Child Death Overview Panel Annual Report 2013-14

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

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Message from the Chairperson

The City and Hackney Child Death Overview Panel (CDOP) is an independent multidisciplinary panel that provides a review of deaths of children who are aged under 18 years and resident in the London Borough of Hackney or the City of London.

On behalf of the CDOP I would like to offer my condolences to the families, carers and friends of those children and young people whose deaths were considered by the CDOP during the reporting period. The death of a child is always emotional. Each one touches the lives of the child's family, friends, those who worked with the child and the broader community.

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 the moral imperative to act to protect young lives by identifying and addressing risks and making recommendations for improvement of services.

The CDOP's process and annual report aim to promote the transparency of the child death case review requirement by ensuring all cases are scrutinised by an independently appointed panel with expertise in the fields of public health, paediatrics and child health, neonatology, paediatric pathology, mental health, children's social care, investigations and child protection, nursing, midwifery, general practice, child safety (police), education, youth crime reduction and other members who can otherwise make a valuable contribution. The expertise of its members assists the CDOP to fulfil its role to apply a child-focused consideration to each individual review and to develop recommendations for improvement.

The City and Hackney CDOP became active on the 1st of April 2008, since then it has reviewed the deaths of 179 children and young people and all recommendations made by the CDOP have been implemented or are in the process of being implemented.

During the 2013-14 reporting period the CDOP reviewed the deaths of 26 children and young people. Many of the children to whom this report refers are aged less than 1 year of age and have sadly died at, or just after, birth. However, this year nine of the 26 deaths are in children aged 10-18 years. This is a further increase in deaths in this age group from four last year and two the year before that. Though the causes of death were different in many of the cases this is a worrying trend and we are continuing to investigate to attempt to identify any underlying causes or risk factors.

In conclusion, I would like to take this opportunity to thank the current members who have brought an immense and diverse wealth of experience to the child death review process for their commitment, important contribution and support. I would also like to thank the relevant agencies across all sectors and its staff for the support they have given to the process. I trust the information in this report will continue to be useful to all those involved in protecting children and promoting their wellbeing.

Dr Penny Bevan, CBE, MB, ChB, MPH, FFPH
Director of Public Health
Chairperson of 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 in environmental, social health and cultural factors in relation to child deaths in the City of London and London Borough of Hackney are identified, with a consideration of how these might be prevented in the future;
- liaison with relevant agencies occurs when preventable factors are identified;
- the Police or the Coroner are informed of any specific new information that may influence their enquiries;
- the Chair of the City and Hackney Safeguarding Children Board (CHSCB) is notified of the need for further enquiries under s 47 of the *Children Act 2004* or of the need for a Serious Case Review in the light of new information which may become available;
- there is an appropriate rapid response process by professionals to each sudden unexpected death and review the reports produced;
- the CHSCB is advised on the resources and training required to ensure effective interagency working on child deaths;
- regional and national initiatives in response to prevention of child deaths are carried out locally.

The review process is an opportunity to analyse and evaluate the service delivery and system responses with the potential to improve outcomes for children and families, improve interagency working and identify, prioritise and plan for local needs.

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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, mental health, children's social care, investigations and child protection, nursing, midwifery, child safety (police), education, youth crime reduction, general practice 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, through the CDOP coordinator, 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. The CDOP also categorises the deaths for annual submission to the Department for Education.

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 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

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

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;
- 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, family members 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 and inquest are available and can be shared.

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 and the rapid response process will be followed.

Chapter 2

Overview of the CDOP's operation

2.1 Number of child deaths

In the 12 month period from the 1st of April 2013 to the 31st of March 2014, there were 26 deaths in children and young people who were normally resident in the London Borough of Hackney (there were no deaths of children and young people who were normally resident in the City of London). The most recent released child mortality rate (age 1-17 years) as at March 2014 from the Child and Maternal Health Observatory (Chimat) *Child Health Profile* is 16.3 in Hackney and City of London compared to a national average of 12.5 per 100,000 children.[4] The infant mortality rate is 5.5 per 1000 births compared to a national average of 4.3. Both rates remain higher locally.

2.2 Number of meetings held and reviews conducted

The CDOP has reviewed 27 cases and completed 26 cases during the period from the 1st of April 2013 to 31st March 2014. The 26 cases completed included 5 outstanding cases from the previous year, that is, from 1st of April 2012 to 31st of March 2013 and 21 cases from the current year (1st of April 2013 to 31st March 2014).

