Enter

Child Death Overview Panel (CDOP) Annual Report

2020-2021

North Yorkshire Safeguarding Children Partnership

City of York Safeguarding Children Partnership

Child Death Overview Panel Annual Report 2020-2021

Foreword

As I write this, the nation is looking forward to the easing of the lockdown measures put in place to protect us from the threat of the global coronavirus pandemic. However, not everyone will emerge from this difficult year unscathed. People have been bereaved, lost employment and educational opportunities which the effects of which may be delayed. All these thing will have an impact on children and young people, by recognising this CDOP members are continuously working to build children and young people's resilience and reducing the negative impacts of the pandemic. During the last year the child death review partners have not been notified of any child deaths relating to COVID-19, however they are mindful of an increase in drug related deaths which may well be an indication of reduced mental wellbeing amongst young people, for which coronavirus could be a contributing factor. This is something as a panel we will be monitoring closely.

The two task and finish groups formed to look at our priority areas of safer sleep and suicide prevention will be reporting back their findings to the panel . It has been agreed that this work continues over throughout 2021/2022 to ensure learning and recommendations can be embedded into service provision.

Working remotely is now a way of life and CDOP have continued to review child deaths effectively and efficiently. Multi-agency membership is robust and meetings are conducted inclusively. I feel that this is a testament of the commitment from panel members to safeguard children and young people and reduce the risk of child death. I would like to take this opportunity as CDOP Chair to thank everyone involved.

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 are to be reviewed 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 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.

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.

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 (VoY CCG and NY CCG)
- Designated Doctor for Child Death (VoY and NY CCG)
- Child Death Overview Panel Chair (CYC Public Health)
- Child Death Review Coordinator (NYSCP)
- Partnership Business Unit Managers (NYSCP and CYSCP)

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 and 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, York and Scarborough Teaching Hospitals 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
Carol Kirk	Detective Inspector, 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	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 Foundation Trust
Ali Firby	Child Death Review Officer for North Yorkshire and City of York

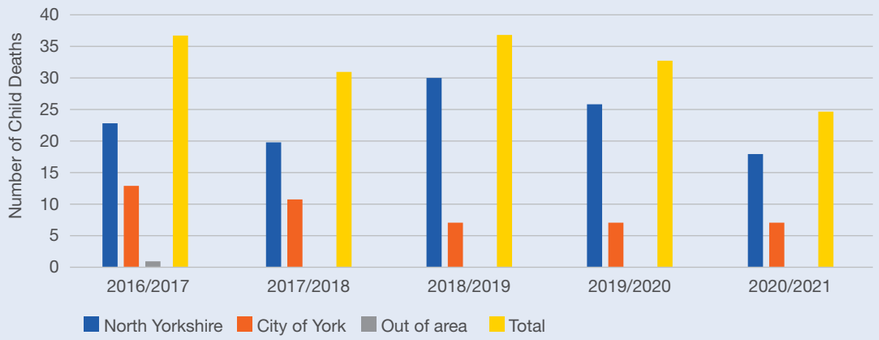
CDOP Panel Membership – at 31st March 2021

Data Analysis

Total number of infant and child deaths

A total number of 25 children residing in North Yorkshire and City of York died in 2020/2021. Since 2016/2017 the number of child deaths have fluctuated as detailed in table 1.

Table 1. Child Deaths in North Yorkshire and City of York 2016-2021

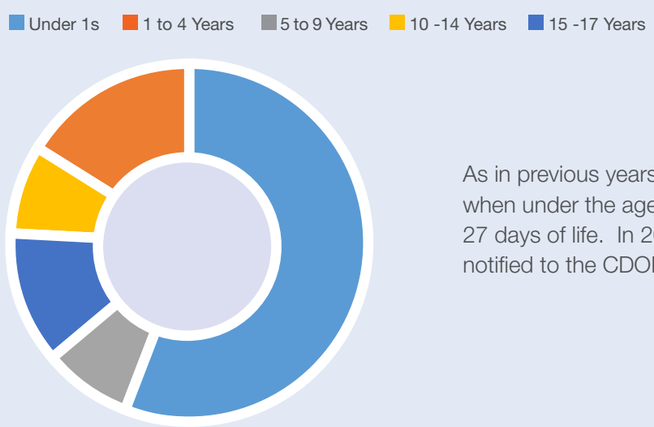


(Source: North Yorkshire and City of York CDOP Data)

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. Although we have seen a decline in cases notified to CDOP in 2020/2021 in comparison to previous years, there has been a significant rise in complex cases, for example drugs related deaths and Sudden and Unexpected Deaths in Infancy (SUDI). The multifactorial nature of these cases require more detailed analysis to draw out learning across the North Yorkshire and City of York multi-agency partnerships.

