Cumbria Safeguarding Children Partnership

CSCP

Child Death Overview Panel Annual Report

1st April 2022 – 31st March 2023

Foreword

This is the last year that I have chaired Cumbria CDOP before handing over to my Public Health colleague, who will continue to ensure that CDOP provides the oversight and assurance of the child death review process to the statutory partners.

This annual report reflects on the learning from those cases the panel considered throughout 2022-23, the achievements of the panel and our priorities for the year 2023-24. Although during this time period the Covid restrictions had been removed, the CDOP was mindful of the indirect impact the pandemic continued to have on child deaths. The panel have initiated multi-agency working groups to take forward key areas of learning from the deaths reviewed, thus strengthening our response to child deaths.

Virtual working is now a way of life, and I would like to thank our panel members in ensuring that we have continued to review child deaths effectively and efficiently throughout this year. This could not have been possible without the work behind the scenes of our CDOP administrator who ensures the panels run smoothly. It has been a pleasure to work with a panel of multi-agency partners who share a commitment to safeguard children and young people and reduce the risk of child death.

Kirsty Cleary
Chair of Child Death Overview Panel

Contents

Introduction

The death of a child is a devastating loss that profoundly affects all those involved. Since April 2008 all deaths of children up to the age of 18 years, excluding still births and planned terminations should be reviewed by a Child Death Overview Panel (CDOP) to accommodate the national guidance and statutory requirements. From 1st April 2019 notifications of still births and planned terminations where a clinician is not present have been notified and reviewed by the CDOP.

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

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

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

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

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

Child Death Review (CDR) Process

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

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

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

The process for expected deaths: the death of an infant or child which was anticipated following on from a period of illness that has been identified as terminal differs slightly as they do not usually require a JARM.
Supporting and engaging with a family who have lost a child is of the utmost importance throughout the whole child death review process. Recognising the complexities of the process and the differing emotional responses that bereavement can bring, families are given a single named point of contact, called a 'key worker'. Regardless of the professional background this person should

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

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

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

Child Death Overview Panel

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

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

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

The functions of the CDOP are:

- To collect and collate information about each child death, seeking relevant information from professionals;
- To analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;
- To make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and well-being of children;
- To notify the Child Safeguarding Practice Review Panel (CSPR) and Local Safeguarding Partnership (LSP) when it suspects that a child may have been abused or neglected;

- To notify the Medical Examiner and the Doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;
- To provide specified data to the National Child Mortality Database (NCMD); to produce an annual report for child death review partners on local patterns and trends in child deaths, any lessons learnt, and actions taken, and the effectiveness of the wider child death review process; and
- To contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

Although during this time period the COVID restrictions had been removed, the CDOP remained mindful that there may still have been impacts of the Covid-19 pandemic, that may have had an impact on child deaths as an indirect result of Covid-19. This could include deaths from abuse as a result of domestic violence, deaths from late presentation of serious medical conditions (either due to an assumption the symptoms were Covid-19 related, or due to a reluctance or inability to present to medical services in a timely manner) and potentially deaths due to other infectious diseases as a result of delayed vaccination during the pandemic. During 2022/23, there was 1 notification of a death that directly related to Covid-19, however, this case was reviewed in the reporting year 2023/24 (May 2023).

Introduction of the eCDOP system in Cumbria

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

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

Membership and Panel Meetings

The Child Death Overview Panel meetings are held on a bi-monthly basis and have had consistent organisational commitment since they were established in 2008. Membership for April 2022-March 2023 can be seen below:

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

Data Analysis

Total Number of Infant and Child Deaths

A total number of 18 children residing in Cumbria died in 2022/23. During this time a total of 11 cases were reviewed and signed off for that year.

Since 2018/19, the number of deaths has remained similar, with an increase in 21/22 as detailed in table 1, for this year the number of deaths were under 20 for the first time in the last 5 years, however, this is not statistically significant due to low numbers and should be used with caution when drawing conclusions.

