



Child Death Overview Panel Executive Summary

2008-2010



Contents

1	Introduction	3
2	Background	4
3	Population Demographics	4
4	Child Mortality in Bradford	4
	4.1 Infant Mortality	5
	4.2 Child Mortality	6
5	Funding arrangements	6
6	Child Death Overview Panel	7
7	Notification of Death	7
8	Serious Case Reviews	7
9	Activity Analysis of reviewed deaths	8
	9.1 Reviewed deaths: by Age	8
	9.2 Reviewed deaths: by Gender	9
	9.3 Reviewed deaths: by Ethnicity	9
	9.4 Reviewed deaths: by Category of death	10
	9.5 Risk factors	13
	9.6 Preventability of child deaths	13
10	Summary	14
11	Recommendations	15
	References	16
	Appendix 1 - Terms of Reference	17

1 Introduction

The Bradford District infant mortality rate is one of the highest in the country and in response to this, Bradford set up an Infant Mortality Commission in 2004 to look in depth at the reasons for this and set out a plan of action for all partners in the district to address the causal factors. Work is now well underway to reduce the risk factors which contribute to such a high mortality rate and the Every Baby Matters Steering Group leads the programme to reduce infant mortality rates. In addition, an ambitious and pioneering research project was commenced, Born in Bradford (www.borninbradford.org.uk). This is now tracking the lives and health of 10,000 children born in Bradford through to adulthood.

In April 2008, the Bradford Safeguarding Children Board established the Child Death Overview Panel in response to the statutory requirement set out in Working Together to Safeguard Children¹. This was a welcome addition to the work already being undertaken in the district. The aim of Overview Panels is to systematically analyse all child deaths from birth to 18th birthday in order to try to prevent deaths in the future.

Since its inception, 193 deaths have been reported to the Panel between 1st April 2008 and 31st March 2010 in children under 18 years of age. Of these deaths, 91 (47%) have been formally reviewed over the course of the two years and this includes 2 deaths that were actually reviewed in April 2010. This report details the work of the Panel over its two years of activity. Although it is still too early to comment upon any trends in the data, the information gathered by the Panel indicates that between 2008 and 2010, 71% of the reviewed deaths were due to either chromosomal, genetic or congenital anomalies or perinatal /neonatal events. Of the 91 reviewed child deaths, 2 have been identified as being preventable and 6 have been categorised as potentially preventable.

We look forward to the important work being undertaken by the Child Death Overview Panel and its contribution to reducing the incidence of childhood deaths in the district in the future.

Professor Nick Frost
Chair of Bradford Safeguarding Children Board



2 Background

In response to the Child Death Review requirement detailed in Working Together, the Bradford Safeguarding Children Board (BSCB) established a working group in January 2008 in order to develop the systems, procedures and protocols required to comply with this statutory responsibility.

The working group met frequently and using the guidance from Working Together established a Child Death Overview Panel, Terms of Reference and the multi agency protocols required by staff dealing with child death. They have also coordinated the establishment of the necessary staff training programmes.

Bradford also participated in a West Yorkshire-wide group which met to consider similar information in order to ensure a consistent approach across the sub-region.

3 Population Demographics

Bradford has a significantly higher proportion of children and young people than the UK average. The total population of Bradford was estimated as 502,000 in 2008. A large proportion of the Bradford population are from ethnic minority communities, which comprise nearly one quarter of the population total.

Three quarters of the population describe themselves as White British; around 18% of the ethnic minority population described themselves as Pakistani (15%) or Indian (3%)⁶. The birth rate in Bradford district is continuing to grow and Bradford has a higher percentage of young people in all age groups than is the average for England⁶. The population of children and young people is higher than the national average and projected to rise significantly over the next 20 years by nearly 30%; this, together with higher fertility rates in South Asian communities, will further contribute to increasing births across the district.

Presently, it is estimated that 38% of Bradford's children under 20 years of age are of South Asian origin⁷.

4 Infant and Child Mortality in Bradford

Infant and child mortality rates are higher in Bradford district than regionally or nationally (see overleaf). Amongst Bradford's total child population aged 0-18 years, 63% of the total deaths occurred in infants under one year of age and 37% of deaths occurred in children between 1 and 18 years.

