Pan Cheshire Child Death Overview Panel (CDOP)

Annual Report 2022-23

Mike Leaf, Chair of the Pan-Cheshire CDOP

February 2024

Introduction

Each child death is a tragedy.

As a society, it is vital that we learn from the heartbreaking losses of children and young people so that we can understand where we can reduce the likelihood of similar tragedies occurring in the future.

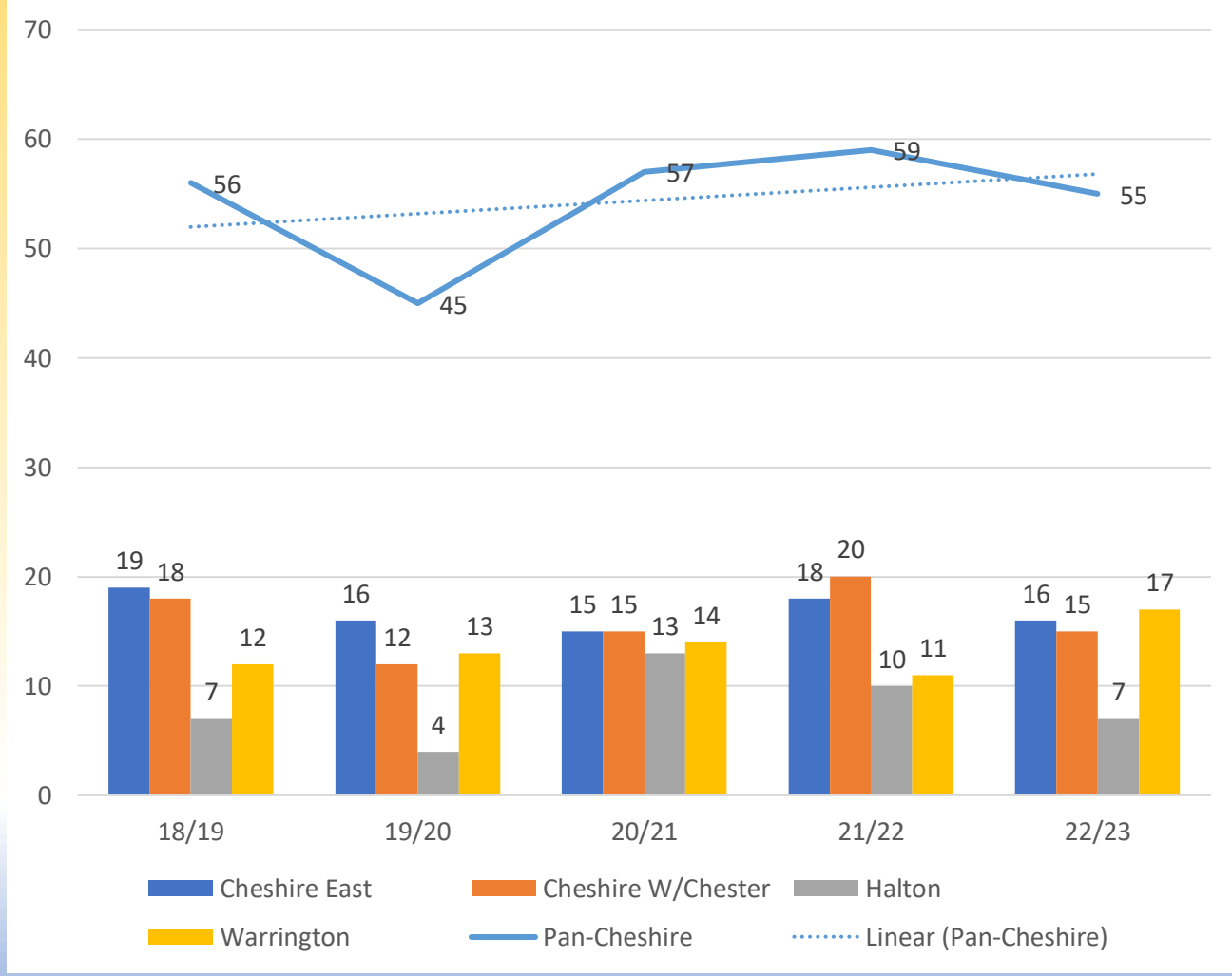
While infrequent It is imperative that we glean lessons from these heartbreaking losses, pinpoint any aspects we can change, and adopt improved approaches to reduce the likelihood of similar future tragedies.

