Gloucestershire Child Death Overview Panel (CDOP)

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

1st April 2012 – 31st March 2013

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Acknowledgments

In order for the Child Death Review Process to have successfully continued to be implemented, commitment provided by professionals including those in Health, Social Care and the Police plus lay and faith people across a range of partner agencies must be acknowledged.

Special thanks to:

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A big thank you also to colleagues involved in the South West CDOP Network for the continued support given in relation to the everyday running of the child death review processes, sharing of good practice and being at the end of the phone for advice.

Abbreviations

CDOP	Child Death Overview Panel
CHC	Continuing Health Care
DfE	Department of Education
DVT	Deep Vein Thrombosis
GP	General Practitioner
GSCB	Gloucestershire Safeguarding Childrens Board
LSCB	Local Safeguarding Childrens Board
NGT	Nasogastric Tube
SIDs	Sudden Infant Deaths

References

Working Together to Safeguard Children 2006, 2010 & 2013.

Executive Summary

'Working Together to Safeguard Children 2006, 2010 and 2013' specified that a mandatory multi-agency response and review process for all deaths in childhood (from birth to 18 years) had to be implemented by April 2008 across England. The purpose of the process was to ensure all professionals responded to childhood deaths and reviewed each death in a uniform manner to identify lessons to be learnt and potentially prevent similar tragedies. The two key elements to this process are a "rapid response" and "child death overview".

April 2012 – March 2013 was the fifth year for the child death review process in Gloucestershire, a process which has continued to build upon the good practice laid down in the previous years. In this year:

- There were 44 child deaths, all of whom were Gloucestershire residents.
- The Child Death Overview Panel met to discuss cases on 5 occasions and 33 cases were reviewed.
- Specialists in their field attended the Child Death Overview Panels to support the core membership in this review process.
- Recommendations/actions identified at Final Case Discussions and Child Death Overview Panel aimed at reducing risks and supporting families, have been taken forward.
- The child death protocol has been updated and continues to be implemented successfully.
- Dedicated administrative support continues with strong links to the South West Child Death Review Team.
- Funding for the operation of the process continues till March 2014.

A Consultant in Public Health was appointed to take over the role of Chair of the Child Death Overview Panel (CDOP) from summer 2010. She has since stepped down from this role as Public Health relocate to the Local Authority. In addition to facilitate more efficient working, the Child Death Overview Panel has divided the work-load into Business Meetings and Case Review Meetings. The new Public Health Consultant for Gloucestershire with the Lead for Children will Chair the new proposed Business Meetings and the Chair of the Gloucestershire Safeguarding Childrens Board (GSCB) will Chair the case meetings. In this way close partnerships will continue between this process, the GSCB and Public Health.

1. Background to the Process

'Working Together to Safeguard Children 2006, 2010 and 2013' specified that a mandatory multi-agency response and review process for all deaths in childhood (from birth to 18 years) be implemented by April 2008 across England. The purpose of the process was to ensure all professionals responded to childhood deaths and reviewed each death in a uniform manner to identify lessons to be learnt and potentially prevent similar tragedies. There are two elements to this process:

The rapid response

A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child {an unexpected death is defined as the death of an infant or child (less than 18 years old) which: was not anticipated as a significant possibility for example, 24 hours before the death or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death}.

The purpose of this case discussion is:

- To establish, where possible, a cause or causes of death (in conjunction with the coroner).
- To identify any contributing factors.
- To provide on-going support to the family/professionals involved with the child/family.

During the 2012/13 year the Paediatric Liaison Health Visitor, who also covers the rapid response process in a lead role, transferred to Gloucestershire Care Services NHS Trust. In addition Specialist Nurses for Safeguarding Children from Gloucestershire Care Services took on the role of the rapid response nurses. Support for these roles has been formalised and regular debrief, supervision/peer review sessions take place to allow reflection on practices for each case.

Following the initial case discussion meetings concerning unexpected child deaths, in the majority of cases, the rapid response nurses have contacted the families to share the summaries of the meetings with them. The feedback received from families in response to this contact has been largely positive. It gives the families the opportunity to contribute to the child death review process. Any information the family wishes to be shared about their child or verification of accuracy of events leading to their child's death or the sharing of experiences at the hospital, for example, are captured following these meetings. Any questions, comments or amendments are shared at the final case discussion meetings and outcomes fed back to the families following this meeting.

The child death overview

An overview of all child deaths in the Local Safeguarding Children's Board (LSCB) areas covered by the Child Death Overview Panel (CDOP) will be undertaken. This is an anonymised paper exercise, based on information available from those who were involved in the care of the child, both before and immediately after the death, and other sources including, the Coroner.

The panel:

- Has a fixed core membership to review these cases, with flexibility to co opt other relevant professionals as and when appropriate.
- Holds meetings at regular intervals to enable each child's case to be discussed in a timely manner.
- Reviews the appropriateness of the professionals' responses to each unexpected death of a child, their involvement before the death, and relevant environmental, social, health and cultural aspects of each death, to ensure a thorough consideration of how such deaths might be prevented in the future. It makes recommendations accordingly.
- Identifies any patterns or trends in the local data and reports these together with identified recommendations to the LSCB.

From the 1st April 2012 in order to comply with working together principles the Child Death Overview Panel (CDOP) process divided into two separate forums, the Case meeting, chaired by the Chair of the Gloucestershire Safeguarding Childrens Board (GSCB) and a Business meeting, chaired by a Consultant in Public Health.

The purpose of the case discussion meetings:

1. To monitor the appropriateness of the response of professionals to an unexpected child death.
2. To review the support of services offered to families and
3. To identify any relevant public health issues through the work of the child death review team, led by the Designated Doctor.

The Business group will oversee the CDOP functions. Its role is to ensure:

- The recommendations of CDOP are actioned.
- Assess the responsiveness of the child death review process and its work plans.
- Consider and share appropriately the learning points, outcomes and actions derived from the local case review meetings monitoring outcomes through audit.
- Respond to local and national identified themes and data.
- Produce an Annual Report and share it with the respective partner organisation's governance leads and the appropriate regional network.

The CDOP Business group have met 4 times. It has a permanent core membership drawn from the key organisations represented on the GSCB and from other relevant organisations.

Each death of a child is a tragedy and poses different problems and issues. Over the past 5 years all agencies involved in the process have had change of personal and roles however they have adapted their own processes in line with the joint protocol for child death review appropriately. Good communication between all parties adapting their systems to account for the changes continues. It should be recognised that the input from the police and social care colleagues, to the child death review process has been invaluable.

2. Child Death Review Process 1st April 2012 – 31st March 2013

44 deaths were notified to Gloucestershire Child Death Overview Panel (CDOP) of these 25 expected and 19 unexpected.

