Healthier Futures
Black Country Integrated Care System

Black Country
Child Death Overview Panel

Black Country CDOP

Learning from Operational Panels

Modifiable factors highlighted in recent cases:

- High Maternal BMI
- Smoking during pregnancy
- Mother - known to smoke, declined smoking cessation services in pregnancy.
- Household smoking (father known to smoke)
- Possible delay in treating an infection which was identified on swabs taken in the days prior to delivery but not actioned until post-delivery.
- Communication - parents shared the inability to get through on the phone, and this delayed the attendance into the unit for treatment.
- Vitamin D deficiency - lack of Vitamin D would have increased the vulnerability for this child.
- Referral sent to Childrens services and home assessment completed by health visitor - home smoky and child's clothing soiled.
- Parents poorly engaged with health visiting and health care services, failed to attend appointments, and had been referred to Childrens Services.

LEARNING Points

Maternity/Neonatal

- Type 1 diabetes was recognised to be an increased risk of congenital heart disease.
- Tertiary Hospitals needing to share notes/plans.
- Link between maternal mental health and increased risk in prematurity that had been mentioned in previous Panel meetings.
- To explore practise within other Trusts in relation to the use of size 2 ET tubes for extremely preterm births.
- Documentation of 2nd dose for surfactant and rationale needed.
- To screen for infection within the first hour if there are clinical concerns.
- Respiratory management of the baby during the first 24 hours was not appropriate.
- The decision to transfer the baby to another unit could have been made sooner.
- Persistent high oxygen requirement post surfactant should be discussed with tertiary unit.
- The placenta was not sent for histological examination (missed opportunity to support family with future pregnancy plans.)
- Hypertension and maternal tachycardia were not adequately investigated.
- To remind staff in foetal medicine to refer and investigate appropriately when women have abnormal observations.
- Estimated foetal weights from scans had not been plotted on a chart.

- Discussion for future pregnancy the parents could opt for pre-implantation genetic testing and should seek advice from the fertility department for other options.
- For a future pregnancy optimising her blood pressure control before embarking on pregnancy would be important given the placental histology findings.

Communication (Maternity)

- Impact of not being able to get through to Triage, and to ensure communication with families if this is an issue, who else could be contacted.

Communication (111/999)

- During an emergency call a mother in labour with a breech presentation was not given the correct information to aid delivery, due to mishearing the response, therefore the instructions for delivery were advised, not breech birth.
- Early dispatch of enhanced care services would benefit patients and improve care outcomes.
- Consider a flag system within to identify newly qualified to ensure NQP's are not dispatched as a solo response.
- The importance of experienced midwives/trained clinicians within the call centre.

Communication (interpreting services)

- Lack of compliance throughout pregnancy with interpreting service not used to capture mother's voice.
- Language barrier and perception of families understanding – the team felt that the family understood all conversations and they did not always want an interpreter, however after their death, there were a lot of questions, concern the family did not understand everything.
- Increased access to interpreters and more consistent use of 'language line' or the 'Dora' interpreting system should be utilised when required.

Medical intervention

- A team leader for clinical support and scene management should be considered in time critical situations to avoid delays on scene and should not be limited to cardiac arrest management.

Service discrepancies (home visits/CONI/WNB etc…)

- Health not currently conducting home visits out of hours, currently in the process of resolving.
- CONI Scheme was not available at the time of the new birth.
- Health visitors should be recommending Vitamin D for under 4 years old.
- Inconsistencies across the Black Country on Health Start vitamins offer.
- Importance of follow up the missed 2-year development check in community.
- The WNB policy was not followed.
- The DNA policy was not followed.

Teams/staff feedback

- Listening session for PICU staff – a neutral platform to prepare & support frontline staff in managing challenging cases.
- Effectiveness of a debrief – to ease moral distress and reassure teams of a dignified end.

Communication with parents

- Early recognition & instituting parallel planning in a child with life-threatening/ life-limiting condition can help parents' understanding their values & prepare for a more seamless journey when care is redirected towards prioritising comfort vs curative.
- Parents requested professionals listen to the family- when they report their child is not well for their concerns to be acknowledged rather than looking at clinical picture.
- Parents hadn't realised that sepsis is so serious, and it can lead to death.

Multi-agency learning

- The importance of looking at the whole family and any previous concerns e.g.a pattern of issues previously?
- Check wider family records and information from school - Especially in cases of poor engagement from family, and history of previous involvement from social services.

Bereavement support

- Where bereavement support is declined, understand the reason for the decline in support. Is there another option for bereavement care to ensure a neutral offer.
- Teams supporting parents for some time during the grieving process.

SUDI response

- Home visit not completed as felt to be a medical cause following a multi-agency discussion – highlighted the importance to ensure the documentation is clear that the immediate decision making with a multi-agency team.
- The SUDIC process was delayed (one week later) and did not include the police to make an appropriately timed conversation.

Palliative Care

- There is no 24-hour palliative care / community nursing care available in some areas.
- Refer to hospice earlier - prior to death.

Mental Health

- There was no access to adult mental health services for the parents despite frequent escalations from the oncology team about concerns for their mental health.

Themes highlighted:

- High BMI
- Polycystic Ovaries Syndrome (PCOS)
- Poverty and Deprivation
- Key worker role
- Palliative Care
- SUDIC and catastrophic collapse
- Universal distribution of Vitamin D
- Communication with parents (use of an interpreter)