WEST OF ENGLAND

CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT
April 2023 – March 2024

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UOB Confidential

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Acknowledgements

We would like to acknowledge the hard work of all professionals involved in every step of the Child Death Review process, and those who sit on the Child Death Overview Panel (CDOP), who have made the content of this report possible.

This is the final report of West of England CDOP as the decision has been made to align Panels to Integrated Care System footprints going forward. We would therefore particularly like to acknowledge the contribution of partners from Bath & North East Somerset in this report and recognise the positive collaboration we have had with Bristol, North Somerset and South Gloucestershire colleagues which we are confident will continue, albeit in a different way in future years.

We acknowledge the contribution of Sarah Webb-Phillips, Senior Public Health Intelligence Specialist, South Gloucestershire Council, who has provided analytical support and background demographics.

Mary Gainsborough
Consultant Community Paediatrician
And Designated Doctor for Children's Deaths
And
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Foreword

The West of England Child Death Overview Panel is a multi-professional panel that covers the four Unitary Authority areas of Bristol, North Somerset, South Gloucestershire and Bath & North East Somerset. It is made up of representatives from a range of organisations, including health, social care and the Police. The CDOP also has representation from those with experience of losing a child or of supporting families bereaved through a child's death.

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

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

The review process is not about allocating blame but is about learning lessons to prevent deaths in the future. All CDOP Members have a responsibility for sharing learning from panel discussions and as Chair of the Panel for the last two years I have encouraged every Member to consider this responsibility carefully in each meeting so that learning is maximised and we take all opportunities to improve the care and support for children and their families and communities and make changes where there may be opportunity to prevent further deaths.

This report presents a summary of data about child deaths notified to and reviewed by West of England CDOP in 2023/24. It also summarises actions taken in response to the Panel's learning and reflection. As you read this report, I ask that you also consider the data and learning within it and how this is relevant to your work and what actions you can take in response that might help ensure that children receive excellent care, and families are well supported or prevent further deaths.

I want to commend the hard work and dedication of the Panel members, and the support from Dr Mary Gainsborough, Designated Doctor for Children's Deaths, and the team in the Child Death Enquiry Office whose

dedication makes sure that we focus our efforts on making things safer for children and families across our area.

Sarah Weld
Director of Public Health, South Gloucestershire
Chair of CDOP

Executive Summary

This report provides an overview of all deaths notified to the Child Death office between 1st April 2023 and 31st March 2024 of children who are normally resident in the areas represented by the West of England CDOP and those cases reviewed by the Child Death Overview Panel over the same period.

Data related to Child Death Notifications

- 55 child deaths were notified to the West of England Child Death Enquiries Office between 1st April 2023 and 31st March 2024. This is similar to the total of 59 deaths reported in 2022-23, and more than the preceding 2 years (2020-21 47; 2021-22 51). One of these was a late notification from 2022-23 but included in this year's annual report for completeness.
- Over the 12 month period, 61% died in hospital (NICU, PICU, ED and Hospital Wards/Delivery Suite/Labour ward), 33% at home or in a relative's home, public place or other location and 6% in a hospice.
- 15 notifications (27%) were received for babies dying in the neonatal period (0-27 days). A further 13 (24%) died in the first year of life, 7 deaths (13%) were children aged between 1-4 years old, 5 (9%) were aged 5-9 years old, 2 (3%) were children between 10-14 years and 12 (24%) of deaths were of children aged between 15-17.
- Regarding ethnicity, there was a strong evidence of a higher mortality rate in those who were registered as Black African, Black Caribbean or Black British, and weak evidence of a higher mortality rate amongst Asian and Asian British and other ethnicity children, compared to white children mortality rates.
- Mortality rates by local area relative deprivation quintile indicate a relationship with greater deprivation, but there was only weak evidence of a higher rate in the most deprived quintile compared to the least deprived quintile
- 22 (40%) of cases triggered a Joint Agency Response.

Data from cases reviewed by the Child Death Overview Panel

- The West of England CDOP reviewed 55 cases between 1st April 2023 and 31st March 2024.
- There is an inevitable time-lag between notification of the child's death to CDOP review. There are 3 cases of children who died during the period of 2019-20 which are still outstanding. There are also 3 cases still to be reviewed from 2020-2021, 5 cases from 2021-22 and 24 from 2022-23. The majority of these are ongoing due to Police Investigations, Coronial Processes, deaths out of area or abroad. All other children who died before 2019 have been reviewed by CDOP. There are 54 cases to review from 2023-24 although many of these have already had a Child Death Review meeting.
- The most common Category of death was chromosomal, genetic or congenital anomaly, which occurred in 42% of cases.
- The most common Mode of Death was withholding, withdraw or limitation of life sustaining treatment which occurred in 42% of deaths reviewed.
- Mental health of a parent is mentioned in 51% or reviewed cases and smoking in 36%.

- CDOP identified 'modifiable factors' in (20) 36% of cases. Modifiable factors are defined as 'one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.
- It is known that family bereavement follow-up was documented as offered in 97% of cases and was offered or provided by a range of professionals depending on the type and location of the child's death. 3% of families declined support during 2023-2024.
- Due to the small numbers, there is only weak evidence of any differences in mortality by different ethnic groups, however it does appear that in those cases reviewed there were disproportionally more deaths amongst Asian, mixed and other ethnicities compared to their respective population, and proportionally fewer deaths amongst white children compared to their population.

Service Improvement
CDOP has taken forward actions arising from individual cases which include contacting local Hospital Trusts, ICBs and Local Authorities. Specific actions relate to learning from unsafe sleep environments for babies, risk factors for suicides, and the effect of unbooked pregnancies.

Achievements and Future Priorities
These include the departure of BANES from the West of England CDOP arrangements from 1st April 2024, establishing KPIs & working arrangements with the Child Death Partners, and improved working together to deliver Joint Agency Responses.

1. Background

1.1 The Child Death Review Process

Since 1st April 2008, Local Safeguarding Children Boards (LSCBs) in England had a statutory responsibility for child death review processes which was continued by the alternative local safeguarding arrangements implemented from 2019. The relevant legislation is enshrined within the Children Act 2004 and applies to all young people under the age of 18 years. The processes to be followed when a child dies are currently outlined within Working Together to Safeguard Children 2018: Chapter 6 Child Death Review Processes[1]. The process focuses on identifying 'modifiable factors' in the child's death. Child Death Review: Statutory and Operational Guidance[2] was published in October 2018 and applies to all the deaths reviewed in this year's report. The overall purpose of the child death review process is to understand how and why children die, to put in place interventions to protect other children and to prevent future deaths. It is intended that these processes will:

- Document and accurately establish causation of death in each individual child.
- Identify patterns of death in a community so that preventable factors can be recognised and reduced.
- Contribute to improved multi-professional collection of medical, social and forensic evidence in the small proportion of deaths where there has been maltreatment or neglect.
- Ensure appropriate family and bereavement support is in place.
- Identify learning points for service provision, which relate to care of the child.

Working Together (2023) and the CDR Statutory Guidance (2018) outline two inter-related processes…a **'Joint Agency Response'** where a group of professionals came together for the purpose of evaluating the cause of death in an individual child, where the death of that child was not anticipated and the cause is not fully

[1] Chapter 6: Child death reviews (workingtogetheronline.co.uk)
[2] https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidanceengland

understood, and a **'Child Death Overview Panel**' (CDOP) that comes together to undertake an overview of *all* child deaths under the age of 18 years in a defined geographical area.

In the area of the former county of Avon, four neighbouring LSCBs (Bristol, North Somerset, South Gloucestershire and Bath and North East Somerset) came together to form a single West of England (WoE) CDOP in 2008. The membership of the Panel (Appendix A) is arranged to ensure that there is the necessary level of expertise and experience, and that each of the four Local Authority areas is appropriately represented. During 2023/24, the WoE CDOP Chair was taken by the South Gloucestershire Director of Public Health. The Terms of Reference, Governance Arrangements and Membership are summarised in documents available from the Child Death office at the University of Bristol which administers all functions of the WoE CDOP.

The WoE CDOP reviews information on every child who has died whose post code of residence is within its geographical boundary. Some of these deaths may occur outside the West of England. The WoE CDOP additionally reviews the deaths of some non-resident children who may be under the care of a specialist paediatric medical or surgical team in Bristol, but this follows review by their local CDOP and these cases are no longer counted in the total of cases reviewed by WoE CDOP.

A child's case is reviewed at the CDOP after it has been discussed at a local Child Death Review meeting. Standard information on each child is collected on national Notification Forms and Reporting Forms during the child death review process. The Notification Form is a basic notification form that has essential identifying information on the child and key professionals. Reporting Forms are completed by all agencies involved in the care of a child and capture clinical and social data on the child and background information relating to the family. An Analysis Form is completed at the local Child Death Review meeting and aims to identify modifiable factors relating to the child's death, as well as highlight learning that arises from each case. All patient information is made anonymous. A detailed compilation of all data on Reporting Forms & Analysis Form on each child is presented to the CDOP as an anonymous case record. At CDOP meetings each case is reviewed, and the Panel deliberates on the decisions reached at the local Child Death Review meeting. The panel will agree any additions or amendments on a final Analysis Form for each child. The CDOP Chair records recurring themes relating to modifiable factors and takes responsibility for any actions arising from the case discussion.

All CDOP Members have a responsibility for sharing learning from panel discussions. Data and learning gathered through the CDR process also feeds into the National Child Mortality Database (NCMD)[3] which records comprehensive data, standardised across a whole country (England), on the circumstances of children's deaths. The purpose of collating information nationally is to ensure that deaths are learned from, that learning is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die.

1.2 Production of annual report (processing and verification of data)

This is the fifteenth Annual Report of the West of England CDOP and is a is a publicly available document. Previous Annual Reports can be found online
https://bristolsafeguarding.org/professional-resources/child-death-overview-panel
or requested from the Child Death office at University of Bristol.

The Child Death office use the following sources to ensure optimal notification of child deaths:

- Weekly returns from the Local Registrar's Offices
- Regular checks on BadgerNet for missing cases
- Joint Agency Response phone calls and reports
- Close working with the Child Health Information Service

[3] About the NCMD - National Child Mortality Database

CDOP is required to produce an annual report each year outlining the work of the panel and relevant learning from the cases reviewed to inform the priorities of the CDR Partners. The annual report is produced using data collected by the University of Bristol through the Child Death office. Information collected at the point of notification of death is entered onto the eCDOP case management tool. Information collected from statutory forms, CDRMs and CDOP reviews is populated onto eCDOP as the case progresses through the child death review process. The eventual CDOP multi-agency dataset is extremely comprehensive. eCDOP dataset is submitted to the National Child Mortality Database who produce data summaries on a quarterly basis and this report is based on the quarter 4 report from 2023/24.

Note: The UK Office for National Statistics advises that care should be taken regarding publishing small numbers of events in person-related statistics. This is due to the need to preserve confidentiality as there may be a risk that individuals could be identified.

2. Summary Death Notification Data 2023/24

This section summarises all deaths notified to the Child Death office between 1st April 2023 and 31st March 2024 of children who are normally resident in the areas represented by the West of England CDOP.

A proportion of deaths occurring each year in the West of England area are of children residing in areas outside the West of England region (BANES, Bristol, North Somerset and South Gloucestershire), including children visiting the area from other parts of the UK. This is because Bristol has tertiary referral units for neonates and children and specialist services including cardiology, oncology and neurology. These cases are then notified to their own area CDOPs so do not form part of this dataset.

It should be noted that UHBW produce an Annual Report on child deaths reviewed within the Bristol Royal Hospital for Children (BRHC) which includes children cared for from out of area, and this is available from the Child Death Review Coordinators at BRHC.

