3-borough

Child Death Overview Panel Annual Report

Westminster,

Hammersmith and Fulham

Kensington and Chelsea

2012-2013

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1. Executive Summary

This report provides information regarding the child deaths reviewed during 2012-13. The analysis has been carried out regarding those cases reviewed rather than those notified during the year. Reviews took place of cases of children who died between 2010 and 2012.

The timing of a review is subject to:

- The information available from agencies involved
- Other processes such as police investigation, serious case review or inquest
- Number of cases relating to particular themes

33 deaths were reviewed by the Child Death Overview Panel during 2012-13. Of these 12 were unexpected.
The main category of death continues to be perinatal events. This is consistent with the national trend. There will need to be more comparison with the national picture to identify clear messages for learning from the reviews.

In March 2013, the Department for Education published its revised Working Together to Safeguard Children Statutory Framework. This reinforced the requirement for the Child Death Reviews to continue as a duty of the Local Safeguarding Children Board.

Nicky Brownjohn
Chair of the CDOP
Associate Director for Safeguarding CWHH CCG Collaborative/ Designated Nurse for Safeguarding Children for West London and Central London CCGs

July 2013

2. Legislation and Definitions

2.1 The Regulations relating to child death reviews

The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, 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:
(i) Any case giving rise to the need for a review mentioned in regulation 5(1)(e);
(ii) Any matters of concern affecting the safety and welfare of children in the area of the authority;
(iii) Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

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

N.B The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate of the cause of death (and therefore is not the responsibility of the Child Death Overview Panel (CDOP)).

2.2 Functions of the CDOP

The functions of the CDOP as set out in Working Together to Safeguard Children (2013) include:

- reviewing all child deaths up to the age of 18, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
- discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
- determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- identifying patterns or trends in local data and reporting these to the LSCB;
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required;
- agreeing local procedures for responding to unexpected deaths of children; and cooperating with regional and national initiatives – for example, with the

National Clinical Outcome Review Programme – to identify lessons on the prevention of child deaths.

- The aggregated findings from all child deaths should inform local strategic planning, including the local Joint Strategic Needs Assessment, on how to best safeguard and promote the welfare of children in the area.

2.3 Definition of an unexpected death of a child

Working Together to Safeguard Children (WTG) (2013) defines an unexpected death as:

'*the death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death'*

2.4 Definition of preventable child deaths

WTG (2013) defines preventable child deaths as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

In reviewing the death of each child, the CDOP should consider modifiable factors and make recommendations for action on a local, regional or national level to reduce the risk of these factors in the future.

3. Progress from 2011/12

3.1 Responsibilities

The Revised Working Together to Safeguard Children (2013) confirms that:

- Clinical Commissioning Groups (CCGs) take on the PCT responsibility for securing the expertise of a Designated Paediatrician for unexpected child Deaths.
- The LSCB remains responsible for the provision of a Single Point of Contact/ Designated Person for collecting information.
- Regulation 6 (see section 1) remains in place.

3.2 Child Death Overview Panels

Themed panels took place during 2012/13 as planned. The themes were:

- Neonatal
- Accidents
- SUDI
- Suicides
- Life limiting illnesses

This enabled the panel to co-opt specialist members for key areas to strengthen the learning from cases.

3.3 Reporting

Reports have been provided to the LSCB to highlight areas for dissemination and learning. This has led to a more joined up approach in considering issues for more development.

3.4 Rapid Response for unexpected deaths

As part of the Clinical Commissioning Group authorisation there was a requirement for there to be a Designated Paediatrician for Unexpected Child Deaths.

