Bradford District Child Death Overview Panel (CDOP)

Annual report 2019/20 and 2020/21

Report Authors:

Duncan Cooper - Chair of Bradford CDOP, Consultant in Public Health CBMDC

Louise Clarkson – SUDIC/CDOP Manager, BTHFT

Mary Cronin – Public Health Intelligence Specialist, CBMDC

Published: February 2022

Contents

Key messages

1. The death of a child is a devastating loss for families and communities. In Bradford District all child deaths up to the age of 18 years are reviewed within a Child Death Review (CDR) process and quality assured by the Child Death Overview Panel (CDOP).

2. This report presents child mortality data from the pre COVID period (2019/2020) and the first year of the pandemic (2020/2021).

3. In 2019/20 there were 74 child deaths and in 2020/21 68 child deaths. During the COVID-19 pandemic period there has not been an increase in child deaths in Bradford District (or at a national level).

4. Neonatal deaths (deaths within the first 28 days of life) account for the largest proportion of all deaths, 45% of deaths in 2019/2020 and 40% in 2020/21.

5. The rate of child deaths for those from Asian backgrounds is three times higher than for White ethnic background. Data analysis and child death review notes show this excess is associated with a mixture of genetic, cultural and social factors.

6. Two categories of death accounted for 2/3 of all child deaths, continuing the trend of recent years. These were, chromosomal, genetic and congenital anomalies (Category 7) (19/20: 33% of deaths, 20/21: 43% of deaths) and perinatal/neonatal events (Category 8) (19/20: 34% of deaths, 20/21: 25% of deaths).

7. In 2019/20, 22% of all deaths were considered modifiable. Identified modifiable factors were smoking during pregnancy, unsafe swimming, suicide, genetically inherited conditions, unsafe sleeping practices, and COVID-19 infection.

8. Sadly, there have been a small number of children with underlying health conditions that have died with COVID-19 infection, although the infection is very rarely fatal in children and young people.

9. There is a trend of increasing child death rates with increasing levels of social deprivation and poverty in Bradford District (rates in the poorest areas are fourfold the most affluent). The message here is clear, we must reduce poverty to save lives.

10. Recommendations have been made by the CDOP for partners to consider action within their own programmes of work.

Introduction

The death of a child is a devastating loss affecting families' friends, schools and professionals working with the child and communities. In Bradford District (as with other areas of the country) all deaths of children up to the age of 18 years, (including medically unattended stillbirths) excluding still births and planned terminations, are reviewed firstly via the Child Death Review process. This precedes the independent multi-agency panel review by the Child Death Overview Panel (CDOP) whereby quality assurance of the CDR process is carried out and recommendations made.

The Bradford District CDOP was established by the Bradford Safeguarding Children Board (BSCB) in 2008. It accommodates the national guidance and statutory requirement which was updated in 2018 with the publication of the Child Death Review Statutory and Operational Guidance. This builds on Working Together to Safeguard Children (2018) and details how professionals and organisations across all sectors involved in the Child Death Review should contribute to guided standardised practice nationally and enable thematic learning to prevent future child deaths [1]. This process is undertaken locally for all children who are normally resident in the Bradford District.

The CDOP is multiagency with differing areas of professional expertise contributing and meets 6-8 times per year. The aim of the CDOP is to systematically review all child deaths (from birth to 18 years) to improve the understanding of how and why children in Bradford District die, identify whether there were modifiable factors which may have contributed to each death, and use the findings to take action to prevent future deaths. The panel brings in expertise from a wide range of partners to ensure the discussions within the meetings are robust and challenging where required **(Appendix 2; Appendix 3).**

The CDOP also has a role in categorising a child's death into one of 10 causes of death categories. Definitions around modifiable factors and the cause of death categories are contained within **Appendix 4.**

[1] Working together to safeguard children (Chapter 5). 2018 https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

Data analysis for deaths reviewed in 2019/20 and 2020/21

CDOP review process

In 2019/20 (1st April 2019 – 31st March 2020) there were 74 child deaths recorded in Bradford District. Of the 74 child deaths, 63 (85%) were reviewed by the CDOP, four (5%) were out of area, leaving 7 (10%) awaiting review by CDOP.

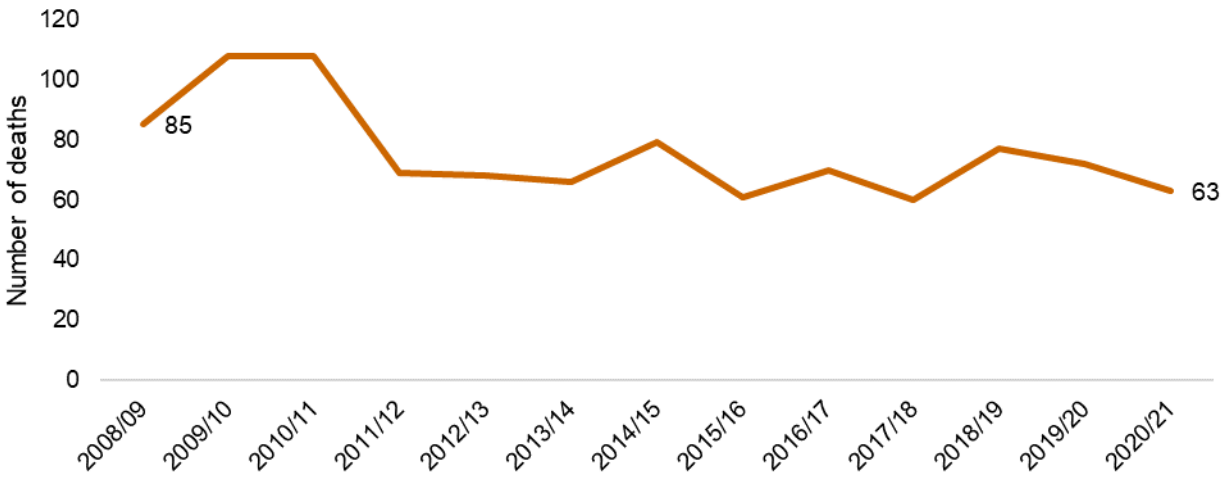
In 2020/21 (1st April 2020 – 31st March 2021) there were 68 child deaths recorded in Bradford District. Of the 68 child deaths 46 (68%) were reviewed by the CDOP, five (7%) were out of area, leaving 17 (25%) awaiting review by CDOP.

The following analysis is based on the number of children dying in the years 1st April 2019 to 31st March 2020 and 1st April 2020 to 31st March 2021.

Trend in deaths

The number of child deaths has remained relatively stable the past decade with a previous peak in 2010/11 of 108 deaths. The average number of child deaths recorded per year is 69 **(Figure 1).**

Figure 1: Number of deaths per year* 2008/09 to 2020/21



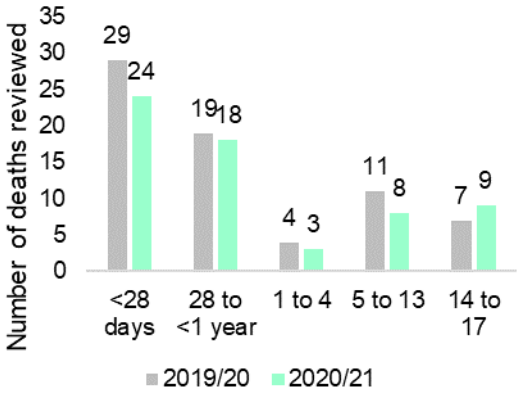
**** year of death of the child*** *– as opposed to the year the child's death was reviewed*

Demographics

In 2019/20 there were slightly more males (56%) than female (44%) child deaths reviewed whereas in 2020/21 there was an equal split between males and females. Neonatal deaths (deaths within 28 days of life) accounted for the largest proportion of all deaths in both 2019/20 (45%) and 2020/21 (40%), followed by those aged 28 days to less than one year **(Figure 2; Table 1)**.

Figure 2: Age distribution of all child deaths - 2019/20 and 2020/21 a) number of deaths; b) rate per 10,000 population

