A review of Child Deaths in North East Lincolnshire 2008/09 – 2015/16

July 2016

A report of the North East Lincolnshire
Local Safeguarding Children Board
Child Death Overview Panel

Child Deaths in North East Lincolnshire, April 2008 to March 2016
'Every child death is a tragedy'

Executive Summary

The purpose of this report is to give organisations and professionals in North East Lincolnshire an understanding of the details, patterns, trends, and contributory factors of child deaths in North East Lincolnshire, with the aim of identifying areas for improvements and for opportunities to reduce the risk from modifiable factors in future child deaths. For the purposes of this report, a child death is defined as the death of a person aged under 18 years and normally resident in the North East Lincolnshire Local Safeguarding Children Board (LSCB) area.

The Child Death Overview Panel (CDOP) reviewed 11 child deaths in 2015/16, which was four more than during 2014/15. Due to the processes involved there is often a considerable amount of time between the date of death and the date of the panel at which the death was reviewed and signed off, therefore the date of a child's death and the date of the panel at which it was reviewed can be in different financial years. There were 98 child deaths between 2008/09 (when the current CDOP process started) and 2015/16, of which ten were still under investigation as at 31 March 2016 and the full details still to be signed off at panel.

North East Lincolnshire is a relatively small authority with a total population of 159,804 and an under 18 population of 34,309 according to ONS mid 2014 population estimates (ONS, 2015). Whilst each death is a tragedy, the number of deaths is relatively small, therefore inferences and trends based on these small numbers must be made with caution.

Further to the analysis of child deaths between 2008/09 and 2015/16, the findings show that on average, there have been 12 deaths per year. The majority of child deaths (63%) are infant deaths under one year of age. Over half (56%) of child deaths over this eight year period were classed as unexpected. Since 2010/11, approximately one fifth of all child deaths were categorised as perinatal / neonatal events, with a further fifth categorised as chromosomal genetic and congenital anomalies. For neonatal deaths from 2008/09, where length of gestation was known, 75% were premature. Since 2008/09 there were 13 child death reviews where modifiable factors were identified, which equates to 14% of all child death reviews. Of the deaths reviewed during 2015/16, one was identified as having modifiable factors. 62% of all deaths with modifiable factors were infant deaths (<1 year). There is a strong association with deprivation as 77% of deaths with modifiable factors were of children from the two most deprived quintiles.

This report is derived from information provided by agencies involved in the child's life, as part of the CDOP process, and the quality and completeness of data has become better in more recent years, particularly since 2010/11. It should be noted that this report includes data that was missing or incomplete from previous years, and therefore as figures have been refreshed this may result in differences to that published previously and therefore comparisons between this report and previous CDOP reports should be made with caution.

As sensitive information is provided on child deaths, including small numbers, the distribution and circulation of this report is restricted. A reduced public version of this report is published at
http://nelsafeguardingchildrenboard.co.uk/child-death-process/

Introduction

Local authorities have the overarching responsibility for safeguarding and promoting the welfare of all children and young people in their area. They have a number of statutory functions under the 1989 and 2004 Children Acts (HM Government, 2015). Local authority children's services are the key statutory agency responsible for planning and providing child protection services (House of Commons Education Committee, 2012). In England, Local Safeguarding Children's Boards (LSCBs) ensure that the key agencies involved in safeguarding children work together effectively. LSCBs were put on a statutory footing in 2006. Their core membership is set out in the Children Act 2004, and includes local authorities, health bodies, the police, and others including the voluntary and independent sectors (House of Commons Education Committee, 2012).

The LSCB functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. From 1 April 2008, LSCBs have had a statutory duty to review deaths of all children from birth (excluding still born babies) up to 18 years old, who are normally resident within their area. This is known as the Child Death Review Process (Department for Education, 2016a). These reviews are undertaken by the CDOP. The roles of the CDOP are outlined in Appendix 1. The main policy guidance for the CDOP process is the statutory and non-statutory guidance contained in 'Working Together to Safeguard Children' (HM Government, 2015). The Department for Education currently oversees the policy on CDOPs and provides a national data collection service, and an annual statistical publication based on the information it has received. A child death is defined as the death of a person aged under 18 years and normally resident in the North East Lincolnshire LSCB area, and excludes stillbirths. It is important to note that not all child deaths which occur each year will have their child death review completed by 31 March. This is because it may take a number of months to gather the information to fully review a child's death, and circumstances differ from case to case. Therefore a child death review may occur in a financial year (reporting period) after that of the actual death.

As part of the CDOP process, public health intelligence which is part of the local authority Commissioning and Strategic Support Unit, have produced this annual CDOP report, using information provided by the LSCB Coordinator and the LSCB Business Specialist, adding to and updating on previous years information. This includes a comprehensive review and analysis of local child deaths along with national benchmarking to identify patterns, trends, and causes of death, with the aim of reducing risks from modifiable factors in the future. Each year as additional data are pooled, a clearer picture is emerging of child deaths in North East Lincolnshire. Continual improvements are also being made regarding the coordination and facilitation of the CDOP with data quality and completeness improving greatly since 2010/11, and a new joint CDOP with North Lincolnshire effective from 2016/17.

This report is presented to the LSCB and disseminated among associated sub groups. CDOP members (listed in Appendix 2) are tasked with taking the report findings back to the

organisations they represent to share and to identify how the lessons learnt can be applied within their organisations and among their professional groups. Updates received from CDOP members regarding how the previous report has been used are detailed in Appendix 4.

There were a series of recommendations included in the previous report for 2014/15, and an update on these is presented in Table 1.

Table 1 Progress with the 2014/15 CDOP recommendations

Recommendations from the 2014/15 report	Progress made
1.That the report is shared with the LSCB and associated sub-groups to inform future work especially in the areas of high deprivation.	The CDOP report was shared with the LSCB.
2 That the report is shared with the Health and Wellbeing Board to inform priorities.	The CDOP report is to be shared with the Children's Partnership Board.
3.That each member of the CDOP share the report with their organisation and identify actions to be taken to reduce the risk from modifiable factors in future child deaths, and to explore the targeting of areas of high deprivation.	Each NEL CDOP member agency have shared the learning from the 2014/15 CDOP report within their organisations.
4. That the report is updated each year including reporting on actions that have been undertaken.	Ongoing.
5.That further comparison between North East Lincolnshire, national and other similar areas is undertaken where possible and to explore ways to overcome barriers of information not being readily available.	A full comparison with North Lincolnshire has been undertaken as a result of the development of their joint CDOP.
6. That the North East Lincolnshire CDOP continues to work with the North Lincolnshire CDOP in sharing learning and potential resources.	The first meeting of the Joint NEL/ North Lincolnshire CDOP took place on the 28th of April. Learning will be shared on a continual basis and resources where appropriate.
7. That the CDOP maintains an overview of the support provided to bereaved parents and families including any siblings, when a child dies unexpectedly.	The CDOP has maintained an overview of support offered to bereaved children and families locally.
8. That the CDOP reviews progress against core functions and reviews membership as required.	CDOP membership has been reviewed as part of the development of the joint NEL/ North Lincolnshire CDOP.
9. That the CDOP maintains an overview of the coping with crying pilot along with the national outcomes and potential roll out.	The CDOP has maintained an overview on the copying with crying pilot which has now ended.
10. Key findings, analysis, and emerging issues are fed into the Joint Strategic Needs	The JSNA is an overarching local assessment of current and future health and

Assessment (JSNA) process to ensure the work of the CDOP is captured by the local strategic assessment.	social care needs. Key findings from the CDOP analysis have been included in the JSNA along with a wide range of other child and maternal health information.

