SOUTH YORKSHIRE
CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT
APRIL 2019 – MARCH 2020

C O N T E N TS

FOREWORD AND INTRODUCTION

Foreword

2019/20 was a challenging year, beginning with the revision to South Yorkshire Child Death Overview arrangements, the move to the National Child Mortality Database, together with a focus on broader learning across South Yorkshire and finally the COVID-19 pandemic.

The South Yorkshire CDOP has implemented the new working arrangements, has worked together to implement the National Child Mortality Database and held two thematic reviews, one on safe sleeping and the other on suicide.

Further thematic reviews will resume as part of the recovery from COVID-19 although in 2020/21 there will still be a focus on improving data collection.

All areas are looking to improve the experience and support for bereaved families at the time of the death of a child.

Dr Rupert Suckling,
Director of Public Health, Doncaster Council
Chair, South Yorkshire Child Death Overview Panel 2019/2020

Introduction

In response to Working Together 2018 the four local authorities of South Yorkshire, Sheffield, Rotherham, Barnsley and Doncaster formally agreed their partner and agencies arrangements for child death reviews for the South Yorkshire Child Death Overview Partnership (SYCDOP). The published arrangements were submitted to the Department of Health and Social Care (DHSC) in June 2019.

The formal agreement published highlighted a key focus to identify shared learning that may help to prevent future child deaths across South Yorkshire. The South Yorkshire Child Death Overview Partnership (SYCDOP) will also contribute to local, regional and national initiatives to improve learning from all child death reviews.

In South Yorkshire there are on average between 80 and 100 child deaths per year; the four areas working together provide a larger cohort of data, to enable improved identification of themes, trends and shared learning.

The key function and responsibilities of each of the four local area Child Death Overview Panels (CDOPs) in South Yorkshire are to:

- To collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members.

- To analyse information obtained, including the reports from Child Death Review meetings, 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.

- To make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children.

- To notify the Child Safeguarding Practice Review Panel and their local Safeguarding Partners when it is suspected that a child or children may have been abused or neglected.

- To notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction.

- To provide specified data to the National Child Mortality Database; this is via the shared web-based eCDOP software system used on a South Yorkshire wide basis.

- To produce an annual report for the Child Death Review partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process.

- To provide data and analysis for the South Yorkshire Child Death Overview Panel to enable patterns, themes and trends to be analysed on a wider footprint to enable learning.

- To contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

- To provide an annual report for the local Child Death Review Partners highlighting the effectiveness of the local child death review arrangements.

2019/2020 SYCDOP OVERVIEW

There were four SYCDOP meetings held during 2019/2020:

4th June 2019
12th September 2019
3rd December 2019
11th March 2020

SYCDOP Membership and meeting attendance has remained consistent with representation from the four Local Authorities, Health Services (including Designated Doctors), Safeguarding Partnerships, Public Health, Social Care and Clinical Commissioning Groups. Invited representatives from other sectors, eg the Lullaby Trust also attended and contributed to the thematic reviews undertaken.

The key themes and actions from the four meetings included:

- eCDOP. The set up and implementation across all four areas, transferring all the relevant cases to be reported through eCDOP to NCMD for the 2019/2020 reporting year.
- The SYCOP Terms of Reference were agreed and submitted to the Department of Health and Social Care.
- A Memorandum of Understanding was agreed and developed, which includes the key principles of the four areas work in practice.
- The four Annual Reports for 2018/2019 of each area were shared which identified the modifiable factors of **Safe Sleeping** and **Suicides** as the two appropriate themes to undertake for shared learning reviews.
- The lack of bereavement services that are available for children, particularly for siblings, across South Yorkshire.
- The Missed Appointments (children not brought to appointments by parents/carers) policies across all areas to be reviewed to consider whether aligning the policies would be a worthwhile exercise.
- Escalation policy. To establish a joint approach in dealing with outstanding essential child death case review paperwork, particularly from neighbouring hospital trusts.

FINANCIAL OBLIGATIONS

eCDOP Costings:
For the set up and implementation of eCDOP in 2019/2020 the shared web-based platform, the financial commitment was £15,512.40 in total, which equated to £3,878.10 per local authority area.

