Cambridgeshire and Peterborough Child Death Overview Panel

Annual Report 2019-2020

Confidential

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 2019-2020.

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 2020.

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 via the National Child Mortality database mean that accurate regional and national comparisons are now readily available.

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

1.5 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 2008. Their primary function is to understand how and why children die, put into place interventions to protect other children, and prevent future deaths.

1.6 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. 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

1.7 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

4 The Process

1.8 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.

1.9 During 2019-20, the CDOP met four times to review anonymous information about child deaths. The panel is chaired by an independent chairperson (Currently the Independent Scrutineer) and has members from all relevant agencies.

1.10 A separate panel which reviews neonatal deaths has been discontinued. It has been replaced by the CDOP manager holding meetings with risk midwives after the Perinatal Mortality Reviews have taken place. Information from these detailed reviews are 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. They produce annual 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 very limited. The results of this meeting are available to the National Child Mortality database similar to the results of an ordinary CDOP meeting.

1.11 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.

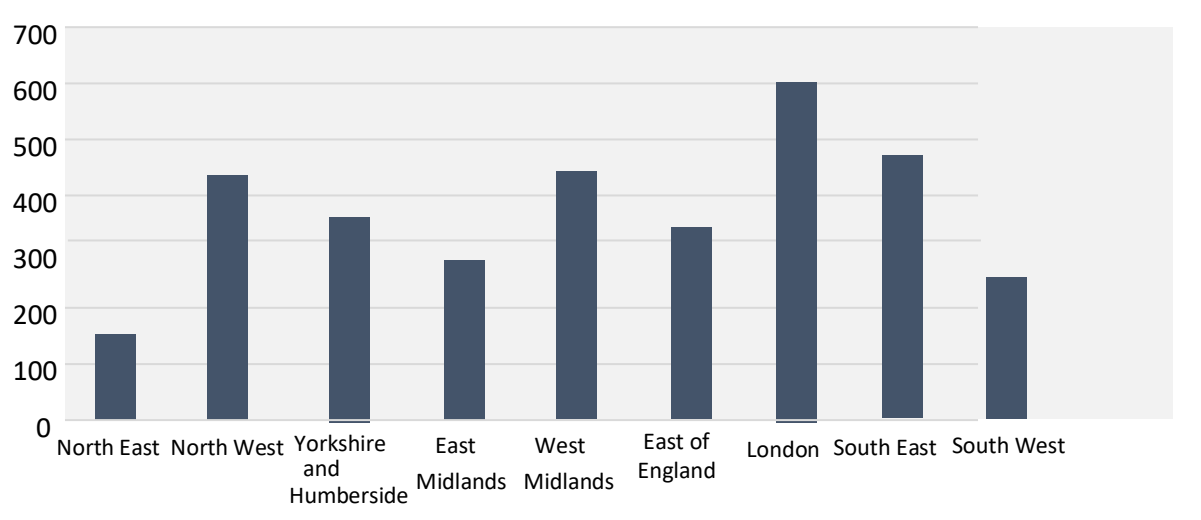
5 The National Picture

1.12 The infant mortality rate is the number of children that die under one year of age in a given year, per 1000 live births[1]. The infant mortality rate for U.K. in 2020 was 3.593 deaths per 1000 live births, a 2.31% decline from 2019. The infant mortality rate for U.K. in 2019 was 3.678 deaths per 1000 live births, a 2.26% decline from 2018.

1.13 The number of child death reviews completed by Child Death Overview Panels in England between 2019/ 2020 is 3,347. CDOPs in the London Region submitted the most child death notifications and the least in the North East.

