Norfolk & Suffolk Child Death Overview Panel (CDOP)

Annual Report 2019-2020

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Forward

The Child Death Overview Panel (CDOP) annual report is a summary of the activity carried out by the panel. The aim is to seek to improve outcomes for children across Norfolk and Suffolk.

In October 2018 the National Health Service (NHS) England published new statutory and operational guidance for reviewing child deaths which covers all deaths of children before their 18th birthday regardless of the cause of death. The guidance "Child Death Review: Statutory and Operational Guidance (England)" aims to put bereaved families at the heart of the review process. The guidance advised that CDOPs reviewing less than 60 deaths should combine with another CDOP. Norfolk and Suffolk share Waveney which sits within Suffolk, but health services are commissioned by Norfolk thus a shared report will meet both counties requirements.

Norfolk and Suffolk have been working towards incorporating this guidance into their reviews. This report is to summarise the work of both CDOP panels and the cases that have been reviewed. The data collected is now automatically uploaded to the National Child Mortality Database (NCMD) via the use of E-CDOP software. More detailed information collected by CDOPs across England will be captured in one place. This will enable data from smaller CDOPs to feed into a database from which it should be possible to draw out a greater level of background information regarding children who die and factors that may contribute to their deaths, to enable a more systematic approach to reducing child death were possible and to learn how best to support bereaved families.

The review process is important and can be challenging but is rewarding and thanks to all those who have taken part and contributed to this process in Norfolk and Suffolk.

Executive Summary

The local Child Death Overview Panels (CDOP) review the death of every resident child aged under 18 in Norfolk and Suffolk.

In 2018 the national leadership for the child death review process was transferred from the Department for Education to the Department of Health and Social Care. The "Child Death Review: Statutory and Operational Guidance (England)" was issued with the aim of standardising the outputs of the child death review process, thereby enabling thematic learning. The child death review process is overseen by the Designated Doctor for Child Deaths.

Both CDOP panels and partners have worked hard to implement the new statutory guidance and to use E-CDOP, an electronic database to collect all the data for CDOP. In addition, Suffolk have developed a new Child death review team who started in September 2019.

The local CDOPs have continued their function during 2019-2020: Norfolk and Suffolk met on 6 occasions each.

There were 78 deaths of Norfolk and Suffolk resident children aged under 18 years old reported to CDOP in 2019-2020. This was a higher number than in 2018-2019 when there were 50 deaths reported in Norfolk and Suffolk.

In 2019-2020 Norfolk and Suffolk reviewed 53 deaths which had occurred between 2016 and 2020. Delays in completing the child death review (CDR) process of over a year were due both to challenges in accessing adequate information and due to other statutory processes (criminal investigations, coroner's inquest, serious case/practise review and serious incident investigations in hospitals).

Of these deaths, 24 were in an infant under a year of age. This age group had the highest proportion of deaths assessed as having modifiable factors which is in line with the national trend. This includes neonatal deaths (0-27 days) and infant deaths (28-364 days).

For 2019-2020, key findings in relation to neonatal deaths:

- The two predominant categories of deaths were due to congenital/chromosomal/genetic conditions and extreme prematurity.
- The Neonatal Panel made the following recommendation in the year 2019-2020:
    - Recognition of sepsis and use of early warning scores such as New-born early warning trigger and track (NEWTT)
    - Improve communication to ensure parents aware of risk their behaviour may have on a pregnancy (such as smoking, management of chronic disease), but also between staff and parents to ensure parents feel heard when express their concerns. This includes good record keeping of discussions.
    - 'Don't kiss babies with a cold sore' to prevent Herpes simplex infection which is rare but devastating.
    - Consider oxygen saturation monitoring in new-born babies before discharge to identify congenital heart disease
    - Professional curiosity

For 2019-2020, key findings in relation to child deaths:

- The commonest category of death was
    - Congenital/chromosomal/genetic followed by
    - Chronic medical condition
    - Malignancy
    - Sudden unexpected death

- The deaths associated most with modifiable factors were in
    - Infants aged 28 - 364 days (73%), followed by
    - Those aged 10 – 14 years (43%) (figure 10)

This follows the national picture where modifiable factors were identified most frequently in deaths that were classed as Sudden unexpected deaths in infancy (SUDI) and those where children died due to trauma or self-harm.

The key learning from 2019-2020 included themes relating to

- Communication - communication was identified as a possible contributing factor in 5 cases this includes communication between agencies, communicating risk to families about their behaviour (in pregnancy) or missed opportunities to communicate due to unrecognised condition in patient
- Safer sleeping – co-sleeping with substance misuse and smoking were identified as contributory factors
- Sepsis
- Safety related and unintentional causes of death
    - Texting when driving
    - Danger of loose cables Danger of aerosol use
    - Water safety

Introduction

The aim of this report is to summarise the work of the Child Death Overview Panels (CDOP) in Norfolk and Suffolk during 2019-2020.

