Cumbria Safeguarding Children Partnership

CSCP

Child Death Overview Panel Annual Report

1st April 2023 – 31st March 2024

Foreword

As the newly appointed Chair of the Cumbria Child Death Overview Panel (CDOP), I have the honour of presenting this annual report. I succeeded Kirsty Cleary in April 2023, and I want to express my deepest gratitude to Kirsty for her exceptional leadership and dedication. Her efforts have ensured that the Cumbria CDOP has maintained rigorous oversight and assurance of the child death review process for our statutory partners.

I am honoured to be in this position. The death of a child is a profoundly tragic and traumatic event that impacts families, friends, and communities. Being able to contribute to the scrutiny of these deaths and identify opportunities for recommendations and improvements to support children and families in the future is a privilege. Although the work can be challenging, it is incredibly rewarding.

This annual report reflects on the cases reviewed by the panel in 2023-24, highlighting our achievements, challenges, and priorities for 2024-25. Our multi-agency working groups are diligently advancing key areas of learning from the reviewed deaths, thereby strengthening our response to child mortality.

The CDOP comprises a diverse range of agencies, including health, social care, local authorities, and policing. Together, panel members meticulously examine the circumstances of each case. The process in Cumbria is further complicated by the presence of two new Unitary Authorities and two Integrated Care Boards (ICBs) with non-aligned footprints.

I am consistently impressed by the dedication of our panel members, who often confront the most tragic and distressing circumstances. I extend my heartfelt thanks to them for ensuring the continued effective and efficient review of child deaths throughout the year. This achievement would not have been possible without the behind-the-scenes work of our CDOP administrator, who ensures the smooth operation of our panels.

Additionally, I would like to thank Craig Whitelaw the FY2 Doctor who, during his placement with Public Health, conducted valuable research into child deaths in Cumbria and their possible links to deprivation.

It has been a privilege to work with such a committed panel of multi-agency partners, all dedicated to safeguarding children and young people and reducing the risk of child deaths.

Carol Stewart
Chair of Child Death Overview Panel

Contents

Introduction

The death of a child is a devastating loss that profoundly affects all those involved. Since April 2008 all deaths of children up to the age of 18 years, excluding still births and planned terminations should be reviewed by a Child Death Overview Panel (CDOP) determine whether there is anything that can be learned that might help prevent future deaths. From 1st April 2019 notifications of still births and planned terminations where a clinician is not present have been notified and reviewed by the CDOP.

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

Child Death Review partners, the Local Authorities and Integrated Care Boards (ICB) for Cumbria now hold responsibility for the delivery of the Child Death Review Process as set out in the Children Act 2004, as amended by the Children and Social Work Act 2017. The CDOP is multiagency with differing areas of professional expertise. This process is undertaken locally for all children who are normally resident in Cumbria.

The collation and sharing of all learning from Child Death Reviews and the CDOP is managed by the National Child Mortality Database (NCMD) which has been operational since 1st April 2019. The NCMD is an NHS funded project, delivered by the University of Bristol, that gathers information on all children who die across England with the aim to learn lessons that could lead to changes to improve and save children's lives in the future.

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

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

Child Death Review (CDR) Process

A Joint Agency Response (JAR) will be triggered in full for all child deaths that are sudden or unexpected. An unexpected death is a term used for the death of an infant or child whose death was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death. Within this process the lead agency will be either the Police or the Consultant Paediatrician involved in the care of the child, who will inform the Child Death Review Officer, who then ensures a meeting takes place within 72 hours of the child's death. The aim of the JAR is to enable the sharing of information, multi-agency discussions and planning to safeguard other individuals if identified.

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

Following notification being received by Child Death Review Officer, each agency that was involved in the care of the child prior to their death must complete a 'Reporting Form'. This form captures all the relevant information about the child and family to inform the CDOP process when considering modifiable factors. In addition to the reporting form there are a number of supplementary forms that the Child Death Review Officer uses to collect information from the relevant professionals. This information is also shared with the National Child Mortality Database (NCMD) and collated for review by the CDOP.

The process for expected deaths: the death of an infant or child which was anticipated following on from a period of illness that has been identified as terminal differs slightly as they do not usually require a JAR.

Supporting and engaging with a family who have lost a child is of the utmost importance throughout the whole child death review process. Recognising the complexities of the process and the differing emotional responses that bereavement can bring, families are given a single named point of contact, called a 'key worker'. Regardless of the professional background this person should:

- Be a reliable and readily accessible point of contact for the family after the death;
- Help co-ordinate meetings between the family and professionals as required;
- Be able to provide information on the child death review process and the course of any investigations pertaining to the child;
- Liaise as required with the Coroner's Officer and Police Family Liaison Officer;
- Represent the 'voice' of the parents at professional meetings, ensure that their questions are effective addressed and to provide feedback to the family afterwards;
- Signpost to expert bereavement support if required.

All expected and unexpected child deaths are required to have a Child Death Review (CDR) meeting. This is a multi-agency meeting where all matters relating to an individual child are discussed by professionals directly involved in the care of that child during their life. A CDR meeting can take many forms such as a Local Case Discussion, Perinatal Mortality Meeting, an NHS Serious Incident Investigation or a Hospital Morbidity and Mortality Meeting and typically, this meeting happens three months or more following the death of a child.

The purpose of the CDR Meeting is to discuss and review the background history, treatment and outcomes of investigations to determine, as far as possible, the likely cause of death; to ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment and service delivery; to describe any learning arising from the death and, where appropriate, to identify actions that should be taken by an organisation involved to improve the safety or welfare of children or the child death review process and to review the support provided to the family and to ensure that the family are provided with the outcomes of any investigation into their child's death. The analysis form is drafted within the meeting which is then presented to the CDOP.

Child Death Overview Panel

CDR Partners have a legal responsibility to ensure that the deaths of children normally resident in their area are reviewed. This function is carried out by the Child Death Overview Panel (CDOP) to ensure that a review is undertaken for all infant/child deaths age 0-17 years, excluding babies who are stillborn, late foetal loss and planned terminations of pregnancy carried out within the law.

In reviewing the death of each child, the CDOP considers relevant factors and modifiable factors in the family environment, parenting capacity and service provision. The CDOP identifies what action could be taken locally, regionally or at a national level with the aim of preventing child deaths and to improve the health and safety of children and young people.

The purpose of the Child Death Overview Panel is to consider any learning or factors that could prevent future deaths of children. Following the completion of the CDR process and once the cause of the child's death has been determined for both expected and unexpected child deaths, the information relating to the case is anonymised apart from the first name, which is to keep the focus on the child and is taken to the CDOP for discussion and review.

