



Pan-Cheshire Child Death Overview Panel

Annual Report

1st April 2016 – 31st March 2017

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Mike Leaf
Independent Chair
Cheshire CDOP
31st October 2017

Forward from the Independent CDOP Chair

This is my first report as newly appointed Independent Chair for the Pan-Cheshire CDOP. I have attempted to present the report in a way that not only reflects on the cases the panel has considered throughout 2016/17, but also the achievements of the partnership, and the future priorities for action.

We anticipate significant changes to the CDOP arrangements following the publication in March 2016 of the Wood Review. The Report recognises that over 80% of child deaths have a medical or public health causation, and therefore recommends that ownership of the arrangements for supporting CDOPs should move to the Department of Health. As a former Director of Public Health, I welcomed this recommendation, but also recognise the importance of continuing the development of well-established relationships with the children's safeguarding partners. Currently, we are still awaiting details about how this transfer will take place and the potential implications that this will have on the workings of CDOP. I see part of my role ensuring that the current processes we have developed across Cheshire are robust and fit for purpose, and provide the necessary assurances to the current and future safeguarding partners. I see another part of the role to have an eye on the future, to ensure that child death reviews are undertaken in the most effective way, and are in line with the latest guidance and within the resources available.

It should be noted that having only recently taken over the Independent Chair role, this Annual Report is limited somewhat in content. I will endeavour, however, to ensure that any issues that come to my attention throughout the year, will be dealt with or escalated to the respective boards, and that there will also be an update against the identified priorities in next year's report.

Thanks are given to all the Panel members, for their continued commitment and hard work to this difficult task, and in particular, to Anne McKenzie for the hard work that goes on behind the scenes to ensure that the Panel runs smoothly. Also a specific thank you goes to Dr Nisar A Mir, Consultant Paediatrician who provided analysis and recommendations concerning modifiable factors that were identified.

Mike Leaf
Independent Chair
Pan-Cheshire CDOP
31st October 2017

Section 1: Executive Summary

The Pan-Cheshire CDOP is a sub-group of the four Local Safeguarding Children Boards (Cheshire East, Cheshire West and Chester, Halton and Warrington LSCBs) and has a statutory responsibility to review the deaths of all children up to the age of 18 years old (excluding infants live-born following planned, legal terminations of pregnancy and stillbirths) resident within the four Local Authority areas. The focus of CDOP should be on identifying any modifiable factors that may help prevent unnecessary future child deaths or harm.

The purpose of this Annual Report is to:

- Clarify and outline the processes adopted by the Pan-Cheshire CDOP
- Assure the four Cheshire LSCBs that there is an effective inter-agency system for reviewing child deaths across Cheshire
- Provide an overview of information on trends and patterns in child deaths reviewed across Cheshire during the last reporting year (2016-17)
- Highlight issues arising from the child deaths reviewed between April 2016 and March 2017
- Report on achievements and progress from last year's annual report
- Make recommendations to agencies and professionals involved in the children's safeguarding system across Cheshire

Achievements during 2016-17

- ✓ A CDOP action plan has been developed (Appendix 2)
- ✓ Active participation in the North West Directors of Public Health Sector Led Improvement programme on child deaths under one year old
- ✓ A positive relationship with the coroner's office has been developed
- ✓ Pan-Cheshire CDOP continues to play an active role in both regional and national networks, influencing programmes, and gaining insight into proposed changes to the CDOP function in the future
- ✓ Contribution to the Kennedy Guidelines
- ✓ Presentation and discussion on CAMHS services across Cheshire
- ✓ Active participation in the organisation and the delivery of the National CDOP Conference
- ✓ Pan Cheshire seminar was held and led by the police and a senior paediatrician to raise the profile of the CDOP (see photo)



Summary of key points and themes:

Of those deaths reviewed

- 38% of the deaths occurred before the child reached 28 days (33 deaths)
- 56.7% of the deaths occurred before the child reached one year of age (51 deaths)
- 16% of the deaths occurred in Children aged 1 year to 4 year (15 deaths)
- 9% of the deaths occurred in Children aged 5 years to 9 years (8 deaths)
- 8% of the deaths occurred in Children aged 10 years to 14 years (7 deaths)
- 10% of the deaths occurred in Children aged 15 years to 17 years (9 deaths)
- 41% of the deaths were male (37 deaths)
- 35% were Perinatal/Neonatal events (32 Deaths)
- 53% were children with life limiting conditions (48 deaths)
- 11% of deaths were classed as 'unexpected' (10 deaths)
- 18% of deaths reviewed had 'modifiable factors' (16 deaths)
- The most common modifiable factors identified included domestic abuse, smoking during pregnancy, alcohol misuse, safe sleep arrangements, behavioural and emotional factors, and dangerous driving.

Priorities for 2017-18:

- ✓ Develop a Memorandum of Understanding (MOU) between CDOP and LSCBs
- ✓ Revise and update Terms of Reference
- ✓ Provide assurance that agreed Safer Sleep protocols are being implemented across all relevant agencies
- ✓ Explore suicide prevention initiatives, particularly with other existing PH networks e.g. CHAMPs
- ✓ Consider the implications of the emergent national CDOP Database
- ✓ Develop a Memorandum of Understanding between CDOP and Coroner's office.
- ✓ Explore how we can improve the notification of deaths of children living outside of Cheshire
- ✓ Support the delivery of the recommendations of the NW Sector-led improvement programme
- ✓ Establish an agreed budget for CDOP

Recommendations for Local Safeguarding Partners

LSCBs are asked to:

1. Note the content of the report and the priorities identified for the coming year
2. Note the Priority Action Plan at Appendix 2

Thematic reviews - Suicide Prevention

3. Assure themselves that existing multi-agency strategies aimed at reducing the incidence of mental health issues, include issues relevant to children and young people, in particular:
 - suicide and self-harm prevention;
 - training for various staff groups on management of suicidal behaviour and self-harm;
 - active engagement of children and young people in strategy development;
4. Assure themselves that existing mental health services that care for children and young people with MH issues (e.g. CAMHS and third sector) include:
 - an appropriate level of provision to match the need;
 - appropriate ease of access;
 - effective inter-agency working;
 - active engagement of children and young people in service development;

Thematic reviews - Sudden unexpected deaths in infancy

5. Assure themselves that all agreed policies and guidance designed to reduce the risk of Sudden Unexpected Death in Infancy are being adhered to by all relevant staff groups. These include:
 - Safer Sleep (Co-sleeping; safe sleep environment)
 - Local guidance on Care of Next Infant (CODI)
 - Escalation policies to ensure concerns are heard
 - Graded Care Profile and Signs of Safety Neglect assessments
 - Observation protocols for early identification of sick infants and children
 - Repeated clinic non-attendance protocols
 - Smoking in pregnancy
6. Assure themselves that there are effective multi-agency strategies in place to reduce:
 - Smoking around children
 - Substance / alcohol misuse
 - Domestic abuse

An update on the above recommendations, if accepted, will be provided in next year's Pan Cheshire Annual Report. Assurances should be sought before 31st March, 2018.