In March 2016, the Department for Education published Alan Wood's review into the role that LSCBs play in protecting and safeguarding children (Department for Education, 2016d). As a result of this review, the government intends to put in place arrangements to transfer national oversight of CDOPs from the Department of Education to the Department of Health (Department for Education, 2016e).

The aggregated findings from all child deaths inform local strategic planning including the Joint Strategic Needs Assessment (JSNA). This CDOP annual report pulls together information to inform the LSCB, which in turn is used to inform the LSCB annual report.

The JSNA is published at http://www.nelincsdata.net/JSNA

The LSCB annual report is published at
http://nelsafeguardingchildrenboard.co.uk/about-lscb/reports-plans/

Child Deaths in Context

Number of child deaths

Table 2 presents the number of child deaths per year in North East Lincolnshire. With 98 deaths over the period 2008/09 to 2015/16, this equates to an average of 12 deaths per year. To put this into context, North East Lincolnshire has a 0-17 (under 18) years population of 34,309 (ONS, 2015). Nationally 3,665 child death reviews were completed in England during 2015/16 which was an increase from the 3,515 reviews completed during 2014/15 (Department for Education, 2016b).

Table 2 Number of child deaths, North East Lincolnshire, 2008/09 – 2015/16

Year	Number
2008/09	15
2009/10	12
2010/11	13
2011/12	12
2012/13	12
2013/14	8
2014/15	13
2015/16	13
2008/09 - 2015/16	98

Source: North East Lincolnshire LSCB

Age at time of death

The numbers and percentages of child deaths by broad age category are presented in Tables 3 and 4. It is clear that each year the majority (79% overall) of child deaths are of children aged 0 to 4 years (n=77).

Nationally, 76% (2,760) of all child deaths reviewed during 2015/16 were under the age of 4 years, of which most were infant deaths (under 1 year old) as these accounted for 64% (2,337) of all child deaths (Department for Education, 2016b).

Table 3 Number of child deaths by age category, North East Lincolnshire, 2008/09 to 2015/16

	Age category (years)				
Year	**0 to 4**	**5 to 9**	**10 to 14**	**15 to 17**	**Total**
2008/09	11	1	1	2	15
2009/10	9	0	0	3	12
2010/11	10	0	0	3	13
2011/12	11	1	0	0	12
2012/13	10	1	0	1	12
2013/14	8	0	0	0	8
2014/15	11	1	1	0	13
2015/16	7	3	1	2	13
Total	77	7	3	11	98

Source: North East Lincolnshire LSCB

Table 4 Percentage of child deaths by age category, North East Lincolnshire, 2008/09 to 2015/16

	Age category (years)				
Year	**0 to 4**	**5 to 9**	**10 to 14**	**15 to 17**	**Total**
2008/09	73%	7%	7%	13%	100%
2009/10	75%	0	0	25%	100%
2010/11	77%	0	0	23%	100%
2011/12	92%	8%	0	0	100%
2012/13	83%	8%	0	8%	100%
2013/14	100%	0	0	0	100%
2014/15	85%	8%	8%	0	100%
2015/16	54%	23%	8%	15%	100%
Total	79%	7%	3%	11%	100%

Source: North East Lincolnshire LSCB

Of the 77 children aged 0 to 4 years, 81% were aged under 1 year (n=62). Deaths of children aged under 1 year are defined as infant deaths and accounted for 63% of all deaths. Deaths of children aged under 28 days are defined as neonatal deaths and accounted for 40% of all deaths (n=39). Deaths of children aged under 7 days are defined as early neonatal deaths and accounted for 24% of all deaths (n=24). Figures of child deaths by infant death category are presented in Table 5. National figures show that for child death reviews carried out in England during 2015/16, 64% were for infant deaths, which is close to the local North East Lincolnshire figure (Department for Education, 2016b).

Table 5 Number and percentage of child deaths by infant death category, North East Lincolnshire, 2008/09 to 2015/16

	Number	Percentage
Total child deaths	98	100%
Total infant deaths (<1 year)	62	63%
Total neonatal deaths (<28 days)	39	40%
Total early neonatal deaths (<7 days)	24	24%

Source: North East Lincolnshire LSCB

Further analysis of infant deaths has determined that 39% of infant deaths occurred under 7 days of age (n=24), 24% of infant deaths occurred between 7 days and under 28 days of age (n=15), and 37% of infant deaths occurred between 28 days and under 1 year of age (n=23). These figures are presented in Table 6.

Table 6 Number and percentage of infant deaths by age at death, North East Lincolnshire, 2008/09 to 2015/16

	Number	Percentage
Total infant deaths	62	100%
Infant deaths <7 days	24	39%
Infant deaths 7 days to <28 days	15	24%
Infant deaths 28 days to <1 years	23	37%

Source: North East Lincolnshire LSCB

Gender

Overall during the period 2008/09 to 2015/16 there have been six more male deaths (n=52) than there have been female deaths (n=46). The numbers and percentages of deaths by gender are presented in Table 7.

The North East Lincolnshire gender split (53% male compared to 47% female) is narrower than the England split since the latest national figures show that of child death reviews carried out during 2015/16, 58% were of males and 42% were of females (Department for Education, 2016b).

Table 7 Number and percentage of child deaths by gender, North East Lincolnshire, 2008/09 to 2015/16

	Male		**Female**	
Year	Number	Percentage	Number	Percentage
2008/09	9	60%	6	40%
2009/10	7	58%	5	42%
2010/11	6	46%	7	54%
2011/12	6	50%	6	50%
2012/13	6	50%	6	50%
2013/14	2	25%	6	75%
2014/15	9	69%	4	31%

2015/16	7	54%	6	46%
2008/09 to 2015/16	52	53%	46	47%

Source: North East Lincolnshire LSCB

Ethnicity

Of the 90% of deaths for which ethnicity is recorded (n=88), 89% of children were White (n=78) and 11% of children were Other than White (n=10). The numbers and percentages of deaths by ethnicity are presented in Table 8. This percentage of deaths which are of Other than White children, is higher than the percentage of Other than White children attending state funded primary and secondary schools in North East Lincolnshire (7%) as reported by the January 2016 school census (Department for Education, 2016c).

Local trends differ to those at a national level as the latest national figures show that of child death reviews carried out in England during 2015/16, 68% were for White children and 32% were for Other than White children (Department for Education, 2016b). The much lower figure for child deaths of children with Other than White ethnicity in North East Lincolnshire is largely a reflection of the overall population of ethnic minorities within North East Lincolnshire (4.6%) being significantly lower than both regional (14.2%) and national (20.2%) comparators (ONS, 2015).
Note that since the recording of ethnicity is not complete for either all local child deaths or for all national reviews, where ethnicity is not known it has not been included in the percentage calculations.