a) number



b) rate per 10,000

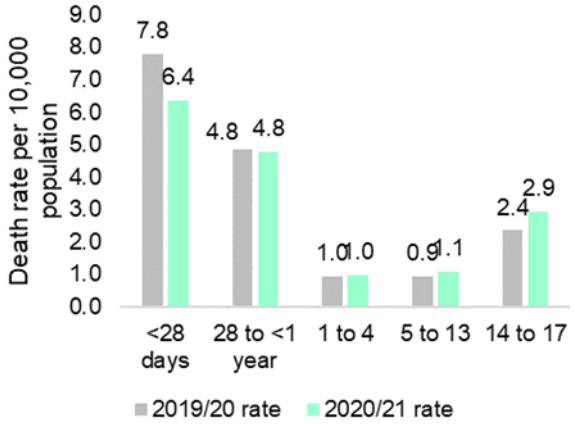


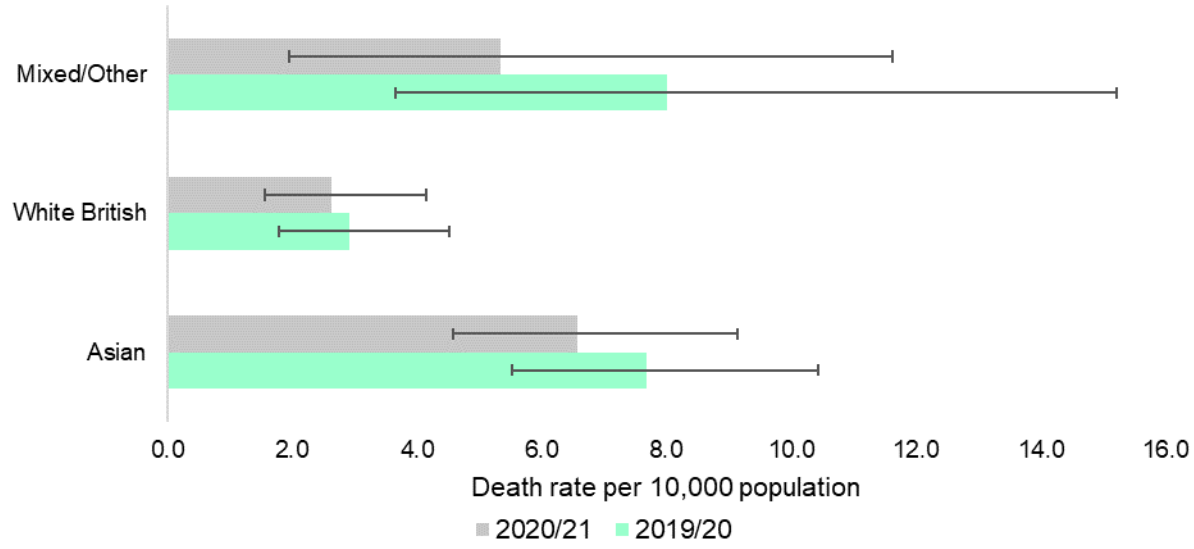
Table 1: Number of child deaths and rate per 10,000 population – by age group

Age group	2019/20 n (rate per 10,000)	2020/21 n (rate per 10,000)
<28 days	29(7.80)	24(6.38)
28 to <1 year	19(5.11)	18(4.78)
1 to 4	4(1.27)	3(0.97)
5 to 13	11(1.49)	8(1.08)
14 to 17	7(2.35)	9(2.94)

According to the 2011 census 39% of the population aged 0 – 17 years of age were classified as of Asian ethnicity (mainly South Asian Pakistani and Bangladeshi heritage) and 53% are White (1). However, 59% of all child deaths reviewed by CDOP were of South Asian ethnicity and just under a third of deaths occurred in children of White ethnicity in both 2019/20 and 2020/21 **(Figure 3)**. 1. T

The rate of child deaths is statistically significantly higher in those from a South Asian ethnic background in comparison to those from a White ethnic background with almost three times the rate **(Figure 3)**. The rate is also higher in those from a mixed ethnic background, although (with overlapping confidence intervals) this difference is not statistically significant.

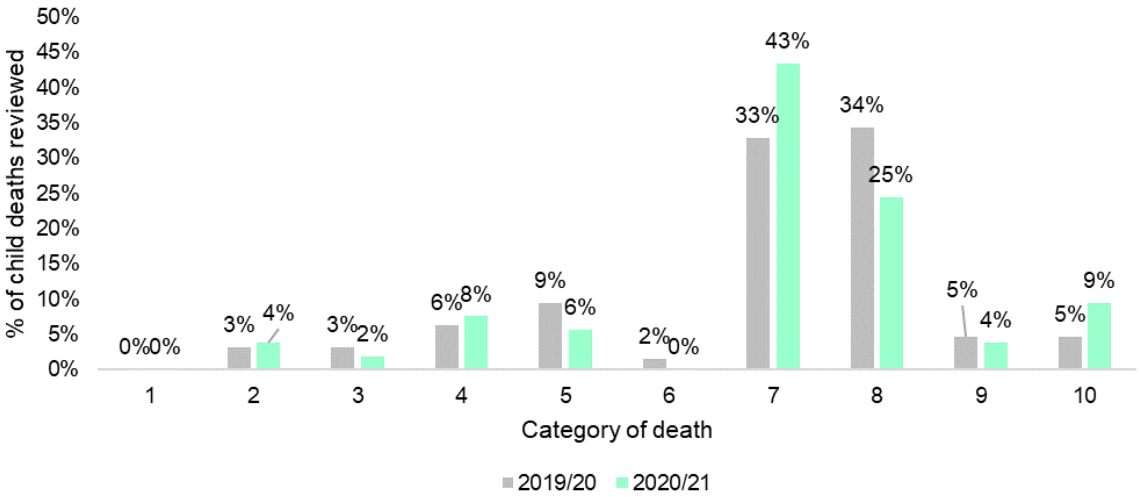
Figure 3: Rate per 10,000 population all child deaths 2019/20 and 2020/21 broken down by ethnic group. **Data source: 2011 Census**



Cause of death

There are ten separate categories for cause of death recorded by the Child Death Overview Panel (CDOP). In 2020/21, 43% of deaths reviewed which were Category 7 (chromosomal, genetic and congenital anomalies) a higher proportion than 2019/20 where 33% were category 7 **(Figure 4)**. Overall however, there was a similar distribution amongst the categories of death in 2019/20 and 2020/21, with Category 7 and 8 (perinatal / neonatal event) accounting for two-thirds of deaths reviewed.

Figure 4: All child deaths reviewed 2019/20 and 2020/21 broken down by category of cause of death



** some deaths appear in more than one category*

Category	Description (further details in Appendix 3)
1	Deliberately inflicted injury
2	Suicide or deliberate self-inflicted harm
3	Trauma and other external factors
4	Malignancy
5	Acute medical or surgical condition
6	Chronic medical condition
7	Chromosomal, genetic and congenital anomalies
8	Perinatal/neonatal event
9	Infection
10	Sudden unexpected death

COVID-19 deaths in children

COVID-19 is very rarely fatal in children and young people, even amongst those with underlying serious health conditions. National research during the pandemic found that 3,105 children and young people died in England from *all causes* during the first year of the pandemic. Of these 61 children tested positive for COVID-19 but 25 died as a direct result of COIVD-19 infection (2 per million children in England)[2]. Children between 10 and 18 years old, of Asian and Black ethnic backgrounds, and with serious health conditions were over-represented compared to other children. Sadly, there have been a small number of children with underlying health conditions that have died with COVID-19 infection (but not as a direct result of COVID) in Bradford District. Reducing the spread of COVID-19 through schools and communities will continue to require a sustained and coordinated programme of work across District partners.

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'*[3]

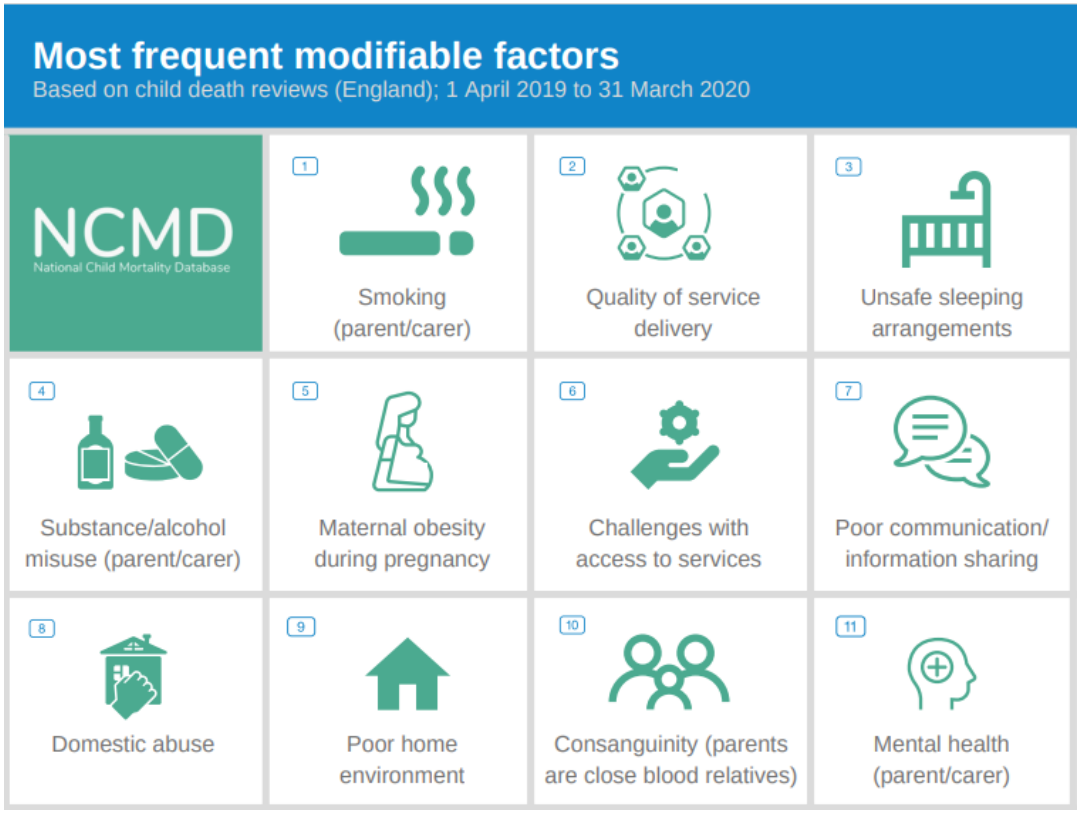
Figures 5 and 6 outline modifiable factors associated with child deaths at a national level[4]. These are taken from the national review of child deaths and not from Bradford District analysis. They demonstrate that the physical environment (e.g. sleeping arrangements), the social environment (e.g. substance misuse) and service provision (e.g. quality guidelines /pathways) are all important modifiable factors we can influence at a local level.

