REPORT FOR:	**HEALTH AND WELLBEING BOARD**
Date of Meeting:	14 October 2015
Subject:	**INFORMATION REPORT** – Child death Overview Panel Annual Report 2014
Responsible Officer:	Dr Andrew Howe Director of Public Health Harrow Council
Exempt:	No
Wards affected:	All
Enclosures:	Child death Overview Panel Annual Report 2014

Section 1 – Summary

This report sets out the finding of the Child Death Overview panel in 2014 which has the responsibility to review all deaths in children up to the age of 18 years. .

FOR INFORMATION

Section 2 – Report

This report provides background information on the role and function of Child Death Overview Panels, a description of the work undertaken during the year by the Harrow Panel (together with some statistical analysis) and, importantly, identifies some of the themes and learning emerging from the reviews of child deaths and the actions resulting from this.

The purpose of the report is to enable the Harrow Local Safeguarding Children Board to provide information on safeguarding activity in 2014 and also to provide an honest appraisal of the safeguarding of children and young people in the Borough. The report was presented to the Harrow LSCB in July 2015.

The panel met three times during the calendar year and a total of 13 cases were reviewed in the period. Due to low numbers, it is impossible to make any statistical inferences.

Infant deaths are the highest proportion of all child deaths, therefore measures to improve the health of pregnant women, reducing smoking and improving childcare practices to reduce the risk factors for sudden and unexpected infant deaths will have most effective impact on decreasing mortality.

In an attempt to overcome the issues for small numbers, a London –wide analysis is being undertaken with a workshop planned in October.

Section 3 – Further Information

Further Annual reports will be brought to the HWB in future years.

Section 4 – Financial Implications

The administration of CDOP is funded from the Public Health ring-fenced grant. The DH are currently consulting on a reduction in the grant of £200m nationally (estimated at £665k for Harrow) and the grant allocations for future years are expected to be announced as part of the comprehensive spending review in the autumn. In Harrow there is an expectation that Public Health outcomes will continue to be contained within the grant financial envelope.

Section 5 - Equalities implications

Was an Equality Impact Assessment carried out? No

The report covers data on age, gender and ethnicity. Due to small numbers it is not possible to undertake an EQIA.

Section 6 – Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

Please identify how the report incorporates the administration's priorities.

• Making a difference for the vulnerable	Yes It covers children from birth to 18
• Making a difference for communities	
• Making a difference for local businesses	
• Making a difference for families	Yes, child deaths impact on the whole family.

STATUTORY OFFICER CLEARANCE
(Council and Joint Reports

Name: Donna Edwards	✓	on behalf of the Chief Financial Officer
Date: 14 August 2015		

Ward Councillors notified:	NO .

Section 7 - Contact Details and Background Papers

Contact: Carole Furlong, Consultant in Public Health, 020 8420 9508

Background Papers: none

Child Death Overview Panel (CDOP)
2014 Annual report

Contents

Welcome

The Child Death Overview Panel (CDOP) is an inter-agency forum that meets regularly to review the deaths of all children normally resident in Harrow. It acts as a sub-group of the Local Safeguarding Children's Board. The CDOP is accountable to the LSCB. During the review process, the CDOP may identify issues that need to be addressed such as:

- any cases requiring a Serious Case Review;
- any matters of concern affecting the safety and welfare of children and;
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area; a specific recommendation would be made to the LSCB.

The Panel held 3 meetings during 2014 in which 13 cases were discussed compared to 19 cases in 2013.

Child death is a very sensitive issue of crucial importance. Our panel is committed to learning from every such incident and where possible, identify preventable factors and to inform action that can be taken to reduce the number of child deaths in the future. Within this report, we have identified some of the learning from those cases reviewed in 2014 and the subsequent steps that we have taken.

It is understandably difficult to find appropriate ways to seek the views of families about the support they receive after their child has died. However, parents are informed when their child's death is about to be reviewed, and are encouraged to contact me as Chair of the panel. In response, I have spoken to or had contact with a number of bereaved families following panel meetings.

It is important to recognise and should be noted that as the number of child deaths is small, it is difficult to compare any conclusions with other National data.

