



**Cambridgeshire and Peterborough Child Death  
Overview Panel**

**Public Annual Report 2015 - 2016**

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## 1. Introduction

- 1.1 The aim of this report is to summarise the work of the Cambridgeshire and Peterborough Child Death Overview Panel (CDOP) during 2015-16.
- 1.2 It gives a summary of the deaths reported to and reviewed by the panel during the last year together with an analysis of the data and emerging themes from 2008 when figures were first collected through to March 2016.
- 1.3 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, they are included in this report.
- 1.4 Because the number of child deaths is small it may be possible to identify individual children. All text, data, tables and figures in this public version of the report where they represent individual children have been removed. The full version of the report is available to professionals on request. Please contact the CDOP Coordinator via [capccg.cdop@nhs.net](mailto:capccg.cdop@nhs.net)

## 2. 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.<sup>1</sup> 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 the area 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 Local Safeguarding Boards of Cambridgeshire and Peterborough form a single Child Death Overview Panel.

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<sup>1</sup> 'Working Together to Safeguard Children' has been revised and was reissued in March 2015. The responsibilities of Child Death Overview Panels are set out in chapter 5 and remain unchanged.

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 Chairs of the local Safeguarding Children Boards (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. 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. The Process**

- 4.1 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.
- 4.2 During 2015-16, the CDOP has met three times to review anonymous information about child deaths. The panel is chaired by the Cambridgeshire LSCB chair and has members from all relevant agencies.

- 4.3 A separate panel which reviews neonatal deaths is chaired by the Designated Doctor for Death in Childhood and has met twice this year. 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 and reports any relevant issues to the main CDOP.
- 4.4 The administration of the CDOP process is hosted by NHS Cambridgeshire and Peterborough Clinical Commissioning Group and funded jointly with the Peterborough and Cambridgeshire Children's Services Departments.

## 5. The National Picture

- 5.1 Every year it is estimated that 1,951 additional children – around 5 a day – die in the UK compared to Europe's best performing country for child mortality, Sweden. The key areas where the UK rates appear to be relatively high are infant deaths and deaths among children and young people who have chronic conditions.<sup>2</sup> The UK infant mortality rate (deaths of babies aged under 1 year per 1000 live births) in 2014 was 3.6, the lowest ever recorded in England and Wales and a decrease from 3.8 in 2013. Sweden and Norway have the lowest rates in Europe with an infant mortality rate of 2.6 and 2.5 deaths per 1000 births.
- 5.2 Babies who die under the age of one tend to be from deprived households, have a low birth weight and have parents who smoked. Between the ages of one and five, deaths are mostly linked to injuries, accidents and serious diseases.
- 5.3 The number of child death reviews completed has decreased year on year from 4061 in the year ending March 2011 to 3515 in the year ending March 2015. The percentage of child death reviews identified as having modifiable factors increased slightly from 20% in the year ending 31 March 2011 to 24% in the year ending 2015.
- 5.4 Nearly two thirds of child deaths in England and Wales in 2013 were of children aged under one year with the main causes of death being

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<sup>2</sup> *Why Children Die: Death in Infants, children and young people in the UK*. Royal College of Paediatrics and Child Health and National Children's Bureau 2014.

perinatal events and chromosomal, genetic and congenital abnormalities. Congenital related conditions and cancers remain the most common form of death for children aged under 16 years.<sup>3</sup> External factors such as road traffic accidents, drowning and assault are the main cause of death of young people aged 15-19 years.

## 6. Local Overview

### Reported Deaths

- 6.1 Infant and child mortality rates are slightly below the England average in Cambridgeshire and slightly higher than average in Peterborough, although not significantly different (see appendix A, mortality rates by Council area).
- 6.2 Over the last year, the deaths of 48 children were reported to the CDOP across Cambridgeshire and Peterborough, 29 in Cambridgeshire and 19 in Peterborough. 62% of these children were babies under one year old and 37% died due to a perinatal or neonatal event irrespective of their age. The majority died in the neonatal period, having never left hospital. There were 9 unexpected deaths reported this year, 4 in Cambridgeshire and 5 in Peterborough.
- 6.3 19 (40%) of the children died from a known life limiting condition this year, spread across all age groups.
- 6.4 Chart 1 below shows a similar pattern of deaths across the age groups since data was first collected. See appendix A for deaths reported by council area.

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<sup>3</sup> *Childhood, Infant and Perinatal Mortality in England and Wales, 2013*. Office for National Statistics March 2015

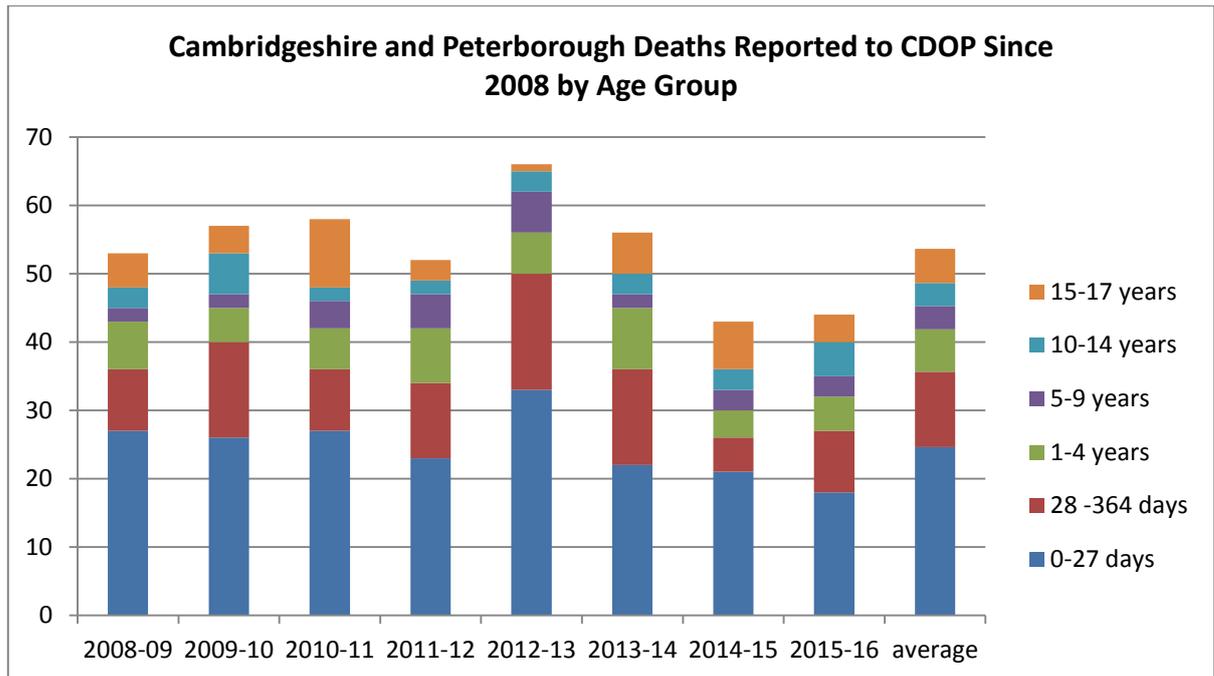


Chart 1 – Deaths reported to Cambridgeshire and Peterborough CDOP 2008 – 2016 by age group