The CDOP work with multi-agency partners across North Yorkshire and City of York. Where, needed cases or themes are raised to identify learning for multi-agency partners. For example linking in to the county and city Emerging Drugs Trends Meetings and engaging in to both NYSCP and CYSCP Safeguarding Practice Review Groups where it is felt cases are needed to be explored in more detail.

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 2020/2021, 44% of the child deaths notified to the CDOP were under 27 days old.

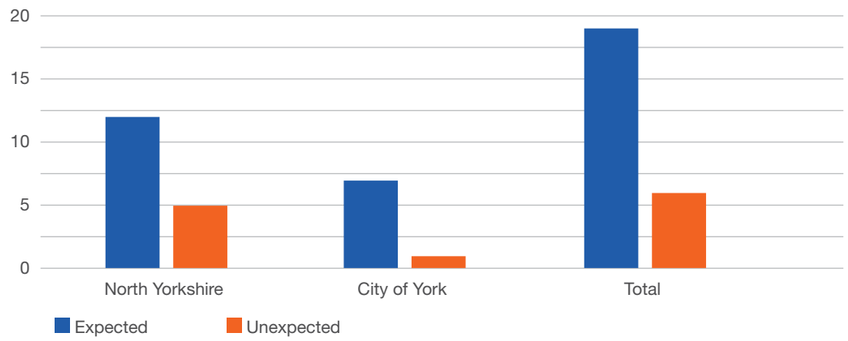
Expected and Unexpected child deaths

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 a 5 year average there have been 103 expected deaths and 59 unexpected deaths notified to CDOP. Table 3, shows the number of deaths which have been notified as expected and unexpected in 2020/2021.

Table 3. Category of Child Deaths in North Yorkshire and City of York 2020/2021



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

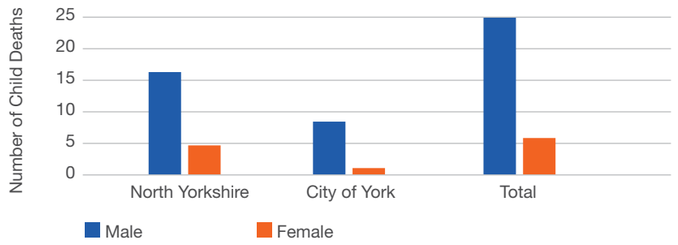
Location of death

Of the 25 deaths notified to CDOP in 2020/2021, 19 occurred within a hospital setting and the remaining 6 at home, in a public place or a hospice.

Infant and child deaths by gender

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



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

Ethnicity

Of the 25 child deaths notified to CDOP in 2020/2021, they were classified as "White British" or "White Other". This reflects the population demographics for our regional area.

Disabled children

Out of the 25 child deaths notified in 2020/2021 there were 2 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.

Categories of Child Deaths

During the CDOP meeting, members categorise all child deaths which are then recorded on a CDOP system. Categories of child death are identified nationally and are provided by the Department for Education. Detailed in table 5 are the categories of child deaths that have been agreed as of 31 March 2021.

