Child Death Overview Panel

Annual Report 2011-12

1.0 Introduction

The aim of this report is to summarise the work of the Cambridgeshire and Peterborough Child Death Overview Panel during 2011/12.

Fortunately it is rare for children to die in this country and therefore the number of child deaths in any particular age range within a local area is very small in number. However, this means that generalisations are rarely appropriate and for lessons to be learned data needs to be collected and reported on nationally and over a number of years.

Current methods of data collection mean that accurate regional and national comparisons are not readily available, but where relevant, it is included in this report.

2.0 Background

Child Death Overview Panels (CDOP) were established in April 2008 as a new statutory requirement as set out in Chapter 7 of 'Working Together to Safeguard Children' 2006. Their primary function (as required by the Local Safeguarding Boards Regulations 2006) is to undertake a comprehensive and multiagency review of all deaths of children normally resident in Peterborough and Cambridgeshire aged under 18 years of age, in order to understand better how and why they die and to use the findings to take action to prevent other deaths and to improve the health, wellbeing and safety of children and young people.

The CDOP has specific functions laid down in statutory guidance, including:

- Reviewing the available information on all deaths of children up to 18 years (including deaths of infants aged less than 28 days) to determine whether the death was preventable.
- Collecting, collating and reporting on an agreed national data set for each child who has died.
- Meeting regularly to review and evaluate the routinely collected data on the deaths of all children, and thereby identifying lessons to be learnt or issues of concern.
- Monitoring the response of professionals to an unexpected death of a child
- Referring to the Chair of the local Safeguarding Children Board (LSCB) any deaths where the panel considers there may be grounds to consider a serious case review.
- Monitoring the support services offered to bereaved families.
- Identifying any public health issues and considering, with the Director of Public Health, how best to address these and their implications for the provision of both services and training.

3.0 The Process

Child deaths are reviewed through two interrelated processes; a paper based review of all deaths of children under the age of 18 years and a rapid response service which looks in greater detail at the deaths of children who die unexpectedly.

During 11/12, the CDOP has met four times to review anonymous information about child deaths. The panel is chaired by the LSCB chair and has members from all relevant agencies (see appendix 2 for list of members).

A separate panel which reviews neonatal deaths (babies aged under 28 days who have not been discharged from hospital) met twice. Neonatal deaths are reviewed separately because the reasons such young babies die is almost always health related and the added value of attendance by agencies such as the police and children's social care services is very limited. This meeting, therefore, is multi disciplinary rather than multi agency (see appendix 2 for members) and reports any relevant issues to the main CDOP.

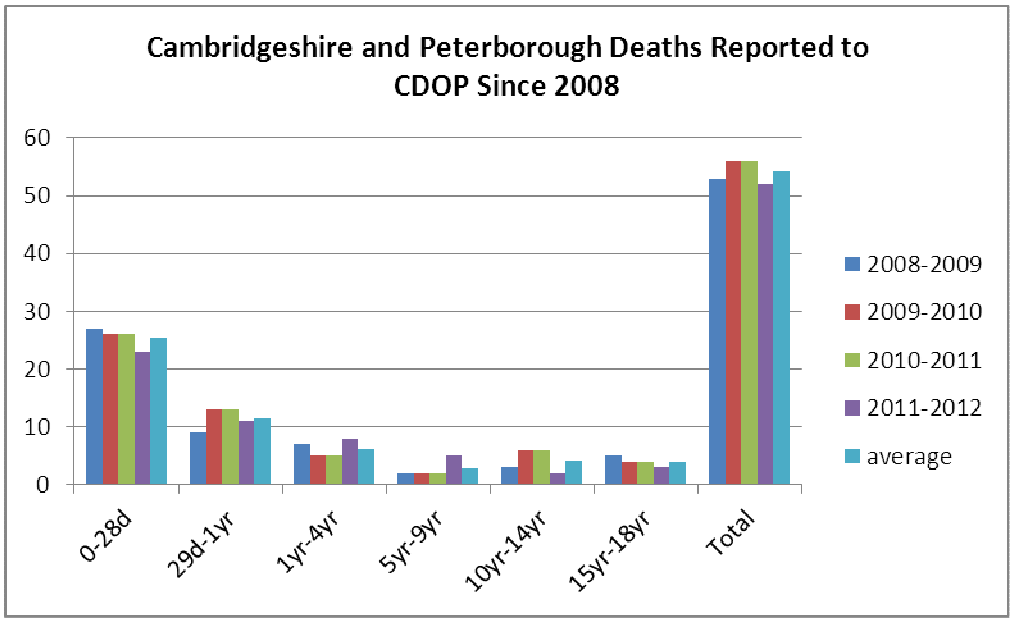
In September 2011, the administration of the CDOP process was amalgamated with the administration of the Rapid Response Service and is hosted within the primary care trust, whilst being funded jointly by Peterborough and Cambridgeshire Children's Services Departments. The joining of these related processes has proved to be a more efficient way of working.

