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Child Death Overview Panel (CDOP) Annual Report **2019-2020**



Child Death Overview Panel Annual Report 2019-2020

Foreword

This year's CDOP annual report has been written during the unprecedented times of a global pandemic of coronavirus. The pandemic has impacted many services and seen personal tragedies through the loss of family and friends to the virus. On behalf of the panel I would like to extend our condolences to all those affected.

We have continued to review the deaths of children from across York and North Yorkshire and have embraced technology to discharge the duties of the panel in a safe and appropriate way, giving due consideration to each child and their family and carers so that any lessons learned and recommendations may contribute to mitigating risks to children where possible.

I am pleased to tell you that the governance arrangements which were introduced in the last annual report are now embedded and are working well.

Over the last year York and North Yorkshire have seen a doubling of the number of children who have died as a result of unsafe sleeping practices. Therefore, safe sleep will be one of two priority areas of focus for the coming year.

The panel will be conducting an audit across services who are responsible for safe sleep advice to parents and carers. Led by the evidence of the audit we will be recommending actions and campaigns to be put in place to raise awareness across organisations.

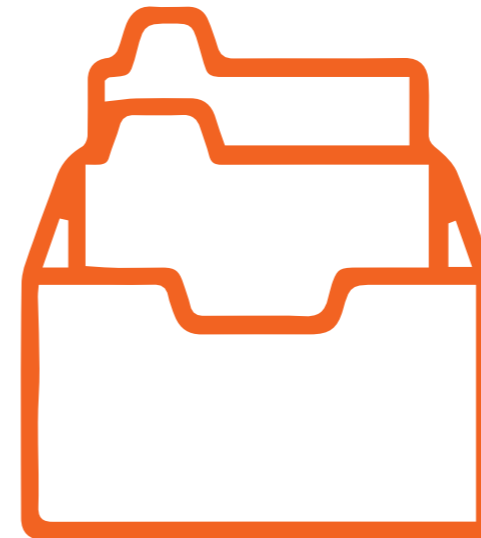
This year the panel have reviewed seven children and young people who have lost their life to suicide although these children died over a two-year period. Therefore, suicide will be the second priority area for audit by the panel. The panel will also be seeking out research which can inform practice on the prevention of suicide in children and young people. This work is of particular concern as we move through the coronavirus pandemic and its long term impact on mental health in this age group.

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



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1. Introduction

- 1.1** 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 are to be reviewed by a CDOP to accommodate the national guidance and statutory requirement set out in [Working Together to Safeguard Children 2018](#). From 1st April 2019 notifications of still births and planned terminations where a clinician is not present have been notified and reviewed by the CDOP.
- 1.2** The publication of 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 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.
- 1.3** Child Death Review partners, the Local Authorities and Clinical Commissioning Groups for North Yorkshire and City of York now 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 multiagency with differing areas of professional expertise. This process is undertaken locally for all children who are normally resident in North Yorkshire and City of York.
- 1.4** As part of the new 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 Overview group to provide strategic oversight for the Child Death Process in the county and city. Meeting are held twice a year and the membership includes:
- Directors of Children and Young People's Services (NYCC and CYC)
 - Chief Nurses for the Clinical Commissioning Groups (VY CCG and NY CCG)
 - Designated Doctor for Child Death (NY CCG)
 - Child Death Overview Panel Chair (CYC Public Health)
 - Child Death Review Coordinator (NYSCP)
 - Partnership Business Unit Managers (NYSCP and CYSCP)
- 1.5** 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 is an NHS funded project, delivered by the University of Bristol, that gathers information on all children who die across England with the aim to learn lessons that could lead to changes to improve and save children's lives in the future.
- 1.6** 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.

