Pan-Cheshire Child Death Overview Panel

Annual Report

1st April 2020 – 31st March 2021

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Mike Leaf
Independent Chair
Pan-Cheshire CDOP

Forward from the Independent CDOP Chair

This is my fifth report as Independent Chair for the Pan-Cheshire CDOP, and reflects an historical year in which we have had to deal with the pressures of managing a global pandemic, which left no-one unaffected. All of the public sector were directly involved in responding to unprecedented demands and changes in roles, which was clearly going to have an impact on child death review processes, and this has resulted in a significant drop in cases being brought to panel. Only 28 cases were considered, so care needs to be taken in making too many conclusions from a single year. As always, we try and look at trends over several years, although 2020-21 was unusual for many reasons, but all related to the pandemic. CDOP is the last part of the child death review process and can only usefully review a child death once all other enquiries/ reviews have been completed. These include:

- Coroners inquests (temporarily suspended during the covid pandemic during 2020-21)
- Criminal enquiries (delayed through covid pandemic during 2020-21)
- Internal reviews including Root Cause Analysis, Perinatal Mortality Reviews (PMRT), Health Safety Investigation Board (HSIB) reviews, Child Death Review Meetings (CDRMs)
- Peer reviews including the NW Neonatal Operational Delivery Network (NWNODN)

During 2020-21 covid had a significant impact on all of these processes. Figure 7 in this report illustrates this shift in the time taken to review cases.
In terms of how we will deal with the backlog, I am recommending that we put on some additional panels once we are clear that we have all the necessary information to complete the reviews.

The report aims to not only reflect the cases the panel has considered throughout 2020/21, but also the achievements of the partnership, future priorities for action, and issues related to the implementing the statutory child death review processes, during a year affected by Covid 19.

A Memorandum of Understanding between CDOP and the statutory partners for child death review (Local Authorities and Clinical Commissioning Groups) clarifies the respective expectations of each partner for appropriate effective delivery and oversight of 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 how they switched swiftly to virtual working, without compromising the quality of the panel meetings. I would like to thank all the Panel members, for their continued commitment and hard work, and in particular, to Anne Barber for the hard work that goes on behind the scenes to ensure that the Panel runs smoothly, and keeps pace with the changing landscape, particularly during a year when this has meant her often working in isolation.

Mike Leaf, Independent Chair

Pan-Cheshire CDOP, Autumn, 2021

Section 1:
Executive Summary

There is a statutory requirement for the statutory partners to *make arrangements to carry out child death reviews. These arrangements should result in the establishment of a Child Death Overview Panel (CDOP), or equivalent, to review the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children*.
Responsibility for reviewing child deaths no longer sits with local safeguarding arrangements and sits with the following:
Halton Borough Council
Warrington Borough Council
Cheshire East Borough Council
Cheshire West and Chester Council
Eastern Cheshire Clinical Commissioning Group (CCG)
South Cheshire CCG
Vale Royal CCG
West Cheshire CCG
Halton CCG
Warrington CCG

It has been agreed that Pan-Cheshire CDOP will:

- provide oversight and assurance of the new Child Death Review processes and ensure that it meets the required statutory standards.
- review all infant and child deaths under 18 years of age. This includes neonates where a death certificate has been issued, irrespective of gestational age.
- identify and highlight any modifiable factors, and bring these to the attention of strategic partners, including Health and Wellbeing Boards, Multi-Agency Safeguarding Arrangements and Community Safety Partnerships where necessary in order to inform their preventative planning and commissioning arrangements.

The purpose of this Annual Report is to:

- Clarify and outline the processes adopted by the Pan-Cheshire CDOP
- Assure the 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 (2020-21)
- Highlight issues arising from the child deaths reviewed
- Report on achievements and progress from last year's annual report
- Make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across Cheshire

Achievements and impact during 2020-21

- ✓ Managed and modified oversight of the Child Death Review processes
- ✓ Engaged with other CDOPs across the NW and nationally, and sharing good practice
- ✓ CDOP Study/ Development day delivered on post-mortems
- ✓ ICON[11] – CDOP has supported the Implementation of the ICON Programme throughout Pan Cheshire. This is an evidenced programme that is has been designed by to reduce Abusive Infant Head Trauma through primary prevention interventions, population based awareness, raising public health interventions and secondary prevention interventions. Several key members of the CDR Panel have been key members of the Steering Group and have been involved in the co-ordination and implementation.
- ✓ Switched to virtual working and maintained functionality
- ✓ Circulated good practice, learning and tools across Cheshire
- ✓ Challenged and sought assurance from providers on elements of inadequate care / deviation from protocols arising from case reviews at panel, to assure quality
- ✓ Provided support and guidance to local providers on new processes
- ✓ Ensured that exceptional care is recognised by writing to providers where care has gone beyond that which might be expected.
- ✓ Updated Sudden Unexpected Death protocol
- ✓ Quarterly liaison meetings with child death review partners in Wales have been established to explore cross-border issues, due to the different child death review processes

Summary of key points and themes:

Of those deaths reviewed [2019-20 percentage in square brackets]:

- 49% of the deaths occurred before the child reached 28 days (20 deaths)[44.4%]
- 68% of the deaths occurred before the child reached one year of age (29 deaths)[64.4%]
- 11% of the deaths occurred in Children aged 1 year to 4 year (5 deaths) [11.1%]
- 5% of the deaths occurred in Children aged 5 years to 9 years (3 deaths) [6.6%]
- 12% of the deaths occurred in Children aged 10 years to 14 years (5 deaths)[11.1%]
- 5% of the deaths occurred in Children aged 15 years to 17 years (3 deaths) [6.6%]
- 46% of the deaths were male (13 deaths) [51%]
- 39.3% were Perinatal/Neonatal events (11 Deaths) [24.4%]
- 50% of deaths reviewed had 'modifiable factors' (14 deaths) [38%]
- 61% deaths were classified as 'unexpected' [40%]
- 50% of cases reviewed had modifiable factors. Of these, 64.3% were linked to deaths under one year of age, which was similar to the previous year (64.7%).

