Pan-Cheshire Child Death Overview Panel

Annual Report

1st April 2018 – 31st March 2019

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Mike Leaf
Independent Chair
Pan-Cheshire CDOP
September 2019

Forward from the Independent CDOP Chair

This is my third report as Independent Chair for the Pan-Cheshire CDOP, which comes at a time of tremendous change in terms of Safeguarding and the Child Death Review processes. The report aims to not only reflect the cases the panel has considered throughout 2018/19, but also the achievements of the partnership, and the future priorities for action.

Clearly one of the key priorities for this coming year will be the successful implementation of new Child Death Review Guidance and development of new processes and partnerships. Whilst over 80% of child deaths nationally have a medical or public health causation, ALL include an element of vulnerability and as a result, we need to recognise the importance of continuing the development of well-established relationships with the children's safeguarding partners.

At the time of writing, a Memorandum of Understanding between CDOP and the statutory partners for child death review (Local Authorities and Clinical Commissioning Groups) is being considered, which aims to clarify the respective expectations of each partner for an effective child death review system. As Chair, it will be my responsibility to ensure that CDOP provides oversight and assurance of the child deaths review processes, to the statutory partners.

I would like to thank all the Panel members, for their continued commitment and hard work, and in particular, to Anne McKenzie and Rosie Lyden for the hard work that goes on behind the scenes to ensure that the Panel runs smoothly, and keeps pace with the changing landscape.

Mike Leaf

Independent Chair

Pan-Cheshire CDOP

September,2019

Section 1:
Executive Summary

Whilst there will be changes in the future, the Pan-Cheshire CDOP formed a sub-group of the four Local Safeguarding Children Boards (Cheshire East, Cheshire West and Chester, Halton and Warrington LSCBs) and has a statutory responsibility to review the deaths of all children up to the age of 18 years old (excluding infants live-born following planned, legal terminations of pregnancy and stillbirths) resident within the four Local Authority areas. The focus of CDOP should be on identifying any modifiable factors that may help prevent unnecessary future child deaths or harm.

The purpose of this Annual Report is to:

- Clarify and outline the processes adopted by the Pan-Cheshire CDOP
- Assure the four Cheshire LSCBs and future Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across Cheshire, which meets national guidance
- Provide an overview of information on trends and patterns in child deaths reviewed across Cheshire during the last reporting year (2018-19)
- Highlight issues arising from the child deaths reviewed between April 2017 and March 2018
- Report on achievements and progress from last year's annual report
- Make recommendations to agencies and professionals involved in the children's safeguarding system across Cheshire

Achievements during 2018-19

- ✓ Managed the transition of Child Death Review process across Cheshire, liaising with statutory partners
- ✓ Pan-Cheshire CDOP continues to play an active role in both regional and national networks, influencing programmes, and gaining insight into proposed changes to the CDOP function in the future
- ✓ Active participation in the organisation of the National CDOP Conference
- ✓ Engagement with other CDOPs across the NW and nationally and sharing good practice
- ✓ Processes have been reviewed in the light of the neo-natal ongoing neonatal enquiry at the Countess of Chester Hospital. All numbers of child death notifications from hospital are monitored
- ✓ Development of top tips to infant safer sleep
- ✓ CDOP Study/ Development day delivered
- ✓ Proposal for eCDOP developed following positive evaluation of using the system

Summary of key points and themes:

Of those deaths reviewed [2017-18 percentage in square brackets]:

- 46.9% of the deaths occurred before the child reached 28 days (23 deaths)[36.2%]
- 67.3% of the deaths occurred before the child reached one year of age (33 deaths)[58.6%]
- 8.2% of the deaths occurred in Children aged 1 year to 4 year (4 deaths) [8.6 %]
- 10.2% of the deaths occurred in Children aged 5 years to 9 years (5 deaths) [8.6%]
- 8.2% of the deaths occurred in Children aged 10 years to 14 years (4 deaths)[8.6%]

- 6.1% of the deaths occurred in Children aged 15 years to 17 years (3 deaths) [15.5%]
- 77.5% of the deaths were male (38 deaths) [53.4%]
- 46.9% were Perinatal/Neonatal events (23 Deaths) [43%]
- 39% of deaths were classed as 'unexpected' (19 deaths) [24%]
- 45% of deaths reviewed had 'modifiable factors' (22 deaths) [40%]

Update on action plan

- ✓ Manage a smooth transition of the Child Death Review process from Local Safeguarding Boards to new governance arrangements- *several briefing papers have been presented to strategic partners over the last 12 months; several workshops organised to explore issues and solutions;*
- ✓ Further develop the relationship with CHAMPS suicide network- *links further developed;*
- ✓ Ensure that the new guidance is implemented including:
    - Ensuring all child death review meetings (e.g. perinatal mortality; hospital mortality; etc) inform the CDOP process in a standardised/ structured manner
    - Implementation of any changes to the reporting processes e.g. Forms A, B, C

  All revised forms have been circulated and are being used; challenges and issues are being monitored, particularly the current duplication of mortality review processes; eCDOP should make the processes easier in the future.
- ✓ Ensure that there is a stronger link with the neonatal network- *meetings have been held between the CDOP Chair and the NW Neonatal Operational Delivery Network (NWNODN) to clarify the protocols for the new arrangements; processes have now been established; The network will provide conclusions and recommendations of their independent reviews for CDOP to consider at panel.*
- ✓ Ensure all agencies understand the new guidance and relevant processes - *CDOP has consulted and engaged with all statutory agencies and other strategic partners to alert them to the new guidance and implications; various briefing documents have been circulated; engagement events have been organised;*
- ✓ Deliver a multi-agency learning event- *a successful interagency/ multi-professional event was organised with a focus on bereavement support;*
- ✓ Ensure that safer sleep messages are being promoted in a consistent way across Cheshire- *Assurance has been provided from health that information and advice is given at planned contacts visits as per NICE guidance (NICE Postnatal Care Guidelines CG37 2014). The Pan Cheshire Multi-Agency Guidance for Infant Safer Sleep 2019 has now been ratified and multi-agencies and awareness will be raised via the Pan Cheshire CDOP newsletter; In conjunction with the launch of the Pan Cheshire Multi-Agency ICON (Infants Cry You Can Cope) programme, an update regarding Infant Safer Sleep is to be provided.*
- ✓ Update the Pan-Cheshire CDOP protocol in accordance with the new guidance- *Processes have been updated, and a self-assessment against standards will be completed in the next year.*
- ✓ Ensure that data is collected for Adverse Childhood Experiences (ACEs), Suicides and Children with learning disabilities- *processes have been implemented partway through the year; a full*