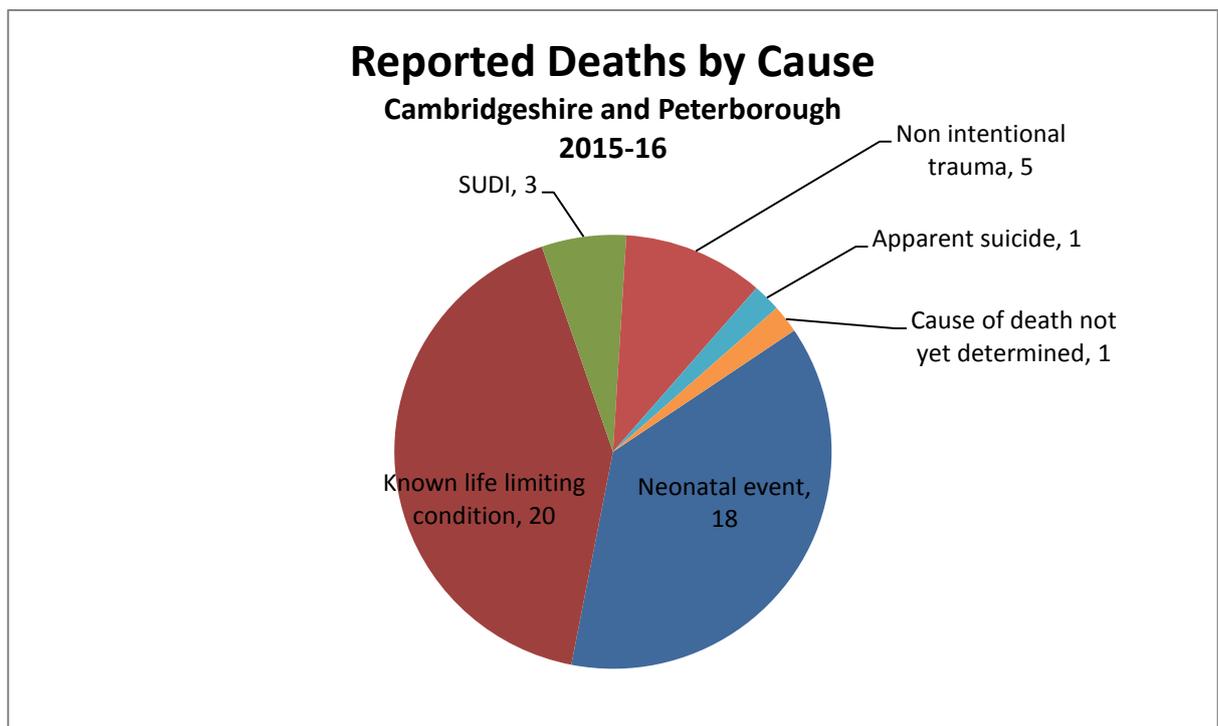


Chart 2 – Deaths reported to Cambridgeshire and Peterborough CDOP 2015-16 by cause

## Deaths reviewed

- 6.5 A total of 33 deaths were reviewed in 2015/16; 20 Cambridgeshire children and 13 Peterborough children. 21 deaths were reviewed by the main CDOP Panel and 12 by the Neonatal Panel. This number is substantially less than the previous year where the figure was 53 deaths reviewed. There are two reasons for this reduction; the first is because there were an unusually high number of child deaths in 13/14 which was reflected in the increased number of reviews the following year (14/15). The second is that the panel scheduled for March 2016 was cancelled due to the CDOP manager post remaining vacant for a short period thus resulting in cases being delayed.
- 6.6 One of the purposes of the child death review process is to identify 'modifiable' factors for each child that dies. That is, any factor which, on review, might have prevented that death and might prevent future deaths. There were 8 child deaths last year where a modifiable factor was identified by the main panel.
- 6.7 Not all of the deaths which were reviewed occurred in this year, some will have occurred the previous year or even earlier. There is generally a gap of several months between a reported death and that death being reviewed to enable all relevant information to be gathered. CDOP is unable to review a death until other processes have been completed such as NHS Trusts Serious Incident Investigations, Serious Case Reviews, post mortem reports and Coronial inquests. The table below shows that 24% of the deaths reviewed this year actually occurred the year before (2014 -15). 61% of deaths reviewed this year also occurred in 2015-16. 74% of cases reviewed this year were completed within 12 months which is in line with the national figure of 72% of reviews being completed within 12 months of the child's death. The DfE acknowledges that reviewing child deaths is an extremely complex task and these figures are not used as a performance measure.

<b>Year Death Reported</b>	<b>Number of Deaths Reviewed in 2015-2016</b>	<b>Number of deaths where modifiable factors were identified</b>	<b>Number of deaths where insufficient information was available to make a judgement</b>
<b>2013-14</b>	5	2	0
<b>2014-15</b>	8	3	0
<b>2015-16</b>	20	3	0
<b>Total</b>	33	8	0

Table 1 – Deaths reviewed by year of death, Cambridgeshire and Peterborough 2015-2016

- 6.8 As in previous years the majority of children whose death was reviewed were less than a year old; 73% for both areas, 76% for Cambridgeshire and 70% for Peterborough.
- 6.9 The next highest age range was children aged 1-4 years, 15% of deaths reviewed were in this age group. 3 of the 5 deaths in this age group were children who died of a known life limiting condition.
- 6.10 The main causes of death reflected similar years, with 43% of deaths being the result of perinatal or neonatal difficulties and 33% of the children dying from known life limiting conditions. See appendix A for charts by council areas.

