# Child Death Overview Panel (CDOP) Annual Report

## 2022 - 2023

North Yorkshire
Safeguarding Children Partnership

City of York
Safeguarding Children Partnership

# Child Death Overview Panel (CDOP) 2022 - 2023

## Foreward

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

The panel have co-produced a number of successful campaigns over recent years and this is testament to the hard work and dedication of the group in seeking to ensure the death of each and every child is thoughtfully considered and learnt from and for this I would like to give my upmost thanks.

In the coming year we are likely to see sustained difficulties for families as the cost of living crisis continues and in North Yorkshire and York, we are thankful that we have not yet seen children dying as a result of this.

The Child Death Overview Panel (CDOP) are mindful of both the local and national picture for children and their families and are considering how we can work together in the hope of preventing harm across our shared locality which will include working closely with partners from Public Health and Housing.

In the coming year there will be two task and finish groups formed to look at our priority areas of “Who’s Sober” and “Roadwise” and they will be reporting back their findings to the panel. This work will continue over 2023/2024 to ensure learning and recommendations can be embedded into service provision.



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## Foreward

# Introduction

One of the most devastating things for a family to experience is the death of a child and it is recognised this will have a profound and long-lasting impact on everyone involved in that child's life. All deaths of children up to the age of 18 years, excluding stillbirths and planned terminations have been reviewed by the Child Death Overview Panel (CDOP) since April 2008. The Child Death Review process is undertaken in accordance with national guidance and statutory guidance as set out in Working Together to Safeguard Children 2018.

The Child Death Review Statutory and Operational Guidance in 2018 builds on the requirements set out in Chapter 5 of Working Together to Safeguard Children 2018. Working Together to Safeguard Children 2018 (publishing.service.gov.uk)

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 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 deaths, 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.

Child Death Review statutory partners (the Local Authorities and Integrated Care Board for North Yorkshire and City of York) have a responsibility to undertake the Child Death Review Process as set out in the Children Act 2004, as amended by the Children and Social Work Act 2017. However, relevant agencies are also included within our CDOP panel to ensure that there are multi-agency representatives who provide differing areas of professional expertise. The process is undertaken locally for all children who are normally resident within North Yorkshire and City of York.

North Yorkshire and City of York Local Authorities and Integrated Care Boards created a Strategic Child Death Review Group to provide strategic oversight for the Child Death Review Process. Meetings are held twice a year and membership includes:

- Directors of Children and Young People's Services (NYC and CYC)
- Director of Nursing for the Integrated Care Board (Humber and North Yorkshire ICB)
- Designated Doctor for Child Death (Humber and North Yorkshire ICB)
- 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 to reduce child mortality.



# Child Death Overview Panel

The Child Death Overview Panel meetings are held on a bi-monthly basis, the membership is listed below

| Member | Role and Organisation |
|---|---|
| Anita Dobson | Nurse Consultant Public Health Consultant, City of York, Child Death Overview Panel Chair for North Yorkshire and York |
| Dr Gill Kelly | Public Health Consultant, North Yorkshire Council |
| Jemma Cormack | Safeguarding Manager, North Yorkshire Police |
| Dave Ellis | Detective Chief Inspector, North Yorkshire Police |
| Dr Sally Smith | Designated Doctor for Child Deaths & Consultant Paediatrician, City of York and North Yorkshire |
| Dr Natalie Lyth | Designated Doctor for Safeguarding and Children in Care, North Yorkshire and City of York |
| Dr Sarah Snowden | Children's Designated Doctor for Safeguarding and Children in Care, North Yorkshire and City of York |
| Hannah Ellingworth | North Yorkshire Safeguarding Children Partnership Manager |
| Sophia Lenton-Brook | City of York Safeguarding Children Partnership Manager |
| Dallas Frank | Head of Quality Assurance, Safeguarding, Principal Social Worker, Children's Social Care, City of York Council |
| Sarah Howarth | Group Manager, Children's Social Care, North Yorkshire Council |
| Alexandra Burton | Named Nurse for Safeguarding, Harrogate District NHS Foundation Trust |
| Helen Pulleyn | Named Nurse for Safeguarding, York & Scarborough Teaching Hospital NHS Foundation Trust |
| Andrea Pitman | Healthy Child Team Service Manager, Public Health, City of York Council |
| Leanne Likaj | Head of Midwifery, Harrogate District NHS Foundation Trust |
| Sarah Ayre | Head of Midwifery, York & Scarborough Teaching Hospital NHS Foundation Trust |
| Alison Brunton | Child Death Review Officer for North Yorkshire and City of York |

