Dudley Child Death Overview Panel (CDOP) Report 2018-19

An analysis of the child deaths reviewed by Dudley CDOP in the year ending 31 March 2019

Foreword

This is the tenth Annual Report of the Dudley Death Overview Panel (CDOP) and reflects activity for the year from 01 April 2018 to 31 March 2019.

The process of reviewing child deaths was first established in 2008 initially outlined in Chapter 7 of Working Together to Safeguard Children 2010 and updated in Chapter 5 of Working Together to Safeguard Children 2013 and 2015. This statutory guidance directed the responsibility for undertaking a review of every death of a child normally resident in their area to the Local Safeguarding Children Boards (LSCBs).

Dudley CDOP under the auspice of Dudley Safeguarding Children Board (DSCB) was established on 1st April 2008. The overall purpose of Dudley Child Death Overview Panel and the contents of this report are prescribed according to the CDOP mandate being:

- to undertake a multi-disciplinary review of all child deaths (excluding stillbirths and planned terminations of pregnancy carried out within the law) up to the age of 18 to better understand how and why children in Dudley die; and
- use these findings to identify any recommendations that might serve to reduce the chance of similar deaths in the future, take action to prevent other deaths and;
- improve the health, safety and wellbeing of children.

The previous report alluded to change on the horizon for Dudley CDOP, and this change has seen Dudley merging its CDOP functions with one of our neighbouring Black Country authority, Sandwell, with the first joint meeting taking place in September 2018. This merger is the beginning of what is likely to become a wider amalgamation to establish a wider strategic forum spanning across the four Black Country boundaries in the coming year.

The formation of a Black Country Strategic CDOP has derived from the 2018 revised version of Working Together to Safeguarding Children and new national guidance about child deaths. This shifts the responsibilities for CDOP away from Local Safeguarding Children Boards (which are being abolished), and directs these duties to Clinical Commissioning Groups and Local Authority Public Health Services. Through the success of an Early Adopter's bid awarded to Dudley, the Black Country Child Death Arrangements will be published and in place by September 2019.

As this will be the final report under the remit of Dudley Safeguarding Children Board, for and behalf of Dudley CDOP, I wish to thank those whose hard work all year round makes it possible for the Dudley CDOP to fulfil its function. My gratitude and thanks to Clare Acton, Child Death Nurse and Donna Thorneycroft, CDOP/SCR Administrator. I also wish to acknowledge the hard work of all the CDOP members, many of whom have served on the Panel for several years, and also DMBC Intelligence Team, who have for many years collated the data presented in these reports.

The detailed guidance on how a child death should be investigated in Dudley and across the Black Country boundaries can be found here.

Gillian Ming
Business Manager – Dudley Safeguarding Children Board

CONTENTS

(Click on title to go to section)

Executive Summary

- A total of **18 deaths were reviewed** by the Child Death Overview Panel in Dudley between April 2018 and March 2019. This represents a reduction on the totals for the previous two years (26 and 23 deaths);
- Of the reviews in 2018-19, **half were completed within six months** of the associated death, although 17% were not completed within twelve months;
- As in previous years, the two largest categories of death were: **perinatal and neonatal** events; and **chromosomal and other anomalies**. Together, these represented half of deaths reviewed;
- A number of deaths in Dudley – six in the year to March 2019 – were identified with factors which could be **modified to reduce future child deaths**. The current high proportion of deaths with modifiable factors in Dudley (33%) is unprecedented in our records;
- A **rise in the identification of modifiable factors** is also shown in the data for the West Midlands Region and for England. This is likely to be the result of an improving ability to identify these factors.
- In cases in Dudley in 2018-19 where modifiable factors were identified, common factors which contributed or might have contributed to child deaths were: **acute/sudden onset illness**; **emotional/behavioural/ mental health condition in the child**; **poor parenting/ supervision**; and **child abuse/neglect**;
- **Deaths of children under one year** accounted for three in every five of the child deaths reviewed in Dudley (62%) in the six years ending in 2018. In the latest year the proportion was above this average at 72%;
- For the deaths reviewed during the two years to March 2019, ten percent of **mothers were aged 40 or over** when the child was born. This compares to an equivalent figure of three percent for all births in Dudley Borough;
- Compared to the wider populations in Dudley, a relatively large number of child death reviews over the last seven years have been of **Black and Minority Ethnic children**.

INTRODUCTION

The Children Act 2004 first placed a statutory duty on local authorities in England to set up Local Safeguarding Children Boards (LSCBs). One of the LSCBs' functions was to review the deaths of all persons under 18 years who are normally resident in their area via a Child Death Overview Panel (CDOP). This function became mandatory in April 2008, although LSCBs were able to do this from 2006. The publication *Working Together to Safeguard Children* (HM Government 2018) set out guidance to be followed by LSCBs and CDOPs for the period covered by this report.

CDOPs were established to review every death of a child in an area[1]. In each area the Panel's purpose is to identify lessons that might improve the future safety and welfare of children, as well as any wider public health concerns arising from an individual or pattern of deaths. It is this latter objective which is the focus of this report.

In 2018/19 the Dudley CDOP met on six occasions to discuss child deaths, the same number of times as the previous year. This report summarises the findings of the child death reviews completed during the year 1 April 2018 to 31 March 2019 and makes reference to reviews completed during the previous year. Owing in part to the time elapsing between a death and the conclusion of its review, the number of reviews in this period is not the same as the number of children who have died.

