city & hackney safeguarding children board

Child Death Overview Panel
Annual Report 2016/17

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

Contents

Message from the Chairperson

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 like to offer my condolences to the families, carers and friends of those children and young people whose deaths occurred during this reporting period.

Complementary to any judicial process, 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.

The City and Hackney Child Death Overview Panel (CDOP) is the 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. This enquiry is carried out in a manner which promotes learning and transparency and, in order that future lives are protected, identifies and addresses risks and makes recommendations, locally and nationally, to change or improve services.

The City and Hackney CDOP became active on the 1st of April 2008, since when it has reviewed the deaths of 253 children and young people. All recommendations made by the CDOP have been implemented or are in the process of being implemented.

This year's Annual Report of CDOP reports on the processes and findings. During the 2016-17 reporting period the CDOP reviewed the deaths of 18 children and young people.

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.

In 2016, Ofsted graded the City & Hackney Safeguarding Children Board as outstanding for its work in City & Hackney – this is the first time an LSCB in the UK has been awarded outstanding. Ofsted mentioned specifically that arrangements for the review of child deaths were highly effective, and the identification of issues of concern led to well-targeted public awareness across City and Hackney.

I would like to take this opportunity to thank the members of CDOP for their contribution to the review process. They have brought a wealth of experience, commitment, challenge and support over the last year. 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 Yasmin Mulla and Kerry Littleford for their unfailing commitment, and efficient support to myself and 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 s47 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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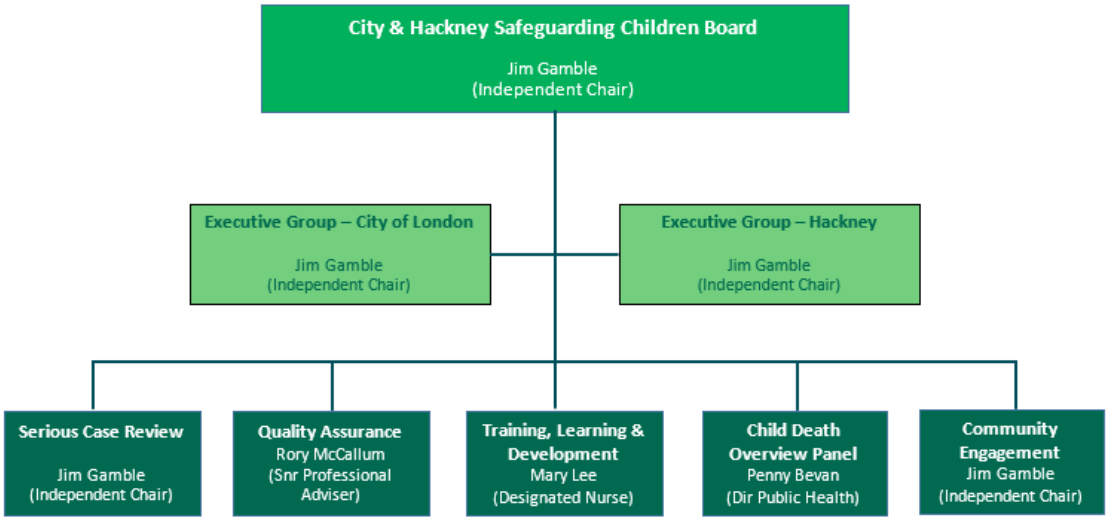
[1] *Royal College of Paediatrics and Child Health Guidance on Child Death Review Processes* (2008) 2.
[2] *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* (2015).

Figure 1.1 Structure of the CHSCB



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, 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 and acts as Single Point of Contact (SPOC) for all child death notifications.

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 are normally resident 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 completes a statistical data return for annual submission to the Department for Education and produces this annual report.

1.3.2 Neonatal deaths

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 homicide, and deaths as a result of medical causes.

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, and consider bereavement support for any other children, family members or members of staff who may be affected by the child's death.
- 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, making sure the appropriate professionals maintain 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;

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.

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

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 of April 2016 to the 31st of March 2017, there were 26 deaths in children and young people who were normally resident in the London Borough of Hackney, and one death of a child who was normally resident in the City of London.

The most recent released child mortality rate (age 1-17 years) as at March 2017 from the Child and Maternal Health Observatory (Chimat) *Child Health Profile* is 14.4 in Hackney and City of London compared to a national average of 11.9 per 100,000 children.[4] The infant mortality rate is 5.4 per 1000 births compared to a national average of 3.9. Both rates remain higher locally. You can see rates locally and nationally from 2010 – 2017 in table 2.1.

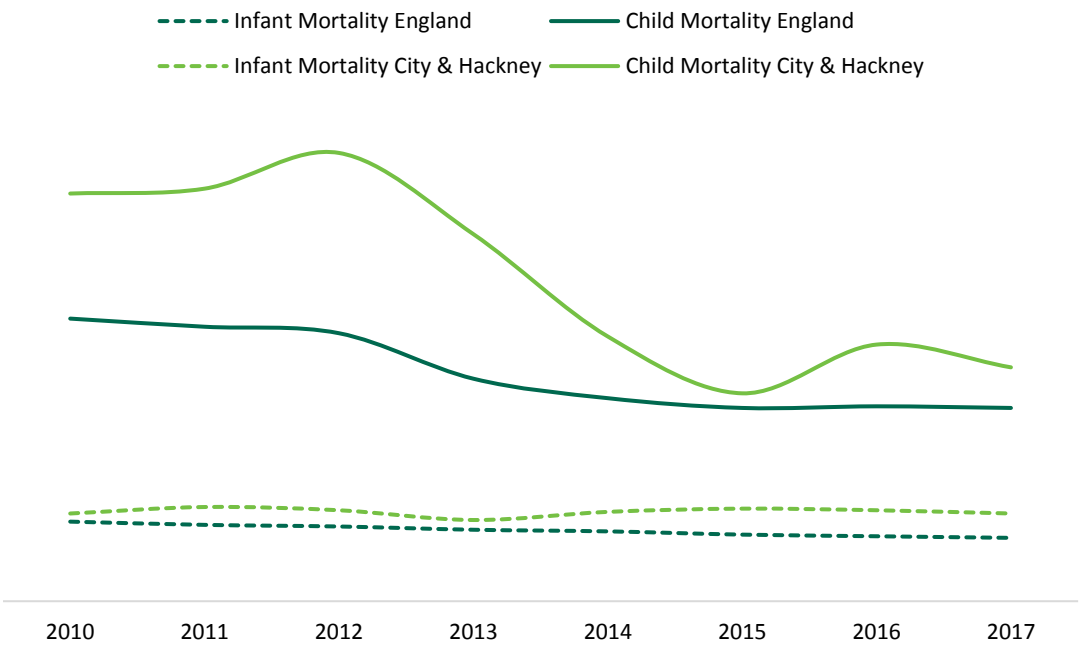
Between 2010 and 2017 there has been a steady downward trend in mortality rates nationally both for infants and children. City and Hackney have seen increases in the earlier years, followed by a decline until the end of 2015. 2016 saw a small increase, which has decreased again in 2017. In particular it is worth noting the sharp decrease in child mortality rates in the City and Hackney from 2013 shown in figure 2.1. Please note that these figures have been taken from Chimat where aggregated data for the previous 3 years make up each year's figure.