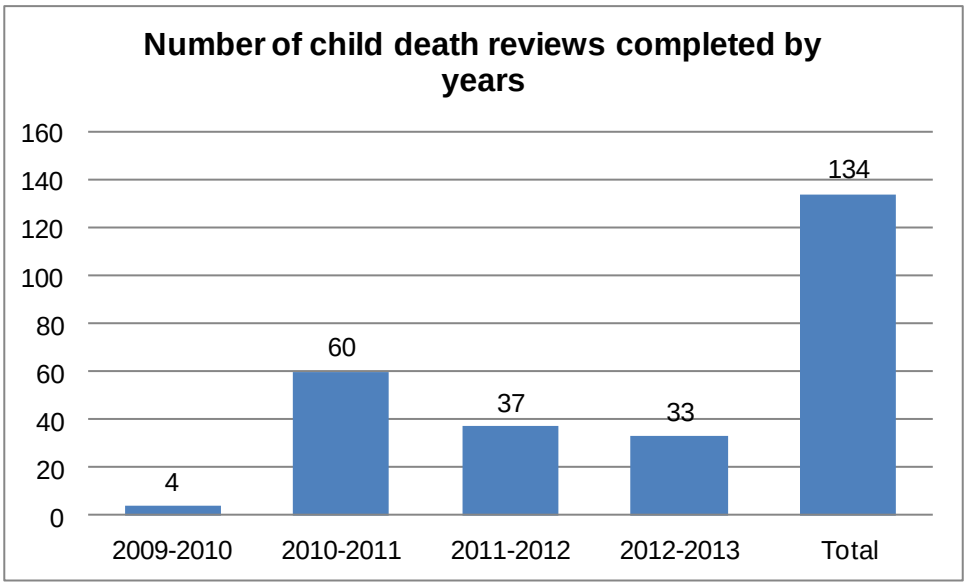
3.5 Sharing learning

The Chair has continued to work as a member of the Pan London CDOP Chairs' Group to share learning and has contributed to a national research project due to be published in 2013.

4. CDOP Reviews 2012-13

4.1 Number of reviews completed

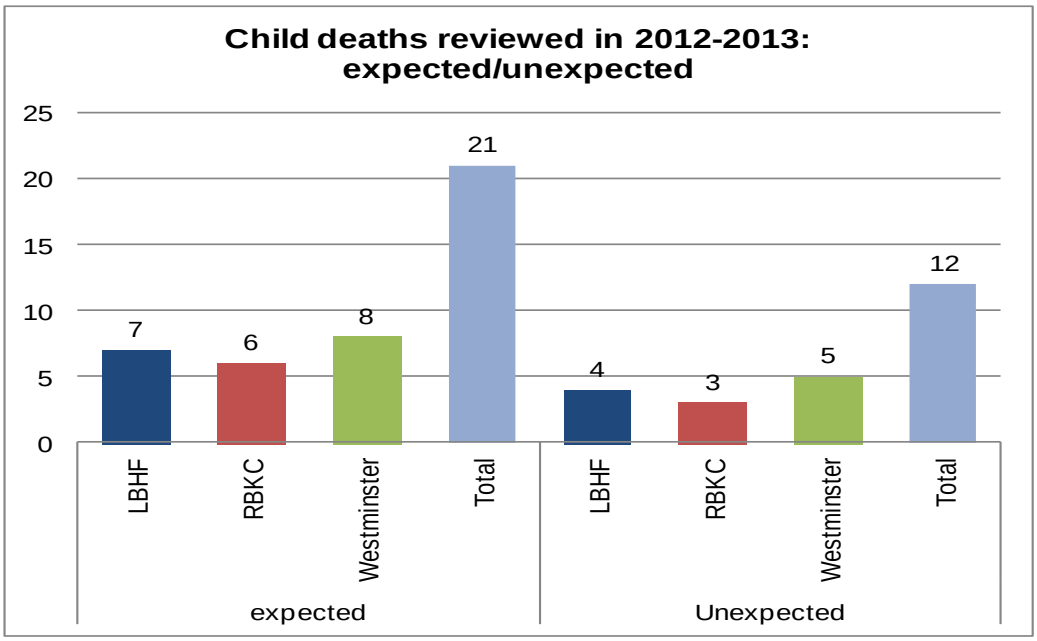
Table 1



Between April 2008 and March 2013 there have been 134 child death reviews the largest proportion were completed during 2010-2011 to enable the deaths notified in 2008-09 and 2009-2010 to be considered by the panel. The numbers of reviews during 2011-2012 and 2012-2013 are comparable and indication that these numbers are the likely volume of cases that the Child Death Overview Panel will consider in any one year. At 31st March 2013 there were 36 child deaths which had not been reviewed by Child Death Overview Panel.

