PHAST
HEALTHIER OUTCOMES FOR EVERYBODY

# Bexley Child Death Overview Panel (CDOP)

# Annual Report 2013/14 & Report of Aggregate Analysis 2008 - 2014

## CHAPTER 1: INTRODUCTION

### 1.1 Purpose & structure

The Child Death Overview Panel (CDOP) process was implemented by Bexley Local Safeguarding Children Board (BSCB) for the London Borough of Bexley (LBB) in 2008. The CDOP is accountable to BSCB, and as such is statutorily required to report to them on its work each year, and to advise on the on-going findings of its work to BSCB and other key partners, including the Director of Public Health and Bexley Clinical Commissioning Group (CCG).

The 2014 Ofsted review of the BSCB reported that Bexley's CDOP functioned effectively.

This report considers analysis of child deaths occurring and notified to the Bexley CDOP in the most recent annual period (April 2013 - March 2014), and as per recommendations in previous annual reports, aggregated data for the entire period of the Panel's existence (January 2008 – March 2014).

As recommended in previous CDOP annual reports, the aggregate analysis seeks to maximise insight into the larger complete CDOP cohort of child deaths in Bexley, to complement the year-on-year analyses undertaken for successive annual reports.

The findings for these two time-periods are set-out separately in Chapters 2 and 3 of the report, and both include consideration of all deaths and the sub-set of unexpected deaths.

### 1.2 Methods

The analysis presented for all deaths includes the following:

- Gender
- Age
- Ethnicity
- Cause of death
- Place of death
- Home address deprivation score

Based on full consideration at a CDOP meeting, the analysis presented for unexpected deaths additionally seeks to include:

- Contributory factors relevance scores in relation to:
  - Child needs
  - Family & environment
  - Parenting capacity
  - Service provision
- Preventability/modifiable factors (3 categories)

Annual time trend analyses have been included in the 2008 – 2014 section of the report.

Statistical consideration of differences was undertaken by calculating 95% confidence limits, and any relevant statistically significant results are reported where found.

Unfortunately, informative comparison of Bexley child deaths with other areas, including England as a whole is hampered by the lack of a well designed national data analysis system. The annual CDOP statistics published by the Department for Education (DfE) focus on the administrative or process reporting of CDOP work or adopt a different format of reporting, and are of limited value as comparators from a local epidemiological perspective[i] [ii]. However, where feasible, comparisons between national DfE findings[ii] and Bexley made throughout the report.

Such comparison may be facilitated in future by the outputs of a tendering process for the development of a national CDOP information system[iii].

In the meantime, annual reports of other CDOPs are available individually, and a limited number of ad hoc comparative reports have been circulated through London CDOP networks[iv]. However, these do not generally provide a practical systematic basis for comparison of local CDOP findings.

Otherwise, Public Health England (PHE) publish a child health profiles for all local authorities, allowing benchmarking assessment of Bexley against relevant national child health care and health outcome targets[v].

### 1.3 Child Death Overview Panel function

The CDOP mechanism undertakes detailed reviews of the individual circumstances of child deaths to allow local learning and a chance to avoid future similar deaths.

Each death of a child is a tragedy for his or her family, and subsequent enquiries/investigations should keep an appropriate balance between forensic and medical requirements and the family's need for support. In all cases, enquiries should seek to understand the reasons for the child's death, address the possible needs of other children in the household, the needs of all family members; and also consider any lessons to be learnt about how best to safeguard and promote children's welfare in the future, as well as any wider public health or safety issues and ensuring procedures are in place for a co-ordinated response.

The CDOP is responsible for reviewing the deaths of all children resident within the geographical area covered by Bexley LSCB from birth to 18yrs, including:

- **Perinatal death**: Death of a foetus or new-born occurring after 24 weeks of pregnancy, during childbirth and up to 7 days of life.
- **Neonatal death:** From birth to 28 days of life
- **Infant death**: Birth to 1 year
- **Childhood death**: 1 year to 18 years

The panel is not responsible for reviewing stillbirths or planned terminations of pregnancy carried out within the law.

The CDOP meets quarterly. The panel is drawn from key organisations represented on the Bexley Safeguarding Children Board (BSCB) and relevant professional groups. There is good support and engagement from a core membership:

- Head of Service, Ellenor Lions Hospice

- Designated Nurse Safeguarding Children, Bexley CCG (Chair)
- Consultant in Public Health, PHAST (on behalf of LBB)
- Oxleas NHS Trust (Community Services)
- Designated Doctor for child deaths
- Child Abuse Investigation Team, Metropolitan Police
- Borough Police
- Deputy Director, Youth, Access & Behaviour LBB
- Children's services Manager, Lewisham and Greenwich NHS Trust (Queen Elizabeth Hospital)
- Consultant Paediatrician Dartford and Gravesham NHS Trust (Darent Valley Hospital)
- Single Point of Contact (SPOC), Administrator, LBB

The child death process is supported by the Single Point of Contact provided by the local authority. She also acts as clerk/administrator. The Designated Doctor for Child Deaths is a Consultant CommunityPaediatrician at Oxleas NHS Trust. The Designated nurse for Safeguarding Children chairs the meeting.

Bexley CDOP is required to collect and collate an agreed national minimum dataset on each child who has died.

The Single Point of Contact is the designated person who should be notified of the death of every child resident in Bexley usually within 24 hours of the death.

Deaths designated as unexpected are subject to more detailed information collection and consideration at a CDOP meeting.

The CDOP Single Point of Contact/Administrator and PHAST have developed a spreadsheet which is used to record all the data collected for each child, and the CDOP's consideration and conclusions in cases of unexpected deaths. The completeness and quality of information from the relevant agencies has gradually improved with greater awareness apparent of the role of CDOP.

Last year's annual report made 2 recommendations:

1. A more detailed aggregate analysis of Bexley CDOP findings should be undertaken on the data accumulated over the full available period since 2008, including consideration of ethnicity (as follows in Chapter 3).

2. An audit of the involvement of specialist palliative care services in appropriate child deaths considered by the CDOP. The results are included in this report.

## CHAPTER 2: APRIL 2013 - MARCH 2014

This chapter reports on deaths notified to and considered by the CDOP for the most recent annual period alone. However, the findings are compared with other reporting periods in Chapter 3.

### 2.1 All child deaths 2013/14

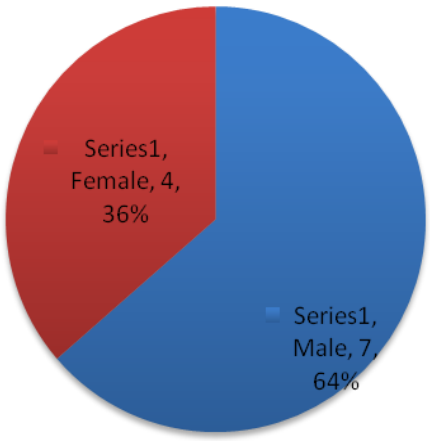
Table 1 below shows the numbers and percentages of cases (expected, unexpected, & all).

