Norfolk Safeguarding Children Board

Norfolk Child Death Overview Panel

Annual Report 2016-2017

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Definitions

Unexpected death of a child

An unexpected death is defined by the Department of Education as the death of an infant or child, which was not anticipated as a significant possibility 24 hours before the death, or where there was similarly unexpected collapse or incident leading to or precipitating the events that led to the death[1].

Preventable child deaths

Preventable child deaths are those in which modifiable risk factors may have contributed to death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths [1].

Legislation

Regulations relating to child death reviews

Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14 of the Children's Act 2004 sets out the boards responsibilities in relation to the child death review process. It states that Local Safeguarding Children's Boards are responsible for;

Collecting and analysing information about each death with a view to identifying any

I. case giving rise to the need for a review as mentioned in regulation 5(1)(e)

II. matters of concern affecting the safety and welfare of children in the area of the authority

III. wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

1 **Department of Education** (2016) *Working together to safeguard children*

1.0 Introduction

The aim of this report is to summarise the work of the Norfolk Child Death Overview Panel (CDOP) during 2016-2017. It provides a summary of all deaths notified to the Norfolk Local Safeguarding Children's Board (LSCB) between the period of 1st April 2016 and 31st March 2017, and analysis of the trends of child deaths since 2008 when figures were first collected.

Key findings for Norfolk 2016/17

The deaths of 41 children aged 0-17 years were reported to the Norfolk CDOP

29 reviews were completed, 83% within 12 months of the child's death

The Infant Mortality Rate and Child Mortality Rate for Norfolk are statistically similar to those of England

Issues identified from the reviews undertaken included co-sleeping, smoking in pregnancy, guidelines for health professionals, education relating to the safe use of social media, awareness of the importance of vaccinations during pregnancy and availability of bereavement support.

2.0 Background and Functions of the Child Death Overview Panel (CDOP)

Established in 2008 as a new statutory requirement[1], CDOP's primary function is to undertake a comprehensive and multiagency review of all deaths of children aged under 18, resident in Norfolk. The purpose is to understand how and why children die, put in place interventions to protect other children, and prevent future deaths.

This is achieved by:

- Reviewing the available information on all deaths of children up to 18 years (including deaths of infants aged less than 28 days) to determine whether there were any modifiable risk factors which may have contributed to the child's death
- Collecting, collating and reporting to an agreed national data set for each child who has died
- Meeting regularly to review and evaluate the routinely collected data for the deaths of all children, and thereby identifying lessons to be learnt or issues of concern
- Monitoring the response of professionals to an unexpected death of a child
- Referring to the Chair of the local Safeguarding Children Board (LSCB) any deaths where the panel considers there may be grounds to consider a serious case review
- Monitoring the support services offered to bereaved families
- Identifying any public health issues and considering, with the Director of Public Health, how best to address these and their implications for the provision of both services and training

Reviewing deaths involves collating information on the cause, location and other circumstances of deaths. It is not an investigation into why a child has died and it is not a serious case review, although a serious case review may be completed in respect of a death where abuse or neglect is considered to be a factor.

[1] **Department of Education** (2016) *Working together to safeguard children*

As the CDOP process has evolved reviews of similar deaths in subsequent years may have resulted in different assessments of whether there were modifiable factors. Emerging local trends might suggest that deaths have been assessed as having 'modifiable' factors, when previously this might not have been the case[2].

2.1 The principles

Four underlying principles guide the overview of all child deaths:

1) Every child's death is a tragedy
2) Learning lessons
3) Joint Agency Working
4) Positive action to safeguard and promote the welfare of children

3.0 The Process

3.1 Improvements to the Norfolk CDOP arrangements

In 2015 an Ofsted inspection[3] considered the work of CDOP to be 'underdeveloped', the annual report for 13/14 had not been completed, attendance at panels was inconsistent and a third of meetings had been cancelled. This had led to a backlog of cases (84 children) that had not been reviewed.

Actions were taken in 2015/16 to improve the systems and processes in place for CDOP, to support timely and systematic review of cases, to improve the governance and communication arrangements and to support raising awareness of modifiable factors where identified.

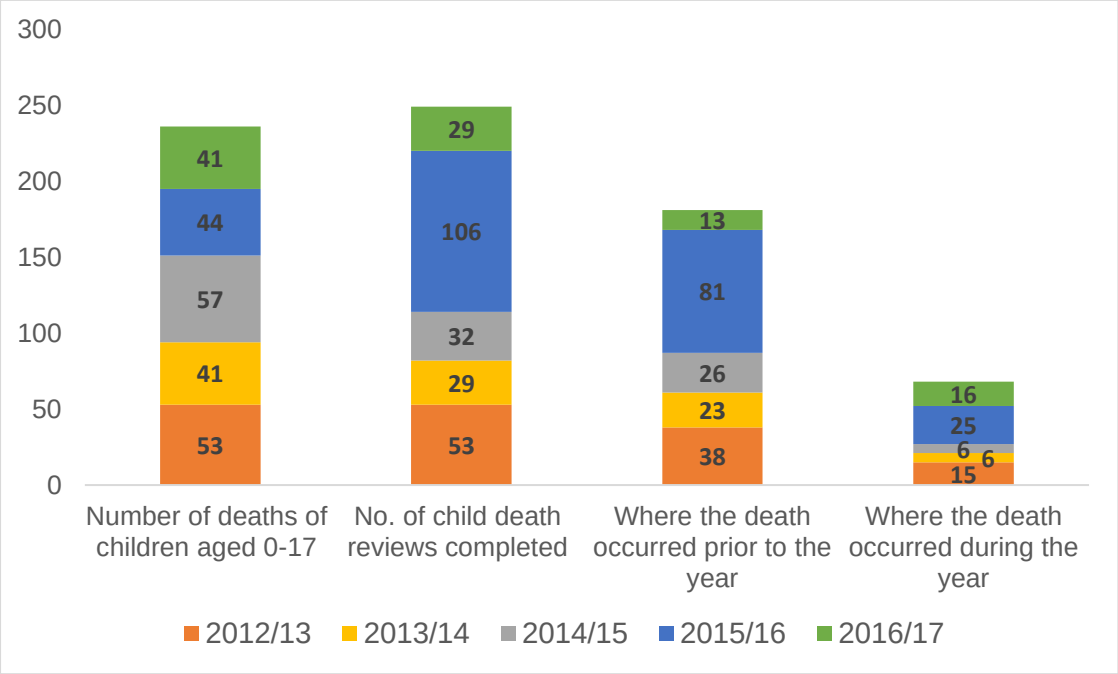
Throughout 2016-17 CDOP has been chaired by a Consultant in Public Health; panels have been held consistently every two months; information to support the panel to review cases in a timely fashion is collected via a system based on national guidelines; and a database to record information and monitor the status of outstanding cases has been put in place

Due to taking action to address the backlog of cases in 2015/16, the number of cases reported to have been reviewed in 2015/16 increased significantly compared to previous years (Figure 1). This should be taken into consideration when comparing the statistics for Norfolk compared to other areas or previous and subsequent years. It is important to note this does not reflect an increase in the number of deaths reported. The number of cases reviewed in 2016/17 reverted in line with previous years.