4.0 Overview of 2011/12

Reported Child deaths

Over the last year, fifty two children have died across Cambridgeshire and Peterborough, thirty two in Cambridgeshire (which is slightly less than the previous two years which were 38 and 39 respectively) and twenty in Peterborough (the same number as last year). Of those children who died, the majority, nearly 70%, were babies under a year old, with many dying in the first few days and weeks of life, having never left hospital.

The chart below demonstrates a similar pattern since data was first collected. Figures for the two local areas are shown at appendix 1a and also show a similar pattern.

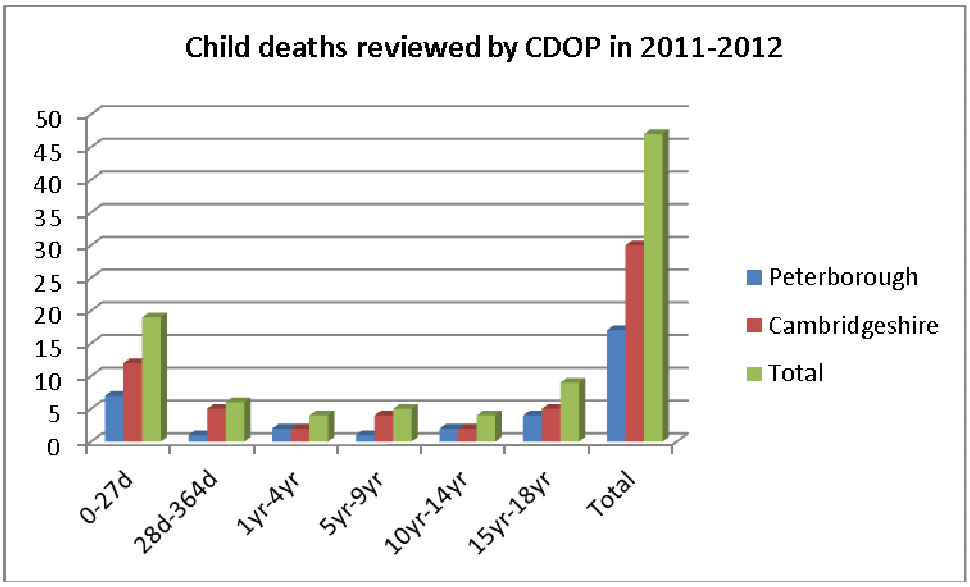


Deaths reviewed

Not all the children who died this year have been reviewed by the CDOP panel, which this year reviewed the deaths of forty seven children (some of whom will have died the previous year). There is often a gap of several months between a death and that death being reviewed whilst all relevant information is gathered. Cases are generally not reviewed until after the inquest has taken place.

Of the deaths which were reviewed, the pattern of deaths was similar to that noted above with the majority being babies and infants under a year old. The next largest group was teenagers aged 15- 18 years old, with nine young people dying, four in Peterborough and five in Cambridgeshire. Although this figure is similar to previous years in Cambridgeshire, it represents a significant change for Peterborough where there had been no teenage deaths reviewed in the previous two years (see appendix 1b). The reasons for the deaths were varied and are commented on below in paragraph 7. The gender and ethnicity of those children whose deaths were reviewed both this year, and since figures were collected, are provided in appendix 1f & g. As in previous years, more boys than girls died. The figures with regard to ethnicity are considered too small to enable conclusions to be drawn.

The most common cause of death was as a result of a chromosomal or genetic condition (see appendix 1e)



Modifiable factors

One of the purposes of the child death overview panel is to identify any 'modifiable' factors for each child that dies. That is, any factor which, with hindsight, might have prevented that death and might prevent future deaths. There were five child deaths last year where a modifiable factor was identified (see appendix 1d for detail). Each case was quite different, so it is not possible to make any general statements. However, regional figures suggest that of all child deaths, the one cause which is both prevalent and modifiable is Sudden Unexpected Death in Infancy (SUDI). For this reason, it is proposed to that some development work on safe sleeping advice and assessments, focussing on vulnerable families, is included in the current business plan.

Serious Case Reviews

There were no cases identified by the panel this year, where a serious case review might be considered. One infant death was referred to the serious case review subcommittee in Peterborough for further investigation because of a number of apparent risk factors. However, following a multi agency review, the subcommittee concluded that there were no modifiable factors and the death could not have been prevented.

