Cambridgeshire and Peterborough Child Death Overview Panel (CDOP)

Annual Report 2022/23

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1. Introduction

Cambridgeshire and Peterborough Child Death Overview Panel (CDOP) reviews the death of every child and young person resident to Cambridgeshire and Peterborough who sadly dies. The aim of the CDOP is to prevent future deaths whilst looking to improve support for children, young people, and their families.

2. Purpose

2.1 As per Working Together to Safeguard Children (2018) and Child Death Review Statutory and Operational Guidance (2018) the CDOP has specific functions, including:

- To review all deaths of children up to 18 years (including deaths of infants aged less than 28 days), excluding those who are stillborn or planned terminations of pregnancy.
- Reviewing and evaluating the deaths of all children, and thereby identifying lessons to be learnt, contributory factors and/or issues of concern which may prevent future child deaths.
- 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.
- To contribute to local, regional, and national initiatives to improve learning from child death reviews.

2.2 Child deaths are reviewed on a quarterly basis by the CDOP members. A number of deaths may be reviewed as part of a joint agency response (JAR), this would be triggered 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 (SUDI/C).

- occurs in custody, or where the child was detained under the Mental Health Act.
- where the initial circumstances raise any suspicions that the death may not have been natural.

During 2022/23 the CDOP members met four times to review information regarding the deaths of Cambridgeshire and Peterborough children. The CDOP is made up of the following members –

Job Title	Agency
Independent CDOP Chair	
Designated Doctor Safeguarding Children and Child Death (Deputy Chair)	Cambridgeshire and Peterborough Integrated Care Board
CDOP Manager	Cambridgeshire and Peterborough Integrated Care Board
Designated Nurse Safeguarding Children	Cambridgeshire and Peterborough Integrated Care Board
Senior Lead for the LeDeR Programme	Cambridgeshire and Peterborough Integrated Care Board
Medical Examiner	North West Anglian NHS Foundation Trust
Named Doctor Safeguarding Children	Cambridgeshire University Hospitals NHS Trust
Medical Examiner	Cambridgeshire University Hospitals NHS Trust
Lead Nurse for Children's Community Specialist Nursing	Cambridgeshire Community Services NHS Trust
Named Nurse Safeguarding Children	Cambridgeshire Community Services NHS Trust
Head of Safeguarding	Cambridgeshire Partnership NHS Foundation Trust
Head of Operations	East of England Ambulance Service NHS Trust
Matron	East Anglia Children's Hospice
Consultant	Public Health
Service Manager (Cambridgeshire)	Children's Social Care
Deputy Safeguarding Lead (Peterborough)	Children's Social Care
Detective Inspector	Cambridgeshire Constabulary
Case Review Project Officer	Safeguarding Partnership Board
Education Safeguarding Manager	Education

The CDOP can also call upon local subject experts, such as the Road Safety Partnership or neonatologists if required.

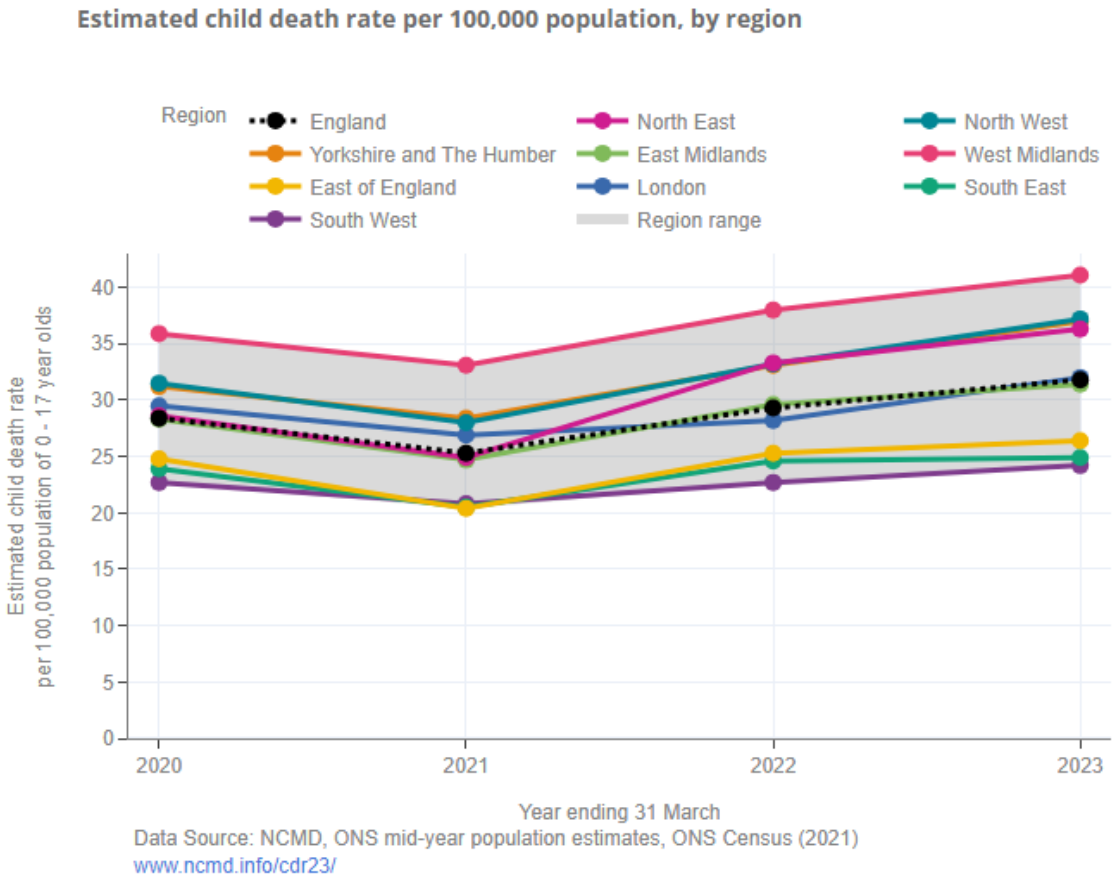
2.3 In the instance of a neonatal death, a perinatal mortality review toolkit (PMRT) will be used to review the baby's death by perinatal mortality review teams in Cambridgeshire University Hospitals NHS Trust and North West Anglia NHS Foundation Trust. The PMRT is then shared with the CDOP for review at the quarterly CDOP meeting.

