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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 second annual report for the City and Hackney Child Death Overview Panel (the CDOP) for the period 1st April 2009 to date.

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 2009 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 has developed 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 2009 to date, 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




CHILD DEATH OVERVIEW PANEL ANNUAL REPORT 2009-10

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

Contents

Message from the Chairperson

This is the second annual report of the City and Hackney Child Death Overview Panel (CDOP). This report provides a summary of the work undertaken by the CDOP since April 2009 and sets out the priorities for future development to address the principle strategic objective of reducing child deaths in the City of London and the London Borough of Hackney.

An independent process for responding to each unexpected death; reviewing the coordination processes and the delivery of frontline services to every child that has died and identifying significant risk factors that could have contributed to the child death provides an essential accountability and learning mechanism.

The reviews provide an opportunity to reflect in detail on the history of the involvement of every child with the different agencies across all sectors and to consider whether there are any lessons to be learnt, issues to be addressed or opportunities for improvement of services.

Often it will be the case that the death is 'not preventable' (in terms of agencies meeting its service delivery obligations). This is because children die as a result of accidents and natural causes. However, a transparent and effective process for reviewing the services provided to these children and the identification of significant risk factors and trends of epidemiological, environmental, social and cultural nature in relation to these deaths is important to ensure continuous learning and identify opportunities for improvements to children's safeguarding and welfare in the City of London and the London Borough of Hackney.

The City and Hackney CDOP became active on the 1st of April 2008. Its credibility is largely derived from the multidisciplinary professional expertise and independence of its members. 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.

During the period 1 April 2009 to 31 March 2010 the CDOP was notified of 45 deaths, with 64% of these occurring in the first year of life. In 2009-10, the CDOP reviewed the service history of 56 children and young people.

The CDOP has identified scope for continuous improvement in a number of key areas including: increasing awareness by general practitioners around Antibiotic Prophylaxis; increasing awareness by practitioners about Septicaemia in children; immunisation of asplenic children; vitamin D supplementation and nutrition; co-sleeping messages; and strengthening interagency working relationships and processes.

The death of a child is always a tragedy and I would like to offer my condolences and those of the CDOP members, to the families, carers and friends of those children and young people who died during the previous year.

This is the second year of the City and Hackney CDOP. 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 thank the relevant agencies across all sectors and its staff for the support they have given to the process.

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 (SCB) 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 City and Hackney SCB 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, child safety (police), education 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. NHS City and Hackney 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 considered as preventable or potentially preventable.

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 has determined that it will only consider neonatal deaths where the liveborn infant's gestational age was 24 weeks or over. That is, within the gestational age at which the fetus is considered viable. The CDOP does not consider stillbirths.

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;
- 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;

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

- 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 2009 to the 31st of March 2010, there were 45 deaths in children and young people who were normally resident in the City of London and the London Borough of Hackney.

2.2 Number of meetings held and reviews conducted

The CDOP has during the period from the 1st of April 2009 to date completed and reviewed 56 cases. The 56 cases reviewed include both outstanding cases from the previous 12-month period, ie from the 1st of April 2008 to the 31st of March 2009 (13); from the 1st of April 2009 to the 31st of March 2010 (36); and from 1st of April 2010 to date (7). Twenty-two cases are pending review of the CDOP, of these, 2 cases are subject to police investigations, 2 cases are subject to Serious Case Reviews, 4 cases are open to the rapid response group and are pending inquests, and 14 cases require additional information, in particular post mortem reports, 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 19 of the 45 children and young people notified during the period 1st of April 2009 to 31st of March 2010. The findings of all rapid response meetings are discussed at the monthly Serious Case Review sub committee. Following each of two sudden deaths considered during 2009-10, it was recommended by the rapid response group that a Serious Case Review be undertaken.

2.2.2 Preventability

Until April 2010 the CDOP has been required to determine whether a death could be classified as 'preventable', 'potentially preventable' or 'not preventable' based on the analysis of all information and documents obtained from the different agencies that had involvement with the respective child. Two of the deaths reviewed during 2009-10 were considered preventable by the CDOP. Six deaths were considered potentially preventable by the CDOP.

