



Gloucestershire Child Death Overview Panel (CDOP)

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

1st April 2017 – 31st March 2018

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1. 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 factors¹ 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 are also reviewed by this panel.

2. Background to the Child Death Review Process

Chapter 5 of “Working Together to Safeguard Children” (2015) 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, social care and health rota is staffed during office hours (Monday to Friday 9am to 5pm) to provide this response. 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.

3. 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.

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.

4. 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 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. 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.

5. Notifications of child deaths

5.1 Summary Data (2013 – 2018)

This section summarises all the deaths notified to the Child Death Enquiries Office between 1st April 2013 and 31st March 2018, of children resident in the Gloucestershire area. This data is drawn from the notification database.

5.2 Analysis of notifications by year (2013-2018)

During the period 2013-2018, 157 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.

Table 1: Numbers of deaths notified by year 2013 to 2018 in Gloucestershire

	Number of child deaths notified					
	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	Total
Gloucestershire	26	45	19	36	31	157

5.3 Duration of reviews

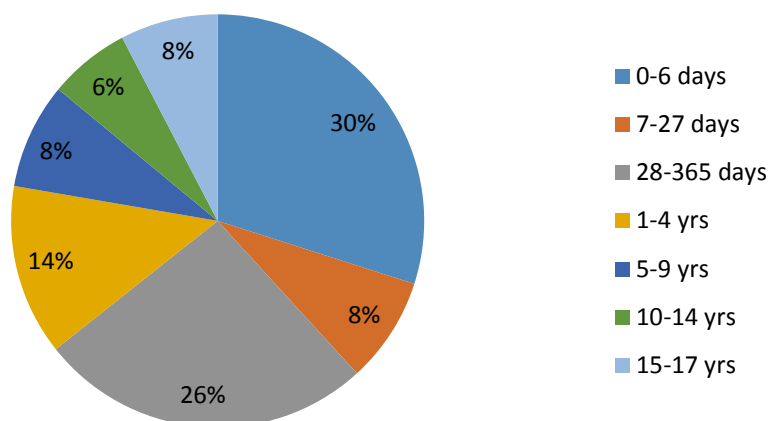
There is an inevitable time-lag (4-12 months) between notification of a child's death and discussion at CDOP. There are various factors that contribute to this: the return of Form Bs from professionals, the completion of the final post mortem report by the pathologist and receipt of the final report from the FCD 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.

5.4 Age at death

Using five year data, the greatest proportion of notifications (38%) were received for babies dying in the neonatal period (under one month of age), especially in the first week after birth (30%). This figure increases to 64% when all deaths under one year are included, this is the same as is observed nationally².

² Department for Education *Child Death Reviews: Year Ending 31 March 2017*, Department for Education, SFR 36/2017, 31st July 2017

Figure 1: Notifications by Age, 2013 - 2018

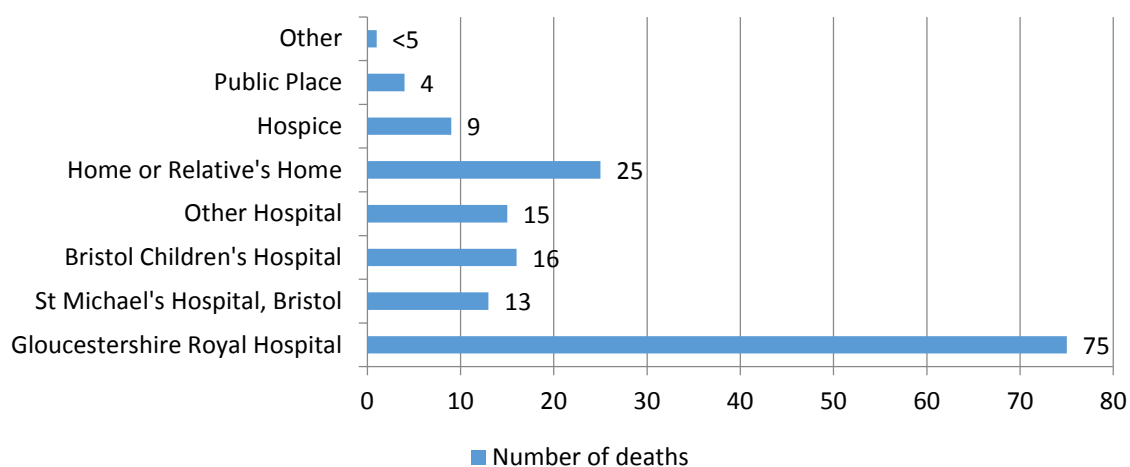


5.5 Location of death – where child was confirmed deceased

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 119 deaths (76%) occurred in a hospital setting. 6% of deaths occurred in a hospice, this is slightly higher than nationally where 4% of children die in a hospice. 2.5% of the deaths were in public places, which is lower than the 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 CDOP 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, 2013 - 2018



