Hull City Council

NHS Hull Clinical Commissioning Group

CHILD DEATH OVERVIEW PANEL

Annual Report 2020/21 (for publication)

CONTENTS

1. Introduction Page 2
    - 1.1 Local arrangements
    - 1.2 The purpose of the child death review process
    - 1.3 Process flowchart and review meetings
    - 1.4 Implementation of statutory guidance and governance

2. Hull population Page 9

3. CDOP facts and figures for 2020/21: Page 11
    - 3.1 Notifications
    - 3.2 Comparison with previous years
    - 3.3 Deprivation

4. Reviews Page 16
    - 4.1 Ongoing reviews
    - 4.2 Modifiable factors

5. Learning from child death reviews - CDOP impact 2020/21 Page 20

6. FOCUS on Safer Sleeping Page 23
    - 6.1 Background
    - 6.2 CDOP role and learning
    - 6.3 Local services and initiatives
    - 6.4 Next steps

7. Child death and links with deprivation Page 28

8. Other child death review updates Page 29
    - Training, CDOP e-bulletin, eCDOP, National Child Mortality Database

-

9. Recommendations Page 31
    - 9.1 Recommendations from 2019/20 annual report
    - 9.2 Recommendations for 2021/22

1. INTRODUCTION

1.1 Local arrangements

Clinical Commissioning Groups (CCG) and Local Authorities are required to establish Child Death Review Arrangements in order to meet the statutory obligations of the Children Act 2004 and ensure the requirements of the Child Death Review: statutory and operational guidance (2018) are fulfilled.

The geographical footprint for the Hull Child Death Review arrangements is the City of Hull local authority area. This footprint corresponds with that of NHS Hull Commissioning Groups' footprint. The partners in Hull are Hull City Council and NHS Hull Clinical Commissioning Group.

The Hull Child Death Review arrangements will:

- Ensure an appropriate review of the deaths of all Hull resident children (up to and including those aged 17), and babies born to Hull resident mothers, is undertaken whether the child dies in Hull or outside the area.
- Consider the deaths of non-Hull resident children where learning for Hull services may be identified.
- Support and contribute to the learning through Child Death Review processes in other localities where Hull resident children have died, and there may be learning in those external areas. The Lead Health Professionals and the Designated Doctor for Child Deaths will support discussions in relation to the most suitable locality to lead the review
- Align with and complement review processes across the wider footprint of the Humber Coast and Vale Integrated Care System (HCV ICS)

This report is to update child death review partners on local patterns and trends in child deaths, lessons learnt and actions taken, and the effectiveness of the wider child death review process.

The information relates to child death **notifications** received during April 2020 to March 2021 and **reviews** taken place during April 2020 to March 2021. Not all child deaths which occur each year will have their child death review completed by 31st March; this is mainly because it may take a number of months to gather sufficient information to fully review a child's death.

The National Child Mortality Database (NCMD) continued to be reported to by the Hull Child Death Overview Panel (CDOP) for real time surveillance on all child deaths nationally. The NCMD is an NHS funded project, delivered by the University of Bristol, to gather information using standardised forms on all children who die across England, with the aim to learn lessons that could lead to changes to improve and save children's lives in the future.

The direct and indirect impact of COVID-19 has and will continue to be monitored for all child deaths during 2020/2021 and beyond.

Since January 2021 Hull has used an online notification, recording, casework and reporting system. The eCDOP system automatically transfers data at each relevant stage of the process into the National Child Mortality Database.

This information is then used to analyse data nationally to improve learning and implement strategic improvements in health care for children in England, with the overall goal to reduce child mortality.

1.2 Purpose of the child death review process

The purpose of the child death review process is to try to ascertain why children die and put in place interventions to protect other children, prevent future deaths wherever possible as well as improving services to families and carers.

Since 1 April 2008, there has been a legal requirement that Child Death Overview Panels (CDOP) conduct a review for all child deaths aged 0-17 years who normally reside in their area (excluding stillbirths and legal terminations of pregnancy). Revised Child Death Review: Statutory and Operational Guidance was published in October 2018 for child death review partners (partners are defined in section 16Q of the Children Act 2004 as the Local Authority and Clinical Commissioning Group). The guidance sets out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements set out in Working Together to Safeguard Children 2018 and clarifies how individual professionals and organisations across all sectors involved in the child death review contribute to reviews. The guidance sets out the process in order to:

- improve the experience of bereaved families, and professionals involved in caring for children
- ensure that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths

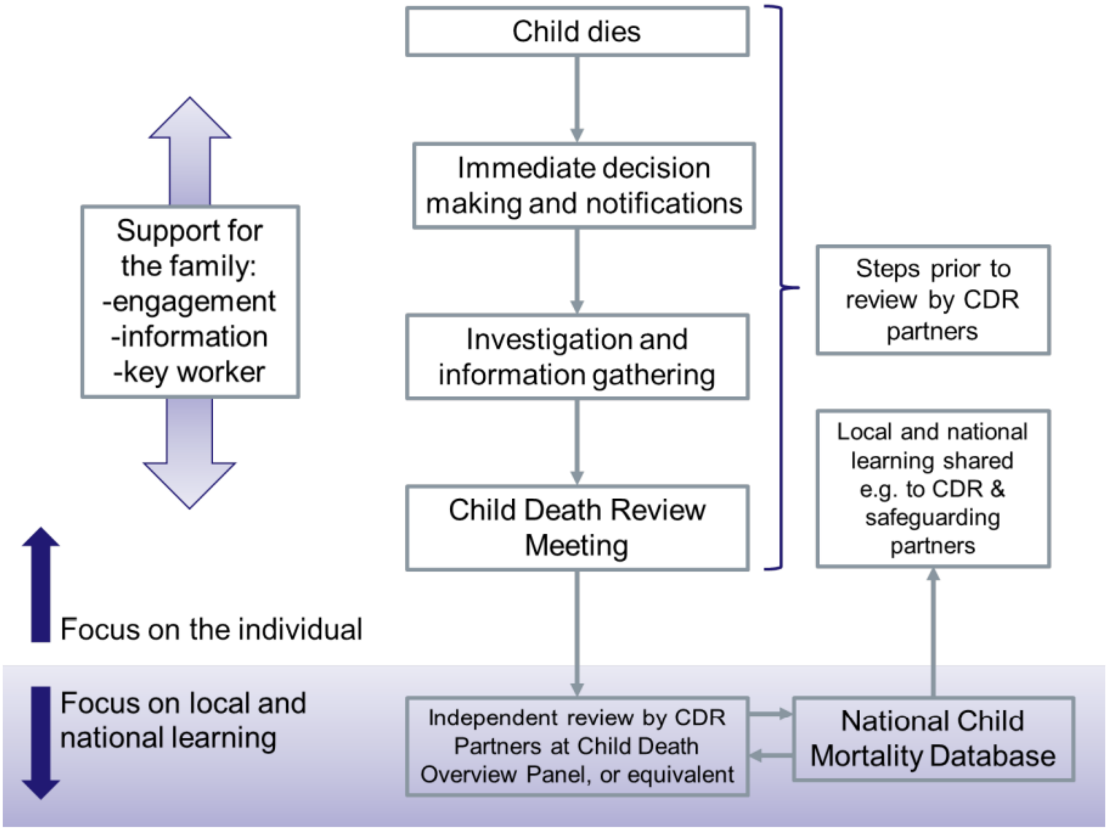
The guidance outlined changes to the bodies responsible and the process of safeguarding children and reviewing child deaths, mandating that from September 2019, all CDR Partners are required to:

- Cover a geographical and population 'footprint' area which would enable the review of a minimum 60 child deaths per year to enable thematic analysis
- Ensure that a 'Joint Agency Response' (JAR) is established in the immediate aftermath of all deaths which meet certain criteria which can broadly be defined as 'unexpected'
- Continue to notify and liaise with safeguarding partners where abuse or neglect is known or suspected
- Use updated and standardised templates and datasets for the notification, reporting and analysis of all child deaths
- Ensure that local multi-agency Child Death Review Meetings (CDRM) are conducted to review each child's death prior to an independent review by the CDOP
- Ensure that a senior paediatrician or 'designated doctor for child deaths' continues to lead on the coordination of responses and health input to the child death process within the new footprint
- Share data with the new National Child Mortality Database (NCMD) from April 2019
- Inform relevant persons or organisations of any action that they should take to improve the care and services that they deliver as a result of any review

- Publish reports on what changes had resulted from the child death review arrangements in their area, and how effective the arrangements had been in practice

1.3 Process flowchart and review meetings

The chart below illustrates the full process of a child death review, including both the statutory responsibilities of CDR partners to review the deaths of children at an independent multi-agency panel/CDOP and the processes that precede or follow this independent review.



The local arrangements for reviewing child deaths in Hull were published in June 2019 and are in the process of being updated.

Child death review arrangements are committed to reviewing every child death to identify whether there is any learning to influence better outcomes for children and young people at both local and national level. Processes ensure appropriate links are made by the Child Death Overview Panel, or as part of the Child Death Review process, with other statutory review processes:

- [1]Perinatal Mortality Review Tool (for infants under 28 days or older who died on Neonatal Intensive Care (NICU)

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[1] The PMRT is a web-based tool that is designed to support a standardised review of care of perinatal deaths in neonatal units from 22+0 weeks gestation to 28 days after birth. It is also available to support the review of post-neonatal deaths where the baby dies in a neonatal unit after 28 days but has never left hospital following birth. The PMRT is integrated with the national collection of perinatal mortality surveillance data.

- [2]NHS Serious Incident investigations
- [3]Post Mortem examination
- [4]Inquest
- [5]Coroner's Regulation 28 report to prevent future deaths
- Police criminal investigation
- Road Traffic Collision investigation
- [6]Learning Disabilities Mortality Review (LeDeR)
- [7]Child Safeguarding Practice Review completed by the Hull Safeguarding Children Partnership
- [8]National Guidance on Learning from Deaths - A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care

Below is a brief description of the professional meetings required within the child death review process:

- **Joint Agency Response meetings (JARs) -** The "Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation (2016)" gives comprehensive advice and expectations of all agencies involved in a Joint Agency Response (JAR), a co-ordinated multi-agency response which is triggered if a child's death:
- is or could be due to external causes;

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[2] Serious Incidents in health care are adverse events where there are significant consequences to patients, families and carers, staff or organisations and investigations are undertaken with the sole aim of learning about any problems in the delivery of healthcare services and in understanding the causes and contributory factors of those problems.

[3] A PM is detailed physical examination of the child after he or she has died. A coroner may order a post-mortem examination, that is, without the permission of the family. Any other post-mortem examination will only take place with the consent of the family.

[4] An Inquest is an investigation into a death which appears to be due to unknown, violent or unnatural causes, designed to find out who the deceased was, and where, when and how they died. It is different to other Courts because there are no formal allegations or accusations and no power to blame anyone directly for the death. At the end of the Inquest, the Coroner will give his/her Conclusion and this will appear on the final Death Certificate. The death can then be officially registered.

[5] If any information is revealed as part of the Coroner's investigation or during the course of the evidence heard at the Inquest, which gives rise to "a concern that circumstances creating a risk of other deaths will occur, or will continue to exist in the future;" and if the Coroner is of the opinion that action needs to be taken, under Paragraph 7 of Schedule 5 of the Coroner and Justice Act 2009, the Coroner has a duty to issue a report to a person, organisation, local authority or government department or agency. The Coroner's Regulation 28 Report will set out the concerns and request that action should be taken. All Regulation 28 Reports and the responses are sent to the Chief Coroner and in most cases these will be published on the judiciary.gov.uk website.