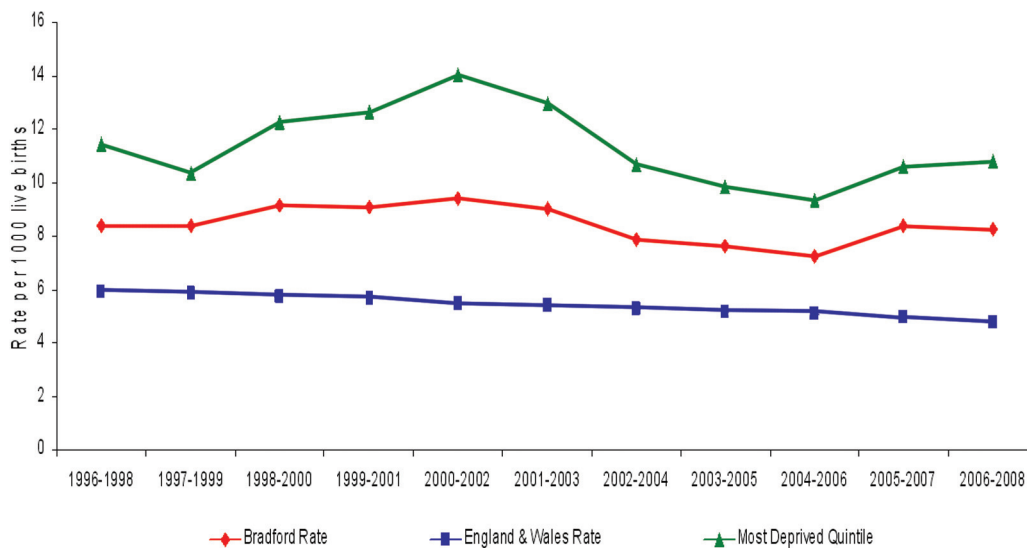
It is important to note that the remit of the CDOP is to review all deaths that occur from birth up to 18th birthday and therefore the CDOP report includes only data relating to the 47% of all child deaths which have been reviewed during the defined period April 2008 to March 2010 in that category.

4.1 Infant Mortality (under 1 year)

Infant mortality is defined as the number of deaths in the first year of life per 1000 live births. The latest infant mortality rate for Bradford district (8.2 per 1000 live births) remains above the England average (4.8 per 1000 live births) for the period 2006-2008. Bradford’s infant mortality rate is one of the highest in the country and is higher than other areas in the region.

Infant mortality rates have reduced since the peak in 2000-2002 but remain much higher than the England and Wales average and rates are higher in the more deprived parts of the district as the graph below demonstrates.

**Infant Mortality Rates per 1,000 live births across Bradford district:
3 year rolling averages 1996/98 - 2006/08**



Source: Public Health Intelligence and Analysis, NHS Bradford and Airedale, based on ONS data

An independent Infant Mortality Commission was set up in Bradford district in 2004-2006 to investigate why some babies born in the district die during their first year of life and a key report was produced⁸. Infant mortality is linked with poverty and deprivation as well as other risk factors such as smoking, alcohol and substance misuse, young motherhood and increased risk of congenital anomalies; these factors are more common in some communities in Bradford district. The work of the Commission continues as part of the Every Baby Matters Steering Group agenda and focuses on the 10 recommendations within its original report⁸.

4.2 Child Mortality (1-18 years)

Neonatal mortality rates, infant mortality rates (per 1,000 live births) and child mortality rates (per 10,000 population) in Bradford district are all higher than other districts in the region and higher than England and Wales for 2005 to 2007⁹.

Summary mortality rates: Yorkshire & Humber 2005 to 2007

	Number (rolling average)
Total births	62,960
Live births	62,594

	Neonatal mortality rate, < 28 days	Infant mortality rate, < 1 year	Child mortality rate, < 19 years
Bradford & Airedale	5.4	8.3	7.7
Total Yorkshire & Humber	4.0	5.8	5.0
Total England	3.4	4.9	4.7

Source: ONS Vital Statistics 2007

5 Funding Arrangements

Funding arrangements have been successfully implemented. The Bradford Safeguarding Children’s Board (BSCB) agreed to fund a full-time Child Death Administrator Post and this post has been fully operational since May 2008. The funding was agreed for a part-time SUDIC Paediatrician and the post became immediately operational in November 2008. Bradford Teaching Hospitals NHS Foundation Trust hosts both posts.

