Bexley Child Death Overview Panel (CDOP)

Annual Report 2014/15

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 2014 - March 2015).

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)

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

Definitions and categories of child death

Neonatal Death
The death of a child under 28 days of age, including premature births but excluding stillbirths.

Sudden Unexpected Death in Infancy (SUDI)
The sudden death of an infant under one year that is unexpected by medical history and remains unexplained after a thorough post mortem examination and a detailed death scene investigation [(then referred to as Sudden Infant Death Syndrome (SIDS)].

Expected Deaths
An expected death is that which was anticipated 24 hours before the death.

Unexpected Deaths
The death of an infant or child (less than 18 years old) 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.[1]

Modifiable death
A modifiable death is defined as where there are factors which may have contributed to the death. These factors are identified as those which by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

The panel is not responsible for reviewing stillbirths or planned terminations of pregnancy carried out within the law. However practice within maternity units around babies who show brief signs of

[1] Department for Education (2015). Working together to Safeguard Children https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf

life have varied, with some units labelling this as neonatal death and others a stillbirth. WTSC guidance states that if a baby shows any sign of life at all they should be considered a child death and not a stillbirth. This is likely to affect the number of neonatal deaths reported.

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, NHS 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, LB Bexley

Panel Meetings
During 2014/2015, CDOP met four times. The panel is chaired by the designated nurse for safeguarding Children and has members from relevant agencies.

The CDOP has a fixed core membership of experts drawn from the key organisations represented on Bexley Safeguarding Children Board who should be present at each meeting. Other members can be co-opted to contribute to the discussion of certain types of death when they occur.

The child death process is supported by the Single Point of Contact. She also acts as administrator. 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. The Designated Doctor for Child Deaths is a Consultant CommunityPaediatrician at Oxleas NHS Trust. The doctor is responsible for deciding if a Rapid Response is required.

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

Timeliness and outcomes of cases discussed at CDOP in 2014/15
Reviewing child deaths is a complex and it can take a number of months to gather all the relevant information to be able to fully review the death, this will be affected by

- slow returns of Form Bs (data collection forms)
- time taken for the post mortem or coroner's autopsy reports to be released
- awaiting the findings of criminal proceedings or Serious Case Reviews
- the panel requested further information

During the year 2014/15, 19 child deaths were discussed at the panel meetings and all but 4 of these were completed. Of the 19 cases discussed, 2 were from 2012, 3 from 2013, 7 from 2014 and 5 from 2015.

Cases that take a long time to complete at CDOP are generally more complex. The cases completed this year from 2012 include one serious case review and one child death overseas. Both of these cases are now completed and issues identified and recommendations are included later in this document.

The cases from 2013 completed this year were all unexpected, all had modifiable factors and all 3 identified issues in service provision. This requires the CDOP to wait for serious incident analyses to be completed in the relevant organisations before discussion at CDOP can be completed.

6 cases from 2014 were discussed and 5 completed. The outstanding case is awaiting a Serious Incident report from a hospital. 5 cases from 2015 have been discussed and 3 cases completed at CDOP. All the completed cases were expected deaths.

National Picture

According to the Department of Education[2], whilst the number of deaths of children registered in England has continued to decline, there are just over 4000 child deaths a year; the main causes of death continue to be neonatal or perinatal events and chromosomal, genetic and congenital anomalies. This reflects the fact that nearly two-thirds of deaths were to children who were under the age of one year.

Local Picture

All child deaths 2014/15
Table 1 below shows the numbers and percentages of cases (expected, unexpected, & all).

Table 1. **Summary of child deaths in Bexley, April 2008 to March 2015**

	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Total	**13**	**12**	**11**	**18**	**21**	**11**	**11**
Female:male	**4:9**	**8:4**	**5:6**	**8:10**	**8:13**	**4:7**	**7:4**
Rapid Response							**1**
Age	**Number**	**Number**	**Number**	**Number**	**Number**	**Number**	**Number**
< 1 month	2	3	3	9	7	6	6
> 1 month to < 1 year	3	6	2	5	3	3	2
1-4 years	2	2	3	1	5	0	1
5-9 years	1	0	1	0	1	0	1
10-14 years	1	0	0	2	2	3	0
15-18 years	4	1	2	1	3	0	1
Total (unexpected)	**13 (4)**	**12 (4)**	**11 (2)**	**18 (10)**	**21 (12)**	**11 (2)**	**11 (3)**
CDOP sign-off							**7***