3. Local overview

3.1 Cambridgeshire and Peterborough CDOP were notified of 46 deaths of children and young people during the period from 1st April 2022 until 31st March 2023.

Nationally, there were 3,743 child (0 – 17 years) deaths in England in the year ending 31 March 2023, an estimated rate of 31.8 deaths per 100,000 children. The number of deaths increased by 8% on the previous year and was the highest number of deaths in a year since NCMD started data collection in 2019. Infant (children under 1 year) deaths increased by 4% on the previous year and deaths of children aged between 1 and 17 years increased by 16%.

There were 391 deaths during December 2022, the highest in any single month since 2019.



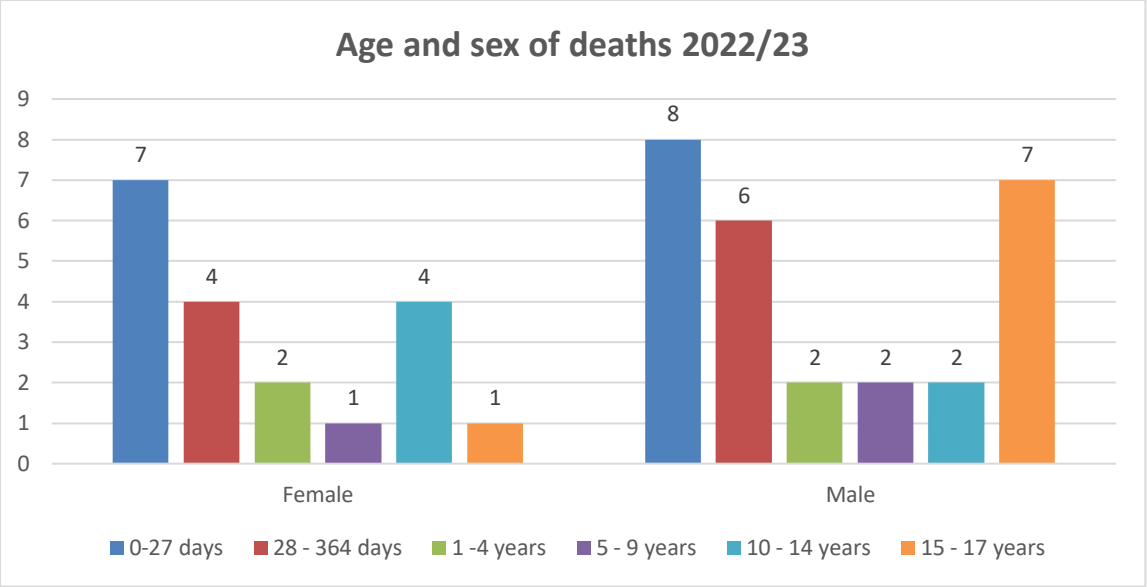
3.2 The number of child deaths reviewed by the Cambridgeshire and Peterborough CDOP during this period was 50.

