Anita Dobson, CDOP Chair

In North Yorkshire, the smoking in pregnancy rate has reduced from 2016/2017 but continues to be worse than the England average. 11.7% of women, which equates to 595 women in 2017/2018, smoked in pregnancy. The England average was 10.8%. Similarly, the smoking in pregnancy rate in City of York (10.4% or 177 women) is in line with the England average but remains under the Tobacco Plan national target of 6% by 2022.

National data shows a correlation between deaths and deprivation, however, analysis of local data shows no obvious correlation locally. Many factors can impact on rates of both infant mortality and Sudden Unexpected Death in Infancy (SUDI), including:

- Low birth weight (increases the likelihood of death in the first year after birth by 27%).
- Poverty (there is a link between deaths and socioeconomic status).
- Age (infant mortality is higher in babies born to a young mother).
- Smoking (babies are at greater risk of unexpected death when a mother smokes during pregnancy or, if there is smoking in the home).
- Sleeping habits - greater risk is associated with placing a baby on the front or side to sleep or in a room alone. Bed sharing with a baby when a parent is a smoker or under the influence of drugs or alcohol may also increase the risk.
- Overcrowding has been identified as a factor in affecting sleeping habits in the home.

Action to reduce child deaths:

- Early (antenatal) education of carers and parents on ‘safer sleeping actions’, including:
  - Ensuring that infants sleep in the supine position.
  - Keeping the baby’s head uncovered by placing the baby in the ‘feet to foot’ position.
  - Ensuring that infants sleep in a separate cot.
  - Ensuring that infants sleep in the same room as their parents.
  - Avoid sleeping on a sofa or in an armchair with the infant.
  - Reduce smoking in pregnancy and parents, and reduce exposure to tobacco smoke in the home and cars.
  - Encouraging and supporting mothers to breastfeed.
  - Addressing maternal obesity by incorporating community-based public health services starting from preconception.
  - Timely and complete immunisations of children is one of the most important aspects of prevention in primary care.
  - Focusing prevention programmes on families most at risk, in particular those with social circumstances that expose infants to more risk and promote parental behaviour change.
  - Training carers and parents in rescue and resuscitation techniques to minimise the severity of outcomes.
  - Ongoing awareness raising and education about SUDI using available resources and by disseminating learning from investigated cases across all agencies.
  - Provision of adequate support to affected parents and families.
1. Introduction

1.1 The death of a child is a devastating loss that profoundly affects all those involved. Since April 2008 all deaths of children up to the age of 18 years, excluding still births and planned terminations are to be reviewed by a Child Death Overview Panel (CDOP) to accommodate the national guidance and statutory requirement set out in Working Together to Safeguard Children 2018. From 1st April 2019 still births and planned terminations will be reviewed by the CDOP if a clinician was not present.

1.2 The publication of the Child Death Review Statutory and Operational Guidance in 2018 builds on the requirements set out in Chapter 5 of Working Together to Safeguard Children 2018 and details how individual professionals and organisations across all sectors involved in the Child Death Review should contribute to guided standardised practice nationally and enable thematic learning to prevent future child deaths.

1.3 Child Death Review partners, the Local Authorities and Clinical Commissioning Groups for North Yorkshire and City of York now hold responsibility for the delivery of the Child Death Review Process as set out in the Children Act 2004, as amended by the Children and Social Work Act 2017. The CDOP is multi-agency with differing areas of professional expertise. This process is undertaken locally for all children who are normally resident in North Yorkshire and City of York.

1.4 The collation and sharing of all learning from Child Death Reviews and the CDOP is now managed by the National Child Mortality Database (NCMD) which became operational on 1st April 2019.

1.5 The purpose of the Child Death Review Process is to try to ascertain why children die and put in place interventions to protect other children and prevent future deaths wherever possible. The process intends to:

- Document, analyse and review information in relation to each child that dies in order to confirm the cause of death, determine any contributing factors and to identify learning arising from the process that may prevent future child deaths
- To make recommendations to all relevant organisations where actions have been identified which may prevent future deaths or promote the health, safety and wellbeing of children
- To produce an annual report on local patterns and trends in child death, any lessons learnt and actions taken, and the effectiveness of the wider Child Death Review Process
- To contribute to local, regional and national initiatives to improve learning from Child Death Reviews.
2. Membership and Panel Meetings

2.1 The Child Death Overview Panel meetings are held on a bi-monthly basis and have had consistent organisational commitment since they were established in 2008. The Chair of the CDOP is Anita Dobson, Nurse Consultant in Public Health and she has been the chair since September 2018. Prior to this Katie Needham, Public Health Consultant chaired the CDOP between April and September 2018.

