London Borough of Hammersmith & Fulham | The Royal Borough of Kensington and Chelsea | Westminster City Council

3-borough

Child Death Overview Panel Annual Report

Westminster,

Hammersmith and Fulham

Kensington and Chelsea

2011-2012

CONTENTS

Executive Summary

This is the fourth Annual Report of the Westminster, Hammersmith and Fulham Kensington and Chelsea Child Death Overview Panel (CDOP). It gives a summary of the work undertaken by the Panel in the last year, and sets out future action.

The work of the Panel itself has focussed on examining specific incidents of child deaths across the three boroughs, drawing conclusions about whether those deaths were preventable, and considering factors that seemed to have contributed to those deaths.

The CDOP has been fully functioning with key agencies contributing to the process during the last year. During 2011 the panel met on 4 occasions and completed full child death reviews on 36 children of children of families resident in the boroughs of Westminster, Hammersmith & Fulham and Kensington & Chelsea. These cases were from 2009-10, 2010-11 and 2011-12. It should be acknowledged that the CDOP is not effectively able to fully review a death until information is gathered and other processes have been completed such as inquests and serious case reviews.

1. **Introduction to CDOP**

1.1 Terms of reference

Since 1st April 2008 all LSCBs have been required to have arrangements in place to respond to and review child deaths in their borough, as outlined in *Working Together to Safeguard Children 2010, Chapter 7*. The arrangements include:

- A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child (par. 7.18-7.49); and
- An overview of all child deaths (under 18 years, excluding those babies who are stillborn) in the LSCB area undertaken by a panel (par. 7.50-7.56)

The overall principles are that for all child deaths enquiries should be made to understand the reasons for the child's death, to address possible needs of the other children in the household and any other members of the family and also, to consider any lessons to be learnt about how best to safeguard and promote the children's welfare in the future.

If during the review process, the CDOP identifies:

- any cases requiring a Serious Case Review (SCR);
- any matters of concern affecting the safety and welfare of children in the area; or
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area;

The Department of Children, Schools and Families (DCSF) guidance suggested that a review panel should cover a total population of at least 500,000 in order for possible themes for deaths to be identified. For this reason, the boroughs of Hammersmith and Fulham (mid 2007 population 172,500), Kensington & Chelsea (178,600) and Westminster (234,100) set up one review panel covering a total population of 585,200. The CDOP was established as a sub-committee for each of the three Local Safeguarding Children Boards (LSCBs) with accountability to the three LSCB Chairs. During 2011-12 arrangements were made to create a single LSCB for the three boroughs. This was established in April 2012 and the CDOP transferred as a sub group with accountability to the one chair.

1.2 Core membership

The Core membership of the Westminster, Kensington & Chelsea, and Hammersmith & Fulham) Child Death Overview Panel consists of senior multi agency representation from the PCTs, police and Children's services from the three boroughs with specialist representation from organisations for particular areas. Neonatal deaths make up a significant proportion of the deaths in the tri borough and so dedicated panels are held for these cases; this has included the involvement of senior midwifery and neonatology clinicians from either Imperial or Chelsea and Westminster Trusts. (See appendix 1 for a full list).

1.3 Definitions

1.3.1 Child death categories:

- Neonatal
  Death of a live born baby during the first 28 days of life – within this CDOP the neonatal panel also discusses children who die after 28 days but who have never left hospital.

- SUDI
  Sudden Unexpected Death in Infancy – up to age 2 years

- Unexpected
  The number of 'unexpected' deaths as reported on the notification form is also shown for each borough and for the 3 boroughs combined.

  Working Together to Safeguard Children 2010 provides the following definition of an 'unexpected' death of a child:

  > *An 'unexpected' death is defined as the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly 'unexpected' collapse leading to or precipitating the events that led to the death. The designated paediatrician responsible for 'unexpected' deaths in childhood should be consulted where professionals are uncertain about whether the death is 'unexpected'.*

- Expected
  Deaths from natural causes, for example, a disease, birth defect, congenital abnormality; extreme prematurity, that is judged to be contributory to the death or is incompatible with life

