SOUTH YORKSHIRE CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT

APRIL 1ST 2020 – MARCH 31ST 2021

South Yorkshire Child Death Overview Panel (SYCDOP) 2020/21 Annual Report
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C O N T E N T S

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With thanks to colleagues in Barnsley, Doncaster and Rotherham for their contributions.

INTRODUCTION

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. In 2020/21 there has been 76 deaths reported across our local region, slightly less than for 2019/20 [86], none of the deaths recorded were found to be as a result of Covid-19.

Following the Safer Sleeping and Suicide Themed Reviews in 2019/2020 the identified outcomes were actioned:

- A Regional Steering group was established to work together to provide a combined South Yorkshire wide approach for the Safer Sleep awareness week in March 2021. Plans had to be adapted due to Covid restrictions still being in place. The group included representatives from all areas including each local areas Communications teams, Public Health representatives and CDOP Safer Sleep leads. Budgets were pooled together to enable a bigger footprint and enable a more effective campaign and end area duplication.

- South Yorkshire wide communications were planned for throughout 20/2021 and to also promote safer sleeping across South Yorkshire twice yearly as a minimum, and specifically through infant mortality groups.

- A regional group was established for the rollout of ICON Babies Cry, You Can Cope which launched in January 2021 with media coverage across the area.

- Response/Contagion plan. All areas have completed or have work in progress to ensure there is a suicide response/ contagion plan that is up to date and has been shared with partners.

- Training. To consider what training is needed for staff to raise awareness of suicide risk and how this can be disseminated across all areas.

- Working with others, review and check what services are available across all South Yorkshire areas, particularly for low-level mental health support.

2020/21 SYCDOP OVERVIEW

There were four SYCDOP meetings planned during 2020/2021:

3rd June 2020 – *cancelled due to covid-19 pressures*
2nd October 2020
13th January 2021
1st April 2021

Overall **71** deaths were reviewed in 2020/21 by their respective panels. Most deaths still occur in those under 1 year with Chromosomal, Genetic & Congenital Abnormality and Perinatal/Neonatal Event being the primary cause of death. There was no apparent difference in relation to ethnicity.

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

The key themes and actions from the three meetings included:

- eCDOP continues to be used across the region with all areas feeding into further developments of the system to enhance its use. There is now an agreement in place for the Host area able to access a regional dataset to help with the monitoring of any emerging themes across the area.

- The Missed Appointments / Was Not Brought work which had been started in the previous year resulted in a Task and Finish Group being set up to explore how we can improve the sharing of information around WNB across our Trusts

- Limitation of Treatment Agreement (LOTA) – how these are updated and who needs to be informed? Ownership, where are they held?

- CDOP/ Joint Agency Response contacts across all areas and cross-border arrangements discussed and clarified. Contacts list produced to aid more timely response when there is an unexpected child death out of our own area.

- Healthcare Safety Investigation Branch (HSIB). Taking into consideration that Nationally Neonatal deaths, maternal deaths and intrapartum stillbirths were noted to have increased since start of covid-19 pandemic HSIB were invited to attend SYCDOP to explore how we can better link together in our work. This would include the sharing of reports and dissemination of learning.

- Key Worker. This continues to be an area of development and discussion with varying offers across our local region, and nationally.

- Bereavement services – current service provision and gaps. Further consideration of what does ‘good bereavement support’ look like?

- Escalation policy. To establish a joint approach in dealing with outstanding essential child death case review paperwork, particularly from neighbouring hospital trusts.

eCDOP

For use of eCDOP the shared web-based platform, the financial commitment for 2020/21 was £13,330.80 in total, which equates to £3,332.70 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. Sheffield was the host authority for 2020/21 led by Diane Shahlavi, Deputy Designated Nurse/CDOP Manager with administrative support for 2020/21 was provided through Sheffield Safeguarding Children's Partnership.

2020/21 THEMATIC REVIEWS UNDERTAKEN

Having identified several deaths during this period where palliative care was a feature a themed panel was held with additional representation sought from professionals working in this field. We were interested to analyse how well the child's voice is heard in such cases, considering their support needs when requiring end of life care and their final place of death.

Please see *Appendix Three* for findings.

WHAT'S WORKING WELL?

Partnership working - SYCDOP has resulted in increased and more effective joint working across all areas, this is evident through:

- Increased understanding of Sudden Unexpected Death of an Infant (SUDI), collaboration across all areas in the promotion of safer sleep messages and recognising the risk.

- Collaborative approach for Safer Sleep Awareness Week and the launch of ICON Babies Cry, You Can Cope; both tackling some of the risks highlighted in the Safer Sleep themed review.

