Barking and Dagenham Child Death Overview Panel (CDOP)

CDOP Annual Report 2018-19

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Barking & Dagenham Safeguarding Children Board

Contents of the CDOP Annual Report

Comments and Questions

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Barking & Dagenham Safeguarding Children Board

Message from the Barking & Dagenham CDOP Chair

Welcome to the 2018/19 Child Death Overview Panel (CDOP) Barking and Dagenham Annual Report. This is the final report of the Barking and Dagenham CDOP which has played an important role in understanding the reasons why children die in our borough, and in formulating recommendations to help to prevent future deaths.

Early 2018 the decision was made by the London boroughs of Barking & Dagenham, Havering and Redbridge Local Safeguarding Children's Boards to combine the three existing Child Death Overview Panel's (CDOPs) and child death review process into single arrangements in line with the requirements from "Working Together to Safeguard Children" (2018). This expanded the footprint of a single CDOP to cover around 60 deaths per annum, in order to improve processes to maximise efficiency, resource use and outcomes.

Plans have progressed rapidly since publication of the new guidance. A Child Death Review Implementation Steering Group has been established to ensure that Barking Havering and Redbridge Clinical Commissioning Groups (CCGs) and partner organisations fulfil all legislative requirements and expectations on individual services as there are a number of significant changes from responsibility shifting from the LSCBs to a joint partnership of local authorities and CCGs, named Child Death Review Partners (CDRP); the establishment of Barking, Havering and Redbridge geographical footprint for each CDRP; and changes to the review mechanism and family support functions.

These changes must be implemented by **29th September 2019** and each local CDRP must publish plans of how they intend to configure and resource themselves to meet these new requirements by **29th June 2019.**

In addition, the National Child Mortality Database (NCMD), a national programme which will collect and report on data of all child deaths across England will go live on **1st April 2019**. From this date, CDRPs, through their local Child Death Overview Panels (CDOPs), the multi-agency panel established by each CDRP to review the deaths of children normally resident in their area, must supply data to NCMD on all open and new cases; the Child Death Review partners have agreed the new model for the CDR process will go live on **1st April 2019** and require plans for the assurance required.

This report will provide information to our Local Safeguarding Children's Board to inform LSCB partners in respect of preventable child deaths and risk factors which impact on safeguarding children and young people. The LSCB will report on CDOP activity within the LSCB Annual Report to demonstrate on how we have made a difference to the lives of children and young people. The CDOP Annual Report is a powerful resource for driving public health action and promoting child safety and well-being.

Finally, as ever, I wish to thank my colleagues in the CDOP, whose hard work all year round makes it possible for the CDOP to fulfil its function.

Matthew Cole
Director Public Health and Chair CDOP Panel

Context and Legislation 2018

The Child Death Overview Panel (CDOP) is the multi agency Panel that meets quarterly to review all deaths of children normally resident in Barking and Dagenham.

The purpose of the review is to determine whether the death was deemed preventable, that is one in which there are no identified modifiable factors which 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. If this is the case the Panel must decide what, if any, actions could be taken to prevent such deaths in future

Following ratification of the Children & Social Work Act 2017 and the release of Working Together 2018, plans were put in place to makes changes to the CDOP process with effect from 1st April 2019.

Legislation sets out the Child Death Review (CDR) Partners as the local authority and any clinical commissioning groups for the local area.

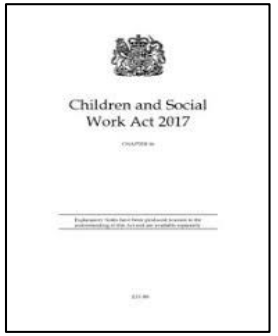
CDR partners are also required to set out their formal arrangements for child deaths. This plan should be in place and published by June 2019, with full implementation by September 2019.

During this period of transition however, existing processes continued to be followed.

