# Gloucestershire Child Death Overview Panel (CDOP)

## Annual Report for Child Death Reviews
## Gloucestershire Safeguarding Children Board (GSCB)

## 1st April 2014 – 31st March 2015

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**This report is provided to professionals working in the field of safeguarding children. As such, if this report is further distributed, it should only be forwarded to persons that it is appropriate to do so, given the nature of its contents.**

**July 2015**

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## Introduction

We are fortunate that a child death is a rare event in our society, however, each death represents a tragedy for the family and the purpose of the Child Death Review process (CDR) is to identify potentially modifiable factors[1] which may prevent future deaths from occurring. The CDR process is also able to identify local and regional trends to inform the work of Commissioners, Providers and other relevant organisations. For example in the case of children with life-limiting conditions the CDR process is able to consider whether these children were in receipt of appropriate care during their life and had access to appropriate support services at the end of life. Where the CDR process identifies learning this is fed back to the relevant agencies by the Child Death Overview Panel on behalf of the Local Safeguarding Children Board (LSCB) in Gloucestershire.

At the beginning of the CDR process in 2008 the Gloucestershire Child Death Overview Panel (CDOP) was established in line with guidance set out in *Working Together to Safeguard Children*. This CDOP continues to review the deaths of all children resident in this area. Some of these deaths may occur outside of the region and these will also be reviewed by this panel.

## Background to the Child Death Review Process

Chapter 5 of "Working Together to Safeguard Children" (2013) provides the framework for processes to review all child deaths. Under statutory national guidance LSCBs are required to establish a procedure to respond rapidly in the event of an unexpected death of any child under 18 years of age. In Gloucestershire a joint police and health rota is staffed during office hours (Monday to Friday 9am to 5pm). Outside of these hours an initial safeguarding discussion occurs at the time of death between police, social care, health and the Coroner's Officer. On the next working day a formal initial case discussion (rapid response) is undertaken. This involves statutory agencies and all professionals involved with the child. LSCBs are also required to ensure there is a Child Death Overview Panel (CDOP) process. The two are separate processes, but are closely linked. The Rapid Response process ensures early notification of the unexpected death of a child and a prompt process of investigation. The CDOP process ensures that every child's death is comprehensively reviewed and lessons learnt so that action can be taken to prevent future deaths where possible.

## The Child Death Review Process

A child's death is reviewed by CDOP after a range of standard information has been collected using statutory forms and the case has been discussed by professionals involved in the child's life at a final case discussion (FCD) meeting. Following the FCD meeting a detailed compilation of data from the statutory forms (Form Bs) and outcomes of the FCD meeting (Form C) is produced and anonymised by the Child Death Enquiries Office at the University of Bristol for presentation to CDOP. CDOP reviews each case with the aim of identifying modifiable factors and highlights any learning identified. The CDOP panel aims to identify those factors in the course of a child's life, and leading to the child's death, which might have directly led to the child's death or increased their vulnerability, and which might have been amenable to modification. It also makes recommendations which may prevent similar deaths occurring in the future. However it may also make recommendations related to service improvement, where changes in practice could lead to improved experiences for children and young people at the end of life or during the course of their treatment.

## Production of this report

The 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 LSCBs. This annual report has been produced using data collected by the University of Bristol through the Child Death

[1] A modifiable death is defined as one where there are factors which may have contributed to the death which, by means of nationally or locally achievable interventions, could be modified to reduce the risks of future child deaths.

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Enquiries Office. Information collected at the point of notification of death is entered onto a **Notification Database**. Information collected from statutory forms, final case discussion meetings and CDOP reviews is entered onto a separate **CDOP Database**. The eventual CDOP multi-agency dataset is extremely comprehensive. This year the annual report includes five years of data to help reduce year on year variations associated with rare events such as a child death. This allows better identification of longer term trends or key themes which may not have been as apparent within a single year of data.

## Notifications of child deaths

### Summary Data (2010 – 2015)

This section summarises all the deaths notified to the Child Death Enquiries Office between 1st April 2010 and 31st March 2015, of children resident in the Gloucestershire area. This data is drawn from the notification database.

### Analysis of notifications by year (2010-2015)

During the period 2010-2015, 184 child deaths were notified. Year on year variation in notifications is to be expected (as shown in Table 1) and with rare events such as a child death, small variations can appear to represent a big difference. However because the number of notifications for one area of residence are so small the most likely explanation for any patterns is random year-on year variation. Nationally, the year ending March 2014 showed a year on year decrease in child death reviews from the year ending March 31 2011.

**Table 1: Numbers of deaths notified by year 2010 to 2015 in Gloucestershire**

| | **Number of child deaths notified** | | | | | |
|---|---|---|---|---|---|---|
| | 2010-2011 | 2011-2012 | 2012-2013 | 2013-2014 | 2014-2015 | Totals |
| **Gloucestershire** | 37 | 31 | 44 | 26 | 46 | 184 |

### Duration of reviews

There is an inevitable time-lag (4-12 months) between notification of a child's death and discussion at CDOP**.** There are various factors that contribute to this: the return of Form B's from professionals, the completion of the final post mortem 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 Serious Case Review will also affect when a case is discussed at Panel. See Appendix A for a full breakdown of duration of reviews by year.

### Age at death

Using five year data, the greatest proportion of notifications (40%) were received for babies dying in the neonatal period (under one month of age), especially in the first week after birth (33%). This figure increases to 64% when all deaths under one year are included, similar to 66% observed nationally[2].