**Table 1: Child death notifications (April 13 - March 14)**

| Expected | | Unexpected | | All |
|---|---|---|---|---|
| **No cases** | **% of total** | **No cases** | **% of total** | |
| 9 | 82% | 2 | 18% | 11 |

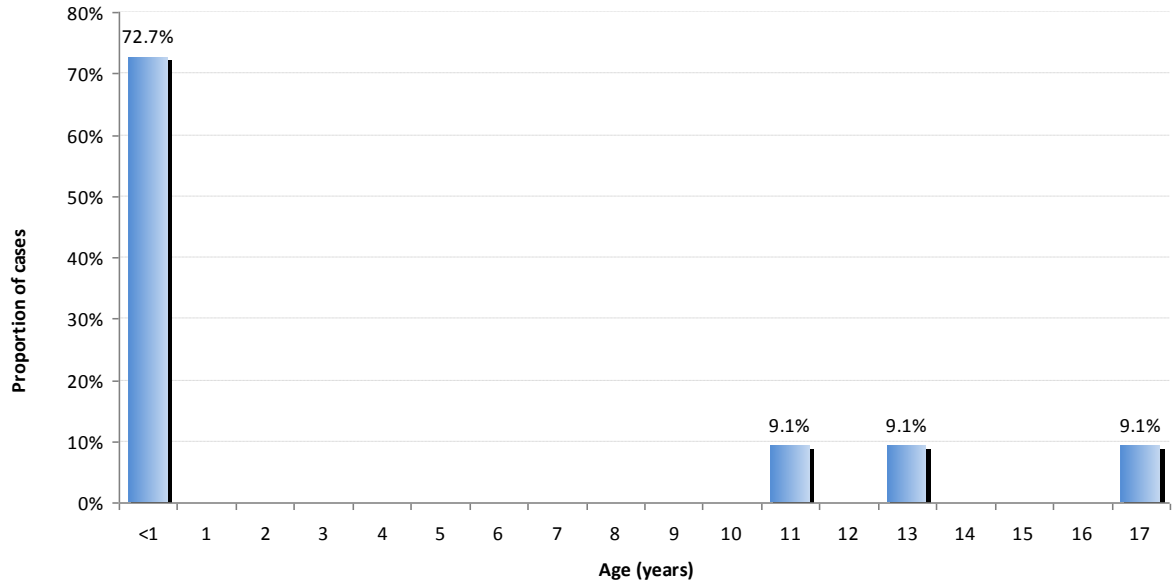
The numbers and percentages of general characteristics for all child death cases are shown in Figures 1 - 4 and Table 3 below.

**Figure 1: Gender profile of all child deaths: Bexley Apr 2013 - Mar 2014 (n=11)**



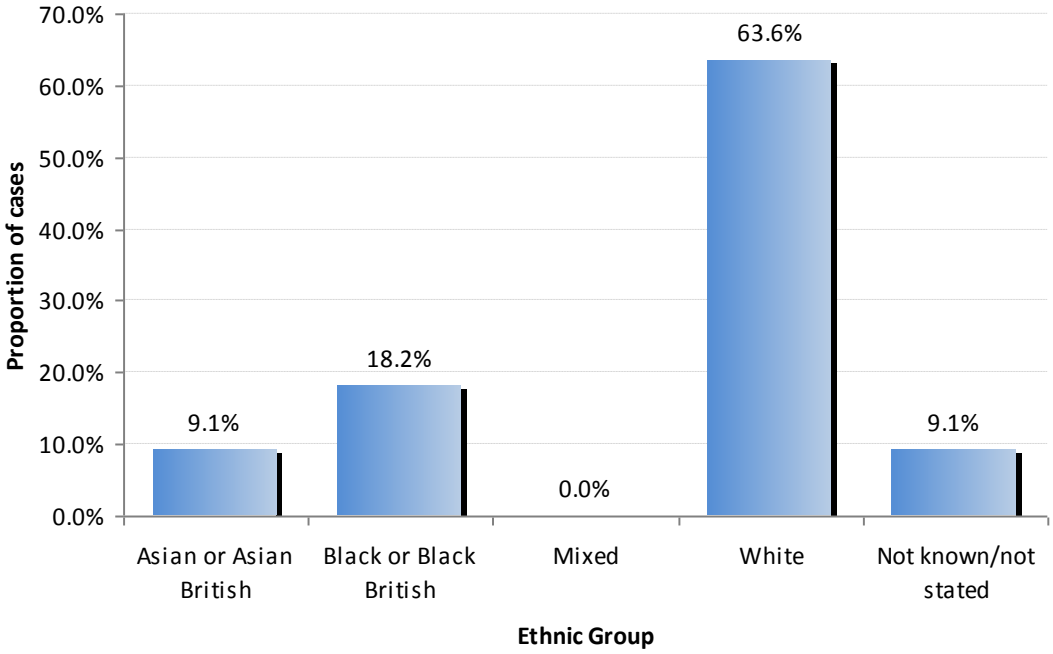

Of the 11 deaths, 7 were male and 4 female.

**Figure 2: Age profile of all deaths Bexley CDOP: Apr 2013 - Mar 2014 (n=11)**




Of the 11 deaths, 8 were of infants aged <1 year, and one each were aged 11, 13 and 17 years.

**Figure 3: Ethnicity of all deaths Bexley CDOP: Apr 2013 - Mar 2014 (n=11)**




Of the 11 deaths, 7 were white, 2 black/black British, 1 asian/asian British, and in one case ethnicity was not known/not stated.

Table 2 below shows categorised causes of death.

**Table 2: Cause of all deaths Bexley CDOP: Apr 2013 - Mar 2014 (N=11)**

| CDOP Category | Name | Cases |
|---|---|---|
| 1 | Deliberately inflicted injury, abuse or neglect | 0 |
| 2 | Suicide or deliberately self-inflicted harm | 0 |
| 3 | Trauma & other external factors | 0 |
| 4 | Malignancy | 2 |
| 5 | Acute medical or surgical condition | 0 |
| 6 | Chronic medical condition | 0 |
| 7 | Chromosomal, genetic & congenital anomalies | 2 |
| 8 | Perinatal/neonatal event | 6 |
| 9 | Infection | 0 |
| 10 | Sudden unexpected, unexplained death | 0 |
| n/a | Reviewed outside of Bexley | 1 |
| **All** | | **11** |

Of the 11 deaths, 55% were due to a perinatal/neonatal event, 18% malignancy, and 18% chromosomal, genetic or congenital anomalies. One death is being reviewed by another CDOP and information is currently incomplete.

Figures 4 and 5 consider the place of child deaths.

**Figure 4: All child deaths: Place of death: Bexley: Apr 2013 - Mar 2014 (n=11)**

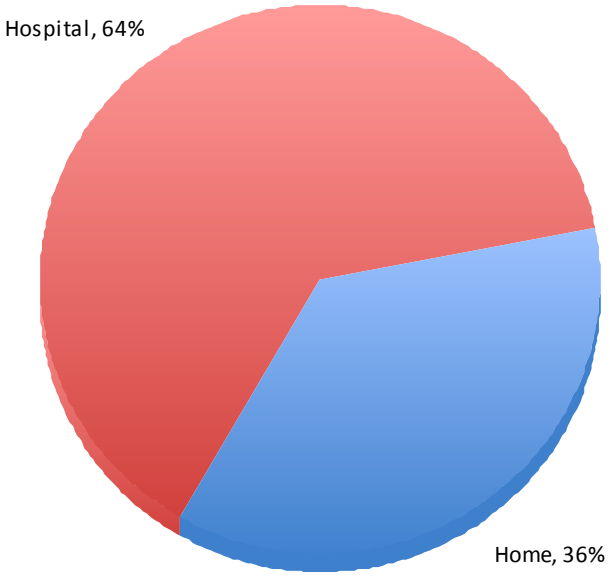
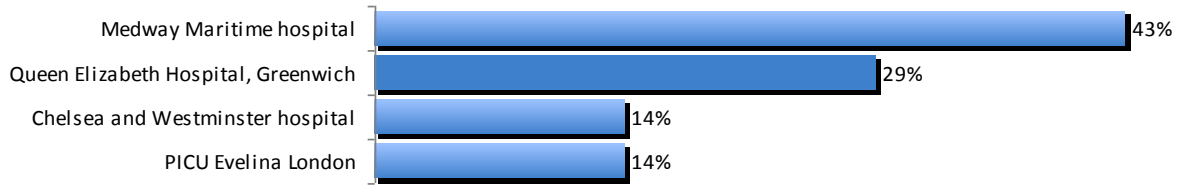


**Figure 5: Hospital deaths: Bexley CDOP: Apr 2013 - Mar 2014 (n=7)**




Of the 11 deaths, 7 occurred in a hospital (3 Medway Maritime, Queen Elizabeth, 1 Chelsea & Westminster, 1 Guys & St Thomas') and 4 at home.