The South Yorkshire eCDOP contract with QES is a yearly rolling contract and Barnsley local authority are the local contractual lead authority with Quality Education Solutions Ltd (QES) the software management provider. Barnsley Council pay QES annually and re-charge each area accordingly.

Hosting arrangements
The hosting arrangement for SYCDOP is based on a rotating system of each local authority hosting for an annual reporting year. Doncaster was the host authority for 2019/2020 led by Dr Rupert Suckling, Director of Public Health and Chair following on from Barnsley in the previous year. Sheffield will be the host organisation in 2020/2021.

The administrative support for 2019/2020 was provided through Doncaster Safeguarding Children's Partnership, with additional support as and when required from Barnsley, Rotherham and Sheffield CDOP administrators.

2019/2020 THEMATIC REVIEWS UNDERTAKEN

1. SAFE SLEEPING

The Safe Sleeping shared learning review was undertaken in December 2019 and the key points agreed to action included:

- A joined South Yorkshire wide approach for the safe sleeping awareness week in March 2020.
- A regional Steering group to be established to work together for a South Yorkshire joined up campaign.
- The Steering group representatives will include each local areas Communications teams, Public Health representatives and CDOP Safe Sleeping leads.
- To consider pooling budgets to enable a bigger footprint and enable a more effective campaign and end area duplication.

The outcomes achieved following the review included:

- ✓ A very successful South Yorkshire wide Safe Sleeping Steering Group was established that co-ordinated a consistent approach to 2020 Safe Sleeping awareness week (9th – 15th March 2020).
- ✓ The Safe Sleeping Steering Group identified more Safe Sleeping champions outside of health agencies, eg Social Care.
- ✓ South Yorkshire wide communications were planned for throughout 2020 and to also promote safe sleeping across South Yorkshire twice yearly as a minimum, and specifically through infant mortality groups.

2. SUICIDE

The Suicide shared learning review was undertaken in March 2020 and the information of the young people who had sadly died by suicide across South Yorkshire between 2017 and 2019 was collated and shared prior to the review.

A total of nine cases were recorded; five of the cases were female and four male with ages ranging from 14 years 10 months to 17 years 6 months.

Sheffield	5
Doncaster	3
Barnsley	1
Rotherham	0

Seven of the cases were a result of hanging, one young person was hit by a train and one jumped from height.

The key points noted at the review included:

- It was identified there is an issue across all four areas regarding parents and young people having easy access to services for lower levels of mental health support.
- Parents had identified particularly not knowing how to access services and where to go for support for their children.
- Self-harm is an indicator.
- Bullying, children “feeling different”, social isolation, having small friendship groups are common themes.
- Adverse Childhood Experiences (ACE) patterns were noted in some cases.
- Collaboration issues. There are often pockets of information known but not enough to raise concerns.

- There is sometimes a lack of early intervention, eg children referred into a service where parents did not follow up the support available and being offered.
- The lack of ongoing support to families bereaved by suicide is an issue, particularly when inquests are delayed and there is no information available as to why.
- Hanging is the most prevalent method used.
- Social media. It was noted as important that all agencies do not promote trending bad/dark websites but to offset by actively promoting positive websites.
- The lack of access to an individual's social media activity for possible useful information following a death to fully review cases cannot be done without police or Coroner intervention, which is not usually considered unless a crime has been committed. Being able to access social media accounts for information would be particularly useful for cases where there is no obvious reason why a young person has died by suicide. It was noted that due to the capacity of South Yorkshire police to support such access, including the prohibitive costs involved and data protection issues when accessing secure social media accounts, highlighted this issue will continue to be difficult to address.
- Manchester University have completed work around suicides across the country which was highlighted as a worthwhile report to review, particularly regarding the trends and recommendations.