6 Child Death Overview Panel

The Child Death Overview Panel was established in Bradford, in line with the statutory guidance in Working Together to Safeguard Children in April 2008, and is under review following publication of the 2010 version. It is composed of a standing core membership as follows;

- Paediatrician for Sudden and Unexpected Death in Childhood (SUDIC)
- Pathologist
- Children's Social Care
- Health – Primary care
- Health – Secondary care
- Education
- Public Health
- Police
- Coroners Office
- Faith member of the panel

Also in attendance are the manager of the Bradford Safeguarding Children Board, as an advisor, and the CDOP administrator.

7 Notification of Death

Any professional who becomes aware of a child death is required to notify the Child Death Administrator at the Child Death Review office either by completing a notification form or by telephoning the office. The Coroners Office and the Registrar of Births Deaths and Marriages all now have a statutory responsibility to engage in the child death review process by notifying the Administrator of all deaths reported to them. There can be confidence therefore, that information on all deaths is captured by the child death review team.

Each agency has a nominated individual who takes responsibility for coordinating the information required for the review of each death. The data collection forms (agency report forms) are distributed via the administrator and copies of the various forms can be found on the BSCB website.

8 Serious Case Reviews

Local Safeguarding Children Boards (LSCB) commission serious case reviews when a child has died or been seriously harmed through abuse or neglect. The purpose of the serious case review is to ensure that lessons are learned which help to better protect children in the future. The CDOP may refer a case to its LSCB Chair if it considers the criteria for a Serious Case Review may be met and has not been initiated.

Between April 2009 and March 2010 there have been two serious case reviews in Bradford. The CDOP have not referred any of the deaths reviewed for a Serious Case Review. Any case that is considered under the remit of Serious Case Review will not be reviewed by the Child Death Overview Panel until the Serious Case Review has taken place.

9 Activity Analysis of reviewed deaths

The following data has been collated from the deaths in children under 18 years of age of age, (up to the 18th birthday and described as 0-17 years), resident in Bradford district formally reviewed and reported to the panel over the course of the two years from 1st April 2008 to March 31st 2010. It must be noted that the analysis includes only the 91 deaths reviewed; this was 47% of all 193 total deaths that occurred that were reported to CDOP panel and must be treated with caution as it does not include information on all the child deaths reported for the two year period.

Child deaths reported / reviewed 1st April 2008 to 31st March 2010

	2008 - 2009	2009 - 2010	Total
Reviewed deaths	36 (42%)	55 (51%)	91(47%)
Reported deaths	85	108	193

Source: CDOP database and Public Health Intelligence Team, NHS Bradford and Airedale

A total of 91 deaths were reviewed over the two years; 36 deaths were reviewed out of a total 85 deaths (42%) notified in 2008-2009 and 55 deaths (51%) were reviewed out of 108 deaths notified in 2009-2010. The % of deaths reviewed in Bradford is one of the highest in the region (range 13-48% for 2008/9 in Yorkshire and Humber) and this is despite the fact the actual number of deaths to be reviewed are 3 to 5 times greater than other districts in the region ^{9,10}.

9.1 Reviewed Deaths: by age

Most of the cases reviewed were infant deaths. In 2008-2009, 88% of cases reviewed were infant deaths and in 2009-2010, 76% of reviewed cases were infants.

Child deaths reviewed, by age under 1 year and 1-17 years

Age Bands	2008-2009	Percentage	2009-2010	Percentage
Under 1 year	32	88%	42	76%
1-17 years	4	12%	13	24%
All Under 18 years	36	100%	55	100%

Source: CDOP database and Public Health Intelligence Team, NHS Bradford and Airedale

Child deaths reviewed, by ages under 1 year

Age Bands	2008-2009	Percentage	2009-2010	Percentage
0-28 days	17	53%	24	57%
28 days to 52 wks	15	47%	18	43%
All Under 1 year	32	100%	42	100%

For infant deaths reviewed under one year of age, 53% in 2008-09 and 57% in 2009-10 were 0-28 days of age (neonatal period).

