HULL CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT

2021/22

Hull City Council

NHS Hull Clinical Commissioning Group

CONTENTS

1. CHAIR'S FOREWORD

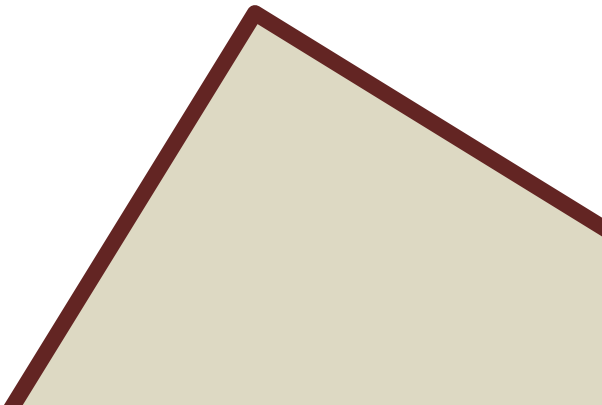
This report aims to give an account of the work of Hull's Child Death Overview Panel in 2021-22, and to ensure that as a system we learn all we can from every death we review to help prevent future deaths and improve the quality of care we provide.

I wasn't chair of the CDOP during the time period covered by this report, but I have studied each of the analysis forms. What struck me most was the additional stresses and pressures that most of the families had already been suffering at the time they lost their child. It's the families in our community who already carry the heaviest burdens of poverty and of disadvantage and of illness who are at the greatest risk of losing a child, as the National Child Mortality Database's thematic report on Child Mortality and Social Deprivation evidenced. Whilst the specific learning from every individual death is extremely valuable in preventing future deaths, we also need to be mindful that reducing poverty, reducing adverse childhood experiences, and improving children's health and wellbeing will all actively contribute to reducing future child deaths as well.

The loss of a child you love echoes throughout the rest of your life. Everyone involved in the CDOP work in Hull strives to fulfil their role with the respect and care that's owed to the children, their families and professionals and I trust that this report reflects that.

Helen Christmas,

Public Health Consultant and CDOP Chair



2. INTRODUCTION and 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.

Child Death Overview Panels (CDOP) became statutory in April 2008. CDOP has a statutory responsibility to review the deaths of all children up to the age of 18 years old (excluding babies who are stillborn, late foetal loss and planned terminations of pregnancy carried out within the law) resident within the Local Authority area of Hull. It includes any infant death where a death certificate has been issued, irrespective of gestational age.

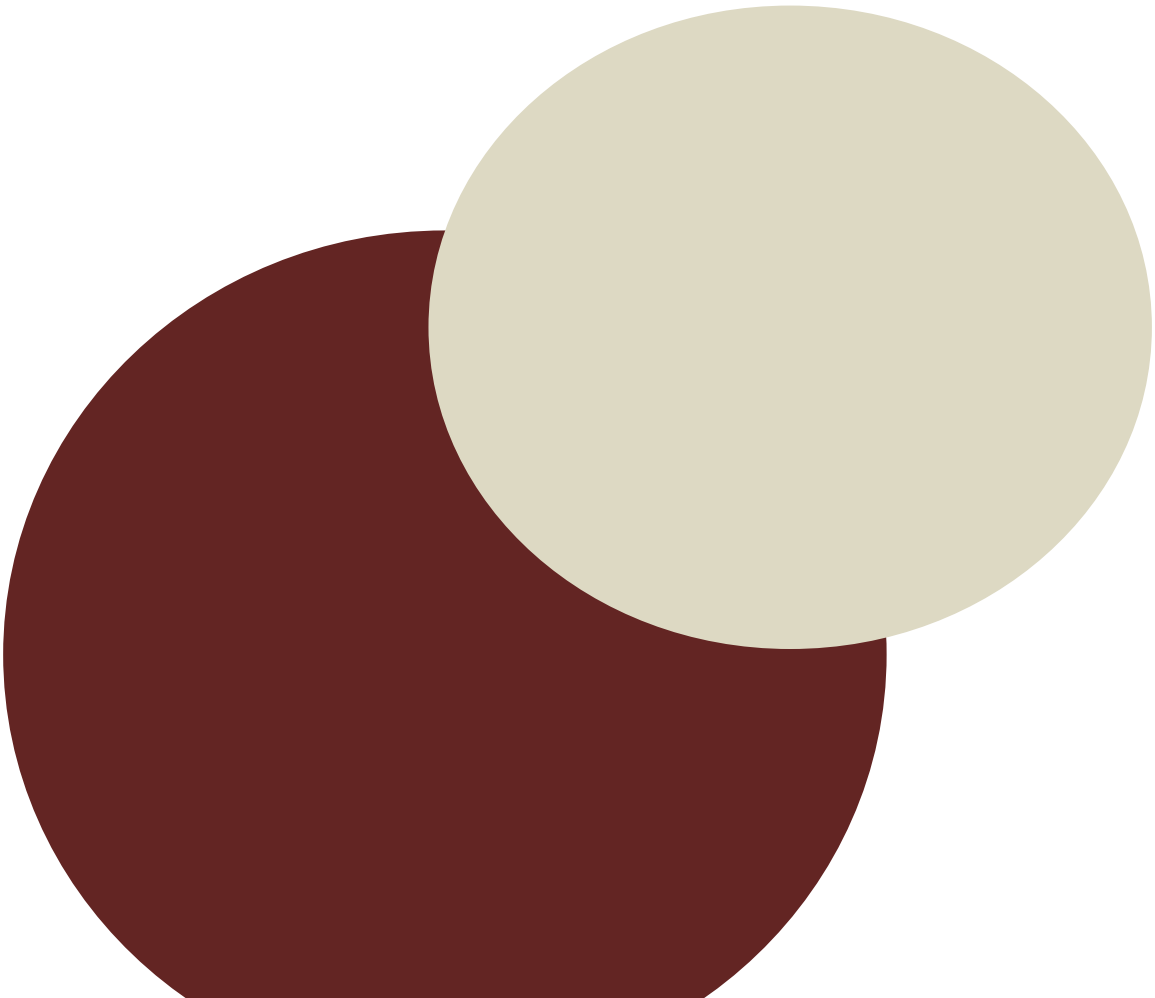
The publication of the Child Death Review Statutory and Operational Guidance in 2018 builds on the requirements set out in Chapter 5 of Working Together to Safeguard Children 2018 and details how individual professionals and organisations across all sectors involved in the Child Death Review should contribute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

