BRENT LSCB AND NHS BRENT CCG

CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT

1st APRIL 2014 – 31st MARCH 2015

Dr Melanie Smith -– Director of Public Health
Dr Arlene Boroda -– Designated Doctor for Unexpected Child Deaths
Oosman Tegally -– Child Death Overview Panel Coordinator

Brent Local Safeguarding Children Board
Child Death Overview Panel
Annual Report for 01/04/2014 – 31/03/2015

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 2013, (previously Chapter 7 of Working Together to Safeguard Children 2006, reviewed in March 2010 and March 2013).

This is the seventh annual report. The CDOP reviews all child deaths of residents in the London Borough of Brent. Terms of reference have been agreed and revised to include the latest guidance.

The process for management for unexpected child deaths is revised regularly and uploaded on the LSCB website (http://media.inzu.net/884ef2e464a01b98abb12a62a68a525c/mysite/articles/100/1_ChildDeathArrangementsRapidResponseProcessSept2012.pdf).

The CDOP continued the child death review process for the deaths that were 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

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

Table 1: Total Number of Reported Child Deaths in Brent - 01/04/2008 31/03/2015

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

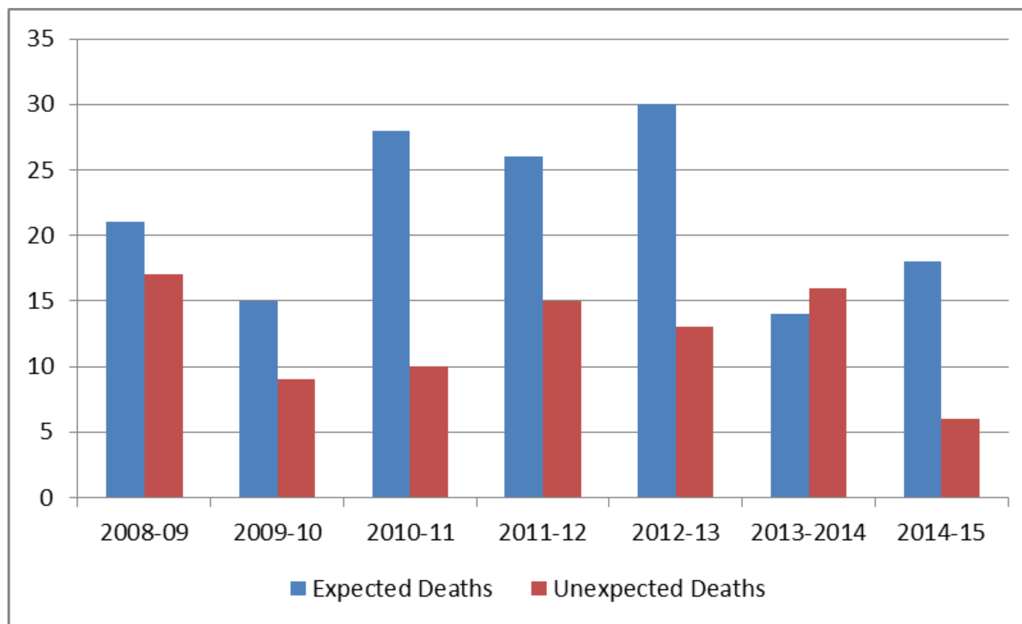


Chart 1: Expected/Unexpected Child Deaths per year.

The total number of reported deaths for the year 01/04/2014 – 31/03/2015 is 24

Age range of deaths	Unexpected	Expected	TOTAL
Neonatal deaths (<4wks)	**2**	**10**	**12**
Infant death (4wks – 1yr)		**4**	**4**
Children between 1-4 years of age	**4**	**3**	**7**
Children between 5-9 years of age			
Children between 10– 14 years of age			
Young people between 15 – 18 years of age		**1**	**1**
Total	**6**	**18**	**24**

Table 2: Age range of child deaths for the year 2014-2015

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 1 & 2).

The Designated Paediatrician for Unexpected Deaths in Childhood is also the Designated Doctor for Safeguarding Children. The Designated Doctor and Named Nurse for Community Services Brent 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 2014/15 has been summarised in Appendix 3. 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:

- 03/07/2014
- 10/09/2014
- 15/01/2015
- 04/03/2015

The CDOP reviewed 29 child deaths cases in the year 2014-2015.
(03/07/2014 – **8**, 10/09/2014 – **5,** 15/01/2015 **- 12,** 04/03/2015 **- 4)**

5. Rapid Response

The current arrangements for the on call rota in NHS Brent are in line with Working Together 2006, revised in 2010 and 2013, 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. It is anticipated that there will be an expanded team to join the rota.

Two home visits have been provided by a Hospital team where the children were certified as passed away. There were rapid response child death strategy meetings to share information regarding the death and to agree what processes will be followed to ascertain the cause of the child's death.

Of the 6 **unexpected child deaths**, there were 4 rapid response meetings which were attended by a number of professionals. Those cases where rapid response meetings were not held were in cases where rapid response home visits were undertaken and full information was shared at the time or the death was in a health setting that gave a full picture of what was known about the case. 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
  Death 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 in, 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 2014 and 31st March 2015, **24** 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 – 31/03/2015 is outlined in the chart above (Chart 1).

- **Number of deaths each month**

The number of deaths each month over 2014 – 2015 has varied from 1 to 4 as shown below.

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
2	**2**	**3**	**3**	**3**	**4**	**0**	**0**	**2**	**4**	**0**	**1**

Table 3: Monthly figures of child deaths.

- **Gender**

The 24 deaths (2014-2015) comprised a total of 12 males and 12 females

Gender of cases	
Males	**Females**
12	**12**

Table 4: Gender of child deaths.

