Tees

child death overview panel

ANNUAL REPORT 2022-2023

Hosted by Redcar & Cleveland Council on behalf of NHS North East and North Cumbria ICB, Hartlepool Council, Middlesbrough Council, Redcar & Cleveland Council and Stockton-on-Tees Borough Council

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1. Introduction from CDOP Chair

As CDOP looks back at the priorities identified in 2021/22 our focus has been on becoming a more robust learning process.

This report highlights that Tees CDOP now sits within the governance of the two Local Safeguarding Children Partnerships. CDOP have developed closer links with the Tees Partnerships in respect of learning from child deaths , and we have referred six cases where CDOP considered further investigation was required to review and identify any learning that could prevent future child deaths. Due to closer links and a more robust process between CDOP and the partnerships the number of cases referred in this year has doubled compared to the 3 referred in 2021/22.

Learning from child deaths remains the focus and work will be ongoing into 2023/24 and the launch of the new CDOP website has helped to provide information for families/ professionals of bereaved children and going forward this will aid CDOP to disseminate learning from child deaths.

eCDOP was implemented in 2022/23 which is an electronic database to record all deaths which links to the National Child Morbidity Database (NCMD). Whilst our numbers are small from a statistical perspective, we contribute our learning to NCMD so numbers and trends can be aggregated to further inform practice. Implementing eCDOP has also strengthened the learning process as alerts for learning can be identified immediately to NCMD who will monitor this nationally and also identify and disseminate any learning from child deaths. eCDOP has supported the improvement of quality information provided on child death notification forms and as we move to the next steps of the implementation it is hoping that it will become the platform for information on all child deaths and utilise staff resources more effectively.

This report outlines the data across Tees regarding total child deaths and child deaths reviewed in 2022/23, outlining modifiable factors determined through multi-agency discussion and explores the areas of learning identified from the work of CDOP and partners. CDOP has also identified priority areas to explore learning in more depth in 2023-24, and build assurance that agencies have implemented recommendations.

Once again, thank you to all those who continue to support and commit to the work of CDOP.

2. Introduction

The Tees CDOP is responsible for reviewing the deaths of children normally resident in the four local authority areas across the Tees, namely Hartlepool, Middlesbrough, Redcar & Cleveland and Stockton-on-Tees.

This report covers the period from 1 April 2022 to 31 March 2023 and provides information on the total number of child deaths reported and the child deaths reviewed across the Tees area for this period.

The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. Families experiencing such a tragedy should be met with empathy and compassion. They need clear and sensitive communication. They also need to understand what happened to their child and know that people will learn from what happened. The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths.

The death of a child is a tragedy and by reviewing the circumstances surrounding the death of a child we can:

- Identify any changes in practice that might help to prevent similar deaths in the future
- Share any learning with colleagues, locally, regionally and nationally to have a wider impact on preventing future child deaths.
- Analyse trends to deliver a response

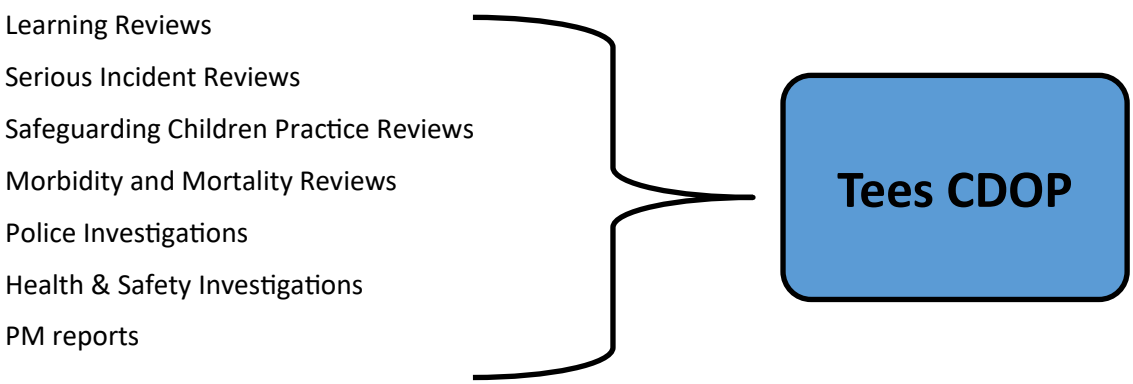
With the establishment of the NCMD, the quality of local CDOP data collection improved compared to previous years. Consistent and enhanced local data has allowed the NCMD to conduct national analysis and produce a variety of reports and findings. [Publications - National Child Mortality Database (ncmd.info)]

The key functions of CDOP are:

- 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 improve learning from Child Death Review.

Other Reviews/Investigations

It is important that any other reviews/investigations, when completed, arefed into CDOP to ensure informed discussions are held before the child death review can be closed.



