



Cambridgeshire and Peterborough Child Death Overview Panel

Public Annual Report 2017-18

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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 2017-18.
- 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 2018.
- 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; this is therefore a confidential report. A public version of this report will be made available for wider circulation.

2 Background

- 2.1 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'.¹ Their primary function is to understand how and why children die, put into place interventions to protect other children, and prevent future deaths.
- 2.2 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.

¹ '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.

- 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

3.1 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 2017-18, the CDOP has met four times to review anonymous information about child deaths. The panel is chaired by an independent chairperson 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 There were 2,651 infant deaths (deaths of those aged under 1 year) that occurred in England and Wales in 2016, compared with 2,578 in 2015. The infant mortality rate was 3.8 deaths per 1,000 live births, compared with 3.7 in 2015. Cancers remain the most common cause of death for children aged 1 to 15 years, accounting for 20.6% of deaths in 2016.²
- 5.2 The number of child death reviews completed by Child Death Overview Panels in England has fallen slightly from 3,665 in the year ending 31 March 2016 to 3,575 in the year ending 31 March 2017. Over the same period, the percentage of reviews with modifiable factors has increased from 24% to 27%.
- 5.3 Consistent with previous years, approximately two thirds of reviews completed were of children who died under the age of one; with 43% for children aged 0-27 days; and a further 21% for children aged between 28 and 364 days at the time of death³.

² Child Mortality in England and Wales:2016. Office for National Statistics [Accessed at <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2016>]

³ *Child Death reviews: year ending 31 March 2017*. Department for Education [Accessed at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/627206/SFR36_2017_Text.pdf]

6 Local Overview

Reported Deaths

- 6.1 Infant mortality rates for both Cambridgeshire and Peterborough are slightly below the England average although not significantly different (see appendix A, mortality rates by Council area).
- 6.2 Over the last year, the deaths of 55 children were reported to the CDOP across Cambridgeshire and Peterborough, 33 in Cambridgeshire and 22 in Peterborough. 62% of these children were babies under one year old and 51% 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 15 unexpected deaths reported this year, 10 in Cambridgeshire and 5 in Peterborough.
- 6.3 17 (31%) of the children died from a known life limiting condition this year, spread across all age groups.
- 6.4 Chart 1 below illustrates a slight decrease in deaths reported on the previous year.

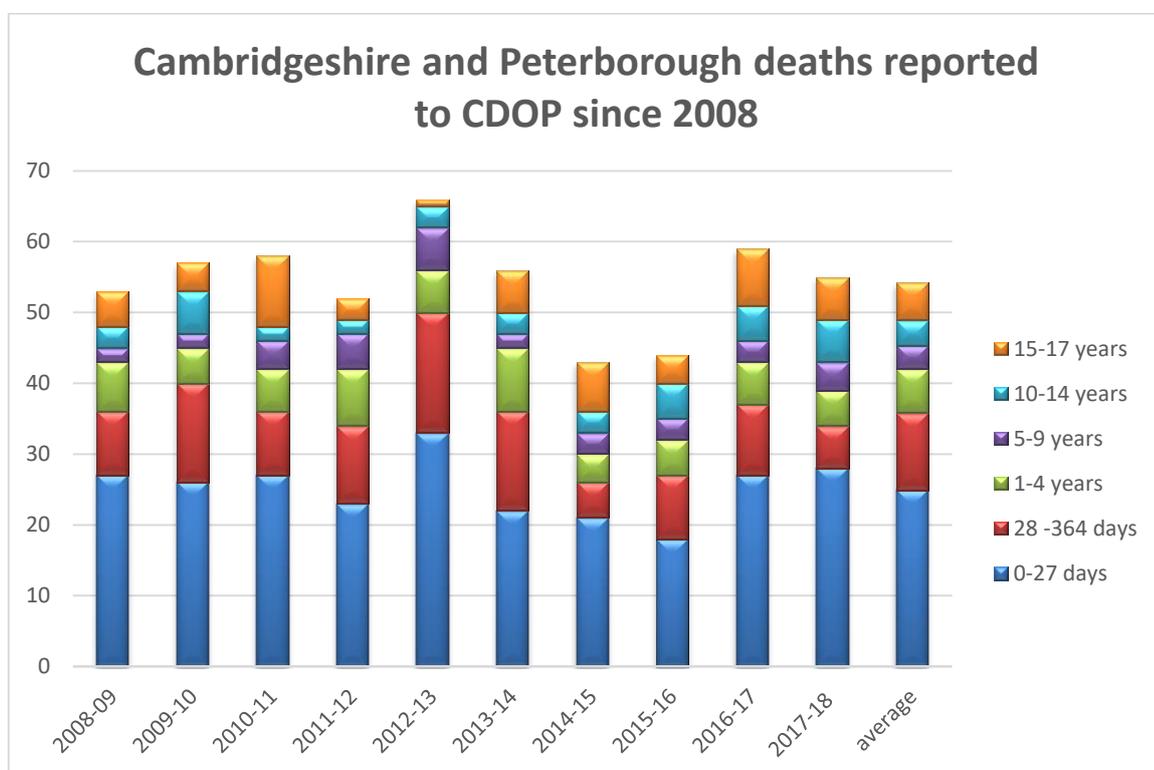


Chart 1 – Deaths reported to Cambridgeshire and Peterborough CDOP 2008 – 2018 by age group

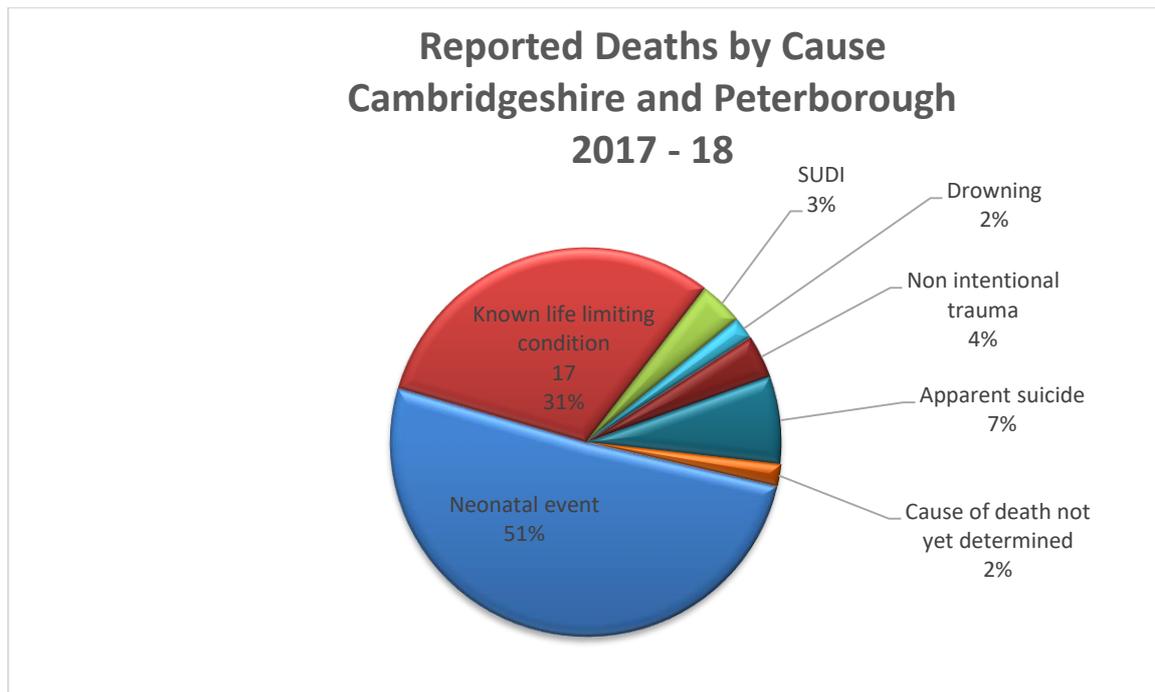


Chart 2 – Deaths reported to Cambridgeshire and Peterborough CDOP 2017-18 by cause