- **Child Deaths by Locality**

Willesden - 3
Kingsbury - 6
Harlesden - 6
Kilburn - 2
Wembley - 7

- **Postcode of family home at time of child death**

Area	NW2	NW6	NW9	NW10	HA0	HA3	HA9	W11	W10
No.	**3**	**1**	**6**	**6**	**5**	**1**	**1**	**1**	**0**

Table 5: Postcode of family home of child deaths

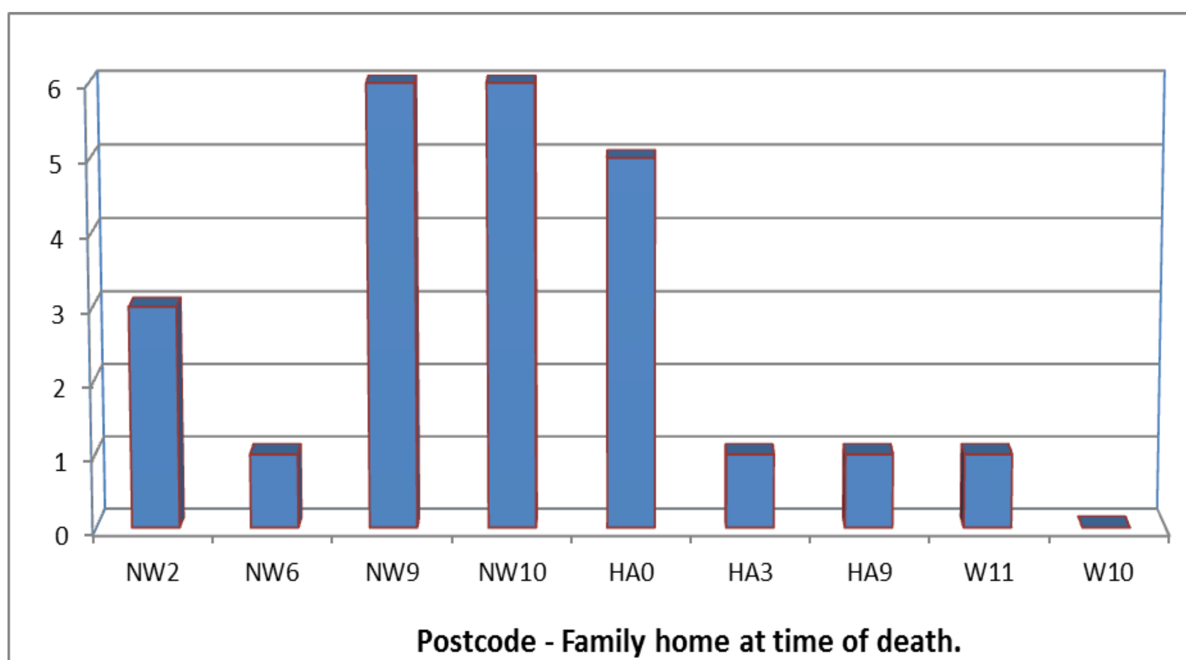


Chart 2: Postcode of family home of child deaths

- **Place of Death**

The child deaths in hospital were recorded at one of eight hospitals. The number of deaths in each hospital ranged from 1 to 9. 19 of the deaths occurred in a hospital setting and 4 in a hospice or at home.

St. Mary's Hospital.	NWLH	Royal Free Hospital.	Chelsea and Westminster Hospital	QCCH	UCLH	The Royal Brompton Hospital	Birmingham Children's Hospital	Home/ Hospice
2	9	1	1	3	1	2	1	4

Table 6: Hospitals/ Locations of Child deaths

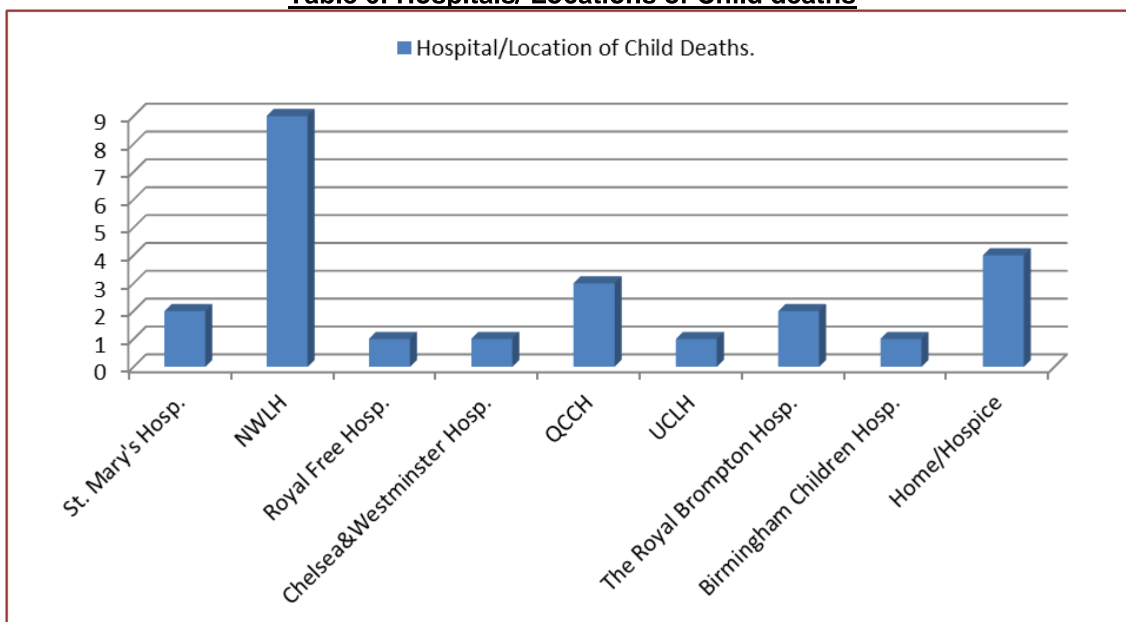


Chart 3: Hospitals/ Locations of Child deaths.

7. 3 Comparison of infant mortality rates in London Boroughs:

(Information provided by Brent Council public health team)

Chart 4 compares infant mortality rates in Brent against our statistical neighbours and against the London and England averages during the periods 2010-12 and 2011-13. In Brent, the rate of infant deaths in 2011-13 was 5.1 per 1,000 live births[2]. This equates to a total of 80 deaths during that period, or about 25 deaths per year. The rate of infant mortalities in Brent in 2011-13 was higher than in London, England, and any of the statistical neighbours.

Figure 1

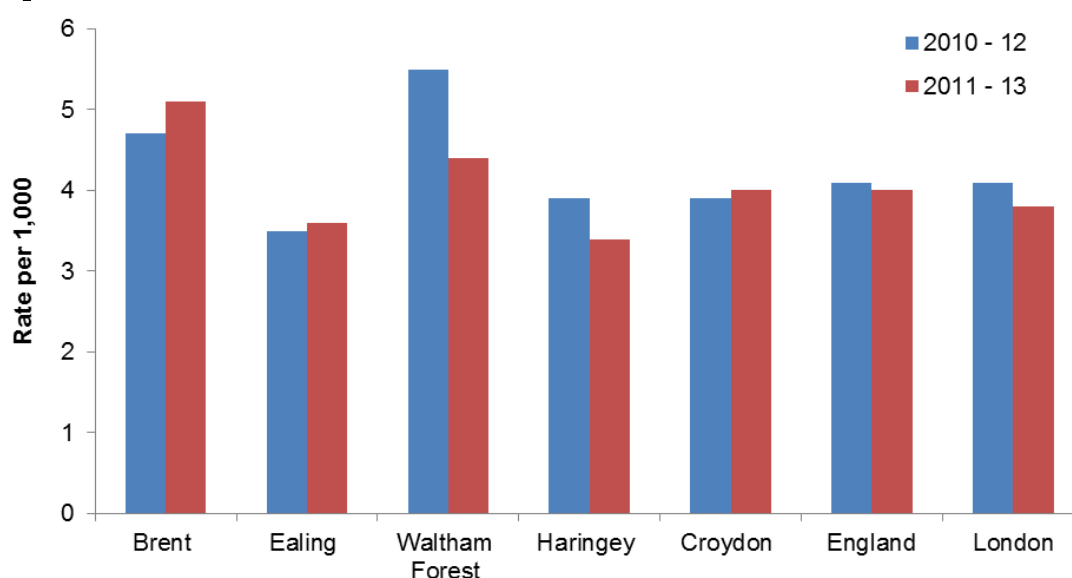


Chart 4: Brent Infant Mortality Rates compared to statistical neighbours 2010-2012, 2011-2013