[2] Working together to safeguard children: https://www.workingtogetheronline.co.uk/chapters/chapter_five.html

[3] Deaths in Children and Young People in England following SARS-CoV-2 infection during the first pandemic year: a national study using linked mandatory child death reporting. https://www.researchsquare.com/article/rs-689684/v1

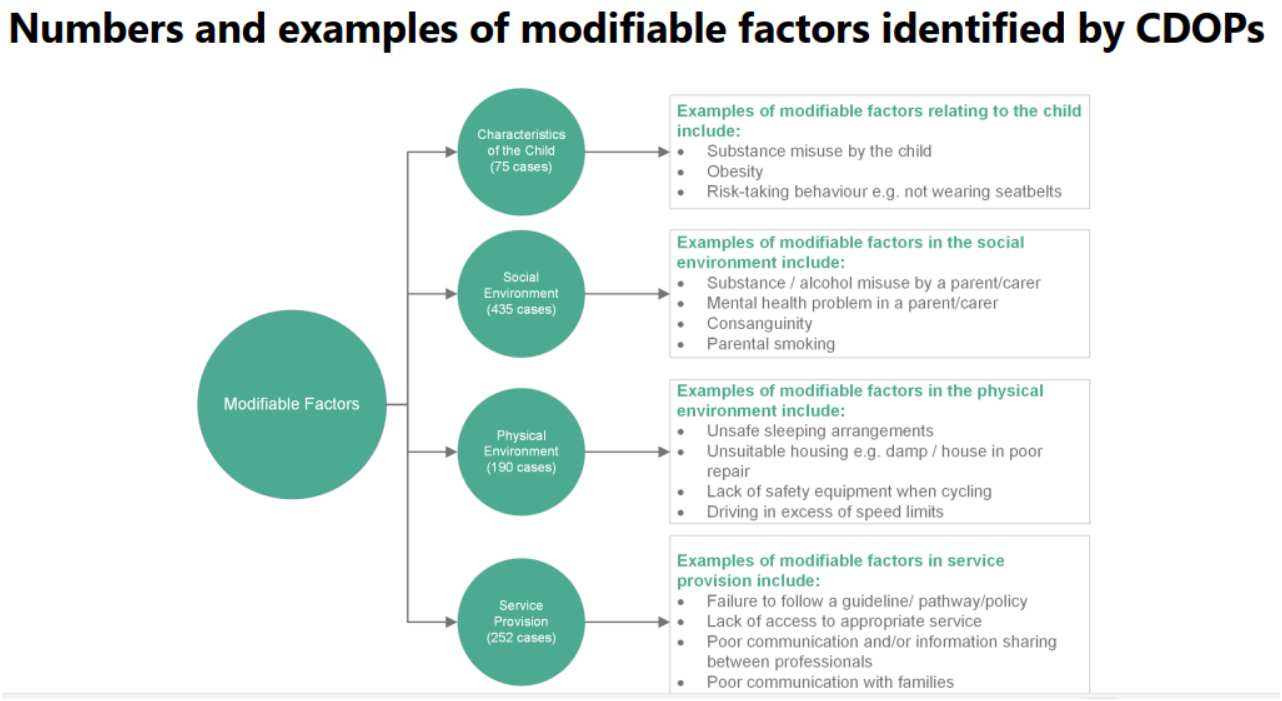
[4] Second Annual Report National Child Mortality Database Programme. June 21. https://www.ncmd.info/wp-content/uploads/2021/06/NCMD_2nd_Annual_Report_June-2021_web-FINAL.pdf

Figure 5: Most frequent Modifiable factors – national data. **Source: National Child Mortality Database Second Annual Report**



Source: National Child Mortality Database Second Annual Report

Figure 6: Numbers and examples of modifiable factors identified by CDOPs. **Source: National Child Mortality Database Second Annual Report**

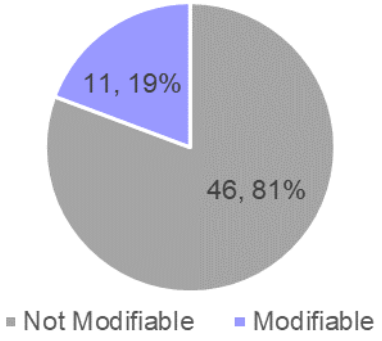


Source: National Child Mortality Database Second Annual Report

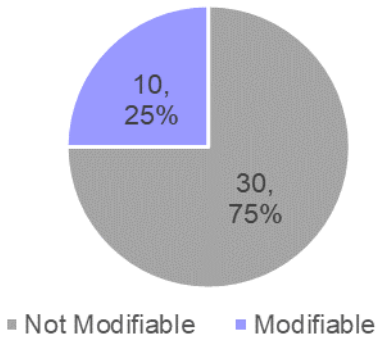
In 2019/20, 19% of all deaths reviewed by Bradford District CDOP were considered to be modifiable with 25% of deaths considered modifiable in 2020/21 **(Figure 7).**

Figure 7: Child deaths broken down modifiability 2020/21 [based on deaths reviewed by Bradford District CDOP]

a) 2019/2020



b) 2020/2021



Modifiable factors associated with child deaths in Bradford (2019-2021) were smoking during pregnancy, unsafe swimming, suicide, genetically inherited conditions, unsafe sleeping practices, and COVID-19 infection (Table 2).

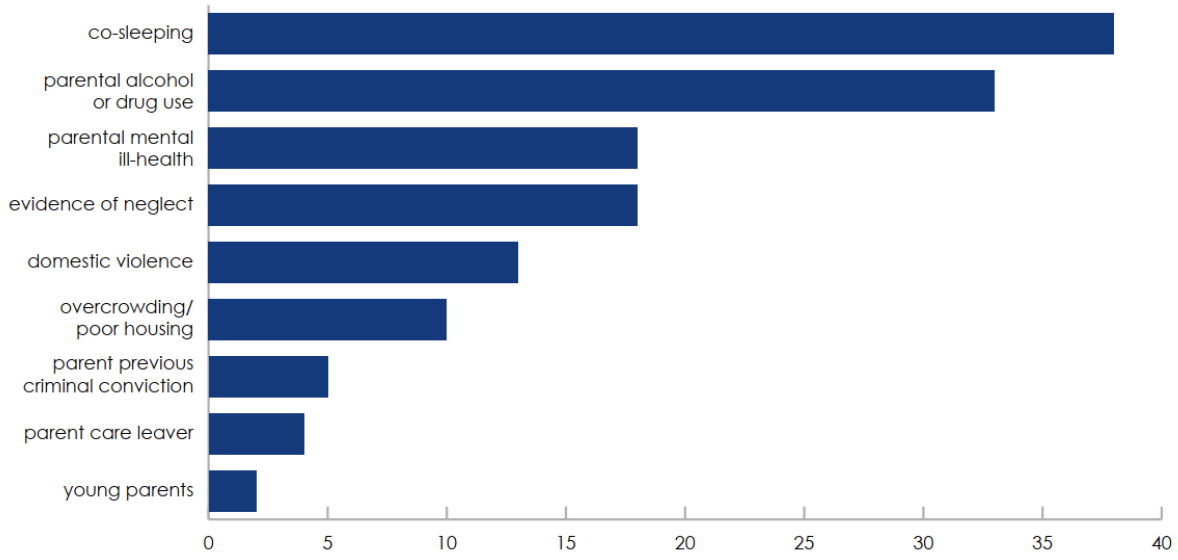
Table 2: Modifiable factors identified in deaths that occurred between 2019-2021, Bradford District CDOP

Smoking in pregnancy
Unsafe swimming
Suicide
Genetically inherited conditions
Unsafe sleeping practices relating to sudden infant death syndrome (i.e. bed sharing, parental drug and alcohol use, overheating)
COVID-19 in children with underlying health conditions
Foetal alcohol syndrome/spectrum disorder

Sudden Unexpected Death in Infants (SUDI)

Alongside the national reduction in the incidence of sudden unexpected death in infancy (SUDI), there has been a steady shift towards a greater proportion of these deaths in families from deprived socioeconomic backgrounds. Almost all of these tragic incidents involve parents co-sleeping in unsafe sleep environments with infants, often when parents have consumed alcohol or drugs (Figure 8), and this is also the case in Bradford District (Table 2). There are often wider safeguarding concerns involving cumulative neglect, domestic violence, parental mental health concerns and substance misuse. The national analysis showed that a particular danger point seems to be when infants are between one and two months old.[4]

Figure 8: Risk factors identified in notified cases of sudden unexpected death in infancy (SUDI) – national study. **Source: The Child Safeguarding Review Panel (2020)**



Unexpected child deaths

There are two categories of child deaths:

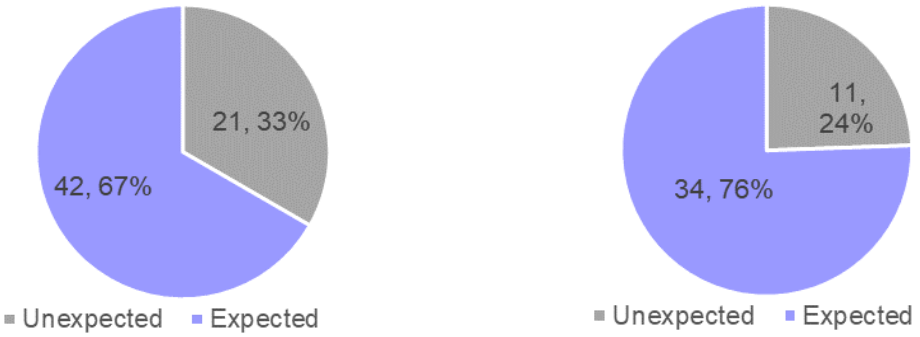
1. A child death is “expected” where the death of an infant or child was anticipated due to a life limiting condition.

