



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

### **Public Annual Report 2016-17**

Natalie Jones

Child Death Review Manager

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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 2016-17.
- 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 2017.
- 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'.<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 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.

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<sup>1</sup> 'Working Together to Safeguard Children' has been revised and was reissued in March 2015. The responsibilities of Child Death Overview Panels are set out in chapter 5 and remain unchanged.

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 Chairs of the local Safeguarding Children Boards (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**

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 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 2016-17, the CDOP has met four times to review anonymous information about child deaths. The panel is chaired by an independent chairperson 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 with the Peterborough and Cambridgeshire Children's Services Departments.

## 5 The National Picture

- 5.1 Every year it is estimated that 1,951 additional children – around 5 a day – die in the UK compared to Europe's best performing country for child mortality, Sweden. The key areas where the UK rates appear to be relatively high are infant deaths and deaths among children and young people who have chronic conditions.<sup>2</sup> There were 2,578 infant deaths in England and Wales in 2015. The infant mortality rate was 3.7 deaths per 1,000 live births, an increase from 2014 where the rate was 3.6 deaths per 1,000 live births, the lowest rate ever recorded in England and Wales.
- 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 shown a rise this year after steadily decreasing over previous years. There were 3665 reviews completed by Child death Overview Panels in England during the year ending 31 March 2016, compared to 3515 in the year ending 31 March

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<sup>2</sup> *Why Children Die: Death in Infants, children and young people in the UK*. Royal College of Paediatrics and Child Health and National Children's Bureau 2014. [www.rcpch.ac.uk](http://www.rcpch.ac.uk)

2015. The proportion of deaths which were assessed as having modifiable factors has remained unchanged this year at 24 % following a year on year increase since the year ending 31 March 2012<sup>3</sup>.

- 5.4 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.

## 6 Local Overview

### Reported Deaths

- 6.1 Infant mortality rates for both Cambridgeshire and Peterborough are slightly below the England average although not significantly different (see appendix A, mortality rates by Council area).
- 6.2 Over the last year, the deaths of 59 children were reported to the CDOP across Cambridgeshire and Peterborough, 35 in Cambridgeshire and 24 in Peterborough. 63% of these children were babies under one year old and 46% 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 19 unexpected deaths reported this year, 11 in Cambridgeshire and 8 in Peterborough.
- 6.3 18 (30%) of the children died from a known life limiting condition this year, spread across all age groups.
- 6.4 Chart 1 below illustrates the extent of the rise in deaths reported which followed a decline in previous years. See appendix A for deaths reported by council area.

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<sup>3</sup> Child Death Reviews – Year ending 31 March 2016. Department for Education ( Accessed at <https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2016>)

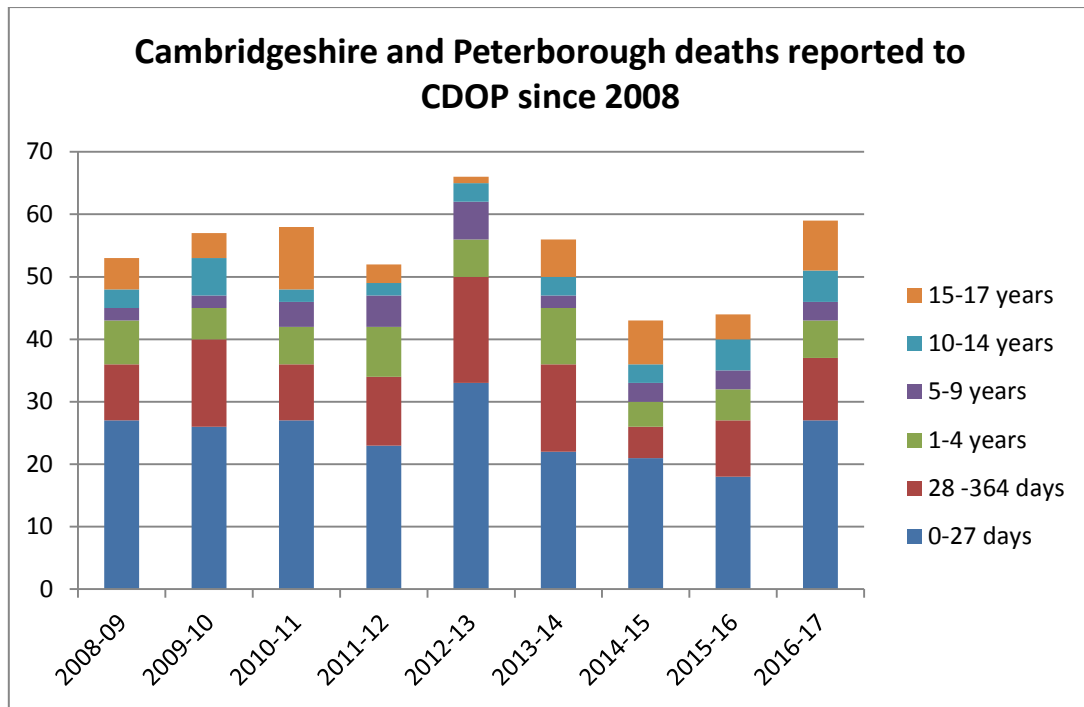


Chart 1 – Deaths reported to Cambridgeshire and Peterborough CDOP 2008 – 2017 by age group

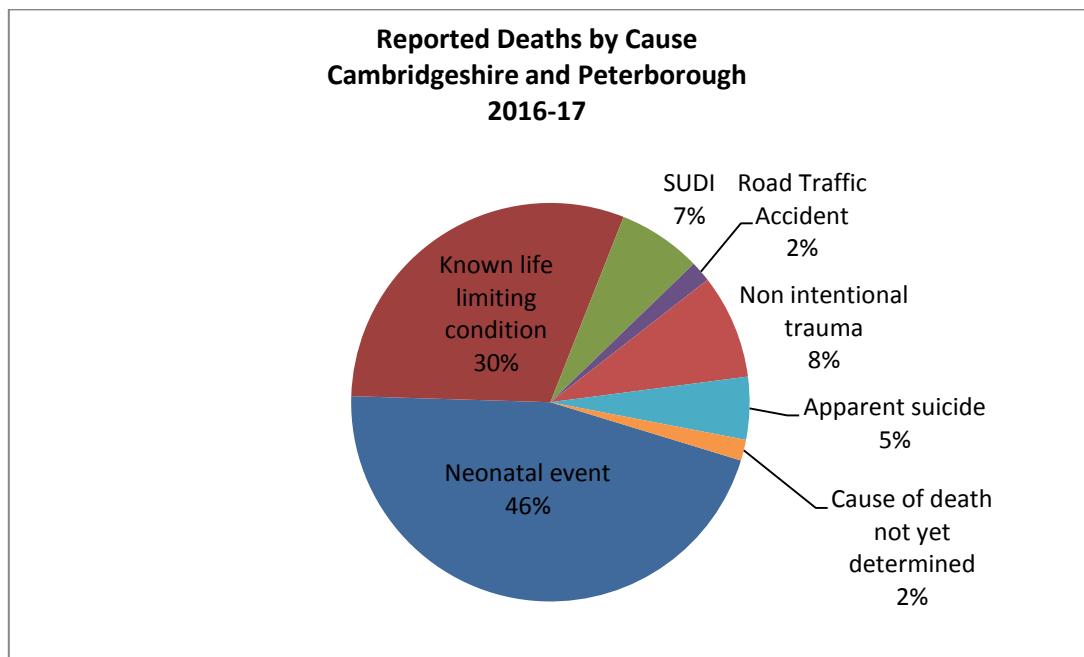


Chart 2 – Deaths reported to Cambridgeshire and Peterborough CDOP 2016-17 by cause