9.2 Reviewed Deaths: by Gender

For the whole period 2008 – 2010, 48% of the deaths reviewed were female and 52% were male.

Child deaths reviewed, by gender

Gender	2008-2009	2009-2010	Total reviewed	Percentage
Female	14	30	44	48%
Male	22	25	47	52%
TOTAL	36	55	91	100%

Source: CDOP database and Public Health Intelligence Team, NHS Bradford and Airedale

9.3 Reviewed Deaths: by Ethnicity

Of the 91 child deaths reviewed over 2 years (2008-2010), 67% were self reported as South Asian, 26% as White British, 6% as Mixed or Eastern European.

Ethnic classification of reviewed child deaths, 2008-2010

Ethnicity	Total 2008-2010	Percentage
British White	24	26%
South Asian	61	67%
Eastern European & Mixed	6	6%
TOTAL	91	100%

Source: CDOP database and Public Health Intelligence Team, NHS Bradford and Airedale

9.4 Reviewed Deaths: by Category of Death

The following categories are used by the CDOP to classify the child deaths reviewed. These categories are standardised nationally and have been provided by the Department for Children, Schools and Families, now the Department for Education. The following table shows the number of child deaths that have been reviewed in 2008-2009 and 2009-2010, and the categories of death into which they have been classified.

Child deaths under 18 years reviewed, by category of death

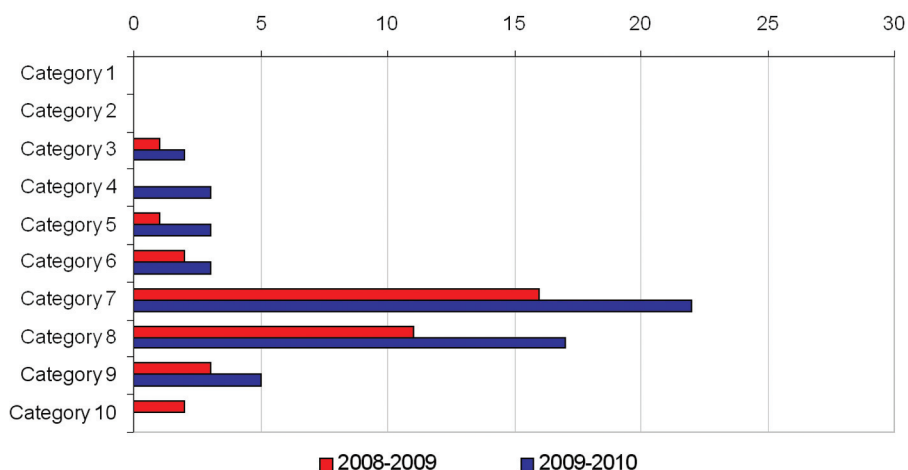
Categories of death	2008-2009	Percentage	2009-2010	Percentage
1. Deliberately inflicted injury, abuse or neglect	0	0%	0	0%
2. Suicide or deliberate self-inflicted harm	0	0%	0	0%
3. Trauma and other external factors	1	2.8%	2	3.6%
4. Malignancy	0	0%	3	5.5%
5. Acute medical or surgical condition	1	2.8%	3	5.5%
6. Chronic medical condition	2	5.6%	3	5.5%
7. Chromosomal, genetic and congenital anomalies*	16	44%	22	40%
8. Perinatal / neonatal event*	11	31%	17	31%
9. Infection*	3	8.3%	5	9%
10. Sudden unexpected, unexplained death	2	5.6%	0	0%
TOTAL	36	100%	55	100%

* 3 most common causes of death for all children under 18 years

Source: CDOP database and Public Health Intelligence Team, NHS Bradford and Airedale

(2 cases included which were actually reviewed in April 2010 but all deaths occurred during period April 2008-March 2010 and total of 47% of all deaths that actually occurred were reviewed in this period of time.)

