Child Death Overview Panel Annual Report

Coventry, Warwickshire and Solihull

2018-2019

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Contents

Introduction

Child Death Overview Panels (CDOP) were created in 2011 by the Government as a final process for reviewing the deaths of all children from birth to their 18th birthday who resided within the UK. The main functions of CDOP are to collate information from the services involved in the life and death of a child and to review the circumstances of the child's death. This involves reviewing the support and services provided to the child and their family in order to identify possible modifiable factors [1] and ultimately, to reduce the potentially preventable deaths in children in the UK. CDOP does not review still births or legal terminations of pregnancy. The overarching aim of CDOP is to deduce learning that will reduce childhood mortality; this is specified within section 5 of this report.

This CDOP report outlines the analysis of cases and the main conclusions derived from panels held in Warwickshire, Solihull and Coventry during the period from 1 April 2018 to 31 March 2019. It also examines the actions and learning that has been undertaken as a result of CDOP working over the given period.

<u>Executive Summary</u>

During this reporting year there were a total of 13 panels held and 55 cases reviewed. Of the 13 panels, 5 were held in Warwickshire, 5 in Coventry and 3 were held in Solihull. All the panels were chaired by the Public Heath Lead for the respective local authority.

48% of all deaths reviewed during 2018-19 occurred in under one year olds; 27% occurred in the neonatal period (<28 days old) and 21% occurred after the neonatal period (28-364 days). In deaths reviewed with modifiable factors, there was a more even split between age groups (25% neonatal <28 days and 30% between 28 days and 364 days), while in deaths without modifiable factors there was a higher proportion occurring in the neonatal period (28% vs. 16%). A modifiable factor is defined as that where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced.

Out of 55 deaths reviewed, 67% recorded an acute hospital as the place of death, 21% occurred at the home of normal residence, 10% in a public place and 2% occurred in a private residence other than the home of normal residence.

The core learning from this CDOP reporting year is highlighted in section 7. The majority of CDOP learning comes from when modifiable factors within the death are identified and actions are set by the panel to address this. The main learning from this reporting year can be summarised into the following points:

- Maternal smoking, BMI of over 30 and domestic violence were the most frequently noted as modifiable factors. In some cases these modifiable factors were considered to have contributed to the neonatal and perinatal deaths, however, they varied in their assessed contribution; an overview of this can be found at section 4.2. Actions were taken to contact antenatal providers and give feedback and advice about smoking cessation and the identification and questioning relating to domestic violence.

- In older children, factors relating to early identification of sepsis and agency response to road traffic deaths were identified as the main modifiable factors. Identified learning will reinforce the current guidelines for sepsis recognition and treatment and contribute to the new Sudden Unexpected Deaths in Infants & Children under18 (SUDC) protocol developments.

[1] *Those in which modifiable factors may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced.*

During this reporting year CDOP was tasked with reflecting on and subsequently enacting the changes required within the "Working Together 2018" Statutory Guidance. In the section entitled 'Transformative changes' there is a brief synopsis of some of the changes that CDOP has undergone.

CDOP Aims and Purpose

The CDOP review is intended to be the final scrutiny over a child's death. This involves multiagency panels and core competency professionals that assess the information supplied. The aim is to provide a complete picture of the child's death and living circumstances.

Once the information is collated and processed, panel members can analyse, discuss and identify factors that can be altered to prevent future child death. The overarching purpose is to use professional scrutiny to identify actions and learning to reduce child mortality.

CDOP aims to review deaths through an independent and enquiry-based method where learning based actions can be taken, if possible. During the year 2018-2019 the aims of this CDOP sub-region were to continue in the same methodology focusing on timely review, involvement of families and improving the process as a whole.

The aims for 2019-2020 will be as follows;

- Set and apply measurable actions within a panel setting, which can be scrutinised in their effectiveness, by setting specific, measurable, achievable, realistic and time sensitive (SMART) targets.
- Engage with further regional action groups and panels to improve the wider impact of action and learning. Specifically, to work with the West Midlands Regional CDOP network to form a larger themed panel approach for specialist cases.
- Partnership working with West Midlands regional CDOP network to form a larger themed panel approach for more complex cases that require further explanation.
- Review the transition process through the CDOP executive working group to meet with the statutory duties set out in Working Together (2018) and evaluate the effectiveness and compliance of the new approach.
- To effectively use sub-regional data, analyse and share learning to benefit the safeguarding and wellbeing of children living within Coventry, Warwickshire and Solihull.
- To expand and set up new 'single point of contact' networks with child death review meetings being effectively managed by individual providers through the electronic child death overview panel platform.
- To review, scope, outline and establish the fixed membership quotas for themed panels.

CDOP Partnerships

This Warwickshire, Coventry and Solihull CDOP is comprised of seven statutory partners, all contributing and benefiting from the CDOP panel process. The statutory partners are: Warwickshire County Council, Coventry City Council, Solihull Metropolitan Council, Warwickshire North Clinical Commissioning Group, South Warwickshire Clinical Commissioning Group, Coventry and Rugby Clinical Commissioning Group and Birmingham and Solihull Clinical Commissioning Group.

This Warwickshire, Coventry and Solihull CDOP is also a member of the West Midlands Regional CDOP group and a part of the National Network of CDOP, enabling participation in regional developments and national learning.

Transformative Changes

In this CDOP year a full scoping of existing processes and services was undertaken by Coventry, Solihull and Warwickshire CDOP. This scoping involved examining compliance of CDOP with the old Working Together 2015 and then a gap analysis of the new guidance in Working Together 2018. From this analysis CDOP identified the actions needed to implement the new guidance and set a timescale for the implementation. When the changes were decided CDOP Coventry, Solihull and Warwickshire set itself 3 main overriding outcomes:

- To deliver high quality panels that recognises the need to support families who have been bereaved, are compliant with National guidance and focus on learning from cases.

- To increase the output of learning from cases and implement effective change.

- To establish networks of accountable and dedicated professionals to show rigour and quality within the child death review process.

During this reporting year CDOP worked closely with its statutory partners to examine the new roles that were required in Working Together 2018 and how all partners should be involved. A working group was established, to develop new arrangements in the region. This CDOP has adopted and published its new arrangements within the statutory timescale. Access to this CDOP's strategic change can be found at: https://www.warwickshirenorthccg.nhs.uk/mf.ashx?ID=37a674de-606b-4784-baa4-bbc25332ceae

1. Annual Overview

1.1. Number of panels and reviews

A total of 13 panels were held across Coventry, Solihull and Warwickshire during 2018-19 in which 55 deaths were reviewed as summarised in the table below. Of these 55 deaths reviewed, 20 (36.4%) were assessed as having modifiable factors. This proportion was higher in Solihull (70%), although there were smaller numbers in total. None of the child deaths reviewed by Warwickshire, Coventry and Solihull CDOP in this year, were recommended for a serious case review.

Area	Panels held	Deaths reviewed	Modifiable factors identified (%)
Coventry	5	26	9 (35%)
Solihull	3	10	7 (70%)
Warwickshire	5	19	4 (21%)
Total	13	55	20 (36%)

Table 1 CWS CDOP Report 2018-2019

1.2. The Timing of Reviews

When looking at reviews where modifiable factors were identified, there was a higher proportion of children whose deaths had occurred prior to the period of review (i.e. 01 April 2018 to 31 March 2019,). The main reasons for this disparity is that for a case to be brought to panel all prior processes including investigations need to be completed. In many of the cases that were brought at a later date, i.e. in years prior to this period of review, there were significant investigations or processes. In cases where there are significant investigations, there is a much higher chance that modifiable factors will be identified.

