NHS
Somerset
Clinical Commissioning Group

Report to the NHS Somerset Clinical Commissioning Group on 31 March 2022

Title: Somerset Child Death Review Arrangements Annual Report 2020-21	**Enclosure J**

Version Number / Status:	1
Executive Lead	Val Janson, Director of Quality and Nursing / Executive Lead for Safeguarding
Clinical Leads:	Dr Tamsyn Nicole, Designated Paediatrician for Child Deaths (East Somerset) Dr Chris Knight, Designated Paediatrician for Child Deaths (West Somerset) Dr Nicola Johnson, Designated Paediatrician for Child Deaths (West Somerset)
Authors:	Marie Davis, Designated Nurse Safeguarding Children Dr Tamsyn Nicole, Designated Paediatrician for Child Deaths (East Somerset) Dr Chris Knight, Designated Paediatrician for Child Deaths (West Somerset) Dr Nicola Johnson, Designated Paediatrician for Child Deaths (West Somerset)

Summary and Purpose of Paper

There is a requirement for the CCG to receive an annual report on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process; in line with Child Death Review Statutory and Operational Guidance (England)

This report sets out the work of the local Child Death Review partners in Somerset in association with the joint Pan Dorset and Somerset Child Death Review arrangements.

This report relates to the 16 child death cases reviewed from April 2020 to March 2021, which differs to the 22 child death notifications received during the same time period.

Recommendations and next steps

The number of deaths reviewed from April 2020 to March 2021 is small which makes statistical analysis difficult. However, the report contains a summary of learning identified from Somerset child death cases reviewed during this period.

The Governing Body is being asked to approve the content of this report and actions taken to address the learning identified.

Somerset CCG Safeguarding children team will continue to work collaboratively to engage in work streams to improve the quality of Child Death Review arrangements, alongside both Somerset and Dorset CDR partners as part of the joint Pan Dorset and Somerset Child Death review arrangements.

This report, once approved by the Governing Body, will then be considered by the Somerset Safeguarding Child Partnership, in light of the alignment between Child Death Review and Safeguarding Children arrangements.

Impact Assessments – key issues identified				
Equality	Commissioning and delivery of high quality and accessible statutory Child Death Review (CDR) arrangements will ensure that data on all child death cases (expected and unexpected) are review and analysed to classify the cause of death, identify any modifiable factors associated with the case and decide on the preventability of each death.			
Quality	The CDR arrangements will identify any matters of concern affecting the safety and welfare of children, wider public health or safety concerns arising from a particular death or pattern of deaths. This includes a review of the appropriateness of the response of professionals to the unexpected death of a child.			
Privacy	Information sharing processes are already established; there are no breaches of privacy expected.			
Engagement	Meeting statutory Child Death Review requirements is a shared responsibility. Somerset CCG works closely with its Providers, (Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust), Primary Care and all key partners of the Pan Dorset and Somerset Child Death review arrangements to ensure these are met.			
Financial / Resource	Resources required to implement and support statutory Child Death Review arrangements are in place; shared between Somerset County Council and Somerset Clinical Commissioning Group			
Governance or Legal	The provision of statutory Child Death Review arrangements are governed by the following legislation and statutory guidance: • Children Act 2004 • The Children and Families Act 2014 • The Children and Social Work Act 2017 • Working Together to Safeguard Children 2018 • Safeguarding children, young people and adults at risk in the NHS: Safeguarding and Accountability framework 2019 • Child Death Review Statutory and Operational Guidance (England) 2019			
Risk Description				
Risk Rating	Consequence	Likelihood	RAG Rating	GBAF Ref