Graph 1 – Number of child deaths annually since 2018/19

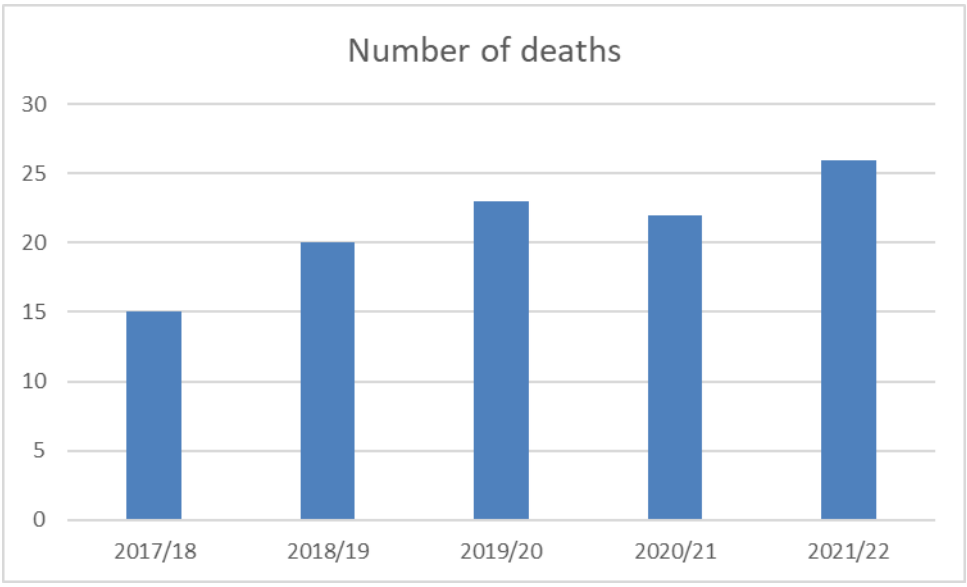


Table 1 – Number of child deaths annually since 2018/19

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

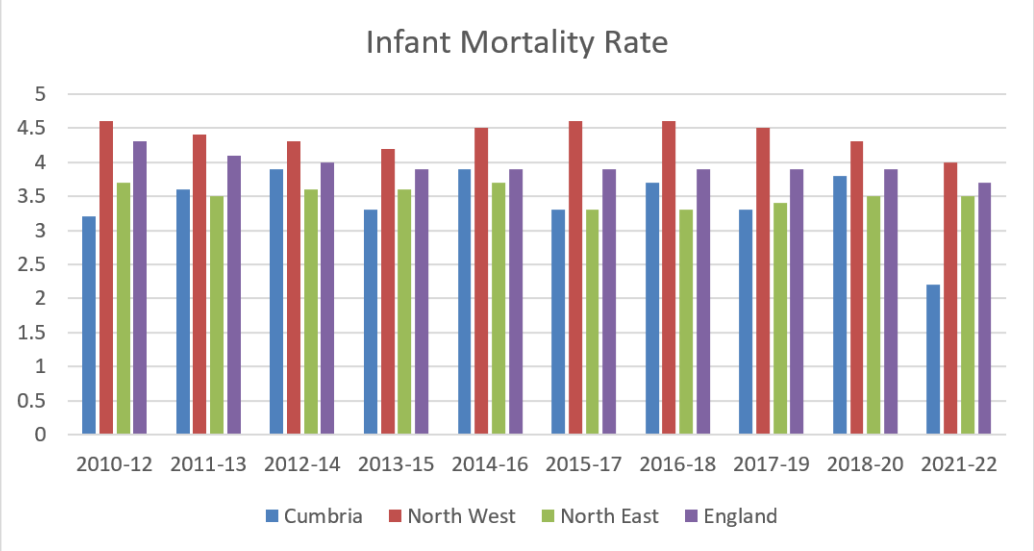
Source – Cumbria CDOP data

Cases Closed by the CDOP

Once the CDRM has taken place, all investigations have concluded and sufficient information has been collated, the CDOP holds the final multi-disciplinary review. Examining deaths using the data of cases discussed and closed at panel, provides a full dataset to conduct analysis. This annual report focuses on data relating to the 11 cases discussed and closed by the CDOP from 1 April 2022 to 31 March 2023 (2022/23). Of the 11 cases closed during 2022/23, all of them were historical cases, where the death occurred prior to 1 April 2022. Year on year, there has been variations in the number of cases closed by the Cumbria CDOP, with an average of 19 cases closed per year.

During 2022/23, the Panel reviewed and signed off a total of 11 cases, all of which occurred during the year 2021/22. Cases can take over six months and longer to be brought to Panel for review. This may be because the CDOP is awaiting information from agencies, for example post-mortem reports or if there is an on-going Police investigation, in which case the discussions may be deferred pending the result of the enquiry. It should be noted that the child's death cannot be discussed at Panel until all information is received.

