Child Death Reviews in 2023: Key Updates

Vicky Sleap, Deputy Director, NCMD

Thursday 27th April 2023

11.00am to 12.15am

Presentation will start at 11.05am to allow participants time to join

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Vicky Sleap

Deputy Director, NCMD

27 April 2023

NCMD

National Child Mortality Database

Knowledge, understanding and learning to improve young lives

What will this webinar cover?

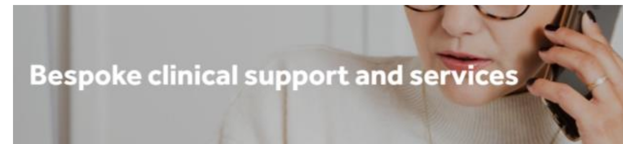
- NCMD Update
- Chief Coroner Guidance on Terminations of Pregnancy
- CDOP Alerts
- Field updates for the system and statutory forms
- NCMD thematic reports for 2023
- Ongoing and upcoming work

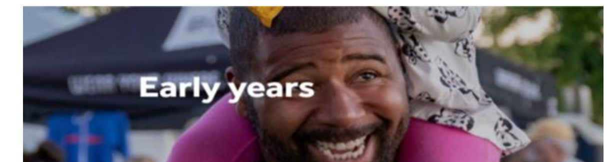
NCMD Update

- The NCMD programme has been recommissioned and our collaboration has been successful in the tender pending contract signature
- This funding will enable the programme to continue until 30th June 2026.
- The collaboration will continue to be led by University of Bristol in partnership with QES, UCL Partners, University of Oxford, Cardiff University and our new partner the Anna Freud Centre
- Peter Fleming is due to retire from University of Bristol in June 2023 although he will continue to work on a few things he will be less involved with NCMD.

The Anna Freud Centre

- ***The leading Centre for Children and Young People's Mental Health treatment and research development in the UK.***
- For over 70 years, they have championed research and channelled it into action to support children and young people.
- ***Lead evidence-based research both for the UK and provide teaching and training to mental health professionals all over the world.***
- In partnership with UCL, AFNCCF hosts the Evidence Based Practice Unit (EBPU) which conducts research, develops tools, provides training, evaluates interventions and disseminates evidence across four themes: risk, resilience, change and choice. Including:
  - collecting and analysing longitudinal data, to understand change for children's outcomes over time and
  - evaluating mental health and wellbeing programmes across a broad range of professionals, and settings, that come into contact with children, young people and families.
- **Help translate learning into practice, including supervision and training** of multi-disciplinary professionals across the early years, schools, health, social care, secure environments, prison and criminal justice sectors
- **Provide specialist Trauma, Early Years and complex Adolescent services** for children who are most in need and support for parents, carers and infants experiencing mental health difficulties and trauma during the perinatal period





Anna Freud
National Centre for
Children and Families

The Anna Freud Centre

- **Systems change and clinical expertise** enables them to speak with confidence on matters relating to death and bereavement, suicide, life-limiting illness, trauma and socio-economic deprivation.
- **Work extensively with experts in equity, diversity and inclusion** (EDI), and representatives from local communities experiencing exclusion, discrimination and harm, to ensure that their resources and training are culturally humble, inclusive and informed by lived experience.
- ***Network of practitioners supports dissemination of accessible information to multi-professional audiences*** and experience of translating evidence, learning and policy to frontline staff and leaders across the children's services system nationally, so that it is embedded into practice, including:
  - Early Years Network of 21,000 workers and Schools in Mind (SiM) network for education staff and school communities of over 38,000 members;
  - Mentally Healthy Schools (MHS) newsletter of 15,000 subscribers, reaching professionals across local authorities, schools and NHS trusts;
  - Director of Children's Services and Lead Member for Children's services national network;
  - National network of criminal justice and prison supervisees; and the national crisis network (all age).

Clinical support and services | Anna Freud Centre

Chief Coroner's Guidance on TOPs

- Chief Coroner's Guidance No. 45 was issued in February 2023
- It states that local coroners should advise CDOPs of the deaths of babies liveborn following a legal termination of pregnancy
- However, the CDR statutory guidance is clear that legal terminations are excluded from the process
- The Children Act (2004), does not currently provide a legal basis to set aside the Duty of Confidentiality owed to the family in order for CDOPs to review babies who are liveborn following a legal termination of pregnancy
- NCMD and ACDRP have jointly written to the Chief Coroner to highlight this
- For the sake of clarity, if you are notified of the death of a liveborn baby following a legal termination of pregnancy you should not add the case to the NCMD portal or eCDOP and should delete the information.