[2] **Department of Education** (2016) *Child Death Reviews – Year ending 31 March 2016*

[3] https://reports.ofsted.gov.uk/local-authorities/norfolk

Figure 1: Norfolk's Child Death Overview Panel activity 1st April 2013 - 31st March 2017 (Source: CDOP database)



3.2 Duration of reviews

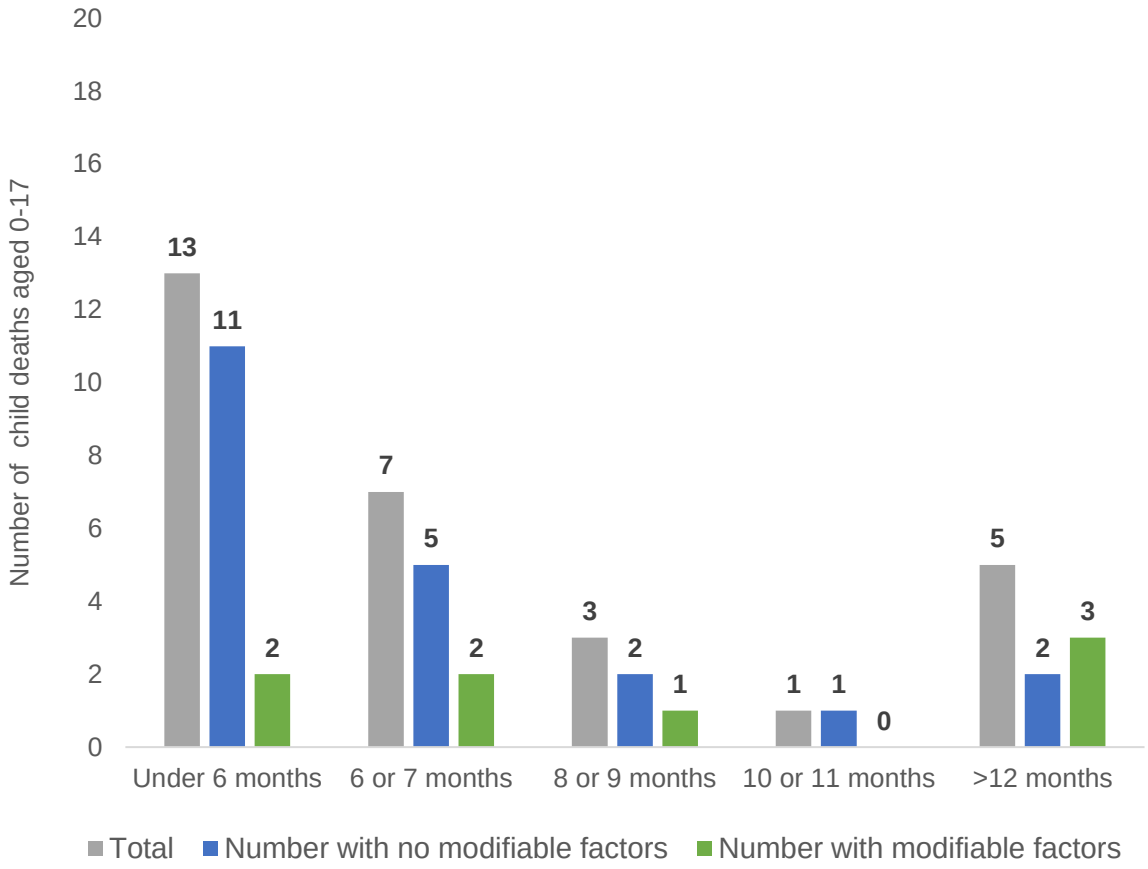
The circumstances surrounding each child death are different and the timeliness of the CDOP review depends upon the length of time other investigations take to be completed (such as police and hospital investigations, coroner's inquests and Serious Case Reviews).

There is no set standard, but nationally 76% of reviews were finalised within 12 months of the child's death in 2016/17, which was an improvement from 70% in 2015/16.

In Norfolk, during the period 1st April 2016 – 31st March 2017, 83% of child death reviews completed were finalised within 12 months of the child's death (Figure 2), this is a significant improvement on the previous year when 52% had been completed within 12 months of the child's death.

Last year our aim was to move towards the national average to improve the timeliness of our reviews and avoid a backlog of cases building up in the future. We have exceeded our target and aim to continue to meet or exceed the national average next year.

Figure 2: Time taken to complete child death reviews in Norfolk 1st April 2016 - 31st March 2017



4.0 Infant and Child Mortality rates

Infant mortality is the term used to describe the death of children before their first birthday. The infant mortality rate (IMR) is the number of infant deaths that occur for every 1,000 live births. IMR can be used as an indicator to measure the health and well-being of a population, as factors affecting the health of the entire population can impact mortality in infants.

Since 2001-2003 infant mortality in England has been steadily decreasing from a rate of 5.4 to 3.9 in 2013-2015, the same trend has occurred in the East of England region; from a rate of 4.5 in 2001-2003 to 3.4 in 2013-2015 (Figure 3).

In Norfolk, the infant mortality rate does not follow the same smooth downward trend as England and the East of England, but this should be interpreted with caution due to the small number of infant deaths involved. The confidence intervals corresponding to the infant mortality rate for Norfolk, shown in Figure 3, incorporate the national and regional infant mortality rates; suggesting that Norfolk's infant mortality rate is not significantly different from the rest of the country. Figure 4 shows that Norfolk's infant mortality rate is comparable with other upper tier local authorities in the East of England.

Figure 3: Crude Infant Mortality Rates per 1000, East of England, England and Norfolk: 2001-2015