Dr. Andrew Howe
Director of Public Health and Chair, Child Death Overview Panel, The London Borough of Harrow

Introduction

This report provides background information on the role and function of Child Death Overview Panels, a description of the work undertaken during the year by the Harrow Panel (together with some statistical analysis) and, importantly, identifies some of the themes and learning emerging from the reviews of child deaths and the actions resulting from this.

The Harrow Child Death Overview Panel (CDOP) has the responsibility to review all deaths in children up to the age of 18 years.

The key principles underlying the overview of all child deaths are[1]:

- Every child's death is a tragedy
- Learning lessons to prevent future child deaths
- A joint agency approach
- To make recommendations to the LSCB so that positive action to safeguard and promote the welfare of children can be taken

The purpose of this report is to enable the Harrow Local Safeguarding Children Board to provide information on safeguarding activity in 2014 and also to provide an honest appraisal of the safeguarding of children and young people in the Borough.

Child death review processes became mandatory in April 2008 and it is the responsibility of the multi- agency CDOP to review the cases of all child deaths to identify potentially preventable deaths. This report presents, at an aggregate level, an analysis of the information and summarises the actions taken over the last year.

The panel is formed of the following multi agency professionals from Harrow that are committed to safeguarding children.

Andrew (Dr)	Howe	Harrow CDOP Chair, Director of Public Health
Ruby (Dr)	Schwartz	Designated Doctor Child Death Review
Sue	Dixon	Designated Nurse, Safeguarding Children
Neil	Harris	Children's Services
Marie	Hourihan	CDOP Coordinator
Melanie	Zubrugg	Named Nurse, NPH
Lawrie	Roach	Coroner's Officer
Elizabeth	Major	Partnership Coordinator, Children's Services Harrow
Liam	Adams	Metropolitan Police, CAIT
Marwa	Wilson	Bereavement Specialist Midwife, NPH
Cheryl	Pearce	The Lullaby Trust

Facts and Figures 2013 - 2014

During the year 2014 there were 3 CDOP meetings. The attendance of core members since the Panel's inception has been high. Panel members are expected to attend at least three out of every four meetings with the exception of the Designated Doctor Child Deaths who is expected to attend all meetings.

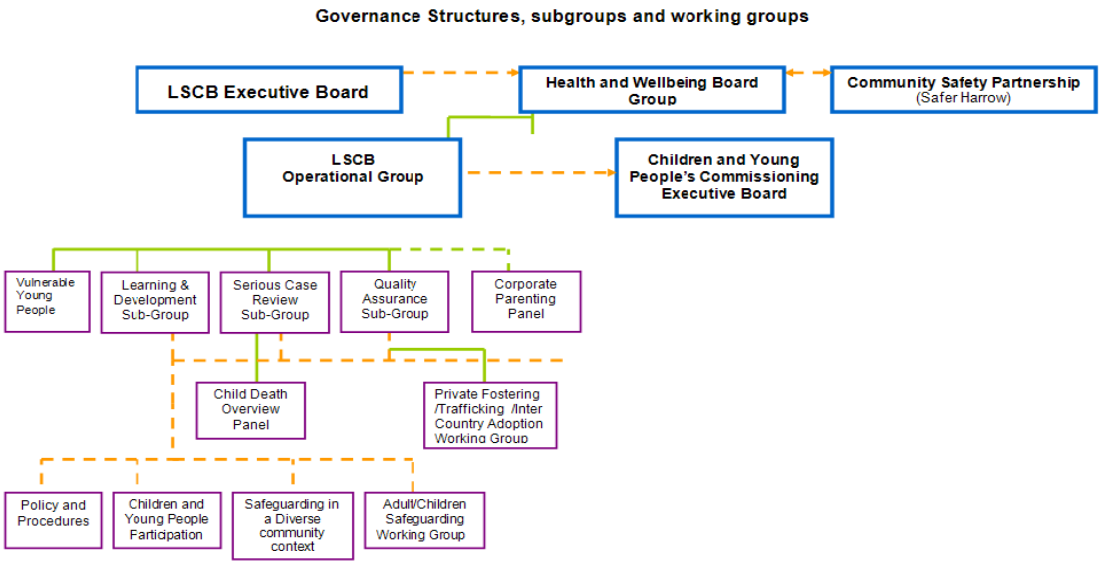
The Harrow Local Safeguarding Children Board (LSCB) is a statutory partnership consisting of senior representatives of all relevant agencies. It is not a delivery or a commissioning body but it is primarily responsible for the monitoring and evaluation of safeguarding children across the Borough, and influencing organisations in relation to improving safeguarding.

