

# WILTSHIRE AND SWINDON CHILD DEATH OVERVIEW PANEL (CDOP) NEWSLETTER

Spring Edition  
2021

The Wiltshire and Swindon Child Death Overview Panel (CDOP) review every child death, to identify whether there were any modifiable factors which may have contributed to the death and what, if any, action could be taken to prevent future deaths.

This newsletter is for professionals working with parents and their children, to highlight some of the learning, guidance and useful resources to support safe, healthy families.

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## CDOP Annual Report (2019/20) Overview

The Wiltshire and Swindon Child Death Overview Panel is required to produce an annual report outlining reviews undertaken and relevant learning from these cases.

The key points highlighted in the 2019/20 report show:

### Number of Child Deaths

- Between 2015-2020, 185 child deaths were notified.
- Between 2019-20 (financial year) there were 14 deaths in Swindon and 23 in Wiltshire.

### Age of Death

- Most deaths between 2015-2020 occurred in the neonatal period (under one month of age) with 50% in Swindon and 41% in Wiltshire.
- When this is extended to children under 1 year of age, there is an additional 15% in Swindon and 17% for Wiltshire falling into this group.

### Gender

- Across the five year data there were more notifications of deaths in boys than in girls in both areas with males consisting of 60% of deaths in Wiltshire and 56% of deaths in Swindon. This is comparable with the national gender split in child deaths.
- For the year ending 2019, 56% of child deaths were boys and 44% girls.



## Location of Death

- The most common location of death for Wiltshire children is in hospital, where 81 children died (72%) between 2015-2020. In total, 32 (28%) children in Wiltshire died at home or at another relative's residence.
- The most common location of death for Swindon children was also in hospital where 52 children died (72%) and 28% (20) of Swindon children died at the parents or another relative's home.

## Ethnicity

- Most deaths in both areas were children of White, British ethnic origin (71% in Wiltshire and 60% in Swindon) although ethnicity was not recorded for 17% of the deaths.
- Where ethnicity was recorded, the proportions of deaths by ethnicity were in line with the ethnicity breakdowns for each area, however ethnicity recording needs to improve in order to provide assurance that there is no disproportionate representation of child deaths by ethnicity. The ethnicity of a child may be recorded as 'not known' if, for example, the professionals notifying CDOP did not have it on record, or someone refused to provide that information.

## Cause of Death

- The majority of cases reviewed in Wiltshire between 2015-2020 were categorised as perinatal or neonatal (31%) with chromosomal genetic and congenital anomalies being the second most common at 23%. The third most common category of death was malignancy with 14% of deaths reviewed during the period falling into this group. This is in line with the national picture.
- The majority of cases reviewed in Swindon between 2015-2020 were categorised as perinatal or neonatal (31%) with chromosomal genetic and congenital anomalies being the second most common at 23%. The third most common category of death was acute medical or surgical condition with 15% of deaths reviewed during the period falling into this group. An example of a death from an acute medical condition would be a child that died of asthma. This data reflects the national picture.
- No modifiable factors were identified in most deaths reviewed. However, modifiable factors were identified in 31% of Wiltshire cases and 20% of Swindon cases reviewed by the panel between 2019-2020 in comparison to the national picture which shows that CDOPs identify 29% of their deaths as modifiable.

## Thematic Analysis of Rapid Reviews

The national Child Safeguarding Practice Review Panel recently published their thematic analysis of Rapid Reviews. This related to serious child safeguarding incidents reported during the initial COVID-19 outbreak (March-September 2020).

The review identified specific factors (shown below) impacted by the pandemic for both families and services and analysed how significant each factor was across the cases audited:

- An increase in parent and family stressors
- Exacerbated vulnerabilities for children and young people
- Impact of school closure: identification, contact with and support for vulnerable children and young people
- Impact of adaptations for COVID-safe practice

Parental and family stressors were found to have had a major impact across cases, as were increasing incidences of domestic violence and mental health concerns.

The review demonstrated that COVID-19 presents a situational risk for vulnerable children and families, with the potential to exacerbate pre-existing safeguarding risks, and bring about new ones.