NHS
Somerset
Clinical Commissioning Group

Somerset Child Death Review Arrangements

Annual Report 2020-21

NHS Somerset Clinical Commissioning Group

CONTENTS

1.0 Introduction

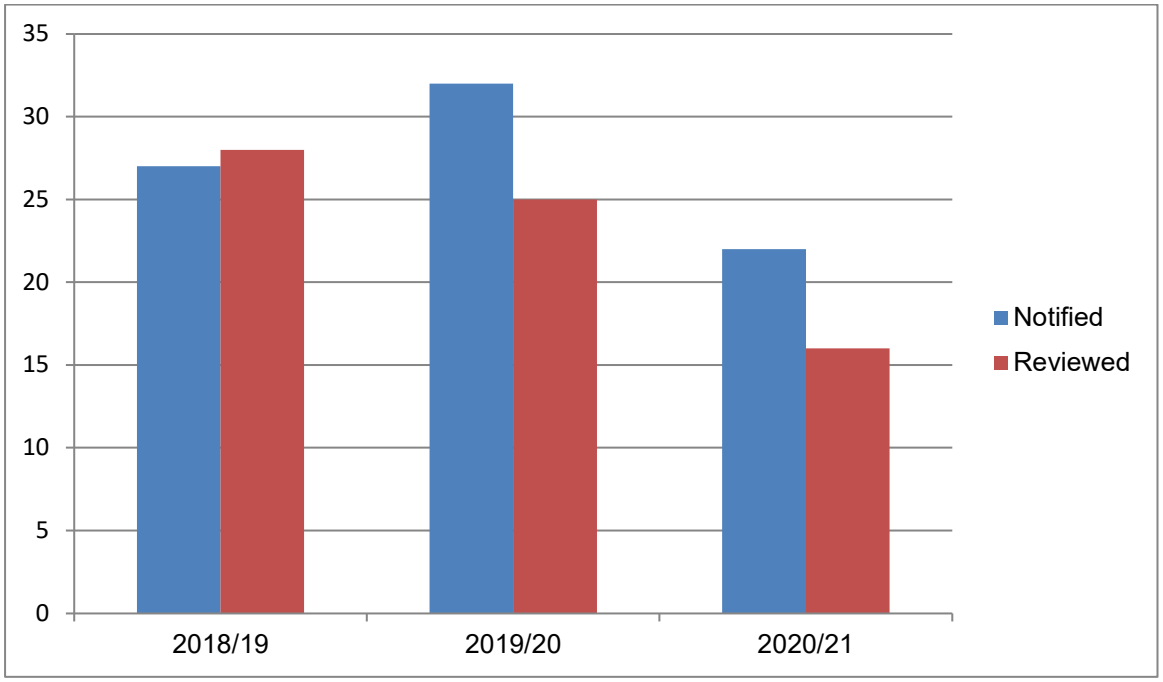
1.1 This annual report on the joint Child Death Review arrangements for Somerset and Dorset covers April 2020 – March 2021. This is a public report which sets out the work of the local Child Death Review partners in Somerset in association with the joint Pan Dorset and Somerset Child Death Review process.

1.2 In July 2020 the joint Child Death Review arrangements had been in place for one year, so the Memorandum of Understanding the Terms of Reference for the joint Somerset and Dorset Child Death Overview Panel (CDOP) were review and agreed by all of the Child death review partners in Somerset and Dorset.

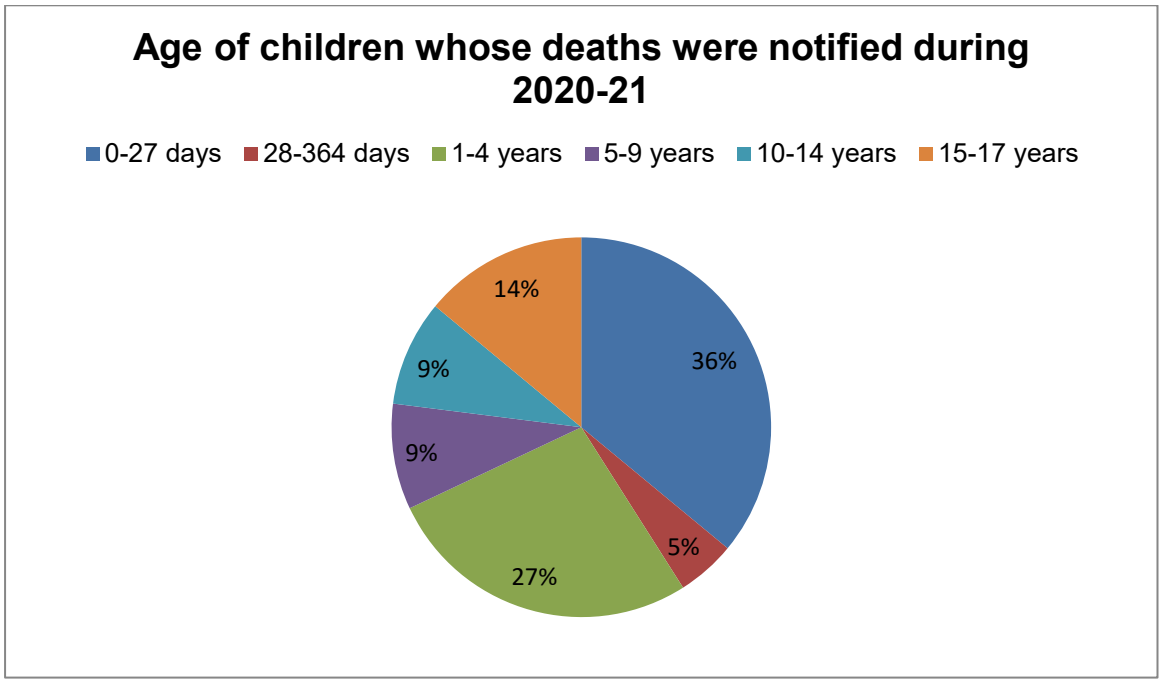
1.3 For further information on the role and function of the Somerset Child Death Review process see: **http://sscb.safeguardingsomerset.org.uk/working-with-children/child-death-review**