## Deaths reviewed

- 6.5 A total of 48 deaths were reviewed in 2016/17; 26 Cambridgeshire children and 22 Peterborough children. 27 deaths were reviewed by the main CDOP Panel and 21 by the Neonatal Panel. This is substantially more than the previous year where the figure was 33 deaths reviewed. There are two reasons for this increase; the first is because there has been an increase in the number of deaths reported this year. The second is that there were three main panel meetings in 2015/16; the fourth and final meeting of the year was cancelled due to the CDOP managers post becoming vacant. These cases were deferred to the next meeting which was in the 2016/17 period thus resulting in more deaths being reviewed.
- 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. There were 4 child deaths last year where a modifiable factor was identified by the main 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, Serious Case Reviews, post mortem reports and Coronial inquests. The table below shows that 48% of deaths reviewed this year occurred this year while 46% of deaths reviewed this year occurred the year before (2015-16).
- 6.8 77% of cases reviewed this year were completed within 12 months which is in line with the national figure of 72% of reviews being completed within 12 months of the child's death. The DfE acknowledges that reviewing child deaths is an extremely complex task and these figures are not used as a performance measure.



<b>Year Death Reported</b>	<b>Number of Deaths Reviewed in 2016 -17</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>2012-13</b>	1	0	0
<b>2013-14</b>	1	0	0
<b>2014-15</b>	1	0	0
<b>2015-16</b>	23	2	0
<b>2016-17</b>	22	2	0
<b>Total</b>	48	4	0

Table 1 – Deaths reviewed by year of death, Cambridgeshire and Peterborough 2016 -17

As in previous years, the majority of children whose death was reviewed were less than a year old; 55% for both areas combined, 61% for Cambridgeshire and 54% for Peterborough.

- 6.10 The next highest age range was children aged 1-4 years, 12% of deaths reviewed were in this age group. 4 of the 5 deaths in this age group were children who died of a known life limiting condition.
- 6.11 The main causes of death reflected similar years, with 46% of deaths being the result of perinatal or neonatal difficulties and 40% of the children dying from known life limiting conditions. See appendix A for charts by council areas.