Graph 2 – Numbers of cases signed of each year.



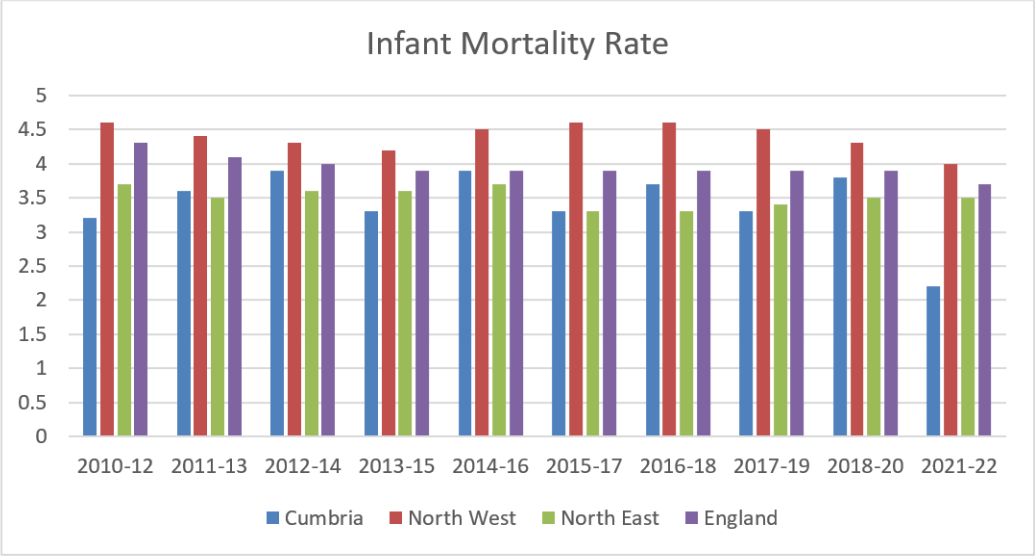
Source – Cumbria CDOP data - please note that not all cases signed off will have necessarily passed away in that year.

Delays in 2022/23 were due to both challenges in accessing adequate information and other statutory processes. This has been identified as an issue nationally, it has been recognised by the NCMD programme team that the interface between the CDRM and CDOP process will impact the timescale of completed reviews due to operational aspects of the revised child death review process. The circumstances leading to death and the nature of the death also impact upon the number of cases closed by the CDOP. Deaths where the cause appears to be unnatural, sudden, and unexpected can be subject to multiple investigations that can remain ongoing for a number of years, which impacts on the timeliness of the CDOP review.

Work will be undertaken in 2023/24 to identify if there are any internal processes within the CDOP which can be improved to reduce any delays in cases being reviewed and signed off.

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

Graph 3 – Infant mortality rate per 1000 population

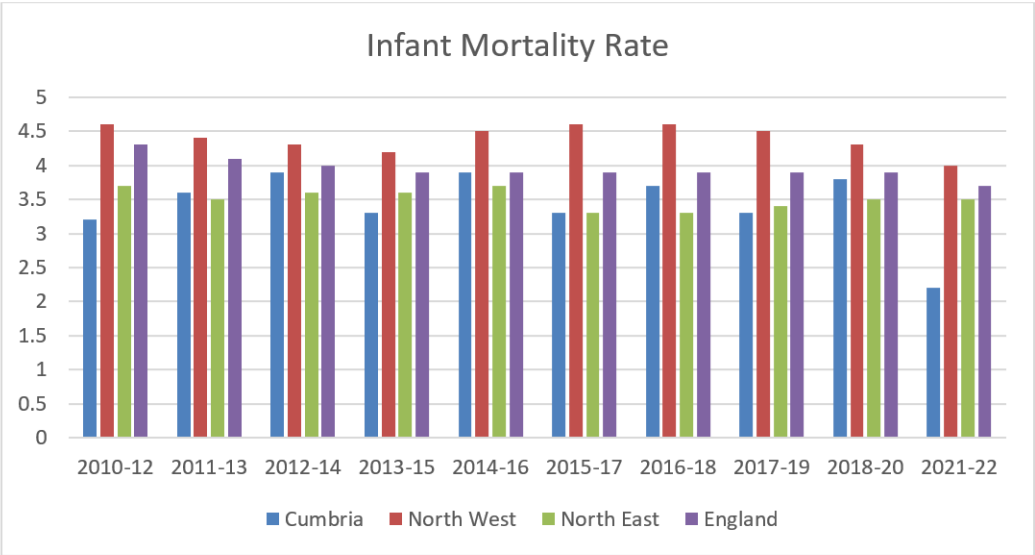


Source: Office for National Statistics (ONS)
Crude rate - per 1000

The most recent data shows that there has been a small decrease in the infant mortality rate (babies under 1 year of age) in Cumbria in the reporting period 2019-21, however, this is not statistically significant due to low numbers and should be used with caution when drawing conclusions. Nationally, rates have remained relatively stable in recent years.