Of the 18 deaths reviewed in 2017-18 by Dudley CDOP, more than a third (seven deaths) took place before 1 April 2018[2]. By the same token, a number of deaths which took place in 2017-18 have not been the subject of a completed review at the time of publication. As Table 1 shows, reviews in Dudley in 2018-19 were generally completed in less time than in England in 2016-17 (the latest year for which data was available at the time of publication).

The report starts by considering the national and regional context for the findings of the child death reviews in Dudley.

Table 1: Period between Death and Completion of Review

Child death reviews completed in Dudley in 2018-19, compared to England in 2016-17

Period between death and completion of review	Dudley 2017-18	Dudley 2018-19	England 2016-17
Under 6 months	52%	50%	32%
6 or 7 months	17%	28%	16%
8 or 9 months	9%	6%	13%
10 or 11 months	9%	-	11%
12 months	0%	-	5%
Over one year	13%	17%	24%

Sources: Child death reviews in Dudley 2017-19; Child death reviews: year ending 31 March 2017, Main tables SFR36/2017.

Note: Totals may not sum to 100% due to rounding

[1] During the period 2018/19 CDOP reviews in Dudley excluded still births and those under 24 weeks gestation although this will change under new arrangements.

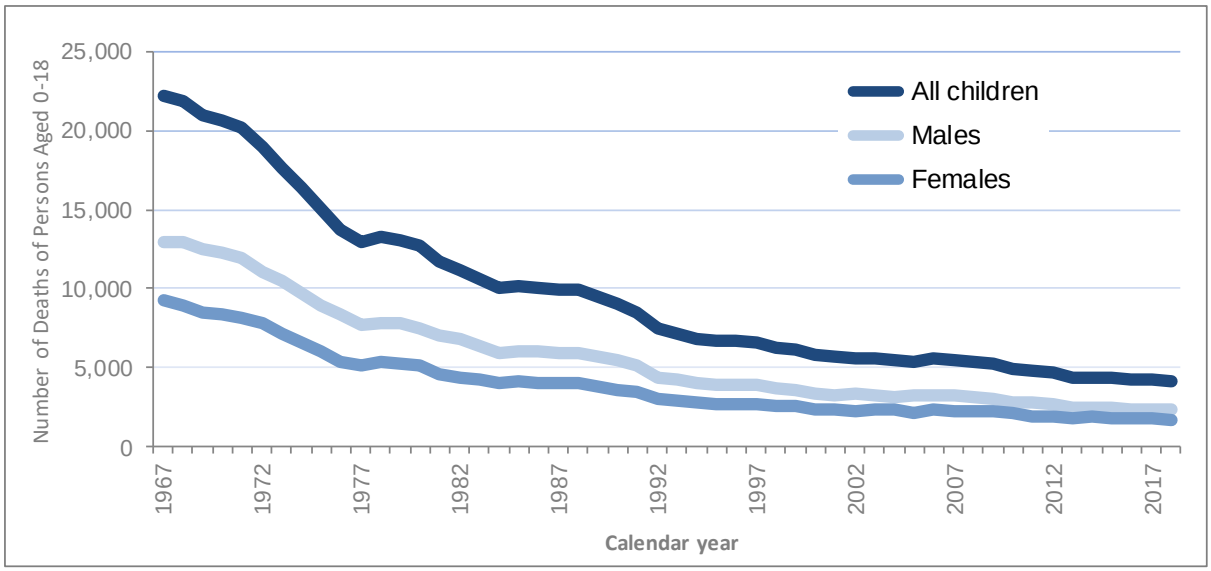
[2] The proportion of deaths which were reviewed in Dudley in 2017-18 but took place before 1 April 2018 was smaller than in England in 2016-17 (i.e. 38% in Dudley in 2017-18 and 64% in England in 2016-17).

DEATHS OF CHILDREN: NATIONAL & REGIONAL TRENDS

Although this report draws primarily on examination of child deaths considered by Dudley CDOP reviews, it is also useful to place this analysis in the context of wider data provided by the Office for National Statistics (ONS).

Figure 1: National Trend in Child Deaths

Persons aged 0-18 years in England and Wales from 1967 to 2018



Source: Office for National Statistics, Deaths by single year of age tables – UK (https://bit.ly/2RyPezT)

Information published by the Office for National Statistics shows 4,123 children under 19 had their deaths registered in 2018, continuing a long-term decline in the number of deaths of children under 19 in England and Wales over the last half century, as illustrated by Figure 1. The number of recorded deaths in this age group in 2017 showed a decrease compared to the previous year of about two percent.

In July 2018 national responsibility for the child death review policy of the UK Government was transferred from the Department for Education to the Department of Health and Social Care. One consequence of this is that the publication of national statistics on child death reviews during 2018-19 has been delayed and at time of writing they are not available[3].

Common Categories of Death in England

Although national data on CDOP reviews for the year ending in March 2018 is not available, we can nevertheless learn from the pattern of deaths in previous years.