Table 8 Number and percentage of child deaths by ethnicity, North East Lincolnshire, 2008/09 to 2015/16

Ethnicity	Number*	Percentage
White	78	89%
Other than White	10	11%
Total	88	100%

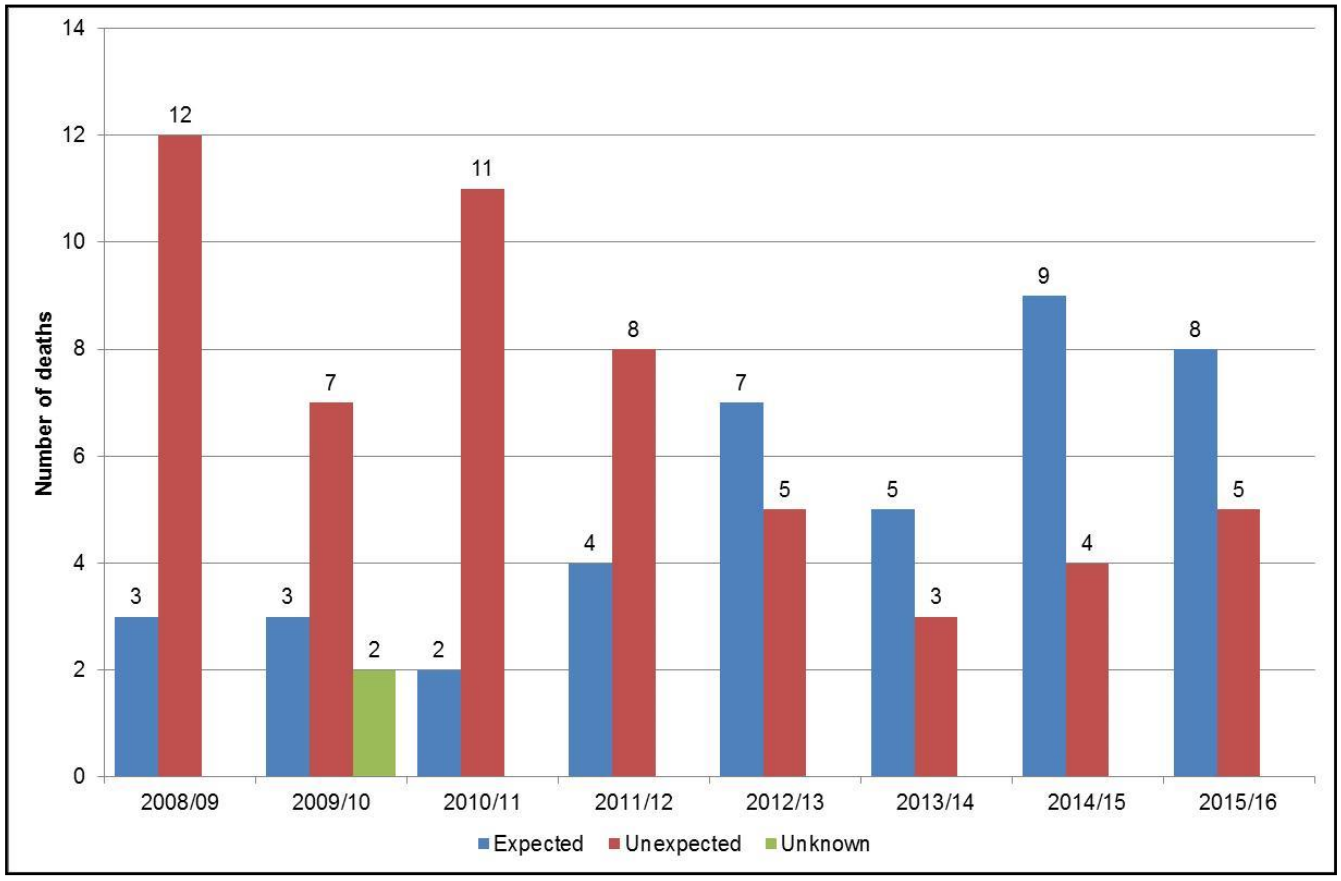
Source: North East Lincolnshire LSCB
* Ethnicity not known n=10

Expected / unexpected deaths

Child deaths fall into two categories which are expected and unexpected. An unexpected death is defined as 'the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death' (HM Government, 2015)

Between 2008/09 and 2015/16, 56% of the 98 deaths were classed as unexpected (n=55). Figure 1 presents the number of expected and unexpected deaths over this period. Over the eight year period, for the first four years more deaths were unexpected than expected, however for the past four years more deaths have been expected than unexpected.

Figure 1 Number of expected / unexpected child deaths, 2008/09 to 2015/16



Source: North East Lincolnshire LSCB

Cause of death

Since 2010/11 the CDOP has been required to assign each death to one of ten nationally defined categories. Definitions for the categories are presented in Appendix 3. If there is more than one cause for the death it is the primary cause that is used for classification purposes.

Of the 71 child deaths since 2010/11 there are seven that are still under investigation as at 1 July 2016 and as such the cause of these deaths have not yet been categorised. The top four causes of death for the 64 categorised child deaths in North East Lincolnshire were:

1. **Perinatal / neonatal** (Death ultimately related to perinatal events, e.g. 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) - **15 deaths**
2. **Chromosomal, genetic and congenital anomalies** (Includes Trisomies, other chromosomal disorders single gene defects, neurodegenerative disease, cystic fibrosis and other congenital anomalies including cardiac) **– 15 deaths**

3. **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) - **8 deaths**
4. **Infection** Any primary infection (i.e., 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. **– 8 deaths**

Just under one quarter of all child deaths were categorised as perinatal / neonatal events, with just under another one quarter categorised as chromosomal genetic and congenital anomalies. These two categories also accounted for the highest proportion of classifications of child deaths reviewed in England during 2015/16, with 32% of deaths categorised as perinatal / neonatal events and 26% of deaths categorised as chromosomal genetic and congenital anomalies (Department for Education, 2016b).

Figures for child deaths occurring during 2015/16 (n=13) and for child deaths reviewed during 2015/16 (n=11) and split by classification category, are presented in Table 9.

Table 9 Classification category of child deaths and child deaths reviewed, North East Lincolnshire, 2015/16

	Child deaths during 2015/16		**Child deaths reviewed during 2015/16**	
Category	**Number**	**Percentage***	**Number**	**Percentage**
1 – Deliberately inflicted injury, abuse or neglect	0	0	0	0
2 – Suicide or deliberate self-inflicted harm	0	0	1	9%
3 – Trauma and other external factors	0	0	1	9%
4 – Malignancy	1	13%	0	0
5 – Acute medical or surgical condition	0	0	0	0
6 – Chronic medical condition	0	0	1	9%
7 – Chromosomal, genetic and congenital anomalies	4	50%	4	36%
8 – Perinatal / neonatal event	2	25%	2	18%
9 – Infection	1	13%	1	9%
10 – Sudden unexpected, unexplained death	0	0	1	9%
Awaiting classification	5	-	0	0
Total deaths	13		11	

Source: North East Lincolnshire LSCB

* deaths awaiting classification not included

The split of child deaths since 2010/11 by classification category along with England comparator figures are presented in Table 10. As previously stated, of the 71 deaths since 2010/11, 64 have been classified and seven are awaiting classification.