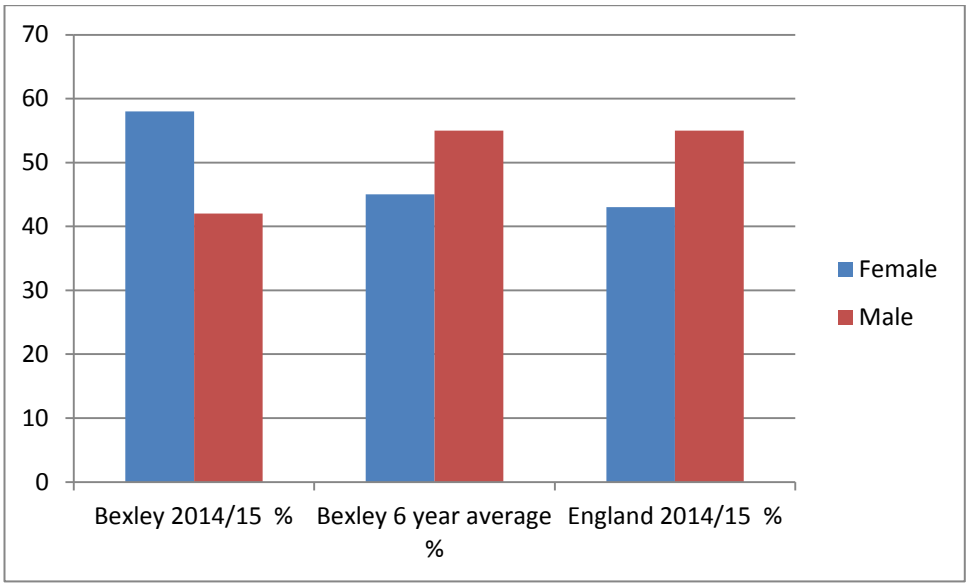
*7 of the 11 deaths in 2014/15 completed at CDOP by time of this report

[2] Department of Education (2013) Child Death Reviews: Year Ending 31 March 2014. https://www.gov.uk/government/statistics/child-death-reviews-year-ending-march-2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223697/SFR26_2013_Text_v2.pdf accessed 03.08.15

Table 2: Gender profile of all child deaths: Bexley Apr 2014 - Mar 2015 (n=11)

Gender	Number 2014/15	Bexley 2014/15 %	Bexley 6 year average %	England 2014/15 %
Female	7	64	45	43
Male	4	36	55	55

Figure 1: Gender profile of all child deaths: Bexley Apr 2014 - Mar 2015 (n=11)



Although the numbers show variation from year to year, overall the proportion of male and female deaths in Bexley reflects the national picture.

Table 3: Age profile of all deaths Bexley CDOP: Apr 2014 - Mar 2015 (n=11)

		Bexley 2014/15 %	Bexley 6 year average %	England 2014/15 %
<1 mth	6	50	37	42
1-12 mth	2	17	24	22
1-4 yr	1	8	14	13
5-9 yr	1	8	5	7
10-14 yr	0	0	8	7
15-17 yr	1	8	12	9

Here the picture in Bexley does show some differences to the data for England 2014/15 although these differences are small and not statistically significant. Comparing 6 years of Bexley data to the England data does show slightly higher mortality rates in teenagers aged 15-17 years and lower mortality in babies under the age of 1 month (which may reflect good maternity care locally).

Figure 2: Age profile of all deaths Bexley CDOP: Apr 2014 - Mar 2015 (n=11)

