CUMBRIA LSCB
CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

Cumbria Child Death Overview Panel

Annual Report

April 2015 – March 2016

Introduction

This is the annual report for the Child Death Overview Panel for the local authority area of Cumbria. A reporting year runs from 1st April in one year through to 31st March the following year. The deaths that are reported here are for all children, from birth up to 18 years old, who were normally resident in Cumbria and died during the stated period. It excludes still births and planned terminations of pregnancy which were carried out within the law. The Cumbrian Child Death Overview Panel (CDOP) meets bimonthly to review information that has been collated regarding the cause, location and other circumstances of each child's death.

Any child's death is a terrible occurrence. The CDOP review process aims to ascertain whether a child's death was thought to be preventable by identifying modifiable factors that may have contributed to a child's death. The review process looks at whether these modifiable factors could be altered, by means of nationally or locally achievable interventions, to reduce future child deaths. The CDOP review of a child's death "is not an investigation into why a child has died and it is not a serious case review." (Department for Education, 2014, page 2).

Thankfully not many children in Cumbria die each year. This means the annual report involves small numbers and as a consequence only limited conclusions can be drawn from the data.

This report includes various child death parameters for Cumbria 2015/2016. For each of these parameters two comparisons have been made; firstly, with national English data for the same period, and secondly, with previous years' data for Cumbria. It should be noted, however, that in line with a recommendation made in the 2014/15 annual report, this report covers all deaths reviewed by CDOP in 2015/16, rather than all deaths that occurred in that year. This brings the local reporting in line with the national reporting arrangements and means that the report does not include partial data. However as this is a change in the previous arrangement, the data are not necessarily comparable with previous years and indeed covers a number of deaths – those that occurred in 2014/15 but were signed off in 2015/16 prior to the publication of the last annual report – that have already been included in the last annual report.

Descriptive summary of child death data

The data which follows relate to a review of child deaths for children who were normally resident in the local authority area of Cumbria that were reviewed from 1st April 2015 to 31st March 2016.

Number of child deaths

Thirty four child deaths were reviewed during 2015/16.

Gender

During 2015/16 boys accounted for nearly two thirds of child deaths. There has been a persistent trend in England for boys to account for over half of child deaths, and Cumbria is not significantly different in this regard.

Table 1. Gender of all Cumbrian child deaths by year of review, and compared to England 2015/16

	Cumbria				England
	2012/13	2013/14	2014/15	2015/16	2015/16
Male	12	19	10	21	
	57%	73%	37%	62%	58%
Female	9	7	17	13	
	43%	27%	63%	38%	42%
Totals	**21**	**26**	**27**	**34**	

Age of child at the time of death

In 2015/16 half of Cumbria child deaths (17 children, 50%) occurred in the neonatal period (deaths under 28 days old). Of these 17 neonatal deaths, 16 occurred in the early neonatal period (death under 7 days old), and 10 (29%) were related to prematurity (8 of these – 24% - to extreme prematurity, at under 24 weeks gestation). The second most frequent age of a child's death was aged 28 days – 364 days (9 children, 26%). Cumbrian data follows national English 2014/2015 findings with the majority of deaths also occurring in the neonatal period, followed by children being 28 days – 364 days old being the second most frequent age group

Table 2. Age at death for all Cumbrian child deaths by year of review, and compared to England 2015-2016

	Cumbria				England
Age	2012/13	2013/14	2014/15	2015/16	2015/16
0 - 27 days	5	8	15	17	
	24%	31%	56%	50%	43.1%
28 - 364 days	8	4	4	9	
	38%	15%	15%	26%	21.4%
1 year - 4 years	2	4	2	3	
	10%	15%	7%	9%	11.7%
5 - 9 years	1	3	1	1	
	5%	12%	4%	3%	7.6%
10 - 14 years	1	3	3	1	

	5%	12%	11%	3%	7.1%
15 - 17 years	4	4	2	3	
	19%	15%	7%	9%	9.1%
Totals	**21**	**26**	**27**	**34**	

Ethnicity

All but one of the 34 cases reviewed by CDOP in 2015/16 were identified as White British.

Category of death (as decided by CDOP)

There are ten categories used to classify the event which led to a child's death. For each child death, the most appropriate category is decided by CDOP. Table 3 sets out the numbers in each category of death for the deaths signed off by CDOP in 2015/16.

Table 3. Number of child deaths by category of death for completed CDOP reviews for Cumbria 2014-2015 (23 child deaths) and comparison with England 2014-2015

	Cumbria				England
Category of child death (hierarchical category number)	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2015/16**
1 - Deliberately inflicted injury, abuse or neglect	0 0%	0 0%	0 0%	0 0%	1.6%
2 - Suicide or deliberate self-inflicted harm	0 0%	2 8%	1 4%	0 0%	3.3%
3 - Trauma and other external factors	3 14%	1 4%	2 7%	3 9%	5.1%
4 - Malignancy	0 0%	2 8%	0 0%	2 6%	7.1%
5 - Acute medical or surgical condition	2 10%	2 8%	2 7%	4 12%	6.1%
6 - Chronic medical condition	0 0%	5 19%	1 4%	4 12%	4.9%
7 - Chromosomal, genetic and congenital anomalies	4 19%	5 19%	9 33%	2 6%	26.0%
8 - Perinatal/neonatal event	5 24%	5 19%	11 41%	16 47%	32.2%
9 - Infection	4 19%	4 15%	0 0%	1 3%	5.9%
10 - Sudden unexpected, unexplained death	3 14%	0 0%	1 4%	2 6%	7.6%
Category unknown/not reported	0 0%	0 0%	0 0%	0 0%	0.3%
Totals	**21**	**26**	**27**	**34**	

The most common category of death was for perinatal/neonatal events (16 child deaths, 47%). While this appears higher than in England as a whole, low numbers are likely to account for this anomaly;

there is no indication from the detailed review of these cases that there is any underlying cause of this figure being high. Usually (and across England) chromosomal, genetic and congenital anomalies is the second most frequent category of death; 2015/16 was unusual in Cumbria with this not being the case. However again very low numbers are likely to account for this.

