Child Death Overview Panel (CDOP)
2015 Annual report

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 4 meetings during 2015 in which 18 cases were discussed compared to 13 cases in 2014.

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:

- 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 2015 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.

Dr Andrew Howe	Harrow CDOP Chair, Director of Public Health, Harrow Council
Liam Adams	Metropolitan Police, CAIT
Carole Furlong	Consultant in Public Health, Harrow Council (since June 2016)
Neil Harris	Service Manager QA and Service Improvement, Children's Services
Marie Hourihan	CDOP Coordinator
Pramod Mainie	London Northwest Healthcare Trust
Coral McGookin	Partnership Coordinator, Harrow Safeguarding Children Board
Cheryl Pearce	The Lullaby Trust
Lawrie Roach	Coroner's Officer
Dr Ruby Schwartz	Designated Doctor Child Death Review, Harrow CCG
Sue Sheldon	Designated Nurse, Safeguarding Children, Harrow CCG
Marwa Wilson	Bereavement Specialist Midwife, London Northwest Healthcare Trust
Melanie Zubrugg	Named Nurse, London Northwest Healthcare Trust

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.

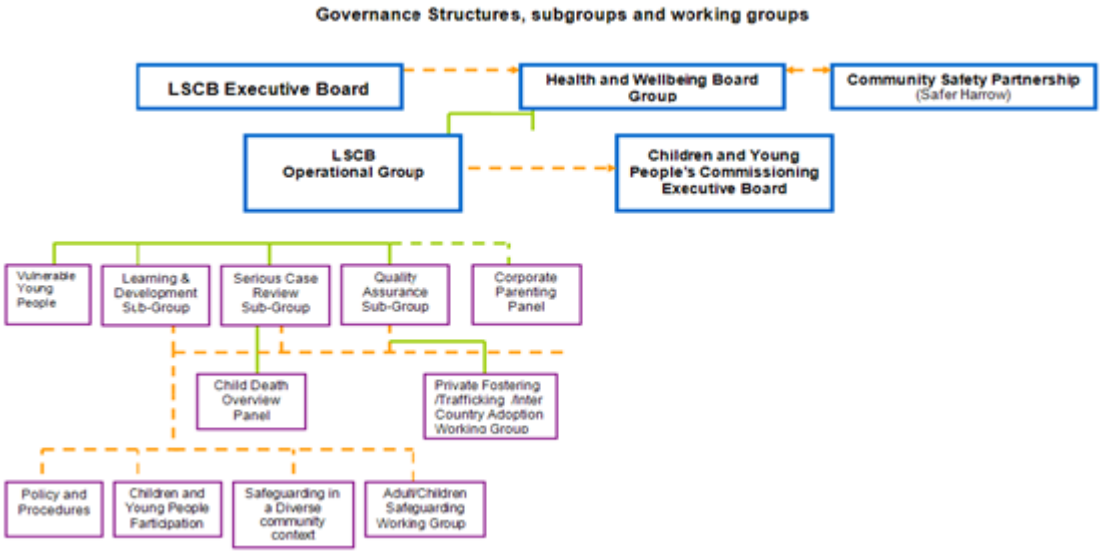
GOVERNANCE

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.

The graphic below 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.



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

Following the introduction of the Health and Social Care Act in 2013, a decision was made to fund and manage CDOP from within Public Health for the purpose of continuity. This remains the case in 2015.

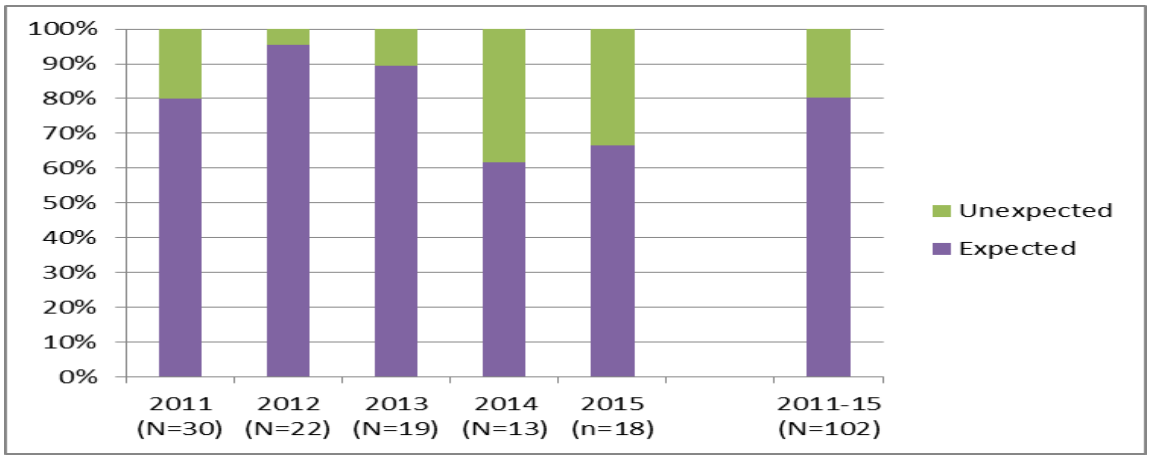
CDOP MEETINGS IN 2015

During the year 1st January 2015- 31st December 2015, there were 4 CDOP meetings: in March, June, September and December. The attendance of core members since the Panel's inception has been high. A total of 18 cases were reviewed in the period.

