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NHS
North East London and the City

CHILD DEATH OVERVIEW PANEL ANNUAL REPORT 2012-13

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 – the Panel) is now in its sixth year of operation and this its fifth annual report.

The Panel is an independent multidisciplinary group 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 2012-13 reporting period the CDOP reviewed the deaths of 46 children and young people, 40 of these reviews were completed.

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

The death of a child is always emotional. Each death touches the lives of the child's family, friends, those who worked with the child and their family as well as the broader community. Many of the children to whom this report refers are infants aged under 1 year and have sadly died due to prematurity or perinatal/neonatal events, whilst the majority of deaths in the older children were due to acute or chronic medical conditions with only one death due to external causes.

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. Since then, the Panel has reviewed the deaths of 153 children and young people and all recommendations made by the Panel have been implemented or are in the process of being implemented.

The Panel'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 independently appointed panel. The expertise of its members assists the Panel to fulfil its role to apply a child-focused consideration to each individual review and to develop recommendations for improvement. Experts involved in the Panel reviews include public health, paediatrics and child health, neonatology, paediatric pathology, mental health, children's social care, child protection, nursing, midwifery, general practice, child safety (police), education, youth crime reduction and other members who can make a valuable contribution.

In conclusion I would like to take this opportunity to thank the relevant agencies across all sectors and its staff for the support they have given to the child death review process, thank the current members of the Panel for bringing an immense and diverse wealth of experience to the Panel, for their commitment, their important contributions and the support they have provided during the past six years. I would also like to sincerely thank all the members of the Rapid Response group for their invaluable contribution to the child death review process and for their commitment to improving service delivery to children and young people. 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 the following, ensuring that:

- local procedures and protocols are developed, implemented and monitored in line with guidance in Chapter 5 of *Working Together to Safeguard Children*[2];
- 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 a review of 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.

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

[2] *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* (March 2013).

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, primary care, mental health, children's social care, 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, demographics, 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 focused 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 live born infant within the first 28 days of life. The CDOP reviews all neonatal deaths which have been registered as live births 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 an infant or child (less than 18 years old) which was not anticipated as a significant possibility, for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.*[3]

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;

[3] HM Government, *Working Together to Safeguard Children* (March 2013) 79.

- 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.[4]

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.

[4] 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 2012 to the 31st of March 2013, there were 33 deaths in children and young people who were normally resident in the City of London and the London Borough of Hackney. The population of Hackney and the City of London has a higher proportion of children (under 5 years old) and young people (under 19) than the England average (7.6% vs. 6.3% and 24.6% vs. 23.9% respectively). The *Child Health Profile* recently released by the Child and Maternal Health Observatory (Chimat, March 2013) describes an infant mortality rate (children under 1 year) for Hackney and the City of London not significantly different from the English average (5.0 per 1000 live births *vs.* 4.4); the child mortality rate for under 18 year old (children aged 1 to 17 years) is significantly higher than the rate for England (22.6 per 100,000 children *vs.* 13.7 for England).[5]

2.2 Number of meetings held and reviews conducted

During the period of this report (1st of April 2012 to 31st March 2013), the Panel met 4 times, reviewed 46 cases and completed 40 of them. The completed reviews included 13 outstanding cases from the previous year (that is, from 1st of April 2011 to 31st of March 2012) and 27 cases from the current year (1st of April 2012 to 31st March 2013).

The reviews of 6 deaths that occurred in the reporting period are still outstanding, 4 cases are currently open to the rapid response group, one case is pending the post mortem report and inquest results and a further case required additional information and will be discussed by the Panel at the next meeting.

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 13 (39%) of the 33 children and young people notified during the period 1st of April 2012 to 31st March 2013. The findings of all rapid response meetings are discussed at the monthly Serious Case Review sub committee. None of the unexpected deaths reviewed by the rapid response group during 2012-13 were recommended to be subject to a Serious Case Review.

The venue of each rapid response meeting depends on where the child has died. During 2012-13, 6 of the rapid response meetings took place at the Homerton University Hospital, 4 took place at Hackney Service Centre and 3 at Royal London

[5] *Child Health Profile: Hackney and City of London,* CHIMAT, March 2013.

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	6
Hackney Service Centre	4
Royal London Hospital	3
Total	13

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 two (5%) of the completed case reviews. One preventable case has co-sleeping with an infant as a possible modifiable factor and the other has vitamin D deficiency as a contributory factor.

