Staffordshire and Stoke-on-Trent Child Death Overview Panel

Annual Report

01 April 2017 to 31 March 2018
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1. Introduction

This is the tenth Annual Report of the Staffordshire and Stoke-on-Trent Child Death Overview Panel (CDOP) and reflects activity for the year from 01 April 2017 to 31 March 2018.

The process of reviewing child deaths was established in April 2008 as outlined in Chapter 7 of Working Together to Safeguard Children 2010 and updated in Chapter 5 of Working Together to Safeguard Children 2013 and 2015. It is the responsibility of Local Safeguarding Children Boards (LSCBs) to ensure that a review of every death of a child normally resident in their area is undertaken by a CDOP.

The overall purpose of the Staffordshire and Stoke-on-Trent Child Death Overview Panel is to undertake a multi-disciplinary review of child deaths, in order to better understand how and why children in Staffordshire and Stoke-on-Trent die and use our findings to take action to prevent other deaths and improve the health, safety and wellbeing of our children.

2. Background to the Child Death Review Process

The statutory Local Safeguarding Children Board (LSCB) responsibilities in relation to the child death review process are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. LSCBs are responsible for:

a) collecting and analysing information about each death with a view to identifying —
   (i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);
   (ii) any matters of concern affecting the safety and welfare of children in the area
        of the authority;
   (iii) any wider public health or safety concerns arising from a particular death or
         from a pattern of deaths in that area; and

b) putting in place procedures for ensuring that there is a coordinated response by the
   authority, their Board partners and other relevant persons to an unexpected death.

There are two inter-related elements to the child death review process:

- The ‘Rapid Response’
- The child death overview
The ‘Rapid Response’

Key professionals come together to enquire into and evaluate each unexpected death of a child. The principal purpose includes:

- to collate and share relevant information;
- to establish, where possible, a cause or causes of death (in conjunction with the coroner);
- to identify any contributing factors;
- to identify any potential learning;
- to provide appropriate support to the family including a co-ordinated bereavement care plan;
- to consider the welfare and support of professionals involved with the child/family;
- to prepare a final report for submission to CDOP and arrange feedback from the family.

The ‘Rapid Response’ processes are outlined in more detail at Part 10 of the Staffordshire and Stoke-on-Trent Safeguarding Children Board procedures (available at www.staffsscb.org.uk and www.safeguardingchildren.stoke.gov.uk).

The Child Death Overview Panel

The Staffordshire and Stoke-on-Trent Safeguarding Children Boards have come together to form a joint Child Death Overview Panel. The panel has two distinct elements:

i. Case reviews

- The panel categorise a cause of death, identify any environmental, extrinsic, medical or personal modifiable factors that may have contributed to the death and consider any agency/SCB/regional or national recommendations to help prevent future deaths.

ii. Business arising

- The panel considers the business arising from case reviews and the other responsibilities and statutory functions of CDOP.
**Membership of CDOP**

CDOP has a fixed core membership with flexibility to co-opt other relevant professionals as and when appropriate, e.g. representatives from West Midlands Ambulance Service, the West Midlands Paediatric Palliative Care Network, the regional police Collision Investigation Unit and a Neonatologist from Royal Stoke University Hospital.

During the period 01 April 2017 to 31 March 2018 Chair, D/Supt Javid Oomer, Manu Sundaram, Mark Tolley, Caroline Dodd, and Deborah Ward left the panel and CDOP would like to extend their thanks to Javid, Manu, Mark, Caroline and Deborah for their contribution to the group.

D/Supt Jennie Mattinson was appointed as Chair in February 2018. Paula Carr, an experienced member of the panel, remains as Deputy Chair.

The CDOP were pleased to welcome new member Paul Cooke, Detective Inspector Safeguarding, Staffordshire Police.

Membership of the Staffordshire and Stoke-on-Trent Child Death Overview Panel as at 31 March 2018 is attached as Appendix A.