Child deaths 0-18 years reviewed, by category of death, by year of review



Source: CDOP database and Public Health Intelligence Team, NHS Bradford and Airedale

In all children under 18 years of age (0-17 years): 83% of the child deaths reviewed in 2008-2009 and 80% of those reviewed in 2009-2010 were in categories 7, 8 and 9. These categories relate to:

- chromosomal, genetic and congenital anomalies (e.g. baby with a severe abnormality at birth due to a genetic cause) - category 7
- perinatal / neonatal events (e.g. premature baby born very early) - category 8
- infections (e.g. a baby dying of bronchopneumonia) - category 9

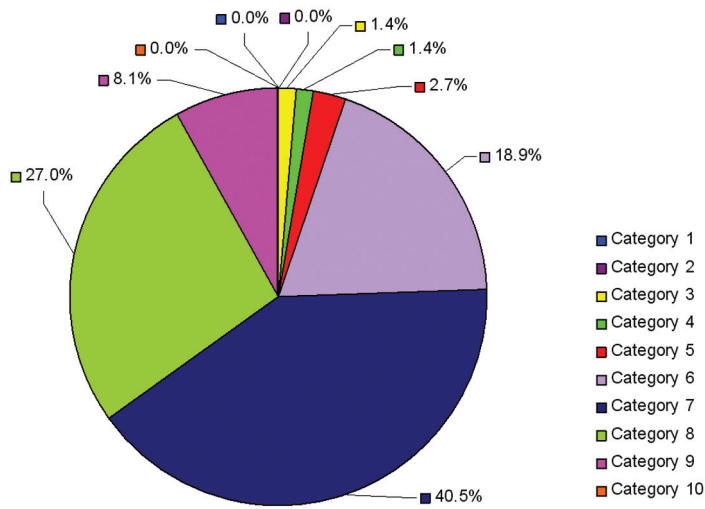
71% of all reviewed deaths were in the top two categories 7 and 8 outlined above.

In children, under 1 year of age, the highest percentages of deaths are in categories 6, 7 and 8; these categories account for a total of 87% of the cause of death amongst reviewed infants under one year of age:

- 41% - Chromosomal, genetic and congenital anomalies - category 7
- 27% - Perinatal /neonatal events - category 8
- 19% - Chronic medical condition (e.g. a progressive disease of the muscles) - category 6

68% of all reviewed deaths occurred in the top two categories 7 and 8 as outlined above.

Categories of reviewed deaths for children <1 year of age 2008-10

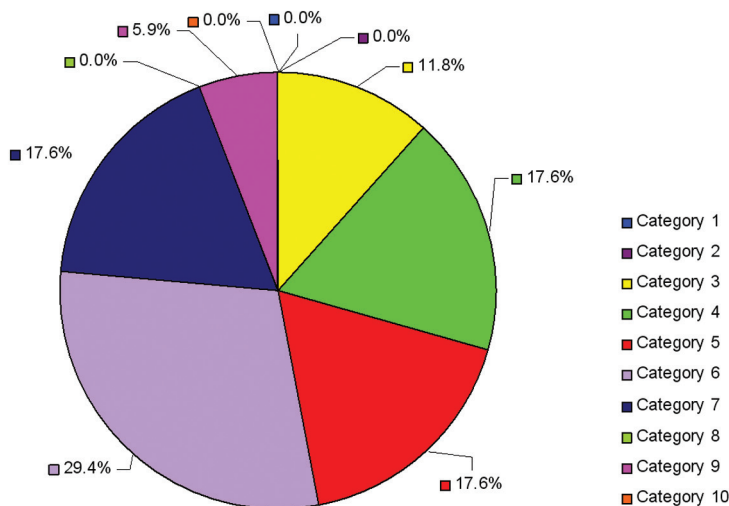


Source: CDOP database and Public Health Intelligence Team, NHS Bradford and Airedale

In children aged 1 to 17 years, the main causes of death differ from those seen in under 1 year olds; the most common four categories amongst the child deaths reviewed are shown below and account for 83% of all deaths reviewed:

- 29% - Chronic medical condition - category 6
- 18% - Malignancy category (e.g. due to cancer) - category 4
- 18% - Acute medical or surgical condition (e.g. a disease which happens over a short period of time - category 5
- 18% - Chromosomal, genetic and congenital anomalies - category 7

Categories of reviewed deaths for children 1-17 years of age 2008-10



It is important to note that these are reviewed deaths only and do not include all reported deaths in the time period.

