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

1st April 2022 – 31st March 2023

Authors:

Juanita Murray

Chair of the Derby and Derbyshire Child Death Overview Panel

Dr Nic Medd

Designated Doctor for Child Death for Derby and Derbyshire

Introduction from the Authors

The child death review team and CDOP members have continued to review child deaths within the framework of the statutory guidance. Through the activity of the child death review team and CDOP, learning has been disseminated across the partnership with an aim to drive improvements in service provision and prevent future child deaths.

This reporting year has allowed us to hear the unique stories of 55 children, young people, and their families. Their stories matter and the privilege of hearing from them allows us to look for ways to prevent and reduce the future deaths of children across Derby and Derbyshire.

We are grateful to all those families who decided to contact us to share their feedback and concerns and give us their child's voice. We will continue to hold the voices of children and their families at the very heart of what we do.

We remain grateful to those members of our partner organisations who time after time go out of their way to make the lives of children and their families their absolute priority. And who, despite often challenging circumstances, work above and beyond to give children the experience that they deserve.

This year's annual report will have a focus on babies and how we learn as a partnership from the tragic loss of a baby within a family.

Derby and Derbyshire hold Neonatal Themed Panels which enable us to group together the deaths of the youngest babies and hear from those with expertise in neonatal care and service provision which enhances the reviews of these babies.

There has also been a focus on how we care and protect all our babies through the Keeping Babies Safe agenda which has been an area of focus and development through CDOP and the Derby and Derbyshire Safeguarding Childrens Partnership.

This annual report will consider in more detail neonates and the safety of all babies.

Finally, we would like to thank the members of the Child Death Review Team, the Child Death Review Partners, and members of CDOP for their hard work, support and commitment to the review of all child deaths in Derby and Derbyshire.

Juanita Murray

Chair of the Derby and Derbyshire Child Death Overview Panel

Dr Nic Medd

Designated Doctor for Child Death for Derby and Derbyshire

Child mortality and deprivation

The National Child Mortality Database (NCMD) produced a thematic report on child mortality and deprivation. A key finding was that 'there was a clear association between the risk of death and the level of deprivation for children who died in England between April 2019 and March 2020. This association appeared to exist for all categories of death except malignancy'. Further analysis also suggested 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. This equates to 700 fewer children dying per year (NCMD 2021).

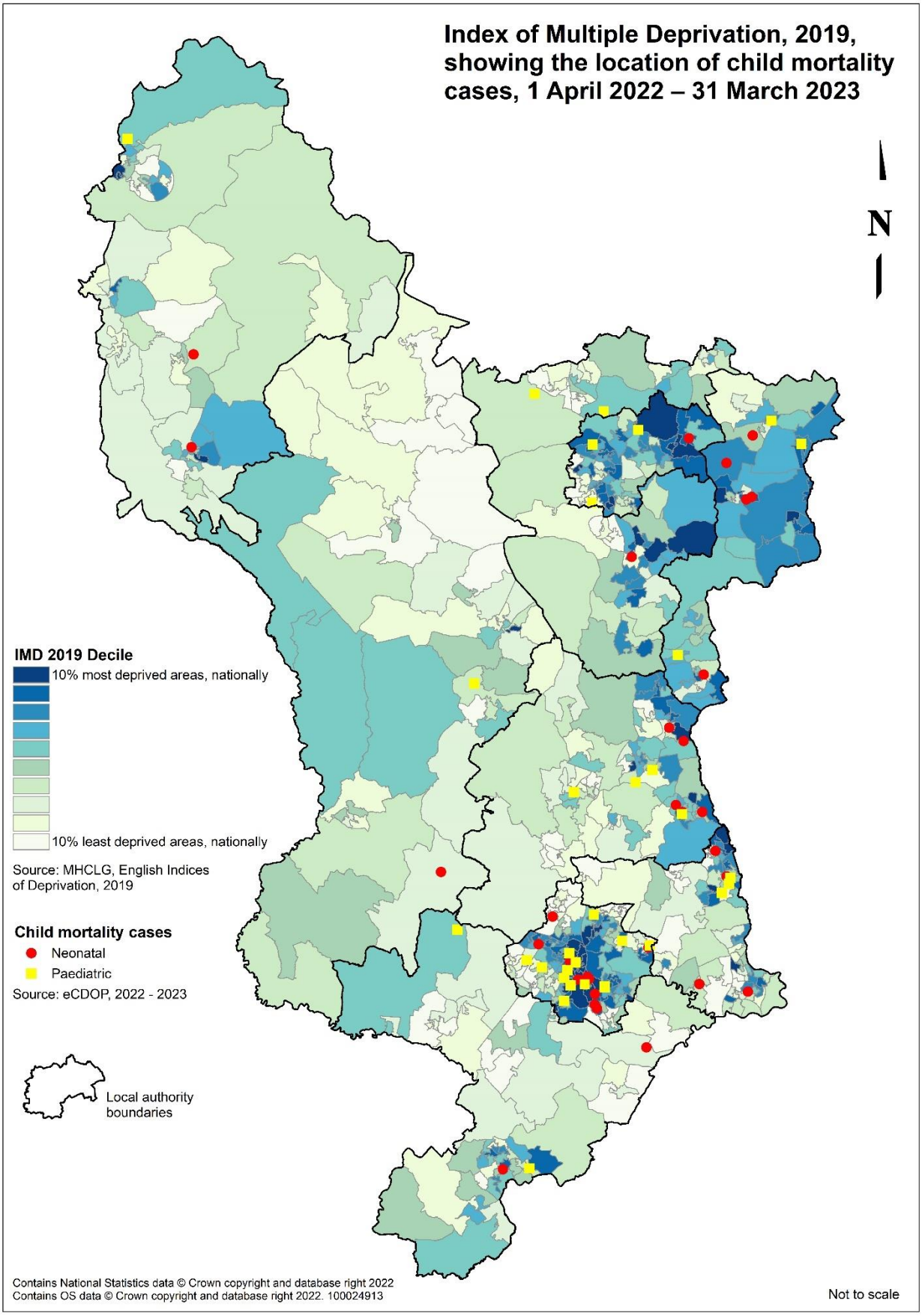
The number of notifications for 2022-2023 in Derby/Derbyshire shows a similar trend to that found nationally. Deaths were more common among children living in the most deprived areas, particularly for neonatal deaths.

The proportion of deaths with identified modifiable contributory factors increased with increasing deprivation; with factors relating to the social environment being most frequently reported. To achieve a more systematic collection and analysis of the contributory and modifiable factors, specific and structured questions related to social deprivation is now collected within the reporting forms for child death reviews.

The Child Safeguarding Practice Review Panel in the report Out of Routine (2020) review identified that environmental factors, such as deprivation and overcrowding, when combined with other risk factors were associated with sudden and unexpected deaths (SUDI) (Out of Routine)

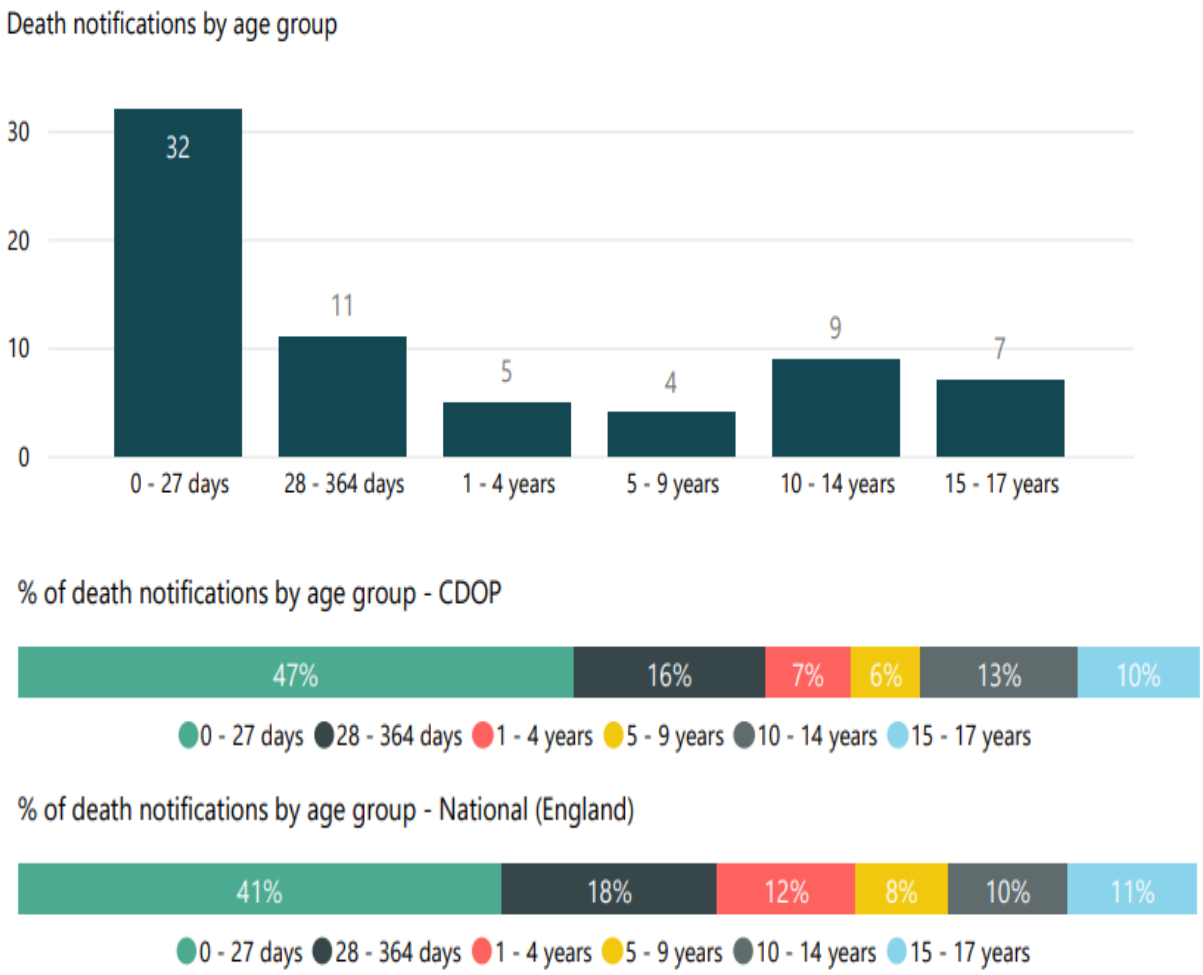
Pregnancy is recognised as a key time to reach families. However, due to time constraints and caseload pressures, the review identified that there was often little opportunity to build relationships and explore family vulnerabilities. This was particularly evident in areas of high social deprivation.

