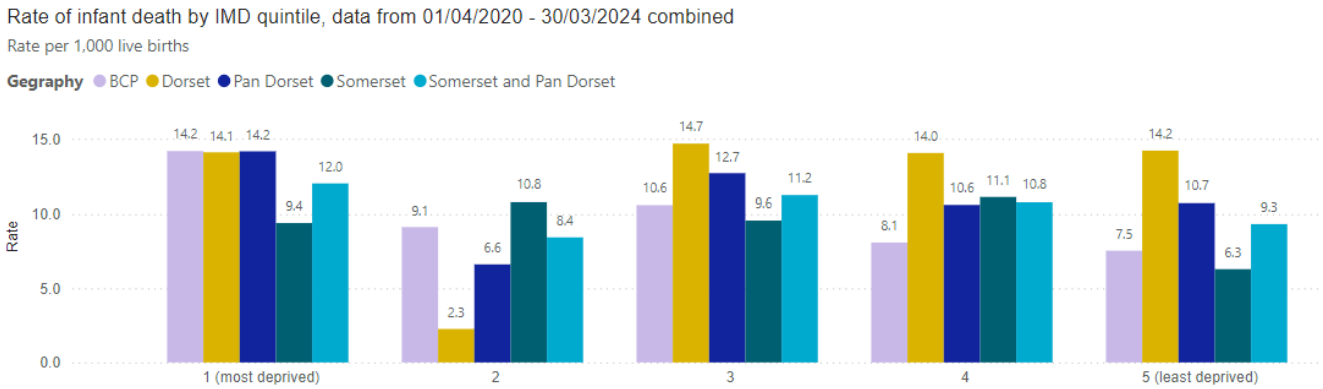


Figure 9 illustrates rates of infant death in the CDOP geography by the Index of multiple deprivation quintiles (child's home postcode). Rates were higher in the most deprived quintile across the CDOP Region (12.0 per 1,000 live births *n=14*) and lowest in the least deprived quintile (9.3 per 1,000 live births *n=14*). The Pan Dorset and Somerset CDOP did not sit as an outlier relating to deaths within Deprivation quintiles or age groups within the data provided by NCMD (4-year trend data for 2022-23). NCMD national comparators for 2023/24 are expected to be published in November 2024.

Figure 9:



Reported Child Deaths with Joint Agency Responses

The Pan-Dorset total number of deaths in 2023/24 (27) is made up of 12 reported in Bournemouth, Christchurch and Poole, 15 in other areas of Dorset. Out of the 27 deaths, 10 were neonatal. In the previous reporting year (2022-23) of the 37 deaths 16 were neonatal deaths.

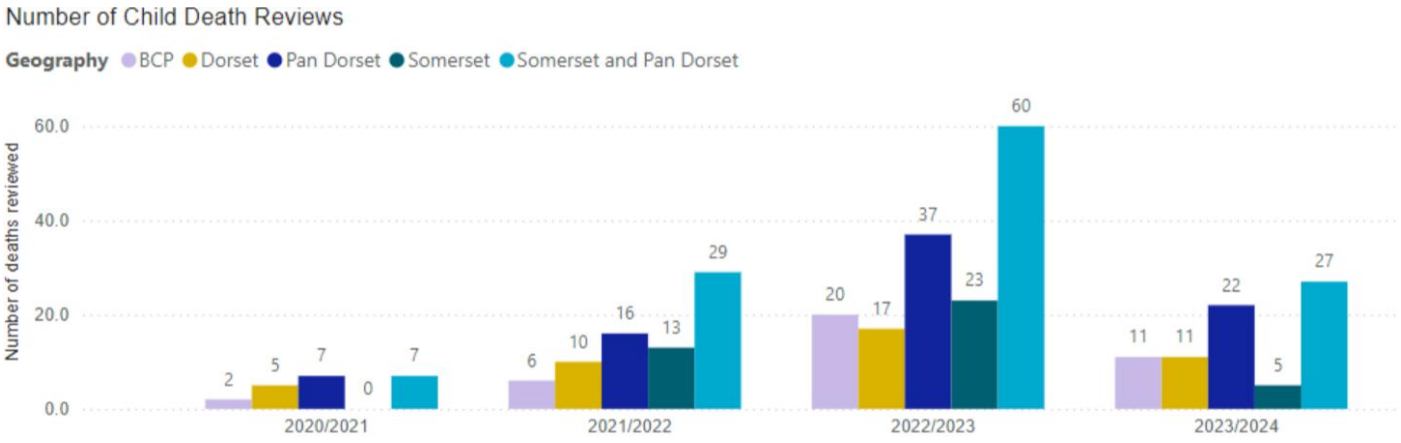
The Somerset total number of deaths in 2023/24 (30) included 8 neonatal deaths, compared to the previous year (2022-23) in which 5 of the 19 deaths reported were neonatal.