3. Analysis of Child Death Notifications: 2022/23

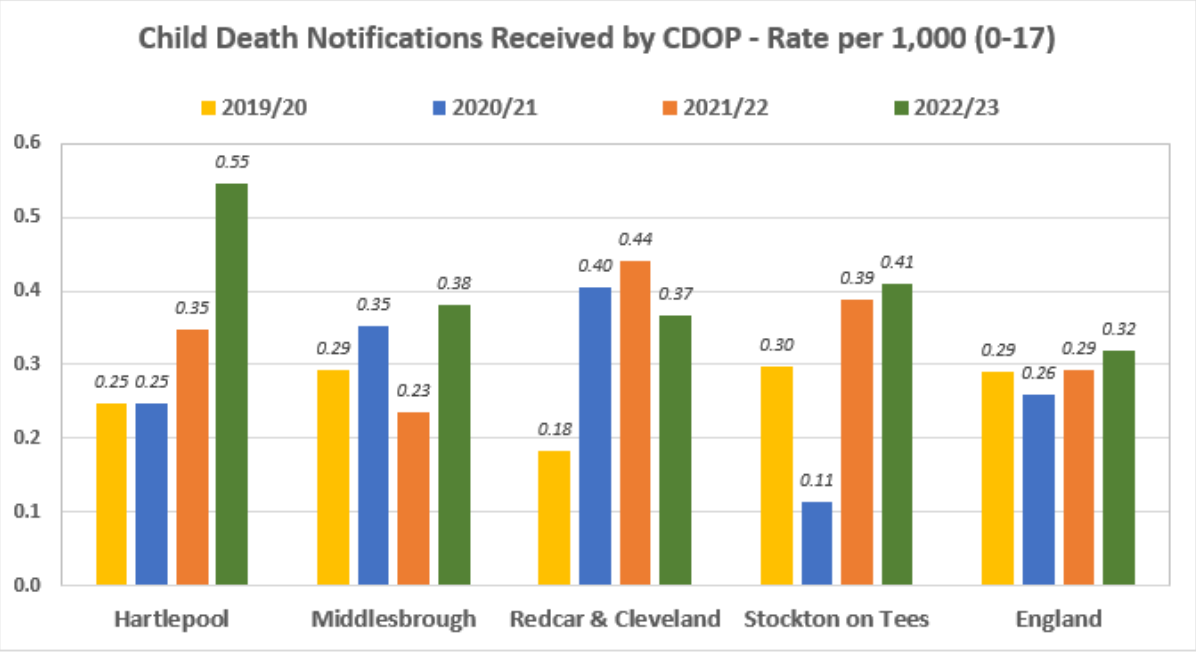
3.1 Number and rate of child deaths

A notification is submitted to Tees CDOP to report deaths (except stillborn babies) of children aged 0 – 17 years old in the Tees Area. Figure 1 below shows the number and rate (rate per 1,000 children aged 0-17) of child deaths for each of the four Tees local authorities for the most recent financial year of 2022/23 alongside the three previous years and the total combined four year periods. The Tees and England totals are included for comparison.

There were a total of 52 child deaths in Tees, or a rate of 0.42 per 1,000 in 2022/23. This was higher than the national rate of 0.32 per 1,000. This is the highest number of deaths of the previous four years. All local authorities, except for Redcar & Cleveland saw increases in 2022/23, particularly Hartlepool. The combined four year periods show that Tees has a higher rate compared to England at 1.29 per 1,000 compared to 1.16 in England. Redcar & Cleveland and Hartlepool have the highest rates as proportions of the 0-17 population.

Figure 1: Child Death Notifications Received by CDOP - *Numbers and Rates per 1,000 children aged 0-17*

Local Authority	0-17 Pop	2019/20		2020/21		2021/22		2022/23		Total	
		No.	*Rate*	*No.*	*Rate*	*No.*	*Rate*	*No.*	*Rate*	*No.*	*Rate*
Hartlepool	20,116	5	0.25	5	0.25	7	0.35	11	0.55	28	1.39
Middlesbrough	34,140	10	0.29	12	0.35	8	0.23	13	0.38	43	1.26
Redcar & Cleveland	27,230	5	0.18	11	0.40	12	0.44	10	0.37	38	1.40
Stockton on Tees	43,802	13	0.30	5	0.11	17	0.39	18	0.41	53	1.21
Tees	125,288	33	0.26	33	0.26	44	0.35	52	0.42	162	1.29
England	11,761,656	3,414	0.29	3,056	0.26	3,454	0.29	3,743	0.32	13,667	1.16