[1] **ICON -** Infant crying is normal; C –Comforting methods can help; O – It's OK to walk away; N – Never, ever shake a baby

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*. Modifiable factors identified for Cheshire during 2020-21 (in order of prevalence) include [last year's %]. As some cases will have more than one modifiable factor, the total percentages can add up to more than 100%:

- Mental health issues (parent or child) (27% of all deaths [17.8%])
- Alcohol / substance misuse (parent/child) (9% of all deaths [13.3%])
- Smoking by the mother/ parent/ or carer during pregnancy or in the first few years of a child's life (30% of all deaths under one (19.2%))
- High maternal body mass index (BMI) (9 % of all deaths under one (15.4%))
- Domestic Violence 6%
- Unsafe sleeping (6% of all deaths under one (11.5%))
- Faulty Trans Warmer
- Bike not road worthy as seat & brakes removed

Update on priorities 2020-21

- ✓ Agree future funding formula for CDOP and broader Child Death Review processes including funding for training and development and streamline the arrangements.
  A funding formula has been agreed across all partners which includes training and development
- ✓ Through the monitoring of the self-assessment framework and risk register, ensure that any elements of non-compliance are managed or escalated to appropriate partners.
  Whilst the self-assessment framework has been considered at the business meeting, no updates have been requested throughout the year in view of the pressures faced by the partners in their response to covid. This will be picked up again through 2021-22 dependent on service demands caused by covid.
- ✓ Ensure that CDOP receives the necessary documentation from Child Death Review meetings.
  Whilst there have been noticeable improvements, there are still areas for more improvement particularly general practice and tertiary centres. This will be followed up throughout 2021-22.
- ✓ Advocate with other CDOPs for NCMD to produce national comparative data to facilitate better benchmarking, help set standards and help drive CDOP performance in terms of "completeness" and "timeliness" of child death reviews in the country.
  CDOP has liaised with the NCMD who have confirmed that the opportunity for national benchmarking will be enhanced as each year passes due to the increased data being held.
- ✓ Strengthen the governance relationship with the local Health and Wellbeing Boards.
  Relations with health and wellbeing boards continue to develop through the partners involved in both child deaths and health and wellbeing.

- ✓ Review any Evaluation/outcome reports of ICON implementation
  Whilst CDOP Business meetings have received verbal updates on the implementation of the programme, no formal evaluation of the programme has been presented.
- ✓ CDOP response to the recent report *A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm (July 2020):* https://www.gov.uk/government/publications/safeguarding-children-at-risk-from-sudden-unexpected-infant-death
  This report reinforces the key messages CDOP has been promoting:

- *promoting consistent information for practitioners about the factors associated with SUDI, based on current national and international evidence*
- *developing the knowledge and skills of practitioners to engage families in healthy lifestyle changes and parenting practices*
- *supporting effective safer sleep conversations, in which risk tools enable parents to assess the risk factors associated with their particular circumstances and make safe and appropriate decisions about the sleep environment*
- *outlining how individual organisations can promote safer sleep messages as part of their everyday work with families, with role-specifc guidance for practitioners*

✓ Support the review of the CDOP Nurse specialist role in relation to developing Cheshire CCG arrangements

CDOP representatives have been liaising with leaders in the emerging CCG for Cheshire to ensure that appropriate structures and staff are in place to service the needs of child death review demands. This will continue throughout 2021-22 as new NHS governance arrangements develop.

✓ Ensure CDOP has a formal set of accounts

Balance sheets feature as a standard agenda item at CDOP business meetings

Priorities for 2021-22:

- ✓ Implement the eCDOP programme across Cheshire, to improve processes and minimise additional administrative burdens;
- ✓ Analyse the data on Adverse Childhood Experiences (ACEs) and report on the findings next year.
- ✓ Through the monitoring of the self-assessment framework and risk register, ensure that any elements of non-compliance are managed or escalated to appropriate partners.
- ✓ Ensure that CDOP receives the necessary documentation from Child Death Review meetings.
- ✓ Improve the scores on the notification and reporting fields highlighted by the National Child Mortality Database [NCMD] report.
- ✓ Clarify the governance arrangements and implications of the emerging NHS re-organisation
- ✓ Review any Evaluation/outcome reports of ICON implementation
- ✓ Ensure that there are opportunities for parents to access non-digital versions of *"When a Child Dies"* leaflet which provides a detailed explanation of many of the processes associated with a child's death.
- ✓ Catch up on the delayed cases coming to panel as a result of covid

Recommendations for Local Strategic Partners
Local Strategic Partners are asked to:

1. Note the contents of this report
2. Children's Safeguarding and Health and Wellbeing partners should clarify and monitor 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
Autumn 2021

Overview and Processes

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/Halton)
- 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 Head of Service, Safeguarding and Quality Assurance Unit
- Local Authority Service Manager, Children's Social Care
- Education Representative from Safeguarding in Education Team.
- Local Safeguarding Children Partnerships
- 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 professionals who have an interest in children's health and safeguarding, and statutory partners. Members are not there to represent their individual organisations, but to represent a professional perspective/ insight to the cases presented. In addition to the specific roles identified below, all members of CCDOP are expected to:

- Ensure that they are fully prepared to contribute at each meeting by reading through the papers, and consulting colleagues where necessary beforehand.
- Ensure that there is a suitable alternative replacement to attend if it is not possible to attend
- Take away action points to their specific geography, agency or professional groups, and ensure that the action is undertaken within the required timescales

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. At the time of writing, virtual meetings are in place as a result of the Covid 19 pandemic.

Agency Representation at Panel Meetings

The Pan-Cheshire CDOP met on five occasions between April 2020 and March 2021, although this was virtual. Attendance is monitored on a regular basis to ensure quoracy and effective representation.

On occasions there are times where professional demands must take priority. Representation has been consistent throughout the year.

