

Cambridgeshire and Peterborough Child Death Overview Panel

Annual Report 2021-22

Confidential

Contents

Introduction	2
1. Background	2
2. Principle	3
3. The Process	3
4. The National Picture	4
5. Local Overview	5
6. Deaths Reviewed	5
7. Safeguarding Practice Reviews	7
8. Unexpected Deaths	7
9. East of England Regional CDOP	8
10. CDOP Training	9
11. Support	9
12. Achievements	9

Introduction

The aim of this report is to summarise the work of the Cambridgeshire and Peterborough Child Death Overview Panel (CDOP) during 2021-22.

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 2022.

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 several years. Current methods of data collection via the National Child Mortality database mean that accurate regional and national comparisons are now readily available.

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.

1. Background

- 1.1 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.
- 1.2 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 guidance's. 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 Local Safeguarding Children Partnership within the reporting area any deaths where the panel considers there may be grounds to consider a Child Safeguarding Practice 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.

2. The principles

- 2.1 The principles underlying the overview of all child deaths are:

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

3. The process

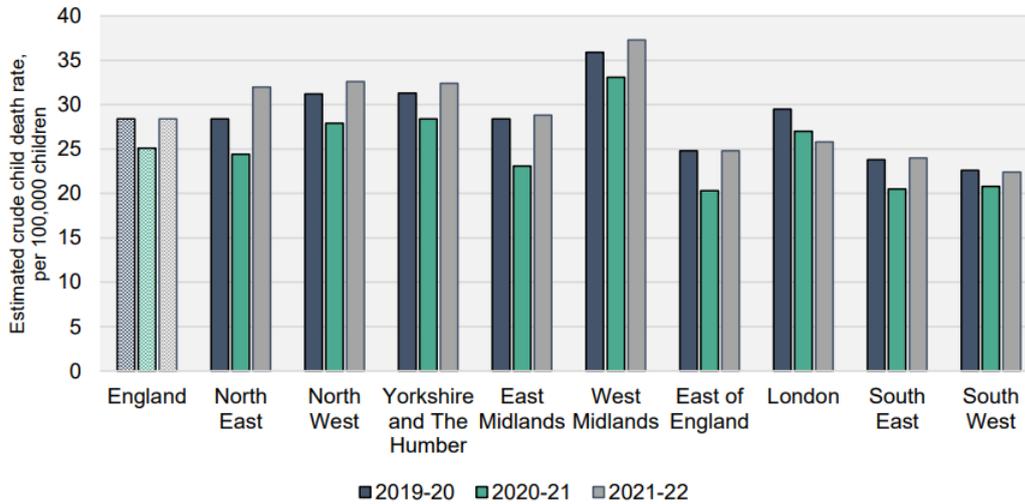
- 3.1 Child deaths are reviewed through two interrelated processes; a review of all deaths of children under the age of 18 years and the Joint Agency Response during reporting period, which looks in greater detail at the deaths of children who die unexpectedly.
- 3.2 During 2021-22, the CDOP met four times to review anonymized information about child deaths. The panel is chaired by an independent chairperson and has members from all relevant agencies.
- 3.3 A separate panel which reviews neonatal deaths has been discontinued. It has been replaced by the CDOP manager holding meetings with the Perinatal Mortality Review Teams at Addenbrookes and Peterborough City Hospital. Information from these detailed reviews is then uploaded onto eCDOP in the same format as a CDOP meeting. A form C is completed. This form marks the final CDOP process. When the Form C is complete with any Modifying Factors included, information from it is used by the National Child Mortality Database. The National Child Mortality Database produce annual (and quarterly) reports indicating Child death trends and themes. Neonatal deaths are reviewed separately because the reasons such young babies die are almost always health related and the added value of attendance by agencies such as the police and children's social care services is limited. The results of these meetings are available to the National Child Mortality database similar to the results of an ordinary CDOP meeting.
- 3.4 The administration of the CDOP process is hosted by NHS Cambridgeshire and Peterborough and funded jointly by them with the Cambridgeshire and Peterborough Local Authorities.

4. The national picture

- 4.1 The infant mortality rate is the number of children that die under one year of age each year, per 1000 live births¹. The infant mortality rate for U.K. in 2022 was 3.422 deaths per 1000 live births. A 2.42% decline from 2021 when the mortality rate was 3.507 deaths per 1000 live births, a 2.39% decline from 2020. The infant mortality rate for U.K in 2020 was 3.593 deaths per 1000 live births, a 2.31% decline from 2019.
- 4.2 The number of child death reviews completed by Child Death Overview Panels in England between 2021/22 is 2,724. This is a national decrease of 362 compared to 2020/21.
- 4.3 CDOPs in the West Midlands Region submitted the most child death notifications and the least in the East of England, Southeast and Southwest.