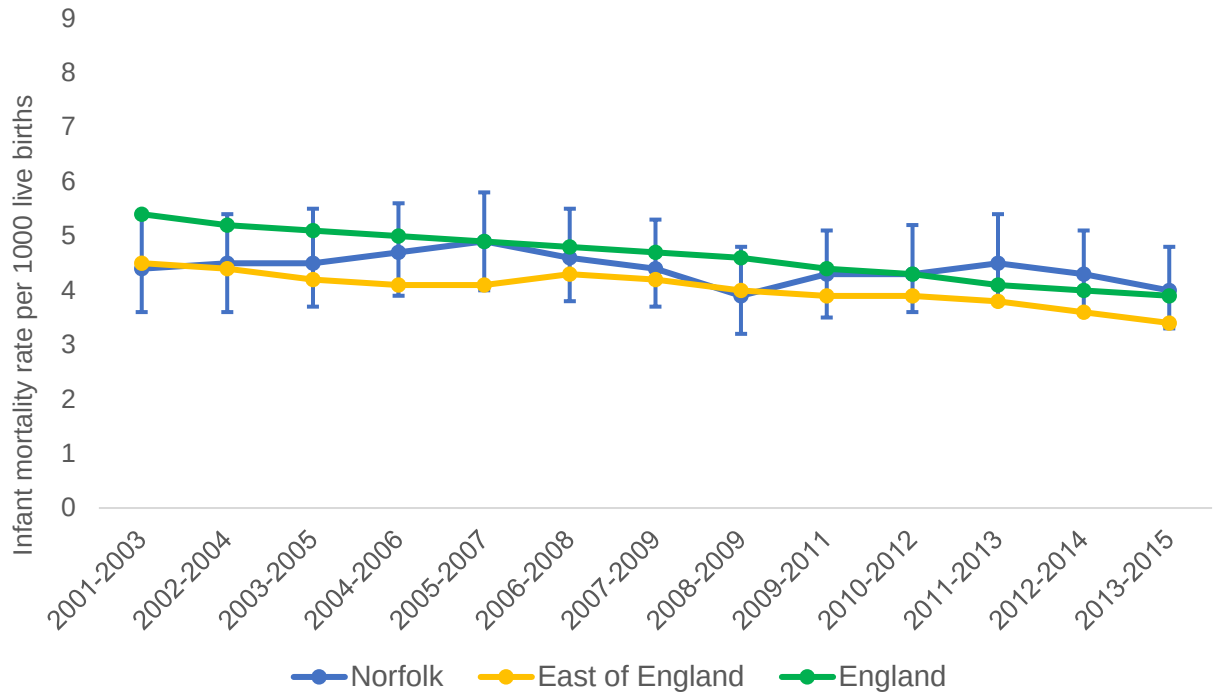
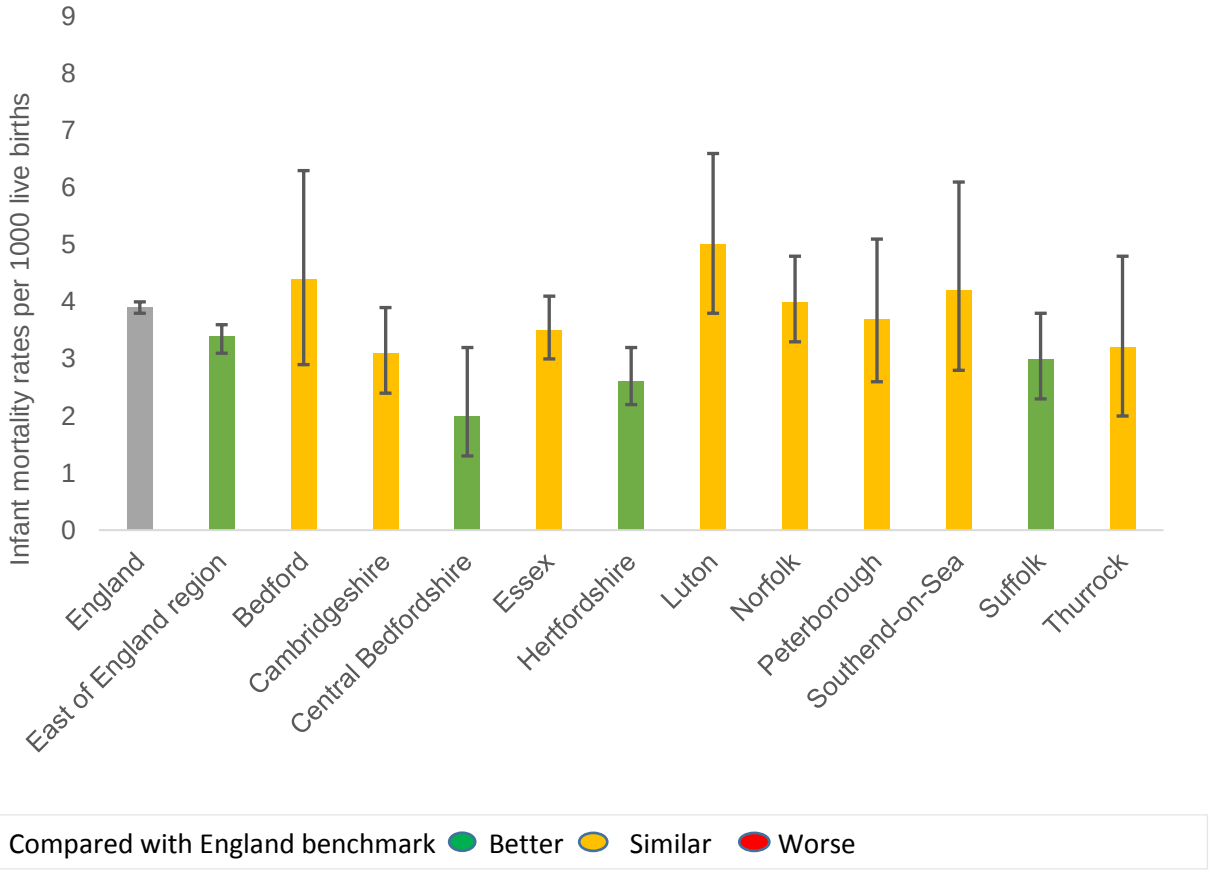


Figure 4: Crude Infant Mortality Rates per 1000, East of England upper tier authorities: 1st April 2013 – 31st March 2015



4.1 Child Mortality

Child mortality is the term used to describe the death of children aged 1-17. The child mortality rate is the number of child deaths for every 100,000 people alive in the population aged from 1-17. To make it possible to compare child mortality rates between regions the number of deaths is applied to a standard population distribution, which produces a standardised rate of child mortality if each region had the same number of children aged 1-17.

Death in childhood represents not only a tragedy for the child's family but also a loss to wider society in terms of years of productive life, in which they contribute to society. Many of the causes of child deaths are potentially avoidable, making it important to monitor child mortality in relation to interventions such as vaccination programmes, road safety and mental health.

Since 2010-2012 child mortality in England has decreased slightly from 12.5 to 11.9 in 2013-2015, in the East of England it has decreased from 11.6 (2010-2012) to 10.4 in 2013-2015 (Figure 5).

In Norfolk, the child mortality rate appears to have slightly increased between 2013-2015, however the results must be interpreted with caution due to the small number of child deaths involved. The confidence intervals corresponding to the child mortality rate in Norfolk, shown in Figure 5, incorporate the national and regional child mortality rates; suggesting that Norfolk's child mortality rate, like infant mortality, is not significantly different from the rest of the country. Figure 6 shows that Norfolk's child mortality rate is also comparable with other upper tier authorities in the east of England.

Figure 5: Directly Standardised Child Mortality Rate per 100,000, East of England, England and Norfolk: 2010-2015

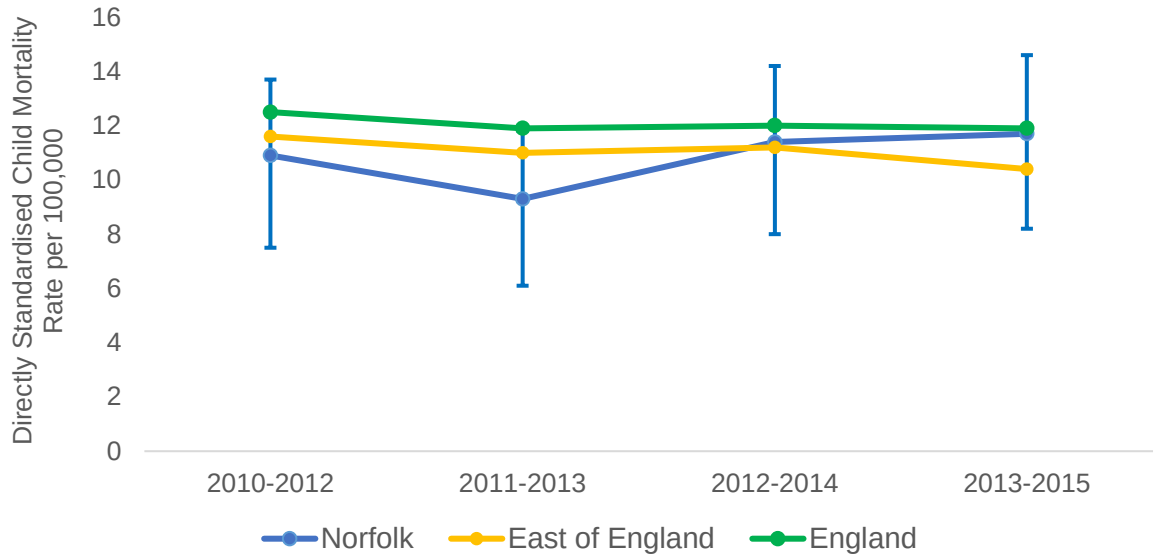
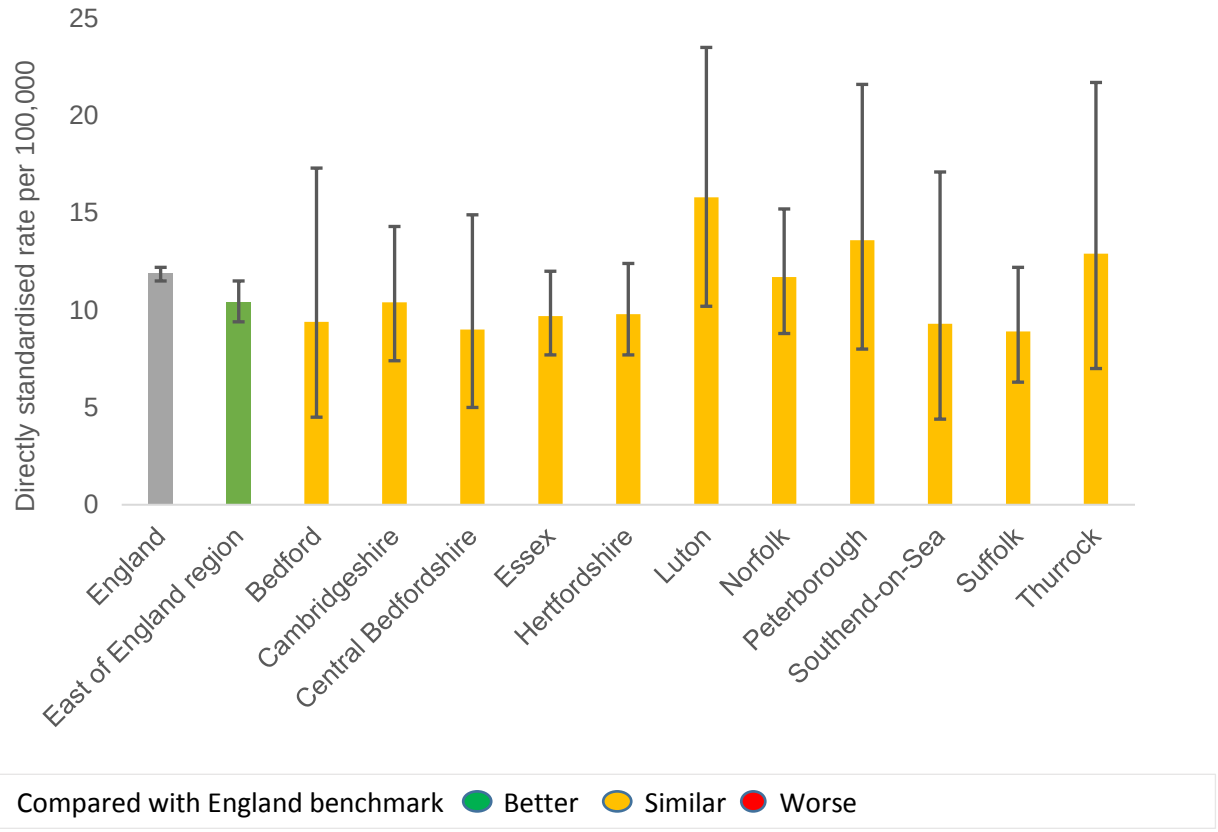