2. A child death is “unexpected” where the death of an infant or child was not anticipated as a significant possibility, for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which led to the death.

Figure 9: All child deaths reviewed broken down by expected/unexpected category

[based on deaths reviewed by Bradford District CDOP]

a) 2019/2020 b) 2020/2021



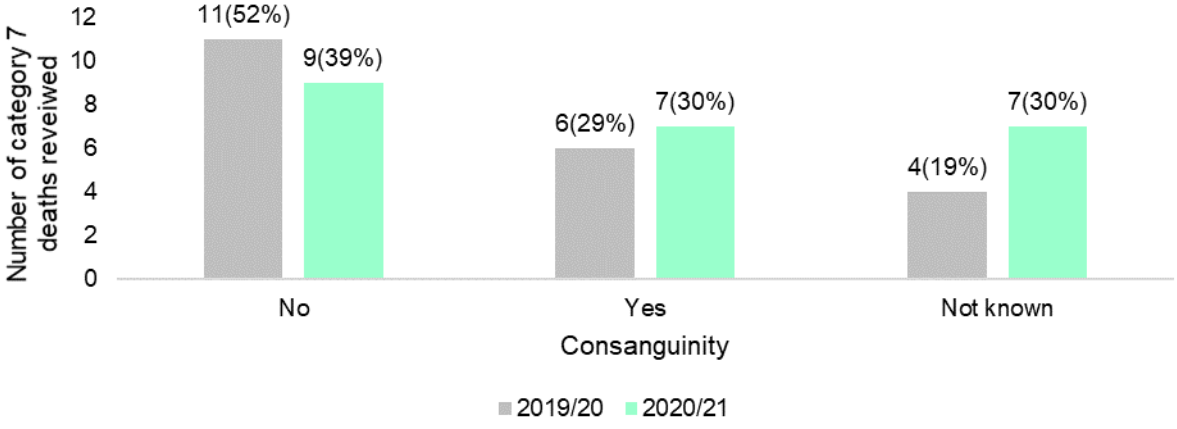
In 2019/20 and 2020/2021, 33% and 24% of all child deaths were 'unexpected' **(Figure 9).** These relate to deaths where there was a sudden unexpected death in an infant (SUDI), suicide or acute medical emergencies.

Consanguinity

Consanguinity is defined as a union between two individuals who are related as second cousins or closer[5]. Research in Bradford District has shown that consanguineous unions are the cause of a local excess in congenital anomalies which are a leading cause of infant death and disability. [4]

Consanguineous union or marriage occurred in 30% of all chromosomal, genetic and congenital anomalies (Category 7) child deaths in 2019/20 and 2020/21.

Figure 10: All Category 7 child deaths reviewed in 2019/20 and 2020/21 broken down by reported consanguinity [based on deaths reviewed by Bradford District CDOP]



[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3419292/

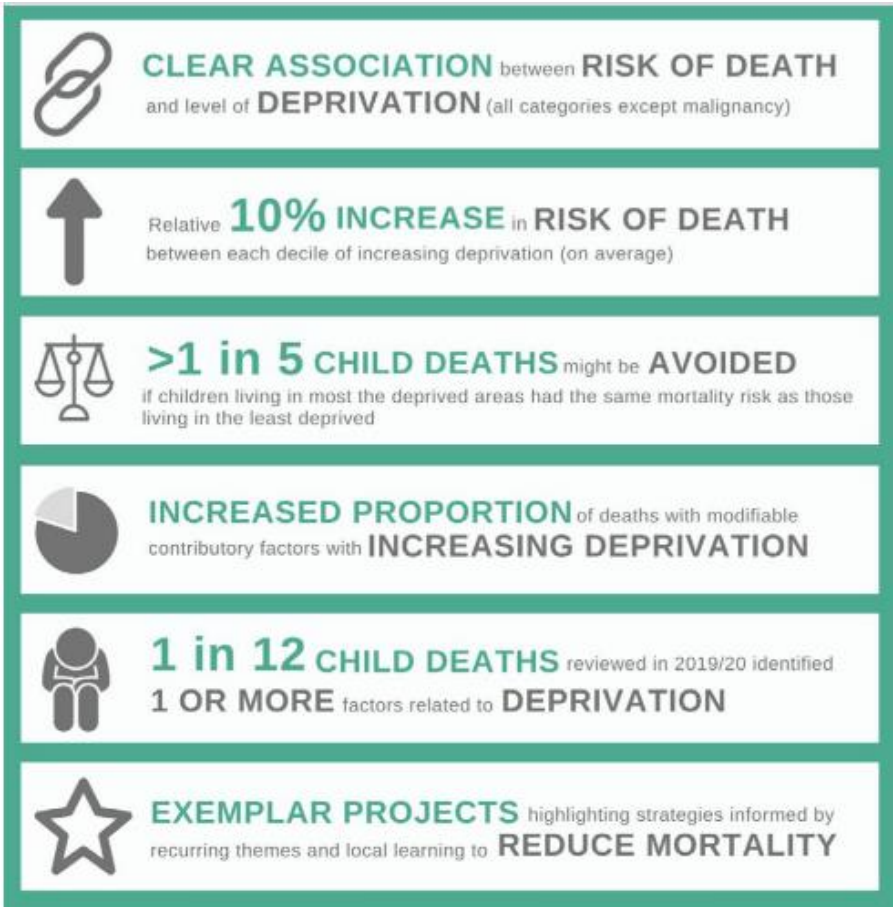
[4] Lancet. 2013 Oct 19;382(9901):1350-9. doi: 10.1016/S0140-6736(13)61132-0. Epub 2013 Jul 4

Deprivation and geographical distribution

It is tempting to assume that it is predominantly medical conditions that cause child deaths, rather than background social factors. This is certainly true in terms of direct causation between life threatening illness and death. Often it is difficult, at child death reviews, to conclude direct causation exists between social factors and a single death. However, when we look at the regularity of medical causes of death across the population a disturbing pattern emerges. National analysis shows that deaths from medical/surgical causes, congenital anomalies, SUDI and perinatal/neonatal events all significantly increase in areas of high deprivation (where a range of social risk factors cluster). The message is clear, we must reduce poverty to save lives.

National research shows that over a fifth of all child deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived[6] (Figure 11). A range of factors including homelessness, poor and overcrowded housing conditions, domestic violence and crime are associated with poverty.

Figure 11. Link between child mortality and social deprivations (national findings)



[6] Child Mortality and Social Deprivation National Child Mortality Database Programme Thematic Report Data from April 2019 to March 2020. May 2021 https://ncmd.info/wp-content/uploads/2021/05/NCMD-Child-Mortality-and-Social-Deprivation-report_20210513.pdf

There is a trend of increasing child death rates with increasing levels of social deprivation in Bradford District. Two-thirds of all child deaths in 2019/20 and 2020/21 occurred in the most deprived fifth of the national population living in Bradford **(Figure 12).** When comparing population rates (rather than numbers) rates of child deaths are roughly four times as high in the most deprived area as least deprived **(Figure 13).** This is similar to the national picture and report that found that approximately three times as many deaths of children who were resident in the most deprived neighbourhoods, compared to those from the least deprived.

Figure 12: Proportion of all child deaths reviewed which occurred in 2019/20 and 2020/21 broken down national deprivation quintile. **Data source: Index of Multiple Deprivation 2019**

