Thanks For Inviting Me Again…!

Learning From the Child Death Reviews In Primary Care

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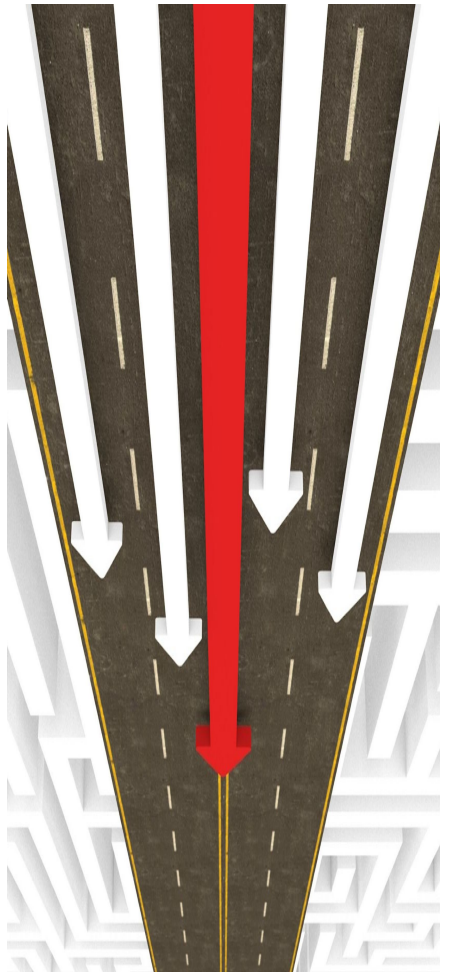
Designated Doctor for the Child Death Review

Objectives

- **Sharing learning from child death reviews focusing on the primary care**

- **Introduction**
- **Case studies X 5 cases with 5 themes.**
- **System Improvement in Primary Care to Prevent Child's Death**



What is a Child Death Review

- **The focus of the CDR is to support parents and improve future safety to prevent future deaths i.e Learning From Deaths.**

  - ❑ Statutory requirement
  - ❑ All deaths under 18 reviewed
  - ❑ Multi-agency process
  - ❑ Identifies modifiable factors: these are factors which increase vulnerability or contribute to deaths.

- **Involves two important key organisations , these are the CDOP and NCMD.**

Key Organisation

Child Death Overview Panel (CDOP)

- ❑ Local review panel
- ❑ Reviews every child death
- ❑ Identifies themes
- ❑ Issues recommendations
- ❑ Reports to safeguarding partners
- ❑ Share identified learning.

National Child Mortality Database (NCMD)

- ❑ Collects all child death data
- ❑ England-wide coverage
- ❑ Identifies national trends and themes
- ❑ Supports prevention
- ❑ **Informs policy and practice changes**

GP Statutory Responsibilities

Requires active participation of GPs at all stages of the CDR:

- Provide clinical information
- Share records lawfully
- Respond to CDOP
- Attend reviews if required
- **Reflect and apply learning into practice early*****

Why Learning From Child Deaths Matters For Primary Care

Child deaths are rare but devastating

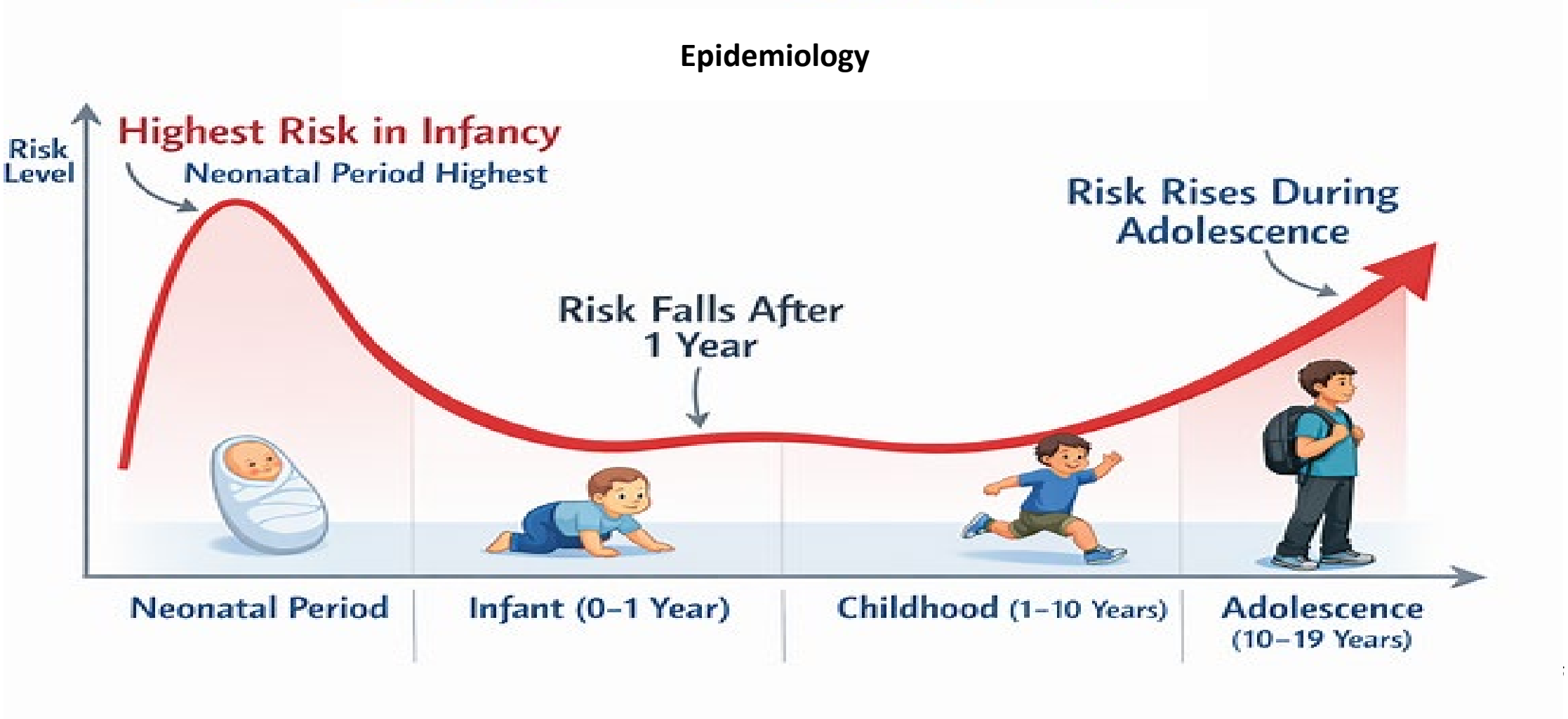
Many deaths involve modifiable factors-provide an opportunity for learning

Statutory process under Children Act 2004

The focus is on prevention. Primary Care is almost always involved and plays key preventive role

This highlights the GP role in providing longitudinal care……..