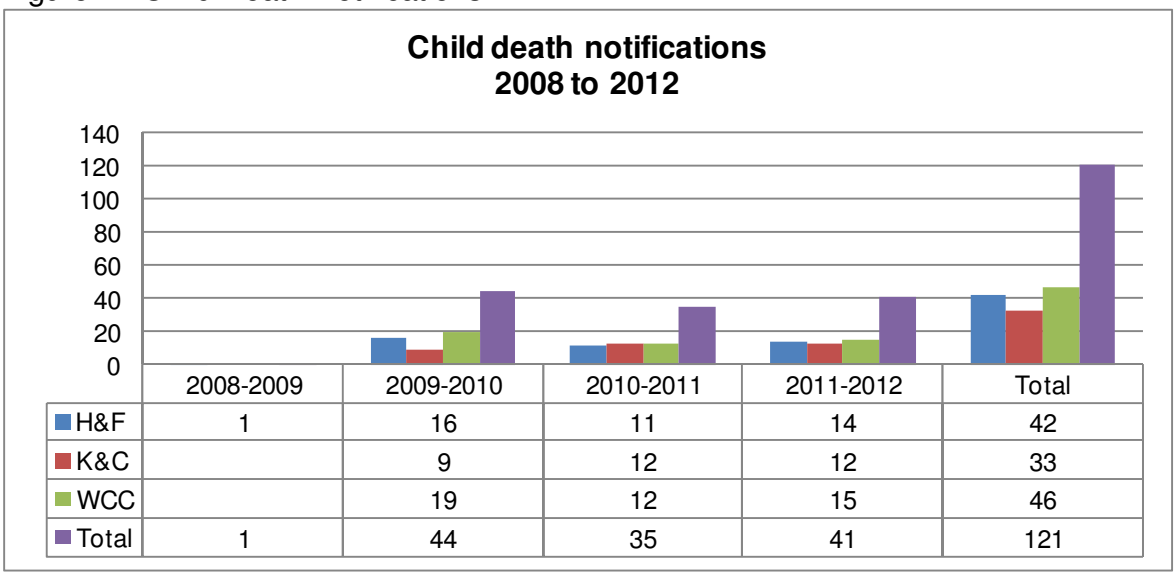
1.3.2 Definition of preventable child deaths

Working Together to Safeguard Children 2010 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.

2. Overview of CDOP operation

2.1 number of deaths in CDOP area

Figure 1 : Child Death Notifications



	2008-2009	2009-2010	2010-2011	2011-2012	Total
H&F	1	16	11	14	42
K&C		9	12	12	33
WCC		19	12	15	46
Total	1	44	35	41	121

The CDOP Coordinator received notifications of 41 children resident to the tri-borough who died between April 2011 and March 2012. Notifications can be submitted by any professional working with the family. They are usually submitted by hospitals, community health staff or police. In addition, the Registrars for births and deaths have a responsibility to notify the CDOP coordinator of any deaths within 7 days of registration.

CDOPs only review the deaths of children resident in their local area so the majority of deaths within the boroughs are reviewed by CDOPs around the country. In the tri-borough there are a high number of child deaths occur of children resident outside the borough which reflects the high level of specialist health provision both NHS and private sector (2010-11 174). These have not been included in this year's report. In the next year there will be some analysis of the amount of work these cases require of local organisations and also to consider any relevant themes than impact on local services.

2.2 Number of meetings and reviews conducted

Meetings were held on 4 occasions. There were 3 main panels, one of these extended to include neonatal cases due to the number of outstanding neonatal deaths and a further separate neonatal panel.

2.3 Organising and resourcing of CDOP

A CDOP Coordinator has been in post since August 2009. Since April 2011 the panel has been chaired by one of the Designated Nurses for Safeguarding Children. She was a member of H&F and Westminster LSCBs and will continue in the role. The Coordinator role has being providing 2 days a week. For the future the coordinator role is now part of the tri-borough LSCB senior Business Support Officer role.