The suicide review focussed particularly on the impact for schools when pupils die by suicide, the key points identified included:

- Schools often need ongoing support on how to deal with issues affecting young people, eg pupils self-harming.
- Support for pupils had been provided and much welcomed at a Rotherham school badly affected by suicides of teaching staff which had particularly impacted vulnerable children.
- It is often high achievers' schools with similar circumstances that struggle with the impact of suicides, eg schools want to be 'fixed' immediately to allow children to move on academically.
- Collaborative work has been done with neighbouring local authorities due to suicides at the same school academy trust that South Yorkshire children attend.
- There is a lot of local and national guidance available for teaching staff of what to do in emergencies, but it was identified there is a need for a simple step by step guide relating to pupil suicide.
- Augmented services in schools eg trailblazer work, Mind Space are available in some South Yorkshire schools.
- A better understanding is needed in schools of what other service offers are available, eg school nurses for low level emotional health and well-being support.

Following the review the outcomes identified to action included:

- ✓ Response/Contagion plan. To ensure all areas have a suicide response plan and contagion plan that is up to date and shared accordingly.

- ✓ Training. To consider what training is needed for staff to raise awareness and how this is deployed.

- ✓ To review and check what services are available across all South Yorkshire areas, particularly the low level mental health support.

- ✓ To look at what the overall approach is to schools around suicides.

- ✓ To review how statutory services (eg South Yorkshire police) respond to and access social media.

SYCDOP FUTURE PLANS

For the upcoming year 2020/2021 the hosting arrangements will be facilitated by Sheffield CDOP and chaired by the Director of Public Health in line with the agreed rotation of a local authority area hosting the quarterly meetings and facilitating the shared learning reviews throughout an annual reporting year.

The four local areas within South Yorkshire will continue with their own local Child Death Overview Panel (CDOP) processes and the supporting pathways to review deaths of children who have died that are normally resident in their own areas. These reviews will contribute collectively in identifying the key themes for shared learning reviews across South Yorkshire.

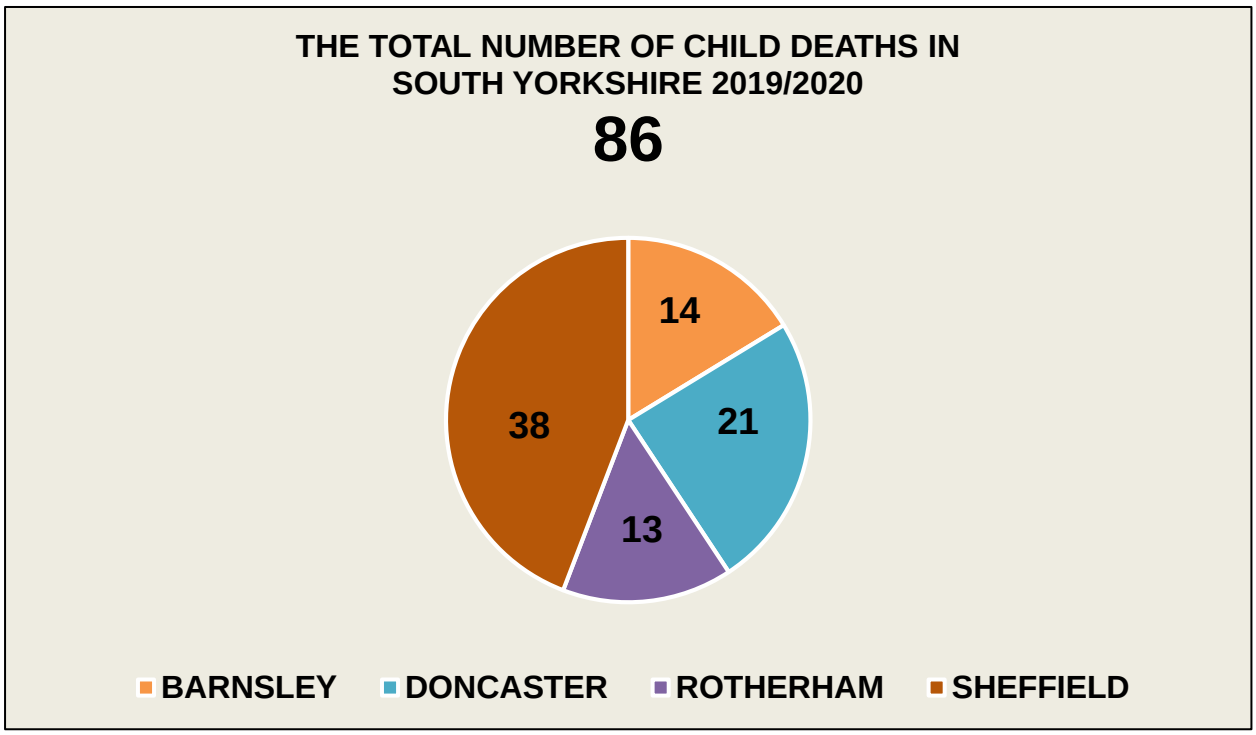
A key focus of SYCDOP throughout 2020/2021 will be:

- To improve the experience following the death of a child of the bereaved families, particularly siblings, and all professionals.

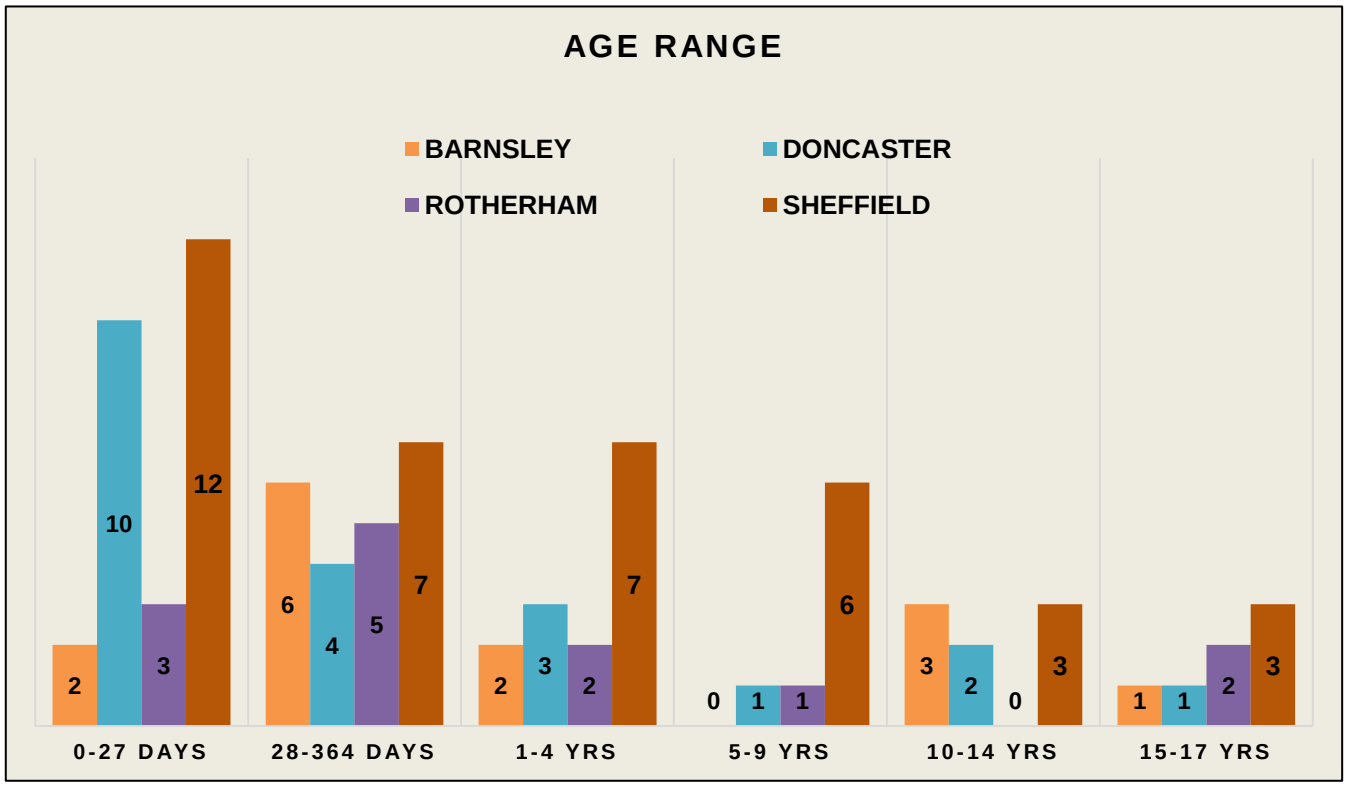
- To ensure that information from the local child death review process is systematically captured through eCDOP through to the National Child Mortality Database; to identify local learning that will inform learning at the national level to inform changes in policies and practice.