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

Graph 4 – Child mortality rate (1-17 years) per 100,000 population



Source: Office for National Statistics (ONS)

Directly standardised rate - per 100,000

The child mortality rate at a local authority level for 2021 to date has not currently been published by the Office for National Statistics. The most recent data shows there was a small increase in the child mortality rate in Cumbria 2018-20, however, this is not statistically significant due to low numbers and should be used with caution. Cumbria continues to have a lower rate than the North West, North East and England as a whole, it is to be noted that due to the small number of deaths in Cumbria there can be variability in the annual data.

In the most recent published Office for National Statistics on infant and child death 2021, the child mortality rates (1-15 years) in England was 8 deaths per 100,000 population. Data is not yet available for Cumbria.
In England and Wales in 2021, the main causes of death among infants and children aged 28 days to 15 years continued to be congenital malformations, deformations and chromosomal abnormalities.

In England and Wales in 2021, there were 32 deaths of infants and children aged 28 days to 15 years where the underlying cause was "coronavirus (COVID-19)."

Age of Infant and Child Deaths for 2022/23

The data detailed in table 4 summarises the age of the Cumbria children at death over the past 5 years.

Graph 5 – Age of infant and child deaths

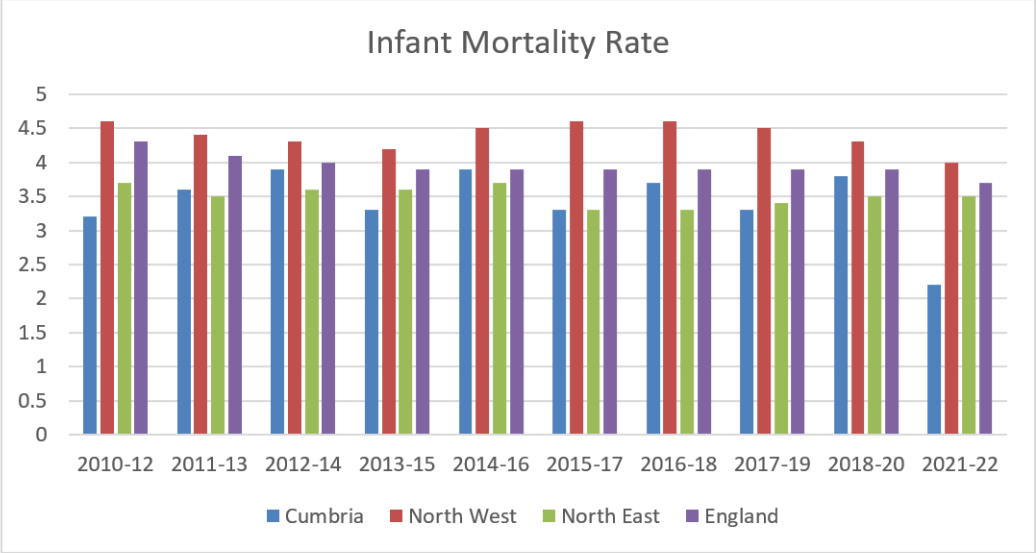


Table 2 - Age of infant and child deaths

Age Range	2018/19	2019/20	2020/21	2021/22	2022/23	Total
0-27 days	11	10	8	6	6	41
28-364 days	3	5	5	5	5	23
1 – 4 years	3	1	4	2	2	12
5 – 9 years	0	1	2	4	0	7
10 – 14 years	3	5	3	1	3	15
15 – 17 years	0	1	0	8	2	11

Source – Cumbria CDOP data

It should be noted a child is most at risk of death when under the age of 1 and particularly within the first 27 days of life. In 2022-23 the highest number of deaths notified were for 0-27 days closely followed by 28-364 days.

Expected and Unexpected Child Deaths

There are two categories for child deaths.