Table 10 Classification category of child deaths, North East Lincolnshire 2010/11 to 2015/16, and England child death reviews 2015/16

	North East Lincolnshire		England
Category	**Number***	**Percentage**	**Percentage**
1 – Deliberately inflicted injury, abuse or neglect	1	2%	2%
2 – Suicide or deliberate self-inflicted harm	4	6%	3%
3 – Trauma and other external factors	2	3%	5%
4 – Malignancy	6	9%	7%
5 – Acute medical or surgical condition	2	3%	6%
6 – Chronic medical condition	8	13%	5%
7 – Chromosomal, genetic and congenital anomalies	15	23%	26%
8 – Perinatal / neonatal event	15	23%	32%
9 – Infection	8	13%	6%
10 – Sudden unexpected, unexplained death	3	5%	8%

Source: North East Lincolnshire LSCB

* 1 death during 2013/14, 1 death during 2014/15, and 5 deaths during 2015/16 are awaiting classification

Further analysis from cause of death and contributory factor information for local deaths since 2008/09 determined the following:

- Twenty one of the 62 infant deaths (< 1 year) involved extreme prematurity
- Eight deaths were caused by external causes (ICD-10 codes V01-Y98), including 5 from road traffic accidents
- Seven deaths were caused by Sudden Infant Death Syndrome (SIDS)
- Four deaths were caused by inappropriate sleeping conditions including co-sleeping
- A considerable number of deaths were caused by a wide range of congenital abnormalities and syndromes, hereditary conditions, and various other perinatal and neonatal conditions.

Place of death

Locally 81% of children were in hospital at the time of death (n=79), 14% were at home (n=14), and 5% were in a hospice (n=5). The numbers and percentages of deaths by place of death are presented in Table 11. National figures differ to the local picture which show that of child death reviews carried out in England during 2015/16, 68% were for deaths that occurred in hospital, 22% were for deaths at home, 4% were for deaths in a hospice, and 6% were for deaths elsewhere (Department for Education, 2016b).

Table 11 Number and percentage of child deaths by place of death, North East Lincolnshire, 2008/09 to 2015/16

Place of death	Number	Percentage
Home	14	14%
Hospital	79	81%
Hospice	5	5%

Total	98	100%

Source: North East Lincolnshire LSCB

Child Protection Status

Section 17 of the Children Act 1989 defines a child as being in need in law if:

- He or she is unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the LA;
- His or her health or development is likely to be significantly impaired, or further impaired, without the provision of services from the LA;
- He or she has a disability.

Locally, child in need (CIN) status has been captured since 2010/11 and was recorded for 69 of the 71 deaths since this time. Of these 69 deaths, 22% were recorded as CIN at the time of death (n=15), with a further 9% recorded as having been CIN previously (n=6).

A child protection conference is held when further to enquiries made under section 47 of the Children Act 1989, if the local authority has reasonable cause to suspect that a child is suffering or is likely to suffer significant harm. The conference will lead to a decision whether or not to make a child subject to a child protection plan. If the child is at continuing risk of significant harm, it will therefore be the case that safeguarding the child does requires inter-agency help and intervention delivered through a child protection plan. A child protection plan is a plan drawn up by the local authority which sets out the steps and services needed to safeguard the child, and how concerns be addressed. Significant harm may be physical abuse, emotional abuse, sexual abuse, or neglect (Citizens Advice, 2015).

Locally, child protection plan status was recorded for all 71 deaths since 2010/11. Of these, 6% were recorded as being subject to a child protection plan at the time of death (n=4), with a further 8% recorded as having been subject to a child protection plan previously (n=6). National figures show that for child deaths reviewed in England during 2015/16, 1% were for children that were subject to a child protection plan at the time of death, and a further 2% were for children that were previously subject to a child protection plan (Department for Education, 2016b).

The 1989 Children Act definition of looked-after children (children in care) is that a child is looked after by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for more than 24 hours.

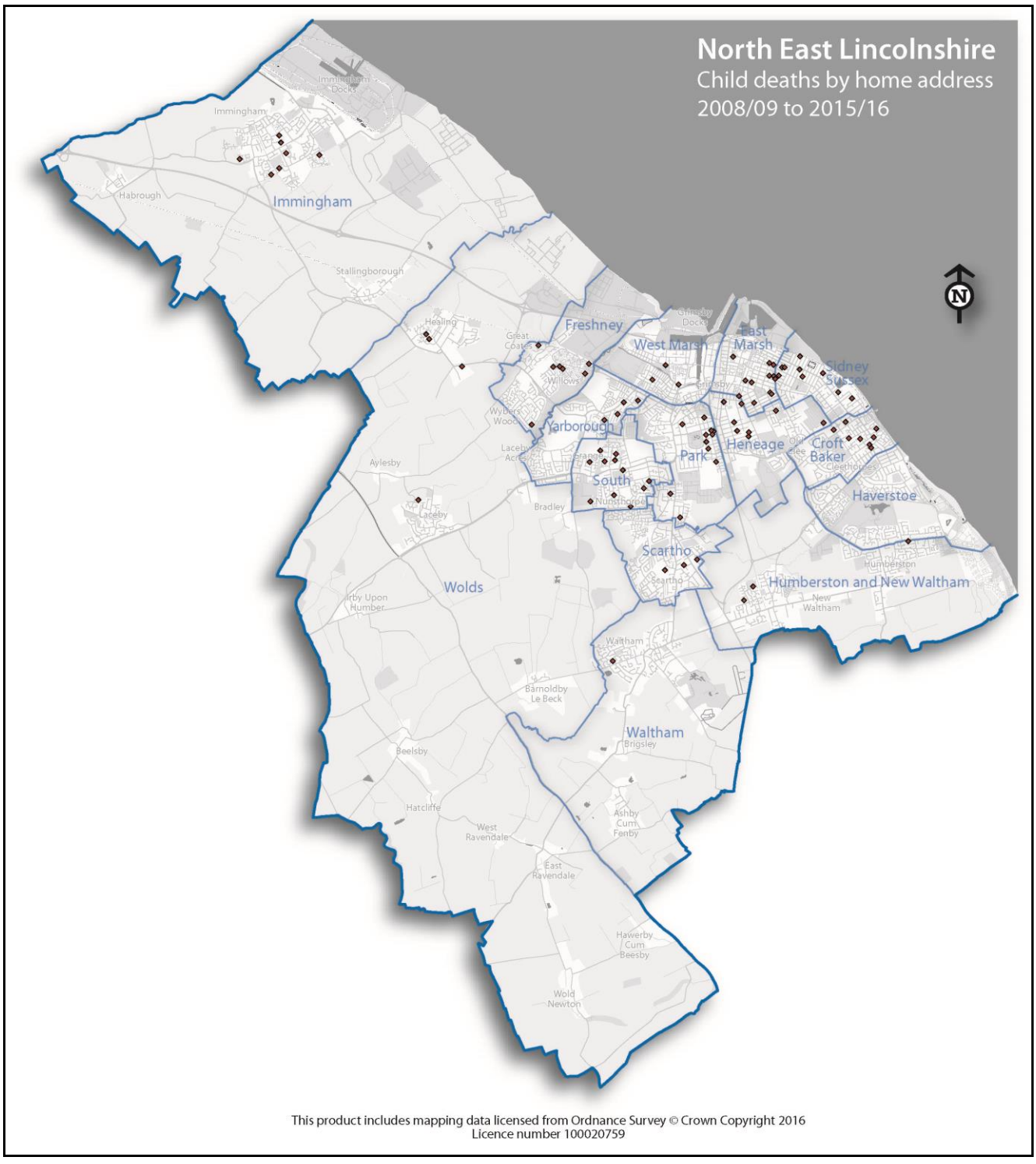
Since 2010/11 one child was recorded as being a looked after child.