Deaths reviewed

- 6.5 A total of 56 deaths were reviewed in 2017-18; 34 Cambridgeshire children and 22 Peterborough children. 33 deaths were reviewed by the main CDOP Panel and 23 by the Neonatal Panel.
- 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. During 2017-18 there were 4 child deaths where a modifiable factor was identified by the panel and these are described in more detail later in this report.
- 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 48% of deaths reviewed this year occurred this year while 46% of deaths reviewed this year occurred the year before (2015-16).

Year Death Reported	Number of Deaths Reviewed in 2017-18	Number of deaths where modifiable factors were identified	Number of deaths where insufficient information was available to make a judgement
2015-16	4	2	0
2016-17	29	2	0
2017-18	23	0	0
Total	56	4	0

Table 1 – Deaths reviewed by year of death, Cambridgeshire and Peterborough 2017-18

- 6.8 79% of cases reviewed this year were completed within 12 months which is in line with the national figure of 76% 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.
- 6.9 As in previous years, the majority of children whose death was reviewed were less than a year old; 59% for both areas combined, 61% for Cambridgeshire and 55% for Peterborough.
- 6.10 The next highest age range was children aged 1-4 years, 12% of deaths reviewed were in this age group. 5 of the 7 deaths in this age group were children who died of a known life limiting condition.
- 6.11 The main causes of death reflected similar years, with 43% of deaths being the result of perinatal or neonatal difficulties and 41% of the children dying from known life limiting conditions. See appendix A for charts by council areas.

