

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

March Edition  
2022

---

The Wiltshire and Swindon Child Death Overview Panel (CDOP) review every child death to identify 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.

## In this edition:

- Wiltshire and Swindon Child Death Overview Panel Report
- SUDIs and Safe Sleeping: How can we make a difference?
- Suicide: Children and Young people
- Stillbirth – ethnicity related risks
- Case learning: Co-ordination of care
- Translation Services

## Wiltshire and Swindon Child Death Overview Panel (CDOP) Report

The twelfth annual report of the Wiltshire and Swindon Child Death Overview Panel covered April 2016 – March 2021. The key statistics are summarised below:

- CDOP reviewed 13 Swindon deaths and 20 Wiltshire deaths from 2020-21.
- The most common cause of death for children under 1 was a perinatal or neonatal event (across both areas).
- Most deaths reviewed found no modifiable factors, however, modifiable factors were identified in 35% of Wiltshire cases and 17% in Swindon (nationally CDOPs identify 31% of their deaths as modifiable) during 2020-21.
- Most child deaths between 2016-2021 occurred in the first month of life (46% Swindon and 45% for Wiltshire). When extended to look at children under 1 year of age, 15% in Swindon and 18% in Wiltshire fell into this group. The national figures relating to this were not available at time of reporting.
- In Swindon it is estimated that 9% of the 0–18-year-old population are Asian. Of 54 deaths reported to CDOP between 2016 -2020, 10 (19%) were Asian children. Of these cases the majority died in the first 28 days of their life.



The panel identified the following learning points and action to improve onward practice:

- Delays in receipt of analysis and reporting forms, reviews, and legal processes impacted upon the timeliness of CDOP reviews. Panel members raised this with their respective organisations to reiterate the importance of timely completion and submission of forms to allow prompt review.
- Members agreed to hold an additional meeting to increase capacity to review cases.
- CDOP will monitor review timelines twice yearly at panel meetings.
- A review of cases in Swindon was undertaken to identify reasons for the disproportionate number of deaths in Asian children. Whilst the review identified some potential hypotheses, there were no clear factors linking these cases nor any modifiable factors. CDOP will continue to monitor deaths by ethnicity carefully, particularly given this disparity is reflected nationally.

## SUDIs and Safe Sleeping

### How can we make a difference?

#### Safe Sleeping

There is rarely a CDOP newsletter where the issue of safer sleeping isn't covered, sadly, this edition is no different. The panel reviewed two cases where the sleeping environment may have contributed to the child's death. This raised reminders about the risks of smoking in the home and potential for overheating. CDOP discussed the importance of health visitors seeing children's sleeping environment to reinforce safe sleeping guidance to parents.



In relation to overheating, materials used for bedding were considered and it was noted:

- Advice should be given on the type of material used for bedding, e.g., fleece or wool are likely to be too warm and do not allow for breathability of a recommended cellular blanket
- Advice should cover mother's clothing, sometimes placed with a baby or child with the view that this may provide a comforting smell
- Pillows and duvets are not safe for babies under one year old (NHS)

The National Child Mortality Database maintains evidence that informs [safe sleeping advice](#).

#### Sudden Unexpected Death in Infancy (SUDI)

In July 2020, the national Child Safeguarding Practice Review Panel published their review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm: [Out of Routine](#).

- Between June 2018 and August 2019, the national panel received 568 serious safeguarding incident notifications for children who had died or suffered serious harm.
- Of these, 40 (7%) related to incidents of SUDI, representing one of the largest groups of cases notified to the panel.
- Almost all cases involved parents co-sleeping with their infants in unsafe sleep environments, including those where the parents had consumed alcohol or drugs. In addition, there were wider safeguarding concerns, often involving cumulative neglect, domestic violence, parental mental health concerns and substance misuse.

**The Swindon Safeguarding Panel has requested a local audit of practice against recommendations in the report. The scope of the audit is currently being defined and the results will be shared in a future edition of this newsletter.**

## Suicide: Children and Young People

Suicide has widespread and devastating impacts on family, friends and communities. Services are amongst those vital to ensuring young people feel supported to ask for and access help when they need it.