The functions of the CDOP are:

- To collect and collate information about each child death, seeking relevant information from professionals;
- To analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;
- To make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and well-being of children;
- To notify the Child Safeguarding Practice Review Panel (CSPR) and Local Safeguarding Partnership (LSP) when it suspects that a child may have been abused or neglected;
- To notify the Medical Examiner and the Doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;

- To provide specified data to the National Child Mortality Database (NCMD); to produce an annual report for child death review partners on local patterns and trends in child deaths, any lessons learnt, and actions taken, and the effectiveness of the wider child death review process; and
- To contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

Although during this time period the COVID restrictions had been removed, the CDOP remained mindful that there may still have been impacts of the Covid-19 pandemic, that may have had an impact on child deaths as an indirect result of Covid-19. This could include deaths from abuse as a result of domestic violence, deaths from late presentation of serious medical conditions (either due to an assumption the symptoms were Covid-19 related, or due to a reluctance or inability to present to medical services in a timely manner) and potentially deaths due to other infectious diseases as a result of delayed vaccination during the pandemic. During 2023/24 there were no notifications of deaths that directly related to Covid-19, however, two Covid-19 cases were reviewed, one which occurred in 2021 and another which occurred in 2022.

The eCDOP system in Cumbria

The eCDOP system is being used across England and feeds into the National Child Mortality database. The eCDOP Database management with Quality Education Systems continues to be used for meaningful data collection, consolidation, and analysis of data from panel reviews.

The eCDOP system provides an online procedural structure for notifications, reporting and meeting protocol for Cumbria and supports coordination of interaction between the two parts of a child death review as required under the new working arrangements for Child Death Overview Panels.

Membership and Panel Meetings

The Child Death Overview Panel meetings are held on a bi-monthly basis and have had consistent organisational commitment since they were established in 2008. Membership for April 2023-March 2024 can be seen below:

Title	Organisation
Designated Nurse for Safeguarding Children and Looked After Children	Lancashire & South Cumbria ICB
Designated Doctor for Safeguarding (Vice-Chair)	North East & North Cumbria ICB
Consultant in Public Health (Chair)	Public Health, Cumberland Council
Consultant in Public Health	Public Health, Westmorland & Furness Council
Lead Midwife, Safeguarding	North Cumbria Integrated Care
Consultant Paediatrician for Child Death	North East & North Cumbria ICB
Consultant Paediatrician	North Cumbria Integrated Care
Designated Doctor	Lancashire & South Cumbria ICB
Detective Superintendent	Cumbria Constabulary
Detective Superintendent	Cumbria Constabulary
Service Manager, Children's Services	Cumberland Council
Senior Manager, Children's Services	Westmorland & Furness Council
Safeguarding Practitioner	North West Ambulance Service
Named Midwife for Safeguarding	University Hospitals of Morecambe Bay Trust
Named Nurse for Safeguarding	University Hospitals of Morecambe Bay Trust
CSCP Partnership & Improvement Manager	Cumbria Safeguarding Children Partnership
CSCP Child Death Review Co-ordinator	Cumbria Safeguarding Children Partnership

Data Analysis

Total Number of Infant and Child Deaths

A total number of 18 children residing in Cumbria have been reported as died in 2023/24.

Figure 1 and Table 1 show the number of child deaths in Cumbria between 2018/19 and 2023/24. During this period, the number of child deaths has fluctuated between 18 and 26, with the highest number of deaths (26) in 2021/22 and the lowest number (18) in 2022/23 and 2023/24.

Figure 1 – Number of child deaths annually in Cumbria 18/19 – 2023/2024

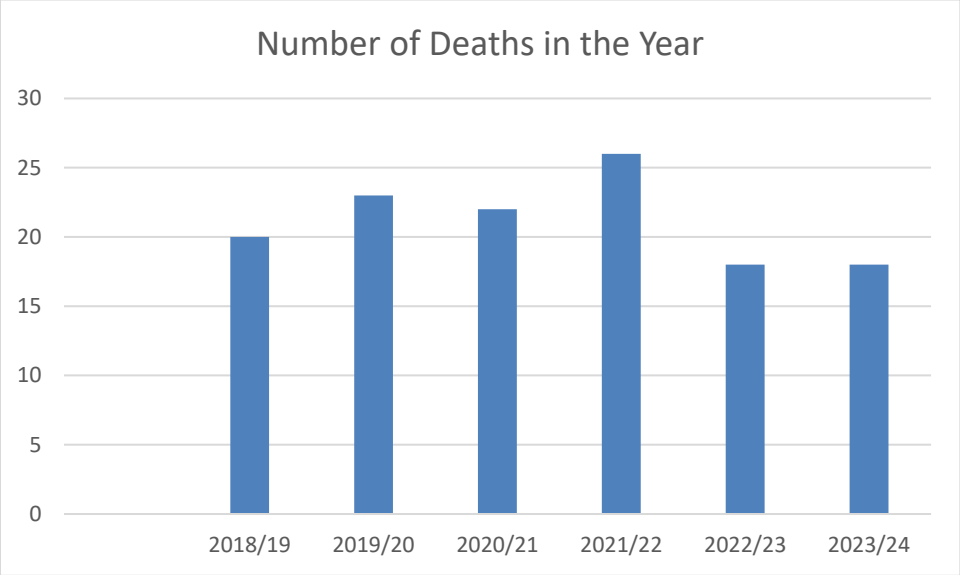


Table 1 – Number of child deaths in Cumbria 2018/19 – 2023/24

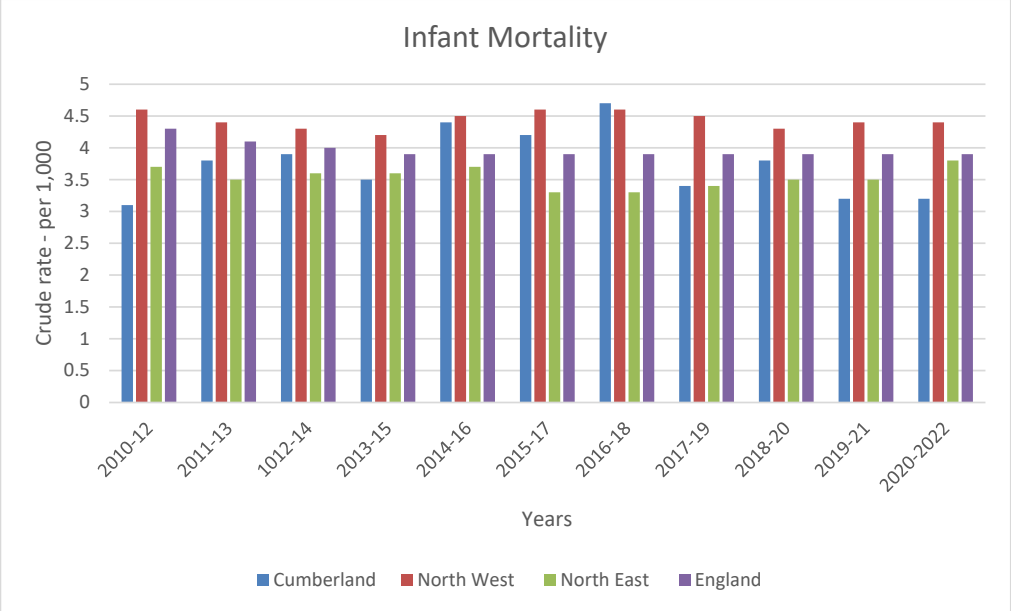
Year	Number of Deaths in the Year
2018/19	20
2019/20	23
2020/21	22
2021/22	26
2022/23	18
2023/24	18

Source – Cumbria CDOP data

Infant mortality rate in Cumberland, North West, North East and England

Please note following Local Government Reform the data for Cumbria has been separated into data for Cumberland and for Westmorland and Furness. Figures 3 and 4 show the crude mortality rates (per100,000) for each of the local authority areas.

