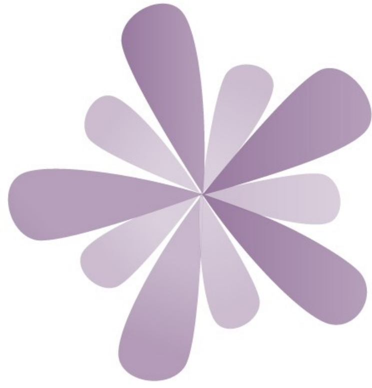


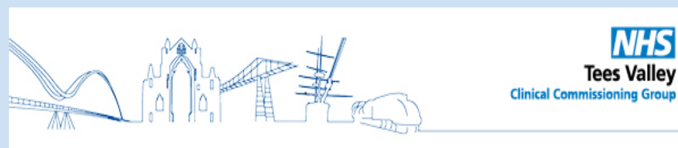
Tees

child death overview panel

ANNUAL REPORT 2020-2021

Hosted by Redcar & Cleveland Council

on behalf of Tees Valley Clinical Commissioning Group, Hartlepool Council, Middlesbrough Council, Redcar & Cleveland Council and Stockton Borough Council



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1. Foreword

Preventing deaths in children is an issue we take seriously on Teesside. Our Child Death Overview Panel forms part of a national programme to examine all child deaths - reviewing the circumstances around the child and determining what can be learned to prevent further deaths and better support families and communities affected by the death of a child.

The Child Death Overview Panel continued to review the deaths of children throughout the pandemic and have embraced technology to discharge the duties of the Panel in a safe and appropriate way, giving the same full consideration to each child and their family and carers as we would have done had we met in person.

There is a broad network of dedicated and caring professionals across Teesside who are involved in this work and and in my role as Chair I see evidence of this commitment in many ways and in every meeting. Their difficult work is often unseen but absolutely crucial in improving services and support for children, their families and communities.

The report outlines the numbers and patterns (if any) of child deaths across Tees. Whilst each death is extremely distressing for the families involved, our numbers are small from a statistical perspective so we contribute our learning to the National Child Mortality database so numbers and trends can be aggregated to further inform practice.

CDOP have focused on the following in 2020/21:

To have continuing discussions with the statutory partners to create an effective CDRP team. The structure and the funding for CDRP has been agreed and new staff will be in place in 2021/22.

To reduce the backlog of child death reviews (deaths should be reviewed by CDOP within 6 months of the date of the death, if not these reviews are overdue). In April 2020 19 reviews were outstanding which was reduced to 13 in March 2021. CDOP raised the backlog in PM reports with the Pathologist and also the delay in receiving the CDRP paperwork from other Trusts.

To ensure that relevant professionals/agencies are in attendance at CDRP meetings; Joint Agency Response, Child Death Reviews and Child Death Overview Panels. This has ensured that all relevant information is provided at the meeting to make informed decisions.

There was a challenge in respect of what palliative care was available for children and young people in the Tees area. The Children's Holistic, Integrated, Palliative Care Service (CHIPS) is now set up however only offers a limited service. This will continue to be monitored by CDOP.

Mark Adams
Director of Public Health South Tees and Chair of Tees CDOP

2. Introduction

1.1 This report covers the period from 1 April 2020 to 31 March 2021 and provides information on the total number of child deaths and the child deaths reviewed across the Tees area.

1.2 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.

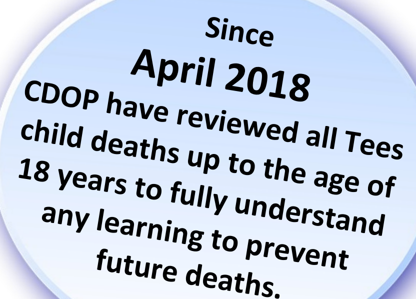
1.3 The death of a child is a tragedy and by reviewing the circumstances surrounding the death of a child we can:

- 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

1.4 The purpose of the review is to determine whether the death was deemed preventable, that is one in which there are identified modifiable factors which may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced. If this is this case the Panel must decide what, if any, actions could be taken to prevent such deaths in the future.

1.5 Within the Child Death Review Process the following definitions are used:

- A **Child** is defined as anyone who has not yet reached their 18th birthday.
- **Preventable Child deaths** are those in which modifiable factors may have contributed to the death. The factors include those in the family or environment, parenting capacity or service provision (this includes the input of all partner agencies who are ordinarily involved in the welfare of our children and families) as well as actions that could be taken at a regional or national level.