2. Membership and Panel Meetings

- 2.1** The Child Death Overview Panel meetings are held on a bi-monthly basis and have had consistent organisational commitment since they were established in 2008. The Chair of the CDOP is Anita Dobson, Nurse Consultant in Public Health

Membership of the Child Death Overview Panel

Member	Organisation
Anita Dobson	Nurse Consultant in Public Health, City of York Council
Victoria Ononeze	Public Health Consultant, North Yorkshire County Council
Dr Sally Smith	Designated Doctor for Child Deaths & Consultant Paediatrician, York Teaching Hospital Foundation Trust
James Parkes	Safeguarding Children Partnership Manager, North Yorkshire
Sophia Lenton-Brook	Interim Safeguarding Children Partnership Manager, City of York
Rose Howley	Group Manager, Multi-Agency Safeguarding Hub, City of York Council
Danielle Johnson	Head of Safeguarding, Children & Families Service, North Yorkshire County Council
Jemma Cormack	Safeguarding Manager, North Yorkshire Police
Freya Oliver	Head of Midwifery, York Teaching Hospital Foundation Trust
Alison Pedlingham	Head of Midwifery, Harrogate District Foundation Trust
Dr Natalie Lyth	Designated Doctor for Safeguarding Children & Children in Care, Vale of York & North Yorkshire Clinical Commissioning Groups
Dr Sarah Snowden	Designated Doctor for Safeguarding Children & Children in Care, Vale of York & North Yorkshire Clinical Commissioning Groups
Andrea Pitman	0-19 Healthy Child Service West Team Manager, City of York
Rachel Wiggin	5 - 19 Service, Clinical Lead, Harrogate District Foundation Trust
Jane Webster	Health Visiting Professional Lead, Harrogate District Foundation Trust
Barry Thomas	City of York Safeguarding Children Partnership LAY Member
Ali Firby	Child Death Review Officer for North Yorkshire and City of York

