Keeping children safe is everyone's responsibility

CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT

1 APRIL 2017 – 31 MARCH 2018

Dr Melanie Smith -– Director of Public Health
Dr Arlene Boroda -– Designated Doctor for Unexpected Child Deaths

Brent Local Safeguarding Children Board
Child Death Overview Panel
Annual Report for 1 April 2017 – 31 March 2018

1. OVERVIEW

This annual report is provided by the Child Death Overview Panel (CDOP) for the Brent Local Safeguarding Children Board (LSCB). The CDOP is a subgroup of Brent LSCB as set out in Regulation 6 (SI No 2006/90) of the Children Act 2004. The Child Death review process is a statutory requirement as outlined in Chapter 5 of the Working Together to Safeguard Children 2015, (previously Chapter 7 of Working Together to Safeguard Children 2006, reviewed in March 2010 and March 2013).

The process for management for unexpected child deaths is revised regularly and uploaded on the LSCB website.

The CDOP are notified of all deaths of children who are resident within the London Borough of Brent and continue the child review process for these deaths.

The total number of reported deaths for the year 01/04/2017 – 31/03/2018 is **26.**

Deaths reported in the previous years:

- 38 deaths in 2008 – 2009 (this was the year in which CDOPs were established).
- 26 in 2009 – 2010
- 38 in 2010 – 2011
- 41 in 2011 – 2012
- 43 in 2012 – 2013
- 30 in 2013 – 2014
- 24 in 2014 – 2015
- 23 in 2015 – 2016
- 26 in 2016 – 2017
- 26 in 2017 – 2018

Table 1: Total Number of Reported Child Deaths in Brent - 01/04/2008 31/03/2018

Deaths	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Expected	21	15	28	26	30	14	18	13	20	19
Unexpected	17	9	10	15	13	16	6[1]	10	6	7
Total	**38**	**26**	**38**	**41**	**43**	**30**	**24**	**23**	**26**	**26**

Table 2: Age range of child deaths reported for the year 2016-2017

[1] One of these deaths initially classified as 'unexpected' was later determined by the CDOP paediatrician to be 'expected'

Age range of deaths	Unexpected	Expected	TOTAL
Neonatal deaths (<4wks)	1	10	**11**
Infant death (4wks – 1yr)	2	4	**6**
Children between 1-4 years of age	2	1	**3**
Children between 5-9 years of age	-	2	**2**
Children between 10– 14 years of age	2	2	**4**
Young people between 15 – 18 years of age	-	-	**-**
Total	**7**	**19**	**26**

2. STAFFING

The Chair is the Director of Public Health from the Brent Local Authority and the Vice Chair is the Designated Paediatrician for Unexpected Deaths in Childhood.

The child death co-ordinator commenced in May 2009 as a fixed term, part time post-holder, taking over from a locum independent consultant. The post became permanent part–time in 2012 and is managed by the Designated Doctor (see structure chart - Appendix A).

The Designated Paediatrician for Unexpected Deaths in Childhood is also the Designated Doctor for Safeguarding Children. The Designated Doctor can provide the Rapid Response home visits for unexpected child deaths.

3. OFFICE ACCOMMODATION

The Designated Single Point of Contact (SPOC), who is also the Child Death Overview Panel (CDOP) coordinator, is based at Wembley Centre for Health and Care in NHS Brent CCG. This arrangement provides good access to specialist health advice and access to the Safeguarding Children Team (who undertake the rapid response).

4. CDOP PANEL MEETINGS

There have been regular meetings to discuss and review the Child Death cases. There has been good attendance from key partner agencies. All CDOP panel meetings have taken place at the Wembley Centre for Health and Care. Attendance for 2017/18 has been summarised in Appendix B. The Child Death Overview Panel meets quarterly, or more often, depending on the number of child death cases that are ready for review.

Meetings were held on the:

- 10/05/2017- 4
- 19/07/2017- 6
- 04/10/2017- 6
- 06/12/2017- 5
- 21/02/2017- 6

The CDOP reviewed 27 child deaths cases in the year 2017- 2018.

5. RAPID RESPONSE

The current arrangements for the on call rota in NHS Brent are in line with Working Together to Safeguard Children 2015, covering 9am–5pm, Monday to Friday, weekends and bank holidays. Three health professionals have completed the Warwickshire University Advanced Child Death training programme and also nurses and social workers.

