15th November 2012

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East London and the City

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Ms Fran Pearson
Chairperson
City and Hackney Safeguarding Children Board
Hackney Service Centre
1 Hillman Street
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Dear Ms Pearson,

Please find enclosed the annual report for the City and Hackney Child Death Overview Panel (the CDOP) for the period 1st April 2011 to 31st March 2012.

This report is made in accordance with chapter 7 of *Working Together to Safeguarding Children*. It provides a summary of the work undertaken by the CDOP since April 2011 and sets out the priorities for future development to address the principle strategic objective of reducing child deaths in the London Borough of Hackney and the City of London.

The CDOP plays a key role in improving the health, safety and wellbeing of all children who are resident in the London Borough of Hackney and the City of London. Its main function is to review all deaths occurring in children (under 18 year old), in order to assess the degree of preventability and to identify if there were any predisposing factors or failures within the system that could have contributed to each individual death. The CDOP maintains a database which contains information from all deaths in the area. This information is analysed to identify the main causes of death and to recognise trends, risks (particularly preventable risks) and predisposing factors such as service anomalies. The CDOP looks at epidemiological, environmental, social and cultural factors that could be associated with child deaths locally; and will produce recommendations to contribute to reduce risk factors and to improve the quality of frontline services for children and young people preventing future deaths from occurring.

The CDOP's role is also critical in building government and community confidence in the ability of key agencies to respond quickly and transparently in a concerted manner when a child who is normally resident in the City of London and the London Borough of Hackney dies.

This report includes data collected and information related to child death case reviews that were conducted in the period from 1st April 2011 to 31st March 2012, identification of substantive issues and our recommendations made for improvement to the delivery of frontline services for children and young people in the City of London and the London Borough of Hackney.

Yours sincerely,

Dr Jose Figueroa
Chairperson
Child Death Overview Panel

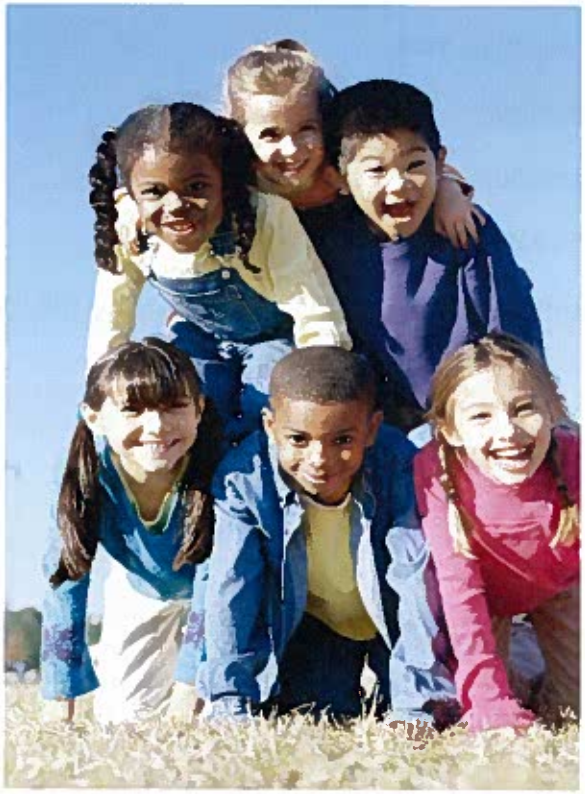
chscb

NHS
North East London and the City




CHILD DEATH OVERVIEW PANEL ANNUAL REPORT 2011-12

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



Contents

Message from the Chairperson

The City and Hackney Child Death Overview Panel (CDOP) is now in its fifth year of operation and this is the fourth annual report published by the CDOP.

The CDOP is an independent multidisciplinary panel that provides a review of deaths of children who are under 18 and resident in the London Borough of Hackney or the City of London. During the 2011-12 reporting period the CDOP reviewed the deaths of 30 children and young people.

On behalf of the CDOP I would like to offer my condolences to the families, carers and friends of those children and young people whose deaths were considered by the CDOP during the reporting period.

The death of a child is always emotional. Each one touches the lives of the child's family, friends, those who worked with the child and the broader community. Many of the children to whom this report refers are aged under 1 year of age and have sadly died due to a perinatal event, whilst some of the older children are from complex family circumstances that may include parental mental illness, parental conflict, separation and neglect.

When a child dies, there is statutory requirement and public expectation that the death will be comprehensively reviewed and that services provided to the child will be evaluated in a manner which promotes learning and transparency. The review process is also compelled by a deeply entrenched moral imperative to act to protect young lives by identifying and addressing risks and making recommendations for improvement of services.