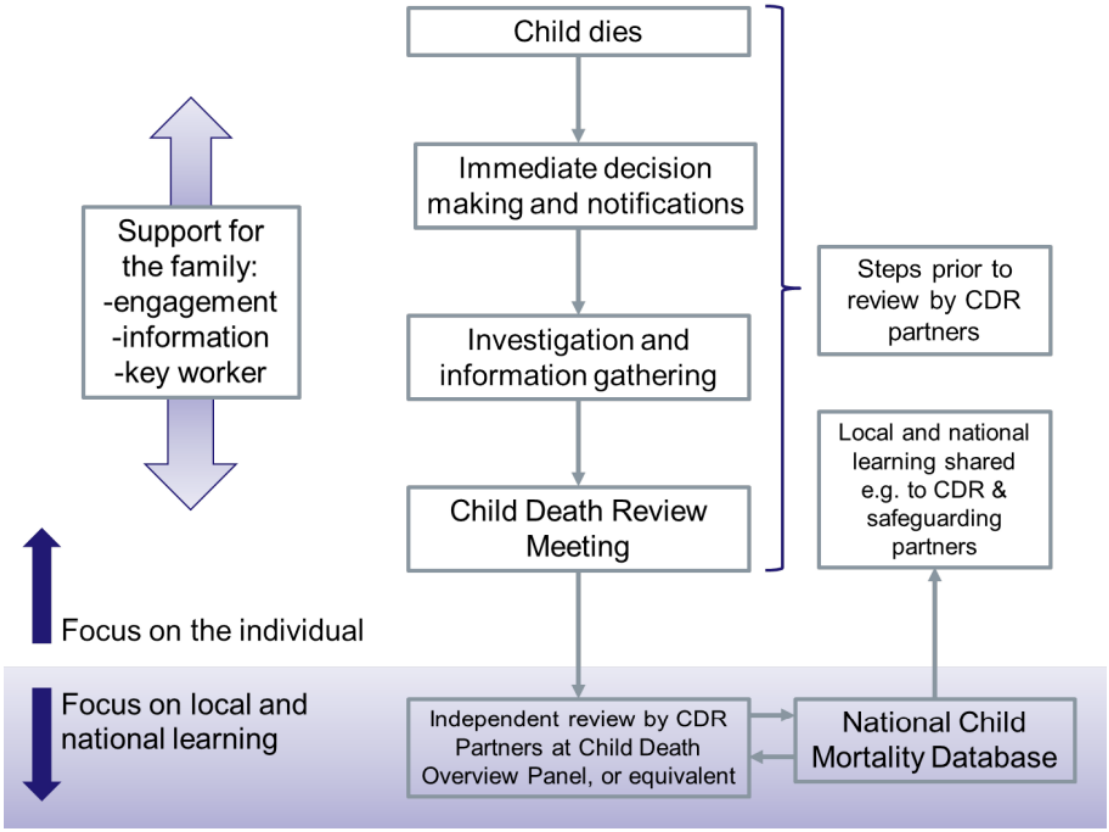
As part of our local arrangements Hull CCG (now Humber and North Yorkshire Integrated Care Board, Hull Place) and Hull City Council as Child Death Review partners lead a Child Death Review Operational Group to ensure our arrangements comply with statutory guidance and are working effectively. The group meet regularly to progress a local delivery plan. A Child Death Review Executive Group provides strategic oversight for the local child death review process.

Membership comprises of joint chairs, Director of Public Health, and Interim Director of Nursing and Quality, also CDOP chair, Designated Nurse Safeguarding, Designated Doctor for child deaths, Child Death Review Co-ordinator.

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 care for children in England, with the overall goal to reduce child mortality.



The chart below illustrates the full process of a child death review.



Processes ensure appropriate links are made with other statutory review processes, for example:

- [1]Perinatal Mortality Review Tool (for infants under 28 days or older who died on Neonatal Intensive Care (NICU)
- [2]NHS Serious Incident investigations
- [3]Post Mortem examination
- [4]Inquest

[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] 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,

- [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

Each review at CDOP is informed by information collated from the notification and from a range of meetings, depending on the circumstances of the death.

CDOP is the culmination of the CDR processes and aims to draw together thematic learning.

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.

Child Death Overview Panel (CDOP)

The Child Death Overview Panel is multi-agency with differing areas of professional expertise. Core membership of Hull's CDOP can be found on page 6. Panels meet several times a year to review all the child deaths in their area. Panels are not given the names of the children who died or the professionals involved in their care. The main purpose is to prevent similar deaths in the future.

CDOPs do not produce reports on individual child deaths, which is why parents do not receive any information from the panels about their individual child. The panels do, however, produce an annual report which is a public document.

The CDOP review ensures independent 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.

Statutory guidance suggests CDOP reviews should take place approximately 6 weeks after a CDRM or after an Inquest. Hull CDOP schedule their meetings monthly but due to catching up with some historical cases and a maximum number of cases that can feasibly be discussed in one meeting, meetings can take longer than 6 weeks to discuss. During 2021/22, Hull CDOP met 11 times and reviewed 24 child deaths. Eight of these deaths occurred in 2019/20 and 16 occurred in 2020/21.

