Norfolk Safeguarding Children Partnership

Suffolk Safeguarding Partnership

Norfolk & Suffolk Child Death Overview Panel (CDOP)

Annual Report 2021 - 2022

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Introduction

The two local Child Death Overview Panels (CDOP), one for Norfolk and one for Suffolk, review the death of every resident child aged under 18 years in Norfolk and Suffolk. They report in respectively to Norfolk and Suffolk Safeguarding Children Partnerships.

In October 2018, the Department of Health and Social Care (DHSC) assumed national leadership of the child death review process and published guidance; *Child Death Review: Statutory and Operational Guidance (England)*[1] for reviewing the deaths of all children[2] regardless of the cause of death. This guidance aims to put bereaved families at the heart of the review process. It also sought to standardise practice and outputs to enable thematic learning. The data collected is uploaded to the National Child Mortality Database (NCMD) via the use of E-CDOP software which captures data from CDOPs across England in one place. This makes it possible to draw out a greater level of background information regarding children who die and the factors that may contribute to their deaths, enables a more systematic approach to reducing child death where possible and assists learning about how best to support bereaved families[3].

The guidance advised that CDOPs reviewing less than 60 deaths should combine with another CDOP Norfolk and Suffolk both meet this criterion, and a joint annual report was first produced in 2019/20.

The Child Death Overview Panel (CDOP) annual report is a summary of the activity carried out by the panels in line with the national guidance which include child mortality trends, causes of death, modifiable factors, actions taken, and any lessons learnt – all of these to be considered by CDOP for each child death. The aim is to seek to improve outcomes for children across Norfolk and Suffolk.

This report summarises the work of both CDOPs and the cases that have been reviewed in the period from April 2021 to the end of March 2022. This timeframe coincided with the global pandemic of COVID-19, which led to a number of necessary practice changes; one of the most significant of which was a move to virtual meetings using the collaborative communication platform Microsoft Teams.

Suffolk developed a new Child Death Review Team (CDRT) in September 2019 and Norfolk followed suit from April 2021. These have both proved instrumental in improving the quality and effectiveness of practice.

The CDOP process is important, can be challenging and is rewarding. Thanks are due to all those who have taken part and contributed to this process in Norfolk and Suffolk.

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[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf

[2] before their 18th birthday

[3] See https://www.ncmd.info/wp-content/uploads/2021/06/NCMD_2nd_Annual_Report_June-2021_web-FINAL.pdf

Executive Summary

During 2021/22, Norfolk and Suffolk CDOPs met on thirteen occasions (7 in Suffolk; 6 in Norfolk). Panels have been held consistently every two months.

There were 84 deaths of Norfolk and Suffolk resident children aged under 18 years old notified to CDOP during this period, compared to 60 in 2020/21, 79 in 2019/20 and 50 in 2018/19.

In 2021/22 the two CDOPs reviewed 63 deaths that had occurred between August 2019 and December 2021, of which 32 reviews were in Norfolk and 31 in Suffolk. This was a decrease from 2020/21 when 79 cases were reviewed, with the greatest reduction in number in the categories of: 'sudden unexpected, unexplained death'; 'suicide: deliberate self-inflicted harm'; and 'deliberately inflicted injury, abuse or neglect'. The numbers fluctuate year-on-year for a variety of reasons and the numbers are sometimes not high enough to be statistically significant. This is partly the reason why a learning culture is important to establish and maintain so that the lessons from each death are accorded the significance they warrant. In June 2020, a themed neonatal panel was introduced in Suffolk and cases were held back for this, creating an artificially high value in 2020/21. Norfolk had previously established a themed neonatal panel. There were 35 deaths of neonates (0-27 days) reviewed in 2020/21 as opposed to 25 in 2021/22.

Introduction of E-CDOP[4] forms have enabled timely and efficient sharing of information to CDOP.

Key findings were:

Of the 63 deaths reviewed over 50% were under 1 year of age. 25 were neonates (0-27 days), and 11 were in infants aged between 28-364 days.

The main categories of death across all the age groups were 'perinatal/neonatal event', 'chromosomal, genetic and congenital anomalies', 'malignancy', 'sudden unexpected unexplained death' and 'suicide or deliberate self-inflicted harm'. There were no deaths reviewed that were due to 'deliberately inflicted injury, abuse or neglect' in this period.

Modifiable factors were reported most frequently (figure 11) in children aged 15-17 years (10 cases where 80% had modifiable factors) followed by neonates aged 0-27 days (56% had modifiable factors). In adolescents these were in cases due to 'trauma and other external factors including medical/surgical complications/error', 'suicide or deliberate self-inflicted harm', 'sudden unexpected, unexplained death (SUDI)', 'infection' and 'acute medical or surgical conditions'. Nationally, modifiable factors were identified most frequently in deaths that were classed as SUDI and those where children died due to 'deliberately inflicted injury, abuse or neglect' (2021 NCMD data for England).

Norfolk and Suffolk took a median of 223 days between the child's death and CDOP meeting. This is a marked improvement on last year's average of 275 days and is significantly faster than the England average of 335 days (Figure 3).

Norfolk and Suffolk have improved the recording of ethnicity. There was only 1 case where this was unknown compared to 9 last year.

[4] Electronic Child Death Overview Panel

Principal areas of learning were:

We continue to see similar themes recurring as with previous years. These include:

- Improving communication: There were challenges identified regarding communication between and within agencies/organisations and between clinicians and families.
- Issues with non-adherence to safe sleeping guidelines; associated with co-sleeping and use of tobacco, drugs and alcohol
- Parental smoking
- Monitoring patients in clinical situations
- Timely recognition of high-risk situations/unwell patients and appropriate escalation for senior review
- Low threshold to consider severe illness and start treatment, including families recognising their child is seriously unwell, as well as clinicians in the pre-hospital setting.

We have also noted a new theme of COVID-19 related problems with social isolation and the effects on mental health and changes to service provision.

The Child Death Overview Panel (CDOP) Panel

The statutory responsibility of CDOP is set out in the Children Act 2004 and Working Together 2018. CDOP's primary function is to undertake an anonymised secondary review of each child death where the identifying details of the child and treating professionals are redacted.

CDOP should be attended by senior representatives across health, social care, police, education and other agencies (refer to appendix for 2021/22 CDOP panels attendance records). Consultant paediatricians attend to provide clinical expertise from the acute hospitals.

CDOP reviews information on all child deaths to inform local strategic planning, identify any modifiable/contributing factors and consider any lessons to be learned.

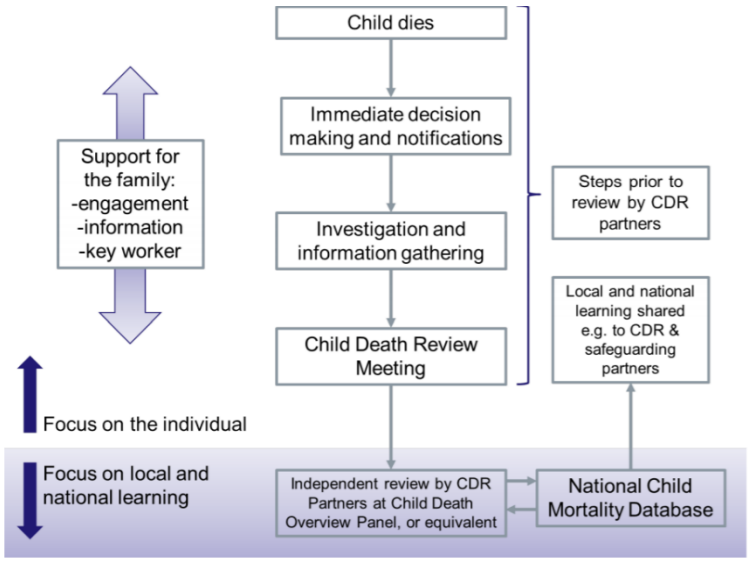
From July 2021 the Norfolk CDOP was chaired by an independent chair. In Suffolk the Independent Chair of the Suffolk Safeguarding Partnership continued as chair of Suffolk CDOP.

