CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT

1st APRIL 2016 – 31st March 2017

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 01/04/2016 – 31/03/2017

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.
http://www.brentlscb.org.uk/main/article.php?tag=cdop&name=role§or=home

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 01/04/2016 – 31/03/2017 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.

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

Table 1: Total Number of Reported Child Deaths in Brent - 01/04/2008 31/03/2017

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

The age range of the reported deaths for the year are as listed below:

Age range of deaths	Unexpected	Expected	TOTAL
Neonatal deaths (<4wks)	**1**	**9**	**10**
Infant death (4wks – 1yr)	**4**	**5**	**9**
Children between 1-4 years of age		**2**	**2**
Children between 5-9 years of age		**2**	**2**
Children between 10– 14 years of age		**1**	**1**
Young people between 15 – 18 years of age	**1**	**1**	**2**
Total	**6**	**20**	**26**

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

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 2015/16 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:
(27/04/2016 – **5** cases discussed**,** 28/09/2016 – **6** cases discussed**,** 16/11/2016- **12** cases discussed , 18/01/2017 – **4** cases discussed and 29/03/2017– **3** cases discussed).

The CDOP reviewed **30** child deaths cases in the year 2016- 2017.

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.

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 (plus one 1**) **unexpected child deaths**, there were 6 (plus one 1**) rapid response meetings which were attended by a number of professionals.
One child was placed in Brent by another Borough (1**) and representatives from the relevant authority attended the rapid response meeting held in Brent. Their borough agreed to review the case as per their CDOP procedures. The death will NOT be included in the Brent CDOP figures as Brent will not be reviewing this death.
The rapid response meetings facilitated good information at the outset.
(see attendance table - Appendix C).

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 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 2016 and 31st March 2017, **26** (plus one 1**) 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 – 31/03/2017 is outlined in the table1.

- **Number of deaths each month**

The range in number of deaths each month over 2016 – 2017 **has varied** from **1 to 5 and is illustrated below.**

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
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**

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

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. This year there were no reported deaths in June and November but in 2015-2016 there were no deaths reported in May and June and in 2014-2015, there were no death reported in October, November 2014 and February 2015.

- **Gender**

The 26 deaths (2016-2017) comprised a total of 14 males and 11 females

Gender of child deaths	
Males	**Females**
14	**12**

Table 4: Gender of child deaths.

- **Child Deaths by Locality**

Willesden - 4
Kingsbury - 1
Harlesden - 6
Kilburn - 3
Wembley - 12

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

Area	NW2	NW6	NW9	NW10	HA0	HA3	HA9	HA8
Number	4	3	1	6	5	3	3	1

Table 5: Postcode of family home of child deaths

- **Place of Death**

The child deaths in hospital were recorded at one of six hospitals. The number of deaths in each hospital ranged from 1 to 11.
25 of the deaths occurred in a hospital setting and 1 at home. On one we have insufficient information.

The locations of the recorded deaths are as follows:
Northwick Park Hospital **5** deaths, St. Mary's Hospital **11** deaths, Chelsea and Westminster Hospital **1**, Queen Charolotte Hospital **3**, Great Ormond Street Hospital **3**, UCLH **1** and The Royal Brompton Hospital **1**.
One death was recorded in the home- this was abroad and recorded as 'outside the UK'.

Northwick Park Hospital	St. Mary's Hospital.	Chelsea and Westminster Hospital	Q.C.C.H.	GOSH	The Royal Brompton Hospital	UCLH	Home/ Outside UK
5	11	1	3	3	1	1	1

Table 6: Hospitals/ Locations of Child deaths

- **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.

White British	1
White: Irish	1
White - Polish	2
White - Romanian	4
White - Kosovan	1
White: Any Other White background- Nepalese	1
Mixed: White & Asian	1
Asian or Asian British: Indian	2
Asian or Asian British: Pakistani	3
Asian or Asian British: Bangladesh	1
Asian or British Asian	1
Black: Caribbean	2
Black: African	1
Black African: Somali	1
Black British	1
Any other Black/African/Caribbean background	1
Potuguese/Brazilian	1
Other – British Filipino	1
TOTAL	**26**

REVIEWS:

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

The panel completed reviews on a total of **30** child deaths during 2016 - 2017.
1 – from year 2013 – 2014.
1 – from year 2014 – 2015.
10 – from year 2015 – 2016 and
18 – for the year 2016 – 2017.

