Child Death Overview Panel (CDOP) Annual Report

2021-2022

Child Death Overview Panel Annual Report 2021-2022

Foreword

As we emerge from the acute phase of the pandemic and into a recovery phase of 'living with covid,' the CDOP's work remains on track. As I stated last year, this is testament and thanks to all those concerned. Learning lessons from the pandemic on the way we work, CDOP members have agreed to continue meeting virtually, as we have been able to continue to give full consideration and respect to those children who have died and their families and carers.

As a panel, we are continually looking at how to improve the quality of our work and in collaboration with other CDOP chairs across the region, this will be a focus area for the coming year. We are also looking to influence a joint communication campaign around the use of the 'What 3 Words' app across North Yorkshire, the City of York and neighbouring areas.

Thank you to all those who support the work of CDOP. I am very much assured that the actions we take, reduce the risk to children and influence policy and professional practice.

Anita Dobson, Nurse Consultant
Public Health, City of York Council,
Child Death Overview Panel Chair

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Introduction

The death of a child is a devastating loss that profoundly affects all those involved. Since April 2008 all deaths of children up to the age of 18 years, excluding still births and planned terminations must receive a Child Death Review by a CDOP to accommodate the national guidance and statutory requirement set out in Working Together to Safeguard Children 2018.

The publication of the Child Death Review Statutory and Operational Guidance in 2018 built on the requirements set out in Chapter 5 of Working Together to Safeguard Children 2018 and details how individual professionals and organisations across all sectors involved in the Child Death Review should contribute to guided standardised practice nationally and enable thematic learning to prevent future child deaths.

Child Death Review partners, the Local Authorities and Clinical Commissioning Groups for North Yorkshire and City of York hold responsibility for the delivery of the Child Death Review Process as set out in the Children Act 2004, as amended by the Children and Social Work Act 2017. The CDOP is multi-agency with differing areas of professional expertise. The process is undertaken locally for all children who are normally resident within North Yorkshire and City of York.

As part of the Child Death Review requirements set out in Working Together (2018), North Yorkshire and City of York Local Authorities and Clinical Commissioning Groups created a Strategic Child Death Review Group to provide strategic oversight for the Child Death Review Process in the county and city. Meetings are held twice a year, the membership includes:

- Directors of Children and Young People's Services (NYCC and CYC)
- Chief Nurses for the Clinical Commissioning Groups (VoY CCG and NY CCG)
- Designated Doctor for Child Death (VoY and NY CCG)
- Child Death Overview Panel Chair (CYC Public Health)
- Partnership Business Unit Managers (NYSCP and CYSCP)
- Child Death Review Officer (NYSCP)

The collation and sharing of all learning from Child Death Reviews and the CDOP is managed by the National Child Mortality Database (NCMD) which has been operational since 1st April 2019. The NCMD gathers information on all children who die across England with the aim to learn lessons that could lead to changes to reduce child mortality.

The purpose of the Child Death Review Process is to try to ascertain why children die and put in place interventions to protect other children and prevent future deaths wherever possible. The process intends to;

- Document, analyse and review information in relation to each child that dies in order to confirm the cause of death, determine any contributing factors and to identify learning arising from the process that may prevent future child deaths
- To make recommendations to all relevant organisations where actions have been identified which may prevent future deaths or promote the health, safety and wellbeing of children
- To produce an annual report on local patterns and trends in child death, any lessons learnt and actions taken, and the effectiveness of the wider Child Death Review Process
- To contribute to local, regional and national initiatives to improve learning from Child Death Reviews

Membership and Panel Meetings

The Child Death Overview Panel meetings are held on a bi-monthly basis, the membership can be seen below:

Membership of the Child Death Overview Panel

Member	Organisation
Anita Dobson (Chair)	Nurse Consultant in Public Health, City of York Council
Victoria Ononeze (Vice Chair)	Public Health Consultant, North Yorkshire County Council
Dr Sally Smith	Designated Doctor for Child Deaths & Consultant Paediatrician, VoY and NY CCG
James Parkes	Safeguarding Children Partnership Manager, North Yorkshire
Sophia Lenton-Brook	Interim Safeguarding Children Partnership Manager, City of York
Rose Howley	Head of Service Multi-Agency Safeguarding Hub (MASH), Assessment and Targeted Intervention, City of York Council
Zoe Fryer	Group Manager, Children & Families Service, North Yorkshire County Council
Jemma Cormack	Safeguarding Manager, North Yorkshire Police
Carol Kirk	Detective Inspector, North Yorkshire Police
Sara Collier-Hield	Head of Midwifery, Supervisor of Midwives, York Scarborough Teaching Hospitals NHS Foundation Trust
Alison Pedlingham	Head of Midwifery, Supervisor of Midwives, Harrogate & District NHS Foundation Trust
Sue Oxendale	Bereavement Midwife, Harrogate & District NHS Foundation Trust
Dr Natalie Lyth	Children's Designated Doctor for Safeguarding, VoY and NY CCG
Dr Sarah Snowden	Children's Designated Doctor for Safeguarding, VoY and NY CCG
Andrea Pitman	0-19 Healthy Child Service West Team Manager, City of York
Sarah Neale	Named Nurse for Safeguarding, Harrogate & District NHS Foundation Trust
Ali Firby	Child Death Review Officer for North Yorkshire and City of York

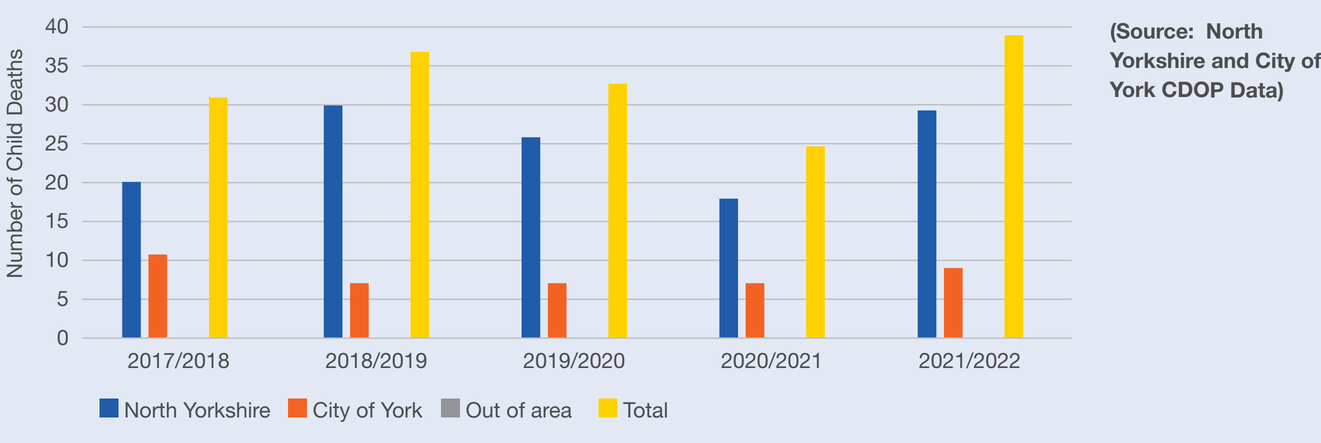
CDOP Panel Membership – as of 31st March 2022

Data Analysis

Total number of infant and child deaths

A total of 38 children residing within North Yorkshire and City of York died in 2021/2022. A significantly lower number of cases were notified to CDOP in 2020/2021 in comparison to other years, this is believed to be due to the impact of the restrictions put in place during the pandemic. In 2021/2022, cases increased to the highest level seen over the 5 year period.