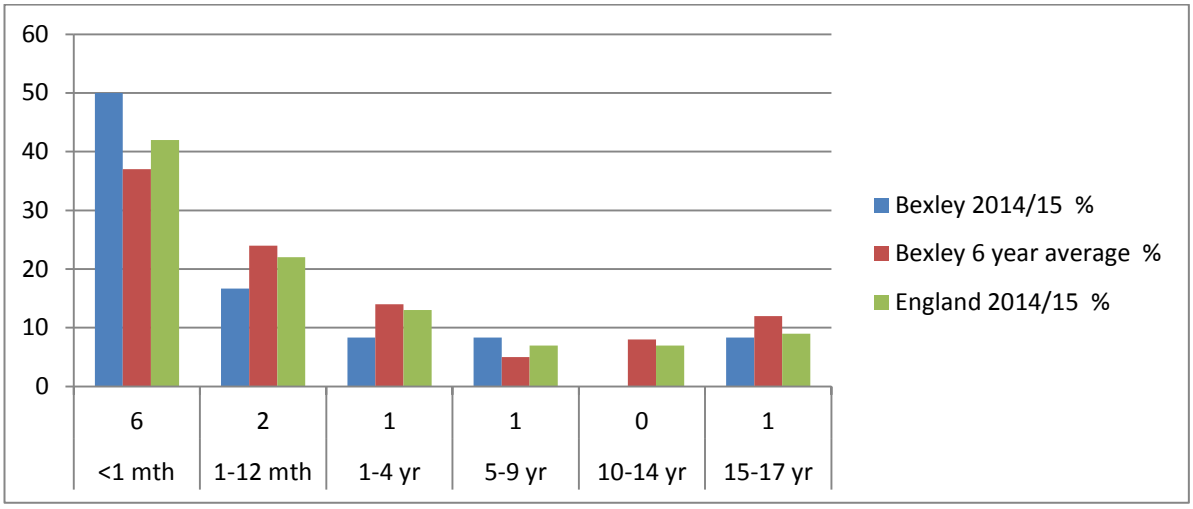


Table 4: Ethnicity of all deaths Bexley CDOP: Apr 2014 - Mar 2015 (n=11)

	Bexley 2014/15 number	Bexley 2014/15 %	Bexley 6 year average %	Bexley population 2011 census	All child deaths England 2014/15 %
White British	2	18	40	77	60
White other	0	0	2	5	
Black African	0	0	20	9	7
Black Caribbean	0	0	5		
Asian	1	9	2	7	16
Mixed	1	9	8	2	5
Not recorded	7	64	22	1	2

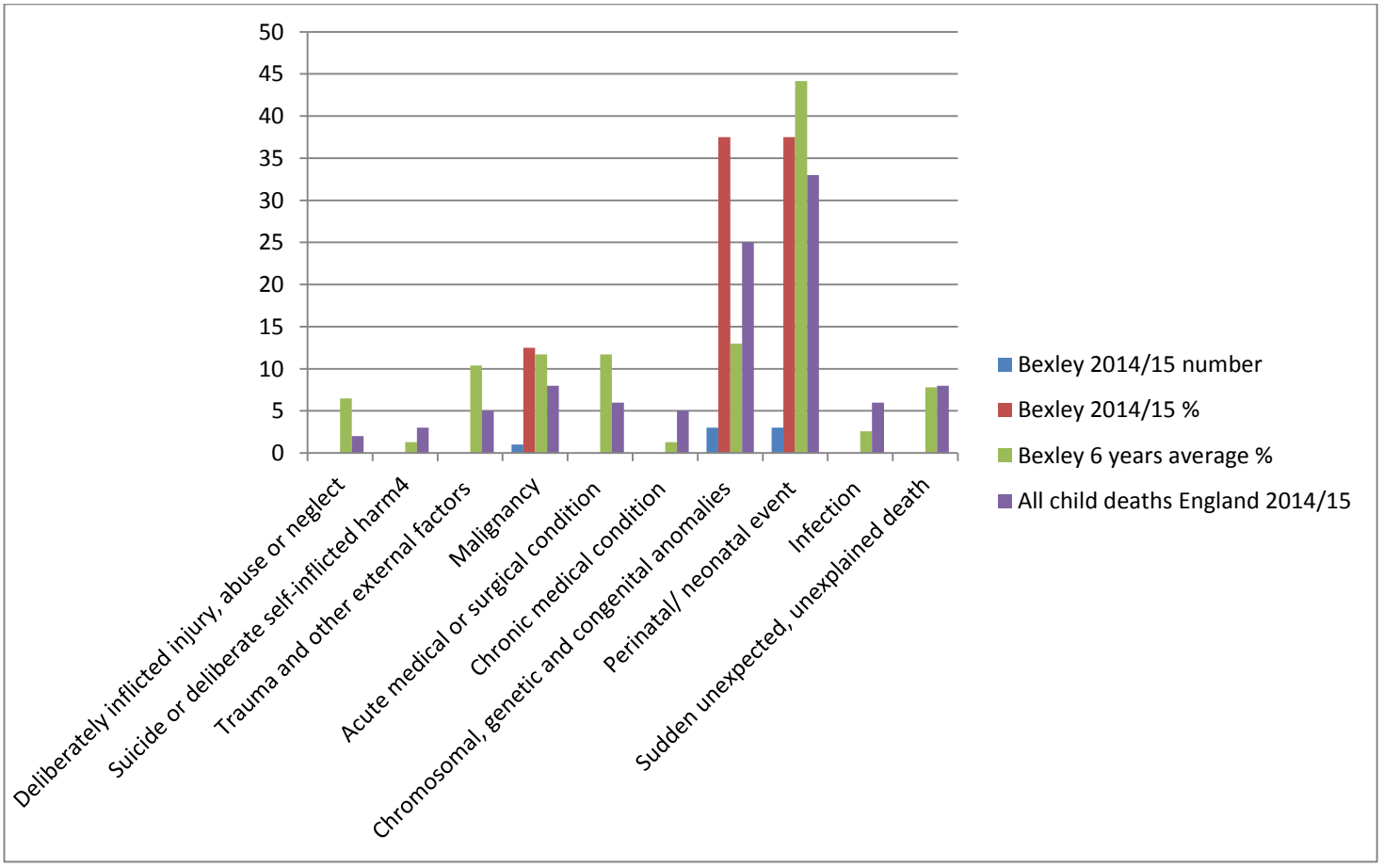
Although these numbers are small and the data is incomplete, it does indicate a higher mortality rate in black children than would be expected from national child death data. Comparing the proportion of the Bexley population recorded as black in the 2011 census does not indicate that this reflects the local population. Table 5 shows categorised causes of death.