Home address by electoral ward and deprivation quintile

Figures 2 shows child deaths in North East Lincolnshire for the period 2008/09 to 2015/16 mapped by the location of the postcode of the home address of the child (n=97). One additional death was recorded with a home address in Louth which is in the neighbouring LSCB area of Lincolnshire. The wards with the highest numbers of deaths, South (n=13),

Park (n=12), East Marsh (n=12), and Sidney Sussex (n=10) wards represent just under 50% of all North East Lincolnshire deaths. Haverstoe ward was the only ward to have zero deaths during the period, and this ward is the least deprived within North East Lincolnshire.

Figure 2 Child deaths by postcode and electoral ward of home address, North East Lincolnshire, 2008/09 to 2015/16



Whilst certain wards have higher numbers of child deaths than others it is important to note that there are considerable variations in the size of the child population between these wards. Six wards have a higher percentage of the child deaths than the percentage of the North East Lincolnshire under-18 population that is resident within the ward and therefore

deaths are over represented in these wards (Croft Baker, East Marsh, Freshney, Park, Sidney Sussex and South). Converting numbers of child deaths to crude death rates per 100,000 under-18 population, shows that North East Lincolnshire has an average of 35.3 deaths per 100,000 population. Even though data have been pooled over eight years, due to low numbers and small geographical areas, confidence intervals for the rates of child deaths are wide therefore there are no statistically significant differences between wards. These figures are presented in Table 12 and wards are ordered by descending rates of child deaths.

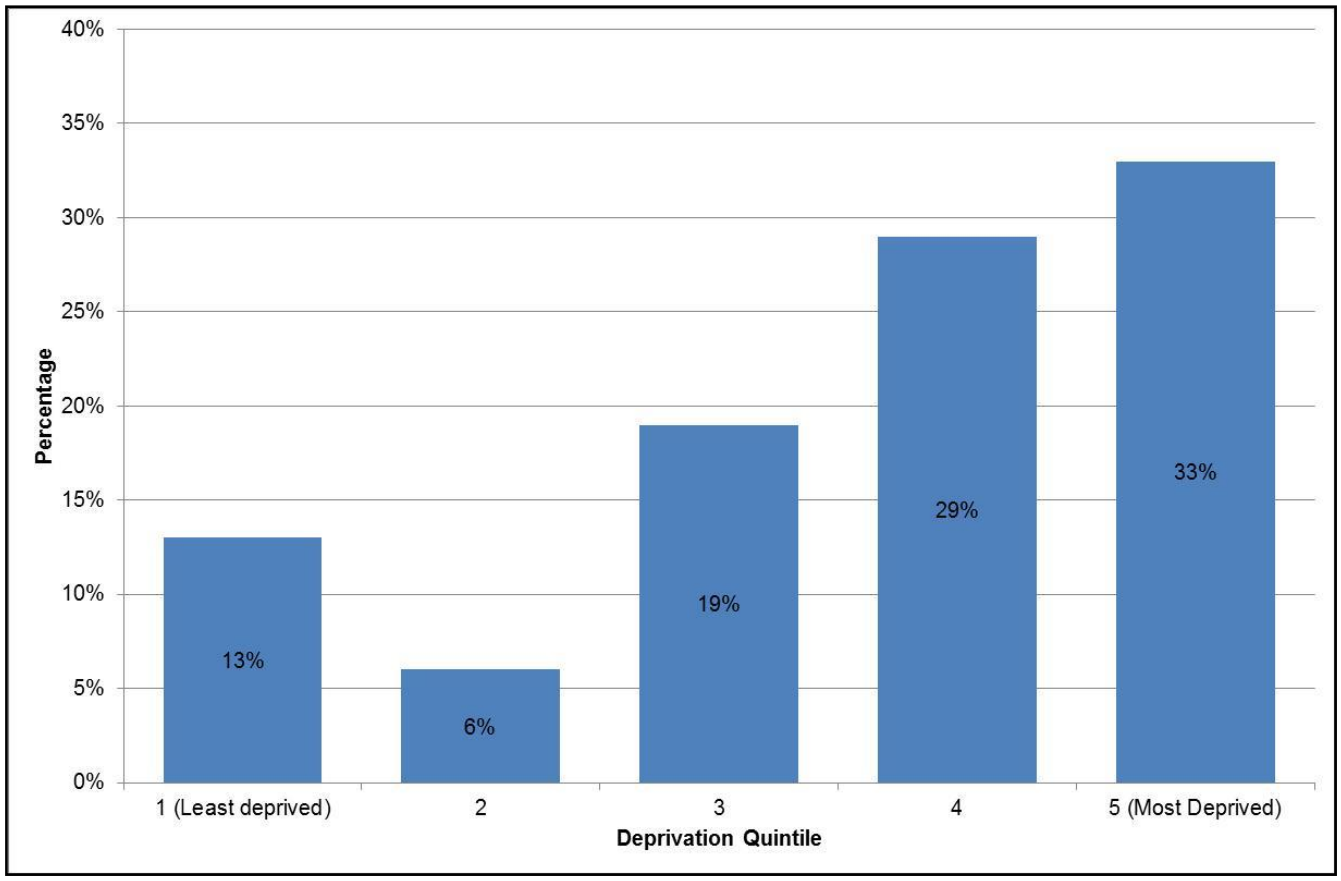
Table 12 Child deaths by electoral ward, North East Lincolnshire, 2008/09 to 2015/16

Area	Resident population <18 years	Percentage of North East Lincolnshire resident population <18 years	Number of child deaths	Percentage of North East Lincolnshire child deaths	Crude rate of child deaths per 100,000 resident population <18 years
North East Lincolnshire	34358	100%	97	100%	35.3
Park	2392	7.0%	12	12.4%	62.7
Freshney	2083	6.1%	9	9.3%	54.0
East Marsh	2816	8.2%	12	12.4%	53.3
South	3482	10.1%	13	13.4%	46.7
Croft Baker	2215	6.4%	8	8.2%	45.1
Sidney Sussex	3219	9.4%	10	10.3%	38.8
Immingham	2473	7.2%	7	7.2%	35.4
Heneage	2833	8.2%	8	8.2%	35.3
Wolds	1574	4.6%	4	4.1%	31.8
Yarborough	2422	7.0%	4	4.1%	20.6
West Marsh	1817	5.3%	3	3.1%	20.6
Humberston and New	1938	5.6%	3	3.1%	19.3
Scartho	2096	6.1%	3	3.1%	17.9
Waltham	1261	3.7%	1	1.0%	9.9
Haverstoe	1737	5.1%	0	0%	0.0

Source: Office for National Statistics, Crown Copyright. North East Lincolnshire LSCB.

The English Indices of Deprivation are a measure of deprivation at Lower Super Output Area (LSOA) level (DCLG, 2011). LSOAs in North East Lincolnshire were assigned to local deprivation quintiles, by dividing LSOAs into five parts, with each quintile representing 20% (one fifth) of the LSOAs. The first quintile represents the least deprived fifth of LSOAs, whilst the fifth quintile represents the most deprived fifth of LSOAs. Deprivation is not just financial but refers to a general lack of resources and opportunities. Figure 3 shows the percentage of child deaths in North East Lincolnshire by deprivation quintile, with 62% of all home addresses being from the two most deprived quintiles. With the exception of quintile 2, there is a pattern of increasing numbers of deaths with increasing deprivation.