Figure 2 illustrates the categories of child deaths reviewed over the latest five years for which data is available. Of a total of 18,143 deaths, the two largest categories were those

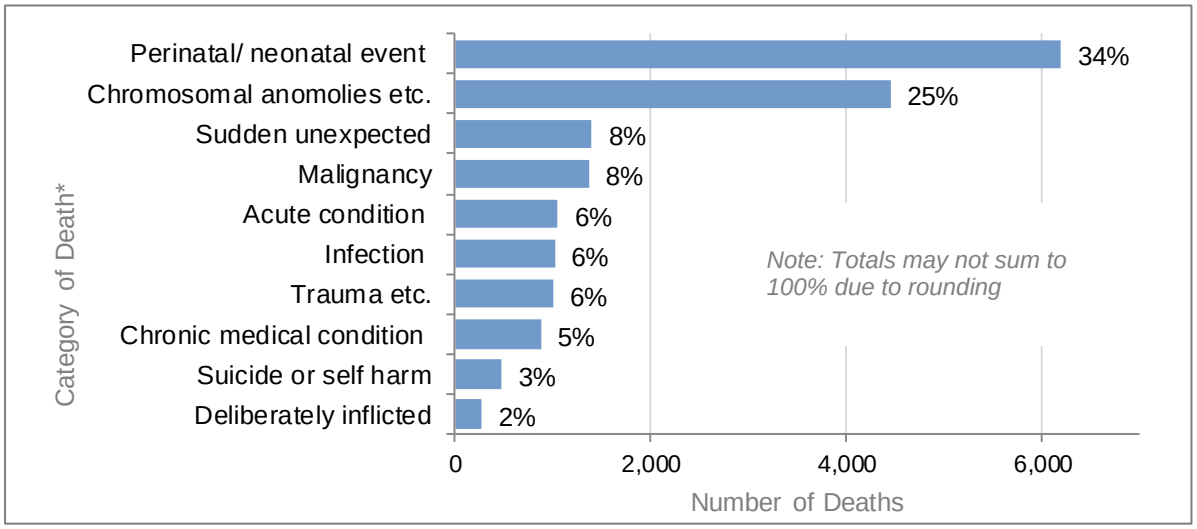
[3] https://www.gov.uk/government/collections/statistics-child-death-reviews.

due to perinatal or neonatal events (34%) and chromosomal, genetic and congenital anomalies (25%). These proportions are similar to those in Dudley over the same period.

Reflecting the preponderance of perinatal and neonatal events among the categories of death, deaths reviewed in England are often within infancy. In 2016/17 for example, nearly two in every three deaths were within the first year of life, as illustrated by Figure 3.

Figure 2: Child Deaths Reviews in England by Category

All child death reviews completed in the five years ending 31 March 2017



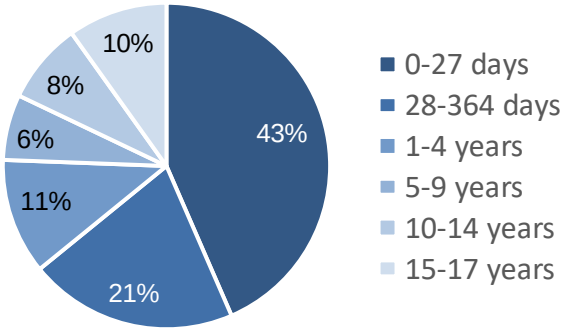
*The full titles of the categories defined by ONS are: Deliberately inflicted injury, abuse or neglect; suicide or deliberate self-inflicted harm; trauma and other external factors; malignancy; acute medical or surgical condition; chronic medical condition; chromosomal, genetic and congenital anomalies; perinatal/ neonatal event; Infection; Sudden unexpected, unexplained death; Unknown.
The total number of deaths represented in this chart excludes 22 which took place in the year ending 2013 and for which no information was available to determine whether factors contributing to the death were modifiable.

Source: NHS Digital, Statistics – Child Death Reviews (https://bit.ly/2AMRxdl)

Figure 3: Age of Child at the Time of Death in England

All child death Reviews completed in the year ending 31 March 2017

Source: Department for Education, Child death reviews: year ending March 2017



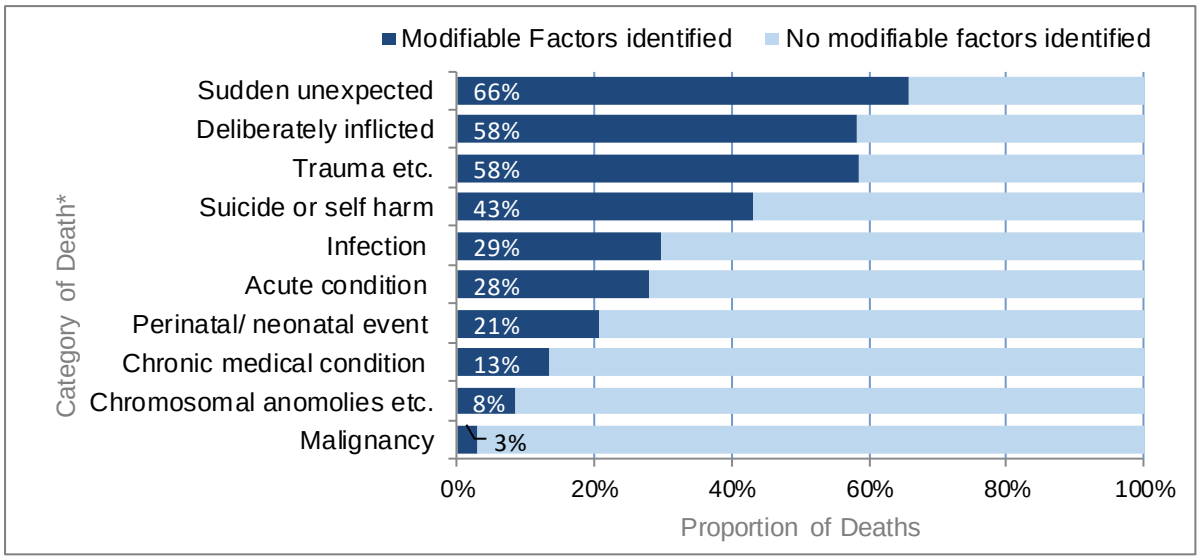
Modifiable Factors

Since 1 April 2010, a requirement has existed to determine whether there were 'modifiable factors' in the death of a child when reviewing the death. Modifiable factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce future child deaths.

