Cambridgeshire and Peterborough Child Death Overview Panel (CDOP)

Annual Report 2023/24

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1. Introduction

Cambridgeshire and Peterborough Child Death Overview Panel (CDOP) reviews the death of every child and young person resident to Cambridgeshire and Peterborough who sadly dies. The aim of the CDOP is to prevent future deaths whilst looking to improve support for children, young people, and their families.

2. Purpose

2.1 As per Working Together to Safeguard Children (2023) and Child Death Review Statutory and Operational Guidance (2018) the CDOP has specific functions, including:

- To review all deaths of children up to 18 years (including deaths of infants aged less than 28 days), excluding those who are stillborn or planned terminations of pregnancy.
- Reviewing and evaluating the deaths of all children, and thereby identifying lessons to be learnt, contributory factors and/or issues of concern which may prevent future child deaths.
- Referring to the Local Safeguarding Children Partnership within the reporting area, any deaths where the panel considers there may be grounds to consider a Child Safeguarding Practice Review.
- Monitoring the support services offered to bereaved families.
- To contribute to local, regional, and national initiatives to improve learning from child death reviews.

2.2 Child deaths are reviewed on a quarterly basis by the CDOP members. A number of deaths may be reviewed as part of a joint agency response (JAR), this would be triggered if a child's death –

- is or could be due to external causes.

- is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy/childhood (SUDI/C).
- occurs in custody, or where the child was detained under the Mental Health Act.
- where the initial circumstances raise any suspicions that the death may not have been natural.

During 2023/24 the CDOP members met on a quarterly basis (four times) to review information regarding the deaths of Cambridgeshire and Peterborough children. The CDOP is made up of the following members –

Job Title	Agency
Independent CDOP Chair	
Designated Doctor Safeguarding Children and Child Death (Deputy Chair)	Cambridgeshire and Peterborough Integrated Care Board
CDOP Manager	Cambridgeshire and Peterborough Integrated Care Board
Designated Nurse Safeguarding Children	Cambridgeshire and Peterborough Integrated Care Board
Senior Lead for the LeDeR Programme	Cambridgeshire and Peterborough Integrated Care Board
Medical Examiner	North West Anglian NHS Foundation Trust
Named Doctor Safeguarding Children	Cambridgeshire University Hospitals NHS Trust
Medical Examiner	Cambridgeshire University Hospitals NHS Trust
Lead Nurse for Children's Community Specialist Nursing	Cambridgeshire Community Services NHS Trust
Named Nurse Safeguarding Children	Cambridgeshire Community Services NHS Trust
Head of Safeguarding	Cambridgeshire Partnership NHS Foundation Trust
Head of Operations	East of England Ambulance Service NHS Trust
Matron	East Anglia Children's Hospice
Consultant	Public Health
Service Manager, Children's Social Care	Cambridgeshire County Council
Deputy Safeguarding Lead, Children's Social Care	Peterborough City Council
Detective Inspector	Cambridgeshire Constabulary
Case Review Project Officer	Cambridgeshire and Peterborough Safeguarding Partnership Board
Education Safeguarding Manager	Education
Lead Coroner	Coroner's Office, Cambridgeshire and Peterborough
General Practitioner (GP)	Lensfield Medical Practice (representing General Practice across Cambridgeshire and Peterborough)

The CDOP can also call upon local subject experts, such as the Road Safety Partnership or neonatologists if required.

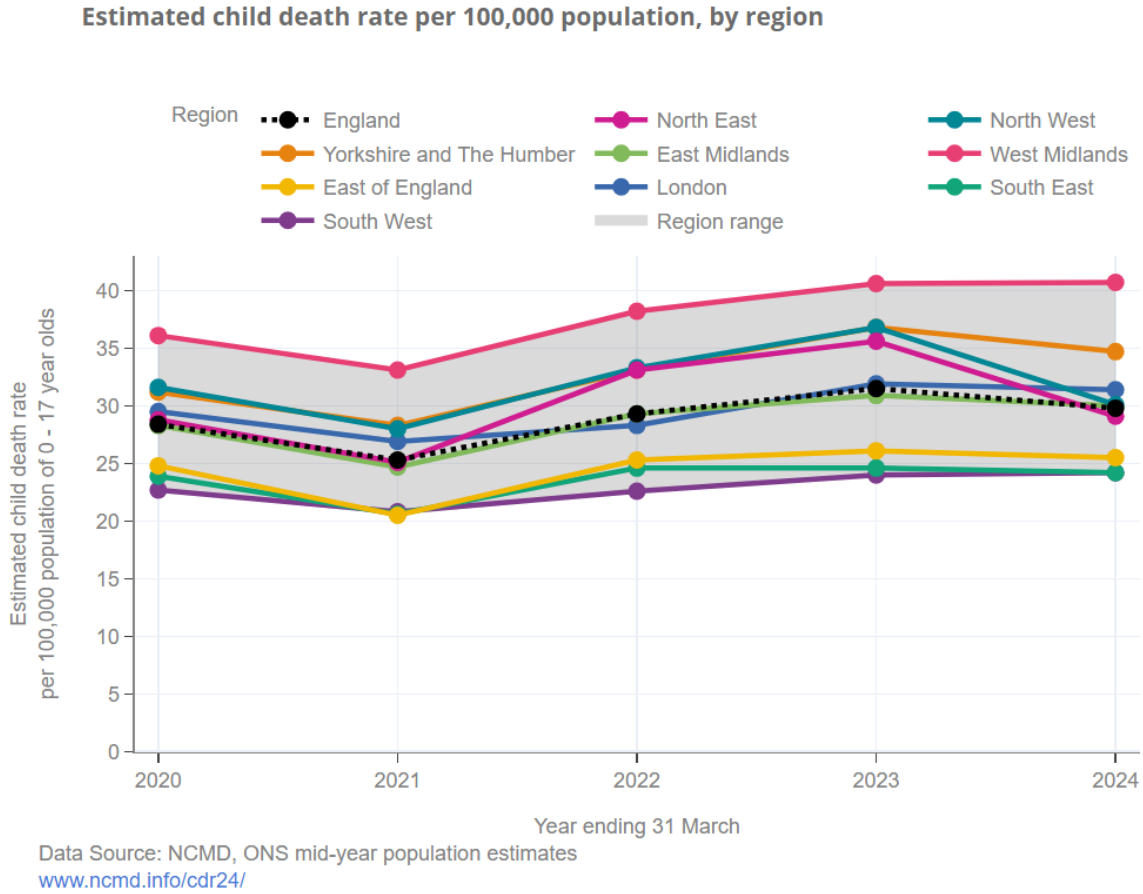
2.3 In the instance of a neonatal death (0 – 28 days old), a perinatal mortality review toolkit (PMRT) will be used to review the mothers and baby's care, as well as the circumstances of the baby's death. This review is led by the neonatal teams in Cambridgeshire University Hospitals NHS Trust and North West Anglia NHS Foundation Trust. Where a local baby has died out of area, the hospital that the baby died in will host the PMRT meeting. The child death review team are invited to PMRT meetings for