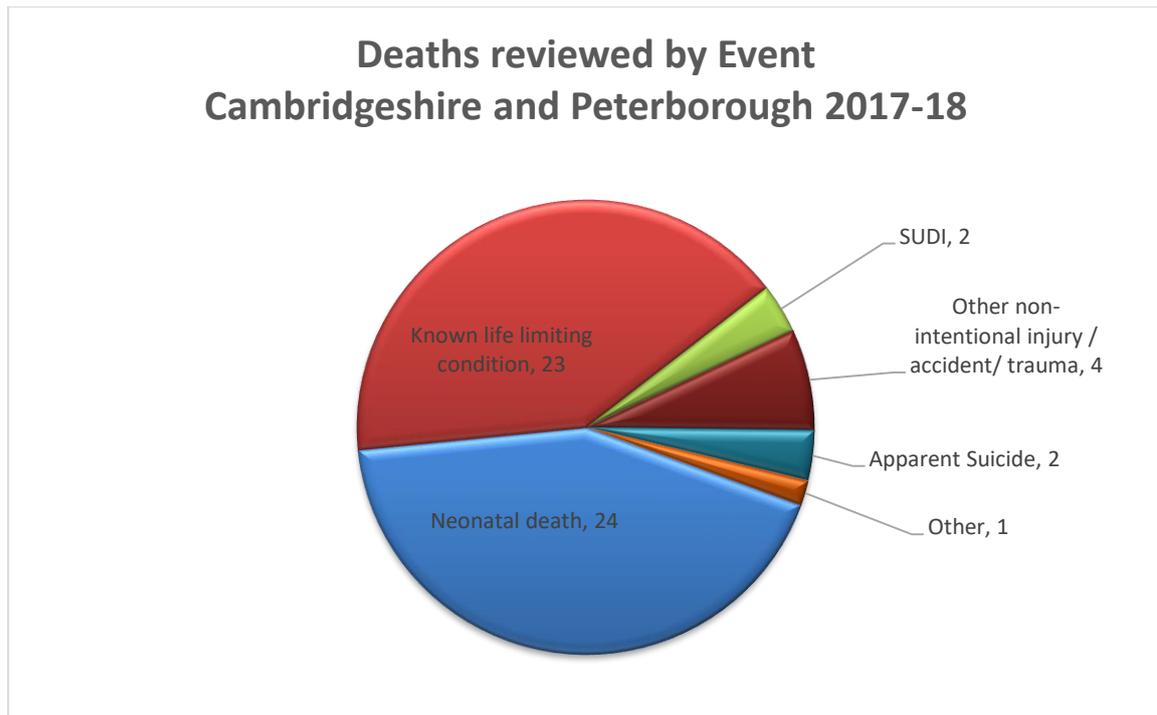


Chart 3 – Deaths reviewed by Event, Cambridgeshire and Peterborough 2017-18

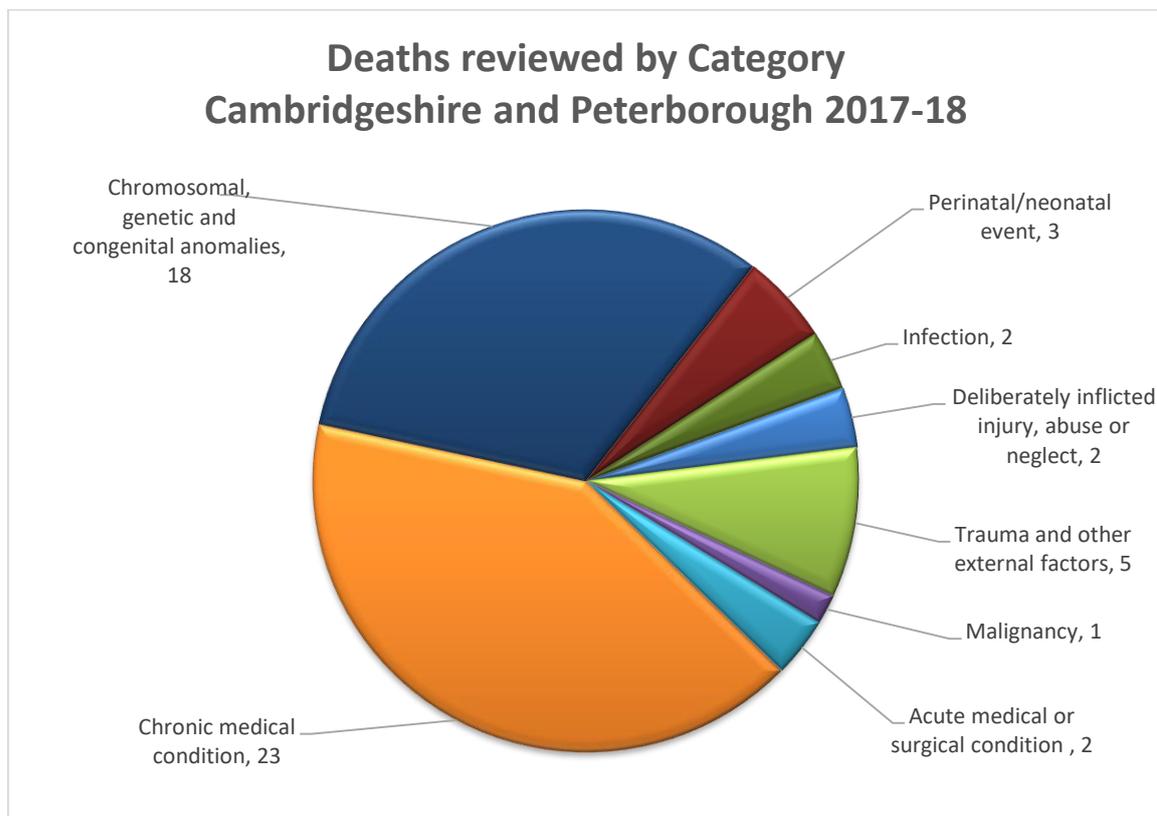


Chart 4 – Deaths reviewed by Category, Cambridgeshire and Peterborough 2017-18

CDOP Main Panel – Modifiable Factors

- 6.12 The main CDOP panel met four times and reviewed the deaths of 33 children. Modifiable factors were identified in the case of 2 Peterborough children and 1 Cambridgeshire child.
- 6.13 Chart 5 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.

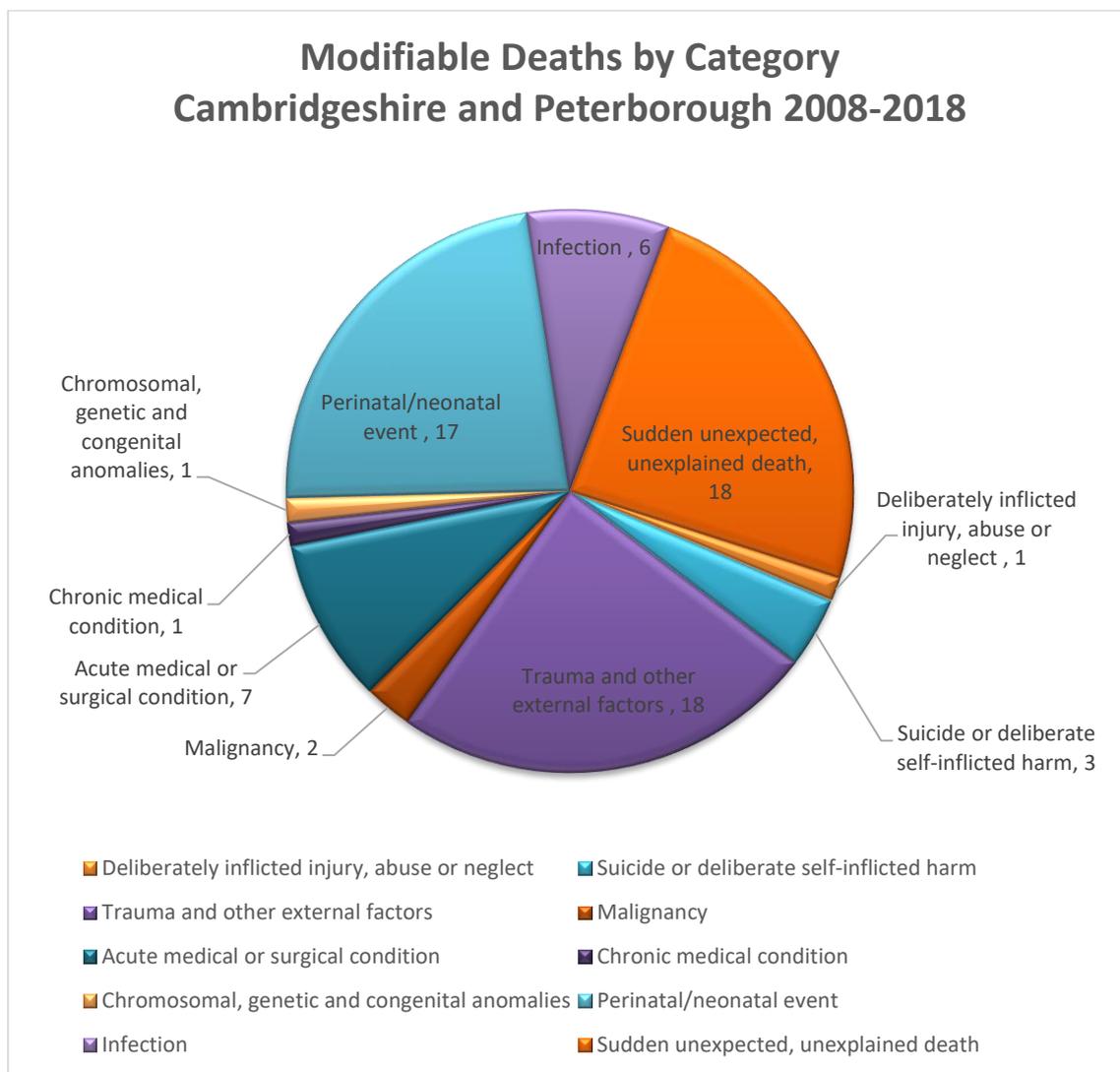


Chart 5 – Deaths where modifiable factors were identified by Cambridgeshire and Peterborough CDOP 2008-2018 by category of death.

Neonatal Panel – Modifiable Factors

- 6.14 The Neonatal CDOP met twice over the course of 2017-18 and completed a review of 23 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.
- 6.15 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. 9 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.
- 6.16 Modifiable factors were identified by the Neonatal panel in 1 of the deaths reviewed.

7 Serious Case Reviews

- 7.1 None of the deaths reviewed this year were the subject of serious case review.

8 Unexpected Deaths / Rapid Response Service

Arrangements for home visits

- 8.1 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. 13 children died unexpectedly this year; 7 in Cambridgeshire and 6 in Peterborough. This is a similar figure to previous years.
- 8.2 A rapid response joint agency home/scene visit was undertaken for 4 of the 13 unexpected deaths.
- 8.3 In 9 out of the 13 unexpected deaths home visits were not conducted. 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 and in 5 cases a home visit was deemed inappropriate. In 4 cases the rapid response process for responding to the unexpected death of a child was not appropriately initiated.

- 8.4 The Designated Doctor and CDOP Chair delivered training to Detective Inspectors regarding the processes around responding to unexpected death in childhood.

9 Suicide or deliberate self-inflicted harm

- 9.1 During 2017/18 two cases have been reviewed where a young person has died by suicide or deliberate self-inflicted harm.
- 9.2 It is noted that there has been a slight increase in the frequency of deaths by suicide or deliberate self-inflicted harm across Cambridgeshire and Peterborough.
- 9.3 Chart 6 shows the breakdown of deaths by suicide or deliberate self-inflicted harm reported by year.
- 9.4 Chart 7 shows the factors that were identified as present.