Chart 1 – Expected/Unexpected child deaths

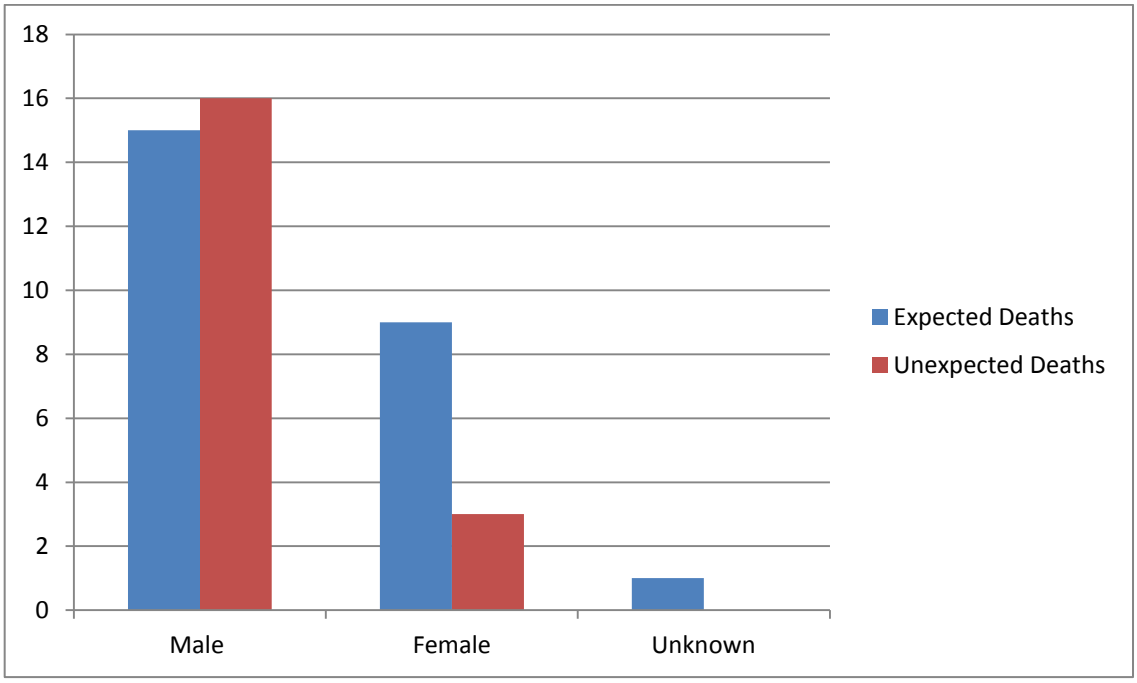


Chart 2 – Gender for all death

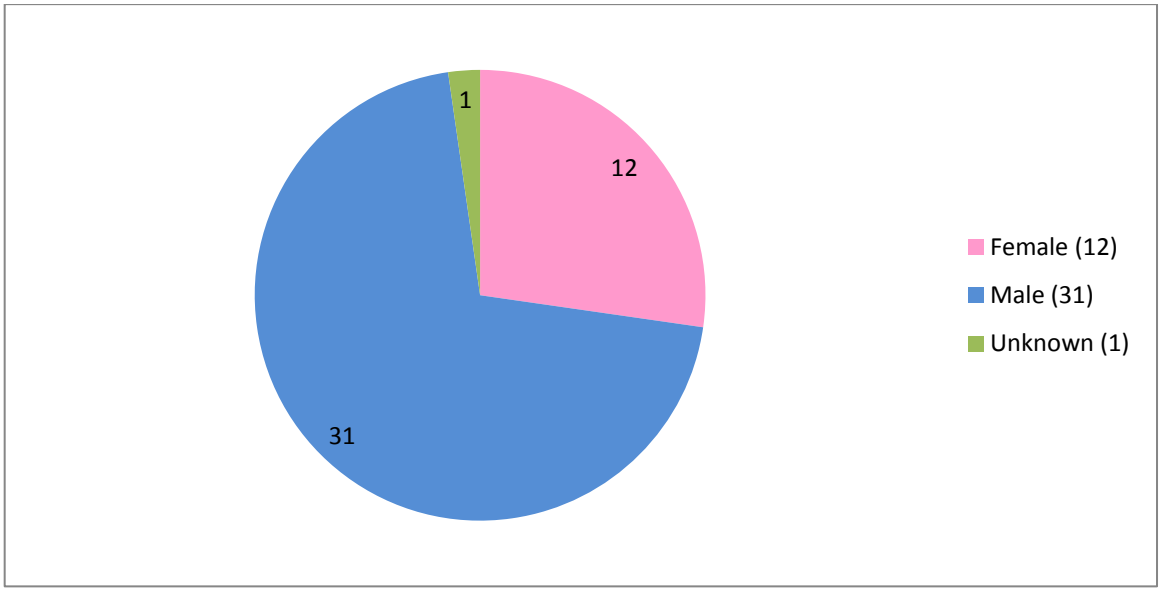


Chart 3 – Month of Death expected/unexpected

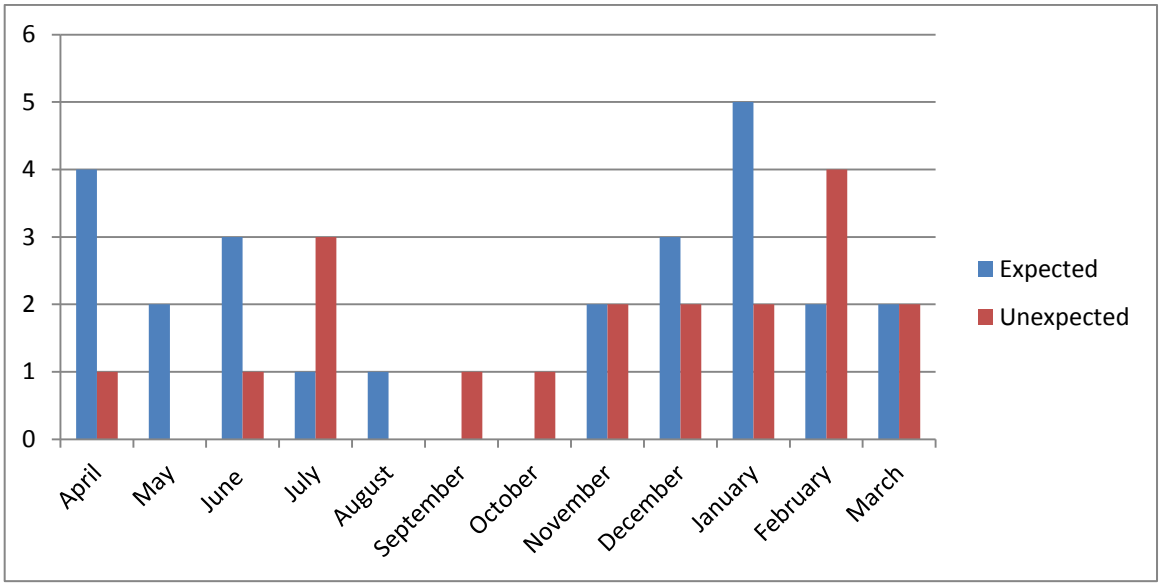


Chart 4 – Day of week of death expected/unexpected

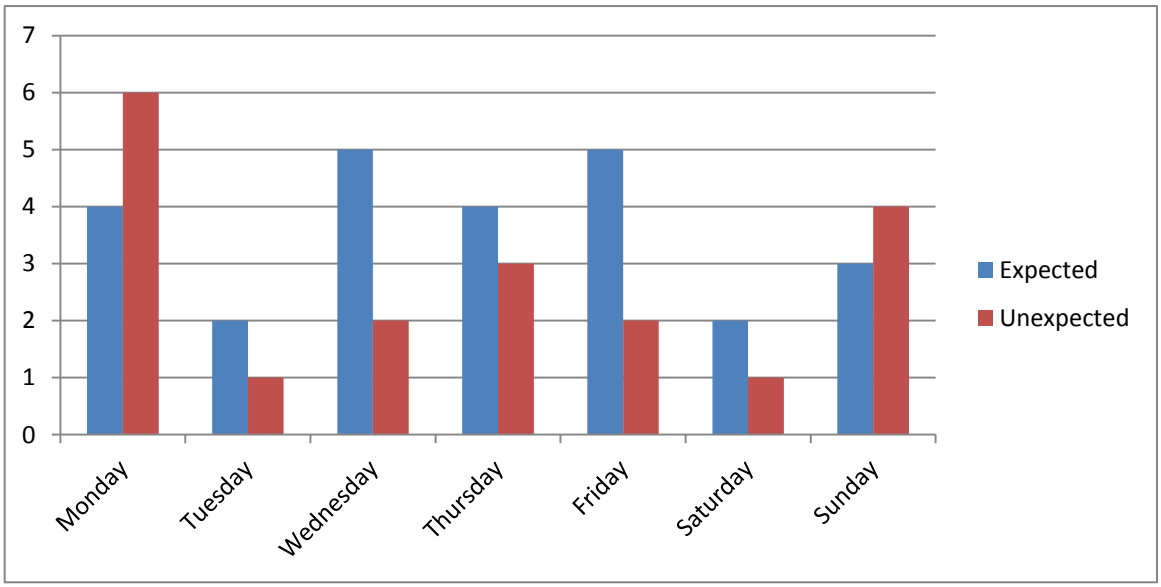


Chart 5 – Age Group for all deaths

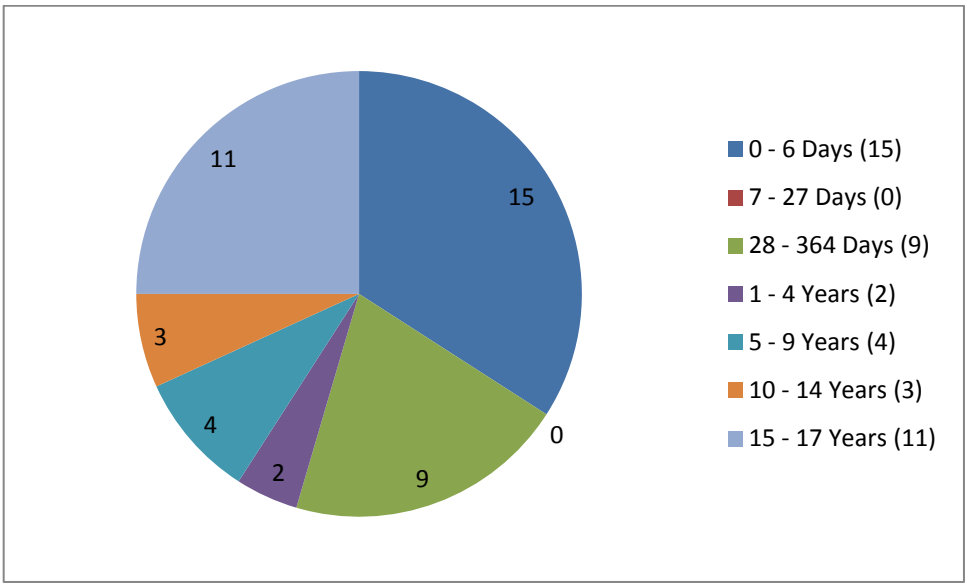


Chart 6 – Age Group unexpected deaths

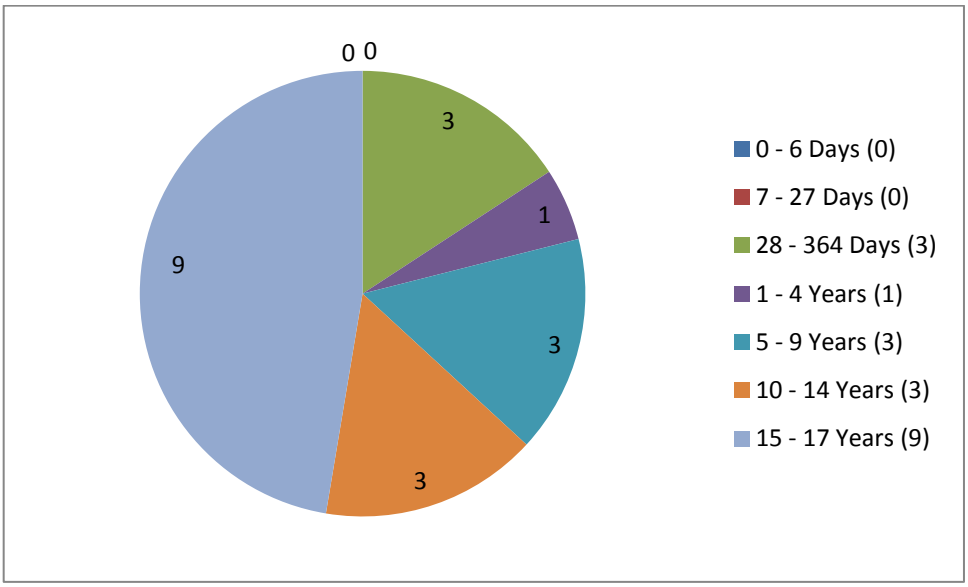


Chart 7 – Ethnicity for all deaths

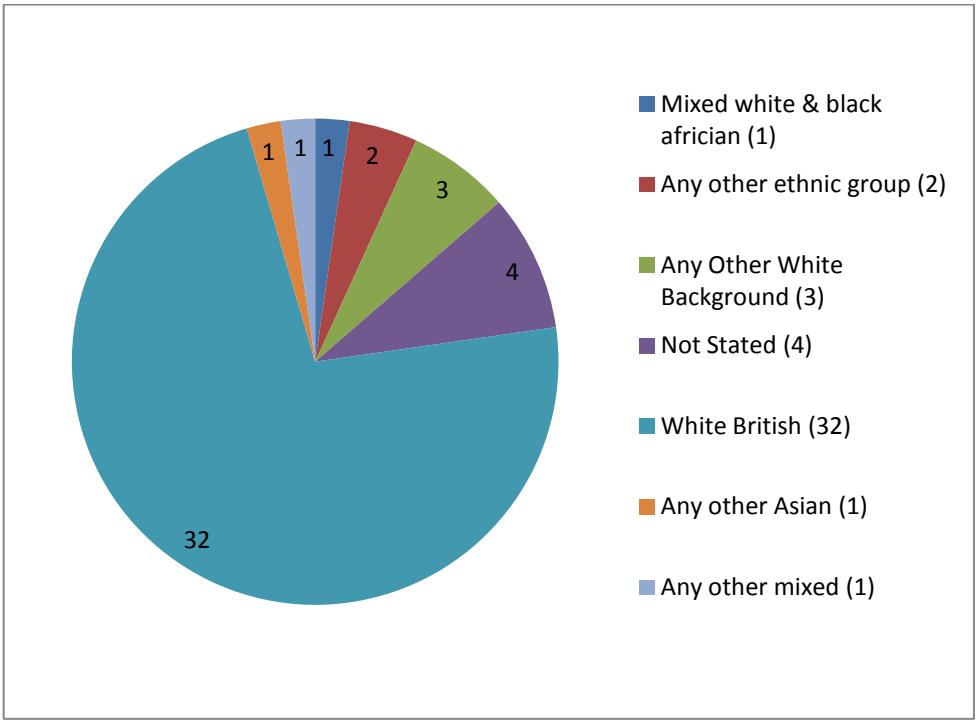


Chart 8 – Ethnicity for unexpected deaths

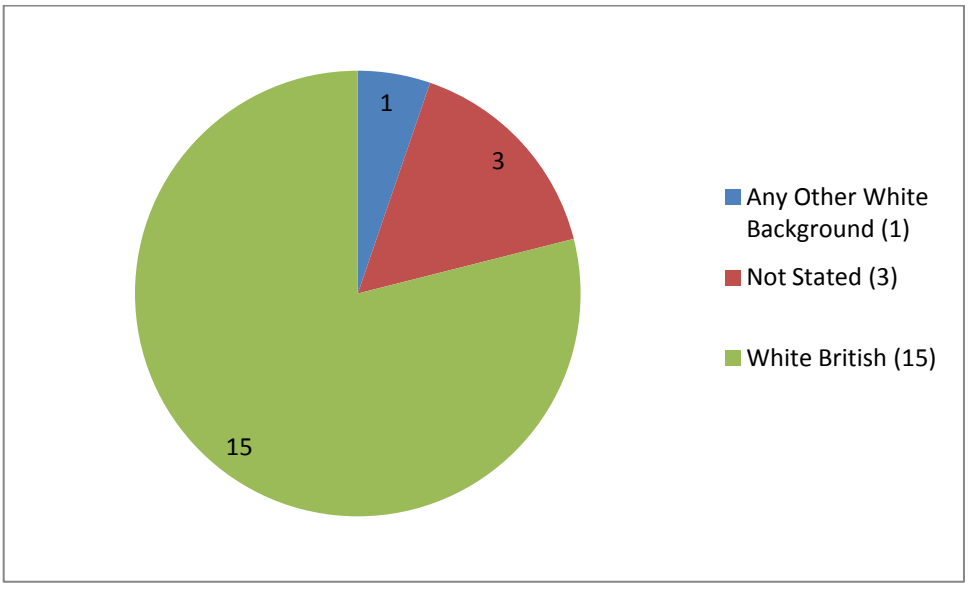


Chart 9 – Place of all deaths

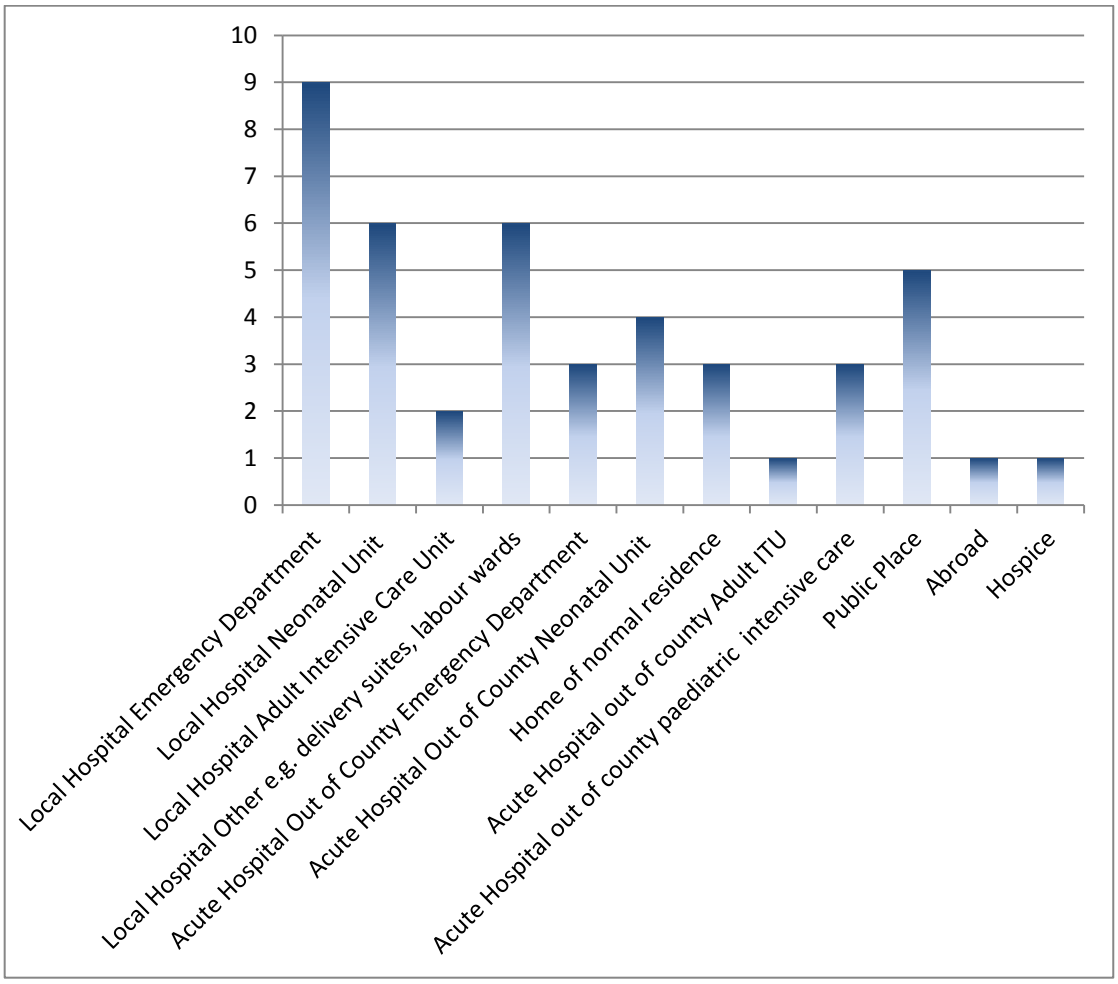


Chart 10 – Place of unexpected deaths

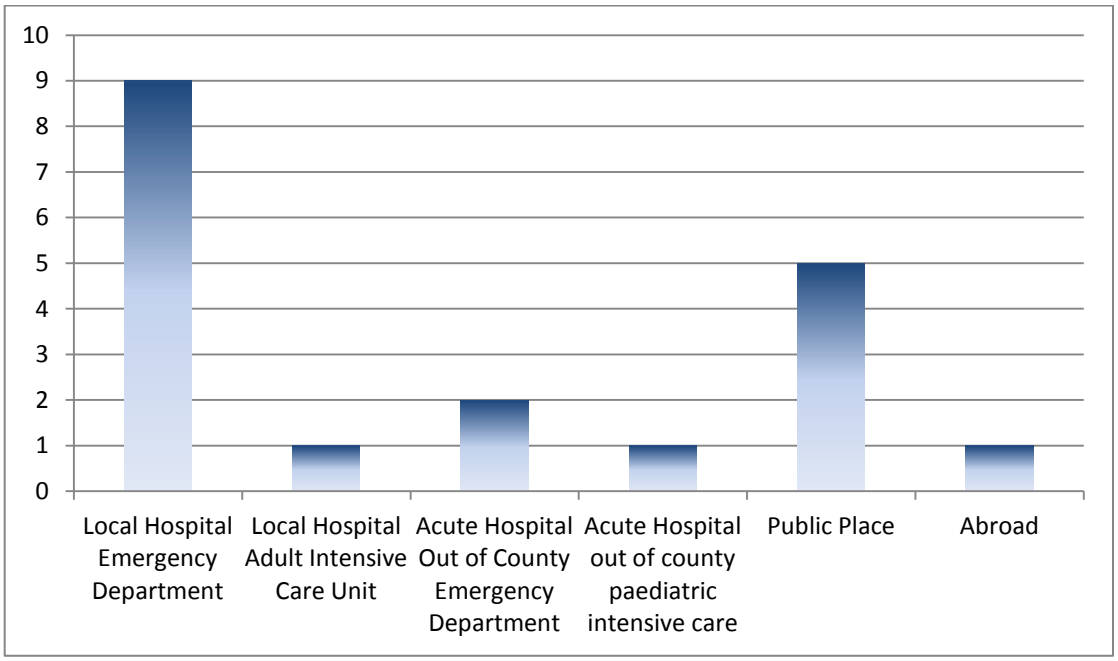


Chart 11 – Category of death for all deaths

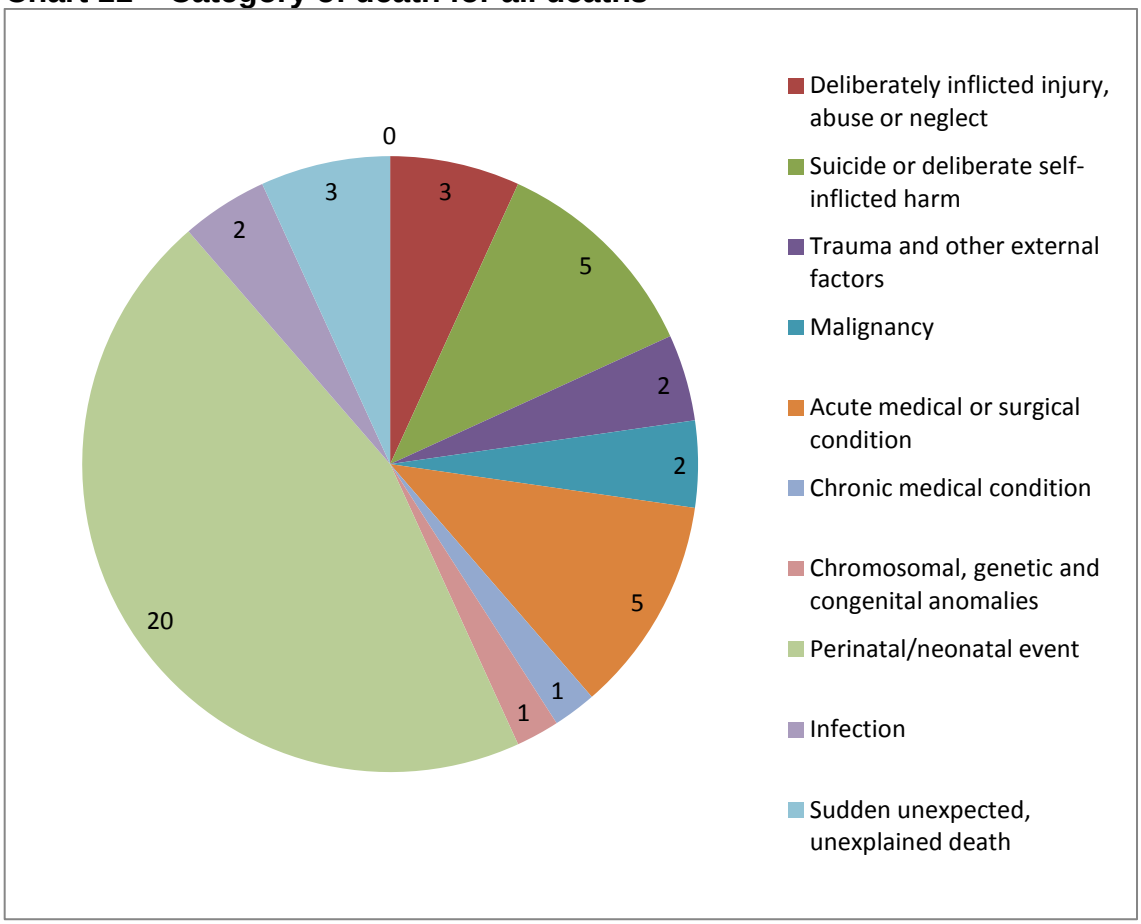
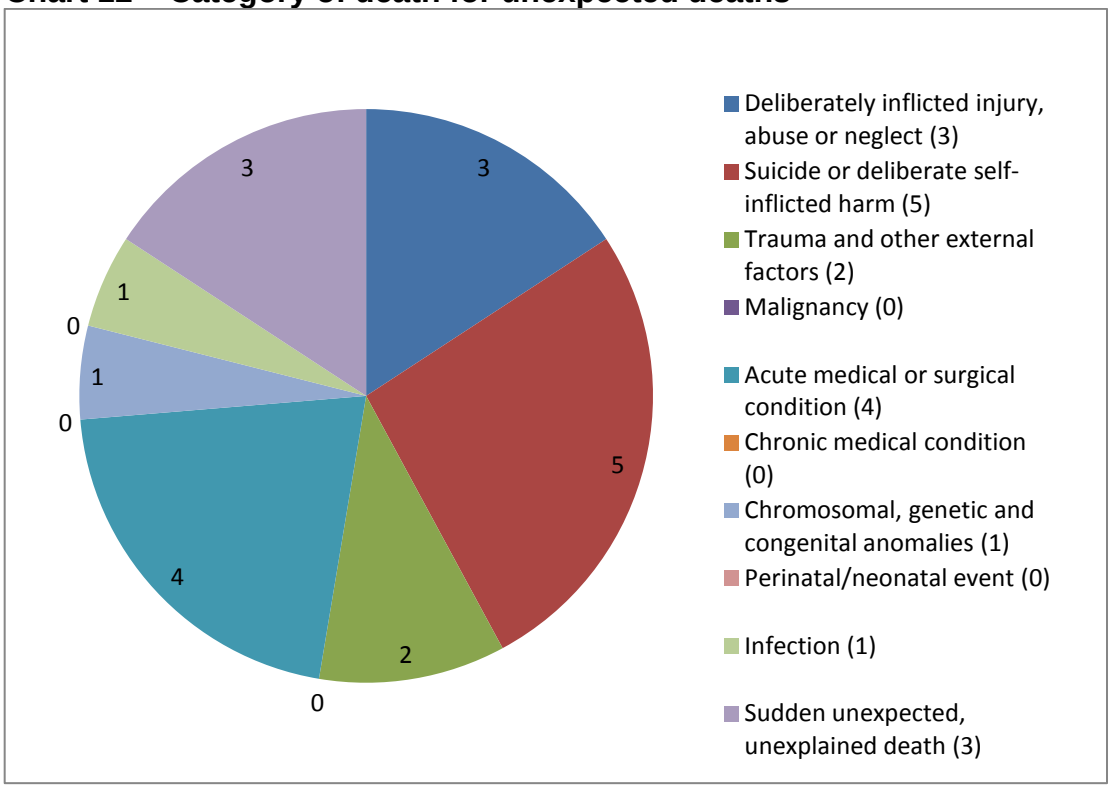


Chart 12 – Category of death for unexpected deaths



3. Learning points from child death review case discussions 1st April 2012 – 31st March 2013:

- Police to review of management of a child at scene of suspected suicide.
- Designated Doctor to discuss child death review process with Adult Intensive Care Unit.
- Home Deliveries – with the Government's intention for increased home deliveries, the need for increased vigilance by midwives to the possibility of deterioration in fetal wellbeing and the need for early escalation to the consultant led unit in accordance with NHS guidelines to be highlighted.
- Delay identified in relation to sharing summary of initial child death review meeting with mother.
- Terminology around not understanding health conversations particularly around complex conditions for children.
- Coordination of appointments is not always possible e.g. failed health appointments process and policies to be put in place to review reasoning for missed appointments.
- To ensure access to help/counselling services is easier.
- Work with Road Traffic Police in relation to raising awareness of child death review protocol.
- For Child Death Review Team – following initial case discussion meeting – attendee's sheet contact details to be circulated, this will help identify who is contacting who.
- Designated Doctor to review information around protein shakes and effects on young males.
- Child death process to discuss with coroner's officer the consideration of taking hair samples for toxicology in circumstances of collapsed child with no immediate indication of cause of death.
- Child death review team to raise concerns in relation to easily accessible alcohol within the county with Health and Wellbeing Team.

4. Recommendations from child death review case discussions 1st April 2012 – 31st March 2013:

- Case to be used as a training case to educate staff and raise awareness of parental mental health issues impact on children, particularly those who care for their parents.