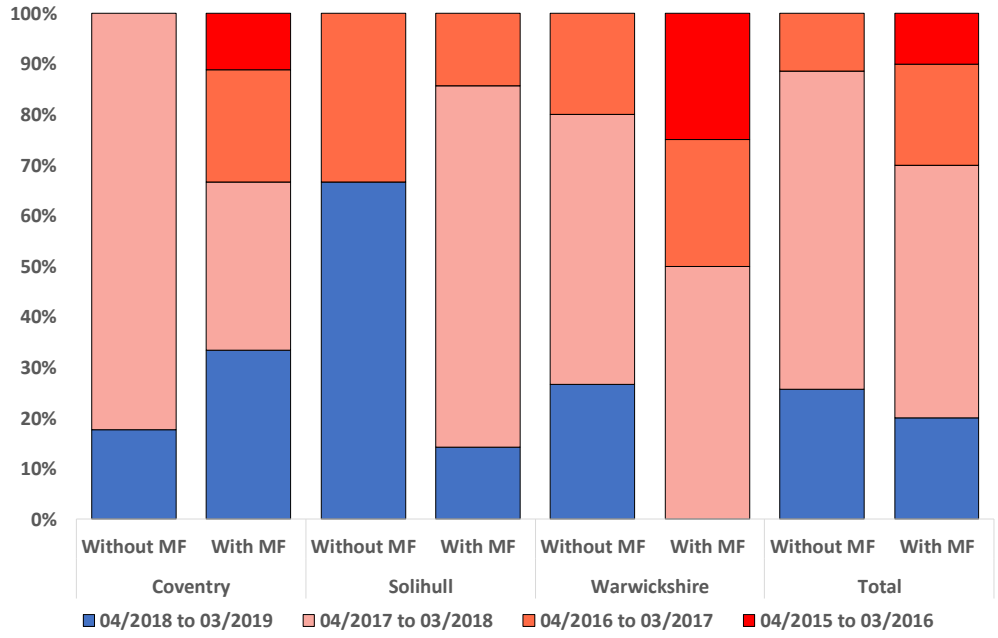

Figure 1 CWS CDOP Report 2018-2019

When looking at how long after death the review was completed, 50% of deaths assessed as having modifiable factors occurred over a year before the review was completed compared to 34% without

modifiable factors. It should be noted that reviews of two deaths in Warwickshire and one death in Solihull could not rule out the possibility of modifiable factors.

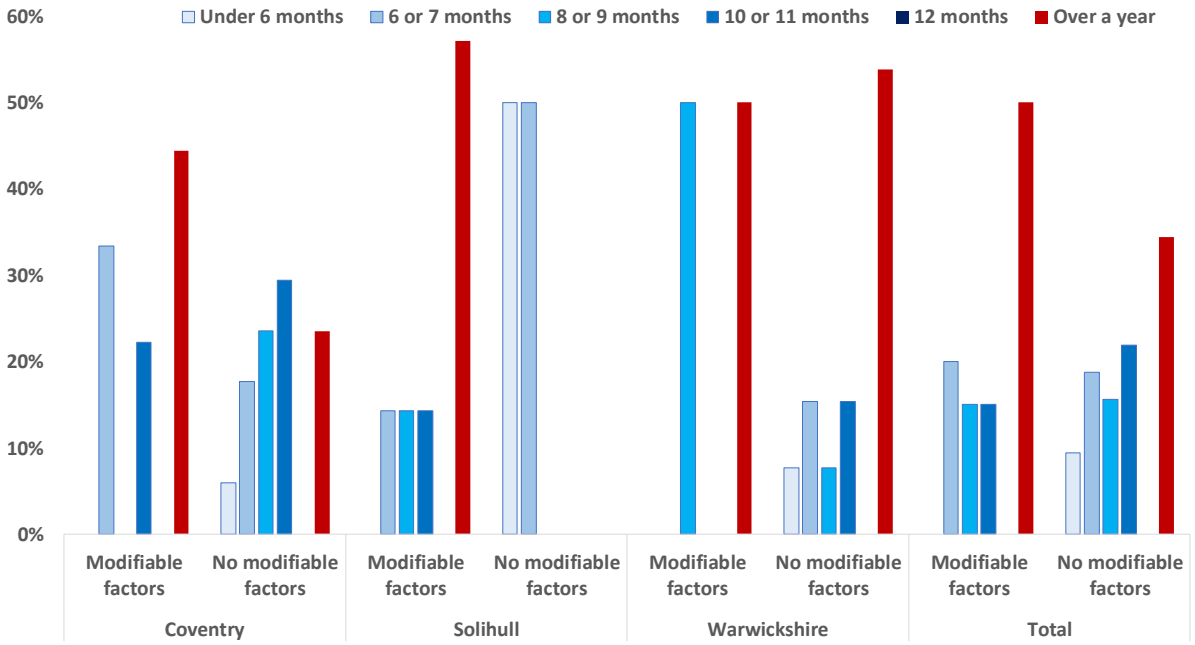

Figure 2 CWS CDOP Report 2018-2019

A total of 82 deaths were reported as having an ongoing review on 31 March 2019 across the area (27 in Coventry, 9 in Solihull and 43 in Warwickshire). The majority of these deaths (91%) occurred in the same period as the current review (01 April 2018 to 31 March 2019). One death occurring in the period between 01 April 2015 to 31 March 2016 has not yet been reviewed at CDOP.

In 2018/19, there were no deaths discussed or subsequently reviewed where the child was not normally resident in the area.

CDOP reviews deaths when all of the investigatory processes have been completed. In the majority of deaths awaiting a review for nine months or over, there was a requirement to await the cases investigatory stage completion prior to panel.

2. Demographic Data Analysis

2.1. Age

48% of all deaths reviewed during 2018-19 occurred in under one year olds: 27% occurred in the neonatal period (<28 days old) and 21% occurred after the neonatal period (28-364 days). In deaths reviewed with modifiable factors, there was a more even split between age groups (25% neonatal <28 days and 30% between 28 days and 364 days), while in deaths without modifiable factors there was a higher proportion occurring in the neonatal period (28% vs. 16%).

Deaths in 1-4 year olds accounted for 23% of those reviewed and deaths in 5-9 year olds for 15% of all deaths reviewed. In these age groups, there was a higher proportion of deaths where no modifiable factors were identified (44%) compared to those with modifiable factors (30%).

Of the 12 deaths in the age range of 1-4 years old, 2 were found to have modifiable factors and 6 had no modifiable factors. In the 15-17 year old age range those with modifiable and non-modifiable factors were evenly split with 3 deaths in each group.

For Solihull and Warwickshire, the majority of deaths with no modifiable factors were in <28d olds whereas in Coventry it was 1-4-year olds, though generally the deaths were more evenly distributed. For deaths where modifiable factors were identified, in Coventry the majority were in 28-364d olds, while in Solihull and Warwickshire it varied (although numbers are small).

	Age at death (%)					
	0-27 days	28-364 days	1-4 years	5-9 years	10-14 years	15-17 years
With modifiable factors	5 (25%)	6 (30%)	4 (20%)	2 (10%)	0 (0%)	3 (15%)
Without modifiable factors	9 (28%)	5 (16%)	8 (25%)	6 (19%)	1 (3%)	3 (9%)
Total	14 (27%)	11 (21%)	12 (23%)	8 (15%)	1 (2%)	6 (12%)

Table 2 CWS CDOP Report 2018-2019

2.2. Gender

Of the 55 deaths reviewed, 20 were male, 32 were female and 3 were gender unidentifiable[2]. The proportion by gender was fairly consistent throughout the localities in which the cases were reviewed.

2.3. Ethnicity

In total, 62% of deaths were reported to be in White children (44% English/Welsh/Scottish/Northern Irish/British and 17% White other). 15% of deaths were in Asian or Asian British children
19% of the child deaths reviewed were in Mixed/Multiple ethnicity, 13% were in Black or Black British ethnic group and 3% reported to be Other or Unknown.