- Resources – moving towards the development of combined processes/ policies to improve consistency across the local area.

- Learning points from cases / initiatives allowing for mutual shared learning.

- Practice relating to Child Death Review process – improved information sharing across the region.

WHAT COULD WE DO BETTER?

- Review and evaluate the key worker process, role and responsibilities, in line with the relevant guidance to ensure more clarity and consistency across our local area.

- Contribute to the further development of a Lead Clinician model for complex patient care management, and pathways to enhance care and support needs for those requiring end of life care.

- Improve our knowledge and understanding of LOTA'S and their application.

- Further analysis of our local data.

- Improve consistency with modifiability.

- Recognising there are some inconsistencies between how effectively eCDOP is being used and utilise opportunities to disseminate the NCMD learning/ guidance.

- Embed the Child Death Review Meeting across all organisations.

- Embed the Key worker role in all provider organisations.

- Bereavement – working across the Integrated Care System, assist others to gain an understanding of the current needs and any gaps in services for those families experiencing the sudden death of a child, sibling or parent.

SYCDOP FUTURE PLANS

For the upcoming year 2021/22 the hosting arrangements will be facilitated by Rotherham CDOP and chaired by 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 2021/22 will be:

- Bereavement support - To improve the experience following the death of a child for all those family members, particularly siblings involved.

- 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.

- Modifiability - To consider how we can ensure that possible factors relating to social deprivation are captured in a more standardised format

- The recent NCMD Thematic report on Child Mortality and Social Deprivation - with a clear association between child deaths and social deprivation SYCDOP will need to consider how we can collectively support and influence future strategies to reduce inequalities, recognising that at this time our Public Health colleagues have ongoing priorities with the pandemic.

LOCAL AREA CDOP UPDATES – 2020/21

BARNSLEY

Barnsley CDOP has a fixed core membership drawn from organisations represented on the Barnsley Safeguarding Children Partnership and is chaired by the Head of Public Health with the flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate. In 2019-20 Child Death Review partners reviewed Child Death arrangements across the Borough and strengthened the functions of the CDOP management and administration.

Between 1st April 2020 and 31st March 2021, four Barnsley CDOP meetings were held, and 14 cases were reviewed and completed.

The age at time of death ranged from 10 days to 17 years. Most deaths reviewed were aged under 1 year (N = 7); one of these occurred within the first four weeks of life (neonatal period).

It may be of use to note that, at the time of death, none of the cases were Looked After Children, Child in Need, or on a child protection plan. Although previously, 3 of the cases had been classed as a Child in Need. One of the cases was reported at the time of death as being an asylum seeker.

Of the 14 cases completed, 10 were categorised as unexpected. Of these, 6 were male and 3 of these were categorised as Sudden Unexpected Death of an Infant (SUDI).

Four cases had at least one modifiable factor. Modifiable factors identified were in relation to Sudden Unexpected Death of an Infant including parental substance misuse (tobacco, cannabis, alcohol); and the handling of sexual abuse reporting and missed GP appointments.

What's worked well

Development of local guidance to ensure the child death process, including the rapid response work, could continue safely via virtual means considering the Covid-19 pandemic.

Process put in place to ensure that Covid-19 testing has been carried out in all cases prior to transfer for post-mortem. Fortunately, there were no Covid-19 deaths in children during the period covered by this report either directly or indirectly as a result of the pandemic.

Development of a 'key worker' process that ensures families are given a single, named point of contact, identified at the Joint Agency Response (JAR) meeting. This person will act as a single point of contact for the bereaved family, who they can turn to for information on the child death review process, and who can signpost them to sources of support.

Development of a "Health Passport" for children with additional needs, which has been agreed across the partnership. Barnsley Hospital NHS Foundation Trust are currently undertaking a review of this document, as part of the SEND preparation. This will ensure that the 'passport' contains the right information relating to the child's health and communication needs, preventing them having to update every member of staff when they attend any BHNFT appointments.

Mobilisation of a local SUDI Task and Finish Group, which brings together a range of practitioners from across services who serve children and families in Barnsley (including Health, Social Care, Early Years, Housing, Probation, South Yorkshire Police and South Yorkshire Fire and Rescue). The group aims to:

- Evaluate current local practise around SUDI risk (including safe sleep) across wider services, not merely health
- Ensure collective understanding of the continuum of risk for SUDI
- Identify and prioritise actions to improve how we embed safer sleeping advice for families, particularly those with children considered to be at risk of significant harm through a whole system approach, recognising the continuum of risk for SUDI
- Develop underpinning systems and processes with relevant policies, procedures and practice tools that support effective multi-agency practice across the continuum of risk for SUDI
- Develop co-ordinated multi-agency guidance and training to help promote a shared understanding about a safer sleep environment, enabling practitioners to reflect on their individual role in promoting safer sleep messages and recognising risk.