Table 1: Agency representation

Sector	Role
Chair	Independent CDOP Chair
Health	Designated Doctor CE
	Designated Doctor CWAC
	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)
	Local Authority Safeguarding Children Partnerhip 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 national 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.

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. Quarterly liaison meetings with child

death review partners in Wales have been established to explore cross-border issues, due to the different child death review processes.
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. Professionals have a responsibility to notify the CDOP administrator if they learn of the death abroad of a either a child or an infant born to a mother who normally resides in the Cheshire area so that the death may be verified, SUDIC procedures implemented and a JAR initiated.

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. Parents are invited to contribute any comments to the review of their child's death, and CDOP will monitor this.

Deaths involving other reviews and investigations

Child deaths are considered at panel once all relevant investigations and reports have been completed. These include any Children's Safeguarding Practice Review, Coroners enquiry, Healthcare Safety Investigation Board review, criminal enquiry, or internal 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 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 often a difference between the number of death notifications, and the number of reviewed cases. In 2020/21, there was a large difference between the number of child death notifications (57) and the cases considered at CDOP (28), largely due to processes affected by Covid 19.

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 this has not been possible during Covid.

National Network
Some Cheshire CDOP members form part of the national network group which advises on issues of national interest, together with flagging issues with the National Child Mortality Database (NCMD).

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. CDOP will continue to monitor and remind partners of this obligation. Where the panel have insufficient information to make a decision, further details are sought, and the case postponed.

National annual statistical data

All data from CDOPs in England is now incorporated into the National Child Mortality Database which receives timely information from all areas. NCMD produces quarterly reports, together with an annual report for each CDOP. This report forms the basis of the Pan-Cheshire CDOP report contained in Appendix I.

Priorities for 2021-22:

- ✓ Implement the eCDOP programme across Cheshire, to improve processes and minimise additional administrative burdens;
- ✓ Analyse the data on Adverse Childhood Experiences (ACEs) and report on the findings next year.
- ✓ Through the monitoring of the self-assessment framework and risk register, ensure that any elements of non-compliance are managed or escalated to appropriate partners.
- ✓ Ensure that CDOP receives the necessary documentation from Child Death Review meetings.
- ✓ Clarify the governance arrangements and implications of the emerging NHS re-organisation
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        - 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

Section 3:

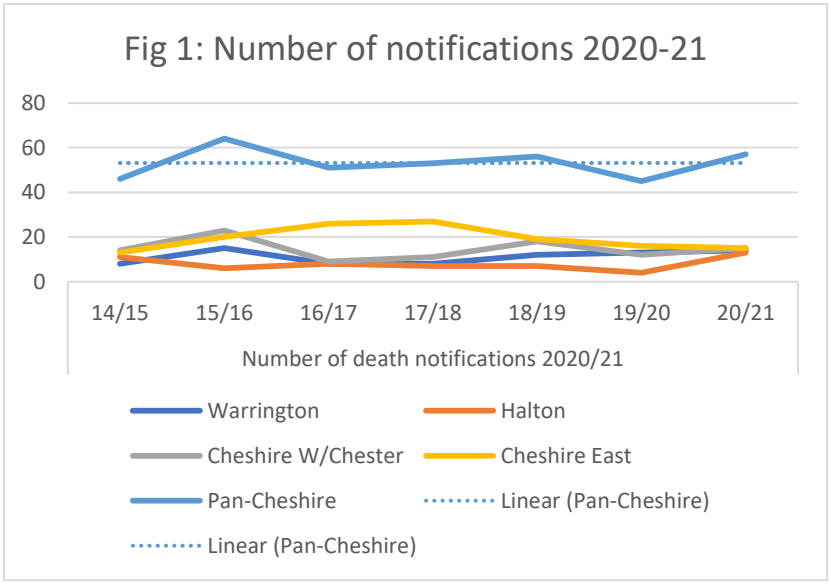
Data and Analysis

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.

This section differs from previous years in that the first part (a) describes Cheshire trends over several years, followed by (b) the narrative to accompany the National Child Mortality Database (NCMD) data contained in Appendix I, which is its first annual data output.

(a) Trends

When dealing with relatively small numbers, there can be wide fluctuations year on year. By considering numbers over time, one can look at trends in the figures.



Child death notifications over time

Encouragingly, Figure 1 shows a slight downward trend in child death notifications per year for Cheshire (see trend line). The mean average number of notifications over the last 5 years is 54.3, which is slightly below the recommended lower limit of 60 deaths per year by NHSE.

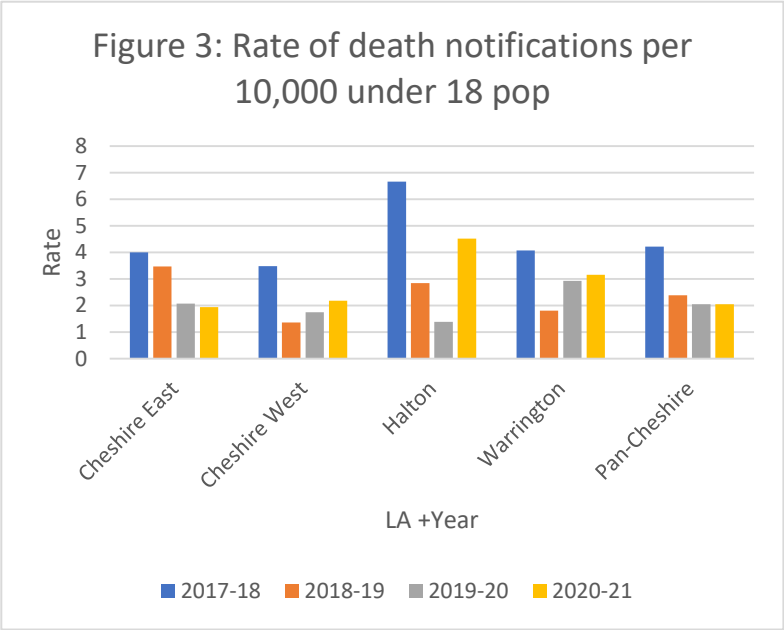
Child Population

The child population estimates in each of the four Local Authority areas are detailed in the following Figure 2.