[2] ONS

Chart 5 identifies the longer term trend of infant mortalities since 2001-03 comparing Brent against its statistical neighbours. Infant mortality rates in Brent have fluctuated quite significantly between 2001-03 and 2011-13. In 2001-03, the rate of infant mortality in Brent was 8 per 1,000 live births, higher than any of its statistical neighbours.

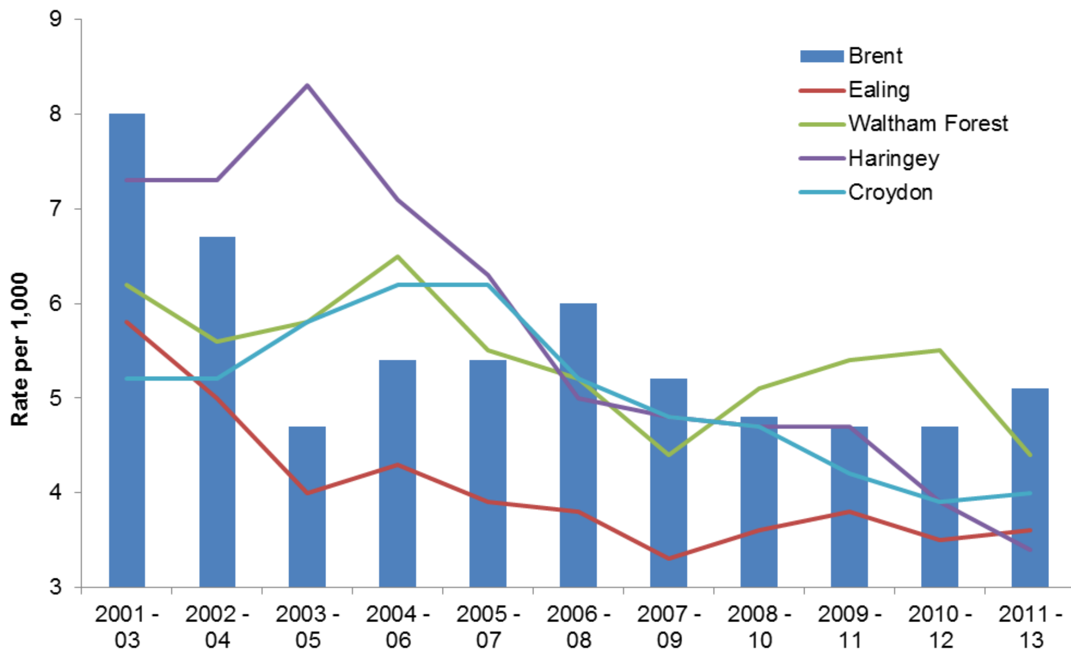


Chart 5: Brent Infant Mortality Rates compared to statistical neighbours from 2001-2013

Chart 6 compares rates of child mortalities (ages 1-17 years) in Brent for 2009-11 and 2010-12. In 2010-12, the rate of child mortality in Brent was 18.3 per 100,000 children aged 1-17 years. This equates to 12 deaths per year. The rate in Brent is significantly higher than the England average which was 12.5 per 100,000.
Furthermore, the child mortality rate in Brent in 2010-12 was higher than any of its statistical neighbours. However, the rate in Ealing (19.4 per 100,000) was slightly higher than the rate in Brent (17.6 per 100,000) in 2009-11.

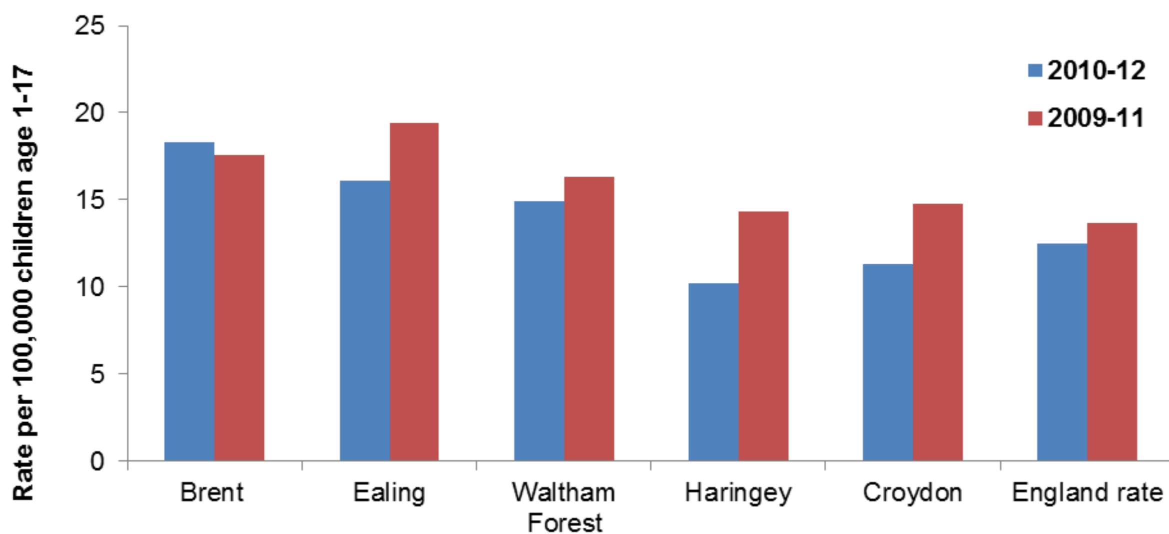


Chart 6: Brent rates of child mortalities (ages 1-17 years) for 2009-11 and 2010-12

8.0 CHILD DEATH OVERVIEW AND PANEL MEETINGS APRIL 2014 – MARCH 2015.

The panel completed reviews on a total of **29** child deaths during 2014-2015.
1 from the year April 2011 – March 2012,
1 from the year April 2012 – March 2013,
7 from the previous year April 2013 – March 2014 and
20 for this period April 2014 – March 2015.

