Pan-Cheshire Child Death Overview Panel

Annual Report

1st April 2021 – 31st March 2022

Forward

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Mike Leaf
Independent Chair
Pan-Cheshire CDOP
Winter 2022

Forward from the Independent CDOP Chair

The report aims to not only reflect the cases the panel has considered throughout 2021-22, but also the achievements of the partnership, future priorities for action, and issues related to the implementing the statutory child death review processes, during a year affected by Covid 19.

The global pandemic continued to interrupt and impact on child death review processes across the county, much as it did across most of the country. In addition, there were some personnel changes to the Business Administration function, which led to one of the panel meetings having to be cancelled. This means whilst there was a slight improvement from last year, only 30 cases were reviewed and completed, compared to an average of 61 for the 3 years prior to Covid (2017-20).

I would like to thank all the Panel members, for their continued commitment and hard work, and in particular to the interruptions. As well as thanking all panel members, particular thanks go to Anne Barber who, following her retirement from her Business Administration role, has stepped back into the fray to support the new team member, Joann Woolstencroft following the untimely resignation of Anne's successor.

Mike Leaf

Independent Chair

Pan-Cheshire CDOP

Winter, 2022

Section 1:
Executive Summary

There is a statutory requirement for the statutory partners to *make arrangements to carry out child death reviews. These arrangements should result in the establishment of a Child Death Overview Panel (CDOP), or equivalent, to review the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children*.
Responsibility for reviewing child deaths no longer sits with local safeguarding arrangements and sits with the following:
Halton Borough Council
Warrington Borough Council
Cheshire East Borough Council
Cheshire West and Chester Council
Cheshire Clinical Commissioning Group (CCG)

In 2022, the CCG will be replaced by a single health body called the Integrated Commissioning Board.
It has been agreed that Pan-Cheshire CDOP will:

- provide oversight and assurance of the new Child Death Review processes and ensure that it meets the required statutory standards.
- review all infant and child deaths under 18 years of age. This includes neonates where a death certificate has been issued, irrespective of gestational age.
- identify and highlight any modifiable factors, and bring these to the attention of strategic partners, including Health and Wellbeing Boards, Multi-Agency Safeguarding Partnerships and Community Safety Partnerships where necessary in order to inform their preventative planning and commissioning arrangements.

The purpose of this Annual Report is to:

- Clarify and outline the processes adopted by the Pan-Cheshire CDOP
- Assure the Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across Cheshire, which meets national guidance.
- Provide an overview of information on trends and patterns in child deaths reviewed across Cheshire during the last reporting year (2021-22)
- Highlight issues arising from the child deaths reviewed.
- Report on achievements and progress from last year's annual report
- Make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across Cheshire.

Achievements and impact during 2021-22

- ✓ Managed and modified oversight of the Child Death Review processes
- ✓ Engaged with other CDOPs across the NW and nationally, and sharing good practice.
- ✓ CDOP Study/ Development Day delivered on post-mortems
- ✓ Circulated good practice, learning and tools across Cheshire.
- ✓ Challenged and sought assurance from providers on elements of inadequate care / deviation

from protocols arising from case reviews at panel, to assure quality.

- ✓ Provided support and guidance to local providers on quality processes.
- ✓ Ensured that exceptional care is recognised by writing to providers where care has gone beyond that which might be expected.
- ✓ Quarterly liaison meetings with child death review partners in Wales have continued to explore cross-border issues, due to the different child death review processes.

Also, as a result of discussions at CDOP, partners have also developed several initiatives including:

- ✓ Developed 7 Minute Briefings on infant sleeping; preventing shaking babies (ICON)
- ✓ Supported Out of Routine - "Think Family": Infant Safe Sleep
- ✓ Promoted Infant Safe Sleep Week 13-17 of Dec 2021
- ✓ Christmas tips for child allergies
- ✓ "Think Family": Learning Following a Recent Child Death Due to Anaphylaxis
- ✓ Lunch and learn event - "Think Family": Learning Following a Recent Child Death Due to Anaphylaxis
- ✓ Lunch and learn event - Out of Routine - "Think Family": Infant Safe Sleep
- ✓ Support of ICON (Infant Crying is Normal you can Cope Programme) week - webinars, posters, and social media platforms – Action against head trauma.
- ✓ An Audit of ICON in Cheshire East and Cheshire West & Chester was carried out in 2021. Unfortunately, Warrington and Halton could not participate due to capacity issues associated with the Covid Pandemic.

