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NHS
East London and the City

**Public Health Department**
Clifton House
75-77 Worship Street
London EC2A 2EJ

Tel: 020 7683 4335
Fax: 020 7247 1554
e-mail: jose.figueroa@chpct.nhs.uk

Ms Fran Pearson
Chairperson
City and Hackney Safeguarding Children Board
Hackney Service Centre
1 Hillman Street
Hackney
E8 1DY

Dear Ms Pearson,

Please find enclosed the third annual report for the City and Hackney Child Death Overview Panel (the CDOP) for the period 1st April 2010 to 31st March 2011.

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 2010 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 years 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 and completed in the period from 1st April 2010 to 31st March 2011, 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 2010-11

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

# Contents

# Message from the Chairperson

This is the third 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 the 1st of April 2010 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.

The Rapid Response is 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 to identify possible 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 the different agencies across all sectors with every child 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 to 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.

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.

During the period 1 April 2010 to 31 March 2011 the CDOP was notified of 28 deaths, with 57% (16) of these occurring in the first year of life. In 2010-11, the CDOP reviewed the service history of 48 children and young people.

The CDOP has identified scope for continuous improvement in a number of key areas including: increasing awareness by primary and social care practitioners about the management of Asthma in children; vitamin D supplementation and nutrition; co-sleeping messages; awareness raising with Hackney Homes re fall prevention strategies; supporting the need for community midwifes to be trained in resuscitation of babies and have access to portable equipment for homebirths; and ensuring in relevant cases that parents are referred for genetic counselling.

This is the third 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 contributions and support during the past three 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 an established review process of 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, midwifery, general practice, 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. NHS East London and the City (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 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 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;

[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.*[4]

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.
[4] NHS London, *Serious Untoward Incident Reporting Policy Including the Procedure to be followed for Safeguarding Children* (2009) 11.

# Chapter 2

## Overview of the CDOP's operation

### 2.1 Number of child deaths

In the 12-month period from the 1st of April 2010 to the 31st of March 2011, there were 28 deaths in children and young people who were normally resident in the City of London and the London Borough of Hackney. This represents a mortality rate of 0.43 per 1,000 children aged under 18 in City and Hackney.

### 2.2 Number of reviews conducted

The CDOP has completed and reviewed 48 cases during the period from the 1st of April 2010 to 31st March 2011. The 48 cases reviewed included both outstanding cases from previous 12-month periods, that is, from 1st of April 2008 to 31st of March 2009 (1); from 1st of April 2009 to 31st of March 2010 (28); and from 1st of April 2010 to 31st March 2011 (19).

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 12 (43%) of the 28 children and young people notified during the period 1st of April 2010 to 31st of March 2011. The findings of all rapid response meetings are discussed at the monthly Serious Case Review sub committee. None of the sudden deaths considered by the rapid response group during 2010-11 were recommended to undertake a Serious Case Review, but one case was recommended for independent review and two cases were subject to Gold Group meetings.[5]

The venue of each rapid response meeting will depend on where the child has died. During 2010-11, the majority (5) of rapid response meetings took place at the Royal London Hospital. See table 2.1 below for a breakdown of all rapid response venues during the last year.

[5] A Gold Group is the command centre during a critical incident. The Rapid Response process runs in parallel with a Gold Group and the chair of the Rapid Respond meeting will always be part of Gold Group. Gold Groups are usually coordinated by the Borough Police. The investigating officer of the Gold Group will attend the Rapid Response meeting to ensure information is shared across two parallel processes.

## Table 2.1 Venues of rapid response meetings

| Venue | Number of meetings held |
|---|---|
| Royal London Hospital | 5 |
| Homerton University Hospital | 4 |
| Whittington Hospital | 2 |
| Hackney Town Hall | 1 |
| **Total** | **12** |

### 2.2.2 Preventability

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. The CDOP identified modifiable factors in 12 (25%) of the cases reviewed and completed.

## 2.3 Organisation and resourcing of the CDOP

The City and Hackney SCB has significant responsibilities in relation to child deaths. NHS East London and the City (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 East London and the City (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 2010-11:

- 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;
- 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

Table 2.2 (below) displays a break-down of agency attendance at the CDOP meetings from 1st April 2010 to 31st March 2011, during this period, there were three meetings.

