

# **Pan Cheshire Child Death Overview Panel (CDOP)**

**Encompassing the Local Safeguarding Children Boards for**

**Cheshire East**

**Cheshire West and Chester**

**Halton**

**Warrington**

## **Annual report for Child Death Reviews**

**April 2013 – March 2014**

**Caryn L Cox**

**Director of Public Health, Cheshire West and Chester Council**

**Karen Newton**

**Pan Cheshire Child Death Co-ordinator, Cheshire East Council**

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**This report is provided to professionals working in the field of safeguarding children in the  
four LSCBs listed above**

**As such, if this report is further distributed, it should only be forwarded to persons that it is  
appropriate to do so, given the nature of its content**



**The Local Safeguarding  
Children Board**  
Working to Keep West Cheshire's  
Children and Young People Safe

## Contents

Acknowledgements.....	2
Glossary.....	2
Abbreviations.....	2
Foreword.....	3
Executive Summary.....	4
Membership of the Pan Cheshire CDOP .....	5
Background to the Child Death Overview Processes .....	6
Key data, April 2013 – March 2014 .....	7
Deaths by gender, April 2013 - March 2014.....	8
Ethnicity of child for all deaths, April 2013 – March 2014.....	8
Deaths reviewed by CDOP with modifiable factors, April 2013 - March 2014.....	8
Category of death, April 2013 - March 2014.....	8
Event that led to cause of death, April 2013 - March 2014 .....	9
Expected and unexpected deaths reviewed by CDOP, April 2013 - March 2014.....	9
Child protection, April 2013 - March 2014.....	9
Statutory orders, April 2013 - March 2014.....	9
Place of death, April 2013 – March 2014.....	10
National annual statistical data .....	10
CDOP Recommendations and learning points, April 2013 - March 2014.....	10
Safe sleeping.....	10
Disengagement by families from services .....	10
Suicide.....	11
Child death rapid response .....	11
Identifying deaths in hospital for children aged 16-18 years .....	11
Learning from child deaths – sharing widely to prevent future deaths .....	12
Administrative/support processes.....	12
Future work for the CDOP .....	12
CDOP Priority Action Plan.....	12
References.....	14

## Acknowledgements

My thanks go to all the panel members – past and present who have made this report possible. Particular thanks are extended to Karen Newton, the Pan Cheshire CDOP Co-ordinator.

My thanks also extend to all those who have sat on the panel as subject experts and those who respond to child deaths, for their continued dedication and success in implementing the child death review process.

Thanks are extended to Eileen O’Meara, Director of Public Health at Halton Council who very kindly Chaired the first Pan Cheshire CDOP in July 2014.

## Glossary

<b>Term</b>	<b>Meaning</b>
Child	A person aged 0-18 <sup>th</sup> birthday
Expected death	A death that could have been reasonably predicted 24 hours before the death occurred or 24 hours before the immediate events leading to the death occurred
Infant	Aged less than 1 year of age
Modifiable factors	Factors associated with a death which by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths
Neonatal period	From birth until 28 days of life
Perinatal period	From viable gestation (around 23 weeks of pregnancy) until 7 days following birth
Unexpected death	A death that could not have been reasonably foreseen 24 hours before it occurs – or where there was an unexpected collapse or precipitating events leading to the death

## Abbreviations

CDOP – Child Death Overview Panel

SUDI – Sudden Unexplained Death in Infants

LSCB – Local Safeguarding Children Board

## **Foreword**

I write the foreword to this report as Director of Public Health for Cheshire West and Chester Council and as the current Chair of the newly formed Pan-Cheshire Child Death Overview Panel (CDOP) – a sub-Committee of the four Local Safeguarding Boards of Cheshire East, Cheshire West and Chester, Halton and Warrington.

This report presents a summary of the work of the panel over the past year April 2013 – March 2014.

The panel undertakes a rigorous review of child deaths of those children ordinarily resident in one of the four areas and is a good example of effective multi-agency partnership. With the joining of the four panels we are able to provide a robust overview and insight into how child deaths can be prevented. The wide ranging experience and expertise of those who contribute to the panel either on a regular basis or through contributing as an expert in a particular field means that evidenced conclusions can be drawn to inform changes in policies, procedures and day to day practices to reduce the incidence of childhood death.