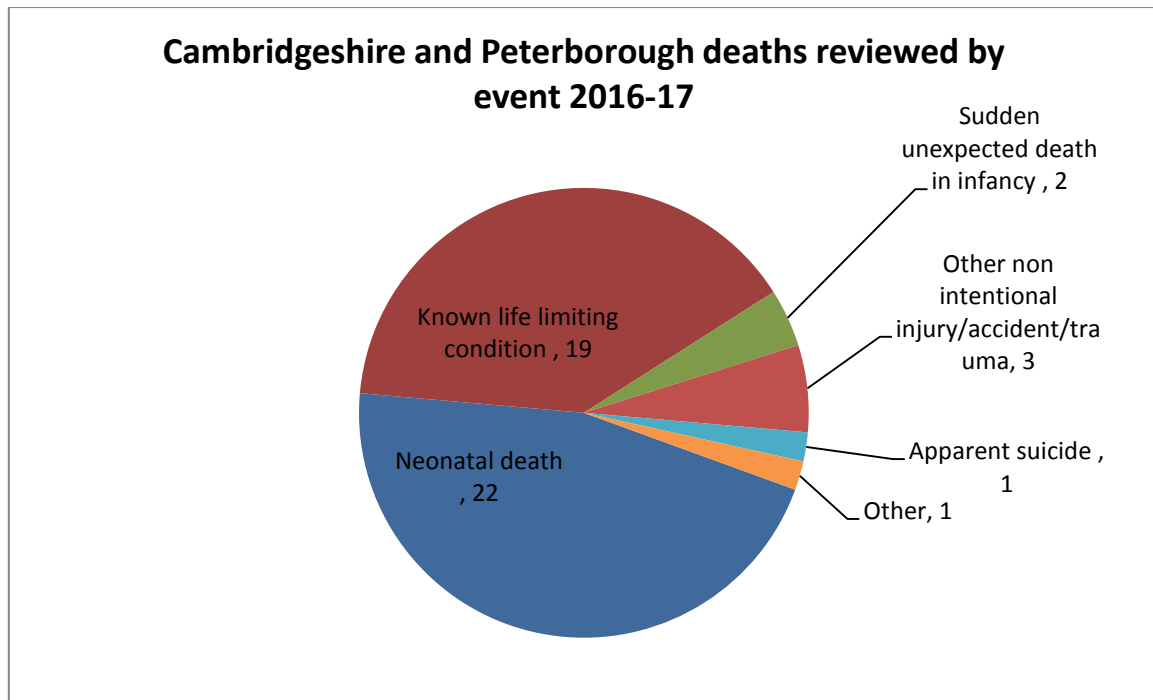


Chart 3 – Deaths reviewed by Event, Cambridgeshire and Peterborough 2016 - 17

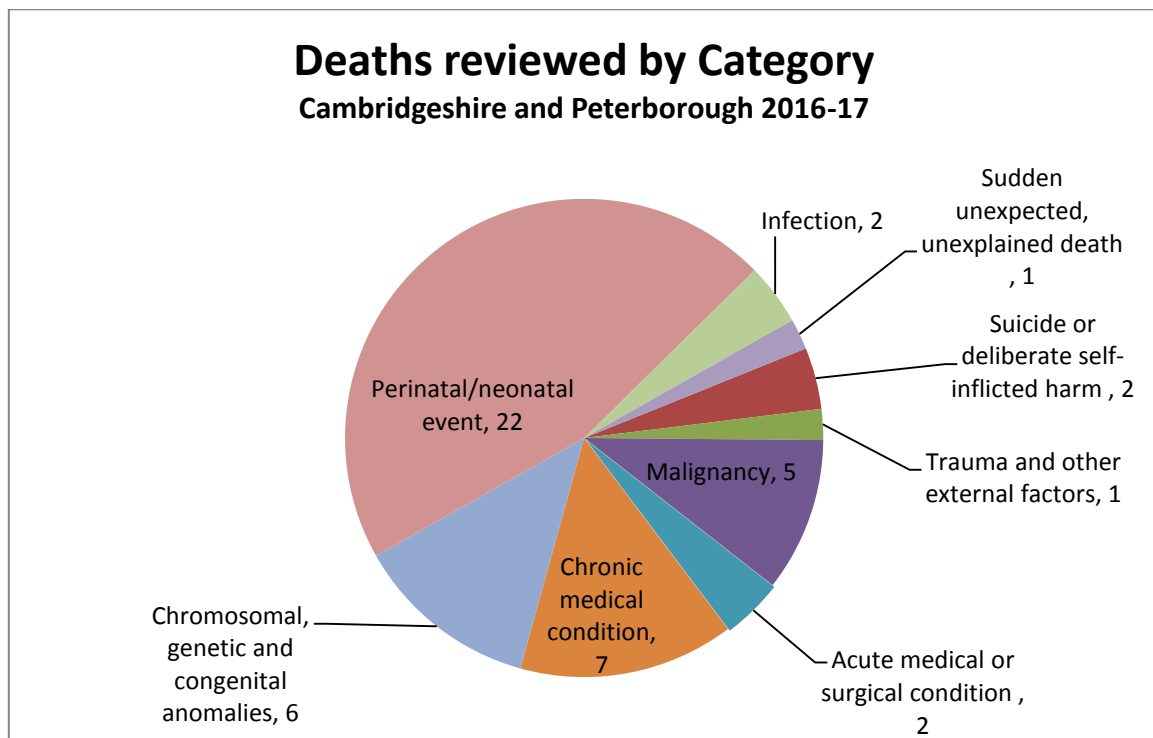


Chart 4 – Deaths reviewed by Category, Cambridgeshire and Peterborough 2016-17

### CDOP Main Panel – Modifiable Factors

- 6.12 The main CDOP panel met four times and reviewed the deaths of twenty seven children. Modifiable factors were identified in the case of one Peterborough child.
- 6.13 Chart 5 provides a breakdown by category for deaths where modifiable factors were identified over the eight years in which figures have been collected. See appendix A for modifiable deaths charts by council area.

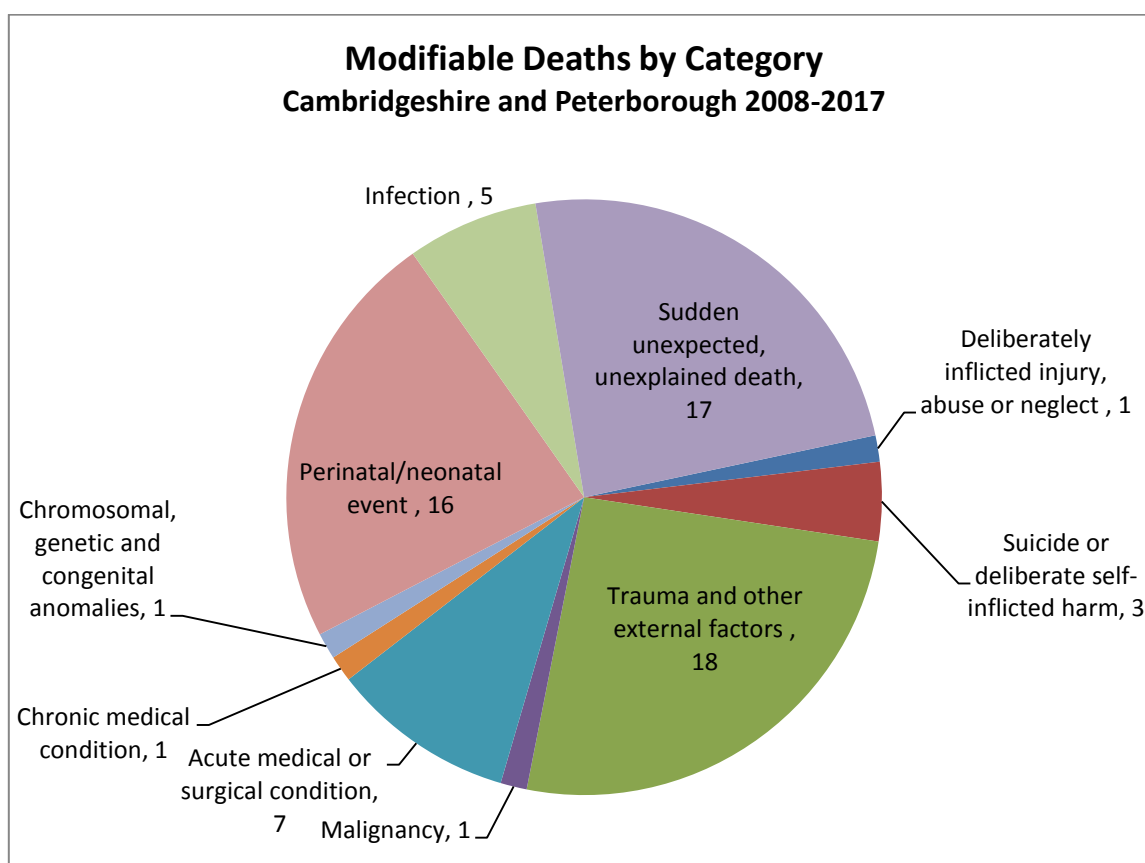


Chart 5 – Deaths where modifiable factors were identified by Cambridgeshire and Peterborough CDOP 2008-2017 by category of death.

### Neonatal Panel – Modifiable Factors

- 6.14 The Neonatal CDOP met twice over the course of 2016-17 and completed a review of 21 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 for three of the deaths reviewed.

## 7 Serious Case Reviews

- 7.1 None of the deaths reviewed this year were the subject of serious case review.
- 7.2 With the release of the latest research from Brandon et al 'Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011-2014', six workshops with 90 people attending were facilitated across the county including findings from the LSCB's domestic violence audits and comparisons with local SCRs.