The main reasons for delay in reviewing cases were outstanding Coroner's post mortem reports/inquest findings, criminal proceedings, and timeliness of PMRT meetings and subsequent reports being shared with CDOP.

3,271 child deaths were reviewed by CDOPs in England between 1 April 2022 and 31 March 2023 (some of these deaths may have occurred in earlier years), a 19% increase on the previous year and the highest number since 2019.

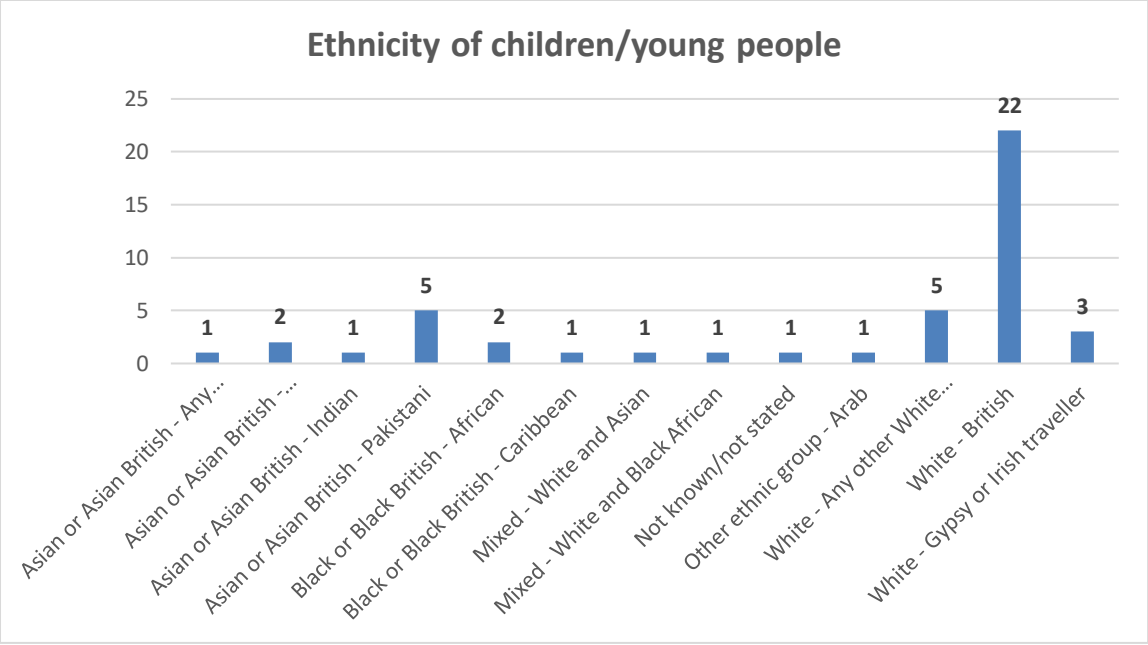
4. Local demographics

4.1 There was a total of 27 (59%) male deaths and 19 (41%) female deaths during the reporting period. Below is a breakdown of age of the child/young person when they died and their gender. The highest number of deaths is seen in the neonatal period and first year of life. Additionally, a higher number of deaths seen in males between 15 and 17 years of age.



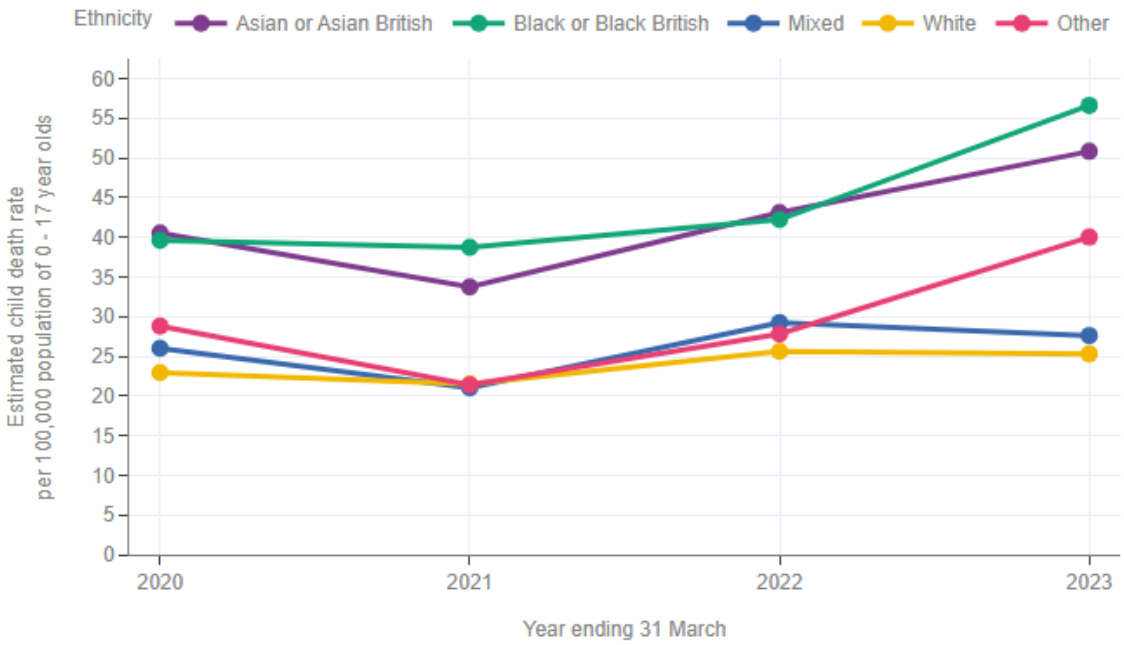
4.2 There were 30 deaths of children from White British or White or other White ethnic groups, 14 deaths from Black or Black British ethnicity and Asian or Asian British ethnicity. There was one death in Arabic ethnic group and for one death not known/stated.