Themed neonatal CDOPs were held every 6 months. This has proved a successful approach to reviewing neonatal deaths and encourages representation from governance leads of antenatal services (Midwifery and Obstetrics) as well as post-natal services. When relevant CDOPs take place once a Perinatal Mortality review (PMRT) has been completed.

The Child Death Review (CDR) Process

All CDRs follow systems and processes recommended in “Working Together to Safeguard Children, 2018” (Figure 1).

Figure 1



The guidance requires that Child Death Review Meetings (CDRM) are held to support the gathering of information and liaison between professionals involved in the case. This is not only to provide information but also to ensure the family and those involved in the child’s life are supported.

E-CDOP

This was the third year in which both CDOPs have used the E-CDOP webpage to collect and collate information. Notification of a child death can be made at any time of the day or night and will automatically be sent to the relevant CDOP Manager/Administrator and CDRT. Notifications must be made within 48 hours of the child’s death and include whether the child had tested positive for COVID-19 or not. We noted delays in notification of deaths in babies who die on the labour ward without receiving neonatal care. As a result, we developed training with the midwifery teams to address this issue. It is vital that understanding of the notification process is well established.

All the data is automatically uploaded to the National Child Mortality Database (NCMD) at the point of notification and updated when cases are completed. If there is a concern that needs to be alerted to other CDOPs, this can be raised at the time of notification. Since 2019/20 the NCMD have produced annual reports using the national data. NCMD provide each local CDOP with a breakdown of their activity. This Norfolk and Suffolk annual report is based on the data we provided to NCMD.

Unexpected Deaths

The commonest category of unexpected death in the cases reviewed was Sudden Unexpected Deaths in infancy/childhood (SUDI/SUDIC), followed by suicide/self-inflicted harm and infection.

There is a robust system to ensure multi-agency meetings are held after each unexpected death. Initial multi-agency/SUDIC meetings were chaired by Children's Services in both Norfolk and Suffolk[5] during 2021/22.

Serious Incident investigations are carried out within Hospital Trusts when a child dies unexpectedly during a hospital admission or there are concerns within an individual agency.

The final CDR meeting[6] is generally held about 2 months after the death but may be delayed if the post-mortem results are not available. Post-mortem results are delayed for forensic cases (where the post-mortem is usually done in London) or if toxicology and or genetic results are requested. If parents have queries that they have not yet had answered these should be discussed at the meeting and feedback provided by the family's key worker.

In Norfolk the acute trusts hold regular Morbidity and Mortality meetings (M&M) chaired by the lead consultant for child death to review both expected and unexpected deaths. The organisation of these meetings has improved significantly. They are held via Microsoft Teams. This enables staff from different organisations to be invited.

In Suffolk both hospital trusts hold Morbidity and Mortality/Governance meetings which includes feedback and learning from CDOP. West Suffolk Hospital (WSH) invite the CDR team to all Morbidity and Mortality meetings whereas Ipswich Hospital is more inconsistent. Ipswich Hospital have recognised that they need to make these meetings more robust and to extend them to include expected as well as unexpected deaths and will be working towards this over the next year. Both Ipswich Hospital and WSH have made significant improvements to the child death review processes within their hospitals including in the sharing of information and learning.

The final CDR meeting is when all the care and treatment provided including the clinical care should be scrutinised in detail to maximise learning and to consider questions from the child's family. It is important that CDR partners work together to reduce delay because it is challenging for families and staff and delays the dissemination of learning. It is beneficial for all those who were involved in the care of the child to help understand what other professionals' roles are and provides a holistic review of the child. This is improving in both Norfolk and Suffolk.

[5] in Suffolk all initial meetings are called SUDIC meetings.

[6] Review SUDIC in Suffolk.

Expected Deaths

For infants under a year of age, the main cause of death continues to be chromosomal, genetic and congenital anomalies and perinatal deaths.

For children over a year of age, these are mostly due to malignancy and chronic medical conditions. The palliative care teams have regular multi-agency meetings in place prior to and after the death for children with malignancies. The debrief meetings consider learning for the teams but do not always consider wider learning for acute teams for instance who were involved early on but not at the end of life. The CDRTs are working with the palliative care teams to embed the dual process of CDOP reviews as well as internal debriefs. If the child died out of area, then the local hospital would hold the final meeting.

In Suffolk all the meetings for expected deaths are held by the CDR team as a final meeting and this is the only meeting that is a full multidisciplinary meeting.

Perinatal Mortality Review Tool

The Perinatal Mortality Review Tool (PMRT) is a standardised national tool which was developed to support high-quality standardised perinatal reviews. It was developed through a collaboration led by MBRRACE-UK[7] and was released in January 2018.

There is an expectation on all neonatal units to use the PMRT to review all deaths of babies born after 22 weeks who die within 28 days or after 28 days if they were receiving neonatal care. It has taken time to implement this tool locally due to staffing levels and provision of sufficient support to enable the administrative processes.

The PMRT focuses on clinical care. The CDOP processes have a wider, more holistic approach. Thus, they overlap but do not duplicate.

[7] MBRRACE is a report which is led by the National Perinatal Epidemiology Unit, at the University of Oxford, this report is an analysis and investigation into the cause of maternal death, stillbirths and infant death.

Child Death Review Teams (CDRTs)

Suffolk: the dedicated CDRT of 3 nurses (1.8 FTE) and an administrator is overseen by the Designated Nurse for Safeguarding and coordinates the CDR process after a child has died, offering support and follow up for families and clinicians throughout the process.

Norfolk: from April 2021 a dedicated CDRT of 3 nurses (2.2 FTE) and an administrator was established. This has made a significant difference to the child death review process in Norfolk and most importantly to the support that families receive after the death of their child, particularly when this was unexpected.

Child Death Review Teams:

- co-ordinate the health response for Norfolk and Waveney and Suffolk following all child deaths, including co-ordination of Child Review Meetings, information gathering and sharing.
- share information with the Child Death Overview Panel.
- support the Designated Doctor for Child Deaths.
- act as a key worker for the family where appropriate.
- ensure that all families and professionals are fully supported throughout the child death review process.
- provide training and development on the Child Death Review Process and learning from child deaths across the health economy to ensure the process is conducted as effectively as possible and that learning is shared to prevent future child deaths.
- Work with the LeDeR teams to complete a LeDeR[8] review.
- Work closely with relevant professionals to promote best practice around palliative care.

[8] The LeDeR process is a review of any child over four years of age who had died. It is to examine the quality of health and social care the child received and whether there could have been improvements to such.

CDOP Panel Activity Data 2021 – 2022

Death Notifications

84 deaths were reported between 1st April 2021 – 31st March 2022, of which 45 were in Norfolk and 39 in Suffolk. Over the last three years the number of notifications has varied. There were 60 deaths in 2020/21 during the first year of the pandemic (33 in Norfolk; 27 in Suffolk) and 78 in 2019/20 (41 in Norfolk; 37 in Suffolk).

To contextualise the 84 deaths relative to the population, Table 1 shows the 2021 Census data from the Office for National Statistics[9]. It has not been possible to find robust data specifically for under 18-year-olds. A rate of 1 in every 4289 0–19-year-olds or 0.000233%.