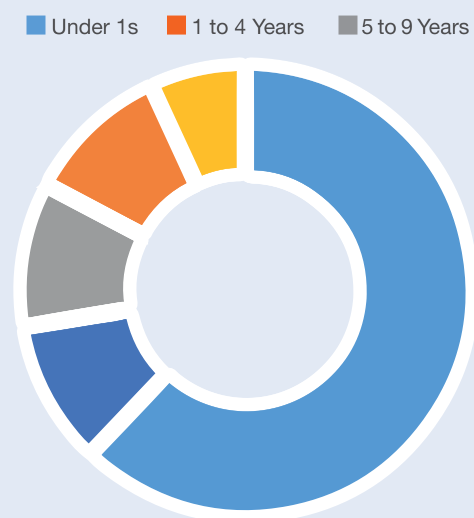
Table 1. Child Deaths in North Yorkshire and City of York 2017 - 2022



(Source: North Yorkshire and City of York CDOP Data)

The data detailed in table 2 summarises the age of the North Yorkshire and City of York children at death over the past 5 years.

Table 2. Age of infant and child deaths



As in previous years a child is most at risk of death when under the age of 1, and particularly within the first 27 days of life. In 2021/2022, 47% of the child deaths notified to the CDOP were under 27 days old.

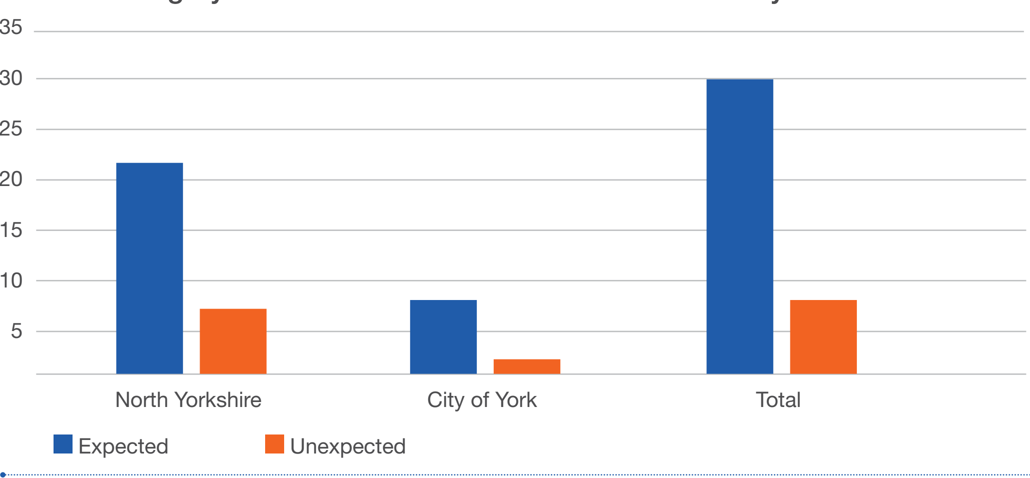
Expected and Unexpected child deaths

There are two categories of child deaths:

- A child death is an "expected" death where the death of an infant or child was anticipated due to a life limiting condition.
- A child death is an "unexpected" death where the death of an infant or child was not anticipated as a significant possibility, for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which led to the death.

Over the past 5 years there have been 113 expected deaths and 50 unexpected deaths notified to CDOP.

Table 3. Category of Child Deaths in North Yorkshire and City of York 2021/2022



(Source: North Yorkshire and City of York CDOP Data)

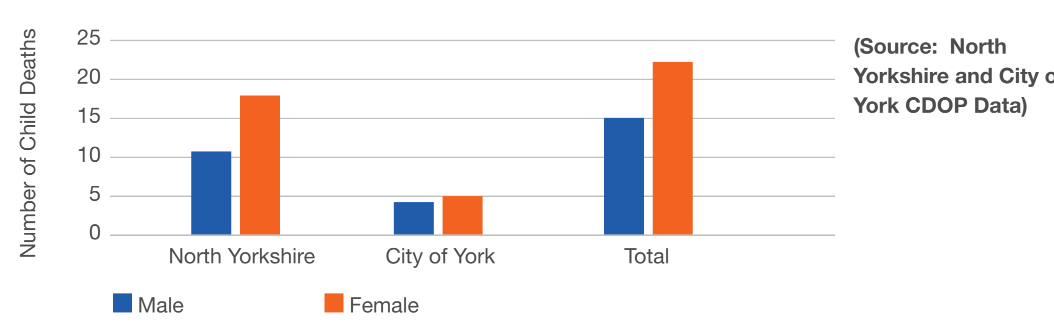
Location of death

Of the 38 deaths notified to CDOP in 2021/2022, 33 (87%) occurred within a hospital trust and 5 (13%) occurred outside of a hospital setting. It is of note, out of the 38 deaths, 27 (81%) occurred at an out of area hospital trust, which is an increase in comparison to previous years.