5. Comparative Boroughs Data for Gloucester City 2012/13

Chart 13

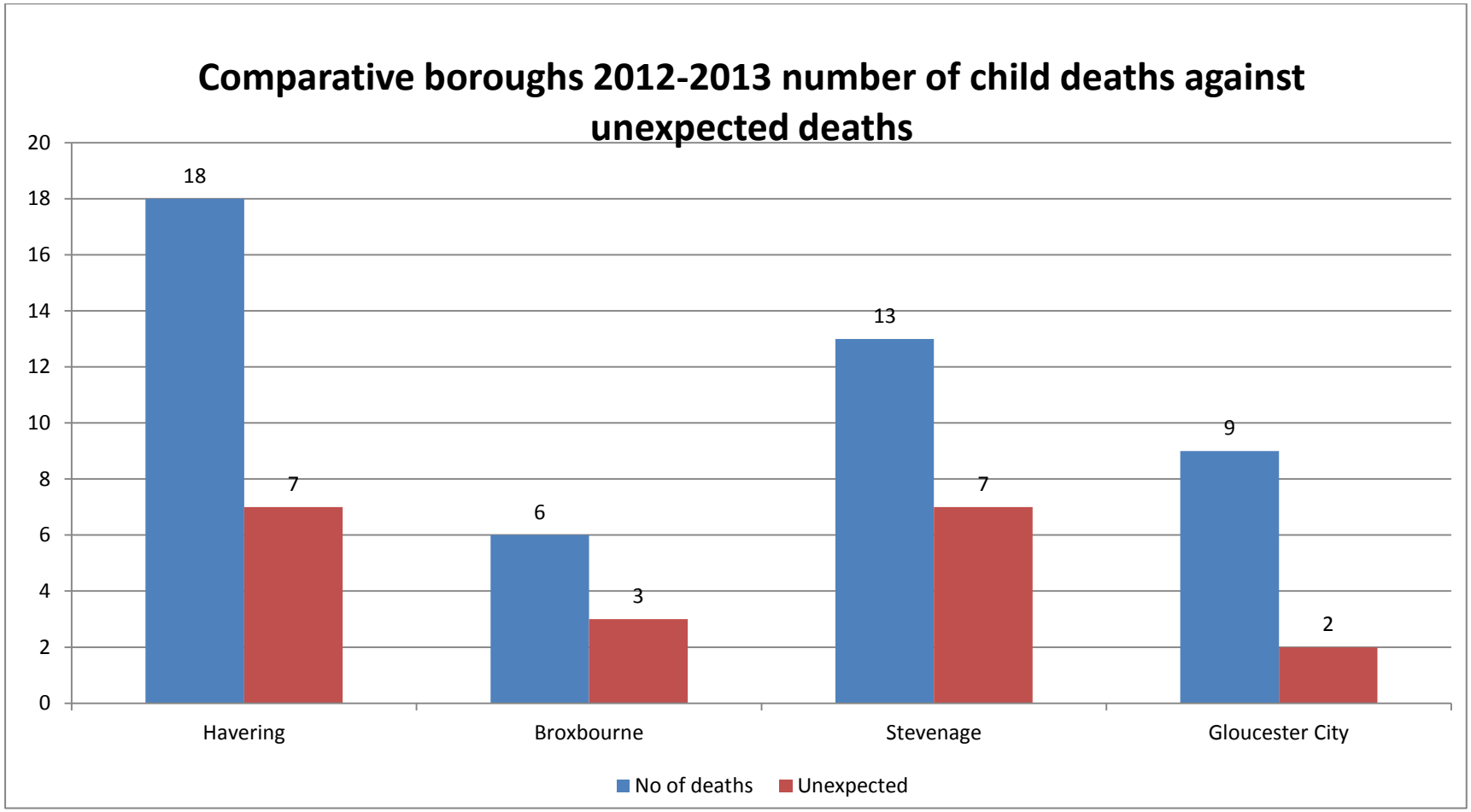


Chart 14

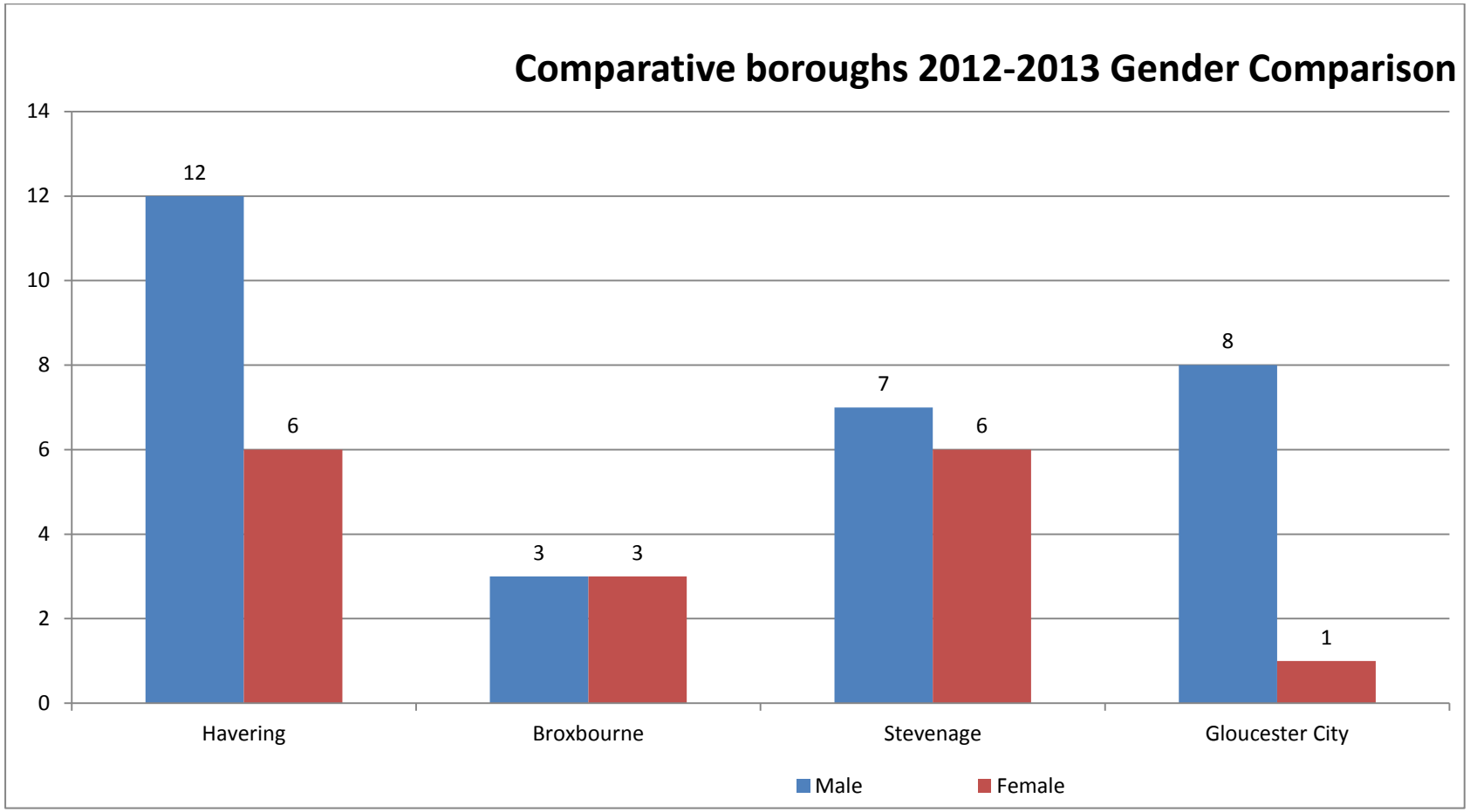

Comparative boroughs 2012-2013 Gender Comparison
14
12
10
8
6
4
2
0
12
6
3
3
7
6
8
1
Havering
Broxbourne
Stevenage
Gloucester City
Male
Female

Chart 15

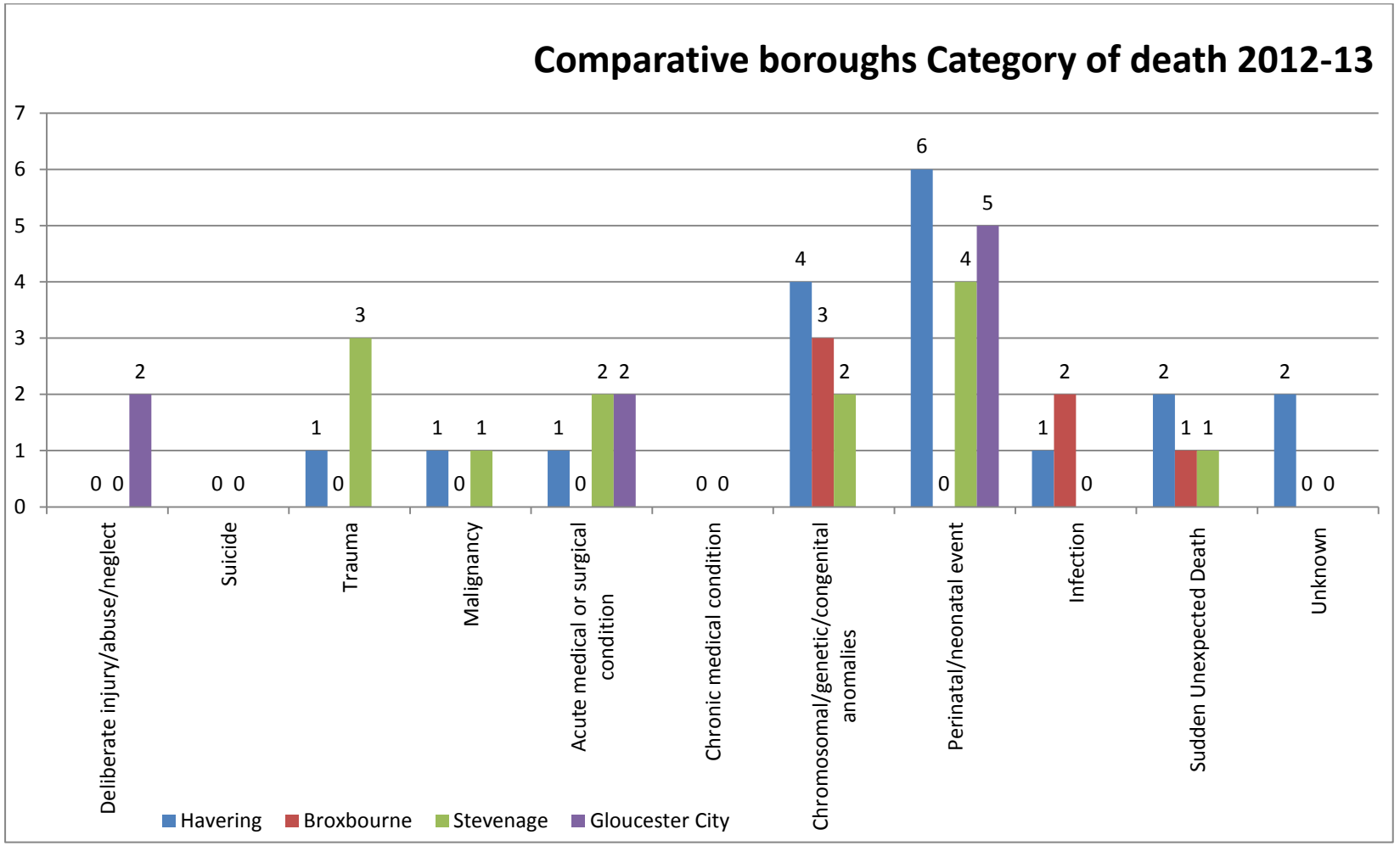
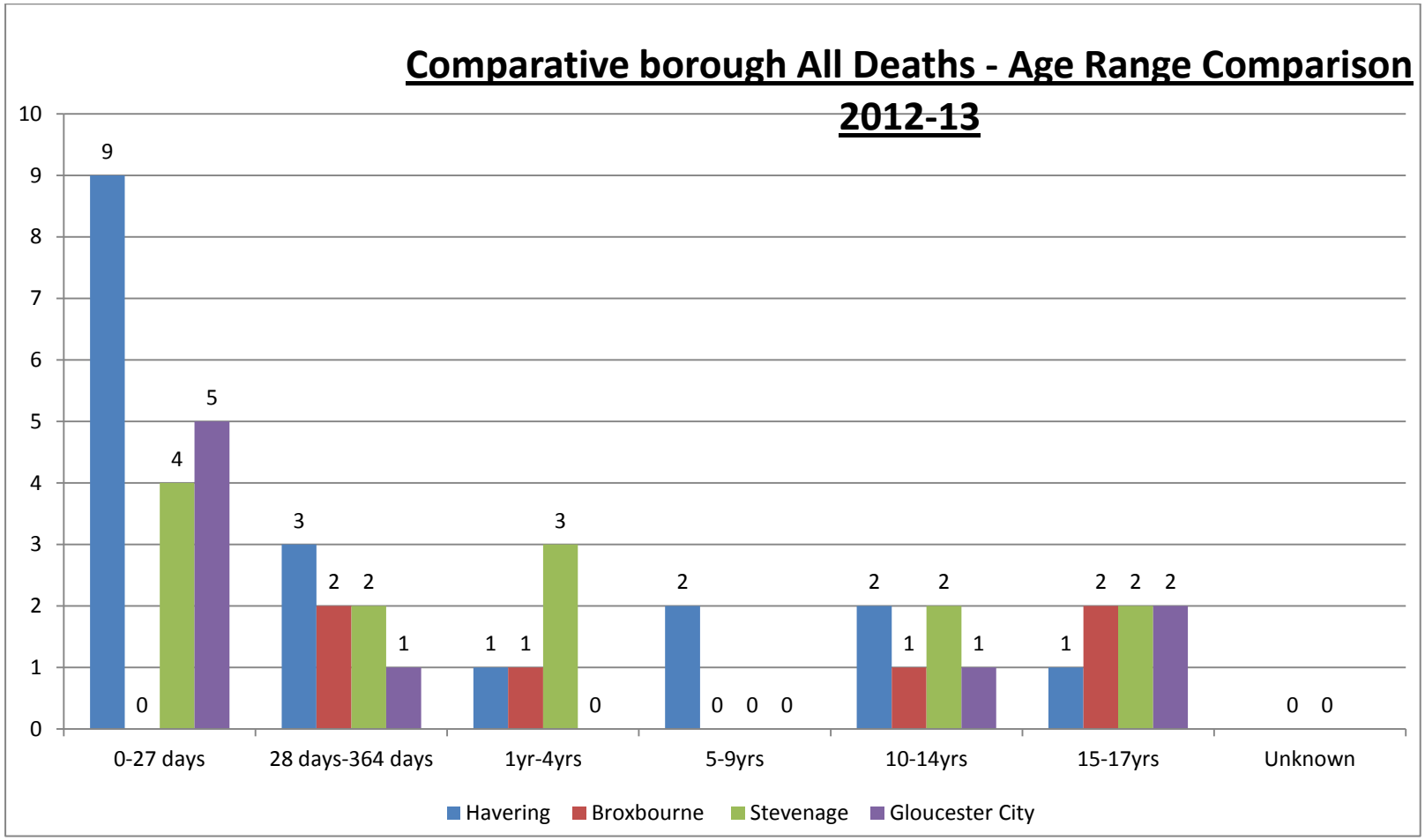