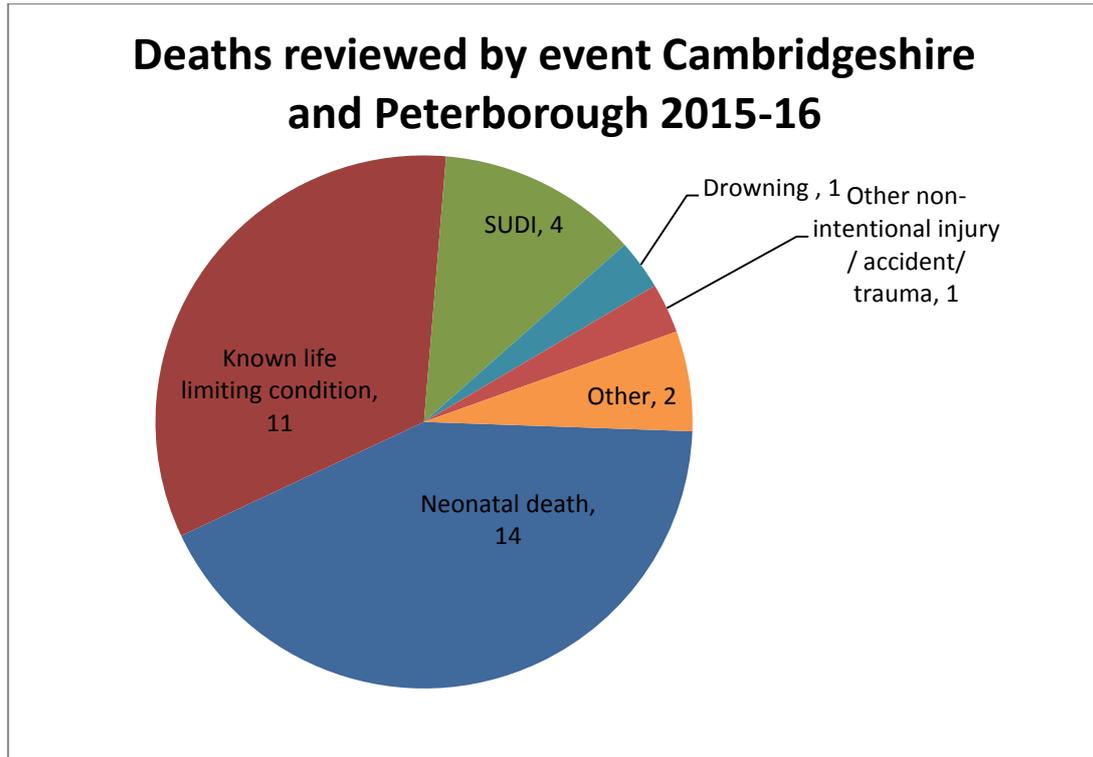


Chart 3 – Deaths reviewed by Event, Cambridgeshire and Peterborough 2015-16

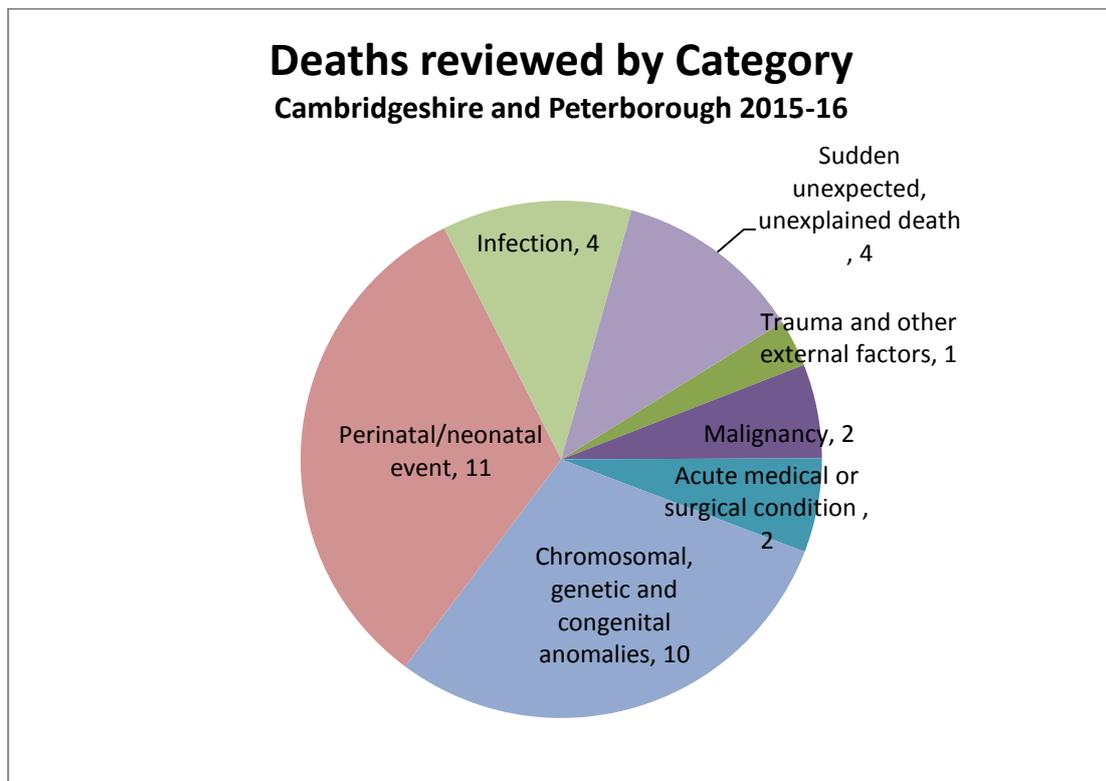


Chart 4 – Deaths reviewed by Category, Cambridgeshire and Peterborough 2015-16

### CDOP Main Panel – Modifiable Factors

- 6.11 The main CDOP panel met three times and reviewed the deaths of twenty one children. Modifiable factors were identified in eight cases (6 for Cambridgeshire children and two for Peterborough children).
- 6.12 Chart 4 provides a breakdown by category for deaths where modifiable factors were identified over the eight years in which figures have been collected. See appendix A for modifiable deaths charts by council area.

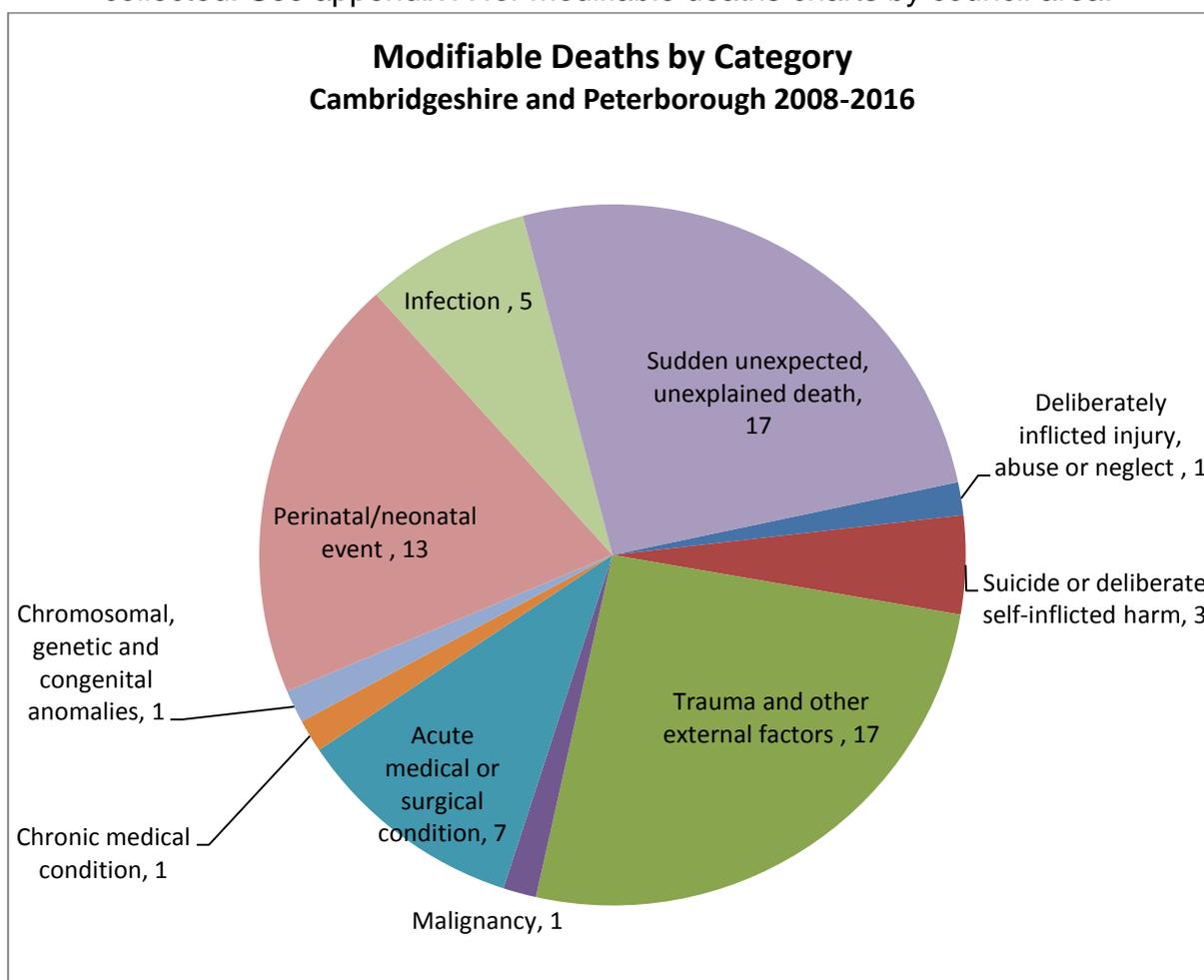


Chart 4 – Deaths where modifiable factors were identified by Cambridgeshire and Peterborough CDOP 2008-2016 by category of death.

