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Birmingham and Solihull

2022 Annual Report of the Birmingham and Solihull Child Death Review Team and Child Death Overview Panel

Terminology

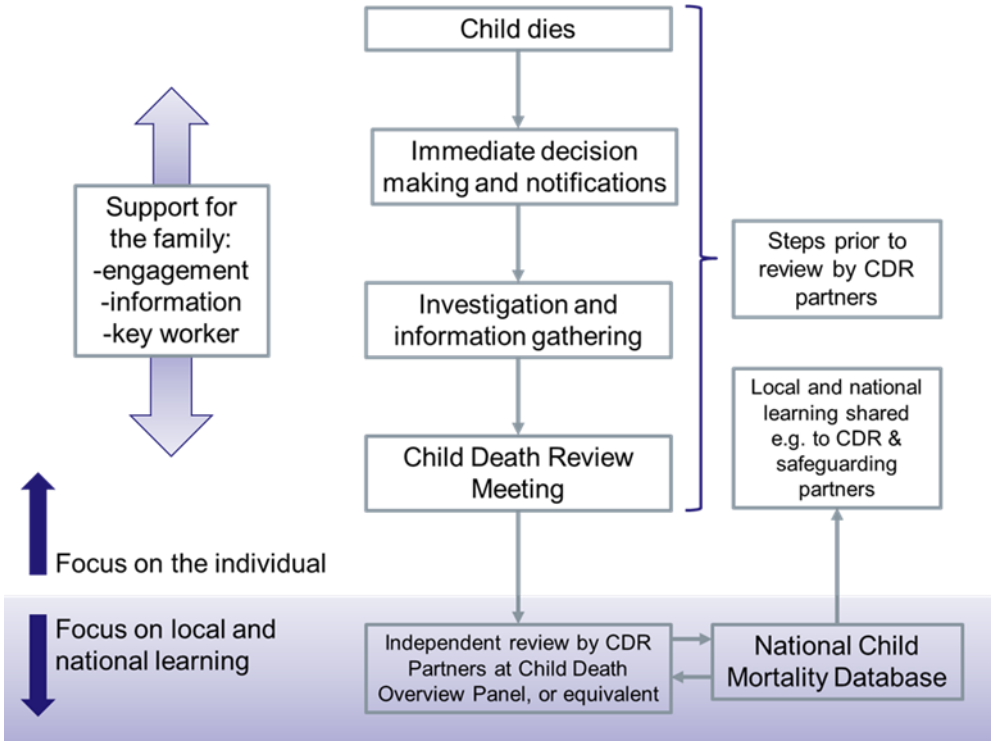
CDOP – Child Death Overview Panel
CDRT – Child Death Review Team
CDRM – Child Death Review Meeting
PMRT – Perinatal Mortality Review Tool
SUDIC – Sudden and Unexpected Death in Childhood
JAR – Joint Agency Response
NCMD – National Child Mortality Database
HSIB – Healthcare Safety Investigation Branch

1.0 Introduction

Working Together to Safeguard Children (2018)[1] outlines the governance arrangements of the statutory duty to review deaths of children resident in the City Council's area or resident elsewhere but Looked After by the City Council. The Child Death Review Partners during 2021-22 were Birmingham and Solihull CCG and Birmingham City Council (local authority). Following the Health and Care Act 2022 the Birmingham and Solihull CCG was succeeded by NHS Birmingham and Solihull Integrated Care Board in July 2022.

The Statutory and Operational Child Death Review guidance [2] set out the responsibilities of the Child Death partners and details explicit operational guidance. The Flow Chart in the guidance (Figure 1) illustrates the full process of a child death review. It identifies the responsibility of the local review by professionals involved in the care of the child (Child Death Review Meeting) and the review of an independent multi-agency panel (Child Death Overview Panel - CDOP) organised by the Child Death review Partners. These processes were implemented during the CDOP year 2019-20.

Figure 1 Child Death Review Processes, 2018



1.1 Time period

The CDOP year follows the financial year reporting period. This annual report covers the period from 01 April 2021 to 31 March 2022.

2.0 The Birmingham and Solihull Child Death Review Team

The multi-professional Child Death Review Team (CDRT) is part of the Safeguarding Team at NHS Birmingham and Solihull Integrated Care Board (ICB). Birmingham and Solihull CDOP is managed by the CDRT. The offices for the CDRT are at the Wesleyan Building in Birmingham. The meetings were a mixture of virtual and face to face; the Neonatal Panel meetings were all virtual and the General/SUDIC meetings were face to face/hybrid meetings where possible.

Birmingham CDOP took over the responsibility for reviewing Solihull child deaths from 01 April 2021, so cases reviewed include children resident in either Birmingham or Solihull.

The CDRT are directly responsible for the co-ordination of the Joint Agency Response (JAR) to unexpected child deaths (SUDIC – Sudden Unexpected Death In Childhood) for both Birmingham and Solihull resident children. The CDRT oversees CDR services provided by NHS Trusts.

Terms of reference for the CDRT are available here:
https://www.birminghamsolihull.icb.nhs.uk/application/files/3616/6791/8309/Terms_of_Reference_for_BSol_Child_Death_Review_Team_2021.pdf

2.1 CDRT staff

Dr Joanna Garstang	Designated Doctor for Child Death
Dr Helen Chaplin	Designated Doctor for Safeguarding – Lead for Neonatal Deaths
Sarah Hunt & Sue Cope	Lead Nurses for Child Death Review

Melisha McKenzie	Administrator until Sept 2021 then CDRT manager from Sept 2021
Joanne Fox	Administrator

There was a vacancy in Administrator role from Sept 2021 until June 2022.