5.0 Unexpected Deaths/Rapid Response Service

Cambridgeshire

There have been 6 unexpected child deaths and 4 joint home visits with police and health. One child died out of area and for the second who died after drowning it was not appropriate to undertake a joint visit.

Peterborough

There have been 7 unexpected deaths but one infant had major cardiac abnormality and was well known to health so a home visit was not undertaken. 2 children died as a consequence of trauma so joint visits were not done.1 child died out of area after drowning. The remaining 4 all had joint visits.

Half of the home visits were done between 9-5pm, 3 were over the weekend/bank holidays and 1 was undertaken late evening.

All unexpected deaths have involved a discussion between Police and the Health professional on the rota except for one child who died in a traffic accident out of area.

Case discussions

These continue to be chaired by the designated doctor for childhood deaths. Initial face to face case discussions have been convened usually within 5 days of death when it was clear that there were a number of agencies involved with the family or there were concerns raised. For others it was more appropriate to have a telephone discussion with relevant professionals-usually the GP and health visitor.

Most have final case discussions when the post mortem results are available unless there is a serious case review undertaken or there are criminal proceedings underway. For one child this was not done because the hospital was very involved with the family and they were from the Lakenheath airbase but the designated doctor had already discussed the child with the relevant health professionals.

An audit was undertaken with regard to the case discussions at the end of October 2011in order to streamline the process.

6.0 Infant deaths (including regional comparisons)

Regional figures for the East of England mirror those of Peterborough and Cambridgeshire, with two thirds of all child deaths in 2010 (latest available figures) being infants aged under one year, with the majority occurring within the first 28 days of life. The infant death rates for both Peterborough and Cambridgeshire at 4.3 and 3.9 deaths per 1000 live births respectively are slightly lower than the rate for England (4.6) but higher than the rates of some other countries, for example Japan at 2.4 per 1000 and Iceland at 1.8 per 1000.

The majority of infant deaths are due to events occurring in pregnancy, although regionally, 12% of infant deaths were attributed to Sudden Unexpected Death in Infancy (SUDI). Three SUDIs were reviewed last year across Cambridgeshire and Peterborough.

A recent report by Sands (Stillbirth & neonatal death charity) entitled ‘Preventing Babies’ Deaths’ (Jan 2012), points out that whilst nationally the number of babies

who die in the first 28 days has fallen by 20% over the last decade, one in 300 babies still dies in the first four weeks of life and around a quarter of these are born at term.

There was only one infant death reviewed this year where a modifiable factor was identified. This was a two month old baby where severe jaundice went undetected following discharge from hospital, leading to severe brain damage and subsequent death. A recommendation from the serious incident investigation was a more widespread use of bilirubin metres, which measures levels of jaundice. This has now been implemented.

7.0 Deaths of Children & Young People (1-17 years)

Deaths of children and young people aged 1-17 years are rare. Compared to the England average of 16.5 deaths per 100,000, the death rate for Cambridgeshire is slightly lower at 15.9 whereas the rate for Peterborough, at 25.8, is in the worst quartile. This figure for Peterborough reflects the data for both children's overall health and wellbeing and for child poverty.

Amongst this age group, both regionally and locally, the death rates are highest in young adults. However, the reasons for the deaths of those young people who died locally were varied, with the numbers too few to make generalisations. Of the nine young people whose deaths were reviewed, three had cancer, three were involved in accidents, two were suicides.

Of the five deaths reviewed this year where modifiable factors were identified, four were teenagers. However, they related to very different issues from not wearing a seat belt in a car to the ambulance service needing to respond more proactively to an irregular EEG.

8.0 Support to bereaved families

It is understandably difficult to find an appropriate way to seek the views of families about the support they receive after their child has died. However, every parent is informed when their child's death is about to be reviewed and following feedback from a small number of families, this year we have rewritten the letter we send out and created a dedicated CDOP logo instead of using the two LSCB logos, which distressed some parents with their links to child protection.

Parents have also told us that the standard DCSF leaflet focuses too much on unexpected deaths, which form only a minority of child deaths. In the coming year, it is proposed to introduce an alternative leaflet which focuses on expected deaths.

9.0 Plans for 12/13

The 12/13 business plan is attached as appendix 3. The priority actions are summarised below:

- Agree and establish funding arrangements for the rapid response service from April 2013
- Review the support available to bereaved parents across Peterborough & Cambridgeshire and identify both gaps and good practice.
- Introduce appropriate information for parents where their child's death was expected
- Develop a public awareness campaign around safe sleeping, focussing on vulnerable families.
- Clarify the links between the CDOP, public health and the Health & Wellbeing Boards to ensure that information about child deaths is collated with information about accidents.