The full briefing is available here: [Child Safeguarding Practice Review Panel Briefing](#)



Child Safeguarding  
Practice Review Panel

## Panel Case Review – Grunting in Babies

CDOP reviewed a case of infant death where shortly following birth, the infant was making intermittent grunting noises which soon became persistent. The cause of death was presumed Group B Streptococcus septicaemia. At the onset of illness, the infant was in the Neonatal Intensive Care Unit. CDOP noted some good-practice, for example once a full team was established, good care was provided, however, the recognition of grunting and subsequent treatment wasn't proactive enough. Services are reminded of the importance of recognising respiratory distress starting more than 4 hours after birth as a red flag and prioritising antibiotic treatment if required.

Learning points taken from the review are shown below:

- Importance of clarity of communication SBAR (situation, background, assessment, recommendation)
- Importance of prioritising early antibiotic treatment

Please see NHS guidance below on red flags to be aware of in babies:

- [Is your baby or toddler seriously ill? - NHS \(www.nhs.uk\)](https://www.nhs.uk/health-a-z/your-baby-or-toddler-seriously-ill/)

Please see the NICE Guidance for further information:

- <https://www.nice.org.uk/guidance/ng195>

## Translation of Critical Information

Services are reminded that key information should always be accessible to parents and translated accurately where there is any doubt. CDOP reviewed a case where critical information in maternity services was relayed to the mother through translation by the father and there was insufficient assurance that the message had been understood by the mother. This is a reminder to ensure that [Language Line](#) or other commissioned translation services are used by default and that professionals only rely on family members for translation when they are adamant they do not want to use a translation service. There are national translated written resources on critical information for giving to families such as:

- [Safer Pregnancy Leaflets and Posters from Mama Academy](#)
- [Fetal Movements Leaflets from Tommy's](#)
- ['Screening tests for you and your baby' leaflet from Public Health England](#)
- [Pain relief for labour and when having a caesarean from Labour Pains](#)
- [Pre-eclampsia from Action on Pre-Eclampsia](#)
- [Breastfeeding, formula feeding and sterilizing feeding equipment from UNICEF](#)
- [Safer sleeping for babies from The Lullaby Trust](#)

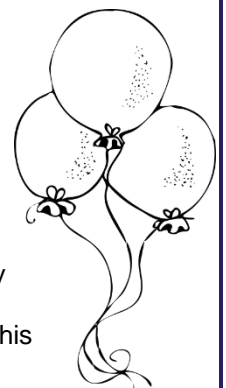


Whilst it wasn't noted in this case, it is also important to remember there may be other barriers to translation via a family member that are cultural or personal, for example a woman not wanting to ask about female-specific issues via her husband.

## Keeping Records up to Date – 13th Birthday Card

CDOP noted the good practice at a GP practice for ensuring accessibility to services for young people and keeping their records up to date. This was particularly important as in this case, the surgery was unable to make contact with the parent.

The Practice had written to all young people asking them to get in touch if contact details weren't up to date. Further, going forward when a young person turns 13, they are considering sending a birthday card which advises them of the contact details held on record for them. It would also advise them that they can have their own phone number on their records if they wish. Staff would then record whether this is the patient's number or the parent's on the record.



## Adrenaline Injector Training for Friends

CDOP reviewed a case of a young person who had tragically passed away as a result of anaphylaxis. The young person was carrying an Epipen but was with a friend who did not know how to use it. This case provides an important reminder for professionals to promote training for close friends of young people who carry adrenaline injectors. The need for training should be reviewed as young people begin to become more independent, going out with friends and not just family or professionals, such as a school staff.

