city & hackney safeguarding children board

Child Death Overview Panel
Annual Report 2014/15

Review of child deaths in the City of London and the London Borough of Hackney

Contents

Message from the Chairperson

The City and Hackney Child Death Overview Panel (CDOP) is an independent multidisciplinary panel that provides a review of deaths of children who are aged under 18 years and resident in the London Borough of Hackney or the City of London.

It is a statutory requirement that when a child dies, the factors around the death, including services provided to the child, will be comprehensively reviewed and evaluated in a manner which promotes learning and transparency. It is also important that future lives are protected by identifying and addressing risks and making recommendations, both locally and nationally to change or improve services.
The City and Hackney CDOP became active on the 1st of April 2008, since then it has reviewed the deaths of 213 children and young people and all recommendations made by the CDOP have been implemented or are in the process of being implemented.

The CDOP's process and annual report aim to promote the transparency of the child death case review requirement by ensuring all cases are scrutinised by an independently appointed panel with expertise in the fields of public health, paediatrics and child health, neonatology, mental health, children's social care, child protection, nursing, midwifery, general practice, child safety (police), education, youth crime reduction and other relevant members. The expertise of its members assists the CDOP to fulfil its role to apply a child-focused consideration to each individual review and to develop recommendations for improvement.

During the 2014-15 reporting period the CDOP reviewed the deaths of 34 children and young people. Many of the children to whom this report refers are aged less than 1 year of age and have sadly died at, or just after, birth. On behalf of the CDOP I would like to offer my condolences to the families, carers and friends of those children and young people whose deaths were considered by the CDOP during the reporting period. The death of a child touches the lives of the child's family, friends, those who worked with the child and the broader community.
I would also like to take this opportunity to thank the current members, who have brought a wealth of experience to the child death review process, for their commitment, challenge and support over the last years. I would also like to thank the relevant agencies across all sectors and its staff for the support they have given to the process. I trust the information in this report will continue to be useful to all those involved in protecting children and promoting their wellbeing.

My particular thanks go to Kerry Littleford for her unfailing efficiency and support to the panel.

Dr Penny Bevan, CBE, MB, ChB, MPH, FFPH
Director of Public Health
Chairperson of City and Hackney Child Death Overview Panel

Chapter 1

Introduction to the CDOP for the City of London and the London Borough of Hackney

> *The overall purpose of the child death review process is to conduct a comprehensive, multidisciplinary review of all child deaths, to understand how and why children die and to use the information to develop interventions to improve the health and safety of children in order to prevent future deaths.*[1]

1.1 Terms of reference

The CDOP's core functions as set out in its terms of reference include the following, ensuring that:

- local procedures and protocols are developed, implemented and monitored in line with guidance in Chapter 5 of *Working Together to Safeguard Children*[2];
- the cause and manner of each death is accurate, consistent and timely reported on;
- a minimum dataset of information on all child deaths in the City of London and London Borough of Hackney is collected and collated;
- lessons to be learnt from the deaths of all children normally resident in the City of London and London Borough of Hackney are identified and shared across agencies;
- significant risk factors and trends of environmental, social health and cultural factors in relation to child deaths in the City of London and London Borough of Hackney are identified with a consideration of how these might be prevented in the future;
- liaison with relevant agencies occurs when preventable factors are identified;
- the Police or the Coroner are informed of any specific new information that may influence their enquiries;
- the Chair of the City and Hackney Safeguarding Children Board (CHSCB) is notified of the need for further enquiries under s 47 of the *Children Act 2004* or of the need for a Serious Case Review in the light of new information which may become available;
- there is an appropriate rapid response process by professionals to each sudden unexpected death and review the reports produced;
- the CHSCB is advised on the resources and training required to ensure effective interagency working on child deaths;
- regional and national initiatives in response to prevention of child deaths are carried out locally.

The review process is an opportunity to analyse and evaluate the service delivery and system responses with the potential to improve outcomes for children and families, improve interagency working and identify, prioritise and plan for local needs.

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[1] *Royal College of Paediatrics and Child Health Guidance on Child Death Review Processes* (2008) 2.
[2] *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* (March 2013).

1.2 Core membership

Following commencement of the provisions establishing the CDOP on 1st of April 2008, appropriately qualified and suitable persons were selected to become members of the CDOP and invited to participate.

To ensure a multidisciplinary child death case review process, the selected members belong to a wide variety of local services and have expertise in the fields of public health, paediatrics and child health, neonatology, paediatric pathology, mental health, children's social care, investigations and child protection, nursing, midwifery, child safety (police), education, youth crime reduction and other members who can otherwise make a valuable contribution.

A coordinator supports the work of the CDOP to ensure it fulfils its statutory requirements.

1.3 Definitions of child death categories

1.3.1 All child deaths

The CDOP has the responsibility to review all child deaths up to, but not including, 18 years of age. The CHSCB, through the CDOP coordinator, maintains an up to date register of the deaths of all children and young people under 18 years of age that occur in the City of London and the London Borough of Hackney, including information on cause of death, demographic information, services involved and other relevant factors. This information is reviewed by the CDOP to identify and report on patterns and trends of child mortality. On the basis of this review, the CDOP makes recommendations that are focussed on reducing risk factors associated with all those deaths where modifiable factors 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. The CDOP also categorises the deaths for annual submission to the Department for Education and produces this annual report.

1.3.2 Neonatal

A neonatal death is defined as the death of a live born infant within the first 28 days of life. The CDOP reviews all neonatal deaths which have been registered as live with the General Registrar's Office. However, the CDOP does not consider stillbirths and planned terminations of pregnancy carried out within the law. The CDOP has also agreed to monitor, but not review, the deaths of infants that are born under 23 weeks gestation.

1.3.3 Unexpected child deaths

An unexpected death is defined 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 led to the death.*[3]

The unexpected death category includes both deaths as a result of external factors, such as a traffic accident or a stabbing incident, and deaths as a result of medical causes.

[3] HM Government, *Working Together to Safeguard Children* (2015) 85.

Whenever a child dies unexpectedly, a rapid response team constituted by a group of professionals from different key agencies comes together for the purpose of assessing all information, enquiring into and evaluating the death.

The purpose of the rapid response is to ensure that the appropriate agencies are engaged and work together to:

- respond without delay to the unexpected death of a child;
- ensure support for the bereaved family members, as the death of a child will always be a traumatic loss – the more so if the death was unexpected;
- identify and safeguard any other relevant children;
- make immediate enquiries into and evaluate the reasons for and circumstances of the death, in agreement with the coroner when required;
- undertake the types of enquiries that relate to the current responsibilities of each organisation when a child dies unexpectedly;
- collate information in a standard format;
- cooperate appropriately post death, maintaining contact at regular intervals with family members and other professionals who have ongoing responsibilities to the family, to ensure that they are appropriately informed;
- consider media issues and the need to alert and liaise with the appropriate agencies;
- consider bereavement support for any other children, family members or members of staff who may be affected by the child's death.