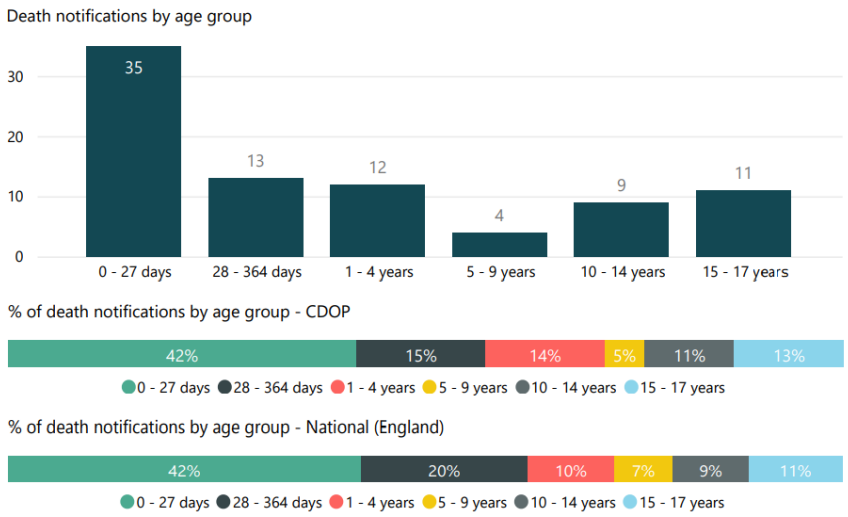
Table 1

Age	Suffolk	Norfolk
0-4 years	37,200	49,000
5-9 years	41,800	46,900
10-14 years	43,000	50,800
15-19 years	39,000	52,600
Total	161,000	199,300

Notifications of neonates remains the highest proportion of notifications, followed by infants aged 28 - 364 days. This has been consistent over the last three years. Of the 35 neonatal death notifications in the 2021/22 period, 11 babies (31%) were 24 weeks or less gestation at death compared with 29 in 2020/21 period, of which 38% (11/29) were 24 weeks or less gestation at death. These are broadly similar to the 2021 England average of 36%.

When death notifications were examined according to month, the numbers varied from 4 in April 2021 to 10 in both October 2021 and January 2022. When compared to 2019/20 and 2020/21, no significant trend was observed. Some deaths could be seasonal.

Figure 2



[9] Office for National Statistics. *Population and household estimates, England and Wales: Census 2021.* https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationandhouseholdestimatesenglandandwalescensus2021. [Accessed 12 July 2020].

Number of Reviews

In 2021/22 Norfolk and Suffolk CDOP panels reviewed a total of 63 deaths (32 Norfolk and 31 Suffolk). This was lower than 2019/20 when 79 cases were reviewed. The higher number in 2020/21 will have been affected by the decision to delay the review of some Suffolk neonatal cases from 2019/20 until the neonatal panel started in June 2020.

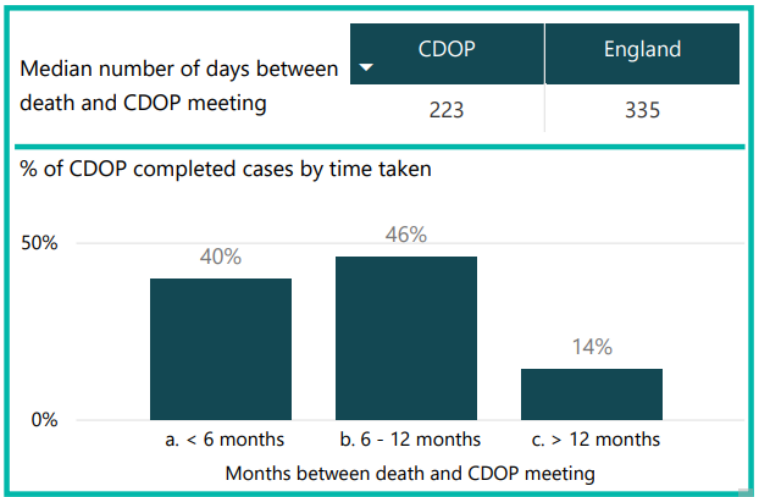
Table 2[10]

	Neonatal deaths reviewed (0-27 days)	Total deaths reviewed
2019/20	13	53
2020/21	35	79
2021/22	25	63

Duration of Review

Of the 63 reviewed cases across Norfolk and Suffolk, 86% (54/63 cases) were completed within 12 months of the child's death, with 40% of cases completed within 6 months of the date of death. Norfolk and Suffolk took a median of 223 days between the child's death and the CDOP meeting. This has markedly improved from last year's average across both counties. (Figure 3).

Figure 3



Reducing the time taken to complete reviews is a noteworthy achievement. This is likely to be due to several factors, some of which the CDR teams have control over and others they do not. E-CDOP is a more efficient process and tool for recording information and professionals are now more used to using the system. The CDR teams can support others completing the forms and in Suffolk the CDR Nurses complete the forms with professionals during the CDRMs.

[10] Table 2 shows there were fewer neonatal reviews in the previous year due to cases being held back.

The time taken to complete reviews reflects the individual circumstances and the complexity of cases, including necessary investigations from hospitals, coroner's inquests (which were further delayed by the COVID-19 pandemic), criminal investigations, and Child Safeguarding Practice Reviews. Criminal investigations can take well over a year before concluding. In 2021/22, 2 cases in Norfolk (due to road traffic accidents) and 1 case in Suffolk (SUDI) were subject to criminal investigations. However, these cases should be discussed in Child Death Review Meetings so that any immediate learning can be actioned. There is an option to alert NCMD if there is a risk of serious harm identified.

Norfolk data:

- Section 47 review: 1
- Serious Untoward Incident investigation: 9
- Safeguarding Children Practice Review: 0 (1 case referred but not accepted).
- Inquests: 7 (RTA/SUDI/Suicide/Neonate)
- Criminal investigations: 2

Suffolk data

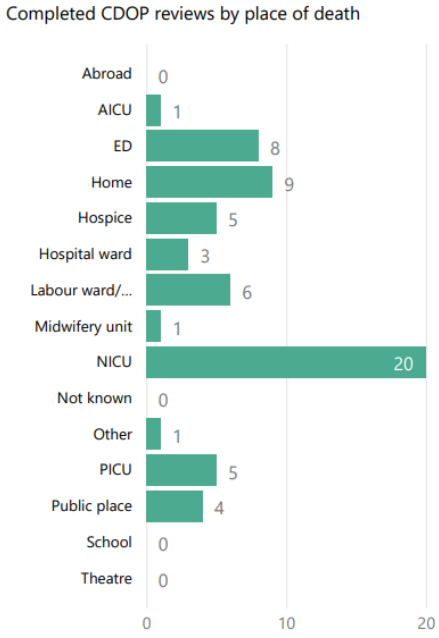
- Section 47 review: 1
- Serious Untoward Incident investigation: 3
- Safeguarding Children Practice Review: 1
- Inquests: 4 (Suicide/SUDIC)
- Criminal Investigations: 1

Summary of reviewed cases in 2021/22

Location of Death

Norfolk and Suffolk CDOP reviewed 63 deaths in 2021/22 which occurred in the following settings: 9 at home, 8 in the emergency department, 5 in a hospice, 4 in a public place, 1 in a grandparent's residence and the rest (36) in a hospital (the majority in a neonatal unit) (Figure 4). This mirrors the national pattern.

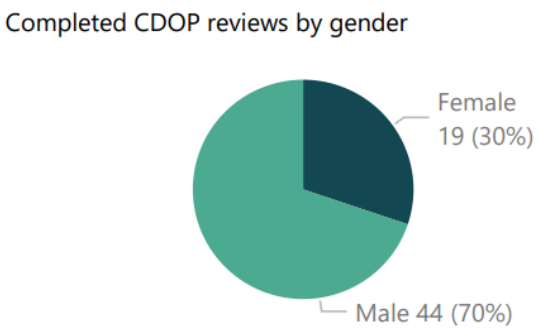
Figure 4



Gender

Nationally the mortality rate is slightly higher for males than females (males 56%; females 44% for 2020/21 England child death notifications). Of the deaths reviewed in 2021/22 across Norfolk and Suffolk, 70% (44/63) of deaths occurred in males and 30% in females (19/63) (Figure 5). This is a significantly different to the position in England as a whole but may prove to be an anomalous year. It is important that we gather this data on all the deaths, as the 2021 England data still had unknown gender information on 0.6% of cases.