Since April 2010 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. In four cases the CDOP identified modifiable factors.

2.3 Organisation and resourcing of the CDOP

The City and Hackney SCB has significant responsibilities in relation to child deaths. NHS City and Hackney has taken a leading role in supporting the CDOP and responding to the City and Hackney SCB's responsibilities. Therefore, for all practical purposes, NHS City and Hackney 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;
- receipt of all child death notifications and cascading relevant information to key agencies;
- coordination of rapid response meetings;
- management of a 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

The table below displays a break-down of agency attendance at the CDOP meetings from May 2009 to 1 July 2010 - during this period, there were four meetings.

Organisation	% of meetings attended
Chair	100%
Child Death Overview Panel & Rapid Response Co-ordinator	75%
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	100%
City & Hackney Primary Care Trust	
• Consultant Paediatrician	100%
• Named Nurse Child Protection	100%
City of London	
• Director, Family & Young People Services	25%
City of London Police	
• Detective Sergeant	50%
East London NHS Foundation Trust	
• Named Professional for Safeguarding Children	25%
Education – The Learning Trust	
• Head of Attendance & Behaviour	75%
Hackney Borough Police – Metropolitan Police Service	
▪ Detective Inspector	100%
Homerton University Hospital – NHS Trust	
• Consultant Paediatrician	75%
• Consultant Neonatologist and Lead Clinician	25%
Royal London Hospital	
▪ Consultant Paediatric Pathologist	50%

The CDOP has during the year experienced poor responses from health practitioners when information is requested at the time of a child's death. This delays the CDOP's ability to properly review a case and contributes to a backlog of cases, which cannot be reviewed in a timely manner.

Chapter 3

Commentary on the 56 cases reviewed by the CDOP

This chapter refers to all 56 cases reviewed during the period from the 1st of April 2009 to date. This includes 13 deaths from the 1st of April 2008 to the 31st of March 2009; 36 deaths from the 1st of April 2009 to the 31st of March 2010; and 7 deaths from 1st of April 2010 to date.

3.1 Neonatal deaths

Of the 56 cases reviewed by the CDOP, 19 (34%) occurred within the first 28 days of life, increasing to 36 (64%) within the first year of birth. The majority of deaths, 14 (39%) 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. Thirteen deaths (36%) were classified as due to chromosomal, genetic and congenital anomalities. In one of these cases the parents were consanguineous, two cases involved non-consanguineous parents and in the other 10 cases the CDOP had not received any information about whether the parents were consanguineous.

3.2 Unexpected deaths

Twenty of the 56 cases were defined as unexpected deaths. Morbid conditions accounted for 12 deaths. Five deaths were due to external causes. External causes included a car accident, three fatal assaults and a death by misadventure.

Table 3.1 Unexpected child deaths reviewed by the CDOP 2009-10

Age	Cause of death		
	External causes	Diseases/morbid conditions	SUDI
Under 1	1	4	3
1-4 years	0	2	N/A
5-9 years	1	2	N/A
10-14 years	1	1	N/A
15-17 years	2	3	N/A
Total	5	12	3

Two of the unexpected deaths were classified by the CDOP as preventable and five were classified as potentially preventable. As a result, the CDOP made recommendations in response to the issues identified in the reviews with the view of potentially improving the health and safety of children. These recommendations will be further discussed in chapter 5 of this report.

3.3 SUDIs

Three cases reviewed by the CDOP, were classified by the CDOP as a sudden unexpected, unexplained death and by the Coroner as: Sudden Infant Death Syndrome in unsafe sleeping environment; Sudden Infant Death Syndrome – Natural causes; and Sudden Unexpected Death in Infancy, respectively. It was evident in two of the cases from the history provided, that the babies died whilst sleeping in bed with their mother. The CDOP noted that bed-sharing is a serious risk factor for sudden death of babies under four months of age. Due to the circumstances of both of those cases, the CDOP determined that these deaths were potentially preventable. See chapter 6 for a discussion of the CDOP's response to the issues identified in the SUDI cases.