Comparative boroughs Category of death 2012-13
7
6
5
4
3
2
1
0
0 0
2
0 0
1
0
3
1
0
1
1
0
2 2
0 0
4
3
2
6
0
4
5
1
2
0
2
1 1
2
0 0
Deliberate injury/abuse/neglect
Suicide
Trauma
Malignancy
Acute medical or surgical condition
Chronic medical condition
Chromosomal/genetic/congenital anomalies
Perinatal/neonatal event
Infection
Sudden Unexpected Death
Unknown
Havering
Broxbourne
Stevenage
Gloucester City

Chart 16


Comparative borough All Deaths - Age Range Comparison 2012-13
10
9
8
7
6
5
4
3
2
1
0
9
0
4
5
3
2
2
1
1
1
3
0
2
0
0
0
2
1
2
1
1
2
2
2
0
0
0-27 days
28 days-364 days
1yr-4yrs
5-9yrs
10-14yrs
15-17yrs
Unknown
Havering
Broxbourne
Stevenage
Gloucester City

6. Child Death Overview Panel (CDOP) 1st April 2012 – 31st March 2013

33 child deaths were reviewed by the CDOP.

The panel identified 16 cases as having modifiable factors. The national definition of 'modifiable factors' is the 'the panel have identified 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'.

The South West Child Death Review Team based in Bristol continues to be responsible for anonymising and compiling the information on all deaths in childhood for Gloucestershire. Cases are then grouped according to cause of death e.g. infant deaths, deaths due to road traffic collisions etc. and discussed at themed meetings with co-opted specialist input. It is the role of the CDOP to determine any local trends and make appropriate recommendations.

The reviewing of child deaths is an extremely complex task and it may take a number of months to gather all the relevant information to be able to fully review the death. The Department for Education (DfE) requested information to assess the average length of time between a child's death and the completion of the review. The DfE have confirmed that this information will not be used as a performance measure. Of the 33 deaths reviewed all had taken over a year to be reviewed.

7. Cases reviewed by CDOP – Data reported to the Department for Education 2012/13 (Tables 1 – 6)

Table 1 – Total number of child deaths with modifiable and non modifiable factors

	Prior to April 2008	01/04/08 – 31/03/09	01/04/09 – 31/03/10	01/04/10 – 31/03/11	01/04/11 – 31/03/12	01/04/12 – 31/03/13	Totals
Total number of Deaths	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Modifiable Factors identified	**0**	**2**	**3**	**9**	**2**	**0**	**16**
Non modifiable factors identified	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Table 2 – Death according to gender with modifiable and non modifiable factors

	Number of child deaths with modifiable factors	Number of child deaths with no modifiable factors	Number of child deaths where there was insufficient information to assess if there were modifiable factors
Male	**12**	**7**	**1**
Female	**4**	**9**	**0**
Unknown	**0**	**0**	**0**
Not stated	**0**	**0**	**0**
TOTAL	**16**	**16**	**1**

Table 3 – Category of child death

	Number of child deaths with modifiable factors recorded under this category of deaths	Number of child deaths with no modifiable factors recorded under this category of deaths	Number of child deaths where there was insufficient information to assess if there were modifiable factors
Deliberately inflicted injury, abuse or neglect (category 1)	0	0	0
Suicide or deliberate self-inflicted harm (category 2)	0	0	0
Trauma and other external factors (category 3)	1	0	0
Malignancy (category 4)	0	2	0
Acute medical or surgical condition (category 5)	0	0	0
Chronic medical condition (category 6)	4	1	1
Chromosomal, genetic and congenital anomalies (category 7)	0	6	0
Perinatal/neonatal event (category 8)	3	6	0
Infection (category 9)	2	1	0
Sudden unexpected, unexplained death (category 10)	6	0	0
TOTAL	16	16	1

Table 4 – Age group

	Number of child deaths with modifiable factors	Number of child deaths with no modifiable factors recorded under this event	Number of child deaths where there was insufficient information to assess if there were modifiable factors
0-27 days	3	8	0
28 days- 364 days	7	2	0
1 year-4 years	3	4	1
5-9 years	2	0	0
10-14 years	0	2	0
15-17 years	1	0	0
Unknown	0	0	0
TOTAL	16	16	1

Table 5 – Ethnicity

	Number of child deaths with modifiable factors	Number of child deaths with no modifiable factors	Number of child deaths where there was insufficient information to assess if there were modifiable factors
White: English/Welsh/Scottish/Northern Irish/British	15	14	1
Mixed/multiple ethnic groups: White & Black African	0	0	0
Mixed/multiple ethnic groups: White & Asian	1	1	0
Mixed/multiple ethnic groups: Any other mixed/multiple ethnic background	0	1	0
TOTAL	16	16	1

Table 6 – Place of death

		Number of child deaths with modifiable factors	Number of child deaths with no modifiable factors	Number of child deaths where there was insufficient information to assess if there were modifiable factors
Acute hospital	Emergency Department	1	0	0
	Paediatric Ward	0	0	0
	Neonatal Unit	2	3	0
	Paediatric Intensive Care Unit	0	1	0
	Adult Intensive Care Unit	0	1	0
	Other (including delivery suites, labour wards, transplant units, etc)	0	3	0
	Unknown	0	0	0
Home of normal residence		8	7	0
Other private residence		2	0	0
Foster home		0	0	0
Residential Care		0	0	0
Public place (including roads, railways, parks, restaurants, beaches, etc)		1	0	0
School		0	1	0
Hospice		1	0	1
Mental health inpatient unit		0	0	0
Abroad		1	0	0
Other (specify below)		0	0	0

Table 7 – CDOP Recommendations

Date of Recommendation	Recommendation for Action	Update/Outcome
May 2011	CDOP to raise concerns in relation to Sat Navs/distractions and implications of their distraction of drivers in relation to road traffic collisions.	Chair wrote to the Head of the Gloucestershire Road Safety Partnership, to highlight concern. Data reviewed from them currently not identified as an issue.
July 2011	The panel identified there is a need for placentas to be kept for future investigation in children who have died unexpectedly in the neonatal period. This may provide valuable information at post mortem in identifying factors contributing to the death.	Chair wrote to head of Midwifery, Gloucestershire Royal Hospital. It is understood that there has been a change to procedures and this recommendation has been added to the intrapartum guidelines.
July 2011	The 'Widening of the elective transfer of sub 26 week infants within the Western neonatal network to include ex-utero transfers from 01/05/08" and the "South West Neonatal Services in–utero Transfer Policy 2010" had been circulated to the group for information. Panel requested evidence as to the audit outcome of the service.	Chair wrote to South West Neonatal Network Chair. Currently no data available to support policy. March 2013 ongoing discussion with Neonatal Network in relation to obtaining this data.
September 2011	CDOP recommended single asthma policy for all schools. Education Representative to take to GSCB Education and Learning Sub Group for discussion and approval.	Standardised Asthma policy for schools written and agreed by GSCB Education & Learning Sub Group, added to GSCB website. http://www.gscb.org.uk/index.cfm?articleid=22092
September 2011	CDOP Public Health representation to discuss with Smoking Cessation Service the need to reference how smoking can be a trigger for asthma in the home.	The smoking cessation service already discusses the effects of smoking on asthma in children and this is part of the one to one conversations with smokers.
September 2011	CDOP - task and finish suicide sub group was set up in November 2010 to review cases over the past 4 years in relation to preventability and assisting schools with dealing with an unexpected child death. Strands of work have been linked into the Countywide Suicide Prevention Strategy published July 2011.	Action plan of group to be monitored through CDOP. Unexpected or Traumatic Death of a Pupil – Guidance agreed by Education & Learning sub group of GSCB. Now on GSCB website. http://www.gscb.org.uk/index.cfm?articleid=92071
September 2011	For Social Care - effective communication continues to be essential in all child protection cases – and in particular when a section 47 process is closed. All individual agencies need to be notified of the closure.	Taken to GSCB.

Date of Recommendation	***Recommendation for Action***	***Update***
September 2011	For all agencies - management of child protection cases should follow local processes and or procedures irrespective of any individual's background, job and other external factors.	Taken to GSCB.
January 2012	Currently body armour is not specifically recommended for horse-jumping. This case to be highlighted to the Pony Club and National Institutes suggesting they give consideration to recommend body protectors for all horse related activities.	Child Death Review Team has written to organisations with recommendation. January 2013 posters in relation to horse safety and the wearing of Body armour have been distributed to stables and schools.
January 2012	Child death review process: There is a need to review support to staff following traumatic events.	Continually being reviewed.
January 2012	Schools to raise awareness of child death review process during next Schools Partnership Meeting.	Completed.
January 2012	Child death review process needs to consider funding for specialist professional advice (e.g. CAMHS) in rapid response process. Chair of CDOP to contact Children's commissioning team in relation to inclusion in their contract.	Part of new contract.
January 2012	Chair of CDOP to raise incident with the Home Safety Team in relation to checking patio doors when carrying out home safety checks.	Letter Written.

In Gloucestershire the majority of any learning points and recommendations are picked up at the final case discussion meetings held by the child death review team. Any work involved in relation to these is normally completed prior to the cases being presented at the CDOP. Therefore more than often any specific identified recommendations have already been addressed and the CDOP will approve the recommendations and refer appropriately to the agencies involved if not completed or additional actions are required.

8. Cumulative Data for all Deaths in Childhood 1st April 2008 – 31st March 2013

A total of 195 deaths have been notified to the CDOP.

