Child Death Overview Panel
Annual Report 2012 – 13
(Summary Version)

Felicity Schofield
CDOP Chair

1.0 Introduction

The aim of this report is to summarise the work of the Cambridgeshire and Peterborough Child Death Overview Panel during 2012/13.

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 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.

This version of the annual report excludes any reference to data or action taken which might lead to the identification of an individual child. A fuller, confidential version of the annual report is available for relevant professionals.

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.

'Working Together to Safeguard Children' has been revised and was reissued in March 2013. However, the responsibilities of the Child Death Review Process remain unchanged.

3.0 The Principles

The principles underlying the overview of all child deaths are:

1. Every child's death is a tragedy
2. Learning lessons
3. Joint agency working
4. Positive action to safeguard and promote the welfare of children

4.0 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 12/13, the CDOP has met four times to review anonymous information about child deaths. The panel is chaired by the Cambridgeshire LSCB chair and has members from all relevant agencies (see appendix 2a for list of members).
A separate panel which reviews neonatal deaths (babies aged under the age of 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 2b for members) and reports any relevant issues to the main CDOP.

The administration of the CDOP process is 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. This process transferred into the newly established Cambridgeshire and Peterborough clinical commissioning group (CCG) on 1 April 2013.

5.0 The National picture

The number of children who die has reduced significantly since 1985 but 5,000 children a year still die and the United Kingdom still has one of the highest childhood death rates in Europe. For example, if we had the same childhood death rate as Sweden, 2,000 fewer children would die each year. The main cause of death continues to be congenital and perinatal problems in babies under the age of twelve months.

To date, it is still not possible to quantify the difference made by the introduction of a process which systematically reviews all childhood deaths. This is because the numbers of deaths reviewed by individual CDOPs are too small and there is a lack of robust data collection and analysis at a national level.

Nationally, about 20% of deaths are considered by CDOPs to be preventable, which is a similar figure to other countries with similar processes. Two thirds of deaths which are either unexplained or are as a result of external trauma are deemed to be preventable. Preventable deaths are those where modifiable factors have been identified which could have contributed to the death.

