# The Child Death Review Process for County Durham and Darlington Annual Report

2023/24

# Foreword

## Chair of County Durham & Darlington Child Death Overview Panel

Welcome to the annual report of County Durham & Darlington Child Death Overview Panel (CDOP). This report summarises the panel's activity over the last year which aims review all deaths of children normally resident in the County Durham and Darlington area in order to learn lessons and share any findings for the prevention of future deaths.

The child death process requires agencies to contribute and participate in the review process prior to the case being considered by the Child Death Overview Panel. Thanks must go to all frontline staff and managers involved in this process, without whom we could not fulfil our task.

Meeting virtually is well established and has facilitated professionals' attendance at Joint Agency Response Meetings (JARs) and Child Death Review Meetings (CDRMs) leading to improved information sharing and learning.

The County Durham & Darlington CDOP met four times within the timeframe of this annual report with very good multi-agency attendance. We continue to welcome observers to the Panel from constituent agencies and one Child Death Review partner attended as an observer during the reporting period.

CDOP seeks to take action on modifiable risk factors with examples highlighted within the report

This annual report will assist in ensuring that learning from child deaths reviews is shared with partners and other relevant partnerships including the Health & Wellbeing Board. It is also used to inform the wider Durham Safeguarding Children Partnership and Darlington Safeguarding Partnership annual reports.

I would like to extend a huge thanks to Panel members and Emma Maynard as CDOP Co-ordinator for their commitment, support and expertise within the Child Death Review process.

Amanda Healy

Chair of County Durham & Darlington Child Death Overview Panel

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# Introduction

The death of a child is a devastating loss which profoundly affects all those involved. Since April 2008, all deaths of children up to the age of 18 years, excluding stillbirths and planned terminations, are reviewed by CDOP to comply with the statutory requirement set out in Working Together 2018. In the event of a birth which is not attended by a healthcare professional, child death partners may carry out initial enquiries to determine whether the baby was born alive. If the baby was born alive then the death must be reviewed.

The Children Act 20042 requires Child Death Review (CDR) Partners, (2 Local Authorities from one ICB in our footprint) to ensure arrangements are in place to carry out child death reviews, including the establishment of a CDOP. The reviews are conducted in accordance with Working Together 2018 alongside the Statutory and Operational Guidance (England) 2018. Legislation allows for CDR partners to arrange for review of a death of a child not normally resident there. This process is pragmatic with consideration given to where the most learning can take place.

In April 2019 the National Child Mortality Database (NCMD) became operational and is a national repository of data relating to all children's deaths in England. This will enable more detailed analysis and interpretation of all data arising from the child death review process. County Durham and Darlington CDOP continue to be fully compliant within this process.

## Child Death Review Process

The purpose of a 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.

In addition, the Child Death Review Partners:

- Must prepare and publish reports on:
  - what they have done as a result of the child death review arrangements in their area, *and*
  - how effective the arrangements have been in practice;
- may request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process - the person or organisation must comply with the request, and if they do not, the child death review partners may take legal action to seek enforcement
- may make payments directly towards expenditure incurred in connection with arrangements made for child death reviews or analysis of information about deaths reviewed, or by contributing to a fund out of which payments may be made; and may provide staff, goods, services, accommodation, or other resources to any person for purposes connected with the child death review or analysis process.

Where a case has been subject to an internal or external review/investigation, a copy of the completed action plan that demonstrates that all actions have been addressed is submitted to the CDOP for assurance and recording purposes.

There are three interrelated processes for reviewing child deaths:

1. **Joint Agency Response**

   A co-ordinated multi-agency response (on-call health professional, police investigator, duty social worker), should be triggered if a child's death:

   - is or could be due to external causes;
   - is sudden and there is no immediately apparent cause (including SUDI/C);
   - occurs in custody, or where the child was detained under the Mental Health Act;
   - where the initial circumstances raise any suspicions that the death may not have been natural; *or*
   - in the case of a stillbirth where no healthcare professional was in attendance.

2. **Child Death Review Meeting (CDRM)**

   This is a multi-agency meeting where all matters relating to an individual's child's death are discussed. The CDRM should be attended by professionals directly involved in the care of that child during life and those involved in the investigation after death. The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved.