The work of the panel as demonstrated in this report should help to improve outcomes for children and young people across the four areas by identifying areas for reducing the risk of deaths where factors were identified that may have been modified to potentially prevent future deaths. This report will provide information to each of the Local Safeguarding Children Boards. It should serve as a powerful resource for driving public health improvement and promoting child safety and wellbeing.

Anonymity is a corner-stone for all data presented to CDOP, the LSCBs, shared regionally and nationally, to protect the identity of deceased children and their families. This report represents a summary of the full professional report. Numbers of deaths in individual areas and as a result of specific causes may not be reported as whole numbers where the number of incidents is less than 5, although the findings and outcomes of reviews will be included. This is for the protection of all those involved.

**Caryn Cox**  
**Chair – Pan Cheshire Child Death Overview Panel**  
**and**  
**Director of Public Health, Cheshire West and Chester Council**

## Executive Summary

'Working Together to Safeguard Children 2006, 2010 and 2013' specified that a mandatory multi-agency response and review process for all deaths in childhood (from birth up to 18<sup>th</sup> birthday) had to be implemented by April 2008 across England. The purpose of the process was to ensure all professionals responded to childhood deaths and reviewed each death in a uniform manner to identify lessons to be learnt and potentially prevent similar tragedies. The two key elements to this process are a "rapid response" and "child death overview".

This report brings together data from the first year that the newly formed Pan Cheshire panel has been meeting - since April 2013. The main report identifies the data relating to child deaths reviewed across the four LSCB areas; later annexes show the data for each specific LSCB area.

The report highlights the key data and findings of the panel.

- 58 child deaths were notified in the period April 2013 – March 2014
- 35 child deaths were reviewed by the panel from April 2013 - March 2014
- The Child Death Overview Panel met on five occasions over the year, four of these to review child deaths

Of those deaths reviewed

- 63% of the deaths occurred before the child reached one year of age (22 deaths)
- 63% of the deaths were male (22 deaths)
- Perinatal/Neonatal events accounted for 37% of deaths (13 deaths)
- 74% of deaths were classed as 'unexpected' (26 deaths)
- 31% of deaths reviewed had 'modifiable factors' (11 deaths)
- Recommendations/actions identified at case discussions and at the panel aimed at reducing risks and supporting families, have been taken forward.

When considering relatively rare events such as child deaths small variations in numbers can represent a large proportional difference. Therefore considering these figures together as a Pan Cheshire panel can help to establish a clearer representation of emerging trends or patterns but care must still be exercised.

## Membership of the Pan Cheshire CDOP

Membership during 2013/14 has comprised the following

Position	Agency	Comments
Director of Public Health Chair of Panel	Cheshire West and Chester Council	
CDOP Co-ordinator		
Consultant Paediatrician (Designated Doctor)	Mid Cheshire Hospitals NHS Trust	
Specialist Nurse for the Child Death Overview Panel	East Cheshire Trust	
Specialist Nurse Safeguarding Children	Countess of Chester Hospital NHS Trust	
Inspector – Public Protection Unit	Cheshire Police	
Superintendent – Strategic Public Protection Unit	Cheshire Police	
Safeguarding Manager	Cheshire East Council	
Social Worker	Warrington Council	
Senior Midwife	Countess of Chester Hospital NHS Trust	Left the panel January 2014
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Designated Safeguarding Nurse	Warrington and Halton Hospitals NHSTrust	Left the panel October 2013
Designated Safeguarding Nurse	Warrington CCG	
Lay Member	Warrington	
Consultant Paediatrician	Warrington and Halton Hospitals NHS Trust	
Board Manager	Halton Safeguarding Children Board	
Head of Midwifery	Bridgewater Community Healthcare NHS Trust	
Consultant Community Paediatrician (Designated Doctor)	Countess of Chester Hospital NHS Trust	

## **Background to the Child Death Overview Processes**

Since 1st April 2008 Local Safeguarding Children Boards (LSCBs) have held a statutory responsibility to review deaths of all children normally resident in their area. The criteria for a death to be reviewed is, any instance whereby a death certificate is issued for a person aged 0 - 18 years, with the exception of babies who are stillborn and planned terminations of pregnancy. In order to carry out this function the LSCB is required to appoint a committee known as the Child Death Overview Panel (CDOP). The CDOP is then required to report to the LSCB chair, in order that any findings can be used to inform planning on how best to safeguard and promote the wellbeing of children within the local area.