2.3 Organisation and resourcing of the CDOP

The CHSCB support the administrative processes needed to ensure adequate collaboration and coordination between the CDOP and other agencies and entities. The CDOP Coordinator post was transferred to the CHSCB, from January 2012; since then, the lead role in supporting the CDOP, the rapid response group work and responding to the CHSCB child death review responsibilities reverted from NHS East London and the City to the CHSCB.

For example, the following administrative support has been provided to the CDOP during 2012-13:

- 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) shows a break-down of agency attendance at the four CDOP meetings from April 2012 to March 2013.

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	25%
City of London	
• Director, Family & Young People Services	75%
City of London Police	
• Detective Sergeant	100%
East London NHS Foundation Trust	
• Named Professional for Safeguarding Children	75%
City and Hackney PCT	
• **Named GP for Safeguarding Children**	50%
• **Designated Nurse**	75%
Education – The Learning Trust	
• Head of Attendance & Behaviour	100%
Hackney Borough Police – Metropolitan Police Service	
• Detective Inspector	25%
Homerton University Hospital – NHS Trust	
• Consultant Paediatrician	100%
• Consultant Neonatologist and Lead Clinician	75%
• Consultant Midwife – Public Health & Named Midwife for Safeguarding	100%
• Consultant Community Paediatrician, Designated Doctor for Child Deaths	100%
• Named Nurse Child Protection	75%
Royal London Hospital	
• Consultant Paediatric Pathologist	50%
Young Hackney	
• Assistant Director, Youth Crime Reduction	0%

The Panel reports its findings annually to the CHSCB. In addition, the Chair of the Panel 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 in 2012.

The Chair of the rapid response group together with the CDOP Coordinator also presents the CDOP's data, findings and learnings to health care professionals. Recent presentations took place in October 2012 and February 2013.

The CDOP's key findings and recommendations are also as of April 2013 published in the CHSCB's news bulletin, which is available from CHSCB's website (http://www.chscb.org.uk/).

Chapter 3

Commentary on the 40 cases reviewed by the CDOP

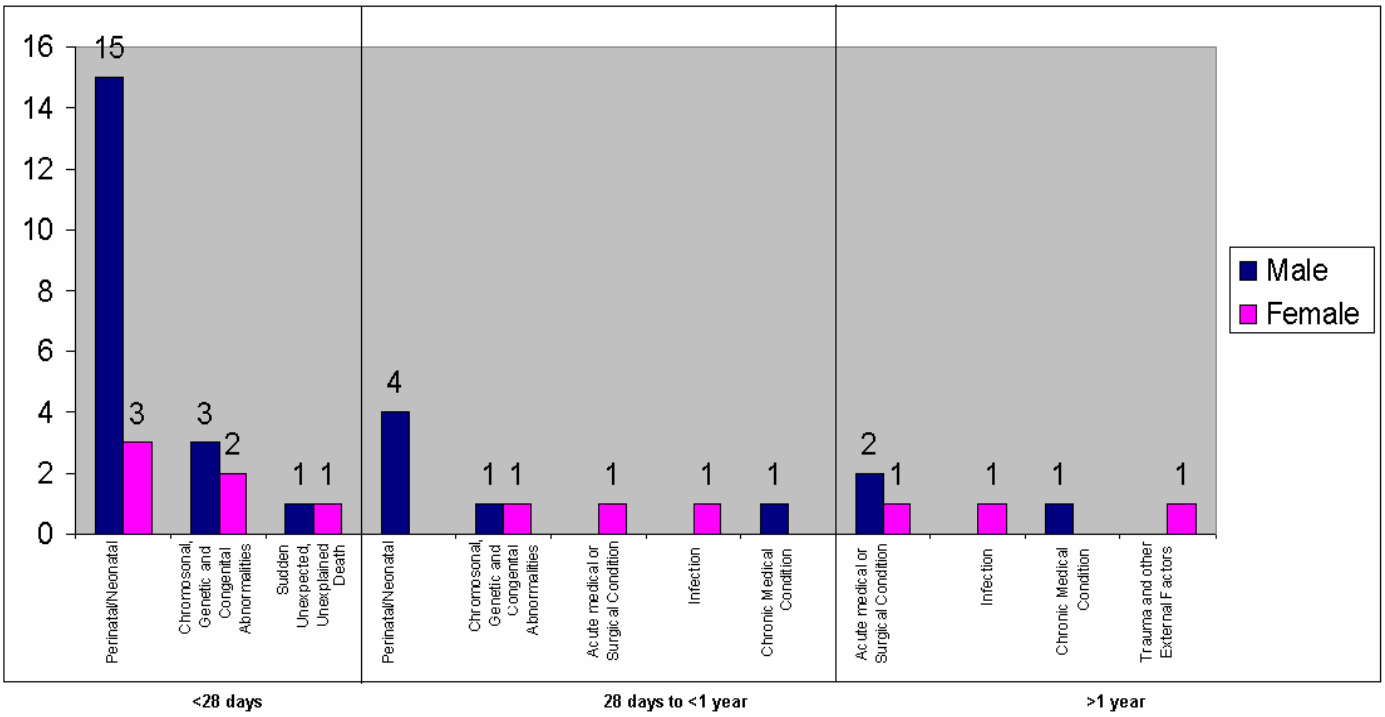
This chapter refers to the 40 cases reviewed and completed during the period 1st April 2012 to 31st March 2013; 13 cases were from the 2011/12 period and 27 from 2012/13.