Due to the low numbers involved, it is difficult to provide a robust trend analysis. However we have presented summary data for the previous 5 years for comparison. Regardless of the small numbers, CDOP will continue to act as advocate for families to improve the health and wellbeing for infant and maternal health.

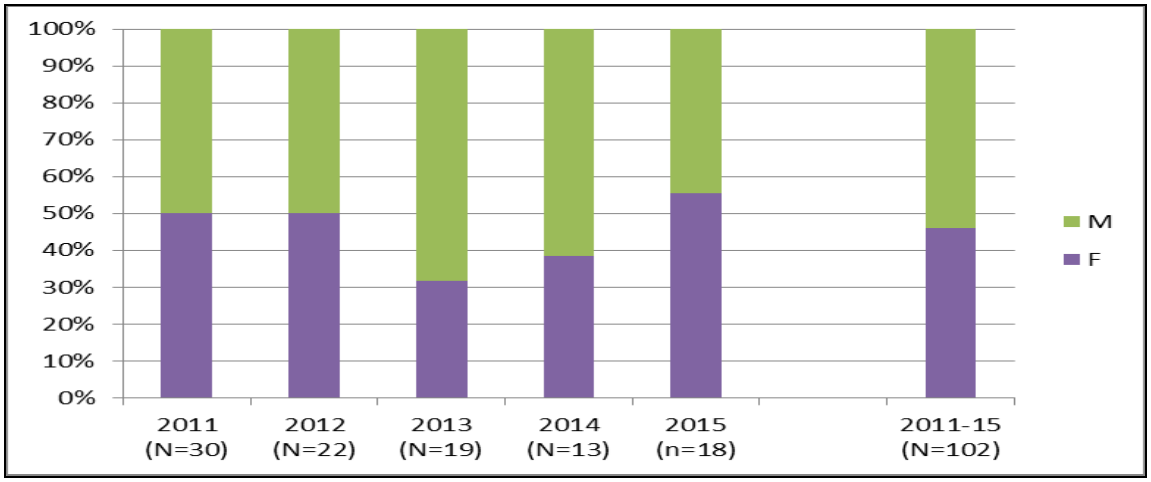
EXPECTED VS UNEXPECTED DEATHS

Over the past 5 years, only 20% of child deaths are classified as unexpected. In the past two years this proportion is higher although the small numbers make it impossible to say if this is an ongoing trend. Of the 20 unexpected deaths occurring in the past 5 years, almost all had a rapid response meeting or visit.

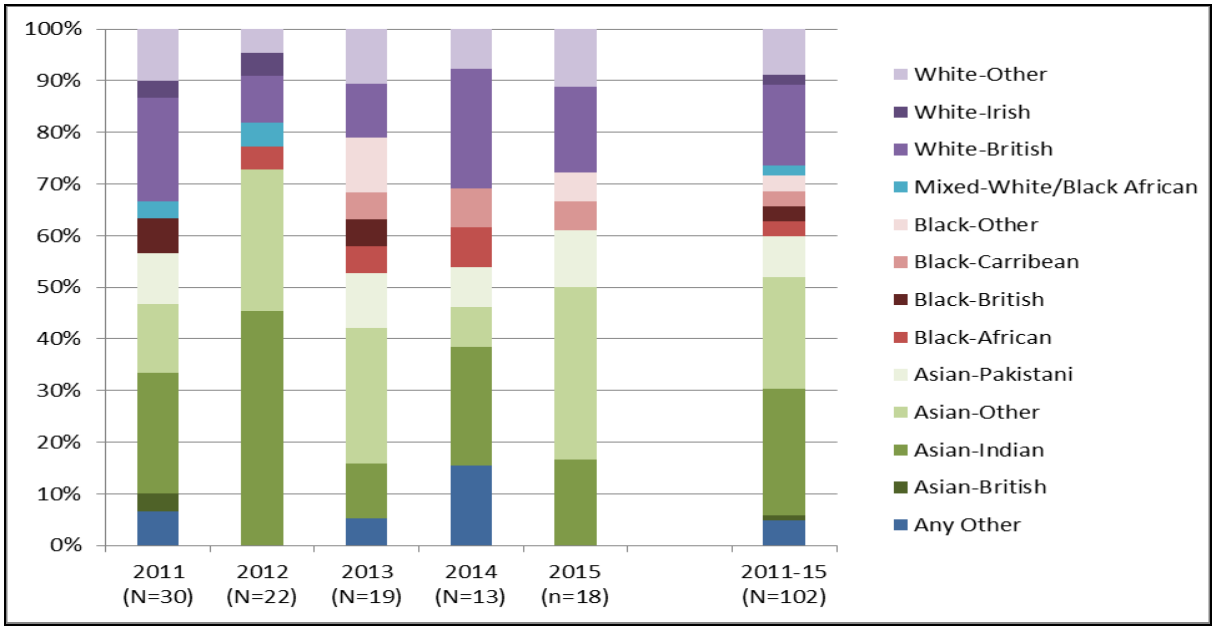


CHARACTERISTICS OF CASES

Between 2011 and 2014, deaths were higher in males than in females. In 2015, female deaths accounted for 56% of cases reviewed by CDOP.