The Anaphylaxis Campaign provides information on anaphylaxis and use of adrenaline injectors:

<https://www.anaphylaxis.org.uk/> and free online training for parents and carers: [AllergyWise Anaphylaxis Online Training - Anaphylaxis Campaign](#)

Schools and other professionals can seek training and advice from their School Nursing Service:

[Services for Children - Schools Online \(swindon.gov.uk\)](#)

[Wiltshire School Nursing Service](#)



## Out of Routine: A Review of Sudden Infant Death in Infancy in families where the children are considered at risk of significant harm

The Child Safeguarding Review Panel has published this report examining the links between sudden unexpected death in infancy (SUDI) and other risk factors and how we can work collaboratively to reduce the incidence of SUDI. Key points to note:

- There has been a steady shift to these tragedies happening predominantly in families from deprived socio-economic backgrounds whose circumstances put them at risk, not just of SUDI, but of a host of other adverse outcomes. Many of the recognised risk factors for SUDI overlap with those for child abuse and neglect.
- It is apparent that while the safer sleep messages may be rigorously delivered by health professionals, many of those families who are most at risk are either unwilling or unable to receive or act on those lessons for a multitude of reasons.
- We need to have a better understanding of the circumstances in which these babies are dying, how and why their parents are making choices about their infants' care and sleeping arrangements, and how practitioners are seeking to engage and work with families whose children are at risk.
- The report outlines a 'prevent and protect' practice model that needs to be embedded within respectful and authoritative relationship-based safeguarding practice. This work needs to be embedded in multi-agency working and not just seen as the responsibility of health professionals.

Read the full report here:

- [Safeguarding children at risk from sudden unexpected infant death - GOV.UK \(www.gov.uk\)](#)

## Sudden Infant Death Syndrome in the South West

As you may be aware, the 2018 SIDS (Sudden Infant Death Syndrome) rates for England and Wales were released by the Office of National Statistics (ONS) in the summer.

The rates indicated that numbers have increased by 7% and on average 4 babies die every week in the UK. The latest results from the ONS showed that in 2018, SIDS rates in the South West have also increased from 0.29 in 2017 to 0.31 in 2018. Rates of SIDS deaths in the South West are now above the average rate in England and Wales of 0.30.

The Lullaby Trust has produced [a briefing](#) with information on how The Lullaby Trust can support us to reduce the number of deaths in the South West, covering:

### 1. Support Safer Sleep Week 2021



The Lullaby Trust's Safer Sleep Week campaign took place from 15th-21st March 2021 and aimed to reach as many families as possible with life-saving safer sleep advice. The focus for 2021 was on dads. Dads often have a key role in the care of their baby, in some cases they are the primary carer. It is therefore crucial they understand how to reduce the risk of SIDS and sleep their baby safely. For more information about Safer Sleep Week see the Lullaby Trust website or contact [communications@lullabytrust.org.uk](mailto:communications@lullabytrust.org.uk).

## 2. Ensure All Professionals Know the Advice

Any professional coming into contact with families with young babies can make a difference. Health professionals are key, but others including housing, social care and emergency services have made a difference in some areas. The Lullaby Trust offers training and advice to staff who work with families with babies and young children. You could run a SIDS training day for early year's professionals – the Lullaby Trust can provide an expert speaker and training resources.

Visit the website to find out more about the training available: [The Lullaby Trust - Training](#).

## 3. Support Vulnerable Families in your area

We know how hard it is for bereaved families to have another baby, particularly if their baby died suddenly and unexpectedly. It is common for parents to worry that the same thing will happen again. Working with the NHS, the Lullaby Trust runs a national health visitor led service for bereaved parents. The Care of Next Infant (CONI) programme supports families before and after the birth of a new baby.

For more information visit: [CONI - Care of Next Infant Programme](#)

[The Lullaby Trust](#) also has a range of print and online information on all aspects of safer sleep and practices that can reduce the risk of SIDS; ranging from Easy Read cards (produced in 22 languages) to more in-depth information.

For more information about CDOP, or if you have any ideas or suggestions for future editions of the Wiltshire and Swindon CDOP newsletter, please email: [publichealth@swindon.gov.uk](mailto:publichealth@swindon.gov.uk).

The CDOP newsletter will be produced twice a year.



Wiltshire  
**Safeguarding  
Vulnerable**  
People Partnership



Swindon  
**Safeguarding  
Partnership**