



**Cambridgeshire and Peterborough Child Death  
Overview Panel**

**Annual Report 2013 – 2014**

**Public Version**

## Contents

1.	Introduction .....	4
2.	Background .....	4
3.	The Principles .....	5
4.	The Process .....	5
5.	The National Picture .....	6
6.	Local Overview .....	7
	Reported Deaths .....	7
	Deaths reviewed .....	7
	CDOP Main Panel .....	9
	Neonatal Panel.....	9
7.	Action Taken in Response to Modifiable Factors and Trends Identified .....	10
	Consanguinity in Peterborough .....	10
	Water Safety .....	11
	Safe Sleeping Campaign .....	11
8.	Serious Case Reviews .....	12
9.	Unexpected Deaths / Rapid Response Service .....	12
	Arrangements for home visits .....	12
10.	East of England Regional Child Death Overview Network.....	13
11.	CDOP Training .....	13
12.	Support to Bereaved Families .....	13
13.	Plans for the Year 2014-15.....	14
14.	Appendix A – Graphs and Tables .....	15
	Appendix B1 – Membership of Child Death Overview Panel.....	17
	Appendix B2 – Membership of Neonatal Child Death Overview Panel .....	18
	Appendix C – Business Plan for 2014-15.....	19

Appendix D – Water Safety Flyer ..... 20

## 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 2013-14. This is the panel's 6<sup>th</sup> annual report.
- 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 2014.
- 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 This is an edited version of the full report which is confidential as the numbers referred to above mean that it may be possible to identify individual children. Sections which refer to individual cases and graphs and tables containing numbers 1 to 5 inclusive where they represent individual children have been removed. The full version of the report is available to professionals on request – please contact the CDOP Coordinator.

## 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.<sup>1</sup> Their primary function (as required by the Local Safeguarding Boards Regulations 2006) is to undertake a comprehensive and multiagency review of all deaths of children normally resident in the area aged under 18 years of age, in

---

<sup>1</sup> 'Working Together to Safeguard Children' has been revised and was reissued in March 2013. However, the responsibilities of the Child Death Review Process remain unchanged.

order to understand better how and why they die and to use the findings to take action to prevent other deaths and to improve the health, wellbeing and safety of children and young people. The Local Safeguarding Boards of Cambridgeshire and Peterborough form a single Child Death Overview Panel.

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.
- 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 Chair of the local Safeguarding Children Board (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**

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 2014-15, the CDOP has met four times to review anonymous information about child deaths. The panel is chaired by the Cambridgeshire LSCB chair and has members from all relevant agencies (see appendix B1 for a list of members).
- 4.3 A separate panel which reviews neonatal deaths is chaired by the Designated Doctor for Death in Childhood. 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 (see appendix B2 for members) 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 Peterborough and Cambridgeshire Children's Services Departments.

## 5. The National Picture

- 5.1 Children in the UK are more likely to die before they reach their fifth birthday than in any other western European country except Malta. Child death rates are high in the first six weeks of life, between one month and one year and between the age of one and four. The UK rate per 1000 births in 2012 was 4.9, compared to 2.4 deaths per 1000 in Sweden, Finland and Norway who have the lowest rates in Europe.
- 5.2 Babies who die under the age of one tend to be from deprived households, have a low birth weight and have parents who smoked. Between the ages of one and five, deaths are mostly linked to injuries, accidents and serious diseases.
- 5.3 The number of child death reviews completed has remained relatively stable over the last three years, as has the proportion of deaths where modifiable factors were identified (21% in the year ending 31 March 2013 compared to 20% in the year ending March 31 2012).
- 5.4 The main causes of deaths continue to be neonatal or perinatal events and chromosomal, genetic and congenital abnormalities. This reflects the fact that nearly two thirds of deaths were children who were aged under one year.

## 6. Local Overview

### Reported Deaths

- 6.1 Over the last year, 53 children died across Cambridgeshire and Peterborough, 30 in Cambridgeshire and 23 in Peterborough. 34 of these deaths (64%) were babies under one year old, with many dying in the neonatal period having never left hospital. These figures reflect national statistics. 34% of the deaths reported this year were unexpected.
- 6.2 In last year's annual report, the highest figure of child deaths (66) was reported since the CDOP process began in 2008. However the figure for 13/14 reflects the pattern of earlier years where the average number of deaths has been 56.
- 6.3 43% of children died from a known life limiting condition this year, a significant proportion of these were babies born with a congenital condition who died in the neonatal period. The death of 32% of children was ultimately related to perinatal events (such as prematurity) irrespective of their age. Chart 1 below shows a similar pattern since data was first collected. See appendix A for deaths reported by council area.