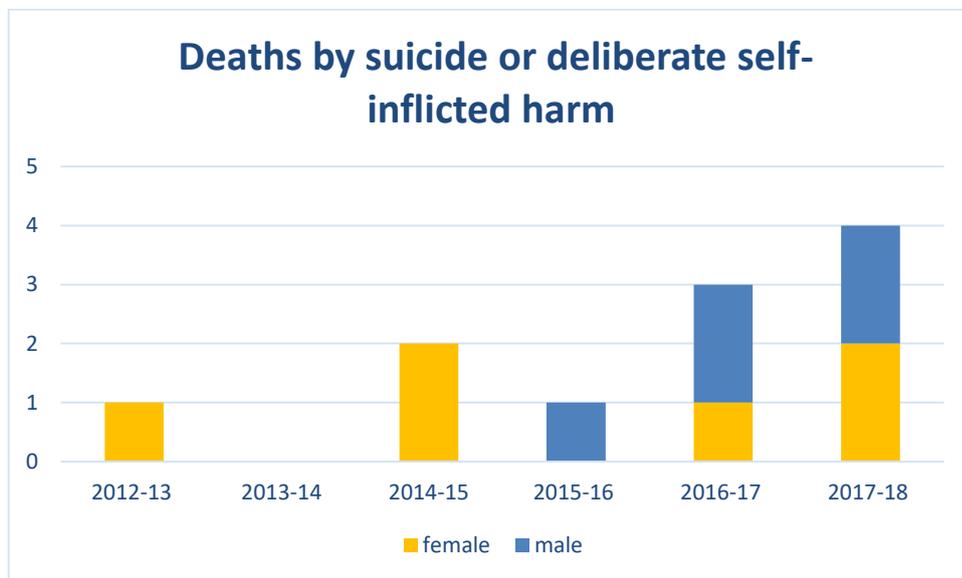


Chart 6 – Deaths by suicide or deliberate self-inflicted harm, reported between 2012-2018.

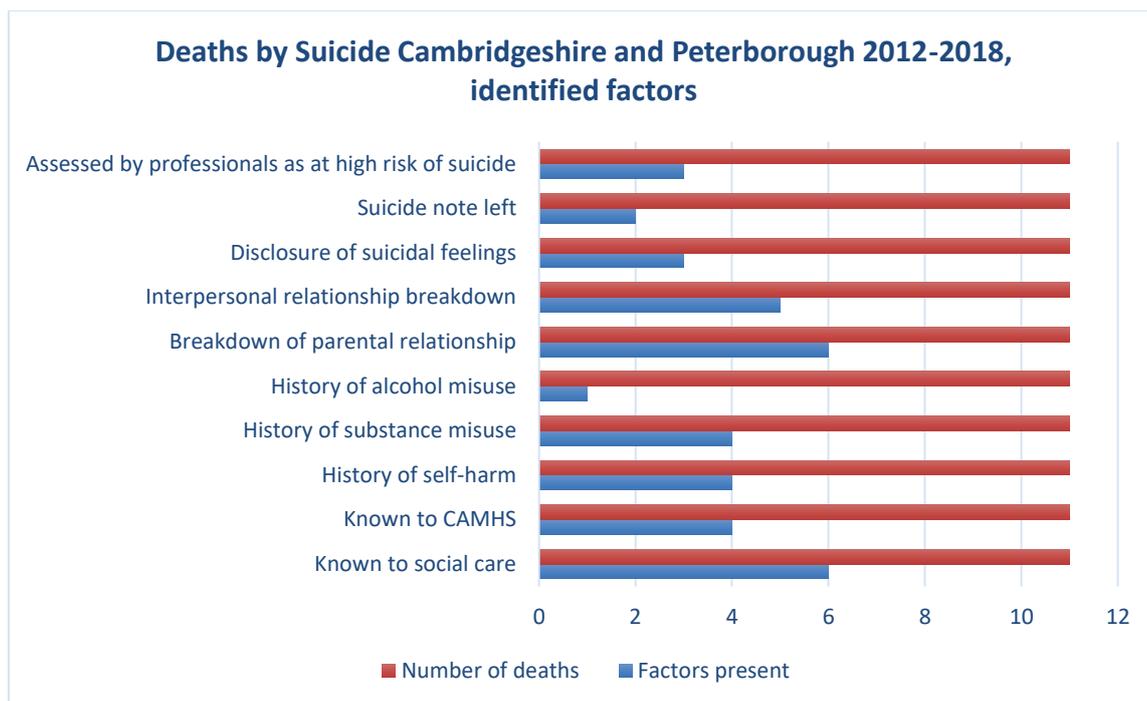


Chart 7 – Deaths by suicide 2012-18, Factors Present

10 East of England Regional CDOP Network

- 10.1 This network which established in 2017 is a sub-group of the East of England Children and Young People's Safeguarding Forum and meets three times a year. It aims to identify best practice and promote consistency and equity to support the ongoing development of the child death overview process across the geographical area of the East of England in order to achieve better outcomes for children and families.
- 10.2 The key purposes of the network are to support CDOP practitioners in developing robust systems for reviewing child deaths and promoting good practice in the East of England:
- To share information on local, regional and national developments.
 - To identify particular work streams to promote regional good practice.
 - To support the development of consistent regional policies and procedures.
 - To improve the way sudden unexpected deaths are investigated and co-ordinate responses to challenges in the system such as cross county issues.
 - To enable regional trends and issues to be identified.
 - To identify areas that require research or innovation.

- To identify regional training and development needs and training opportunities.
 - To facilitate safeguarding supervision specific to CDOP/SUDIC practice.
 - To report to the National CDOP Network as and when required.
- 10.3 The network reports back to the East of England Children and Young People's Safeguarding Forum via the Chair who sits on the forum or by a designated representative.

11 CDOP Training

- 11.1 There is no distinct course on CDOP within the LSCB training calendar, rather the findings from CDOP are referred to within the most relevant safeguarding children courses. Where Serious Case Reviews are mentioned and form part of exercises and illustrations, local and national CDOP findings are an integral element of that discussion and debate. The campaigns of safer sleeping and safety in water are promoted within the; LSCB basic safeguarding children training, child and adolescents training and General Practitioner training as well as being promoted throughout the year via the LSCB website and LSCB conferences. There was one safer sleeping workshop scheduled during 2017 – 2018 though this was cancelled due to poor take up.
- 11.2 For 2018 a number of workshops are planned across the county which will be focusing on; local audits, a child sexual exploitation management review and local serious case review themes. CDOP findings and new CDOP literature will be referred to within those groups.

12 Support to Bereaved Families

- 12.1 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. The CDOP Manager has developed a bereavement support directory of both local and national support organisations, this is enclosed with the letter along with The Lullaby Trust booklet *The Child Death Review: A guide for parents and carers*⁴.