Within Derby and Derbyshire, identifying vulnerabilities (including the potential impact of deprivation) within families is a key focus of the multi-agency Keeping Babies Safe strategy, particularly when promoting safer sleep. Parents may consider deprivation being out of their control and therefore they may not feel that anything they do will make a difference to what happens to their baby. Timely and accessible preventative services have a key role in supporting families in these circumstances, particularly where there is enhanced home visiting, to build trust and engage parents in making safe and appropriate decisions about the sleep environment. Being able to build a relationship to explain how the situational risk of deprivation interacts with other risk factors in relation to SUDI (sudden and unexpected death in infancy) and discussing practical solutions, may help parental understanding and promote behaviour change, particularly when considering safer sleep in 'out of routine' situations.



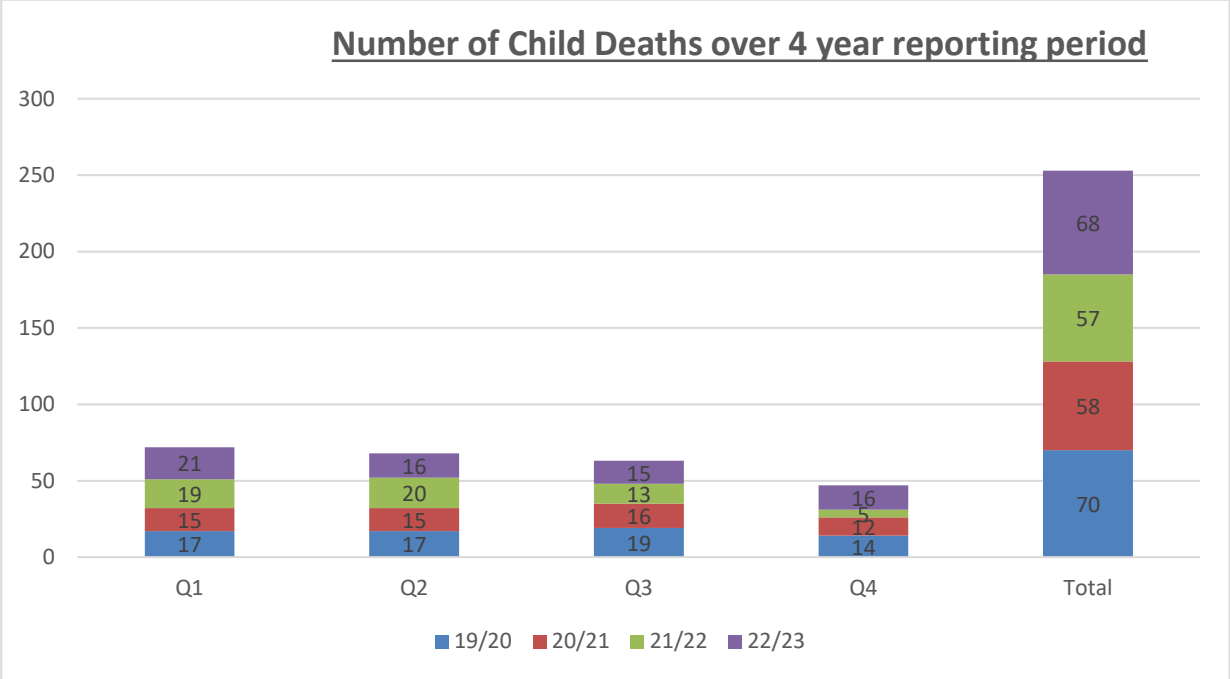
68 Child Deaths between 1st April 2022 and 31st March 2023

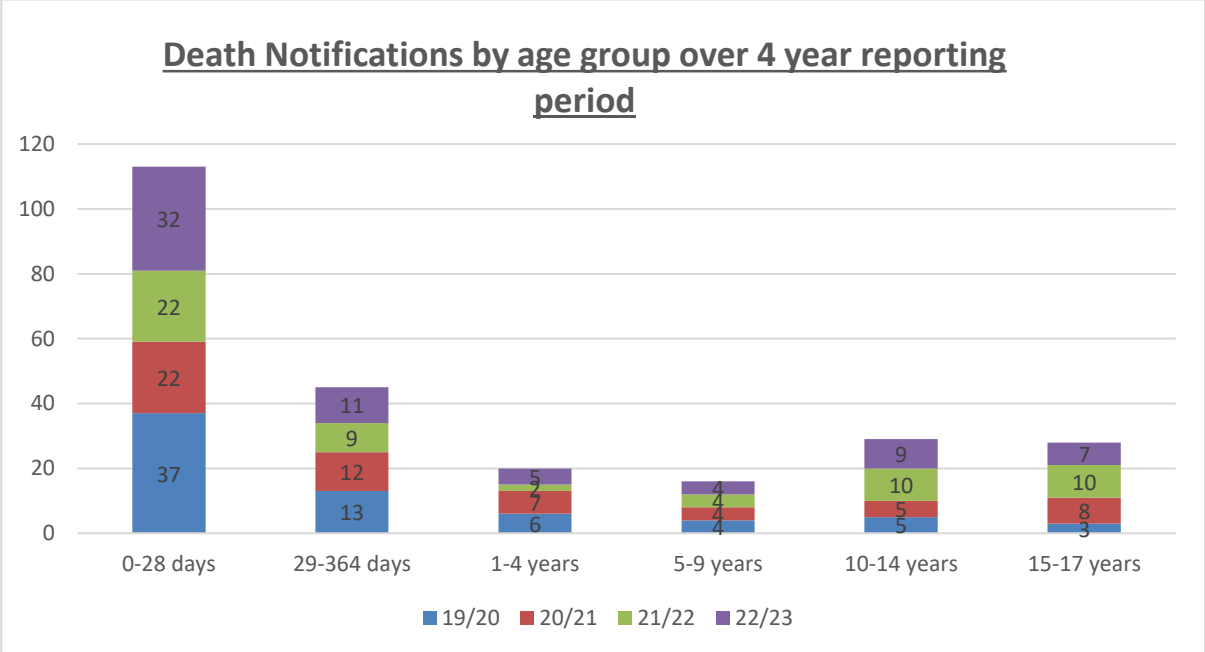
Notifications of Death



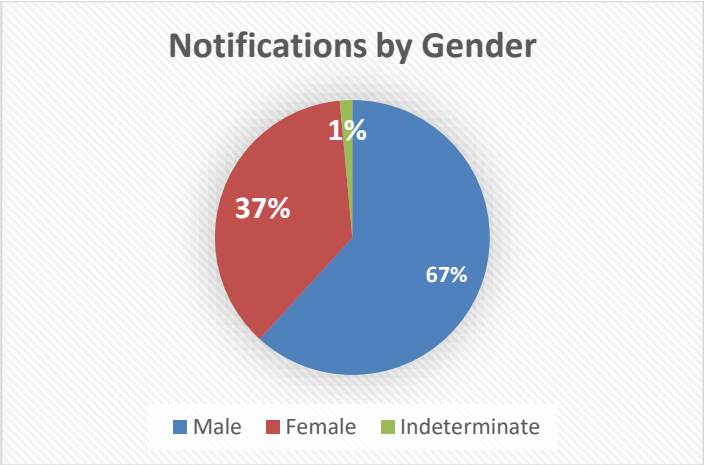
Notifications of death should be submitted via ECDOP within 48 hours of the death of a child by the health provider where the child has died. Most notifications are for neonatal deaths at 47%. This number has increased since last year with an additional 10 neonatal deaths. The numbers of neonatal deaths are now above the national average for England which is 41%. All other rates of death have remained consistent with last year and national averages however deaths in 1–4-year olds at 7% remains low compared to the national average of 12%.

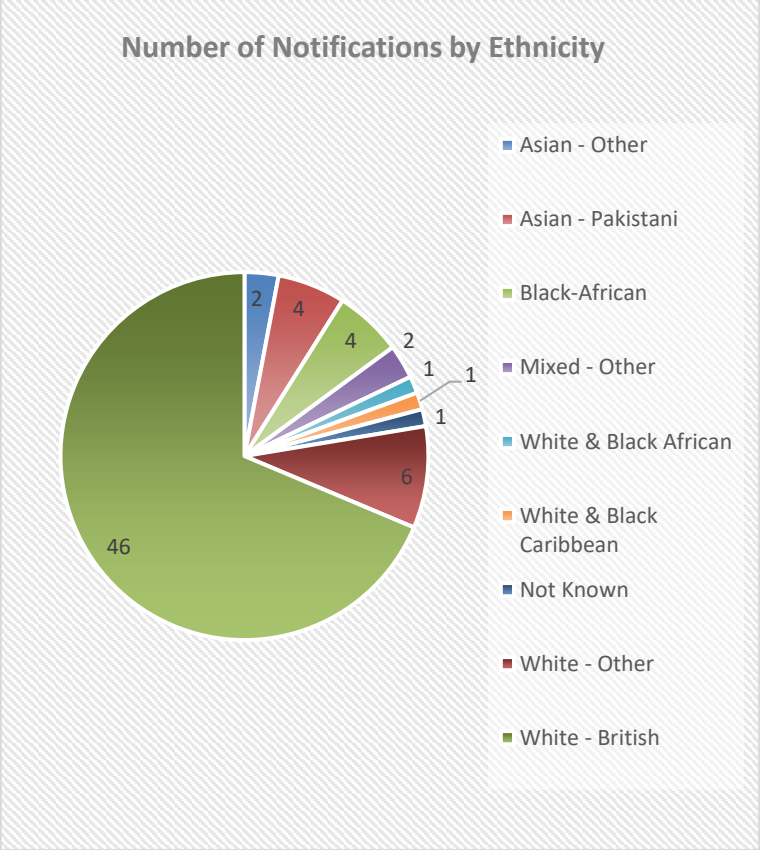
Comparison of data over the last 4 years of reporting





There was an increase in all deaths when compared to the last two reporting years this was likely due to COVID 19 and the overall drop in child mortality which was seen UK wide during this time, with numbers now coming back to pre-pandemic levels. Derby and Derbyshire neonatal deaths have consistently been lower than the England average however they are now slightly higher. There are limitations when considering raw data such as numbers and not considering the wider determinants that may have an impact. The child death review team and CDOP will monitor these numbers over the coming year and report any trends to the Child Death Review Partners.