CDR partners are responsible to:

- Review all child deaths under 18 years, regardless of cause of death
- Establish a structure and process to review cases
- Consider core representation of Panel
- Agree funding structures
- Review geographical footprint (80-120 cases per annum)
- Appoint Designated Doctor and necessary resource

Legislation and Guidance 2018



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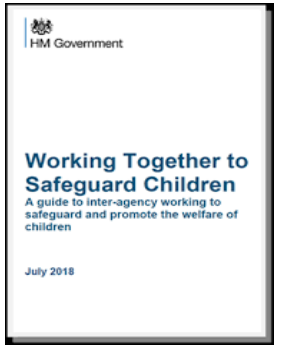
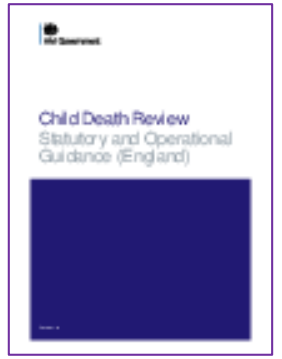


http://www.workingtogetheronline.co.uk/



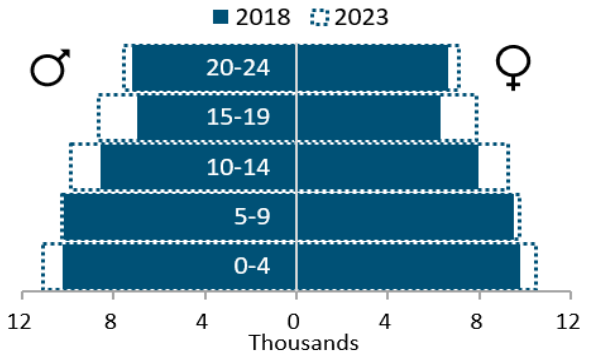
https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

Demographics

Population size

A large and growing young population

- Highest proportion of 0–17s in UK
- Highest birth rate in England and Wales
- +6,900 0–17s in next 5 years (+11%)
- +2,100 18–25s in next 5 years (+10%)



Population, 2018–2023

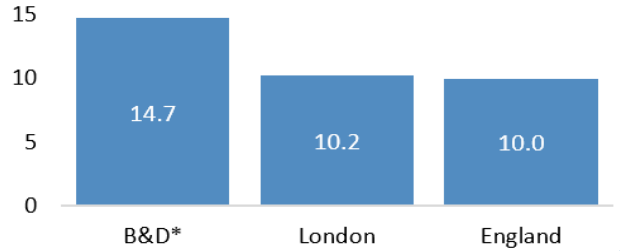
Age	2018	2023	% change
0–4	20,000	21,600	+8%
5–9	19,700	20,000	+2%
10–14	16,500	19,200	+16%
15–19	13,300	16,600	+25%
20–24	13,800	14,600	+6%
All ages	*211,700*	*232,200*	*+10%*

Deprivation

High levels of deprivation

- 11th highest in England and 4th in London for income deprivation affecting children
- 15% of dependent children live in workless households (10% in London)
- 16% of secondary school pupils claim free school meals, similar to London

% dependent children living in workless households



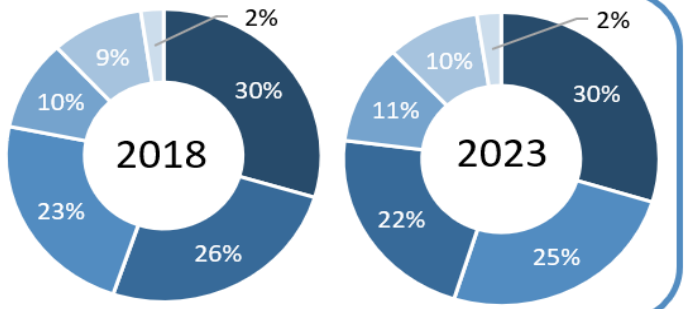
Ethnicity & language

A diverse population

- 74% of 0–17s are from ethnic minorities compared with 64% in Barking and Dagenham as a whole
- 56% of primary school pupils do not have English as their first language, higher than London (49%)

Ethnicity, 0–17

- Black
- White British
- Asian
- White Other
- Mixed
- Other



**Estimate is potentially unreliable due to sample size*

CDOP Membership and Governance

Barking & Dagenham CDOP is a multi-agency partnership and is made up of senior representatives from fields of expertise within Public Health, Paediatrics and Child Health, Children's Social Care, Child investigations, Nursing and General Practice.

The Panel is also supported by a CDOP Co-Ordinator.

All work together to ensure each child death is reviewed fully to ensure that agencies worked in a co-ordinated way and supported the family effectively.