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

During 2022/23 there have been 11 expected deaths and 7 unexpected deaths notified to CDOP. Over a 5-year average there have been 59 expected deaths and 50 unexpected deaths notified to CDOP

The categories of death are described later on the report at Table 6.

Graph 6 – Expected or unexpected child death

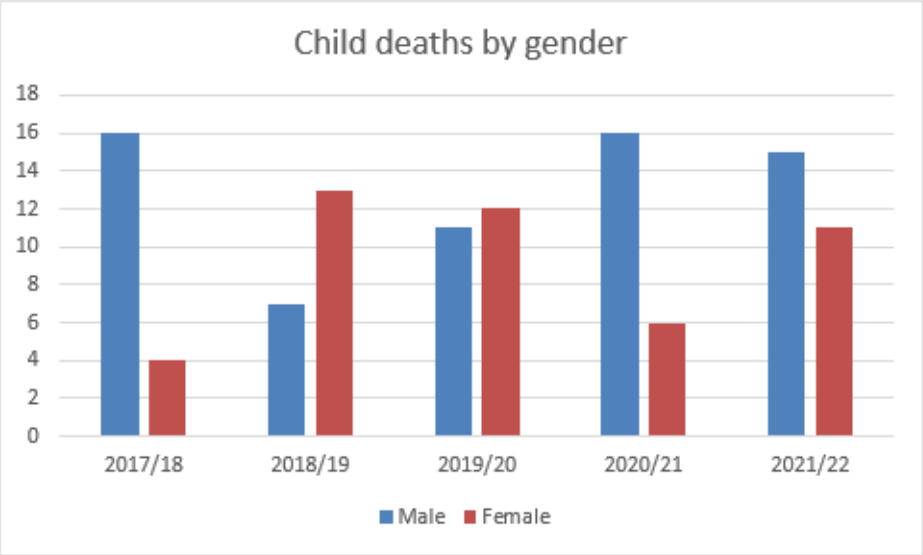


Table 3 - Expected or unexpected child death

	2018/19	2019/20	2020/21	2021/22	2022/23	Total over 5 years
Expected	12	12	12	12	11	59
Unexpected	8	11	10	14	7	50

Source – Cumbria CDOP data

Location of Death

The 18 deaths notified to CDOP in 2022/23 occurred in the following settings.

Graph 7 – Location of deaths 2022/23

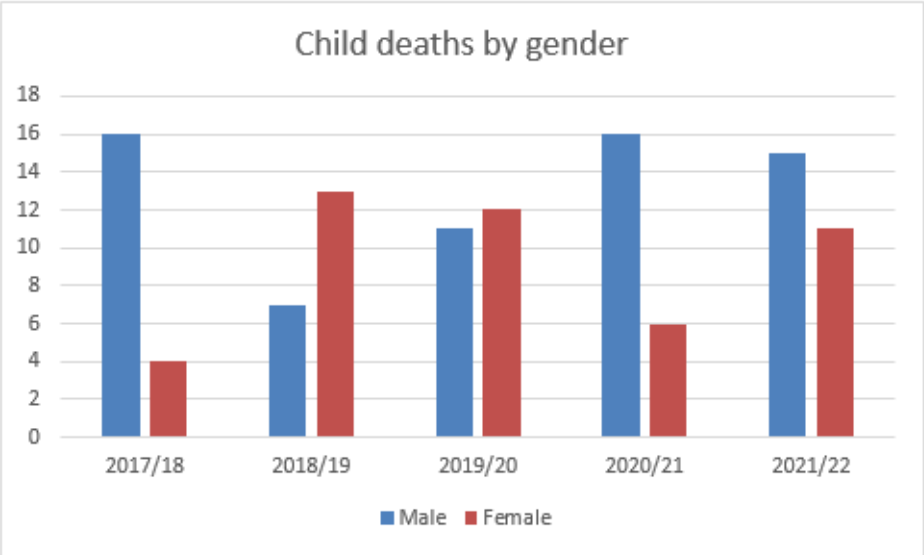


Table 4 - Location of deaths 2022/23

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

Source – Cumbria CDOP data

It should also be noted that the figures for 2022/23 include a death at school and a death abroad.