Chart suppressed: Chart 1 – Deaths reported to Cambridgeshire and Peterborough CDOP 2008 – 2014 by age group

Chart suppressed: Chart 2 – Deaths reported to Cambridgeshire and Peterborough CDOP 2013-14 by cause

### Deaths reviewed

- 6.4 A total of 82 deaths were reviewed in 2013/14, 35 by the main CDOP panel and 47 by the neonatal panel.
- 6.5 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. There were 10 child deaths last year where a modifiable factor was identified.
- 6.6 Not all of the deaths which were reviewed occurred in this year, some will have occurred the previous year or even earlier – the table on page 9 shows that over half of the deaths reviewed this year actually occurred the year before. Just over a third of

the deaths that occurred this year were reviewed in the same year. This figure mirrors the national figure for 2012/13 of 38% of child deaths were reviewed in the year of their death.

- 6.7 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 serious incident investigations, serious case reviews, post mortem reports and coronial inquests.
- 6.8 The Ministry of Justice launched a new legal framework in June 2013 which requires most inquests in England to be completed within 6 months of the death which should enable CDOP to review these deaths sooner than has been the case until now.

Table suppressed: Deaths where modifiable factors were identified by year of death

- 6.9 As in previous years the majority of children (74%) who died were less than a year old. This percentage was the same in Peterborough and Cambridgeshire. There was no other age group where there were significant numbers of deaths.
- 6.10 In Peterborough the next highest age range was children aged 1- 4 years, where six child deaths (17%) were reviewed, but with no modifiable factors identified.
- 6.11 In Cambridgeshire the next highest age range was young people aged 15 – 17 years (11%), but again, no modifiable factors were identified.
- 6.12 The main causes of death reflected similar years, with 45% of deaths being the result of perinatal or neonatal difficulties and 39% of the children dying from known life limiting conditions.
- 6.13 As stated above, the number of deaths over this year is similar to that of previous years apart from a higher number of deaths in 2012-13. This rise last year was in the deaths of babies aged less than one year. The majority of these deaths have now been reviewed. No obvious cause was identified for this rise.

## CDOP Main Panel

- 6.14 The main CDOP panel met four times and reviewed the deaths of 35 children. Modifiable factors identified include unsafe sleeping arrangements, antenatal smoking / smoking in the home environment and the absence of lifesaving equipment near a known wild swimming location.
- 6.15 Chart 3 on page 11 provides a breakdown by category for deaths where modifiable factors were identified over the six years in which figures have been collected. No modifiable deaths were identified in the 'chromosomal, genetic and congenital anomalies' category. See appendix A for modifiable deaths by council area.

Chart suppressed: Chart 3 – Deaths where modifiable factors were identified by Cambridgeshire and Peterborough CDOP 2013-14 by category of death.

## Neonatal Panel

- 6.16 The Neonatal CDOP met three times over the course of 2013-4 and completed a review of 47 deaths. The panel would usually meet twice a year however a proactive approach to obtaining all relevant information necessary for neonatal deaths meant most outstanding cases could be reviewed.
- 6.17 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.
- 6.18 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. 33% of neonatal deaths reported in 2013-14 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.

## 7. Action Taken in Response to Modifiable Factors and Trends Identified

### Consanguinity in Peterborough

- 7.1 Although the ethnicity of each child who dies is recorded by CDOP, the number of child deaths is too small to comment on any pattern within a year. However, after analysis of figures since 2008, it has been noted that the number of deaths of children in Peterborough with an Asian / Asian British ethnicity reported to the CDOP is disproportionate to the Asian / Asian British population in Peterborough.
- 7.2 In the period from 1 April 2008 to 20 February 2014 the number of deaths of children with Asian / Asian British ethnicity reported to CDOP in Peterborough was 36. This is 29.3 % of all Peterborough deaths reported in this period. The percentage of children with an Asian / Asian British ethnicity in the population aged 0-17 years in Peterborough is 17.2 % <sup>2</sup>
- 7.3 Of these 36 children, 58% died of a congenital abnormality. In 52% of these cases it has been confirmed that the child's parents are related other than by marriage (consanguineous). Consanguinity has not been consistently recorded until 2013 and for some recent deaths not all relevant information has been gathered yet, so the percentage may be higher than this.
- 7.4 In Cambridgeshire, 14 children out of 206 reported deaths were of Asian / Asian British ethnicity which is 6.8%. The percentage of children with an Asian / Asian British ethnicity in the population aged 0-17 years in Cambridgeshire is 4.4%
- 7.5 Consanguinity is a major risk factor for congenital anomaly. CDOP panels across England have noted concerns that inter-family couples do not have sufficient understanding of the increased risks of having a child with a disability or of having a child die under the age of 5<sup>3</sup>
- 7.6 A report setting out these figures has been brought to the attention of the Director of Public Health in Peterborough to take forward.