Mike Leaf
Independent Chair
Pan-Cheshire CDOP
31st October 2017

Section 2: Overview and Processes

CDOP Panel Meetings

CDOP Membership

Pan-Cheshire CDOP has a core membership of:

- Independent Chair
- CDOP Coordinator
- Designated Nurse for Safeguarding Children (Warrington and Halton)
- CDOP Nurses x 3 (Cheshire East, Cheshire West and Warrington)
- Special Midwife (Cheshire West)
- Designated Doctor for Child deaths x 3 (Cheshire East, Cheshire West, Warrington/Halton)
- Police Chief Superintendent from PPU Directorate
- Local Authority Service Manager, Safeguarding Unit
- Local Authority Service Manager, Children's Social Care
- Education Representative from Safeguarding in Education Team.
- LSCB Business Manager x 1
- Co-opted Advisory Member (Paediatrician/Deputy Coroner)
- North West Ambulance Service (where needed in cases of unexpected deaths)

The Pan-Cheshire CDOP has permanent representatives drawn from the key professional areas represented on participating LSCBs. Members of the CDOP attend the meetings as representatives of their profession/designation rather than representing their employing organisation. Members have a responsibility to disseminate recommendations and learning to agency representatives on the Boards in the other Pan Cheshire LSCB areas. Other members may be co-opted to contribute to the discussion of certain types of death when they occur.

Quoracy

A representative from the police, one Doctor, one Nurse and a minimum of one LSCB Business Manager will ensure that a meeting is quorate.

Frequency of Meetings

The panel currently meet on a quarterly basis and for a whole day. It has been agreed that this frequency will remain to unless there was a significant number of cases to review.

Agency Representation at Panel Meetings

The Pan-Cheshire CDOP met on six occasions between April 2016 and March 2017. Attendance is shown in Table 1 below. On occasions there are times where professional demands have to take priority, and members, in these cases are expected to provide a replacement.

Sector	Role	% attendance
Chair	Independent CDOP Chair	83%
Health	Designated Doctor (Cheshire East)	83%
	Designated Doctor (Cheshire West and Chester)	100%
	Designated Doctor (Warrington/ Halton)	66%
	Cheshire East Specialist CDOP Nurse	66%
	Cheshire West Specialist CDOP Nurse	83%
	Warrington Designated Nurse Safeguarding	66%
	Designated Nurse Halton CCG	83%
	Supervisor of Midwives CWAC	33%
	Warrington Safeguarding Nurse	83%
Local Authority	Public Health Consultant	50%
	Cheshire East Head of Service – Children’s Safeguarding	66%
	Public Health Consultant (Cheshire W. and Chester)	100%
	LSCB Business Manager for Warrington Borough Council	100%
Police	Public Protection Unit	100%

Table 1: Agency representation and attendances at CDOP meetings

Processes/ Networks/ Reviews and Sub-groups

Notification Process

Despite some earlier issues with relevant partners in Warrington and Halton, the notification process via paediatric liaison and hospital/hospice staff functions well. By cross-referencing with the annual DfE return (regarding notifications from Registrars to DfE), CDOP is now confident that it is notified of all child deaths. When Cheshire child deaths occur out of area, CDOP is often notified by Cheshire agencies, as well as by the CDOP contact in the respective area where the death occurred. This demonstrates effective communication between local organisations and CDOP.

SUDiC Protocol

The SUDiC Protocol is regularly reviewed, and whilst the protocol revision was not completed during 2016/17 the revised protocol forms part of the action plan for 2017/18, as a matter of urgency. This is being led by a Senior Paediatrician with links to the coronial services, who involves a range of professionals through a task and finish group.

Currently, Cheshire is effectively non-compliant with *Working Together to Safeguard Children 2015* and the *Baroness Kennedy Report 2016*, in that not all children receive a joint visit. A decision to undertake a joint home visit by Police and a Health professional following SUDiC is made on a case by case basis, based on need and added value, in the interests of effective utilisation of resources. Technology in the form of videos and photographs of the scene of death is used to inform rapid response procedures in cases of SUDiC, in some parts of Cheshire and has been found to be useful. The provision of photographs of the ‘scene’ for the strategy meeting participants to assist with the identification of risk factors is included in the revised protocol, and has been considered sufficient at present and will be kept under review. CDOP will ensure that the protocol is delivered consistently across all agencies.

Links to Coroners and Registrars

Within Cheshire there is an excellent working relationship with the Coroners offices, with coroner's officer representation being explored to clarify queries for the panel and ensure good links with the team.

Deaths of Children Living Outside Cheshire

Whilst CDOP is responsible for the review of child deaths resident in Cheshire, there is an expectation that it should receive notification of child deaths for children who live out of area, but have died within the boundary. As Cheshire borders Wales, where there is a different process for reviewing child deaths, the numbers of these children may be significant. CDOPs across the country should notify the CDOP where the child died, and vice versa.

Communicating with Parents, Families and Carers

Leaflets and a letter are made available to any parent following the death of a child. The national Lullaby Trust leaflet: '[The Child Death Review, A Guide for Parents and Carers](#)' is a more detailed explanation of many of the processes associated with a child's death.

Deaths involving Serious Case Reviews/ Critical Incident Reviews

Child deaths are considered at panel once all relevant investigations and reports have been completed. These include those that have been the subject of Serious Case Reviews, Critical Incident Reviews or any learning review. This approach is consistent with that undertaken across the north-west and much of England. This may, on occasions, result in a delay between notification and completion that exceeds the specified six month timescale, CDOP will continue to monitor this process.

Regional/ National Links/ Updates:

North-west meetings

Pan-Cheshire CDOP continues to be represented at the north-west CDOP meetings. A common dataset was agreed for all north-west annual reports to allow for the compilation of an overview report covering the area. A north-west CDOP report is produced annually, although usually falls out of sequence from local CDOP annual reports.