local babies. Learning from the review, positive elements of care and action points is shared with the team for consideration at the final CDOP review.

3. Local overview

3.1 Cambridgeshire and Peterborough child death review team were notified of 57 deaths of children and young people during the period from 1st April 2023 until 31st March 2024. This is a 21% increase on the previous reporting year.

Nationally, there were 3,577 child (0 – 17 years) deaths in England in the year ending 31 March 2024, an estimated rate of 29.8 deaths per 100,000 children. The number of deaths decreased by 4% on the previous year but remained higher than 2019-20. Infant (children under 1 year) deaths decreased by 2% on the previous year and deaths of children aged between 1 and 17 years decreased by 8% (Figure 1). Although the number of infant deaths decreased, the estimated infant death rate increased from 3.8 to 3.9 per 1,000 live births.



Per 1,000 live births, in Cambridgeshire and Peterborough there were 2.5 estimated neonatal deaths (below the national average of 2.7) and 2.9 estimated infant deaths (below the national average of 3.9).

Per 100,000 population between ages 1 – 17 years old, in Cambridgeshire and Peterborough there were 16.7 estimated deaths (above the national average of 12.4).

3.2 The number of child deaths reviewed by the Cambridgeshire and Peterborough CDOP during this period was 28. Within the East of England, the numbers of cases reviewed by CDOP in Cambridgeshire and Peterborough were lower than all other counties in the area. Considering this it was agreed that

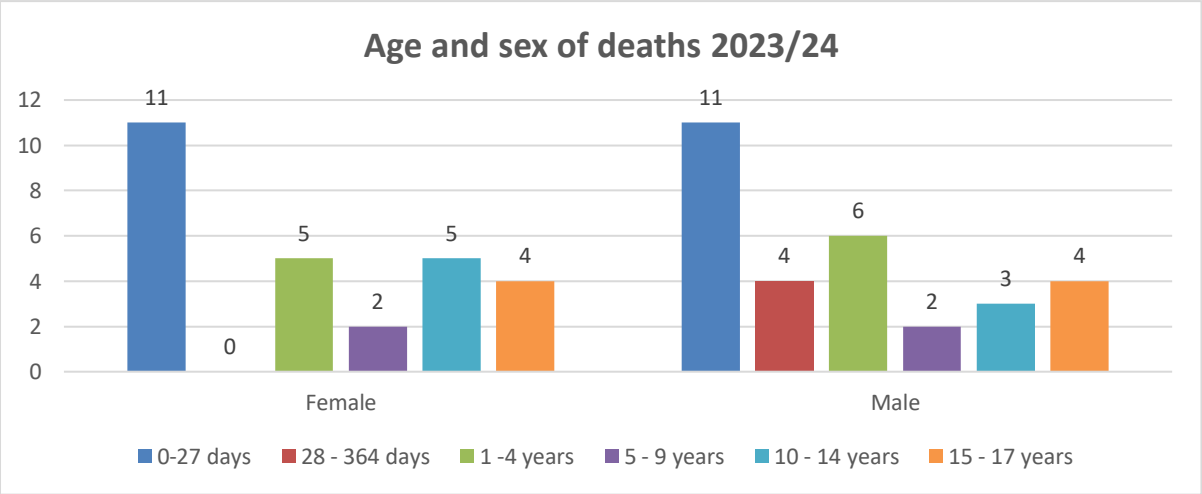
the frequency of the CDOP meetings would increase from quarterly to bi-monthly. This was implemented within the financial year and as such, six cases are reviewed by the CDOP every other month.

The main reasons for delays in review were due to outstanding Coroner's post mortem reports, on going child safeguarding practice reviews (CSPR's) and delays in receiving reporting forms from professionals. To support with timely information sharing via reporting forms, single points of contact for agencies have been identified, with some agencies such as Cambridgeshire University Hospitals NHS Foundation Trust having introduced a dedicated child death review function.

3,345 child deaths were reviewed by CDOPs in England between 1 April 2023 and 31 March 2024 (some of these deaths may have occurred in earlier years); a similar number to the previous year and the highest number since 2019-20.