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

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

Infant and Child Deaths by Gender

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

Graph 8 – Infant and child death by gender since 2018/19

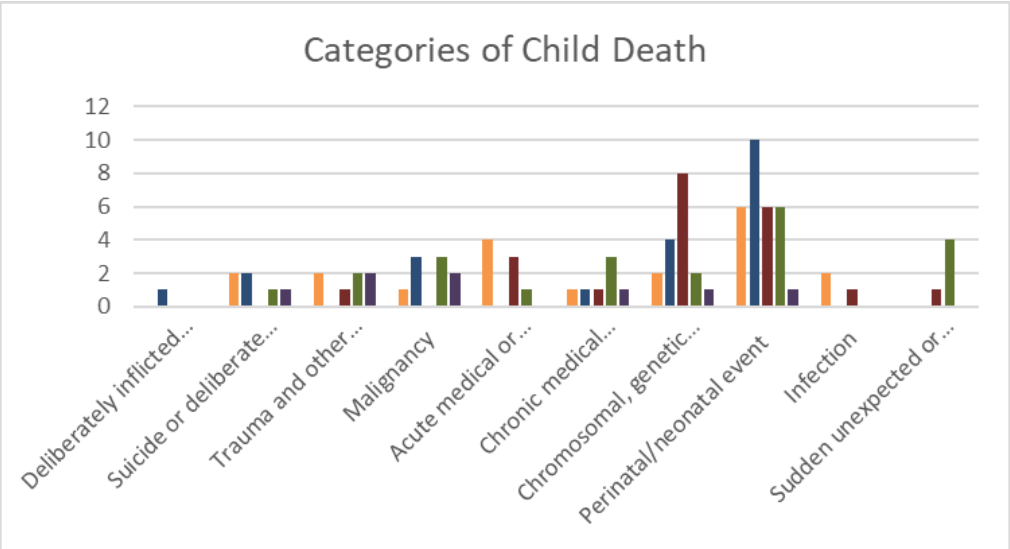


Table 5 Infant and child death by gender since 2018/19

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

Source – Cumbria CDOP data

Deprivation

Infant mortality risk varies by socio-economic background. In 2021, the 10% most deprived areas in England had higher infant mortality rates compared with the 10% least deprived areas.

Nationally the child death rate of children resident in the most deprived neighbourhoods in England (40.1 deaths per 100,000 children) was more than twice that of children resident in the least deprived neighbourhoods (18.9 deaths per 100,000 children). The death rate increased for all quintiles in 2021-22 in comparison to the previous year and reverted back to similar levels in 2019-20. The rate surpassed 2019-20 rates only in the least deprived quintiles.

Additionally, babies with a parent from a routine and manual background had higher infant mortality rates compared with babies with a parent from a higher managerial, administrative and professional background.

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

A piece of work led by public health, is planned to interrogate the local data to identify if recurring themes in modifiable factors are linked to deprivation.

Ethnicity

Ethnicity of child deaths for 2022/23 were all White British. These numbers reflect the population demographics for our regional area.

Nationally the ethnic group was recorded in 3,330 (96%) death notifications. Of these, 64% (n=2,139) of deaths were of children who were recorded as being from a White ethnic group, 18% (n=601) of deaths were of children from an Asian or Asian British background, 8% (n=275) were from a Black or Black British background, 7% (n=227) were from a Mixed background and 3% (n=88) were from any other ethnic group. These proportions were similar to the previous year.

4% of all child death notifications in 2021-22 were submitted where the ethnicity of the child was not known or it was not recorded. This drop from 13% in 2020-21 is a marked improvement in completeness for ethnicity records. Continued improvement in this completeness should help ensure mortality differences by ethnicity can be measured accurately in future years and the future release of the most recent census data will enable more in-depth analyses of differences across ethnic groups.