[2] Department for Education. Child Death Reviews – Year Ending March 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332619/SFR21_2014_revised.pdf



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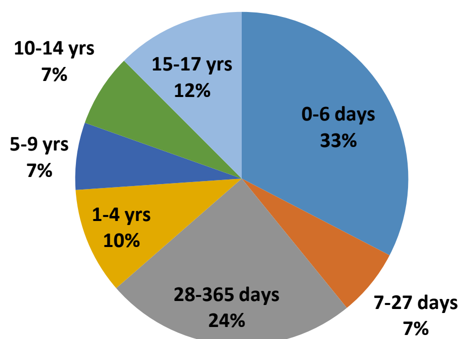
**Figure 1: Notifications by Age, 2010 - 2015**

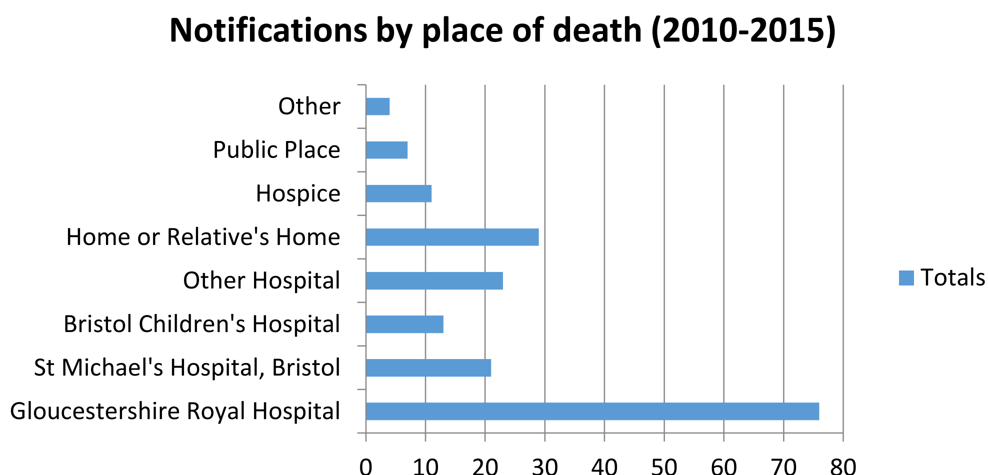



## Location of death

This data records where the child actually died. Many children resident in Gloucestershire may be transferred to tertiary hospitals in other regions for treatment. A number of these children go on to die in those locations as can be seen in Figure 2 below. The figures in this section represent the total number of deaths at each location during the five year period. A total of 133 deaths (72%) occurred in a hospital setting. This is slightly higher than the national figure of 68%. About 6% of deaths occurred in a hospice, much higher than the 3% nationally. This is felt to be due to the very proactive work of the hospice that provides services for children in Gloucestershire and their high level of engagement with professionals, children and their families. 3.8% of the deaths were in public places, which is in line with national figure of 4%[3].

Children resident in Gloucestershire are treated in many different hospitals. This reflects the wide geographical area covered by Gloucestershire and the number of counties in which residents receive healthcare services including Bristol, Oxfordshire, Swindon and Birmingham and their willingness to contribute to the process. This can present particular issues for Gloucestershire for the timely and complete collation of information for the review of children's deaths due to the wide range of organisations that must be engaged.

**Figure 2: Notifications by Place of Death, 2010 - 2015**




[3] Department for Education. Child Death Reviews – Year Ending March 2014

The most common location of death is in hospital, where 133 children died (72.2%). In total 29 (15.8%) children died at home or at a relative's home in the five year period. This can include both expected deaths where a child has received palliative care support at home and unexpected deaths that happened within the home setting. 24% (14/58) of unexpected deaths happened within the home setting.

### Gender

There have been more notifications of deaths in boys than in girls as can be seen in the table below. In total 56.5% of deaths were male and 43.5% were female. This is in line with national trends for childhood deaths which also show slightly higher proportions of deaths registered in England were for male children[4].

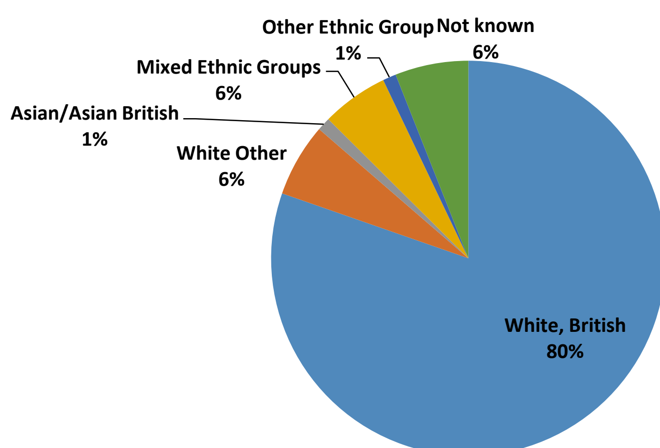
**Table 2: Numbers of deaths notified between 1st April 2010 and 31st March 2015 by gender**

| | Male | Female |
|---|---|---|
| **Gloucestershire** | 104 | 80 |

### Ethnicity

Figure 3 shows that the majority of deaths for Gloucestershire are children of White British ethnic origin. The 2011 Census showed Gloucestershire's residents to be 91.6% White British, 3.1% White Other, 2.2% Asian, 0.9% Black, 1.5% Mixed and 0.2% Other. Though Figure 3 shows that ethnicity was unknown in 6% of cases, there may be over-representation of children from Mixed Ethnic and White Other groups. With increasing migration from East European countries into the county from 2004, the White Other population in the county more than doubled between 2001 and 2011.

**Figure 3: Notifications by Ethnic Groups, 2010 - 2015**




### Unexpected and Expected Deaths

An unexpected death is defined as the death of a child which was not anticipated as a significant possibility 24 hours before the death or, where there was a similarly unexpected collapse or incident leading to or precipitating the events that led to the death. During the five year period 58 deaths (31.5%) were unexpected. The remaining 126 were expected deaths of children with known illnesses or life-limiting conditions.