³ Department for Education. Child Death Reviews – Year Ending March 2016

In Gloucestershire, Policy recommends that all collapsed children are brought into hospital. In total 25 (16%) 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. 28% (16/56) of unexpected deaths were confirmed deceased within the home setting.

5.6 Gender

There have been more notifications of deaths in boys than in girls as can be seen in the table below. In total 51.5% of deaths were male and 48.5% 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 children⁴.

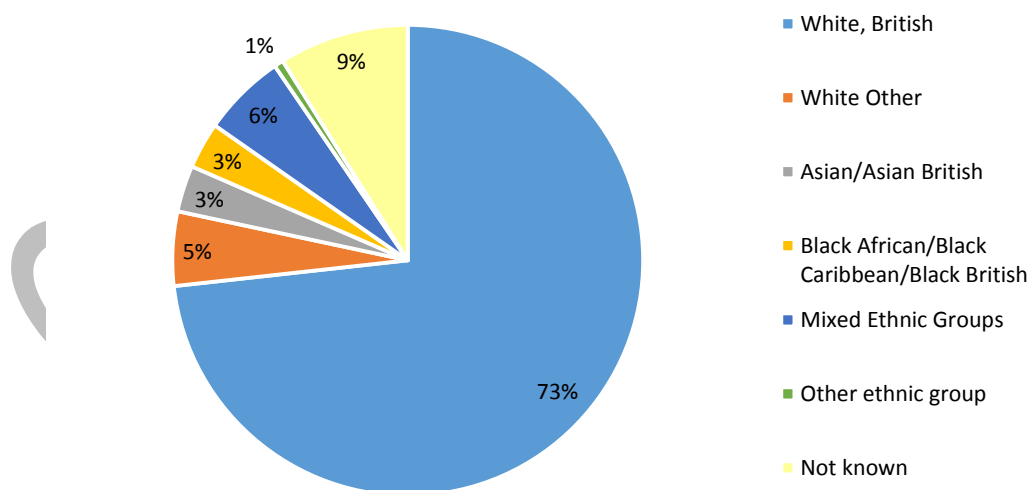
Table 2: Numbers of deaths notified between 1st April 2013 and 31st March 2018 by gender

	Male	Female
Gloucestershire	81	76

5.7 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 9% 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, 2013 - 2018



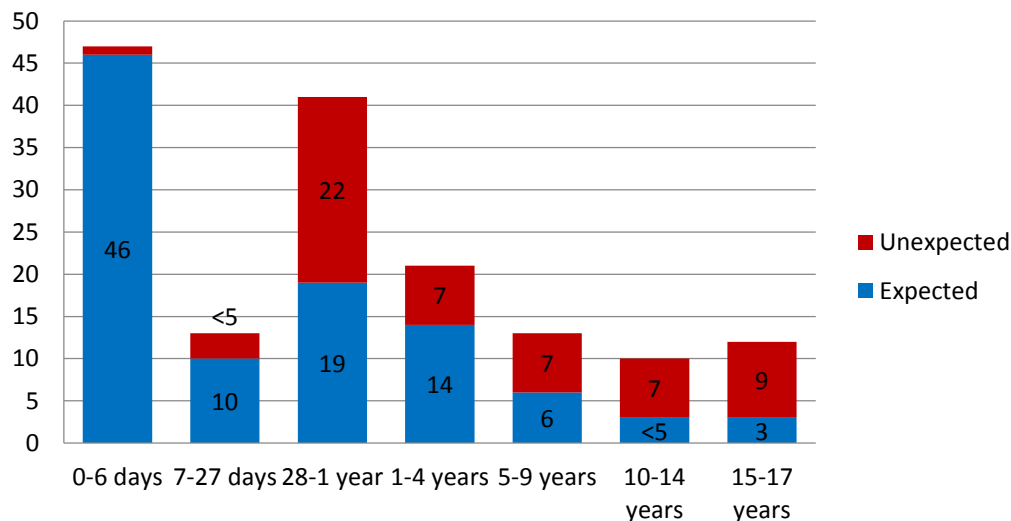
⁴ Department for Education *Child Death Reviews: Year Ending 31 March 2017*, Department for Education, SFR 36/2017, 31st July 2017

5.8 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 56 deaths (36%) were unexpected. The remaining 101 were expected deaths of children with known illnesses or life-limiting conditions.

