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Child Death Overview Panel (CDOP) Annual Report 2016/2017

Report: Andrea Nixon

Child Death Overview Panel
Annual Report covering the period
1st April 2016 to 31st March 2017

FOREWORD

This annual report of Hillingdon Child Death Overview Panel (CDOP) outlines work undertaken by the Panel during 2016/17

The majority of this work was focussed on examining all child deaths across the borough. When a child dies the impact on a family can be profound and lifelong, therefore, it is important to prevent and reduce child deaths by learning lessons and identifying any modifiable factors. The CDOP reviewed child deaths with the aim of identifying preventability. During the last year, the CDOP met on 3 occasions with participation and input from key agencies. Where modifiable factor(s) were identified which might have contributed to a child's death, recommendations were made by the CDOP for influencing preventative action by service providers.

It should be acknowledged that the CDOP is procedurally unable to complete the review of a death until information is gathered and other processes have been completed such as Inquests and Serious Case Reviews.

Nationally, the NHS has set out an ambition to halve the rates of stillbirths by 2030, with a 20% reduction by 2020. In order to meet this aspiration, local action on early access to maternity, reduction in smoking in pregnancy and after, breast feeding support and safer sleeping will need to be enhanced.

1. Child Death Overview Panel - Background

The Child Death Overview Panel (CDOP) for the London Boroughs of Hillingdon is a statutory requirement of the Children's Act 2004 which came into effect on 1st April, 2008 and conforms to the guidance of Chapter 5 of Working Together 2015.

1.1. Terms of Reference/Purpose

Through a comprehensive and multi-disciplinary review of child deaths, the Child Death Overview Panel aims to improve the understanding of how and why children die and use the findings to take action to prevent future child deaths and more generally to improve the health and safety of the children in the area.

In carrying out activities to pursue this purpose, the CDOP meets the Local Safeguarding Children Board (LSCB) functions, as set out in Chapter 5 of Working Together to Safeguard Children 2015, in relation to the deaths of any children normally resident in the area by:

(a) collecting and analysing information about each 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,

(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area.

(b) putting in place procedures for ensuring that there is a co-ordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

It has been a government directive since April 2008, that all Local Safeguarding Children's Boards have suitable Child Death Overview Panel arrangements in place to ensure;

i) An initial rapid response following the unexpected death of a child by a group of key professionals involved with the family at the time for the purpose of enquiring into and evaluating each unexpected death of a child.

ii) A full review of all deaths of children under 18 years in the LSCB areas undertaken by the Panel. (This excludes babies who are stillborn or planned terminations that have been carried out within the law).

For the period covered by this report (2016-2017) the panel was chaired by Christina Atchinson, Consultant in Public Health, London Borough of Hillingdon and Steve Ashley, Independent Chair of the Local Safeguarding Children Board. The CDOP has a fixed core membership of senior professionals which is drawn from the key organisations represented on the LSCB, with a flexibility to co-opt other relevant professionals as and when appropriate.

At the end of each reviewing year government forms (LSCB1) are submitted to the Department for Education for the purpose of pooling data into a national database in order to identify national problems/trends.

1.2 Rapid Response Teams

After any unexpected death a Rapid Response Meeting is held within 5 – 7 days of the death and chaired by the Designated Consultant Paediatrician for Child Death of Hillingdon Hospital. This meeting brings together all professionals involved with the child and/or family prior to or at the time of death to discuss the circumstances, any family or agency concerns and to ensure bereavement support. The Rapid Response Meeting also identifies any immediate actions required to prevent future deaths of other children in the area. This allows for change in either environment, policy or procedures prior to the case being taken to panel, as most unexpected deaths require inquests and this may take many months or years before a verdict is reached.

Hillingdon: Chaired by Dr Jide Menakaya, the Designated Paediatrician from Hillingdon Hospital.
Rapid Response Co-ordinator/Julie Gosling

There were (5) Rapid Response Meetings in Hillingdon from 1st April 2016 to 31st March 2017. All Rapid Response Meetings generated immediate actions for agencies which were predominantly around bereavement support or dissemination of early opportunities to change/review practise

All information obtained at the Rapid Response Meetings is shared with the Coroner.

1.3 The Child Death Overview Panel (CDOP)

CDOP Membership 2016/2017

The Panel has convened three (3) times in the reporting year and has been well attended by all agencies throughout the year.

Name	Organisation
Steve Ashley	Independent Chair, Hillingdon LSCB
Dr Jide Menekaya	Designated Consultant Paediatrician, Hillingdon Hospital
Janice Altenor	Head of Service, Safeguarding & Quality Assurance, LBH
Andrea Nixon	Development and Business Manager, Hillingdon LSCB
Julie Gosling	CDOP, Rapid Response Coordinator, LBH
Jenny Reid	Designated Nurse, Safeguarding Children, NHS Hillingdon CCG
Sarah O'Toole	Metropolitan Police, Child Abuse Investigation Team
Steve O'Connor	Borough Police, Metropolitan Police

2. CDOP Information

2.1 Website:

A dedicated page has been established on the Hillingdon LSCB website that provides information and referral forms regarding the CDOP process. (www.hillingdonlscb.org.uk)

2.2 Links:

The CDOP co-ordinator attends the pan London SPOC meetings.