CDOP Panel Membership – at 31st March 2020

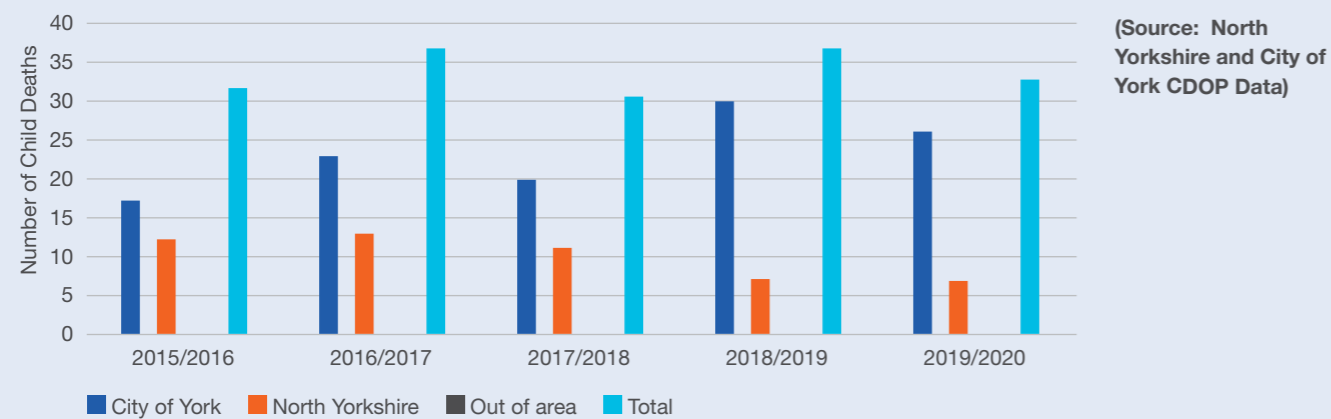


3. Data Analysis

3.1 Total number of infant and child deaths

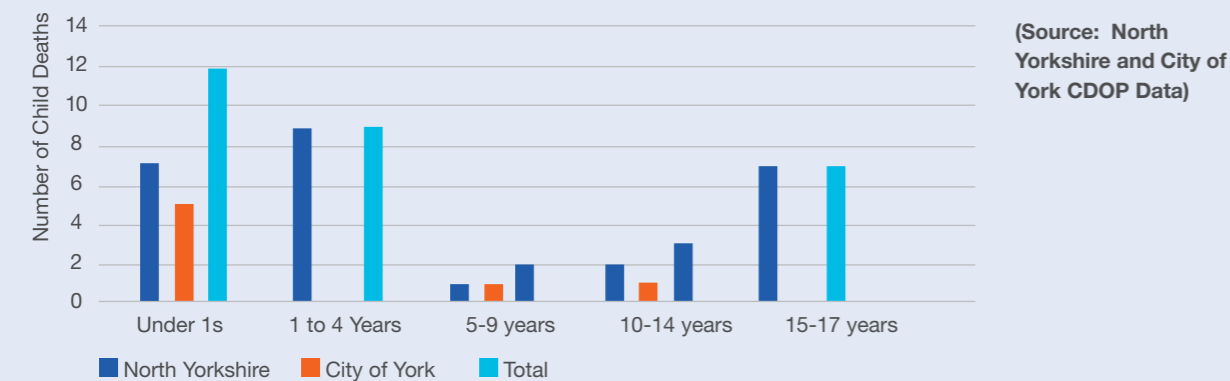
3.3.1.1 A total number of 33 children residing in North Yorkshire and City of York died in 2019/2020. Since 2015/2016 the number of child deaths have fluctuated as detailed in table 1.

Table 1. Number of Child Deaths notified to CDOP in 2019/2020



3.1.3 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. As in previous years a child is most at risk of death under the age of 1, and particularly within the first 27 days of life, however 2019/2020 saw an increase in deaths of infants aged 28 – 364 days.

Table 2. Age of Child Deaths in North Yorkshire and City of York 2019 - 2020

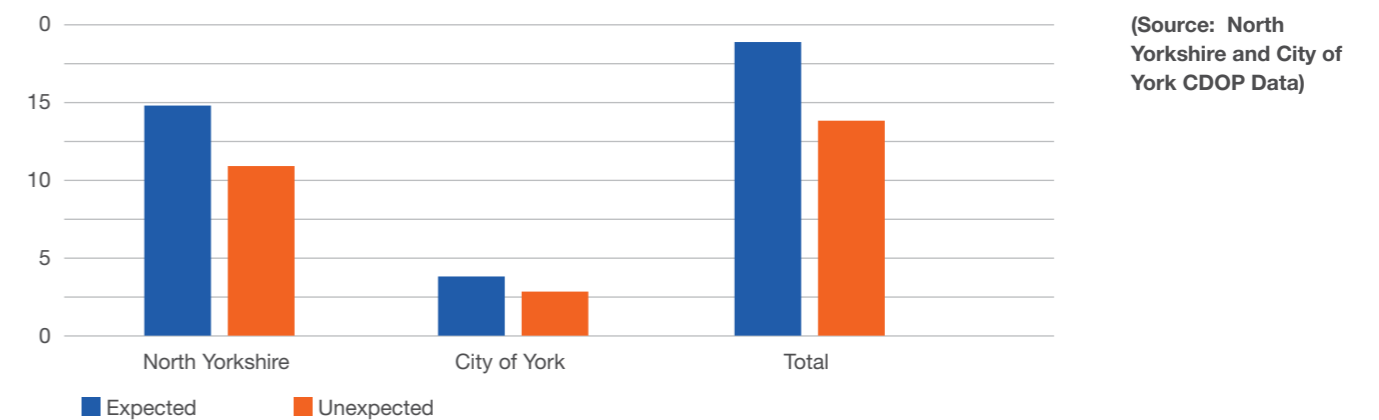


3.2 Expected and Unexpected child deaths

3.2.1 There are two categories of child deaths: 1. A child death is “expected” death where the death of an infant or child was anticipated due to a life limiting condition. 2. 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.

3.2.2 Over a 5-year average there have been 101 expected deaths and 68 unexpected deaths notified to CDOP. Table 3, shows the number of deaths which have been notified as expected and unexpected in 2019/2020.