Over two thirds (28/40, 70%) of the completed reviewed deaths were in males; 85% (34/40) were deaths occurring in infants –within the first year of life. Three quarters of the infant deaths were in males (25/34, 74%), and the majority (25/34, 74%) occurred during the neonatal period – i.e. within the first 28 days of life.

Four of the remaining six deaths were in young children up to the age of 5 and 2 were in children aged 11 and 13 years. The majority of these deaths were due to acute medical or surgical conditions (3) with the remainder due to chronic medical condition (1), infection (1) and one death due to external causes (specifically accidental drowning).

The CDOP classified almost a fifth of deaths occurring within the first year of life (7/34, 21%) as due to chromosomal, genetic and congenital abnormalities. Parental consanguinity was identified in one of these cases.

Figure 3.1 Category of death classified between 1st April 2012 and 31st March 2013



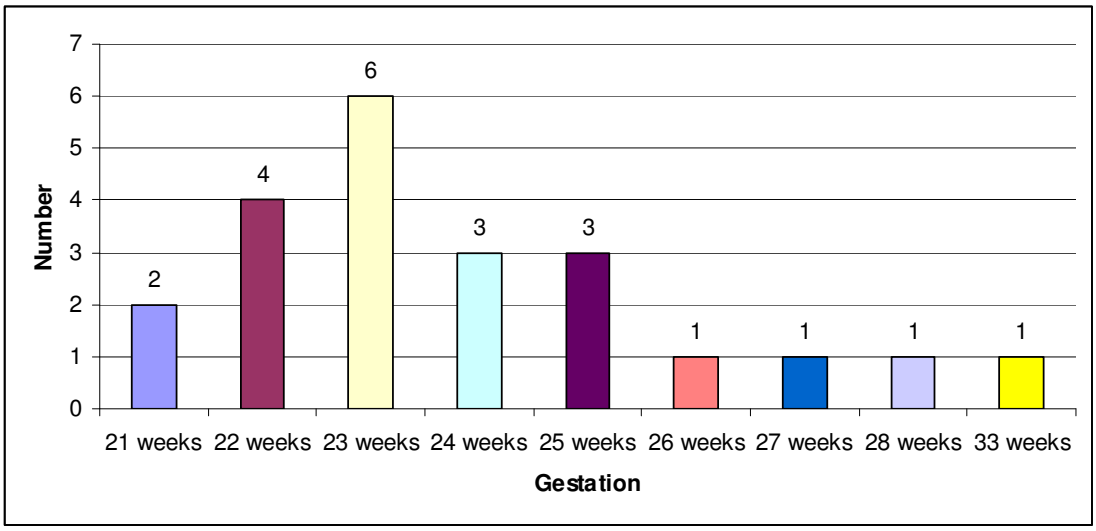
3.1 Neonatal deaths

Neonatal deaths are those occurring within the first 28 days of life; the majority of infant deaths were in the neonatal period (25/34, 74%); 18 of these neonatal deaths (72%) were classified by the Panel as due to a 'perinatal/neonatal event'. That is, a

death ultimately related to perinatal events, including, sequelae of prematurity, antepartum and intrapartum anoxia, bilirubin encephalopathy, bronchopulmonary dysplasia and post-haemorrhagic hydrocephalus irrespective of age at death. Four other infant deaths occurring in infants older than 28 days and up to 7 months fulfilled the definition of perinatal/neonatal events and were classified by the Panel as such bringing the total of deaths due to perinatal/neonatal events to twenty-two.

Five of the neonatal deaths (5/25, 20%) were due to chromosomal abnormalities (these have been included in the seven deaths classified as due to chromosomal, genetic and congenital abnormalities mentioned above) and two (8%) were due to SIDS and will be discussed later.