National Network

Some Cheshire CDOP members form part of the national network group which advises on issues of national interest, including the transfer of the CDOP responsibilities to the Department of Health. Panel members attend the national event and feed back to panel.

National Database Development Project

Pan-Cheshire CDOP continued to participate, by invitation, on the working group to determine the need for a national CDOP database. The necessity was confirmed and a tendering process was expected to conclude in July 2016. The desired completion date for development is in 2017. The national database will be able to

access CDOP data through data extraction rather than needing input into two systems.

Funding

Contributions

Each LSCB and Public Health department contributed an additional £665 (£5320 total) in 2016-17 towards Independent Chair funds with additional population-based contributions to cover the CDOP Business Administration costs (Table 2). All 4 LSCBs and Public Health Departments have committed to funding the Independent Chair and administrative resource around CDOP into 2017-18. The LSCBs will continue to cover the costs of the administration to this process and the LSCBs and Public Health will equally provide contributions to the Chair fund for the period. Moving forward the budget will need to be reviewed and set within the context of maximising the effectiveness of CDOP and the implications from the revised national guidance.

Table 2: Contributions to CDOP process for 2016-17 by LSCB area

	Warrington	Halton	Cheshire West and Chester	Cheshire East	Total
20% for panel admin	£1,326.70	£1,326.70	£1,326.70	£1,326.70	£5,306.80
80% for child deaths	£4,772.98	£2,763.30	£6,782.66	£6,908.26	£21,227.20
Total	£6,099.68	£4,090.00	£8,109.36	£8,234.96	£26,534.00

Issues Identified

Missing Data

There has been an improvement on the details provided on the forms, but the failure to provide consistent information can create issues. For example, the lack of details of the father/significant male/other parent in the family is particularly relevant in relation to necessary checks regarding domestic violence. This forms part of an ongoing dialogue with representatives, and remains under scrutiny.

Modifiable Factors

A modifiable factor is one 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 of future child deaths. Overall the modifiable factors identified for Cheshire include:

- domestic abuse
- smoking during pregnancy
- alcohol misuse
- safe sleep arrangements

- behavioural and emotional factors
- dangerous driving

In addition to the modifiable factors identified, Cheshire CDOP is made aware of any outcomes from serious case reviews, multi- and single agency reviews and internal review processes that occur within agencies. In these circumstances implementation of any action to address the modifiable factors, and the monitoring of the progress rests with the agency or agencies identified within the reports and the specific sub-group identified by the LSCBs.

Unsafe sleeping practices continue to remain an issue, and it is important to gain assurance that Safe Sleep initiatives are being implemented and applied in a consistent way across the Cheshire footprint. At least one neighbouring CDOP has undertaken an audit of safe sleep practices.

National annual statistical data

The LSCBs are required to collect a considerable amount of data following the death of every child and then submit an annual return to the Department for Education. The CDOP Co-ordinator is responsible for this function on behalf of each of the four LSCBs. The Department for Education, in turn, consolidates the returns and publishes a statistical release in July. The data can be found on the Department for Education website.

National data returns for 2016/17:

- A) The percentage of child death reviews identified as having modifiable factors: (17.8%)
- B) Perinatal/Neonatal cases reviewed 2016-2017: 33 cases
- C) The percentage of deaths reviewed that were for children under one year old in the year ending 31st March 2017: 51 cases
- D) Serious Case Reviews: (There has been one Serious Case Review held in respect of a child death completed within Pan Cheshire during 2016/17)

CDOP priorities for 2017/18

- ✓ Develop a Memorandum of Understanding (MOU) between CDOP and LSCBs
- ✓ Revise and update Terms of Reference
- ✓ Develop a Performance Framework and action plan
- ✓ Revise and re-launch SUDiC Protocol
- ✓ Ensure partner agencies with links to the SUDiC protocol undertake staff briefings to raise awareness of the revised protocol and for the LSCB to seek assurance that this has been done
- ✓ Provide assurance that agreed Safer Sleep protocols are being implemented in a consistent way across all relevant agencies
- ✓ Explore suicide prevention initiatives, particularly with other existing PH networks e.g. CHAMPS

- ✓ Consider the implications of the emergent national CDOP Database
- ✓ Develop a risk register
- ✓ Develop a Memorandum of Understanding between CDOP and Coroner's office.
- ✓ Explore how we can improve the notification of deaths of children living outside of Cheshire

Section 3: Data and Analysis

It should be noted that it is often difficult to make clear conclusions from analysing data from a relatively small number of cases reviewed each year. The learning from each individual case is noted at each CDOP meeting, with the appropriate action taken at that time. Cheshire's figures are amalgamated to other CDOP data across the NW to provide opportunities for identifying more reliable trends.

Number of Deaths

The Pan Cheshire CDOP met on six occasions between April 2016 and March 2017. The total number of child deaths notified across the Pan Cheshire footprint between April 2016 and March 2017 was 51. The total number of child deaths reviewed by the panel between April 2016 and March 2017 was 90 (Cheshire East (30), Cheshire West and Chester (23), Halton (18) and Warrington (19)).

End of Year Case	
Was awaiting inquest	11
Subject to SCR	2
Additional paperwork required	5
Cases less than 6 months old at 31/03/2017	11
TOTAL	29

At the end of 2016-17 there were 29 child deaths outstanding which have not yet been considered by CDOP. A total of 13 were subject to additional processes including inquests and serious case reviews.

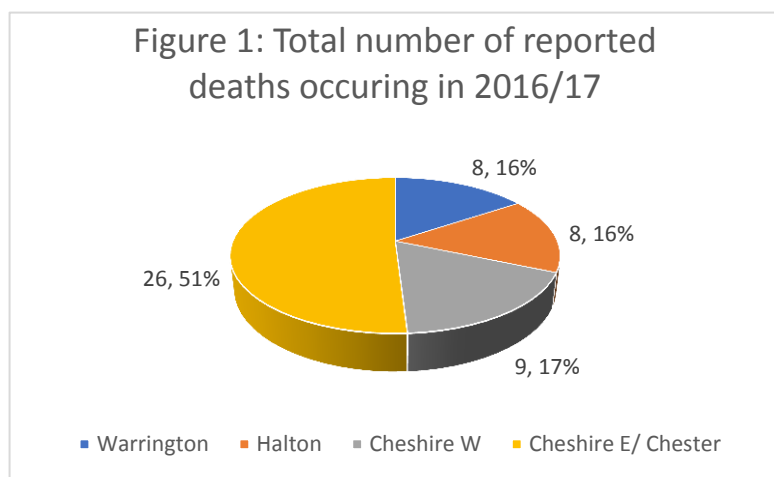


Figure 1 shows the percentage split of the numbers of notified deaths, by local authority area. Because we are dealing with small numbers, it is sometimes useful to consider trends. Table 3 shows the number of child death notifications since 2013/14.