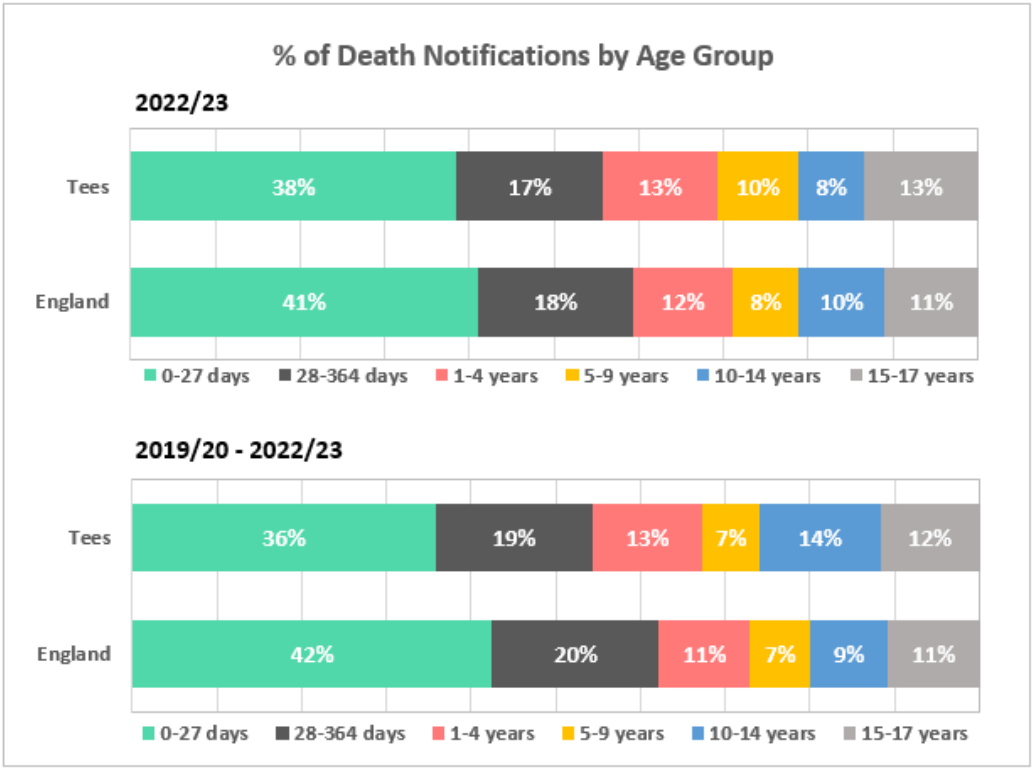


3.2 Age ranges

Figure 2 below shows the number of child deaths by age category for the most recent financial year of 2022/23 and the four year period (2019/20 – 22/23) for the four Tees local authorities and comparison against England. In Tees, 38% of deaths are in the 0-27 day age category in 2022/23 compared to 41% in England. When looking at the 2019/20 – 22/23 period the gap is wider with 36% of child deaths in the 0-27 day category in Tees compared to 42% in England. The largest differences are seen in the 1-4 year category with a 2% higher proportion of deaths in Tees compared to England and the 10-14 year category with 5% higher proportion in Tees.

Figure 2: Child Deaths by Age of Child

	Tees				England			
	2022/23		2019/20 - 2022/23		2022/23		2019/20 - 2022/23	
0-27 days	20	38%	58	36%	1,534	41%	5,804	42%
28-364 days	9	17%	30	19%	687	18%	2,695	20%
1-4 years	7	13%	21	13%	439	12%	1,465	11%
5-9 years	5	10%	11	7%	291	8%	973	7%
10-14 years	4	8%	23	14%	380	10%	1,248	9%
15-17 years	7	13%	19	12%	412	11%	1,482	11%
Total	52	100%	162	100%	3,743	100%	13,667	100%



3.3 Sex

Figure 3 shows that of the 52 child deaths in 2022/23, 62% were male and 38% were female. This is higher proportion for males compared to England where 58% of deaths were male and 42% were female. Looking at the four year period the Tees proportion for males and females is similar to England at 58% for males and 42% for female. Redcar and Cleveland has a higher proportion of male deaths whilst in Stockton-on-Tees the proportions are relatively evenly split.

Figure 3 also shows child deaths by sex in Tees and also by age group over the four year period 2019/20 – 22/23. The proportion of males and females for deaths in children aged under 5 years old in Tees are more evenly split compared to England. However in the aged groups over 5 years old the proportion is very heavily weighted towards males with over 70% of deaths and these proportions are higher than the England rates.

Figure 3: Child Deaths by Sex

	2022/23					2019/20 - 2022/23				
Local Authority	Male		Female		Total	Male		Female		Total
Hartlepool	5	45%	6	55%	11	16	59%	11	41%	27
Middlesbrough	8	62%	5	38%	13	25	58%	18	42%	43
Redcar and Cleveland	8	80%	2	20%	10	26	68%	12	32%	38
Stockton-on-Tees	11	61%	7	39%	18	27	51%	26	49%	53
Tees	32	62%	20	38%	52	94	58%	67	42%	161
England	2,166	58%	1,537	42%	3,703	7,740	57%	5,796	43%	13,536

Child Deaths by Sex & Age at Death

	Tees					England				
Age Group	Male		Female		Total	Male		Female		Total
0-27 days	30	53%	27	47%	57	3,197	56%	2,495	44%	5,692
28-364 days	15	50%	15	50%	30	1,528	57%	1,160	43%	2,688
1-4 years	11	52%	10	48%	21	796	54%	667	46%	1,463
5-9 years	8	73%	3	27%	11	564	58%	407	42%	971
10-14 years	16	70%	7	30%	23	704	57%	541	43%	1,245
15-17 years	14	74%	5	26%	19	951	64%	526	36%	1,477
Total	94	58%	67	42%	161	7,740	57%	5,796	43%	13,536

3.4 Ethnicity

Figure 4 below shows the number and proportion of child deaths in Tees by ethnicity group, alongside the England figures for comparison. The under 24 year old populations proportions by ethnicity group are shown from the census. In Tees 87% of the population are white British, compared to 73% in England. There are 12% of cases where ethnicity it not known, however the minority ethnic group proportions are similar to the population rates.

