Derby and Derbyshire Child Death Review and Child Death Overview Panel Annual Report

1st April 2020 – 31st March 2021

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Introduction from the Authors

This has been an unprecedented year, the global pandemic which has emerged and taken hold this year has been a challenge for us all, both in our personal and working lives. All agencies and partnerships have been thrown into a health emergency where the priority and response is to protect lives from a dangerous virus. Organisations across Derby and Derbyshire and across the country had to respond quickly to protect patients, service users, their own staff, families, and themselves from what was a little-known threat at the start of the year and still a considerable threat to health and well-being by the end of the year.

Due to the critical response required to manage Covid 19 there have been considerable changes to service delivery and to the way practitioners and professionals are able to support and care for their service users. For practitioners working directly with people they have had to contend with restrictions, the use of Personal Protective Equipment and the demands of caring for people who are extremely sick and losing their lives due to the virus. Many other practitioners and professionals have been working from home throughout the last year. There have been several lockdowns to manage and redeployment of staff across the health system to support the response to the pandemic and support the vaccination programme.

The statutory requirements for the review of child deaths have not changed in light of the pandemic however there is a national recognition that the review of deaths is likely to be delayed due to the effect of the Covid 19 pandemic on the child death review process.

This year's report will outline our local response to the challenges of managing the child death review process and Child Death Overview Panel (CDOP) during a health crisis. The report highlights that despite local system pressures the Child Death Review Team and CDOP functioned well this year and were effective in reviewing the deaths of our children and disseminating the learning across the system.

All professionals and practitioners involved with the child death review process and CDOP will have had their own struggles and loses but they continued to work tirelessly to support families of bereaved children and ensure that learning from child deaths is still shared widely.

This has been a challenging and difficult year for everyone. Dr Medd and I would like to thank all those who have contributed in any way to this process and our thoughts are with the families who have faced ill health and bereavement in this most difficult of years.

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2.0 COVID 19 Pandemic

This year has been dominated by the Covid 19 Pandemic health emergency. All agencies had to respond quickly and effectively to meet the needs of service provision whilst protecting patients, service users, their families and the staff that work across the partnership. This was an unprecedented and enormous challenge for everyone from the frontline staff, managers, strategic leaders, and organisations. The necessary response to the Covid 19 pandemic fundamentally changed the way all professionals involved in the child death review process were able to meet the statutory requirements set out in Working Together (2018) and Child Death Review – The Statutory and Operational Guidance (2018).

It became clear that most members of the child death review team and CDOP are frontline practitioners, senior managers or strategic leads in health, the Police or Children's Social Care. These professionals and practitioners had a whole host of new priorities related to the pandemic and ensuring the safety of patients, service users and their own staff.

The review of child deaths has remained a statutory requirement throughout the pandemic. It became clear that there needed to be a contingency plan to ensure that this process continued and met the requirements laid out within the statutory guidance. There were some practical considerations with the emergence of remote working, imposed lockdowns and restrictions and the use of Personal and Protective Equipment (PPE) when having contact with service users. Staff were being redeployed to meet the covid 19 response and the system was on the highest alert for business continuity. As the year progressed it became apparent that the impact of Covid 19 would need to be an area of consideration for CDOP when reviewing the deaths of children who have died during the pandemic.

Guidance from the Department of Health and NHSE

There has been no change or additions to the statutory guidance for child death review taking into account the Covid 19 pandemic. The National Child Mortality Database (NCMD) team are leading on behalf of NHSE on the communications with professionals involved in child death review and CDOP.

The NCMD have informed child death review teams that the statutory timeframes remain in place (6 months to review a death) however there is an expectation that timeframes will lapse during the pandemic which may well have an effect on the CDOP figures during this reporting year. NHSE have produced some guidance on the changes to the Joint Agency Response (JAR) taking into account some additional requirements during the pandemic.

The Notifications of Death have been strengthened and now include some mandatory questions related to COVID 19. The NCMD require any information where COVID 19 is a factor in the child's death to be reported either on the Notification Form or later through ECDOP. The NCMD are collating the data and will be reporting the national picture on child deaths where COVID 19 is the cause or a factor in the future.

Child Death Review and CDOP Contingency Plan

A contingency plan for Child Death Review and CDOP was developed in April 2020. This was agreed by the Child Death Review Partners and was reviewed and reported on quarterly. The contingency plan had a final review in March 2021 with all actions having been completed.

The aim of the contingency plan was to enable the Child Death Review Team to continue to review the deaths of children in a timely way and within the statutory timescales where possible. The contingency plan made arrangements for:

- Notifications of death
- COVID 19 reporting in line with the NCMD
- Management of the Joint Agency Response (JAR)
- Enhance support for agencies to complete the Reporting Forms
- Monitoring and supporting the Child Death Review meetings
- RAG rating of child deaths to ensure the status of the progress of the process for each death
- Preparation of cases to be heard at CDOP
- Managing the CDOP meeting
- Reporting to the Child Death Review Partners

The challenges and risks related to the child death review process and CDOP which were mitigated for within the contingency plan are:

RAG rating of child deaths open to CDOP

The team RAG rated all cases to allow an understanding of the progress of the process and any delay to ensure that the CDR partners had a clear understanding of the picture of CDR across Derby and Derbyshire. This tool has been effective and will continue to be part of the CDOP quarterly reporting.

Information gathering and Child Death Review Meetings

This was extremely challenging particularly in the early months of the pandemic and when there were additional waves of the virus. Frontline practitioners and child death mortality leads, who are Paediatricians, were unable to complete the statutory reporting and analysis forms due to the pressures of the pandemic. They were redeployed to provide clinical care for patients.

All health trusts cancelled all meetings initially and this included the Child Death Review meetings. This created a backlog which was a challenge to overcome.

Child Death Overview Panel Meetings

CDOP became a virtual meeting via Microsoft Teams and has remained so in this reporting year. Some meetings were cancelled due to not enough cases being ready to review. No CDOP meetings were cancelled due to poor attendance, which shows a real commitment to this process despite pressures on services.

Reporting to Child Death Review Partners

The Chair of CDOP commenced quarterly reporting to the Child Death Review Partners to ensure assurance was given around the progress on cases, management of the CDR process and the CDOP meetings.

Changes to the Joint Agency Response process

In April 2020 NHS England brought out an amendment to the JAR process during the COVID pandemic. These were agreed locally with HM Coroner and disseminated to the JAR teams of Police and Paediatricians.