Norfolk and Suffolk agreed to work together following the 2018 guidance that recommended a CDOP was able to review and analyse at least 60 child deaths annually. From September 2019, the two LSCB's were replaced by Safeguarding Partnerships in line with new legislation. This emphasised how the 'statutory partners' – health, the police and the council/s- need to exercise greater system leadership than in the previous arrangements.

The report provides the number of deaths notified to the two CDOP panels in Norfolk and Suffolk between the period of 1 April 2019 and 31 March 2020, and an analysis of the deaths that were reviewed in that period and trends of child deaths that were identified.

The Child Death Overview Panel (CDOP) Panel

The statutory responsibility of CDOP panels are set out in the Children's Act 2004 and Working Together 2018. CDOP's primary function is to undertake an anonymised secondary review of each child death where the identifying details of the child and treating professionals are redacted.

CDOP are attended by senior representatives across health, social care, police, education and other agencies. Consultant paediatricians attend to provide clinical expertise from the acute hospitals. CDOP reviews information on all child deaths to inform local strategic planning, identify any modifiable/ contributing factors and consider any lessons to be learned.

The new guidance encourages learning from deaths and uses the term modifiable factors to mean 'factors that might by means of locally or nationally achievable intervention be modified to reduce the risk of future child deaths'. There is some variability in what might be classed as modifiable thus deaths may now be assessed as having 'modifiable' factors, when previously this might not have been the case. This change is partly due to better and more detailed information being gathered as part of the child death review and the change in terminology to modifiable factors rather than 'preventable' deaths.

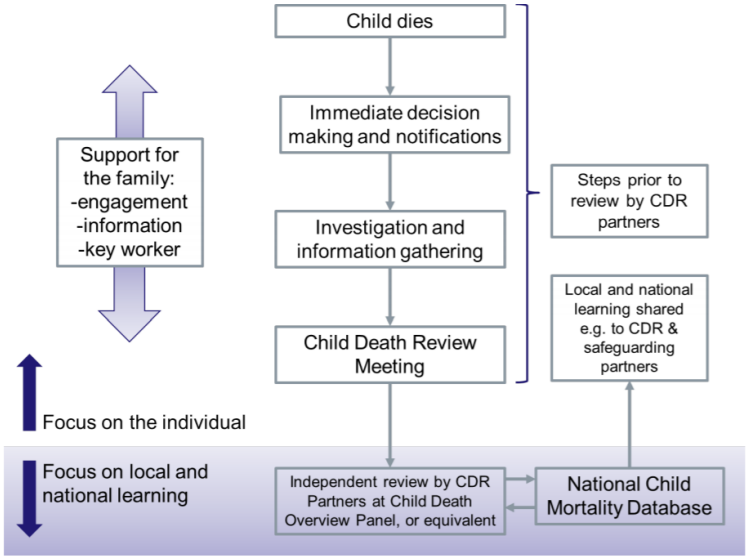
The Norfolk CDOP was chaired by the Deputy Director of Public Health. In Suffolk, CDOP was chaired by the Consultant in Public Health until December 2019. The Independent Chair of the Suffolk Safeguarding Partnership has been chairing since January 2020 to date. Panels have been held consistently every two months, with a total of 6 Norfolk (reviewing 35 deaths) and 6 Suffolk (reviewing 18 deaths) meetings taking place between 1 April 2019 and 31 March 2020.

Norfolk introduced a themed neonatal panel in March 2019. This has been a more useful approach to reviewing neonatal deaths and has included representation from antenatal services (Midwifery and Obstetrics) as well as Post-natal services. This has tied in with the introduction of Perinatal Mortality reviews which emphasize the importance of antenatal factors as a contributory factor to neonatal deaths and a focus on potentially modifiable factors during pregnancy which may lead to premature delivery such as smoking. Suffolk's first themed Neonatal CDOP was delayed in March 2020 due to Covid-19 restrictions.

The Child Death Review (CDR) Process

From 1st April 2019 the new systems and processes continue to be put in place in line with "Working Together to Safeguard Children, 2018" (figure 1).

Figure 1



The guidance requires that child death review meetings are held in order to support the gathering of information and liaison between professionals involved in the case. This is not only to provide information but also to ensure the family are supported and to support those involved in the case.

Electronic CDOP (E-CDOP)

In order to review a death effectively it is important to gather information. In April 2019 Norfolk and Suffolk introduced E-CDOP software to support the collection of data. All information previously collected on paper forms is now collected automatically as the forms are completed and uploaded to the National Child Mortality Database (NCMD) at the point of notification and when cases are completed. The NCMD produce an annual report on local CDOP activity as well as a national report. This Norfolk and Suffolk annual report is based on the data we provided to NCMD.

Unexpected Deaths

There is a robust system to ensure that multiagency meetings are held after the death. The initial multiagency meetings are currently chaired by Children's services in Norfolk and Suffolk. If at this meeting serious concerns are identified, this may trigger a Safeguarding practice review (if related to safeguarding practice), or if there are concerns within an agency this would result in a serious incident investigation. The meeting is required to consolidate information gathered and review all the information obtained since the child's death and any

new information which may be available from initial post-mortem findings. This is an opportunity to complete a reporting Form B for E-CDOP although this is not yet embedded. A date should be agreed for an additional initial child death meeting if it is felt this would be beneficial. A date for the final Child death review meeting should also be agreed which is held about 2 months after the death, but may be delayed if the post mortem results are not available or if there are any serious incident reports in which case the meeting should be held once these have been completed to maximise learning.

