Suffolk Safeguarding Partnership

NHS Suffolk and North East Essex Integrated Care Board

NORFOLK & SUFFOLK CHILD DEATH OVERVIEW PANEL (CDOP)

Annual Report 2023 - 2024

NHS Norfolk and Waveney Integrated Care Board

Norfolk Safeguarding Children Partnership

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Introduction

The Norfolk and Suffolk Child Death Overview Panels (CDOP), review the death of every resident child aged under 18 years in Norfolk and Suffolk. They report into the respective Safeguarding Children Partnerships.

In October 2018, the Department of Health and Social Care (DHSC) assumed national leadership of the child death review process and published guidance; *Child Death Review: Statutory and Operational Guidance (England)* for reviewing the deaths of all children regardless of the cause of death. This guidance aims to put bereaved families at the heart of the review process.
It also aims to standardise practice and outputs to enable thematic learning. The data collected is uploaded to the National Child Mortality Database (NCMD) via the use of E-CDOP software which captures data from CDOPs across England in one place. This makes it possible to draw out a greater level of background information regarding children who die and the factors that may contribute to their deaths, enables a more systematic approach to reducing child death where possible and assists learning about how best to support bereaved families. NCMD produces annual monitoring and thematic reports into specific areas of practice.

The Child Death Overview Panel (CDOP) annual report is a summary of the activity carried out by the panels in line with the national guidance which include child mortality trends, causes of death, modifiable factors, actions taken, and any lessons learnt – all of these are considered by each CDOP for every child death. The aim is to seek to improve outcomes for children across Norfolk and Suffolk. This report summarises the work of both CDOPs and the cases that have been reviewed in the period from April 2023 to the end of March 2024.

Each county has established a specific Child Death Review Team (CDRT), Suffolk since 2019 with Norfolk following from April 2021. These have both proved instrumental in improving the quality and effectiveness of practice.

The Child Death Review process is important, can be challenging and is rewarding. Thanks are due to all those who have taken part and contributed to this process in Norfolk and Suffolk.

Executive Summary

Number of deaths during 23/24:	Total cases with review ongoing:	Number of cases reviewed 23/24:
78	57	83

During 2023/2024, Norfolk and Suffolk CDOP's met on 14 different occasions (8 for Suffolk and 6 for Norfolk).

There were 78 deaths in children under the age of 18 years old in total between Norfolk (46), Waveney (3) and Suffolk (29). This was a reduction from 88 deaths last year. The decrease was in the number of deaths in Suffolk. 55 of the 78 deaths (70%) were in babies under a year of age. This compares with 61% in England. There was an increase in deaths of infants under a year of age both in the 0-27 days age range and infants 28-364 days, in comparison to 2022-23.

Between April 2023 and March 2024, Suffolk and Norfolk reviewed 83 deaths. Norfolk reviewed 41 cases and Suffolk reviewed 42 cases (38 Suffolk and 4 Waveney). In 27 cases (33%) modifiable factors were identified. This is comparable to 34% of cases identified in Norfolk and Suffolk last year and lower than the national average of 43% of cases in 2023/24.

The main categories of death were Chromosomal/Genetic Abnormalities (30 cases), Neonatal/Perinatal Events (25 cases), Malignancy (10 cases) and Acute Medical Conditions (6 cases) and 4 cases were secondary to Sudden Infant Death Syndrome (SUDI).
Amongst cases with identified modifiable factors, the most frequent primary category of death was perinatal/neonatal events, constituting almost half (48%) of cases (Figure 1 - Page 11). This was followed by chromosomal genetic and congenital anomaly which covered 15% of cases; sudden unexpected/unexplained death and suicide or deliberate self-inflicted harm followed, making up 11% of all cases with identified modifiable factors respectively.

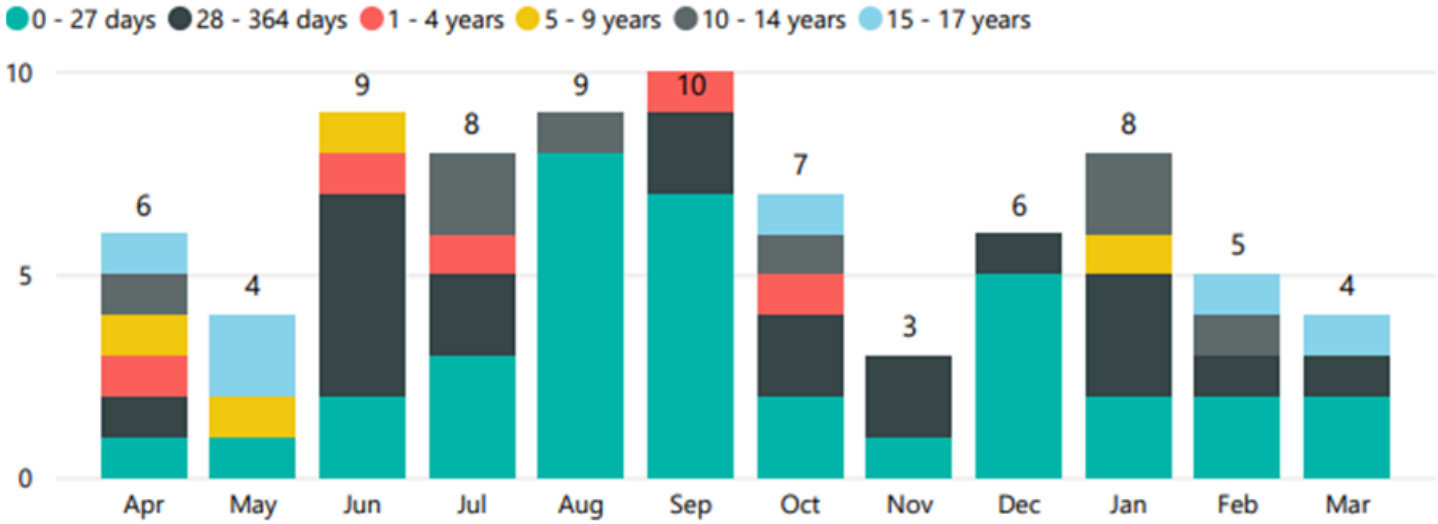
41% of all 27 cases with modifiable factors occurred in the perinatal/neonatal period (Table 3 - Page 14). Infants between one month and 1 year of age comprised 30% of all cases with modifiable factors. The third most common age group involved children aged 15-17 years, with 5 cases (19%). Importantly CDOP identified modifiable factors in service provision (47% of all modifiable factors in all cases). For infants, the modifiable factors related to social environment played an important role (safer sleeping).

The median number of days from the child's death to review at the CDOP panel was 228 days which compares extremely well with the average for England at 411.

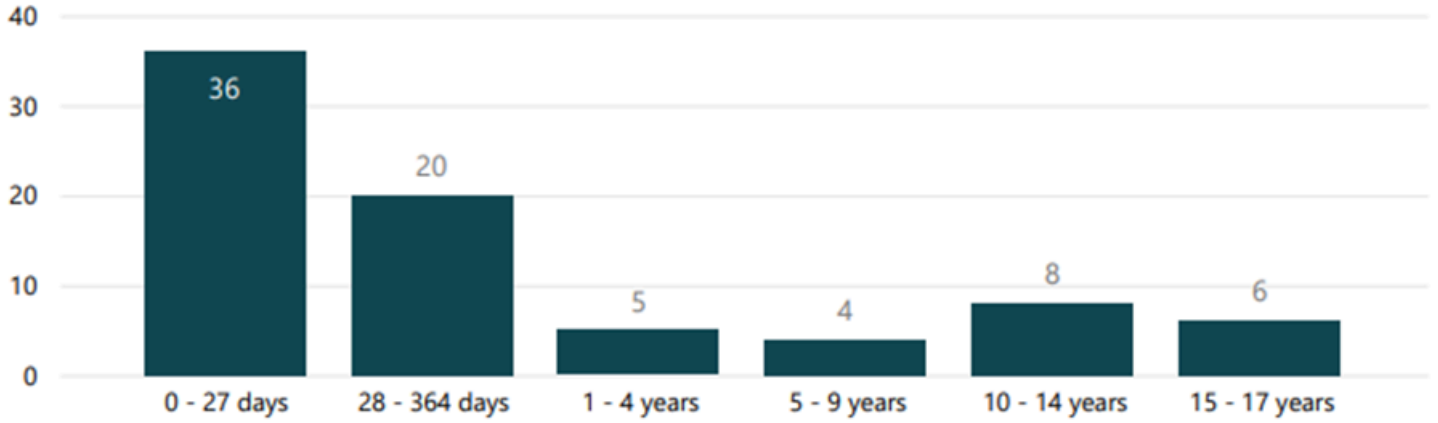
Notifications

The CDOP panel were notified about 78 deaths between the 1st of April 2023 and 31st of March 2024. 22/78 of these cases met the criteria for a joint agency response. A joint agency response is a multiagency response to a death occurring in any of the following circumstances: death due to external causes/occurring in suspicious circumstances/death that is sudden/or death of a child under the MHA.