This pattern was generally consistent by area accounting for the background difference in population ethnicity.

[2] *All three cases concerned extremely premature babies where the gender was not overtly apparent, and at parental request no further investigation/identification was undertaken. Cases such as these may be reported to the national mortality database as gender 'unidentifiable'.*

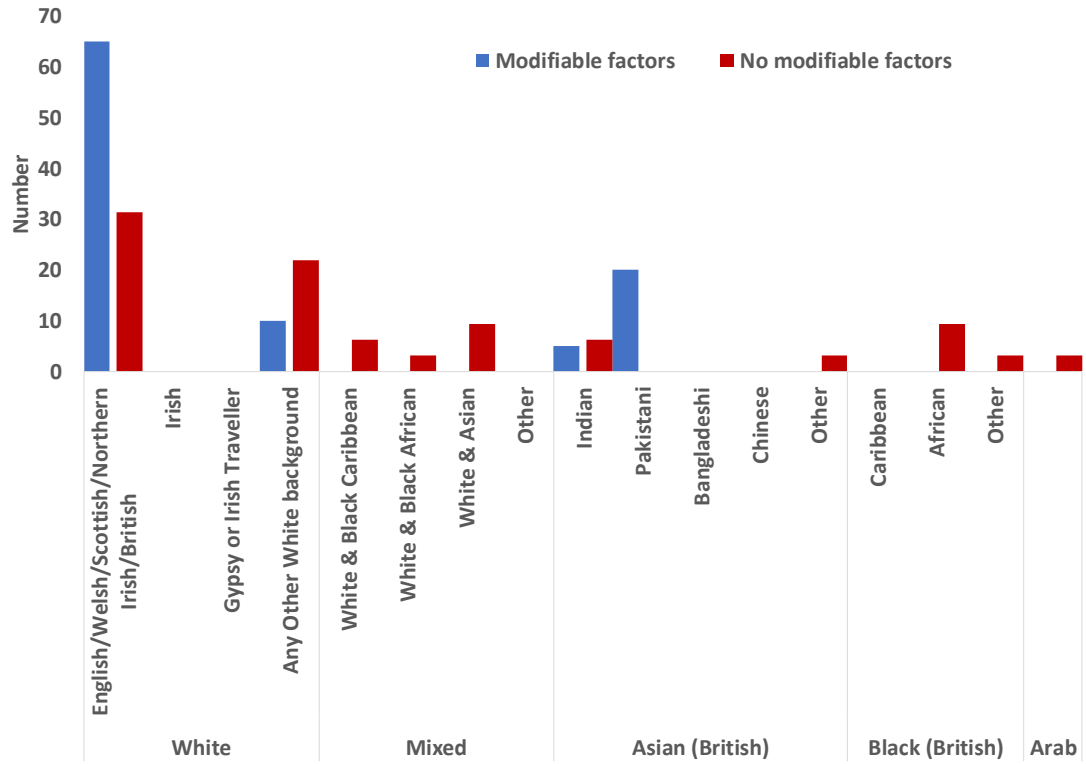

Figure 3 CWS CDOP Report 2018-2019

2.4. Vulnerability Status

Across all 55 reviews completed, none of the cases were seeking asylum at the time of death. No children were subject to a child protection plan at the time of death or prior to their death. No children were reported to be under a statutory order either previously or at the time of death. The statutory orders that CDOP requests information about are: Police Powers of Protection

Emergency Protection Order, Interim Care Order, Care Order, Supervision Order, Residence Order, Section 20 (Children Act 1989) , Antisocial behaviour order or other court order.

3. Place of Death

Across all 55 deaths reviewed, 67% had Acute Hospital recorded as the location at the time of the event/condition which led to the death. 25% were in a neonatal unit, paediatric intensive care unit or a paediatric ward while 42% were in another location in the hospital (including delivery suites, labour wards and transplant units). There were fairly equal proportions of deaths with modifiable factors and deaths with no modifiable factors throughout the aforementioned locations. Of deaths occurring in Acute Hospital, a higher percentage were found to have no modifiable factors (72%). Children who died in other places were more likely to have modifiable factors identified (60%).

21% of reviews recorded the home of normal residence as the place of death, 25% of these deaths were recorded with modifiable factors compared to 19% of deaths with no modifiable factors.

10% of deaths were recorded in a public place including roads, railways, parks, restaurants and beaches. 15% of these deaths had modifiable factors compared to 6% of deaths with no modifiable factors.

The remaining 2% of total deaths occurred in a private residence other than the home of normal residence and had no modifiable factors.

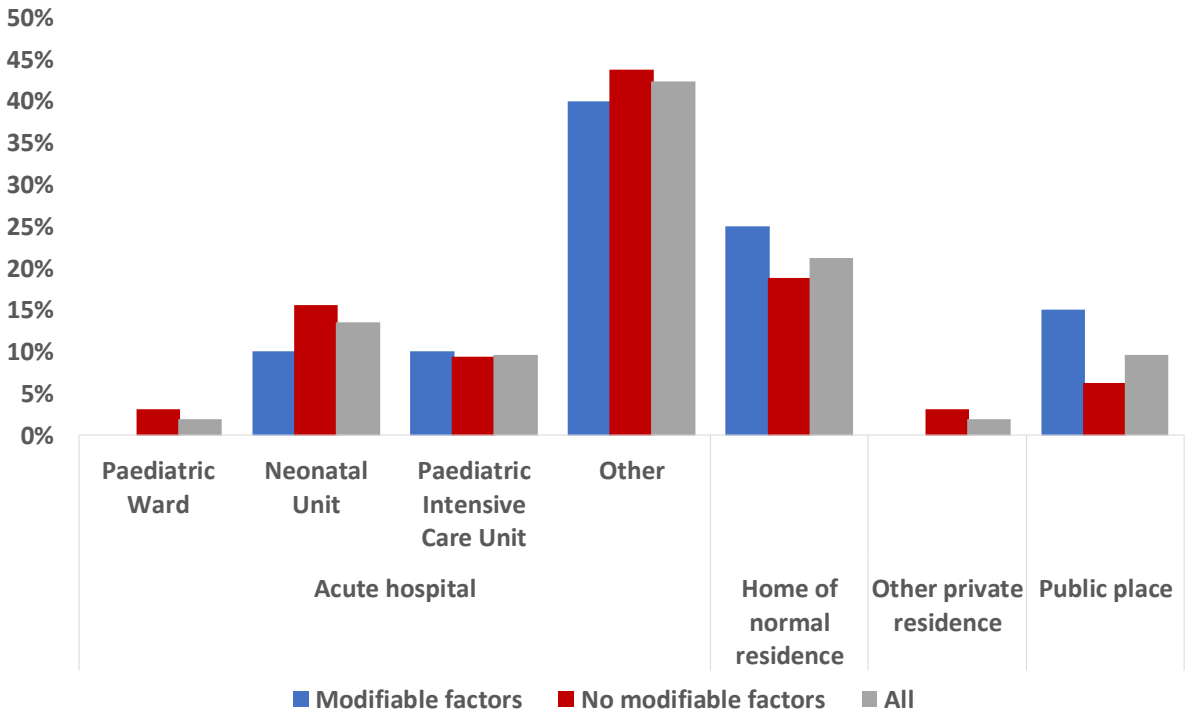

Figure 4 CWS CDOP Report 2018-2019

A similar distribution of location of death was reported in Coventry, Solihull and Warwickshire.

4. Generic Themes Across the Sub-Region

4.1. Category of death

Figure 5 below shows the categories of death for the CDOP cases for the period 1st April 2018 to 31st of March 2019, while the text below examines the relationship between the modifiable/non-modifiable factors and the category of death.