Figure 2: Child Populations by local authority

LSCB area	Child population size* (0-17 years)
Cheshire East	77,290
Cheshire West & Chester	68,656
Halton	28,770
Warrington	44,391
Pan Cheshire	219,107

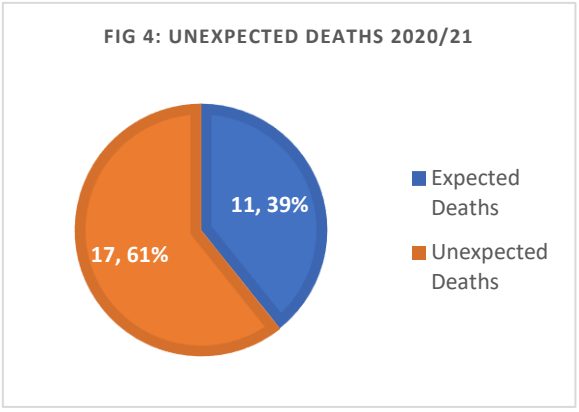
* Source: ONS mid-Year Population Estimates, 2019



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 3 shows the rate of deaths per 10,000 under 18 population over the last 4 years, and highlights a gradual reduction in the rate amongst all areas. The most current ONS Mid-year estimate was used for each year.

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.* During 2020/21, 17 (61%) deaths were classified as 'unexpected' (Fig 4).



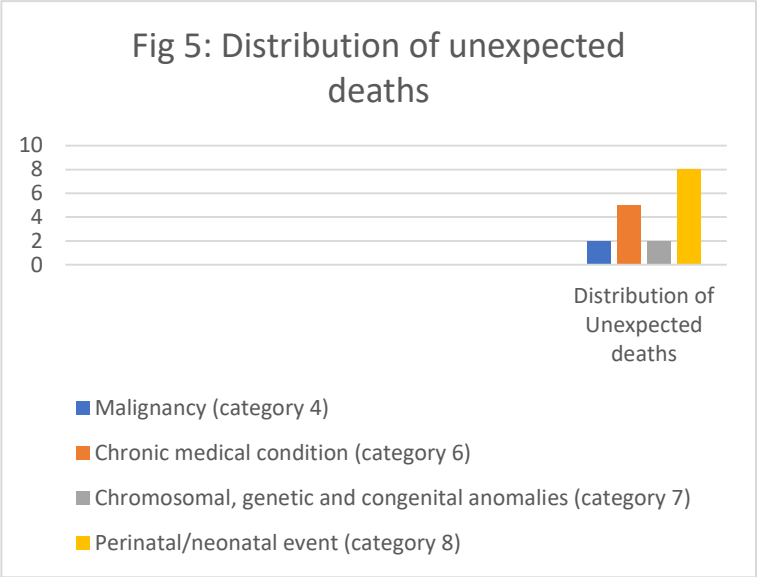


Fig 5 shows the distribution of unexpected deaths by category of death. The biggest proportion of the unexpected deaths occurred in the Perinatal/ neonatal category.

(b) National Child Mortality Database (NCMD) data (Appendix I)

The following narrative describes the various elements contained in Appendix I which is the first report from the NCMD.

Deaths and Case Completions (Table A; Tables 1-4 – Appendix I)

There was a total of 57 deaths notified during the last year, and 28 cases closed (completed by Pan-Cheshire CDOP). 60 deaths were registered with NCMD during the last delivery year, some outstanding from the previous year. At 31st March 2021, 60 cases were ongoing, **Table 2** highlighting the breakdown of closed and open cases by local authority area. The number of closed/ open cases by age group is covered in **Table 3** which broadly reflects the expected distribution of deaths by age, with the majority occurring under the age of one year old, which follows the national pattern. **Table 4** provides a breakdown of cases completed by local authority areas. The proportion of cases completed broadly follows the split of local authority under 18 populations.

Deaths by gender (Table 5)

From April 2020 – March 2021 of the 28 child deaths reviewed by the CDOP, 13 were male or 46% (49% previous year) and 15 or 54% were female (51% previous year).

Completed reviews by primary category of death and by age (Tables 6-7)

The majority of all deaths (54%) had a cause associated with chromosomal, genetic, congenital anomaly or as a result perinatal/neonatal event **(Table 6)**, and 64% of all deaths occurring under the age of one year **(Table 7).** There was 1 instance where death was attributed to deliberately inflicted injury, abuse or neglect.

Completed reviews by place of death and onset of illness/incident (Tables 8-9)

As one might expect, most deaths (82%) occur with a hospital **(Table 8)** and of those who died in hospital, 74% (17) died in the perinatal/neonatal/maternity/labour units. **Table 9** provides the breakdown of where the onset of illness or incident occurred.

