



**Coventry, Solihull & Warwickshire
Safeguarding Children Boards**

CHILD DEATH OVERVIEW PANELS

ANNUAL REPORT

2014 - 2015

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1 The focus for 2014-2015 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.

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

16 panels were held across the sub-region during 2014-2015 and 84 deaths were reviewed (78 reviewed in 2013-2014). Of the 84 deaths reviewed, 32 (38%) 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 very similar to the previous year where 29 (37 %) had modifiable factors. The breakdown for each LSCB is detailed in the table below:

LSCB	Panels held	Deaths Reviewed	Modifiable Factors
Coventry	6	35	13 (37%)
Solihull	3	12	8 (67%)
Warwickshire	7	37	11 (30%)
Total	16	84	32 (38%)

2.1 Of the 6 Coventry panels held, 5 were full CDOPs and one a Fast Track CDOP. Solihull held 3 full CDOPs. The August 2014 panel was cancelled due to the number of CDOP members on annual leave. This meeting has now been moved back to September in 2015 so it does not clash with the peak holiday season. Warwickshire held 6 full CDOPs and 1 Fast Tack CDOP.

3 Recommendations and actions arising from Coventry CDOP during 2014-2015

3.1 26 actions were progressed from deaths reviewed during 2014-2015. The following is a summary of the learning identified and the actions initiated:

3.2 Deaths with modifiable factors and actions identified:

3.3 Consanguinity:

Following the reviews of 2 children where consanguinity contributed to their vulnerability, CDOP compiled data on deaths reviewed to date where consanguinity was identified as a contributory factor. In view of the available data, CDOP agreed to present a report to the LSCB to discuss what the local authority should do to engage with the community in order to raise awareness. The report was not presented to the wider LSCB but was discussed at the LSCB Business Management meeting which is attended by Subcommittee Chairs. It remains on the agenda and will be discussed again in due course.

3.4 Sudden Infant Death Syndrome (SIDS)

Coventry CDOP reviewed one death from SIDS during 2014-2015 where alcohol misuse, smoking and co-sleeping with a parent and older sibling were found to be contributory factors. A week prior to this child's death Children's Social Care received a referral relating to concerns around Mother's drinking. The case was referred to the LSCB Serious Cases Subcommittee to consider whether the criteria for a serious case review were met. A reply was subsequently received from the LSCB Chair explaining why the criteria were not met, which CDOP accepted. No further actions were identified on review but further work around SIDS has been progressed which is outlined in more detail in paragraph 8.3.

3.5 Sudden Infant Death – External Factor:

The death of a young child from accidental airway obstruction revealed that the child had been placed on its front to sleep. At the time of death the child and a sibling were subject of child protection plans for emotional abuse due to domestic abuse. This death did not fit the criteria for a serious case review but a practitioner's learning event was held as there were a number of

agencies involved with the family. The information provided to the child death review process was used for the learning event, which was also attended by the CDOP Manager and CDOP Officer. A number of learning points were identified which were endorsed at the subsequent CDOP review. CDOP also concluded that parental smoking, an unsafe sleep position and poor parenting by ignoring safe sleeping advice were contributable factors.

- 3.5.1 As accidental airway obstruction was found to be the cause of death following a post-mortem examination, it was not appropriate to classify this as a SIDS death, however it will be included in SIDS data due to the contributory factors identified.

3.6 *Contra-indicated medication:*

A young person who died from a cardiac arrest due to end stage cardiac failure, had Duchene's Muscular Dystrophy with a known severe cardiomyopathy. He was prescribed Domperidone by a GP, who was unaware that a drug alert had been issued 6 months prior advising that Domperidone was contra-indicated with underlying heart conditions. The prescription was hand written during a home visit where the GP did not have access to IT support available at the surgery. Although the medication did not cause this young person's death it did contribute to his vulnerability and the following actions were therefore initiated: (i) to re-circulate the Domperidone warning again to GPs and Pharmacies (ii) the Head of Medicine Management at the CCG to look at a more effective way of disseminating information to GPs (iii) updating the 'ScripSwitch' message system which will involve a prescribers computer screen displaying a new message in red whenever a drug is to be prescribed and issued (iv) to liaise with the Local Pharmaceutical Committee and community pharmacies to initiate the same process for pharmacies as outlined in (iii).

3.7 *Service Provision:*

In the review of a young child who died suddenly from an unexplained respiratory arrest it was noted that the child had been admitted to hospital on two previous occasions with breathing difficulties whilst being fed. On the latter admission an irregularity was noted on a brain CT scan and the child was discharged home with arrangements to return two days later for further investigations. The child however died suddenly before this appointment. In the absence of any other explanation the pathologist suggested that the possibility of asphyxia due to mechanical airway obstruction needed to be considered and it may be helpful to explore the feeding and nursing practices of the parents in more detail. The ambulance conveying the child to hospital on the second occasion made a referral to Children's Social Care due to unexplained blood found and enquiries were made with two hospital doctors who reassured that the blood could be explained, although investigations were still being conducted at this time. Although it was clear that no medical cause had been missed whilst the child was an in-patient, CDOP concluded on reflection that it may have made a difference if the child had remained in hospital until all investigations had been conducted. Poor parenting/supervision was also considered to be a contributory factor in light of the pathologist's comments. CDOP also queried if Children's Social Care had continued to consider child protection until all assessments /investigations had ruled this out, as per SCR learning. A response was received which CDOP accepted as a reasonable response in that consideration was not given to a further assessment due to the medical opinion given and there being no other children in the household.

- 3.7.1 This child's death was also subject of a multi-agency rapid response investigation as per the Sudden and Unexpected Death in Children (SUDC) Protocol and CDOP noted that the final case discussion meeting had not taken place. An action was identified to find out why and a reasonable explanation was provided by the Consultant Paediatrician concerned. A meeting did subsequently take place.

3.7.2 It is appropriate to mention that this family has sadly lost another young child since in similar circumstances, which is currently subject of a multi-agency investigation.

3.8 Deaths with modifiable factors but no actions identified:

- 3.9 A young child who had complex medical needs due to suffering a lack of oxygen at birth, died unexpectedly from pneumonia. CDOP identified parental smoking, parental cannabis use and maternal smoking in pregnancy as contributory factors. It was also ascertained that an internal investigation had been conducted by the out of area hospital where the child was born which concluded that professional error by three midwives managing Mum's labour contributed to the child's life limiting conditions. The hospital concerned fully co-operated with CDOP in providing all of the information and this was acknowledged in writing to their chief executive.
- 3.10 There were 6 premature births reviewed where a high maternal BMI or maternal smoking in pregnancy (or a combination) were identified as contributory factors. Further reporting and findings with regards to maternal BMI is outlined in paragraph 6.1.

3.11 Learning and actions identified in non-modifiable deaths:

- 3.12 Following the review of a young child who died suddenly from a rare congenital condition after being seen at an outpatient's clinic the previous day, CDOP wished to ascertain what the Trust's process was to ensure that learning from child death reviews was disseminated to all paediatricians, in both acute and community services. CDOP was satisfied with the processes evidenced.
- 3.13 In the review of a child who died following a relapse from Acute Myeloid Leukaemia the GP faxed an urgent referral to the local hospital when the child presented with relapse symptoms. CDOP noted that the referral had to be chased by the GP Practice and although a delay had not occurred with the child being seen due to the GP's prompt actions, feedback was given back to the GP that a telephone call to the on-call paediatrician is considered to be better practice than faxing a referral.
- 3.14 In the review of two neonates it was identified that health visitors had attempted to contact the parents to arrange a visit, unaware that in one case, the child was in hospital with complex medical needs and in the other case, the health visitor contacted the neonatal unit to enquire on the progress of a neonate to be told that the child had died 10 days earlier. A breakdown in communication between the midwifery and health visiting service was flagged to CDOP on both occasions which concluded that the absence of a paediatric liaison nurse contributed to the lack of communication and information sharing. This was highlighted to the Director of Nursing and Director of Operations, of the partnership trust who assured that processes had been put in place to improve information exchange and this will continue. At present, health visitors are receiving notifications from the neonatal unit by fax but a system of notifying by secure e-mail (nhs.net) is being looked into.
- 3.15 The review of two deaths from life limiting conditions identified that the school attended by the siblings had not been made aware by the parents that a sibling was ill or had in fact died, which came as a shock to both schools. Both schools stated that they would have benefitted by knowing so that they could adequately support the siblings. Schools are in an ideal position to monitor the welfare and needs of siblings and CDOP concluded that parents should be encouraged to share information with them. Although it was accepted that it is parental choice whether to share information with schools, an action was disseminated to Community Paediatricians to discuss with parents of life limiting children with siblings of school age, the benefits of sharing information with schools.

- 3.16 A 17 year old was sadly found unresponsive in bed and was found to have died from a sudden cardiac death. The ambulance crew, A&E staff and the coroner's office treated this as an adult death, the police were therefore not notified and a multi-agency investigation under the SUDC Protocol was not instigated. Hospital staff were reminded of the child death review procedures which relates to children and young persons from 0-17 years of age. West Midlands Ambulance Service shared the learning and reviewed their protocols as a result.
- 3.17 Following the death of a neonate who also had congenital problems, parents initially consented to a post mortem examination but then changed their minds on the advice of their religious leader. A post mortem examination would have been beneficial in this case in terms of counselling parents on a future pregnancy and in fact was not against their religion. The clinical lead for Neonatology identified that in future it would be good practice for the consultant neonatologist caring for the child to meet with the parents and their religious leader so that the religious leader understands the consequences of the advice given.
- 3.18 An infant born prematurely at 23 weeks was discharged home on oxygen due to chronic lung disease, after spending their first four months of life in hospital. A week following discharge the child died suddenly at home. This was a Coroner's case as a cause of death could not be ascertained and following investigations the cause of death was found to be cardiac failure. Blood samples taken as per the SUDC Protocol grew Group B streptococcus after 24 hours so the paediatricians on the panel queried the cause of death. The post mortem report was requested from the Coroner which outlined how the cause of death was determined and this was accepted by the panel.
- 3.19 *Good Practice:*
- (i) Acknowledged good practice by a GP who promptly referred a child for blood tests on the day of presentation which resulted in the child being diagnosed with an aggressive cancer and admitted to hospital that same day.
 - (ii) Acknowledged the excellent support provided by a school to the family and school peers of a child who died from a life limiting illness.
- 3.20 *Actions involving the wider family:*
- (i) Ascertain why the siblings of a child who died from a life limiting illness were not allocated school places for some time after coming to the UK.
 - (ii) An adult safeguarding concern was identified in relation to a bereaved mother which the panel asked to be followed up and appropriate support given if required.
 - (iii) Further information and reassurance was sought where the child and siblings were subject of a Common Assessment Framework initiated by the school.

4 Recommendations and actions arising from Solihull CDOP during 2014-2015

4.1 15 actions were progressed from deaths reviewed during 2014-2015. The following is a summary of the learning identified and the actions initiated:

4.2 *Deaths with modifiable factors and actions identified:*

4.3 *Death Referred for a Serious Case Review*

Following the review of a child who died prematurely from Cystic Fibrosis, CDOP concluded that the criteria for a Serious Case Review were met due to poor parenting and parental neglect which contributed to this child's untimely death and made this recommendation to the LSCB.

The Solihull LSCB Chair has agreed that the criteria have been met and a Serious Case Review will be conducted.

4.4 *Re-assess risk during pregnancy and service provision:*

Following the review of a neonatal death where the patient presented initially to a midwifery led unit and who then needed to be transferred to another hospital, there was a perceived delay in the ambulance attending to transfer the patient to a Level 3 hospital. CDOP wrote to West Midlands Ambulance Service (WMAS) to ascertain how the service was going to sustain its attendance targets with increased demands being placed on the service. In this particular case the target time was found to be met and CDOP was reassured by the response received from WMAS, i.e. the plans in place to recruit 400 paramedic students over the following year, ordering additional vehicles and introducing additional shifts to provide more flexibility during peak demands. This death was subject of a Root Cause Analysis investigation which was conducted by the Trust concerned. A number of learning points were identified with regards to ensuring that patients are re-assessed for risk if problems occur later in the pregnancy and to ensure that the presentation and birth takes place at an appropriate hospital and not a low risk midwifery led unit. CDOP had sight of the RCA report and accompanying action plan and endorsed the recommendations and actions arising from the review.

4.5 *Paediatric Assessment:*

In the review of an infant who died suddenly and unexpectedly at home from an undiagnosed heart condition, CDOP learned that advice was sought from NHS 111 the previous evening by a parent reporting that the infant was suffering from fever, vomiting and blackouts. The parent was advised to attend an appropriate hospital with a children's A&E department, however the parent chose to take the child to a nearer hospital which did not have a paediatric A&E facility. Investigations focussed on the fever and vomiting and not the blackouts and therefore a full physical examination, including cardiac investigations and prolonged observations did not occur. A Serious and Untoward Incident (SIU) investigation was conducted by the Trust concerned and although it was accepted that the cardiac defect may not have been detected even if the infant had presented to a children's A&E, there were a number of learning points identified with regards to the process for hospital staff to follow when a child presents with a history of blackouts.

- 4.5.1 Although not a contributory factor in this case, the SIU investigation also highlighted that the signage at the hospital where the infant was taken is misleading as the signage indicates an A&E department, whereas the hospital has a minor injuries unit only. CDOP has since learned that the signage at this hospital has been altered to accurately reflect the A&E service provided.

4.6 *Sudden Infant Death Syndrome (SIDS)*

Solihull CDOP reviewed one death from SIDS in 2014-2015 where it was identified that smoking by both parents, maternal smoking during pregnancy and the room temperature being too hot were all contributory factors. No actions were identified on review but further work around SIDS has been progressed, which is outlined in more detail in paragraph 8.3.

4.7 *Sudden and Unexpected Death - Missed Opportunity for a Multi-Agency Investigation:*

In the review of a 17 year old young person with a life limiting condition who died from cardiogenic shock following a fall from his wheelchair, CDOP identified that this young adult fell from his wheelchair as there was not a lap-belt in place to secure him, which precipitated his deterioration and was therefore a contributory factor. This young person was known to Adult Social Care who conducted a management review of their involvement. Learning and actions were identified to ensure assessments and reviews are carried out as per procedures and checks are conducted to ensure equipment is fit for purpose. The family contributed to the CDOP review and it was ascertained that the family did not raise the missing lap-belt with professionals involved.

4.7.1 CDOP also identified that this death should have triggered a multi-agency 'Rapid Response' investigation under the Sudden and Unexpected Death in Children (SUDC) Protocol and by not initiating one there were missed opportunities in obtaining further information, particularly from a home visit which would have enabled an examination of the wheelchair in situ and further information from the family. The treating hospital accepted this retrospectively and steps were put in place to raise awareness amongst its staff. This young person was treated as an adult on admission and the medical staff working in acute adult services were not aware that 17 year olds fall within the child death review process. (A lack of awareness of older children coming under the Sudden and Unexpected Deaths in Children (SUDC) Protocol has previously been highlighted across the sub-region).

4.8 *Neonatal Deaths:*

There were 3 premature births reviewed where a high maternal BMI or maternal smoking in pregnancy were identified as contributory factors. Actions were identified to ascertain if appropriate referrals were made. Further reporting and findings with regards to maternal BMI is outlined in paragraph 6.1.

4.9 ***Learning and actions identified in non- modifiable deaths:***

4.10 In a neonatal death CDOP acknowledged the excellent support provided by staff on the specialist bereavement suite and a letter of recognition was sent to the Chief Executive of the Trust concerned.

4.11 Further information was sought from the police in relation to a potential safeguarding concern relating to a sibling.

4.12 *Actions involving the wider family:*

On reviewing a neonatal death, CDOP was aware that the Education Welfare Service was prosecuting the parents for failing to send an older sibling to school. Behavioural concerns were also highlighted by the school in relation to the same sibling and in another sibling also. CDOP sought reassurance from the Education Welfare Service that any safeguarding concerns were also being addressed.

5 **Recommendations and actions arising from Warwickshire CDOP during 2014-2015**

5.1 **52** actions were progressed from deaths reviewed during 2014-2015. The following is a summary of the learning identified and the actions initiated:

5.2 ***Deaths with modifiable factors and actions identified:***

5.3 *Missed opportunities to diagnose a very sick child:*

In the review of a child who died unexpectedly from the consequences of both a viral and bacterial infection of the upper respiratory tract, CDOP was aware that the child had been seen by three different health practitioners within the previous 36 hours, (an A&E Doctor, Advanced Nurse Practitioner and GP) all of who failed to identify a seriously ill child. Aware that internal reviews and two independent reviews were being conducted (one initiated by the Trust concerned and the other by NHS England), CDOP made representations to the Senior Coroner that an Inquest should be held. (The Coroner had earlier agreed that an Inquest did not need to take place as death was from natural causes, as per the changes in the Coroner's rules). CDOP provided the Senior Coroner with all of the additional information it had obtained and an Inquest was subsequently held. On conclusion the presiding Coroner also issued a 'prevent future deaths' report with specific actions for the NHS Trust concerned. (Under the Coroner's Investigations Regulations of 2013, the Coroner now has a duty to issue a report if the

investigation reveals something which gives rise to a concern that there is a risk of deaths in the future and that action should be taken to eliminate or reduce that risk).