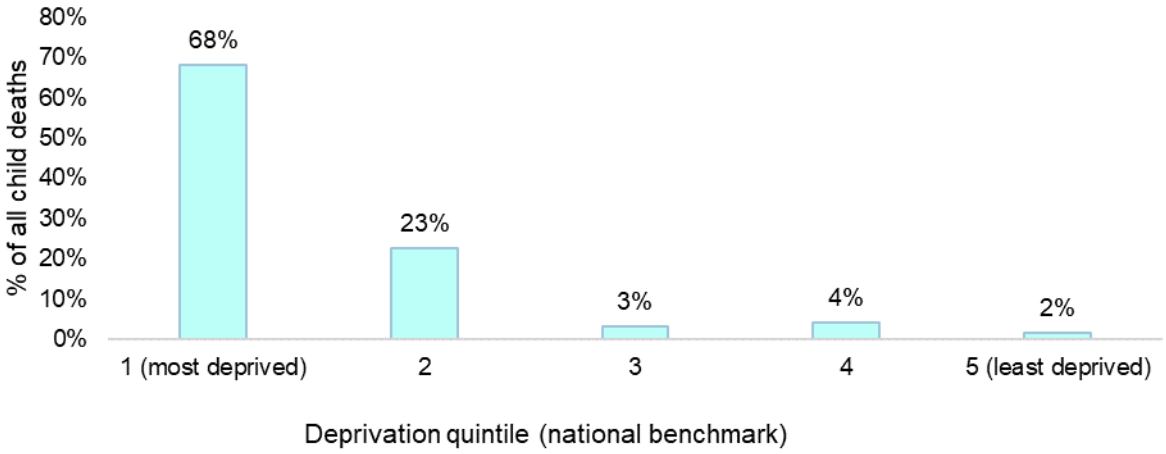
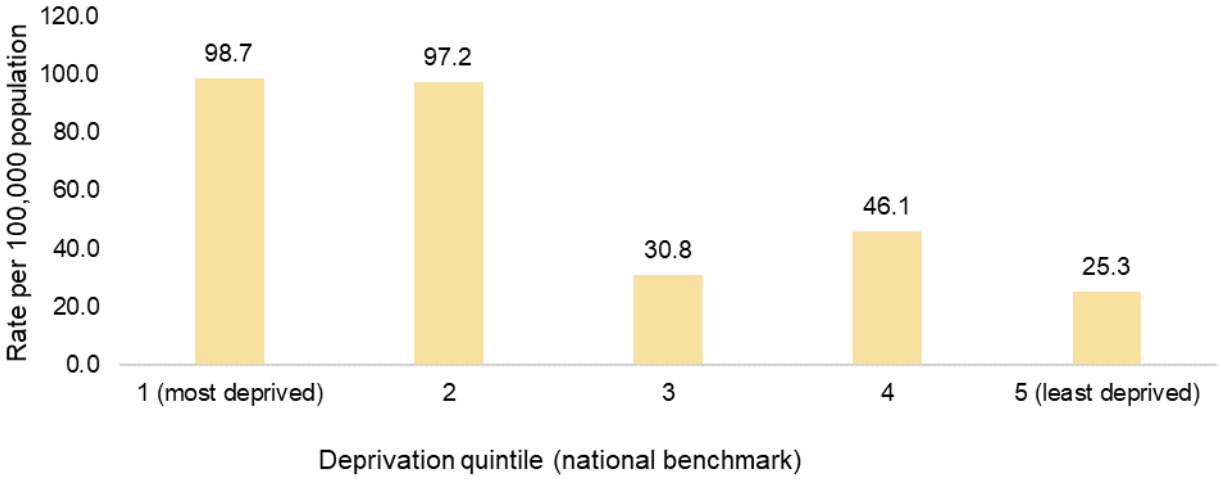
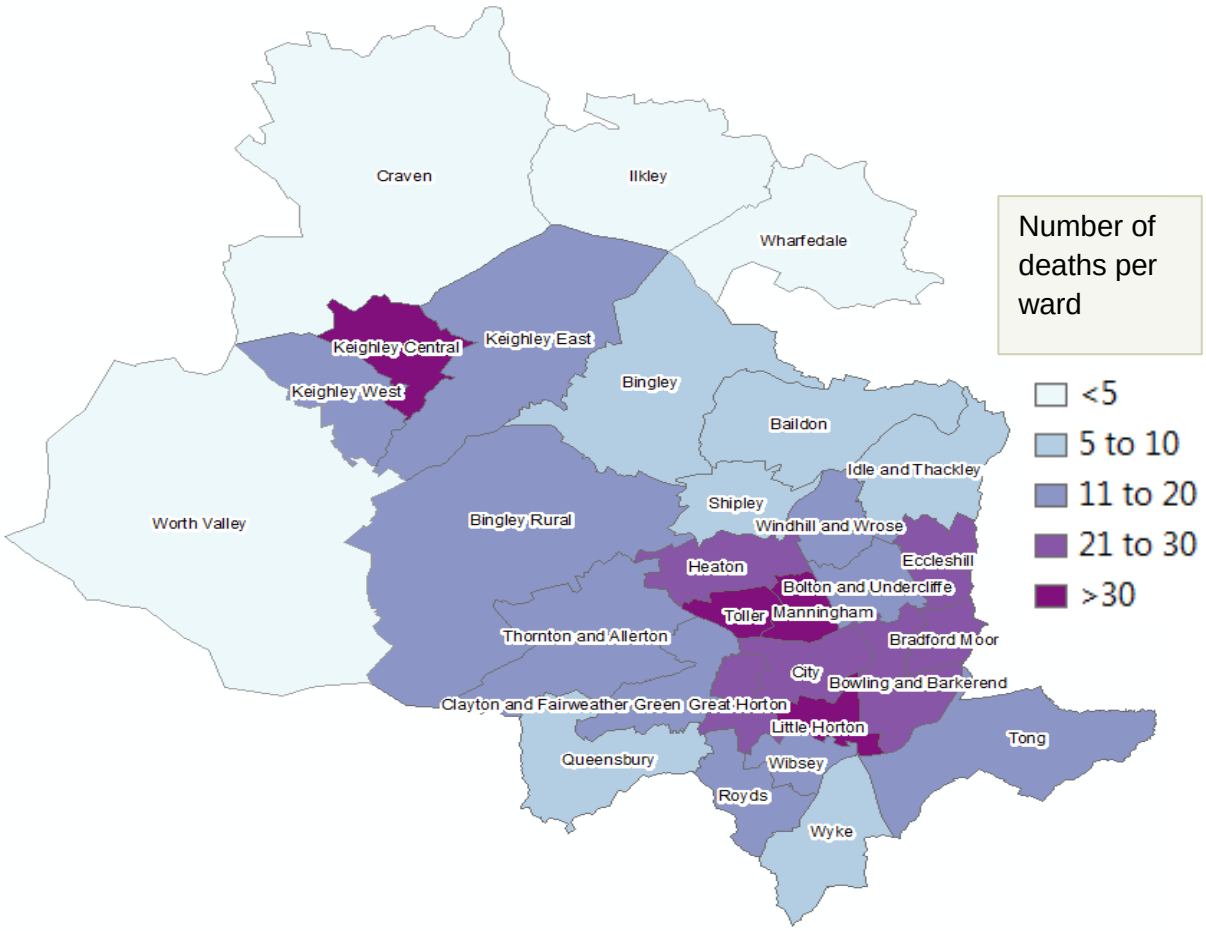


Figure 13: Rate of child deaths per 100,000 population which occurred in 2019/20 and 2020/21 broken down national deprivation quintile. **Data source: Index of Multiple Deprivation 2019**



The number of child deaths is not equally distributed across the district with more urban deprived wards such as Toller and Little Horton experiencing a higher number of child deaths in comparison to less deprived wards on the periphery of the District (Wharfedale, Ilkley and Craven) **(Figure 14).** In the last two years Keighley Central is the only ward to have a statistically significantly high rate of child deaths in comparison to the Bradford average.

Figure 14: Geographical distribution of all child deaths by ward, 2013/14 to 2020/21 (n=513; 24 no postcode recorded)



Local surveys (from Born in Bradford) show that compared to pre-Covid-19 levels, fewer Bradford District families are living comfortably (33% compared to 20%) and 37% of families are worried about the job security of the main earner; 23% are worried about paying the rent; 12% worry about losing their home (eviction/repossession)[7]. In addition, 23% of respondents reported that food often didn't last and they couldn't afford to buy more; 10% had to skip meals because there wasn't enough money for food. Two-fifths of respondents self-reported depression or anxiety and this was more common than before the pandemic. The risk of poor mental wellbeing is higher in those struggling financially. It is therefore important that support services that work with families experiencing these risk factors are aware of the vital role they play in reducing the risk of child mortality across the District.

[7] "Will we ever return to normality?" Findings from Phase 2 (Oct – Dec 2020) of the Born in Bradford. September 21. Covid-19 Adult Survey https://www.bradfordresearch.nhs.uk/wp-content/uploads/2021/09/Will-we-ever-return-to-normality-phase-2.pdf