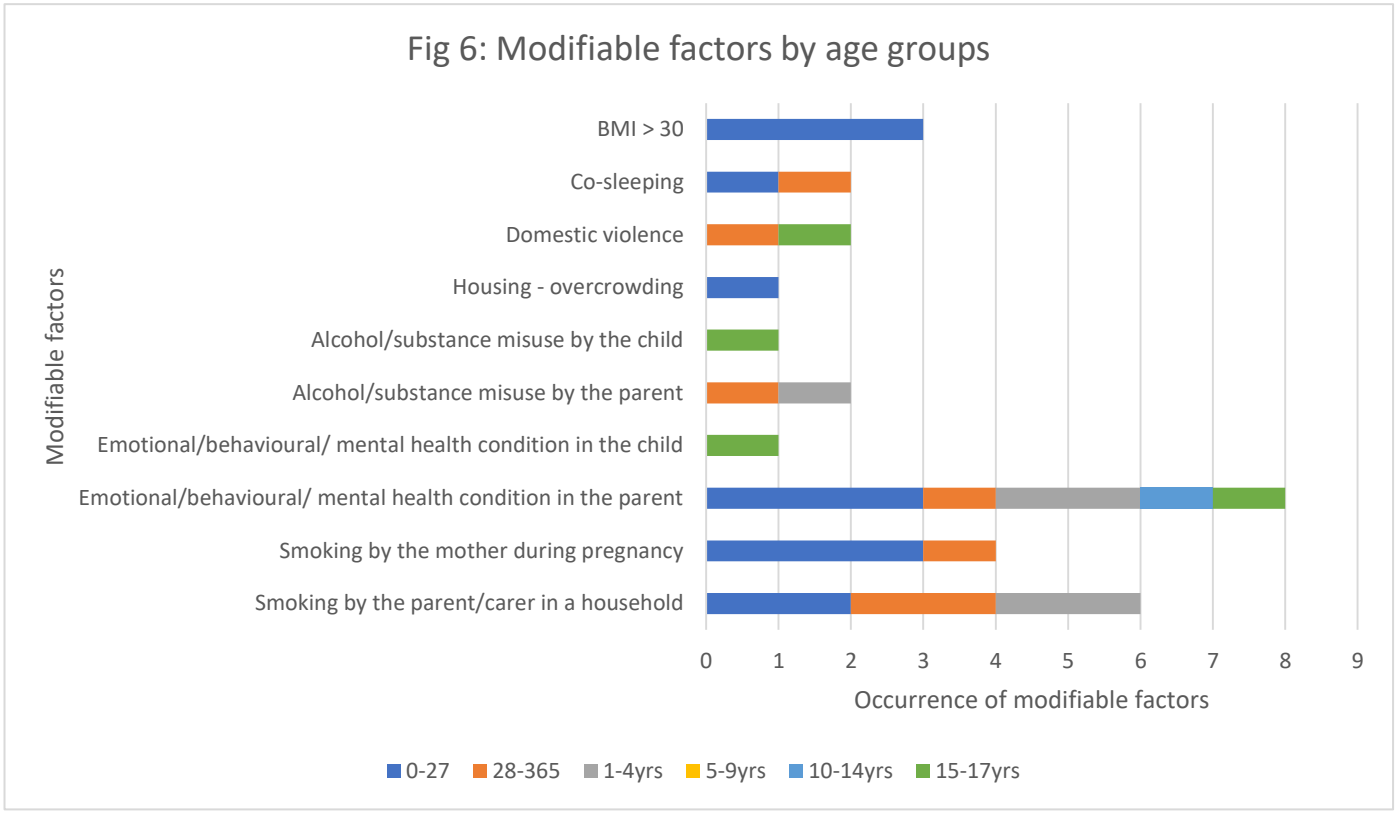
Ethnic groups and category of death (Tables 10-11)

90% (25) of those children who died where categorised as white **(Table 10). Table 11** shows the primary category of death by ethnicity. There are no specific patterns in relation to ethnicity, particularly having reviewed only 28 cases.

Deaths reviewed by CDOP with modifiable factors (Tables 12-15)

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*.

It can be seen that from **Table 12**, 50% of cases reviewed (14) had identifiable modifiable factors, which is higher than the national average of 34%. Of these (7), 58% were linked to deaths under one year of age **(Table 14).** For all categories except chromosomal, genetic and congenital anomalies;



chronic medical condition; infection; and malignancy, modifiable factors where identified in all cases reviewed **(Table 13)**.

Fig 6 gives a breakdown of the modifiable factors identified by age (in order of prevalence) [last year's %]:

- Mental health issues (parent or child) (32.1% of all deaths [17.8%])
- Alcohol / substance misuse (parent/child) (12.5% of all deaths [13.3%])
- Smoking by the mother/ parent/ or carer during pregnancy or in the first four years of a child's life 43.1% (44.4% of all deaths under one [19.2%])
- High maternal body mass index (BMI) (23% of all deaths under 28 days)
- Domestic Violence
- Unsafe sleeping
- Child Abuse or Neglect
- Housing overcrowding

- Failure by parents to access services when child had long term symptoms

The highest annual number of deaths occur neonatally (under 28 days), often as a result of complications through prematurity. Smoking, alcohol consumption, high maternal BMI, and domestic abuse all are known to 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.

Death notifications (Tables 16 – 20)

CDOP can be notified of the death of a child by any organisation or an individual. CDOP may receive several notifications for the same child, but where this occurs, it will be classified as a single notification. A breakdown of notifications by Local Authority area is provided in **Table 16** which broadly correlates to the relevant under 18 populations in each area.

Table 17 shows the number of Joint Agency Responses (JARs) undertaken. A JAR is a coordinated multi-agency response which is triggered if a child's death:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (including SUDI/C);
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural; or
- in the case of a stillbirth where no healthcare professional was in attendance.

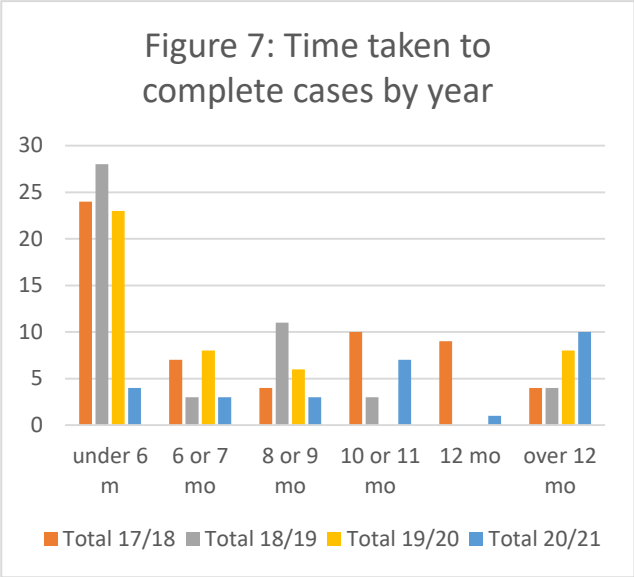
In Cheshire, 49% of death notifications did not indicate whether a JAR had been undertaken or not. This may partly be down to the person completing the form at the time, not knowing whether a JAR had been instigated, but this should be corrected further into the process once SUDC processes are activated. The reasons for this will be explored by CDOP Business group.