Of the child deaths reviewed in England over the five years to 2017, just less than a quarter (24%) were identified as having modifiable factors[4].

Figure 4: Child Death Reviews in England by Category

All child death reviews completed in the five years ending 31 March 2017



*The full titles of the categories defined by ONS are (in the order they appear in the chart): sudden unexpected, unexplained death; deliberately inflicted injury, abuse or neglect; trauma and other external factors; suicide or deliberate self-inflicted harm; infection; acute medical or surgical condition; perinatal/ neonatal event; chronic medical condition; chromosomal, genetic and congenital anomalies; and malignancy.

Source: NHS Digital, Statistics – Child Death Reviews (https://bit.ly/2AMRxdl)

Figure 4 shows how the cases with modifiable factors were distributed between different categories of deaths. The three categories with the highest percentage of modifiable factors in England were:

- sudden unexpected, unexplained death;
- deliberately inflicted injury, abuse or neglect; and
- trauma and other external factors.

This illustrates that modifiable factors are more important in preventing deaths which have causes which might be thought of as less 'medical' in their character, i.e. causes more obviously 'external' to the long-term health of the children concerned.

This is supported by other data at a national level: for the last year for which figures available (the year ending March 2017), the events that caused death with the highest percentage of identified modifiable factors were:

- Road traffic accidents/collisions (69% with modifiable factors);
- Drowning (64%)
- Apparent homicide (64%)

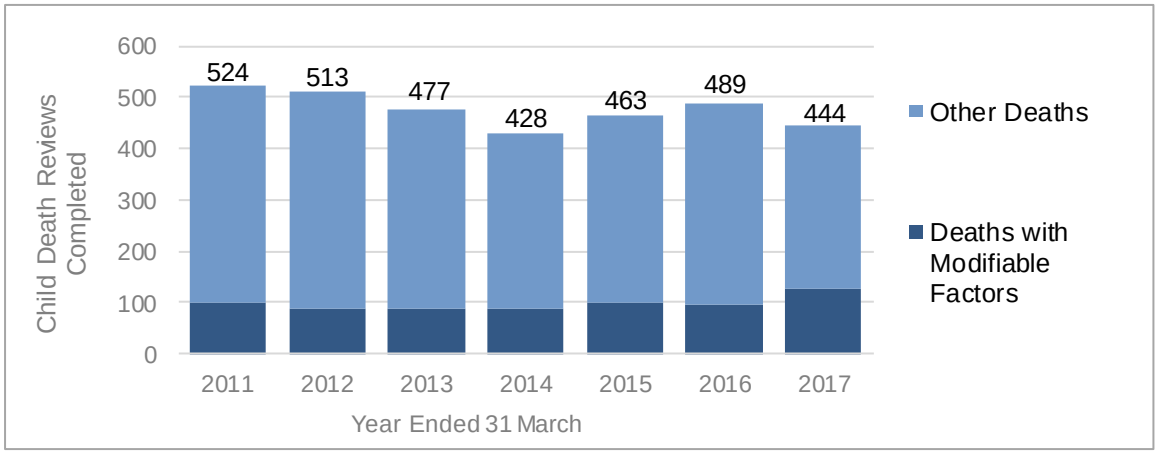
[4] There were 20 deaths in England in 2017 where it was not known if there were modifiable factors. In 2016, there were 39 such deaths, in 2015, there were 31, in 2014 there were 40, and in 2013 there were 22.

Although these categories had high rates of modifiable factors associated with them, the actual numbers of deaths in these categories were relatively low. The largest of the categories above, road traffic accidents and collisions, covered 89 deaths—less than 3% of the total for that year.

As in the case of the national data, statistics on the number of child death reviews in the West Midlands region are not yet available for the years ending in March 2018 and 2019. However, by looking at the previous seven years overall, we can see a falling trend in the number of deaths reviewed, as illustrated by the chart in Figure 5. Deaths with identified modifiable factors represented 28% of the total in 2016-17.

Figure 5: Trend in Child Death Reviews in the West Midlands Region

Reviews completed by CDOPs, seven years ending 31 March 2017



Sources: Child death reviews: year ending 31 March 2017, Main tables SFR36/2017, Table 1; SFR23_2015, Table 1.