CDOP membership

Di Rhoden	CCG Head of Safeguarding, Chair
Dr Joanna Garstang	Designated Doctor for Child Death
Dr Helen Chaplin	Designated Doctor for Safeguarding – Lead for Neonatal Deaths
Sarah Hunt	Lead Nurse for Child Death Review
Sue Cope	Lead Nurse for Child Death Review
Melisha McKenzie	Administrator until Sept 2021 then CDRT manager from September 2021

Detective Inspector Joseph Davenport, Ladywood Public Protection Unit, West Midlands Police
Dr Yasmin Hussain, Named GP for Safeguarding, BSol CCG

Birmingham:
Dr Marion Gibbon, Assistant Director of Public Health Children and Families
Judith Beddow, Head of Child Protection Review, Birmingham Children's Trust
Paul Nash, Head of Service, Independent Review, Birmingham Children's Trust
Micho Moyo, Head of Safeguarding Education, Birmingham City Council
Dr Michael Plunkett, Named Doctor for Safeguarding, General Paediatrician, University Hospital Birmingham

Solihull:
Dr Rob Davies, Consultant in Public Health, Solihull Metropolitan Borough Council
Hasina Miah, Independent Reviewing Officer, Children's Services, Solihull Metropolitan Borough Council
Natasha Chamberlain, Senior Education Improvement Adviser, Solihull Metropolitan Borough Council

Neonatal Meetings:
Dr Vikki Fradd, Consultant Neonatologist, University Hospitals Birmingham
Joselle Wright, Consultant Midwife, University Hospitals Birmingham (left position in October 2021 and was not replaced during rest of 2021-22 year)
Dr Matt Cawsey, Consultant Neonatologist, Birmingham Women's and Children's Hospital
Louisa Davidson, Consultant Midwife, Birmingham Women's and Children's Hospital

3.0 Local Child Death Review Meetings

The statutory guidance requires that all child deaths should be reviewed at a local child death review meeting (CDRM). With the exception of deaths requiring a Joint Agency Response (JAR), which are directly managed by the CDRT, it is the responsibility of the health care trust caring for the child at the time of death to hold the CDRM.

Birmingham Community Healthcare Trust holds CDRM for children who die under their palliative care team; Acorns hospice contributes to these reviews.

University Hospitals Birmingham holds CDRM for children dying on the paediatric wards, and for neonatal deaths in addition to using the Perinatal Mortality Review Tool (PMRT).

Birmingham Women and Children's Hospitals are using the PMRT for neonatal deaths. They have an established mortality review programme for deaths at Birmingham Children's Hospital but this only considers provision of care during recent treatment within the hospital; these meetings are not

compliant with the Working Together to Safeguard Children (2018) Statutory Guidance. They have received substantial support from the CDRT to commence holding CDRM and started doing so in April 2022 so outside of the time frame of this report.

City and Sandwell Hospitals are using the PMRT for neonatal deaths.

For neonatal deaths where the baby was transferred antenatally or postnatally, a joint PMRT between both Hospital Trusts has been established.

All trusts have found challenges in having primary care and other agencies join CDRM. The CDRT are reminding trusts of this requirement and supporting them to invite the appropriate professionals.

4.0 Joint Agency Response (JAR)

The CDRT provides oversight and administrative support for any death which requires a JAR. The JAR should be started if a child's death:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (incl. 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;
- in the case of a stillbirth where no healthcare professional was in attendance

There is a consultant Paediatrician from either Birmingham Community Healthcare NHS Trust or University Hospitals Birmingham NHS Trust on call 24 hours per day to support the JAR and ensure that joint home visits with the police can take place as soon as possible. This on-call duty is alongside existing clinical commitments so although the Paediatrician is always available for advice they may not be immediately able for home visits. Other neighbouring areas have much more limited JAR cover. During working hours, the lead nurse on-call from the CDRT will accompany the Paediatrician.

Each SUDIC case has an allocated lead nurse from the CDRT who supports parents/carers and attends the initial and final multi-agency meetings. The CDRT nurses also lead on homicide cases and deaths that occur abroad.

All agencies follow the 2016 Kennedy Guidelines[3] for investigation of SUDIC. A local Birmingham multi-agency guideline was agreed between West Midlands Police, the Birmingham Coroner and BSol CCG in May 2021. National multi-agency guidance for the JAR during the COVID-19 pandemic was issued in April 2020, and this was followed when necessary.

4.1 JAR audit

Joint Agency Response Audit

Audit of JAR for children dying between 01 April 2021 and 31 March 2022

The JAR is audited annually to provide assurance compliance with national standards. A summary of the audit is presented here. It takes a minimum of 4 months (and often much longer) to complete a JAR due to the length of time needed for post-mortem reports to be completed, therefore few cases will have completed the JAR process yet. At present there is only one paediatric pathologist

in the West Midlands able to undertake infant post-mortems with older children sent out of region, and a national shortage of paediatric pathologists.

There were 28 deaths subject to JAR; 2 additional cases started the JAR process but were promptly stepped down following the initial JAR meeting as medical causes of death were confirmed. 23 children were Birmingham residents and 5 Solihull, 15 were female and 13 male. The median age at death was 7 years with a range of birth to 17 years.