Figure 4 presents data on expected versus unexpected deaths for 2013-18 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 the vast majority of deaths within the first week of life were expected. Within the 28-364 day 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, 2013 - 2018



6. Child Death Overview Panel Review Data

This data is drawn from the CDOP database. It summarises the panel's review decisions for 2013-2018 and its learning for 2017-2018. 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 Form C. 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 189 deaths between 1st April 2013 and 31st March 2018. Of the 157 deaths notified between 1st April 2013 and 31st March 2018, there are currently 38 that have not yet been reviewed by CDOP. Only one child who died before 1st April 2016 has yet to be reviewed due to other investigations being carried out including Serious Case Review, Domestic Homicide Review and legal matters. See Appendix A for a full breakdown.

During the 2017/18 child death review year the Gloucestershire CDOP panel reviewed a total of 28 deaths.

Table 3: Number of child deaths reviewed by CDOP, 2013 - 2018

	2013-14	2014-15	2015-16	2016-17	2017-18	Totals
Gloucestershire	34	34	55	38	28	189

6.1 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 (37%) followed by chromosomal, genetic and congenital anomalies (20%). The other categories are much less common.

Figure 5: Categorisation of Deaths for Children Reviewed by CDOP, 2013 - 2018

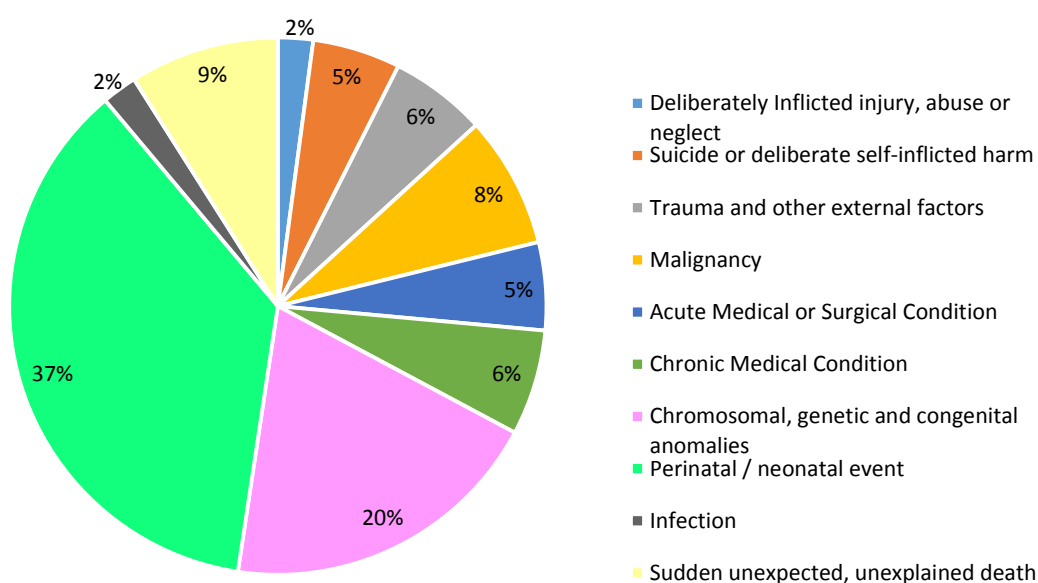
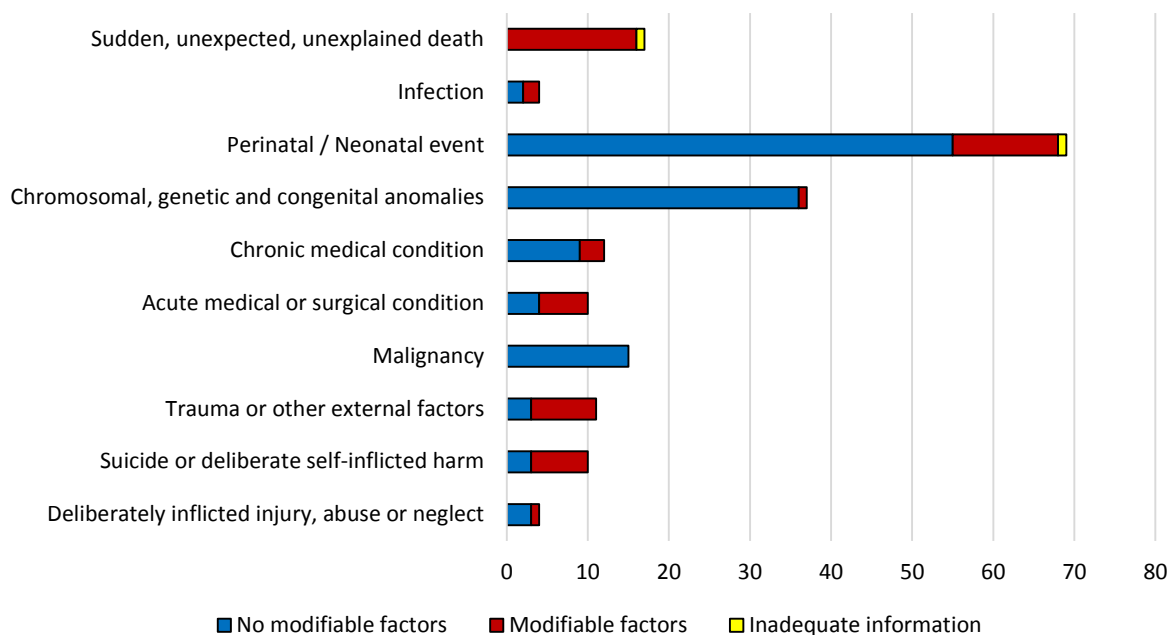