Table 3. Category of Death in North Yorkshire and City of York 2019/2020



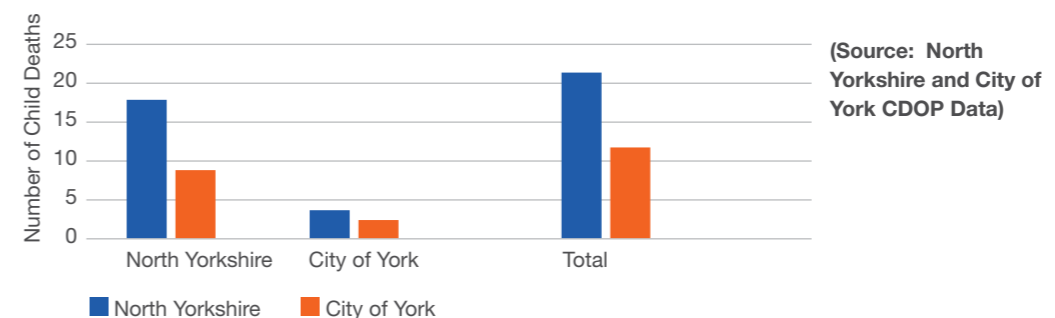
3.3 Location of death

3.3.1 The 33 deaths notified to CDOP in 2019/2020 occurred in the following settings; at home (4), in a public place (2), in a hospital (26) and in a hospice (1).

3.4 Infant and child deaths by gender

3.4.1 A breakdown of the number of child deaths by gender is outlined in Table 4. Nationally and locally the mortality rate for males is higher than females.

Table 4. Gender



3.5 Ethnicity

3.5.1 Of the 33 child deaths notified to CDOP in 2019/2020, 29 were classified as “White British”, 2 as “White Other” and 2 as Asian or Asian British”. These numbers reflect the population demographics for our regional area.

3.6 Disabled children

3.6.1 Out of the 33 child deaths notified in 2019/2020 there were 3 children who were known to have a disability. Those child deaths have been notified to the [Learning Disabilities Mortality Review Programme \(LeDeR\)](#) by CDOP to assist with their review and share learning from deaths of children with disabilities.

