



## **Cambridgeshire and Peterborough Child Death Overview Panel**

**Annual Report 2018-2019**

**Confidential**

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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 2018-19.
- 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 2019.
- 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'. 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 This guidance was updated in Working Together to Safeguard Children (2018) and Child Death Review Statutory and Operational Guidance (2018). This report has been written in accordance with both of these guidance's.
- 2.3 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) (changed to Safeguarding Children Partnership within the reporting area) 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 review of all deaths of children under the age of 18 years and a rapid response service (Changed to Joint Agency Response during reporting period) which looks in greater detail at the deaths of children who die unexpectedly.
- 4.2 During 2018-19, the CDOP has met four times to review anonymous information about child deaths. The panel is chaired by an independent chairperson (Currently the Independent Chair of the Safeguarding Children Partnership) 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 by them 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 3.9 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.<sup>1</sup>
- 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 death<sup>2</sup>.

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<sup>1</sup> Child Mortality in England and Wales:2016. Office for National Statistics [Accessed at <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2016> ]

<sup>2</sup> *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](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 Public Health data from 2015-2017 indicates that Infant mortality rates for Cambridgeshire is slightly below the national average whereas Peterborough is slightly above the England average. Child mortality rates for Cambridgeshire are lower than the England average whereas Peterborough has a significantly higher child mortality rate than the national average (see appendix A, mortality rates by Council area).
- 6.2 Over the last year, the deaths of 51 children were reported to the CDOP across Cambridgeshire and Peterborough, 26 in Cambridgeshire and 25 in Peterborough. 70% of these children were babies under one year old and 58% 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 11 unexpected deaths reported this year, 6 in Cambridgeshire and 5 in Peterborough.
- 6.3 10 (20%) 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.

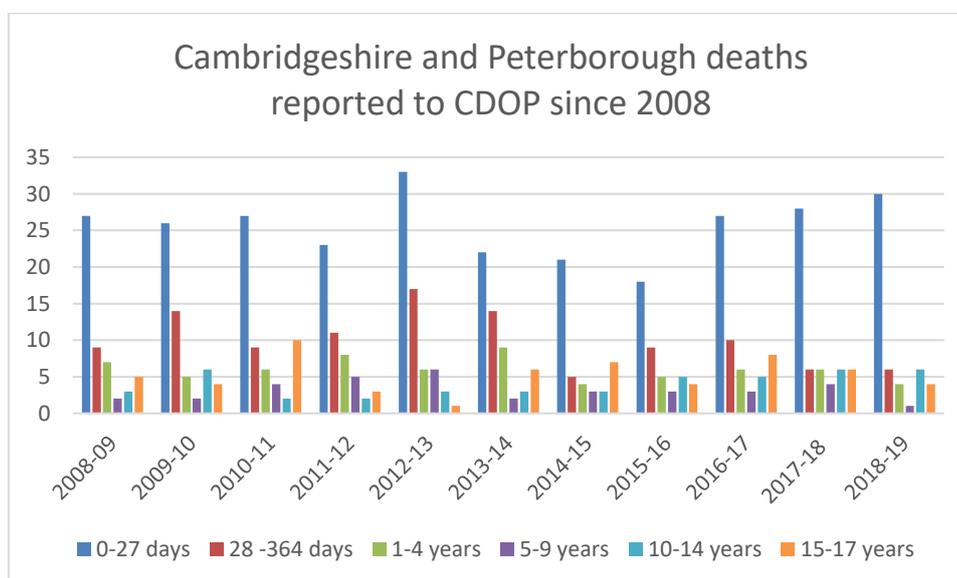


Chart 1 – Deaths reported to Cambridgeshire and Peterborough CDOP 2008 – 2019 by age group

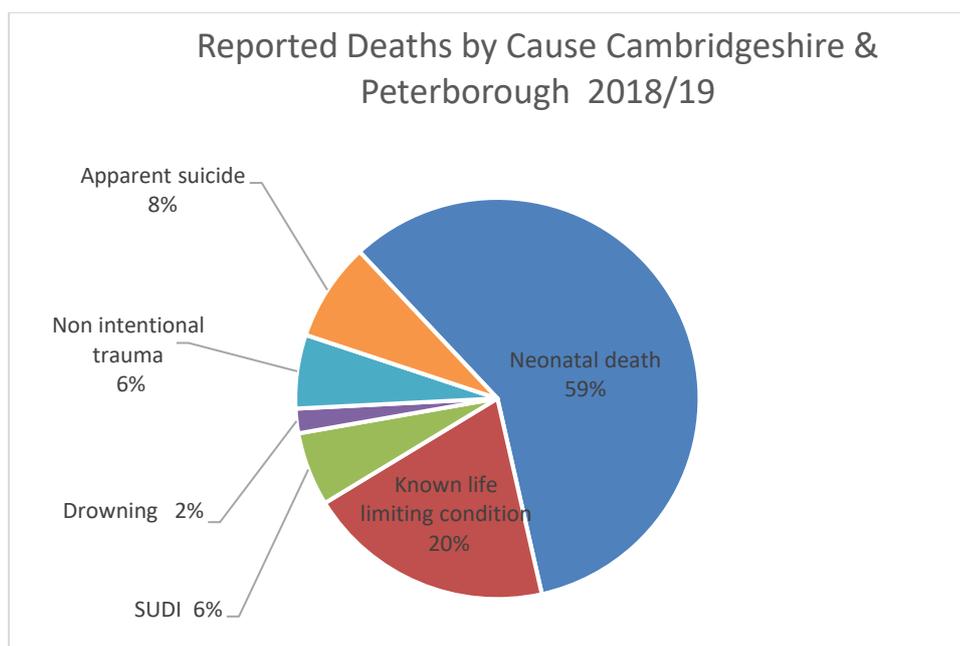


Chart 2 – Deaths reported to Cambridgeshire and Peterborough CDOP 2018-19 by cause