## Table 2.2 Agency attendance at the CDOP meetings

| Organisation | % of meetings attended |
|---|---|
| **Chair – NHS ELC** | 100% |
| **Child Death Overview Panel & Rapid Response Co-ordinator – NHS ELC** | 66.6% |
| **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 Community Paediatrician, Designated Doctor Safeguarding | 100% |
| • Consultant Community Paediatrician[6] | 50% |
| • Named Nurse Child Protection | 100% |
| • PG Medical Director[7] | 100% |
| **City of London** | |
| • Director, Family & Young People Services | 66.6% |
| **City of London Police** | |
| • Detective Sergeant | 100% |
| **East London NHS Foundation Trust** | |
| • Named Professional for Safeguarding Children | 66.6% |
| **Education – The Learning Trust** | |
| • Head of Attendance & Behaviour | 33.3% |
| **Hackney Borough Police – Metropolitan Police Service** | |
| ▪ Detective Inspector | 100% |
| **Homerton University Hospital – NHS Trust** | |
| • Consultant Paediatrician | 66.6% |
| • Consultant Neonatologist and Lead Clinician | 66.6% |
| • Consultant Midwife-Public Health & Named Midwife for Safeguarding[8] | 100% |
| **Royal London Hospital** | |
| ▪ Consultant Paediatric Pathologist | 100% |

The CDOP reports its themes and learning annually to the City and Hackney SCB. In addition, the Chair of the CDOP presents 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 an annual basis. The most recent presentation by the Chair took place on the 18th October 2010.

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

[6] New member who has attended one of the two meetings scheduled since becoming a member.
[7] New member who has attended the one meeting scheduled since becoming a member.
[8] New member who has attended the two meetings scheduled since becoming a member.

# Chapter 3

## Commentary on the cases reviewed by the CDOP

This chapter refers to the 48 cases reviewed during the period 1st of April 2010 to 31st March 2011.

### 3.1 Neonatal deaths

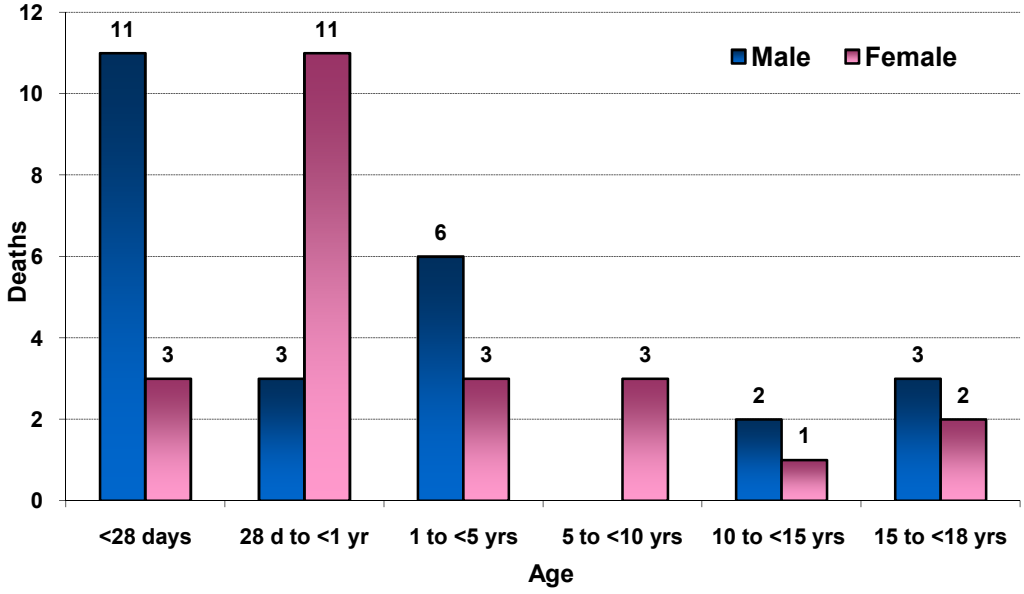
Nearly a third of the 48 cases reviewed by the CDOP were deaths occurring within the first 28 days of life (14, 29%) and over half (28, 58%) occurred within the first year. The majority of deaths (11, 39%) occurring within the first year of life were classified as due to chromosomal, genetic and congenital anomalies.