The CDOP committee carries out two inter-related processes, the 'rapid response' and the overview panel. Firstly, if the death of a child has been 'unexpected' a rapid response is completed. This involves a group of professionals meeting to determine the reasons that the child died, address the needs of any other children living in the household, and the needs of all family members and to address any public health issues that arise during the review. This rapid response is usually co-ordinated between the Police, a lead Paediatric Consultant (or other trained healthcare professional) and the LSCB senior team to ensure the necessary professionals are included and any information gathering can take place quickly following the death.

Secondly, the child death overview panel meet regularly to review all child deaths in the local authority area including those reviewed at rapid response. The panel has a fixed core membership and will include additional professional groups as necessary for the cases to be reviewed. The child death overview panel does not review child deaths until all investigations and criminal justice and inquest proceedings have been completed. Therefore, for unexpected child deaths, there may be a significant delay between the rapid response and the death being reviewed by the overview panel.

The purpose of the CDOP process is to gain insight into how and why children in the local area die, with the intention of protecting other children and helping to prevent future child deaths. This involves accurately establishing the cause of death, any emerging patterns of death and identifying any modifiable factors which may have contributed to a child's death. As part of this process the CDOP is required to decide if a child's death was precipitated by any modifiable factors. If modifiable factors are found, then a thorough consideration and action plan detailing how such deaths may be avoided in the future will be carried out by the CDOP. It is also a statutory requirement of the CDOP to collect local data for the Department for Education in order that regional and national data can be compiled.

## Key data, April 2013 – March 2014

The child population estimates in each of the four LSCB areas is detailed in the following table.

LSCB area	Child population size* (0-17 years)
Cheshire East	74,998
Cheshire West & Chester	66,052
Halton	28,105
Warrington	44,103
<b>Total</b>	<b>213,258</b>

\* Source: ONS Mid Year Population Estimates, 2012

The Pan Cheshire CDOP met on five occasions between April 2013 and March 2014.

The total number of child deaths notified across the Pan Cheshire footprint between April 2013 and March 2014 was 58.

The total number of child deaths reviewed by the panel between April 2013 and March 2014 was 35.

At the commencement of the new Pan Cheshire panel, there were a large number of cases (31 deaths) which were 'outstanding' from the four predecessor panels and passed through to the new Pan Cheshire panel for review.

During 2013/14 the panel considered a large number of these 'outstanding' cases (23 deaths). As of April 2014 there were still eight deaths from 2012/13 that had not yet been reviewed by the CDOP (of these three are ready for the panel and five are waiting for inquests to be completed).

There are, as of April 2014, 46 child deaths which were notified between April 2013 to March 2014 which are still to be reviewed (of these 10 are ready for the panel, 17 will require a themed panel and 27 are waiting for an inquest to be completed).

For any deaths where the review processes are not completed, even if the death occurred in 2013/14, these deaths are not included in any of the following analysis, except when considering number of deaths in each LSCB area, as they have enabled a crude death rate to be calculated which can be compared with the death rates for England.

From the cumulative data the greatest proportion of deaths occurred during the neonatal period (0-27 days). The neonatal period accounts for 37% of all the child deaths reviewed, and 63% of all deaths occurred before the child reached one year of age. More than 77% of child deaths occurred before the child reached their fifth birthday.

### **Deaths by gender, April 2013 - March 2014**

There is a higher mortality rate amongst male children, this reflects the data nationally. From April 2013 – March 2014 of the 35 child deaths reviewed by the CDOP, 13 were female and 22 were male.