The final child death review meeting should be a multi-professional meeting where all matters relating to the child's death are discussed by the professionals involved in the child's care. This is usually a hospital mortality review meeting unless the child had no links to the hospital and the meeting may be hosted by the Designated Safeguarding team. Professionals from outside the organisation have not been routinely invited to hospital mortality meetings however with the new guidance the acute hospitals have been encouraged to invite other professionals for a holistic review of the child. It is important that the learning from a serious incident (SI) report is discussed in this meeting.

Expected Deaths

For infants under a year of age, the main cause of death is due to Chromosomal, genetic and congenital anomalies. For children over a year of age, these are mostly due to malignancy and chronic medical conditions. The palliative care teams have regular multiagency meetings in place prior to and after the death. The debrief meetings already consider learning which should be reported through to CDOP.

The main challenge is to avoid duplication of reports; however, it is important to get details of the child's treatment and death into the E-CDOP forms. These forms should be completed by clinicians known to the child. This is not yet embedded, and it can prove challenging to get full information returned to CDOP.

When children die in tertiary hospitals it has been difficult to access meetings held to review deaths and obtain the necessary information particularly the learning. It is important for those involved in the care of the child to agree which hospital should hold the mortality review and invite others out of their hospital to this.

Suffolk

In Suffolk a business case for a new Child death review team was agreed and a team of 3 nurses were recruited by the Designated Nurse for Safeguarding. They started work in September 2019 and have had a significant and positive impact on the CDR process in Suffolk. They are employed to provide a dedicated service and support to families and professionals for all deaths both expected and unexpected and including neonatal deaths. They are able to coordinate the CDR process and offer follow up for families and clinicians throughout the process. Please see separate report for Suffolk CDR team.

Norfolk

Norfolk have a very experienced Rapid Response Team who provide a dedicated on-call service for unexpected deaths and provide immediate support and information gathering in the first 24 hours. However, Norfolk does not have a single dedicated full time CDR team to manage the CDR process for all deaths.

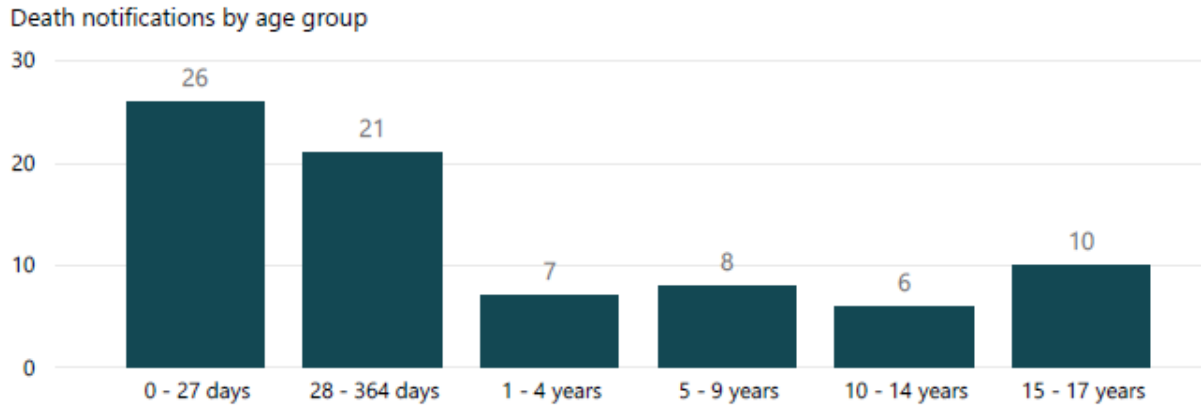
Important Note: interpretation of report
In 2018 the Department of Health took over the responsibility for national oversight for the CDOP process from the Department of Education. Since then the national annual CDOP report, generally published in July, was not published (for 2017-2018 or 2018-2019). However, the National child mortality data base have released information for 2019-2020 thus this can be used for comparisons for this report.

CDOP Panel Activity Data between 2016-2017 – 2019-2020

Death Notifications

78 death notifications were reported in 2019-2020, of which 41 were Norfolk and 37 Suffolk (figure 2).

