HEALTH AND WELLBEING BOARD

29 JULY 2014

Title: Barking and Dagenham Child Death Overview Panel Annual Report 2013/14	
Report of the Director of Public Health	
Open Report	**For Information**
Wards Affected: All	**Key Decision: No**
Report Author: Matthew Cole Director of Public Health / Chair Child Death Overview Panel Roselyn Blackman CDOP Co-ordinator	**Contact Details:** Tel: 020 8227 3657 E-mail: matthew.cole@lbbd.gov.uk Tel: 0208 227 2826 Email: roselyn.blackman@lbbd.gov.uk

Sponsor:

Matthew Cole, Director of Public Health

Summary:

The aim of the Child Death Overview Panel Annual Report is to inform the Local Safeguarding Children Board (LSCB) and the Health and Wellbeing Board of child death patterns. Through a comprehensive and multi agency review of child deaths, the Child Death Overview Panel (CDOP) aims to understand how and why children die in Barking and Dagenham and use the findings to take action to reduce the risks of future child deaths and to improve the health and safety of the children in the area.

The Report provides a breakdown of child deaths notified to CDOP, child deaths reviewed and recommendations made during 2013/14.

Recommendation

The Health and Wellbeing Board is asked to note the recommendations made by CDOP as well as those arising from other investigative processes.

Reason(s)

There is a requirement to present an annual CDOP report to the LSCB which recommends its findings to the Health and Wellbeing Board as part of the process of influencing health and social care commissioning priorities. Under Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, set out the function of the Local Safeguarding Children Board (LSCB) in relation to child deaths, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

a) collecting and analysing information about each death with a view to identifying:

- any case giving rise to the need for a review mentioned in regulation 5(1)(e);

- any matters of concern affecting the safety and welfare of children in the area of the authority;
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

b) establishing procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Barking and Dagenham CDOP is asked to categorise the likely cause of death, record the event that caused the death and any modifiable factors.

1. Background and introduction

1.1 The Child Death Overview Panel (CDOP) is a Committee of the Barking & Dagenham Local Safeguarding Children Board (LSCB) with the responsibility of reviewing all child deaths between 0-18 years. This statutory duty is intended to ensure that factors contributing to the death that may have been modifiable are identified. The CDOP is required to look at trends and patterns and makes recommendations to reduce the risks of future child deaths, to the LSCB, Department for Education through an annual return and relevant agencies.

1.2 This paper is an executive summary of the annual report and readers are advised to read the whole report which can be accessed via the following link http://www.bardag-lscb.co.uk/Pages/CDOP.aspx.

2. Summary of CDOP activity

2.1 Deaths that have been notified to the Barking and Dagenham CDOP are not all reviewed and closed during the same year of notification. The Department of Education recognise it may take a number of months (or years in some cases) to gather sufficient information to be able to fully review a child's death. This can be due to criminal proceedings, autopsies, coroners' reports, serious incidents (SIs) and serious case reviews (SCRs). Barking and Dagenham CDOP will await the conclusion of these investigations before a review is undertaken. In 2013-14, 18 out of 27 child deaths have been reviewed by CDOP due to the points raised above. The activity undertaken by CDOP is summarised in the table below:

Summary of Child Death Review Process activities 2013-14	
Number of child deaths notified to CDOP	27
Of the deaths notified to CDOP, the number of rapid response meetings	10
Number of LSCB CDOP meetings	6
The number of child death reviews completed by BDCDOP	18
Of the deaths where the review was completed, the number the panel assess and identifying **Modifiable Factors**	5
Of the deaths where the review was completed, the number the panel assess and identifying **No Modifiable Factors**	13
Of the deaths where the review was completed, the number the panel assess and identifying **Insufficient information**	0
Of the deaths where the review was completed the number identified as unexpected	8
Of the deaths where the review was completed the number identified as expected	10

3. Child Death Reviews

3.1 In 2013-14, the CDOP spent considerable time reviewing its governance and practice against Chapter 5 Child Death Reviews in the Working Together to Safeguard Children 2013 https://www.gov.uk/government/publications/working-together-to-safeguard-children. This was required as preparation for the anticipated Ofsted inspection which took place 29 April to 22 May. The following key points should be noted:

