Wiltshire and Swindon

Child Death Overview Panel (CDOP)

Thirteenth Annual Report

1st April 2017 - 31st March 2022

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Executive Summary

Whilst child death is a rare event, each one has a devastating impact on the family, friends community and professionals involved. The Annual Child Death Overview Panel Report provides an opportunity to review the data around child death to identify patterns and trends as well as an opportunity to ensure the Panel is working effectively.

Summary Statistics:

- In 2021 to 2022, the Wiltshire and Swindon CDOP panel reviewed a total of 47 cases, 25 of which were Wiltshire resident children and 22 of which were Swindon resident children. This represents an 81% increase compared with the previous year (26 cases reviewed in total). This is due to improvements in timeliness of cases getting to Panel, not due to increase in number of deaths.
- The most common cause of death for children across Wiltshire and Swindon was a perinatal or neonatal event. The second most common categorisation was Chromosomal.
- In the majority of deaths reviewed no modifiable factors were identified. Modifiable factors were identified in nearly one in five cases in Swindon and in one in three cases in Wiltshire. In a very few cases (2%) there was inadequate information. Nationally CDOPs identify 31% of their deaths as modifiable in 2020.
- The majority of child deaths between 2017-2022 occur in the first month of life (47% Swindon and 48% for Wiltshire). When this is extended to look at children under 1 year of age there are 14% in Swindon and 18% for Wiltshire of children falling into this group. The 2019/20 National report (last published) shows 42% of deaths occurred during the first month after birth and a further 21% of deaths occurred when the baby was aged between 28 and 364 days.
- Ethnicity recording needs to improve for both Wiltshire and Swindon in order to provide assurance that there is no disproportionate representation of child deaths by ethnicity.
- One fifth of all cases (12) in Swindon was recorded for those of Asian/Asian British ethnicity. This is a significantly higher proportion than local population estimates/projections for those of Asian/Asian British ethnicity which is between 7- 9% of the population aged 0-17 years in Swindon.
- The majority of children die in hospital, 73% of Swindon children, and 77% of Wiltshire children.

Key Learning Points and Actions:

Much of the key learning in cases will be specific to organisations, and when this is highlighted the organisation is written to by the CDOP Chair and assurance is sought that improvements are now in place. The actions related to this are monitored regularly at the CDOP.

In addition to this:

- CDOP has reviewed the timeliness of reviewing cases and identified that delays in receiving Analysis Forms, Reporting Forms, holding Child Death Reviews (CDR) and legal processes are the reasons for this.

- Members of the CDOP Panel have reviewed improved ways of working and are raising the importance of the timely completion of Reporting Forms with all Agencies concerned.
- CDOP have agreed to hold an additional meeting to increase capacity to review cases
- CDOP monitor timelines of review twice yearly at Panel.
- Review of cases in Swindon by the ethnicity of the child to understand the disproportionate number of cases of children with Asian ethnicity. The review found that the disproportionate number of deaths in Asian/Asian British children is not just a local, but a national, issue that does not have a single clear determinant. However, steps can be taken to mitigate possible contributing factors. The report recommended that CDOP continue to monitor disparities in deaths in ethnic groups, also focusing on differences between sub-groups i.e. specifically high number of Indian child deaths.
  CDOP reviewers to be mindful of this disparity in future. Ensuring attention in future cases is given to the contributory effects of language barriers and access to/utilisation of healthcare, in all healthcare interactions in the acute phase and prior to first presentation. Encourage CDOP reporters to clearly document if language was an issue and, if it was, how it was mitigated. Ensure rapid and easy access to translation facilities at all patient-healthcare interaction points, and ensure healthcare staff and public are aware of these service options. Promote GP services to migrant families.

CDOP often identified opportunities for highlighting learning. The CDOP Newsletter is used to share learning, alongside Panel members taking learning to their own organisations and forums they attend. In 2021-22 the newsletter covered twelve items:

- Awareness and training in the use of EpiPens among friends and acquaintances of allergy sufferers. 'Adrenaline injector training for friends' article.
- Clarification of signs of life in extreme prematurity babies. Current guidance from MBRACE was included.
- The importance of completing Reporting Forms in a timely manner and links to the NCMD webinar were circulated.
- Link to information from the Kicks Count website which publishes information on reduced fetal movement in several languages.
- Information on the risks of Listeria Infection and the importance of raising awareness of dietary advice in pregnant women.
- Raised awareness of premature rupture of membranes.
- Raising awareness of the rising use of sleep pods / nests and associated increased risk of SIDS.
- Safe sleep advice on bedding usage in babies and children was clarified.
- Highlighted the increased risk of mid-trimester fetal loss for Black African women.
- After a review of Asian deaths, available services were highlighted and professionals asked to familiarise themselves with the pathways to live translation.

CDOP Have engaged with National Child Mortality Database (NCMD) and shared/requested data for comparisons where some cases may relate to a national trend and to further encourage professionals to use the NCMD Website and Webinars to further knowledge and

skills when conducting Child Death Reviews and completing forms. NCMD also circulate quarterly Data Quality and Completeness Returns to highlight the areas for improvement when completing forms and notifications.

- Increased awareness of the benefits of signing up to the NCMD Newsletter.
- Circulated the NCMD Reporting Form webinar details to CDOP.
- Child Death Office to provide anonymised exemplars of well completed Reporting Forms.
- CDOP to write to Midwifery Services to request support for Midwives when completing Reporting Forms via the Link Midwife.
- Details of the NCMD Webinar on how to complete a Reporting Form were circulated to panel.
- We conducted a review of Asian deaths and asked NCMD if there is a national theme. They have touched on this in their Second Annual Report on Page 36. https://www.ncmd.info/publications/2nd-annual-report/

Introduction

We are fortunate that a child death is a rare event in our society, however, each death represents a tragedy for the family, community and professionals involved. The purpose of the Child Death Review (CDR) process is to identify potentially modifiable factors 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 of services 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 Child Death Review Partners (CDR Partners) in Swindon and Wiltshire respectively. The CDR partners are Local Authorities and Integrated Care Boards and are joined on the Panel by partner from across health, social care and the Police.

The Wiltshire and Swindon Child Death Overview Panel (CDOP) has been in place since April 2008. The processes to be followed when a child dies are currently outlined within Working Together to Safeguard Children 2018: Chapter 5 Child Death Review Processes[1]. The statutory guidance was published in July 2018 and must be followed for all deaths occurring after 1st April 2019. For the purposes of this annual report, the previous version of Working Together to Safeguard Children (2015) was in place and governed the process for the children described in this report who died prior to 1st April 2019.

The role of the panel is to review the death of every Wiltshire and Swindon child aged under 18 years using a national methodology. The CDOP has a particular focus on identifying whether there were modifiable factors which may have contributed to the death and what, if any, actions could be taken to prevent future such deaths.

At the beginning of the CDR process in 2008 the CDR Partners (previously Local Safeguarding Children Boards) in Swindon and Wiltshire came together to form a single Child Death Overview Panel (CDOP). This CDOP continues to review the deaths of all children resident in Wiltshire and Swindon. Some of these deaths may occur outside of the region and these will also be reviewed by this panel. In addition, and in line with the 2018 guidance, the panel may choose to review the deaths of non-resident children who die in the Swindon or Wiltshire area if appropriate e.g. in the case of a road traffic collision.

The CDOP is currently chaired by a Consultant in Public Health (Swindon). A full list of panel members can be found in Appendix A.