The CDOP classified 10 deaths (36%) as due to 'perinatal/neonatal events'. That is, a death ultimately related to perinatal events, including, sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia and post-haemorrhagic hydrocephalus.

Parental consanguinity was identified in only one of these cases, three cases involved non-consanguineous parents and there was no mention of consanguinity or no information available in the remaining seven cases.

There was no statistically difference in the gender distribution of the completed reviews during this period.

**Figure 3.1 Age and gender of child deaths that occurred between 1st April 2010 and 31st March 2011**




### 3.2 Unexpected deaths

Twenty (42%) of the 48 cases reviewed by the panel in the period of this report were defined as unexpected deaths. Morbid conditions accounted for 13 deaths (65% of the unexpected deaths); external causes accounted for 5 deaths (25%) and included a car accident and four fatal assaults; 2 (4%) other cases in infants were classified by the CDOP as a sudden unexpected death of an infant (SUDI).

**Table 3.1 Unexpected child deaths reviewed by the CDOP 2010-11**

| Age | Cause of death | | |
|---|---|---|---|
| | External causes | Diseases/morbid conditions | SUDI* |
| **Under 1** | 2 | 4 | 2 |
| **1-4 years** | 1 | 5 | N/A |
| **5-9 years** | 0 | 1 | N/A |
| **10-14 years** | 0 | 1 | N/A |
| **15-17 years** | 2 | 2 | N/A |
| **Total** | 5 | 13 | 2 |

* Sudden unexpected death of an infant

The CDOP considered that modifiable factors may have contributed to the child death in 8 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.

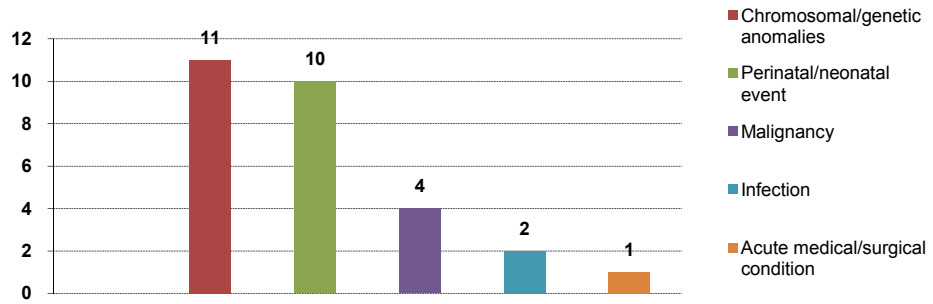
## 3.3 SUDIs

Two infant deaths reviewed by the CDOP were classified as sudden unexpected, unexplained death and by the Coroner as: Sudden Unexpected Death in Infancy - Natural Causes; and Sudden Infant Death Syndrome - Natural Causes. It was evident in one of the cases that the baby died whilst sleeping in bed with her mother (co-sleeping). The CDOP noted that bed-sharing is a serious risk factor for sudden infant deaths, particularly in babies under four months of age. Due to the circumstances of this case, the CDOP identified the following risk factors linked to Sudden Infant Death Syndrome as modifiable factors: smoking; co-sleeping; and use of duvet and pillow. See chapter 6 for a discussion of the CDOP's response to the issues identified in the SUDI cases.

## 3.4 Expected deaths

Twenty-eight (58%) of the 48 reviews completed by the CDOP were defined as expected deaths. Over a third of these cases, 11 (39%), were classified as 'chromosomal, genetic and congenital anomalies'; 10 (36%) were classified as perinatal/neonatal events; 4 (14%) cases were classified as malignancies; 2 (7%) were due to infections and one (4%) was due to an acute medical or surgical condition.

**Figure 3.2 Expected child deaths reviewed by the CDOP 2010-11**



# Chapter 4

## Child death statistics

This chapter refers to the 28 deaths in children and young people that the CDOP was notified of during the period 1st of April 2010 to 31st of March 2011.