Table 3; Number of child death notifications

Year	2013-14	2014-15	2015-16	2016-17
No. of deaths	59	46	64	51

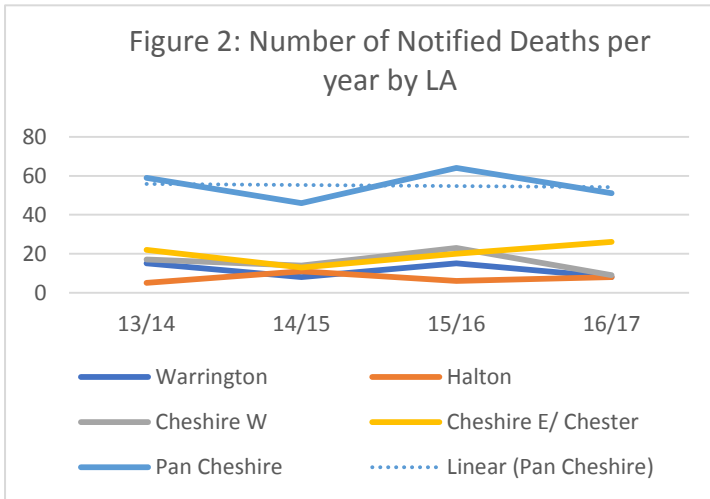


Figure 2 shows that there is a very slight downward trend in child death notifications over the last four reporting years, but this is unlikely to be of any significance, because of the small numbers involved.

Child Population

The child population estimates in each of the four LSCB areas is detailed in the following table 4.

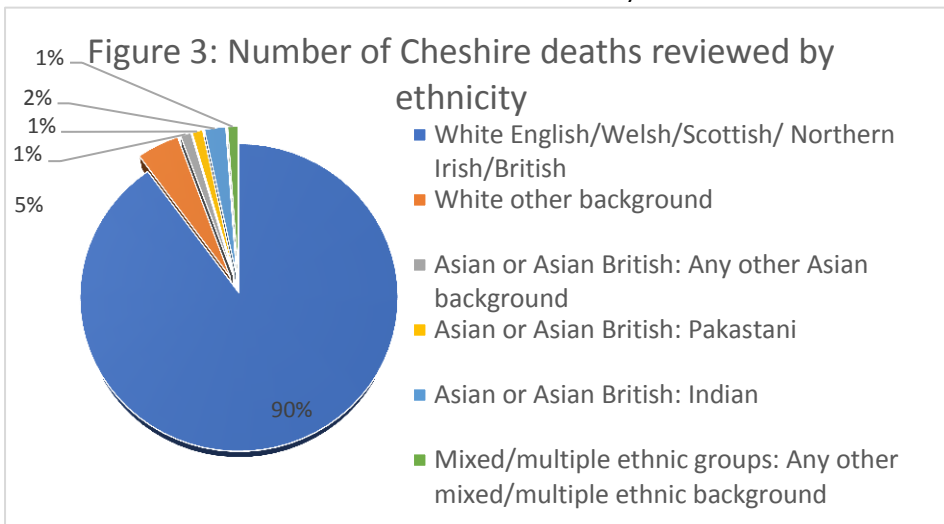
Table 4: Child Populations by local authority

LSCB area	Child population size* (0-17 years)
Cheshire East	74,998
Cheshire West & Chester	66,052
Halton	28,105
Warrington	44,103
Total	213,258

* Source: ONS mid-Year Population Estimates, 2012

Ethnicity of the child

Figure 3 shows that the vast majority (90%) of the child deaths categorised during 2016-17 were of 'British White' ethnicity. From the national 2011 Census data in England and Wales, 19.5% of the population were not from the White English/Welsh/Scottish h/ Northern Irish/British ethnic group.



From the national 2011 Census data in England and Wales, 19.5% of the population were not from the White English/Welsh/Scottish h/ Northern Irish/British ethnic group.

Normally, one would expect to see the numbers of deaths in each geography, to be proportionate to the number of under 18-year olds living in each, but there may be differences according to deprivation levels.

Figure 4: Rate of Notified Cases per 10,000 of the under 18 population

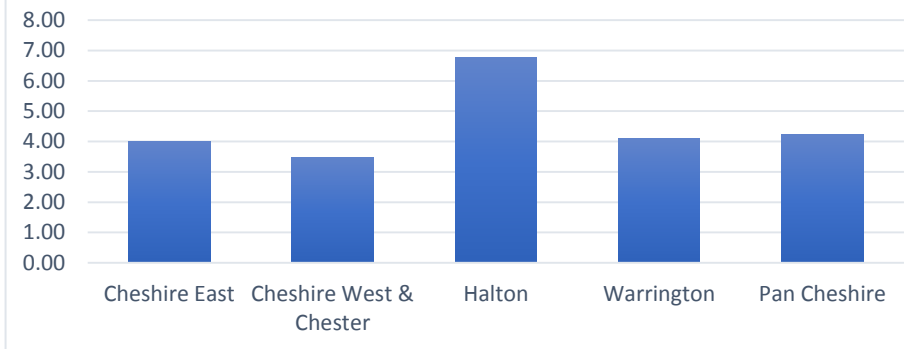
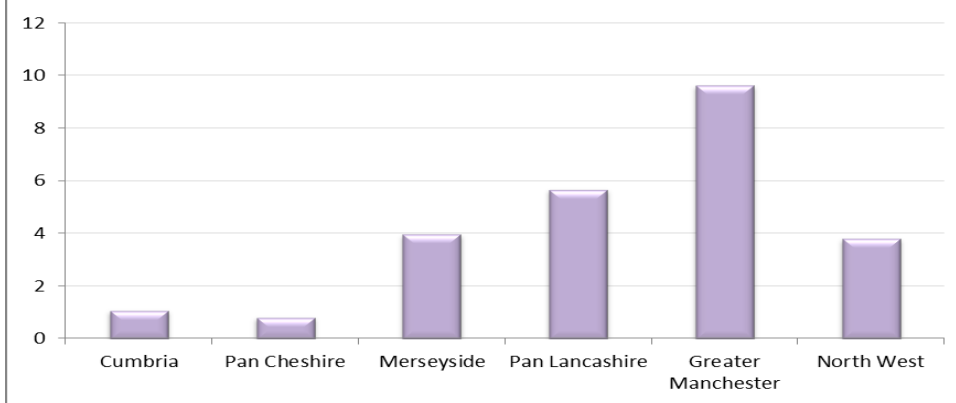