Chart 17 – Expected/unexpected deaths

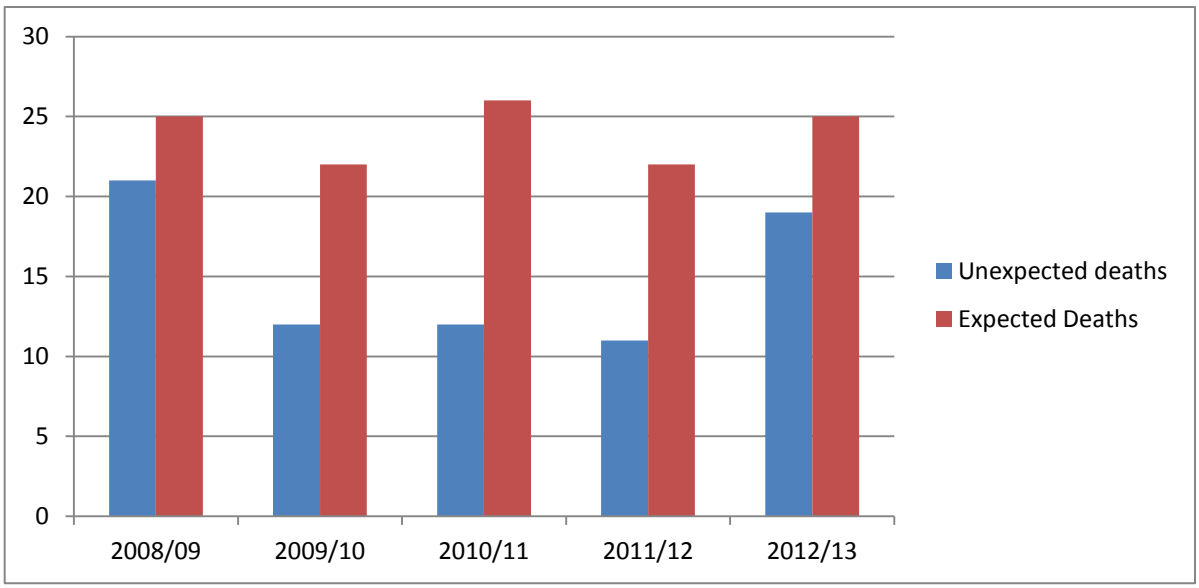


Chart 18 – Gender for all deaths

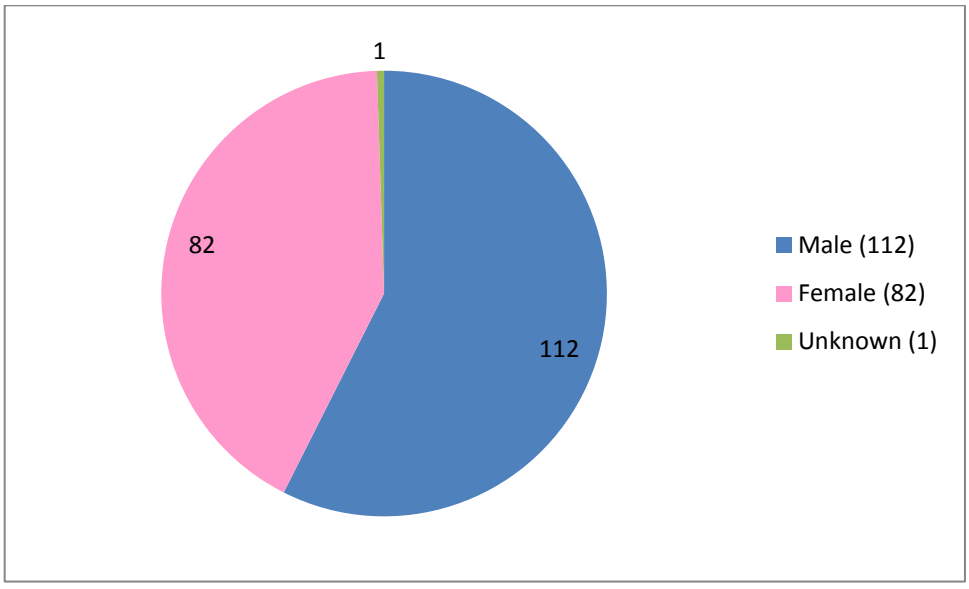


Chart 19 – Month of expected/unexpected death

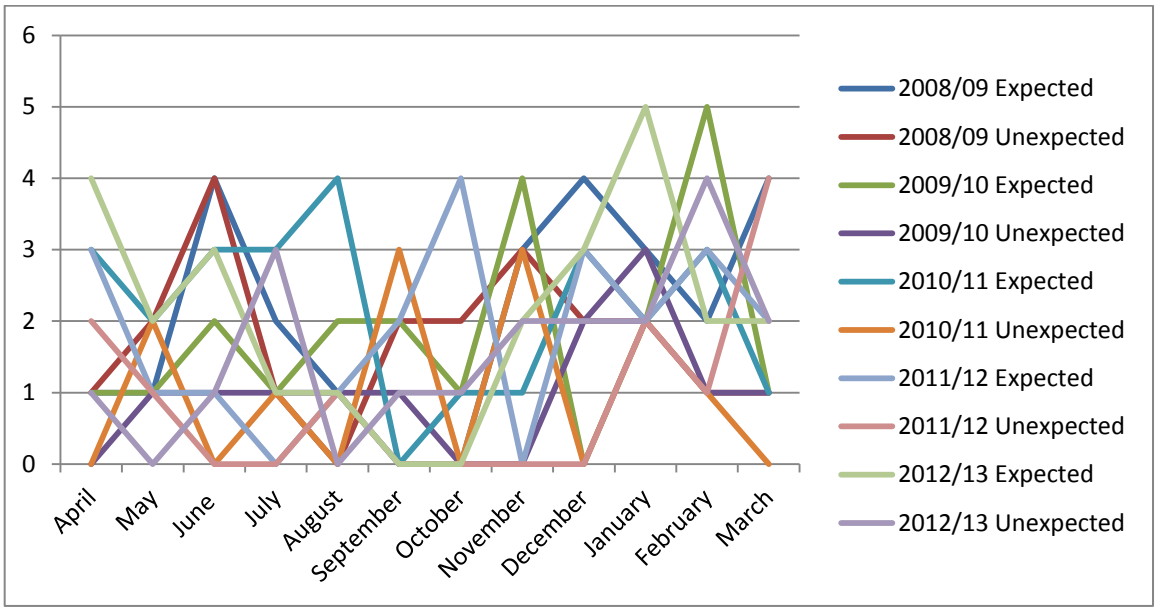


Chart 20– Day of death expected/unexpected

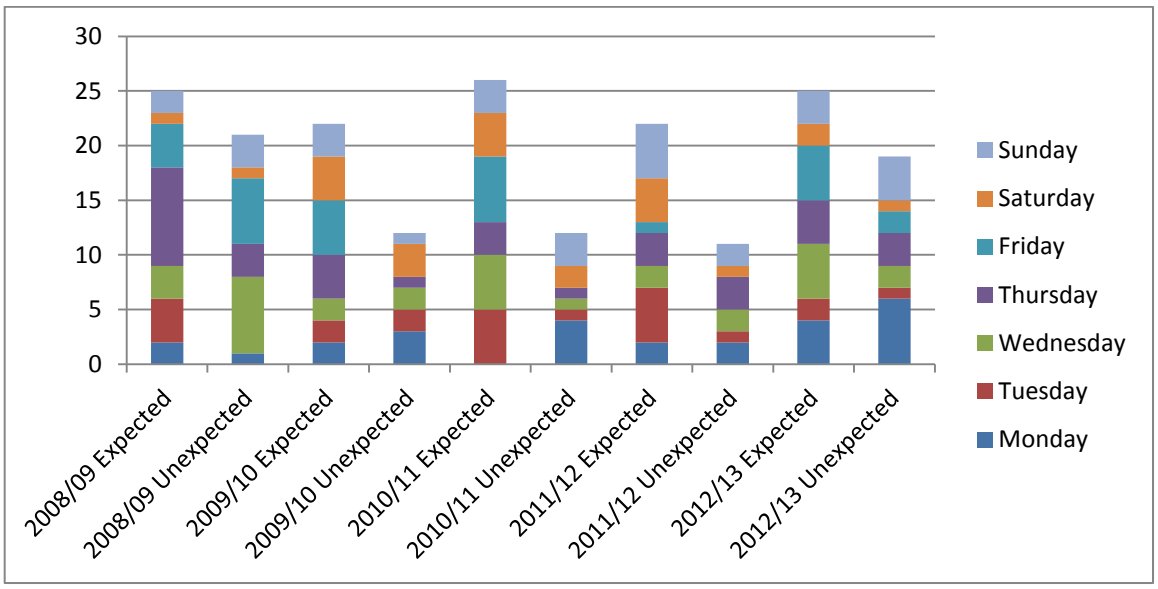


Chart 21 – Place of death for all deaths

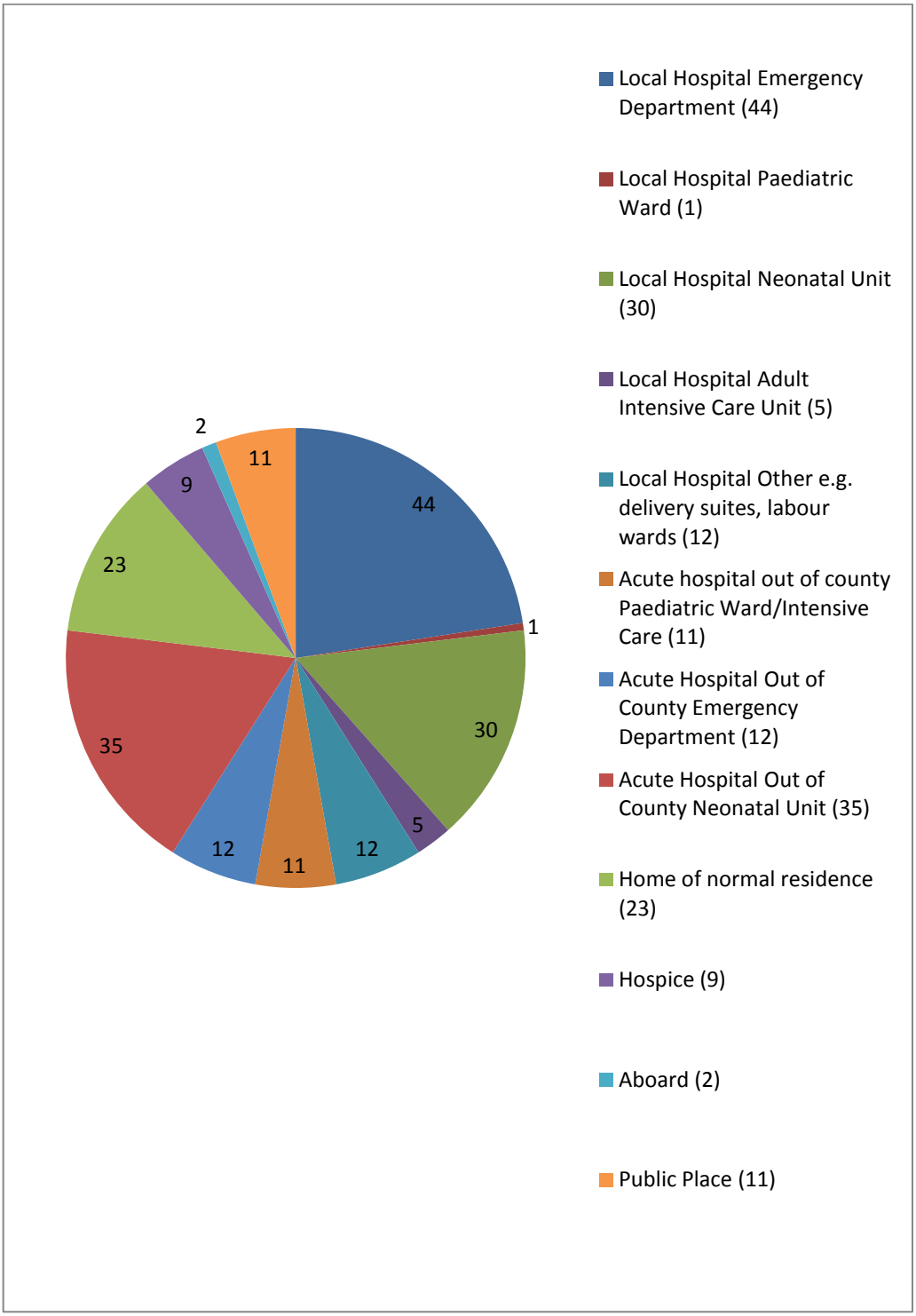


Chart 22 – Place of death for unexpected deaths