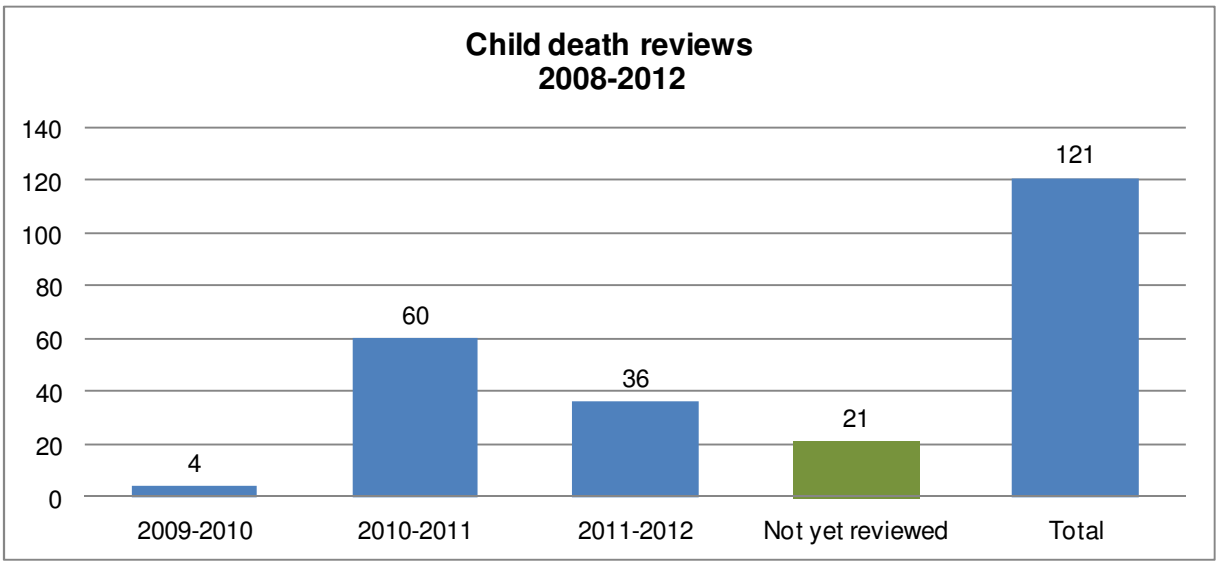
Support in the analysis of data is provided by Rowena Ward**,** Business Analyst within Westminster Children's Services. This support will continue from the tri-borough team led by Rowena.

2.4 Commentary on CDOP operation – staffing, backlog, attendance

Cases are only reviewed once all other processes such as serious case review, police investigation or inquest have been completed.

Attendance has been quorate. There is good commitment from all the relevant organisations. The number of panels has been halved from the previous year. Many of the deaths have been expected. This has resulted in discussions being medically orientated which can be a different experience for those from social care and the police. This is dependent on the types of deaths requiring a review and acknowledging that unexpected deaths take longer to reach the panel. This issue will be discussed further in recommendations for the next year.

Figure 2 : Number of Child Death Reviews completed during 2011-12



The CDOP has managed to improve its performance in reviewing deaths since 2009-10. 121 deaths have been reviewed over three years. The dip in number for 2011-12 compared with 2010-11 is due to a reduction in the number of panels held (from 10 down to 4).

Of the 36 reviews held in 2011-2012 ten had modifiable factors.

21 cases have not yet been reviewed. 19 of these are from 2011-12. 2 remain outstanding from 2009 -10. The reason for the delay in reviewing these is that both cases were subject to serious case review and inquest. Therefore, those processes have taken priority. There is a plan in place to review all of the 21 cases by December 2012.

3. Commentary on cases reviewed

3.1 Expected deaths

18 expected deaths were reviewed during 2011-12.

14 were neonatal deaths:

- 5 congenital, genetic or chromosomal abnormalities
- 8 perinatal events, one with modifiable factors

- 1 malignancy

There were reviews of 4 expected deaths of older children:

- 3 congenital, genetic or chromosomal abnormalities
- 1 chronic medical condition

Two of the expected deaths were considered to have modifiable factors, whilst one did not have enough information provided to make the decision. Of the two that had modifiable factors:

One was a disabled child (this was reported on in last year's report) who contracted H1N1.

One was a neonatal death due to prematurity.

3.2 Unexpected deaths

18 cases reviewed were unexpected deaths. 9 were found to have modifiable factors. These involved potential accident prevention factors, public health interventions and medical diagnosis. The key issues will be discussed in the themes section.

- 1 Sudden unexplained death of an infant (SUDI) was reviewed during 2011-12. This involved a young baby found unresponsive in the morning by the parents. The baby had been well and fed in the night. The cause of death remains unexplained.

  N.B. SUDIs are not reviewed until the rapid response and inquest has been completed.

- 1 due to deliberately inflicted injury. This was a fatal stabbing. There have been other stabbings within the area but the other fatal cases have been adults. This case was viewed to be particularly vicious. The panel identified that social media had brought young people together to instigate the attack.

- 2 children died in a house fire. The family were staying with extended members of the family.

- 2 children died in a road traffic collision abroad. The panel related this to a previous case that occurred on holiday. The panel considered police information regarding prosecutions in the boroughs. Although this is not totally relevant as in Westminster due to the number of people coming through the borough.