3.4 Expected deaths

Thirty-six cases reviewed were defined as expected deaths. The majority of these cases, 15 (42%) cases were classified as ‘chromosomal, genetic and congenital anomalies’. Fourteen (39%) were classified by the CDOP as a perinatal/neonatal event. Four cases were classified as malignancy, two as an acute medical or surgical condition and one as an infection.

Chapter 4
Child death statistics

This chapter refers to the 45 deaths in children and young people that the CDOP was notified of during the period 1st of April 2009 to 31st of March 2010.

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 of children in the London Borough of Hackney and the City of London during this period was 'diseases/morbid conditions' (ICD-10). This category includes congenital abnormalities, perinatal conditions, cancer and infections such as Streptococcal or Staphylococcus aureus septicaemia.

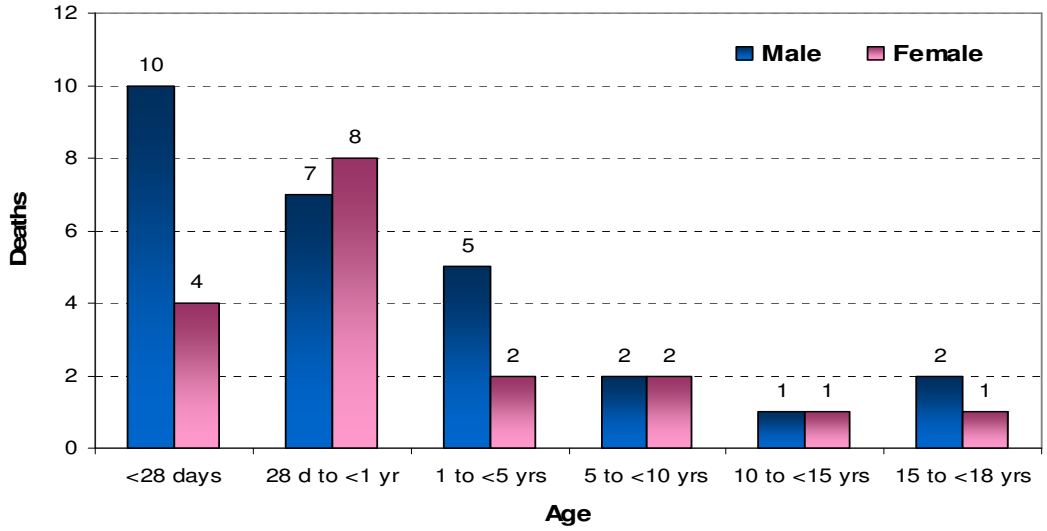
External cases accounted for 5 deaths of children (11%) and included a car accident, a fatal assault, two deaths by misadventure (suicide) and a fall.

Figure 4.1 Child deaths in City and Hackney in 2009-10 by cause of death

4.2 Age and gender

The majority of deaths (64%) occurred in infants (between birth and 1 year of age) and 14 of these occurred within the first 28 days of life. Two thirds of the deaths in the period were in males (60%).