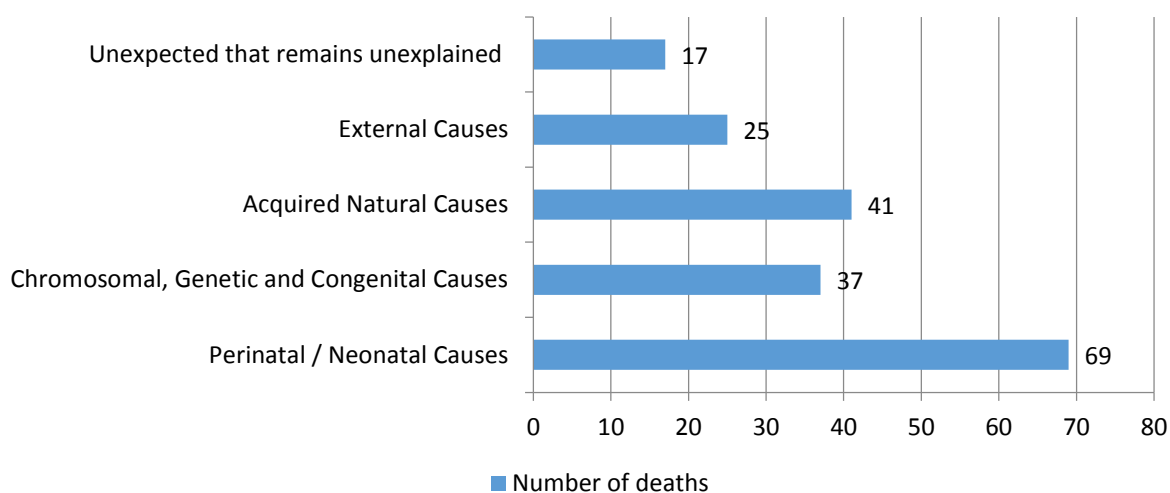
Figure 6, below, shows the proportion of deaths within each category that were considered to have modifiable factors following review by CDOP. This shows that the categories that represent unexpected deaths, e.g. suicide or deliberate self-inflicted harm, trauma and other external factors and sudden, 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, 2013-2018



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, chronic medical conditions and infection. 'External Causes' groups together 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, 2013 - 2018