Membership:

- Director of Public Health – Chair of CDOP Panel
- Designated Paediatrician - Chair of Rapid Response Meetings
- Operational Director, Children's Care and Support
- Designated Nurse Safeguarding, BD Clinical Commissioning Group (BDCCG)
- Consultant Paediatrician and Named Doctor BHRUT
- Detective Inspector, East Area BCU Police
- Named GP for Safeguarding CCG
- Named Midwife, BHRUT
- Safeguarding Paediatric Liaison Nurse BHRUT
- Additional members as required

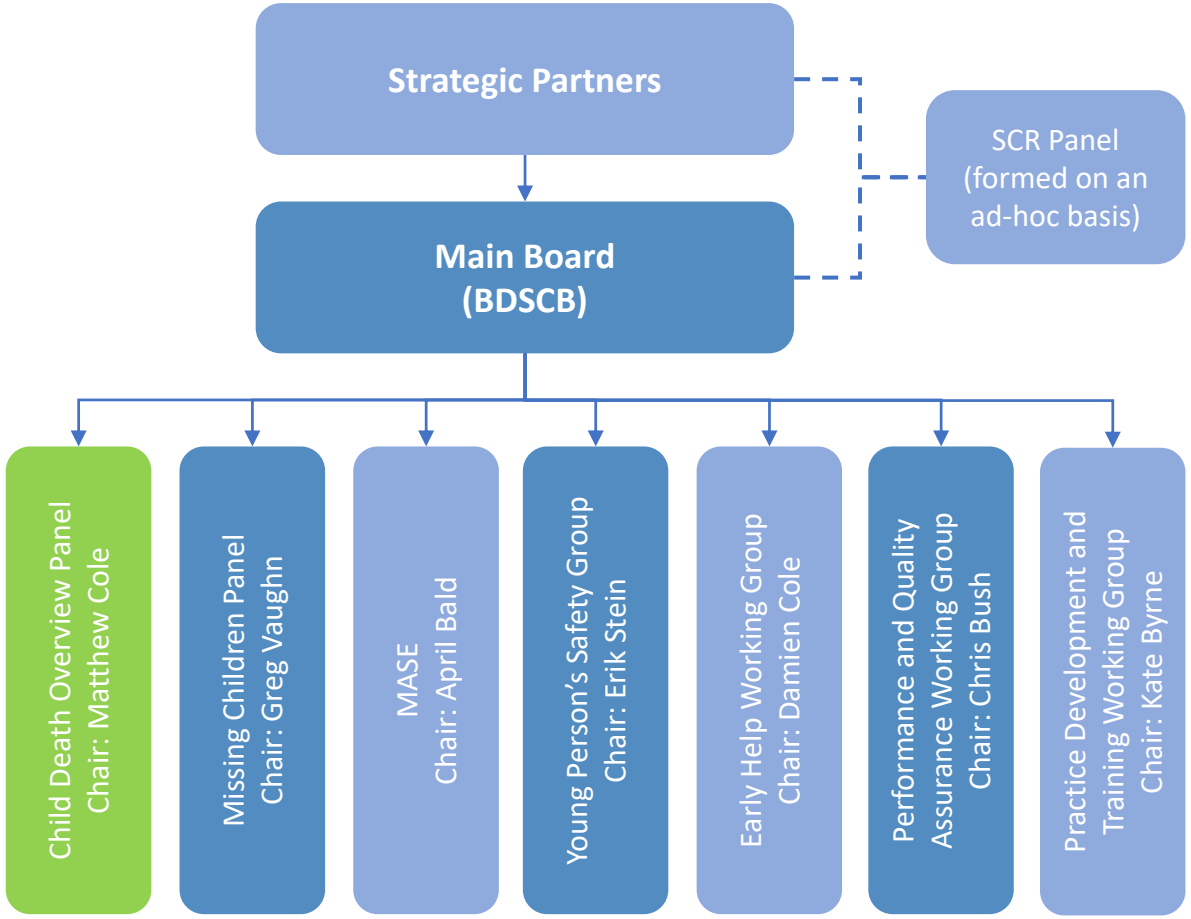
The CDOP Panel reports directly to the Barking and Dagenham Safeguarding Children Board (BDSCB). The BDSCB has three tiers of activity:

Strategic Partners: is made up of representatives from the three key statutory agencies and has strategic oversight of all Board activity. Strategic Partners takes the lead on developing and driving the implementation of the partnership's work.

Main Board: this is made up of representatives of the partner agencies as set out in WT15. Board members must be sufficiently senior to ensure they are able to speak confidently and have the authority to sign up to agreements on behalf of their agency.

Working Groups: these groups work on the board's priority areas on a more targeted and thematic basis. They report to the Main Board.