Child Population

The child population data from the 2021 census - Age by single year - Office for National Statistics (ons.gov.uk).

Local Authority Area	Child Population 0 -17 years
Derby City	58,627
Derbyshire	151,608
Total	**210,235**

These figures account for the child population on one day in the year when the census was taken and there will be some small inaccuracies. Derby City account for 28% of the total child population and Derbyshire for 72%. There were 28 deaths of Derby City children this year and 40 of children living in Derbyshire. There is a higher rate of child deaths in Derby City compared to population size at 41% of the total number of deaths. This is not unexpected due to the known links between child death and deprivation as Derby City have more areas of deprivation according to IMD decile.

The Child Death Overview Panel

The panel comprises of senior representatives from key partner agencies who together have expertise in a wide range of services regarding children's health and wellbeing.

The attendance at CDOP meetings has been very good over the last year and in line with the terms of reference for the group. The continued contribution from CDOP's Lay Member is valued by the group MST has not been a barrier for attendance however the supportive element of the CDOP meeting is more challenging to achieve virtually.

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

Child Death Review Team

A small team including the Designated Doctor for Child Death, Lead Nurse for Child Death Review and the CDOP Coordinator manage and prepare all the children's stories to ensure they are reviewed at CDOP in a timely manner.

The development of the child death review processes, planning and innovation is managed by the team led by the Designated Nurse Safeguarding Children on behalf of Derby and Derbyshire Integrated Care Board

The Child Death Review Partners

The three partners are the two Directors of Public Health for Derby City and Derbyshire and the Chief Nurse for Derby and Derbyshire ICB. The partners are assured of the progress of CDOP to review child deaths in line with the statutory guidance quarterly by the Chair of CDOP. The partners are also made aware of any learning, positive practice, risks or concerns regarding the functions of CDOP.

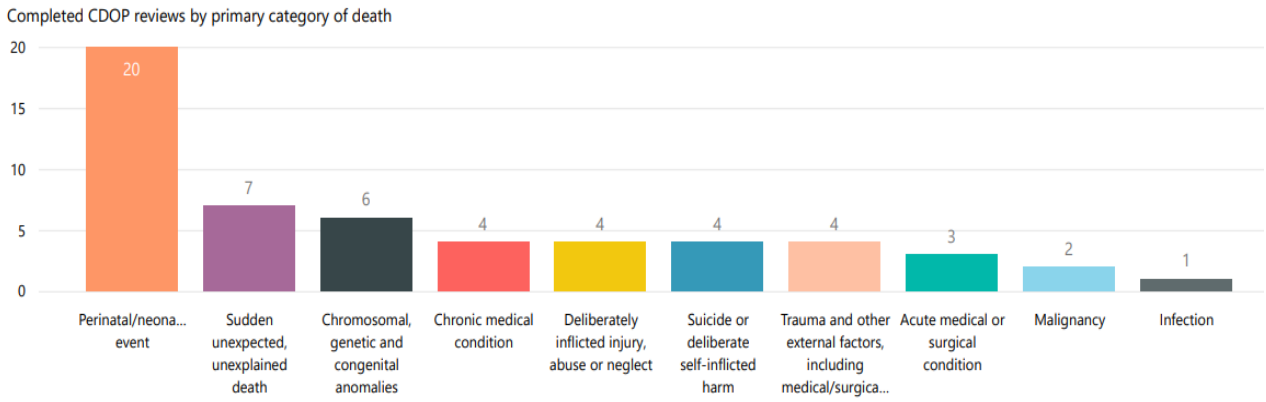
Child Deaths Reviewed

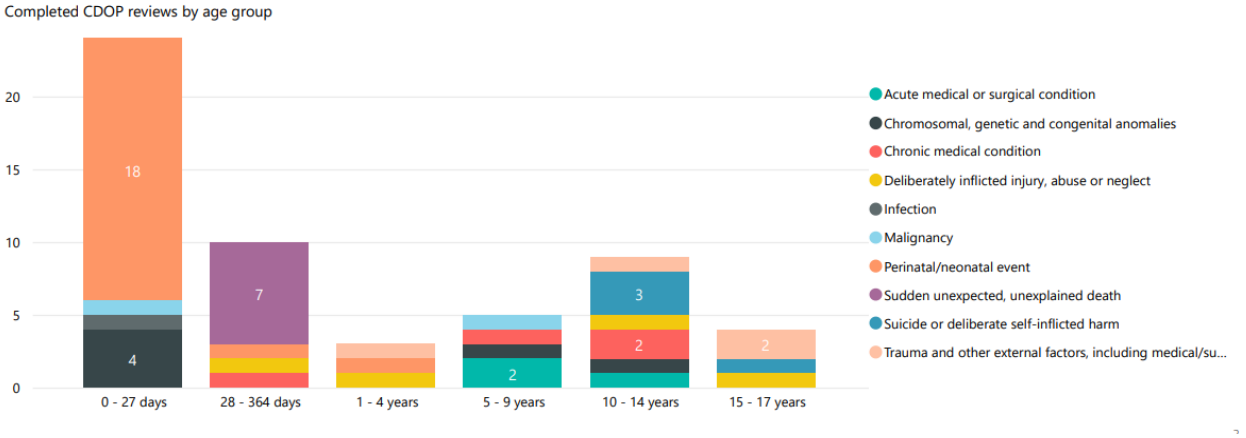
55 child deaths reviewed between 1st April 2022 and 31st March 2023

CDOP Meeting	Number of deaths reviewed	Number of cases closed
April – Neonates	7	7
May	4	4
June	4	4
July – Neonates	Cancelled meeting not quorate	
August	5	5
September	4	4
October – Neonates	9	9
November	5	5
December	4	4
January - Neonates	8	8
February	Cancelled not enough cases ready to hold the meeting	
March	5	5
Total	**55**	**55**

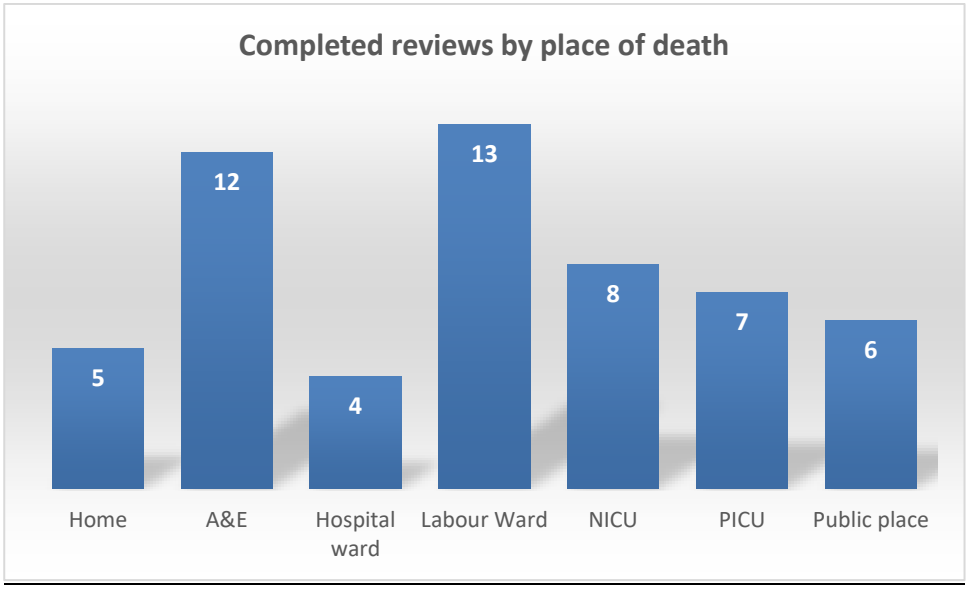
The children reviewed are not necessarily the same children who have died within this reporting year. Review at CDOP can be delayed significantly by coronial processes and criminal proceedings. The numbers of deaths reviewed is increasing each year following the COVID 19 pandemic.

Demographics of Completed Reviews





Neonatal deaths are the most common type of event reviewed by the panel and are reviewed as a themed panel to enhance the learning. This is followed by babies who have died suddenly and unexpectedly and then closely by children with chromosomal or genetic conditions. The child death review team will often group deaths together where there are similar characteristics to maximise the discussion and learning.



Modifiable Factors

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.

This year the Child Death Review Team and CDOP have continued to ensure a consistent approach to modifiable factors. There is rich discussion in the CDOP meeting and guidance available locally to support decision making.

Most Common Modifiable Factors

Unsafe sleep Practice

Parental and Household Smoking

Maternal Alcohol Use

Maternal Smoking

Inadequate Information Sharing

Identifying modifiable factors supports learning and any initiatives or activity that takes place with the aim of improving health and preventing future deaths.

Most Common Modifiable factors identified this year.

