1 INTRODUCTION

1.1 Following a number of high profile court cases, the Royal College of pathologists and the Royal College of Paediatrics and Child health established an intercollegiate working group to review how sudden deaths in infancy should be investigated; the report was published in 2004.\(^1\) Although there is a need for more research to understand why some infants die, there was a greater need to establish a national protocol for the investigation of unexpected death in infancy.

1.2 In March 2013, the Department of Education published its revised guidance ‘Working Together to Safeguard Children’,\(^2\) which reinforced the requirement for the Child Death Review process to continue as a duty of the Local Safeguarding Children Board.

1.3 The process of reviewing every child death has been a statutory requirement since April 2008. The statutory requirement is that the death of every child is reviewed from all live births up until the day before a child’s eighteenth birthday.

1.4 The Child Death Review Manager (CDRM), who is employed by the Somerset Clinical Commissioning Group, manages the Child Death Overview Process on a day-to-day basis and is responsible for collating the information for the Child Death Overview Panel.

1.5 During the year April 2013 until March 2014 there have been 35 child deaths notified to the Child Death Review Manager. The Child Death Overview Panel is not able to review a death until all information is gathered and other processes have been completed, such as post mortem reports and coronial inquests. This in effect means that a number

---


\(^2\) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. DfE (March 2013)
of cases will be subject to review this present year although 15 of the cases have been reviewed at the Panel during this reporting year.

1.6 This report summarises the work of the Somerset Child Death Overview Panel during 2013-2014 and looks at the emerging themes from the previous years. This is Somerset’s sixth annual report.

2 HM CORONIAL SYSTEM

2.1 The Coroners and Justice Act 2009 has introduced a new concept of a “coronial investigation”, which became law on 25 July 2013. The whole process (including the inquest itself) is now known as an investigation, which commences as soon as a death is reported to the coroner.

2.2 The Coroner will continue to require a post mortem examination for unexpected deaths, but when the Coroner confirming death by natural causes has received the final post mortem report, a letter will be sent to the family advising them that this is the case and the investigation is being discontinued. It is hoped that with these changes, it will be less distressing for parents and where there is a need for an inquest, this will be a speedier process.

2.3 In cases where the inquest had already been formally opened, it must be concluded in accordance with previous practice.

3 CHILD DEATH REVIEW PROCESS

3.1 The overall purpose of the child death reviews is to understand how and why children and young people die identifying any interventions or improvements to services, which may help to prevent future deaths and/or improve experiences for families receiving services.

The process of the child death review is to:

- document the cause of death for the child or young person
- recognise any factors which may require a more in depth review by agencies and/or make recommendations for review of service provision
- identify any pattern of deaths within the local community to enable recognised modifiable factors to be reduced

3.2 Under the requirements in Chapter 5 of Working Together 2013, there are two major components to the Child Death Review Process, firstly the Rapid Response, including the multi-agency meeting, parental involvement and data collection, and secondly the Child Death Overview Panel.
Rapid Response

3.3 The Rapid Response describes a process of communication, collaborative action and information sharing following the unexpected death of a child. Its purpose is to ensure that agencies work together:

- to respond promptly to the unexpected death of a child
- make immediate enquiries into the reasons for and circumstances of the death, in agreement with the Coroner and Police
- undertake enquiries that relate to the current responsibilities and actions of each organisation when a child dies unexpectedly, to include the collation of information to enable future case analysis
- ensure ongoing support and communication with family members and relevant professionals to share information as appropriate.

3.4 The importance of following the correct procedure was brought to the Child Death Overview Panel following the publication of a serious case review by another authority, in which neither the protocol was followed nor were safeguarding concerns adequately investigated. Although the process is well established in Somerset the learning from the review, served to embed the reasons for compliance.

3.5 The Somerset process following all unexpected deaths includes:

- an early strategy meeting with liaison in person or by telephone with Children Social Care
- examination of the deceased child by the police and paediatrician, including collection of Kennedy samples (as described in the paediatric protocol) so that examination of tissues is enabled promptly to ascertain the cause of the child’s death.
- joint visit to the child’s home by senior police officer and paediatrician to view the family home; hear the narrative of events from the family as well as advising them of the process of the review. The joint visit allows for a fuller in depth analysis of events leading up to the child’s death.