[1] HM Government Department for Education (June 2013)

Background to the Child Death Review Process

Chapter 5 of "Working Together to Safeguard Children" (WT) (2018) sets out the framework for processes to review all child deaths. The process focuses on identifying 'modifiable factors' in the child's death. Alongside the 2018 revision of WT, Statutory and Operational Guidance for Child Death Reviews (SOG) was published in October 2018. Under WT and the SOG, the CDR Partners are required to put in place arrangements for a Joint Agency Response (JAR). A JAR is a coordinated multiagency response (on-call health professional, police investigator, duty social worker), to be triggered if a child's death:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (including SUDI/C[2]);
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural; or
- in the case of a stillbirth where no healthcare professional was in attendance.

The full process for a Joint Agency Response is set out in the SUDI/C Guidelines[3] which can be found here:

https://www.rcpath.org/uploads/assets/874ae50e-c754-4933-995a804e0ef728a4/Sudden-unexpected-death-in-infancy-and-childhood-2e.pdfunexpected-death-in-infancy-and-childhood-2e.pdf

The Wiltshire and Swindon, Joint Agency Response and Child Death Overview are two separate processes but are closely linked.

The Joint Agency Response process ensures early notification of the death of a child that meets the above criteria, and a prompt process of investigation. Key professionals come together to enquire into and evaluate each of these deaths. The principal purpose includes:

- to collate and share relevant information.
- to establish, where possible, a cause or causes of death (in conjunction with the coroner)
- to identify any contributing factors.
- to identify any potential learning.
- to provide appropriate support to the family including a co-ordinated bereavement care plan.
- to consider the welfare and support of professionals involved with the child/family.

[2] Sudden Unexpected Death in Infancy and Childhood

[3] Sudden Unexpected Death in Infancy and Childhood: Multi-agency Guidelines for care and investigation [4] Current forms available here https://www.gov.uk/government/publications/child-death-reviews-forms-forreporting-child-deaths

- to prepare a final report for submission to CDOP and arrange feedback from the family.

The Child Death Overview Process ensures that every child's death is comprehensively reviewed, and lessons learnt so that action can be taken to prevent future deaths where possible.

The Child Death Review Process

A child's death is reviewed by CDOP after a range of standard information has been collected using statutory forms (Notification Form, Reporting Form, Supplementary Reporting Form and Analysis Form[4]) and the case has been discussed by professionals involved in the child's life at a local child death review meeting (CDRM). Following the Child Death Review Meeting a detailed compilation of data from the statutory forms mentioned above is collated and anonymised by the Child Death Enquiries Office at the University of Bristol for presentation to CDOP. CDOP reviews each case with the aim of identifying modifiable factors and highlights any learning identified. The CDOP panel aims to identify those factors in the course of a child's life, and leading to the child's death, which might have directly led to the child's death or increased their vulnerability, and which might have been amenable to modification. It also makes recommendations which may prevent similar deaths occurring in the future. However, it may also make recommendations related to service improvement, where changes in practice could lead to improved experiences for children and young people at the end of life or during the course of their treatment.

Production of this report

The CDOP is required to produce an annual report each year outlining the work of the panel and relevant learning from the cases reviewed to inform the priorities of the CDR Partners. This report is 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 the eCDOP case management tool. Information collected from statutory forms, Child Death Review Meetings and CDOP reviews is populated onto eCDOP as the case progresses through the child death review process. The eventual CDOP multi-agency dataset is extremely comprehensive. The annual report includes five years of aggregate data to help reduce year on year variations associated with rare events such as a child death. This allows better identification of longer-term trends or key themes which may not have been as apparent within a single year of data.

Notifications of child deaths

Summary Data (five year average data from 2016 – 2021)

This section summarises all the deaths notified between 1st April 2017 and 31st March 2022, of children resident in the Swindon and Wiltshire areas. It is important when looking at the numbers from Wiltshire and Swindon to note that the size of the population base of Wiltshire is approximately twice that of Swindon. These data are drawn from the eCDOP case management tool. This allows us to present information as a rolling total across the last five years. Data presented this way helps to "smooth out" the year on year variations that we expect if we are looking at rare events one year at a time.

Analysis of notifications by year (2017-2022)

During the period 2017-2022, there were 179 child deaths notified for across Swindon and Wiltshire. There were 59 in Swindon (6 in 2021/22) and 120 in Wiltshire (21 in 2021/22).

Year on year variation in notifications is to be expected and with rare events such as a child death, small variations can appear to represent a big difference.

Table 1: Numbers of deaths notified to CDOP by year 2017 to 2022 in Wiltshire and Swindon.

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22*	**Totals**
Wiltshire	23	27	23	23	26	21	**120**
Rate of death (per 10,000)	2.18	2.56	2.18	2.17	2.45	1.98	
Swindon	14	15	11	14	13	6	**59**
Rate of death (per 10,000)	2.83	3.00	2.19	2.78	1.51	1.18	

N.B. Rates calculated using mid-year population estimates

***using most recently available ONS mid-year population estimates for 2020, published June 2021.**

Age at death

Figure 1 shows that between 1st April 2017 and 31st March 2022, 47% of child death cases in Swindon and 48% of cases in Wiltshire occurred in the neonatal period (under one month of life), with a further 14% in Swindon and 18% in Wiltshire dying in the first year of life (29-365 days). Across both areas combined therefore, nearly two thirds (64%) of all child deaths occur under one year of age. In Wiltshire, the percentage of deaths by age group decreases with age. However, in Swindon the percentage drops from the 0-28 day age group to its lowest in the 1-9 years age group, and slowly rises again. Of note is the 15-17 year old age group which account for approximately 1 in 5 child deaths in Swindon, compared with less than 1 in 10 in Wiltshire.

