Worcestershire Health and Care NHS
NHS Trust

The Child Death Review Process For Worcestershire

Tenth Annual Report

2017-2018

Contents

Foreword and Introduction

We present the Worcestershire Child Death Overview Panel's (WCDOP) 10th Annual Report, which illustrates the evolution of the Child Death Review process with ever increasing opportunities to identify areas for improvement and development of services for children in Worcestershire.

The Worcestershire CDOP continues to be effective in fulfilling its statutory function, as part of the responsibilities of the local safeguarding Children Board, to review the deaths of every child under the age of 18 years residing in the county; the key purpose of this is to learn lessons and reduce the incidence of preventable child deaths in the future.

WCDOP contributes directly to the work of Worcestershire Safeguarding Children Board, which is the statutory partnership for ensuring that agencies work in effective collaboration to safeguard and promote the welfare of children to produce positive outcomes for children and their families.

The Child Death review process has now been in existence for ten years following its inception in April 2008. Since that time, the statutory guidance has been updated with the publication of Working Together to Safeguard Children in March 2010, with revisions in 2013, 2015, 2017 with a further revision expected in mid-2018

During 2017-18 WCDOP met **9** times reviewing a total of **25** deaths.

Previous annual reports of the Worcestershire Child Death Overview Panel have included information about the "raison d' être" for the child death review process, a summary of the statutory guidance and other information to assist those unfamiliar with the process. In the 2013/14 Annual Report we set a precedent to produce more concise reports and have continued that practice.

WCDOP Data Summary 2017/18

- Between 1st April 2017 and 31st March 2018, Panel received a total of **25** Death Notifications of Worcestershire resident children along with managing information about the deaths of 10 non-residents
- **76%** of notifications were **male** with **24% female**
- **60 %** of deaths recorded were of **children aged less than 1 year**
- **9** of the **25** deaths were unexpected and managed (in whole or in part) through the Rapid Response Process
- Of these **25** deaths reported to CDOP in 2017/18, **14** cases were reviewed at Panels in this year
- A further **11** of these cases await review
- Since 2008, the average number of annual notifications received is **36**

Child Deaths Reviewed by Panel, 2017 - 18

- From 2008-2018 Worcestershire CDOP has reviewed **342** child deaths; **95%** of all received **Notifications [360]**

- WCDOP is most fortunate to have a very experienced independent chair to lead **9** members of Panel representing a range of agencies including 3rd Sector, West Mercia Police, WCC Children's Social Care, WCC Local Safeguarding Board, NHS WH&C Paediatrics, NHS WAHT Paediatrics and Safeguarding CCG

- During the last 2 years there have been many personnel changes in representing agency participants but Panel still has **4 experienced** members who have served for over **5 years**

- During the first 5 years, Panel, developed considerable expertise and consistency in the Child Death Review process with up to 15 established participants from a range of agencies.
  Both WCC Legal Services and WMAS support WCDOP, participating as and when their expertise is requested.
  Panel is keen to further expand participation and with WSCB support has recruited a participant from Education.

- Between 1st April 2017 and 31st March 2018 Panel and Perinatal Sub-Group met on **9** occasions to successfully review **25 cases:**
  NB
  Unusually, the number of deaths reviewed is equal to the number of deaths notified. However, child death reviews are not necessarily concluded in the financial year in which they occur and may also be involved with a range of explorative activities i.e. Coroner's Inquest, Police Investigations, and Litigation (ref Figure 1).

- Modifiable Factors were identified in **40%** of cases.

- There are **4 historic cases** undergoing further investigation processes.

- In 2015/16, there was a back log of Rapid Response (RR) child deaths pending review which, despite many fewer unexpected deaths, has now risen again. This is due, in part to delays in post-death processes such as Post Mortem and or Inquest.

Figure 1 Worcestershire CDOP Activity Since 2008

Data Breakdown for Child Deaths Reviewed by Panel in 2017/18 will be found in Appendix 1b

	Child Deaths Reviewed by WCDOP 2008-09	Child Deaths Reviewed by WCDOP 2009-10	Child Deaths Reviewed by WCDOP 2010-11	Child Deaths Reviewed by WCDOP 2011-12	Child Deaths Reviewed by WCDOP 2012-13	Child Deaths Reviewed by WCDOP 2013-14	Child Deaths Reviewed by WCDOP 2014-15	Child Deaths Reviewed by WCDOP 2015-16	Child Deaths Reviewed by WCDOP 2016-17	Child Deaths Reviewed by WCDOP 2017-18	Pending Child Death Reviews	Child Deaths Reviewed	Number of Child Death Notifications Received
2008-09	11	21									0	**32**	**32**
2009-10		23	18	3	1	1					0	**46**	**46**
2010-11			18	16	1		1+1*				0	**36+1**	**36**
2011-12				10	23						0	**33**	**33**
2012-13					15	23	2	1	1		1	**42**	**43**
2013-14						14	21	1		1	0	**37**	**37**
2014-15							23	19			1	**42**	**43**
2015-16								14	20	2	2	**36**	**38**
2016-17									15	8	4	**23**	**27**
2017-18										14	11	**14**	**25**
Totals	**11**	**44**	**36**	**29**	**40**	**38**	**47+1**	**35**	**36**	**25**	**19**	**341+1**	**360**