### Deaths reviewed

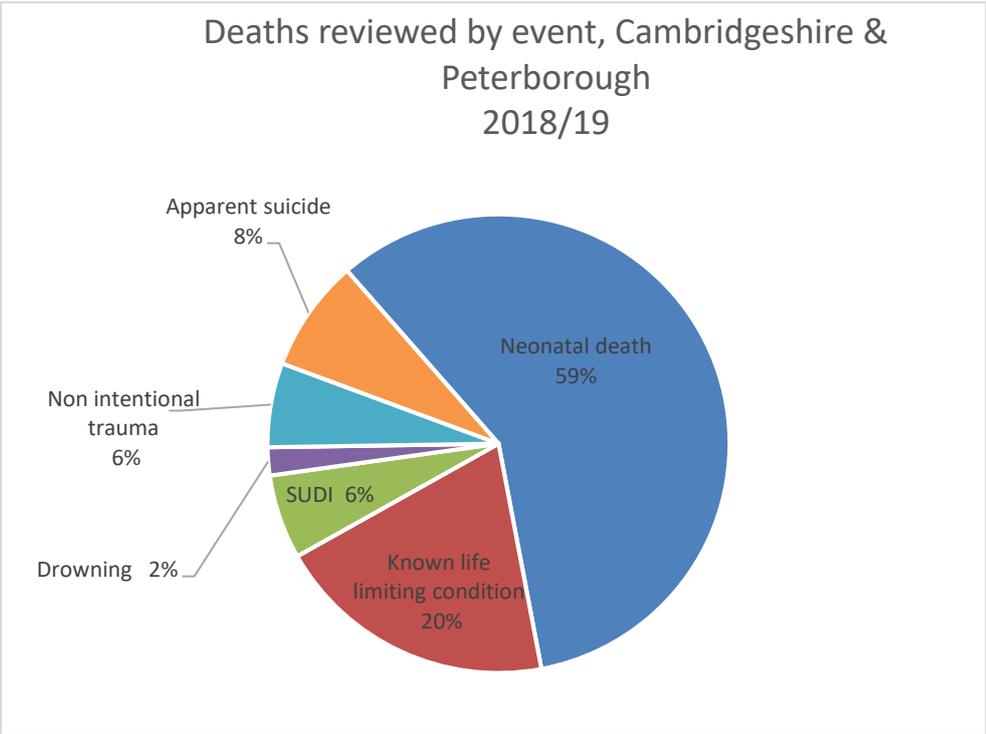
- 6.5 A total of 51 deaths were reviewed in 2018-19; 26 Cambridgeshire children and 25 Peterborough children. 21 deaths were reviewed by the main CDOP Panel and 29 by the Neonatal Panel.
- 6.6 One of the purposes of the child death review process is to identify ‘modifiable’ factors for each child that dies. That is, any factor which, on review, might have prevented that death and might prevent future deaths. During 2018-19 there were 7 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, post mortem reports and Coronial Inquests. The table below shows that 47% of deaths reviewed this year occurred this year while 41% of deaths reviewed this year occurred the year before (2017-18).

<b>Year Death Reported</b>	<b>Number of Deaths Reviewed in 2018-19</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>2016-17</b>	6	1	0
<b>2017-18</b>	21	5	0
<b>2018-19</b>	24	1	0
<b>Total</b>	51	7	0

Table 1 – Deaths reviewed by year of death, Cambridgeshire and Peterborough 2018-19

- 6.8 68% of cases reviewed this year were completed within 12 months which is below the national figure of 76%. One of the reasons for the delay is the current backlog locally for Coronial inquests. 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; 71% for both areas combined, 73% for Cambridgeshire and 68% for Peterborough.
- 6.10 Following this, the next highest age ranges were children aged between 28 days and 364 days and 10- 14-year olds, both accounting for 6 deaths.
- 6.11 The main causes of death reflected similar years, with 59% of deaths being the result of perinatal or neonatal difficulties and 20% 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 2018-19



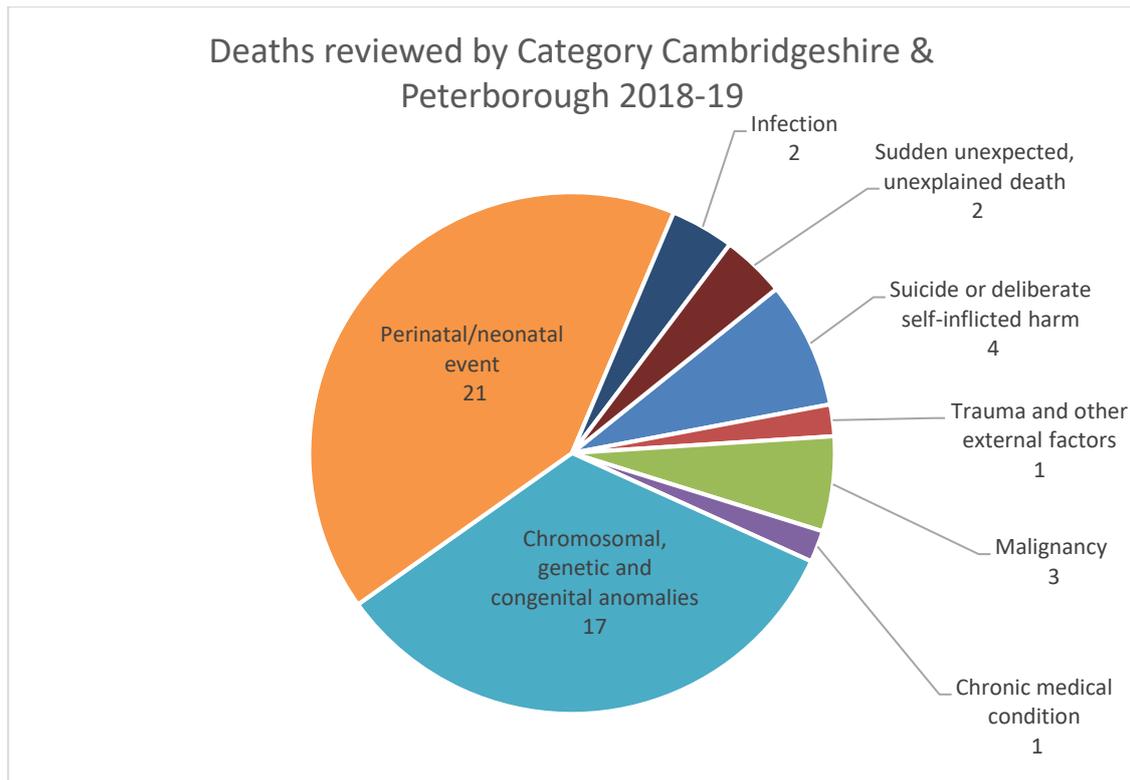


Chart 4 – Deaths reviewed by Category, Cambridgeshire and Peterborough 2018-19

### CDOP Main Panel – Modifiable Factors

6.12 The main CDOP panel met four times and reviewed the deaths of 51 children. Modifiable factors were identified in the case of 5 Peterborough children and 2 Cambridgeshire children:

- *A 17-year-old took their life by suicide – See section on Serious Case Reviews for the learning in this case.*
- *A Child of 2 years old drowned at a family event held by the river. The CDOP had concerns around the suitability of the location for a family event held by the river. An internal investigation was conducted by the event organisers which identified six learning points that were shared with the group. These learning points included the need for detailed risk assessments prior to holding such events.*
- *A 2-month-old baby died at home from sudden unexpected death in infancy whilst co-sleeping with mother. The baby was premature and both parents were smokers, smoking cessation had been offered but*

*declined. The Health Visiting had given advice regarding safe sleeping. Co-Sleeping and smoking were noted as risk factors in the baby's death*

- 6.13 Chart 5 provides a breakdown by category for deaths where modifiable factors were identified over the eleven years in which figures have been collected. See appendix A for modifiable deaths charts by council area.