Summary of key points and themes:

Of those deaths reviewed [2020-21 percentage in square brackets]:

- 53% of the deaths occurred before the child reached 28 days (16 deaths) [49%]
- 70% of the deaths occurred before the child reached one year of age (21 deaths)[68%]
- 7% of the deaths occurred in Children aged 1 year to 4 year (2 deaths) [11%]
- 0% of the deaths occurred in Children aged 5 years to 9 years (0 deaths) [5%]
- 13% of the deaths occurred in Children aged 10 years to 14 years (4 deaths)[12%]
- 10% of the deaths occurred in Children aged 15 years to 17 years (3 deaths) [5%]
- 47% of the deaths were male (14 deaths) 46%]
- 47% were Perinatal/Neonatal events (14 Deaths) [39.3%]
- 40% of deaths reviewed had 'modifiable factors' (12 deaths) [50%]
- 30% deaths were classified as 'unexpected' [61%]

A modifiable factor is one *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*. Modifiable factors identified for Cheshire during 2021-22 continue to highlight the same top three factors, despite the relatively small numbers. These include in order of prevalence:

- Mental health issues (parent or child)
- Smoking by the mother/ parent/ or carer during pregnancy or in the first few years of a child's life
- Alcohol / substance misuse
- High maternal body mass index (BMI)

- Unsafe sleeping

Update on priorities 2020-21

- ✓ Implement the eCDOP programme across Cheshire, to improve processes and minimise additional administrative burdens.
  eCDOP continues to form part of an integral component of the CDOP business process. There is an ongoing commitment to expand its use, although some of the progress has been interrupted with staff changes within the business administration function.
- ✓ Analyse the data on Adverse Childhood Experiences (ACEs) and report on the findings next year.
  The pandemic has meant that PH analytical support for this analysis has not been available, although their remains a commitment to provide a report when resources can be secured. This would be a useful project for one of the trainee Specialist Registrars from one of the four PH teams.
- ✓ Through the monitoring of the self-assessment framework and risk register, ensure that any elements of non-compliance are managed or escalated to appropriate partners.
  In view of the pressures faced by partners in their response to the covid 19 pandemic, the focus on the SAF was suspended until covid 19 rates become more manageable. The risk register is reviewed at each business meeting.
- ✓ Ensure that CDOP receives the necessary documentation from Child Death Review meetings.
  There has been a gradual improvement in the quality and extent of reporting documentation. CDOP will continue to monitor this and explore opportunities for improvement.
- ✓ Improve the scores on the notification and reporting fields highlighted by the National Child Mortality Database [NCMD] report.
  The data completeness indicator relating to whether cases have been discussed with the new Medical Examiner does not feature in the NCMD report for 2021-22, so we have no feedback on current performance. The indicator relating to data completeness in relation to JAR cases remain sub-standard and this will be explored by the Business Group to improve these fields.
- ✓ Clarify the governance arrangements and implications of the emerging NHS re-organisation.
  This issue remained a standard agenda item of the Business Group throughout the year. The group was assured that child death reviews processes were being considered, although exact details would be clarified once the ICB was established, which had a 3-month delay. We have assurance that Child Death Review processes will be embedded in emerging processes.
- ✓ Review any Evaluation/outcome reports of ICON implementation.
  An Audit of ICON in Cheshire East and Cheshire West & Chester was carried out where it was found that within the 0-19 service the ICON initiative was embedded into systems and the ICON message was being delivered at the key touch points. Most parents remember some of the key messages and many reported that they had used some of the ICON methods. A number of recommendations were made in the Report and a further and final audit is being considered for 2023.
- ✓ Ensure that there are opportunities for parents to access non-digital versions of *"When a Child Dies"* leaflet which provides a detailed explanation of many of the processes associated with a child's death.
  The leaflet is now available electronically.
- ✓ Catch up on the delayed cases coming to panel as a result of covid.

Several changes in the Business Administration team, including the retirement and resignation of the Business Administrator replacement, has meant that this catch-up has been delayed. This continues to be a significant risk and will feature as a priority for the following year.

Priorities for 2022-23:

- ✓ Establish a resilient Business Administration function.
- ✓ Analyse the data on Adverse Childhood Experiences (ACEs) and report on the findings next year.
- ✓ Ensure that CDOP receives the necessary documentation from Child Death Review meetings.
- ✓ Minimise the backlog that has developed over the covid period.
- ✓ Strengthen the governance of CDOP and CDR processes following ICB formation.
- ✓ Improve data completeness as compared to national NCMD standards in relation to recording of JAR cases and ethnicity.
- ✓ Ensure that all parents whose child has died has access appropriate bereavement services.
- ✓ Ensure the potential of the eCDOP programme can be accessed to improve processes and minimise additional administrative burdens across Cheshire.
- ✓ Ensure that all parents whose child has died are able to contribute to the review process.
- ✓ Ensure that the Pan-Cheshire CDOP has a resilient Business Administrative function.
- ✓ Ensure that the ICON programme is effectively implemented.