Figure 3 Child deaths by deprivation quintile of home address, North East Lincolnshire, 2008/09 to 2015/16



Maternal smoking status

Figures from the National Institute for Health and Care Excellence (NICE) show that smoking is the leading cause of preventable morbidity and early death in England, with smoking being attributable for approximately one out of every six deaths in England (NICE, 2013). Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes. An increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy are all pregnancy related health problems associated with smoking during pregnancy (Department of Health, 2014). Breathing second-hand smoke (passive smoking) can also affect the health of people who do not smoke (NICE, 2013), with children being particularly at risk. Smoking is the biggest factor contributing to the gap in healthy life expectancy seen across the socioeconomic status gradient (NICE, 2013). Smoking is associated with many components of deprivation including employment, income, housing, and education (Richardson, 2001).

North East Lincolnshire has the third highest adult smoking prevalence rate for 2014 out of the 15 local authorities in the Yorkshire and the Humber region. The North East Lincolnshire

smoking prevalence (23%) is statistically significantly higher than both the England (18%) and the Yorkshire and the Humber (20%) averages.

Maternal smoking status was recorded for 63 of the 71 deaths since 2010/11. Figures presented in Table 13 show that 40% of mothers were smokers (n=25) which is a much higher smoking prevalence than the North East Lincolnshire average adult prevalence of 23%.

Table 13 Maternal smoking of child deaths, 2010/11 to 2015/16

Smoking status	Number*	Percentage
Smoker	25	40%
Non-smoker	38	60%

Source: North East Lincolnshire LSCB
*8 records had no smoking status recorded

Table 14 presents maternal smoking status by the age of the child at death, split by those aged under one year (infant mortality) and those aged one year and over. There is no difference in maternal smoking prevalence by the age of the child at death, with approximately 40% of mothers smoking in cases of both infant deaths and deaths of older children. Of the 25 deaths of children with mothers who smoked, 60% of these were infant deaths (n=15). It is difficult to assess the influence maternal smoking may have had on the infant deaths, however it is important to remember that smoking during pregnancy is known to be a considerable risk factor for infant mortality (Department of Health, 2014).

Table 14 Maternal smoking status by age of child at death (infant death / non-infant death), 2010/11 to 2015/16

	Smoker		Non-smoker		Total
Age of child	Number	Percentage	Number	Percentage	Number*
< 1 year	15	39%	23	61%	38
>= 1 year	10	40%	15	60%	25
Total	25	40%	38	60%	63

Source: North East Lincolnshire LSCB
*8 records had no smoking status recorded

Alcohol and substance misuse

Alcohol and substance misuse can have significant impacts on children and families, whether as a result of one or both parents engagement in heavy drinking, or from wider family members hazardous drinking. Whilst substance misuse can impair parenting capacity, harm is not inevitable and infrequently exists as a consequence of substance misuse in isolation (Manning et al, 2009), however patterns of binge drinking and recreational drug use may expose children to sub-optimal care. Much of the risk of harm, depends on the age of the child, the nature and patterns of substance misuse and contextual factors in which the substance misuse occurs (Suchman et al, 2009). Babies and young children may be particularly vulnerable to harm as parental drug misuse can

compromise a child's health and development from conception onwards. Parental substance misuse has been associated with genetic, developmental, psychological, psychosocial, physical, environmental and social harms to children (Kroll et al, 2003). An unborn child may be adversely affected by direct exposure to alcohol and drugs through maternal substance misuse. Alcohol or substance misuse can affect a person's control of emotions, judgement and ability to respond to situations, particularly during periods of intoxication (Manning et al, 2009). The potential for cumulative disadvantage for children living with adults with multiple problem behaviours is a particular concern as co-morbidity has been linked to additional difficulties in parenting (Cleaver et al, 1999). Poverty, social exclusion, poor housing, a stressful environment, family tension and conflict, collectively heighten the risk of harm (Suchman et al, 2009).

Parental alcohol misuse status was recorded for 56 deaths since 2010/11. Of these, 14% were recorded as having a known alcohol misuse issue within the family unit (n=8).

Parental substance misuse status was recorded for 59 deaths since 2010/11. Of these, 20% were recorded as having a known substance misuse issue within the family unit (n=12), and included cases of misuse by the mother, father, and during pregnancy.

Domestic abuse

Children can experience domestic abuse in a number of ways, both directly and indirectly. In relationships where there is domestic violence, 75% of children have witnessed abuse, 50% have been abused themselves and these children are more likely to be sexually and/or emotionally abused (Royal College of Psychiatrists, 2004). As of March 2013 the Government's definition of domestic violence and abuse is "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality." (Home Office, 2013)

The presence of issues relating to domestic violence was recorded for 56 deaths 2010/11. Of these, 32% were recorded as having issues of domestic violence within the family unit (n=18) either at the time of death or previously.

Known to Humberside Police

Whether the parents were previously known to the police was recorded for 65 deaths since 2010/11. There are many reasons why parents may have been known to the police, for example domestic violence, other offending, or previous safeguarding issues. Of those deaths where this was recorded, 51% were known to police (n=25). These figures are presented in Table 15.

Table 15 Parents known to Humberside Police prior to child death, 2010/11 to 2015/16

Parents known to Police	Number*	Percentage
Yes	33	51%
No	32	49%

Source: North East Lincolnshire LSCB

*Not recorded for 6 deaths

Parental responsibility

The adult(s) who the child lived with in the household and who were responsible for the child was recorded for 62 deaths since 2010/11. Where a child died and had never left hospital this includes those they would have lived with. Just under 70% of children lived in a household with both their mother and father (n=43). A further 21% of children lived with their mother (n=13) and 5% lived with their father (n=3). One child was in foster care at the time of death, one with adoptive parents and one with an older sibling following maternal death. These figures are presented in Table 16.

Table 16 Responsible adult(s) the child lived with / would have lived with, 2010/11 to 2015/16

Lived with	Number*	Percentage
Mother and father	43	69%
Mother	13	21%
Father	3	5%
Adoptive / foster parents	2	3%
Older sibling	1	2%

Source: North East Lincolnshire LSCB
*Not recorded for 9 deaths

Age of mother at childbirth

The mothers age at the time of childbirth has been recorded since 2010/11. Table 17 presents the age of mothers at childbirth by 5 year age categories, and shows that 38% of mothers were aged under 25 years at childbirth (n=27) with a further 34% aged 25 to 29 years (n=24).

Table 17 Mothers age at the time of childbirth, 2010/11 to 2015/16

Mothers age (years)	Number*	Percentage
<20	5	7%
20 to 24	22	31%
25 to 29	24	34%
30 to 34	13	19%
35 to 39	5	7%
40+	1	1%

Source: North East Lincolnshire LSCB
*Not recorded for 1 death

Pregnancy term/gestation

For neonatal deaths where length of gestation is known, 75% were premature which includes those extremely premature (<28 weeks gestation) and those premature (>= 28 and < 38 weeks gestation). Figures showing the breakdown of length of gestation by prematurity and full term for all neonatal deaths are presented in Table 18.