3.0 Child Death Overview Panel Meetings between April 2020 and March 2021

The Child Death Overview Panel (CDOP) meetings have been delivered virtually via Microsoft Teams (MST) in line with contingency plan during this reporting year. The attendance at CDOP meetings has been very good over the last year and in line with the terms of reference for the group. MST has not been a barrier for attendance however the supportive element of the CDOP meeting is more challenging to achieve virtually. CDOP recognise the commitment and contribution of previous members to the review of the deaths of children and wish them well for the future.

The continued contribution from CDOP's Lay Member is valued by the group.

The panel has been well represented by practitioners from all of our main partners and agencies in Derby and Derbyshire these include:-

- Derbyshire County Council Children's Services
- Derby City Council Children's Services
- Derbyshire Community Health Services NHSFT
- Chesterfield Royal Hospital NHSFT
- Derbyshire Healthcare NHSFT
- University Hospitals of Derby and Burton NHSFT
- Derby and Derbyshire CCG
- Derbyshire Constabulary
- Derby City Council Public Health
- Derbyshire County Council Public Health

The commitment and hard work from panel members should be recognised this year.

CDOP welcomes visitors, and attending the meeting is a valuable learning experience for practitioners working with children. The CDOP meeting has welcomed several visitors this year from our local providers and partners.

4.0 Reviews of Deaths at CDOP April 2020 – March 2021

ECDOP

ECDOP is a confidential and secure electronic case management system and has been in use to manage child deaths since April 2019. The use of ECDOP has significantly improved data collection and consistency of case management for Derby and Derbyshire child death review team. The data from ECDOP is automatically transferred to the National Child Mortality Database (NCMD) which will produce a local and national view on CDOP activity. The NCMD have produced their second Annual Report during this year.

Number of Child Deaths between April 2020 and March 2021

58 children have died in Derby and Derbyshire in this reporting year.

Table 1: Number of Child Deaths

Child Deaths- Age	Number
0 - 28 days - Neonates	23
28 days – 1 year	11
1 – 4 years	7
5 – 17 years	17
Total	**58**

Sudden and unexpected death occurred for 14 children and 13 of those families received a Joint Agency Response (JAR).

Notifications of Death

Table 2: Notifications of death by age group – Derby and Derbyshire CDOP

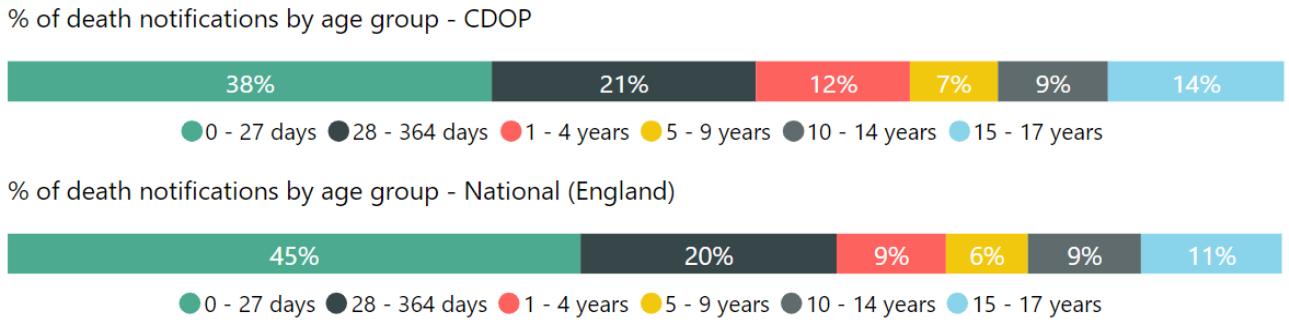
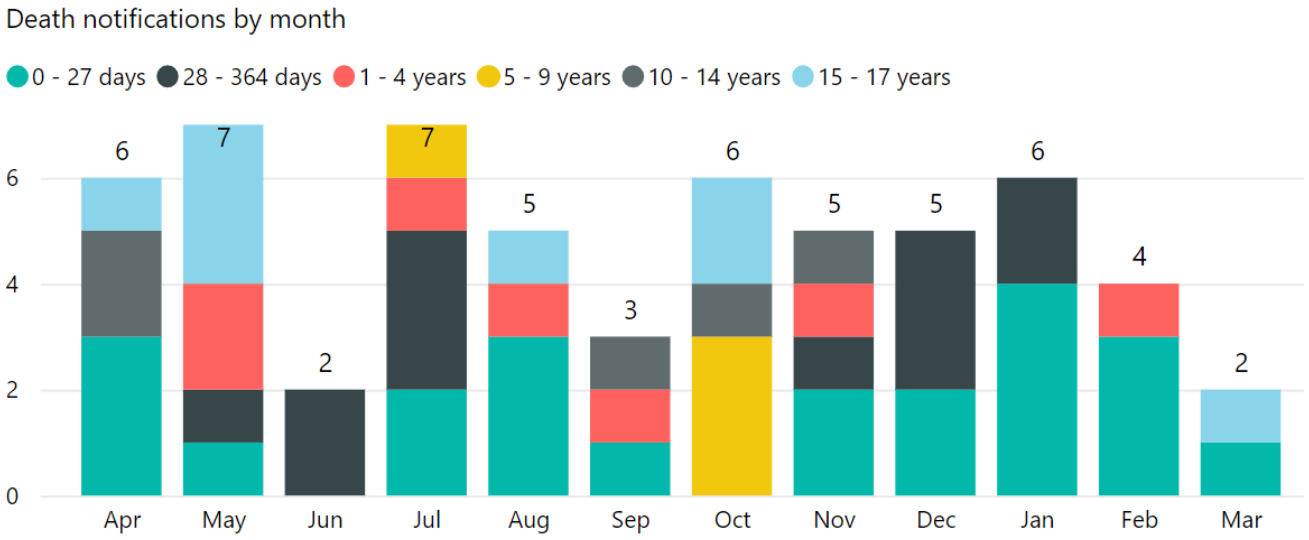


Table 3: Notifications of death by month – Derby and Derbyshire CDOP



Notifications of death should be submitted via ECDOP within 48 hours of the death by the health provider where the child died. The majority of notifications are for neonatal deaths, however in this reporting year there has been a significant reduction in neonatal deaths from 53% of all child deaths to 38%. There has been an increase rate of deaths of children between 15-17 years at

14% of all child deaths. As in previous years the numbers of child deaths fluctuate month by month.