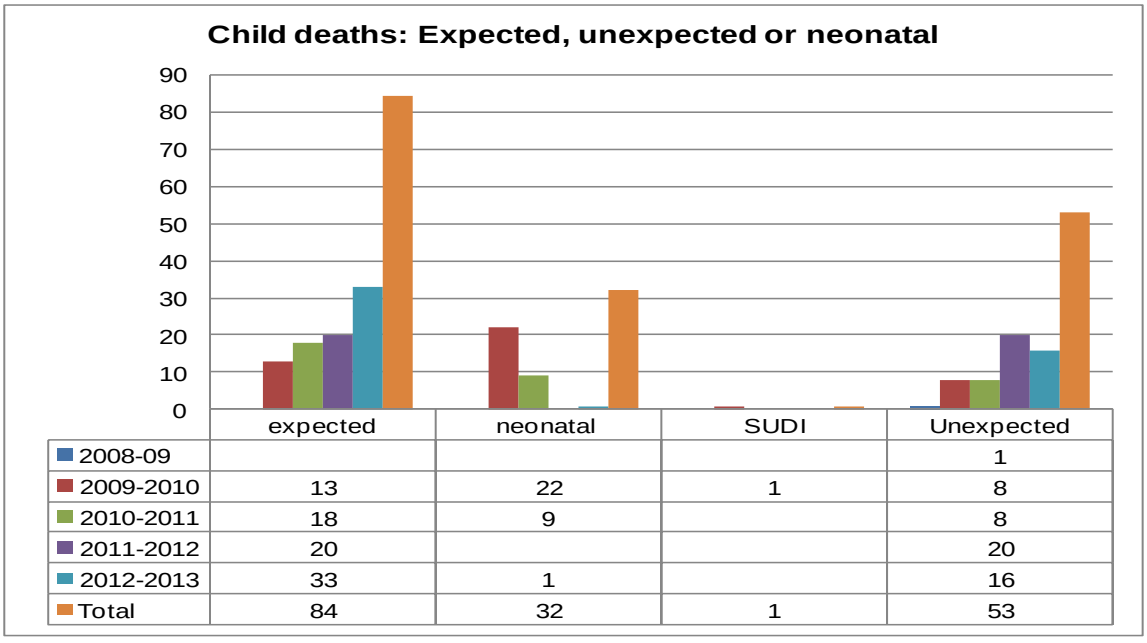
4.2 Number of Expected / Unexpected deaths

Table 2



33 cases reviewed by the Child Overview Panel during 2012-2013, 21 (64%) deaths were expected.
The unexpected deaths required a rapid response investigation led by the Designated Paediatrician for Unexpected Child Deaths to ensure there were effective multi agency investigations carried out and that the families were supported through their bereavement.