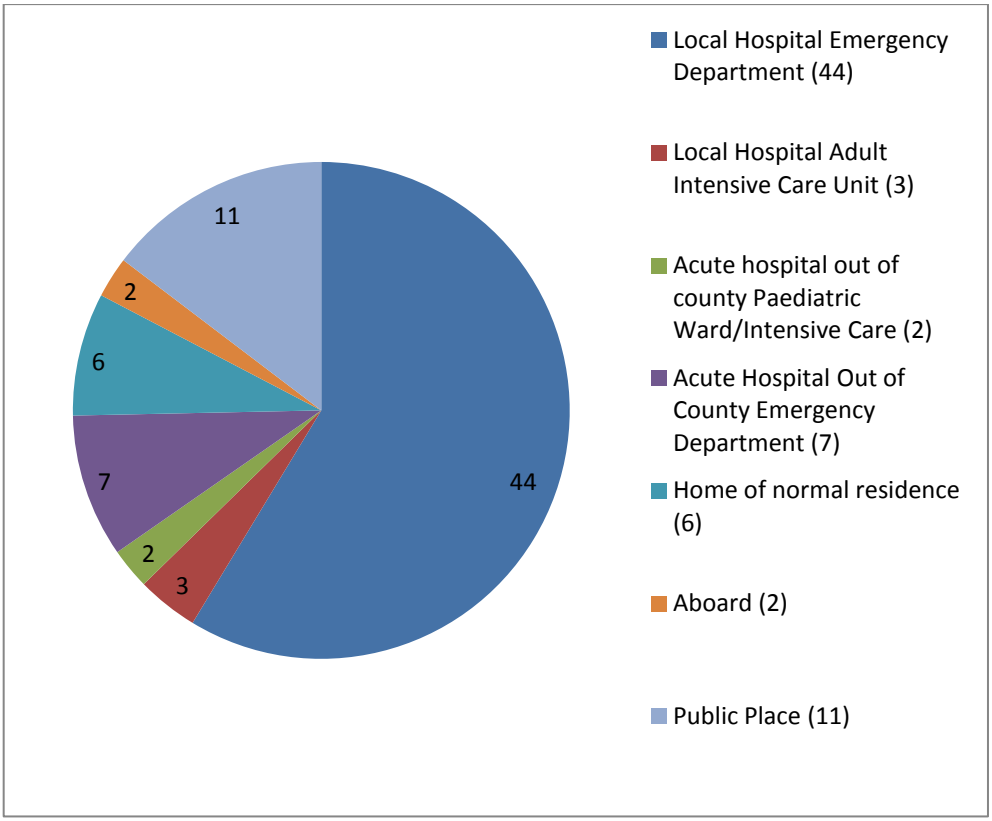


Chart 23 - Age Group for all deaths

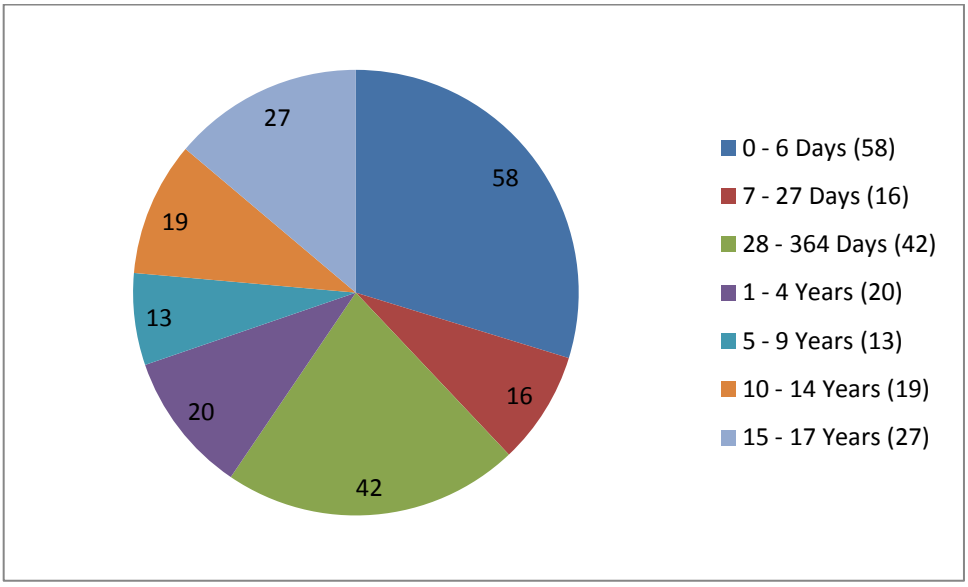


Chart 24 – Age Group for unexpected deaths

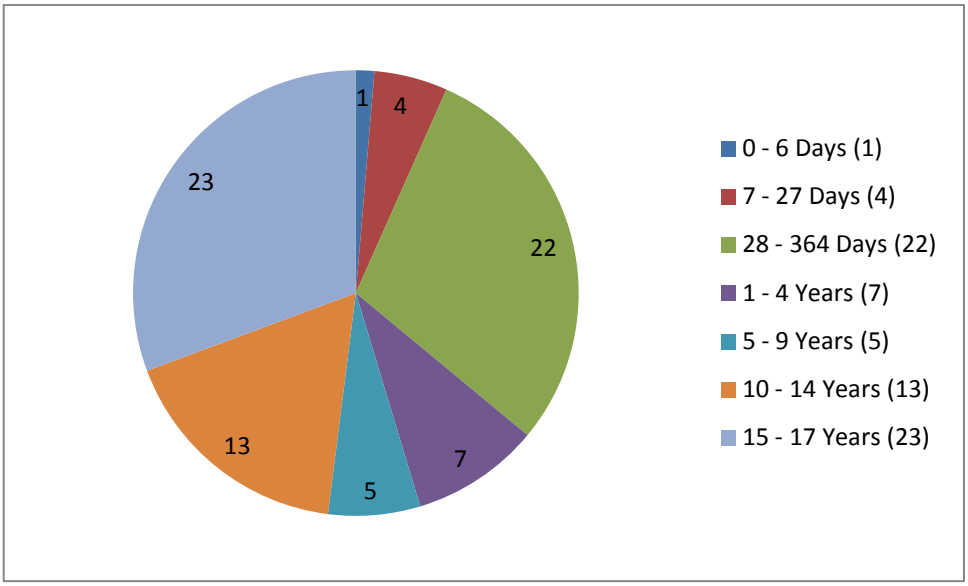


Chart 25 – Category of death for all deaths

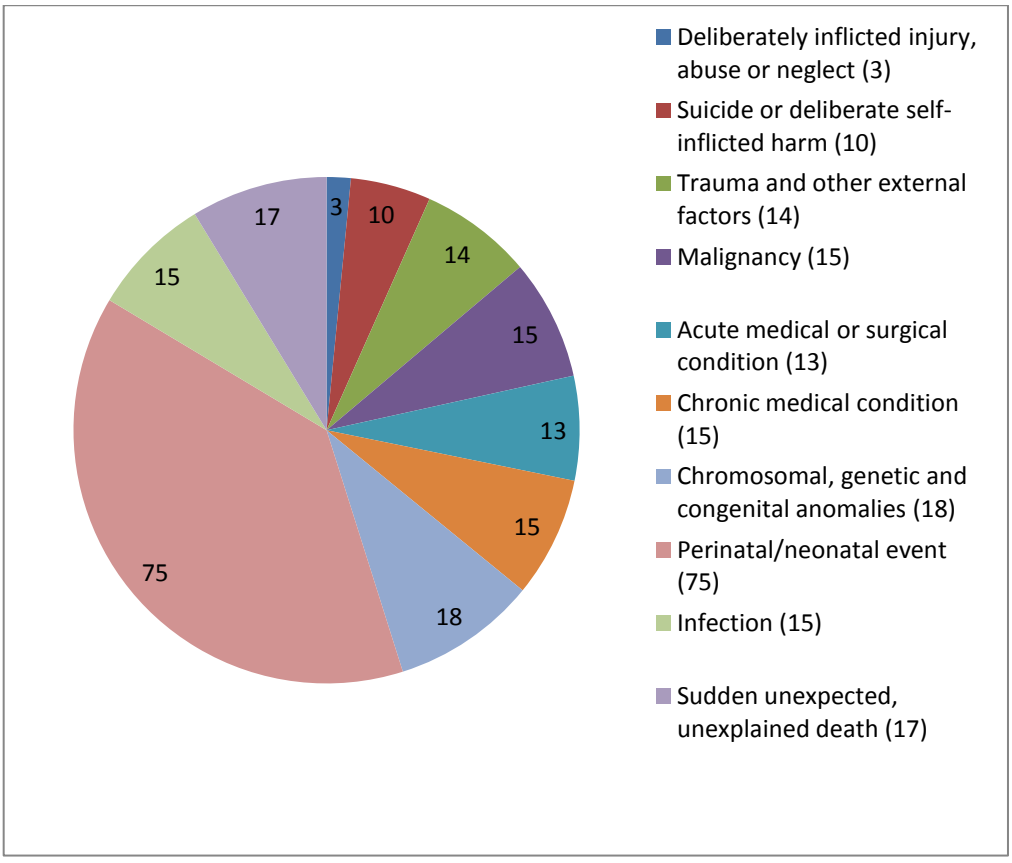


Chart 26 – Category of death for unexpected deaths

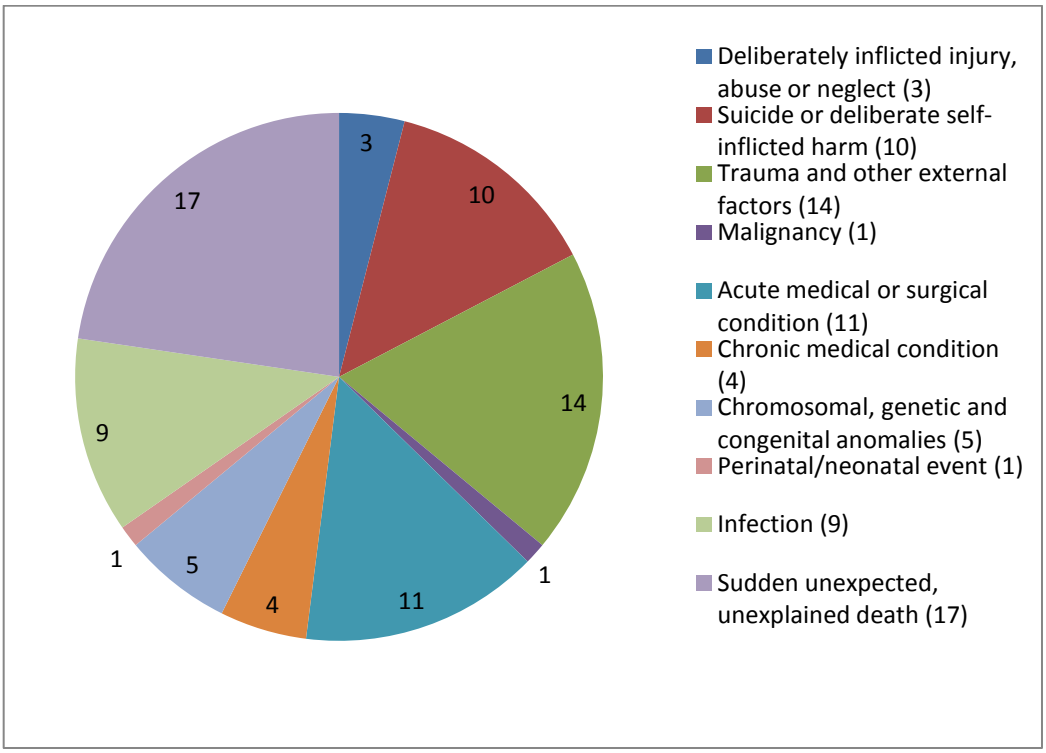


Chart 27 – Ethnicity all deaths

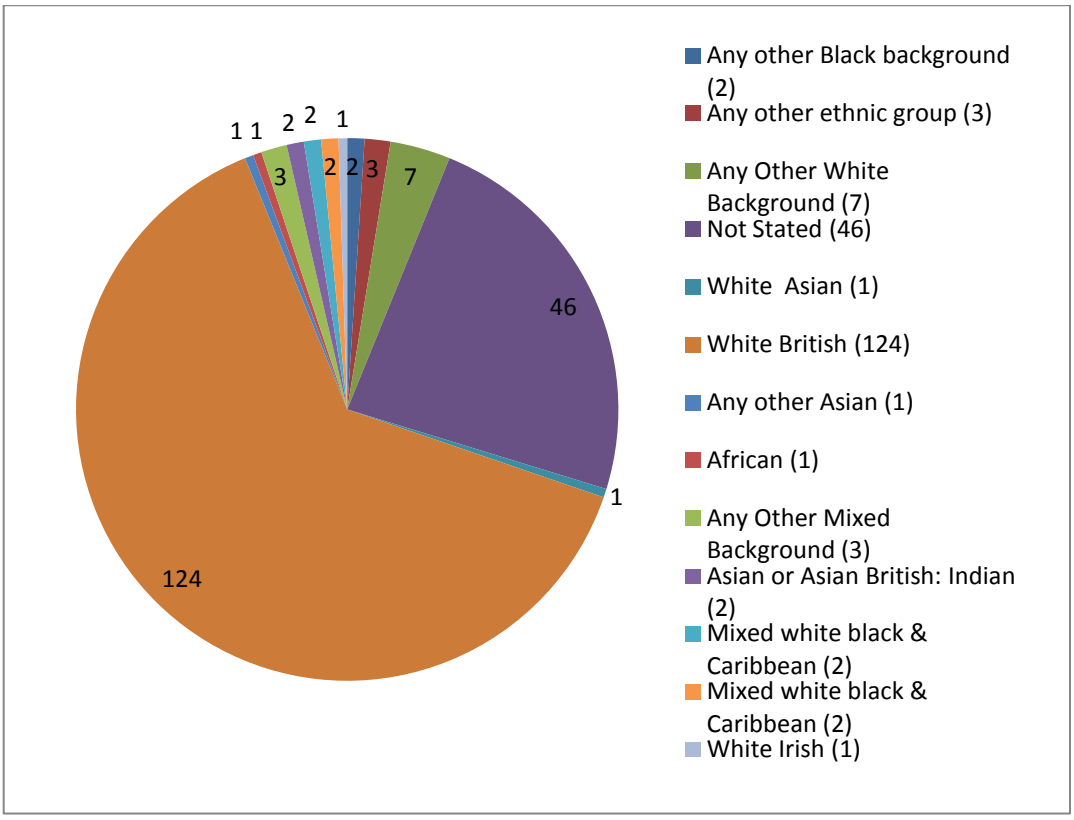
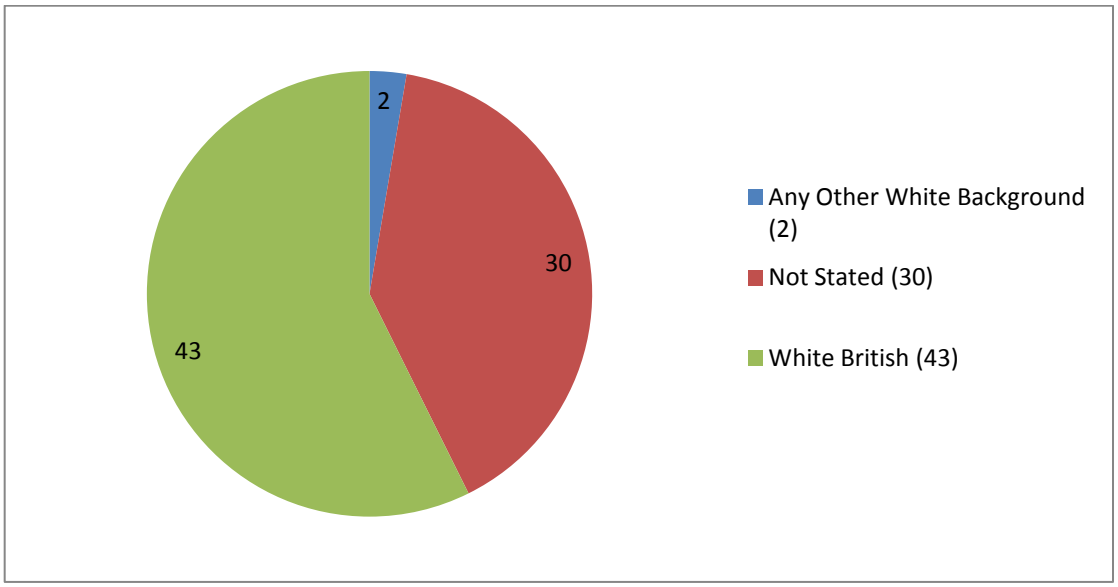