[6] The LeDeR programme supports local areas to review the deaths of people with learning disabilities (aged 4+ years), identify learning from those deaths, and take forward the learning into service improvement initiatives. Its overall aims are to support improvements in the quality of health and social care service delivery and to help reduce premature mortality and health inequalities for people with learning disabilities.

[7] CSPRs are undertaken when a child dies (including death by suspected suicide) or is seriously harmed, and abuse or neglect is known or suspected. The prime purpose of a CPR is for agencies and individuals to learn lessons to improve the way in which they work, both individually and collectively, to safeguard and promote the welfare of children.

[8] Guidance to help standardise and improve the way acute, mental health and community Trusts identify, report, review, investigate and learn from deaths, and engage with bereaved families and carers.

- is sudden and there is no immediately apparent cause (incl. Sudden and unexpected Death in Infancy/Childhood (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

A JAR should also be triggered if children are brought to hospital near death, are successfully resuscitated, but are expected to die in the following days.

At the start of the pandemic the National Child Mortality Database issued some interim guidance on Joint Agency Response (JAR) to child deaths during COVID-19 to support professionals to undertake a JAR during the pandemic. It was acknowledged that the circumstances in which a JAR is required are unchanged, how they are enacted may need to change depending on circumstances.

A JAR meeting is an initial information-sharing and planning meeting to consider outstanding investigations, notification of agencies, arrangements for the post mortem examination, plans for a visit to the home or scene of collapse and consider if abuse or neglect is known or suspected (in which case, it may meet the criteria for a child safeguarding practice review). JAR meetings will be attended by professionals involved with the child prior to, at the time of death, and with the family immediately after the death.

- ➢ For every child death, agencies / professionals known to the child/family will be asked for reports about their involvement, including medical information and support to the family; a **Child Death Review Meeting (CDRM)** will take place (*usually within 3 months following the death or receipt of post mortem report /conclusion of police and other investigations, but prior to an Inquest, if applicable*) – this is a meeting of professionals where all matters relating to an individual child's death are discussed by the professionals directly involved in the care of that child during life and those involved in the investigation and family support after death.

The CDRM focuses on local learning with the aim of:

- reviewing the background history, treatment, and outcomes of investigations, to determine, as far as is possible, the likely cause of death;
- ascertaining contributory and modifiable factors across domains specific to the child, the social and physical environment, and service delivery;
- describing any learning arising from the death and, where appropriate, to identify any actions that should be taken by any of the organisations involved to improve the safety or welfare of children or the child death review process;

- reviewing the support provided to the family and to ensure that the family are provided with:
    - the outcomes of any investigation into their child's death;
    - a plain English explanation of why their child died (accepting that sometimes this is not possible even after investigations have been undertaken) and any learning from the review meeting;
- ensuring that CDOP and, where appropriate, the coroner is informed of the outcomes of any investigation into the child's death; and
- reviewing the support provided to staff involved in the care of the child.

➢ The CDRM will prepare a draft report (Analysis Form) providing an analysis of the factors around the death, as well as the learning identified and future actions to prevent a future death. This report receives independent scrutiny and/or affirmation by the **Child Death Overview Panel (CDOP).** Statutory guidance suggests this should take place approximately 6 weeks after a CDRM.

CDOP is a multi-agency panel set up to review the deaths of all children normally resident in Hull and, if appropriate, deaths of non-resident children, in order to learn lessons and share any findings for the prevention of future deaths.

The CDOP review is informed by a standardised analysis report from the CDRM and ensures independent, multi-agency scrutiny by senior professionals with no named responsibility for the child's care during life. This is an anonymised secondary review of each death in order to:

- confirm or clarify the cause of death,
- determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;
- make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children.

The CDOP is multi-agency with differing areas of professional expertise; during 2020/21 the core membership of Hull's CDOP included the following:

- Assistant Director Health and Wellbeing/Deputy Director of Public Health (Chair)
- DCI or DI Public Protection Unit
- Assistant Director Safeguarding or Head of Service, Children's, Young People and Family Services
- Designated Doctor for child deaths
- Designated Doctor for safeguarding children
- Designated Nurse for safeguarding children
- Named Doctor for safeguarding in Primary Care
- Assistant Coroner
- Bereavement Midwife
- Hull Child Death Review Co-ordinator

Parents and families are not invited to attend child death review meetings; however, parents are provided with an opportunity to contribute information and questions and can request feedback on the conclusions and learning from their child's review.

1.4 Implementation of statutory guidance and governance

Currently there is no clear national structure for CDOPs to report to but locally a structure has been established to support local processes.

- **Child Death Review Operational Group** was established by the Hull Clinical Commissioning Group and Hull City Council/Local Authority (Child Death Review Partners) to understand and put in place arrangements to comply with the new requirements, including new processes, resources, new roles and responsibilities e.g. the Designated Doctor, Lead Professional and Key Worker. The Group meet regularly to progress a local implementation plan.

- **A Child Death Review Executive Group** has been established; jointly chaired by Director of Public Health (LA) and the Director of Nursing (CCG) and attended by the CDOP Chair and the Designated Doctor for child deaths, to:
    - establish assurance processes to ensure that CDR arrangements and the CDOP in Hull are operating effectively and meeting the requirements as set out in the statutory guidance
    - Receive an annual report from the Hull Child Death Overview Panel (CDOP) and provide this report to individual partner organisations and statutory Boards as appropriate
    - establish links with the Hull Safeguarding Children Partnership (HSCP)
    - agree funding and resource arrangements for the CDR partnership
    - ensure the learning from Hull CDR arrangements and CDOP reports feeds into the regional partners (Hull, East Riding of Yorkshire, North Yorkshire and York, North and North East Lincolnshire)
    - ensure that the Hull CDR partners contribute fully to the development of the regional CDR arrangements ensuring appropriate representation at this group.
    - maintain an overview of the effectiveness of each aspect of the local CDR process arrangements for Hull
    - take action to address any barriers to the effective operation of the CDR arrangements in the City
    - receive feedback from the operational colleagues in commissioned services, directly delivered services, partnership agencies on the impact the CDR process is having on
        - the experience of bereaved parents
        - how lessons learned are informing local policy procedures and practice
        - any barriers to effective working and the impact of action taken to address these
        - the use of resources to improve children's health and wellbeing reflecting the learning from the CDR process.

2. Hull population overview *(taken from Hull's Joint Strategic Needs Assessment)*

Hull has a relatively young population compared to England:

- In 2019, it is estimated that 259,778 people live in Hull with almost one-quarter (24.4%) of them aged 0-19 years (63,469).
- In January 2019, 22.8% of children attending Hull schools were from Black and Minority Ethnic groups (9,701 children out of 42,613).
- There are just over 3,000 births each year in Hull.

Poverty and deprivation:

- Hull is among most deprived 2% of local authorities in England (fourth out of 317).
- Three in ten children in Hull living in relative poverty compared to 18% for England.
- The rate of households with dependent children or pregnant women as unintentionally homeless and eligible for assistance was twice as high as England in 2017/18 (3.6 versus 1.7 per 1,000 households).
- At March 2021, 20.6% of households (25,395) in Hull were claiming Universal Credit, compared with 15.3% for England for the same period.
- Parental alcohol and substance abuse, parental mental health and domestic abuse rates are all relatively high in Hull and can have a dramatic effect on children and their families. These three factors are often referred to as the 'toxic trio'.
- The rate of children with Special Educational Needs or Disabilities is also relatively high in Hull.

Children in Need and Children Looked After:

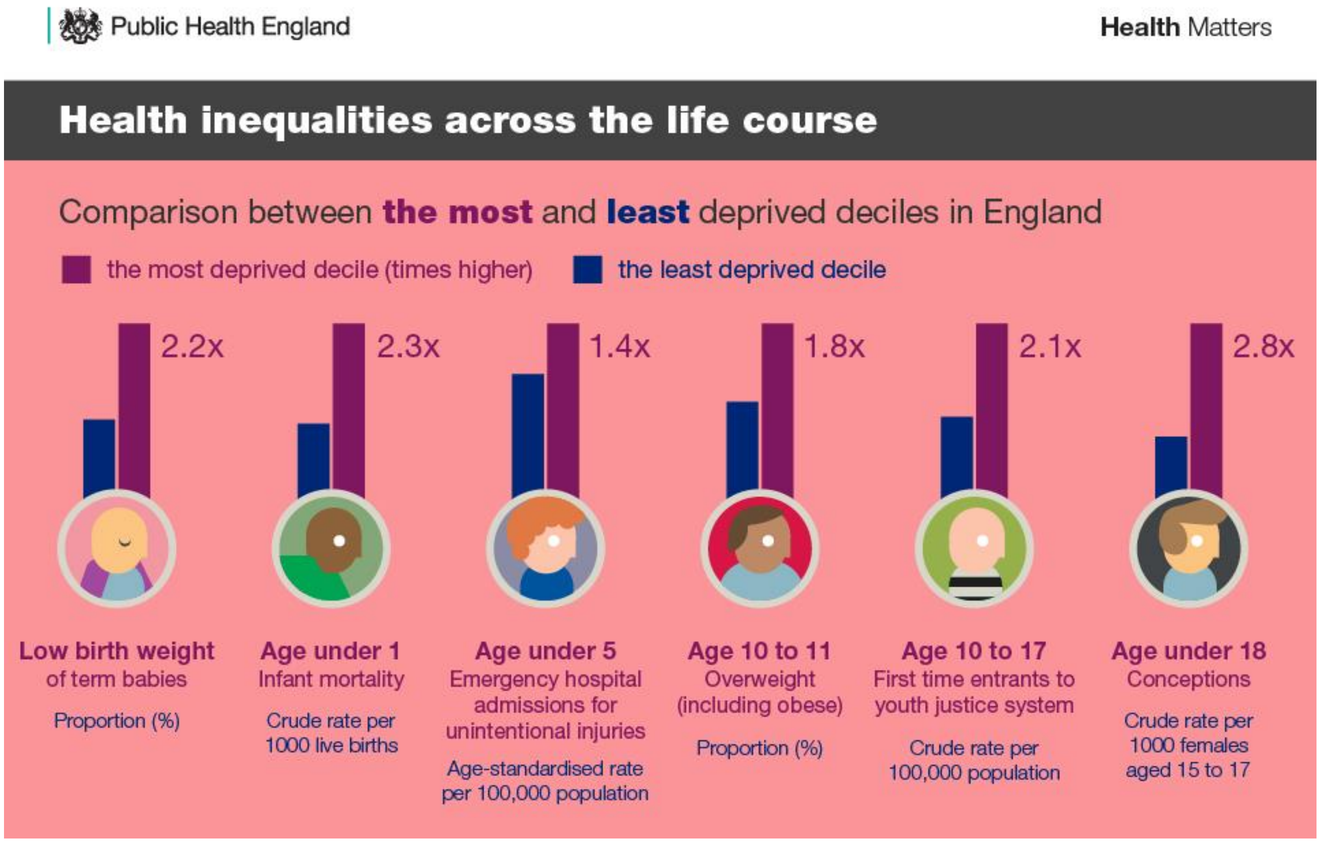
- In 2018, 2,513 children were identified as 'in need of protection', abuse or neglect identified as the primary reason which represents a rate of 445 per 10,000 children which is more than twice as high as England (181).
- There is a very high rate of children looked after in Hull with twice the rate compared to England.