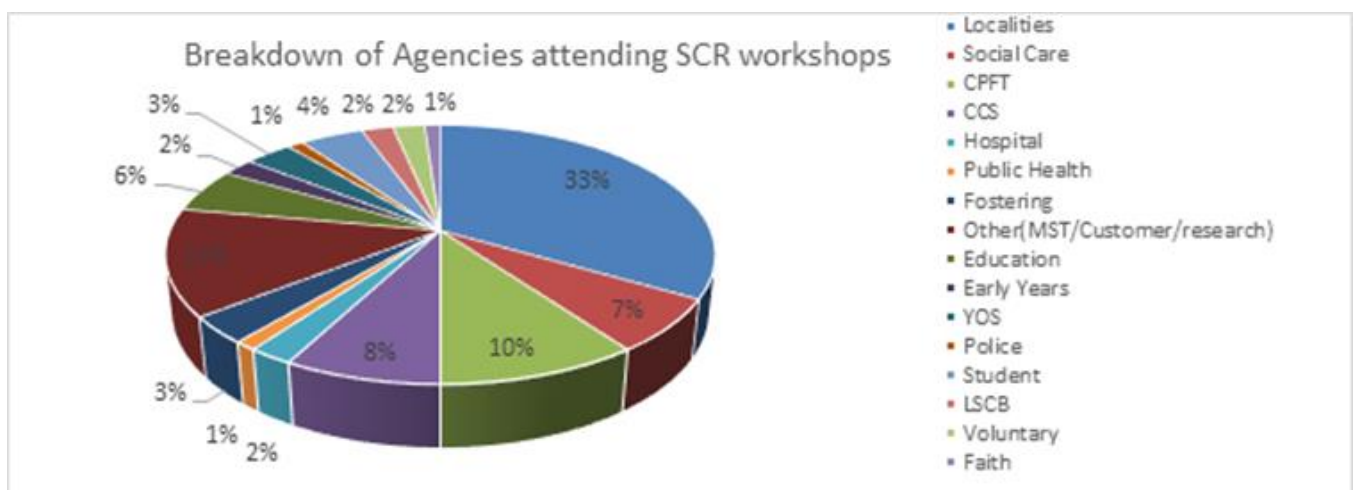


Chart 6 - Agency breakdown of attendees at SCR Workshop

## 8 Unexpected Deaths / Rapid Response Service

### Arrangements for home visits

- 8.1 Changes to the on call element of the Health Rapid Response Service were implemented last year. As of 1 April 2016 the service became Paediatrician led consisting of six Paediatricians.
- 8.2 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. Eleven children died unexpectedly this year; six in Cambridgeshire and five in Peterborough. This is the same figure of unexpected deaths as 2016/17.
- 8.3 A rapid response joint agency home visit was undertaken for one of the eleven unexpected deaths. This visit led to important additional information being obtained from the history given by the parents and from observations within the home.
- 8.4 In 10 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 6 cases death was due to a clear medical cause and therefore a home visit was deemed inappropriate. In 1 case death occurred out of area and therefore police colleagues conducted a home visit the details of which were shared and discussed at an information sharing meeting. In 3 cases the rapid response process for responding to the unexpected death of a child was not appropriately initiated.
- 8.5 The Force Lead for child death within Cambridgeshire Constabulary identified a gap in knowledge and experience of Senior Investigating Officers who perform the on call role. Training was delivered regarding the role and responsibilities when a child death occurs with future training planned. Training included a session delivered by the Child Death Overview panel Independent Chair, the Designated Doctor for Death in Childhood and the Designated Doctor for Safeguarding Children.

## 9 CDOP Training

9.1 For the year April 2016 until March 2017 there was one course scheduled for May, unfortunately there were not enough applicants for the course to go ahead. Over the past few years the LSCB has facilitated a distinct course on CDOP and findings from SCR though it is thought that most professionals have now attended the course which may be the reason for the declining number of applicants over the past two years. Currently this course is no longer advertised within Peterborough and Cambridgeshire training calendars, though the findings from national and local CDOP are disseminated through other LSCB courses and workshops. The safer sleeping and safety in water campaigns along with local serious case reviews and lessons learned were discussed within the specialised SCR workshops which took place across the county, feedback from practitioners included :

- Opportunity to meet other professionals and understand their role and what they bring to working with struggling families
- Having a range of relevant SCR which put it into perspective
- The importance to share information with other professionals
- Lots of thought provoking information that I had not heard of before – maternal ambivalence / curiosity regarding child's voice etc
- Reminder think sibling

## **10 Support to Bereaved Families**

10.1 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 that they think the panel should know about regarding the support they received following their child's death. Very few families chose to make contact this year which is reflected nationally. However, those that did make contact did so to offer feedback regarding the content and timeliness of the letter. Several parents reported that they found the content of the letter upsetting and some found the letter came as a shock in some cases having received the letter up to a year

after their child's death. In view of this feedback and with the agreement of the panel, the letter template and timeframe for sending it was revised.

## **11 Plans for the Year 2017/18**

11.1 The 2017/18 business plan is attached as appendix B, the priority actions are summarised below:

- Implement the recommendations from the National review of LSCBs which included a review of CDOPs
- Continue to raise awareness around the dangers of co-sleeping, especially after drinking alcohol
- Review the rapid response rota.

## 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), 2013-15<sup>4</sup>

Local Authority	Infant Mortality Rate (2013-15)	England average
Cambridgeshire	3.1	3.9
Peterborough	3.7	3.9

#### 2) Child Mortality Rate (directly standardised rate per 100,000 children age 1-17 years), 2013-15<sup>4</sup>

Local Authority	Child Mortality Rate (2013-15)	England average
Cambridgeshire	10.4	11.9
Peterborough	13.6	11.9

