Child Death Overview Panel (CDOP)

2016 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 and is accountable to the LSCB. In the coming year, there may be changes in the CDOP as a result of the Wood report but all deaths in children and young people under the age of 18 will continue to be reviewed by a CDOP panel

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;
- any matters about the care of a specific case requiring action 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 2016 in which 26 cases were discussed compared to 18 cases in 2015.

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.

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 or the designated Professional, Sue Sheldon, have spoken to or had contact with a number of bereaved families either before or 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 make any comparisons 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.

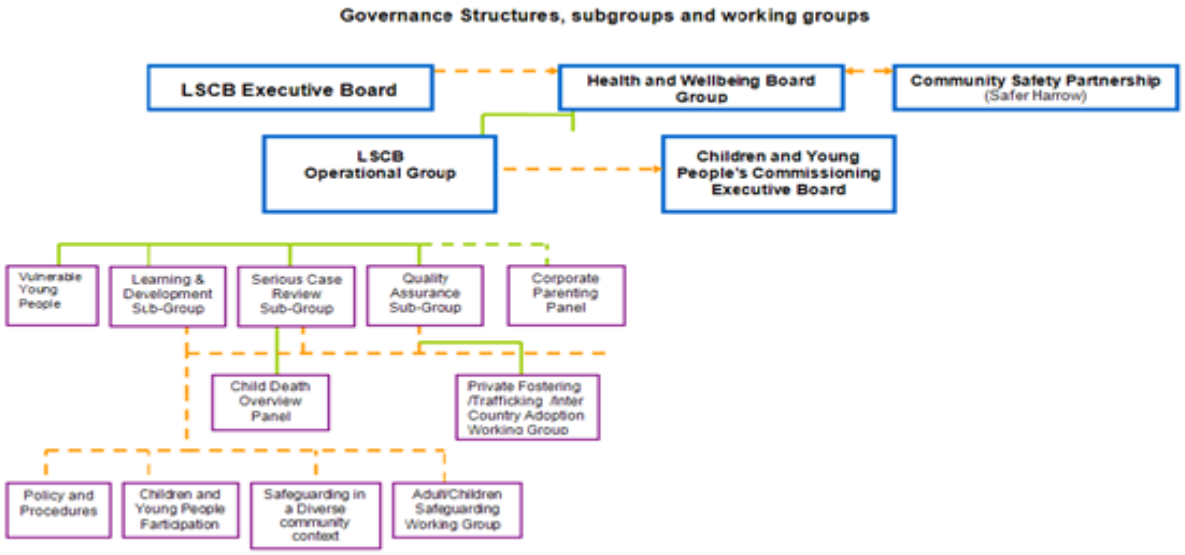
GOVERNANCE

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 the Public Health ring fenced budget rather than from the LSCB budget for the purpose of continuity. This remains the case in 2016.

During 2016, we saw the publication of the Wood review of local safeguarding children boards. The review included recommendations regarding CDOPs. It said that Child death reviews should continue to be carried out by multi-agency arrangements but as only 4% of child deaths relate to safeguarding, Child Death Overview Panels (CDOPs) should be hosted within the NHS, supported by the Department of Health. The government agreed to put in place arrangements to transfer national oversight of CDOPs from the Department for Education to the Department of Health while embedding the focus on learning within child protection agencies.

Across London, the CDOP leads and members have been coming together to learn from each other and to improve the consensus on classifying cases. The group also recognises that the footprint of each CDOP s probably too small to be sustainable and there are likely to be changes in the At this time, there are no concrete plans for changes to the Harrow CDOP but we are actively discussing merging CDOPs to provide a bigger footprint.

MEMBERSHIP AND ATTENDANCE AT CDOP

The child death overview panel is formed of a group of multi agency professionals from Harrow that are committed to safeguarding children. Panel members are expected to attend at least three out of every four meetings with the exception of the Designated Professional who is expected to attend all meetings and the CAIT lead from the Metropolitan Police who attends only when there is a suspicious death.

Four meetings of the panel were held in 2016. The membership and attendance at the meetings is shown below.