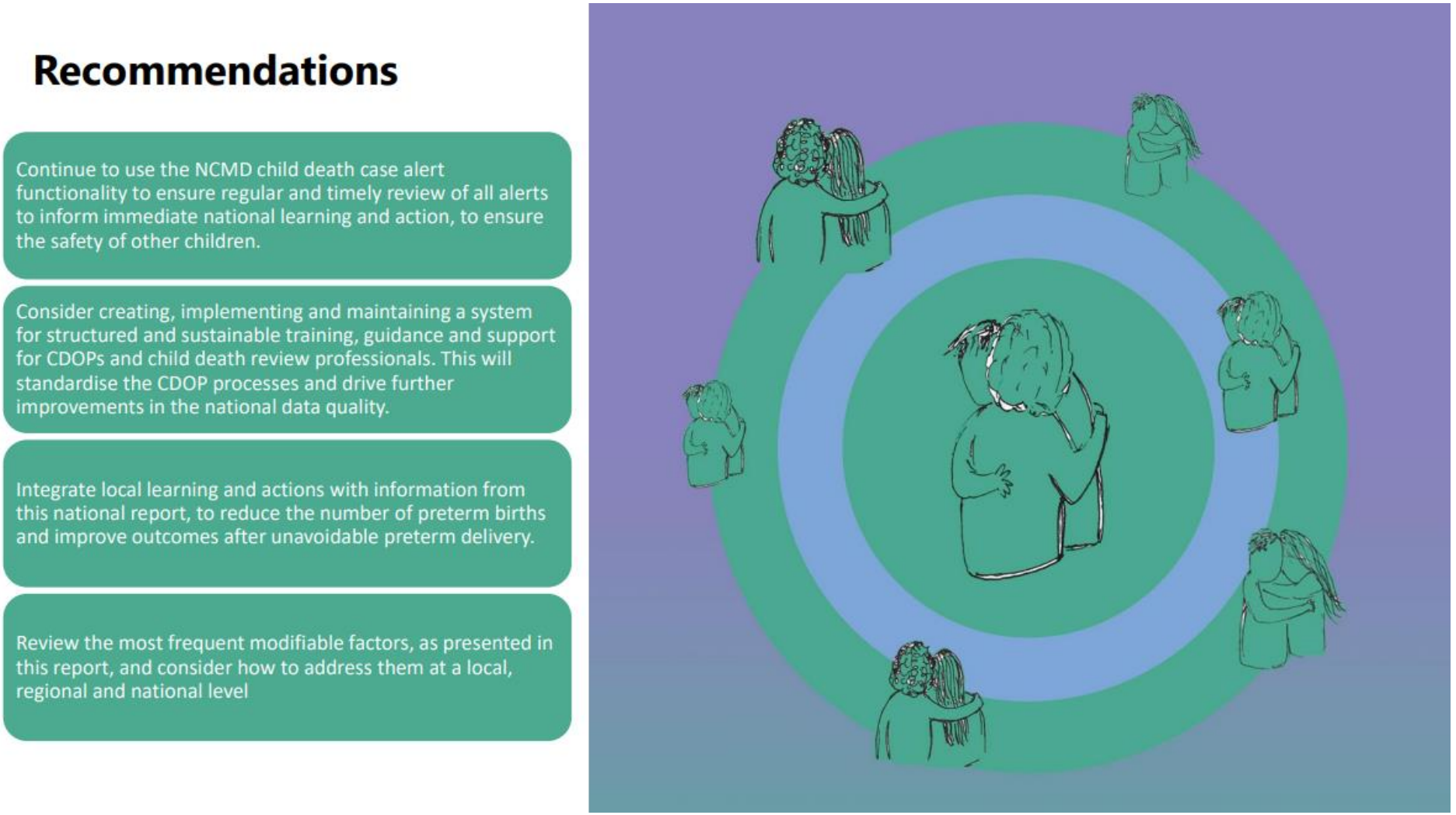
Recommendations

The following recommendations are made from the analysis presented in this report and learning from Child Death Review and CDOP meetings. The CDOP asks partners to consider these recommendations for action within their own programmes of work and other work to prevent child deaths (see Appendix 1).

Recommendation	Responsible partners
1. Support national efforts to improve CDOP and child mortality registration (see national recommendations below; Figure 15)	Bradford District CDOP
2. Reduce infant mortality in Bradford District through a coordinated response to reduce modifiable risk factors, specifically: • Sudden Unexpected Deaths in Infants (SUDI) and unsafe sleeping arrangements • Substance misuse / alcohol misuse by parents • Parental mental health issues • Genetic risk associated with consanguinity • Parental Smoking	Every Baby Matters programme and Better Births *Act as One* partnership, specifically sub-groups: • Bradford safe-sleep task and finish group ensure local partners are offered West Yorkshire training package 'Every Sleep a Safe Sleep' (to be launched March 2022). • Drug and Alcohol sub-group • Perinatal mental health partnership • Genetic awareness sub-group • Smoking in Pregnancy sub-group
3. Monitor child deaths that occur as a direct or indirect result of Covid-19 and make appropriate recommendations for action to Bradford District COVID Outbreak control board	Bradford District CDOP. [Reducing the spread of COVID-19 through schools and communities will continue to require a sustained and coordinated programme of work across District partners].

4. Ensure safe swimming campaign messages are shared with the Living Well Schools programme ahead of summer and pro-actively ahead of predicted heat waves.	Public Health (Bradford Council)
5. To seek assurance that partners are working collectively on the suicide prevention agenda (and that bereavement support services are available to Children, Young People, and Families)	Public Health working with Bradford District Suicide Prevention group
6. Support efforts to reduce and mitigate against poverty and associated factors (domestic abuse, mental health, crime, poor and overcrowded housing, homelessness, access to services and benefits)	All partners
7. Share the CDOP annual report findings and recommendations with strategic partnerships (Bradford District Well-Being Board, newly established Children and Young People & Family Partnership, and Childrens Safeguarding Board)	Bradford District CDOP

Figure 15: National recommendations from the National Child Mortality Database review



APPENDIX 1: Action to prevent child deaths locally

Three specific areas of prevention work are described below.

Better Births and the Every Baby Matters programme

Two-thirds of child deaths in Bradford District occur before the first birthday. Therefore, CDOP requires strong working arrangements to support the first 1,000 days agenda (the maternity period and first two years of life).

Every Baby Matters is a coordinated programme of work led by Bradford Council public health team and is part of the local maternity strategy *Better Births*. **Better Births** aims to improve the outcomes for maternal care across Bradford District and Craven and reduce disparities in birth experience by addressing health inequalities.

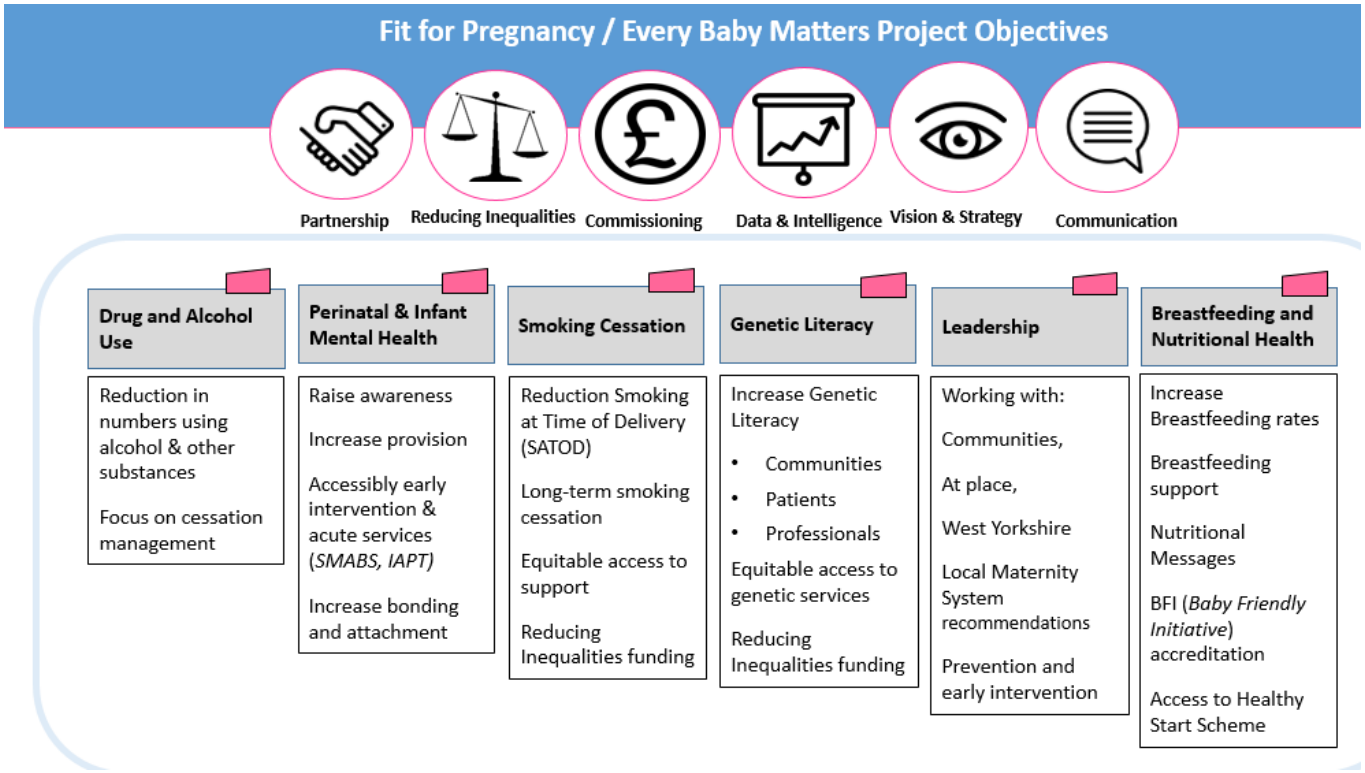
Every Baby Matters takes a lead on prevention efforts for the Better Births programme. During the pandemic it has led a coordinated programme across various public health issues (see below) with subgroups working to reduce alcohol/drug use and smoking during pregnancy, and increase genetic literacy, breastfeeding, good nutrition, and safe-sleeping practice. The programme also works closely with the Bradford District programme dedicated to improving the mental health of expectant or new mothers (peri-natal mental health).