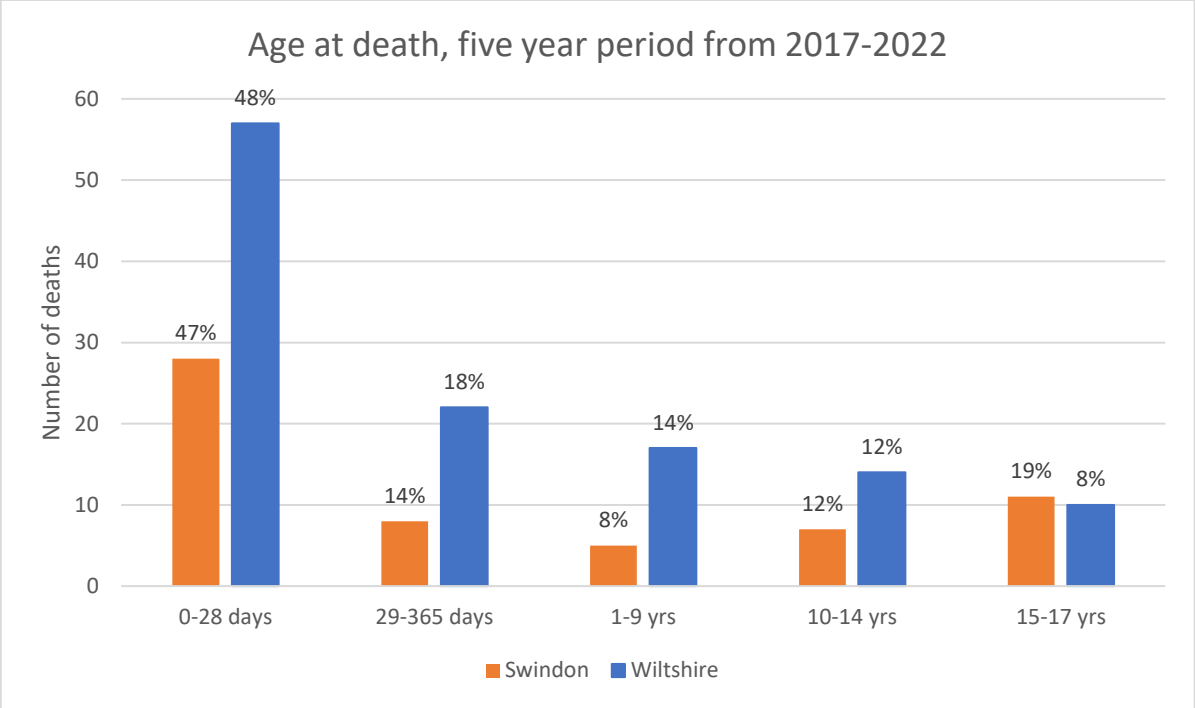

Figure 1: Age at death, Swindon and Wiltshire, five year period 2017-22

Location of death

Many children who live in Swindon and Wiltshire may be transferred to tertiary hospitals in other regions for specialist treatment. A number of these children die in these hospitals. The figures in this section represent the total number of deaths at various locations during the five year period.

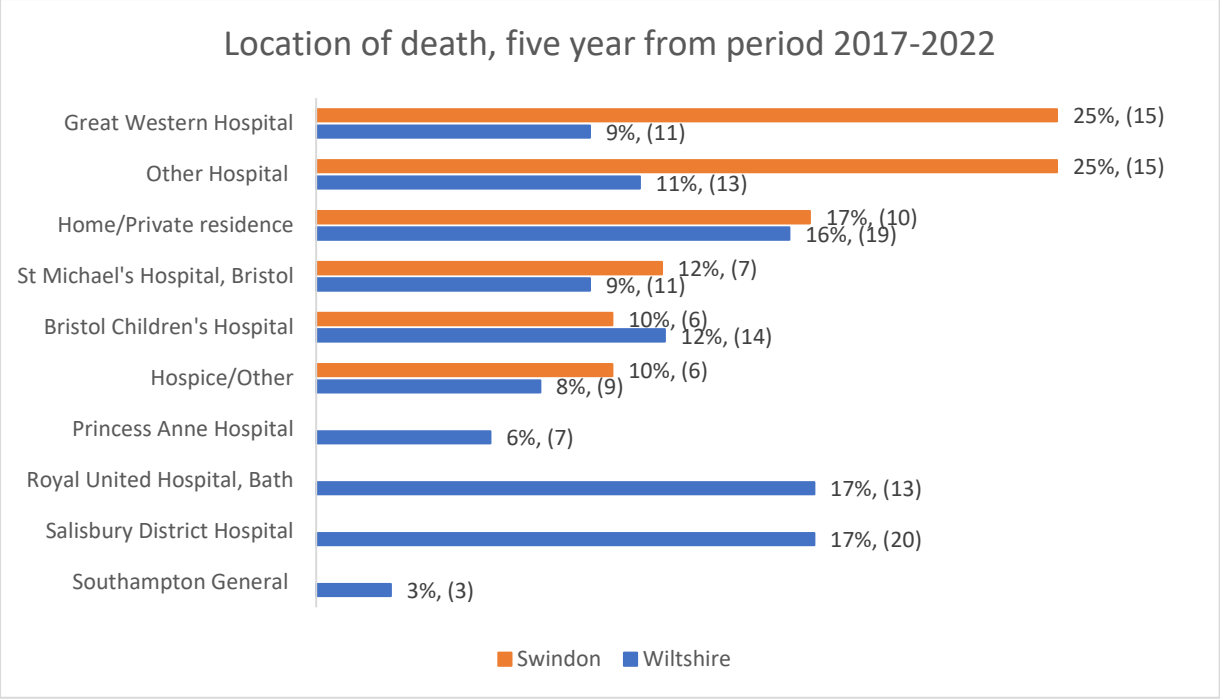

Figure 2: Location of death by area of residence, Swindon and Wiltshire, five year period from 2017-2022

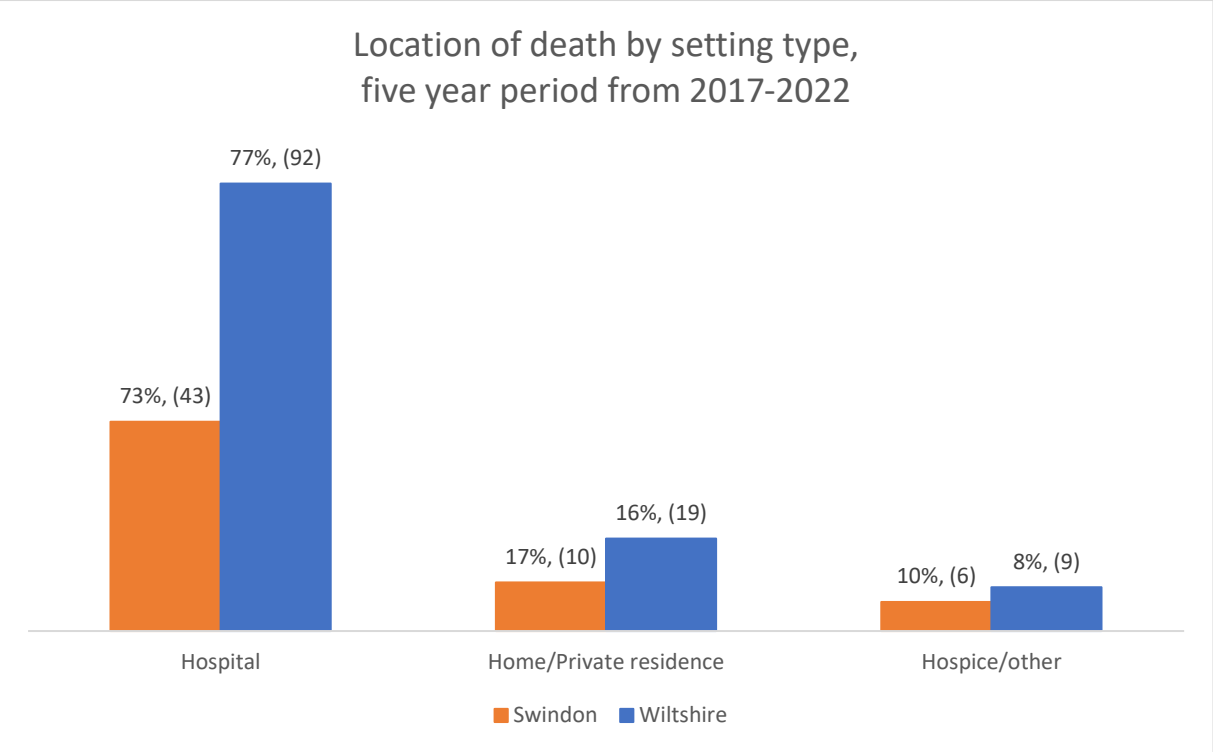

Figure 3: Location of death by setting type, Swindon and Wiltshire, five year period from 2017-2022. (Note: Percentages might not add up to 100% due to rounding)

Both in Swindon and Wiltshire, approximately one quarter of child deaths occur outside of hospital i.e. in private residences or hospices (27% and 24% of all deaths respectively). However, the most common location of death for children resident in Swindon and Wiltshire is in hospital (Figure 3). Children who live in Wiltshire are treated in a greater number of

hospitals than children living in Swindon. This reflects the wide geographical area covered by Wiltshire and the number of counties in which Wiltshire residents receive healthcare services including Hampshire, Bristol, Swindon and Bath. This can present particular issues for Wiltshire 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.