### **Ethnicity of child for all deaths, April 2013 – March 2014**

From the national 2011 Census data in England and Wales 19.5% of the population were not from the White English/Welsh/Scottish/ Northern Irish/British ethnic group.

The North West data shows that 12.9% of the population were not from the White English/Welsh/Scottish/ Northern Irish/British ethnic group.

Across the four LSCB areas 33 child deaths reviewed (94%) were in the White English/Scottish/Welsh/Northern Irish/ British ethnic group, <5 deaths (6%) occurring in any other ethnic group

### **Deaths reviewed by CDOP with modifiable factors, April 2013 - March 2014**

A key purpose of the CDOP review process is to identify any modifiable factors contributing to the death. Modifiable factors are defined as one or more factors, which may have contributed to the death of the child and which by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths (DfE 2013).

For the period April 2013 – March 2014 of those cases reviewed, there were 11 child deaths (31%) with modifiable factors. This is higher than the average for England which is around 23%.

82% of child deaths where modifiable factors were identified were in children under the age of five years.

### **Category of death, April 2013 - March 2014**

The most common category of death was a perinatal/neonatal event (37%). The second most common category was death due to an acute medical or surgical condition (17%), followed by deaths categorised as due to a chronic medical condition or congenital, genetic or chromosomal abnormalities. These four categories of death account for 77% of all child deaths.

36% of the deaths reviewed which had modifiable factors identified were perinatal/neonatal deaths . 31% of all deaths within this category were found to have modifiable factors.

One quarter of all deaths with modifiable factors were related to infection. 40% of all deaths categorised as infection were found to have modifiable factors; this is higher than the average across England which is currently 26%. However the numbers are small and therefore small fluctuations in numbers produces a large percentage change.

All deaths in the categories 'sudden, unexpected and unexplained deaths' and 'trauma and other external factors' were found to have modifiable factors.

### **Event that led to cause of death, April 2013 - March 2014**

Over the period April 2013 to March 2014 neonatal deaths were the most common cause of death reported by CDOP, this accounted for 37% (n=13) of all deaths . The next most common causes of death were 'known life limiting condition' and sudden unexpected death in infancy' (each n=10) which presented each in 29% of all child deaths.

The most common cause of death with modifiable factors was sudden unexpected death in infancy.

### **Expected and unexpected deaths reviewed by CDOP, April 2013 - March 2014**

An expected death refers to a death that could reasonably been foreseen by clinicians for a period of at least 24 hours before it occurred. An unexpected death is then defined as the death of an infant or child which was not anticipated as a significant possibility 24 hours before the death or, where there was an unexpected collapse or incident precipitating the events that led to that death.

Between April 2013 and March 2014 there were 26 deaths (74%) where the death was classified as 'unexpected'. Of the 11 deaths which were identified as having modifiable factors nine were unexpected deaths (82%).

### **Child protection, April 2013 - March 2014**

There were no child deaths over the period April 2013 - March 2014 reviewed by CDOP in which a Child Protection Plan was in place at the time of the child's death.

### **Statutory orders, April 2013 - March 2014**

There were no deaths reviewed by CDOP in which a Statutory Order had been in place at the time of the child's death. Statutory Order, refers to section 31 of the Children Act 1989, (care orders).

## **Place of death, April 2013 – March 2014**

During the period April 2013 – March 2014 the most common place of child death was within an acute hospital setting (83%) with the greatest number within a Neonatal Unit (31%). Five children (14%) died within their home of normal residence.

## **National annual statistical data**

The LSCBs are required to collect a considerable amount of data following the death of every child and then submit an annual return to the Department for Education. The CDOP Co-ordinator is responsible for this function on behalf of each of the four LSCBs. The Department for Education, in turn, consolidates the returns and publishes a statistical release in July. This document is circulated to the members of CDOP as the national data “paints a picture” and can act as a “health check” as to how the CDOP is performing and compares to national data. The data is at a national level and in some parts at a regional level but it is not possible to compare individual LSCBs. The data can be found on the Department for Education website and is referenced in this document.