  year's ACE data will be available next year and will feature in next year's report.
- ✓ Explore the observed rise in deaths per u18 population in Cheshire East- *an in-depth analysis on the increased rate was undertaken involving PH England, which provided the CDOP representatives with the necessary assurance that there were no reasons for concern*
- ✓ Ensure that children's deaths are categorised in accordance with the new guidance in terms of either place of local authority residence, or GP registration. Figures will be verified by the

panel at the end of the reporting year- *There have been no anomalies identified since the changes were adopted last year.*

Update on recommendations for Local Safeguarding Partners in the annual report 2017-18 *(in italics)*

Local Safeguarding Partners are asked to:

1. Note to contents of this annual report
2. Ensure that the new Safeguarding arrangements maintain strong links with the child death review processes as they evolve, and in particular, ensure full involvement of the relevant partners- *Local Children's Safeguarding Partnerships will receive periodic reports, and will be alerted of any recommended action from CDOP where safeguarding issues have been identified; this will be defined in the MOU*
3. Work collaboratively to ensure that lessons learned from the COCH neonatal review are effectively cascaded across all appropriate networks, and ensure that robust processes are in place to establish unusual patterns of unexpected child deaths in hospitals – *the Royal College provided a review with recommendations and have been shared through various clinical networks; All numbers of child death notifications from hospital are monitored*

Priorities for 2019-20:

- ✓ Embed the new Child Death Review processes and develop reporting processes for local Children's Safeguarding Arrangements and health and wellbeing Boards
- ✓ Support Trusts in developing robust child death review meetings (e.g.perinatal mortality; hospital mortality; etc) to inform the CDOP process in a standardised/ structured manner
- ✓ Ensure all agencies understand the new guidance and relevant processes
- ✓ Undertake a self-assessment against the standards identified in the new operational guidance, and identify corrective actions to ensure compliance;
- ✓ Develop and agree a MOU between the Statutory Partners (LAs/CCGs) to clarify roles and expectations;
- ✓ Agree future funding formula for CDOP and broader Child Death Review processes.
- ✓ Implement the eCDOP programme across Cheshire, to improve processes and minimise additional administrative burdens;
- ✓ Undertake an audit of LeDeR cases to determine the percentage of cases that did not meet the agreed protocol;
- ✓ Analyse the data on Adverse Childhood Experiences (ACEs) and report on the findings next year.
- ✓ Establish a formal business meeting, separate to the review meetings. (This will not be additional time but will provide opportunities for process development and oversight.)

Recommendations for Local Safeguarding Partners

Local Children's Safeguarding Partners are asked to:

1. Note the contents of this report
2. Endorse the priorities identified
3. Ensure that the CDR processes remain embedded in the new Safeguarding arrangements until at least April 2020.
4. Transfer the responsibility for CDR/CDOP to Health and Wellbeing Boards after 2020.

5. Children's Safeguarding and Health and wellbeing partners should clarify what interagency initiatives are required to reduce the prevalence of modifiable factors identified in the under one population including:
    - Safe sleeping
    - Risk factors for reducing premature births including:
        - High BMI (including healthy diet and physical activity)
        - High blood pressure (linked to high BMI)
        - Smoking
        - Alcohol use
        - Substance misuse
        - Domestic violence
        - Mental health
        - Diabetes (often linked to BMI)
        - Lack of physical activity

Mike Leaf
Independent Chair
Pan-Cheshire CDOP
September, 2019

CDOP Panel Meetings

CDOP Membership

Pan-Cheshire CDOP's core membership comprised of:

- Independent Chair
- CDOP Coordinator
- Designated Nurse for Safeguarding Children (Warrington and Halton)
- CDOP Nurses x 3 (Cheshire East, Cheshire West and Warrington)
- Specialist Midwife
- Public Health
- Coroner's officer
- Designated Doctor for Child deaths x 3 (Cheshire East, Cheshire West, Warrington/Halton)
- Police Representative from PPU Directorate
- Local Authority Service Manager, Safeguarding Unit
- Local Authority Service Manager, Children's Social Care
- Education Representative from Safeguarding in Education Team.
- LSCB Business Manager x1
- Co-opted Advisory Member (Paediatrician/Deputy Coroner)
- North West Ambulance Service (where needed in cases of unexpected deaths)

The Pan-Cheshire CDOP has permanent representatives drawn from the key professional areas represented on participating LSCBs. Members of the CDOP attend the meetings as representatives of their profession/designation rather than representing their employing organisation. Members have a responsibility to disseminate recommendations and learning to agency representatives on the Boards in the other Pan Cheshire LSCB areas. Other members may be co-opted to contribute to the discussion of certain types of death when they occur.

Quoracy

A representative from the police, one Doctor, one Nurse and a minimum of one LSCB Business Manager will ensure that a meeting is quorate. Quoracy is being reviewed in the light of new child death review arrangements.

Frequency of Meetings

The panel currently meet on a quarterly basis and for a whole day. It has been agreed that this frequency will remain unless there was a significant number of cases to review. The business meeting will follow the panel meeting.

Agency Representation at Panel Meetings

The Pan-Cheshire CDOP met on four occasions between April 2018 and March 2019. Attendance is monitored on a regular basis to ensure quoracy and effective representation. On occasions there are times where professional demands have to take priority, and members, in these cases are expected to provide a replacement. Representation has been consistent throughout the year.