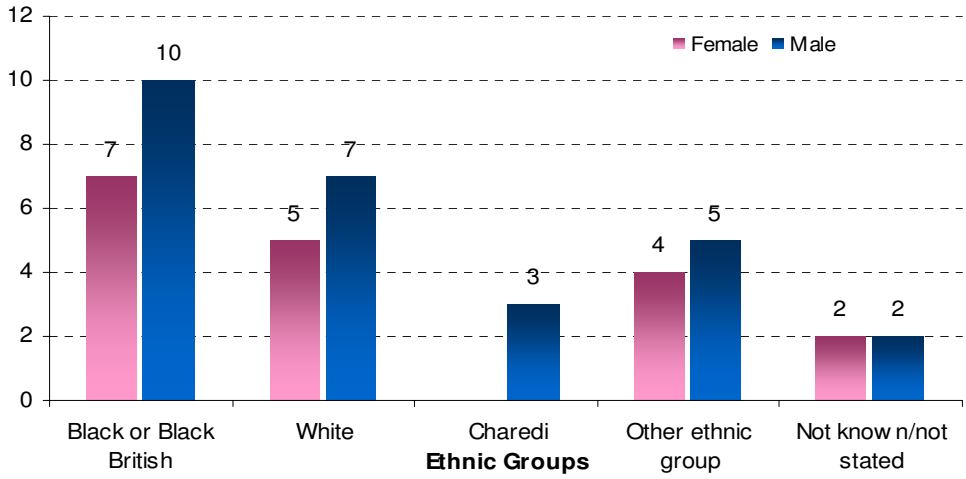
Figure 4.2 Age and gender of children



4.3. Ethnicity

Ethnicity data was missing in four (9%) child deaths. Over a third of the deaths (17, 38%) occurred in Black or Black British children (these groups represent 21% of the total City and Hackney population);[4] 12 (27%) in White and 9 (20%) in children from other ethnic groups.