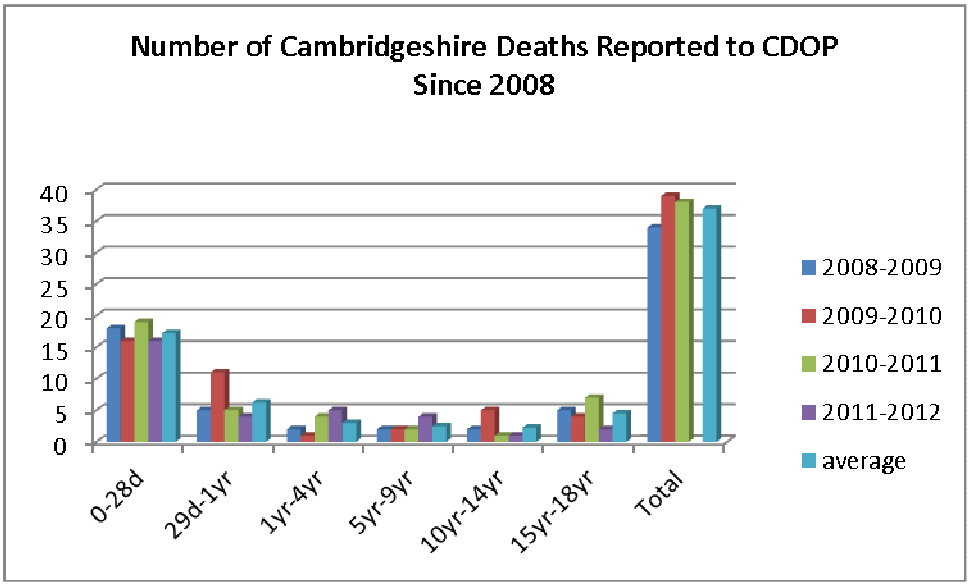
F.Schofield

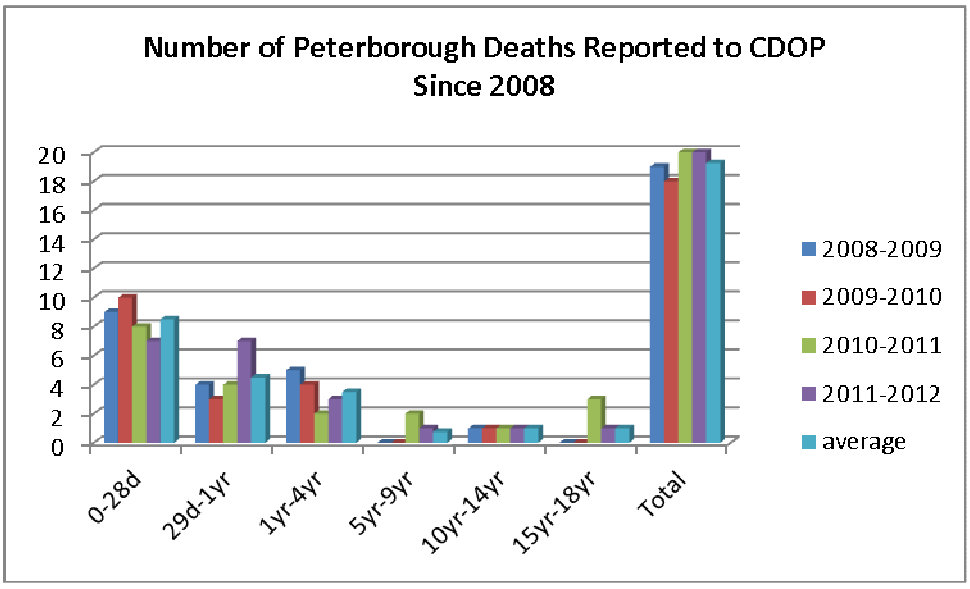
CDOP Chair

June 2012

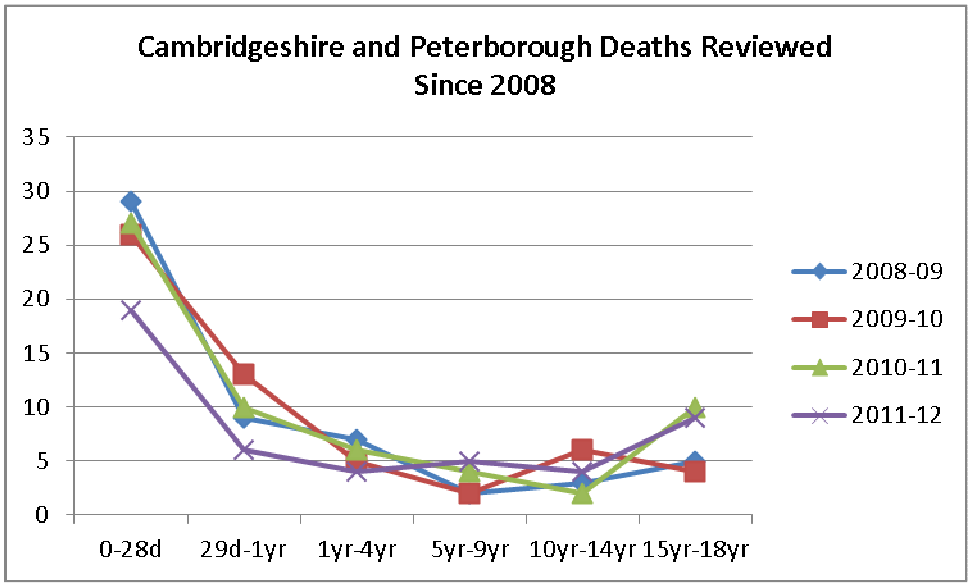