Table 18 Length of gestation for neonatal deaths, 2008/09 to 2015/16

Gestation	Number*	Percentage
<28 weeks extreme prematurity	17	49%
<38 weeks premature	9	26%
Full term	9	26%

Source: North East Lincolnshire LSCB
*Not recorded for 4 deaths

Modifiable factors

One of the main roles of the CDOP is to determine whether deaths were preventable. Preventable child deaths are defined as those in which modifiable factors may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced. (HM Government, 2015)

Nationally 24% (n=863) of child deaths reviewed in England during 2015/16 were identified as having modifiable factors, which is the same percentage as for during 2014/15, and a small increase from the 22% during 2013/14. Within the Yorkshire and Humberside region, 28% of child deaths reviewed during 2015/16 were identified as having modifiable factors which was a considerable rise from the 23% during 2014/15 (Department for Education, 2016b).

Of the ten death classification categories and for all child death reviews carried out in England during 2015/16, there are three categories for which over 50% of deaths assigned to these categories had modifiable factors identified:

- Sudden unexpected, unexplained death – 65% of deaths had modifiable factors identified.
- Deliberately inflicted injury, abuse or neglect - 60% of deaths had modifiable factors identified.
- Trauma and other external factors - 56% of deaths had modifiable factors identified.

Locally those deaths that are still under investigation have not yet been classified in terms of modifiable factors. One death reviewed during 2015/16 identified modifiable factors. Figures for local deaths where modifiable factors were identified are presented in Table 19.

Since 2008/09:

- 14% of classified deaths were categorised as having modifiable factors identified (n=13) which is lower than the England average.
- There is a general local trend of decreasing numbers of deaths with modifiable factors identified, however it should be remembered that five of the unclassified deaths are of deaths during 2015/16 which is the most recent period.
- 62% of local deaths with modifiable factors were infant deaths (<1 year).
- 92% of local deaths with modifiable factors were unexpected deaths.

- The cause of death for 38% of deaths with modifiable factors was either sudden infant death syndrome or inappropriate sleeping. A further 23% of deaths involved road traffic accidents.
- A clear trend is evident regarding the deprivation quintile of the home address, with 77% of deaths with modifiable factors being of children from the two most deprived quintiles, and zero deaths from the two least deprived quintiles.

Table 19 Deaths with modifiable factors identified, by year of death, age of child at death, expected/unexpected death, cause of death, and deprivation quintile, 2008/09 to 2015/16

	Number of deaths	Percentage
Total number of deaths		
Total deaths	90*	100%
Total deaths with modifiable factors	13	14%
	Number of preventable deaths	**Percentage**
Year of death		
2008/09	2	15%
2009/10	2	15%
2010/11	3	23%
2011/12	3	23%
2012/13	1	8%
2013/14	0	0
2014/15	2	15%
2015/16	0	0
Age at death		
Infant deaths (<1 year)	8	62%
Deaths (>= 1 year)	5	38%
Expected / unexpected death		
Expected deaths	1	8%
Unexpected deaths	12	92%
Cause of death		
Sudden infant death syndrome	3	23%
Trauma – road traffic accident	3	23%
Inappropriate sleeping	2	15%
Bronchitis / pneumonia	2	15%
Accidental overdose	1	8%
Non-accidental injury	1	8%
Neonatal events	1	8%
Deprivation quintile		
1 – least deprived	0	0
2	0	0
3	3	23%
4	4	31%
5 – most deprived	6	46%

Source: North East Lincolnshire LSCB

***** Additional deaths are awaiting classification

Local actions to address identified modifiable factors

Learning dissemination

In addition to the information being collated and sent on an annual basis as a national return which informs national approaches, locally CDOP members have continued to share the findings from child deaths within their organisations in informing learning and practice. There is potential for further work exploring how learning can be shared and disseminated to reduce the risk from modifiable factors for future child deaths.

Joint CDOP Panel

A joint NEL/ North Lincolnshire Child Death Review Panel was established in April 2016. This will lead broader and shared learning.

Guidance

The joint guidance between North East Lincolnshire and North Lincolnshire LSCBs regarding safer sleep guidance has also been produced, and which includes a pathway of information and support from antenatal (34 weeks contact by midwives) through to early childhood. This will be reviewed during 2015/16.

Burial/ Cremation Services

Work was undertaken with the Cremation services and the Hospital to reported explore difference between cremation and burial services between NEL and north Lincolnshire. The work enabled clarification of local arrangements and led to further guidance being provided to bereaved families on the available options in respect of burial/ cremation

Bereavement support

Losing a child in any circumstances is a tragedy and we need to ensure that support is in place in the short and longer term as required. Although not a formal role of the CDOP, locally we have reviewed the support provided to bereaved families, including any surviving siblings, and have identified that there is a robust process in place where children have an end of life plan in place or have been supported by the hospice. This support is provided by the team at St Andrews's Children Hospice. However it has been identified that there is no recognised funded support process for families, including any siblings, where a child dies unexpectedly. The hospice could potentially provide this support but would require funding and for this to be commissioned. This was identified as a gap with commissioners and during 2015 this process was reviewed as part of a local review on bereavement support, and the hospice team have subsequently supported children and families when there has been an unexpected child death.

Key Points – Child deaths 2008/09 to 2015/16

- The number of child deaths per year has been largely static since 2008/09, with 13 deaths during both 2014/15 and 2015/16, and an average over the eight year period of 12 deaths per year.
- The majority of child deaths (63%) were infant deaths (<1 year).
- Over half (56%) of child deaths were classed as unexpected.
- Approximately one fifth of all child deaths were categorised as perinatal / neonatal events, with a further fifth categorised as chromosomal genetic and congenital anomalies.
- Wards with the highest rates of child deaths were Park, Freshney, East Marsh, South and Croft Baker. Haverstoe ward was the only ward with zero deaths.
- Children from the two most deprived quintiles of North East Lincolnshire accounted for 62% of all child deaths.
- For neonatal deaths, where length of gestation was known, 74% were premature.
- The percentage of deaths categorised as having modifiable factors identified (14%) was lower than the England average.
- 62% of local deaths with modifiable factors were infant deaths (<1 year).
- The cause of death for 61% of deaths with modifiable factors was either sudden infant death syndrome, trauma from a road traffic accident, or inappropriate sleeping.
- There is an association with deprivation as 77% of deaths with modifiable factors belonged to the two most deprived quintiles.

Key Points – Child deaths reviewed by the CDOP during 2015/16

- The CDOP reviewed 11 child deaths during the year (six of these deaths occurred in 2014/15 and 5 during 2015/16).
- Seven children were male and four were female.
- Six deaths were infant deaths (<1 year) and three of these children were born prematurely.
- Nine of the children were of White ethnicity.
- Five deaths were unexpected.
- The review for one of the deaths identified modifiable factors.
- Four of the children had been assessed as children in need, one child was subject to a child protection plan at the time of death, and two children had previously been subject to a child protection plan.

- Three deaths were sudden unexpected deaths of an infant (SUDI), three further deaths were neonatal deaths, three more deaths were due to life limiting conditions, one death was due to a road traffic accident, and one death due to self-inflicted harm.

Key Learning

Since 2008/09 the LSCB has been collating information on child deaths which are reported nationally and also informs the CDOP annual report, with the information also being disseminated to the LSCB and a range of other sub-groups and professionals. There were 13 child deaths in North East Lincolnshire during 2015/16, and during this year the CDOP reviewed 11 deaths. The majority of deaths were of young children, since 79% of children who died were aged 0 to 4 years, and 63% were infant deaths (<1 year). Overall, there were similar numbers of deaths for each gender (53% male, 47% female). Where recorded, 89% of local child deaths were of White ethnicity, which partly reflects the local population which is less diverse than the national population. Child deaths fall into two categories which are expected and unexpected, with over half (56%) of child deaths classed as unexpected locally.