Reviews of Deaths at CDOP April 2019 to March 2020

The work of CDOP for this year includes reviewing child deaths that may not have occurred within this reporting year as the panel reviews any outstanding deaths from previous years. The CDOP review should be the last point at which a child's death is discussed and reviewed. Reviews can be significantly delayed for several reasons including the serious case review process, criminal or coronial investigation and coronial inquests.

Any delays in reviewing deaths of children are reported to the Child Death Review Partners and to the Derby and Derbyshire Safeguarding Children Partnership.

CDOP have reviewed 49 child deaths within this reporting year

Table 4: Number of Child Deaths Reviewed

CDOP Meeting	Number of deaths reviewed	Number of cases closed
April	Cancelled - due to COVID 19	-
May	6	6
June	3	3
July – Neonates	Cancelled - no available cases	-
August	5	5
September	5	5
October	8	8
November - SUDI Themed Panel	6	6
December	5	5
January - Neonates	5	5
February	Cancelled - no available cases	-
March	6	6
Total	**49**	**49**

There has been a reduction in the numbers of child deaths being reviewed by CDOP this reporting year. This has been due to the direct impact of the COVID 19 pandemic. All organisations responded to the pandemic immediately with an emergency response that encompassed all practitioners including those that support the child death review process and CDOP. The impact was a slower child death review process, an inability to hold Child Death Review meetings and cases not being ready to be reviewed.

Demographics of Completed Reviews

Table 5: Age range of completed reviews

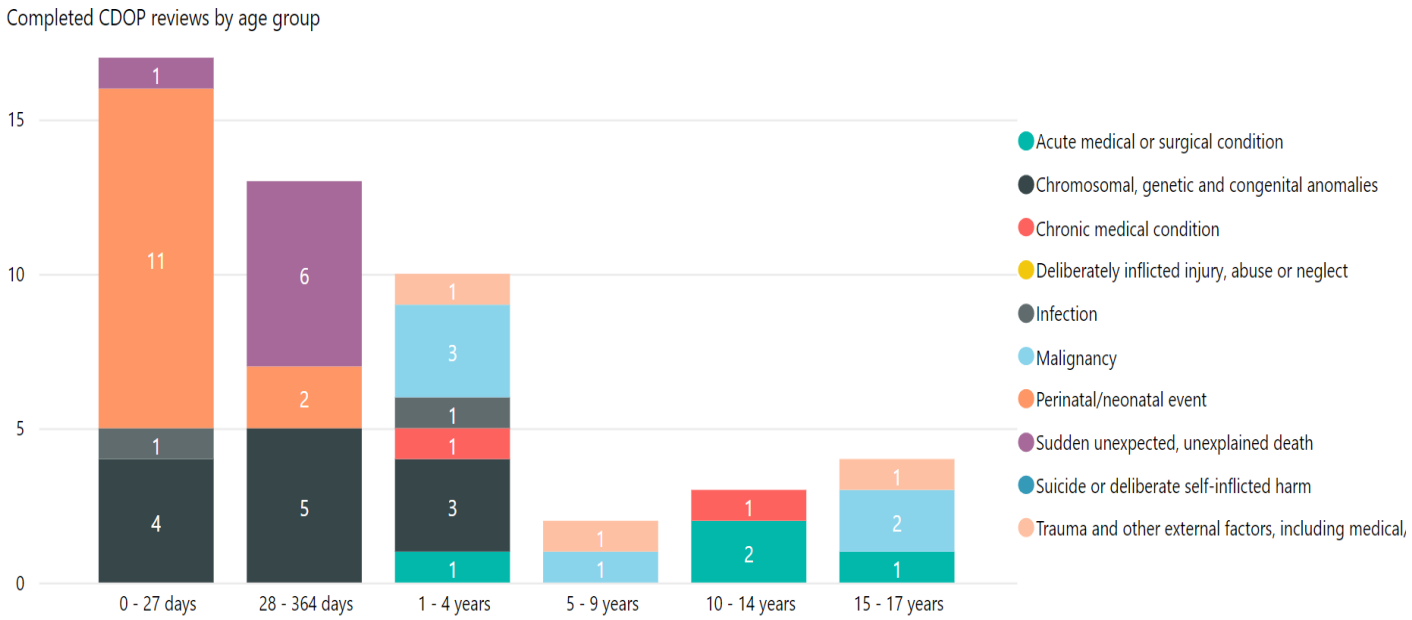
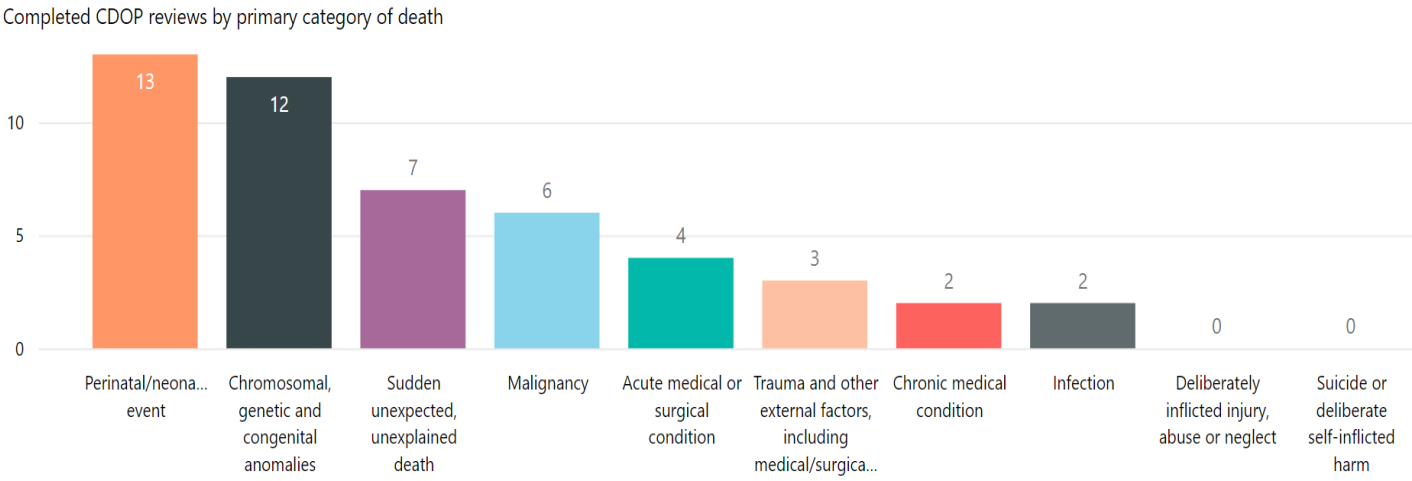


Table 6: Primary Category of Death



Neonatal deaths are the most common type of event reviewed by the panel, followed by children with chromosomal or genetic conditions.