3. CDOP Membership and Panel Meetings

2.1 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.

2.2 In 2020/2021 the newly appointed Director of Public Health South Tees (Middlesbrough & Redcar and Cleveland) became the Chair of CDOP and in March 2021 the Lead Nurse for Children and Young people (JCUH) was appointed as Vice Chair.

2.3 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.

2.4 The Tees CDOP met 5 times in 2020/21 reviewing an average of 3.3 deaths per meeting. The Tees CDOP core membership is detailed below:

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

4. Child Death Review Process (CDRP)

The CDRP consists of the following processes:

Immediate Decisions – Within 1-2 hours if possible, senior professionals with responsibility for the child at the end of their life should identify the available facts about the circumstances of the child's death;

- determine whether the death meets the criteria for a Joint Agency Response (see criteria below) and if so, contact the on-call representatives for the police, children's social care and health to initiate the joint agency response
- determine whether an Medical Certificate of Cause of Death (MCCD) can be issued, if not, consider whether the death should be referred to the coroner
- determine whether an issue relating to health care or service delivery has occurred or is suspected and therefore whether the death should be referred to the coroner and/or a serious incident investigation
- identify how best to support the family
- determine whether any actions are necessary to ensure the health and safety of others, including family or community members, healthcare patients and staff .

In all deaths, these discussions should be recorded on a relevant proforma. The outcome of these discussions should also be fed back to the family.

Joint Agency Response (JAR) (Previously known as Rapid Response Meetings) – usually held within 48 hours of a sudden and unexpected child death, with the exception of neonatal deaths. A Joint Agency Response 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 Sudden Unexplained Deaths in Infants or Children (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
- in the case of a stillbirth where no healthcare professional was in attendance

Key professionals from all agencies involved with the child are expected to attend the meeting.

Child Death Review Meeting (CDRM - previously known as Local Case Discussion) – this review meeting takes place in respect of all child deaths once the post-mortem examination results are available (where appropriate) and once the cause of death has been established. This meeting includes all those professionals who knew the family and were involved in investigating the child's death. The professionals should review any further available information, including any that may raise concerns about safeguarding issues. This is in order to share information about the cause of death or factors that may have contributed to the death and to plan future care of the family. A record of the discussion is shared with the coroner, where appropriate, and the relevant CDOP, to inform the child death review.

Child Death Overview Panel *(CDOP)* – An overview of all child deaths up to the age of 18 years occurring in the Tees area is undertaken by the panel. This takes place at the bi-monthly CDOP meetings. The CDOP panel considers information available from those who were involved in the care of the child, both before and immediately after the death, and other sources, including, perhaps, the Coroner. This provides a further opportunity for scrutiny and challenge. Following satisfactory discussion, cases are closed at this stage.

CDRP Forms —The following forms are used as part of the Child Death Review Process:

- Notification Form - National form completed by agencies to report a child death
- Reporting Form (Agency Form B) - completed by agencies who are unable to attend a JAR
- JAR Form (Internal form) completed by the CDOP Business Unit to record minutes of the JAR meeting
- Analysis Form - National form completed by the Chair of the CDRM
- Supplementary forms—There are 20 supplementary forms depending on the nature of the death.

5. Tees Child Death Notifications: 2020 - 2021

(Total child deaths reported)

A notification is submitted to report all deaths of children who reside in the Tees area.

Table below shows the **total number of child death notifications** for each Local Authority area across the Tees in 2020/21. (Figures in brackets are neo-natal deaths). This table also illustrates the notifications as a percentage of total child population for each LA and for the Tees. The data clearly identifies that the higher the population in that LA does not necessarily reflect that that LA will have the highest number of child deaths: Stockton has the highest population but has the lowest number of child deaths in 2020/21.

Table - Total number of Notifications 2020/21			
	Total	**Total Child Population**	**% of total child population**
Hartlepool	5 (2)	20,108	0.024%
Middlesbrough	13 (7)	33,129	0.039%
Redcar & Cleveland	10 (1)	27,607	0.036%
Stockton	5 (2)	44,021	0.011%
Tees Total	**33**	124,865	0.024%

Unexpected/Expected Categorisation: As part of the child death process, deaths are no longer categorised as expected/unexpected. JARs are considered for all child deaths, with the exception of neonatal deaths, to identify any immediate learning or safeguarding concerns in respect of the child death or their siblings.