Figure 2

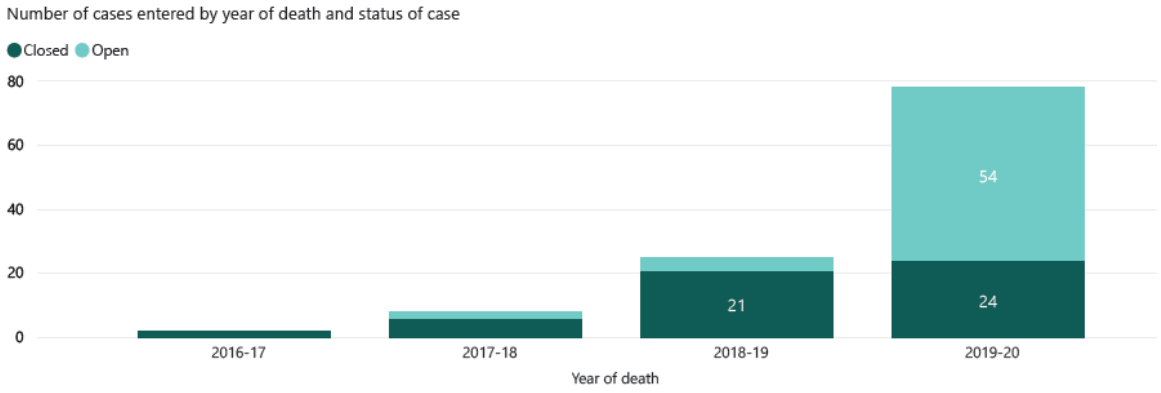


A total of 113 cases were reported via E-CDOP from Norfolk and Suffolk in last 3 years (2016-2017 – 2019-2020). This is not the total number of deaths for that period but is the number of cases that had not been reviewed by either CDOP panel at the time E-CDOP was introduced and data has been added to the E-CDOP data base.

Number of Reviews

In 2019-2020 Norfolk and Suffolk CDOP panels reviewed a total of 53 deaths (35 reviews Norfolk and 18 Suffolk) and are currently dealing with 60 ongoing cases (figure 3). In 2018-2019 there were 65 cases reviewed across the two panels.

Figure 3



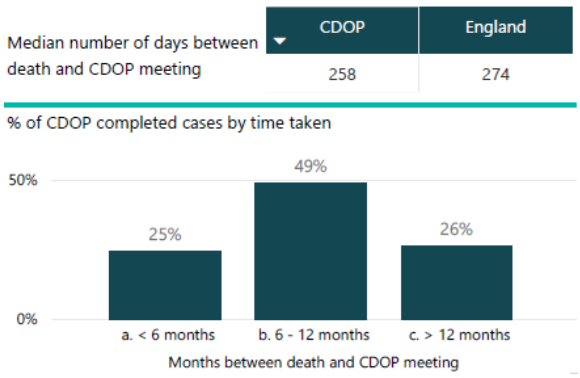
The national data shows decreasing trend for both child deaths and reviews. However, there was a significant decrease in 2019-2020 nationally due to a combination of reduction in panels whilst incorporating the new national guidance and the cancellation of panels in March 2020 due to COVID.

In 2019-2020 both the number of child deaths reported to both Norfolk and Suffolk CDOP and case reviews completed have increased and were higher than the previous two years but similar to numbers in 2016-2017.

Duration of Reviews

Of the 53 reviewed cases across Norfolk and Suffolk, 74% (67 % nationally) were completed within 12 months of the child's death. Of the 78 child deaths that occurred in 2019-2020, 24 (31%) have been discussed at panel, (nationally 27%). Norfolk and Suffolk took an average 258 days between the child's death and CDOP meeting compared to 274 days for England (figure 4).

Figure 4



The time taken to complete reviews reflects the individual circumstances and complexity of cases, including necessary investigations from hospital, coroner's inquests, criminal investigations and Serious Case Reviews/Child Safeguarding Practice Reviews. Cases can therefore take over a year to be brought to panel for review. It should be noted that a child's

death cannot be discussed at panel until all information is received. All deaths that result in a police investigation and SCR will be coroner's cases. Most unexpected deaths will be coroners' cases, however, if a cause of death becomes clear it may not go to inquest. Neonatal deaths rarely go to inquest.

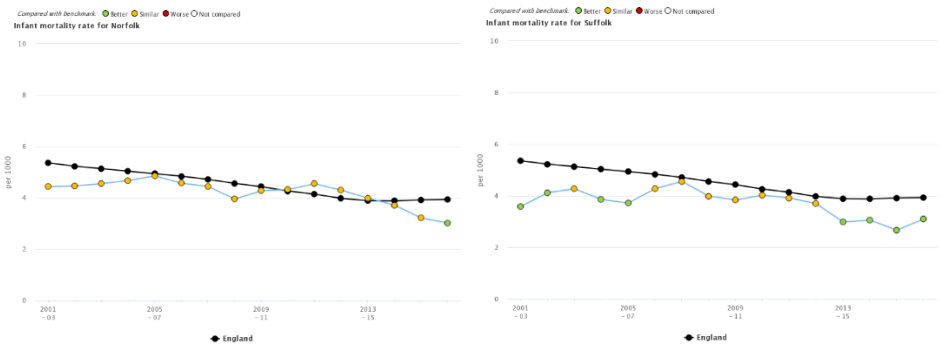
Where cases took over 1-year, delays were due to police and coroners' investigations. A significant cause of delay has also been due to challenges in having and getting enough information to complete the review.