Table 2.1 Child and Infant Mortality 2010-20170 (Chimat)

	2010	2011	2012	2013	2014	2015	2016	2017
Infant Mortality (England)	**4.9**	**4.7**	**4.6**	**4.4**	**4.3**	**4.1**	**4.0**	**3.9**
Infant Mortality (City & Hackney)	**5.4**	**5.8**	**5.6**	**5.0**	**5.5**	**5.7**	**5.6**	**5.4**
Child Mortality (England)	**17.4**	**16.9**	**16.5**	**13.7**	**12.5**	**11.9**	**12**	**11.9**
Child Mortality (City & Hackney)	**25.1**	**25.4**	**27.6**	**22.6**	**16.3**	**12.8**	**15.8**	**14.4**

[4] *Child Health Profile: Hackney and City of London,* CHIMAT, March 2017.

Figure 2.1 Child and Infant Mortality 2010-2017 (Chimat)



2.2 Number of meetings held and reviews conducted

The CDOP has reviewed and completed 18 cases during the period from the 1st of April 2016 to 31st March 2017. The 18 cases completed included 6 outstanding cases from the period covering 1st April 2015 to 31st March 2016 and 12 cases from the current year, 1st of April 2016 to 31st March 2017.

15 cases are pending review of the CDOP.

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

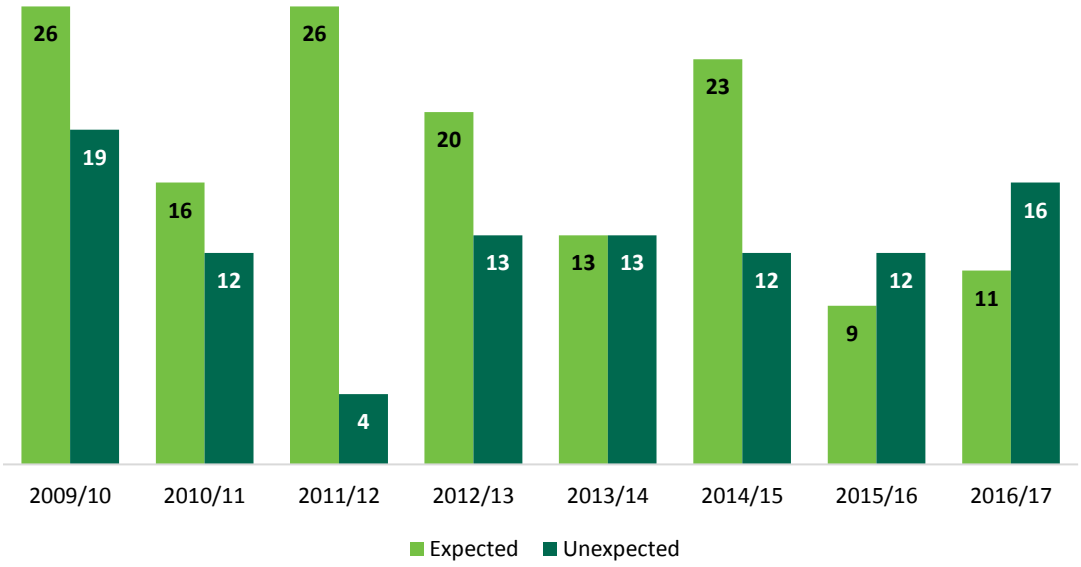
- categorisation of death;
- modifiable factors of death;
- issues;
- learning points;
- recommendations;
- follow up plans for the family (where relevant); and
- whether the case warrants referral to another agency for further investigation.

2.2.1 Rapid response group

The rapid response group, which is monitored by the CDOP, has considered the unexpected deaths of 16 (59%) of the 27 children and young people notified during the period 1st of April 2016 to 31st March 2017. This is the second year in a row that unexpected deaths were higher than expected (as shown in figure 2.2), and only the second year that this has happened since the CDOP was established. Expected deaths have seen a steady decline from 2009 to 2014, with a sharp drop in 2015 – however a small increase was seen in 2016. Unexpected deaths declined rapidly between 2010 and 2012, but remained fairly constant from 2012 to 2015 – rising slightly in 2016.

Some child deaths considered at rapid response meetings may require further review. These are discussed at the Serious Case Review sub-group. None of the sudden deaths reviewed by the rapid response group during 2016-17 were recommended to be subject to a formal Serious Case Review. However, the death of one child was subject to a local multi-agency review and the suicides of two young people and a 19 year old have resulted in the commission of a review to explore the themes, patterns and trends arising within these cases.

Figure 2.2 Expected and Unexpected deaths 2009-17



The venue of each rapid response meeting will depend on where the child has died. During 2016-17, 5 venues were used to hold rapid response meetings. See table 2.2 for a breakdown of all rapid response venues during the last year. Attendance has been positive throughout the year, with the Police, Local Authority, Education and Health staff (including the London Ambulance Service) prioritising their contributions to these important meetings.

Table 2.2 Venues of rapid response meetings

Venue	Number of meetings held
Homerton University Hospital	10
Hackney Service Centre	1
Great Ormond Street Hospital	1
Whipps Cross Hospital	1
Royal London Hospital	2
Total	**15**

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 5 of the 18 completed case reviews (27.8%), including co-sleeping, and unclear communication.