The rapid response process begins at the point of death and ends with the completed report to the CDOP following the case discussion meeting when the final results of the post mortem and inquest are available and can be shared.

1.3.4 Sudden and Unexpected Death in Infancy (SUDI)

A sudden and unexpected death in infancy (SUDI) is an initial classification for infant deaths under 1 year of age, sharing similar characteristics. These deaths are later assigned an official cause of death by a pathologist, such as sudden infant death syndrome (SIDS), respiratory illness or accidental asphyxiation.

1.3.5 Expected child deaths

An expected death is defined as: *a death where the child's demise is anticipated as a significant possibility 24 hours before the death and plans have been put in place and the cause of death is known. There are no suspicious circumstances to suggest that anything untoward has occurred.*

Unless the CDOP is sure the death is expected and that the above criteria hold true, the death will be treated as unexpected and the rapid response process will be followed.

Chapter 2

Overview of the CDOP's operation

2.1 Number of child deaths

In the 12 month period from the 1st April 2014 to the 31st March 2015, there were 35 deaths of children and young people who were normally resident in the **London Borough of Hackney**. There were no deaths of children and young people who were normally resident in the **City of London**. The most recent released child mortality rate (age 1-17 years) as at March 2015 from the Child and Maternal Health Observatory (Chimat) *Child Health Profile* is 12.8 (down from 16.3 last year) in Hackney and City of London compared to a national average of 11.9 (down from 12.5 last year) per 100,000 children.[4] The infant mortality rate is 5.7 (up from 5.5 last year) per 1000 births compared to a national average of 4.1 (down from 4.3 last year). Both rates remain higher locally.

2.2 Number of meetings held and reviews conducted

The CDOP has reviewed 35 cases and completed 34 cases during the period from the 1st April 2013 to 31st March 2014. The 34 cases completed included 1 outstanding case from the period covering 1st April 2012 to 31st March 2013, 5 outstanding cases from 1st April 2013 to 31st March 2014 and 28 cases from the current year, 1st April 2014 to 31st March 2015.

One case is pending review of the CDOP, which requires actions to be completed before being closed.

The CDOP carries out an assessment against national templates when conducting a review, this includes a consideration of the following matters:

- categorisation of death;
- modifiable factors of death;
- issues;
- learning points;
- recommendations;
- follow up plans for the family (where relevant); and
- whether the case warrants referral to another agency for further investigation.

2.2.1 Rapid Response group

The rapid response group, which is monitored by the CDOP, has considered the unexpected deaths of 12 of the 35 children and young people notified during the period 1st April 2014 to 31st March 2015. The findings of all rapid response meetings are discussed at the monthly Serious Case Review sub-committee. One child death reviewed by the rapid response group during 2014-15 was subject to a Serious Case Review (SCR) and one child death was subject to a Desktop Learning Review, which did not meet the threshold of an SCR but would benefit from learning being shared. At the time of writing, this SCR is ongoing.

The venue of each rapid response meeting will depend on where the child has died. During 2014-15, 8 of the rapid response meetings took place at the Homerton

[4] *Child Health Profile: Hackney and City of London,* CHIMAT, March 2015.

University Hospital, 1 took place at Royal London Hospital, 2 took place at Hackney Service Centre and 1 at Great Ormond Street Hospital. See table 2.1 for a breakdown of all rapid response venues during the last year.

Table 2.1 Venues of rapid response meetings

Venue	Number of meetings held
Homerton University Hospital	8
Hackney Service Centre	2
Royal London Hospital	1
Great Ormond Street Hospital	1
Total	12

2.2.2 Preventability / Modifiable factors

The CDOP is required to categorise the preventability of a death by considering whether modifiable factors 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. The CDOP identified modifiable factors in three (9%) of the thirty-four cases that were reviewed. Whilst 9% is lower than the national average of 24%, this is due to the majority of child deaths in Hackney being categorised as 'Medical' (82% of cases).

The national statistics show that just 11% of 'Medical' deaths are classed as modifiable, this is in line with the percentage of modifiable deaths locally. The City and Hackney CDOP is confident that all cases are reviewed comprehensively, and that professional challenge remains a central part of the review process.

2.3 Organisation and resourcing of the CDOP

The CHSCB and Public Health both have significant responsibilities in relation to child deaths. From January 2012 when the CDOP Coordinator post was transferred to the CHSCB, the lead role in supporting the CDOP and responding to the CHSCB child death review responsibilities reverted back from NHS East London and the City to the CHSCB. Since April 2013 the CDOP Coordinator post has been funded through Public Health, as part of the London Borough of Hackney. The CHSCB support the administrative processes needed to ensure adequate collaboration and coordination between the CDOP and other agencies and entities.

For example, the following administrative support has been provided to the CDOP during 2014-15:

- coordination of the CDOP's meetings and workflow planning;
- preparation of information pro-formas (Form Cs) to assist CDOP members in conducting reviews;
- liaison with relevant agencies and bodies about the provision and exchange of confidential information in relation to each of the child deaths;
- completion and return of annual local safeguarding children board child death data collection to Department of Education;

- receipt of all child death notifications and cascading relevant information to key agencies;
- coordination of rapid response meetings;
- follow up on CDOP and rapid response actions and recommendations;
- presenting to front-line staff on recommendations made by the CDOP;
- management of the child death register; and
- implementation of guidelines and processes for collection, storage, retrieval and destruction of highly confidential and sensitive child death case review information.

2.4 Commentary on CDOP operation

Table 2.2 (below) shows a break-down of agency attendance at the CDOP meetings from April 2014 to March 2015 - during this period, there were four meetings.

Table 2.2 Agency attendance at CDOP meetings

Organisation	% of meetings attended
Chair – Public Health	100%
Child Death Overview Panel & Rapid Response Co-ordinator – CHSCB / Public Health	100%
Child Abuse Investigation Team - Metropolitan Police Service	
• Detective Inspector	25%
Children's Social Care – Hackney Council	**75%**
• Head of Safeguarding	50%
• Head of Children in Need	50%
City and Hackney Safeguarding Children Board Team	
• Professional Advisor/Board Manager	50%
City of London	**25%**
• Director, Family & Young People Services	0%
• Children's Social Care	25%
City of London Police	
• Detective Sergeant	25%
Clinical Commissioning Group	**100%**
• Named GP	75%
• Designated Nurse Safeguarding Children & Young People	100%
East London NHS Foundation Trust	
• Named Professional for Safeguarding Children	75%
Education – Hackney Learning Trust	
• Head of Attendance & Behaviour	75%
Hackney Borough Police – Metropolitan Police Service	
• Detective Inspector	50%
Homerton University Hospital – NHS Trust	**100%**
• Consultant Paediatrician	100%
• Consultant Neonatologist and Lead Clinician	75%
• Consultant Midwife – Public Health & Named Midwife for Safeguarding	75%
• Consultant Community Paediatrician, Designated Doctor for Child Deaths	100%
• Named Nurse Child Protection	75%
Royal London Hospital	
• Consultant Paediatric Pathologist	0%

The CDOP reports its themes and learning issues annually to the CHSCB. In addition, the Chair of the CDOP presents the CDOP's findings and recommendations about the health, safety and wellbeing of all children in the London Borough of Hackney and the City of London together with CDOP's system level data to the CHSCB on an annual basis.