There were 55 notifications in the last 12 month period. This is similar to the total of 59 deaths reported in 2022-23, and more than the preceding 2 years (2020-21 47; 2021-22 51). These data are drawn from the eCDOP Notification database. However, in addition this total includes one death that was a late notification of a death out of area from 2022-23 but is included in this year's annual report for completeness. However, NCMD were able to include this case retrospectively in the final quarter 2022-23 dataset.

Table 1: Notifications by LSCB 2023-24

LSCB name	Cases
Bath & North East Somerset	4
Bristol City	29
North Somerset	7
South Gloucestershire	15
Total	55

Data from the NCMD indicates that nationally, following a significant reduction in child deaths during the first year of the pandemic (2020-21), mortality returned to close to pre-pandemic levels in the following year and subsequent years.

Table 2: West of England Notifications by year 2019-20 to 2023-2024

All death notifications from 1st April 2019 to 31st March 2024 by month and year

Month of Death	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
April	3	3	2	8	6
May	1	6	3	4	1
June	1	1	7	5	2
July	7	5	3	4	4
August	5	6	4	2	5
September	6	4	2	5	4
October	5	2	1	4	2
November	7	1	6	6	5
December	5	5	5	7	6
January	2	6	7	3	7
February	3	3	5	2	9
March	6	5	6	10	4
Totals:	**51**	**47**	**51**	**60**	**55**

2.1 Analysis of notifications by Area of Residence

Figure 1: Notifications by area of residence 2023-2024

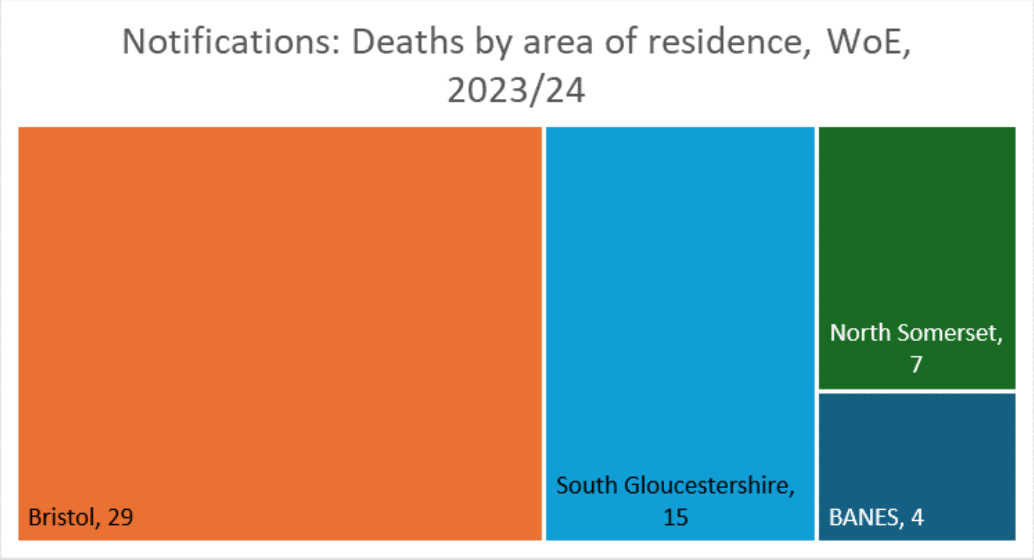
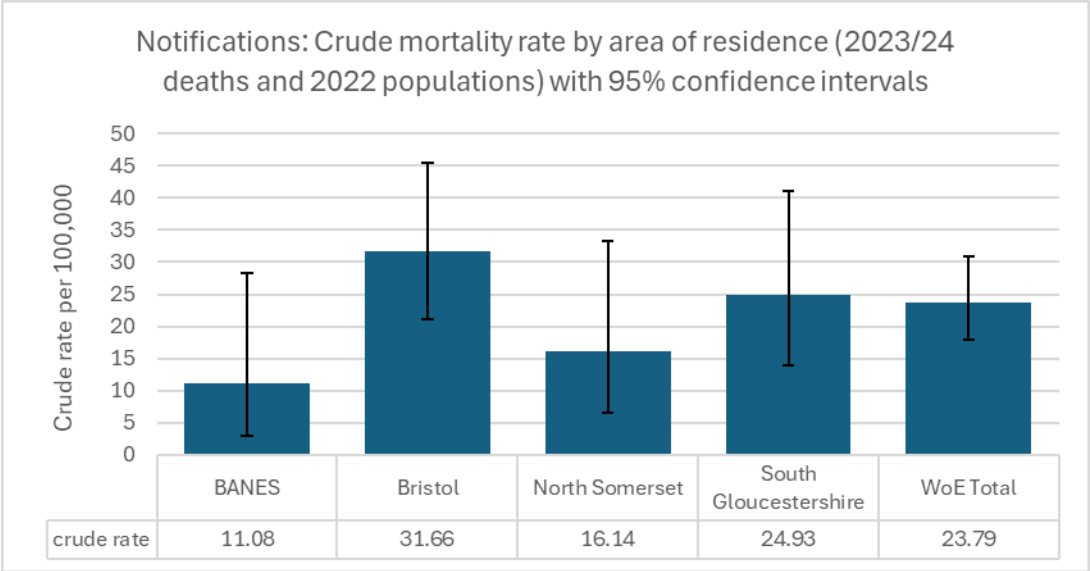


Figure 2: Notifications by Crude Mortality Rate by area of residence (2023/24 deaths and 2022 populations with 95% confidence intervals.



There is no evidence of a significant difference in mortality rates between West of England areas of residence. There is weak evidence of a lower rate of deaths in BaNES and a higher rate in Bristol, but caution should be applied as these rates are informed by small numbers.

The numbers of notifications for any one area of residence are small so that the most likely explanation for any pattern is random year-on-year variation. However, CDOP should always try to exclude contributory factors such as differences in coding practice or an increase in a particular category of death.

2.2 Place of deaths notified

Over the 12 month period, 61% died in hospital (NICU, PICU, ED and Hospital Wards/Delivery Suite/Labour ward), 33% at home or in a relative's home, public place or other locations and 6% in hospices.

Figure 3. Location of Death - deaths notified to West of England CDOP in 2023/24

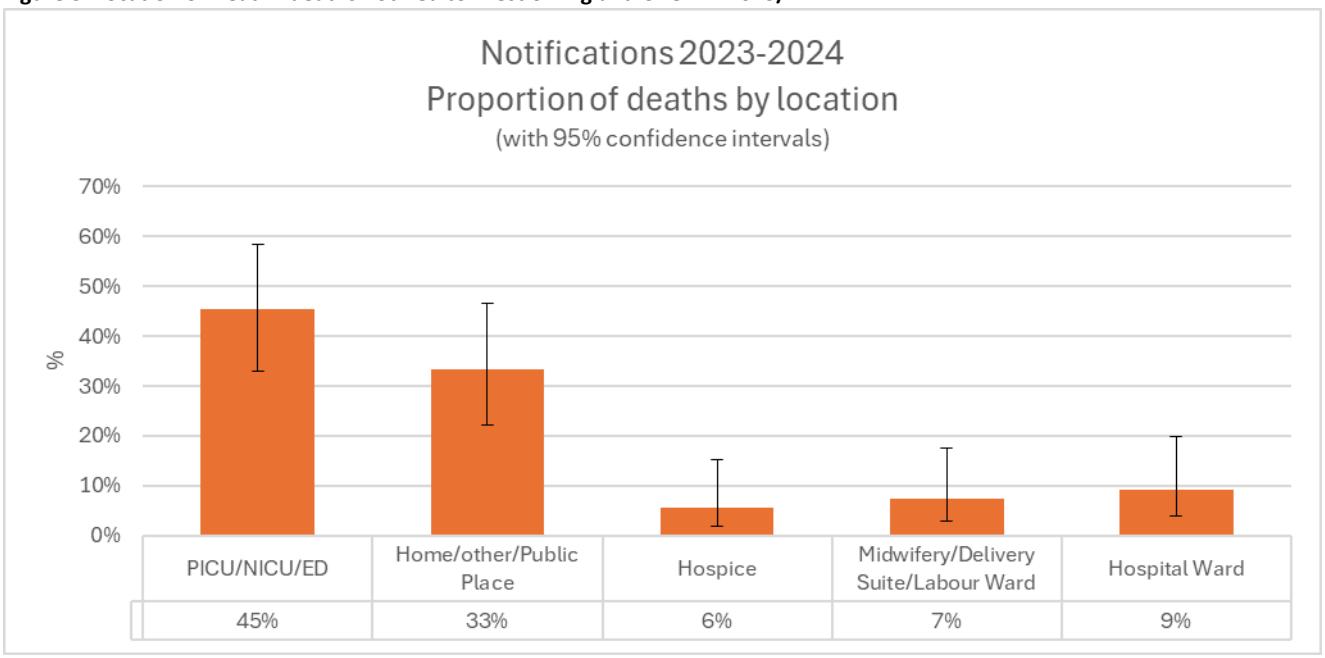
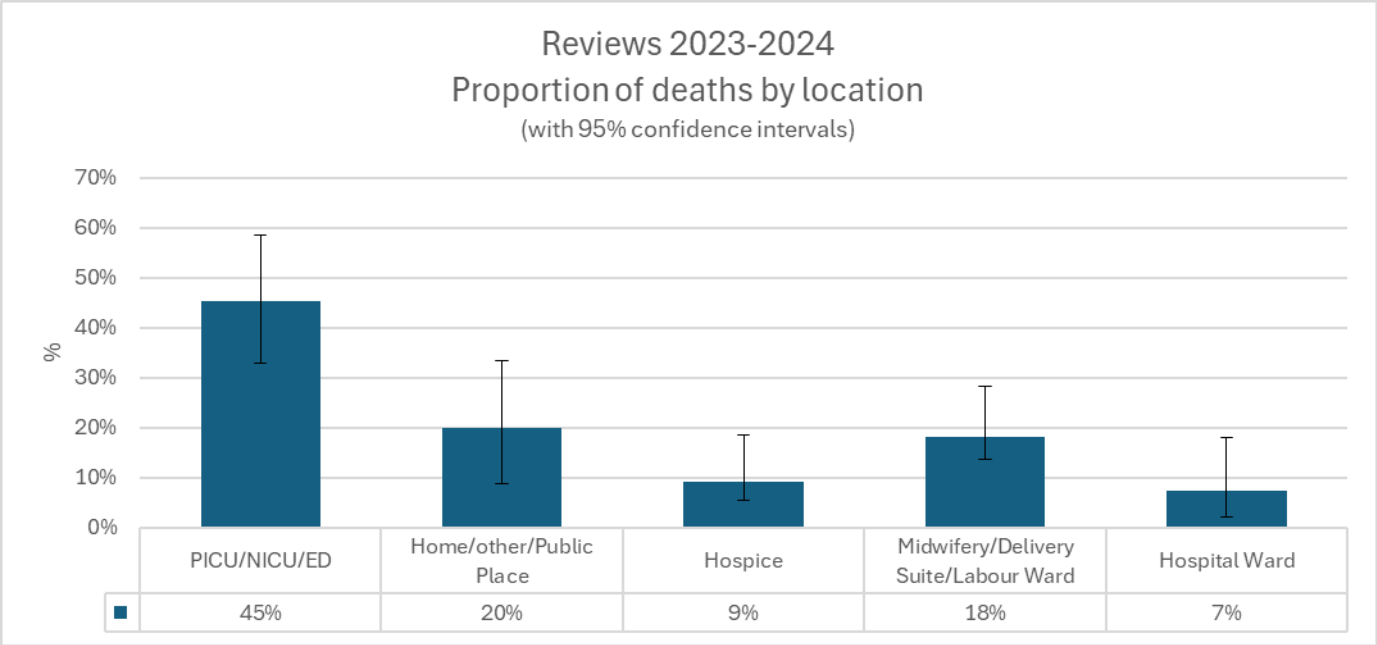


Figure 4: Place of Death - deaths reviewed by West of England CDOP in 2023/24



2.3 Age at Death of notifications

In 2023-24 of the total number of notifications of death received 27% were received for babies dying in the neonatal period (0-27 days). A further 24% died in the first year of life, 13% deaths were children aged between 1-4 years old, 9% were aged 5-9 years old, 3% were of children between 10-14 years and 24% of deaths were of children aged between 15-17. Death rates were highest in the neonatal period. This is consistent with data from previous years. Rates for other age groups have fluctuated year on year but indicate a higher rate in 15-17 year olds than other age groups.