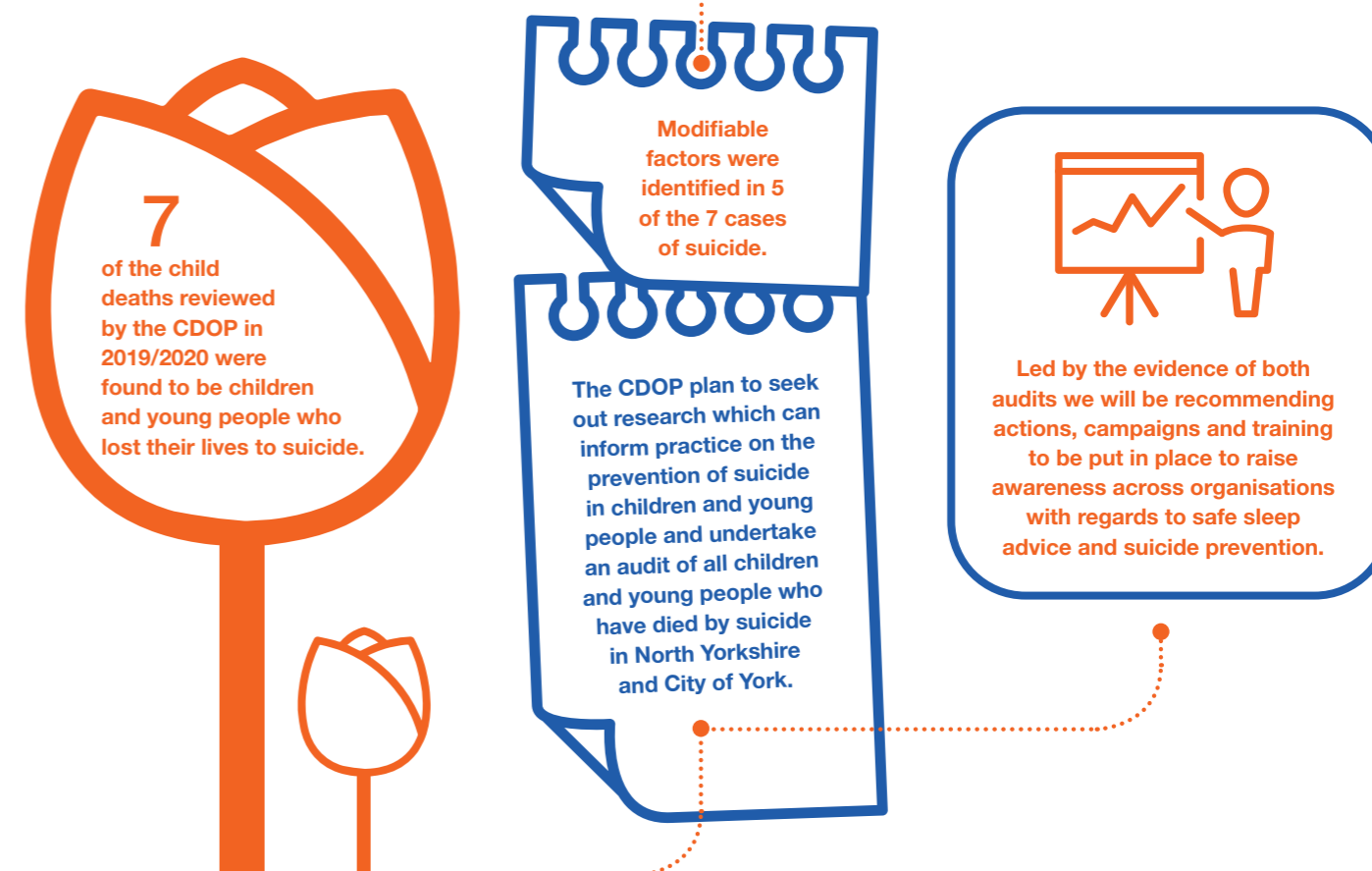
3.7 Categories of Child Deaths

3.7.1 During the CDOP members categorise all child deaths which are then recorded on a CDOP system. Categories of child death are identified nationally and are provided to CDOPs by the Department for Education. Detailed in table 5 are the categories of child deaths that have been agreed as of 31 March 2020.

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

	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020	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.	5	0	2	1	7	15
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.	0	2	3	3	4	12
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.	1	3	4	3	6	17
5. Acute medical or surgical condition - A brief sudden onset of illness which resulted in the death of a child.	2	4	6	2	2	16
6. Chronic medical condition – A medical condition which has lasted a long time or was recurrent and resulted in the death of child.	3	2	2	1	0	8
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.	8	4	3	6	6	27
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.	14	8	8	6	8	44
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.	0	5	1	1	4	11
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	0	1	2	6
Total number of child deaths reviewed by CDOP	34	30	29	24	39	156

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



3.7.2 There is 1 child death which occurred in 2017/2018, 3 child deaths which occurred in 2018/2019 and 27 child deaths which occurred in 2019/2020 which have not yet been reviewed by the panel. These are planned for review during 2020/2021. The information on these deaths will also be included in the 2020/2021 annual report.

3.7.3 As detailed in Table 5, of the 156 child deaths that have been reviewed by panel over the past 5 years, the main categories of the child deaths are:

- Category - Perinatal/ neonatal event (29%)
- Category - Chromosomal, genetic and congenital anomalies (17%)

“The York and Scarborough teams (paediatric, ED, and safeguarding) are extremely grateful for the involvement and support of the CDOP team regarding these most challenging cases and circumstances. The CDOP team are always easily accessible and approachable, providing practical and empathetic advice and support, and are extremely knowledgeable and helpful regarding necessary procedures, with the family experience paramount, together with any learning being highlighted. Their sensitive and supportive approach is much appreciated”.

Dr Elizabeth Baker, Consultant Paediatrician, York Teaching Hospital NHS Foundation Trust

4. CDOP Process

- 4.1** A Joint Agency Response Meeting (JARM) will be instigated in full for all child deaths that are sudden ununexpected. An unexpected death is a term used at presentation for 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 aim of the JARM is to enable the sharing of information, multi-agency discussions and planning to safeguard other individuals if identified.
- 4.2** It is the Coroner's responsibility to determine the cause of death where this 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.
- 4.3** 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 an '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 forms which the Child Death Review Officer uses to collect information from the relevant professionals which is also shared with the National Child Mortality Database (NCMD) and collated for review by the CDOP.