### Neonatal Panel – Modifiable Factors

- 6.13 The Neonatal CDOP met twice over the course of 2015-2016 and completed a review of 12 deaths. The deaths reviewed were of babies who died in the neonatal period (0 – 27 days) or shortly after and who had

never left hospital. The CDOP is required to review the deaths of all babies if they are registered as live births, regardless of gestational age at delivery. This excludes terminations of pregnancy carried out within the law but includes miscarriages as early as 19 weeks gestation.

- 6.14 The age of viability is 24 weeks gestation but many of the neonatal deaths that have been reviewed are babies born before the age of viability, who had a heart rate and sometimes other signs of life present for some time after delivery. 4 (25%) of the neonatal deaths reviewed were non-viable babies. These deaths are often the result of complex antenatal causes and inclusion of them in the statistics may not paint an accurate picture of the neonatal death rate.
- 6.15 Modifiable factors were identified by the Neonatal panel for one of the deaths reviewed.

## **7. Action Taken in Response to Modifiable Factors and Trends Identified**

- Four of the cases with modifiable factors were children under four years of age where the use of alcohol and/or drugs was a modifiable factor. Three of these cases were under 1 year and were co-sleeping. Raising awareness regarding the importance of safe sleeping, especially when parents have been drinking alcohol, has been highlighted this year through practitioner workshops and will continue to be a feature in future LSCB training events.
- Coded warning signs have now been installed along the river where a child drowned to enable Ambulance and other rescue personnel to locate where a person has gone into the river. The Coroner also raised concerns at the inquest about the cancellation of swimming lessons at the local secondary school and has written to the Minister for Education to ask that they be included in the National Curriculum for all secondary school pupils.
- In the case of a child who died following an acute asthma attack, the child's surgery reviewed their management of asthma in the practice for all patients, high risk asthmatics were invited to attend a review. A practical asthma management session was organised for the whole team and the practice aims for all patients diagnosed with asthma to have a clear asthma action plan.

## 8. Serious Case Reviews

One child who was reviewed this year had been the subject of a serious case review which was published by the Cambridgeshire LSCB in March 2015. The child had died in 2014. He was severely disabled. The main learning from the serious case review was the need to ensure that early help services are properly coordinated and linked in to other mainstream support services. The impact of the mother's vulnerability as a young single mother who had experienced significant difficulties as an adolescent was underestimated.

## 9. Unexpected Deaths / Rapid Response Service

### Arrangements for home visits

- 9.1 The on call element of the Health Rapid Response Service was reviewed and subsequently changed to a Paediatrician led service as of 01/04/2016. The on call service now consists of six Paediatricians, two of which are from Cambridgeshire and four from Peterborough.
- 9.2 Ten children died unexpectedly this year; six in Peterborough and four in Cambridgeshire. This is an increase on unexpected deaths during 2014/15 where there were a total of 8 unexpected deaths all of which were Cambridgeshire children. An unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death.
- 9.3 A rapid response joint agency home visit was undertaken for six of these deaths. Two of these deaths were of children that been unwell in the days/hours preceding their deaths. The parents of both children had contacted and were advised by the 111 service, these calls are now undergoing Serious Incident reviews. Two of the children were co-sleeping at the time of death, in one case the child was found unresponsive under his four year old sibling and bedding. An inquest concluded that the circumstances of the death were inconclusive however the panel identified that the use of alcohol whilst caring for small children as a modifiable factor. The other child was co-sleeping with parents who were also under the influence of alcohol which again was identified as a modifiable factor.
- 9.4 The visits led to important additional information being obtained either from additional history or from observations within the home. If parents

were too distressed to return home, arrangements were made for them to be seen at an alternative location.

- 9.5 The unexpected deaths were reviewed against the criteria for joint agency home visits as specified in the Multi Agency Protocol for the Management of Unexpected Death in Childhood. A home visit was not conducted in four of the cases due to a clear medical cause of death and the deaths occurring after a period of time in hospital.

## 10. CDOP Training

- 10.1 In previous years the two LSCB's have jointly delivered training in 'Understanding the Impact of Serious Case Reviews and the Child Death Overview Process' however, due to low interest in the sessions in the Peterborough area this was not feasible this year.

Cambridgeshire LCSB ran one session which was attended by 8 people with participants from various agencies including Health Providers and Children's Services. There were two sessions planned however one was cancelled due to lack of attendance. Two more sessions are planned in the next training year. The session was well received; some of the comments from the course evaluation forms are included here:

- Consistent themes and recommendations – disseminate to colleagues
- Better awareness of CDOP process – disseminate to colleagues

Peterborough LSCB had 2 sessions planned for this year however both were cancelled due to lack of attendance.

### 10.2 Safe Sleeping

Cambridgeshire and Peterborough Local Safeguarding Children Boards in partnership with the Designated Doctor for Deaths in Childhood and Health Visitor Safeguarding Leads re-launched the 'Safe Sleeping Campaign' to promote awareness to professionals and parents about safer sleeping with babies. This year 2 workshops were delivered to early help workers, early years, locality teams and children's centres, across the Region. The workshops provided information and materials for making parents aware of the risks of sleeping with babies.

## 11 . Support to Bereaved Families

- 11.1 Prior to a child's death being reviewed, his or her family is normally written to, advised about the purpose of CDOP and encouraged to make contact if there is anything they think the panel should know about regarding the support they received following their child's death. Only one family chose to contact the panel this year. This is similar to the national picture with very few families, for understandable reasons, choosing to make contact with CDOPs. However, for unexpected deaths, the information sharing meetings, which are held in primary care settings, enable practitioners to coordinate bereavement support.
- 11.2 The mother of a baby girl who died at an out of area hospital contacted the CDOP Manager regarding her concerns that Cambridgeshire and Peterborough CDOP had not made contact with her following the death of her baby. The CDOP manager responded by clarifying our current process of writing to parents shortly before the case is due to be reviewed. The mother was invited to share her views on what she felt may be a more appropriate time to make contact.

## 12 . Plans for the Year 2016-17

- 12.1 The 2016/17 business plan is attached as appendix B. The priority actions are summarised below:
- Implement the recommendations from the National review of LSCBs which included a review of CDOPs
  - Review and publish the leaflet on bereavement support – work on this was delayed by the departure of the previous CDOP manager
  - Continue to raise awareness around the dangers of co-sleeping, especially after drinking alcohol
  - Review the newly established rapid response rota.