Recommendations for Local Strategic Partners

Children's Safeguarding and Health and Wellbeing partners are asked to:

1. Note the contents of this report and in particular:
    a. The summary of achievements, key points and themes, and priorities for 2021-22
    b. A drop in performance in terms of the time taken to bring cases to panel.
    c. The disruption to some of the internal processes due to CDOP Business Administration personnel changes.
    d. The priorities for 2022-23
2. Provide assurance that interagency initiatives are being monitored to reduce the prevalence of modifiable factors identified in the under one population including:
    i. Safe sleeping
    ii. Risk factors for reducing premature births including:
        - High BMI (including healthy diet and physical activity)
        - High blood pressure (linked to high BMI)
        - Smoking
        - Alcohol use
        - Substance misuse
        - Domestic violence
        - Mental health
        - Diabetes (often linked to BMI)

Mike Leaf
Independent Chair
Pan-Cheshire CDOP
Winter 2022

Section 2:
Overview and Processes

CDOP Membership

Pan-Cheshire CDOP's core membership comprised of:

- Independent Chair
- CDOP Coordinator
- Designated Nurse for Safeguarding Children (Warrington and Halton)
- CDOP Nurses x 3 (Cheshire East, Cheshire West and Warrington/Halton)
- Specialist Midwife
- Public Health
- Coroner's officer
- Designated Doctor for Child deaths x 3 (Cheshire East, Cheshire West, Warrington/Halton)
- Police Representative from PPU Directorate
- Local Authority Head of Service, Safeguarding and Quality Assurance Unit
- Local Authority Service Manager, Children's Social Care
- Education Representative from Safeguarding in Education Team.
- Local Safeguarding Children Partnerships
- Co-opted Advisory Member (Paediatrician/Deputy Coroner)
- Northwest Ambulance Service (where needed in cases of unexpected deaths)

The Pan-Cheshire CDOP has permanent representatives drawn from the key professionals who have an interest in children's health and safeguarding, and statutory partners. Members are not there to represent their individual organisations, but to represent a professional perspective/ insight to the cases presented. In addition to the specific roles identified below, all members of CCDOP are expected to:

- Ensure that they are fully prepared to contribute at each meeting by reading through the papers, and consulting colleagues where necessary beforehand.
- Ensure that there is a suitable alternative replacement to attend if it is not possible to attend.
- Take away action points to their specific geography, agency or professional groups, and ensure that the action is undertaken within the required timescales.

Frequency of Meetings

The panel currently meet on a quarterly basis and for a whole day. It has been agreed that this frequency will remain unless there was a significant number of cases to review. The business meeting will follow the panel meeting. At the time of writing, virtual meetings are in place as a result of the Covid 19 pandemic.

Agency Representation at Panel Meetings

The Pan-Cheshire CDOP met on five occasions between April 2021 and March 2022, although this was virtual. Attendance is monitored on a regular basis to ensure quoracy and effective representation. On occasions there are times where professional demands must take priority. Representation has been consistent throughout the year.

Table 1: Agency representation

Sector	Role
Chair	Independent CDOP Chair
Health	Designated Doctor CE
	Designated Doctor CWAC
	Designated Doctor Warrington & Halton
	Cheshire East Specialist CDOP Nurse
	Cheshire West Specialist CDOP Nurse
	Warrington Designated Nurse Safeguarding
	Designated Nurse Halton CCG
	Supervisor of Midwives CWAC
	Warrington Safeguarding Nurse
	Coroner Officer
Local Authority	Cheshire East Head of Service – Children's Safeguarding
	Public Health Consultant (Cheshire W. and Chester)
	Local Authority Safeguarding Children Partnership Business Manager for Warrington Borough Council
Police	Public Protection Unit

Notification Process

The notification process via paediatric liaison and hospital/hospice staff functions well. By cross-referencing with the annual NHS England return (regarding notifications from Registrars to NHS England), CDOP is confident that it is notified of all child deaths. When Cheshire child deaths occur out of area, CDOP is often notified by Cheshire agencies, as well as by the CDOP contact in the respective area where the death occurred. This demonstrates effective communication between local organisations and CDOP.

SUDiC Guidance

The Pan-Cheshire SUDiC guidance has been updated and widely circulated, and aligned to the national Statutory and Operational Child Death Review Guidance.

Links to Coroners and Registrars

Within Cheshire there is an excellent working relationship with the coroners offices, with senior coroner's officer representation at panels, where possible. This helps clarify and resolve issues in a timely manner.

Deaths of Children Living Outside Cheshire

Whilst CDOP is responsible for the review of child deaths resident in Cheshire, there is an expectation that it should receive notification of child deaths for children who live out of area but have died within the boundary. As Cheshire borders Wales, where there is a different process for reviewing child deaths, the numbers of these children may be significant. Quarterly liaison meetings with child death review partners in Wales have been established to explore cross-border issues, due to the different review processes.