6.2 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 123 children (65%) reviewed by CDOP had no co-morbidities at all. Of the remaining children reviewed, 21 (11%), had just one co-morbidity and 45 (24%) had more than one co-morbidity. The chart below 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, 2013 - 2018

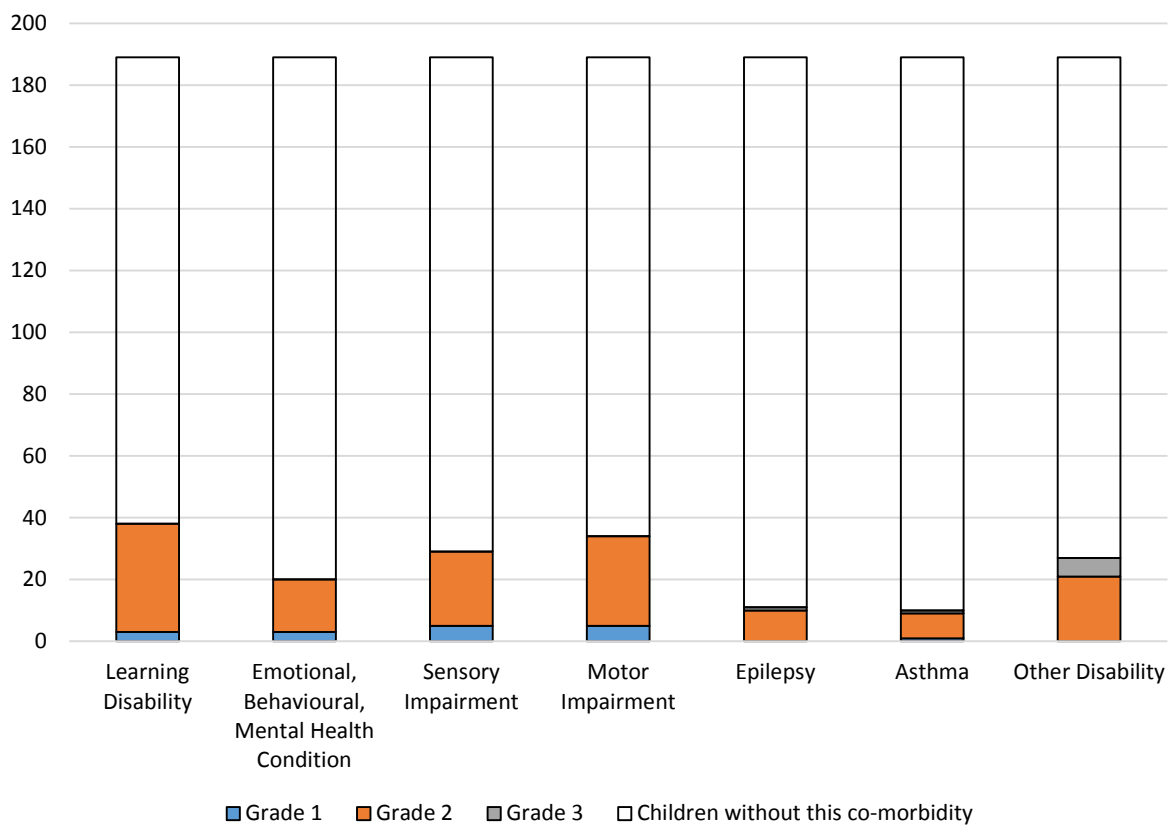


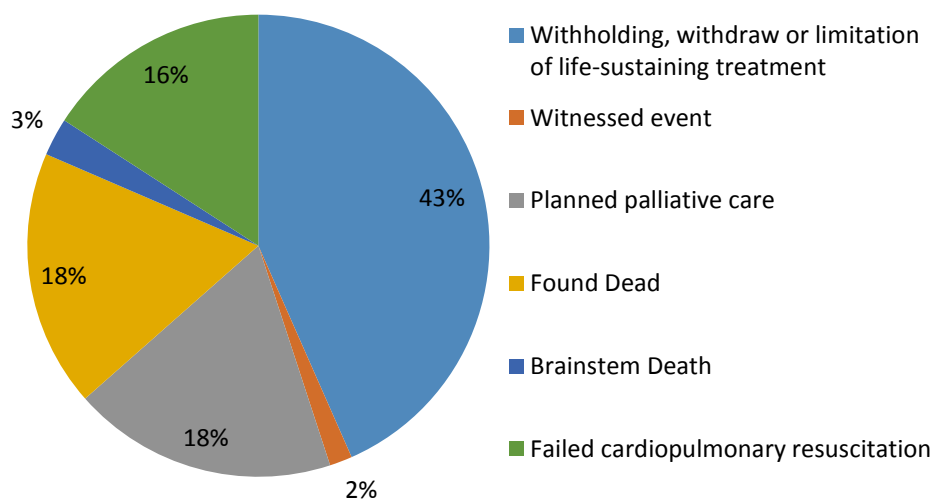
Figure 8 shows that the co-morbidities found to have a significant impact on vulnerability are learning disability, motor impairment, sensory impairment, emotional, behavioural and mental health conditions and other disability. An example of “other disability” would be a child with an underlying chromosomal disorder or a genetic syndrome. Children with a learning disability represent the most common co-morbidity. 38 children had a diagnosed learning disability, and this was considered to be a significant factor in all but 3 cases. Motor impairment is the second most common with 34 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.