Health:

- One in five pregnant women in Hull smoked during their pregnancy; twice as many as England.
- Only one-third of babies were breastfed at 6-8 weeks compared to over 45% in England.
- Vaccination rates among young children (under-fives) are generally comparable to or higher than England, although in some cases are still below the national targets. The exception is the flu vaccination among 2-3 year olds and primary school pupils which is lower that England. Vaccination rates among secondary school pupils are worse though in relation to vaccinations for human papillomavirus (HPV) and the Meningococcal ACWY conjugate.
- One in ten boys and 13% of girls reported having a long-term illness or disability that limited their daily activities.

- Improvements have been made in dental health, but the percentage of 5 year olds with experience of visually obvious dental decay is 50% higher than England.
- Attendance at A&E and admissions to hospital are generally higher than England, particularly for 0-4 years, and relating to diabetes, epilepsy, alcohol and substance misuse. Across all age groups, A&E attendance rates in Hull increased sharply between 2016/17 and 2018/19, and whilst emergency hospital admissions decreased slightly in Hull between 2015/16 and 2018/19, they are still higher than England.
- Smoking, poor diet, inactivity, obesity, and alcohol and substance misuse are high among adults in Hull which has a high impact on children and can also impact on children's future health and health behaviours.
- Just under a half of young people in Hull live with a smoker.
- High levels of child obesity.
- Low levels of children in Hull eating 5-A-DAY.
- High levels of physical inactivity.
- High levels of hospital admission rates for alcohol and substance abuse among young people in Hull.

This graphic from Public Health England shows the differences in health outcomes between the most and least deprived geographical areas in England.



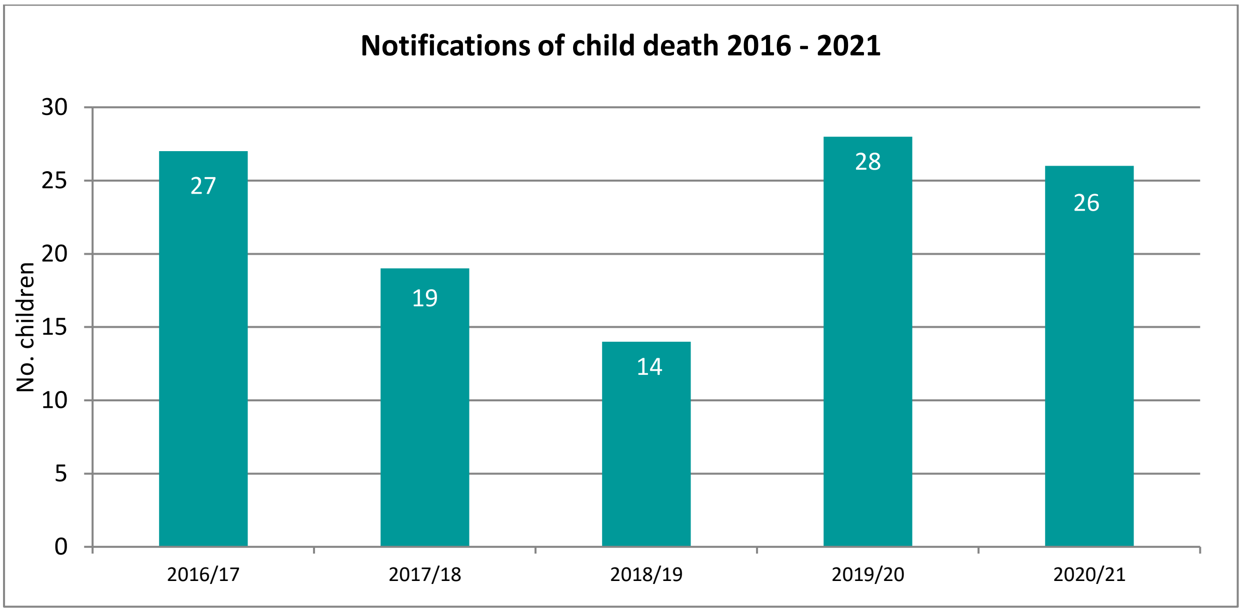
3. Hull Child Death Overview Panel facts and figures, 2020/21

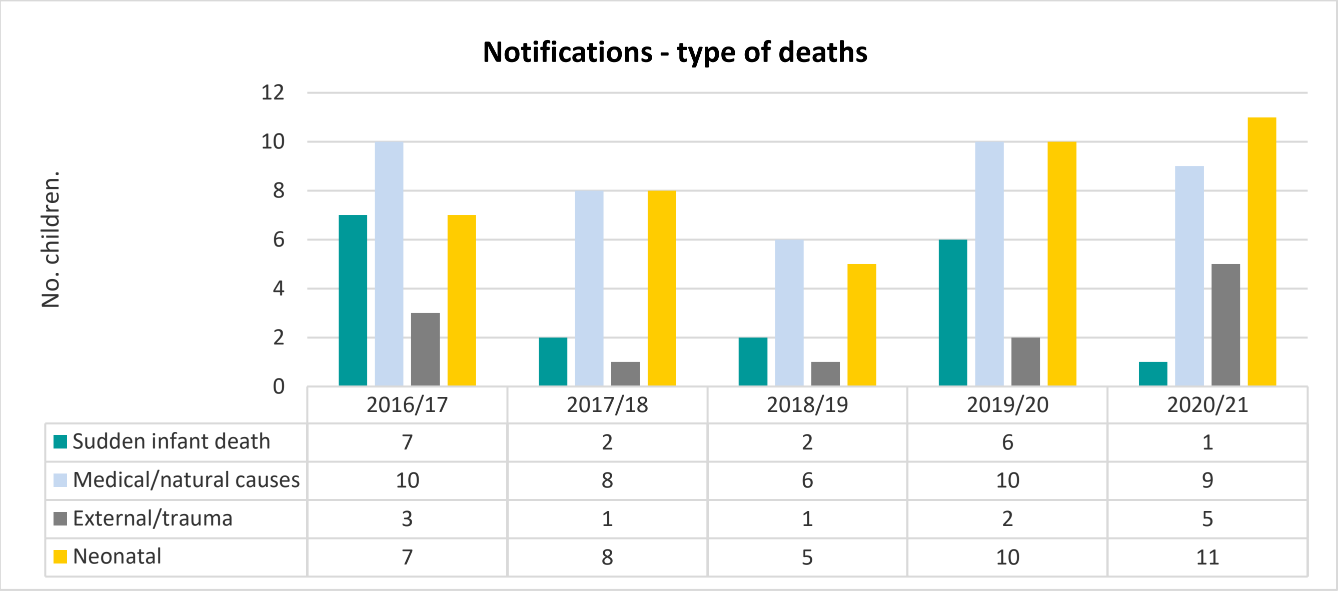
Below are characteristics about the deaths of children from Hull notified to CDOP and those reviewed by our local Panel between 1/4/20 and 31/3/21. Not all child deaths which occurred in 2020/21 will have their child death review completed by 31st March; this is mainly because it may take several months to gather sufficient information to fully review a child's death. More complex cases which are subject to parallel processes/waiting for information from other reviews/investigations will take longer.

From a statistical analysis perspective, Hull has relatively small numbers of child death notifications and child death reviews in a single year.

3.1 Notifications

26 child deaths were notified to the Hull Child Death Overview Panel – a similar number to the previous year (28), and nearly double compared with 2018/19 (14). The number of notifications is similar to the local average over the last 13 years of 24 child deaths notified per year; a total of 312 deaths of children from Hull have been notified in 13 years.



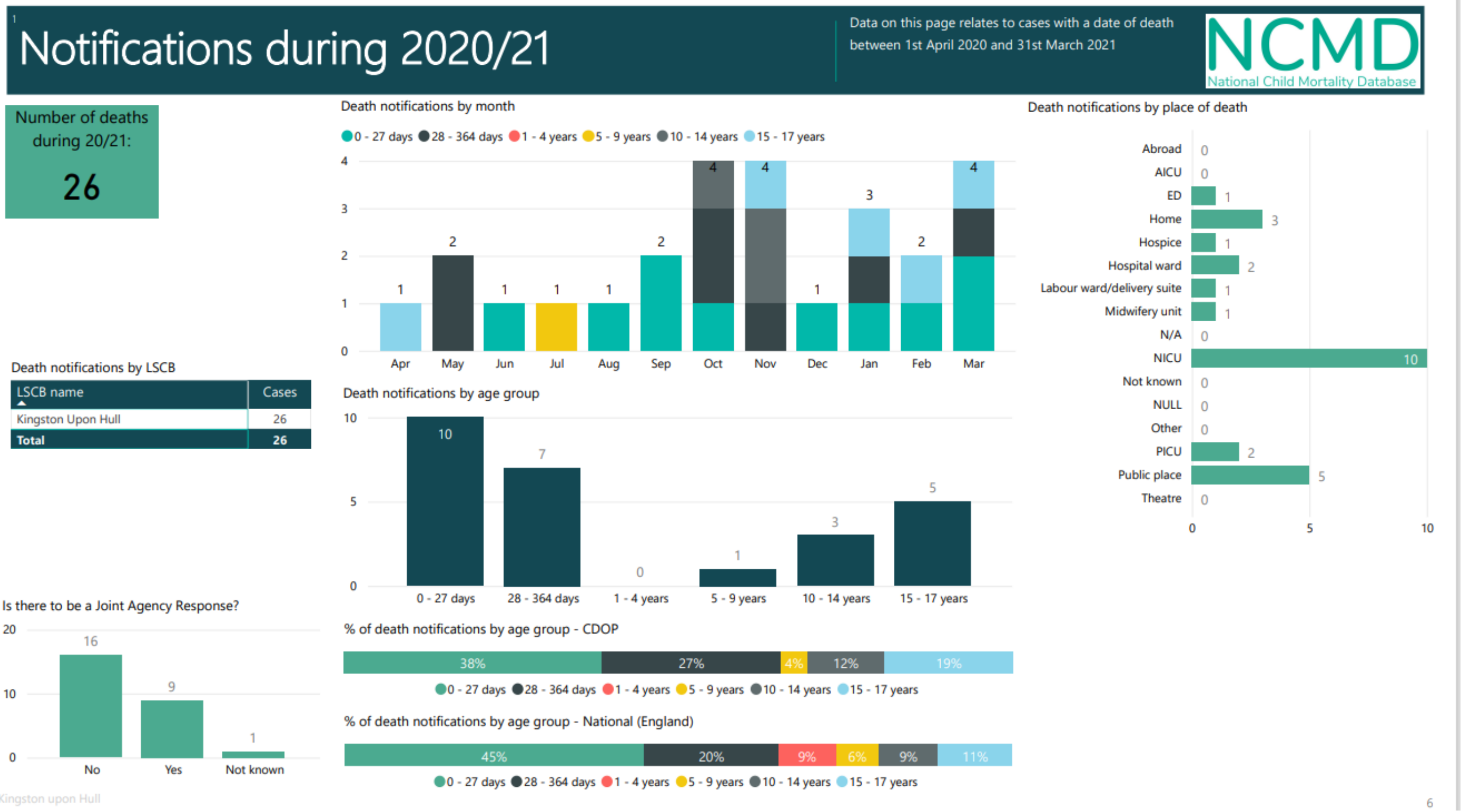


	2016/17	2017/18	2018/19	2019/20	2020/21
Sudden infant death	7	2	2	6	1
Medical/natural causes	10	8	6	10	9
External/trauma	3	1	1	2	5
Neonatal	7	8	5	10	11

Some variation in patterns year on year is expected due to the small numbers. Some comparisons to national and historical Hull trends are set out below:

- In the last 5 years, 2020/21 saw the lowest number of sudden infant deaths and the highest number of neonatal deaths and trauma related deaths.
- 2020/21 saw a reduction in the number of sudden infant/child deaths notified but there were more trauma related deaths. These deaths are either awaiting post mortem results or subject to ongoing investigations at the year-end so have not yet been reviewed by CDOP.
- There have not been any child deaths in Hull where Covid 19 was the cause of the child's death.
- 17 children were aged less than one year old (65%); the same as the national proportion. As in previous years, a child is most at risk of death under the age of 1, and particularly within the first 27 days of life (38% of child deaths in Hull and 45% nationally).
- There were no deaths of children aged 1-4 years. The next lowest number of deaths occurred for children aged between 5 and 9 years.
- Unlike the national data where there were more males than females who died in each age group, in Hull there were more females than males in age groups <28 days and 15+ years.
- Across all age groups, 14 children were male and 12 were female, compared with 13 male and 15 female in the year before.
- 17 children were of White-British ethnicity and 9 (35%) were from other ethnic backgrounds, compared with 21 and 7 (25%) respectively in 2019/20.