Figure 4 shows the rate of deaths per 10,000 0-18 years' population, and highlights that Halton appears to have a disproportionately higher number of child death notifications relative to its under 18 population. This may be related to deprivation, where one might expect greater notifications of child deaths in areas with higher Indices of Multiple-Deprivation (IMD). This is consistently demonstrated nationally and regionally.

The following chart, is taken from the NW CDOP review (2016/17), and illustrates the rate of notified cases by population of each region. Here the chart illustrates that Pan-Cheshire has the lowest rate of notified

Notified Deaths 2016/17 for the North West



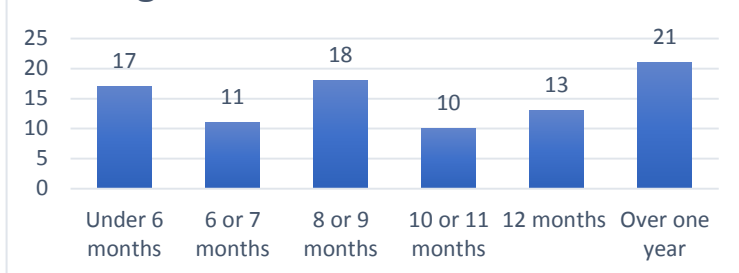
deaths within the under 18 year population.

Review Completion

Review Completion

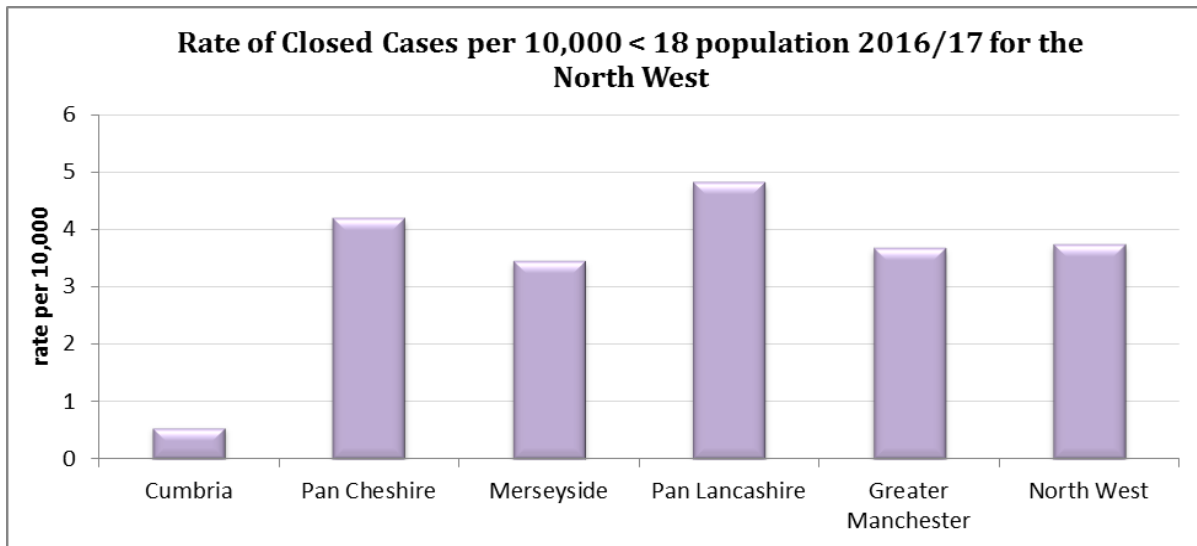
Figure 5 provides a breakdown of the time taken to complete the reviews during this period.

Figure 5: Timeliness of reviews



It shows that 18.9% of reviews were completed within 6 months and 77% within 12 months. Currently, CDOP is confident that unnecessary delays in the process are being kept to a minimum and will keep the matter closely under review. The following table shows a comparison with other NW

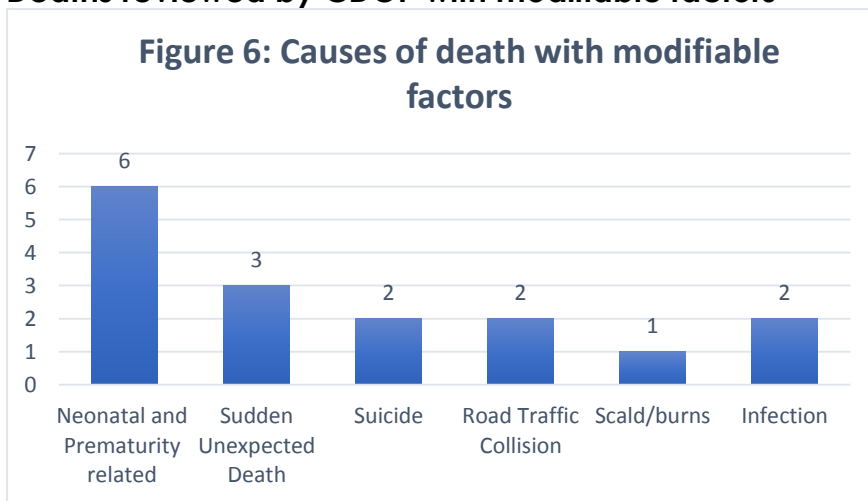
LSCBs, and Pan Cheshire rate per 10,000 of U18 population of closed cases is second highest, and is taken from the NW CDOP review 2016/17.



Deaths by gender

From April 2016 – March 2017 of the 90 child deaths reviewed by the CDOP, 37 were male (41%) whereas 53 were female (59%). This is counter to percentages reflected in national and international statistics, where infant mortality is generally higher in males in most parts of the world, partly explained by differences in genetic and biological makeup, and risk-taking behaviour being more prevalent in teenage males. In view of the involved small numbers, it is unlikely that this is significant.