Table 7: City-County split of the deaths reviewed

Local Authority Residence	Number of Deaths	Proportion of deaths
Derby	13	26.5%
Derbyshire	36	73.5%

Table 8: Number and proportion of reviewed deaths grouped by gender

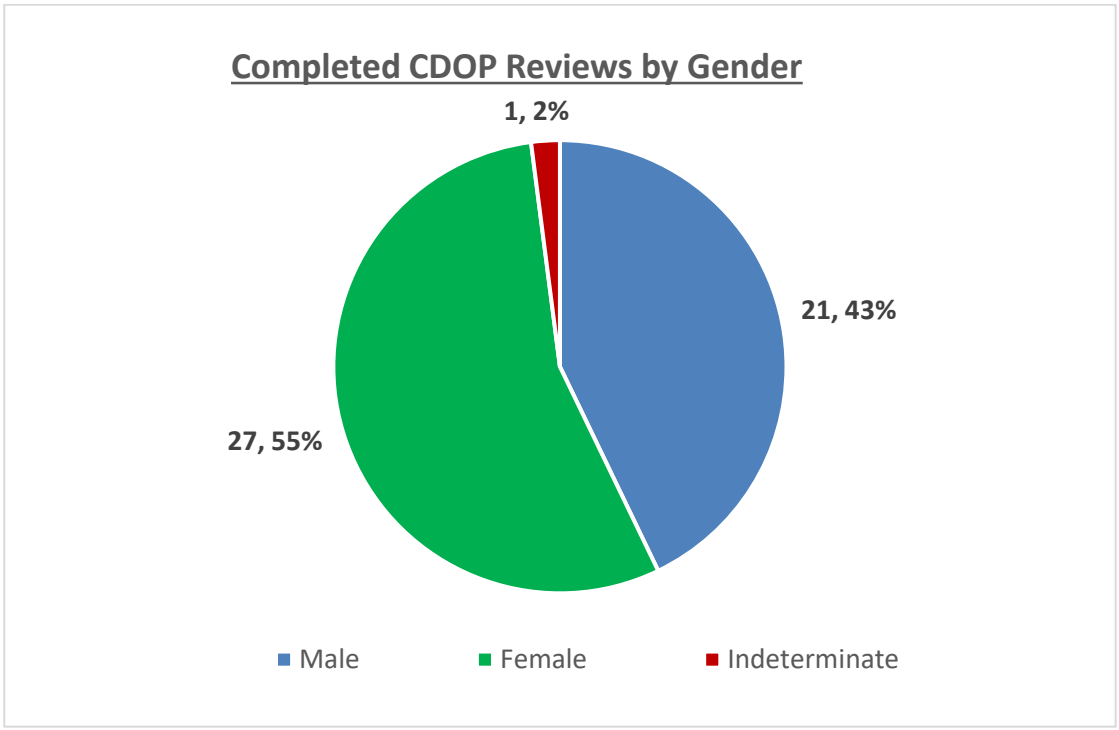


Table 9: Number of cases by place of death

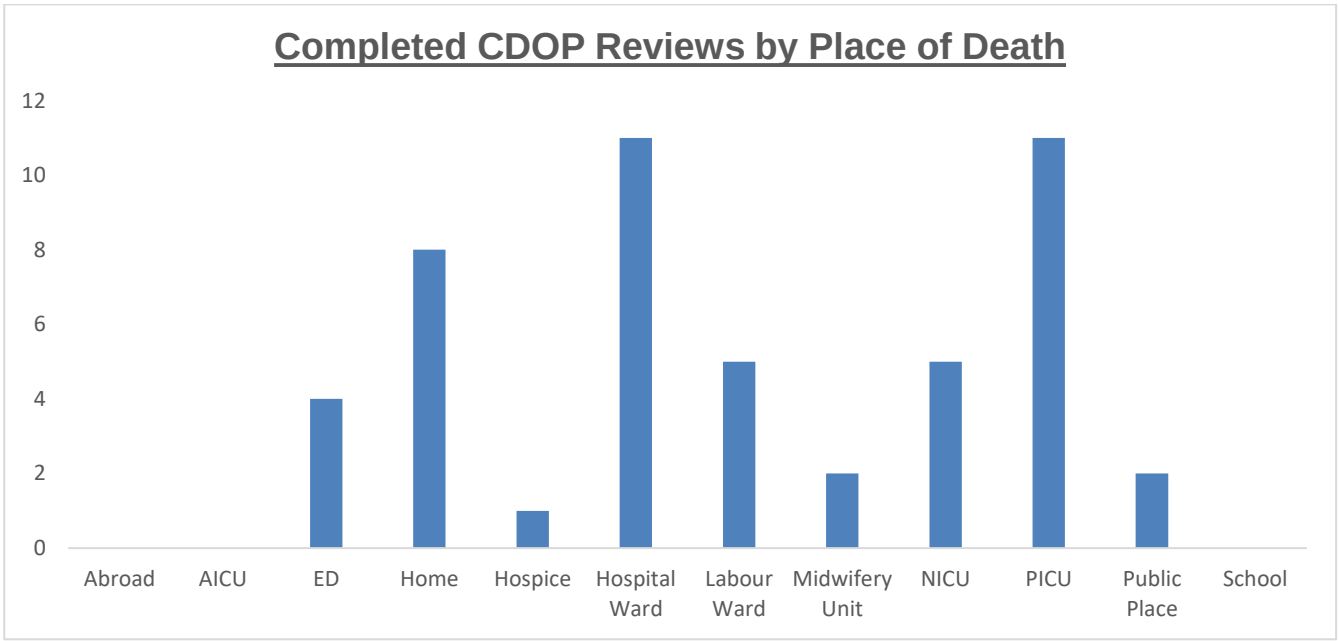


Table 10: Completed reviews by ethnic group and age group

Completed CDOP reviews by ethnic group and age group

Ethnic Group	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	Total
White	12	7	6	2	2	4	**33**
Unknown	1	0	1	0	0	0	**2**
Other	0	0	0	0	0	0	**0**
Mixed	0	3	1	0	0	0	**4**
Black or Black British	0	0	0	0	0	0	**0**
Asian or Asian British	4	3	2	0	1	0	**10**
Total	**17**	**13**	**10**	**2**	**3**	**4**	**49**

Contributory and Vulnerability Factors

A contributory or vulnerability factor is a factor that may contribute to the outcome of a child's death. Some factors may have a direct impact such as extreme low birth weight and some factors may increase a child's vulnerability such as domestic abuse or smoking. Some children may present with several factors that will have an impact on their life and death.