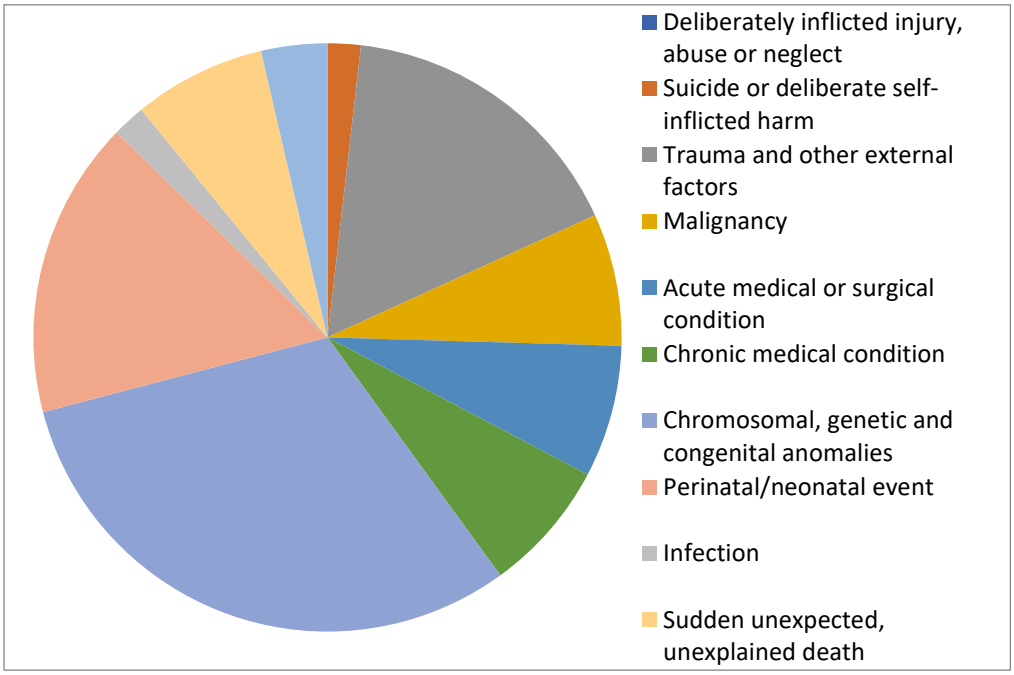

Figure 5 CWS CDOP Report 2018-2019

4.1.1. Chromosomal, genetic and congenital anomalies

Across all deaths reviewed, the majority were categorised as chromosomal, genetic and congenital anomalies (31%), with a higher proportion in deaths with no modifiable factors (34%) than in deaths with modifiable factors (25%). Modifiable factors identified were two cases of consanguinity and a single case with modifiable factors related to service provision factors. This resulted in panel recommending that the family was referred for genetic counselling.

4.1.2. Perinatal/neonatal event

A total of nine deaths categorised as a perinatal/neonatal event were reviewed across the sub-region in 2018/19 (17 %). Of the three deaths reviewed where modifiable factors were identified, the key factors were a late booking of pregnancy, maternal or household smoking, drugs and/or alcohol abuse, mental health issues and domestic violence.

4.1.3. Trauma and other external factors

Nine of the deaths reviewed across the sub region were a result of trauma and other external factors. This category had the highest ratio of modifiable: non-modifiable death factors. Out of the five modifiable death factors, two related to road traffic accidents, two were linked to unsafe sleeping arrangements and one was linked to a sudden and unascertained illness.

The modifiable factors identified in the cases involving unsafe sleeping arrangements related to issues of co-sleeping and non-recommended modifications made to travel cots. One of the road traffic accidents occurred during the commission of a crime and had modifiable safeguarding factors; the other identified modifiable factors related to the working agreements of bus drivers. Actions taken for these cases were: raising workplace health awareness, sharing national learning about travel cots and developing a road traffic SUDC protocol.

4.1.4. Acute medical/surgical condition

Of the four deaths reviewed that resulted from an acute medical or surgical condition, two had modifiable factors linked to smoking within the household. There were other factors reported relating to domestic violence and/or mental health challenges. These factors were present and modifiable, but did not directly contribute to the death.

4.1.5. Chronic medical condition

Of the four deaths resulting from a chronic medical condition, one had maternal smoking as a modifiable factor. The other deaths were concluded to be non-modifiable. These factors were present and modifiable, but did not directly contribute to the death.

4.1.6. Malignancy

Of the four deaths reviewed as resulting from malignancy, one modifiable factor related to expert learning in diagnosis of a very rare form of cancer.

4.1.7. Sudden unexpected unexplained death

Of the four sudden unexpected deaths, two had smoking, alcohol and drug use within the family home identified as modifiable factors. Both of these deaths occurred in children below the age of two.

	Modifiable factors (%)	No modifiable factors (%)	Total (%)
Chromosomal, genetic and congenital anomalies	5 (25%)	11 (34%)	16 (31%)
Perinatal/neonatal event	3 (15%)	6 (19%)	9 (17%)
Trauma and other external factors	4 (20%)	5 (16%)	9 (17%)
Acute medical or surgical condition	2 (10%)	2 (6%)	4 (8%)
Chronic medical condition	1 (5%)	3 (9%)	4 (8%)
Malignancy	1 (5%)	3 (9%)	4 (8%)
Sudden unexpected, unexplained death	2 (10%)	2 (6%)	4 (8%)
Infection	1 (5%)	0 (0%)	1 (2%)
Suicide or deliberate self-inflicted harm	1 (5%)	0 (0%)	1 (2%)

Table 3 CWS CDOP Report 2018-2019

4.2. Factors contributing to death

Having assessed factors in death, there is a subdivision between 'factors that are present but did not contribute to the death', ' factors that were present that may have contributed to the death' and 'factors that provide a complete explanation of the death'.

Across all deaths reviewed in 2018/19, the factors providing a "complete and sufficient explanation" for deaths reviewed were in the acute/sudden onset illness and chronic long-term illness categories.

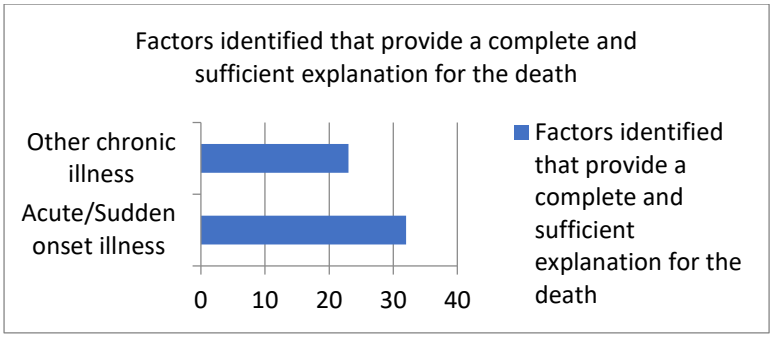

Figure 6 CWS CDOP Report 2018-2019

For factors which "may have contributed", the contributing factors included family and environment; of which the main factor was smoking in the household/by the mother during pregnancy. This was followed by domestic violence, alcohol/substance misuse by a parent/carer, emotional/behavioural/mental health condition in the parent/carer and acute/sudden illness.