BDSCB Governance Architecture



More information can be sourced from BDSCB website https://bdsafeguarding.org/

Child Death Overview Panel (CDOP) Summary

The Child Death Overview Panel (CDOP) met on four occasions during 2018-19, to review all deaths of children normally resident in Barking and Dagenham.

The purpose of the review is to determine whether the death was deemed preventable, that is one in which there are identified modifiable factors which 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. If this is the case the Panel must decide what, if any, actions could be taken to prevent such deaths in future.

Number of Child Deaths in Barking and Dagenham

- Between April 2018 and March 2019 the CDOP was notified of 17 deaths of children who were resident in Barking and Dagenham which is a decrease in the number of deaths since last year.
- Over the course of the 4 CDOP meetings, the Panel discussed 16 Cases. 75% (12) cases were closed, with the remaining 4 cases open, awaiting further information.
- Of these closed cases, one (1) case was from the period April 2016-March 2017, 7 cases were from April 2017-March 2018 and 4 cases were from the period April 2018-March 2019. 15 cases remain open to CDOP at the end of March 2019, five (5) are from 2017-2018 with the remaining received within this reporting period.
- Child deaths within the Black African and White ethnic groups equal the highest cohort recorded, with 2 deaths within each ethnic grouping . Not known/Not stated continues to remain high with 4 cases. Of the closed cases in 2018-19, 4 deaths reviewed (33%) were female, with remaining cases (67%) being male. This is a trend seen over previous year reporting.

Preventability/modifiable factors

CDOP identified one (1) case (8%) with modifiable factors during 2018/19 relating to an unexpected death. The Panel agreed that this death could have been prevented, had early diagnosis of Meningitis been made. A Serious Incident investigation was carried out by the Health Provider and lessons have been shared.

Key priorities and challenges for 2019-20

1. Following publication of Child Death Review (CDR) guidance in 2018, work is underway to revise the existing footprint of CDOP, along with revising a pathway for reviewing child deaths. This is being led by CDR partners: Local Authority and Clinical Commissioning Group(s). An implementation plan should be in place by June 2019, with full implementation by September 2019.
2. Following evaluation of the QES eCDOP case management system, funding need to be secured in order to continue with an electronic system.
3. Continuation of engagement with partners, especially GP and Coronial Services is needed, to ensure information is shared in a timely way, in order to aid reviews.

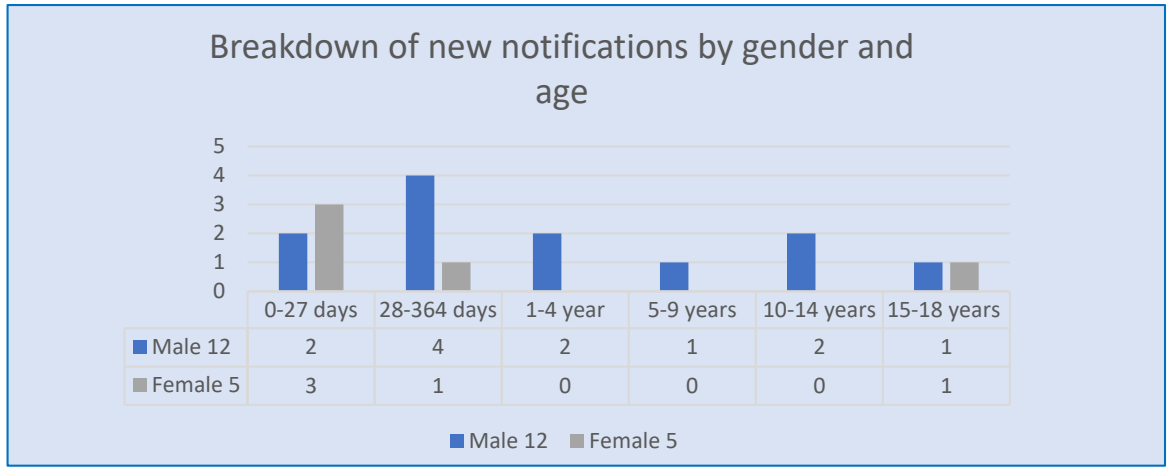
Child Deaths 2018/19:

New Notifications 2018-19:

During 2018-19, Barking and Dagenham CDOP were notified of 17 child deaths. This is a reduction of seven cases on the previous year, and the lowest number of notifications received for a number of years.

There is no clear analysis as to why this is the case, however it is hoped that National awareness raising campaigns such as Safe sleeping, Button Batteries and blind cord safety, along with local learnings and revised pathways within agencies, contribute to assisting a decrease.