Learning from Child Death Review

Of the **25** Child Deaths reviewed by the CDOP in 2016/17, **10 deaths** were considered to have **'Modifiable Factors'**

This term indicates that the Panel has identified one or more factors which in combination, **may** have contributed to the death of the child and, by means of locally, regionally, or nationally achievable interventions, could be modified to reduce the risk of future child deaths

Modifiable Factors Identified during the review of Perinatal Deaths:

- Smoking in Pregnancy
- Substance Abuse in Pregnancy
- Obesity: BMI 30^{+}
- Sub-optimal Delivery Management
- Sub-optimal Post-delivery Management

Modifiable Factors Identified during the review of Child Deaths:

- Sub-optimal Medical Care Management
- Lack of Public awareness that the sharing of suicidal ideas must be taken seriously and acted upon as expert opinion advises; people who express suicidal thoughts go on to take their lives
- Peers with whom suicidal thoughts are vocalised need to be educated that it is not an act of betrayal to share this information with adults
- Mental health support recently self-terminated
- Smoking in Pregnancy
- Smoking in the Home Environment
- Access to and use of illicit or illegal drugs
- Failures in Multi-Agency Information Sharing
- Lack of Professional Curiosity
- Poor parenting capacity; poor supervision

The Child Death Review, CDR, process generates learning points and recommendations from overviews by the Panel. A comprehensive action plan matrix is maintained to record, update, and monitor the actions and to establish completion.

Actions enacted include:

- An annual audit of the management of the Safer Sleeping Initiative following a reduction in the deaths classified as SUDICs. This has included further staff training for professionals to disseminate this message; see Developments and Initiatives

  Encouraging the exploration of improved pathways concerning the management of pre-pregnancy planning in relation to smoking cessation and obesity, factors which can make examination & assessment of pregnancy difficult, particularly abdominal examination. Indeed 25% of Worcestershire women present to book Midwifery Care with a BMI of 30+ and although this is not as high risk as BMIs of 35+, it is a trend that could be addressed via a Public Health Campaign i.e. 'Get Fit B4 U Get Pregnant' including the appreciation of obesity in parents as a risk factor for children.

- Commending the management of inter-agency collaboration following the presentation of young mothers in labour both those aware and unaware of being pregnant.

- Subsequent to PSG review, learning and amendments to training, policies and practises have been cascaded within the Informal CDOP Network in England.

- Following robust PSG procedures which have uncovered and linked many factors of concern; Police and Children's Services are invited to reviews, as appropriate, and subsequent exploration of safeguarding action is undertaken including more thorough multi-agency information sharing.

- Sharing the frequently occurring issues of environmental stresses including overcrowding and deprivation.

- Encouraging the appropriate management of pregnancy and the deployment of Advanced Care Plans for babies with known Life Limited conditions; with the inclusion of Mothers in 'PAGE Study', **P**renatal **A**ssessment of **G**enomes & **E**xomes, which strives to gain a better understanding of genetic variants causing developmental problems during Pregnancy and aims to improve prenatal diagnostics, allowing better genetics-derived prognoses & more informed parental counselling in the future.

- Ensuring good support for families with signposting from the Acute Health Trust Bereavement Midwifery Team to commissioned bereavement support in Worcestershire provided by Acorns, Kemp, St Richards and Primrose Hospices.

- Recommending high quality integrated multi-agency working in relation to many children with life limiting or terminal conditions.

- WCDOP Manager facilitating the development of improved communication pathways between Tertiary and local professionals for both babies and children including follow-up appointments for parents following a negative transfer to a Tertiary Centre. Many examples of excellent collaborative working between WCDOP Manager and local Acute Health Trust Midwifery, Obstetrics and Neonatology; managing information flow and ensuring copies of all documentation is shared.

- Drawing attention to the continuing problems encountered when significant numbers of new-born babies and mothers have to be transferred, both in-utero and ex-utero, to other hospitals with Level 1 specialist neonatal services in locations where neonatal cots are available such as Coventry, Stoke-on-Trent, Bristol, Liverpool and Plymouth since there is no provision for this level of care in Worcestershire. Coupled with issues around locating cots at tertiary centres, an agreement in the West Midlands for all in-utero transfers to be automatic to Birmingham Women's Hospital would be most beneficial?

- Commending the high quality of care and family support provided by Acorns Hospice and the Orchard Service for children and their families in the palliative stage of their care.

- Review of the WSCB Suicide Prevention Policy to include reference to the forwarding on of shared suicidal thoughts and that it is not an act of betrayal to share this information with adults.

- Health and Well Being Board is devising a Suicide Prevention Plan into which many of the issues arising and initiatives undertaken from review of deaths categorised as 'Suicide or Deliberate Self-inflicted -Harm' can be incorporated.

- Historically, Panel has tried to take the view that all Suicides should be preventable and therefore there should always be Modifiable Factors. However, regarding some deaths categorised as 'Suicide or Deliberate Self-inflicted -Harm', in some instances no Modifiable Factors can be identified.