The City and Hackney CDOP became active on the 1st of April 2008. In this period the CDOP has reviewed the deaths of 123 children and young people and all recommendations made by the CDOP has been implemented or are in the process of being implemented.

The CDOP's process and annual report aim to promote the transparency of the child death case review requirement by ensuring all cases are scrutinised by an independent appointed panel with expertise in the fields of public health, paediatrics and child health, neonatology, paediatric pathology, mental health, children's social care, investigations and child protection, nursing, midwifery, general practice, child safety (police), education, youth crime reduction and other members who can otherwise make a valuable contribution. 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 conclusion I would like to take this opportunity to thank the current members who have brought an immense and diverse wealth of experience to the child death review process for their commitment, important contribution and support during the past two years. I would also like to sincerely thank the outgoing Chair of the Rapid Response group for her invaluable contribution to the child death review process and for her commitment to improving service delivery to children and young people. I would also like to thank the relevant agencies across all sectors and its staff for the support they have given to the process. I trust the information in this report will continue to be useful to all those involved in protecting children and promoting their wellbeing.

Dr Jose Figueroa MD, PhD, MPH, MFPHM
Chairperson
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, ensuring that:

- local procedures and protocols are developed, implemented and monitored in line with guidance in Chapter 7 of *Working Together to Safeguard Children*;
- 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 s 47 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.

[1] *Royal College of Paediatrics and Child Health Guidance on Child Death Review Processes* (2008) 2.

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, paediatric pathology, 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.

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 maintains an up to date register of the deaths of all children and young people under 18 years of age that occur 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.

1.3.2 Neonatal

A neonatal death is defined as the death of a liveborn 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.

1.3.3 Unexpected child deaths

An unexpected death is defined as: *the death of a child not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death.*[2]

The unexpected death category includes both deaths as a result of external factors, such as a traffic accident or a stabbing incident, and deaths as a result of medical causes.

Whenever a child dies unexpectedly (birth up to 18th birthday, excluding stillborn babies), 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;

[2] HM Government, *Working Together to Safeguard Children* (March 2010) 212.

- ensure support for the bereaved family members, as the death of a child will always be a traumatic loss – the more so if the death was unexpected;
- 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, maintaining 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;
- consider bereavement support for any other children or members of staff who may be affected by the child's death.

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 are available and can be shared.[3]

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.

[3] City and Hackney Teaching PCT, *City and Hackney Rapid Response Procedure* (February 2009) 3-4.

Chapter 2

Overview of the CDOP's operation

2.1 Number of child deaths

In the 12-month period from the 1st of April 2011 to the 31st of March 2012, there were 30 deaths in children and young people who were normally resident in the City of London and the London Borough of Hackney. The most recent released child mortality rate (age 1-17 years) as at March 2012 from Child and Maternal Health Observatory is 24.9 in Hackney and City of London compared to a national average of 16.5.

2.2 Number of meetings held and reviews conducted

The CDOP has completed and reviewed 30 cases during the period from the 1st of April 2011 to 31st March 2012. The 30 cases reviewed included 13 outstanding cases from previous years, that is, from 1st of April 2009 to 31st of March 2010 (4 cases); from 1st of April 2010 to 31st of March 2011 (9 cases); and 17 cases from the current year (1st of April 2011 to 31st March 2012).

Thirteen cases are pending review of the CDOP, of these, 2 cases are open to the rapid response group and are pending post mortem reports, and 11 cases require additional information before they can be reviewed by 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;
- preventability 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 4 of the 30 children and young people notified during the period 1st of April 2011 to 31st March 2012. The findings of all rapid response meetings are discussed at the monthly Serious Case Review sub committee. None of the sudden deaths reviewed by the rapid response group during 2011-12 were recommended to be subject to a Serious Case Review, but one case was recommended for a joint systematic review with another borough.

The venue of each rapid response meeting will depend on where the child has died. During 2011-12, the majority (3) of rapid response meetings took place at the Homerton University Hospital. See table 2.1 for a breakdown of all rapid response venues during the last year.

Table 2.1 Venues of rapid response meetings

Venue	Number of meetings held
Homerton University Hospital	3
Hackney Town Hall	1
Total	4

It is pleasing to note that Paediatricians from Homerton University Hospital conducted joint home visit with the Police in all of the sudden and unexpected deaths in infancy during the period of 1st April 2011 to 31st March 2012.

2.2.2 Preventability

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 six (20%) of the completed case reviews.

2.3 Organisation and resourcing of the CDOP

The CHSCB has 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 to the CHSCB. Therefore, 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 2009-10:

- 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's recommendations;
- 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 2.2 (below) displays a break-down of agency attendance at the CDOP meetings from April 2011 to March 2012 - during this period, there were five meetings.