[4] Department for Education, Statistical Release - Child Death Reviews: Year ending March 2014



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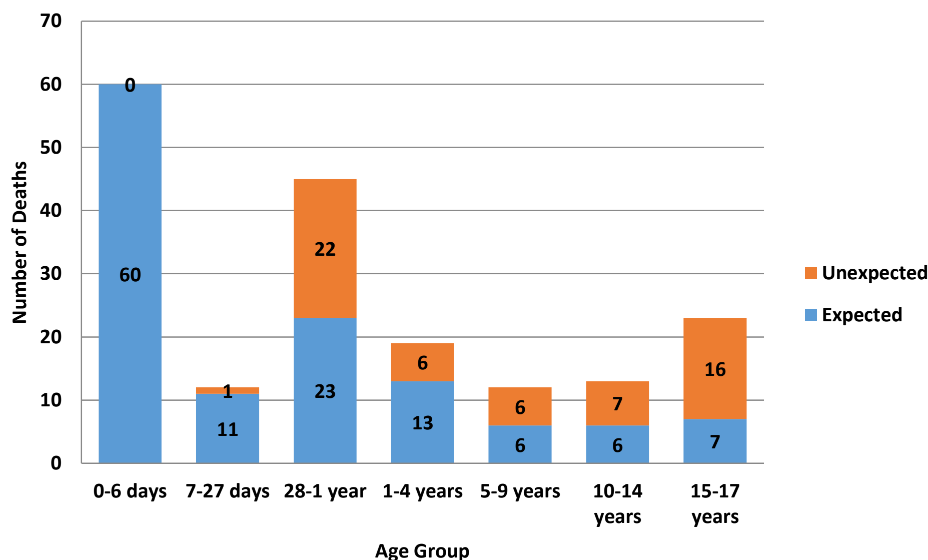
Figure 4 presents data on expected versus unexpected deaths for 2010-15 by age group. This data show that the highest numbers of unexpected deaths occur in the 28-364 day and the 15-17 year age groups, whilst all deaths within the first week of life were expected. Between 28 days and one year of age, expected and unexpected deaths were of equal proportions. Within this age group, the expected deaths would usually be a baby that dies following complications of a premature delivery or of a known chromosomal, genetic or congenital anomaly and the unexpected deaths would include sudden unexpected deaths in infancy and infection.

**Figure 4: Expected vs. Unexpected Deaths by Age, 2010 - 2015**

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## Child Death Overview Panel Review Data

This data is drawn from the CDOP database. They summarise the panel's review decisions for 2010-2015 and its learning for 2014-2015. There is an inevitable time lag between the notification of a child's death and the discussion at CDOP. There are various factors that contribute to this including return of statutory paperwork by professionals, receipt of the final post mortem report and receipt of the report from the final case discussion meeting. The Gloucestershire CDOP took the decision in 2009 to wait for the inquest verdict in child deaths that involve the Coroner. In these cases there may be a delay of over a year before a case might be brought for review by CDOP. The undertaking of a criminal investigation or a Serious Case Review can also affect when a case is discussed at panel. In addition, certain children who have been under the care of specialist regional paediatric teams (e.g. cardiology) will be reviewed at a specialist themed CDOP for the region before coming to Gloucestershire CDOP for final review, to ensure that the relevant expertise is present when identifying learning from these cases.

**For these reasons the population of children described in the notifications section (drawn from the Notification Database) may partially overlap but is distinct from the population of children described in this section (drawn from the CDOP Database).**

The Gloucestershire CDOP has reviewed 159 deaths between 1st April 2010 and 31st March 2015. Of the 184 deaths notified between 1st April 2010 and 31st March 2015, there are currently 74 that have not yet been reviewed by CDOP. See Appendix A for a full breakdown. This backlog is currently being cleared by CDOP through the arrangement of two additional panel meetings in 2015.

During the 2014/15 child death review year the Gloucestershire CDOP panel reviewed a total of 34 deaths. This figure has remained fairly consistent across the previous 3 years, with a slight increase from the number reviewed in 2010/11, as can be seen from the table below.

**Table 3: Number of child deaths reviewed by CDOP, 2010 - 2015**

| | 2010-2011 | 2011-2012 | 2012-2013 | 2013-2014 | 2014-2015 | Totals |
|---|---|---|---|---|---|---|
| Gloucestershire | 24 | 34 | 33 | 34 | 34 | 159 |

## Categorisation of death for cases reviewed by CDOP

As part of the Child Death Review process, each death reviewed by the panel is categorised by the most likely cause of death based on a set of pre-defined categories. The categorisation of deaths for cases reviewed by the panel over the five year period is shown in Figure 5 below. This shows that the most common categorisation is perinatal / neonatal event (43%) followed by chromosomal, genetic and congenital anomalies (16%). The other categories are much less common.