Purpose of the CDOP annual report

- Clarify and outline some of the CDOP processes directed by national guidance
- Assure the Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across Cheshire.
- Provide an overview of information on trends and patterns in child deaths reviewed across Cheshire during the last reporting year (2022-23) and highlight issues arising from the child deaths reviewed.
- Report on achievements and progress.
- Make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across Cheshire.

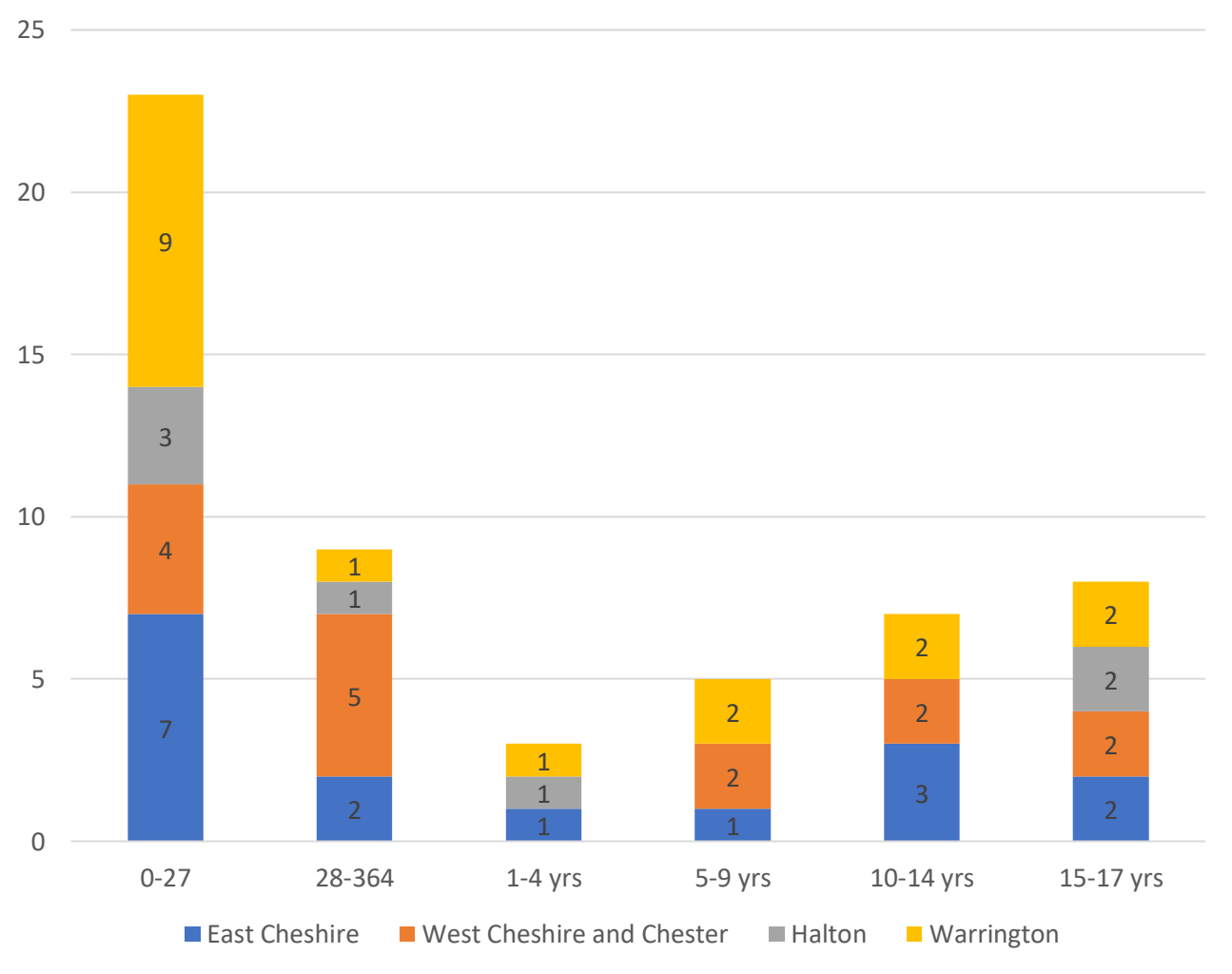
Death by Year

- Numbers fairly consistent
- Dip during covid
- Average remains under 60 per year