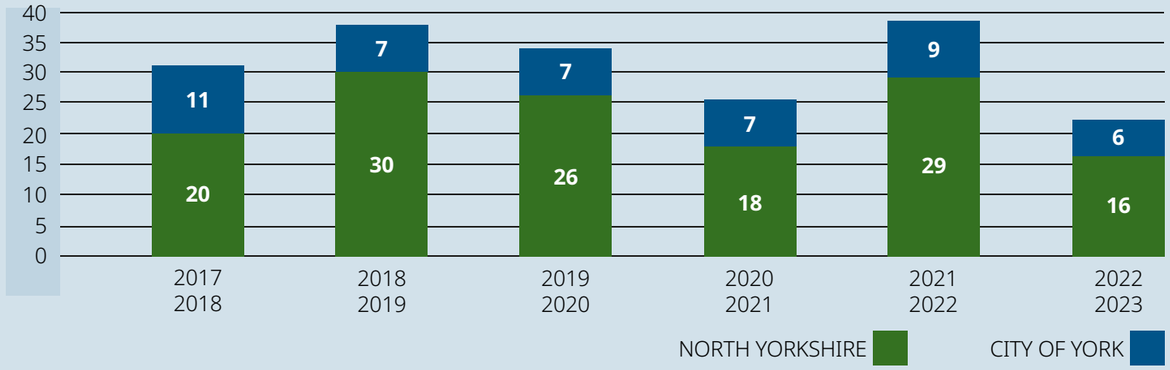
As of March 31 2023

# Data Analysis 2022 - 2023

## Total child deaths

A total number of 22 children and young people died during the period between 1 April 2022 and 31 March 2023 - 16 children resided in North Yorkshire and 6 children resided in the City of York. This is the lowest number of total deaths of children and young people recorded within an annual period during the past 5 years as evidenced in Table 1.

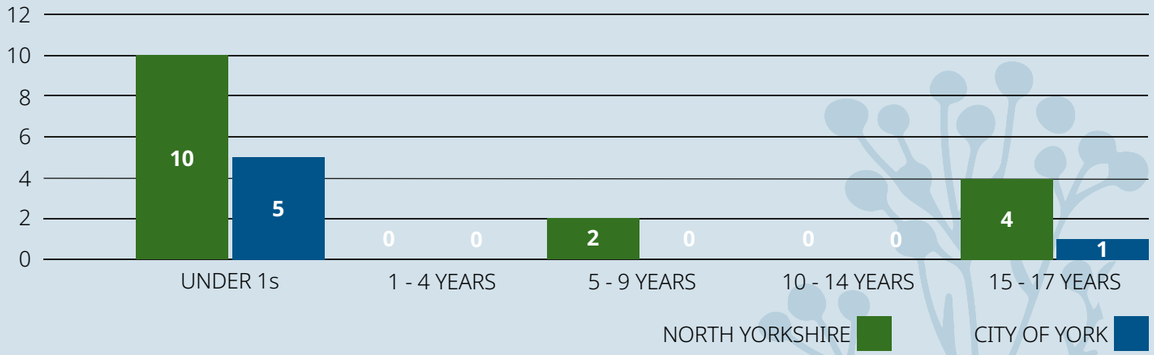
**Table 1. Total child deaths in North Yorkshire and City of York 2017 - 2023**




## Age of Child Deaths

Table 2 summarises the ages of North Yorkshire and City of York children and young people at the time of their death during the period between 1 April 2022 and 31 March 2023. The highest number of child deaths consistently relates to children under 1 year of age. In 2022/2023, 68% of child deaths related to children in this age range.