**Figure 5: Categorisation of Deaths for Children Reviewed by CDOP, 2010 - 2015**

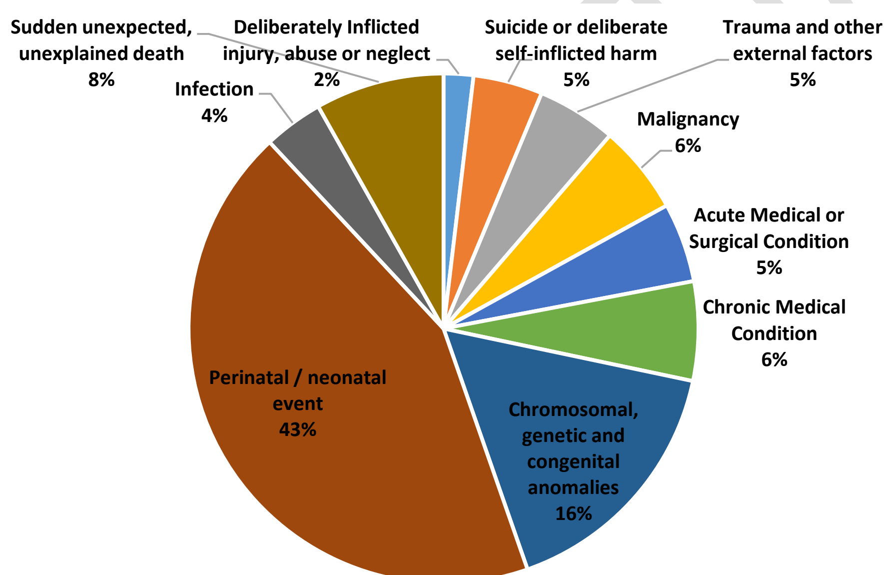
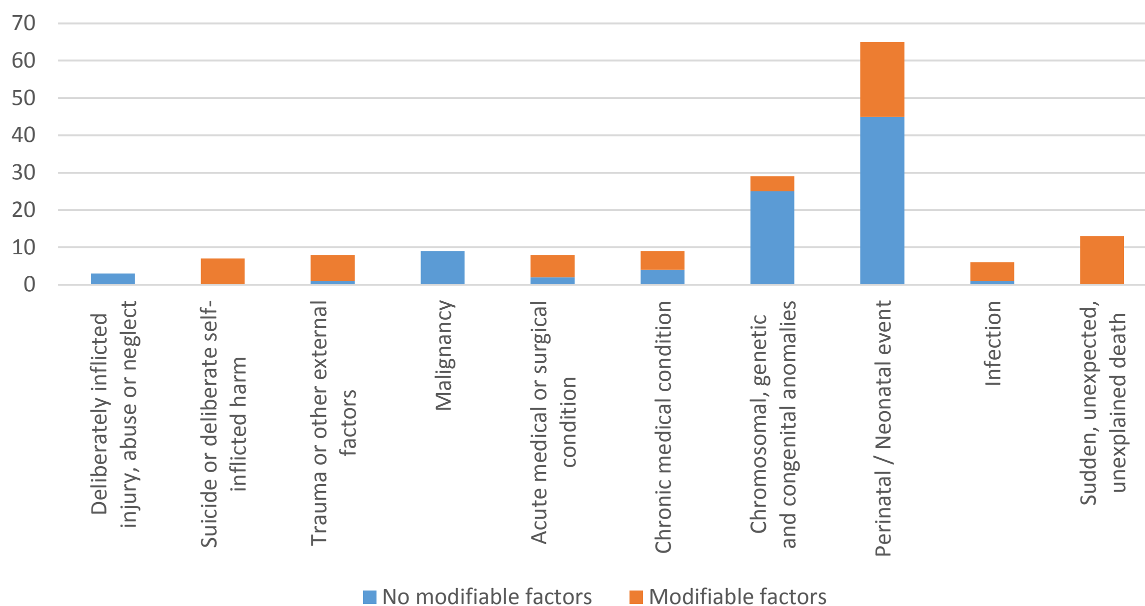


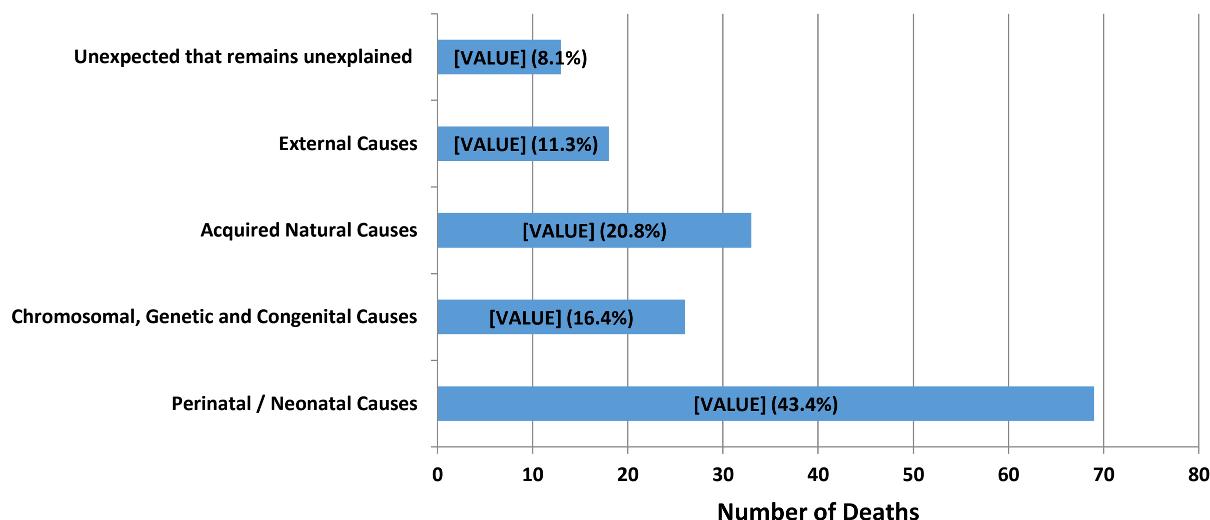

Figure 6, below, shows the proportion of deaths within each category that were considered to have modifiable factors following review by CDOP. This shows that the categories that represent unexpected deaths, e.g. suicide or deliberate self-inflicted harm, trauma and other external factors and sudden, unexpected, unexplained death, have the highest proportion of modifiable factors associated with them. This is as expected and is in line with the national picture. Perinatal or neonatal event, malignancy and chromosomal, genetic and congenital anomalies have the lowest proportion of modifiable factors associated with them, this is also in line with the national picture.

**Figure 6: Modifiable factors by category of death, 2010-2015**




The same data can be grouped into the categories below. This shows that perinatal/neonatal causes remain the largest category, followed by 'Acquired natural causes', which groups together malignancy, acute medical or surgical conditions and infection. 'External causes' groups deliberately inflicted injury, suicide, trauma and other external factors. The smallest group are those unexpected deaths that remain unexplained following a full investigation and final case discussion meeting.

**Figure 7: Causes of Death of Cases Reviewed by CDOP, 2010 - 2015**




## Co-morbidities

As well as categorising the cause of death CDOP considers information on co-morbidities in children who die. These are underlying conditions which, while not considered to be the direct cause of death, are thought to have potentially contributed to vulnerability in the child, for example by making treatment more complex or contributing additional challenges to a child living a full and active life. It should be noted however that the existence of a co-morbidity does not necessarily have an impact on the circumstances that led to a child’s death.

