Bexley Child Death Overview Panel (CDOP)

Annual Report 2015/16

1. Introduction

Bexley Child Death Overview Panel (CDOP) has been reviewing the death of every child aged under 18 resident in Bexley since April 2008. CDOP functions are set out in *Working Together to Safeguard Children 2015*. The CDOP works to a national methodology which assists with clarifying the cause and circumstances of a child death. The CDOP also identifies whether there were modifiable factors which may have contributed to the death and what, if any, actions could be taken to prevent future deaths.

The CDOP is accountable to BSCB, and must prepare an annual report for the BSCB.

The annual numbers of child deaths notified to Bexley CDOP have varied over the period 2008/9 to 2015/16 with between 11 and 20 cases being considered by the CDOP each year. In the period covered by this annual report, 16 child deaths occurred.

The numbers of annual child deaths in a single Borough like Bexley are low. Consequently it is difficult to undertake an analysis of potential common characteristics, causes or trends.

The aggregated findings from all child deaths should inform local strategic planning including the local Joint Strategic Needs Assessment (JSNA).

2. The CDOP Process

2.1 Statutory guidance on CDOP

The CDOP has specific functions, set out in statutory guidance outlined in 'Working Together to Safeguard Children' (HM Government 2015):

- Reviewing all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law.
- Collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members.
- Discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family.
- Making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible.
- Identifying patterns or trends in local data and reporting these to the LSCB.
- Determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths.
- Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case to the LSCB Chair for consideration of whether an SCR is required.
- Agreeing local procedures for responding to unexpected deaths of children.

The statutory guidance describes the arrangements for a Rapid Response to an unexpected death and the Child Death Overview Panel (CDOP) process. The two are separate processes, but are closely linked.

2.2 Rapid Response

A Rapid Response is triggered following notification of an unexpected death of a child. An unexpected death is defined as the death of an infant or child (less than 18 years old) 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.

A team of key professionals who know the child/family come together for the purpose of enquiring into and evaluating the death. This procedure enables the capturing of immediate information about unexpected child deaths. In addition it will assist the support to the bereaved family. The information on such cases will inform the LSCB Child Death Overview Panel (CDOP).

The Rapid Response process is led by the Designated Paediatrician for child deaths. The process includes a meeting between professionals involved with the child in order to establish the circumstances and context of the death. The meeting will consider whether there are immediate safeguarding concerns for siblings, if a serious case review or similar might be required and what bereavement support can be offered. A record of the meeting is included in the documentation shared at the final review of the case by the CDOP. The arrangements for the rapid response process are well established in Bexley.

During 2015/16 there was an increase in the number of Rapid Response meetings held. There were 10 deaths between 1st April 2015 and 31st March 2016 for which a rapid response meeting was held. These included notification of the murder of 2 children and the death of a child with complex needs which raised some safeguarding concerns. These cases were referred to the Chair of the BSCB for consideration for serious case review or management review. The cases will be reviewed in full following the completion of judicial processes and management reports.

2.3. The work of the Child Death Overview Panel

The CDOP meets quarterly. The CDOP has a fixed core membership of experts drawn from the key organisations represented on Bexley Safeguarding Children Board. Other members can be co-opted to contribute to the discussion. A Public Health Consultant, joined the Panel this year. Her expertise and local knowledge is a huge asset to the Panel. There is good support and engagement from the core membership. Core members are noted below:

- Head of Service, Ellenor Lions Hospice
- Designated Nurse Safeguarding Children, NHS Bexley CCG (Chair)
- Consultant in Public Health, Bexley/Bromley
- Oxleas NHS Trust (Community Services)
- Designated Paediatrician for child deaths
- Child Abuse Investigation Team, Metropolitan Police (also representing Borough Police)
- Head of Service, Quality Assurance and Workforce Development LB Bexley
- 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, BSCB

During 2015/2016, CDOP met four times to review anonymised information about child deaths. The panel is chaired by the Designated Nurse for Safeguarding Children.

CDOP processes are co-ordinated by the Single Point of Contact provided by the BSCB. The Single Point of Contact is the designated person notified of the death of every child resident in Bexley usually within 24 hours of the death.