## Appendix A - Graphs and Tables

### Mortality Rates by Council Area

#### 1) Infant Mortality Rate (deaths of babies aged under 1 year per 1,000 live births), 2012 - 2014<sup>4</sup>

Local Authority	Infant Mortality Rate (CHIMAT 2012 -2014)	England average
Cambridgeshire	3.5	4
Peterborough	4.2	4

#### 2) Child Mortality Rate (directly standardised rate per 100,000 children age 1-17 years), 2012- 2014<sup>4</sup>

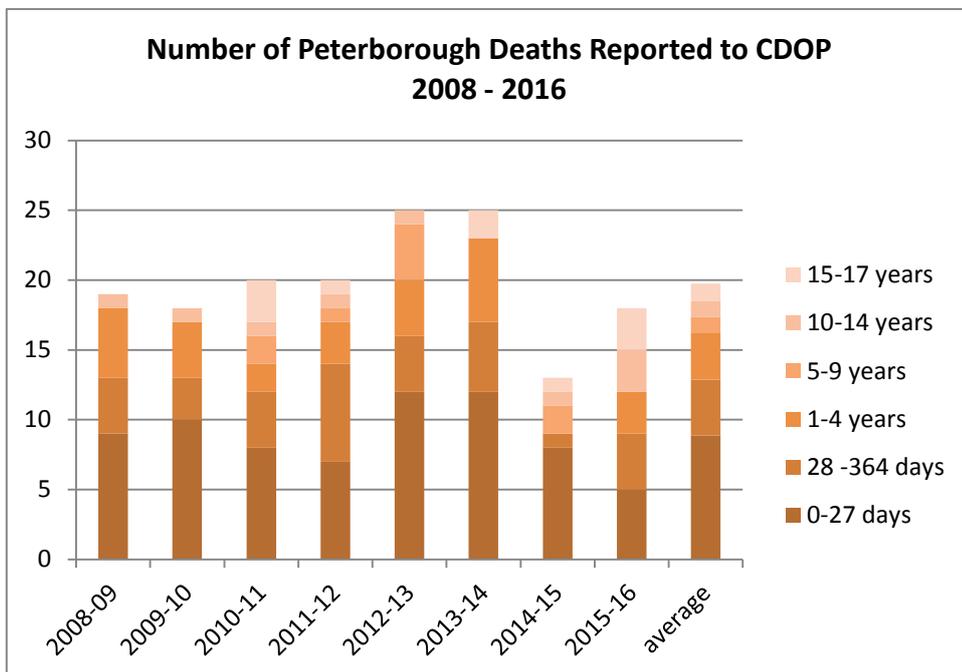
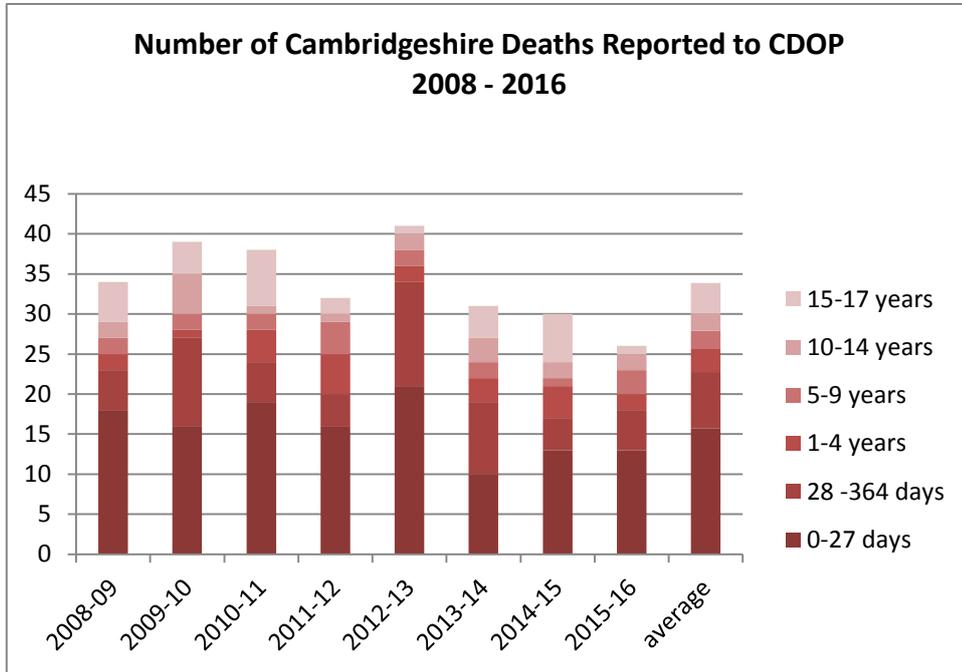
Local Authority	Child Mortality Rate (CHIMAT 2010-12)	England average
Cambridgeshire	10.7	12
Peterborough	14.8	12

#### 3) Reported Deaths by Gender 2015-16

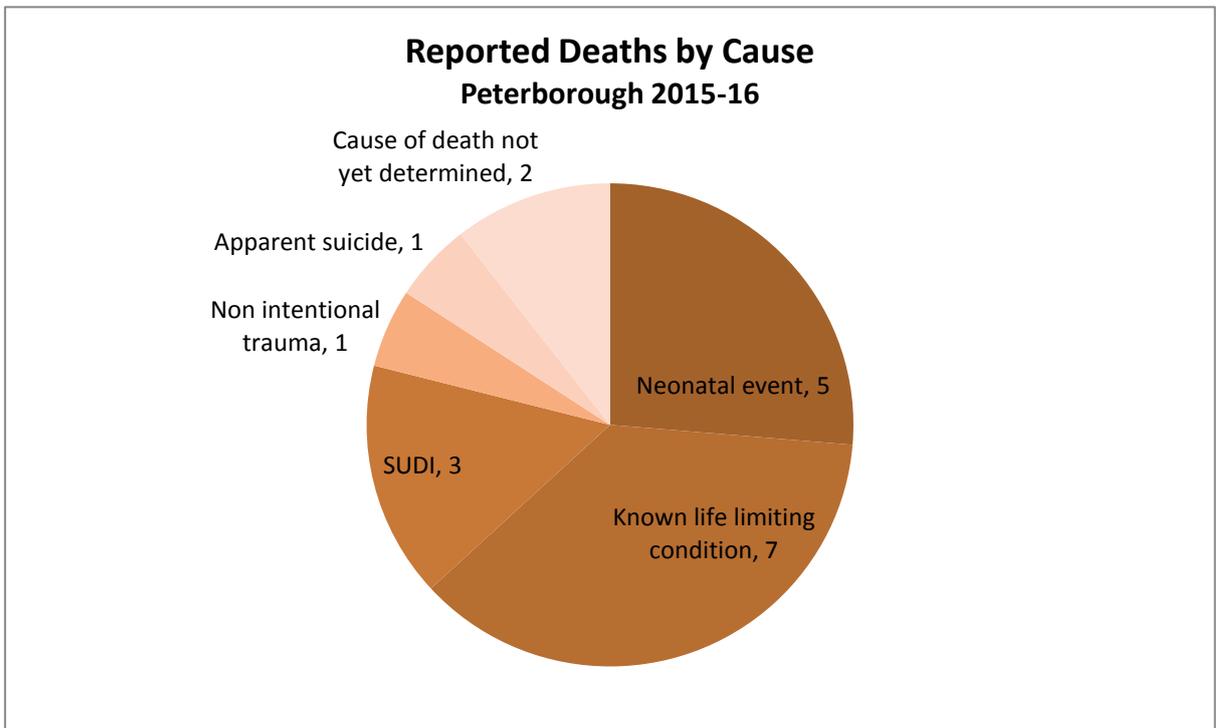
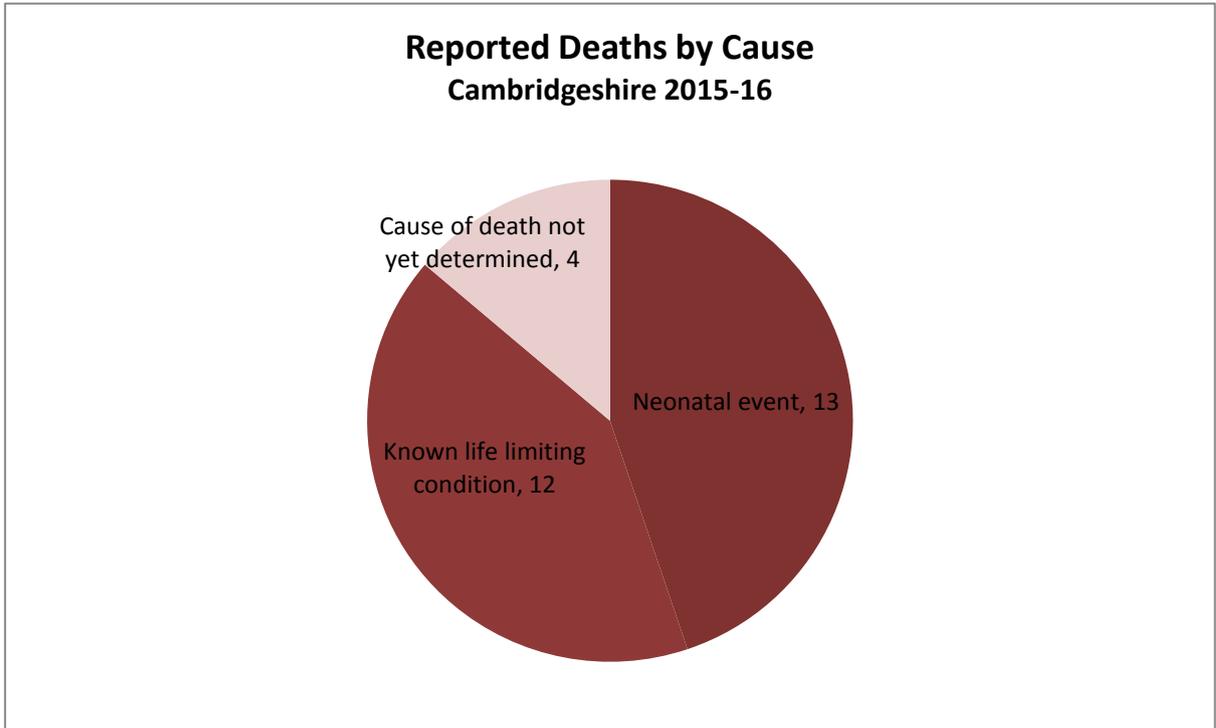
Gender	Cambridgeshire	Peterborough	Total
Male	14	9	23
Female	11	9	20
Indeterminate	1		1