Infant and child deaths by gender

Within 2021/2022 we have seen 15 males and 23 female deaths. A breakdown of the number of child deaths by gender is outlined in Table 4. Nationally the mortality rate for males is higher than females, however locally there have been a higher number of female deaths, the reason for this is unknown.

Table 4. Gender



(Source: North Yorkshire and City of York CDOP Data)

Ethnicity

Of the 38 child deaths notified to CDOP in 2021/2022, 34 were classified as "White British" which reflects the population demographics for our regional area.

Disabled children

Children who are known to have a learning disability are notified to the Learning Disabilities Mortality Review Programme (LeDeR) by the CDOP to assist with their review and share learning from deaths of children with disabilities.

Categories of Child Deaths

During the CDOP meeting, members are required to categorise all child deaths which are then recorded locally and reported to the NCMD.

The categories of child deaths that have been agreed as of 31 March 2022 are detailed in table 5. It is of note, there will always be a disparity in numbers between the deaths notified to CDOP and the deaths reviewed by CDOP in the reporting period as outlined on page 12.

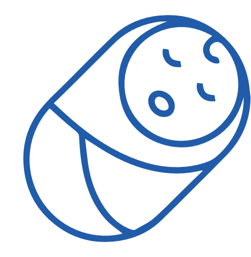
Table 5 – Category of child deaths reviewed by CDOP (includes both North Yorkshire and City of York)

	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	2021/ 2022	Total
1. Deliberately inflicted injury, abuse or neglect - This includes numerous physical injuries, which may be related to homicide as well as deaths from war, terrorism or other mass violence. It also includes severe neglect leading to death.	0	0	0	0	0	**0**
2. Suicide or deliberate self-inflicted harm - This includes any act intentionally to cause one's own death. It will usually apply to adolescents rather than younger children.	1	7	2	1	1	**12**
3. Trauma and other external factors - This relates to unintentional physical injuries caused by external factors. It does not include any deliberately inflicted injury, abuse or neglect.	3	4	1	1	1	**10**
4. Malignancy - This includes cancer and cancer like conditions such as solid tumours, leukaemia & lymphomas, and other malignant proliferative conditions, even if the final event leading to death was infection, haemorrhage etc.	3	6	5	5	4	**23**
5. Acute medical or surgical condition - A brief sudden onset of illness which resulted in the death of a child.	2	2	2	3	2	**11**
6. Chronic medical condition – A medical condition which has lasted a long time or was recurrent and resulted in the death of child.	1	0	2	0	2	**5**
7. Chromosomal, genetic and congenital anomalies – Medical conditions resulting from anomalies in genes or chromosomes as well as a defect that is present at birth.	6	6	6	7	7	**32**
8. Perinatal/neonatal event – The death of child as a result of extreme prematurity, adverse outcomes of the birthing process, intrauterine procedure or within the first four weeks of life.	6	8	7	10	10	**41**
9. Infection – This can be any primary infection (i.e., not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby.	1	4	3	0	0	**8**
10. Sudden unexpected or unexplained death – This is where pathological diagnosis is either Sudden Infant Death Syndrome (SIDS) or 'unascertained', at any age.	1	2	3	2	2	**10**
Total number of child deaths reviewed by CDOP	**24**	**39**	**31**	**29**	**29**	**152**

(Source: North Yorkshire and City of York CDOP Data)