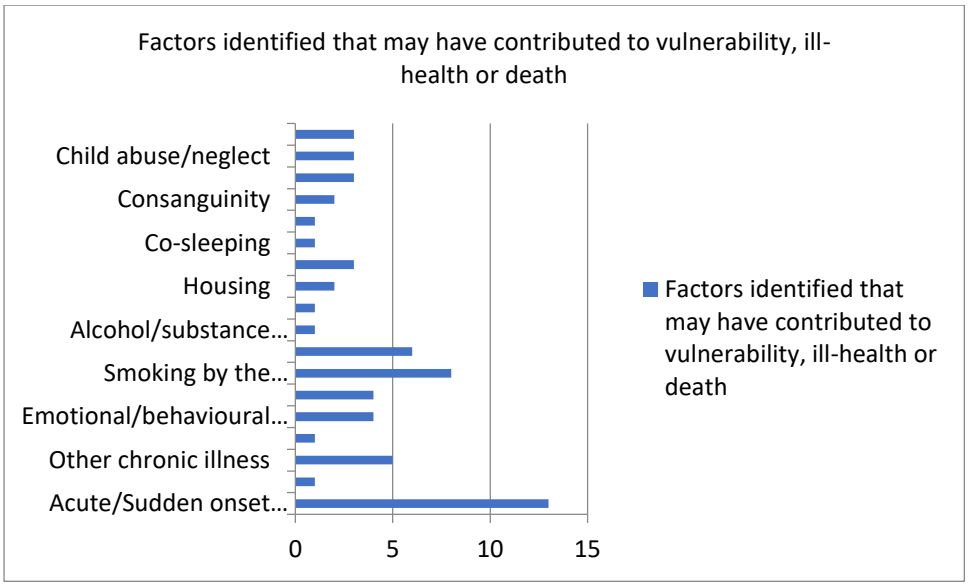

Figure 7 CWS CDOP Report 2018-2019

Factors "present but unlikely to have contributed to the death", included chronic long-term illness (other than asthma or epilepsy), acute illness, and disability and impairment. A breadth of factors in death were identified, although those listed below were not found to have contributed to the deaths of the children reviewed. Acute and sudden onset factor was the greatest non-contributing factor present. This column can include illnesses in children with an underlying condition, for example chest infections within immuno-compromised children.

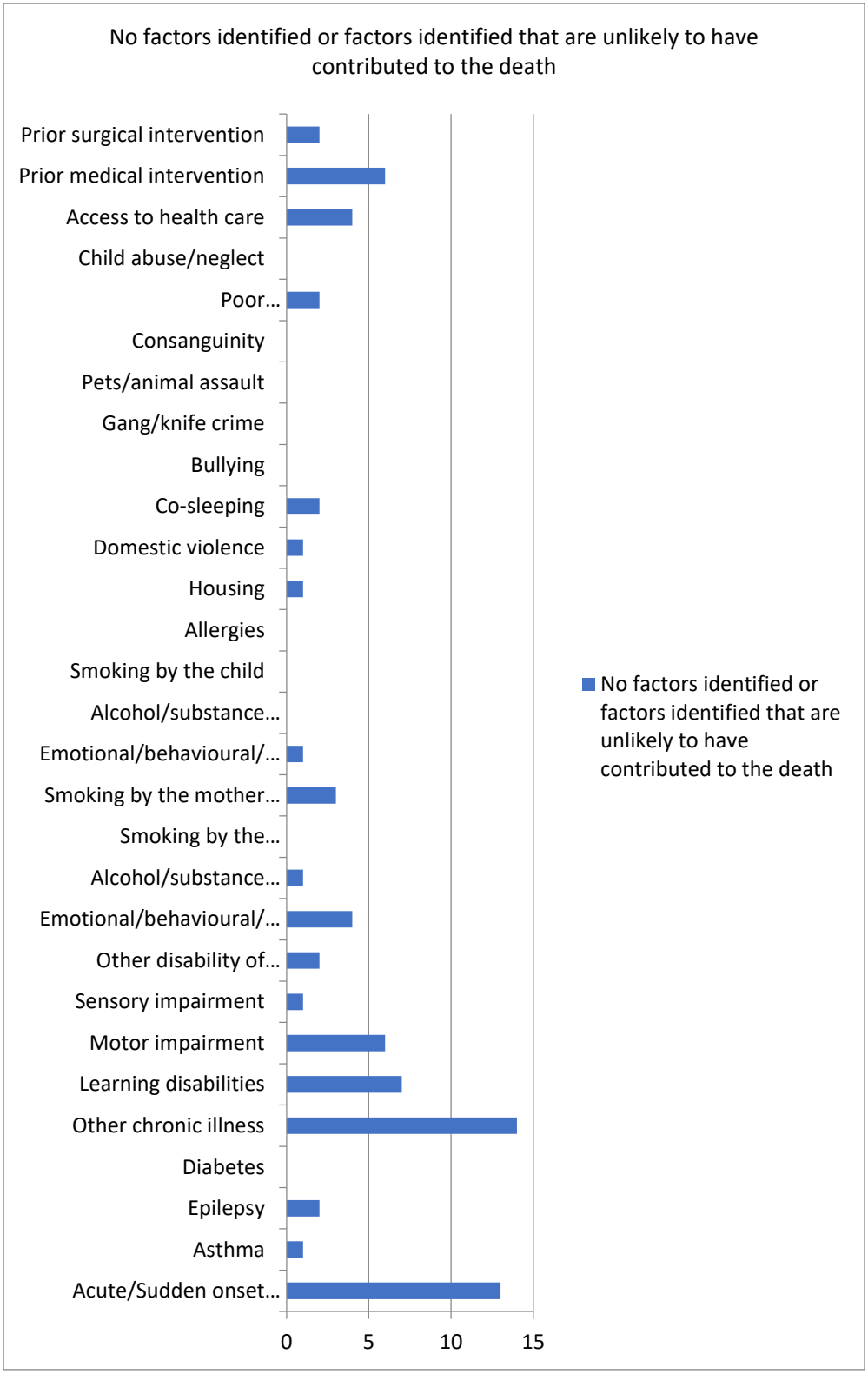

Figure 9 CWS CDOP Report 2018-2019

Examining the data by age group and "factors providing a complete and sufficient explanation for the death" showed that the primary factor in children aged 0-27 days old was listed as an acute cause. There was a more even split between acute and chronic long term health problems for age groups between 28 days to 17 years.

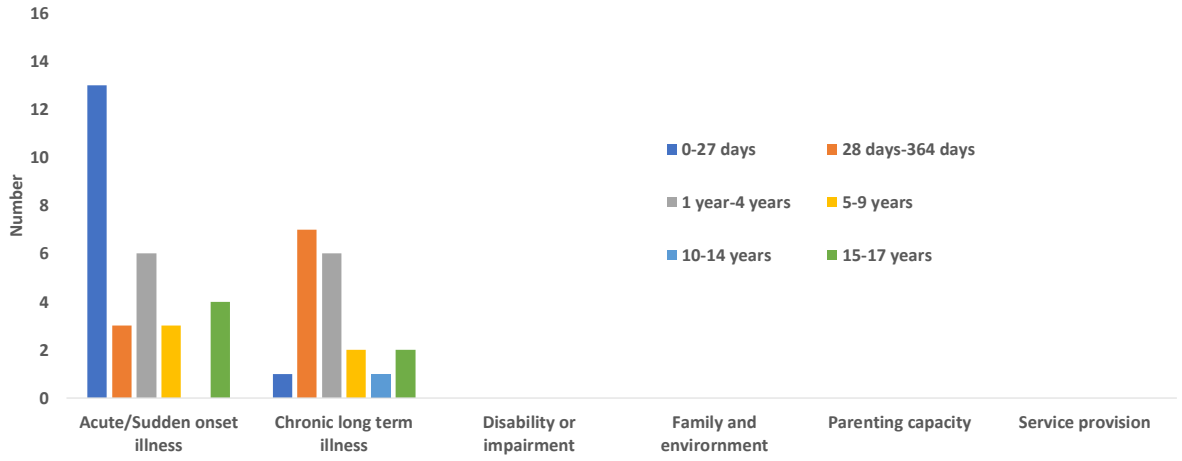

Figure 10 CWS CDOP Report 2018-2019

For "factors that may have contributed to the death", in children under one year old, the main identified factors were family and environment, other factors like service provision and parenting capacity were also noted. The older age groups had a number of different "factors that may have contributed to the death".