   The CDRM could take the form of a final case discussion following a Joint Agency Response, a perinatal mortality review group meeting in the case of a baby who dies in a neonatal unit, or a hospital-based mortality meeting following the death of a child in hospital.

3. **Child Death Overview Panel (CDOP)**

   A multi-agency panel set up by CDR partners to review the deaths of all children normally resident in County Durham and Darlington in order to learn lessons and share any findings for the prevention of future deaths.

   The CDOP should be informed by a standardised report from the CDRM, and ensures independent multi-agency scrutiny by senior professionals who were not directly involved in the child's care during life.

   The Panel has two distinct elements:

   - **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.

   - **Business**

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

## Role of Lead Professionals

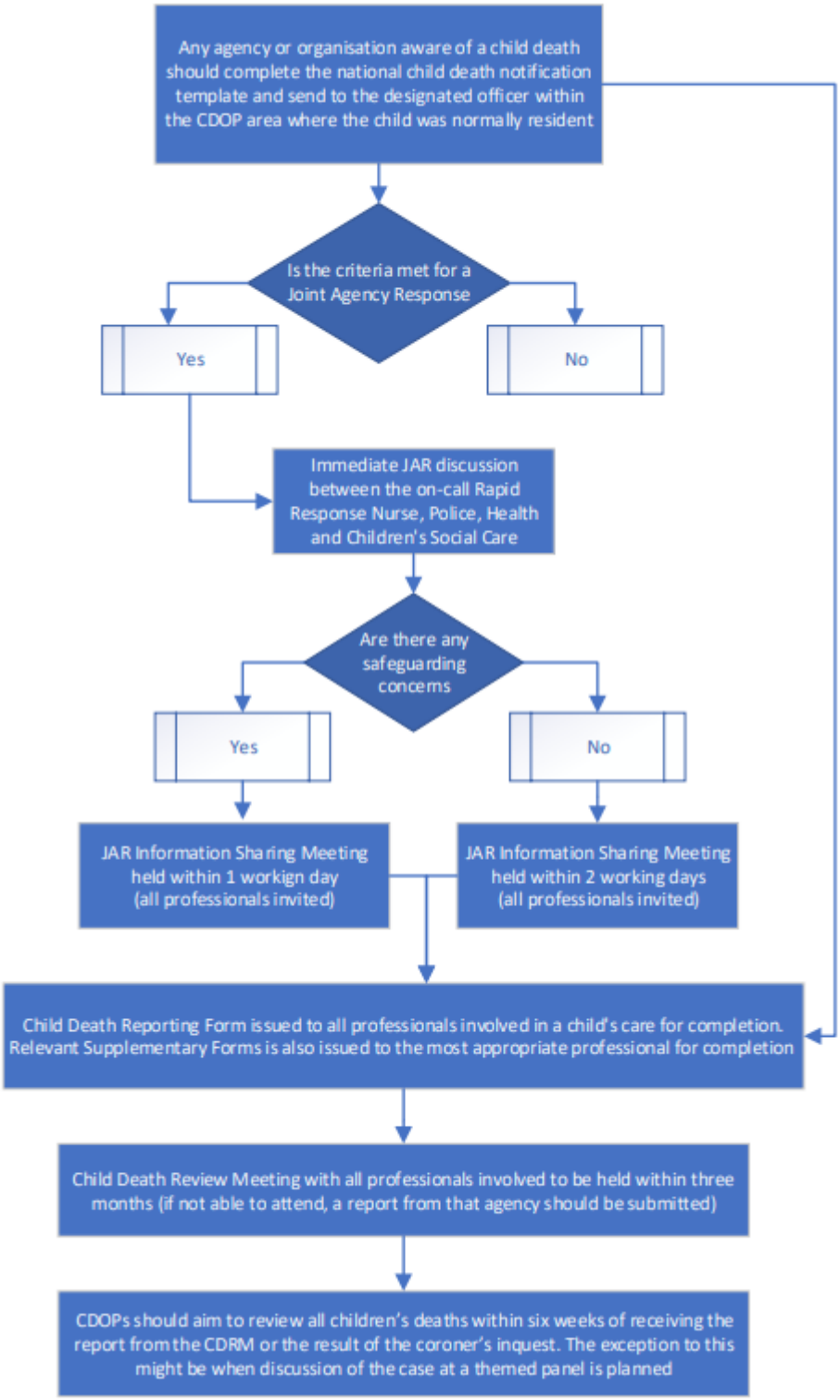
The role of the Designated Doctor (child deaths) is carried out by a Consultant Paediatrician and leads in the co-ordinating of responses and health input to the Child Death Review process in County Durham and Darlington.