- 5.3.1 NHS England also produced a Patient Safety Newsletter showing a traffic light system for identifying risk of serious illnesses, which has been circulated to all GPs in Coventry, Warwickshire, Herefordshire and Worcestershire.
- 5.3.2 CDOP received excellent communication from all parties in sharing their reports, recommendations and learning for the CDOP review. CDOP did however request further clarification on the internal review conducted by the GP Practice.
- 5.3.3 This case also highlights another missed opportunity by not instigating a multi-agency 'Rapid Response' investigation as per the Sudden and Unexpected Death in Children (SUDC) Protocol. There was a delay in the police being notified of the death and the lack of communication and co-ordination contributed to the anguish felt by the parents. It was apparent that medical staff working in the acute service were not familiar with procedures and following this review the Trust concerned produced a protocol for the management of sudden unexpected childhood deaths which a local paediatrician with relevant expertise contributed to. CDOP was made aware that the protocol was being presented to the Trust's committee for ratification in March 2015.
- 5.3.4 It also has to be recognised that the parents of this young child were instrumental in initiating some of the reviews that were conducted in their tenacity to find out why their child died. The parents also greatly contributed to the CDOP review.
- 5.4 *Sudden Infant Death Syndrome (SIDS)*
This review identified an unsafe sleeping environment, parental smoking and parental substance use as contributory factors. The 'rapid response' investigation identified that there was a delay in conveying the child to a hospital as per the SUDC protocol which prohibited the taking of necessary medical samples. As a result, Police and West Midlands Ambulance Service (WMAS) processes were reviewed to prevent future incidents.
- 5.5 *Sudden Infant Death – External Cause:*
In the review of a young infant who died from brain damage due to accidental asphyxiation, the infant was co-sleeping with a parent on a sofa after a feed. The parent had also consumed a small amount of alcohol during the evening but this was not found to be a contributory factor. It was recognised however that the infant was a colicky baby and therefore probably took longer to feed and that this was a case of unintentional co-sleeping with the parent falling asleep during or after the feed. CDOP felt that safe feeding needs to feature in the safe sleeping advice given so a conversation can be had with parents about keeping their baby safe when feeding, particularly with parents whose babies are difficult feeders. CDOP therefore wrote to Heads of Midwifery and Health Visiting Services across the sub-region to advise that this should be included, if not already being done. They were also reminded that the National Institute for Health and Care Excellence (NICE) Postnatal Care Guidance amended in December 2014 recommends that parents should be made aware of intentional and unintentional co-sleeping and the associated risks. A positive response was received from all Heads of Midwifery and Health Visiting Services who stated that they would disseminate the learning and look at their practices and advice given to promote safer feeding.
- 5.5.1 A further action was identified to raise safe feeding advice with The Lullaby Trust (formerly the Foundation into the Study of Infant Deaths) to incorporate safe feeding and intentional and unintentional co-sleeping in their advice leaflets to parents and professionals. Again, a positive response was received from their Research and Information Manager who stated that following the updated NICE guidance they will indeed be looking at their advice on co-sleeping, and will be sure to take this case and other SIDS data provided to them into consideration, including the risks involved in feeding.

- 5.5.2 As accidental asphyxiation was found to be the cause of death following a post-mortem examination, it was not appropriate to classify this as a SIDS death, however it will be included in SIDS data due to co-sleeping being a contributory factor.
- 5.6 *Sudden and Unexpected Death – Misdiagnosis:*
A child known to have a brain cyst, developmental delay and autism was admitted to an out of area hospital with seizures. The consultant caring for the child suspected intra-cranial pressure and sought advice from a neurosurgeon registrar at an out of area specialist hospital. On seeing the scans the registrar diagnosed seizures and the child was transferred to another out of area hospital for treatment. When the child failed to respond to treatment for seizures the child was transferred to the specialist hospital where advice was initially sought and intra-cranial pressure was confirmed. The child underwent emergency surgery but was found to have suffered substantial brain damage and care was re-orientated to palliative care. A Root Cause Analysis investigation was carried out by the specialist hospital concerned which identified that a diagnosis should not have been made by viewing scans only and that a bedside review should have also taken place and in any case the registrar should have deferred to a consultant neurosurgeon. CDOP acknowledged that a thorough review had been conducted and endorsed the learning, recommendations and actions put in place.
- 5.7 *Prematurity and High Maternal BMI:*
In the review of a neonate of 23 weeks gestation, it was noted that the maternal BMI was 44.2. CDOP questioned if Mother had been referred to a dietician and what the Trust's policy was for referring expectant mothers with a high BMI. It was ascertained that all expectant mums with a raised BMI are offered a referral to a dietician and also to a maternal exercise scheme, however there is no record of this mum being referred. This was fed back to the midwife who booked Mother's pregnancy. The Trust in question does however have a BMI threshold policy for BMIs >30, >35 and >40. The Trust has a specialist midwife for maternal obesity and the Maternal Obesity Lead continually audits the care of all women with a BMI >35 booked at the Trust to ensure compliance with guidelines and to reduce risk. The Trust is also in the process of producing a BMI in pregnancy booklet for women booking at this Trust.
- 5.7.1 CDOP reviewed another neonate of 27 weeks gestation where maternal BMI was recorded as 42.5. No actions were identified as Mother was assessed as high risk and referred for consultant led care.
- 5.7.2 In the review of another neonate of 23 weeks gestation, CDOP found that Mother's age and BMI were singularly both just under the threshold for a referral for consultant care, however by taking both into account CDOP felt this should have triggered a higher risk and a referral to a consultant. An action was identified to explore with the Trust a way to capture and act on accumulative factors. The Trust identified this as an issue for the Clinical Commissioning Group (CCG) as it would lead to an increase in referrals to a consultant and require additional funding. CDOP was reassured however that current practice allows for flexibility in that midwives can use their own clinical judgement to refer women to a consultant.
- 5.8 *Prematurity and a Low Maternal BMI:*
A raised BMI is known to be a risk factor in premature births, however in this review CDOP concluded that Mother's low BMI may have contributed to the child's vulnerability. Antenatal monitoring revealed there was reduced amniotic liquor around the baby who was born spontaneously at 27 weeks gestation. Mother's pregnancy was booked at a different Trust and CDOP questioned if Mother's low BMI was flagged as a risk at her antenatal booking. It was ascertained that she had been assessed as high risk and referred for Consultant led care due to her BMI and a history of pre-term births. CDOP also looked into Mother's previous pregnancies and found that Mother had a low BMI when booking her previous two pregnancies at a Warwickshire Trust but her low BMI was not identified as a risk and both babies were also born prematurely. An eating disorder was suspected by non-health professionals but this was denied by Mother. In light of this, CDOP sought to ascertain what the Trust's threshold was for referring

expectant mothers with a low BMI and found that there was no formal guidance. In view of this the following actions were identified; (i) the Trust to produce guidelines (ii) the Trust to research previous pregnancies where a BMI of between 17-19 was recorded to ascertain if premature labour was a feature in these pregnancies (iii) to liaise with the Trust's Eating Disorder Clinic to assist with producing guidelines to manage mothers who may have an eating disorder.

5.9 *Prematurity, Maternal Smoking and Anti-Clotting Medication:*

In a premature birth due to placental abruption, CDOP noted that Mother was being managed by the Fetal Medicine Department and was on Clexane and Aspirin to reduce blood clots. Whilst appreciating the need for Mother to be on this medication CDOP did request however if there was any evidenced based research which linked this medication with placental abruption. This was done and no link between the two could be found. It was also noted that Mother was a heavy smoker which increases the risk of placental abruption.

5.9.1 CDOP also learned that an older sibling was being home schooled however there was no record on Warwickshire's Local Authority database to this effect. It was ascertained that home schooling was arranged with a previous local authority when the family were living outside the Warwickshire area and once agreed, there is no requirement to inform a new local authority when moving to that area. CDOP was concerned with this as it raised a safeguarding concern and wished to pursue this but closed the action when it learned that the LSCB Special Cases subcommittee was already looking into this.

5.10 *Prematurity and Service Provision:*

The following two reviews illustrate the benefits of parents, families or carers contributing to the review and you will see that the full circumstances would not have been known had information not have been provided by the parents.

5.10.1 The first review relates to a young infant who died from the Herpes Simplex Virus at 13 days old. The infant was born at term and discharged home with Mother the following day. Parents took the child to their local hospital at 10 days of age on the advice of their community midwife who was concerned about the child's significant weight loss, poor feeding and lethargy. The child was found to be very unwell and admitted to hospital where she died 3 days later. The death was subject of a Coroner's investigation as treating doctors could not determine a cause of death. The CDOP Manager wrote to the parents to inform them of the CDOP process as there were no professionals still involved with the family. Parents responded with a number of concerns and questions regarding Mum's antenatal care and the infant's care following birth and admission to hospital. Parents' main concern was that the community midwife who visited on Day 6 had concerns about a loss in weight and although not over the threshold to refer, arranged for another midwife to attend to re-weigh. A Community Midwife did attend on Day 8 but failed to re-weigh the infant. The infant was referred to hospital on Day 10 when found to have lost a pound in weight. Parents wished to know if the outcome would have been different if their child had been weighed on Day 8 and brought to hospital sooner.

5.10.2 The hospital conducted a review under their complaints procedure and conceded that the infant should have been weighed on Day 8 but that it probably would not have changed the outcome. A lack of communication between the two midwives was identified as a factor and the learning was shared with the community midwifery team. CDOP concluded that by not weighing the infant there was potentially a missed opportunity to refer the infant to hospital sooner which did contribute to their vulnerability and was therefore a modifiable factor.

5.10.3 CDOP also queried why the hospital had not conducted a root cause analysis as routine as the circumstances fitted the criteria. The Trust responded that they have since changed their processes to capture all incidents which fit the criteria.

- 5.10.4 All of the other concerns and questions raised by the parents were addressed by the hospital to their satisfaction. This is an example of where parental participation assisted the review process and at the same time the CDOP Manager helped facilitate answers for the parents.
- 5.11 In the death of a 30 week neonate who died shortly after birth from cardiopulmonary failure, parents contacted the CDOP Manager to provide information to the review process. The Trust concerned had conducted a root cause analysis which concluded that the baby should have been delivered sooner and a number of learning points and actions were identified. Mother provided detailed information about the care provided to her during and after the birth and although complimentary about the support provided by the staff, she did outline some aspects of care which the panel found concerning. CDOP requested another investigation be conducted by the Trust concerned to include the wider aspects of care outlined by Mother. This was done, CDOP accepted the explanations provided and no additional learning was identified.
- 5.12 Deaths with no modifiable factors but actions identified:**
- 5.12.1 *Sub-regional care pathway for acute high risk pregnancies and elective/ planned multiple births:* CDOP reviewed the death of a neonate born at 37 weeks who died shortly after birth due to pulmonary hypoplasia (underdeveloped lungs). A root cause analysis was initiated by the head of midwifery and an action was identified to ensure that midwifery staff are up to date with the resuscitation of neonates and to have the opportunity to practice simulations regularly.
- 5.12.2 The panel was informed that the Trust concerned was meeting with neighbouring Trusts to formulate a regional care pathway for high risk pregnancies and CDOP requested an update. CDOP was subsequently informed that the Trust went on to produce their own care pathway as there was not a will across the sub-region to produce a sub-regional one.
- 5.13 CDOP later went on to review the premature deaths of triplets who were born at 23 weeks gestation. Mum went into spontaneous labour and was taken to a level 3 tertiary hospital in the locality but the triplets were too premature to be stabilised. CDOP was made aware that the birth was planned at a level 1 hospital as opposed to a tertiary hospital providing level 3 specialist care. Although no modifiable factors were identified, CDOP conclude that this reinforced the need for a sub-regional care pathway for acute high risk pregnancies and for elective/ planned multiple births and wrote to the clinical leads and heads of midwifery at the three local hospitals with this recommendation. A response is currently being awaited from the three Trusts concerned.
- 5.14 *Service provision:*
A mother who had booked her pregnancy with a local Trust presented to an out of area hospital at 24 weeks gestation and gave birth in the A&E toilets whilst waiting to be triaged. A Root Cause Analysis investigation was conducted by the hospital concerned and a number of learning points and actions were identified for this hospital, which Warwickshire CDOP endorsed. Mother was known to have cognitive impairment and had delayed seeking medical attention which was also a contributory factor. CDOP wished to ascertain if Mother's level of understanding was probed at her antenatal booking to ensure she understood the advice being given to her. It was ascertained that there were no concerns with this mother's level of understanding but the Trust did reiterate to all midwifery staff the importance of checking levels of understanding when mothers are known to have cognitive impairment.
- 5.15 In the review of a 36 week neonate who died from severe hypoxic ischaemic encephalopathy (brain damage due to lack of oxygen) after Mother presented to hospital with reduced fetal movements, a Root Cause Analysis was conducted by the Trust concerned. It was found that Mother had been given verbal advice on reduced fetal movements but there was no record that written advice in the form of a leaflet was given too. A safety alert was circulated to all midwifery staff to ensure that they also record when a leaflet is given.

- 5.16 Warwickshire CDOP reviewed a neonatal death on behalf of a neighbouring CDOP as the learning all related to a local Trust where antenatal care was booked and where the birth and death took place. This is the first time we have reviewed a death where the family has not resided in the LSCB area but the rationale made sense. The mother in this case was a member of staff at the local Trust where the baby was born and she chose to have a midwifery friend assist with her labour (sanctioned by a line manager) who was also performing the role of labour co-ordinator for the ward at the same time. There were complications with the labour and the Root Cause Analysis identified that caring for close friends or family by a midwife can be extremely distressing if there is a poor outcome and that both Supervisors of Midwives and Midwifery Management need to ensure that midwives are aware of the possible ramifications of a poor outcome and both national and local LSA guidelines are followed when providing midwifery care for a close friend or family member.
- 5.17 In another review of a child with a life limiting condition who died from septic shock, CDOP became aware that the Integrated Disability Service (IDS) who were supporting with a 'child in need' care package, closed the case after parents declined further support following a dispute over direct payments. The case was closed at a time when there were concerns raised regarding the home conditions and care of the child. An internal review was conducted by IDS which concluded that the change of social workers allocated to the case and the direct payment issue prevented the social worker from being able to provide effective challenge to the parents about the care being provided. The findings of the review were shared with the team and it was agreed that IDS will contribute to the discussions taking place within Children's Social Care regarding the identification of an assessment tool for neglect. It was also noted that since this death the service has been re-structured which promotes improved continuity of social worker and there has been a programme of training for disability social workers on child protection.
- 5.18 *Good Practice:*
In the review of an infant who was diagnosed with a terminal illness shortly after birth, the child's end of life care was provided on a ward at an out of area specialist hospital at parents' request. End of life care is not usually provided in a hospital setting and CDOP acknowledged that this was enabled due to the excellent care provide by the staff on the Paediatric Assessment Unit at the specialist hospital together with support from Warwickshire's Community Children's Nurses. CDOP wrote to both services to acknowledge this and also asked that it be highlighted in the annual report.
- 5.19 In a similar review, a young person who had a life limiting condition chose to have their end of life care at the same out of area specialist hospital. Again CDOP acknowledged how staff at the hospital and the Warwickshire palliative care team worked excellently together to provide end of life care in a hospital setting which was clearly very child focussed and in keeping with this young person's wishes.
- 5.20 In the circumstances outlined in paragraph 5.23, the school nurse provided excellent support to pupils by attending the school regularly in the days following the incident and on the day of the funeral and making herself available to pupils who wished to talk.

Miscellaneous actions:

- 5.21 A number of actions were instigated to ensure that follow up support was provided to parents and siblings.
- 5.22 In two deaths, GPs indicated that they had not been notified of the death. This was fed back to the hospitals concerned.
- 5.23 In the review of a young person who died on a Friday evening in a triple fatal road traffic collision where all of the casualties attended the same school, the Head Teacher liaised with the

Education Safeguarding Children Manager over that weekend to request support and the Critical Incident Team (CIT) were notified. The Head Teacher had learned of the tragedy via messages on social networking sites and had to contact the police to confirm the information before putting an announcement on the school's website. The Head Teacher reflected that it would have been helpful if CIT had been able to access the police to confirm the facts of what had happened so that the Head could have mobilised support and the school's response more promptly. The Education Safeguarding Manager met with the Head Teacher to discuss their concerns and a need was identified to clarify what emergency/incident planning/response information all schools should have and then undertake an exercise to make sure it is available consistently across the county. A communication protocol between the police and Head Teachers was also identified to assist with communication in the future. The Education Safeguarding Children Manager has liaised with the CDOP Police representative with regards to devising a protocol and has also liaised with the local authority Emergency Planning Department.

5.23.2 CDOP also liaised with the Road Safety Team to ascertain if any road safety improvements had been identified at the location but all were deemed adequate.

5.24 In the review of a premature neonate where the placenta was not sent for histology (tests) the Risk Manager at the hospital concerned was notified to remind all staff.

Generic themes identified in the categories of deaths reviewed during 2014-2015

6.0 Neonatal deaths:

As in previous years, neonatal deaths were the highest category of deaths reviewed during 2014-2015, accounting for 43% (**36** out of **84**) of the total reviewed. Of the **36** deaths reviewed, modifiable factors were identified in **16** (44%) deaths and no modifiable factors were identified in **20** (56%). The ratio of modifiable deaths in 2014-2015 is higher than in the previous two years, i.e. in 2012-2013, 31% were modifiable and in 2013-2014, 39% were modifiable.

6.1 Of the **16** neonatal deaths reviewed where modifiable factors were identified, a raised/high body mass index (BMI) was a contributory factor in **6** cases, a low BMI was a contributory factor in **1** case, maternal smoking during pregnancy was a contributory factor in another **6** cases and in **1** case a combination of both a high BMI and maternal smoking were contributory factors. In addition to this, **1** case (outlined in paragraph 5.12.1) also featured maternal smoking and a raised BMI, however the panel concluded this death as non-modifiable. Another premature death reviewed in 2014-2015 featured a low maternal BMI but the panel concluded this death as non-modifiable also. Modifiable factors identified in prior medical intervention, surgical intervention or access to health care featured in **2** cases.

6.1.1 This learning reflects the findings of the previous two years where the majority of modifiable factors in premature deaths were linked to lifestyle choices as opposed to service provision. In the previous two reporting years, i.e. 2012-2013 and 2013-2014 there were a total of **13** premature deaths reviewed where smoking in pregnancy was a contributable factor and when added to this year, it brings the total to **19** across the sub-region. With regards to a raised BMI there were **4** deaths reviewed during 2013-2014 where a raised BMI was considered a contributory factor, however it must be stressed that BMI information was only routinely obtained across the sub-region from the middle of 2013-2014 reporting year so potentially it is not a true reflection.

6.1.2 The cases referred to paragraph 6.1.1 were found across the sub-region and due to the number featuring maternal BMI, each CDOP sought to ascertain what their area hospital's referral and care pathway was in relation to a high or low BMI. Individual hospitals are not usually mentioned in the annual report but in order to accurately reflect current practices the following is a summary of care and referral care pathways:

University Hospitals Coventry and Warwickshire (UHCW):

The vast majority of expectant mothers from Coventry and Rugby (Warwickshire) book their antenatal care and deliver at this hospital. UHCW policy is to refer women for Consultant led care if the BMI is <18 or >35.