At the year end, Hull CDOP had reviewed 92% of child death notifications received since the process commenced on 1st April 2008. Going into 2022/23 there were 27 child deaths pending review, at various stages of the process:

- 7 deaths were undergoing parallel processes and pending conclusion of enquiries and investigations
- 10 deaths were waiting for child death review meetings to be organised 3 deaths were within the timeframe of 3 months from notification/conclusion of parallel process and 10 were outside of timeframe but within 12 months.
- 7 child death review meetings were booked in for dates in 2022/23

- 3 child death review meetings had taken place and were pending final review at a CDOP meeting in 2022/23

The local child death review Operational Group and Exec Group track and monitor all pending cases and are aware that the impact of the COVID-19 pandemic on slowing some progress against the intended objectives with key staff needing to take lead roles in the pandemic response, restoration and recovery. Also, the transition to the new arrangements in 2019 resulted in delays in the completion of some CDRM, particularly with those reviews of children who died out of Hull hospitals. Through 2020 the CDR Operational Group has been working to ensure completion of those cases delayed for non-statutory reasons (e.g. Coroners cases) however this has remained a challenge during 2021 on which the CDR Executive is sighted.

The CDR Operational Group has continued to maintain oversight of individual child deaths and the scheduling of CDRMs during 2021-22. In acknowledging the challenges, the group have supported a revised approach to existing processes, to enable CDRM meetings to progress; this includes the use of virtual meetings and the `clustering` of similar cases whereby the medical and clinical teams and professionals are the same. This has enabled an increase in the number of reviews completed in 2021/22 compared with the previous year.

National Child Mortality Database (NCMD)

The NCMD is an NHS funded project, delivered by the University of Bristol and since 1st April 2019 it has undertaken real time surveillance of all child deaths in England. Using national standardised forms, CDOPs are required to input notifications, agency reporting forms and analysis forms into the database for them to gather and analyse the data with the aim to learn lessons that could lead to changes to improve and save children's lives in the future.

Child death review partners and CDOP members engage in the NCMD Webinars which are designed to provide detailed updates on the NCMD, discuss emerging issues and obtain information around the latest events and research publications.

3. MEMBERSHIP AND PANEL MEETINGS

The Child Death Overview Panel meetings are held on a monthly basis. The membership at 31/3/22 can be seen below:

Assistant Director of Health & Well Being Public Health	Hull City Council (Chair)
Consultant Paediatrician for Deaths in Childhood	Hull University Teaching Hospitals Trust and NHS Hull CCG
Consultant Neonatologist and Designated Doctor Safeguarding Children and Young People	NHS Hull CCG
Designated Nurse, Safeguarding Children and Young People	NHS Hull CCG
Named GP, Safeguarding Children and Young People	NHS Hull CCG
Detective Chief Inspector, Safeguarding Governance Unit	Humberside Police
Head of Service (EHASH/Assessment/VEMT/EDT)	Hull Children, Young People & Families Services, Hull City Council
Assistant Coroner	East Riding and Hull Coroner's Service
Bereavement Midwife	Hull University Teaching Hospitals Trust
Child Death Review Co-ordinator	Hull City Council

4. HULL CDOP DATA ANALYSIS

This section of the report outlines Hull child deaths that were notified to CDOP and those reviewed by our local Panel between 1st April 2021 and 31st March 2022. Not all child deaths which occurred in 2021/22 will have their child death review completed in the same year. This is because it may take several months to gather sufficient information to fully review a child's death and some cases are subject to parallel processes which need to conclude prior to a review at CDOP, such as post mortem examinations, health reviews and Inquests.