The Chair of the rapid response group together with the CDOP Coordinator also presents the CDOP's data, findings and learnings to health care professionals. The most recent presentations took place in February 2015 to health visitors and midwives on safe-sleeping, April 2014 to the Community Paediatricians, and in November 2013 to GPs.

The CDOP's key findings and recommendations are also published in the CHSCB's news bulletin, which is available from CHSCB's website (http://www.chscb.org.uk/).

Chapter 3

Commentary on the 34 cases reviewed & completed by the CDOP

This chapter provides an analysis into the 34 cases reviewed and completed by the CDOP during the period 1st April 2014 to 31st March 2015.

3.1 Neonatal deaths

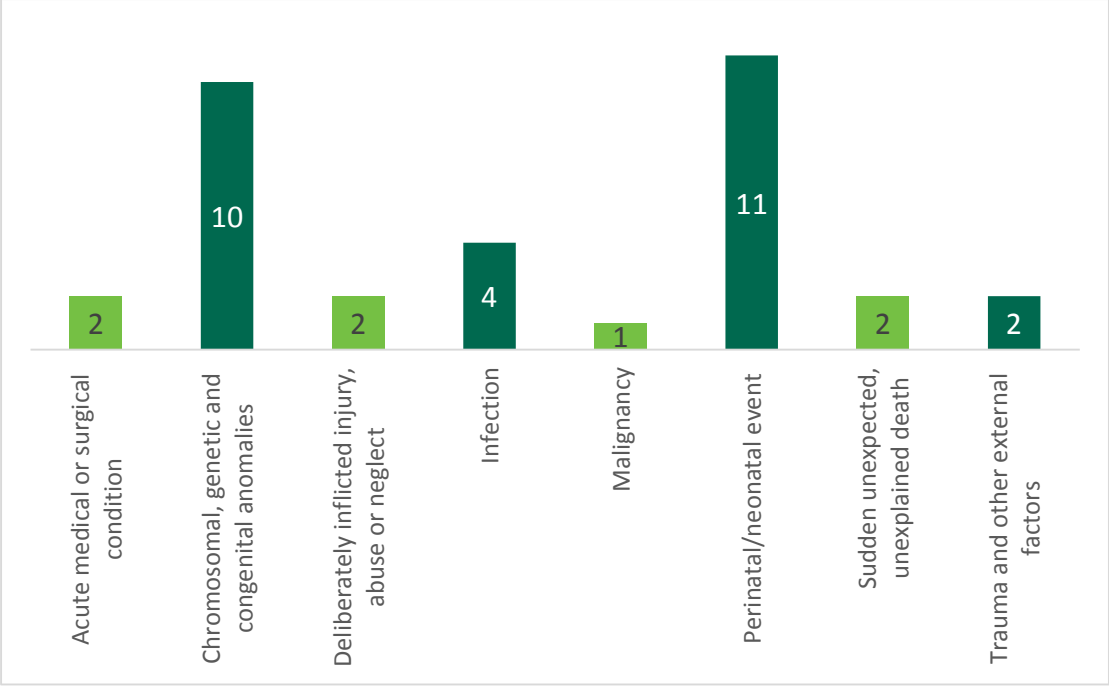
Just under half (16, 47%) of the 34 cases reviewed by the CDOP were deaths occurring within the first 28 days of life (up from 27% last year) and over two-thirds (23, 68%) occurred within the first year of life (up from 58% last year).

Almost half of deaths, (11, 48%) occurring *within* the first year of life were classified by the CDOP as a 'perinatal/neonatal event'. That is, a death ultimately related to perinatal events, including, sequelae of prematurity, antepartum and intrapartum anoxia, bilirubin encephalopathy, broncho pulmonary dysplasia and post-haemorrhagic hydrocephalus irrespective of age at death.

The CDOP classified nearly a third (7, 30%) of deaths occurring *within* the first year of life as due to chromosomal, genetic and congenital abnormalities and just under a tenth (2, 9%) due to sudden unexpected, unexplained deaths. The other three cases were due to infection (2) and acute medical or surgical condition (1).

Just under two-thirds (61%) of the reviewed deaths of children under 1 year were in males.

Figure 3.1 Category of death classified between 1st April 2014 and 31st March 2015



3.2 Gestation at birth

Of the twenty-three deaths that occurred before the first year of life, the gestation of nine (39%) were under 25 weeks, the other fourteen (61 %) being between 30-41 weeks gestation.

Of the eleven 'Perinatal/Neonatal' deaths, nine (82%) of these were under 25 weeks gestation with one born at 39 weeks and one born at 40 weeks gestation.

Figure 3.2 Gestation of baby whose death occurred before the first year of life, reviewed between 1st April 2014 and 31st March 2015