George Elliot Hospital, North Warwickshire (GEH):

All expectant mums with a raised BMI are offered a referral to a dietician and also to a maternal exercise scheme. The Trust has a BMI threshold policy for BMIs >30, >35 and >40. The Trust has a specialist midwife for maternal obesity and the Maternal Obesity Lead continually audits the care of all women with a BMI >35 booked at the Trust to ensure compliance with guidelines and to reduce risk. The Trust is also in the process of producing a BMI in pregnancy booklet for women booking at this Trust. A referral regarding a low BMI is made if the BMI is <18.

South Warwickshire NHS Foundation Trust (SWFT):

SWFT's Obesity and Weight Management in Pregnancy Policy outlines their referral policy. All women are given advice on diet and exercise in pregnancy. For women with a BMI of 30 and above, a referral is made to the dietician, exercise and smoking cessation (if appropriate). Women with a BMI between 30- 34.9 are offered a consultant clinic appointment to discuss associated risks. If no other risk factors are present they are then referred back to midwifery led care. Women with a BMI over 35 are referred for obstetric led review and further guidelines are stipulated for women with a BMI over 40.

SWFT did not have a low BMI care pathway in place when the case outlined in paragraph 5.8 was reviewed. In view of this an action was identified at this review for the Clinical Governance Midwife at SWFT to produce guidance. This is now in place and patients with a BMI of under 18 are reviewed by a consultant obstetrician and are subject of serial scanning.

Another action which arose following the review outlined in paragraph 5.8 was for the Clinical Governance Midwife to liaise with the Eating Disorder Clinic at SWFT so they could assist with producing guidelines on how to manage expectant mums who may have an eating disorder. The Eating Disorder Clinic was keen to see pregnant women with a diagnosed eating disorder, however they would not be able to diagnose themselves as they do not have the capacity to do so. A suggestion was made for midwifery staff to use the local Arden Mental Health Assessment Team (AMHAT) service for diagnosis and that midwives use a tool at booking for potential patients to be screened and when positive to refer them to AMHAT. However, the clinical psychology team have been given funding for perinatal psychiatry and to that end, it is felt that this newly created service will have capacity for eating disorder diagnosis and treatment during pregnancy and the postpartum. They are currently recruiting personnel and SWFT anticipate that this service will be fully functioning by the start of 2016. In the interim the Clinical Governance Midwife has raised awareness amongst the midwifery team with regards to detection and referral to the AMHAT for screening and diagnosis.

Heart of England NHS Foundation Trust (HEFT)

HEFT's Obesity in Pregnancy Guidelines, revised in January 2013, outlines their referral policy. All women with a BMI over 30 are given advice on diet and exercise in pregnancy and a referral is made for maternity team based care, which comprises of midwives, obstetricians, anaesthetists, dieticians, neonatologists and other specialists working in partnership. Women with a BMI of less than 18 or 35 or above are referred for obstetric led care. Further guidelines are stipulated for women with a BMI over 40.

Following one of the reviews referred to in paragraph 4.8, a discussion was had at Solihull CDOP as to whether expectant Mums with a high BMI were being referred to the Maternal and Early Years Obesity Pathway. Solihull used to have a referral service but this ceased in September 2014 and it is a commissioning decision whether to commission a referral obesity service. HEFT would like to extend their service to Solihull expectant Mums which Solihull will have to buy into.

6.1.3 This has been reflected on in previous annual reports but 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 (RCA) and Serious Untoward Incident (SUI) reports with action plans, as well as feedback from internal review meetings, which greatly assists the CDOP review.

6.1.4 With regards to the number of neonatal deaths notified across the sub-region in 2014-2015, there were **31** neonatal deaths notified, which is a decrease of 28% from year 2013-2014 and back in line with the number reported in year 2012-2013, i.e. (**43** neonatal deaths notified in 2013-2014 and **31** in 2012-2013). The decrease has been seen across all of the sub-region.

7 Chromosomal, Genetic and Congenital Anomalies:

21 deaths were reviewed during 2014-2015 which were classified under this category. (**20** deaths reviewed during 2013-2014). **12** (57%) were congenital defects identified antenatally or shortly after birth and where death occurred during the neonatal period or within the first year of life. A further **10** had a recognised life limiting condition and died from a cause associated with their condition. One death was sudden and unexpected death as outlined in paragraph 3.12 due to an undiagnosed congenital condition. Modifiable factors were identified in **5** (24%) deaths, these being consanguinity (as outlined in paragraph 3.3), prior medical attention (as outlined in paragraph 3.6) and maternal smoking and/or substance misuse during pregnancy.

7.1 Consanguinity

Since 2008 there have been **20** deaths reviewed where parents were consanguineous (i.e. blood related and usually first or second cousins). Coventry CDOP has reviewed **16** and Warwickshire CDOP has reviewed **4**. Of the 20 reviews, **11** (55%) were identified as being modifiable (8 in Coventry and 3 in Warwickshire.)

7.2 There is a lot of debate across the country as to whether consanguinity should be regarded as a modifiable factor and judging by the e-mail correspondence between CDOP Managers and Co-ordinators across the country, different approaches are being taken. The sub-regional approach is that if medical information indicates that parents are consanguineous and both have an autosomal recessive gene which increases the risk of the genetic disorder the child has, then this will be regarded as a contributable and modifiable factor as the definition of a contributable factor is that it 'may have contributed to vulnerability, ill-health or death.' In the case where a child of consanguineous parents dies of an unrelated cause then this will be regarded as non-modifiable. Hence the reason why there are some deaths identified as modifiable and others not.

7.3 In 2011 Coventry CDOP had reviewed 8 deaths of children from consanguineous parents and highlighted this Coventry Safeguarding Children Board (CSCB). The CSCB agreed that there should be some sensitive work with community leaders to raise awareness in communities where consanguineous marriages are a norm and recommended that this be progressed by the Equality and Diversity Theme Group of the Local Strategic Partnership. A small working group was formed from members of the Equalities and Community Cohesion Group but unfortunately the group disbanded before any work could be progressed.

7.4 At this same time Warwickshire CDOP had reviewed 4 deaths and was made aware of the work being progressed by Coventry. Warwickshire CDOP took the decision to monitor the situation and to date has not reviewed any further deaths.

7.5 Coventry on the other hand has continued to review deaths and as such has brought this to the attention of CSCB as outlined in paragraph 3.3.

8 Sudden and Unexpected Deaths of Children (SUDC):

17 deaths were reviewed during 2014-2015 (**18** reviewed in 2013 – 2014). A breakdown of the type or cause of death is as follows:

11 = Medical cause ascertained (*referred to in paragraphs 3.9, 3.12, 3.16, 3.18, 4.5, 4.7, 5.3, 5.6 5.10, and 5.17*)

2 = Sudden Infant Death Syndrome (*paragraphs 3.4, 4.6 and 5.4*)

2 = Trauma due to unsafe sleeping (*paragraphs 3.5 and 5.5*)

1 = Road Traffic Collision (*paragraph 5.23*)

1 = Unexplained (*paragraph 3.7*)

8.1 Actions were identified in all of the above deaths, irrespective of whether modifiable factors were identified.

8.2 *Rapid Response Investigations in relation to deaths reviewed during 2014-2015:*

7 of the 17 unexpected deaths were subject of a multi-agency rapid response investigation under the Sudden and Unexpected Deaths in Children (SUDC) Protocol where the protocol was complied with in full. In a further 2 the protocol was adhered to in part, i.e. samples and a history were taken at the hospital and a final case discussion meeting took place, but a joint home visit between the police and a paediatrician did not take place. In one case the paediatrician was not available as they were committed with another investigation (case highlighted in 4.5) and in the other the home visit was disjointed, with the police visiting on their own initially, followed by a visit from a paediatrician (case highlighted in 5.5). In 3 cases a joint rapid response investigation was not instigated at all, as outlined in paragraphs 3.16, 4.7 and 5.3. In 4 cases the child was an inpatient at the time of their death and the cause of death was either known or ascertained following a Coroner's investigation. (In 2 of these deaths an internal review was conducted as outlined in paragraphs 5.6 and 5.10).

The remaining 1 death from a fatal road traffic collision was a police investigation conducted on behalf of the Coroner.

8.2.1 The 2013-2014 CDOP Annual Report makes reference to a Warwickshire unexpected death where Warwickshire CDOP recommended a serious case review (SCR). The SCR has been completed and in relation to the learning, the CDOP Manager was asked to comment on how 'rapid response' investigations were conducted in Warwickshire. In January 2015 the CDOP Manager conducted an audit of all sudden and unexpected deaths over a three and three quarter period from 1 April 2011 to December 2014 and identified cases which fitted the criteria for a multi-agency rapid response investigation. This amounted to **17** deaths. The key elements of the protocol were audited using information provided to the child death review process against the flowchart in Appendix 'D' which has been lifted from the statutory guidance 'Working Together to Safeguard Children' 2015. To clarify the data, the deaths referred to in the following paragraph are separate to the deaths referred to in paragraph 8.2. Of the **17** deaths which fit the criteria for a multi-agency rapid response investigation:

8.2.2 **6** complied with the whole of the rapid response protocol, however it must be noted that in **5** of the deaths the lead paediatrician involved was from University Hospitals, Coventry and Warwickshire (UHCW) where the child was initially taken to by the ambulance. In the other death a Warwickshire paediatrician was involved in the investigation.

8.2.3 **8** deaths had some elements but the most prevalent was that in **6** deaths, a joint home visit between the police and a paediatrician did not take place due to the unavailability of a paediatrician or other health professional. In the other **2** deaths the final case discussion did not take place.

8.2.4 In **1** death involving a 17 year old the protocol was not complied with at all as the police dealt with this young person as an adult and therefore did not instigate the process.

- 8.2.5 In a further **2** cases involving young persons (a suicide and drugs overdose) which were investigated by the police, CDOP concluded on review that a joint investigation with an input from health would have been beneficial.
- 8.2.6 Conducting joint home visits between the police and a paediatrician has proved to be problematic in Warwickshire. This is due to there being only an informal arrangement for Warwickshire where a community paediatrician and a health colleague are the only health professionals who conduct rapid response investigations. If neither are available then the police conduct the home visit on their own. A joint home visit is not only conducted to gain a clearer understanding of how the child/young person died but is also an opportunity to explain the whole process to the family, provide a point of contact for the family (which is usually the paediatrician) and identify any ongoing support.
- 8.2.7 The audit also looked at the day of the week and time of the death or collapse to ascertain if there was any correlation between the time of death and the unavailability of a paediatrician. All of the 8 deaths referred to in paragraph 8.2.3 where a paediatrician was not available occurred on a weekday evening or over a weekend which identifies a need for an on-call agreement. The one death referred to in paragraph 8.2.2 where a Warwickshire paediatrician was available, occurred on the morning of a weekday where availability is more likely.
- 8.2.8 Where joint home visits have been conducted in a timely manner these have occurred when the child has been taken to UHCW and where a UHCW Paediatrician has started the process, including the home visit. Of the 5 rapid response investigations referred to in paragraph 8.2.2 where a UHCW Paediatrician was involved, four occurred during the early morning of a week day and one on a Sunday morning. UHCW has built resilience amongst its Consultant Paediatricians to conduct rapid response investigations.
- 8.2.9 The CDOP Manager will be conducting a similar audit in relation to Coventry and Solihull rapid response investigations. Unfortunately capacity has not allowed for this to be done in time for this annual report but should be completed by the end of October 2015.
- 8.3 *Sudden Infant Death Syndrome (SIDS)*
3 deaths categorised as SIDS were reviewed during 2014-2015 as outlined in paragraphs 3.4, 4.6 and 5.4, where the sleeping environment and parental smoking were identified as contributable factors in both cases.
- 8.3.1 There were a further **2** deaths reviewed as outlined in paragraphs 3.5 and 5.5 where accidental asphyxiation /obstruction was found to be the cause of death following a post mortem examination. They were therefore recorded under the category of 'trauma' at the CDOP review but as both featured unsafe sleeping environments which were contributable factors, they will be included in the overall SIDS data.
- 8.3.2 **35** SIDS deaths have been reviewed across the sub-region to date, from April 2008 to March 2015 (16 each at Coventry and Warwickshire CDOP and 3 at Solihull CDOP). Of the 35, **32** (91%) were preventable with modifiable factors being identified. It is known that in **22** (63%) 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 of the deaths, parent(s) were considered to be vulnerable and/or leading chaotic lifestyles.
- 8.3.3 The above information only relates to the deaths that have been reviewed at CDOP so far. Further deaths did occur in 2014-2015 which indicate characteristics of SIDS and are still subject of investigation.
- 8.3.4 In the last two annual reports reference is made to work being conducted on formulating a SIDS risk assessment tool, to be bound in the Personal Child Health Record (red book), which

Community Midwives will complete at the first home visit post discharge. The assessment will include a physical check of where baby sleeps (both night and day time) and if any risk(s) are identified, a plan will be agreed with parent(s) to reduce the risks. The Health Visitor will then review the assessment at the primary birth visit and any other professionals involved with the family will also be made aware of any risks so that safe sleeping messages are reinforced. It is pleasing to update that a tool has been devised which will be presented to the West Midlands PCHR Working Group in July 2015, attended by Health Visitor and Midwifery Managers for consultation and endorsement.

- 8.3.5 Solihull Health Visiting Service is in the process of implementing a paper risk assessment tool in the interim. One has been devised based on the original template produced by Derbyshire NHS and a Standard Operating Procedure is in place. Their Care of Next Infant (CONI) Co-ordinator and a colleague have also booked onto Derbyshire's SIDS training course in June 2015. A start date will be notified in due course.

9 Chronic Medical Condition:

6 deaths were reviewed during 2014-2015 which fell in this category and all died from their chronic condition or a medical cause associated with it. None of the reviews identified any modifiable factors although some identified actions (not all relating to the death) as outlined in paragraphs 3.19 and 5.19.

10 Malignancy:

5 deaths were reviewed during 2014-2015, none of which had modifiable factors identified. As mentioned in previous annual reports, 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. In last year's report a recommendation was made to deliver inputs to GP Protected Learning Time (PLT) sessions to raise the awareness of 'red flag' symptoms particularly in brain tumours, due to the number of reviews where an earlier diagnosis was not made. These sessions have taken place across Coventry and Warwickshire during 2014-2015 and plans are in place to replicate this in Solihull. All of the 5 deaths reviewed identified a prompt referral by the GP and the actions in relation to these deaths was to acknowledge in writing the prompt action by GPs and the excellent support provided by schools.

- 10.1 As in previous years, the excellent cross-agency working between tertiary hospitals, GPs and community palliative care services has been recognised in supporting the child or young person and their family during the end of life stage. You will have also previously noted that in a couple of cases excellent end of life care was provided in a hospital setting to accommodate the wishes of the child or their family, which has been acknowledged (paragraphs 5.18 and 5.19 refer).

11 Trauma and other external factors

5 deaths were reviewed during 2014-2015 which were classified under this category. 2 deaths were as a result of accidental airway obstruction/asphyxiation as referred to in 8.3.1. 2 deaths were as a result of road traffic collisions, one a pedestrian where no modifiable factors or actions were identified and one a front seat passenger where again no modifiable factors were identified but actions identified, as referred to in paragraph 5.23. The fifth is the death referred to in paragraph 4.7.

- 11.1 Some analysis was conducted in last year's annual report on road traffic collisions and no specific themes or 'hotspot' locations were identified. This remains the same taking into account the two deaths reviewed this year.

12 Infection:

4 deaths were reviewed during 2014-015. 2 had modifiable factors in relation to prior medical intervention which are outlined in paragraphs 5.3 and 5.10.1. The other 2 had no modifiable factors but one identified learning not associated with the death as outlined in paragraph 5.17.

13 Acute medical or surgical condition:

2 deaths were reviewed under this category. Both were subject of a 'root cause analysis' investigation and both had modifiable factors identified in relation to prior medical intervention. These two cases are outlined in paragraphs 4.5 and 5.6.

14 Serious Case Reviews:

None of the deaths reviewed during 2014-2015 were subject of a serious case review (SCR). Solihull CDOP did recommend an SCR in the death outlined in paragraph 4.3.

14.1 There are however 5 deaths to date across the sub-region which are subject of an SCR and it is anticipated that most, if not all, will be reviewed during 2015-2016.

15 Additional information on the deaths reviewed where modifiable factors were identified:

Of the 32 deaths reviewed during 2014-2015 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.

15.1 Age:

14 were 0-27 days, 11 were 28-364 days, 3 were 1-9 years, 2 were 10-14 years and 2 were 15-17 years. This mirrors the findings of the deaths reviewed during 2013-2014 where the two youngest age groups were the highest age bands, which in 2014-2015 accounts for 78% of the modifiable deaths.

15.2 Gender:

17 were male and 15 were female. Again this mirrors the finding of 2013-2014 where there were slightly more males than females.

15.3 Ethnicity:

22 were White British, 4 were of Asian origin and 3 from Black African or Asian and White mixed ethnicity. The remainder were too small a number to categorise. Again, this mirrors the ratio in the deaths reviewed during 2013-2014. With regards to the cause of death in the deaths from minority ethnic origin, there was nothing to indicate in the review that their death or the modifiable factors identified were linked in any way to their ethnicity. With regards to social factors, parent(s) from minority ethnic origin tended to be in low income employment or full time carers for their child. In one death the child was subject of a child protection plan for emotional abuse, however no further details can be provided as this may identify the family.

15.4 Category of death:

16 were categorised as a 'Perinatal/Neonatal event', 5 as 'Chromosomal, Genetic and Congenital Anomalies', 4 as a Sudden Unexpected, Unexplained death', 3 from 'Trauma and other External factors', 2 as 'Acute medical or surgical condition' and 2 from 'Infection.' As in 2013-2014, the category of 'Perinatal/Neonatal Event' was the highest category.