Table 2.2 Agency attendance at CDOP meetings

Organisation	% of meetings attended
Chair – NHS ELC	100%
Child Death Overview Panel & Rapid Response Co-ordinator - CHSCB	100%
Child Abuse Investigation Team - Metropolitan Police Service	
• Detective Inspector	100%
Children's Social Care – Hackney Council	
• Head of Safeguarding	100%
• Head of Children in Need	40%
City of London	
• Director, Family & Young People Services	60%
City of London Police	
• Detective Sergeant	40%
East London NHS Foundation Trust	
• Named Professional for Safeguarding Children	20%
Education – The Learning Trust	
• Head of Attendance & Behaviour	80%
Hackney Borough Police – Metropolitan Police Service	
• Detective Inspector	100%
Homerton University Hospital – NHS Trust	
• Consultant Paediatrician	80%
• Consultant Neonatologist and Lead Clinician	40%
• Consultant Midwife – Public Health & Named Midwife for Safeguarding	80%
• Consultant Community Paediatrician, Designated Doctor for Child Deaths	100%
• Consultant Community Paediatrician	20%
• Named Nurse Child Protection	40%
Royal London Hospital	
• Consultant Paediatric Pathologist	20%
Young Hackney	
• Assistant Director, Youth Crime Reduction	40%

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. The most recent presentation by the Chair took place on the 7th September 2011.

The Chair of the rapid response group together with the CDOP Coordinator also presents the CDOP's data, findings and learnings to medical professionals. The most recent presentation took place on the 14th April 2011.

The CDOP's key findings and recommendations are also as of April 2012 published in the CHSCB's news bulletin, which is available from CHSCB's website (http://www.chscb.org.uk/).

Chapter 3

Commentary on the 30 cases reviewed by the CDOP

This chapter refers to the 30 cases reviewed during the period 1st of April 2011 to 31st March 2011.

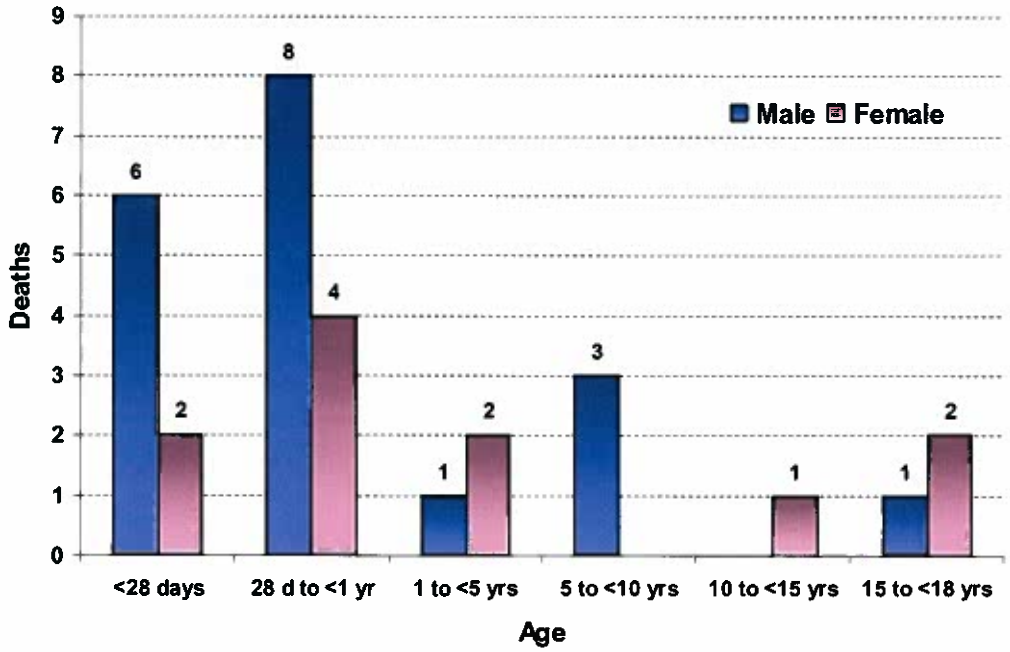
3.1 Neonatal deaths

Nearly a third of the 30 cases reviewed by the CDOP were deaths occurring within the first 28 days of life (8, 27%) and two thirds (20, 67%) occurred within the first year of life. The majority of deaths, (8, 40%) 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, cronchopulmonary dysplasia and post-haemorrhagic hydrocephalus irrespective of age at death.

The CDOP classified 5 deaths occurring within the first year of life (17%) as due to chromosomal, genetic and congenital anomalities. Parental consanguinity was not identified in any of these cases.

Nearly two thirds (19, 63%) of the reviewed deaths were in males.