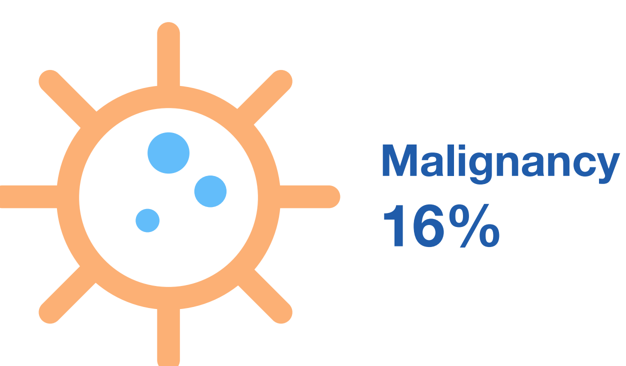
Once these child deaths have been reviewed, they will be reported on in future annual reports.

As detailed in Table 5, of the 151 child deaths that have been reviewed by panel over the past 5 years, the main categories of the child deaths are:



Perinatal/ neonatal event
27%

Chromosomal, genetic and congenital anomalies
21%



Malignancy
16%

Child Death Review Process

A Joint Agency Response (JAR) will be triggered in full for all sudden and unexpected child deaths. An unexpected death is a term used to describe the death of an infant or child whose death was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death.

Within this process the lead agency, which may be either the Police or the Consultant Paediatrician involved in the care of the child, will inform the Child Death Review Officer who ensures a meeting takes place within 72 hours of the child's death. The purpose of the JAR Meeting is to enable the sharing of information, multi-agency discussions, planning to safeguard other individuals, if identified and to ensure support is put in place for the child's family, peers and professionals.

It is the Coroner's responsibility to determine the cause of death where it is not known. If it is not possible to find out the cause of death from the post mortem examination, or the death is found to be unnatural, the Coroner will hold an inquest, a public court hearing held by the Coroner in order to establish who died and how, when and where the death occurred.

Following notification being received by Child Death Review Officer, each agency that was involved in the care of the child prior to their death must complete a reporting form. This form captures all the relevant information about the child and family to inform the CDOP process when considering modifiable factors. In addition to the reporting form there are a number of supplementary reporting forms which the Child Death Review Officer uses to collect information from the relevant professionals which is also shared with the NCMD and collated for review by the CDOP.

The process for expected deaths; the death of an infant or child which was anticipated following on from a period of illness that has been identified as terminal differs slightly as they do not usually require a JAR Meeting.

Supporting and engaging with a family who have lost a child is of the utmost importance throughout the whole Child Death Review Process. Recognising the complexities of the process, and the differing emotional responses that bereavement can bring, families are given a single named point of contact, called a 'Key Worker'. Regardless of the professional background this person should;

- Be a reliable and readily accessible point of contact for the family after the death;
- Help co-ordinate meetings between the family and professionals as required;
- Be able to provide information on the Child Death Review process and the course of any investigations pertaining to the child;
- Liaise as required with the coroner's officer and police family liaison officer;
- Represent the 'voice' of the parents at professional meetings, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards; and
- Signpost to expert bereavement support if required.

All expected and unexpected child deaths are required to have a Child Death Review (CDR) Meeting. This is a multi-agency meeting where all matters relating to an individual child are discussed by professionals directly involved in the care of that child during their life. The CDR Meeting can take many forms such as a Local Case Discussion, Perinatal Mortality Meeting, an NHS Serious Incident Investigation or a Hospital Morbidity and Mortality Meeting and typically, this meeting happens three months or more following the death of a child.

The purpose of the CDR Meeting is to discuss and review the background history, treatment and outcomes of investigations to determine, as far as possible the likely cause of death; to ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment and service delivery; to describe any learning arising from the death and, where appropriate, to identify actions that should be taken by an organisation involved to improve the safety or welfare of children or the Child Death Review process and to review the support provided to the family and to ensure that the family are provided with the outcomes of any investigation into their child's death. The analysis form is drafted within the meeting which is then presented to the CDOP.

Training

The Designated Doctor for Child Death and Child Death Review Officer delivered 4 Child Death Review: Advanced Training for Professionals sessions across North Yorkshire and City of York in 2021/2022 with over 40 delegates attending.