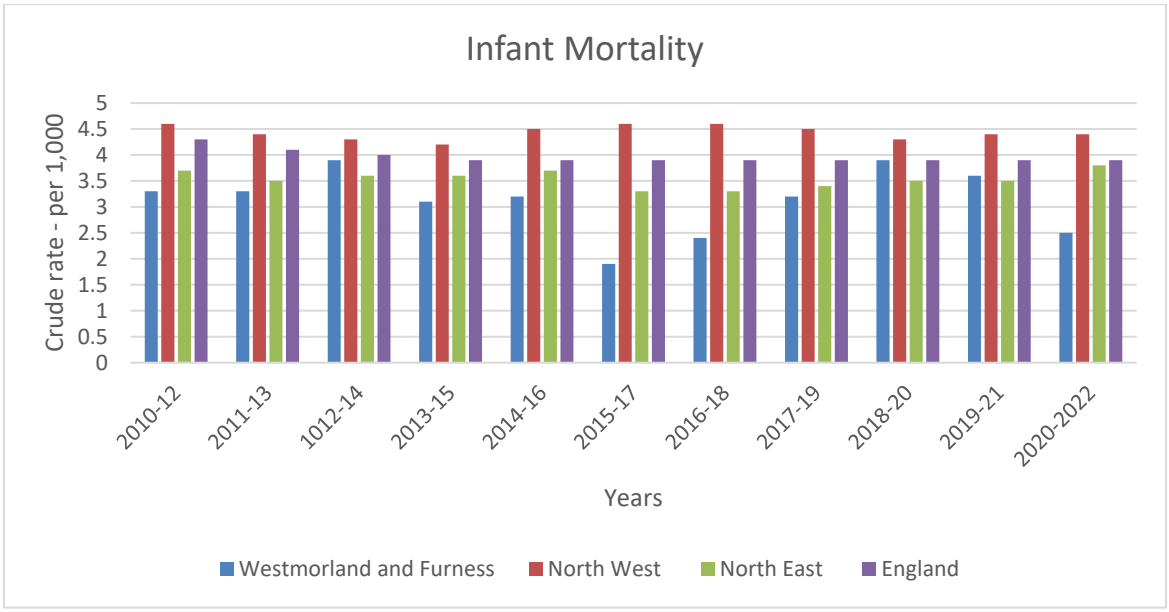
Figure 2 – Crude infant mortality crude rate per 1000 population Cumberland, North West, North East and England (2010/12 – 2020/22)



Source: Office for National Statistics (ONS)
Crude rate - per 1000

The most recent data shows that there has been a small decrease in the infant mortality rate (babies under 1 year of age) in Cumberland in the reporting period 2019-21 which stayed the same in 2020-22, however, this is not statistically significant due to low numbers and should be used with caution when drawing conclusions.

Figure 3 - Crude Infant mortality rate per 1,000 in Westmorland and Furness, North West, North East and England (2010/12 – 2020/22)



Source: Office for National Statistics (ONS)
Crude rate - per 1000

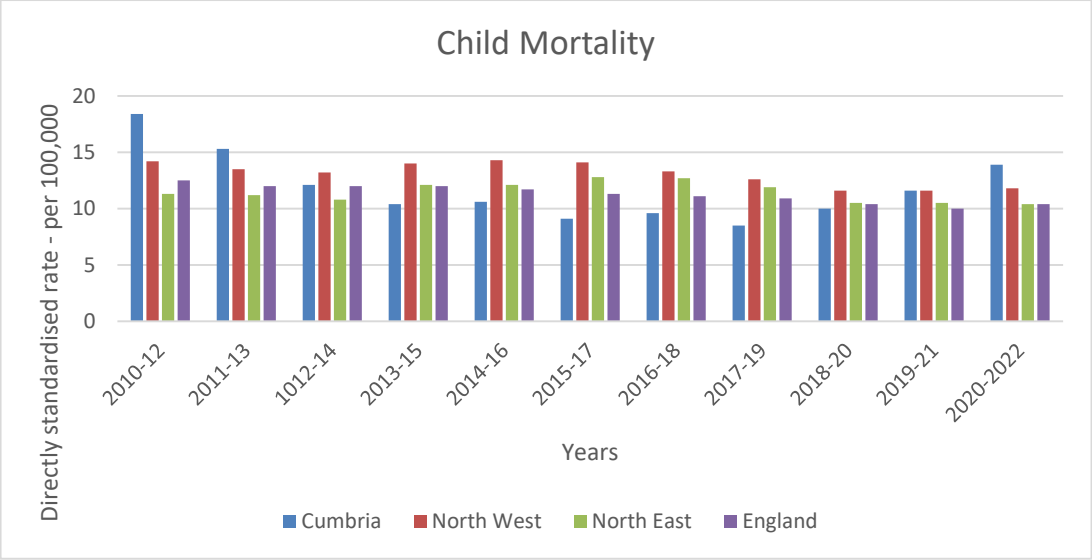
The Office for National Statistics has issued a note of caution when interpreting some of these statistics - Data for the time period 2020 to 2022 have been revised, due to an error found in the number of live births (i.e. the denominator for this indicator) in 2022, in England and lower-level geographies. Incorrect data suggested England's infant mortality rate for the time period 2020 to 2022 was 4.0 per 1,000, but the correction of the data shows that England's infant mortality rate in 2020 to 2022 was 3.9 per 1,000. This means the infant mortality rate has stayed the same (3.9 per 1,000) since the time period 2013 to 2015.

The error led to 7% of live births in 2022 in England being omitted from the calculation of the rate. As such, this means that rates have either stayed the same or decreased, due to the denominator increasing. Please go to **Public health profiles - OHID (phe.org.uk)** for more information.

NCMD reports that deaths of infants (babies under 1 year of age) in England accounted for 59% of all child deaths in the year ending 31 March 2023. The infant death rate was 3.8 per 1,000 live births, an increase from 3.6 in the previous year. However, the estimated death rate for infants born at 24 weeks or over was 2.7 deaths per 1,000 live births of the same gestational age, the same rate as the previous year.

Child mortality rate Cumbria, North West, North East and England

Figure 4 – Child mortality directly standardised rate per 100,000 population in England, North West, North East and Cumbria (2010/12 – 2020/22)



Source: Office for National Statistics (ONS)
Directly standardised rate - per 100,000

The most recent data shows there was a small increase in the child mortality rate in Cumbria 2018-20, and another increase in 2020-22 however, this is not statistically significant due to low numbers and should be viewed with caution.