JARS: There were 13 JARs held from the notifications submitted in 2020/21 compared to 14 held in 2019/20.

JARs held in 2020/21		JARs held in 2019/20	
Hartlepool	2	Hartlepool	2
Middlesbrough	4	Middlesbrough	4
Redcar & Cleveland	5	Redcar & Cleveland	2
Stockton	2	Stockton	6
Total	13	**Total**	14

Referrals for Consideration of Child Safeguarding Practice Reviews (CSPR) or Learning Reviews (LR): Immediately following a child death any agency can submit one of these referrals if the review may highlight Improvements needed to safeguard and promote the welfare of children. Of the 33 child death notifications received in 2020/21, 3 referrals were submitted immediately following the child death.

Child Death Notifications by Local Authority:

Child Death Notifications by Local Authority						
	2016/17	**2017/18**	**2018/19**	**2019/20**	**2021/21**	**Total**
Hartlepool	11(8)	5 (2)	2 (1)	4 (2)	5	**27**
Middlesbrough	13(2)	14 (8)	9 (5)	10 (3)	13	**59**
Redcar & Cleveland	9(4)	7 (3)	13 (7)	5 (3)	10	**44**
Stockton	16(8)	12 (6)	12 (3)	14 (9)	5	**59**
Tees Total	**49(22)**	**38 (19)**	**36 (16)**	**33 (17)**	**33**	**189**

The table above shows the total number of child deaths notifications in each Local Authority across the Tees from 2016/17 to 2020/21: (Numbers in brackets are unexpected deaths). The data demonstrates that the number of notifications in 2020-21 has remained the same as 2019/20 however over the last 5 years the total number of notifications for each year have decreased.

6. Overview of Child Deaths Reviewed: 2020/21

PLEASE NOTE: The total number of child deaths reported in 2020/21 will be different to the total number of deaths reviewed by CDOP in 2020/21 because cases can take in excess of 6 months to be reviewed by CDOP therefore:

- **some child deaths reviewed in 2020-21 will have occurred in 2019/20 or earlier (see Table 3 below), and**
- **some child deaths which occurred in 2020-21 may not be reviewed until 2021/22.**

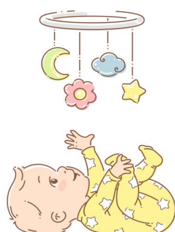
Table 1 - Tees Reviewed Child Deaths 2020/21				
	Total	**Year Death Occurred 2020/21**	**Year Death Occurred 2019/20**	**Year Death Occurred 2018/19**
Hartlepool	3	0	3	0
Middlesbrough	10	3	7	0
Redcar & Cleveland	9	3	4	2
Stockton	10	1	9	0
Tees Total	**32**	**7**	**23**	**2**

In 2020/21, 21% of the total child deaths were reviewed in that year and the majority (23) of the deaths reviewed were from 2019/20. 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).
- Increased number of ongoing investigations e.g. police, Serious Case Reviews, Learning Reviews, Serious Incidents. Child deaths cannot be reviewed by CDOP until these investigations are complete.
- The continuing impact of Covid 19 pandemic.

Table 1 above also clearly identifies that the most deaths reviewed in 2020/21 were from Middlesbrough (10) and Stockton LA (10).

Of the 32 deaths reviewed in 20-21, 13 (40%) were neonatal deaths:



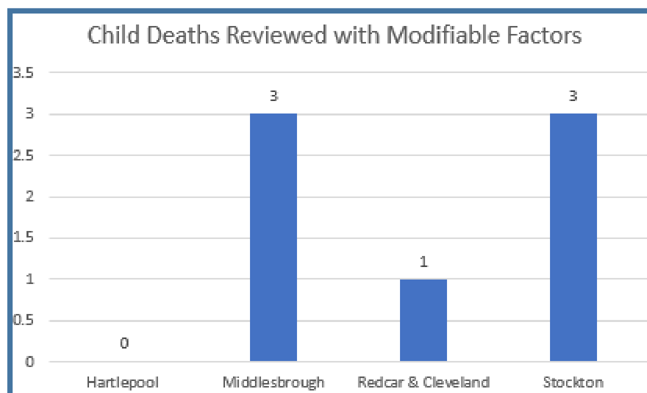
- 7 females and 6 males
- 3 were categorised as Sudden unexplained death
- The majority of neonatal deaths were categorised as a perinatal/ neonatal event.