Extract from NCMD Annual Report for Hull, 2020/21:



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:

26

Death notifications by LSCB

LSCB name	Cases
Kingston Upon Hull	26
Total	**26**

Is there to be a Joint Agency Response?

Death notifications by month

Death notifications by age group

% of death notifications by age group - CDOP

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

Death notifications by place of death

Kingston upon Hull

6

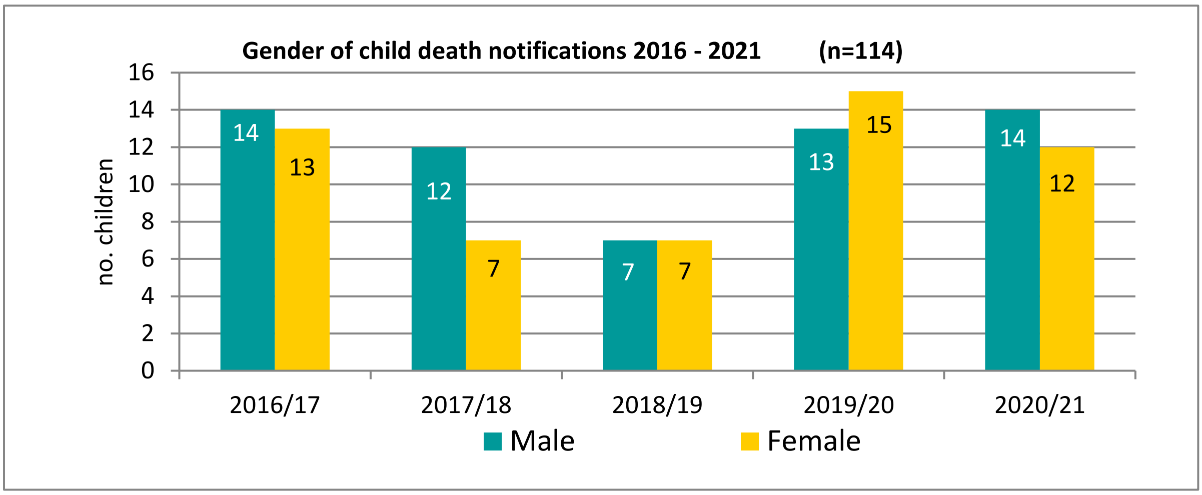
Multiagency reviews:

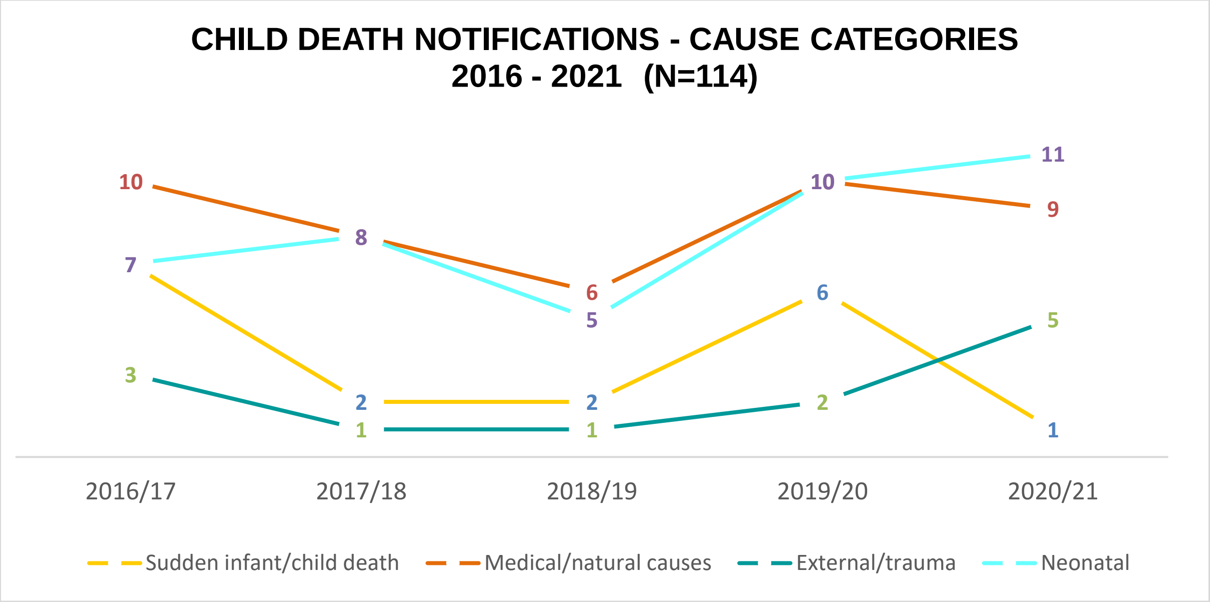
- 9 deaths in 2020/21 met the criteria for a Joint Agency Response (a thorough and systematic investigation that is sensitive to and supportive of parents when their child has died unexpectedly and/or it is unexplained at the time). None of these deaths were reviewed at CDOP in 2020/21; they were pending further information/conclusion of other investigations.
- 1 death met the criteria for notification to the Learning Disabilities Mortality Review Programme (LeDeR) so our review will assist with sharing learning from deaths of children with disabilities. This death had not yet been reviewed by CDOP by the year end.

3.2 Comparison with previous years

Compared with 2019/20 there was a slight decrease in the number of child deaths in Hull but the number of children under 1 year was the same. There was a shift in the months the deaths occurred. In 2020/21 more children died in the Autumn months (September – November) compared with the previous year when more children died in the summer months (June – August).

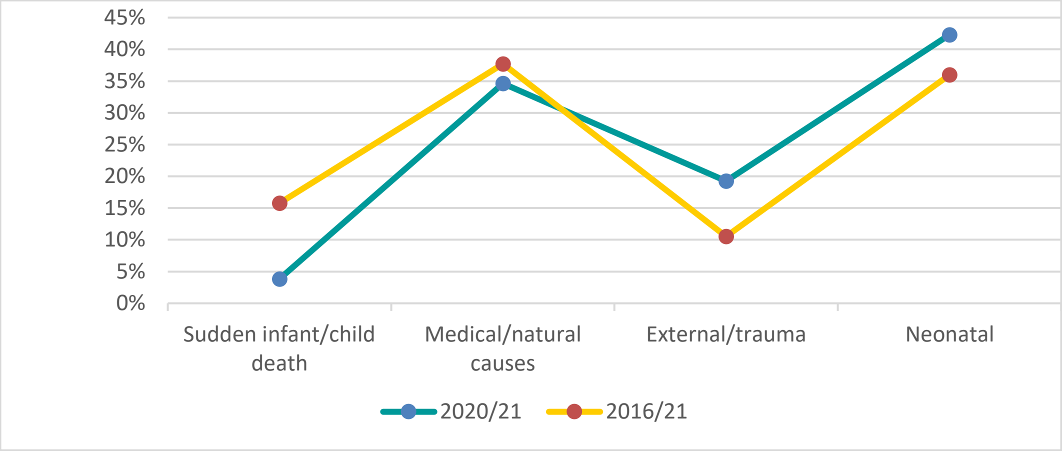
Over the last five years, 53% of children who died in Hull were male and 47% were female.





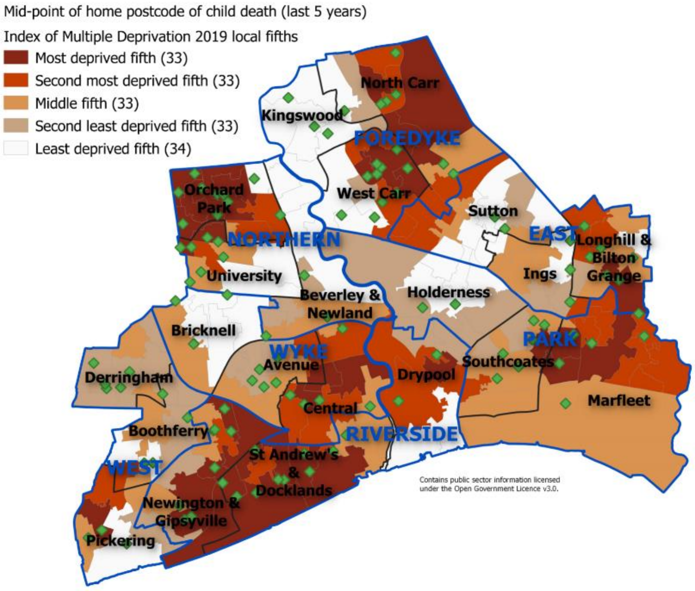
Compared with the average of the last 5 years' notifications (n=114), 2020/21 shows that the average number of deaths in the broad cause of death categories is less for sudden deaths and medical/natural causes, but higher than average for external and neonatal deaths.

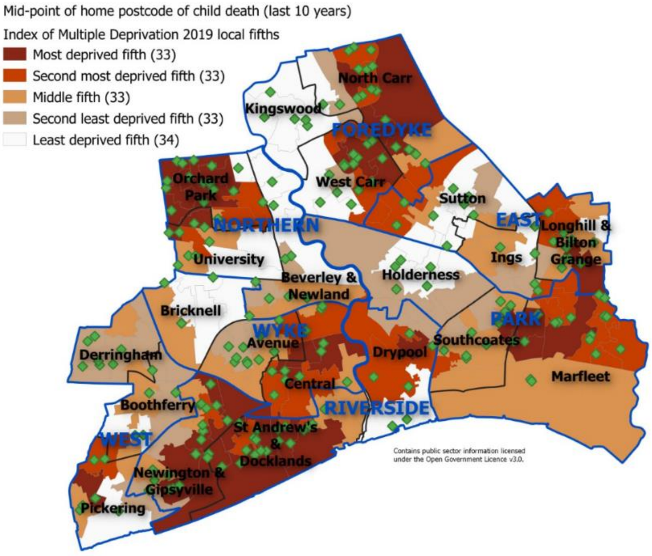
	2020/21	**Average 5 years**
Sudden infant/child death	4%	16%
Medical/natural causes	35%	38%
External/trauma	19%	11%
Neonatal	42%	36%



3.3 Deprivation

The maps below show the midpoint postcode for child death notifications in the last 5 and 10 years, plotted within the index of multiple deprivation local fifths. This shows that child mortality rates are statistically significantly higher for children living in the most deprived fifths of areas of Hull compared to children living in other areas of Hull (the least deprived four-fifths of areas of Hull.





