Cumbria Child Death Overview Panel
Annual Report
April 2017 – March 2018

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 whose deaths were reviewed 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 2017/2018. 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 that this report covers all deaths reviewed by CDOP in 2017/18, rather than all deaths that occurred in that year.

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 2017 to 31st March 2018.

Number of child deaths

Twenty child deaths were reviewed during 2017/18.

Gender

During 2017/18 boys accounted more than three quarters of child deaths signed off. There has been a persistent trend in England for boys to account for slightly over half of child deaths; while Cumbria's figures in 2017/18 appear much higher than this, the small numbers involved mean that substantial year on year fluctuations are to be expected – and this notably contrasts with the previous year, when boys accounted for about a third of deaths. Over the longer term Cumbria is not significantly different in this regard, with boys accounting for 56% of deaths over the last five years.

Table 1. Gender of all Cumbrian child deaths by year of review, and compared to England 2017/18

	Cumbria					Cumbria	England
	2013/14	2014/15	2015/16	2016/17	2017/18	5 years	2017/18
Male	19	10	21	10	16	**76**	
	73%	37%	62%	34%	80%	**56%**	**56%**
Female	7	17	13	19	4	**60**	
	27%	63%	38%	66%	20%	**44%**	**44%**
Totals	**26**	**27**	**34**	**29**	**20**		

Age of child at the time of death

In 2017/18 two fifths of Cumbria child deaths (8 children, 40%) occurred in the neonatal period (deaths under 28 days old). Of these 8 neonatal deaths, 3 occurred in the early neonatal period (death under 7 days old), and 3 (38%) were related to prematurity. One fifth of deaths reviewed were in children aged 28 days – 364 days (4 children, 20%). While still subject to annual variation due to the small numbers involved, Cumbrian data largely follows national English figures overall 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. However, across the last five years as a whole there is a somewhat higher proportion of deaths at older ages (10+) than the national average. This may be correlated to cause of death: see the commentary on Table 3 (category of death) below.

Table 2. Age at death for all Cumbrian child deaths by year of review, and compared to England 2017-2018

	Cumbria					Cumbria	England
Age	2013/14	2014/15	2015/16	2016/17	2017/18	5 years	2017/18
0 - 27 days	8	15	17	8	8		
	31%	56%	50%	28%	40%	**41%**	**43%**
28 - 364 days	4	4	9	8	4		
	15%	15%	26%	28%	20%	**21%**	**21%**
1 year - 4 years	4	2	3	1	3		
	15%	7%	9%	3%	15%	**10%**	**11%**
5 - 9 years	3	1	1	0	0		
	12%	4%	3%	0%	0%	**4%**	**6%**
10 - 14 years	3	3	1	7	2		
	12%	11%	3%	24%	10%	**12%**	**8%**
15 - 17 years	4	2	3	5	3		
	15%	7%	9%	17%	15%	**13%**	**10%**
Totals	**26**	**27**	**34**	**29**	**20**		

Ethnicity

All of the 20 cases reviewed by CDOP in 2017/18 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 2016/17.

Table 3. Category of child deaths by year of review, and compared to England 2016-2017

			Cumbria			Cumbria	England
Category of child death (hierarchical category number)	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**5 years**	**2017/18**
1 - Deliberately inflicted injury, abuse or neglect	0 0%	0 0%	0 0%	2 7%	0 0%	**1%**	**1%**
2 - Suicide or deliberate self-inflicted harm	2 8%	1 4%	0 0%	2 7%	2 10%	**5%**	**3%**
3 - Trauma and other external factors	1 4%	2 7%	3 9%	3 10%	2 10%	**8%**	**6%**
4 - Malignancy	2 8%	0 0%	2 6%	3 10%	1 5%	**6%**	**7%**
5 - Acute medical or surgical condition	2 8%	2 7%	4 12%	3 10%	4 20%	**11%**	**6%**
6 - Chronic medical condition	5 19%	1 4%	4 12%	1 3%	1 5%	**9%**	**5%**
7 - Chromosomal, genetic and congenital anomalies	5 19%	9 33%	2 6%	6 21%	2 10%	**18%**	**25%**
8 - Perinatal/neonatal event	5 19%	11 41%	16 47%	6 21%	6 30%	**32%**	**34%**
9 - Infection	4 15%	0 0%	1 3%	2 7%	0 0%	**5%**	**6%**
10 - Sudden unexpected, unexplained death	0 0%	1 4%	2 6%	1 3%	2 10%	**4%**	**7%**
Category unknown/not reported	0 0%	0 0%	0 0%	0 0%	0 0%	**0%**	**0%**
Totals	**26**	**27**	**34**	**29**	**20**		