The Joint Agency Response process is carried out by a team of senior nurses to manage and deliver the process for sudden and unexpected deaths. This ensures their active involvement at the onset of the review process in line with Government guidance. The Joint Agency Response

process augments the local review of all unexpected deaths and ensures that parents are engaged and received appropriate support during the process.

| CDOP Membership as at 31 March 2024 | |
|---|---|
| Amanda Healy (Chairperson) | Director of Public Health<br>Durham County Council |
| Paula Mather | Business Manager, Durham Safeguarding Children Partnership |
| Amanda Hugill | Business Manager, Darlington Safeguarding Partnership |
| Emma Maynard | Child Death Overview Panel Co-ordinator<br>Durham Safeguarding Children Partnership Officer |
| Dr Juliet Jude | Designated Doctor for the Child Death Review Process<br>North East & North Cumbria Integrated Children's Board |
| Catherine Hodgkiss | Rapid Response Manager<br>County Durham & Darlington NHS Foundation Trust |
| Joanne Stout | Associate Director of Nursing – Family Health<br>County Durham & Darlington NHS Foundation Trust |
| Dr Nicola Cleghorn | Designated Paediatrician for Safeguarding Children<br>North East & North Cumbria Integrated Children's Board |
| Detective Superintendent Andy Reynolds | Head of Safeguarding<br>Durham Constabulary |
| Siobhan Arbon | Strategic Manager – Safeguarding & Professional Practice<br>Durham Children & Young People's Service |
| Alison Lavender | Head of Service – Early Intervention & First Contact<br>Darlington Children's Services |
| Michelle Baldwin | Strategy Manager – Starting Well<br>Public Health - Durham County Council |
| Nichola Howard | Named Lead Professional for Safeguarding Children<br>North East Ambulance Service NHS Foundation Trust |
| Amy Cross | Named Nurse Safeguarding Children<br>Tees, Esk & Wear Valleys NHS Foundation Trust |
| Julie Potts | Named Nurse Child Protection<br>Harrogate & District NHS Foundation Trust |

# Child Death Review Process Flowchart



# Key Achievements for 2023/24

## Learning from Child Death Reviews

The aggregated findings from all child deaths informs local strategic planning including the joint strategic needs assessment and assets assessment, on how to best safeguard and promote the welfare of children in the area.

The CDOP is not commissioned to deliver public health interventions but learning from CDOP is shared with partners and integrated into programmes to support the health and wellbeing of children in County Durham and Darlington.

### Tobacco Dependency in Pregnancy (TDiP)

Smoking is a leading cause of preventable harm and health inequalities affecting mothers and babies in County Durham. It is the single most modifiable risk factor in pregnancy and remains a persistent challenge, despite ongoing public health efforts.

Prenatal exposure to tobacco smoke can lead to complications such as preterm birth, low birth weight, and placental problems, increasing the risk of infant mortality.

Postnatal smoke exposure, such as exposure to second-hand smoke in the home, can contribute to respiratory issues and infections, further heightening the risk of infant and child mortality. To protect infants' health, it is crucial for pregnant women to quit smoking and for households to maintain a smoke-free environment.

County Durham has the highest % of smoking at the time of delivery (SATOD) in the North East, with 14.6% of those giving birth known to be smokers at the time of delivering their baby (around one in seven women). Nationally, County Durham is ranked 8th out of 152 local authorities for SATOD.