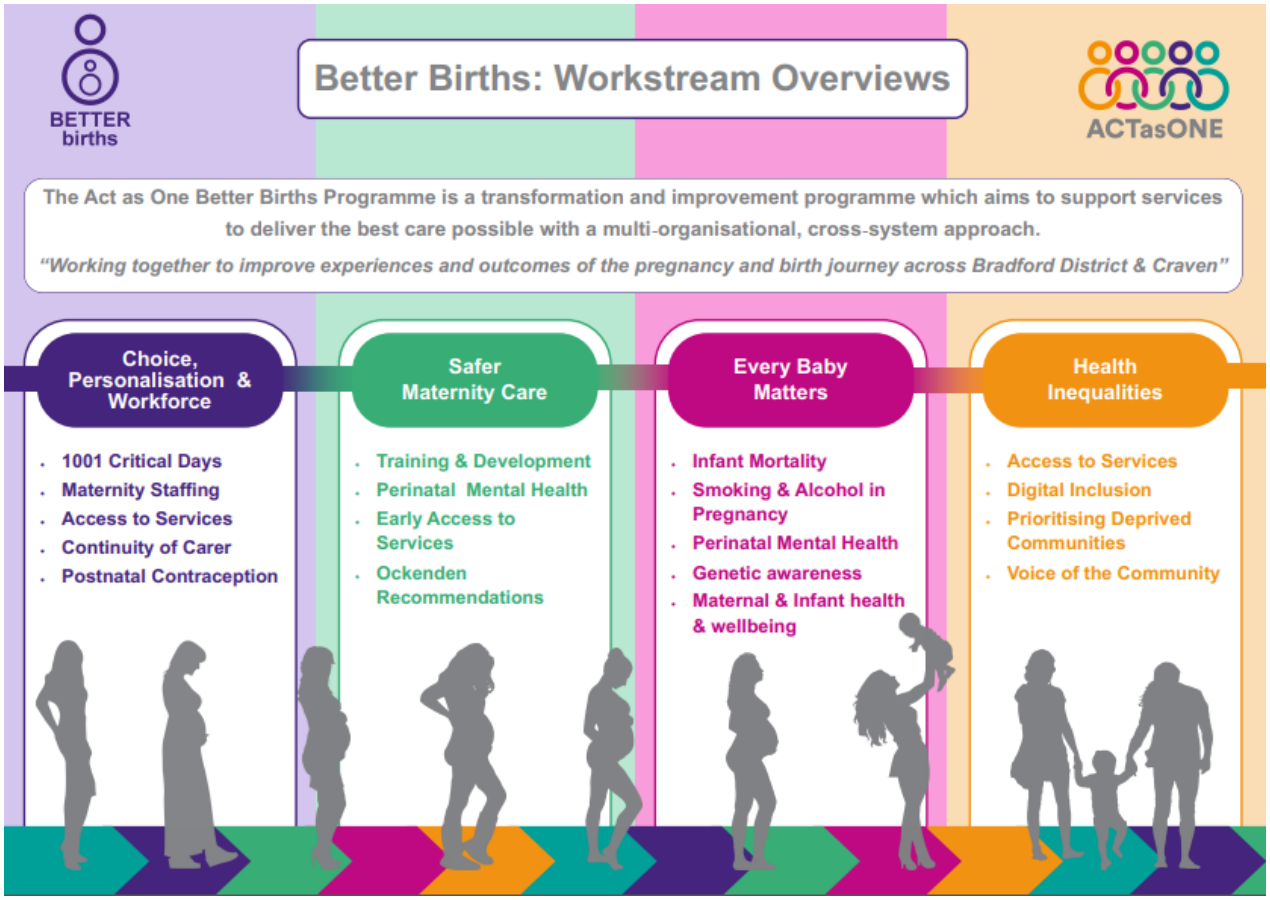
As a response to the service disruption caused during COVID-19 and successive lockdowns members of the Every Baby Matters programme have also developed on-line Public Health Early Years guidance for families on various topics. These addressed the risk factors for infant mortality including immunisations, coping with crying, getting health advice if your child is unwell, smoke free homes, support for families with no English.

Please see for the full list of guidance: https://www.bradford.gov.uk/health/improve-your-childs-health/public-health-early-years-guidance-for-families/

A separate report covering inequalities for key outcomes addressed by the Every Baby Matters programme can be found on Bradford District JSNA website: https://jsna.bradford.gov.uk/documents/Children%20and%20Young%20People/Every%20Baby%20Matters/Every%20baby%20matters%20report%20-%20April%202021.pdf (April 2021)

The Better Births programme is part of Bradford and Cravens Act as One programme and takes a leadership role for improving maternity care. Different partners contribute to four overlapping themes Choice Personalisation and Workforce, Safe Maternity Care, Every Baby Matters (mentioned above) and Reducing Health Inequalities in maternity outcomes.


Fit for Pregnancy / Every Baby Matters Project Objectives
Partnership
Reducing Inequalities
Commissioning
Data & Intelligence
Vision & Strategy
Communication
Drug and Alcohol Use
Reduction in numbers using alcohol & other substances
Focus on cessation management
Perinatal & Infant Mental Health
Raise awareness
Increase provision
Accessibly early intervention & acute services (SMABS, IAPT)
Increase bonding and attachment
Smoking Cessation
Reduction Smoking at Time of Delivery (SATOD)
Long-term smoking cessation
Equitable access to support
Reducing Inequalities funding
Genetic Literacy
Increase Genetic Literacy
Communities
Patients
Professionals
Equitable access to genetic services
Reducing Inequalities funding
Leadership
Working with:
Communities,
At place,
West Yorkshire
Local Maternity System recommendations
Prevention and early intervention
Breastfeeding and Nutritional Health
Increase Breastfeeding rates
Breastfeeding support
Nutritional Messages
BFI (Baby Friendly Initiative) accreditation
Access to Healthy Start Scheme


BETTER births
Better Births: Workstream Overviews
ACTasONE
The Act as One Better Births Programme is a transformation and improvement programme which aims to support services to deliver the best care possible with a multi-organisational, cross-system approach.
"Working together to improve experiences and outcomes of the pregnancy and birth journey across Bradford District & Craven"
Choice, Personalisation & Workforce
1001 Critical Days
Maternity Staffing
Access to Services
Continuity of Carer
Postnatal Contraception
Safer Maternity Care
Training & Development
Perinatal Mental Health
Early Access to Services
Ockenden Recommendations
Every Baby Matters
Infant Mortality
Smoking & Alcohol in Pregnancy
Perinatal Mental Health
Genetic awareness
Maternal & Infant health & wellbeing
Health Inequalities
Access to Services
Digital Inclusion
Prioritising Deprived Communities
Voice of the Community

Suicide Prevention in Children and Young People

Recent local work and initiatives to reduce suicide risk in young people include:

- The Education based Emotional Well-being Practitioners (EEWP) workforce in schools which has been extended to run in 2022. This team is working with pupils with mild to moderate mental health needs. It is normal for children and young people to experience mild to moderate emotional well-being difficulties, such as worry, anxiety and low mood, particularly during transition between school, college and work life, and during times of uncertainty (e.g. the COVID-19 pandemic). EEWP early interventions are short term & individually tailored to facilitate recovery.
- A regional sequence of self-harm workshops is planned for 2022 which will have attendance from professionals working with children with social, emotional and mental health difficulties across the district. Self-harm is a recognised risk factor for suicidal ideation and behaviour in Young People.
- A local suicide prevention campaign is planned using young actors and will involve those with lived experience and insight.
- The Suicide Prevention Strategy group are providing local input into collaborative research with Bradford University to understand risk and prevention for suicide ion young people.
- A range of mental health support for young people in Bradford District is accessed via Bradford Healthy minds https://www.healthyminds.services/content-article/healthy-minds-support-services-for-children-and-young-people, covering:

    1. **Universal services**: Kooth, Mental Health Champions, Healthy Minds, Guideline.
    2. **Additional needs**: Mental Health Support Teams, Youth in Mind, counselling
    3. **Extensive support** for: Eating Disorders, Looked After and Adopted Children Team, Neuro-diversity, Early Intervention in Psychosis
    4. **Safeguarding and Crisis**: Safe Spaces, Frist Response, Social Care, Emergency Duty Team.

- These initiatives are part of the local Suicide Prevention Strategy supported by the Suicide Prevention Strategy Group. This group also undertakes surveillance of suicides in all ages (confirmed and suspected) and suicide risk factors in partnership with West Yorkshire Police and West Yorkshire Suicide Prevention Strategy.

Learning Disability Mortality Review Programme

Where a child aged over 4 and under 18 years dies, the statutory process undertaken by CDOPs (Child Death Overview Panels) is initiated and is accepted as the LeDeR (learning from deaths from people with a learning disability) report due to the comprehensive process already in place. The LeDeR processes takes its lead from the statutory CDOP review and its findings.

Up to 2018/2019 no deaths of children with learning disabilities were reported. In 2019 following work with the CDOP Co-ordinator for the Bradford District reviews covering several years were reported and since this point deaths of children in Bradford with Learning Disabilities have regularly been reported to the LeDeR system. This has enabled learning points from these CDOP Panels to be addressed promptly by the LeDeR team and acted upon.

This means that in 2020/2021 the programme can confident in receiving notifications for all deaths of children over 4 with a diagnosed Learning Disability and in 2020-21 8 reviews of children aged between 4 and 18 were notified to Bradford District and Craven CCG via the LeDeR process.

Positive key working relationships with the Bradford and Airedale CDOP team have been maintained with the local LAC (Local Area contact) for LeDeR. Where possible the Primary LAC for LeDeR now attends CDOP panels which has enhanced ensuring triangulation with the CDOP and LeDeR processes. This is also in line with wider system working as we move to an ICS level.