3.6 The Rapid Response Protocol was followed for nine unexpected deaths during 2013 – 2014. The following table (1) provides a breakdown of the age ranges instigating the rapid response process for this reporting year.
Rapid Response 2013 - 14 per age range (Table 1)

<table>
<thead>
<tr>
<th>AGE RANGE</th>
<th>Number of Rapid Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth - four weeks</td>
<td>2</td>
</tr>
<tr>
<td>Four - six weeks</td>
<td>1</td>
</tr>
<tr>
<td>Three months - six months</td>
<td>2</td>
</tr>
<tr>
<td>Two - five years</td>
<td>2</td>
</tr>
<tr>
<td>Eleven - eighteen years</td>
<td>2</td>
</tr>
</tbody>
</table>

Multi-Agency Meeting

3.7 The multi-agency meeting should be held as soon as practicable within two – three months after the child’s death, although can be delayed due to outstanding post mortem reports and the availability of Consultant Paediatric Pathologists. One of the two Designated Doctors for Child Death chairs the meeting.

3.8 In essence, the multi-agency meeting can provide the story of the child, ‘the child’s journey’. Parents have often by this stage contributed to the review through their contact with one of the key professionals, or by sending questions to the Child Death Review Manager. Following the meeting feedback is then offered to the family by an appropriate known professional, often the Paediatrician or the family GP.

3.9 Professional attendance at the multi-agency meeting varies between cases being dependent on the health and social needs of the child, age of the child and whether the death was expected or unexpected. For children with chronic or complex health needs professional involvement may include out of county teams from the tertiary hospital. The importance of full professional attendance cannot be over emphasised and can provide both the specialist and local context to the child’s story, as well as fuller analysis and the opportunity to learn lessons.

Example of a Multi-Agency Meeting (Table 2)

<table>
<thead>
<tr>
<th>Chair</th>
<th>Designated Doctor for Child Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-ordinator</td>
<td>Child Death Review Manager</td>
</tr>
<tr>
<td>Local Hospital</td>
<td>Consultant Paediatrician</td>
</tr>
<tr>
<td></td>
<td>Paediatric Dietician</td>
</tr>
<tr>
<td></td>
<td>Community Children’s Nurse</td>
</tr>
<tr>
<td>Integrated Services</td>
<td>Speech and Language Therapist</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td></td>
<td>Physiotherapist</td>
</tr>
<tr>
<td>Primary Care</td>
<td>GP</td>
</tr>
<tr>
<td></td>
<td>Health Visitor</td>
</tr>
<tr>
<td>Tertiary Centre</td>
<td>Consultant Paediatrician</td>
</tr>
<tr>
<td></td>
<td>Specialist Consultant Paediatrician</td>
</tr>
<tr>
<td>Hospice</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Children Social Care</td>
<td>Social Worker Disabilities Team</td>
</tr>
<tr>
<td></td>
<td>Vision Support Worker</td>
</tr>
</tbody>
</table>
Parental Involvement

3.10 Each death of a child is a tragedy for family and friends and enquiries should be appropriately balanced between the forensic and medical requirements whilst supporting the family at a difficult time.

3.11 Professionals supporting parents and family members should assure them that the objective of the child death review is not to apportion blame, but to learn lessons to prevent further such child deaths.

3.12 Bereavement support information is sent to professionals who are most likely to be involved with supporting the family; this includes details of a number of charities who provide listening services and/or on-line web pages, which may be suitable for siblings to use.

3.13 The letter that is sent to parents has been revised this year in an effort to increase transparency of the death review process, to make it easier for parents to contribute. A number of parents have made contact since the letter was revised in June 2013.

3.14 Parental enquiries and contributions have included:

- a mother requesting information with regard to a follow up appointment with the tertiary hospital centre. Following contact with the paediatrician involved, it transpired that there had been efforts to contact the mother. When informed of this outcome the mother who understood the need for the review process stated that it was helpful that she was able to make direct contact with the team.

- a telephone contact involved a mother requesting when she would be able to meet with the designated paediatrician, this gave her an opportunity to talk about the loss of her child and how the family were coping.

- a mother was able to seek clarification about the parallel coronial and Child death Overview Panel enquiries. She was advised of the process and progress of the review and encouraged to contact the team if further assurance was required.