Figure 3.2 Gestational age of Perinatal/Neonatal deaths classified between 1st April 2012 and 31st March 2013



Of the 22 Perinatal/Neonatal deaths that were classified between 1st April 2012 and 31st March 2013, 15 (68%) were in babies born with a gestational age of ≤24 weeks.

3.2 Unexpected deaths

Nine (23%) of the forty cases reviewed by the Panel in the period of this report were unexpected deaths. Morbid conditions accounted for six of them (67%); one (11%) death was due to external causes (drowning); and two (22%) were classified by the Panel as sudden unexpected deaths of infants (SUDI), see below.

The CDOP considered that modifiable factors may have contributed to the child death in 2 (22%) 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.

Table 3.1 Unexpected child deaths reviewed by the CDOP 2012-13

Age	Cause of death		
	External causes	Diseases/morbid conditions	SUDI*
Under 1	-	3	2
1-5 years	1	1	-
5-10 years	-	-	-
10-15 years	-	2	-
15-18 years	-	-	-
Total	1	6	2

* Sudden unexpected death of an infant.

3.3 Sudden Unexpected Death of an Infant (SUDIs)

Two neonatal deaths reviewed by the Panel were classified as sudden unexpected, unexplained death and by the Coroner as: Sudden Infant Death Syndrome – Natural causes, although 1 of these deaths was classified more specifically as a sudden unexpected postnatal collapse (SUPC).

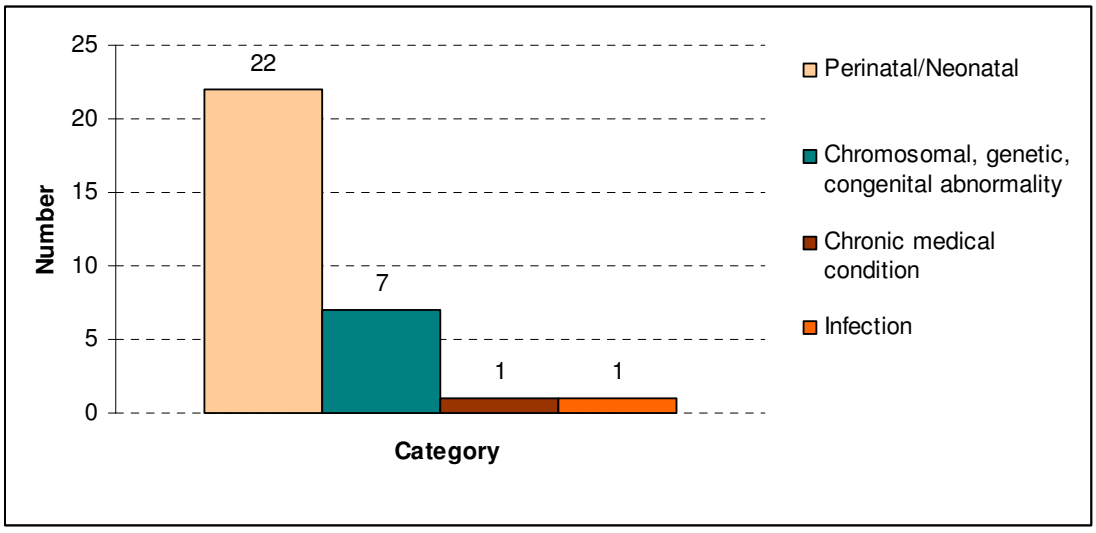
It was evident in one of the cases from the history provided, that the baby died whilst sleeping in bed with their mother (co-sleeping). The Panel noted that bed-sharing is a significant risk factor for sudden infant deaths of babies under four months of age and due to the circumstances in this case, the Panel identified modifiable factors. Co-sleeping has also been recognised as a national problem in recent news reports: http://www.bbc.co.uk/news/health-22594587

In the other SUDI case it was noted that low vitamin D levels may have contributed to the death and recommendations have been made to the family's GP.

3.4 Expected deaths

Thirty one deaths (78%) were not unexpected. The majority of them (22/31, 71%) were classified as 'perinatal/neonatal events' where prematurity played a key role; 7 (23%) were classified as 'chromosomal, genetic and congenital anomalies'; 1 (3%) was classified as chronic medical condition; and 1 (3%) was due to infection.

Figure 3.3 Expected child deaths reviewed by the Panel 2012-13



Chapter 4

Child death statistics

This chapter refers to the 33 deaths in children and young people that the Panel was notified of during the period 1st April 2011 to 31st March 2012.