Figure 6: Directly Standardised Child Mortality Rates per 100,000, East of England upper tier authorities 2013-2015



5.0 Overview of CDOP Reviews

5.1 The National picture

Nationally the number of completed child death reviews has fallen slightly over the last year (1st April 2016 – 31st March 2017), after a slight rise in the previous year (Figure 7). The proportion of deaths assessed as having modifiable factors increased from 24% to 27%.

5.2 East of England and Norfolk CDOP Reviews

The number of completed child death reviews in the East of England and Norfolk reflects the national picture, with a drop in the number of completed reviews in 2015-2017, following an increase in 2015/16 (Figure 8). It must be noted that the numbers of reviews undertaken in Norfolk in 2015/16 were disproportionately higher than normal (see 3.1).

The proportion of deaths assessed as having modifiable risk factors in the East of England was 32%; this remains higher than the proportion with modifiable factors in the aggregate England data. The proportion with modifiable factors in Norfolk was 28%, a 4% increase since last year, and 1% higher than the England average (27%).

Figure 7: Number of completed child death reviews in England: 2012-2017

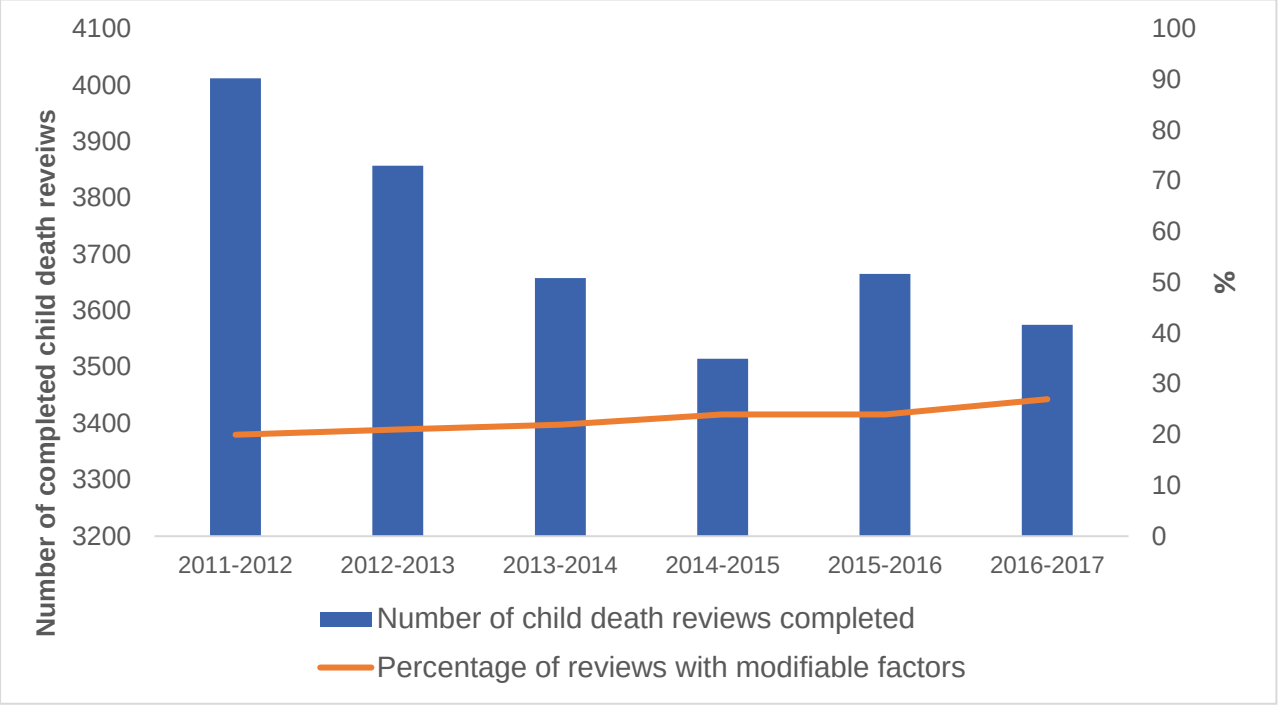
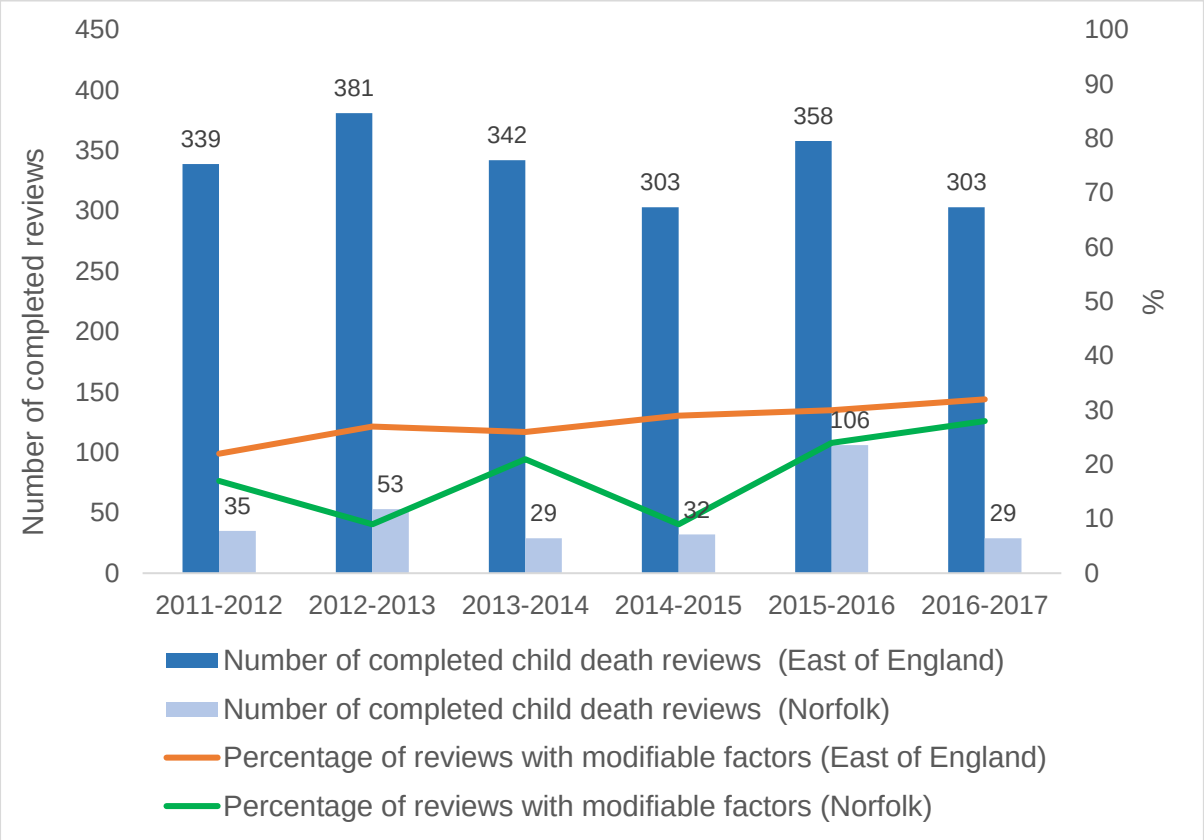