CHILD DEATH REVIEWS IN DUDLEY

Numbers of Deaths Reviewed

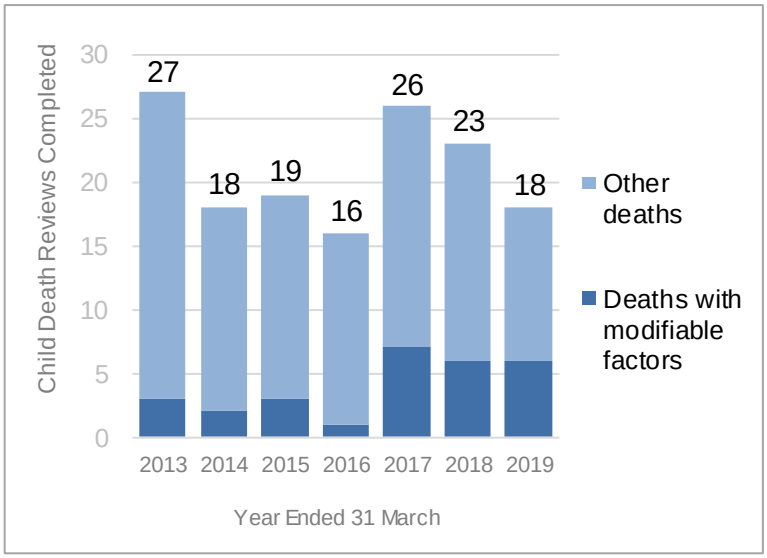
A total of 18 deaths were reviewed by the Child Death Overview Panel in Dudley between April 2018 and March 2019. This represented a reduction on the previous year when 23 were reviewed.

Of the deaths reviewed in 2018-19, six were identified as having a modifiable factor, representing 33% of the total. Although in percentage terms this represents an increase on last year (which accounted for 26%), this is in line with the increasing propensity to identify modifiable factors, discussed below.

Figure 6:
The Trend in Child Death Reviews in Dudley

Based on all child death reviews in the seven years ending 31 March 2019

Source: Child Death Overview Panel Dudley



Causes of Death

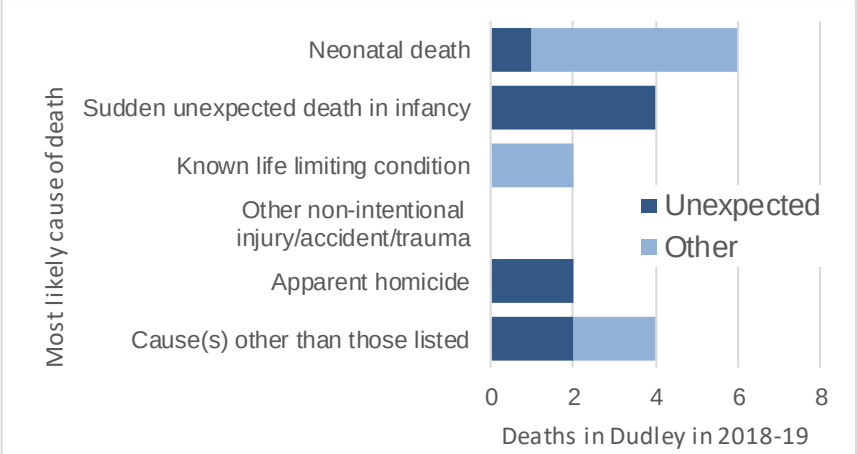
The most common categories assigned to deaths reviewed by the Dudley CDOP in the last seven years have been Perinatal/neonatal events and chromosomal, genetic and congenital anomalies, each accounting for around three in every ten deaths reviewed.

In addition to monitoring deaths by their category, child deaths are allocated to predefined causes. As illustrated by Figure 7, the two most common causes of deaths reviewed in Dudley in the year ending in March 2019 were Neonatal Death and Sudden Unexpected Death in Infancy (SUDI).

Figure 7: Child Death Reviews in Dudley by Most Likely Cause

Based on all child death reviews in the year ending 31 March 2019

Source: Child Death Overview Panel Dudley



Contributory Factors

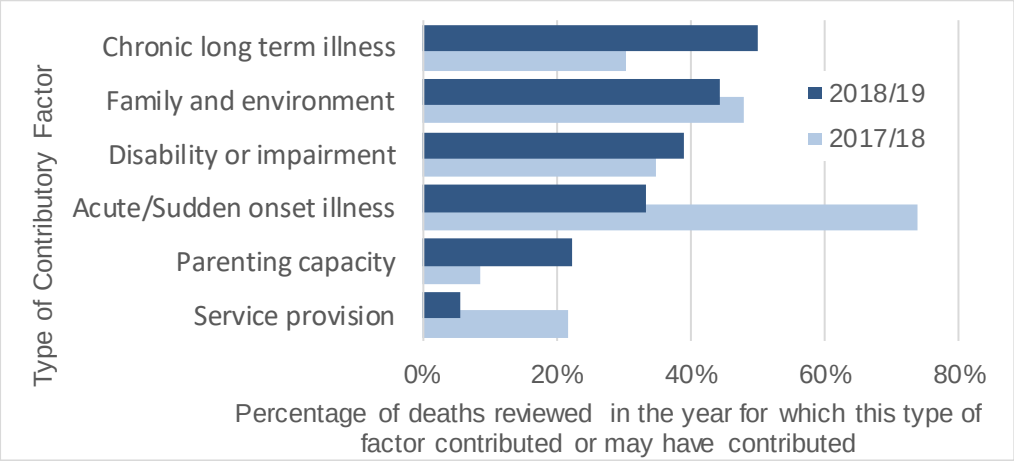
The form currently used to collect data on child deaths monitors 28 factors which might have contributed to any death subject to a CDOP review. Unfortunately, in some previous years information was not always available to the panel to allow them to record whether the factor contributed to the death or not. In 2017-18, for example this was particularly the case for data on smoking where, for half of cases, no information was available on its possible role in the death. This situation has been remedied during the year 2018-19 and now, in all cases a view was recorded whether any of the 28 factors might have had an effect.

In 2017-18 acute or sudden onset illness was a common contributory factor. However, Figure 8 shows that other issues were important in 2018-19, particularly factors connected with chronic long-term illness or the family and its environment.