Of the 7 **unexpected child deaths**, there were 5 rapid response meetings which were attended by a number of professionals. These meetings are to agree what processes will be followed to ascertain the cause of the child's death.
Rapid response meetings were not held in 2 cases – causes not discussed as due to low numbers details may identify cases.
The rapid response meetings facilitated good information at the outset.

6. ANALYSIS

Child Deaths are categorised into four groups:

- **Neonatal –** under 28 days old in hospital
- **SUDI –** sudden unexpected death of an infant under 2 years
- **Unexpected –** death of a child under 18 years (**not expected** in the previous 24 hours)
- **Expected -** death of a child under 18 years **(natural causes)**

The panel reviews every death of a child irrespective of the category it falls under, to ensure the appropriate involvement and response from the statutory agencies. The Panel considers the time period before, at and following the child's death and may include the antenatal period.

In some of the cases the reviews were delayed until all the information was made available from the Coroners' investigations which took extended time.

7. SUMMARY OF FINDINGS

Between1st April 2017 and 31st March 2018, **26** child deaths were notified to the CDOP for children who were **resident** within the Brent LSCB area at the time of their deaths.
This number is not the same as the **number of deaths reviewed.** There can be a delay in obtaining information particularly when inquests need to be completed so cases may not be considered for review in the same year as they are notified.

The number of Brent child deaths reported from 01/03/2008 – 31/03/2018 is outlined in table 1.

The range in number of deaths each month over 2017 – 2018 **has varied** from **1 to 4 and is illustrated below.** A monthly comparison of the last two years, figures demonstrates that there is no emerging pattern in the number of deaths, or when they occur.

Table 3: Monthly figures of child deaths 2014 - 2015, 2015 – 2016, 2016-2017 and 2017-2018

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2017-2018	**0**	**1**	**4**	**2**	**3**	**3**	**2**	**1**	**3**	**3**	**1**	**3**
2016-2017	**0**	**1** (+1**)	**0**	**3**	**4**	**3**	**4**	**0**	**1**	**5**	**2**	**3**
2015-2016	**3**	**0**	**0**	**4** (+1**)	**3**	**1**	**1**	**3**	**2**	**1**	**3**	**2**
2014-2015	**2**	**2**	**3**	**3**	**3**	**4**	**0**	**0**	**2**	**4**	**0**	**1**

Gender
The 26 deaths (2017-2018) comprised a total of 17 males and 8 females, 1 indeterminate

Table 4: Gender of child deaths reported

Males	**Females**	**Indeterminate**
17	8	1

Child Deaths by Locality

Willesden	11
Kingsbury	1
Harlesden	3
Kilburn	3
Wembley	8

Postcode of family home at time of child death

Table 5: Postcode of family home of child deaths

Area	NW2	NW6	NW9	NW10	HA0	HA3	HA9
Number	6	2	1	9	3	2	3

Place of Death

The child deaths in hospital were recorded at one of nine hospitals. The number of deaths in each hospital ranged from 1 to 5.
22 of the deaths occurred in a hospital setting and 3 at home. One in a public space – following a road traffic collision.

The locations of the recorded deaths are as follows:
Northwick Park Hospital **4** deaths, St. Mary's Hospital **4** deaths, Chelsea and Westminster Hospital **2**, Queen Charlotte Hospital **5,** UCLH **3** and Kingston Hospital **1**, Birmingham Children Hospital **1**, St Georges Hospital **1**, Royal London PICU **1**.
Three deaths were recorded in the home (on end of life care plans).
The one road traffic collision victim was certified at the scene.

Table 6: Hospitals/ Locations of Child deaths

Northwick Park Hospital	St. Mary's Hospital	Chelsea and Westminster Hospital	Q.C.C.H.	St Georges Hospital	Birmingham Children Hospital	UCLH	Royal London PICU	Home/ Public Place	Kingston Hospital
4	4	2	5	1	1	3	1	3 +1	1

Ethnicity

Ethnicity data is collected for all child deaths and linked into research about Child Deaths not only within London but nationwide. This provides valuable information especially within Brent due to its ethnically diverse population

Table 7: Ethnicity of child deaths from 1st April 2016 – 31st March 2017.