15.5 Place of event which led to the child's death

21 were in hospital at the time of death, either in the Neonatal Unit, Paediatric Intensive Care Unit, High Dependency Unit, Paediatric Ward or Delivery Suite. It should be noted that in 16 of these deaths, modifiable factors did not relate to the medical care given but were due to lifestyle choices, i.e. maternal smoking, obesity, alcohol or substance misuse during pregnancy and consanguinity. In the other 6 deaths modifiable factors related to prior medical or surgical intervention and access to health care. The 11 remaining deaths took place at the home address.

15.6 Child Protection Plans / Statutory Orders:

1 child was subject of a Child Protection Plan for emotional abuse at the time of their death and another child was subject of a Statutory Contact Order at the time of their death.

16 West Midlands CDOP Region

The West Midlands Regional CDOP Forum has not met during this reporting year. The CDOP Manager has met recently with Helen Hipkiss, Deputy Director Nursing and Quality, NHS England and Regional Head of Safeguarding, and Julia Greensall, Network Development Manager for Partners in Paediatrics (PIP) to progress ownership of this forum. It is anticipated that the forum will become a sub-group of the West Midlands Safeguarding Forum however this is yet to be confirmed. PIP has agreed to provide a venue and administrative support for the meetings.

- 16.1 A West Midlands Regional Annual Report has not been produced since 2012. This was a four year report covering 2008-2012 which was produced by the last regional CDOP Chair.

17 National learning from deaths reviewed during 2014-2015

The annual returns on deaths reviewed during 2014-2015 were submitted to the Department for Education in May 2015. Their annual statistical release is usually published towards the end of July and this will be circulated separately when received.

18 Processes:

18.1 *Involving families in the child death review process*

In the 74 deaths notified in 2014-2015, 58 leaflets were handed to the family by a professional known to the child/family or involved with their child's death and 16 were posted by the CDOP Manager as a professional was no longer involved with the family. Only 2 parents from this year have responded to date, both to the CDOP Manager.

- 18.2 Since the start of this process in July 2013, **12** families have contributed to their child's review (5 Warwickshire, 4 Coventry, 3 Solihull). **11** responded to the CDOP Manager after receiving a letter and leaflet and one parent contributed via the paediatrician involved in their child's death. Parents provided information to the cases outlined in paragraphs 4.7, 5.3, 5.10 and 5.11 which would not have been known to the panel. .

- 18.2 As can be seen, the uptake is low and the majority of contact has been in response to the CDOP Manager's letter. One reason for this may be that where a professional is still involved with the family they have been provided sufficient information and have had answers to any questions they may have had, so have not felt the need to ask any further questions or contribute.

18.3 *CDOP Membership:*

Warwickshire CDOP is well represented by South Warwickshire NHS Foundation Trust with a Consultant Paediatrician, Consultant in Child Health, Assistant Head of Children, Young People & Family Services, and Clinical Governance Midwife all from this Trust. A request has been made for a paediatrician from George Eliot Hospital (GEH) to attend Warwickshire CDOP when cases involving GEH are being reviewed, to facilitate the exchange of information and take ownership of any actions in relation to this Trust. A response is currently being awaited.

- 18.4 None of the three CDOPs currently have a Vice Chair and work is being undertaken by the 3 LSCBs to progress this.

18.5 *Collation of national child death data and national CDOP learning:*

This was reported on in the 2013-2014 annual report and the frustration that 6 years (now 7 years) from the start of this process in 2008, no progress has been made to develop a national database to capture national child death data and CDOP learning. This prompted the Warwickshire LSCB Chair to write to the Secretary of State Nicky Morgan in 2014 and the letter was co-signed by both Coventry and Solihull LSCB Chairs. A response was received to the effect that the National Perinatal Epidemiology Unit (NPEU) at University of Oxford was commissioned by the Healthcare Quality Improvement Partnership in October 2014. The work will take 18 months and will be reported on in the autumn of 2016. The database will not be

created then but will be ready to be commissioned. The NPEU are currently holding regional consultation workshops and the CDOP Manager and CDOP Officer attended the West Midlands workshop on 18 June 2015.

- 18.5.1 It is anticipated that a review of the national template forms will be reviewed as part of this work as the form used for reviews (known as Form C) is no longer adequate to record all information, particularly around prematurity. There is no facility in the 'factors intrinsic to the child' section to record prematurity and conditions intrinsic to premature babies. Also 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 and are often placed in free text. 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.

19 CDOP Working Group

The CDOP Working Group, formed in 2007 to progress the operational elements of the child death review process met once during 2014-2015. The group usually meets twice annually but one meeting had to be cancelled twice due to last minute unforeseen commitments by LSCB representatives. All on-going work is reflected in the CDOP Manager's work plan, which is monitored by the CDOP Working Group.

19.1 Other work:

Following the presentation of the 2013-2014 CDOP Annual Report at Warwickshire LSCB, Warwickshire child death data for the last 2 years has been requested by Warwickshire CCGs to assist with any commissioning requirements that may be identified. This data is currently being compiled and will be provided to the CCGs in a separate report.

20 CDOP Budget - Expenditure 2014 – 2015

Salaries: CDOP Manager and CDOP Officer.		£59,598
Travel		£336
Office costs (stationary, photocopying, phones, IT charges.)		£1,606
Central establishment charges		£16,146
Training (SIDS risk assessment)		£276
Carry forward from 2013-14 Reimbursement of trainer's travel by CCG	£4,000 £21	
Contribution from Warwickshire	£36,141	
Contribution from Solihull	£13 000	
Contribution from Coventry	£24,800	
Total Income	£77,962	
Total expenditure		£77,962

21 Sub-Regional data on child deaths notified in 2014 – 2015

- 21.1 During 2014-2015, **74** deaths were notified to the child death review process across the sub-region, which is slightly lower than the **82** deaths notified in 2013-2014. (81 deaths were reported in the 2013-2014 annual report, however a late notification of a child that died in the 2013-2014 reporting year was made known in November 2014 which has been added to the 2013-2014 statistical data). The reduction is seen mainly in Warwickshire deaths across all

categories (33 reported in 2014-2015 compared to 39 in 2013-2014). Coventry and Warwickshire have also seen a very slight reduction of one death each.

- 21.2 Appendix 'E' gives a breakdown of deaths reported year on year under each category and Appendix 'F' gives a breakdown on the types of sudden and unexpected deaths.

22 Sub-regional deaths by Category 2014-2015 (Total 74)

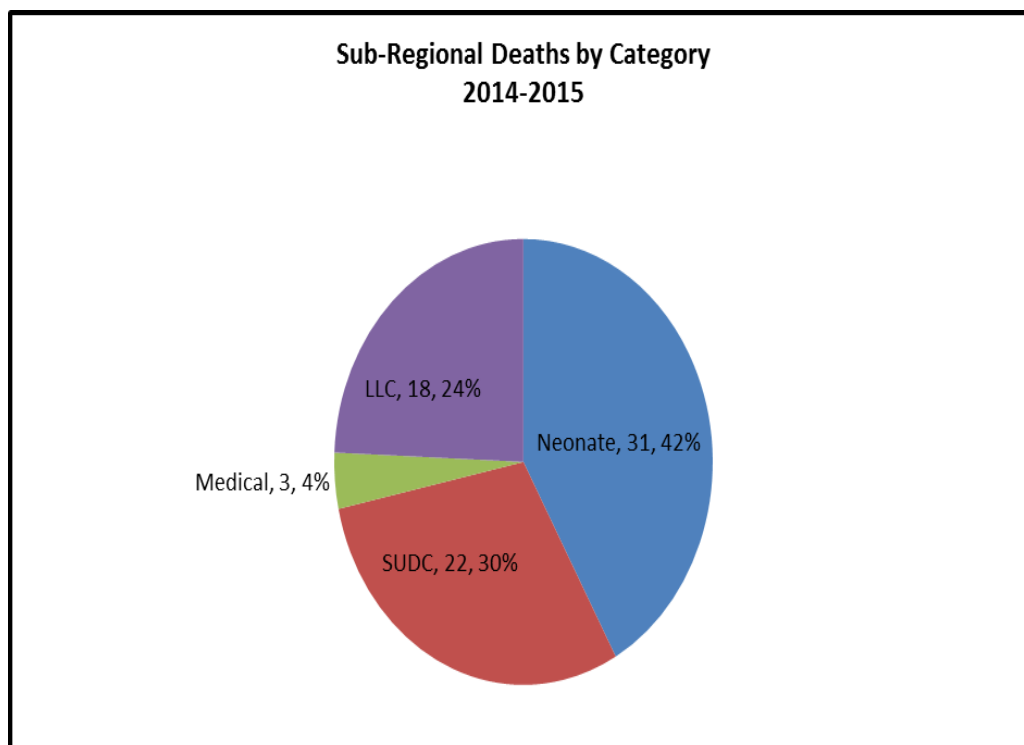
Definitions of the categories used are as follows:

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

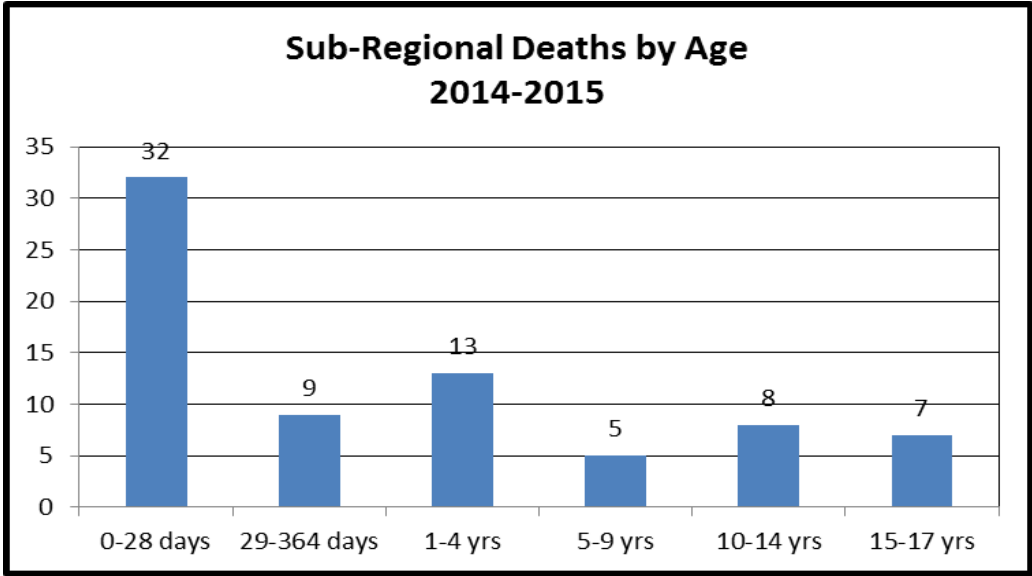
SUDC – Sudden and Unexpected Death where the cause of death is not known and where a multi-agency 'Rapid Response' investigation under the SUDC Protocol has been conducted or a police investigation on behalf of the Coroner.

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

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

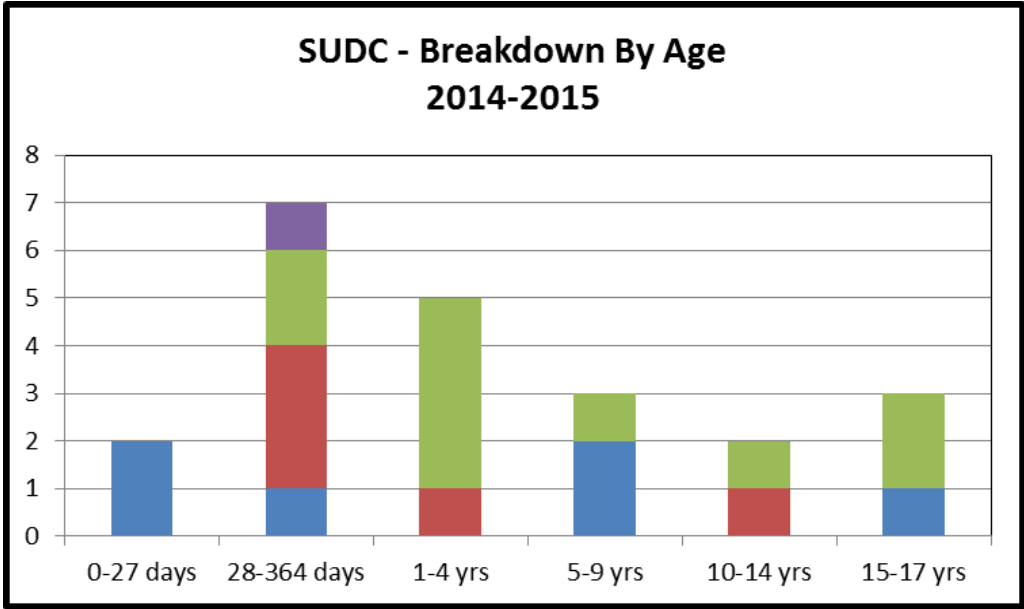


22.1 Sub-regional Deaths by Age 2014-2015 (Total 74)



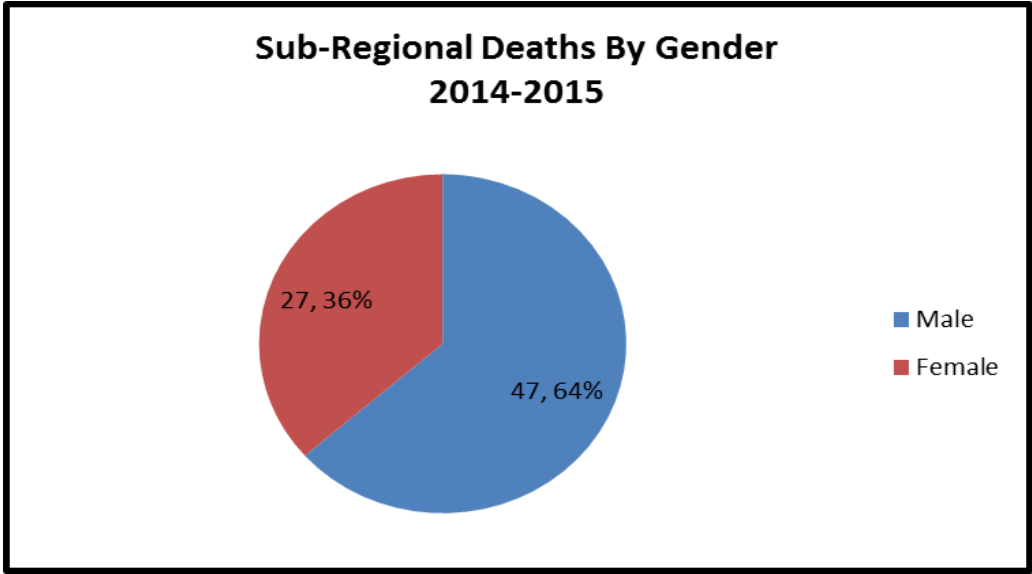
22.2 Deaths in the 0-28 day category are the highest group as predicted, which also mirrors that of 2013-2014 data, however for the first time, age group 1-4 years is the second highest and overtakes the 29-364 days age group (1- 4 years ranked 4th in 2013-2014). Of the 13 deaths in this age group, 9 were sudden and unexpected deaths with a known medical cause or a medical cause ascertained following an investigation. The other 4 were from life limiting conditions. 6 deaths in this age group were reviewed in 2014-2015 and no modifiable factors were identified in any of them. The remaining 7 have yet to be reviewed.

22.3 The following chart gives a breakdown by age of the sudden and unexpected deaths notified in 2014-2015 (total of 22). N.B. Not all of have been reviewed.



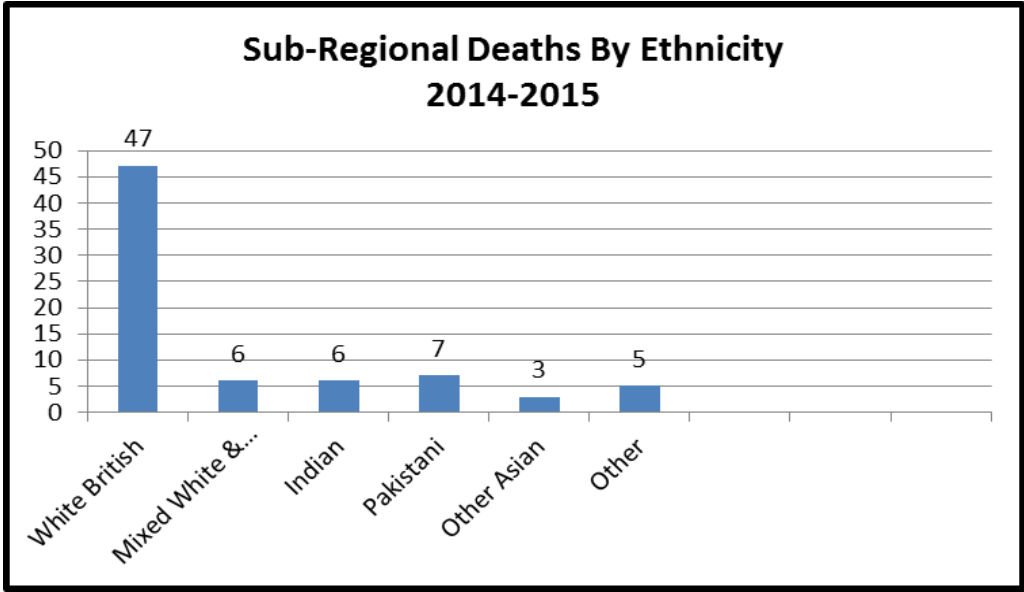
Key for above chart
Not reviewed yet Trauma Medical Cause SIDS

22.4 Sub-Regional Deaths by Gender 2013-2014 (Total 74)



22.4.1 In 2013-2014 there were more female than male deaths across the sub-region which bucked the national trend. National data for 2014-2015 is not yet available however national trends in previous years have shown more male than female deaths so the sub-regional data for this year is in keeping with the national trend.