Data on Age Distribution of Deaths
Provides an opportunity for Age-specific vigilance



Data on Causes of Child Deaths provides opportunities for prevention

In Infants < 1 year of age:

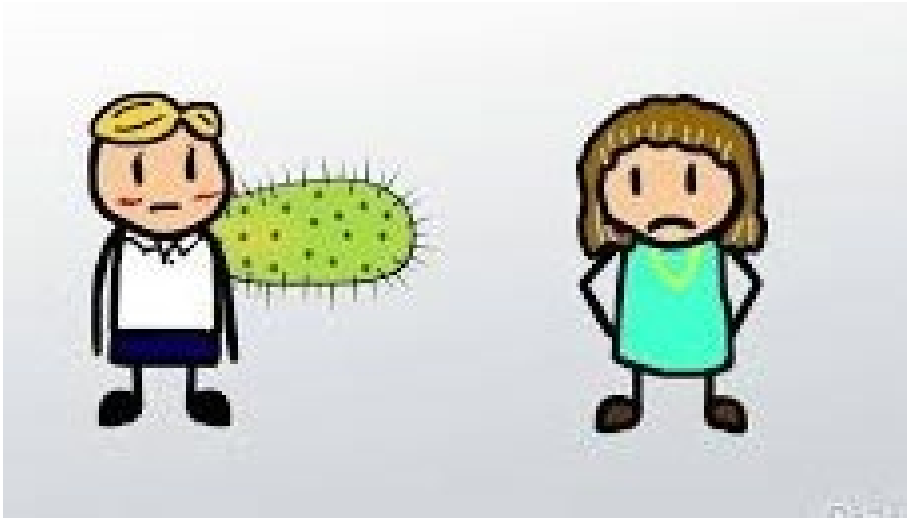
- ❑Perinatal causes
- ❑Prematurity
- ❑Congenital anomalies
- ❑Infection
- ❑Sudden unexpected death

In Older Children:

- ❑Chronic disease
- ❑Infection
- ❑Injury
- ❑Neurodisability
- ❑Suicide in adolescents

Higher Child Deaths associated with Deprivation and Inequality

- Child death is linked to Deprivation, social classes and inequality.
- **Child death is 3 times Higher in most deprived area.**
- **<u>Contributing factors:</u>**
  - Poor housing
  - High poverty
  - Parental mental health
  - Reduced access to care
- **Deprivation and inequality are High in Barnsley**