There is a national CDOP online forum which shares important messages in child death prevention that have been identified through reviews across the country and these messages are shared across our boroughs as preventative measures.

Excellent links are established with all agencies and in all relevant tertiary London Hospitals especially Great Ormond Street, Queen Charlottes, St Mary's and Chelsea & Westminster, as well as with bordering boroughs and counties.

2.3 Parents:

All parents or carers with parental responsibility receive a letter, either after the Rapid Response Meeting or two weeks after the death of their child, explaining the CDOP process and informing them that the CDOP will be gathering information relating to the death from many agencies. The letter invites them to contact the CDOP Manager or if they prefer, the Consultant Paediatrician who provided care to the child, to discuss the CDOP process or to express any concerns regarding any agency or environmental factors or views about their child's care which should be taken to the CDOP panel with a view to change and to prevent the future deaths of children. Attached to the letter is a leaflet giving details of the process and how to access bereavement services. There is a national agreement that parents will not be invited to attend Rapid Response or CDOP meetings.

2.4 Finance:

CDOP is managed through the LSCB business unit and therefore does not have a standalone budget.

3. Review Procedure

Child Deaths are categorised into four groups under the Child Death Guidance

Neonatal, (under 28 days old)

SUDI, (sudden unexpected death of an infant under 2 years)

Unexpected death of a child between 2 years and under 18 years

Expected death of a child under 18 years (natural causes)

- An unexpected death is defined as the death of an infant, child or young person (less than 18 years old) which:

was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

The Panel reviews EVERY death of a child to ensure the appropriateness of any professional response and involvement before, at the time and after every death of a child and considers relevant environmental, social, health and cultural aspects of each death to ensure a thorough consideration of how such deaths might be prevented in the future.

The review considers the findings from any other agency review that has been undertaken – i.e. serious cases review, internal management review; serious incident reviews or inquests and takes account of their report, recommendations and action plans. The panel can refer a case to the Serious Case Review panel if necessary.

After each review the Panel decides whether the child death falls into one of two categories;

No Modifiable Factors Identified	Death caused by intrinsic or extrinsic factors, with no identified modifiable factors
Modifiable Factors Identified	Potentially modifiable factors extrinsic to the child or: One or more modifiable factor in any domain may have contributed to the death of a child which by means of national or locally achievable interventions could be modified to reduce the risk of future child deaths.

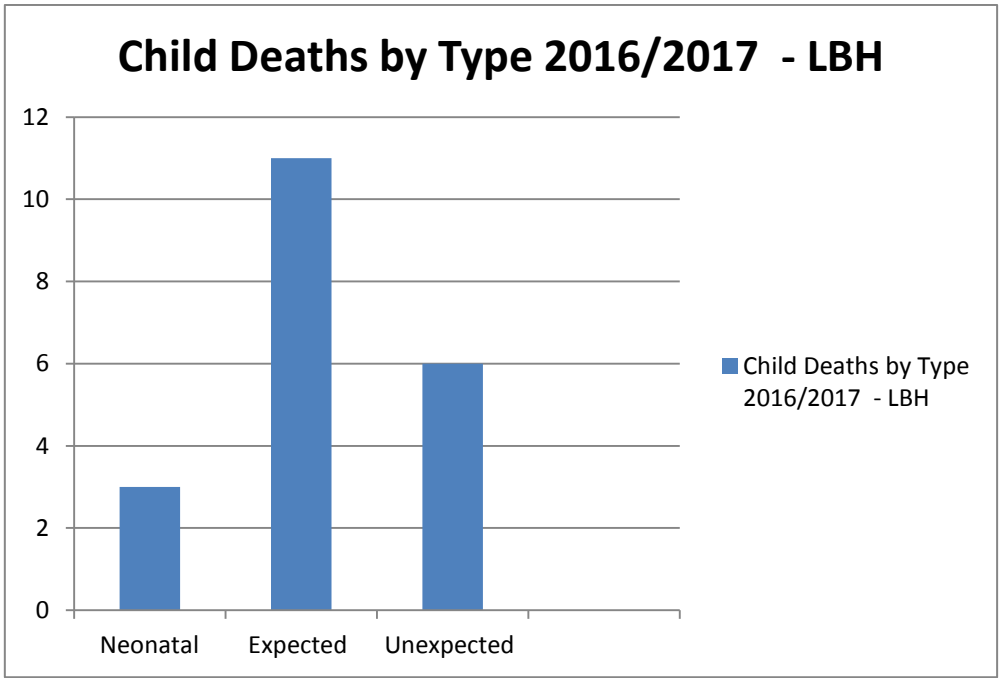
Modifiable Factors relate to family and environment, parenting capacity or service provision.