The National Child Mortality Database (NCMD) data release for the year ending March 2023 reports there that were 3,743 child (0 – 17 years) deaths in England in the year ending 31 March 2023, an estimated rate of 31.8 deaths per 100,000 children. The number of deaths increased by 8% on the previous year and was the highest number of deaths in a year since NCMD started data collection in 2019. Infant (children under 1 year) deaths increased by 4% on the previous year and deaths of children aged between 1 and 17 years increased by 16%. There were 391 deaths during December 2022, the highest in any single month since 2019.

The child death rate in each region of England ranged from 24.2 to 41.1 per 100,000 population of 0–17-year-olds, an increase on the previous year for most regions.

Age of Infant and Child Deaths for 2023/24

The data detailed in table 4 summarises the age of the Cumbria children at death over the past 6 years.

Figure 5 – Age of infants and children at time of death in Cumbria (2018/19 – 2023/24)

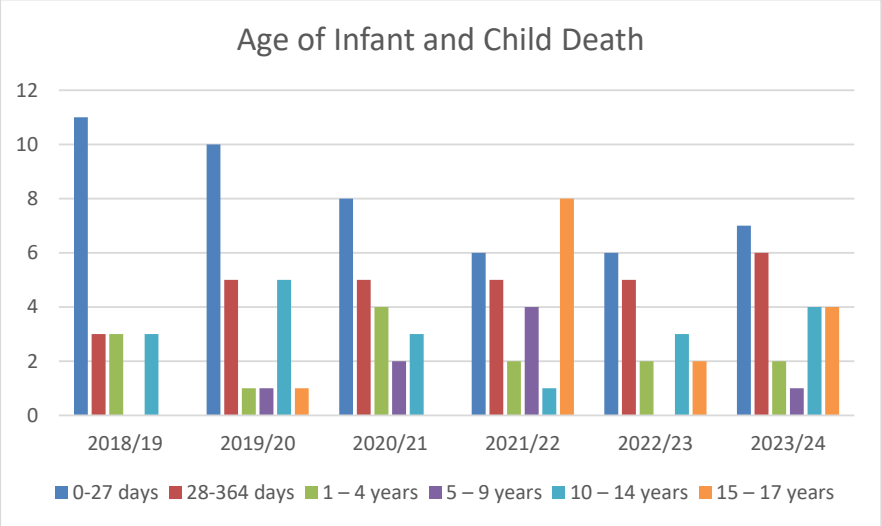


Table 2 - Age of infants and children at time of death in Cumbria *2018/919 – 2023/24)

Age Range	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
0-27 days	11	10	8	6	6	7	48
28-364 days	3	5	5	5	5	6	29
1 – 4 years	3	1	4	2	2	2	14
5 – 9 years	0	1	2	4	0	1	8
10 – 14 years	3	5	3	1	3	4	19
15 – 17 years	0	1	0	8	2	4	15

Source – Cumbria CDOP data

It should be noted NCMD data shows that a child is most at risk of death when under the age of 1 and particularly within the first 27 days of life. In 2023-24 the highest number of deaths notified in Cumbria were for 0-27 days closely followed by 28-364 days.

In 2021/22 there was an increase in the number of deaths in the 15–17-year age group. There were 4 deaths that were categorised as trauma and other external factors/suicide, 2, deaths that were categorised as acute medical or surgical condition, and 2 deaths that were categorised as chronic medical condition or malignancy. Six of the deaths were unexpected and two were expected, none of the deaths were linked.

Expected and Unexpected Child Deaths

There are two categories for child deaths.

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

During 2023/24 there have been 12 expected deaths and 6 unexpected deaths notified to the Cumbria CDOP. Over a 5-year average there have been 71 expected deaths and 47 unexpected deaths notified to CDOP, as illustrated in figure 7 and table 3.

The categories of death are described later in the report (Table 6).

Figure 6 – Numbers of expected or unexpected child deaths in Cumbria (2018/19 – 2023/24)

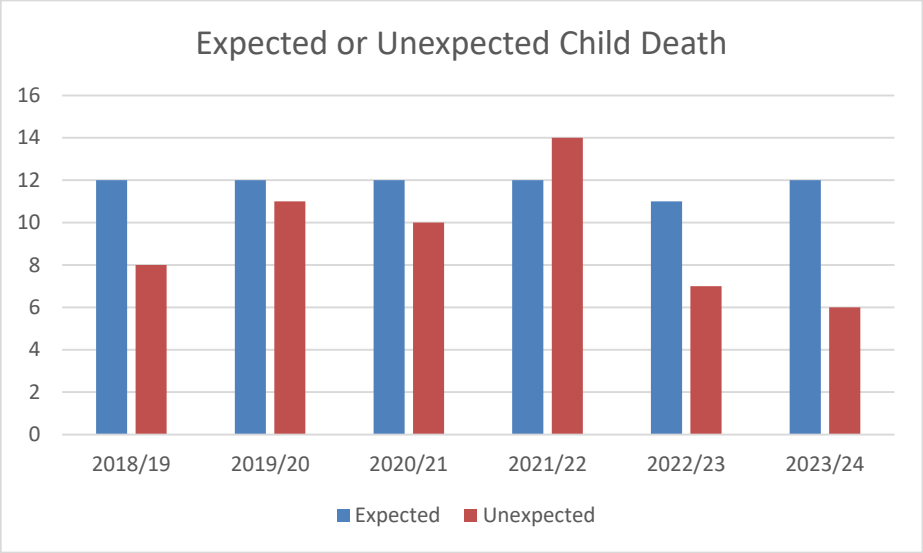


Table 3 – Numbers of expected or unexpected child deaths in Cumbria (2018/19 – 2023/34)

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total over 6 years
Expected	12	12	12	12	11	12	71
Unexpected	8	11	10	14	7	6	56

Source – Cumbria CDOP data

Location of Death

Figure 7 shows the location of child deaths between 2018/19 – 2023/24 in Cumbria. Hospital was the main location of death, and over the last four years, the home was the second.

Figure 7 – Location of deaths (number) in Cumbria 2018/19 - 2023/24

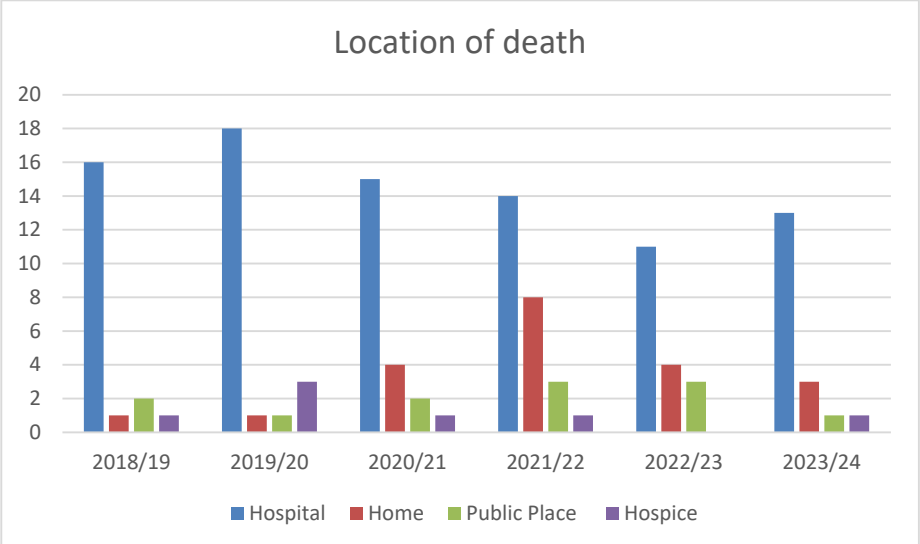


Table 4 - Location of deaths (number) in Cumbria 2018/19 - 2022/23

Location	2018/19	2019/20	2020/21	2021/22	2022/23	2023/23
Hospital	16	18	15	14	11	13
Home	1	1	4	8	4	3
Public Place	2	1	2	3	3	1
Hospice	1	3	1	1	0	1