22.5 Sub-Regional deaths by Ethnicity 2014-2015 (Total 74)

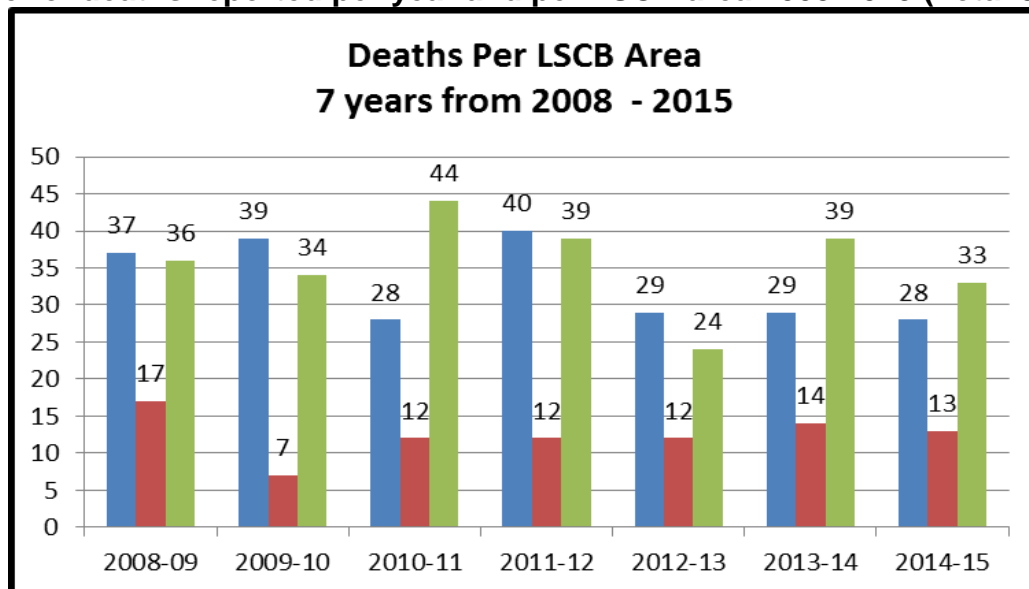


22.5.1 Mixed White and African, White and Asian and White and Caribbean have been grouped together due to the low numbers.

22.5.2 At the presentation of the 2013-2014 annual report, Warwickshire LSCB requested more information on the deaths of children from ethnic minority groups. Further information on this is outlined in Appendix 'C'.

23 Aggregated Sub-Regional Data 2008 – 2015:

23.1 Number of deaths reported per year and per LSCB area 2008-2015 (Total 566)

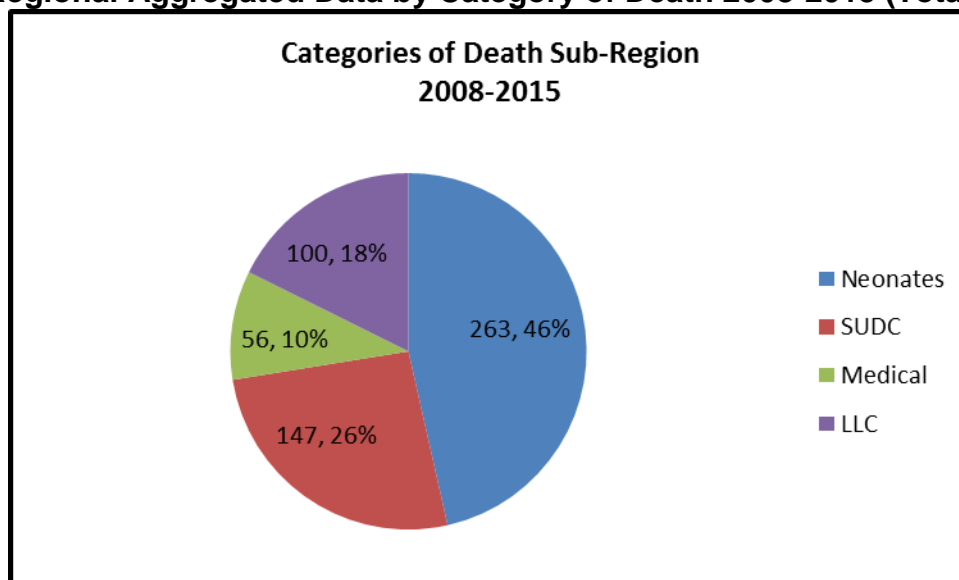


Key: **Coventry**

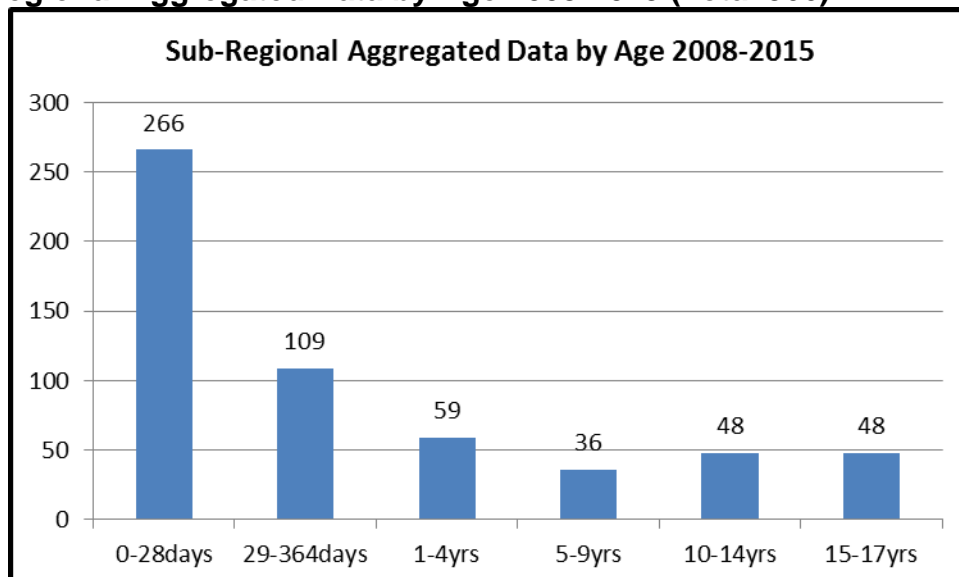
Solihull

Warwickshire

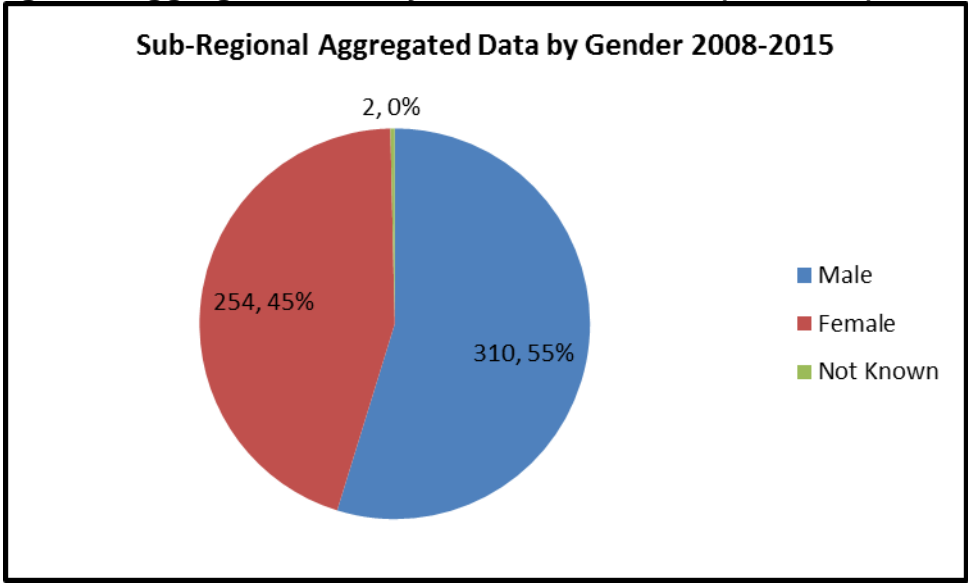
23.2 Sub-Regional Aggregated Data by Category of Death 2008-2015 (Total 566)



23.3 Sub-Regional Aggregated Data by Age 2008-2015 (Total 566)

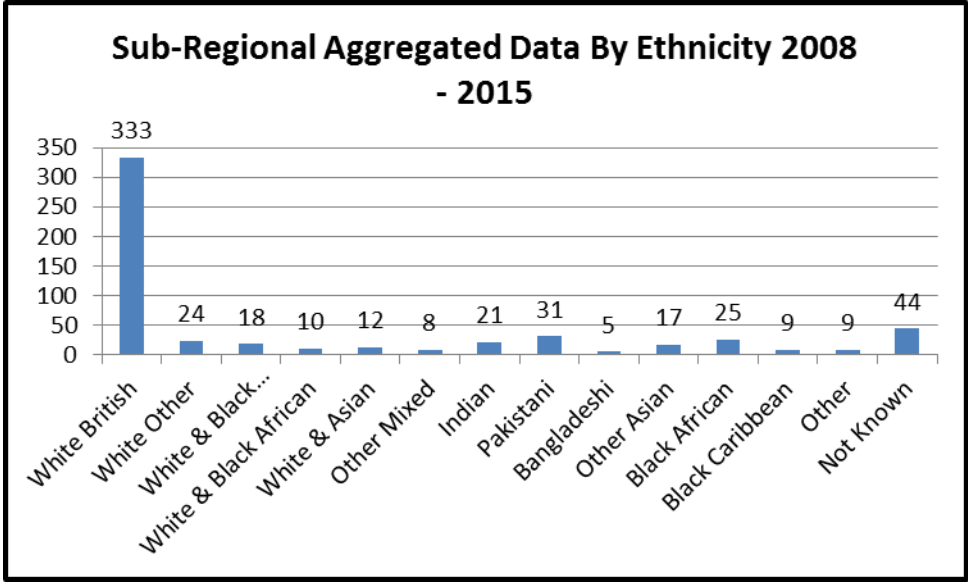


23.4 Sub-Regional Aggregated Data by Gender 2008-2015 (Total 566)



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

23.5 Sub-Regional Aggregated Data by Ethnicity 2008-2015 (Total 566)



23.5.1 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 2014-2015:

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 Sally Simpson, 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

1.1 Co-opted Members:

Dr Kate Blake, Consultant Neonatologist
Andrew Proctor, Safeguarding Manager, West Midlands Ambulance Service

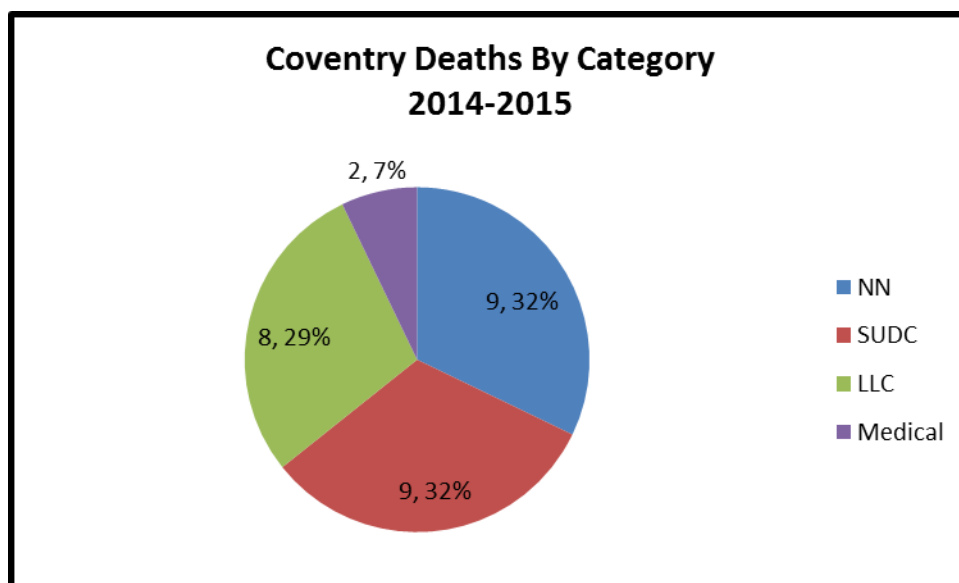
2 Details of the number of CDOPs held and the number of deaths reviewed is outlined in paragraph 2 of the annual report. A summary of the recommendations and actions arising from Coventry CDOP are outlined in paragraph 3.

3 **Coventry Child Death Data:**

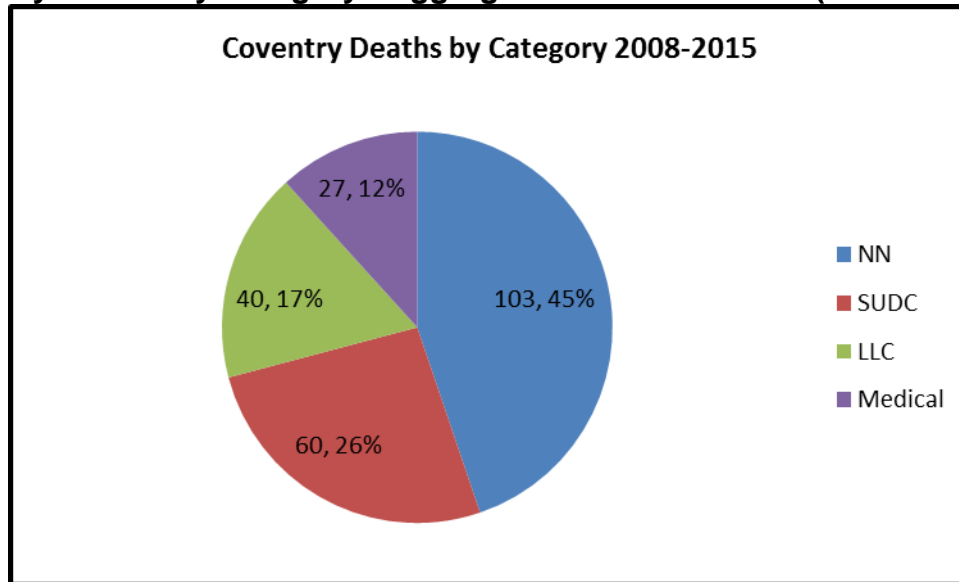
28 deaths were notified in 2014-15, one less than in 2013-2014, making them fairly static over the last three reporting years, i.e. 29 deaths reported in 2012-2013 and 2013-2014. Deaths reported year on year since the process began in 2008 are shown in paragraph 23.1.

3.1 Explanations of the abbreviations and categories are outlined in paragraph 22. 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.

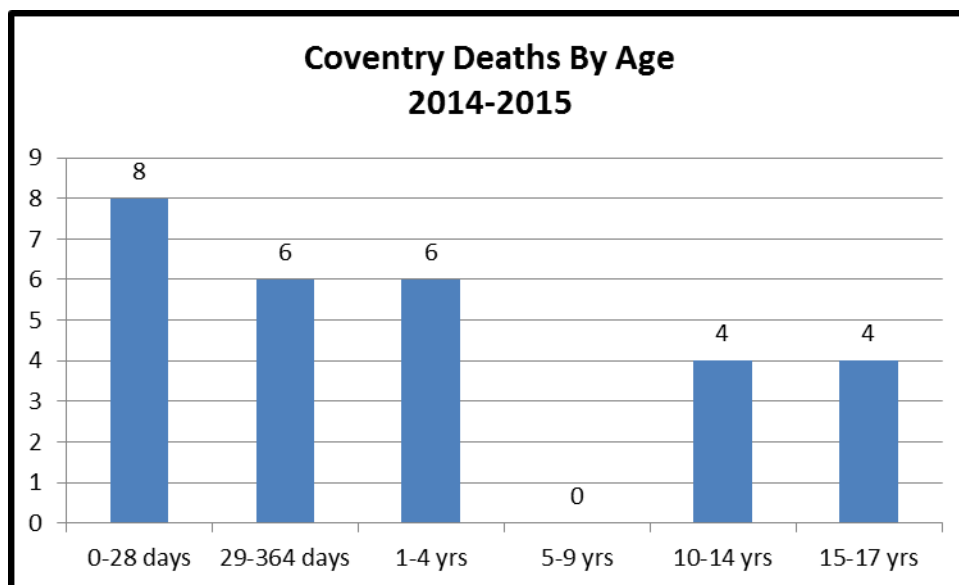
3.2 **Coventry Deaths by Category 2014-2015 (Total 28)**



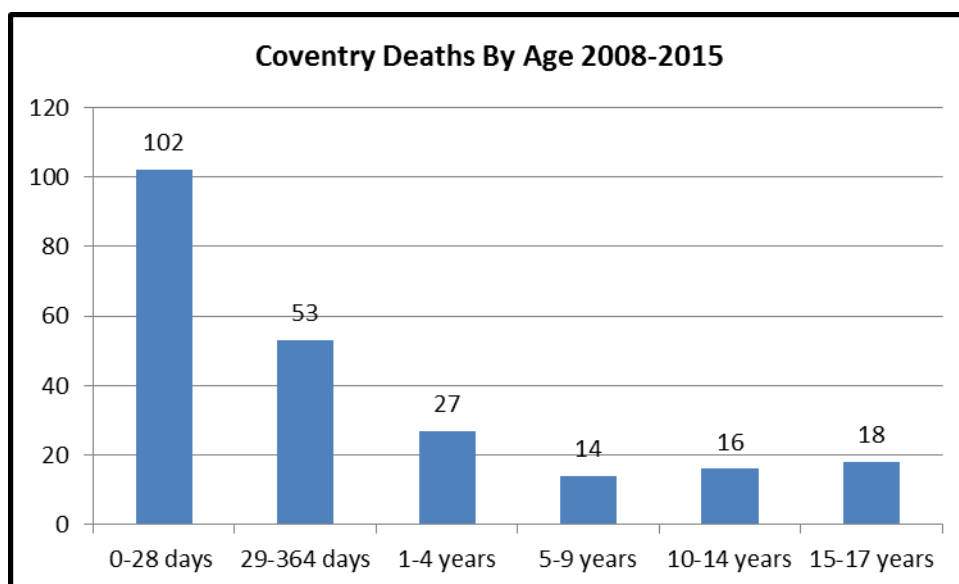
3.3 Coventry Deaths by Category– Aggregated Data 2008-2015 (Total 230)