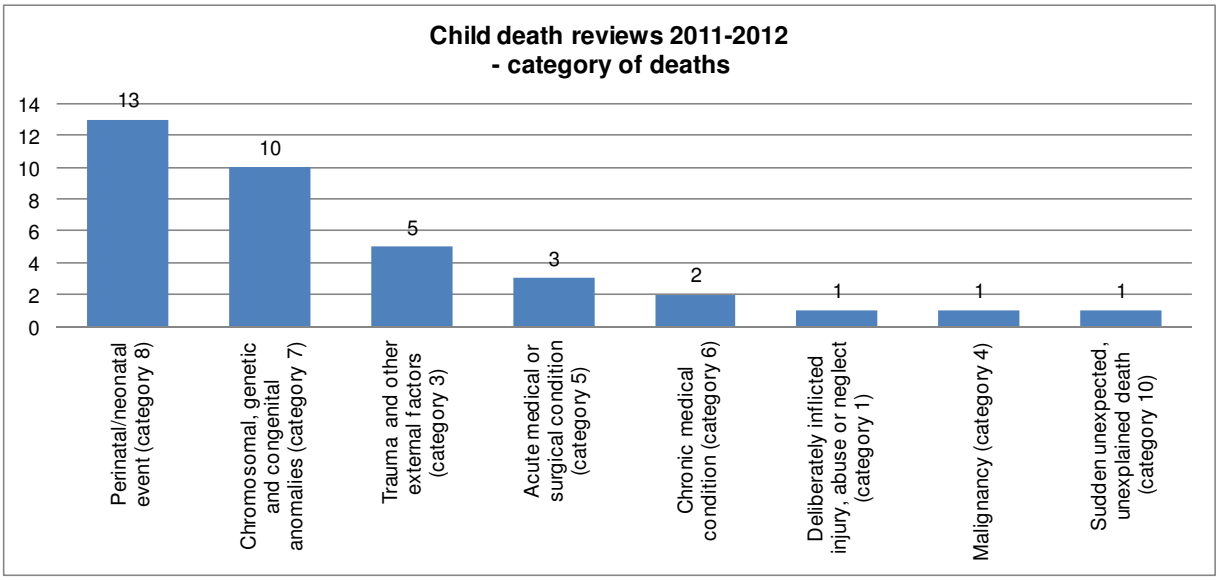
- 1 child died in a road traffic accident following a fall from his bike without any other reported road users involved.
- 1 child died from hypoxia and brain swelling having suddenly become acutely ill following a cold.
- 1 child was an unaccompanied asylum seeker from another borough but fostered in the area. He had heart disease that was not known about.
- 1 child suffered a cardiac arrest following an asthma attack.
- 2 children died due to underlying medical conditions, one of these was a neonatal death.
- 1 had a disability which was life limiting but the child had not been expected to die in the previous 24 hours.
- 1 neonatal death due to an acute infection of the amniotic fluid not known about prior to birth
- 4 neonatal cases due to B strain streptococcal infections. These deaths took place in different hospitals so the CDOP did not find any worrying links between the cases. However, the panel did discuss the benefits of prophylactic antibiotic treatment if the infection is suspected.

  Arrangements have been made to improve the information sharing from the hospitals for these cases and to reduce duplication of work. Many neonatal deaths are already reviewed internally by the acute trusts. In light of the number of neonatal deaths being unexpected there has been a strengthening of rapid response process for hospital deaths.

Recording of unexpected deaths has improved over the last two years. Between 2009 and March 2012 there were 29 unexpected deaths including those categorized as SUDIs and neonatal. 11 unexpected deaths have not yet been reviewed. 2 of these were from 2010 were delayed due to SCR and inquests.