Ethnicity	Number
British- Asian/Pakistani	2
Black- British	1
Black- African	2
British Asian	4
British Afro Caribbean	1
British Asian/Indian	5
British/Black/Other/Asian/Other	1
British/Filipino	1
British/Pakistani	1
British/Portuguese/Black Caribbean	1
Mixed-White/Japan	1
White-British/Polish	1
White-Other (Southern & Other European	1
White British	3
White Other - Bulgaria	1
Total	**26**

REVIEWS:

8. CHILD DEATH OVERVIEW PANEL MEETINGS APRIL 2016 – MARCH 2017.

The panel completed reviews on a total of **27** child deaths during 2017 - 2018.
1 – for the year 2015-2016,
6 – for the year 2016 – 2017 and
20 – for the year 2017 – 2018

The table below shows the time span in which the child death cases were brought to panel and completed (from date of death to the date the review was completed).

Table 8: Time span of Child Death review

No. of deaths reviewed within the following time periods.	Deaths reviewed with Modifiable Factors	Deaths reviewed with No Modifiable Factors
Under 6 months	4	17
6 - 7 months	3	-
8 - 9 months	1	-
10 - 11 months	-	-
12 months	-	-
Over 12 months	1	1
Total	**9**	**18**

9. DEMOGRAPHICS

Table 9. Age ranges for child deaths reviewed for April 2017 - March 2018.

Age range of deaths	Unexpected	Expected	TOTAL
Neonatal deaths (<4wks)	1	11	**12**
Infant death (4wks – 1yr)	3	5	**8**
Children between 1-4 years of age	1	2	**3**
Children between 5-9 years of age	-	-	**-**
Children between 10– 14 years of age	-	-	**-**
Young people between 15 – 18 years of age	1	3	**4**
Total	6	21	**27**

Gender of Reviewed cases.
From the **27** children reviewed at panel**,** 1 April 2017 – 31 March 2018**,** their gender was as per table

Table 10: Gender of reviewed cases in 2017-2018

Males	Females	Indeterminate
16	10	1

Table 11: Ethnicity of 16 child deaths reviewed from 1st April 2017 – 31st March 2018

White: English/Welsh/Scottish/Northern Irish/British	2
White- British/Polish	1
White: Other European	1
Mixed: White- Japan	1
British Asian: Indian	11
British: Asian- other	1
Asian or Asian British: Pakistani	3
Black: British	2
Black: Caribbean/Portuguese	1
Black: British- African	1
Black: African	1
British – Filipino	2
TOTAL	**27**

10. CATEGORIES OF DEATH

The panel reviews cases and agrees with the category the death should be classified within. There are two categories into which each death is classified:
Modifiable Factors (Preventable) and No Modifiable Factors (Not Preventable)

Modifiable Factors Identified	The panel have identified one or more factors, in any domain, which 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
No Modifiable Factors Identified	The panel have not identified any potentially modifiable factors in relation to this death.

It is important to recognise that this categorisation is to inform efforts to reduce childhood deaths, it does not in itself carry any implication of blame on any individual party, but simply acknowledges where factors are identified which, had they been different, may have resulted in the death being prevented.

Table 12: Breakdown of categories for the 27 deaths reviewed 2017- 2018:

Expected death from natural causes:	
• Chromosomal, genetic and congenital anomalies 7	9
• Perinatal/neonatal event - category 8	8
• Malignancy - category 4	4
• Infection – category 9	1
Unexpected deaths – these include	
• SUDI / SIDS - category 10	1
• Perinatal/neonatal event - category 8	3
• Deliberate Inflicted Injury – Homicide- category 1	1
Total	**27**

There were 2 SUDIs reviewed.

- In one case the baby was placed in the parental bed.
  Recommendations are to promote safer sleep awareness for parents and carers of babies.
- One of the babies was a sudden postnatal collapse.

Deliberate Inflicted Injury – Homicide.

- One young person died from a knife incident in a public place.
- The case was reviewed following the criminal trial.
- A lessons learnt session convened by Brent LSCB focused on contextual safeguarding which also included tackling knife crime

11. THE CHILD DEATH REVIEW PROCESS

The process for the review of child deaths has followed the London Child Protection procedures and Working Together to Safeguard Children 2015. Notifications of deaths to the SPOC have improved as London-wide partner agencies are now more aware of the need to ensure effective communication. The professionals working in this field are increasingly aware of the need to ensure effective, timely and comprehensive referrals.