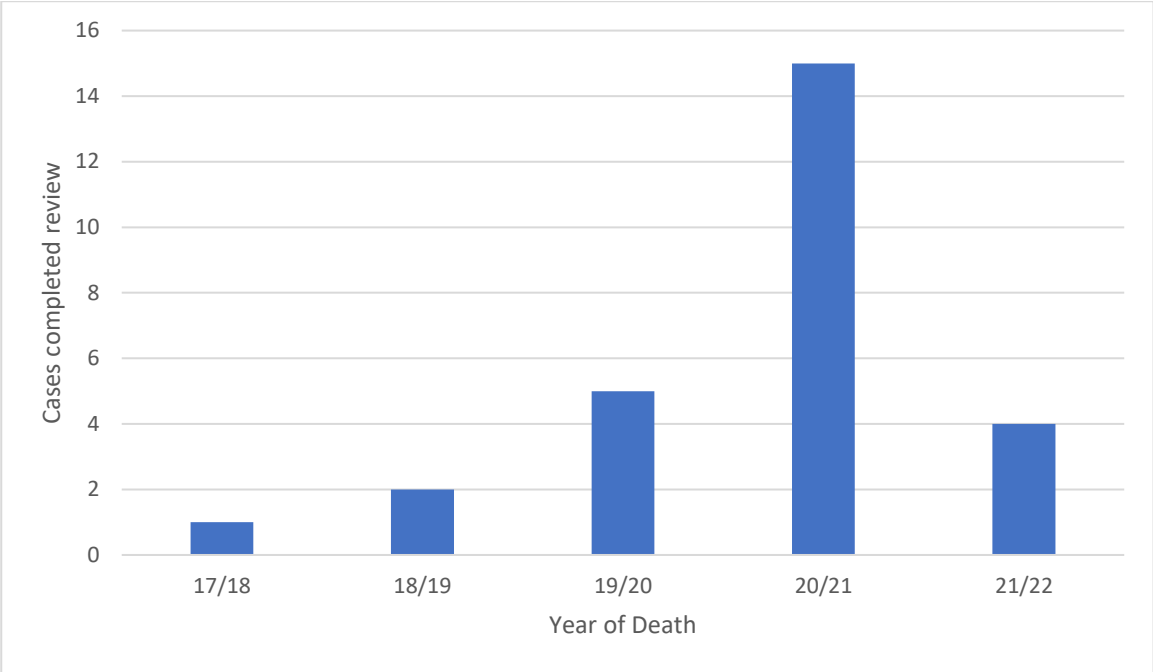
Table 1 Performance against JAR audit standards

Audit standard	Number of eligible cases	Number of cases achieving standard (%)
Joint home visit by police and paediatrician	21 (7 in public place/ out of region)	16 (76%) (all same day, 5 police only)
Initial multi-agency sharing meeting	26 (1 complex strategy meeting held instead and 1 meeting not required)	26 (100%) (Mean 4 days after death)
Final case discussion to review cause of death	22 (6 not required)	5 (72%) (mean 5 months after death – others still waiting post-mortem result)
Parents offered feedback from final case discussion	11	7(64%) 2 additional cases supported by police 4 families accepted feedback meeting
Final case discussion prior to Inquest (if held)	4	3 (75%)

Audit of JAR cases finalised at CDOP between 01 April 2021 and 31 March 2022

There were 27 JAR cases finalised in this time period: 24 from Birmingham and 3 from Solihull. The year of death is shown in figure 1, 15/27 cases died in 2020-21.

Figure 1 Year of death for cases finalised at CDOP 2021-2



There was good attendance at initial and final multi-agency meetings from all agencies. Coroner's investigators attended 20/27 initial JAR meetings compared to none in the previous year. Coroner's investigators do not attend Final Case Discussions to ensure independence although all documents are shared with them.

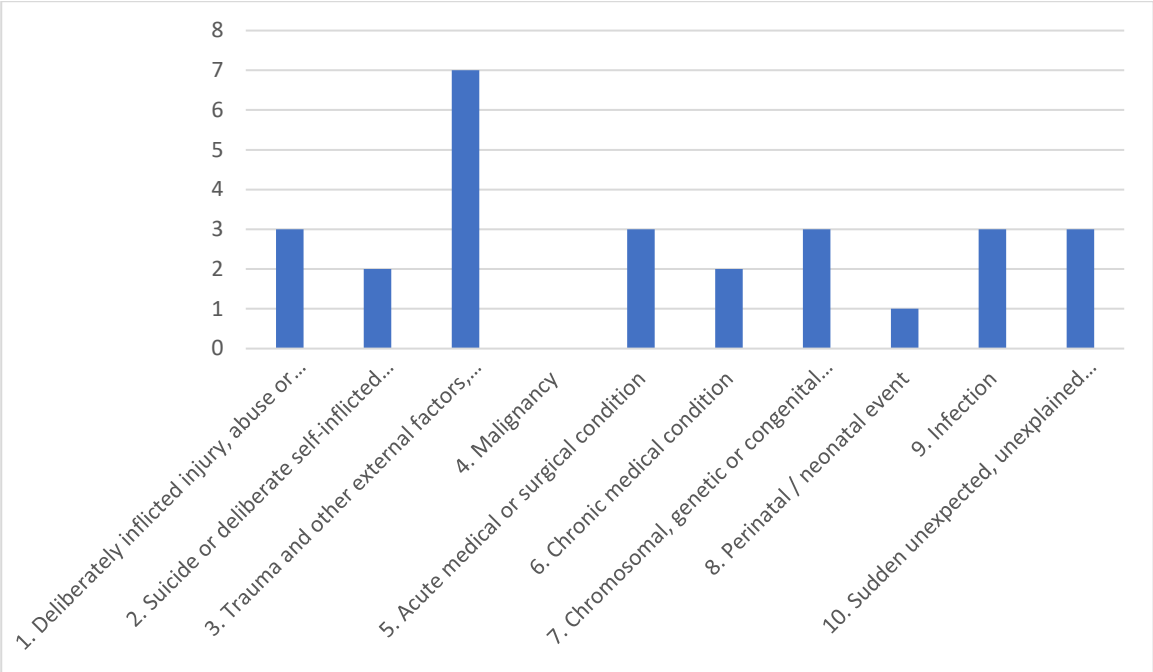
Final case discussions took place for 16 cases at a mean of 5.3 months. Final case discussions were not required in 11 cases mainly because complete information on the child, cause of death and potential modifiable factors was available at initial information sharing meeting.