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).

No. of deaths reviewed within the following time periods.	Deaths reviewed with Modifiable Factors	Deaths reviewed with No Modifiable Factors	Number of child deaths where there was insufficient information to assess if there were modifiable factors
Under 6 months		20	
6 - 7 months			
8 - 9 months		1	
10 - 11 months		1	
12 months		3	
Over 12 months	3	1	
Total	**3**	**26**	

Table 7: Time span of Child Death review

9.0 DEMOGRAPHICS

Table 2 : Age ranges for child deaths reviewed for April 2014 - March 2015

Age range of deaths	Unexpected	Expected	TOTAL
Neonatal deaths (<4wks)	2	10	12
Infant death (4wks – 1yr)	4	3	7
Children between 1-4 years of age	1	4	5
Children between 5-9 years of age	2		2
Children between 10– 14 years of age	2		2
Young people between 15 – 18 years of age		1	1
Total	**11**	**18**	**29**

Table 8: Age ranges for child deaths Reviewed for April 2014- March 2015

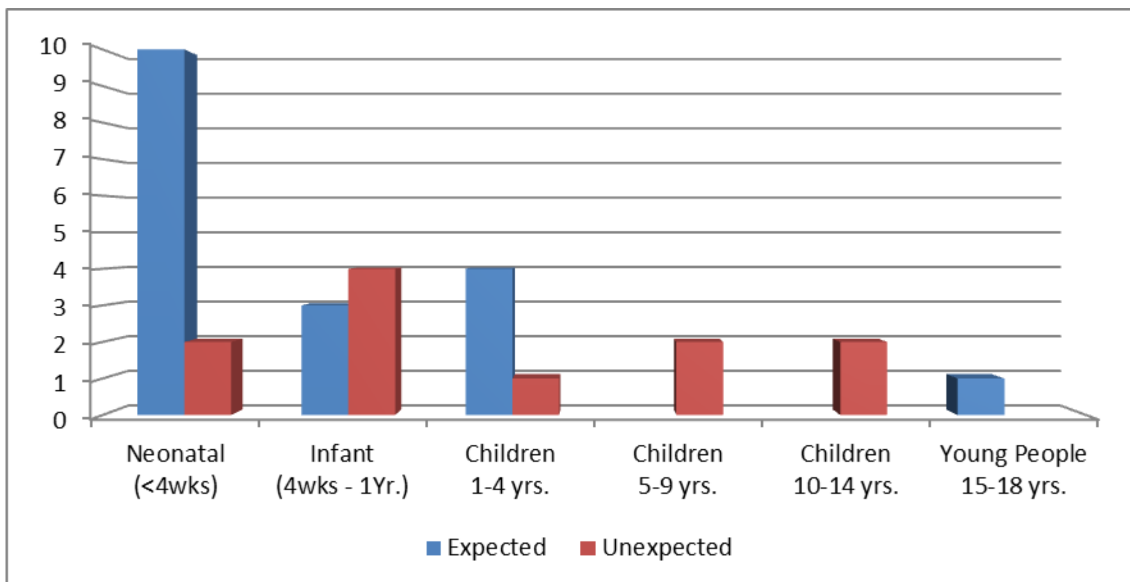


Chart 7: Age ranges for child deaths reviewed - April 2014 - March 2015

- **Gender of Reviewed cases.**

From the **29** children reviewed at panel, 1 April 2014 – 31 March 2015**,** their gender was:

Gender of reviewed cases	
Males	**Females**
18	**11**

Table 9: Age ranges for child deaths Reviewed for April 2014- March 2015

- **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 10: Ethnicity of 24 child deaths from 1st April 2014 – 31st March 2015.

White: English/Welsh/Scottish/Northern Irish/British	3
White: Irish	1
White: Gypsy or Irish Traveller	
White: Any Other White background	
Mixed: White & Black Caribbean	
Mixed: White & Black African	
Mixed: White & Asian	
Mixed: Any other mixed/multiple ethnic background	
Asian or Asian British: Indian	4
Asian or Asian British: Pakistani	2
Asian or Asian British: Bangladeshi	

Asian or Asian British: Chinese	
Asian or Asian British: Any other Asian background	3
Black: Caribbean	3
Black: African	4
Any other Black/African/Caribbean background	
Other: Arab	2
Other: Any other	1
Not stated	1
TOTAL	**24**

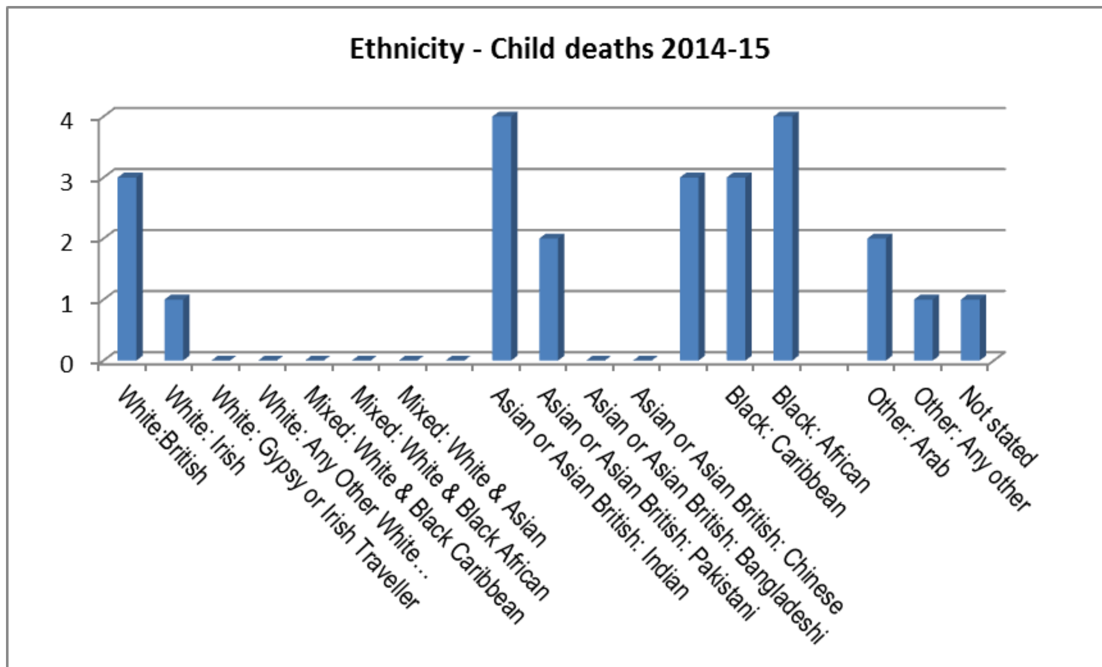


Chart 8 – Ethnicity of Child Deaths in Brent

10.0 CATEGORIES OF DEATH

The panel reviews cases and decides on 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 11: Breakdown of categories for the 29 deaths reviewed:

Expected death from natural causes: TOTAL Chromosomal, genetic and congenital anomalies Perinatal/neonatal event Chronic medical condition	 10 7 1		18
Unexpected deaths – these include SUDI Trauma - Road traffic accident Chromosomal, genetic and congenital anomalies Deliberately inflicted injury - Murder by asphyxia Perinatal/neonatal event (prematurity) Acute medical or surgical condition 1). SUDEP. 2). Stevens Johnson Syndrome Infection		 2 1 2 2 1 2 1	11
Total	**18**	**11**	**29**

Expected deaths:
Modifiable Factors: The panel found that there were modifiable, or possible modifiable factors, in three of the cases reviewed. In one case there was a possible link to Vitamin D deficiency.
One child was found lying on his front and possible modifiable factor was identified in that safer sleep information might have prevented this death.
One child with pre-existing medical conditions died after an anaphylactic reaction to medication.

Unexpected Deaths:
This year the CDOP completed the review for 2 siblings who died at the hands of their mother from asphyxia. They were also the subject of a Brent SCR and a number of recommendations were made across the partnerships.They are the first children the CDOP has reviewed that have died from inflicted injury

12.0 TRAINING

The Paediatrician for Child Deaths attended the study day Unexpected Death in Childhood on 11 April 2014 in Birmingham organised by the Child Bereavement Charity.

A study session titled ‘Preventing Child Deaths’ was convened by Brent CDOP on Friday 12th of September 2014 in the CCG. This was very well attended. There were speakers and presentations on consanguinity, clinical mishaps, Vitamin D Deficiency, and talks by the Lullaby Trust, Child Bereavement Charity and Brent Samaritans. There was good discussion during these sessions on all the topics presented:

- Consanguinity – at the NWLH genetics clinic there is a rapid referral system for families needing urgent input and advice re genetic implications for the unborn baby.
- Recognition by primary care of the needs of ill babies and the need to respond quickly was reinforced.
- Bereavement counselling – referral for families to the relevant charities for support
- Safer sleep practices and preventing child deaths – material supplied as produced by the Lullaby Trust

13.0 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 2013 as previously happened. Notifications of deaths to the SPOC have improved as London-wide people are now more aware of the need to ensure good communication. The professionals working in this field are increasingly aware of the need to ensure effective, timely and comprehensive referrals.

14.0 LINKING UP WITH LONDON CDOP

The CDOP coordinator attended one London SCB SPOC meeting. The Paediatrician for Child Deaths has attended three of the London SCB CDOP Chairs network meetings. A joint meeting took place with the Harrow CDOP on 31 October 2014 to share interesting cases and learning.

15.0 PUBLIC HEALTH AND PREVENTION

15.1 Detection of GROUP B strep infection antenatally, preventing infection and possible mortality: (Report by Dr Rao and Mrs Nartey, LNWHC Trust, March 2015):

Dr Rao and Ms Nartey reported that there were a total of 4842 infant births from March 2014 – February 2015 at Northwick Park Hospital (NPH). A total of 3085 (64%) pregnant women were screened after 35 weeks for Group B infection, as the programme was rolled out across services provided by NPH for Brent and Harrow mothers.

From the total number of pregnant women screened, 28-30% were found to be GBS positive. There were no mothers who were screened or babies of mothers screened that developed an infection post-delivery.

In the group that were not screened, 2 babies were found to have an early infection and were treated accordingly and 3 mothers had bacteraemia which is associated with GBS and was treated accordingly.

None of the women who received antibiotics had an adverse reaction to antibiotics.

In 2012, the early onset GBS invasive infection rate in neonates was 1.14/100 live births and maternal blood stream infection rate was 0.76/1000 live births. The 2013 rates were similar. (Information provided by NPH)

15.2 Sudden unexplained deaths in infancy (SUDI):

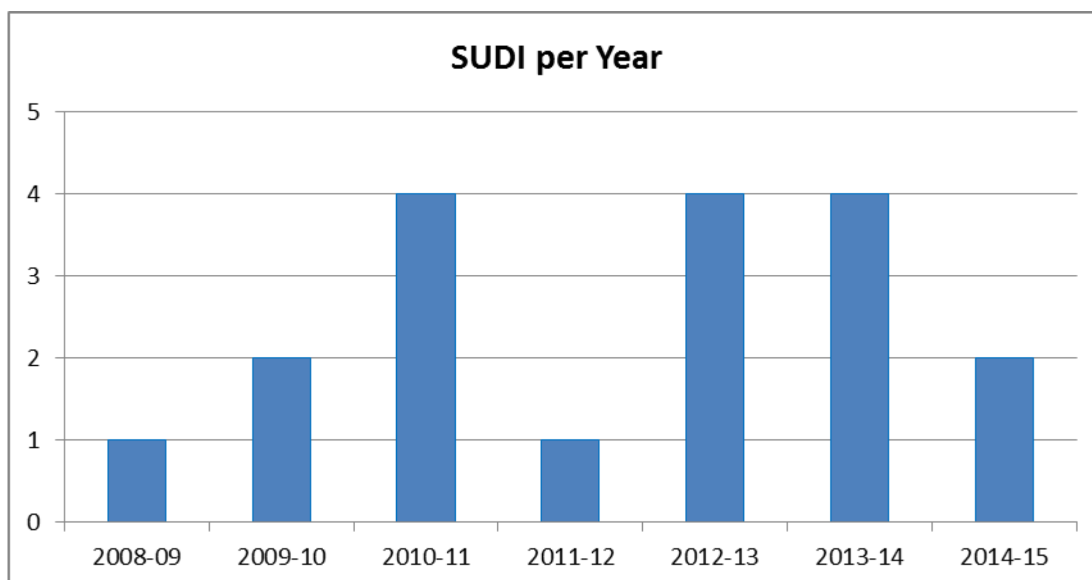


Chart 9 – Numbers of Brent SUDI's per year

There have been 18 reported of cases of SUDI since 2008 as shown in table 10.