Membership of the Child Death Overview Panel

<table>
<thead>
<tr>
<th>Member</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anita Dobson</td>
<td>Nurse Consultant in Public Health, City of York Council</td>
</tr>
<tr>
<td>Katie Needham</td>
<td>Public Health Consultant, North Yorkshire County Council</td>
</tr>
<tr>
<td>Victoria Ononeze</td>
<td>Public Health Consultant, North Yorkshire County Council</td>
</tr>
<tr>
<td>Dr Sally Smith</td>
<td>Designated Doctor for Child Deaths &amp; Consultant Paediatrician, York Teaching Hospital Foundation Trust</td>
</tr>
<tr>
<td>James Parkes</td>
<td>Safeguarding Children Board Manager, North Yorkshire</td>
</tr>
<tr>
<td>Juliet Burton</td>
<td>Safeguarding Children Partnership Manager, City of York</td>
</tr>
<tr>
<td>Jo Gomerson</td>
<td>Group Manager Referral &amp; Assessment Service, City of York Council</td>
</tr>
<tr>
<td>Louise Hollick</td>
<td>Group Manager, Children &amp; Families, North Yorkshire County Council</td>
</tr>
<tr>
<td>Jemma Cormack</td>
<td>Safeguarding Manager, North Yorkshire Police</td>
</tr>
<tr>
<td>Elizabeth Ross</td>
<td>Head of Midwifery, Supervisor of Midwives, York Teaching Hospital Foundation Trust</td>
</tr>
<tr>
<td>Alison Pedlingham</td>
<td>Head of Midwifery, Supervisor of Midwives, Harrogate District Foundation Trust</td>
</tr>
<tr>
<td>Dr Natalie Lyth</td>
<td>Children’s Designated Doctor for Safeguarding, Harrogate District Foundation Trust</td>
</tr>
<tr>
<td>Dr Sarah Snowden</td>
<td>Children’s Designated Doctor for Safeguarding, York Teaching Hospital Foundation Trust</td>
</tr>
<tr>
<td>Kate Dawson</td>
<td>Strategic Clinical Lead, Health Child Service, City of York</td>
</tr>
<tr>
<td>Rachel Wigin</td>
<td>5 – 19 Service, Clinical Lead, Harrogate District Foundation Trust</td>
</tr>
<tr>
<td>Jane Webster</td>
<td>Health Visiting Professional Lead, Harrogate District Foundation Trust</td>
</tr>
<tr>
<td>Patricia Handy</td>
<td>North Yorkshire Safeguarding Children Board LAY Member</td>
</tr>
<tr>
<td>Barry Thomas</td>
<td>City of York Safeguarding Children Partnership LAY Member</td>
</tr>
<tr>
<td>Ali Firby</td>
<td>Child Death Review Coordinator for North Yorkshire and City of York</td>
</tr>
</tbody>
</table>

Table 1 - CDOP Panel Membership – as at 31st March 2019

3. Data Analysis

3.1 Total number of infant and child deaths

3.3.1.1 A total number of 37 children residing in North Yorkshire and City of York died in 2018/2019. Since 2014/2015 the number of child deaths have fluctuated as detailed in table 1.

3.1.3 The data detailed in table 2 summarises the age of the North Yorkshire and City of York children at death over the past 5 years. 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, however 2018-2019 saw an increase in deaths of infants aged 28 – 364 days. 7 of the 11 deaths in this age range are unexpected.

### Child Deaths in North Yorkshire and City of York 2014 -2019

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

### Age of Child Deaths in North Yorkshire and City of York 2014 - 2019

(Source: North Yorkshire and City of York CDOP Data)
3.2 Expected and Unexpected child deaths

3.2.1 There are two categories of child deaths:
1. A child death is “expected” death where the death of an infant or child was anticipated due to a life limiting condition.
2. A child death is an “unexpected” death where the death of an infant or child was not anticipated as a significant possibility, for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which led to the death.

3.2.2 Over a 5 year average there have been 73 unexpected deaths and 105 expected deaths. Table 3, shows the number of deaths which have been notified as expected and unexpected for the last 5 years.

3.3 Location of death

3.3.1 The 37 deaths notified to CDOP in 2018/2019 occurred in the following settings; at home (2), in a public place (2), in a hospital (28) and in a hospice (5).