**Table 2. Age of child deaths in North Yorkshire and City of York 2022/2023**




Child deaths fall under one of two categories:

- **Expected Death:** A child death is an "expected" death when the death of an infant or child was anticipated, such as for children born with life limiting conditions.
- **Unexpected Death:** An unexpected death is defined as a death that 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.



## Expected and Unexpected child deaths

Table 3 provides the detail of expected and unexpected child deaths in 2021/2022 with a total of 30 expected and 8 unexpected deaths. When comparing this data to the current reporting year of 2022/2023, there were 12 expected deaths and 10 unexpected deaths (Table 4).

**Table 3. Category of child deaths in North Yorkshire and City of York 2021/2022**

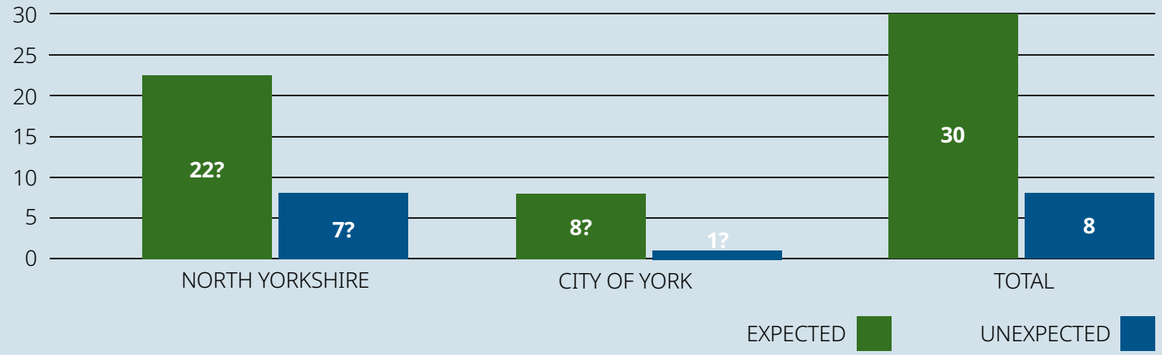
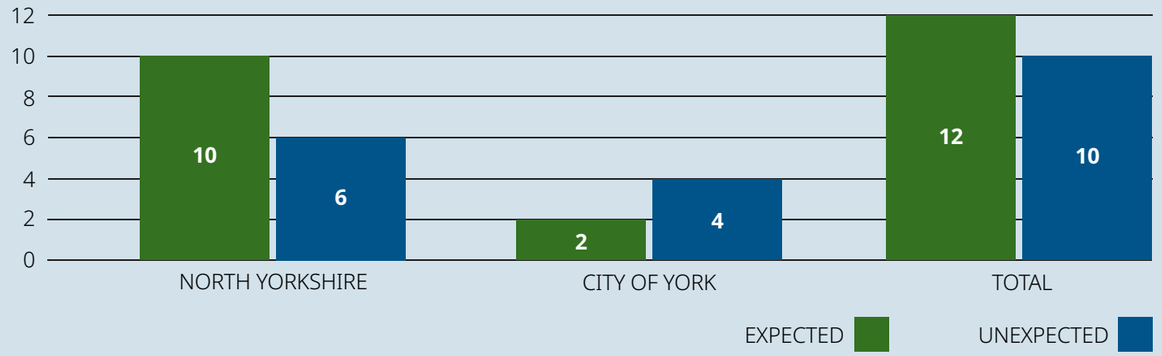