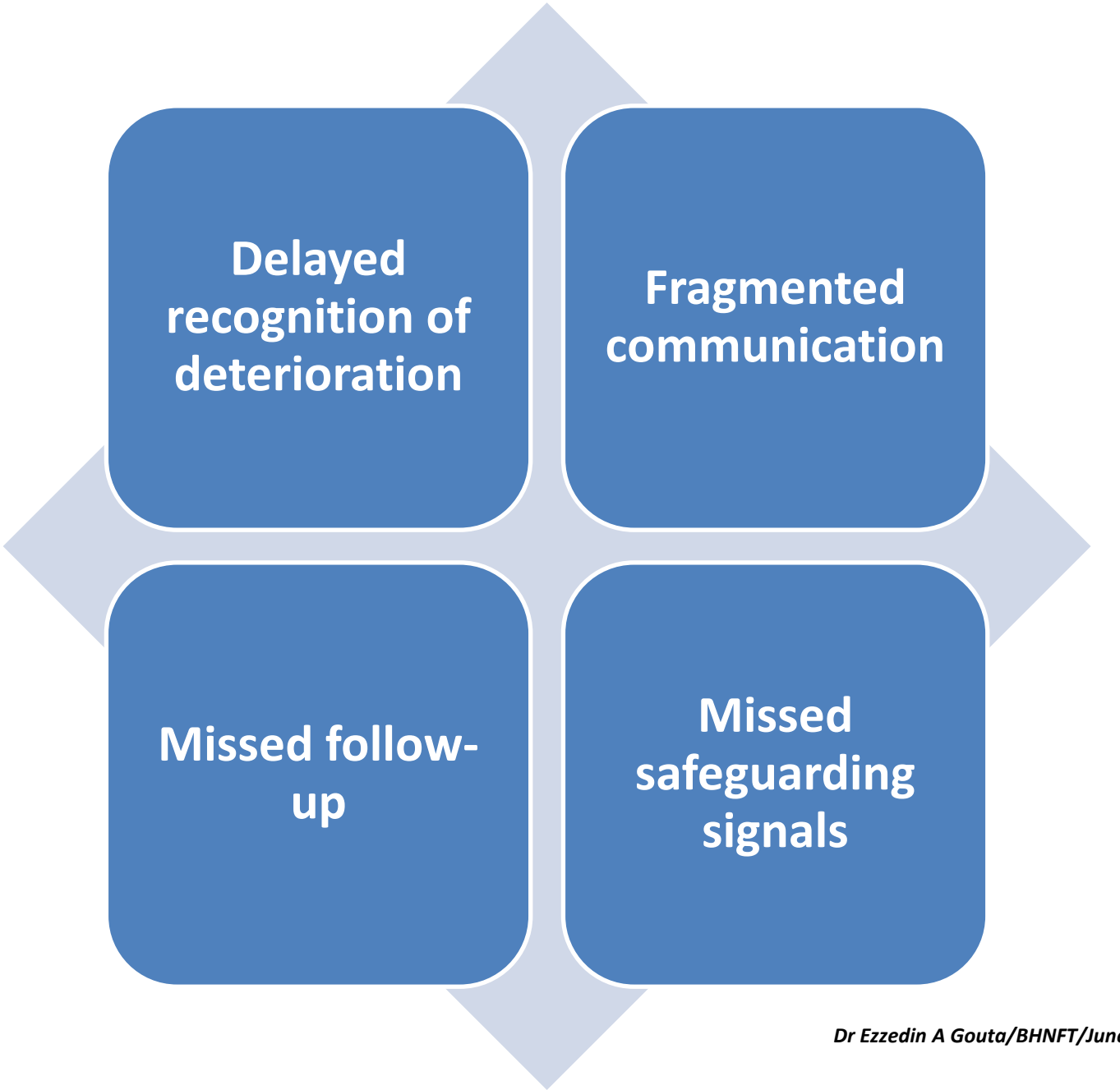


Modifiable Factors
provide opportunities for learning and prevention

- **<u>Definition</u>: Factors which increase vulnerability and/or contribute to deaths as determined by CDOP.**
- **Present in one third (1/3rd) of all Child Deaths.**
- **Includes the following categories:**
  - ❑ Clinical management issues
  - ❑ Social risk factors
  - ❑ System failures
  - ❑ Communication problems

Common Themes of modifiable factors in Child Death Reviews:NCMD

THÈMES



GP Contact Before Child's Death

- ❑ Most children who died had **recent** GP contact
- ❑ Often **multiple** consultations
- ❑ **Common modifiable factors** related to GP care:
  - Missed deterioration
  - Failure to recognise patterns of presentation
  - Delayed escalation
- ❑ Accordingly, Opportunities for prevention exist in primary care

➢ This highlights the importance of continuity of care Primary Care i.e. Longitudinal Care…….

Case Studies (X5)

Themes of the Case Studies (X 6)

1. Repeated presentations & missed deterioration **(e.g. Sepsis)**
2. Safety-netting & follow-up ownership **(e.g. Bronchiolitis)**
3. Repeated Symptoms & Absent Risk Stratification **(e.g. Asthma)**
4. Safeguarding **(e.g. NAI)**
5. Social determinants & vulnerability **(e.g. Mental health)**
6. **Communication & Continuity of care - Featured in all cases**

- **Case studies based on Real Child Death Review Learning**
- Focus on diagnostic, management pitfalls and system learning relevant to GPs **and** Child Safety in General Practice

NCMD
National Child Mortality Database

CDOP

Depending on time 1-2-3-4-5

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Case Study 1

Repeated Presentations and Missed Deterioration

- The case focuses on recognising longitudinal deterioration in children.
- This case illustrates the importance of pattern recognition over single-visit assessments.

Case study 1

Case summary:

- Child aged 18 months
- Previously well
- Lives in high deprivation area
- Multiple GP contacts over 10 days

- **Outcome: Died from overwhelming sepsis**

Case study 1

Clinical timeline:

- **Day 1**. Fever and cough. Diagnosed viral URTI. Safety netting minimal
- **Day 4**. Persistent fever and reduced intake. Reassessed by a GP. Reassured. No review of prior contact.
- **Day 7**. Lethargy and poor feeding. Seen by different GP. No trajectory assessment.
- **Day 10**. Collapsed at home. Admitted late. Died within 24 hours, cause of death overwhelming sepsis.

Case study 1

Key Issues Identified

- Each consultation assessed in isolation
- No cumulative review of repeated presentations
- Illness trajectory not assessed or documented
- Reattendance not recognised as a risk signal
- Escalation delayed despite progression
- Minimal and non-specific safety netting

Risk Factors Identified but not recognised:

- High deprivation is linked to increased child mortality
- Socio-economic context may contribute to delayed escalation
- Multiple contacts over a short period is a risk factor, should trigger concern

Case study 1

System Learning (CDR and NCMD)

- ❑ Most children who die from infection had prior healthcare contact
- ❑ Multiple primary care consultations before death are common
- ❑ Risk is often missed due to snapshot assessments
- ❑ Failure relates to pattern recognition, not clinical knowledge
- ❑ Longitudinal oversight is a recurrent modifiable factor in children who died of sepsis

Case study 1

GP actions and learning from this case

Action	Why this matters
Review previous consultations before concluding assessment	As continuity and record review are core GP safety functions.
Assess and document illness trajectory explicitly	And treat repeat attendance as a **"red flag". It is a critical safety signal**
Ask directly about progression: "Is this getting worse?"	**As early signs were non-specific but cumulative & deterioration often occurres over days, not hours**
Escalate earlier on reattendance, even with borderline signs	As earlier escalation leads to earlier treatment
Pattern recognition	As this helps identifying hidden risk. Risk emerges from patterns, not isolated encounters
Provide clear, time-bound safety netting	As this ensures timely re-presentation

Case study 1

Take-Home Messages/Core Learning Point

- Repeat attendance is a critical safety signal
- Risk emerges from patterns, not isolated encounters

Case study 1

Reflective Questions

- How do you recognise deterioration across multiple consultations?
- What should trigger escalation when each individual review appears low risk?
- How can repeat attendance be used as a clinical warning sign?
- How do you maintain continuity and awareness across different clinicians?