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 PCT 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 2016-17:

- coordination of the CDOP's meetings and workflow planning;
- preparation of information proformas (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 2.3 (below) shows a break-down of agency attendance at the CDOP meetings from April 2016 to March 2017 - during this period, there were four meetings.

Table 2.3 Agency and Professional 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	**25%**
• Head of Safeguarding	0%
• Service Manager, Children in Need	25%
City and Hackney Safeguarding Children Board Team	
• Professional Advisor/Board Manager	25%
City of London	
• Children's Social Care	25%[5]
City of London Police	
• Detective Sergeant	0%[5]
Clinical Commissioning Group	**50%**
• Named GP	0%
• Designated Nurse Safeguarding Children & Young People	50%
East London NHS Foundation Trust	
• Named Professional for Safeguarding Children	75%
Education – Hackney Learning Trust	
• Head of Wellbeing and Education Safeguarding	100%
Hackney Borough Police – Metropolitan Police Service	
• Detective Inspector	75%
Homerton University Hospital – NHS Trust	**100%**
• Consultant Paediatrician & Named Doctor	25%
• Consultant Neonatologist and Lead Clinician	50%
• Consultant Midwife – Public Health & Named Midwife for Safeguarding	100%
• Consultant Community Paediatrician, Designated Doctor for Child Deaths	100%
• Named Nurse Child Protection	25%

In terms of attendance at CDOP meetings, it is important to note that whilst both the Metropolitan Police Service and ambulance services haven't been able to attend formal panel meetings, as services, both have been highly engaged, responsive and extremely proactive in all the rapid response meetings held during 2016-17.

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.

[5] There were 0 deaths in City of London residents that were reviewed in 2016/17. City representatives on the panel are only requested when there are cases to be discussed.

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. Further presentations about the CDOP Process are being planned with the local Neonatal team, and safer sleeping training for professionals is also being planned.

The CDOP continues to highlight the importance of attendance at both CDOP meetings and rapid response meetings to partners.

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 18 cases reviewed & completed by the CDOP

This chapter refers to the 18 cases reviewed and completed by the CDOP during the period 1st of April 2016 to 31st March 2017.

3.1 Neonatal deaths

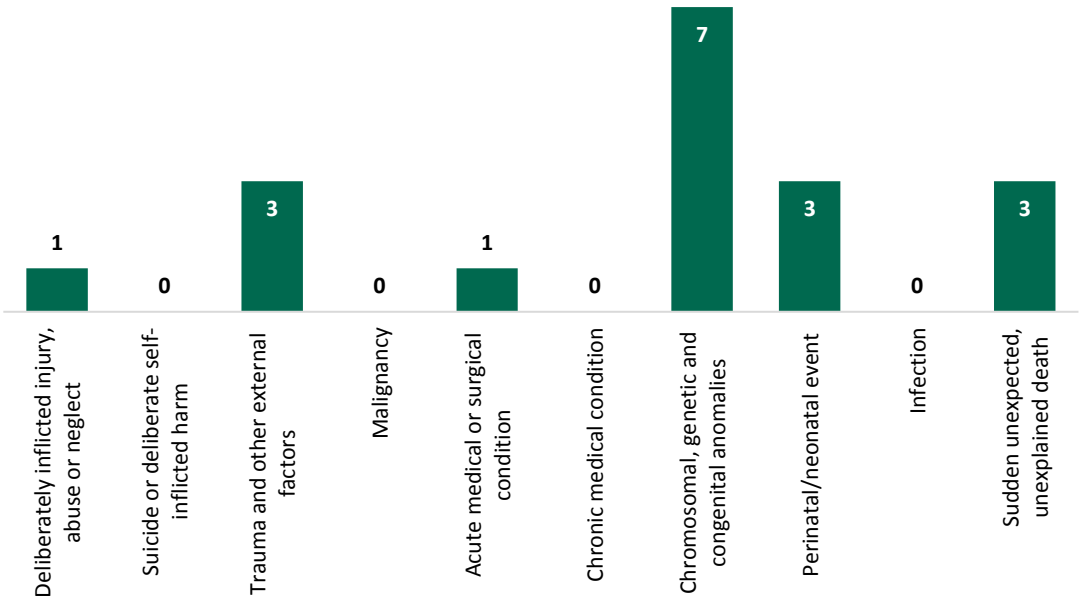
Seven (39%) of the eighteen cases reviewed by the CDOP were deaths occurring within the first 28 days of life (down from 50% last year and 47% the year before) and ten (56%) occurred within the first year of life (down from 86% last year and 68% the year before).

Almost a third of deaths, (3, 30%) 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, bronchopulmonary dysplasia and post-haemorrhagic hydrocephalus irrespective of age at death.

The CDOP classified half (5, 50%) of deaths occurring *within* the first year of life as due to chromosomal, genetic and congenital abnormalities. The other two cases (20%) were due to sudden unexpected, unexplained death.

Five (50%) of the reviewed deaths of children under 1 year were in females. This is down from 58% females last year.

Figure 3.1 Category of death classified between 1st April 2016 and 31st March 2017

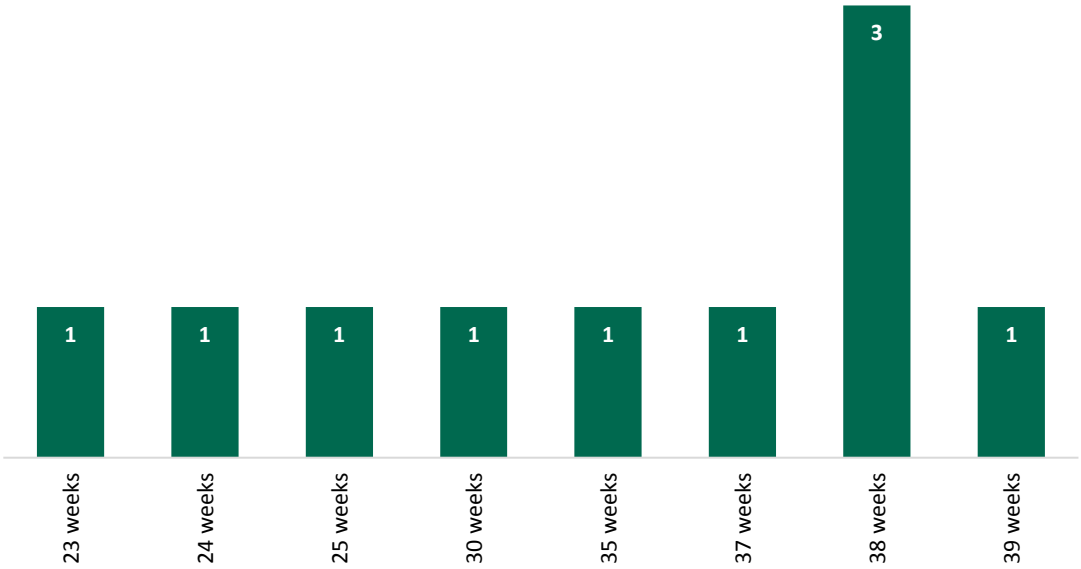


3.2 Gestation at birth

Of the ten deaths that occurred before the first year of life, the gestation of three (30%) were up to and including 25 weeks (up from 16% last year), and seven (70%) were between 26-42 weeks gestation.