Figure 8: Number of completed child death reviews in the East of England and Norfolk: 2012-2017



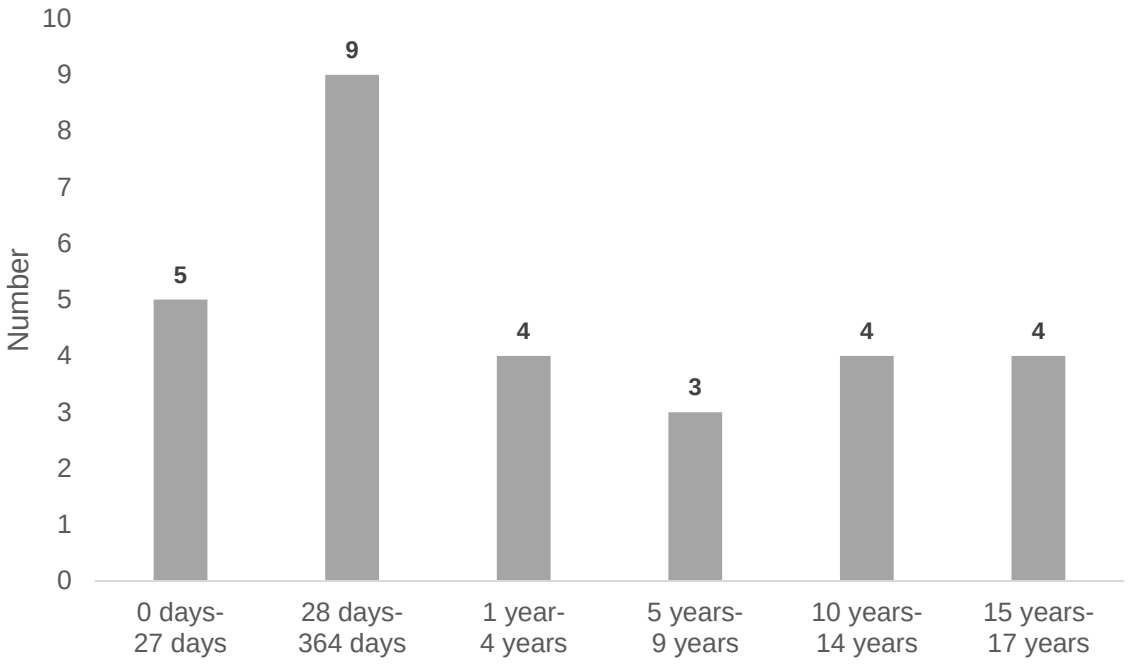
6.0 Norfolk CDOP analysis 2016/17

6.1 Characteristics

6.1.1 Age

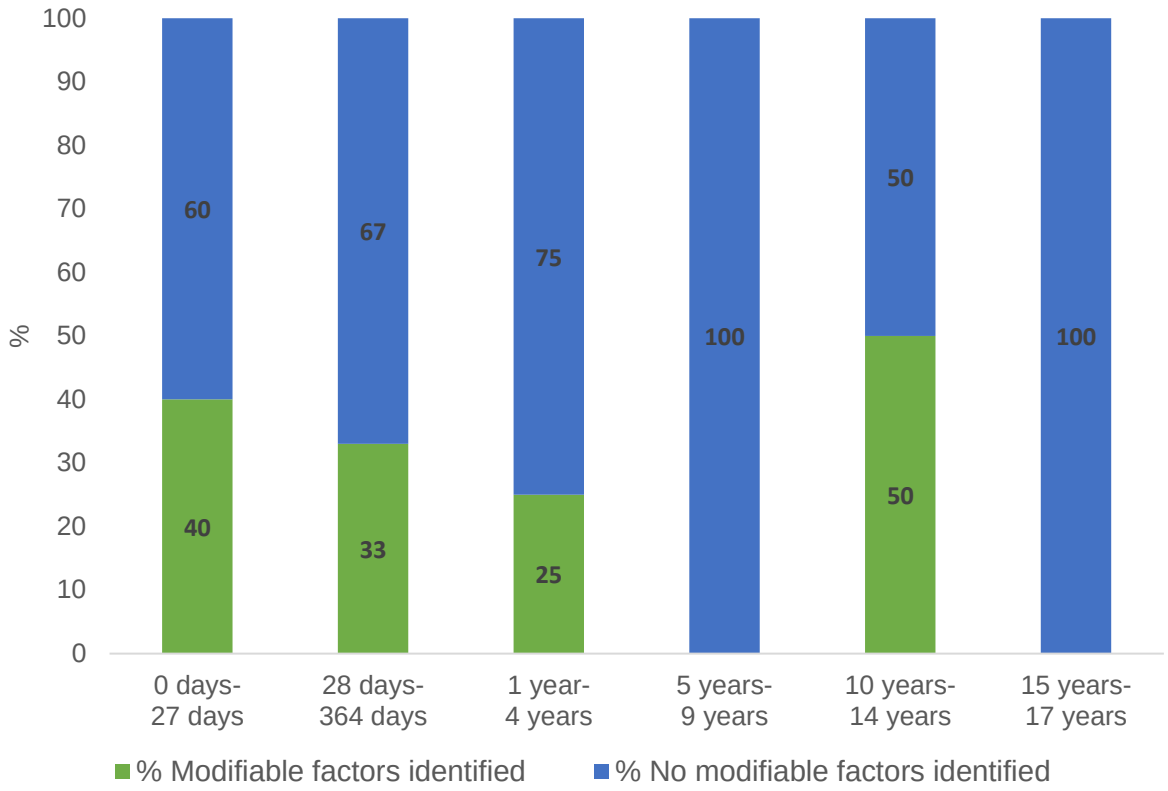
Almost half (48% 14/29) of the reviews completed from 1st April 2016-31st March 2017 were of children who died under the age of one (Figure 9). 17% of the children were aged 0-27 days; and a further 31% age between 28-364 days at the time of death.

Figure 9: Number of child death reviews completed by age in Norfolk 2016/2017



Children aged 10-14 years had the highest proportion of deaths assessed as having modifiable factors (50%); followed by those aged 0-27 days (40%). Children aged 5-9 years and 15-17 years had no deaths assessed as having modifiable factors (Figure 10).