Completion of an audit of Barnsley cases of Sudden Unexpected Death of an Infant (SUDI) with findings that will feed into the above SUDI Task and Finish Group.

Development and delivery of a Borough-wide Safe Sleep Communications Plan, bringing together Communications Leads from Barnsley Council, Barnsley Hospital and Barnsley Clinical Commissioning Group.

Areas for development

Delivery of a working group to develop a clear pathway/process around SARC to ensure follow up, especially where child or young person declines.

Recommunicate “Was Not Brought” process in General Practice and consideration of risks following failed attendances.

Training on trauma-informed practice for services working with children and young people.

Review and evaluate the key worker process, role and responsibilities, in line with the relevant guidance.

DONCASTER

The main challenges for the 2020/2021 year have been:

The operational demands of COVID significantly reduced the frequency of CDOP meetings, which in turn has led to a back log of cases.

The number of child deaths increased over this period, 28 deaths in total which is the highest figure for Doncaster since 2015/2016.

There has also been a turnover in membership at the CDOP panel.

The DSCP Safeguarding Business Unit transitioned from Doncaster Children's Services Trust to Doncaster Council in September 2020, at the same time as the responsibility for Doncaster CDOP transferred from the Safeguarding Children Partnership Board to the Health and Wellbeing Board at Doncaster Council.

On a positive note, Doncaster CDOP does have a stronger link with the Medical Director at Doncaster Bassetlaw Teaching Hospital Trust if practice issues need to be addressed. Also an excellent link with Our Starting Well Strategy Group to take forward actions to address child deaths in the 0-5 age range.

When the Doncaster CDOP have met during 2020/2021, the panel members have still found the eCDOP forms less user friendly and more laborious to use than the previous approach. It has been identified ongoing training for those contributing to the eCDOP reports is still a major issue.

As we move into the reporting year of 2021/2022 Doncaster CDOP will have a new designated doctor and a new lead nurse for child death reviews.

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ROTHERHAM

With the support of our deputy chair and contribution from panel members, Rotherham CDOP has continued to function well during the pandemic and made a smooth transition to virtual meetings. March 2021 has seen the appointment of a new chair to CDOP and governance continues to be within the Rotherham Safeguarding Children Partnership.
Rotherham recorded 11 child deaths in total 2020/21; this is significantly below the average for years 2017-2020 (average 18 child deaths).

What's working well in Rotherham?

- The introduction of the role of the Lead Nurse for Child Death within TRFT in April 2020, has proved fundamental in developing, embedding and supporting the CDR process in Rotherham. Learning from audit, local and national themes and trends is shared and where appropriate has influenced change in local practice.

- The appointment of the role of keyworker has proved invaluable in highlighting the need for parental/carer voice to be heard during the child death review process. Parental /carer feedback has been key to identifying key learning, particularly in relation to service delivery in the first couple of weeks following a child death. Bereaved parents/carers now have a single point of contact Mon-Friday, 9am-5pm to whom they can turn to for information on the child death review process. The keyworker discharges their care once parents/carers have been offered contact and seen by Designated Dr Child Death, Lead Nurse and Keyworker following the child death review meeting.

- The Child Death Review meetings for all child deaths have worked effectively in terms of attendance and participation. The keyworker attends the child death review meeting to ensure that the voice of parents/carer are heard and taken into account.

- Direct contact and liaison with the NCMD (National Mortality Data Base) has enabled CDOP to remain compliant with CDR guidance e.g. grading system used to identify modifiable factors.

- CDOP and the CDR process has continued during the COVID-19 pandemic and a number of outstanding historical cases have now been concluded at CDOP.

- There has been improved liaison with Leeds Children's Hospital, Sheffield Children's Hospital and Jessop Wing, leading to improved information sharing for deaths of children resident in Rotherham occurring outside of the area.

- The CDR meetings and use of the eCDOP system has enabled more focused discussion and evaluation of the case at CDOP, enabling more time to discuss learning points.

- There has been increased awareness of the CDR process in obstetrics and maternity services in TRFT resulting in timely initiation of relevant processes.

- The use of Rapid Response Meetings for relevant cases continues to offer an effective step at the early stages of a death to identify support for the family including siblings and schools.