Although consanguinity had been a possible factor in five cases reviewed in 2017/18, none were identified in 2018/19 where it was relevant.

Figure 8: Child Death Reviews in Dudley by Most Likely Cause

Based on all child death reviews in the year ending 31 March 2019

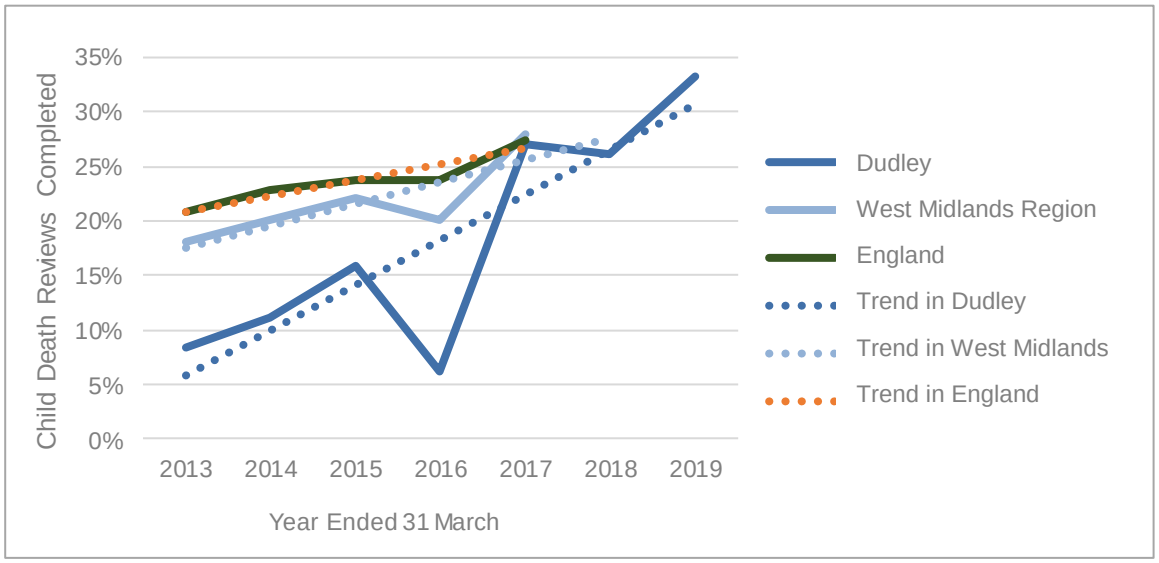


Source: Child Death Overview Panel Dudley

Since modifiable factors started being recorded (in 2010) there has been a national increase in the proportion of deaths for which they have been identified. This is also the case in Dudley, where the current high proportion of deaths with modifiable factors (one in every three) is unprecedented in our records. However, this apparent increase is also reflected in the trends for the West Midlands Region and for England, shown in Figure 9. This increase is generally the result of an improving ability of CDOPs to identify modifiable factors.

Figure 9: Trends in the Percentage of Deaths with Modifiable Factors

Based on all child death reviews in the seven years ending 31 March 2019



**In the year ending 2016, the category of one death was unknown, and this death has not been included in this chart. In the year ending March 2017 one death was assigned two categories.*

Sources: Child Death Overview Panel Dudley; NHS Digital, Statistics – Child Death Reviews (https://bit.ly/2AMRxdl).

Unexpected Deaths

Half of the deaths reviewed in the year ending in March 2019 were identified as unexpected (i.e. not expected to die within the 24 hours preceding the death). This compares with 57% in the previous year.

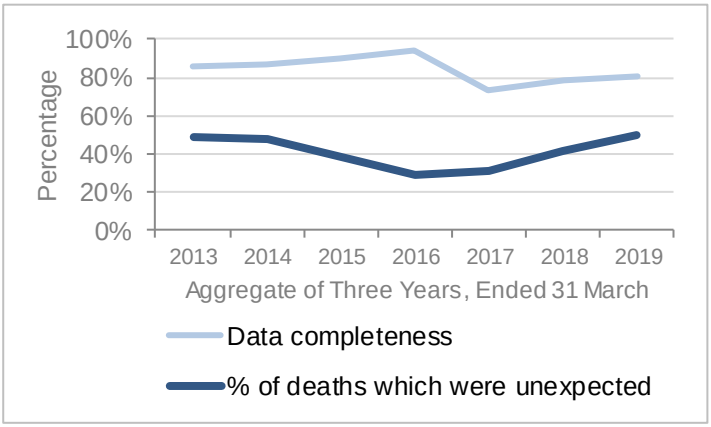
Figure 10 shows a rolling average of unexpected deaths as a percentage of all deaths. This shows that the long-term trend appears to be relatively stable, although this conclusion cannot be drawn with any degree of statistical confidence. In previous years there have been cases where data has not been recorded to say whether a death was expected or not and as a result, as Figure 10 illustrates, average completeness for this measure has generally only been 80% or 90%. For the latest two years however the data has been 100% complete.

Among unexpected deaths reviewed in 2018-19, the causes were classified as: sudden unexpected death in infancy; apparent homicide; neonatal death; and other.

Figure 10: Reviews of Unexpected Deaths in Dudley

Based on all child death reviews in the six years ending 31 March 2019

Source: Child Death Overview Panel Dudley



Child Deaths by Age and Sex

Deaths of children under one year have accounted for three in every five of the child deaths reviewed in Dudley (62%) in the seven years ending in 2018. In the latest year the proportion was above this average at 72%, which is higher than both the local average in previous years and the national position as shown in Figure 3.