12. SERIOUS CASE REVIEWS (SCR) AND LSCB.

The CDOP also identifies other issues and links with other processes such as serious case reviews (SCR) and significant incidences (SI).

a) Serious Case Reviews SCRs
   There were no cases declared as SCRs.

b) Significant Incident reviews and NHS.
   CDOP links with the NHS Significant incident processes. Reports are reviewed by the Designated Professionals for safeguarding children and key messages highlighted at the CDOP case reviews.

Cases reviewed covered four SI reviews.

13. LINKING UP WITH LONDON CDOP

The Paediatrician for Child Deaths has attended the London Safeguarding Children Board CDOP Chairs network meetings. The Chair and the Paediatrician attended a London Workshop to review the roles and data processes for CDOP.

Healthy London Partnership work:
The following Programme Workshops were attended by panel members of Brent CDOP-

- Understanding and Tackling Neonatal Deaths- 25th May 2017
- Bereavement Support - 29th June 2017

The London Chairs meetings were attended by CDOP members to link with the wider network.

Brent CDOP and Brent LSCB has promoted the work of the Lullaby Trust and supported their safer sleep week. Safer Sleep Week is The Lullaby Trust's national awareness campaign targeting anyone looking after a young baby. From the 19-23 March 2018 The Lullaby Trust and partners aim to make sure parents in the UK know the importance of safer sleep and are aware of how to reduce the chance of Sudden Infant Death Syndrome (SIDS).

Brent LSCB promotes their work via links on the LSCB website, e-mailing messages across the partners and staff, placing poster displays in health settings

14. INFANT MORTALITY RATES IN BRENT

Data from Public Health England allows the numbers of child deaths in Brent to be considered as rates per 1000 live births and provide comparison with national and London rates:

Infant mortality is the rate if deaths under one year per 1000 live births. Because of the small numbers in any single year, three year rolling averages are used to compare areas. Examining historical data shows a downward trend for Brent and nationally, with rates in Brent now similar to those nationally.

