SOUTH YORKSHIRE
CHILD DEATH OVERVIEW PANEL

Annual Report

BARNSLEY ADDENDUM

April 1st 2022 – March 31st 2023

CONTENTS

INTRODUCTION

The death of a child is a devastating loss. Since April 2008, all deaths of children up to the age of 18 years, excluding stillbirths and planned terminations, are to be reviewed by a Child Death Overview Panel (CDOP) to comply with the statutory requirement set out in Working Together.

South Yorkshire Child Death Overview Panel (CDOP) has a statutory responsibility under Working Together to Safeguard Children (2018) and Child Death Review: Statutory and Operational Guidance (2018) to review all deaths of children from birth to the 18th birthday who are residents of South Yorkshire.

In South Yorkshire around 80 to 100 child deaths are expected per year. There is random variation in the data year-to-year, due to the small numbers involved. The total number of child deaths recorded in South Yorkshire during 2022-23 was 108. This is greater than 2021-22 when there were 104.

Nationally, there were 3,743 child (0 – 17 years) deaths between 1st April 2022 and 31st March 2023; representing a rate of 31.6 deaths per 100,000 children (estimated), and an increase of 8% from the previous period. It is the highest recorded national rate since data collection began in 2019.[i]

The figure in South Yorkshire represents a rate of 38.2 deaths per 100,000 population, higher than the national average, and an increase from the 2021/22 South Yorkshire rate.

South Yorkshire CDOP

Across South Yorkshire, individual Child Death Overview panel (CDOP) review processes continue to cover each local authority area. It is felt that this remains the most efficient and practical ways to carry out individual reviews, enabling the best alignment to networks of healthcare, social care, education, and other related agencies.

In order to review a larger cohort and satisfy the need for Child Death Overview Panels to review at least 60 cases each year, the South Yorkshire CDOP provides a forum for the four areas to work together. Through this collaboration, Barnsley, Doncaster, Rotherham and Sheffield data is combined to enable improved opportunity to identify themes, trends and shared learning than can be achieved at local authority level. This arrangement has been in place since 2018. The 2022/23 annual report provides the findings and learning for South Yorkshire.

The hosting arrangement for SYCDOP is based on an annual rotating system between the constituent local authority areas. Rotherham chaired the meetings in April 2022 and July 2022, with Barnsley taking over chair and coordination role from October 2022.
There were five SYCDOP meetings during 2022/2023 period:

- 7th April 2022
- 29th July 2022
- 13th October 2022

- 15th December 2022
- 9th March 2023

The purpose of CDOP panels are to:

- Ascertain why a child has died by a thorough but proportionate review of the facts and circumstances surrounding the death.
- Determine the contributory and modifiable factors.
- To make recommendations to all relevant organisations where actions have been identified which may prevent further deaths or promote the health, safety and wellbeing of children.
- Provide detailed data to NCMD which they analyse nationally and produce regular reports.
- Produce an annual report highlighting local trends and patterns and any actions taken.
- Contribute to the wider learning locally, regionally and nationally.

For South Yorkshire, the review process for each child death is completed at local level and the processes for producing the annual report and further contribution to learning are completed at SYCDOP level.

CDOPs themselves do not undertake public health campaigns or deliver interventions arising from the learning from reviews. Instead, through Health and Wellbeing Boards and Safeguarding Children Partnerships, lessons learned are incorporated into policy and appropriate interventions are developed.

eCDOP

eCDOP provides a shared IT system for each of the areas that make up South Yorkshire CDOP to enable notification of child death and rapidly allows wraparound support for families and schools. The four local authorities jointly procure a licence on an annual rolling basis with Barnsley acting as the contractual lead authority.

In April 2019, the National Child Mortality Database (NCMD) became operational and pulls from the relevant data within eCDOP. NCMD data is used to generate the annual report for SYCDOP.

Membership and Attendance

The arrangements document for SYCDOP sets out a list of roles that are required to form the core membership. For a meeting to be quorate, at least one representative from each local authority should be in attendance. Core membership comprises:

Public Health
Designated Doctor for Child Deaths
Children’s Social Care Services
South Yorkshire Police
Bluebell Wood Children’s Hospice
Safeguarding Health Practitioner

Primary Care (GP or health visitor)
Nursing and/or midwifery
Lay representation

Through 2022/23, attendance and representation across geographical areas and responsibility areas was consistent.

DEATHS NOTIFIED IN SOUTH YORKSHIRE IN 2022/2023

There were 108 child deaths in South Yorkshire in 2022/23, compared with 104 in the previous year. This number differs from the number of cases which are reviewed by the panels as collating data for the panel meetings can take several months, particularly if there are police or coronial processes to be concluded.