Deaths reviewed by CDOP with modifiable factors



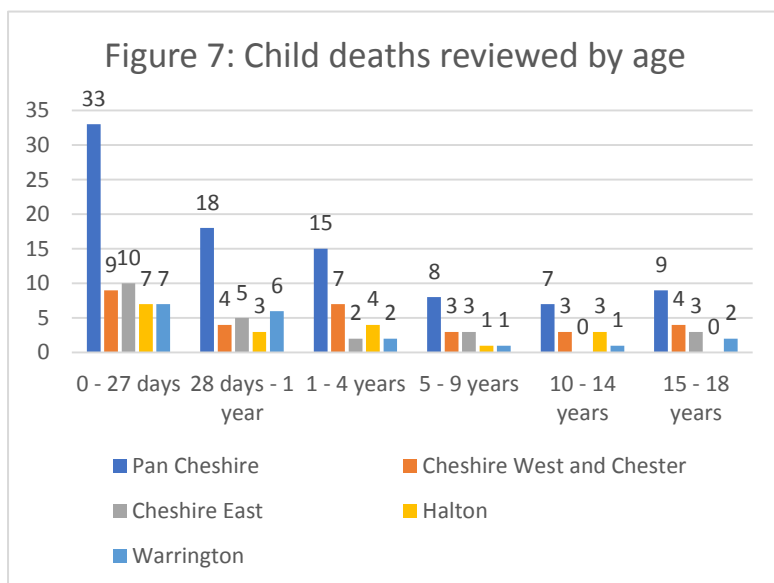
A key purpose of the CDOP review process is to identify any modifiable factors contributing to the death. Modifiable factors are defined as *one or more factors, which may have contributed to the death of the child and which by means of locally or nationally achievable interventions, could be*

modified to reduce the risk of future child deaths (DfE 2014).

For the period April 2016 – March 2017 sixteen cases (17.8%) had modifiable factors. Twelve of these children were under the age of four years, which is 75% of all modifiable cases (13% of cases overall). Modifiable factors included domestic abuse, smoking during pregnancy, alcohol misuse, safe sleep arrangements, behavioural and emotional factors, and dangerous driving. Figure 6 shows the breakdown of cause of child deaths having modifiable factors. Of the 90 deaths which were categorised during this reporting year, the ratio of modifiable: non-modifiable factors was 16:74 (17.8%). Across the NW the percentage was 30% for the same period. This means that of the deaths reviewed across Cheshire, there was a smaller proportion of cases where modifiable factors could be identified.

Child Deaths Reviewed by Age (DfE categorisation)

Figure 7 shows that the largest number of child deaths occurred within the first twelve months of life (55.6%). Nationally, 60% of deaths in childhood occur during the first year of a child's life, and are strongly influenced by pre-term delivery and low birth weight; with risk factors including maternal age, smoking and disadvantaged circumstances ([Wolfe and Macfarlan, 2015](#)).



Both figures also show the typical skewed “u-shaped” curve replicated at national level.

In Summary:

- 38% of the deaths occurred before the child reached 28 days (33 deaths)
- 56.7% of the deaths occurred before the child reached one year of age (51 deaths)
- 16% of the deaths occurred in Children aged 1 year to 4 year (15 deaths)
- 9% of the deaths occurred in Children aged 5 years to 9 years (8 deaths)
- 8% of the deaths occurred in Children aged 10 years to 14 years (7 deaths)
- 10% of the deaths occurred in Children aged 15 years to 17 years (9 deaths)

Category of Child Death

The CDOP panel is required to record each death against 1 of 10 nationally-set categories as follows:

Category 1: Deliberately inflicted injury, abuse or neglect (0)

Category 2: Suicide or deliberate self-inflicted harm (4)

Category 3: Trauma and other external factors (4)

Category 4: Malignancy (11)

Category 5: Acute medical or surgical condition (4)

Category 6: Chronic medical condition (5)

Category 7: Chromosomal, genetic and congenital anomalies (22)

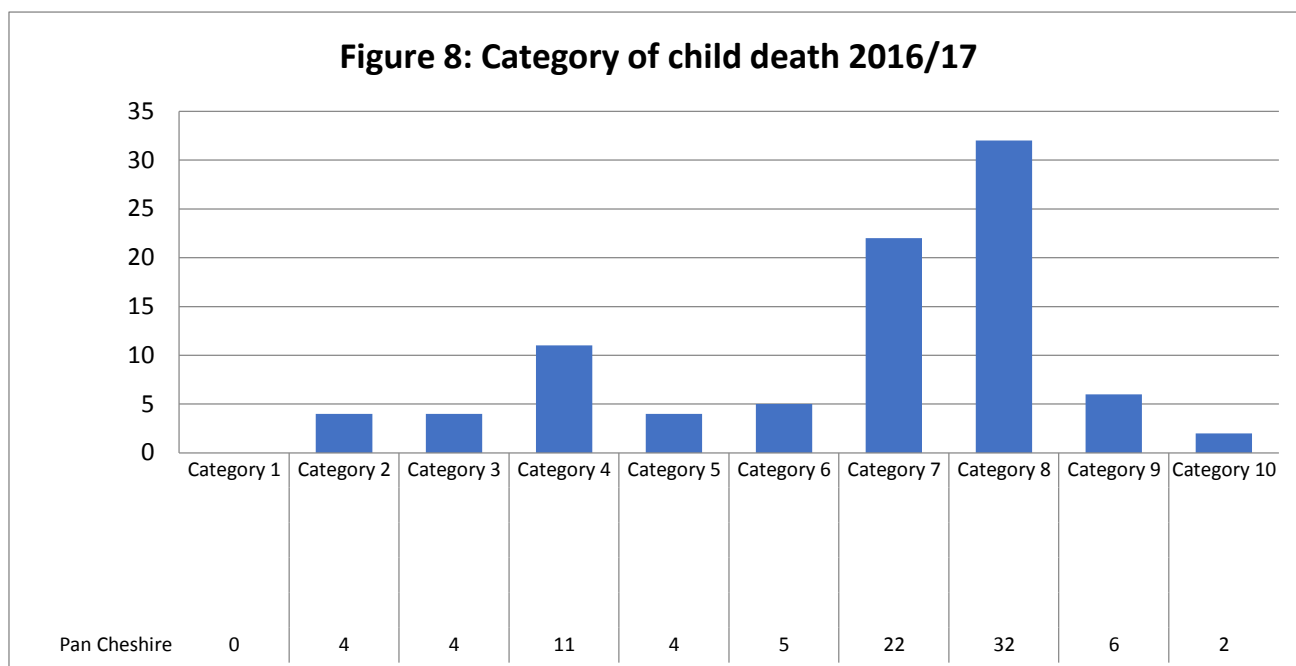
Category 8: Perinatal/neonatal event (32)

Category 9: Infection (6)

Category 10: Sudden unexpected, unexplained death (11)

Further explanations can be found in Appendix 1.