NCMD Death Review Data ending 31 March 2020

Figure 1: The number of child death notifications received by Child Death Overview region, Year ending 31 March 2020



6 Local Overview

Reported Deaths

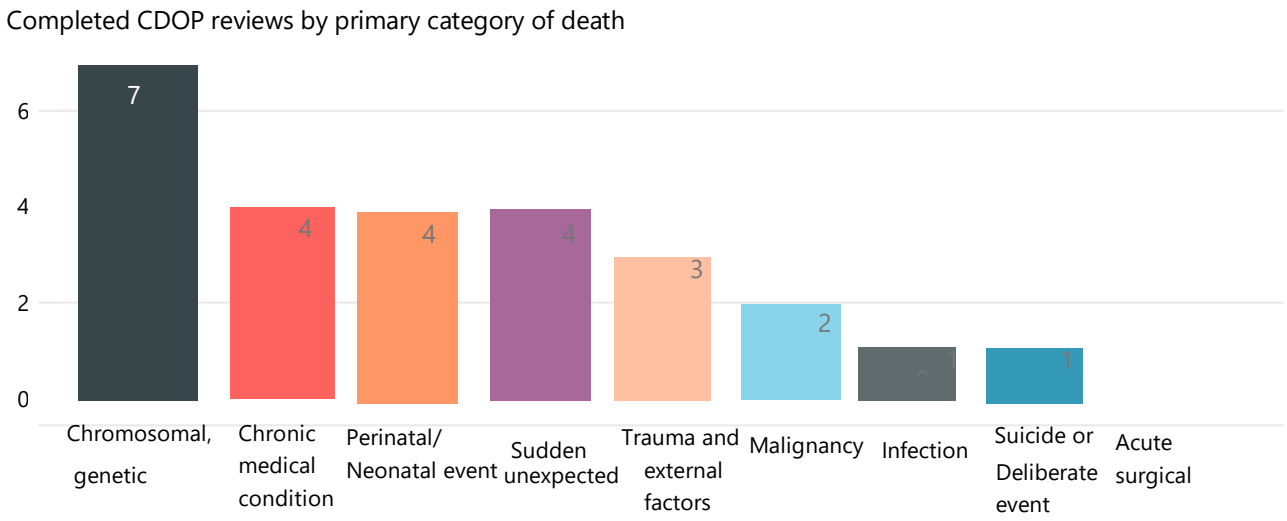
1.14 Public Health data from 2015-2017 indicates that Infant mortality rates for Cambridgeshire is slightly below the national average whereas Peterborough is slightly above the England average. Child mortality rates for Cambridgeshire are lower than the England average whereas Peterborough has a significantly higher child mortality rate than the national average.

[1] Infant and neonatal Mortality, Nuffield Trust 2021

1.15 Over the last year, the deaths of 48 children were reported to the CDOP across Cambridgeshire and Peterborough, this is one less than 2018/2019. 43 in Cambridgeshire and 5 in Peterborough. 60% of these children were babies under one year old compared to the national average in the UK which is 63%. There were 17 unexpected deaths reported this year.

7 Deaths reviewed

1.16 A total of 26 deaths were reviewed in 2019/2020; 21 Cambridgeshire children and 5 Peterborough children.



1.17 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 2019-2020 there were 7 child deaths where a modifiable factor was identified by the panel. One death was unable to categorise due to inadequate information and 18 deaths were unmodifiable.

1.18 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.

1.19 62% 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.

1.20 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

8 Serious Case Reviews

1.21 There was one serious case review in 2020, which was published in the Autumn in redacted form.

9 Unexpected Deaths / Rapid Response Service

Arrangements for home visits

1.22 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.

1.23 During 2019/20 one case has been reviewed where a young person has died by suicide or deliberate self-inflicted harm.

1.24 No Thematic CDOP panel took place during 2019/20. However, for a portion of this period, there was no Designated Dr was in post and the Covid 19 pandemic.

10 East of England Regional CDOP Network

1.25 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 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.

1.26 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

1.27 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.

12 Support to Bereaved Families

1.28 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]

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

Lullaby.pdf

1.29 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 Achievements 2020

1.30 A new Designated Doctor for Child Death Review was appointed in October 2020

1.31 eCDOP has been fully embedded.

1.32 CDOP Protocol has been updated and recirculated.

1.33 There has been an operative procedure for Rapid Response visits. The team will reinstate quarterly meetings.

1.34 CDOP Manager now attends all Child Death Review Meetings. This increases CDOP's visibility and function as well as the contribution and receipt of knowledge and details.