Death notifications by month of death

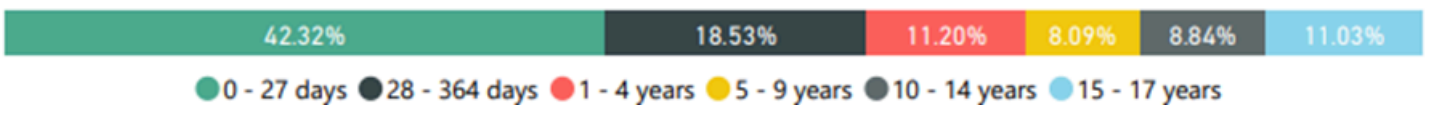


Death notifications by age group



% of death notifications by age group - CDOP

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



Notifications - Annual Comparison

Death notifications by LAA and year

LAA name	2019-20	2020-21	2021-22	2022-23	2023-24
Norfolk	42	33	45	45	49
Suffolk	37	27	39	43	29
Total	**79**	**60**	**84**	**88**	**78**

The population of Norfolk is approximately 916000 of which there are 168000 children under the age of 18. Suffolk has a population of approximately 763000. There are approximately 144700 children under 18 years. Although the rate of child deaths over a 5 year period for Norfolk and Suffolk are similar. There are year to year variations . In 2023-24 the rate in Norfolk was 29 deaths /100,000 and Suffolk 20 deaths per 100,000. It will be important to monitor this over time. Norfolk had a greater proportion of neonatal deaths notified and sudden unexpected deaths notified than Suffolk.

Death notifications by age group and year

Age group	2019-20	2020-21	2021-22	2022-23	2023-24
0 - 27 days	27	29	35	30	35
28 - 364 days	21	8	13	16	20
1 - 4 years	7	3	12	11	5
5 - 9 years	8	8	4	10	4
10 - 14 years	6	3	9	11	8
15 - 17 years	10	9	11	10	6
Total	**79**	**60**	**84**	**88**	**78**

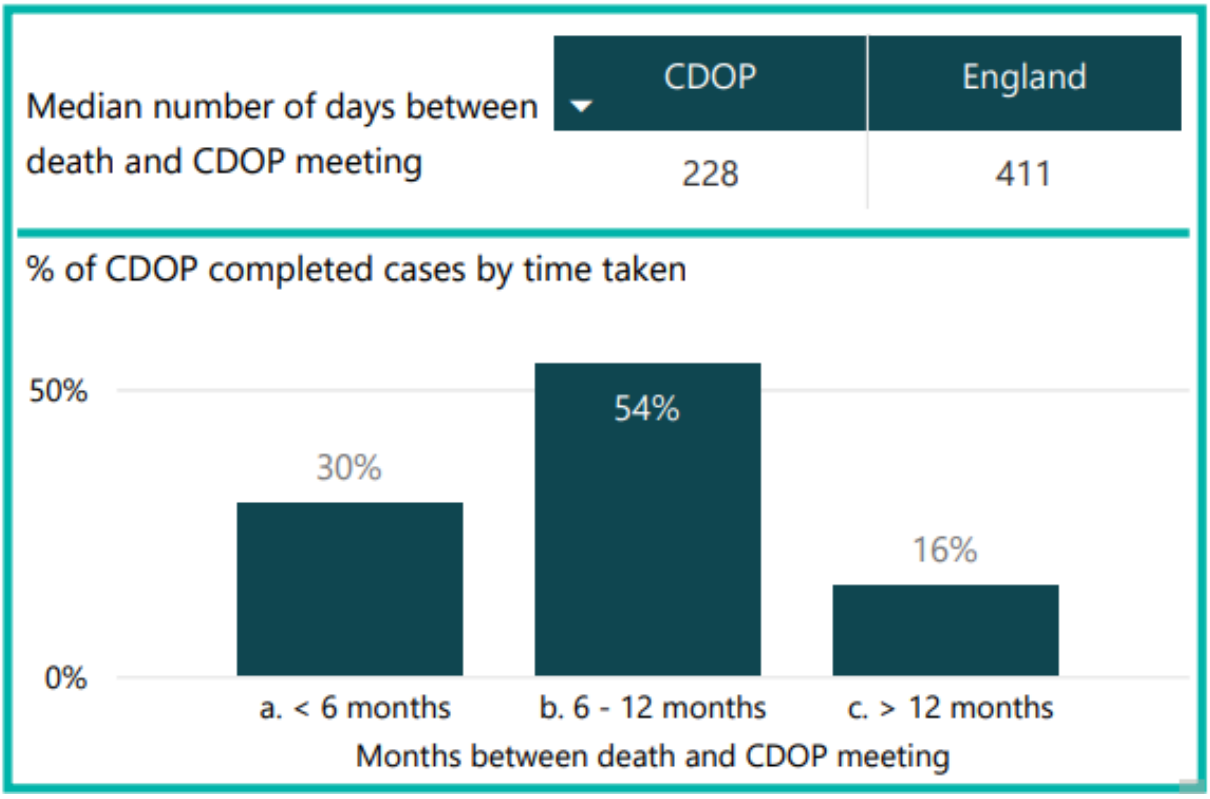
All death notifications from 01/04/19 by month and year

Month of death	2019-20	2020-21	2021-22	2022-23	2023-24
Apr	7	5	4	5	6
May	4	5	5	8	4
Jun	5	3	6	4	9
Jul	7	6	7	8	8
Aug	9	6	8	9	9
Sep	7	5	6	6	10
Oct	7	3	10	6	7
Nov	5	7	5	7	3
Dec	12	3	9	7	5
Jan	6	7	10	10	8
Feb	8	4	9	11	5
Mar	2	6	5	7	4
Total	**79**	**60**	**84**	**88**	**78**

This year 55 of the 78 deaths (70%) were in babies under a year of age. This compares with 61% in England. The number of notifications does vary from year to year and it is difficult to know if there is any reason for this or it is due to natural variation. The notifications for Suffolk dropped and this appears to be mostly due to a lower number of deaths in the neonatal period in Suffolk between 2022-23 and 2023-24. Whilst Norfolk had a slight increase. When comparing the numbers, 2020-21 still stands out for the low numbers of infant deaths (28-364 days).

Efficiency

Median number of days between death and CDOP meeting	CDOP	England
	228	411



The child death review process in Norfolk and Suffolk continues to be efficient and the majority of deaths are brought to review at CDOP in less than 12 months. This is significantly better than the average for England. It is not clear why there is such a wide variation in time to review deaths. Deaths which require a criminal investigation take the longest to review followed by inquests. There is an outstanding death from 2019 which is awaiting a reopening of an inquest and another from 2021 awaiting inquest.

In Norfolk and Waveney we are very fortunate to have a paediatric pathologist and thus as can be seen below the time for a post mortem report is much shorter in Norfolk than Suffolk. Any forensic cases will have a post-mortem elsewhere and the time to receiving the post mortem report can be over a year.