A long-term key priority in County Durham is to enable every child to have the best start in life by reducing smoking in pregnancy. A core deliverable of this strategic priority is to support women to achieve a smoke-free pregnancy through whole system change, tackling tobacco dependency in pregnancy as an addiction, not a lifestyle choice.

In September 2023, the CDOP received an update from the County Durham TDiP Steering Group regarding the work of the group and the overarching action plan which provided a level of assurance regarding the commitment and work to reduce tobacco dependency during pregnancy.

### Eyes on the Baby Project

This project was initiated following an initial brief from CDOP that identified SUDI as a theme and key stakeholders were asked to consider what action was needed to reduce the number of sudden infant deaths in the area. They Eyes on the Baby project was a collaborative piece of work conducted by key stakeholders. A training and implementation package to promote safer sleeping and prevent sudden infant deaths was launched in 2023

### Finalised Child Death Reviews

43 Child Death Reviews were finalised by the Child Death Overview Panel during 2023/24. The aggregated findings from all child deaths informs local strategic planning including the joint strategic needs assessment and assets assessment, on how to best safeguard and promote the welfare of children in the area.

The finalised Child Death Reviews have been uploaded to the National Child Mortality Database which is a repository of data relating to all children’s deaths in England. This will enable more detailed analysis and interpretation of all data arising from the child death review process, to ensure that lessons are learned following a child’s death that learning is widely shared, and that actions are taken, locally and nationally, to reduce child mortality.

### Review of the Governance of the Child Death Overview Panel

This work was completed in February 2024 and a decision was made by the Safeguarding Partners to move the governance out of DSCP arrangements. As a result, a working group has been set up to review the CDOP functions and business support arrangements.

### Designated Doctor for Child Deaths

A new Designated Doctor for Child Deaths was successfully appointed in 2023 following the retirement of the previous Designated Doctor. This ensures that there is continuation of the role in leading in co-ordinating the responses and health input to the Child Death Review process.

### Child Death Overview Panel Escalation Process

This was developed and agreed in early 2024. The aim of the process is to improve the timeliness of submission of child death review paperwork by relevant agencies. The impact of this will be evaluated during 2023-24.

### Guidance for Practitioners on how to complete an effective Child Death Reporting Form

This was developed to support practitioners and provide clarification as to what should be considered when completing the child death paperwork. This has been positively received, particularly those practitioners who have not had any experience in completing such paperwork.

## Child Death Review Data & Analysis

There is a well established and system for notifying the CDOP of the death of a child in line with the statutory requirements to report all deaths of children up to the age of 18 years within 24 hours (or next working day) after the death.

Table 1: Total number of notifications of deaths

| Local Authority area | 2020-21 | 2021/22 | 2022/23 | 2023-24 |
|---|---|---|---|---|
| **Durham** | 18 (62%) | 38 (81%) | 32 (82%) | 30 (79%) |
| **Darlington** | 11 (38%) | 9 (19%) | 7 (18%) | 8 (21%) |
| **County Durham & Darlington Total** | **29** | **47** | **39** | **38** |

There were 38 deaths notified to the CDOP in 2022/23, compared to 39 the previous year. The number of cases notified to CDOP differed from the number of cases reviewed by the Panel during a reporting period as the child death review process prior to the CDOP meeting is often delayed due to other parallel processes, such as coronial, police, Child Safeguarding Practice Reviews, to be concluded.

Table 2: Age of child at time of notification of death

| Local Authority area | 2020-21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|
| **0-27 days** | 10 (34%) | 18 (38%) | 14 (36%) | 20 (53%) |
| **28-364 days** | 5 (17%) | 7 (15%) | 8 (21%) | 5 (13%) |
| **1-4 years** | 1 (4%) | 4 (8%) | 6 (15%) | 3 (8.5%) |
| **5-9 years** | 6 (21%) | 5 (11%) | 2 (5%) | 3 (8.5%) |
| **10-14 years** | 2 (7%) | 6 (13%) | 3 (8%) | 5 (13%) |
| **15-17 years** | 5 (17%) | 7 (15%) | 6 (15%) | 1 (3%) |
| **County Durham & Darlington Total** | **29** | **47** | **39** | **38** |