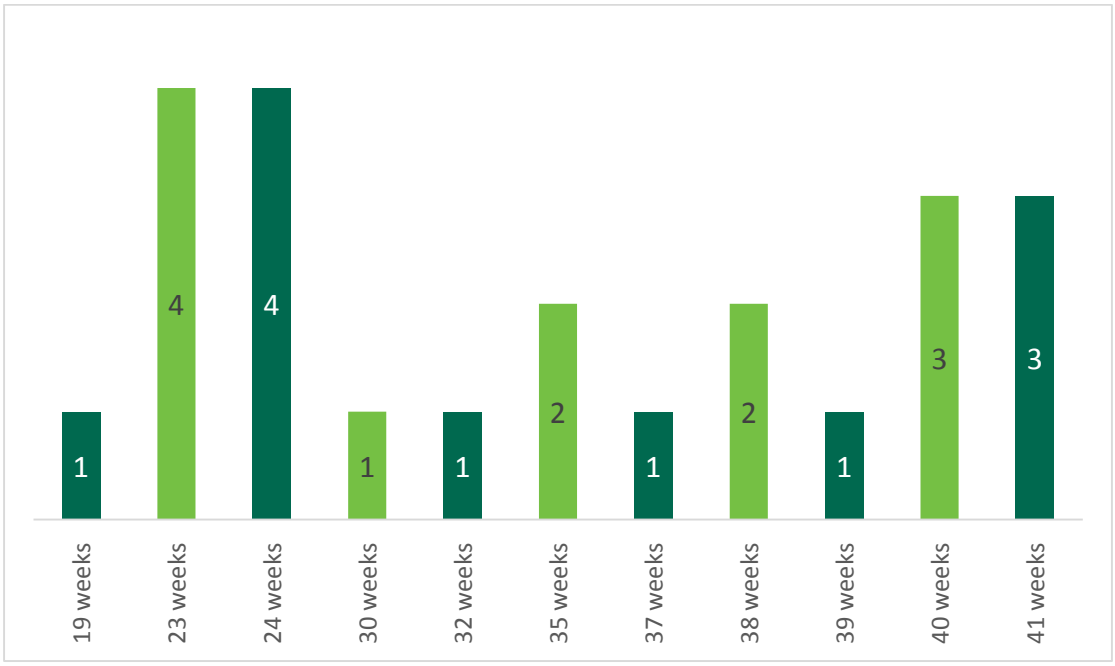
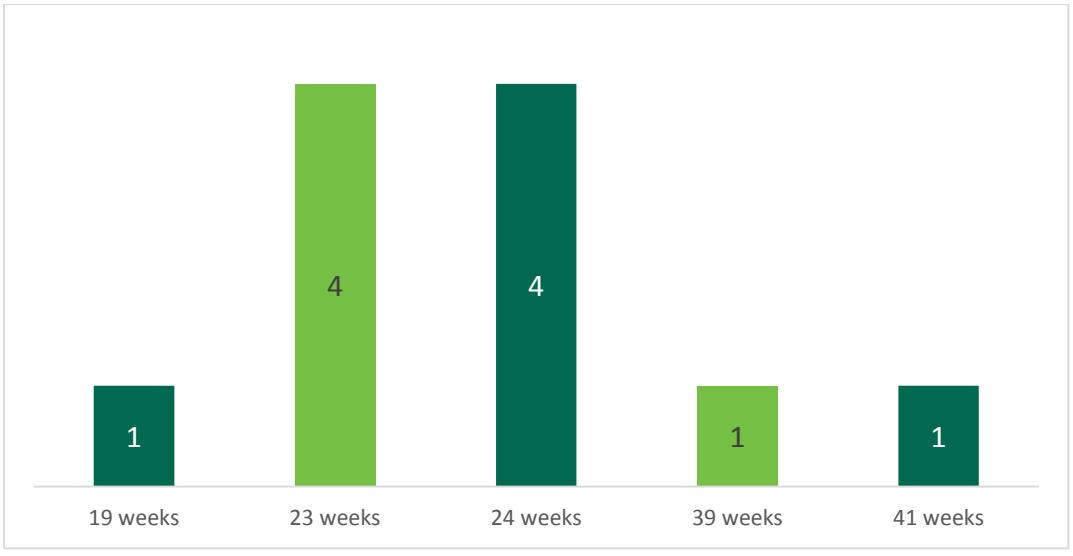


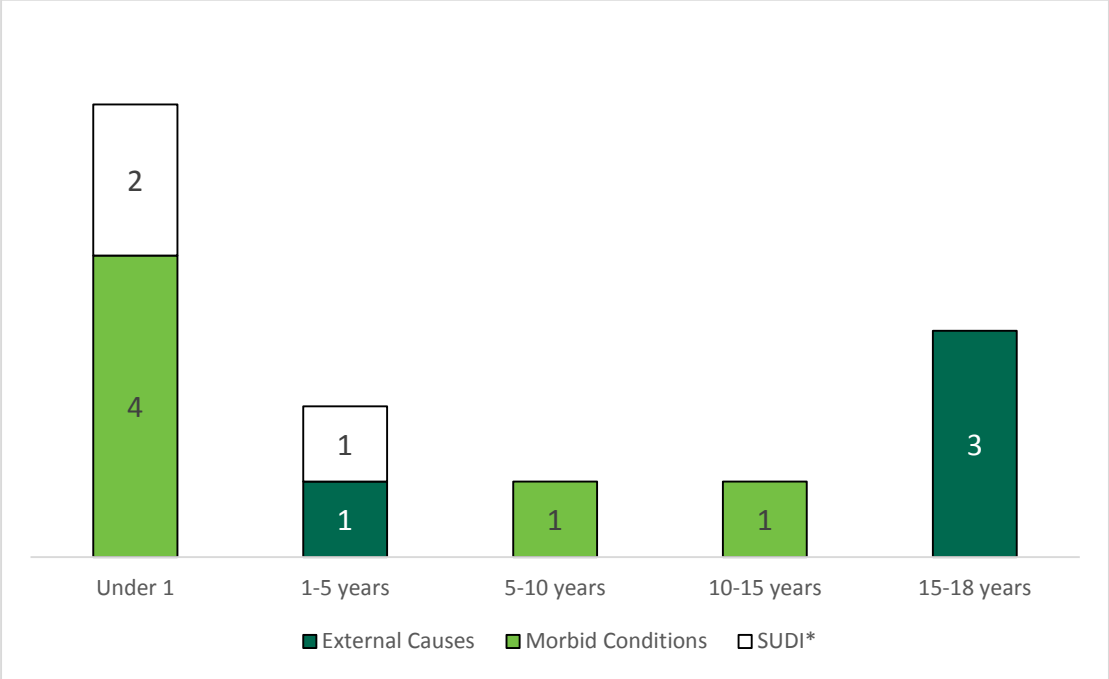
Figure 3.3 Gestation of baby whose death was classified as 'Perinatal/Neonatal', reviewed between 1st April 2014 and 31st March 2015



3.3 Unexpected deaths

Thirteen (38%) of the thirty-four cases reviewed by the CDOP in the period of this report were defined as unexpected deaths (a decrease from 50% last year). Of these unexpected deaths morbid conditions accounted for 6 (46%); external causes accounted for 4 deaths (31%) including three apparent homicides; and 3 (23%) cases were classified by the CDOP as a sudden unexpected death of an infant (SUDI).

Figure 3.4 Unexpected child deaths reviewed by the CDOP 2014-15



* Sudden unexpected death of an infant.

The CDOP considered that modifiable factors may have contributed to the child death in 2 (15%) of the deaths classified as unexpected; this means that locally or nationally achievable interventions could reduce the risk of future child deaths. Although this is below the national average of 24%[5] classed as having modifiable factors, the numbers locally are small (one death = 8%) and so this is not statistically significant.

As a result, the CDOP made recommendations in response to the issues identified in these reviews with the view to potentially improving the health and safety of children. These recommendations are highlighted in chapter 5 of this report.