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
Under 6 months	2	19
6 - 7 months		2
8 - 9 months	1	
10 - 11 months		
12 months	3	
Over 12 months	3	
Total	**9**	**21**

Table 8: Time span of Child Death review

9.0 DEMOGRAPHICS

Table 9. Age ranges for child deaths reviewed for April 2016 - March 2017.

Reviews Age Range:

Age range of deaths	Unexpected	Expected	TOTAL
Age range of deaths	**Unexpected**	**Expected**	**TOTAL**
Neonatal deaths (<4wks)		**7**	**7**
Infant death (4wks – 1yr)	**4**	**8**	**12**
Children between 1-4 years of age	**3**	**2**	**5**
Children between 5-9 years of age	**1**	**3**	**4**
Children between 10– 14 years of age			
Young people between 15 – 18 years of age	**2**		**2**
Total	**10**	**20**	**30**

- **Gender of Reviewed cases.**

From the **30** children reviewed at panel**,** 1 April 2016 – 31 March 2017**,** their gender was:

Gender of reviewed cases	
Males	**Females**
16	14

Table 10: Age ranges for child deaths Reviewed for April 2016- March 2017.

Table 11: Ethnicity of 16 child deaths reviewed from 1st April 2016 – 31st March 2017

White: English/Welsh/Scottish/Northern Irish/British	1
White: Irish	1
White: European – Romanian	4
White: European – Kosovan	1
White: Other European	2
White: Any Other White background - Nepalese	1
Mixed: White & Asian	1
Mixed: Any other mixed/ ethnic background	1
Asian or Asian British: Indian	1
Asian or Asian British: Bangladeshi	1
Asian or Asian British: Pakistani	3
Asian or Asian British: Any other Asian background	1
Black: British	2
Black: Caribbean	4
Black: African (Somali)	2
Black: African	1
Any other Black/African/Caribbean background	
Any other – Portuguese/ Brazilian	1
Other: Any other (British – Filipino)	1
Other - Arab	1
TOTAL	**30**

10.0 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 30 deaths reviewed 2016-2017:

	Expected	Unexpected
Expected death from natural causes:		
Chromosomal, genetic and congenital anomalies	14	
Perinatal/neonatal event	4	
Malignancy	1	
Unexpected deaths – these include		
SUDI / SIDS		3
Chronic medical condition	1	1
Infection		2
Trauma following - Road traffic collision		2
- Drowning		1
Deliberate Inflicted Injury - Homicide		1
Total	**20**	**10**

Unexpected deaths:
Modifiable Factors: The panel found that there were modifiable, or possible modifiable factors, in 10 of the cases reviewed.

Modifiable Factors Identified.

There were 3 SUDIs reviewed.

- In two cases co-sleeping was identified where it was noted that the parents had taken the baby into the parental bed.
- In one case the baby was placed in the parental bed and propped up on the sides with pillows.

Recommendations are to promote safer sleep awareness for babies

Three cases of Trauma: two following road traffic collision:.

- One young person fell off a hoverboard in a public road and was run over by a bus.
- One child was hit by a car in a car park open to the public following reckless driving

- There was one case where a child died from drowning whilst left unattended in a bath.

Deliberate Inflicted Injury – Homicide.

- One young person died following a knife incident in a public place.

Infection:

Vaccines can prevent infections. One child death related to absence of immunisations. Early detection and management is key especially in vulnerable patients.

Audit of Brent SUDI's from 2008-2017: There have been 23 cases.

Year	No. of SUDI	Issues identified
2008-09	1	Found at end of cot
2009-10	2	One case of co-sleeping
2010-11	4	All four cases reported to be co-sleeping
2011-12	1	Limited information.
2012-13	4	Three cases reported to be co-sleeping
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.
2015-2016	1	Nil
2016-2017	4	All co-sleeping
TOTAL	23	

There were 13 cases of co-sleeping; three infants were reported to be sleeping on their front (prone postion). One infant was found at the end of his cot wrapped in a blanket.
Two infants were ex-premature babies
One infant was placed on his side with a wedged pillow in his cot.
One was a twin

There were no factors identified in the four other cases.