Of the three 'Perinatal/Neonatal' deaths, two (67%) of these were under 25 weeks gestation (up from 38% last year), and one was born at 25 weeks gestation.

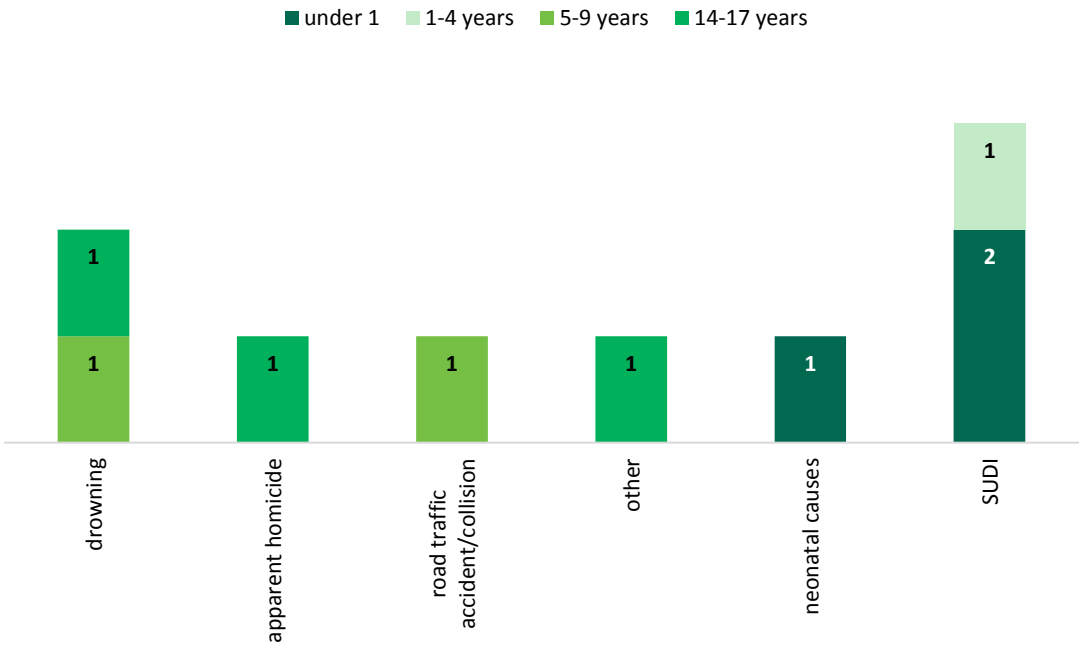
Figure 3.2 Gestation of babies whose death occurred before the first year of life, reviewed between 1st April 2016 and 31st March 2017



3.3 Unexpected deaths

Nine (50%) of the eighteen cases reviewed by the CDOP in the period of this report were defined as unexpected deaths (the same percentage as last year). Of these unexpected deaths 'sudden and unexpected death in infancy [SUDI]' accounted for 3 (33%); 'drowning' accounted for 2 (22%) there was one 'apparent homicide' (11%), one 'road traffic accident/collision' (11%), one 'neonatal death' (11%) and 1 (11%) case was classified by the CDOP as 'other' (due to an acute medical or surgical condition).

Figure 3.3 Unexpected child deaths reviewed by the CDOP 2016-17



The CDOP considered that modifiable factors may have contributed to the child death in 5 (28%) of the deaths classified as unexpected; this means that locally or nationally achievable interventions could reduce the risk of future child deaths. This is slightly higher than the national average of 27%[6].

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

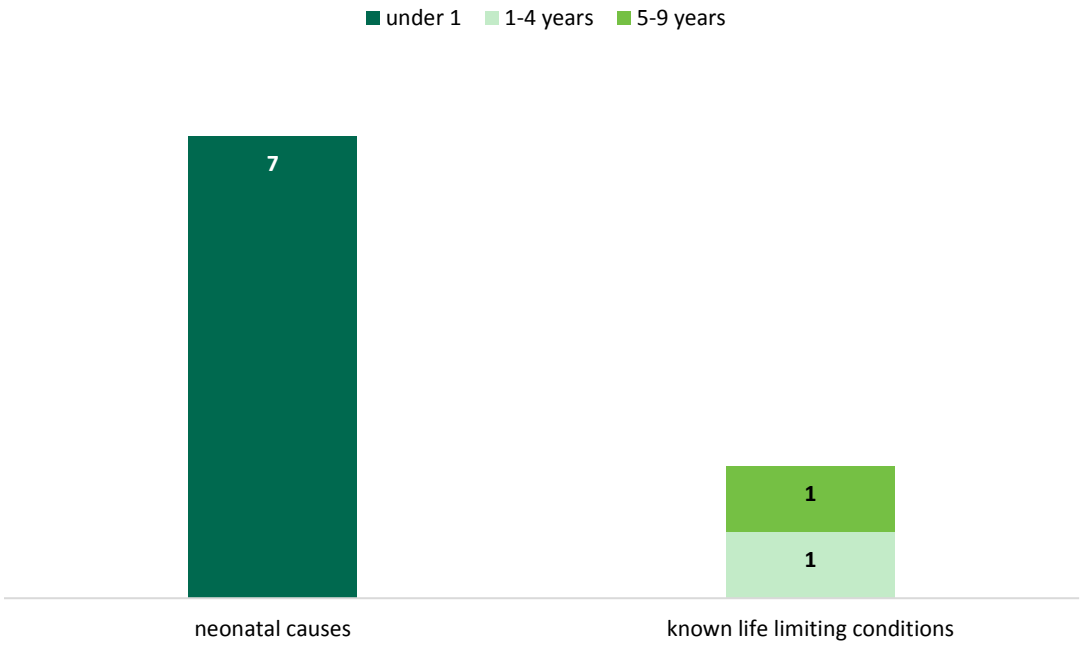
Three infant deaths reviewed by the CDOP were classified as sudden unexpected, unexplained death and by the Coroner as: Sudden Unexpected Death in Infancy (SUDI) in unsafe sleeping environment, Sudden Unexpected Death in Childhood (SUDC), and Sudden Unexpected Death in Infancy (SUDI) associated with co-sleeping.