Figure 10: Proportion of child death reviews assessed as having modifiable factors by age: Norfolk 2016/2017

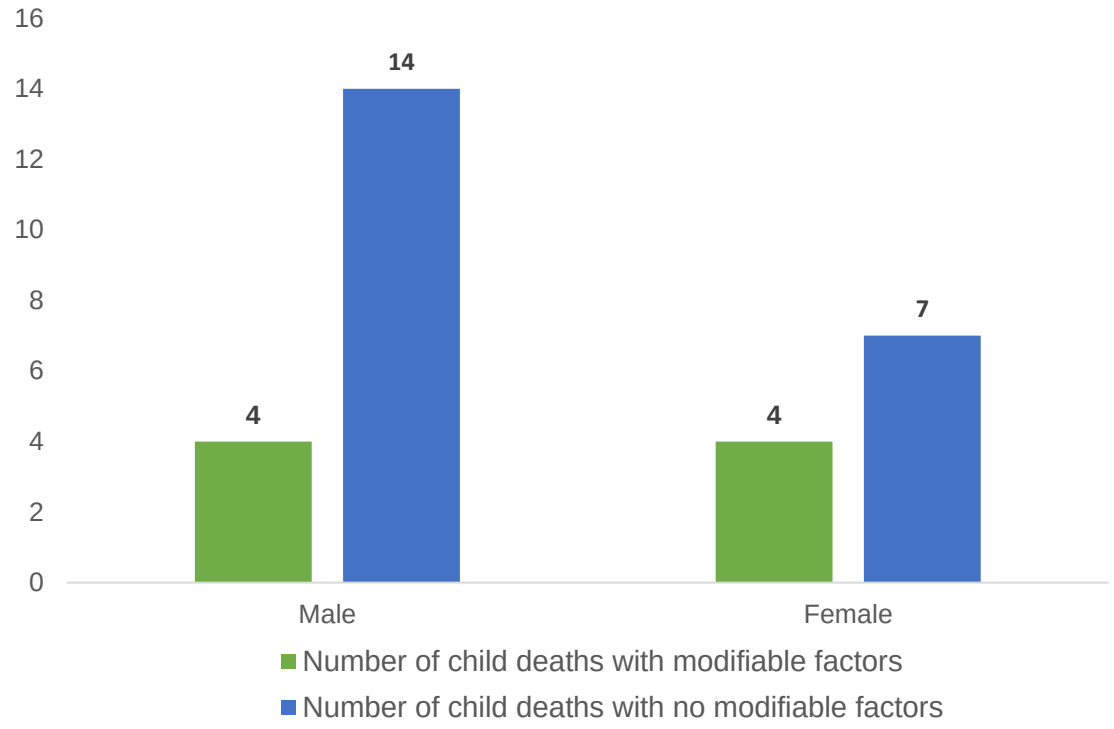


6.1.2 Gender

62% of deaths occurred in males compared to 56% nationally.

Nationally, reviews identified a slightly higher percentage of boys with modifiable factors (28%) than girls. In contrast, in Norfolk 57% of females had modifiable factors compared to 28% of males (Figure 11).

Figure 11: Number of child deaths assessed as having modifiable factors by gender: Norfolk 2016/2017



6.1.3 Ethnicity

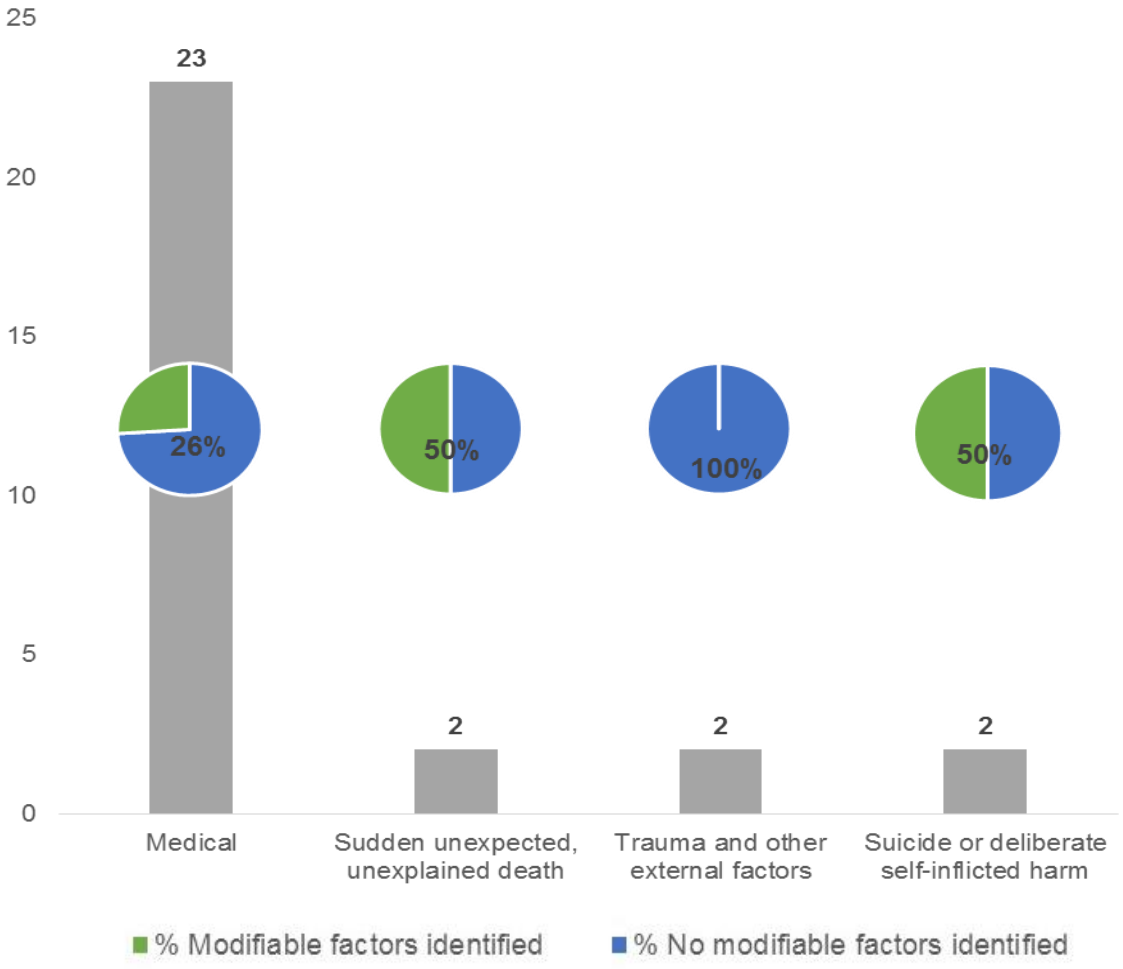
Ethnicity data was reported for 72% (21/29) of cases reviewed from 1st April 2016-31st March 2017. White: English/Welsh/Scottish/Northern Irish/British ethnicity was reported for 17 of the children representing 81% of all children who had ethnicity recorded. In four of the eight child deaths where modifiable factors were identified ethnicity was not reported.

This is a significant improvement from last year when only 35% (36/104) of child deaths reviewed by the panel had ethnicity recorded, however there is still room for improvement for the panel in 2017/18.