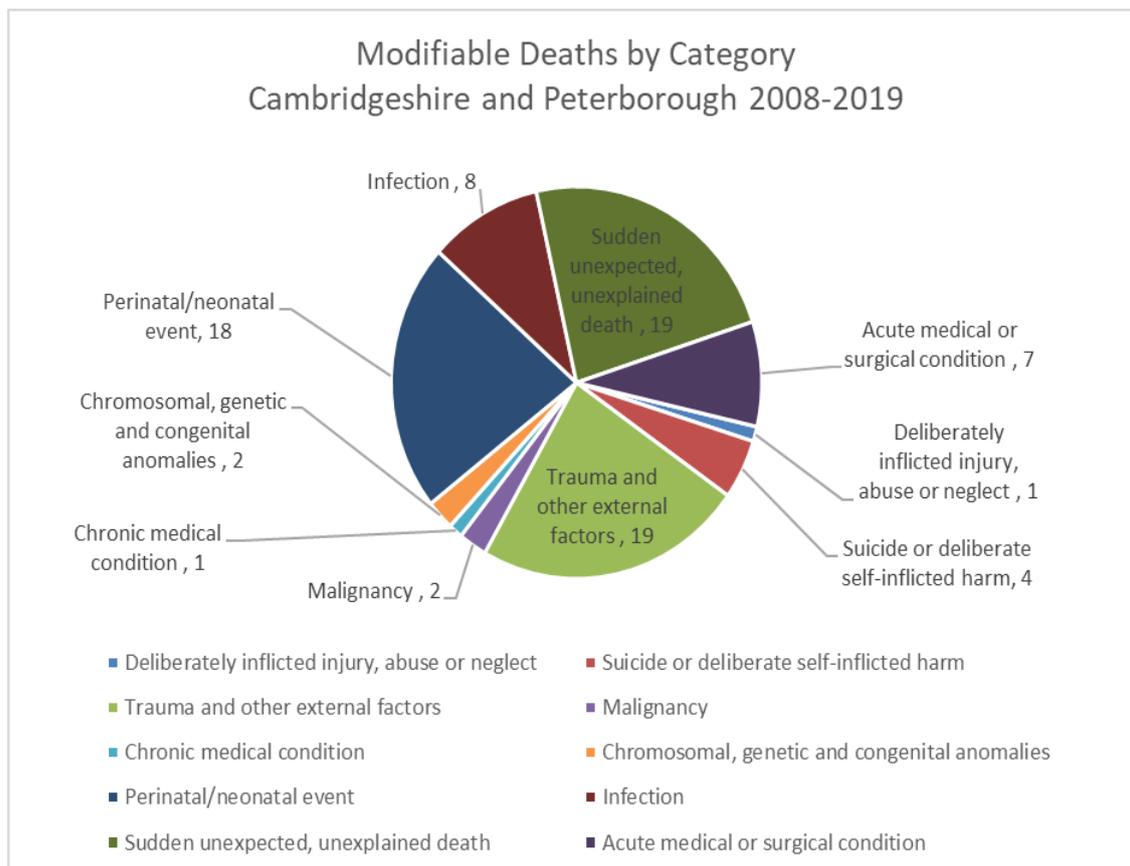


Chart 5 – Deaths where modifiable factors were identified by Cambridgeshire and Peterborough CDOP 2008-2019 by category of death

### Neonatal Panel – Modifiable Factors

- 6.14 The Neonatal CDOP met twice over the course of 2018-19 and completed a review of 29 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. 8 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 2 of the deaths reviewed:
- *Mother was left alone as not diagnosed to be in labour. Resuscitation equipment was not ready in the room but was easily accessible. As part of the perinatal death review process specific actions to prevent likelihood of reoccurrence focused on 'complex' women not being left unattended until the clinical situation is clear and an appropriate management plan has been formulated and the need to check readiness of resuscitation equipment in delivery rooms.*
  - *High risk family, consanguinity noted and discussed. Poor prognosis due to cardiac anomaly and genetic abnormalities. Genetic counselling had been offered to the family but declined. It was therefore agreed that on a Public health level, that death was modifiable.*

## 7 Serious Case Reviews

- 7.1 One of the deaths reviewed this year were the subject of serious case review. This case involved the death of a 17-year-old who took her life by suicide. It was noted during this review that the father of the young person had a very different view to that of the GP. The young person had a good relationship with her dad and visited the GP on numerous occasions accompanied by her dad. Dad was never told of his daughter's suicidal ideation; he feels strongly that if he had of known he could have chased up referrals. Other learning focused on the GP referral to CAMHS, this was marked as urgent but the information within the referral did not necessarily reflect the urgency of the referral and highlighted a number of positive factors rather than cause for concern. Other learning is identified in the Serious Case Review recommendations and learning events have been held.

## **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. 11 children died unexpectedly this year; 6 in Cambridgeshire and 5 in Peterborough. This is a similar figure to previous years.
- 8.2 A joint agency response was undertaken for 2 of the 11 unexpected deaths.
- 8.3 In 9 out of the 11 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 4 cases a home visit was deemed inappropriate. In 5 cases it is unclear why 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 2018/19 four cases have been reviewed where a young person has died by suicide or deliberate self-inflicted harm.
- 9.2 The number of deaths by suicide or deliberate self-inflicted harm across Cambridgeshire and Peterborough have remained the same for 2018/2019
- 9.3 Chart 6 shows the breakdown of deaths by suicide or deliberate self-inflicted harm reported by year.
- 9.4 A Thematic CDOP panel took place during the reporting period to try and identify what factors were present in these deaths (including similar deaths from recent previous deaths) Chart 7 shows the factors that were identified as present.