The CDOP continues to be committed to raising awareness of safer sleeping 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 through health professionals, and safer sleeping seminars have been presented by the CDOP coordinator for front-line healthcare professionals. Further training for health professionals around safer sleeping is also being planned.

3.5 Expected deaths

Nine (50%) of the eighteen reviews completed by the CDOP were defined as expected deaths. Seven of these cases (78%) were classified as 'chromosomal, genetic and congenital anomalies', and two of these cases (22%) were classified as 'perinatal/neonatal events'.

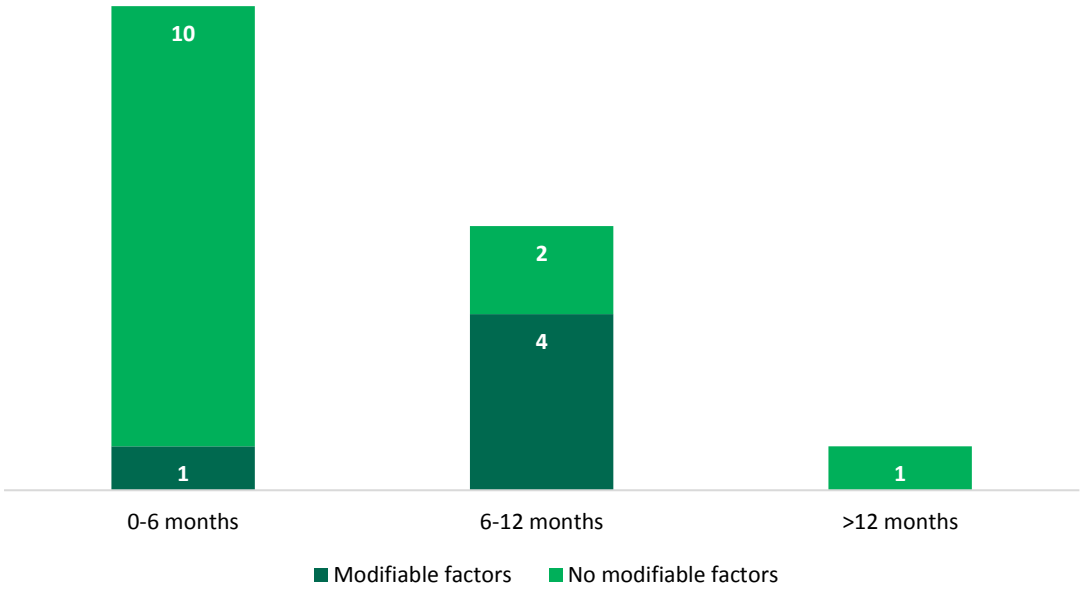
Figure 3.5 Expected child deaths reviewed by the CDOP 2016-17



3.6 Time from death to completion of review

The below graph shows the time taken from the date of the death to completion of review. The majority of cases (61%) were completed within 6 months of death.

Figure 3.6 Percentage of reviews completed in 2016/17 with modifiable factors by time taken



Chapter 4

Child death statistics

This chapter refers to the 27 deaths in children and young people that the CDOP was notified of during the period 1st of April 2016 to 31st of March 2017.

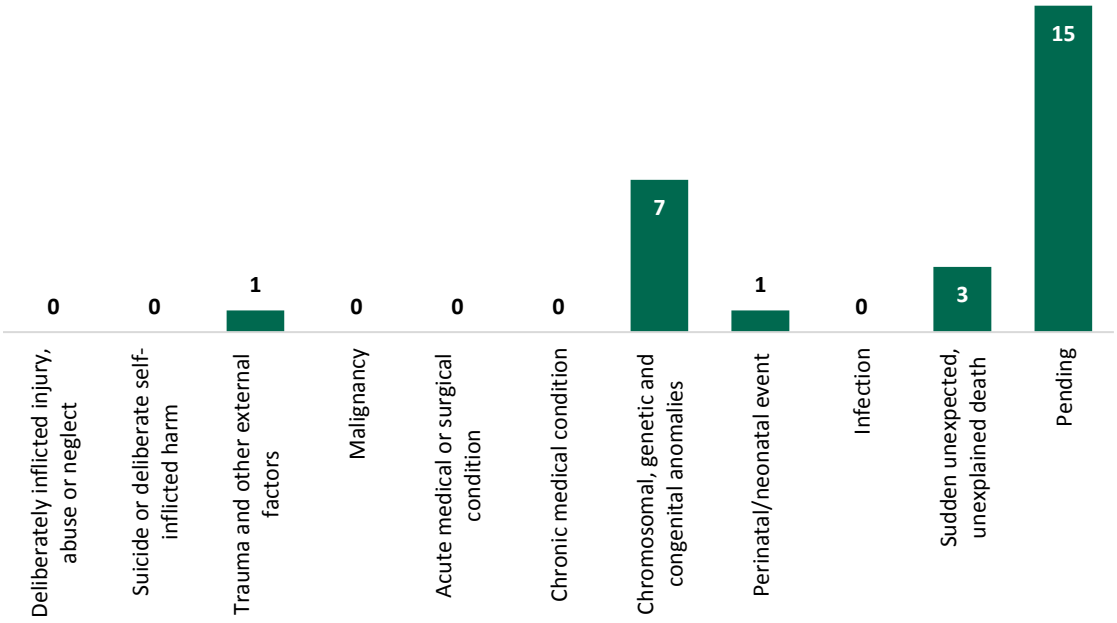
4.1 Cause of death

The CDOP categorises cause of death according to classifications determined by the Department for Education. There are 10 categories and these can be seen in Figure 4.1.