**Table 4. Expected and Unexpected Deaths 2022/2023**




## Location of Death

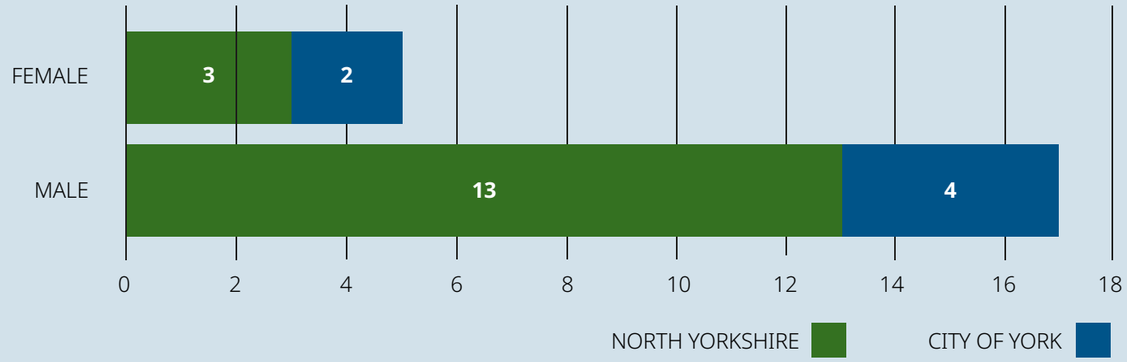
Of the 22 children and young people who died during the period between 1 April 2022 and 31 March 2023, 20 (90.5%) occurred within a hospital or hospice setting and 2 children (8.5%) died in a place other than a hospital or hospice setting.

## Child Deaths by Gender

Nationally, the mortality rate for males is higher than females and the child deaths reported to this CDOP for 2022/2023 reflect this national picture.

The table below provides a breakdown of the number of child deaths by gender during 2022/23.

**Table 5. Child deaths by Gender**




Of the 22 child deaths notified to CDOP between 1 April 2022 and 31 March 2023, 21 were classified as White British and 1 was classified as White Other.

## Children with a Learning Disability

Children who are known to have a learning disability are notified to the Learning Disabilities Mortality Review Programme (LeDeR) by the CDOP. Of the 22 cases reported to CDOP in 2022-2023, no children were identified as having a learning disability.

## Child Death Processes

The notification of a child's death is received by the Child Death Review Officer who will ensure all relevant agencies complete a reporting form. This form captures all the relevant information about the child and family to inform the CDOP process. 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 Coroner is responsible for determining the cause of death and carrying out a post-mortem examination. Where the post-mortem examination is not able to identify cause, or the death is found to be unnatural, the Coroner will hold an inquest to examine any relevant factors in order to provide details on the cause of death.



## Categories of Child Deaths

All child deaths discussed at CDOP are categorised using a national template analysis form provided by the NCMD. This information is reported back to the NCMD who provide national data on deaths of children on an annual basis.

The below table details the category of child deaths in North Yorkshire and York from 2017 to 2023.178 child deaths have been reviewed by the panel over the past 6 years. The majority of child deaths in 2022/2023 occurred as the result of a perinatal or neonatal event (11), with the next most common category being recorded as malignancy (5). Sudden Unexplained Infant Deaths (SUDIs) accounted for 4 child deaths in this reporting period.