- a mother when she met to discuss the death of her child with the named paediatrician felt that the letter received by parents was blaming her for her child’s death. Following her comments, renewed efforts have been made to ensure that professionals who may see the parents discuss the letter and offer to take any parental comments or questions to the multi-agency meeting.
- A grandfather telephoned the Patient Advice and Liaison Service (PALS), whose number is given on the letter to parents, to request bereavement support for his son and daughter-in-law. Prompt liaison with the Child Death Review Manager and the PALS Officer facilitated contact with the health visiting team to ensure the parents were offered support.

**Data Collection**

3.15 The information collected for the Child Death Overview Panel includes quantitative and qualitative data. The collection of qualitative data provides the narrative of professionals who have been part of the child’s story, supporting the analysis of the case review but also providing the basis for learning and service improvement.

3.16 To review each individual child’s death requires the collection of information about the circumstances of the death, categorising the cause of death in accordance with the national dataset, identifying if there were any modifiable factors that may have prevented the death, and determining what lessons can be learnt.

3.17 Aggregated anonymised data is also submitted once each year to the Department of Education who report the year’s data centrally and publish an Official Statistical Release every year. This provides the comparable data for England and informs the strategic planning for services.

3.18 During the year April 2013 until March 2014, the Child Death Overview Panel reviewed 30 retrospective cases.

**Child Death Overview Panel**

3.19 The Child Death Overview Panel (CDOP) is a multi-agency group of professionals who are responsible for reviewing information collated on all child deaths, expected or unexpected, in Somerset. The panel considers every death of a child or young person under the age of 18 years.

3.20 The Panel chair is a Consultant for Public Health, although during the interim period of the post being vacant, the Director of Quality and Patient Safety from the Clinical Commissioning Group and the Local Safeguarding Children Board Safeguarding Manager provided the continuity of scrutiny and compliance.

3.21 During this reporting year, the panel has met four times and there has been consistent senior representation and commitment from participating agencies, enabling a collaborative discussion for specific recommendations to improve services for children, young people and their families.
The number of deaths has shown little variation in the last three years following the previous 41 deaths reported in 2009-2010 and 24 in 2010-2011. (Table 4)

**Child Deaths and CDOP Case Reviews for 2008-2014 (Table 4)**

The highest numbers of deaths has occurred in the first year of life, with Birth – 28 days showing a slight downward trend in the last two years (Table 5) and a correlated upward trend for 28-365 days, during the same period. One reason for this is that infants born prematurely fall into both these categories.

**Child Deaths: Birth-28days (Table 5)**
The pattern of child deaths seen locally reflect those identified in national findings with the highest numbers of deaths being in the first year of life, the primary causation of this is due to causes being related to perinatal or neonatal events with prematurity being the major contributing factor. Table 6 provides the breakdown of child deaths for the last three years.

### Percentage of Child Deaths per Age Group 2011-2014 (Table 6)

Improving Outcomes for Children and Young People

In reviewing each death the Child Death Overview Panel has a particular focus on identifying whether there were any modifiable factors which may have contributed to the death and what, if any, actions need to be taken to prevent future such deaths.

For children who have chronic or a life threatening illness the focus is also to review the services provided and making recommendations for informed changes to improve the care and support for children, young people and their families.

### FINDINGS FROM CHILD DEATH REVIEWS 2013-2014

During 2013-2014, the Child Death Overview Panel has reviewed thirty child deaths. A requirement of the panel is to record the reason for the child’s death in the category 1-10 in the analysis Form C, this data is used in the annual return to the Department for Education. Table 7
4.2 As in previous years, the highest numbers of child deaths relate to perinatal or neonatal events with babies who die before 28 days; in some cases, a perinatal event may result in a later death although the cause remains that of prematurity. In Somerset 18 neonatal deaths were discussed in this reporting period. Of these, 13 were classified as being extremely premature for babies being born before 26 weeks, and a further 5 babies were born before 37 weeks.

4.3 The Panel members also noted that congenital abnormalities and malignant disease have also been associated with the deaths of babies in the neonatal period. When a health visitor has been made aware of an antenatal diagnosis of foetal anomaly, there has been evidence of excellent liaison with the health visitor maintaining contact with both the hospital and the mother, enabling the development of a therapeutic relationship with the mother, which was invaluable when sadly the baby died.