Brent SUDIs from 2008- 2017 - Postal codes						
NW10	NW6	NW9	NW2	W10	HA0	HA9
9	3	3	2	1	4	1

Brent SUDIs from 2008- 2017 - Ethnicity			
White British	4	Mixed White/Black	1
White Irish	1	British Asian - Pakistani	1
White Other	3	Other - Filipino	1
Black British	3	Other - Arab	1
Black Caribbean	2	Asian British	3
Black African	3	TOTAL	23

Hospital attending to SUDI babies	Numbers
Northwick Park Hospital	9
St. Mary's Hospital	10
Royal Free Hospital	2
Hammersmith & Fulham Hospital	1
Overseas	1

11.0 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 2015 happened. 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.

12.0 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 reveiwed by the Desiganted Professionals for safeguarding children and key messages highlighted at the CDOP case reviews.

Cases reviewed covered three SI reviews. In two other cases the SI reports are not complete.

13.0 LINKING UP WITH LONDON CDOP

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

Healthy London Partnership work

Brent CDOP and Brent LSCB has promoted the work of the Lullaby Trust and supported their safe sleeping week
https://www.lullabytrust.org.uk/safer-sleep-week

Safer Sleep Week is The Lullaby Trust’s national awareness campaign targeting anyone looking after a young baby.
From the 13-19 March 2017 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 and via a

briefing in Kilburn Times on 14/03/2017.
http://www.kilburntimes.co.uk/news/health/brent-council-working-to-raise-awareness-of-cot-death-1-4930237

14. INFANT MORTALITY RATES IN BRENT:
Information suppied by Public Health team in Brent Local Authority

Chart 1 shows the comparison of the Brent infant mortality rate with its statistical neighbours, London and England for 2011-13, 2012-14 and 2013-15. The infant mortality rate refers to the rate of deaths in infants aged under 1 year per 1,000 live births
Brent started the period 2011-13 with a rate of 5.1 per 1000. At that time Brent had the highest infant mortality rate of compared to its neighbours and the regional and national comparator. Infant mortality is one of the general indicators of the health of the population
During the period in question there has been a year on year decline in the infant mortality rate. By the end of the period in question 2013- 15 Brent's infant mortality rate was very similar to the London average and comparable with its statistical neighbours.

Chart 1:
Brent Infant Mortality Rates compared to statistical neighbours 2011-13 and 2012-14
Source: Public Health England Child Health Profiles