Gender

There have been more notifications of deaths in boys than in girls in both Swindon and Wiltshire as can be seen in Figure 4. In total 52% of deaths in Wiltshire and 58% of deaths in Swindon were male. This is comparable with the national gender split in child deaths for the year ending 2020.

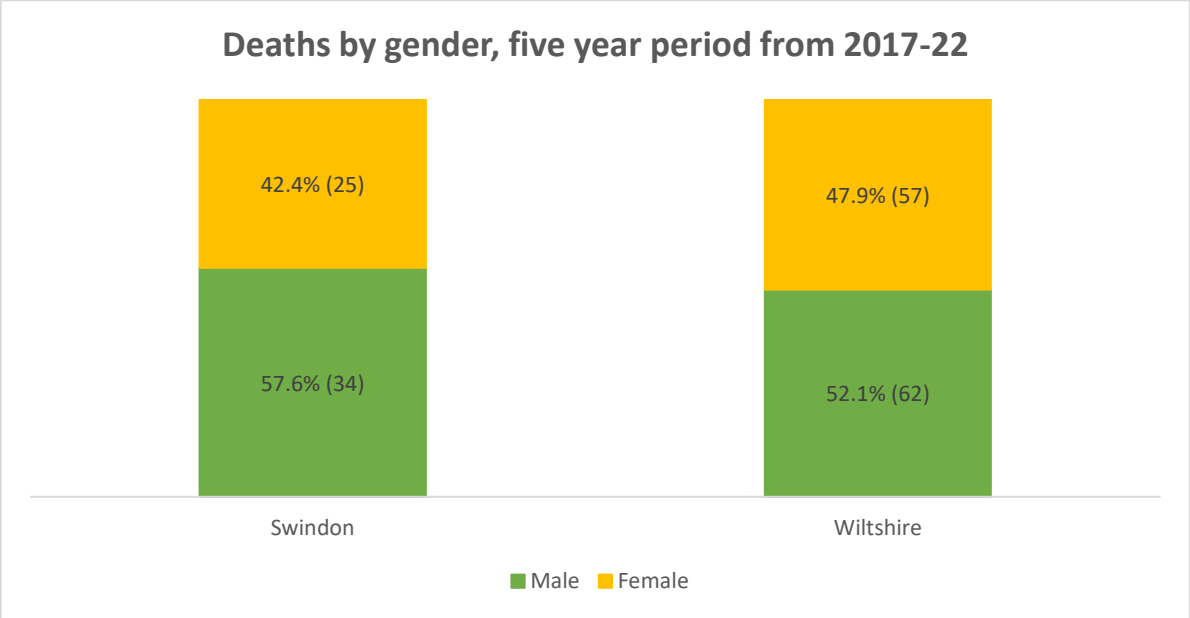

Figure 4: Deaths by gender, Swindon and Wiltshire, five year period from 2017-2022

Ethnicity

The National Child Mortality Database Second Annual Report shows that where ethnicity was recorded 78%, (n=2,596), 62% (n=1,605) were of children from a White ethnic group, 19% (n=502) were from an Asian or Asian British background, 9% (n=227) were from a Black or Black British background, and 7% (n=172) were from a Mixed background.

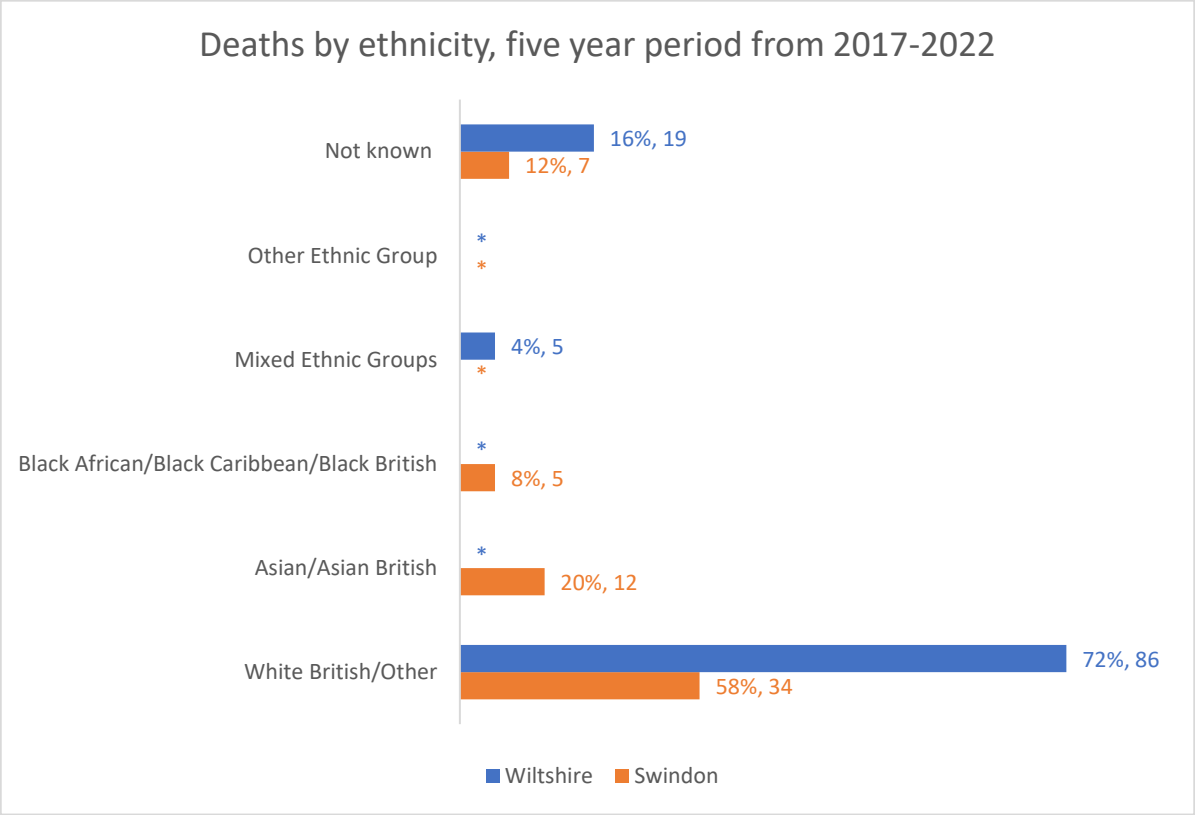

Figure 5: Deaths by ethnic group, Swindon and Wiltshire, five year period from 2017-2022
*(Note: * values of less than 5 have been suppressed)*

Ethnicity recording needs to improve in order to assess if there is disproportionate representation of child deaths by ethnicity.

The data presented in Figure 5 shows that the majority of child death cases in Swindon and Wiltshire were recorded for those of White British/Other ethnicity. Population ethnicity estimates from the 2011 Census and ethnic population projections for 2020/21 indicate that between 82 - 86% of 0-17 year olds in Swindon and between 93 – 95% of 0-17 year olds in Wiltshire are from a White British/Other ethnic group. This is much higher than the percentage of child death cases recorded in either area as being from a White British/Other ethnic group.