Table 3: Place of Death at time of notification of death

| Place of Death | 2020-21 | 2021/22 | 2022/23 | 2023-24 |
|---|---|---|---|---|
| **Hospital** | 25 (86%) | 33 (70%) | 32 (82%) | 25 (66%) |
| **Home** | 2 (7%) | 12 (26%) | 7 (18%) | 11 (29%) |
| **Public Place** | 2 (7%) | 2 (4%) | 0 | 0 |
| **Abroad** | 0 | 0 | 0 | 1 (2.5%) |
| **Other Residency** | | | | 1 (2.5%) |
| **County Durham & Darlington Total** | **29** | **47** | **39** | **38** |

Table 4: Gender

| Gender | 2020-21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|
| **Male** | 22 (76%) | 19 (40%) | 17 (44%) | 18 (47%) |
| **Female** | 7 (24%) | 28 (60%) | 22 (56%) | 20 (53%) |
| **County Durham & Darlington Total** | **29** | **47** | **39** | **38** |

Table 5: Ethnicity

| Ethnicity (Broad) | 2020-21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|
| **White** | 27 (93%) | 45 (96%) | 36 (94%) | 33 (87.5%) |
| **Mixed** | | | 1 (2%) | 1 (2.5%) |
| **Asian** | 1 (3.5%) | 1 (2%) | | 1 (2.5%) |
| **Black** | | | 1 (2%) | 2 (5%) |
| **Other** | 1 (3.5%) | 1 (2%) | 1 (2%) | 0 |
| **Not Stated** | 0 | 0 | 0 | 1 (2.5%) |
| **County Durham & Darlington Total** | **29** | **47** | **39** | **38** |

## Deaths which have been reviewed and finalised at CDOP

County Durham & Darlington CDOP reviewed and finalised 43 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.

Table 6: Total number of deaths reviewed and finalised by the Panel

| Local Authority area | 2020-21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|
| **Durham** | 32 (76%) | 17 (65%) | 18 (78%) | 38 (88%) |
| **Darlington** | 10 (24%) | 9 (35%) | 5 (22%) | 5 (12%) |
| **County Durham & Darlington Total** | **42** | **26** | **23** | **43** |

Table 7: Age of Child

| Age of Child | 2020-21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|
| **0-27 days** | 18 (43%) | 5 (19%) | 9 (39%) | 24 (56%) |
| **28-364 days** | 12 (29%) | 6 (23%) | 4 (17.5%) | 3 (7%) |
| **1-4 years** | 6 (14%) | 5 (19%) | 1 (4%) | 3 (7%) |
| **5-9 years** | 3 (7%) | 3 (12%) | 4 (17.5%) | 2 (4.5%) |
| **10-14 years** | 0 | 3 (12%) | 2 (9%) | 6 (14%) |
| **15-17 years** | 3 (7%) | 4 (15%) | 3 (13%) | 5 (11.5%) |
| **County Durham & Darlington Total** | **42** | **26** | **23** | **43** |

Table 8: Place of Death

| Place of Death | 2020-21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|
| **Hospice** | 0 | 1 (4%) | 0 | 0 |
| **Abroad** | 2 (5%) | 0 | 0 | 0 |
| **Hospital** | 35 (83%) | 17 (65%) | 19 (83%) | 34 (79%) |
| **Home** | 4 (10%) | 5 (19%) | 4 (17%) | 8 (19%) |
| **Public Place** | 1 (2%) | 3 (12%) | 0 | 1 (2%) |
| **School** | 0 | 0 | 0 | 0 |
| **County Durham & Darlington Total** | **42** | **26** | **23** | **43** |

Table 9: Gender

| Gender | 2020-21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|
| **Male** | 21 (50%) | 13 (50%) | 9 (39%) | 22 (50%) |
| **Female** | 21 (50%) | 13 (50%) | 14 (61%) | 22 (50%) |
| **County Durham & Darlington Total** | **42** | **26** | **23** | **43** |