Cambridgeshire and Peterborough deaths by ethnicity



Nationally, the child death rate in the year ending 31 March 2023 was highest for children of black or black British ethnicity (56.6 per 100,000 population) and Asian or Asian British ethnicity (50.8 per 100,000 population) (Figure 3). The rates for both of these ethnic groups continued to increase in comparison to previous years, whilst the death rate for children of white ethnicity decreased from the previous year and remained lower than all other ethnic groups.

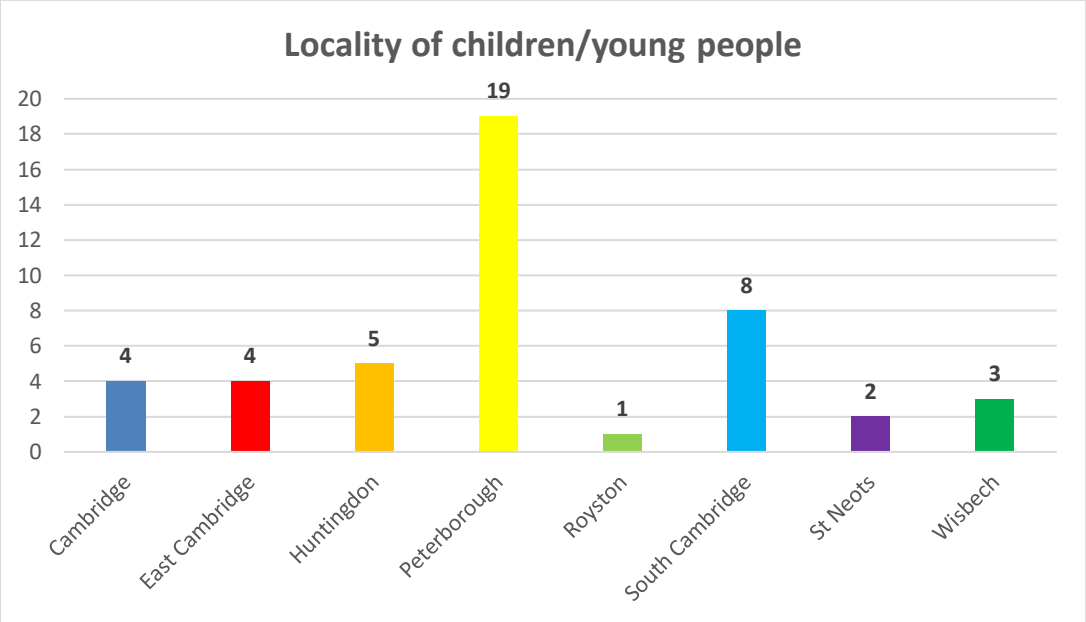
Estimated child death rate per 100,000 population, by ethnicity