6.3 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 died following planned palliative care and children who were found dead (18% each) and then those children who died following failed cardio-pulmonary resuscitation (16%).

Of the children who died following withdrawal of treatment 72/82 (87%) were expected deaths, similarly of the children who died following planned palliative care 29/35 (83%) were expected deaths. This reflects the national picture. All the children who were found dead died unexpectedly. 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, 2013 - 2018

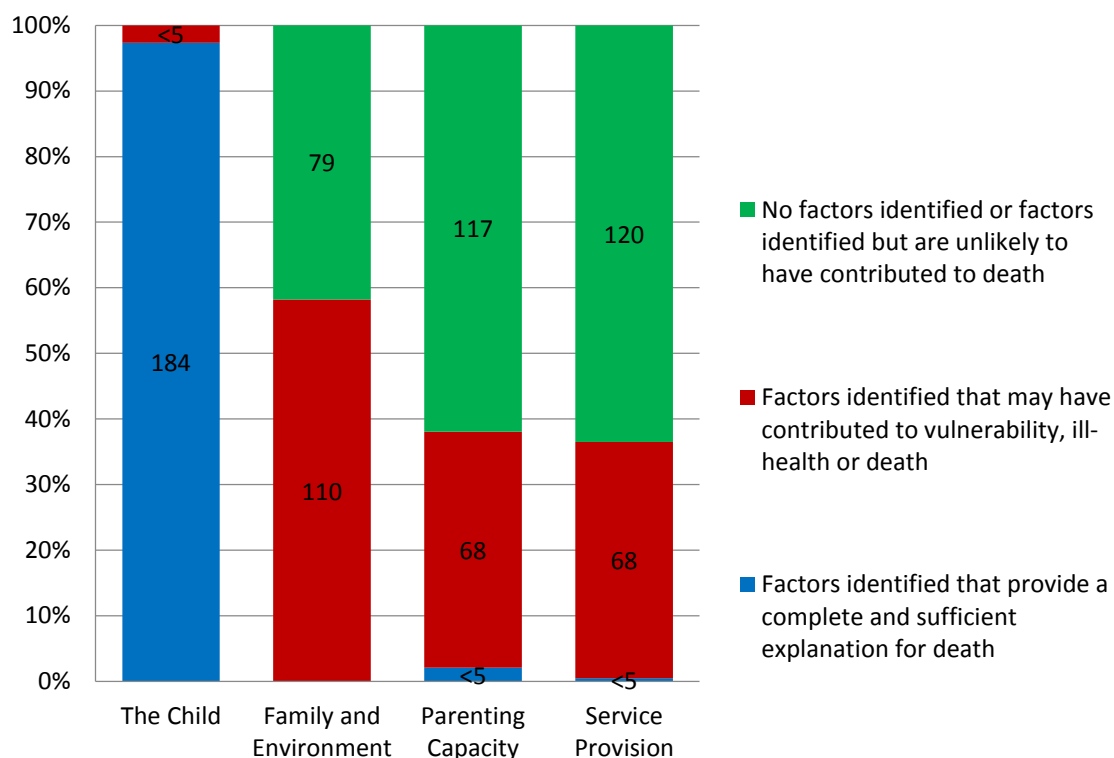


6.4 Factors identified as having contributed to death

Form C of the national dataset requires CDOP to identify and 'grade' factors that have contributed to the child's death.