Table 1: Agency representation

Sector	Role
Chair	Independent CDOP Chair
Health	Designated Doctor CE
	Designated Doctor CWAC
	Designated Doctor (Warrington/ Halton)
	Cheshire East Specialist CDOP Nurse
	Cheshire West Specialist CDOP Nurse
	Warrington Designated Nurse Safeguarding
	Designated Nurse Halton CCG
	Supervisor of Midwives CWAC
	Warrington Safeguarding Nurse
Local Authority	Coroner Officer
	Cheshire East Head of Service – Children's Safeguarding
	Public Health Consultant (Cheshire W. and Chester)
	LSCB Business Manager for Warrington Borough Council
Police	Public Protection Unit

Processes/ Networks/ Reviews and Sub-groups

Notification Process

The notification process via paediatric liaison and hospital/hospice staff functions well. By cross-referencing with the annual NHS England return (regarding notifications from Registrars to NHS England), CDOP is confident that it is notified of all child deaths. When Cheshire child deaths occur out of area, CDOP is often notified by Cheshire agencies, as well as by the CDOP contact in the respective area where the death occurred. This demonstrates effective communication between local organisations and CDOP.

SUDiC Guidance

The Pan-Cheshire SUDiC guidance has been updated and widely circulated, and aligned to the new Statutory and Operational Child Death Review Guidance.

Links to Coroners and Registrars

Within Cheshire there is an excellent working relationship with the Coroners offices, with senior coroner's officer representation, and specific investigatory work being undertaken e.g. a *review of fatal self-harm in children and adolescents*.

Deaths of Children Living Outside Cheshire

Whilst CDOP is responsible for the review of child deaths resident in Cheshire, there is an expectation that it should receive notification of child deaths for children who live out of area, but have died within the boundary. As Cheshire borders Wales, where there is a different process for reviewing child deaths, the numbers of these children may be significant. CDOPs across the country should routinely notify the CDOP where the child died, and visa versa. Any deviations from this process are followed up. In the future, some deaths may be reviewed of non-resident children where there is local learning to be uncovered, but this will be discussed with the CDOP of the child's residency. This will be done on a case by case basis.

Communicating with Parents, Families and Carers

Leaflets and a letter are made available to any parent following the death of a child. A new NHS England leaflet has been produced for use locally. "When a Child Dies" provides a detailed explanation of many of the processes associated with a child's death.

Deaths involving Serious Case Reviews/ Critical Incident Reviews

Child deaths are considered at panel once all relevant investigations and reports have been completed. These include those that have been the subject of Serious Case Reviews, Critical Incident Reviews or any learning review. This approach is consistent with that undertaken across the north-west and much of England, and will continue under the new local and national Safeguarding procedures. This may, on occasions, result in a delay between notification and review completion and CDOP will continue to monitor this process and any delays. This explains why there is usually a difference between the number of death notifications, and the number of reviewed cases.

Regional/ National Links/ Updates:

North-west meetings
Pan-Cheshire CDOP continues to be represented at the north-west CDOP meetings. A common dataset was agreed for all north-west annual reports to allow for the compilation of an overview report covering the area. A north-west CDOP report is produced annually, although falls out of sequence from local CDOP annual reports.

National Network
Some Cheshire CDOP members form part of the national network group which advises on issues of national interest, including the transfer of the CDOP responsibilities to the Department of Health. Panel members attend the national event and feed back to panel.

National Child Mortality Database (NCMD)
Pan-Cheshire CDOP continued to participate, by invitation, on the working group to determine the need for a national CDOP database, and provide data as part of national piloting, prior to the launch of the database in April 2019. Recommendations have been made for Pan-Cheshire CDOP to adopt the eCDOP programme which links directly to the NCMD which will reduce the additional administrative burden resulting from changes to the CDR processes. At the time of writing, decisions to fund the licence have still to be made.

Funding

Contributions

Each LSCB and PH department contributes £1625 (£13000pa total) with additional population-based contributions to cover the CDOP Business Administration costs (Table 2). Funding will continue to be reviewed in light of the expectations placed on partners as a result of the new CDR statutory guidance.

Table 2: Contributions to CDOP process for 2018-19 by LSCB area

	Warrington	Halton	Cheshire West and Chester	Cheshire East	Total
20% for panel admin	£1,179.25	£1,179.25	£1,179.25	£1,179.25	£4,717.00
80% for child deaths	£3,957.80	£2,431.10	£5,592.36	£6,886.74	£18,868.00
Total	**£5,137.05**	**£3,610.35**	**£6,771.61**	**£8,065.99**	£23,585.00

Issues Identified

Missing Data

There has been an improvement on the details provided on the forms, but the failure to provide consistent information can create issues. For example, the lack of details of the father/significant male/other parent in the family, is particularly relevant in relation to necessary checks regarding domestic violence. This forms part of an ongoing dialogue with representatives and remains under scrutiny. These processes will be strengthened with the new child death review processes as there is a legal responsibility for organisations to provide information.

Modifiable Factors

A modifiable factor is one *which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions could be modified to reduce the risk of future child deaths*. Overall the modifiable factors identified for Cheshire during 2018/19 (in order of prevalence) include:

- Smoking by the mother/ parent/ or carer during pregnancy or in the first few years of a child's life (57% of all neonatal deaths)
- Mental health issues (parent or child) (29% of all deaths)
- Alcohol / substance misuse (parent/child) (18% of all deaths)
- High maternal body mass index (BMI) (22% of all neonatal deaths)
- Domestic Violence
- Unsafe sleeping
- Housing overcrowding

The highest annual number of deaths occur neonatally (under 28 days) often as a result of complications through prematurity. Smoking, alcohol consumption and a high maternal BMI all increase the risk of prematurity and low birth weight, resulting in an increased level of vulnerability and risk of early infant death.

It is important that all parts of the health and social care system reinforce messages that reduce risk of prematurity and low birth weight, especially during pregnancy.