Infant and Child Mortality

The latest published data is for 2016-2018 in which infant mortality for Norfolk (3.0 per 1000) and Suffolk (3.1 per 1000) are both lower than the regional (3.4 per 1000) and national averages (3.9 per 1000) (figure 5). Only slightly higher than the nearest statistical neighbour Lincolnshire (3.0 per 1000).

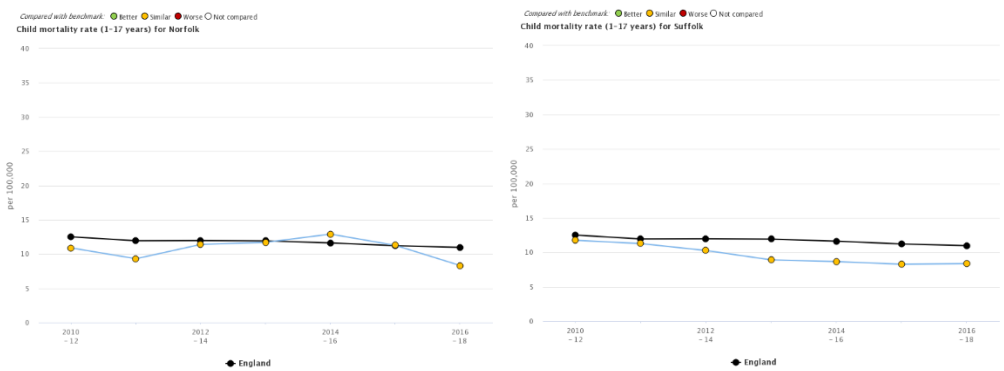
Nationally and regionally the rate of infant mortality had been declining steadily and this is reflected in Norfolk and Suffolk (figure 5). The overall decline in infant mortality rates in recent decades is likely to reflect general improvements in healthcare and more specific improvements in midwifery and neonatal intensive care.

Figure 5



Norfolk (8.3 per 100,000) and Suffolk (8.4 per 100,000) both have much lower child mortality rates compared to statistical neighbour Lincolnshire (10.4 per 100,000), regional (10.3 per 100,000) and national (11.0 per 100,000) averages (figure 6).

Figure 6



In 2019-2020 there were 78 child deaths, of which 59 were infants across Norfolk and Suffolk. Of the reviews done in 2019-2020 nearly half were infants, 24 of the 53 reviews.

Summary of reviewed cases in 2019-2020

Location of Death

Norfolk and Suffolk CDOP reviewed 53 deaths in 2019-2020 which occurred in the following settings; 14 at home, 1 in a public place, 36 in a hospital (including neonatal unit or hospice) and 2 at other locations (holiday accommodation and other/not known). This mirrors national pattern.

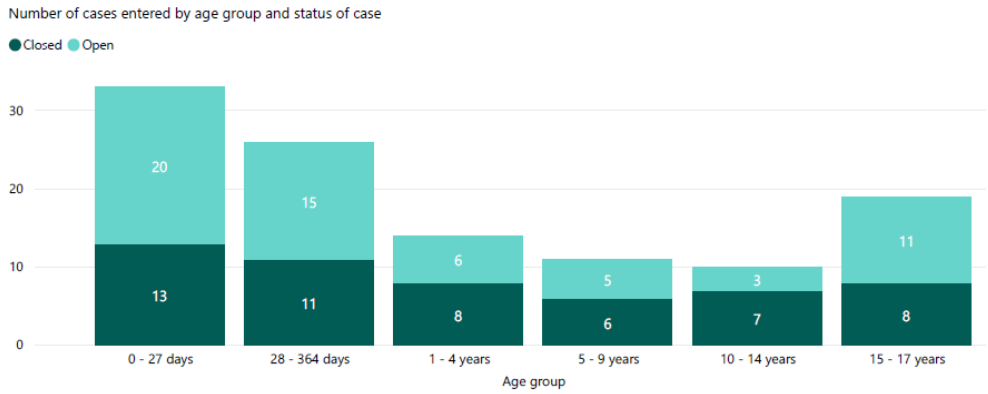
Gender

Nationally and locally the mortality rate for males is slightly higher than for females. 51% of deaths occurred in males in 2019-2020 across Norfolk and Suffolk.

Age

Nearly half (24) of the 53 reviewed deaths were of children who died under the age of one (figure 7). This is lower than the national figure of 63%. Neonatal deaths accounted for 25% of all reviewed cases (nationally 41%). There is a second peak occurring in adolescence (15-17year olds), half of which were due to medical conditions and half were potentially modifiable.

Figure 7



There were 12 neonatal (0-27 days) and 4 infant deaths in Norfolk and 1 neonatal and 7 infant deaths in Suffolk reviewed. Suffolk reviewed 17 neonatal cases in the previous year (2018-2019) and had planned to introduce a neonatal panel which was cancelled hence the small number of neonatal reviews that were undertaken in 2019-2020.

Ethnicity

Ethnicity data were reported for all cases reviewed with 43 classified as 'White' (81%, compared to 65% nationally), 7 'unknown', 2 'Black or Black British' and 1 'mixed' (5 % compared to 31% nationally) (figure 8).