Table 11: Reviewed cases grouped by vulnerability and contributory factors

Contributory and Vulnerability Factors	Number	% present in cases reviewed
Social Care Involvement	21	43%
Child Medical Conditions	16	33%
Household smoking	13	27%
Smoking in pregnancy	12	25%
Extreme preterm < 28/40	10	20%
Parental Mental Health	10	20%
Low Birth Weight	9	18%
Known to the Police	8	16%
Parental Substance Misuse	7	14%
Parental Concerns	7	14%
Palliative Services	6	12%
Domestic Abuse	6	12%
Developmental delay	5	10%
Unsafe sleep	5	10%
Hospital transfer	5	10%
Physical environment	5	10%
Learning Disability	4	8%
Parental Alcohol Misuse	4	8%
Surgical Intervention	4	8%

Preterm 28-37	3	6%
Physical disability	3	6%
Co-sleeping	3	6%
Family History	3	6%
Consanguinity	2	4%
Housing	2	4%
Neglect	2	4%

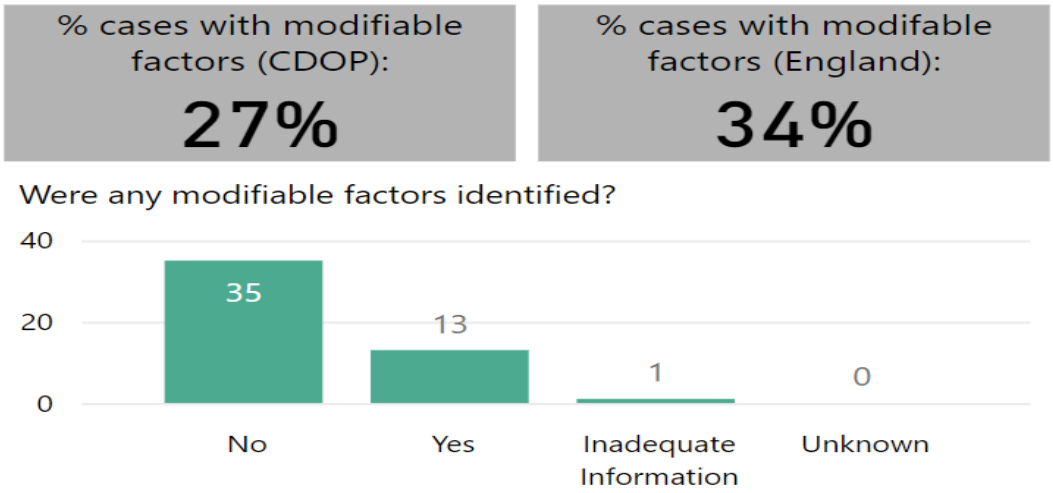
The Child Death Overview Panel are more accurately recording vulnerability factors as part of the child's review. This provides rich data on the circumstances of the child and allows the panel to understand some of the lived experience of the child. The most common vulnerability factor recorded was the family being known to or being supported by Children's Social Care at 43%. This is almost half of the children reviewed and reminds us of the links between vulnerability and child death. We would expect factors associated with neonatal deaths to be at the top of this list however CDOP have reviewed fewer neonatal deaths this year which may account for the low numbers of vulnerability factors associated with neonates in this chart. Smoking remains a significant factor; both maternal and household smoking and is an issue discussed in the Sudden and Unexpected Death of Infants (SUDI) Themed Panel held within this reporting year.

Modifiable Factors

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

The definition of modifiability is challenging and there is a lack of consensus nationally of how to define if a factor is modifiable or not. There is a drive nationally to look at the standardization of modifiable factors. The NCMD are considering national guidance to support CDOP's in their decision making.

Table 12: Modifiability of reviewed cases



Derby and Derbyshire recording of modifiable factors has increased this year from 7% to 27% and is becoming comparable with the average for England. Derby and Derbyshire CDOP have in-depth and rich discussions about modifiable factors on a case-by-case basis and are producing a local guide on modifiable factors to support decision making and aid consistency.

Table 13: Age range for cases with modifiable factors

% 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	17	2	12%
28 - 364 days	13	7	54%
1 - 4 years	10	2	20%
5 - 9 years	2	1	50%
10 - 14 years	3	1	33%
15 - 17 years	4	0	0%
Total	**49**	**13**	**27%**

Table 14: Modifiable Factors Identified

Modifiable Factors Identified	Number of Cases
Unsafe Sleep Practice: - Co-sleeping - Side sleeping - Use of bedding	9 3 2 3
Parental Smoking	5
Smoking in pregnancy	2
Parental alcohol use	3
Parental substance misuse	2
Parental mental health	2
Consanguinity	2
Dangerous driving	1
Incorrect use of car seat	1
Lack of new-born screening for SCID	1
Delay in treatment	1

The majority of modifiable factors identified by CDOP were related to unsafe sleep practice. One reason for this was that the SUDI Themed Panel were able to identify unsafe sleep practice as a theme. Parental smoking continues to be another identified modifiable factor.