The remaining 19 deaths reviewed were older children aged 28 days to 17yrs :

- 12 males and 7 females
- The 3 highest categories for these deaths: Chronic Medical Condition, Chromosomal, Genetic and Congenital Anomalies and Suicide or deliberate self-inflicted harm

6. Overview of Child Deaths Reviewed: 2020/21

Modifiable Factors

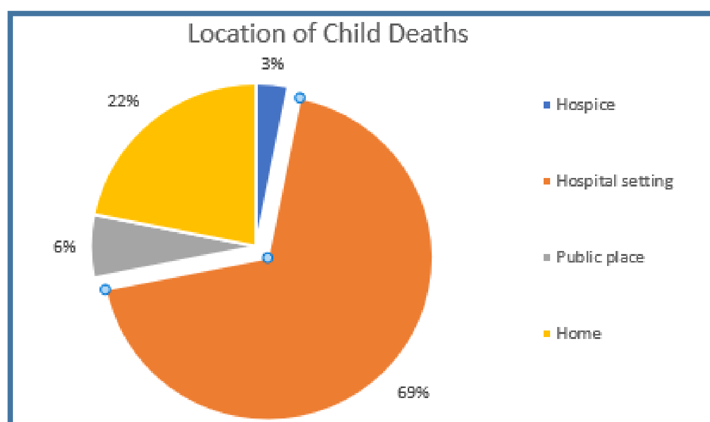


The table opposite shows the child deaths reviewed with Modifiable Factors. These are defined as 'those where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced'.

Tees CDOP reviews all Tees deaths and will discuss any known modifiable factors and also identify new modifiable factors that may have prevented the death. In 2020/21, 7 (21.5%) out of the 32 deaths reviewed had identified modifiable factors which in line with 7 in 2019-20, 7 in 2018-19. Some of these included risk factors such as:

- Maternal Smoking
- Co-sleeping/inappropriate sleeping arrangements
- Alcohol use by parents whilst a child is in their care
- Sepsis diagnosis in children with complex needs

Where modifiable factors are identified, the Panel has taken action to address these where appropriate (please see page 12, outcomes and actions).



Location of Child Deaths

From the pie chart opposite the most deaths (69%) occurred in a hospital setting which is in line with neighbouring CDOPs and national statistics. The highest number of deaths also occurred in a hospital setting in 2019/20 within the Tees.

Category of Child Deaths

The table opposite shows that from the 32 child deaths reviewed, the highest number of child deaths were categorised as perinatal/Neonatal event as with previous years for Tees data and national data.

Category of Child Death	
Perinatal/neonatal event	**9**
Chromosomal, genetic and congenital anomalies	**6**
Chronic medical condition	**4**
Suicide or deliberate self-inflicted harm	**3**
Sudden unexpected, unexplained death	**3**
Malignancy	**3**
Infection	**2**
Acute medical or surgical condition	**1**
Trauma and other external factors	**1**

6. Overview of Child Deaths Reviewed: 2020/21

Ethnicity of Child Deaths Reviewed

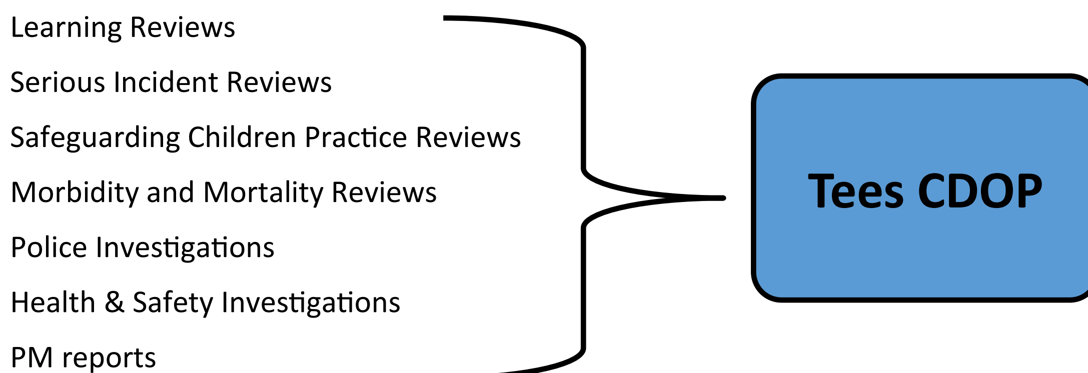
68% of child deaths reviewed in 20/21 were White British. However, 21% of child deaths reviewed did not have the ethnicity recorded and this will be a recommendation going forward.