The Safeguarding Children Board has a structure of sub-groups and work-streams that will assist in the delivery of these objectives. Each sub-group is chaired by a member of the Safeguarding Children Board and is made up of key safeguarding staff from all agencies.

The LSCB has a number of established Sub groups to ensure that identified priorities are met. Each Sub group is chaired by a member of the LSCB and has delegated responsibility from the Board.

Figure 1 shows the current structure of the Harrow Local Safeguarding Children Board and the sub-groups, work-streams and associated mechanisms such as the Child Death Overview Panel.

Figure 1: Harrow LSCB Structure Chart



- The SCR Sub Group reviews the referrals against the criteria for holding a SCR and makes appropriate recommendations to the LSCB Board.
- The SCR Sub Group considers serious cases including those identified through the CDOP process which do not meet the criteria for holding a SCR case review, but have a multi-agency element and provide scope for learning around multi agency practice and procedures.
- The SCR Sub Group undertakes reviews of serious cases and advises the local authority and the LSCB board on lessons to be learned.
- The SCR Sub Group provides an annual report to the LSCB

- All child deaths are reported to the SCR subcommittee and LSCB operational group at all meetings

Commentary on cases reviewed

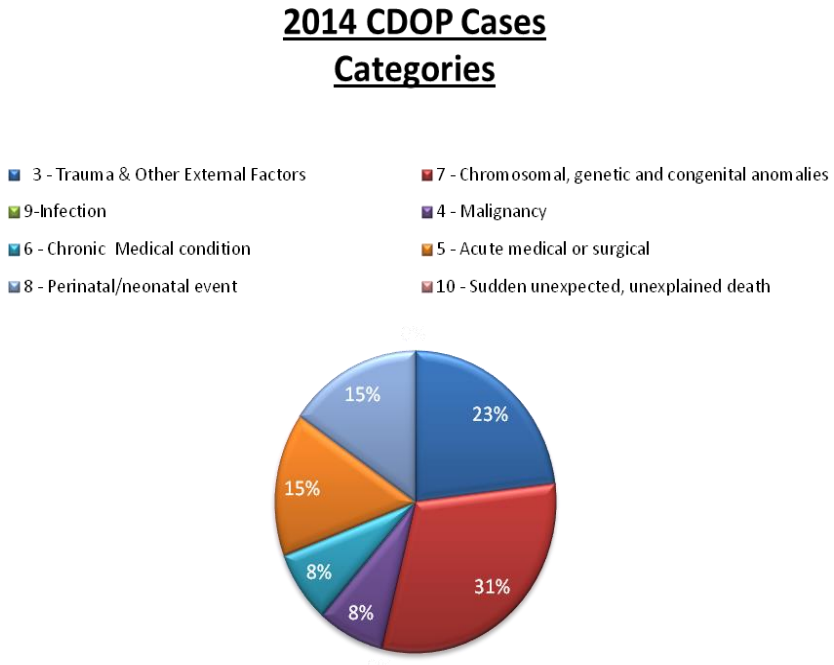
A total of 13 cases were reviewed in the period 1st January- 31st December.

Due to the low numbers involved, it is difficult to complete any trend analysis. However we should continue to act as advocate for families to improve the health and wellbeing for infant and maternal health.

Gender

Overall, the CDOP figures for deaths in 2014 were 62% male and 38% female children. National statistics suggests that there are more deaths in boys than girls during the perinatal period, which is consistent with the 2013 data.