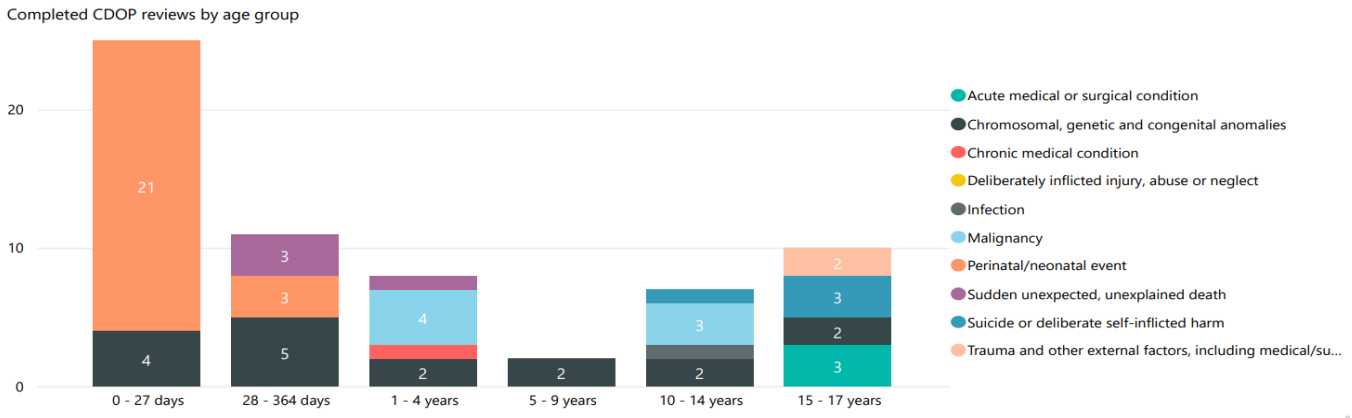
Figure 5



Age

57% (36) of the 63 cases were of children under the age of one. This is broadly comparable to the national figure of 65%. 40% (25) of the 63 deaths reviewed were of neonates, compared to the national figure of 45%. There were 25 neonatal (0 - 27 days) and 11 infant (27 days – 364 days) deaths reviewed in Norfolk and Suffolk and both counties have introduced twice-yearly neonatal panels. The lowest number of deaths were in children aged 5-9 years (3%, 2/63 cases), which is also similar to the national values (6%). (Figure 6).

Figure 6



Ethnicity

In 2021/2022, ethnicity data was recorded in 98% (62/63) of cases (Figure 7). It was unknown in one case. This is a significant improvement from last year when 9 cases did not have ethnicity recorded. Ethnicity was not known or not stated in 7.3% of cases from the 2021 England data.

Figure 7

Completed CDOP reviews by ethnic group and age group

Ethnic Group	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	Total
White	19	11	7	2	6	9	54
Unknown	1	0	0	0	0	0	1
Other	2	0	0	0	0	0	2
Mixed	0	0	1	0	1	0	2
Black or Black British	1	0	0	0	0	0	1
Asian or Asian British	2	0	0	0	0	1	3
Total	**25**	**11**	**8**	**2**	**7**	**10**	**63**

Category of Death

Categories of child death are identified nationally and were provided to CDOPs by the Department for Education. Of the Norfolk and Suffolk child deaths; 24 (38%) were due to perinatal/neonatal events, 17 (27%) were due to chromosomal, genetic or congenital anomalies, and 7 (11% due to malignancy). (Figure 8). Similar patterns were evident across both Suffolk and Norfolk. Of the 24 perinatal/neonatal events, 12 were from Norfolk and 12 were from Suffolk. Of the 17 cases due to chromosomal, genetic or congenital anomalies, 9 were from Norfolk and 8 from Suffolk.

Figure 8

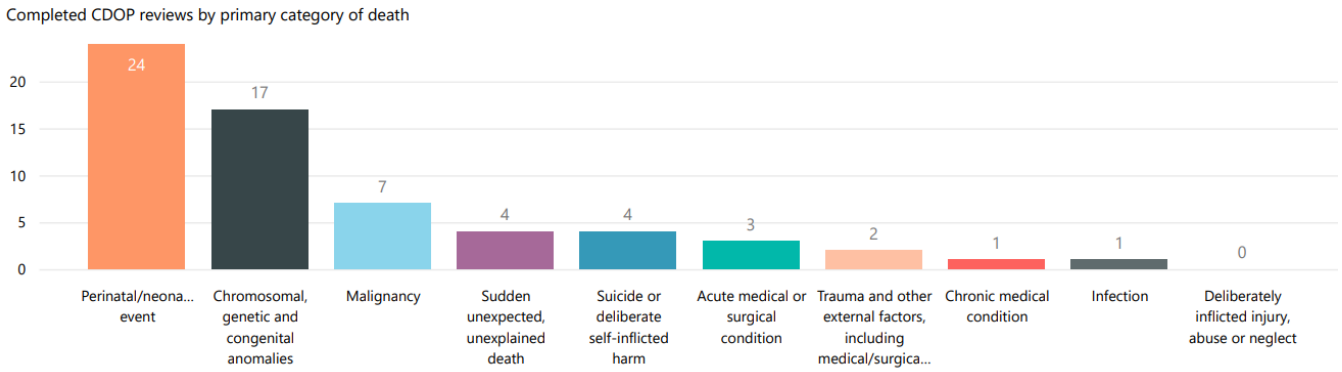
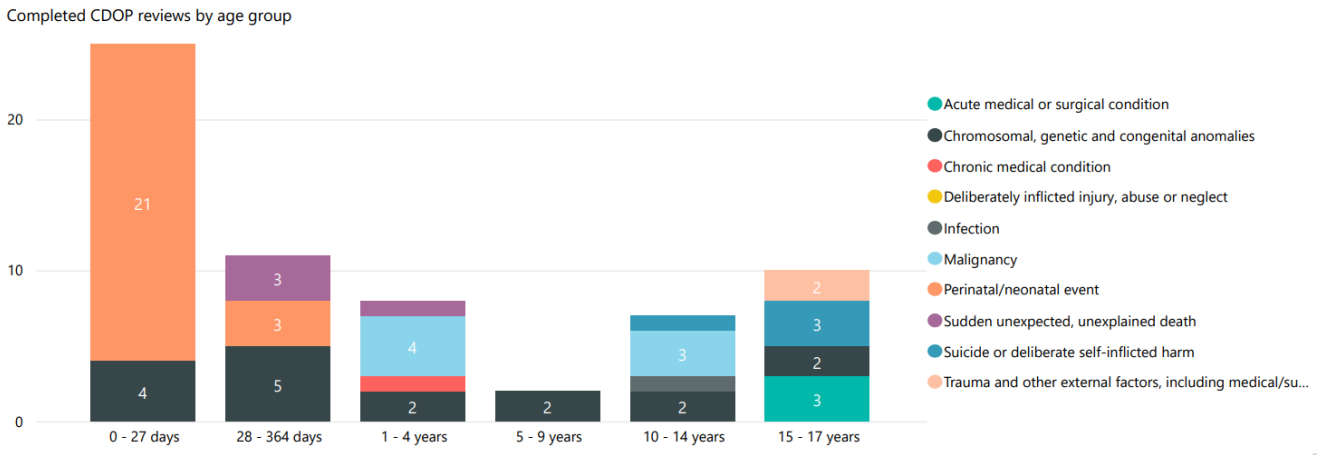


Figure 9 details the breakdown of category of death by age group. Deaths due to chromosomal, genetic, or congenital anomalies were seen across the age range. Peak age for sudden, unexpected unexplained death is 28 - 364 days (3/4 cases).

Figure 9



Modifiable Risk Factors

Of the 63 child deaths reviewed by the panels in 2021/22, 49% (31) of the cases identified modifiable factors that may have contributed to the child's death. The 2021 national average for England was 34%. There is wide variation between regions. Norfolk is at the upper end of the range.

Norfolk and Suffolk may have overestimated how many of the contributory factors identified are potentially modifiable. This is an area that requires continued discussion at the CDOP and these have begun during the first half of 2022/23. NCMD have introduced a training video on modifiability in CDOP reviews aimed at improving national consistency. This is available at: https://uclpartners.com/ncmd-webinars/**.** This was not available last year when decisions were made about potentially modifiable factors in CDOP. The current advice from NCMD is that unless the panel have considered a possible intervention then a factor may be contributory but should not be recorded as modifiable. If an intervention has been available and offered but the parent has not followed the advice, then the factor is not modifiable. This is open to debate, and it is important that CDOP panels consider how an identified factor may be modified.