National annual statistical data

The LSCBs are required to collect a considerable amount of data following the death of every child. From the 2018 -2019 year onwards the information will be submitted and published by NHS England. The CDOP Co-ordinator is responsible for this function on behalf of each of the four LSCBs. NHS England, in turn, consolidates the returns and publishes a statistical release. At the time of writing, no data has been published by NHS England.

Priorities for 2019-20:

- ✓ Undertake a self-assessment against the standards identified in the new operational guidance, and identify corrective actions to ensure compliance;
- ✓ Develop and agree a MOU between the Statutory Partners (LAs/CCGs) to clarify roles and expectations;
- ✓ Agree future funding formula for CDOP and broader Child Death Review processes.
- ✓ Implement the eCDOP programme across Cheshire, to improve processes and minimise additional administrative burdens;
- ✓ Undertake an audit of LeDeR cases to determine the percentage of cases that did not meet the agreed protocol;
- ✓ Analyse the data on Adverse Childhood Experiences (ACEs) and report on the findings next year.
- ✓ Establish a formal business meeting, separate to the review meetings. (This will not be additional time but will provide opportunities for process development and oversight.)
- ✓ Support the Multi agency ICON & Safe sleep campaign which was developed to support practitioners to deliver the right messages to parents and carers.

Section 3: Data and Analysis

It should be noted that it is often difficult to make clear conclusions from analysing data from a relatively small number of cases reviewed each year. The learning from each individual case is noted at each CDOP meeting, with the appropriate action taken at that time. Where reviews have already been undertaken e.g. hospital mortality reviews, action has usually already been taken. Cheshire's figures are amalgamated with other CDOP data across the NW to provide opportunities for identifying more reliable trends. Notified deaths are categorised according to place of residency using postcodes.

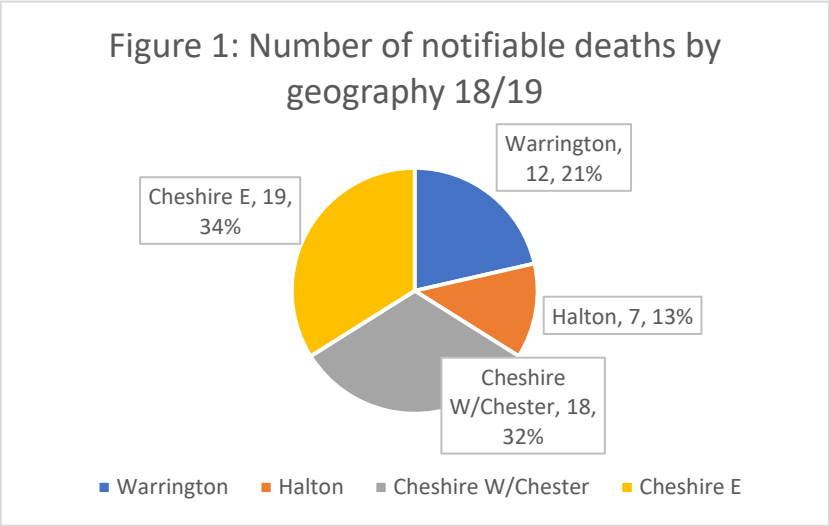
Number of Deaths

The Pan Cheshire CDOP met on four occasions between April 2018 and March 2019. The total number of child deaths notified across the Pan Cheshire footprint was 56. (Cheshire East (19), Cheshire West and Chester (18), Halton (7) and Warrington (12)).

End of Year Case	
2015 - 2016	1
2016 - 2017	2
2017 -2018	4
2018 – 2019 Qtr 1 to Qtr 3	6
2018 – 2019 Qtr 4	15
TOTAL	**28**

At the end of 2018-19 there were 28 child deaths outstanding which have not yet been considered by CDOP. A total of 13 were subject to inquests 15 where reported in the final 3 months of the year.

Figure 1 shows the percentage split of the numbers of notified deaths, by local authority area. A small increase or decrease in notifications can cause significant swings in these proportions each year, and it is sometimes more useful to con
sider trends over a period of time.



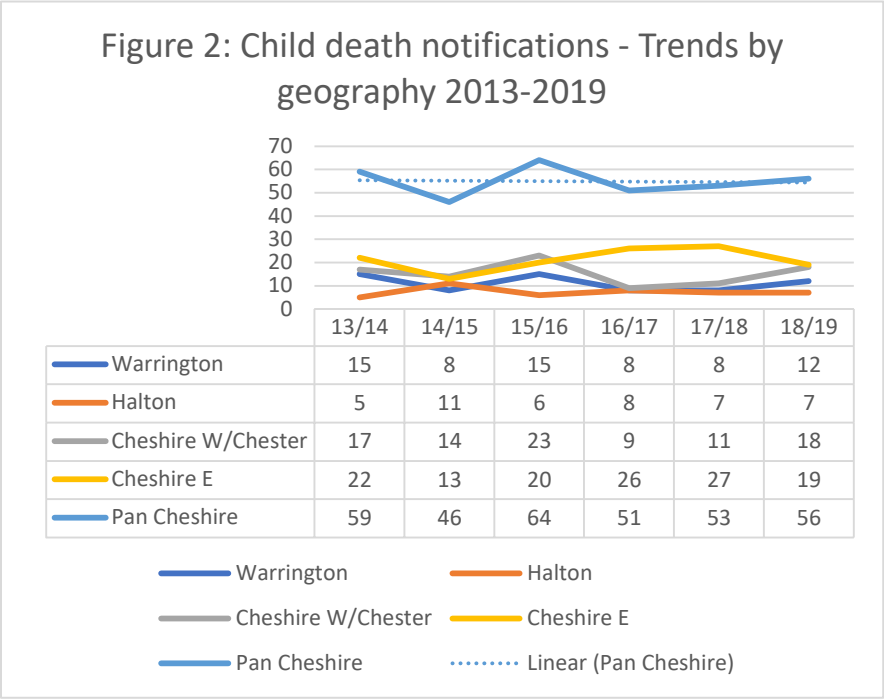
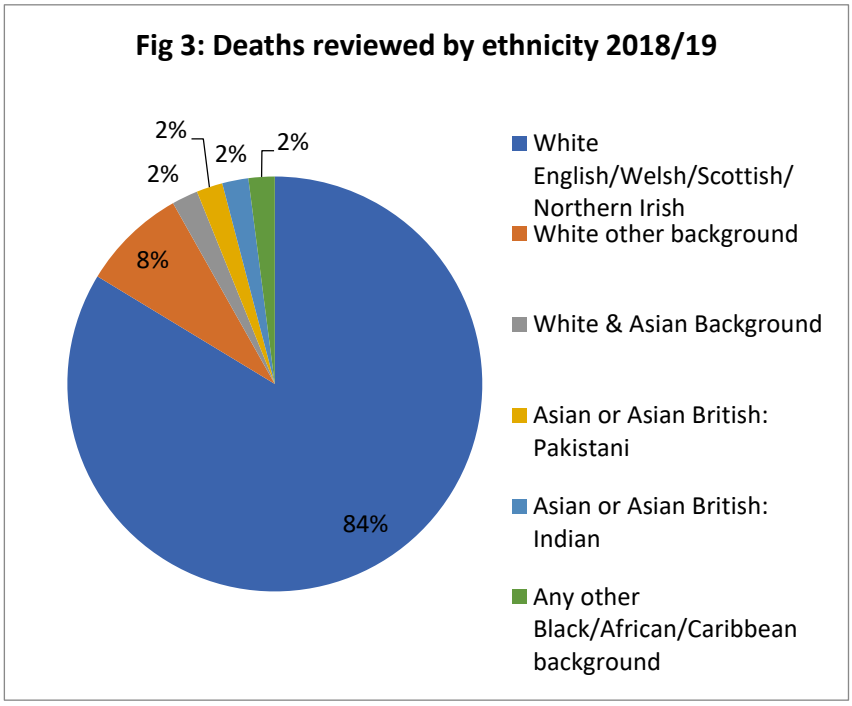