Figure 8: Category of child death 2016/17

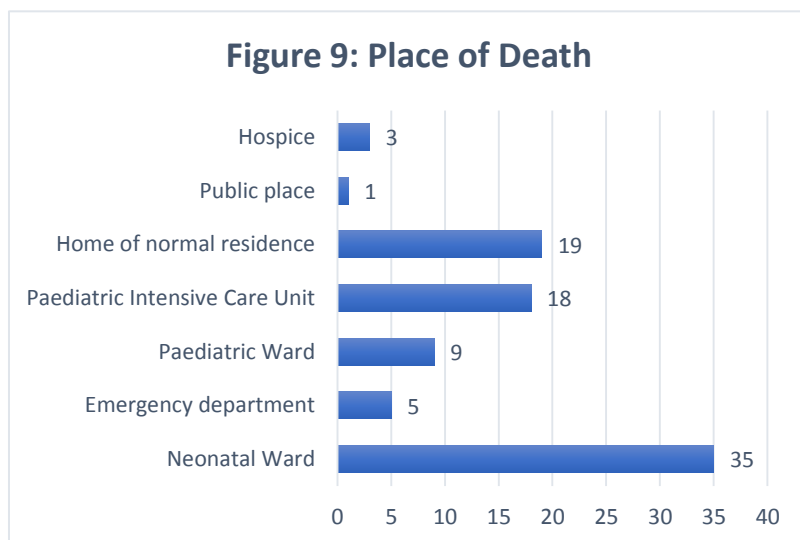


It can be seen in Figure 8 that the greatest proportion of deaths relate to perinatal//neonatal event (category 8) which compares with the patterns seen in the NW and nationally. Chromosomal, genetic and congenital anomalies (category 7) is the second highest category, as it was last year.

Location of Child Death

The majority of deaths (74%) occurred within a hospital setting, the majority of these occurring in the neonatal units followed by paediatric intensive care units (Figure 9). This is unsurprising because, by their very nature, they provide care to the most vulnerable and poorly.

Figure 9: Place of Death



The information reflects the deaths in a Neonatal Unit (38.9%) and (5.5%) died in a emergency department. Outside of the deaths recorded in hospital, nineteen children (21%) died within their home of normal residence.

Causes of Child Death

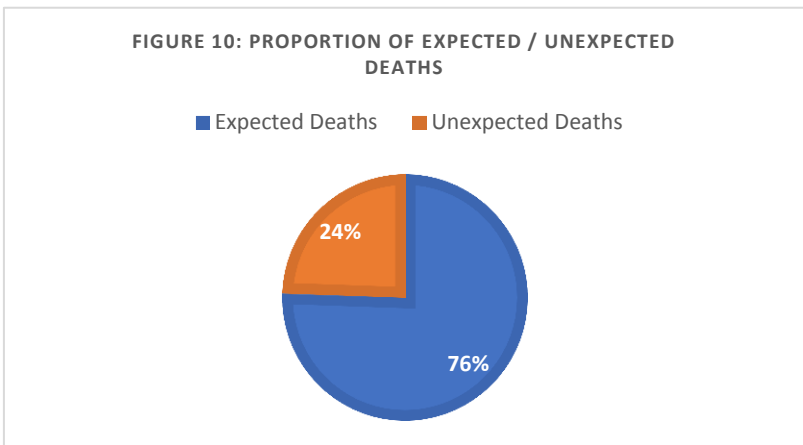
Figure 10 on the next page shows the cause of death, with the majority (51%) occurring neonatally, followed by others with a known life-limiting condition (33%). 'Other' refers to child deaths not covered by supplementary forms B2 – B12 that relate to specific conditions:

B2: neonatal deaths

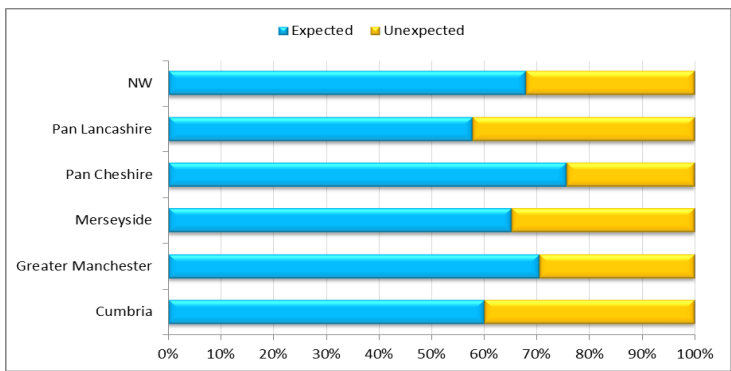
- B3: death of a child with a life limiting condition
- B4: sudden unexpected death in infancy (SUDI)
- B5: road traffic accident
- B6: drowning
- B7: fire/burns
- B8: poisoning
- B9: other non-intentional injury
- B10: substance misuse
- B11: apparent homicide
- B12: apparent suicide

Expected / Unexpected deaths

An expected death refers to a death that could reasonably be foreseen by clinicians for a period of at least 24 hours before it occurred. An unexpected death is then defined 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 an unexpected collapse or incident precipitating the events that led to that death.