4. Local demographics

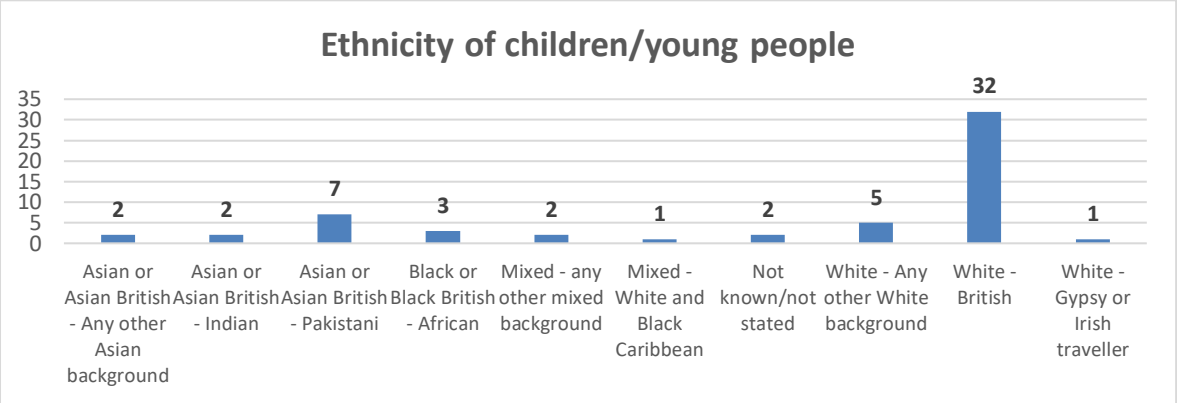
4.1 There was a total of 30 (53%) male deaths and 27 (47%) female deaths during the reporting period. Below is a breakdown of age of the child/young person when they died and their gender. The highest number of deaths continued to be seen in the neonatal period and first year of life.



Nationally, 80% of neonatal deaths were of babies born at a premature gestational age (before 37 weeks), which was an increase from those seen in previous years. The proportion of neonatal deaths notified to CDOPs of babies born under 24 weeks gestation also increased (39% vs 33% in the year ending March 2020).

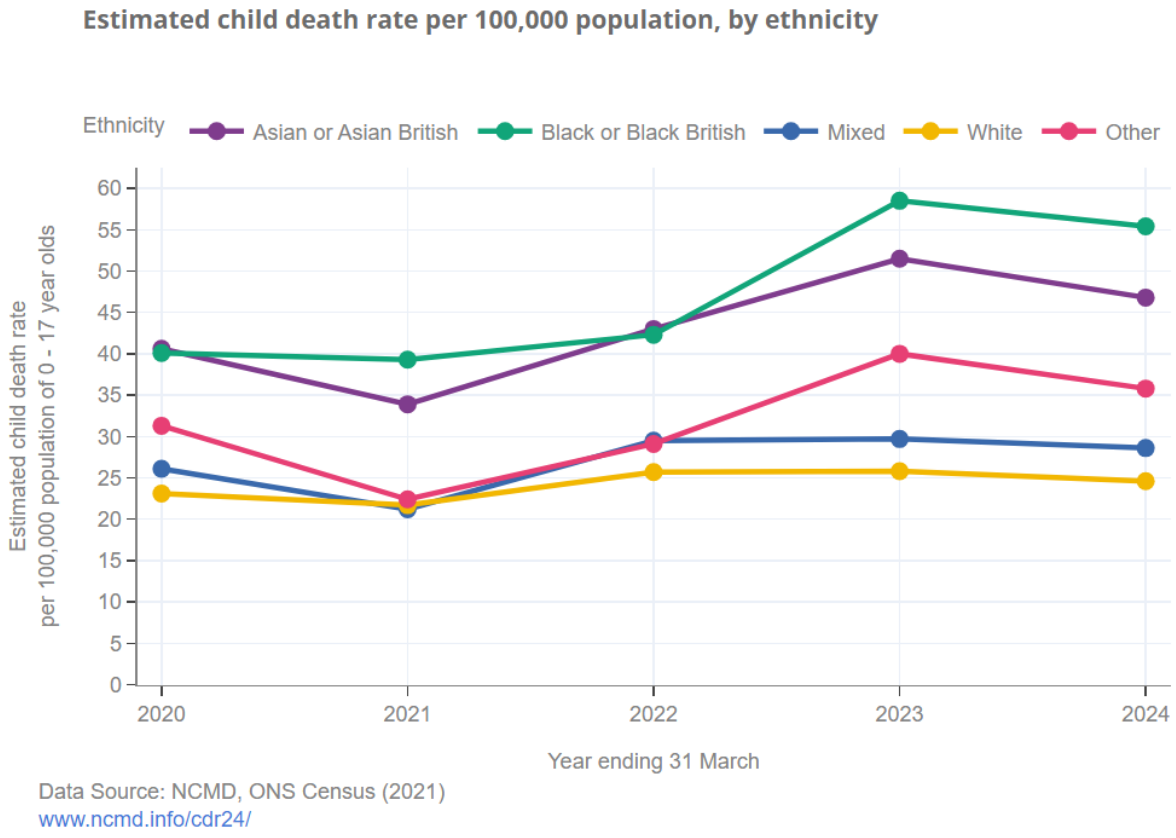
This increase in deaths of babies under 24 weeks is difficult to interpret but may be impacted by multiple factors, such as more consistent recognition of signs of life by clinical teams, babies receiving survival focused care, appropriate completion of MCCDs (medical certificate of cause of death), and better reporting to CDOPs.

Cambridgeshire and Peterborough deaths by ethnicity



4.2 There were 38 deaths of children from White British or White or other White ethnic groups, three deaths from Black or Black British ethnicity and 11 Asian or Asian British ethnicity. Three deaths were of children identified as mixed race, and a further two deaths noted that the family preferred not to state their ethnicity.