Modifiable Factor	Percentage
Unsafe sleep	37.5%
Paternal/Household smoking	33%
Maternal Alcohol	25%
Maternal Smoking	21%
Lack of Information sharing	17%
Drowning	12.5%
Dangerous driving	12.5%
Procedures not followed	8%
Lack of Palliative care	8%
Delay in diagnosis/treatment	8%
Stabbing/gunshot	8%
Out of routine	8%
Lack of Professional curiosity	8%
Unrestrained in car	8%

CDOP held a themed panel for children who died from trauma which included children who died in road traffic accidents and from drowning. CDOP identified modifiable factors in these cases which is highlighted in the table above.

Contributory Factors

A contributory factors is an issue that may contribute to the outcome of a child's death. Some factors may have a direct impact on the outcome and some may increase the child's vulnerability. Some children may present with several factors which will have an impact on their life and death.

Most Common Contributory Factors

Child

Medical Condition
Developmental Impairement
Abuse and Neglect
Learning Disability
Gestational Age

Parental

Safeguarding Concerns
Parental Mental Health Concerns
Domestic Abuse
Parental Crminality
Parental Alcohol/Substance Misuse

Environment

Household Smoking
Unsafe Sleep Practice
Poor Home Conditions
Deprivation
Frequent Home Moves

Service Delivery

Inadequate Information Sharing
Delay in Diagnosis or Treatment
Impact of COVID 19
Care Concerns
Lack of Pallative Care Services

The Child Death Overview Panel are more accurately recording contributory factors as part of the child's review. The table above depicts those contributory factors that are recorded in 20% of cases and above. Recording contributory factors provides rich data on the circumstances of the child and allows the panel to understand some of the lived experience of the child.

Learning Themes

The Importance of Learning from Child Deaths

All child deaths are important to CDOP. We can all learn from individual deaths by sharing positive practice as well as the consideration of improving practice across the partnership. CDOP has a role to look at themes and trends and to focus on any improvements that can be made to prevent future deaths and improve care and services to children.

Learning from the Deaths of Neonates

Derby and Derbyshire CDOP hold quarterly Neonatal Themed Panels. This allows the panel to focus on the deaths and learning for the youngest babies from birth to 28 days. The panel includes regular panel members with the addition of specialist neonatologists, midwives, and bereavement nurses. Public health is represented and are key partners in taking forward important messages to help reduce future deaths.

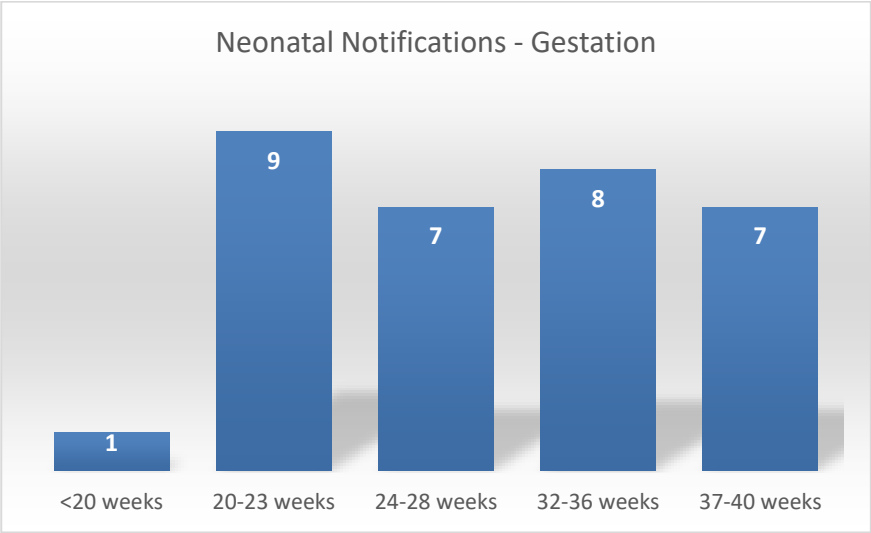
Neonatal deaths have several reviews which all feed into the CDOP meeting. Most babies will have a standard review of care in the form of a child death review meeting (CDRM) or a perinatal mortality review tool (PMRT) at the Trust where the baby was cared for. Some babies have further reviews from the Coronial system and/or the Health Services Investigative Branch (HSIB). Some babies and mothers care will have undergone a more detailed review by the attending Trust such as a serious incident investigation. Often the learning from the deaths of babies is also discussed at a regional network level. As with all child deaths feedback from families is also welcomed and the child death review team will provide feedback to families following the CDOP review.

Optimising maternal wellbeing and newborn care is vital in reducing mortality. Increasingly there is an understanding that newborn health is vital, not only to that precious early period of life, but it can also affect health and chance of dying for the rest of people's lives. It is increasingly important to understand the effects that factors in the womb have on the baby and how factors before birth can play a part in the diseases that affect a child later, even contributing to their premature death outside of infancy.

The importance of the first 1000 days, from conception to a child's 2nd birthday, are now acknowledged at a national level as being crucial to the future development and wellbeing of the population with interventions to improve health outcomes here crucial for reducing overall morbidity and mortality.

Neonatal Notifications

There were 32 neonatal notifications in this reporting year. The largest number of deaths are in those extremely preterm babies who are born at the edge of viability. Some babies were born before the limit of viability (which is at 22 – 23 weeks). This is because they have been born with signs of life and so, although unable to survive due to their gestation, they have a birth and death certificate and so under statutory legislation are reviewed by CDOP.



24 neonatal cases were reviewed this year. 80% of the deaths were classified as 'perinatal/neonatal' event. This includes premature births and those where there is perinatal compromise at delivery. The remaining 20% included babies with a genetic condition that were life limiting.

CDOP considered the modifiable and contributory factors for all the deaths reviewed and considered 4 main learning themes.

Four Learning Themes from the Neonatal Themed Panels

Maternal Obesity

Obesity is defined as a BMI of 30 or higher in a non-pregnant person and CDOP use the same definition. This is usually ascertained at the booking appointment when the pregnant mother first contacts maternity services in the early stages of pregnancy. Maternal obesity was considered a modifiable factor in 42% of the neonatal deaths reviewed.

During pregnancy obese women are at increased risk of having:

- Gestational diabetes - three times more likely to develop gestational diabetes
- Blood clots
- High blood pressure and preeclampsia - risk of pre-eclampsia is 2–4 times higher
- Some reduction in feeling fetal movements potentially leading to delayed presentation
- There is a small but significant increase of maternal morbidity and mortality
- Maternal size can make the assessment of fetal size, presentation and monitoring of fetal heart tracing more challenging

During delivery obese women are at risk of:

- Increased need for induction of labour, caesarean birth, are at risk of anaesthetic complications and wound infections
- Difficulties in the monitoring of labour
- Increased risk of an obstructed delivery
- Increased risk of preterm birth
- Higher risk of post term birth
- Increased risk of postpartum haemorrhage
- Risk of miscarriage is increased from 1:5 to 1:4
- Risk of stillbirth doubles from 1:200 to 1:100

Effects on the newborn infant:

- Adverse neonatal outcome at delivery and newborn problems
- Babies are more likely to be born weighing more than 4kg which increases risk for baby and mother
- Breast feeding initiation and maintenance rates are also lower in obese women
- Increased risk of congenital abnormalities with the risk of neural tube defects doubled as well as increased risk of cardiac and other defects
- Increased risk of perinatal, neonatal and infantile death
- Potential longer-term effects of maternal obesity on the child with an increased risk of cancer in later life
- Associated with childhood obesity and metabolic disorders including development of diabetes and cardiovascular disease

Considerations

- The Royal College Obstetricians and Gynaecologists (2019) 'Care of women with obesity in pregnancy' details important care considerations including the opportunity for all women to optimise their weight prior to pregnancy and support being part of preconceptual advice. Weight loss in-between pregnancies is also advised if the maternal BMI is greater than 30.
- Folic acid supplementation is advised for a 1 month prior to conception in all obese women. The RCOG have produced a leaflet for women considering pregnancy or pregnant regarding the risks and care they will receive during pregnancy.
- As obesity is the most common health problem in women of reproductive age, it is essential for services to take this health issue seriously. Its management requires a lifelong approach. Loss of 5 – 10% of body weight has been shown to alter the metabolic factors thought responsible for many of the problems.
- Antenatal lifestyle modifications are key and intervention prior to pregnancy initiation is the best time to target women for the best response.
- Management of obesity is complex and requires support. It is also acknowledged that there can be stigma and bias for obese women in pregnancy which can affect their quality of care.
- Using patient preferred weight terminology, e.g. BMI rather than obese
- Offering antepartum care focused on nutrition, physical activity, and weight management.

Local Practice

Derby City offer perinatal weight management and adult weight management - Live Well

Perinatal weight management | Livewell (livewellderby.co.uk) Lose Weight | Livewell (livewellderby.co.uk)

Derbyshire - Live Life Better

Losing weight - Live Life Better Derbyshire

Exposure to smoking

The effects of smoking on the wellbeing of a baby are perhaps better acknowledged within society than those of obesity. Despite this a significant number of women choose to continue to smoke in pregnancy as do their household members. The Neonatal Themed Panels identified that maternal smoking was a modifiable factor in 29% of cases and household smoking in 21%. Smoking exposes a baby to harmful chemicals as well as reducing the oxygen and nutrition reaching the baby in the womb.

Smoking is associated with an increased risk of:

- Miscarriage
- Ectopic pregnancy
- Stillbirth
- Neonatal death – a third of stillbirths and neonatal deaths are thought to be due to smoking (RCOG)
- Congenital abnormalities such as cleft lip and palate and face defects
- Smaller babies – poor growth in the womb and low weight at birth
- Abruption of the uterus
- Preterm birth
- Sudden infant death syndrome
- Asthma, chest and ear infections, pneumonias
- Behavioural problems including ADHD
- Reduced educational attainment
- Poorer language development

Considerations

- Pregnant women exposed to passive smoke have similar risks.
- The Saving Babies' Lives Care Bundle version2 provides a practical approach to reducing smoking in pregnancy, including the use of carbon monoxide testing for all women at the antenatal booking appointment and as appropriate throughout pregnancy, and referral for support from trained stop smoking advisors.
- NICE (NG209) guidance also recommends that carbon monoxide testing is used and that there should be an opt out referral to all pregnant women who smoke.
- Referring family members to stop smoking services to reduce passive smoking in pregnant women.