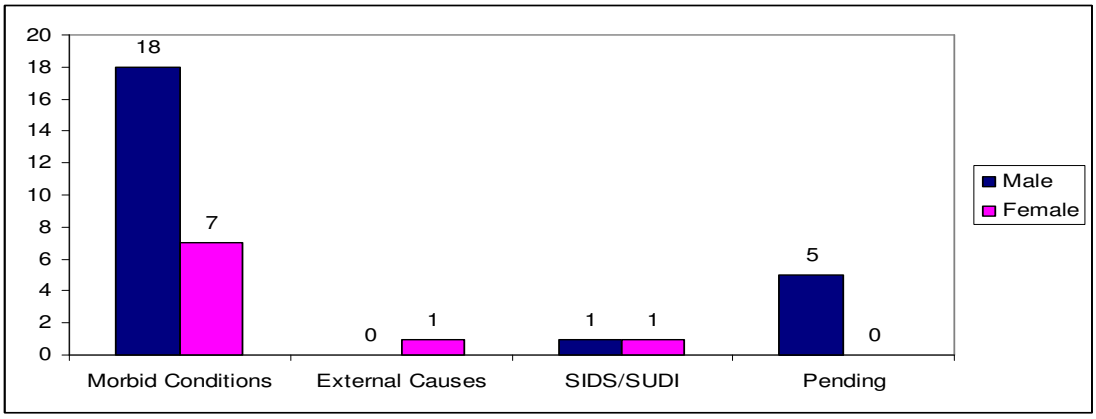
4.1 Cause of death

The Panel 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 (25/33, 76%) 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 and infections.

External cases accounted for 1 death (accidental drowning, 3%), 2 deaths (6%) were classified as SIDS/SUDI and the cause of death is currently pending in 5 (15%) cases.

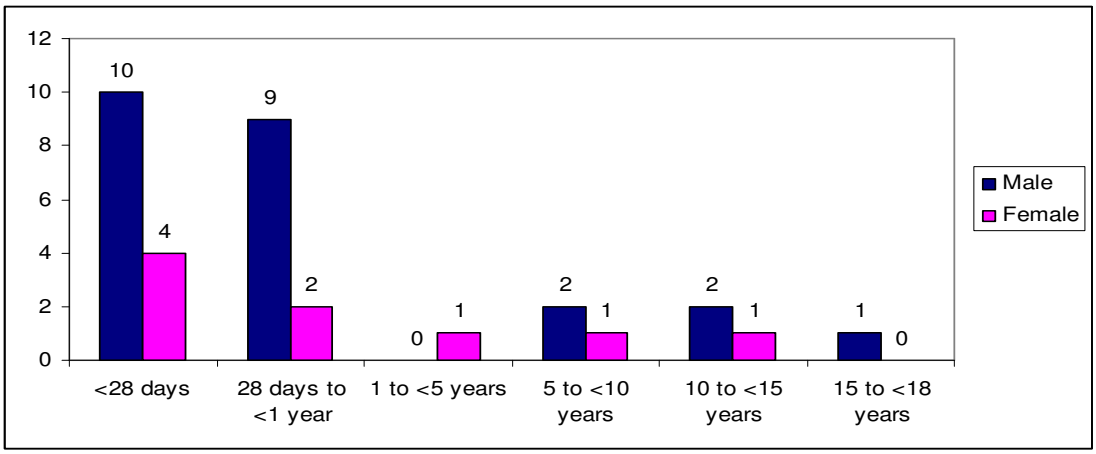
Figure 4.1 Child deaths in City and Hackney in 2012-13 by cause of death



4.2 Age and gender

Of the 33 deaths that occurred in the period covered by this report, nearly three quarters were in males (24, 73%); 25 deaths (75%) occurred in infants within the first year and 14 of these infant deaths (56%) occurred within the first 28 days of life.

