Child Death Overview Panel Annual Report

2023-2024

North Yorkshire
Safeguarding Children Partnership

City of York
Safeguarding Children Partnership

Child Death Overview Panel Annual Report 2023-2024

Foreword

As chair of the Child Death Overview Panel, I would like to take this opportunity to focus on the professionals who make up the panel. The expertise provided by panel members facilitates open discussion and detailed analysis. It is only through their continued commitment in coming together with care, diligence and respect for our children that we are able to raise awareness of issues which can be mitigated and contribute to keeping children safe and as well as possible.

This commitment means that during this year we have been able to form a dedicated sub-group which will lead on communication campaigns agreed by the panel. Over the coming year we will continue to formulate and produce materials to help people understand the importance of children and young people being visible to road users and traveling safely especially during the winter months. We will also be highlighting the need to have an adult who is responsible for children and young people which may mean a designated person who abstains from alcohol at family gatherings such as BBQs and family occasions.

Our deepest condolences are always with those families who are bereaved.

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

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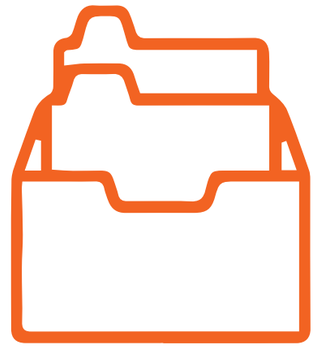


Introduction

One of the most devastating things for a family to experience is the death of a child and it is recognised that this will have a profound and long-lasting impact on everyone involved in that child's life. All deaths of children up to the age of 18 years, excluding stillbirths and planned terminations, have been reviewed by the Child Death Overview Panel (CDOP) since April 2008. The Child Death Review process is undertaken in accordance with national guidance and statutory guidance set out in Working Together to Safeguard Children 2023.The Child Death Review Statutory and Operational Guidance 2018 builds on the requirements set out in Chapter 6 of Working Together to Safeguard Children 2023.

The purpose of the Child Death Review Process is to try to ascertain the cause of a child death's and put in place interventions to protect other children and prevent future deaths wherever possible. The process intends to;

- Document, analyse and review information in relation to each child that dies to confirm the cause of death, determine any contributing factors and to identify learning arising from the process that may prevent future child deaths
- To make recommendations to all relevant organisations where actions have been identified which may prevent future deaths or promote the health, safety and wellbeing of children
- To produce an annual report highlighting 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.

Child Death Review partners, the Local Authorities and Integrated Care Boards for North Yorkshire and City of York have a responsibility to undertake the Child Death Review Process as set out in the Children Act 2004, and as amended by the Children and Social Work Act 2017.

The CDOP is multi-agency with differing areas of professional expertise with the child death review process being undertaken locally for all children who are normally resident within North Yorkshire and City of York.

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

- Directors of Children and Young People's Services (NYC and CYC)
- Chief Nurses for the Integrated Care Board (Humber and North Yorkshire ICB)
- Designated Doctor for Child Death (Humber and North Yorkshire ICB)
- Child Death Overview Panel Chair (CYC Public Health)
- Child Death Overview Panel Vice-Chair (NYC Public Health)
- Partnership Business Unit Managers (NYSCP and CYSCP)
- Child Death Review Officer (NYSCP)

The collation and sharing of all learning from Child Death Reviews and the CDOP is managed by the National Child Mortality Database (NCMD) which has been operational since 1st April 2019. The NCMD gathers information on all children who die across England with the aim to learn lessons to reduce child mortality.

Child Death Overview Panel (CDOP)

The Child Death Overview Panel has a statutory requirement to review all deaths of children normally resident in the local area and of any non-resident children who have died in their area.

Membership and Panel Meetings

The Child Death Overview Panel meetings are held on a bi-monthly basis, the membership can be seen below:

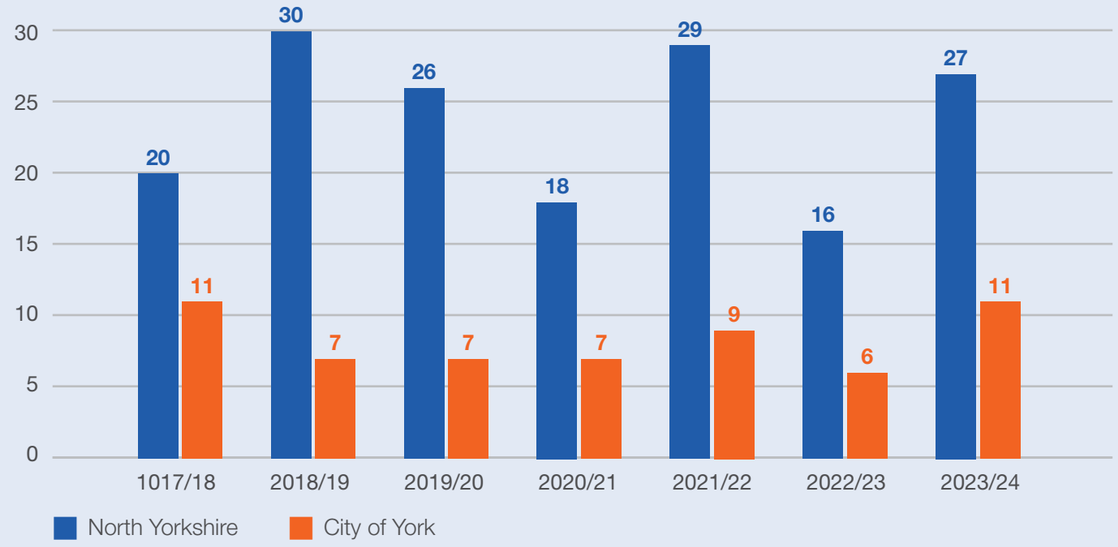
Member	Role and Organisation
Anita Dobson	Nurse Consultant in Public Health, City of York Council
Dr Gill Kelly	Public Health Consultant, North Yorkshire Council
Jemma Cormack	NYP Safeguarding Manager
Dave Ellis	Detective Inspector, North Yorkshire Police
Dr Sally Smith	Designated Doctor for Child Death
Dr Natalie Lyth	Designated Doctor for Safeguarding Children & Children in Care, North Yorkshire & Humber ICB (York & North Yorkshire Place)
Dr Sarah Snowden	Designated Doctor for Safeguarding Children & Children in Care, North Yorkshire & Humber ICB (York & North Yorkshire Place)
Hannah Ellingworth	NYSCP Manager
Sophia Lenton-Brook	CYSCP Manager
Dallas Frank	Head of Safeguarding, Children's Social Care
Sarah Howarth	Team Manager, Children's Social Care
Rosie Conlin	Named Nurse, Child Protection, North Yorkshire, HDFT
Helen Pulleyn	Named Nurse for Safeguarding, YSTHFT
Andrea Pitman	Healthy Child Team Service Manager, CYC
Leanne Likaj	Head of Midwifery, HDFT
Sascha Wells-Munro	Head of Midwifery, YSTHFT
Alison Brunton	Child Death Review Officer

Data Analysis 2023 - 2024

A total number of 38 children and young people residing in North Yorkshire and City of York died between 1 April 2023 and 31 March 2024.