**Table 6. Category of child deaths in North Yorkshire and York, 2017 - 2023**

| | 2017 • 2018 | 2018 • 2019 | 2019 • 2020 | 2020 • 2021 | 2021 • 2022 | 2022 • 2023 | 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 | 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. | 2 | 1 | 7 | 2 | 1 | 1 | 14 |
| **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 | 3 | 4 | 1 | 1 | 1 | 13 |
| **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. | 4 | 3 | 6 | 5 | 5 | 5 | 28 |
| **5. Acute medical or surgical condition -** A brief sudden onset of illness which resulted in the death of a child. | 6 | 2 | 2 | 2 | 3 | 0 | 15 |
| **6. Chronic medical condition –** A medical condition which has lasted a long time or was recurrent and resulted in the death of child. | 2 | 1 | 0 | 2 | 0 | 0 | 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. | 3 | 6 | 6 | 6 | 7 | 1 | 29 |
| **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. | 8 | 6 | 9 | 7 | 10 | 11 | 51 |
| **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 | 1 | 4 | 3 | 0 | 2 | 11 |
| **10. Sudden unexpected or unexplained death –** This is where pathological diagnosis is either Sudden Infant Death Syndrome (SIDS) or 'unascertained', at any age. | 0 | 1 | 2 | 3 | 2 | 4 | 12 |
| **Total number of child deaths reviewed by CDOP** | 29 | 24 | 39 | 31 | 29 | 25[1] | 178 |

[1] 22 children died in North Yorkshire and York in 2022/2023. 25 cases were reviewed by CDOP which comprises of child deaths over 2021-2023.

# CDOP Death Review Process

## Joint Agency Response Meeting

When a child dies unexpectedly a Joint Agency Response Meeting (JARM) will be convened within 72 hours of the death. The purpose of the JARM is to enable the sharing of information between partners, facilitate multi-agency discussions and ensure any immediate safeguarding concerns are addressed.

Supporting and engaging with a family who have lost a child is of the utmost importance throughout the Child Death Review process, recognising the complexities of the process and the differing emotional responses that bereavement can bring. In North Yorkshire and York, the JARM will identify the most appropriate agency support for the bereaved family, defined locally as a Key Worker.

The Key Worker 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 office and Police Family Liaison Officer (if involved)
- Represent the 'voice' of the parents at professional meetings, ensuring their questions are effectively addressed, and providing feedback to the family afterwards
- Signpost to expert bereavement support if required

## Child Death Overview Panel (CDOP)

The purpose of the panel is to consider any learning or factors that could prevent future deaths of children. Following the completion of the CDOP 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 reviewed by the CDOP.

CDOP review child deaths at the end of any statutory processes and a child's death cannot be discussed until all relevant information pertaining to the death is obtained and as such, children may not always be reviewed by the panel in the year of their death. During 2022/2023, the panel has reviewed a total of 25 deaths which account for children who died between the years of 2021 to 2023.

## Child Death Review Meeting

Both expected and unexpected child deaths are required to have a Child Death Review Meeting (CDRM). 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. A CDRM typically happens three months or more following the death of a child. The draft analysis form is completed within this meeting which is then presented to and confirmed with the CDOP.



## Learning and Modifiable Factors

Of the 22 child deaths reviewed in 2022/2023, CDOP identified 12 cases (54%) where modifiable factors were present.

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".[2] 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 and what actions are required as a result. All actions are monitored by the CDOP.

The CDOP process seeks to identify learning from all child deaths to identify common themes, ways of working and strategies to minimise the risk of future deaths. The CDOP will identify modifiable factors which, had they been in place, may have reduced the risk of harm.

## Training

The Designated Doctor for Child Death and the Child Death Review Officer delivered the Child Death Review: Advanced Training for Professionals across North Yorkshire and City of York in 2022/2023 with a range of multi-agency professionals totalling 28 delegates attending over three sessions.

The Child Death Review Officer and North Yorkshire Children's Partnership (NYSCP) Manager regularly 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.

Feedback from the Child Death Review Training.

**"Really helpful to understand more about the CDOP process from start to finish - really well delivered - thank you" and "Excellent course and will be useful to me in my work".**

[2] Working Together to Safeguard Children 2018 (publishing.service.gov.uk)

# What has CDOP achieved over 2022/2023?

## Regional CDOP Learning Event

In December 2022, North Yorkshire and City of York held what was the first of planned annual Regional CDOP Learning Events. 32 people attended the in-person event which included representatives from Health, Police and the Local Authorities of East Riding, North Yorkshire, York, Hull and North East Lincolnshire. North Yorkshire and York's Day or Night Sleep Right campaign was showcased and a table top discussion took place regarding Sudden Unexpected Deaths in Infancy (SUDI). Each regional area was asked to share a case example to highlight areas of good practice in respect of the panel's work and these were shared amongst the group through a discussion, question and answer session. The feedback from the event was positive and the next event will be hosted by a neighbouring CDOP.