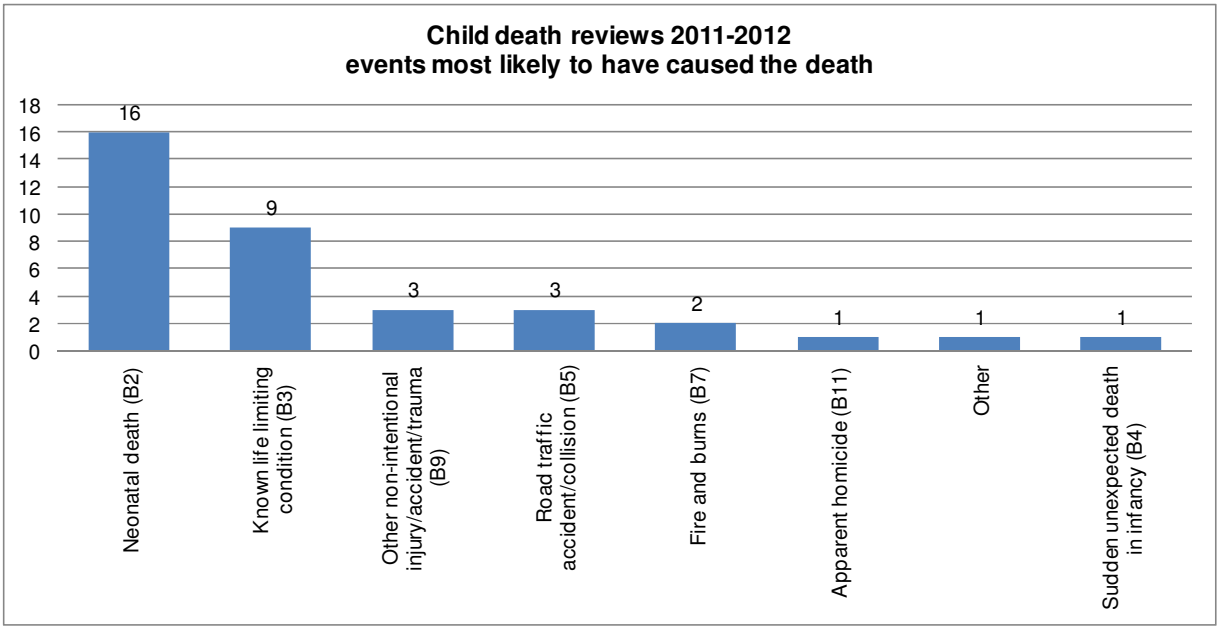
4. Child Death Statistics

Figure 3: Category of deaths



This shows that most deaths are due to perinatal or neonatal events. However, this chart shows that some of these can be accounted for by chromosomal or genetic deficiencies.

Figure 4: Cause of death

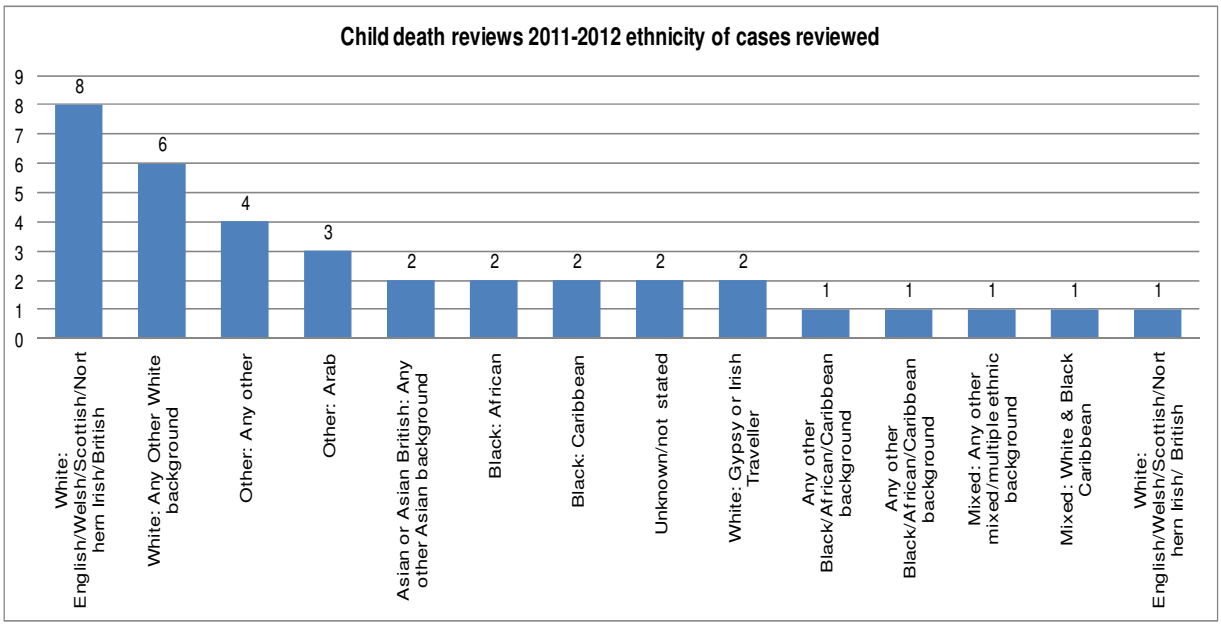


This shows that the majority of the deaths are neonatal. There are also a significant number due to life limiting conditions. Two siblings died in the same road traffic accident. Two siblings died following a fire.