The CDOP considers the death of each child, and is required to complete a national proforma for each child. The proforma includes factors relating to:

- the child and family
- service provision
- categorisation of the cause of death (see table 6 and appendix 1);
- a judgment regarding whether there were modifiable factors
- learning points and recommendations
- immediate follow up actions for the family
- whether the case should be referred to the LSCB Chair for consideration of a Serious Case Review.

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.

Informative comparison of Bexley child deaths with other local authority areas and with 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 administration of the CDOP process and are of limited value as comparators from a local epidemiological perspective[i] [ii]. Where feasible, comparisons between national DfE findings[ii] and Bexley are 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 the London CDOP network[iv]. However, these do not generally provide a practical systematic basis for comparison of local CDOP findings.

Public Health England publish a child health profile for all local authorities. These provide some benchmarking against relevant national child health care and health outcome targets[v].

3. National Picture

According to the Department of Education[1], 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 of children who were under the age of one year.

Early in 2016 the Department for Education began a review of LSCBs. This included a review of the CDOP function.

[1] 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

4. CDOP cases - numbers and causes

4.1 Timeliness

Reviewing child deaths is complex and it can take a number of months to gather all the relevant information needed to fully review the death. Timescales are affected by **the following:**

- 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 requesting further information

4.2 Number of child deaths

During the year 2015/16, 16 child deaths were discussed at CDOP meetings. 5 deaths discussed occurred in 2014/5. This is illustrated in Table 1 below.

Table 1. Summary of child deaths in Bexley, April 2008 to March 2016

	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	Total	%	England % 14/15
Total	13	12	11	18	21	11	12	16	**114**		
F:M	4:9	8:4	5:6	8:10	8:13	4:7	7:5	7:9	**44:54**		43:55
Rapid Response							1	11			
<1 mth	2	3	3	9	7	6	6	3	**39**	34	42
1-12 mth	3	6	2	5	3	3	2	4	**28**	25	22
1-4 yr	2	2	3	1	5	0	1	2	**16**	14	13
5-9 yr	1	0	1	0	1	0	2	5	**10**	9	7
10-14 yr	1	0	0	2	2	3	0	0	**8**	7	7
15-17 yr	4	1	2	1	3	0	1	2	**14**	12	9

The number of deaths is variable but numbers are too small to comment on trends.

As noted in Table 2 below, although the numbers show variation from year to year, overall the proportion of male and female deaths in Bexley reflects the national picture.

Table 2: Gender profile of all child deaths: Bexley Apr 2015 - Mar 2016)