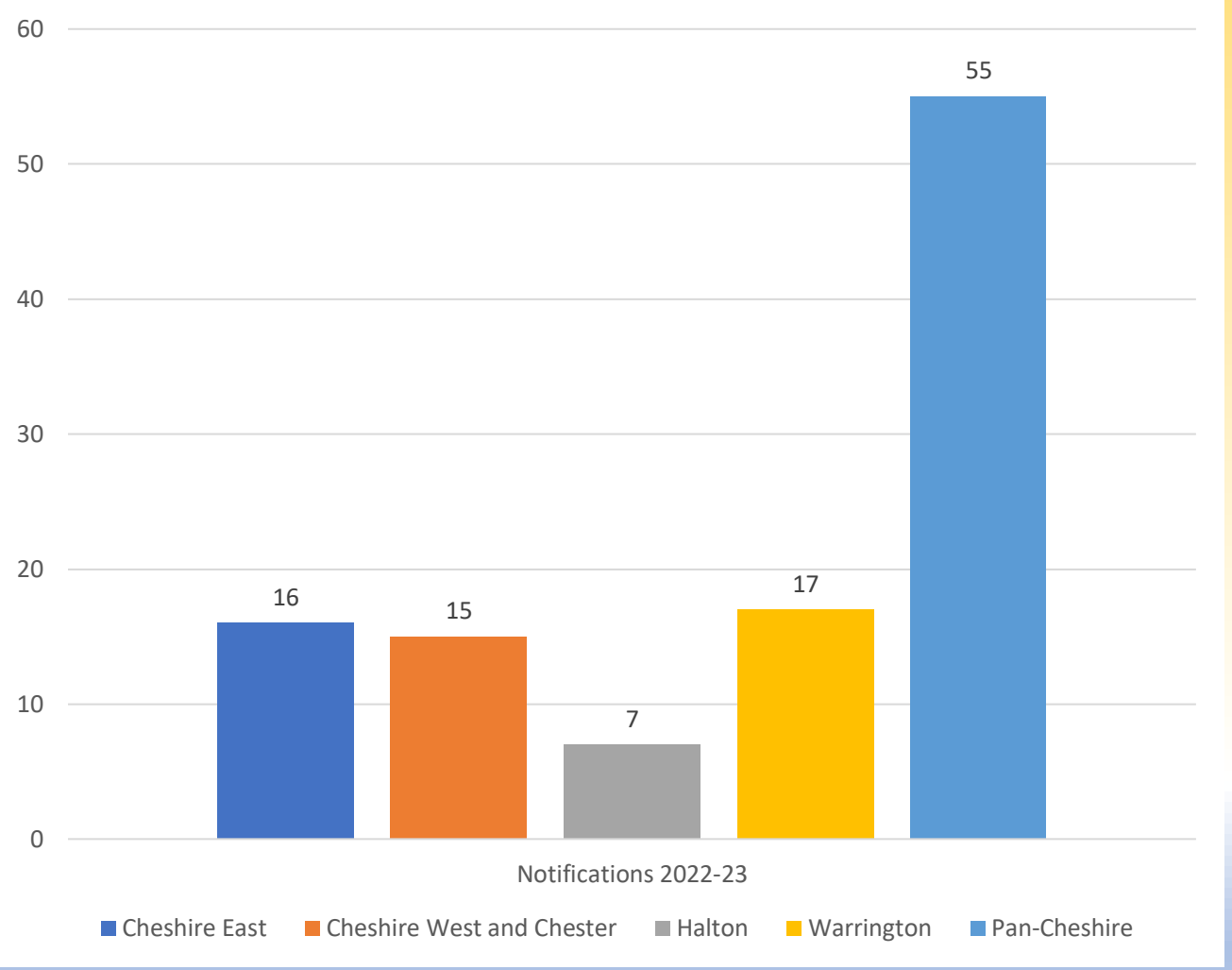
Deaths by Age

- Majority (58%) of deaths are under 1 year of age
- Follows national pattern (“skewed U-Shaped curve”)