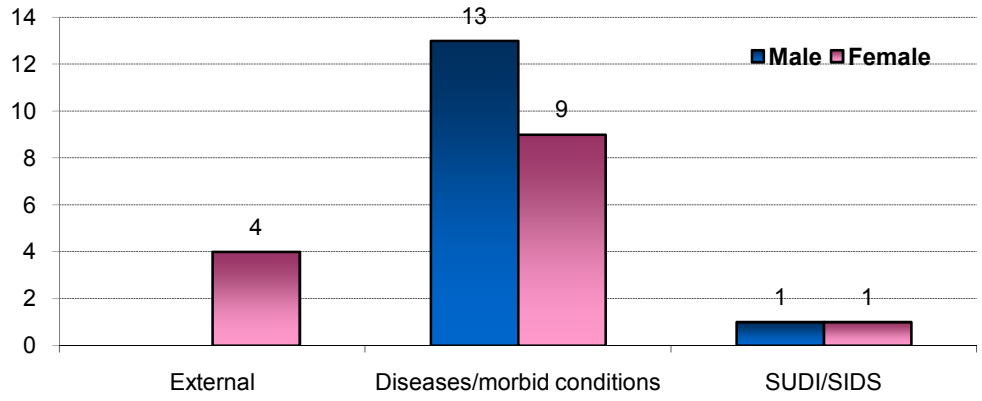
### 4.1 Cause of death

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 (22, 79%), 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 (glioma and ependymoma), sickle cell disease/subarachnoid, acute asthma attack, acute histiocytosis and bronchiolitis/adenovirus.

External cases accounted for 4 deaths of children (14%) and included a road traffic accident, two fatal assaults and a death by misadventure. Two (7%) additional deaths in infants were classified as SUDI/SIDS.

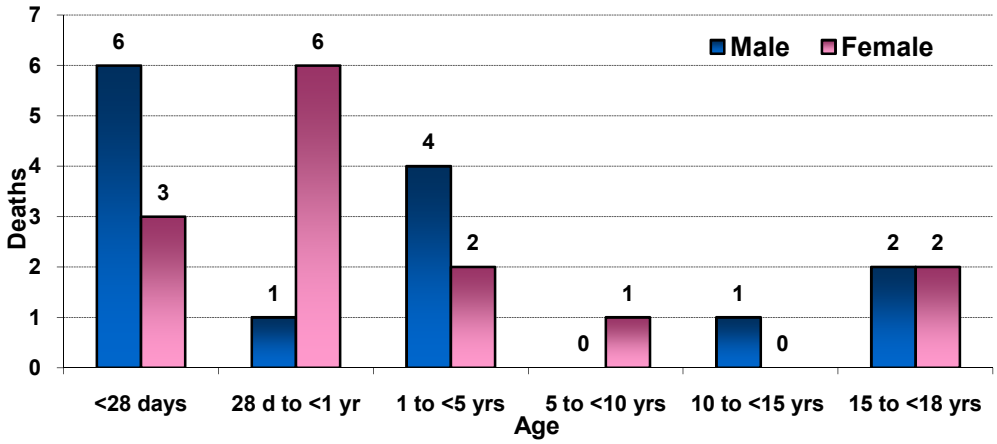
**Figure 4.1 Child deaths in City and Hackney in 2010-11 by cause of death**




### 4.2 Age and gender

Of the 28 deaths that took place in the period covered by this report there were an equal number of female and male deaths; 16 deaths (57%) occurred within the first year and more than half of them 9 (56%) occurred within the first 28 days of life.

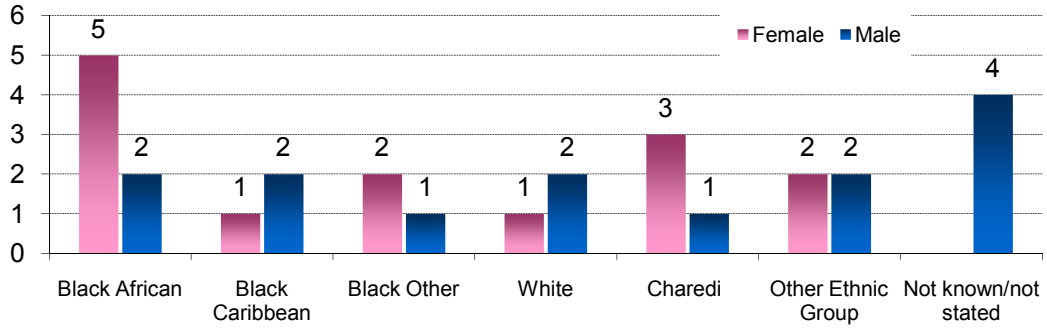
**Figure 4.2 Age and gender of child deaths that occurred between 1st April 2010 and 31st March 2011**




## 4.3. Ethnicity

Ethnicity data was missing in 4 (14%) child deaths. The majority of deaths (13, 46%) occurred in Black children, including Black African, Black Caribbean and Black British children (these groups represent 21% of the total City and Hackney population);[9] 4 (14%) in Orthodox Jewish children, 4 (14%) children from other ethnic groups and 3 (11%) in White children.