Developments and Initiatives

Review of West Mercia SUDIC Policy

The document "Sudden Unexpected Death in Infancy and Childhood" is a report which gives multi-agency guidelines for subsequent care and investigation of such cases. This report was generated by a working group, Chaired by Baroness Helena Kennedy QC, convened by The Royal College of Pathologists, endorsed by The Royal College of Paediatrics and Child Health and was published late November 2016.

Subsequent to this the West Mercia Protocol for Sudden, Unexpected Deaths in Infants and Children (WM SUDIC Protocol) has been reviewed in 2017/18 to ensure advice from the above report is incorporated into the local practices for the management of Rapid Response deaths, now referenced as Joint Agency Response deaths, JARs.

Safer Sleeping Initiative

The Worcestershire Safer Sleeping Risk Assessment Form has been operational since October 2013. All new born babies now have an in-depth review of their sleeping arrangements and a discussion of risks pertinent to them, to enable parents and carers to make informed decisions about how to care for their baby during sleep time.

During 2017/18, for the first time since the inception of WCDOP, **NO** child deaths were categorised as 'sudden and unexpected deaths in infancy'. Is this testament to the efficacy of the Safer Sleeping Initiative?

Following interest from the West Midlands Parent Held Record Group in the Worcestershire Safer Sleeping Initiative, a safer sleeping pro-forma has been devised which is now included in the Health Visiting 'Red Book' and implemented throughout the West Midlands region. This initiative has now been further adopted by Child Health agencies in several areas of England.

Rapid Response

There were significant personnel changes to the Rapid Response Team with appointments to the SUDIC Nurse and Administrator posts in 2016/17, which are now bedding-in.

During 2016/17 and 2017/18 for a variety of reasons, a back log of Rapid Response cases developed. These have been examined fully and specifically addressed to ensure that, going forwards, reviews are undertaken in a timely fashion. This has included discourse with the Coroner to ensure optimum information flow between agencies.

9 unexpected deaths were reported in 2017/2018; 36% fewer deaths than the 10 year average of 14. An audit of these deaths has been undertaken to ensure the protocol is being followed appropriately. Some key learning points identified include:

Continuing to ensure all children who have died are transported to Acute Hospital Emergency Department so that a full review and SUDIC samples can be obtained.

It is unfortunate that in 2 instances this was not undertaken. However, these deaths took place outside Worcestershire where the deceased children were taken to Tertiary Centres unaware of their local SUDIC Protocols; learning has been disseminated to the local CDOOPs involved.

Acute Trust Bereavement Midwifery Team

The Panel is delighted to share that its persistent endorsement of the Department of Health recommendation for the CCG supported appointment and deployment of a Bereavement Midwife is having synergistic effect on child death bereavement support and future pregnancy planning.

Indeed such is the efficacy of this role that in 2017/18, an additional member of staff has been recruited now providing 7 full time days [weekly] Bereavement Midwifery personnel.

In 2018/19 there are plans to increase staffing to a Midwifery Bereavement Team of 3; providing 9 days full-time [weekly] Bereavement Midwifery Services to families.

Following child death reviews at PSG, the Worcestershire Acute Health Trust, WAHT, Bereavement Midwifery Team has been proactive in cascading learning with colleagues with many notable positive outcomes for women and babies such as:

- √ Addressing the issue of Early Booking for Mothers with multiple miscarriages or Pre-Term Delivery History; Local Midwifery Audit has recognised that women with history of early pregnancy losses are now seen at an earlier stage in subsequent pregnancies.

- √ Raising the Obstetric and Paediatric cognizance of consultant promotion of Post Mortems (PM) with parents; although not always giving exact Cause of Death a PM outcome may rule out particular issues & support future pregnancy planning.

- √ The amendment of Midwifery Policy to address non-attendance at any antenatal appointments.

- √ The development of a local 'Neonatal Palliative Care Guideline'; to support parents in cases of known Life Limited conditions i.e. Edwards Syndrome & issues of organ donation.

- √ Ensuring that women who have undergone surgical cervical procedures are clearly aware of the time delay required between surgery and conception since in such instances there is higher risk of cervical incompetence

- √ Addressing the local management of post mortem examination of placentas.

Perinatal Mortality Review Tool

A collaboration led by MBRRACE-UK has been appointed by the Healthcare Quality Improvement Partnership [HQIP] to develop and establish a national standardised Perinatal Mortality Review Tool [PMRT].

The PMRT has been designed with user and parent involvement to support high quality standardised Perinatal Reviews .The aim of the PMRT programme is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales.

The tool supports:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each Stillbirth and Neonatal Death, and the deaths of babies who die in the post-neonatal period having received neonatal care

- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process

- A structured process of review, learning, reporting and actions to improve future care

- The contract for the PMRT programme will run for three years until 31st January 2020

This tool was adopted by WAHT in the final quarter of 2017/18 to support the well-established WAHT Perinatal Morbidity Mortality Meetings, PMMMs; now re-named PMRT meetings.

However, whereas a Form C was completed following PSG meetings and used to inform and support local Perinatal Morbidity, Mortality Review, we have decided to convene PSG meetings post-PMRT to review a Draft Form C of all available collated information from agencies involved along with the locally or tertiary completed PMRT.

Often there are outcomes arising from the PSG CDR which are in addition to issues highlighted at PMRT review since information is provided by a wider data set, inclusive of CSC, Police and GP, to the exclusively medical nature of the PMRT. As before, learning and improvements are disseminated accordingly.