Appendix 1

a) Reported deaths by Council area

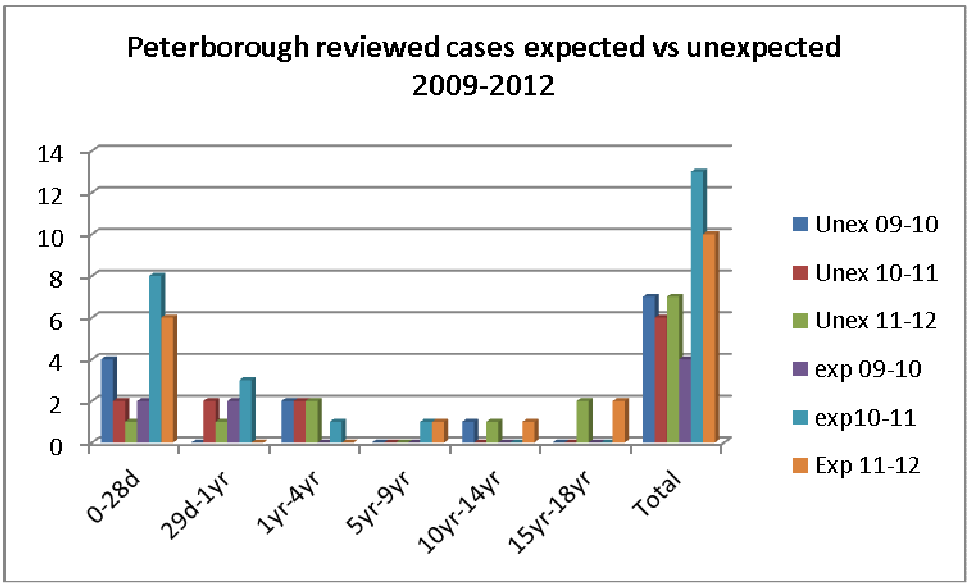


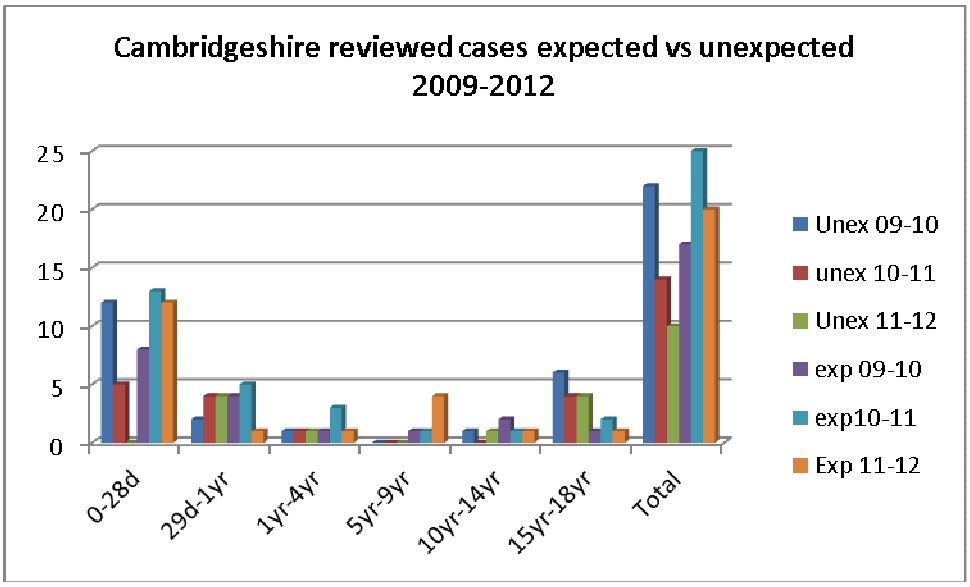


b) Reviewed Deaths since CDOP established