3.4 SUDIs

Three infant deaths reviewed by the CDOP were classified as sudden unexpected, unexplained death and by the Coroner as: two Sudden Unexpected Death in Infancy (SUDI), and one Natural Cause: Exact Aetiology Unascertained – all were noted as natural causes.

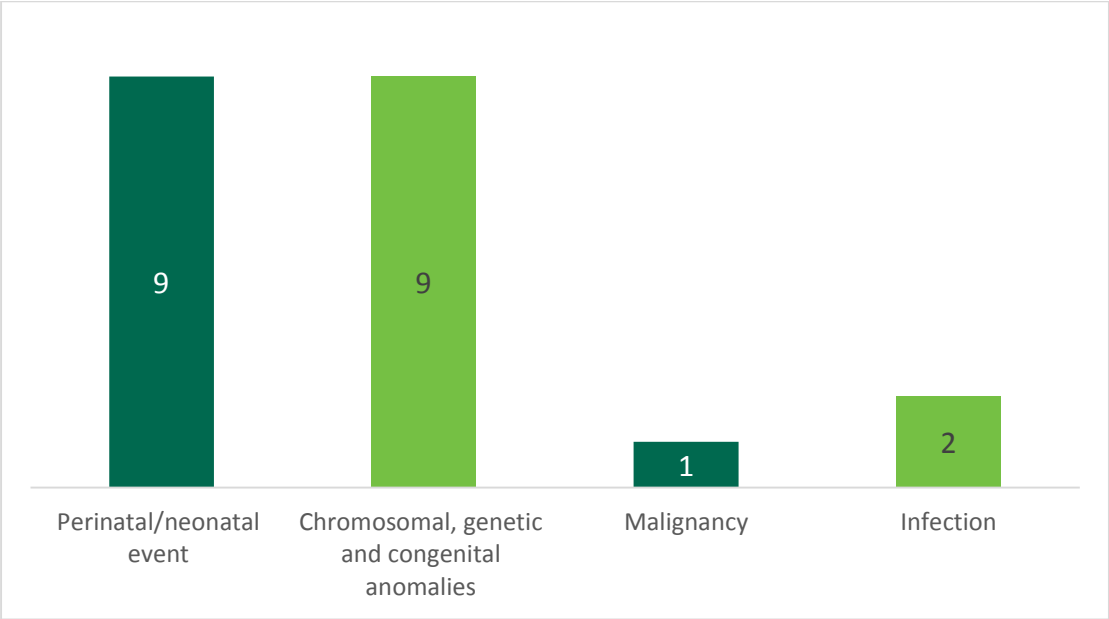
[5] "Child death reviews: year ending 31 March 2015"; https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/444788/SFR23-2015.pdf

The CDOP would like to note that there were no deaths reviewed in this period where co-sleeping was a factor. The CDOP has been committed to raising awareness of this issue since 2008 as a serious risk factor for sudden infant deaths of babies under four months of age. Safer sleeping leaflets continue to be distributed at Children's Centres and safer sleeping seminars have been presented by the CDOP coordinator for front-line healthcare professionals.

3.5 Expected deaths

Twenty-one (62%) of the 34 reviews completed by the CDOP were defined as expected deaths. All of these cases were caused by Morbid Conditions. Nine of these cases (43%) were classified as 'perinatal/neonatal events'; nine (43%) were classified as 'chromosomal, genetic and congenital anomalies'; 2 (10%) were classified as infection; and 1 (5%) was classified as malignancy.

Figure 3.5 Expected child deaths reviewed by the CDOP 2014-15



Chapter 4

Child death statistics

This chapter provides an analysis into the 35 deaths in children and young people that the CDOP was notified of during the period 1st April 2014 to 31st March 2015.

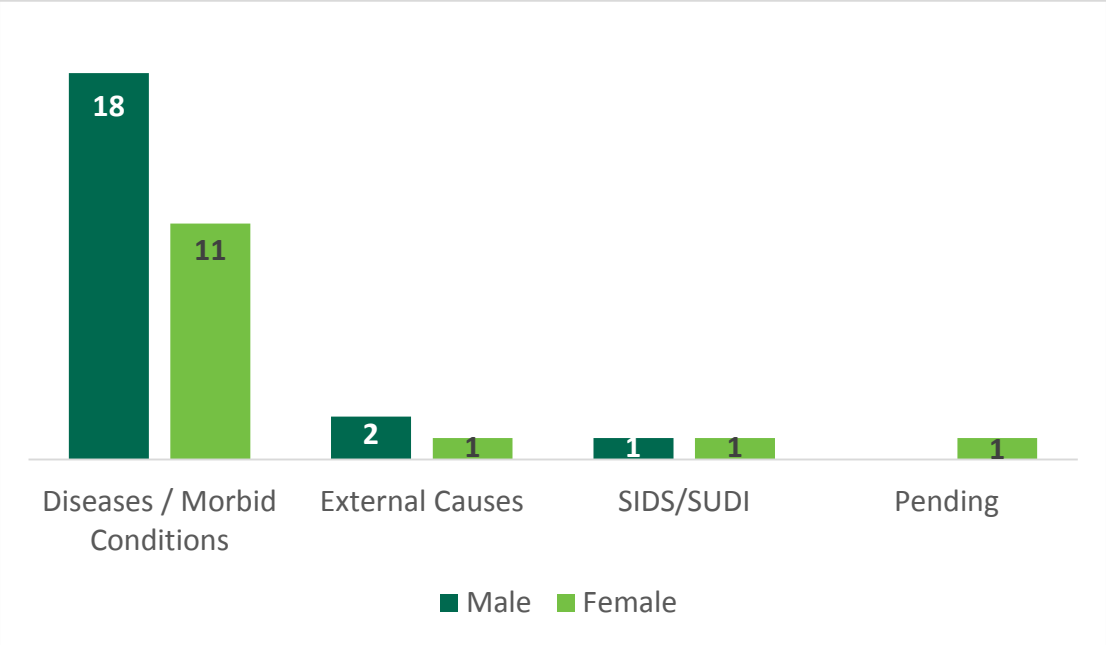
4.1 Cause of death

The CDOP categorises cause of death according to the World Health Organisations' *International Classification of Diseases and Related Health Problems* 10th revision (ICD-10).

The main cause of death (29, 83%) in children in the London Borough of Hackney and the City of London during this period was 'diseases/morbid conditions' (ICD-10). This category included: congenital abnormalities, perinatal conditions and infections.

External cases accounted for 3 deaths (9%), 2 (5%) deaths were classified as SIDS/SUDI and the cause of death is currently pending in 1 (3%) case due to an outstanding inquest.