CDOPs across the country should routinely notify the CDOP where the child died, and visa versa. Any deviations from this process are followed up. In the future, some deaths may be reviewed of non-resident children where there is local learning to be uncovered, but this will be discussed with the CDOP of the child's residency. This will be done on a case-by-case basis. Professionals have a

responsibility to notify the CDOP administrator if they learn of the death abroad of a either a child or an infant born to a mother who normally resides in the Cheshire area so that the death may be verified, SUDIC procedures implemented, and a JAR initiated.

Communicating with Parents, Families and Carers

Leaflets and a letter are made available to any parent following the death of a child. A new NHS England leaflet has been produced for use locally. *"When a Child Dies"* provides a detailed explanation of many of the processes associated with a child's death. Parents are invited to contribute any comments to the review of their child's death, and CDOP will monitor this.

Deaths involving other reviews and investigations.

Child deaths are considered at panel once all relevant investigations and reports have been completed. These include any Children's Safeguarding Practice Review, Coroners enquiry, Healthcare Safety Investigation Board review, criminal enquiry, or internal review. This approach is consistent with that undertaken across the North-West and much of England and will continue under the new local and national procedures. This may, on occasions, result in a delay between notification and review completion and CDOP will continue to monitor this process and any delays. This explains why there is often a difference between the number of death notifications, and the number of reviewed cases. In 2021-22, there was a large difference between the number of child death notifications (57) and the cases considered at CDOP (28), largely due to processes affected by Covid 19.

Regional/ National Links/ Updates:

North-West meetings

Pan-Cheshire CDOP continues to be represented at the north-west CDOP meetings. A common dataset was agreed for all North-West annual reports to allow for the compilation of an overview report covering the area. A North-West CDOP report is produced annually, although this has not been possible during and immediately following Covid, due to competing pressures.

National Network

Some Cheshire CDOP members form part of the national network group which advises on issues of national interest, together with flagging issues with the National Child Mortality Database (NCMD).

Income and Expenditure 2021-22 (Provided by Cheshire East)

	Warrington	Halton	Cheshire West and Chester	Cheshire East	Total	Variance
Independent Chair	£3,000	£3,000	£3,000	**£3,000**	**£12,000**	**£870**
e CDOP	**£3,000**	**£3,000**	**£3,000**	**£3,000**	**£12,000**	**0**
20% for panel admin	£1250.88	£1250.88	£1250.88	**£1250.88**	**£5003.52**	**0**
80% for child deaths	**£4203.04**	**£2601.09**	**£6004.34**	**£7204.20**	**£20,014.08**	**0**
Management costs	**£625**	**£625**	**£625**	**£625**	**£2,500**	**0**
Development costs	**£1,000**	**£1,000**	**£1,000**	**£1,000**	**£4,000**	**0**
Total	**£13,078.92**	**£11,477.78**	**£14,880.22**	**£16,080.08**	**£55,517.60**	

The independent Chair was forecast £12,000 and the actual was £11,130. The £870 underspend was absorbed into the overall staffing costs which are £25017.60 and are then allocated by the 80/20% formula to reflect fixed administration costs and the differing child populations of the four boroughs.

Issues Identified

Missing Data

There has been an improvement on the details provided on the forms, but the failure to provide consistent information can create issues. For example, the lack of details of the father/significant male/other parent in the family, is particularly relevant in relation to necessary checks regarding domestic violence. This forms part of an ongoing dialogue with representatives and remains under scrutiny.

National annual statistical data

All data from CDOPs in England is now incorporated into the National Child Mortality Database which receives timely information from all areas. NCMD produces quarterly reports, together with an annual report for each CDOP. This report forms the basis of the Pan-Cheshire CDOP report contained in Appendix I.