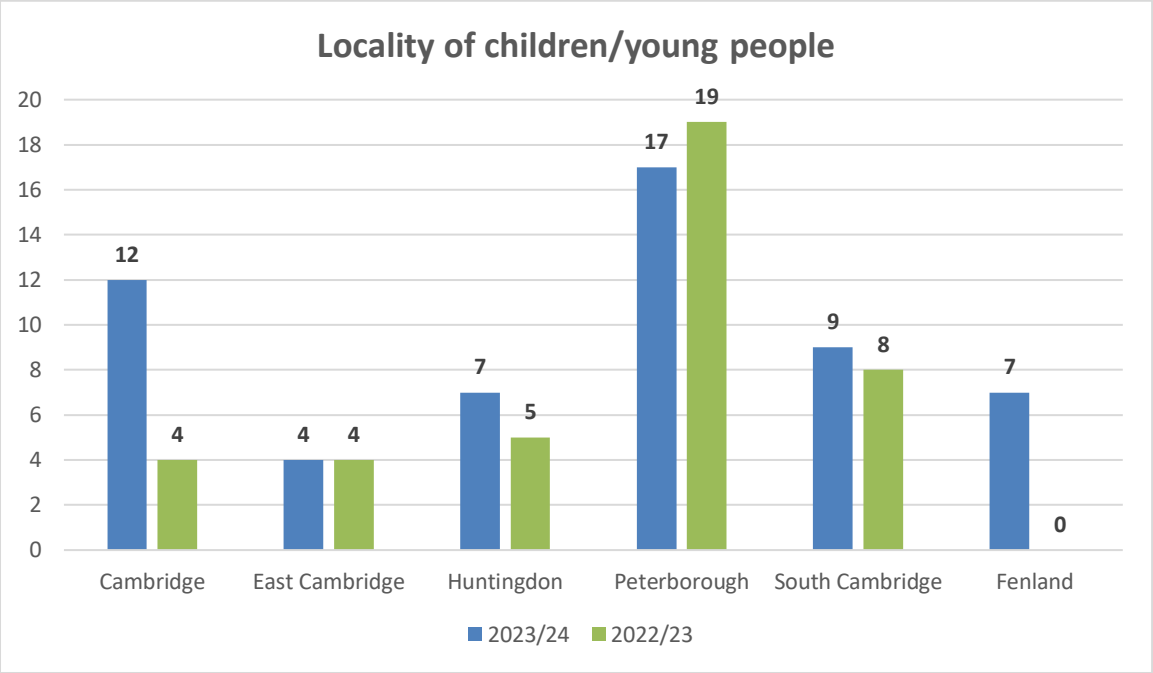
Nationally, the child death rate in the year ending 31 March 2024 remained highest for children of black or black British ethnicity (55.4 per 100,000 population) and Asian or Asian British ethnicity (46.8 per 100,000 population). The rates for all ethnic groups have decreased in comparison to the previous year.



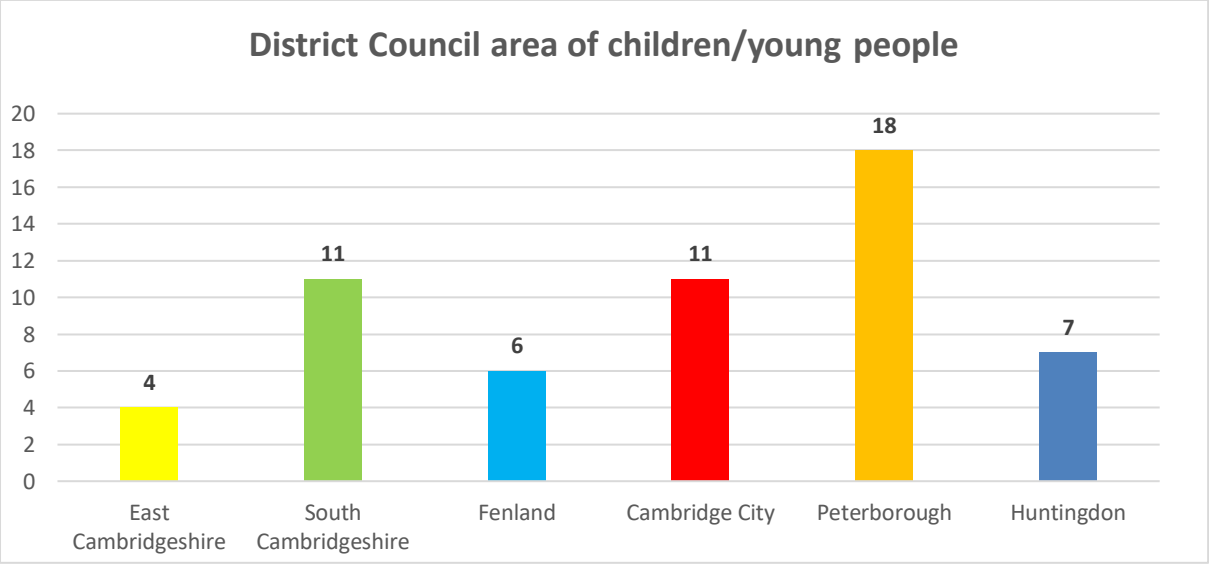
Nationally within these ethnicity groupings, over a five-year period, the child death rate was highest for children of Asian Pakistani ethnicity (57.0 per 100,000 population), followed by any other Asian background (51.8 per 100,000 population), black African (51.3 per 100,000 population) or black

Caribbean (51.3 per 100,000 population). This was more than double the rate of children from a white British ethnic background (22.9 per 100,000 population). The child death rate was lowest for those of Chinese ethnicity (16.4 per 100,000 population).

Cambridgeshire and Peterborough deaths by locality/district council area



Unlike last year (2022-23), there were no child deaths in Royston, St Neots or Wisbech. The number of deaths of children in Peterborough remains the highest, however this has decreased slightly in comparison to the year prior, with an increase seen in Cambridge City (numbers have tripled), Huntingdon and South Cambridgeshire.