The CDOP panel ordinarily meets quarterly although extra meetings can be arranged dependent on circumstances. The CDOP panel met on three occasions from 1st April 2016 to 31st March 2017.

3. Child Deaths occurring from 1st April 2016 - 31st March 2017

Between 1st April, 2016 and 31st March 2017 there were (20) child deaths in Hillingdon Borough.

Child deaths by type 2016/2017



Neonatal Deaths: 2016/2017
Under 28 days old

Neonatal Deaths (under 28 days old	
	Hillingdon
2008/09	8
2009/10	18
2010/11	12
2011/12	7
2012/13	8
2013/14	12
2014/15	7
2015/16	9
2016/17	3
2008/2017	85

Expected Deaths: 2016/17

An expected death is the natural and inevitable end to an irreversible terminal illness and death is recognised as an expected outcome.

Expected Child Deaths	
	Hillingdon
2008/09	5
2009/10	11
2010/11	14
2011/12	3
2012/13	10
2013/14	1
2014/15	7
2015/16	14
2016/17	11
2008/2017	76

Unexpected Deaths 2016/2017

An Unexpected death is one that was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

Unexpected Child Deaths	
	Hillingdon
2008/09	5
2009/10	4
2010/11	3
2011/12	3
2012/13	4
2013/14	7
2014/15	2
2015/16	2
2016/17	5
2008/2017	36

Sudden Unexpected Deaths

Infants under 2 years old (SUDI/SIDS)
*A **SUDI** is any sudden unexpected death of an Infant under 2 years with a known cause and **SIDS** is Sudden Infant Death Syndrome where there is no known cause at post mortem.*

Sudden Unexpected Deaths	
	Hillingdon
2008/09	4 0 SIDS 4 SUDI
2009/10	2 0 SIDS 2 SUDI
2010/11	1 0 SIDS 1 SUDI
2011/12	4 0 SIDS 4 SUDI
2012/13	3 0 SIDS 3 SUDI
2013/14	2 2 SIDS 0 SUDI
2014/15	2 1 SIDS 1 SUDI
2015/16	0 0 SIDS 0 SUDI
2016/17	1 1 SIDS 1 SUDI
2008/2017	19

CHILD DEATHS BY MONTH

There are no statistically reliable trends in the months when child deaths occur in *Hillingdon*.

	Child Deaths by Age			
	Hillingdon			
	0-28 days	29 days - under 2 years	2-10 years	11-18 years
2008/09	8	7	5	2
2009/10	17	8	6	4
2010/11	12	10	3	5
2011/12	7	7	1	2
2012/13	8	9	4	4
2013/14	14	0	7	1
2014/15	4	7	7	0
2015/16	9	6	5	5
2016/17	4	4	8	4

CHILD DEATHS BY GENDER

2016/2017

	Child Deaths by Gender	
	Hillingdon	
	Male	Female
2008/09	9	13
2009/10	11	14
2010/11	10	7
2011/12	14	16
2012/13	21	14
2013/14	11	11
2014/15	12	6
2015/16	14	11
2016/17	8	12

CHILD DEATHS BY ETHNICITY 2010 – 2017

Ethnicity follows LSCB DfE format from 2010-2017 **HILLINGDON**

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	Total
White: English/Welsh/Scottish/Northern Irish/British	8	3	7	5		8	5	31
White: Irish	1						0	1
White: Gypsy or Irish Traveller		1					0	1
White: Any Other White background		1		5	1		0	7
Mixed/multiple ethnic groups: White & Black Caribbean	1						0	1
Mixed/multiple ethnic groups: White & Black African	2						0	2
Mixed/multiple ethnic groups: White & Asian			1				0	1
Mixed/multiple ethnic groups: Any other mixed/multiple ethnic background			2		5	1	0	8
Asian or Asian British: Indian	5	6	3	6	5	3	3	28
Asian or Asian British: Pakistani	1	3	1			2	1	7
Asian or Asian British: Bangladeshi	2	1	1		1	1	1	6
Asian or Asian British: Chinese					1	2	0	3
Asian or Asian British: Any other Asian background	2		3	1	2	3	2	11
Black/Black British: Caribbean	1		1	1		1	1	4
Black/Black British: African	6	2	4	2	1	3	3	18
Any other Black/Black British/African/Caribbean background					2		0	2
Other: Arab			2	2		1	1	5
Unknown/not stated	1						3	1

LESSONS LEARNT

It is important to note that due to the low number of deaths, this makes it impossible to provide an accurate statistical interpretation or trend analysis. All unexpected deaths were managed appropriately using rapid response process.

When a child is born if they take any breath it is classified as a live birth irrespective of viability. Thus a 20 week foetus that breathes will be classed as a live birth even though births under 24 weeks gestation are not considered viable.

As in previous years, infant deaths are the highest proportion of all child deaths; therefore measures to improve the health of pregnant women are vital. Early booking gives the best and making lifestyle changes such as stopping smoking.

The members of CDOP are committed to safeguarding children and learning lessons from previous child deaths Hillingdon.