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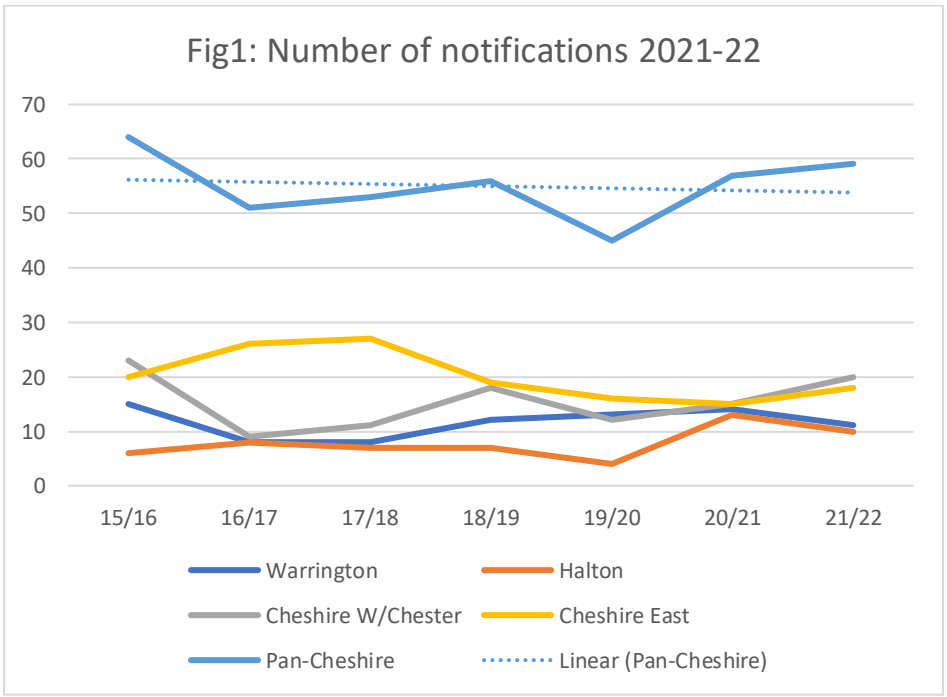
- Alcohol use
- Substance misuse
- Domestic violence
- Mental health
- Diabetes (often linked to BMI)

Section 3:
Data and Analysis

It should be noted that it is often difficult to make clear conclusions from analysing data from a relatively small number of cases reviewed each year. The learning from each individual case is noted at each CDOP meeting, with the appropriate action taken at that time. Where reviews have already been undertaken e.g., hospital mortality reviews, action has usually already been taken. Cheshire's figures are amalgamated with other CDOP data across the NW to provide opportunities for identifying more reliable trends. Notified deaths are categorised according to place of residency using postcodes.

Trends

When dealing with relatively small numbers, there can be wide fluctuations year on year. By considering numbers over time, one can look at trends in the figures.



Child death notifications over time

Figure 1 shows a slight downward trend in child death notifications per year for Cheshire (see trend line) but remains fairly level. There was a slight drop in covid affected year 2019-20, which reflected the national pattern. The mean average number of notifications over the last 7 years is 55, which is slightly below the recommended lower limit of 60 deaths per year by NHSE.

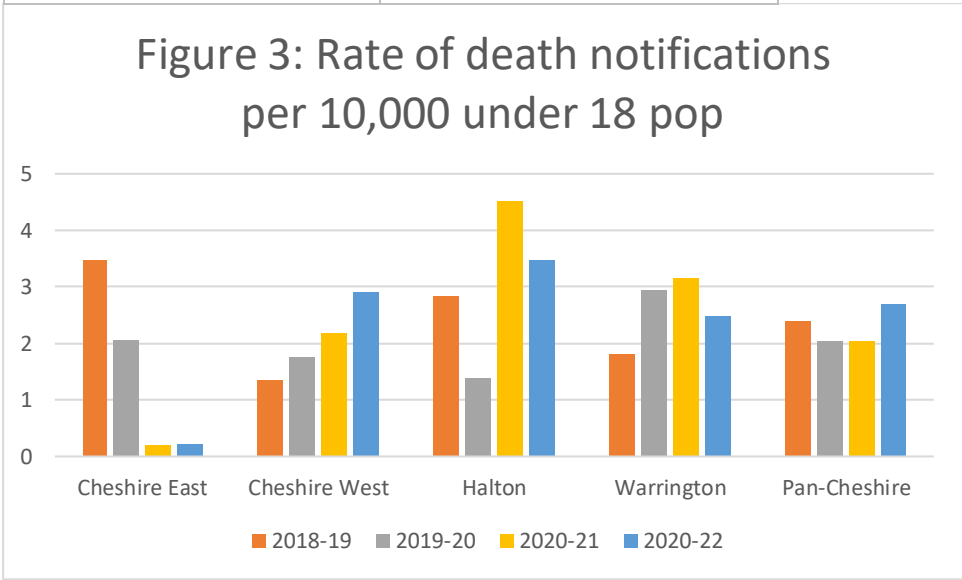
Child Population

The child population estimates in each of the four Local Authority areas are detailed in the following Figure 2.

