The Child Death Review Process for County Durham and Darlington Annual Report

2021/23

Foreword

Chair of County Durham & Darlington Child Death Overview Panel

Welcome to the first bi-annual report of County Durham & Darlington Child Death Overview Panel (CDOP). This report summarises the panel's activity over the last two years which aims review all deaths of children normally resident in the County Durham and Darlington area in order to learn lessons and share any findings for the prevention of future deaths.

The child death process requires agencies to contribute and participate in the review process prior to the case being considered by the Child Death Overview Panel. Thanks must go to all frontline staff and managers involved in this process, without whom we could not fulfil our task.

Meeting virtually is well established and has facilitated professionals' attendance at Joint Agency Response Meetings (JARs) and Child Death Review Meetings (CDRMs) leading to improved information sharing and learning.

The County Durham & Darlington CDOP met seven times within the timeframe of this annual report with very good multi-agency attendance. We continue to welcome observers to the Panel from constituent agencies and one Child Death Review partner attended as an observer during the reporting period.

CDOP seeks to take action on modifiable risk factors with examples highlighted within the report

This annual report will assist in ensuring that learning from child deaths reviews is shared with partners and other relevant partnerships including the Health & Wellbeing Board. It is also used to inform the wider Durham Safeguarding Children Partnership and Darlington Safeguarding Partnership annual reports.

I would like to extend a huge thanks to Panel members and Emma Maynard as CDOP Co-ordinator for their commitment, support and expertise within the Child Death Review process.

Amanda Healy

Chair of County Durham & Darlington Child Death Overview Panel

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Introduction

The death of a child is a devastating loss which profoundly affects all those involved. Since April 2008, all deaths of children up to the age of 18 years, excluding stillbirths and planned terminations, are reviewed by CDOP to comply with the statutory requirement set out in Working Together 2018. In the event of a birth which is not attended by a healthcare professional, child death partners may carry out initial enquiries to determine whether the baby was born alive. If the baby was born alive then the death must be reviewed.

The Children Act 20042 requires Child Death Review (CDR) Partners, (2 Local Authorities from one ICB in our footprint) to ensure arrangements are in place to carry out child death reviews, including the establishment of a CDOP. The reviews are conducted in accordance with Working Together 2018 alongside the Statutory and Operational Guidance (England) 2018. Legislation allows for CDR partners to arrange for review of a death of a child not normally resident there. This process is pragmatic with consideration given to where the most learning can take place.

In April 2019 the National Child Mortality Database (NCMD) became operational and is a national repository of data relating to all children's deaths in England. This will enable more detailed analysis and interpretation of all data arising from the child death review process. County Durham and Darlington CDOP continue to be fully compliant within this process.

Child Death Review Process

The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If the Child Death Overview Panel identify action that be taken by a person or organisation, they must inform them.

In addition, the Child Death Review Partners:

- Must prepare and publish reports on:
  - what they have done as a result of the child death review arrangements in their area, *and*
  - how effective the arrangements have been in practice;
- may request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process - the person or organisation must comply with the request, and if they do not, the child death review partners may take legal action to seek enforcement
- may make payments directly towards expenditure incurred in connection with arrangements made for child death reviews or analysis of information about deaths reviewed, or by contributing to a fund out of which payments may be made; and may provide staff, goods, services, accommodation, or other resources to any person for purposes connected with the child death review or analysis process.

Where a case has been subject to an internal or external review/investigation, a copy of the completed action plan that demonstrates that all actions have been addressed is submitted to the CDOP for assurance and recording purposes.

There are three interrelated processes for reviewing child deaths:

1. **Joint Agency Response**

   A co-ordinated multi-agency response (on-call health professional, police investigator, duty social worker), should be triggered if a child's death:

   - is or could be due to external causes;
   - is sudden and there is no immediately apparent cause (including SUDI/C);
   - occurs in custody, or where the child was detained under the Mental Health Act;
   - where the initial circumstances raise any suspicions that the death may not have been natural; *or*
   - in the case of a stillbirth where no healthcare professional was in attendance.

2. **Child Death Review Meeting (CDRM)**

   This is a multi-agency meeting where all matters relating to an individual's child's death are discussed. The CDRM should be attended by professionals directly involved in the care of that child during life and those involved in the investigation after death. The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved.

   The CDRM could take the form of a final case discussion following a Joint Agency Response, a perinatal mortality review group meeting in the case of a baby who dies in a neonatal unit, or a hospital-based mortality meeting following the death of a child in hospital.

3. **Child Death Overview Panel (CDOP)**

   A multi-agency panel set up by CDR partners to review the deaths of all children normally resident in County Durham and Darlington in order to learn lessons and share any findings for the prevention of future deaths.