An analysis of CDOP reviews undertaken in the last 5 years (2016/17 – 2020/21) in relation to deprivation was undertaken.

- There is a suggestion from the data that the mortality rate is higher for children aged 1-9 years among children living in the most deprived areas of Hull compared to other areas. However, the numbers are relatively small from a statistical point of view, so it is not possible to draw firm conclusions.

  - Child mortality rates among those aged under 28 days are statistically significantly higher for children living in the most deprived fifths of areas of Hull compared to children living in other areas of Hull (the least deprived four-fifths of areas of Hull).

  - Child mortality rates for chromosomal, genetic and congenital anomalies, and relating to perinatal or neonatal events are statistically significantly higher for children living in the most deprived fifths of areas of Hull compared to children living in other areas of Hull (the least deprived four-fifths of areas of Hull).

  - Whilst there appears to be more sudden unexpected, unexplained deaths among children living in the most deprived areas of Hull compared to the least deprived areas of Hull, numbers are too small to draw firm conclusions.

4. REVIEWS 2020/21

Up to 31st March 2021, 90% of child death notifications (258) have been reviewed since the process started in 2008.

During the year ending 31st March 2021, the CDOP met four times and reviewed 15 children’s deaths. Due to the implications of COVID-19, which had significant impacts through the whole of 2020/21 on staff resources/clinician availability, a lower number of cases than usually expected were reviewed in Child Death Review Meetings which is a prerequisite to a final review at CDOP. Substantial work is ongoing to monitor and address the backlog of cases pending a child death review meeting.

Three of the cases were subject to NHS Serious Incident investigations, and the coroner issued a Regulation 28 report[9] – identifying learning and action required at the local and specialist hospitals to prevent a future child’s death.

Four of the deaths reviewed in 2020/21 had occurred over 2 years ago – due to the time taken to publish a Serious Case Review, conclusion of police investigations and inquests and awaiting local implementation of the multi-agency Child Death Review Meeting process.

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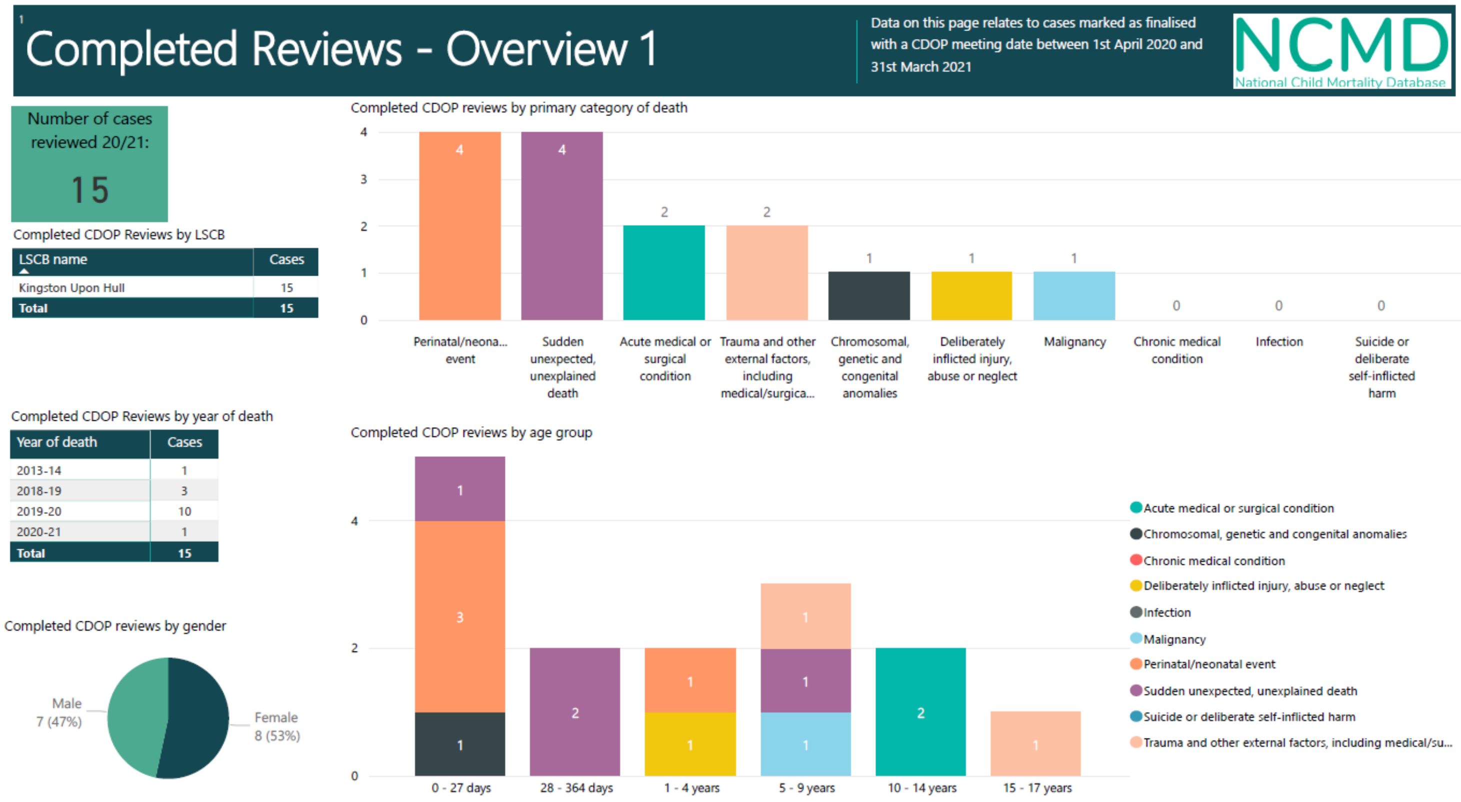
[9] Coroners and Justice Act 2009 provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths. Details of the procedures are set out in Regulations 28 and 29, Coroners (Investigations) Regulations 2013.

Extracts from NCMD Annual Report for Hull, 2020/21:



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

Number of cases reviewed 20/21: 15

Completed CDOP Reviews by LSCB

LSCB name	Cases
Kingston Upon Hull	15
Total	**15**

Completed CDOP Reviews by year of death

Year of death	Cases
2013-14	1
2018-19	3
2019-20	10
2020-21	1
Total	**15**

4.1 Ongoing Reviews

As of 31 March 2021, there were 39 children's death awaiting review. Three of these had been reviewed at a multi-agency Child Death Review Meeting (CDRM) and were pending completion at CDOP and 36 were awaiting a CDRM and completion at CDOP.

Local implementation of the new guidance in relation to the CDRM process and the effect the pandemic had on the capacity for professionals were reasons for these meetings taking longer than the recommended time scales.

The local Child Death Review Operational Group and Child Death Review Executive Group were briefed and monitored the progress of arrangements for completing outstanding reviews.

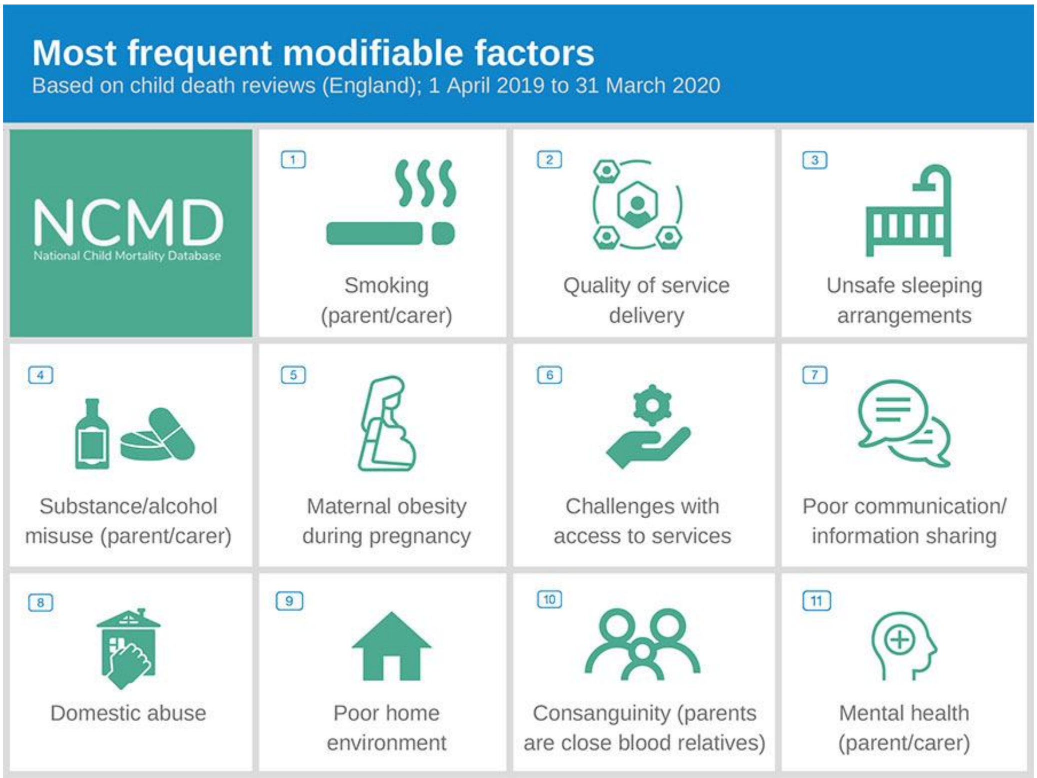
4.2 Modifiable factors

The review meeting for each child identifies factors that may have contributed to vulnerability, ill health or death and agree any **modifiable factors that may have prevented the death or may prevent another death in the same or similar circumstances**. It's important to be clear that when the CDOP identify a modifiable factor during a review, it doesn't necessarily mean it was a causal factor in that particular child's death.

Modifiable factors are defined as ‘those, where, if actions could be taken through national, regional or local interventions, the risk of future child deaths could be reduced’.

Of the 15 reviews undertaken in 2020/21, factors that may have contributed to vulnerability, ill health or death were identified in 10 reviews (67% of the total cases reviews). Where modifiable factors are identified, agencies involved in the child death review process and CDOP members take action to address these and monitor their progress until CDOP are assured that the necessary action has been taken – our key learning and actions are described later in this report.

The national average for modifiable factors was 34%, but the small number of reviews in Hull and a variation in how CDOPs around the country determine what is modifiable makes meaningful comparison with national data difficult.