Table 3

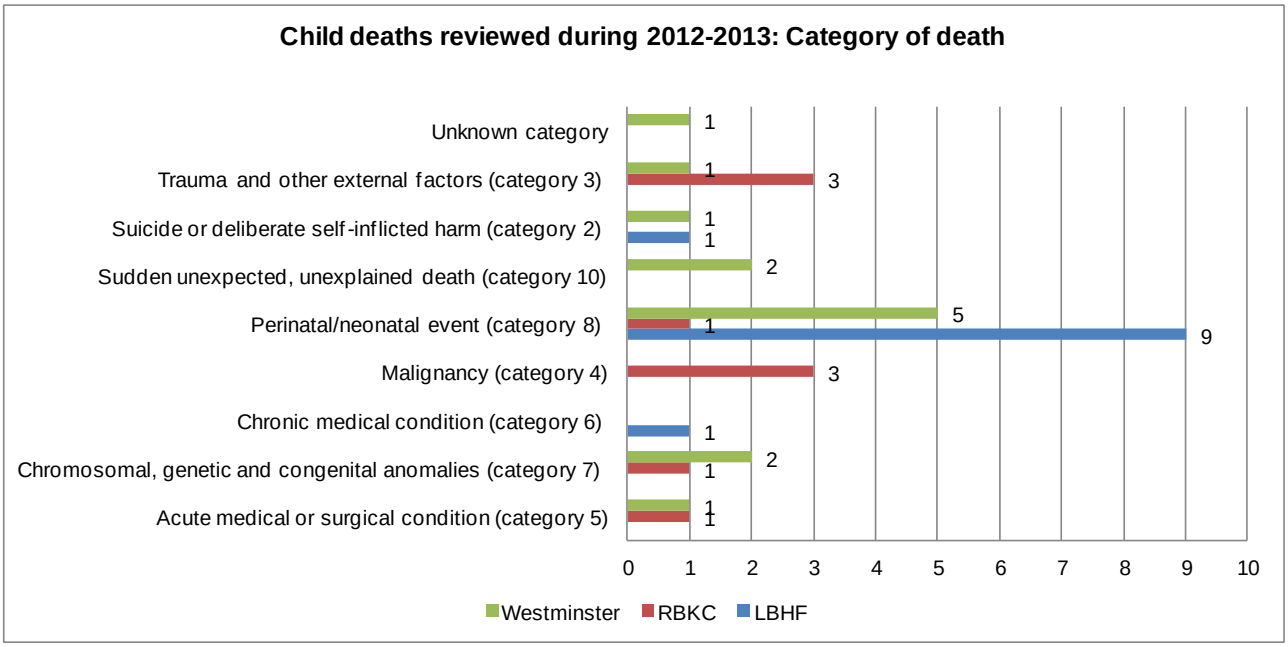


	expected	neonatal	SUDI	Unexpected
2008-09				1
2009-2010	13	22	1	8
2010-2011	18	9		8
2011-2012	20			20
2012-2013	33	1		16
Total	84	32	1	53

Of the child deaths received since April 2008 the majority, 48%, were expected and 31% unexpected. 19% were neonatal.

4.3 Category of Death

Table 4