Figure 2 Category of death – Harrow CDOP cases 2014



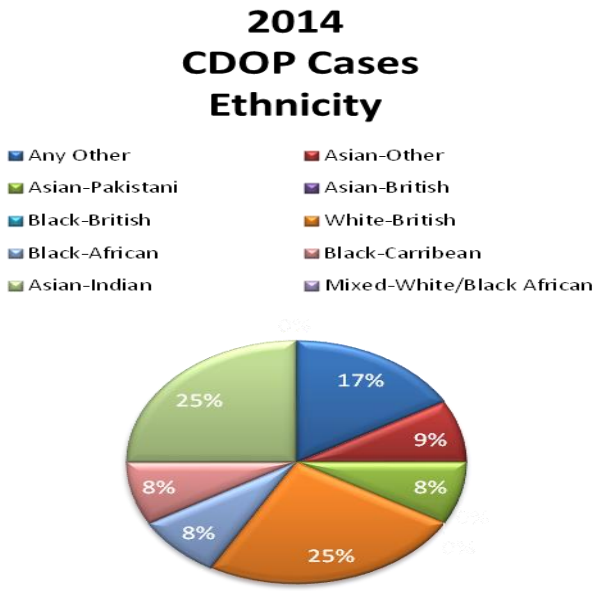
Source: CDOP database 2014

Nationally, it has been shown that the two most common causes of perinatal deaths are perinatal/neonatal events due to prematurity and congenital malformations[2]. For Harrow in 2014, perinatal or neonatal events most of which were due to prematurity accounted for the majority of child deaths reviewed by CDOP.

Ethnicity

Ethnicity is not recorded on death certificates therefore it is not possible to compare this information with the total number of deaths occurring in children. It is not possible to ascertain whether the numbers of child deaths is truly disproportionately higher in children from BME backgrounds. The largest cohort of child deaths in 2014 is equally split amongst White – British and Asian – Indian, both at 25%.

Figure 3 Ethnicity of child deaths reviewed by CDOP in Harrow 2014



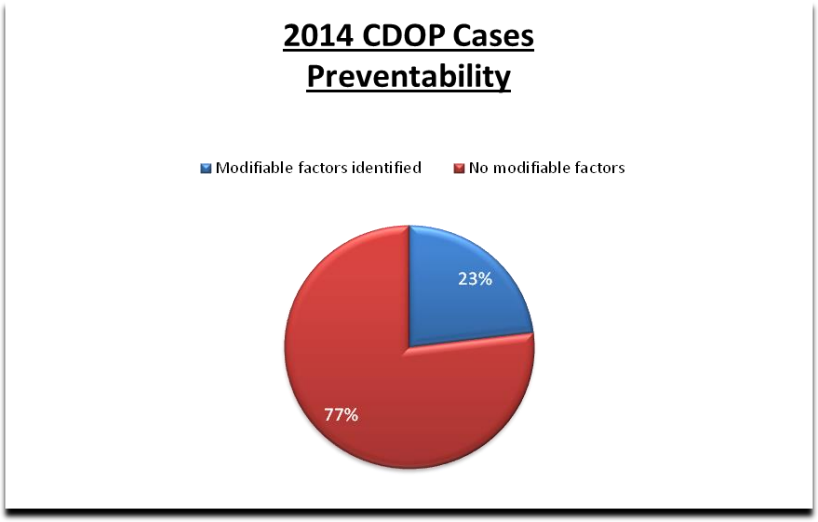
SUDIs – Sudden Unexpected Death of Infants

During 2014, none of the deaths were categorised as sudden unexplained infant death. Due to the low numbers involved, it is difficult to complete any trend analysis. An unexpected death of a child is defined as death that was not anticipated as a significant possibility 24 hours prior to the occurrence.

Cause of Death

From 1st April 2010, CDOPs were asked to identify whether or not there were 'modifiable factors' in a death. However, there are difficulties in distinguishing between these categories, i.e. of factors which definitely contributed to the death and of factors which may have contributed to the death, and ensuring a nationally consistent approach. These are factors, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.

Figure 4 Preventability of child deaths reviewed by CDOP in Harrow 2014



There were believed to have been 3 modifiable deaths in 2014. Due to the relatively small numbers of child deaths in Harrow, further information related to individual cases cannot be made available.