⁴ The Child Death Review: A guide for parents and carers. The Lullaby Trust (Accessed at) <https://www.lullabytrust.org.uk/wp-content/uploads/lullaby-cdr-booklet.pdf>

13 Plans for the Year 2018-19

- 13.1 The 2018-19 business plan is attached as appendix B, the priority actions are summarised below:

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), 2014-16⁵

Local Authority	Infant Mortality Rate (2014-16)	England average
Cambridgeshire	3.4	3.9
Peterborough	3.7	3.9

2) Child Mortality Rate (directly standardised rate per 100,000 children age 1-17 years), 2014-16⁵

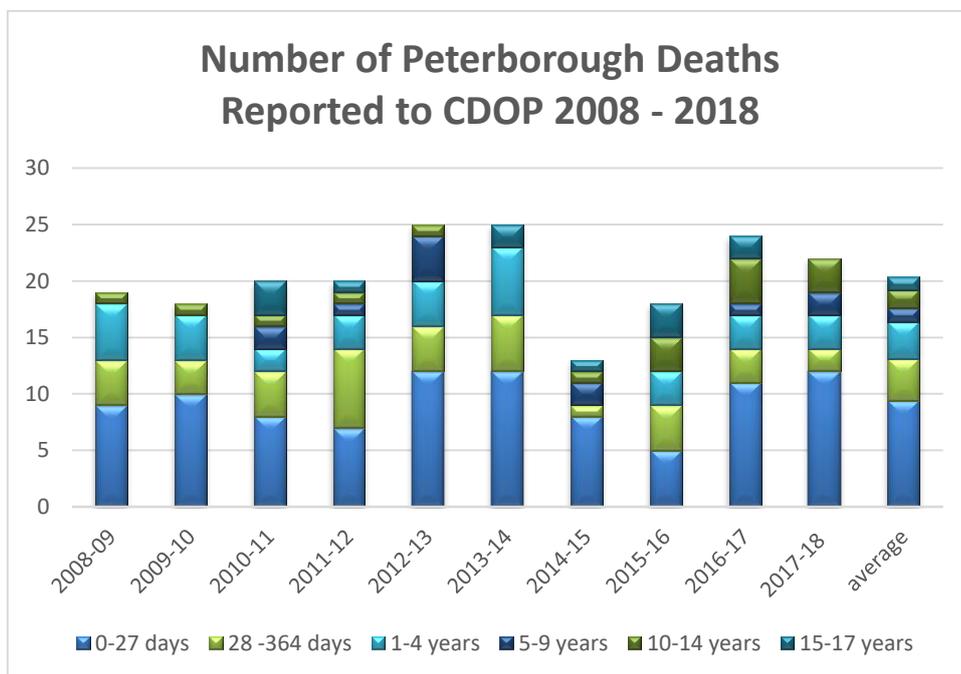
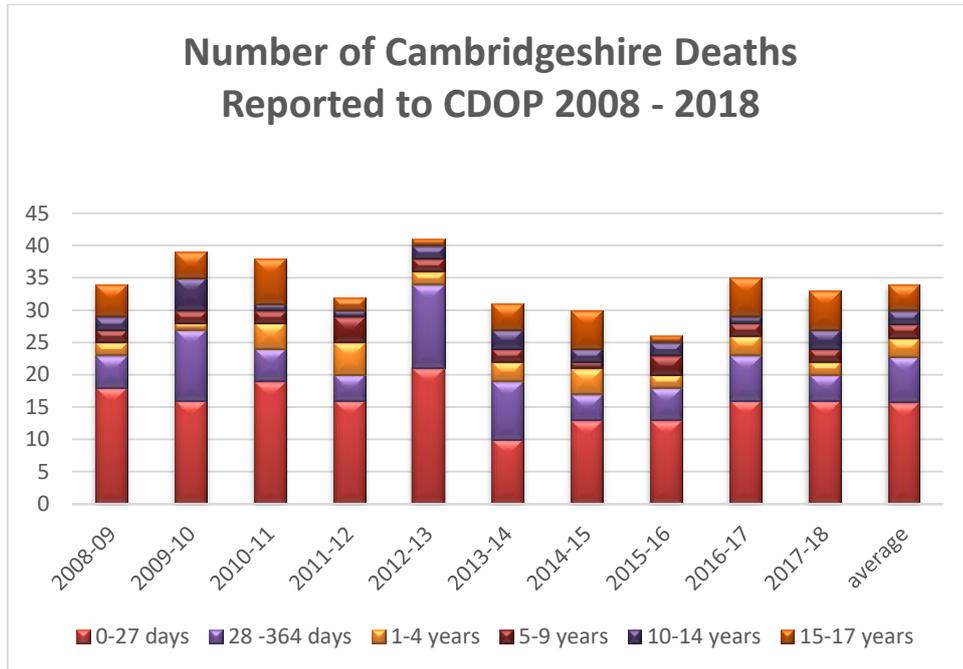
Local Authority	Child Mortality Rate (2014-16)	England average
Cambridgeshire	10.6	11.6
Peterborough	18.3	11.6

3) Reported Deaths by Gender 2017-18

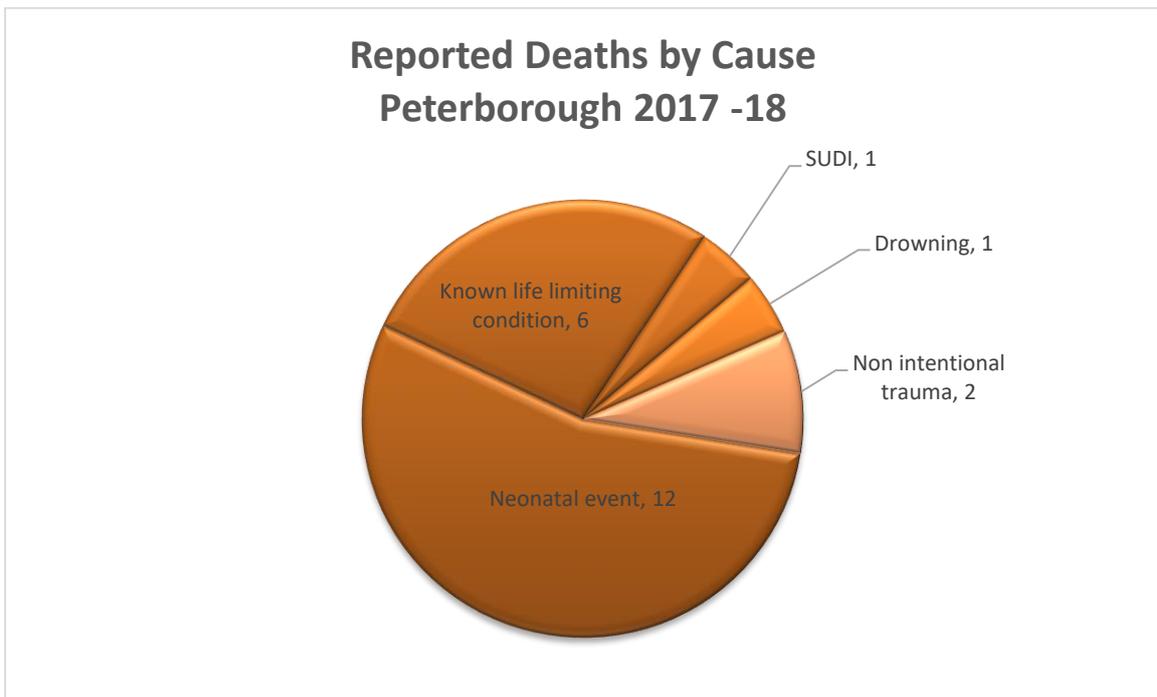
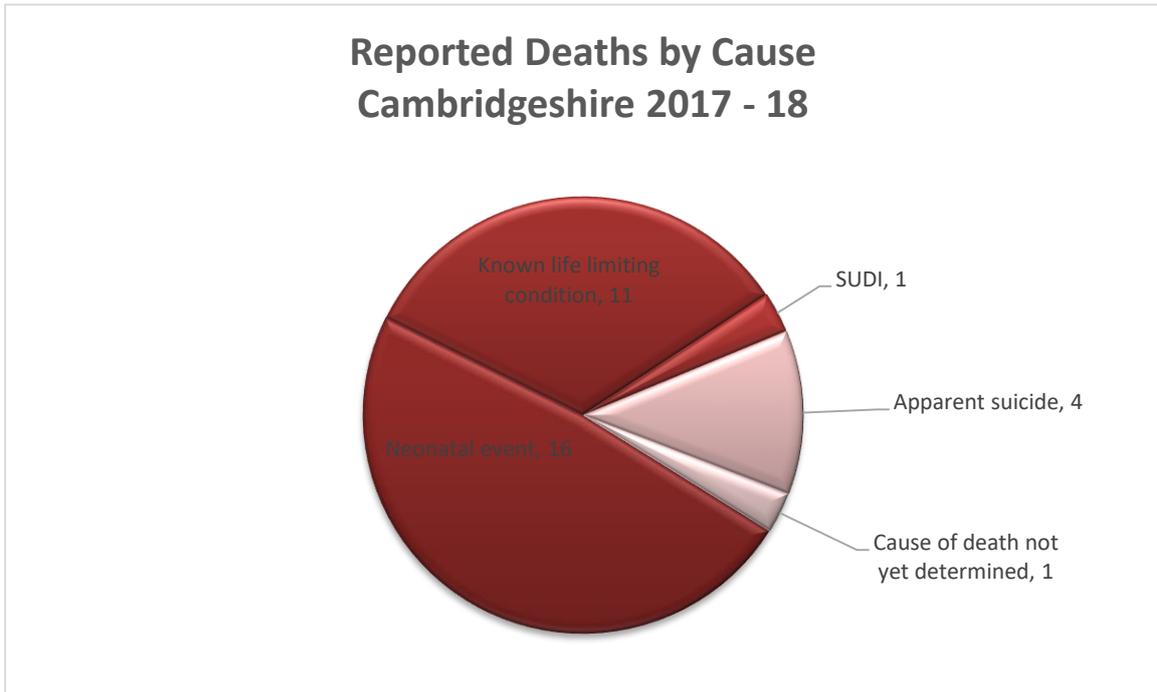
Gender	Cambridgeshire	Peterborough	Total
Male	15	12	27
Female	17	10	27
Indeterminate	0	1	55