2.0 Number of Notifications 2020-21

2.1 During 2020-21 there were 22 child deaths of children resident in Somerset:

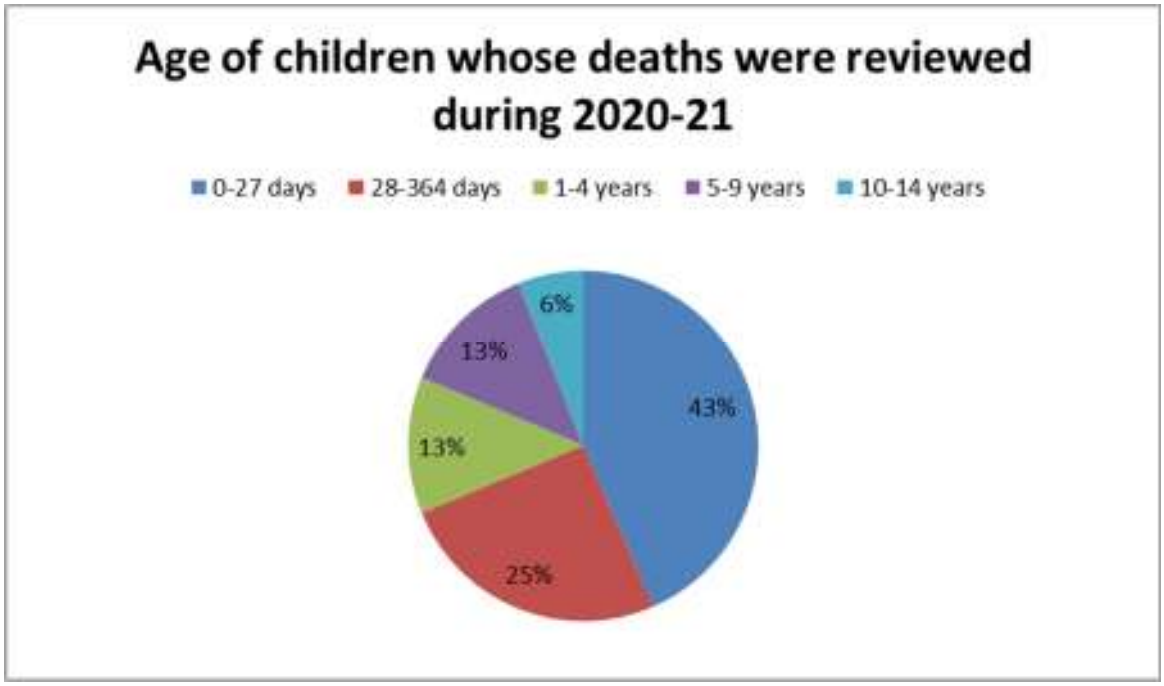


2.2 The majority of deaths were infant deaths; with 36% of deaths involving a child 0-27 days old. See table below for breakdown of ages of child deaths in Somerset:



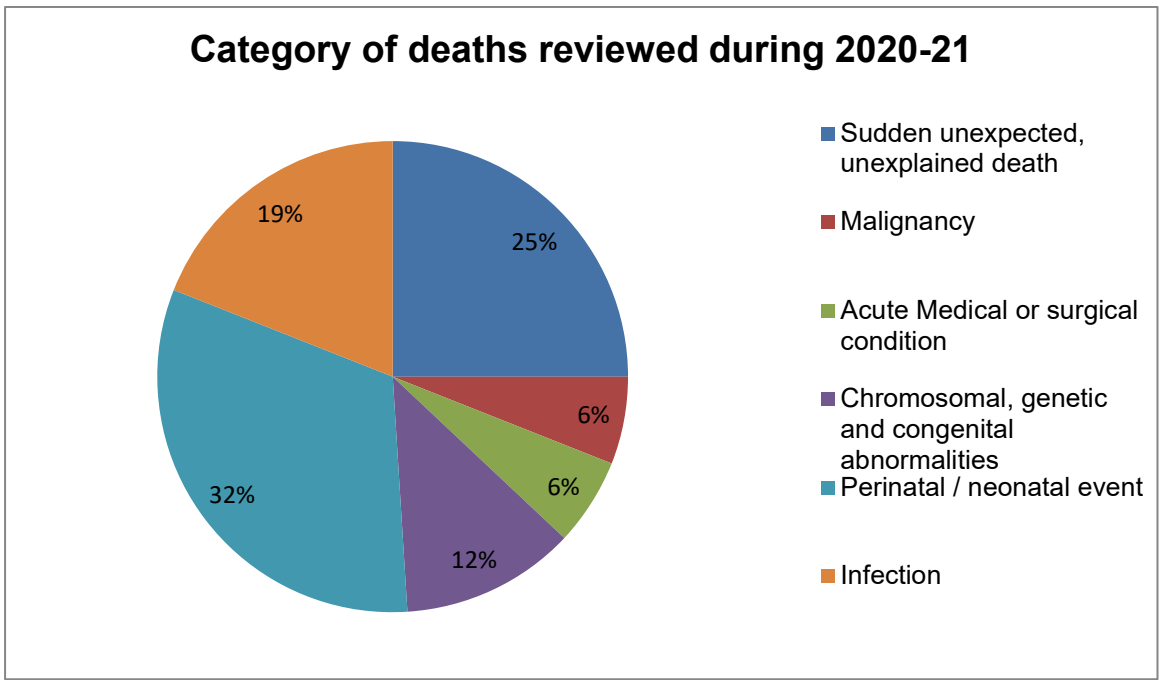
3.0 Number of Child Death Reviews completed in 2020-21

3.1 In 2020-21 16 child deaths were reviewed but these deaths occurred across a number of years. See table below for breakdown of age of children subject to a child death review in 2020-21. There were no child death reviews for children aged between 15 to 17 years, which is why this age group does not feature below:



3.2 32% of the children subject to a child death review were related to perinatal or neonatal events. Further breakdown of the categories of child deaths reviewed is outlined in the table below, in accordance with categories

provided by the National Child Mortality Database. There were no child deaths reviewed in 2020 to 2021 related to Trauma or Suicide, which is why they do not feature in the chart below.



4.0 Unexpected Deaths

4.1 An unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility, for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.

4.2 It is no longer a requirement to categorise deaths into expected and unexpected cohorts for the national data return. But we are still aware of unexpected deaths as they will initiate a Joint Agency Response. 38% of Somerset Child Deaths reviewed in 2020-21 were unexpected.

5.0 Modifiable Factors Related to Somerset Child Deaths

5.1 The Pan Dorset and Somerset Child Death Overview Panel (CDOP) considers modifiable factors; intrinsic to the child or related to the family environment, parenting capacity or service provision, and considers what action could be taken locally and what action could be taken at a regional or national level. These are factors, where if such actions could be taken, the risk of future child deaths could be reduced.

5.2 56% (9) of Somerset child deaths reviewed during 2020-21 identified modifiable factors. Examples of potentially modifiable factors identified at the CDOP from Somerset child death cases reviewed during 2020-21 are:

- Smoking by mothers in pregnancy

- High BMI of mothers during pregnancy
- Smoking in the household
- Unsafe sleeping arrangements
- Parental mental health

6.0 Safeguarding Children Cases

6.1 In circumstances where a child has died, and abuse or neglect is known or suspected, at any point during the Child Death Review process professionals should notify the safeguarding children partners whose responsibility it is to determine whether the case meets criteria for a Child Safeguarding Practice Review (CSPR). None of the cases reviewed this year led to a case for consideration for a review.

6.2 A particular issue arose this year due to Covid-19 arrangements. Arrangements for medically approved, ie legal, termination of pregnancy were changed to allow telephone consultation followed by issue of abortifactant pills by post for pregnancies estimated to be less than 10 week's gestation. This resulted in the delivery of a stillborn baby estimated at 22-24 weeks gestation.