### 2.2 Unexpected child deaths 2013/14

For the purposes of CDOP an unexpected death is defined as:

- The death of an infant or child under 18 years which was not anticipated as a significant possibility 24 hours before the death, or;
- Where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death (Working Together to Safeguard Children 2013).

While learning from all cases of child death is valuable in terms of improvements that could potentially be made to services supporting families in preparation for the death of a child, learning from cases of unexpected child death is valuable in terms of action to prevent similar future deaths.

As per the CDOP's policies and procedures, full reviews are undertaken of all notified deaths classified as unexpected.

However, as shown in Table 1 earlier, just 2 of the 11 deaths notified in this annual period have been classified as unexpected (RY/13/0011 & RY/13/0012). Furthermore, to date, full CDOP consideration has only been completed in one of these cases (RY/13/0011).

Consequently, given the limited information that can be added from a single case, no further analysis is provided here for unexpected cases in 2013/14, but the case is included in the aggregate analysis set-out in Chapter 3 following.

### 2.3 Audit of hospice referrals

EllenorLions Hospices Children & Young Peoples Service (chYps) has been part of the Bexley CDOP since 2011. The service provides a Hospice at Home service for children and young people in Bexley who have a life limiting or life threatening condition. It was recognised by the panel that the cause of death of several infants and children would have made them eligible for chYps support but had not been referred.

The audit reviewed 44 deaths in the period of 21/01/2011 – 27/3/2013. 7 cases were referred to the hospice team. A further 14 expected deaths were identified as being eligible for their services and may have benefited from hospice care and support. As a result of these findings the ChYps have circulated information about the service to all local hospitals and regional centres, in particular, Special Care Baby units; explaining chYps support available locally to offer pre bereavement support for the whole family, 24/7 on call service and support post birth and bereavement as needed.

**2.4 Summary findings 2013/14**

In summary, consideration child deaths notified to Bexley CDOP in 2013/14 shows that:

- Deaths in childhood are relatively uncommon.
- Compared to some earlier years, a low number of child deaths have occurred in this period.
- Similar numbers of males and females died.
- Most deaths occur in newborns and young infants, and older teenagers.
- The most common cause of child deaths continues to be issues related Perinatal/neonatal events.
- A very low number of unexpected deaths occurred in this period (n=2) and considerations are incomplete in one case. Consequently analysis of these cases has not been undertaken.

## CHAPTER 3: JANUARY 2008 – MARCH 2014

### 3.1 Introduction

This chapter reports the aggregate analysis of Bexley child deaths by the CDOP since its formation in 2008. It seeks to maximise insight into the larger complete CDOP cohort of child deaths in Bexley, to complement the year-on-year analyses undertaken for successive annual reports.

### 3.2 All child deaths (2008/9 – 2013/14)

As shown in Table 3 below, a total of 88 child deaths have been notified to Bexley CDOP between its inception (1/1/08) and the end of the most recent annual reporting period (31/3/14).

Of these, 54 (61%) were categorised as expected and 34 (39%) as unexpected.

**Table 3: Annual child deaths: Bexley (2008/9 – 2013/14)**

| Categories | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2008-2014 |
|---|---|---|---|---|---|---|---|
| **All deaths (n)** | **15** | **12** | **11** | **19** | **20** | **11** | **88** |
| Expected (n) | 11 | 8 | 9 | 9 | 8 | 9 | **54** |
| Expected (%) | 73% | 67% | 82% | 47% | 40% | 82% | **61%** |
| Unexpected (n) | 4 | 4 | 2 | 10 | 12 | 2 | **34** |
| Unexpected (%) | 27% | 33% | 18% | 53% | 60% | 18% | **39%** |

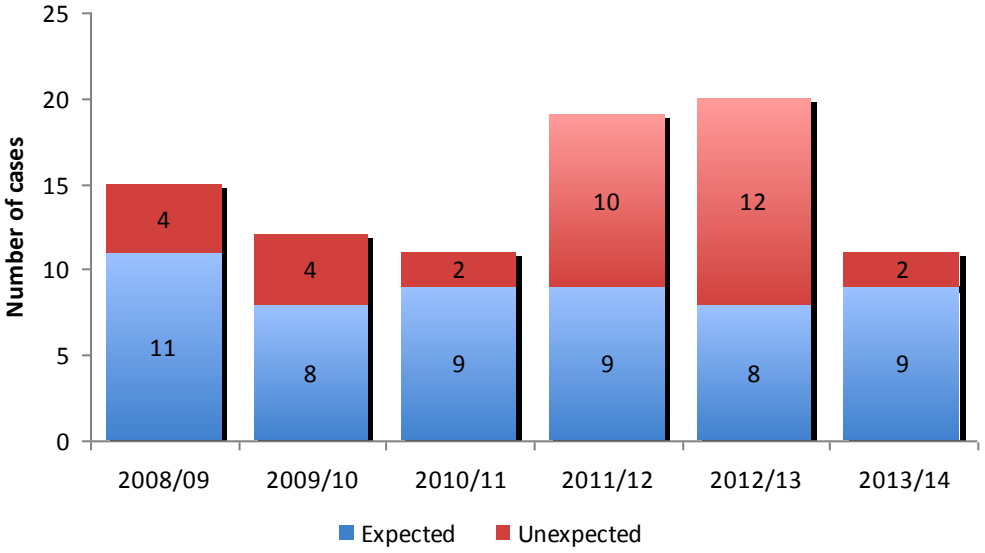
As shown below in Table 3 and Figure 6, the total number of annual deaths has varied between a high of 20 (2012/13) and lowest years (2010/11 & 2013/14).

Similarly the percentages of expected and unexpected deaths have varied annually. The percentage of unexpected deaths ranges between a high of 60% (2013/14) and lows of 18% (2010/11 & 2013/14).

Statistical analysis shows that none of these annual differences are statistically significant, and so are potentially due to expected variation in a small numbers.

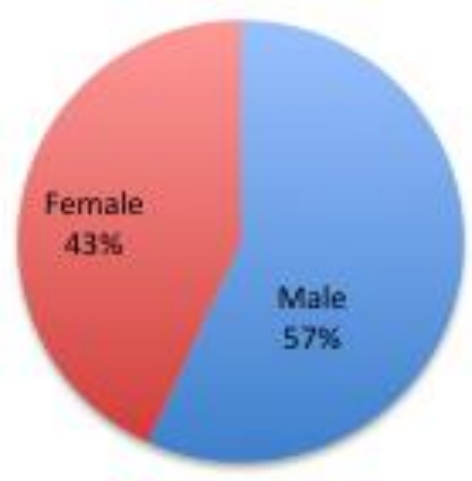
The coincidence between the trends in total deaths and unexpected deaths, suggests that the excess of deaths in years with higher totals is potentially made up of ‘excess’ unexpected cases

**Figure 6: Annual child deaths: Expected & unexpected: Bexley (2008/9 – 2013/14) (n=88)**




As shown in Figures 7 and 8 below, the overall differential and time-trends of child deaths by gender show a generally consistent pattern of greater deaths in males than females, with the exception of 2009/10. In total, there were 50 deaths in males and 38 in females.