- 4.4** 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 JARM.
- 4.5** 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.



- 4.6** All 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 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.
- 4.6.1** The purpose of the CDRM 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.

“As the service manager of a voluntary sector organisation I have been involved in a small number of Joint Agency Response Meetings following the deaths of young people in the county. The meetings that I have attended have provided clear guidelines in terms of the purpose of the meeting and attendee's roles and have incorporated the appropriate amount of structure to proceedings whilst not stifling comment, questions or appropriate professional challenge from fellow attendees. In my experience the chairs have each actively encouraged open, honest disclosures from all partner agencies involved and have not shied away from asking probing questions while still managing to acknowledge the potential distress caused by the situation and remain both sensitive and respectful. I have also attended training on the CDOP process which was informative and enlightening”.

Lisa Gale, Service Manager, Compass REACH & Compass BUZZ

4.7 Child Death Overview Panel

4.7.1 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 taken to the CDOP for discussion and review.

4.7.2 During 2019/2020, the panel has reviewed a total of 39 cases. Of these cases, of the deaths occurred in the previous years. Cases can take over six months to be brought to panel for review. This may 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.

4.7.3 Of the 33 child deaths that occurred in 2019/2020, 7 have been discussed at panel with the remainder being scheduled for 2020/2021.

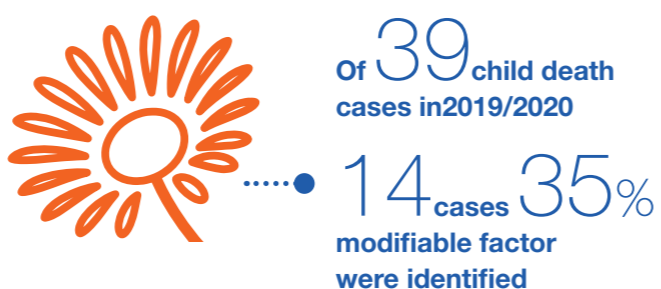
4.7.3 The CDOP is mindful that in the current Covid-19 pandemic there is the possibility of child deaths occurring as an indirect result of Covid-19 and the actions taken during "lockdown". This could include deaths from abuse as a result of domestic violence, deaths from late presentation of serious medical conditions (either due to an assumption the symptoms were Covid-19 related, or due a reluctance or inability to present to medical services in a timely manner) and potentially deaths due to other infectious diseases as a result of delayed vaccination during the pandemic.

4.8 Modifiable factors

4.8.1 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'

4.8.2 When the panel has reviewed the death of a child they will then identify and agree any modifiable factors that may have prevented the death. Out of the 39 child deaths reviewed by the panel in 2019/2020, there were 14 cases, 35% where modifiable factors were identified.

4.8.3 Where modifiable factors are identified the Panel has taken action to address these where appropriate. It is not usually within the remit of CDOP to take action directly, but any issues identified, learning points and recommendations are passed to relevant agencies to enable them to take action as appropriate. When this is felt necessary, it is placed on an action log until CDOP are assured that the necessary action has been taken,



5. 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.