Source – Cumbria CDOP data

It should also be noted that the figures for 2023/24 ten deaths occurred in hospitals which were outside of Cumbria.

It is worth noting that in most instances the location of the child death is recorded as in hospital, in most cases this is because the child is usually transferred from the community for emergency treatment/assessment before pronounced deceased but may also be because:

- Neonatal death where the child is already in the hospital setting.
- Children with malignancy or chronic condition who are being cared for in hospital.
- The child or parent's choice of where the child receives end of life care.

Infant and Child Deaths by Gender

A breakdown of the number of child deaths by gender since 2018/19 is:

Figure 8 – Infant and child death by gender (number) 2018/19 – 2023/24

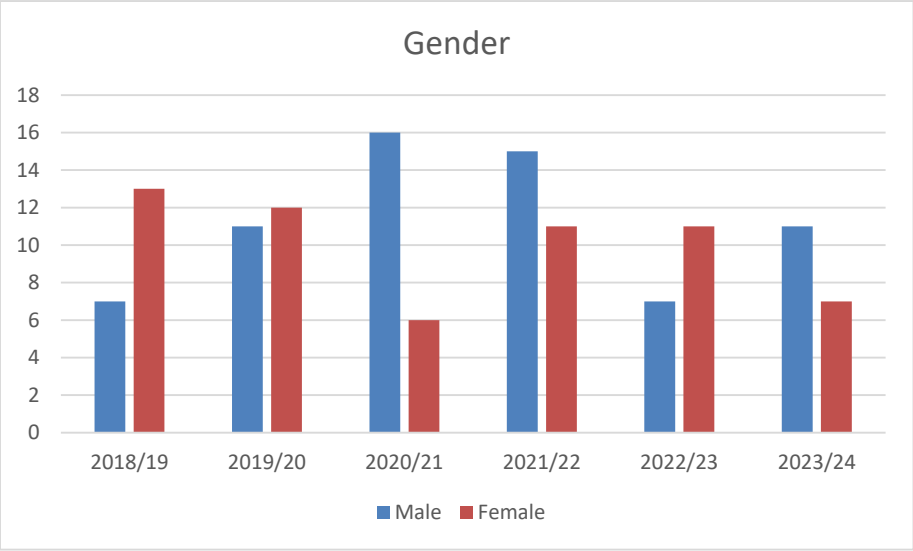


Table 5 Infant and child death by gender (number) 2018/19 – 2023/24

Gender	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Male	7	11	16	15	7	11
Female	13	12	6	11	11	7

Source – Cumbria CDOP data

Deprivation

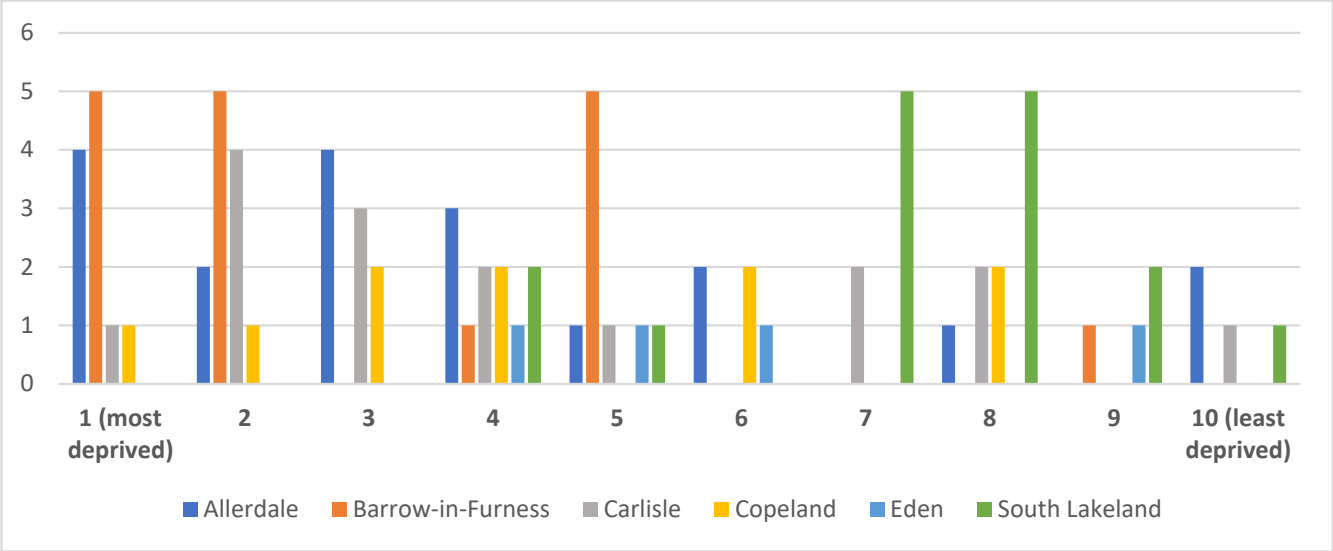
Infant and child mortality risk varies by socio-economic background. NCMD data shows the child death rate for children resident in the most deprived neighbourhoods of England in 2023 was 48.1 per 100,000 population, more than twice that of children resident in the least deprived neighbourhoods (18.7 per 100,000 population). Whilst the death rate in the least deprived neighbourhoods decreased slightly from the previous year, the death rate for the most deprived areas continued to rise, demonstrating widening inequalities.

The death rate of infants who were resident in the most deprived neighbourhoods of England was 5.9 per 1,000 infant population, more than twice that of infant's resident in the least deprived neighbourhoods (2.2 per 1,000 infant population). Similar to all child deaths, inequalities in infant deaths widened, with the infant death rate for the most deprived having increased, despite the rate for the least deprived having decreased from the previous year.

The social deprivation and the increased risk of child death has been highlighted at a national level following the publication of the NCMD Child Mortality and Social Deprivation Report15. The report analyses data for children who died during 2019/20 in England and identifies a clear association between the risk of child death and the level of deprivation (for all categories of death except cancer) for the place of residence. More specifically, the report states that over a fifth of all child deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived – which translates to over 700 fewer children dying per year in England. The report's authors are now calling on policy makers and those involved in planning and commissioning public health services as well as health and social care professionals to use the data in the report to develop, implement and monitor the impact of strategies and initiatives to reduce social deprivation and inequalities.