Table 12: Chart of SUDIs from 2008-2015

Year	No. of SUDI	Issues identified	No factors identified
2008-09	1	Found at end of cot	
2009-10	2	One case of co-sleeping	1
2010-11	4	All four cases reported to be co-sleeping	
2011-12	1		1
2012-13	4	Three cases reported to be co-sleeping	1
2013-14	4	2 cases of children lying prone, face down, one was an ex-premature baby and one co-sleeping.	
2014-15	2	One child was supported by a wedge in cot and one reported to be co-sleeping.	
TOTAL	18		

Table 13: Postal Codes of Brent SUDI's from 2008- 2015

NW10	NW6	NW9	NW2	W10	HA0	HA9
7	2	2	2	1	3	1

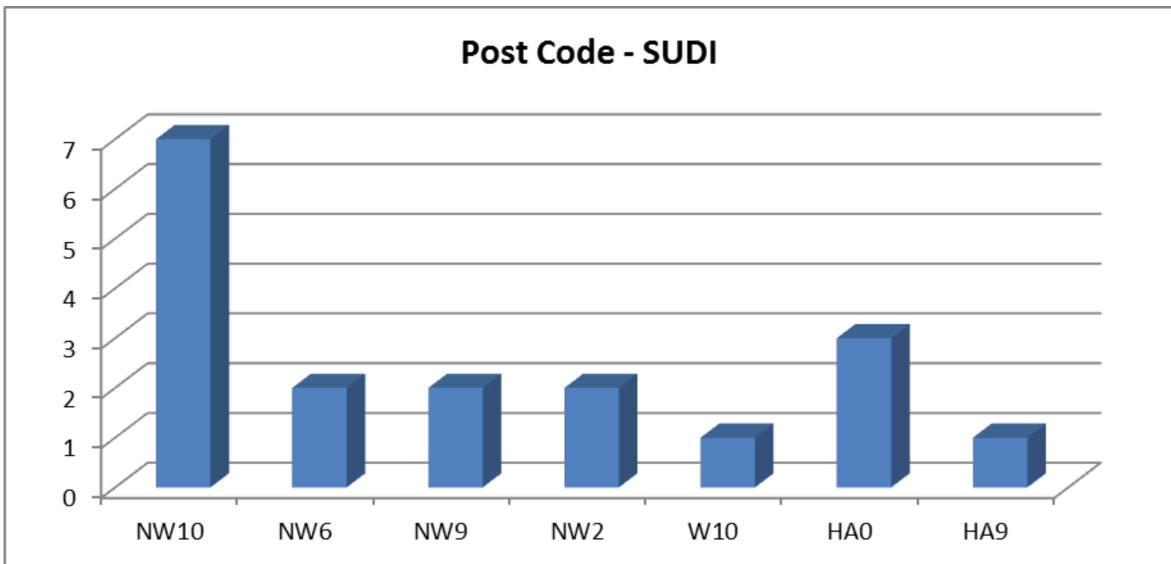


Chart 10 – Postal code of SUDI's from 2008- 2015

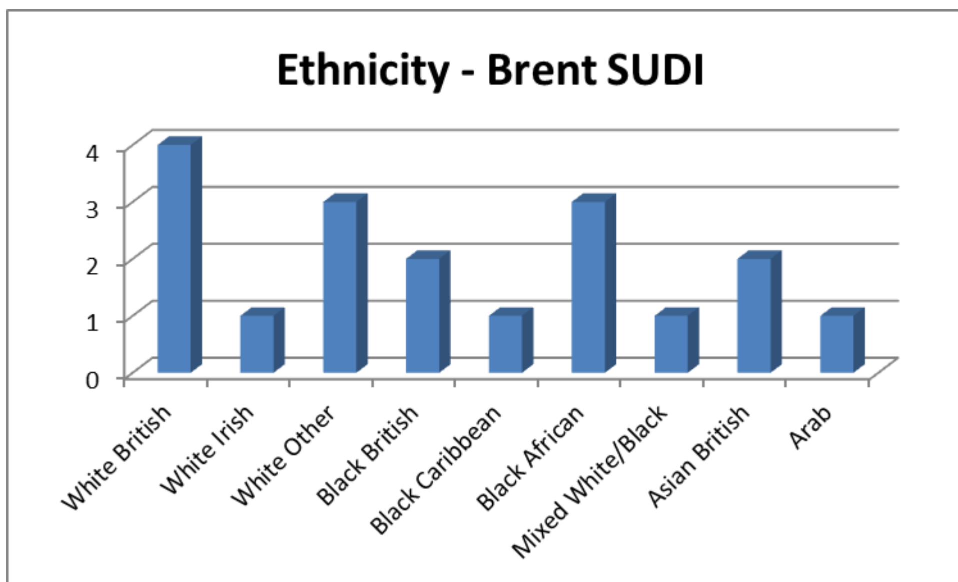


Chart 11 – Ethnicity – Brent SUDI

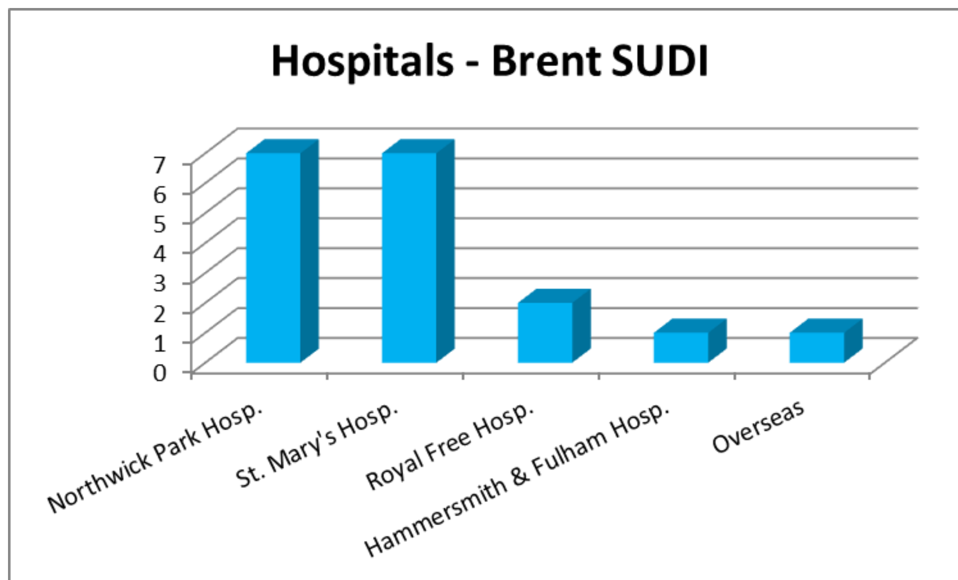


Chart 12 - Hospitals where child attended/died

There were 10 cases of co-sleeping; two infants were reported to be sleeping on their front. One infant was found at the end of his cot with a blanket around him.
One infant was an ex-premature baby and one infant was placed on his side with a wedged pillow in his cot.

There were no factors identified in the three other cases.

Despite being low in comparison to the number of live births in the Borough (5240 in 2010; ChiMat 2012), each of these infant deaths are catastrophic events for families (Waite et al 2011).