Hull’s reviews this year identified modifiable factors in 7 of the 11 most frequently identified areas nationally. Those identified a number of times during 20/21 reviews were:

- Smoking during pregnancy and in the household
- Parental substance use
- Unsafe sleeping arrangements
- Domestic abuse
- High maternal BMI
- Quality of service delivery

From an analysis of Hull CDOP reviews undertaken in the last 5 years (2016/17 – 2020/21):

- The majority of child deaths which occurred prior to the age of five years had modifiable factor(s) present.
- More than six in ten infant deaths (<1 year) which occurred due to a perinatal or neonatal event or an infection had modifiable factor(s), and almost nine in ten sudden unexpected, unexplained deaths involving infants had modifiable factors identified.
- It is not possible to examine the association between modifiable factors and deprivation in detail without more years of data as the numbers are too small for a robust statistical comparison.

Modifiable factors have been analysed on a national scale by the National Child Mortality Database's 2nd Annual Report, (which had been published at the time of writing this report), enabling key areas for improvement to be identified. Across all categories of death, the most frequent modifiable factor identified was smoking by a parent or carer, followed by gaps in service delivery.

The NCMD is calling on all professionals involved in planning or providing services to children to use the data in this report to inform local, regional and national actions in order to reduce the number of children who die.

Hull CDOP has shared details of this report within partner agencies and its key messages will be the topic of discussions during 2021 and beyond to determine next steps for action by agencies and professionals.

A more detailed analysis of local mortality and deprivation of the previous 5 and 10 years' child death notifications, 5 years' of reviews and background/context information about Hull's population and its relevance to child/infant mortality and morbidity was provided to members of CDOP, CDR Executive Group and Hull Safeguarding Children Partnership

5. Learning from child death reviews - CDOP impact 2020/21

The CDOP has shared a range of learning from the cases we have reviewed during 2020/21, and amplified learning from other stages of the child death review processes including coroner investigations, CDRMs, JARs and NHS Serious Incident Investigations. Child death review partners have also taken action to improve services and support for families who lose a child. Learning and actions from this year are summarised below:

Pregnancy, birth and infants

- Due to the associated risks of maternal smoking on a range of abnormal outcomes in pregnancy, CDOP members recommended that obstetricians introduce reminders to mothers at their follow-up appointments re smoking cessation for subsequent pregnancies.

- Improvements to the diabetes in pregnancy pathway have been made, including the creation of a Diabetes Specialist Midwife role.

- A new leaflet about fetal movement has been developed and is discussed at the 16 week gestation appointment.

- CDOP shared data and characteristics of local deaths over a 6-year period with the Hull Child Death Review Exec Group for their support in prioritising future initiatives to raise awareness of parental lifestyle risks on local infants' safer sleep which puts them at risk of sudden death.

- CDOP welcomed and were reassured by a presentation in December 2020 from members of the Hull Maternity Voices Partnership on specific focused work related to the safety and care of new-born and infants including the multi-agency approach to safer sleeping, both locally and across the Humber Coast and Vale areas – see 'focus on safer sleep' section for more details.

- Police and Doctor training by Designated Paediatrician will include reminders about the importance of informing parents at the hospital that it is routine practice in sudden infant deaths for parents to be asked for voluntary blood or urine samples for toxicology, taken by the forensic medical examiner.

- Local data on sudden infant deaths is updated with the circumstances and characteristics of each death and this is shared with CDOP and with the local infant safer sleep trainer in City Health Care Partnership for sharing at the local infant safer sleep training course. Information is also shared with the Hull and East Riding Safer Sleep Infant Sleeping Steering Group (responsible for developing local safer sleep key messages and guidelines and procedures).

- CDOP members continually promote the risk factors and safety messages through professionals within their organisations using The Lullaby Trust and Unicef Baby Friendly publications to support new parents and help change a perceived culture of complacency. A review this year promoted the circulation of specific advice around staying away from home.

- Public Health's re-commissioning of local 0-19 services will consider how other initiatives and creativities around smoking cessation can be part of an enhanced pathway for health visiting.

- Public Health leads for smoking cessation team were informed of CDOP's suggestions to promote smoking cessation to other family members and make better use of social media to inform the community about healthy pregnancy habits, local unsafe sleeping stats and implications of not following safety guidance. e.g. using screens in GP surgeries, twitter, texts to pregnant parents, pregnancy apps, etc.

Deliberate abuse

- A serious case review reminded of the need for professionals to be persistent, curious, and child-centred when pursuing concerns about the welfare of children – although the death was not attributed to failings of professionals. Actions were monitored through the local Safeguarding Children Partnership and they disseminated the learning.

Trauma reviews

- Partners agreed to be supportive of any future measures to support safety around ownership of firearms.

Care for bereaved families

- A suggestion for a condensed version of the full-day Joint Agency Training to reach more professionals and include reminders about taking children to the Emergency Department rather than the mortuary, so that parents can spend time with their child, as well as preparing bereavement work/memory box.

- Adult Social Care did not have a process of offering condolences to bereaved families who were previously known to them. Future child death notifications received by children's services to be communicated with Adult Social Care for them to determine any previous family involvement and consider future needs.

- The need for the most appropriate person to share the child death review booklet with bereaved families to be discussed by the Child Death Review Operational Group; this was previously sent in the post by the CDOP Co-ordinator but new guidance introduced the role of keyworker, and although it was agreed that this person would be the most appropriate, this process has not yet been fully implemented locally.

- JAR meetings to consider communication links with organisations/agencies around any potential social media coverage, to help prevent any undue distress to families.

- As part of the local bereavement pathway, clinicians are prompted to discuss post mortem options with parents prior to their baby's death as part of end of life care.

- CDOP heard about the commendable and compassionate pastoral support schools and colleges put in place when they experienced the death of a student, for the benefit of peers, teachers, family and the wider community.

Medical deaths

- As a precaution for parents of children with shunts, neurosurgeons to be asked to remind them at every appointment to contact the hospital if their child complains of a headache.

- CDOP acknowledged that capacity for vagus nerve stimulation (VNS) surgery/waiting lists for epilepsy patients will have an impact on children waiting for this surgery to reduce their risk of SUDEP. Although this issue is on the Risk Register for the Neurodiversity Group, CDOP gathered evidence/current patient experience to inform any future escalation to NHSE/specialised commissioning for their perspective. Fortunately, by the year end the situation had improved and the waiting list had reduced so there was no need for escalation.

- Recognition that children with epilepsy would benefit from a more holistic health management, particularly around respiratory problems - Specialists in the local hospital trust to discuss e.g. upper airway problems, sleep apnoea, impacts of immune deficiencies.

- The Children & Families Disability Team, Consultant, Specialist Epilepsy Nursing, the Police and Housing agreed to open up discussions to provide co-ordinated help and support to children with complex medical needs and their families with any issues they are experiencing.

- Proposal for a drop-in clinic for safeguarding on the paediatric wards for increased information sharing/holistic approach to supporting children and families.

- The Children & Families Disability Team Manager will liaise with the occupational therapy team about thinking more broadly than support for just at home; by considering ways of supporting children with physical difficulties through practical solutions to help them remain in school for longer.

- CDOP suggested Sudden Unexpected Death in Epilepsy (SUDEP) as a future thematic report for the NCMD.

- CDOP to seek a local discussion on further understanding the links between LeDeR and CDOP processes to ensure CDOP is meeting expectations and supportive of the process

Some of these recommendations/actions were work in progress at the year-end 2020/21.

6. Focus on Safer Sleeping

The CDOP held a focussed meeting on safer sleep on 9th December 2020, and this section of our annual report details the learning from it.

6.1 Background data

- The Lullaby Trust record that on average 4 babies die, suddenly and unexpectedly, every week in the UK and no cause will be found (recorded as SIDS or Unascertained). Increased awareness of safer sleep practices has led to a significant reduction in the number of deaths and rates have fallen by 80% since the 1991 Back to Sleep campaign.

- At the time of writing this report the Office for National Statistics (ONS) had just published data on Unexplained deaths in infancy, England and Wales: 2019, which showed that there were 170 unexplained infant deaths, a notable decrease on the previous year (213 deaths). This could be because the coronavirus (COVID-19) pandemic has caused more registration delays than usual; final data will be published next year. All infant deaths have also declined since 2004 from 3,218 deaths to 2,390 infant deaths in 2019. Unexplained infant deaths accounted for 7.1% of all infant deaths in 2019. This year we have had fewer unexplained infant deaths than last year in Hull, but as our numbers are small some variation year on year is to be expected.

- SIDS rates in Yorkshire and the Humber have also increased for the second year from 0.29 in 2017, 0.43 in 2018 to 0.50 in 2019 (per 1,000 live births). The rates of SIDS deaths in Yorkshire and the Humber is now the highest region in England and Wales, considerably higher than the average rate in England and Wales of 0.27 per 1,000 live births.

- From an analysis of the last five years' child death reviews in Hull, there were 13 sudden unexpected, unexplained deaths among children living in the most deprived three-fifths of areas of Hull compared to three deaths among children living in the least deprived two-fifths of areas of Hull giving mortality rates of 117 and 52 per 100,000 population respectively. Due the small numbers, there is no statistically significant difference between the two groups (p=0.20). Nor is there a difference comparing the most deprived fifth with the least deprived four-fifths (p=0.51).

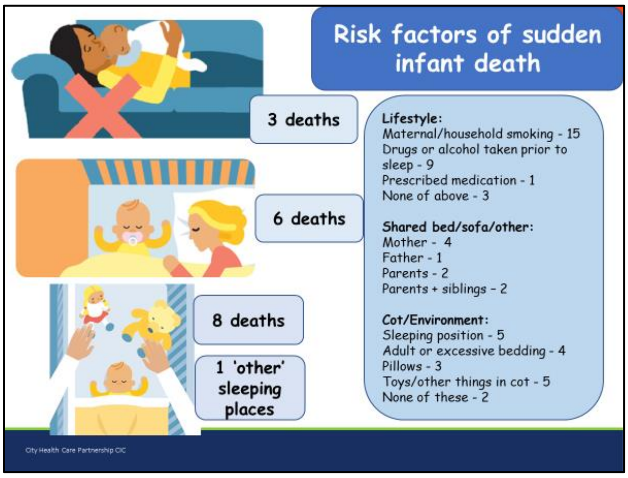
6.2 CDOP role and learning

CDOP partner agencies want to ensure that all parents and carers have access to information on how to reduce the risk of SIDS. If all parents followed safer sleep advice, many more babies' lives could be saved. In 2019, The Lullaby Trust, Public Health England, Unicef UK Baby Friendly Initiative and Basis (Baby Sleep Info Source, Durham University) collaborated to create a range of resources for parents and health professionals; local agencies use these to provide lifesaving information to all families on how to reduce the risk of SIDS.

Each year, Hull CDOP encourages local agencies to support the Lullaby Trust's annual Safer Sleep Week campaign and reach as many families as possible with life saving safer sleep advice. This year the campaign focused on Dads. Due to the pandemic and restricted public meetings and gathering, agencies used social media to share the key messages, compared with lots of activities in the communities and with families in the previous years.

We are keen to advocate that any professional coming into contact with families with young babies can make a difference. Health professionals are key, but others including housing, social care, substance misuse services and emergency services are targeted with resources and invited to local training.

The graphics below shows some of the characteristics of 18 infant deaths determined as SIDS and Unascertained in 6 years (January 2015 – December 2020) which are used in local safer sleep training for professionals.