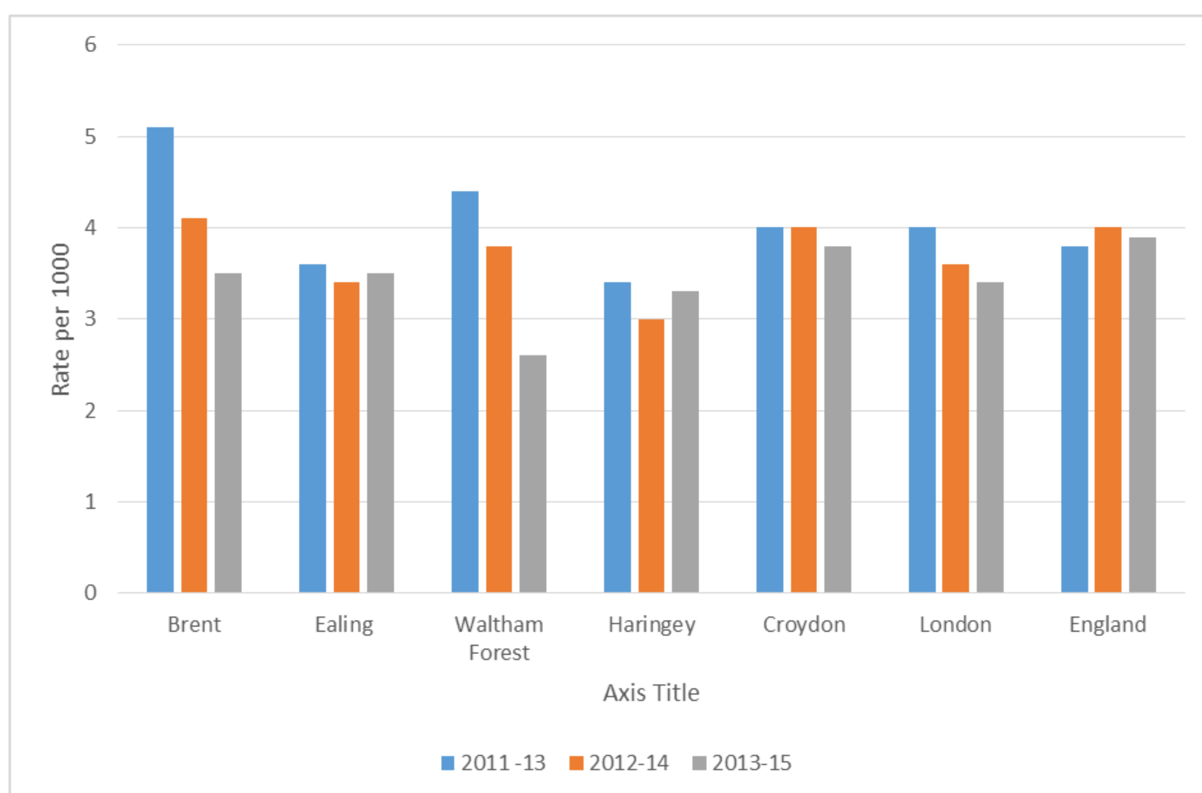
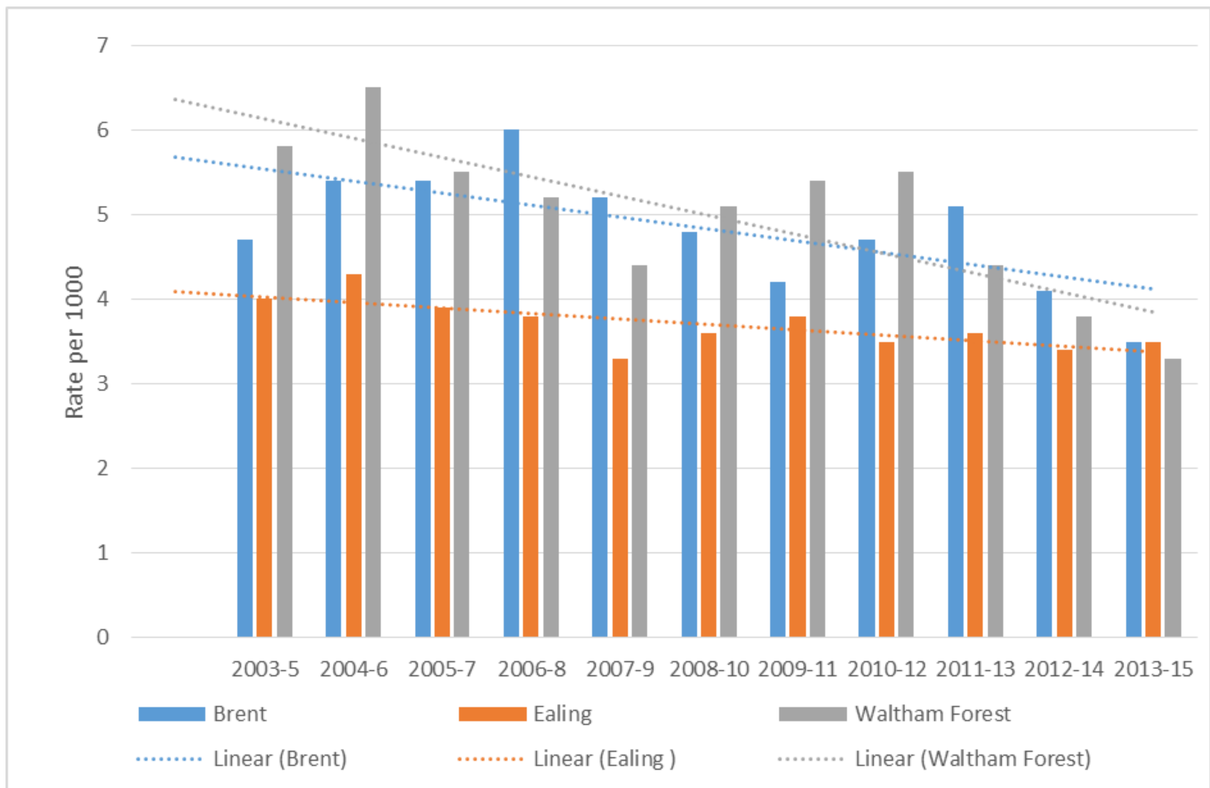


Chart 2 shows the longer term variation in infant mortality over the past decade from 2003-5 until 2013-15. In addition to infant mortality being a general health indicator it also reflects the relationship between specific causes of infant mortality and the wider determinants of health. Over the period in question despite some fluctuation, there has been a downward trend in Brent. This has also been reflected in the comparator

boroughs Ealing and Waltham Forest. The variation between the boroughs has also decreased over time and the rates are now quite similar.