   The CDOP should be informed by a standardised report from the CDRM, and ensures independent multi-agency scrutiny by senior professionals who were not directly involved in the child's care during life.

   The Panel has two distinct elements:

   - **Case reviews**

     The Panel categorise a likely/cause of death, identify any environmental, extrinsic, medical or personal modifiable factors that may have contributed to the death and consider any agency, strategic, regional and/or national recommendations to prevent future deaths.

   - **Business**

     The Panel considers the business arising from case reviews and the other responsibilities and statutory functions of CDOP.

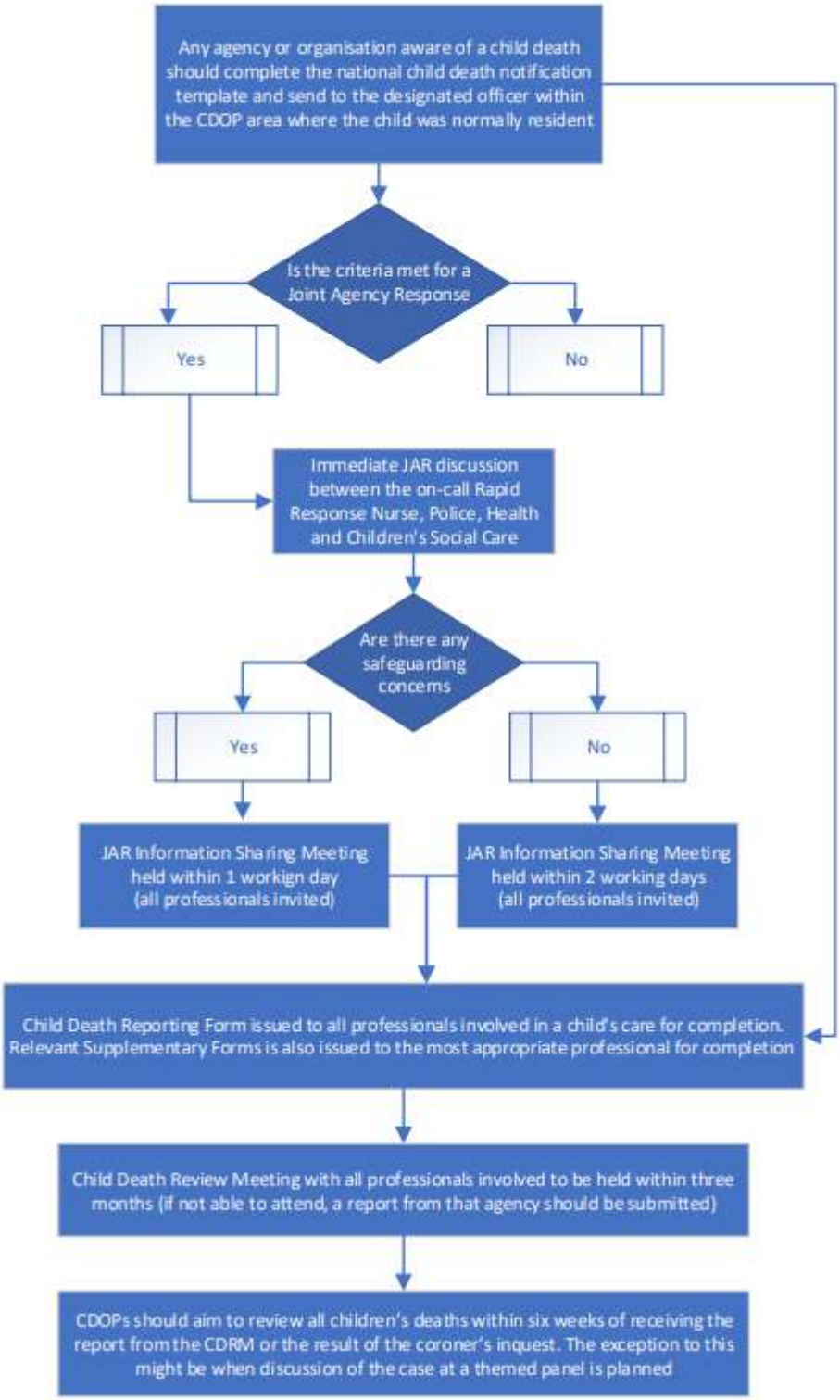
Role of Lead Professionals

The role of the Designated Doctor (child deaths) is carried out by a Consultant Paediatrician and leads in the co-ordinating of responses and health input to the Child Death Review process in County Durham and Darlington.