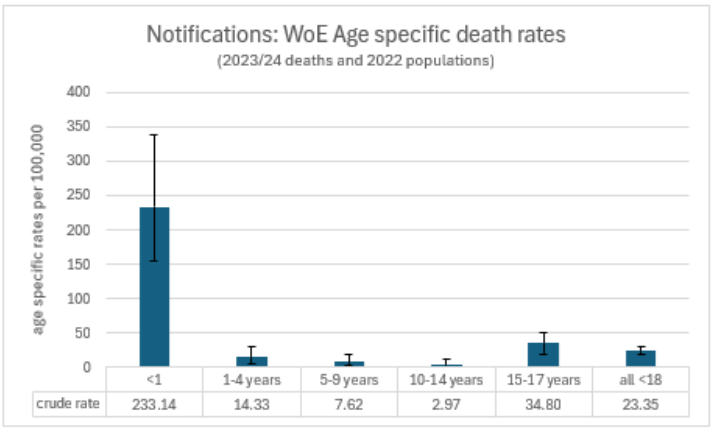
Table 3: Notifications of death by age and year (NCMD)

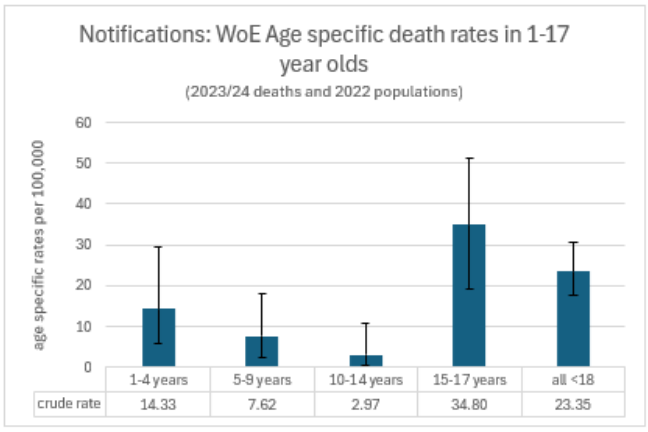
	2021-2022	2022-2023	2023-2024
0-27 days	20	24	15
28 days - 364 days	17	10	13
1 - 4 years	1	7	7
5 - 9 years	2	5	5
10 - 14 years	3	9	2
15 - 17 years	8	4	13
TOTAL	**51**	**59**	**55**

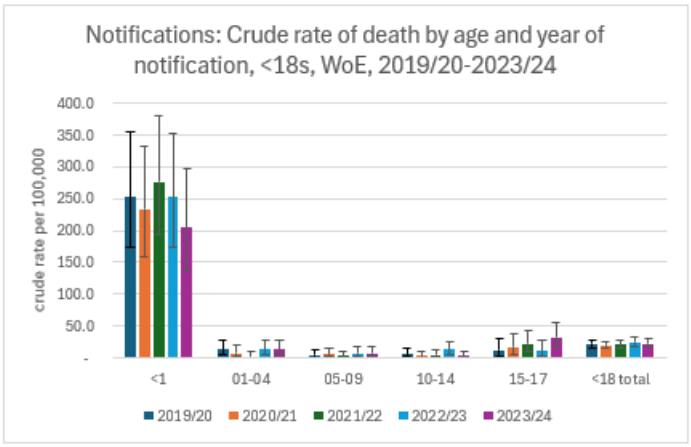
Table 4: Crude rate of death notifications by year and age per 100,000 population (using ONS 2018 based population projections)

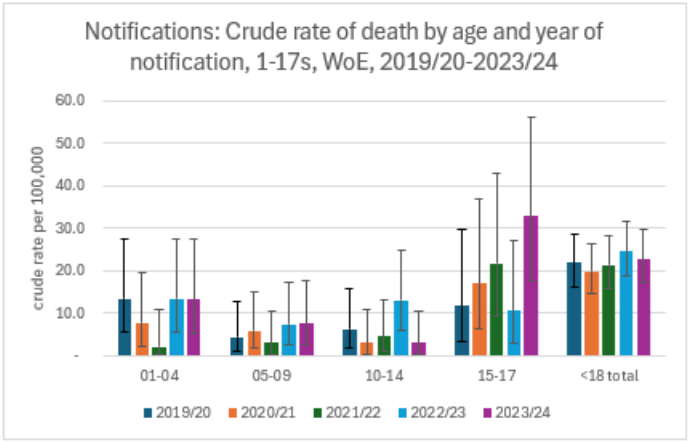
Age	2020/21	2021/22	2022/23	2023/2024
<1 years	233.4	276.0	251.9	233.14
1-4 years	7.6	1.9	13.4	14.33
5-9 years	5.8	2.9	7.4	7.62
10-14 years	3.0	4.4	13.0	2.97
15-17 years	16.9	21.7	10.5	34.80
All <18	19.8	21.3	24.5	23.35

Figure 5, 6, 7 and 8: Crude Rate of Death Notifications 2020-2024





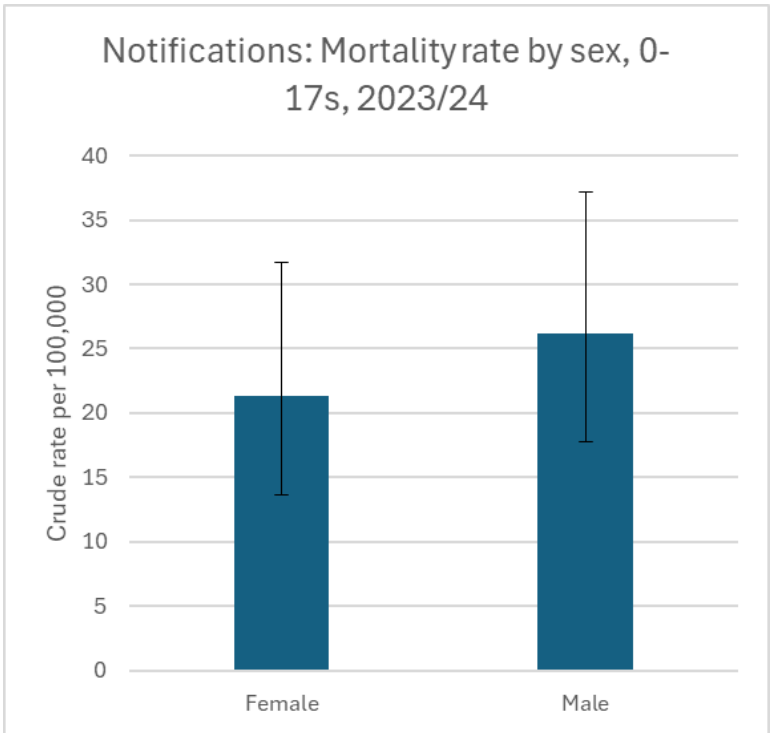




2.4 Gender of deaths notified

56% of notifications of deaths were of boys and 44% of girls.

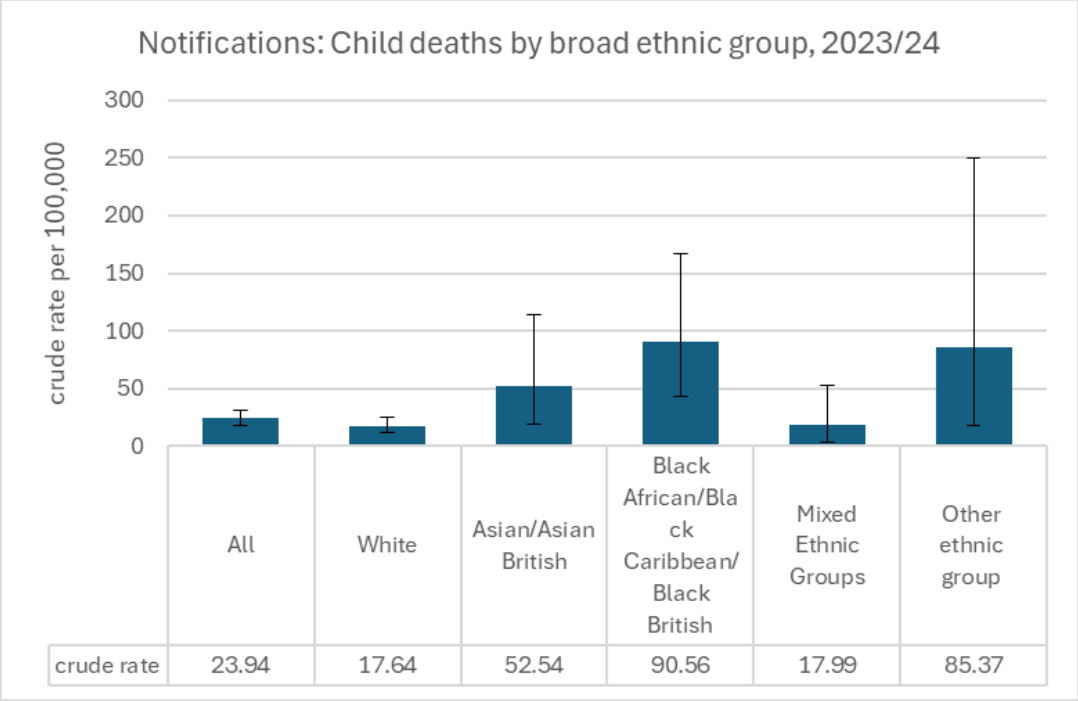
Figure 9: Mortality rate by Gender 0-17s

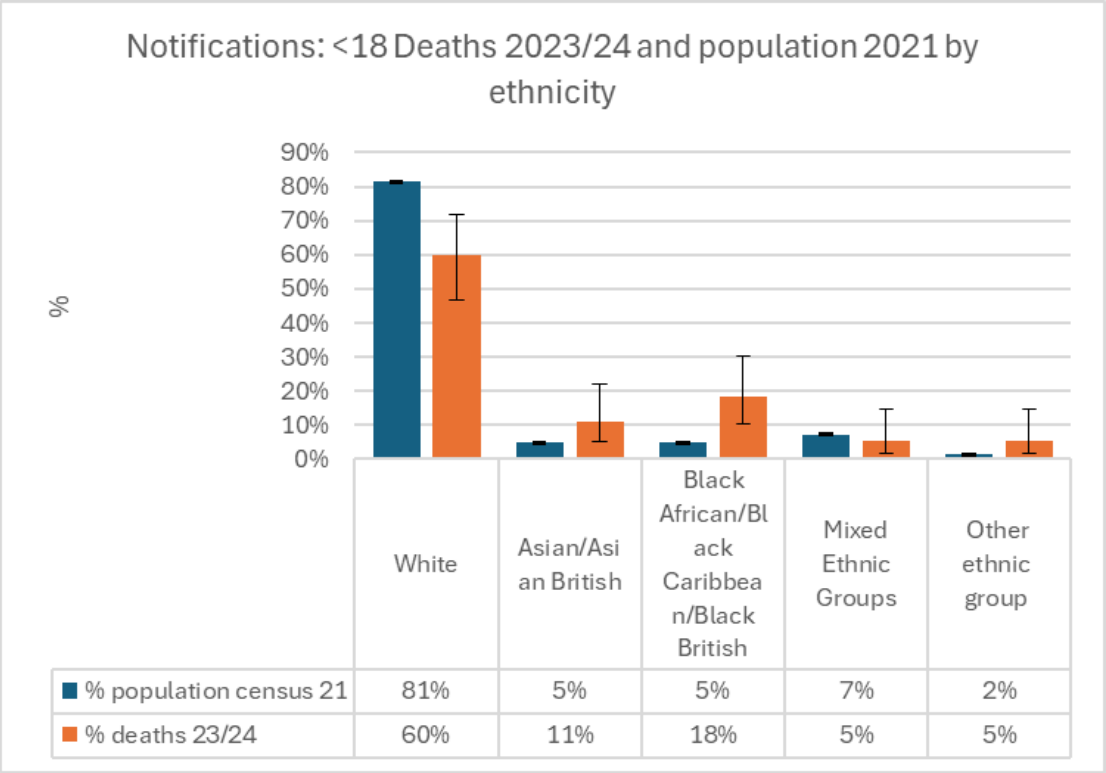


2.5 Ethnicity of deaths notified

The 2023/24 notifications data show strong evidence of a higher mortality rate amongst those who are registered as 'Black African/Black Caribbean/Black British ' compared to the all-child or white mortality rate, with the rate amongst black children is over 5 times that of white children. There was also weak evidence of a higher rate of deaths amongst Asian / Asian British and those from other ethnic groups compared to the white population. Another way of illustrating the inequality is to look at deaths in a particular ethnic group compared to their proportion of the population. There is strong evidence of disproportionality more deaths compared to population amongst black ethnic groups and weak evidence of a disproportionally more deaths amongst Asian and other ethnicities compared to their respective populations. Conversely, strong evidence that there are disproportionately fewer white children in the mortality data compared to their proportion of the population.