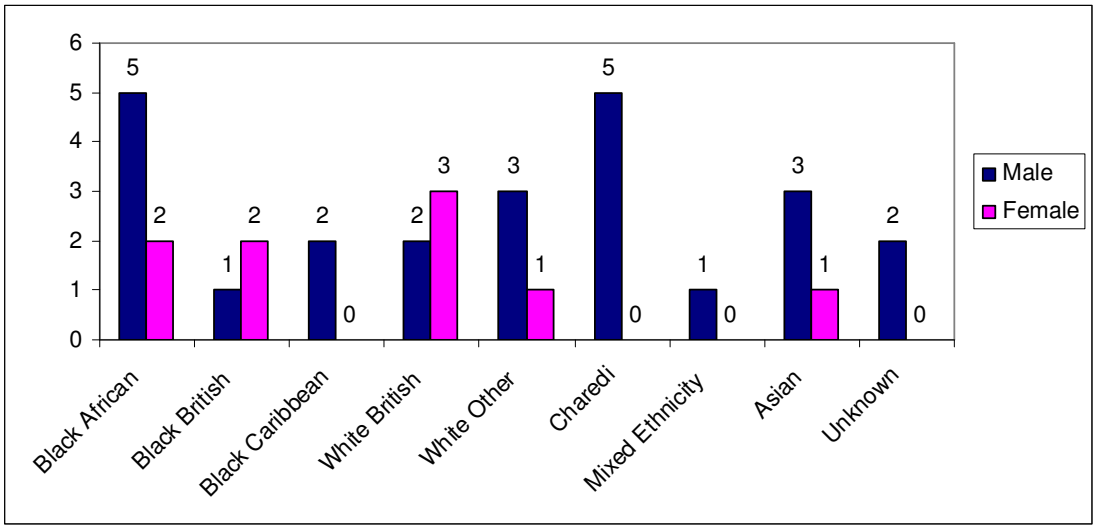
Figure 4.2 Age and gender of child deaths that occurred between 1st April 2012 and 31st March 2013



4.3. Ethnicity

When assessing the deaths by ethnic group, children from Black ethnic groups, including Black African, Black Caribbean and Black British were over-represented with 12 deaths (37%) in children in these ethnic groups even though these groups represent 21% of the total City and Hackney population;[6] 4 deaths (12%) occurred in Asian children; 9 (27%) in White children; 1 (3%) child of mixed heritage and 5 deaths (15%) in Orthodox Jewish children. Information on ethnicity is currently missing in two cases (6%).

Figure 4.3 Ethnic groups of deaths occurring during the reporting period



Although our ethnicity analyses suggest that some groups within the population are at greater risk of experiencing infant mortality, particularly women of Black African and Black Caribbean origin and the Charedi community, these groups represent a greater percentage of the deliveries in Hackney.