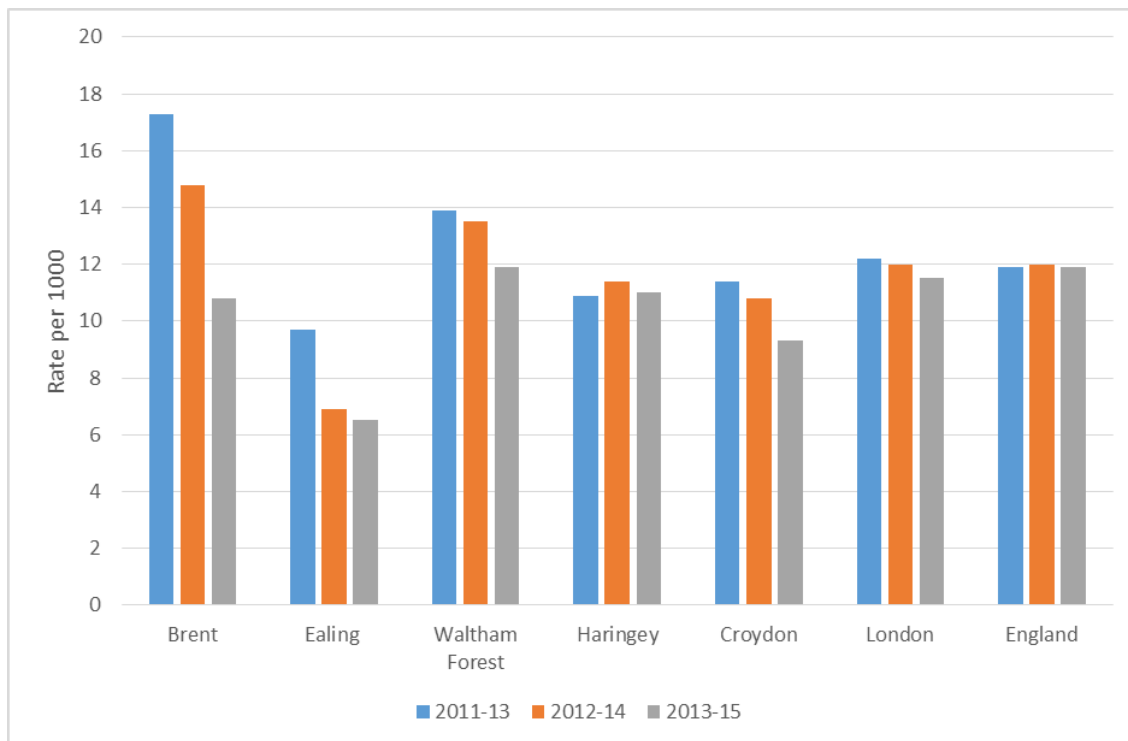
Chart 2.
Brent Infant Mortality Rate compared to statistical neighbours from 2003-05 to 2013-15
Source: Public Health England Child Health Profiles



Child mortality rates in Brent

Chart 3 shows the comparison of the child mortality rates of Brent with its Statistical neighbours, London and England for 2011-13, 2012-14 and 2013-15. The child mortality rate refers to the directly standardised rate of death due to all causes in persons aged 1-17 years. Brent started the period in question with a higher infant mortality 17.3 per 1000 than its statistical neighbours as well as London and England. During the period on question the child mortality rate has fallen rapidly. It is now 10.8 per 1000 and comparable to its statistical neighbours. It is also now less than London and England.

Chart 3
Brent child mortality rates (1-17) compared to its statistical neighbours.
Source: Public Health England Child Health Profiles



15.0 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 investigation. Communication with the Coroners' offices is via Coroners officers.
Accessing information from health providers has been 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.

16.0 LESSONS LEARNT:

Significant Incidents SIs involving Brent child deaths during this period have covered the following:

- A child with a chronic condition required the first responders LAS at a critical time. LAS conducted an SI review in response to concerns by the parent covering the screening of the telephone calls for help and the timescales of the response. This was shared with the parent.