## **CDOP Recommendations and learning points, April 2013 - March 2014**

Learning points identified following multiagency review of child deaths at the CDOP, including lessons identified at any internal reviews of the child death by individual agencies, were disseminated nationally where relevant, via the CDOP co-ordinators national network, to facilitate learning and improved quality of care.

The following summarises key themes from the recommendations, learning and action points gathered from CDOP meeting minutes. These themes are related to factors associated with all child deaths discussed.

### **Safe sleeping**

One of the key areas that the CDOP identified from their considerations during the year was the number of deaths where unsafe sleeping positions or “co-sleeping” had been a modifiable factor. As a result of their considerations, the panel commenced a subgroup to review safe sleep (relating to deaths where co-sleeping or safe sleeping was raised as an issue). This group has joined with the Merseyside CDOP and are planning to run a joint campaign on safe sleep across the Cheshire and Merseyside footprint – to ensure consistency of messages and to reduce duplication and costs.

### **Disengagement by families from services**

The CDOP identified that there had been a number of cases where families had “disengaged” from health, social care or other related support services. The CDOP wrote to the Chairs of the LSCBs to highlight this issue and also to key agencies to request that they ensure a suitable pathway was in place to follow up with families who “did not attend” scheduled appointments to ensure they had not actively disengaged from services.

## **Suicide**

The Panel identified that whilst numbers of deaths through suicides notified in the year it met were low, there was, what appeared to be an increased number within the Cheshire East LSCB area. Cheshire East Council advised the panel that it planned to undertake an in depth review of suicides in children over the past few years and would report back on the findings to the panel in due course.

## **Child death rapid response**

The CDOP has identified that a “true rapid response process” is not undertaken for unexpected deaths across the Pan Cheshire footprint whereby a suitably trained health professional undertake a visit to the home where a child death occurred, alongside the police. A letter was sent to the six CCGs covering the four LSCBs advising them that this was identified within the guidance. Warrington CCG have agreed to take a lead with a view to commissioning and implementing a true rapid response process across the four LSCB areas. The panel will continue to monitor this to ensure this is undertaken.

## **Identifying deaths in hospital for children aged 16-18 years**

When a child reaches the age of 16, in a healthcare setting they are treated as an adult and not placed on a children’s ward or under the care of a paediatrician. As such if a child dies between the ages of 16 and 18 they are treated as an adult. It is possible therefore that some child deaths may not be notified to the CDOP Co-ordinator and therefore a review into the death of that child may not take place. Following a presentation by a Paediatric Consultant from a neighbouring area who had tackled this issue successfully in their own area, the CDOP contacted all the Acute Trusts to request that a similar notification system was put in place.

## **Smoking in pregnancy**

The CDOP identified that there were a number of cases where the mother had smoked during pregnancy, smoking in pregnancy can lead to a range of health issues for newborns as well as premature births and underweight babies. The panel wrote to acute trusts and Directors of Public Health requesting that reducing smoking in pregnancy remains a key priority through smoking cessation services and through specially trained midwives who work with mums to reduce the numbers smoking in pregnancy.

## **Medical advances - resuscitation**

The Consultant Paediatricians cascaded to acute trusts the findings from a case of a failed newborn resuscitation that could potentially have been avoided through the use of a ‘Meconium aspirator device’ attached to the endotracheal tube, to enable suction of the airways during resuscitation. This led to enquiries from other hospitals in the country so they can procure the kit and incorporate into their practise.

## **Learning from child deaths – sharing widely to prevent future deaths**

The CDOP wrote to one Acute Trust following a child death where a Root Cause Analysis (RCA), (an RCA is a systematic method for reviewing adverse incidents, ie a problem solving methodology for discovering the real, or root cause(s) of problems or difficulties) had been undertaken in the trust to request that the learning points from the RCA be shared across the Pan Cheshire footprint.

## **Administrative/support processes**

Perinatal mortality and summary information - The CDOP wrote to each Acute Medical Director in NHS hospital trusts where Cheshire children may be admitted and subsequently die, to request that minutes from Perinatal Mortality meetings were submitted to the CDOP Co-ordinator so that any learning from these meetings can be reviewed as part of the panel considerations.