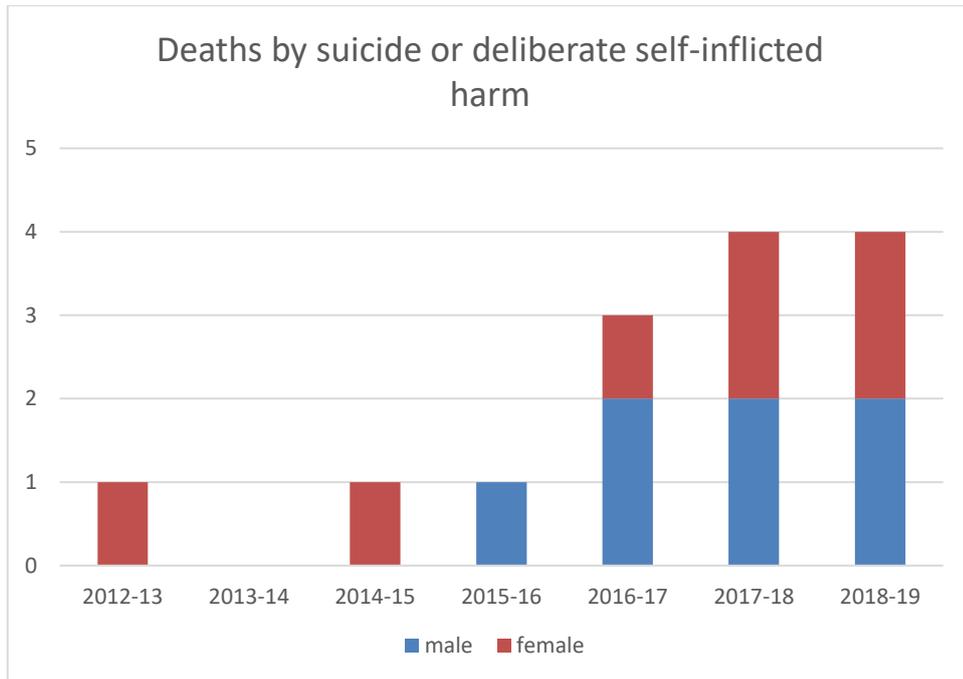


Chart 6 – Deaths by suicide or deliberate self-inflicted harm, reported between 2012-2019

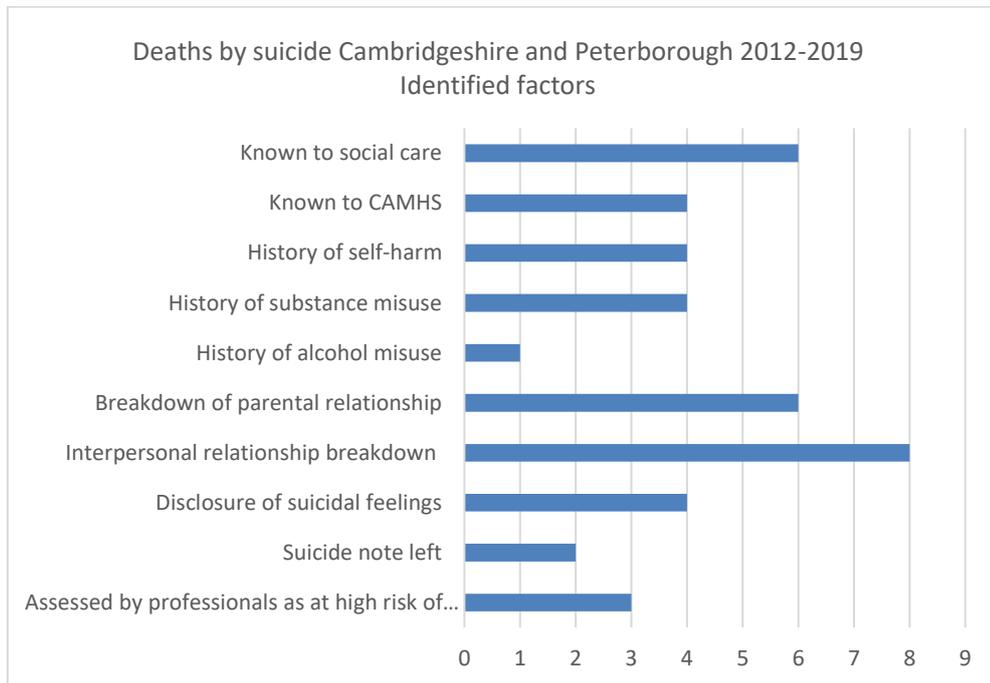


Chart 7 – Deaths by suicide 2012-19, Factors Present

## 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 Safeguarding Partnership Board training calendar, however 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; Safeguarding Partnership Board (Adult and Children) basic safeguarding children training, child and adolescents training and General Practitioner training as well as being promoted

throughout the year via the Safeguarding Partnership Board website and conferences. Online training tutorials have been shared with partner agencies on how to use ECDOP.

- 11.2 In 2019 a conference was organised for Headteachers in Cambridgeshire and Peterborough to support education staff in supporting pupils in the aftermath of a suicide. Multi-Agency guidance was also released by the Safeguarding Partnership Board to support schools and colleges in responding to suicides in teenagers.

## 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*<sup>3</sup>.
- 12.2 When a Child Dies which is sent to parents as part of the CDOP process outlines the role of the keyworker in supporting bereaved families. The CDOP Panel has identified that in expected deaths this role should be allocated by the lead paediatrician at the time of death. In unexpected deaths this should be allocated as part of the initial sharing meeting.

## 13 Plans for the Year 2019-2020

- 13.1 The 2019-2020 business plan is attached as appendix B, the priority actions are summarised below:
- 13.2 i) Embed eCDOP system locally ii) Support the development of new arrangements to comply with statutory guidance iii) Review and update protocols in line with the new statutory guidance iv) Work with the regional CDOP group to collate data at a regional level v) Review and Update rapid response training.

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<sup>3</sup> 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>

## 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), 2015-17<sup>4</sup>

Local Authority	Infant Mortality Rate (2014-16)	England average
Cambridgeshire	3.3	3.9
Peterborough	4.3	3.9