Suffolk, Waveney & Norfolk

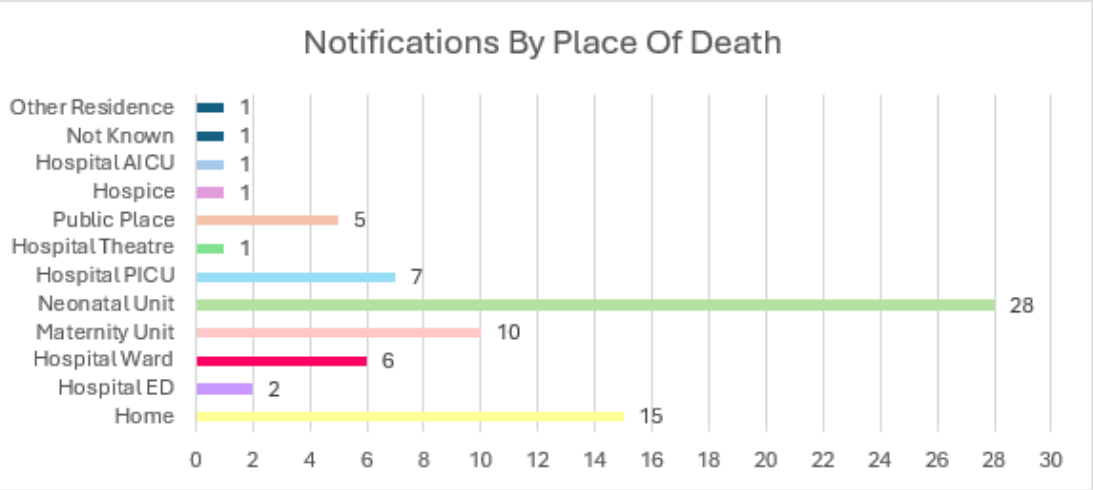
78 Notifications Received

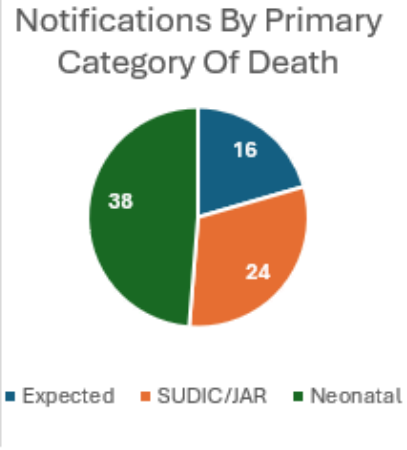
49 Males

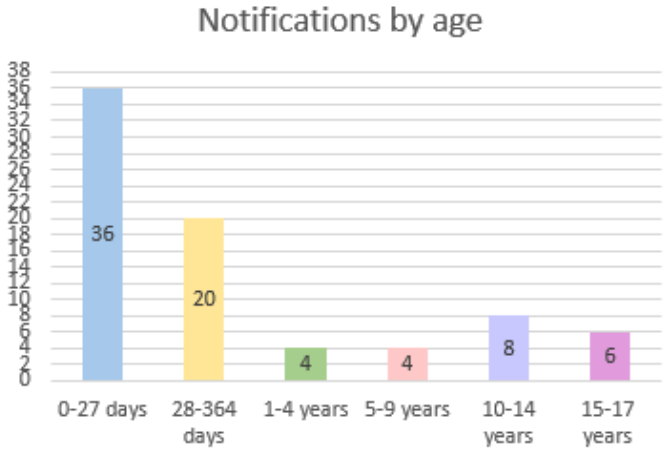
1 Gender Indeterminate

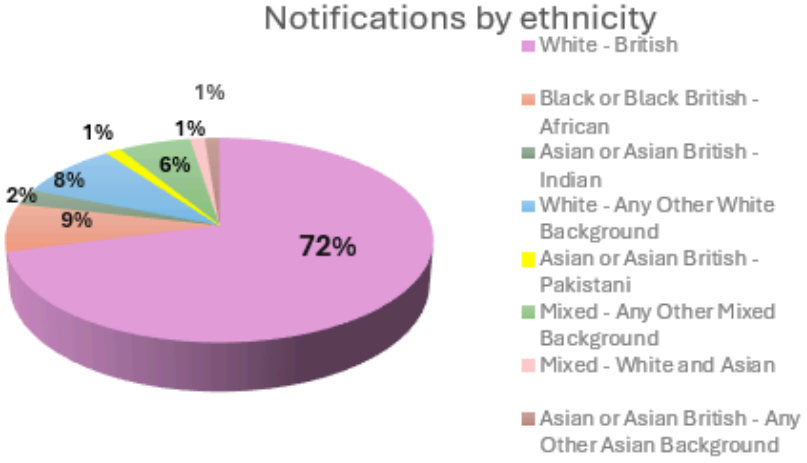
28 Females

22 SUDIC/JARS



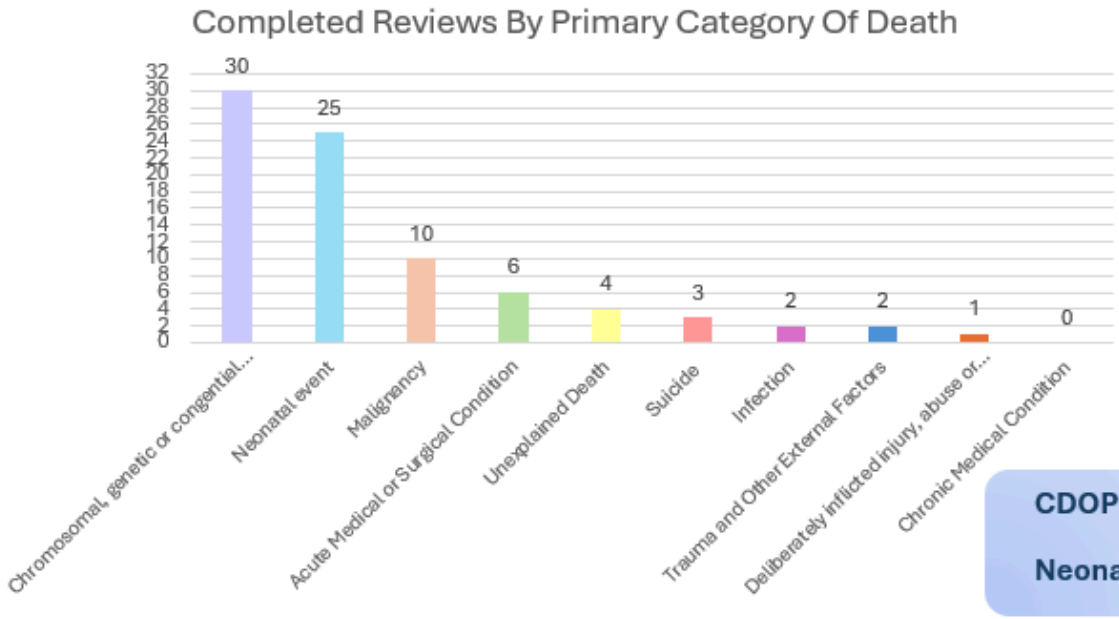






Most deprived area	1	2	3	4	5	6	7	8	9	10	Least deprived area
Number of deaths	2	13	11	2	11	11	10	3	5	8	

Two Postcodes were not found & one case was of no fixed abode



83 Cases reviewed and closed at CDOP

27 CDOP cases with modifiable factors

CDOP Meetings: 12

Neonatal CDOP Meetings:4

Total: 142 caseloads for year:

- 79 new cases
- 63 cases carried over from last year
- 81 Cases closed
- 61 Cases carried over into new year

Of the 142 cases:

- SUDIC/JAR: 34
- Safeguarding: 19
- LeDeR: 11
- Mental Health: 11

SUDIC/JAR total:

- 46 active cases this year with a JAR (23 new, 23 ongoing from previous year).
- 17 of the 46 cases had safeguarding concerns.
- 19 of the 46 cases were closed at CDOP –27 remain open.

Average time for PMRT Report to be received:

28 weeks for Suffolk

12 weeks for Norfolk & Waveney

Average time for an Inquest to be held:

59 weeks for Suffolk

49 weeks for Norfolk & Waveney

Average time for a PM report to be received (unexpected death):

41 weeks for Suffolk

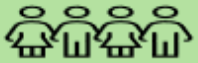
14 weeks for Norfolk and Waveney

19 Cases with a Criminal Investigation

- 2 Completed Case with a Criminal Investigation
- 17 Ongoing Cases with a Criminal Investigation

16 Cases with a Safeguarding Practise Review

- 7 Completed Cases with a Safeguarding Practise Review
- 9 Ongoing Cases with a Safeguarding Practise Review



25 Cases with a patient safety investigation:

- 22 Completed Cases
- 3 Ongoing
- 3 Involved more than one organisation.

Organisations involved in investigation.

- GP: 4
- Ambulance: 1
- Ipswich Hospital: 5
- West Suffolk Hospital: 3
- NSFT: 4
- Addenbrookes: 1
- HSE: 1
- QEHKL: 2
- NNUH: 6

42 Cases involving Inquest.

- 30 cases awaiting Inquest.
- 12 Completed Cases with an Inquest
- 2 Completed Cases involving a Prevention of Future Death (PFD) report (no previous PFD reports over last 5 years).

18 Cases with a LeDeR Review

- 7 Ongoing Cases with a LeDeR Review
- 11 Completed Cases with a LeDeR Review
- Out of the 18 Cases, only 8 had an EHCP and 3 were awaiting an assessment.
- Out of the 18 cases, 7 were registered with a LD.

Learning From Cases

The child death review process encourages those who take part in the reviews to consider what has been learnt. Learning covers the whole period leading up to the death and what happens after the child dies. How was the child death review process managed and how were the families supported.

The CDOP panel records all the learning that has been identified. Of particular importance is the consideration of factors that are potentially modifiable to prevent future deaths. This is challenging and there is much debate about what might be modifiable. Some might appear relatively straightforward if there is a clear cause identified such as blind cord safety features, securing a swimming pool at home. However, even these rely on human behaviour to put the safety features in place. This is much more challenging to change when we consider complex systems within health care or wider social policy such as reducing poverty.

The panel also reports on learning relating to management of child death and the importance of recognising good practice that has enabled families to cope with the death of their child more positively.

Between April 2023 and March 2024, the two CDOPs reviewed 83 deaths, 45 cases from Norfolk and 38 in Suffolk, of which 4 were from Waveney.

Norfolk and Suffolk identified modifiable factors in 33% (27/83) of cases reviewed as compared to 43% in England.

% 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	33	11	33%
28 - 364 days	19	7	37%
1 - 4 years	8	2	25%
5 - 9 years	7	1	14%
10 - 14 years	6	1	17%
15 - 17 years	10	5	50%
Total	**83**	**27**	**33%**

% of cases where modifiable factors were identified by ethnic group

Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
White	70	23	33%
Unknown	0	0	0%
Other	1	1	100%
Mixed	5	1	20%
Black or Black British	4	1	25%
Asian or Asian British	3	1	33%
Total	**83**	**27**	**33%**

Modifiable Factors

Key points

- A third of completed reviews in 2023-24 identified modifiable factors
- Half of cases with modifiable factors involved perinatal/neonatal events
- The most common modifiable factors fell under factors relating to service provision, followed by factors intrinsic to the child and factors in the child's social environment

Overview

There are 83 completed reviews included in this 2023-24 CDOP report, of which 27 (33%) identified modifiable factors. This is comparable to 34% of cases identified in Norfolk and Suffolk last year and lower than the national average of 43% of cases in 2023/24.

Amongst cases with identified modifiable factors, the most frequent primary category of death was perinatal/neonatal events, constituting almost half (48%) of cases (Figure 1). This was followed by chromosomal genetic and congenital anomaly which covered 15% of cases; sudden unexpected/unexplained death and suicide or deliberate self-inflicted harm followed, making up 11% of all cases with identified modifiable factors respectively.