Figure 4.1 Child deaths in City and Hackney in 2014-15 by cause of death

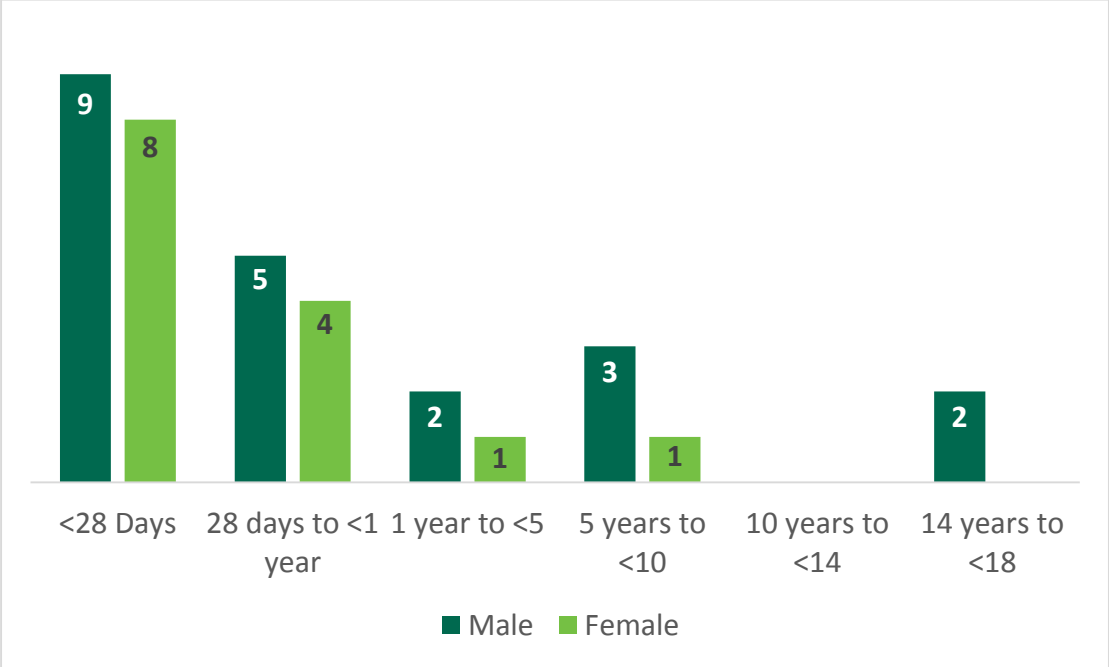


4.2 Age and gender

Of the 35 deaths that took place in the period covered by this report, twenty-one were in males (60%) and fourteen in females (40%).

Three-quarters of all deaths (26, 74%) occurred within the first year and a quarter of all deaths (9, 26%) occurred within the first 28 days of life.

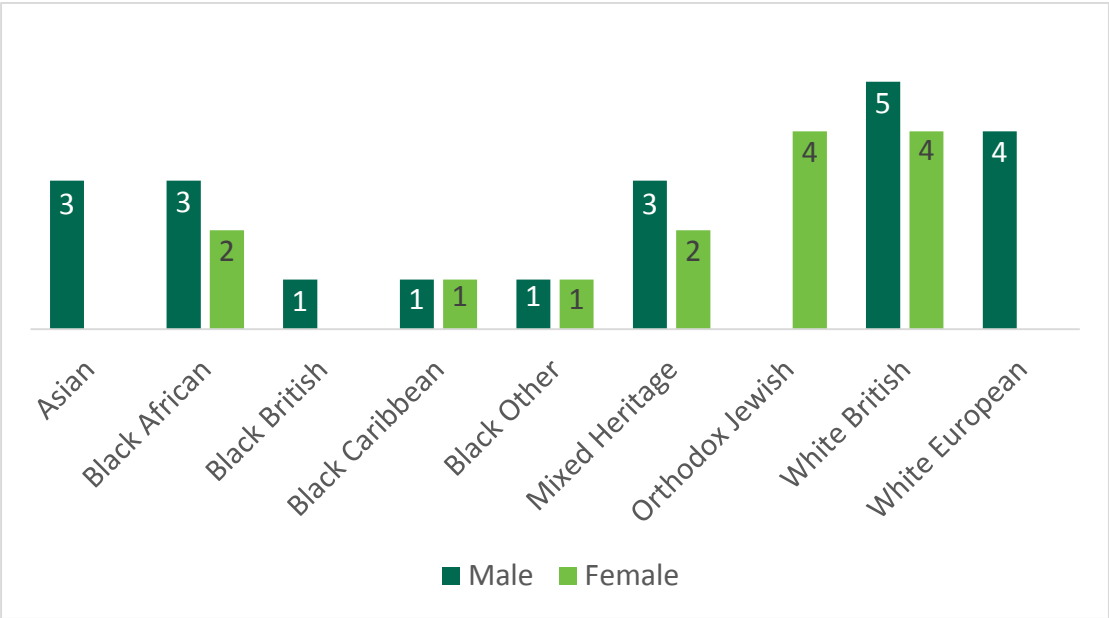
Figure 4.2 Age and gender of child deaths that occurred between 1st April 2014 and 31st March 2015



4.3. Ethnicity

When assessing the deaths by ethnic group, children from Black ethnic groups, including Black African, Black Caribbean, Black British and Black Other continue to be over-represented with 10 deaths (29%) of the total (these groups represent 21% of the total City and Hackney population).[6] However, this is down from 43% last year. 3 deaths (9%) in Asian children; 13 (37%) in White children; 5 (14%) in children of Mixed heritage and 4 (11%) in Orthodox Jewish children.