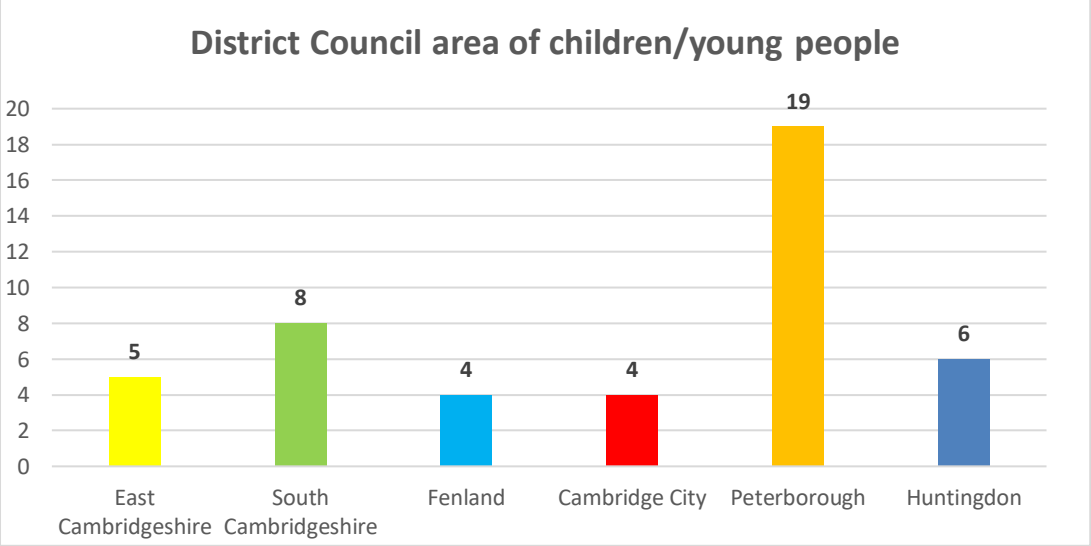


Data Source: NCMD, ONS Census (2021)
www.ncmd.info/cdr23/

4.3 Within the Peterborough locality there is a notable increase in the number of deaths in the PE1 postcode area. The CDOP team continues to work with partners to monitor this increase and consider ways in which this community can be supported.

Cambridgeshire and Peterborough deaths by locality/district council area



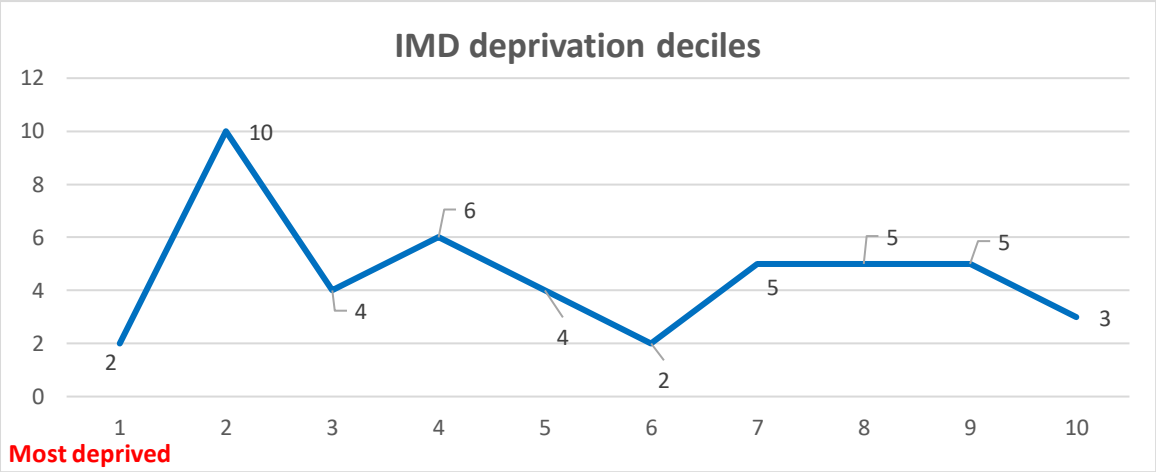


Breakdown of deaths within the Peterborough locality

Postcode area	Number of deaths
PE1	9
PE2	5
PE3	1
PE4	3
PE7	1

Cambridgeshire and Peterborough deaths by deprivation decile

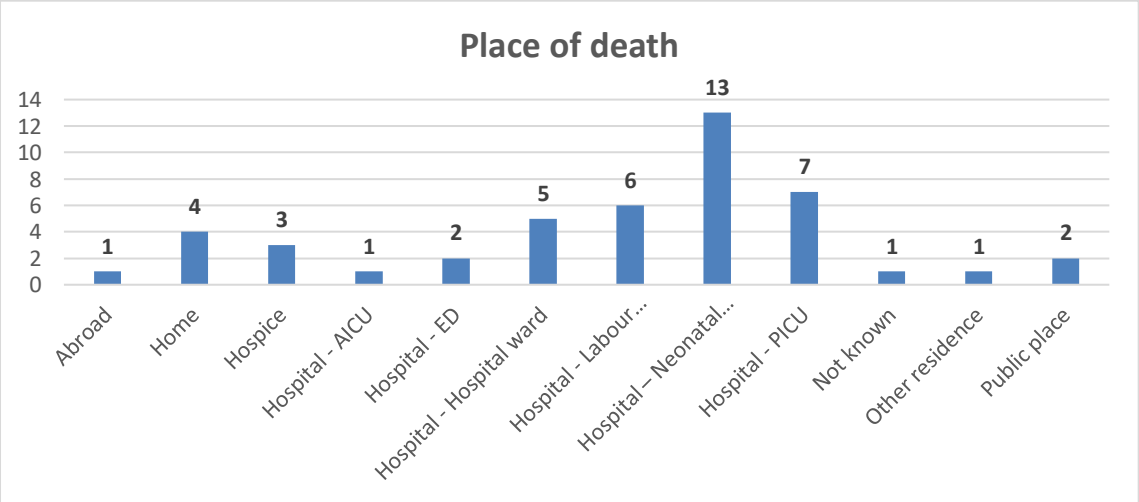
The below chart identifies the number of child deaths that occurred in each of the deprivation deciles (calculated by postcode of residence) The NCMD report *Child Mortality and Social Deprivation* (May 2021) found a clear association between the risk of child death and the level of deprivation (for all categories of death except cancer). It more specifically states that over a fifth of all child deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived – which translates to over 700 fewer children dying per year in England.