Total Child Deaths

Table 1: Child Deaths in North Yorkshire and City of York 2017 - 2024



Age of Child Deaths

Table 2: Age of Child Deaths in North Yorkshire and City of York 2023 - 2024

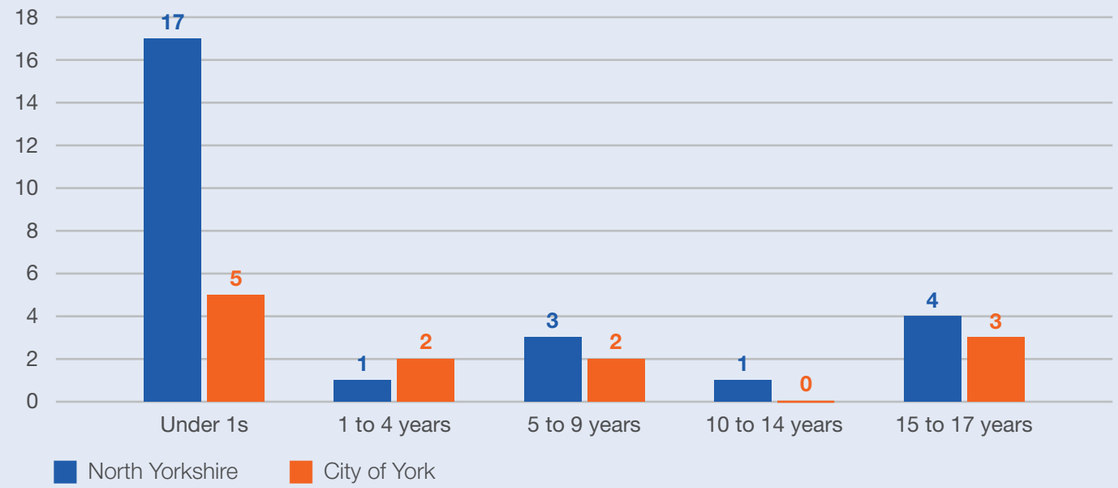


Table 2 summarises the age of North Yorkshire and City of York children at death over the last year.

The highest number of child deaths consistently relates to children under 1 year of age. In 2023/2024, 58% of child deaths related to children in this age range compared to 68% in the previous year.

Child deaths fall under one of two categories:

- **Expected Death:** A child death is an "expected" death when the death of an infant or child was anticipated, such as for children born with life-limiting conditions.
- **Unexpected Death:** An unexpected death is defined as a death that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death.

Expected and Unexpected Child Deaths

Table 3:

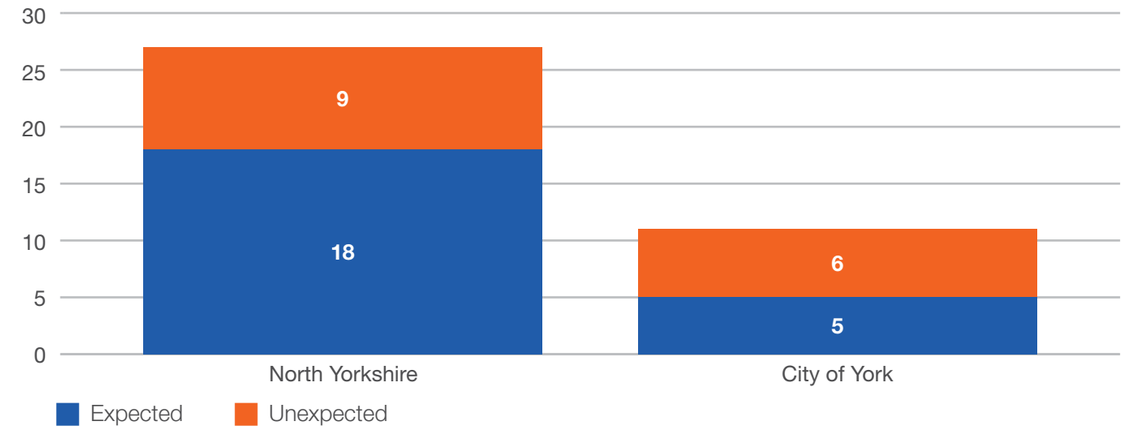


Table 3 shows the number of expected and unexpected deaths between 1st April 2023 and 31st March 2024.

Child Deaths by Gender

Nationally the mortality rate for males is higher than females and the deaths reported to this CDOP for 2023-2024 reflect this national picture.

Table 4:

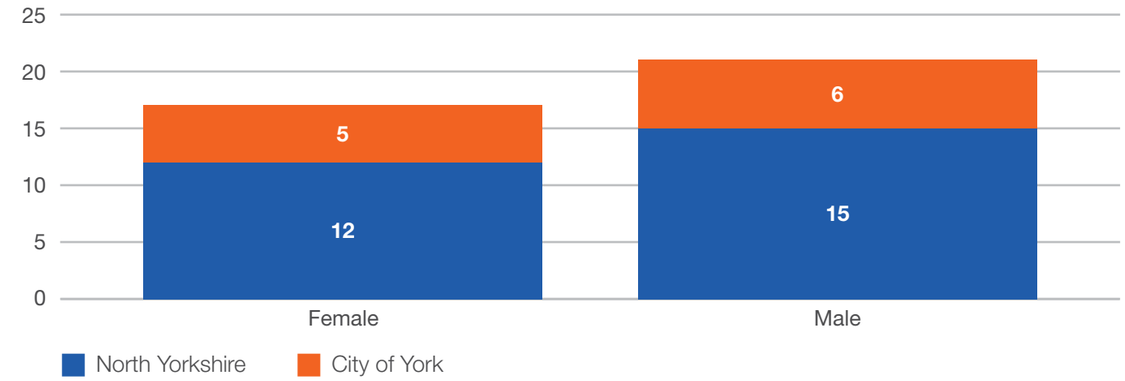


Table 4 provides the breakdown of the number of child deaths by gender

Ethnicity

Of the 38 child deaths notified to this CDOP between 1st April 2023 and 31st March 2024, 35 were classified as “White British”, 1 “Asian British” and 2 were recorded as “Other” which reflects the demographics of North Yorkshire and the City of York.