Figure 1. Infant mortality rates over time

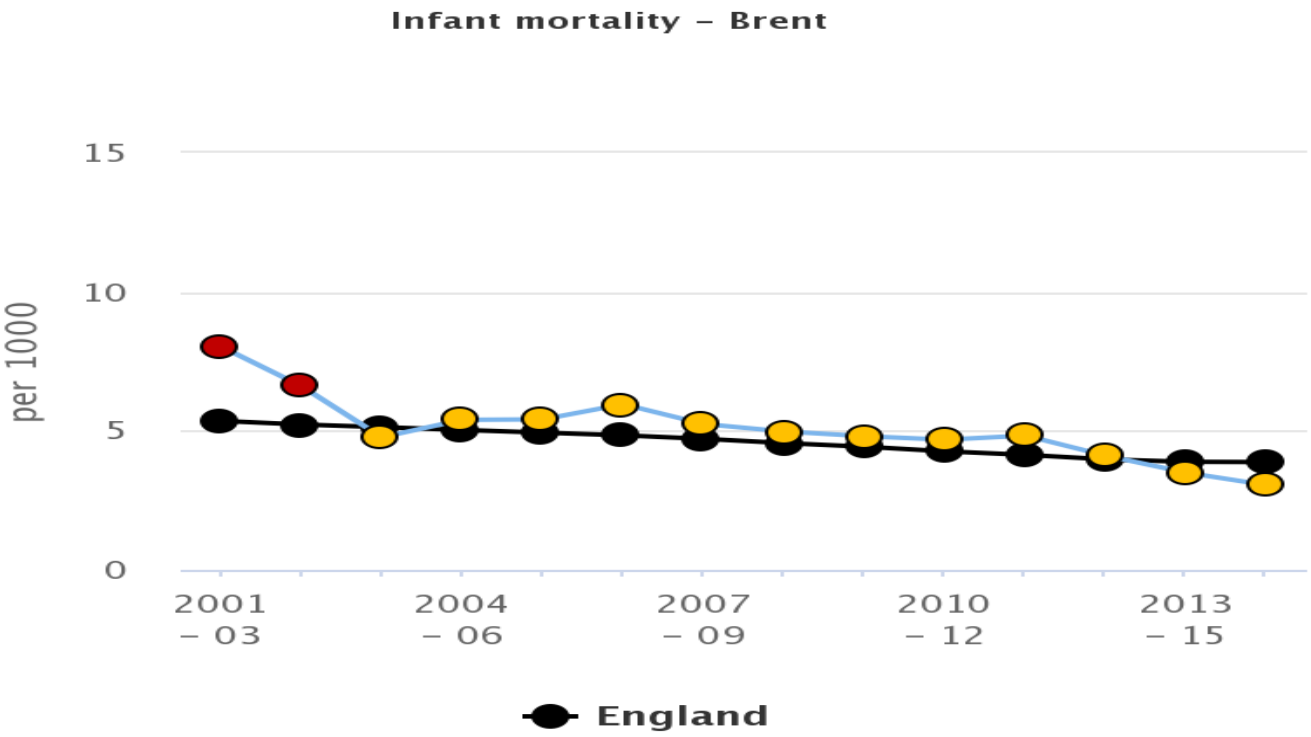


Table 13: Infant mortality rates

Period		Brent	London	England
2001 - 03		8.0	5.7	5.4
2002 - 04		6.6	5.4	5.2
2003 - 05		4.8	5.2	5.1
2004 - 06		5.4	5.0	5.0
2005 - 07		5.4	4.8	4.9
2006 - 08		6.0	4.6	4.8
2007 - 09		5.2	4.4	4.7
2008 - 10		5.0	4.5	4.6
2009 - 11		4.8	4.4	4.4
2010 - 12		4.7	4.2	4.3
2011 - 13		4.8	3.9	4.1
2012 - 14		4.1	3.6	4.0
2013 - 15		3.5	3.4	3.9
2014 - 16		3.0	3.2	3.9

Source: Office for National Statistics (ONS)

Child mortality rates

The child mortality rate is calculated as the directly standardized rate of deaths of children aged 1 to 17 years. Direct standardization allows for the age distribution of the child population and allows comparisons between different areas with different age distributions. Historical data show a downward trend in the child mortality rate for Brent with rates now similar to England.

Figure 2: Child mortality rates over time - Brent

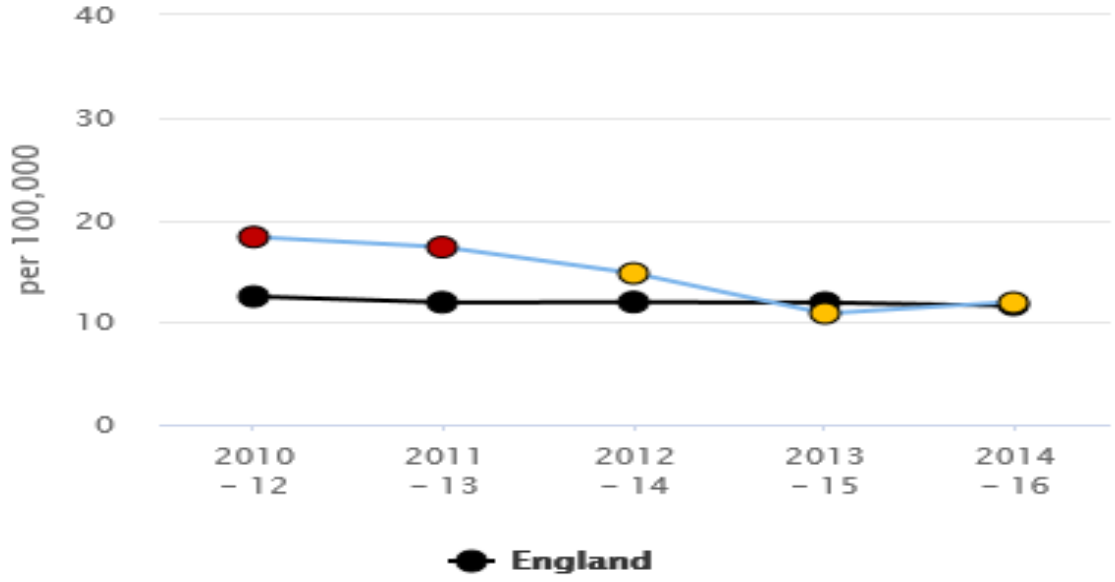


Table 14 Child Mortality rates

Period		Brent	London	England
2010 - 12		18.3	13.7	12.5
2011 - 13		17.3	12.2	11.9
2012 - 14		14.8	12.0	12.0
2013 - 15		10.8	11.5	11.9
2014 - 16		12.0	11.6	11.6