Figure 4: Child deaths by ethnicity group

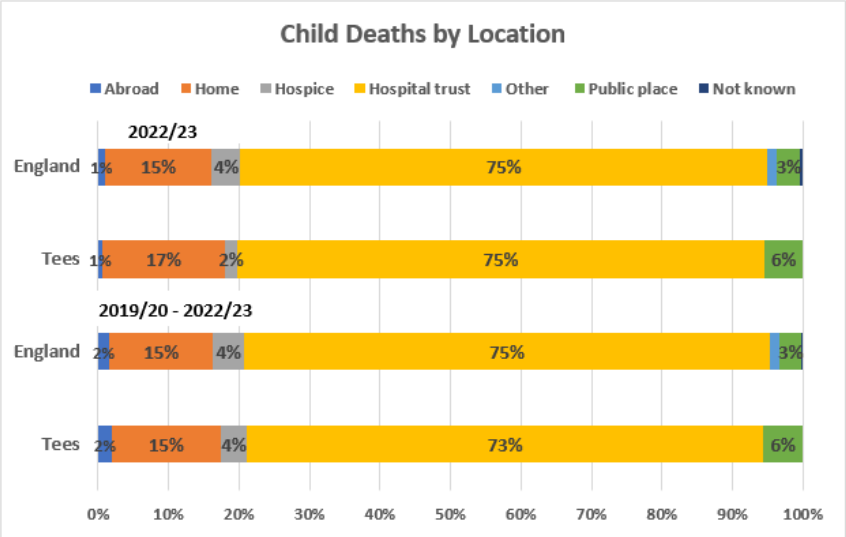
	Tees			England		
Ethnic Group	*Population**	*Deaths*	*%*	*Population**	*Deaths*	*%*
Asian or Asian British	7%	12	7%	12%	736	20%
Black or Black British	2%	5	3%	6%	380	10%
Mixed	3%	3	2%	6%	221	6%
White - British	87%	115	71%	73%	2159	58%
Other	2%	6	4%	3%	125	3%
Not known/not stated		20	12%		122	3%
Total	100%	161	100%	100%	3743	100%

** Population proportions based on under 24 year old population from Cenus 2021 data*

3.5 Location

Figure 5 below shows the location of the child deaths across Tees and in England for both the latest 2022/23 period and the combined four year period (2019/20 – 2022/23). The proportion of locations are similar between Tees and England and between time periods, with 75% of deaths occurring in hospital and approximately 15% occurring in the home.

Figure 5: Child deaths by location



3.6 Deprivation

Figure 6 below shows the number and proportion of child deaths that are from the most deprived quintile (the most deprived 20% of communities in England). More than twice the population in Tees live in the most deprived quintile at 42% compared to 20% in England. For the four year period of 2019/20 – 22/23, 59% of child deaths were from the most deprived quintile compared to 36% in England. Redcar & Cleveland was the only local authority in Tees where the proportion was similar to England at 39% in quintile 1, with higher proportions in quintile 2 and 3.

Figure 6: Child deaths by Deprivation Quintile

Local Authority	Population living in Quintile 1	Deprivation Quintile - (1 most deprived & 5 least deprived)										Total
		1		2		3		4		5		
		No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	
Hartlepool	53%	18	64%	1	4%	2	7%	5	18%	2	7%	28
Middlesbrough	57%	27	63%	5	12%	3	7%	5	12%	3	7%	43
Redcar and Cleveland	36%	15	39%	12	32%	6	16%	2	5%	3	8%	38
Stockton-on-Tees	29%	35	66%	6	11%	0	0%	7	13%	5	9%	53
Tees	42%	95	59%	24	15%	11	7%	19	12%	13	8%	162
England	20%	1,357	36%	862	23%	620	17%	495	13%	409	11%	3,743

4. Analysis of Child Deaths Reviewed: 2022/23

PLEASE NOTE: The total number of child deaths reported in 2022/23 will be different to the total number of deaths reviewed by CDOP in 2022/23 because deaths can take an excess of 6 months to be reviewed by CDOP therefore:

- Some child deaths reviewed in 2022-23 will have occurred in previous years.
- Some child deaths which occurred in 2022-23 may not be reviewed until 2023/24.

4.1 Child deaths reviewed

In 2022/23 the total number of child deaths reviewed were 23, which is similar to the previous year as shown in Figure 7. Figure 8 below illustrates that the majority of deaths reviewed were from the previous year.