**Statutory Responsibilities of the Child Death Overview Panel**

The functions of the CDOP are laid down in statutory guidance (Chapter 5 of Working Together to Safeguard Children 2015) and are attached as Appendix B.

Working Together to Safeguard Children (2015) confirms that the LSCB has responsibility for the provision of a Designated Person. In Staffordshire and Stoke-on-Trent this function is fulfilled by the Child Death Co-ordinator, a position jointly funded by both the Staffordshire and Stoke-on-Trent SCBs and a key member of the joint CDOP. All child deaths are to be notified to the Child Death Co-ordinator and it is their responsibility to co-ordinate the information collection.

This section summarises all deaths notified to the Staffordshire and Stoke-on-Trent CDOP between 01 April 2008 and 31 March 2018 and provides additional information in relation to gender, age, ethnicity. It includes all children who are normally resident in the area but who have died elsewhere. The data is collected from the database of notifications to CDOP.
Notifications

Between April 2008 and March 2018 there have been a total of 767 deaths of children and young people under the age of 18 years and normally resident in Staffordshire and Stoke-on-Trent. The total number of deaths between April 2017 and March 2018 is 53, and during this period 76 deaths were reviewed. Year on year variation in notifications is to be expected but the overall number of notified deaths are at the lowest for the reporting period since the panels formation in 2008. It is not possible to comment further on this data until those deaths have been reviewed over the coming year.
Gender

Since the introduction of CDOP in April 2008 boys’ deaths nationally have consistently accounted for over half (56%) of all notifications. The reporting period from April 2017 to March 2018 demonstrated a local position in keeping with this national picture.
### Age

#### Age Range for All Deaths (2008-18)

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>0-27 days (neonatal)</td>
<td>30</td>
<td>49</td>
<td>34</td>
<td>45</td>
<td>42</td>
<td>32</td>
<td>28</td>
<td>33</td>
<td>25</td>
<td>27</td>
</tr>
<tr>
<td>28-364 days (postnatal)</td>
<td>17</td>
<td>24</td>
<td>25</td>
<td>18</td>
<td>27</td>
<td>9</td>
<td>26</td>
<td>14</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td>1-4 years</td>
<td>5</td>
<td>13</td>
<td>7</td>
<td>5</td>
<td>9</td>
<td>3</td>
<td>8</td>
<td>7</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>5-9 years</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>10-14 years</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>2</td>
<td>5</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>15-18 years</td>
<td>9</td>
<td>13</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>
**Ethnicity**

Please note as per the Office for National Statistics and the Health and Social Care Information Centre guidance relating to the publication of births and death statistics, a count of less than 5 data is suppressed. As such, suppressed data has not been reported on and is represented by ‘0’ in the table below. With relatively rare events such as child deaths, small variations each year can appear to represent a significant difference in overall numbers.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>White: English/Welsh/Scottish/Northern Irish/British, White: Irish, White: Gypsy or Irish Traveller, White: Any Other White background</td>
<td>35</td>
<td>65</td>
<td>63</td>
<td>50</td>
<td>62</td>
<td>37</td>
<td>51</td>
<td>52</td>
<td>63</td>
<td>40</td>
</tr>
<tr>
<td>Mixed/ multiple ethnic groups: White &amp; Black Caribbean, White &amp; Black African, White &amp; Asian, Mixed/multiple ethnic groups: Any other mixed/multiple ethnic background</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Asian or Asian British: Indian, Pakistani, Bangladeshi, Chinese, Any other Asian background</td>
<td>6</td>
<td>8</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>11</td>
<td>12</td>
<td>9</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Black / Black British: Caribbean, African, Any other Black / Black British/African/Caribbean background</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Other: Any other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Unknown / not stated</td>
<td>24</td>
<td>26</td>
<td>12</td>
<td>15</td>
<td>20</td>
<td>9</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
4. CDOP Findings (2017-18)

The Staffordshire and Stoke-on-Trent CDOP met 5 times between 01 April 2017 and 31 March 2018 and reviewed 76 cases. Reviewing deaths involves collating information on the cause, location and other circumstances of the death, but is not an investigation into why a child has died.