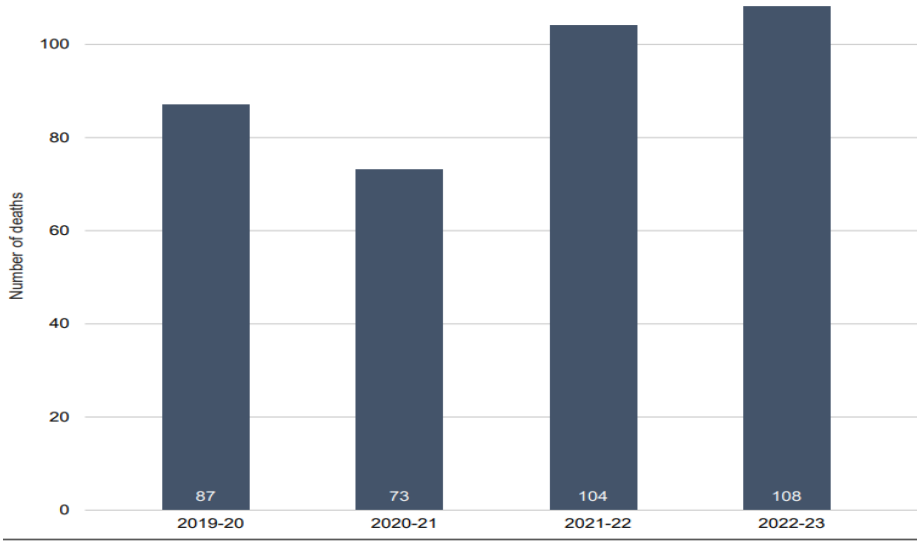

Fig 1: Total number of child deaths by year of death 2019/20 to 2022/23 in South Yorkshire

Age of Child at Time of Notification of Death

In 2022/23, 61 of the 108 child deaths occurred in infants aged under 1 year old. The number of infant deaths in South Yorkshire decreased from the previous (2021/22) reporting period, from 5.1 per 1,000 live births to 4.2. However, the figure is still higher than the national average of 3.8 per 1,000 live births.

	2019-20	2020-21	2021-22	2022-23	**Total**
Barnsley	8	9	9	10	**36**
Doncaster	15	16	14	16	**61**
Rotherham	8	6	17	6	**37**
Sheffield	19	17	34	29	**99**

Fig 2: Total number of infant deaths (age under 1 year) by area and year

In the age group categories 5-9 years, 10-14 years and 15-17 years, numbers have been relatively stable between 2019/20 and 2022/23. There is more variation in the 1-4 years age group in comparison to previous years. Overall, the small numbers of child deaths can make any increase apparent, particularly as data is broken down into smaller age bands. The rate (deaths per 100,000 population) for 2022/23 for South Yorkshire is 29.5 compared to a rate of 17.3 in all other regions, this is a wider margin of comparison than has been observed in previous years when comparing rates.

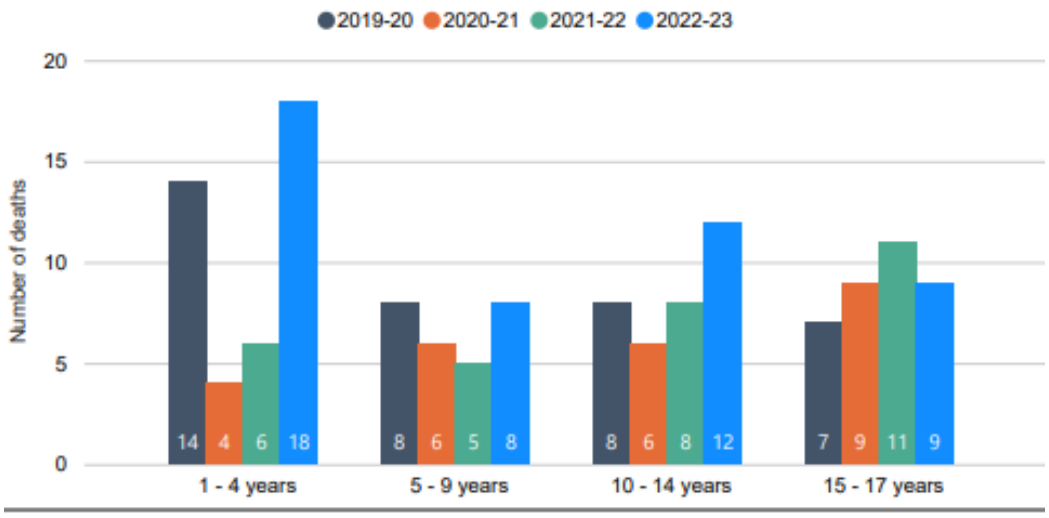

Fig 3: Total number of deaths of children aged 1-17 years, by age group and year

Place of Death Identified at Notification

Data on Place of Death is provided by NCMD as aggregate data over a 4 year period 2019/20 to 2022/23. The majority of deaths occur at Hospital (74%) with 21% happening at home or a public place.

CDOP	Home or public place	Hospice	Hospital	Other
Barnsley	14		43	
Doncaster	18	3	75	
Rotherham	12	3	45	2
Sheffield	34	7	110	3
Total	**78**	**13**	**273**	**5**

Fig 4: Total number of deaths of children aged 0-17 years, by place of death

Primary Category of Death

Data on primary category of death for children aged 0-17 is listed by each CDOP review year. As data is broken down into smaller bands, it can be challenging to identify trends or anomalies.