Ethnicity is not recorded on death certificates and so the data on ethnicity of CDOP cases has been gathered from hospital records and/or based on the recorded ethnicity of the parents. Due to small numbers the pattern of deaths varies by ethnic group. On average over the past five years, the number of deaths in children from BAME groups is slightly higher than might be expected given the makeup of the Harrow population.



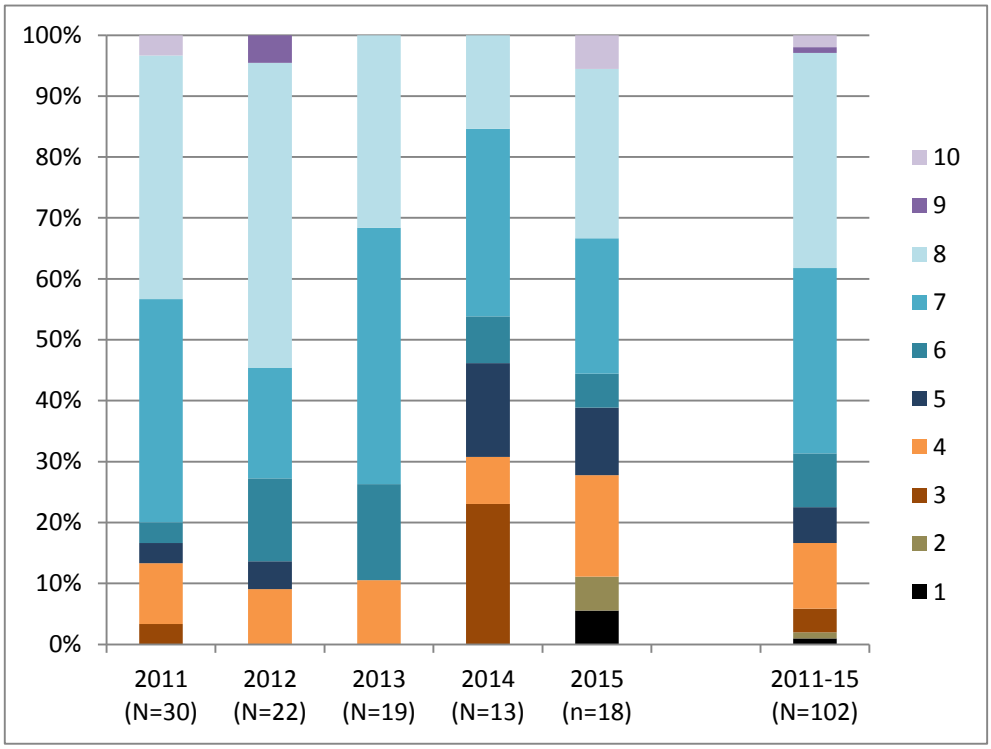
In almost half of all child deaths, religion was not known or not recorded. No conclusions can be drawn from this data.

CDOP CATEGORIES

The role of the Child Death Overview panel is to determine which category each cases falls into and to determine if there were any modifiable risk factors. There are 10 categories and the panel will choose the most appropriate category for the cause of death. Where there are more than one possible category, the panel will choose the more significant category (i.e. with the lower number).

Category	Name & 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, leukaemias & 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, eg 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 (ie, 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).

In common with that national data, both in 2015 and over the past five years, the most categories were that of perinatal/neonatal events and chromosomal, genetic and congenital abnormalities.



In 2015, there were three cases that were unusual for Harrow. There was one case in each of categories 1 and 2 both of which have been subject to serious case reviews and had modifiable risk factors.

The third case of note was a sudden unexplained death in Infancy, the first in Harrow since 2011. An unexpected death of a child is defined as death that was not anticipated as a significant possibility 24 hours prior to the occurrence. The case had no modifiable risk factors but the panel suggested that thought should be given to refreshing awareness about reducing the risk of SUDI/ SIDS.

Modifiable Risk Factors

From 1st April 2010, CDOPs were asked to identify whether or not there were 'modifiable factors' in a death. 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. 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.

There were believed to have been 4 modifiable deaths in the cases examined in 2015. Due to the small numbers of child deaths in Harrow, further information related to individual cases cannot be made available.

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 chance of identifying problems, implementing any changes in the woman's management and making lifestyle changes such as stopping smoking. It was brought to the attention of the panel that the health visitor who is the designated lead for Care of the Next Infant (CONI) is on long term sick leave. The panel has asked that the commissioner for health visiting raise the need for a deputy for this role.

As a result of the SUDI case, a programme of training for early years workers in children's centres, private nurseries and private child minders has been initiated in collaboration with the Lullaby Trust. The training on safer sleep practices includes information on referral to stop smoking services, the use of child slings and the availability of support for bereaved parents.

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 case reviews which will determine future learning.

Report prepared by

Carole Furlong

Public Health Consultant

June 2016