This difference may be in part be attributable to the fact that ethnicity was not known or recorded for more than one in ten cases in Swindon and for one in six cases in Wiltshire. 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 possibly someone was asked their ethnicity and refused to provide that information.

Nevertheless, one fifth of all cases (12) in Swindon was recorded for those of Asian/Asian British ethnicity. This is a significantly higher proportion than local population estimates/projections for those of Asian/Asian British ethnicity which is between 7- 9% of the

population aged 0-17 years in Swindon. A deep dive into these deaths was conducted and discussed in the key learnings and action section at the beginning of this document.

Child Death Overview Panel Review Data

These data summarise the panel's review decisions for 2017-2022 and its actions for 2021-2022. 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 Child Death Review Meeting. The Wiltshire and Swindon CDOP took the decision in 2009 to wait for the inquest verdict in child deaths that involve the Coroner before reviewing the case. 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 can also affect when a case is discussed at panel.

For Swindon cases reviewed during 2017-2022, 25 had a post mortem, 2 had a Police Investigation and 5 were subject to a Safeguarding Review. For Wiltshire cases reviewed during 2017-2022, 31 had a post mortem, 2 had a Police Investigation and 2 were subject to a Safeguarding Review. The Wiltshire and Swindon CDOP has reviewed 151 cases between 1st April 2017 and 31st March 2022. 92 were children resident in Wiltshire and 59 were children resident in Swindon.

During the period 1st April 2021 to 31st March 2022, the Wiltshire and Swindon CDOP panel reviewed a total of 47 cases, 25 of which were Wiltshire resident children and 22 of which were Swindon resident children. This represents an 81% increase in 2021/22 compared with the previous year (26 cases reviewed in total). Figure 6 shows that this increase was mostly driven by the number of cases reviewed in Swindon. This was due to the Panel focussing on timely review of cases, not an increase in deaths.

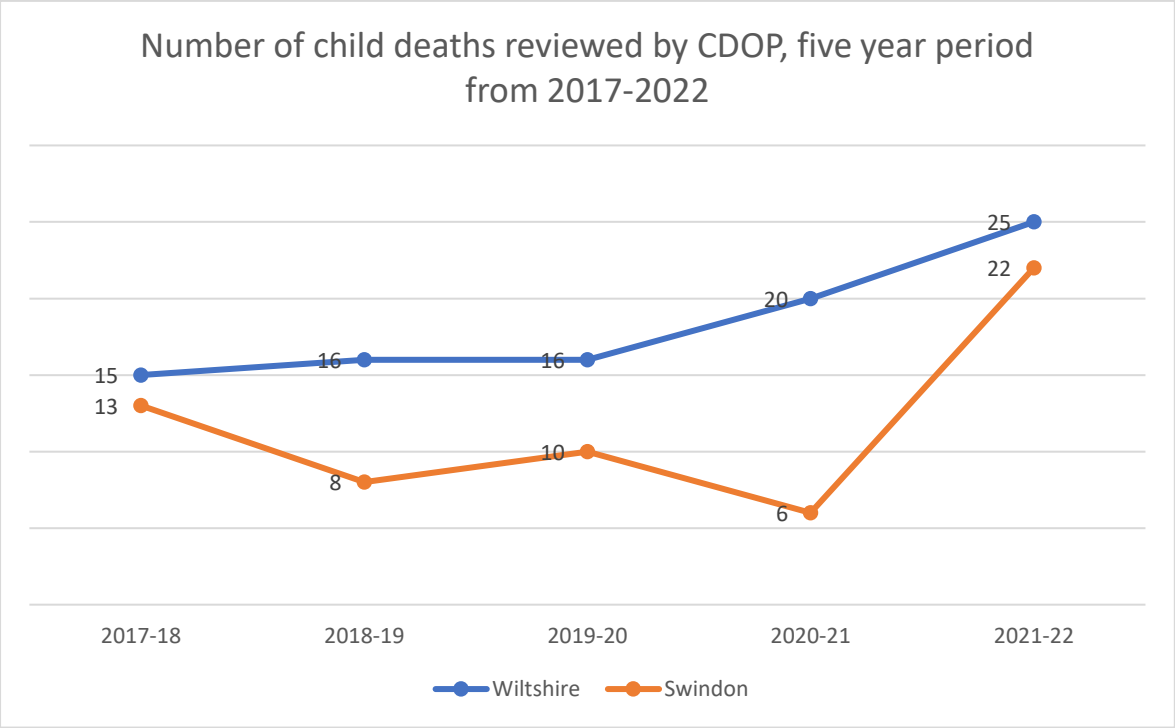

Figure 6: Number of child deaths reviewed by CDOP, Swindon and Wiltshire, five year period from 2017-2022

LeDeR

CDOP also works with the LeDeR Programme which reviews deaths of children and adults from the age of four years. The total of the cases reviewed which link to LeDeR during 2020/21 was one (this is incorporated into our total figures for 2021-22 and was a Swindon case).

Further information regarding LeDeR and their Annual Reports can be found here https://bswccg.nhs.uk/docs-reports/strategies-and-reports

Length of time from death to review

It can take a number of months for a child's death to be reviewed by CDOP. The third CDOP annual report (2010/11) made a recommendation that CDOP would aim to review every child's death within 1 year, other than where there are outstanding legal procedures.

Figure 7 shows that between 2017-2022, only 22% of cases in Swindon and 24% of cases in Wiltshire were reviewed within 12 months. In both areas, nearly half of all cases in this time period took longer than 18 months to be reviewed. Cases are reviewed in date of death order, so cases which were older and ready to go to panel were prioritised over those more recent deaths. We would expect to see more recent cases being reviewed in the next year's figures due to the significant increase in number of cases that have been reviewed in this reporting period. In both Swindon and Wiltshire from 2019/20 onwards there was a sharp increase in the number of cases which took over 12 months to review. It is possible that this is a result of the Covid-19 pandemic (i.e. delayed administration due to lockdown restrictions affecting working methods) or indicate a change in policy.

A review of factors affecting cases coming to CDOP has been held locally to understand the issues surrounding the timelines of case review and found a number of issues, including the timely returning of forms, the holding of child death review meetings and not having enough meeting capacity to review cases in the required depth. The actions to improve this situation are described later in this document.