	Review Year			
Primary category of death	**2019-20**	**2020-21**	**2021-22**	**2022-23**
Deliberately inflicted injury, abuse or neglect	4	4	2	3
Suicide or deliberate self-inflicted harm	7	2	6	3
Trauma and other external factors, including medical/surgical complications/error	5	6	2	8
Malignancy	8	2	6	5
Acute medical or surgical condition	10	3	7	1
Chronic medical condition	4	3	4	1
Chromosomal, genetic and congenital anomalies	20	22	25	17
Perinatal/neonatal event	30	18	30	22
Infection	5	6	2	6
Sudden unexpected, unexplained death	7	6	7	12

Fig 5: Number of child (0 - 17 years) deaths in south Yorkshire by year of CDOP review and primary category of death

As expected, categories with higher numbers are for perinatal or neonatal events, which applies to many of the babies born at early gestation. Numbers for chromosomal, genetic and congenital anomalies are also higher. Both categories are a little lower in 2022/23 than in most previous years. There has been an increase in the categories of sudden unexpected, unexplained death and trauma and other external factors, including medical/surgical complications/error, particularly in the most recent data for 2022/23, this should be considered when future data is available to understand if there is a possible trend. There has been a small decrease in the categories suicide or deliberate self-inflicted harm and acute medical or surgical condition, which has continued to fall since 2019/20. When combining data on Acute Medical or Surgical Conditions and Chronic Medical conditions there has been a decrease from 14 in 2019/20 to 2 in 2022/23, although with variation over the four year time period.

Caution should be applied when considering this data as numbers are small overall and data applies to year of review rather than year of death.

Modifiable Factors

The CDOP review process requires panels to identify if there are any modifiable factors in relation to each death. The purpose of this is to enable agencies to learn lessons, improve practice and ultimately prevent further deaths. A modifiable factor is defined as something which: “may have contributed to the death of the child and which, by means of locally and nationally achievable interventions, could be modified to reduce the risk of future child deaths”.

Of the 78 cases reviewed in 2022/23, modifiable factors were identified in 42 (54%). This represents an increase in comparison to previous years.

Year of Review	2019-20			2020-21			2021-22			2022-23		
CDOP	Number of reviews	Modifiable factors identified	Modifiable factors identified (%)	Number of reviews	Modifiable factors identified	Modifiable factors identified (%)	Number of reviews	Modifiable factors identified	Modifiable factors identified (%)	Number of reviews	Modifiable factors identified	Modifiable factors identified (%)
Barnsley	17	7	41%	15	4	27%	13	7	54%	6	4	67%
Doncaster	14	7	50%	8	6	75%	37	9	24%	31	21	68%
Rotherham	30	12	40%	14	3	21%	12	2	17%	7	6	86%
Sheffield	39	14	36%	35	12	34%	29	5	17%	34	11	32%
Total	**100**	**40**	**40%**	**72**	**25**	**35%**	**91**	**23**	**25%**	**78**	**42**	**54%**

Fig 6: Number of deaths reviewed by CDOP panel by year of review and proportion that identified modifiable factors

It is recognised nationally that there have been inconsistencies in data recording and interpretation of modifiable factors over previous years. There is a degree of subjectivity when modifiable factors are decided on a case-by-case basis and is reliant on the thorough completion of national CDOP reporting forms by clinicians which takes place after the Child Death Review Meeting (CDRM) where all the relevant professionals who know the family share knowledge of the child's life and circumstances of the death. Across

South Yorkshire, there is some variation in the agreement of modifiable factors, particularly around parental smoking status.

Four domains are used to categorise the information with a corresponding level of relevance (0-2):

Domain A: Factors intrinsic to the child
Domain B: Factors in social environment including family and parenting capacity
Domain C: Factors in the physical environment
Domain D: Factors in service provision.

The child death process also creates an opportunity at the meetings for services to identify other changes to practice, e.g. a need for workplace training or amendments to policies and procedures.

According to data available from the second national NCMD annual report and based on child deaths included in all reviews between 1 April 2019 to March 2020 in England, at national level, the most frequent modifiable factor identified was smoking by a parent or carer. Other frequently identified modifiable factors were associated with quality of service delivery and children dying because of unsafe sleeping arrangements. Challenges with access to services and poor communication also feature in the most frequently identified modifiable factors.

LEARNING FROM CHILD DEATHS

During the process of reviewing a child death, if CDOP panels and SY CDOP as a group identify a theme or matter of concern that could affect the safety or welfare of children in South Yorkshire, or any wider public health concerns arising from a death or from a pattern of deaths in the area, action will be taken, and specific recommendations made. Learning is also routinely shared with professionals through SY CDOP meetings and wider Safeguarding children groups and networks.