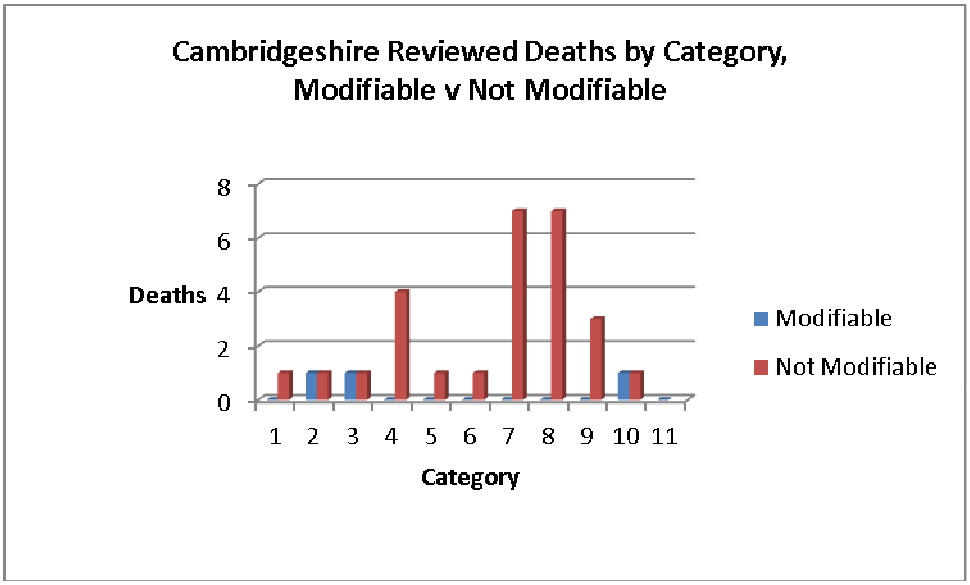


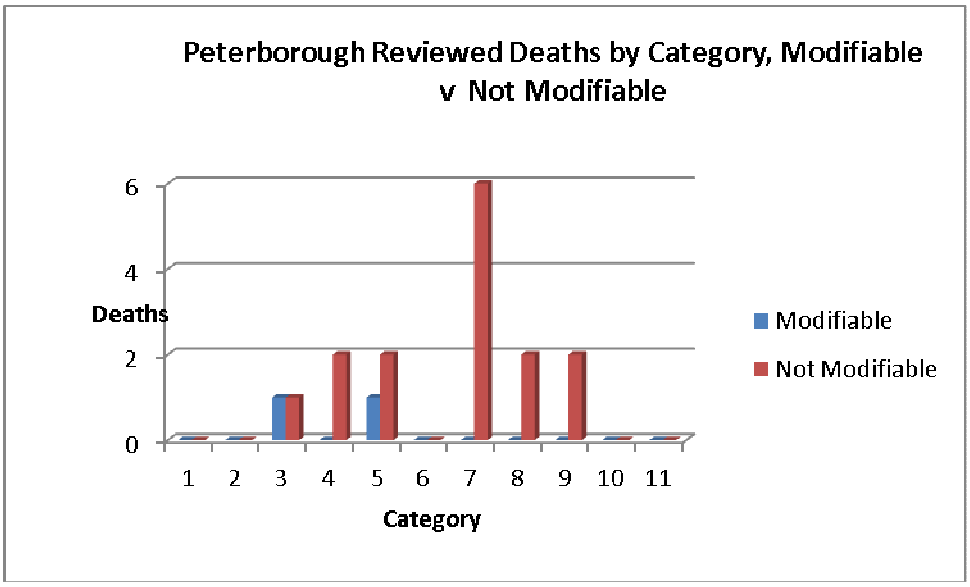
c) Unexpected & Expected Deaths by council area