Figure 3.1 Age and gender of child deaths that were reviewed between 1st April 2011 and 31st March 2012



3.2 Unexpected deaths

Eleven (37%) of the 30 cases reviewed by the CDOP in the period of this report were defined as unexpected deaths. Morbid conditions accounted for 5 deaths (45% of the unexpected deaths); external causes accounted for 4 deaths (36%) and included an Open Verdict, a death by misadventure and two fatal assaults; and 2 (18%) cases were classified by the CDOP as a sudden unexpected death of an infant (SUDI).

Table 3.1 Unexpected child deaths reviewed by the CDOP 2011-12

Age	Cause of death		
	External causes	Diseases/morbid conditions	SUDI*
Under 1	N/A	3	2
1-5 years	1	1	N/A
5-10 years	1	N/A	N/A
10-15 years	N/A	1	N/A
15-18 years	2	N/A	N/A
Total	4	5	2

* Sudden unexpected death of an infant.

The CDOP considered that modifiable factors may have contributed to the child death in 6 (55%) of the cases classified as unexpected deaths; this means that locally or nationally achievable interventions could reduce the risk of future child deaths. 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.

3.3 SUDIs

Two infant deaths reviewed by the CDOP were classified as sudden unexpected, unexplained death and by the Coroner as: Sudden Infant Death Syndrome – Natural causes.

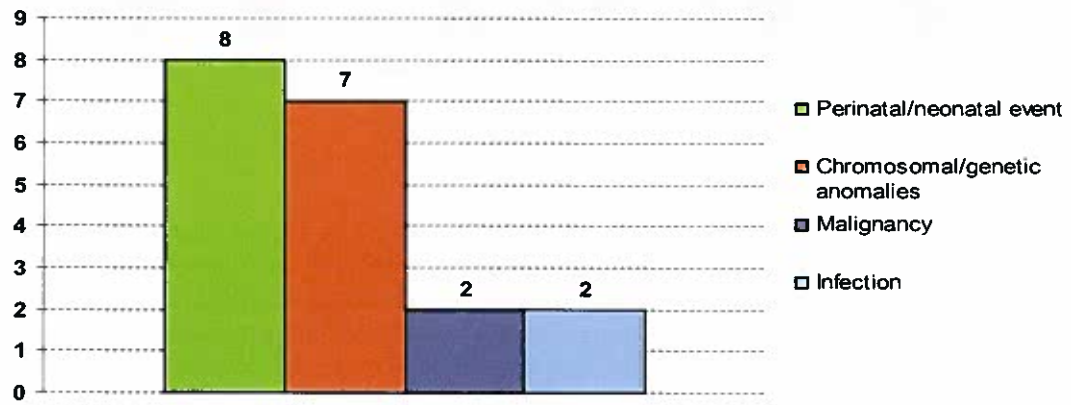
It was evident in one of the cases from the history provided, that the baby died whilst sleeping in bed with their mother (co-sleeping). The CDOP noted that bed-sharing is a serious risk factor for sudden infant deaths of babies under four months of age and due to the circumstances in this case, the CDOP identified modifiable factors.

There were no definite risk factors in the other case and no modifiable factors identified. However, issues around 'bedding' and safe sleeping were identified and low vitamin D levels were noted.

3.4 Expected deaths

Nineteen (63%) of the 30 reviews completed by the CDOP were defined as expected deaths. The majority of these cases, 8 (42%) cases were classified as 'perinatal/neonatal events'; 7 (37%) were classified as 'chromosomal, genetic and congenital anomalies'; 2 (10,5%) were classified as malignancies; and 2 (10,5%) were due to infections.

Figure 3.2 Expected child deaths reviewed by the CDOP 2011-12



Chapter 4

Child death statistics

This chapter refers to the 30 deaths in children and young people that the CDOP was notified of during the period 1st of April 2011 to 31st of March 2012.

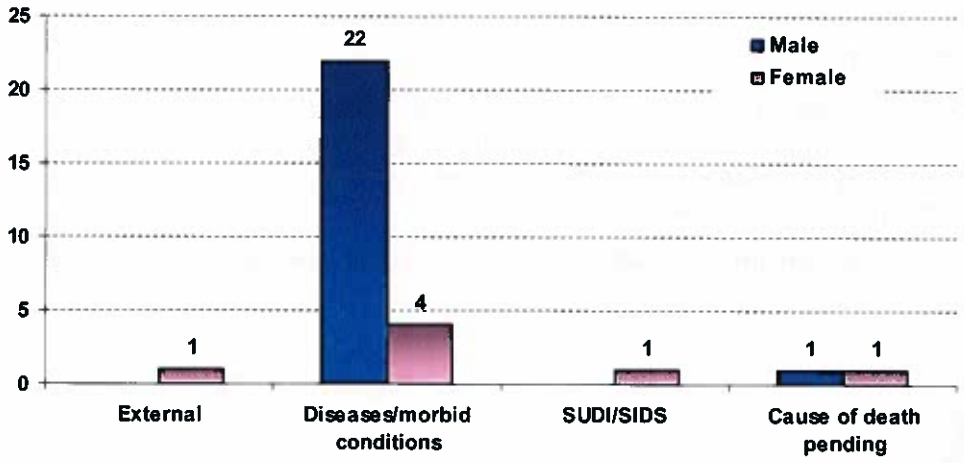
4.1 Cause of death

The CDOP categorises cause of death according to the World Health Organisations' *International Classification of Diseases and Related Health Problems* 10th revision (ICD-10).