Learning Topics and Themes

South Yorkshire CDOP brings together wider views and learning from across each of the 4 CDOP panels. The South Yorkshire CDOP invites suggestion of discussion topics and themes and includes regular reporting and issue raising from each area. A summary of discussion topics for learning from 2022/23 is provided in the following table below:

	Date of SY CDOP meeting	**Topic**	**Views and Learning Shared**
Topics	April 2022	Lack of translated materials	Information and other materials may not be available or easily available in other languages or formats (e.g. easy read)
	April 2022	Maternal Obesity	Recognition of incidence of increase maternal weight in reporting
	July 2022	Children with complex health needs	Improved information for parents on what to do during periods of minor illness for children with complex needs Requirement for earlier health assessment
	October 2022	Safe Sleep	Doncaster's safe sleep "Where should baby wake up" campaign
	December 2022	Equality & Diversity	Non-mandatory fields can be left not completed
	March 2023	Smoking	Parents not accessing or engaging with services
	July 2022	Overseas charging policy	Standard Operating Procedure now in place for a more empathetic approach and co-ordinated care
Process	July 2022 December 2022 March 2023	Review process	Backlog of PMRTs. Backlog of case reviews and impact of covid Process of reviewing complex cases Capacity of CDOP administration support Time delays in receiving information from CDRMs

	December 2022 and March 2023	Information sharing	Issues with receiving notifications Streamlining of post mortem reports Receiving notifications when children have died outside of the CDOP area. Cross boundary notification issues Cross boundary working issues
	October 2022 December 2022	Safeguarding Partnership	Annual reporting pathway

APPENDIX ONE

Report for Barnsley Place

Please note production of the South Yorkshire report has been delayed and relates to 2022 -2023. As Barnsley have already produced a report for this period, the data below relates to 2023-2024.

Data 2023-2024

Between 1st April 2023 and 31st March 2024, 6 Barnsley CDOP panels were held, and 28 cases were reviewed and completed with the aim of understanding how and why children die, and to inform future prevention work. There were 18 cases with a review ongoing during this reporting period.

Most deaths were in infants aged under 27 days (n=16); four of these were due to chromosomal, genetic and congenital anomalies and 12 were due to perinatal/neonatal events. Males made up more than half of the total deaths (64%), all except one of the cases were amongst children whose ethnicity was recorded as White British; the remaining case was recorded as Mixed. The majority of deaths occurred in hospital (n=20), six deaths occurred at home and two occurred abroad (these were siblings). Of those that occurred in hospital, 14 were in the Neonatal Intensive Care Unit (NICU), four occurred on a hospital ward and two occurred on a labour ward.

Of the 28 cases reviewed, seven cases (25%) were identified as having at least one modifiable factor. This is lower than the national average (43%).
The majority of modifiable factors were in the 15-17 year old age category and appropriate actions have been taken or are progressing to address.

Crucially no themes have been identified during this period and there is nothing that requires escalation to the partnership.

Please see the graphs below (pge 14) which provide more detailed information.

Developments 2023-2024

This reporting period has also seen a change in chairing arrangements with Alicia Sansome stepping down as Chair of the panel and Carrie Abbot (Service Director Public Health & Regulation) **s**tepping in. This has been positive in bringing a fresh perspective to the proceedings. After many years without a key worker, we have also now secured this position with the CDOP administrator taking on the additional role of key worker. This will bring benefit to families in helping them understand and input into the CDOP process.

Learning from Child Deaths and Action Taken

After the significantly high numbers of deaths from SUDI in 2020 (5) we had a period of 4 years with no SUDI deaths (we would normally average 1-3 per year). Unfortunately, since the beginning of the year we have had two deaths that whilst currently progressing

through the CDOP process, initial findings would suggest these will be classed as SUDI. This emphasises the need to continue with the multi-agency work that has been done to reduce these and promote safe sleep. This has included, developing multi-agency safe sleep guidance and a training programme (which is now being adopted across South Yorkshire) and a public awareness campaign that has included digital and social media and radio interviews. To continue this, we have recently held a week-long event in Meadowhall to promote safe sleep week and are currently working with local publications to raise the profile. Barnsley are taking a lead in this across the region.

Similarly following a death in 2020 from abusive head trauma, we have rolled out the ICON programme and again we have seen no deaths since this time relating to this issue. However, audits show that the programme is not yet fully embedded across all relevant agencies and work continues. As with safe sleep, we are again leading on this across the region and have developed and run digital and social media campaigns and rolled out multi-agency training. In September we are planning several events to promote ICON awareness week and raise public and professional awareness.

These work streams have been led by Public Health and the ICB but are very much multi-agency endeavours.

NCMD
National Child Mortality Database

NCMD Monitoring Report for CDOPs

Barnsley CDOP

Report created on: 23/05/2024

Quarter 4 2023/24

This report contains confidential information which is intended for use by the CDOP for monitoring and data quality purposes. The data the report is based on are as reported at that time and will be continuously updated each quarter. Please note that small numbers may be included when you consider appropriate onward sharing.