Review Proforma 'Form Cs'

Adapted Form Cs to support the review of SUDIC, Perinatal/Neonatal and Suicide Deaths were initially introduced in 2012/13 and continue to be further improved to provide more effective tools to identify risk factors pertinent to the review of particular deaths.

By request, these proformae have been shared within the CDOP Network England.

Review Proforma 'Form Bs'

The adapted Form Bs and exemplars have also been further been improved to aid ease of information sharing and completion.

However, although some professionals, particularly in Worcestershire, are keen to share information and provide a variety of documentation to support review, it is very challenging when Tertiary Centres do not promptly forward information. We are continuing to engage with the West Midlands Strategic Maternal and Children's Network and West Midlands CDOP Group to address this issue.

Other Developments and Initiatives:

- The active participation of WCDOP in the pooling of initiatives and child death information through an informal England-wide CDOP Network.
  Learning noted elsewhere is further shared at WCDOP including concerns raised by a Coroner regarding a baby death related to sleeping in a 'Poddle Pod'. These issues have subsequently been disseminated by WCDOP Manager to Worcestershire agencies.

- Further engagement with the Manchester University Study into Suicide and Young People.

- With reference to this Manchester Study, Panel requested an independent thematic review of historic Worcestershire CDRs categorised as 'Suicide or Deliberate Self-Inflicted Harm' and reviewed by Panel to 2008-2016; data was found to be broadly in-line with findings from Manchester Suicide Study.

- Further improvements to the Worcestershire Child Death Leaflet to explain the WCDOP processes along with a second leaflet providing details of helping organisations to support bereaved families.
  An audit has demonstrated these leaflets have been provided for all parents of children experiencing an expected death by either a Health Care Professional known to the family, Acorns or the Worcestershire Acute Health Trust Bereavement Midwife Team and are published on our annually up-dated website.

- An excellent working relationship between WCDOP and the Acute Trust Bereavement Midwifery Team is now well established to support information gathering to support review along with communication and feedback from PSG to bereaved families and advice for future pregnancy planning.

- WCDOP has established a bespoke approach to working with bereaved families and provides feedback from the WCDOP Child Death Review processes at the direction of the Chair.

- Thematic Perinatal/Neonatal Reviews (including those requiring a RR) continue to be undertaken by a well-established sub-group of Panel, the Perinatal Sub-Group (PSG). This group is hosted at Worcester Acute Trust Hospital with committed participation by Neonatology and Obstetric Consultants along with the Bereavement Midwife and is led by Panel Deputy Chair with other agencies invited as appropriate to the CDRs undertaken
  95% of PSG reviews are completed within 6 months of death so ensuring parents receive timely feedback and support with future pregnancy planning.

- Thematic reviews of children who have died following Life Limited/Life Threatened condition continue to be undertaken by a well-established sub-group of Panel, the LL/LT Sub-Group (LL/LTG). This group is hosted at Acorns Hospice for the Three Counties and is led by Panel Chair with agencies invited as appropriate to the CDRs undertaken.

- Most WCDOP reviews have been completed as quickly as the necessary pre CDOP processes (PM, Inquest etc.) are concluded, with the information available to inform the review, provide timely feedback to families and support the implementation of recommended actions. However, increasingly there are cases outstanding because parents are pursuing legal redress or there are delays in the coronial process

- Effective communication between Panel and Acute Health Trust Paediatrics is now established with a nominated Consultant Paediatrician joining each WCDOP meeting. The strong relationship between CDOP and the Acute Health Trust has again been positively commented on by Care & Quality Commission, CQC, praising this partnership of open and proactive review

- Panel has established effective communication to and from WSCB with WCDOP Manager attending the Improving Frontline Practice Group, IFPG, to which WCDOP provides quarterly reports.

- Panel has also developed effective relationships with Worcestershire Health and Well-being Board and Public Health through active participation and information flow via the Public Health representation at CDOP and IFPG meetings.

- Continued support of the Review of Children's Services and WCDOP's Child Death Review processes, with requested documentation shared.

- Membership of both the West Midlands and the proactive England CDOP Network; which actively promotes the sharing of good practice and initiatives along with data sharing and data analysis.

- Working with Birmingham University to support the provision and implementation of in-service training of healthcare professions re Child Death Review

Future Activities

Changes to the Processes of Child Death Review
The Government's response to the publication of the Wood Report [December 2015] was shared in the form of a series of draft publications [Autumn2017] outlining proposed changes to the current Child Death Processes.

Feedback was sought via a series of 'Workshop' Events [attended by WCDOP Chair, Manager and WSCB Manager] along with written comments from interested parties including WSCB.

The outcomes of this consultation process were published early during 2018 and draft publications adjusted accordingly.

The transfer of National oversight of CDOPs from the Department of Education to the Department of Health is most welcome; WCDOP has long campaigned for this initiative.