The majority of deaths notified are expected / neonatal which is in accordance with national profiles; expected deaths also outnumber unexpected deaths. Of the deaths reviewed by Child Death Overview Panel the majority (45%) were category 8 Perinatal/neonatal events.

4.4 Modifiable Factors

Table 5

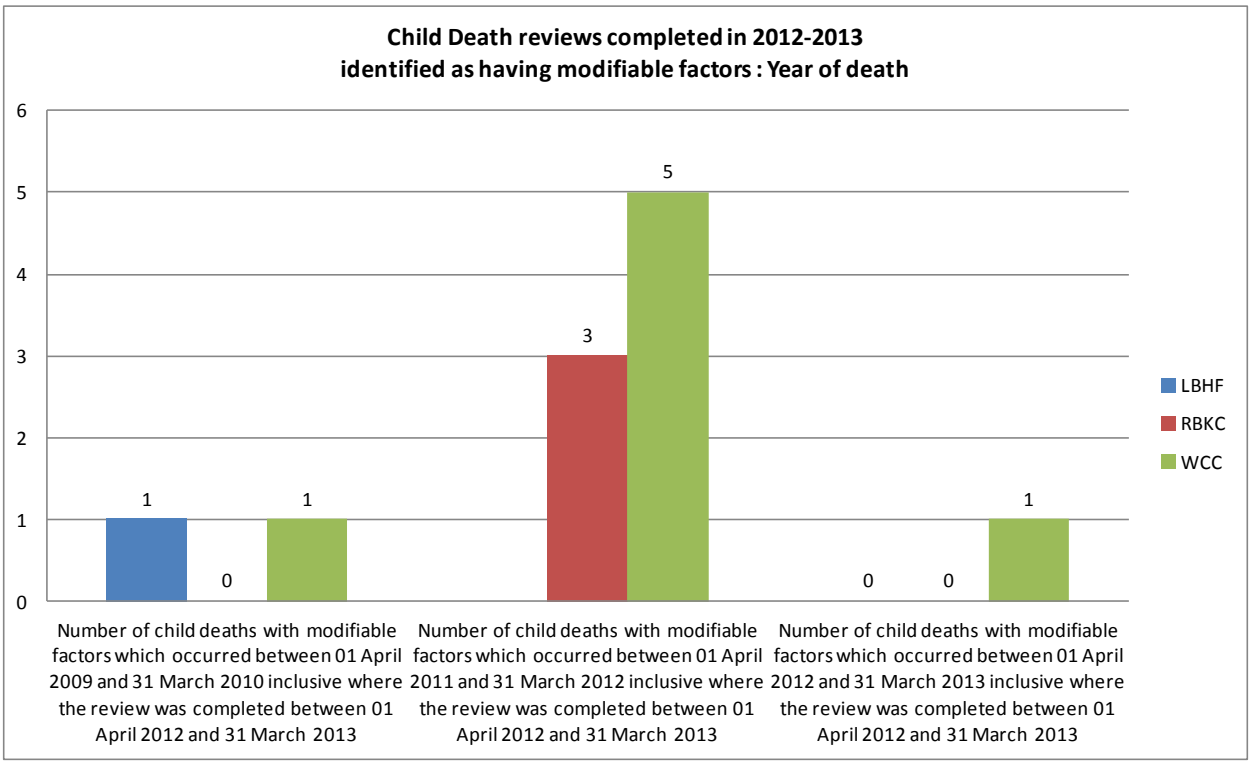
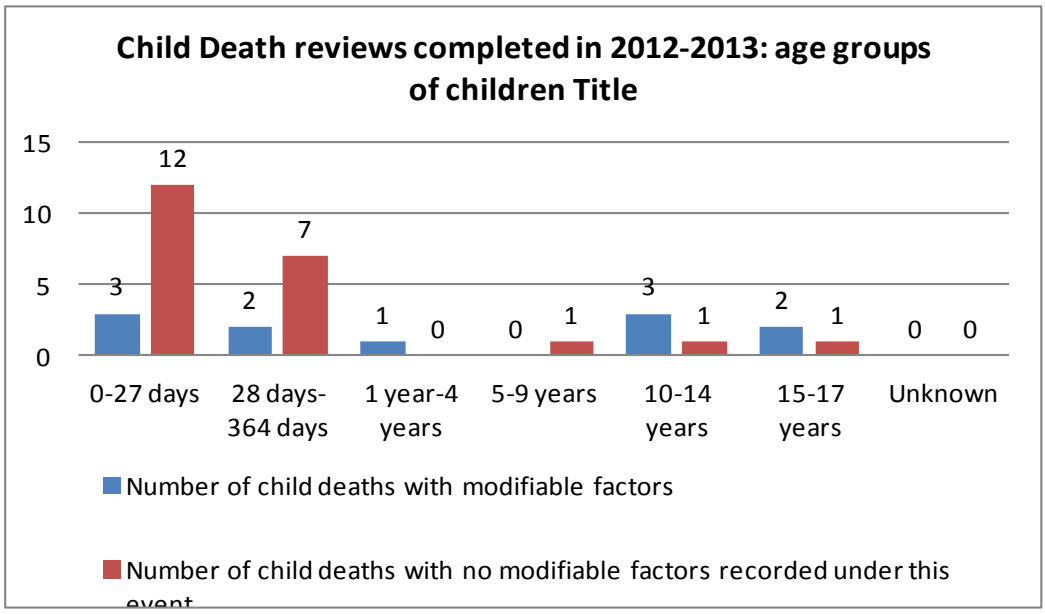