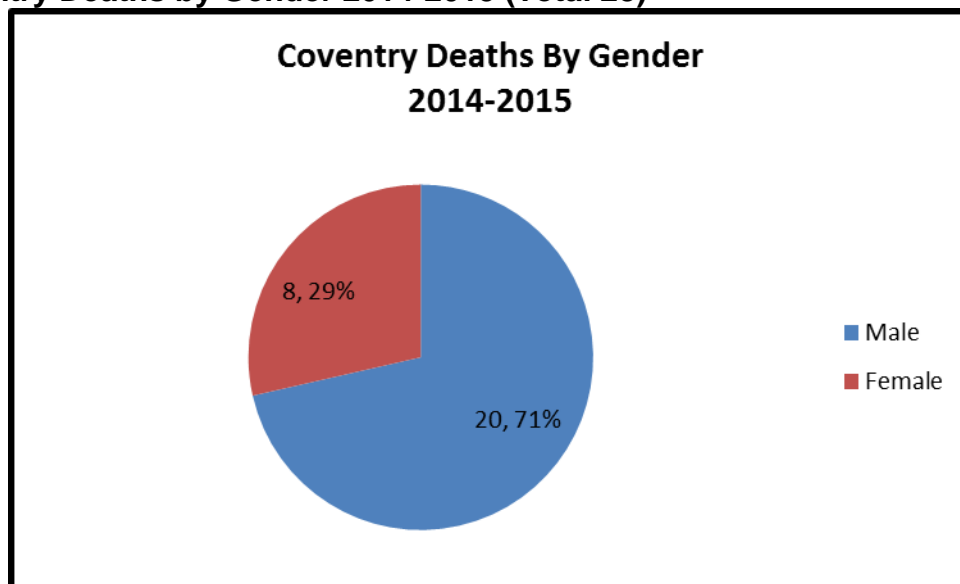
3.4 Coventry Deaths by Age 2014-2015 (Total 28)



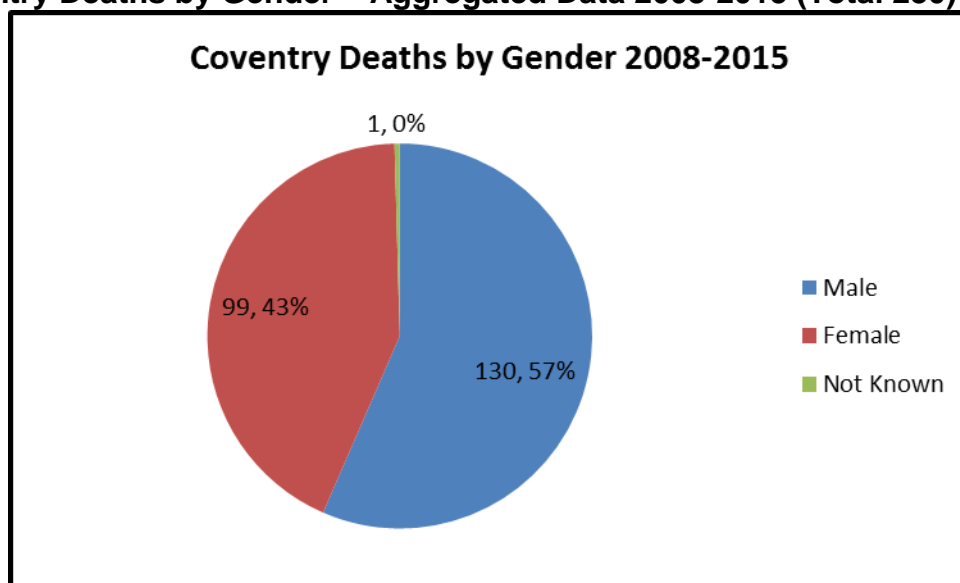
3.5 Coventry Deaths by Age - Aggregated Data 2008-2015 (Total 230)



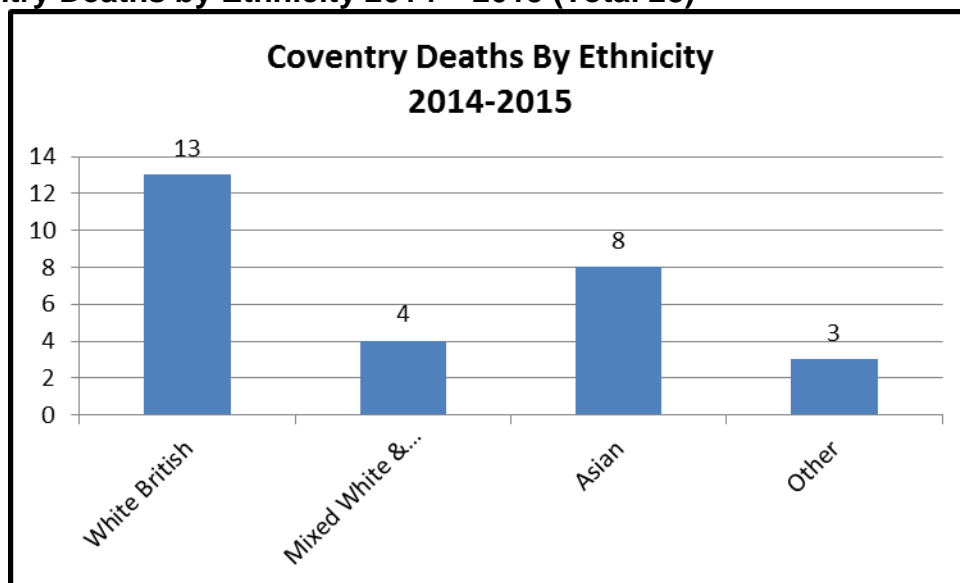
3.6 Coventry Deaths by Gender 2014-2015 (Total 28)



3.7 Coventry Deaths by Gender – Aggregated Data 2008-2015 (Total 230)

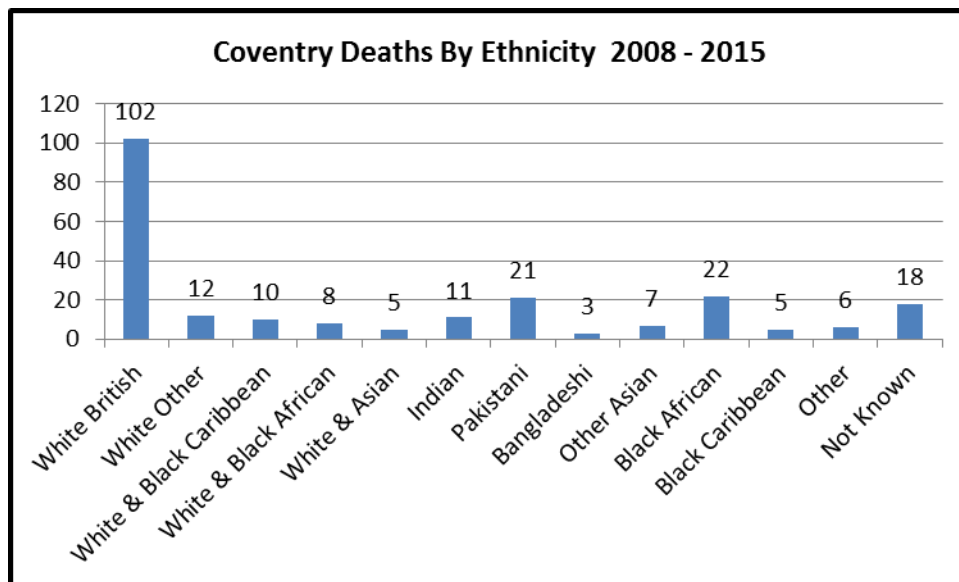


3.8 Coventry Deaths by Ethnicity 2014 – 2015 (Total 28)



3.8.1 Mixed White and African, White and Asian and White and Caribbean have been grouped together due to the low numbers.

3.9 Coventry Deaths by Ethnicity – Aggregated Data 2008 – 2015 (Total 230)



4 Summary:

- 4.1 Although the number has remained static compared to 2013-2014, there are changes within the categories, i.e. there were 5 fewer neonatal deaths in 2014-2015 than in 2013-2014, there was a slight increase in deaths from life limiting conditions (8 in 2014-2015 compared to 6 in the previous year) and 2 deaths from sudden medical conditions which did not feature in 2013-2014. The number of 'sudden and unexpected deaths' remains the same as the previous year. (See Appendix 'E' for a further breakdown).
- 4.2 Neonatal deaths have consistently been the highest category of death since the process began in 2008, however for the first time, the number of neonatal deaths is equal to the number of sudden and unexpected deaths. That said, neonatal deaths are the highest category when looking at the 7 years of aggregated data.
- 4.3 0-28 days remains the highest age group as it has in previous years in both yearly and aggregated data. Looking at the aggregated data, 155 (67%) of deaths occurred within the first year of life which is consistent with previous national findings and mirrors the findings of Solihull and Warwickshire too.
- 4.4 With regards to gender, both the yearly data and aggregated data show more male deaths than females which have mirrored previous national findings. (The national data will not be released until late July 2015 so cannot be compared with this year's national findings yet).
- 4.5 With regards to ethnicity, children of White British origin remains the single highest category both in the yearly and aggregated data. However when grouping the categories of non 'White British' together this total is larger in both the 2014-2015 data and aggregated data. Warwickshire LSCB requested further analysis last year on the deaths from ethnic minority groups. This can also be conducted for Coventry LSCB if this would be useful.
- 4.6 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 2014-2015:

Ian Mather, Consultant in Public Health (Chair)
Mohammed Bham, Principle Education Psychologist
Alison Frost, Team Leader, Solihull MBC Legal Services
Carol Owen, Midwifery Services, Heartlands Hospital
Eleni Prodromou, Assistant Team Manager, Solihull Children's Social Care
Detective Inspector Sally Simpson, West Midlands Police
Dr Alan Stanton, Consultant Paediatrician (Community)

1.1 Co-opted member:

Dr Richard Mupanemunda, Consultant Neonatologist, Heartlands Hospital.
Andrew Proctor, Safeguarding Manager, West Midlands Ambulance Service

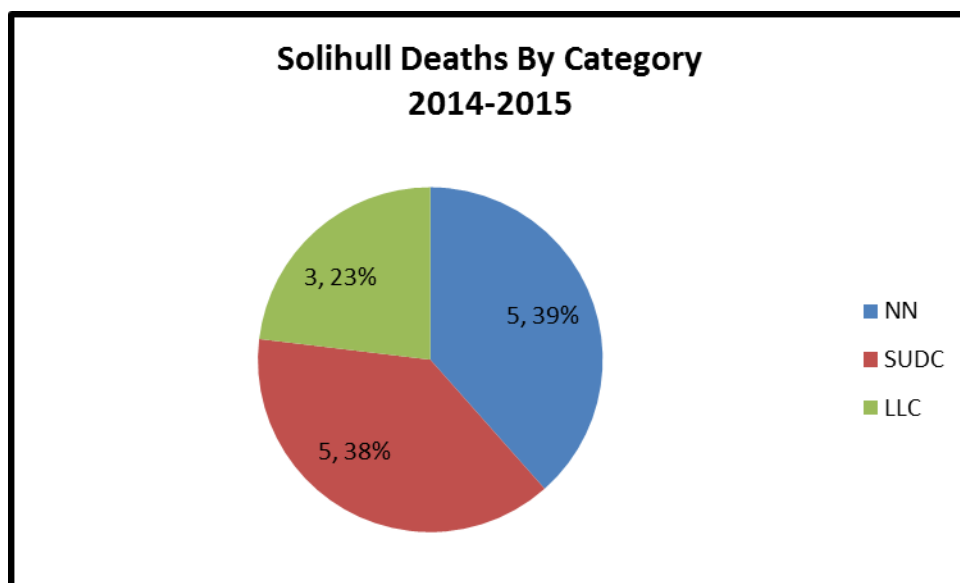
2 Details of the number of CDOPs held and the number of deaths reviewed is outlined in paragraph 2 of the annual report. To date it has not been necessary to convene a Fast Track CDOP but this will be considered if the numbers demand. A summary of the recommendations and actions arising from Solihull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

3 Solihull Child Death Data

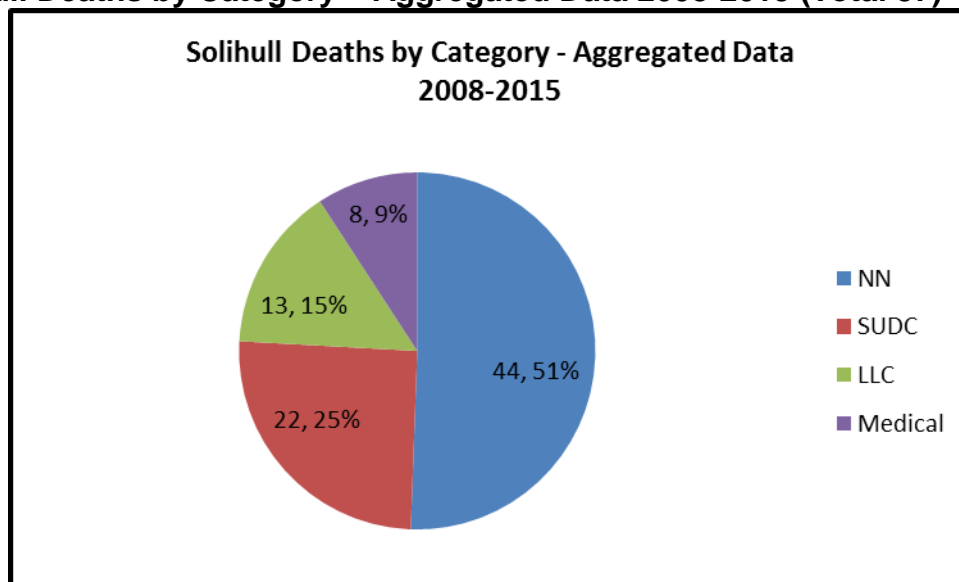
13 deaths were notified in 2014-2015, one less than in 2013-2014. Deaths reported year on year since the process began in 2008 are shown in paragraph 23.1 and as can be seen the number has been fairly consistent over the last 5 years.

3.1 Explanations of the abbreviations and categories are outlined in paragraph 22. 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.

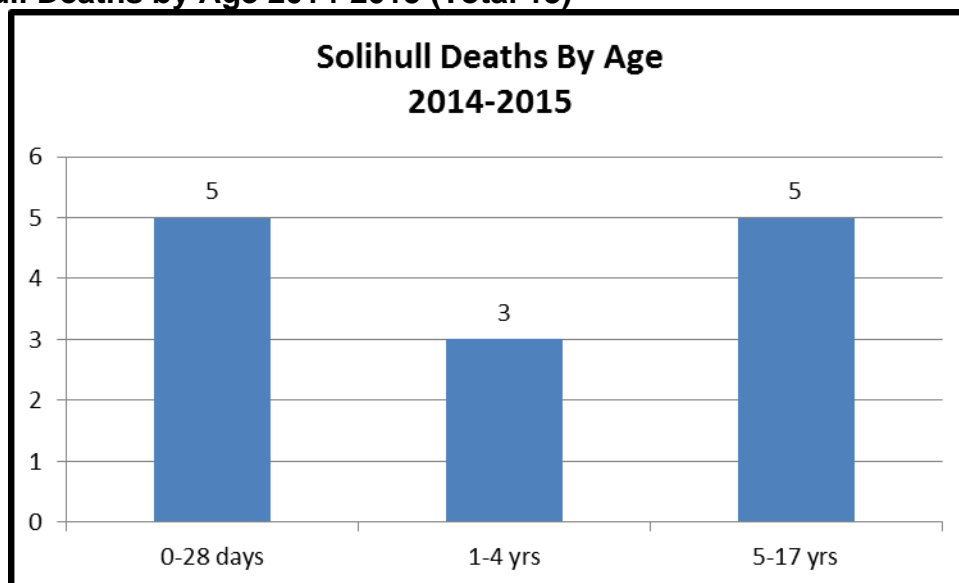
3.2 Solihull Deaths by Category 2014-2015 (Total 13)



3.3 Solihull Deaths by Category – Aggregated Data 2008-2015 (Total 87)

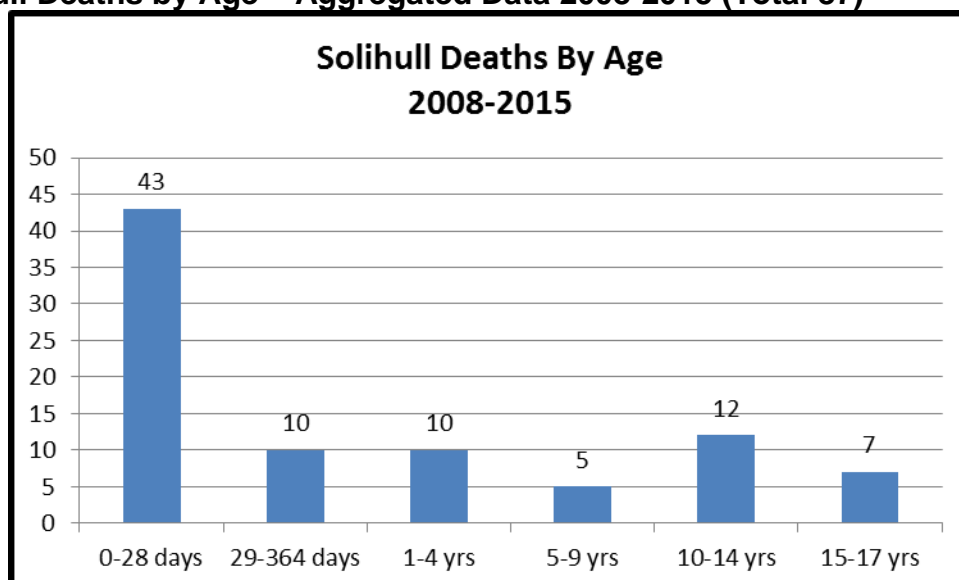


3.4 Solihull Deaths by Age 2014-2015 (Total 13)

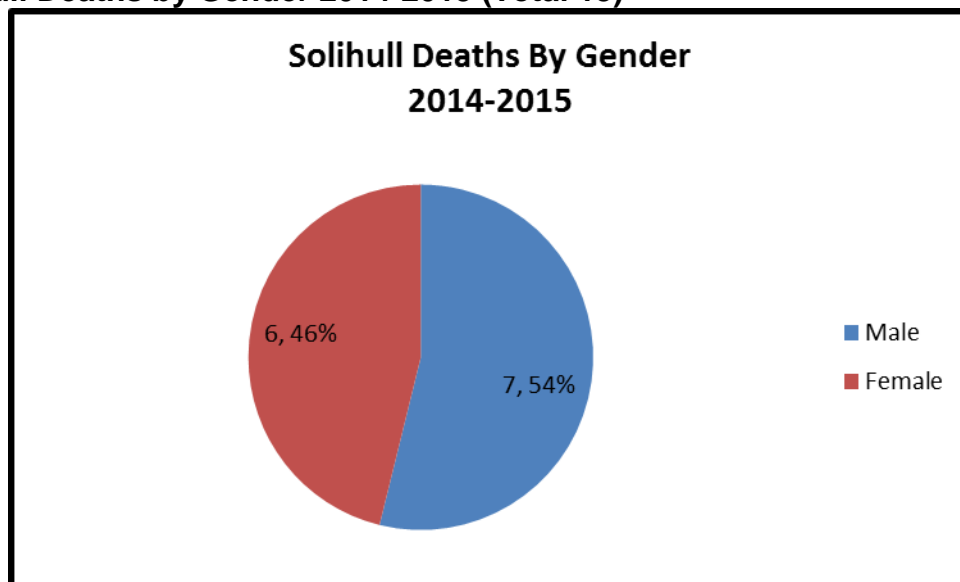


3.4.1 Age groups 5-9, 10-14 and 15-17 years have been merged due to the low numbers. There were no deaths in the 29-364 days group.