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

	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	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.	0	2	1	7	2	**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**.**	2	3	3	4	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.	3	4	3	6	5	**21**
5. Acute medical or surgical condition - A brief sudden onset of illness which resulted in the death of a child.	4	6	2	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.	2	2	1	0	2	**7**
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.	4	3	6	6	6	**25**
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	8	6	8	7	**37**
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.	5	1	1	4	3	**14**
10. Sudden unexpected or unexplained death – This is where pathological diagnosis is either Sudden Infant Death Syndrome (SIDS) or 'unascertained', at any age**.**	2	0	1	2	3	**8**
Total number of child deaths reviewed by CDOP	**30**	**29**	**24**	**39**	**31**	**152**

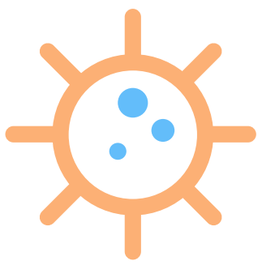
(Source: North Yorkshire and City of York CDOP Data)

There are a total of 23 cases which have occurred between 2018 and 2021 which are yet to be reviewed at CDOP. The information on these deaths will also be included in the 2021/2022 annual report.

As detailed in Table 5, of the 152 child deaths that have been reviewed by panel over the past 5 years, the main categories of the child deaths are:

Perinatal/ neonatal event
24%

Chromosomal, genetic and congenital anomalies
16%



Malignancy
13%

"I think it's fair to say that this has been a challenging year for everyone, but I feel that the CDOP have managed the potential difficulties well here in North Yorkshire and City of York, continuing with our core business including multi-agency child death review meetings, training and panel meetings virtually throughout the coronavirus pandemic. In some ways our ability to work virtually has given us ideas that we can continue to use in the future. Our large geographical footprint has meant that meeting virtually has saved a lot of time and our training has been extremely well attended. We have been able to deliver more sessions as a result of reduced travelling time, increased accessibility and the ability to provide more sessions for specific staff groups on request without needing to physically accommodate everyone in one room".

Dr Sally Smith, Designated Dr for Child Deaths, Vale of York and North Yorkshire CCG

Child Death Review Process

A Joint Agency Response (JAR) will be triggered in full for all child deaths that are sudden or unexpected. 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.

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 will be held by the Coroner in order to establish who died and how, when and where the death occurred.

Following notification being received by the 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.

The process for expected deaths; i.e. 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,

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. A 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. Where appropriate, 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.

"I have attended several meetings of the North Yorkshire and City of York CDOP, and one of the associated CDR Meetings. Both meetings, which deal with potentially difficult and distressing materials around the events surrounding child mortality, whether a child's death has been expected or unexpected, are thoroughly professional. They are well chaired, take account of all professional views, expertise and opinions, record their discussions and conclusions effectively and appropriately, and report on each agency's approaches to reviewing the matters brought to the meetings. All professionals present at and contributing to the meetings I have attended have shown great respect for and awareness of the fact that in every instance they are discussing the sad loss of a young life to a family, friendship group and community.

CDR Meeting discussions are carried out with scrupulous professionalism, including taking due account of the need for any directly involved clinicians to step aside from the meeting's concluding decision making regarding formal recording of the causes and clinical circumstances of a child's death.

Both meetings are often undertaken around crowded agendas, but in each case due care, attention and time are given to the discussion of each child in the appropriate degree of detail so that the Partnerships in both the North Yorkshire and the City of York are kept duly informed. Lessons that may need to be learned by services when a child or young person has died are also captured, and CDOP's reports, and records of its discussions and conclusions, all contribute to wider Partnership learning or practice reviews when a child death requires that one is undertaken".

Maggie Atkinson, NYSCP and CYSCP Independent Chair and Scrutineer.

Training

The Designated Doctor for Child Death and Child Death Review Officer have delivered 5 courses for Child Death Review: Advanced Training for Professionals across North Yorkshire and City of York in 2020/2021, with over 80 delegates attending. They have also delivered bespoke training to individual agencies including Children's Social Care and contributed to a Paediatric Community Regional Training Day.

The Child Death Review Officer and NYSCP Partnership Manager engages 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 CDR sector. Information from these events is shared with North Yorkshire and City of York's Child Death Review Partners on a regular basis.

"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".

Feedback from the Child Death Review Training.

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 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.

During 2020/2021, the panel has reviewed a total of 31 cases. Of these cases, some 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.

Of the 25 child deaths that occurred in 2020/2021, 7 have been discussed at panel with the remainder being scheduled for 2021/2022.

The CDOP continues to remain mindful that through the Covid-19 pandemic there is the possibility of child deaths occurring as an indirect result of Covid-19. 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. We are pleased to report that during 2020/2021 we have received no notifications of death relating directly or indirectly relating to Covid-19.