Table 4 shows the number of child death reviews the Panel considered to have modifiable factors and so made recommendations to reduce the risks in the future. This shows that 11 out of the 33 cases reviewed were deemed to have modifiable factors. Nationally, for 2011-12, 20% were found to have modifiable factors (DFE, 2012) . Prior to 2011 CDOPs looked at whether the deaths were preventable rather than modifiable factors. As CDOPs become more refined in how they are reviewing cases and acknowledge a further change in definition (DFE, 2013) the data should become more statistically robust.

4.4.1 Age

Of those with modifiable factors identified there is no clear link regarding the age of the child. There appear to be two distinct areas: those under one year (6 cases) and 10-17 years (5 cases). More examination of these factors could help to identify trends.

Table 6

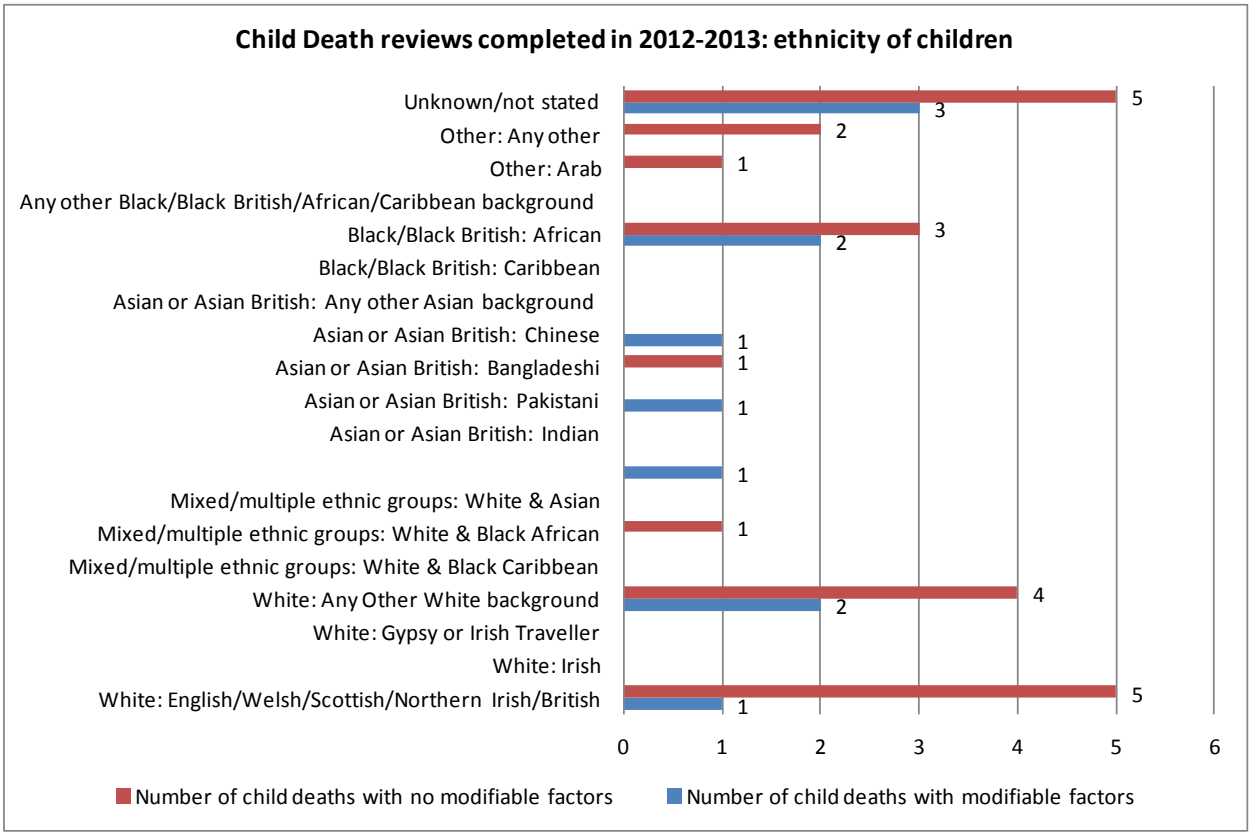


15% of the deaths with modifiable factors were children under 1 year. This is consistent with the national data (18% in 2011-12, DFE 2012). However, the national picture shows a higher percentage of modifiable factors in children aged 15-17 years (6% to national in 2011-12 at 32%)

4.4.2 Ethnicity

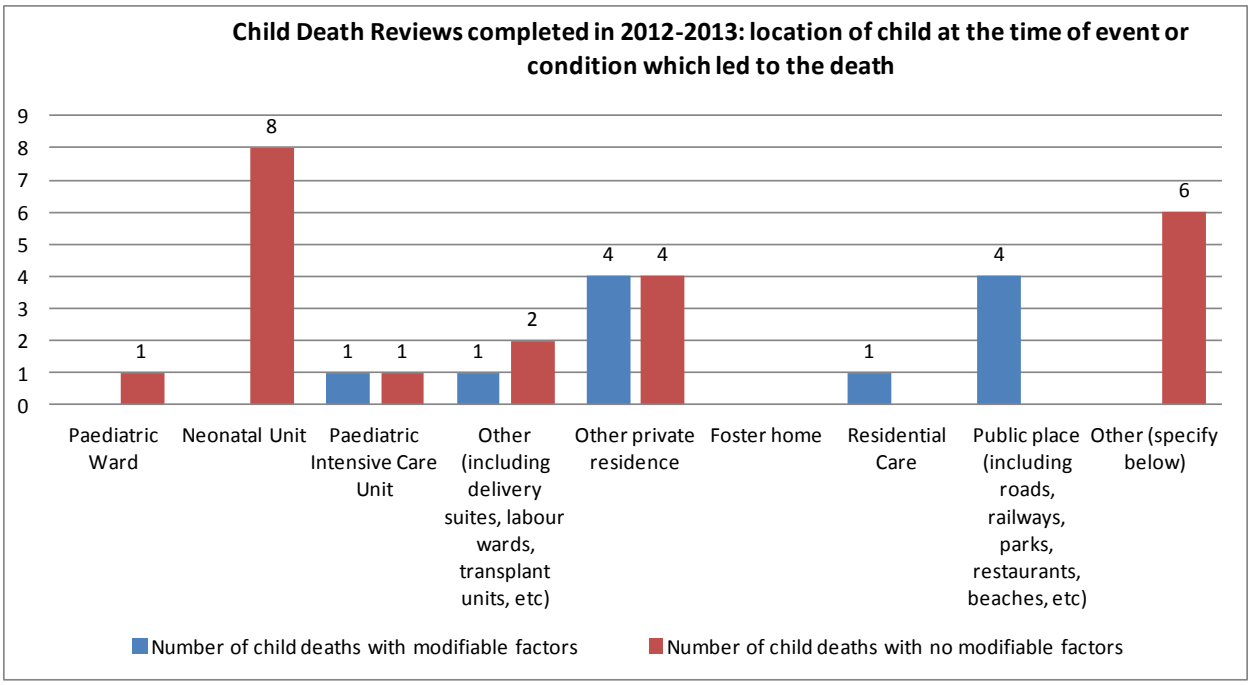
There are still a significant number of cases where ethnicity is not known. This could be due to a recording issue of neonatal deaths.