Figure 5: Age profile

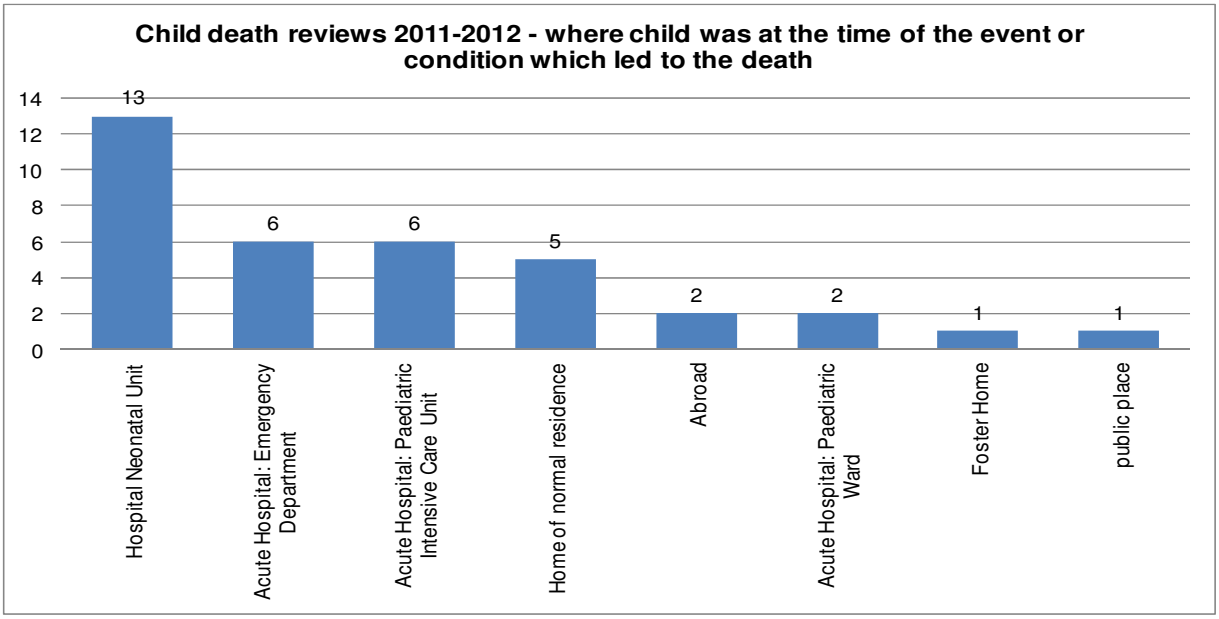
This shows that the majority of the deaths of tri-borough children are due to perinatal events. These deaths can be due to extreme prematurity, life limiting disorders identified antenatally or immediately after birth unexpectedly.

Figure 6: Ethnicity



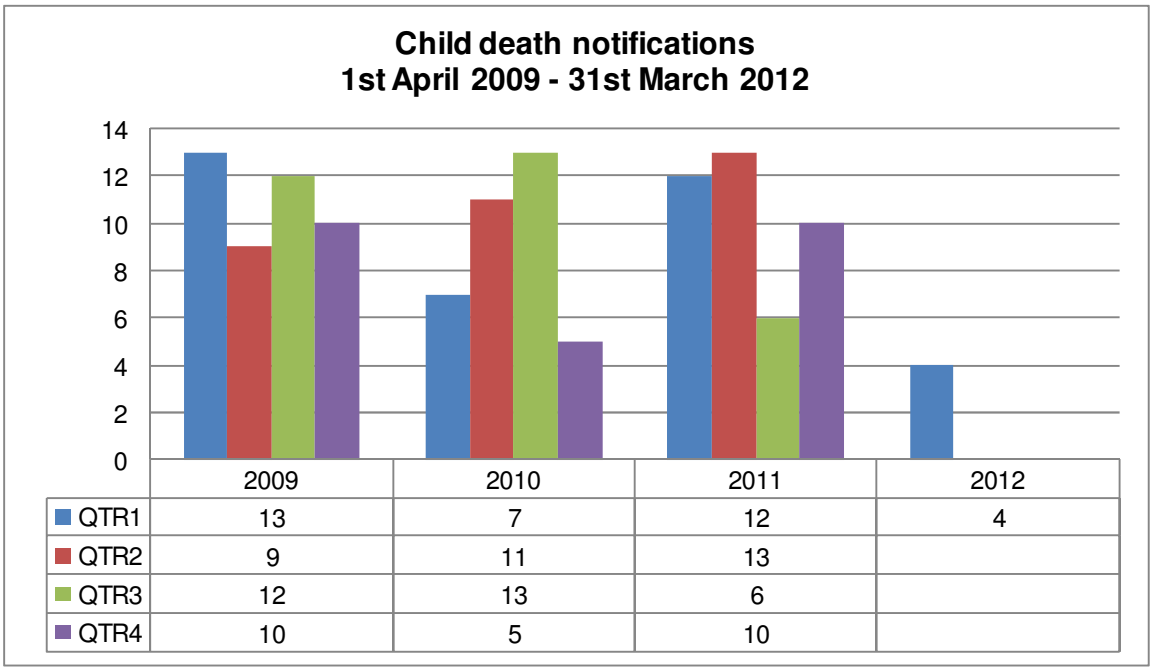
This reflects demographic Tri-borough profile.