- A baby passed away from an irremediable condition but the level of maternal/baby care was reviewed as requiring improvement. This report was shared with the parents.
- An unvaccinated toddler died from (vaccine preventable) septicaemia having been seen by health professionals in the few days prior to the death. The health provider completed an SI and made changes to their pathways for under 5s including easier acceptance of cases from GPs , development of further patient triage guidelines and improving the interface between their Urgent Treatment Centre UTC and the paediatric Accident and Emergency.

The coroner issued Rule 28s during this period:

i. *Unvaccinated toddler and pneumococcal septicaemia: Rule 28*
A concern that there was a lower threshold for admission for paediatric doctors in the Emergency Department and the Urgent Care Centre doctors.
A concern that CCG (commissioning UTC) should review, in partnership with local Paediatricians and providers of local emergency care, the safety of local paediatric pathways'.

Following a review of the referral pathway to paediatric services a new process has been agreed to be implemented whereby a child under the age of 5 years that presents to the Urgent Care Centre having already accessed healthcare services on 2 or more occasions over a 5 day period will instigate a referral for paediatric review.

ii. SUDI /SIDS – cases.

In one case after extensive investigation and a detailed inquest hearing with many expert witnesses, the Coroner gave a narrative ruling and issued a Rule 28.

SIDS: Rule 28 from Coroner to DOH and Yellow Card Scheme:
"Posters and forms detailing the Yellow Card Scheme are not routinely available in a GP Surgery".
(… concerns raised at the inquest that the death was connected with the use of the MMR vaccine and that the Yellow Card Scheme should be more widely publicised. It was suggested that a poster and forms might be helpful in GP waiting rooms").

Key points:
- A complex decision involving disagreements between parents and professionals in end- of -life care cases may need a high court involvement as decision makers
- A child died from drowning whilst left unattended in a bath: Children under the age of 5 must not be left unattended in a bath.
- An early presentation to health services may have had a different outcome especially in the neuro-disabled children.
- In SUDIs joint home visits between police and health professionals is beneficial.
- One young person died following a knife incident in a public place. Knife crime is a significant problem in London.
- Road traffic collision due to careless driving can have fatal outcome.

- The first fatality linked to a hoverboard in a road traffic collision was in Brent.
- Co-sleeping is a risk factor for SUDI.
- When a foetal abnormality is diagnosed at antenatal clinics, parents are given advice and genetic counselling to enable them to make informed of choices.
- End of life care plans should be in place for all people with life limiting conditions (NICE standard guidelines).

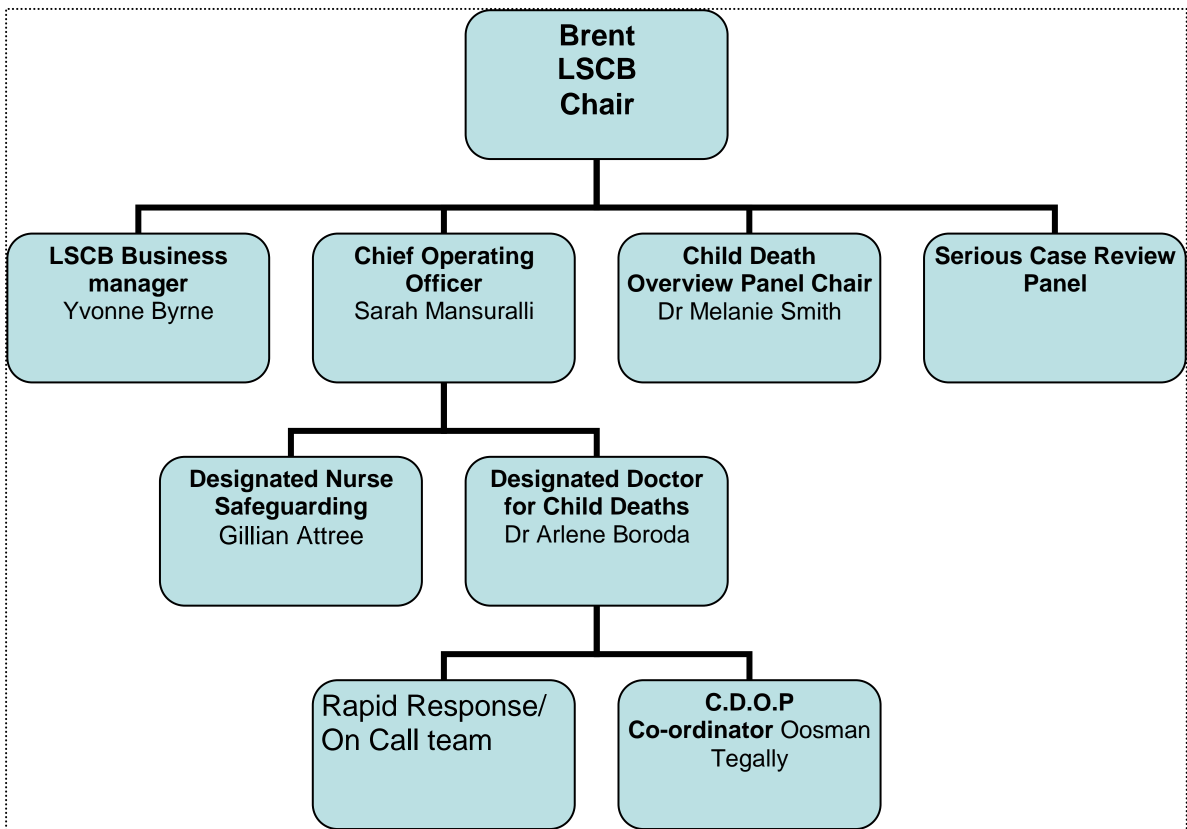
17.0 ENGAGING PARENTS IN CDOP PROCESSES:

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 three families have linked with the CDOP. This has facilitated the communication parents' views with service providers to the children.

Appendix A

Postholders

Executive Lead for Safeguarding Children- 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- Gillian Attree
Rapid response on call – Dr Arlene Boroda
Head of Safeguarding (Social Care) – Sonya Kalyniak/Lavinia Moore
Brent and Harrow Metropolitan Police CAIT – DI Jason Dawson


Brent LSCB Chair
LSCB Business manager Yvonne Byrne
Chief Operating Officer Sarah Mansuralli
Child Death Overview Panel Chair Dr Melanie Smith
Serious Case Review Panel
Designated Nurse Safeguarding Gillian Attree
Designated Doctor for Child Deaths Dr Arlene Boroda
Rapid Response/ On Call team
C.D.O.P Co-ordinator Oosman Tegally

Appendix B:

CHILD DEATH OVERVIEW PANEL MEMBERSHIP ATTENDANCE 2016-2017

	27/04/2016	28/09/2016	16/11/2016	18/01/2017	29/03/2017
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	Present	Apologies	Present	Apologies	Present
Police/CAIT	Present	Present	Present	Present	Present
Social Care - Head of Safeguarding Children - representative	Nil	Present	Present	Present	Present
Bereavement midwife LNWC Trust	Nil	Nil	Nil	Nil	Present
The Lullaby Trust (FSID) - parents	Present	Apologies	Present	Present	Present

Appendix C – Rapid Response meeting Attendances.

Case Number	QK 02/04/2016	QK 05/07/2016	QK 06/08/2016	QK 08/08/2016	QK 18/01/2017	QK 20/01/2017	QK 25/03/2017
Date of meeting:-	16/05/2016	03/08/2016	30/08/2016	07/09/2016	13/01/2017	27/02/2017	08/03/2017
Attendees at meetings							
Designated Consultant for Unexpected Deaths	Y	Y	Y	Y	Y	Y	Y
Consultant Paediatrician	Y- 2		Y	Y	Y	Y	Y- trauma
CDOP Co-ordinator		Y					
Paediatrics Registrar				Y		Y	Y
GP		Y					Nil
Children social care	OT-y		Y		Y	Y	Y
Designated Nurse Safeguarding Children		Y	Y				
Clinical Leads/ HVs – CSB/SN	Y	Y	Y		Y	Y	Y SN
Police	Y	Y	Y	Y	Y	Y	Y
London Ambulance Service	Y	Y	Y	Y		Y	Y
Hospital Nursing/Midwifery	Y		Y	Y	Y	Y	Y
Other Professionals Family Liaison Nurse/ OT/ Risk manager leads.	Y		Y	Y	Y	Y	Y
School							Y