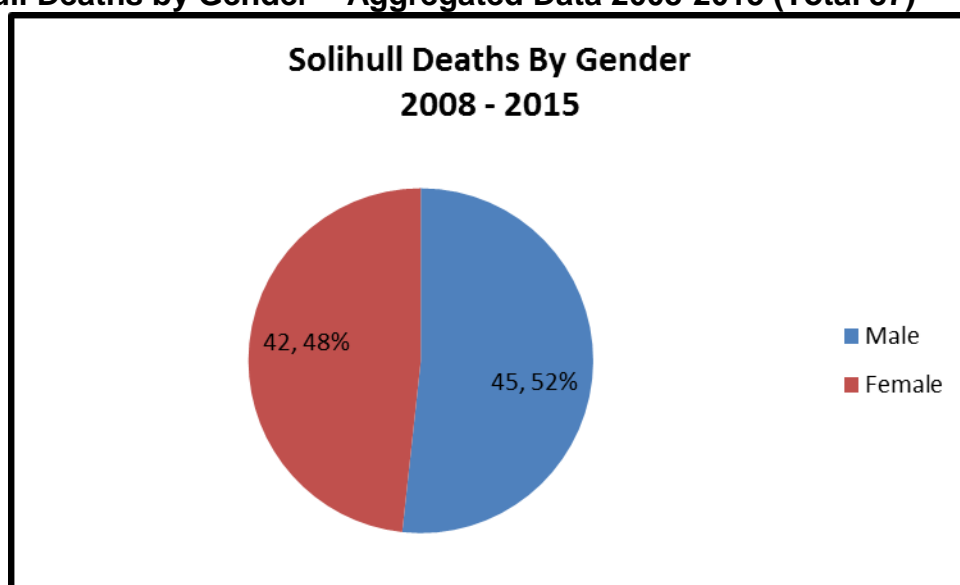
3.5 Solihull Deaths by Age – Aggregated Data 2008-2015 (Total 87)



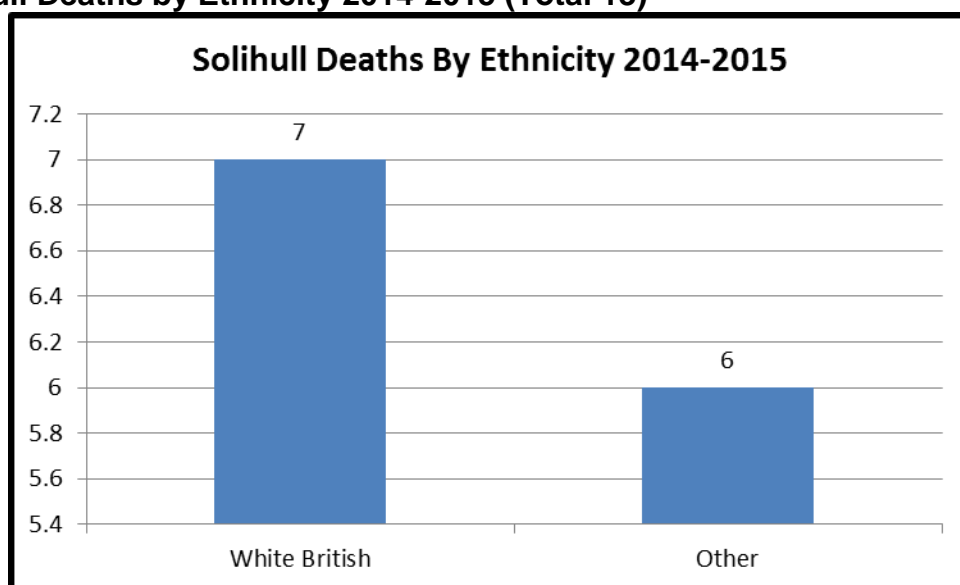
3.6 Solihull Deaths by Gender 2014-2015 (Total 13)



3.7 Solihull Deaths by Gender – Aggregated Data 2008-2015 (Total 87)

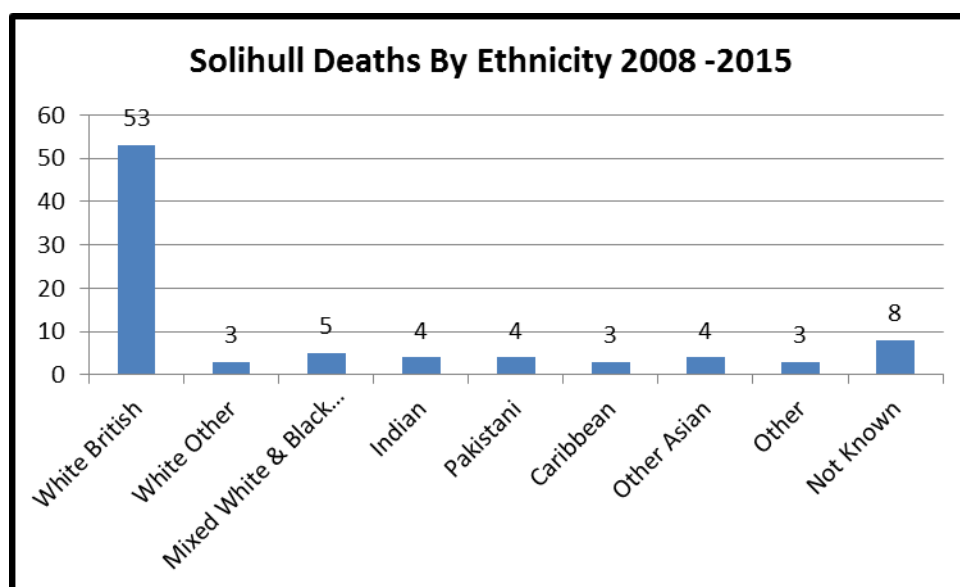


3.8 Solihull Deaths by Ethnicity 2014-2015 (Total 13)



3.8.1 'Other' deaths cannot be categorised due to the low number.

3.9 Solihull Deaths by Ethnicity – Aggregated Data 2008-2015 (Total 87)



4 Summary

- 4.1 Although the number has remained static with 2013-2014, there are changes within the categories, i.e. neonatal deaths were halved in 2014-2015, i.e. 5 compared to the 10 reported 2013-2014. There was an increase in 'sudden and unexpected deaths' in 2014-2015, 5 in 2014-2015 compared to 2 in 2013-2014. Deaths from life limiting conditions has seen a very slight increase, 3 in 2014-2015 compared to 2 in 2013-2014. (See Appendix 'E' for a further breakdown).
- 4.2 0-28 days remains the highest age group as it has in previous years in both yearly and aggregated data. Looking at the aggregated data, 61% of deaths (53 out of 87) occurred within the first year of life which is consistent with previous national findings and mirrors the findings of Coventry and Warwickshire too.
- 4.3 With regards to gender, both the yearly data and aggregated data show more male deaths than females which mirrored previous national findings. (The national data will not be released until late July 2015 so cannot be compared with this year's national findings yet).
- 4.4 With regards to ethnicity, children of 'White British' origin continues to be the highest category as it has done over previous years with 61% (53 out of 87) over the 7 years being of 'White British' origin.
- 4.5 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 2014-2015:

Cornelia Heaney, Development Manager for Warwickshire Safeguarding Children Board (WSCB) (Chair)

Jenny Butlin-Moran, Service Manager, Service Development and Assurance (Children's)

Jonathan Dominguez-Hernandez, Specialist Clinical Governance Midwife, South Warwickshire NHS Foundation Trust

Keith Drinkwater, LSCB Lay Member

Cathy Ellis, Consultant in Child Health

Victoria Gould, Young People Legal Services Manager, Warwickshire County Council

Detective Inspector Nigel Jones / Detective Inspector Alan Townsend, Warwickshire Police

Dr Kathryn Millard, Consultant in Public Health

Adrian Over, Safeguarding Children's Manager for Education

Dr Peter Sidebotham, Consultant Paediatrician (Community)

Linda Watson, Assistant Head for of Children, Young People and Family Service,

1.1 Co-opted member:

Andrew Proctor, Safeguarding Manager, West Midlands Ambulance Service

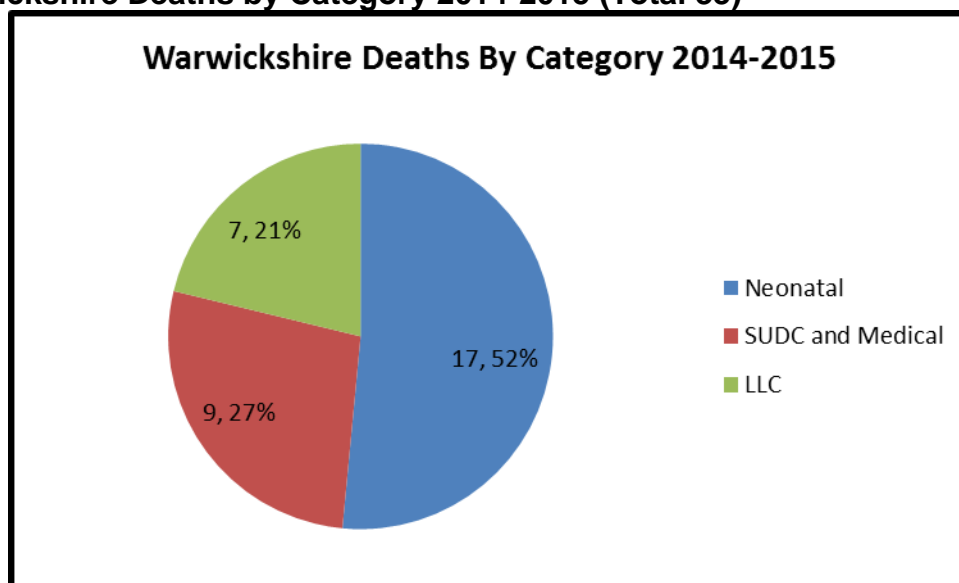
2 Details of the number of CDOPs held and the number of deaths reviewed is outlined in paragraph 2. A summary of recommendations and actions arising from Warwickshire CDOP are outlined in paragraph 5.

3 **Warwickshire Child Death Data:**

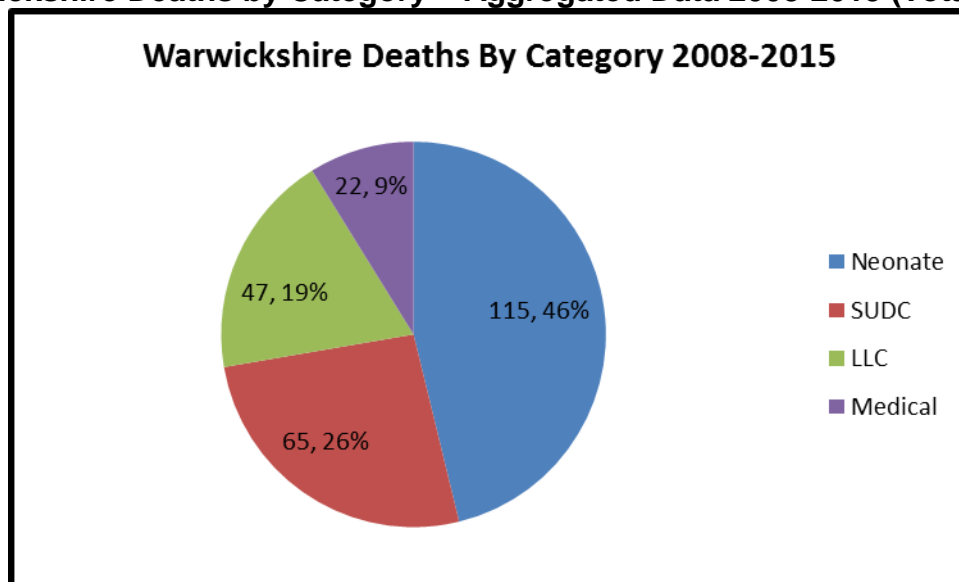
33 deaths were notified in 2014-2015, 5 less than in 2013-2014. Deaths reported year on year since the process began in 2008 are shown in 23.1

3.1 Explanations of the abbreviations and categories are outlined in paragraph 22. 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.

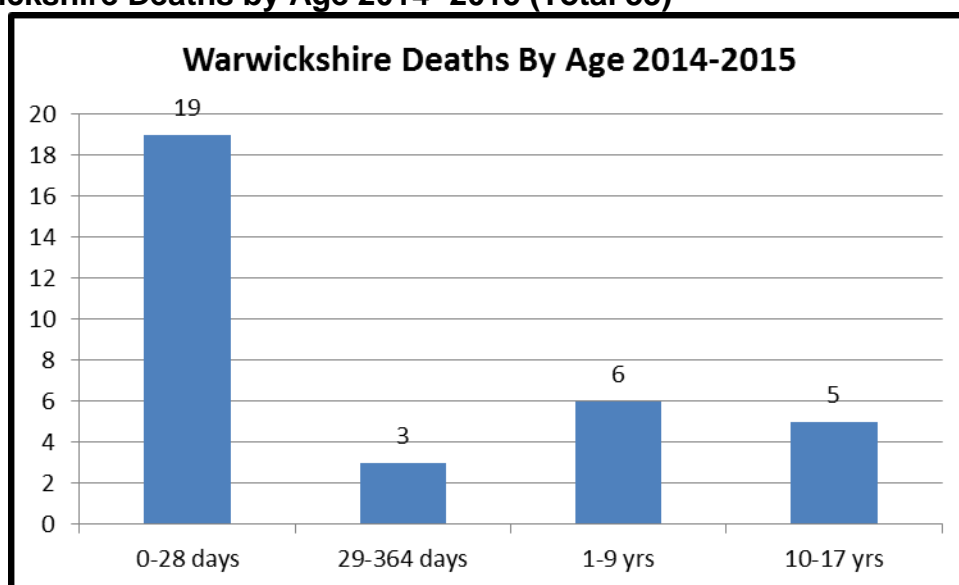
3.2 **Warwickshire Deaths by Category 2014-2015 (Total 33)**



3.3 Warwickshire Deaths by Category – Aggregated Data 2008-2015 (Total 249)

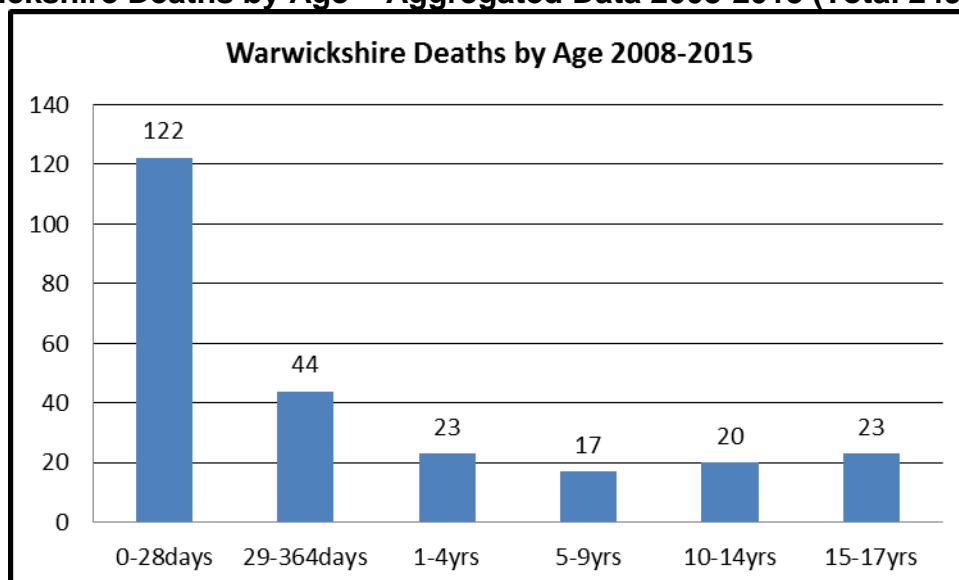


3.4 Warwickshire Deaths by Age 2014 -2015 (Total 33)

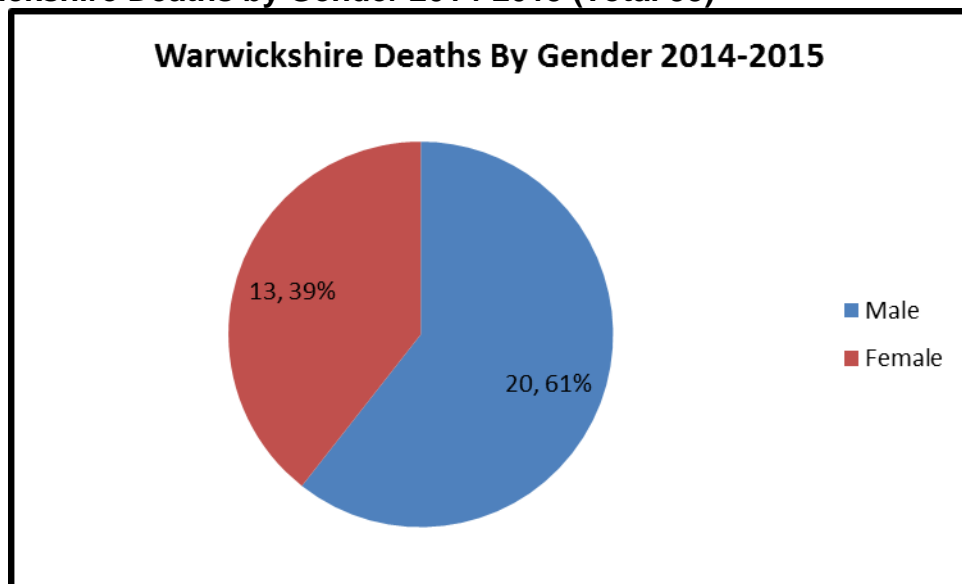


3.4.1 Age groups 1-4 years and 5-9 years have been merged together as have 10-14 years and 10-17 years due to the low numbers.