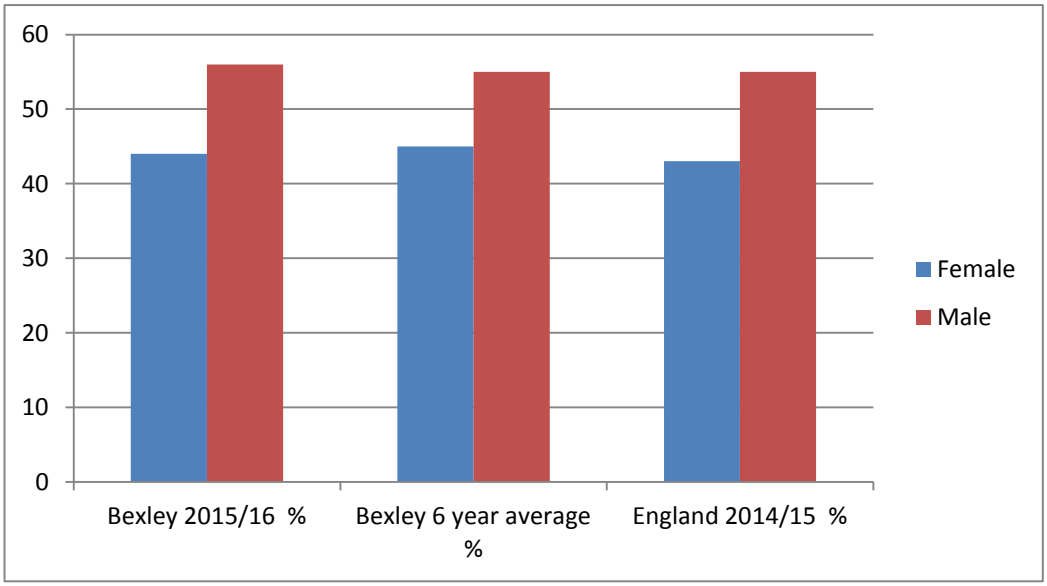
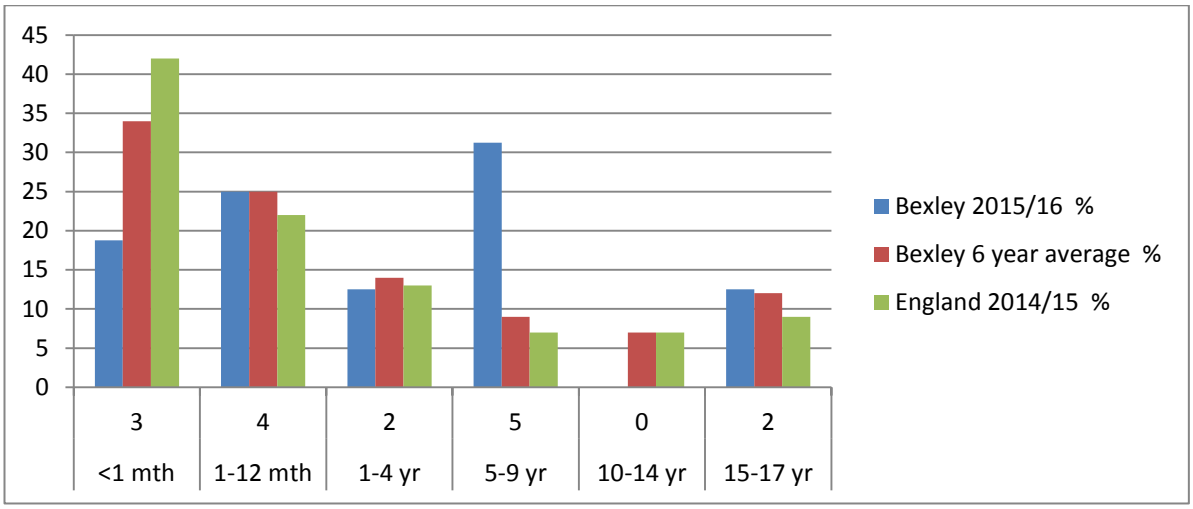


Table 3 which can be found below and the graph which follows the table, show some differences between the Bexley age profile and the age profile data for England in 2014/15. It is important to note that these differences are small and not statistically significant.

Comparing 6 years of Bexley data to the England data does show slightly higher mortality rates in teenagers aged 15-17 years. A very unusual picture has been seen this year of a higher number of number of deaths in the 5-9 yr age range. This is partly due to two homicides of children in this age range. The other three deaths were from different causes and do not indicate any concerning trends. The lower mortality in babies under the age of 1 month or may reflect good maternity care locally or reflect local practice.

Table 3: Age profile of all deaths Bexley CDOP: Apr 2015 - Mar 2016

	15/16 number	Bexley 2015/16 %	Bexley 7 year average %	England 2014/15 %
<1 mth	3	19	34	42
1-12 mth	4	25	25	22
1-4 yr	2	13	14	13
5-9 yr	5	31	9	7
10-14 yr	0	0	7	7
15-17 yr	2	13	12	9



Although numbers are small and the data is incomplete, there is a higher mortality rate in black children than might be expected from national child death data. This is illustrated in Table 4 below. If the proportion of the Bexley 0-19 population who are recorded as black is taken into account, this will help to clarify if this group of children are over-represented in the child death population. The proportion of the Bexley population recorded as black in the 2011 census is smaller than the proportion of black children who have died in Bexley. Although numbers are too small for statistical analysis, this may indicate that more black children are dying than would be expected and this should be monitored.

Table 4: Ethnicity of all deaths Bexley CDOP: Apr 2015 - Mar 2016

	Bexley 2015/16 number	Bexley 2015/16 %	Bexley 6 year average %	Bexley population 2011 census	All child deaths England 2014/15 %
White British	6	38	40	77	60
White other	0	0	2	5	
Black African	3	19	19	9	7
Black Caribbean	0	0	5		
Asian	2	13	4	7	16
Mixed	1	6	8	2	5
Not recorded	4	25	23	1	2

4.3 Cause of child death

Ten standard categories of child deaths have been developed nationally. These categories are shown in Table 5 below. Although there are definitions of each category, these definitions are not always clear. This may result in some child deaths being put in one category by one CDOP, where another CDOP would use a different category. Work is going on nationally and across London to address this. An example of this in the Bexley data is seen when it is compared with the national data (Table 5). The relatively high perinatal/neonatal event and relatively low congenital anomalies rate may represent a substitution, where babies born with a congenital condition were classified as neonatal death (category 8) rather than congenital condition (category 7).
The numbers are involved are small, even when the average rates for 6 years of Bexley data is compared to national rates, but there do appear to be differences between the Bexley data and the national data. Statistical analysis of such small numbers data is not possible, and the following tables are only to give an indication of why Bexley children die.