Figure 1: Primary category of death by cases with and without modifiable factors

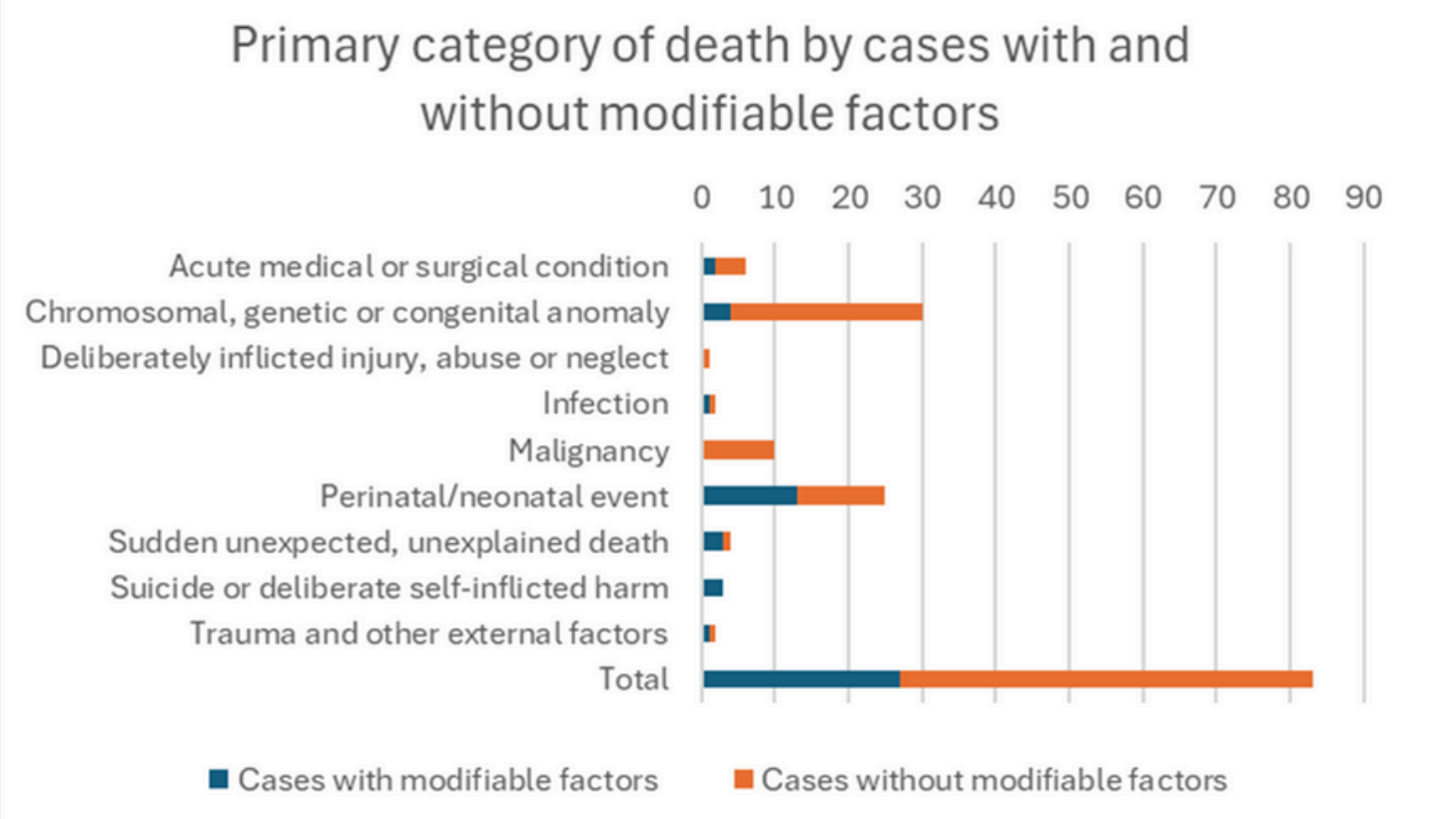


Table 1: Primary categories of death in completed reviews and cases with identified modifiable factors

Primary category of death	Completed reviews	Number of cases with modifiable factors (%) *	Percentage of category of death for cases with modifiable factors (%) ^
Acute medical or surgical condition	6	2 (33)	7
Chromosomal, genetic or congenital anomaly	30	4 (13)	15
Deliberately inflicted injury, abuse or neglect	1	0 (0)	0
Infection	2	1 (50)	4
Malignancy	10	0 (0)	0
Perinatal/neonatal event	25	13 (52)	48
Sudden unexpected, unexplained death	4	3 (75)	11
Suicide or deliberate self-inflicted harm	3	3 (100)	11
Trauma and other external factors, including medical/surgical complications/error	2	1 (50)	4
Total	83	27 (33)	100

*Percentage calculated as cases with modifiable factors divided by completed reviews per category of death

^ Percentage calculated as cases with modifiable factors per category of death divided by total cases with modifiable factors

Which were the most common modifiable factors (domain and subdomain analysis)?

For each case, relevant contributory factors were recorded and deemed modifiable or not. Those with modifiable factors are therefore categorised in the following section in accordance with the NCMD Contributory Factors Guidance 2022*. Most cases had more than one modifiable factor.

Analysis revealed that factors in service provision contributed to over half of all modifiable factors (58%) (Figure 2, Table 2). Of these, issues relating to initiation of treatment/identification of illness, communication within or between agencies and following guidelines/pathway/policy were most frequently identified. This was followed by factors intrinsic to the child, forming almost a quarter of modifiable factors (23%); risk factors in the mother during pregnancy, such as high maternal BMI or smoking/substance abuse during pregnancy, were of particular concern.

*Contributory Factors Guidance. National Child Mortality Database. Accessed at: Contributory-factors-guidance.pdf (ncmd.info)

Figure 2: Pie chart of modifiable factors by domain

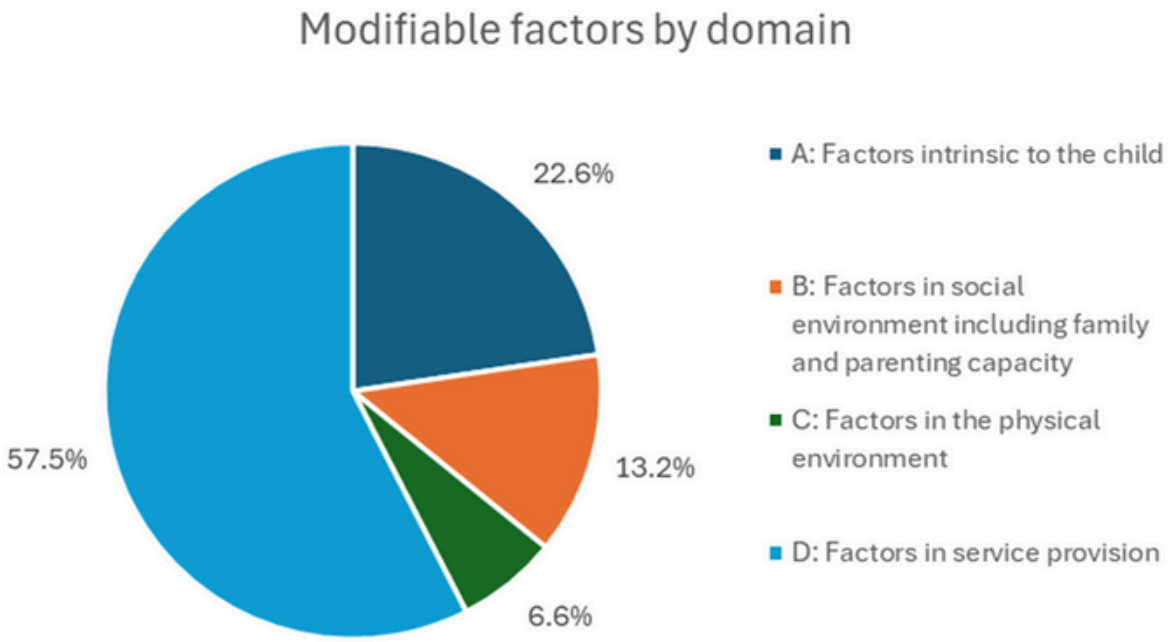


Table 2: Number and percentages of modifiable factors by domain and subdomain

Modifiable factors	Number and percentage of factors (%)
A: Factors intrinsic to the child	24 (23)
Child health history/medical conditions	4
Risk factors in mother during pregnancy/delivery	18
Emotional/behavioural factors	1
Other	1
B: Factors in social environment including family and parenting capacity	14 (13)
Smoking/alcohol/substance misuse/use by a parent/carer	10
Domestic or child abuse/neglect	1
Poverty and deprivation	1
Challenges for parents with access to services	1
Parent/carer's health	1
C: Factors in the physical environment	7 (7)
Sleep environment	4
Home safety/conditions	2
Vehicle collision	1
D: Factors in service provision	61 (58)
Initiation of treatment/identification of illness	19
Following guidelines/pathway/policy	12
Access to appropriate services	4
Staffing/bed capacity/equipment	2
Communication within or between agencies	11
Communication with family	5
Other	8
Total	106 (100)

*Percentage calculated as number of domain factors divided by total modifiable factors

How old were the children in cases with modifiable factors?

Seven out of ten cases involved children who died under the age of 1, with 41% of all cases with modifiable factors occurring in the perinatal/neonatal period (Table 3). Infants between one month and 1 year of age comprised 26% of all cases with modifiable factors. The third most common age group involved children aged 15-17 years, with 5 cases (19%).