The Joint Agency Response process is carried out by a team of senior nurses to manage and deliver the process for sudden and unexpected deaths. This ensures their active involvement at the onset of the review process in line with Government guidance. The Joint Agency Response process augments the local review of all unexpected deaths and ensures that parents are engaged and received appropriate support during the process.

CDOP Membership as at 31 March 2023	
Amanda Healy (Chairperson)	Director of Public Health Durham County Council
Paula Mather	Business Manager, Durham Safeguarding Children Partnership
Amanda Hugill	Business Manager, Darlington Safeguarding Partnership
Emma Maynard	Child Death Overview Panel Co-ordinator Durham Safeguarding Children Partnership Officer
Julie Potts	Named Nurse Safeguarding Children Harrogate & District NHS Foundation Trust
Dr Nicola Cleghorn	Interim Designated Doctor for the Child Death Review Process/ Designated Paediatrician for Safeguarding Children North East & North Cumbria Integrated Children's Board
Catherine Hodgkiss	Rapid Response Manager County Durham & Darlington NHS Foundation Trust
Anne Holt	Associate Director of Nursing – Family Health County Durham & Darlington NHS Foundation Trust
Detective Chief Inspector Nicola Lawrence	Force Lead for Safeguarding Durham Constabulary
Chris Ring	Strategic Manager – Safeguarding & Professional Practice Durham Children & Young People's Service
Amanda Lavender	Head of Service – Early Intervention & First Contact Darlington Children's Services
Michelle Baldwin	Strategy Manager – Starting Well Public Health - Durham County Council
Nichola Howard	Named Lead Professional for Safeguarding Children North East Ambulance Service NHS Foundation Trust
Heather McFarlane	Designated Nurse Safeguarding & Looked After Children North East & North Cumbria Integrated Children's Board
Karen Agar	Associate Director of Nursing & Governance Tees, Esk & Wear Valleys NHS Foundation Trust

Child Death Review Process Flowchart



Examples of Actions taken to reduce Child Death across the CDOP footprint

Learning from Child Death Reviews

The aggregated findings from all child deaths informs local strategic planning including the joint strategic needs assessment and assets assessment, on how to best safeguard and promote the welfare of children in the area.

The CDOP is not commissioned to deliver public health interventions but learning from CDOP is shared with partners and integrated into programmes to support the health and wellbeing of children in County Durham and Darlington.

Durham Safeguarding Children Partnership

There is now an increased emphasis by practitioners on listening and talking to young people about their experiences, as well as understanding and responding to concerns raised by parents. Since 2018, Partnership has also developed new services and support focused on bringing families closer together.

Work is also ongoing to enhance the Partnership's co-ordinated and strategic approach to supporting young people experiencing significant harm outside of the home.

All partners have adopted a new method of working called Signs of Safety, which aims to ensure a consistent approach to risk assessments and to ensure that young people and families receive timely and effective help.

Durham Public Health

Suicide Prevention

Public Health in conjunction with other relevant agencies have undertaken work in a priority location due to the high frequency of people taking their own lives there. Examples include the implementation of additional patrols by rail staff; delivery of mental health first aid training to rail staff; improved lighting and wider local community based prevention work.

Sudden Unexpected Death in Infancy

In February 2022, with funding from the NIHR Applied Research Collaboration (ARC) for North-East and North Cumbria (NENC) the local authority including public health and NHS partners, began working in partnership with Durham University to design and implement a multi-agency SUDI-prevention programme for County Durham to further reduce these tragic deaths in infants. This was implemented during 2022 and free online training packages have been developed and piloted for County Durham staff and partner services who encounter vulnerable families. This graded training offer is reflective of the specific roles and responsibilities. The findings and success of the pilot were evaluated at the end of 2022 and work is underway with key partners to firmly embed the multi-agency 'Eyes on the Baby' SUDI training programme.

Bereavement Support

Public Health as part of the response to COVID have commissioned enhanced support for adults who have suffered any loss which has been widely publicised through number of agencies and commissioned services.

Child Death Review Data & Analysis

There is a well established and system for notifying the CDOP of the death of a child in line with the statutory requirements to report all deaths of children up to the age of 18 years within 24 hours (or next working day) after the death.

Table 1: Total number of notifications of deaths

Local Authority area	2019/20	2020-21	2021/22	2022/23
Durham	28 (88%)	18 (62%)	38 (81%)	31 (82%)
Darlington	4 (12%)	11 (38%)	9 (19%)	7 (18%)
County Durham & Darlington Total	**32**	**29**	**47**	**38**

There were 38 deaths notified to the CDOP in 2022/23, compared with 47 the previous year. The number of cases notified to CDOP differed from the number of cases reviewed by the Panel during a reporting period as the child death review process prior to the CDOP meeting is often delayed due to other parallel processes, such as coronial, police, Child Safeguarding Practice Reviews, to be concluded.