Disabled children

Prior to 1st July 2023, there was no longer a requirement for deaths of children with a learning disability to be notified to Learning Disabilities Mortality Review Programme (LeDeR) as all details relating to learning disabilities are collected via the NCMD notification forms.

Child Death Processes

The notification of a child’s death is received by the Child Death Review Officer who will ensure all relevant agencies complete a reporting form. This form captures all the relevant information about the child and family to inform the child death overview process. In addition to the reporting form there are a number of supplementary forms which the Child Death Review Officer uses to collect information from relevant professionals. All this information is collated for review by the CDOP and is shared with the NCMD.

The Coroner is responsible for determining the cause of death and carrying out a post-mortem examination where appropriate. Where the post-mortem examination is not able to identify cause, or the death is found to be unnatural, the Coroner will hold an inquest to examine any relevant factors in order to provide details on the cause of death.

Categories of Child Deaths

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

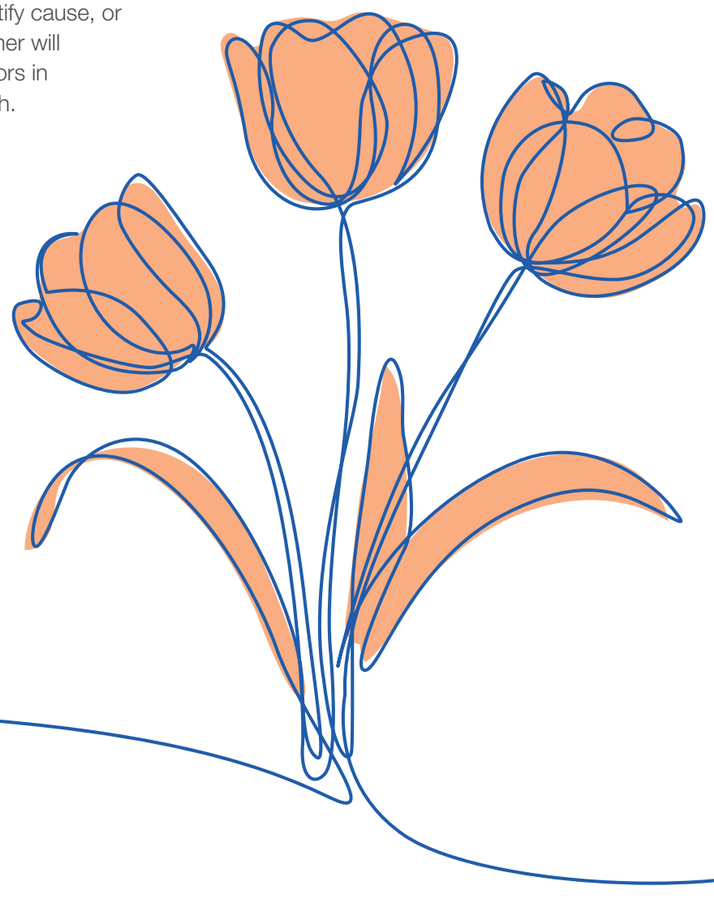


Table 5

Table 5 details the category of child deaths in North Yorkshire and York from 2017 to 2024.