**Figure 4.3 Ethnic groups of deaths occurring during the report period**

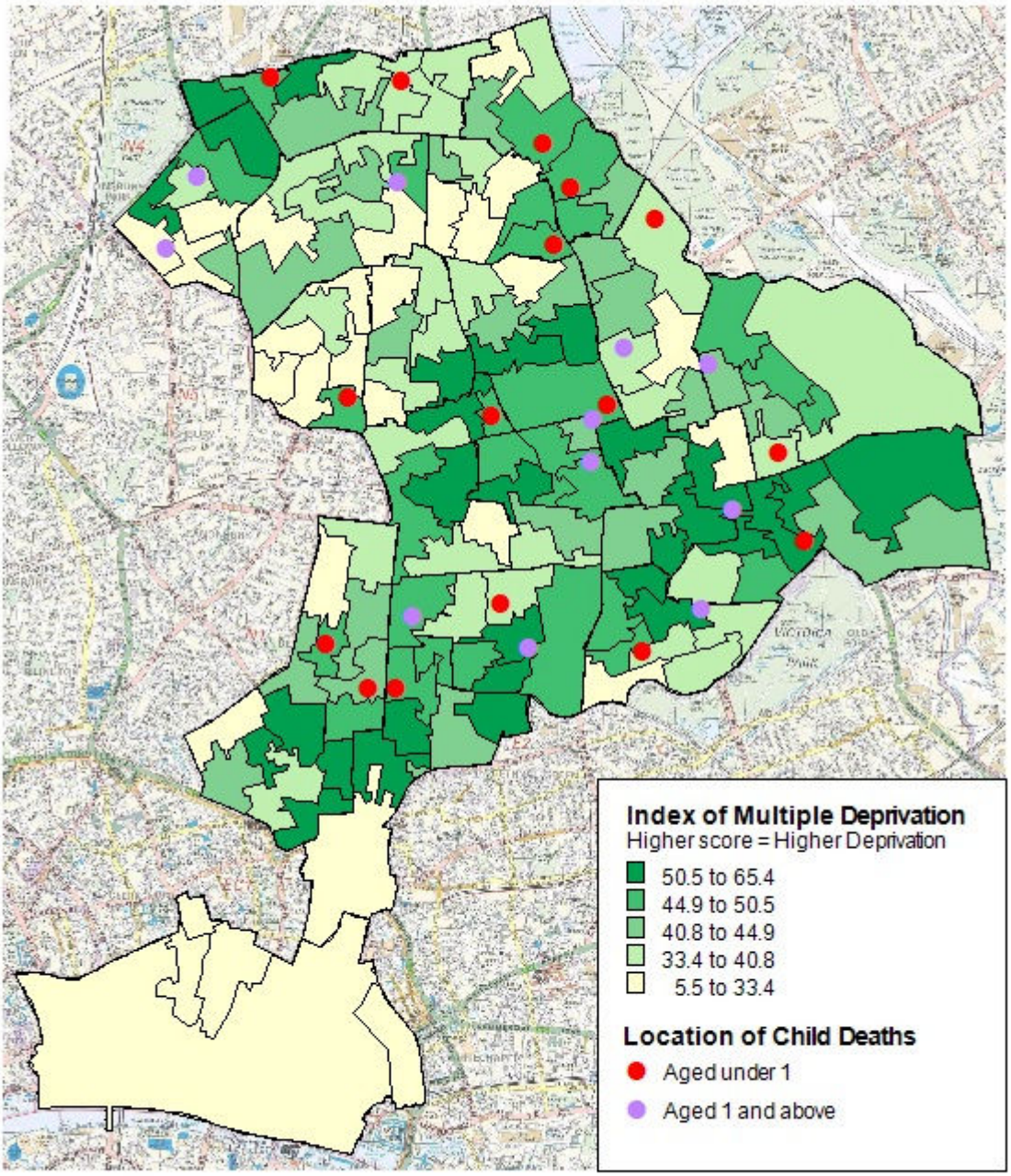



## 4.4 Geographical distribution

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 no child deaths in the City of London; approximately two thirds of the deaths occurred in the most deprived areas within the London Borough of Hackney.