The child death rate for children resident in the most deprived neighbourhoods of England was 48.1 per 100,000 population, more than twice that of children resident in the least deprived neighbourhoods (18.7 per 100,000 population). Whilst the death rate in the least deprived neighbourhoods decreased slightly from the previous year, the death rate for the most deprived areas continued to rise, demonstrating widening inequalities.

The death rate of infants who were resident in the most deprived neighbourhoods of England was 5.9 per 1,000 infant population, more than twice that of infant's resident in the least deprived neighbourhoods (2.2 per 1,000 infant population). Similar to all child deaths, inequalities in infant deaths widened, with the infant death rate for the most deprived having increased, despite the rate for the least deprived having decreased from the previous year.

Cambridgeshire and Peterborough deaths by place of death



4.4 In the reporting period one child died whilst visiting family abroad. In this instance liaison takes place with the Foreign Office Coroner who can carry out investigations on behalf of Cambridgeshire and Peterborough CDOP to ensure information is gathered, allowing for a thorough review.

4.5 Whilst CDOP does not determine the cause of death, a category is selected based on information provided by the Coroner's and medical experts involved in the child/young person's care.

Category of death	Date of death					
	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	2021/ 2022	2022/ 2023
Acute medical or surgical condition	0	2	6	5	6	4
Suicide or deliberate self-inflicted harm	1	3	1	4	2	1
Chromosomal, genetic and congenital anomalies	1	7	16	9	14	10
Malignancy	1	1	1	4	1	3
Infection	0	4	5	2	4	3
Sudden unexpected, unexplained death	1	5	2	2	3	0
Trauma and other external factors, including medical/surgical complications/error	0	3	2	3	4	3
Deliberately inflicted injury, abuse or neglect	1	1	1	0	0	0
Chronic medical condition	2	1	3	0	7	4
Perinatal/neonatal event	0	2	15	9	6	5
Total:	**7**	**27**	**52**	**38**	**47**	**33**

**figures only include closed cases reviewed by the CDOP, note some children and young people have more than one category of death.*

Nationally, the most common primary category (i.e., the likely cause) of death for reviews in 2022-23 was Perinatal/neonatal event, which was recorded for 34% of all child death reviews, followed by Chromosomal, genetic and congenital anomalies (24%), Malignancy (9%) and Sudden unexpected and unexplained death (7%). These patterns were similar to previous years.

Nationally, the most common primary category of death was Perinatal/neonatal event for children aged under 1, Malignancy for children aged between 1 and 9 years, and Suicide or deliberate self-inflicted harm for children aged between 10 and 17 years. Within Cambridgeshire and Peterborough, the most common primary category of death was Perinatal/neonatal event for children aged under 1, Chromosomal, genetic or congenital anomaly and infections for children aged between 1 and 9 years, and Chromosomal, genetic or congenital anomalies for children aged between 10 and 17 years.

4.6 Of the 50 cases reviewed by the CDOP members four were identified as having a learning disability, with one further child suspected to have a learning disability. All these children/young people were referred to the Learning Disabilities Mortality Review Programme (LeDeR) to support the sharing of learning from the deaths of children and young people with learning disabilities.

5. Modifiable factors

When reviewing the death of a child or young person the CDOP should consider modifiable factors such as parenting capacity, family environment, service provision and risk factors during pregnancy.