Further detail of those cases which have been identified as having modifiable factors have been included within the lessons learnt section of this report.

Number of deaths by quarter (Q1-4)

There is no consistent pattern observed in the number of deaths reviewed compared to the number of deaths occurring each quarter.

Lessons Learnt

It is important to note that due to the low number of deaths, this makes it particularly difficult to provide an accurate statistical interpretation or trend analysis over a short period of time. Therefore any attempts to identify trends and patterns on an annual basis are limited.
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 they are not viable with life (less than 24 weeks gestation).

Infant deaths are the highest proportion of all child deaths, therefore measures to improve the health of pregnant women, reducing smoking and improving childcare practices to reduce the risk factors for sudden and unexpected infant deaths will have most effective impact on decreasing mortality.

1. The members of CDOP are committed to safeguarding children and learning lessons from previous child deaths in Harrow. From the 13 cases that were reviewed by the panel in 2014, the panel are awaiting the outcome of two serious case reviews which will determine future learning.

Following the introduction of the Health and Social Care Act, during 2013, the NHS remained in a period of transition, for the purposes of continuity; the CDOP is funded and managed from within Public Health.

What support is available for families when a child dies?

When a child dies, the loss is unimaginable to those who have not been through it. There are specialised support groups who may be able to help, such as those listed below:

Child Bereavement UK
Tel: 0800 02 888 40
Website www.childbereavement.org.uk
Offers confidential telephone support and online forums, along with training for professionals working with grieving families and children.

The Child Death Helpline
Tel: 0800 282 986
Website: www.childdeathhelpline.org.uk
Offers telephone support on every weekday evening from 7pm to 10pm, every Monday and Friday morning from 10am to 1pm and on Tuesday and Wednesday afternoons from 1pm to 4pm.

Cruse Bereavement Care
Tel: 0844 477 9400
Website: www.cruse.org.uk
A national voluntary organisation that offers free, confidential bereavement counselling services to people of all ages.

Samaritans
Tel: 08457 909090
Website: www.samaritans.org

The Compassionate Friends
Tel: 0845 123 2304
Website: www.tcf.org.uk
A national organisation offering support and friendship to bereaved parents and families.

Glossary

Early neonatal death - death of a live born baby occurring less than seven completed days from the time of birth

FSID – Foundation for the Study of infant Deaths (Charity)

Infant mortality rate - number of babies who die before their first birthday per 1,000 of live births

Late neonatal death - death of a live born baby occurring after the seventh day and before 28 completed days from the time of birth.

LSCB – Local Safeguarding Children Board; the Local Authority has a group of senior professionals from agencies who meet to agree how to work together to make sure that local children are kept safe from harm.

Malignancy – is a medical term to describe a severe and progressively worsening disease, potentially resulting in death. Frequently used to describe cancers/tumours.

Modifiable – one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths

Mortality rate – number of deaths per unit of population within a given time period. Usually measured as deaths per 100,000 population per year.
Neonate – child/infant aged less than 28 days old.

Neonatal mortality rate - number of neonatal deaths per 1000 live births.

Neonatologist – doctor who deals with the care and development of newborn babies and the treatment of their diseases.

Perinatal – period surrounding birth, and includes the time from about 24 weeks of pregnancy up to either 7 or 28 days of life.

Perinatal mortality - foetal deaths after 24 completed weeks of pregnancy and death before 7 days.

Premature birth - a baby born before 37 weeks gestation

Rapid response – action taken by health, police and social care in response to an unexpected death to establish, where possible, the cause of death, how it happened, identify contributory factors and provide ongoing support to the family.

Serious Case Review – an in-depth review undertaken by an LSCB into a death caused by abuse or neglect, in order to learn and act on lessons in relation to the way professionals and organisations work together to safeguard and promote the welfare of children.

Unexpected child death – government guidance defines an “unexpected death” as the death of a child that was not anticipated as a significant possibility 24 hours before, or where there was a similarly unexpected collapse leading to or causing the events that led to the death.