Following the full implementation of the Child Death Review Guidance, Barking & Dagenham, Havering and Redbridge CDOPs will merge. This increase in collated information will assist with assessing trends and themes.



In 2017-18, notifications in respect of male children were recorded as higher than female and this trend continued in 2018-19. Unexpected deaths were also the highest in the male cohort at 41% (7) of the total number of new notifications.

The highest number of new notifications was received for the age range under 1 year age group, representing 59% of the overall notifications. This follows the same trend as previous years.

Rapid response meetings were held in respect of all unexpected deaths, within timescale. The breakdown of rapid response meetings per quarter follows:

Quarter 2018-19	Number of Rapid Response	Male	Female
Q2	3	3	0
Q3	4	4	0
Q4	2	0	2

One of the unexpected deaths within 28-364 days age bracket reported in 2018-19, is now subject to a Serious Case Review, following recommendation for consideration from CDOP to the Safeguarding Children Board. One other case, referring to a child within the 15-18 year age bracket, is subject to a Local Practice Learning Review.

All Rapid Response meetings were chaired by the Designated Doctor for CDOP. From October 2018, there was a change in Designated Doctor, from Dr Elhassan Magid to Dr Kanthin Jayawardana.

Dr Jayawardana continues to chair rapid response meetings until the CDR transition is complete.

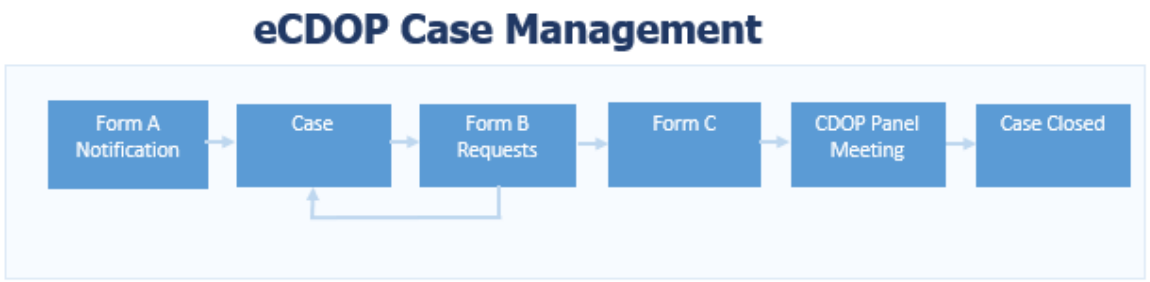
Child Deaths 2018/19:

Case Management system - eCDOP:

Implementation of a new case management system, eCDOP started 1 April 2018. Previously the CDOP process was administered via a paper based and Excel database system.

The eCDOP system, hosted by QES, has streamlined the secure transfer of information from practitioners, and wider sharing with CDOP Panel members.

The eCDOP system will also link with the National Child Mortality Database (NCMD), which is due to go live on 1st April 2019. This will assist the seamless 'real time' data transfer of information to the NCMD, to allow for wider analysis across a bigger CDOP area, and identify any thematic issues for wider learning across the network.



NHS England Public Health commissioning team agreed funding for all 32 London Boroughs in 2018-19 to implement eCDOP, with continued funding agreed for 2019-20.

Funding for eCDOP during 2020 and beyond is subject to individual CDR partners funding streams but it is hoped that this will continue.

Membership:

The full CDOP Panel membership is set out within **page 6**.

The CDOP panels are administered by the Director of Public Health PA support. The CDOP Co-Ordinator attends each meeting to provide an overview of outstanding cases and highlight any pending issues.

During Q4 2018-19 membership was extended to the Integrated Care Director (ICD), NELFT. It is envisaged that the ICD will continue as a member of the Panel in 2019-2020.

With CDOP Panels moving into a transitional period, membership may change, however the Local Authority and Clinical Commissioning Group will lead on this as statutory Child Death Review (CDR) Partners.

Child Deaths 2018/19: Breakdown of closed cases

Closed cases:

In 2018-19 the CDOP Panel met on four occasions. During this time 12 Form C's were analysed and cases closed by the Panel. These cases reviewed originated from: 2016-17 (1), 2017-18 (7) and 2018-19 (4).

The number of cases closed by Panel in 18/19 were reduced from previous years. This was attributed to work underway in 2016/17 and 17/18 to close outstanding historic cases which accounted for the increased numbers discussed at Panel, coupled with a reduced number of new notifications being received.