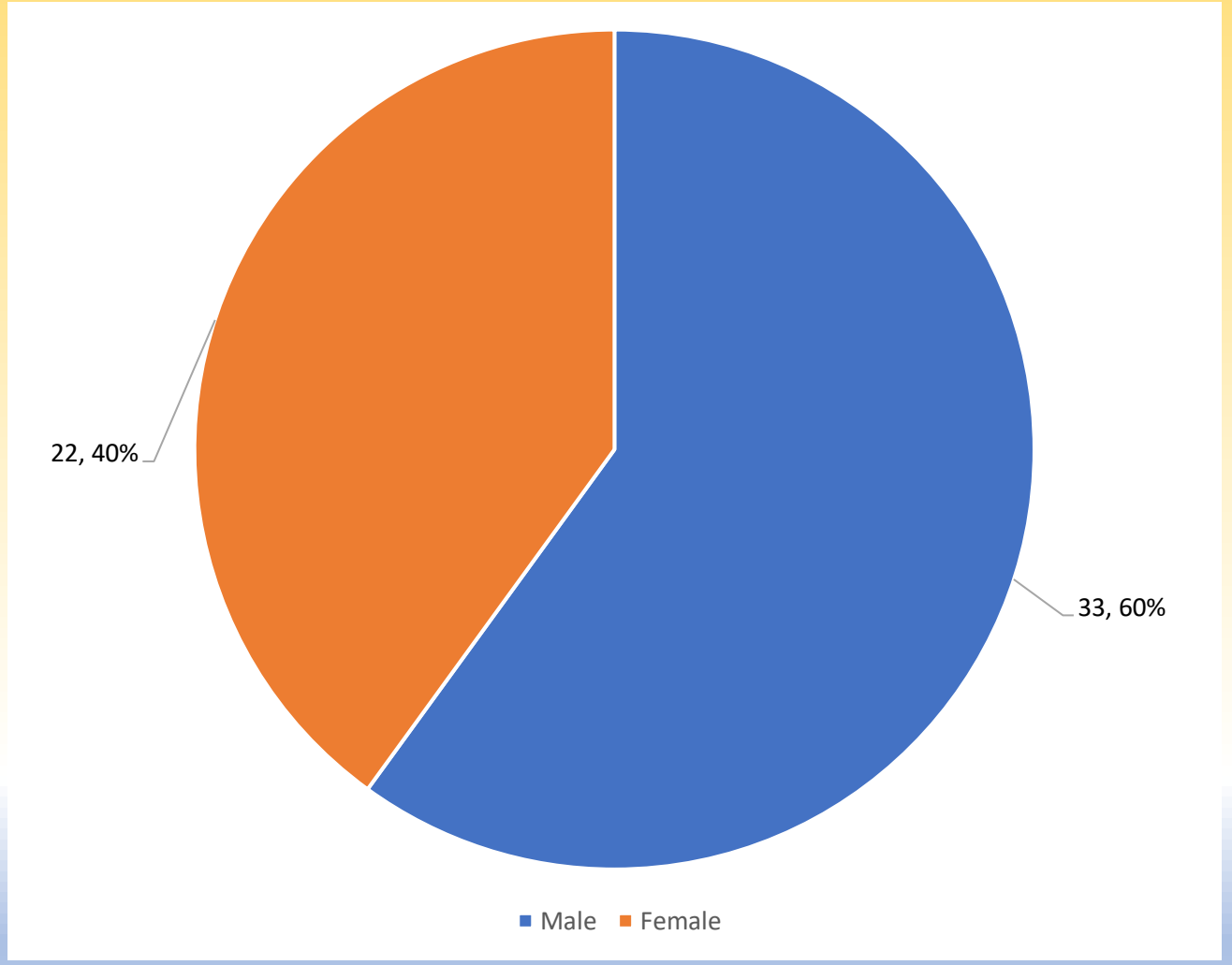
Deaths by LA

- Warrington appears to have a disproportionately high number of deaths for its u18 population
- This is not statistically significant
- Keep monitoring