16.0 LEARNING THE LESSONS:

Over the years of the child death review process the themes are collated and disseminated across front line staff. They are as follows:

1. There are still many cases of SIDS where co-sleeping remains a risk factor. Information and leaflets on safer sleep for babies should be used by frontline professionals to educate parents about safe sleep practices in babies.
2. Vitamin D deficiency was raised as a concern in deaths over the years. Promotion of Vitamin D supplementation in pregnant women and in children with risk factors for this deficiency should continue.
3. Bereavement care for parents and staff is important.
4. Joint home visits following an unexpected child death provide an opportunity to assess the full family picture
5. Following the death of a child in a local hospital, a thorough investigation was carried out of the clinical care of the case. The Trust now has completed an action plan and embedded the lessons learned during the process aiming to improve clinical care and prevent repetition of errors.
6. Listening to concerns that parents have about clinical care is important in addressing concerns and can also avoid unrealistic expectations about chronic conditions in children.

17.0 ISSUES:

Child deaths have needed to be reviewed by the Coroner before coming to the CDOP. In some cases there are delays due to further investigations and information required at the Coroner's inquest hearing or investigation. Communication with the Coroner's offices is via Coroners officers. Recently the CDOP health professionals met with the local Coroner to share information and to refresh communication channels.

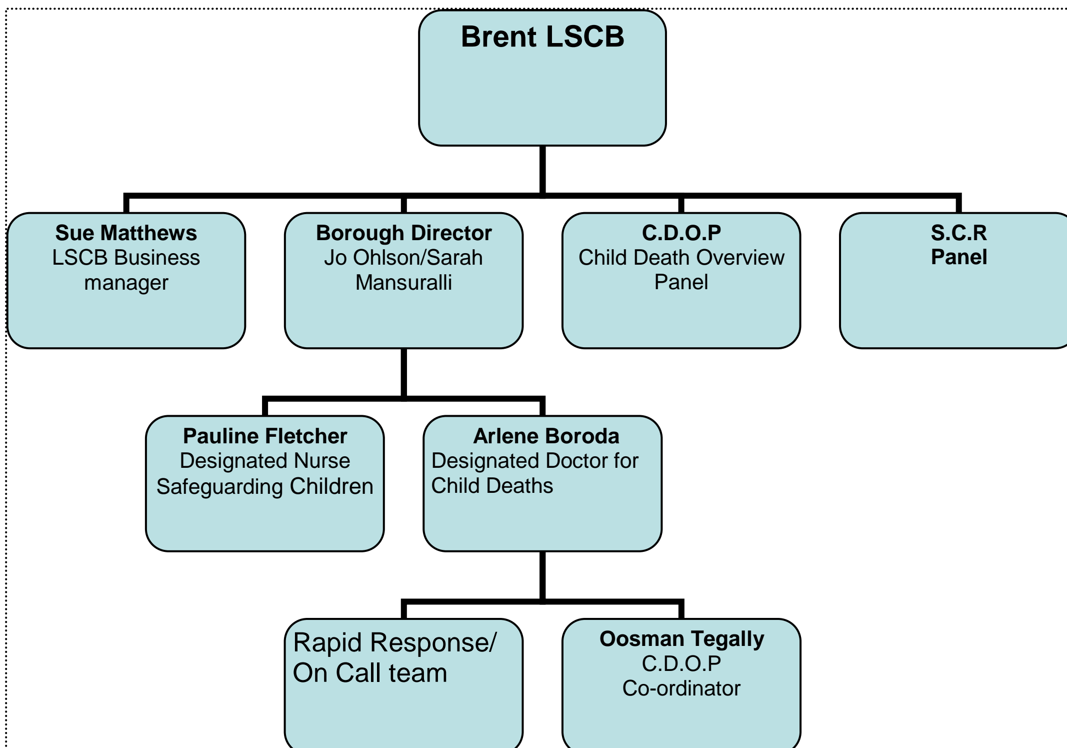
Accessing information from health providers has been difficult in some cases.

Parents have not yet been involved in the review process but they are informed about the Child Death Review process. Information about the Child Death Review process and other relevant information including bereavement care and counselling are 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 decisions with the parents and universal staff including GPs that had contact with the children.

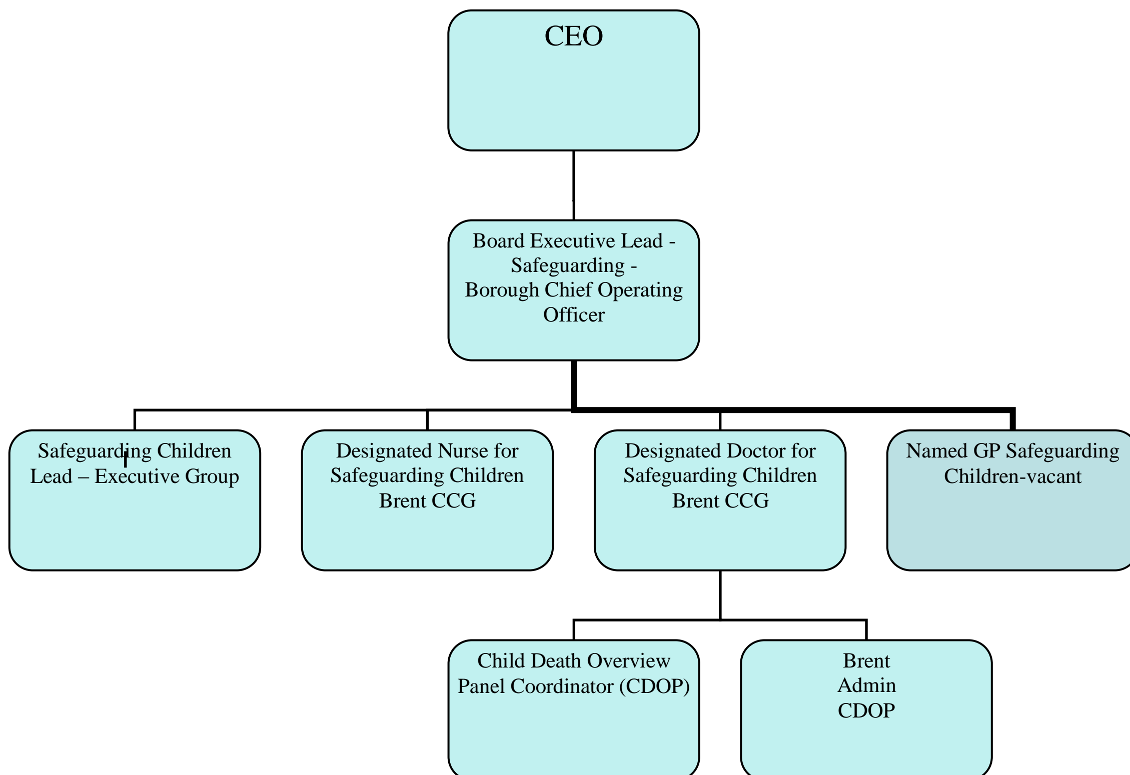
Appendix 1

Postholders

Executive Lead for Safeguarding Children- Jo Ohlson then Sarah Mansuralli
Public Health Consultant –Dr Melanie Smith
Designated Doctor for Unexpected Child Deaths- Dr Arlene Boroda
CDOP Co-ordinator- Oosman Tegally
Designated Nurse for Safeguarding Children NHS Brent CCG- Pauline Fletcher
Rapid response on call – Liz Reid, Dr Arlene Boroda
Head of Safeguarding (Social Care) - Sarah Alexander
Brent and Harrow Metropolitan Police CAIT –DS Jason Dawson
Administration -Maxine McLeod