Table 15: Social Care involvement

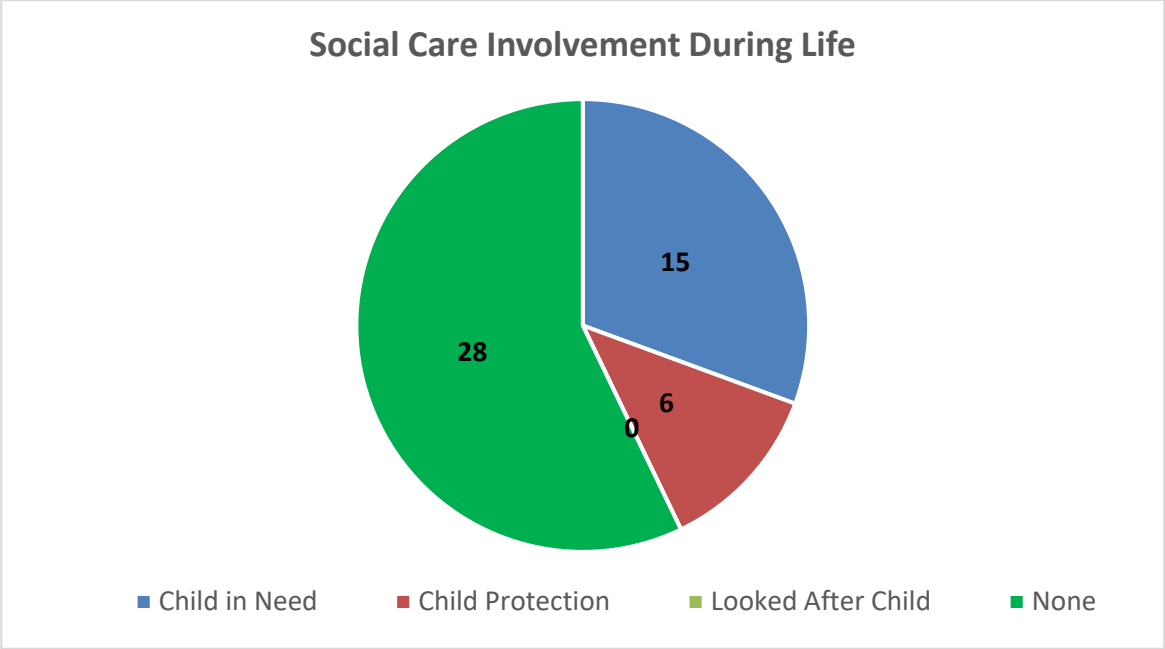


Table 16: Child subject to other reviews

Safeguarding Reviews	Number of Cases	Proportion of cases (%)
Child subject to a Safeguarding Rapid Review	0	0
Child subject to a Safeguarding Practice Review	0	0
CDOP referred to Safeguarding Partnership for consideration of a Safeguarding Review	0	0
Referred for LeDeR review	2	4

5.0 Learning Themes

All deaths are important and practitioners will always learn from individual deaths both in ways to improve practice but also by the examples of positive care which are shared at CDOP and how this practice can be disseminated amongst the partnership. CDOP has a role in looking at themes and trends from child deaths and to focus on any improvements that can be made to prevent future deaths and improve care and services. This year the learning theme to be presented in more depth within the report:

- Sudden and Unexpected Deaths in Infants and the Joint Agency Response

Sudden and Unexpected Deaths in Infants

The Child Death Review Statutory and Operational Guidance (2018) encourages Child Death Overview Panels (CDOP) to hold themed panels when considering the deaths of children where there are common factors. Learning from the Sudden Unexpected Deaths of Infants (SUDI) is an important area of work for all CDOPs and is of national interest due to the nature of these babies' deaths and how learning from CDOP can prevent future deaths.

Derby and Derbyshire had a number of babies who had died unexpectedly and saw the value in holding a themed panel. SUDI and Sudden Infant Death Syndrome (SIDS) is an area of research which is a priority both nationally and internationally. CDOP were fortunate to have an internationally known expert in the area of SIDS who attended the Themed Panel. Professor Marta Cohen is a Consultant Paediatric Pathologist who works at Sheffield Children's Hospital NHSFT and sees many of Derby and Derbyshire babies for their post-mortem examinations.

The vulnerabilities and protection of babies is a priority area of work for the Derby and Derbyshire Safeguarding Children's Partnership (DDSCP). To support the learning of the themed panel CDOP invited colleagues from the safeguarding children's partnership. The Mortality Leads for each health provider were also invited. There were also representatives for the Keeping Babies Safe Steering Group for Derby and Derbyshire.

The SUDI themed panel heard the stories of 6 babies including the voices of some of their parents. Although hearing about the deaths of babies is challenging and extremely sad for the family, the learning from these cases has been invaluable and will support future developments within Derby and Derbyshire as well as contributing nationally to learning through the National Child Mortality Database.

The Child Safeguarding Practice Review Panel completed a report - *Out of Routine: A Review of Sudden Unexpected Death in Infancy* (SUDI) in families where the children are considered at risk of significant harm (DfE 2020). The review found that in 38 out of the 40 deaths co-sleeping was a factor. There were also common themes of alcohol and drug use and issues related to parental mental health. These themes are repeated in the learning from the Derby and Derbyshire SUDI Themed Panel.

Sudden Infant Death Syndrome (SIDS)

Sudden infant death syndrome (SIDS) is the sudden and unexpected death of an infant under 12 months of age with the onset of a lethal episode occurring during normal sleep, this remains unexplained after a thorough investigation which includes a complete post-mortem examination, review of the circumstances of death and the clinical history.

SIDS is a preferred term to register the death of the baby rather than equivalent terms such as 'unascertained' or 'undetermined'. Identifying the baby as dying from SIDS does not exclude the possibility that the child may have died from natural or external causes that have not been ascertained or proven conclusively.

The Office of National Statistics, National Records of Scotland and Northern Ireland Statistics and Research Agency (2020) recent information gives a national view of SIDS.

- 198 unexplained infant deaths occurred in England and Wales in 2018, a rate of 0.30 deaths per 1,000 live births: an increase from 0.28 deaths per 1,000 live births in 2017
- Just over half (57.6%) of all unexplained infant deaths were boys in 2018 (0.34 deaths per 1,000 live births). This is an increase from 55.2% in 2017

- The SIDS rate for babies born to mothers under 20 has declined by 16.5% since 2004. In 2018, the unexplained infant mortality rate was highest for mothers aged under 20 years, at 1.11 deaths per 1,000 live births

- 230 unexplained infant deaths occurred in the entire UK in 2018, a rate of 0.31 deaths per 1,000 live births Statistical information tells us that the rate of SIDS decreased following the 'back to sleep' campaign in 1991

Over the last 25 years, the rate of SIDS deaths has fallen by more than 80% however after the initial improvement of the back to sleep campaign there has been little further progress, and there has been a very slight increase of SIDS from 2017. Boys are more likely affected than girls. The mortality rate was highest for young mothers.

Learning Themes

The Vulnerabilities of Babies

Babies are entirely dependent on their immediate care givers for all their needs and because of this they are vulnerable. Infants are also intrinsically at risk because of their immature anatomy and physiology and their rapid development. A parent's capacity to respond appropriately to the emotions and needs of their baby has a profound impact on baby brain development and general health and wellbeing. All babies need to be safe, nurtured and able to thrive.

The early care a baby receives provides the foundations for all physical, social and emotional development. Whilst most parents do provide the love and care their babies need some parents find the transition into parenthood stressful and demanding and are vulnerable themselves.