The CDOP grading system grades factors identified with a 1 if they are notable but not felt to have contributed to the ill-health or vulnerability of the child, with a 2 if they may have contributed to the ill-health, vulnerability or death of the child and with a 3 if they are felt to provide a complete and sufficient explanation of the death of the child.

Figure 8 shows that 111 children (69.8%) reviewed by CDOP had no co-morbidities at all. Of the remaining children reviewed 19 (11.9%) had just one co-morbidity and 29 (18.2%) had more than one co-morbidity. The chart reflects the number of children reviewed that had each particular co-morbidity and how significant the panel felt that co-morbidity was, using the grading system described above.

**Figure 8: Co-morbidities of Children Reviewed by CDOP, 2010 - 2015**

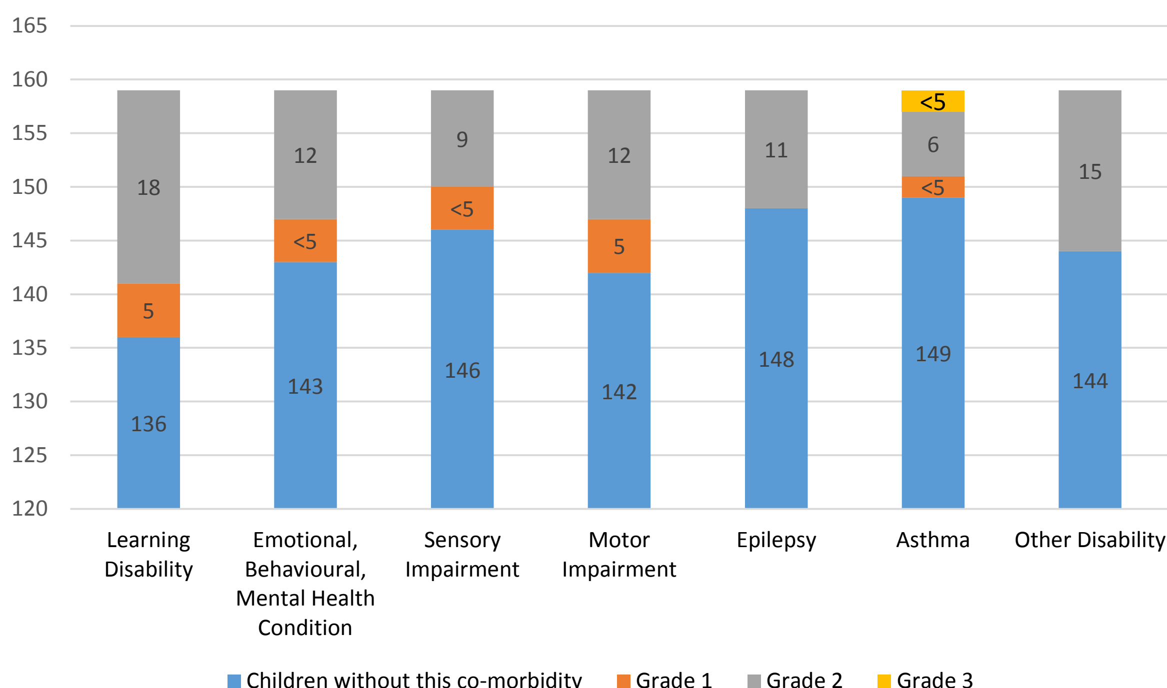



Figure 8 shows that the co-morbidities found to have a significant impact on vulnerability are learning disability, motor impairment and emotional, behavioural and mental health conditions. Children with a learning disability represent the most common co-morbidity. 23 children had a diagnosed learning disability and this was considered to be a significant factor in all but 5 cases. Motor impairment is the second most common with 17 children in that cohort. Learning disability and motor impairment are also identified as the most common comorbidities in children reviewed by CDOP panels across the South West.

'Other disability' was the next most common category. An example of a disability included in the 'other' group are children with a diagnosed syndrome such as Edwards Syndrome. The same number of children reviewed had a motor impairment as had an emotional, behavioural or mental health condition.

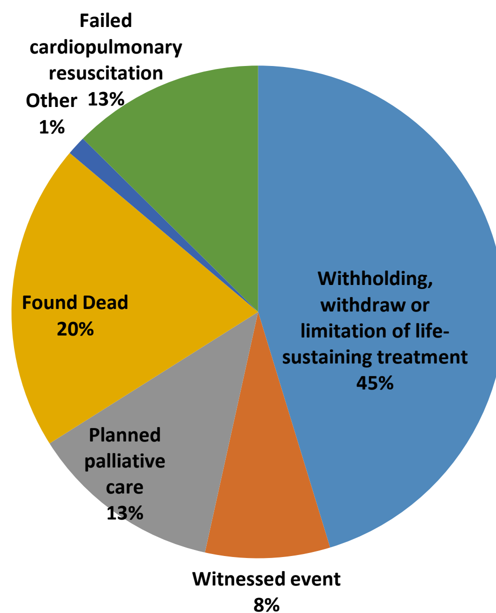
## Mode of death of cases reviewed by CDOP

As can be seen from the pie chart in Figure 9 below, the most common manner of death for Gloucestershire children is withholding, withdrawing or limitation of life-sustaining treatment. This

decision is always made following careful consideration with the child's parents and carers. This is followed by those children who were found dead (20%) and then those children who died following planned palliative care or failed cardio-pulmonary resuscitation (13% each).

Of the children who died following withdrawal of treatment 66/72 (91.6%) were expected deaths, similarly of the children who died following planned palliative care 18/20 (90%) were expected deaths. This reflects the national picture. Of the children who were found dead, the vast majority, 31/32 (97%) were unexpected deaths and of those who died following failed cardio-pulmonary resuscitation, 60% were unexpected. This is similar to other CDOPs in the South West and nationally.