The panel does not normally review cases until all information is gathered and other processes have been completed such as coronial inquests, criminal investigations and serious case reviews (SCR’s).

The dates of death of the cases reviewed by the Staffordshire and Stoke-on-Trent CDOP were as follows:

<table>
<thead>
<tr>
<th>Date of Death</th>
<th>Before April 2014</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviews during 2017/18</td>
<td>2</td>
<td>4</td>
<td>15</td>
<td>39</td>
<td>16</td>
</tr>
</tbody>
</table>
Unexpected Child Deaths

An unexpected death is defined as the death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death (Working Together to Safeguard Children 2015). Unexpected deaths require a ‘Rapid Response’ approach.

Of the 54 notifications in the reporting period 2017/18, 12 were categorised as ‘unexpected’, although a few children had known life limiting conditions.

#### Unexpected Child Deaths 2008-2018

<table>
<thead>
<tr>
<th>Year</th>
<th>Stoke-on-Trent</th>
<th>Staffordshire</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>7</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>2009/10</td>
<td>9</td>
<td>23</td>
<td>32</td>
</tr>
<tr>
<td>2010/11</td>
<td>7</td>
<td>19</td>
<td>26</td>
</tr>
<tr>
<td>2011/12</td>
<td>9</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>2012/13</td>
<td>8</td>
<td>20</td>
<td>28</td>
</tr>
<tr>
<td>2013/14</td>
<td>6</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>2014/15</td>
<td>6</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>2015/16</td>
<td>5</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>2016/17</td>
<td>14</td>
<td>27</td>
<td>41</td>
</tr>
<tr>
<td>2017/18</td>
<td>4</td>
<td>8</td>
<td>12</td>
</tr>
</tbody>
</table>

#### Of the 12 sudden and unexpected Child Deaths four were female and eight were male.
Categorisation and Preventability of Child Deaths

The CDOP categorises the likely/cause of death using a national scheme that is hierarchical and where more than one category could be reasonably applied the highest up the list should be marked. Details of the ten categories are attached at Appendix C.

Preventable child deaths are those in which modifiable factors may have contributed to the death. These factors are defined as those where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced (Working Together to Safeguard Children 2015). Details of the criteria for modifiable factors used nationally by CDOPs are attached as Appendix D.

The table below sets out the categorisation of the 76 cases reviewed by CDOP during this reporting period and where modifiable factors were identified.
Modifiable Factors from REVIEWED Deaths

The meaning of modifiable factors was amended slightly in Working Together to Safeguard Children 2015 – those factors ‘where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced’.

• Modifiable factors were identified in 19 reviewed deaths (%)
  • 16 cases with modifiable factors related to children aged under 1 year
  • 9 cases had modifiable factors associated with sleeping arrangements
  • Smoking was identified as a modifiable factor in 12 of the 19 cases
  • Alcohol / Drug use was identified in 6 cases
  • Consanguinity was identified in some cases

A statutory function of the CDOP is to identify and refer cases of concern to the SCB Serious Case Review (SCR) Sub-groups. The Staffordshire and Stoke-on-Trent CDOP has some shared membership with the SCR Sub-groups and from reviewed cases three were forwarded for consideration of SCR. One of these cases met the threshold for SCR and one had a local learning review. It is of note that there are a number of earlier opportunities for cases to be referred for review by the relevant LSCB SCR Sub group before the formal CDOP stages.
Modifiable Factors from ALL Deaths from 01 April 2015 – 31 March 2018

Please note that some deaths from these periods are yet to be reviewed.