⁵ Area Profiles, Overview of Child Health 2014-16, Public Health England (Accessed at <https://fingertips.phe.org.uk/>)

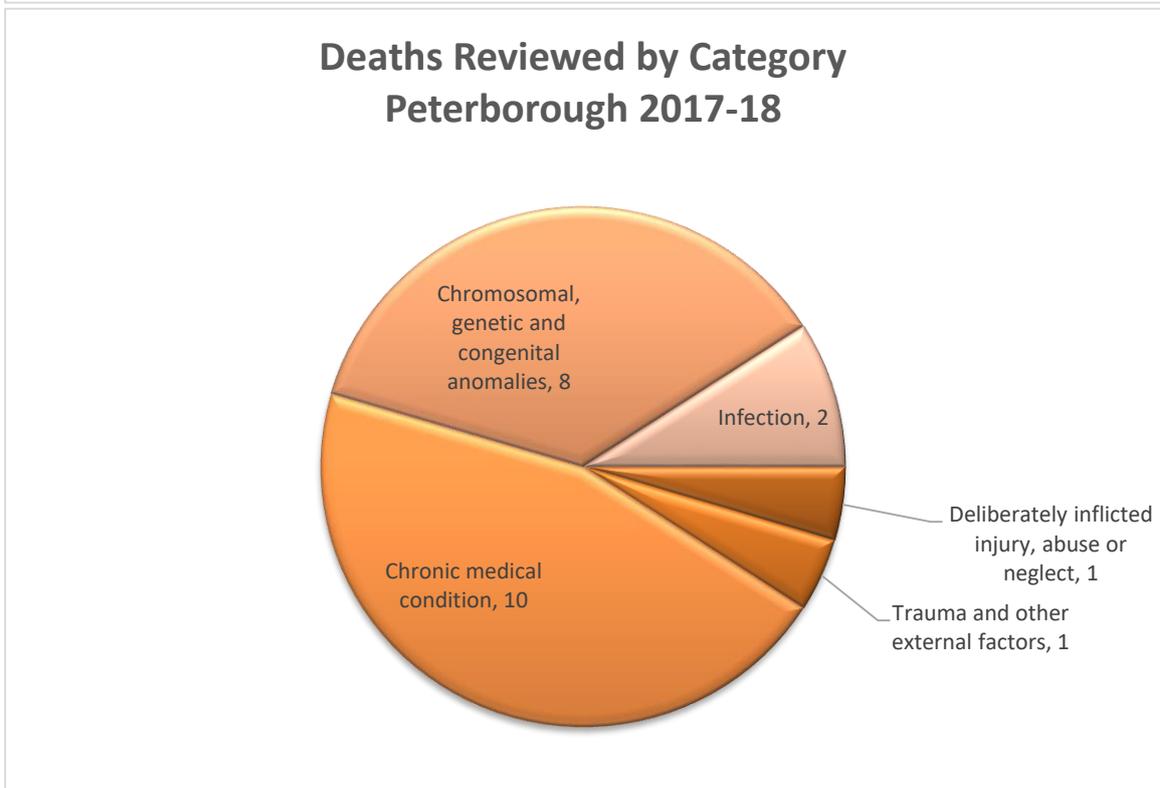
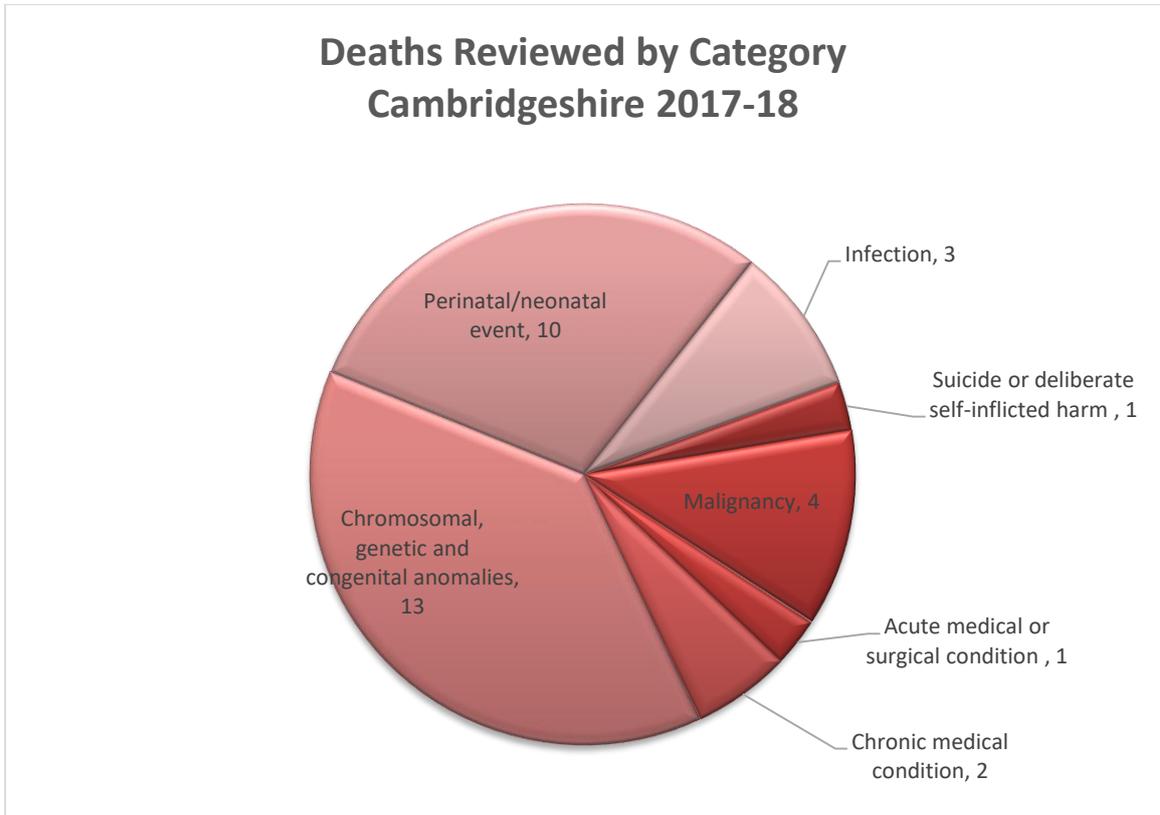
4) Reported Deaths by Council Area, by age, 2008 - 2018