Disabled Children

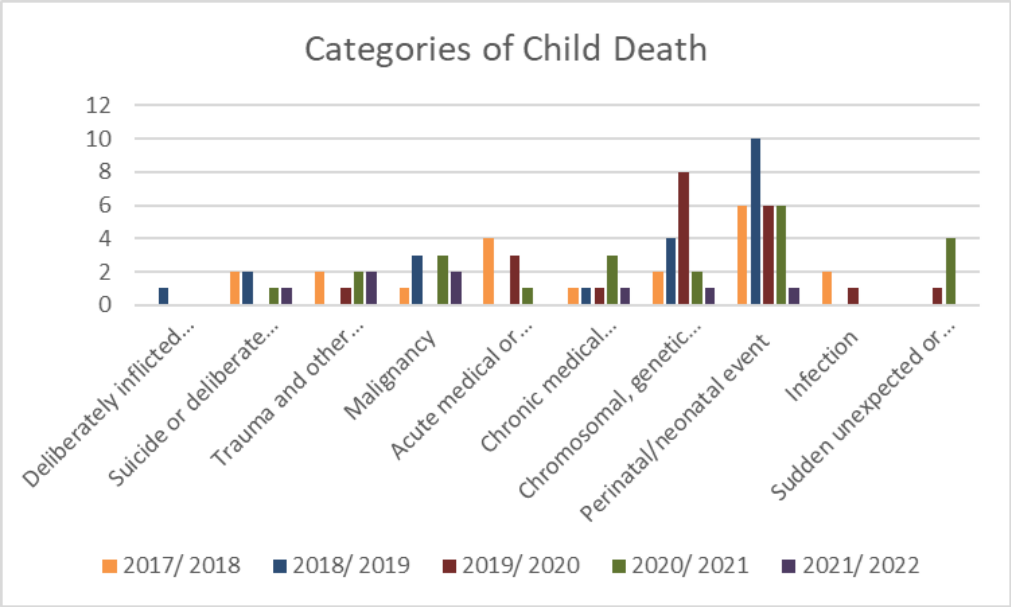
Of those deaths notified in 2022/23, those that were known to have a disability were notified to the Learning Disabilities Mortality Review Programme (LeDeR) by CDOP. The LeDeR programme strives to ensure that reviews of deaths lead to learning which will result in improved health and social care services for people with learning disabilities. It is not an investigation nor is it aimed at holding any individual or organisation to account.

Categories of Child Deaths

During the CDOP meetings, members categorise all child deaths which are then recorded on the eCDOP system. Categories of child death are identified nationally and are provided by the Department for Education. Detailed in the table below are the categories of child deaths that have been agreed for those cases where the child had passed away and the case was signed off during 2022/23.

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

Graph 9 – Categories of child death



Source – Cumbria CDOP data

Table 6 – Categories of Child Death

Category	2018/19	2019/20	2020/21	2021/23	2021/22	Total
1. Deliberately inflicted injury, abuse or neglect – this includes numerous physical injuries, which may be related to homicide as well as deaths from war, terrorism or other mass violence. It also includes severe neglect leading to death	1	0	0	0	1	2
2. Suicide or deliberate self-inflicted harm – this includes any action intentionally to cause one's own death. It will usually apply to adolescents rather than younger children.	2	0	1	1	0	4
3. Trauma and other external factors – this relates to unintentional physical injuries caused by external factors. It does not include any deliberately inflicted injury, abuse or neglect.	0	1	2	2	2	7
4. Malignancy – this includes cancer and cancer like conditions such as solid tumours, leukaemia and lymphomas and other malignant proliferative conditions, even if the final event leading to death was infection haemorrhage, etc.	2	0	3	2	2	9
5. Acute medical or surgical condition – a brief sudden onset of illness which resulted in the death of a child.	0	3	1	0	1	5
6. Chronic medical condition – a medical condition which has lasted a long time or was recurrent and resulted in the death of child.	1	2	3	1	1	8
7. Chromosomal, genetic and congenital anomalies – medical conditions resulting from anomalies in genes or chromosomes as well as a defect that is present at birth.	4	8	2	1	2	17
8. Perinatal/neonatal event – the of a child as a result of extreme prematurity, adverse outcomes of the birthing process, intrauterine procedures or within the first four weeks of life	10	7	6	1	2	26
9. Infection – this can be any primary infection, ie not a complication of one of the above categories, arising after the first postnatal week, oor after discharge of a preterm baby.	0	1	0	0	0	1
10. Sudden unexpected or unexplained death – this is where pathological diagnosis 6is either Sudden infant Death Syndrome (SIDS) or 'unascertained' at any age.	0	1	4	0	0	5

Source – Cumbria CDOP data

Of the 86 deaths that have been reviewed over the past five years –

- 30.2% were due to a perinatal/neonatal events,
- 19.7% were due to chromosomal, genetic and congenital anomalies, and
- 10.4% were due to malignancy.

Modifiable Factors

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

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

Where modifiable factors are identified, the Panel addresses these and utilises the CDOP action tracker to maintain oversight of the progress of these. It is not usually within the remit of CDOP to take action directly, but any issues identified, learning points and recommendations are given to relevant agencies to enable them to take action as appropriate. When this is felt necessary, it is placed on an action log until CDOP are assured that the necessary action has been taken.