The [National Child Mortality Database Programme: Suicide in children and young people thematic report 2021](#) highlighted the following statistics:

- Numbers of child or young person deaths (17 or under) assessed to be 'highly' or 'moderately likely' to have been suicide, equated to about **2 deaths per week** in England between April 2019 and March 2020. This was similar across all regions.
- Where ethnicity was known, **79%** were described as being from a **white ethnic background**.
- The most **common method was hanging or strangulation**. This accounted for 69% of deaths.
- **78% of suicides were in the 15-17 age group**.
- Suicide is **more common in boys**.

The 3 most common risk factors present in deaths reviewed by CDOPs were:

**Household functioning (parent divorce/ separation, living with a parent misusing drugs or alcohol, domestic abuse exposure, living with a parent or carer with a mental health problem, caring for a family member)**

**Loss of key relationships (recognising the importance of peer relationships)**

**Mental health needs of the child/young person**

Key recommendations were made in the report for agencies providing support to children and young people. One recommendation in particular highlighted the lack of confidence in talking about suicide with children and young people.

A reminder to please ensure that you access training and are aware of the services available for people who require support.

Training for professionals is available from:

- [NHS Health Education England](#)
- [Zero Suicide Alliance](#)



## Where can people access help?

### Papyrus Prevention of Young Suicide

Support can be accessed through Papyrus via Hopeline, a confidential support service for children and young people (under 35) experiencing thoughts of suicide, or anyone concerned that a young person could be thinking about suicide.

**Open every day from 9.00am – midnight**

Call: 0800 068 4141

Text: 07860 039 967

Email: pat@papyrus-uk.org

### The Samaritans

Free 24/7 service accessed via 116 123 with online chat, email or letter.

### Shout 85258

24/7 free, confidential, anonymous text messaging support service for anyone struggling to cope.

### Mind

Advice and support for anyone experiencing poor mental health.

## Stillbirth – Ethnicity Related Risks

A CDOP case of third trimester fetal loss prompted recent discussions regarding ethnicity related risk, specifically for black women. There is strong evidence of inequalities for women from black, Asian, and other minority ethnic communities across the perinatal spectrum including risk of:

- Maternal death
- Neonatal death
- Stillbirth

These inequalities are recognised nationally and outlined in the [NHS long term plan](#) and national maternity review: Better Births, improvements are being implemented locally by the Local Maternity and Neonatal System (LMNS). The evidence around fetal loss is split between miscarriage (gestation of less than 24 weeks) and stillbirths (gestation of 24 weeks and above), though there are overlapping themes across the antenatal period.

- Black women have a **40% to 60% greater risk of miscarriage compared to White women**; ([meta-analysis of 19 studies published in the Lancet](#)).
- The UK has one of the highest stillbirth rates in high-income countries ([NHS England, 2016a](#)).
- While UK stillbirth rates in 2017 had reduced to 3.74 per 1 000 total births from 4.20 in 2013 which represents 350 fewer stillbirths ([Draper et al, 2019](#)), stillbirth rates continue to be high for Black women in the UK at 7.46 per 1 000 births in 2017 ([Draper et al, 2019](#)).

Investment in, and successful implementation of, high quality care and health promotion during pregnancy is one of the most effective ways to protect mother and baby, and promote healthy child development outcomes ([Kerber et al, 2007](#)).

Clear and specific circumstances have been noted where differential access or uptake of services contributes to disparities; this includes antenatal diagnosis, timely diagnosis and treatment of pre-eclampsia, and labour induction for post-maturity ([Flenady et al, 2016](#)). Hence, a multitude of factors may contribute to stillbirths in black women with the underlying prevalence of lack of quality healthcare.

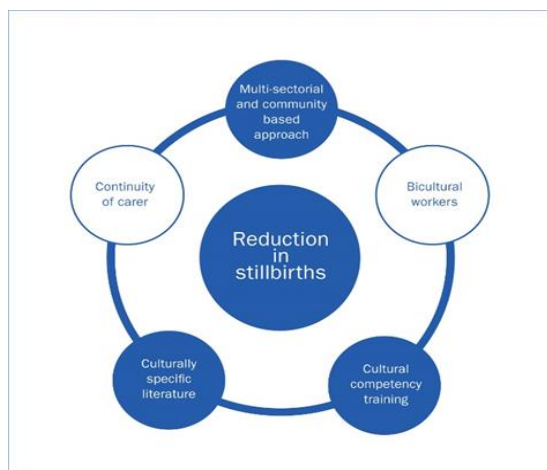
### Stigma and Stillbirth

Stillbirth is associated with stigma in many cultures, making it difficult to approach certain communities about reducing stillbirth rates.