4.4 However unfortunately, the Panel also noted where an antenatal diagnosis of congenital anomaly or malignancy had resulted in care being transferred to the tertiary centre; information was not always shared with the health visitors who were therefore not able to provide the same sensitive and supportive service. These matters have been raised with the appropriate managers at the tertiary centre.
Modifiable Factors

4.5 The number of deaths in Somerset is small but there is a potential to reduce them further and this is from the analysis of modifiable risk factors, which may have contributed to the death of a child over this and previous years.

4.6 Smoking is a known risk factor for premature birth and there is an increased risk of illness or death from passive smoking if one or both parents smoke. From the cases reviewed at the Child Death Overview Panel during 2013-14, in the group of babies who were born before 26 weeks and died in the neonatal period, six mothers were recorded to have smoked through pregnancy.

4.7 In August 2013, a fact sheet published by ASH (Action on Smoking and Health); information was based on a systematic review of scientific literature on the impact of smoking. Researchers concluded that smoking is associated with 5-8% of premature births. The paper states that ‘In the UK, smoking in pregnancy causes up to 5,000 miscarriages, 300 perinatal deaths and around 2,200 premature births each year’.

4.8 During the case reviews maternal obesity was identified as a potentially modifiable factor. A research study published by the British Medical Journal (BMJ) concludes that maternal obesity may be a factor in pre-term birth and subsequent neonatal loss (BMJ 2010; 341c 3428). In July 2010 NICE Guidelines were published on weight management before, during and after pregnancy. Although mothers who meet the criteria are referred antenatally for dietary advice, there is a need for women to have an understanding prior to embarking on pregnancy of the negative outcome to which their obesity could contribute. The BMJ paper states in its concluding sentence that ‘Overweight and obese women should be counselled before pregnancy on their perinatal risks, and appropriate surveillance should be considered during pregnancy’.

5 EMERGING THEMES

5.1 Due to small numbers of deaths each year, identifying trends and learning themes is problematic. Since 2008, the Child Death Overview Panel has identified a number of modifiable factors and risks, during this year and previous years, which may and have been contributing factors including:

- smoking by one or more partners
- co-sleeping or unsafe sleeping arrangements
- alcohol or substance misuse
- the prevalence of parental emotional and mental health problems
risk taking behaviours by adolescents and suicide risks in young people

5.2 Midwives across the County are engaged in educating mothers about the risks of smoking and support is available for mothers who try to quit.

5.3 Regular consistent advice is the key to reducing risks and both midwives and health visitors provide guidance on the dangers of co-sleeping, particularly when accompanied by other risk factors. In addition, supporting leaflets giving advice to parents and carers who drink alcohol or use drugs ‘Keeping Your Child Safe’ are available for both professionals and the public to download from the Safeguarding Children Board website www.somersetsafeguardingchildrenboard.org.uk

5.4 Awareness raising with professionals with regard to safe sleeping was supported by training sessions provided by the Foundation for Sudden Infant Death (FSID) in previous years. Extension of raising awareness in holiday venues where parents may be more accepting of not adhering to safe sleeping arrangements for their infant, should be a local and national consideration.

5.5 Learning from child deaths, case reviews and serious case reviews has highlighted the importance of a holistic assessment of parents’, health and social history to identify risks to provide early intervention and support, including talking to fathers. Encouraging early antenatal booking and the delivery of the Healthy Child Programme is a framework to identify modifiable factors.

5.6 Understanding the child behind the illness or condition and hearing the voice of the child, looking at compliance with treatment and medical attendance particularly for young people with asthma. Sadly over recent years this has accounted for young peoples’ deaths and Somerset was asked to contribute to the National Review of Asthma Deaths, whose report was published in May 2014.

5.7 There has been no cases of suicide discussed at the Child Death Overview Panel this reporting year but nationally Panels have been finding modifiable factors in self-inflicted deaths which is evidencing that there can be risk taking behaviours. There is a need therefore for schools to work together with other agencies in addressing concerns around risk taking behaviours, but in contrast, some cases have also not identified any modifiable factors.