Table 10: Ethnicity

| Ethnicity (Broad) | 2020-21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|
| **White** | 36 (87%) | 23 (88%) | 22 (96%) | 40 (94%) |
| **Mixed** | 1 (2%) | 0 | 0 | 0 |
| **Asian** | 1 (2%) | 1 (4%) | 1 (4%) | 1 (2%) |
| **Black** | 1 (2%) | 0 | 0 | 0 |
| **Other** | 3 (7%) | 2 (8%) | 0 | 1 (2%) |
| **Not Stated** | 0 | 0 | 0 | 1 (2%) |
| **County Durham & Darlington Total** | **42** | **26** | **23** | **43** |

Table 11: Duration of Reviews

| Duration of Review | 2019/20 | 2020-21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|---|
| **Under 6 months** | 2 (10%) | 3 (7%) | 1 (4%) | 0 | 1 (2%) |
| **6-12 months** | 8 (40%) | 13 (31%) | 9 (35%) | 13 (57%) | 14 (32%) |
| **Over 12 months** | 10 (50%) | 26 (62%) | 16 (61%) | 10 (43%) | 29 (66%) |
| **County Durham & Darlington Total** | **20** | **42** | **26** | **23** | **44** |

The majority of cases (66%) reviewed by CDOP were finalised over 12 months from the date of death. There are several factors that may contribute to a longer length of time between the death of a child and the final CDOP review including delay in the return of reporting forms, awaiting completion of necessary investigations including post-mortem reports or a criminal investigation, or the undertaking of a Child Safeguarding Practice review or Coroner's inquest. All other investigations and reports must be completed prior to review and case closure by the CDOP.

## Modifiable Factors

The review process is required to identify modifiable factors in the cases so agencies can learn lessons, improve practice, and ultimately prevent further deaths. A modifiable factor is defined as something which: "may have contributed to the death of the child and which, by means of locally and nationally achievable interventions, could be modified to reduce the risk of future child deaths".

While identified modifiable factors by the CDOP provide significant learning to improve practice and prevent future harm, there are opportunities through the entirety of the child death process (including Joint Agency Response Meetings, Hospital Mortality Meetings and Child Death Review Meetings) to identify learning and opportunities for smaller, micro-changes to practice, e.g., a need for workplace training or amendments to internal policies and procedures.

There is a degree of subjectivity in identifying modifiable risk factors which is decided on a case-by-case basis. Information on factors contributing to the child's death is reliant on the thorough completion of national CDOP reporting forms by clinicians. Completion of the CDOP Analysis Proforma is done after the CDRM where all the relevant professionals who know the family share knowledge of the child's life and the circumstances of the death.

Four domains are used to categorise the identified risk factors with a corresponding level of relevance (0-2):