Figure 8

Completed CDOP reviews by ethnic group and age group

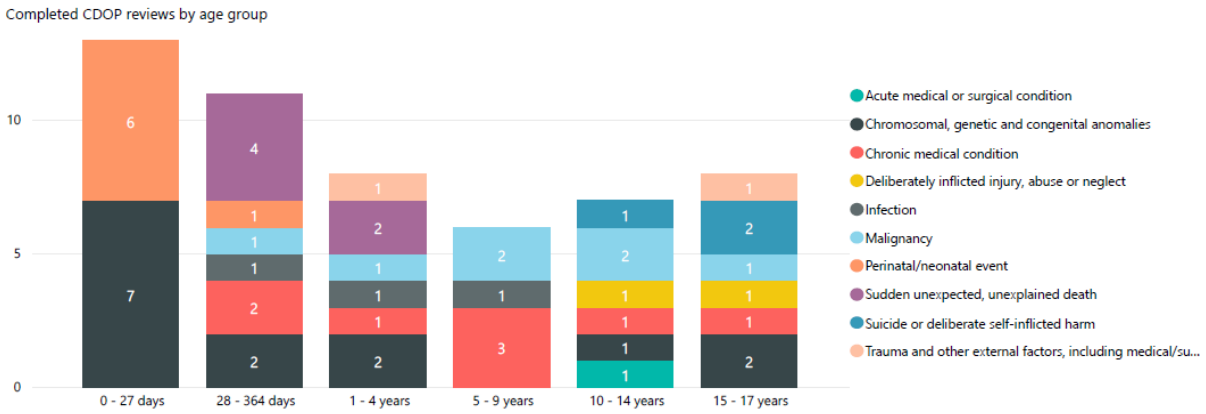
Ethnic Group	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	Total
White	10	9	7	5	6	6	43
Unknown	3	2	1	0	1	0	7
Other	0	0	0	0	0	0	0
Mixed	0	0	0	1	0	0	1
Black or Black British	0	0	0	0	0	2	2
Asian or Asian British	0	0	0	0	0	0	0
Total	**13**	**11**	**8**	**6**	**7**	**8**	**53**

Category of Death

Categories of child death are identified nationally and are provided to CDOPs by the Department for Education. Of the Norfolk and Suffolk child deaths, 7 were due to perinatal/neonatal events (13 %), 14 were chromosomal genetic and congenital anomalies (26%); 8 were due to chronic medical conditions (15%) and 7 due to malignancy (13%).

Figure 9 details the breakdown of category of death by age group. National data 31% perinatal, 25% chromosomal genetic and congenital anomalies, together they comprise 56% of reviews. The lower number in Norfolk and Suffolk is likely to be accounted for, due to a delay in reviewing cases caused by delays in receiving adequate information and the introduction of a neonatal panel where cases were held back for the themed panel.

Figure 9



Modifiable Risk Factors

The 2019-2020 national data shows a variation in the proportion of cases where modifiable factors were identified from 24% to 45 %. The national average for England (31%) and East of England regional (28%). This variability may be due to different amounts of information received by CDOP panels. It may also suggest a lack of consistency across panels in deciding whether there are modifiable factors.

Out of the 53 child deaths reviewed by the panels in 2019-2020, 40% of them (21) have been identified as having modifiable factors. This is an increase from 38% in previous year.

Locally more information is now available to the panel in Norfolk and Suffolk following the development of the CDR team in Suffolk, themed neonatal panels and the national perinatal mortality review. The change in emphasis from preventable deaths to modifiable may have also made a difference to panel's perception.

Infants aged 28 - 364 days had the highest proportion of deaths assessed as having modifiable factors (73%), followed by those aged 10 – 14 years (43%) (figure 10). This follows the national picture where modifiable factors were identified most frequently in deaths that were classed as Sudden unexpected deaths in infancy (SUDI) and those where children died due to trauma or self-harm.

Figure 10

% of cases where modifiable factors were identified by age group

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	13	4	31%
28 - 364 days	11	8	73%
1 - 4 years	8	1	13%
5 - 9 years	6	2	33%
10 - 14 years	7	3	43%
15 - 17 years	8	3	38%
Total	**53**	**21**	**40%**

The modifiable factors identified by the CDOP panels related to safer sleeping and improved communication.

- There were 6 deaths due to SUDI where co-sleeping associated with neglect, drug and alcohol consumption were identified. Parents of two of these cases were convicted of neglect.
- Smoking has also been identified as a possible contributory factor in deaths from premature delivery and from SUDI.
- Communication was identified as a possible contributing factor in 5 cases this includes communication between agencies, communicating risk to families about their behaviour (in pregnancy) or missed opportunities to communicate due to unrecognised condition in patient. The importance to listening carefully to parents and taking a through history cannot be underestimated.