APPENDIX 2: Membership of Bradford District CDOP

CDOP is composed of a standing core membership as follows:

- Specialist Children's Services
- Health – Primary care
- Education
- Police
- Hospital Chaplain
- Public Health
- Sudden Infant Death in Childhood (SUDIC) paediatricians
- Health – Bradford Teaching Hospitals NHS Foundation Trust
- Health - Airedale Hospital NHS Foundation Trust
- Other members as co-opted to specific meetings
- SUDIC/ CDOP Manager

Table 1: Membership of the Bradford District CDOP

Organisation	Name	Role
CBMDC Public Health	Dr Duncan Cooper	Consultant in Public Health (Chair)
BTHFT	Louise Clarkson	SUDIC/CDR/CDOP Manager
BTHFT	Dr Eduardo Moya	Designated Doctor Child Death Bradford and Airedale
BTHFT	Dr Catriona McKeating	Consultant Paediatrician
BTHFT	Dr Tallal Hussain	Consultant Paediatrician
AHNHST	Dr Sarah Hayes	Consultant Paediatrician
BTHFT	Dr Chakra Vasudevan	Consultant Neonatologist
BTHFT	Sara Hollins	Director of Midwifery
BTHFT	Shaheen Kauser	Muslim Chaplain
BTHFT	Jemma Tesseyman	Named Nurse Safeguarding Children
CCGs	Jude MacDonald	Designated Nurse Safeguarding Children (Vice Chair)
CCGs	Alison Wright	Deputy Designated Nurse Safeguarding Children
West Yorkshire Police	Granville Ward	Serious Case Review Officer

West Yorkshire Police	Joanna Fraser	Serious Case Review Officer
CBMDC	Dr Joe Wilson	Senior Educational and Child Psychologist
CBMDC	Amandip Johal	Head of Service – Safeguarding Reviewing and Quality Assurance
BDCFT	Gill Brayshaw	0-19 Service

Deputies

In exceptional circumstances, where a substantive panel member is unable to attend, a suitable designated person should be appointed from each agency. This ensures that quoracy is upheld for the meetings to take place

The Bradford CDOP meets on a bi-monthly basis. Additional members are co-opted to the panel when relevant, for the cases scheduled to be reviewed. Since the establishment of CDOP in 2008, the panel has consistently strived to increase the number of cases reviewed each month, and additional meetings are held if required to ensure a backlog does not build up. This also allows for modifiable factors and issues to be identified sooner, and changes to practice can be implemented. A separate Neonatal CDOP meeting is held to specifically review the neonatal deaths across the district with the attendance of a Consultant Neonatologist.

Notification of Death – eCDOP

2020 saw the introduction of the eCDOP system to Bradford. This is used widely amongst the majority of the 64 CDOPs across the country and was commissioned by Bradford in 2020. This allows any professional who becomes aware of a child death to notify the Child Death Manager at the Child Death Review office via the eCDOP portal. The Coroner's Office and the Registrar of Births Deaths and Marriages have a statutory responsibility to engage in the Child Death Review process by notifying the Manager of all deaths reported to them. There can be confidence, therefore, that information on all deaths is captured by the Child Death Review Manager.

The eCDOP system allows for the notification of all deaths to be recorded and information transferred automatically to the NCMD (National Child Mortality Database). Information requests are sent to agencies to collate information known that then feeds through to the CDR and CDOP meetings.

APPENDIX 3: Terms of reference of Bradford District CDOP

Purpose

The CDOP should undertake a review of all child deaths including unattended stillbirths (excluding medically attended stillbirths and planned terminations of pregnancy) from birth up to the age of 17 years 364 days in the local authority area.

Through a comprehensive and multidisciplinary review of the child deaths, the Bradford District CDOP aims to better understand how and why children die across the Bradford District and use the findings to take action to prevent other deaths and improve the health, wellbeing and safety of children in the area.

The CDOP will meet its function as set out in Chapter 5 of Working Together to Safeguard Children (2018).

Remit

CDOP will collect and analyse multi-agency information about each child with a view to:

- Review each child death (except medically attended still births and planned terminations of pregnancy) of children normally resident in the Bradford District
- To evaluate data on the deaths of all children normally resident in the Bradford District identifying lessons to be learnt or issues of concern
- To understand the cause of death and assess whether the death was preventable.
- Collect and analyse information about each child death with a view to identifying any case giving rise to the need for a serious case review
- To submit data to the National Child Mortality database (NCMD)
- To quality assure information presented and evaluated at the local Child Death Review Meeting
- To learn lessons regarding the death and causes of death in the Bradford District in order to establish if there are any trends/themes
- To learn any lessons about the professional and agency responses to child deaths
- To disseminate lessons and make recommendations to the Wellbeing Board and partner agencies on actions to take to prevent child deaths including guidance/protocols or procedures, raising staff awareness and community awareness campaigns
- To use the rapid response process to review unexpected child deaths
- Cases involving a criminal investigation will not be reviewed before the conclusion of proceedings, as with those cases where an Inquest is being conducted
- To produce and publish an annual report that is aggregated and anonymised

Accountability

The Chid Death Overview Panel is responsible, through its Chair, to the Chair of the Wellbeing Board.

Membership

The agencies forming the core membership of the Group are:

- CBMDC Children's Social Care
- CBMDC Education Services
- CBMDC Public Health
- Clinical Commissioning Groups
- Bradford Teaching Hospital Foundation Trust
- Airedale Hospital Foundation Trust
- West Yorkshire Police

The group may co-opt additional or specialist members as required for the purposes of specific pieces of work. The current list of named representatives is shown at Appendix 2.

Operational arrangements

- The CDOP will be chaired by Public Health and will be directly responsible to the Wellbeing Board
- Meetings will be regarded as quorate or otherwise, in the light of material to be considered and decisions to be taken, at the discretion of the Chair
- Standing meetings of the CDOP will be held bi-monthly and additionally meetings held as and when required
- Administrative support will be provided by the Child Death Review Office located at Bradford Teaching Hospitals. Agendas and associated papers will be circulated at least 5 days in advance of the meeting
- Conflicts of Interest will be declared at each meeting regarding case involvement by panel members

Voice of the child

Bradford SCB is committed to listening to the views of children and young people who use services and benefit from our protocols. We will involve them wherever possible in identifying needs and in planning, developing and improving policy and training

Reporting and Governance Arrangements

Through its Chair the CDOP will:

- Produce an annual report which will be:
    - Presented to the Well Being Board, the Childrens and Young People's and Family Partnership Board and the Act as One Better Births Programme.
    - Incorporated into the BSCB Annual Report
    - Published as part of the Bradford District JSNA
- Review the business/work plan annually

- Review the Terms of Reference every 3 years (unless appropriate to do sooner) and propose amendments to the Bradford District Well Being Board

Dispute

In the event of a dispute or conflict of interest arising between agencies across or within groups, which cannot be resolved, the Chair will draw this to the attention of the Chair for appropriate action and the BSCB Escalation Policy for Resolving Professional Disagreements will be invoked.

APPENDIX 4: Definitions (preventable, modifiable and category of death)

Definitions Used as cited in Statistical Release for Child Death Reviews: year ending March 2011 Dept. for Education July 2011:

1. Preventable/Potentially preventable death: Definition used from April 2008 to March 2010

Preventable – A preventable child death is defined as events, actions or omissions contributing to the death of a child or a sub-standard care of a child who died, and which, by means of national or locally achievable interventions, can be modified.

Potentially preventable – A potentially preventable death with same definition as above.

2. Modifiable death: Definition changed from April 2010 onwards

A modifiable death is defined as "The Panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths".

2.1 CDOP panel agreed from April 2016 to use the following definitions:

To decide if consanguinity is a risk factor and the case is to be deemed modifiable or non-modifiable:

i. If the parents are consanguineous and the child has a genetic condition which is identified for the first time and there is no previous history of similar conditions within the family, the case will be deemed to be NON MODIFIABLE

ii. If the parents are consanguineous, the child has a genetic condition and the same condition has been diagnosed within the family in previous children or close relatives and it is the type of condition associated with consanguinity (autosomal recessive condition) then the case will be deemed MODIFIABLE

To decide if smoking, obesity and other lifestyle risk factors are to be deemed modifiable or non-modifiable:

If a lifestyle risk factor such as smoking or obesity is deemed on the evidence presented to have had a significant role in the cause of death in an individual child, then this will be identified as a MODIFIABLE risk factor

Ten categories for cause of death

Category 1 – Deliberately inflicted injury, abuse or neglect: this includes suffocation, shaking injury, knifing, shooting, poisoning and other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes sever neglect leading to death

Category 2 – Suicide or deliberate self-inflicted harm: 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 people.

Category 3 – Trauma and other external factors: this includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis and other extrinsic factors. Excludes deliberately inflicted injury, abuse or neglect (Category 1).

Category 4 – Malignancy; solid tumours, leukaemias and lymphomas and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.

Category 5 – Acute medical or surgical condition; for example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.

Category 6 – Chronic medical condition; 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.

Category 7 – Chromosomal, genetic and congenital anomalies; Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis and other congenital anomalies including cardiac.

Category 8 – Perinatal/neonatal event; Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral pals without evidence of cause, and includes congenital or early-onset bacterial infection (onset in the first postnatal week).

Category 9 – Infection; 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.

Category 10 – Sudden unexpected death; where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. Excludes Sudden unexpected death with epilepsy (Category 5).

APPENDIX 5: Contact Details

Contact details:

Address: Child Death Review Office, Bradford Royal Infirmary, M1, Duckworth Lane, Bradford BD9 6RJ

Tel: 01274 383519

Email louise.clarkson@bthft.nhs.uk; louiseclarkson@nhs.net