Table 5: Cause of death in completed reviews, Bexley CDOP: Apr 2015 - Mar 2016

Category of death	Bexley 2015/16 number	Bexley 2015/16 %	Bexley 6 years average %	All child deaths England 2014/15 %
Deliberately inflicted injury, abuse or neglect	0	0	5	2
Suicide or deliberate self-inflicted harm	2	18	4	3
Trauma and other external factors	0	0	8	5
Malignancy	0	0	9	8
Acute medical or surgical condition	1	9	10	6
Chronic medical condition	0	0	1	5
Chromosomal, genetic and congenital anomalies	3	27	13	25
Perinatal/ neonatal event	2	18	38	33
Infection	2	18	4	6
Sudden unexpected, unexplained death	1	9	8	8

Figure 5: **Cause of all deaths Bexley CDOP: Apr 2015 - Mar 2016**

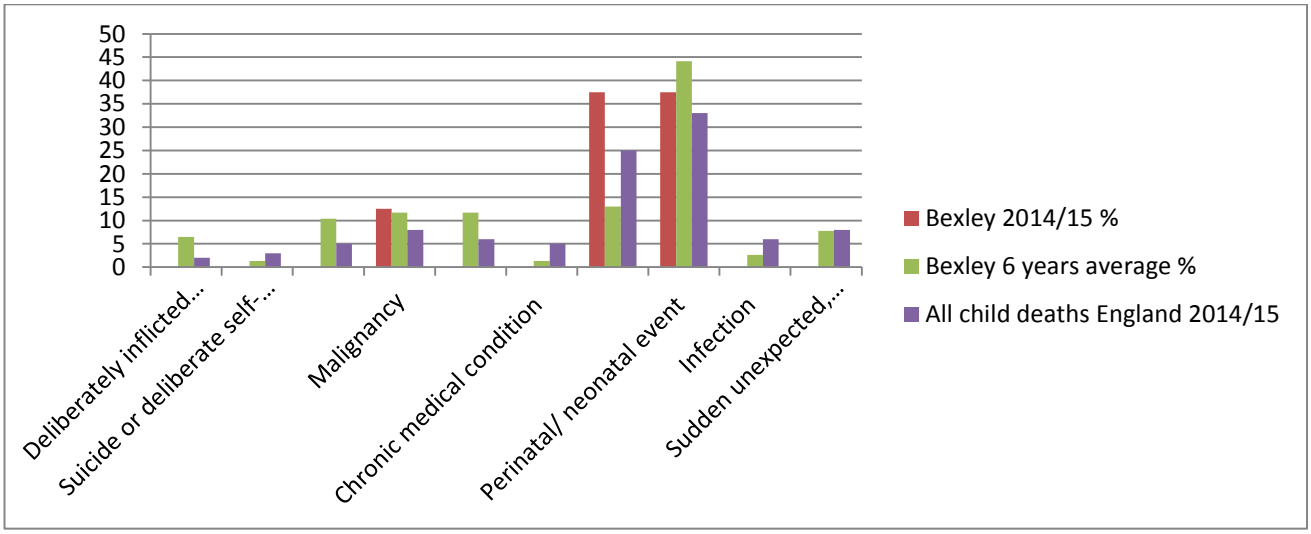


Table 6 Categories of death of Bexley children 2008-2016

Category of death	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	Total	%	England % 14/15
Deliberately inflicted injury, abuse or neglect	2	1	0	1	1	0	0	0	**5**	5	2
Suicide or deliberate self-inflicted harm[4]	0	0	0	0	1	0	1	2	**4**	4	3
Trauma and other external factors	4	1	0	1	1	0	1	0	**8**	8	5
Malignancy	0	0	2	0	4	2	1	0	**9**	9	8
Acute medical or surgical condition	3	0	1	2	3	0	0	1	**10**	10	6
Chronic medical condition	1	0	0	0	0	0	0	0	**1**	1	5
Chromosomal, genetic and congenital anomalies	0	2	1	2	0	2	3	3	**13**	13	25
Perinatal/ neonatal event	1	5	3	11	5	6	5	2	**38**	38	33
Infection	0	0	1	1	0	0	0	2	**4**	4	6
Sudden unexpected, unexplained death	1	3	0	0	1	1	1	1	**8**	8	8

5. Learning from child deaths in Bexley

Learning from expected child death is valuable in terms of improvements that could be made in 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.