Local Practice

A Derbyshire smoke free pregnancy pathway document has been developed to support the consistency of messaging and to standardise practice across all relevant organisations. An implementation group including midwives, health visitors, public health and smoking cessation providers meet regularly.

Family members are referred to smoking cessation services antenatally.

Domestic Abuse (DA)

Domestic abuse is complex. It can go unidentified by agencies, families, and friends, and even victims themselves. To transform the response to domestic abuse, it is important that it is first properly recognised and understood.

Domestic abuse was recorded as a contributory factor in 13% of the cases and a modifiable factor in 4%.

The joint policy statement on domestic abuse by RCOG and Royal College of Midwives, November 2020, states:

- 1:4 women in UK will experience DA or violence in their lifetime
- Victims of DA are more likely to develop serious long-term illnesses and die prematurely
- DA carries a cost to society. The home office estimates it costs £66 billion/year in England and Wales alone
- DA is more likely to begin or escalate in pregnancy
- DA has significant health impacts for women and babies
- DA doubles the risk of preterm birth and low birth weight
- 40% survivors experience mental health problems, anxiety, depression, emotional detachment, which can affect bonding with infant
- Healthcare professionals play an important role – 1:5 victims will contact police but 80% would seek help from health services
- Maternity care professionals who spend time with women in a range of settings are well placed to identify and respond to abuse
- Health professionals need training

The impact of domestic abuse on pregnant women

3 – 9% mothers experience abuse during pregnancy. Risk factors for higher rates of DA include:

- Young age
- Single relationship status
- Ethnic group – worse mortality in African Americans

Socioeconomic deprivation effect of DA on pregnant mothers includes:

- Effect on maternal health behaviours – more likely to miss routine appointments. Increase in smoking, alcohol, and substance misuse.
- Maternal mental health – 40% of abused women report depressive symptomatology, PTSD (post-traumatic stress disorder) reported in 19-84%. 54% of pregnancy associated suicides involved intimate partner conflict.
- Higher maternal mortality - Singh Chandan, J et al, (2020). 45% of maternal homicides in pregnancy were associated with DA.
- Increased risk of abruption (bleeding from the placenta which can affect morbidity and mortality in mother and baby).
- Indirect effects on maternal health such as poor nutrition, poor mental health, increased psychological stress leading to hypertension and gestational diabetes.
- Increased risk of preterm birth although the reason is unclear.

Effect of DA on babies:

- Low birth weight (LBW) and preterm birth – higher rates even after adjusting for other factors up to a 2x increase.
- Small for gestational age at term
- Risk of perinatal death (fetal loss after 20 weeks to neonatal death up to 28 days).

Routine Enquiry of Domestic Abuse

The Importance of Routine Enquiry, practitioners in all agencies should ensure that they make enquires about domestic abuse as this will identify individuals at risk and ensure support is made available. Routine enquiry involves asking service users about their experiences of domestic abuse, regardless of whether there are any signs of abuse, or whether abuse is suspected. Careful consideration must be given when enquiries are being made to ensure risk is not increased, for example risk may increase if enquiries are made in front of partners or someone else. The enquiries should be made whether there are signs or suspicions of abuse.

Routine enquiry is especially important for universal services such as Emergency Departments, Midwifery, Health Visiting, Education staff, School Nursing and GP's. Research tells us that Women have a positive view of being asked about DA in health care settings. 94.4% felt comfortable with a midwife asking about domestic abuse. 96.6% of participants believed it was appropriate for a midwife to ask about domestic abuse and that midwives should be able to respond positively to disclosures.

Local Practice

Reducing the adverse impact of Domestic Abuse on children and families is a priority for the DDSCP and for the newly established Domestic Abuse and Serious Violence Board which takes strategic responsibility for all ages across Derby and Derbyshire. This is being achieved by agencies working together.

Part of the CDOP review is to consider if routine enquiry has been made. CDOP have been assured that in most cases routine enquiry is regularly asked. We continue to highlight this important aspect of maternity care to all practitioners and look for ways to continue to support these women and their children in the most challenging of circumstances.

Preterm delivery and right care in the right place

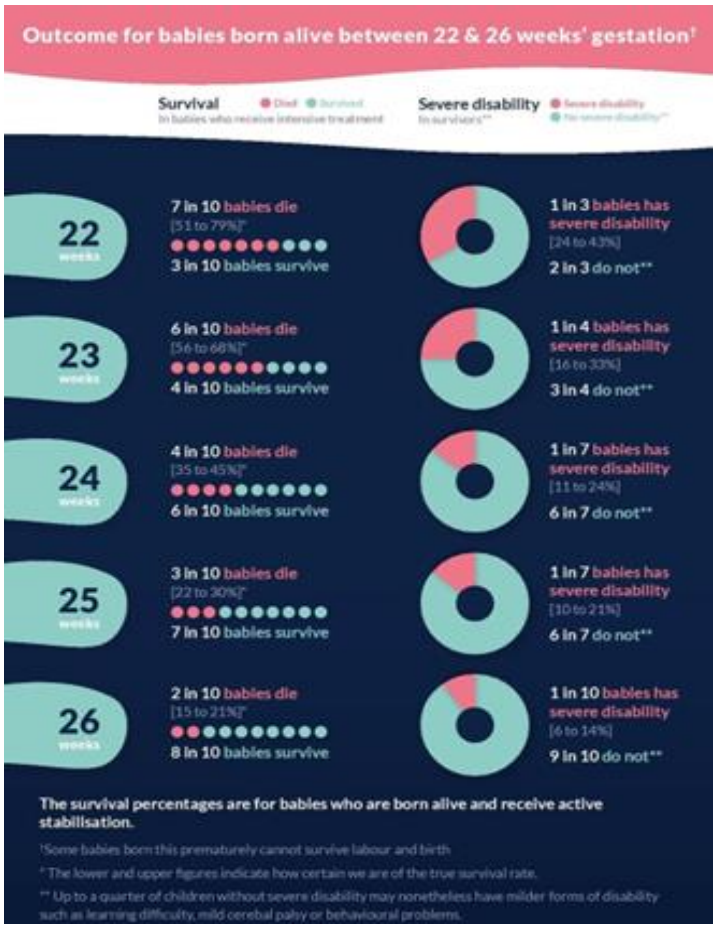
The neonatal themed panel data shows what is nationally recognised by the NCMD, that prematurity is the leading cause of neonatal death. Locally prematurity was a factor in 92% of deaths reviewed.

A preterm delivery is one which occurs less than 37 weeks completed gestation of pregnancy. The lower the gestation at delivery the higher the mortality. Year on year with improvements in neonatal and obstetric care, neonatal survival is increasing, although progress in survival at extremely preterm gestations is challenging.

The National Health Service (NHS) Long Term Plan, responding to the Better Births publication, has committed to realising a 50% reduction in stillbirth, maternal and neonatal mortality and serious brain injury by 2025 with an increased focus on premature birth. Consequently, the

Maternity and Neonatal Safety improvement programme has preterm management as a key priority.

The current survival data for preterm babies used for antenatal counselling by BAPM shows:



Babies can be born prematurely for 2 main categories of reasons:

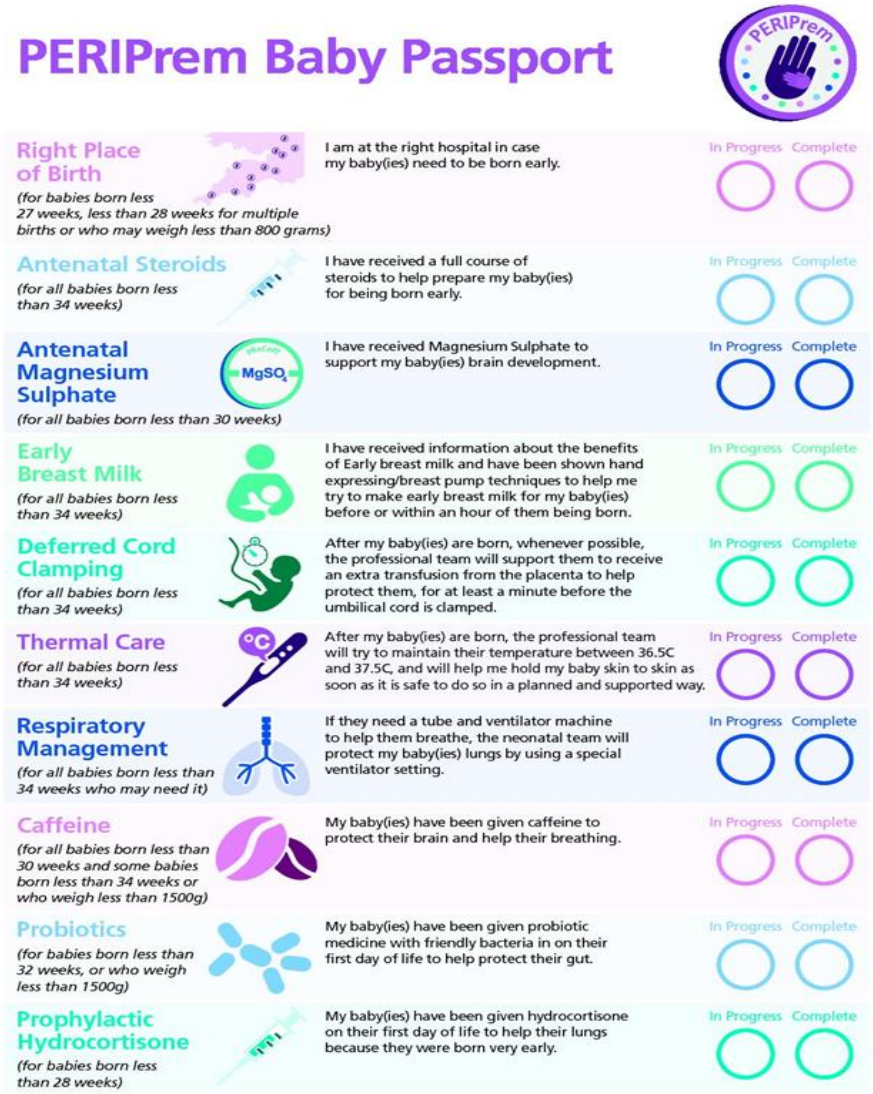
- Spontaneous preterm labour – the mother goes into labour early.
- Delivery of the baby for fetal or maternal wellbeing – the baby is delivered early through induction of labour or caesarean section because there are concerns that continuing with the pregnancy might affect the wellbeing of the mother.