Table 3: Age group at death in completed reviews and cases with identified modifiable factors

Age at death	Completed reviews	Number of cases with modifiable factors (%) *	Percentage of age group for cases with modifiable factors (%) ^
Perinatal/neonatal (<27 days)	33	11 (33)	41
28-364 days	19	7 (37)	26
1-4 years	8	2 (25)	7
5-9 years	7	1 (14)	4
10-14 years	6	1 (17)	4
15-17 years	10	5 (50)	19
Total	83	27 (33)	100

* Percentage calculated as cases with modifiable factors divided by completed reviews per age group at death

^ Percentage calculated as cases with modifiable factors per age group at death divided by total cases with modifiable factors

Modifiable factors in infant cases

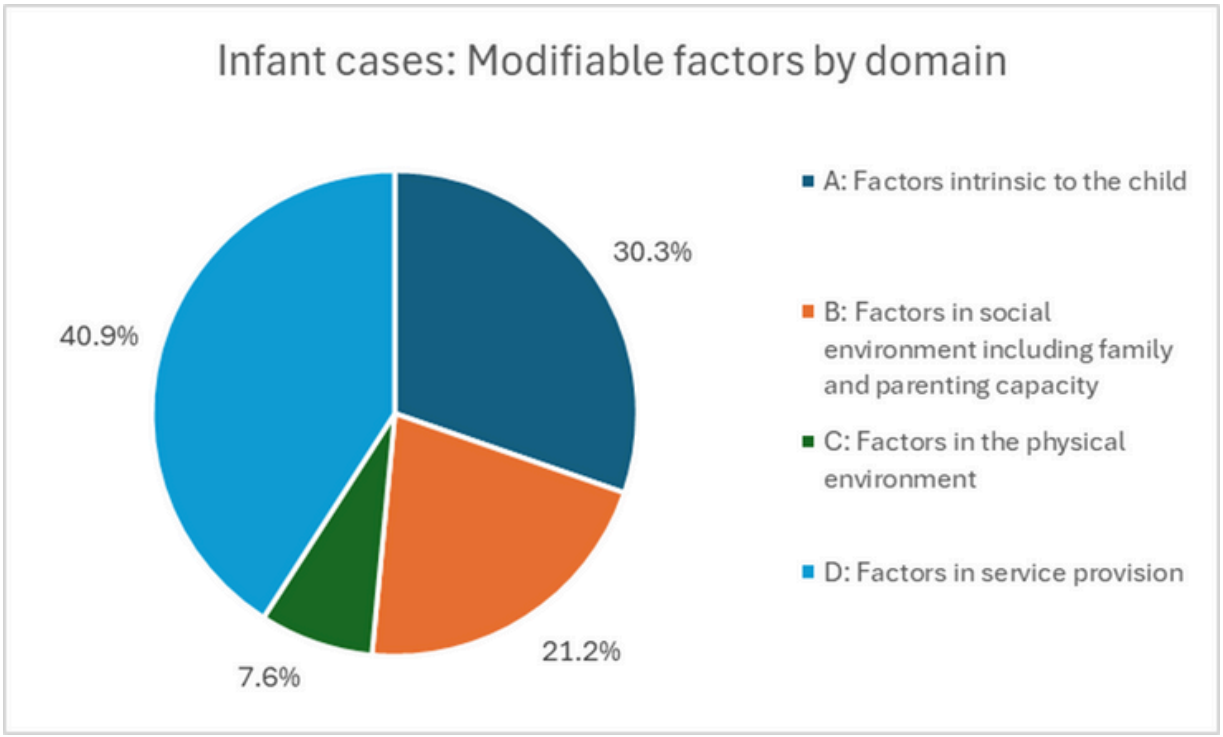
Key points

- 67% of cases with modifiable factors involved infant deaths
- The most frequent modifiable domain was factors in service provision (41% of all modifiable factors in infant cases)
- Factors intrinsic to the child, in particular risk factors in the mother during pregnancy/delivery, also made up a third (30%) of modifiable risk factors.

There were 18 infant cases identified (children who died at or under 364 days of life). Most cases had more than one modifiable factor.

In infant cases, the most frequent modifiable domain was factors in service provision, followed by factors intrinsic to the child, factors in the social environment and factors in the physical environment (Figure 3). The order of this distribution is the same as in cases over all age groups. However, where service provision factors made up 58% of cases over all ages, this is lower at 41% for infant cases. Contrarily, factors intrinsic to the child and factors in the social environment appear to play a more significant role in infant cases with modifiable factors, from 23% compared to 30% and 13% compared to 21% respectively.

Figure 3: Infant cases – modifiable factors by domain



Amongst factors intrinsic to the child, the most frequent modifiable subdomain in infants was risk factors in mother during pregnancy and delivery – this included 7 cases of high maternal BMI, 7 cases of smoking, 3 cases of substance misuse and 1 case of alcohol misuse during pregnancy (Table 4). On a similar note, parental smoking/substance/alcohol misuse constituted the majority of modifiable factors in the social environment.

Factors in the physical environment for infant cases mainly involve unsafe sleeping environments, co-sleeping and crowded living environments. Service provisional factors mainly concentrated in issues in initiating treatment or identification of illness, particularly during childbirth.

Table 4: Number and percentage of infant cases with modifiable factors by domain and subdomain

Modifiable factors	Cases and percentage of factors (%)
A: Factors intrinsic to the child	20(30)
Child health history/medical conditions	1
Risk factors in mother during pregnancy/delivery	18
Other	1
B: Factors in social environment including family and parenting capacity	14 (21)
Smoking/alcohol/substance misuse/use by a parent/carer	10
Domestic or child abuse/neglect	1
Poverty and deprivation	1
Challenges for parents with access to services	1
Parent/carer's health	1
C: Factors in the physical environment	5 (8)
Sleep environment	4
Home safety/conditions	1
D: Factors in service provision	27 (41)
Initiation of treatment/identification of illness	8
Following guidelines/pathway/policy	5
Access to appropriate services	1
Staffing/bed capacity/equipment	1
Communication within or between agencies	5
Communication with family	2
Other	5
Total	66 (100)

*Percentage calculated as number of domain factors divided by total domain factors

Figure 4: Word cloud of all modifiable factors, generated using WordClouds.com

Figure 5: Word cloud of infant modifiable factors, generated using WordClouds.com

Key Themes

Gestational age:

This is a significant cause of early death due to extreme prematurity. Eleven babies were born at 23 weeks gestation or less. In the past some of these deaths might not have been notified and were classed as a late miscarriage.

The potentially modifiable factors identified in 11 cases relate to risk factors in mother during pregnancy and delivery. These include parental behaviour leading to high maternal body mass index, smoking in pregnancy and substance misuse in pregnancy. These are felt to be modifiable in theory although it is recognised that this is much more challenging in practice. A mother needs to acknowledge that they need to change their behaviour. Services also need to be available to help. In many situations, there are wider determinants of health relating to deprivation and poverty. We need to reduce the rate of premature delivery to reduce the number of perinatal deaths.

The Integrated care board are aware of the challenges posed by obesity. This requires a national as well as local initiatives to reduce maternal obesity and improve both maternal health and to reduce premature births.

Smoking is another factor identified in premature births. Suffolk have introduced an initiative to reduce smoking in pregnancy. The ‘Smoke free initiative Suffolk implemented intensive support’ to help mothers to stop smoking during their pregnancy. There have been encouraging results in a reduction of smoking rate reported. This is being introduced in Norfolk as well.

Service-related factors

Service related factors have emerged as potentially modifiable. These included communication between professionals and family, delays in treatment linked to not recognising the seriousness of cardiotocogram traces monitoring the babies' heart rate and thus level of distress, not following guidelines without good reason and staffing capacity.

Some of this relates to training and some due to pressures on staff however it is extremely important that these are addressed in order to reduce infant deaths.

Child

Older children's deaths are less common. The categories where modifiable factors were most identified included Trauma 2/2, Suicide 3/3, Sudden unexpected deaths 3/4 and infection 1/2.

Unsafe sleeping arrangements

Safer sleeping initiatives are a persistent theme. There is a safer sleep awareness tool which is being launched in Suffolk and Norfolk. In Norfolk the CDR team met with GP safeguarding leads and presented a Child death themed Norfolk paediatric education group (NPEG) meeting. NNUH undertook safer sleep audit to consider what information is given to parents with young infants re safer sleep when have been admitted for other conditions which was presented at the NPEG meeting. In Suffolk there has been a safe sleep working group which held a webinar to over 300 professionals which shared the learning from cases in Suffolk. Suffolk are preparing to launch a safer sleep risk assessment tool to help professionals from all agencies assess the risk of SIDS and put an action plan in place.

Understanding the importance of safe sleep is for all professionals who work with families who can highlight the risks to babies, explain why babies are particularly vulnerable in the first few months to parental alcohol and smoking and help parents adopt safer sleep practices. It is important to understand what may prevent parents or make it more challenging for them to implement this advice and to help them to reduce the risk to their babies in the first few months of life when babies are particularly vulnerable.

Infection:

A new sepsis protocol has been introduced as a result of deaths due to infection (Suffolk).
It is well recognised that when child has a learning disability this may affect their presentation and how they cope with treatment. Having support of learning disability nurses within acute trusts can support both staff and children.

Recognition of a sick child continues to pose a challenge. This was also associated with management of chicken pox infection in an immunosuppressed child. Unfortunately, the significance of developing chicken pox whilst on steroids was not recognised and therefore although medical advice was sought by the family the urgency to provide potentially lifesaving treatment was not realised as soon as contact was made with health services. As a result of this case information provided to parents has been reviewed and services within the local tertiary hospital are working together to produce clear guidance. The aim is to have a system approach when health professionals initiate steroids in a child to ensure all local health providers have alerts on their records. Parents may be given information but may not realise the importance or may struggle to persuade health professionals of the importance of early treatment.
Treatment should be started as soon as child has a contact with chicken pox and inpatient treatment if the child has developed signs of infection. Information has been disseminated widely to health professionals to be aware of the seriousness of chicken pox in an immunosuppressed person and admit for treatment.

Immunisations awareness

Children who have conditions that increase their risk of serious chest infection should be offered PPV 23 vaccine from 2 years of age. This was shared through primary care and public health. In addition, it is important that this group of children are offered flu vaccination as well.