NOTE: It is no longer a requirement that we categorise deaths into expected and unexpected cohorts for the national data return. But we are still aware of unexpected deaths as they will initiate a Joint Agency Response (previously known as a Rapid Response) and for the deaths during 2023/24 there were 8/27 where one was commenced in Dorset, and 9/30 where one was commenced in Somerset.

CDOP Cases reviewed

The CDOP reviewed a total of 27 cases over the period 2023/2024. The lower number of cases reviewed in 2023/24 is due to several reasons including the delay in receiving postmortem reports, inquests taking place, awaiting analysis forms from out of area hospitals. This led to us cancelling two panels due to a lack of cases ready for discussion.

Figure 10:



This particularly impacted Somerset cases with only 5 being available for review at CDOP in 2023/24. CDOP will be further escalating issues with centres contributing to our delays where appropriate and collaborating as regional chairs to escalate the issues with delays in postmortems and inquests which is occurring regionally as well as locally. We are looking to put on additional panels in 24/25 to accommodate cases delayed in 23/24. Figure 11 demonstrates the current back log in cases, CDOP activity and number of new deaths reported in 2023/2024.

Figure 11: CDOP Activity 2023/24

ICB geography	No. deaths notified 2023/24	No. cases CDOP reviewed 2023/24	Total cases with review on going at 31/03/2024
Pan Dorset	27	22	37
Somerset	30	5	50

Figure 12 below shows the number of cases reviewed by CDOP by category of death for the previous 4-year period 2020/21 to 2023/24. The most common category of child death during this period was perinatal / neonatal event (30.65% *n=57*) followed by Chromosomal, genetic, and congenital anomalies (21.51% *n = 40*)

Figure 12:

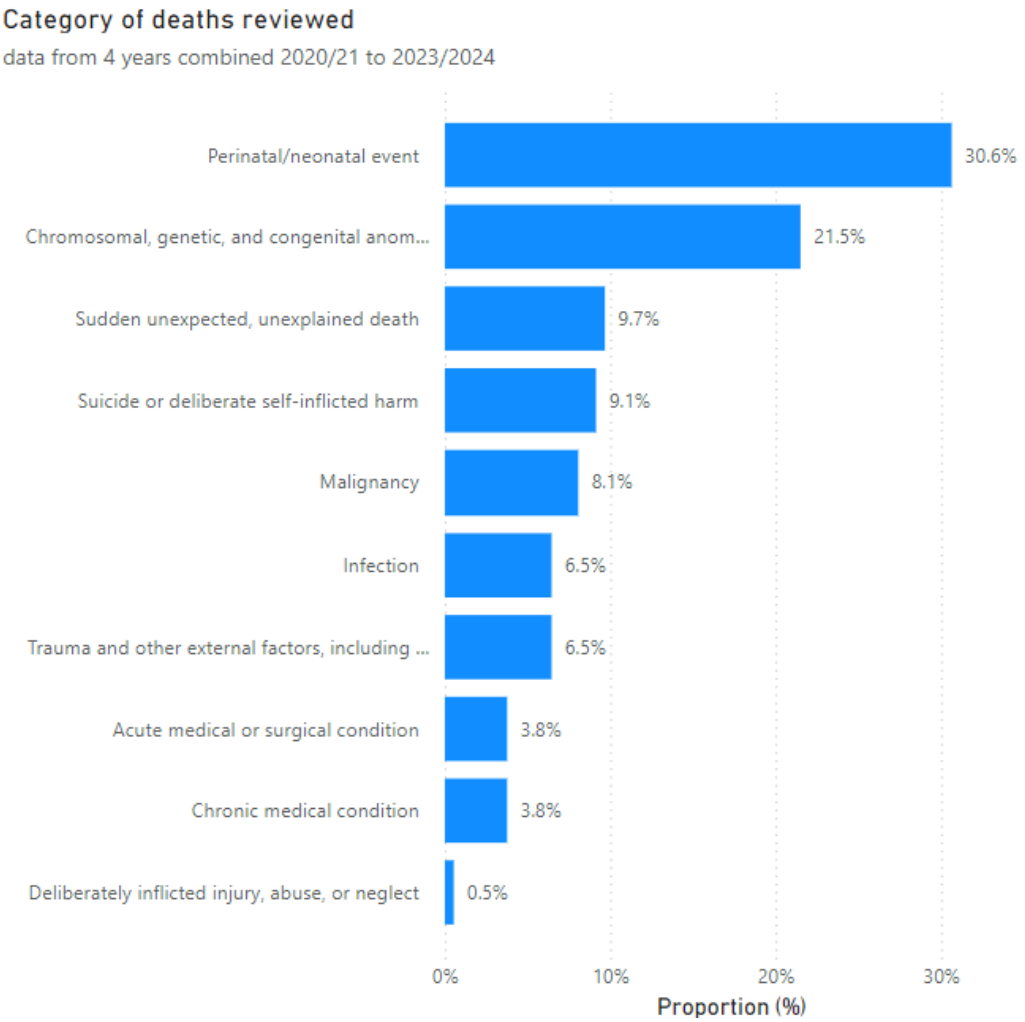


Figure 13: CDOP cases reviewed by category of death by year

Category	2019/20	2020/21	2021/22	2022/23	2023/24	Total
1. Deliberately inflicted injury, abuse, or neglect.	0	0	1	0	0	1
2. Suicide or deliberate self-inflicted harm.	0	5	4	5	3	17
3. Trauma and other external factors, including medical/surgical complications/error.	7	0	5	4	3	19
4. Malignancy.	3	2	8	4	1	18
5. Acute medical or surgical condition.	9	1	2	4	0	16
6. Chronic medical condition.	1	1	2	4	0	8
7. Chromosomal, genetic, and congenital anomalies.	7	11	6	14	9	47
8. Perinatal/neonatal event.	17	11	12	27	7	74
9. Infection.	7	6	3	2	1	19
10. Sudden unexpected, unexplained death.	3	4	6	5	3	21
Total number of deaths reviewed by CDOP	**54**	**41**	**49**	**69**	**27**	**240**

Modifiability

CDOP is required to assess the preventability of each death by considering whether there were factors which may have contributed to the death of the child and if so, whether these could be 'modified' to reduce the risk of future child deaths. During 2023/24 CDOP identified modifiable factors in 14 of the 27 (52%) deaths reviewed.

Since 1 April 2024 the panel are having specific focussed case discussions on modifiability with consistent definition applied that is aligned to other CDOPs regionally. Modifiable factors are those which may have contributed to the death of the child, and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future deaths. An example of a modifiable factor is smoking in pregnancy when the categorisation of death is recorded as extreme prematurity. We would expect the number of cases with modifiable factors to fall in line with our regional peers next year.