[9] NHS City and Hackney, *The Health and Wellbeing Profile for Hackney and the City: Our Joint Strategic Needs Assessment* (2009) 6.

**Figure 4.4 Geographical location of child deaths in the London Borough of Hackney and the City of London 2010-11**






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.

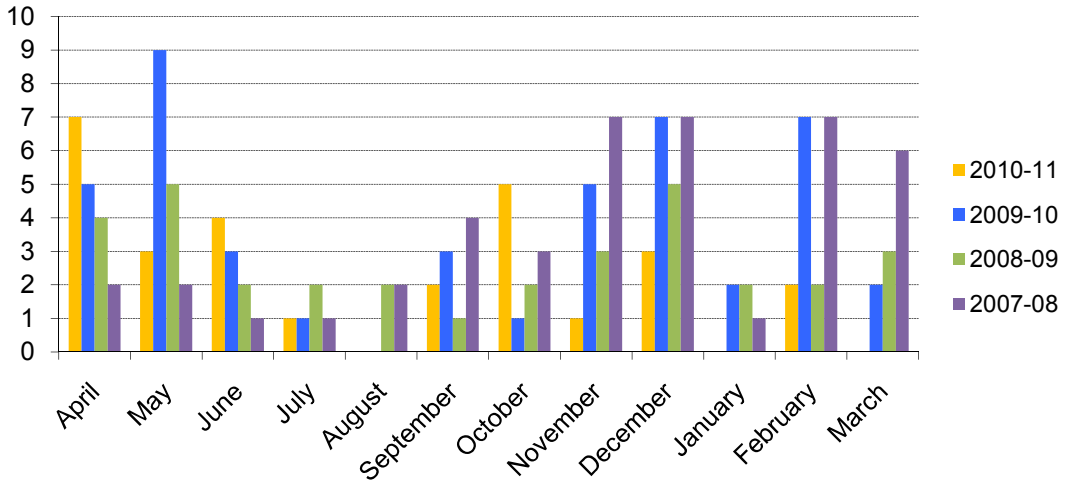
The infant mortality rate in Hackney and the City for the three year period from 2006 to 2008 was 5.7 deaths per 1,000 live births or an average of 26 infant deaths per year. This was higher than the rate for London (4.6 deaths per 1,000 live births) and is the second increase in infant mortality in 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.[10]

## 4.5 Seasonal variability

Although the numbers are too small to discard random variation, death counts from 2007-08, 2008-09, 2009-10 and 2010-11 seem to show some degree of seasonal variation. In 2007-8 children and young people deaths were more common in the 1st and 4th quarters whereas in the following years deaths seem to be more common during the spring and autumn months (2nd and 4th quarter). In general, deaths seem to be more common in the autumn 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 |
|---|---|---|---|---|---|
| 1st Quarter | Jan-March | 14 | 7 | 11 | 2 |
| 2nd Quarter | April-June | 5 | 11 | 17 | 14 |
| 3rd Quarter | July-Sept | 7 | 5 | 4 | 3 |
| 4th Quarter | Oct-Dec | 17 | 10 | 13 | 9 |

[10] NHS East London and the City (City and Hackney), *The Health and Wellbeing profile for Hackney and the City: our joint strategic needs assessment, 2010/11*, 95.

# 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 2010-11 were the:

- appointment to the CDOP of the Consultant Midwife in Public Health and Named Midwife for Safeguarding at the Homerton University Hospital. This member is a valuable resource for the CDOP given the high number of neonatal deaths and deaths within the first year of birth and has made possible the analysis of data referring to pregnancy and antenatal care;
- appointment to the CDOP of the GP Medical Director at City and Hackney NHS. This has facilitated and improved the capacity of the CDOP to communicate messages to primary care practices;
- invitation and involvement of non-CDOP members in the discussion and review of specific cases where they have personal/professional knowledge of the case and are able to make a useful contribution. The presence of a non-member in the review of one case ensured that the CDOP made a meaningful recommendation for an organisation which could be implemented into practice.