Communication

In several cases, challenges with communication emerged as both a contributory factor and potentially modifiable factor. Although each case was slightly different it is important to consider how information is given and how it may be received. Concerns re confidentiality may prevent health care communicating concerns about a young person's mental health which was identified contributing to a young person taking their own life. It is important to consider safeguarding and the potential impact of not informing parents about their child's health. This is also true for communication between mental health and primary care and schools. One theme that emerged is the importance of 'Think family' and to consider the impact of parental mental ill-health on children. This was also related to young man taking their own life.

Learning around "think family" has been shared with professionals across Suffolk and Norfolk so that the learning from child deaths can be included in this much bigger piece of work for Suffolk and Norfolk. The CDOPs have had positive feedback from other organisations on how they are taking the "Think Family" approach forward however more work is still needed to see this embedded in practice.

Record keeping

Fathers not recorded on a child's record continues to be a recurring theme at the CDOP. Whilst mothers and sibling's are recorded, father's or step fathers or partners are often not recorded on the child's record. There has been a lot of work within the safeguarding partnership to consider 'Hidden men'.

Suicide:

There were three cases of suicide reviewed and in all three it was felt that there were potentially modifiable factors. Much of the learning relates to sharing information and good communication. It is important to consider how difficult information is shared with a young person and considering how it may affect their wellbeing. Additional themes included poor risk assessment, delays in assessment and initiating therapy. The importance of good record keeping and communication between organisations. There is a reliance on the mental health services to take control when often others could offer some support if given advice to do so. All those in a young persons life can help to support that young person if they are given some tools to do so and may be more effective than someone the young person has not met before.

WHAT CHANGES HAVE BEEN MADE?

Toxic shock syndrome awareness

Changes to Paediatric early warning scores (PEWS)

Safe Sleep Initiative

Smoke Free Initiative in Suffolk

PPV 23 Awareness

Improvements to school security

EOE Ambulance Waiting Times

Immunisation Awareness

Listening To Parents/Martha's Rule

Sepsis Protocol reviewed

Immunosuppression In Chicken Pox Awareness

Access to Tier 4 provision

Think Family Approach Being Rolled Out Through Organisations

Changes To Practise At NSFT

Last Year's CDOP Objectives

Objectives achieved from last year's forward plan: This is the fifth joint annual report for Norfolk and Suffolk CDOP. In the fourth joint annual report which covered the period April 2022 – March 2023, the following objectives were set for 2023 - 2024

Objective: Norfolk and Suffolk CDOP teams aim to reduce the administrative load for midwives and neonatologist involved in completing the Perinatal Mortality Review Meetings and the E-CDOP forms. UPDATE: Norfolk remains in the pilot for the MBRACE NCMD ECDOP integration system. The CDR nurses attend PMRT meetings and liaise with Midwifery and governance teams to collect data for cases.

Objective: Continue to be active participants in the East of England CDOP professionals' network to share learning and system-led improvement. UPDATE: The child death designated DR for Norfolk and Suffolk continues to chair this regional meeting which feeds into the Association of Child Death Professionals (national group). Both Suffolk and Norfolk CDR nurses attend this meeting and share learning. Over the past year there has been a focus on reviewing modifiable factors across the region, to improve the consistency in identification and recording.

Objective: To work together with the national professional body, the Association of Child Death Review Professionals: UPDATE: Norfolk and Suffolk have good representation in this association, our designated Dr is on the committee and was joined by a social care representative this year who is the first social worker to join the committee. Members of the CDR teams have attended the annual conference and have been approached to hold a workshop for the next event. There has been a focus around whole genome sequencing for unexpected deaths in infancy and childhood and the importance of samples being taken as soon as possible after death. Both Suffolk and Norfolk have been promoting this learning and working together with professionals to ensure theses samples are taken and that processes are in place.

Objective: To Audit CDR processes across Norfolk and Suffolk to review compliance with statutory guidelines and identify areas of weakness. UPDATE: Audits were conducted throughout the year and shared with relevant key groups. CDR processes have been continuously reviewed and changes put in place to strengthen the service. Both teams are currently waiting the launch of the key worker tool kit which is hoped to strengthen the key worker role.

Objective: To continuously improve data completeness, ensuring that we are capturing 100% of the data required. Improving this data will enable us to understand trends locally but also for the NCMD to link with other data sets, leading to more comprehensive analysis in future. UPDATE: Norfolk had 97-100% data completeness, and Suffolk 100% for Notifications. Norfolk achieved between 87-100% in reporting fields, Suffolk 95-100%. Both Norfolk and Suffolk achieved 100% data completion for Analysis fields.

Objective: Ensure delegate attendance at CDOP is robustly documented. UPDATE: There is now systemic process in place to document attendance of CDOP meetings. There is good attendance at all panels and no CDOP have been cancelled due to not have the keys services in attendance.

Objective: To record deprivation index data for every case. UPDATE: Suffolk and Norfolk now complete the deprivation of index for all cases, analysing and presenting the data at CDOP so that deprivation and its impact can be considered in each case. Suffolk were able to identify the index for 100% of cases, Norfolk were not able identify the index in 3 cases (X2 postcodes not found, X1 case of no fixed abode)

Deprivation figures for all cases brought to Suffolk and Norfolk CDOP:

Most deprived area	1	2	3	4	5	6	7	8	9	10	Least deprived area
Number of deaths	2	13	11	2	11	11	10	3	5	8	

Forward CDOP Plan for 2024

- Ensure that eCDOP is used efficiently and to its full potential for the purposes of data analysis and auditing.
- A joint Norfolk and Suffolk action plan for NCMD thematic reports
- Continued work around MBRACE/NCMD system integration
- Ongoing participation in East Regional CDOP Network and the Association of Child Death Review Professionals (ACDRP).
- Continued delivery of multiagency training sessions including in-person learning events
- Continue to monitor initiatives in place to review the long-term impact such as smoke free pregnancy in Suffolk on premature delivery.
- Strengthen the audit process to review compliance with statutory guidelines and identify areas of excellence and where improvement is required.
- To ensure that CDOP learning is shared across the integrated care systems and that the learning is evidenced.

The Child Death Review Teams

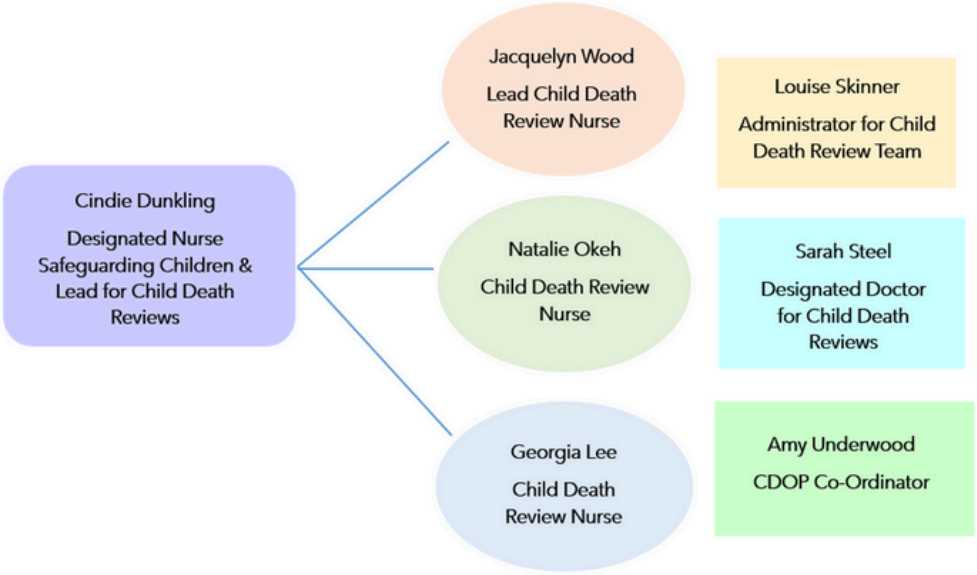
Suffolk: The team is made up of 3 nurses (2 FTE) and an administrator (0.8 FTE)
Norfolk: The team is made up of 3 nurses (3 FTE) and a part time administrator 0.5 WTE

Both teams have had changes in team members, which along with sickness and annual leave has been challenging to manage at times due to being small teams with minimal access to bank.

The purpose of the Child Death Review Team is to:

- Co-ordinate the health response for Norfolk and Waveney and Suffolk following all child deaths, including co-ordination of Child Review Meetings, information gathering and sharing.
- Share information with the Child Death Overview Panel.
- Support the Designated Doctor for Child Deaths.
- Act as a key worker for the family where appropriate.
- Ensure that all families and professionals are fully supported throughout the child death review process.
- Provide training and development on the Child Death Review Process and learning from child deaths across the health economy to ensure the process is conducted as effectively as possible and that learning is shared to prevent future child deaths.
- Work with the LeDeR teams to share learning.
- Work closely with relevant professionals to promote best practice around palliative care.

Meet The Suffolk Child Death Review Team



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Designated Doctor for Child Death Reviews

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Meet The Norfolk Child Death Review Team

Meet our team

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CDR Doctor

Anne-Marie Freeman
Lead CDR Nurse

Helen Bradbury
CDR Nurse

Amy Edwards
CDR Nurse

Vacancy

Administrator
Vacant post

Contact us

The service is open Mondays to Fridays 08.00 to 18.00, excluding bank holidays.

Email address:

nwicb.childdeathreviewteam@nhs.net

Emails are monitored daily Monday to Friday. We will respond to emails within 72 working hours.

Phone number:

01603 257160

Suffolk CDR Team's Achievements & Deliverables

Objective: Task and finish group for SIDS to deliver safe sleep webinar and to create a multiagency risk assessment tool. UPDATE: A multiagency safe sleep webinar was held which over 300 participates attended. The task and finish group have continued to meet to discuss and roll out the safer sleep risk assessment tool. The tool is now available on the Suffolk Safeguarding website for staff to access and use.