Chart 28 – Ethnicity unexpected deaths



9. Local Links – Other work in the County

SkillZONE
SkillZONE is a state-of-the-art life size village. It is a fully interactive learning environment to teach people of all ages how to recognise dangerous situations and stay safe.

There are 16 zones, which will cover a range of scenarios including road, rail and water safety, an internet cafe, as well as opportunities to cover home and personal safety. The child death review team have worked with colleagues in public health to ensure that some of the scenarios in the centre reflect learning from some of the child deaths.

Suicide
Various previous pieces of work in regards to linking prevention work to the county's suicide prevention strategy have taken place over the years. Due to the numbers of suicides for the county in 2012/13 a short term working sub group linking into the suicide prevention strategy group and GSCB has been established.

One of the first priorities for the group was to send an alert to all school head teachers in December via the Education and Learning Sub Group of the GSCB communication links, work is on-going.

Using the child death review coordinators national email network a request for information on numbers of suicides being experienced across the country was circulated. Nineteen areas kindly responded to the request.

Since 2008 the areas have had a total of 82 child deaths under the category of Suicide or deliberate self-inflicted harm.

The children's gender split is 57 males (70%) and 25 females (30%). The method overwhelmingly used was hanging (76%) which resulted in death. Ages of the children can be seen in the table below.

Table 8 - Age of child death under category of suicide or deliberate self inflicted harm 1st April 2008 – 31st March 2013 across 19 areas.

Age Years	9	10	11	12	13	14	15	16	17	14 to 17	Unknown	
Male	1	1	3	1	3	4	5	9	14	10	6	**57**
Female	0	0	0	1	2	1	2	5	4	7	3	**25**
Totals	**1**	**1**	**3**	**2**	**5**	**5**	**7**	**14**	**18**	**17**	**9**	**82**

Asthma

Following two teenage deaths from asthma, during the last five years, key factors identified within the reviews demonstrated the need to ensure compliance of taking regular medication and ensuring asthma reviews at practices were attended by the child. These learning points have formed part of GP Training programmes.

In addition a piece of work to identify children being either admitted to hospital or attending the emergency department with asthma is being carried out by the child death review team to determine The number of young people who present in this way and their management plans.

Results will be forwarded to the County Respiratory Teams to determine future strategic management plans.

Allergies

Following a child death as a result of an allergic reaction the child death review team reviewed the allergy services available for children were available in the county.

From January 2013 Gloucestershire have one nurse covering all of the allergy clinics. This service includes:

- Running nurse led allergy clinics across the county (4 per month in total) the 30 minute slot can include skin prick testing
- Epipen training, advice re useful websites (such as Allergy UK)
- Reading food labels
- Medic alert jewellery
- Travel advice
- Encouraging carrying a specific 'allergy bag' at all times with necessary kit (e.g. inhaler, piriton, Epipen and action plan).

Telephone advice is also available as well as occasionally home visits and also school / Nursery / playgroup visits if a child has an Epipen. These

sessions include how to avoid contact with known allergen, how to recognize and treat an anaphylactic reaction and how to administer an Epipen. This is an invaluable service for the families who use it and the child death team are delighted in highlighting its existence.

Car seats
Following three deaths involving car seats in the county since the child death review process commenced in 2008 the Designated Doctor has been in correspondence with other colleagues across the country to highlight concerns of children in car seats. Previous research in relation to the type of car seats, angles babies were laid to sleep/sit has been carried out nationally. Studies published on medical websites have found that, because of restricted airways, oxygen saturation levels (the amount of oxygen in your blood) are lower when children are in child car seats. The child death review team would support any further research into these types of deaths.

10. Future Process changes

From 1st April 2013 the coordination for child death reviews responsibility will sit under the GSCB Business Unit. We would like to extend our thanks to Ginny Davies our departing coordinator, who has joined an NHS succession organisation, for her tireless commitment and dedication to the child death process. Ginny has been a major drive and instigator in Gloucestershire's CDOP process. We are delighted to introduce Charlene Sampson as the new coordinator. Charlene can be contacted on charlene.sampson@gloucestershire.gov.uk 01452 426321.

One of the first tasks for Charlene will be to update the Joint Child Death Review Protocol with all the partner agencies.

Designated Doctor for Safeguarding Children, including the Child Death Review role (Dr Imelda Bennett imelda.bennett@nhs.net) will sit under the NHS Gloucestershire Clinical Commissioning Group, along with the Designated Nurse (Helen Chrystal 0300 421 1607) helen.chrystal@nhs.net) .

The Rapid Response Nurse roles, as mentioned previously will sit under the Gloucestershire Care Services NHS Trust.

Appendix 1

Child Death Review Team Work

National Links

Over the past 5 years the child death review coordinators have corresponded through a national email network allowing collection of information and distribution of lessons learnt e.g. the role of bath seats.

In 2008 – 2012 there were 7 known deaths of children in England between the ages of 7-15 months, involving the unsupervised use of bath seats as reported by a number of CDOPs nationally. There were a further 2 deaths where bath seats were suspected to have been in use but where this was not confirmed.

In 6 of the 7 cases parental supervision was intermittent. In the majority of cases parents reported leaving the bathroom for a matter of minutes to attend to other matters in the household such as chores.

In 2 cases, a sibling was also present in the bath at the time of the incident leading to death. In 1 further case siblings were present previously. For 1 case this information is not known and there were 4 cases were the child was alone in the bath.

Actions and recommendations arising from Bath Seats CDOP reviews:

Not all deaths have yet been reviewed by the respective CDOPs. From those that have been reviewed, below are a list of the recommendations/actions arising from the various CDOPs:

- Safer bathing campaign undertaken
- Advert added to health guide
- RoSPA notified of the death
- LSCB's to raise public awareness of consequences of lack of bath-time supervision by adult
- Notify HV leads and ask them to circulate message promoting awareness and supervision at all times.
- Work with other CDOPs and Child Safety Charities
- Health Alert required for all Health Visitors and Midwives in relation to bath seats for infants, also to be targeted to any relevant voluntary agencies. Information on this potentially hazardous device to be circulated more widely, including to the Child Accident Prevention Trust.
- CDOP Chair to pass information on this device to the DCSF nationally.
- CDOP Chair to write to Public Health Nursing Lead to emphasise the importance of the routine 9 month check – particularly giving safety information to parents.

From this list there is a consensus around the need for the following:

- Public awareness of the need for supervision to ensure safe bath-times for children.
- All professionals working closely with children of the relevant age, to be aware of the risks that bath seats may pose and to discuss these with parents.
- National accident prevention charities and the Department for Education to be made aware of the potential risks of this equipment and to assist in raising awareness amongst public, professionals and industry.

Key learning includes:

- Babies and Children must be supervised in the bath at all times.
- Bath seats must not be relied upon as a substitute for parental supervision as it is possible that they may malfunction and case a child to become submerged, which may lead to death. Likewise the presence of a sibling should not be relied upon to alert a parent to any problem that may occur.

Recommendations

- The findings have been shared with national child accident prevention charities such as RoSPA and CAPTShare findings with CDOPs nationally in order that they can cascade local agencies to raise awareness via health alerts or similar.
- Shared findings with manufacturers of bath seats in the UK so consideration of the prominence of safety messages on the product. Findings shared with DfE in order to raise their awareness or the risks posed and the work undertaken in relation to them.

As a result of the accidental death of a baby, Gloucestershire has been able to publish a national alert warning about the use of bath seats for very young children. Gloucestershire has been praised for the effectiveness with which this new process has been introduced a Health Alert required for all Health Visitors and Midwives in relation to bath seats for infants was also circulated.

Appendix 2

Child Death Review Team Work

Regional Links

South West Child Death Overview Panel Network

Following the implementation of the child death review process from April 2008 it was recognised by the then Government Office South West (GOSW) and the then South West Strategic Health Authority (SW SHA) that with a new process being implemented that support to achieve effective processes and procedures should be considered by the South West Region as a whole.

Therefore the South West Regional CDOP Coordinators Network meetings were founded.

During this time there were several meetings largely facilitated by GOSW Safeguarding Children's Advisors.

Following the disbandment of the GOSW in September 2010 in order to continue the links between CDOP managers and coordinators a decision was taken by the members of the regional network group to continue to meet. It was agreed each area would host and facilitate a meeting annually.

The meetings would continue to identify best practice to support the on-going development of child death overview process in the South West in order to achieve better outcomes for children and their families.

The network would also provide peer support opportunities for members, in order to:

- share experience and knowledge
- support regional communication
- keep up to date with research
- share policies, protocols, procedures and resources
- learn from each other and problem solve
- provide a link with Department of Education
- Identify regional training and development needs and training opportunities.

During this time the network have also been involved in three themed regional CDOP meetings which have included Cardiac, Children with Learning Disabilities and Suicide themed meetings.

Examples of shared good practice:

- CDOP Annual Reports are shared across the network.
- Audit using National Template for Rapid Response – areas identified good practice are shared with the network – along with any learning points and issues identified.
- Attendance of regional themed CDOP meetings which have included suicide, cardiac and learning disabilities.
- Attendance at regional meetings of Designated and Named Safeguarding professionals.
- The sharing of information, literature, leaflets, letter templates in relation to contacting families following a child death across the network.
- Audits of bereavement care at local case discussion meeting completed by Dorset and shared with the network.
- Sharing of information relating to Benefits following Bereavement – paper circulated with useful information on it regarding child benefit, funeral grants, child trust fund and child tax credit to the network. The information is useful to share with bereaved families.
- Work across the region in relation to definitions of the 'preventability' of the child's death "modifiable factors identified" and "no modifiable factors identified" to ensure similar interpretation across the south west CDOPs.
- Standardised responses across the region in relation to collating data on previable births. Schools guidance for unexpected or traumatic deaths of a pupil, produced by Gloucestershire shared with the network.
- Standard agenda items agreed for each network meeting. Including discussion of National/Regional emails in relation to child death enquiries to ensure the network continue to be up to date with national as well as regional learning.
- Attendance/facilitation of Rapid Response training for lead professionals including police, social care and health representatives have been arranged by colleagues from the Peninsula. This has given opportunity to network and share good practice across the country.

Challenges

- Payment request for completion of Form Bs from GPs
- Children who die abroad
- Funding of CDOPs

The continuation of the network is instrumental for those who attend to ensure the continued high standards being achieved within the region are maintained and best practice shared amongst those who are fundamental to the child death review processes.