Children aged 15-17 years had the highest proportion of deaths recorded as having modifiable factors (80%; 8/10 cases). Two of the cases in the acute medical or surgical category were adolescents dying from untreated diabetic ketoacidosis. In both cases this went unrecognised initially and it is important to raise awareness of the signs of diabetic ketoacidosis.

The next highest proportion of cases with modifiable factors identified were in those aged 0-27 days (56%; 14/25 cases) and 5-9-year-olds (50%; but just one of two cases). Last year, the highest proportion was the 1-4 years category, but the absolute numbers were small (83%, 5/6 cases), and the second highest group teenagers aged 15-17 years (55%, 6/11 cases).

Figure 10

% of cases where modifiable factors were identified by age group

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	25	14	56%
28 - 364 days	11	5	45%
1 - 4 years	8	1	13%
5 - 9 years	2	1	50%
10 - 14 years	7	2	29%
15 - 17 years	10	8	80%
Total	**63**	**31**	**49%**

When we consider the category of death; potentially modifiable factors were identified in all the cases classed as 'acute medical and surgical' (3/3), 'infection' (1/1), 'suicide or deliberate self-inflicted harm' (4/4), 'trauma and other external factors, including medical/surgical

complications/error' (2/2) and 'sudden unexpected, unexplained death' (4/4) (Figure 11). 63% (15/24 cases) of deaths due to perinatal/neonatal events were found to have modifiable factors. No modifiable factors were identified in the children where death was expected.

Figure 11

% of cases where modifiable factors were identified by category of death

Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Trauma and other external factors, including medical/surgical complications/error	2	2	100%
Suicide or deliberate self-inflicted harm	4	4	100%
Sudden unexpected, unexplained death	4	4	100%
Perinatal/neonatal event	24	15	63%
Malignancy	7	0	0%
Infection	1	1	100%
Deliberately inflicted injury, abuse or neglect	0	0	0%
Chronic medical condition	1	0	0%
Chromosomal, genetic and congenital anomalies	17	2	12%
Acute medical or surgical condition	3	3	100%
Total	**63**	**31**	**49%**

Norfolk and Suffolk CDR teams are aiming to ensure that contributory factors (factors which contributed to the death but were not modifiable), and modifiable factors (factors which if an intervention was introduced/offered may have affected the outcome) are identified and differentiated. In cases where modifiable factors are identified, ideas are sought as to how they can be addressed. Of the 31 cases reviewed in 2021/22 as having a modifiable factor, these were further reviewed and split into contributory and modifiable factors (Table 3).

Table 3: Contributory and modifiable factors

These are the modifiable factors from cases reviewed in 2021/22 in Suffolk and Norfolk.

Category	Domain	Contributory factors	Modifiable factors	How can we address this?
Suicide or deliberate self-inflicted harm	Factors intrinsic to the child	• Young people with possible underlying neurodevelopmental conditions • Young people with mental health issues		
	Social environment		• COVID-19 related isolation leading to poor emotional wellbeing. • Confidence amongst young people's friends in knowing whom to talk to escalate mental health concerns/crisis	• Mental health awareness campaigns • Range of means of accessing mental health provisions • Mental health workers in school
	Service provision	• COVID-19 related school closure • Importance of deciding what is in the best interests of the child/young person especially with regards to confidentiality and sharing information	• Communication at all levels and organisations • Reducing delay for input from mental health services	• Highlight importance of information sharing • Consider alternative models of provisions to address delay in access to services • Suffolk Children Young People Suicide Prevention Plan 2022-2027 • East of England Mental Health Strategy
Trauma and other external factors	Factors intrinsic to child	• Child did not stop at the road junction. • Prevalence of risk-taking behaviour in young people		• Education on road safety
	Physical environment	• The road was dark with no streetlights. • Road safety messages: use of cycle lights, helmet or reflective clothing.	• Safe use of stairgates	• Public health messages on safe use of stair gates
	Social environment	• Child involved in criminal activity.	• Driving under the influence of alcohol	• Increase access to existing campaigns for disengaged/hard-to-reach young people

Category	Domain	• Contributory factors	Modifiable factors	• How can we address this?
Acute medical or surgical condition	Factors intrinsic to the child	• Obesity • Unrecognised learning difficulties		• Improving teenagers' awareness of 111 services • Improving general awareness of symptoms of diabetic ketoacidosis, the 4 T's [11](i.e. text message to all patients)
	Physical environment	• COVID-19 lockdown impacts living arrangements • Child not at school		
	Social environment	• Adolescent neglect		
	Service provision	• COVID-19 related change to service provision and face to face appointments • Diagnostic overshadowing • Communication between adult services and paediatric services	• Clarity on whether to use paediatric or adult guidelines for management of adolescent	• Hospitals to have an agreement in advance about adolescent management
Chromosomal, genetic, and congenital anomalies	Factors intrinsic to child	• Parents are related • Rare metabolic condition with no screening available		
	Service provision	• Staffing of ambulance for extremely unwell children • Communication between professionals and with parents regarding level of clinical concern		
Perinatal/neonatal event	Factors intrinsic to child		• High maternal BMI	• National policy on managing obesity
	Social environment	• Parental smoking. • Concealed pregnancy		• Establish network of communication between maternity units to allow training with maternity units.

[11] Toilet, Thirst, Tired and Thinner

Category	Domain	• Contributory factors	Modifiable factors	• How can we address this?
Perinatal/neonatal event	Service provision	• Communication between professionals • Following guidelines appropriately • Decisions about obstetric care Recognition as a high-risk pregnancy due medical and obstetric background. • Adequate staffing to provide timely response	• Inexperienced ambulance crew having ready access to information to enable delivery of babies • Ambulance crew not familiar with hospital layout	• Increase staffing and consider their location (BAPM[12] recommends 24/7 immediately available resident Tier 2 practitioner coverage dedicated to neonatal unit, and separate to paediatrics) • Ensure all ambulance crew know geography of hospitals • Ensure new staff are well trained and supported • Obstetric care: to consider the important of "helicopter view" of the clinical situation by senior.
Sudden, unexplained, unexpected death	Physical environment	• Safer sleeping – room temperature		• Safer Sleeping
	Social environment	• Parental smoking • Mental health of parents • Neglect		
	Service provision		• Mental health support to parents	
Infection	Service provision		• Recognition of low temperature and other key triggers as being indicative of sepsis	• Training to improve recognition of sepsis

[12] British Association of Perinatal Medicine

Learning and Recommendations from 2021/22 Child Deaths Reviews

The aggregated learning from CDOP and the Neonatal CDOP for all child deaths should inform local strategic planning on how to best safeguard and promote the welfare of children across Norfolk and Suffolk.

The modifiable factor themes and the associated learning, to emerge in 2021/22 are:

1: Communication

The importance of good communication skills cannot be over-emphasised, and miscommunication or misunderstanding can have wide reaching consequences when we fail to communicate information effectively. The ability to communicate is one of our most powerful tools.

We underestimate how often we can miscommunicate and not listen actively to families, colleagues and between agencies. Effectively communicating risk to families about their behaviour, for instance in pregnancy, is a challenge. There may be missed opportunities to communicate due to language barriers. CDOP identified there were challenges for (a) young people knowing who to talk to when they were worried about a friend and (b) concerns about confidentiality could prevent professionals communicating with parent(s).

There have been individual cases where it was recognised that communication between health professionals both within hospitals and between hospitals could have been improved. This is a theme both in preventing deaths but also afterwards when sharing information and supporting families. However there have also been examples of excellent communication which has been recognised and appreciated by families.

2: Safer sleeping

Safer sleeping continues to emerge as a recurrent theme in CDOP reviews locally, regionally, and nationally. Co-sleeping, especially combined with additional factors including substance misuse, alcohol and smoking (indoors and outdoors) and a change of routine were identified as contributory factors to SUDI and SUDIC particularly if the baby was premature or suffered a recent viral illness.

It is important that the issue of safer sleeping is raised with parent(s)/carer(s), at every opportunity by both health and social care professionals who should also make themselves aware of sleeping arrangements for any baby under their professional supervision.