The most common category of death was for perinatal/neonatal events (6 child deaths, 30). This is similar to the England average. While small numbers in each category mean that there sometimes appear to be very significant variations from the England average, when viewed over the last five years the proportion of deaths in each category is very similar to the average. There may be a somewhat lower proportion of deaths associated with chromosomal, genetic and congenital abnormalities, and it may be that the slightly higher rates of suicide and trauma go some way to explaining the higher proportion of deaths at older ages described in Table 2, as these deaths tend to happen at an older age.

Modifiable deaths

Ascertaining whether a child death was modifiable is a key part of the CDOP review process. Of the 20 deaths in Cumbria, 17 (85%) were felt to have no modifiable factors. This is comparable with England as a whole, where 73% of child deaths were felt to have no modifiable factors. Of the remaining three, one case related to infant sleeping, and in two cases factors relating to healthcare were identified, though in neither case were these factors directly a cause of death. Unusually, parental smoking was not identified as a factor in any of the deaths reviewed in 2017/18.

Place of death

In light of the national guidance on CDOP arrangements as part of the Working Together review, it is worth noting the pattern of deaths across the County where NHS services have been most involved. Of the 20 deaths in total, four could be described as "non-medical" – injury, suicide or trauma – even where the death actually occurred in a hospital. Five deaths occurred at home or in a hospice. The remaining 15 deaths happened in a hospital. Of the 10 hospital deaths in West, North and East Cumbria, only three actually occurred within a Cumbrian hospital; the other seven were in hospitals in the North East, mainly the Royal Victoria Infirmary in Newcastle. Conversely – and in a change to the previous year – of the five South Cumbria hospital deaths, four occurred at Furness General.

As with last year this pattern, together with the main causes of death, continues to lend some support to the proposition that child death is largely something that has to be seen in a medical context, and that reviewing them as part of a clinical system may be more appropriate than doing so as part of a safeguarding system. The Working Together guidance does not make this easy in Cumbria, as it does not allow the safeguarding geography to be split north and south, which would make more sense from a clinical perspective. This means it is impossible for Cumbria's CDOP to comply with all aspects of the guidance: operating as a stand-alone County panel it does not review sufficient cases in a year, but integrating with any one neighbouring panel does not take account of clinical flows. This challenge will need to be kept under review.

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 these data as some investigations cannot be completed quickly, particularly for more complex cases. However for many years the length of time taken to sign off deaths in Cumbria has been too great. In 2017/18 the position continued to improve, with 60% of reviews being carried out within 9 months, in line with the national average for the first time. However the fact that Cumbria still carried out no reviews within 6 months of death is an ongoing cause for concern: 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 by year of review, and compared to England 2017/18

	Cumbria					England
	2013/14	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2017/18**
Under 6 months	23%	0%	3%	0%	0%	**32%**
6 - 7 months	4%	0%	9%	17%	20%	**16%**
8 - 9 months	8%	15%	15%	21%	40%	**13%**
10 – 11 months	15%	19%	18%	34%	15%	**11%**
12 months	8%	7%	12%	3%	0%	**5%**
More than 12 months	42%	59%	44%	24%	25%	**24%**

Recommendations

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

- Cumbria's CDOP should review its operation within 2019/20 in light of the Working Together guidance to determine whether to continue operating as an independent Panel or to propose alternative ways of working for the longer term.
- CDOP still needs to understand why it takes so long to receive undertake a review of a child's death in Cumbria, where no cases where completed in the first 6 months compared to over 30% nationally.

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