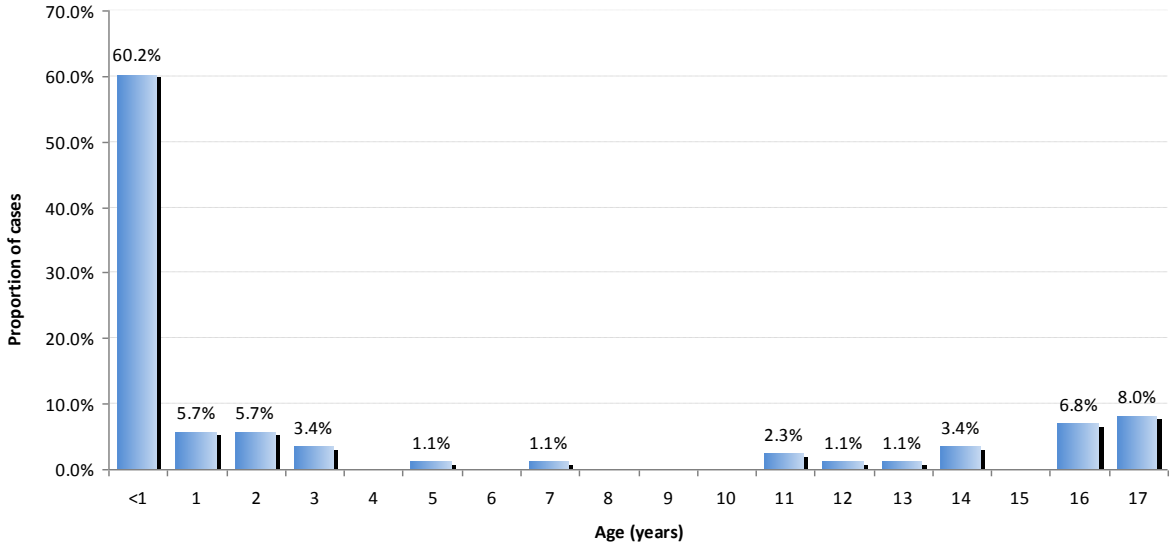
**Figure 7: Total child deaths: Males & females: Bexley (2008/9 – 2013/14) (n=88)**




DfE reported similar percentages of all deaths in males (56%) and females (44%) in their most recent annual analysis (2013/14)[ii].

The age profile of all child deaths is shown in Figure 9. The majority of deaths occur under one year of age (n=53), with a later and smaller peak in the late teens (16 & 17 year olds, n=13).

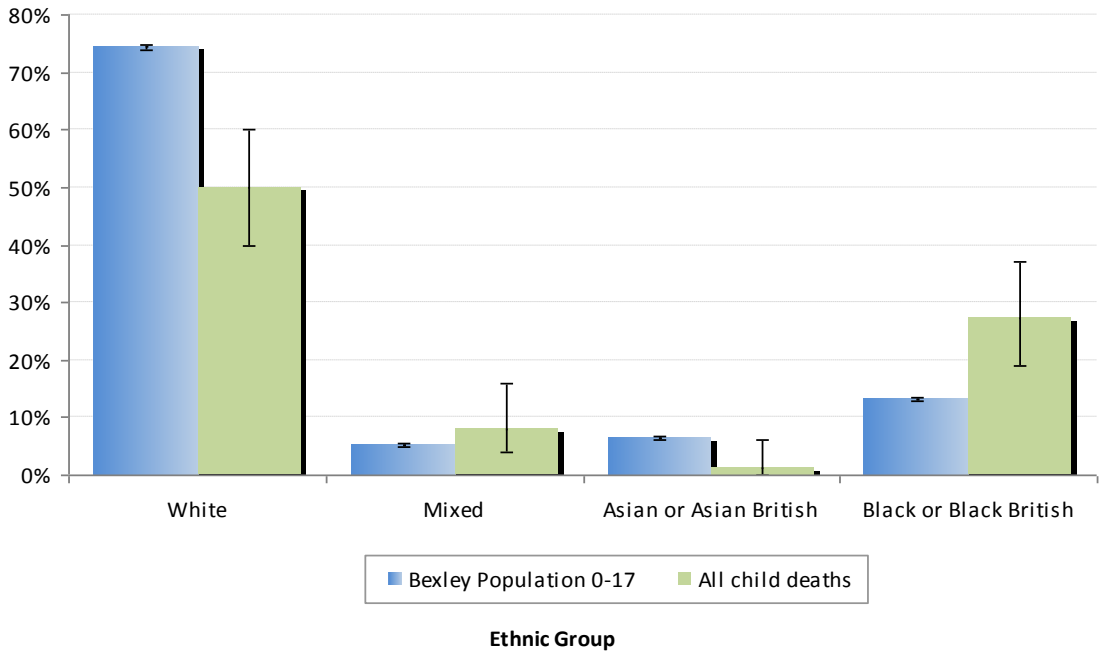
**Figure 8: Total child deaths: Age profile: Bexley (2008/9 – 2013/14) (n=88)**




DfE reported a similar percentage of all deaths occurring in infants aged under 1 year of age (66%) in their most recent annual analysis (2013/14)[ii].

Figure 9 below examines the percentage of all child deaths and Bexley's population aged 0-17 (Census, 2011) by ethnic group.

**Figure 9: % Total child deaths & ethnic group: Bexley (2008/9 – 2013/14) & % population (0-17 years) (n=76)**



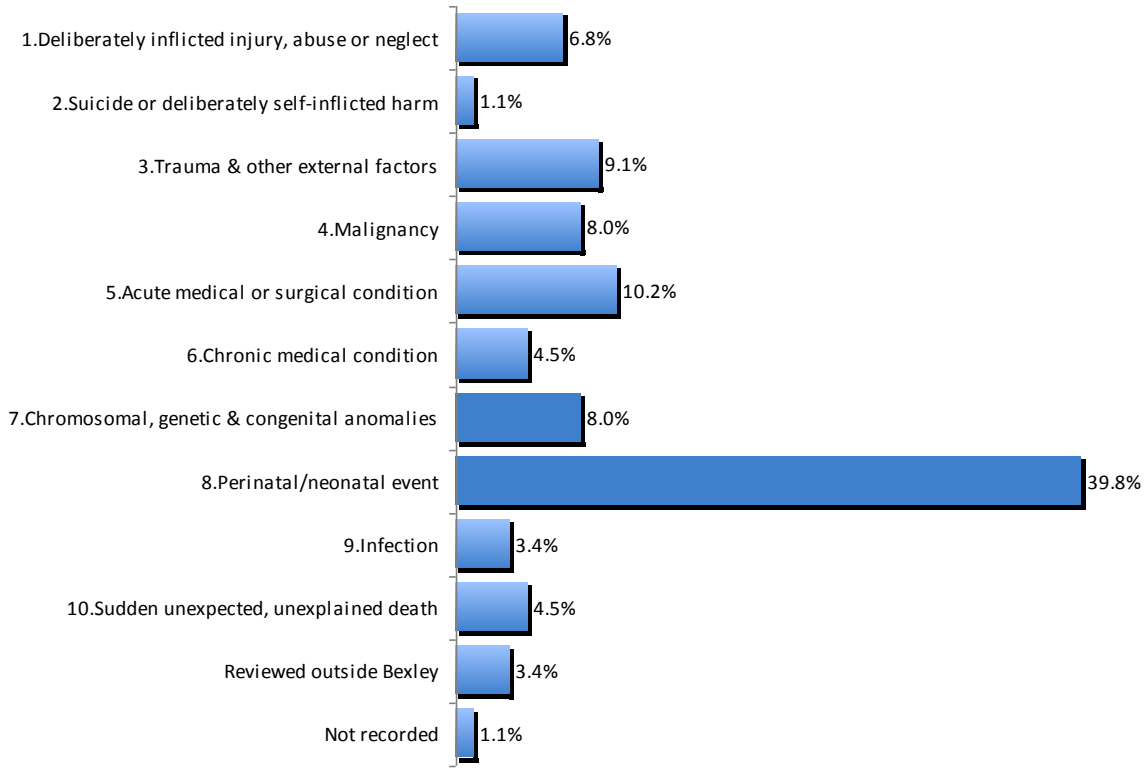
This shows that the percentage of all child deaths that were of white ethnicity (n=44) are statistically lower than the percentage of children aged 0-17 in the Bexley population, and statistically higher in black or black British children (n=24). No ethnicity was recorded for 12 deaths.

Table 4 and Figure 10 below show causes of all deaths.