<sup>4</sup> Child Health Profiles for Local Authorities, National Child and Maternal Health Intelligence Network, [chimat.org.uk](http://chimat.org.uk)

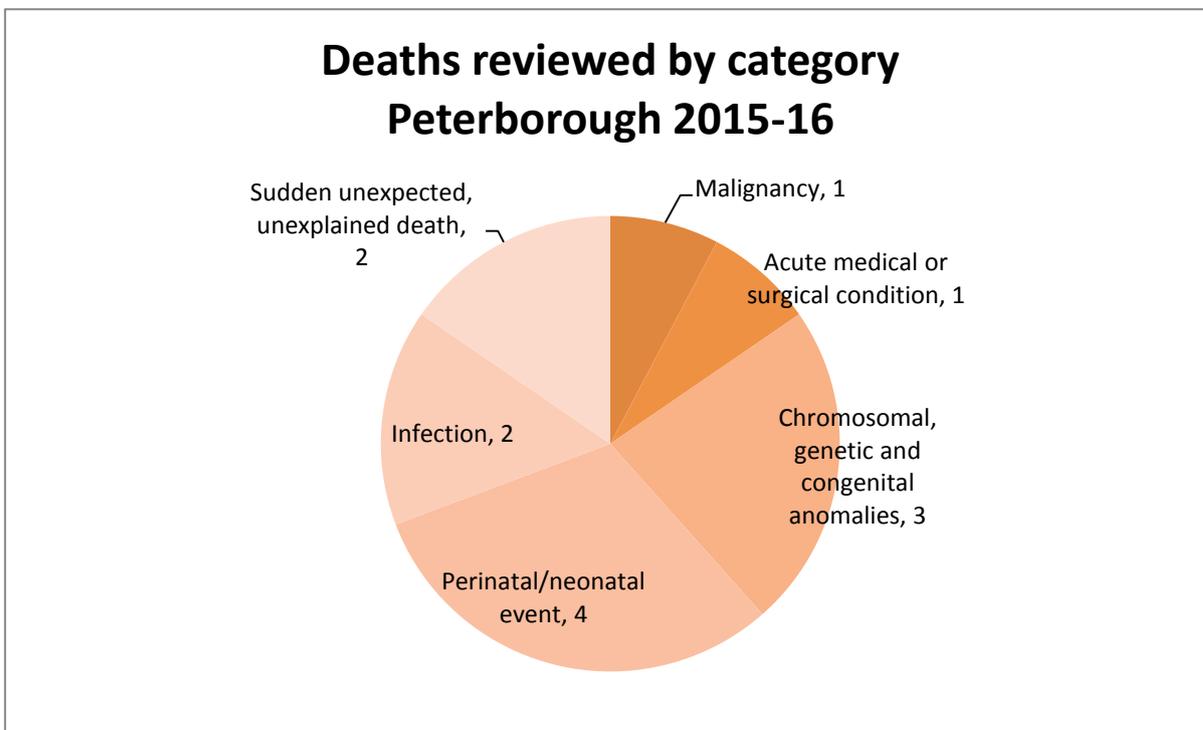
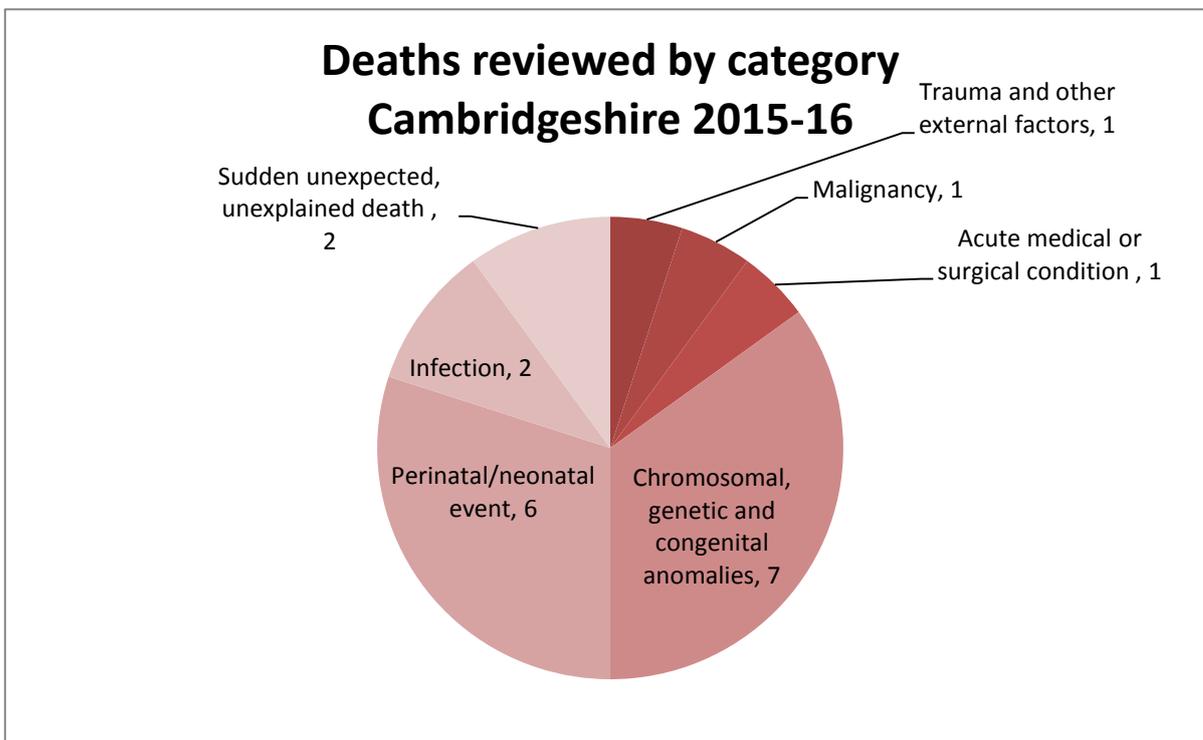
4) Reported Deaths by Council Area, by age, 2008 - 2016