Figure 2 shows that the very slight downward trend in child death notifications highlighted last year has levelled off. Cheshire East has seen a small decrease in notifications over the same period (see trend line). The mean average number of notifications over the last 5 years is 54.8, which is slightly below the recommended lower limit of 60 deaths per year by NHSE.

Ethnicity of the child

Figure 3 shows that the majority (84%%) of the child deaths reviewed during 2018-19 were of 'British White' ethnicity.



Child Population

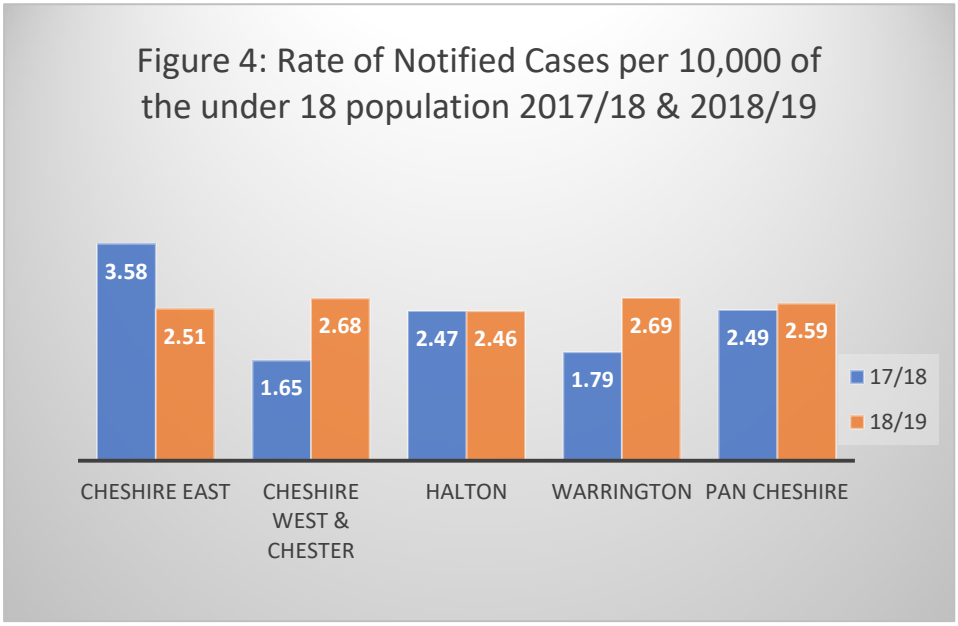
The child population estimates in each of the four LSCB areas is detailed in the following table 4.

Table 4: Child Populations by local authority

LSCB area	Child population size* (0-17 years)
Cheshire East	75,834
Cheshire West & Chester	67,284

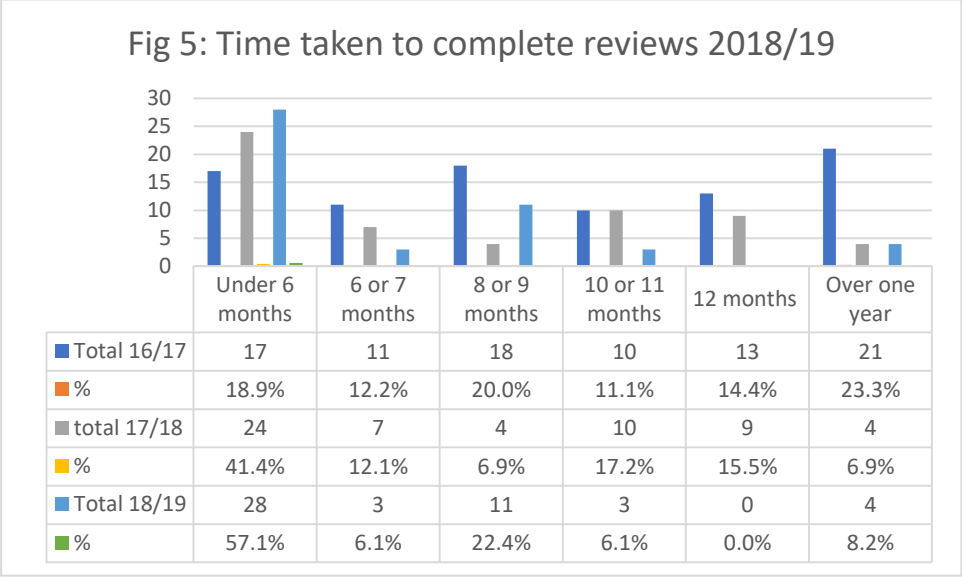
Halton	28,408
Warrington	44,646
Pan Cheshire	216,172