0 - Information not available

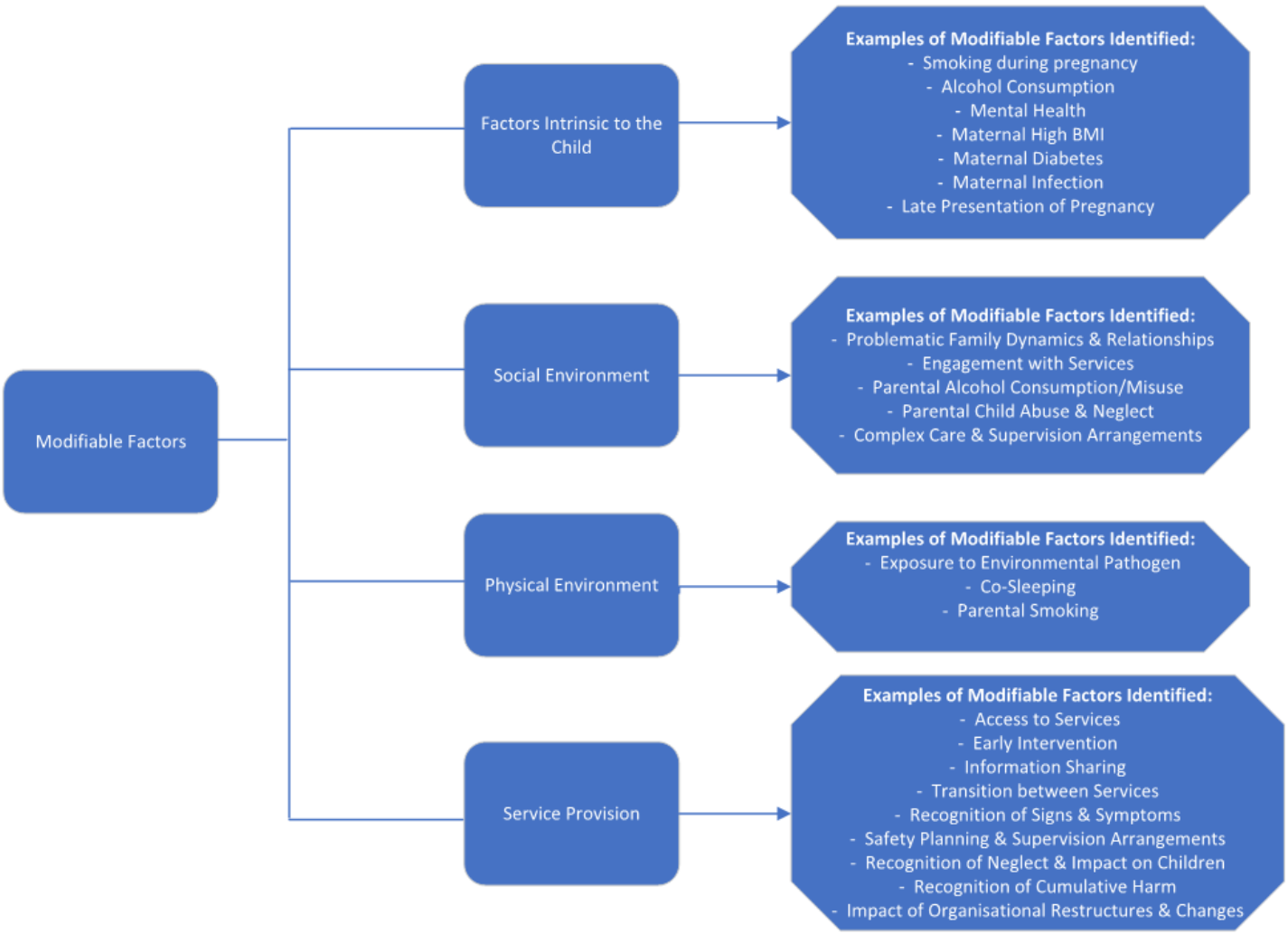
1 - No factors identified, or factors identified but are unlikely to have contributed to the death

2 - Factors identified that may have contributed to vulnerability, ill health or death

## Table 12: Number and % of reviews completed with identified Modifiable Factors

| Area | Total Number of Cases | | No Modifiable factors | | Modifiable Factors | | % with modifiable Factors | |
|---|---|---|---|---|---|---|---|---|
| | 22/23 | 23/24 | 22/23 | 23/24 | 22/23 | 23/24 | 22/23 | 23/24 |
| **Durham** | 18 | 38 | 11 | 22 | 7 | 17 | 30% | 39% |
| **Darlington** | 5 | 5 | 5 | 2 | 0 | 3 | 0% | 7% |
| **County Durham & Darlington Total** | **23** | **43** | **16** | **24** | **7** | **20** | **30%** | **45%** |

## Diagram 1: Examples of modifiable factors identified by CDOP



### Maternal Obesity in Pregnancy

A modifiable and relevant factor highlighted by County Durham & Darlington CDOP is the mother's body mass index (BMI) during pregnancy. For most adults, an ideal BMI is in the 18.5 to 24.9 range (health weight range). The NHS defines the BMI categories as:

- Below 18.5 – underweight;
- Between 18.5 and 24.9 – healthy weight range;
- Between 25 and 29.9 – overweight range;
- Between 30 and 39.9 – obese weight range;
- 40 and over – severe obese weight range.

Being overweight or obese increases the risk of complications for pregnant women and her baby including gestational diabetes, pre-eclampsia, high blood pressure, shoulder dystocia, premature delivery and risk of stillbirth and birth defects. The higher a woman's BMI, the high the chance of these complications.