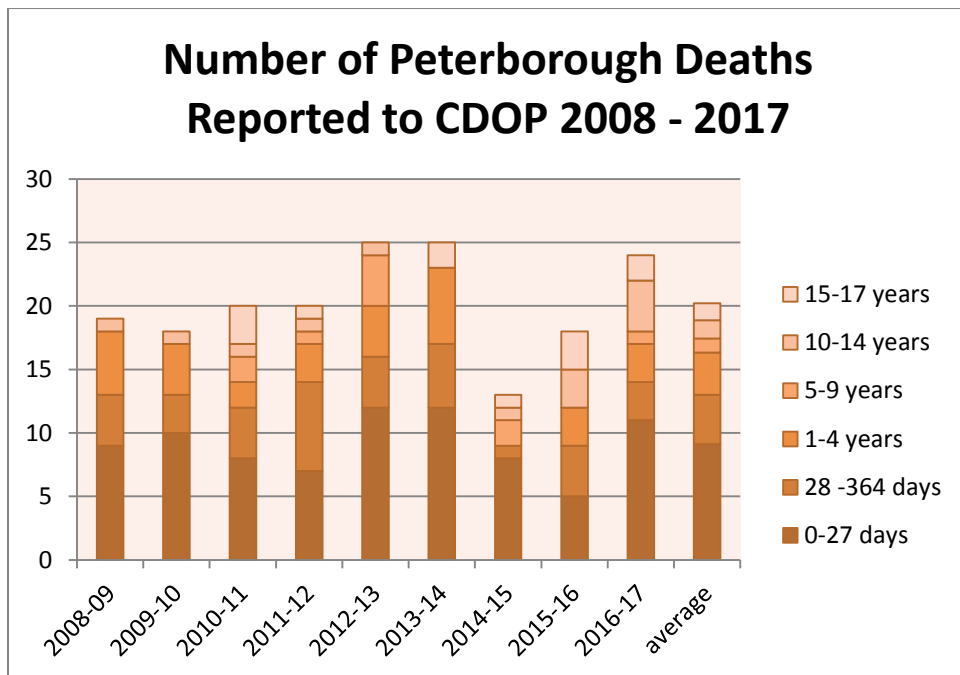
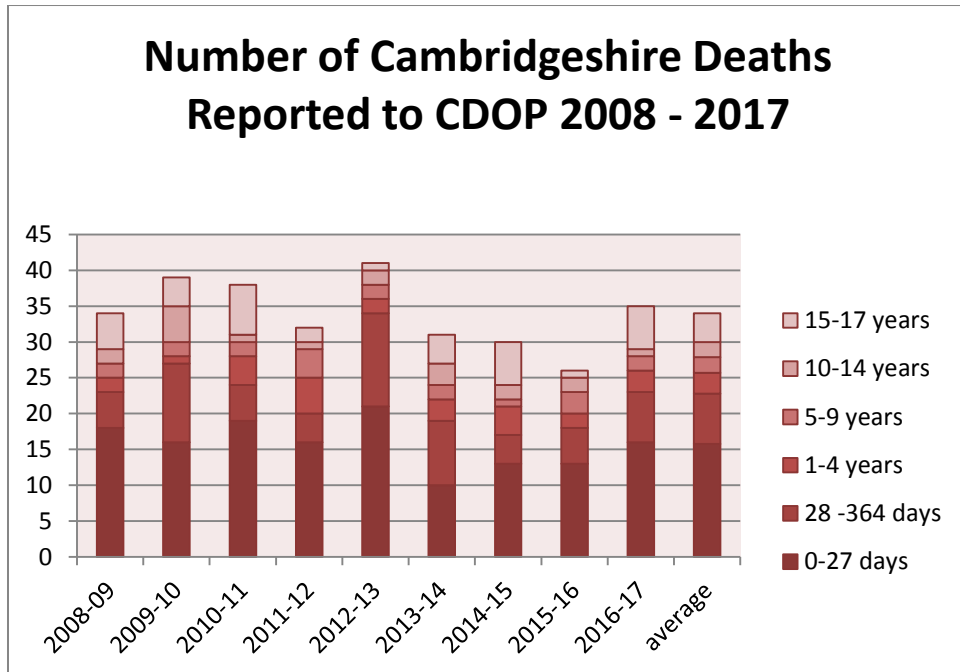
#### 3) Reported Deaths by Gender 2016-17

Gender	Cambridgeshire	Peterborough	Total
Male	20	14	34
Female	15	10	25
Indeterminate	0	0	0

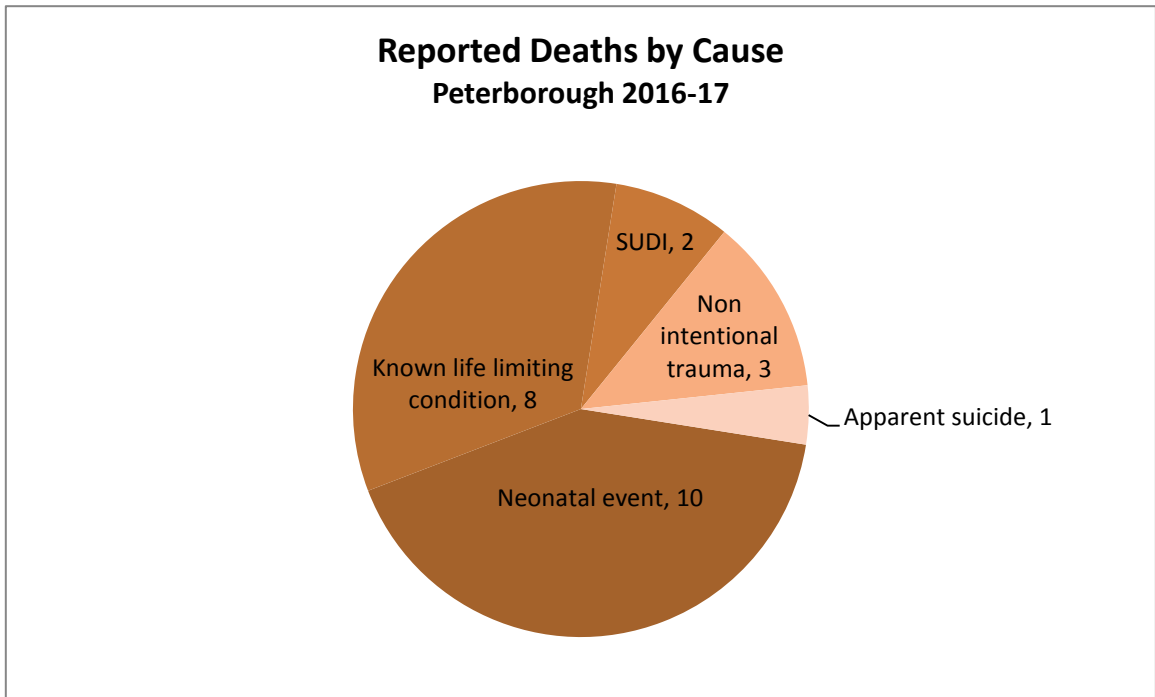
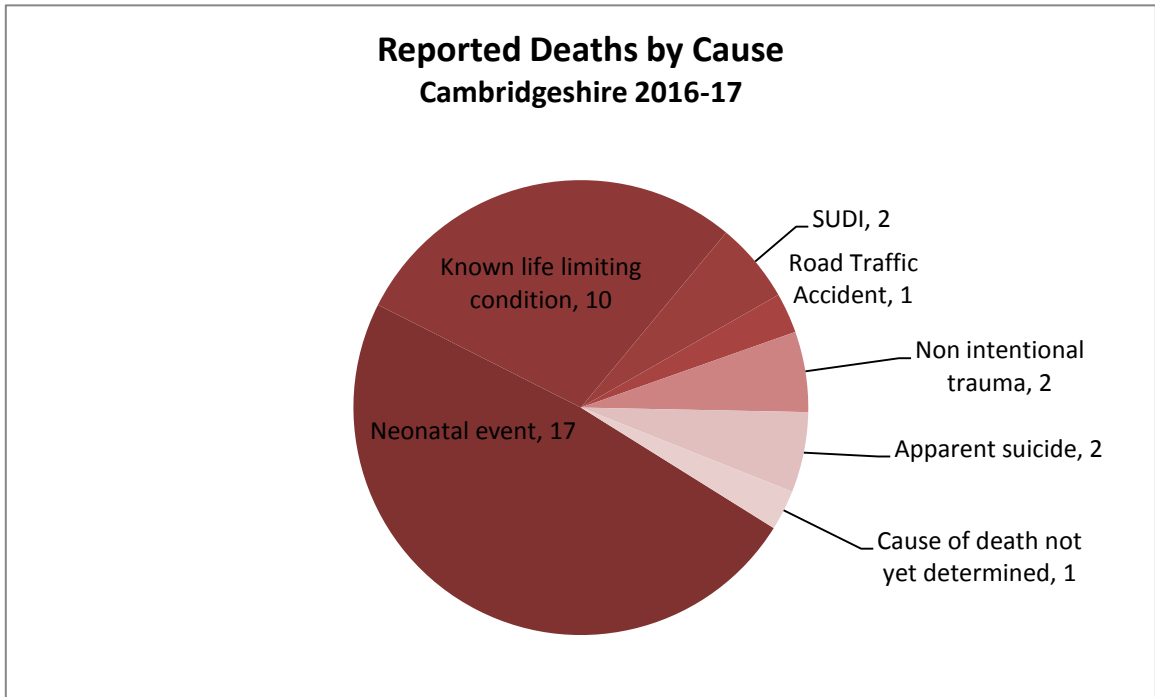
<sup>4</sup> Area Profiles, Overview of Child Health 2013-15, Public Health England (Accessed at <https://fingertips.phe.org.uk/>)