In 97.4% 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, 2013 - 2018



In 58% 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 38% 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 36% 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 meeting or at CDOP that may have contributed to vulnerability, ill-health or death, the context is carefully reviewed and appropriate actions logged on the Child Death Review Team Work Plan or CDOP action log to be followed up.

6.5 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 final case discussion 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 2013-2018

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	31	47	0	107	4	25%
Alcohol or substance misuse by a parent or carer	10	31	0	139	9	16%
Smoking by a parent or carer / Smoking by Mum during pregnancy	30	51	0	97	11	27%
Housing	10	31	0	148	0	16%
Domestic violence	12	35	0	139	3	18.5%

Table 4 above shows significant factors to include smoking in a parent/carer, emotional, behavioural or mental health condition in a parent/carer and alcohol/substance abuse in a parent/carer. Domestic violence is also a significant factor in 18.5% of cases.

6.6 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 30% of cases. In the majority of cases, (130/189) 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 2017/18 10% of cases reviewed identified modifiable factors associated with a child's death. This is lower than the national figure, where 27% of deaths were categorised as having modifiable

factors⁵. This represents an increase from 24% for the previous two years. Panels across England have identified modifiable factors in between 22 and 32% of the child death reviews they complete.

7. Summary statistics, Key Themes, Recommendations and Actions taken in 2017/18

7.1 Summary Statistics

- The majority of child deaths are expected deaths accounting for 58% of child deaths this year.
- This year 52% of child deaths occurred in the perinatal or neonatal period and 84% occurred within the first year of life.
- The most common category of death in Gloucestershire this year was perinatal or neonatal event (39%). This is in line with the national picture.
- Deaths from external causes, which includes deliberately inflicted abuse or neglect, trauma and external factors or self-inflicted harm and suicide are rare. This year they accounted for 10% of deaths (equivalent to <5 child deaths in 2017-18).
- In the majority of deaths reviewed no modifiable factors were identified. However modifiable factors were identified in 10% of cases reviewed by the panel in 2017/18. Nationally this figure is 27%.

7.2 Key Themes

- The importance of the role of a good lead professional to facilitate communication/co-ordination with professionals involved out of county
- A number of cases reviewed this year illustrated communication difficulties between tertiary and secondary hospitals. It is helpful for families with Care Plans to have a copy even when they have Open Access to their local hospital, as this is very beneficial should the child be admitted to another hospital.
- High maternal age is known to be an increased risk factor for congenital anomalies
- Agency foster carers do not routinely have access to all training or information provided to Local Authority Social Workers.
- Parents find the support provided by the hospice post death invaluable, however this remains an unfunded service.
- A number of cases reviewed this year have involved issues with the Ambulance Service which has resulted in a number of Serious Incident Reports being logged within South Western Ambulance Service Trust (SWAST). Issues have included concern with regard to potential resuscitation coding and whether CPR should be performed. Potential missed opportunity to verify an address and evidence of non-compliance with expected standards and a lack of contact to Police. However, it was felt that these incidents did not adversely affect delivery of care and CDOP has been reassured that appropriate internal action has been taken in each case.
- CDOP reviewed cases where there were a number of elements which led to a poor level of direct surveillance of babies by parents and carers. These included a) the use of video monitors resulting in a lack of direct observation, which the panel felt could provide false reassurance for parents and b) moving the baby into their own room before 6 months of age which is contrary to current guidance

⁵ Department for Education *Child Death Reviews: Year Ending 31 March 2017*, Department for Education, SFR 36/2017, 31st July 2017

- CDOP reviewed one case where there had been a significant history in the week prior to the unexpected death of a young person and this was not explored in detail by attending Police Officers and was not available for the final case discussion. CDOP were reassured that the Police have now changed practice and provided specialist training to officers for these types of deaths.
- Concern was raised by a parent about poor communication from the Coroner's Office about the post-mortem report and the processes following death. This included a) the return of clothing and b) visiting the child in the mortuary. These issues were discussed in a meeting between the Coroner's Office and the Designated Doctor for Child Deaths and feedback was provided to the parents.
- CDOP discussed the difficulty in having an 'unascertained' cause of death on post-mortem. Current guidance from the Chief Pathologist on giving a 'SUDI' cause of death is strict and 'unascertained' is given when pathologists are unable to fulfil the criteria for 'SUDI'.
- There is currently no funding for a Care of the Next Infant (CONI) scheme in Gloucestershire, which would be of benefit to the parents bereaved by a sudden infant death.
- The importance of information sharing has been highlighted this year in particular with primary care and the hospice.
- On discharging a child from hospital for end of life care either at home or at the hospice, it is essential that the child is discharged with all appropriate medication and equipment. The Lead Nurse for Child Death represents the Child Death Review Team on the Paediatric Palliative Care Group to ensure linking of processes.