Children with a Learning Disability

Deaths of children with learning disabilities are reviewed as part of the Disabilities Mortality Review (LeDeR).   This programme *"supports local areas to review all deaths of people with learning disabilities, aged 4 years and over. Reviews are completed to identify good practice and what has worked well, as well as where improvements to the provision of care could be made".* The LeDeR review is more of a holistic approach. Of the 32 child deaths reviewed, 3 deaths were reviewed further as part of LeDeR.

Other Reviews/Investigations

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



Referrals for Consideration of Safeguarding Children Practice Reviews or Learning Reviews

When a child death is reviewed at CDOP a decision can be made to submit a referral for consideration of a Child Safeguarding Practice Review (previously known as a Serious Case Review) to the relevant Safeguarding Children Partnership. This review is to identify any relevant learning from the death that may prevent future deaths. From the 32 child deaths reviewed by CDOP in 2020-21, CDOP did not submit any referrals as other agencies had already commenced this referral process prior to the CDOP meeting.

Covid 19 Pandemic

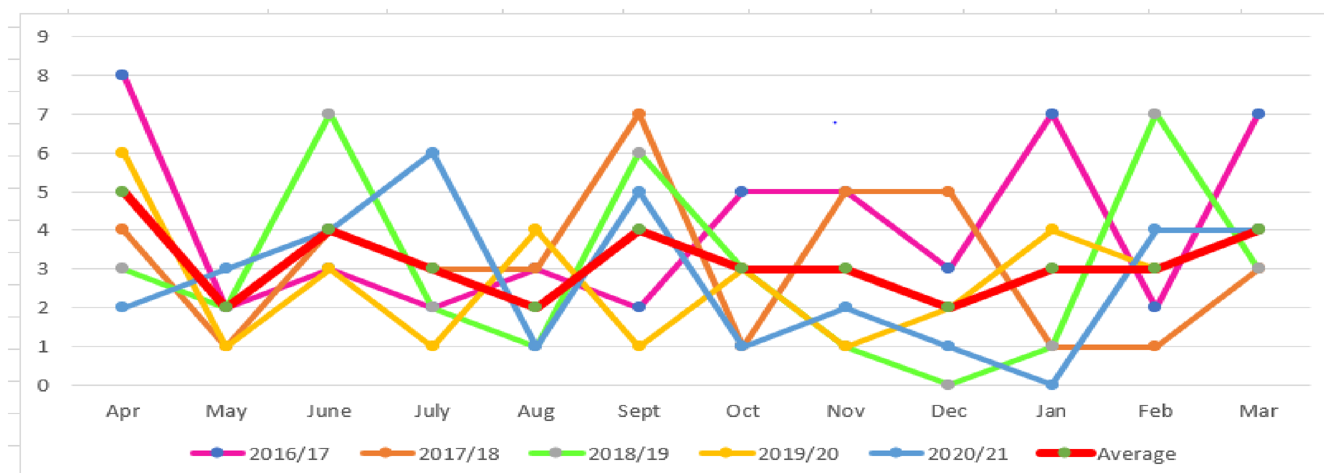
We are working to fully understand what impact, if any the pandemic has had on child deaths.
This will continue to be monitored both locally and nationally.

7. Analysis of Child Death Notifications: 2016 - 2021

The following analysis is in respect of child death notifications from 1 April 2016 to 31 March 2021.

Year on Year Notification of Deaths, by Month

The graph below illustrates that year on year there are peaks and troughs for notifications. Across the five years the average remains consistent. However, there is a minor change to the average with April the highest number of notifications (5).



	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	8	2	3	2	3	2	5	5	3	7	2	7
2017/18	4	1	4	3	3	7	1	5	5	1	1	3
2018/19	3	2	7	2	1	6	3	1	0	1	7	3
2019/20	6	1	3	1	4	1	3	1	2	4	3	4
2020/21	2	3	4	6	1	5	1	2	1	0	4	4
Average	5	2	4	3	2	4	3	3	2	3	3	4

Year on Year, Notification of Deaths, by Age Group

When analysing the data over the 5 years it shows that the greatest of notifications (62, 32%) are from the neonatal period (0-28 days). The table below highlights that the first year of a child's life is the most risky with 58% of deaths occurring in this period which is consistent with national statistics.