Figures 10 and 11: Mortality rate by ethnicity 0-17s and proportion of deaths and population by ethnicity

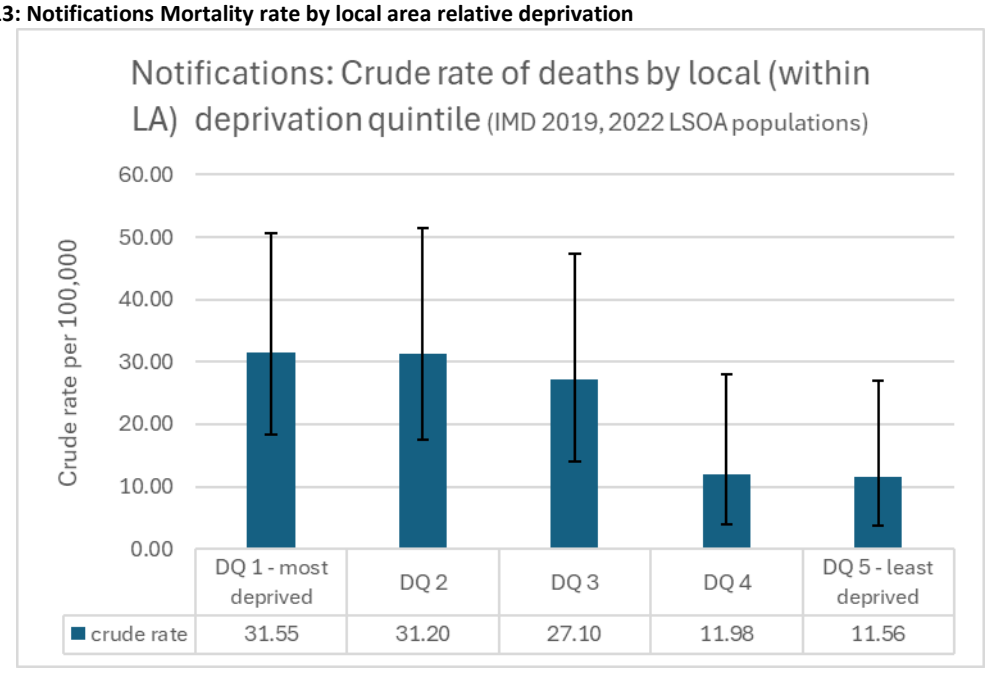


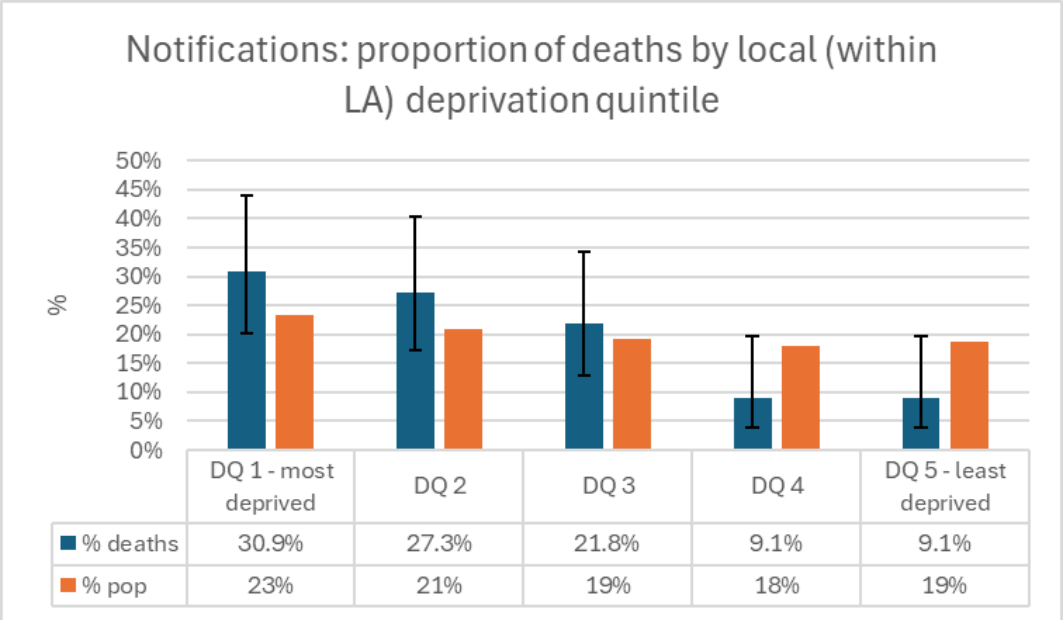


2.6 Area Deprivation (Indices of Multiple Deprivation) of notifications

Using each areas local quintiles based in IMD 2019 scores, the 2023/24 notification data shows weak evidence of a higher rate of deaths in the most deprived quintile compared to the least deprived. When proportion of deaths are looked at, there is strong evidence of a higher rate amongst the most deprived areas compared to the least deprived – this is driven by both the slightly larger child population, and the higher death rate among those children.

Figures 12 and 13: Notifications Mortality rate by local area relative deprivation





	DQ 1 - most deprived	DQ 2	DQ 3	DQ 4	DQ 5 - least deprived
% deaths	30.9%	27.3%	21.8%	9.1%	9.1%
% pop	23%	21%	19%	18%	19%

2.7 Postmortem examinations in Deaths notified

Postmortem examinations make an important contribution to explaining how a child dies and may be ordered by the coroner or offered by the attending clinician when the circumstances surrounding the death remain unclear. A postmortem occurred in 29 deaths notified during 2023-2024 (54%). 26 (46%) cases did not have a postmortem at the point of notification of the death.

2.8 Deaths notified requiring a Joint Agency Response (JAR)

Since the inception of the child death review process there has been a requirement to perform further investigations for children who die where the cause is unknown. This was previously called a Rapid Response, but the terminology was changed following the publication of the Child Death Review Statutory and Operational Guidance in 2018 and it is now referred to as a Joint Agency Response (see Section 4 above). The full guidance for conducting a JAR can be found in the Kennedy guidelines 2016[4].

A Joint Agency Response should be triggered if a child's death[5]:

- is or could be due to external causes
- is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy/childhood (SUDI/C))
- occurs in custody, or where the child was detained under the Mental Health Act
- where the initial circumstances raise any suspicions that the death may not have been natural
- in the case of a stillbirth where no healthcare professional was in attendance

A JAR is also required when a child collapses unexpectedly, is resuscitated and admitted to hospital but expected to die shortly.

For the Notifications received during 2023-2024, there were 22 (40%) cases which required a Joint Agency Response, 33 (60%) did not have a Joint Agency Response.

[4] Sudden-unexpected-death-in-infancy-and-childhood-2e.pdf (rcpath.org)
[5] Child Death Review Statutory and Operational Guidance (England) (publishing.service.gov.uk)

3. Child Death Overview Panel Review Data 2023-24

This section summarises characteristics of the children reviewed at CDOP 2023-24. The West of England CDOP reviewed 55 cases between 1st April 2023 and 31st March 2024. There is an inevitable time-lag (6-12 months) between notification of a child's death and discussion at CDOP**.** There are various factors that contribute to this: the return of Reporting Forms from professionals, the completion of the final postmortem report by the pathologist and receipt of the final report from the local child death review meeting. On occasion when the outcome of a Coroner's inquest is awaited, there may be a delay of over a year before a case might be brought before CDOP. The undertaking of a criminal investigation or a Child Safeguarding Practice Review will also affect when a case is discussed at Panel.

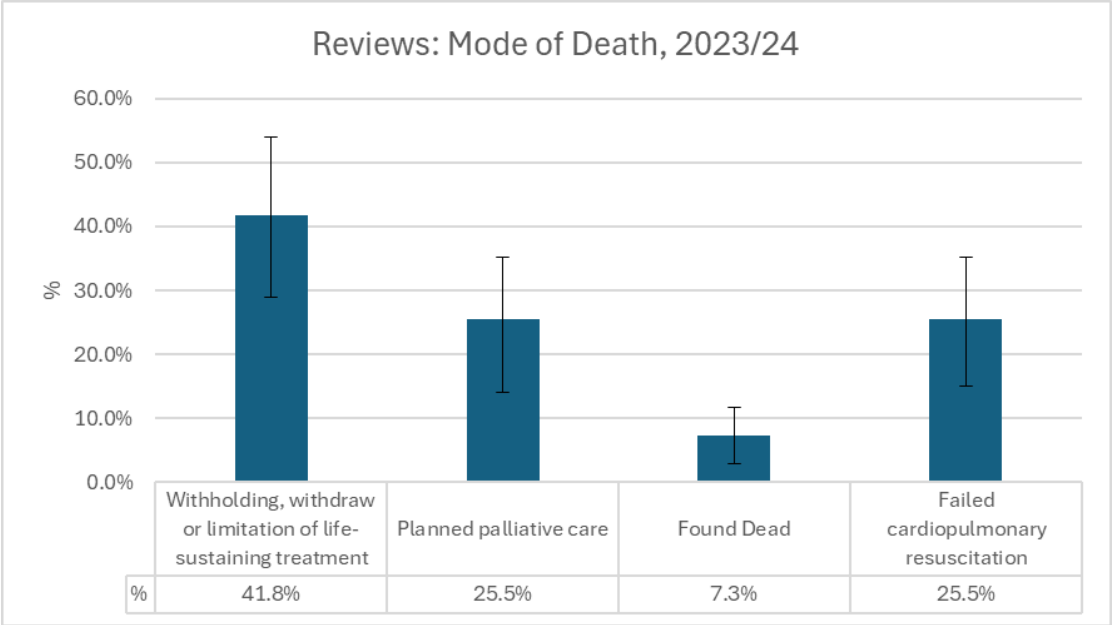
Table 5: The number of Completed CDOP reviews each year by year of death

	2019/2020		2020/2021		2021/2022		2022/2023		2023/2024	
Total number of notifications	51		48		51		59		55	
Years of Review	**Number reviewed**	**%**	**Number reviewed**	**%**	**Number reviewed**	**%**	**Number reviewed**	**%**	**Number reviewed**	**%**
2019/20	1	2								
2020/21	27	53	2	4						
2021/22	17	33	26	54	3	6				
2022/23	3	6	11	23	27	53	3	5		
2023/24	0	0	6	12	16	31	32	54	1	2
Totals	**48**	**94**	**45**	**93**	**46**	**90**	**35**	**59**	**1**	**2**