- Safe Sleep in children's and maternity acute services audit has taken place. The audit identified excellent practice in SCBU and a good level of knowledge and understanding of national guidance amongst practitioners. However, national guidance was not always promoted when baby/child was in receipt of care from TRFT. The audit included attendance at UECC and paediatric outpatient services.

What could we do differently or better in Rotherham?

- The quality of CDR documentation and reports, which feed into the CDR process need to be improved.

- There needs to be improved consistency of the JAR process in terms of completion of documentation to evidence multi –agency decision making and actions to be taken. This is particularly in relation to the immediate decision-making stage and engagement with partner agencies.

What are our plans for 2021-22?

Rotherham will host South Yorkshire CDOP from September 2021

- Improved liaison with the Coroner's Office in relation to role and function of coroner's officer and keyworker, and how they can work jointly to support families/carers.

- Audit and assurance of TRFT compliance with child death review statutory and operational guidance will take place.

- Embed child death review training on paediatric and obstetric registrar induction days and paediatric nurse training days.

- Consider and develop effective systems for cascading learning from CDOP to the wider partnership.

- Development session for CDOP members

- Review Rotherham SUDI/C multi -agency safeguarding procedures

- Consider the learning from National Reviews – eg NCMD Annual Report and webinars.

- Rotherham will be hosting the SYCDOP for 2021-22; in conjunction with members, consider a number of themes throughout the year.

TRFT will undertake self-assessment in relation to Bereavement Care Standards and identify actions which may need to be addressed before they can achieve National Care Pathways 2020, Bereavement Care Standards.

SHEFFIELD

What We Achieved in 2020/21
This year Sheffield CDOP met on 6 occasions with 1 panel cancelled at the beginning of the pandemic, reviewing 35 deaths. South Yorkshire CDOP panel met on 3 occasions with one cancelled at the beginning of the pandemic. With operational demands of COVID and restrictions in place we have moved to a predominantly virtual way of working; with some intermittent technical issues but on the whole a positive experience with good attendance achieved by all agencies.

There were 24 deaths recorded during this period significantly less when compared to average of 44 in the years 2008-2019. Once again, most of the deaths occurred in those under 1 year (58% 0-27 days, 13% 28-364 days) this is comparable to the national figures. Chromosomal, genetic and congenital abnormalities and Perinatal/neonatal events account for the highest categories of death in those reviewed 2020/21(63%).

It is hard to provide a rationale for the decrease in number of deaths, some suggestions being with COVID restrictions, less face to face contact may account for a drop in infectious diseases or childhood accidents. We hope national analysis of this data may offer some insight.

60% of deaths were reviewed within 12 months; 49% between 6-12 months and 11% in less than 6 months, this is less than last year (80%) however we need to take into account that the review period covered is during the COVID pandemic with impact early on with how meetings could take place effectively in a virtual setting. It should also be noted that of those reviewed over 12 months many had been delayed due to external issues such as inquests or other reviews being undertaken. Despite the CDOP Chair (Director of Public Health) being unavailable for the review period and Vice Chair retiring, we successfully managed to continue with meeting frequency ,the Designated Doctor Child Deaths stepping up to Chair. This has helped with keeping cases on track.

The median number of days between death and CDOP meeting is 333 nationally – the figure for Sheffield is 254.

The reviews consider modifiable factors, which are defined as actions that could be taken through national or local interventions, which could reduce the risk of future child deaths. Modifiable factors were assessed to be present in 34% of cases which is the same percentage as England overall.

What impact have these achievements had on the outcomes for children and young people in Sheffield?
We continue to feed into The National Child Mortality Database which is used to systematically capture information following a child death; this has enabled local learning but is also increasingly identifying learning at a national level and informing changes in policy and practice. This has been particularly important during the pandemic with real-time surveillance being introduced to highlight any issues

There is now a good level of data completeness at notification and reporting stages although it is acknowledged that some providers still struggle with eCDOP and ongoing training is required.

CDOP has supported actions taken in 2020/21 to help reduce risk factors and improve how services respond following a child death. We have continued to strive towards a joint and consistent approach across all areas with a collaborative approach for Safer Sleep Awareness Week and the launch of ICON Babies Cry, You Can Cope both tackling some of the risks highlighted in the Safer Sleep themed review.

We will continue to explore how those families where there are complex care needs can be better supported through co-ordination of care needs with the role of a lead clinician and work with Trusts to develop their understanding of the role of a Key Worker after a child dies.

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

How have you listened to children, young people and families?
Working in collaboration with the Designated Doctor Child Deaths there is continued work with Trusts to develop their understanding of the role of a Key Worker after a child dies.