Notifications

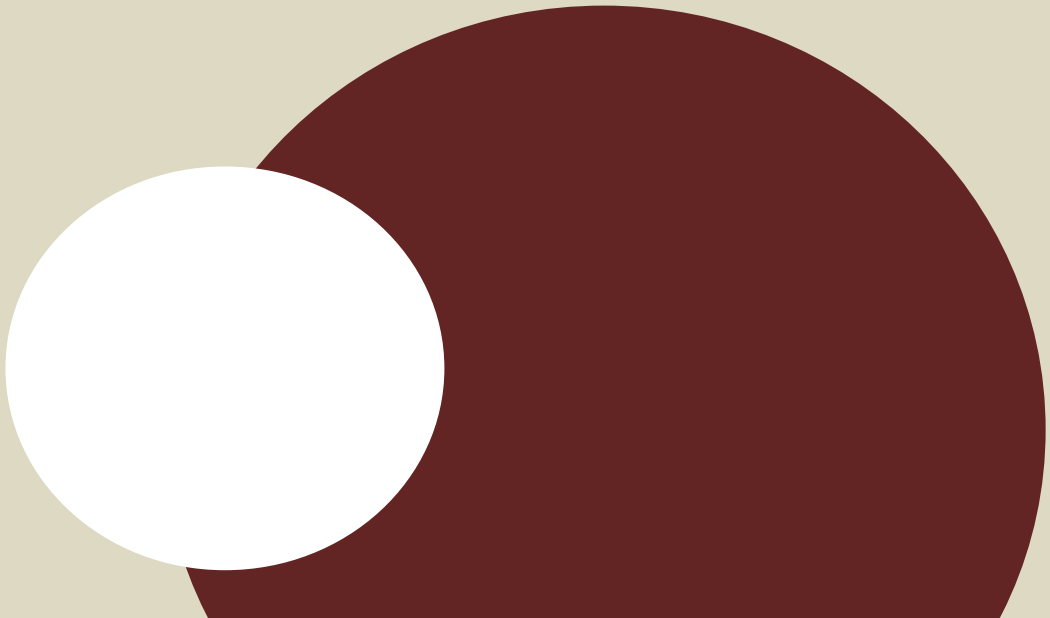
Number of infant and child deaths

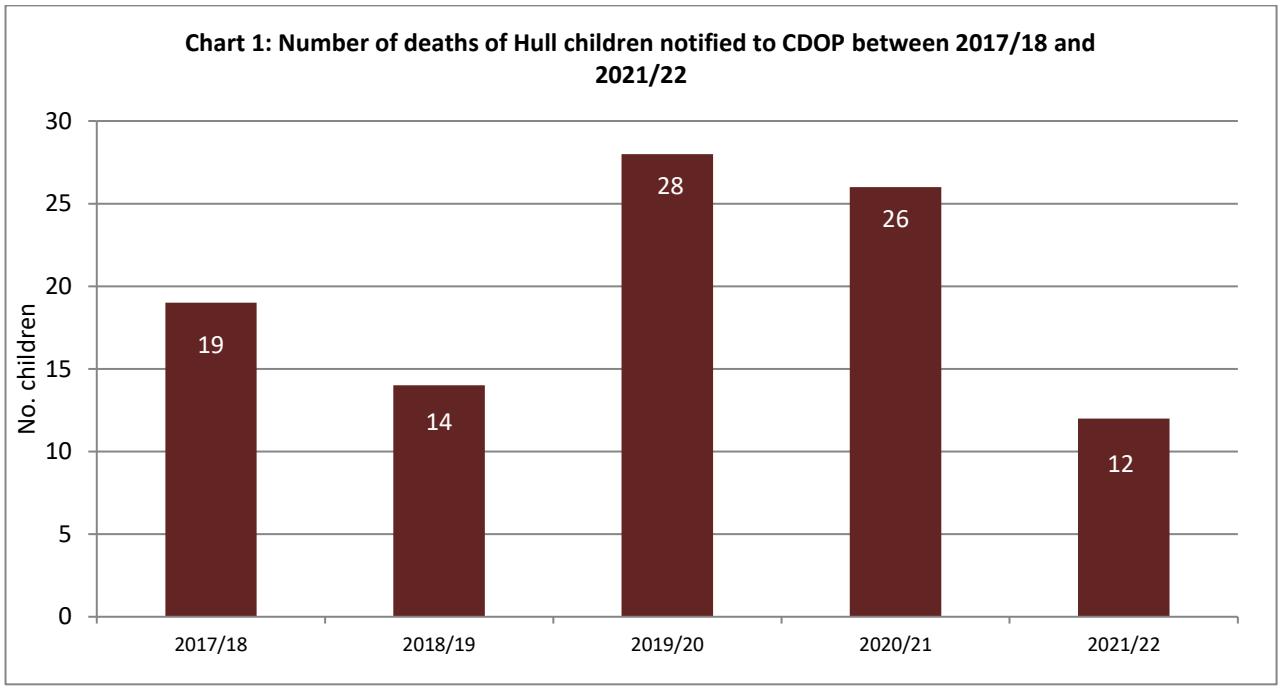
The latest comparative national data on mortality rates covers the period 2018-20 and during this time Hull's rates were similar to national:

- our neonatal mortality rate was the same as England's (2.8 per 1,000 live births)
- our mortality rate for post-neonates (28 days to 1 year) was slightly higher in Hull (1.4) than England (1.1)
- our child (age 1-17) mortality rate per 100,000 was slightly lower than England at 9.9 compared to 10.3.

The National Child Mortality Database (NCMD) was notified of 3,470 child deaths in England between April 2021 and March 2022, 396 more than the previous year.

A total of 12 children living in Hull died in 2021/22.This is a significantly lower number than the number of children in the previous two years, but numbers are expected to vary year on year. The five year average is 19.8 child deaths per year in Hull. Three deaths met the criteria for a Joint Agency Response meeting. Of the 12 deaths during the year, one was discussed at CDOP with the remainder scheduled for 2022/2023.

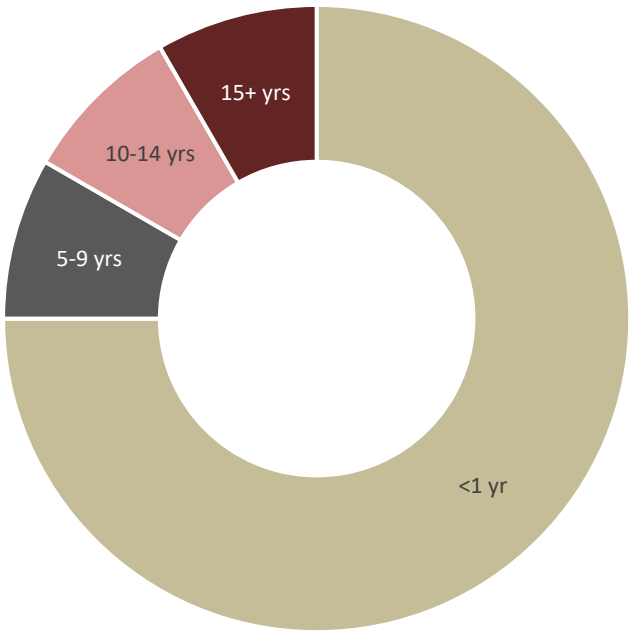




The data detailed in Table 2 summarises age at time of death over the past five years. As in previous years a child is most at risk of death when under the age of one.

In 2021/2022, 42% of the child deaths notified to the CDOP were under 28 days old; this is consistent with the national data reported for the same period. There were no deaths in the 1-4 years age group this year or last year.

Chart 2: Age of infant and child deaths 2021/22

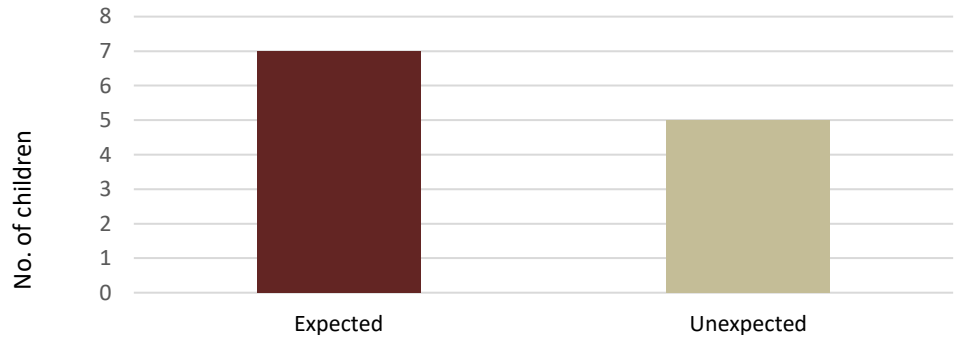


Expected and Unexpected child deaths

There are two categories of child deaths:

- A child death is an “expected” death where the death of an infant or child was anticipated due to a life limiting condition.
- 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.
- Over the past 5 years there have been 99 infant and child deaths notified to Hull CDOP and 46 of these were unexpected.