- Concern has been expressed on how the outcomes and learning identified through the child death reviews is then incorporated into frontline practice. In order to close the quality loop, the CDOP will now share learnings with the Learning and Improvement Committee of the LSCB. The recommendations presented in the CDOP's monitoring reports to the LSCB will now be monitored through the Performance and Quality Assurance committee, providing both assurance to CDOP Chair and the independent Chair of the LSCB.
- CDOP training was delivered to Child Protection Education Leads to reduce the time delay of late notifications from schools.
- A briefing was developed and circulated to all GPs surgeries and frontline staff in response to a non receipt of child death notification.
- London Ambulance Service (LAS) are one of the first professionals on the scene and the professional confirming the fact of death; however they are not required by their procedures to notify CDOP of a child death. Work was commenced with the LAS to incorporate the CDOP notification process within their national procedures.
- Serious Incident alerts are now received by the Single Point of Contact in a timely manner
- A consent form was devised so that full Post Mortems can be included in the CDOP review. The form was shared with Havering and Redbridge CDOPs to promote consistency in local working.
- National CDOP responses are inconsistent to babies born prior to 24 weeks gestation. Barking and Dagenham CDOP agreed that all live births will be reviewed by CDOP regardless of weight or gestation. This criterion was shared with Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), Havering and Redbridge CDOPs to promote consistency in local working.

4. Summary from the cases reviewed

4.1 The highest number of deaths notified to CDOP are within the neonatal age (0-27 days) and children under 1 year of age. Some CDOPs are responding to this national trend by having specialist neonatal meetings where neonatologists and obstetricians are in attendance. Scheduled in the 2014-15 priorities will be how BD CDOP will respond to this trend.

4.2 The rate of childhood mortality in Black African and Caribbean children has been higher than the rate in other ethnic groups over the past six year period from 2008/09. The Director of Public Health did not find a statistical significant difference in the rates. This means that currently there is no evidence of a true difference in rates. Because childhood deaths are a rare event the confidence intervals are wide and it can be difficult to detect true differences in death rates where they do exist. Pooling data from several boroughs would increase the power to detect differences. As a result, further analysis will be made through examining the deaths across the boroughs of north east London. This work will be conducted in 2014-15.

4.3 Barking and Dagenham contributed to 48% of all Sudden Unexpected Death in Infants (SUDI)s in London since 2005. In the east region, 61% of SUDIs occur in Barking and

Dagenham, Hackney and Newham combined. As these deaths are very few, ranging from 1-4 deaths per year, the specific questions are a challenge as the answers can only be drawn out from individual child death reviews. Apart from those cases where there is an underlying clinical condition the only other modifiable associations are with parental smoking and sleep position. The Director of Public Health has this under review as a CDOP priority.

4.4 Since 2009- 2014, the child deaths where modifiable factors were identified have varied but collectively account for 32%. This shows the majority (68%) of child deaths, during the past five years, did not include modifiable factors.

4.5 Where death is confirmed by the London Ambulance Service (LAS), notifications are delayed. Working Together recommends that the professional confirming the death should inform the Designated Paediatrician for Unexpected Child Deaths at the same time as informing the coroner and police. This recommendation is not included in the Pan London LAS Procedures. Work is continuing to incorporate this to speed up the process of child death reviews.

4.6 The number of deaths that occur abroad is very small however the issues identified are important to note.

- CDOP is unable to determine a cause of death as this is not always recorded on the death certificate
- There is no coroner involvement if the body is not returned to the UK
- Metropolitan Police have no jurisdiction to investigate these deaths occurring abroad.
- Information sharing between countries is inconsistent
- The review is not thorough as CDOP is unable to obtain all the necessary information

5. Learning and recommendations:

Appendix 1 outlines the modifiable factors and recommendations made following the child death reviews in 2013-14. The following sub-sections below summarises the recommendations from the review of cases by organisation. As previously mentioned, these recommendations will be monitored through the Performance and Quality Assurance committee, providing both assurance to CDOP Chair and the independent Chair of the LSCB that they have been enacted.

5.1 London Ambulance Service (LAS)
LAS to ensure crews have checked their equipment and have different sized masks within its paediatric bag valve mask pack - a neonatal mask, an infant mask and a child mask.