Figure 4.3 Ethnic groups

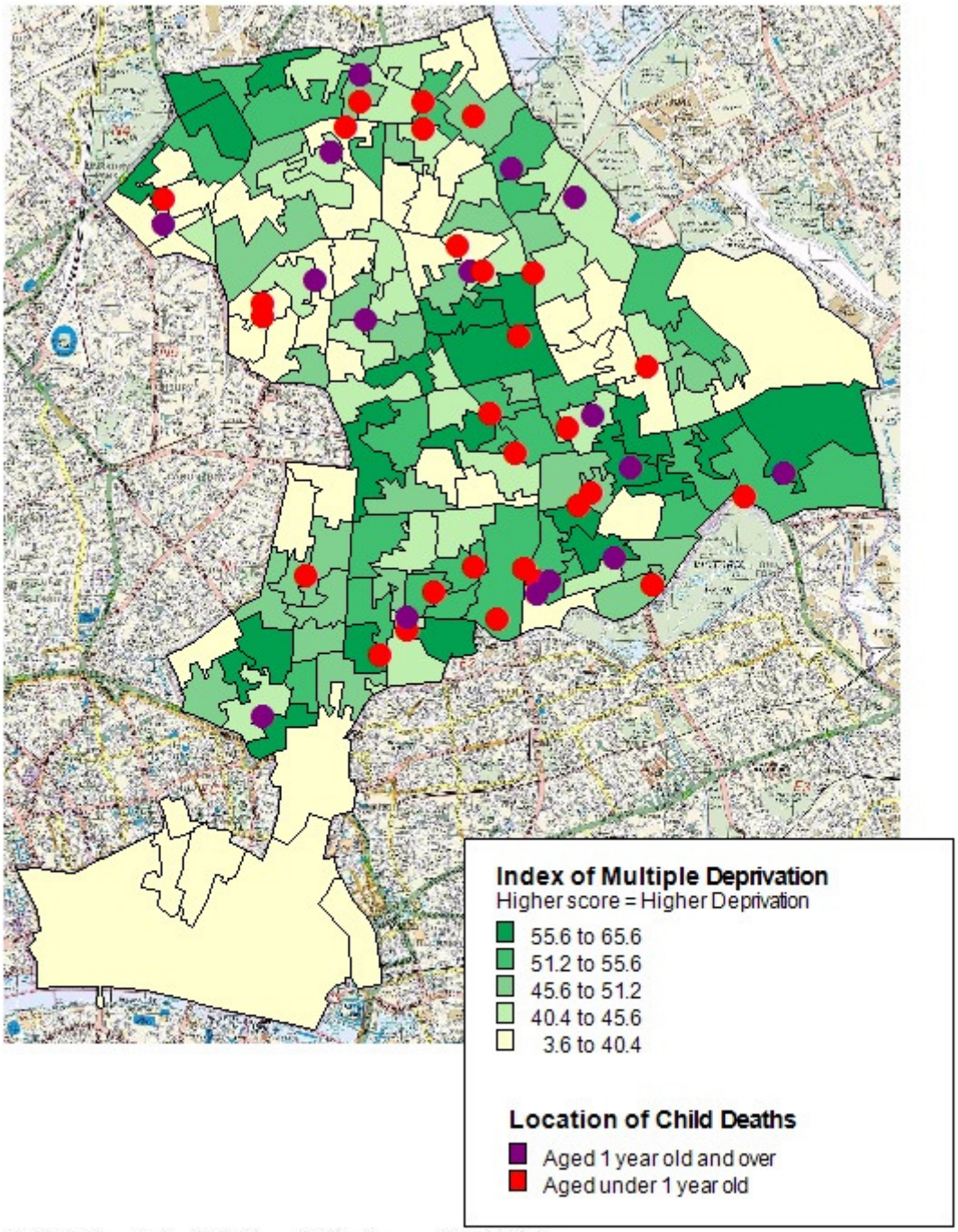


4.4 Geographical distribution

As shown in figure 4.4, the location of all child deaths for 1st April 2009 to 31st March 2010 has been mapped over an Index of Multiple Deprivation score within City and Hackney Primary Care Trust.

Figure 4.4 Geographical location of child deaths in the City of London and the London Borough of Hackney 2009-10.[5]

[4] NHS City and Hackney, *The Health and Wellbeing Profile for Hackney and the City: Our Joint Strategic Needs Assessment* (2009) 6.
[5] Source: Indices of Deprivation 2007, Public Health Mortality File, Child Death Overview Panel.

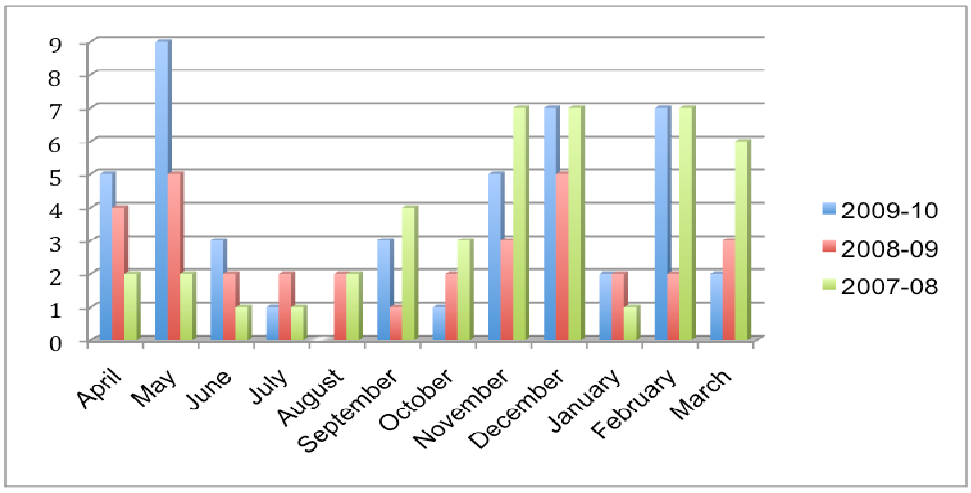


Approximately two thirds of the deaths occurred in the most deprived areas within the borough. There was no significant difference identified in this mapping exercise in relation to the location of the child deaths and the two age groups (aged 1 year and over; and aged under 1 year old). However, it is important to note that the London Borough of Hackney and the City of London has been successful in reducing the infant mortality rate. The pooled rate for 2006-08 is 5.7 deaths per 1,000 births. This is below the London cosmopolitan average of 5.8 deaths per 1,000 births.

4.5 Seasonal variability

Although the numbers are small, death counts from 2007-08, 2008-09 and 2009-10 showed some degree of seasonal variation. In 2007-08, deaths were more common in winter whereas in 2008-09 and 2009-10 deaths were more common in winter and spring.

Figure 4.5 Deaths per month



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.

5.2 Response to issues identified in relation to the child death review process

In 2009-10 the CDOP identified the following potential improvements to the child death review process, the need to:

- have a member of obstetrics or midwifery to sit on the CDOP, given the high number of neonatal deaths and deaths within the first year of birth;
- have the named general practitioner sitting on the CDOP;
- strengthen interagency working relationships and processes in relation to information sharing following a child's death with general practitioners;
- involve NHS Direct in specific cases;
- clarify the coronial process in relation to post mortem results; and
- differentiate between groups within the Jewish community.