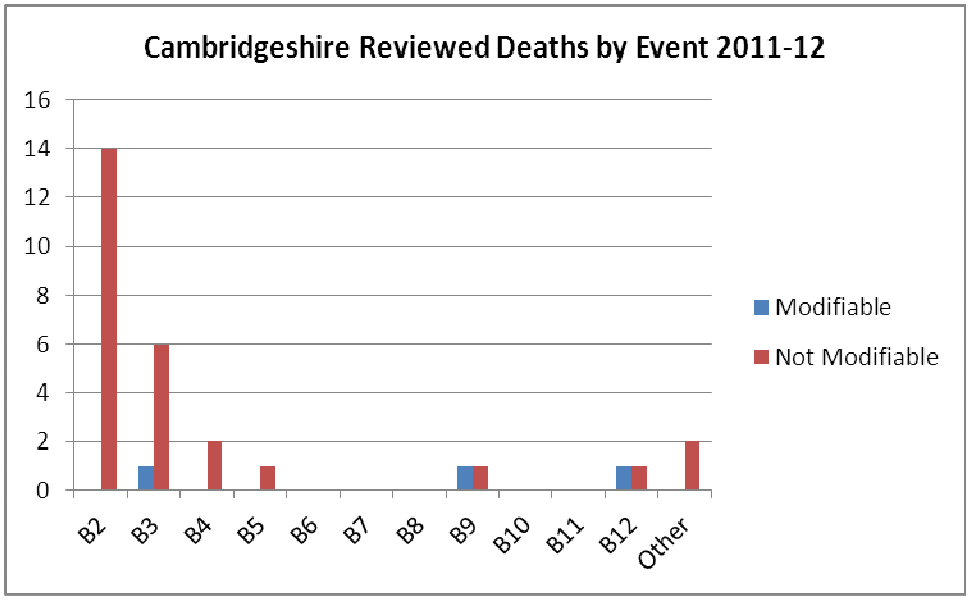
d) Child Deaths by Category

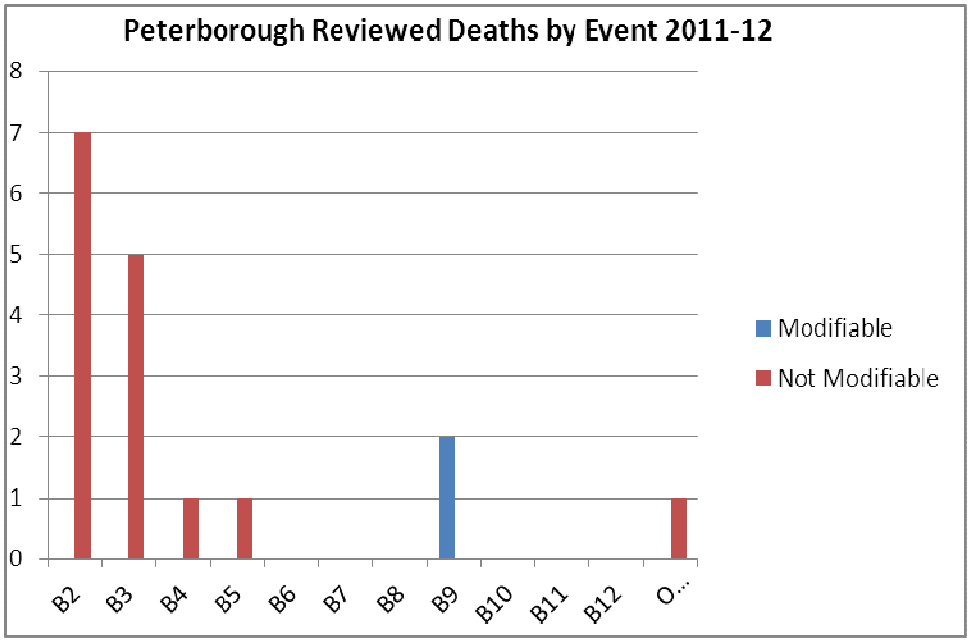




Deliberately inflicted injury, abuse or neglect (category 1)
Suicide or deliberate self-inflicted harm (category 2)
Trauma and other external factors (category 3)
Malignancy (category 4)
Acute medical or surgical condition (category 5)
Chronic medical condition (category 6)
Chromosomal, genetic and congenital anomalies (category 7)
Perinatal/neonatal event (category 8)
Infection (category 9)
Sudden unexpected, unexplained death (category 10)
Unknown category 11

e) Child Deaths by Event





Neonatal death (B2)
Known life limiting condition (B3)
Sudden unexpected death in infancy (B4)
Road traffic accident/collision (B5)
Drowning (B6)
Fire and burns (B7)
Poisoning (B8)
Other non-intentional injury/accident/trauma (B9)
Substance misuse (B10)
Apparent homicide (B11)
Apparent suicide (B12)
Other

f) Child Deaths reviewed by Ethnicity

Cambridgeshire reviewed deaths between 2008-2012 by ethnicity

	White	Mixed	Asian	Black	Other	Not Recorded
0-28d	45	2	4	2	0	2
29d-1yr	20	2	0	0	0	0
1yr-4yr	8	1	1	1	0	0
5yr-9yr	8	0	0	0	0	0
10yr-14yr	6	0	0	0	0	0
15yr-18yr	15	1	0	0	0	0
Total	102	6	5	3	0	2