Table 18 shows death notifications by month/age, where it can be seen that the highest number of notifications occurred in August. This Table will become more useful when we can see trends from year to year and national comparisons. Notifications by age group feature in **Table 19** which clearly indicates that the majority of deaths occur in the first year of life (67%) compared to 65% nationally. 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). **Table 20** shows death notifications by place of death.

Data completeness- Notifications and Completed Reviews (Tables 21-24)

The NCMD Report is a national repository for data from all CDOPs across England, and consequently provided an opportunity to provide comparative data. Clearly, there will be longer term benefits each year new data is gathered. In the first report, there has been an attempt to established national standards for completion of certain information. Reliable comparisons can only be made if all CDOPs collect and provide the same information. **Tables 21, 22 and 23** highlight that in the first year of collecting information, Pan-Cheshire CDOP has under-reported on :

- ✓ Joint Agency Responses (mentioned above)
- ✓ Cases discussed with the medical examiner (relatively new role).



Pan-Cheshire CDOP tends to take marginally less time to bring cases to panel from initial notification compared to national figures (315 days compared to 333 **Table 25).** (Figure 7 provides a breakdown of the time taken to complete the reviews over the last 4 years. It shows that during 2020-21, only 14% of reviews were completed within 6 months compared to 51% the previous year, and 36% took more than 12 months to review, compared to 18% in the previous year. Some of these delays have been as a result of delays from the North West Neonatal Operational Delivery Network (NWNODN) reviews, which has also been impacted by the Covid 19 pandemic.

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

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 Barber who ensures the panel runs smoothly.

Mike Leaf
Independent CDOP Chair
Autumn 2021

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 I

NCMD
National Child Mortality Database

NCMD Monitoring Report for CDOPs

Pan Cheshire CDOP

Report created on: 12/05/2021

Quarter 4 2020/21

This report contains confidential information which is intended for use by the CDOP named above for monitoring and data quality purposes. **This report must not be shared with anyone who does not have a role within the CDOP**. All data presented within this report is unvalidated and therefore should be interpreted with caution. Only data which has been submitted to NCMD is included within this report and therefore may not be representative of all child deaths within the area.

Produced by National Child Mortality Database Programme Team. If you have any queries please contact ncmd-programme@bristol.ac.uk

1

Overview

Data on this page relates to deaths after 01/04/20 or where CDOP review was outstanding at 01/04/20, up to and including 31st March 2021

NCMD
National Child Mortality Database

Number of cases reviewed 20/21:	Total cases with review ongoing:
28	60

Number of deaths during 20/21:
57

Table A

Number of ongoing cases entered by LSCB

LSCB name	Cases
Cheshire East	15
Chester and Cheshire West	19
Halton	14
Warrington	12
Total	**60**

Table 2

Number of ongoing cases by year of death and status of case

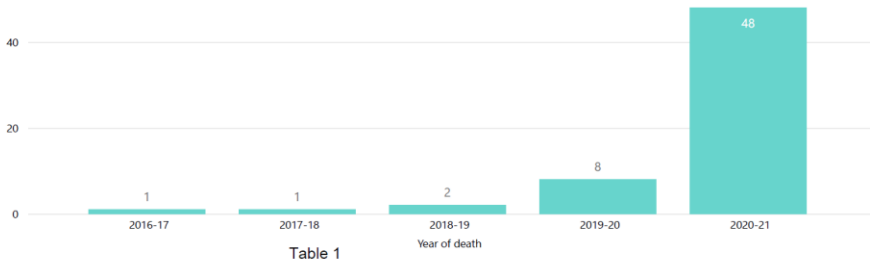


Table 1

Number of ongoing cases by age group and status of case

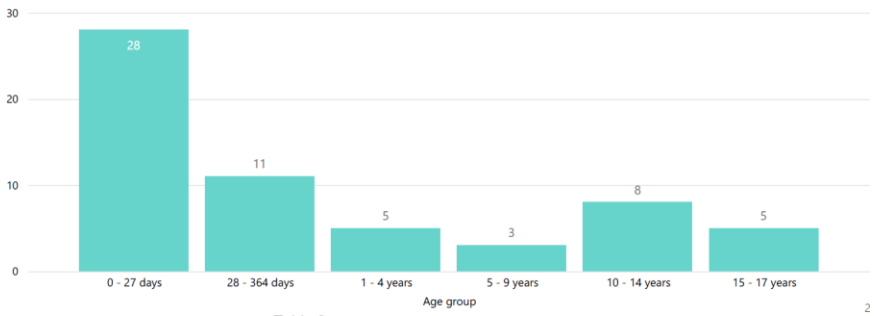


Table 3

Pan Cheshire

2

Completed Reviews - Overview 1

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2020 and 31st March 2021

NCMD National Child Mortality Database

Number of cases reviewed 20/21:

28

Completed CDOP Reviews by LSCB

LSCB name	Cases
Cheshire East	10
Chester and Cheshire West	6
Halton	1
Warrington	11
Total	**28**