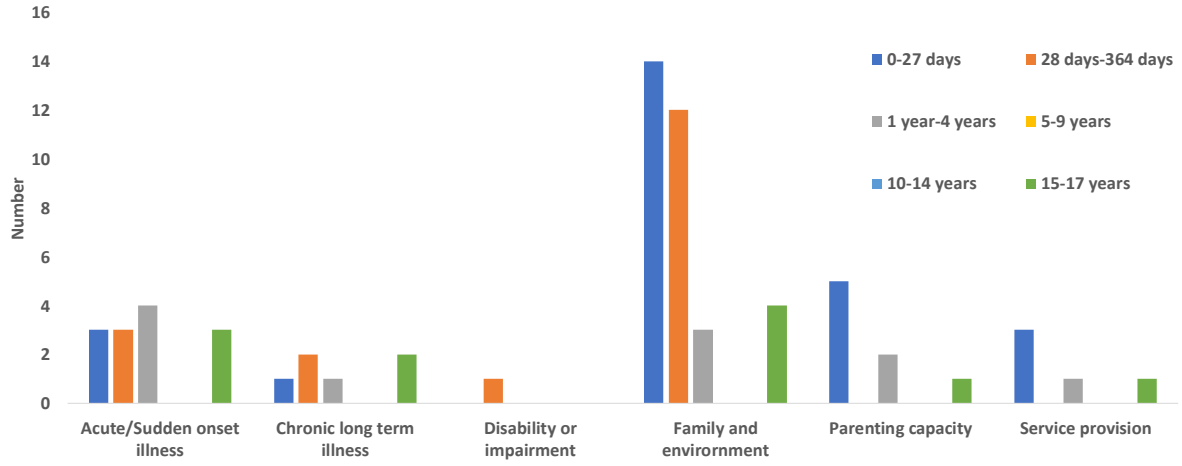

Figure 11 CWS CDOP Report 2018-2019

5. Additional Information on Deaths with Modifiable Factors

5.1. Deaths with modifiable factors

A total of nine deaths with modifiable factors were reviewed in Coventry during 2018/19.
Two deaths with modifiable factors were reviewed in Solihull during 2018/2019.
Four deaths with modifiable factors were reviewed in Warwickshire during 2018/19.

5.1.1. Sudden and unexpected death

There were six sudden unexpected deaths where modifiable family and environmental factors were identified.

One child could not have a cause of death established by a post-mortem and this was recorded as unascertained. There was evidence of a number of parental actions in this case which, while not directly impacting on the death, may nevertheless have affected their parental responsiveness. These include alcohol consumption, drug use and possible drug dealing in the home, a history of domestic violence and smoking in the household. The death was referred to and discussed by the Serious Case Review sub group of the Coventry LSCB which concluded the criteria for a Serious Case Review was not met.

The second child died from an unascertained acute/sudden onset illness. Smoking in the household and issues around co-sleeping were reported factors. The parents had not followed advice from health professionals.

There was one traumatic death in a child in which modifiable factors were identified. The cause of death was a road traffic collision and the child died at the scene. There was learning around SUDIC procedures, and new SUDIC guidance around road traffic collisions were created by the West Midlands Police. There was an action for the CDOP panel to obtain a copy of this, which was shared with the developers of the upcoming West Midlands SUDC protocol.

Another death involved a child who was involved in a road traffic collision. There were no modifiable factors identified within this particular case directly linked to the death, although a number of actions linked to multi-agency services were disseminated following its review.

One child died from blunt head injuries as a result of road traffic injuries. Recommendations made by the CDOP panel included a need to raise awareness of workplace health issues locally, with a letter written to both a Member of Parliament and a bus company to draw attention to this case. The GP was also advised about appropriate communication with the Driver and Vehicle Licensing Agency in similar instances in the future.

Finally, a child died with an unascertained cause of death. A travel cot had been adapted during a period of temporary residential change. Modifiable factors identified were the arrangement of the bedding, along with a combination of the physical environment and age-related vulnerability of the infant, contributing to death. A recommendation was made by the CDOP panel to raise awareness amongst parents of young children around the dangers of modifying travel cots as this can cause an unsafe sleeping environment. The panel recommended that parents should also be made aware that travel cots should always be used following the manufacturer's instructions. The CDOP Chair wrote to the regional community nurses asking them to add the learning identified in this review to a national campaign and the learning was shared with the local safeguarding structures. Advice around the use of travel cots was also disseminated via the Warwickshire Safeguarding Children Board newsletter.

5.1.2. Perinatal/neonatal event

There were two perinatal/neonatal deaths with modifiable factors identified. In both cases, they resulted from acute/sudden onset illnesses and maternal smoking was reported. Both were extremely premature.

In the death of one child there were additional environmental factors recorded, including mental health factors and domestic violence reports.

The second child also died in the neonatal period following preterm labour. The mother had accessed healthcare late and was failing to attend healthcare appointments. Furthermore, there were concerns over the impact of domestic abuse. Although this was reported to be historic, there remained concerns that there was undisclosed ongoing domestic abuse.

5.1.3. Infection

There was one death resulting from infection where modifiable factors were identified. The child died after presenting at a Walk in Centre. Modifiable factors identified included access to healthcare and smoking in the household. At the CDOP panel a decision was made to feed back to the CCG the importance of the awareness of the screening process in line with the Sepsis Strategy.

5.1.4. Chronic medical condition

There were two deaths resulting from a chronic medical condition where modifiable factors were identified:

One child died as the result of a neurodegenerative disorder. Maternal smoking during pregnancy was identified as a modifiable factor although it was clearly stated that this would not have contributed to the death.

The second death was in a child who was suffering from a malignancy where modifiable factors were identified. This was a very complex, rare case with several questions raised by the parent through the CDOP process. It was noted by the review panel that in the future, parents must be supported to understand the new arrangements and the role of CDOP as this will be helpful when dealing with complex cases such as this. A review of the new literature being sent to parents was undertaken and suitability agreed. Feedback was given to parents through the use of collaborative professionals who were involved in the child's treatment; a meeting to answer questions directly was facilitated.

5.1.5. Chromosomal/genetic/congenital

There were three deaths resulting from a genetic condition where modifiable factors were identified:

The first child died following a cardiac arrest and had a congenital heart condition. The parents were reported to be consanguineous.

The second child died from a mitochondrial disease which was complicated by sepsis. The parents were identified as consanguineous. There was an action for CDOP to check if they had had genetic counselling, which was passed onto the relevant provider who confirmed that this had been offered.

The third case occurred in a child who died after being diagnosed with multiple congenital abnormalities in the antenatal period. Maternal smoking and alcohol consumption during the pregnancy were identified as modifiable factors.

5.1.6. Acute medical or surgical condition

There was one death resulting from an acute medical condition where modifiable factors were identified. The child died from streptococcal pneumonia and a rare kidney condition. Smoking in the household by the mother and another relative was identified as a modifiable factor, but would not have affected the death of the child. Depression in a family member and domestic violence were also identified as factors. Again, these did not relate to either the infection or the kidney condition. There was a recommendation made by the CDOP panel to ensure clarity in the SUDIC process in initial communications between paediatricians and the police. This will be addressed in the West Midlands SUDIC protocol.

6.0 CDOP Actions

During this CDOP reporting year there were a total of 74 completed actions. These actions were divided into categories such as recognition, advice, change, clarity requests and extraordinary actions. Below is the overview of these actions.