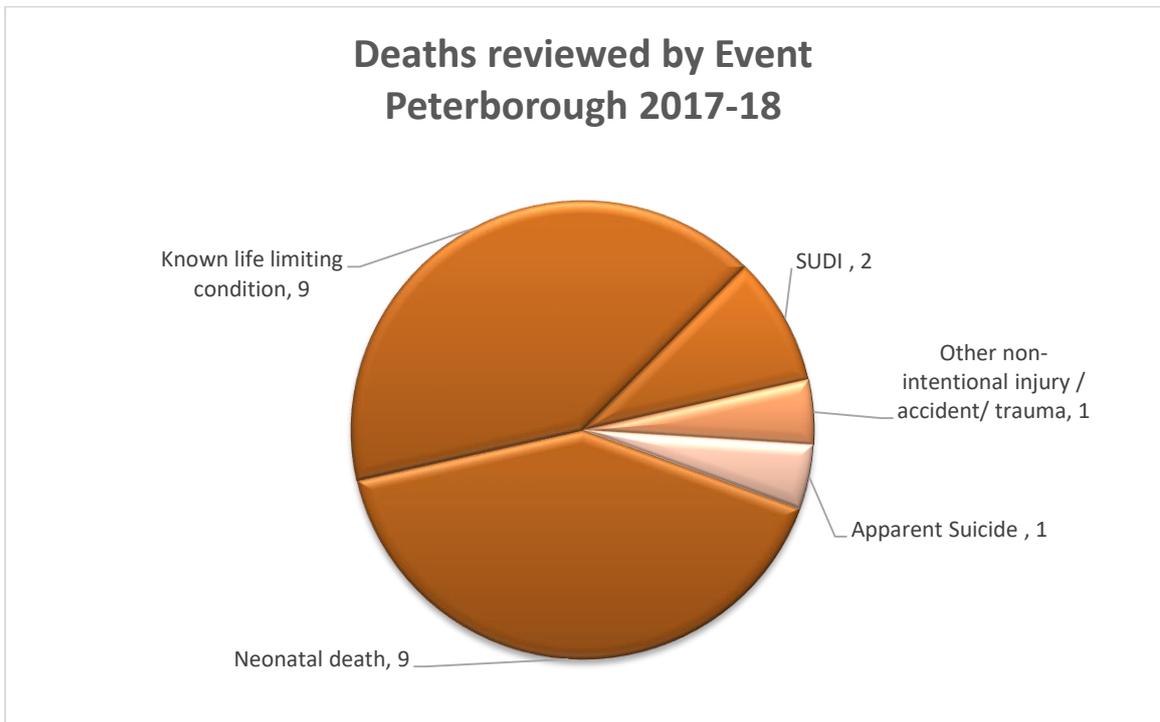
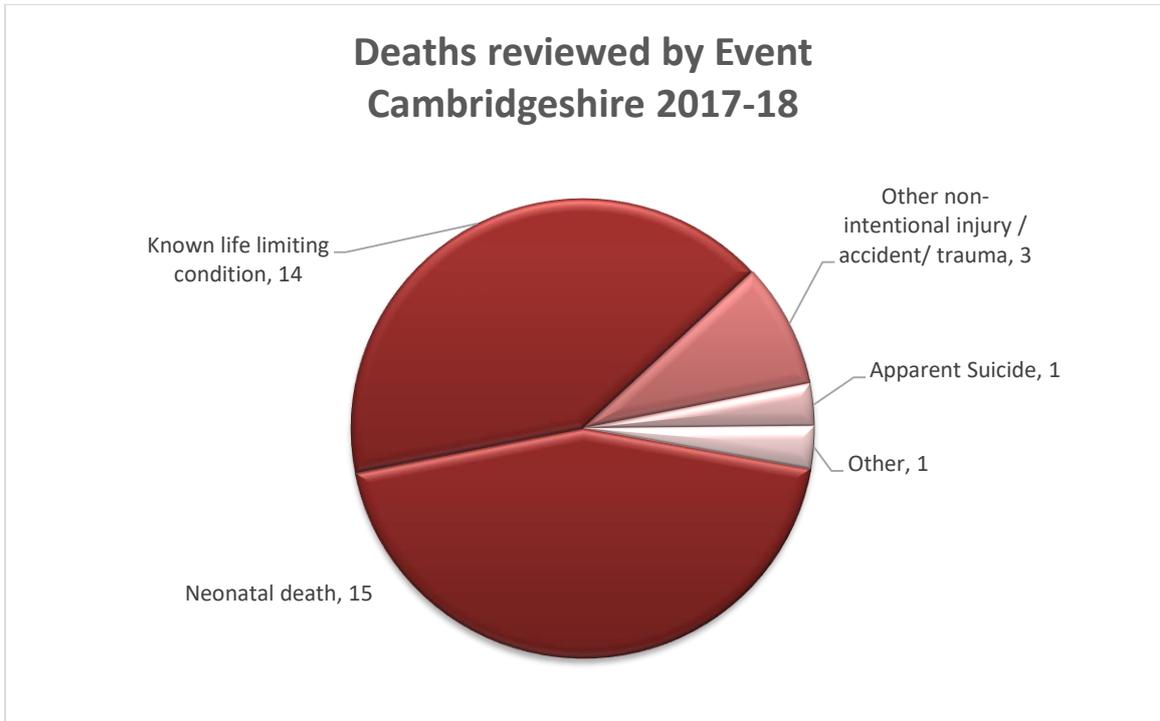
5) Reported Deaths by Council Area, by Cause of Deaths, 2017-18