In addition, it is recognised it is important to meet fathers and to ensure that both parents are aware of messages about safer sleeping.

For 2022/23, three key priority themes have been identified by Norfolk Safeguarding Children Partnership (NSCP) as key to reducing safeguarding risk in Norfolk. These include; **Protecting Babies**: The onset of the COVID-19 pandemic highlighted risks posed to babies nationally, with a significant rise in reports of children who suffered non-accidental injuries.

To support this there are specific ‘Protecting Babies’ communications objectives to:

- raise awareness of risk to babies through accidental death, particularly through safer sleeping guidance
- increase understanding of baby behaviour to support parents in looking after children safely

- manage responses to the rise in reporting of non-accidental injuries through Serious Case and Safeguarding Practice Reviews

The *Just One Norfolk* website, commissioned by Norfolk County Council and provided by Cambridgeshire Community Services NHS Trust, is a key platform for the hosting and sharing of resources and advice for many of the campaigns produced by NSCP. The website aims to help the public understand how to protect children's mental and physical health and is therefore a natural home for the Protecting Babies and Child Neglect priority areas. Annually, campaigns will be developed which raise awareness of safeguarding in line with the communication objectives. These campaigns will have a clear focus and generate content for multiple outputs. For 2022/23, the following campaigns have been identified for inclusion as priorities for the Partnership:

Safer Sleep: The Safer Sleep campaign continues to help raise awareness of best practice for safe sleep for babies. It provides advice and shows examples of how to keep babies safe whilst sleeping, alongside of warnings of the consequences of poor practice.

All Babies Cry: crying is part of a baby's language. Crying is normal but can be hard to cope with.

On behalf of Norfolk Safeguarding Children Partnership, **Safer Sleep Training** has been developed by Cambridgeshire Community Services and is open for booking for multi-agency sessions from May 2022. The aim of this half-day course, delivered virtually via MS Teams is for practitioners to increase their knowledge and awareness of safer sleep and how to discuss this with the families they are working with. It is designed for front-line practitioners and managers working with families with young children with the aims of

- providing a greater knowledge of safe sleep
- building confidence to discuss safer sleeping with families
- understanding why certain sleep positions or practices are unsafe
- increasing awareness of the multi-agency role we all play in protecting babies
- creating awareness of resources which can be shared with families and the links on 'Just One Norfolk' and 'Healthy Suffolk' websites.
- raising professional's' confidence to discuss and professionally challenge any unsafe sleeping practices they identify or observe, which could put the baby at risk of Sudden Unexplained Infant Death
- informing professionals so they know what to do when worried

3. Recognition and management of acute illness

Last year we discussed the challenges in recognition of the sick younger child. This year, it was significant illness in adolescents that was not sufficiently recognised.

Two young people developed and subsequently died from new onset diabetic ketoacidosis. In one case there had been contact with health services although late on in development of the condition. A serious untoward event (SUI) investigation was undertaken to learn from this case. There were service-related factors that contributed to his death. One contributing factor was different pathways for the paediatric and adult management of diabetes. It was found that there was poor communication between clinicians which affected the management of their treatment and care. In addition, due to COVID-19, the family who knew the young person well were not able to be on the ward. This may have prevented diagnostic overshadowing, of the young person's agitation that staff thought was due to previous behaviour issues rather than a sign of cerebral irritation.

In the second case the young person felt ill at home and wanted to go to hospital but due to the complex social background was not taken. It was apparent that they had been neglected prior to this episode and sadly as they became more unwell it went unrecognised and the diagnosis was made at post-mortem.

The third case had unusual symptoms that had been mis-attributed to anxiety. The main learning was the importance of careful history-taking and recording observations which may have suggested an alternative cause for the symptoms, which in turn had been exacerbated due to obesity.

These deaths happened during one of the COVID-19 lockdowns when access to primary care was less straightforward. In addition, they were not attending school so had not been observed by teachers or friends as they became unwell.

The emergence of COVID-19 caused challenges and uncertainty for many young people. Although COVID-19 did not directly cause any health problems for children the community response to COVID-19 did have an impact due to lack of access to health services and schools and their peer groups.

4. Road Safety

A collaboration between Norfolk County Council's Road Safety Team and students at City College Norwich devised a 45-minute play to promote safer travel to and from school which aims to help give young people the confidence to travel independently and encouragement to walk or cycle. It was delivered to thousands of Years 7 and Year 8 students in fifteen different schools over a two-week period in March 2022 and targeted at this age group as they are considered to have a significantly increased risk of being involved in road accidents as they begin travelling independently. Important issues were covered such as understanding how to cycle as safely as possible, knowing what safe behaviours are when travelling, safe behaviour as a passenger, and how to be aware as a pedestrian. The messages are presented in a way pupils can relate to, with interactive, visual, humorous, and honest portrayals.

5. Suicide

The NCMD analysed data from deaths of children who died by suicide between April 2019 and March 2020 and identified fifteen common factors in their report: Suicide in Children and Young People (2021) which can be found here: https://www.ncmd.info/publications/child-suicide-report/.

The common characteristics for children who died by suicide in Norfolk and Suffolk were:

- Being bullied at school (all)
- Having breakdowns in the relationship with parents, grandparents, bereavement or loss of relationship (some)
- Parental substance misuse (some), relationship, separation/stepfamily (some), mental health (majority)
- Displaying some, undiagnosed, neurodevelopmental conditions, bounced between services (majority)
- Lack of timely sharing of information from services (GP) with parents and between services (majority)
- Mental health (all), attempted suicide (some), self- harm (majority), sexual abuse (minority)
- Parental pressure to do well at school (few)

- Parental/Adult Mental health education - Parents do not know what signs to look for of mental health issues, not knowing what is normal for teen behaviour, how to communicate with them and what to do and who to contact (all)

Figure 12

Following the publication of the NCMD report, Suffolk CDOP undertook a thematic review on suicide and analysed six cases (3 in Norfolk and 3 in Suffolk). These children were from all walks of life. In Suffolk, the young people lived within 2 miles radius of each other (but did not know each other). This could be coincidental.

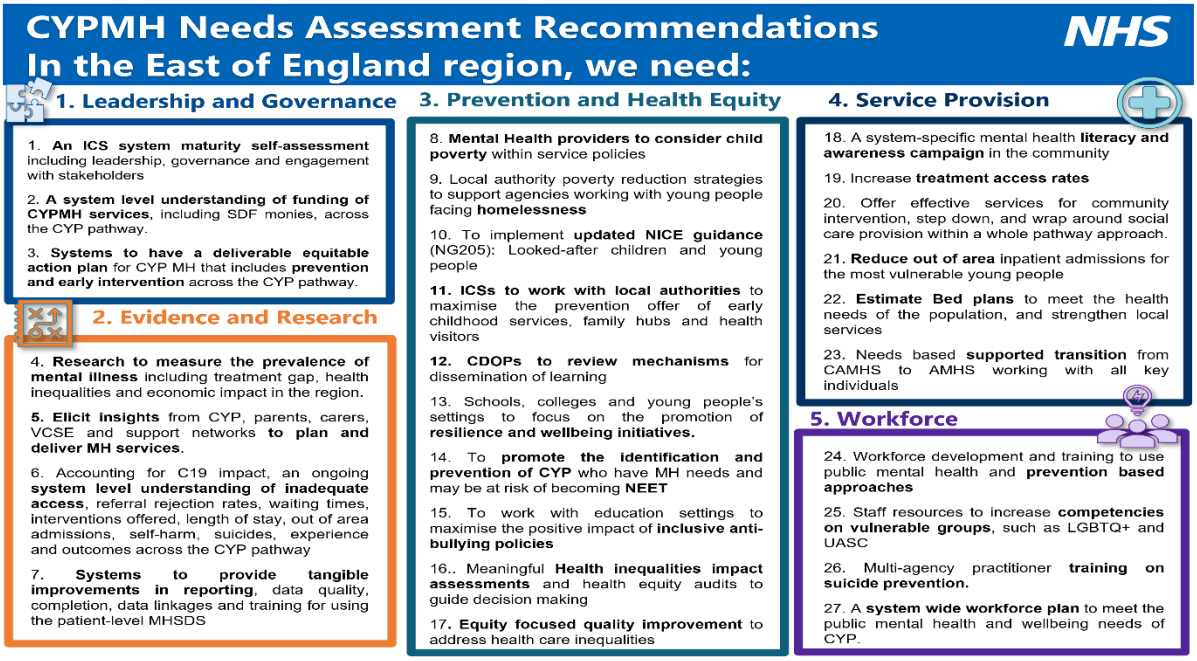
The risk factors identified in the national report are in line with the evidence review undertaken in Suffolk. The number of children who die because of suicide is very small. Sometimes, there are deep rooted vulnerabilities and risk factors which can be linked to Adverse Childhood Experiences (ACE). These small numbers are likely to be the tip of an iceberg of our vulnerable children.