#### 2) Child Mortality Rate (directly standardised rate per 100,000 children age 1-17 years), 2015-17<sup>5</sup>

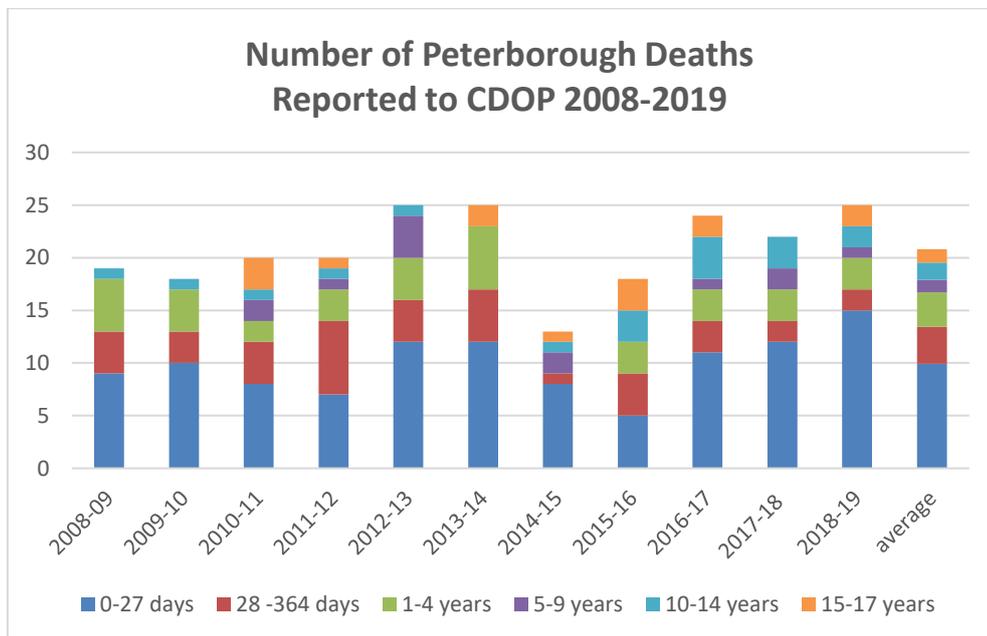
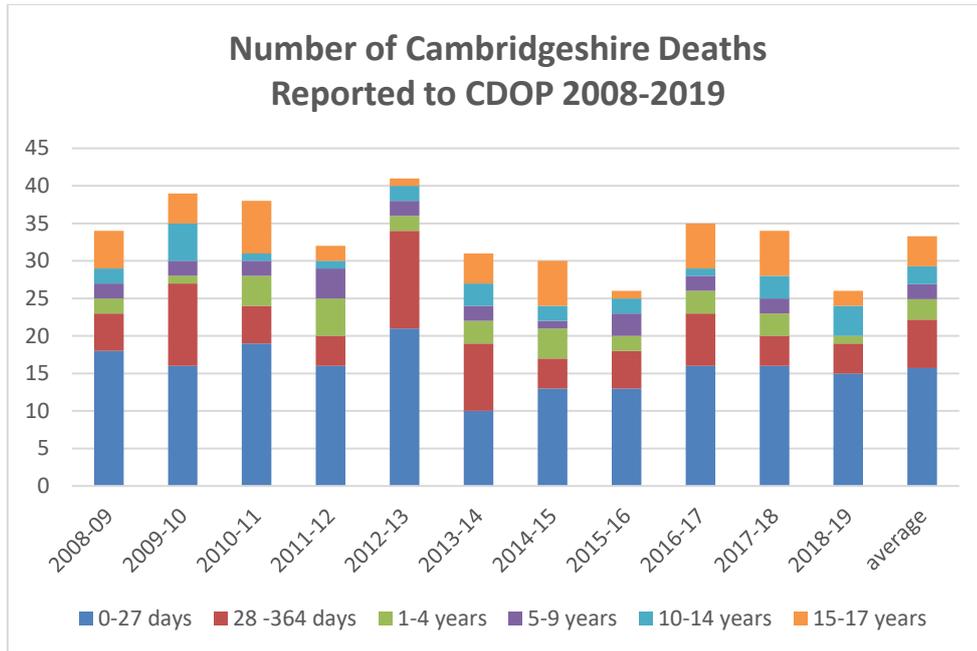
Local Authority	Child Mortality Rate (2014-16)	England average
Cambridgeshire	10.5	11.2
Peterborough	17.1	11.2

#### 3) Reported Deaths by Gender 2017-18

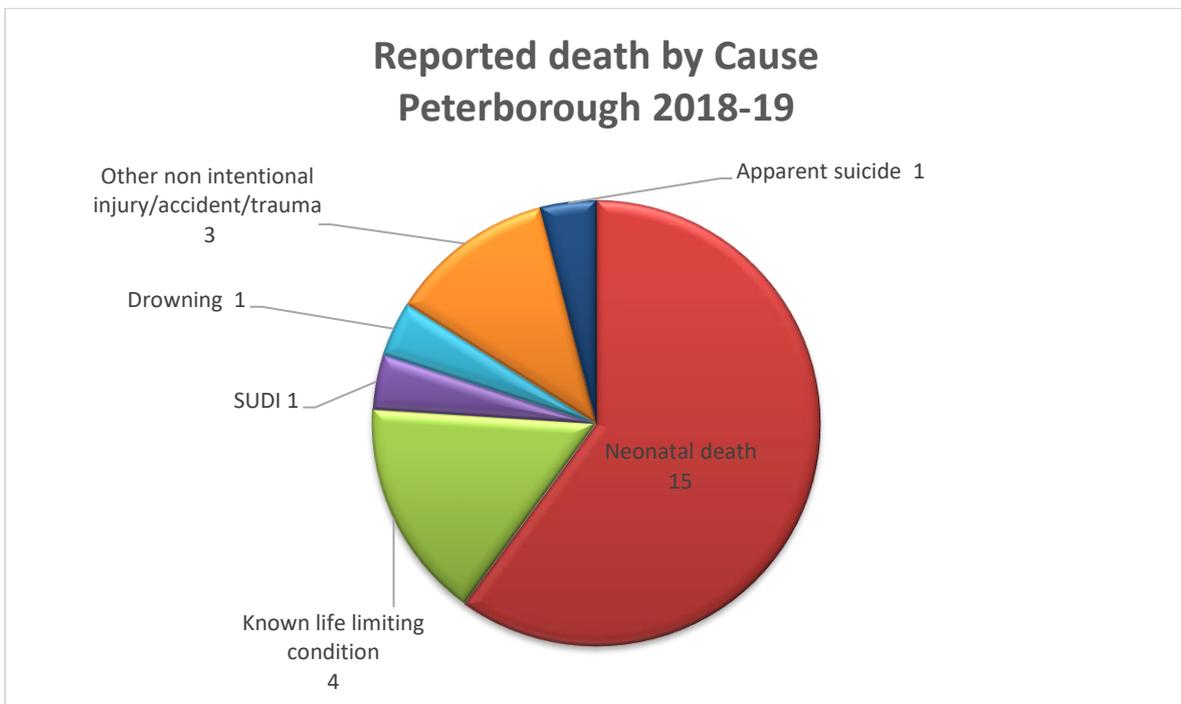
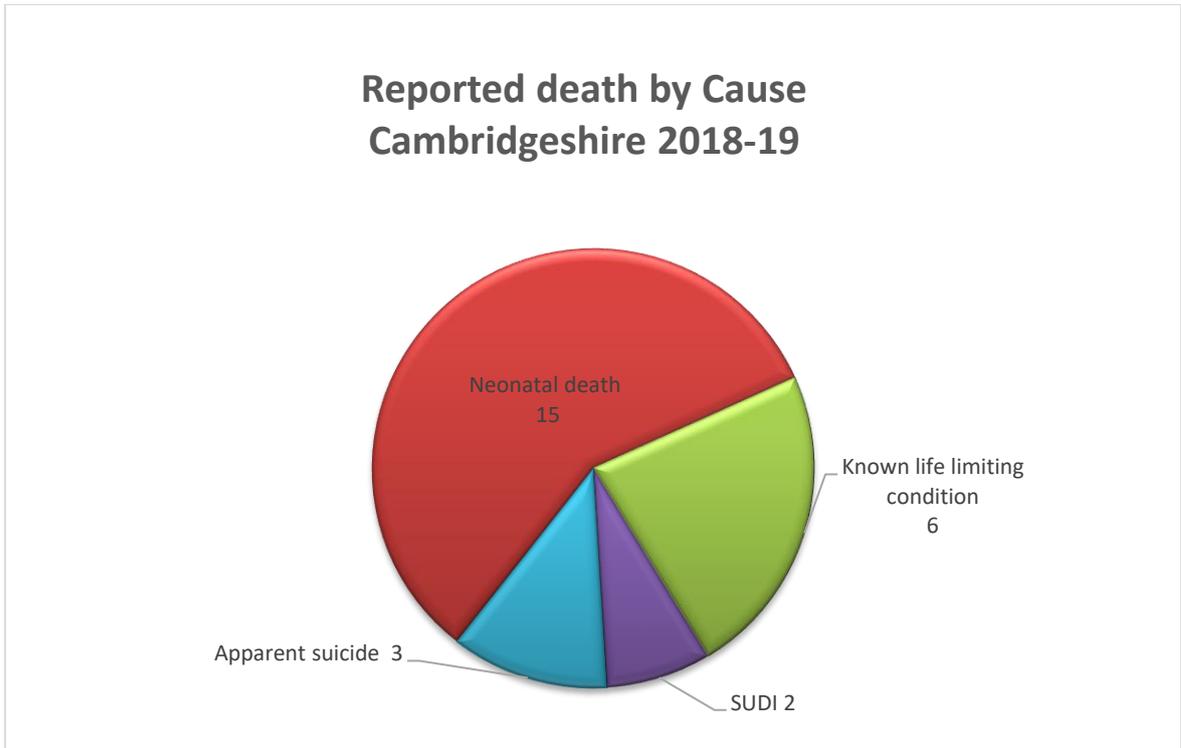
Gender	Cambridgeshire	Peterborough	Total
Male	11	11	22
Female	15	11	26
Indeterminate	0	3	3