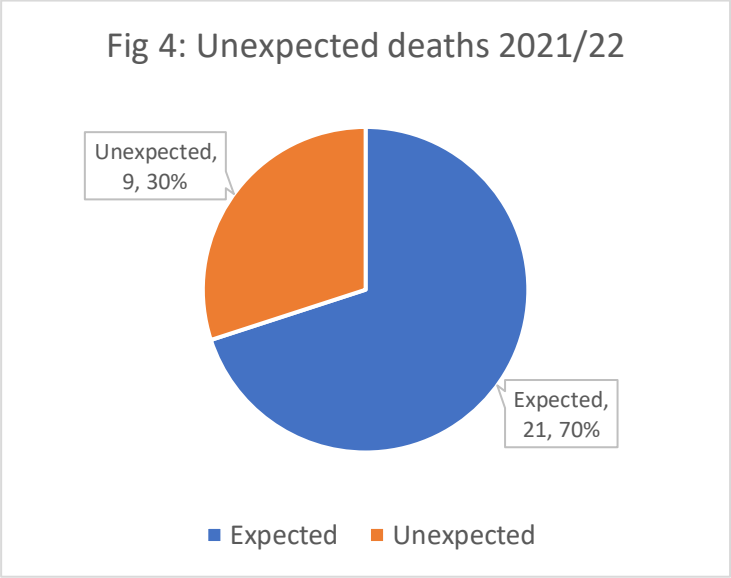
Figure 2: Child Populations by local authority

LSCB area	Child population size* (0-17 years)
Cheshire East	77,290
Cheshire West & Chester	68,656
Halton	28,770
Warrington	44,391
Pan Cheshire	219,107

* Source: ONS mid-Year Population Estimates, 2019-20



Local child populations are useful when comparing local areas. Normally, one would expect to see the numbers of deaths in each geography, to be proportionate to the number of under 18-year-olds living in each, but there may be differences according to deprivation levels. Figure 3 shows the rate of deaths per 10,000 under 18 population over the last 4 years, and highlights that there have been significant reductions in the rate in Cheshire East. The 2019-20 ONS Mid-year estimate was used for each year.



Expected / Unexpected deaths.

An expected death refers to *a death that could reasonably been foreseen by clinicians for a period of at least 24 hours before it occurred. An unexpected death is then defined as the death of an infant or child which was not anticipated as a significant possiblity 24 hours before the death or, where there was was an unexpected collapse or incident precipitating the events that led to that death.* During 2021-22, 9 (30%) [61%] deaths were classified as 'unexpected' (Fig 4).

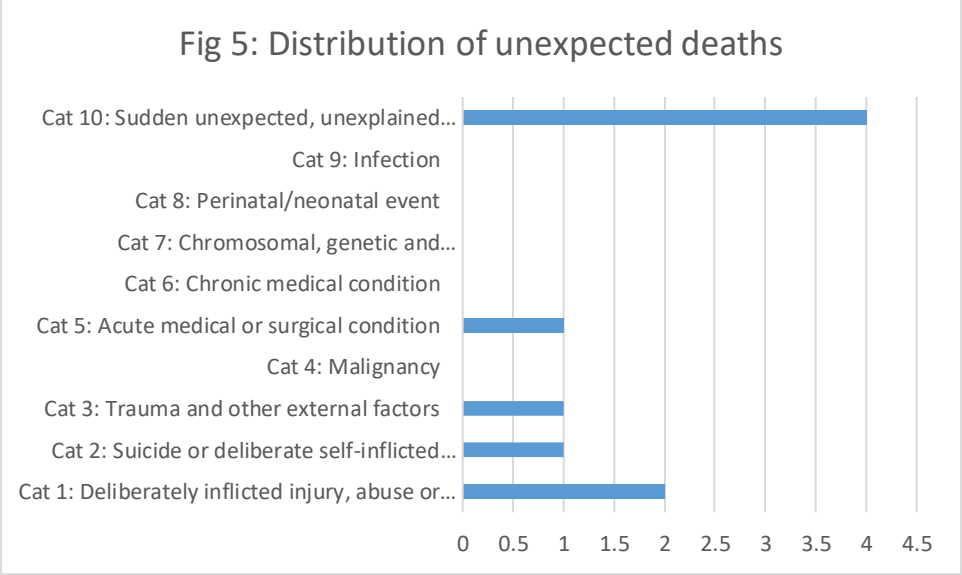


Fig 5 shows the distribution of unexpected deaths by category of death. The biggest proportion of the unexpected deaths occurred in the Sudden Unexpected, unexplained death. Last year it was the Perinatal/ neonatal category, but small numbers (9) are likely to cause fluctuations.

Deaths and Case Completions [2020-21's figures in brackets]

There was a total of 59 [57] deaths notified during the last year, and 30 [28] cases closed (completed by Pan-Cheshire CDOP). 88[60] deaths were registered with the National Child Mortality Database (NCMD) which had not been closed and were ongoing.

Deaths by gender

From April 2021 – March 2022 of the 30 child deaths reviewed by the CDOP, 14 were male or 47% (48% previous year) and 16 or 53% were female (52% previous year).