9.5 Risk factors

Data is collected by the CDOP on a range of factors that potentially influence child deaths including for example smoking, alcohol intake, domestic violence and consanguinity (marriage with a close family member e.g. cousin). These were collated together with postcode data and other key demographics. For example smoking in pregnancy is known to be associated with increased low birth weight rates and poorer outcomes for infants and consanguinity is also linked to increased infant mortality and morbidity due to the increased risk of autosomal recessive conditions ^{8,12}.

The CDOP panel will continue to monitor these key factors and demographics and as sufficient data becomes available over time these will inform future recommendations.

9.6 Preventability of Child Deaths

Of the 91 child deaths reviewed from April 2008 to March 2010 there have been 2 deaths in which there were modifiable factors which would have made the death preventable and they relate to category 3 (trauma and other external factors).

There were 6 deaths which were potentially preventable, or where factors were potentially modifiable, and these related to categories 3 (trauma and other external factors), 5 (acute medical or surgical condition), 7 (chromosomal, genetic and congenital anomalies), 8 (perinatal / neonatal event) and 10 (sudden unexpected, unexplained death).

The majority of child deaths were not preventable and were caused by a range of factors.

10 Summary

The Bradford district has a population of children and young people which is greater than the UK average and the Bradford district infant mortality is one of the highest in the country. Bradford Safeguarding Children Board responded to the statutory guidance and implemented the Child Death Overview Process during 2008. We now have two years of comparative data. Overall, the most common causes of death in children under 18 years who were reviewed were either due to chromosomal, genetic and congenital anomalies or due to perinatal /neonatal events; these two categories of cause of death accounted for 71% of all reviewed deaths. In addition, 83 of the 91 deaths reviewed were not considered to have any modifiable factors which may have prevented the death.

In the remaining 8 deaths where there were considered to be modifiable factors which could or may have made the death preventable, the causes of death relate to trauma and other external factors, acute medical or surgical conditions, chromosomal, genetic and congenital anomalies, perinatal /neonatal events and sudden unexpected, unexplained deaths.

The Panel have made recommendations to BSCB or single agencies where appropriate. The report contains much in depth and detailed data on category of death, ethnicity, gender and other details but it must be remembered that this report relates only to reviewed deaths and not all reported deaths.

Although the activity undertaken by the panel is significantly higher than other panels regionally there remain a number of deaths that require review and the panel will continue to develop the review process within the statutory guidance in order to expedite reviews and to ensure the necessary data is available for future reports.

11 Recommendations**Recommendation for Bradford Safeguarding Children Board**

- BSCB to discuss with other Safeguarding boards in Yorkshire and Humber the organisation of a campaign to increase the profile of the risk associated with overlaying and co-sleeping.
- BSCB to cooperate with the Every Baby Matters initiative's information and public awareness campaigns in relation to the infant mortality rate and of inherited conditions as a consequence of interfamilial relationships.
- BSCB to further develop the rapid response process and management of rapid response in the case of sudden and unexpected death and the co-ordination of bereavement support to parents.
- BSCB training unit to continue as required to provide training to multi-disciplinary professionals on the role of the management of unexpected deaths, the Child Death Overview Panel and its processes.

Recommendations for Child Death Overview Panel

- To gather more detailed and specific information on child deaths which can be used to inform service provision locally, including the smoking status of both parents and information on consanguinity, safeguarding, alcohol and substance misuse and bereavement support.
- Data collection tools to be reviewed and modified according to any additional local information that may need to be gathered and analysed and be more specific to professionals completing the forms.

Single Agency Recommendations for Bradford Hospital Foundation Trust

- The development of guidelines for staff to follow and document when telephone advice is sought about a sick child or baby.

Single Agency Recommendations for Airedale NHS Foundation Trust

- The development of an assessment protocol which determines level of senior intervention required for obstetric care depending upon categories of risk