Source: Office for National Statistics (ONS)

15. ISSUES

Child deaths have been reviewed by the Coroner before coming to the CDOP. In some cases there are inherent delays due to further investigations and information required at the Coroner's inquest hearing or police investigation.
Communication with the Coroners' offices is via Coroners officers.
Accessing information from health providers remains difficult in some cases.

Information about the Child Death Review process and other relevant information including bereavement care and counselling is shared with parents at the hospitals.
A representative from the charity The Lullaby Trust (formerly FSID) attends the CDOP meeting and is a representative of the parents.

The panel communicates the final CDOP decisions with the parents and universal staff including GPs that had contact with the children.

16. LESSONS LEARNT

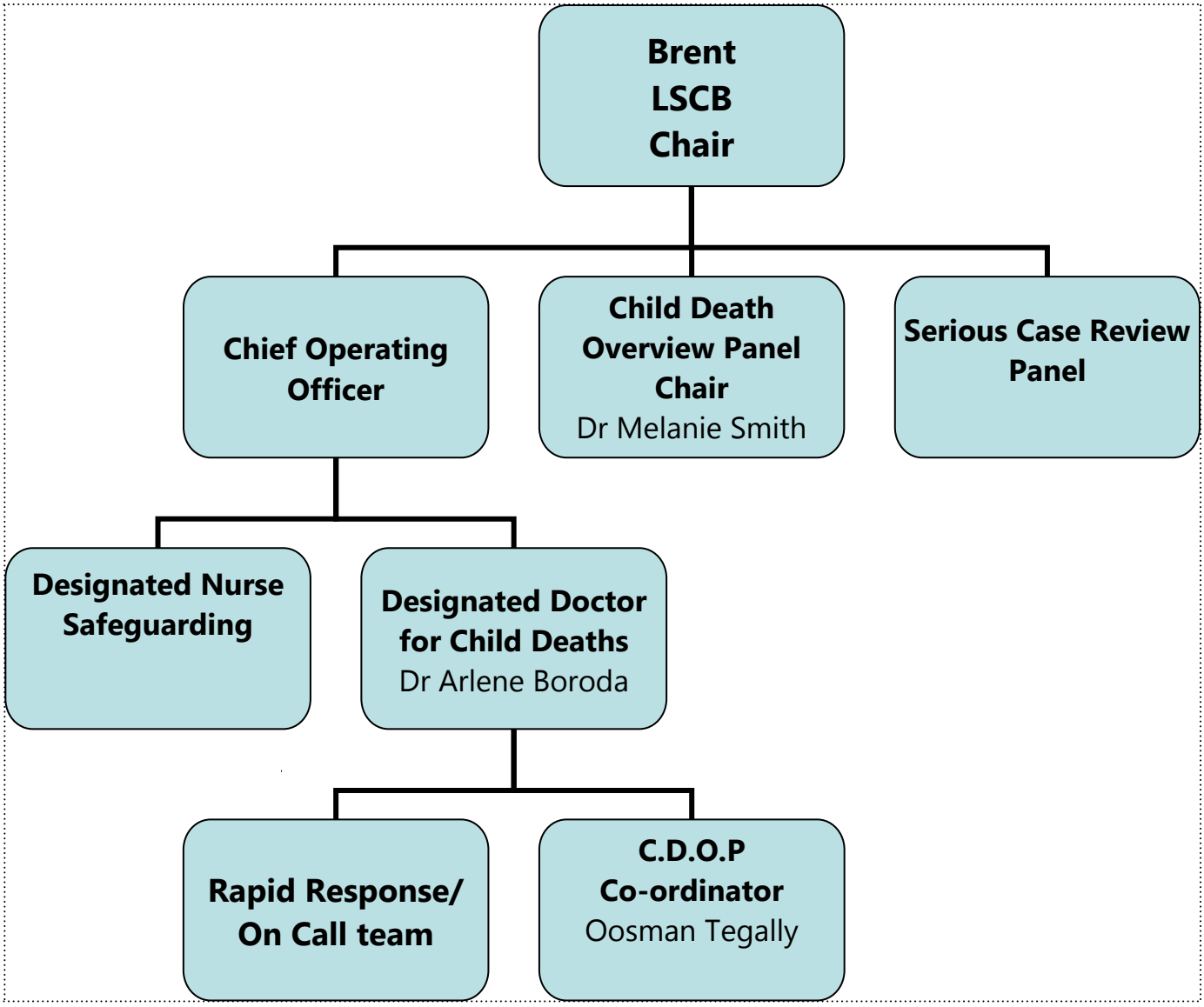
- Safer sleep advice should be promoted by front line professionals who have contact with parents of newborns and babies
- The need to improve the recognition of foetal distress by clinical staff and appropriate action to optimise outcome for babies.
- Increased surgical expertise is required for a Caesarean section for an overweight pregnant mother
- Increased maternal BMI is linked to babies being born with congenital abnormalities
- Professionals seeing expectant mothers for antenatal care should advise on what to do if they have reduced foetal movements
- Mothers who have sought advice for but not proceeded to termination should be encouraged to have antenatal care as babies born extremely prematurely are being offered neonatal care.
- A number of deaths due to congenital abnormalities have occurred with consanguineous parents. Brent CDOP does not regard these deaths as preventable but is concerned that parents receive appropriate antenatal counselling and genetic counselling where appropriate to ensure parental choice
- Professionals attending meetings do so as part of an organisation, not as individuals and have a responsibility to record decisions and deliver on agreed actions
- Knife crime and youth violence is a cause of preventable deaths
- End of life care plans in chronically ill babies / children avoid unnecessary distress when these children die
- Clinicians should all be aware of reporting of unexpected deaths in under 2s as part of Project Indigo Procedures
- Clinicians should understand SI reporting
- Maternity Units should review the recording of telephonic advice given to parents by their birthing centre
- Sepsis pathway is being implemented by the local Trust