	2018-19	2017-18	2016-17
Cases Closed by Panel	12	24	24
New Notifications received	17	24	21

During 2017-18, there was an increase in the ratio of deaths of males aged 0-18, compared to females. This trend continues in 2018-19: Male (9) 75 % Female (3) 25%.

A more detailed breakdown of these closed cases follows.

Categorisation of deaths:

In order to fully review cases, each should be attributed against 10 categorisations in accordance with statutory guidance. These are:

Category and Definition	Category and Definition
CAT 1 Deliberately inflicted injury, abuse or neglect	CAT 6 Chronic medical condition
CAT 2 Suicide or deliberate self-inflicted harm	CAT 7 Chromosomal, genetic and congenital anomalies
CAT 3 Trauma and other external factors	CAT 8 Perinatal/Neonatal event
CAT 4 Malignancy	CAT 9 Infection
CAT 5 Acute medical or surgical condition	CAT 10 Sudden unexpected, unexplained death

The cases reviewed and closed during 2018-19, were catergorised as follows:

Categorisation of death	% age (number of cases)
Category 5	7% (1)
Category 7	17% (2)
Category 8	42% (5)
Category 9	17% (2)
Category 10	17% (2)

The Categorisation of Perinatal/Neonatal events continues to have the largest number of deaths attributed within it. This mirrors previous CDOP reporting:

Year	% age of overall cases reviewed
2018-19	42% (5)
2017-18	40% (10)
2016-17	50% (8)

No additional analysis can be attributed to this data at present, however this should improve with the introduction of wider CDOP footprints, post September 2019, with increased numbers of cases being reviewed.

No cases reviewed within 2018-19 were previously known to Social Care, or had any statutory orders in place at time of death.

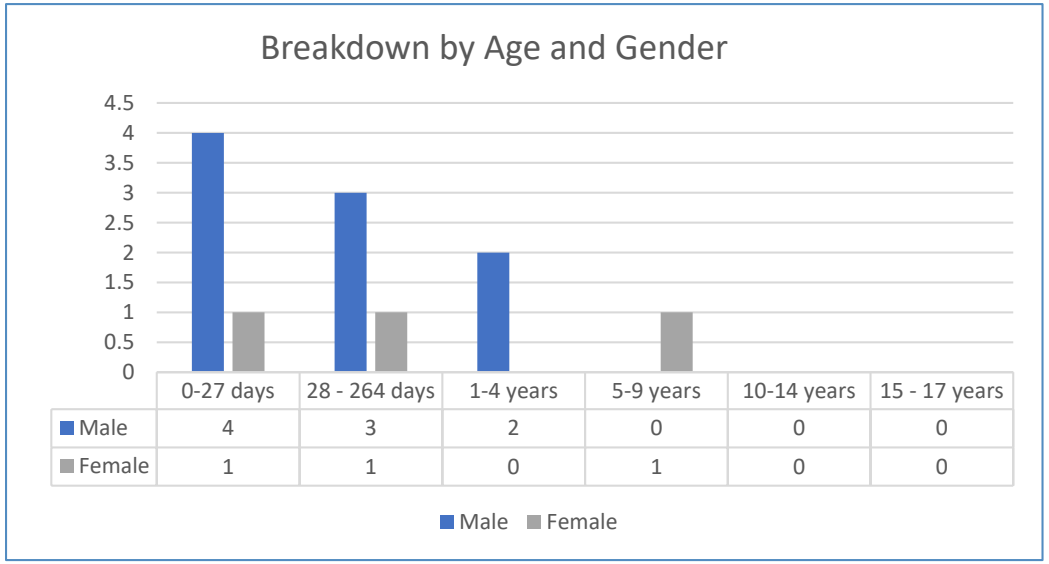
Child Deaths 2018/19: Breakdown of closed cases continued

Of the 12 cases closed, 75% (9) were completed within 12 months from point of notification, with 25% (3) completed in excess of 1 year.

Delays to closing cases can be attributed to length of time in obtaining Post Mortem reports, or other parallel process being in place i.e. Serious Case Review, Serious Incidents, or Criminal investigations.