Figure 4.3 Ethnic groups of deaths occurring during the reporting period

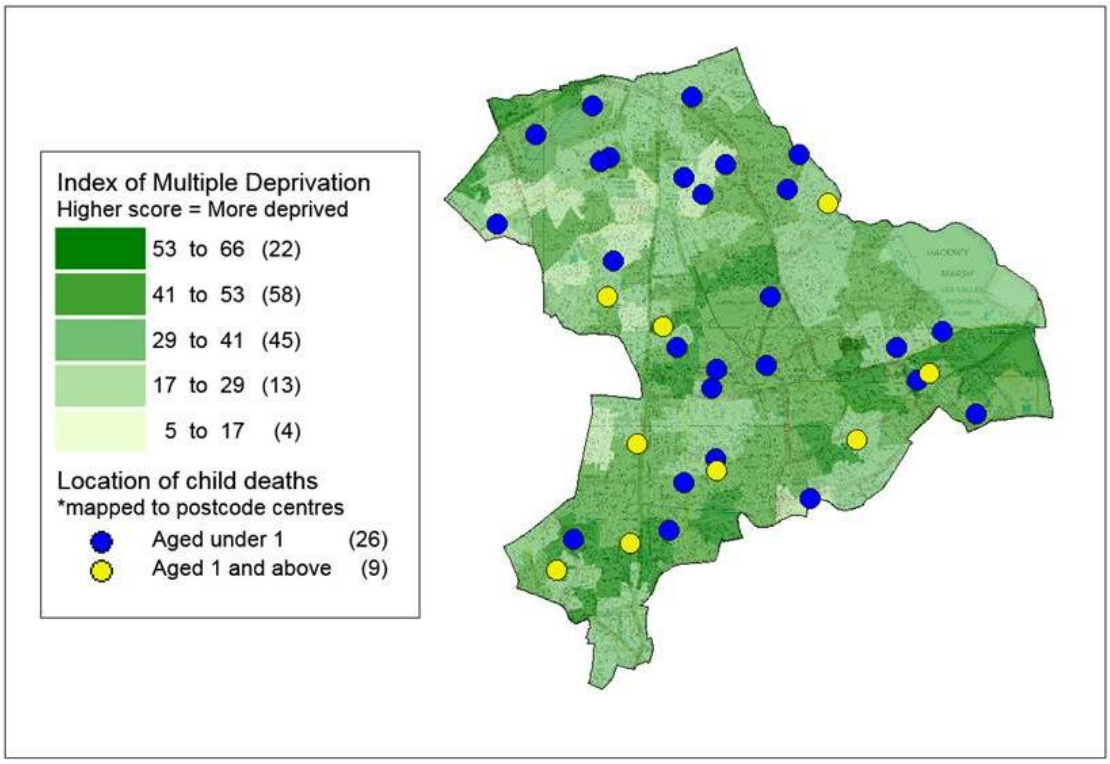


[6] NHS City and Hackney, *Health and Wellbeing Profile 2010/11: Our Joint Strategic Needs Assessment* (2010) 17.

4.4 Geographical distribution

Figure 4.4 shows the location of all child deaths occurring during the period covered by this report, mapped over an Index of Multiple Deprivation score within London Borough of Hackney and the City of London. There were no child deaths in the City of London; over half of the deaths occurred in the most deprived areas with the London Borough of Hackney.

Figure 4.4 Geographical location of child deaths in the London Borough of Hackney and the City of London 2014-15.[7]



There was no significant difference identified in this mapping exercise in relation to the location of the child deaths and the two age groups (infant deaths –aged under 1 year old and deaths in children aged 1 year and over). This has been the trend over the last three years.

The infant mortality rate in Hackney and the City for 2011-2013 according to CHIMAT was 5.7 deaths per 1,000 live births or an average of 26 infant deaths per year[8]. This is an increase from 5.5 last year.

Hackney and the City continue to see a trend in higher numbers of child deaths in the Black ethnic group, this year seeing 29% of deaths in these groups (these groups represent 21% of the population). This figure was 43% of deaths in 2013/14, and 37% in 2011-12 and 2012-13 and so we are seeing a decrease overall.

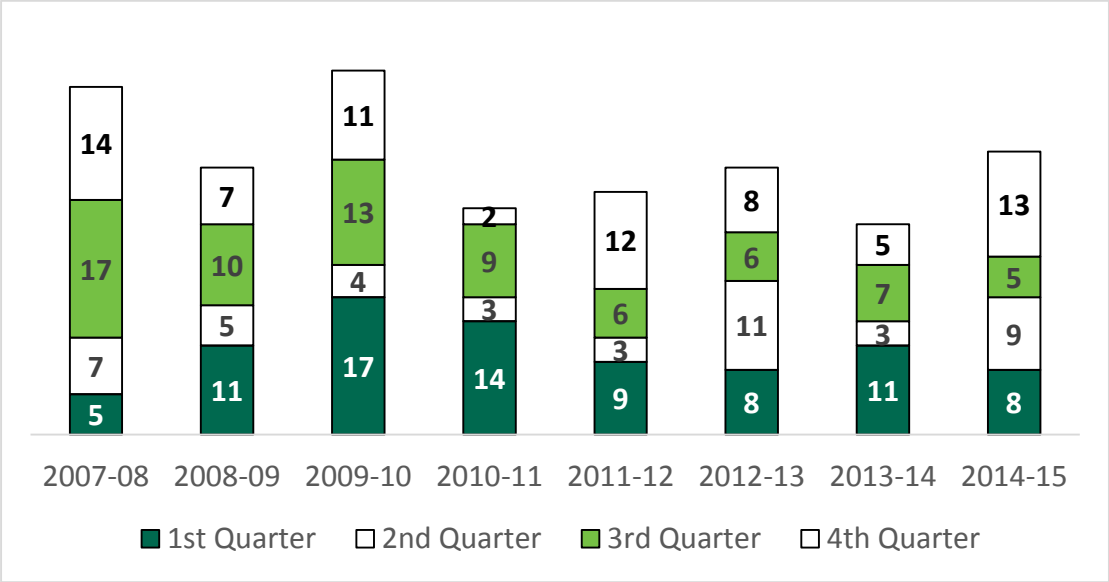
4.5 Seasonal variability

Although the numbers are too small to discard random variation, death counts from 2007-08 until 2014-15 seem to show some degree of seasonal variation. In 2007-08 deaths in children and young people were more common in the 3rd and 4th quarters whereas in the following years deaths seem to be more common during the spring

[7] Source: Indices of Deprivation 2007, Public Health Mortality File, Child Death Overview Panel.
[8] *Child Health Profile: Hackney and City of London,* CHIMAT, March 2015.

and autumn months (1st and 3rd quarter). Quarter 2 tends to see the least deaths. However, 2014-15 saw deaths most common in quarters 2 and 4. It must be noted that the figures are small and the differences are not statistically significant.

Figure 4.5 Deaths stratified by month of occurrence



Chapter 5

Recommendations to the City and Hackney Safeguarding Children Board

5.1 Learning points and recommendations

Wherever possible the CDOP seeks to improve the child death review process and indirectly impact upon the safety and wellbeing of children and young people in the area. The main reason for focussing on the child death review process itself is that its quality directly influences the extent of learning derived from the process. The identification of learning in turn plays a significant role in informing and improving the safety, wellbeing and services to children and young people in the London Borough of Hackney and the City of London.

5.2 Response to issues identified in relation to the child death review process

The achievements of the CDOP and the rapid response group in improving the child death review process during 2014-15 include:

- the panel decided unanimously that baby deaths with a gestational age of less than 23 weeks will no longer be discussed or reviewed at CDOP due to their age being non-compatible with life, to allow for a more detailed discussion of other cases and to continue to focus on learning and improvements;
- the delivery of a safer-sleeping presentation (February 2015) by the Single Point of Contact for child deaths to health visitors, children's centre staff and midwives as part of their induction and development programmes;
- highlighting the importance of the child death process, particularly the need for information sharing, by writing to the Senior Coroner and having her attend CDOP for a broader discussion with key partners;
- highlighting the need to collect more robust information on children who die abroad, by writing to the Foreign and Commonwealth Office and requesting a change in protocol;
- completion of the suicide audit by the Public Health Team, following an increase in numbers of self-inflicted deaths recorded the previous year in Hackney.