	2016/17	2017/18	2018/19	2019/20	2020/21	Total
0-27 days	10	13	14	13	12	**62**
28-364 days	14	8	12	8	6	**48**
1-4 years	6	8	0	0	4	**18**
5-9 years	5	5	2	3	1	**16**
10-14 years	3	1	4	5	6	**19**
15-17 years	11	3	4	4	4	**26**
Total	49	38	36	33	33	**189**

From the data in the remaining age groups (79), the highest number of notifications are in the 15-17 year age group (26) representing 33% over the five year period.

Year on Year Notifications by Gender

	2016/17	2017/18	2018/19	2019/20	2020/21
Male	28	24	19	19	17
Female	21	14	17	14	15

8. Local Learning Outcomes and Actions from Child Death Reviews 2020/21

Issue	CDOP Action	Response
Ongoing Serious Case reviews/Learning Reviews	Discussion held with Hartlepool & Stockton Safeguarding Children Partnership (HSSCP) and South Tees Safeguarding Children Partnership to ensure regular updates are received.	A representative from each Safeguarding Children Partnership is a member of CDOP to provide these updates.
The high number of outstanding reviews of child deaths	Letters sent to Clinical Directors of North Tees NHSFT, South Tees NHSFT and Newcastle NHSFT to highlight the outstanding reviews and request the actions each Trust is implementing to clear this backlog.	CDOP forms have been received for the majority of the outstanding reviews. There are still outstanding reviews due to a delay in PM reports which is a national issue as well as other delays.
LA Directors of Children's Social Care to be notified separately of child deaths.	Discussions held with local authority Directors whether this would be beneficial.	HSSCP and STSCP are now responsible for informing the Directors/Assistant Directors of child deaths who reside in their area.
Ensure Electronic CDRP forms are easily accessible	The CDOP website is no longer available. Email sent to Tees Procedures to request CDRP forms are uploaded for use.	CDRP forms now fully accessible through Tees Procedures. Updated forms are uploaded when required.
The importance of Health Visitors being invited and attending JAR/CDRMs	Email sent to request that all health visitors are invited to JAR/CDRMs. Email sent to request that health visitors attend a JAR/ CDRM and the importance of this.	Health Visitors have been added to the SPOC lists for both South Tees NHSFT and South Tees NHSFT to ensure they are invited. A health visitor will always attend a JAR/CDRM when the child is under 4 years old.
Lack of dedicated Palliative care team in the Tees area	Letter sent to Newcastle NHSFT to request an update in respect of the palliative care available for the Tees area.	The Children's Holistic, Integrated, Palliative Care Service (CHIPS) has been set up as a regional wide service to offer Paediatrics Palliative care. This support is available via the telephone during working hours over 5 days a week. Information leaflet was circulated to both Trusts. This service has been added to the CDOP forward work plan for monitoring.
Responsibilities of Hospices in the Child Death Review Process	Letter sent to both Hospices in the Tees area to highlight their responsibilities in the child death review process.	At the time the letter was sent, 1 hospice was temporarily closed. However, a discussion was held with the other hospice and they now fully understand their expectations within the process. CDOP will continue joint working with Hospices.
Receiving of PM reports	Letter was sent to the pathologist requesting any actions that have been implemented to ensure PM reports are received in a timely manner.	The pathologist does not reside in the Tees area and is the pathologist covering a number of different regions, which can be a challenge. Also the pathologist is working across a number of different areas and this can be difficult. This has been added to the CDOP forward work plan and will be monitored.