**Table 4: Total child deaths: Causes: Bexley (2008/9 – 2013/14)**

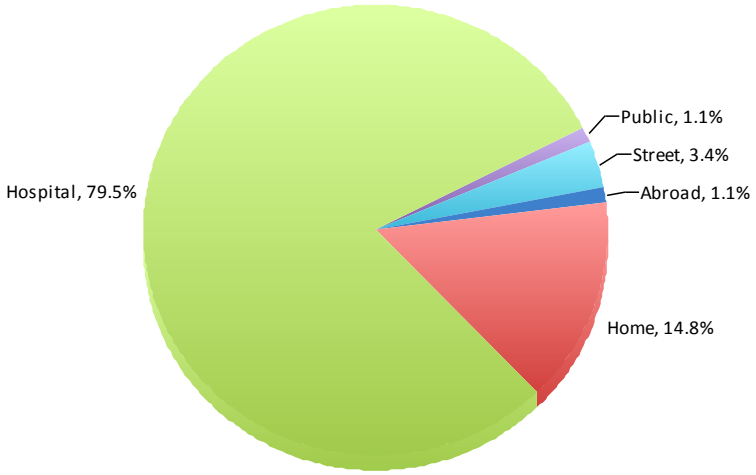
| Category | Cause of death | Cases |
|---|---|---|
| 1 | Deliberately inflicted injury, abuse or neglect | 6 |
| 2 | Suicide or deliberately self-inflicted harm | 1 |
| 3 | Trauma & other external factors | 8 |
| 4 | Malignancy | 7 |
| 5 | Acute medical or surgical condition | 9 |
| 6 | Chronic medical condition | 4 |
| 7 | Chromosomal, genetic & congenital anomalies | 7 |
| 8 | Perinatal/neonatal event | 35 |
| 9 | Infection | 3 |
| 10 | Sudden unexpected, unexplained death | 4 |
| n/a | Reviewed outside of Bexley | 3 |
| n/a | Not recorded | 1 |
| **All** | | **88** |

**Figure 10: Total child deaths: Causes: Bexley (2008/9 – 2013/14) (n=88)**



The most common cause of death category by far is Perinatal/neonatal Event. The other most common, by smaller margins, are Acute medical/surgical conditions; Chromosomal, genetic and congenital anomalies; Malignancy; and Trauma and other external factors. Figure 11 below shows the place in which child deaths occur.

**Figure 11: Total child deaths: Place of death: Bexley (2008/9 – 2013/14) (n=88)**




Of the 88 deaths, 70 occurred in a hospital and 13 at home.

DfE reported that the percentage of all deaths occurring in hospital 68% in 2013/14[ii], compared to 79.5% in Bexley (2008/9 – 2013/14).

As shown in Figure 12 below, the most common location of hospital deaths were Queen Elizabeth (Greenwich), St Mary's (Sidcup), and Medway Maritime.

**Figure 12: Total child deaths in hospital: Bexley (2008/9 – 2013/14) (n=70)**

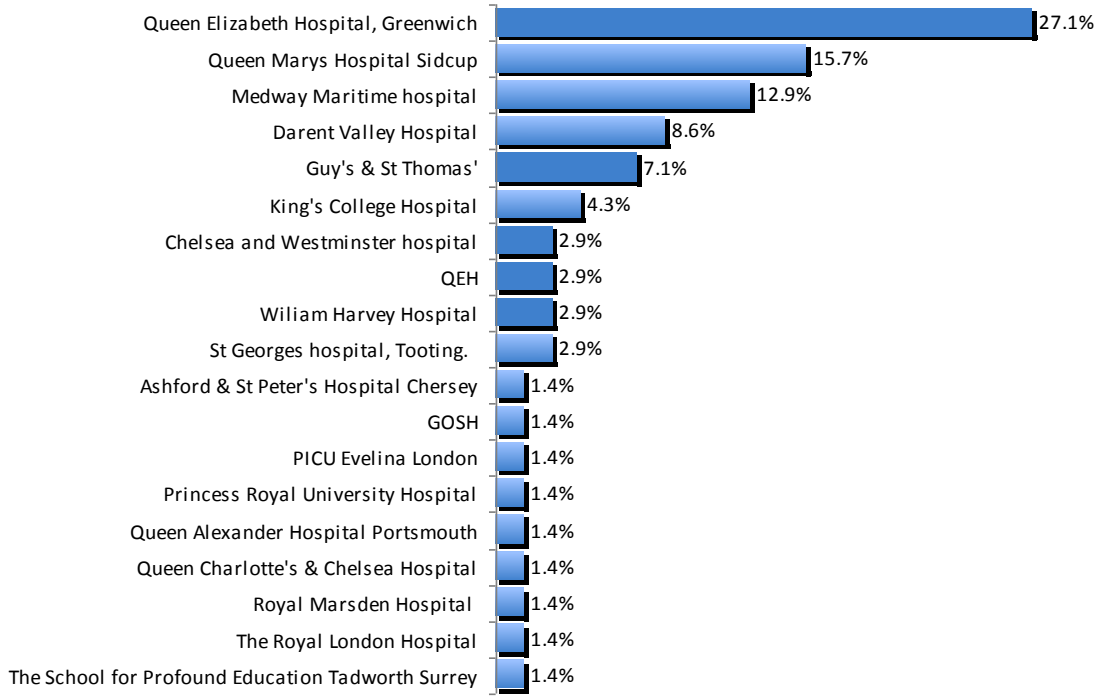
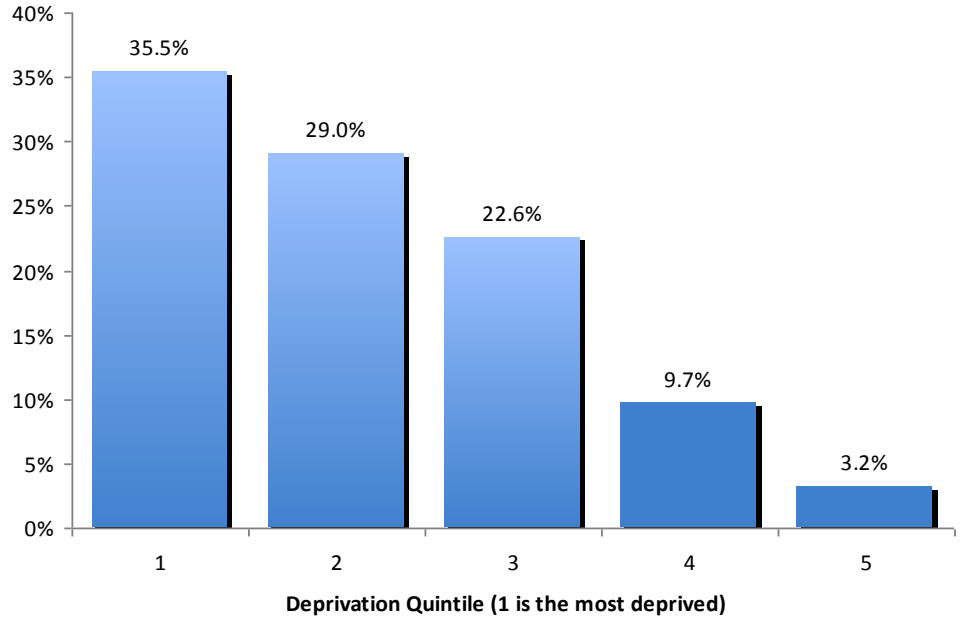



Figure 13 below examines the deprivation quintile of the home address for all child deaths. Recording of this information by CDOP was only added in 2012/13 and consequently the analysis is based on a smaller number of cases (n=31).

**Figure 13: All child deaths: Home address deprivation quintile: Bexley: 2012/3 – 2013/14 (n=31)**




While the differences between individual quintiles are not statistically significant and population death rates have not been calculated, this demonstrates a clear gradient, with a trend of an increasing percentage of deaths with increasing deprivation.

### 3.3 Unexpected child deaths (2008/09 – 2013/14)

The CDOP definition of an unexpected child death was set-out earlier in Section 2.2.

This section of the report seeks to examine the available aggregate information (2008/9 – 2013/14) on unexpected child deaths produced and recorded as part of the Bexley CDOP process in order to:

- Identify patterns of unexpected child deaths;
- Outline any associated resulting learning;
- Where appropriate draw conclusions and make recommendations for action.