Completed CDOP Reviews by year of death

Year of death	Cases
2018-19	5
2019-20	14
2020-21	9
Total	**28**

Table 4

Completed CDOP reviews by gender

Table 5

Completed CDOP reviews by primary category of death

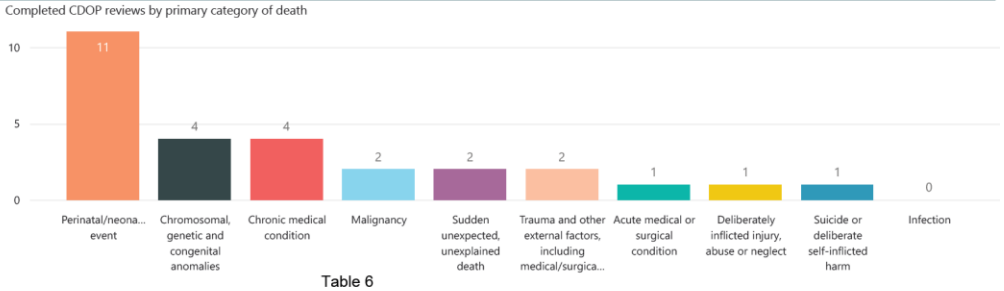


Table 6

Completed CDOP reviews by age group

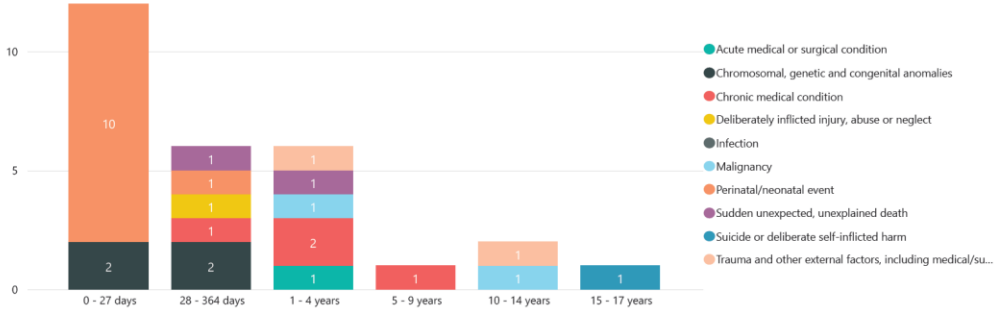


Table 7

Completed Reviews - Overview 2

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2020 and 31st March 2021

NCMD National Child Mortality Database

Number of cases reviewed 20/21:

28

Completed CDOP reviews by place of onset of illness/incident

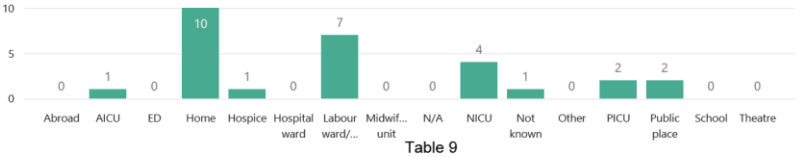


Table 9

Completed CDOP reviews by place of death

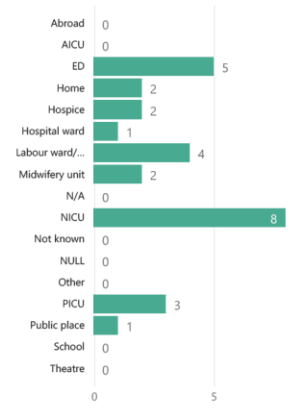


Table 8

Completed CDOP reviews by ethnic group and age group

Ethnic Group	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	Total
White	12	5	5	1	2	0	25
Unknown	0	1	0	0	0	0	1
Other	0	0	1	0	0	0	1
Mixed	0	0	0	0	0	0	0
Black or Black British	0	0	0	0	0	0	0
Asian or Asian British	0	0	0	0	0	1	1
Total	**12**	**6**	**6**	**1**	**2**	**1**	**28**

Table 10

Completed CDOP reviews by ethnic group and primary category of death

Ethnic Group	Acute medical or surgical condition	Chromosomal, genetic and congenital anomalies	Chronic medical condition	Deliberately inflicted injury, abuse or neglect	Infection	Malignancy	Perinatal/neonatal event	Sudden unexpected, unexplained death	Suicide or deliberate self-inflicted harm	Trauma and other external factors, including medical/surgical complications/error	Total
White	1	4	2	1	0	2	11	2	0	2	25
Unknown	0	0	1	0	0	0	0	0	0	0	1
Other	0	0	1	0	0	0	0	0	0	0	1
Mixed	0	0	0	0	0	0	0	0	0	0	0
Black or Black British	0	0	0	0	0	0	0	0	0	0	0
Asian or Asian British	0	0	0	0	0	0	0	0	1	0	1
Total	**1**	**4**	**4**	**1**	**0**	**2**	**11**	**2**	**1**	**2**	**28**

Table 11

Completed Reviews - Modifiable Factors

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2020 and 31st March 2021

NCMD National Child Mortality Database

Number of cases reviewed 20/21: **28**

% cases with modifiable factors (CDOP):	% cases with modifiable factors (England):
50%	34%

Were any modifiable factors identified?

Table 12

% of cases where modifiable factors were identified by age group

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	12	7	58%
28 - 364 days	6	2	33%
1 - 4 years	6	3	50%
5 - 9 years	1	0	0%
10 - 14 years	2	1	50%
15 - 17 years	1	1	100%
Total	**28**	**14**	**50%**

Table 14

% of cases where modifiable factors were identified by category of death

Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Acute medical or surgical condition	1	1	100%
Chromosomal, genetic and congenital anomalies	4	0	0%
Chronic medical condition	4	0	0%
Deliberately inflicted injury, abuse or neglect	1	1	100%
Infection	0	0	0%
Malignancy	2	0	0%
Perinatal/neonatal event	11	8	73%
Sudden unexpected, unexplained death	2	1	50%
Suicide or deliberate self-inflicted harm	1	1	100%
Trauma and other external factors, including medical/surgical complications/error	2	2	100%
Total	**28**	**14**	**50%**

Table 13

% of cases where modifiable factors were identified by ethnic group

Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Asian or Asian British	1	1	100%
Black or Black British	0	0	0%
Mixed	0	0	0%
Other	1	0	0%
Unknown	1	0	0%
White	25	13	52%
Total	**28**	**14**	**50%**