All families were offered follow-up following the conclusion of the JAR. The Child Death Review team offered this to 22 families, 14 families accepted and 8 declined. Of the remaining 5 cases; 4 families had a follow-up visit from police or other healthcare professionals and 1 family was offered follow-up from another CDOP as the SUDIC process had commenced in their area.

The final CDOP category of death is shown in figure 2. The most common category was trauma and external factors; this includes Road Traffic Collisions, drowning and accidental asphyxia of infants.

There were four unexpected and unexplained sleep related deaths of infants under the age of one year. Risk factors included co-sleeping and smoking, babies sleeping on their fronts, overheating and hazardous items in the bedspace.

Figure 2 Final Category of Death JAR cases reviewed 2021-2



In 4 cases, children had significant pre-existing medical conditions and in all of these children their death was directly due to this condition. This is in direct contrast to last year where 15 children with a life limiting illness died unexpectedly and 9 of these deaths were not due to underlying conditions.

The JAR identified child protection concerns in five families.

Modifiable factors were identified in 16/27 deaths, these included;

Factors intrinsic to the child:
- undiagnosed mental health conditions in children and the influence of social media upon children's mental health,
-denied/concealed pregnancy

Factors in social environment including family and parenting capacity:
- carers not recognising signs and symptoms of deteriorating illness
-Co-sleeping, babies not sleeping on their backs
-school exclusion
-gang affiliation
-smoking-antenatally and postnatally
-asthma management

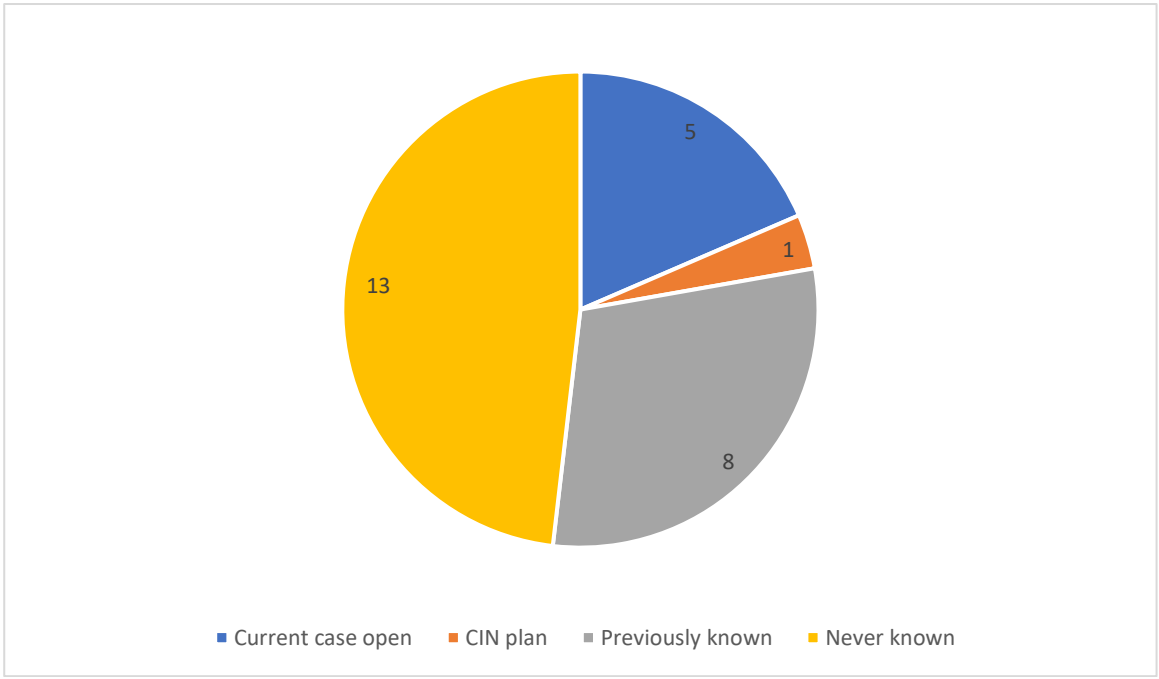
Factors in the physical environment:
-unsafe sleep for infants: over heating or hazardous items in bedspace
-home safety
-dangerous driving

Factors in service provision:

-inadequate triage by healthcare professionals
-lack of written information for parents/carers in relation to deteriorating illness in child
-Inadequate discharge planning from acute trusts
-delays in elective surgery
-asthma management by professionals
-Emergency Department provision for teenage trauma patients
-language barriers

A Local Child Safeguarding Practice Review was held in 3 cases. Most families were not known to social care prior to the death, social care status is shown in figure 4.