Figure 7: Location of child at time of death or at time of incident which led to death



This will require more analysis over the next year as the data does not effectively demonstrate where the child was when the event which caused the death occurred, e.g home, road.

Figure 8 Deaths notified by quarter



	2009	2010	2011	2012
QTR1	13	7	12	4
QTR2	9	11	13	
QTR3	12	13	6	
QTR4	10	5	10	

5. Rapid Response for unexpected deaths

The work of the Designated Paediatrician for Unexpected Child Deaths encompasses the following areas:

- Deaths at St Mary's – Unexpected Child Deaths at St Mary's Hospital / Charing Cross and Hammersmith are all dealt with by the Designated Paediatrician for Unexpected Child Deaths. Rapid Response meetings are organized for all children and attended by the Designated Paediatrician for Unexpected Child Deaths if possible.

- Following all deaths there is more work to be completed in bereavement support for parents, coordinating blood samples to be analysed, comunication with the Coroner.

- Deaths in the community. These are rare but unexpected deaths in the community where the body is not brought into hospital are dealt with by the Designated Paediatrician for Unexpected Child Deaths.

- If the children are from out of borough the hospitals host the rapid response meetings if the children were resident in neibouring boroughs. If they were resident further away then the rapid response meeting will be done over the telephone with medical staff on site and social services/ police at place of residence. Most of the out of area deaths come from the neighboring borough, Brent.

- The experience of investigating child deaths has led to further work, including collaboration with pathologists investigating deaths of infants in slings and car seats, learning about taking appropriate samples at time of death such as fibroblast cultures and storing DNA to allow postmortem diagnoses.

6. Summary of key themes

6.1 Gangs

The panel identified gaps in knowledge regarding the communication systems for young people involved with gangs. The panel recommend that the LSCB develop tri-borough learning for dealing with gangs e.g. School to school knowledge, social network information

The panel discussed the need to establish what research the London LSCB is carrying out to gain a fuller picture of gangs / perpetrators Pan London. This will be asked at the Pan London Group.

6.2 Road traffic accidents

The panel found that there had been three deaths caused by road traffic accidents since the CDOP started in 2008. These deaths had all occurred when the children were on holiday, out of the borough, and without seatbelts being worn.

The police analysis of data regarding offences involving non use of seatbelts in local boroughs was presented to the panel to establish whether local parents were more inclined not to use seatbelts for their children. The evidence was inconclusive.

The CDOP recommend that a survey of schools is undertaken regarding their role in promoting road safety with children and parents:

- Crossing roads
- Use of seatbelts
- Driving abroad

This has not yet been achieved. The panel hopes that education will take this forward and feed back the results.

6.3 Fires

Two siblings died in a fire due to an electrical fault. The CDOP confirmed with housing departments that there were safety checks undertaken by housing associations.

6.4 Life limiting conditions

The panel considered several deaths of children with life-limiting conditions. There was evidence of good palliative care practice.

The panel questioned whether an unexpected death of a child with a life limiting illness is treated in the same way as other unexpected deaths. This will be considered in the monitoring of the rapid response process over the next year.