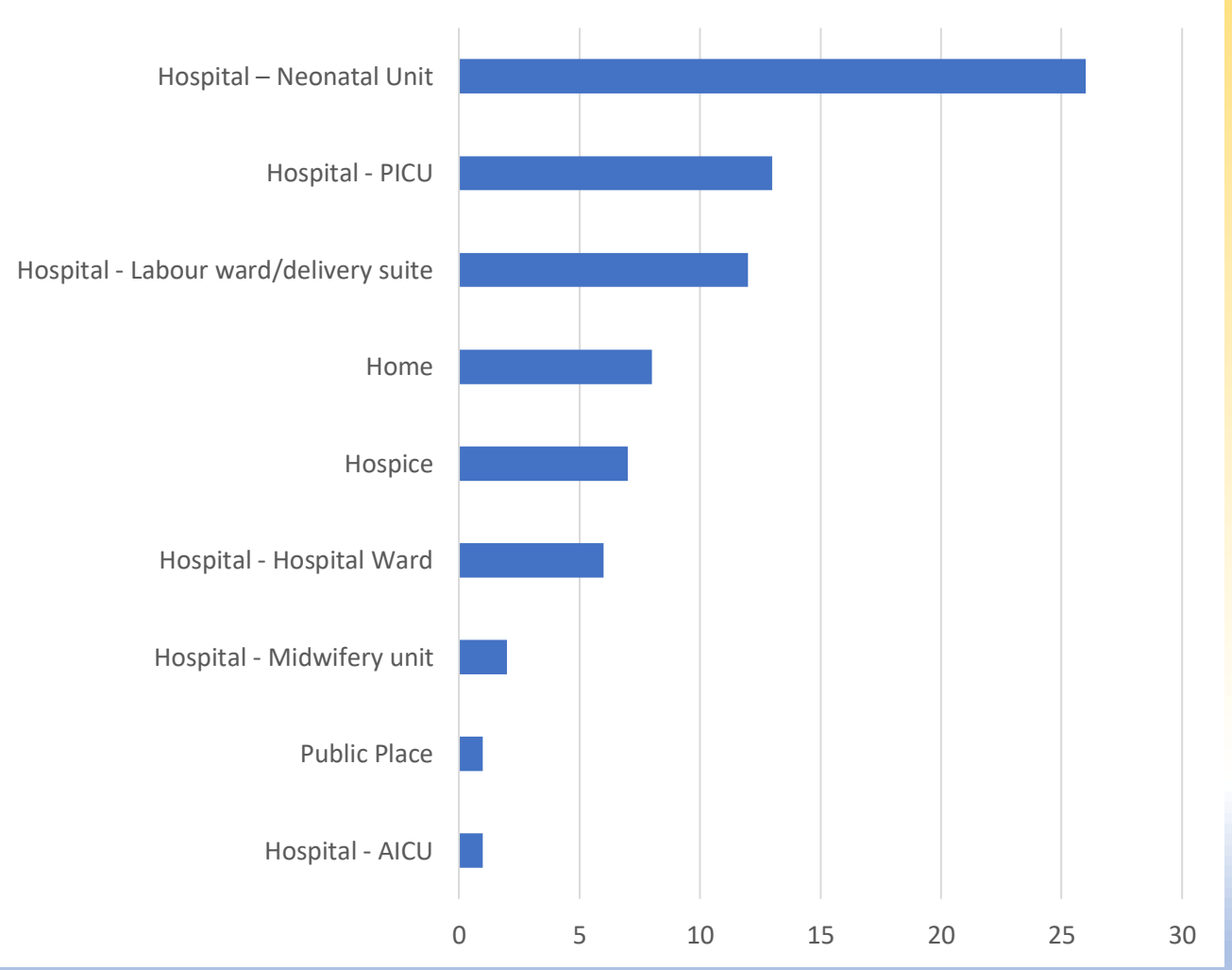
Deaths by Gender

- More males than females
- Similar pattern nationally



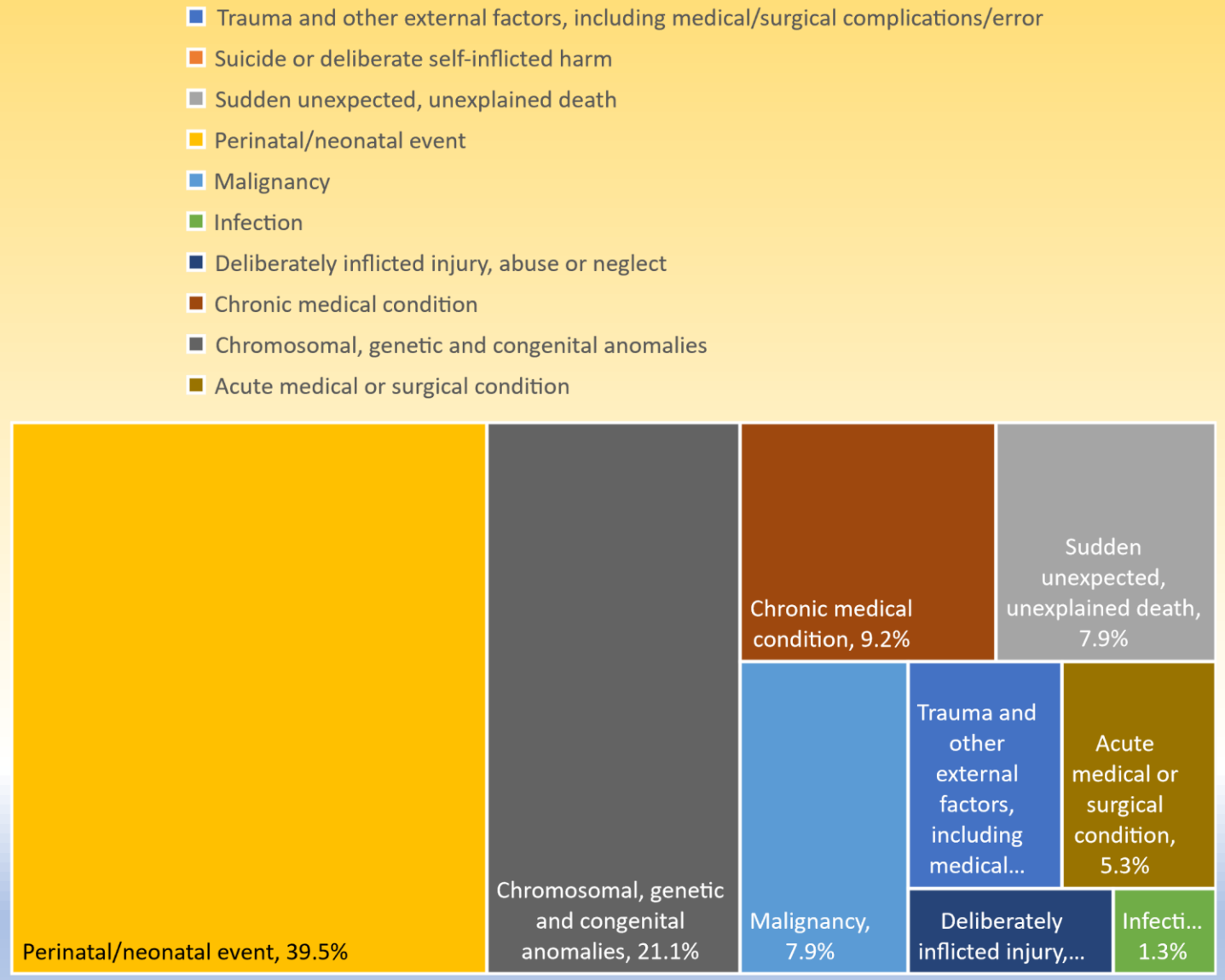
Reviewed Deaths by Place

- The majority (78.9%) of deaths reviewed occurred in hospital
- 10.5% occurred in the home