<sup>4</sup> Area Profiles, Overview of Child Health 2015-17, Public Health England (Accessed at <https://fingertips.phe.org.uk/>)

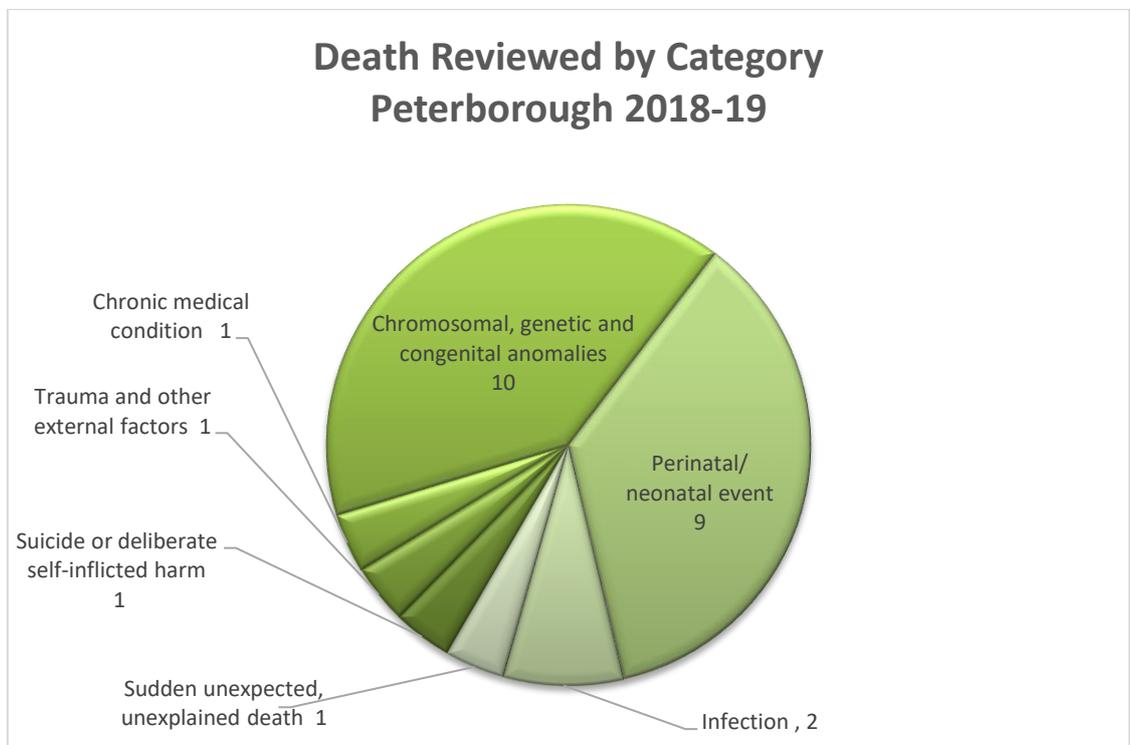
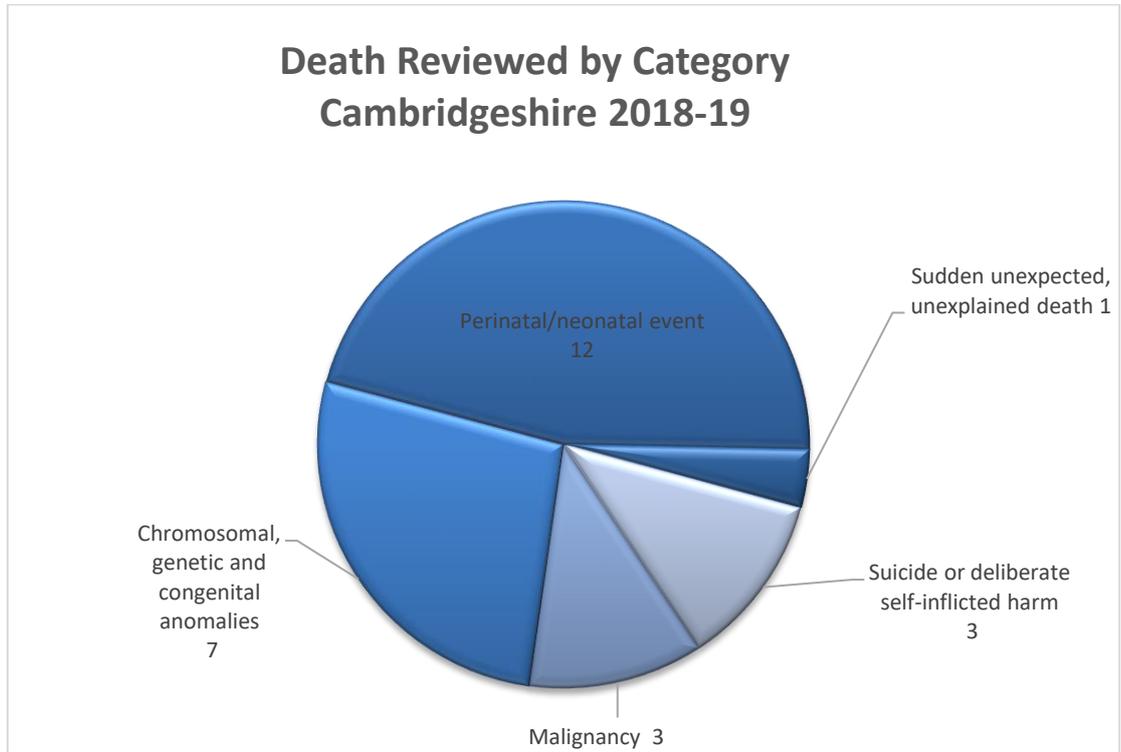
**4) Reported Deaths by Council Area, by age, 2008 – 2019**