Table 2: Age of child at time of notification of death

Local Authority area	2019/20	2020-21	2021/22	2022/23
0-27 days	14 (44%)	10 (34%)	18 (38%)	14 (36%)
28-364 days	6 (19%)	5 (17%)	7 (15%)	8 (21%)
1-4 years	5 (16%)	1 (4%)	4 (8%)	6 (15%)
5-9 years	3 (9%)	6 (21%)	5 (11%)	2 (5%)
10-14 years	2 (6%)	2 (7%)	6 (13%)	3 (8%)
15-17 years	2 (6%)	5 (17%)	7 (15%)	6 (15%)
County Durham & Darlington Total	**32**	**29**	**47**	**39**

Table 3: Place of Death at time of notification of death

Place of Death	2019/20	2020-21	2021/22	2022/23
Hospital	25 (78%)	25 (86%)	33 (70%)	32 (82%)
Home	5 (16%)	2 (7%)	12 (26%)	7 (18%)
Public Place	1 (3%)	2 (7%)	2 (4%)	0
Abroad	1 (3%)	0		0
County Durham & Darlington Total	**32**	**29**	**47**	**39**

Table 4: Gender

Gender	2019/20	2020-21	2021/22	2022/23
Male	15 (47%)	22 (76%)	19 (40%)	17 (44%)
Female	17 (53%)	7 (24%)	28 (60%)	22 (56%)
County Durham & Darlington Total	**32**	**29**	**47**	**39**

Table 5: Ethnicity

Ethnicity (Broad)	2019/20	2020-21	2021/22	2022/23
White	26 (81%)	27 (93%)	45 (96%)	36 (94%)
Mixed				1 (2%)
Asian	4 (13%)	1 (3.5%)	1 (2%)	
Black	1 (3%)			1 (2%)
Other	1 (3%)	1 (3.5%)	1 (2%)	1 (2%)
County Durham & Darlington Total	**32**	**29**	**47**	**39**

Deaths which have been reviewed and finalised at CDOP

County Durham & Darlington CDOP reviewed and finalised 49 cases during this reporting period. The Panel does not review cases until all information is gathered and other processes have been completed such as Serious Incident Reviews, Root Cause Analysis, criminal proceedings and Serious Case Reviews. At each Panel, the Designated Doctor for Child Deaths presents the circumstances of each death to the multi-agency panel. The case is reviewed in detail and recommendations/actions logged for monitoring purposes.

Table 6: Total number of deaths reviewed and finalised by the Panel

Local Authority area	2019/20	2020-21	2021/22	2022/23
Durham	17 (85%)	32 (76%)	17 (65%)	18 (78%)
Darlington	3 (15%)	10 (24%)	9 (35%)	5 (22%)
County Durham & Darlington Total	**20**	**42**	**26**	**23**

Table 7: Age of Child

Age of Child	2019/20	2020-21	2021/22	2022/23
0-27 days	8 (40%)	18 (43%)	5 (19%)	9 (39%)
28-364 days	3 (15%)	12 (29%)	6 (23%)	4 (17.5%)
1-4 years	1 (5%)	6 (14%)	5 (19%)	1 (4%)
5-9 years	2 (10%)	3 (7%)	3 (12%)	4 (17.5%)
10-14 years	3 (15%)	0	3 (12%)	2 (9%)
15-17 years	3 (15%)	3 (7%)	4 (15%)	3 (13%)
County Durham & Darlington Total	**20**	**42**	**26**	**23**

Table 8: Place of Death

Place of Death	2019/20	2020-21	2021/22	2022/23
Hospice	0	0	1 (4%)	0
Abroad	0	2 (5%)	0	0
Hospital	14 (70%)	35 (83%)	17 (65%)	19 (83%)
Home	5 (25%)	4 (10%)	5 (19%)	4 (17%)
Public Place	0	1 (2%)	3 (12%)	0
Other Residence	1 (5%)	0	0	0
County Durham & Darlington Total	**20**	**42**	**26**	**23**

In the majority of cases (83%) reviewed by CDOP the death occurred at hospital which is consistent with the pattern from previous years.

Table 9: Gender

Gender	2019/20	2020-21	2021/22	2022/23
Male	12 (60%)	21 (50%)	13 (50%)	9 (39%)
Female	8 (40%)	21 (50%)	13 (50%)	14 (61%)
County Durham & Darlington Total	**20**	**42**	**26**	**23**

The majority of cases (61%) reviewed by CDOP were female children.