Janette Reynolds - Chair CDOP

Louise Clarkson - CDOP administrator

June 2009

Barbara Cox - Interim Chair CDOP

Dr Shirley Brierley - NHSBA Public Health Intelligence Team and CDOP Panel

December 2010

11 References

1. Department of Children, Schools and Families (2006) Working Together to Safeguard Children. London. The Stationery Office. London. DCSF
2. Department of Children, Schools and Families (2010) Working Together to Safeguard Children revised version London. The Stationery Office. London. DCSF
3. CM 5207 (1) (2001) The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995 Learning from Bristol. Ian Kennedy. The Stationery Office London
4. CM 5730 (2003) The Victoria Climbié Inquiry. Lord Laming. London. The Stationery Office
5. Department of Children, Schools and Families (2003) Every Child Matters - change for Children Programme. London. The Stationery Office
6. Director of Public Health Report 2008-09 NHS Bradford and Airedale based on ONS data Published 2009
7. WYCSA download August 2009 NHS Bradford & Airedale Public Health Intelligence downloaded August 2010
8. Bradford Vision, Bradford District Infant Mortality commission (2006) Summary report. Bradford Vision; Bradford
9. Yorkshire and Humber Government Office (2010) Yorkshire and Humber Child Death Review Report 2008-09
10. Personal communication with Bradford CDOP and Chairs from other areas in the district 2009
11. Bittles A.H. (1998) Centre for Human Genetics Empirical estimates of global prevalence of consanguineous marriages in contemporary societies Western Australia and California Stanford University
12. Bennett R.L., et al. Genetic Counseling and Screening of Consanguineous Couples and Their Offspring: Recommendations of the National Society of Genetic Counselors (2002) Journal of Genetic Counseling 11(2):97-119(23).

Appendix 1

Terms of Reference

7.2.1 Purpose

The purpose of the Child Death Overview Panel is to:

- a) collect and analyse information about each child's death with a view to identifying:
 - i) any case giving rise to the need for a serious case review
 - ii) any matters of concern affecting the safety and welfare of children in the area of the authority; and
 - iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area
- b) put in place procedures for ensuring that there is a coordinated response by professionals to an unexpected death.

The Panel will review deaths of all children aged 0-18 (excluding stillbirths) normally resident in the Local Authority area of the Bradford Safeguarding Children Board. Where the Panel is made aware of the death of a child in their area who would normally be resident in another Local Authority area, or vice versa the Child Death Review Administrator will liaise with his/her opposite number in the other Local Authority area to ensure both Panels are notified of the death and to determine which Panel is best placed to carry out a review of that child's death. Where possible it is advised that the panel in the child's area of residence takes responsibility for the review although it is recognised that circumstances will dictate the most appropriate outcome.

7.2.2 Functions

The Child Death Overview Panel will:

- Meet regularly to complete a multi-agency evaluation of all child deaths in their area;
- Where appropriate undertake a detailed and in-depth evaluation into specific cases, including all unexpected deaths, assessing all relevant social, environmental, health and cultural aspects, or systemic or structural factors of the death, along with the appropriateness of the professionals' responses to the death and involvement before the death, in order to complete a thorough consideration of whether and how such deaths might be prevented in future;
- Collect and collate information using the agreed templates (DCSF, 2008) and where relevant seek further information from professionals and family members;
- Identify local lessons and issues of concern, requiring effective inter-agency working;
- Identify and report any local Public Health issues and consider, with the Director of Public Health and other provider services how best to address these and their implications for both the provision of services and for training;

- Identify and advocate for needed changes in legislation, policy and practices, or public awareness, to promote child health and safety and to prevent child deaths;
- Ensure concerns of a criminal or child protection nature are shared with the police, children's social care and the coroner;
- Ensure any case identified as meeting criteria for a Serious Case Review are referred to the chair of the BSCB;
- Provide information to professionals involved with families so that this can be passed on in a sensitive and timely manner;
- Implement, review and monitor the local procedures for rapid response arrangements in line with Working Together;
- Monitor the quality of information, support and assessment services to families of children who have died;
- Co-operate with any regional and national initiatives in order to identify lessons on the prevention of child deaths.

7.2.3 Accountability

- The Child Death Overview Panel will be responsible, through its chair, to the chair of the Bradford Safeguarding Children Board. The Panel will provide to the BSCB and all constituent agencies, an annual report (in which all information should be aggregated and anonymised) which shall be a public document. In addition, the Panel will report to the BSCB any matters of concern arising from the course of its work as set out above.
- The BSCB will take responsibility for disseminating the lessons to be learned to all relevant organisations; ensuring that relevant findings inform the Children and Young People's plan; and acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.
- The BSCB will supply data regularly on every child death, as required by the Department for Children, Schools and Families, to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.