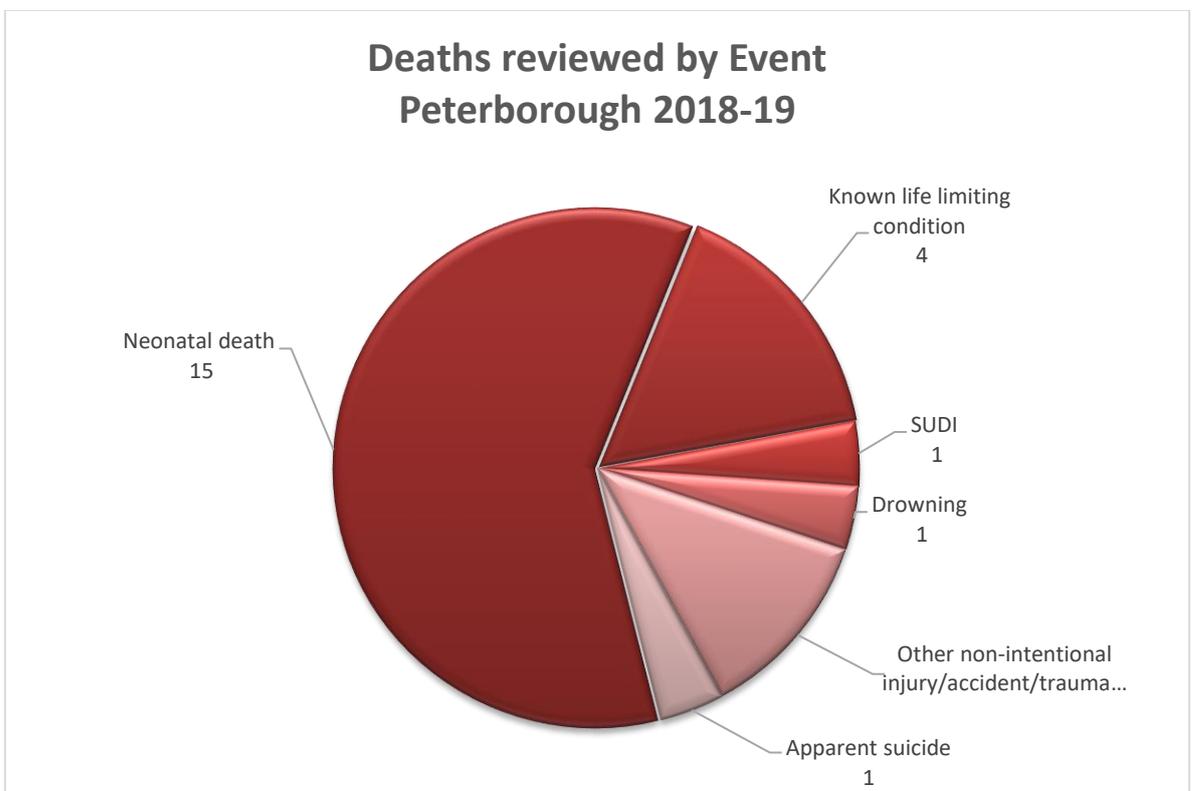
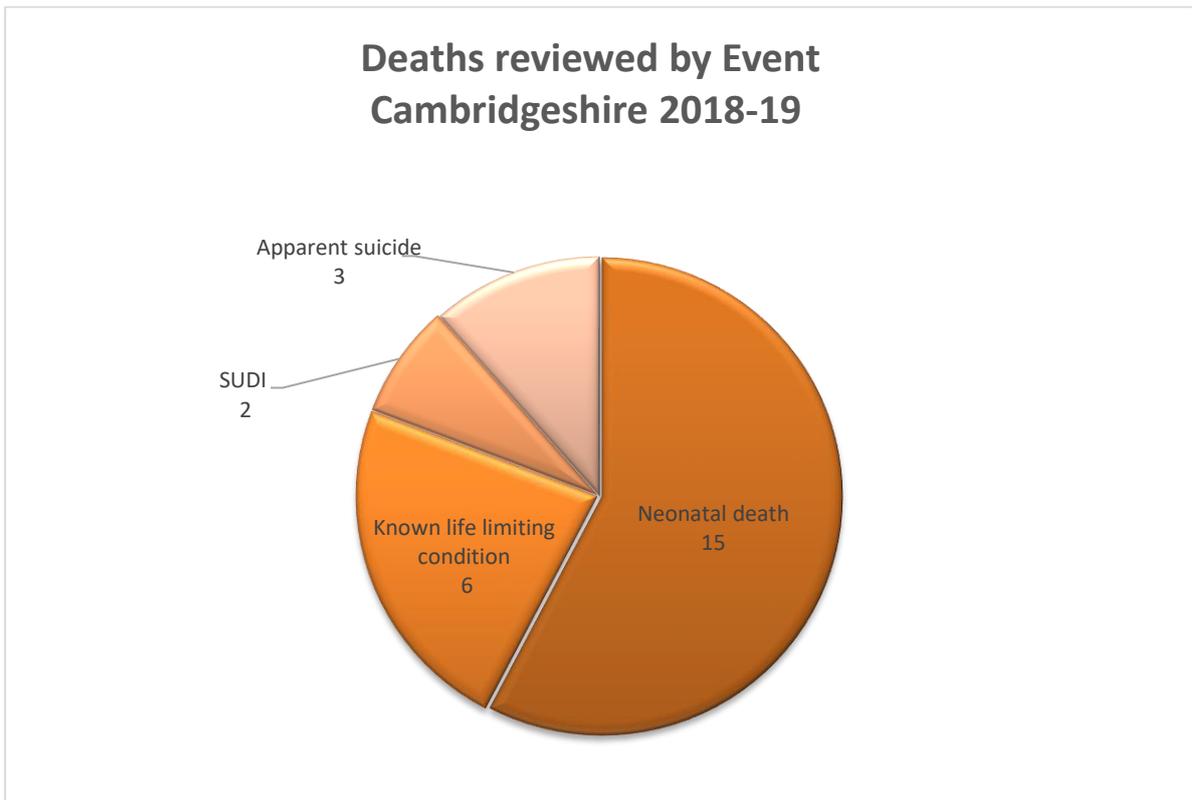
**5) Reported Deaths by Council Area, by Cause of Deaths, 2018-19**