Learnings and Recommendations from 2019-2020 Child Deaths Reviews

The work of CDOP this year has been to embed new practice using the E-CDOP software and the new statutory guidance. Although there has been learning identified in reviews the dissemination of that learning has been more challenging to achieve and it is important that both CDOP panels work together to consider how best to promote learning. Due to the relatively small numbers it is hard to see a statistical difference over a one-year period. However, the learning from CDOP and the Neonatal CDOP aggregated findings from all child deaths should inform local strategic planning on how to best safeguard and promote the welfare of children across Norfolk and Suffolk. The modifiable factor themes and learnings to emerge from 2019-2020 are:

1) **Communication**

Telephone triage: To share learning across the acute trusts in development of tool to improve recording and decision making and to have a low threshold for review in a complex child. Be wary of underestimating and missing significance of what may appear to be a 'common condition'.

All staff need to really listen to and hear parents' concerns. Be wary of dismissing concerns as parents know their children and if genuinely concerned a thorough set of observations should be completed and borderline results not seen as normal on a background of parental concern.

There have been individual cases where it was recognised that communication between health professionals and parents could have been better and communication between agencies. The importance of good communication skills cannot be over emphasised and has wide reaching consequences when we fail to communicate information effectively.

2) **Safer sleeping**

Several different themes have emerged from the review of the SUDI. Safer sleeping is a recurrent theme in CDOP reviews and the importance of raising the issue of safer sleeping at all opportunities both by health professionals and social care has been discussed and recommended.

In addition, it is recognised it is important to meet fathers and to ensure that both parents are aware of messages regarding safer sleeping.

Suffolk Safer Sleep Campaign was launched in October 2016 and it had a positive impact on the Suffolk SIDS rate for a couple of years. Suffolk child health and maternity services (midwifery, health visiting and GPs) worked together to inform parents about potential risks of SIDS and measures they can take to safeguard their family especially very young children. The work is underway to revisit the current strategy, its messages and intensify joint working of agencies and public health campaign/health promotion materials.

This campaign was later adopted by Norfolk panel which has been running since This was evaluated, and the social media campaign was repeated in Spring 2019, with some minor amendments. The link to the web pages: https://www.norfolk.gov.uk/care-support-and-health/health-and-wellbeing/childrens-health-and-wellbeing/safer-sleeping

- Panels agreed to review the deaths from Sudden infant death syndrome to consider whether there were any additional themes.
- Market Apps used to promote and inform service users about issues such as safer sleeping.

3) Sepsis

Public Health and CCGs work to raise awareness of the recognition of sepsis and taking of vital signs to aid diagnosis across the Norfolk and Suffolk Health Economy.

Recognition of the sick child continues to be a challenge and highlights the importance of:

- Listening to parents' concerns
- Examination and recording of vital signs
- Using recommended guidance

Recognition of the contribution of viral causes when there is an unwell child has been incorporated into the septic child workup.

CDOP wrote to all Primary Care regarding the recognition of sepsis. Collaborations with public health have raised the awareness of immunisation programme.

4) Unintentional deaths

- Managing asthma conditions following on from a Partnership review in Suffolk. Suffolk has launched "My Spira" app in December 2019 to teach young children to learn to manage their condition through an interactive tool understanding their triggers, knowing what to do and how to use their devices in more effective ways. This app is free to all children and families in Suffolk.
- Risk of strangulation from a loose wire connecting a video monitoring device. This was reported to trading standards, although there is guidance for fixing devices securely to walls. Recommended that 0-19 service discuss safety with parents when considering where child goes to sleep.
- Dangers from Aerosol use reported in EDP, work with Mathew project
- Road safety: The danger of texting and driving has led to national campaigns and school education.

5) Groups and networks

The East of England Regional CDOP Professionals Network has continued to meet regularly in 2019-2020 to share learning and support system-led improvement across the region. This provides a forum to support developments in particular the development of the CDR team in Suffolk.

CDOP Panel Achievements

- Working Together 2018: review of existing systems and processes for child death review in Norfolk undertaken in 2018-2019 by child death review partners to meet the new statutory requirements. Norfolk and Suffolk continue to implement and refine the new child death pathway, including raising awareness with key stakeholders regarding their roles and responsibilities. Suffolk have developed a Child death review team who are employed to work solely on supporting the child death process. They have been able to work closely with the acute trusts in Suffolk to support their role in reviewing all child deaths and act as key workers for families to support them throughout the child death process until more formal bereavement support is identified if available.

- The appointment of a new post – the Designated Doctor for Child Death was agreed in Norfolk in December 2018 and in Suffolk in June 2019.

- Both panels continue to implement the E-CDOP software to ensure the most effective collection of data. Notification of deaths can now be made at any time using the E-CDOP website rather than waiting to call the coordinator.

- Norfolk and Suffolk CDOP have produced a joint annual report for 2019-2020. They will continue to develop joint local analysis of trends and focus on areas for further action such as safer sleeping.

- Neonatal themed panels were introduced in Norfolk in March 2019. A significant proportion of child deaths are due to neonatal deaths and deaths in infancy many of who may not have gone home form the neonatal unit. Two themed neonatal panels were held in 2019-2020, bringing together both neonatal experts, obstetrics and midwifery across Norfolk and Suffolk for comprehensive review of neonatal deaths reported to CDOP. These panels worked well and enabled a detailed discussion of contributory factors for premature delivery such as smoking and poorly controlled chronic medical conditions.