Case study 2
Safety-Netting and Follow-Up Ownership

The Case Focus is on having:

- Effective safety-netting
- Clear follow-up responsibility
- Awareness of the risks of relying solely on parental judgement

Case study 2

Case summary:

- Child: 6 months
- Born at 35 weeks gestation
- History: Previous bronchiolitis admission required HDU care
- Lives with young first-time parents

- **Outcome: Died from severe respiratory infection (RSV+ Bronchiolitis)**

Case study 2

Clinical Timeline

- **Day 1:**
  - Cough and poor feeding; examination borderline, not too unwell
  - Diagnosed viral illness
  - Verbal safety-netting only. Not documented
  - No clear timeframe or defined red flags documented
- **Day 3:**
  - Increased lethargy and reduced feeding
  - Delayed re-presentation due to parental uncertainty
- **Day 4:**
  - Emergency admission with respiratory failure
  - Death in PICU, cause severe RSV+ bronchiolitis

Case study 2

Key Issues and Risks Identified

- ❑ Prematurity and prior respiratory illness needed HDU care not recognised as risk factors for severe bronchio.
- ❑ Parental inexperience not factored into risk assessment
- ❑ **Illness trajectory and risk of deterioration not explained**
- ❑ Safety-netting vague, non-specific, and undocumented
- ❑ No clear timeframe for re-assessment
- ❑ No explicit red flags or action plan
- ❑ Follow-up responsibility left to parents
- ❑ No planned GP review despite high-risk features
- ❑ Lack of GP ownership of illness trajectory

Case study 2

Why This Matters

- ❑ Clear guidance reduces delayed re-presentation
- ❑ Defined follow-up reduces reliance on parental judgement
- ❑ Planned review enables earlier detection of deterioration
- ❑ Documentation ensures continuity across clinicians

Case study 2

System Learning (CDR and NCMD)

- ❑ **Failures occur despite initially reasonable clinical assessment**
- ❑ Poor safety-netting is a common modifiable factor
- ❑ Parents often unclear when to seek help
- ❑ Red flags frequently not documented
- ❑ Planned follow-up often absent

- **This learning is a recurrent and preventable pattern**

Case study 2

GP actions and learning from this case

- ❑ **Provide explicit, time-bound safety-netting** – e.g. if feeding not improving within 12 hours. Clear guidance reduces delayed re-presentation.
- ❑ **Clearly define red flags** – e.g. Reduced wet nappies, increasing lethargy , worsening work of breathing, or continuing concerns etc.
- ❑ **Explain how and where to seek urgent care** e.g. open access arrangements.
- ❑ **Confirm parental understanding + written information**
- ❑ **Document all safety-netting clearly**: as documentation ensures continuity across clinicians
- ❑ **Arrange proactive follow-up for high-risk infants**: as defined follow-up reduces reliance on parental judgement & Planned review enables earlier detection of deterioration

Case study 2

Take-Home Messages/Core Learning Points

- ❑ Giving safety-netting is a clinical professional duty, not optional advice.
- ❑ Safety-netting must be specific, documented, and time-bound
- ❑ Verbal advice alone is insufficient, should be augmented with written advice and red flags must be clear and actionable
- ❑ High-risk children require proactive follow-up.
- ❑ Follow-up responsibility should not rest solely with parents.
- ❑ Planned review reduces risk of deterioration and late escalation
- ❑ Use structured documentation and safety-netting checklists.
- ❑ Ownership of the illness trajectory must remain with the clinician

Case study 2

Reflective Questions

- ❑ How do you provide clear and actionable safety-netting?
- ❑ How do you confirm parental understanding?
- ❑ When should you arrange proactive follow-up?
- ❑ How do you ensure safety-netting is consistently documented?

Case Study 3
Repeated Symptoms and Absent Risk Stratification-Chronic Conditions

Session Focus:

This case examines **asthma management in primary care**, with emphasis on:

- ❑ Repeated presentations as markers of **poor control and escalating risk**
- ❑ The impact of **absent risk stratification**
- ❑ The role of **proactive, structured management in preventing deaths**

- **Core principle here is that:**
  Preventable asthma deaths **are often preceded** by **missed opportunities, missed patterns recognition, inadequate review, and failure to escalate risk.**
- **Same principles apply for other chronic conditions e.g. epilepsy etc.**

Case Study 3

Case Summary

- **Child:** 9 years old
- **Diagnosis:** Asthma since age 3
- **Care setting:** Registered with GP practice
- **Healthcare use:** Multiple unscheduled contacts over 12 months

- **Outcome:** Died from an **acute asthma attack at home**

Case Study 3

Clinical Timeline

Over a 12-month period before death:

- Multiple GP and out-of-hours visits for wheeze
- **Three courses of oral steroids**
- **Four salbutamol canisters/inhalers in 6 months**
- No documented **annual asthma review**
- No **personalised asthma action plan**
- **No recorded assessment of:**
  - Inhaler technique
  - Adherence

Case Study 3

Key Risks, missed signals and Management Failures identified:

A. Clinical Risk Indicators and Key missed signals not recognised:

- **Frequent exacerbations requiring steroids**: - ≥2 steroid courses per year → **poor control**
- **Repeated urgent contacts** → indicates **failure of baseline management and poor asthma control**
- **Excess reliever inhaler use** → is a **deterioration marker and poor asthma control**
- **Persistent symptoms requiring urgent care** → indicate **high-risk asthma, this is not routine disease activity**

B. System Failures include:

- Absence of structured annual review
- Lack of risk stratification
- Reactive rather than proactive care

C. Management Gaps include:

- No personalised asthma action plan
- No inhaler technique assessment
- No adherence review

Case Study 3

Understanding Risk in This Case

A. Key missed signals not recognised:

- **Frequent exacerbations requiring steroids**:
- **Repeated urgent contacts**
- **Excess reliever inhaler use**
- **Persistent symptoms requiring urgent care →**Repeated symptoms and treatment escalation indicate **high-risk asthma**, not routine disease activity

Repeated or persistent symptoms and treatment escalation indicate **high-risk asthma**, not routine disease activity

B. System Failures include:

- Absence of structured annual review
- Lack of risk stratification
- Reactive rather than proactive care

C. Management Gaps include:

- No personalised asthma action plan
- No inhaler technique assessment
- No adherence review

Case Study 3

HIGH-RISK ASTHMA (Children)

- From NICE implementation data and pathway criteria:

- **Major risk markers:**
  - ≥4 SABA prescriptions/year
  - steroid use in last year ≥2 Oral steroid courses in last year.
  - Previous hospital admission / ED visits
  - Poor adherence or technique
  - Ongoing symptoms despite treatment

Case Study 3

Missed Pattern Recognition and Missed Opportunities are evident in this case

- **The following pattern should have triggered action as they indicate poorly controlled asthma:**
  - ❑ Increasing reliever use
  - ❑ Steroid use in last year- ≥2 Oral steroid courses in last year.
  - ❑ Recurrent exacerbations
  - ❑ Ongoing frequent unscheduled care
- **The Missed Opportunities include:**
  - No structured reassessment after steroid courses
  - No escalation despite repeated risk markers
  - No transition from reactive to planned care