Name	Designation Agency	Apr-16	July-16	Sept-16	Dec-16
Dr Andrew Howe	Harrow CDOP Chair, Director of Public Health, Harrow Council	✓	✓	✓	✓
Carole Furlong	Consultant in Public Health, Harrow Council	✓	✓	✓	✓
Sue Sheldon	Designated Professional, Safeguarding Children, Harrow CCG	✓	✓	✓	×
Marie Hourihan	CDOP Coordinator (funded by Public Health)	✓	✓	✓	✓
Neil Harris	QA and Service Improvement Manager, Children's Services, Harrow Council	×	×	×	×
Dr Pramod Mainie	Consultant Neonatologist London Northwest Healthcare Trust	✓	✓	✓	✓
Coral McGookin	Partnership Coordinator, Harrow Safeguarding Children Board	✓	✓	✓	×
Melanie Zubrugg	Named Nurse, London Northwest Healthcare Trust	×	×	×	×
Cheryl Pearce	Regional Development Officer The Lullaby Trust	✓	×	×	×
Lawrie Roach	Barnet Coroner Coroner's Office	×	×	×	×
DI Jason Dawson	Child Abuse Investigation Team (CAIT) Metropolitan Police	N/A	N/A	N/A	N/A

Poor attendance was highlighted at the Harrow Safeguarding Children Board and has now been resolved.

CDOP MEETINGS IN 2016

During the year 1st January 2016 - 31st December 2016, there were 4 CDOP meetings: in March, July, September and December. A total of 26 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 6 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 6 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 6 years, almost all had a rapid response meeting or visit.

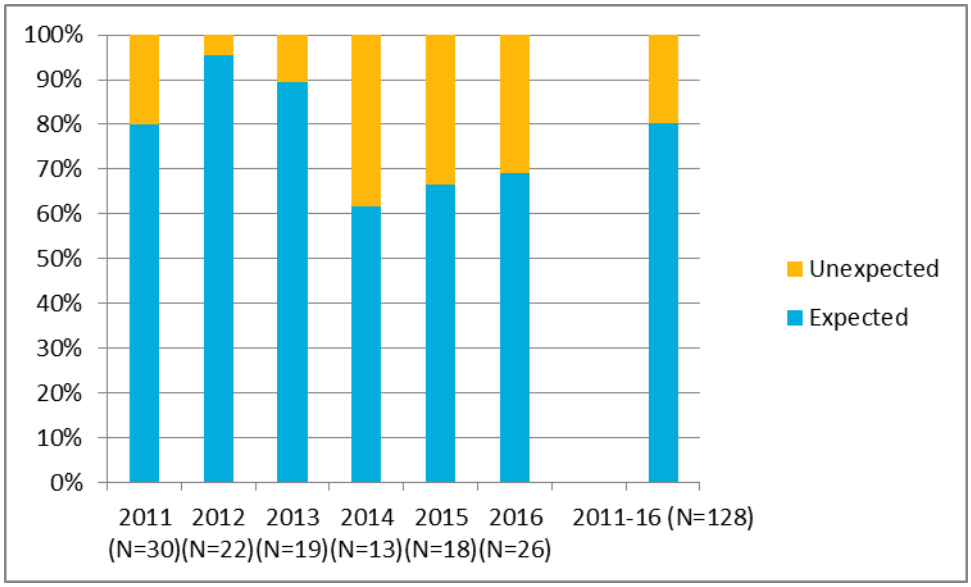


Figure 1 Harrow CDOP cases classified as Expected Vs unexpected deaths –2011-16

CHARACTERISTICS OF CASES

On average, between 2011 and 2016, a slightly higher proportion of deaths were seen in males than in females. In 2016, of the deaths reviewed by CDP over 70% were males.