Peterborough reviewed deaths between 2008 - 2012 by ethnicity

	White	Mixed	Asian	Black	Other	Not Recorded
0-28d	15	3	7	3	1	1
29d-1yr	7	1	2	0	0	0
1yr-4yr	3	1	5	0	1	0
5yr-9yr	1	0	1	0	0	1
10yr-14yr	1	0	1	0	0	0
15yr-18yr	5	0	0	0	0	0
Total	32	5	16	3	2	2

g) Child Deaths reviewed by Gender

Cambridgeshire reviewed deaths 2011-12 by gender

	Modifiable factors		No modifiable factors		Total
Male	2		18		20
Female	1		9		10

Peterborough reviewed deaths 2011-12 by gender

	Modifiable factors		No modifiable factors		Total
Male	2		9		11
Female	0		6		6

Cambridgeshire reviewed deaths 2009-12 by gender

	Modifiable factors		No modifiable factors		Total
Male	11		51		62
Female	6		39		45

Peterborough reviewed deaths 2009-12 by gender

	Modifiable factors		No modifiable factors		Total
Male	6		22		28
Female	2		18		20

Appendix 2

Membership of Child Death Overview Panel

Agency / Member	Deputy
Felicity Schofield, Independent Chair	Elaine Lewis, Deputy Chair
Dr Elaine Lewis – Consultant Paediatrician, Cambridgeshire Community Services / Designated Doctor for Childhood Death, NHSC/P	
Dr Fay Haffenden - Consultant in Public Health, NHS Cambridgeshire	
Dr Lucy Preston - Consultant Paediatrician, Emergency Department, CUHFT	Peter Heinz
Dr Peter Heinz, Consultant Paediatrician, Emergency Dept, CUHFT	Lucy Preston
Paula South, Designated Nurse Safeguarding CYP, NHSC/P	
Neil Spike, East of England Ambulance Service (Cambs)	Phill Parr, East of England Ambulance Service (Peterborough)
Sam Hunt, Assistant General Manager, Peterborough & Stamford Hospitals NHS Foundation Trust	Gill Giaffreda, Named Nurse for Safeguarding, Peterborough & Stamford Hospitals NHS Foundation Trust
Dr Emilia Wawrzkowicz, Consultant Paediatrician Cambridgeshire and Peterborough Foundation Trust / Designated Doctor Safeguarding CYP, NHSC/P	
Julie Bunn, Health Visiting Team Manager, CCS	
Lesley Edmonds – Coroner's Officer	Katie Roberts
Katie Roberts - Coroner's Officer	Lesley Edmonds
Judy Jones – LSCB Business Manager	Josie Collier
Josie Collier – Business Manager – Cambs LSCB	Judy Jones

John Scott - Interim Service Manager for Integrated Safeguarding, Peterborough City Council	
Lynda Davies, Service Manager Safeguarding / LADO Unit, Cambridgeshire County Council	
Simon Megicks – Head of Public Protection, Cambridge constabulary	DCI Melanie Dales

Appendix 3

CDOP Business Plan 2012-13

	Objective	Lead	Action and timescale	Outcome
1.	Establish & review bereavement support for families	EL/ Deputy Designated Nurse	Describe the type & amount of support available across the County & identify gaps, good practice and variances. Dec 2012	Better support for bereaved families as measured by feedback
2.	Introduce separate information for parents where a child's death is expected	FS	Identify & distribute information September 2012	More sensitive communication with and involvement of families where a child's death was expected
3.	Link CDOP findings with findings from accidents	FS/FH	Establish links with revised Children's Trust arrangements & Health & Wellbeing Boards in order to join up information gathered from child accidents and child deaths. Dec 2012	More informed commissioning for accident prevention work
4.	Establish future arrangements for Rapid Response Service	EL/EW/JH	Agree future commissioning arrangements for Rapid Response Service from 1/4/13 January 2013	Future of Rapid Response service established post March 2013
5.	Respond to recommendation from TW	PPP/FS/EW/AA	Rewrite CDOP local procedures to address shortcomings identified by the	1. CDOP and Child protection procedures more closely aligned 2. Better protection of siblings when

	SCR		TW SCR June 2012	a child dies and abuse is suspected.
6.	Run a public awareness campaign around safe sleeping	Deputy Designated Nurse / Health Safeguarding Group	Jan 2013	Reduction in SUDIs
7.	Ensure both LSCBs are kept informed of the work of CDOP	FS	Annual report. July 2012	Lessons learned from CDOP shared with safeguarding partners