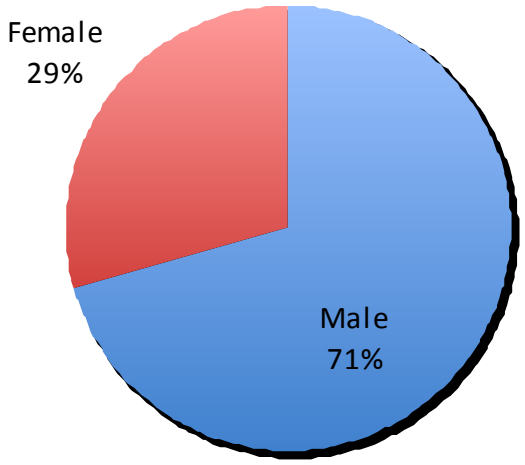
Characteristics of deaths

As shown in Table 3 earlier, 34 (39%) of the total 88 child deaths notified to the CDOP in the period 2008/9 – 2013/14 were classified as unexpected.

As described in Section 1.2 earlier, more information is gathered on these cases and they are fully considered at a CDOP meeting. Consequently, a more detailed analysis of these 34 cases is provided in the following sections.

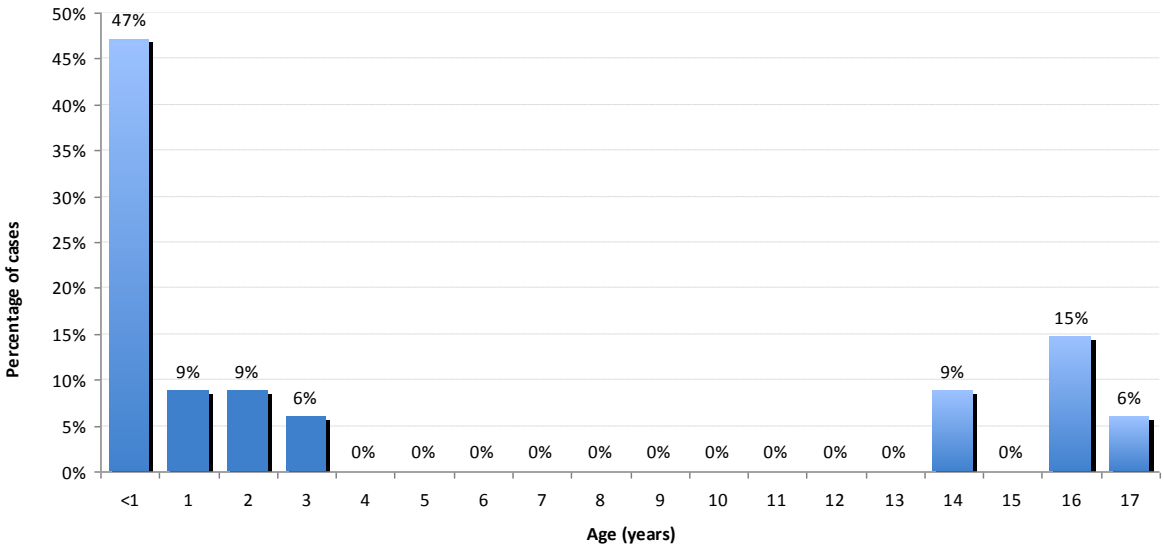
Figure 14 below, shows that more unexpected deaths were in males (n=24) than females (n=10).

**Figure 14: Unexpected child deaths: Males & females: Bexley (2008/9 – 2013/14) (n=34)**




The age profile of all child deaths is shown in Figure 15 below.

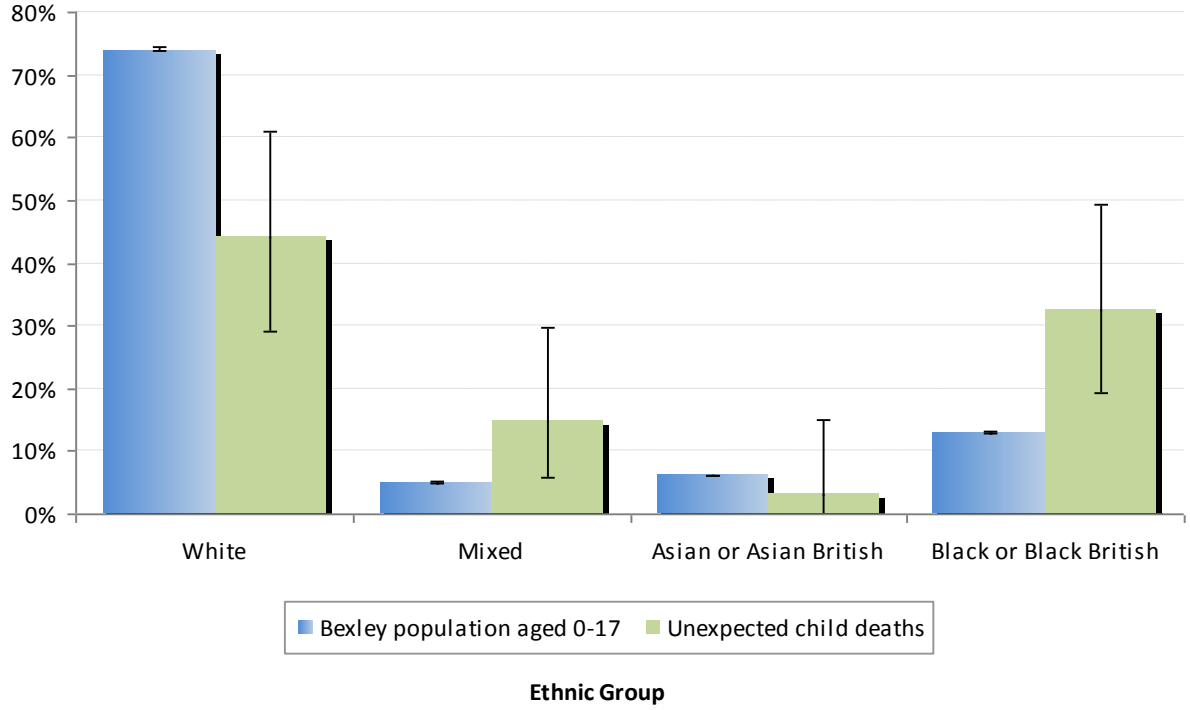
**Figure 15: Unexpected child deaths: Age profile: Bexley (2008/9 – 2013/14) (n=34)**




The majority of deaths occur under one year of age (n=16), with a later and smaller peak in the late teens (16 & 17 year olds, n=5).

Figure 16 below examines the percentage of unexpected child deaths and Bexley's population aged 0-17 (Census, 2011) by ethnic group.