The cause of premature preterm labour is not fully understood. Overall, it is thought to be due to multiple mechanisms and be multifactorial.

Predicting preterm birth in time to allow optimisation of the mother and baby through treatment and administration of medication and then transfer to the appropriate health care setting has been a priority and challenge for obstetric services. Developing tools to predict the likelihood of preterm birth have been key to improving the timeliness of those key interventions.

Preventing preterm birth from happening in the first place is perhaps a harder challenge and is an area of national and international research. Perinatal Excellence to Reduce Injury in Preterm Birth (PERIPrem) is a new initiative consisting of an 11-element perinatal care bundle designed to improve the outcome for preterm babies. Each of the 11 elements of the care bundle is evidence based, and the combined benefit to preterm infants is an estimated 50% reduction in mortality

and severe brain injury. The passport is given to women who present in threatened preterm labour and highlights to parents and staff the key factors for optimisation of care.



Right Place of Birth

One intervention to reduce mortality is for extremely preterm babies to be born in a level 3 maternity and neonatal hospital. This forms part of the PERIprem passport - 'Right Place of Birth' and has previously been identified by CDOP as a contributory factor in some cases. Derby and Derbyshire do not have a Level 3 neonatal unit so mothers would be transferred to tertiary units, outside of Derby and Derbyshire.

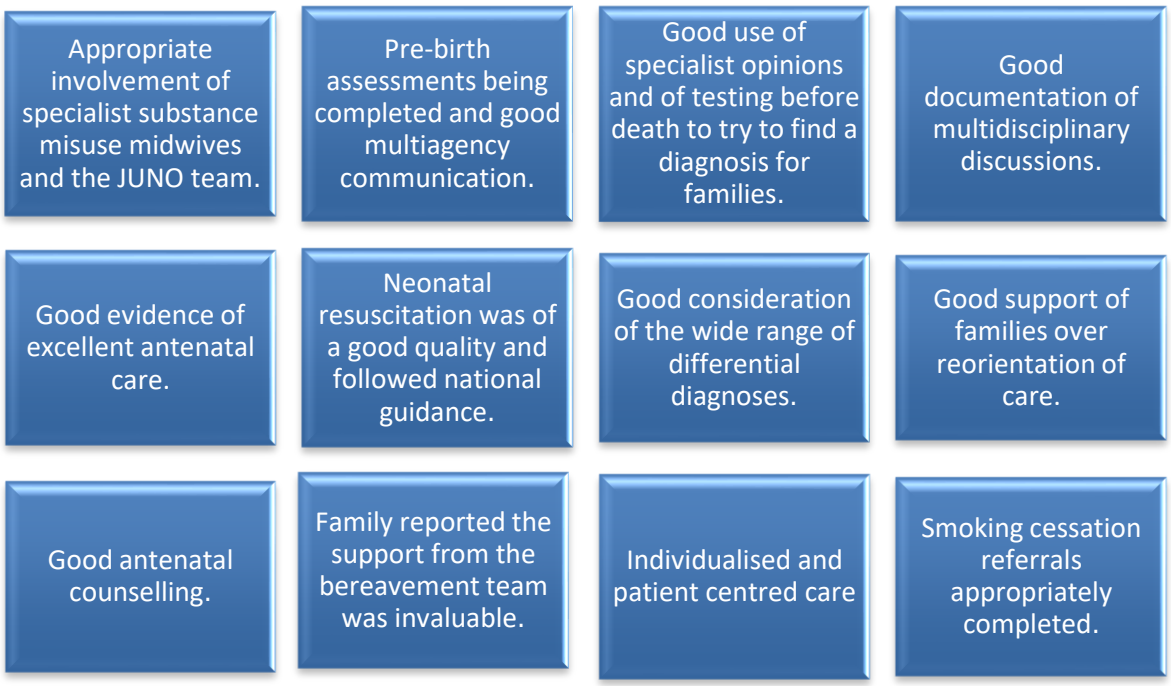
An in-utero transfer (IUT) is not always possible if labour progresses quickly, or a woman's clinical condition is too unstable for a safe transfer. However previously CDOP has identified that capacity issues at tertiary units have played a part and women who have been stable enough and fulfilled the criteria for transfer, have not always been transferred due to capacity at local tertiary units. Tackling this challenge has required a network approach from the local maternity and neonatal networks. CDOP have noted positive working together in gaining consensus and approval for a new model of working where women fulfilling the criteria for an IUT are now accepted by the birth centre if a neonatal cot is available. Thresholds for in utero transfer have been agreed and pathways created to ensure an equitable and efficient process.

The 2021 National Child Mortality Database (NCMD) report identified prematurity and its sequelae as being key factors in childhood mortality. The aspiration of a 50% reduction in neonatal and perinatal deaths through implementing the PERIPrem bundle will not only impact neonatal mortality rates but overall childhood mortality rates. The impact is likely to have benefits to children, society, and healthcare institutions across at least the first decade of life.

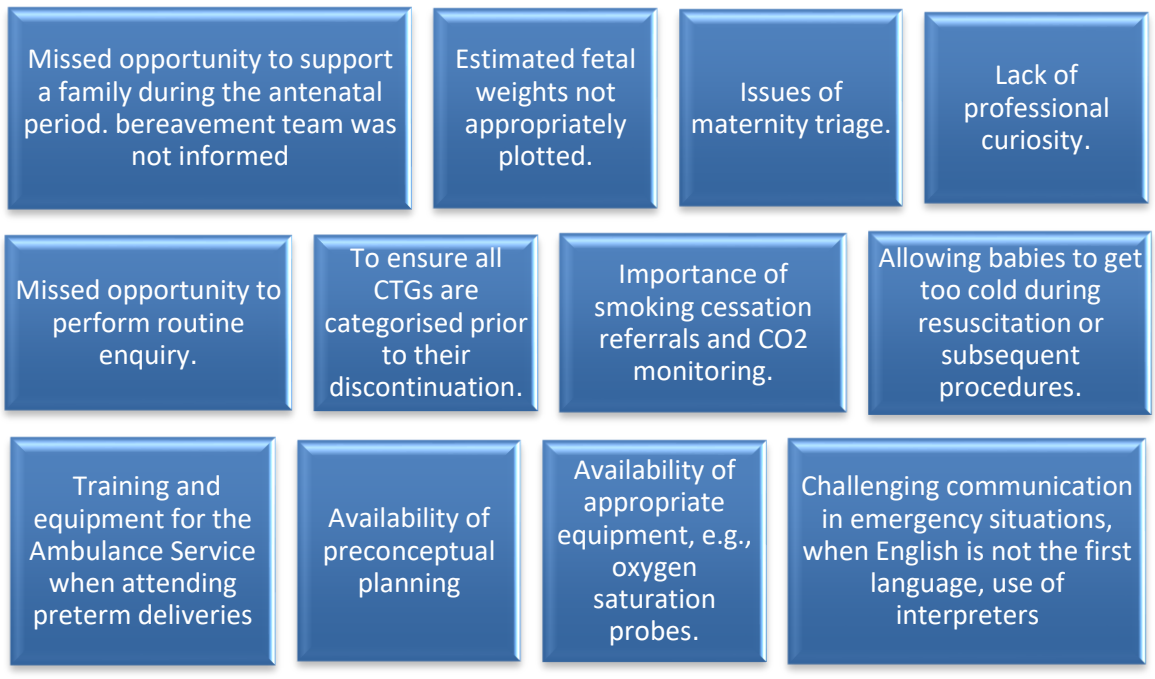
Local Practice

In this reporting year one of our providers implemented the PERIPrem care bundle and passport.

Identified Positive Practice from Neonatal Themed Panels



Identified Learning from CDOP Neonatal Themed Panels



During this year there has been investment in the Bereavement Teams in the two hospitals which is positive and bereavement support to families is discussed and monitored by CDOP as part of the child's review. The Bereavement Midwife at UHDB produced a Comfort Care Pathway. This is for babies with life limiting conditions where parents choose to continue with the pregnancy rather than opt for termination of pregnancy but whose babies are expected to die soon after birth. CDOP has noted during the reviews of babies the positive impact that this pathway has made to families.

Keeping Babies Safe in Derby and Derbyshire

The Keeping Babies Safe Strategy – the Three Steps for Baby Safety was published in 2021 and underpins the work this year around the number one priority of Derby and Derbyshire Safeguarding Partnership – The Safety of Babies.