Completed reviews by primary category of death and by age.

The majority of all deaths 56% [54%] had a cause associated with chromosomal, genetic, congenital anomaly or as a result perinatal/neonatal event, and 70% [64%] of all deaths occurring under the age of one year.

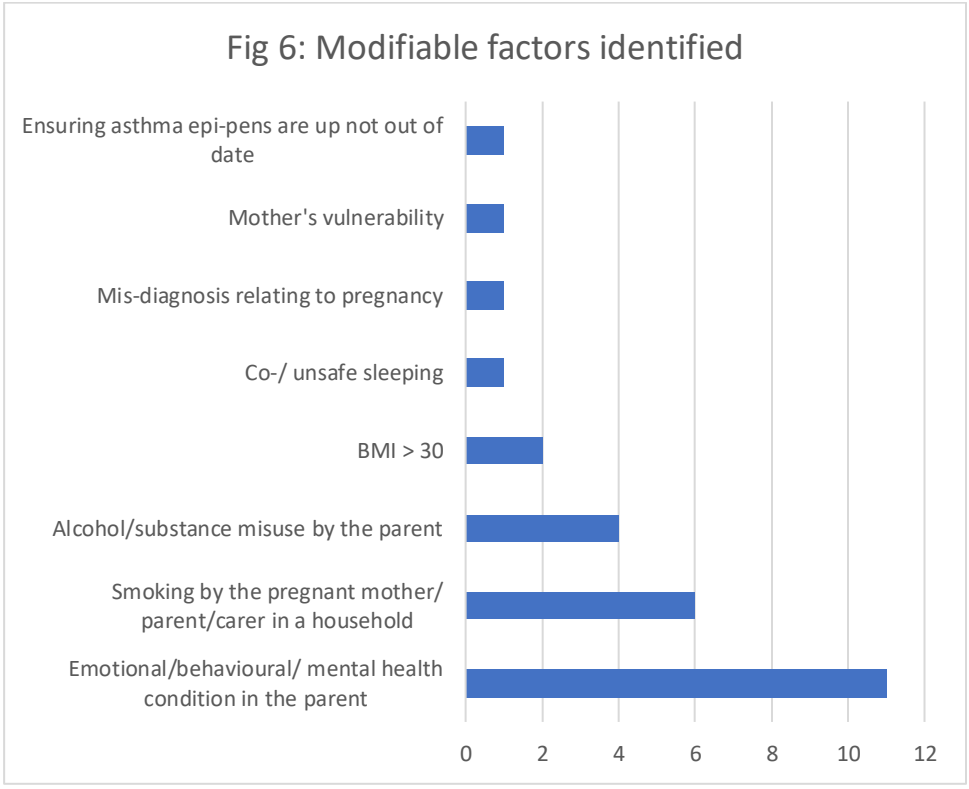
Completed reviews by place of death and onset of illness/incident.
As one might expect, most deaths 83% [82%] occur within a hospital and of those who died in hospital, 64% (16) [74% (17)] died in either the perinatal/neonatal/maternity/labour unit.

Ethnic groups and category of death
25 (83%) [25(90%)] of those children who died where categorised as white.

Deaths reviewed by CDOP with modifiable factors.
A modifiable factor is one *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*.

During the year, 40% [50%] of cases reviewed (12) [14] had identifiable modifiable factors, which is again higher than the national average of 37% [34%]. Of these, 83% [58%] were linked to deaths under one year of age. For all categories except suicide/ self-inflicted harm; chronic medical condition; infection; and malignancy, modifiable factors were identified in all cases reviewed.

Fig 6 gives a breakdown of the modifiable factors identified in order of prevalence.



- Mental health issues (parent or child) continue to be the most frequent modifiable factor being prevalent in 36.7% [32.1%] of deaths reviewed.
- Smoking by the mother/ parent/ or carer during pregnancy accounted for 20% of cases. [43.1%]
- Alcohol / substance misuse (parent/child) (13.3% of all deaths [12.5%])
- High maternal body mass index (BMI) (6.7% of all deaths under 28 days)
- Unsafe sleeping 3.3%

- Specific factors relating to prevention of allergic reactions and ensuring where epi-pens have been prescribed, they are up to date.
- Mother's vulnerability