Case Study 3

System learning from CDR and NCMD

- **Key findings from NCMD (National Child Mortality Database and child death reviews):**
  - Most children who died from asthma were **known to primary care**
  - Care was often **reactive rather than planned**
  - **Risk stratification was absent** in many cases
  - Excess reliever use was **not recognised or acted upon**
  - Frequent courses of steroids **was not recognised or acted upon**

- **Failures are driven by:**
  - Lack of proactive monitoring
  - Failure to recognise high-risk patterns
  - Inadequate escalation

Case Study 3

GP actions and learning from this case

for the Prevention of Future Deaths from Asthma

A. Proactive Identification by:

- Use **asthma registers** to track patients
- Identify **high-risk features**: e.g. Frequent steroid use; Excess reliever prescriptions; Missed reviews

B. Follow Structured Management

- Ensure **annual asthma reviews**
- Conduct **structured assessments** at every exacerbation

C. Provide Core Clinical Interventions

- Provide **written personalised asthma action plans**
- Check: Inhaler technique ; - Check medication adherence

D. Follow Risk-Based Escalation

- Escalate early to **specialist care** when risk markers present
- Do not delay escalation e.g. Recurrent exacerbations ; Poor control despite treatment

E. Documentation

- **Record** e.g. Risk status ; Review findings ; Management plan etc.
- Document **patterns over time**, not isolated contacts

Case Study 3

GP Actions: Core Learning Points

for the Prevention of Future Deaths from Asthma

A. Proactive Identification by:

- Use **asthma registers** to track patients
- Identify **high-risk features**: e.g. Frequent steroid use; Excess reliever prescriptions; Missed reviews

B. Follow Structured Management

- Ensure **annual asthma reviews**
- Conduct **structured assessments** at every exacerbation

C. Provide Core Clinical Interventions

- Provide **written personalised asthma action plans**
- Check: Inhaler technique ; Medication adherence

D. Follow Risk-Based Escalation

- Escalate early to **specialist care** when risk markers present
- Do not delay escalation e.g. Recurrent exacerbations ; Poor control despite treatment

E. Documentation

- **Record** e.g. Risk status ; Review findings ; Management plan etc.
- Document **patterns over time**, not isolated contacts

The combination of the following directly reduces asthma mortality:

1. **Planning**
2. **Documentation**
3. **Proactive intervention**

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Case Study 3

Preventing Future Deaths from Asthma

Effective prevention requires:

- Structured, regular reviews
- Early identification of deterioration
- Personalised action planning
- Proactive escalation to specialist services

- **The combination of the following** directly reduces asthma mortality:
  - Planning
  - Documentation
  - Proactive intervention

Case Study 3

Key Take-Home Messages are to recognise that:

- Repeated symptoms indicate **high-risk asthma.**
- Repeated healthcare contact is a **warning signal, not reassurance**
- Risk stratification must be **explicit and ongoing**
- Written asthma action plans are **essential for safety**
- Excess reliever use is a **critical warning sign**
- Preventable deaths result from **missed escalation, not lack of access**
- Early escalation prevents deterioration and death

The Practice Application are:

- Use **practice data** (prescriptions, attendance, registers) to flag risk
- Implement **proactive monitoring systems**
- Shift from **reactive care to longitudinal management**

Case Study 3

Reflective Questions

- How do you identify **high-risk asthma patients** in your practice?
- When should escalation to specialist care occur?
- How do you ensure inhaler technique and adherence are consistently reviewed?
- How do you stratify asthma care?
- How can asthma registers be used to **prevent missed reviews**?

Case Study 4

Safeguarding – Recognising Cumulative Harm

Session Focus

- This case examines safeguarding in children with an emphasis on **cumulative risk** rather than isolated incidents.

Core principle here is that:

- Harm often results from **patterns of low-level concerns over time**, not single high-risk events. Early recognition and proactive intervention are essential to prevent avoidable harm.

Case Study 4

Case Summary

- **Child:** 3 years old
- **Medical history:** Known to GP since birth.
- **Family context:** unemployed parnets and Parental mental health difficulties.
- **Engagement:** Repeated missed healthcare contacts
- **Outcome:** Death following accidental injury in an unsafe home environment

Case Study 4

Clinical Timeline and Emerging Concerns

Over an 18-month period:

- Repeated missed GP and health visitor appointments (Multipe DNAs)
- Poor attendance at immunisations and developmental reviews
- Multiple minor injuries recorded
- No linkage between incidents
- Parents appeared cooperative, but engagement was inconsistent
- No safeguarding referral made due to absence of a single high-risk trigger.

Case Study 4

Key issue and Risks Identified

The Key issue is that Concerns remained fragmented and unconnected, preventing escalation.

A. Indicators of the child's Vulnerability:

- Young age (high dependency)
- Exposure to unsafe home conditions
- Parental mental health challenges

B. Indicators of Neglect:

- Missed appointments
- Poor healthcare engagement
- Unmet developmental & medical needs

C. System-Level Risks are:

- Failure to connect repeated concerns
- Lack of escalation without a "trigger event"
- No information sharing across services

Case Study 4

Key Risks Identified

A. Indicators of the child's Vulnerability:

- Young age (high dependency)
- Exposure to unsafe home conditions
- Parental mental health challenges

B. Indicators of Neglect:

- Missed appointments
- Poor healthcare engagement
- Unmet developmental & medical needs

C. System-Level Risks are:

- Failure to connect repeated concerns
- Lack of escalation without a "trigger event"
- No information sharing across services

Case Study 4

Understanding Cumulative Risk is important for safeguarding issues:

- **Cumulative harm arises when:**
  - Multiple **low-level concerns persist over time**
  - No single incident appears severe enough to trigger action
  - Patterns are **not recognised or documented holistically**
- **Safeguarding urgency should be based on accumulated evidence, not isolated events**

Case Study 4

Pattern Recognition is important in This Case

- **The following pattern should have been identified:**
  - Recurrent DNAs
  - Ongoing poor engagement
  - Repeated minor injuries
  - Inconsistent parental follow-through

- **There was a missed Opportunity as Linking these factors could have:**
  - **Identified escalating risk**
  - **Triggered earlier safeguarding intervention**
  - **Prevented prolonged exposure to harm and death (in this case)**

Case Study 4

Disguised Compliance not uncommon…!