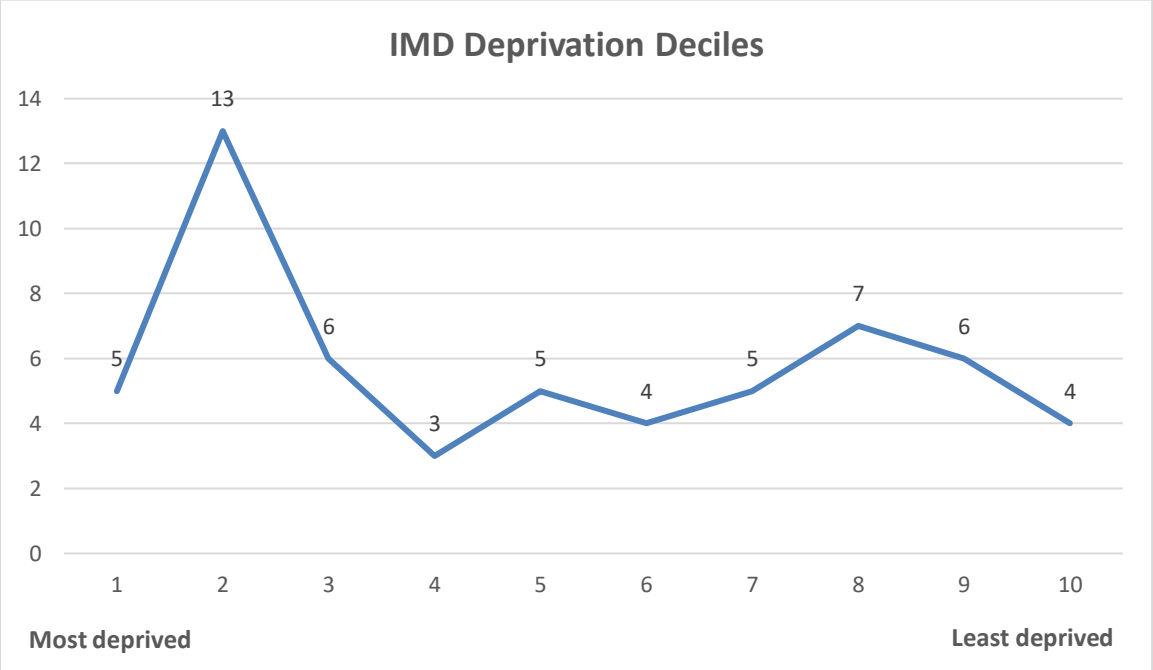


Last years report noted a higher number of deaths in the 'PE1' area (central Peterborough), the child death review team have continued to monitor this, ensuring families in this area are supported. The child death review team worked with Public Health to raise these concerns, and a focused piece of

work took place, with PE1 being a focus for North Place. In the year 2023-24 there has been a decrease of deaths in the PE1 area, with it now falling in line with expected death rates in this locality per birth rates/number of live children.

Cambridgeshire and Peterborough deaths by deprivation decile

The below chart identifies the number of child deaths that occurred in each of the deprivation deciles (calculated by postcode of residence) The NCMD report *Child Mortality and Social Deprivation* (May 2021) found a clear association between the risk of child death and the level of deprivation (for all categories of death except cancer). It more specifically states that over a fifth of all child deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived – which translates to over 700 fewer children dying per year in England.

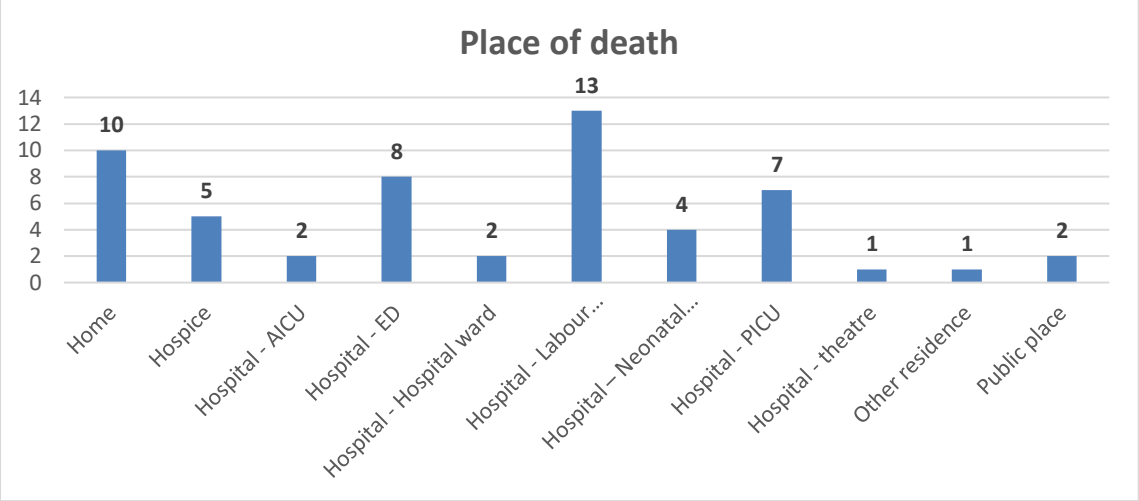


The child death rate for children resident in the most deprived neighbourhoods of England was 42.9 per 100,000 population, more than twice that of children resident in the least deprived neighbourhoods (17.2 per 100,000 population). The child death rates decreased from the previous year for both quintiles, although the difference in rates between these areas is still higher than any year recorded before 2023.

Over the five-year period, death rates for children of Black and Asian ethnicity remained higher than for children of White British ethnicity across all five deprivation quintiles.

The death rate of infants who were resident in the most deprived neighbourhoods of England (5.5 per 1,000 infant population), remained more than twice that of infant's resident in the least deprived neighbourhoods (2.0 per 1,000 infant population). Similar to all child deaths, the infant death rates for the most and least deprived areas have decreased compared to the previous year but the difference in rates between these areas remained higher than the prior three years.

Cambridgeshire and Peterborough deaths by place of death



4.4 In the reporting period three children were notified to the Cambridgeshire and Peterborough child death review team where it was identified that whilst they died within the locality, they resided out of area and that the review would be better undertaken by their local child death review team. These three cases were transferred to the children's local CDOP team to lead on the review process and are not included in local numbers.

4.5 Whilst CDOP does not determine the cause of death, a category is selected by the CDOP based on information provided by the Coroner and medical certificate of cause of death.