2015-2016 IDENTIFIED MODIFIABLE FACTORS IN ALL DEATHS

- Poor parenting/neglect
- Mental Health
- Environment
- Smoking/ and or smoking during pregnancy
- Consanguinity
- Not accessing healthcare/seeking medical assistance
- Unsafe sleeping environment
- Alcohol

2016-2017 IDENTIFIED MODIFIABLE FACTORS IN ALL DEATHS

- Poor parenting/neglect
- Mental Health
- Environment
- Smoking / and or smoking during pregnancy
- Consanguinity
- Not accessing healthcare/seeking medical assistance
- Unsafe sleeping environment
- Alcohol

2017-2018 IDENTIFIED MODIFIABLE FACTORS IN ALL DEATHS

- Poor parenting/neglect
- Mental Health
- Environment
- Smoking - during pregnancy and after/partners
- Consanguinity
- Not accessing healthcare/seeking medical assistance
- Unsafe sleeping environment
- Domestic Violence
- Alcohol
5. Developments During 2017-2018

Safer Sleeping Campaign

UNICEF and the Lullaby Trust recommends the safest place for a baby to sleep for the first six months is in a separate cot or moses basket in the same room as parents/carers – day and night.

Staffordshire and Stoke-on-Trent CDOP continues to promote safer sleeping through the CDOP Safety Booklet, promotion of Safer Sleep Week through CDOP Prevention Newsletter, the Safe Sleep Assessment and Safer Sleeping Workshops. Bed sharing increases the change of Sudden Infant Death Syndrome (SIDS) and is particularly dangerous if:

- Parents/carers smoke (even if it’s not in the bedroom)
- Parents/carers have drunk alcohol or taken drugs (including medications that may make them drowsy)

Similarly, bed sharing with a baby of low birth weight or a premature baby (37 weeks or less) is strongly linked to an increased risk of SIDS.
During this reporting period there were 3 deaths where modifiable factors associated with co-sleeping/unsafe environment were identified.

As is displayed in the previous pie diagrams on page 16 - co-sleeping with modifiable environmental factors / sleeping in an unsafe environment remains a factor in sudden and unexpected preventable deaths.

Smoking during pregnancy / smoking by parents and carers continues to be identified as a modifiable factor in all deaths.
The ‘Protect your little Bundle’ safety booklet was updated and re-printed in February 2017. This booklet continues to be funded and circulated for the next 2 years through Public Health and is targeted through the health visitors to all new parents and carers. Families are encouraged to share information and booklets with their extended family, i.e. grandparents, and additional copies are available. An electronic version of the booklet is available on each LSCB website.

The safety advice given is consistent with the priorities identified in the Public Health England/RoSPA/CAPT June 2014 publication ‘Reducing unintentional injuries in and around the home among children under five years’ and reflects key safety messages identified in respect of local child deaths.
Child Death Nurse Practitioners

......An update from our Child Death Overview Panel Nurse in South Staffordshire:

From April to November 2017 the CDOP Nurse for South Staffordshire, Rebecca Sage was on Maternity Leave. Senior Sister, Caroline Dodd, provided cover on a part-time basis (24 hours per week) and acted as a contact point for professionals and families. Ongoing projects and preventative work was paused until Rebecca’s return in November 2017, when role commitments were quickly re-established.

From November, Child Death Panel and sudden unexpected death awareness sessions were arranged and completed within key areas of the Hospital. Ongoing links are currently being forged with intensive care units and Rebecca is collaborating with key bereavement staff within the trust to build foundations to enhanced bereavement support to include elements of the SWAN model.

Future aspirations for Rebecca include developing regional multi-agency CDOP/joint agency investigation training for staff. This will be designed to coincide with the proposed plan for the new Child Death Review guidance and updates to Working Together to Safeguard Children.

The Lullaby Trust’s safer sleep awareness week took place from 12-18 March 2018, and in support Rebecca held two awareness stands on the 14 and 15 March at Burton Hospitals. During awareness week the ‘three in the bed’ campaign was displayed on the hospitals computer screensaver, and details of the stand and safer sleep messages were shared on social media.

The launch of the countywide safer sleep workshops followed on from safer sleep week, kicking off on the 27 March 2018. The training package was updated to reflect current and best practice.