The following modifiable factors were identified by CDOP during the reporting period –

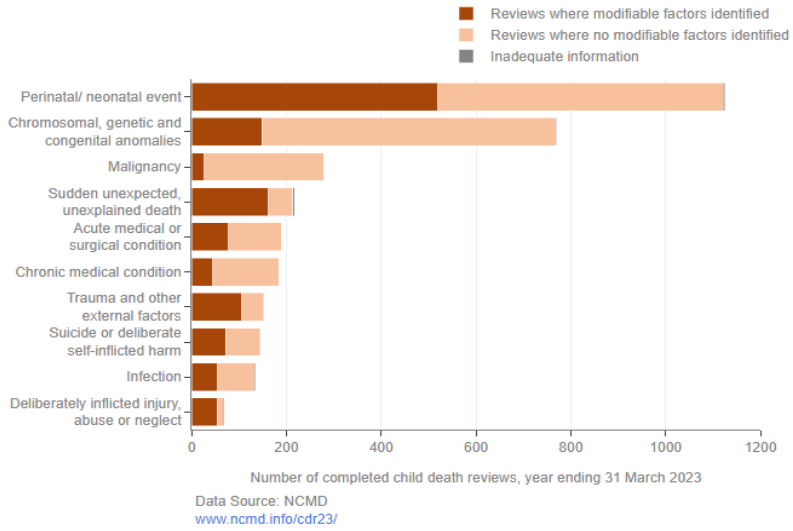
- Gestational Diabetes
- Mothers BMI >40

- Mother's mental health
- Child left unsupervised.
- Mother is known to misuse alcohol.
- Mother known to misuse drugs.
- Mother is known to smoke (multiple cases).
- Father is known to smoke.
- Child not appropriately restrained while in vehicle (multiple cases).
- Speeding over the limit (multiple cases).
- Child travelling in age-inappropriate car seat at time of incident.

Nationally, the proportion of reviews that identified modifiable factors continued to rise with 39% of deaths reviewed in the year ending 31 March 2023 identifying modifiable factors. The proportion of reviews with modifiable factors varied per region from 27% to 52%

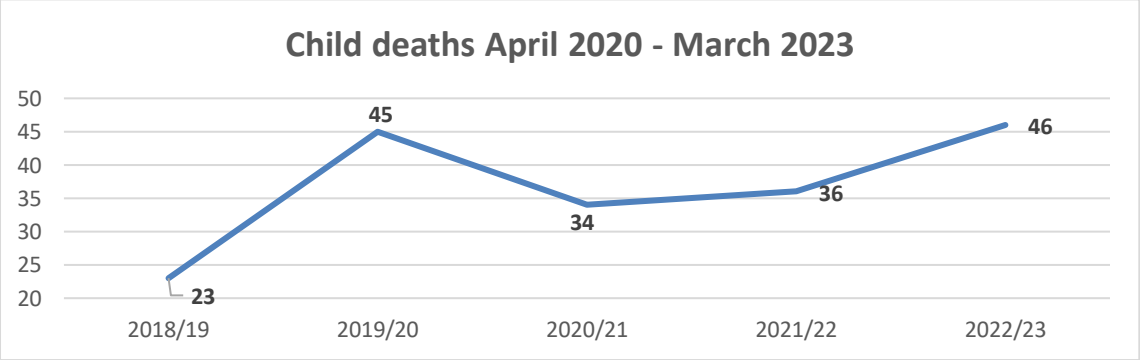
Nationally, deaths categorised as Deliberately inflicted injury, abuse or neglect had the highest proportion of reviews with modifiable factors (81%), followed by Sudden unexpected and unexplained death (76%), Trauma or other external factors (71%) and Suicide or deliberate self-inflicted harm (50%).

Number of reviews completed by CDOPs by primary category of death and whether modifiable factors were identified, year ending 31 March 2023