A piece of work led by public health in Cumbria, was undertaken in 2023/24 to interrogate the local data on child death in relation to deprivation. All Cumbrian child deaths during 2018-22 were mapped by postcode looking at the Index of Multiple Deprivation (IMD).

Figure 9 – Number of Paediatric Deaths by IMD in Cumbria 2018-22, shown at a district level



Source Cumbria CDOP data.

The analysis of the data does show that a higher proportion of deaths occurred in infants and children who live in the IMD five most deprived centiles. However, the numbers are small, so caution is required when looking at the data.

The Index of Multiple Deprivation (IMD) is a widely used tool for measuring deprivation across different regions, combining data on income, employment, health, education, housing, environment, and crime. However, its application in rural areas has several limitations. Therefore, while the IMD provides a valuable tool for assessing deprivation, its application in rural areas requires careful consideration and potentially supplementary methods to ensure that the unique challenges and characteristics of these areas are accurately represented. Adjustments or alternative indices might be necessary to provide a more comprehensive understanding of rural deprivation.

One such alternative is using proxy markers of deprivation to analyse child death rates; this involves identifying and utilising indirect indicators that can reflect underlying socio-economic conditions. These markers help to provide a more nuanced understanding of how deprivation impacts child mortality, especially in areas where direct data may be sparse or unreliable. Relevant proxy markers could be –

- Parental education levels
- Housing conditions
- Employment and income
- Access to healthcare
- Nutrition and Food Security
- Health indicators
- Social and family structure

The CDOP forms for Cumbrian child deaths during 2018-22 were analysed to assess if it was possible to identify proxy markers of deprivation. Due to changes in the information on the forms and what information is collated it was not possible to identify consistent markers which would allow analysis.

Ethnicity

In 2023/24 out of the 18 deaths notified, there was 1 infant/child who was of white/mixed ethnicity, 2 were infants/children who were of white/Asian ethnicity and, 2 were infants/children who were of white/other ethnicity. The other infants/children were all classified as white/British. These numbers reflect the population demographics for our regional area.

NCMD data reports that the child death rate in the year ending 31 March 2023 was highest for children of black or black British ethnicity (56.6 per 100,000 population) and Asian or Asian British ethnicity (50.8 per 100,000 population). The rates for both of these ethnic groups continued to increase in comparison to previous years, whilst the death rate for children of white ethnicity decreased from the previous year and remained lower than all other ethnic groups.

National patterns of infant deaths were similar to those reported for all child deaths. The estimated infant death rate continued to be highest for infants of black or black British ethnicity (8.7 per 1,000 live births), approximately three times the rate of infants of white ethnicity (3.0 per 1,000 live births) (Figure 7). The death rate of infants of Asian or Asian British ethnicity (6.2 per 1,000 live births) also continued to be higher than white infants. Infant death rates for those of black or Asian ethnicity increased in comparison to the previous year, however, the rate of deaths for infants of white ethnicity decreased.

Disabled Children

Of those deaths notified in 2023/24, none were known to have a disability. Therefore, none were notified to the Learning Disabilities Mortality Review Programme (LeDeR) by CDOP. The LeDeR programme strives to ensure that reviews of deaths lead to learning which will result in improved health and social care services for people with learning disabilities. It is not an investigation nor is it aimed at holding any individual or organisation to account.

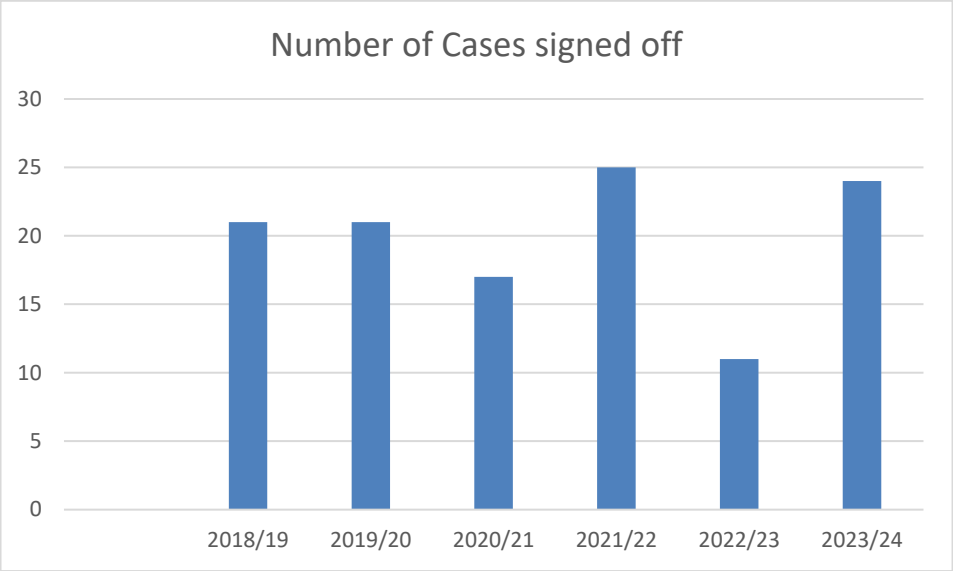
Cases Closed by the CDOP

Once the CDRM has taken place, all investigations have concluded and sufficient information has been collated, the CDOP holds the final multi-disciplinary review. Examining deaths using the data of cases discussed and closed at panel, provides a full dataset to conduct analysis.

The remainder of this report focuses on data relating to the 24 cases discussed and closed by the CDOP from 1 April 2023 to 31 March 2024 (2023/24). Of the 24 cases closed during 2023/24, all except for 1 case were historical cases, where the death occurred prior to 1 April 2023. Year on year, there has been variations in the number of cases closed by the Cumbria CDOP, with an average of 21 cases closed per year.

Cases can take over six months and longer to be brought to Panel for review. This may be because the CDOP is awaiting information from agencies, for example post-mortem reports or if there is an on-going Police investigation, in which case the discussions may be deferred pending the result of the enquiry. It should be noted that the child's death cannot be discussed at Panel until all information is received.

Figure 10 – Numbers of cases signed of each year (2018/19 – 2023/24).



Source – Cumbria CDOP data - please note that not all cases signed off will have necessarily passed away in that year.

Delays in 2023/24 were due to both challenges in accessing adequate information and other statutory processes. This has been identified as an issue nationally, it has been recognised by the NCMD programme team that the interface between the CDRM and CDOP process will impact the timescale of completed reviews due to operational aspects of the revised child death review process. The circumstances leading to death and the nature of the death also impact upon the number of cases closed by the CDOP. Deaths where the cause appears to be unnatural, sudden, and unexpected can be subject to multiple investigations that can remain ongoing for a number of years, which impacts on the timeliness of the CDOP review.