6.3 In response to the local and national concerns raised the Designated Professionals for Safeguarding Children and Child Death have been invited to contribute to the newly formed Somerset Termination of Pregnancy Procurement Board (STOPPB).

6.4 Whilst the Somerset Child Death Review arrangements are no longer part of the Somerset safeguarding children partnership (SSCP) arrangements, there is increased alignment with safeguarding children priorities through the Health Safeguarding Children Partnership, a sub group of the SSCP. Effectiveness of, and learning identified through, the child death review arrangements are a standing agenda item

7.0 Themes Emerging from the Review of Child Deaths in 2020-21

7.1 The number of deaths reviewed is small which makes statistical analysis difficult. However, some learning has been identified from Somerset child death reviews, which included:

- The general pattern of child deaths in Somerset tallies with the national pattern although the overall death rate is low.
- In 2021 a National Child Mortality Database (hereafter referred to as 'NCMD') report into Child Mortality and Social Deprivation found a clear link between the risk of child death and the level of deprivation for all categories of death, except cancer[1]. In 2020 to 2021 Somerset reviewed a SUDI which had a strong association with deprivation and previous

[1] Child Mortality and Social Deprivation | National Child Mortality Database (ncmd.info)

concerns about neglect and safeguarding which is also in line with the NCMD's second annual report[2].

- Reviews in Somerset also identified the success of hospice arrangements for expected deaths, which were flexible and included support for children dying at home.
- Unsafe sleeping, in particular co-sleeping is an ongoing factor, despite evidence that health professionals have clearly delivered the message. Work is being undertaken locally and nationally to explore why advice is not always acted upon.

7.2 In addition learning identified from Dorset Child Death Reviews identified through the joint Pan Dorset and Somerset Child Death Overview Panel was also shared with Child Death Review partners across Somerset.

8.0 Actions Taken as a Result of the Review of Child Deaths in 2020-21

8.1 This report does not detail actions taken related to specific children or individual practitioners, to preserve confidentiality. This report describes actions taken to address system issues which will improve outcomes for children and reduce the risk of child deaths in future. Actions undertaken as a result of child deaths reviewed in 2020-21 included:

- Safe sleeping advice for both professionals and parents/carers was included in the Somerset's maternity toolkit which has now been published online.

- Somerset GP Practices are using the Child Not Brought policy for when parents/carers do not bring babies for their 6 week check, this information is passed on to the Health Visitor for the family. This policy was shared with GP Practices in Dorset.

- Agreement with the Somerset coroner that Post Mortem reports are shared as soon as available with the Child Death Review Co-ordinator, and with the Paediatrician involved so that feedback to families is not delayed. The Child Death Overview Panel are aware that there is a national issue with the delay in obtaining paediatric post mortems.

9. National Child Mortality Database (NCMD)

9.1 The Pan Dorset and Somerset CDOP (Child Death Overview Panel) fulfil its statutory responsibility to submit Child Death data through the eCDOP case management system. The NCMD recently published an annual report for

[2] NCMD second annual report - National Child Mortality Database

2019 to 2020[3]. A number of the findings in this report are mirrored in Somerset as described above, although the overall death rate in Somerset is currently low.

10. LeDeR and Somerset Child Death Review arrangements

10.1 The Learning Disabilities Mortality Review (LeDeR) programme describes a review process for the deaths of people aged 4 years and over with learning disabilities in England. It is important to specifically recognise and record if a child or young person has learning disabilities, irrespective of any other diagnoses or syndromes that are recognised. For further information: https://www.england.nhs.uk/learning-disabilities/improving-health/mortality-review/

10.2 There have been closer working arrangements between the CDR Co-ordinator and the local LeDeR team to ensure that all notifications to LeDeR are completed in a timely manner. Local processes have been aligned and there is now LeDeR representation at Child Death Review meetings and the Child Death Overview Panel when required.

It is clear that the Child Death Review arrangements take precedence chronologically over LeDeR enquiries but they can dovetail better adding richness to both.

11. Conclusion

The Child Death review partners in Somerset strive to ensure all Child Death Review processes and systems put in place are robust and effective. There has been a huge amount of work and developments to improve processes and build on existing relationships, systems and procedures in 2020-21. Further work will be undertaken in 2021 to 2022 to ensure greater alignment where possible between the local Child Death Review systems and processes in Somerset and Dorset.

[3] NCMD second annual report - National Child Mortality Database