WCDOP was also pleased to be advised that many practices undertaken as culture by our Panel are to be incorporated into the 'New Arrangement for CDR':

- Removal of term 'Preventability' focused move to '**Modifiable Factors'**
- Themed CDOP Review Meetings
- Introduction of Statutory 'Key worker' role for Bereaved Parents
- Revised Analysis Form [formerly Analysis Form C]

WCDOP Chair and Manager expect these documents to be the principal focus for changes to the WCDOP processes during 2018/2019 and look forward to working with our Safeguarding & CDR Partners to support the successful implementation of these 'New Arrangements'.
Please refer to:
Figure 2 ***Implementation Timeframe re 'New Arrangements for Statutory Child Death Review'***

Figure 2 Implementation Timeframe re 'New Arrangements for Statutory Child Death Review'

This information is correct as of 27 July, 2018

Phase	Completed	Task	Notes
Autumn 2017	30 December 2017	Consultation	WCDOP contributed via workshops & narrative submission
Early 2018	Mid-March 2018	Assess Consultation Responses & Necessary Amendments	Delayed
Spring 2018	04 July 2018	Working Together & Transition Documents Published	Delayed
29 June 2018 to 29 June 2019	Currently	Proposed 12 month period for Safeguarding & CDR Partners to Agree, & Publish 'New Arrangements'	Challenging owing to 3 month delay in publication of CDR Statutory Guidance
Summer 2018	Pending	Parliamentary Scrutiny & Debate completed Cross Government clearance of Guidance & Regulations	Publication of CDR Statutory Guidance expected mid-September 2018
29 June 2019 to 29 September 2019		Proposed 4 month period for CDR Partners to Implement 'New Arrangements'	
30 September 2019		'New Arrangements' for Child Death Review commence	
30 September 2019 to 29 January 2020		Period in which all outstanding Child Death Reviews [Notifications received before 30 September 2019] are completed by current CDOPs	

Other Activities Under Consideration Include:

- What could Public Health Worcestershire undertake to reduce smoking during pregnancy and smoking by parents with young families? Along with, the promotion of pre-pregnancy education i.e. 'Get Fit B4 U Get Pregnant' campaign addressing obesity, smoking and incompetent cervix issues with women planning a future pregnancy.

- Improvement to the Safer Sleeping Risk Assessment Form to include obesity along with smoking, drinking alcohol and co sleeping, which are discussed with parents as key risks for SIDS.

- Widening membership of WCDOP to include the participation of a faith group representative to strengthen the multi-agency nature of Child Death Review.

- The devising of an advice pack for Schools 'Experiencing a Child Death' has been explored with the recently appointed WCC Safeguarding Advisor and is anticipated to be completed during 2018/19

NB

With reference to Figure 1 [Page 6]:

* line '2010-11' / Column 'Child Deaths Reviewed 2014-15' relates to a Child Death reviewed by Panel a 2nd time.

Appendix 1a DfE Child Death Review Data

Owing to the changes in Child Death Review processes at Government level WCDOP, along with all CDOPs in England was advised [March 2018] that data from 2017/18 would be collected to support comparative analysis; with further detail to follow ……

Since March 2018 WCDOP Manager has undertaken regular communication with both DfE and DH regarding the collection of data in England; at this juncture there has been no further correspondence received on this matter.

We feel it is best to produce the Annual Report for 2017/18 without this comparative data rather than delay publication further.

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Appendix 1b Data Breakdown for Cases Reviewed by Panel 2017/18

Figure 3: Breakdown of Child Death Reviews completed by CDOP 2017/18 arranged by Category of Death and indicating No Modifiable Factors / Identified Modifiable Factors