Table 10: Ethnicity

Ethnicity (Broad)	2019/20	2020-21	2021/22	2022/23
White	20 (100%)	36 (87%)	23 (88%)	22 (96%)
Mixed	0	1 (2%)	0	0
Asian	0	1 (2%)	1 (4%)	1 (4%)
Black	0	1 (2%)	0	0
Other	0	3 (7%)	2 (8%)	0
County Durham & Darlington Total	**20**	**42**	**26**	**23**

The majority of cases (96%) reviewed by CDOP were relating to white children which is consistent with the distribution seen in previous years and is reflective of the geographical footprint.

Table 11: Duration of Reviews

Duration of Review	2019/20	2020-21	2021/22	2022/23
Under 6 months	2 (10%)	3 (7%)	1 (4%)	0
6-12 months	8 (40%)	13 (31%)	9 (35%)	13 (57%)
Over 12 months	10 (50%)	26 (62%)	16 (61%)	10 (43%)
County Durham & Darlington Total	**20**	**42**	**26**	**23**

The majority of cases (57%) reviewed by CDOP were finalised within 6 months of the date of death. There are several factors that may contribute to a longer length of time between the death of a child and the final CDOP review including delay in the return of reporting forms, awaiting completion of necessary investigations including post-mortem reports or a criminal investigation, or the undertaking of a Child Safeguarding Practice review or Coroner's inquest. All other investigations and reports must be completed prior to review and case closure by the CDOP

Modifiable Factors

The review process is required to identify modifiable factors in the cases so agencies can 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".

While identified modifiable factors by the CDOP provide significant learning to improve practice and prevent future harm, there are opportunities through the entirety of the child death process (including Joint Agency Response Meetings, Hospital Mortality Meetings and Child Death Review Meetings) to identify learning and opportunities for smaller, micro-changes to practice, e.g., a need for workplace training or amendments to internal policies and procedures.

There is a degree of subjectivity in identifying modifiable risk factors which is decided on a case-by-case basis. Information on factors contributing to the child's death is reliant on the thorough completion of national CDOP reporting forms by clinicians. Completion of the CDOP Analysis Proforma is done after the CDRM where all the relevant professionals who know the family share knowledge of the child's life and the circumstances of the death.

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

0 - Information not available

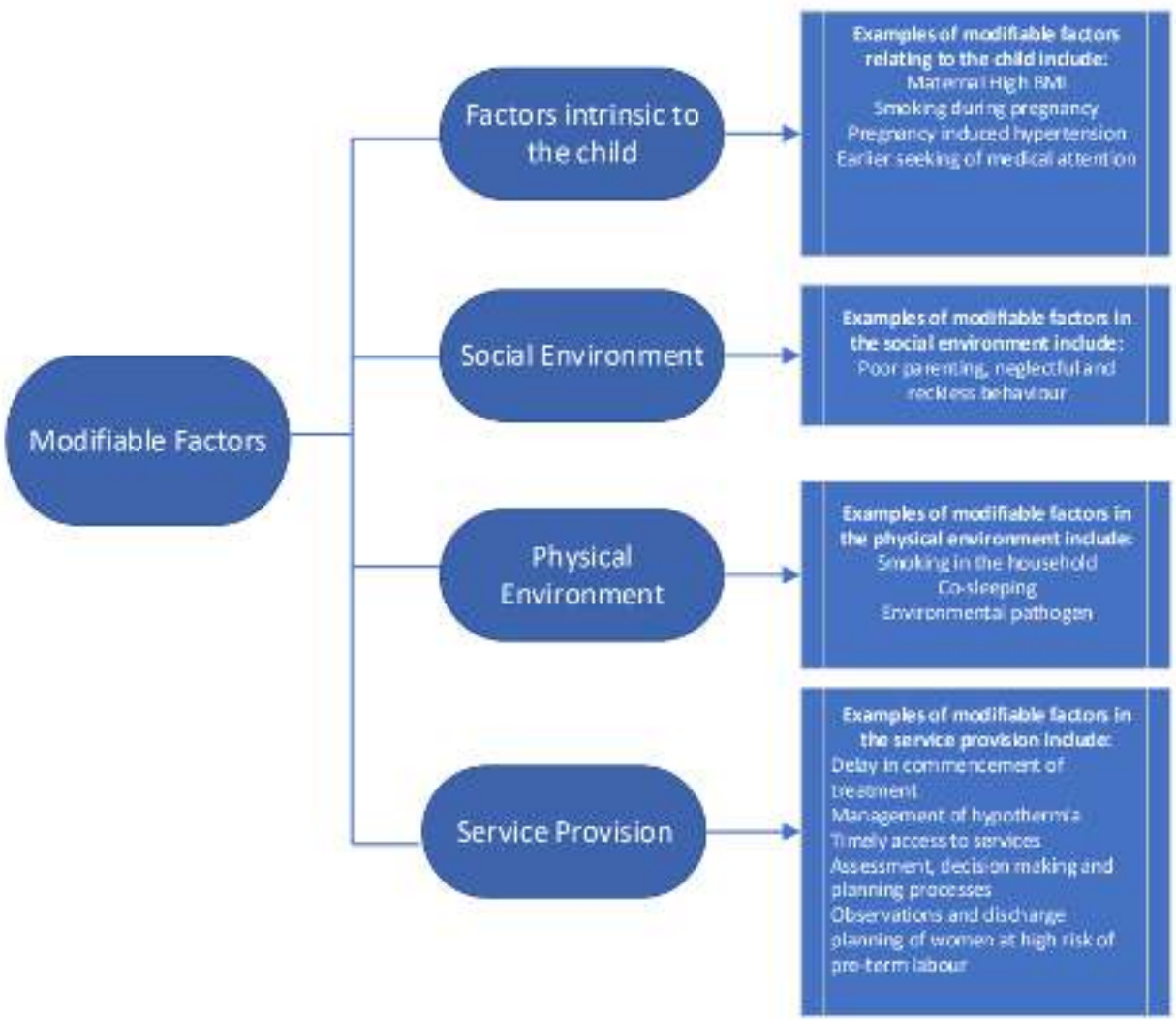
1 - No factors identified, or factors identified but are unlikely to have contributed to the death