Work was undertaken in 2023/24 to identify if there were any internal processes within the CDOP which could be improved to reduce any delays in cases being reviewed and signed off. The CDOP panel now has as a standing item on the agenda to discuss numbers of historical cases and what actions can be taken to move them forward. NCMD data shows that 3,271 child deaths were reviewed by CDOPs in England between 1 April 2022 and 31 March 2023 (some of these deaths may have occurred in earlier years), a 19% increase on the previous year and the highest number since 2019. 45% of reviews in the year ending 31 March 2023 were completed by the CDOPs within 12 months of the death, a similar proportion to the previous year, but a fall from 2020 where 67% of reviews were completed within 12 months. The median time taken to complete reviews in 2022-23 was 392 days (around 13 months).

Categories of Child Deaths

During the CDOP meetings, members categorise all child deaths which are then recorded on the eCDOP system. Categories of child death are identified nationally and are provided by the Department for Education. Detailed in the table below are the categories of child deaths that have been agreed for those cases where the child had passed away and the case was signed off during 2023/24.

To note: the figures in the below tables from 2018/19 – 2019/20 were for cases reviewed and signed off. The figures for 2020/21 and 2021/22 are for child deaths notified to CDOP in that year and signed off in that year. Figures for 2022/23 are for those cases reviewed and signed off and were for deaths from the year 2021/22. One of the deaths reviewed and signed off, was from 2022/23.

Figure 11 – Categories of child death

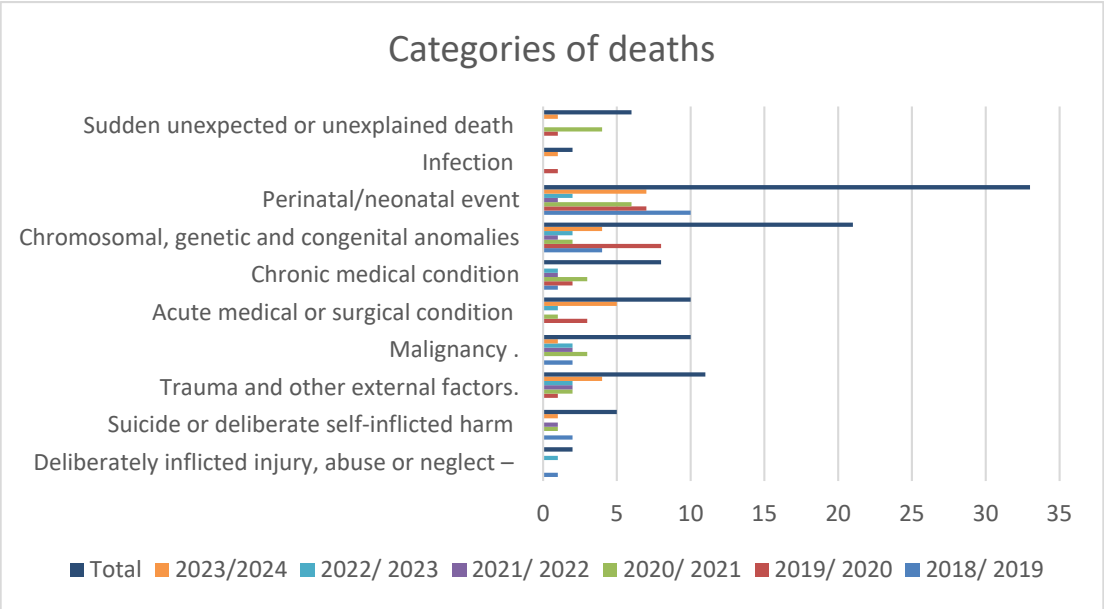


Table 6 – Categories of Child Death

Category	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
1. Deliberately inflicted injury, abuse or neglect – this includes numerous physical injuries, which may be related to homicide as well as deaths from war, terrorism or other mass violence. It also includes severe neglect leading to death	1	0	0	0	1	0	2
2. Suicide or deliberate self-inflicted harm – this includes any action intentionally to cause one's own death. It will usually apply to adolescents rather than younger children.	2	0	1	1	0	1	5
3. Trauma and other external factors – this relates to unintentional physical injuries caused by external factors. It does not include any deliberately inflicted injury, abuse or neglect.	0	1	2	2	2	4	11
4. Malignancy – this includes cancer and cancer like conditions such as solid tumours, leukaemia and lymphomas and other malignant proliferative conditions, even if the final event leading to death was infection haemorrhage, etc.	2	0	3	2	2	1	10
5. Acute medical or surgical condition – a brief sudden onset of illness which resulted in the death of a child.	0	3	1	0	1	5	10

Category	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
6. Chronic medical condition – a medical condition which has lasted a long time or was recurrent and resulted in the death of child.	1	2	3	1	1	0	8
7. Chromosomal, genetic and congenital anomalies – medical conditions resulting from anomalies in genes or chromosomes as well as a defect that is present at birth.	4	8	2	1	2	4	21
8. Perinatal/neonatal event – the of a child as a result of extreme prematurity, adverse outcomes of the birthing process, intrauterine procedures or within the first four weeks of life	10	7	6	1	2	7	33
9. Infection – this can be any primary infection, ie not a complication of one of the above categories, arising after the first postnatal week, oor after discharge of a preterm baby.	0	1	0	0	0	1	2
10. Sudden unexpected or unexplained death – this is where pathological diagnosis 6is either Sudden infant Death Syndrome (SIDS) or 'unascertained' at any age.	0	1	4	0	0	1	6

Source – Cumbria CDOP data

Of the 108 deaths that have been reviewed over the past six years:

- 30.5% were due to a perinatal/neonatal events,
- 19.4% were due to chromosomal, genetic and congenital anomalies,
- 10.1% were due to trauma and other external factors,
- 9.2 % were due to malignancy, and
- 7.4% were due to chronic medical conditions.

In England in 2023, from the deaths reviewed by CDOP's NCMD **Child death data release 2023 | National Child Mortality Database (ncmd.info)** reports the most common primary category (i.e., the likely cause) of death for reviews in 2022-23 was Perinatal/neonatal event, which was recorded for 34% of all child death reviews, followed by Chromosomal, genetic and congenital anomalies (24%), Malignancy (9%) and Sudden unexpected and unexplained death (7%). These patterns were similar to previous years.

The most common primary category of death was Perinatal/neonatal event for children aged under 1, Malignancy for children aged between 1 and 9 years, and Suicide or deliberate self-inflicted harm for children aged between 10 and 17 years.

Modifiable Factors

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

When the Panel has reviewed the death of a child, they will then identify and agree any modifiable factors that may have prevented the death. This information forms part of the reporting to NCMD who reviews all the information provided by each local CDOP to provide a national overview.