Produced by National Child Mortality Database Programme Team. If you have any queries please contact ncmd-programme@bristol.ac.uk

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Overview

Data on this page relates to deaths after 1st April 2019 or where CDOP review was outstanding at 1st April 2019, up to and including 31st March 2024

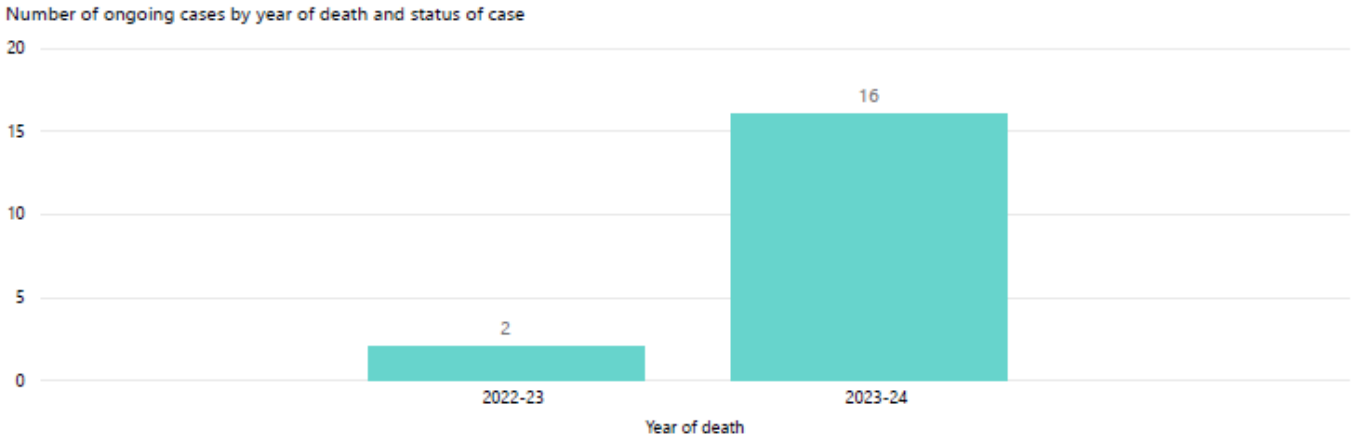
NCMD National Child Mortality Database

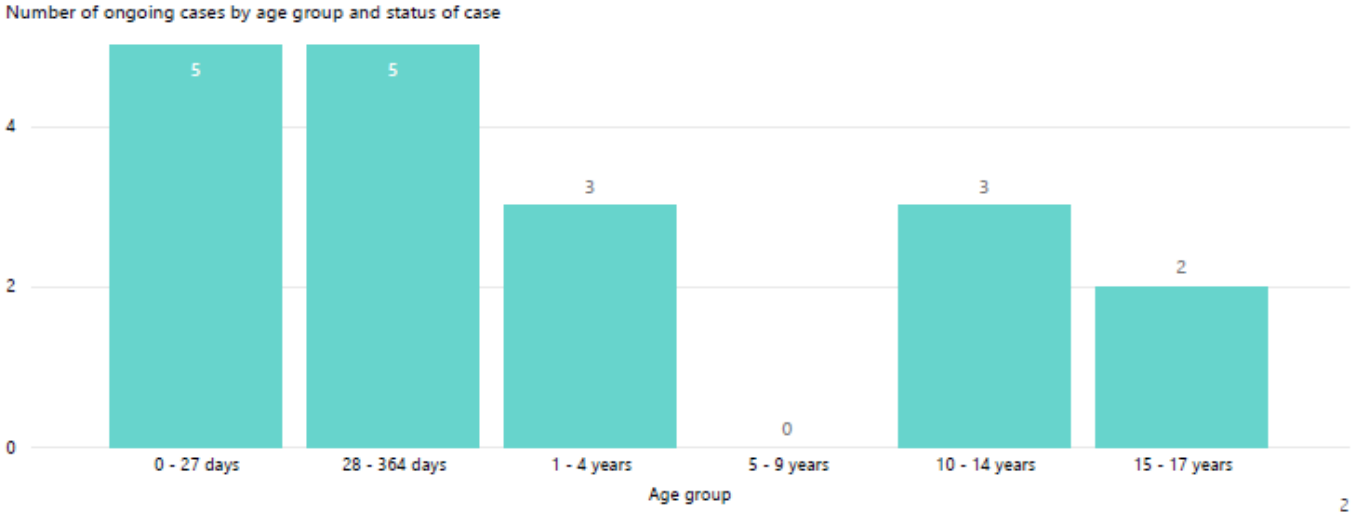
Number of cases reviewed 23/24:	Total cases with review ongoing:
28	18