Figure 7: Child deaths reviewed by year

Local Authority	2019/2020	2020/2021	2021/2022	2022/2023	Total
Hartlepool	2	3	4	5	14
Middlesbrough	5	9	7	4	25
Redcar and Cleveland	4	10	6	8	28
Stockton-on-Tees	9	10	7	6	32
Total	**20**	**32**	**24**	**23**	**99**

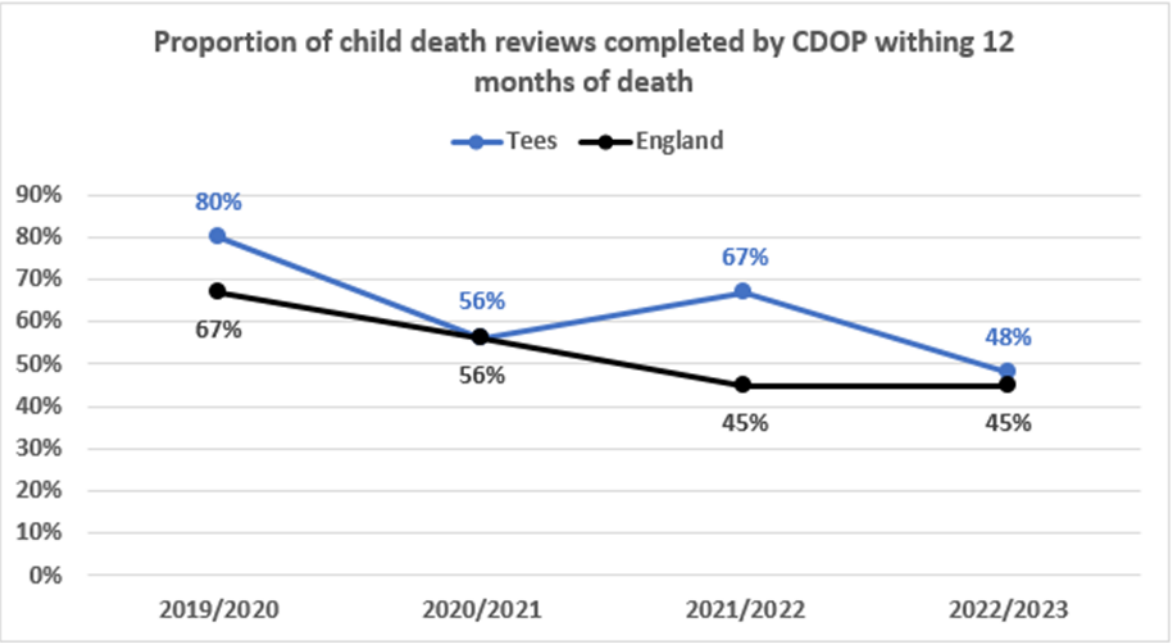
Figure 8: Child deaths reviewed in 2022/23 by year of death

Local Authority	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	Total
Hartlepool			1	2	2	5
Middlesbrough		1	1	2		4
Redcar and Cleveland	1		1	6		8
Stockton-on-Tees			1	5		6
Total	**1**	**1**	**4**	**15**	**2**	**23**

There are various reasons why there may be a delay in reviewing child deaths at CDOP which may include:

- Delays in receiving Post Mortem reports (this is a national issue). There is a national shortage of Paediatric Pathologists which does impact upon the ability to perform PMs. As the procedure is prioritised over the production of reports (for obvious reasons) this can and does impact upon the timely receipt of the reports.

Figure 9: Time taken to review deaths



4.2 Child deaths by category

Figure 10 below shows the category of death for those reviewed in Tees in 2022/23 and the four year combined period (2019/20 – 22/23) alongside comparisons with England. Perinatal/neonatal events was the most common category in Tees and England, followed by chromosomal, genetic and congenital anomalies and malignancy. In 2022/23 Tees has higher proportions of malignancy, although numbers are small. Looking at the four year period Tees has slightly lower proportions of chromosomal, genetic and congenital anomalies compared to England and slightly higher proportions of malignancy, trauma and other external factors and suicide or unexplained death.

Figure 10: Child deaths by category

Category of Death	Tees				England			
	2022/2023		2019/20 - 22/23		2022/2023		2019/20 - 22/23	
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Perinatal/neonatal event	6	26%	32	32%	1,125	34%	3,806	33%
Chromosomal, genetic and congenital anomalies	6	26%	21	21%	770	24%	2,706	24%
Malignancy	5	22%	11	11%	280	9%	946	8%
Trauma and other external factors	2	9%	8	8%	152	5%	544	5%
Suicide or deliberate self-inflicted harm	1	4%	8	8%	145	4%	488	4%
Sudden unexpected, unexplained death	2	9%	7	7%	218	7%	846	7%
Chronic medical condition	1	4%	5	5%	184	6%	591	5%
Acute medical or surgical condition	0	0%	4	4%	191	6%	689	6%
Infection	0	0%	3	3%	136	4%	555	5%
Deliberately inflicted injury, abuse or neglect	0	0%	0	0%	69	2%	239	2%
Total	23	100%	99	100%	3,270	100%	11,410	100%

Figure 11 shows that when comparing category of death by sex over the four year period, chromosomal, genetic and congenital anomalies deaths are seen more in females, alongside sudden, unexplained deaths whilst more deaths of trauma and other external factors, chronic medical condition, acute medical/surgical conditions and infections are seen in males.