Identified Vulnerability Factors

- Parental mental health
- Parents known to the police
- Previous parental substance misuse
- History of domestic abuse
- Evidence of disguised compliance
- Known to Childrens Social Care

Identified Modifiable factors

- Household smoking and smoking in pregnancy
- Low level alcohol use the night of the baby's death
- Bedsharing or co-sleeping
- Unsafe sleep practices

By identifying the modifiable and vulnerability factors CDOP are able to build a picture of learning themes from these 6 cases which will lead to learning for practitioners and developments in practice to support the aim of all practitioners and the wider system in Derby and Derbyshire to prevent infant deaths in the future. There are some clear areas of learning:

Safe Sleep Practice

Although SIDS is now very rare, approximately 230 babies still die every year in the UK (Lullaby Trust 2020) https://www.lullabytrust.org.uk/professionals/statistics-on-sids/. The risk of babies dying from SIDS would be reduced if families followed the clear messages developed from research.

It is important that all practitioners and professionals are delivering clear and consistent messages to support families to understand how to avoid the specific risks to their baby.

There needs to be an assessment of vulnerability factors within a family. Messages need to be targeted towards the specific needs of some families taking into consideration the level of understanding, language and cultural considerations.

It is important that all carers for babies receive the messages including fathers.

Asking parents where and how babies sleep should be a routine enquiry, Practitioners who visit the home should see where the baby sleeps both day and night.

Smoking

The research on smoking and SIDS is clear: Smoking cigarettes during pregnancy or after birth can significantly increase the chance of SIDS. Scientific evidence shows that around 30% of sudden infant deaths could be avoided if mothers didn't smoke when they were pregnant. Taken together with the risks of smoking around a baby at home, this means that smoking could be linked to 60% of sudden infant deaths (Lullaby Trust).

In any family where either parents smoke or anyone smokes within the home this would be considered a smoky environment, this includes in the garden. Babies need a smoke free environment.

Smoking continues to be a modifiable factor and was identified as a risk factor in all of the deaths reviewed in this themed panel. Smoking cessation is offered to all mothers at midwifery booking of their pregnancy to support the health of the unborn baby, this is not routinely offered to fathers. It is not clear how many pregnant women take up the offer of smoking cessation. Carbon Monoxide monitoring appears to be a motivator for smoking cessation however this has ceased during the COVID 19 pandemic. It is reported that there is a reduction in people accessing smoking cessation support.

Parental alcohol use when caring for an infant

The use of alcohol by parents and then co-sleeping with an infant is a known risk factor for SIDS and would create an unsafe sleep environment for babies. The panel identified 4 babies where one or both parents had consumed alcohol that day/night of the death some of whom went on to bed share with their baby. The alcohol was reported to be low level and the panel considered the messaging around alcohol use and the care of infants.

Alcohol use is often under reported and is an acceptable substance used by the general population and many parents. This issue has been considered by Birmingham Safeguarding Partnership, who are running a campaign 'Who's In Charge' and have produced two videos. The campaign has been launched in response to increasing concerns that growing numbers of babies and children are at risk of serious harm because of the way some parents and carers consume alcohol at home. It urges parents, and others with responsibility for children, to be aware of a range of potentially dangerous consequences of drinking alcohol while caring for children.

Current scientific considerations

CDOP were extremely grateful to Professor Marta Cohen who attended the SUDI themed panel. Professor Cohen is a Consultant Histopathologist at Sheffield Children's Hospital NHSFT and has a particular research interest in SIDS. She has published widely on the condition and her expertise has also helped to frame our Derbyshire Joint Agency Response (JAR).

The cause of SIDS is still a mystery and more and continued research is needed in this area if we are to understand these devastating cases better and prevent them from happening.

Although numerous theories abound the focus for CDOP was to consider:

- The role of Infection as there was recent viral illness present in 5 of the 6 SUDI cases
- The role of the metabolic system

- The role of genes
- Current research by Dr Cohen including Hippocampal abnormalities and Vitamin D deficiency

Identified Good Practice

- Continuity of professionals encouraged engagement with the family and enabled positive change to be clearly evidenced.
- Local offering of the Care Of the Next Infant (CONI) scheme to support parents who have previously lost a child to SIDS.
- Evidence that safe sleep is being discussed with families
- Parental contact with CDOP has been encouraged and one parent was able to make contact and express her concerns
- Evidence of positive multi-agency discussions were held about the possibility of non-accidental injury. This highlighted and evidenced good identification, professional curiosity and working together
- Positive cross-boundary working.

Recommendations and Actions

- Publication and dissemination of the Derby and Derbyshire *'Keeping Babies Safe Strategy -Three Steps to Baby Safety'.*
- Training and promotion of the Keeping Babies Safe Champions
- Development of an assessment tool for safe bed sharing in line with the KBS Strategy
- Consideration with partners and Public Health regarding the messaging on smoking
- Promotion of the video and information from Birmingham Safeguarding Children Partnership regarding alcohol use by parents when caring for an infant
- CDOP newsletter to include the importance of vitamin D supplements in line with DoH guidelines

It remains a tragedy that potentially modifiable factors exist in the majority of cases of SUDI/SIDS. Safe sleep, smoking and vulnerability factors are not easy to address and reduce in families. The focused work of the Derby and Derbyshire Safeguarding Childrens Partnership in the document, '*Three Steps for Baby Safety: Partnership Strategy to Support the Safety of Babies in Derby and Derbyshire' (2021)* is a vital and timely area of work which is hoped will have a positive impact on the likelihood of future deaths from SIDS. The strategies focus on the three areas – safe sleep, safe handling, safe space and will address many of the factors that we have identified in the SUDI themed panel.

The benefit of having themed panels has once again been demonstrated. A themed panel helps to identify common themes and learning. The learning is disseminated amongst the partnership and some elements will be monitored through an action plan. CDOP value this approach and will continue to arrange themed panels for SUDI cases and other relevant categories of child death. CDOP remain committed and focused to review the deaths of babies with compassion and determination, to look for ways to prevent such tragedies from happening to others.

6.0 Keeping Babies Safe in Derby and Derbyshire sub-group of CDOP

The Keeping Babies Safe steering group in Derby and Derbyshire is a sub-group of CDOP. The Terms of Reference of this group have been strengthened due to the importance of learning from Child Practice Reviews. The group has been identified as supporting the Keeping Baby's safe agenda and the work will be sighted by the Derby and Derbyshire Safeguarding Children Partnership. The group is a multi-agency forum including all multi-agency partners. The focus of the group is to consider the vulnerabilities of babies and how the group can support practitioners to provide research-based information, share learning from Child Practice Reviews and CDOP and provide advice and support to families to ensure that babies are cared for safely and protected from abuse and neglect.