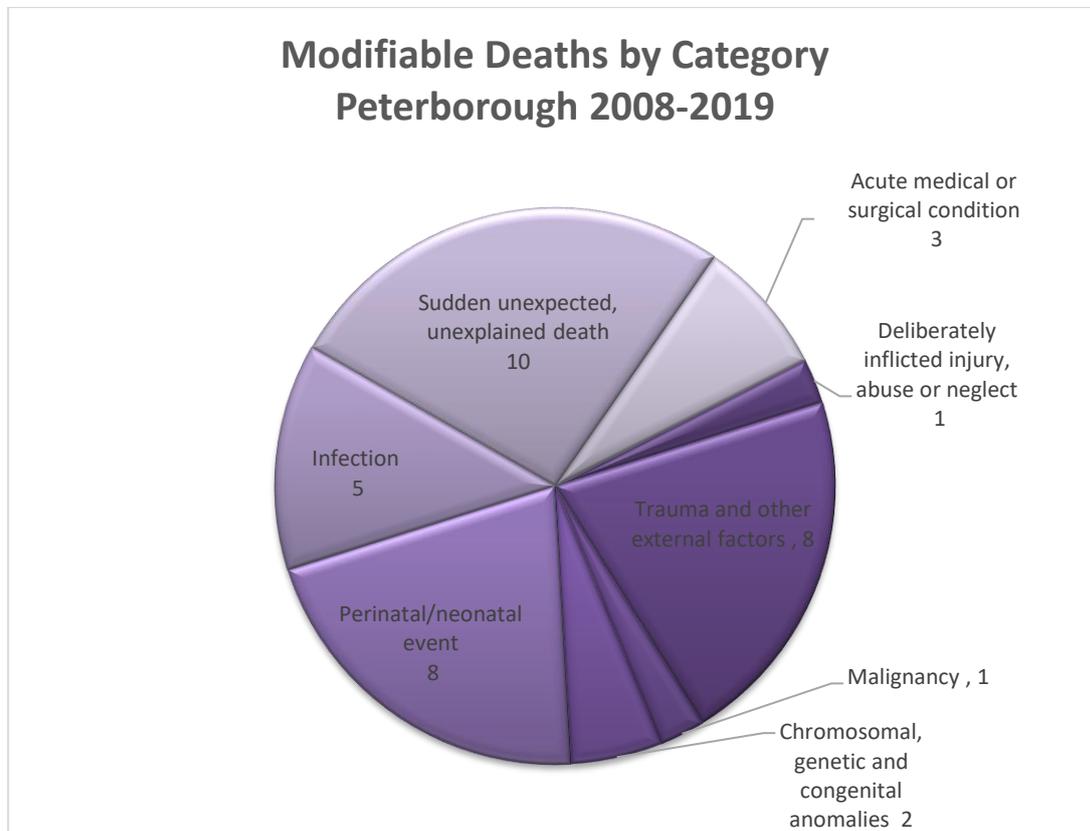
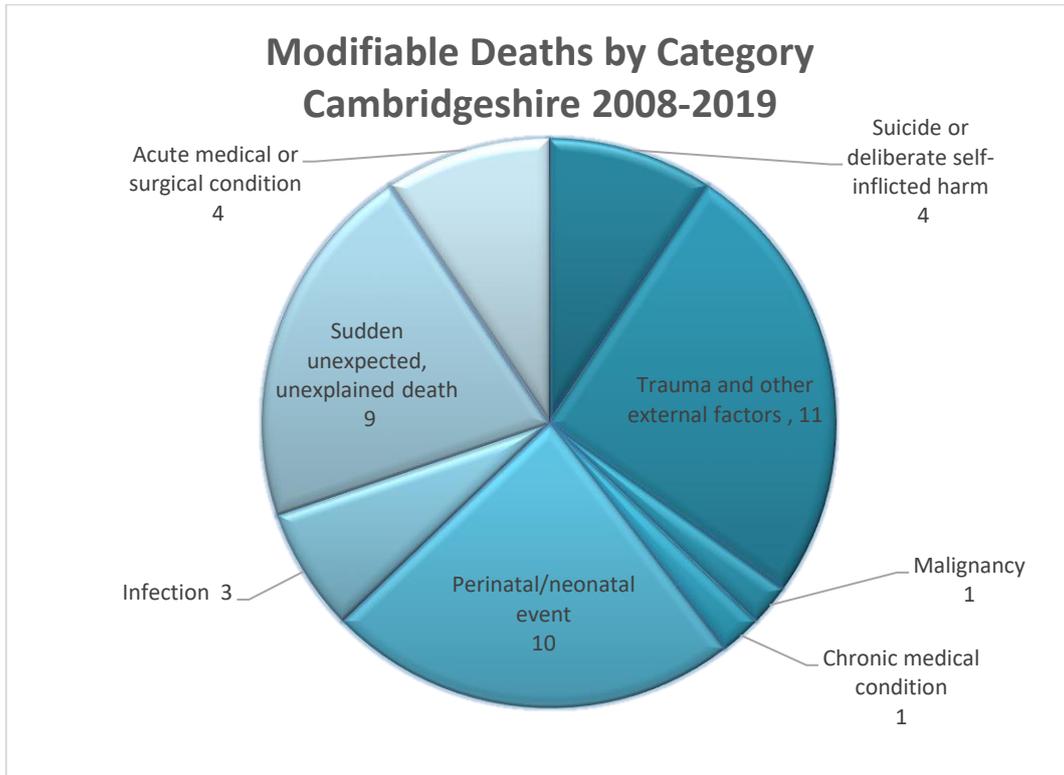
6) Reviewed Deaths by Council Area, by Category 2018-19



**7) Reviewed Deaths by Council Area, by Event 2018-19**



**8) Modifiable Deaths by Council Area, by Category 2008 – 2019**



**Appendix B Business Plan 2019/20**

	<b>Objective</b>	<b>Lead</b>	<b>Action and timescale</b>	<b>Outcome</b>	<b>Progress</b>
<b>1.</b>	Embed eCDOP system locally	CDR Manager	02/01/2020	Enable staff to feel competent in using eCDOP.	
<b>2.</b>	Support the development of new arrangements to comply with statutory guidance.	DD/Chair/CDR Manager	01/12/2019	Meet the requirements of the statutory guidance.	
<b>3.</b>	Review and update protocols in line with the new statutory guidance.	DD/Chair/CDR Manager	01/12/2019	Meet the requirements of the statutory guidance.	

4.	Work with the regional CDOP group to collate data at a regional level.	DD/CDR Manager	Ongoing	Improved identification of patterns, trends and themes.	
5.	Review and Update rapid response training	DD/CDR Manager	1/04/2018	Timely response to unexpected death in childhood.	
<p>Chair = CDOP Independent Chair</p> <p>DD = Designated Doctor for Death in Childhood</p> <p>CDR Manager = Child Death Review Manager</p> <p>CDOP = Child Death Overview Panel</p>					