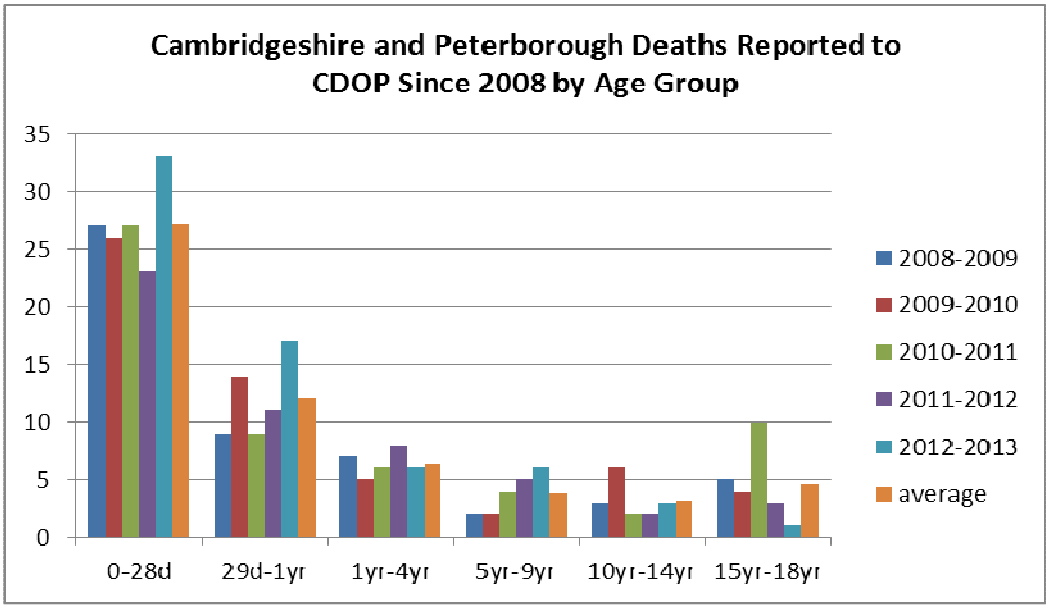
6.0 Overview of 2013/14

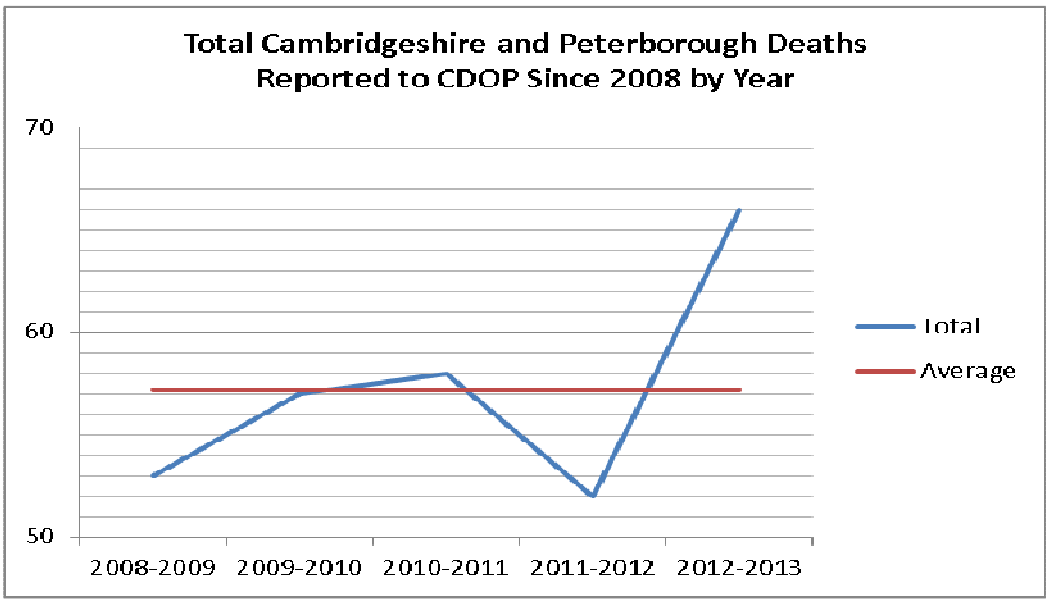
Reported Child deaths

Over the last year, sixty six children have died across Cambridgeshire and Peterborough which is considerably more than the previous two years, which were 52 and 58 respectively, and is the highest figure since the CDOP process began in 2008. However, it is not possible to comment further on this higher figure until those deaths have been reviewed over the coming year.

This pattern is reflected in both local authority areas. In Cambridgeshire forty one children died compared to 32 and 38 in the previous two years. The picture is similar for Peterborough where 25 children died compared to twenty in both of the previous two years.

Of those children who died, the majority, nearly 80%, 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. It can be seen that the age range where the number of deaths has increased in babies less than a year old.





Deaths reviewed

Not all the children who died this year have been reviewed by the CDOP panel, which this year reviewed the deaths of fifty two children (some of whom will have died the previous year or even earlier). 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 an inquest has taken place or once a serious case review has been completed.

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 children aged between one and four years of age, with ten children being reviewed, five from Peterborough and five from Cambridgeshire. The reasons for the deaths were varied with no identifiable pattern, some being as a result of life limiting conditions, others through childhood cancer or tragic accidents.

There has been a drop in the number of deaths for young people aged 15 – 18 compared to last year. However, the numbers are very small and it would be inappropriate to comment on trends on the basis of a change in a single year's figures.

With regard to gender, as with previous years, considerably more boys than girls died and were reviewed (36 and 16 respectively). The numbers with regard to ethnicity are considered too small to enable conclusions to be drawn.
The most common causes of death were neonatal deaths and as a result of a chromosomal or genetic condition.