Table 7



4.4.3 Location of Child at Time of Incident Which Precipitated the Death

Table 8



4.5 Learning from themes

- **Suicides**
  The cases highlighted the need for agencies to be aware of the use of 'suicide websites' by vulnerable young people. Nationally there is an indication that CDOPs are finding modifiable factors in self- inflicted deaths (DFE 2012). This shows that there can be risk taking behaviour. This requires schools to work together with other agencies to be vigilant in identifying risk taking behaviour and for a multi-agency response to addressing the behaviour.

- **Sudden Unexpected Death of an Infant**
  Nationally, in 57% of cases, deemed as sudden unexpected death in infancy, reviewed in 2011-12 were found to have modifiable factors (DFE 2012). Public health awareness regarding safety issues for young babies in relation to sleeping arrangements. This continues to be a national issue and some areas have commissioned short lived campaigns but these have been found to be unsuccessful in having any sustainable change (DFE 2012). The Lullaby Trust (previously FSID) has recently published revised leaflets to educate both parents and professionals in this issue.

- **Road Safety**
  For school age children, both nationally and locally this raises lessons to learn in environmental factors, school procedures for walking to / from school, assessment of an individual child's ability to look after themselves on the road

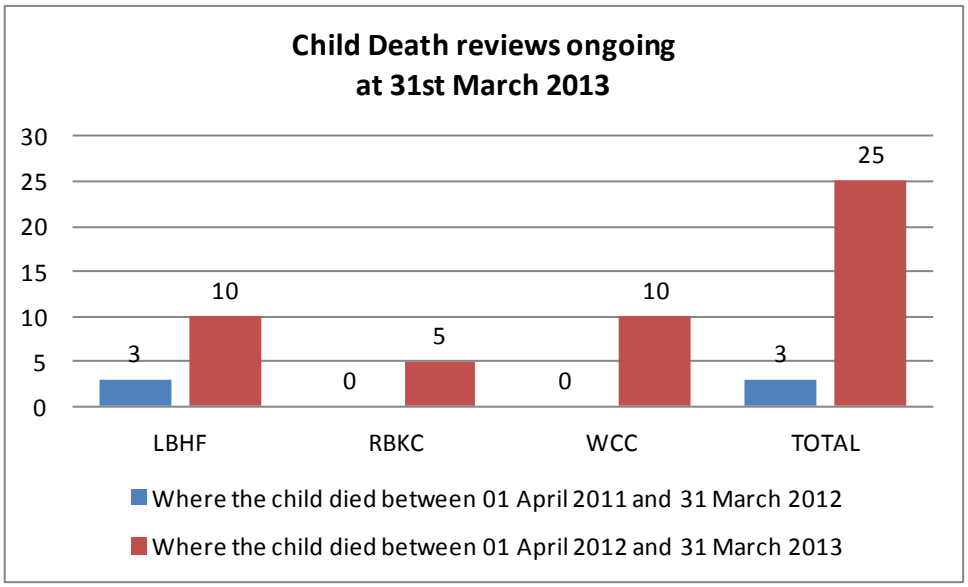
- **Long Term Medical Conditions**
  The panel reviewed several cases where there had been long term conditions. There was evidence in some cases of good practice in supporting the children and their families

- **Isolated parents**
  This is an issue that does not seem to have been noted in the national data. However, locally some parents, particularly those with language difficulties or new to the area, appeared to find it difficult to ask for or access the help available to them from services to support their children.

4.6 Reviews not yet completed

Reviews take place once any other investigations have been completed and all the relevant information is available to the panel to make an informed decision regarding modifiable factors. These means that there will be a substantial number of cases not reviewed each year.