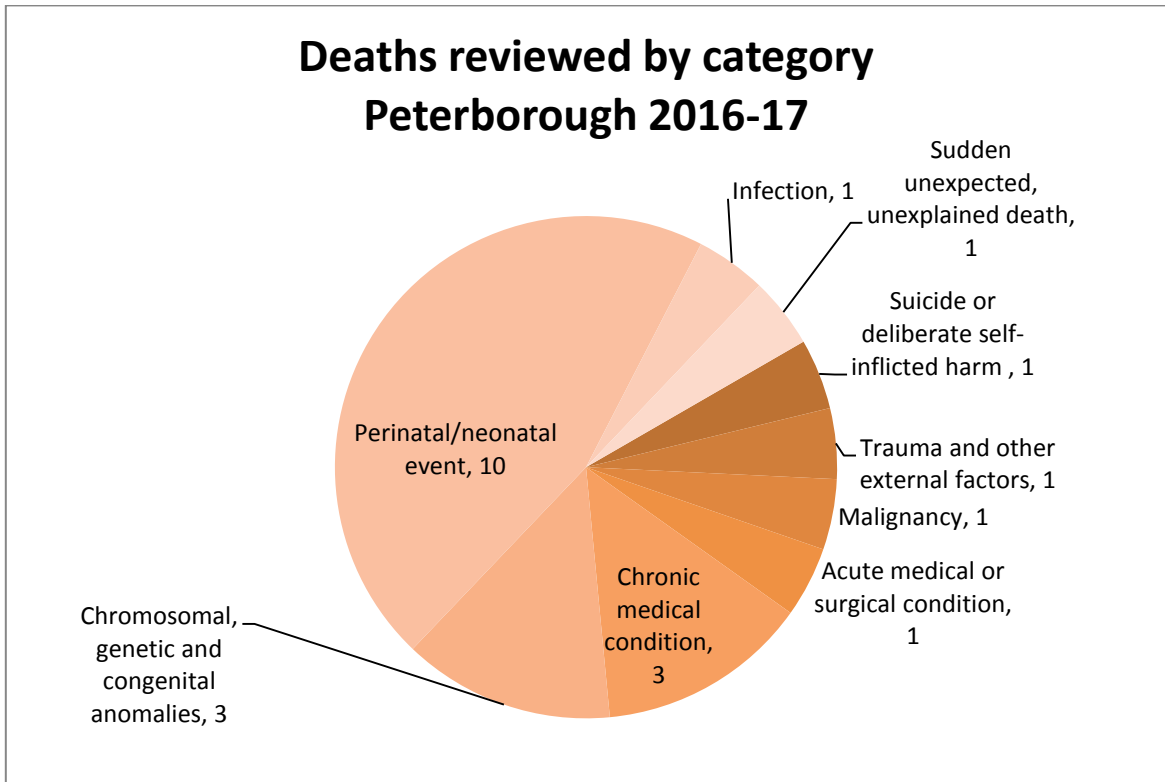
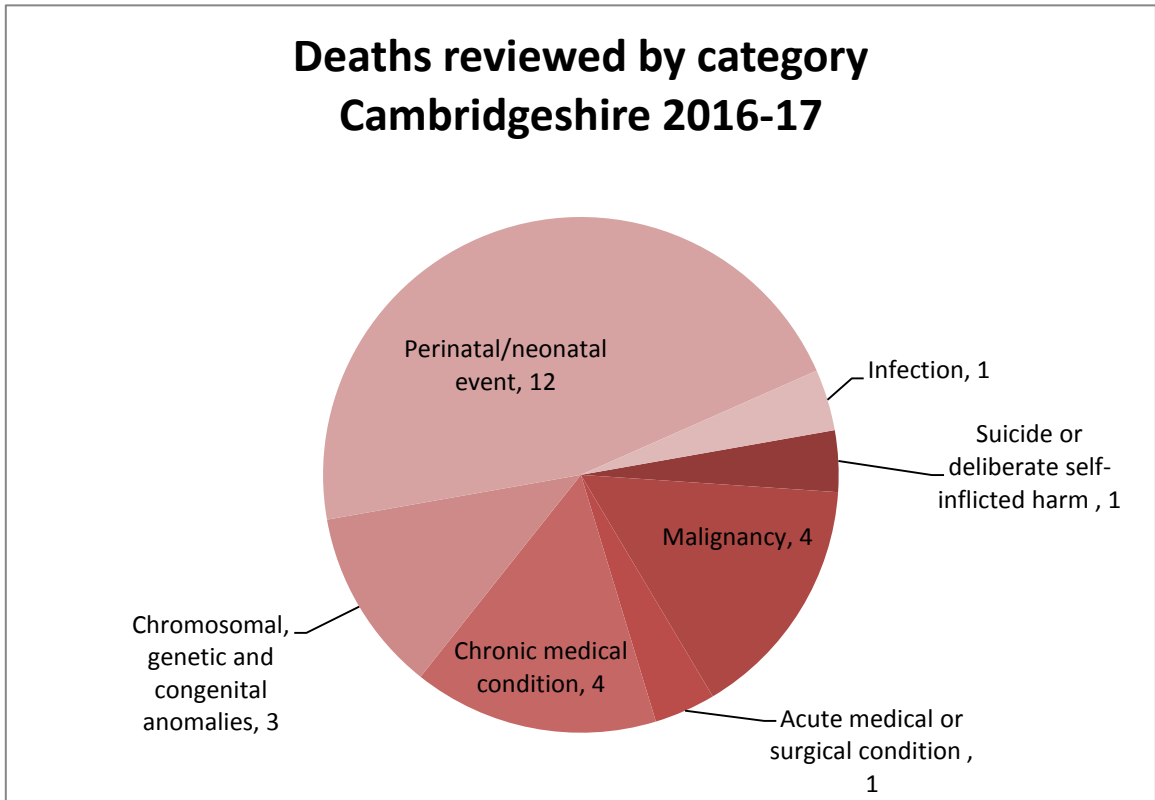
4) Reported Deaths by Council Area, by age, 2008 - 2017