	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	2021/ 2022	2022/ 2023	2023/ 2024	Total
1. Deliberately inflicted injury, abuse or neglect - This includes numerous physical injuries, which may be related to homicide as well as deaths from war, terrorism or other mass violence. It also includes severe neglect leading to death.	0	0	0	0	0	0	0	**0**
2. Suicide or deliberate self-inflicted harm - This includes any act intentionally to cause one’s own death. It will usually apply to adolescents rather than younger children.	2	1	7	2	1	1	2	**16**
3. Trauma and other external factors - This relates to unintentional physical injuries caused by external factors. It does not include any deliberately inflicted injury, abuse or neglect**.**	3	3	4	1	1	1	3	**16**
4. Malignancy - This includes cancer and cancer like conditions such as solid tumours, leukaemia & lymphomas, and other malignant proliferative conditions, even if the final event leading to death was infection, haemorrhage etc.	4	3	6	5	5	5	1	**29**
5. Acute medical or surgical condition - A brief sudden onset of illness which resulted in the death of a child.	6	2	2	2	3	0	1	**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	1	0	2	0	0	0	**5**
7. Chromosomal, genetic and congenital anomalies – Medical conditions resulting from anomalies in genes or chromosomes as well as a defect that is present at birth.	3	6	6	6	7	1	3	**32**
8. Perinatal/neonatal event – The death of child as a result of extreme prematurity, adverse outcomes of the birthing process, intrauterine procedure or within the first four weeks of life.	8	6	9	7	10	11	4	**55**
9. Infection – This can be any primary infection (i.e., not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby.	1	1	4	3	0	2	1	**12**
10. Sudden unexpected or unexplained death – This is where pathological diagnosis is either Sudden Infant Death Syndrome (SIDS) or ‘unascertained’, at any age**.**	0	1	2	3	2	4	0	**12**
Total number of child deaths reviewed by CDOP	**29**	**24**	**39**	**31**	**29**	**25**	**15**	**192**

192 child deaths have been reviewed by the panel over the past 6 years. The majority of child deaths in 2023/2024 occurred as the result of a perinatal or neonatal event, with the next two most common categories being recorded as chromosomal, genetic and congenital anomalies and trauma and external factors. Of these cases, some occurred in the previous years as cases can take over six months to be brought to panel for review. This can 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 inquiry. It should be noted that a child’s death cannot be discussed at panel until all information is received.

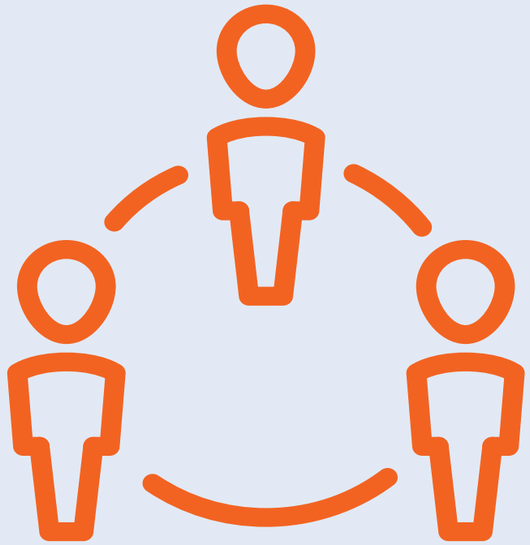
Joint Agency Response Meeting

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

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

The Key Worker should:

- Be a reliable and readily accessible point of contact for the family after the death
- Help co-ordinate meetings between the family and professionals as required
- Be able to provide information on the Child Death Review process and the course of any investigations pertaining to the child
- Liaise as required with the Coroner's office and Police Family Liaison Officer (if involved)
- Represent the 'voice' of the parents at professional meetings, ensuring their questions are effectively addressed, and providing feedback to the family afterwards
- Signpost to expert bereavement support if required.



Child Death Review Meeting

Both expected and unexpected child deaths are required to have a Child Death Review Meeting (CDRM.) This is a multi-agency meeting where all matters relating to an individual child are discussed by professionals directly involved in the care of that child during their life. A CDRM typically occurs three months or more following the death of a child. The draft analysis form is completed within this meeting which is then presented to and confirmed when the child is reviewed by the child death overview panel.

Child Death Overview Panel

The purpose of the panel is to consider any learning or factors that could prevent future deaths of children.

CDOP review child deaths at the end of the statutory processes and a child's death cannot be discussed until all relevant information pertaining to the death is obtained. During 2023/2024, the panel has reviewed a total of 15 children.

Learning and Modifiable Factors

Of the **15** child deaths **reviewed** in 2023/2024 Child Death Overview Panel (CDOP) identified **2** instances where modifiable factors were present.

Modifiable factors are defined as 'those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced'. When the panel reviews the death of a child, they identify and agree if there are any modifiable factors that may have prevented the death and what actions are required as a result. All actions are monitored through the Child Death Overview Panel (CDOP) governance processes via an action log.

The Child Death Overview Panel (CDOP) process seeks to identify learning from all child deaths to identify common themes, ways of working and strategies to minimise the risk of future deaths. The Child Death Overview Panel (CDOP) will identify modifiable factors which, had they been in place, may have prevented the death of a child.