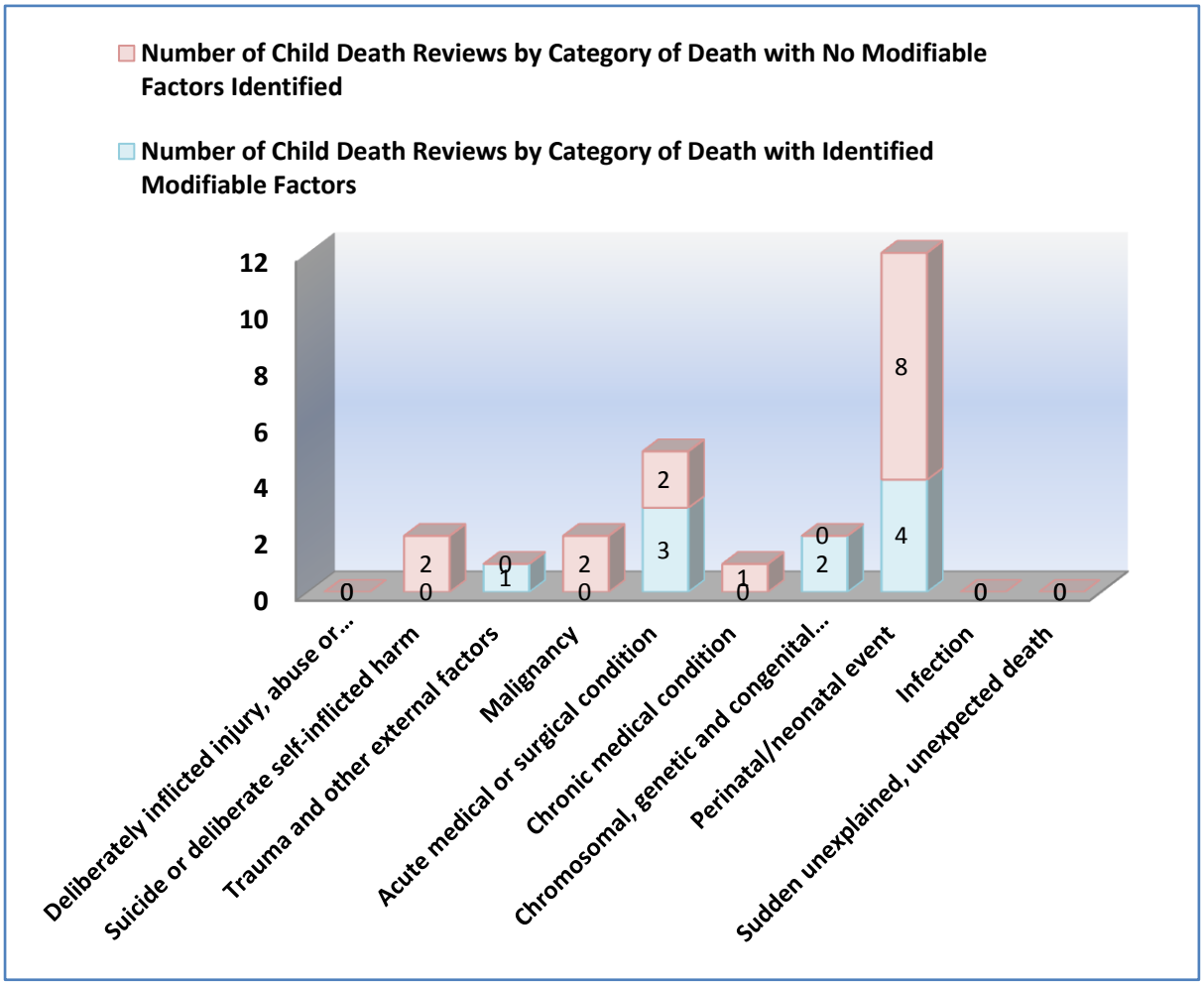


Figure 4: Breakdown of Child Death reviews completed in 2017/18 arranged by Location of the Child Death