3.4 Gender

3.4.1 A breakdown of the number of child deaths by gender is outlined in Table 4. Nationally and locally the mortality rate for males is higher than females.

3.5 Ethnicity

3.5.1 Of the 37 child deaths notified to CDOP in 2018/2019, 35 were classified as “White British”, 1 as “Pakistani” and 1 as “Any other white ethnic background”.

3.6 Disabled children

Out of the 37 child deaths notified in 2018/2019 there were 3 children who were known to have a disability. Those child deaths have been notified to the Learning Disabilities Mortality Review Programme (LeDeR) by CDOP to assist with their review and share learning from deaths of children with disabilities.
3.7 Categories of Child Deaths

3.7.1 During the CDOP meeting the panel members categorise all child deaths which are then recorded on a CDOP system. Categories of child death are identified nationally and are provided to CDOPs by the Department for Education. Detailed in table 5 are the categories of child deaths that have been agreed as of 31 March 2018.

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

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>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.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. Suicide or deliberate self-inflicted harm - This includes any act intentionally to cause one’s own death. It usually apply to adolescents rather than younger children.</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>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.</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>4. Malignancy - This includes cancer and cancer like conditions such as solid tumours, leukaemia &amp; lymphomas, and other malignant proliferative conditions, even if the final event leading to death was infection, haemorrhage etc.</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>5. Acute medical or surgical condition - A brief sudden onset of illness which resulted in the death of a child.</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>6. Chronic medical condition – A medical condition which has lasted a long time or was recurrent and resulted in the death of a child.</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>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.</td>
<td>8</td>
<td>8</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>29</td>
</tr>
<tr>
<td>8. Perinatal/neonatal event – The death of a child as a result of extreme prematurity, adverse outcomes of the birthing process, intrauterine procedure or within the first four weeks of life.</td>
<td>14</td>
<td>14</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td>50</td>
</tr>
<tr>
<td>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.</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>10. Sudden unexpected or unexplained death – This is where pathological diagnosis is either Sudden Infant Death Syndrome (SIDS) or ‘unascertained’, at any age.</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total number of child deaths reviewed by CDOP</strong></td>
<td><strong>34</strong></td>
<td><strong>34</strong></td>
<td><strong>30</strong></td>
<td><strong>29</strong></td>
<td><strong>24</strong></td>
<td><strong>151</strong></td>
</tr>
</tbody>
</table>

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

3.7.1 The increase in the number of cases to be reviewed by CDOP is due a panel meeting of 2018/2019 being re-arranged for a later date. The review of these cases will be reflective in the 2019/2020 annual report.

3.7.2 There are 13 child deaths which occurred in 2017/2018 and 28 child deaths which occurred in 2018/2019 which have not yet been taken to panel. These are planned for review during 2019/2020. The information on these deaths will also be included in the 2019/2020 annual report.

3.7.3 As detailed in Table 5, of the 151 child deaths that have been reviewed by panel over the past 5 years, the main categories of the child deaths are:
- Category - Perinatal/neonatal event (33%)
- Category - Chromosomal, genetic and congenital anomalies (19%)
- Category – Acute medical or surgical condition (11%)
4. CDOP Process – Unexpected Deaths

4.1 When an unexpected child death occurs, a “Joint Agency Response Meeting” is initiated. Within this process the lead agency which may be either the Police or the Consultant Paediatrician involved in the care of the child will inform the Child Death Review Coordinator who will ensure a meeting takes place within 72 hours of the child’s death. The aim of the Joint Agency Response meeting is to enable the sharing of information, multi-agency discussions and planning to safeguard other individuals if identified.

4.2 Within the next few months, a follow up meeting (known locally as a ‘Child Death Review’ meeting) reviews the unexpected death. Of the 12 unexpected deaths that occurred within 2018/2019, 4 child deaths have been reviewed at a Child Death Review meeting. There are 2 Child Death Review meetings arranged for April 2019 and the remainder are due to take place by September 2019.

4.5.1 It is the Coroner’s responsibility to determine the cause of death where this is not known. If it is not possible to find out the cause of death from the post mortem examination, or the death is found to be unnatural, the Coroner will hold an inquest, a public court hearing held by the Coroner in order to establish who died and how, when and where the death occurred.