5.1 Suicides

In 2015/16 Bexley CDOP reviewed the deaths of 3 young men who took their own lives. This was a cause for concern in Bexley. There was similar concern expressed by Chairs of Child Death Overview Panels (CDOP) and Public Health departments in Greenwich, Lewisham and Bromley, who had reviewed a number of suicides in their Panels..

Agencies from the four boroughs met to collate information about the suicides and consider how to increase and develop prevention work. This work needs to be set in the context of growing national concern about the wellbeing and mental health of young people. This is being addressed in Bexley by a needs assessment commissioned by the Health and Wellbeing Board and work by Bexley's Safeguarding Children Board (BSCB) and CDOP to look at wider issues such as self-harming behaviours. The group agreed a number of actions:

- Contacting the police to ensure a consistent approach with regard to accessing social media accounts of young people who die by suicide.
- Working with the local press to ensure responsible reporting reflecting press guidance. Bexley will lead here. An initial meeting took place between the communications leads from the local authority and the Bexley Clinical Commissioning Group.
- Preparing a template press statement if needed for suicide cases which get media attention. It should be noted that the lessons from the well-known suicide cases in Bridgend and elsewhere is that detailed publicity for suicide cases can be harmful in that it may encourage copycat behaviour.
- Good practice was shared including briefings and materials prepared by Lewisham for schools.
- A SE London Data surveillance function to monitor teenage suicides and attempted suicides will be led by Greenwich.
- Raising awareness of key professionals, for examples, schools and GPs is particularly important. Bexley Safeguarding Children Board (BSCB) will commission a training organisation called Suicide Safer London to deliver training. Suicide Safer London have delivered workshops across London to a range of professionals tailored to their needs. The aims of the training are to reduce anxiety and to develop skills to identify those at risk. Workshops have been evaluated and the training often leads to a change in the culture of the organisation. The training will be offered to two teachers from each secondary school. GPs will also be encouraged to attend.
- Make support materials available direct to to young people, parents and schools. Through the BSCB webpage and elsewhere.

The BSCB Chair and the Chair of Bexley Child Death Overview Panel met with the Bexley Youth Council to discuss this work and they agreed with proposals to develop the skills of teachers and also to raise awareness with young people on keeping themselves and their friends safe

In March 2016, the BSCB agreed to a 'Keeping Yourself and Your Friends Safe' Campaign to be run though 2016-2017 focusing on safety and wellbeing issues for children and on developing mutual and peer support.

A longer term response is also required and Public Health England have published a suicide prevention strategy. This suggests a community action plan for children and young people and setting up a panel to specifically oversee suicide prevention work

The strategy is available at: https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england

The joint South East London Group will develop this work collectively led by Public Health.

5.2 Neonatal deaths

During 2015/16 the panel reviewed a sudden infant death(SIDS). With these type of cases there is no one obvious cause of death. Death could be due to a combination of factors. Experts believe SIDS occurs at a particular stage in a baby's development, and that it affects babies who are vulnerable to certain environmental stresses, including tobacco smoke, getting tangled in bedding, overheating, put to sleep on front/side, a minor illness or a breathing obstruction. There's also an association between co-sleeping on a bed, sofa or chair particularly with an adult who may have used alcohol or drugs. The housing in this case was significantly overcrowded and damp.

Two further cases of possible SIDs have resulted in rapid response meetings in 2016 (outside this reporting period). The BSCB, with Public Health will consider how to raise the profile of what parents can do to reduce risks. Bexley CCG is working with providers to review information provided to identify any gaps and the best way of publicising key safe sleeping messages.

5.3 Bereavement services for families

Queen Elizabeth Hospital (QEH) and Darent Valley Hospital (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.

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Bexley CDOP Chair
Bexley Clinical Commissioning Group

[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. 2015

Appendix 1

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.[v]

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.

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