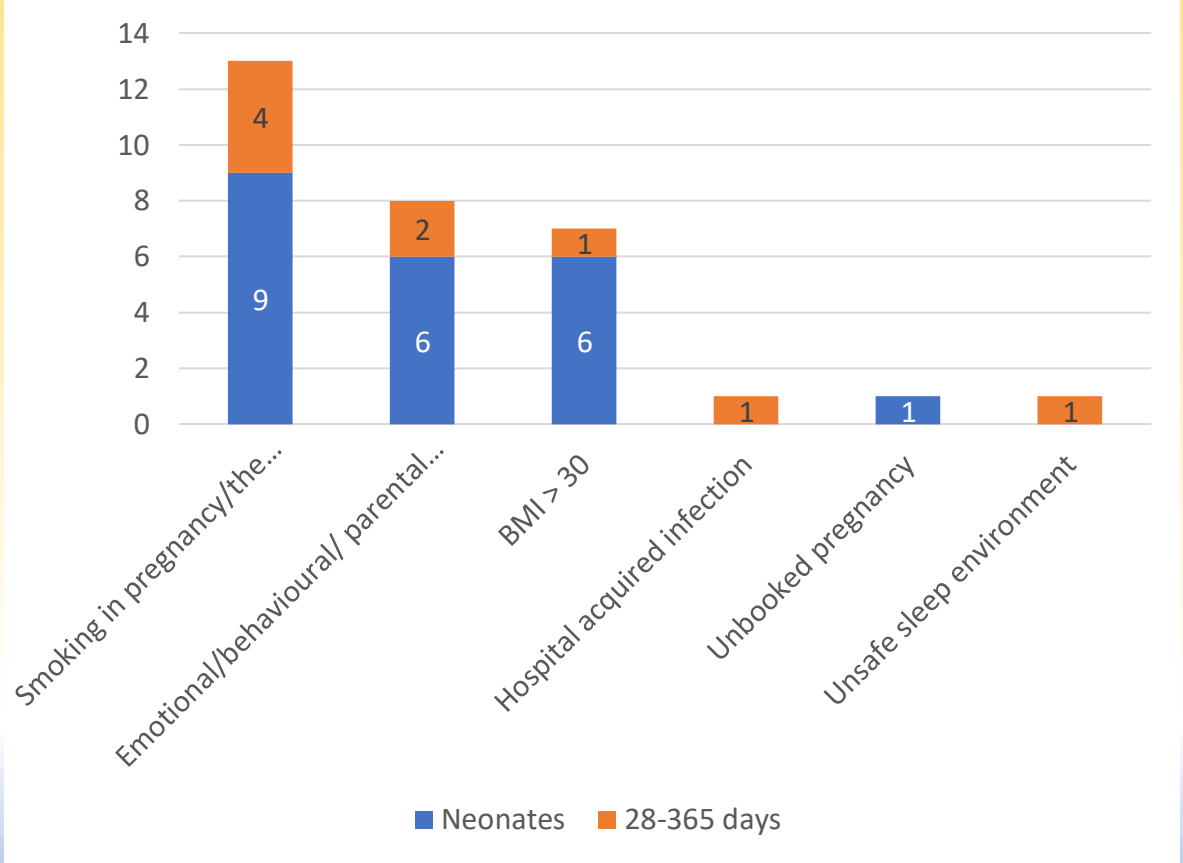
Reviewed Death Categories

- Perinatal/ neonatal events and Chromosomal, genetic and congenital anomalies most common categories
- 60.6% of all cases
- Linked to majority of deaths (58%) being under 1 year of age



Notable trends in child deaths across the Cheshire CDOP footprint

- The majority of those child deaths reviewed occurred within the first year of life, particularly the neonatal period.
- The majority of deaths reviewed were children from a white British background.
- Frequently identified modifiable risk factors associated with infant deaths (children aged under 1 year old) included:
  - Smoking in pregnancy or the household
  - Mental health
  - Maternal excess weight were the highest modifiable factors identified in infant deaths (the largest group).



Developments in child death review processes

During 2022-23, considerable progress has been made in:

- Strengthening CDOP governance approaches
- Improved recording and use of eCDOP (an electronic paperless software system for managing all child death data)
- Improved processes after death e.g. clarification of destination of ambulance
- The number of cases reviewed compared to the number of notifications received. Of note, some cases are reviewed within a different year to the year in which they were notified to the panel.
    - 55 notifications
    - 76 cases reviewed

Local actions following child death reviews

Local actions that have followed child death reviews have focussed on the following themes:

- Safe sleep promotion
- Promotion of the ICON programme (a programme to prevent baby shaking)
- Water safety
- Fire safety
- Anaphylaxis management
- Drugs and alcohol
- Infection control and prevention
- More general accident prevention.