- COVID-19 emerged as a significant public health threat by March 2020. Despite the challenges the first virtual panel took place in March 2020 and thus there was no interruption to the CDOP panels despite the disruption that COVID has caused.

- Pool safety and Bath safety use of bath seats with supervision had been promoted through CDOP links.

- Bereavement Poster has been produced and distributed.

- Review into the suspension of the optician Honey Rose was completed.

- Implementation Webinar was carried out.

- Suicide awareness and prevention was shared widely.

- Learning disability mortality review (LeDeR) reports and findings now being shared widely with CDOPs

Forward Plan for 2020-2021

- Norfolk to develop a coordinated CDR team to support all partners and families to facilitate the CDR process.

- Suffolk to continue to implement and refine the new child death pathway, including raising awareness with key stakeholders regarding their roles and responsibilities.

- Audit CDR process across Norfolk and Suffolk to review compliance with statutory guidelines and identify areas of weakness.

- Improve the process of capturing learning in a format for easy reference (data system/dashboard) and ensure sharing on a regular basis and ensuring shared/fed-back across the system.

- Continue to implement the E-CDOP software to ensure the most effective processes are in place. E-CDOP has a range of functions that are not yet fully utilised by either CDOP. There continues to be difficulties in getting completion of reporting forms however when these are completed well the information from all those contributing can be consolidated into one form. It is important that all those contributing to the CDR process complete information in good time. We continue to develop this process.

- Cross boundary working to be improved upon. Although this has been worked on and improved across 2019 there is further work to be done. - E-CDOP has helped with these links as has development of CDR teams.

- To develop process with teams undertaking perinatal mortality review meetings to ensure close coordination with CDOP panels and reduce duplication of meeting but ensure learning disseminated.

- Continue to be active participants in the East of England CDOP professionals' network to share learning and system-led improvement.

- Suffolk to revisit Safer Sleeping Strategy/action plan in view to reduce SIDS

Appendices

Definitions

- ***Stillbirth rate***: The number of babies born after the 24th week of pregnancy who do not show any signs of life per 1000 total births (live and still births).
- ***Perinatal mortality rate***: The number of stillbirths plus the number of babies dying within the first week of life per 1000 total births (live and still births).
- ***Low birth weight rate***: The number of babies born weighing less than 2500g expressed as a percentage of total births (live and still births).
- ***Infant mortality rate***: The number of deaths of children aged under one year per 1000 live births.
- ***Neonatal mortality rate***: The number of neonatal deaths (those occurring during the first 28 days of life).
- ***Post-neonatal mortality rate***: The number of infants who die between 28 days and less than one year.
- ***Child mortality***: the number of child deaths for every 100,000 people alive in the population aged from 1-17.
- ***Unexpected death of a child***: defined by the Department for Education as the death of an infant or child, which was not anticipated as a significant possibility 24 hours before the death, or where there was similarly unexpected collapse or incident leading to or precipitating the events that led to the death.
- ***Modifiable child deaths***: those in which modifiable risk factors may have contributed to death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Child Death Review Panel legislation and principles

Regulations relating to child death reviews

Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14 of the Children's Act 2004 sets out the board's and now the Partnership's responsibilities in relation to the child death review process. It states that the Partnerships are responsible for:

a. Collecting and analysing information about each death with a view to identifying -
i. Any case giving rise to the need for a review as mentioned in regulation 5(1)(e);
ii. Any matters of concern affecting the safety and welfare of children in the area of the authority; and
iii. Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area.
b. Putting in place procedures for ensuring that there is a coordinated response by the authority, their agency partners and other relevant persons to an unexpected death.
c. The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate of the cause of death (and therefore is not the responsibility of the Child Death Overview Panel (CDOP)).
d. In reviewing the death of each child, the CDOP should consider modifiable factors, for example, in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level as a result of a set of circumstances.

The principles

Four underlying principles guide the overview of all child deaths:

1) Every child's death is a tragedy
2) Learning lessons
3) Joint Agency Working
4) Positive action to safeguard and promote the welfare of children

The function of CDOP is achieved by:

- Reviewing the available information on all deaths of children up to 18 years (including deaths of infants aged less than 28 days) to determine whether there were any modifiable risk factors which may have contributed to the child's death

- Collecting, collating and reporting to an agreed national data set – the National Child Mortality Database (NCMD) - for each child who has died

- Meeting regularly to review and evaluate the routinely collected data for the deaths of all children, and thereby identifying lessons to be learnt or issues of concern

- Monitoring the response of professionals to an unexpected death of a child

- Referring to the Chair of the Local Safeguarding Children Partnership any deaths where the panel considers there may be grounds to consider a child safeguarding practice review

- Monitoring the support services offered to bereaved families

- Identifying any lessons or improvements and considering how best to address these and their implications for the provision of both services and training.