¹ Infant and neonatal Mortality, Nuffield Trust 2021

Figure 2: The estimated crude child death rates per 100,000 population by region

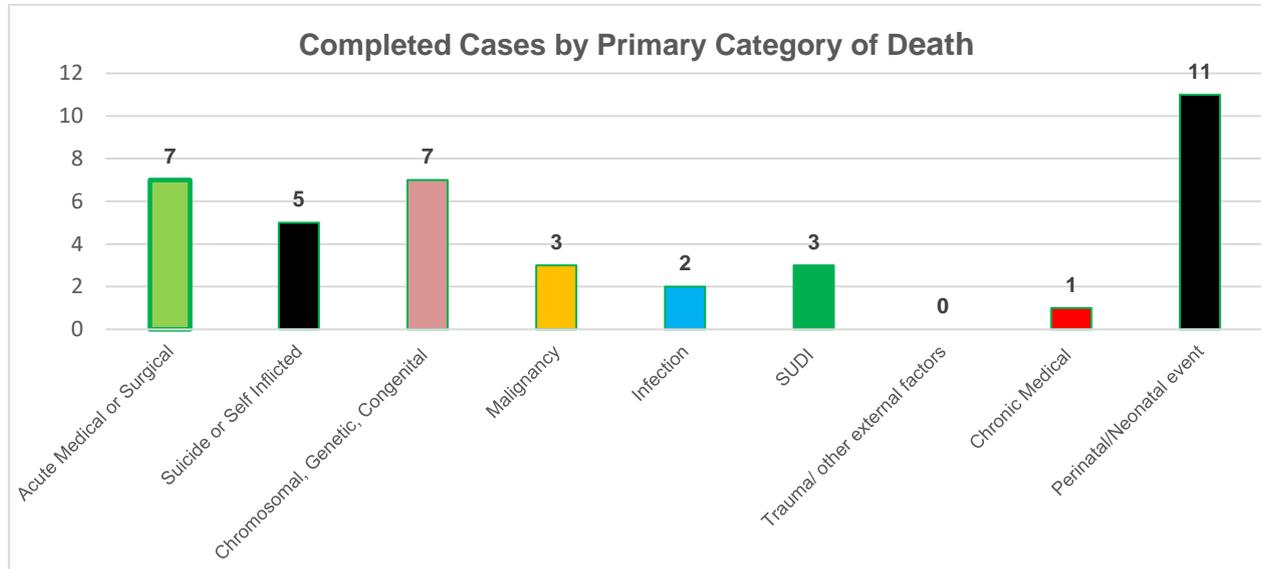


5. Local overview

- 5.1 The child death rates for the East of England in 2021-22 were 25 per 100,00 children. The infant death rates of the East of England in 2021-22 were 3 per 1,000 infants. Cambridgeshire and Peterborough were below average for child death rates (totaling 14), however above the average for infants (totaling 22).
- 5.2 Over the last year, the deaths of 36 children were reported to the CDOP across Cambridgeshire and Peterborough, this is 2 more than 2020/21. 21 in Cambridgeshire and 15 in Peterborough. There were 11 unexpected deaths reported this year.
- 5.3 The highest month for notifications in 2021/22 was December, when there were five notifications. The second highest were July and November with four each.
- 5.4 The highest notifications by place of death were NICU and PICU. The lowest was hospital wards.

6. Deaths reviewed

6.1 A total of 39 deaths were reviewed in 2020/21: 23 Cambridgeshire children and 16 Peterborough children.



6.2 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 2021/22 there were 13, 33%. In the UK 37% of cases were classified as modifiable.

6.3 The modifiable factors identified included consanguinity, invisible children, cannabis use, inexperienced motorcyclist/non road worthy vehicle.

6.4 Not all 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.

6.5 Each year ending, all Child Death information collected on eCDOP is evaluated by the National Child Mortality Database. From this, a report is created providing an overview of completed reviews.



Cambridge and
Peterborough CDOP -

7. Child safeguarding practice reviews

7.1 There were two child safeguarding practice reviews in which a child death occurred during the reporting period. All published reviews can be found on the [Safeguarding Partnership Board](#) website.

8. Unexpected deaths/Joint Agency Response (JAR) service

8.1 A Joint Agency Response is required if a child's death:

- is or could be due to external causes.
- is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy/childhood)
- occurs in custody, or where the child was detained under the Mental Health Act.
- occurs where the initial circumstances raise any suspicions that the death may not have been natural.
- occurs in the case of a stillbirth where no healthcare professional was in attendance.

8.2 There were 11 sudden unexpected, unexplained deaths during 2021-22. All unexpected, unexplained deaths are subject to a joint agency discussion between Police and the rapid response Doctor(s) as to whether a home visit is required. A home visit would usually be carried out for all infants (those under one years old), and for deaths by suicide.

During the time period three home visits were carried out by the rapid response Doctor and Police, one case required a joint agency discussion but due to criminal proceedings it was deemed not appropriate for the rapid response Doctor to join Police at the home.

9. East of England Regional CDOP Network

9.1 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.

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 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.

9.2 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.

- 9.3 A pilot is currently ongoing for the NDMC to produce a Regional Report of Child Deaths enabling us to see the variations and similarities between our regions. Feedback is currently being collated.

10. CDOP training

- 10.1 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's courses. Where Child Safeguarding Practice 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. 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. 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*'²



Lullaby.pdf

- 11.2 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.

12. Achievements 2022

Safer sleep campaign

CDOP supported a safer sleep campaign in conjunction with the Safeguarding Partnership Board. A letter was shared across the system promoting the use of the lullaby trust leaflet on 'safer sleeping' to parents and safer sleep was one of the topics covered within the LSCB General Practitioner training.

Consanguinity

Consanguinity was highlighted as a modifiable factor in 2021-22, featuring in four closed cases. As such, CDOP worked to raise awareness around the risks of consanguinity, creating a leaflet which was promoted by the Safeguarding Partnership Board and later adopted by other areas.

Post-mortem findings

The Designated Doctor for Child Death agreed with the Cambridgeshire Coroner's office that all post-mortems would be shared with CDOP directly. Following receipt of a post mortem the CDOP team would then be able to share this with relevant professionals who can discuss

² *The Child Death Review- a Guide for Parents and Carers* Lullaby Trust

findings with the deceased parents/family members. This change in process has allowed for a more personalised and appropriate discussion regarding the findings, delivered by a professional with subject knowledge and pre-established relationships with families.

Prevent future deaths

The CDOP team established a database to record all prevent future death findings to allow local monitoring and implementation of recommendations and actions.