Objective: To develop and set up a peer support group for bereaved parents and carers in Suffolk. UPDATE: The Suffolk CDR team have been successful in setting up a peer support group for bereaved parents. This group meets once a month and is open to all parents and carers who have lost a child under 18 years old. The group is facilitated by the CDR team with keynote speakers invited into sessions. The aim is, after a year some of the parents to be able to access training so that they can run the group moving forward.

Objective: To continue to deliver CDR training with MDT professionals ensuring new staff and teams are aware of the CDR process. UPDATE: The Suffolk CDR team have continued to deliver training across health, police, social care and education. They have also continued to hold their yearly learning from child death study day which continues to have excellent attendance and feedback.

Objective: To have more interaction and communication with senior colleagues within the ICB to improve the sharing and implementation of learning. UPDATE: The Suffolk CDR team are now embedded within the ICB leadership team and working closer with teams who have impact and influence on taking actions forward.

Objective: To support colleagues within NHS trusts to be able to initiate the CDR process out of hours when our team are not at work. (To continue to embed the SUDIC webpage into practice to support practitioners out of hours). UPDATE: The Suffolk SUDIC webpage is still fully active and accessible to the MDT, it has been updated with the changes to the Suffolk SUDIC policy.

Objective: To raise awareness of domestic abuse in Child Death Reviews. UPDATE: The Suffolk CDR team have a domestic abuse champion who reviews all cases through a DA lense this has helped us to take wider consideration on the impact of domestic abuse in cases brought to CDOP and created a wider in depth discussion

Objective: To improve the recording of CDOP actions using the SMART model. UPDATE: Actions from CDOP are now being recorded in the recommended NCMD recording modelling (Action, Who, When), a summary document is sent out after CDOP clearly identifying actions and monitored through the CDOP action plan which is reviewed at every CDOP**.**

Norfolk CDR Team's Achievements & Deliverables

Objective: Continue to improve communication with the tertiary units with both the expected and unexpected child deaths. UPDATE: We have continued to improve communication and working better together with tertiary units, and partner agencies. Promoting attendance at CDRMs both chaired locally and away. Continue to improve information gathering from professionals that work out of our area.

Objective: Continue to deliver training to all partner agencies involved with the children and their families. UPDATE: Norfolk Paediatric education group- training session completed 'child death review process' virtual session 100+ attendees, recipients included paediatricians, nurses, health colleagues. Feedback received from 68 participants. All positive. Virtual training session completed with safeguarding leads from GP surgeries across Norfolk- 20 participants. Face to face training session by Lead CDR nurse and safeguarding GP lead for children- 'Child death review process'.

Objective: Develop strategies to raise awareness of the importance of face-to-face meetings between families and medical teams involved with the care of the child who died. Interim meetings to answer families' questions prior to feedback of results can alleviate mistrust and anger. UPDATE: The CDR team have facilitated feedback meeting at all three of our acute hospitals between paediatricians, obstetricians and bereaved parents. The assistance in facilitation of these meetings has been positively received by both parents and professionals.

Objective: We strive to maintain a standard which gives best outcomes for families with the family audit feedback tool and will aim to extend this to professionals in 23/24 to ensure we identify future training needs. UPDATE: We have found it difficult as a team to use a feedback tool for families who have lost a child by a SUDIC as it can appear insensitive and cause more distress. As an alternate we record adhoc feedback that is received from parent verbally or via email or test. We now contact all families prior to CDOP and request feedback as part of the CDOP letter process.

Objective: Due to retirements in the next year, there will be changes to the staffing of the CDR nursing team and a recruitment process. UPDATE: Following retirement a new Lead nurse has been appointed. Two FTE Band 7 Child Death Review nurses have been appointed, trained and working closely with recently suddenly bereaved families providing support. The administrator for the CDR team has resigned and as a team we will now share the administrators with all age safeguarding team. Training of the administrators has commenced.

Norfolk & Waveney and Suffolk Child Death Review Teams Objectives 2024-2025

- Continue to improve communication and working better together with tertiary units, and partner agencies. Promoting attendance at CDRMs both chaired locally and away. Continue to improve information gathering from professionals that work out of our area.

- Amalgamate statutory guidelines and job descriptions for CDR nurses and develop a keyworker standard operating procedure for the CDR nurses. In line with trauma informed practice rename the Child Death Review Nurses 'Compassionate review nurses' and embed the key worker toolkit in practice.

- Commence annual memorial service for bereaved families across Norfolk and Waveney localities, including a book of remembrance. Send anniversary card to families whose child has died suddenly and unexpected and they have received assistance from the CDR team.

- Improve the CDR team's visibility by working face to face in the acute hospitals on a rotating basis providing a drop in service for professionals. To improve working relations, promote awareness of the child death review statutory process and the work of our team.

- Create a set of online education videos regarding the CDR process. These videos will be user friendly, succinct and easily accessible. They can be added to mandatory training from all paediatricians and nurses and extended across the network.

- Deep dive analysis of child deaths over past three years looking at the deprivation deciles and cause of deaths.

- Review access to bereavement support across Suffolk exploring quality and equity highlighting and escalating the need for improved provision of bereavement support for unexpected deaths. Availability and access to resources for all families following a child death to be reviewed.

Training And Education Delivered By CDR Teams

Suffolk CDR Newsletter
160 Receivers
4 Publications in 2023-2024

Norfolk & Waveney CDR Newsletter
173 Receivers
3 Publications in 2023-2024

To subscribe to the Suffolk CDR Newsletter, please email:
child.death.review@snee.nhs.uk

To subscribe to the Norfolk & Waveney CDR Newsletter, please email: nwicb.childdeathreviewteam@nhs.net

Learning From Child Death in Suffolk – Wednesday 18th October 2023

75 people attended the event

"Interesting and engaging case-based discussions"

"Very Interesting & informative"

"Excellent organisation of the event, thank you for all the efforts put into this educational/training event"

"Case studies and family experience very insightful & informative"

"Thank you for sharing cases as allows us to reflect on our own practise"

"Useful to be in a room with a multitude of services"

"Enjoyed being able to network"

"Brilliant information about the whole process so we can support families and each other if a child death occurs"

"It was great for it to be face to face and meet new people within Suffolk"

"Coroner was very interesting"

"This event was very useful and very helpful discussing cases"

"Now feel part of a blended community of partners all working together to help children and families through bad times"

"Would recommend to other healthcare professionals"

"Family voice was invaluable, so important to learn from"

From the evaluation forms, 100% of attendees found the training useful.

"Variety of subjects and speakers - all different but relevant - excellent learning opportunity"

"Very informative and useful to find out the other roles in the SUDIC process"

"Food was amazing, and location was great"

"Fabulous Training"

"10/10 Overall"

"2nd year of coming, love it! Found the sessions so useful and informative, speakers were great too!"

"Case studies very powerful and useful"

"Really interesting, made me think a lot about how I can apply my learning in my role as a MASH SW. I will be reflecting on and writing about this training as part of my SWE CPD"

"Fab day - full of info, thank you"

"Everyone was very knowledgeable"

"It was wonderful to see SUDIC including expected and neonatal death. I tried to push this 20 years ago when the first protocol was written. Also, for keeping SUDIC in the title, partners involved in the original protocol will be proud of how this has moved forward over the years. Suffolk families are very lucky to have such a cohesive response to a death of a child."

"Really interesting and thought-provoking day, especially enjoyed the coroner's talk"

"Thank you for allowing students to attend"

"Lovely lunch"

97% of attendees enjoyed the event being held face to face and would like this to continue at future events

Norfolk Paediatric Education Group (NPEG) – January 2024

Feedback

Professional and Family Feedback 2023-2024

Phone call to parent after inquest. Mother was so grateful I attended the inquest in her absence and thanked the team for all they have done for her and her family. She said she couldn't have got through this without us - Parent

Text message received from a mother of bereaved child: "thank you for your call the other day it really helped" - Parent

Phone call to bereaved parent with update from CDOP. Mum was very thankful for the CDR team working together with the coroner and the paediatrician to enable their parent's wishes to be heard with not wanting a PM. Mum said she isn't sure how they would have coped if their son had to have a PM - Parent

Phone call to parent after CDOP. Mum very grateful for me listening to her concerns about medical practitioners "listening to parents" and pleased to listen that learning has taken place and that changes have been made in the primary care setting - Parent

Just read your email. The questions/comments have been captured perfectly. Thank you for your time and effort you have put into this for us - Parent

Phone call to parents newly bereaved. Spoke to mum who said she was so pleased to be able to talk to someone about her daughter, She said that I had enabled her to off load, and she felt so much calmer after the call which she thanked me for - Parent

Thank-you so much. You were a great support for the family and me. It was very difficult and very emotional. The translator was excellent.

- Consultant paediatrician following joint appointment with family to go through postmortem.

"Thank you very much we appreciate everything you have done for us" - Parents

The CDR is a very valuable service which should be maintained, and we would recommend it to anyone in a similar circumstance.

As for its staff, we cannot thank them enough for the wonderful work they do. We will forever be grateful to the team- Parents

I just wanted to say I think this case highlights the value provided by the CDR team to these families, without you I feel their story about the hospice and when a child dies leaflet wouldn't be heard for example, and you provide the coordination and joined up care needed – Consultant Paediatrician

Feedback from Suffolk CDR Team

Appendices

1. 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.