6.2 Circumstances

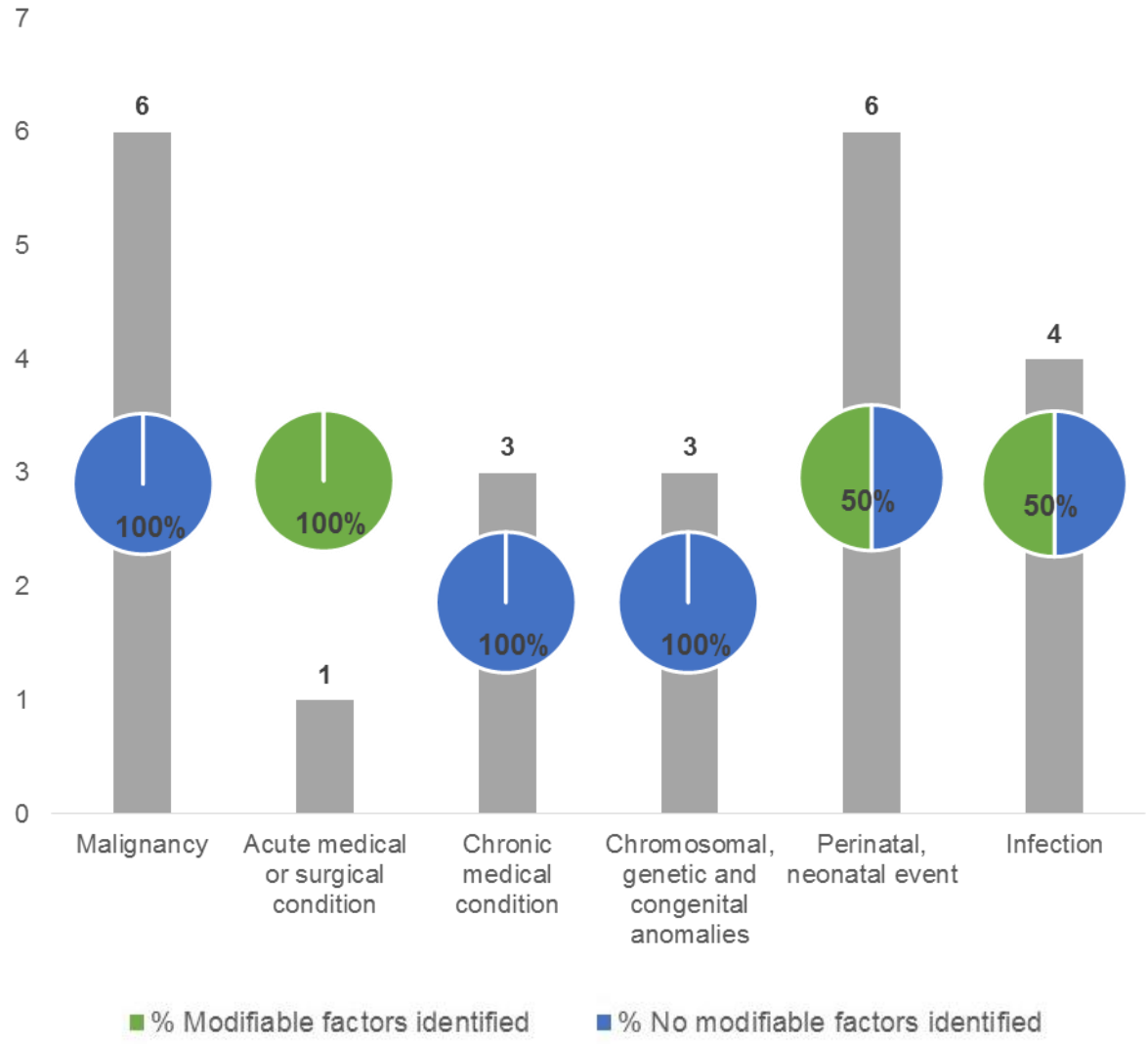
Figure 12 shows the rate of deaths reviewed and percentage with modifiable factors by category of death. Child deaths due to medical causes, including malignancy; acute medical or surgical condition; chronic medical condition; chromosomal, genetic and congenital anomalies; perinatal/neonatal event; and infection represent the largest category of child deaths; this is consistent with previous years.

Figure 12: Number of deaths reviewed and percentage with modifiable factors by category of death: 2016/2017



26 % of child deaths due to medical causes were assessed as having modifiable factors; deaths as a result of malignancy, chronic medical condition and chromosomal genetic and congenital anomalies were not assessed as having any modifiable factors (Figure 13). Perinatal, neonatal events represented the medical category with the highest number of identified modifiable factors (three out of six cases) followed by infection (two out of four cases).

Figure 13: Number of child deaths reviewed due to medical causes and percentage with modifiable factors: 2016/2017



In the year ending 31st March 2017, 45% of the deaths reviewed occurred in an acute hospital or hospice compared with 73% nationally; 41% died in their home of normal residence. Deaths occurring in an acute hospital or hospice had a lower percentage of modifiable factors (23%) compared to 33% in deaths occurring at home. This is similar to the national picture.

6.3 Modifiable factors identified

The panel identified modifiable factors "one or more factors, in any domain, which may have contributed to the death of the child, and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk in future" in 28% (8/29) of the child death cases reviewed. These factors included co-sleeping; smoking in pregnancy; lack of clear local or national guidelines for medical professionals; delays in identification of a sick child; education about the safe use of social media; and public awareness of the importance of vaccinations during pregnancy. Access to bereavement support was also identified as an area for further consideration.

7.0 Actions taken in response to modifiable risk factors and trends identified in 2015/16

7.1 Child deaths due to Meningitis, Septicaemia and Sepsis in Norfolk

Vaccination has played a major role in preventing infections in the UK; however they cannot prevent all strains of infections, which can still cause life threatening conditions, particularly in vulnerable members of the population (such as the very young). The prompt recognition of the signs and symptoms of serious conditions such as meningitis, septicaemia and sepsis is key to preventing the deaths of children and young people.

In Norfolk, 11 children died from meningitis, septicaemia or sepsis from 1st April 2012 to 31st March 2016.

An analysis was undertaken to review the incidence of meningitis, meningococcal disease and septicaemia and deaths due to these infections; review the factors contributing to those deaths; identify any system-wide issues and to formulate recommendations that could contribute to reducing child deaths in Norfolk in the future.

7.1.2 Key findings

- Between 1st April 2012 and 31st March 2016, infection as cause of death has been attributed to 5.5% (805/14,648) of all child deaths in England and 8.1% (18/222) of all child deaths in Norfolk. However the small number of child deaths in Norfolk make national comparisons difficult and should be interpreted with caution.
- In England and Wales, the number of deaths due to meningococcal disease and sepsis, in children and young people aged 0-24, increased in all age groups from 2014-2015.
- In Norfolk 11 child deaths (aged 0-17) from 1st April 2012 to 31st March 2016 were attributable to meningitis, septicaemia or sepsis. The proportion of child deaths due to infection in Norfolk is not statistically different from the rest of the country.
- The proportion of children vaccinated against all possible types of infections which can cause meningitis in Norfolk is higher than the rest of England.
- Modifiable factors were identified during Norfolk CDOP reviews of four child deaths which identified common themes relating to delays recognising a sick child by healthcare professionals and delays receiving appropriate treatment, which may have contributed to their death.
- No system wide issues were identified.
- Individual Organisations involved provided feedback that they had acted on the areas for improvement highlighted by the Child Death Overview Panel.

7.1.3 Actions undertaken as a result of the analysis

1. NHS Commissioners and the NSCB sought assurance that NICE guidance relating to the management of sepsis is fully implemented across the system.

   a. In line with NICE guidance, local protocols for the identification and management of children and young people with sepsis should be up to date and regularly audited, in Hospitals, Ambulance service and GP practices.

b. NSCB included this as part of the Section 11 audit.

2. The NSCB Health Advisory Group (HAG) shared the findings and to continue to raise awareness of signs of infection and sepsis with families and the wider NHS, education and social care workforce, and stressing the importance of early action.

3. A communications process for CDOP findings has been established to ensure:

a. That improvements identified have been actioned

b. Commissioners are kept informed of any issues identified

c. Lessons are shared across the wider health and social care system, beyond those directly involved in the child's death

7.2 Child deaths due to Sudden Infant Death Syndrome

Sudden Infant Death Syndrome (SIDS) is the sudden and unexplained death of an apparently healthy baby under the age of one, where no cause of death is found after detailed post mortem. There is extensive evidence which demonstrates that the risk of SIDS can be significantly reduced by following safer sleeping guidance.