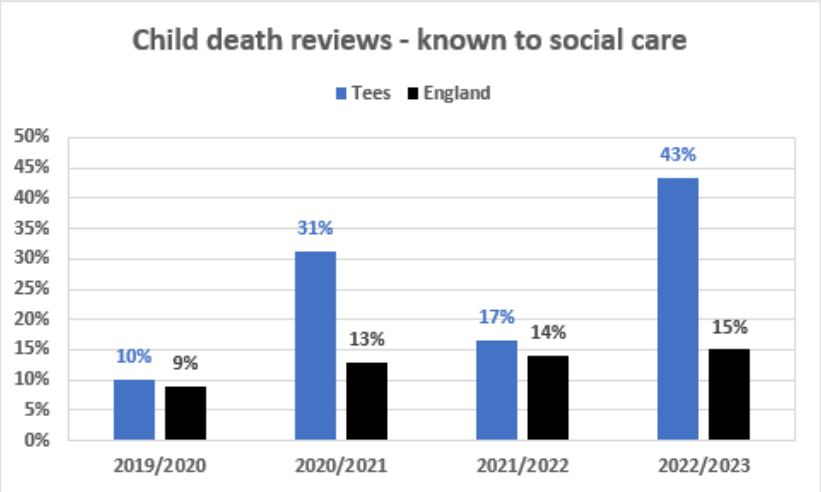
Figure 11: Child deaths by category and sex

Category of Death	2019/20 - 22/23				
	Female		Male		Total
Chromosomal, genetic and congenital anomalies	14	67%	7	33%	21
Perinatal/neonatal event	15	48%	16	52%	31
Malignancy	5	45%	6	55%	11
Trauma and other external factors	2	25%	6	75%	8
Sudden unexpected, unexplained death	5	71%	2	29%	7
Chronic medical condition	1	20%	4	80%	5
Suicide or deliberate self-inflicted harm	3	38%	5	63%	8
Acute medical or surgical condition	0	0%	4	100%	4
Infection	0	0%	3	100%	3
Total	45	46%	53	54%	98

4.3 Known to social care

For reviews completed in the year ending 2022/23, 43% (10 of 23) of children in Tees were known to social care at the time of their death compared to 15% in England. Of those 10 children known to social care, Redcar & Cleveland was highest with 6 followed by Middlesbrough with 2. Proportions fluctuate each year but on average over the four year period Tees had a rate of 26% of deaths where the child was known to social care compared to 13% in England.

Figure 12: Child deaths known to social care



Modifiable factors

Child deaths reviewed with 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'. Tees CDOP will discuss any known modifiable factors as part of the review and also identify any new modifiable factors that may have prevented the death.

Of the 23 child deaths in Tees reviewed in 2022/23, 7 or 30% of cases had modifiable risk factors. This compares to 39% of cases in England. Four domains are used to categorise the information with a corresponding level of relevance (0-2):

Domain A: Factors intrinsic to the child
Domain B: Factors in social environment including family and parenting capacity
Domain C: Factors in the physical environment
Domain D: Factors in service provision.

Figure 13 shows the cases reviewed in 2022/23 and the category of deaths where there were modifiable factors. Also shown is the domain of these factors – note that more than one domain can be applicable for a single death. Recent changes to reporting of modifiable factors means that previous years data cannot be easily compared.

Figure 13: Modifiable factors by category and domain

			Domains *(cases can have multiple)*			
Category of Death	**Total**	**Modifiable Factors**	**A**	**B**	**C**	**D**
Chromosomal, genetic and congenital anomalies	6	1	1			
Perinatal/neonatal event	6	2	1			2
Malignancy	5	0				
Sudden unexpected, unexplained death	2	2	1	2	1	
Trauma and other external factors	2	1		1		
Chronic medical condition	1	0				
Suicide or deliberate self-inflicted harm	1	1		1		1
Total	**23**	**7**	**3**	**4**	**1**	**3**

5. Learning from Child Deaths

Local learning from child deaths, where possible, is a continuing priority for CDOP. However, it must be noted that learning cannot always be identified. One of the Child Death Panel responsibilities/functions is (CDOP Guidance 2018):

> ***"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"***

Learning from child deaths can be identified through one or more of the following mechanisms:

- **Child Death Review Process (CDRP)**

The Joint agency response (JAR) meeting provides immediate opportunity to identify any learning from a child death as this is held within 48 hours of the death. For those deaths where a JAR is not held the Child Death Review Meeting (CDRM) captures any learning.

- **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 reviews the death of a child they identify and agree if there are any modifiable factors that may have prevented the death.

Although, it is not usually within the remit of CDOP to take action directly, they ensure that any issues identified, learning points and recommendations are assigned to relevant agencies to enable them to take action as appropriate.

- **National Child Mortality Database (NCMD)**

NCMD is the electronic system that stores all the data in respect of the child deaths in England and identifies any learning and/or themes which is widely both locally and nationally.

- **NHS Serious Incidents**

The NHS England Serious Incident National Framework defines a Serious Incident as:

'A Serious incident is an event in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations'. This framework describes the process and procedures to help ensure Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.

- **Child Safeguarding Practice Reviews (CSPR) or Local Learning Reviews (Local LRs)**

Taken from Working Together 2018; *"The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Reviews should seek to prevent or reduce the risk of recurrence of similar incidents."* These reviews are considered and conducted by South Tees Safeguarding Children Partnership or Stockton and Hartlepool Safeguarding Children Partnership depending on where the child lived.

- **Individual Agency Investigations**

Agencies involved with the child/family leading up to the death may consider whether an internal investigation should be completed to identify any learning. This is recorded at the JAR meeting.