For the deaths under one year, Figure 11 shows the pattern of age at death for the latest year compared to each of the previous six years. In recent years children dying in their first week have generally represented a smaller share of the total dying in their first year. This may indicate better care in the perinatal period.

Thirteen deaths of children under one year were reviewed in Dudley in 2018-19. For nine of these we have a recorded gestation period. However, of these, only three (i.e. 33%) were known to have been born at full-term (i.e. more than 36 weeks gestation). This appears especially low when viewed in the national context, where more than nine in every ten live births of more than 24 weeks gestation are full-term[5].

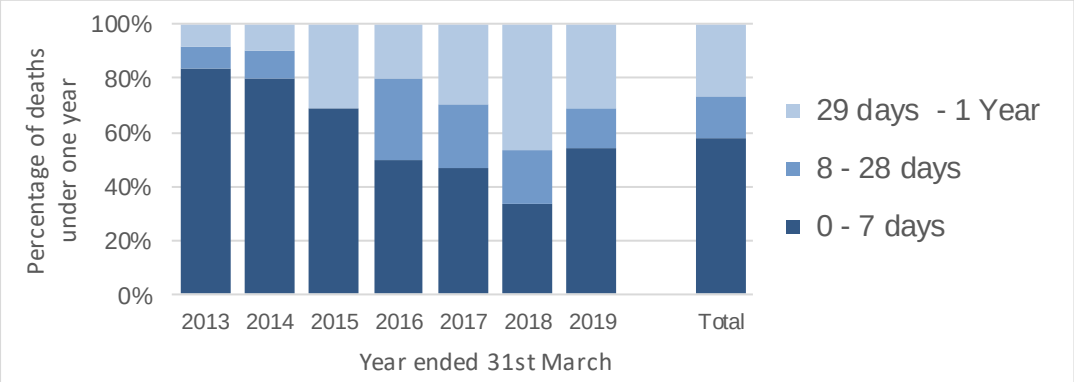
For the year 2018-19 the child deaths reviewed in Dudley were born to mothers between the ages of 17 and 38. However, looking at the last two years, the percentage of deaths reviewed where the mother's age was 40 or over at the time of birth is shown in Figure 12. The chart suggests that, among child death reviews in Dudley, there are a disproportionate number of children born to older mothers, although the data from two years' reviews is not sufficient to show a statistically significant variation.

Over the last six years more male children have been subject to CDOP reviews in Dudley than females (53% to 47%), as illustrated by Figure 13. In the year ending in March 2019 the gender balance was equal: deaths of nine males and nine females were reviewed.

[5] In 2017 for example, there were 675,875 live births in England and Wales at a gestation period of 24 weeks or more, of which 622,899 (92%) were born at full-term (Source: birthcharactieristicsworkbook2017.xls;

Figure 11: Reviews Child Deaths in Dudley Aged One Year or Less

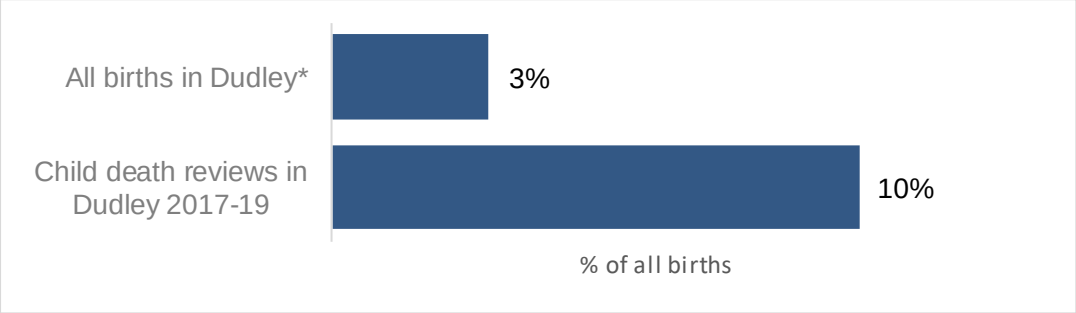
Years Ending 31st March



Source: Child Death Overview Panel Dudley

Figure 12: Mothers Aged 40+ at Time of Birth

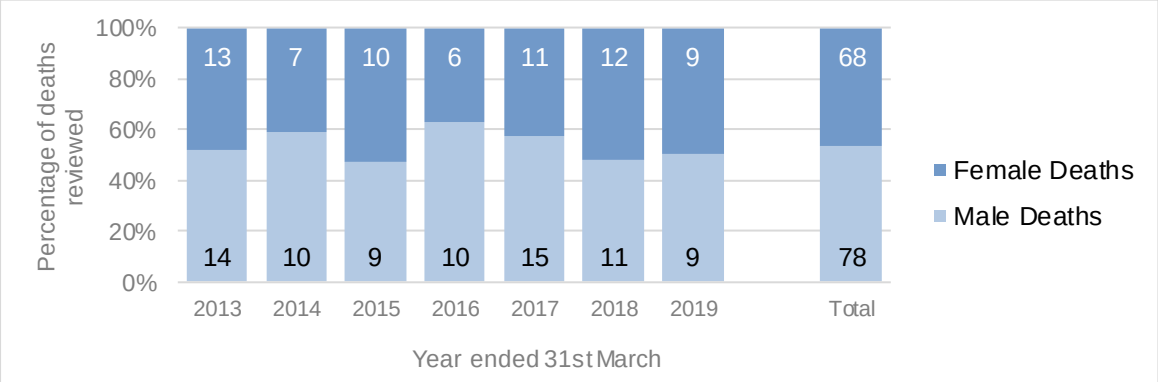
Child death reviews in Dudley compared to all births