- **A key feature in this case was a disguised compliance:**
  - Parents appeared cooperative e.g. cancellation of appointments
  - Alternating DNAs with occasional attendance
  - However, **behaviour did not translate into sustained engagement**
- **Interpretation**
  - Superficial compliance should not override **objective risk indicators**
  - This requires **professional curiosity and verification**

Case Study 4

System learning from CDR and NCMD

- **Key safeguarding insights:**
  - Neglect is a major contributing factor in child deaths
  - Harm often results from **accumulation of unmet needs**
  - Missed appointments frequently precede serious incidents
  - Warning signs are often visible across multiple services
- **Failures commonly occur due to:**
  - Poor pattern recognition
  - Lack of information sharing
  - Fragmented records

Case Study 4

What do we need to prevent Future deaths from Safeguarding issues?

- **Effective safeguarding requires**:
  - Early recognition of cumulative harm
  - Strong multi-agency communication
  - Avoidance of siloed/isolated decision-making
  - Vigilance in tracking longitudinal patterns
  - Professional curiosity to challenge assumptions
- **The Outcome Principle is that:**
  - Earlier intervention reduces **duration and severity of exposure to risk and may prevent deaths in some cases.**

Case Study 4

GP actions and learning from this case to prevent deaths from safeguarding issues

***Safeguarding urgency should be based on accumulated evidence, not isolated events**

A. Risk Identification

- Treat repeated DNAs as **safeguarding indicators**, not administrative issues
- Regularly review **full child history**, including: Attendance patterns and Injury records

B. Timely Escalation

- Act on **emerging patterns**, not waiting for a critical event
- Initiate safeguarding referrals **based on cumulative concern**

C. Appropriate Documentation

- Record **patterns and trends explicitly.**
- Avoid documenting **events in isolation**

D. Effective Communication

- Share concerns proactively with: Health visitors and Safeguarding teams
- Contribute to **multi-agency awareness**

Case Study 4

Key Take-Home Messages

- Safeguarding depends on **pattern recognition over time.** Preventable harm often results from **missed patterns, not missed events.**
- Repeated low-level concerns can signal **serious underlying risk.**
- The absence of a single critical incident does **not** indicate safety.
- Missed appointments are **clinical risk indicators.**
- Superficial compliance should not override **objective risk indicators**
- Documentation must reflect **cumulative concern**
- Strong Multi-agency communication is essential to prevent oversight.

- ❑ Earlier intervention reduces **duration and severity of exposure to risk and may prevent deaths in some cases**
- ❑ Safeguarding is a **proactive responsibility**, not reactive. It requires professional curiosity to challenge assumptions.

Case Study 4

Reflective Questions

- How can cumulative risk be recognised earlier in clinical practice?
- What strategies help identify disguised compliance?
- When should repeated missed appointments trigger escalation?
- How can safeguarding concerns be effectively shared across services?

Case Study 5

Adolescent Mental Health – Bullying, Gender Identity, and Depression

Session Focus

- This case examines **adolescent mental health vulnerabilities** with a focus on:
  - Depression and emerging self-harm risk
  - Bullying and social exclusion
  - Gender identity-related distress

CAMHS
Child & Adolescent Mental Health Services

- **Core principle is that:**
  Adolescent harm often arises from **cumulative psychosocial stressors over time**, requiring early recognition, longitudinal monitoring, and proactive intervention.
- **The GP role in all of this is:**
  To identify **patterns across consultations**, assess psychosocial risk comprehensively, and coordinate timely, multi-agency support.

Case Study 5

Case Summary:

- **Patient:** 13-year-old female
- **Presented with:**
  - Persistent low mood and multiple non specific somatic complaints
  - Poor sleep
  - Loss of interest in school
- **The Psychosocial context included:**
  - Bullying and social exclusion at school
  - Gender identity concerns causing distress at home and school
- **The Outcome was:**
  - Worsening depression
  - Emergence of self-harm thoughts and behaviour
  - Delayed help-seeking
  - **Finally committed suicide**

Case Study 5

Clinical Timeline and the Missed Opportunities

Over a 3-month period before death:

- **Had Multiple GP consultations for:**
  - Low mood
  - Somatic non-specific multiple complaints: headaches, aches all over her body, lethargy, dizziness, poor appetite
  - Self-harm behaviour: slashing of wrists and cut marks.
- **There was Missed follow-up appointments as she was worried due to:**
  - Anxiety if discussing bullying and identity concerns
- **There was No documentation of early:**
  - School involvement
  - Community or psychological support
- **In the final consultation before death: there was** Disclosure of self-harm ideation, BUT nc escalation for support
- **There was Critical gaps in coordination of care which included:**
  - No formal referral to mental health services
  - No coordinated management plan initiated

- **Outcome: Committed suicide by hanging**

Case Study 5

Key Risks and Vulnerabilities identified include:

A. The Psychological Risk include:

- Persistent/Recurrent depressive symptoms
- Emerging self-harm ideation and behaviour
- Multiple nonspecific somatic complaints

B. The Social Risk identified include:

- Bullying and peer exclusion
- Lack of school-based support

C. The Identity-Related Vulnerabilities are:

- Gender identity distress
- Conflict between home and school environments

D. The Engagement Risks are:

- Missed appointments;
- Difficulty disclosing sensitive issues

E. The Escalation issue is:

- Repeated presentations without escalation

F. The Pattern recognition issue missed is:

- Not recognising and interpreting patten of presentation across the timeline

Case Study 5

System learning from CDR/NCMD Principles (Applied to Mental Health)

- Repeated healthcare contact without escalation increases risk
- Early identification of bullying and minor stress is protective
- Outcomes improve with **multi-agency coordination** (health, school, family)
- **Failures often result from:**
  - Fragmented care
  - Lack of proactive follow-up
- **Accumulated psychosocial harm can be as life-threatening as physical illness when self-harm risk emerges**

Case Study 5

GP actions and learning from this case

- ❑ Conduct thorough psychosocial assessment at each visit
- ❑ Ask directly about bullying, identity concerns, and mental health issues
- ❑ Recognise bullying, gender identity concerns & family stress as high-risk indicators
- ❑ Refer promptly to child and adolescent mental health services (CAMHS)
- ➢ Liaise with school and family to support protective environment
- ➢ Document discussions, risk assessment, and planned follow-up clearly
- ➢ Maintain continuity and build trust with adolescent patients
- ❑ Identify and monitor psychosocial risk factors over time
- ❑ Document mood trajectory, self-harm risk, and support systems
- ➢ Longitudinal monitoring and proactive engagement.
- ➢ Creating a safe space for disclosure.