Category of death	**Date of death**						
	2017/ 2018	**2018/ 2019**	**2019/ 2020**	**2020/ 2021**	**2021/ 2022**	**2022/ 2023**	**2023/ 24**
Acute medical or surgical condition	0	2	6	5	6	4	5
Suicide or deliberate self-inflicted harm	1	3	1	4	2	1	1
Chromosomal, genetic and congenital anomalies	1	7	16	9	14	10	2
Malignancy	1	1	1	4	1	3	1
Infection	0	4	5	2	4	3	1
Sudden unexpected, unexplained death	1	5	2	2	3	0	1
Trauma and other external factors, including medical/surgical complications/error	0	3	2	3	4	3	3
Deliberately inflicted injury, abuse or neglect	1	1	1	0	0	0	0
Chronic medical condition	2	1	3	0	7	4	4
Perinatal/neonatal event	0	2	15	9	6	5	10
Total:	**7**	**27**	**52**	**38**	**47**	**33**	**28**

**figures only include closed cases reviewed by the CDOP, note some children and young people have more than one category of death.*

Nationally, the most common primary category (i.e., the likely cause) of death for reviews in 2023-24 was Perinatal/neonatal event, which was recorded for 31% of all child death reviews, followed by Chromosomal, genetic and congenital anomalies (24%), Sudden unexpected and unexplained death (8%), Acute medical or surgical condition (8%) and Malignancy (8%) (Figure 16). These patterns were similar to previous years.

The most common primary category of death for children under 1 was Perinatal/neonatal event; for children aged between 1 and 9 years it was Chromosomal, genetic and congenital anomalies; and for children aged between 10 and 17 years it was Malignancy.

4.6 Of the deaths reported to the child death review team, 13 of the children were known to have a learning disability, with a further one child suspected to have a learning disability. Where it is identified that a child/young person has a learning disability, a discussion will take place between the child death review team and the Learning Disabilities Mortality Review Programme (LeDeR) locally to ensure their expertise is utilisied during the review process, and so that any learning and sharing of this can be captured effectively by both teams. The LeDeR team also became regular CDOP members during the financial year to strengthen this further.

5. Modifiable factors

When reviewing the death of a child or young person the CDOP should consider modifiable factors such as parenting capacity, family environment, service provision and risk factors during pregnancy.

The following modifiable factors were identified by Cambridgeshire and Peterborough CDOP during the reporting period –

- Routine vitamin K prophylaxis for the prevention of Vitamin K Deficiency Bleeding (VKDB) was inadvertently omitted on admission.
- Domestic abuse
- Smoking during pregnancy*
- Vehicle travelling at 60-70mph with no signs of braking before colliding with the stopped vehicle.
- Driver of vehicle positive for drug use.
- Driver of vehicle using mobile phone to browse social media in a cradle at the time of the collision.
- Baby not cared for in a cold cot/cold cot not offered.
- Young person not supported following sexual assault.

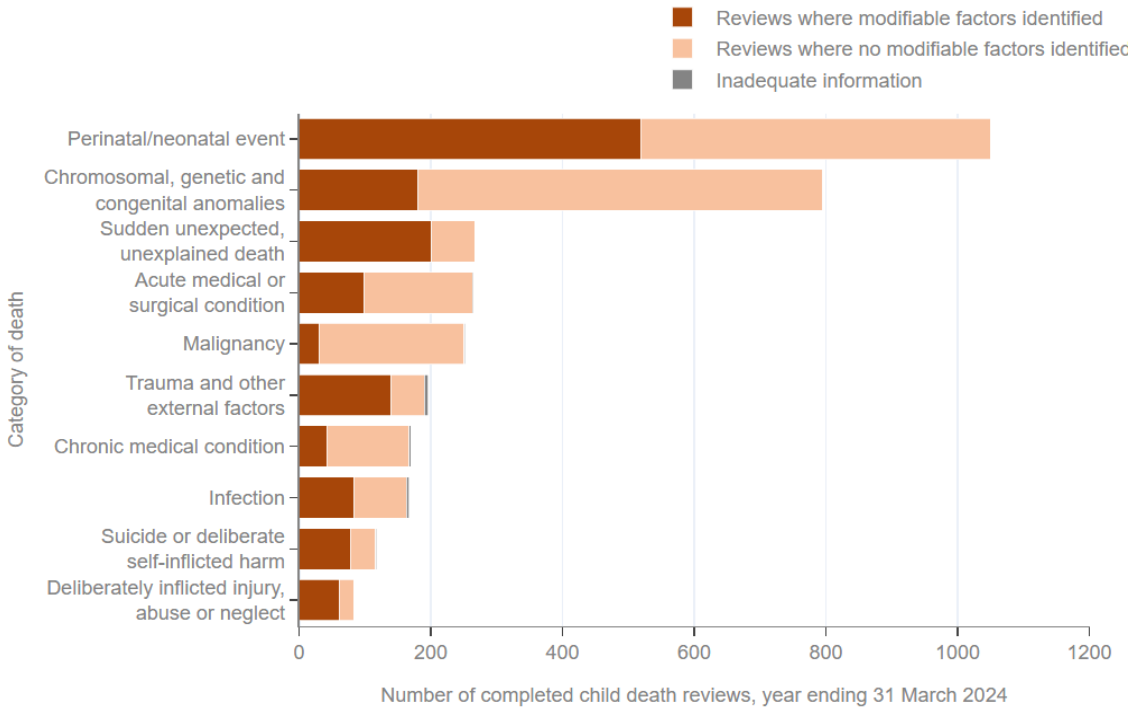
*Two cases noted smoking in pregnancy as a modifiable factor, locally all expectant parents are informed of the risks of smoking during pregnancy, with those who continue to smoke tobacco being referred to smoking cessation services to manage this.