**Figure 9: Modes of Death of Cases Reviewed by CDOP, 2010 - 2015**

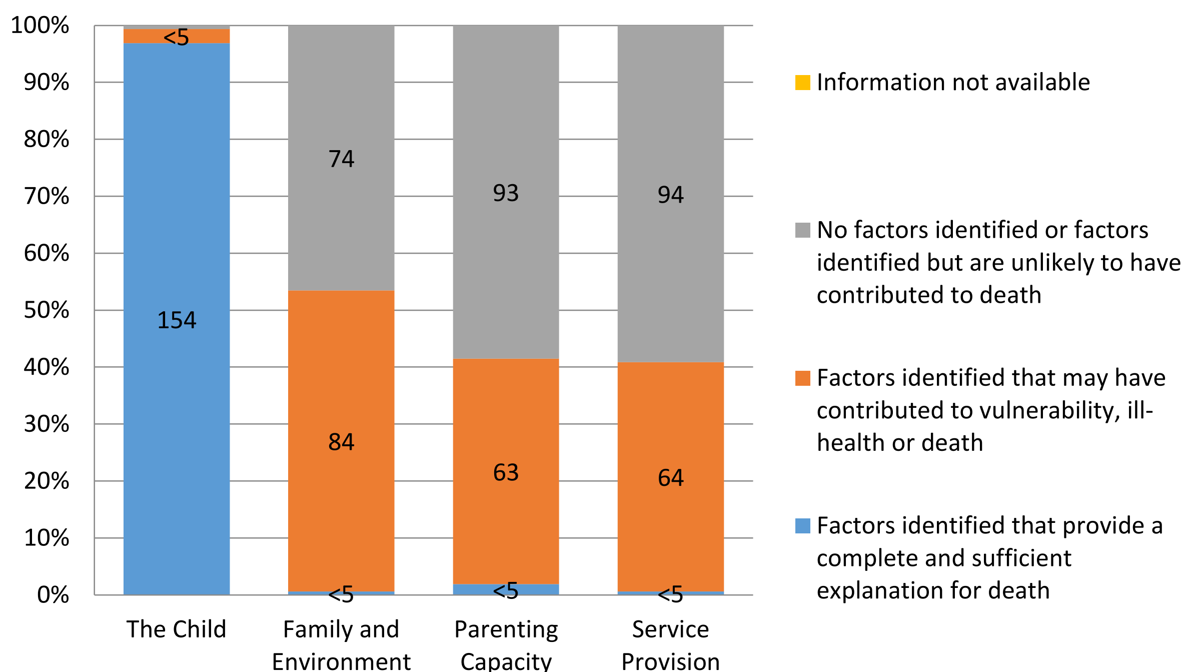



## Factors identified as having contributed to death

Form C of the national dataset requires that the professionals present at the final case discussion meeting identify and 'grade' factors that have contributed to the child's death. CDOP may make additions or amendments to the information recorded on Form C at the final case discussion meeting after full deliberation of the facts. CDOP amended some information in 88% of child deaths reviewed over the five year period. This is consistent with the level of amendments made by other CDOPs in the South West.

In 97% of deaths reviewed factors in the child (i.e. the underlying medical or surgical condition) provided a complete and sufficient explanation of the death.

**Figure 10: Contributory Factors in Cases Reviewed by CDOP, 2010 - 2015**




In 53% of children factors in the family and environment were identified that may have contributed to the vulnerability, ill health or death of the child. These would be factors such as drug or alcohol use by a parent or carer, smoking during pregnancy or a physical or mental health condition in a parent or carer.

In 40% of children factors in the parenting capacity were identified that may have contributed to the vulnerability, ill-health or death of the child. This includes parents who are unable to prioritise the needs of their child e.g. not seeking medical attention appropriately, poor engagement by parents with professionals and lack of attendance at obstetric appointments during pregnancy.

In 40% of children reviewed, factors related to service delivery were identified that may have contributed to the vulnerability, ill-health or death of the child. These included poor communication between agencies, delay in transfer of the child or access to appropriate treatment, no access to translation services for non-English speaking families (particularly in the acute situation) and difficulties accessing appropriate housing for vulnerable families.

In any case where factors are identified at the final case discussion or at CDOP that may have contributed to vulnerability, ill-health or death, the context is carefully reviewed and appropriate actions logged on the Rapid Response Nurse Work Plan to be followed up.

## Additional social factors in the family and environment

The presence or absence of social factors in the family and environment such as mental health issues and drug abuse are routinely collected on the Form B dataset from professionals who have contact with the families. These are summarised on the Form C dataset at the local child death review meeting and carefully reviewed by CDOP. They are shown in the Table 4 below. Please note that these factors are not necessarily considered to be modifiable in every case and may not have been directly contributory to the child's death, rather this data reflects the presence or absence of a social factor within the family or environment.

**Table 4: Factors in the family and environment recorded in cases reviewed by CDOP of children resident in Gloucestershire**

| Factor | Grade 1 | Grade 2 | Grade 3 | Factor known not to be present | Not known if factor present | % of cases where factor considered to be significant |
|---|---|---|---|---|---|---|
| **Emotional, behavioural, mental health condition in a parent or carer** | 17 | 31 | 0 | 97 | 14 | 19.5 |
| **Alcohol or substance misuse by a parent or carer** | 7 | 23 | 0 | 112 | 17 | 14.5 |
| **Smoking by a parent or carer / Smoking by Mum during pregnancy** | 27 | 34 | 0 | 81 | 17 | 21.4 |
| **Housing** | 6 | 11 | 0 | 142 | 0 | 7 |
| **Domestic violence** | 9 | 18 | 0 | 131 | 1 | 11.3 |

Table 4 above shows significant factors to include smoking in parent/carer, emotional, behavioural or mental health condition in parent/carer and alcohol/substance abuse in parent/carer. Domestic violence is also a significant factor in more than one in 10 cases.