The main cause of death (26, 87%) in children in the London Borough of Hackney and the City of London during this period was 'diseases/morbid conditions' (ICD-10). This category included: congenital abnormalities, perinatal conditions, cancer and seizure secondary to epilepsy.

External cases accounted for 1 death (3%) due to a fatal assault, 1 (3%) death was classified as SIDS and the cause of death is currently pending in 2 (7%) cases.

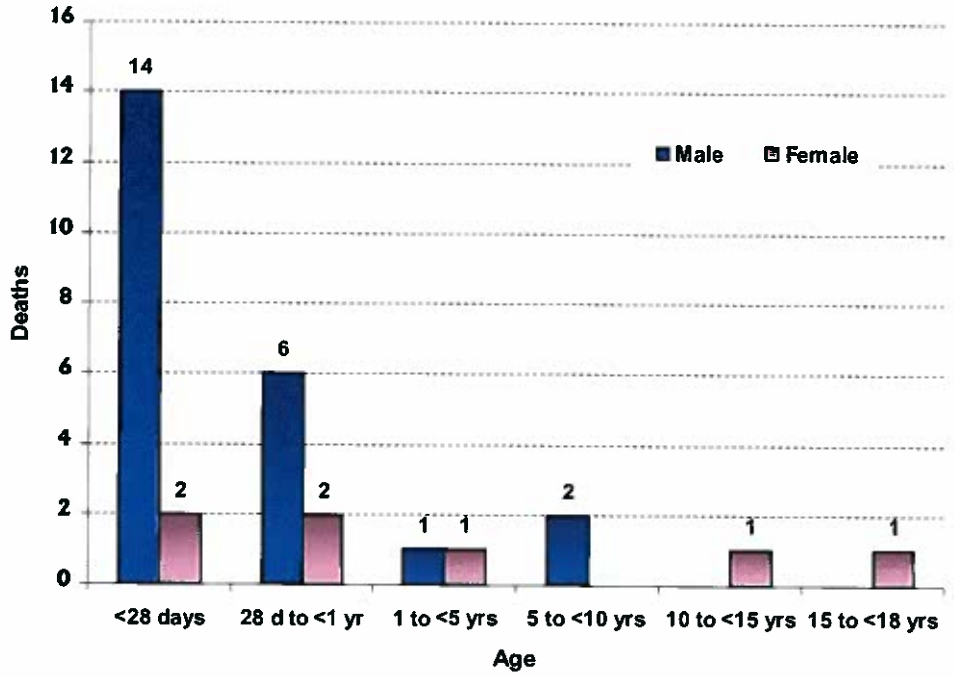
Figure 4.1 Child deaths in City and Hackney in 2011-12 by cause of death



4.2 Age and gender

Of the 30 deaths that took place in the period covered by this report, more than three quarters of the deaths were in males (23, 77%); 24 deaths (80%) occurred within the first year and more than two thirds of them (16, 67%) occurred within the first 28 days of life.