Within the 5 year reporting period the mortality rate in children and young people is the lowest it has ever been. It is believed this could be in relation to the restrictions imposed by the Covid-19 pandemic.

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 has reviewed the death of a child they will then identify and agree any modifiable factors that may have prevented the death.

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.

Out of the **31** child deaths reviewed by the panel in 2020/2021, there were 6 cases, **19%** 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 2020/2021

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 Response Meetings for all 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. In some cases it has been appropriate for CDOP to arrange this meeting for expected child deaths in order to ensure suitable information is gathered or clarified. 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 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 completed**	The CDOP has established links and sits on the North Yorkshire Suicide Prevention Suicide Surveillance Group and the City of York Suicide Safer Delivery Group which allows us to work with our colleagues in adult services to learn and explore how we can work collectively to educate and put in place preventative measures to tackle suicide, ensuring that the right support is available much earlier on to support children's social, emotional and mental health.
To identify and share bereavement support services that are available to Children, Young People, Families and Communities.	**Action completed**	Colleagues from North Yorkshire County Council, partner organisations and parents have worked together to create the 'North Yorkshire Self-Harm and Suicidal Ideation 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.

Priority	Progress	Evidence
The CDOP 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.	**Action ongoing**	During 2020 and beyond CDOP will ensure Covid-19 is monitored and escalated as appropriate.
SUDI Prevention	**Action ongoing**	In response to the increase in sudden and unexpected deaths across North Yorkshire and City of York, which was detailed in the 2019/2020 CDOP Annual Report, the CDOP identified the need to undertake an audit across services in North Yorkshire and City of York who are responsible for providing safer sleep advice and information to parents and carers. A SUDI Prevention task and finish group was set up which included representatives from NYSCP and CYSCP members to coordinate this piece of work. Following this audit, the task and finish group were assured that the safer sleep information provided to parents and carers was consistent across the county and reflected national guidance. In addition, the task and finish group reviewed the Children Safeguarding Practice Review Panel (CSPRP) second thematic report 'Out of routine: A review of SUDI in families where the children are considered at risk of significant harm' which was published in July 2020. The task and finish group found it was consistent with what is happening locally. Both the audit and the review of the CSPRP's thematic report led to recommending actions and campaigns to be put in place to raise awareness across organisations with regards to safe sleep advice and SUDI Prevention. The task and finish group concluded that both NYSCP and CYSCP should consider developing a multiagency SUDI risk prevention model, in line with the CSPRP's 'Prevent and Protect' practice model, which recognises a continuum of risk of SUDI. At the time of writing this report proposals are set to seek agreement from both NYSCP and CYSCP in the next reporting year 2021/2022.

Priority	Progress	Evidence
Suicide Prevention	**Action ongoing**	Following the CDOP review of seven child deaths in 2019/2020 which related to suspected or confirmed suicides (as identified from findings of the Coroner), the CDOP agreed that Suicide Prevention would be one of their two priorities for 2020/2021. A Suicide Prevention task and finish group was set up which included representatives from NYSCP and CYSCP members to coordinate this piece of work. The task and finish group conducted an audit across services in North Yorkshire and City of York to clarify what suicide prevention support is available to professionals, parents, carers and young people. They also sought out research to inform local practice on suicide prevention which led to the task and finish group making a number of recommendations. The task and finish group has driven and overseen the implementation of a number of actions to assist in raising awareness across organisations with regards to suicide prevention. Some examples are; • All agencies to promote and encourage individuals to undertake the training through the #Talksuicide campaign across North Yorkshire and City of York • Amendments to the NYSCP and CYSCP Training courses to include suicide prevention • Amendments to school safeguarding policies to include specific guidance on self-harm and suicide ideation • Updates to the NYSCP and CYSCP Self-Harm and Suicide Ideation Pathway.

CDOP Priorities for 2021/2022

The prevention of SUDI and Suicide will remain the two priority areas for CDOP to ensure learning continues to be undertaken and embedded within service across North Yorkshire and City of York.

Child Death Overview Panel (CDOP) Annual Report

2020-2021

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