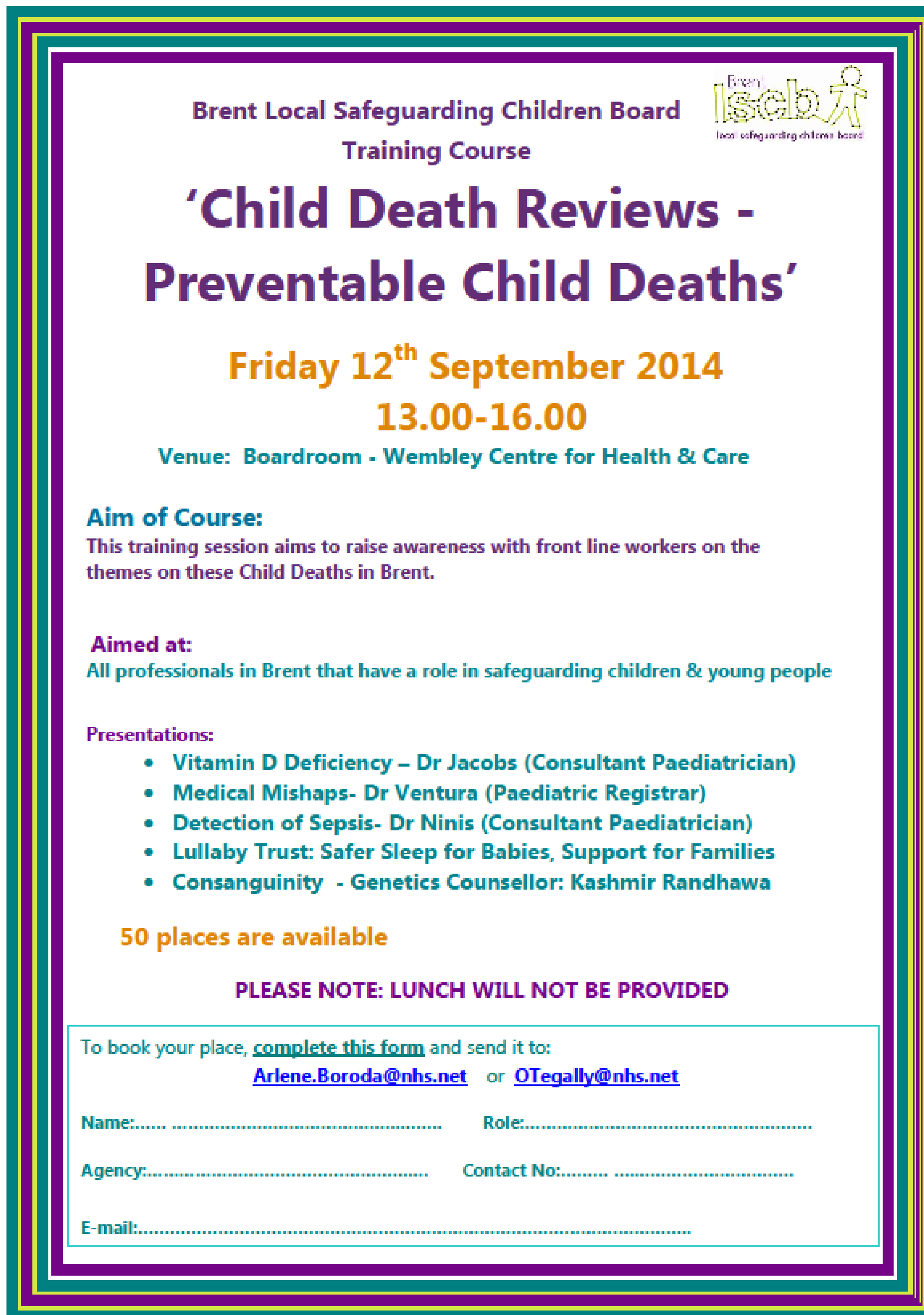
Appendix 2
NHS BRENT SAFEGUARDING CHILDREN STRUCTURE CHART



Appendix 3:
CHILD DEATH OVERVIEW PANEL MEMBERSHIP ATTENDANCE 2014 - 2015

	03/07/2014	10/09/2014	15/01/2015	04/03/2015
Public Health Consultant	Present	Apologies	Present - Chair	Present - Chair
Designated Doctor for Child Deaths for NHS Brent CCG	Present - Chair	Present - Chair	Present	Present
CDOP Co-ordinator	Present	Present	Present	Present
Designated Nurse for Safeguarding Children NHS Brent CCG	Present	Present	Present	Present
Police/CAIT	Present	Present	Represented – (MIT)	Present
Social Care - Head of Safeguarding Children	Present	Present	Present	Present -Represented
Bereavement midwife NWLH	Present	Present	Present	-
The Lullaby Trust (FSID)-parents	Present	Present	Apologies	Present

Appendix 4


Brent Local Safeguarding Children Board
Training Course

'Child Death Reviews - Preventable Child Deaths'

Friday 12th September 2014
13.00-16.00

Venue: Boardroom - Wembley Centre for Health & Care

Aim of Course:
This training session aims to raise awareness with front line workers on the themes on these Child Deaths in Brent.

Aimed at:
All professionals in Brent that have a role in safeguarding children & young people

Presentations:
- Vitamin D Deficiency – Dr Jacobs (Consultant Paediatrician)
- Medical Mishaps- Dr Ventura (Paediatric Registrar)
- Detection of Sepsis- Dr Ninis (Consultant Paediatrician)
- Lullaby Trust: Safer Sleep for Babies, Support for Families
- Consanguinity - Genetics Counsellor: Kashmir Randhawa

50 places are available

PLEASE NOTE: LUNCH WILL NOT BE PROVIDED

To book your place, complete this form and send it to:
Arlene.Boroda@nhs.net or OTegally@nhs.net

Name:...... .... Role:...

Agency:.. Contact No:......... ....

E-mail:..