5.3 Response to issues identified in relation to children and young people's safety, health and wellbeing and delivery of services

As noted previously the review process is an opportunity to analyse and evaluate the service delivery and system responses with the potential to improve outcomes for children and families, improve interagency working and identify, prioritise and plan for local needs.

The CDOP aims to ensure that its child death case reviews identify issues that may indicate broader trends which could be intervened upon to improve the health and safety of children and prevent child deaths. In general, the achievements of the CDOP and the rapid response group in furthering the child death review process and

improving the wellbeing and safety of children and young people during 2014-15 were:

- continuing to ensure in relevant cases that parents and siblings are referred to genetic screening and counselling;
- working with Public Health to produce a Suicide Audit;
- working with the Lullaby Trust to amend a leaflet advising parents of the CDOP process, to allow full engagement and a transparent process in a local way;
- ensuring baby packs that are sent to new parents in Hackney, supported by the Public Health team, contain safe sleeping and sling-safety leaflets;
- continuing the implementation of the universal vitamin D supplementation to pregnant women and children under 4 years old through the “A Healthy Start for All” programme through community pharmacies.

Chapter 6
Emerging themes and future developments

6.1 Emerging themes

In response to possible themes identified by the CDOP through its case reviews, the CDOP will organise a 'themed' meeting with the aim of furthering the panel member's knowledge and awareness. The CDOP highlighted in last year's annual report that it has seen a sharp increase in the number of deaths categorised as self-inflicted or suicide (in 2013-14 [9, 35%], compared to previous years 2012-13 [4, 12%] and 2011-12 [2, 7%]), and so held a themed meeting on self-harm, presented by the East London Foundation Trust. Public Health also presented the findings of the Suicide Audit to the panel, to aid knowledge and understanding on suicides and self-harm.

The CDOP can also use quarterly panel meetings to invite key stakeholders to present on their functions and work in relation to child deaths; to further the relationships between agencies and to ensure the focus remains on information sharing with an aim to prevent future deaths. In the period 2014-15 the CDOP invited the Senior Coroner for Inner North London to speak to the panel, to increase the knowledge of CDOP members on Coronial processes. The Coroner attended a meeting in the period 2015-16 and so will be reported on fully in next year's annual report.

The panel discovered historic Female Genital Mutilation (FGM) in one case of the mother of the deceased child. An FGM strategy for the City of London and Hackney has been developed by the Public Health team in conjunction with social care, health, the police and education to develop protocol for all agencies to refer cases of identified or suspected FGM.

6.2 Implementation of recommendations from 2013-14 and outcomes

The following updates can be noted in relation to recommendations highlighted in last year's annual report as requiring future actions to prevent child deaths:

- Awareness raising of safe sleeping messages continues to be a priority for the CDOP and the Single Point of Contact for child deaths presented on Safer Sleeping to health visitors, children's centre staff and midwives.
- continuation of the universal vitamin D supplementation to pregnant women and children under 4 years old through the "A Healthy Start for All" programme through community pharmacies.
- The London Ambulance Service Quality and Nursing Director has met with the Chief Coroner with a view to changing the direction for the removal of bodies of over 2's to be in line with Working Together, outcome pending.
- The CDOP has gained consent from the Coroner to allow Paediatric Consultants to take metabolic samples shortly after death and before the post mortem.
- The Coroner has agreed to send learning and recommendations, through Regulation 28 reports, directly to the CDOP following inquests, to further extend the learning from child deaths across agencies.

Appendix 1

Impact log: 2014/15

Date	Source[9]	Problem/Issue	Action	Impact
July 2014	CDOP Quarterly Meeting.	More robust details needed from hospital forms for babies.	Request yellow forms from hospitals for all baby deaths.	More robust information collected, leading to comprehensive reviews of child deaths.
July 2014	CDOP Coordinator, through communication with other CDOPs nationally.	Deaths have occurred nationally involving improper use of baby slings. There have been no deaths locally due to improper use of baby slings.	CDOP secured a sling safety leaflet and will distribute to all new parents in the borough via the 'baby box' – a new project piloted by the Hackney Public Health team.	Impact will be measured over a longer period of time - Hackney and the City have not seen any sling-related deaths since collection of information began in 2008. However, the CDOP hopes this will proactively encourage safe sling use and mitigate future risks of sling-related deaths.
July 2014	CDOP Quarterly Meeting.	Parents awareness of the CDOP process – greater transparency wanted in Hackney and the City of London	CDOP has worked with the Lullaby Trust to tailor a local leaflet to inform parents of the CDOP process whilst informing them of their options after losing a child	Raising awareness of CDOP amongst parents/relatives and allowing parents input into the process. This will provide a more comprehensive and robust review.
September 2014	Rapid Response Meeting.	LAS protocol differs to 'Working Together' guidance on removal of	LAS are currently reviewing their practice and the Medical Director	No immediate impact whilst we await confirmation

[9] This refers to the source in which the issue was identified.

		young people's bodies to A&E. LAS only practice this for children aged 2 or under. Working Together states all under 18s must be taken to a hospital first (with the exception of forensic cases) for history to be taken.	has met with the Chief Coroner to discuss further.	of these changes. To be monitored.
September 2014	Rapid Response Meeting.	Possible deterioration of samples when taken at PM with metabolic disease – hospitals unable to take samples post death due to Coroner protocol.	CDOP wrote to the Coroner to ask that Consultant Paediatricians be allowed to take samples from children and young people immediately after death to aid the Coroner's investigation – Coroner has allowed this and change in policy has been cascaded to local hospitals.	Potential impact of underlying metabolic conditions contributing to death being discovered whilst samples are still viable. This will further the understanding of some children's deaths and aid learning and improvement through the CDOP process.
January 2015	CDOP Quarterly Meeting.	Suicide/deliberated inflicted death by injury increase in 2013/14 in Hackney.	Suicide Audit completed by Public Health team.	Local review of suicides and self-harm to help CDOP members understand the issue and to flag with CHSCB. There have been no self-inflicted deaths in the year 2014/15.
February 2015	CDOP Coordinator	The information exchange that follows a death abroad is very limited.	CDOP has written to the Foreign Commonwealth Office (cc'ed Department for Education) to request that	The CDOP awaits a response before it can begin to measure impact.

			routine information be gathered by the FCO and shared with the relevant CDOP.	
March 2015	CDOP Quarterly Meeting.	Disjointed working between CDOP and the Coroner – can be an obstacle to reviewing deaths, particularly with PM reports.	Senior Coroner to attend a CDOP meeting in July 2015.	Impact to be measured following visit.