The response to the delivery of a stillbirth is dependent on the cultural belief and practices of the affected family ([Homer and ten Hoop-Bender, 2016](#)). There are many tribes among black British communities where stillbirth is rarely discussed openly at home or within the community ([Kiguli et al, 2016](#); [Murphy and Cacciatore, 2017](#); [Adebayo et al, 2019](#)).

**Stillbirth has severe psycho-social adverse effects on parents and family. Providing targeted information to black women and communities is crucial.**

### British Journal of Midwifery model for reducing stillbirths



#### CPD reflective questions

Is there provision of culturally specific health literature relating to stillbirth prevention in your organisation?

Do you utilise bicultural workers or interpreters to provide health advice to women on prevention of stillbirths for high-risk women?

What steps are being taken by your organisation to reduce stillbirths in high-risk women?

#### Useful Resources

- [Miscarriage Matters - The Lancet](#)
- [Miscarriage Leaflets - Miscarriage Association](#) - free leaflets to download, they are available in a range of languages and assessable options
- [Evidence and recommendations on stillbirths in Black women - British Journal of Midwifery](#)

### Case Learning: Co-ordination of Care

CDOP recently reviewed the death of a baby with a chronic medical condition. Poor continuity of care was identified and lack of recognition of the complexity of the case from both social and medical perspectives.

This resulted in treatment opportunities being missed and a lack of appropriate monitoring.

This case highlights the importance of coordination of care when there are significant social issues alongside complex medical care, and particularly the value of a lead professional being identified to ensure better joined up thinking and continuity in maternity care.



Please find below a midwife's reflection on another case where coordination of care had been successful.

---

*"I received some feedback from a family who were very satisfied with their care. Their baby was diagnosed in the antenatal period with a condition which was severely life limiting, so much so there was uncertainty as to whether the baby would survive pregnancy or labour. I took some time to reflect on what made this family's experience so positive despite such difficult circumstances.*

*Early on in their journey the parents had a key person they could contact any questions or concerns, or to clarify what the family had been told by different professionals. This Key person provided an open channel of communication, easy for the family to access via phone or email, and importantly responsive to any communications. The key person had an overview of the care this family were receiving and the ability to coordinate multidisciplinary team, which was particularly important as the care was being provided from several different specialist centres.*

*Continuity of care was also incredibly important, the family were able to meet the same Obstetrician, Neonatologist and Specialist Midwives, enabling them to build a trusting relationship, the family were able to explore a range of options open to them for the care of their baby, over several appointments a plan was made that facilitated the families hopes and wishes for their limited time with their child, alongside this parallel planning took place for alternative scenarios should 'Plan A' not be possible.*

*Each time a planning meeting took place a detailed letter was written and shared with the family and team this helped to ensure everybody had a shared understanding of the current plan. Technology was also useful as experts from further afield were able to dial into joint meetings, something which would have been more difficult without Microsoft Teams!*

*My main learning from this reflection is how important the key contact person was in facilitating smooth coordinated communication between the family and the teams involved in their care. When so many professionals are involved, communication can often be a challenge, this can be stressful and frustrating for families and professionals alike, having this key contact person alleviated many of these concerns."*

---

## Translation Services

A reminder that effective communication is vital in healthcare, therefore meeting the communication needs of patients must be met freely and at the point of delivery.

Professionals are reminded to ensure they are aware of how to access language interpretation (spoken or British Sign Language) and translation services (written word or braille transcription) within their organisations to ensure patients aren't disadvantaged when accessing effective healthcare.



### Key Points to consider:

- ❖ Interpretation requires additional time and should be factored in
- ❖ Language preferences and communication requirements should be logged in patient records (this should be passed on in the case of onward referrals)
- ❖ When supporting children with interpreting services, every effort should be made to respect their rights (any person under the age of 18 years and especially those under 16 years of age) and support them in ensuring that interpreting services are provided to them.

For more information about CDOP or if you have any 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