2 - Factors identified that may have contributed to vulnerability, ill health or death

Table 12: Number and % of reviews completed with identified Modifiable Factors

Area	Total Number of Cases		No Modifiable factors		Modifiable Factors		% with modifiable Factors	
	21/22	22/23	21/22	22/23	21/22	22/23	21/22	22/23
Durham	17	18	12	11	5	7	19%	30%
Darlington	9	5	3	5	6	0	23%	0%
County Durham & Darlington Total	**26**	**23**	**15**	**16**	**11**	**7**	**42%**	**30%**

Diagram 1: Examples of modifiable factors identified by CDOP



Maternal Obesity in Pregnancy

A modifiable and relevant factor highlighted by County Durham & Darlington CDOP is the mother's body mass index (BMI) during pregnancy. For most adults, an ideal BMI is in the 18.5 to 24.9 range (health weight range). The NHS defines the BMI categories as:

- Below 18.5 – underweight;
- Between 18.5 and 24.9 – healthy weight range;
- Between 25 and 29.9 – overweight range;
- Between 30 and 39.9 – obese weight range;
- 40 and over – severe obese weight range.

Being overweight or obese increases the risk of complications for pregnant women and her baby including gestational diabetes, pre-eclampsia, high blood pressure, shoulder dystocia, premature delivery and risk of stillbirth and birth defects. The higher a woman's BMI, the high the chance of these complications.

Smoking

Smoking continues to have a negative impact on the general health of children and remains a key modifiable factor for child deaths in the North East. The CDOP collates information regarding the smoking status including maternal smoking in pregnancy and smoking in the household during the child's life.

Smoking during pregnancy has well known detrimental effects for the growth and development of the unborn baby as well as the health of the mother. Smoking during pregnancy can cause serious complications including an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy (SUDI). Maternal smoking in pregnancy and/or parental household smoking was the most common occurring modifiable factor which the CDOP deemed a significant relevant factor in relation to the cause of death. A smoke-free home is the best way of protecting babies and children.

Modifiable factors associated with Sudden and Unexpected Death in Infancy/Childhood (SUDI/C)

Unexpected and unexplained deaths where the pathological cause of death was recorded as either 'sudden infant death syndrome (SIDS)' or 'unascertained', continue to be associated with multiple modifiable factors relating to unsafe sleeping arrangements. Unsafe sleeping arrangements such as co-sleeping, are particularly dangerous if the parent/carer has consumed alcohol or ingested substances, which may limit their awareness. Other known risk factors for co-sleeping include co-sleeping with babies born prematurely or those with a low birth weight. Other factors associated with SUDI include; overheating, covering baby's face or head while sleeping, loose bedding and falling asleep with baby on a sofa or in an armchair.

In deaths categorised as sudden unexpected or unexplained, the CDOP highlighted several modifiable factors identified including:

- Unsafe sleeping arrangements such as co-sleeping.
- Substance misuse by the young person.

