Health and Wellbeing Board

23 July 2024

Child Death Annual Report 2021-23

Report of Amanda Healy, Director of Public Health, Durham County Council (Chair of CDOP)

Electoral division(s) affected:

Countywide

Purpose of the Report

1 The purpose of the report is to present to the 2021/23 County Durham and Darlington Child Death Overview Panel (CDOP) Bi Annual Report (Attached as appendix) and to give a brief summary of the main report.

Executive summary

2 This year's Annual report contains the summary of activity carried out by the County Durham and Darlington Child Death Overview Panel (CDOP) which seeks to drive improvements improve the health, safety and wellbeing of children and young people in County Durham and Darlington. The child death review process covers children under 18 years of age. A child death review must be carried out for all children regardless of the cause of death.

3 There were 38 deaths notified to the CDOP in 2022/23, compared with 47 the previous year.

4 County Durham & Darlington CDOP reviewed and finalised 49 cases during this reporting period. The Panel does not review cases until all information is gathered and other processes have been completed such as Serious Incident Reviews, Root Cause Analysis, criminal proceedings and Serious Case Reviews. At each Panel, the Designated Doctor for Child Deaths presents the circumstances of each death to the multi-agency panel. The case is reviewed in detail and recommendations/actions logged for monitoring purposes.

5 The following modifiable factors and key learning points identified from the Child Death Reviews completed during 2021/23 have been condensed into the following concise bullet points to maintain the anonymity of the cases discussed:

a) Maternal Obesity in Pregnancy

b) Smoking during pregnancy/Smoking in the Household
c) Management of high risk pregnancies
d) Co-sleeping
e) Poor parenting
f) Timely access to services
g) Early intervention
h) Assessment, decision making and planning processes

Key Actions to reduce Child Death across the CDOP Footprint

Durham Safeguarding Children Partnership

6 There is now an increased emphasis by practitioners on listening and talking to young people about their experiences, as well as understanding and responding to concerns raised by parents. Since 2018, Partnership has also developed new services and support focused on bringing families closer together.

7 Work is also ongoing to enhance the Partnership's co-ordinated and strategic approach to supporting young people experiencing significant harm outside of the home.

8 All partners have adopted a new method of working called Signs of Safety, which aims to ensure a consistent approach to risk assessments and to ensure that young people and families receive timely and effective help.

Health and Wellbeing Board

9 The Health and Wellbeing Board (HWB) can provide additional focus and action to those modifiable risk factors identified in the child death review process that align to the HWB priorities. This includes:

- Making smoking History – to help address:
    - Smoking during pregnancy/Smoking in the Household
    - Management of high risk pregnancies.
- Enabling Healthy Weight for All – to help address:
    - Maternal Obesity in Pregnancy
    - Management of high risk pregnancies

Durham Public Health

Suicide Prevention

10 Public Health in conjunction with other relevant agencies have undertaken work in a priority location due to the high frequency of people taking their own lives there. Examples include the implementation of additional patrols by rail staff; delivery of mental health first aid training to rail staff; improved lighting and wider local community based prevention work. Sudden Unexpected Death in Infancy

11 In February 2022, with funding from the NIHR Applied Research Collaboration (ARC) for North-East and North Cumbria (NENC) the local authority including public health and NHS partners, began working in partnership with Durham University to design and implement a multi-agency SUDI-prevention programme for County Durham to further reduce these tragic deaths in infants. This was implemented during 2022 and free online training packages have been developed and piloted for County Durham staff and partner services who encounter vulnerable families. This graded training offer is reflective of the specific roles and responsibilities. The findings and success of the pilot were evaluated at the end of 2022 and work is underway with key partners to firmly embed the multi-agency 'Eyes on the Baby' SUDI training programme.

Bereavement Support

12 Public Health as part of the response to COVID have commissioned enhanced support for adults who have suffered any loss which has been widely publicised through number of agencies and commissioned services.

Recommendations

13 Health and Wellbeing Board is recommended to:

a) Note the content of this report and the associated CDOP Annual Report as assurance CDOP is fulfilling its responsibilities as a sub-group of the DSCP.

b) Note the modifiable risk factors aligned to the HWB priorities and consider any additional actions required to mitigate against them.

c) Continue to promote a 'call to action' and continue to take forward the recommendations from the Tobacco Control update report presented in March 2024

Background

14 The Child Death Overview Panel (CDOP) is a joint sub-group of Durham Safeguarding Children Partnership and Darlington Safeguarding Partnership. The Child Death Overview Panel meetings are held on a bi-monthly basis and there has been consistent organisational commitment since the Panel was established in 2008.

15 Since April 2008 all deaths of children up to the age of 18 years, excluding still births and planned terminations are to be reviewed by a Child Death Overview Panel (CDOP) to accommodate the national guidance and statutory requirement set out in Working Together to Safeguard Children.

16 There are 3 interrelated processes for reviewing child deaths (detail in main report):

1. Joint Agency Response
2. Child Death Review Meeting
3. Child Death Overview Panel

17 The purpose of a Child Death Review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If the Child Death Overview Panel identify action that be taken by a person or organisation, they must inform them.

18 The Panel has two distinct elements:

1. **Case Reviews**
   The Panel categorise a likely/cause of death, identify any environmental, extrinsic, medical or personal modifiable factors that may have contributed to the death and consider any agency, strategic, regional and/or national recommendations to prevent future deaths.

2. **Business**
   The Panel considers the business arising from case reviews and the other responsibilities and statutory functions of CDOP.

19 The HWB supported the recommendations from the Tobacco Control update report presented in March 2024. In summary this included:

a) supporting a renewed emphasis on tobacco control work to address the smoking prevalence across the County.

b) Continue to support the work of the Tobacco Control Alliance to deliver on its actions.

c) Champion Tobacco Control to become everyone's business.

d) To champion stop smoking advice and support to become a core part of all council directorates.

e) To support with the vaping agenda.

f) Commit to conduct local research.

g) Commit to support the key recommendations regarding Treating Tobacco Dependency in Pregnancy to reduce preventable harms to mother and unborn baby.

20 A report reflecting healthy weight is scheduled to be presented to the HWB in September 2024 where modifiable risk factors relating to maternal obesity will be reflected.

Conclusion

21 The CDOP annual report is a statutory requirement and provides a strategic summary of the child deaths during the year and the outcomes of the child death reviews that have been considered by CDOP.

Author

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Appendix 1: Implications

Legal Implications
DCC meets its statutory requirement as a child death review partner by working in line with HM Government Child Death Review Statutory and Operational Guidance, October 2018 and Working Together to Safeguard Children 2018. In addition, working in line with Section 16Q of the Children Act 2004, as amended by the Children and Social Work Act 2017.

Finance
Statutory partners continue to work within financially challenging times. The CDOP requirement is a statutory obligation placed upon the Council to continue to meet. Staffing support is met by the DCC and DSCP arrangements.

Consultation
No implications.

Equality and Diversity / Public Sector Equality Duty
No implications.

Climate Change
No implications.

Human Rights
No implications.

Crime and Disorder
Close partnership working exists under the requirements of CDOP. The relevant statutory partners working together to address any requirements in relation to reporting and in the prevention and detection of crime.

Staffing
No implications.

Accommodation
No implications.

Risk
The risk to child death review partners, (the Council) is minimal due to the statute requirement.

Procurement
No implications.