Figure 3 Social care status at time of death

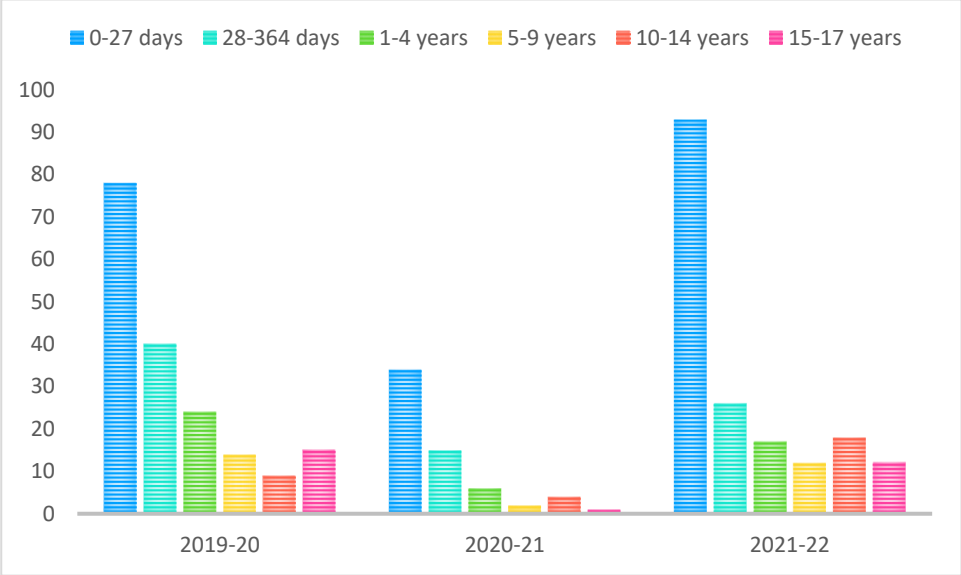


5.0 Deaths Reviewed by Birmingham CDOP

179 deaths were reviewed by Birmingham CDOP, compared to 62 in 2020-21 and 180 in 2019-20. COVID was the reason for the reduction in reviews in 2020-21, with several CDOP meetings cancelled and delays in getting the information required from acute hospitals. The number of cases that have been reviewed in 2021-22 is back similar to pre-COVID figures. There were 161 deaths in 2021-22, and 120 in 2020-21. Therefore there has been some catch up of the backlog of cases not able to be reviewed in 2020-21 due to COVID.

The majority of deaths are in infants under the age of 1 year. The breakdown of ages is shown in figure 2 with data for 2019-20 and 2020-21 shown for comparison.

Figure 4 Age of children reviewed at CDOP 2021-22 with 2019-20 and 2020-21 for comparison

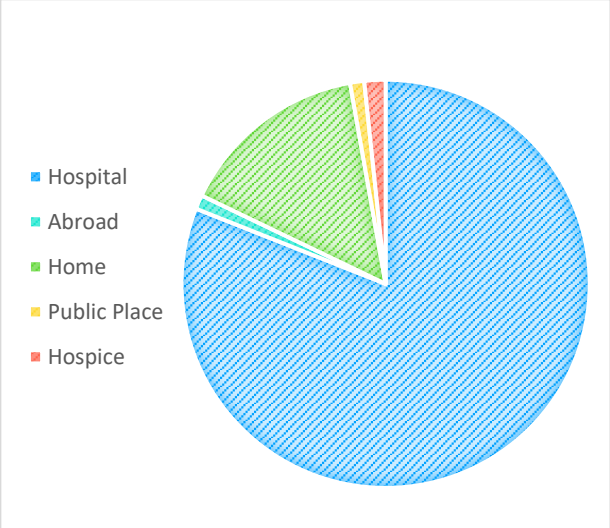


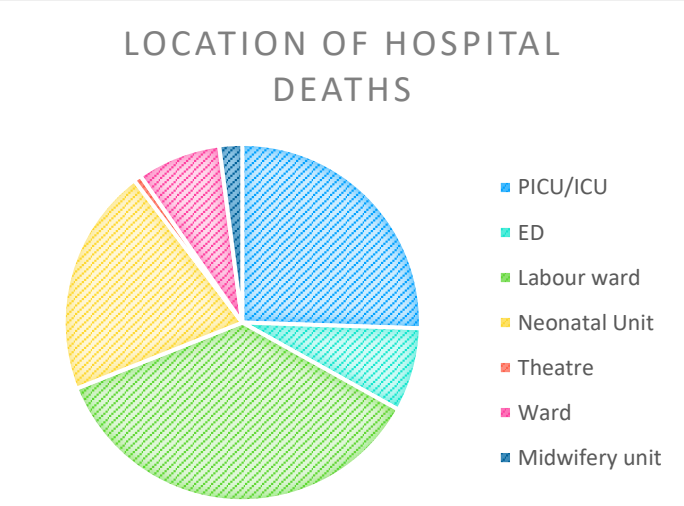
The median time for a review to be completed was 360 days (range 91-1472). This compares to 235 days (range 42 to 908) in 2021-22. There are often lengthy delays while CDOP wait to receive information from hospitals, particularly for mortality reviews to be completed at Birmingham Children's Hospital, in part due to their multi-layered mortality review process. Further delays are also unavoidable if there are criminal investigations, prosecutions or Safeguarding Practice Reviews. However, the increase in time compared to 2020-21 is likely to be due to the backlog of cases delayed due to COVID with more complex cases having longer delays than before COVID.

5.1 Place of death

The majority of the deaths occurred in hospital (80%) or at home (15%). Most of the hospital deaths occurred on labour ward, the neonatal unit or PICU. This is illustrated in figure 3.