Nationally, deaths categorised as Trauma or other external factors had the highest proportion of reviews with modifiable factors (76%), followed by Sudden unexpected and unexplained death (75%), Deliberately inflicted injury, abuse or neglect (73%) and Suicide or deliberate self-inflicted harm (68%).

The most common recorded modifiable factors by CDOPs during reviews of infant deaths were smoking by a parent/carer (198, 27% of infant death reviews with categorised modifiable factors, 10% of all infant death reviews), high maternal body mass index (BMI) (169, 23%, 8%), and smoking in pregnancy (164, 22%, 8%).

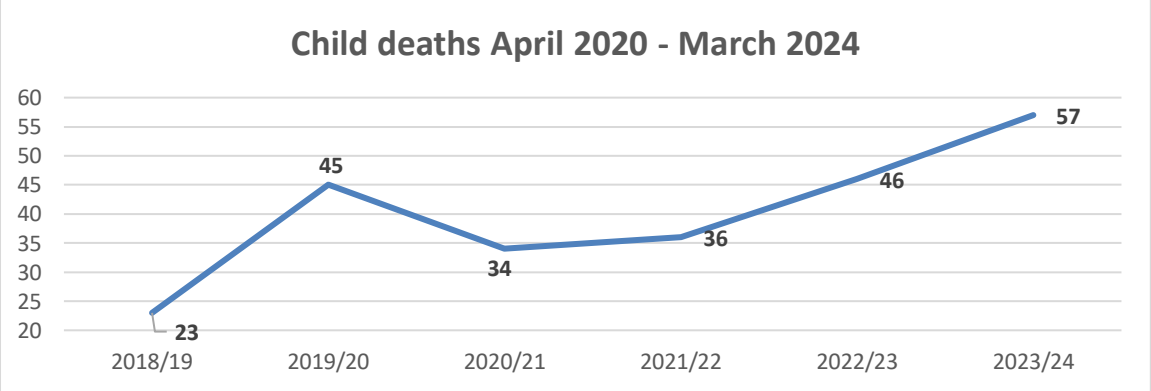
The most common recorded modifiable factors by CDOPs during reviews of deaths of children aged 1 – 17 years were poor communication between agencies (46, 12% of child death reviews (1 – 17 years) with categorised modifiable factors, 4% of all child death reviews (1 – 17 years)), issues with treatment (e.g., delay in starting treatment, side effects or complications developed as a result of treatment, or medical or surgical error) (37, 9%, 3%) and lack of appropriate supervision (e.g., young child unsupervised in a bath) (34, 9%, 3%).

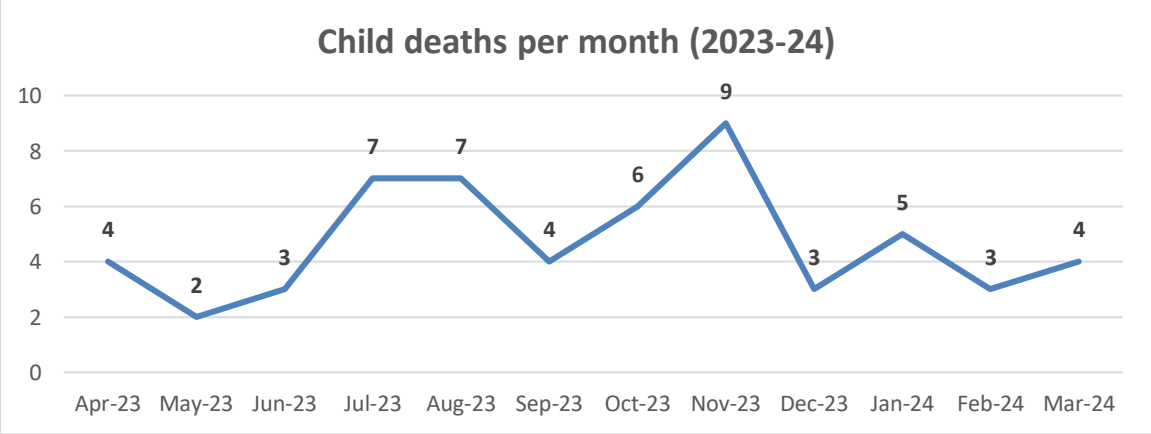
National figures – category of death and numbers of modifiable factors identified for reviewed cases:



6. Themes and trends

There has been a 24% increase in the number of child deaths locally in comparison to 2022/23 although there are no clear themes to account for this increase. The highest reporting month for notifications in 2032/24 was November 2023 with nine deaths having been reported into CDOP.





7. Learning points

The CDOP identified 23 learning points from 14 of the 28 cases reviewed in 2023/24, with some learning points being derived from serious incidents (SI's), Trust level child death review meetings (CDRM's) and perinatal mortality review toolkit (PMRT) meetings, all of which feed into the final CDOP review. One of the reviews had been subject to a child safeguarding practice review (CSPR), these learning points are monitored by the Safeguarding Partnership Board and are therefore not included in this report.

Agency/service specific learning is fed back via the agencies CDOP representative, where there is multi-agency learning the child death review team will ensure this is disseminated via appropriate channels such as a quarterly newsletter which was implemented at the start of 2023/24 to ensure timely learning from CDOP is shared across the system, Trust level mortality committee's and via the Safeguarding Partnership Board.

Actions taken forwards by the child death review team following identification of learning were as follows:

- Disseminating information across all local Health organisations regarding the importance of offering Vitamin K to newborn babies.
- Internal escalation to the ICB regarding the lack of respiratory physiotherapy service in the community.
- Feedback to the Peterborough and Cambridge Rape Crisis Care Group around training provided to professionals to ensure staff are equipped to support victims.
- Ongoing dissemination amongst agencies regarding the offer available via the Each Anglia Children's Hospice (EACH) for children and their families.

8. Unexpected deaths

There were 27 sudden, unexpected deaths during 2023/24, which is an increase from 17 in 2022/23 and 11 in 2012/22. This equates to an increase of 59% within the financial year.