Training

The Designated Doctor for Child Death and the Child Death Review Officer delivered the "Child Death Review: Advanced Training for Professionals" across North Yorkshire and City of York in 2023/2024 with a range of multi-agency professionals totalling 43 delegates attending over three sessions.

The Child Death Review Officer and North Yorkshire Children's Partnership (NYSCP) Manager regularly engage in the NCMD Webinars which are designed to provide detailed updates on the NCMD, discuss emerging issues and obtain information around the latest events in the Child Death Review sector. Information from these events is shared with North Yorkshire and City of York's Child Death Review Partners on a regular basis.

What has CDOP achieved over 2023/2024

Between 2017 and 2022, North Yorkshire Council (NYC) and City of York Council (COY) recorded 10 babies who had died with a reported cause of death as SUDI. In March 2021 a paper was presented to NYSCP Executive highlighting the need for a partnership response to reducing the risks of SUDI, with a particular focus on supporting families with additional vulnerabilities. This paper was in response to findings from a report published by the Safeguarding Children Practice Review Panel in July 2020 and learning arising from a number of North Yorkshire and York cases where there had been the unexpected death of an infant in families with existing safeguarding vulnerabilities.

The partnerships agreed to adopt a "Prevent and Protect Model" of SUDI Risk Minimisation. This model was subsequently named the 'Day or Night, Sleep Right' campaign and aimed to look at SUDI risk minimisation through a safeguarding lens, focusing on supporting professionals from all relevant agencies to feel competent and confident to work with families to promote safe sleep practice. In addition to an extensive program of single agency training, multi-agency training is available to practitioners. A multiagency masterclass was developed which has now had 446 views on the NYSCP YouTube channel and SUDI podcast has been listened to 76 times.

The Day or Night, Sleep Right work is ongoing with the aim of establishing safe sleep as a fundamental aspect of multiagency work. As a result of this work North Yorkshire Children and Young People's Independent Reviewing Officers have committed to ask questions to understand where babies will be sleeping to ensure this is a multi-agency conversation that takes place.

The campaign has been recognised by researchers at Durham University (Durham Infancy and Sleep Centre) as one of very few multiagency SUDI risk minimisation programmes across the Country.

The North Yorkshire Safeguarding Children Partnership on 1st April 2024 launched #Ask Me Campaign which is aimed at professionals across North Yorkshire. This campaign is encouraging conversations with new and expectant parents which encompass safe sleep and are linked to the Day and Night Sleep Right campaign.

The key messages are derived from a series of common things that are often a concern to new parents. The campaign was borne out of learning from a thematic review undertaken by NYSCP that considered three similar cases of non-accidental injury to non-mobile infants. As part of the campaign planning, the NYSCP was able to link in with parents who had tragically suffered the death of their child due to SUDI. The parents bravely shared their experiences with the partnership, explaining that they hoped their involvement might support others and their views were then incorporated into the #AskMe conversation prompts. The NYSCP would like to sincerely thank both parents for their courage and determination in sharing their insights in order to develop future safeguarding practice.

The campaign is based around the consolidation of key resources for partners that are easily accessible on one page on the NYSCP website, alongside a series of conversation prompts (#AskMe) to build confidence and raise awareness of the need to ask parents about how they are feeling around aspects of caring for their baby in those crucial first few months of life. The resources and conversation starters cover such topics as:

- Safe sleep
- Safe feeding
- ICON (Babies cry you can cope)
- Parental mental health