Rebecca has also been collaborating with midwifery services at Burton Hospitals to support the development of the ‘shaking your baby is just not the deal’ parent education programme to prevent the non-accidental head injury in infants. Plans are in place for this programme to be launched in 2018.
……An update from our Clinical Nurse Specialist for Child Death Reviews in North Staffordshire and Stoke-on-Trent:

From a solid paediatric base, Gill has endeavoured to continue with her strong philosophy of family centred care throughout the Child Death Review process. Based from the learning from the cases last year, there has been a strong need to empower professionals involved, to be able to be an advocate and a voice for the families in order to facilitate what matters to them, not only in the first hours after death but during the review process.

This has been positively evaluated by the nursing staff who have attended update sessions for the Child Death Review process.

Within the Child Health Directorate it has been recognised that there have been inconsistencies in the bereavement care for families depending on where their child dies. In response to this a Liaison Nurse for the Paediatric Intensive Care Unit has been employed and funding has been secured for a Bereavement Nurse within Child Health. The vision is that a virtual team consisting of CNS Child Death Reviews, Liaison Nurse for Paediatric Intensive Care Unit and a Paediatric Bereavement Nurse, will facilitate improved and consistent bereavement care across all areas within the Child Health Directorate.
Bereavement Services

CDOP have built on their extensive work during 2016/2017 and continue to support the Stoke-on-Trent and Staffordshire Children’s Palliative Network and hosted for the second time an alliance study day. The event was attended by over 100 professionals...another event is planned later in 2018.

Panel members Faith Lindley-Cooke and Rebecca Sage, along with DI Victoria Downing from Staffordshire Police met with Fiona Murphy MBE, Associate Director of Nursing Bereavement Support, Salford, Bolton and Wigan NHS at the start of the year to discuss her pioneering work in bereavement support. Fiona has led an innovative nurse-led bereavement service that has transformed services across three large acute trusts, which also provided support following the terrorist attack at the MEN Arena. Staffordshire are currently developing their own bereavement support plans, learning from the SWAN model and shared data.

A day-long event ‘collaborative bereavement ‘has been arranged for the 24th April to introduce the work of the SWAN model of care.
The newsletter is widely circulated to all LSCBs members and front-line practitioners working with children and their families. It is also shared with other key local partner agencies and forums. This information is publicly available on the LSCB websites.

The newsletter has been re-named ‘Child Death Prevention Newsletter’
Other Developments

Throughout 2017/18 Staffordshire and Stoke-on-Trent CDOP has continued to work with partners locally and nationally to continue to develop the functions and responsibilities of CDOP. This year we have:

- Continued to attend and support the National Network of CDOPs to share best practice, exchange information and collectively support each other to prevent and reduce child deaths.

- Continued to attend and support the West Midlands CDOP Network and build on regional relationships. This network shares local good practice and takes forward identified issues both regionally and nationally. A workshop was arranged at Bescott Stadium in Walsall.

- Continued to work with regional colleagues in the palliative care network to improve the quality of Advanced Care Plans to support children and young people and their families in circumstances where there are life limiting conditions. A Bereavement Study Working Day was held in October 2017 at Police Headquarters.

- The CDOP has also continued to work with colleagues and external agencies, and collaborate with safety alerts and campaigns. CDOP newsletter are cascaded down through agencies to share learning and raise awareness to pick up on both local and national trends.

- Continue to support and promote the work of local and national support charities and raise awareness of key safeguarding issues.

- The ‘protect your bundle’ safety booklet has been updated and new paper copies continue to be circulated to all new parents and carers throughout the county by health visiting teams across the county.