**Figure 16: Unexpected child deaths: Ethnicity: Bexley (2008/9 – 2013/14) (n=32)**



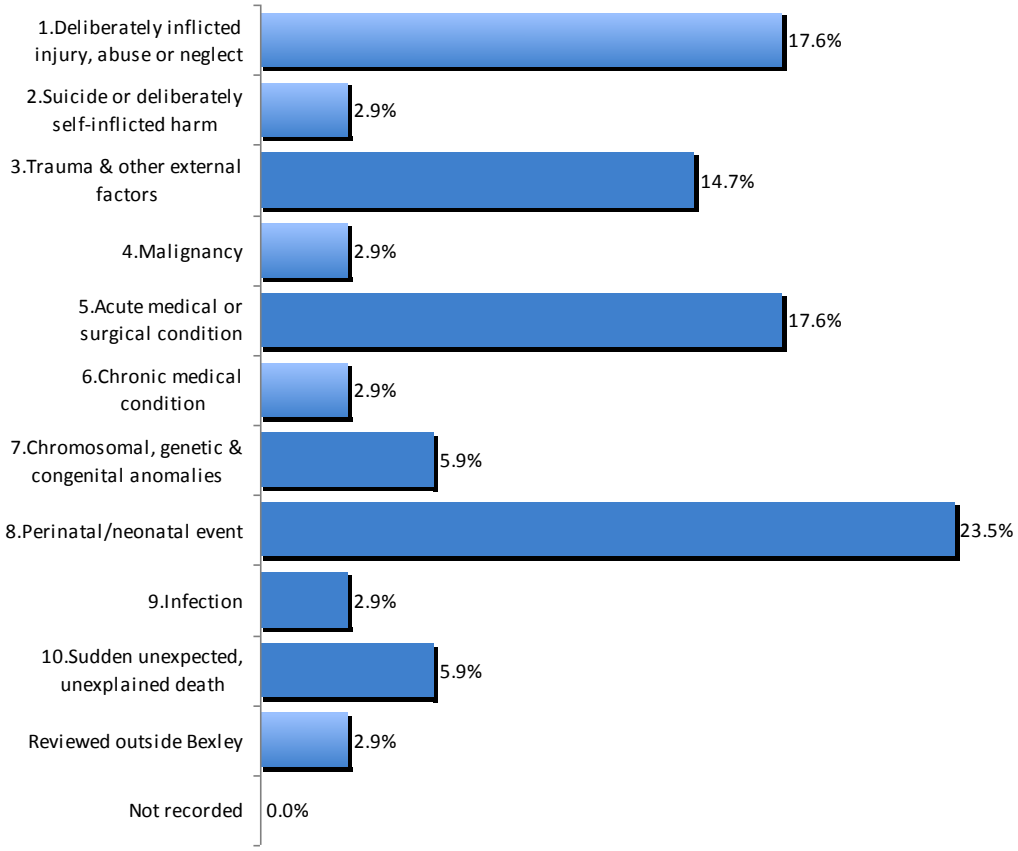

As in the earlier consideration of ethnicity in all child deaths in Figure 9, this shows that the percentage of unexpected child deaths that were of white ethnicity (n=15) are statistically lower than the percentage of children aged 0-17 in the Bexley population, and statistically higher in black or black British children (n=11). No ethnicity was recorded for 2 unexpected deaths.

Table 5 and Figure 17 below show causes of all deaths.

**Table 5: Unexpected child deaths: Causes: Bexley (2008/9 – 2013/14)**

| CDOP Category | No. Cases |
|---|---|
| 1. Deliberately inflicted injury, abuse or neglect | 6 |
| 2. Suicide or deliberately self-inflicted harm | 1 |
| 3. Trauma & other external factors | 5 |
| 4. Malignancy | 1 |
| 5. Acute medical or surgical condition | 6 |
| 6. Chronic medical condition | 1 |
| 7. Chromosomal, genetic or congenital anomalies | 2 |
| 8. Perinatal/neonatal event | 8 |
| 9. Infection | 1 |
| 10. Sudden unexpected, unexplained death | 2 |
| Reviewed outside of Bexley | 1 |
| **All known** | **34** |

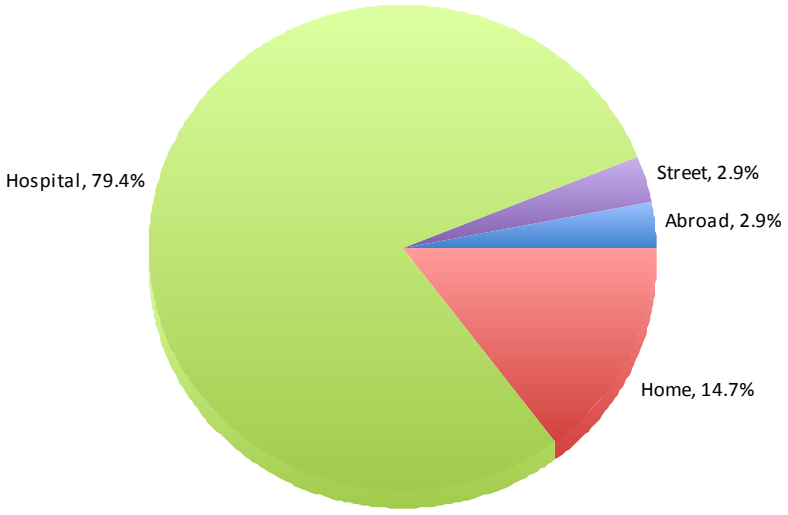
**Figure 17: Unexpected child deaths: Causes: Bexley (2008/9 – 2013/14) (n=34)**




As in the analysis of all deaths earlier, the most common cause of death category remains Perinatal/neonatal event (n=8). However, the second most common categories are Acute medical or surgical condition (n=6) and Deliberately inflicted injury, abuse or neglect (n=6).

Figure 18 below shows the place in which child deaths occur.

**Figure 18: Unexpected child deaths: Place of death: Bexley (2008/9 – 2013/14) (n=34)**



Of the 34 unexpected deaths, 27 occurred in a hospital and 5 at home.

As shown in Figure 19 below, of unexpected deaths in hospital, the largest majority of occurred at Queen Elizabeth (Greenwich).

**Figure 19: Unexpected child deaths: Place of death: Bexley (2008/9 – 2013/14) (n=27)**

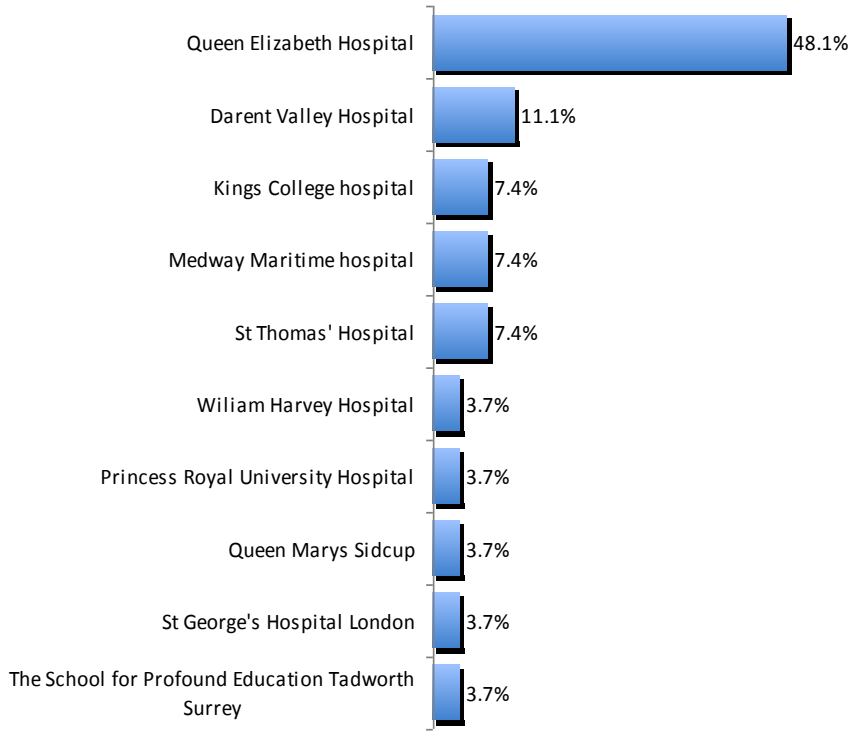
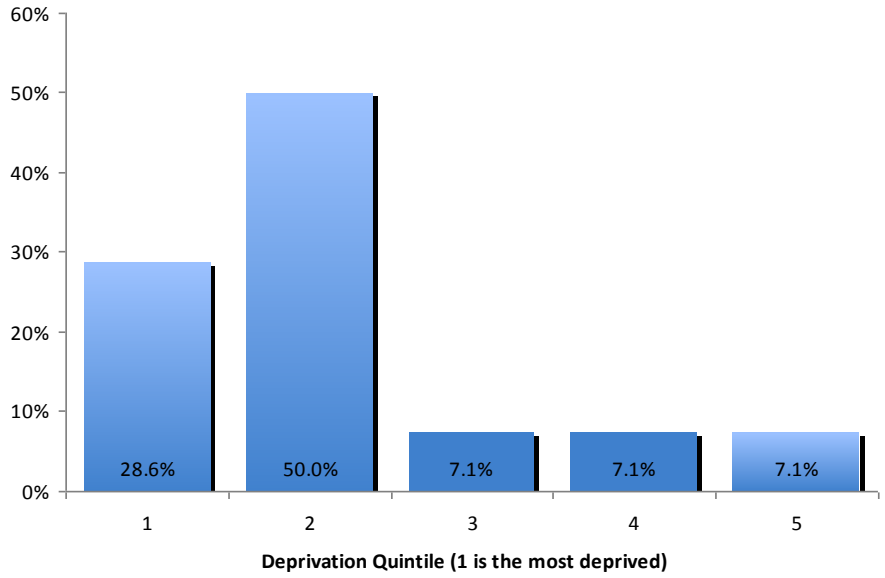



Figure 20 below examines the deprivation quintile of the home address for unexpected child deaths. Recording of this information by CDOP was only added in 2012/13 and consequently the analysis is based on a smaller number of cases (n=14).