What did children, young people and families say about your agency / service?
We continue to encourage family feedback at every stage with an attempt for this to then be shared and to influence overall system learning and outcomes.

We routinely send out information to those families experiencing the loss of a child and monitor any responses; actively encourage feedback and where a family makes contact we endeavour to respond in answer to their queries; we have listened to feedback and this has resulted in changes to process.

What We Will Do Next in 2021/22

What do you intend to achieve in 2021/22 that contributes to better outcomes for children and families within Sheffield?
For the upcoming year 2021/22 the hosting arrangements for SYCDOP will be facilitated by Rotherham CDOP 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.

Sheffield will continue with their 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 for Sheffield throughout 2021/2022 will be:
- To contribute to the development of Multi-agency South Yorkshire and Bassetlaw Joint Safer Sleep Guidance / practice.
- Continued roll-out of ICON across out local area.
- To participate in further thematic reviews with our Regional partners
- Completion of a local Contagion Plan
- Bereavement support

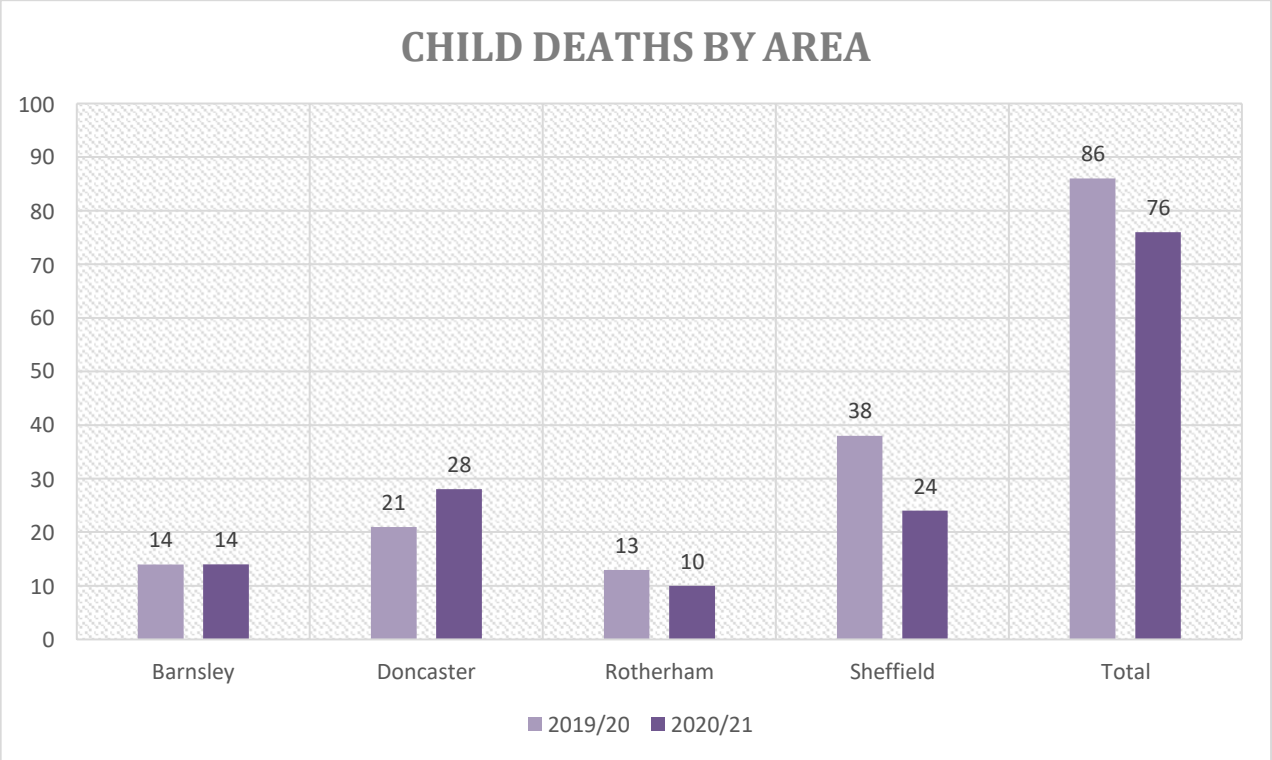
How will you support the local priorities of Mental Health, Neglect, and Contextual Safeguarding?
A major focus for CDOP is in continuing to influence where possible the overarching issues within mental health, and Crisis care, particularly for those in transition between children and adult services in the prevention of death by suicide in this cohort.