2019/2020 SOUTH YORKSHIRE AREA CHILD DEATH DATA

The total number of child deaths across South Yorkshire during 2019/2020:



The child death age range per South Yorkshire area:



The percentage (%) of death notifications in South Yorkshire by age group during 2019/2020 compared to the national (England) percentage:

	0 – 27 days	28 – 364 days	1 – 4 years	5 – 9 years	10 – 14 years	15 – 17 years
SOUTH YORKSHIRE	32%	26%	16%	9%	9%	8%
ENGLAND	42%	21%	12%	7%	8%	10%

2019/2020 South Yorkshire Death Notifications by month:

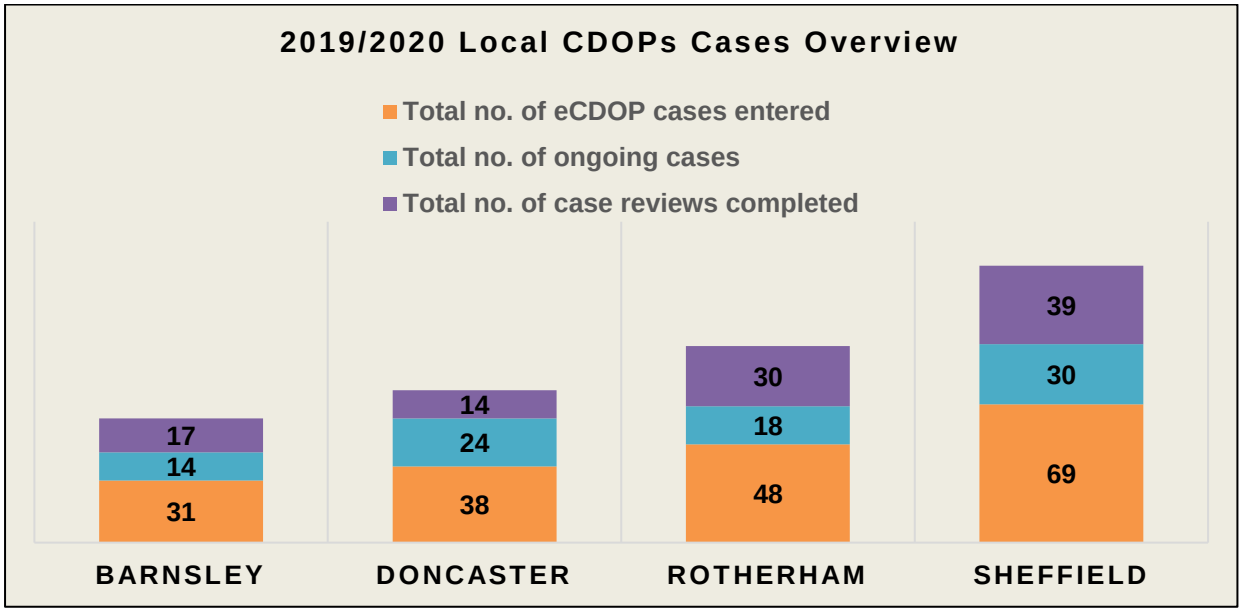
AREA	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	TOTAL
BARNSLEY	0	0	1	1	0	4	1	1	1	1	2	2	14
DONCASTER	2	0	0	3	2	2	0	2	3	3	3	1	21
ROTHERHAM	1	1	1	1	3	0	2	2	2	0	0	0	13
SHEFFIELD	2	2	2	5	0	4	6	4	2	3	7	1	38
TOTAL	5	3	4	10	5	10	9	9	8	7	12	4	86