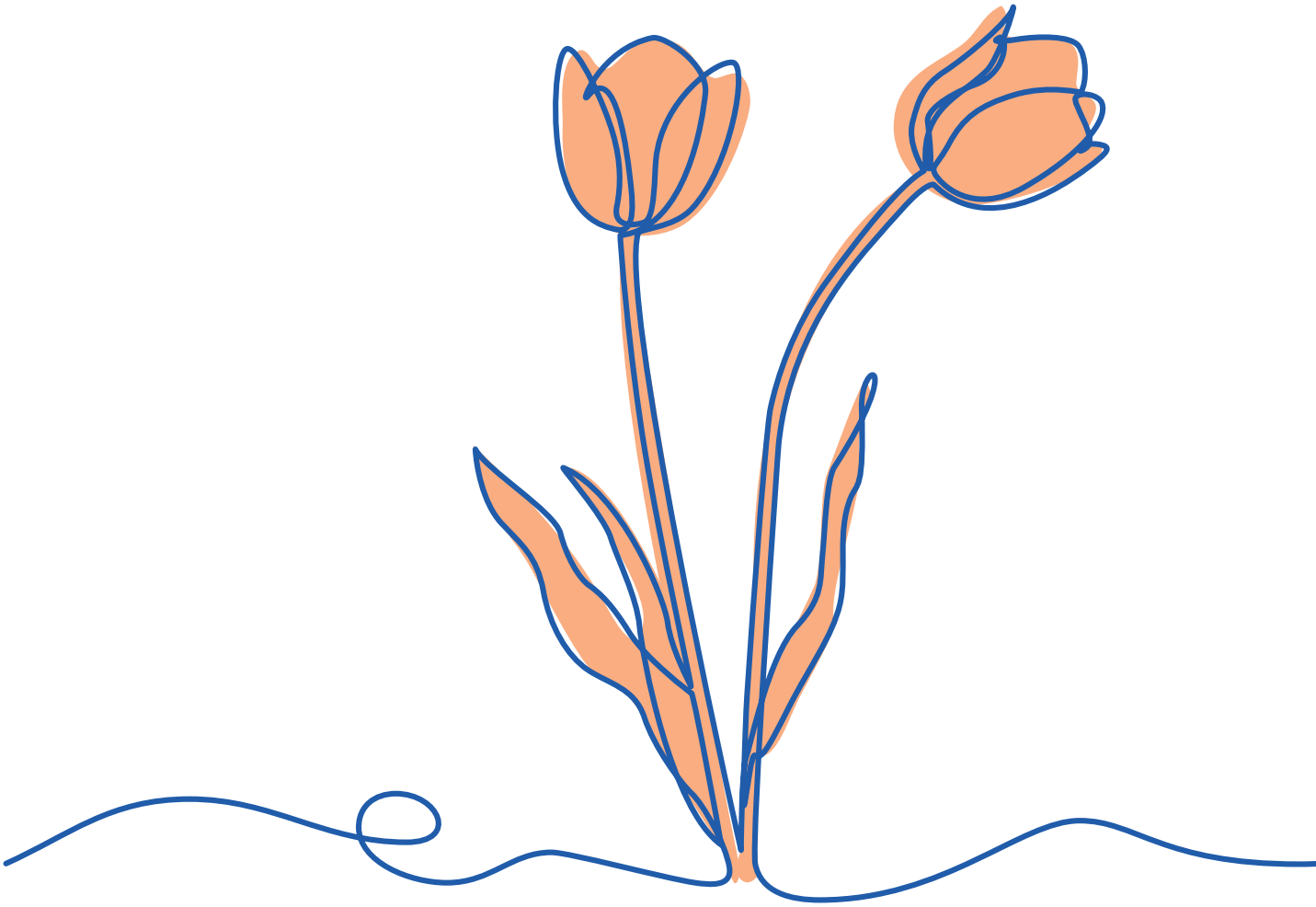
The campaign was launched with a social media presence throughout March and April with a post reach of over 3500 and a masterclass delivered by the two designated safeguarding nurses, highlighting learning from recent thematic reviews that have led to the production of the campaign. The session was attended by 100 partners with positive feedback of the value of the campaign received.

"It was good to see ideas and resources to help address issues, often we hear about the issues but with little content to help address them."

CDOP Priorities 2024/2025

1 “Who’s Sober” The CDOP is working with COY Comms and Engagement teams to develop and promote this campaign, aimed at new parents and encouraging families to develop their own solutions when caring for new babies and young children.

2 The CDOP is working with the Comms and Engagement teams regarding a campaign for Road Safety across North Yorkshire and York and will focus on how children, young people and their families can be safe on North Yorkshire and York roads throughout the year. This campaign will engage with schools across the county to ensure there is helpful educative work done with children and young people, particularly those children transitioning from primary to secondary schools.



Contact us

Online: **safeguardingchildren.co.uk/professionals/cdop**
By telephone: Child Death Review Officer **01609 532624** or the NYSCP **01609 535123**
By email: **cdop@northyorks.gov.uk**

North Yorkshire and City of York CDOP, County Hall, Northallerton, North Yorkshire, DL7 8AD

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