We are continually working with other services for mental health support, particularly low level mental health support and for those families bereaved by suicide or more recently during the pandemic to improve the experience of children, including siblings.
The recent NCMD Thematic report on Child Mortality and Social Deprivation will also be a key focus for the forthcoming year with a clear association between child deaths and social deprivation CDOP will need to consider how we support and influence future strategies to reduce these inequalities.

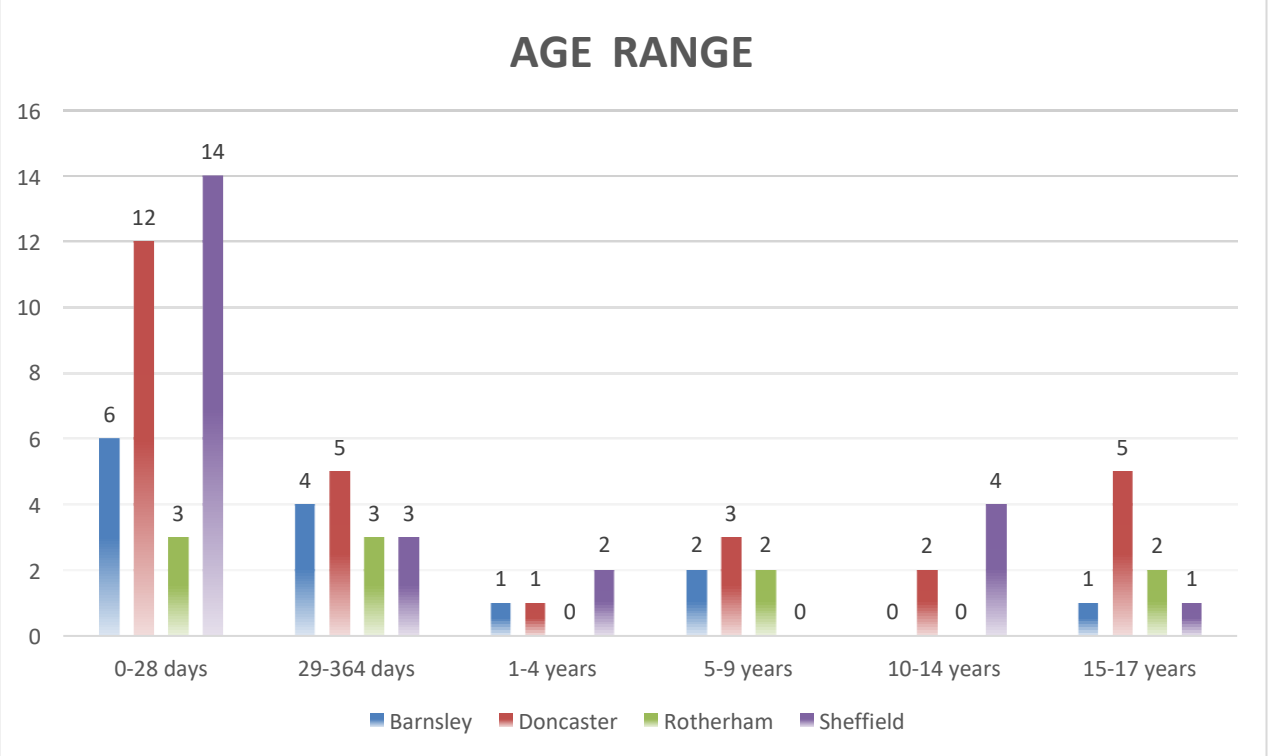
APPENDIX ONE

SOUTH YORKSHIRE AREA CHILD DEATH DATA

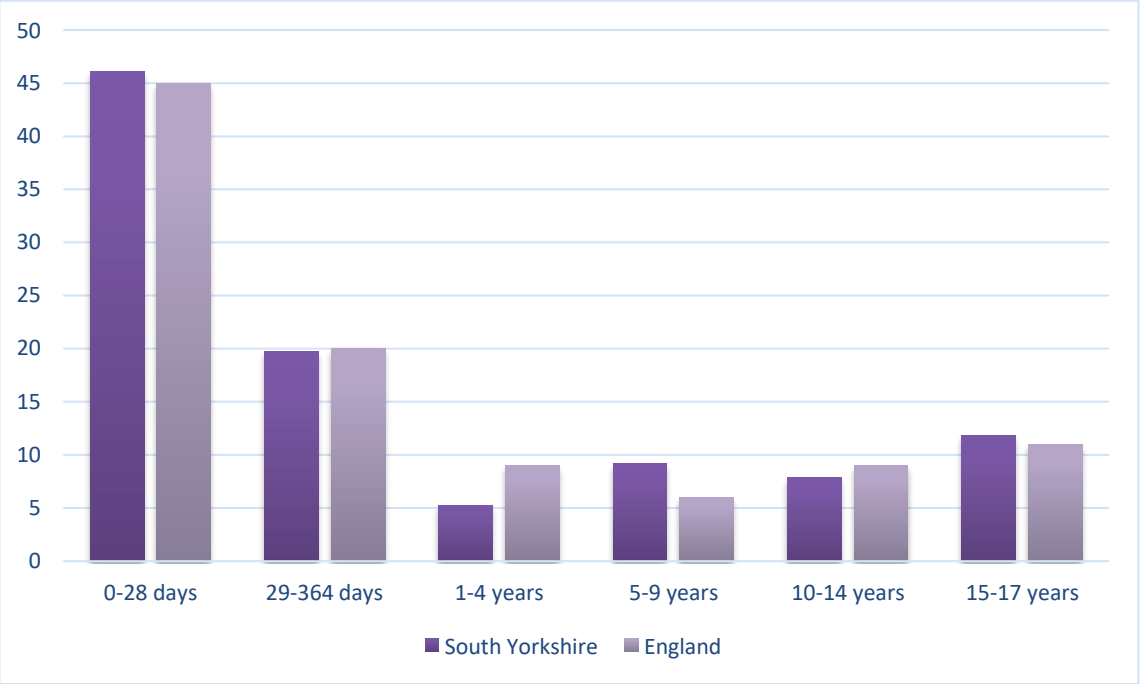
The total number of child deaths across South Yorkshire:



The child death age range per South Yorkshire area:



The percentage (%) of death notifications in South Yorkshire by age group during 2020/21 compared to the national (England) percentage:



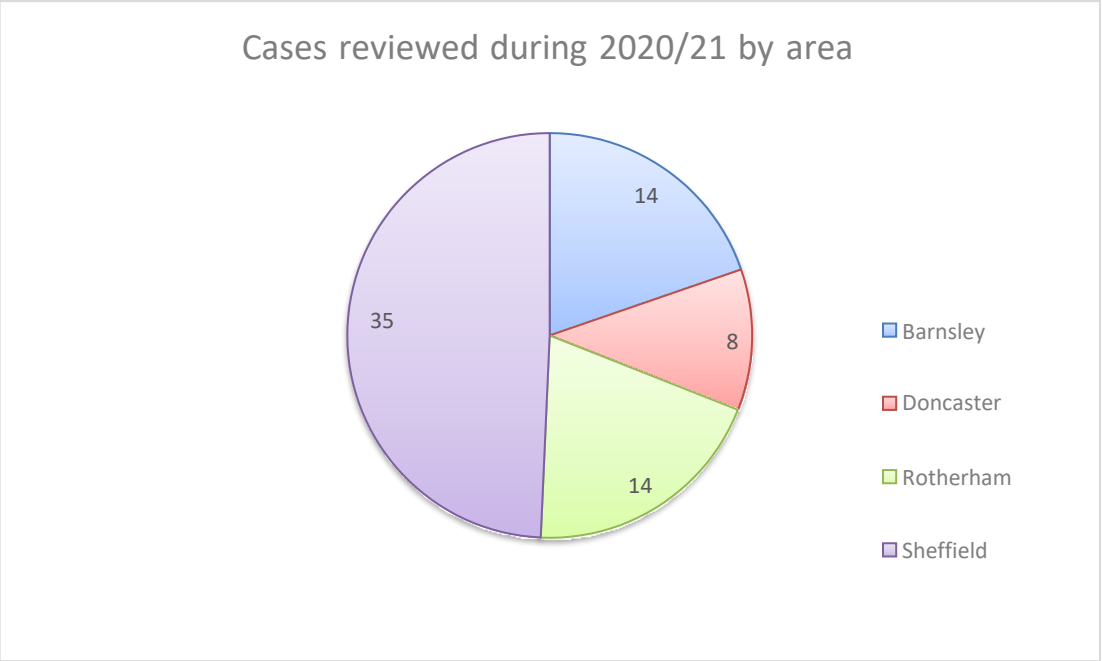
The percentage of death notifications in South Yorkshire by Ethnicity 2020/21 compared to 2019/20.

Ethnicity	2019/2020	2020/2021
Asian or Asian British - Any other Asian background	1%	0%
Asian or Asian British - Bangladeshi	0%	1%
Asian or Asian British - Pakistani	7%	9%
Black or Black British - African	2%	4%
Black or Black British - Any other Black background	0%	1%
Mixed - Any other mixed background	1%	0%
Mixed - White and Asian	5%	1%
Mixed - White and Black African	0%	1%
Mixed - White and Black Caribbean	1%	0%
Not known/not stated	21%	12%
Other ethnic group - Any other ethnic group	5%	0%
Other ethnic group - Chinese	1%	0%
White - Any other White background	5%	4%
White - British	51%	64%
White - Gypsy or Irish traveller	0%	1%

2020/21 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) case reviews.