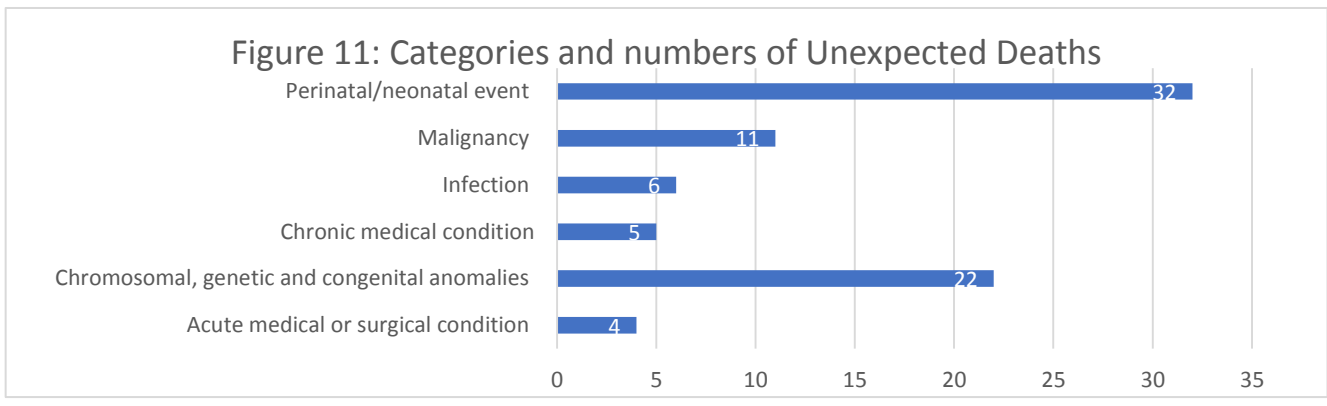


Between April 2016 and March 2017, there were 22 deaths (24%) that were classified as 'unexpected'.



The chart (left) is taken from the NW CDOP Review, and illustrates that the majority of closed cases in children under 18 years were expected. Of the NW CDOP panels, Pan Cheshire had the lowest proportion of unexpected deaths.

Fig 11 (below) shows the categorisation of the unexpected deaths throughout Cheshire.



Acknowledgements

As noted in the foreword much of the business of the CDOP is dependent on the continued support of panel members and the administrative support. I would like to take this opportunity to thank the panel members for continued support and especially Dr Mir for his work on analysis of the data we have collated. Likewise, this work would not be possible without the dedication of Anne McKenzie which ensures the panel runs smoothly.

Mike Leaf

Independent CDOP Chair

31st October 2017

Glossary of Terms

Term	Meaning
Child	A person aged 0-18 th birthday
Expected death	A death that could have been reasonably predicted 24 hours before the death occurred or 24 hours before the immediate events leading to the death occurred
Infant	Aged less than 1 year of age
Modifiable factors	Factors associated with a death which by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths
Neonatal period	From birth until 28 days of life
Perinatal period	From viable gestation (around 23 weeks of pregnancy) until 7 days following birth
Unexpected death	A death that could not have been reasonably foreseen 24 hours before it occurs – or where there was an unexpected collapse or precipitating events leading to the death

Abbreviations

CDOP – Child Death Overview Panel

SUDI – Sudden Unexplained Death in Infants

LSCB – Local Safeguarding Children Board

Appendix 1: Classification of Death

This classification is hierarchical: where more than one category could reasonably be applied, the highest up the list should be marked.

Category	Name & description of category	Tick box below
1	<p>Deliberately inflicted injury, abuse or neglect This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.</p>	<input type="checkbox"/>
2	<p>Suicide or deliberate self-inflicted harm This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.</p>	<input type="checkbox"/>
3	<p>Trauma and other external factors This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Excludes Deliberately inflicted injury, abuse or neglect. (category 1).</p>	<input type="checkbox"/>
4	<p>Malignancy Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.</p>	<input type="checkbox"/>
5	<p>Acute medical or surgical condition For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.</p>	<input type="checkbox"/>
6	<p>Chronic medical condition For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Includes cerebral palsy with clear post-perinatal cause.</p>	<input type="checkbox"/>
7	<p>Chromosomal, genetic and congenital anomalies Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.</p>	<input type="checkbox"/>

8	<p>Perinatal/neonatal event Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral palsy without evidence of cause, and includes congenital or early-onset bacterial infection (onset in the first postnatal week).</p>	<input type="checkbox"/>
9	<p>Infection Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.</p>	<input type="checkbox"/>
10	<p>Sudden unexpected, unexplained death Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5).</p>	<input type="checkbox"/>

The panel should categorise the 'preventability' of the death – tick one box.

Preventable child deaths are defined in Chapter 5, paragraph 11 (p85) of Working Together to Safeguard Children (2015).

Appendix 2: Priority Action Plan

Priority	Action	Timescales	Outcome
Improve the visibility of the CDOP amongst local safeguarding partners	<ul style="list-style-type: none"> • Deliver regular events across Cheshire that share trends, themes and messages for practice • Develop a Memorandum of Understanding (MOU) between CDOP and LSCBs • 	Quarterly	To ensure clear accountability to the Pan-Cheshire LSCBs in using lessons learnt to reduce child deaths locally
Oversight of mental health & wellbeing and the lead to cascade to frontline professionals	<ul style="list-style-type: none"> • Monitor cases with mental health and wellbeing factors to identify any trends that require challenge and promotion to the LSCB partners 	Quarterly	Pan-Cheshire has a robust appreciation of factors affecting child and young people's mental health and wellbeing and is able to use learning to work to potentially reduce child deaths from such factors
Secure a clear link to education sector	<ul style="list-style-type: none"> • Identify a suitable Pan-Cheshire Education input for CDOP to inform education related cases and actions 	July 2017	Develop clear links to education sector that inform CDOP understanding of practice issues and challenges within education so that lessons learnt from child deaths are correctly identified and cascaded within the education sector
Produce a Pan-Cheshire Communications Strategy	<ul style="list-style-type: none"> • Develop a regular format to disseminate key messages from CDOP to Pan Cheshire frontline professionals i.e. 7 minute briefings or newsletters • Agree moving forward the frequency and content of communications documents • Issue cascade documentation for LSCBs to 	July 2017 Ongoing (quarterly)	Ensure that professionals are aware of trends, themes and messages for practice emerging from CDOP reviews and apply them in practice

Priority	Action	Timescales	Outcome
	collate so enable CDOP to document the impact of communications dissemination on practice		
Rapid response	<ul style="list-style-type: none"> • Present business case to LSCBs identifying gaps and realistic process for Pan-Cheshire that achieves appropriate evidence and support around Child Deaths 	December 2018	To ensure that Child Death investigations are supported to effectively respond utilising evidence based practice
Review revised Working Together Guidance to identify appropriate CDOP restructure	<ul style="list-style-type: none"> • Review draft Working Together • Offer Proposals to Pan-Cheshire LSCBs of potential changes for CDOP moving into 2018 to be compliant with revised statutory guidance 	December 2017 March 2018	To ensure all families who experience a sudden unexpected death of a child receive a high quality service in line with national guidance