* Source: ONS mid-Year Population Estimates, 2017



Local child populations are useful when comparing local areas. Normally, one would expect to see the numbers of deaths in each geography, to be proportionate to the number of under 18-year olds living in each, but there may be differences according to deprivation levels. Figure 4 shows the rate of deaths per 10,000 0-18 years population over the last 2 years, and highlights that the number of child death notifications relative to the under 18 population of an area is similar to Cheshire as a whole.

Review Completion



	Under 6 months	6 or 7 months	8 or 9 months	10 or 11 months	12 months	Over one year
Total 16/17	17	11	18	10	13	21
%	18.9%	12.2%	20.0%	11.1%	14.4%	23.3%
total 17/18	24	7	4	10	9	4
%	41.4%	12.1%	6.9%	17.2%	15.5%	6.9%
Total 18/19	28	3	11	3	0	4
%	57.1%	6.1%	22.4%	6.1%	0.0%	8.2%

Figure 5 provides a breakdown of the time taken to complete the reviews over the last 3 years. It shows that during 2018/19, 57.1%% of reviews were completed within 6 months compared to 41.4% in the previous year. This has been a steady improvement over the last 2 years. CDOP is confident that unnecessary delays in the process are being kept to a minimum and will keep the matter closely under review.

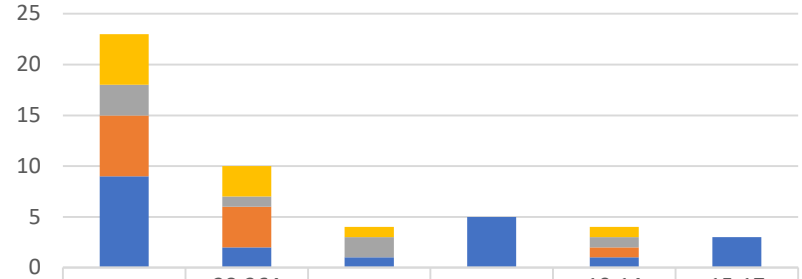
Deaths by gender

From April 2018 – March 2019 of the 49 child deaths reviewed by the CDOP, 38 were male (77.5%) and 11 were female (22.5%).

Child Deaths Reviewed by Age (DfE categorisation)

Figure 6 shows that the largest number of child deaths occurred within the first twelve months of life (67.3%). Nationally, 60% of deaths in childhood occur during the first year of a child's life, and are strongly influenced by pre-term delivery and low birth weight; with risk factors including maternal age, smoking and disadvantaged circumstances (Wolfe and Macfarlan, 2015).

Fig 6: Deaths reviewed by age 2018/19



	0-27 days	28-364 days	1-4 years	5-9 years	10-14 years	15-17 years
WA	5	3	1	0	1	0
HA	3	1	2	0	1	0
CW	6	4	0	0	1	0
CE	9	2	1	5	1	3

In Summary (last years' figures in [brackets]:

- 46.9% of the deaths occurred before the child reached 28 days (23 deaths)[36.2%]
- 67.3% of the deaths occurred before the child reached one year of age (33 deaths)[58.6%]
- 8.2% of the deaths occurred in Children aged 1 year to 4 year (4 deaths) [8.6 %]
- 10.2% of the deaths occurred in Children aged 5 years to 9 years (5 deaths) [8.6%]
- 8.2% of the deaths occurred in Children aged 10 years to 14 years (4 deaths)[8.6%]
- 6.1% of the deaths occurred in Children aged 15 years to 17 years (3 deaths) [15.5%]

Deaths reviewed by CDOP with modifiable factors

A modifiable factor is one *which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths*.