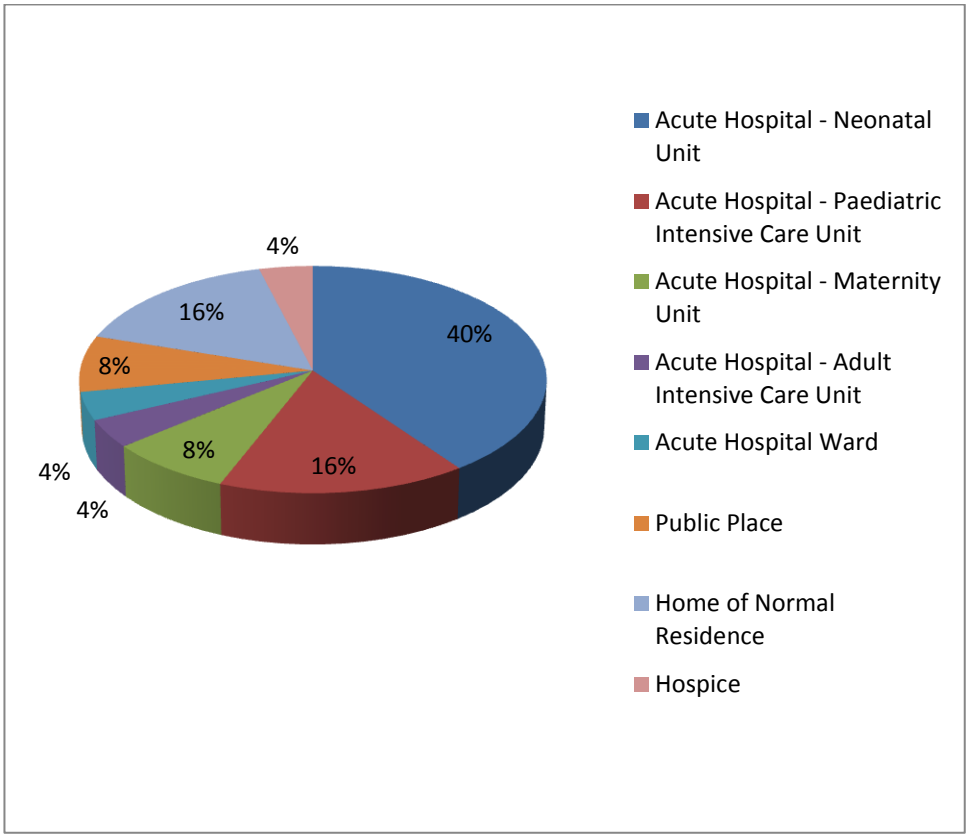
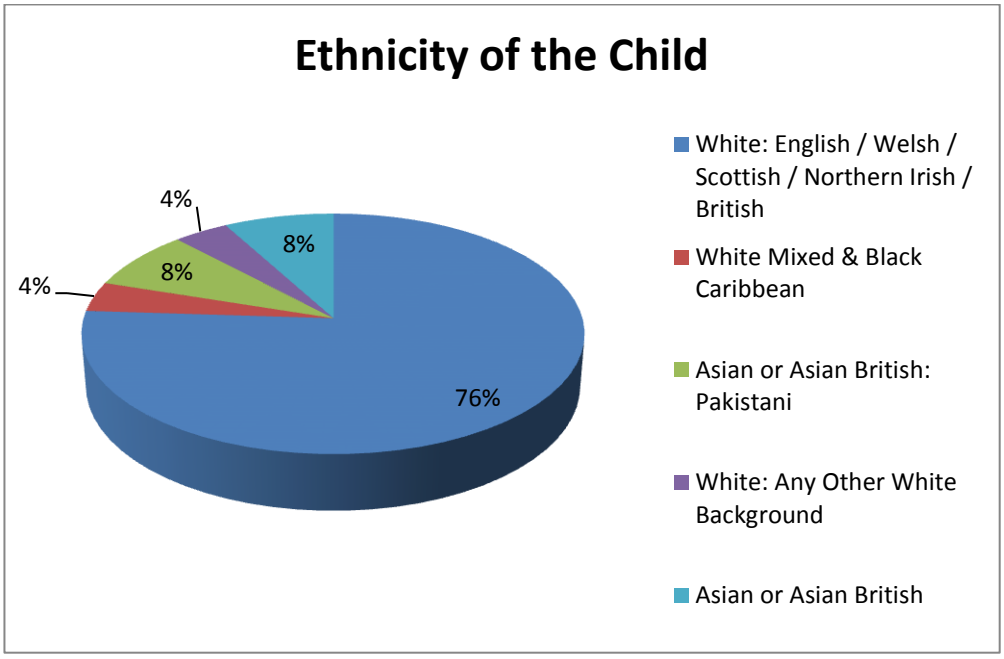
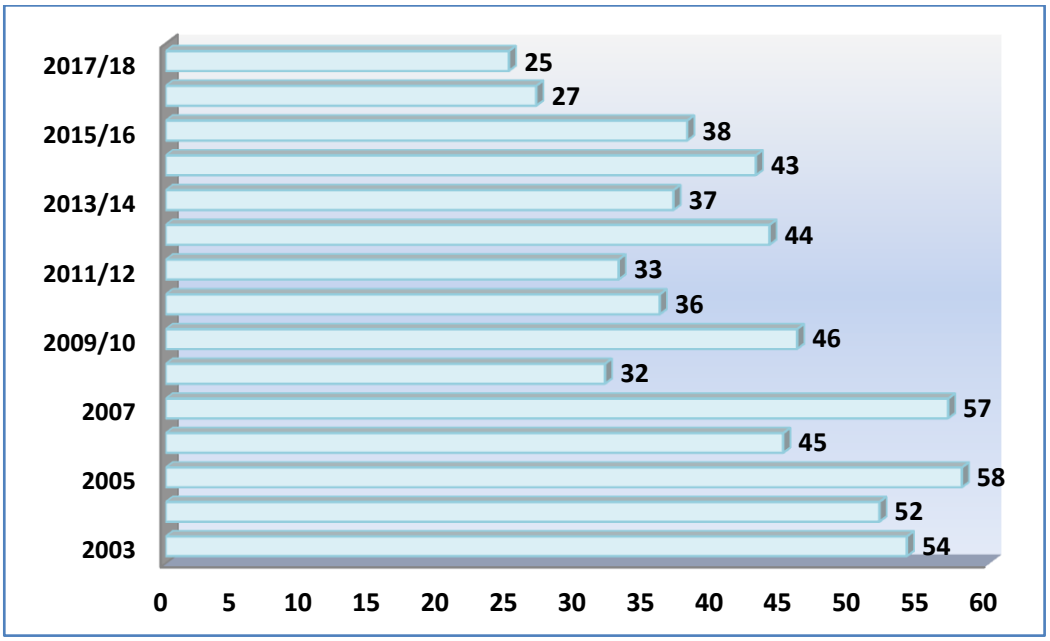


Figure 5: Breakdown of the 25 Child Death reviews completed by CDOP 2017/18 arranged by Ethnicity