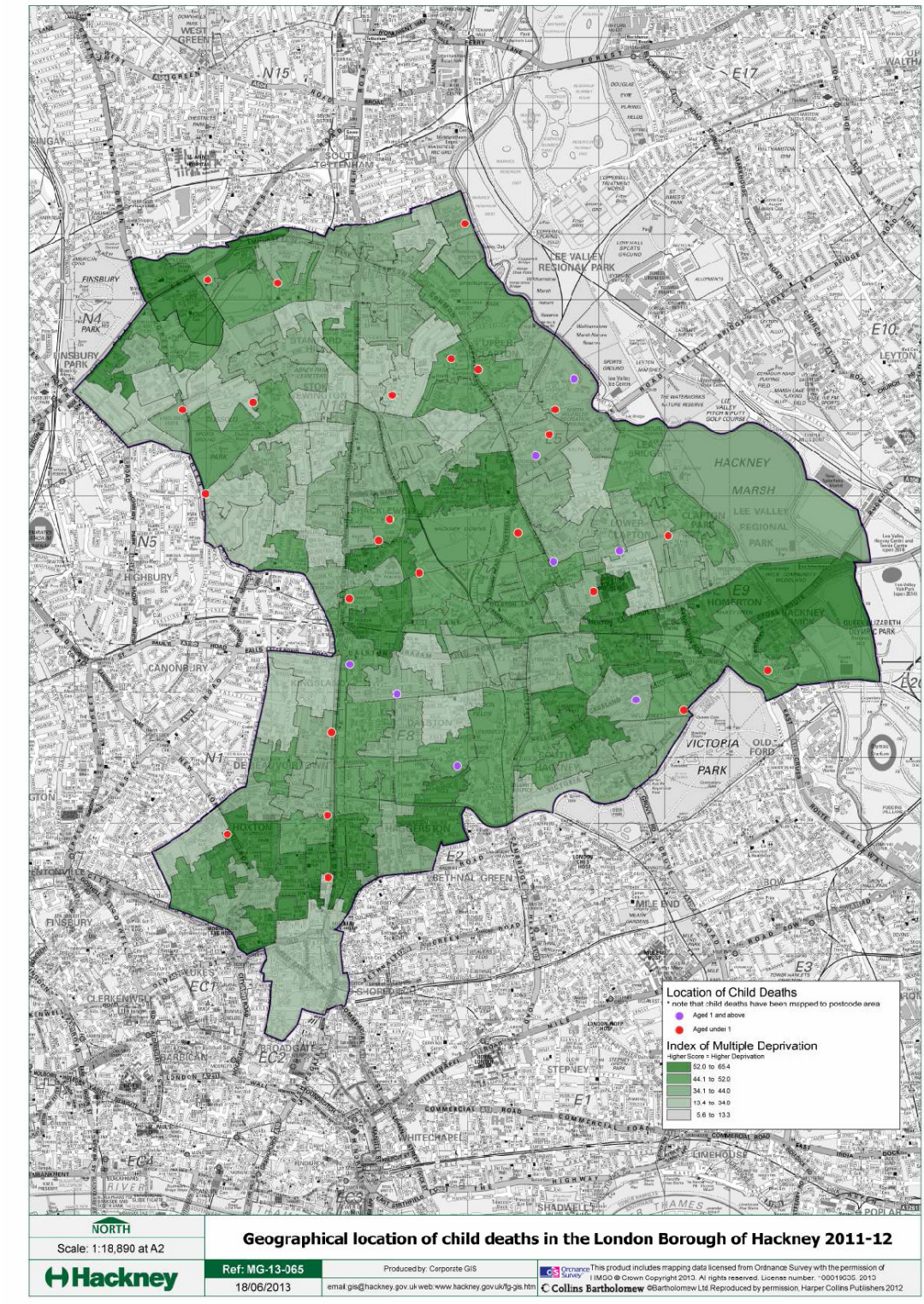
4.4 Geographical distribution

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 half of the deaths occurred in the most deprived areas within the London Borough of Hackney. However, no statistically significant differences were 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) or in relation to deprivation throughout the borough. Although nearly half of the deaths occurred in the most deprived boroughs, the numbers are too small to highlight any statistically significant difference and this has been the trend over the last three years.

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

Figure 4.4 Geographical locations of child deaths in the London Borough of Hackney 2012-13 by infant (red) and non-infant (blue) deaths.

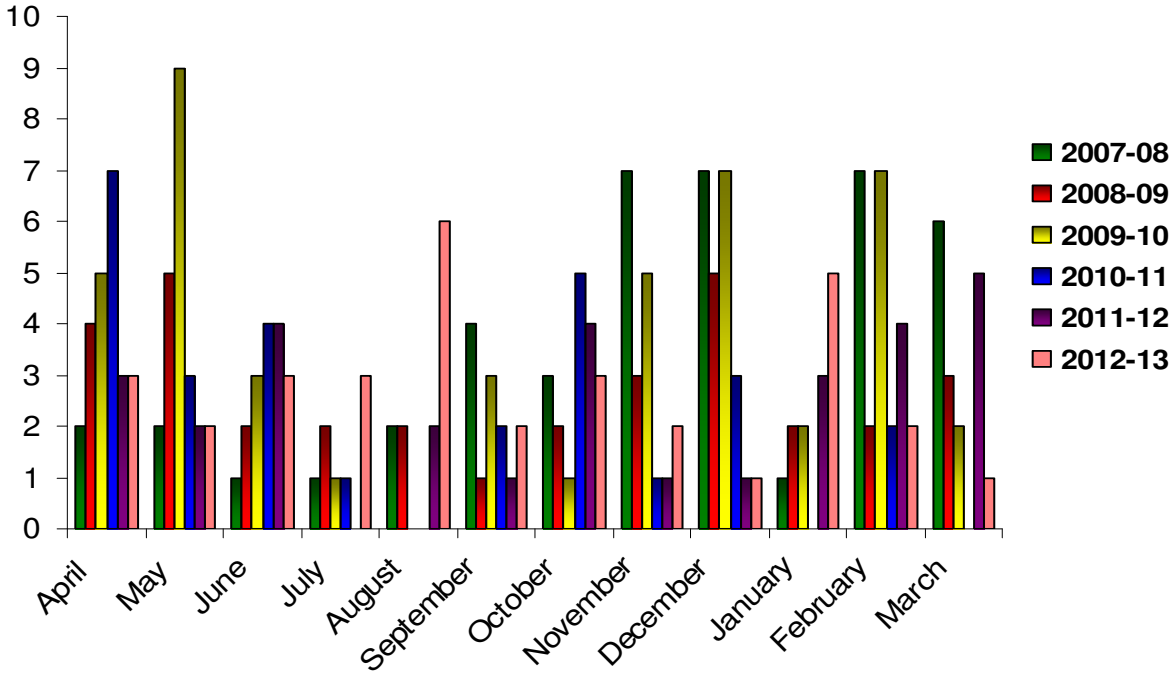


4.5 Seasonal variability

Although the numbers are too small to discard random variation, we assessed the dates of deaths from the previous six years (07/08 through to 12/13) to try to identify any pattern of seasonal variation. In 2007-08 deaths in children and young people