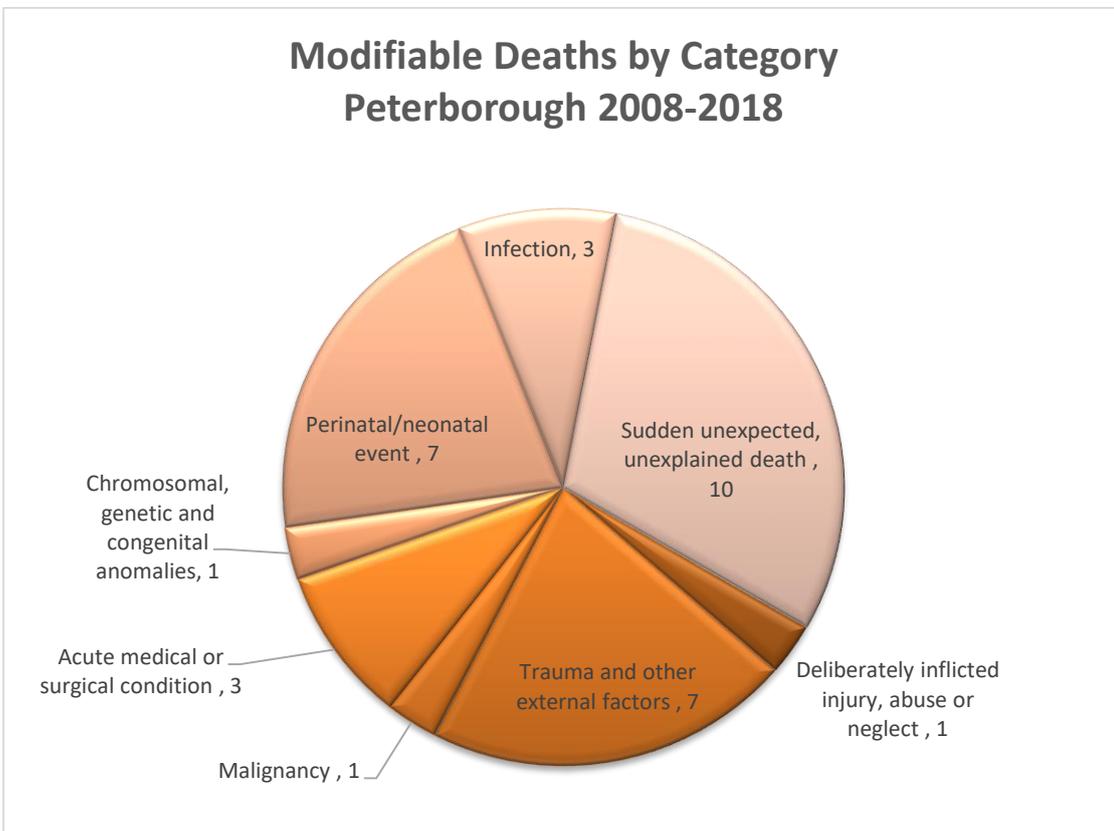
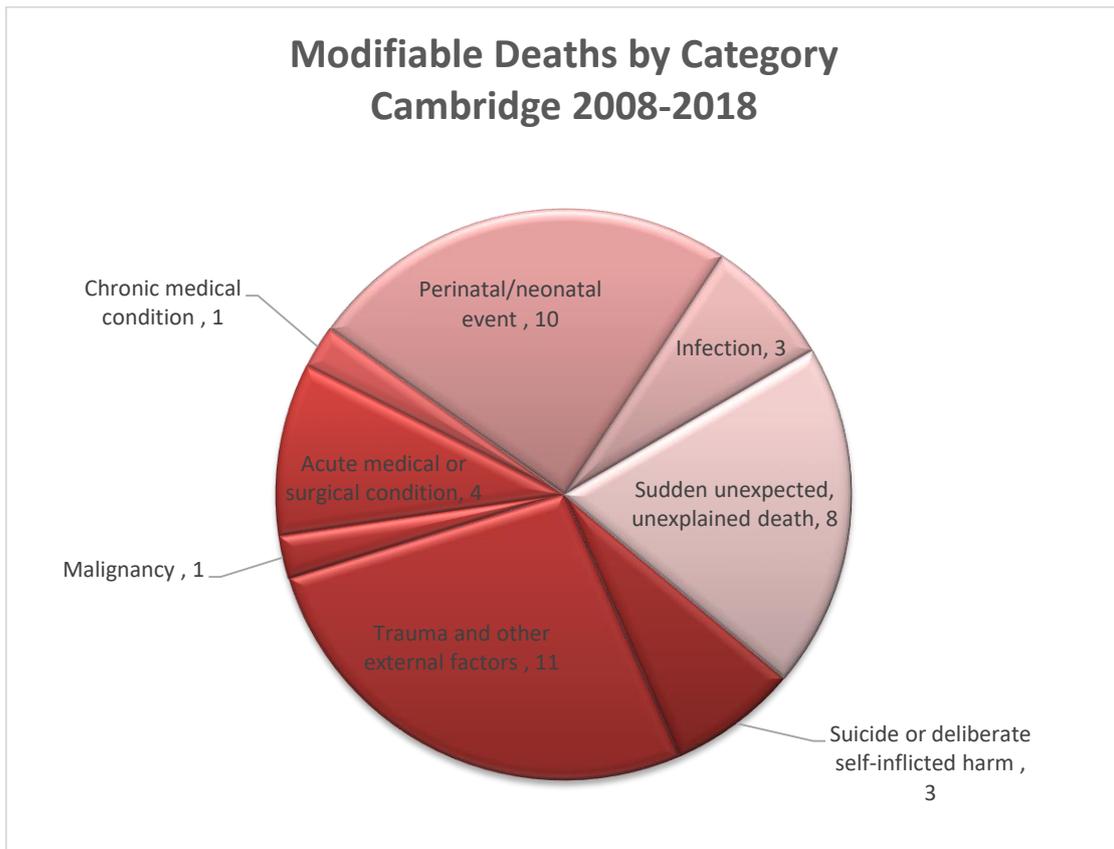
6) Reviewed Deaths by Council Area, by Category 2017-18



7) Reviewed Deaths by Council Area, by Event 2017-18



8) Modifiable Deaths by Council Area, by Category 2008 – 2018



Appendix B Business Plan 2018-19

	Objective	Lead	Action and timescale	Outcome	Progress
1.	Develop new arrangements to comply with the new statutory guidance.	RW/RB/NJ	1/04/2018	Meet the requirements of the statutory guidance.	
2.	Review and update protocols in line with the new statutory guidance.	RW/RB/NJ	1/04/2018	Meet the requirements of the statutory guidance.	
3.	Work with the regional CDOP group to collate data at a regional level.	RB/NJ	Ongoing	Improved identification of patterns, trends and themes.	

4	Review and Update rapid response training	RW/RB	1/04/2018	Timely response to unexpected death in childhood.	
RW = Dr Russell Wate, Independent Chair					
RB = Dr Richard Brown, Designated Doctor for Death in Childhood					
NJ = Natalie Jones, Child Death Review Manager					
CDOP = Child Death Overview Panel					