Figure 3 Location of death 2021-22

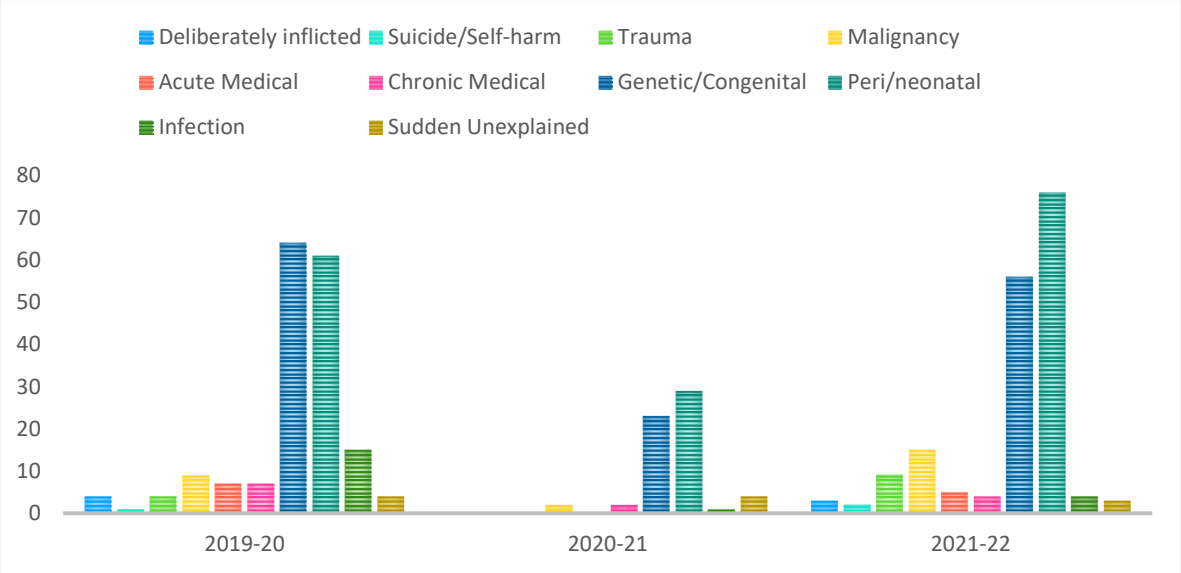




5.2 Causes for death and modifiable factors

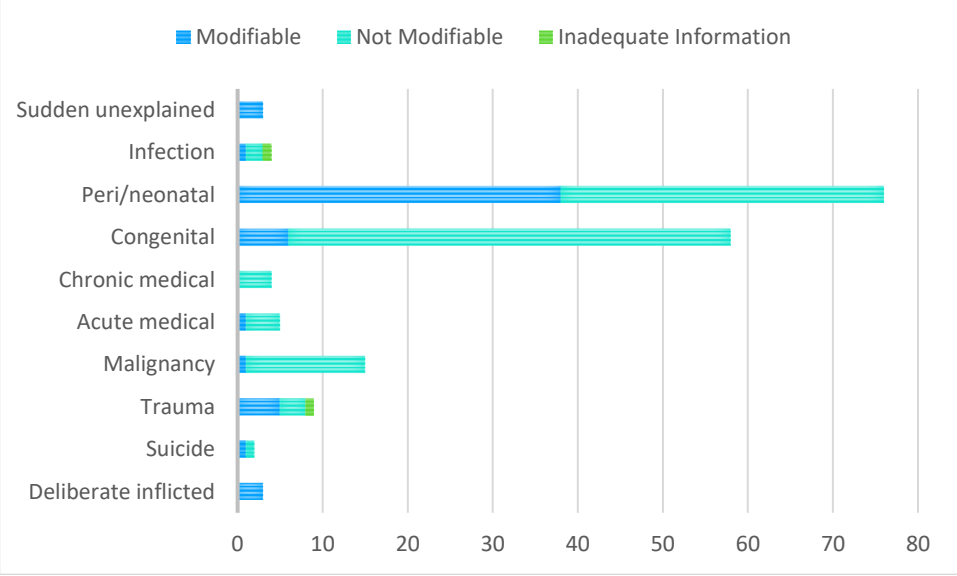
CDOP categorises deaths into broad categories, the frequency of deaths in each category varies with age as shown in figure 4. As with 2020-21, there were no deaths directly due to COVID.

Figure 4 Causes for death 2021-22, with 2019-20 and 2020-21 for comparison



CDOP consider whether each death is preventable based on the presence of modifiable factors. These are defined as '… factors in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.' In total 59/179 (33%) of deaths had modifiable factors, which is similar to 2020-21 (34%). The modifiability per category of death is illustrated in figure 5.

Figure 5 Modifiable factors and category of death 2021-2022



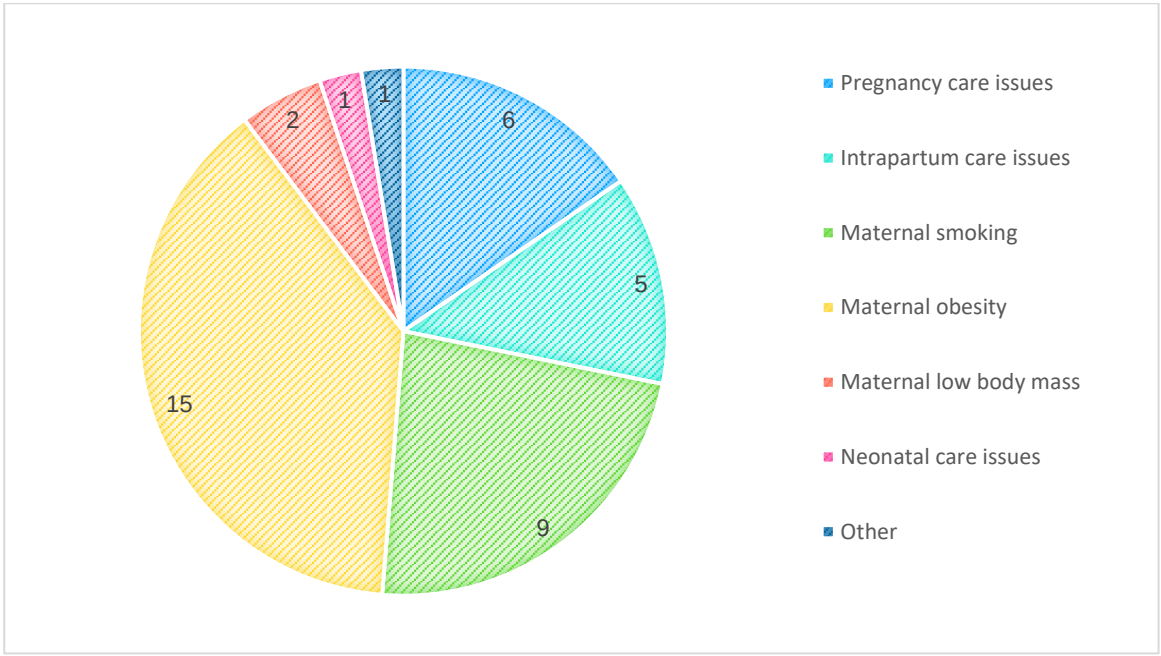
5.3 Modifiable factors for Perinatal and Neonatal Deaths

Notably, 50% (38/76) of our perinatal/neonatal deaths had one or more modifiable factor recognised. This has been an increase over the last 2 years, from 13% in 2019-20 and 42% in 2020-21. We now receive high quality information in the form of the hospital completed Perinatal Mortality Review Tool (PMRT)[4], which is an evidence based template for reviewing stillbirths and neonatal deaths born after 22 weeks gestation. In addition to this, deaths of term babies (over 37 weeks gestation) who died within the first week of life were also reviewed by the Healthcare Safety Investigation Branch (HSIB)[5] and these reports were also reviewed as part of the CDOP process.

