Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 17 July 2018
	Report from the Director of Public Health and the Designated Doctor for Unexpected Child Death

Child Death Overview Panel (CDOP) Annual Report 2017/18

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	N/A
Background Papers:	N/A
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1.0 Purpose of the Report

1.1 The Child Death Review Panel (CDOP) is a subcommittee of the Local Safeguarding Children Board (LSCB). Brent LSCB received the 2017/18 CDOP Annual Report at its June 2018 meeting. The report is presented to the Health and Wellbeing Board with an account of the LSCB deliberations.

2.0 Recommendation

2.1 The Board note the CDOP 2017/18 Annual Report

3.0 Detail

3.1 The child death review process is a statutory process. There is a rapid response process for unexpected deaths of children resident in Brent, irrespective of place of death. In addition all deaths of children, both expected and unexpected, are reviewed by a multi-professional panel, CDOP. Child deaths may also result in a serious case review, a serious incident being declared by health services or a Coroner's investigation or inquest.

3.2 The specific purpose of the CDOP process is to consider whether there were modifiable factors associated with the death. Modifiable factors are those which may have contributed to the death and which, by locally or nationally achievable interventions could be modified to reduce the risk of future child deaths.

3.3 The LSCB in receiving the report noted that CDOP identifies factors which are associated with a death, it cannot determine whether such factors are causative. A determination that modifiable factors were present does not imply blame on any individual party nor does it mean that that particular death was preventable. It simply means that there is the potential for an intervention to prevent future deaths.

3.4 The LSCB considered the CDOP report in the light of rates of infant (under 1 year) and child mortality which are declining.

3.5 In 2017/18, CDOP reviewed 27 deaths of which 5 were unexpected. Lessons may be learnt from expected as well as unexpected deaths, for example CDOP has emphasised the importance of end of life care plans being put in place.

3.6 In 2017/18, there were no serious case reviews. Four deaths were treated as serious incidents by health services. The LSCB were concerned that CDOP should receive timely and full information from SI reviews as this provides useful potential for learning. CDOP is particularly concerned that learning from SIs is acted upon.

3.6 Some deaths are associated with factors beyond health care; a number of expected deaths occur due to congenital abnormalities where there are consanguineous parents. The LSCB discussed this issue. Brent CDOP does not regard these deaths as preventable but is concerned to ensure that parents receive appropriate antenatal and genetic counselling and are able to make informed choices.

3.7 The report outlines lessons learnt during 2017/18. In 2017/18 learning was presented and discussed at a Paediatric Grand Round which is a very welcome development. There are a number of lessons specifically for health care professionals including the advice given to parents and the recording thereof, the particular risks of maternal obesity. A new sepsis pathway has been introduced as a result of lessons learnt.

4.0 Financial Implications

4.1 The CDOP office and co-ordinator are funded by Brent CCG.

5.0 Legal Implications

5.1 The CDOP is a subgroup of the Local Safeguarding Children Board (LSCB) as set out in Regulation 6 (SI No 2006/90) of the Children Act 2004. The child death process is a statutory process covered by Chapter 5 of Working Together to Safeguard Children 2015.

6.0 Equality Implications

6.1 None.

7.0 Consultation with Ward Members and Stakeholders

7.1 Not applicable.

Report sign off:

Melanie Smith
Director of Public Health