Number of deaths during 23/24:
20

Number of ongoing cases entered by LAA

LAA name	Cases
Barnsley	18
Total	**18**





Barnsley

2

1

Completed Reviews - Overview 1

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2023 and 31st March 2024

NCMD National Child Mortality Database

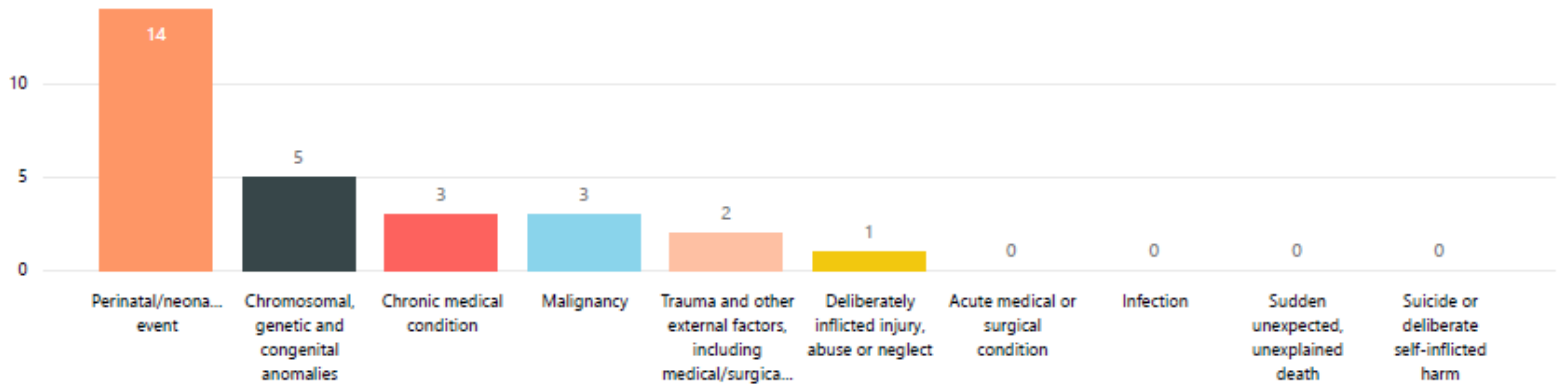
Number of cases reviewed 23/24:

28

Completed CDOP Reviews by LAA

LAA name	Cases
Barnsley	28
Total	**28**

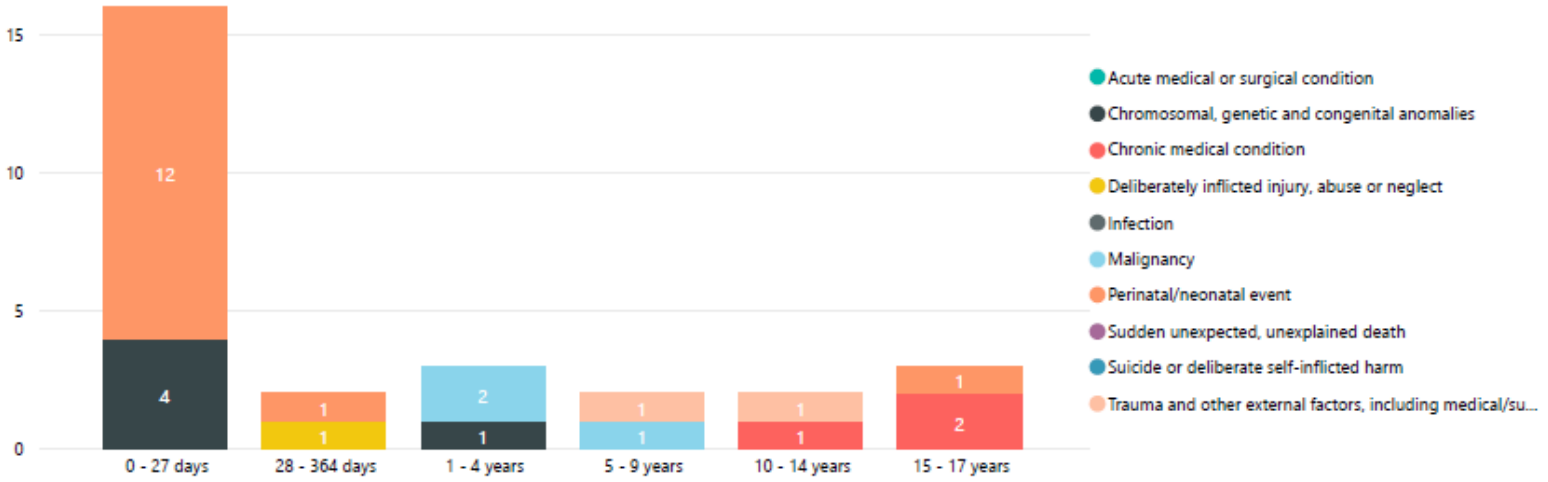
Completed CDOP reviews by primary category of death



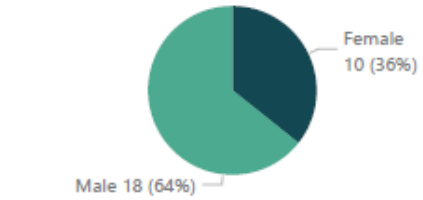
Completed CDOP Reviews by year of death

Year of death	Cases
2018-19	1
2021-22	5
2022-23	18
2023-24	4
Total	**28**

Completed CDOP reviews by age group



Completed CDOP reviews by gender



Barnsley

3

Completed Reviews - Overview 2

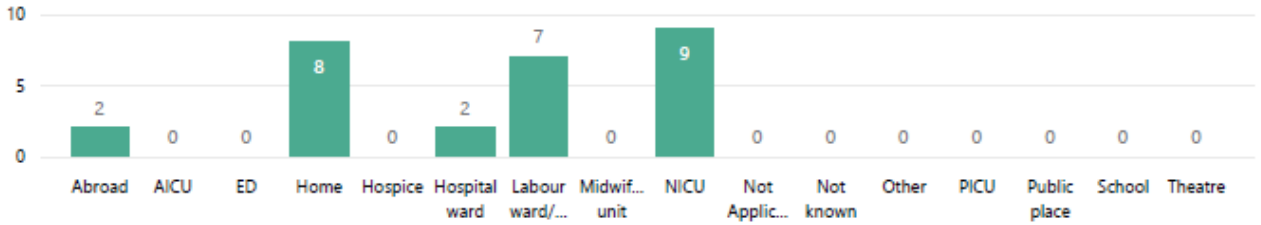
Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2023 and 31st March 2024