- Work with national organisations to promote safety and assist in relational co-ordination.
6. Looking Forward to 2018/19

The Staffordshire and Stoke-on-Trent Child Death Overview Panel Business Plan (2018/19) is attached as Appendix E and will continue to focus on our overall purpose of preventing future deaths and improving the health, safety and wellbeing of our children. It will continue to build on the strong joint arrangements between the Staffordshire and Stoke-on-Trent Safeguarding Children Boards. CDOP Business Plan for 2018/19 is available from the respective LSCB websites:

- [www.staffsscb.org.uk](http://www.staffsscb.org.uk)
- [www.safeguardingchildren.stoke.gov.uk](http://www.safeguardingchildren.stoke.gov.uk)

Other CDOP activity for 2018/19 will enhance our objectives outlined in the Business Plan and will include the following:

- To respond to demand from professionals and work with colleagues from the Staffordshire Children & Families Bereavement Alliance.
- To respond to demand from professionals to continue to deliver Safer Sleep Awareness Workshops to support multi-agency practitioners in their role in preventing and reducing Sudden Infant Death Syndrome.
- To build on the work undertaken with Staffordshire Police to enhance their response to investigating child deaths and use this learning to refresh the LSCB child death procedures in line with the expected new national changes.
- To continue to develop the support available to bereaved families through working with local services to develop support networks, such as the ‘Star Café’ at venues across the county.
- To respond to recommendations relevant to CDOP from the national review of LSCBs and update guidance as required.
- To participate in learning reviews and disseminate information/learning through agencies to improve services.
- To update the CDOP web pages contained within the LSCB safeguarding board websites to promote consistency across the county. Create short easy process guides for professionals in relation to the CDOP process.
- Participate and aid in the development of a regional learning day/conference.
- Participate and deliver multiagency training to promote the Child Death Overview Panel and its support and review functions.
### Appendix A: CDOP Membership at 31 March 2018

<table>
<thead>
<tr>
<th>Member</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jennie Mattinson</td>
<td>Chair, Detective Superintendent Staffordshire Police</td>
</tr>
<tr>
<td>Paula Carr</td>
<td><strong>Deputy Chair</strong> Designated Nurse for Child Protection, Stoke-on-Trent Clinical Commissioning Group</td>
</tr>
<tr>
<td>Faith Lindley-Cooke</td>
<td>Child Death Co-Ordinator</td>
</tr>
<tr>
<td>Azhar Manzoor</td>
<td>Designated Doctor for Unexpected Death, South Staffordshire</td>
</tr>
<tr>
<td>Martin Samuels</td>
<td>Designated Doctor for Unexpected Death, North Staffordshire &amp; Stoke-on-Trent</td>
</tr>
<tr>
<td>Alex Tabor</td>
<td>Designated Doctor for Unexpected Death, North Staffordshire &amp; Stoke-on-Trent</td>
</tr>
<tr>
<td>Paul Cooke</td>
<td>Detective Inspector, Staffordshire Police</td>
</tr>
<tr>
<td>Rebecca Sage</td>
<td>Child Death Nurse Practitioner, South Staffordshire (role covered from March – Oct 2017 by Caroline Dodd)</td>
</tr>
<tr>
<td>Gill Devine-Skellern</td>
<td>Clinical Nurse Specialist for Child Death Reviews, North Staffordshire &amp; Stoke-on-Trent</td>
</tr>
<tr>
<td>Carole Preston</td>
<td>Stoke-on-Trent Safeguarding Children Board Manager</td>
</tr>
<tr>
<td>Carrie Wain</td>
<td>Staffordshire Safeguarding Children Board Manager</td>
</tr>
<tr>
<td>Angela Jervis</td>
<td>Head of Safeguarding, Staffordshire &amp; Stoke-on-Trent Partnership NHS Trust</td>
</tr>
<tr>
<td>Stephanie Lowe</td>
<td>Designated Nurse for Safeguarding and Looked After Children South East Staffordshire &amp; Seisdon Peninsula Clinical Commissioning Group</td>
</tr>
<tr>
<td>Andrea Muirhead</td>
<td>Children and Young People Public Health Lead, Stoke-on-Trent Directorate : Public Health</td>
</tr>
<tr>
<td>Natalie Kelly</td>
<td>Child Health and Wellbeing Commissioning Lead, Families and Communities Staffordshire County Council (role currently covered by Tilly Flanagan)</td>
</tr>
<tr>
<td>Teresa Murray</td>
<td>County Manager, Specialist Safeguarding North, Staffordshire County Council</td>
</tr>
<tr>
<td>Sue Cope</td>
<td>Safeguarding Team Leader (Staffordshire) Birmingham Community Healthcare</td>
</tr>
</tbody>
</table>