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 ten child deaths last year where a modifiable factor was identified. The numbers within different categories are too small to make generalisations. However, three babies died as a result Sudden Unexpected Death in Infancy (SUDI). Regional figures suggest that of all child deaths, the one cause which is both prevalent and modifiable is SUDI.

Serious Case Reviews

There were two serious case reviews undertaken over the last year, one in Peterborough and one in Cambridgeshire, although this has still to be reviewed by the CDOP. The Peterborough case review was initiated following the murder of a five year old boy in March 2011 and published in May 2012 at the conclusion of the criminal trial.

Some of the learning from the Serious Case Review was consistent with the findings reached by Ofsted in its inspections of safeguarding in Peterborough in March 2010 and August 2011. Therefore work was already underway to address many of the recommendations arising from the review. Other recommendations included:

- A need for better systems for notifying schools about incidents of domestic violence.
- Better planning for children leaving hospital where there is any suspicion of abuse
- Raised awareness for practitioners and managers about the risk to children arising from living with domestic abuse.
- Raised awareness for practitioners about the importance of involving male partners in assessments of risk, especially when there is a known history of domestic abuse.

All of these actions have now been implemented.

The Cambridgeshire serious case review has only recently been completed and will be reviewed by the CDOP shortly. It involved the unexplained death of a young baby where alcohol was a significant factor. The review will be published later in the year and the findings are being used to inform the work of the safe sleeping task and finish group.

7.0 Unexpected Deaths/Rapid Response Service (appendix 1c)

Arrangements for home visits

This last year has seen more change to the personnel on the rota, both health and police. At the start of the year, seven health members were on the rota but by May

this had fallen to three due to a combination of sickness, retirement and change of post. There were also uncertainties about the future funding arrangements but fortunately it has now been confirmed that this will be in place for the next financial year. Fortunately, the health team are now back to full strength and includes two consultant paediatricians and five senior safeguarding nurses.

The police team had increased to 10 on the rota at the beginning of the year. However since December 2012, as the on call arrangements for senior detectives have altered, this has meant that overnight (8pm – 8am) there is a generic on call system which comprises up to 30 senior officers. All the officers have been trained, but their experience with child protection will be variable. During the day, the specialist rapid response officers are available and continue to undertake home visits with health colleagues.

We have yet to see the effect of this change in the police rota but there are arrangements currently for the Detective Inspector leading in child abuse to be the key contact during the day for an unexpected chid death when possible and to be the officer most likely to undertake the visit.

There are regular meetings of the rapid response team including the police so that there are opportunities for joint learning and training needs can be identified.

Home visits

From April 2012-March to 2013 there were 13 unexpected deaths in childhood in Cambridgeshire and Peterborough, excluding road traffic accidents. Of these, 12 had joint home visits; for one young person it was not appropriate but an initial information sharing meeting was held quickly and involved representatives of all agencies who knew the young person and family. In comparison there were 10 unexpected deaths in Cambridgeshire and Peterborough in 2010-2011 resulting in 7 home visits and 8 in 2011-2012 with 7 home visits.

Sadly of the unexpected deaths in 2012-13, 6 involved very young infants and all had some degree of unsafe sleeping arrangements, confirming the need for the proposed LSCB campaign on safe sleeping.

All visits led to important additional information being obtained either from additional history or from observations within the home. All visits were in day time hours, but some were at weekends or bank holidays. If parents were too distressed to return home, arrangements were made for them to be seen at a relatives' or friends home.

Any learning from the joint visits is discussed by the CDOP when the child death is reviewed. Some of the deaths referred to above have still to be reviewed; however, as stated elsewhere in this report, the one area where work could be done to reduce unexpected child death is that of safe sleeping.