The main category of death (7, 26%) determined in children in the London Borough of Hackney and the City of London during this period was 'Chromosomal, genetic and congenital abnormalities'. 3 deaths (11%) were categorised as sudden, unexpected, unexplained death, 1 (4%) was categorised as being due to trauma and other external factors, and 1 death (4%) was categorised as a perinatal/neonatal event.

The cause of death is currently pending in the other 15 (55%) cases due to either waiting to be reviewed at the next CDOP, outstanding Coroner inquests, or agency investigations. The number of pending reviews is higher than normal, due to the fact that a large proportion of the deaths occurring in 2016/17 (44%) occurred in the final quarter of the year.

Figure 4.1 Child deaths in City and Hackney in 2016-17 by category of death

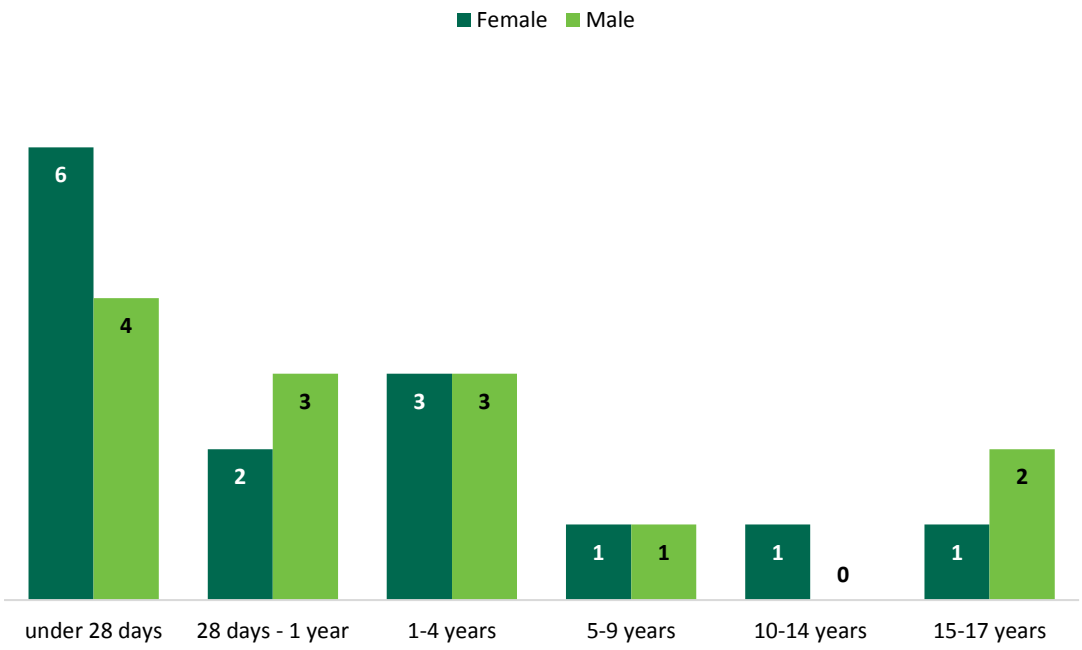


4.2 Age and gender

Of the 27 deaths that the CDOP was notified of in the period covered by this report, fourteen were in females (52%) and thirteen (48%) in males. The previous year was 43% and 57% respectively.

15 deaths (56%, down from 76% last year) occurred within the first year, and 10 deaths (37%) occurred within the first 28 days of life, down from 52% life year.

Figure 4.2 Age and gender of child deaths that occurred between 1st April 2016 and 31st March 2017

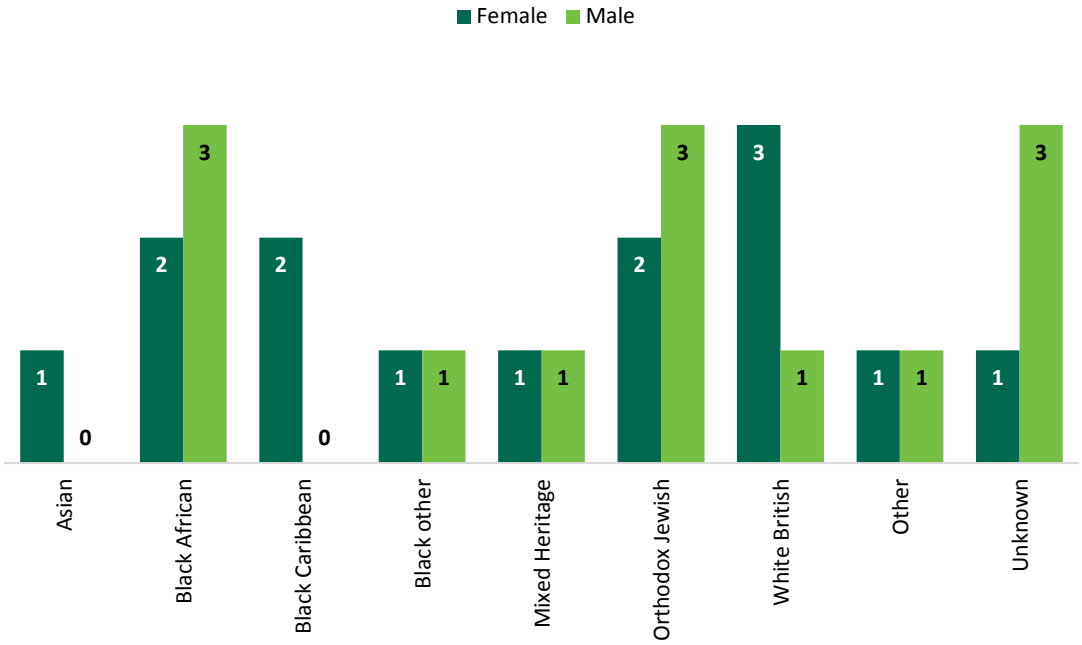


4.3. Ethnicity

When assessing the deaths by ethnic group, children from Black ethnic groups, including Black African, Black British and Black Other continue to be over-represented with 9 deaths (33%) of the total (these groups represent 23% of the total City and Hackney population).[6] This is down from 48% last year. 2 deaths (7%) in Asian children; 6 (22%) in White children (up from 9% last year); 2 (7%) in children of Mixed heritage, 5 (19%) in Orthodox Jewish children and 1 (4%) in children from Latin America. The ethnicity of 2 children is unknown.