**Figure 20: Unexpected child deaths: Home address deprivation quintile: Bexley: 2012/3 – 2013/14 (n=14)**



As in the case of patterns of all deaths across Bexley's deprivation quintiles shown earlier in Figure 13, whilst the differences between individual quintiles shown above are not statistically significant and population death rates have not been calculated, it appears that unexpected child deaths are more common in the two most deprived population quintiles.

Analysis of contributing factors & modifiability

As outlined earlier in Section 1.2, full consideration of unexpected cases at a CDOP meeting contributes conclusions on issues including: domains of factors contributing to an unexpected death, and preventable/modifiable factors. Analysis of these is summarised below.

Table 6 below, sets-out the CDOP's scores for the following four domains of contributing factors associated with unexpected deaths:

- Child's needs
- Family & environment
- Parenting capacity
- Service provision

**Table 6: Unexpected child deaths: Contributing factors: Bexley (2008/9 – 2013/14)**

| Score | Contributing Domain | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Child's Needs | | Family & environment | | Parenting capacity | | Service provision | |
| | n | % | N | % | n | % | n | % |
| 0: Information not available | 0 | 0.0% | 2 | 5.9% | 2 | 5.9% | 1 | 2.9% |
| 1: No factors identified or factors unlikely to have contributed to the death | 2 | 5.9% | 14 | 41.2% | 14 | 41.2% | 13 | 38.2% |
| 2: Factors identified that may have contributed to vulnerability, ill-health or death | 9 | 26.5% | 5 | 14.7% | 5 | 14.7% | 7 | 20.6% |
| 3: Factors identified that provide a complete and sufficient explanation for the death | 12 | 35.3% | 0 | 0.0% | 1 | 2.9% | 1 | 2.9% |
| No information recorded | 11 | 32.4% | 13 | 38.2% | 12 | 35.3% | 12 | 35.3% |
| TOTAL | 34 | | 34 | | 34 | | 34 | |

The findings in relation to contributing factors can be summarised as follows:

- Child's needs where the factor most likely to provide a complete & sufficient explanation (35% n=12), or that may have contributed to unexpected deaths (27% n=9).
- All three other factors were most likely to have not contributed or were unlikely to have contributed to deaths (family & environment [41% n=14], parenting capacity [41% n=14], service provision [38% n=13]).
- Service provision may have contributed in 20% (n=7) of cases, and provided a full and complete explanation in one case.
- Parenting capacity may have contributor in 15% (n=5) of cases, and provided a full and complete explanation in one case.

Based on DfE processes, the CDOP categorised unexpected deaths in terms of their preventability over the period 2008 – 2010/11, and in terms of modifiability 2011/12 – 2013/14. Consequently in this analysis all categorisations were transformed into the most recent categories.

Table 7, below, presents CDOP findings on the extent to which unexpected deaths where preventable/modifiable factors were identified.

**Table 7: Unexpected child deaths: Modifiable factors: Bexley (2008/9 – 2013/14)**

| Decision | No. Cases | % |
|---|---|---|
| Modifiable | 12 | 35% |
| Not modifiable | 13 | 38% |
| Missing data | 8 | 24% |
| TBC | 1 | 3% |
| **All known** | **34** | 100% |

Given a substantial number of cases with missing data, this shows that modifiable factors are were identified in at least 12 cases (35%).

DfE reported that the percentage of all deaths with modifiable factors was 22% in 2013/14[ii], compared to the equivalent percentage of 14% in Bexley (2008/9 – 2013/14).

### 3.4 Bexley, Bromley and Greenwich Joint Neonatal meeting

Perinatal and neonatal deaths are challenging to review and fully informed judgements are difficult without the appropriate expertise (e.g. neonatologists, midwifery, obstetricians). Therefore, since 2011, Greenwich, Bexley and Bromley CDOP's hosted an annual meeting with the single acute trust to review selected neonatal deaths from the three boroughs.

South London Healthcare NHS Trust was dissolved in October 2013 The hospitals which made up theTrust are now run by different NHS Trusts. As most of Bexley's deaths in this category occur at Queen Elizabeth hospital, the panel will explore the possibility of linking with Greenwich CDOP to make a similar arrangement with the hospital.

### 3.5 Conclusions

The initial rapid response process to child death referrals continues to highlight the importance of having timely meetings and on-going consultation between the key professionals involved in the investigations and those professionals who are in contact with the bereaved family.

The annual numbers of child deaths notified to Bexley CDOP have varied noticeably over the period 2008/9 – 2013/14, between 11 and 20 cases. In the most recent annual period (April 2013 – March 2014) only 11 child deaths occurred.

The number of annual deaths categorised as unexpected varies more markedly, between 2 and 12 cases. In years with higher numbers of total child deaths, the 'excess' appears to be made-up of unexpected deaths, in addition to a more stable number of expected deaths each year. Only 2 unexpected deaths occurred in the most recent annual period.

The numbers of annual child deaths in a single Borough like Bexley are low. Consequently it is difficult to undertake powerful analysis of potential common characteristics, causes or trends. The aggregation of data on child deaths over the period 2008/9 – 2013/14 has enabled analysis of a larger cohort of cases (total deaths n=88 & unexpected deaths n=34).

While year-on-year variation remains substantial, hampering the meaningful identification of time-trends, the larger number of cases allows more confidence to be gained in the overall picture of Bexley child deaths considered by the CDOP.

Annual variation in the total number of deaths appears explained by chance 'excesses' of unexpected deaths in association with a stable number of expected deaths.

Statistical analysis of deaths among sub-groups (e.g. age, gender, cause) did not reveal statistically significant differences, except in the case of ethnicity. Here comparison of the percentages of deaths made-up by different ethnic groups, in both total and unexpected deaths, suggests a potential excess of deaths in black/black British children.

Also, though not found to be statistically significant, analysis of the proportions of total and unexpected deaths by deprivation groups, showed a clear gradient and threshold, with proportionately more deaths in the more deprived.

The continued absence of systematic regional or national epidemiological analysis prevents powerful benchmarking and consideration of the number of expected and observed levels of deaths in Bexley.

In light of this and given the main purpose of the CDOP process is not benchmarking the numbers of deaths between areas, it is important that Bexley Public Health staff consider overall rates of death in infants, children and young adults using routine standardised PHE data sources to complement CDOP analyses of individual cases.

As in earlier reports it remains reassuring reviews suggest that few cases of unexpected child deaths are directly contributed to service failings. However, modifiable factors of some form were identified in 35% of unexpected deaths, and local serious case reviews have identified learning for Bexley services. The learning, recommendations and action plans are managed and monitored by the Serious Incidents Sub Group (formally Standing Serious Case Review Panel) and therefore review is not duplicated by CDOP. The details are not transferred onto the CDOP database in full so annual analysis will not consistently include these, and as a consequence could underestimate some findings.

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## References

[i] DfE. Statistical Release: Child Death Reviews 2012/13 (2013)
[ii] DfE. Statistical Release: Child Death Reviews 2013/14 (2014)
[iii] Healthcare Quality Improvement Partnership (HQIP). ITT NCA134: CDOP Information System & Development Project (Lot 2) (April 2014)
[iv] Russell Vinner/NHS England. Child Death Reviews in London 2012 (2014)
[v] PHE. Bexley Child Health Profile. 2014