What happens when you send NCMD an alert?

- We receive alerts in two ways, either through the system or occasionally by email
- Nick, NCMD's data coding and analysis officer, extracts all the alerts from the system every week and add them to any we have received by email
- I then review them all and decide whether they need to be discussed at the NCMD POG meeting, whether we need more information or whether no additional action is needed
- For the ones that are very clinical in nature, I will discuss with one of the NCMD clinicians before making a decision

Alerts where we take no additional action

- Often the alerts we receive will not need any additional action because:

- there is already work happening in relation to the issue raised e.g. notification of Group A Strep cases
- There is no clear, **urgent** national action identified e.g. notification of a death with a particular feature such as co-sleeping
- The issue is to be included in analysis of a forthcoming thematic report

Alerts discussed by NCMD POG

- The kind of alerts we take action on are:

- Those where we are alerted to a possible increase in numbers of a type of death or a cluster of similar deaths in an area
- Those that relate to a product e.g. prop feeding pillows, baby slings
- Those that relate to failure of medical equipment to ensure notification to MHRA
- Those that relate to a possible failure of care within a specific agency e.g. an NHS never event

Following discussion by NCMD

- We might take a number of different actions including:
  - Escalation to NHS England or another appropriate body
  - Discussion with organisations with relevant expertise e.g. ROSPA or OPSS
  - Submission of a confidential enquiry topic proposal where we think a deeper dive is needed on a specific issue of concern
- We might decide no further action is required

Feeding back to CDOPs

- We aim to feedback to CDOPs directly on the alerts they send us that are discussed at the POG
- This is an area for improvement for us at present as it has not always happened as quickly or consistently as it should
- We receive too many alerts to be able to feedback on the ones that we don’t take any additional action on
- If you have a question about an alert that you have sent, where you haven’t heard from us and were expecting to, please do get in touch via email at ncmd-programme@bristol.ac.uk

Updates to Reporting Forms

- Date of post mortem examination
- Date post mortem report received

- ‘Was the child death notified as an incident to the Child Safeguarding Practice Review Panel?’ has been added.

- ‘Did the child have any known drug or alcohol dependency issues?’ will now only appear for children aged 10 years and over.

- Sudden unexpected death supplementary form: It is now possible to select multiple options on the question ‘Had anyone sharing the sleep surface taken the following in the past 8 hours prior to sleep’

Updates to the Analysis Form

- ‘Did the family provide any questions or comments during the CDR process?’ has been added. A further option has been added to document input from family

- Next field updates will be released October 2023

CDR data release 2023

- Death notifications and reviews up to 31st March 2023, publication around November 2023.
- Data has been frozen, we are now undertaking data quality checks on draft dataset.
- Opportunity for CDOPs to check numbers to be reported are correct (as per previous years).
- Some changes based on data requests received through the year.
- Regional reports also to be distributed around the same time.

NCMD Thematic Reports for 2023

- Deaths of children and young people due to traumatic incidents: Vehicle Collisions, Drownings, Violence and maltreatment and Unintentional Injuries (July 2023)

- Infections (December 2023)

Ongoing and upcoming work

- Developing a supplementary reporting form for sudden and unexpected deaths of children over 1 year
- Developing a JAR checklist for this group
- Reviewing child deaths in-person training days
- Working with SUDC-UK on an awareness raising event for JAR professionals
- Continuing work with the APPG on Temporary Accommodation around housing issues
- Provided data to Royal Life Saving Society for work they are doing with the FCDO to try and reduce drownings abroad
- Working with the APPG on Water Safety to provide data and analysis to contribute to UK drowning prevention strategy
- Starting to develop an online family hub to draw together information for families on all the processes that might happen when a child dies
- Speaking at a number of conferences to share analysis and learning including West Midlands CDR Conference, RCPCH Conference, World Drowning Prevention Conference, the 6th Annual SIDS summit, National Police Chiefs Council Conference

Questions

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