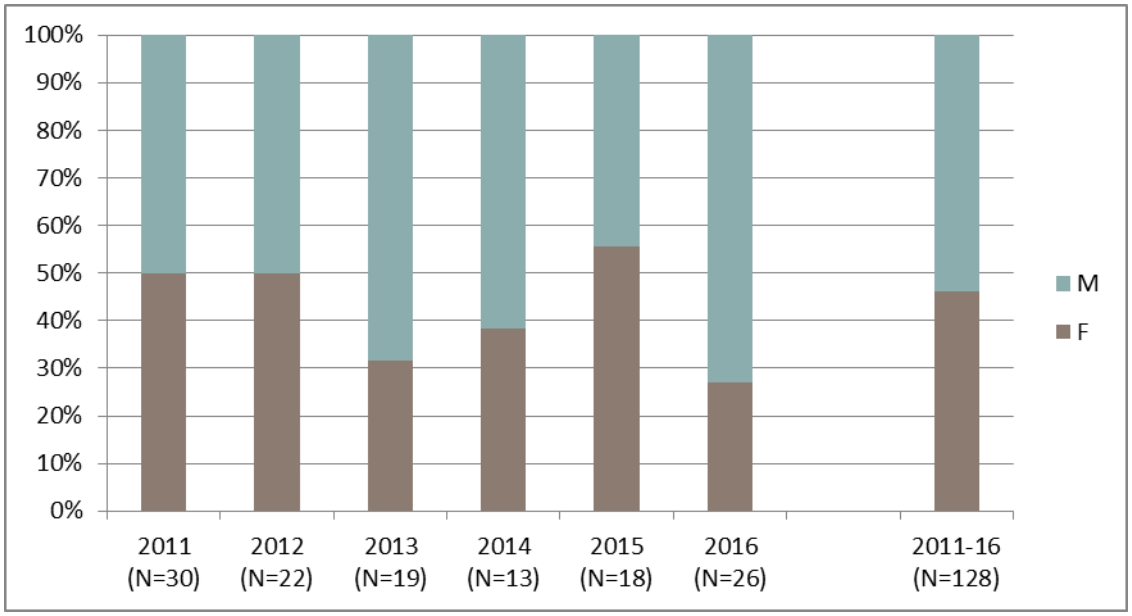


Figure 2 CDOP cases by gender 2011-16

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 or mother where father's details are not available. Due to small numbers the pattern of deaths varies by ethnic group. On average over the past six years, the number of deaths in children from BAME groups is slightly higher than might be expected given the makeup of the Harrow population.

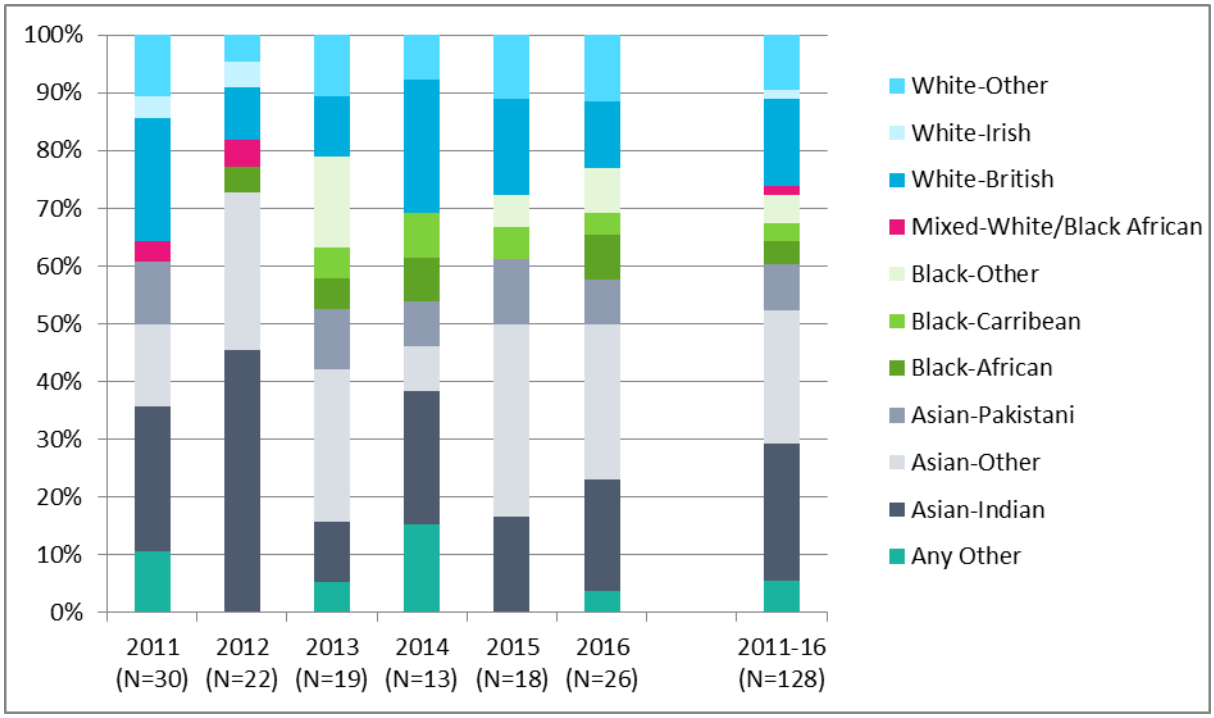


Figure 3 CDOP cases by ethnic group 2011-16

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

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). In common with that national data, both in 2016 and over the past five years, the most categories were that of perinatal/neonatal events and chromosomal, genetic and congenital abnormalities.