Reasons for delayed cases

Reason	Wiltshire	Swindon
Ongoing Criminal Investigation or Child Safeguarding Practice Review	4	1
Delayed Analysis Forms	6	2
Death Abroad	1	
Ongoing Independent Review	1	
Delayed Child Death Review Meeting	3	

Awaiting Post Mortem	1	
Awaiting Slot at Panel	2	3
Total	18	6

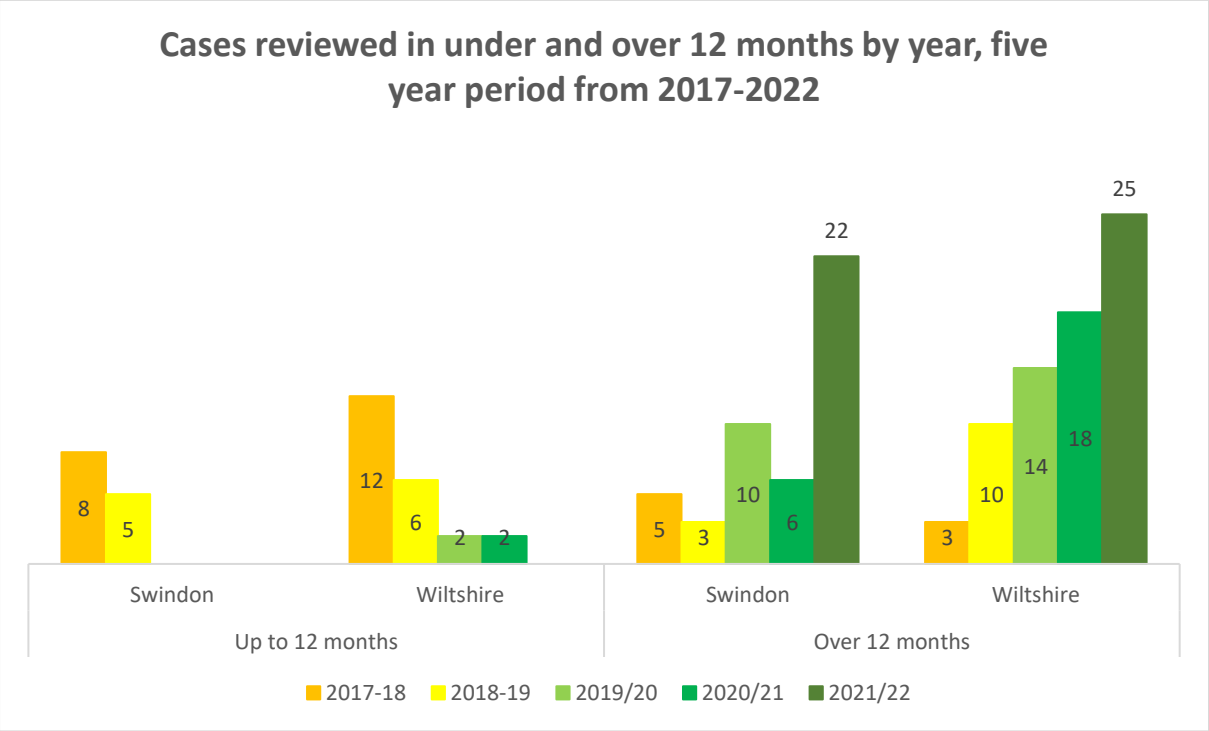

Figure 7: Number of cases reviewed in under and over 12 months by year, Swindon and Wiltshire, five year period 2017-2022

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 CDOP categories. Figure 8 shows the categorisation of deaths in Swindon and Wiltshire over a five year period.

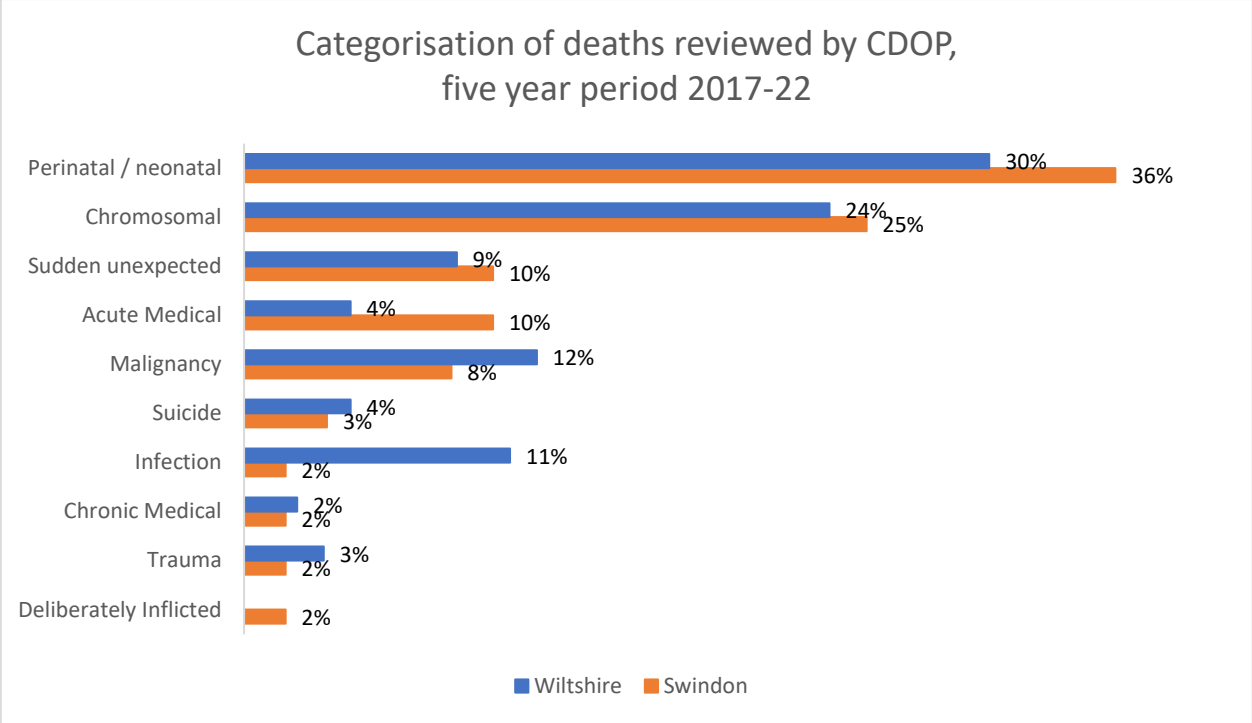

Figure 8: Categorisation of deaths reviewed by CDOP, Swindon and Wiltshire, five year period from 2017 -2022

Approximately one third of child death cases reviewed in Swindon and Wiltshire between 2017-2022 were categorised as perinatal/neonatal deaths (defined as the death of a live born baby/stillborn baby of 20 or more completed week or within 28 days of birth). One in five deaths in both areas was categorised as chromosomal (i.e. when the baby dies in the womb before 20 weeks of pregnancy). In Swindon, one in ten deaths was categorised as sudden unexpected or acute medical. However in Wiltshire, 12% were categorised as malignancy and 11% as infection. National figures are not yet available for comparison for this time period.

Mode of death of cases reviewed by CDOP

The most common manner of death for both Wiltshire and Swindon children is withholding, withdrawing or limitation of life-sustaining treatment (Figure 9). This decision is always made following careful consideration with the child's parents and carers. Unsuccessful cardio-pulmonary resuscitation accounts for a third of cases in Swindon and nearly a quarter of cases in Wiltshire. A further quarter of cases in Wiltshire were recorded as planned palliative care, followed by 8% of cases where the child was found dead.