### Modifiable Factors – Reducing the Risk of Future Deaths

The focus of the Child Death Review process is to assess modifiable factors in each child's 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". Panels can identify modifiable factors in the child's direct care by any agency, including parents, latent, organisational, systemic or other indirect failure(s) within one or more agency. Therefore a death identified as having modifiable factors may not necessarily be due to a failure of the Local Authority or other agencies to safeguard the child's welfare. 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.

For cases reviewed by CDOP during the five year period, modifiable factors were identified in 42% of cases. In the majority of cases, (90/159) no modifiable factors were identified. In the case of two children reviewed during the period there was inadequate information on which to make a judgment.

In 2014/15 41.2% of cases reviewed identified modifiable factors associated with a child's death. The proportion of deaths where modifiable factors have been identified have generally been higher than the national average (Table 5). South West CDOPs as a whole record a higher level of modifiable factors than anywhere else in the country and this is felt to be due to the high level of scrutiny to which these cases are subject during both the local and CDOP reviews. In addition, around 32% of the overall deaths of children in Gloucestershire are unexpected and these would be the deaths that might be expected to identify modifiable factors. A closer review of the data has not shown any

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particular themes or patterns of death in Gloucestershire children, either in terms of age at death or cause of death.

**Table 5: Percentage of cases where sufficient information was available and modifiable factors were identified, by year of review**

| | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|
| **Gloucestershire** | 33% | 50% | 48.5% | 35.3% | 41.2% |
| **England** | 20% | 20% | 21% | 22% | - |

## Lessons Learnt, Actions Taken and Recommendations as a Result of the Gloucestershire CDOP in 2014/15

### Lessons Learnt

- The majority of child deaths are expected deaths accounting for 68.5% of child deaths in the past 5 years.
- 40% of child deaths occur in the perinatal or neonatal period and 64% occur within the first year of life.
- The most common causes of death in Gloucestershire were perinatal or neonatal event (43%) followed by chromosomal, genetic or congenital anomalies (16%). This is in line with the national picture.
- Deaths from external causes, which includes trauma from external factors or self- inflicted harm and suicide are rare but still accounted for 12% of deaths reviewed in the last 5 years (equivalent to 18 child deaths).
- In the majority of deaths reviewed no modifiable factors are identified. However modifiable factors were identified in 41.2% of cases reviewed by the panel in 2014/15. This is roughly double the national picture.
- Importance of recognition by the Emergency Department that a slow pulse, small pupils and unusual response as well as reduced level of consciousness are all signs of potential cerebral catastrophe
- The need to ensure airway management is a priority for patients with reduced conscious levels, with auditable set parameters for referral to / response by anaesthetists.
- Consideration of guidance on the advisability of use of sedative agents in patients with reduced conscious levels where diagnosis has not been confirmed
- Maximise psychological and emotional support (be this via specific psychologists or other team members) to enable young people and their families to cope with extremely stressful and exhausting treatment
- Importance of midwives being aware of a pregnant mother's previous experience, potential background factors and past history which can predict future events
- Importance of children and young people understanding the need to carry Epipens at all times if they suffer from serious allergies
- Increased teaching and training regarding risk of car seats recommended to midwifery and health visitor service, that children are removed within 1-1.5 hours of being placed in a car seat. Within health organisations areas have been identified where a child can be placed in a safe environment to encourage this practice
- CDOP identified that sub-optimal communication between professionals and mothers whose first language is not English and/or whose cultural background is not British appeared to be a theme in cases reviewed this year.

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## Actions Taken

- CDOP has ensured that  that hospital policy is followed  regarding referral for families following abnormal growth scans
- This year CDOP welcomed representation from the Coroner's Office on to the panel. This has been particularly useful when discussing unexpected deaths and understanding decisions on post-mortem examinations and inquest verdicts.
- CDOP reviewed a number of cases where a Gloucestershire child had died in another region and there had been difficulty in obtaining information from tertiary hospitals to enable full review of the death. This was followed up by a letter to Sir Bruce Keogh highlighting this issue
- CDOP has engaged with the Road Safety Partnership, following review of deaths of children involved in road traffic collisions.
- CDOP has engaged with the GSCB Education Sub-committee on two issues this year. The first was a recommendation that the sub-committee find ways by which the subject of organ donation can be discussed in schools and the second was to request that they review their recommendation of a teacher accompanying a child to ensure this does not delay transfer to hospital
- CDOP identified some housing difficulties for families with children with complex health needs and wrote to the local authority to request a review of local district policies for housing of disabled children to ensure children with complex health needs are prioritised
- Review of cases this year highlighted that there can often be missing or incomplete information available on fathers of children who have died. In addition CDOP felt more detailed information was needed regarding the level of spoken English of parents to allow further discussion of this issue and the support available for families in future cases. In order to better capture this information CDOP has approved the addition of a carefully worded question to Form B and has set up a new process for improving information collection on fathers with the midwifery service. If this process is effective it can then be extended to other agencies.
- Three Gloucestershire children have died abroad over the 5 year period and this year Gloucestershire CDOP lent its support to a letter signed by a number of CDOPs and sent to the Department for Education regarding concerns around children who die abroad. The issue highlighted was the lack of information available on these deaths and the concerns that children may be taken abroad and unlawfully killed or may still be alive abroad and simply not returned to the UK. The letter requested that it should be a legal requirement to notify local British authorities when any British resident dies and is buried abroad to allow formal confirmation of death and to prompt closure or relevant records within the UK.
- The GSCB Chair attended the 18th August 2014 CDOP Panel meeting to learn more about the work of CDOP and to take the opportunity to discuss opportunities for problem solving in terms of the current CDOP workload. As a result a review of the CDOP processes has been carried out and improvements made.
- The Gloucester Child Death Review Process Manager and CDOP Co-ordinator sit on the South West CDOP Network to ensure that learning from Gloucester is disseminated region wide and that learning from other CDOP areas is disseminated in Gloucestershire.
- In June 2014, as part of UK Child Safety Week, CDOP sponsored a campaign to raise awareness of four themes which had been identified through child death reviews. Using leaflets prepared by ROSPA and the Lullaby Trust, a poster and power point presentation was developed. This was sent to all GP practices, Health Trusts, primary schools, children