The annual rate of SIDS cases in Norfolk is on a par with the rate in the rest of the UK (0.3 per 1000 live births (95% CI for Norfolk 0.0-0.9)). In November 2016 an analysis was undertaken on child deaths due to SIDS in Norfolk. Since April 1st 2013 to March 31st 2016 there had been eight child deaths with cause of death documented as being due to sudden infant death syndrome on the coroner's report in Norfolk. The median age of the SIDS cases was 48 days (IQR 36.5-66.75 days). In four of the eight deaths (50%) co-sleeping was identified as a risk factor contributing to the babies' deaths. In two of the four cases parents reported co-sleeping as they were not in their own residence and didn't have a travel cot or alternative for the baby to sleep in. In two of the eight cases (25%) alcohol and drugs were identified as potential hazards contributing to death. In three of the eight deaths (37.5%) there was evidence of over-wrapping or heating which could have led to the possibility of a restriction to ventilation and breathing, or risk of smothering.

As a result of these findings CDOP have established a multi-agency sub-group to design and develop a social media campaign which will deliver consistent Sleep Safe messages to the Norfolk population. The campaign is due to be launched in December of this year.

8.0 Forward Plan for 2017/18

1. Launch and evaluate Norfolk's Sleep Safe Campaign
2. Continue to develop new CDOP reporting and monitoring system.
3. Complete the review of the Child death policy for the management of unexpected deaths and booklet for parents.
4. Continue to analyse the modifiable factors for every child death to identify trends or areas for further in-depth analysis and action.

8.1 Children and Social Work Act 2017- implications for Child Death reviews

The Children and Social Work Act 2017 includes new provisions for the local arrangements for safeguarding and promoting the welfare of children, including child death reviews. Local Safeguarding partners will need to work together to agree the local arrangements for Child death reviews in the future.

Representatives from the Norfolk CDOP will work with regional colleagues as part of an East of England group to identify best practice for the future.

Appendix A: Norfolk Children Safeguarding Board Child Death Overview Panel – Terms of Reference

1 Purpose

To undertake the responsibility for ensuring that a review of each death of a child normally resident in Norfolk is undertaken by a Child Death Overview Panel (CDOP) in accordance with chapter 5 of Working Together to Safeguard Children 2013.

2. Responsibilities

2.1 Core functions of the CDOP include:
2.1.1 Reviewing all child deaths up to the age of 18, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
2.1.2 Collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
2.1.3 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
2.1.4 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;
2.1.5 Making recommendations to Norfolk Safeguarding Children Board (NSCB) or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
2.1.6 Identifying patters or trends in local data and reporting these to the Norfolk Safeguarding Children Board (NSCB)
2.1.7 Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the NSCB's Chair for consideration of whether an SCR is required;
2.1.8 Agreeing local procedures for responding to unexpected deaths of children;
2.1.9 Cooperating with regional and national initiatives - for example, with The National Clinical Outcome Review Programme - to identify lessons on the prevention of child deaths.

2.2 Work Programme

2.2.1 The Chair and Vice Chair will ensure that membership comprise relevant representatives from all statutory and voluntary agencies involved in working directly or indirectly with children, in accordance with Chapter 5. Attendance will be monitored and reported upon regularly.

2.2.2 The CDOP will maintain a current work plan and produce an annual report containing relevant information for the NSCB. The work plan will include a quarterly themed meeting to discuss emerging issues.

2.2.2 The CDOP will supply anonymised information on child deaths to the Department for Education.

2.2.3 The CDOP will establish, where necessary, time limited task groups that will report back to the Panel. It is the responsibility of the Panel to monitor and support such task groups.

3. Membership

3.1 The Panel will have a fixed core membership drawn from organisations represented on the LSCB with flexibility to co-opt other relevant professionals to discuss certain types of deaths as and when appropriate.

3.2 The Chairing arrangements will be agreed by NSCB on a 2 year agreement.

3.3 Agencies attendance required from:

- Public Health
- Norfolk Police
- Norfolk Coroner
- Norfolk County Council Children's Services–
- Health Services, at least one representative to be agreed from each of the following:
    - Norfolk and Norwich University Hospital Trust, incl reps from
        - Rapid Response Team (countywide)
        - Pathology
    - Queen Elizabeth Foundation Trust
    - James Paget Foundation Trust
    - Norfolk & Suffolk Foundation Trust
    - NCH&C
    - Cambridgeshire Community Services
    - East of England Ambulance Trust
    - Designated Safeguarding Team
    - Hospices

3.4 The Child Death Overview Panel shall be administered (by way of agenda preparation, production and circulation of action notes) by the CDOP Administrator.

3.5 At the start of each meeting, attendees will be asked to sign an attendance sheet. A record of attendance for each member will be reported as part of the annual report to the Norfolk Safeguarding Children Board. Members will be expected to attend no less than 75% of meetings. Any member not attending 3 consecutive meetings will be invited to consider their membership position and this will be reported to the Norfolk Safeguarding Children Board and the Chief Officer of their agency.

3.6 Deputies should attend if a member of the Child Death Overview Panel is not available, but it is incumbent upon members to accept their responsibility for routine attendance and to complete any actions required of them irrespective of whether they are in attendance or not.

3.7 For the Child Death Overview Panel to be considered quorate, at least 3 partner agencies must be represented to include the Consultant Paediatrician and Public Health.

3.8 Each Panel will receive expert advice on governance and remit from an appropriate member of the Safeguarding Business Unit.

4. Linkage to other groups

4.1 The Child Death Overview Panel work will be undertaken on behalf of Norfolk Safeguarding Children Board. An Annual Report, work plan and reporting on an exceptional basis will therefore be an expected outcome from the Sub Group.

4.2 The NSCB Annual Report is presented to the Health & Wellbeing Board, where the NSCB Independent Chair will identify themes for action based on the learning from child deaths.

4.3 The representatives from the NHS Designated Team (Designated Doctor and Nurse) will also report back to the Clinical Commissioning Groups on any quality assurance issues through the NSCB Health Safeguarding Advisory Group.

5. Declaration of interest
5.1 It is the responsibility of each member to declare any conflict of interest with an agenda item either at the start of the meeting or as the discussion unfolds.

6. Business Conduct
6.1 Meetings will be held at least quarterly and unless there are exceptional circumstances, will last for no longer than two hours.

6.2 The agenda for each meeting will be agreed with the Chair prior to publication. Any member of the Child Death Overview Panel is entitled to put an item forward for the agenda. Agendas should be issued at least 5 working days before the meeting and all paperwork should be subject to Chair/Vice Chair control. Minutes from meetings will usually be issued within 10 working days of the meeting.

6.3 All meetings will:

- Start and end on time as agreed
- Show respect for, and value the contribution of each member
- Encourage all members to participate
- Ensure that the agreed work plan is developed and progressed at
- each meeting

6.4 All information received and discussed will remain confidential and must not be shared outside of the meeting without the express permission of the Chair.

7. Monitoring
7.1 The effectiveness of the Child Death Overview Panel will be monitored against:

- Number of times the meeting is held in accordance with its Terms of
- Reference
- Number of times the meeting is quorate
- Level and spread of attendance at meetings
- Feedback from participants by way of the Annual report

8. Governance Arrangements
8.1 The Terms of Reference will be agreed by the Chair and Panel Members.

8.2 Once agreed, the Terms of Reference will be ratified by Norfolk Safeguarding Children Board.

8.3 Terms of Reference will be reviewed biennially.

8.4 Minutes of meetings, works plans and exceptional reporting is open for scrutiny by Norfolk Safeguarding Children Board.

To NSCB Date Ratified: March 2016

Review Date: March 2017