The Child Death Review Officer and North Yorkshire Children's Partnership (NYSCP) Manager continually engage in the NCMD Webinars which are designed to provide detailed updates on the NCMD, discuss emerging issues and obtain information around the latest events in the Child Death Review sector.

Information from these events is shared with North Yorkshire and City of York's Child Death Review Partners on a regular basis.

Child Death Overview Panel

The purpose of the panel is to consider any learning or factors that could prevent future deaths of children. Following the completion of the Child Death Review process and when the cause of the child's death has been determined for both expected and unexpected child deaths, the information relating to the case is anonymised and is taken to the CDOP for discussion and review.

During 2021/2022, the panel has reviewed a total of 29 cases. Of these cases, some occurred in the previous years as cases can take over six months to be brought to panel for review. This can be because the CDOP is awaiting information from agencies, for example post mortem reports or if there is an on-going police investigation, in which case the discussions may be deferred pending the result of the enquiry. It should be noted that a child's death cannot be discussed at panel until all information is received. Of the 38 child deaths that occurred in 2021/2022, 12 have been discussed at panel with the remainder scheduled for 2022/2023.

The CDOP continues to monitor the effect of the Covid 19 pandemic on paediatric mortality locally, this work is also ongoing nationally. The CDOP are careful in ensuring they consider both the potential direct and indirect effects of the pandemic on a child's death when discussing individual cases and feed this up to inform the national picture.

"The North Yorkshire and York CDOP was well organised and systematic with good structure and flow of information".

Dr Ahmed Shakir Mohammed, Designated Doctor for Child Death, North Lincolnshire

Modifiable factors

Modifiable factors are defined as 'those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced'. When the panel reviews the death of a child they identify and agree if there are any modifiable factors that may have prevented the death.

Although, it is not usually within the remit of CDOP to take action directly, they ensure that any issues identified, learning points and recommendations are assigned to relevant agencies to enable them to take action as appropriate.

All actions are monitored via an action log until the panel are assured that the necessary action has been completed.

Out of the **29** child deaths **reviewed** by the panel in 2021/2022, there were 5 cases, **17%** where modifiable factors were identified.

Learning from child deaths

The aggregated findings from all child deaths informs local strategic planning including the joint strategic needs assessment, on how to best safeguard and promote the welfare of children in the area.

What has CDOP achieved in 2021/2022

Sudden Unexpected death in Infancy (SUDI) Prevention

The sudden and unexpected death of an infant is one of the most devastating tragedies that could happen to any family. At least 300 infants still die suddenly and unexpectedly each year in England and Wales. NYSCP and City of York Safeguarding Children Partnerships (CYSCP) identified an increase in the number of infants who have died where unsafe sleep practices were present over recent years, some of which have resulted in multi-agency reviews.

In July 2020, the National Child Safeguarding Practice Review Panel (CSPRP) published a report on "Out of Routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm". This report identified that these tragic deaths occur more frequently in families that are particularly vulnerable, with many of the risk factors associated with SUDI overlapping with those for child abuse and neglect.

In response, the NYSCP and CYSCP's agreed to adopt a SUDI 'Prevent and Protect Model'. A key aspect of this model is the introduction of this multi-agency SUDI risk minimisation guidance.

A Task and Finish Group was established with multi-agency representation from NYSCP and CYSCP to develop the SUDI 'Prevent and Protect Model' and awareness campaign. The Task and Finish Group established a brand for the model with expert guidance from North Yorkshire County Council Marketing and Customer Communications Team the Task and Finish Group agreed the 'strap line' 'Day or Night, Sleep Right'.

Day or night,
Sleep right.
A safe sleep campaign for North Yorkshire and York
www.safeguardingchildren.co.uk/sleepright
#dayornightsleepright

The Task and Finish Group developed multi-agency practice guidance which provides clear research based information on factors which increase the risk of SUDI and practical tips on how practitioners can work together with all families, to adopt safe sleep practice. The practice guidance can be found here.