5.2 Barking, Havering, Redbridge University Hospitals NHS Trust (BHRUT)
Calls and triage notes into the labour ward at Queens will be reviewed to ensure documentation of appropriate advice is relayed to LAS and families. Training was carried out by BHRUT Safeguarding of the Maternity Midwifes with regards to late child death notifications.

5.3 North East London NHS Foundation Trust (NELFT)
Associated factors relating to co-sleeping, alcohol consumption and placing the baby

face down to sleep (against national recommendation) were identified in the SUDIs reviewed.

5.4 General Practitioners
Changes in NHS from 2013 have presented challenges in performance management of general practitioners' responses to CDOP learning and contributions, as well as how learning is incorporated into general practice. CDOP recommends that there is an NHS England representative on CDOP.

5.5 Barts Health NHS Trust (Newham)
Newham University Hospital to review local guidance for responding to LAS calls for assistance. Local flowchart to record all LAS calls and support clear communication and decision making.

5.6 Response times to actions and recommendations
CDOP agreed the maximum response time to an action is between 1-6 months and should be in response to the need of the individual action. CDOP Recommendations will be reviewed 6 months after the case is closed. This review will be included in the 6 monthly report to LSCB.

5.7 CDOP
All CDOP minutes are to be succinct with actions clearly assigned. When action is complete, this is to be recorded in the minutes and removed from the action log.

5.8 Tri-borough Learning
Barking and Dagenham, Havering and Redbridge are working together to share learning and improvement at Manager and Panel levels.

6. Priorities for 2014-15:

In addition to the recommendations outlined above, the following priorities were agreed by the Panel for the coming year:

- Raise the profile of CDOP by attending the LSCB Conference.
- Devise and carry out CDOP Training to professionals.
- Lead on the CDOP Tri Borough Development/Study Day. This event is intended to share learning and promote joint working with BHRUT, Havering and Redbridge CDOPs to develop the effectiveness of CDOP.
- As some deaths bypass the usual A&E route and are taken directly to the mortuary, CDOP will liaise with BHRUT Mortuary so they are included in the CDOP Notification process to reduce the risk of non receipt of notification.
- Continue to work with the 7 borough CDOP for statistical analysis of neonatal, infant and child mortality rates.
- Revise national forms in response to local need.

7. Mandatory implications

7.1 Joint Strategic Needs Assessment (JSNA)

The JSNA has a section dedicated to the analysis of child deaths. The annual CDOP report is used to update this section of the JSNA annually.

7.2 Health and Wellbeing Strategy

The review of child deaths is an integral part of the safeguarding elements in our Health and Wellbeing Strategy. At this point there is no need to change the focus of the Health and Wellbeing Strategy as a result of this annual report.

7.3 Integration

The review of child deaths and the work of the Barking and Dagenham Local Safeguarding Board for Children is multiagency and integrated in its approach.

7.4 Financial implications

There are no financial implications to this report and it is assumed that all CDOP training will be conducted by the CDOP Manger and not commissioned externally.

Implications completed by: Patricia Harvey Interim Group Manager Children's Finance

7.5 Legal implications

There are no specific legal implications arising out of the recommendations in this report. The statutory provisions relating to the child death review processes have been set out in the body of this report. Legal services will continue to support the service delivery to achieve the improvements identified. In addition appropriate advice will be given on any changes to governance arrangements to ensure responsibilities are clearly defined and information exchanged to support the continued delivery of these improvements.

Panel is invited to note that child deaths and the review process can lead to interest from the media and other parties, such as the local community. Panel should be aware of the management of requests for information, from whatever source. Legal services shall support the appropriate marketing and communications team in managing such requests.

Implications completed by: Chris Pickering, Principal Solicitor - Litigation & Employment, Legal and Democratic Services

7.6 Risk management

The work of the CDOP links very closely into the Francis Report recommendations in respect of safeguarding and quality of care. The comprehensive and multi agency review of child deaths aims to understand how and why children die in Barking and Dagenham and use the findings to take action to reduce the risks of future child deaths and to improve the health and safety of the children in the area.

8 Appendices

Appendix 1 – Modifiable Factors / Recommendations to child death reviews 2013-14