3.1 Mode of death

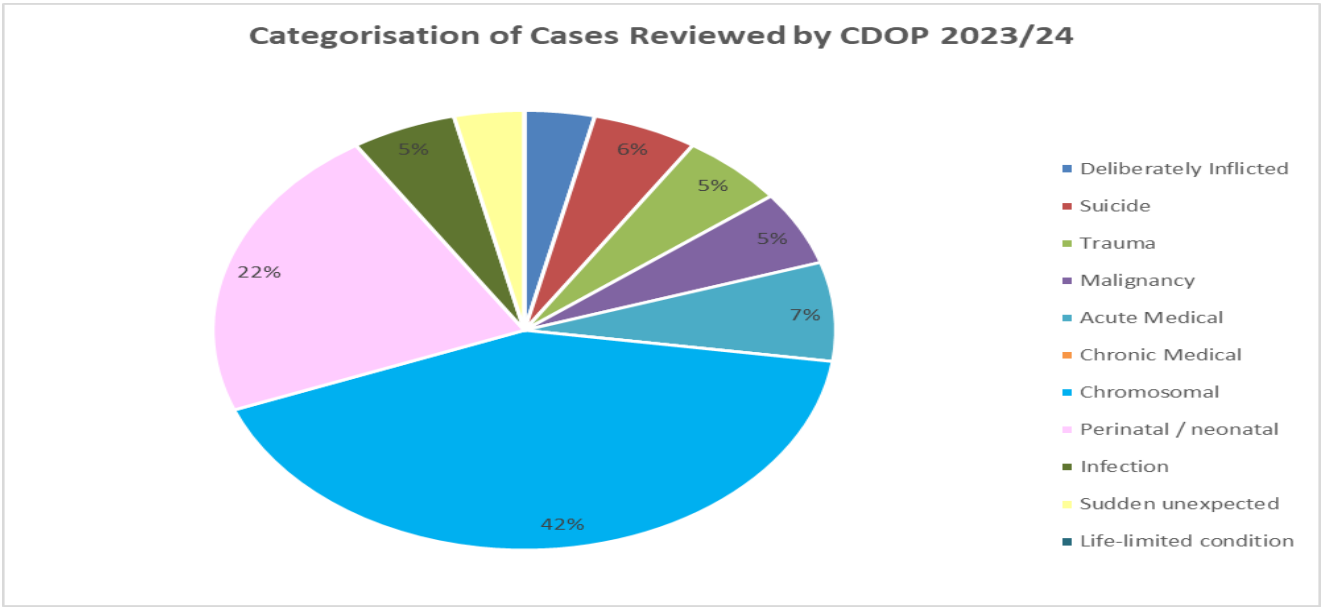
The most common way children died was following active withholding, withdrawal or limitation of life sustaining treatment, most commonly in an intensive care situation (this decision is always made following careful consideration with the parents and carers). This occurred in 42% of the deaths reviewed by CDOP. In 26% of cases the child died following planned palliative care and 25% after failed cardio-pulmonary resuscitation attempts, although the child may have been critically ill on NICU or PICU prior to the final event. In 7% of cases the child was found dead.

Figure 14: Mode of death of cases reviewed by CDOP between 1st April 2023 and 31st March 2024



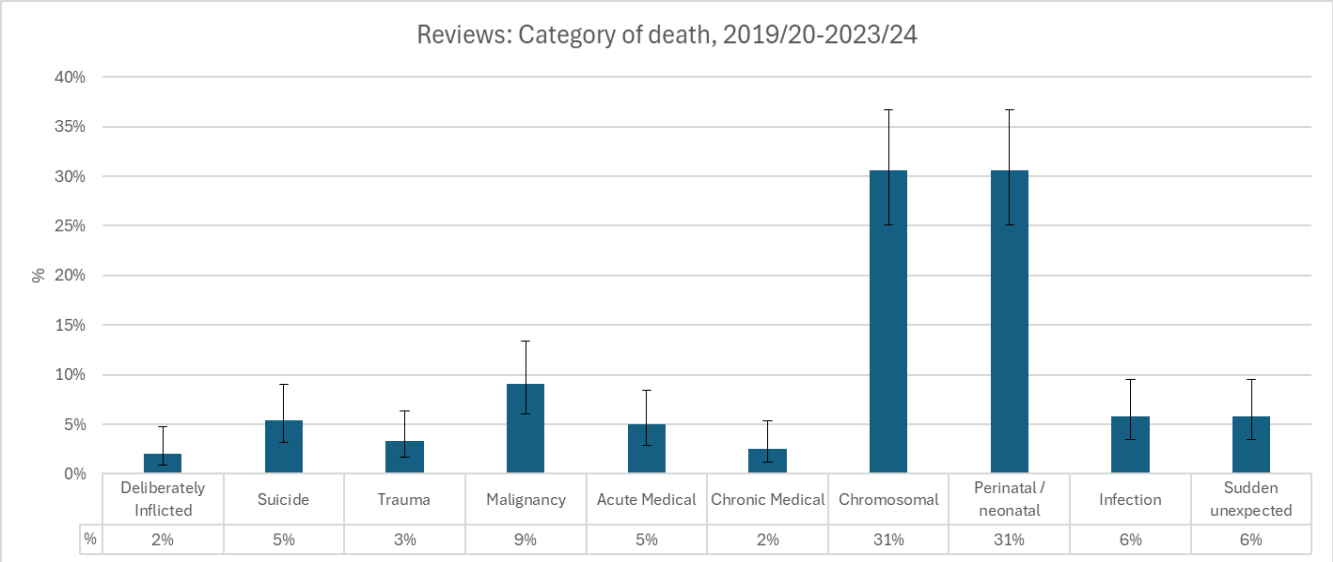
3.2 Category of Death

In 2023/24 the most frequent category of death in cases reviewed was Chromosomal, Genetic and Congenital Anomalies (42%), followed by Perinatal and Neonatal deaths (22%). 5% of deaths were due to malignancy, 5% Trauma and other external factors, 7% were because of an acute medical condition. 6% were due to suicide. 5% were due to Infection, Less than 5% were due to Sudden or unexplained deaths and less than 5% were caused by deliberate or self-inflicted harm. There were no cases due to Chronic medical condition.



Three years pooled data of reviews that took place between 2019/20 and 2023/24 show that 31% of deaths were categorised as due to Chromosomal, genetic and congenital anomalies or Perinatal / neonatal event, with strong evidence that these categorisations were higher than all other causes.

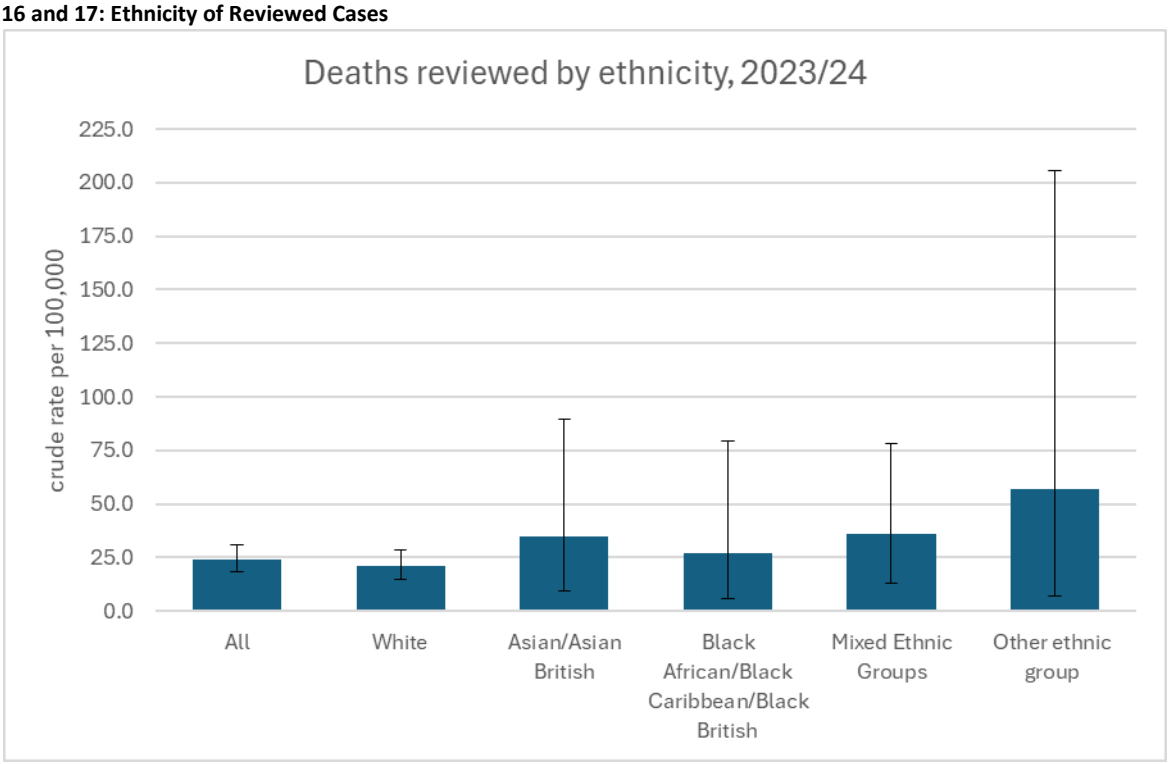
Figure 15: Category of Death 2019/20-2023/24

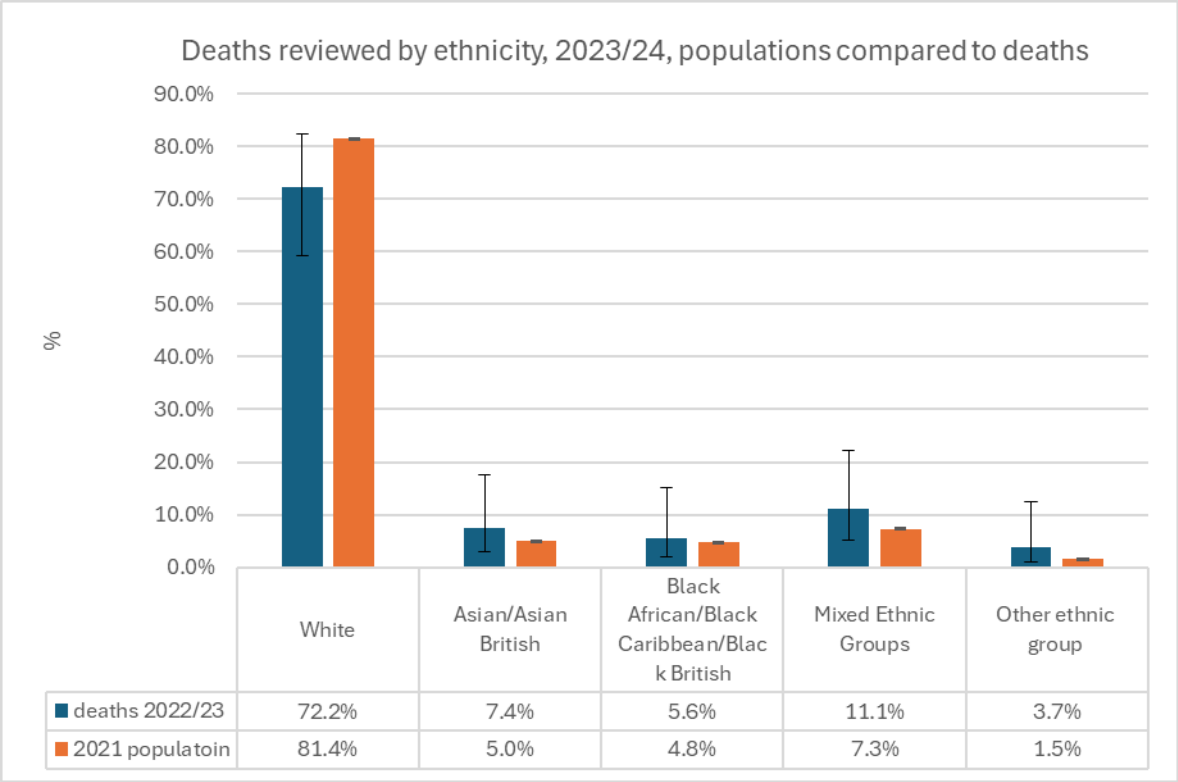


3.3 Ethnicity of cases reviewed

Figure 16 shows that 64% of cases reviewed by CDOP between 2023 and 2024 were children of White British origin. The number of reviews for children whose ethnicity was recorded as Mixed was 11%, those described as White, other was 7%. Black African, Black Caribbean or Black British was 5%. Other ethnicities were recorded as 11% and 2% did not have ethnicity recorded.