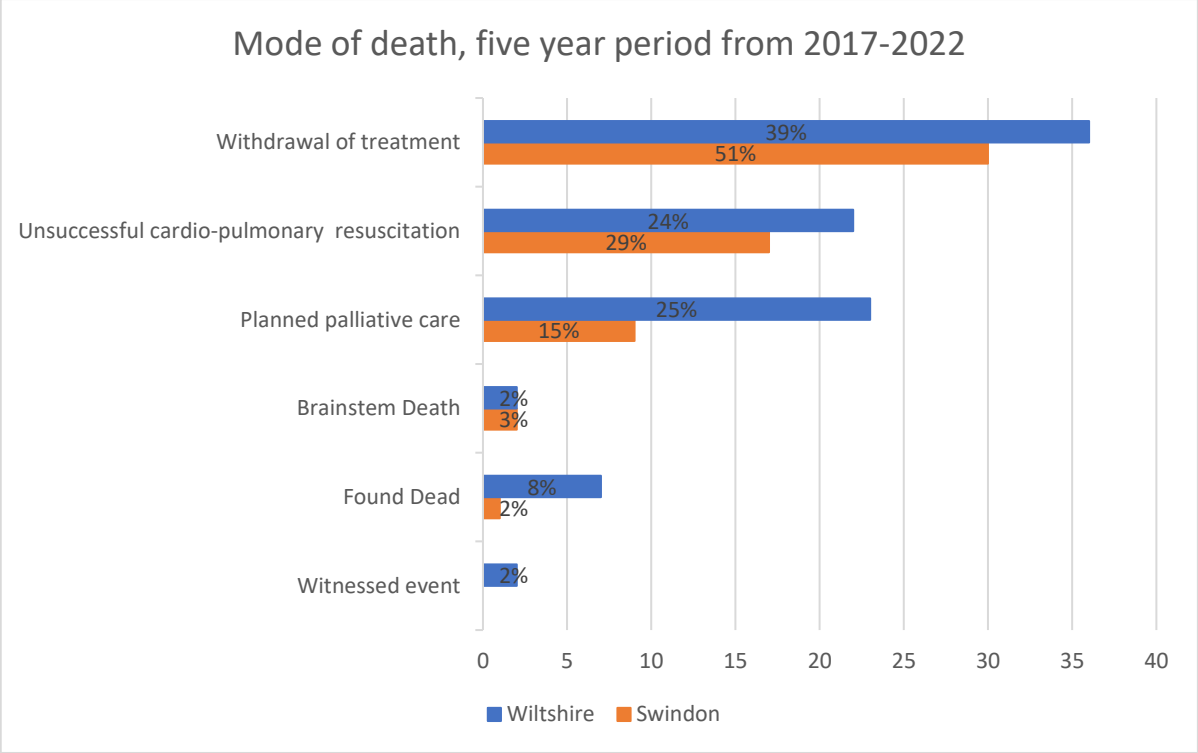

Figure 9: Mode of death, Swindon and Wiltshire, five year period from 2017-2022

Additional factors in the Social 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 Reporting Form dataset from professionals who have contact with the families. These are summarised on the Analysis Form dataset at the Child Death Review Meeting and carefully reviewed by CDOP. They are shown for Swindon and Wiltshire in Table 10. Please note that these factors may not have been directly contributory to the child's death, rather this data reflects the presence or absence of a factor within the social environment.

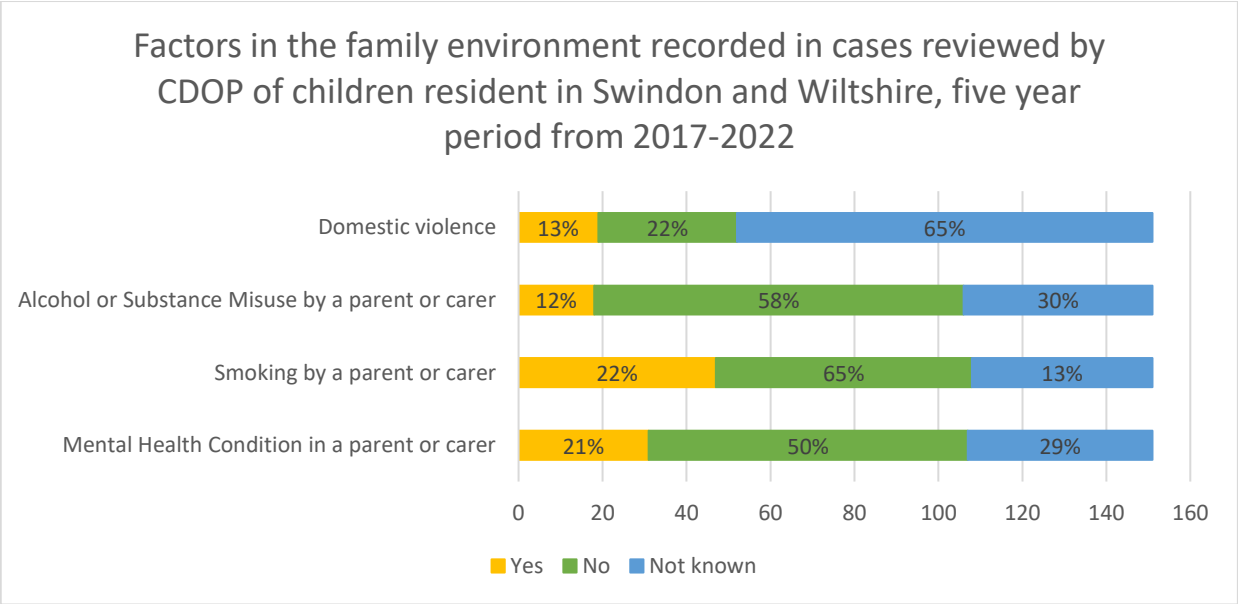

Figure 10: Factors in the family environment recorded in cases reviewed by CDOP of children resident in Swindon and Wiltshire, five year period from 2017-2022

Figure 10 above shows that for both Swindon and Wiltshire children the most common factors recorded in the social environment are smoking by a parent or carer and mental health issues. However, it should be noted that the existence of one or more of these factors does not necessarily have an impact on the circumstances that led to a child's death.

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 parent, 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 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. In addition, CDOP would regard a death as having modifiable factors if practice had changed due to learning arising from that child's death, even when the outcome for that particular child might not have changed. This allows for a precautionary approach with the aim of using learning identified to limit future deaths.

In both Swindon and Wiltshire during the five period from 2017-2022, no modifiable factors were identified for the majority of cases (Figure 11). Modifiable factors were identified in nearly one in five cases in Swindon and in one in three cases in Wiltshire. In a very few cases (2%) there was inadequate information.

The latest national figures reported in the NCMD Second Annual Report for the year ending 31st March 2021 report 31% of child deaths were found to have modifiable factors nationally.