4.3 CDOP Process – Expected Deaths

4.4 The process for expected deaths differs slightly. When a notification is received by Child Death Review Coordinator, each agency that was involved in the care of the child prior to their death must complete an ‘Agency Report Form’. This form captures all the relevant information about the child and family to inform the CDOP process when considering modifiable factors. On 1st April 2019, new child death review forms were released by NHS England which will replace previous ones. In addition to the reporting form there are a number of supplementary forms which the Child Death Review Coordinator will use to collect information from the relevant professionals to upload to the National Child Mortality Database (NCMD) and collate for the CDOP review.

4.6 Child Death Overview Panel

4.6 The purpose of the panel is to consider any learning or factors that could prevent future deaths of children. Following the completion of the CDOP Process and when the cause of the child’s death has been determined for both expected and unexpected child deaths, the information relating to the case is anonymised and is taken to the Child Death Overview Panel for discussion and review.

4.6.2 During 2018/2019, the panel has reviewed a total of 24 cases. Of these cases, 15 of the deaths occurred in the previous years, the oldest case being from November 2015. Cases can take over six months to be brought to panel for review. This may be because the CDOP is awaiting information from agencies, for example post mortem reports or if there is an on-going police investigation, in which case the discussions may be deferred pending the result of the enquiry. It should be noted that a child’s death cannot be discussed at panel until all information is received.

4.6.3 Of the 37 child deaths that occurred in 2018/2019, 9 have been discussed at panel.

4.7 Modifiable factors

4.7.1 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”.

4.7.2 When the panel has reviewed the death of a child they will then identify and agree any modifiable factors that may have prevented the death. Out of the 24 child deaths reviewed by the panel in 2018/2019, there were 8 cases 33.33% where modifiable factors were identified.

4.7.3 Where modifiable factors are identified the Panel has taken action to address these where appropriate. For example we continue to re-enforce safe sleep messages and the risk of alcohol misuse and smoking during pregnancy.

4.7.4 Part of the NHS Neonatal Plan is to reduce by Neonatal Deaths by 20% by 2021 and 50% by 2025.
5. Learning from child deaths 2018/2019

The aggregated findings from all child deaths informs local strategic planning including the joint strategic needs assessment, on how to best safeguard and promote the welfare of children in the area. This annual report will assist in ensuring that learning from CDOP is shared with partners and informs the wider NYSCB and CYSCP annual reports.

6. What has CDOP achieved in 2018/2019

- CDOP developed its relationship with the Major Incident Response Team (MIRT) which has strengthen the understanding of the services both CDOP and MIRT deliver. MIRT contributed to the NYSCB Managers Masterclasses which assisted in raising awareness to services across North Yorkshire and York for their work including post-vention suicide support.

- The Designated Doctor for Child Death and Child Death Review Coordinator have developed the new Child Death Review Training for Professionals. The training incorporates the new guidance and how it is implemented locally and can be accessed here.

- CDOP continue to contribute to the Paediatric Mortality Review Meetings with each of the Sudden and Unexpected Death in Infancy and Childhood (SUDIC) leads to review child death that have occurred at hospitals across the county to establish effective working relationships and information sharing.

- CDOP actively engages with the Yorkshire and Humber Regional CDOP Coordinator Meetings and Sub Regional CDOP meetings sharing information to develop our understanding of child deaths across the region, share best practice and understand the challenges faced.

- The Designated Doctor for Child Death has been appointed as the CDOP representative on the National Network for Designated Health Professionals.

- CDOP along with NYSCB Business Unit have been a key supporter of the Suicide Prevention work within the county and are actively contributing to the development of the North Yorkshire Self Harm Pathway that will be published in summer 2019.

- CDOP has undertaken joint work with the 0-5 Health Child Service to promote Safe Sleep

7.1 CDOP Priorities for 2019/2020

1. Reduce the mortality rate of children and young people in North Yorkshire through a coordinated response with actions to prevent recurrence.

2. To seek assurance that partners are working collectively on the Suicide Prevention agenda

3. Launch the Self-Harm and Suicide Prevention pathway.

4. CDOP to attend and engage with Paediatric Mortality Meetings to gathering further information in relation to neonatal deaths across the county.

5. To raise the profile of the Child Death Review Process by delivering multi-agency training across the county.

6. Reintegrated the letter to parent’s and booklet informing them of the Child Death Review Process to sure better parental involvement in the Child Death Review Process

7. To identify and share bereavement support services that are available to Children, Young People, Families and Communities.
Contact details:

North Yorkshire & City of York CDOP
South Block
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