Figures 16 and 17: Ethnicity of Reviewed Cases





	White	Asian/Asian British	Black African/Black Caribbean/Black British	Mixed Ethnic Groups	Other ethnic group
deaths 2022/23	72.2%	7.4%	5.6%	11.1%	3.7%
2021 populatoin	81.4%	5.0%	4.8%	7.3%	1.5%

Looking at a single year's worth of data, there is only weak evidence of a higher rate of deaths in Asian and other ethnic groups compared to white ethnicity.

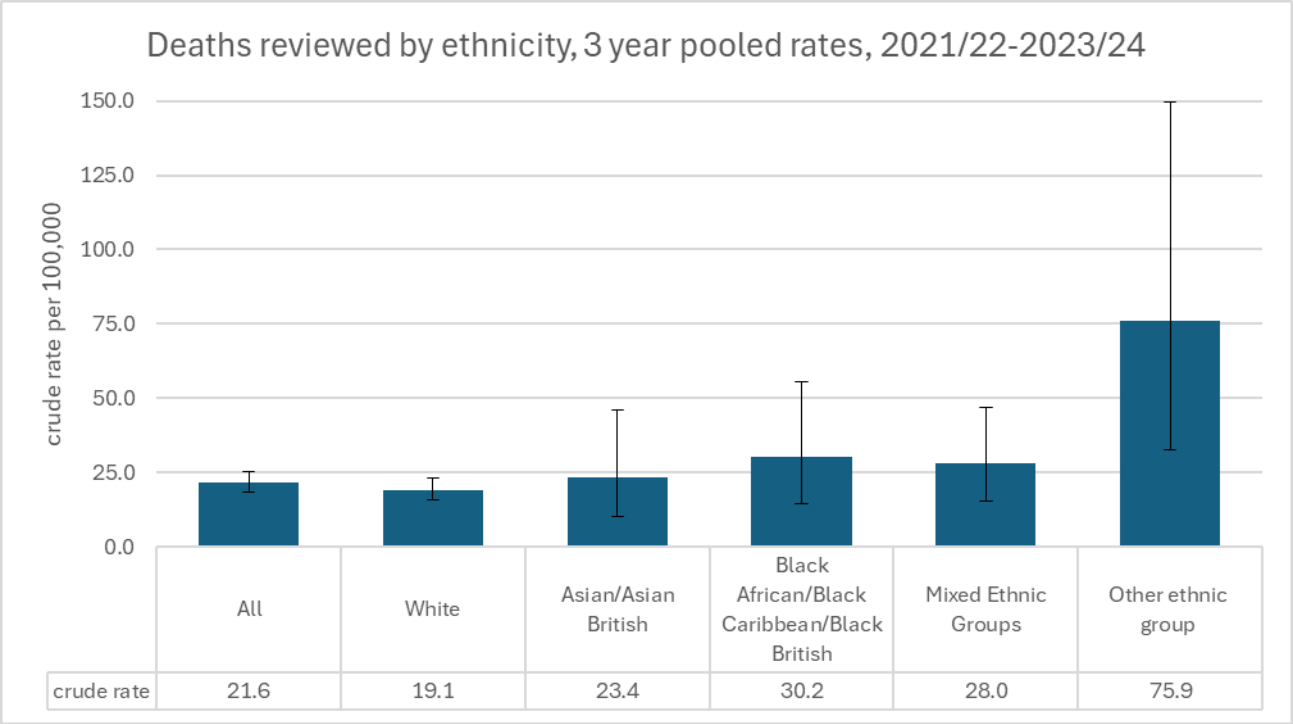
There is weak evidence of a lower proportion of deaths reviewed amongst children of white ethnicity in 2023/24 compared to the proportion of the population. Conversely, there is weak evidence of a higher proportion of deaths compared to the population in the mixed and other ethnic groups.

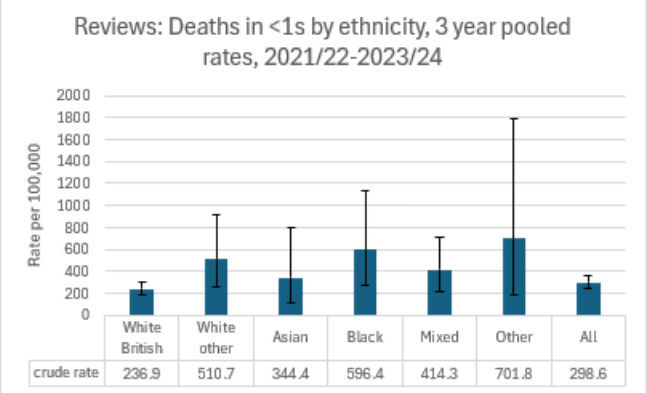
Looking at single years of data, with small numbers in certain ethnic groups, mean that one or two more or fewer deaths in any one group can dramatically affect rates. Looking at several years' worth of data can help to improve confidence that what we're observing is not just down to chance.

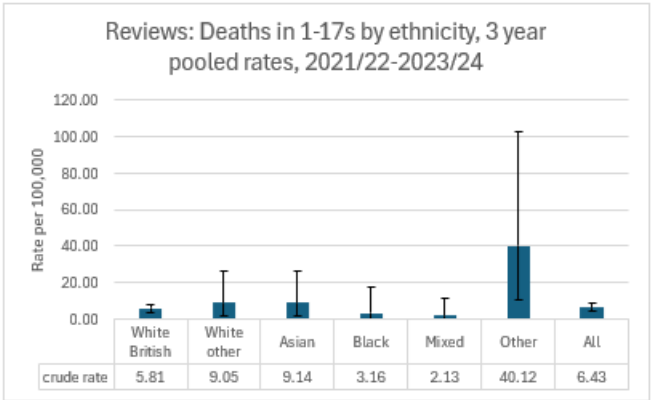
Supplementary three year pooled data suggest that there is strong evidence of a higher rate of deaths amongst other ethnic groups compared to the rate for all children or white children. Looking at deaths in under ones and 1-17 year olds separately, the patterns by ethnicity change subtly, but the group 'other ethnicity' remains highest with strong evidence of a difference in the 1-17 year olds despite the small numbers.

There is a possibility that there is a disconnect between the recording of ethnicity in this data, and the recording of ethnicity in the census. This should be looked into further to establish whether it is a coding error, or whether there is a higher death rate amongst those with ethnicity classified as other.

Figures 18, 19 and 20: Deaths Reviewed by Ethnicity, 3 year pooled rates, 2021/22-2023/24



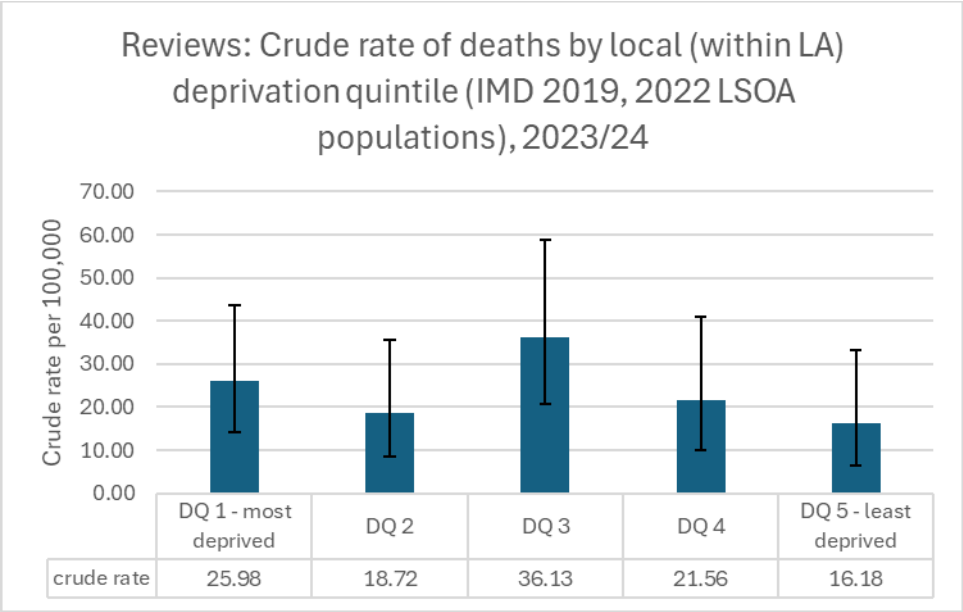


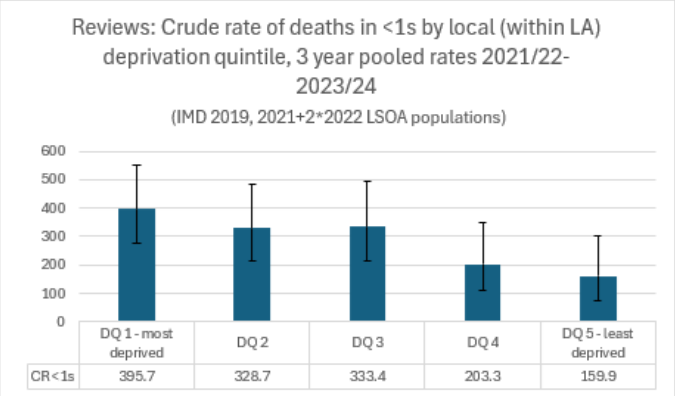


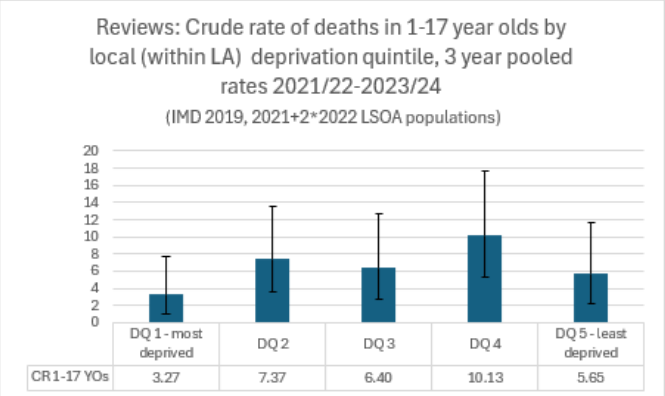
3.4 Local area deprivation of cases reviewed

Figure 21 shows that there was weak evidence of a higher rate of cases reviewed in the median deprivation quintile (DQ 3), but no overall pattern associated with local area deprivation. Supplementary analysis on three years pooled data (2021/22-2023/24) show that amongst children who died aged under 1, there was an association with area deprivation whereby rates were highest in the most deprived quintile, and lowest in the least deprived. Conversely, in children who died between the ages of 1 and 17, rates were highest in the second least deprived quintile, so there was almost an inverse relationship with area deprivation. Small numbers, especially in 1 to 17 year olds should be taken into account when interpreting these results though.

Figures 21, 22 and 23: Deaths reviewed by local area deprivation.