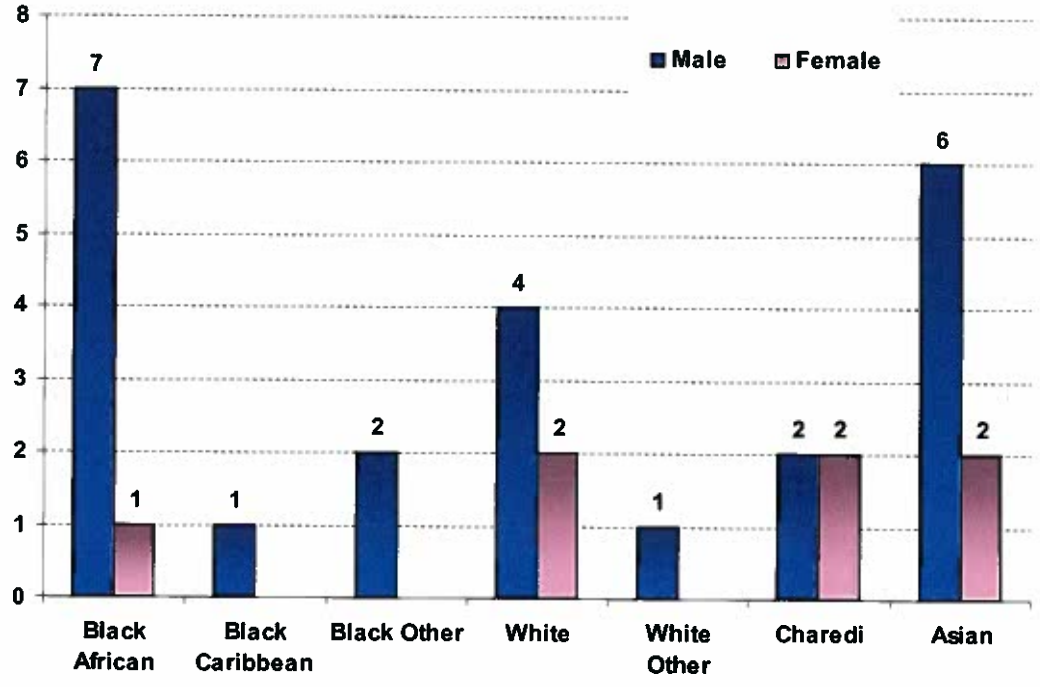
Figure 4.2 Age and gender of child deaths that occurred between 1st April 2011 and 31st March 2012



4.3. Ethnicity

The majority of deaths (11, 37%) occurred in Black children, including Black African, Black Caribbean and Black British children (these groups represent 21% of the total City and Hackney population);[4] 8 (27%) in Asian children; 7 (23%) in White children; and 4 (13%) in Orthodox Jewish children.