Regarding causes of death, approximately one fifth of all child deaths locally were categorised as perinatal / neonatal events, with a further fifth categorised as chromosomal genetic and congenital. The CDOP determined that 14% of North East Lincolnshire child deaths that have been reviewed had modifiable factors. The majority of child deaths are from families from the most deprived areas of North East Lincolnshire, since 62% of all home addresses were from the two most deprived quintiles, suggesting a pattern of increasing numbers of deaths with increasing deprivation. This is particularly true for deaths with modifiable factors, since 77% of deaths with modifiable factors were of children from the two most deprived quintiles, and zero deaths were of children from the two least deprived quintiles.

Locally work to review and strengthen data sharing to support the prevention agenda by way of inter-agency working, sharing responsibilities, sharing information on potential indicators of harm and risk, and engaging with issues before they can escalate, will further help to focus activity where it is most needed and can be most effective, with particular emphasis on supporting vulnerable pregnant women, families and communities. The new joint North Lincolnshire / North East Lincolnshire CDOP will help provide this development via economies of scale, the sharing of resources and intelligence, and by the aggregated analysis of child deaths across Northern Lincolnshire.

Future arrangements

NHS England published the National Maternity Review – Better Births in February 2016 (NHS England, 2016). Whilst acknowledged improving outcomes the review determined that maternity services in England must become safer, more personalised, kinder, professional, and more family-friendly. The report contains a number of recommendations regarding child deaths, including that serious incident investigations should be triggered for a range of scenarios including all neonatal deaths. The report recommends that the new Health Services Investigation Branch will set standards and promote best practice techniques for high quality investigations. Funding has been secured for the development of a standardised perinatal mortality review tool, and the report recommends that the Department of Health should consider how this tool could be expanded to cover all neonatal deaths.

In March 2016, the Department for Education published Alan Wood's review into the role that LSCBs play in protecting and safeguarding children (Department for Education, 2016d). This review sets out recommendations for making LSCBs more effective, and the recommendations for CDOPs along with the government's response are detailed in Appendix 5.

A finding of the Wood Review was the need for child deaths to be reviewed over a population size that gives a sufficient number of deaths to be analysed for patterns, themes and trends of death. It has already been acknowledged in this report that North East Lincolnshire is small local authority area, and that the numbers of deaths whilst acknowledging that every death is a tragedy are small for robust statistical purposes, therefore inferences and trends based on these small numbers must be made with caution. The joint CDOP with North Lincolnshire from April 2016 will go some way to improving this issue locally since deaths will be pooled and analysed across Northern Lincolnshire. The Wood Review recommends the introduction of a national database to collect information about child deaths from each CDOP as a priority, and this would provide a national analysis of child deaths to inform CDOPs. The Healthcare Quality and Improvement Partnership and NHS England, have commissioned The National Perinatal Epidemiology Unity, University of Oxford, to test the viability of such a national CDOP database and a report is due during the summer of 2016 (Department for Education, 2016d). If a national database is found to be both necessary and feasible, the Wood Review recommends that that its implementation should be a priority and states that it would offer support for a potential regional structure of CDOPs.

Given that the majority of child deaths have medical or public health causes with a minority relating to safeguarding or requiring a serious case review to be carried out, the Wood Review determined that whilst child deaths should continue to be reviewed within local multi-agency arrangements, CDOPs are not best placed within the framework of the multi-agency arrangements for child protection and safeguarding. Consequently the Wood Review considers that the Department of Education is not in the best position to provide the necessary support required for oversight of CDOPs, and therefore recommends that the ownership of the arrangements for supporting CDOPs should move to the Department of Health. In the government's response to the Wood Review, this proposal has been accepted, and the government intends to put in place arrangements to transfer national oversight of CDOPs from the Department of Education to the Department of Health (Department for Education, 2016e).

Recommendations

The National Maternity Review – Better Births includes two developments which are likely to have implications for the way in which CDOPs consider child deaths. The CDOP implications from both serious incident investigations and the perinatal mortality review tool should be considered by the CDOP to ensure these are fully understand.

The Wood Review proposes fundamental change to LSCBs a number of which have direct impacts on CDOPs. The government has stated that it intends to put in place arrangements to transfer national oversight of CDOPs from the Department of Education to the Department of Health. The CDOP should familiarise itself with changing legislation, guidance, and requirements to ensure the implications are fully understand. All the recommendations for CDOPs within the Wood Review should be considered by the CDOP to understand the likely future impacts for the process in Northern Lincolnshire.

The Wood Review highlighted the issue of small area analysis. The new joint North East Lincolnshire and North Lincolnshire CDOP will enable analysis over a larger geography involving a higher number of child deaths, providing more meaningful analysis and increased data richness. The CDOP should explore current reporting and system compatibility to ensure joint analysis can be undertaken effectively.

The Joint CDOP should establish a drug protocol for deaths involving substance misuse.

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Appendix 1- CDOP responsibilities

- Reviewing all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- Collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
- Discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
- Determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- Making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- Identifying patterns or trends in local data and reporting these to the LSCB;
- Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required;
- Agreeing local procedures for responding to unexpected deaths of children; and
- Cooperating with regional and national initiatives – for example, with the National Clinical Outcome Review Programme - to identify lessons on the prevention of child deaths.

Source: Page 84 of 'Working together to safeguard children' (HM Government, 2015).

Appendix 2 – CDOP cause of death categories (only one, the primary, is used)

Cat	Name and description of category
1	**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.
2	**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.
3	**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 inflected injury, abuse or neglect. (Category 1).
4	**Malignancy -** Solid tumours, leukaemia's & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
5	**Acute medical or surgical condition -** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.
6	**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.
7	**Chromosomal, genetic and congenital anomalies -** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.
8	**Perinatal/neonatal event -** Death ultimately related to perinatal events, e.g. 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).
9	**Infection -** Any primary infection (i.e., 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.
10	**Sudden unexpected, unexplained death -** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5).

Appendix 3

Summary of recommendations for CDOPs in the Wood Report (March 2016)

- That the national sponsor for CDOPs should move from the Department for Education to the Department of Health. It should consider how CDOPs can best be supported and sponsored within the arrangements of the NHS.
- If the national study recommends the introduction of a national database for CDOPs, the Department of Health should consider expediting its introduction.
- The department of Health should determine how CDOPs can be organised on a regional basis with sub-regional structures to promote learning and dissemination. They should also give consideration to the membership of CDOP to ensure appropriate representation from both health and non-medical agencies.
- In considering a common national standard for high quality serious incident investigations for child death the Health Safety Investigation Branch of the NHS should consider the role CDOPs will play in this process.
- The Department of Health should consider the role that Health and Wellbeing Boards and the Joint Strategic Needs Assessment play in dealing with child deaths and the role of a CDOP.

Government response to the CDOP recommendations in the Wood Report (May 2016)

The government will put in place arrangements to transfer national oversight of CDOPs from the Department of Education to the Department of Health, whilst ensuring that the keen focus on distilling and embedding learning is maintained within the necessary child protection agencies.