Breakdown by Age and Gender

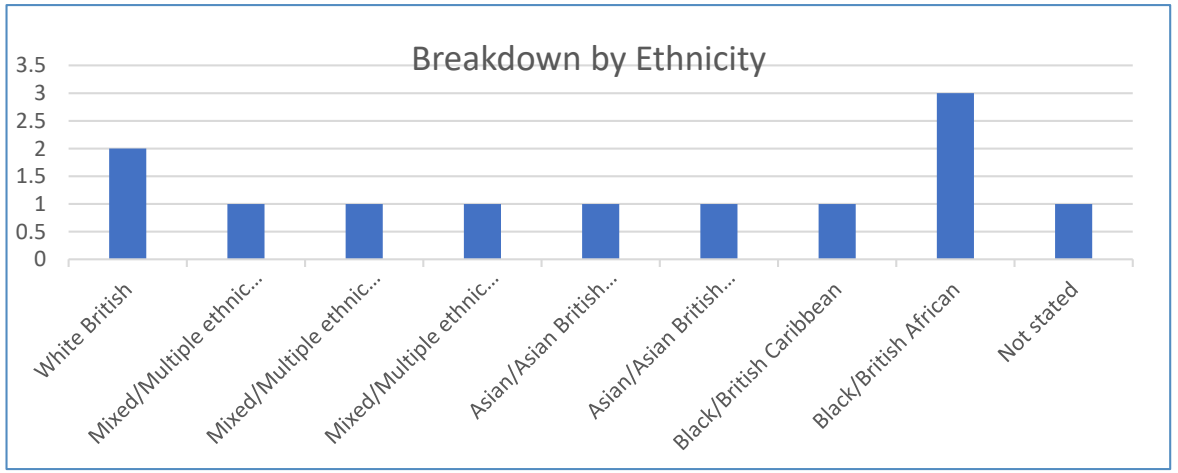
Age categories are reported within six age bands. The breakdown of cases reviewed is shown below:



	0-27 days	28 - 264 days	1-4 years	5-9 years	10-14 years	15 - 17 years
Male	4	3	2	0	0	0
Female	1	1	0	1	0	0

100% of cases reviewed in 2018-19 related to children aged 9 years and under. Children aged under 1 year remains the highest cohort of cases reviewed, at 83%. This trend mirrors previous years within LBBD.

Ethnicity:



75% of child deaths came from an ethnic minority background. Children from a Black/British African background remain the highest cohort for all notifications received at 25%, which mirrors previous years.

Locally, 64% of Barking and Dagenham residents come from a minority ethnic background, with 74% being from 0-17 year cohort.

White British was second highest ethnicity recorded at 17%, which follows the same trend for the previous year. Equal split across all other recorded ethnicities, :

Ethnicity	17/18	18/19
Black African (Highest cohort)	12	3
White British (second highest cohort)	4	2

Continuation:

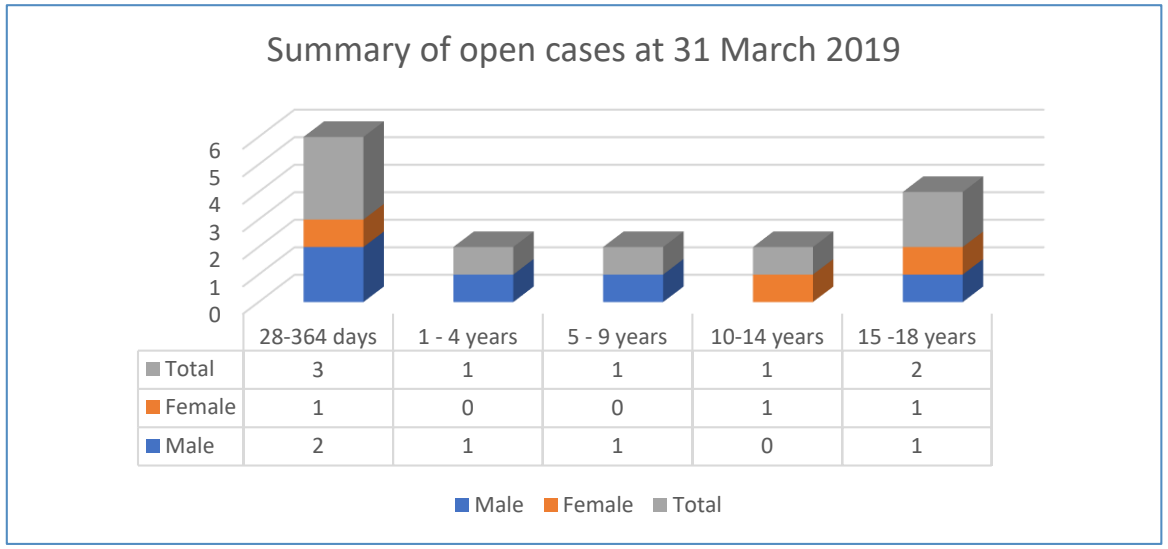
Increased recording of ethnicity continues to be an area for improvement. Some notifications are still being received with limited information recorded.