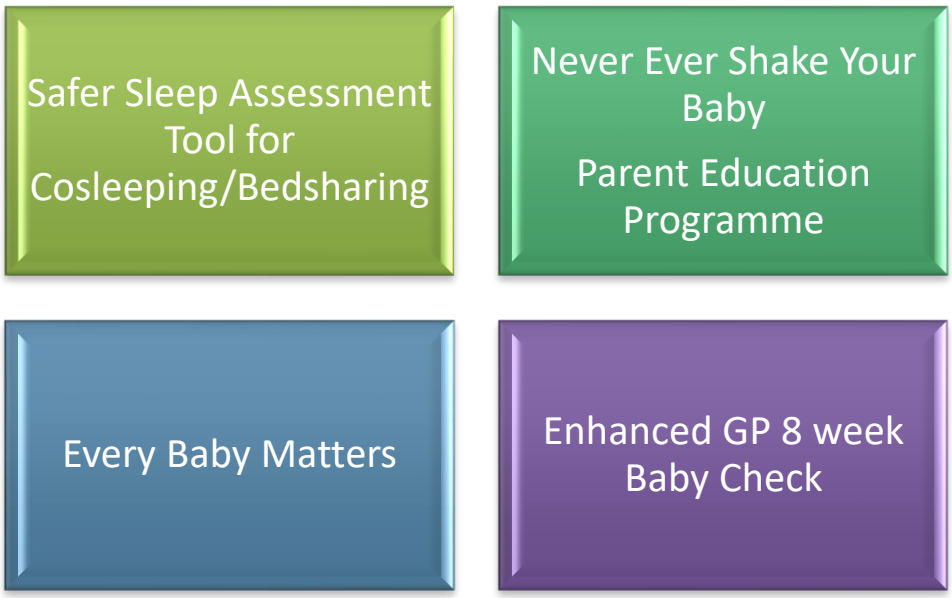
The Derby and Derbyshire Safeguarding Childrens Partnership (DDSCP) recognised that there was a wealth of learning and recommendations following child safeguarding practice reviews, child death reviews and by auditing practice. The KBS strategy became the blueprint to develop practice however it was clear that practitioners needed support, guidance, and training to really make a difference to families and their babies. The DDSCP and the keeping babies safe steering group led the way in the development of initiatives, tools and resources that would provide a consistent approach to the messages shared with families whilst meeting a diverse population and considering the many different practitioners across the multi-agency partnership.

Identified learning themes from CDOP and the DDSCP:

The recognition of the vulnerability of babies and that infants are intrinsically at risk because of their immature anatomy and physiology and their rapid development.

- Identified vulnerability factors in parents and families including mental health concerns domestic abuse and substance misuse
- Unsafe sleep practice and out of routine circumstances for sleep on the night of the death
- Smoking both parental and household
- Parental alcohol use when caring for an infant which was a factor on the night of the death.
- Parents known to services either Children's Social Care or the Police

Key Practice Developments



Keeping Babies Safe Champions

The KBS Champions have had a key role in developing the KBS resources, ensuring that the key safety messages are shared amongst practitioners and have been inventive in how they are shared with parents and families. There has been palpable enthusiasm from the Champions and without them the pace and degree of work around KBS could not have been achieved.

The Strategic Lead for KBS and the Lead Nurse for Child Death Review have trained the KBS Champions. Since 2021 7 training sessions have been delivered, resulting in 141 practitioners becoming KBS champions. 31 champions have since left their role, but there continues to be 110 active champions across Derby and Derbyshire. A network event Is delivered to champions twice a year. These meetings provide an opportunity to update champions on KBS work across the system and allow practitioners to share their experiences. The meetings are well attended and receive positive evaluations.

The role of the KBS Champion is to:

- Support practitioners within a service/team to have a good knowledge and understanding of safer sleep practice, safe handling and home safety
- Support and encourage practitioners to confidently deliver clear consistent messages to parents and carers
- Enable practitioners to recognise that some families may have additional vulnerabilities and require extra support to understand the messages and to make the right choices for their baby's safety
- Be a point of contact for colleagues to offer advice/signposting in relation to baby safety
- Support practitioners to keep up to date with key safety messages
- Disseminate any new information or resources across a service/team

Safer Sleep Assessment Tool for Co-sleeping/bed sharing.

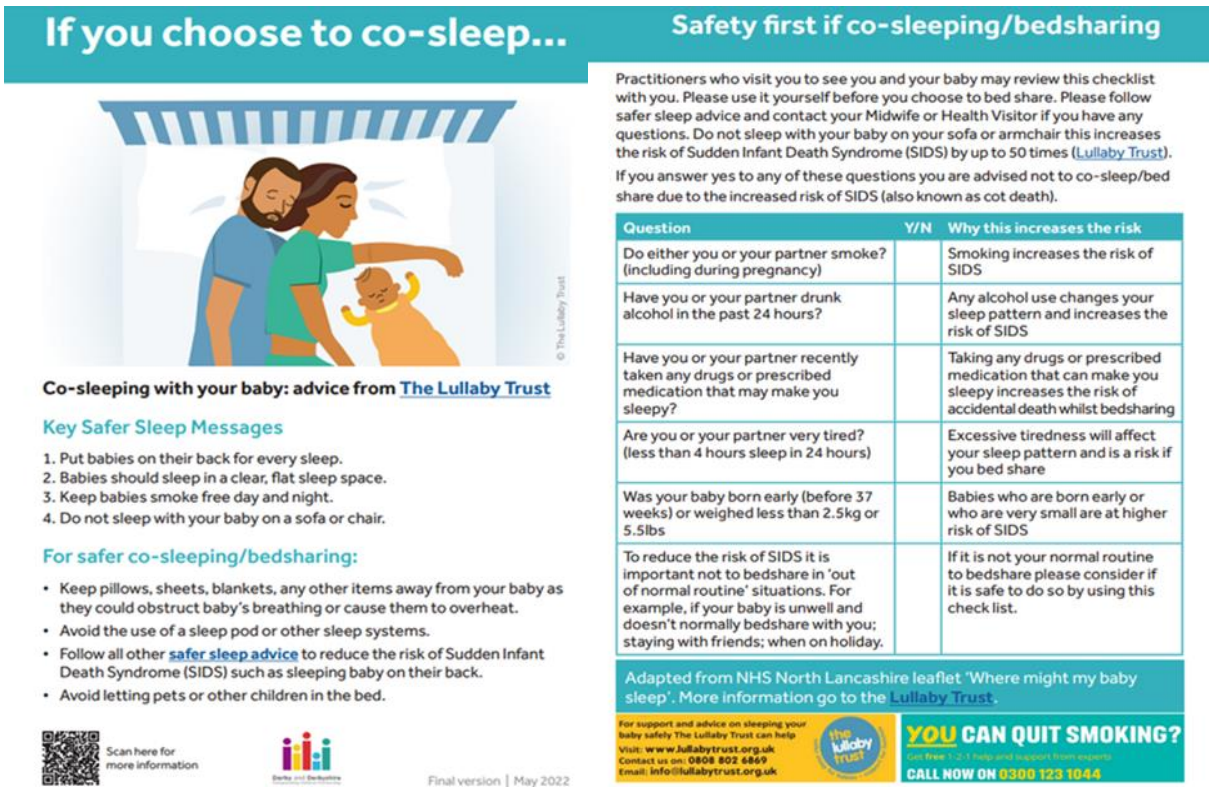
One of the objectives in the KBS strategy is to ensure that practitioners have a good knowledge of safer sleep practice and that practitioners across the partnership can share consistent messages and assess a babies sleep environment.

Research informs us that messaging around safer sleep needs to be delivered clearly and on more than one occasion particularly to families with additional vulnerabilities. All practitioners who support families with babies have a responsibility to understand safer sleep messages and support families to practice safer sleep with their babies. These messages need to be the same across professional groups and organisations to ensure a consistent approach to the safety of babies.

The risks of unsafe sleep practice are reported locally and nationally; babies can and do die in high-risk bed-sharing situations. Information from Child Safeguarding Practice Reviews and CDOP informs us that bed-sharing is something parents do with their babies. National research and a local audit confirm that 40% of parents bedshare, but don't always share this information with practitioners for fear of being judged or feeling they are doing something wrong. The Lullaby Trust found that if parents are told not to bed share with no explanation, they will then feel they cannot discuss the issue and will not seek the correct safety advice.

All families need to be risk assessed and know how to assess their own situation for bed-sharing. We want families who are identified as low risk to have the researched based information to make an informed decision about whether they wish to co-sleep safely and for those that are identified as high risk, not to co-sleep at all.

The assessment tool has been developed to support practitioners and families to make an informed choice and should be used in conjunction with all other safer sleep advice. The assessment tool was tested with practitioners and families prior to being launched in June 2022.



If you choose to co-sleep...

Co-sleeping with your baby: advice from The Lullaby Trust

Key Safer Sleep Messages

1. Put babies on their back for every sleep.
2. Babies should sleep in a clear, flat sleep space.
3. Keep babies smoke free day and night.
4. Do not sleep with your baby on a sofa or chair.

For safer co-sleeping/bedsharing:

- Keep pillows, sheets, blankets, any other items away from your baby as they could obstruct baby's breathing or cause them to overheat.
- Avoid the use of a sleep pod or other sleep systems.
- Follow all other safer sleep advice to reduce the risk of Sudden Infant Death Syndrome (SIDS) such as sleeping baby on their back.
- Avoid letting pets or other children in the bed.

Scan here for more information

Final version | May 2022

Safety first if co-sleeping/bedsharing

Practitioners who visit you to see you and your baby may review this checklist with you. Please use it yourself before you choose to bed share. Please follow safer sleep advice and contact your Midwife or Health Visitor if you have any questions. Do not sleep with your baby on your sofa or armchair this increases the risk of Sudden Infant Death Syndrome (SIDS) by up to 50 times (Lullaby Trust).

If you answer yes to any of these questions you are advised not to co-sleep/bed share due to the increased risk of SIDS (also known as cot death).