Risk factors of sudden infant death

3 deaths

6 deaths

8 deaths

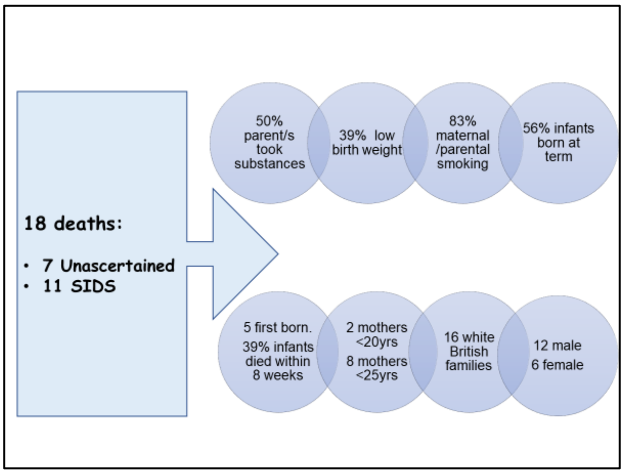
1 'other' sleeping places

Lifestyle:
Maternal/household smoking - 15
Drugs or alcohol taken prior to sleep - 9
Prescribed medication - 1
None of above - 3

Shared bed/sofa/other:
Mother - 4
Father - 1
Parents - 2
Parents + siblings – 2

Cot/Environment:
Sleeping position - 5
Adult or excessive bedding - 4
Pillows - 3
Toys/other things in cot - 5
None of these - 2

City Health Care Partnership CIC



18 deaths:

- **7 Unascertained**
- **11 SIDS**

50% parent/s took substances

39% low birth weight

83% maternal /parental smoking

56% infants born at term

5 first born.
39% infants died within 8 weeks

2 mothers <20yrs
8 mothers <25yrs

16 white British families

12 male
6 female

An analysis of reviews undertaken in the last 5 years identified that whilst there appears to be more sudden unexpected, unexplained deaths among children living in the most deprived areas of Hull compared to the least deprived areas of Hull, the numbers are too small to show a statistically significant difference. Of the 17 sudden, unexpected, unexplained deaths, 14 (82%) had modifiable factors identified. The common themes were smoking in pregnancy and/or in the household, and unsafe sleeping arrangements.

CDOP is represented on a local multi-agency Infant Safer Sleeping Steering Group which co-ordinated the sharing of safer sleeping advice from local and national reviews to support the Lullaby Trust's 5th national Safer Sleep Week campaign (March 2021).

Restrictions associated with the pandemic prevented the usual face to face meetings, activities and promotions with CDOP so instead we used social media to promote guidance, key messages and resources to help parents make informed decisions around infant safer sleeping and highlight the risks of sudden infant death (e.g. adults sleeping with an infant on a sofa or other soft surface and adults sharing a bed with a young infant if the infant was premature or of low birth weight and if parents smoke, take drugs or certain prescribed medication and after drinking alcohol).

6.3 Local services and initiatives

Members of the Hull Maternity Voices Partnership informed CDOP members about the specific focused work related to the safety and care of new-born and infants, locally and across the Humber Coast and Vale areas:

- ICON (Babies Cry, You can Cope) programme
- Safer Sleep programme
- CONI (Care of the Next Infant) Scheme

They described a local multi-agency approach to safer sleeping, incorporating advice and messages from the ”Out of Routine” - 2nd National Child Safeguarding Practice Review into sudden unexpected death in infancy (SUDI) in families where children are considered at risk of significant harm, which advocates using a personal and tailored approach to assessing risk and providing safety advice.

Local training and support – The CHCP Infant Feeding co-ordinator delivers Safer Sleep training to professionals across the partnership; 3 dates a year and is designed as a cascade training resource which is 3 hours long and has to be refreshed every 3 years by Goodwin Development Trust – Breastfeeding Peer Supporters, CHCP staff, Early Help Children’s Centres, Maternity services. The training is also promoted through CDOP for any agency to attend. There is close working with Humber, Coast and Vale Health and Care Partnership Local Maternity System. Some face to face training was cancelled at the start of the pandemic in 2020 but was soon replaced by online training via Microsoft Teams and a further 3 training dates have been scheduled for 2021.

0-19 Health visiting service - From 2019-20, 2116 families had a Health visitor antenatal contact face to face whereby safer sleep would have been discussed. 2057 (87%) received a face-to-face new birth visit by 14 days, 284 (12%) after 14 days. 1% didn’t receive a face-to-face visit, this would be due to declining. 2584 had the 6-8 health visitor visit 8 weeks (94%), 2752 were eligible for a visit. Information is recorded in the Personal Child Health Record (Red Book), including the Lullaby Trust leaflets which are discussed with parents.

Universal Partnership Plus and the Enhanced Parenting Pathway will receive much more intensive support usually within the early stages of pregnancy. Midwives and HV’s are now asking to view where the baby is sleeping, both in the antenatal and postnatal period.

Hull University Teaching Hospitals Midwifery Support - Safe sleep is discussed at all ante and post-natal appointments and two video clips are given to all women before they leave hospital, tailored to breast or bottle feeding – a QR code is also given to them so they can re-watch and refresh at their convenience. The Carousel evenings were held monthly (pre Covid), whereby all pregnant women and family invited during pregnancy, safer sleep discussed. HEY baby antenatal classes.

Early Help Support & Children’s Social Care – all families referred into Early Help Children’s Centres that would receive 1:1 family support would be offered one to one family support through referrals into the Targeted Pregnancy/family support teams.

Family star assessment and plan, and safer sleep would be discussed as part of this support. Lullaby Trust resources are discussed and given to parents and elements of safer sleep training covered.

All centres have Safe Sleep displays in the seating areas when parents wait for their midwifery appointments. Early Help are currently embedding the new 'Parent and Baby Star' which focuses on the perinatal period indepth. Solihull online guide - 'Understanding my Pregnancy and Birth' is offered which also covers safer sleep practices.

The Pre-Birth Assessment pathway – a preventative assessment is undertaken by Children's Social Care, identifying vulnerability and risk in advance of a child being born ensure appropriate support and care are provided. If social care thresholds are not met, the family are offered targeted pregnancy support. Weekly multi-agency meetings began during Covid to identify and agree support for families identified through the pathway.

Breastfeeding support – breastfeeding is a protective factor with regards to SIDS – babies who are fed breastmilk for at least two month have a 50% lower risk of dying from SIDS. Hull's breastfeeding rates at the moment in Hull are 58.1% at initiation, 44.5% at 10 days and 37% at 6-8 weeks (this has shown an increase during the Covid lockdown periods and is not representative of usual rates). Pre-lockdown it was on average 32% at 6-8 weeks. All agencies work closely to support breastfeeding, but further investment is needed across the city. A lot of interventions have taken place and a task and finish group, under the Maternity Voices Partnership, continually tries to increase uptake.

Smoking cessation - Hull has high levels of smoking in the general population and high levels of pregnant women smoking at time of delivery. SIDS data shows that smoking cigarettes during pregnancy or after birth can significantly increase the chance of SIDS.

The Smoking in Pregnancy sub group of Hull Alliance on Tobacco Control work with key partners to drive down the rates of smoking in pregnancy. Key actions include asking pregnant women their smoking status / delivering a brief intervention / onwards referral to a specialist stop smoking service (Smokefree Hull); there is also a city wide campaign 'Bump the Habit' www.bumpthehabit.org.uk and CO monitors are in use. Smokefree Hull has targets on supporting pregnant women's partners to stop smoking also. Unfortunately, the smoking at time of delivery rate has risen to 23.4% recently and compares with a national rate in Q1 of 9.8%.

The temporary loss of CO monitoring intervention due to Covid restrictions was unfortunate. Mothers were still asked for their smoking status and the same smoking cessation discussions and advice was taking place. Mothers are reporting feeling increasingly stressed and continue to smoke to cope. Some mothers could not identify smoking with any adverse risks despite having frank and challenging conversations.

Care of Next Infant (CONI) programme was set up in 1988 and is run in partnership with the Lullaby Trust and public health services. It provides support for families who have experienced or are at higher risk of SIDS or sudden and unexpected baby death, and who are expecting or have given birth to a new baby.

The CONI programme provides specialist advice, information and support to health professionals (midwifery and health visiting) who support bereaved families with their subsequent babies to help them enjoy the first year of their baby's life, as these families are often very anxious. Hull's plan to roll out this intervention is due to go live very shortly and once the traditional elements have been embedded, they can start to build on the added advantage this programme brings; potentially identifying families at greater risk, e.g. smokers, substance misuse, young parents and working with those families to the reduce the risks.

ICON (www.ICONcope.org) – although not directly related to safer sleep the issue of babies crying and parental stress will impact on safer sleep practices. ICON is a national education programme which has been developed to prevent further child injury and death due to shaken baby syndrome. Abusive Head Trauma (AHT), also known as Shaken Baby Syndrome, is a devastating form of child abuse. A campaign started at the beginning of December 2020 and all agencies across the partnership have engaged in the training and roll out of the campaign, which has been rolled out as an LMS area. Next steps will be to work with GPs and pharmacies for training to be aware and offer support. Banners and leaflets are in all the children's centres and all their staff have been trained.

6.4 Next steps

The following next steps were identified:

- Further training for a range of agencies around safe sleep and ICON. Children's Social Care have discussed pulling together multi-agency safeguarding children and it was felt that training around vulnerable babies would be more appropriate, for building in the above issues and interventions rather than the separate safer sleep training.

  The Designated Paediatrician felt there had been missed opportunities to train NICU and ward staff who don't get access to external safer sleep training. She was advised that there is scope for ICON training to be expanded to ward staff and a specific leaflet is under development. Breastfeeding training is also being looked at being offered to hospital staff on the ward.

- Potential for further training in Renew, Refresh, Probation, Housing, Further and Higher Education such as the Venn Boulevard Centre and also nursing staff on the children's wards might find helpful. Such expansion of training likely to require further investment and resource.

- Expansion of CONI programme would enable the identification and support of families considered at greater risk of SIDS / SUDI i.e. parents that smoke, where there is substance misuse, younger parents or low birth weight babies to enable some intervention work.

CDOP members felt reassured from the conversations and fantastic evidence presented that things are happening across the Partnership to reduce the risks to children and improve outcomes for families, on issues CDOP have been aware of and highlighted over the years.

The CDOP chair has taken information back to the public health team and commissioners with regard to funding support for some initiatives e.g. CONI work and support multi-agency training capacity through his position in the Council.

Further discussion to be undertaken by local Safer Sleep Steering Group and business cases produced, where felt appropriate.

7. Child death and links with deprivation

At the time of writing this report the National Child Mortality Database report on "Child Mortality and Social Deprivation" (using data April 2019-March 2020) had been published (May 2021). This report found a clear association between the risk of child death and social deprivation in England, including sudden infant death, and quoted a stark headline of *"Over a fifth of all child deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived. "*

The national report concluded that there is an overall clear gradient of increasing childhood mortality at all ages by increasing deprivation in England, which is not explained by sex, age or rural/ urban location. The only exception to this is deaths from malignancy, which show little evidence of any relationship with deprivation. The proportion of deaths with identified modifiable factors also increased with increasing deprivation; with factors relating to the social environment being the most numerous reported. 700 fewer child deaths a year might be avoided if children who are among the most deprived half of the population had the same mortality risk as the least deprived.

The report's key findings and recommendations are pictured here.