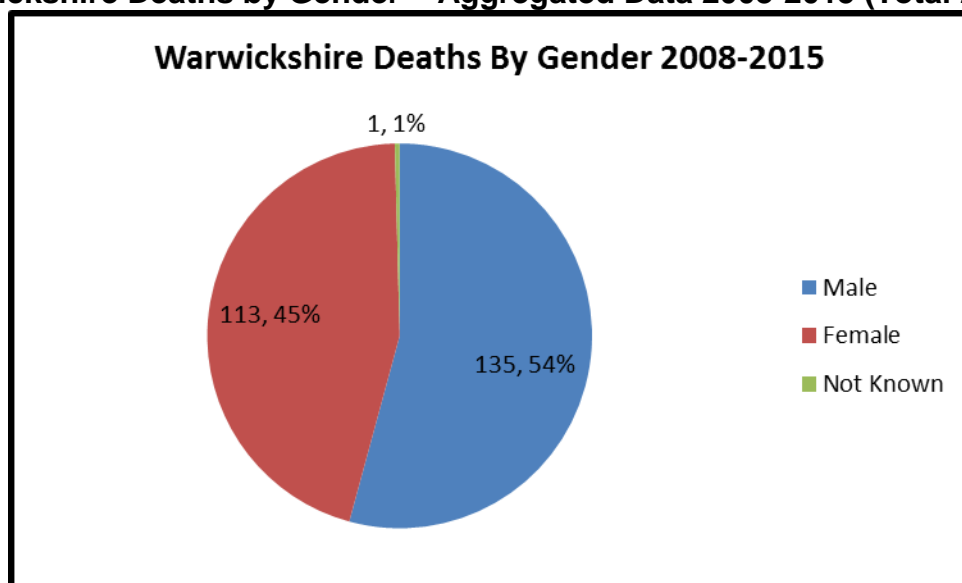
3.5 Warwickshire Deaths by Age – Aggregated Data 2008-2015 (Total 249)



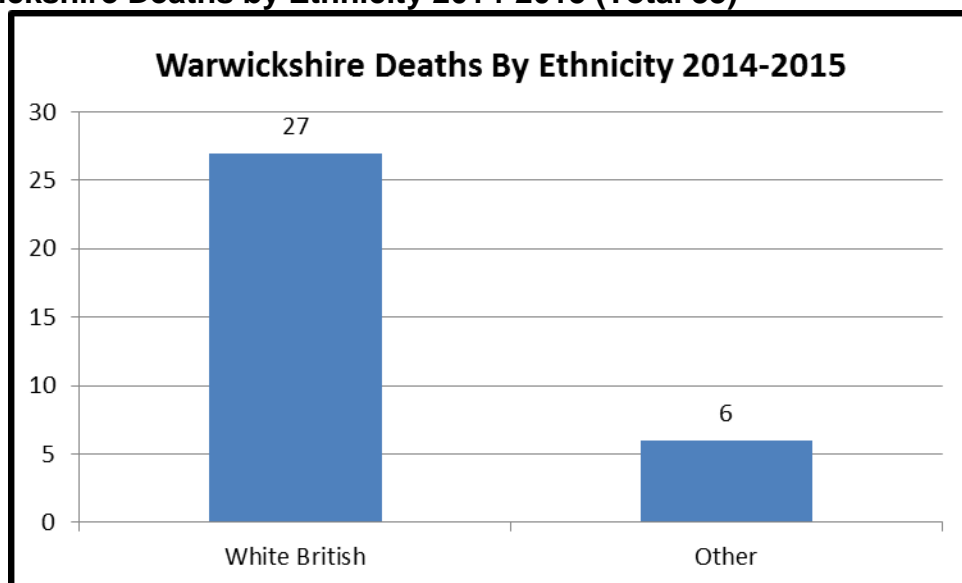
3.6 Warwickshire Deaths by Gender 2014-2015 (Total 33)



3.7 Warwickshire Deaths by Gender – Aggregated Data 2008-2015 (Total 249)

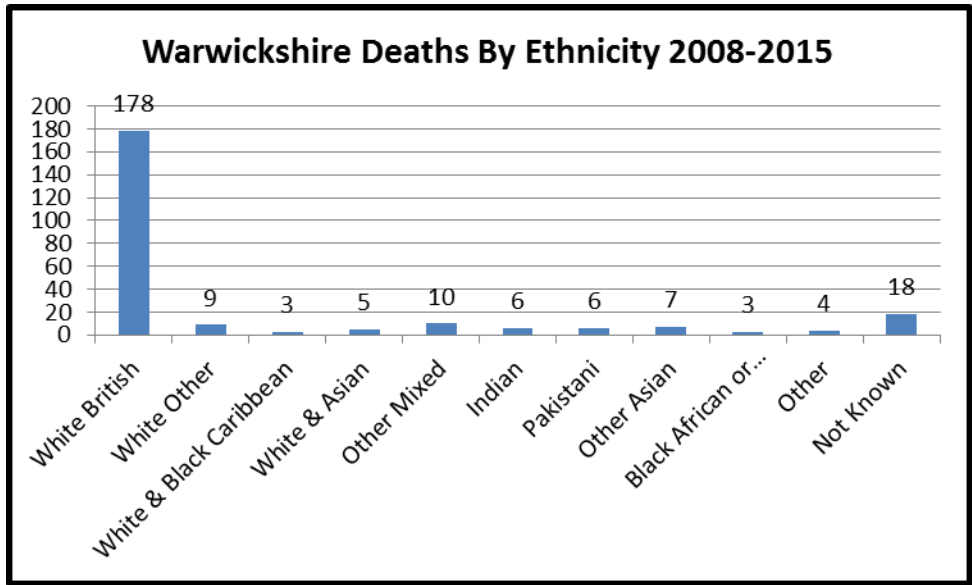


3.8 Warwickshire Deaths by Ethnicity 2014-2015 (Total 33)



3.8.1 'Other' deaths cannot be further categorised due to the low number.

3.9 Warwickshire Deaths by Ethnicity – Aggregated Data 2008-2015 (Total 249)



3.9.1 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.

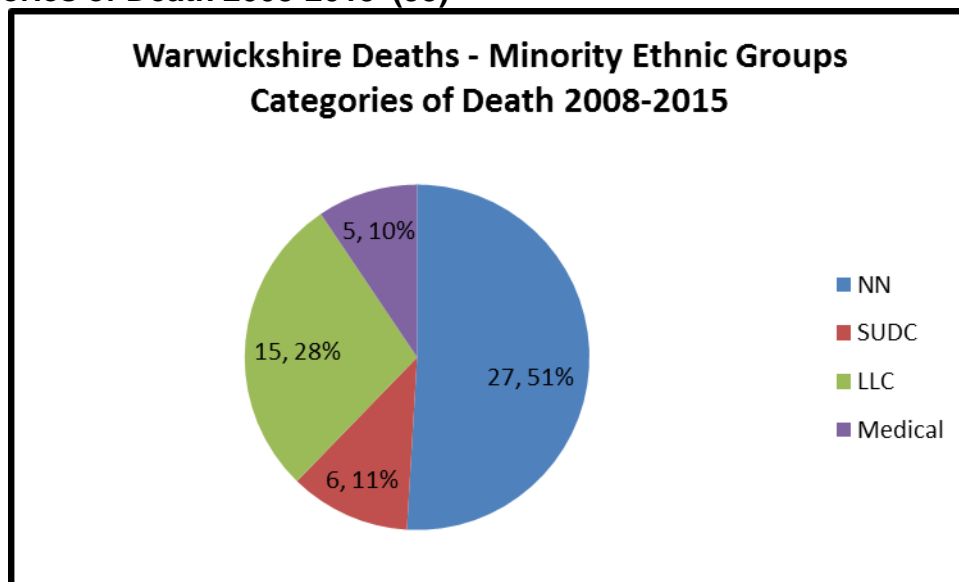
4 Summary

- 4.1 Neonatal deaths continue to be the highest category although this category has seen a decrease of 3 compared to 2013-2014. Sudden and Unexpected Deaths have also seen a decrease of 3, compared to 2013-2014 (see Appendix ‘E’ for a further breakdown).
- 4.2 0-28 days remains the highest age group as it has in previous years in both yearly and aggregated data. Looking at the aggregated data, 67% of deaths (166 out of 249) occurred within the first year of life which is consistent with previous national findings and mirrors the findings of both Coventry and Solihull.
- 4.3 With regards to gender, both the yearly data and aggregated data show more male deaths than females which mirrored previous national findings. (The national data will not be released until late July 2015 so cannot be compared with this year’s national findings yet).

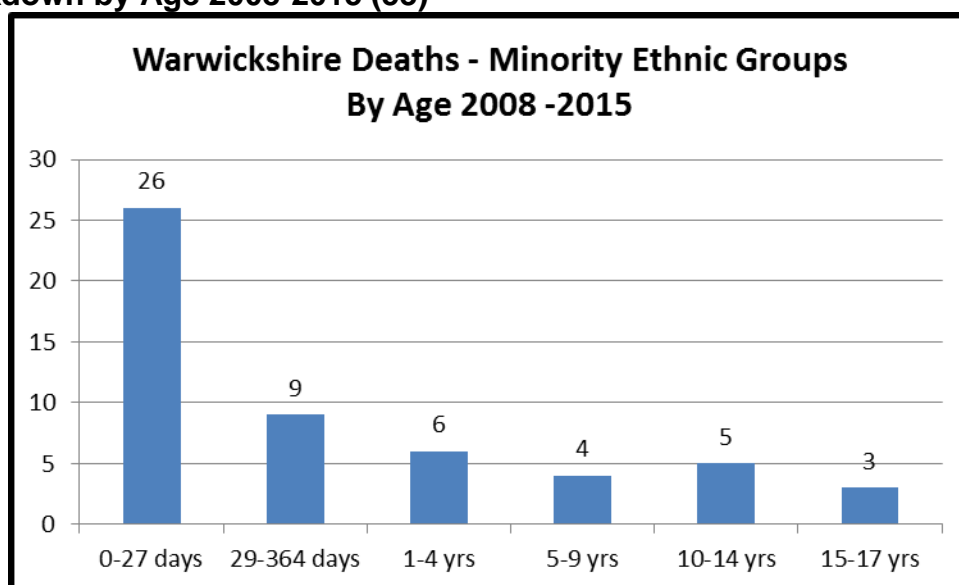
5 Ethnicity:

Following the presentation of the 2014-2014 CDOP Annual Report, further information was requested by the board in relation to deaths of children from non-British ethnic groups. The CDOP Manager has looked through all of the deaths relating to this group and provides the following information on the 53 deaths in this group. This is taken from the graph outlined in paragraph 3.9 above excluding the 179 deaths of White British origin and the 18 unknown.

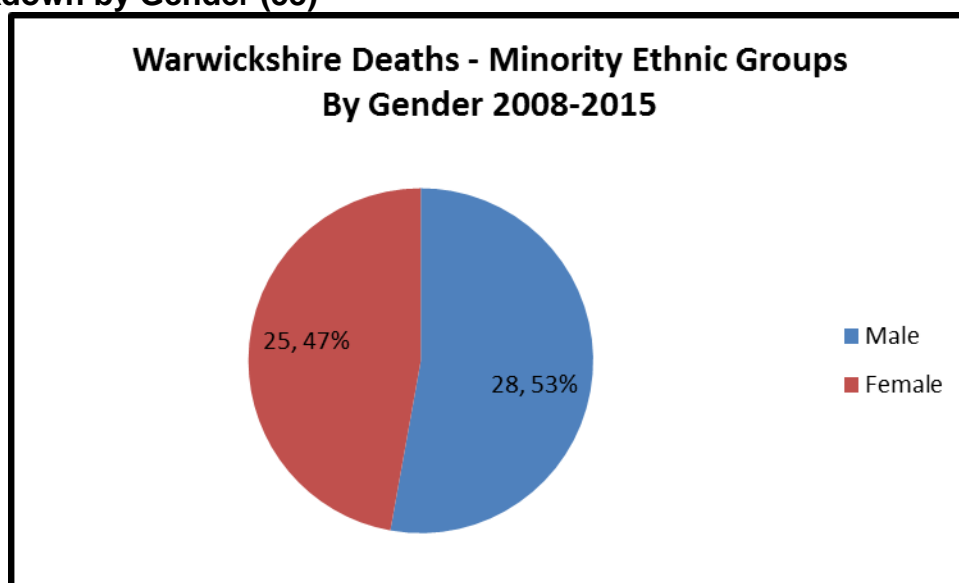
5.1 Categories of Death 2008-2015 (53)



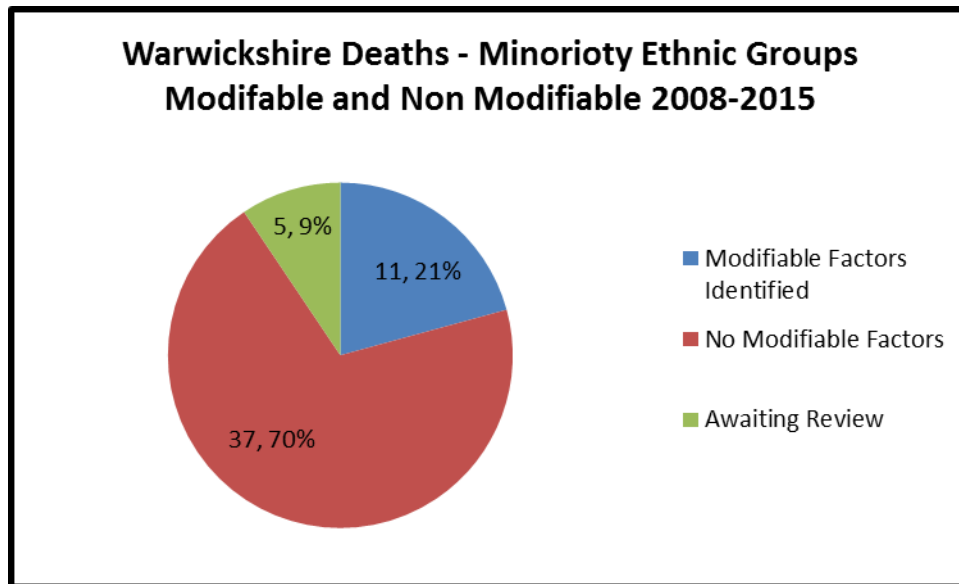
5.2 Breakdown by Age 2008-2015 (53)



5.3 Breakdown by Gender (53)



5.4 Modifiable and Non Modifiable Factors:



- 5.4.1 In **37** deaths (70%) no modifiable factors were identified and the cause of death had no bearing on the child's ethnic origin.
- 5.4.2 In relation to the **5** deaths awaiting review, medical information obtained to date indicates a medical cause of death with no relation to the ethnicity of the child or young person.
- Of the **11** deaths where modifiable factors were identified:
- 5.4.3 **4** related to service provision in relation to prior medical intervention or post-surgical intervention.
- 5.4.4 **2** were sudden and unexpected deaths where an unsafe sleeping environment was a contributable factor in both.
- 5.4.5 In **3** deaths from a life limiting condition, consanguinity was identified as a contributable factor as parents were related by blood and carried an autosomal recessive gene. (CDOP reviewed a 4th death from a life limiting genetic disorder where consanguinity is a risk factor, however medical records did not indicate if parents were consanguineous so CDOP classified this death as non-modifiable). In all four deaths parents were of Asian origin.
- 5.4.6 In **1** death, a raised BMI was a contributory factor to premature labour.
- 5.4.7 In **1** case access to healthcare was a contributory factor due to a language barrier preventing a parent seeking urgent medical care which CDOP concluded could have changed the outcome. The out of area hospital where antenatal care was booked conducted a 'Serious and Untoward Incident' investigation which identified that no contingency plan had been considered for this non-English speaking family in an emergency situation and put processes in place to ensure that language difficulties are identified during antenatal risk assessment and families advised how to summon help in emergency situations. CDOP reviewed this case in year 2012-2013 and identified that this learning should be widely disseminated to all health professionals in the county, which was facilitated via the WSCB Health Subcommittee. The learning was also disseminated to hospitals across the sub-region and wider to all CDOPs across the county.
- 5.4.8 In relation to socio demographic information in relation to the deaths where modifiable factors were identified, the 11 families lived across the county so no geographical 'hotspot' was identified. CDOP does receive some information on social factors but this tends to be limited to the occupations of parents. In relation to the 11 modifiable deaths, parents were either full time carers or in low income employment.

5.4.9 Data on Warwickshire Black and Minority Ethnic (BME) child population is contained in Appendix 'G'. This data is provided by Warwickshire County Councils' Observatory and is from the 2011 Census which is the most recent information available. The data gives the population figures in Warwickshire as a whole and is also broken down into each District and Borough.

Appendix 'D'

Rapid Response Investigation – Sudden Unexpected Death in Children Protocol

Chapter 5 of Working Together to Safeguard Children 2015, 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)

Please see the following flowchart overleaf as detailed in Chapter 5 of Working Together to Safeguard Children 2015.

Process for rapid response to the unexpected death of a child