9. CDOP Priorities/Challenges and Actions Taken

Priorities for 2019/20	Action Completed in 2020/21
To ensure that families are at the forefront of the Child Death Review Process.	Keyworker for the family is now identified at JAR meetings for unexpected deaths.
Provide a consistent CDOP leadership to ensure the commitment of all CDR partners and relevant professionals to the process.	This is an ongoing priority as future CDOP arrangements are confirmed.
Ensure a CDR business unit is in place to co-ordinate child deaths.	Statutory Partners have agreed staffing structure for the CDRP business unit. Implementation 2021/22.
Provide relevant training to professionals to ensure the new Child Death Review Process is fully embedded into practice.	Education Briefing has been developed and circulated to all schools in the Tees area for education representatives to fully understand the JAR meetings. Training will be ongoing and will be a priority for 2021/22
Further develop working relationships with the coroner.	Meetings are now being held every 3 months between CDOP Co-Ordinator, Designated Doctor for Child Death and the coroner.
Work with neighbouring CDOPs to improve the identification of any patterns or trends in child death data.	This will be progressed as a priority in 2021/22 once new CDRP Co-ordinator is appointed.
Continue to work closely with Child Bereavement UK to ensure bereavement support is available for families and professionals.	Child Bereavement share any training/sessions/updates with CDOP members/professionals so this can be relayed to families.
Develop a mechanism to wider disseminate learning from Tees child deaths.	This will need to be considered further once the CDRP Business unit is in place. Currently, any learning is circulated from local CDOPs to relevant professionals.
Improve and work closely with the Learning Disabilities Mortality Review (LeDeR) programme area Lead, to ensure a co-ordinated approach to reviewing deaths of children with learning disabilities.	As part of the process for notifying relevant agencies of any child deaths the LeDeR are now automatically in-formed of any child deaths with LD.
Continue to promote local and national campaigns to prevent future child deaths.	Tees CDOP will always continue to promote national and local campaigns.
To identify an Obstetric Representative to join CDOP to provide valuable information.	An Obstetric Representative has now been identified. Once a child death review meeting has been held the Neo-natal Consultant will contact the Obstetric Representative to clarify if they need to attend the CDOP meeting.
To raise awareness of the Child death process with families.	This will need to be further considered once the new CDRP Co-ordinator is appointed.
To work closely with the Injury Prevention Group, South Tees Public Health	This will need to be further considered once the new CDRP Co-ordinator is appointed.

Challenges for 2020/21	Action Completed in 202/21
The impact of the Covid 19 pandemic on delivering the Child death process.	CDOP have continued to implement the CDRP through the pandemic using different ways of working.
Funding constraints within Local Authorities and CCGs to fulfil the statutory requirements of the Child death process.	Statutory partners have agreed future funding for the CDRP statutory requirements. Ongoing discussions will be held in respect of funding to offer any additional functions within the CDRP.

10. Priorities and Challenges for 2021 - 22

Priorities for 21/22

1. To ensure that families continue to be at the forefront of the Child Death Review Process.
2. To agree a CDOP Governance structure.
3. To develop and launch a new CDOP website.
4. To develop robust links with the Safeguarding Children Partnerships within Tees.
5. To provide a consistent CDOP leadership to ensure the commitment of all CDR partners and relevant professionals to the process.
6. To consider the impact of Covid 19 on child death data.
7. To appoint a Child Death Review Co-ordinator.
8. To launch eCDOP ensuring all professionals who are part of the Child Death Review process receive appropriate training.
9. Work with neighbouring CDOPs to improve the identification of any patterns or trends in child death data.
10. Develop a mechanism to wider disseminate learning from Tees child deaths.
11. To ensure that all CDRP forms are accurately completed. E.g. Ethnicity.
12. Continue to promote local and national campaigns to prevent future child deaths.
13. To develop a working relationship with the Injury Prevention Group, South Tees Public Health.
14. The Palliative Care function for children and young people in the Tees area.

Challenges for 21/22

1. Funding constraints within the statutory partner agencies to provide additional functions to the statutory requirements.
2. Training relevant professionals prior to the implementation of eCDOP.
3. To ensure appropriate resources are in place to fulfil statutory requirements.
4. To ensure all CDRP partners are aware of their expectations.
5. The TVCCG Child death administrator no l longer being in post.

10. Feedback from CDOP members

This section provides valuable feedback from CDOP members in respect of the importance of CDOP, the process, multi agency working and learning from child deaths.

CDOP meetings that they are well organised and chaired, information is shared in a timely manner and any requests are promptly acknowledged and dealt with.

The CDOP process is vital to ensure accuracy of reviews and events around the death of children and identify where care can be improved.

Professionals involved in the Child Death Review Process are very passionate about preventing future child deaths

CDOP provides the opportunity to have an open discussion and to share, learn and challenge each other. We then have the chance to reduce the risk of further child deaths where similar circumstances arise and to allow professionals to provide the best support to children and families.

Thank you to Statutory Partners, CDOP members and external agencies for their commitment and contribution to CDOP in 2020-21.

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Information:

- Child Death Review Process guidance — www.gov.uk
- The Lullaby Trust—www.lullabytrust.org.uk
- Child Bereavement UK— www.childbereavementuk.org.uk
- Cruse Bereavement Care - www.cruse.org.uk
- Childhood Bereavement Network— childhoodbereavementnetwork.org.uk