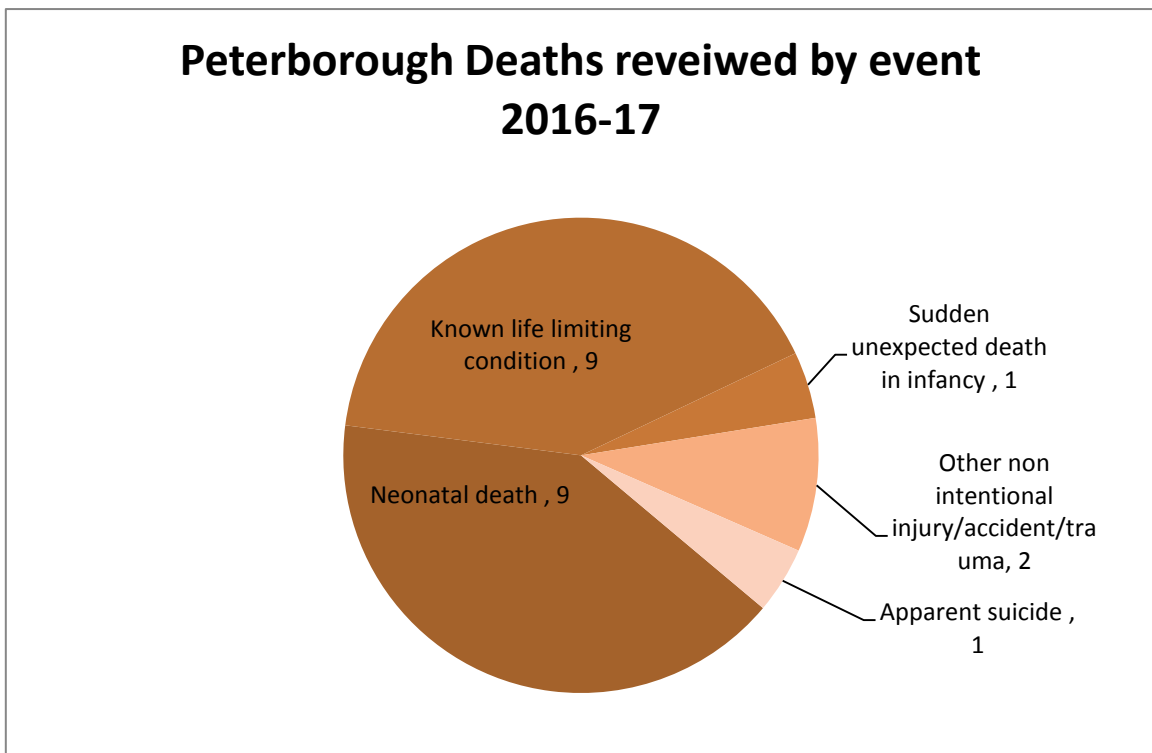
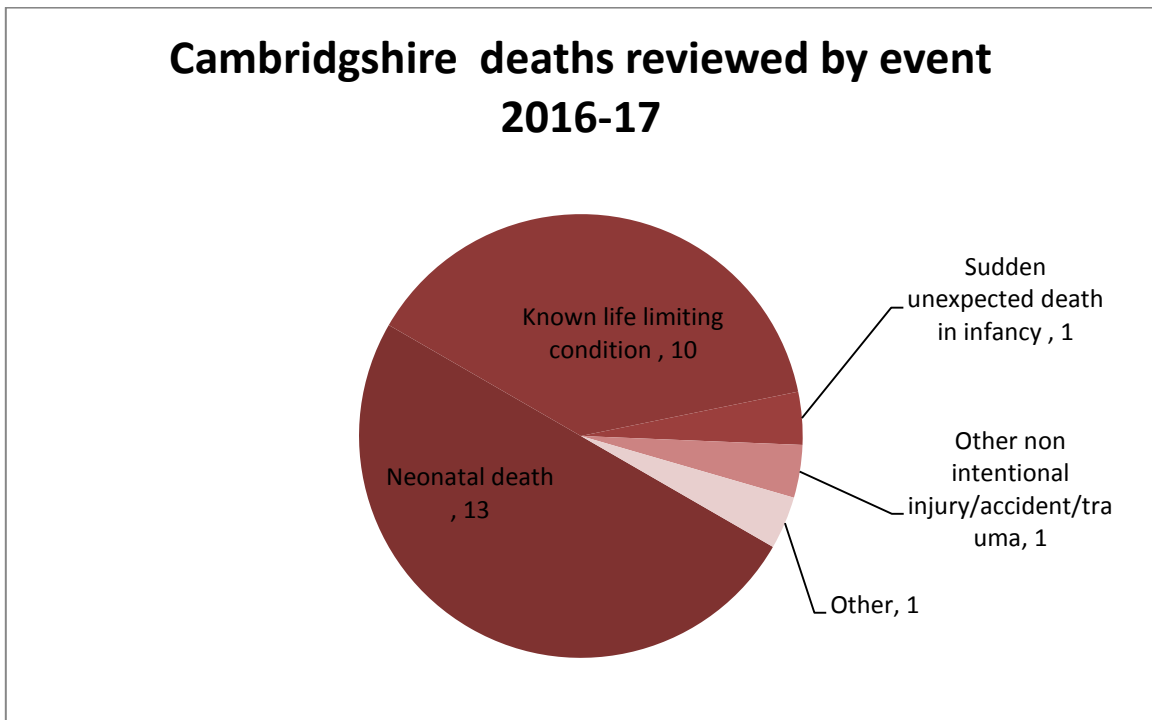
**5) Reported Deaths by Council Area, by Cause of Deaths, 2016-17**