As a result, Suffolk is developing a children and young people Suicide Prevention Plan for 2022/27 which is currently out for consultation.

Educational services in Norfolk are delivering a webinar for schools to cover the NCMD learning and using the curriculum to help children and young people recognise when they need to ask help.

NHS East of England developed a health needs assessment for children and young people's mental health. Recommendations were made in the following domains: leadership and governance, evidence and research, prevention and health equity, service provision and workforce Recommendation 12 specifies that CDOPs should review the mechanisms for dissemination of learning. (See Figure 13).

Figure 13



6. Neonatal deaths

Many of the neonatal deaths are analysed using the Perinatal Mortality Review Tool (PMRT) which requires input from the antenatal and postnatal teams. Themes that emerged included:

- Antenatal: smoking in pregnancy, obesity, concealing pregnancy, working with high-risk fathers.
- Delivery: Monitoring, awareness of risk factors requiring senior review, adequate staffing in high-risk deliveries.
- It remains challenging for staff to communicate with parents to ensure parents understand how unwell their child is and the chances of survival when they may not want to hear the message.

7. Stopping smoking in pregnancy

CDOP identified that there was inconsistent testing and smoking cessation advice in pregnancy. Some of this was related to COVID-19. Each trust must ensure that all pregnant women who smoke or have recently quit are referred for carbon monoxide testing, as per NICE guidelines. Nicotine replacement therapy should be considered at the earliest opportunity in pregnancy and should continue to be provided after pregnancy to prevent relapse. Help to stop smoking should be offered to pregnant women and their partners, parents, and any other household members. Trusts must ensure that midwifery staff have access to testing in all settings.

8. The importance of identifying males involved in the child's care

There was a recurring theme where it was raised that fathers were not recorded on the child's health records. The importance of knowing who the fathers are was highlighted in a review by the National (England) Safeguarding Practice Review Panel (2021) which focused on babies under the age of one year who were harmed or killed by their fathers or their male carers. The review shows links between domestic violence, mental health issues, substance misuse, young parents, care leavers and poverty and debt and death from abusive head trauma in babies.

The report[13] highlights the importance of professionals who see male patients who have children and who identify concerns relating to mental health, domestic violence, debt problems or where their partner may be pregnant, that they share their information with Midwifery or Health Visiting services. They recommended that antenatal and postnatal health provisions should fully include fathers/male carers so that extra support can be provided when needed and risk factors can be identified early.

The importance of being able to identify fathers and male carers within the household was identified in both Norfolk and Suffolk CDOPs. Also, professionals must remember to add the name and date of birth of fathers/male carers to the child's records.

9. Additional learning

Additional learning for bereaved families, organisations and staff after a child's death included:

- Considering organ donation and raising awareness through neonatal units' paediatric wards and intensive care. Antenatal and neonatal teams to improve discussions around organ donation with families as part of end-of-life care. Trusts must ensure that staff have been trained and know where to access information and who to contact about organ donation. It is important to provide support for and manage expectations of staff and parents. (Organ Donation Strategic Plan).
- All NHS Trusts to continue to promote and encourage the COVID-19 vaccine for pregnant women.
- As part of the National Bereavement Care Pathway, the Stillbirth and Neonatal Death Charity (SANDs) are recommending that all bereaved parents should be offered the choice to take their baby's body home. NHS Trusts need to review their current practice and ensure appropriate training and policies are in place to facilitate this. Due regard must be given to legally required Coronial processes around post-mortems where appropriate
- Bereavement resource packs have been created to provide support for bereaved families. These resource packs explain the process after a sudden unexpected death and provides details of support.
- 0-19 service: Named nurses to review policy for recording sibling deaths on the community electronic patient record, most commonly used are SystmOne and EMIS, so that a system is in place to ensure sibling deaths are recorded on both the health visiting and school nursing units.

10. Groups and networks

The **East of England Regional CDOP Professionals Network** has continued to meet regularly in 2021/22 to share learning and support system-led improvement across the region. This provides a forum to support developments. The group has provided an important source of peer review to those working in child death and helped regions to develop their child death review services.

[13] The full report (The Myth of Invisible Men (2021)) can be found here: The Myth of Invisible Men (publishing.service.gov.uk).

Child Death Review Achievements and Deliverables

This is the third joint annual report for Norfolk and Suffolk CDOP. In the second joint annual report which covered the period April 2020 – March 2021, the following objectives were set for 2021 - 2022:

- **Norfolk's new CDR team to support all partners and families to facilitate the CDR process was established in April 2021**. Since this time the team have been attending sudden unexpected deaths and providing valuable support to bereaved families easing their journey through the most traumatic and devastating event that any parent will go through. To be present at these times is an enormous challenge which requires compassion and delicacy in communication and presence. The team have built and continue to build links with all partners and are leading the child death review process in Norfolk, ensuring statutory guidelines are followed and allowing for maximum learning from these tragic circumstances. Every child's life is a unique journey that touches many and leaves a lasting footprint; their death is also unique, and each death is given the utmost care and scrutiny by the CDR team.

- **Suffolk's CDRT continue to implement and refine the child death review pathway,** including raising awareness with key stakeholders regarding their roles and responsibilities**.** Through building relationships, training, and professionals gaining experience, Suffolk have seen a significant positive difference in the management of child deaths in Suffolk and professionals across agencies are working collaboratively The CDR team have been collaborating with the NCMD and were chosen to work together with Newsnight on producing a documentary called young lives lost: "inadequate housing for disabled children" which featured a Suffolk case. This has helped to raise the profile of the importance of reviewing housing as part of the CDR process and Suffolk CDOP now have representation from housing on the panel. The team continue to support families who are at all stages of grief and bereavement following the loss of a child. They are passionate about sharing the learning that comes from child death reviews and implementing and supporting changes in local policies and procedures. The Suffolk team went through a prolonged period without a team administrator. In November the team sourced a bank administrator who then joined full time from March and has provided much needed support to the whole team.

- **Improve the process of capturing learning** in a format for easy reference (data system/dashboard) and ensure sharing across the system on a regular basis. Both panels continue to implement the E-CDOP software to ensure the most effective collection of data. When completed well the information gathered is rich and improves our understanding nationally of circumstances that increase the risk of child death.

  As a result of the data collected the National Child Mortality Database produced a report that shows that nationally child death is linked to deprivation. Interestingly, an analysis of the three-year data 2018 - 2020 for Norfolk did not show any clear link with deprivation. **Going forward both CDOPs will consider the Deprivation Index for each child death.**

- **Continue to be active participants in the East of England CDOP professionals' network** to share learning and system-led improvement. This group will feed into a new national group the Association of Child Death Review partners. The Designated Doctor for Child Death in Suffolk and Norfolk chairs the East of England CDOP panel and is a Designated Doctor representative for the new national group developed to provide more consistent and evidence-based advice for CDOPs w. The Designated Doctor shares any relevant information widely across both the Norfolk and Suffolk CDOP panels.

- **Norfolk and Suffolk panels developed and agreed on a joint Terms of Reference**. These were completed in December 2021 and can be accessed on request from the CDOP administrator.

- **We continue to develop a joint local analysis of trends and focus on areas for further action** such as safer sleeping.