Table 15

Notifications during 2020/21

Data on this page relates to cases with a date of death between 1st April 2020 and 31st March 2021

NCMD National Child Mortality Database

Number of deaths during 20/21: **57**

Death notifications by month

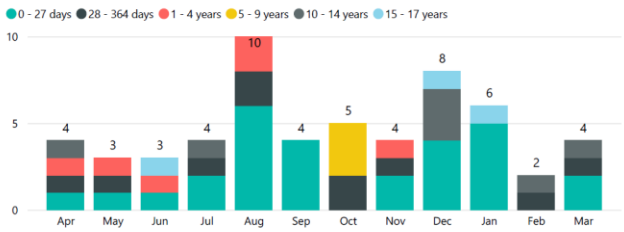


Table 18

Death notifications by place of death

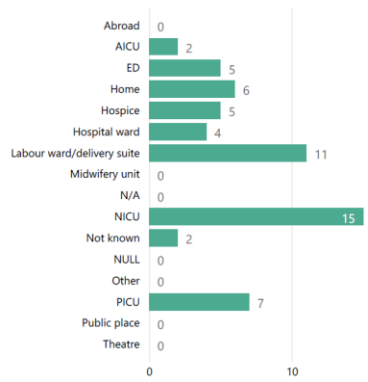


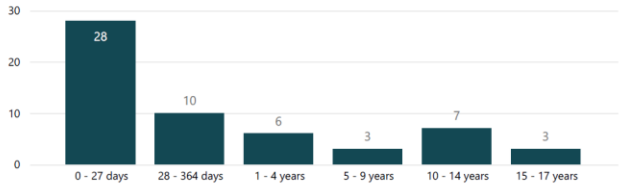
Table 20

Death notifications by LSCB

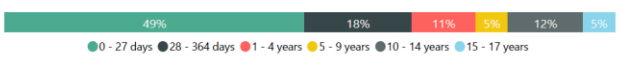
LSCB name	Cases
Cheshire East	15
Chester and Cheshire West	15
Halton	13
Warrington	14
Total	**57**

Table 16

Death notifications by age group



% of death notifications by age group - CDOP



% of death notifications by age group - National (England)

Table 19

Is there to be a Joint Agency Response?

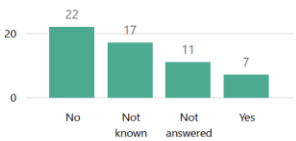


Table 17

Notification fields - % completion of fields (2020/21 notifications)

CDOP Name	Cases	NHS No	DoD	Gender	Postcode	Suspected CoD	Place of Death	Hospital specified^	Joint agency response	Notification Details	Ethnicity
Pan Cheshire	57	98%	100%	100%	93%	100%	100%	100%	81%	100%	100%

Table 21

Notification fields - % completion of fields

CDOP Name	Cases	NHS No	DoD	Gender	Postcode	Suspected CoD	Place of Death	Hospital specified^	Joint agency response	Notification Details	Investigated by Coroner	Discussed with medical examiner	Post Mortem
Pan Cheshire	28	100%	100%	100%	96%	100%	100%	100%	61%	100%	93%	61%	100%

Table 22

Reporting fields - % completion of fields

CDOP Name	Cases	Events occurred selection	Ethnicity	Circumstances of Death	Where at onset of illness	Formal serious investigation	Known to social care*	Subject to SCR
Pan Cheshire	28	100%	100%	100%	100%	93%	96%	100%

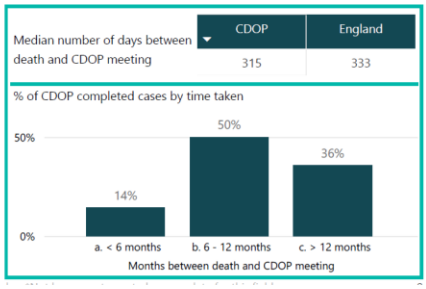
Table 23

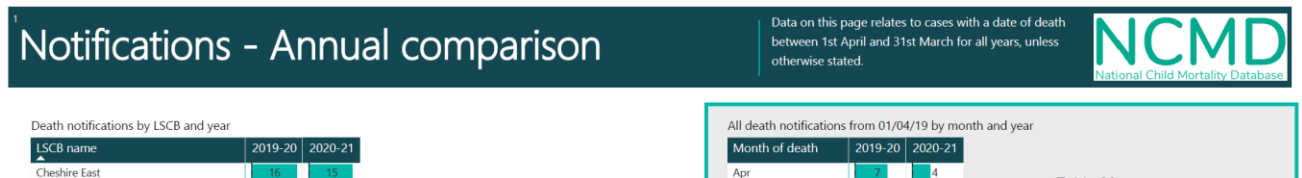
Analysis fields - % completion of fields

CDOP Name	Cases	CDOP category of death	CDOP meeting date	Cause of death	Domain factors recorded (at least 1)	Modifiable factors selection	Learning points text	Actions text
Pan Cheshire	28	100%	100%	100%	100%	100%	100%	100%

Table 24

Table 25





Death notifications by LSCB and year

LSCB name	2019-20	2020-21
Cheshire East	16	15
Chester and Cheshire West	11	15
Halton	4	13
Warrington	14	14
Total	**45**	**57**

Table 26

Death notifications by age group and year

Age group	2019-20	2020-21
0 - 27 days	19	28
28 - 364 days	10	10
1 - 4 years	5	6
5 - 9 years	3	3
10 - 14 years	5	7
15 - 17 years	3	3
Total	**45**	**57**

Table 27

All death notifications from 01/04/19 by month and year

Month of death	2019-20	2020-21
Apr	7	4
May	6	3
Jun	3	3
Jul	3	4
Aug	7	10
Sep	3	4
Oct	6	5
Nov	2	4
Dec	5	8
Jan	1	6
Feb		2
Mar	2	4
Total	**45**	**57**

Table 28

Appendix II: 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).	☐