Modifiable deaths

Ascertaining whether a child death was modifiable is a key part of the CDOP review process. Of the 34 deaths in Cumbria, 25 (74%) were felt to have no modifiable factors. This is comparable with England as a whole, where 76% of child deaths were felt to have no modifiable factors. Of the remaining nine, five related to parental smoking. In one case, incidents during health care provision were identified as having been a possible contributory factor.

Qualitative review

An informal analysis of the qualitative parts of Forms Cs has been undertaken to ascertain whether there are any themes or issues that have not emerged from the quantitative analysis.

It has been recognised by the review process that some services are only available in parts of the county rather than effective for the whole population. For example work is underway to ensure that families and communities have access to the bereavement support they need.

In 2 cases there was a concern raised that for the welfare of the child, withdrawal of treatment should have occurred earlier than it in fact did.

The hazardous nature of the A66 between Crackenthorpe and Temple Sowerby has been highlighted.

A reminder that fever for more than 5 days should always raise consideration of Kawasaki Disease was reinforced across the county and added to the sick child template used in the GP practices and out of hours.

There have been improvements in the process over the year:

- The panel led the development of a Cumbria specific leaflet explaining the Child Death Overview process to families. In this the panel was greatly assisted by the comments and amendments by families who had suffered a bereavement and also families from Barnardos.
- Working together and understanding between police and health has improved significantly, partly as a result of consistently holding rapid response and end of case meetings following sudden unexpected deaths.

- An ongoing problem for families is the length of time it takes to receive post mortem reports. The coroner has now agreed to release these reports to the Designated Doctors, who will co-ordinate with the lead professional for the family.
- There is now more robust liaison and co-ordination in relation to children from Cumbria who do not die in Cumbria.

Quality of CDOP Process: Time taken to review cases

Each child death review cannot take place until all the required information has been collated. It can take many months to amalgamate this data as some investigations cannot be completed quickly, particularly for more complex cases. In 2015/16 this has been particularly notable due to a high number of serious case reviews being carried out on historic cases. However for many years the length of time taken to sign off deaths in Cumbria has been too great. In 2015/16 the proportion of deaths taking more than 12 months to review dropped notably, but remains much higher than the national average. The other notable feature of Cumbria is the extremely low proportion of reviews carried out within 6 months: where cases are relatively straightforward, this is clearly something that could be further improved. Achieving improvements in the time taken to sign off cases will require all agencies concerned to take steps to improve up their own processes, notably ensuring that the single agency Form B is completed quickly and with sufficient detail.

Table 4. Time taken by Cumbria CDOP to sign off cases compared to England, 2015/16

	Cumbria				England
	2012/13	**2013/14**	**2014/15**	**2015/16**	**2015/16**
Under 6 months	5%	23%	0%	3%	29%
6 - 7 months	5%	4%	0%	9%	14%
8 - 9 months	14%	8%	15%	15%	12%
10 – 11 months	5%	15%	19%	18%	10%
12 months	14%	8%	7%	12%	5%
More than 12 months	57%	42%	59%	44%	30%

Recommendations

The following table sets out the recommendations made in the 2014/15 Annual Report and the progress made in implementing these:

Recommendation	**Progress**
Health visiting and social care services should carry out a brief review of the support that they offer to parents who misuse alcohol or drugs in order to	The Quality Assurance Group of the LSCB has reviewed such support and revised actions are in place.

determine whether this is an area that requires further development.	
Maternity services should work to improve their data collection relating to smoking at time of delivery (SATOD) and to support more mothers to quit while pregnant.	In 2015, a mother's smoking status at time of delivery was not known in only 2.7% of cases – better than the England figure of 3.1%, and a significant improvement on previous years. 12.3% of women were known to be smokers at the time of delivery. This is also an improving picture but remains higher than England (10.6%)
CDOP should consider changing the timing of Annual Reports so as to publish in the summer the findings from all deaths signed off in the previous year, rather than waiting nearly 12 months until deaths from that year have mostly been signed off. This would bring the statistics in line with England and prevent annual reports including partial data from deaths that were not able to be signed off prior to the report being written.	Implemented in full in this year's annual report.
CDOP should continue to work to improve the timeliness of its review process and agree a plan to improve performance against those recommendations from last year that are still partly outstanding.	Timeliness is improving but more remains to be done to improve further, particularly with regard to rapid responses to more straightforward cases. Two actions from the previous year had been achieved in part: • Add more social determinants to the case summary and document a mother's obstetric and antenatal history for premature births • Ensure all practitioners completing documentation understand definitions used and have access to the guidelines which explain terms in detail.

Recommendations arising from this year's report are as follows:

- All agencies should take action to improve the quality and timeliness of the completion of Form Bs in order to speed up the CDOP review process.
- In support of this, CDOP should monitor and report on the quality and timeliness of the completion of Form Bs on a regular basis.
- CDOP should consider adopting a rapid sign-off process using email for simple cases where full case discussions have taken place and there is a clear recommendation from the relevant Paediatrician for Child Death.
- CDOP should take steps to ensure further dissemination of the learning arising from each case considered.

References

Department for Education (2012) Guidance Notes for the completion of the Local Safeguarding Children Board Child Death DATA Collection. Available online: https://www.gov.uk/government/publications/child-death-data-collection-2013-to-2014-lscb1-guide

Department for Education (2016) Statistical First Release on Child Death Reviews – Year ending March 2016. Available online: https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2016