---

<sup>2</sup> Office for National Statistics, Census 2011

<sup>3</sup> DFE Statistical release: Child Death Reviews: Year Ending 31 March 2013

### **Water Safety**

- 7.7 The CDOP Chair wrote to the Environment Agency and District Council to request they review public safety measures such as providing lifesaving equipment at a known wild swimming location in Cambridge and any similar location.
- 7.8 Following a number of deaths from drowning in Cambridgeshire and neighbouring areas the flyer in appendix D has been created. It has been brought to the attention of the Children's Trust in Cambridgeshire and will be distributed widely in schools and children's centres just before the school summer holidays.

### **Safe Sleeping Campaign**

- 7.9 After a number of unexpected deaths where unsafe sleeping arrangements were considered to be a modifiable factor Cambridgeshire and Peterborough LSCBs along with Health Visitor leads and the Designated Doctor for Death in Childhood have launched the 'Safer Sleeping Campaign'.
- 7.10 Up until April 2014, there have been four workshops which involved an overview of safer sleeping and infant deaths, a role play on how to engage parents in safer sleeping and the distribution of the Lullaby trust materials. Attendance was positive with around 40 people attending each workshop though the practitioners tended to be from health (health visitors / nursery nurses) and children's centres. It was noted that there were few representatives from Social Care, Doctors Surgeries and family workers from locality teams – participants who we particularly wanted to target. Feedback from the groups was extremely positive and the groups held a lot of discussion surrounding associated risks and advice to give to parents – both for Mums and Dads.
- 7.11 A further workshop has been booked in Peterborough in July and the presentation will be taken to midwives and cascaded back, by attendees at the events, to their single agency teams. Safer Sleeping is already part of the GP training undertaken by the LSCBs and GPs will be sent packs of leaflets shortly for their GP surgeries to give to new and expectant parents.
- 7.12 The LSCBs have set up information pages and links to the Lullaby Trust on their websites and have cascaded the message across LSCB groups, email, twitter, websites and blogs. Leaflets and information are being distributed and the licensing departments for both areas are being contacted; with a view to providing a workshop for publicans to promote the risks to parents who drink about unsafe sleeping with

their babies. The LSCBs have secured funding from NHS England for this year, the health visitors across the region to include the lullaby trust leaflet within the 'red book' for new parents.

## **8. Serious Case Reviews**

- 8.1 One serious case review was considered by CDOP in 2013/14. This review has still to be published because due to ongoing care proceedings. However the action plan arising from the review has been implemented by the LSCB in Cambridgeshire.
- 8.2 A second death was the subject of a serious case review in Peterborough and completed in April 2014. Whilst, this case has still to be considered at the CDOP, it is known that there is recommendation to review the decision making around when to undertake rapid response visits. This action will be included in the review of the CDOP procedures, which is set out in the 14/15 business plan at appendix C.

## **9. Unexpected Deaths / Rapid Response Service**

### **Arrangements for home visits**

- 9.1 Some organisational changes were made during 13/14 to the police representation on the joint on-call rota for unexpected child deaths. Close collaboration between the Designated Doctor for Death in Childhood and the Designated Police Public Protection Department Detective Chief Inspector ensured that the changes did not affect service delivery. The Designated Doctor for Death in Childhood has met with all relevant detective inspectors on the daytime rota to ensure joint working remains smooth.
- 9.2 Fourteen children died unexpectedly in 2013-14, excluding road traffic accidents. 7 of these children lived in Cambridgeshire and 7 lived in Peterborough. 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.
- 9.3 Joint home visits were undertaken where appropriate and led to important additional information being obtained either from additional history or from observations within

the home. If parents were too distressed to return home, arrangements were made for them to be seen at an alternative location.