*Source: Child Death Overview Panel Dudley; *Estimate based on data from fingertips.phe.org.uk*

Figure 13: Child Death Reviews by Gender

Dudley, based on all child death reviews in the years ending 31 March, 2013 to 2019



Source: Child Death Overview Panel Dudley

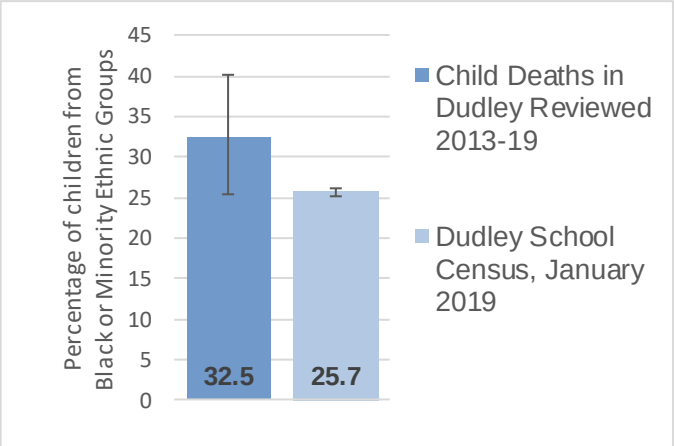
Child Deaths & Ethnicity

Considering the last six years in total, the proportion of deaths of children in Dudley from Black and Minority Ethnic (BME)[6] groups has been 33%. This is proportionately higher than the number of BME pupils in the most recent Dudley School Census for example, as shown by Figure 14, although it is not possible to show a statistically significant difference.

Figure 14:
Black and Minority Ethnic Children

Child death reviews in the seven years ending 31 March 2019, compared to the Dudley School Census in January 2019

Source: Child Death Overview Panel Dudley; Dudley School Census January 2019. Black and Minority Ethnic children are defined as being all those whose ethnicity was not in the category of 'White: English/Welsh/Scottish/ Northern Irish/British'.



Deaths by Location and Deprivation Level

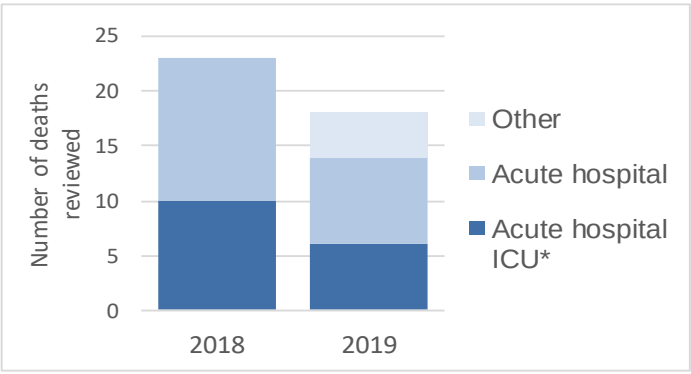
The majority (90%) of the deaths reviewed in the two years ending in March 2018 took place in an acute hospital and, of these, 43% occurred in an intensive care unit.

Figure 15:
Location of Death

Dudley, child death reviews in the years ending 31st March 2018 and 2019.

Source: Child Death Overview Panel Dudley

**ICU refers to either adult or paediatric intensive care unit*



In the same period twelve deaths took place within the first week of life: of these, six were of children born at Russells Hall and four at Birmingham Women's Hospital.

On the basis of the latest year's data alone, there is no evidence of a link between child deaths and the levels of deprivation in their area of residence. However the absence of a link is not unexpected given the small number of deaths overall, and it does not necessarily suggest that the evidence in Dudley contradicts studies elsewhere which have shown associations between child deaths and deprivation levels.

[6] The definition of BME used here includes all ethnic groups except for 'White: English/Welsh/Scottish/ Northern Irish/British'

ACHIEVEMENTS AND FUTURE DEVELOPMENTS

Some achievements in 2018-19

- From September 2018, established system, processes and arrangements for the merging of Sandwell and Dudley CDOP.
- The role of CDOP Nurse is well embedded and has been instrumental in driving the amalgamation of the two panels;
- Dudley CDOP has successfully led the development of a bid to become an early adopter site for developing a Black Country strategic CDOP;
- In continuing with our advocacy role, Dudley CDOP has maintained its support of the sepsis campaign across the Borough.
- The panel oversaw the delivery of a water safety campaign across the Borough;
- We have introduced minute briefings, where the findings/learning and points of interests identified from child deaths reviews are collated and disseminated across all partner agencies.
- In executing its quality assurance role, the panel have referred two child deaths to the attention of the Serious Case Review (SCR) subgroup for the consideration of undertaking a SCR.

Future developments

We are committed to influencing the infant mortality agenda in Dudley.

Continue to embed and strengthen the joint working arrangements within the Sandwell and Dudley CDOP.

Contribute to the development of the Black Country Strategic CDOP in order to:

- provide good quality data on causes of death and modifiable factors in domains related to the child and the wider system;
- develop novel approaches to linking hospital mortality review processes to CDOP reviews and undertaking thematic reviews.