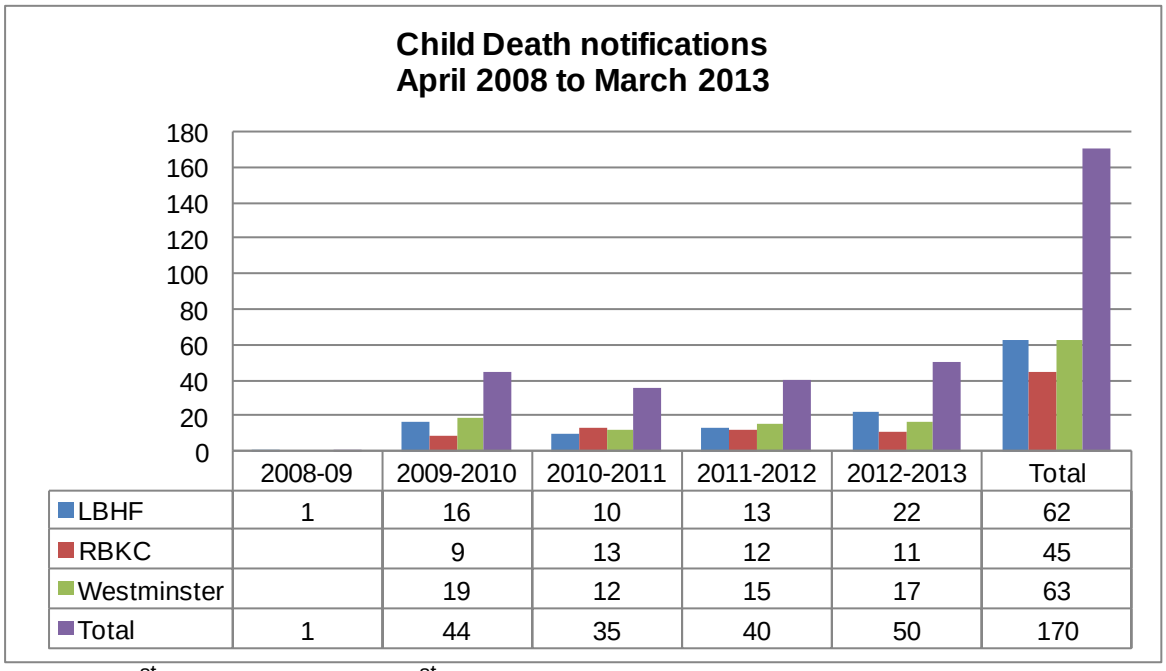
Table 9



5. LSCB Notifications of Deaths 2012/13 Statistics

5.1 Number of deaths within the three boroughs

Table 10



	2008-09	2009-2010	2010-2011	2011-2012	2012-2013	Total
LBHF	1	16	10	13	22	62
RBKC		9	13	12	11	45
Westminster		19	12	15	17	63
Total	1	44	35	40	50	170

Between 1st April 2012 and 31st March 2013, there were 50 deaths of children living in the three boroughs. Hammersmith and Fulham had the highest number and Kensington and Chelsea the lowest. Numbers of death notifications have steadily increased over time with these increased being predominantly in Hammersmith and Fulham where the numbers of child deaths has doubled from the 2010-2011 rate. These cases have received an initial review. There appears to have been more neonatal deaths due to extreme prematurity. There will be a neonatal review during 2013-14.

6. Recommendations for 2013/14

LSCB

- To review child death review process in light of Working Together to Safeguard Children (2013).
- Plan training programme to update agencies on process.
- Ensure learning from CDOP is shared with partner agencies for consideration within practice and commissioning.
- Review management and coordination of child death review process.
- Ensure database meets the DFE requirements for data collection and improve collection of ethnicity data.

CDOP

- Develop research base for key themes and main modifiable factors noted.
- Refer cases of concern in relation to safeguarding to Case Review Subgroup.
- Gather information regarding use of bereavement counselling.

7. Membership of the CDOP 2012-13

The CDOP has been chaired by one of the Designated Nurses for Safeguarding Children during 2012-13

Core membership has included:

- Primary Care Trust /Clinical Commissioning Group:
  -Designated Nurse for Safeguarding Children
  -Designated Paediatrician for Unexpected Deaths
- Public Health
- Acute Health :Paediatrician
- Education Welfare
- Social Care
- Police (CAIT)

Co-opted membership for specialist themed panels:

- Acute health:
  -Neonatologist
  -Senior Midwife
- Community Health
- Mental Health (CAMHS)
- Council (road safety)