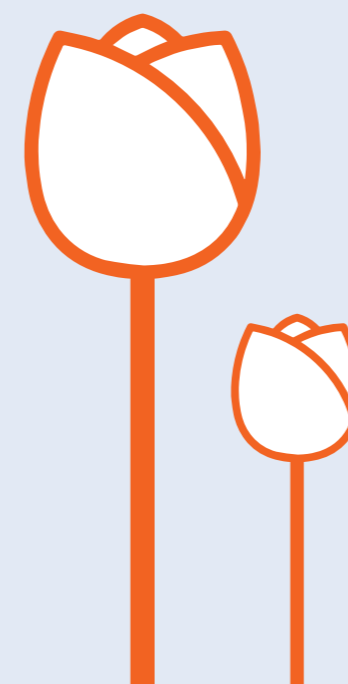
6. What has CDOP achieved in 2019/2020

Priority	Progress	Evidence
Reduce the mortality rate in children and young people in North Yorkshire and City of York through a coordinated response.	Action ongoing ➔	CDOP has embraced the new safeguarding arrangements and ensured timely, multi-agency input to Joint Agency Review Meetings for unexpected child deaths. There remains further work to be done to ensure every child death has a multi-agency Child Death Review Meeting prior to being reviewed by the CDOP. At present Health Services have well established Mortality and Morbidity Meetings which ensure each child death is reviewed and is fed into the CDOP, however the aim is to make these meetings fully multi-agency to include to ensure compliance with the Child Death Review Operational and Statutory Guidance.
To seek assurance that partners are working collectively on the suicide prevention agenda.	Action ongoing ➔	Over recent years the CDOP has seen a number of children who have taken their own lives sadly increase. Each and every death has an impact on a number of different people from family, friend's members of their community. We need to work together to understand, learn and prevent future deaths. As a multiagency partnership we have established links and sit on the North Yorkshire Suicide Prevention Steering Group and the North Yorkshire and York Suicide Surveillance Group. This allows us to work with our colleagues in adult services to learn and explore how we can work collectively to educate and put in preventative measures to tackle suicide ensuring that the right support is available much earlier on to support children's social, emotional mental health. As a result, we have contributed to the creation of the Self harm and Suicide Prevention Pathway which has been a welcome resource to professionals working with children in North Yorkshire.

Priority	Progress	Evidence
The launch of the Self-Harm and Suicide Prevention agenda	Action completed ✓	Colleagues from North Yorkshire County Council, partner organisations and parents have worked together to create the 'North Yorkshire Pathway of support for children and young people with self-harming behaviour and/so suicidal ideation'. The result is an online pathway aimed to help schools, the children's workforce, parents and carers all in one place.
CDOP to attend and engage with Paediatric Mortality Meetings to gathering further information in relation to neonatal deaths across the county.	Action completed ✓	The Child Death Review Officer actively attends Paediatric Mortality Meetings and engages with professionals across York Teaching Hospitals NHS Foundation Trust and Harrogate and District NHS Foundation Trust to obtain information in relation to neonatal deaths.
Reintegrated the letter to parent's and booklet informing them of the Child Death Review Process to sure better parental involvement in the Child Death Review Process.	Action completed ✓	Since 1st April 2019 the Child Death Review Officer has sent a letter to each parent accompanied by the NHS England Booklet, 'When a Child Dies' following the notification of their child's death. Any thoughts or feedback that has been communicated to the Child Death Review Officer by parents has been fed into the review of their child's death by the CDOP.
To identify and share bereavement support services that are available to Children, Young People, Families and Communities.	Action ongoing ↗	The Child Death Review Officer has undertaken a review of National, Regional and Local Bereavement Services available to children, young people and their families. From this a directory of contacts has been created which is shared with professionals who are working with the bereaved families and can inform and advise them on the available Bereavement Services. Progress is underway with regards to the creation of a bereavement page for parents and carers which will be on the NYSCP website. The page will look to provide information on national, regional and local support services for those bereaved by the death of a child or young person.

7.1 CDOP Priorities for 2020/2021

- The panel plan to conduct an audit across services in North Yorkshire and City of York who are responsible for giving safe sleep advice to parents and carers.
- The panel will seek out research which can inform practice on the prevention of suicide in children and young people and undertake an audit of all children and young people who have died by suicide in North Yorkshire and City of York.
- Led by the evidence of both audits we will be recommending actions, campaigns and training to be put in place to raise awareness across organisations with regards to safe sleep advice and suicide prevention.
- We will consider and monitor all child deaths that occur as a direct or indirect result of Covid-19 at the CDOP and ensure any actions which need to be implemented are recommended by the Panel.



Child Death Overview Panel (CDOP) Annual Report

2019-2020

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