Key findings
Child Mortality and Social Deprivation
April 2019 to March 2020

NCMD
National Child Mortality Database

CLEAR ASSOCIATION between RISK OF DEATH and level of DEPRIVATION (all categories except malignancy)

Relative 10% INCREASE in RISK OF DEATH between each decile of increasing deprivation (on average)

>1 in 5 CHILD DEATHS might be AVOIDED if children living in most the deprived areas had the same mortality risk as those living in the least deprived

INCREASED PROPORTION of deaths with modifiable contributory factors with INCREASING DEPRIVATION

1 in 12 CHILD DEATHS reviewed in 2019/20 identified 1 OR MORE factors related to DEPRIVATION

EXEMPLAR PROJECTS highlighting strategies informed by recurring themes and local learning to REDUCE MORTALITY

RECOMMENDATION

Use the data in this report to DEVELOP and MONITOR the IMPACT of future strategies to REDUCE SOCIAL DEPRIVATION and INEQUALITIES

ACTION BY: Policy Makers, Public Health Services, Service Planners and Commissioners at local and national level

8. Other Child Death Review updates

Training

Three full day Joint Agency Response training dates were scheduled for 2020/2021, however, all face to face training was cancelled during the pandemic so no multi-agency courses were held during 2020/21. However, the Designated Paediatrician for Deaths in Childhood undertook single agency training with police officers and hospital doctors.

Facilitators will be reviewing the training with a view to developing an online course during 2021/22.

Since 2008, 663 professionals (across Hull and East Riding area), predominantly from health, police and children's social care, have attended training in responding to the unexpected death of a child which helps contribute to ensuring that each unexpected child death is investigated in a thorough and systematic way that is sensitive to and supportive of parents, and that as professionals and communities we learn lessons to help prevent future deaths. Typical feedback was that delegates left the training more confident about implementing the process due to an increased knowledge and appreciation of other agencies' roles and responsibilities.

CDOP e-bulletin

Members continue to disseminate a locally produced e-bulletin within their respective agencies to share news and advice on learning from child deaths, recommendations from Coroners' inquests, as well as national guidance, research, publications and news from organisations working to prevent child deaths and accidents.

e-CDOP

Like the majority of CDOPs around the country, Hull purchased e-CDOP, a secure web-based software that allows the child death review process to be managed efficiently, with effective sharing of multi-agency information. e-CDOP is fully compliant to the data processing GDPR standards outlined by the ICO and with new Working Together guidance. Hull's system went live on 1st January 2021, recording and reporting on child deaths notified from 1st January. Early indications are that this will support local processes and the professionals involved.

The benefits include:-

- Allows child deaths to be reported quickly and securely online
- Alerts relevant partners about child deaths in real-time
- Enables full case management of child deaths following the government led reporting process
- Provides automated reminders to agencies involved in child death review forms
- Enables CDOP panel members fingertip access to all that's needed for efficient review of child deaths – no need to share hard copy paperwork
- Enhances the ability to undertake thematic analysis

- Gives fast and easy access to data meeting the statutory reporting requirements
- Reduces administration time
- Improves the quality of information shared between agencies
- automatically feeds into the National Child Mortality Database (NCMD)

National Child Mortality Database (NCMD)

The National Child Mortality Database is a publicly-funded project that gathers information on all children who die across England. They aim to learn lessons to support change and help save children's lives in the future.

The NCMD Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices. Its aim is to promote quality improvement in patient outcomes. HQIP holds the contract to commission, manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. NCAPOP is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies www.hqip.org.uk/national-programmes

The NCMD programme and its website for host a 'One-stop-shop' for child death review support and guidance and a wealth of information for professionals involved in any of the elements of the child death review process:

- Joint Agency Response (JAR)
- Multi-Agency Child Death Review Meeting (CDRM)
- Child Death Overview Panel (CDOP)
- Supporting bereaved families
- Safety notices-dangers and warnings identified for national learning from local reviews
- Commissioning of themed reports
- Webinars to launch research and national reports, guidance on child death review processes and forms

CDOPs supported NCMD data which helped to guide the NHS response to the COVID-19 pandemic. The statutory child death notification form was modified from 1 April 2020 to include a COVID-19 specific module. Data linkage with the COVID-19 test results held at Public Health England was established to ensure the COVID-19 status of all children who died is confirmed.

This enabled NCMD to carry out a more rapid review of all child death notifications and feedback commenced to key stakeholders within NHS England to quantify the impact of the pandemic, and the corresponding social changes, on childhood mortality.

These data have helped and continue to guide the NHS response to the COVID-19 pandemic, identifying important features of the direct and indirect effects of the virus to guide policy changes at national level. We can expect to see further analyses on COVID-19 and child mortality in future reports.

9. Recommendations

9.1 Recommendations from 2019/20 annual report

1. **Continue to liaise with colleagues across the Humber Coast and Vale footprint to further develop the joint working across the wider sub-regional CDOP footprint i.e. a local review may be able to identify specific learning but trends analysis at a regional level may identify modifiable factors that could be altered to prevent future deaths.**

   Although there was liaison between CDOP chairs and CCG leads during 2020/21, it was minimal as a result of the Covid pandemic due to competing priorities for members.

   Changes with establishment of Integrated Care Systems (ICS) are rapidly evolving and present opportunities for increased joint working across other areas.

   Networking opportunities increased with the adoption of virtual meetings. There has been greater access to national and regional meetings with the ease of on line forums. As such, there have been new national and local groups that are looking at education, support and local working arrangements for the Designated Doctor and the development of a SUDIC role locally but in collaboration with neighbouring CDOP areas.

   A regional CDOP Co-ordinators’ group discussed the challenges of review processes and opportunities for collaboration during the pandemic. Anonymised information on how and why children die continues to be shared to consider co-ordinating campaigns and communication strategies in response to a particular death or pattern of deaths. Members shared experiences of local systems and processes with a view to building consistency across the region.

2. **Liaise with sub-regional partners to discuss reviewing our different approaches to defining modifiable factors.**

   There had been meetings in previous years with regional colleagues to assure some agreements/consistencies around recording modifiable factors for neonatal/perinatal deaths and parental factors/lifestyles. Conversations will be resurrected as ICS arrangements develop.

3. **Assess the implications of the legislative and structural changes happening within the NHS and Integrated Care Systems in relation to CDOPs and the CDR process generally.**

   Relates to Recommendation 1 above. There are ongoing discussions about new developments and what this means for place-based practice and joint working. Issues identified have been included with local CCG risk registers. There will be continued commitment to ICS arrangements in relation CDOP structures.

4. **Undertake themed CDOP meetings**

   During the Covid pandemic when staff resources were stretched, themed child death review meetings were held for some neonatal deaths, children with learning disabilities (LeDeR cases) and sudden infant death. This approach was welcomed and was felt to bring out rich learning for CDRM participants and CDOP members by reviewing more than one case at a time. There are plans to use this approach in future with other types of deaths.

5. **Seek assurance regarding the extent to which there is appropriate local understanding of the data and trends relating to children killed and seriously injured on roads, and the level of preventive activity taking place locally.**

   When reviewing a road traffic collision, local KSI (killed or seriously injured) highlighted the high number and increasing trend in our area. Local deaths on the road during 2020/21 related to an off road incident and car driver error. The CDOP Chair/Public Health has committed to follow-up links with local safety initiatives/partnerships for conversations about local data, levels of prevention activity and sharing knowledge and awareness of local data and trends.

   Safer Roads Humber will be invited to attend future CDOP meetings when reviewing road traffic collisions.

6. **Continue to address membership of the CDOP with reference to the national guidance e.g. Community Paediatrician and Lay Member etc.**

   Membership is and will continue to be discussed regularly. Members have been satisfied with current representation. There is flexible membership for themed meetings to allow specialist input. Community paediatrician representation will be considered in future for relevant deaths in the community.

9.2 Recommendations for 2021/22

1. Despite the tireless work undertaken by a wide range of professional to support families in promoting safer sleep, reducing unsafe sleeping practices for babies remain a priority. In particular it is necessary to tackle inequalities and the impact it has on the rate of SIDS – **CDOP's future work plan will be to oversee compliance with the recommendations in the NCMD's Annual Report and NCMD report on Child Mortality and Social Deprivation:**

   - The National Child Mortality Database annual report for 2019/20 is calling on all professionals involved in planning or providing services to children to use the data in their report to inform local, regional and national actions in order to reduce the number of children who die.

   - The National Child Mortality Database thematic report on Child Mortality and Social Deprivation has recommended using the data in their report to develop and monitor the impact of future strategies to reduce social deprivation and inequalities

   – see recommendations below.

Recommendation	Action by	Hull response
1.1 Continue to use the NCMD child death case alert functionality. This will ensure regular and timely review of all alerts to inform immediate national learning and action, to ensure the safety of other children.	Child Death Review Professionals, Child Death Overview Panels	
1.2 Consider creating, implementing and maintaining a system for structured and sustainable training, guidance and support for CDOPs and child death review professionals. This will standardise the CDOP processes and drive further improvements in the national data quality.	Department of Health and Social Care	
1.3 Continue to notify NCMD of all child deaths to ensure complete case ascertainment. Registrars of Deaths to notify CDOPs of all deaths of children under 18 years of age, to ensure that CDOPs know about all deaths of children in their area.	Child Death Review Professionals, Child Death Overview Panels, Registrars of Deaths	

1.4 Support availability and access to complete ethnicity and gestational age at birth data at the point of notifying a death to NCMD.	Child Death Review Professionals, Child Death Overview Panels, NHS England, Department of Health and Social Care	
1.5 Integrate local learning and actions with information from the Child Mortality and Social Deprivation report, to reduce the number of preterm births and improve outcomes after unavoidable preterm delivery.	Hospital Trusts, Service Planners, Commissioners and Policy Makers at local and regional level	
1.6 Review the most frequent modifiable factors, as presented in the Child Mortality and Social Deprivation report, and consider how to address them at a local, regional and national level.	Policy Makers, Public Health Services, Service Planners and Commissioners at local and regional level, Local Government, Police and Crime Commissioners	
1.7 Continue to use the child death review process to highlight positive aspects of service delivery and to give detail of examples of excellent care as a powerful way of sharing best practice nationally.	Child Death Review Professionals, Child Death Overview Panels	
1.8 Use the data in the Child Mortality and Social Deprivation report to develop and monitor the impact of future strategies to reduce social deprivation and inequalities.	Policy Makers, Public Health Services, Service Planners and Commissioners at local and national level.	

Hull CDOP has shared details of the two NCMD reports within partner agencies and its key messages will be the topic of discussions during 2021 and beyond to determine next steps for action by agencies and professionals.

2. **CDOP will continue to assess the use of technology for engaging partners in meetings and training.**

3. **Each year, the CDOP annual report will focus on a specific issue for learning – next year’s report will focus on sudden and unexpected infant deaths**

4. **CDOP will review and assess the impact of the Covid-19 pandemic on child deaths, responding to child deaths and managing reviews in relation to resources and processes. Learning will be shared with local and regional partners as appropriate.**

The Child Death Review Operational Group will oversee and provide assurance for the outcomes and recommendations set out in the CDOP annual report. Any matters requiring escalation will be considered by the Child Death Review Executive Group.

Analysis, findings and outcomes from the CDOP Annual Report will be linked into the local joint strategic needs assessment.

The CDOP annual report will be shared with:

- CDOP Chairs across Humber, Coast & Vale
- Hull Safeguarding Children Partnership
- Hull Collaboration Partnership
- CCG Quality & Performance Committee and CCG Board