A talk titled 'learning lessons from CDOP and preventing deaths in Brent' was the theme of a paediatric Grand Round at NPH in November 2017, attended by over 60 clinicians. Talks delivered by the Lullaby Trust and the CDOP paediatrician shared the proposed changes to CDOP across London. Feedback was that the session was well received.

17. ENGAGING PARENTS IN CDOP PROCESSES:

An information leaflet about the Brent CDOP review process has been sent out to bereaved parents since March 2016 inviting them to contact CDOP to share any information which may help the review processes. So far four families have linked with the CDOP. This has facilitated the communication parents' views with service providers to the children.

Appendix A
Post Holders
Executive Lead for Safeguarding Children- Chief Operating Officer Brent CCG
Public Health Consultant – Dr Melanie Smith
Designated Doctor for Unexpected Child Deaths - Dr Arlene Boroda
CDOP Co-ordinator- Oosman Tegally (until end of January 2018)
Designated Nurse for Safeguarding Children NHS Brent CCG- post holder
Rapid response on call – Dr Arlene Boroda
Head of Safeguarding (Brent Children and Young People) – Sonya Kalyniak or a representative
Brent and Harrow Metropolitan Police CAIT – DI Jason Dawson



Appendix B:

CHILD DEATH OVERVIEW PANEL MEMBERSHIP ATTENDANCE 2017-2018

	10/05/2017	**19/07/2017**	**04/10/2017**	**06/12/2017**	**21/02/2018**
Public Health Consultant	Present - Chair	Present - Chair	Present - Chair	Present - Chair	Present Chair
Designated Doctor for Child Deaths for NHS Brent CCG	Present	Present	Present	Present	Present
CDOP Co-ordinator	Present	Present	Present	Present	Present
Designated Nurse for Safeguarding Children NHS Brent CCG	Apologies	Present	Apologies	vacant	vacant
Police/CAIT	Present	Present	Present	Present	Present
Brent Children and Young People - Head of Safeguarding Children	Represented	Represented	Represented	Represented	Represented
LNWH Trust	Represented	Nil	Represented	Apologies	Represented
CLCH- health visiting and school nursing	Not invited	Represented	Represented	Represented	Represented
The Lullaby Trust (FSID) - parents	Apologies	Represented	Present	Present	Present