APPENDIX TWO

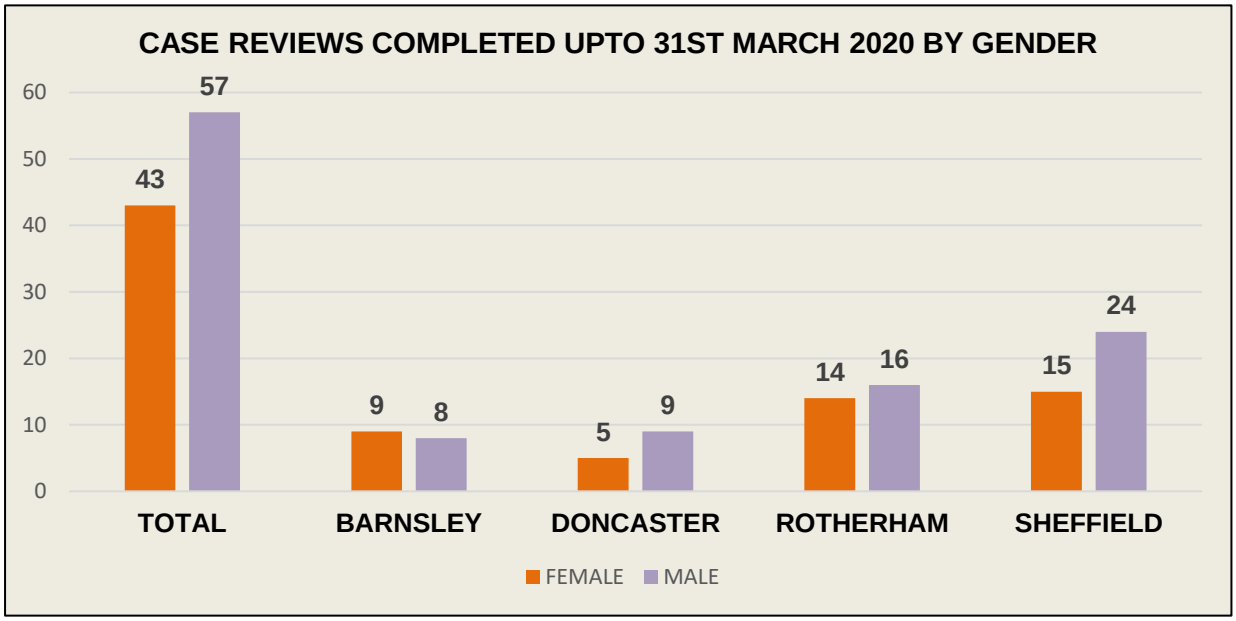
2019/2020 SOUTH YORKSHIRE CHILD DEATH OVERVIEW PANELS DATA

As detailed in the SYCDOP Terms of Reference and Memorandum of Understanding established in 2019, the four local South Yorkshire areas have continued with their own local Child Death Overview Panel (CDOP) processes.

The chart below shows the total number of South Yorkshire child death cases entered onto eCDOP up to 31st March 2020, the number of open cases to be reviewed and the number of cases completed and closed at local CDOP panels during 2019/2020.



The chart below shows the total number of CDOP cases reviewed during 2019/2020 by gender:



The chart below shows the total number of CDOP cases reviewed during 2019/2020 by the **primary category of death** in descending order**:**

CATEGORY	B	D	R	S	TOTAL (100 cases)
Perinatal or Neonatal event	**4**	**3**	**14**	**9**	**30**
Chromosomal, genetic & congenital anomalies	**1**	**4**	**5**	**10**	**20**
Acute medical or surgical condition	**5**	**1**	**1**	**3**	**10**
Malignancy	**1**	**1**	**0**	**6**	**8**
Sudden unexpected, unexplained death	**2**	**3**	**0**	**2**	**7**
Suicide or deliberate self-inflicted harm	**0**	**1**	**1**	**5**	**7**
Deliberately inflicted injury, abuse or neglect	**1**	**0**	**3**	**0**	**4**
Infection	**1**	**1**	**3**	**0**	**5**
Trauma & other external factors, including medical/surgical	**2**	**0**	**0**	**3**	**5**
Chronic medical condition	**0**	**0**	**3**	**1**	**4**