Fig 7: Modifiable factors by age groups 2018/19

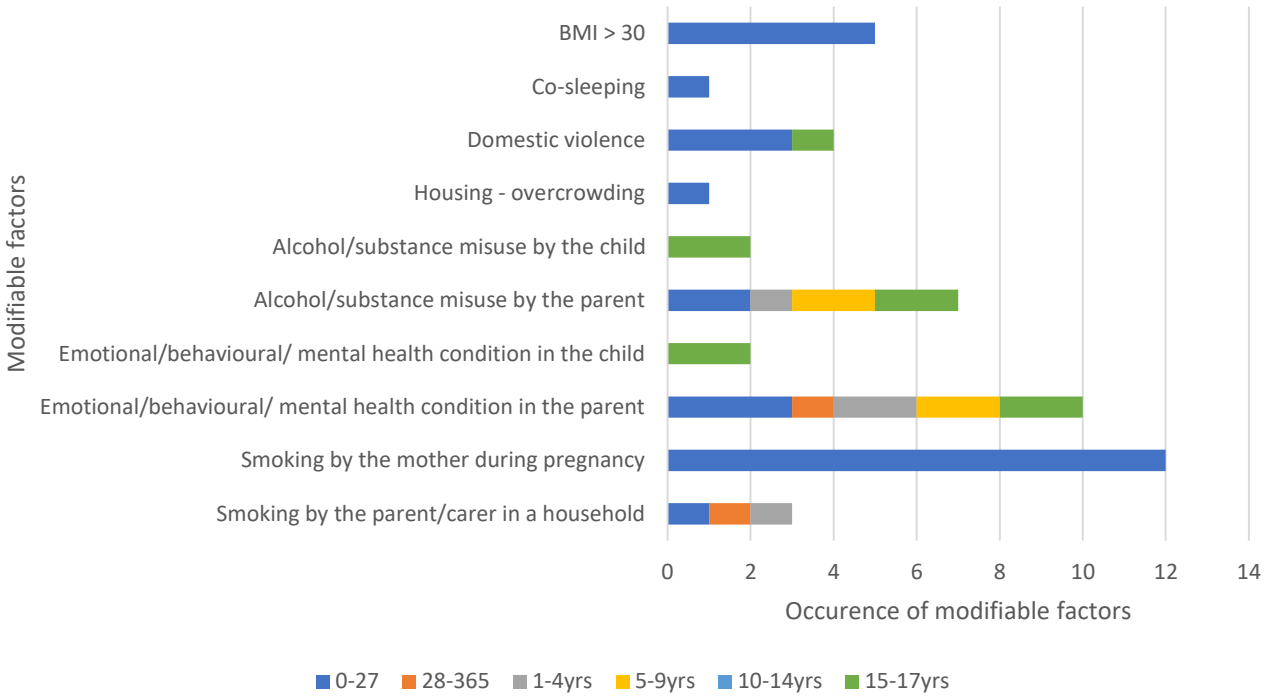


Fig 7 shows the modifiable factors identified for Cheshire including:

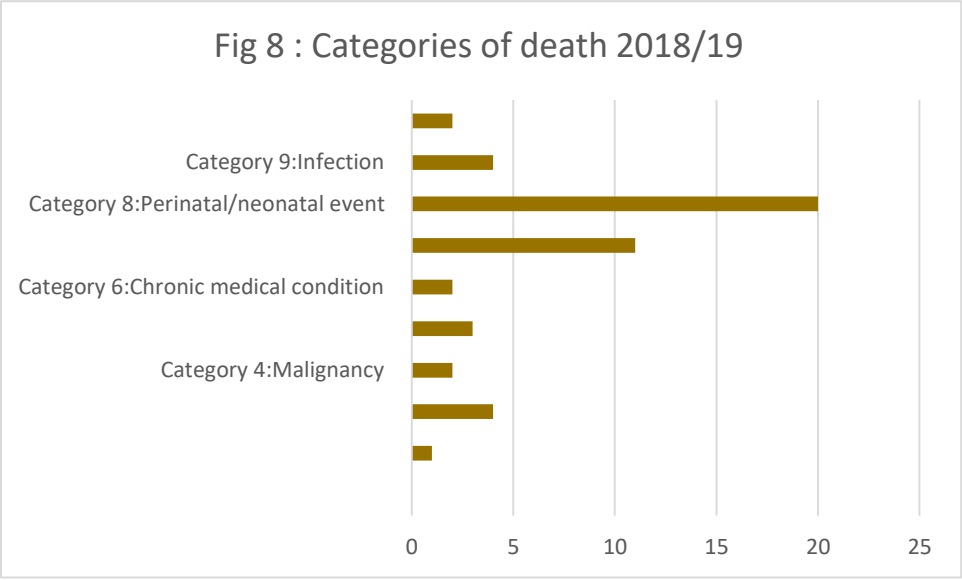
- Smoking by the mother/ parent/ or carer during pregnancy or in the first few years of a child's life (57% of all neonatal deaths)
- Mental health issues (parent or child) (29% of all deaths)
- Alcohol / substance misuse (parent/child) (18% of all deaths)
- High maternal body mass index (BMI) (22% of all neonatal deaths)
- Domestic Violence
- Unsafe sleeping
- Housing overcrowding

The highest annual number of deaths occur neonatally (under 28 days) often as a result of complications through prematurity. Smoking, alcohol consumption and a high maternal BMI all increase the risk of prematurity and low birth weight, resulting in an increased level of vulnerability and risk of early infant death.
It is important that all parts of the health and social care system reinforce messages that reduce risk of prematurity and low birth weight, especially during pregnancy.

Category of Child Death

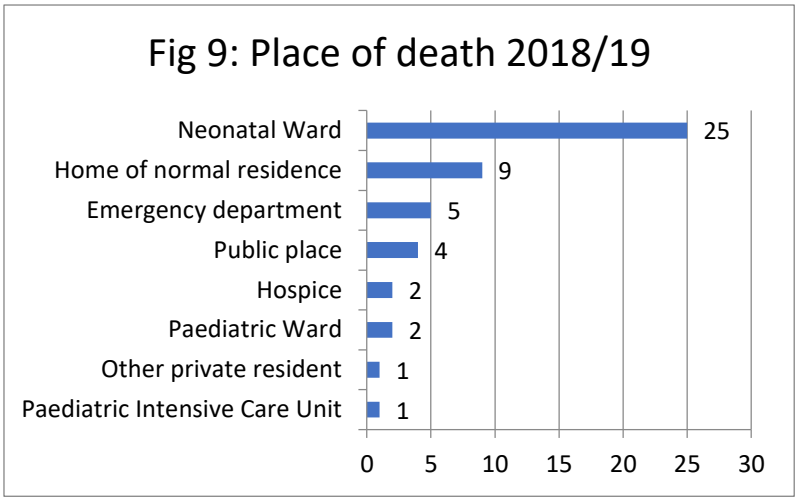
The CDOP panel is required to record each death against 1 of 10 nationally-set categories as follows:

Category 1: Deliberately inflicted injury, abuse or neglect (0)
Category 2: Suicide or deliberate self-inflicted harm (1)
Category 3: Trauma and other external factors (4)
Category 4: Malignancy (2)
Category 5: Acute medical or surgical condition (3)
Category 6: Chronic medical condition (2)
Category 7: Chromosomal, genetic and congenital anomalies (11)
Category 8: Perinatal/neonatal event (20)
Category 9: Infection (4)
Category 10: Sudden unexpected, unexplained death (2)