Deprivation

Deprivation is a key factor that is associated with poorer outcomes for child health and wellbeing. The English Indices of Deprivation are used to assess Lower-layer Super Output Areas (LSOs) of England in terms of seven domains of deprivation. These can be used to compare local authorities in terms of overall deprivation.

The seven domains used to create the Indices of Multiple Deprivation (IMD) are:

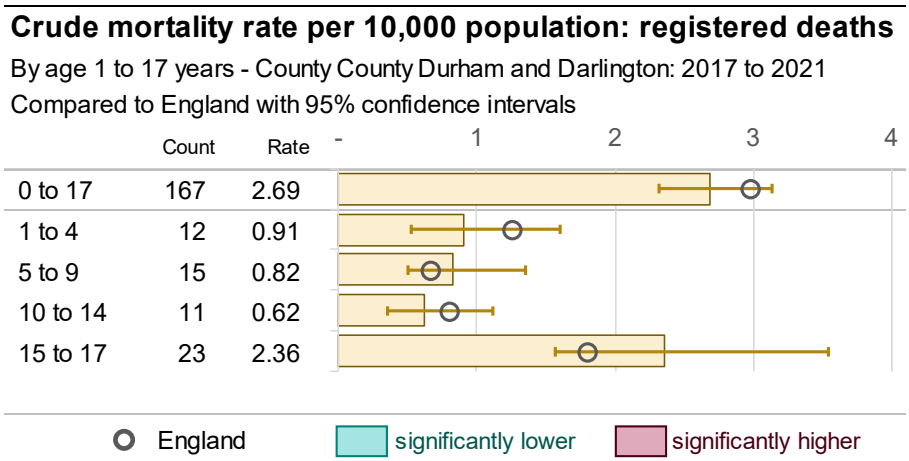
- Income: the proportion of the population experiencing deprivation relating to low income;
- Employment: the proportion of the working age population in and area involuntarily excluded from the labour market;
- Education: measure of the lack of attainment and skills in the local population;
- Health: the risk of premature death and the impairment of the quality of life through poor physical or mental health;
- Crime: the risk of personal and material victimisation;
- Barriers to Housing and Services: the physical and financial accessibility of housing and local services;
- Living Environment: the quality of both the 'indoor' and 'outdoor' local environment.

By creating a weighted average of the combined ranks for the LSOAs in larger areas an IMD ranking can be derived. In this way, local authorities can be ranked in terms of their deprivation; a range of 1 is the most deprived and 317 is the least deprived.

Table 13: IMD2019 rank for Local Authorities in the County Durham & Darlington CDOP

Local Authority	IMD2019 Rank
Durham	50
Darlington	73

Diagram 2: County Durham and Darlington mortality rate per 10,000 population aged 0-17 by deprivation: 2017-21



This shows no statistically significant difference in the child death rate between the County Durham and Darlington footprint and England for any age band.

Deaths in the age range 15 to 17 are statistically significantly higher than the 5 to 9 and 10 to 14 ranges, in line with the national experience.

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Diagram 3: County Durham and Darlington mortality rate per 10,000 population aged 0-17 by deprivation quintile: 2017-21