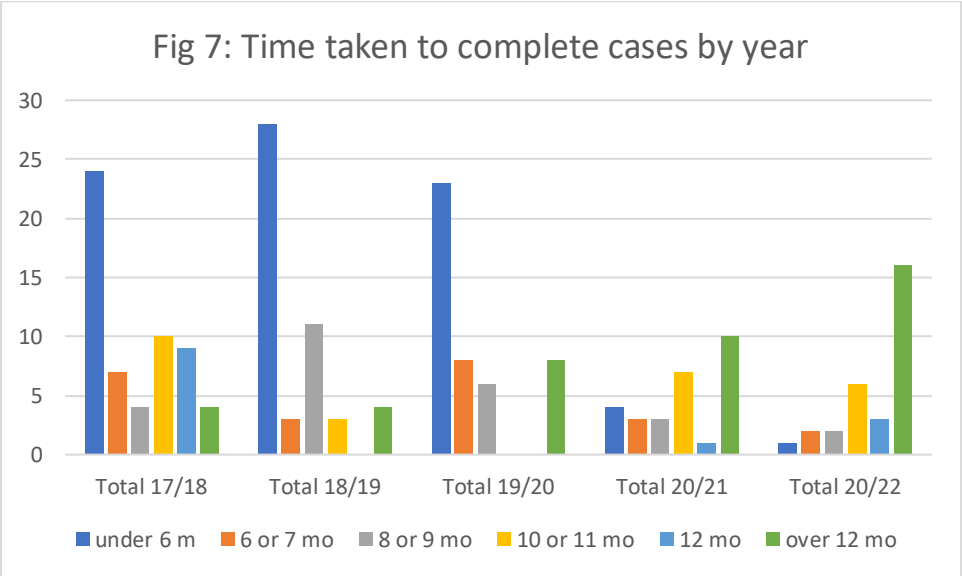
The highest annual number of deaths continue to occur neonatally (under 28 days), often as a result of complications through prematurity. Smoking, alcohol consumption, high maternal BMI, and domestic abuse all are known to increase the risk of prematurity and low birth weight, resulting in an increased level of vulnerability and risk of early infant death. It is important that all parts of the health wellbeing, and safeguarding system reinforce messages that reduce risk of prematurity and low birth weight, especially during pregnancy.

Death notifications

CDOP can be notified of the death of a child by any organisation or an individual. CDOP may receive several notifications for the same child, but where this occurs, it will be classified as a single notification.

The majority of deaths occur in the first year of life 71% [67%] compared to 62% [65%] nationally. Deaths in childhood occur during the first year of a child's life, and are strongly influenced by pre-term delivery and low birth weight; with risk factors including maternal age, smoking and disadvantaged circumstances (Wolfe and Macfarlan, 2015).

Time taken to complete cases.



Pan-Cheshire CDOP has tended to take marginally less time to bring cases to panel from initial notification compared to national figures. For the year 2021/22, this trend has reversed (360 days compared to 335) [315 days compared to 333]. (Figure 7 provides a breakdown of the time taken to complete the reviews over the last 5 years. It shows that during 2021-22, only 1 [4] review was

completed within 6 months and a significant rise in the number of cases that have taken more than 12 months to complete. Some of these delays are beyond the control of CDOP for instance delays from the Northwest Neonatal Operational Delivery Network (NWNODN) reviews, and delays in coronial processes, both impacted by the Covid 19 pandemic. However, there have been additional disruptions to some of the internal processes due to CDOP Business Administration personnel changes which are being resolved.

Category of Child Death

The CDOP panel is required to record each death against 1 of 10 nationally set categories as follows:

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

Acknowledgements

As noted in the foreword much of the business of the CDOP is dependent on the continued support of panel members and the administrative support. I would like to take this opportunity to thank the panel members for their continued support and especially Anne Barber who ensures the panel runs smoothly.

Mike Leaf
Independent CDOP Chair
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Glossary of Terms

Term	Meaning
Child	A person aged 0-18th birthday
Expected death	A death that could have been reasonably predicted 24 hours before the death occurred or 24 hours before the immediate events leading to the death occurred
Infant	Aged less than 1 year of age
Modifiable factors	Factors associated with a death which by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths
Neonatal period	From birth until 28 days of life

Perinatal period	From viable gestation (around 23 weeks of pregnancy) until 7 days following birth
Unexpected death	A death that could not have been reasonably foreseen 24 hours before it occurs – or where there was an unexpected collapse or precipitating events leading to the death

Abbreviations

CDOP – Child Death Overview Panel

SUDI – Sudden Unexplained Death in Infants

Appendix II: Classification of Death

This classification is hierarchical: where more than one category could reasonably be applied, the highest up the list should be marked.

Category	Name & description of category	Tick box below
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also, deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	☐
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 children.	☐
3	**Trauma and other external factors** This include isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury, abuse or neglect. (category 1).	☐
4	**Malignancy** Solid tumours, leukaemia's & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	☐
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.	☐
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.	☐
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease,cystic fibrosis, and other congenital anomalies including cardiac.	☐
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 palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).	☐
9	**Infection** Any primary infection (ie, 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.	☐
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	☐