The Task and Finish Group acknowledged there was a training need across both partnerships to support practitioners to feel both competent and confident when working with families where safe sleep practice may be a concern. The Task and Finish Group developed a range of enhanced training materials which includes power point presentations, a YouTube film and podcast. The Task and Finish Group then agreed a training plan which consisted of both single and multi-agency training with group members committing to take forward training within their own organisation.

Multi-agency training sessions were delivered throughout December 2021 and January 2022 and the single agency training is ongoing.

'This session was really helpful and timely, we are in the process of revising our assessment tools and I'll ensure we include assessment around risks of SUDI'

Substance Misuse Worker

'This has made me think about how we support Women to keep their babies safe when they come into the refuge, they are in a new environment and it's important we help them to follow safe sleep advice'

IDAS Worker

The NYSCP and CYSCP's promoted the 'Day or Night, Sleep Right' campaign assets on their social media platforms during the Lullaby Trusts national Safe Sleep Week. Work will continue with multi-agency partners to ensure regular messaging are embedded in business as usual to ensure the continued focus of safer sleep.

Next Steps

- Sharing good practice: The Task and Finish Group have received a number of enquiries from colleagues across the region expressing an interest in the campaign. They have shared resources and agreed to offer further support to other partnerships who intend to adopt similar campaigns. The campaign has also been shared with the NCMD as a good exemplar of work.

Suicide Prevention

The Suicide Prevention Task and Finish Group continued to focus upon the priority areas below during 2021/22;

- Work has been undertaken by both North Yorkshire and City of York Public Health teams to identify and explore what available training is offered by partners across the county and city. Within North Yorkshire this has been collated and included in the dedicated Headfirst Website that NYCC Public Health has commissioned and delivers
- With regards to training in education within North Yorkshire, NYCC have utilised funding from the 'Wellbeing for Education Return Grant' provided by the Department for Education to offer funded training places for school staff to upskill their knowledge around suicide prevention and self-harm behaviours following concerns emerging around these two areas. This has included five 'Assessing Suicide in Kids' (ASK) courses for teachers totalling up to 106 delegates. Feedback from the ASK training has been really positive with some colleagues in school saying they have used some of the tools straight after the training

"The screening tool will help ensure we respond in the best way possible to risk. Having the opportunity to talk to other pastoral staff was really uplifting and I enjoyed hearing about such amazing practice looking after the heads and hearts of our students."

Due to requests from delegates who have attended the ASK suicide prevention training NYCC will be commissioning Applied Suicide Intervention Skills Training (ASSIST) in 2022.

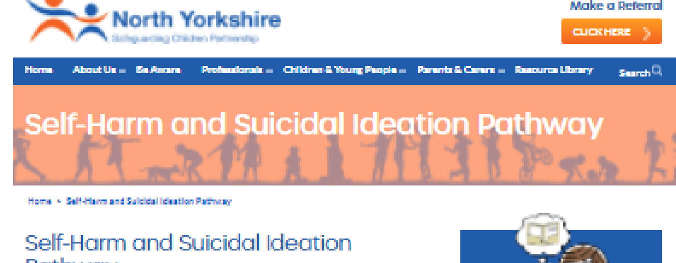
- City of York are working towards dedicated self-harm guidance that will be circulated to schools.
- The North Yorkshire and City of York CCG Designated Nurse has lead a review with North Yorkshire and City of York Local Authority and Health Trusts regarding discharge planning.
- The NYSCP has reviewed the NYSCP Sample School Child Protection Policy and included wording within the social and emotional mental health section around self-harm and around suicide ideation for schools to adopt, this has been sent to every school in the county for consideration.