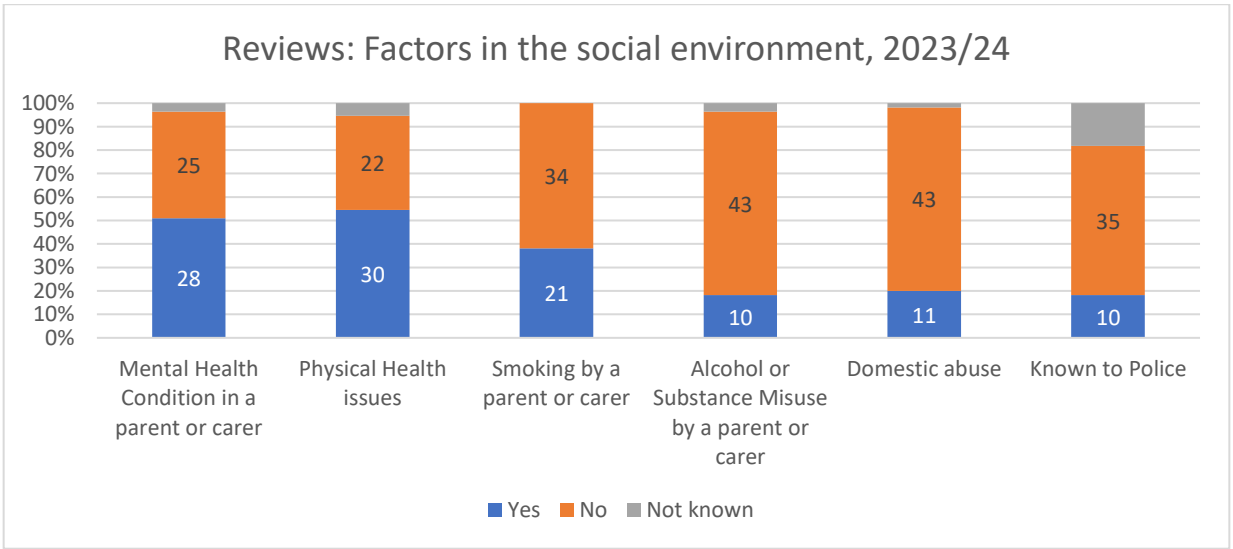






3.5 Social Factors in cases reviewed

Figure 24: Factors in the social environment (including parenting capacity recorded in cases reviewed by CDOP between 1st April 2023 and 31st March 2024)



A mental health condition in a parent or carer is mentioned in 51% of all reviews.

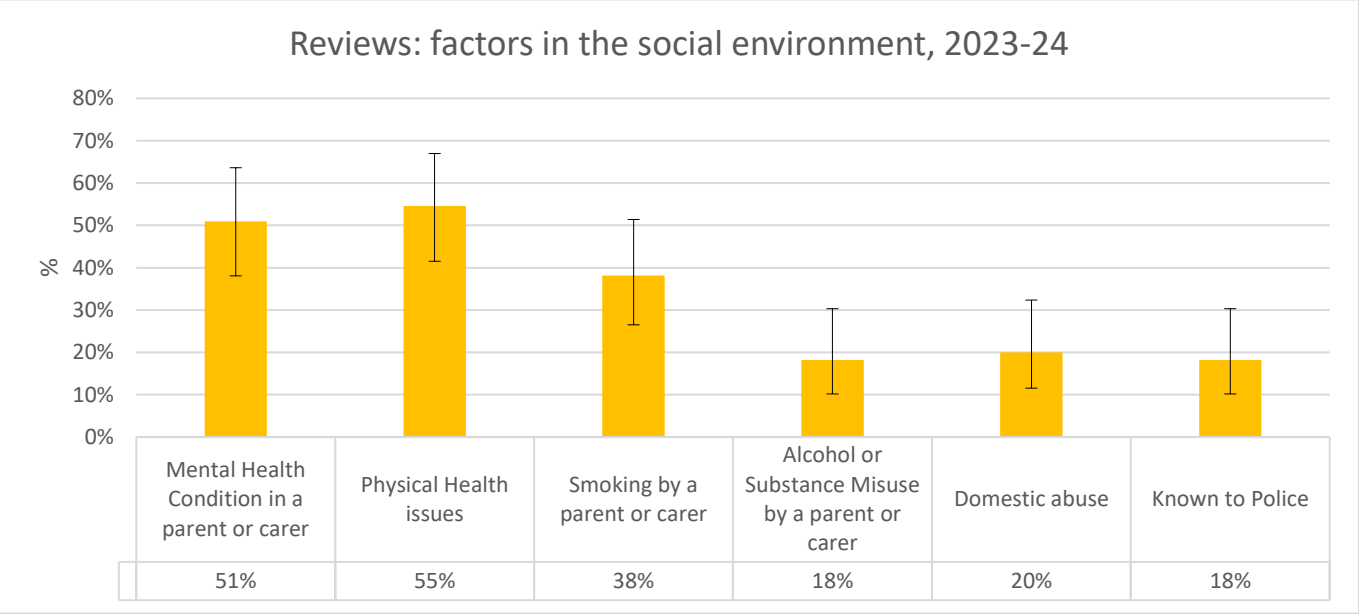
For context, regionally the estimated prevalence of common mental disorders in the population aged 16 and over is 16 %[6].

It is estimated that between 26% and 42% of mothers in England will experience some sort of perinatal mental health condition (OHID), there are no estimates for the mental health of fathers.

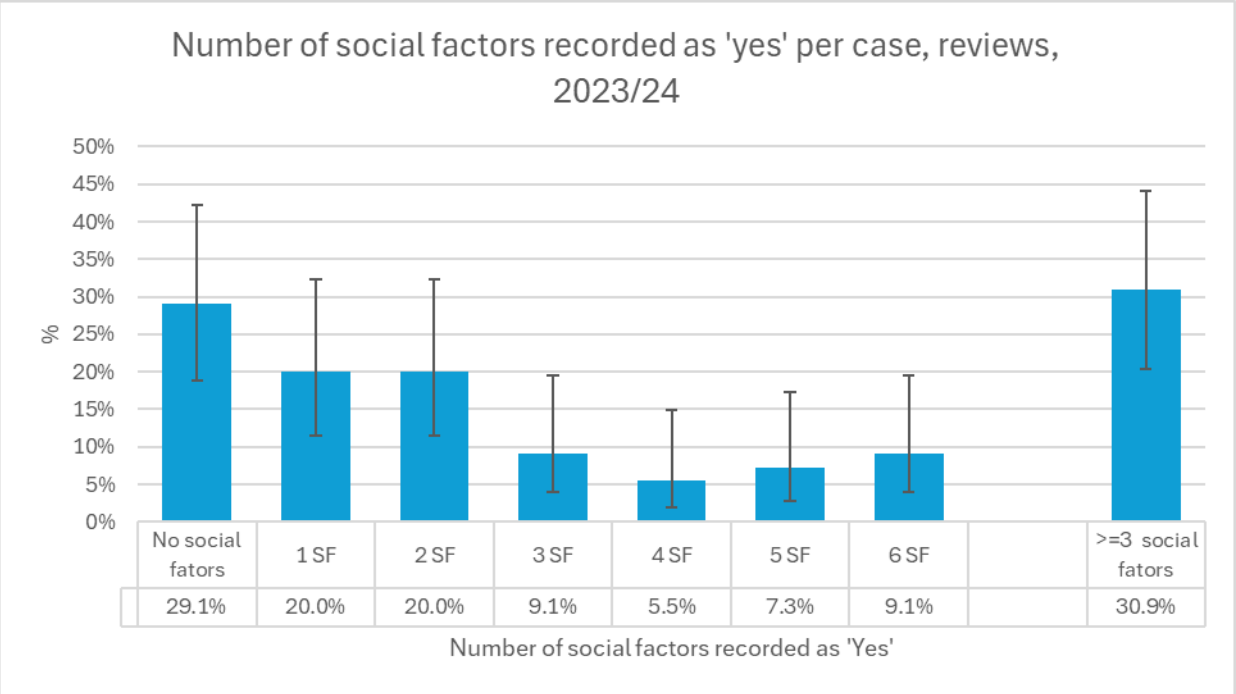
Smoking of a parent is mentioned in 36% of reviews. For context, the South West rate of mothers smoking at time of delivery is around 9.2%. There is no equivalent figure for father or partner smoking or smoking in a child's home more generally, but the smoking prevalence in adults in the South West is 14.7% (QOF 2022/23, taken from OHID fingertips), so smoking prevalence in the reviews data does appear to be disproportionally high.

Overall, only 29% of deaths reviewed had no notable factors related to the social environment recorded, whereas 31% had three or more social factors noted, and 9% had all 6 social factors noted in their records.

Figure 25 and 26: Factors in the social environment in cases reviewed 2023-24



[6] Common Mental Health Disorders - OHID (phe.org.uk)



3.6 Modifiability of category of death

Modifiable factors are defined as one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths. An example of a modifiable factor might be a death resulting from a vaccine preventable infection where the vaccine had not been given to the child.

Of cases reviewed by the West of England CDOP in this twelve-month period 2023-24 modifiable factors were identified in 36% of cases. Nationally 43% of child deaths were assessed as having modifiable factors in the same time period.

Figure 27: Modifiability of cases reviewed by CDOP between 1st April 2023 and 31st March 2024

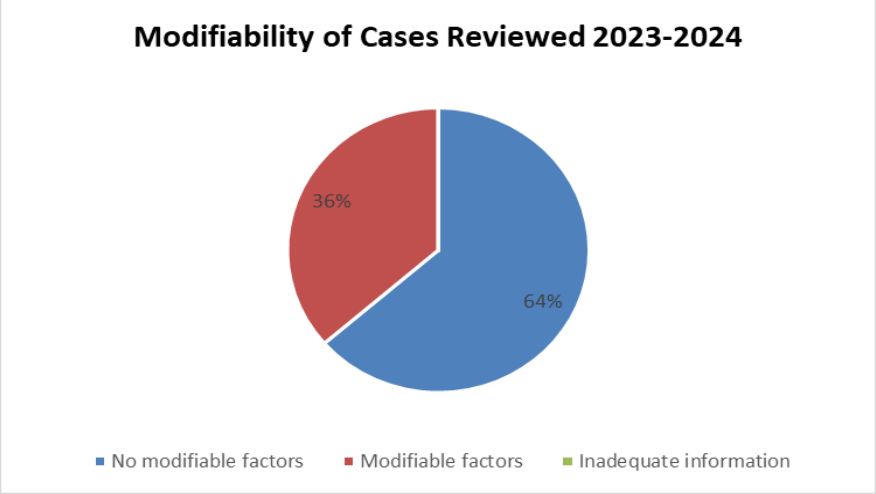


Table 6: NCMD Reviewed Cases Modifiability by Category of Death 2022-2023

Primary Category of Death	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Trauma and other external factors, including medical/surgical complications/error	3	1	33%
Suicide or deliberate self-inflicted harm	3	2	67%
Sudden unexpected, unexplained death	2	2	100%
Perinatal/neonatal event	13	7	54%
Malignancy	3	0	0%
Infection	3	1	050%
Deliberately inflicted injury, abuse or neglect	2	2	100%
Chronic medical condition	0	0	0%
Chromosomal, genetic and congenital anomalies	22	3	14%
Acute medical or surgical condition	5	2	40%
Totals:	**55**	**20**	**36%**

3.7 Family follow up

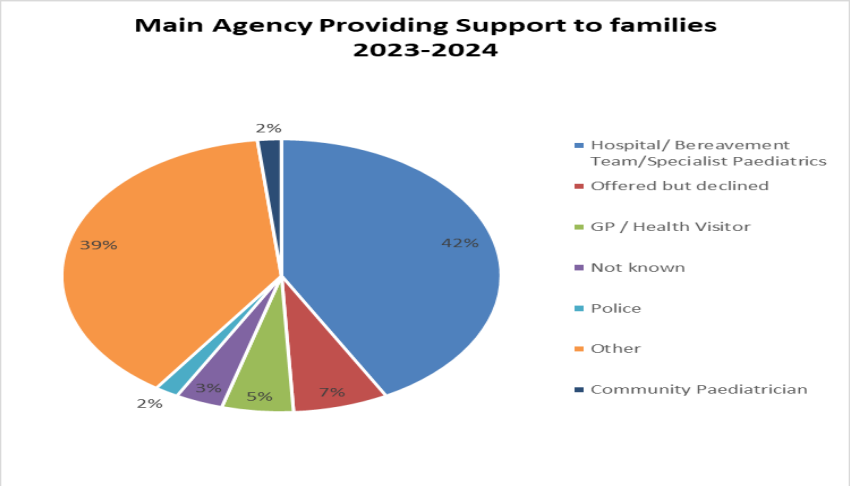
Active engagement with bereaved parents underpins the entire child death review process. Parental input into the child death review meeting should occur as a matter of course. Parents are invited to submit questions to the local child death review meeting, and feedback by the lead health professional on all aspects of this meeting is then given at a follow-up appointment with the family.