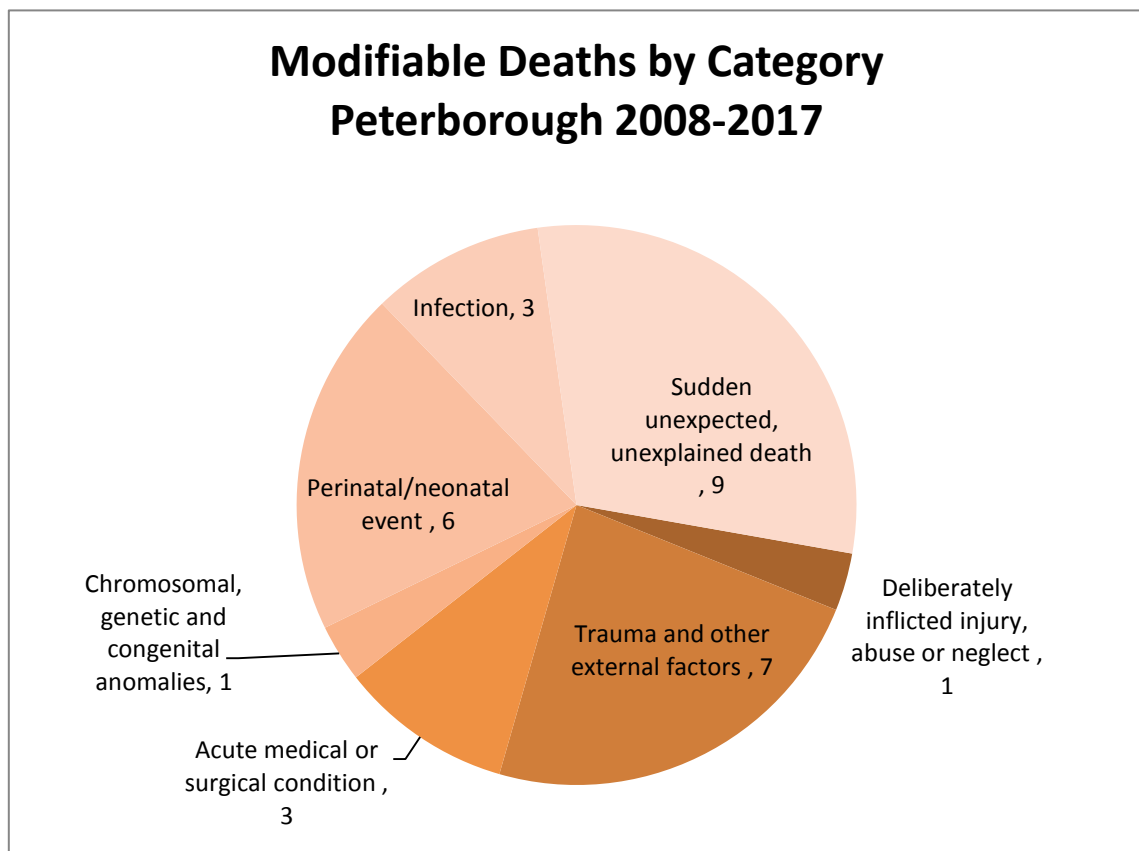
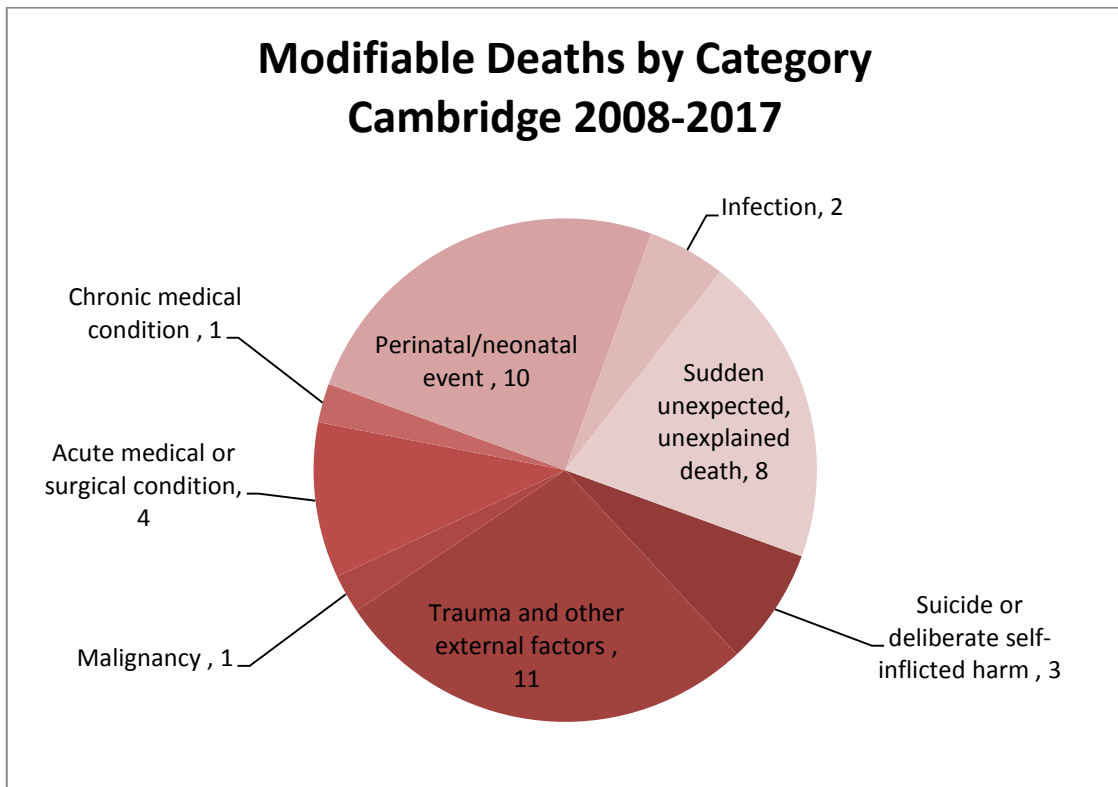
6) Reviewed Deaths by Council Area, by Category 2016-17



7) Reviewed Deaths by Council Area, by Event 2016-17



**8) Modifiable Deaths by Council Area, by Category 2008 – 2017**



**Appendix B Business Plan 2017-2018**

	<b>Objective</b>	<b>Lead</b>	<b>Action and timescale</b>	<b>Outcome</b>	<b>Progress</b>
1.	Implement the recommendations from the National Review of LSCB's which included a review of CDOP's	DD / NJ	Ongoing		The CSW Act 2017, is now in place and the guidance is being written in relation to child death procedures. This will be out for consultation in autumn 2017, and put in place 2018/19. Early indications are that C&P CDOP are already complying with a number of the proposals.
2.	Feed into the development of an Eastern Region CDOP	DD/NJ	Attend and contribute to quarterly meetings	Drive health learning and influence health commissioning as evidenced from thematic reviews.	

3.	Implement process for reporting deaths to LeDer for 4-18 year olds	RW/NJ	Attend LeDer steering group meetings	Support LeDer to: drive improvement in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities in this population, through mortality case review.	
<p>DD = Designated Doctor for Death in Childhood</p> <p>NJ = Natalie Jones, Child Death Review Manager</p> <p>CDOP = Child Death Overview Panel</p>					