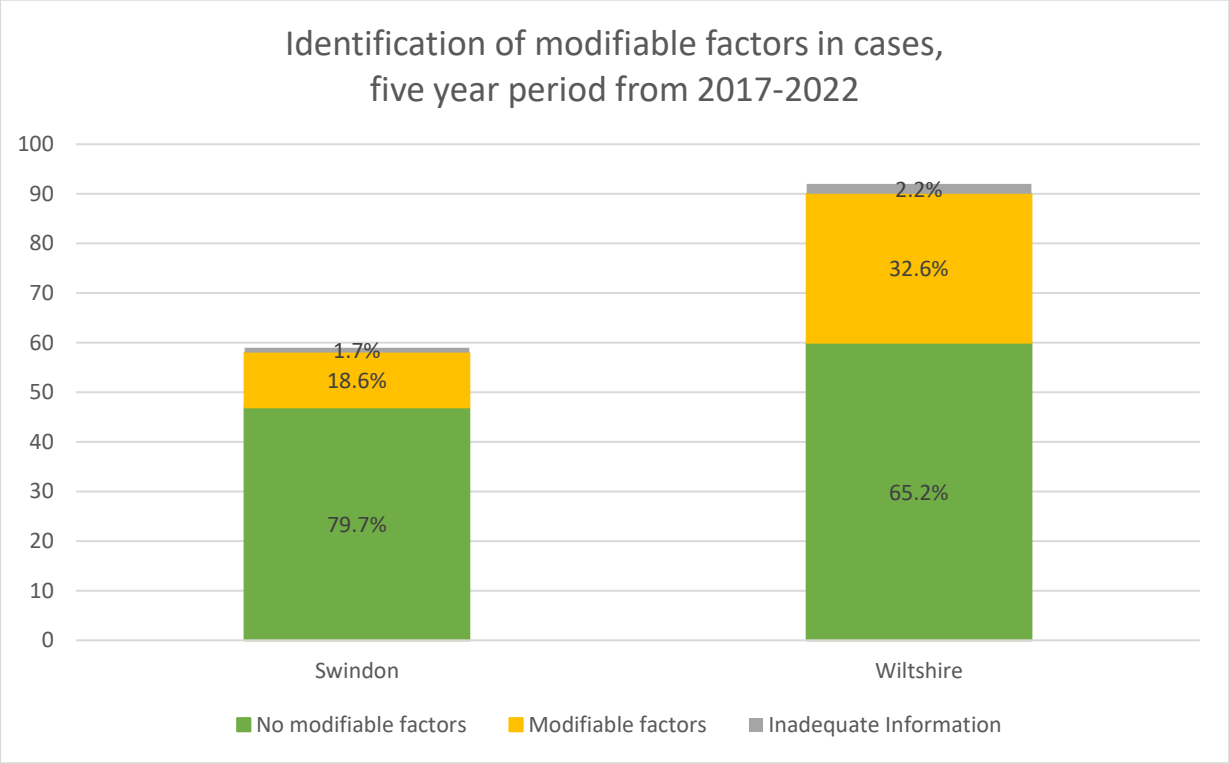

Figure 11: Identification of modifiable factors, Swindon and Wiltshire, five year period from 2017-2022

Family Follow Up

Active engagement with bereaved parents underpins the entire child death review process. Parental input into the child death review meeting should occur as a matter of course. Parents are invited to submit questions to the local child death review meeting, and feedback by the lead health professional on all aspects of this meeting is then given at a follow-up appointment with the family. Families may access follow-up from more than one professional agency.

Figure 12 shows the percentage of families offered follow up from each agency for cases reviewed by CDOP for Wiltshire and Swindon between 1st April 2017 and 31st March 2022. Families may have been offered follow-up by more than one agency following their child's death. The offer of follow-up remains open to families; however, some families may choose not to take-up this offer for months or sometimes years depending on their specific need.

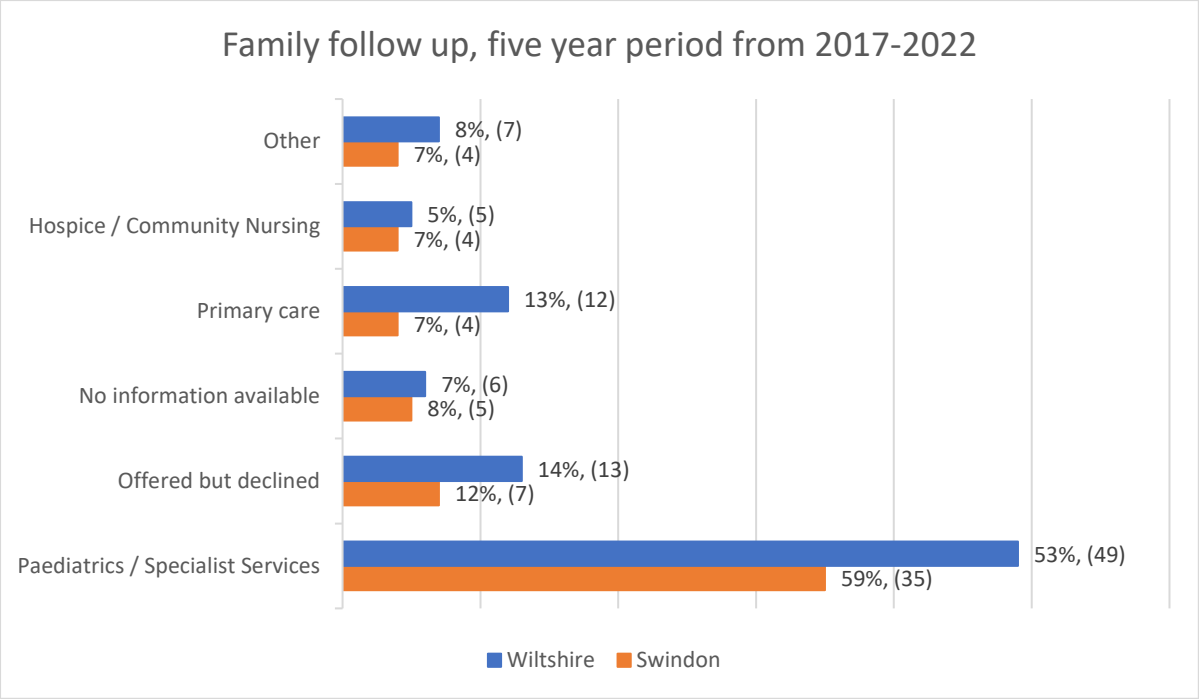

Figure 12: Family follow up, for Swindon and Wiltshire, five year period from 2017-2022

In both Swindon and Wiltshire, over half of families received follow-up from hospital or specialist paediatrics (55% of overall cases in both areas combined). This includes obstetrics, neonatology, cardiology and oncology. In Wiltshire, 13% of families received follow up from primary care (GP or health visitor), compared with 7% in Swindon. The hospice or community nursing organisations such as CLIC Sargent or the Lifetime Service routinely offer follow-up to any family they work with and between these agencies they offered follow-up to 6% of families who had a child who died during 2017-2022. More than one in ten families were offered follow-up but declined the offer. Families are routinely given national and local information on charities offering bereavement support.

Appendix A - CDOP membership April 2021 to March 2022

	Core member	**LSCB/Organisation**
Nominated Chair	Katie Ash	Swindon Borough Council
Consultant in Public Health	Hayley Morgan	Wiltshire Council
Designated Doctor for Child Deaths	Fiona Finlay and Paul O'Keefe (Deputy)	BaNES, Swindon and Wiltshire CCG (BSW CCG)
Wiltshire Children's Social Care	Jen Salter	Wiltshire Council
Swindon Children's Social Care	Fiona Francis Deputy Sharon Laird.	Swindon Borough Council
Designated nurse for safeguarding children	Robert Mills	BaNES, Swindon and Wiltshire CCG (BSW ICB)
Designated nurse for safeguarding children	Jane Murray	BaNES, Swindon and Wiltshire CCG (BSW ICB)
Named Nurse for Safeguarding	Yasmin Gordon, Natalie Herring,	Swindon Borough Council Community Health Services Swindon Borough Council Community Health Services
Midwifery	Rebecca King	Great Western Hospital, Swindon
Obstetrics	Charlotte Sullivan	Great Western Hospital, Swindon
Paediatrics	Paul O'Keeffe	Great Western Hospital, Swindon
Paediatrics	Philippa Ridley	Salisbury District Hospital, Wiltshire
Police	Lucy Thorne	Wiltshire Police
Ambulance Service	Simon Hester	South Western Ambulance Service NHS Foundation Trust
GP Co-Lead	Helen Osborne Michelle Sharma	BSW CCG BSW CCG