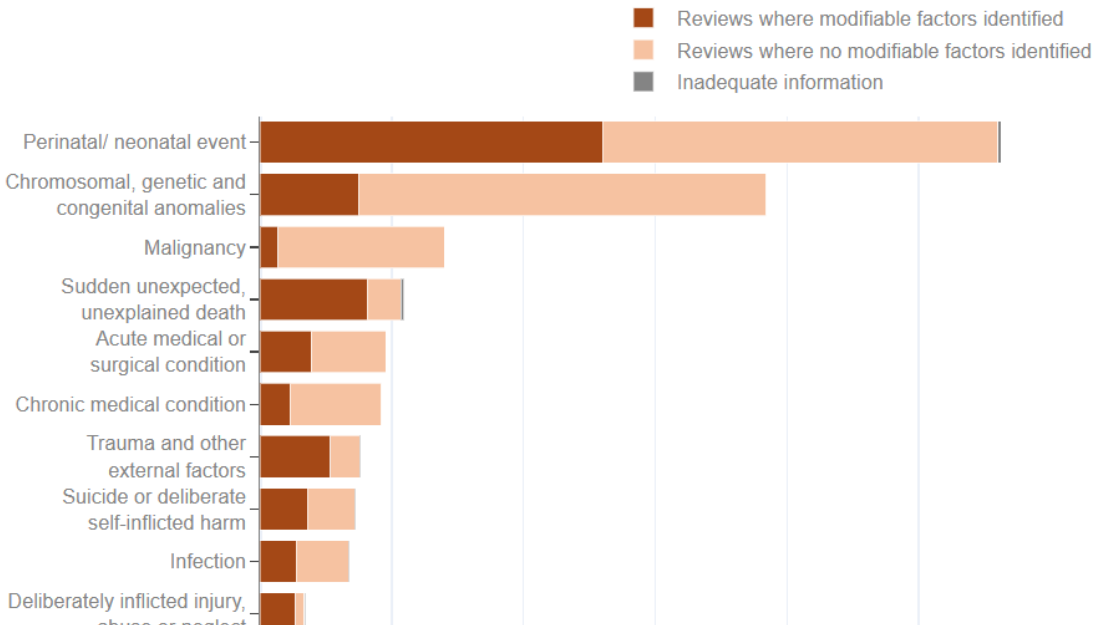
Where modifiable factors are identified, the Panel addresses these and utilises the CDOP action tracker. It is not usually within the remit of CDOP to take action directly, but any issues identified, learning points and recommendations are given to relevant agencies to enable them to take action as appropriate. When this is felt necessary, it is placed on an action log until CDOP are assured that the necessary action has been taken. Out of the 24 deaths that were reviewed and signed off in 2023/24, there were 17 cases where modifiable factors were identified by the Panel.

Factors included: maternal/paternal smoking; unplanned co-sleeping, parents being intoxicated; child not wearing safety equipment/protective head gear; untreated maternal Group B streptococcus, inability to swim, lack of dangerous water warning signs; inappropriate disposal of cigarettes; inappropriate storage of flammable material; unsupervised bathing, inappropriate use of a bath seat; out of date rescue medication; mental health history not shared appropriately; maternal Covid vaccine hesitancy; modified motorised vehicle; a potential for animal hair exacerbating asthma; and mistakes in medical care.

Please note that these modifiable factors may not have been a factor in the cause of death of the child, but may have in some way contributed, or may be a risk factor for other children.

NCMD data shows that nationally deaths categorised as Deliberately inflicted injury, abuse or neglect had the highest proportion of reviews with modifiable factors (81%), followed by Sudden unexpected and unexplained death (76%), Trauma or other external factors (71%) and Suicide or deliberate self-inflicted harm (50%).

Figure 12. Number of reviews completed by English CDOPs by primary category of death and whether modifiable factors were identified, year ending 31 March 2023



Source NCMD Child death data release 2023 | National Child Mortality Database (ncmd.info)

Learning from Child Deaths

The Cumbria CDOP has identified learning points from all deaths and engaged in multi-agency groups to take forward key areas of learning to safeguard and promote the welfare of children in the area. Some of these learning points were:

- Raising awareness of water safety in schools
- Raising awareness of using appropriate safety equipment
- Improvements to multi agency data sharing
- New Standard Operating Procedures (SOPS) introduced into clinical care
- Audits to ensure compliance with SOPS introduced

Training

Members of the Child Death Overview Panel engage relevant learning, training and conferences at a Regional and National level around child deaths. This includes NCMD webinars, which are designed to provide detailed updates on the NCMD, discuss emerging issues and provide information around the latest events in the child death review sector. Information from these events are shared as part of a standing agenda item at the Cumbria CDOP, with reflection as to where the learning and recommendations can be implemented.

Members of the CDOP Panel attend NCMD Webinars and local partnership training is provided.

What has CDOP achieved in 2022/23

Outcome	Action	When	Who	Update	RAG
Safer sleep messages are embedded in practice across the workforce and safe sleep assessments are undertaken	A review of safer sleeping & Icon has been undertaken to ensure: • Consistent application of safety messages by agencies • Audit of use of safe sleep assessment	March 2024	The Safer Sleep Task and Finish Group/ICB	An audit is still to be undertaken. The safer sleeping task and finish group reconvened in 2023 however due to capacity issues this is still to be completed. The aim is to complete this action over 24/25.	
An effective partnership response to child suicide contagion.	Review of Suicide Contagion Protocol has been undertaken including • Audit of process	March 2024	ICB/Public Health/ Police/ CSCP Support Team	Due to LGR and staff changes this work is ongoing. It will be completed by October 24. The protocol should be reviewed annually.	
NCMD are aware of any COVID-19 related actions for national learning	Consider and monitor all child deaths that occur as a direct or indirect result of Covid-19 at the CDOP and ensure any actions which need to be implemented are recommended by the Panel.	March 2024	CDOP	Now undertaken as part of each child death review.	

Outcome	Action	When	Who	Update	RAG
All agencies understand their roles and responsibilities in relation to child death review, improving the quality and outputs of the child death review processes.	Annual training and awareness raising undertaken about CDR process, CDOP and CDOP findings.	March 2024	CDOP	Paperwork has now been aligned, CDOP processes have been aligned. CDOP induction training is being developed and will be in place by December 24.	
Families receive effective support from bereavement services.	Review of bereavement provision • Links to bereavement support network – • Identify how to capture service user experience	March 2024	CDOP/ Bereavement Network	This work is ongoing and should remain a CDOP priority. Links have been made to the bereavement support network. Links have been made with national leads to review current national offer.	

CDOP Priorities for 2024/25

1. Work closely with neighbouring CDOPs for effective learning including participating in regional networks, national webinars and conferences for wider education and understanding of child deaths. Themed Panel Meetings with geographical neighbours.
2. Strengthen child death processes within education, including awareness raising and training.
3. Develop CDOP induction training package.
4. Complete the review of the Suicide Contagion Protocol and circulate the updated Protocol.
5. Continuous embedding of the child death review process by working in partnership to ensure timely response and review of cases prior to CDOP. The panel will continue to oversee the effectiveness of the arrangements.
6. Continue the work to identify if there are any local issues delaying the CDOP process, in order to reduce the number of child death cases that are outstanding to be reviewed.
7. Encourage schools to develop bereavement policies.
8. Implement CDOP operational group to implement actions aimed at reducing risks identified in modifiable factors.
9. Operational group to work with partners to ensure the Audit of use of safe sleep assessment is completed.

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