The chart below shows the total number cases reviewed and closed at local CDOP panels within 2020/21.



The table below shows the total number of CDOP cases reviewed during 2020/21 by the **primary category of death** in descending order**:**

	Barnsley	Doncaster	Rotherham	Sheffield	*Total*
Chromosomal, genetic or congenital anomaly	5	<5	5	11	***22***
Perinatal / neonatal event	<5	<5	<5	11	***17***
Trauma and other external factors	<5	<5	<5	<5	***6***
Infection	0	<5	<5	<5	***6***
SUDI/SUDIC	<5	0	<5	0	***6***
Deliberately inflicted injury, abuse or neglect	0	0	0	<5	***<5***
Acute medical or surgical condition	0	<5	<5	<5	***<5***
Chronic medical condition	<5	0	0	0	***<5***
Malignancy	0	0	0	<5	***<5***
Suicide or self-inflicted harm	<5	0	0	<5	***<5***
Total	*14*	*8*	*14*	*35*	***71***

Modifiable factors

CDOPs are asked to analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any modifiable factors, and to identify learning arising from the child death review process that may prevent future child deaths.

Modifiable factors are defined as '*one or more factors which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future child deaths'.*

Modifiable factors identified in cases reviewed during 2020/21:

	Barnsley	**Doncaster**	**Rotherham**	**Sheffield**	***Total***
Modifiable factors identified	<5	6	<5	12	*25*
No modifiable factors identified	9	<5	10	23	*44*
Not known / Insufficient information	<5	0	<5	0	*<5*
	14	*8*	*14*	*35*	*71*

	Barnsley	**Doncaster**	**Rotherham**	**Sheffield**	***South Yorkshire***
Percentage of cases with modifiable factors identified	29%	75%	21%	34%	*35%*

The overall percentage of cases with modifiable factors identified for England is 34%

APPENDIX THREE

South Yorkshire CDOP Themed Review
Palliative Care

January 2021

Background: What happened and why?

As recommended in the Child Death Review Statutory and Operational Guidance (England) (HM Government, 2018) some child deaths may be best reviewed at a themed meeting.

SYCDOP agreed to collectively review a number of their child deaths, to include those aged 28 days to 18 years where palliative care was a feature. There was a particular interest in the child's voice, place of death, and the role/ involvement of local authority services in the child's care.

There was representation from across the region including a representative from a local Hospice who was invited to join the Panel. Each area presented their cases and learning from a number of their cases over a period of up to 4 years.

A total of 23 cases were discussed – Barnsley (3), Doncaster (7), Rotherham (3), Sheffield (10); 12 males and 11 females across a range of ages.

Key Issues Identified: What did we learn?

- Packages of care to meet child's needs. For those with complex care needs, and multiagency involvement there is often a lack of coordination and responsibility for overall care. Where should the CDRM take place? and are all the right people invited?
  For parents – it can be time consuming and result in parents feeling they are struggling to access the right care at the right time. Advocacy for parents to put forward their views for non-verbal children – wishes and feelings. Where do we capture child's wishes, current paperwork does not lend itself??
- Place of death – this was equally split between home (8), hospice (7) and hospital (7) and clear that in all cases consideration was given to child / parents' wishes. ? commissioning gap for Children's Community Nursing teams to support children who wish to die at home with end of life care.
- LOTA's – LOTA in place but death being expected 'immediately', importance of ensuring it is current and updated and all partners aware.
- Adult staff are not always aware of child death processes for 16+
- Strong links with LeDeR process
- Child in Need – Palliative care is not always considered as Child In Need but housing issues and lack of adaptions affected place of death in some cases. Where a child's need is relatively low level, individual and universal services may be able to take swift action. With more complex needs, help may be required under section 17 of the Children Act 1989 as CIN.

Outcomes: What will we do next?

- All areas to consider how they are disseminating child death review processes to adult providers.
- Raise with commissioners for Children's Community Nursing Teams to extend support for those requiring end of life care
- LOTA's & Pathways reviewed in each area to ensure that all services involved with child/family are notified of admission to hospice.
- Development of complex patient care – lead clinician model.
- Where death of a child outside area, proactively make contact with place of death to determine CDRM lead.

This briefing can be downloaded as a PDF here