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, parents are informed when their child's death is about to be reviewed and are encouraged to contact the Chair of the panel. In response, she has spoken to or had contact with a number of bereaved families following the panel meeting. In addition, and following feedback from a small number of families, we have rewritten the leaflet which is sent to families shortly before the CDOP panel meets.

The children's hospice is also asked to contribute to CDOP meetings where relevant and have provided valuable feedback about the rapid response process on behalf of a family whose son died last year.

9.0 Plans for 13/14

The 13/14 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 2014
- Investigate further the rise in the numbers of child deaths
- Review the support available to bereaved parents across Peterborough & Cambridgeshire and identify both gaps and good practice.
- Implement the recommendations of the safe sleeping task and finish group.

- 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 2013

Appendix 1

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	
Emma de Zoete – Consultant in Public Health Medicine Children & Health Inequalities	
Dr Lucy Preston - Consultant Paediatrician, Emergency Department, CUHFT	Peter Heinz
Dr Peter Heinz, Consultant Paediatrician, Emergency Dept, CUHFT	Lucy Preston
xxxxxx, East of England Ambulance Service (Cambs)	Phill Parr
Sam Hunt, Lead Nurse for Children and Neonates. Named Nurse for Safeguarding Children Peterborough & Stamford Hospitals NHS Foundation Trust	Gill Giaffreda, Specialist Nurse for Safeguarding
Dr Emilia Wawrzkowicz, Consultant Paediatrician Cambridgeshire and Peterborough Foundation Trust / Designated Doctor Safeguarding CYP, NHSC/P	
Fleur Seekins, Health Visiting Team Manager, CCS	
David Hemming – HM Coroner Peterborough	Katie Roberts
Katie Roberts - Coroner's Officer	Lesley Edmonds
Jon Chapman – LSCB Business Manager	
Josie Collier – Business Manager – Cambs LSCB	
Peter Knowles - Interim Service Manager for Integrated Safeguarding, Peterborough City Council	
Janet Farr - Service Manager Safeguarding / LADO Unit, Cambridgeshire County Council	

DS Gary Ridgeway - Head of public protection Cambridgeshire Constabulary	
Ben Brown – Deputy Designated Nurse Safeguarding Children, Cambridgeshire & Peterborough	
Ally Salter, Family Support Practitioner, EACH	

Membership of Neonatal 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	
Janet Driver, General Manager Women's Services, Hinchingbrooke NHS Trust	
Dr Helen O'Reilly, Neonatal Consultant, Addenbrookes	
Sam Hunt, Lead Nurse for Children and Neonates. Named Nurse for Safeguarding Children Peterborough & Stamford Hospitals NHS Foundation Trust	
Susan Woolley, Maternity Services Risk Manager, Addenbrookes	
Gusztav Belzteki, Consultant neonatologist, Addenbrookes	

Appendix 2 - CDOP Business Plan 2013/2014

	Objective	Lead	Action and timescale	Outcome	Progress
1.	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 2013 (carried forward from 12/13)	Better support for bereaved families as measured by feedback	
2.	Implement recommendations from 'safe sleeping' task & finish group	FS	Identify & distribute information December 2013	Improve parental awareness of safe sleeping Reduce the numbers of SUDIs	
3.	Link CDOP findings with findings from accidents	EdeZ	Establish links with revised Children's Trust arrangements & Health & Wellbeing Boards in order to join up information gathered from child accidents and child deaths. September 2013	More informed commissioning for accident prevention work	
4.	Establish future arrangements for Rapid Response Service	EL/EW/BB	Agree future commissioning arrangements for Rapid Response Service from 1/4/14 January 2014	Future of Rapid Response service established post March 2014	
5.	Clarify funding arrangements for CDOP admin post	FS	Service level agreement to be drawn up between the CCG, Peterborough & Cambs Children's services & Cambs LSCB	Clarity about funding arrangements	
6.	Explore the rise in the numbers of child deaths reported in 12/13	EL			
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	