Local actions have included, training, newsletters, alerts and wider sharing of learning from other areas across the country.

Next steps for Cheshire CDOP 2023-24 (1)

Plans for CDOP and the CDOP business team in 2023-4 have included:

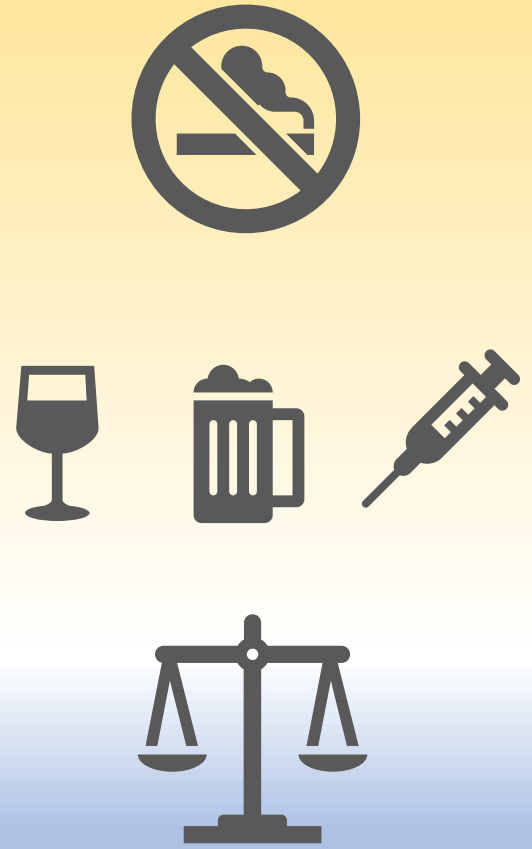
- Ensure that Pan Cheshire CDOP is compliant with the national guidance, including receiving the necessary documentation from partners, and integration with emerging ICS structures.
- Evidence how the functions of CDOP has influenced policy and practice within the local health economy and its impact.
- Ensure that all parents who's child has died has access appropriate bereavement services Develop stronger relationships with the Coroner's office, particularly in relation to information sharing, post-mortem reports and child death review meetings.
- Ensure the potential of the eCDOP programme can be accessed to improve processes and minimise additional administrative burdens across Cheshire;
- Ensure that the Pan-Cheshire CDOP has a resilient Business Administrative function
- Ensure that the reduction of infant/ child death forms part of integrated multiagency strategies Develop a system for identifying and monitoring impact of all learning from the CDR processes
- Pan Cheshire CDOP to be compliant with National Child Mortality Database report Key Performance indicators

Next steps for Cheshire CDOP 2023-24 (2)

- Reduce the number of outstanding deaths ready for review by the CDOP panel through additional meetings if required.
- Analyse trends and themes that will inform awareness raising/ training sessions as required.
- Cooperate and contribute as required to the Thirlwall Inquiry.
- Promote greater participation by partner agencies at Child Death Review Meetings (CDRM) in cases where there has been prior involvement during life. Raise the profile of CDOP and the CDR processes and highlight impacts, with Health and Wellbeing Boards, and children's safeguarding partners.
- Establish a system for monitoring notifications by hospital providers of neonatal and maternity care.

Recommendations for system partners

- To take ownership of these findings, share them with relevant forums, and ensure that local strategies are underpinned by these, and other core intelligence.
- To actively promote joint strategies to minimise the impacts of significant modifiable factors such as: mental health; maternal smoking; smoking in the home; substance and alcohol misuse; maternal excess weight.
- To continue to promote awareness in relation to the ICON (reducing baby-shaking), safe sleep and water and fire safety programmes.
- To work with CDOP to build upon understanding of local longer-term trends.
- To work with CDOP to ensure it has robust capacity for coordinating and administrating the various elements of the child death review system, including CDOP itself.



Any questions?