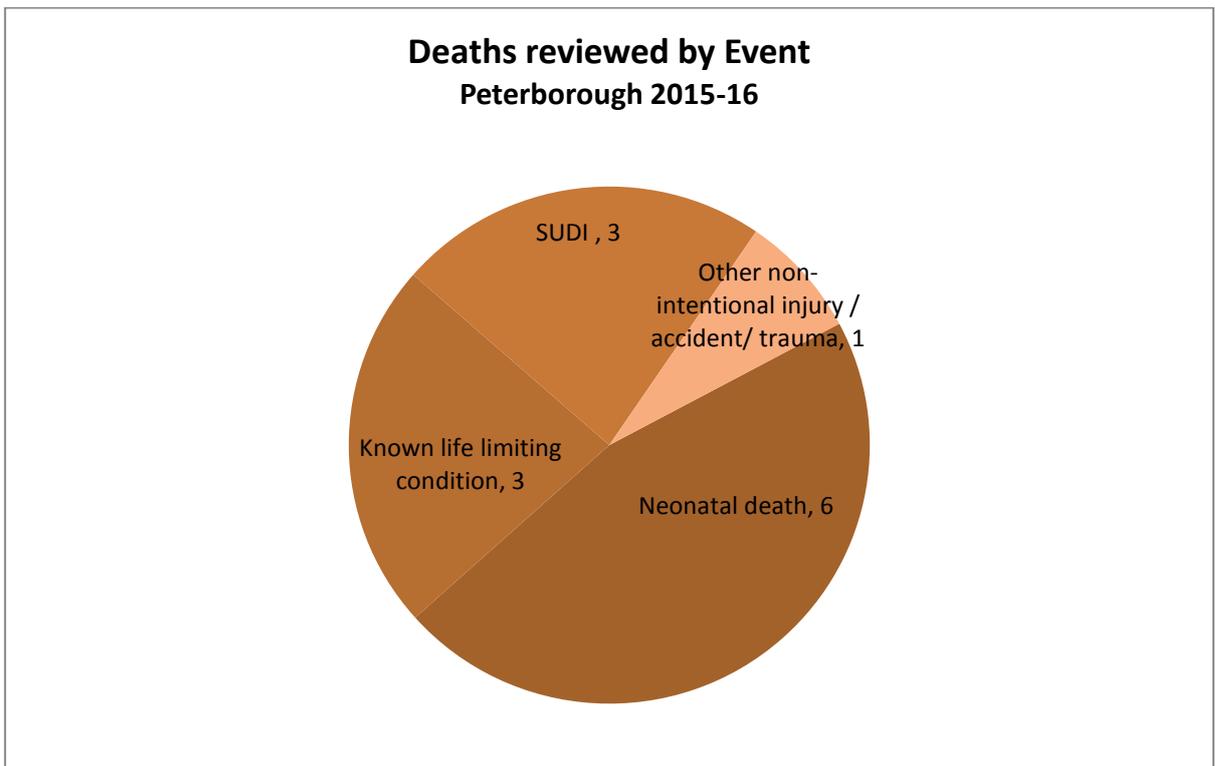
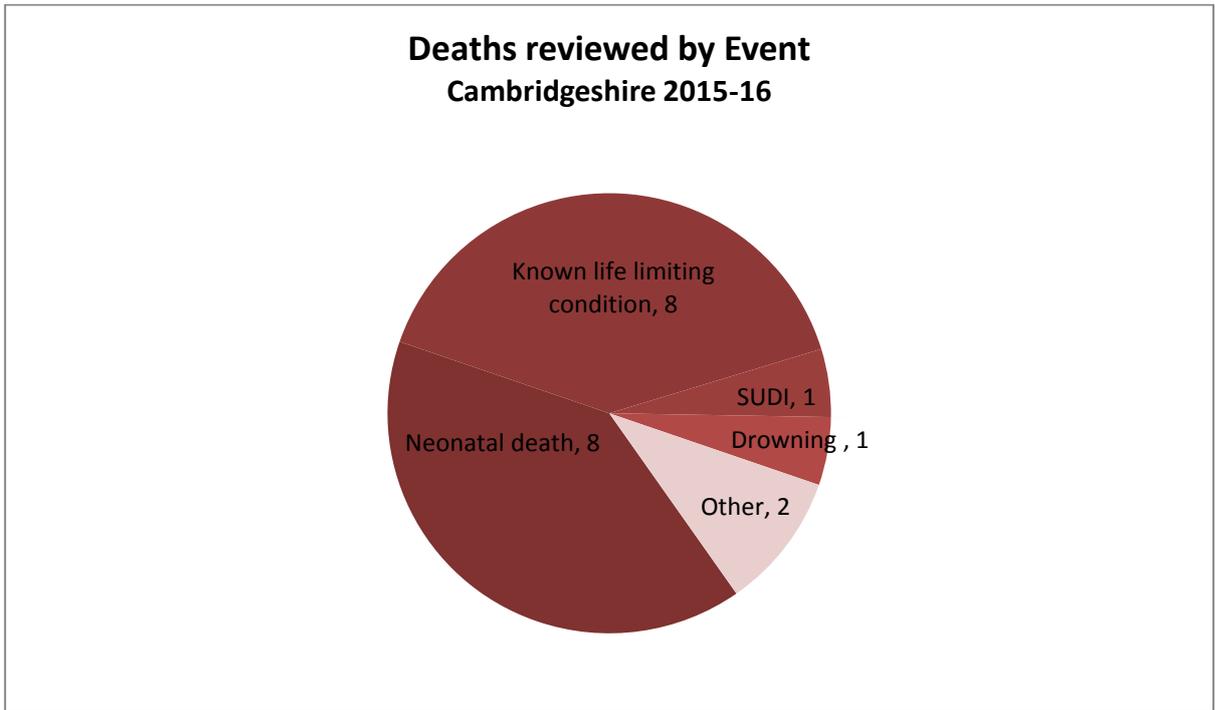
5) Reported Deaths by Council Area, by Cause of Deaths, 2015-16