### Maternal Diabetes

Maternal diabetes can have significant effects on neonatal outcomes. Babies born to mothers with diabetes are at risk of various complications including:

- Perinatal mortality including stillbirths and neonatal deaths;
- Pre-term births (before 37 completed weeks' gestational age);
- Congenital malformations;
- Increased birthweight;
- Neonatal hypoglycaemia;
- Respiratory distress;
- Pre-eclampsia

### Smoking

Smoking continues to have a negative impact on the general health of children and remains a key modifiable factor for child deaths in the North East. The CDOP collates information regarding the smoking status including maternal smoking in pregnancy and smoking in the household during the child's life.

Smoking during pregnancy has well known detrimental effects for the growth and development of the unborn baby as well as the health of the mother. Smoking during pregnancy can cause serious complications including an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy (SUDI). Maternal smoking in pregnancy and/or parental household smoking was the most common occurring modifiable factor which the CDOP deemed a significant relevant factor in relation to the cause of death. A smoke-free home is the best way of protecting babies and children.

### Modifiable factors associated with Sudden and Unexpected Death in Infancy/Childhood (SUDI/C)

In deaths categorised as sudden unexpected or unexplained, the CDOP highlighted several modifiable factors identified including:

- Unsafe sleeping arrangements such as co-sleeping.
- Alcohol consumption by the young person.
- Children and Young People's Mental Health

# Table 14: Category of child deaths

| Category | | No. of deaths categorised by CDOP 2022/23 | 2023/24 |
|---|---|---|---|
| 1 | **Deliberately inflicted injury, abuse or neglect**<br>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 | 1 (4%) | 0 |
| 2 | **Suicide or deliberate self-inflicted harm**<br>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 | 0 | 3 (7%) |
| 3 | **Trauma and other external factors**<br>This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death. Excludes Deliberately inflicted injury, abuse or neglect (category 1) | 0 | 5 (12%) |
| 4 | **Malignancy**<br>Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage, etc. | 1 (4%) | 1 (2%) |
| 5 | **Acute medical or surgical condition**<br>For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy | 1 (4%) | 2 (5%) |
| 6 | **Chronic medical condition**<br>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 | 2 (9%) | 2 (5%) |
| 7 | **Chromosomal, genetic or congenital anomalies**<br>Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac | 2 (9%) | 10 (24%) |
| 8 | **Perinatal/neonatal event**<br>Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral palsy without evidence of cause, and includes congenital or early-onset bacterial infection (onset in the first postnatal week) | 12 (53%) | 15 (35%) |
| 9 | **Infection**<br>Any primary infection (i.e. 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. | 3 (13%) | 2 (5%) |
| 10 | **Sudden unexpected, unexplained death**<br>Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5) | 1 (4%) | 3 (7%) |

# Recommendations and Learning from CDOP 2023/24

## Analysis of learning and action points identified from the 43 cases reviewed:

| Theme/Issue | % of occasions where this was identified |
|---|---|
| Seeking & Sharing Information sharing/triangulation of information | 15% |
| Policies, guidance and pathways | 16% |
| Record keeping & documentation | 10% |
| Escalation | 7% |
| Training/Awareness Raising | 7% |
| Monitoring, Assessment & Decision Making | 5% |
| Utilising multi-disciplinary team discussions | 5% |
| Staff/service capacity | 5% |
| Equipment Issues | 4% |
| Key messages and information provided to families | 4% |
| Professional recognition of acute illness/infection markers | 3% |
| Supervision, Management Oversight & Scrutiny | 3% |
| Early intervention | 3% |
| Timely Access to Services | 3% |
| Robust medical exploration of symptoms | 1% |
| Transition between services | 1% |
| Flagging of records | 1% |
| Management of hypothermia in babies | 1% |
| Utilising internal and external reviews | 1% |
| Management of environmental pathogens | 1% |
| Recognition of parental risk factors and the impact on children | 1% |

## Dissemination of learning from reviews

Panel members are tasked with taking the learning from individual cases and share this widely within their organisations and networks so staff in all partner agencies are aware of modifiable factors when supporting and advising parents/carers and children/young people.

This report will be shared with all these groups and will be available on the websites of Durham Safeguarding Children Partnership and Darlington Safeguarding Partnership.