In 2018-19 only one case was recorded as Not stated/Not known. This was an decrease from last year's recording of two cases.

Open cases

At the end March 2019, there were 8 outstanding cases to carry forward into 2019-2020 financial year. Information from the Coroner (Post Mortem reports), Serious Incidents reports (Providers) and Reporting forms from Partners were awaited on these cases. Once all information is collated, these will be presented to the CDOP Panel for closure.

A breakdown of these outstanding cases are detailed for information:



	28-364 days	1 - 4 years	5 - 9 years	10-14 years	15 -18 years
Total	3	1	1	1	2
Female	1	0	0	1	1
Male	2	1	1	0	1

Within the new structure, from 1st April 2019, all new notifications will be, once ready for closure, be presented to the joint CDOP in Common on behalf of Barking & Dagenham Havering and Redbridge, hosted by and chaired by CCG.

Learning Lessons:

Modifiable (preventable) factors:

As part of the robust reviewing of cases, CDOP are required to consider whether there are any modifiable factors that could have contributed to the death of the child, thus reducing risks further in the future.

Of the 12 closed cases, only one case (8%) was identified as having modifiable factors.

This child was not known to statutory services. The child had a 2 week history of a throat infection, and presented with neck pain, dizziness, headache and inability to bear weight. Conscious levels and observations deteriorated and then this child sadly passed away. The case was reviewed by BHRUT as part of the wider Serious Incident (SI) process, highlighting six key learning points for the Trust to implement. The CDOP Panel had oversight of the full report and action plan.

With the implementation of the new Child Death Review Statutory and Operational Guidance there has been a move towards preventability and preventable factors, so the term modifiable will no longer be reported going forward.

New Reporting Form Bs and Cs have been issued for use with revised terminology. Updated templates within eCDOP will change with effect from 1 April 2019.

Child Deaths 2019-20:

Regulation 28:

The Coroners and Justice Act 2009 allows a coroner to issue a Regulation 28 Report to an individual, organisations, local authorities or government departments and their agencies where the coroner believes that action should be taken to prevent further deaths. Regulation 28 notifications continue to be shared with CDOP, by our presiding Coroner, in order to share wider learning.

Two Regulation 28 notification was issued during this reporting period. One for the BHR reporting area.

Case summary:

A child aged 10 year, who had suffered with Asthma since 9 months of age. Numerous attendances for asthma attacks throughout the child's life. Every presentation by primary and secondary care, treated the symptoms of the immediate presenting and acute attack. The Coroner reported that "There was no appreciation that these episodes were signs of underlying poorly controlled severe chronic asthma".

The child sadly passed away in December 2017, following another attack.

The Coroner raised her concerns with this regulation 28, identifying clear actions for implementation and the Health provider was given 56 days in which to respond.

Following conclusion, a BHR footprint training event was held in order to share the learning from this case. This learning is also scheduled to be reported to the Safeguarding Children Board in Barking and Dagenham in 2019-2020.

Networking:

Coronial Service:

Close operational links with the Coroner and her office continued into 2018-19, with the North East London CDOP Managers and Designated Doctors meeting with the Coroner on a bi-yearly basis to discuss any arising issues or concerns.

Working Together 2018 states 'Coroner's have a duty to notify the child death review partners for the area in which the child died or where the child's body was found within three working days of deciding to investigate a death or commission a post-mortem'. This area of communication continues to be a challenge.

National and Local Networks:

The wider sharing of lessons learned continues to be an important part of the reviewing process. Networks with other CDOPs and National bodies continued to be strengthened in this year, assisting this process.

Social Media continues to be an effective way to share safeguarding messages with professionals and the wider public.

The National Network for CDOPs (NNCDOP) held their annual conference in Birmingham, which was well attended across the partnership. The main focus of this conference was to understand the changes to the Child Death Review process which take effect from 1 April 2019.

Next steps

Restructuring plans are due for publication by 29th June 2019, with full implementation by September 2019. Responsibility for CDOP will transfer to CDR Partners: Local Authority and Clinical Commissioning Groups (CCG).

All plans will be published on the CCG website, along with the individual LSCB websites within each borough.

There is an expectation that eCDOP Case Management system will continue.