[6] City and Hackney Health and Wellbeing Profile JSNA data update, January 2014, p26.

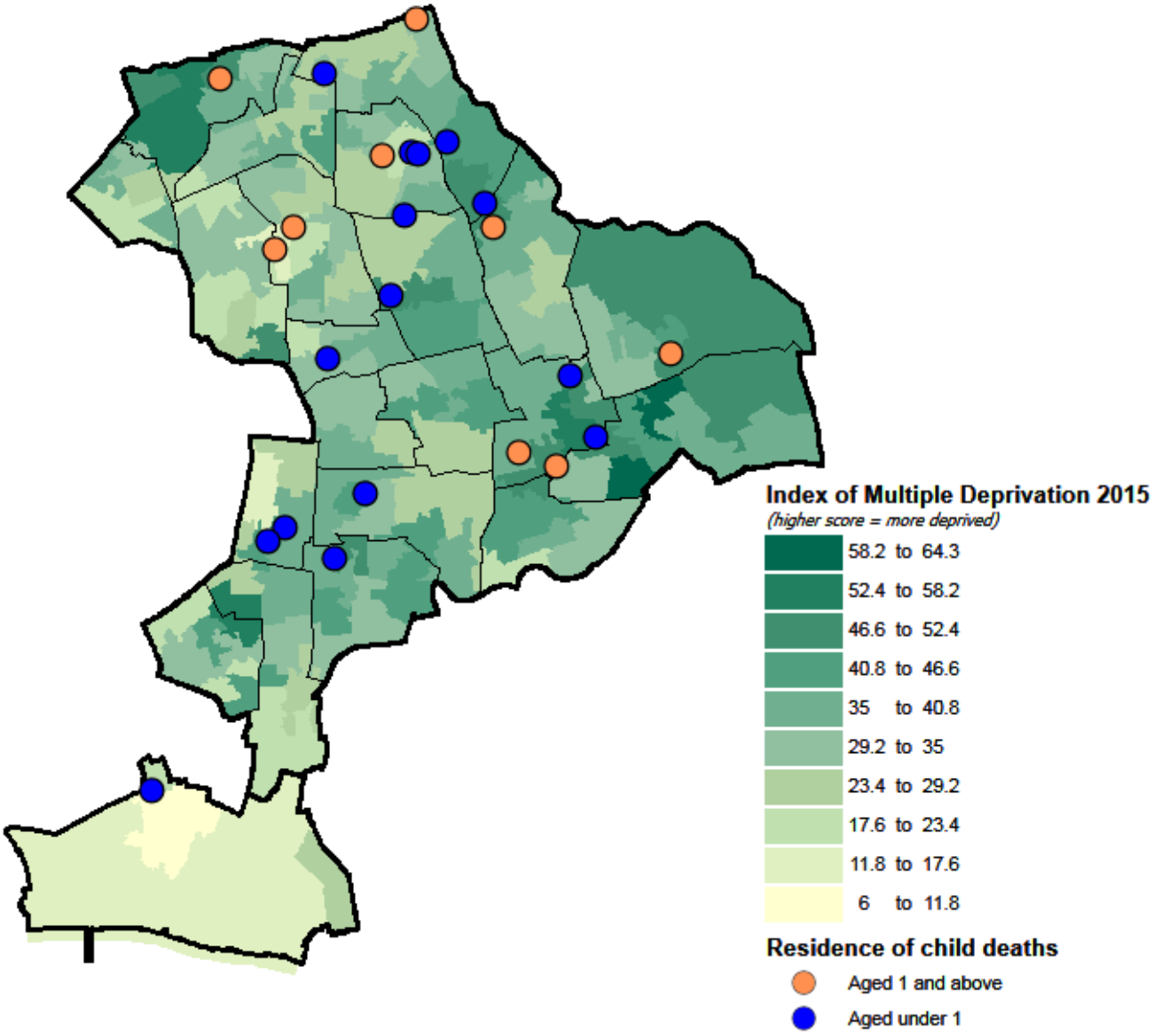
Figure 4.3 Ethnic groups and gender of deaths that occurred between 1st April 2016 and 31st March 2017



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 was one child death in the City of London.

Figure 4.4 Geographical location of child deaths in the London Borough of Hackney and the City of London 2016-17.[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.

Hackney and the City continue to see a trend in higher numbers of child deaths in the Black ethnic group, this year seeing 33% of deaths in these groups (these groups represent 23% of the population). This figure was 48% in 2015/16, 29% in 2014/15,

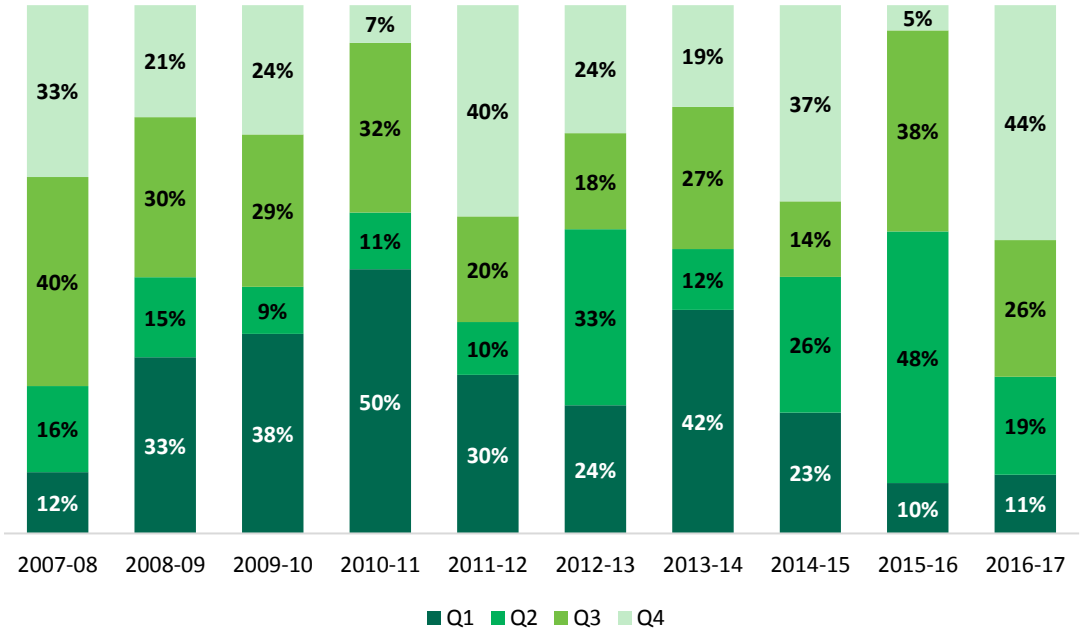
[7] Source: Indices of Multiple Deprivation 2015, Public Health, Child Death Overview Panel.