7.3 Recommendations and Actions Taken

- CDOP reviewed some cases where families had received post-mortem reports by post. Conversations are taking place with the Coroner's Officers to resolve this issue.
- Foster carers receive training and support if coming through local authority, but agency foster carers do not receive the same support. CDOP has highlighted this issue to the local authority and this is being reviewed for all foster carers.
- The learning from one CDOP case has been used in Domestic Violence Training for Midwives to ensure professionals are aware of the potential for escalation in the level of violence during pregnancy.
- CDOP now routinely notifies GPs of issues with domestic violence and provides contact details of support services. Consideration is also given to completion of a DASH form if appropriate.
- Excellent practice by a school in response to the death of a child has been identified and the school has confirmed that they are willing to support other colleagues who find themselves in a similar situation in the future. It is recognised how well this school dealt with the situation with the other students, staff and through continuous communication with the family throughout. The school have put supportive measures in place for their high-risk groups and provided support for colleagues when needed.
- The CDOP manager and CDOP co-ordinator provided training to social workers this year on the child death review process. This included a description of the process, details on how to complete the statutory paperwork when requested and what to expect when attending an initial and/or final case discussion meeting.

- It has been agreed that hospice staff and health professionals will involve GPs in any child who is on an end of life care plan to ensure the child is seen by a doctor every two weeks in order to facilitate the signing of a death certificate once the child has died.
- A teenager who died of asthma had a significant history of poor attendance at the GP Practice Reviews and wheezing during sport activities at school. A piece of work is currently underway to attempt to determine a Symptom High Risk Alert for GP's to enable them to identify the children they need to follow up and chase as a priority. A similar alert will be drafted for schools, so staff are aware of when to raise concerns with families.
- SUDI – work has been undertaken with Public Health Nursing in relation to Safer Sleeping advice for parents and support for professionals who have been involved with the cases.
- CDRT has identified funeral directors who provide funerals for children free of charge (prior to new legislation). This is a basic package and is variable between different providers. CDRT has also identified 'Children of Butterflies' Charity who will assist in providing further funding for extra's over and above what the funeral directors will provide in these packages.
- Cases reviewed by CDOP have been presented at the GP Forum in order to disseminate learning.
- CDOP made a recommendation to the Local Authority to review the Risk Assessment Guidance of Children in Care (CiC) and the timings of reviews when circumstances change for the child. It was recognised that all professionals involved in a child's case have a role to play in identifying risks to the child and sharing concerns.
- Following a teenage death in relation to aerosol inhalation, CDRT worked with Police and Education to raise awareness of the risk in the local area where the prevalence of this form of abuse was found to be higher than previously known. The Commissioning Service are continuing to take this forward.
- CDOP have disseminated a guidance for all schools to follow when they are contacting 999 emergency services to ensure that there is no delay in them gaining access to the sites.

Appendix A: Duration of CDOP Reviews by Year (2013-2018)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Total number of notifications	43	33	36	30	43	26	45	19	36	31
Total number of cases reviewed	6	17	24	34	33	34	34	55	38	28
Years of Review	Number reviewed	Number reviewed	Number reviewed	Number reviewed	Number reviewed	Number reviewed	Number reviewed	Number reviewed	Number reviewed	Number reviewed
2008/09	6	16	14	3	3	0				
2009/10		1	9	16	4	1	1	1		
2010/11			1	15	16	4	0	0		
2011/12				0	10	15	5	0		
2012/13					0	14	25	4		
2013/14						0	3	23		
2014/15							0	27	17	0
2015/16								0	17	2
2016/17									4	17
2017/18										9

- NB: Only one child who died before 1st April 2016 has yet to be reviewed by CDOP
- 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