5.8 It is important that the lessons from child death reviews continue to be shared and embedded in training, to increase awareness in professionals involved with families, of the need to identify the risks. This enables them to work with families to develop strategies, with a focus on reducing the risk of future child deaths and improving health outcomes.
6 PANEL CASE RECOMMENDATIONS FOR 2013-2014

6.1 There have been a number of case recommendations resulting from discussions at Child Death Overview Panel during this reporting period, Appendix 1. The Panel Chair has corresponded with the agencies concerned in order to clarify information or request that appropriate action to improve delivery of care is undertaken.

6.2 Gaps in communication for complex care cases has been identified where timely information has not been received when a Somerset child death has occurred in the tertiary centres, preventing local health professionals particularly GPs, midwives and health visitors from providing early support to the family. The Panel Chair has subsequently written to senior management in these organisations alerting them of these issues and/or to advise them of changes, which have already taken place to improve patterns of care.

6.3 The Panel Chair has also written to individual practitioners from Children’s Social Care, GPs and Health Visiting teams who have clearly offered both a high standard of care and communicated across local and tertiary care. The Child Death Overview Panel Chair has also commended the work of the South West Ambulance Service Trust Crews in terms of their resuscitation efforts whilst transferring children and young people to hospital.

7 RECOMMENDATIONS

7.1 LSCB

- For the Local Safeguarding Children Board to approve the report
- For learning from the Child Death Overview Panel to be shared with partner agencies for consideration in practice and commissioning of services for children and young people
- For the CDOP database to be reviewed and ensure it meets the requirements for Somerset data collection, including the reporting for DfE

7.2 CDOP

- Ensure that all child deaths are reported on the Clinical Commissioning Group Datix, reporting system, to enable prompt review and tracking of cases of concern
- Refer cases of concern to the LSCB Learning and Improvement Subgroup
- Develop a research base for key themes and main modifiable factors identified to inform future commissioning of services and improve outcomes for children and young people

- Review the CDOP Operational Policy in line with National and Local Guidance
### CHILD DEATH OVERVIEW ANNUAL REPORT 2013-2014
Appendix 1: CDOP Case Recommendations

<table>
<thead>
<tr>
<th>Date of CDOP</th>
<th>Rationale</th>
<th>Issue Identified</th>
<th>Action Taken</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2013</td>
<td>Babies who show signs of life at birth are registered as live births. Some babies die shortly after their birth. All babies registered as live births but subsequently die will be reviewed by CDOP</td>
<td>Inaccurate information may be recorded in GP medical records with the information noted as miscarriage rather than infant death; this has been particularly noted where babies are born prior to 24 weeks gestation. The Coroner confirms that if a baby is live born, even with fleeting signs of life prior to death, it should be reported to the Coroner. The baby’s birth should be correctly recorded in the medical notes as a live birth of a child who subsequently died. It is both a legal requirement and distressing for parents to have their live born child referred to as a miscarriage.</td>
<td>Request made to Director of Patient Safety, NHS England, that this issue be highlighted nationally.</td>
<td>His response indicated that further discussions have taken place with the President of the British Association of Perinatal Medicine.</td>
</tr>
<tr>
<td>November 2013</td>
<td>Good practice by professionals has been noted at CDOP and letters have gone on</td>
<td>An example of good practice was related to a Health Visitor’s excellent communication with a mother from antenatal diagnosis</td>
<td>Acknowledgement of good practice was made and is always appreciated by professionals.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
behalf of the Panel to acknowledge this.

of anomaly through her hospital stay and following the child’s death.

| January 2014 | If a mother has a foetal abnormality diagnosed antenatally, her care may subsequently be transferred to tertiary care where plans may be made for intensive care for the baby at delivery. Good communication with the primary care team antenatally and post-delivery is essential if sensitive care is to be delivered following the birth of a baby whose health may be compromised, or who may subsequently die. | If Health Visitors have not been informed that anomalies have been identified antenatally they are not able to plan optimal care for the family including the offer of an antenatal visit for assessment of the family needs and the ability to build on this contact should there be a poor outcome for the baby. An issue about poor communication with primary care were identified by Somerset CDOP and has previously been raised with the relevant NHS Trusts by the CDOP Chair. | A request has gone to the relevant Trust requesting that there be an improvement in communications with primary care and in particular with Health Visitors. | Awaited |