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 2009-10 were:

- increasing awareness by general practitioners about:
    - antibiotic prophylaxis and febrile syndrome;
    - septicaemia in children;
    - immunisation of asplenic children;
    - vitamin D supplementation and nutrition;
- increasing public awareness about:
    - co-sleeping messages;
    - diet and health;
    - child safety;

    - the child death overview process;
- strengthening interagency working relationships and processes particularly in relation to sharing CDOP findings with other boards, hospitals and London boroughs.

Chapter 6
Emerging themes and future developments

6.1 SUDI cases

The CDOP is concerned at the number of deaths occurring in the first year of life that it has come across during its review activities. In two of these cases, the CDOP determined the deaths as potentially preventable.

In order to address concerns in relation to SUDI cases, the CDOP will be raising awareness regarding co-sleeping messages by distributing the following safe sleeping leaflet developed by the Foundation for the Study of Infant Deaths to the public: <http://fsid.org.uk/Document.Doc?id=26>.

The CDOP has also reviewed the Homerton University Hospital's Maternity Clinical Practice Guidelines in relation to Mother and Baby Bed sharing and Co-sleeping. The CDOP agreed that these guidelines are up-to-date and appropriate.

In addition, the CDOP organised a themed 'SUDI' meeting where the paediatric pathologist from the Royal London Hospital presented. The paediatric pathologist also delivered a presentation on subdural haemorrhages to the CDOP at a recent CDOP meeting.

The CDOP will continue its focus for the forthcoming year on deaths in infancy, identifying risk factors and the most effective preventative measures to reduce them.

6.2 Gun, gang and knife related cases

The CDOP remains concerned at the number of gun, gang and knife related cases. The CDOP therefore intends remaining informed about the progress of initiatives about prevention of gun, gang and knife crime and will link, wherever possible, with key agencies to improve outcomes for children and young people in this area. The CDOP notes that the Director of Public Health or the Deputy Director of Public Health NHS City and Hackney is currently participating in a recent initiative in relation to the prevention of gun, gang and knife crime in the London Borough of Hackney and the City of London.

6.3 Benchmarking

To maximise its understanding of how the deaths of children and young people in the London Borough of Hackney and the City of London compare with those in other London Boroughs. The CDOP recently met with two neighbouring boroughs and shared Annual Report findings and statistics. A useful discussion around trends seen and prevention strategies also took place. It was agreed that future joint borough meetings will take place on a 6-monthly basis.

6.4 Liaison with key agencies

The CDOP acknowledges the need to engage in an effective and meaningful way with key agencies in relation to the child death review process. The CDOP will continue to work collaboratively with key agencies to further strengthen interagency working relationship and processes with a particular focus on:

- timely access to post-mortem results;
- participation of the Coroner in the process;
- participation of the CDOP's newly appointed GP representative in the process;

- improving access to culturally appropriate bereavement services;
- developing feedback processes to parents and/or carers; and
- clarifying its relationship and information sharing with other review processes.

The CDOP will also work with key agencies and professionals to increase child health awareness as discussed in chapter 5 of this report.

6.5 System data development

Over time, through its review activities, the CDOP will acquire a data set of value in relation to informing both system-level issues about the health, safety and wellbeing of all children who are resident in the London Borough of Hackney and the City of London and the positive and negative aspects of frontline services for children and young people.

The CDOP will analyse trends, issues and common preventable causes and begin sharing this system-level data with relevant agencies where appropriate. This will enable outcomes for children and young people to be considered across the government and non-government service delivery continuum. It will also facilitate the prioritisation of resources and planning for local needs.

The Chair of the CDOP presented the CDOP's findings 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 City and Hackney SCB on the 18th October 2010.

6.6 Monitoring of recommendations

The CDOP is currently in the process of monitoring the implementation of its recommendations of its completed child death case reviews and measuring their outcomes. The CDOP is also developing a reporting mechanism and feedback pathway for recommendations from the CDOP to the City and Hackney SCB Executive Committee.

6.7 Future development

As the current area based grant funding streams comes to an end in April 2011 to finance the national child death overview process, there is a need to scope potential options for the future continuance of the child death overview process which will be dependant upon future Government funding decisions during 2010-11.