- **Table 5: Cause of death in completed reviews, Bexley CDOP: Apr 2014 - Mar 2015 (N=11)**

Category of death	Bexley 2014/15 number	Bexley 2014/15 %	Bexley 6 years average %	All child deaths England 2014/15
Deliberately inflicted injury, abuse or neglect	0	0	6	2
Suicide or deliberate self-inflicted harm4	0	0	1	3
Trauma and other external factors	0	0	10	5
Malignancy	1	13	12	8
Acute medical or surgical condition	0	0	12	6
Chronic medical condition	0	0	1	5
Chromosomal, genetic and congenital anomalies	3	38	13	25
Perinatal/ neonatal event	3	38	44	33
Infection	0	0	3	6
Sudden unexpected, unexplained death	0	0	8	8

*7 of 11 cases completed at CDOP by time of this report

Figure 3: **Cause of all deaths Bexley CDOP: Apr 2014 - Mar 2015 (N=11)**



The numbers are involved are small but there differences between the Bexley data and the national data, even when the average rates for 6 years of Bexley data is compared to national rates. Firstly, the relatively high Perinatal/neonatal event and relatively low congenital anomalies rate probably represent a substitution. Sometimes a neonatal death is classified as perinatal/ neonatal but in fact there is a congenital condition underlying the neonatal death.

Of more concern is the relatively high rate of deliberately inflicted injury, abuse or neglect (although these numbers are very small) and the deaths from acute medical or surgical condition. This latter discrepancy is supported by the number of serious incident reports generated by local hospitals in the last couple of years.

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 2015).

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.

In this review period 3 deaths were classified as unexpected. These investigations are incomplete and the case reviews will be carried forward.

Rapid Response

The arrangements for a rapid response to the death of a child and review are well established in Bexley.

There were 2 deaths between 1st April 2014 and 31st March 2015 for which a rapid response meeting was held.

Bereavement services for families

QEH and DVH have a bereavement midwife who supports families whose babies die whilst receiving care in the neonatal unit. Bereavement support is also provided by the hospice team health visitors and GP's.

A CDOP leaflet is given to parents at the earliest appropriate opportunity after the child's death. It provides contact details about additional sources of support and advice.

Recommendations to the BSCB and specific agencies following the CDOP reviews in 2014/15

No specific recommendations were made for the BSCB in relation to the reviews during this period. As in earlier reports modifiable factors of some form were identified in some of unexpected deaths, and a local serious case review has identified learning for Bexley services. The learning, recommendations and action plans are managed and monitored by the Serious Incidents Sub Group and therefore review is not duplicated by CDOP.
The following were actioned in relation to others:

- The Panel contacted the National Screening Centre to recommend screening for carnitine deficiency is added to national screening programme
- The Panel has ensured genetic screening has been offered to 2 families
- Information has been circulated to schools, BVSC and youth groups in relation issues for them to consider when undertaking risk assessments when planning school trips.
- The Panel received assurance from an acute trust in relation to improvements in supervision/escalation arrangements for junior medical staff

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 – 2014/15, between 11 and 20 cases. In the most recent annual period (April 2014 – March 2015) only 11 child deaths occurred.

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 undertaken last year enabled analysis of a larger cohort of cases. The Chair will explore options with the Chairs of Bromley and Greenwich CDOP to look at how we can jointly review cases to promote more useful learning.

Perinatal and neonatal deaths are challenging to review and fully informed judgements are difficult without the appropriate expertise (e.g. neonatologists,obstetricians). In previous years Greenwich, Bexley and Bromley CDOP's have hosted meetings with the an acute trust to review selected neonatal deaths from the three boroughs. This will be reinstated during 2016 with at least one of our main maternity providers.

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.

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 consider overall rates of death in infants, children and young adults using routine standardised PHE data sources to complement CDOP analyses of individual cases.

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[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