Figure 4.3 Ethnic groups of deaths occurring during the reporting period

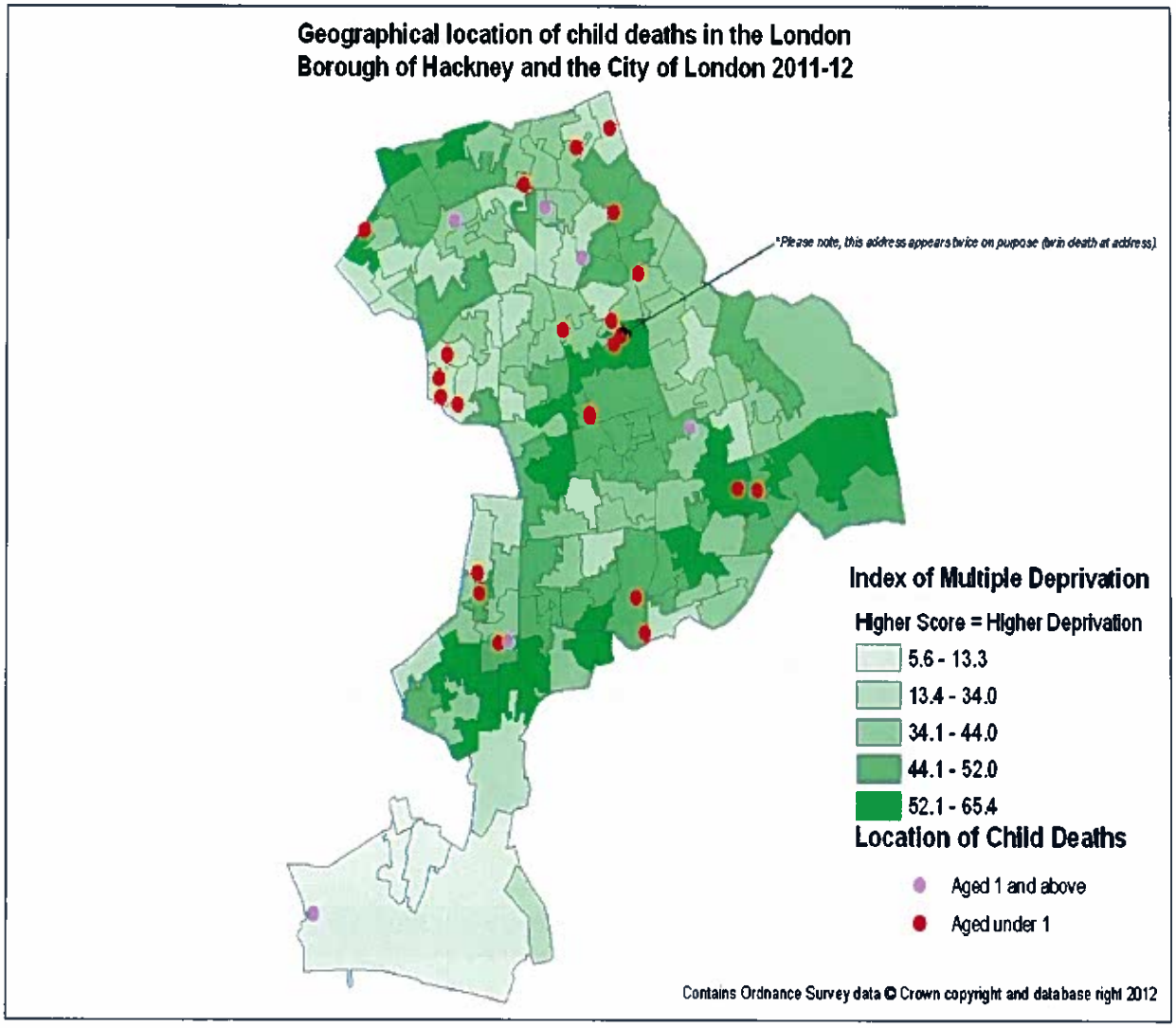


[4] NHS City and Hackney, *Health and Wellbeing Profile 2010/11: Our Joint Strategic Needs Assessment* (2010) 17.

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 were one child death in the City of London; approximately half of the deaths occurred in the most deprived areas with the London Borough of Hackney.

Figure 4.4 Geographical location of child deaths in the London Borough of Hackney and the City of London 2010-11.[5]



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 two years.

[5] Source: Indices of Deprivation 2007, Public Health Mortality File, Child Death Overview Panel.

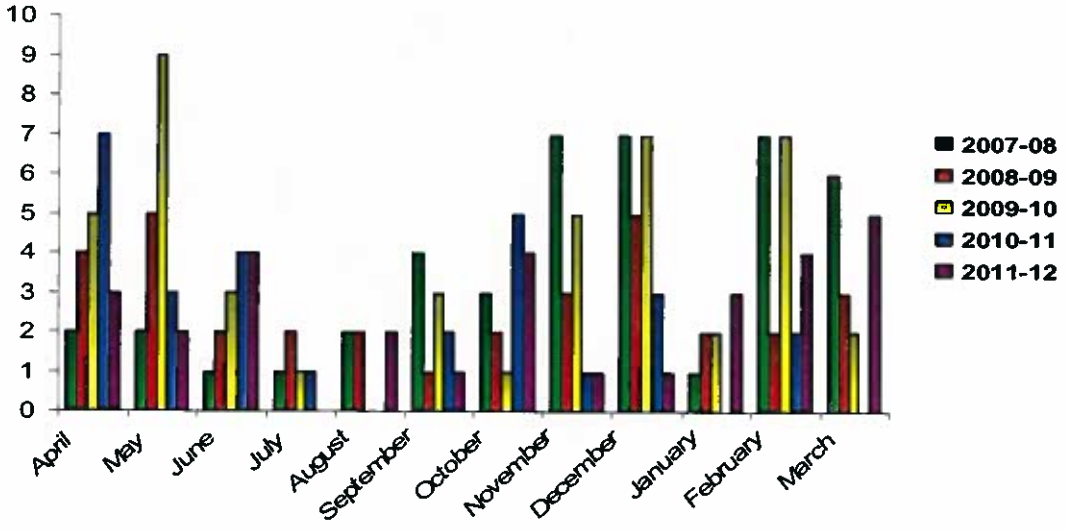
The infant mortality rate in Hackney and the City for the three year period from 2006 to 2008 was 5.7 deaths per 1,000 live births or an average of 26 infant deaths per year. This was higher than the rate for London (4.6 deaths per 1,000 live births) and is the second increase in infant mortality in two years. Although this sustained rise is a cause for concern, it follows a period of record decline in infant mortality. The long-term trend in infant mortality remains downwards.

Local research indicates that some groups within the population are at greater risk of experiencing infant mortality, particularly women of Black African and Black Caribbean origin.[6]

4.5 Seasonal variability

Although the numbers are too small to discard random variation, death counts from 2007-08, 2008-09, 2009-10, 2010-11 and 2011-12 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). In general, deaths seem to be more common in the spring months. However, the figures are small and the differences are not statistically significant.

Figure 4.5 Deaths stratified by month of occurrence



Quarter	Months	2007-08	2008-09	2009-10	2010-11	2011-12
1st Quarter	April-June	5	11	17	14	9
2nd Quarter	July-Sept	7	5	4	3	3
3rd Quarter	Oct-Dec	17	10	13	9	6
4th Quarter	Jan-March	14	7	11	2	12
Total		**43**	**33**	**45**	**28**	**30**

[6] Macfarlane, 2005

Chapter 5

Recommendations to the City and Hackney Safeguarding Children Board

5.1 Learning points and recommendations

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.