Chart 3: Expected and Unexpected child deaths during 2021/22



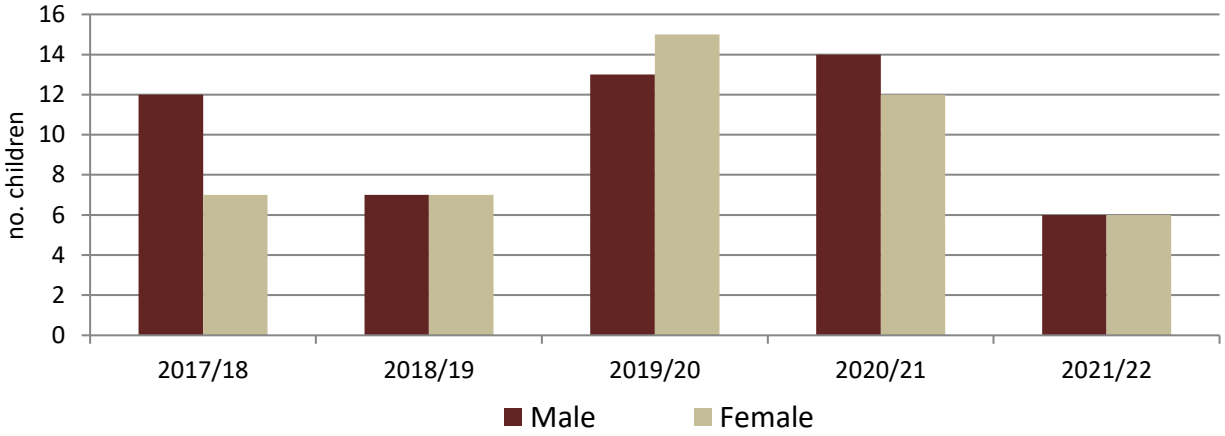
Location of death

Of the 12 deaths notified to Hull CDOP in 2021/2022, 11 (92%) occurred within a hospital trust and 1 occurred at home. Four deaths occurred at an out of area hospital trust, which is an increase in comparison to the previous 2 years.

Infant and child deaths by gender

During 2021/2022 there were an equal number of deaths in male and female children. A breakdown of the number of child deaths by gender is outlined in Chart 4. Nationally, child mortality for males is higher than females.

Chart 4: Gender of child death notifications 1/4/17 - 31/3/22



Ethnicity

Of the 12 children whose deaths were notified to Hull CDOP in 2021/2022, half were classified as being of “White British” ethnicity and half were from a range of other ethnic backgrounds. In previous years, a greater proportion of the deaths have been in children of White British ethnicity.

Children with learning disabilities

Deaths of children who were known to have a learning disability are notified to the Learning Disabilities Mortality Review Programme (LeDeR) by the CDOP to assist with their review and share learning from deaths of children with learning disabilities. There were no reviews in 2021/22 of children with learning disabilities.

5. CDOP REVIEWS

Categories of child deaths reviewed

Between April 2021 and March 2022 the National Child Mortality Database (NCMD) reported that 2,724 child deaths were reviewed in detail by CDOPs in England (the deaths might have occurred during the period or before).

In the same period, Hull CDOP reviewed 24 child deaths. The categories of child deaths from their review at CDOP meetings in the last 5 years are detailed in chart 5.

During the CDOP meeting, members are required to categorise all child deaths using a pre-determined hierarchical list, which are then recorded locally and reported to the NCMD.

3 children tested positive for COVID-19 at the time of their death, but it was not regarded as a contributory factor in their death.

Chart 5: Category of child deaths reviewed by CDOP

	2017/18	2018/19	2019/20	2020/21	2021/22	**Hull Total for 2018-2022**	**National % breakdown 2018-2022**
1.**Deliberately inflicted injury, abuse or neglect** - includes numerous physical injuries, which may be related to homicide as well as deaths from war, terrorism or other mass violence or severe neglect leading to death.	1	0	0	1	0	**2 (2%)**	**2%**
2. **Suicide or deliberate self-inflicted harm** - includes any act intentionally to	0	0	0	0	0	**0**	**4%**

cause one's own death. It will usually apply to adolescents rather than younger children.							
3. **Trauma and other external factors** - relates to unintentional physical injuries caused by external factors. Not including any deliberately inflicted injury, abuse or neglect.	0	1	1	2	0	**4 (4%)**	**5%**
4. **Malignancy** - includes cancer and cancer like conditions such as solid tumours, leukaemia & lymphomas, and other malignant proliferative conditions, even if the final event leading to death was infection, haemorrhage etc.	1	0	0	1	3	**5 (5%)**	**8%**
5. **Acute medical or surgical condition** - A brief sudden onset of illness which resulted in the death of a child.	1	0	0	2	0	**3 (3%)**	**6%**
6. **Chronic medical condition** – A medical condition	0	1	0	0	0	**1 (1%)**	**5%**

which has lasted a long time or was recurrent and resulted in a child death							
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.	6	6	1	1	9	**23 (25%)**	**24%**
8. **Perinatal/neonatal event** –death of child as a result of extreme prematurity, adverse outcomes of the birthing process, intrauterine procedure or within the first four weeks of life	7	8	6	4	9	**34 (37%)**	**33%**
9. **Infection** –can be any primary infection (i.e., not a complication of above categories), arising after the first postnatal week, or after discharge of a preterm baby.	1	2	0	0	0	**3 (3%)**	**5%**

10. **Sudden unexpected or unexplained death** – This is where pathological diagnosis is either Sudden Infant Death Syndrome (SIDS) or 'unascertained', at any age.	8	1	2	4	3	**18 (19%)**	**7%**
Unknown-not enough information						**0**	**2%**
Total number of child deaths reviewed by CDOP	25	19	10	15	24	**93**	

As detailed in Chart 5, of the 93 child deaths that have been reviewed by the Hull Child Death Overview Panel over the past 5 years, the main categories are:

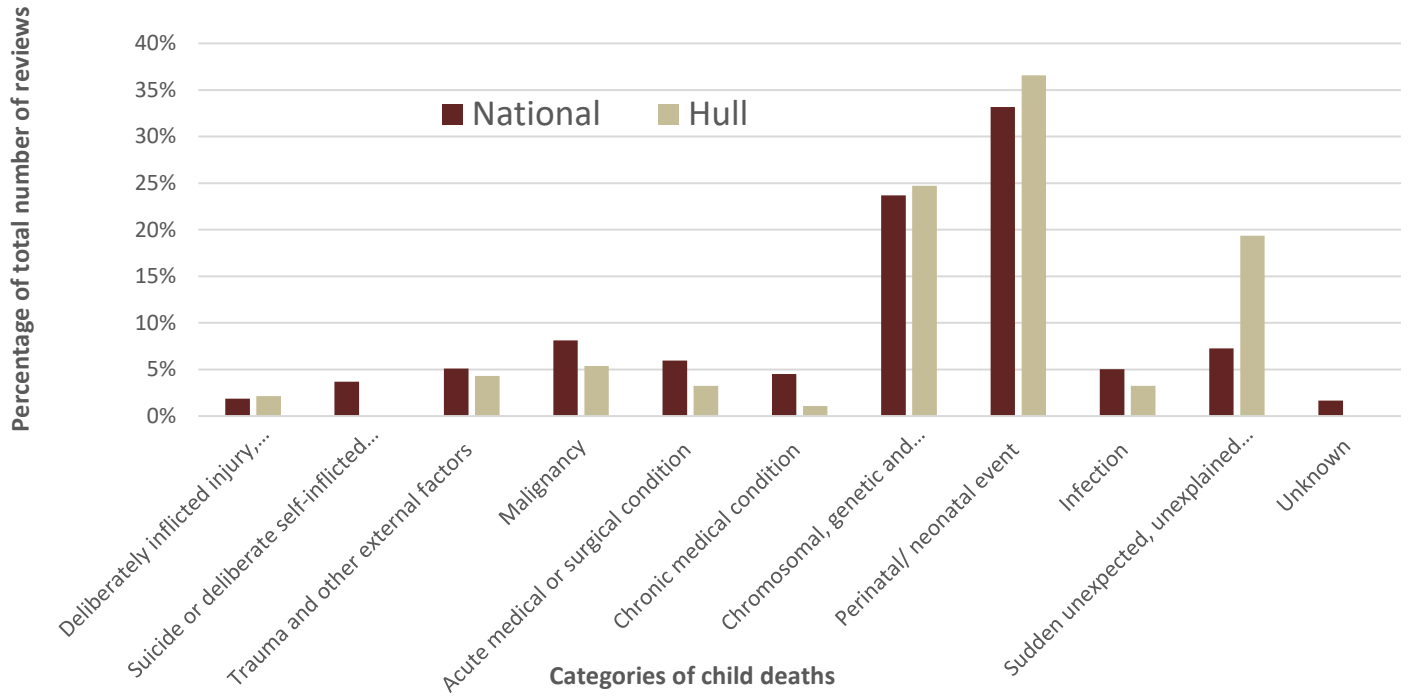
Perinatal/ neonatal event = 36.5%	Chromosomal, genetic and congenital abnormalities = 25%	Sudden unexpected or unexplained death = 19%

Over the 5-year period 2018-2022 the two categories of deaths with the highest number of reviews were the same for Hull and England; Perinatal/neonatal events was the highest followed by Chromosomal/Genetic/Congenital conditions. The third highest for Hull was Sudden Unexpected or unexplained death 19% compared with 7% in England.

Using small numbers raises statistical issues regarding accuracy and usefulness so it is difficult to compare Hull's percentages and rates with national Data but it is helpful to be aware and monitor areas of variance.

Compared with England, Hull has lower percentage proportion of reviews in categories: Suicide or deliberate self-inflicted harm, Malignancy, Acute medical or surgical condition, and chronic medical conditions. It has a higher percentage in categories: Perinatal/ neonatal event and Sudden unexpected/unexplained death. The categories which have a similar percentage of reviews are: Deliberately inflicted injury, abuse or neglect, Trauma and other external factors, Chromosomal, genetic and congenital anomalies and Infection.

Chart 6: Percentage proportion of categories of child death reviews 2018-2022



Modifiable factors

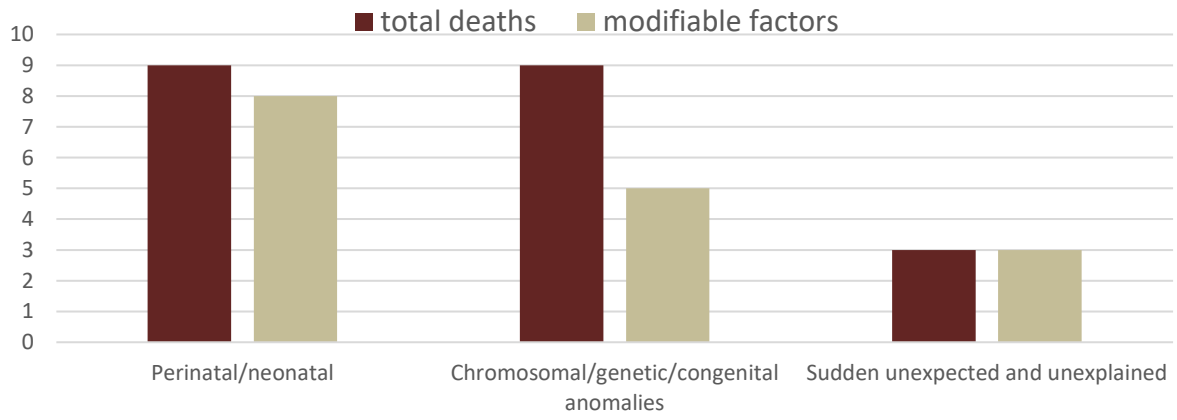
During the review of each death, modifiable factors are identified and analysed to enable learning and preventative action. It's important to be clear that when the CDOP identifies a modifiable factor during a review, it doesn't necessarily mean it was a causal factor in that particular child's death.

Modifiable factors are defined as "Factors which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future deaths." (Working together to safeguard children, 2018).