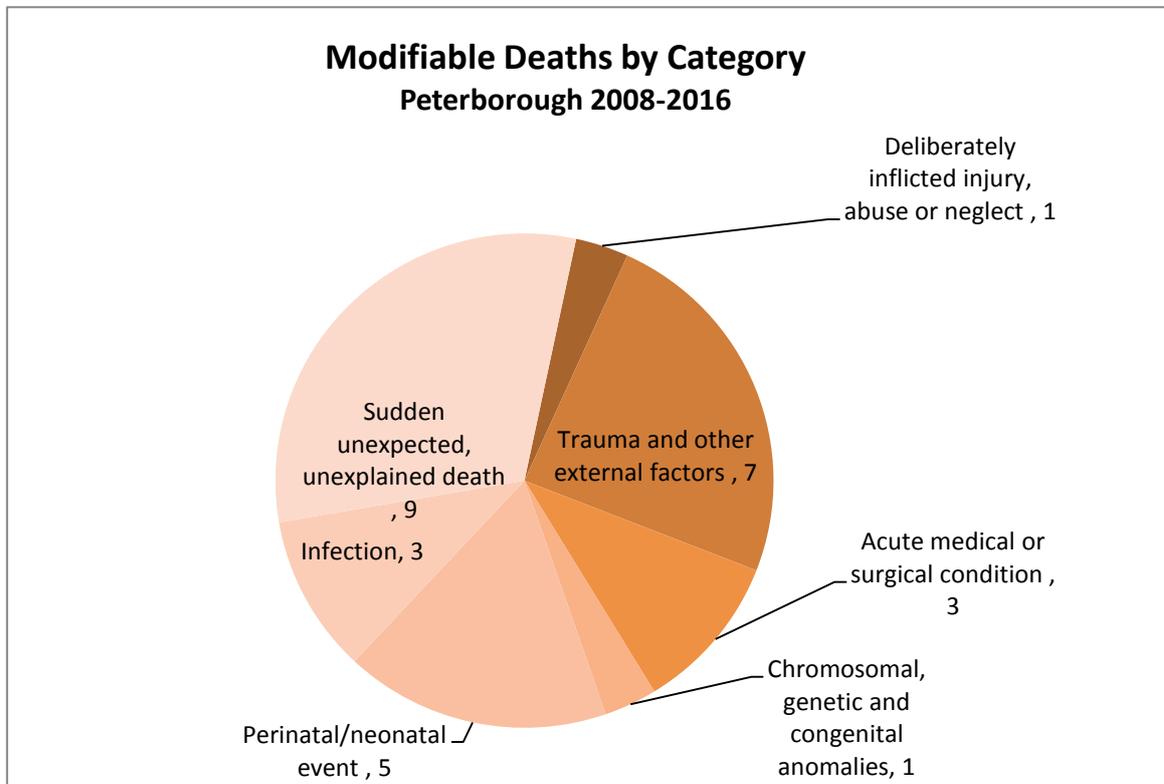
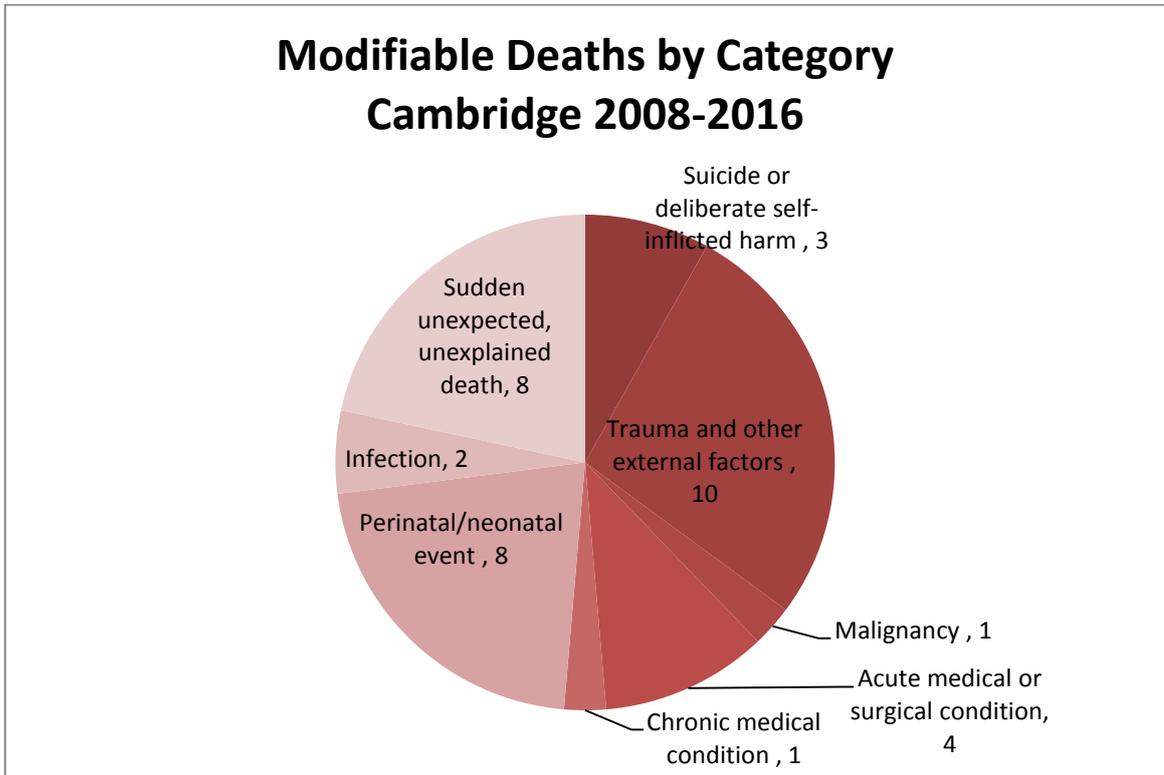
6) Reviewed Deaths by Council Area, by Category 2015-16



7) Reviewed Deaths by Council Area, by Event 2015-16



8) Modifiable Deaths by Council Area, by Category 2008 - 2016



## Appendix B Business Plan 2016 - 2017

	Objective	Lead	Action and timescale	Outcome	Progress
1.	Review bereavement support for families	DD / NJ	Describe the type & amount of support available across the County & identify gaps, good practice and variances. Sept 2016.	Better support for bereaved families as measured by feedback	On-going – carried over from 2015/16 Business Plan. NJ will contact NHS providers and charities to identify support available. The existing bereavement support directory will be updated with this information and will then be updated bi annually.
2.	Implement the recommendations from the National Review of LSCB's which included a review of CDOP's	DD / NJ	Link with regional and national colleagues to understand transformation. Ongoing		
3.	Continue to raise awareness around the	DD / CDOP	Work with providers to ensure that key advice and messages around safe	Improve parental awareness of safe sleeping	Following the June CDOP Kirsteen Watson's (Consultant in Public Health Medicine) Update on

	dangers of co-sleeping, especially after drinking alcohol		sleeping are kept high on the agenda. Ongoing	Reduce the numbers of SUDIs	Prevention of Sudden Infant Deaths was circulated around panel members.
4.	Review the newly established rapid response rota	DD / NJ	To ensure that effective cover is in place to ensure a timely response to Unexpected child deaths. January 2017	A co-ordinated, multi-agency response to unexpected child deaths.	The rapid response rota has been implemented. Following requests from the covering Paediatricians cover is now arranged week commencing Friday to coincide with hospital on call arrangements.

DD = Designated Doctor for Death in Childhood

NJ = Natalie Jones, Child Death Review Manager

CDOP = Child Death Overview Panel