NCMD National Child Mortality Database

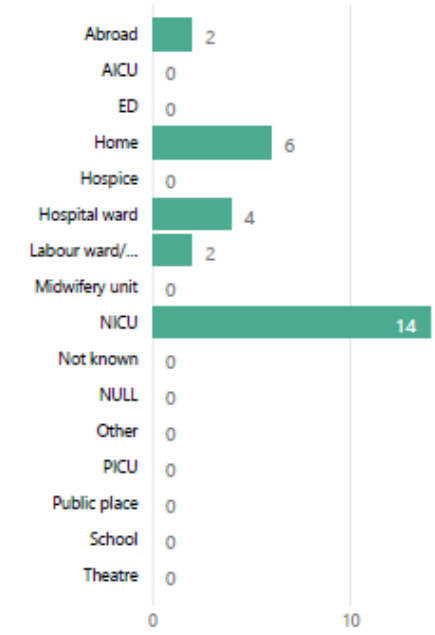
Number of cases reviewed 23/24:

28

Completed CDOP reviews by place of onset of illness/incident



Completed CDOP reviews by place of death



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	15	2	3	2	2	3	27
Unknown	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0
Mixed	1	0	0	0	0	0	1
Black or Black British	0	0	0	0	0	0	0
Asian or Asian British	0	0	0	0	0	0	0
Total	**16**	**2**	**3**	**2**	**2**	**3**	**28**

Completed CDOP reviews by ethnic group and primary category of death

Ethnic Group	Acute medical or surgical condition	Chromosomal, genetic and congenital anomalies	Chronic medical condition	Deliberately inflicted injury, abuse or neglect	Infection	Malignancy	Perinatal/neo natal event	Sudden unexpected, unexplained death	Suicide or deliberate self-inflicted harm	Trauma and other external factors, including medical/surgical complications/error	Total
White	0	5	3	1	0	3	13	0	0	2	27
Unknown	0	0	0		0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0
Mixed	0	0	0	0	0	0	1	0	0	0	1
Black or Black British	0	0	0	0	0	0	0	0		0	0
Asian or Asian British	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**5**	**3**	**1**	**0**	**3**	**14**	**0**	**0**	**2**	**28**

Barnsley

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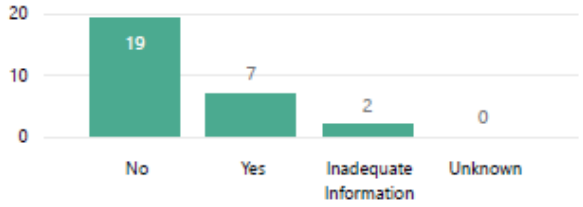
Completed Reviews - Modifiable Factors

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2023 and 31st March 2024

NCMD National Child Mortality Database

Number of cases reviewed 23/24:	% cases with modifiable factors (CDOP):	% cases with modifable factors (England):
28	25%	43%

Were any modifiable factors identified?



% 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	16	5	31%
28 - 364 days	2	0	0%
1 - 4 years	3	0	0%
5 - 9 years	2	0	0%
10 - 14 years	2	0	0%
15 - 17 years	3	2	67%
Total	**28**	**7**	**25%**

% 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	0	0%
Suicide or deliberate self-inflicted harm	0	0	0%
Sudden unexpected, unexplained death	0	0	0%
Perinatal/neonatal event	14	6	43%
Malignancy	3	0	0%
Infection	0	0	0%
Deliberately inflicted injury, abuse or neglect	1	0	0%
Chronic medical condition	3	1	33%
Chromosomal, genetic and congenital anomalies	5	0	0%
Acute medical or surgical condition	0	0	0%
Total	**28**	**7**	**25%**

% of cases where modifiable factors were identified by ethnic group

Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
White	27	7	26%
Unknown	0	0	0%
Other	0	0	0%
Mixed	1	0	0%
Black or Black British	0	0	0%
Asian or Asian British	0	0	0%
Total	**28**	**7**	**25%**

Notifications during 2023/24

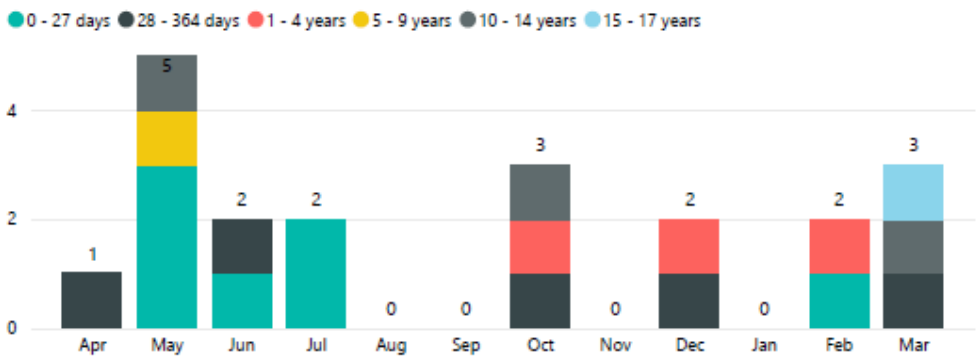
Data on this page relates to cases with a date of death between 1st April 2023 and 31st March 2024