Question	Y/N	Why this increases the risk
Do either you or your partner smoke? (including during pregnancy)		Smoking increases the risk of SIDS
Have you or your partner drunk alcohol in the past 24 hours?		Any alcohol use changes your sleep pattern and increases the risk of SIDS
Have you or your partner recently taken any drugs or prescribed medication that may make you sleepy?		Taking any drugs or prescribed medication that can make you sleepy increases the risk of accidental death whilst bedsharing
Are you or your partner very tired? (less than 4 hours sleep in 24 hours)		Excessive tiredness will affect your sleep pattern and is a risk if you bed share
Was your baby born early (before 37 weeks) or weighed less than 2.5kg or 5.5lbs		Babies who are born early or who are very small are at higher risk of SIDS
To reduce the risk of SIDS it is important not to bedshare in 'out of normal routine' situations. For example, if your baby is unwell and doesn't normally bedshare with you; staying with friends; when on holiday.		If it is not your normal routine to bedshare please consider if it is safe to do so by using this check list.

Adapted from NHS North Lancashire leaflet 'Where might my baby sleep'. More information go to the Lullaby Trust.

For support and advice on sleeping your baby safely The Lullaby Trust can help
Visit: www.lullabytrust.org.uk
Contact us on: 0808 802 6869
Email: info@lullabytrust.org.uk

YOU CAN QUIT SMOKING?
Get free 1-2-1 help and support from experts
CALL NOW ON 0300 123 1044

Parent Education Programme – 'Never Ever Shake Your Baby'

The Derby and Derbyshire Safeguarding Partnership Parent Education Programme 'Never Ever Shake Your Baby' has been updated and launched in March 2023.

Non-accidental head injury (Abusive Head Trauma) involving injury to the brain is the most serious form of physical abuse and can have serious consequences for a child's future development and wellbeing. Non accidental head injury is the leading cause of death among children who have been abused.

Key considerations:

- Non-Accidental Head Injury is the most common form of abuse in babies under 2 years old
- The immediate and long-term impact is far worse than other head injuries
- Fathers or male partners are 5 times more likely to shake a baby than the mother
- Vulnerable families with more stressors in their life are more likely to shake a baby
- Persistent crying is a known factor and not necessarily due to poor parenting

The Parent Education Programme video is primarily delivered by the Midwifery Service following the births of all babies in Derby and Derbyshire. Both parents are shown the video and are given a supportive leaflet, the management of crying is discussed. The Programme is delivered before the baby is discharged from hospital. Where this is not possible including for babies born at home or those at a non-Derbyshire hospital the Programme is delivered at the first visit by the Midwife. Health Visitors then check that families have seen the video. The video is shown to all families who haven't seen it and it is shown again as appropriate. Health Visitors discuss the management of crying to both parents and take account of the vulnerability of families as part of their assessments and visits.

The Video is available to be used by other practitioners across the multi-agency partnership and can be found on the DDSCP YouTube channel. The video is available in several languages. Families should be supported when seeing the video and quality conversations should take place regarding the management of crying.

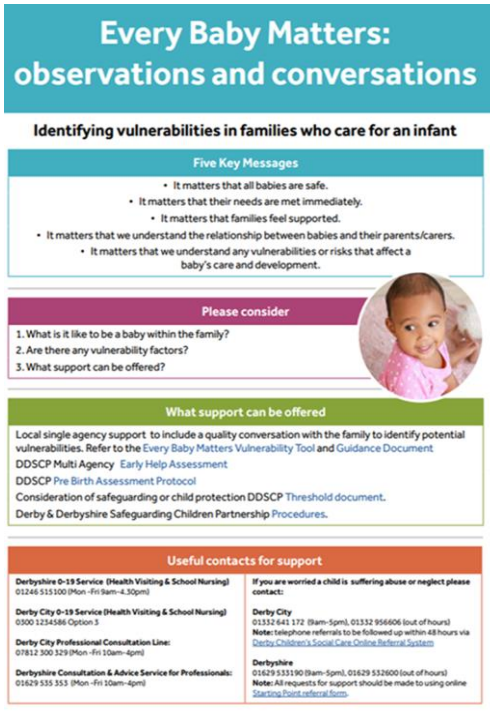
Every Baby Matters

The Derby and Derbyshire Safeguarding Childrens Partnership commissioned a child safeguarding practice review to learn from the lived experiences of two babies. The first recommendation of the review was for the partnership to develop a universal risk assessment tool that could be used within the multi-agency partnership to reinforce the intrinsic vulnerabilities of babies, to support practitioners to identify vulnerabilities within the family including anything putting the family under stress. The aim of the tool is to support practitioners to clearly identify any risks to the baby and keep the baby at the centre of any assessment and decision making.

The aim of the resources is to support practice and they are designed to be used in a way to raise awareness of the vulnerability of babies, there is a specific tool to use with families at the early help stage or as part of larger assessments or pieces of work with families. The tool can be adapted to use in the ante-natal period. The resources can also be used to support practice through training, education, and supervision particularly for newly qualified or newly into role practitioners.

Key messages:

- It matters that all babies are safe
- It matters that their needs are met immediately
- It matters that families feel supported
- It matters that we understand the relationship between babies and their parents/carers.
- It matters that we understand any vulnerabilities or risks that affect a baby's care and development.



Enhanced GP 8-week Baby Check

It is important that messages to parents around the safety of babies are delivered consistently and repeated by all practitioners who support families with babies. One 'touch point' where babies are seen in General Practice is the 8 week baby check. 6 short statements have been developed to be incorporated into the 8 week check to reinforce the messages around safer sleep and the management of crying. These appear on an electronic template and can be delivered succinctly during the baby check and are supported by a KBS leaflet.

A full evaluation of the practice and outcomes of the KBS initiatives was completed by the strategic lead for KBS on behalf of the DDSCP. Evaluation and Impact Report on Three Steps for Baby Safety sets out progress that has been made locally. This including gaining the views of families, frontline practitioners, and leaders. The report is published on the DDSCP website. Recommendations were made for the Keeping Babies Safe Steering group to consider and action appropriately. There has been real enthusiasm, some say a 'buzz' around the KBS work. Practitioners and leaders have been committed to helping families make the right choices for their baby particularly vulnerable families. The KBS work will continue and the aim that the KBS tools and resources become further embedded across the Derby and Derbyshire multi-agency partnership and babies are protected from abuse and harm.

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 the 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.

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 wider partnership.

Joint Agency Response Training

The voice of one family was a central part of the training the child death review team delivered on the Joint Agency Response (JAR). The training was aimed at practitioners particularly from health and police who take an active role in the JAR and visit the family. The team wanted to support practitioners to deliver a high standard JAR and through this appreciate each other's roles in the process and hear the voice of a family who sadly were subject to a JAR. The mother of the child shared her experiences of losing her baby and her reflections of the JAR with the group. This was an invaluable contribution, and the team can't thank her enough as it really brought to life what it feels like to be a parent in these tragic circumstances.

Assurance and Feedback from CDOP Members

To ensure that CDOP is meeting the statutory guidance (2018) it is important to give assurance to the CDR Partners that CDOP is functioning well and is sharing and disseminating the learning across the partnership.

As part of the assurance process the CDR team have asked CDOP members their views on how they feel CDOP functions and how they contribute to the wider functions of preventing future child deaths. An electronic questionnaire was completed by most CDOP members in March 2023.

The CDR Team sought a high level of assurance from CDOP members that they understand the functions of CDOP, feel that they fully contribute to the meeting and understand their role within the child death review process.

The dissemination and sharing of learning is fundamental to the work of the CDR team and CDOP. Through this questionnaire we have sought a high level of assurance from our members regarding how they utilise and disseminate the learning from CDOP. The CDR team also disseminate leaning through other groups such as JUCD Childrens Delivery Board, the Suicide Prevention Partnership and the Derby and Derbyshire Safeguarding Childrens Partnership. The team share learning regionally with the CDR Regional group and nationally with NHSE and the NCMD.

Achievements for the Child Death Review Team and CDOP

- Disseminated and monitored the impact from the learning from the themed panel for Sudden and Unexpected Deaths in Teenagers through the suicide prevention partnership.
- Influenced leaders of the multi-agency partnership on the findings and recommendations of the Themed Panel for Sudden and Unexpected Deaths in Teenagers this included writing to the Chair of the Childrens and Young Peoples Delivery Board.
- Adverse Childhood Experiences (ACEs) are recorded by CDOP when reviewing child deaths.
- Joint Agency Response (JAR) training was developed and delivered by the team to Police and health colleagues at Derbyshire Police Headquarters, 28 professionals attended.
- Assurance and feedback from the CDOP members.
- A long - term audit of non - accidental injuries in children who are presented at CDOP has been commenced.
- Learning newsletter on the dangers of water particularly open water to children have been developed and circulated.
- Maternal BMI and the risks associated with neonatal death is being recorded and monitored by the child death review team.
- The Chair of CDOP attends Maternity Transformation Programme Board.
- Guidance for practitioners on completing child death review reporting forms has been developed and disseminated.
- Themed Panel on deaths by trauma – road traffic accidents and by drowning has been held.
- Learning Newsletter on road safety and deprivation has been developed and circulated.
- CDOP continues to monitor the progress of the commissioning of community palliative care services for children.
- Investment in the bereavement teams in United Hospitals Derby and Burton and Chesterfield Royal Hospital.

Key priorities to be completed in 2023 to 2024:

- Produce a researched based Neonatal Report from the learning identified in CDOP to be shared with partners, providers, and the Maternity Transformation Programme Board.
- Monitor the numbers of neonatal deaths in comparison to the national average.
- Complete a briefing for practitioners on working with families from the travelling communities.
- Raise awareness on the importance of all children being offered swimming lessons and the importance of this life saving skill.

- Plan and deliver a development day for CDOP members, the mortality leads and bereavement nurses.
- Explore the use of deprivation tools with Public Health colleagues to support a better understanding of vulnerability of families as part of the CDOP review.
- Develop a well-being support package for CDOP members and the child death review team to enable reflection and support when listening and dealing with the sensitive and distressing nature of child death.
- Develop an alternative method of case presentation discussion to be used when reviewing cases of inflicted causes of death to enable CDOP to focus on the learning and ensure sensitive and emotional support for panel members.
- Review the guidelines for the Joint Agency Response (JAR)
- Plan further JAR training for 2024/25.