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centres, childminders, libraries, police and social care offices to be displayed for the whole of Child Safety Week. The aim was to raise awareness in relation to the dangers of nappy sacks, cord blinds, falling heavy objects and safe sleeping. Factors which had contributed to the tragic death of children in Gloucestershire. Following this, two Paediatric Middle Grade Doctors and the Designated Doctor for Safeguarding Children developed a questionnaire and with ethical consent from Gloucestershire Hospitals Trust, they asked patients and family attending Gloucester Royal Hospital to provide feedback as to the poster boards and the impact of the messages which were being relayed. The general consensus approved of the boards and although a lot of the adults consulted were aware of the potential dangers, they had not taken strategies to prevent them. The findings were presented at a public health for children meeting in Dubai and as a poster at the National British Association for Child Health. See Appendix B for more information.

**Recommendations:**

- Ensuring timely review of cases remains a challenge and the current model of meeting delivery should be kept under review over the next 12 months to ensure all members are happy that it is meeting the expectations of the GSCB. The GSCB is asked to support commissioners to identify routes for improving the timeliness of the return of statutory paperwork from professionals as part of the Child Death Review Process.
- Closer monitoring of the ethnicity of children who die to explore any potential over-representation of any group.
- The GSCB is asked to identify funding and administrative support to continue the work of the pilot project reviewing near miss suicides in children. The pilot identified a gap in processes available to adequately review near miss suicides and CDOP remains concerned that important learning from these cases may be missed, including identifying appropriate support for this high risk cohort of vulnerable children
- CDOP has identified a theme this year of lack of access to services for non-English speaking families and recommends that all services review the support available to this group, particularly when presenting with acute medical conditions where treatment decisions need to be made promptly

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# Appendix A: Duration of CDOP reviews by year

| | 2008/09 | | 2009/10 | | 2010/11 | | 2011/12 | | 2012/13 | | 2013/14 | | 2014/15 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total number of notifications** | 43 | | 32 | | 36 | | 31 | | 44 | | 26 | | 46 | |
| **Total number of cases reviewed** | 6 | | 17 | | 24 | | 34 | | 34 | | 35 | | 34 | |
| **Years of Review** | **Number reviewed** | **% reviewed** | **Number reviewed** | **% reviewed** | **Number reviewed** | **% reviewed** | **Number reviewed** | **% reviewed** | **Number reviewed** | **% reviewed** | **Number reviewed** | **% reviewed** | **Number reviewed** | **% reviewed** |
| 2008/09 | 6 | | 17 | | 14 | | 3 | | 3 | | | | | |
| 2009/10 | | | 0 | | 9 | | 16 | | 5 | | 1 | | 1 | |
| 2010/11 | | | | | 1 | | 15 | | 15 | | 4 | | 0 | |
| 2011/12 | | | | | | | 0 | | 11 | | 15 | | 5 | |
| 2012/13 | | | | | | | | | 0 | | 15 | | 25 | |
| 2013/14 | | | | | | | | | | | 0 | | 3 | |
| 2014/15 | | | | | | | | | | | | | 0 | |

- NB: The above details the number of cases awaiting review by CDOP, all cases except those of children who died in the last 6 months have already undergone a final case discussion meeting

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# Appendix B: Abstract: A questionnaire based evaluation of parental safety practices and impact of an accident prevention campaign during UK Child Safety Week 2014

**Lucy Plumb, Bianca Cuellar, Charlene Sampson, Imelda Bennett**


**1. Introduction:**

Unintentional childhood injury is a major public health problem associated with significant mortality. In Gloucestershire there have been a number of fatal accidents related to heavy furniture[17], blind-cords[18] and nappy bags[19] as well as potentially harmful practices such as co-sleeping[20]. Over the last few decades, UK injury prevention programmes have halved the number of childhood accidental deaths. There is evidence that community-based campaigns bring about positive behavioural change and have potential to reduce the number of injuries requiring medical attention.

**2. Purpose:**

Our aim was to explore carer awareness of four specific hazards (nappy sacks, cord blinds, co-sleeping and heavy furniture) linked to paediatric deaths within the region through the use of questionnaires and a standardised educational poster display.

**3. Materials and Methods:**

**Poster campaign:** A standardized safety awareness poster board was designed using approved charity leaflets using local council funding. Six-hundred poster packs were distributed to public centers across the county. **Service evaluation questionnaire:** A questionnaire was offered to carers /parents of children attending the Children's centre of Gloucestershire Royal Hospital during Child Safety Week. It explored their current safety practices as well as thoughts on the usefulness and impact of the poster campaign. The survey was approved by the Trust Research board did not require ethical approval.

**4. Results:**

We obtained 103 questionnaire responses over a five day period, 96% of which were from parents. Almost a quarter of respondents were unaware of accidental deaths relating to nappy sacks, although most (82%) kept sacks out of a child's reach. Of the 57 respondents who had cord blinds at home 26% did not have a safety device attached. Despite prominent national campaigns deterring parents from co-sleeping, 42% of all respondents stated they had slept in the same bed as their children when less than one year old. Two-thirds (67%) of respondents reported secure fixtures in place within their home.

Many parents stated they were aware of the hazards highlighted (average 1-10 scale rating, 8.2), and had found the campaign useful (average 1-10 scale rating, 7.3). The potential to alter current practices however was perceived by carers to be negligible (average 1-10 scale rating, 5.3).

**5. Conclusions:**


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A poster campaign highlighting hazards implicated in local deaths is deemed useful by parents but the perceived impact of changing home safety practices is negligible.  Further work through the use of focus groups and parental communication is required to identify how best to promote safety practices for future campaigns.

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