NCMD National Child Mortality Database

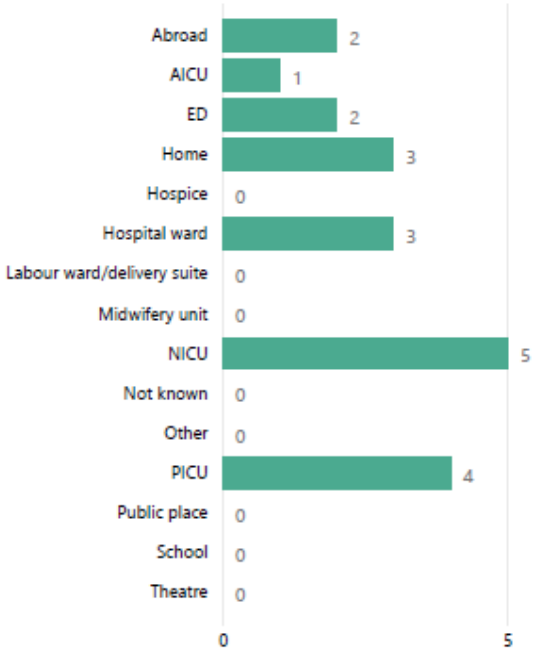
Number of deaths during 23/24:

20

Death notifications by month of death



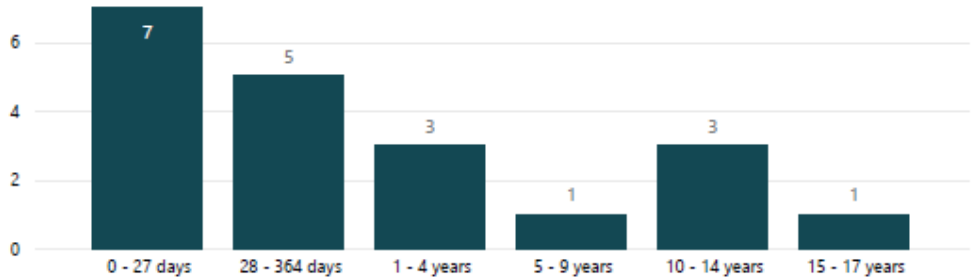
Death notifications by place of death



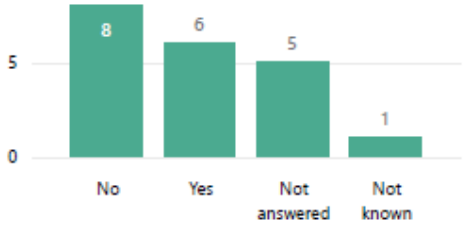
Death notifications by LAA

LAA name	Cases
Barnsley	20
Total	**20**

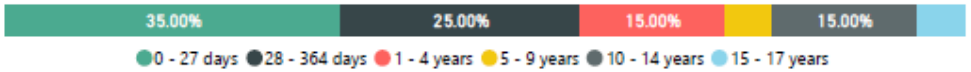
Death notifications by age group



Is there to be a Joint Agency Response?



% of death notifications by age group - CDOP



% of death notifications by age group - National (England)

Barnsley

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Notifications - Annual comparison

Data on this page relates to cases with a date of death between 1st April and 31st March for all years. The table outlined in a blue box relates to all cases from 1st April 2019.

NCMD National Child Mortality Database

Death notifications by LAA and year

LAA name	2019-20	2020-21	2021-22	2022-23	2023-24
Barnsley	14	14	12	20	20
Total	**14**	**14**	**12**	**20**	**20**

Death notifications by age group and year

Age group	2019-20	2020-21	2021-22	2022-23	2023-24
0 - 27 days	2	6	8	10	7
28 - 364 days	6	4	1		5
1 - 4 years	2	1		3	3
5 - 9 years		2	1	1	1
10 - 14 years	3			2	3
15 - 17 years	1	1	2	4	1
Total	**14**	**14**	**12**	**20**	**20**

All death notifications from 01/04/19 by month and year

Month of death	2019-20	2020-21	2021-22	2022-23	2023-24
Apr	0	1	2	1	1
May	0	2	0	2	5
Jun	1	1	1	1	2
Jul	1	1	2	2	2
Aug	0	0	2	3	0
Sep	4	2	1	2	0
Oct	1	3	0	1	3
Nov	1	1	0	4	0
Dec	1	1	3	1	2
Jan	1	0	0	1	0
Feb	2	1	0	1	2
Mar	2	1	1	1	3
Total	**14**	**14**	**12**	**20**	**20**

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