Unexpected deaths are deaths in which 24 hours prior to the event you would not have expected a child to die. Unexpected, unexplained deaths are subject to a joint agency discussion between Police and the rapid response Doctor(s), at this point they may also decide to undertake a joint home visit.

Criteria for a joint home visit –

- The death is or could be due to external causes
- The death is sudden and there is no immediately apparent cause (incl. SUDI/C)
- The death occurs in custody, or where the child was detained under the Mental Health Act
- Where the initial circumstances raise any suspicions that the death may not have been natural
- In the case of a stillbirth where no healthcare professional was in attendance.

Cambridgeshire and Peterborough have five rapid response Doctor's who work on a rotational basis to cover all days of the year, 8am – 8pm. The rapid response Doctor's are also available to provide professionals with advice following an unexpected death, alongside supporting Police with the joint agency response.

During the reporting period 18 joint discussions took place between Cambridgeshire Constabulary and the rapid response Doctor. Of those a joint home visit took place in 13 cases, with the remaining being a Police only visit due to the circumstances of the child's death. One death which occurred during the reporting period was not reported to the Police or rapid response Doctor despite meeting the criteria

for a joint agency response, following this incident learning has been disseminated and shared with those involved.

9. Engagement with families/carers

Following the death of a child the child death review team write to all families, offering them the opportunity to be a part of the review, as well as sharing a number of resources with them to access bereavement support. In the reporting period 2023/24 all parents/carers were written to by the team, and of those two contacted the team to share their views and wishes.

All families are entitled to an identified professional who can support them following the death of their child, this person is often known as the 'key worker'. When a death is classed as unexpected a lead professional/key worker may be identified during the joint agency response (JAR) meeting, they should be in regular contact with families as required and would also be expected to meet with them to discuss the findings of the post mortem report if they wish to do so.

The main duties of the key worker are –

- To be a reliable and readily accessible point of contact for the family after the death.
- To help co-ordinate meetings between the family and professionals as required.
- To be able to provide information on the child death review process and the course of any investigations pertaining to the child, including liaising with the coroner's officer and any police family liaison officer.
- To represent the 'voice' of the parents at professional meetings, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards.
- To signpost to expert bereavement support if required.

During the financial year, North West Anglian NHS Foundation Trust (NWAFT) have put provisions in place for a named key worker within the Trust who can consistently support all families whose children's have had contact with, or have died in, one of their hospital sites. To date the NWAFT key worker has supported 12 families in total, with families sharing that they liked being able to talk to one person and know who to contact for a link with the hospital. Families have found it comforting to have extra support and signposting to help them through the bereavement process.

10. Achievements

During the financial year the Child Death Overview Panel (CDOP) has welcomed the local area Coroner as a permanent member. This will ensure that learning from local child deaths is shared amongst the Coronial service and will allow for their expertise to be utilised as part of each review. In addition to this, a local General Practitioner (GP) has also joined the panel as a permanent member and is able to offer their expertise within Primary Care to the review process, as well as ensuring learning and positive elements of care identified in reviews is shared amongst the practices in Cambridgeshire and Peterborough.

The child death review team has reached a rate of 100% in contacting families following the death of their child.

Cambridgeshire University Hospitals NHS Foundation Trust (CUHFT) have implemented a dedicated child death review team during the financial year. This team consists of a lead Doctor for child death review, two lead Nurses and an administrator. The Cambridgeshire and Peterborough child death review team have been working closely with them to support Trust level processes and strengthening of engagement with the child death review.

The Designated Doctor for Child Death Review led several training sessions for Cambridgeshire Constabulary, ensuring that all staff are aware of the process and purpose of the review.

11. Working Together to Safeguard Children (2023)

Following a public consultation the new version of Working Together to Safeguard Children was published in December 2023. The revision to the guidance focuses on strengthening multi-agency working across the whole system of help, support and protection for children and their families, keeping a child-centered approach while bringing a whole-family focus, and embedding strong, effective and consistent multi-agency child protection practice. Chapter 6 of the new guidance relates to child death reviews and a summary of the main changes is below:

1. The language describing the responsibility of 'child death review partners' towards the review of deaths of non-resident children who have died in their area has been strengthened ('if they consider it appropriate' to 'as indicated').

2. It reflects new guidance requiring coroners to send post-mortem reports to CDOPs for relevant child death reviews.

3. The language around the responsibility to inform relevant safeguarding partners and the Child Safeguarding Practice Review Panel where there has been evidence of abuse or neglect has been strengthened to include all professionals.

Following this update to statutory guidance the Cambridgeshire and Peterborough child death review team took the following action to ensure ongoing compliance:

1. Cambridgeshire and Peterborough child death review team regularly engage with the quarterly East of England CDOP meeting to share updates, best practice and learning across the region. As part of this meeting, discussions have taken place regarding leading and/or supporting reviews for non-resident children who have died in area. It has been agreed that such incidences will be discussed between child death review teams, to agree where support for bereaved families, as well as possible learning is best placed to sit geographically.

   The Cambridgeshire and Peterborough child death review team also provide regular updates at Trust level mortality committees. Attendance at these committees ensures oversight of all deaths in the area, regardless of whether the child is resident here or not.

2. Prior to the updates made to Working Together to Safeguard Children (2023) the Cambridgeshire and Peterborough child death review already had a local level agreement in place with the Coroner regarding sharing of post mortem reports to support both feedback to families, and timely reviews. This continues to be monitored by the team who have a positive and well-established working relationship with the Coroner's office.

3. For all unexpected child deaths, the child death review team organise and chair a joint agency response (JAR) meeting with professionals who knew the child. The JAR meeting considers, as a standing agenda item, whether a Child Safeguarding Practice Review (CSPR) referral should be made where there are concerns regarding abuse and neglect. Safeguarding partners are notified of all child deaths (expected or not) as part of the scoping process and follow internal reporting procedures where there are concerns.