were more common in the 3rd and 4th quarters; in the following year's deaths seem to have been more common during the spring and autumn months (1st and 3rd quarter). In 2012-13 deaths were most common in quarter 2. In general, deaths seem to be more common in the spring months. However, since perinatal/neonatal events account for a high proportion of our children deaths it is important to adjust for variations in delivery patterns during the year. The numbers are too 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	2012-13	Total
1st Quarter	April-June	5	11	17	14	9	8	64
2nd Quarter	July-Sept	7	5	4	3	3	11	33
3rd Quarter	Oct-Dec	17	10	13	9	6	6	61
4th Quarter	Jan-March	14	7	11	2	12	8	54
Total		43	33	45	28	30	33	

Chapter 5

Recommendations to the City and Hackney Safeguarding Children Board

5.1 Learning points and recommendations

Wherever possible the Panel 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 conviction 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 2012-13 were the:

- highlighting the importance of the child death review process and in particular the rapid response process to General Practitioners;
- identification of the need to request a copy of the hospitals 'yellow form' in all perinatal cases in order to obtain all of the key antenatal care data prior to review by the CDOP;
- agreement with the Homerton University Hospital for the provision of the yellow form in all perinatal deaths;
- Plan to highlight the CDOP's concern regarding reviewing deaths in infants born pre 24 weeks gestation and the implication this has on infant mortality rates and abortion statistics to the Department of Education;
- delivery of two presentations about the child death process (October and February) by the Designated Doctor for Child Deaths and the Child Death Overview Panel Coordinator to health visitors as part of their induction programme.

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 could be intervened upon to 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 2012-13 were:

- emphasising the importance of sharing the hospital's discharge summary with the community children's nursing team. Correspondence has taken place with the Medical Director at Homerton University Hospital and the relevant GP about this issue;
- ensuring in relevant cases that parents and siblings are referred to genetic screening and counselling;
- 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 has ensured that the Neonatal Unit at Homerton University Hospital emphasises particular caution in treatment of febrile illnesses in premature babies in the Paediatric Accident and Emergency guidelines;
- advising GPs in relevant cases concerning their patients of the CDOP's findings and recommendations;
- raising awareness of safe sleeping messages for infants (to prevent SIDS) by requesting information about this to be included in the newly developed children's centre health newsletter for staff; and by establishing links between the Regional Development Officer of FSID and relevant staff groups in City and Hackney to enable delivery of the 'reduce the risk of sudden infant death training' to key professionals;
- initiated work on reviewing Asthma trends in primary care and the development of an integrated asthma care pathway;
- continued the implementation of the universal vitamin D supplementation to pregnant women and children under 4 years old through the "A Healthy Start for All" programme through community pharmacies.

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. The CDOP highlighted in last year's annual report that 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. Therefore as listed below, the CDOP has during 2012-13 invited external speakers with expertise in those focus areas to present to the CDOP.

During 2012-13 the following presentations were delivered to the CDOP:

- The work of the Child Abuse Investigation Team (CAIT) across Tower Hamlets, Newham and Hackney delivered by the Detective Constable of CAIT.
- Teenage pregnancy booking data, delivered by the Consultant Midwife in Public Health and Named Midwife for Safeguarding at the Homerton University Hospital.
- Sudden Infant Death: Reduce the Risk, delivered by the Regional Development Officer at FSID.
- Reproductive medicine and risk factors in IVF cases, delivered by the Director, Reproductive Medicine and Assisted Conception Consultant, Homerton Fertility Centre.

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 antenatal and perinatal risk factors and the most effective preventative measures to reduce them.

6.2 Implementation of recommendations from 2011-12 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:

- A specific webpage for CDOP has been created on the CHSCB website, including information about the CDOP, the child death notification process and the relevant forms to use.
- 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 Spring 2013.
- 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

- 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, free 'reduce the risk of sudden infant death training' is being rolled out to key professionals in City and Hackney during spring 2013.
- Implementation of the "A Healthy Start for All", universal vitamin supplementation programme in Hackney and the City of London.