- **Neonatal themed panels continue to take place biannually** in both Norfolk and Suffolk and have proved an effective means of reviewing these deaths. Attendance from antenatal services is crucial in considering how to prevent premature delivery which accounts for the most significant number of neonatal deaths.

- **COVID-19 has had a huge impact to everyone's lives.** Although it does not appear to have had a similar impact on the number of child deaths, it has had an impact on patients' care and family access to the hospital. As a result of COVID-19, panels have taken place virtually and there has been no interruption to the CDOP panels. This has proved an opportunity to improve attendance at CDOP.

- **The Suffolk CDR team produce a newsletter** with learning, in a format for easy reference and this practice has been replicated in Norfolk from February 2022.

- **Norfolk and Suffolk took a median of 223 days between the child's death and CDOP meeting,** as noted in Key Findings.

- **SUDIC webpage**[14] A previous challenge for Suffolk has been the limitation of the working hours of the team with there being no on call service overnight and at weekends. To help overcome this Suffolk have created and launched a SUDIC Protocol webpage which aims to support and guide all professionals through the CDR process when child die out of hours. It also has links to all the important documents such as the SUDIC protocols and patient information leaflets, as well as contact details of all the relevant agencies involved. Improving compliance with this protocol will be worked on during 2022/23.

- **Learning from Child Deaths Event – October 11th - 15th 2021**

    - A second, highly successful 'Learning from Child Death' event took place from October 11th – 15th 2021, coordinated by Cindie Dunkling on behalf of the Eastern CDOP group. There were four talks given over the 5-day period.
        - Losing a Child to Suicide
        - Children with Disabilities
        - Neonatal Deaths
        - Talking about the Death of a Child
    - The details for each session can be found at: *https://eastsafeguardinglearningplatform.co.uk/learningfromchildrensdeaths*

[14] The webpage can be accessed here: https://suffolksudic.org.uk.

Forward Plan for 2022-2023

- Both the Norfolk and Suffolk CDOP teams aim to reduce the administrative load involved in completing the Perinatal Mortality Review Meetings and the E-CDOP forms. Norfolk and Suffolk e-CDOP are one of the pilot sites for Phase 1 of the roll-out of the integrated system for notification of deaths and collection of data for: MBRRACE-UK, Perinatal Mortality Review Tool (PMRT), Child Death Review Process (including Child Death Overview Panels and the National Child Mortality Database). This aims to reduce the need for duplication and reduce administrative time.

- The CDR teams aim to lead on the Paediatric Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) agenda.

- The CDOP teams hope to address the variability in modifiable factors. The introduction of the NCMD training video and the Association of CDR Partners aims to improve the consistency in what is regarded as a modifiable factor should assist in improving practice. Following consultation with CDR professionals in June, the factor-specific dropdown lists will be enhanced and added to the analysis form from October. This change will improve the consistency of reporting across CDOPs, and also streamline the process for recording contributory factors.

- Suicide awareness and advice to professionals on prevention needs to continue.

- Continue to be active participants in the East of England CDOP professionals' network to share learning and system-led improvement.

- A new national professional body, the Association of Child Death Review Professionals, has been created to provide more consistent and evidence-based advice for panels to follow. The Designated Doctor for Child Death in Norfolk and Suffolk is a committee member of this association and will be able circulate relevant guidance, webinars, papers and data.

- Continue to audit CDR processes across Norfolk and Suffolk to review compliance with statutory guidelines and identify areas of weakness.

- Norfolk and Suffolk are adding deprivation index data to the CDOP data, so that future annual reports can include analysis of child death and deprivation. The NCMD Report: Child Mortality and Social Deprivation 2021[15] found a clear association between the risk of child death and the level of deprivation.

- Collate additional learning identified during the CDR process

- Ensure delegate attendance at CDOP is robustly documented.

[15] The report can be found here: Child Mortality and Social Deprivation | National Child Mortality Database (ncmd.info)

Appendices

1. Definitions

- ***Stillbirth rate***: The number of babies born after the 24th week of pregnancy who do not show any signs of life per 1000 total births (live and still births).
- ***Perinatal mortality rate***: The number of stillbirths plus the number of babies dying within the first week of life per 1000 total births (live and still births).
- ***Low birth weight rate***: The number of babies born weighing less than 2500g expressed as a percentage of total births (live and still births).
- ***Infant mortality rate***: The number of deaths of children aged under one year per 1000 live births.
- ***Neonatal mortality rate***: The number of neonatal deaths (those occurring during the first 28 days of life).
- ***Post-neonatal mortality rate***: The number of infants who die between 28 days and less than one year.
- ***Child mortality***: the number of child deaths for every 100,000 people alive in the population aged from 1-17.
- ***Unexpected death of a child***: defined by the Department for Education as the death of an infant or child, which was not anticipated as a significant possibility 24 hours before the death, or where there was similarly unexpected collapse or incident leading to or precipitating the events that led to the death.
- ***Modifiable child deaths***: those in which modifiable risk factors may have contributed to death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

2. Child Death Review Panel legislation and principles

Regulations relating to child death reviews

Regulation 6 of the Local Safeguarding Children Boards Regulations 2006 made under section 14 of the Children's Act 2004 sets out the board's and now the Partnership's responsibilities in relation to the child death review process. It states that the Partnerships are responsible for:

a. Collecting and analysing information about each death with a view to identifying –
   i. Any case giving rise to the need for a review as mentioned in regulation 5(1)(e);
   ii. Any matters of concern affecting the safety and welfare of children in the area of the authority; and
   iii. Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area.
b. Putting in place procedures for ensuring that there is a coordinated response by the authority, their agency partners and other relevant persons to an unexpected death.
c. The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate of the cause of death (and therefore is not the responsibility of the Child Death Overview Panel (CDOP))
d. In reviewing the death of each child, the CDOP should consider modifiable factors, for example, in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level as a result of a set of circumstances.

3. The Principles

Four underlying principles guide the overview of all child deaths:

- Every child's death is a tragedy
- Learning lessons
- Joint Agency Working
- Positive action to safeguard and promote the welfare of children

The function of CDOP is achieved by:

- Reviewing the available information on all deaths of children up to 18 years (including deaths of infants aged less than 28 days) to determine whether there were any modifiable risk factors which may have contributed to the child's death
- Collecting, collating and reporting to an agreed national data set – the National Child Mortality Database (NCMD) - for each child who has died
- Meeting regularly to review and evaluate the routinely collected data for the deaths of all children, and thereby identifying lessons to be learnt or issues of concern
- Monitoring the response of professionals to an unexpected death of a child
- Referring to the Chair of the Local Safeguarding Children Partnership any deaths where the panel considers there may be grounds to consider a child safeguarding practice review
- Monitoring the support services offered to bereaved families
- Identifying any lessons or improvements and considering how best to address these and their implications for the provision of both services and training.

4. Norfolk and Suffolk CDOP – Joint Terms of Reference

- Available from panel administrators if you would like to review.

5. Record of attendance at Norfolk CDOP 2021/22[16]

NORFOLK CDOP Agency	27.5.21	22.7.21	23.9.21 - Neonates	25.11.21	27.1.22	24.3.22 Neonates
Children's Services	x	x	x	x	x	a
Police	x	x	a	x	x	a
Designated Team	x	x	x	a	a	x
Public Health	x	x	x	x	x	x
EACH (Hospice)	x	x	x	x	x	x
Norfolk & Norwich University Hospital (NNUH)	x	x	x	x	x	x
James Paget University Hospital (JPUH)	a	x	x	x	x	x
Queen Elizabeth University Hospital (QEH)	x	x	a	x	x	x
NCHC (Norfolk community Health and Care)	a	a				
NSFT (Norfolk and Suffolk NHS Foundation Trust)	a	a	a	a	x	a
Cambridgeshire Community Services (CCS)	x	x	x	x	x	x
Education	x	x	a	x	x	a
Pathology	x	a	a	a	a	a
Coroner	a	a	a	a	a	x
Ambulance Service	a	x	x	x	x	x

[16] Suffolk CDOP attendance in 2021/22 is not available for this year but will be available for the subsequent year.