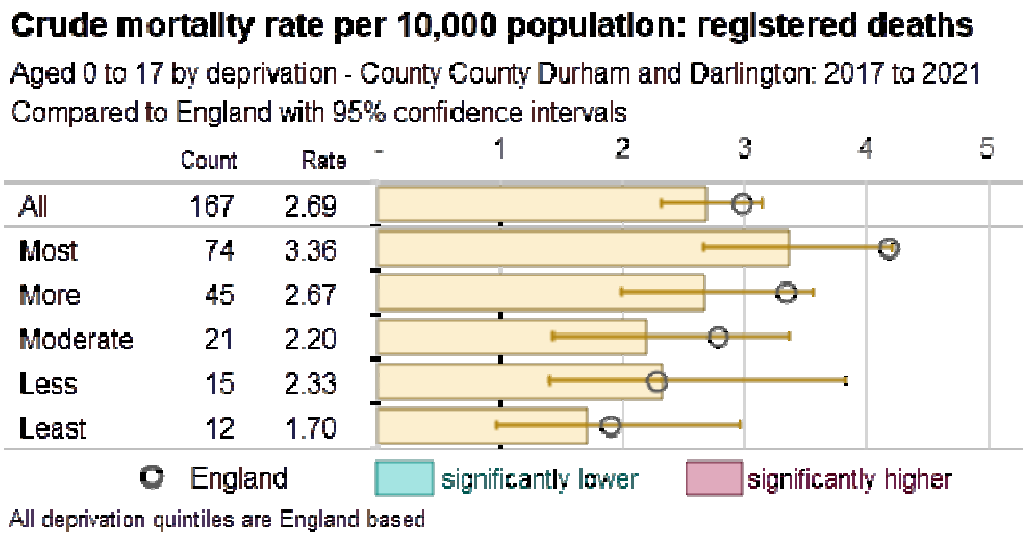
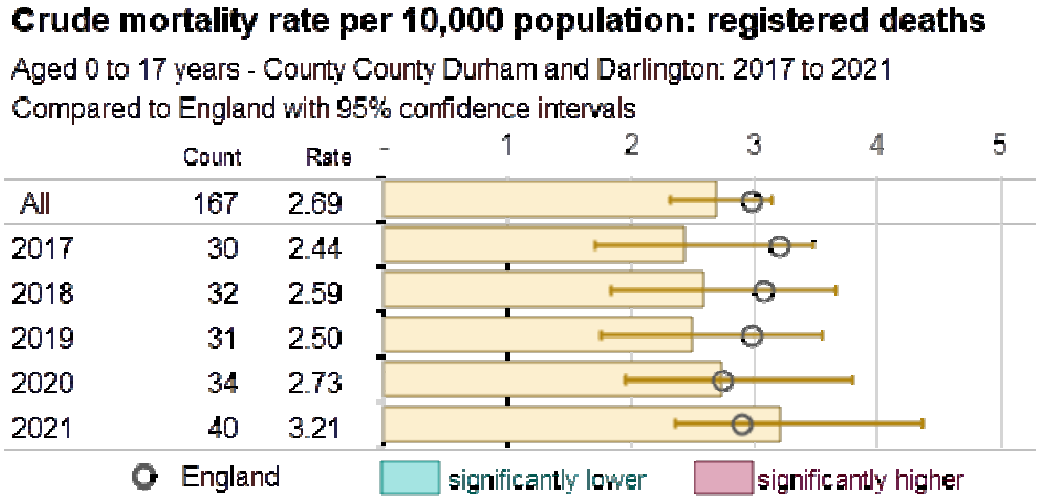


Diagram 4: County Durham and Darlington mortality rate per 10,000 population aged 0-17: registered deaths 2017-21



This shows that there is no statistically significant variation in the rate of child deaths over time locally, which is also the case nationally.

There is also no statistically significant variation between County Durham and Darlington and England for any individual year between 2017 and 2021.

Table 14: Category of child deaths

Category		No. of deaths categorised by CDOP 2021/22	2022/23
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death	0	1 (4%)
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children	3 (11%)	0
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death. Excludes Deliberately inflicted injury, abuse or neglect (category 1)	4 (15%)	0
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage, etc.	1 (4%)	1 (4%)
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy	1 (4%)	1 (4%)
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Includes cerebral palsy with clear post-perinatal cause	2 (8%)	2 (9%)
7	**Chromosomal, genetic or congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac	5 (19%)	2 (9%)
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral palsy without evidence of cause, and includes congenital or early-onset bacterial infection (onset in the first postnatal week)	8 (31%)	12 (53%)
9	**Infection** Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection, etc.	0	3 (13%)
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5)	2 (8%)	1 (4%)

Recommendations and Learning from CDOP 2022/23

Recommendation re smoking during pregnancy and smoking in the household

Smoking is a leading cause of preventable harm and health inequalities affecting mothers and babies in County Durham. It is the single most modifiable risk factor in pregnancy and remains a persistent challenge, despite ongoing public health efforts. CDOP to seek assurance from the relevant Partnership/Steering Group leading on ongoing work to drive towards the regional goal of reducing smoking at time of delivery to 5% or less by 2025 and a local ambition that all pregnant women and mothers will not smoke.

Public Health will provide an update to the CDOP in September 2023 in respect of the Reducing Tobacco Dependency in Pregnancy strategy and action plan.

Recommendation re transitions and pathways for young people aged between 16-17 years

CDOP to consider Transitions for as a topic for discussion at the next CDOP Development/Reflective session during 2023/24.

Dissemination of learning from reviews

Panel members are tasked with taking the learning from individual cases and share this widely within their organisations and networks so staff in all partner agencies are aware of modifiable factors when supporting and advising parents/carers and children/young people.

This report will be shared with all these groups and will be available on the websites of Durham Safeguarding Children Partnership and Darlington Safeguarding Partnership.

CDOP is working with other CDOPS across the North East and North Cumbria region to look at opportunities to standardise analytical reporting processes and develop a thematic review methodology that covers regional footprint.