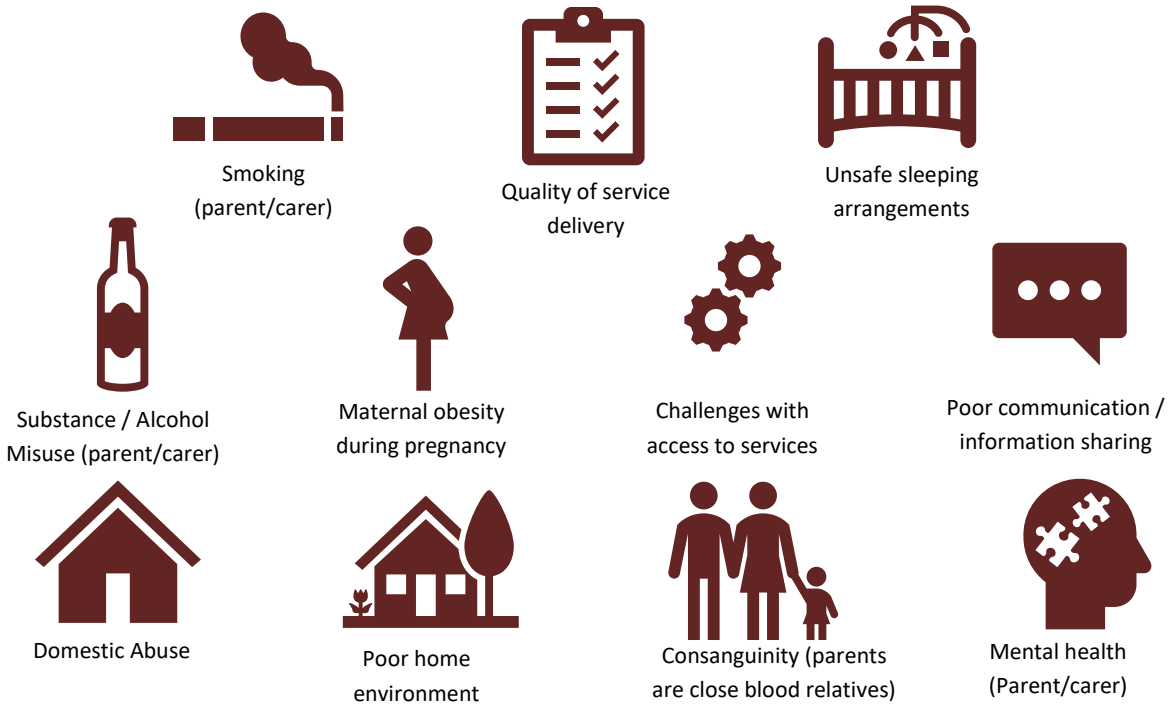
CDOP ensure that any issues identified, learning points and recommendations have been assigned to relevant agencies / professionals to enable them to take action as appropriate. Often this will already have happened earlier in the child death review process. All actions are monitored via an action log until the panel are assured that the necessary action has been completed. Twenty four deaths were reviewed by Hull CDOP during 2021/22, but the deaths occurred across a number of years. There were 16 deaths (67%) where modifiable factors were identified, in 3 categories:

- Perinatal/neonatal
- Chromosomal/genetic/congenital anomalies
- Sudden unexpected and unexplained death

Chart 7: Categories of deaths with modifiable factors



The most recent National Child Mortality Database Annual Report, published in June 2021 highlighted the modifiable factors most frequently identified during CDOP reviews nationally in 2019-20.



The modifiable factors identified in Hull's reviews during 2021/22 were in the following categories (in order of frequency):

- Smoking (parent/carer)
- Quality of service delivery
- Poor communication
- Unsafe sleeping arrangements
- Maternal obesity during pregnancy
- Parental substance or alcohol misuse
- Challenges with access to services

These are based on the information available to us from the child death review(s) – and we are more likely to hear about factors that are routinely recorded in medical notes (such as a mum's smoking status during pregnancy) than we are about less-well documented challenges such as difficulty accessing services. Factors such as domestic abuse or poor home environment may feature in the reviews, but not always be listed as a modifiable factor if they are thought unlikely to have contributed to the death.

Actions and Learning from child deaths reviewed in 2021/22

The learning and analysis from our child deaths inform local needs assessments and strategic planning for safeguarding and promoting the welfare of children in the area. Some examples of that learning being shared are below.

Perinatal / neonatal

- Women booking in later for antenatal care are at a disadvantage during their pregnancy in identifying care needs for mother and unborn - ongoing audit of late booking for review to help understand how better to encourage early booking.
- Documentation of a father's details (and other significant carers) is needed in handheld records to enable a more informative discharge summary - Designated Doctor asked for a reminder go to all midwives about completeness of documentation, recording in hospital electronic system and handheld records.
- If an adult becomes involved with Children's Social Care, learning from their child's death through a Safeguarding Practice Review or child death review would be helpful to professionals undertaking assessments to safeguard another child.
- Hull City Council Children's Services have made changes to record keeping to include learning from child death and serious case reviews.
- Booking in form to be reviewed by Lead Midwife to improve quality of records/ensure fuller completion/accuracy of information so that professionals have an informed account of a mothers' needs and can help with referrals to appropriate support services e.g. smoking cessation.
- Domestic abuse features in a high proportion of child death reviews (in parental relationships or in previous relationships) and although not a contributory factor in this year's reviews, pregnancy and the trauma associated with a child death can compound the vulnerabilities of a relationship/family. CDOP are to undertake a review to record the number of child deaths where DA was a factor in the parental or previous relationships and compare with answers to mother's Routine Enquiry by midwifery.
- Local neonatologists and obstetricians have been reminded about the importance of arranging and recording follow-up appointments with parents following their child's death.
- Designated paediatrician contacted the local Oncology lead to develop local guidelines for women receiving chemotherapy and cancer medications on the risks to pregnancies during treatment.

- CDOP are keen to learn about current diabetes services and care standards – next year the local Specialist Midwife for Diabetes in pregnancy and local Consultant Obstetrician and Gynaecologist have been invited to a CDOP meeting.