5.2 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 2011-12 were the:

- identification of the need to request CHYPS Plus information for every mother under 18 years of age;
- identification of the need to remind agencies of the process of responding to a child death in City and Hackney and the need to create a specific webpage with the same information.

5.3 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 can 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 2011-12 were:

- linking with Hackney Council's Road Safety Team about young children's safety on roads and establishing collaborative work between the NHS East London and the City's Public Health team at a pre-school training event during October 2011;
- reviewing the Homerton University Hospital's Accident and Emergency policy for the identification of fever in premature babies and highlighting particular caution in treatment of feverish illnesses in pre-term babies;
- ensuring in relevant cases that parents and siblings are referred to genetic screening and counselling;
- advising parents about healthy lifestyle choices and risks to children;
- reviewing and learning from recommendations in Serious Case Reviews (SCRs) and relevant Serious Untoward Incident reports (SUI). In addition, the

CDOP is overseeing the implementation of the recommendations in one SUI report;

- ensuring in relevant cases that siblings are supplemented with vitamin D and subsequently monitored;
- monitoring of child deaths in IVF cases;
- monitoring teenage pregnancies (booking data) through six monthly reports to the CDOP from the Consultant Midwife in Public Health and Named Midwife for Safeguarding at the Homerton University Hospital;
- ensuring that sexual education resources and pregnancy information for schools are available and communication with schools are efficient, particularly as the teenage pregnancy partnership in City and Hackney has come to an end;
- highlighting issues of monitoring deaths from Herpes Simplex Virus to the CDOP Pan London group;
- reviewing available leaflets on SIDS to ensure they are culturally appropriate for the Orthodox Jewish Community.

Chapter 6
Emerging themes and future developments

6.1 Emerging themes

In response to a number of possible themes identified by the CDOP through its case reviews, the CDOP organises 'themed' meetings with the aim of furthering the panel member's knowledge and awareness. During 2011-12 the following presentations were delivered to the CDOP:

- Acute Asthma in Children, delivered by the Consultant Paediatrician at the Homerton University Hospital;
- Hackney's gangs culture including information on gun crimes and the riots, delivered by the Detective Inspector of Hackney Borough Police;
- Orthodox Jewish Community: Life, Death & Mourning, delivered by the Manager and the Community Health Worker for the Orthodox Jewish Community at NHS East London and the City.

The CDOP remains concerned at the number of deaths occurring in the first year of life that it has come across during its review activities. The focus in the forthcoming year will particularly be on IVF cases; teenage pregnancies and SUDI cases, identifying risk factors and the most effective preventative measures to reduce them.

6.2 Implementation of recommendations from 2010-11 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:

- In supporting the development of a policy regarding Vitamin D supplementation and the raising of awareness of Vitamin D supplementation within City and Hackney the CDOP is very pleased to report that this is one of the most tangible outcomes of the CDOP's work. The 'A Healthy Start for All' initiative is designed to provide FREE vitamins to ALL pregnant women up to one year post delivery and to all children under 4. The initiative was successfully launched on the 1st of April 2012, all community pharmacies in Hackney now stock Healthy Start vitamins for women and children, and Pharmacists can register Hackney and the City residents onto the scheme.
- The City and hackney Department of Public Health conducted a review of vitamin D supplementation in primary care and develop local guidelines to ensure adequate provision; a leaflet with information for the public was develop and has been widely distributed.
- The review of asthma related deaths in children is currently being undertaken by a Consultant Paediatrician at the Homerton University Hospital in collaboration with the C&H Department of Public Health and a review of the shared care pathway will ensure identification of lessons learnt.
- Awareness raising of safe sleeping messages is an ongoing task for the CDOP and as noted in Chapter 5 of the report, the CDOP is currently reviewing available leaflets on SIDS to ensure that they are culturally appropriate for the Orthodox Jewish Community.
- The review of the Homerton University Hospital's policy in Accident and Emergency for the identification of fever in premature babies is completed and the CDOP is currently liaising with the Neonatal Unit at Homerton University

Hospital about the possibility of highlighting particular caution in treatment of feverish illnesses in pre-term babies.

- The audit of premature and prolonged rupture of membranes cases at the Homerton University Hospital is currently underway by professionals at Homerton University Hospital and Public Health and a progress update is scheduled to be provided to the CDOP in October 2012.
- The independent commissioned report of a City and Hackney child death by stabbing was completed, its findings and recommendations were unclear. The CDOP will continue to foster multi-agency collaboration and discussions to identify areas for improvement to prevent future deaths and safeguard the life and wellbeing of children and adolescents.
- In raising the public's awareness of the child death overview process, the CDOP is currently re-designing its child death leaflet and anticipates that the new version can be printed and distributed widely in the community in the summer months of 2012.