2. 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 –

- Any case giving rise to the need for a review as mentioned in regulation 5(1)(e).
- Any matters of concern affecting the safety and welfare of children in the area of the authority; and
- 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.

3. The Principles

Four underlying principles guide the overview of all child deaths:

- Every child's death is a tragedy.
- Learning lessons
- Joint Agency Working
- 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.

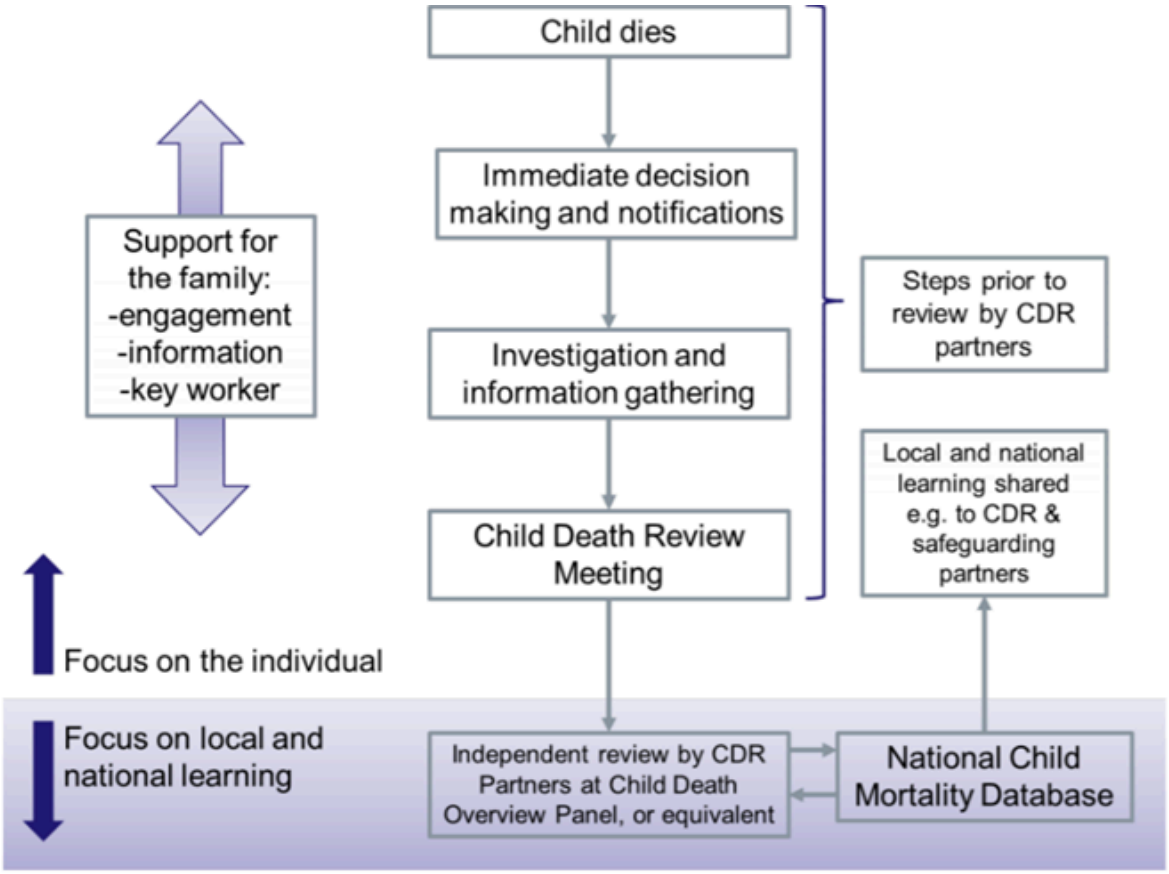
4. Norfolk and Suffolk CDOP – Joint Terms of Reference

Available from panel administrators if you would like to review.

5. Processes

The Child Death Review (CDR) Process

All CDRs follow systems and processes recommended in “Working Together to Safeguard Children, 2018”.



E-CDOP

E CDOP is thoroughly embedded now, and we have been using this system to collect data for five years. Notification of a child death can be made 24 hours a day via this link https://www.ecdop.co.uk/NorfolkSuffolk/Live/Public and will automatically be sent to the relevant CDOP Manager/Administrator and Child death review team. Notifications should be made as soon as possible. More than one notification may be sent. It is more important to make a notification than to wait for all the information to complete the form.
All the data is automatically uploaded to the NCMD at the point of notification and updated when cases are completed. If there is a safety alert this can be raised at the time of notification and will be sent to all CDOPs to be raised nationally.

ECDOP are constantly upgrading their questionnaires and new information relevant to child death is now requested. This helps with a greater depth of analysis. It is there fore important for clinicians and those who know the child to complete their information. There has been an emphasis on including parents and carers views and ensuring all their questions are answered to the best of ‘our’ ability. NCMD produces national annual, regional and individual reports using the data submitted from all the cases reviewed by CDOP panels. https://www.ncmd.info/publications/

CDOP

The statutory responsibility of CDOP is set out in the Children 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 should be 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.
Both the Norfolk and Suffolk CDOPs was chaired by an independent chair. Changes to working together has moved away from independent chairs and a new CDOP Chairs for Suffolk and Norfolk may be allocated for 2024. Suffolk and Norfolk continued to hold themed neonatal CDOP and this has been a successful approach to reviewing neonatal deaths and encourages representation from governance leads of antenatal services (Midwifery and Obstetrics) as well as post-natal services. When relevant. CDOPs take place once a Perinatal Mortality review (PMRT) has been completed.

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.

Suffolk & Waveney CDOP Meetings 2023-2024							
CDOP May 2023	CDOP July 2023	CDOP September 2023	Neonatal CDOP October 2023	CDOP November 2023	CDOP January 2024	CDOP February 2024	Neonatal CDOP March 2024
21 Attendees	19 Attendees	21 Attendees	19 Attendees	21 Attendees	23 Attendees	23 Attendees	22 Attendees

Norfolk CDOP Meetings 2023-2024					
CDOP May 2023	CDOP July 2023	Neonatal CDOP September 2023	CDOP November 2023	CDOP January 2024	Neonatal CDOP March 2024
19 Attendees	19 Attendees	32 Attendees	26 Attendees	37 Attendees	28 Attendees

Unexpected Deaths

There is a robust system to ensure multi-agency meetings are held after each unexpected death. Initial multi-agency/SUDIC meetings were chaired by Children's Services in both Norfolk and Suffolk.

Serious Incident investigations are carried out within Hospital Trusts when a child dies unexpectedly during a hospital admission or there are concerns within an individual agency.

All acute trusts hold Morbidity and Mortality meetings (M&M). They are held either via Microsoft Teams or face to face. Holding them via Microsoft Team has enabled staff from different organisations to be invited regardless of where the child has died. For children who die in tertiary hospitals out of area the review will be held in that hospital although sometimes the local hospital may also hold a review.

The final Child Death Review meetings is ideally held about 2 months after the death but will often be delayed due to waiting for a serious incident report, forensic post-mortem results, a criminal investigation an inquest or a safeguarding practice review. It should provide the best forum to discuss all the care and treatment provided and the opportunity for frank discussions about clinical care. However, this must be done constructively and with the aim of encouraging learning to try to prevent future deaths. It is a chance to consider questions from the child's family. It is also a chance to highlight good practice. The CDR meeting can also be helpful for staff who need support or want to talk about their experience after a child has died.

It is important that all partners work together to reduce delay as it can be challenging for families and staff and delays the dissemination of learning. It should be beneficial for all those who were involved in the care of the child to help understand what other professionals' roles are and provides a holistic review of the child and support to other professions who will have been affected by the child's death. It is important to include schools, voluntary organisations, and other non-clinical staff. It can be challenging for clinicians to discuss complex medical decision making with non-clinical professionals.

Expected Deaths

The palliative care teams have regular multi-agency meetings in place for children expected to die with malignancy. In general, the teams who are well known to the families will act as key workers for the families and take the lead in providing support for them. These children are often well known to the local hospice team.

It is important that the Child Death Review Teams work with the haematology /oncology teams and palliative care teams to embed the statutory process of child death reviews and collation of information about the cases. It is important to reduce any duplication of work from internal debriefs and mortality review meetings. The teams aim to gather information about management of malignancy and other palliative care cases for the National Child Mortality Database. It is important that the hospital that the child presents to is involved in review meetings to ensure any learning is shared with staff. If the child died out of area, then the hospital where they died usually hold the final meeting.

Perinatal Mortality Review Tool

The Perinatal Mortality Review Tool (PMRT) is a standardised national tool which was developed to support high-quality standardised perinatal reviews. It was developed through a collaboration led by MBRRACE-UK4 and was released in January 2018.

There is an expectation that all neonatal units use the PMRT to review all deaths of babies born after 22 weeks, who die within 28 days, or after 28 days if they were receiving neonatal care. It has taken time to implement this tool locally due to staffing levels and provision of sufficient support to enable the administrative processes. The PMRT focuses on clinical care. CDOP processes have a wider, more holistic approach. Thus, they overlap but do not duplicate. The review of babies who die in hospital is very important and consideration should be given to involving the coroner for any deaths that were unexpected, either due to the circumstances at the time of delivery or subsequently on the neonatal unit.

Integrated MBRACE/eCDOP

In 2022 Norfolk and Suffolk joined a pilot project from NCMD to develop a single notification system whereby midwifery staff would notify MBRACE, and it would automatically notify E-CDOP. It has taken some time to iron out the issues that have arisen during the pilot regarding information pulled from one system into another. Due to technical IT difficulties the role out has been delayed and further work is ongoing to integrate the sytems.