## **10. East of England Regional Child Death Overview Network**

This network of CDOP Coordinators was revived this year, with the lead being taken by the Cambridgeshire and Peterborough CDOP. The network provides a forum for sharing data across the region, enabling coordinators to identify trends and issues, facilitate the sharing and dissemination of learning and preventative approaches identified by the CDOP process and share information about local operational and procedural issues. The group will be meeting quarterly.

## **11. CDOP Training**

- 11.1 The two LSCB's have jointly run two training sessions this year entitled 'Understanding the Impact of Serious Case Reviews and the Child Death Overview Process'. 27 people attended these sessions from agencies such as Health, Social Care, Police and Probation.
- 11.2 The Designated Doctor for Death in Childhood gave an overview of CDOP on two occasions to a regional group of paediatric trainees.

## **12. Support to Bereaved Families**

- 12.1 Prior to a child's death being reviewed, his or her family is written to, advised about the purpose of CDOP and encouraged to make contact if there is anything they think we should know about regarding the support they received following their child's death.
- 12.2 No family chose to contact us. This is similar to the national picture with very few families, for understandable reasons, choosing to make contact with CDOPs. However, for unexpected deaths, the information sharing meetings, which are held in primary care settings, enable practitioners to coordinate bereavement support.
- 12.3 The bereavement charity STARS has extended its remit to cover the whole of Cambridgeshire and Peterborough. The service offers support to children and young people aged 0 – 25 years who have experienced the death of an important person in their lives. The bereavement charity Cruse has had to temporarily suspend face to

face support for new clients in March, Chatteris and Wisbech due to a shortage of trained volunteers in these areas, and a high level of people in these areas on their waiting list. The charity hopes to be in a position to recommence face to face support in Fenland later this year. Support through the charity's helpline and telephone support will continue.

### **13. Plans for the Year 2014-15**

The 2014/15 business plan is attached as appendix C. The priority actions are summarised below:

- Review multi agency procedure and protocols
- Evaluate the Safe Sleeping Campaign
- Promote the Water Safety Leaflet
- Link up the work on accidents and deaths from road traffic accidents

## 14. Appendix A – Graphs and Tables

### 1) Mortality Rates by Council Area

Infant Mortality Rate (deaths of babies aged under 1 year per 1,000 live births), 2010-2012

Local Authority	Infant Mortality Rate (CHIMAT 2010-12)	England average
Cambridgeshire	3.9	4.3
Peterborough	4.2	4.3

### 2) Child Mortality Rate (directly standardised rate per 100,000 children age 1-17 years), 2010-2012

Local Authority	Child Mortality Rate (CHIMAT 2010-12)	England average
Cambridgeshire	10.2	12.5
Peterborough	18.2	12.5

### 3) Reported Deaths by Gender 2013-14

Gender	Cambridgeshire	Peterborough	Total
Male	20	11	31
Female	10	12	22

**4) Reported Deaths by Council Area, by age, 2008 - 2014**

Chart suppressed: Number of Cambridgeshire Deaths Reported to CDOP 2008-2014

Chart suppressed: Number of Peterborough Deaths Reported to CDOP 2008-2014

**5) Reported Deaths by Council Area, by Cause of Deaths, 2013-14**

Chart suppressed: Reported Deaths by Cause Cambridgeshire 2013-14

Chart suppressed: Reported Deaths by Cause Peterborough 2013-14

**6) Reviewed Deaths by Council Area, by Category 2013-14**

No deaths were reviewed in the categories 'Deliberately inflicted injury, abuse or neglect', 'Suicide or deliberate self-inflicted harm' and 'Acute medical or surgical condition'.

Chart suppressed: Deaths Reviewed by Category Cambridgeshire 2013-14

Chart suppressed: Deaths Reviewed by Category Peterborough 2013-14

**7) Reviewed Deaths by Council Area, by Event 2013-14**

No deaths were reviewed for deaths caused by poisoning, non-intentional injury / accident / trauma, apparent homicide, apparent suicide, fire and burns, substance misuse.