## The role of the Key Worker

Over 2022/2023, CDOP explored and developed the role of the Key Worker for North Yorkshire and City of York with a view to strengthening the support offered to bereaved families. The task and finish group considered best practice examples nationally, making use of regional and national networks. The strategic CDOP group have confirmed that the process of identifying a key worker within the JARM is now embedded into practice for those families whose children die unexpectedly. The process is written into the JARM agenda and during the CDRM, confirmation of the Key Worker is provided alongside any updates in respect of actions carried out on behalf of the family. This work has been shared with regional and national CDOPs to support the development of best practice at a national level.

## What 3 Words App Campaign

The North Yorkshire and York CDOP undertook 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[3] via a coordinated communication campaign. The CDOP had planned to drive this work forward to ensure greater awareness of What3Words across our sub-regional footprint to support emergency services to get to patients in  a timely manner, with the ultimate aim to preserve life.  After further consultation with Partners, it was felt that as What3Words has a commercial element which could pose a conflict within the CDOP process, therefore it was agreed by the panel to not pursue this priority. It is reassuring to note that, when reviewing data over 2022/2023, there have been no identified instances of modifiable factors in relation to the speed or timeliness of emergency services involvement.

## Neonatal Twin Deaths Audit

The CDOP identified an increase in twin neonatal deaths during 2021/2022.  In response to this, an audit of these children's deaths was undertaken by the Designated Doctor for Child Death. As a result of the findings of the audit the CDOP were reassured that there were no recurring themes, trends or patterns to necessitate any further investigation.

[3] what3words /// The simplest way to talk about location



# Sudden Unexpected death in Infancy

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 die suddenly and unexpectedly each year in England and Wales. North Yorkshire and City of York Safeguarding Children Partnerships (NYSCP & CYSCP) identified an increase in the number of infants who have died where unsafe sleep practices were present in 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 *Out of routine: A review of Sudden Unexpected Death in Infancy (SUDI) in families where the children are considered at risk of significant harm* (publishing.service. gov.uk.)

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 agreed to adopt a SUDI Prevent and Protect Model. A key aspect of this model is the introduction of multi-agency SUDI risk minimisation guidance. A task and finish group was established with multi-agency representation 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 and also agreed the 'strap line' 'Day or Night, Sleep Right' *NYSCP (safeguardingchildren.co.uk).*

Following the implementation of Day or Night, Sleep Right, work has continued with the aim of establishing safe sleep as a fundamental aspect of multi-agency work with families with additional vulnerabilities. The campaign has been recognised by researchers at Durham University (Durham Infancy and Sleep Centre) as one of very few multi-agency SUDI risk minimisation programmes across the country.

In addition to an extensive program of single-agency training, multi-agency training is available to practitioners. A multi-agency masterclass was developed which has now had 446 views on the NYSCP YouTube channel and the SUDI podcast has been listened to 76 times. A podcast on Spotify for Podcasters is also available.

# CDOP Priorities 2023/2024

1. Building on the success of the Day or Night Sleep Right campaign, the CDOP will be launching a further campaign Who's Sober which will help promote the need to have a safe and sober adult in the home when caring for babies and young children. This campaign will be linked to Day or Night Sleep Right and the CDOP will work closely with colleagues in Public Health working on alcohol and substance use.

2. The CDOP will be working closely with Roadwise to promote safe use of roads for pedestrians, drivers and cyclists. This work will consider learning from modifiable factors in child deaths and will also link in with colleagues from North Yorkshire and York Highways and others to ensure a full partnership approach to this work.

# Contact details:

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