All external investigations are presented to CDOP before any child death review is closed.

6. Learning Identified from Child Deaths Reviews 2022-23

Modifiable factors from child deaths reviewed in 2022-23:
In 2022-23, modifiable factors identified included:

- Sleeping practices for children and babies
- Poor parenting/supervision of children
- Timely access to mental health support
- Home conditions/overcrowding
- Reduced face to face contact with families during covid pandemic
- Maternal Smoking
- Maternal Obesity

From the 23 deaths reviewed, 13 had identified learning and the following work has been completed:

- **Recording of information on agency systems**
  Briefings have been circulated to highlight the importance of having information recorded accurately on agency internal systems. In particular recording dates and significant events and those people involved.

- **Communication between hospitals**
  When transferring patients between hospitals, communication and information was sometimes disjointed. A transfer checklist has now been implemented to ensure all information is gathered and communicated to the receiving hospitals

- **Safe Sleeping**
  This learning is continuous both locally and nationally through various campaigns. CDOP are considering how best to deliver the Eyes on the Baby Training across the Tees.

- **Appropriate resources to facilitate rapid escalation of care when needed**
  An emergency buzzer system is available in all delivery suites.

- **Family environment: overcrowding, heightened stress, domestic violence, lone parent**
  Single and multiagency assessments to consider the impact of the family environment on children. Including but not exclusive to overcrowded home conditions , parental stress, domestic abuse, and parents without support networks.

The Safeguarding Partnerships devise single agency and multi agency action plans to monitor any actions from recommendations and the Child Death Co-Ordinator is a member of the learning groups for both partnerships so assurance is provided to CDOP that actions have been completed.

Learning identified a Joint Agency Response (JAR) meetings:

Immediate learning can be, but not always identified at a JAR meeting. If several agencies identify learning this will captured in the JAR minutes and discussions will be held regarding whether a review of this death should be considered by the relevant Safeguarding Children Partnerships.

Areas of immediate learning:

- Consideration of when to submit referrals to Children's Social Care.
- Accurate recording of information on agency systems.
- Accurate information sharing between agencies.
- Consider parent contact with the child depending on the circumstances of the death.
- Consider non-attendance policies to be more robust.
- Consider appropriate support for peers of the child.
- Consider processes for follow up appointments in respect of child mental health

If a review is not completed by the safeguarding children partnerships, individual agencies will progress any learning/actions from the JAR and report to the CDOP co-ordinator for recording. Otherwise they will be encompassed as part of the safeguarding children partnership reviews.

Learning identified through Safeguarding Children Partnerships:

From the 6 referrals to the local safeguarding children partnerships within Tees, all 6 deaths were reviewed. 3 of theses reviews were completed in 2022-23. Multi-agency mechanisms used to identify learning included Child Safeguarding Practice Reviews, Local Learning Reviews, practitioner events and others.

From these reviews the following recommendations was identified:

- Protecting vulnerable children when families move between areas
- Improve multi agency professional skills and ability to work with children deemed 'difficult to engage'
- Recognising and responding to criminal exploitation
- The importance of using interpreters
- Information sharing between agencies
- Viewing incidents in isolation rather than cumulative
- Professional curiosity and challenge
- Domestic Abuse; raising awareness of men being victims, commissioning of support services for both victims and perpetrators

As part of the safeguarding partnership process for these reviews, they devise an action plan from the recommendations and agencies provide assurance that actions are complete. The CDOP Co-Ordinator is a member of both the partnerships learning groups and provides feedback to CDOP regarding the completed actions.

CDOP has agreed to change their approach and focus towards the development of more robust learning processes. The panel will continue to review child deaths in detail, but aims to consider learning in greater detail across multiple cases and multiple years. This learning will encompass areas identified during CDOP discussions and learning from Safeguarding Children Partnerships reviews.

Priority learning for 2023-24

CDOP reviewed all child deaths in 2022-23 and although there are only have a low number, CDOP members recognised that there are factors in child deaths that have continued from previous years. CDOP also wanted to focus on an emerging themes from 2022-23.

From the review the following learning is prioritised for 2023-24 to gain assurance how agencies are actively trying to reduce deaths.

- *Exploitation*
- *Sudden Unexpected Death in Infants (Safe Sleeping)*
- *Suicide and Self-Harm*

7. Achievements and Challenges in 2022-23

Priorities for 2021/22	What we have achieved in 2022/23
To ensure that families continue to be at the forefront of the Child Death Review Process.	This priority is ongoing.
To consider learning from child deaths: • Develop a mechanism to disseminate learning from Tees child deaths. • To link with other Boards, Partnerships in respect of learning from child deaths. • To devise a mechanism to monitor learning from child deaths and ensure CDOP is assured those actions are taken.	This priority is ongoing. Links have been developed with both safeguarding children partnerships Learning groups within the Tees, as the Child Death Co-ordinator is now a member. Links with other Boards and Partnership are being considered. Work is being completed by CDOP members to ensure CDOP is a learning process.
To agree a CDOP Governance structure.	This is complete. CDOP is governed by both safeguarding children partnerships with the Tees.
To develop and launch a new CDOP website.	This is complete. A new website has been developed via Redcar and Cleveland Council website.
To develop robust links with the Safeguarding Children Partnerships within Tees.	This is complete. Robust links have been developed.
To consider the impact of Covid 19 on child death data.	This is ongoing through National Child Mortality Data-base (NCMD)
To launch Tees eCDOP	The launch has commenced in stages.
Continue to promote local and national campaigns to prevent future child deaths.	Local and National campaigns are promoted as when required
The Palliative Care function for children and young people in the Tees area.	This is being monitored through the child death process and the function in place is embedded.