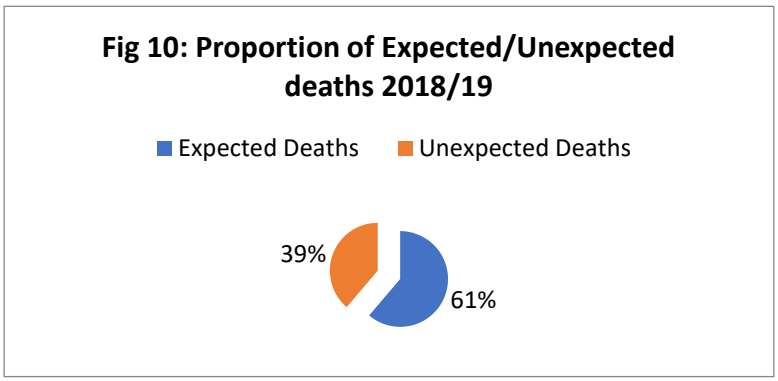


Further explanations can be found in Appendix 1. It can be seen in Figure 8 that the greatest proportion of deaths relate to perinatal/ neonatal event (category 8) which compares with the patterns seen in the NW and nationally. Chromosomal, genetic and congenital anomalies (category 7) is the second highest category, as it has been for the last three years.

Location of Child Death

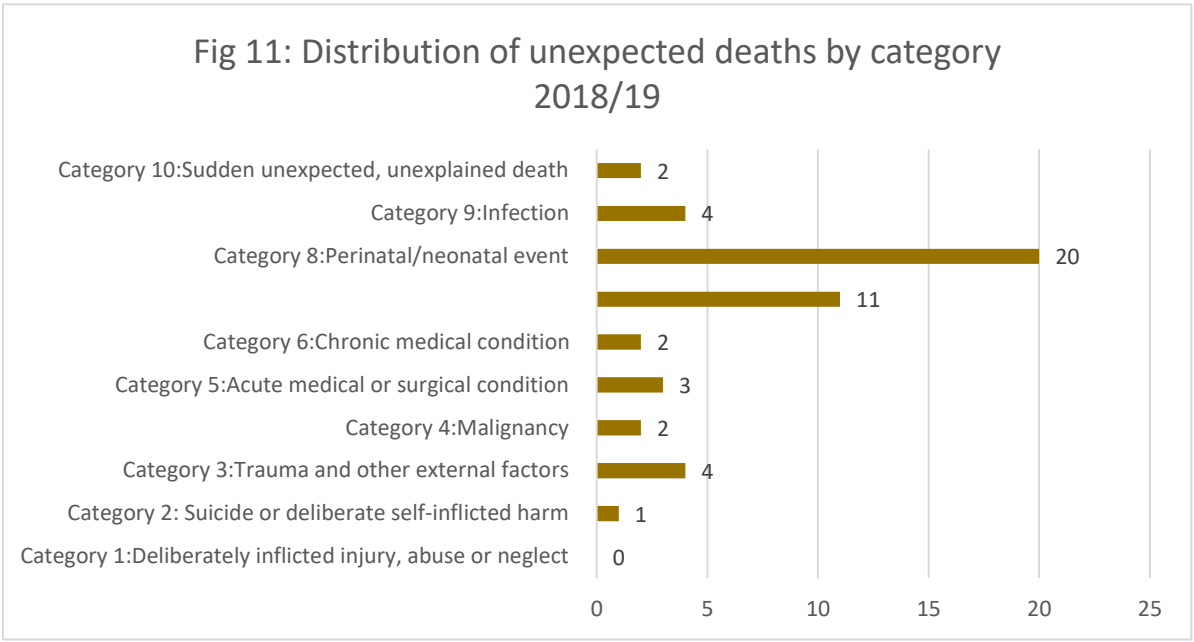


The majority of deaths (69.4%) occur within a hospital setting, the majority (51%) of these occurring in the neonatal units (Figure 9).
This is unsurprising because, by their very nature, these units provide care for premature babies and the most vulnerable/ at risk.



Expected / Unexpected deaths

An expected death refers to a death that could reasonably been foreseen by clinicians for a period of at least 24 hours before it occurred. An unexpected death is then defined as the death of an infant or child which was not anticipated as a significant possiblity 24 hours before the death or, where there was was an unexpected collapse or incident precipitating the events that led to that death. Between April 2017 and March 2018, there were 19 deaths (39%) that were classified as 'unexpected'.



The proportion of unexpected deaths has increased from 11% (2016-17) to 24% (2017-18) to 39% 2018-19. Similar to the previous two years, categories 7 and 8 contain the the most unexpected deaths, but also contain the highest proportion of deaths.

Acknowledgements

As noted in the foreword much of the business of the CDOP is dependent on the continued support of panel members and the administrative support. I would like to take this opportunity to thank the panel members for their continued support and especially Anne McKenzie who ensures the panel runs smoothly.

Mike Leaf
Independent CDOP Chair
September 2019

Glossary of Terms

Term	Meaning
Child	A person aged 0-18th birthday
Expected death	A death that could have been reasonably predicted 24 hours before the death occurred or 24 hours before the immediate events leading to the death occurred
Infant	Aged less than 1 year of age
Modifiable factors	Factors associated with a death which by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths
Neonatal period	From birth until 28 days of life
Perinatal period	From viable gestation (around 23 weeks of pregnancy) until 7 days following birth
Unexpected death	A death that could not have been reasonably foreseen 24 hours before it occurs – or where there was an unexpected collapse or precipitating events leading to the death

Abbreviations

CDOP – Child Death Overview Panel

SUDI – Sudden Unexplained Death in Infants

LSCB – Local Safeguarding Children Board

Appendix 1: Classification of Death

This classification is hierarchical: where more than one category could reasonably be applied, the highest up the list should be marked.

Category	Name & description of category	Tick box below
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	☐
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.	☐
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury, abuse or neglect. (category 1).	☐
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	☐
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.	☐
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.	☐
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease,cystic fibrosis, and other congenital anomalies including cardiac.	☐

8	**Perinatal/neonatal event** Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).	☐
9	**Infection** Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.	☐
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	☐

The panel should categorise the 'preventability' of the death – tick one box.

Preventable child deaths are defined in Chapter 5, paragraph 11 (p85) of Working Together to Safeguard Children (2015).