43% in 2013/14, and 37% in 2011-12,so the proportion has decreased following last year's increase.

4.5 Seasonal variability

Although the numbers are too small to discard random variation, death counts from 2007-08 until 2015-16 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 and autumn months (1st and 3rd quarter). Quarter 2 tends to see the least deaths overall with a few exceptions more recently. This year (2016-17) saw deaths most common in quarters 3 and 4 (70%), which echoes the distribution seen in some years, most recently 2014-15. 2016-17 saw the highest percentage of deaths in the second half of the year since 2007-08 (73%). 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

Learning, recommendations and impact

5.1 Learning points, recommendations and impact

Wherever possible the CDOP seeks to both further the child death review process and improve the wellbeing and safety of children and young people in the area. The main reason for furthering the child death review process is the belief that the quality of the process will directly affect the extent of learning issues that can be derived from the process. These learning issues should in turn play a significant role in informing and improving the safety and wellbeing and services to children and young people in the London Borough of Hackney and the City of London. The impact of these learning points and recommendations made through the CDOP process are shown in Appendix 1: Impact Log 2016-17.

5.2 Implementation of recommendations from 2015-16 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:

- communication between the Coroner's Office and the CDOP has been maintained. Regulation 28 reports continue to be shared with the CDOP, and inquest dates and post mortem reports are also shared more readily;
- safer sleeping messages continue to be disseminated following an increased number of co-sleeping related deaths this year;
- 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;
- continuation of pursuing a challenge to the London Ambulance Service and the Senior Coroner to change LAS protocol for the removal of bodies of over 2's to be in line with Working Together 2015. LAS and London Coroners have fed-back that they are unable to support this motion with small numbers of cases related to safeguarding. The CDOP Coordinator has contacted all CDOPs to ascertain levels of prevalence for conflicting protocols nationally and its impact on child deaths, and is working with the Healthy London Partnership CDOP Programme to reach a solution;
- the installation of ketometers at the local hospital, to measure the level of ketones in children with diabetic ketoacidosis without needing to transfer them to another hospital.

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

The achievements of the CDOP and the rapid response group in furthering the child death review process during 2016-17 include:

- highlighting the need to collect more robust information on children who die abroad, by working with the Foreign and Commonwealth Office to help develop guidelines for reporting the deaths of children abroad;
- highlighting the need for partners to regularly attend CDOP meetings to aid learning and investigations;

- developing links with local housing trusts in order to mitigate immediate housing issues for bereaved families.

5.4 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 2016-17 were:

- continuing to ensure in relevant cases that parents and siblings are referred to genetic screening and counselling;
- 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;
- continuing to disseminate safer sleeping messages;
- ensuring that parents, where relevant, receive CONI (Care of Next Infant) support;
- ensuring that robust and comprehensive school care plans are put in place across the borough for children with long term health conditions, and ensuring this to be of standardised quality;
- ensuring that school bus drivers are trained in basic life support;
- communication with the coroner to ensure the appropriate timing of inquest dates.

Appendix 1

Impact log: 2016/17

Date	Source[8]	Problem/Issue	Action	Impact
April 2016	CDOP Coordinator	RLH have yet to meet their statutory duty to notify the death of an under 18 within 48 hours.	The CDOP Coordinator escalated this to the Lead Named Nurse for Safeguarding Children who has provided assurance that a policy is in place which is embedded in the teams at RLH. Problems such as fax numbers, staff training and a clear protocol for notifying deaths have been assured to be fixed at RLH.	The one notification received directly from RLH in 2016/17 was received within the 48 hour window.
June 2016	CDOP Coordinator	Child death which may have been prevented had the bus driver been trained in basic life support.	The CDOP coordinator sought assurances from staff at Hackney Learning Trust that school bus drivers in Hackney are sufficiently trained.	
July 2016	CDOP Coordinator, through CDOP meeting	The response to a Regulation 28 report from a primary school assured of robust protocols for care plans for children with long-term health conditions. Following this, the CDOP sought assurance from school nursing that robust and comprehensive care	The CDOP wrote to the school nursing lead at the Homerton. The school responded to confirm that all children with severe medical conditions would have their photograph and a summary of their condition and treatment placed in the staff room and medical room.	The school nursing service has developed guidance to ensure that the health care plan process is robust, and are providing relevant training to school staff. This has also been added as a standing item on the school nurse/SENCO agenda for

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

		plans would be in place and the quality standardised across the borough to further mitigate the issues raised in this report.		termly meetings with each school.
January 2017	CDOP Panel meeting	Care of Next Infant (CONI) support is available to parents who have had a child pass away, however it is not clear if this is always being offered	In all cases of a baby or young child passing away, the GP was contacted to ensure that CONI support would be offered.	This has helped ensure that CONI support can be offered to all parents who have lost a child.
January 2017	Rapid Response meeting	Concerns were raised about the way a call to Hatzola (the Jewish Ambulance Service) was handled	Training was held for all Hatzola dispatchers, and new dispatch forms were issued to all Hatzola dispatchers, emphasising the critical questions to be asked.	
February 2017	Rapid Response meeting	A family whose child had recently passed away were due to be evicted, and this only came to light in the Rapid Response meeting when the eviction was imminent	The CDOP contacted the Housing Department to postpone the eviction, and also added Housing to the notification list, to ensure that any future issues can be escalated quicker	The family's eviction was postponed, and the housing team now contact the CDOP to inform of any issues quickly
April 2017	CDOP Coordinator	An inquest for a school child was scheduled during the exam period, which may have been distressing to other students.	The CDOP wrote to the coroner requesting that the inquest date be moved, such that it would fall outside the exam period but still within the 6 month target for inquests.	The coroner agreed to move the inquest date so that it would fall outside the exam period