### 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 the child death case reviews identify issues that may indicate broader trends which if modifiable could prevent further child deaths and improve the health and safety of children. In general, the achievements of the CDOP and the rapid response group in improving the wellbeing and safety of children and young people during 2010-11 were:

- reviewing the Homerton University Hospital's Maternity Clinical Practice Guidelines in relation to Mother and Baby Bed sharing and Co-sleeping; and the NHS City and Hackney Health Visitor pack in relation to its safe sleeping

messages. The CDOP agreed that both the guidelines and the pack are up-to-date and appropriate;

- supporting the need for Great Ormond Street Hospital to join the Image Exchange Portal System as soon as it is practicable possible;
- raising awareness to clinical staff of the importance of early identification of the signs and symptoms related to a blocked cerebral shunt;
- working with Homerton University Hospital in ensuring all community midwifes receive training in cardiopulmonary resuscitation of babies and have access at all relevant times to the portable equipment needed for homebirths;
- advising on a recommendation by the London Ambulance Service about defibrillators in school;
- supporting a literature review of the use of hypertonic nasal spray in infants and its potential link with cerebral oedema by the paediatric pathologist from the Royal London Hospital;
- informing the Medicines and Healthcare Products Regulatory Agency and GPs of potential risks in the use of hypertonic nasal spray in infants;
- supporting parents in a review of agencies policies and procedures in relation to homebirths and ensuring that the recommendations of such review were implemented;
- awareness raising with Hackney Homes in relation to fall prevention strategies from buildings and windows;
- recommending that the Homerton University Hospital's Asthma leaflets are made available to children's social care staff;
- advising about the risks of omitting important vaccines when choosing an alternative immunisation provider, who does not follow national guidelines;
- ensuring in relevant cases that parents are referred to genetic counselling.

In relation to recommendations not yet fully implemented the following point is noted:

A recommendation which has been made around raising the public's awareness of the child death overview process has not yet been fully implemented. This is particularly due to the sensitive nature of this topic and the length of time it has taken to agree on the most appropriate language to use when communicating messages around the process. A leaflet and a letter to parents and carers have been drafted and approved by the CDOP. Outstanding actions points are currently the printing and determination of the most appropriate pathway in relation to sharing this information with parents and carers.

# Chapter 6

## Emerging themes and future developments

### 6.1 Emerging themes

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. As a first step in the process of potentially improving outcomes for children and families in relation to infant mortality, the CDOP has organised a number of themed meetings, including a presentation on the Homerton University Hospital's policy on premature and prolonged rupture of membranes and a presentation on subdural haemorrhages by the paediatric pathologist from the Royal London Hospital.

Recommendations made by the panel about required future actions to prevent child deaths include:

- A review of asthma related deaths in children. However, as a first step in this process, the CDOP organised an Asthma in Children presentation which was delivered by the Consultant Paediatrician at the Homerton University Hospital;
- Awareness raising of safe sleeping messages by distributing the "Sleep sound sleep safe" leaflet developed by the Foundation for the Study of Infant Deaths to the public: http://fsid.org.uk/Document.Doc?id=26 ;
- A review of Homerton University Hospital's policy in relation to policy in Accident and Emergency for the identification of fever in premature babies;
- An audit of premature and prolonged rupture of membranes cases at the Homerton University Hospital;
- Supporting the development of a policy regarding Vitamin D supplementation and the raising of awareness of Vitamin D supplementation within City and Hackney;
- A report by an independent expert of a City and Hackney child death by stabbing, to identify lessons to be learnt and actions to take to prevent future deaths in relation to adolescents.

### 6.2 Current challenges

Current challenges for the CDOP are:

- timely access to post-mortem results;
- measurement of outcomes, benchmarking and system data development;
- development of a feedback pathway for recommendations from the CDOP to the CHSCB who will advise on their implementation and monitor outcomes;
- developing feedback processes to parents and/or carers;
- clarifying its relationship to other review processes;
- further emphasis on the importance of a joint home visit by Police and Paediatricians following an unexpected death;
- uncertainties about the future of the child death review process within the current changes in Health and Social care.