Chart suppressed: Deaths Reviewed by Event Cambridgeshire 2013-14

Chart suppressed: Deaths Reviewed by Event Peterborough 2013-14

**8) Modifiable Deaths by Council Area, by Category 2008 – 2014**

Chart suppressed: Modifiable Deaths by Category, Cambridgeshire 2008-2014

Chart suppressed: Modifiable Deaths by Category, Peterborough 2008-2014

**Appendix B1 – Membership of Child Death Overview Panel**

<b>Agency / Member</b>	<b>Deputy</b>
Felicity Schofield, Independent Chair	Elaine Lewis, Deputy Chair
Dr Elaine Lewis, Consultant Paediatrician, Cambridgeshire Community Services / Designated Doctor for Childhood Death – NHS Cambridgeshire and Peterborough CCG	
Dr Emma de Zoete, Consultant in Public Health Medicine Children & Health Inequalities – Cambridgeshire County Council	
Dr Lucy Preston, Consultant Paediatrician – CUHFT	Peter Heinz
Phil Parr, Assistant General Manager and Safeguarding Lead – East of England Ambulance Service (Cams)	
Sam Hunt, Lead Nurse for Children and Neonates. Named Nurse for Safeguarding Children Peterborough & Stamford Hospitals NHS Foundation Trust	Gill Giaffreda, Specialist Nurse for Safeguarding
Sharon Ward, Named Nurse for Safeguarding Children – Cambridgeshire and Peterborough Foundation Trust	
Mike Higgins, Specialist Health Visitor – Cambridgeshire Community Services	
David Hemming, HM Coroner Peterborough	
Joanne Bramwell, Training and Business Manager – Peterborough LSCB	
Josie Collier, Business Manager – Cams LSCB	
Alison Bennett, Team Manager Conference and Review – Peterborough City Council	
Sarah-Jane Smedmor, Head of Safeguarding and Standards Unit – Cambridgeshire County Council	
Detective Superintendent Gary Ridgeway, Head of Public Protection - Cambridgeshire Constabulary	
Ben Brown, Acting Designated Nurse Safeguarding Children, NHS Cambridgeshire and Peterborough CCG	
Dr Linda Maynard, Nurse Consultant Children's Palliative Care – East Anglia's Children's Hospices (EACH)	

**Appendix B2 - Membership of Neonatal Child Death Overview Panel**

<b>Agency / Member</b>
Dr Elaine Lewis, Consultant Paediatrician – Cambridgeshire Community Services / Designated Doctor for Childhood Death – NHS Cambridgeshire and Peterborough CCG (Chair)
Janet Driver, General Manager Women's Services, Hinchingsbrooke NHS Trust
Anne Guerriero, Acting Lead Nurse Neonatal Unit – Peterborough and Stamford Hospitals NHS Foundation Trust
Dr Gusztav Belzteki, Consultant Neonatologist – CUHFT
Helen Foster, Named Midwife for Safeguarding Children - Peterborough and Stamford Hospitals NHS Foundation Trust

**Appendix C – Business Plan for 2014-15**

	<b>Objective</b>	<b>Lead</b>	<b>Action and timescale</b>	<b>Outcome</b>	<b>Progress</b>
<b>1.</b>	Review bereavement support for families	EL	Describe the type & amount of support available across the County & identify gaps, good practice and variances. Dec 2014 (carried forward from 13/14)	Better support for bereaved families as measured by feedback	
<b>2.</b>	Evaluate 'Safe Sleeping' campaign	FS/SG	Campaign launched April 2014. Review feedback from workshops, review use of learning and materials	Improve parental awareness of safe sleeping. Reduce the numbers of SUDIs	
<b>3.</b>	Run a water safety campaign	FS/KP	Development and distribution of water safety flyer. June 2014.	Greater public awareness of water safety issues	
<b>4.</b>	Review CDOP and MAMUCD Protocols in line with WT 13 & SCR recommendation	FS/EL	Sept 2014	Meet statutory requirements, compliance with 'Working together to safeguard children 2013' and recommendations from Peterborough SCR concerning child A.	
<b>5.</b>	Combine learning from Road traffic accidents and deaths	MH	December 2014	Reduce RTA injuries & deaths	
<b>6.</b>	Ensure both LSCBs are kept informed of the work of CDOP	FS	Annual report. July 2014	Lessons learned from CDOP shared with safeguarding partners	

## Appendix D – Water Safety Flyer

# Keeping Kids Safe in Water in SUMMER



During the school holidays, particularly in hot weather, increasing numbers of children put themselves at risk of drowning.

## To keep your children safe

**Always** supervise children near open water.

**Never** allow children to swim in open water such as lakes or rivers, it may be colder and deeper than expected.

**Remember** garden ponds can present a danger to small children, who can get into difficulties quickly in very shallow water.

**Ensure** your children learn how to swim.

To keep safe always follow the Water Safety Code.

For more information visit [www.rospa.com](http://www.rospa.com)