We hold specialist neonatal CDOPs, with consultant neonatologists and specialist midwives present enabling clinical experts to contribute to reviews. In Birmingham, there are three NHS Trusts with maternity hospitals: Birmingham Women's Hospital, Heartlands Hospital (University Hospitals Birmingham) and City Hospital. We hold separate CDOP meetings for cases from each hospital, with clinicians from the other hospital attending to review cases; this ensures both clinical expertise and a high degree of scrutiny with independent experts.

The majority of modifiable factors identified in perinatal and neonatal deaths were related to suboptimal maternal health, namely maternal smoking (increasing risk of premature delivery and low birth weight) and maternal weight (obesity or underweight). There were some modifiable factors with service provision regarding antenatal care (e.g. booking delays, not optimising management of other medical issues during pregnancy), intrapartum care (around the time of birth, e.g. incorrect monitoring/misinterpretation of cardiotocography monitoring/delay in giving antibiotics) and with neonatal care (e.g. delay in surfactant administration). The modifiable factors for perinatal and neonatal deaths are shown in figure 6.

Figure 6 Modifiable factors for perinatal and neonatal deaths



5.4 Modifiable factors in other deaths (excluding perinatal and neonatal deaths)

There were five sleep-related sudden unexpected infant deaths. Three remained unexplained following full investigation with modifiable factors of co-sleeping in two, parental smoking in one, and a hot sleeping environment in one. Two deaths were categorised by CDOP as trauma these involved accidental suffocation due to unsafe sleeping environments.

Parental smoking was also noted in a death from a respiratory illness. Modifiable factors in health service provision were also identified in two deaths related to staffing issues and waiting times; these issues caused poor communication of results within hospital and delays in gastrostomy surgery.

Parental consanguinity was not noted as a modifiable factor in any of the genetic or congenital deaths, compared to 4 deaths in 2020-21. This is because the National Child Mortality Database (NCMD) gave interim advice to CDOP: to determine if consanguinity was contributory to the death but not to mark it as modifiable. NCMD are currently developing guidelines regarding how CDOPs should determine modifiability of various factors; it is hoped that this will establish a uniformed approach across the country. There were 10 deaths of children from genetic syndromes, whose parents were blood relatives.

5.5 Learning from deaths

63/179 reviews identified relevant learning, even though in most cases this would have made no difference to the outcome for that child. Much of the learning was identified by provider trusts at internal CDRM or through the Healthcare Safety Investigation Branch. It was felt by the CDRT that most cases discussed have some learning and so perhaps lessons identified at CDRM level are not being captured fully enough on the eCDOP Analysis Form (see recommendations Section 7 below).

Learning themes for peri-neonatal deaths included the need for better processes for management of mothers who are book late for antenatal care (5 cases), improving intrapartum care, such as giving steroids and magnesium in a timely way for mothers in preterm labour (4 cases), and better interpretation of Cardiotocography Monitoring to identify fetal distress (4 cases). There was also learning regarding the early management of neonates; giving correct adrenaline dose (2 cases), and ensuring timely stabilisation of the baby on the Neonatal Unit (golden hour) is met (3 cases).

There was also learning regarding management after death;

- Ensuring the Joint Agency Review process is followed correctly (5 cases)
    - E.g. Remembering to consider as a SUDIC when child is ‘expected’ to die several days after an ‘unexpected’ collapse
- Ensuring adequate post-mortem tests (2 cases)
    - E.g. Ensuring post-mortems that are carried out by adult pathologists (on older teenagers) still follow SUDIC Kennedy Guidelines 2016[3], with appropriate histology and ancillary samples being taken.
- Ensuring admission of twins in SUDIC cases (2 cases)
    - SUDIC Kennedy Guidelines 2016[3] advises that if a twin dies suddenly and unexpectedly that the surviving twin should be admitted as an inpatient paediatric unit for close monitoring for at least 24 hours.
- More sensitive communication of post-mortem results to family (3 cases)

- E.g. Ensuring the CDR team is notified immediately when post-mortem results are available so that they can support the family.

Other themes included communication between healthcare professionals (3 cases) and issues with IT systems, for example, difficulty sharing results/information across different services, trusts or agencies (6 cases). Learning included the importance of good communication with families and patients (4 cases) such as involving young people in their care planning and the use of interpreters. The importance of timely referral to palliative care services was also highlighted (3 cases).

One of the deaths highlighted the confusion regarding where West Midland Ambulance Service should take teenagers with severe trauma with older teenagers being diverted from the regional trauma centre Birmingham Children's Hospital purely due to age. Birmingham Children's Hospital only take up to 16 years, with Heartlands Hospital (UHB) and City Hospital accepting any age and Queen Elizabeth Hospital only accepting over 16 years. The Integrated Care Board will be working with hospitals and West Midlands Ambulance Service to ensure that young people with critical injuries are taken to the Emergency Department (ED) best equipped to deal with their clinical presentation rather than selecting the ED based on age alone.