Challenges for 2022/23	What we have achieved in 2022/23
Funding constraints within the statutory partner agencies to provide additional functions to the statutory requirements.	CDOP funding is continuously considered by statutory partners.
Training relevant professionals prior to the implementation of eCDOP.	As this has been implemented in stages the 1st stage did not require any training, however future stages of implementation may require training to be delivered and how will need to be considered by CDOP.
To ensure appropriate resources are in place to fulfil statutory requirements.	Statutory requirements are being met and this is being continuously reviewed.

8. Priorities and Challenges: 2023 - 24

Priorities for 2023/24

1. To ensure that families continue to be at the forefront of the Child Death Review Process; identifying keyworkers for families for all child deaths and gathering families input into the process.

2. To continue partnership working to ensure the child death process focuses on learning to prevent future deaths.
    - To use the CDOP website to disseminate learning from Tees child deaths, that is not facilitated by the Safeguarding Partnerships.
    - To improve links with other multi-agency forums in respect of learning from child deaths.
    - To devise a mechanism to monitor learning from child deaths to ensure CDOP is assured actions are taken from learning
3. To continue to launch Tees eCDOP
4. To continue to promote local and national campaigns to prevent future child deaths.

Challenges for 2023/24

1. To develop CDOP as a learning process
2. Funding constraints.
3. Training professionals prior to implementing future stages of Tees eCDOP.
4. To ensure appropriate resources are in place to fulfil statutory requirements.

CDOP would like to thank agencies for their commitment to Tees CDOP to prevent future child deaths.

Working together to keep our future generation safe.

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Useful Information and Support:

(You may need to hold down the control key whilst clicking on the links below to take you to the website)

- Child Death Review Process Guidance (England) 2018— Child death review: statutory and operational guidance (England) - GOV.UK (www.gov.uk)
- National Child Mortality Database — NCMD | The National Child Mortality Database | National Child Mortality Database
- The Lullaby Trust—The Lullaby Trust - Safer sleep for babies, Support for families
- Child Bereavement UK— Child Bereavement UK
- Cruse Bereavement Care - Home - Cruse Bereavement Support
- Childhood Bereavement Network— Childhood Bereavement Network
- Sands Stillbirth and Neonatal death Charity—Sands | Saving babies' lives. Supporting bereaved families.
- Child Death Helpline - 0800 282 986- Child Death Helpline - Home
- What to do if a child or baby dies —What to do after someone dies: What to do if a child or baby dies - GOV.UK (www.gov.uk)

  Funeral Costs—support for a child's funeral—Support for child funeral costs (Children's Funeral Fund for England): What it does - GOV.UK (www.gov.uk)

Appendix 1— CDOP Membership

The Panel comprises of a fixed core membership of senior professionals drawn from organisations with flexibility to co-opt other relevant professionals to discuss certain issues as and when appropriate. The Tees CDOP met **5** times in 2022/23.

The Tees CDOP core membership is detailed below:

Organisation	Title	Meetings attended
Public Health	Director of Public Health (**Chair**)	5
South Tees Hospitals NHS Foundation Trust	Lead Nurse C&YP, JCUH (**Vice Chair**)	5
Tees Valley Clinical Commissioning Group	Designated Paediatrician for Child Death	2
	*Designated Nurse for Safeguarding & Looked After Children	4
South Tees Hospitals NHS Foundation Trust	Consultant Neonatologist, James Cook University Hospital	5
South Tees Hospitals NHS Foundation Trust	Consultant Paediatrician, James Cook University Hospital	3
Police	Detective Superintendent, Head of Specialist Crime Cleveland Police	5
Midwifery	Patient & Safety Lead, Women's & Children's Services, North Tees and Hartlepool NHS Foundation Trust	3
North East Ambulance Service (NEAS)	*Safeguarding Lead	3
Children's Social Care	Assistant Director, Stockton–on-Tees LA	3
Tees Esk & Wear Valley NHS Trust (TEWV)	*Named Nurse, Safeguarding	5
Education (Tees)	Inclusion Lead, Redcar & Cleveland LA	1
North Tees & Hartlepool NHS Foundation Trust	Consultant Paediatrician, University of North Tees Hospital	3
School Nursing and Health Visiting Service*	Harrogate and District NHS Foundation Trust	1
South Tees Safeguarding Children Partnership	Partnership Manager / Partnership Co-Ordinator	5
Safeguarding Nurse	Redcar and Cleveland Council	1
Lay Member x 1	Independent Lay Member	4

*The Local Authorities commission this service. Harrogate and District NHS Foundation Trust is commissioned by Stockton-on-Tees and Middlesbrough Council. The CDOP member represents the Tees.

*Representatives are members on other regional CDOPs and the panel meetings may occur on the same dates.