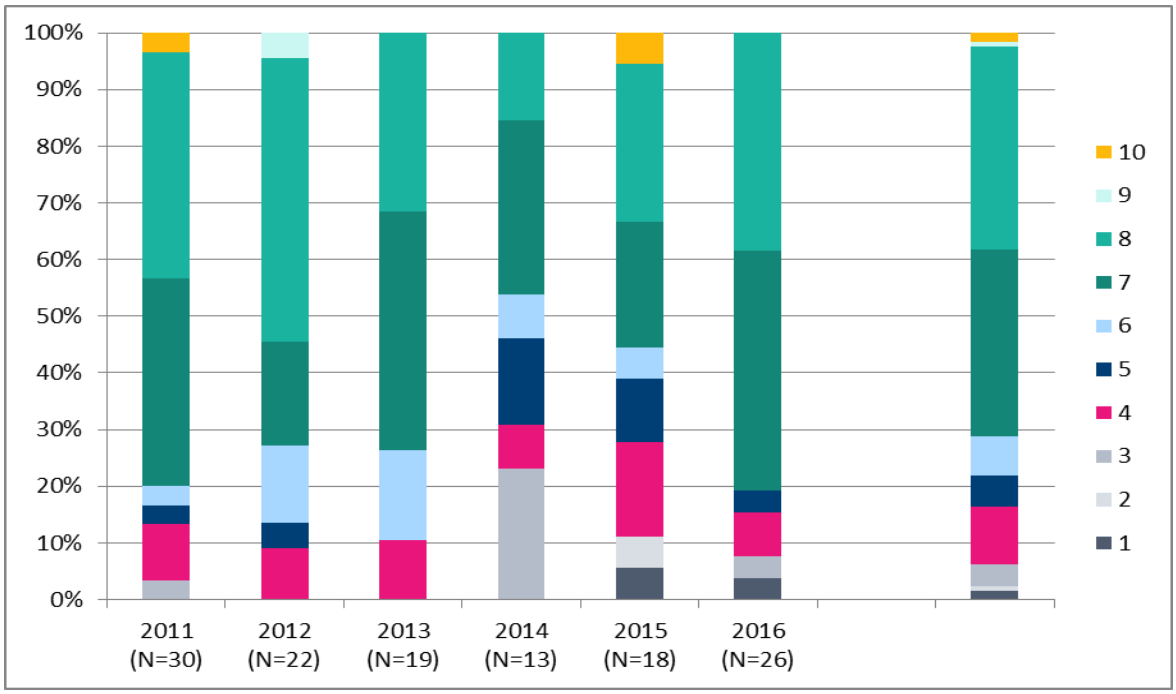


Figure 4 Harrow CDOP cases by Category 2011-16

CDOP CATEGORIES

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).

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 deaths with modifiable risk factors in the cases examined in 2016. Due to the small numbers of child deaths in Harrow, further information related to individual cases cannot be made available.

CONSANGUINITY

Consanguinity is noted on the forms received from clinicians within trusts and from GPs. The numbers of deaths where consanguinity is noted are very low, with fewer than 5 cases per year. Between 2011 and 2016, 10% of all child deaths were identified as being in consanguineous families. It should be noted that consanguinity was not noted as a modifiable factor in these child deaths.

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.

As a result of a death in 2015, the CDOP and LSCB have developed guidance for schools to support children with epilepsy. Training on the guidance has been delivered to the teachers in Harrow schools.

Training also took place as a result of lessons learned on a death from asthma

CDOP has continued to have a good relationship with the Lullaby Trust and training on safe sleeping and reducing the risk of cot deaths has been undertaken within the past year. More training sessions are planned in 2017.

Report prepared by

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June 2017