Learning and Outcomes from CDOP Reviewed Cases

From the cases reviewed by CDOP this year, there have been some specific key learning, and recommendations identified and implemented. Below is a selection of some of these recommendations, actions in progress and outcomes:

Case 1 – CTG interpretation Cases were identified where CTG interpretations were an important factor in the period leading up to death. The panel requested assurance that learning has been embedded regarding CTG findings being interpreted and handed over appropriately.	Escalation to Dorset LMNS about CTG interpretation occurred. There are now new processes in place to include interpretation of CTG's and during ward rounds.
Case 2 – Self discharge policy in Accident & Emergency (A&E) Departments The panel requested exploration of parental/guardian self-discharge processes for their children from A & E's and mechanisms for leaving messages for patients / guardians from A & E clinicians with a call back mechanism.	East Dorset Emergency Department(ED) changed their self-discharge process to include discussion with most senior clinician on duty and all U1's that do not wait notes are now reviewed by paediatrics in the morning and concerns highlighted for consultant call back and GP/Health Visitor notification. The case also provided support for the business case to improve paediatric nursing cover in ED New policies shared with Acutes settings across the CDOP geography for shared learning.
Case 3 - Complex management of chronic conditions CDOP reviewed several cases of children requiring complex management of chronic conditions and palliative care The panel sought reassurance regarding the management of complex cases across multiple acute settings. They noted exemplary palliative care consultant work in Dorset cases.	Hospital passport devised by tertiary centre for Somerset was shared as good practice with Dorset Designated Doctors Poole hospital task and finish group was set up to look at best management of children with complex and chronic conditions both during acute admissions and in the community/palliative settings. Learning was shared with all acute trusts across the CDOP geography

Case 4-Sensitive viewing of the deceased CDOP reviewed several cases where improvements could be made to ensure consistency with the sensitive provision to families for viewing their child after death.	Designated Doctors for Child Death have liaised with hospital mortuaries and police to ensure the same standard of care can be met within the mortuary setting compared to the local gold standard practice of Gullys place. Issues around the lack of a suitable environment for the management of death in childhood in both Somerset hospitals, including provision of a sensitive environment for the family have been raised as a priority to Somerset Foundation Trust senior management.

Other Outcomes

- Parental perspective around police presence at the time of a sudden unexpected death in infancy: Designated Doctors for Child Death have spoken with police and coroner services to see if we can incorporate this into the Pan Dorset and Somerset CDOP learning event in the Autumn.

- Several cases have highlighted the role of drugs in child death. Dorset Designated Doctors for Child Death have a planned session with the police drugs expert providing an educational update to the general paediatricians in Poole. The outcomes will be reviewed for wider benefit at the CDOP learning event, depending on feedback.
- A business intelligence tool has been created to enable breakdown of child death data down to local authority level to provide direct comparison to NCMD regional annual data to provide extra insight for assurance at local authority level.
- Created and implemented refreshed CDOP panel member role descriptors and reviewed Terms of Reference.
- Strengthened CDOP panel membership with increased obstetrician and health visitor representation at system level.
- New child death review coordinator appointed in Dorset to fill a temporary vacancy. The post role descriptor has been aligned to maintain close working with the Somerset child death review coordinator.
- Joint Agency Review (JAR) training was delivered by the Designated Doctors Child Death and Avon and Somerset Police for Somerset Paediatricians. These are held in recognition of the

numbers of staff joining Paediatrics and to ensure continued awareness of statutory Child Death Review protocols.

Future Developments

- Introduction of shared Child Death Learning Events across the Pan Dorset and Somerset geography delivered biannually.
- Regular Unified child death team meetings mirrored in both ICS areas to facilitate smooth system and CDOP function.
- Provide a new CDOP 6 monthly update to CDR partners to include comparisons between local and published NCMD data and key learning.
- Strengthen processes for a more efficient panel. Ensure all cases are being discussed in a timely manner with appropriate focus of discussion on learning and strategic aspects which may impact future deaths. This also included Designated Nurses for Safeguarding Children embedding consideration of statutory safeguarding case reviews throughout the CDR process and aligning these processes across CDOP geography.

Prepared By:

Patsy Temple and Sam Abdollahian, CDOP Chair and Vice Chair.

Alex Cabble and Zoe Hiett, Child Death Review Co-ordinator's.

Date: 26/09/2024