Case Study 5

Key Take-Home Messages

- Multiple psychosocial stressors significantly increase risk
- Repeated presentations require **pattern recognition and escalation**
- Missed appointments are **clinical warning signs**
- Early referral and coordinated care are essential
- Trust and continuity enable **safe disclosure of sensitive issues**

- ❑ Adolescent mental health requires **active, not passive management.**
- ❑ Absence of crisis does **not indicate low risk**
- ❑ **Prevention depends on:**
  - Early recognition
  - Pattern identification
  - Coordinated intervention

Case Study 5

Reflective Questions

- How do you identify cumulative psychosocial risk in adolescents?
- How can trust be built to support disclosure of sensitive issues?
- When should escalation to specialist services occur?
- How can care be effectively coordinated across services?

System Improvement in Primary Care to Prevent Child's Death

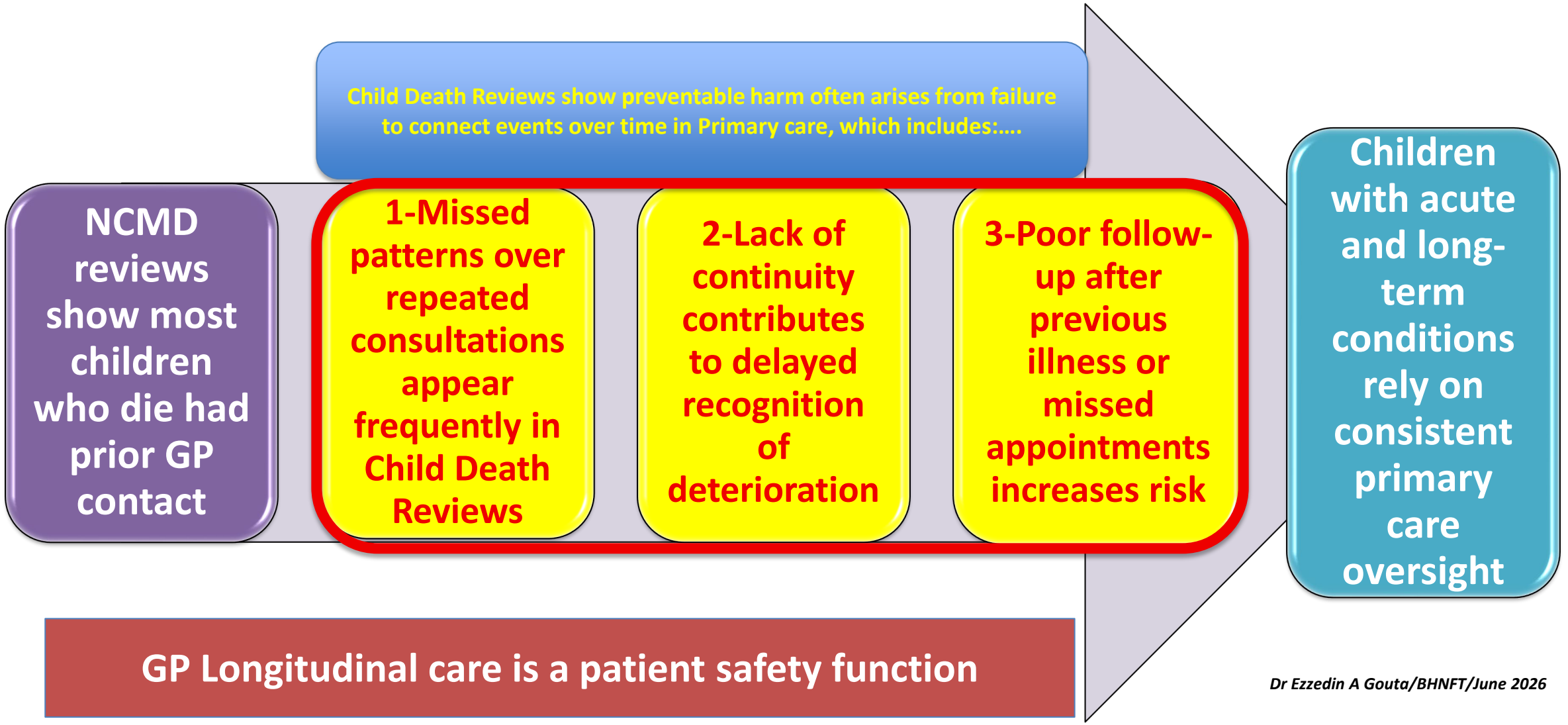
The underlying principles are that:

- ❑ Child death reviews **consistently show preventable factors**
- ❑ **General practice plays a decisive longitudinal role for prevention of child's death.**
- ❑ **Small system changes in primary care prevent future deaths**

[Supporting evidence from national reviews such as the National Child Mortality Database (NCMD), CDOP and Primary Care Reviews.]

NCMD
National Child Mortality Database

Why this matters for Child Death Prevention



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Why GP longitudinal Care is important and what does it mean in practice?

The GP holds an overview of the child's health history from birth through adolescence

The GP links past events, current symptoms, and future risk

The GP provides continuity across routine care, acute illness, chronic disease, and safeguarding, etc.