6.1 Recognition of good service provision

17 letters of recognition of good service or appreciation were sent out this year to recognise the contributions to the child death process. These included thank you letters and communications to parents who contributed to the reviews of their children. Considerable recognition was given to the ambulance service, schools and community/palliative care.

6.2 Provision of Advice and Guidance

14 communications and actions were performed in terms of developing and adding to the provision of advice and guidance. Of the aforementioned actions, many involved feedback on the services provided and suggestions for improvement in individual cases.

One case resulted in the development of a case study to improve midwifery training and processes. This case study was used by one of the hospitals within this CDOP area.

Shared knowledge on bereavement services and national learning/sharing was also a key action within the provision of advice and guidance provided by CDOP this year. This included sending bereavement information to parents as protocol as well as informing partners in the CDOP process of bereavement services available.

A further notable communication involved the sharing of SUDIC protocol developments and a particular focus on the developments for road traffic protocols. Clarity was also gained on the Kennedy Guidance, which allowed for better understanding on when a SUDIC rapid review may not need to be fully instigated.

Further communications included engaging with the coroner's officers serving Coventry, Warwickshire and Solihull. In addition, hospitals were supported to implement sepsis identification protocols.

6.3 Recommended Change

5 actions were undertaken regarding recommending change. The majority of these actions directly related to the protocols that are associated with rapid response to children involved in road traffic collisions and the development of a new response. This action contributes to the wider West Midlands protocol and CDOP has made recommendations. Other acts of recommended change involved amending internal death certification processes and reviewing the way child death decision-making is processed within multi-agency services.

6.4 Further information

35 actions involved the process of requesting further information. These were usually requests by panel to ensure that they had a complete picture so that their analysis of the case was complete.

It should also be noted that CDOP sends a letter to every parent of a child who dies, informing them that their child's death will be undergoing a CDOP review. This letter offers parents the opportunity to contribute to the review but also supplies them with information on the process and provides information on how to access bereavement support.

6.5 Extraordinary Actions
There were 3 extraordinary actions:
1) A referral to the Serious Case Review sub-committee for a case to be considered.

2) The movement of the annual reporting procedures for CDOP.

3) Publication of training to identify children at risk of mental health crisis in schools. The mental health publication also involved an article supplied to head teachers on where to obtain quality first-aid mental health training for staff in schools.

7. CDOP Consolidated Learning

20 of the cases CDOP reviewed had modifiable factors contributing to death. These cases with modifiable risk factors are the focus of learning from child deaths.

The most pertinent modifiable factors in neonatal and perinatal deaths were as follows:

- Maternal smoking during pregnancy or in the household with young children
- Domestic violence
- Mothers with Body Mass Indexes over 30

Within the neonatal and perinatal age group there were also modifiable factors relating to consanguinity and alcohol and drug abuse of a parental figure. Actions aiming to disseminate learning were taken with regards to these factors including:

- Correspondence with ante-natal teams regarding smoking cessation; recording smoking in pregnant mothers; and promoting referral to smoking cessation services.
- Communication with GP practices relating to the identification of and support for victims of domestic violence.
- Hospital communications regarding improving the way domestic violence questions were asked.
- A warning about modifying travel cots was also sent around the National Network of CDOPs (NNCDOP) to be distributed nationally as well as to local authority leads.

In older children, the main modifiable factors identified were:

- Modifications to the road traffic elements of the SUDIC protocol and questions regarding development and sharing of this protocol.
- Identification of sepsis in the early stages

CDOP is currently working on reviewing its SUDIC protocol.

8. Plans for 2019-2020

In 2019-2020, CDOP shall be continuing to put in place the new arrangements in line with both Working Together (2018) and its revisions of its operational policy. The CDOP executive working group has continued to meet on a monthly basis and the upcoming actions are as follows:

- Secure the CDOP chid death review network to ensure a smooth communication between medical reviews and CDOP reviews. This includes providing training and support to providers and working together to establish effective and compliant procedures relating to information sharing and timelines of reporting.

- Review the new method of thematic panels to assess effectiveness, burden on professionals, and compliance with the new statutory guidelines. Share this report within a discussion forum of the CDOP executive board and plan for improvement.

- Securing the arrangements of a Designated Doctor for Child Death and agreeing and establishing their role as per statutory guidance.

- To work in partnership with CCGs and partners to review the SUDIC process alongside the review of the West Midlands protocol.

- Review the compliance of CDOP with the new guidance in place and provide quarterly assurance updates to the CDOP Board.

APPENDIX Figures

1. Demographics

1.1. Age

			Coventry			Solihull			Warwickshire		
			MF	No MF	Total	MF	No MF	Total	MF	No MF	Total
Age at death (%)	0-27 days	n	2	2	4	2	2	4	1	5	6
		%	22	12	15	29	100	44	25	38	35
	28-364 days	n	5	4	9	0	0	0	1	1	2
		%	56	24	35	0	0	0	25	8	12
	1-4 years	n	1	6	7	2	0	2	1	2	3
		%	11	35	27	29	0	22	25	15	18
	5-9 years	n	1	4	5	0	0	0	1	2	3
		%	11	24	19	0	0	0	25	15	18
	10-14 years	n	0	1	1	0	0	0	0	0	0
		%	0	6	4	0	0	0	0	0	0
	15-17 years	n	0	0	0	3	0	3	0	3	3
		%	0	0	0	43	0	33	0	23	18

Table 4 CWS CDOP Report 2018-2019

1.2. Gender

		Coventry			Solihull			Warwickshire		
		MF	No MF	Total	MF	No MF	Total	MF	No MF	Total
Gender	Male	6	11	17	6	1	7	3	7	10
	Female	3	6	9	1	0	2	1	6	7
	Unknown/not stated	0	0	0	0	1	1	0	0	0
	Male/female sex ratio	2.0	1.8	1.9	6.0	NA	3.5	3.0	1.2	1.4