**Independent Chair**
Staffordshire and Stoke-on-Trent Safeguarding Children Board – John Wood
Appendix B: Statutory Responsibilities of the CDOP

The functions of the CDOP are laid down in statutory guidance (Chapter 5 of Working Together to Safeguard Children 2015) and include:

- Reviewing all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- Collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
- Discussing each child’s case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
- Determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- Making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- Identifying patterns or trends in local data and reporting these to the LSCB;
- Where a suspicion arises that neglect or abuse may have been a factor in the child’s death, referring a case back to the LSCB Chair for consideration of whether an SCR is required;
- Agreeing local procedures for responding to unexpected deaths of children; and
- Co-operating with regional and national initiatives – for example, with the National Clinical Outcome Review Programme – to identify lessons on the prevention of child deaths.

In reviewing the death of each child, the CDOP should consider modifiable factors, for example in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level.

The aggregated findings from all child deaths should inform local strategic planning, including the local Joint Strategic Needs Assessment, on how to best safeguard and promote the welfare of children in the area. Each CDOP should prepare an annual report of relevant information for the LSCB. This information should in turn inform the LSCB annual report.
## Appendix C: Categorisation of Child Deaths

<table>
<thead>
<tr>
<th>Category</th>
<th>Name &amp; description of category</th>
<th>Tick box below</th>
</tr>
</thead>
</table>
| 1        | Deliberately inflicted injury, abuse or neglect  
This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death. | ☐ |
| 2        | Suicide or deliberate self-inflicted harm  
This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children. | ☐ |
| 3        | Trauma and other external factors  
This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflicted injury, abuse or neglect. (category 1). | ☐ |
| 4        | Malignancy  
Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc. | ☐ |
| 5        | Acute medical or surgical condition  
For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy. | ☐ |
| 6        | Chronic medical condition  
For example, Crohn’s disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause. | ☐ |
| 7        | Chromosomal, genetic and congenital anomalies  
Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac. | ☐ |
| 8        | Perinatal/neonatal event  
Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. **Includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week). | ☐ |
| 9        | Infection  
Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc. | ☐ |
| 10       | Sudden unexpected, unexplained death  
Where the pathological diagnosis is either ‘SIDS’ or ‘unascertained’, at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5). | ☐ |
Appendix D: Preventability of Child Deaths (Modifiable Factors)

Preventable child deaths are those in which modifiable factors may have contributed to the death. These factors are defined as those factors where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced.

*(Working Together to Safeguard Children 2015)*

The CDOP is required to assess modifiable factors. This assessment does not in itself carry any implication of blame but simply acknowledges where factors are identified which, had they been different, may have resulted in the death being prevented.

The criteria now used nationally are shown in the table below:

<table>
<thead>
<tr>
<th>Modifiable factors identified</th>
<th>The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Modifiable factors identified</td>
<td>The panel have not identified any potentially modifiable factors in relation to this death</td>
</tr>
<tr>
<td></td>
<td>Inadequate information upon which to make a judgement. <em>NB this category should be used very rarely indeed.</em></td>
</tr>
</tbody>
</table>