Figure 28 shows which was the main agency that offered follow-up for cases reviewed by CDOP between 1st April 2023 and 31st March 2024. Families may have been offered follow-up by more than one agency following their child's death. The offer of follow-up remains open to families; however, some families may choose not to take-up this offer for months or sometimes years depending on their specific need.

In addition, families are routinely given national and local information on charities offering bereavement support & counselling.

A bereavement pathway has been developed within University Hospitals Bristol and Weston NHS Foundation Trust and the team have offered support to all families of children who have been seen at the Bristol Children's Hospital since the team was set up, and now extend this offer to the families of children and young people even when death is confirmed outside the hospital. There are also Bereavement teams in NICU at Southmead and St Michaels. Case reviews undertaken by CDOP in 2023-24 have provided evidence that families are consistently offered this support and it is welcomed by many.

Figure 28: Main Agency providing follow up to families in cases reviewed by CDOP between 1st April 2022 and 31st March 2023
The main Agency providing bereavement support to families was the Hospital and other various Agencies which include Hospices and Community Services. A small number of families declined support. (4) In some cases, support was accepted from more than one source.



4. Child Death Overview Panel Activity

4.1 Actions arising from CDR/CDOP review of individual cases

The key purpose of a robust child death review process is to enable effective learning from individual deaths and trends and thematic reviews.

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

Effective governance procedures within organisations should ensure that significant factors are identified and managed through the local child death review meeting. The CDOP also reviewed many cases where good practice had been identified.

To ensure that issues identified at CDOP were rapidly disseminated through their constituent agencies, the Safeguarding Partners within the West of England area have CDOP matters as a standing agenda item at their meetings.

In certain cases, the CDOP sought assurance that a particular action arising from a child's death had been addressed.

4.2. Themes emerging from reviewed cases at CDOP during the year April 2023–March 2024

In 2023/24 there were 3 Neonatal themed meetings. There were no other specific themed CDOP meetings.

The following learning themes have arisen from CDOP review of one of more cases:

Unbooked pregnancies

This covers a number of reasons including 'concealed', unrecognised and undisclosed pregnancies.

Whilst women are not legally obliged to accept any care during pregnancy or childbirth the importance of working with agencies to identify and support women to engage with antenatal services was noted, especially for women whose first language is not English.

There is an awareness of free birthing (unassisted birthing) in small numbers nationally and in the West of England.

The national NHS 111 pathway for abdominal pain has now been amended to include a question about pregnancy for all women of child bearing age early on within the algorithm so that opportunities for identifying pregnancy are maximised.

British Association of Perinatal Medicine toolkit

Good practice was noted applying this to support decision making for parents and professionals at the extremes of viability.

CDOP also note the additional cot capacity required for NICU's which is largely without additional resourcing.

Snowdrops Bereavement Team

The new Snowdrops Bereavement Team at St Michael's Hospital has been noted to provide valuable support, also noting that their neonatal service is only available for babies dying up to 2 weeks of age.

Head circumference measurement in babies

There was significant discussion about current commissioning of Health Visitors in line with NICE Guidance, and the need to maintain awareness and skills for head circumference measurement and plotting, especially in the context of any other health issues and concerns. What, When and How to Measure (rcpch.ac.uk)

Palliative Care Provision

The lack of specialist Paediatric Palliative Care in the tertiary hospital outside working hours was noted, to the detriment of specific children's care.

Considered decision-making in complex disability

CDOP noted the careful decision-making between professionals and parents not to continue with deep suction and NIV which was felt to be distressing to a child. There is a Structured Decision-making tool for starting and discontinuing NIV which is being introduced for future cases.

https://adc.bmj.com/content/107/Suppl_2/A34

First seizure pathway

The local service was not meeting NICE guidelines of offering an appointment within 2 weeks of a first seizure to see a Paediatrician with special interest in epilepsy. Since then, there have been new Consultant appointments, and this standard should be met.

Children with a tracheostomy

CDOP noted that parents should be warned of the around 1% annual risk of blockage.

Safe sleeping

Sleep environments should be appropriate to the developmental abilities of a child. A Moses basket with handles is not suitable for a child who can move around even if young or lower in weight. NCMD are liaising with the Office for Product Safety and Standards (OPSS) and the National Home Safety committee about Moses basket safety.

An enclosed bed may increase the risk of overheating.

There is a need for raised awareness of sleeping in car seats for young babies. Health Visitors sign post to online information on their website which will include the recommended Lullaby Trust fact sheet Car seats and SIDS - The Lullaby Trust.

For baby slings, the Lullaby Trust and RoSPA signpost to the 'T.I.C.K.S. rule' noting this is not evidence based although the best advice available. Health visitors have annual updates and records when sling safety has been discussed. NCMD have been in discussions with the Office for Product Safety and Standards, and it is important to find out details of specific carriers involved in any child deaths and whether new or second hand so that more information can be gathered about safety.

CDOP noted the need to reiterate safe sleeping advice beyond the 8 week check.

Health visitor representation on CDOP has started this year following a number of discussions regarding Safe Sleeping and other aspects of HV led monitoring and safety advice.

The NCMD report, to which our previous CDOP reviews have contributed, was noted https://www.ncmd.info/publications/infants-sudden-unexplained-death/

Suicide

Poor school attendance or 'not in education, employment or training' (NEET) is a risk factor. NCMD thematic Suicide Report https://www.ncmd.info/publications/child-suicide-report/ identified a higher proportion of children or young people who had taken their lives had experienced regular non-attendance.

Adult and Child Mental Health Services need to be better integrated and able to share information proactively to protect family members.

CDOP noted the need to share news with school and school communities in the best way, while acknowledging that news often reaches agencies more quickly via social media.

It is important to ensure that young people know 'What to do if you are worried about a friend'.

Fathers

CDOP again noted the importance of working with fathers, ensuring they have the same safe sleeping, ICON and other safety information when they are involved in caring for babies. CDOP shared resources developed in South Gloucestershire to support Working with Fathers | SafeguardingSouth Gloucestershire Safeguarding (southglos.gov.uk)

Post Mortem results

It is important to work with the coroner to ensure the opportunity for parents to receive results from a health professional.

Departmental Workload

When Serious Incident case reviews are undertaken in West of England hospitals Central Delivery Suite workload is considered for its potential to contribute to individual care. This is being monitored by CDOP.

Training
Case histories have been used in local staff training, such as Fetal monitoring.

Maternal obesity
CDOP noted the link to poorer outcomes and some congenital deformities. CDOP raised local changes in Weight Management Services in pregnancy to system partners including Directors of Public Health.

5. Achievements

The Bristol, North Somerset and South Gloucestershire and Bath and North East Somerset, Swindon and Wiltshire Integrated Care Boards continued to lead the CDOP Strategic quarterly meeting of Child Death Review partners. Key Performance Indicators have now been agreed and reported on, in order to monitor the providers of the CDR process. One of these is around return rates of eCDOP Reporting forms which are low from some professionals and the CDR team continue to offer support but also to escalate when this contributes to a poorer quality of review.

The revisions in Working Together 2023 have been noted by the CDR partners.

The previous nhs.net email address for the Child Death office hosted in the local NHS Trust was successfully migrated from UHBW to be hosted by the Integrated Care Board - this helps to keep the Child Death Enquiries Office independent of service provision.

Biannual Child Death peer review meetings were held for all professionals involved in Joint Agency responses. This includes educational update, such as promoting the new pathway for Genetic testing (Whole Genome Sequencing R441 panel) following a SUDI if no cause of death is found at postmortem.

The annual report was again presented at a virtual event in Oct 2023 which was very well attended, with a range of questions and challenges voiced.

Child Death guidelines for professionals working in our area are being updated, in line with a new local guideline platform in the acute hospital.

A business case for a pilot CDR Nurse post raised significant interest but could not be submitted due to failure to identify a health organisation to host this post at the current time.

CDOP continue to take seriously their remit to monitor trends in child deaths and proactively flag any concerns. As well as through individual reviews, this is achieved through scrutiny of NCMD quarterly data releases for local area.

Observers at CDOP have included Chairs from other areas, who have commented favourably about the meeting structure and quality of scrutiny.

Having a lay rep on the Panel continues to be greatly appreciated and other CDOPs have asked advice about setting up this arrangement.

The Designated Doctor sits on the Executive of the Association of Child Death Review Professionals (as SW representative) ensuring benchmarking local arrangements against national good practice.

6. Future Priorities

A public health led impact evaluation of CDOP is planned. This annual report will be presented in October 2024 and plans are for a BNSSG CDOP Conference learning event in 2025.

Following negotiations with all involved, Bath and North East Somerset left the West of England CDOP at the end of 31st March 2024. A new title of Bristol, North Somerset and South Gloucestershire CDOP has been agreed to describe the geographical covered which now aligns with Bristol, North Somerset and South Gloucestershire Integrated Care Board.

7. Appendix A - CDOP membership April 2023 to March 2024

Role	Core member	Organisation
Nominated Chair	Sarah Weld from August 2022	Director of Public Health South Gloucestershire.
Designated Doctor for Children's Deaths	Dr Mary Gainsborough	Sirona Care & Health on behalf of ICBs
Consultant Neonatologist	Dr Ziju Elanjikal / Dr Claire Rose	University Hospitals Bristol and Weston NHS Trust/North Bristol NHS Trust
Coroner's Officer	Debra Neil	Avon Coroner's Office
Children's Social Care	Emma Collings	Strategic Safeguarding Service Manager, South Gloucestershire Council
Designated Nurse Safeguarding Children Deputy Designated Nurse for All Age Safeguarding	Toyah Carty-Moore Louise Field	BNSSG BSW ICB
Midwifery Ward Manager	Sara Arnold	Midwifery Ward Manager, University Hospitals Bristol and Weston NHS Trust
Consultant Obstetrician	Dr Rachna Bahl	University Hospitals Bristol and Weston NHS Trust
General Practitioner	Dr Patrick Nearney and Dr Elaine Lunts	Bristol
Police	Detective Inspector Louise Caitlin	Avon & Somerset Constabulary
Paediatric Palliative Care Team	Catherine Osborn	University Hospitals Bristol and Weston NHS Trust
Consultant Paediatric Intensivist	Dr Alvin Schadenberg	University Hospitals Bristol and Weston NHS Trust
Consultant, Paediatric Emergency Medicine	Dr Nick Sargant and Bianca Cuellar	University Hospitals Bristol and Weston NHS Trust
Consultant Community Paediatrician / Designated Doctor for Safeguarding	Dr Fiona Finlay & Dr Caroline Furnell	Bath & North East Somerset Locality of NHS Bath & North East Somerset BANES
Safeguarding Specialist and Lead for Child Deaths	Chris Rogers	South Western Ambulance Service NHS Foundation Trust
Lay Representative	Julie Kembrey	Bereaved Parent and Ambassador for Jessie May Trust with an interest in Bereavement Services.