One death identified lessons to be learnt regarding management of developmental delay. As a result a training package regarding developmental delay, arrest and regression was produced by the CDRT and rolled out to primary care staff.

5.6 Learning from what went well

As well as learning from what went wrong, it is also and important role of CDOP to review and highlight positive factors in provision and examples of best practice. 54/175 deaths reviewed had examples of positive service provision or best practice. Examples included members of staff coming to work on their days off to help, good joint working with hospital teams and palliative care, support from primary care providers such as GPs and Health Visitors, and support from school for families both before and after children had died.

5.7 Learning Disability Mortality Review (LeDeR)

The Birmingham and Solihull (BSOL) Child Death Overview Panel (CDOP) reports deaths of children with a learning disability to LeDeR via the online referral form and provides core information about the child. Additional CDOP documentation containing details regarding the circumstances leading to death is submitted following the comprehensive review at CDOP. This analysis form is then uploaded to the LeDeR database. The analysis form lists any common contributory factors leading to deaths:

- Factors that may have contributed to the vulnerability, ill health or death of the child
- Modifiable factors that may reduce the risk of future child deaths
- Learning points and issues identified in the review
- Recommendations and actions that may inform and support local, regional or national learning

This information is submitted to the LeDeR platform and themes and trends are collated for the city.

The LeDeR representative has recently started attending CDOP at which the death is reviewed.

During the CDOP meeting, the LeDeR representative may offer advice and expertise about learning disabilities (if appropriate) and ensure that the CDOP provides sufficient core data to support the LeDeR programme.

Total number of deaths in 2021-22 were 161 (Note these refer to deaths during 2021-22, rather than completed reviews, as in figure 2).

Number of LeDeR referrals was 9 (5.5%)

7 of these deaths were expected 2 were sudden and unexplained (SUDIC).

Reviews completed so far are 5 (4 are still waiting to be reviewed by CDOP)

Age range		**Gender**	
8 - 10	3	Male – 33%	
11 - 13	5	Female – 66%	
14 - 17	1		

Ethnicity	
White British	4
Black or Black British African	1
Asian/Asian British – Pakistani	3
Black or Black British - Caribbean	1

Classification of death at CDOP	
Chromosomal, genetic or congenital anomaly.	4
Infection	1
Cases not yet reviewed at CDOP	4

Modifiable factors	
Modifiable factors	1
No modifiable factors	4
Not yet reviewed at CDOP	4

Modifiable factors Modifiable are defined as 'those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced'

Of the 9 cases that have been referred 6 had appropriate advanced care plans (ACP) in place. Themes throughout the cases are good working relationships and good communication between all teams involved with the child and family. Including a child being able to stay at home for end of life care as the cardiac consultant and nurse supported complex medications usually only used in

hospital to mange difficult symptoms and ensure that the child was able to remain at home as per the families wishes.

Covid featured in the cases and in one case the child hadn't been seen face to face in clinic due to the pandemic for over 12 months.

6.0 Progress towards targets

In our last annual report we stated the following targets for this year as:

1. To address the backlog of deaths needing review at CDOP

   This has been addressed somewhat (see section 5.0) but it is expected there will be the need for some further catch up during 2021-22.

2. To support Birmingham Women's and Children's Hospital (BWCH) to implement effective Child Death Review Meetings

   Significant support has been given to assist implementation. Some joint CDR meetings have occurred, and the benefit has been acknowledged. BCWH have made a business case for a coordinator to assist in implementation. BCWH have committed that all deaths from 1 April 2022 are to be subject to CDR meetings.

3. To review the provision of SUDIC services for Solihull, given the retirement of the current consultant providing 24/7 cover.

   This has been addressed by combining the rota for Birmingham and Solihull. An additional Acute Paediatrician from UHB has joined the SUDIC rota to help support this.

4. To disseminate learning from deaths promptly by the use of tools such as 7 minute briefings

   7 minute briefings have been produced for CDOP, SUDIC, Safer sleep, CONI and Bereavement support. A 10 minute training video has been produced regarding learning from a case of Arrested Development.

5. To continue to support the Infant Mortality Task Force

   The CDRT and in particular Dr Garstang (Designated Doctor for Child Death) works closely with the newly established Birmingham Infant Mortality Task Force.

7.0 Recommendations for 2022-23

1. To ensure BCH implement joint CDRM for all deaths
2. To continue to catch up on cases delayed due to the Covid-19 pandemic
3. Ensure that all lessons learnt from the whole death review process are captured on eCDOP Analysis Form.
4. Ensure all CDRM are multi-agency and external professionals invited
5. To provide Joint Agency Response (JAR) training for health, police and coroners staff
6. Closer working with public health. Completing thematic analysis of deaths:
   a. Consanguinity
   b. Deaths compared to social deprivation
   c. Perinatal deaths and maternal health

8.0 Conclusion

The year 2021-22 has been busy as there were a backlog of cases due to the pandemic. The quality of information has improved significantly, which has led to better recognition of modifiable factors and more learning arising from deaths. However, this rich information also in turn has associated challenges as CDOP meetings and the associated preparation takes much more time. We aim to continue working closely with the Birmingham Infant Mortality Task Force and hope to contribute to further themed CDOP meetings over the next year.

References

1. HM Government. Working Together to Safeguard Children. London: Department for Education, 2018
2. HM Government. Child Death Review Statutory and Operational Guidance (England). In: Department for Health and Social Care, ed. London, 2018.
3. Sudden unexpected death in infancy and childhood, 2nd Edition, November 2016, The Baroness Helena Kennedy QC
4. National Perinatal Epidemiology Unit. Perinatal Mortality Review Tool / Parent Engagement Tools 2020 [Available from: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials.
5. Healthcare Safety Investigation Branch, Maternity Investigations. https://www.hsib.org.uk.