Sudden and unexpected deaths:

- A need for a pathway around S47 decision making was identified
- Clarified advice about safer sleep and bonding / skin to skin advice
- Impact on families of transfers to other hospitals identified and raised with commissioners
- Safer Sleep service are updated on learning from cases where unsafe sleeping arrangements were identified, so that training can reflect this.

Learning from other review following a child's death:

Some of the modifiable factors highlighted though the child death review process have already been identified through other processes such as the perinatal Mortality Review Tool and Serious Incidents (SI). Learning and actions from these reviews in relation to service delivery and communication/information sharing are endorsed by CDOP members and these are monitored through the PMRT and SI processes and governance arrangements.

Additional learning:

- Some reviews highlighted how housing situations can cause additional stresses for families living with poorly children. A presentation by the Local Authority Neighbourhood and Housing provided members with a greater understanding on the rules and regulations around direct lets, how families with children with life-limiting conditions/disabilities can be accommodated and the barriers and challenges facing families and housing departments. Members shared guidance with professionals to better support effective housing applications through improved knowledge and working protocols.

- CDOP members learned there was a misconception that organ donation is not applicable for infants with Anencephaly. A local neonatologist liaised with colleagues to dispel the myth and discuss the potential for a pathway to manage organ donation for infants who are expected to die or have died due to Anencephaly.

- The National Child Mortality Database (NCMD) wrote to all CDOPs regarding the issue of NHS charging for maternity care, explaining that some pregnant women who are not ordinarily resident in the UK are charged for NHS maternity care and this can provide a barrier to accessing treatment and services, which may ultimately impact on the health of mother and her unborn or infant. Some hospital trusts are applying the charging rules in different ways which can have a detrimental impact on some families, so they asked CDOPs to consider what they can do to help, including using a recommended template letter which sets out the rules around maternal charging and requests that the trust review its processes.

  Hull CDOP members received a presentation from the hospital trust's Overseas Visitors Team to help members understand existing local processes. Members were assured by the presentation but agreed to share national recommendations with the hospital trust's Chief Executive and Finance Director as an opportunity to review current practices. Members used their agency communication frameworks to widely disseminate awareness of the issues and how barriers can be alleviated. The issue and recommended actions were also shared with the Local Maternity System.

Commendations

During the year the CDOP highlighted outstanding practice, and commended:

- Our local Education Safeguarding Officer for his proactive and knowledgeable contribution and support to schools following a bereavement with child death review processes and with communication and support routes for students, families and staff, as well as applying learning and using a high level of initiative in achieving early intervention.
- The local Doula service provided by Goodwin Development Trust, for going above and beyond for a pregnant client whose first language was not English.

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.

6. RECOMMENDATIONS

Progress against last year's recommendations

In the 2020-21 CDOP annual report we made a series of recommendations for action this year. These are set out below along with the progress made.

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 and 21/22 update
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	Routinely implemented in 2021/22

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	Routinely notified.
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	CDR Co-ordinator sent reminder to hospital neonatologists and Midwifery and follows up information if not routinely provided.
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	Oversight by CDR partners and action ongoing to implement.

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	Monitoring and oversight by CDR partners and action ongoing to implement.
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	Core element of local CDRMs and recorded on analysis form for CDOP review. Feedback to agencies where good practice identified.
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.	CDOP has the role of sharing data in annual report through public health workstreams, CCG (now ICS) and Safeguarding Children Partnership

2. CDOP will continue to assess the use of technology for engaging partners in meetings and training.
   - **CDR meetings continued during the year using virtual platforms which facilitated engagement with clinicians and professionals.**

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.
   - **This was postponed with an intention to incorporate in report for 2022/23.**

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.

   - There was no increase in the number of child deaths during 2021/22, and there were no cases reviewed by Hull CDOP during the reporting period that identified COVID-19 as a cause of death. However, we are mindful that the impact of the COVID-19 period will continue to be seen in future years.
   - The impact of COVID-19 restrictions and workforce capacity on the CDR process led to backlogs of reviews. The CDR exec and operational groups continue to monitor these and good progress is being made with getting back on track.
   - A separate review of the CDR response to COVID-19 and lessons learned for any future pandemics will be led by the CDR Exec.

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.

Recommendations for 2021/22

1. The main focus for 2021/22 is to overcome the backlog of reviews that developed during COVID-19 due to reduced system capacity, so that cases are being reviewed within expected timeframes (where this is within the CDOP's control).

2. To revisit the postponed action from 2020/21 to undertake a more detailed review on Sudden and Unexpected Infant Deaths for the next annual report.

Contact details:

Hull CDOP correspondence address: Anlaby Suite, Hull Royal Infirmary, Anlaby Road, Hull HU2 3JZ

www.hullsafeguardingchildren.org/child death review

Email: cdop@hullcc.gov.uk

Tel: (01482) 311085

Appendix 1 – Child death review professionals meetings

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

Joint Agency Response meetings (JARs) are a co-ordinated multi-agency response which is triggered if a child's death:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (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.

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.

A JAR meeting is held within 72 hours of a child's death; it 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.

Child Death Review Meeting (CDRM) - For every child death, agencies / professionals known to the child/family will be asked for Agency Reporting Forms to record their involvement, including medical information and support to the family; for contributing to a multi-agency meeting of professionals where all matters relating to an individual child 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.

National guidance states that this should take place 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). Locally, our timescales have exceeded 3 months due to a back log in cases created during the pandemic, the capacity of clinicians to contribute to review reports and meetings and administrative support to organise multi-agency reviews for all deaths. Grouping some cases of similar causes has alleviated some resource issues and has brought about rich learning.

All child death notifications and reports are recorded and reported on via a secure web-based software called e-CDOP, which allows the local child death review process to be managed efficiently, with confidential sharing of multi-agency information. e-CDOP is fully compliant to the data processing GDPR standards outlined by the ICO and with Working Together guidance. E-CDOP feeds into the National Child Mortality Database.

Training

Our full day in-person Joint Agency Response training did not take place during 2021/22 during periods of the pandemic/face to face restrictions. However, the Designated Paediatrician for child death has undertaken single agency training with police officers and hospital doctors.

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, carers and professionals.