Out of the 11 deaths that were reviewed and signed off in 2022/23, there were 4 cases where modifiable factors were identified by the Panel. Factors included: maternal smoking; maternal involvement in lambing; parents use of butane gas; not wearing safety equipment and unsecure structures.

Learning from Child Deaths

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

Significant delays in postmortems causing unnecessary upset for families. Contact was made with the coroner to request initial update to be provided to families when there is a delay with an accurate waiting time provided. This will be done on a case-by-case basis. It should be noted that postmortem delays is a known national issue.

The panel identified the need for strengthening education support with child death processes – some issues raised was the importance of schools having a bereavement policy, relevant training; and support for affected learners (of all ages).

Learning for young people regarding risk taking behaviours – ensuring they wear appropriate safety equipment when riding motorbikes.

Discussions held between CDOP members and out of area hospitals to ensure local teams are invited to CDRMs so that any learning for Cumbria can be followed through.

Training

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

Whilst the covid restrictions saw a reduction in the ability to offer local training face to face in this reporting period, this provided the opportunity to consolidate the police and health training and subsequently a partnership approach is now offered across the county, led by the Paediatrician for Child Death and the Lead Senior Investigating Officer, Cumbria Police.

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

What has CDOP achieved in 2022/23

Outcome	Action	When	Who	Update	RAG
Safer sleep messages are embedded in practice across the workforce and safe sleep assessments are undertaken.	A review of safer sleeping & Icon has been undertaken to ensure - • Consistent application of safety messages by agencies • Audit of use of safe sleep assessment	March 2023	The Safer Sleep Task and Finish Group	An audit is still to be undertaken. The safer sleeping task and finish group is to reconvene in 2023 and will take this forward.	
An effective partnership response to child suicide contagion.	Review of Suicide Contagion Protocol has been undertaken including • Audit of process	March 2023	ICB/Public Health/ Police/ CSCP Support Team	Contagion protocol has been followed once since its launch. Meeting held to discuss changes to protocol. The protocol is to be revised based on the review and learning from cases and other areas.	
NCMD are aware of any COVID-19 related actions for national learning	Consider and monitor all child deaths that occur as a direct or indirect result of Covid-19 at the CDOP and ensure any actions which need to be implemented are recommended by the Panel.	March 2023	CDOP	Now undertaken as part of each child death review.	
All agencies understand their roles and responsibilities in relation to child death review, improving the quality and outputs of the child death review processes.	Annual training and awareness raising undertaken about CDR process, CDOP and CDOP findings.	March 2023	CDOP	CDR training taking place in March 2023. Wider awareness raising on CDOP process to be undertaken	
Families receive effective support from bereavement services	Review of bereavement provision • Links to bereavement support network – • Identify how to capture service user experience	March 2023	CDOP/ Bereavement Network	This work is ongoing and should remain a CDOP priority. Links have been made to the bereavement support network. Links have been made with national leads to review current national offer.	

CDOP Priorities for 2023/24

1. Work closely with neighbouring CDOPs for effective learning including participating in regional networks, national webinars and conferences for wider education and understanding of child deaths. Themed Panel Meetings with geographical neighbours.
2. Strengthen child death processes within education, including awareness raising and training.
3. Continuous embedding of the child death review process by working in partnership to ensure timely response and review of cases prior to CDOP. The panel will continue to oversee the effectiveness of the arrangements.
4. Undertake work to identify if there are any local issues delaying the CDOP process, in order to reduce the number of child death cases that are outstanding to be reviewed.
5. Undertake a piece of work to review the local data to identify if there are any recurring themes in modifiable factors linked to deprivation.
6. Encourage schools to develop bereavement policies.
7. Implement CDOP operational group to implement actions aimed at reducing risks identified in modifiable factors.

Contact Details

CSCP CDOP
Cumbria House
117 Botchergate
Carlisle
CA1 1RD

Sharon Mitchell, Child Death Review Co-ordinator
Email: CDOP@cumbria.gov.uk
https://cumbriasafeguardingchildren.co.uk/professionals/cdop.asp

Contact Details

CSCP CDOP
Cumbria House
117 Botchergate
Carlisle
CA1 1RD

Sharon Mitchell, Child Death Review Co-ordinator
Email: CDOP@cumbria.gov.uk
cumbriasafeguardingchildren.co.uk/professionals/cdop.asp