Table 5 CWS CDOP Report 2018-2019

1.3. Ethnicity

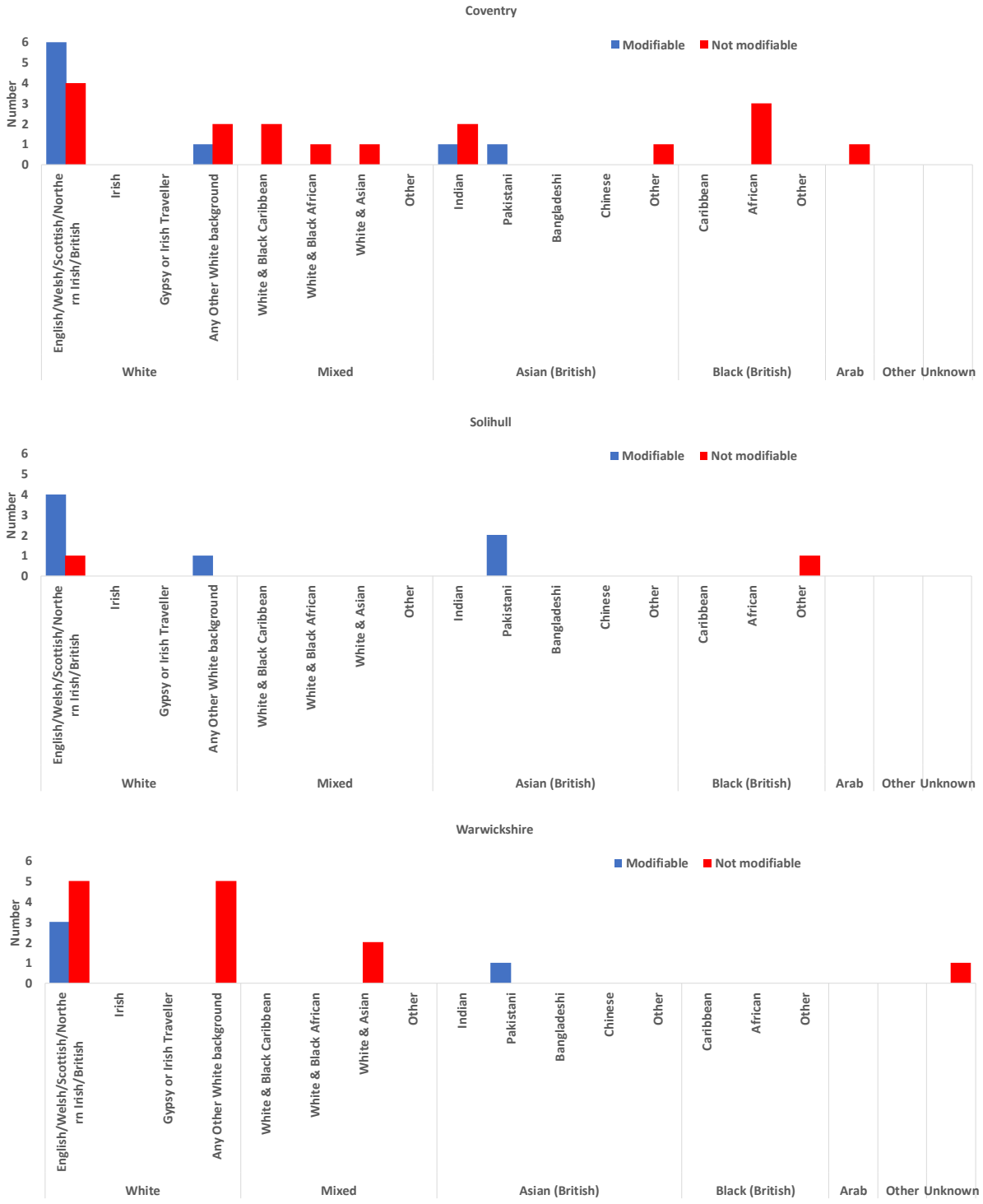

Figure 12 CWS CDOP Report 2018-2019

2. Place

			Coventry		Solihull		Warwickshire	
			MF	No MF	MF	No MF	MF	No MF
Location at the time of the event/condition which led to the death	Acute hospital	Emergency Department	0	0	0	0	0	0
		Paediatric Ward	0	0	0	0	0	1
		Neonatal Unit	2	3	0	0	0	2
		Paediatric Intensive Care Unit	1	3	1	0	0	0
		Adult Intensive Care Unit	0	0	0	0	0	0
		Other[1]	4	7	2	2	2	5
		Unknown	0	0	0	0	0	0
	Home of normal residence		1	3	3	0	1	3
	Other private residence		0	0	0	0	0	1
	Foster home		0	0	0	0	0	0
	Residential Care		0	0	0	0	0	0
	Public place[2]		1	1	1	0	1	1
	School		0	0	0	0	0	0
	Hospice		0	0	0	0	0	0
	Mental health inpatient unit		0	0	0	0	0	0
	Abroad		0	0	0	0	0	0
	Other		0	0	0	0	0	0

Table 6 CWS CDOP Report 2018-2019

[1] including delivery suites, labour wards, transplant units, etc.
[2]including roads, railways, parks, restaurants, beaches, etc

3. Category of death

	Coventry		Solihull		Warwickshire	
	MF	No MF	MF	No MF	MF	No MF
Deliberately inflicted injury, abuse or neglect	0	0	0	0	0	0
Suicide or deliberate self-inflicted harm	0	0	1	0	0	0
Trauma and other external factors	1	3	1	0	2	2
Malignancy	0	1	1	0	0	2
Acute medical or surgical condition	1	1	1	0	0	1
Chronic medical condition	1	2	0	0	0	1
Chromosomal, genetic and congenital anomalies	1	8	2	0	2	3
Perinatal/neonatal event	2	2	1	2	0	2
Infection	1	0	0	0	0	0
Sudden unexpected, unexplained death	2	0	0	0	0	2
Unknown category	0	0	0	0	0	0

Table 7 CWS CDOP Report 2018-2019

4. Causative event

	Coventry		Solihull		Warwickshire	
	MF	No MF	MF	No MF	MF	No MF
Neonatal death	2	3	1	2	1	5
Known life limiting condition	2	9	1	0	1	4
Sudden unexpected death in infancy	5	4	4	0	2	4
Road traffic accidents/collision	0	0	0	0	0	0
Drowning	0	0	0	0	0	0
Fire and burns	0	0	0	0	0	0
Poisoning	0	0	0	0	0	0
Other non-intentional injury/accident/trauma	0	0	0	0	0	0
Substance misuse	0	0	0	0	0	0
Apparent homicide	0	0	0	0	0	0
Apparent suicide	0	0	0	0	0	0
Other	0	1	1	0	0	0

Table 8 CWS CDOP Report 2018-2019

5. Factors contributing to death

		Level of contribution to death								
		Coventry			Solihull			Warwickshire		
		✗	?	✓	✗	?	✓	✗	?	✓
Acute/Sudden onset illness	TOTAL	6	5	11	2	5	6	5	3	12
Chronic/long term illness	Asthma	0	0	0	0	1	0	1	0	0
	Epilepsy	1	0	0	0	0	0	1	0	0
	Other chronic illness	11	2	8	0	3	4	3	0	7
	TOTAL	12	2	8	0	4	4	5	0	7
Disability/impairment	Learning disabilities	5	0	0	0	0	0	2	0	0
	Motor impairment	3	0	0	0	0	0	3	0	0
	Sensory impairment	0	0	0	0	0	0	1	0	0
	Other disability of impairment	0	0	0	0	0	0	2	1	0
	TOTAL	8	0	0	0	0	0	8	1	0
Family and environment	Emotional/behavioural/mental health condition in the parent/carer	1	3	0	0	1	0	3	0	0
	Alcohol/substance misuse by a parent/carer	0	1	0	0	2	0	0	1	0
	Smoking by the parent/carer in a household	0	6	0	0	1	0	3	1	0
	Smoking by the mother during pregnancy	0	4	0	0	0	0	1	1	0
	Emotional/behavioural/ mental health condition in the child	0	0	0	0	1	0	0	0	0
	Alcohol/substance misuse by the child	0	1	0	0	0	0	0	0	0
	Housing	1	1	0	0	0	0	1	1	0
	Domestic violence	2	3	0	0	0	0	0	1	0
	Co-sleeping	0	1	0	0	0	0	0	0	0
	Bullying	0	0	0	0	1	0	0	0	0
	Consanguinity	0	1	0	0	0	0	0	1	0
	Total	4	21	0	0	6	0	8	6	0
Parenting capacity	Poor parenting/supervision	2	2	0	0	1	0	0	1	0
	Child abuse/neglect	0	1	0	0	2	0	0	1	0
	Total	2	3	0	0	3	0	0	2	0
Service provision	Access to health care	1	2	0	0	2	0	3	0	0
	Prior medical intervention	3	1	0	0	0	0	3	0	0
	Prior surgical intervention	2	0	0	0	0	0	0	0	0
	Total	6	3	0	0	2	0	6	0	0

✗ *No factors identified/unlikely to have contributed to the death*
? *Factors identified that may have contributed to vulnerability, ill-health or death by age*
✓ *Factors identified that provide a complete and sufficient explanation for the death*
Table 9 CWS CDOP Report 2018-2019

Glossary

CDOP	Child Death Overview Panel
ECDOP	Electronic platform for Child Death Overview Panel
SUDC	Sudden and Unexpected Deaths in Infancy or Childhood
CDRM	Child Death Review Meeting