- NYSCP and CYSCP wrote to all schools, colleges and further education settings outlining the following areas of action that can be taken within their own organisations. The information included the following areas:
    - Set the scene regarding the purpose of the Task and Finish Group
    - Link to the Talk Suicide training and Head First website
    - Links to NYSCP/CYSCP website pages
    - Draft Wording to link in wider hidden harm
    - Promotion of the NYSCP Self Harm and Suicide Ideation Pathway
    - Promotion of the Child Death Review: Advanced Training for Professionals
    - Signposting to the NYSCP and CYSCP Child and Family Bereavement Support webpages
- The Task and Finish Group explored opportunities to raise the awareness of Suicide Prevention and have recommended to NYSCP and CYSCP to promote the regional #TalkSuicide campaign that has been created by the Humber, Coast and Vale Health and Care Partnership. The campaign aims to reduce the stigma around talking about suicide by raising awareness of free suicide prevention training available from the Zero Suicide Alliance.
- The Zero Suicide Alliance is a partnership of Health Service Trusts, businesses and individuals who are committed to suicide prevention in the United Kingdom and beyond. The Alliance has a free, 20 minute online suicide prevention training programme. The aims of this training are to enable people to identify when someone is presenting with suicidal ideation and behaviours; help them to speak out in a supportive manner; and empower them to signpost the individual to the correct services or support.
- A relaunch of the NYSCP Self Harm and Suicide Ideation Pathway took place including the parent and carers section co-created by parents with lived experience. This resource can be found here: NYSCP (safeguardingchildren.co.uk)
- To promote the work of the Task and Finish Group the NYSCP hosted a themed Managers Masterclass on Suicide Prevention in May 2021 with guest presenter Pat Sowa from Star Fish. To watch the masterclass online visit https://youtu.be/Od1BZMTAI_w

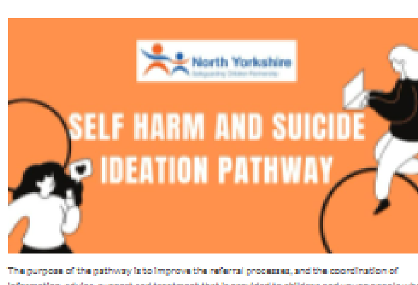
Masterclass
Suicide Prevention
28th May 2021
Pat Sowa

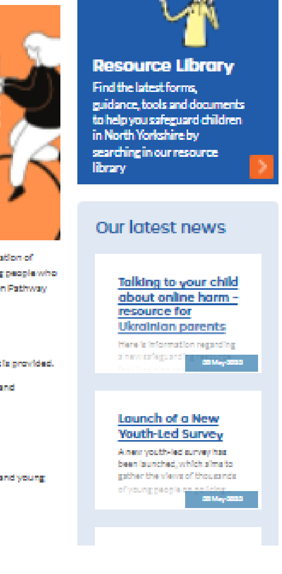
'You must be the change you wish to see' Gandhi

starfish psowa.starfish@gmail.com @pat_sowa



Self-Harm and Suicidal Ideation Pathway





Who is the document for?

CDOP Priorities for 2022/2023

Each year the CDOP identifies areas of priority, the following have been identified for 2022 / 2023;

1. The role of the Key Worker

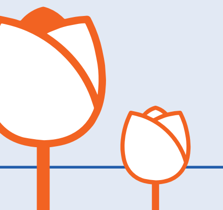
The CDOP plan to explore and develop the role of the Key Worker for North Yorkshire and City of York in the wish to strengthen the offer to families. They intend to do so by using best practice from across the country and seeking views from parents who have sadly lost a child to fully ensure support is in place for the future.

2. What 3 Words App Campaign

The CDOP plan to undertake a piece of multi-agency work with Hull, East Riding, North Lincolnshire and North East Lincolnshire CDOPs to promote the use of the What3Words app via a coordinated communication campaign. The CDOP will drive this work forward to ensure greater awareness of What3Words across our sub regional footprint to help to ensure emergency service get to patients in the most timely of manners, with the ultimate aim to preserve life.

3. Neonatal Twin Deaths Audit

The CDOP have identified an increase locally in twin neonatal deaths notified in 2021-2022. In response to this, they intend to undertake an audit of these cases to establish any emerging themes, patterns or trends. The findings will be shared with the relevant professionals along with any recommendation and actions, if identified.



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2021-2022

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