The panel also requested that the Acute Trusts send to the CDOP Co-ordinator, the 'Summary Letter' that is sent to GPs from the Paediatricians to aid the panel considerations.

Letters to families - The CDOP introduced a process whereby a letter is sent to the parents or guardians of a child following their death. The letter, sent some three to four weeks after the death, advises them of the child death overview process and also invites them to meet the Chair of the panel if they feel they have anything they wish to disclose to the panel to support the core aim of the panel in preventing future deaths. During 2013/14 only one family took up this offer.

Timely notification - The CDOP identified that some notifications were not made in a timely way - in particular those which had involved road traffic incidents where a child died. The Cheshire Police who are a member of the panel have liaised with relevant colleagues to ensure that notification is undertaken in a timely way. This is being monitored.

Missing data – a number of older forms have incomplete data on them – particularly in relation to the wider family and the father of the child. Key members of CDOP are working with partner and provider organisations to support them to understand the importance of having robust information to support the panel considerations and to improve the information that is supplied to the panel on the forms.

Ambulance Trust – CDOP identified that the Ambulance Trust were not following the established processes and protocols for child deaths. The panel wrote to the Ambulance Trust to ensure that they were aware of the protocols so that these could be followed.

## **Future work for the CDOP**

### **CDOP Priority Action Plan**

Priority	Action	Lead	Timescales	Outcome
Safe Sleep	1) Create a set of Pan	Janice	Dec 2014	Reduce the number of

	<p>Cheshire Integrated Working Guidelines</p> <p>2) Benchmarking advice to identify current practice of training for professionals and current practise for parental education.</p> <p>3) Implementation of guidelines by all LSCB Board members to be cascaded</p> <p>4) Dissemination of information and training</p> <p>5) Repeat exercise in 2) after Action Plan completed</p>	<p>Bleasdale</p> <p>Janice Bleasdale</p> <p>All Board Members</p> <p>Board Sub-Groups and individual agencies</p> <p>Janice Bleasdale</p>	<p>Jan 2015</p> <p>Feb 2015</p> <p>Oct 2015</p> <p>Dec 2015</p>	<p>deaths where unsafe sleeping has been identified as a risk factor.</p>
Teenage Suicide	<p>1) All LSCB's to have shared the learning from Cheshire Easts Thematic Review</p>	Boards	12 months from publication	<p>1) Improve the management of risk teenage suicide.</p> <p>2) To ensure that all relevant practitioner and commissioners are aware of the learning and individual agencies implement relevant learning into their organisation.</p>
Bereavement Services	<p>1) CDOP to be assured of the provision of bereavement counselling from LSCB representatives</p> <p>2) CDOP Task and Finish Group to be set up to work on Website and other avenues of dissemination of information</p>	<p>Boards</p> <p>CDOP</p>	<p>Dec 2014</p> <p>Within the next 12 months</p>	<p>To improve the response to bereaved parents and siblings</p>

During 2014/15 the panel will continue where feasible to review cases using a thematic process – themes planned for 2014/15 include – cardiac cases where a Consultant specialising in Paediatric Cardiology from Alder Hey will be invited to attend the panel as a subject expert to support the panel in their considerations. A further CDOP will focus on neonatal deaths.

However it must be borne in mind that reviews should not be overly delayed due to lack of sufficient number of deaths of similar nature.

The Panel are proposing to hold a half day professional development day for relevant health and social care professionals and academics who may work in areas where they respond or deal with child deaths.

The Pan Cheshire CDOP will continue to explore the potential of closer working with the Merseyside CDOP.

The CDOP will also during 2014/15 give consideration to the frequency of the meetings in order to assist progress in presenting cases to the CDOP in a timely fashion. The panel currently meet on a quarterly basis and for a whole day.

The panel through the CDOP Co-ordinator are looking to produce a set of Pan Cheshire CDOP webpages that can be embedded within each LSCB website.

## **References**

(Accessed July 2014)

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