6.5 Asylum seeking children with undiagnosed health problems

The CDOP reviewed the death of a child who was an unaccompanied asylum seeker placed in the tri-borough from another borough. He was found to have an underlying health disorder. He was due to be assessed by a paediatrician but had missed appointments, despite living with foster carers.

This was fed back to the LSCB concerned. The CDOP would also like to highlight to the tri-borough LSCB the need for missed appointments for children placed in foster care to be followed up.

7. Feedback from previous year

Priorities for 2011/12

1. LSCBs to agree to reporting mechanism i.e. quarterly or 6 monthly reporting of key learning and any recommendations - **Started June 2011**
2. Create process for disseminating learning to frontline – **To be agreed with through the tri borough LSCB arrangements.**
3. Reduce number of panels - **Completed**
4. Revision of database to enable more effective collection of data for DfE **Completed**
5. Review information sharing protocol- review complete. A revised protocol has been drafted. **In process of being signed by organisation leads.**
6. Identify areas of duplication with other processes and establish a clear pathway for reviewing cases- **In process**
7. Improve liaison with neighbouring boroughs for joint learning from cases- **Chair is now co chair of the Pan London Chairs' group. Joint learning has been discussed at that group. Reviews of annual reports have done to identify key themes. Meetings are planned around some of the key themes.**
8. Chair to be a member of the pan London CDOP Chairs' Group - **completed**
9. Monitoring of rapid response process and quality assurance role for panel- Plans in place. **Data to be presented from September 2011**. The rapid response process is under review within the NHS reforms to develop a more effective process that meet the needs of the local structures.

8. Plans for 2012-13

8.1 Responsibilities

The child death processes remain a statutory function. Clinical Commissioning Groups (CCGs) take on the PCT responsibility for securing the expertise of a Designated

Paediatrician for unexpected child Deaths whilst the LSCB remains responsible for the provision of a Single Point of Contact.

8.2 Panels

The panels for 2012 have been planned.

A panel was held in May which considered a range of cases. From July to December there will be 3 panels. These panels will be themed. The themes for the year will be:

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

This will enable more efficient discussion at the panels and an improved quality of information being fed back to the LSCB. The themed approach will also allow effective dissemination of learning and identification of need for any significant lcal change to practice or requests for national alerts.

8.3 Reporting

A report will be presented to the LSCB following panels. The report will highlight:

- Performance
- Themes
- Learning / Research
- Dissemination process

8.4 Rapid Response for unexpected deaths

The process will undergo a review during 2012-13 to consider:

- Effectiveness of partnership working regarding the assessment of the home circumstances. Currently police carry out home visits and liaise with a paediatrician rather than actual joint visits, although if the necessity arose then this would be done.
- Quality of information collected to ensure that there are thorough forensic and medical investigations completed.

- Level of work regarding out of borough cases to inform commissioners and the LSCB.
- CCG service specification for Designated Paediatrician for Unexpected Deaths to ensure there is sufficient capacity to deliver a good service.
- Evaluation of family follow up and bereavement services.

8.5 Sharing learning

The Chair will continue to work as a member of the Pan London CDOP Chairs' Group to share learning. This will be fed back to the local CDOP.

Appendix 1

Core Membership 2011 -12

Nicky Brownjohn Designated Nurse for Safeguarding Children (NHS INWL PCTs) (Chair)

Dr Paul Hargreaves Designated Doctor for Safeguarding Children (NHS INWL PCTs)

Dr Nelly Ninis Designated Paediatrician for Unexpected Child Deaths (NHS INWLPCTs)

Dr Jean Chapple Consultant in Public Health (NHS INWL PCTs)

Debbie Raymond Head of Safeguarding WCC

Tim Deacon, Head of Safeguarding & Quality Assurance, H&F

DI Jim Wingrave, Detective Inspector for Central CAIT

Iwona Puszczewicz-Moreno, CDOP Manager

Williams Jonathan, LSCB Manager, Kensington and Chelsea

Additional members 2011 – 12

Wendy Allen, Named Midwife for Safeguarding Children, Chelsea and Westminster NHS Foundation Trust (C&W Hospital Trust)

Therese Chapman, Consultant Midwife, Named Midwife for Safeguarding, Imperial College HealthCare NHS Trust

Dr Gary Hartnoll, Neonatologist, C&W Hospital Trust

Alex Mancini, Matron, Neonatal Unit, Chelsea and Westminster Hospital Trust

Dr LydiaTyszczuk Neonatalogist, Queen Charlotte Hospital, Imperial College HealthCare NHS Trust