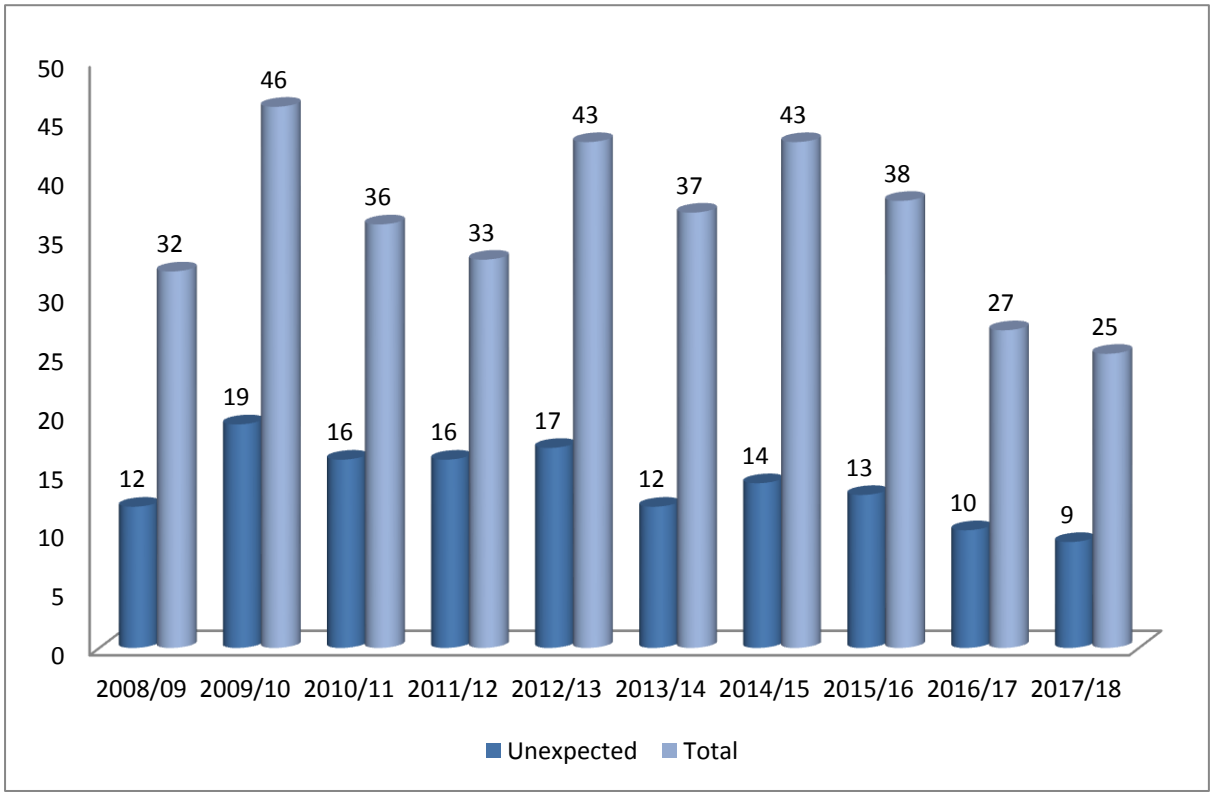
Appendix 1c Cumulative data 2008 – 2018

Figure 6: Number of Child Deaths in Worcestershire



Since 2008, the average number of annual notifications received is **36.**
NB data was collected by a different method prior to 2008/9

Figure 7: Breakdown of Notifications received 2008/09 to 2017/18 by Unexpected Death



The data for 2013/14 to 2017/18 would indicate a reduction of deaths reported to Panel that were unexpected compared to the previous years

Figure 8: Child Deaths in Worcestershire 2008/09- to 2017/18 by age at Death and by Gender

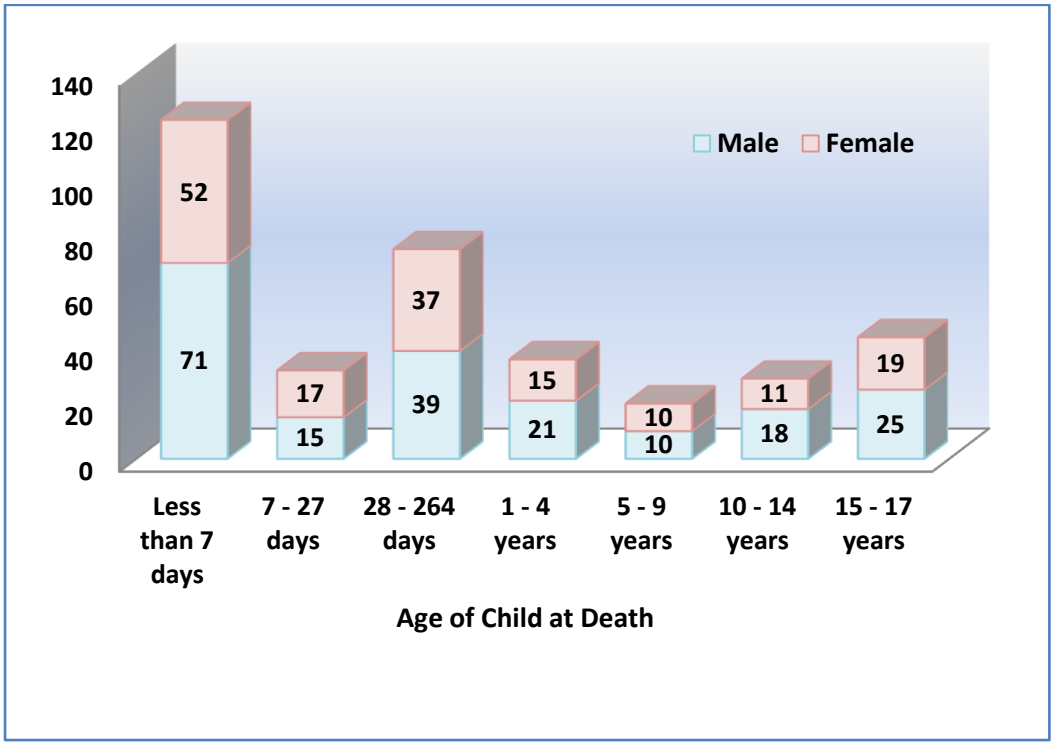


Figure 9: Child Deaths Reviewed Identified as Having Modifiable Factors, 2008 to 2018