## Child Death Overview Panel Business Plan 2018/19

**Key Objective:** Create and maintain a learning system and ensure a coordinated response to child deaths

<table>
<thead>
<tr>
<th>No</th>
<th>Objective</th>
<th>Detail</th>
<th>By Who</th>
<th>Timescale</th>
<th>Result and Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Agree continued joint funding arrangements with Staffordshire and Stoke-on-Trent LSCBs</td>
<td>CDOP chair to agree with Exec and Board members the ongoing funding arrangements. Joint funding arrangements to be confirmed for 2018-2019.</td>
<td>CDOP Chair/ LSCBs</td>
<td>April 2018</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>To collect, analyse information and create campaign information to determine those deaths where modifiable factors may have contributed and to identify actions that could be taken through national or local interventions to reduce the risk of future child deaths and improve the health and safety of children</td>
<td>Preventable and potentially preventable deaths are examined and appropriate actions identified by CDOP members to ensure any risk factors are addressed. Twice yearly ‘Themes and Trends’ data will be produced and circulated to members.</td>
<td>CDOP members</td>
<td>April 2018 -March 2019</td>
<td></td>
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<tr>
<td></td>
<td>To produce a CDOP Annual Report which includes patterns or trends in local data and recommendations on action required to help improve the health and safety of children living in Stoke-on-Trent and Staffordshire.</td>
<td>An annual CDOP report is produced to evidence the work undertaken by CDOP and to identify any local safety trends or themes. Any recommendations to prevent future deaths must be shared (as applicable) with the LSCB, Health and Wellbeing Board (HWB), local public health services &amp; /or the Children's Strategic Partnership (CSP) and appropriate action to help to reduce the risk must be taken by the relevant organisation or strategic Board.</td>
<td>CDOP members</td>
<td>September 2019</td>
<td></td>
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<td>---</td>
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<tr>
<td>4</td>
<td>To ensure that local procedures and protocols for responding to unexpected deaths of children are developed.</td>
<td>To work with partners to develop local procedures to support an effective and appropriate multi-agency response to unexpected child deaths. This response will help to support grieving parents and relatives of the child, enable a multi-agency understanding of any modifiable factors and will inform activity required to safeguard any siblings and any future children who may be born into the family concerned.</td>
<td>CDOP members</td>
<td>April 2018 -March 2019</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>To deliver a bespoke bereavement model, tailored to the needs of the parents/carers and siblings.</td>
<td>Support and assistance is given to parents/carers and siblings through Child Death Nurse Practitioners for sudden and unexpected deaths.</td>
<td>CDOP members</td>
<td>April 2018 -March 2019</td>
<td></td>
</tr>
</tbody>
</table>
Child Death Nurses to continue to support the work of the Designated Doctors for Unexpected Deaths (DDUDS) in providing support for bereaved families.

<table>
<thead>
<tr>
<th>6</th>
<th>The CDOP partnership is strengthened through making strategic links with other relevant forums and networks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To co-operate with local, regional and national partners and initiatives to identify lessons on the prevention of child deaths.</td>
</tr>
<tr>
<td></td>
<td>To work with local and regional partners to capture data and learning from neonatal deaths.</td>
</tr>
<tr>
<td></td>
<td>To engage with local and regional Palliative Care networks to capture learning from expected child deaths.</td>
</tr>
<tr>
<td></td>
<td>To receive reports from local strategic partnerships in respect of road traffic child deaths</td>
</tr>
<tr>
<td></td>
<td>To continue to provide robust links with the National Learning Disabilities Mortality Review Programme, support the programme and review in the deaths of children with learning disabilities.</td>
</tr>
<tr>
<td></td>
<td>CDOP members</td>
</tr>
<tr>
<td></td>
<td>April 2018 - March 2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7</th>
<th>Where a suspicion arises that neglect or abuse may have been a factor in the child’s death, to notify the Chair of the LSCB of those</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>To ensure that appropriate cases are referred to identify lessons learned to better safeguard and promote the welfare of children.</td>
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<tr>
<td></td>
<td>CDOP members</td>
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<td></td>
<td>April 2018 - March 2019</td>
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<tr>
<td></td>
<td>concerns for consideration of a Serious Case Review scoping panel</td>
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<td>---</td>
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<tr>
<td>8</td>
<td>Aggregated findings from all child deaths should be used by CDOP to inform strategic planning and the local Joint Strategic Needs Assessment (JSNA). <em>WT Action Plan Recommendation 46</em></td>
</tr>
<tr>
<td>9</td>
<td>A prevention campaign of harm and awareness to focus on teens and adolescence.</td>
</tr>
</tbody>
</table>
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