The GP coordinates input from health visitors, hospitals, community services, and social care

The GP monitors change over time, not just isolated contacts

GP escalate care as required

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The key longitudinal functions highlighted in Child Death Reviews (NCMD) to prevent deaths

The GPs are uniquely placed to do this, and evidence consistently supports this role

1-Tracking repeated presentations e.g. infection, breathing problems, feeding issues, or pain, etc.

2-Identifying cumulative risk from social vulnerability, deprivation, or safeguarding concerns

3-Ensuring regular review of chronic conditions e.g. asthma, epilepsy, neurodisability, complex needs, etc

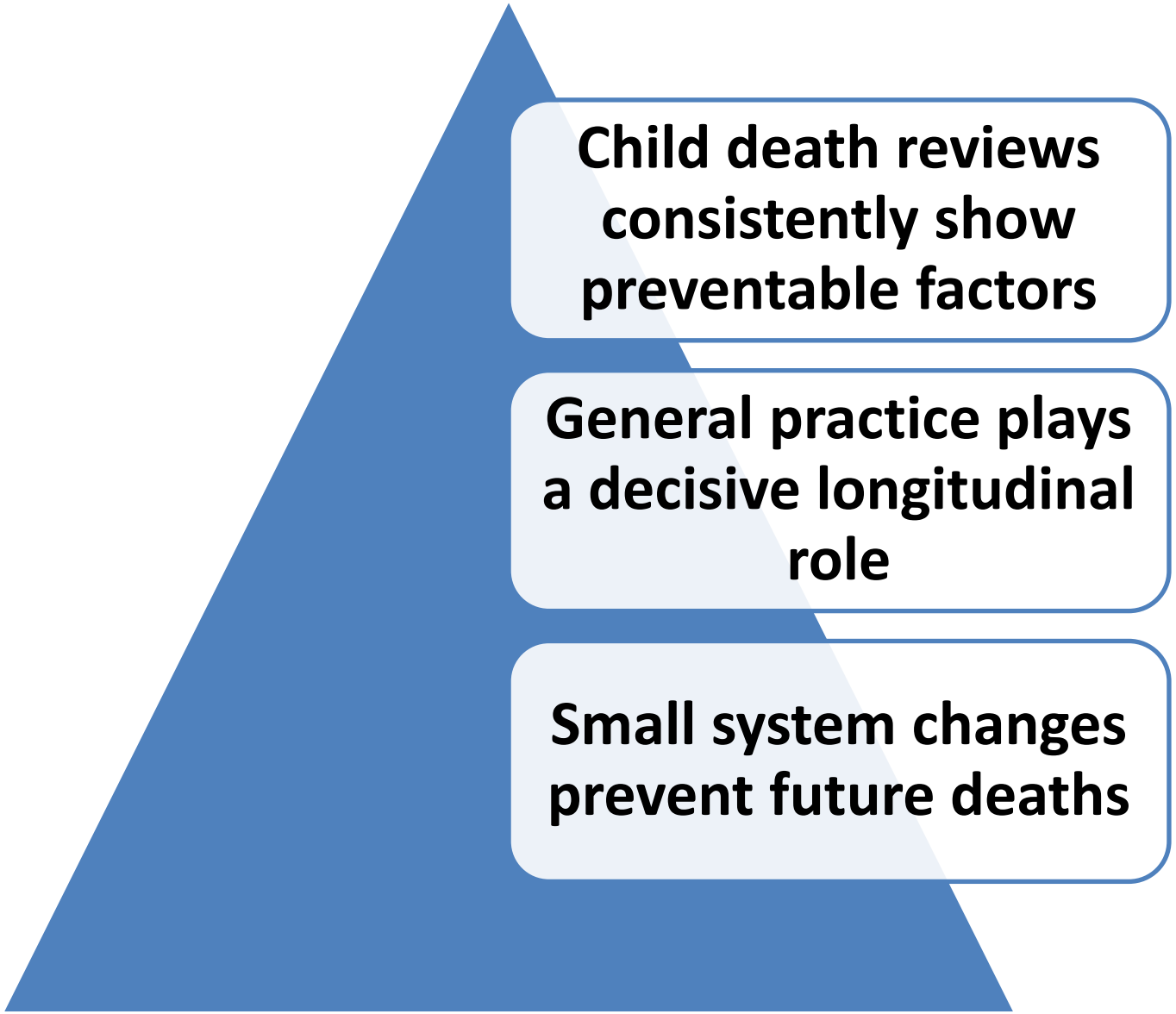
4-Providing anticipatory guidance, safety-netting, and planned follow-up

5-Escalating concerns when trajectories worsen, even if each contact appears minor.

Summary of Key Small System Changes and GP practice improvement and impact checklist

System Change	Expected Impact
Standardise Safety-Netting Practice in All Consultations-verbal and written	Better early re-presentation decisions
Proactively Follow Up High-Risk Children	Reduced delayed escalation
Use Structured Chronic Disease Registers and Recall	Earlier identification of high risk e.g. Asthma, Complex needs, Mental health, Medication adherence or over use
Treat Repeated Missed Appointments as Risk Signals	Early safeguarding action
Improve Record-Keeping & Documentation Quality	Continuity of care and learning
Systematic Review before Closing Consultations	Reflect for Pattern recognition
Identify& Flagging Vulnerability and High Risk in Records	Focused care coordination and referral e.g. Chronic illness, Disability, Social adversity, Repeated attendance, Missed appointments
Improve Communication Across Services	Reduced handover gaps e.g. Discharge, follow-up, Clear documentation, Share concerns, Close loops.
Multidisciplinary Case Review and Learning	Shared learning culture i.e. Participate in review, Reflect openly, SEA, Change systems
Practice-Level Quality Improvement Work	Continuous improvement
Embed a Just-Culture Approach to Safety	Encourages reporting and learning Dr. Ezzedin Gouta/BHNFT/June 2026

Closing message



References

- National Child Mortality Database
- Working Together guidance
- Children Act 2004
- RCGP Safeguarding Toolkit
- NICE Sepsis NG51
- NICE asthma guidelines
- Others

Questions?

The Child Death Review
"Feedback, Learning and Update"

Dr Ezzedin Gouta

17 June 2026