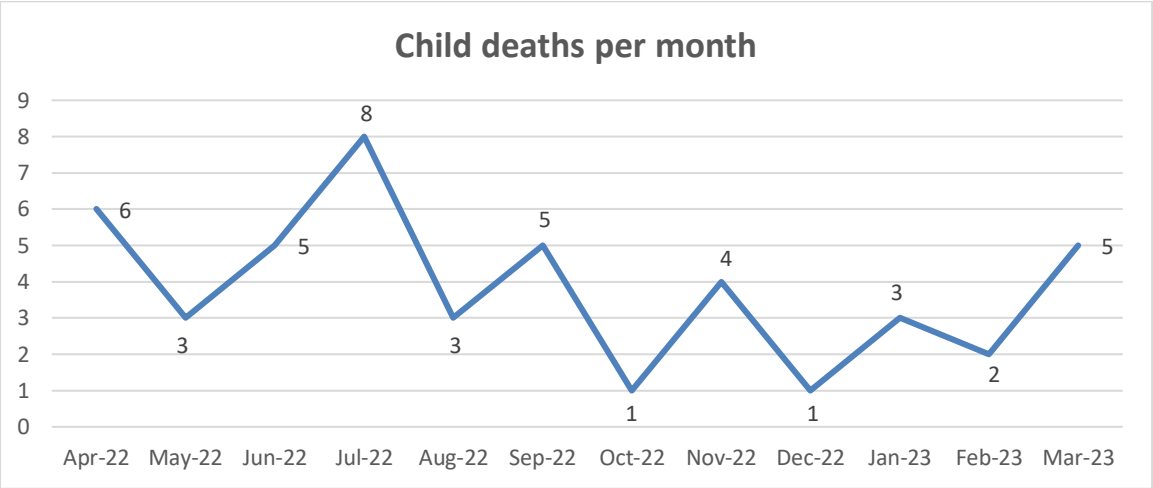


6. Themes and trends

There has been a 33% increase in the number of child deaths in comparison to 2021/22 although there are no clear themes to account for this increase. The highest reporting month for notifications in 2022/23 was July 2023 with eight deaths having been reported into CDOP.



It is noted that between 2020 - 2022 there was a national decrease in child death numbers related to the Covid-19 pandemic and subsequent periods of lockdown.



7. Learning points

The CDOP identified learning points from seven of the 50 cases reviewed in 2022/23, with some learning points being derived from serious incidents (SI's) which may have taken place alongside the CDOP review and PMRT reports.

One of the cases was reviewed by Great Ormond Street Hospital (GOSH) with learning identified by the child death review team there and signed off locally by the Cambridgeshire and Peterborough CDOP. Actions taken following learning were as follows:

- Further cold cots were purchased to allow for triplet pregnancies to be managed in a Cambridgeshire and Peterborough neonatal unit.
- The offer of a hospital post mortem has been included in the bereavement checklist for all local neonatal services.
- A reminder was shared with family liaison and palliative care teams are offering parents a recording of their child's heartbeat as part of memory making.

8. Unexpected deaths

There were 17 sudden unexpected, unexplained deaths during 2022/23 which is an increase from 11 in 2021/22. Unexpected deaths are deaths in which 24 hours prior to the event you would not have expected a child to die. Unexpected, unexplained deaths are subject to a joint agency discussion between Police and the rapid response Doctor(s), at this point they may also decide to undertake a joint home visit. A home visit would usually be carried out for all infants (those under one year old), and for deaths by suicide.

Cambridgeshire and Peterborough have five rapid response Doctor's who work on a rotational basis to cover all days of the year, 24 hours a day.

During the reporting period three joint discussions and subsequent home visits were carried out by the rapid response Doctor and Police. A further 11 joint discussions took place, in which it was concluded that a home visit would not be required or beneficial to the case. For example, one of the children was well known to the local acute hospital and the scene had been visited by the HEMS team, both agencies had no concerns, thus it was felt that a joint visit would not be of further benefit.

One of the deaths occurred abroad and as such the rapid response process was not triggered. Two cases were not reported to the rapid response Doctor by Police, although this is an improvement on prior years and did not have an impact on the child death review response and process.

9. Engagement with families/carers

From the 1st March 2023 the CDOP team created a letter to parents and carers which would be sent following the death of a child/young person. The letter details the CDOP process, offers parents/carers the chance to share their thoughts into CDOP and is accompanied with the Lullaby Trust 'When a baby or young child dies suddenly and unexpectedly' leaflet.

To date 11 letters have been sent to the parents/carers of deceased children and young people. With one father engaging with the CDOP team to share his thoughts and wishes.

When a death is classed as unexpected a lead professional will be identified to support bereaved families. This decision is usually made during the information sharing meeting and the professional will be in regular contact with families as required and would also share post mortem findings with the family once they are available via CDOP.

10. Achievements

In March 2023 the CDOP held a thematic review of deaths by suicide from 2019 – 2022. The group used the NCMD's 'suicide in children and young people' report (October 2021) which identified the common characteristics of children and young people who died by suicide. The identified characteristics were discussed for each of the deaths by suicide locally to ascertain whether they applied to each of the children reviewed. A total of 11 cases were reviewed, which was the same number as the previous thematic review carried out in 2018. The full thematic review report will be shared with the CDOP members and the Safeguarding Partnership Board to aid local learning and recommendations to prevent future deaths by suicide.

A review of current local CDOP processes took place in November 2022 which streamlined information gathering avenues, the collation of Form Bs from all involved agencies and the timescales regarding information sharing/joint agency response meetings. Following this review, the CDOP team were able to close nine outstanding cases which dated between 2019 – 2021.

A full review of the CDOP membership was undertaken to ensure all agencies are represented at the quarterly CDOP meetings. A core group was established with identified deputies. There may be occasions where the CDOP team feel that additional panel members should be co-opted into the meeting to discuss cases or subjects, for example, the road safety partnership or specialist nurses.