Keeping Babies Safe Strategy – The Three Steps for Baby Safety

The Designated Nurse Safeguarding Children and Lead Nurse for Child Death Review have written and published a '*Keeping Babies Safe Strategy for Derby and Derbyshire - The Three Steps for Baby Safety'* with the contribution and support of the wider group. The strategy will be the focus of the work of the Keeping Babies Safe Steering Group and a priority of the Derby and Derbyshire Safeguarding Childrens Partnership for next year.

Aims of the Strategy:

- Derby and Derbyshire Safeguarding Children Partnership (DDSCP) and the Child Death Overview Panel (CDOP) encourage and support partners in all agencies who care for or support families with babies under a year old to utilise this strategy and deliver the clear consistent messages regarding baby safety to families, including all fathers and wider family members, and to their colleagues within their own organisation.

- All practitioners in Derby and Derbyshire should have access to research-based practice and information to educate and support parents and carers so that they are able to make safe choices when caring for their baby.

- The partnership aims to reduce the numbers of babies who die or are seriously injured following unsafe sleep practice, unsafe handling and those that die accidentally.

The Keeping Babies Safe Champions

An important element of the strategy is to train and support some Keeping Babies Safe Champions. The vision for Derby and Derbyshire is to have Champions across the partnership including all health providers, Childrens Social Care and Police. Champions training commenced in February this year and will continue across the next year.

The role and responsibility of the Baby Safe Champions:

- Be a resource regarding baby safety within their team and agency
- Attend training and updates on baby safety
- Disseminate any learning from child practice reviews and CDOP regarding baby safety
- Raise the awareness of the importance of Safe Sleep, Safe Handling and Safe Space and the use of the strategy and toolkit to support families with babies

The Baby Safe Champions will be supported and updated by the Keeping Babies Safe Steering Group for Derby and Derbyshire

Governance Arrangements

The governance arrangements for this group are through CDOP. The group has an action plan which is reported to and monitored by CDOP. The progress of the action plan was reported to the Child Death Review Partners through the quarterly reporting.

7.0 The voices of Parents and the Child in the Child Death Review process and CDOP

When a child dies it is a tragedy for any family no matter what the circumstances are. Families and individuals manage the death of a child in their own way. Some will want to have an understanding about the child death review process and want to contribute their thoughts and feelings about their child's care and share personal information about their child, others want to grieve in their own way and do not wish to contribute the processes following the death.

It is important to Derby and Derbyshire Child Death Review Team that we contact every family following the death of their child and encourage a dialogue and the sharing of information if that is what a family wish to do. This is very much in the hands of the family. The team respect the wishes of families and their decisions.

The CDOP meeting will always consider the voice of the child and if the family have shared any views or information or would like any feedback following CDOP meeting. As time has progressed there has been an increase in families contacting us. In this reporting year 23 families contacted the Child Death Review Team. Some of the reasons for contact are:

- To inform us of care concerns they have had for their child. The Lead Nurse signposted to the provider of services or to the Coroner in these cases
- To talk about their experience of services around the time of the death
- To tell us about their child, their likes and dislikes, their interests and about their personality. This information is always shared in the CDOP meeting to ensure the voice of the child is heard
- To provide photographs for the CDOP review. This brings the child into the room and has a positive impact on the importance of reviewing the child's story and subsequent death
- To tell us about the importance of clear communication with families particularly at the time of the death and in those early weeks
- To let us know what the legacy of their child's death has meant for them: For example - fund raising or charity events

The Lead Nurse for Child Death Review is a link for the families regarding the child death review processes. This includes liaising with the Coroner around care concerns, signposting families to support and bereavement services and answering any questions regarding the CDOP processes and meetings.

Any family requesting feedback will receive a letter from the Chair of CDOP thanking them for their contribution and with any learning that has been gained from hearing their child's story.

The team and CDOP believe it is important to get the balance between an independent review of a child's death and remembering the importance of the child's life and voice and how this can enrich any learning for CDOP and our widder partnership.

8.0 Challenges in this reporting year:

- Establishing and maintaining a child death review process during the Covid 19 pandemic
- Planning and managing the CDOP meetings virtually
- Delay of reviewing cases due to factors directly related to the Covid 19 pandemic

9.0 Key priorities to be completed in 2021 to 2022:

- The Contingency Plan for Covid 19 will be monitored and reviewed and the effectiveness reported to the Child Death Review Partners
- Quarterly reporting to the Child Death Review Partners in line with the Governance and Accountability document
- CDOP will hold a Themed Panel on the Sudden and Unexpected Deaths of Teenagers in Spring 2021
- The team will continue to actively encourage the voices of children and their families within the CDOP meeting
- The team are planning to hold a virtual education event for providers and partners - Child Death Review Seminar in January 2022
- Development of a Neonatal Pathway for Child Death Review for both provider organisations
- Development of regular newsletters disseminating the learning from CDOP
- The team will develop a guideline for modifiable factors taking into account work by the NCMD
- Development of a CDOP page on the Derby and Derbyshire Safeguarding Childrens Partnership website
- CDOP will monitor the progress of the commissioning of community palliative care services for children
- The Team and CDOP will consider any factors related to Covid 19 for the deaths of children who have died during the pandemic

10.0 Conclusions:

This has been a challenging and difficult year globally, nationally, and locally due the Covid 19 pandemic. The response to the pandemic has demanded a system wide approach in Derby and Derbyshire to ensure the safety of our service users, the public, professionals, and practitioners as well as our own family and friends. Everyone has been touched by the pandemic.

Despite the challenges and demands made on all of us by the response to the pandemic the arrangements for Child Death Review and CDOP have remained in place with some adjustments in line with the contingency plan. The statutory requirements for Child Death Review have not changed and have been met by the Child Death Review Team and CDOP in Derby and Derbyshire. The focus on learning from child deaths has remained a priority and has been supported by the Child Death Review Partners.

CDOP and the Child Death Review Team should be proud of what has been achieved in this year despite Covid 19. CDOP has continued to move forward with practice as well as holding a Themed Panel and planning future learning events. The recognition of the importance of learning from child deaths is clear due to the commitment and hard work from the team, CDOP and the wider partnership.