One case is pending review of the CDOP which requires actions to be completed from a previous review at a previous CDOP before being closed.

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 of the 26 children and young people notified during the period 1st of April 2013 to 31st March 2014. The findings of all rapid response meetings are discussed at the monthly Serious Case Review sub committee. None of the sudden deaths reviewed by the rapid response group during 2013-14 were recommended to be subject to a Serious Case Review.

Although there were 13 unexpected deaths, 15 rapid response meetings were held. Three meetings were held for one case where professionals who held essential information were unable to attend the original meeting, the extra 2 meetings being held at The Royal London Hospital and a GP practice.

[4] *Child Health Profile: Hackney and City of London,* CHIMAT, March 2014.

The venue of each rapid response meeting will depend on where the child has died. During 2013-14, 3 of the rapid response meetings took place at the Homerton University Hospital, 1 took place at a GP practice, 5 took place at Hackney Service Centre and 6 at Royal London Hospital. See table 2.1 for a breakdown of all rapid response venues during the last year.

Table 2.1 Venues of rapid response meetings

Venue	Number of meetings held
Homerton University Hospital	3
Hackney Service Centre	5
Royal London Hospital	6
GP Practice	1
Total	15

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 four (15%) of the completed case reviews. Two of these cases were regarding the influenza vaccination being given to children with neuro-developmental disorders and pregnant women, one case was regarding vaccination for Hepatitis B positive pregnant women being decided by a senior member of staff, and the final case involved GP's ability to identify patients with potential symptoms of diabetes, including screening young people who present as obese.

2.3 Organisation and resourcing of the CDOP

The CHSCB and Public Health both have significant responsibilities in relation to child deaths. From January 2012 when the CDOP Coordinator post was transferred to the CHSCB, the lead role in supporting the CDOP and responding to the CHSCB child death review responsibilities reverted back from NHS East London and the City to the CHSCB. Since April 2013 the CDOP Coordinator post has been funded through Public Health, as part of the London Borough of Hackney. The CHSCB support the administrative processes needed to ensure adequate collaboration and coordination between the CDOP and other agencies and entities.

For example, the following administrative support has been provided to the CDOP during 2013-14:

- 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 and rapid response actions and 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 CDOP meetings from April 2013 to March 2014 - during this period, there were four meetings.

Table 2.2 Agency attendance at CDOP meetings

Organisation	% of meetings attended
Chair – Public Health	100%
Child Death Overview Panel & Rapid Response Co-ordinator – CHSCB / Public Health	100%
Child Abuse Investigation Team - Metropolitan Police Service	
• Detective Inspector	50%
Children's Social Care – Hackney Council	
• Head of Safeguarding	75%
• Head of Children in Need	50%
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	75%
Education – Hackney Learning Trust	
• Head of Attendance & Behaviour	100%
Hackney Borough Police – Metropolitan Police Service	
• Detective Inspector	0%
City & Hackney Clinical Commissioning Group (CCG)	
• Named GP	75%
• Designated Nurse	100%
Homerton University Hospital – NHS Trust	
• Consultant Paediatrician	100%
• Consultant Neonatologist and Lead Clinician	25%
• Consultant Midwife – Public Health & Named Midwife for Safeguarding	100%
• Consultant Community Paediatrician, Designated Doctor for Child Deaths	100%
• Named Nurse Child Protection	100%
Royal London Hospital	
• Consultant Paediatric Pathologist	0%

The CDOP reports its themes and learning issues annually to the CHSCB. In addition, the Chair of the CDOP presents the CDOP's findings and recommendations about the health, safety and wellbeing of all children in the London Borough of

Hackney and the City of London together with CDOP's system level data to the CHSCB on an annual basis.

The Chair of the rapid response group together with the CDOP Coordinator also presents the CDOP's data, findings and learning's to health care professionals. The most recent presentations took place in April 2014 to the Community Paediatricians, in December 2013 to health visitors and school nurses, and in November 2013 to GPs.

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

Chapter 3

Commentary on the 26 cases reviewed & completed by the CDOP

This chapter refers to the 26 cases reviewed and completed by the CDOP during the period 1st of April 2013 to 31st March 2014.

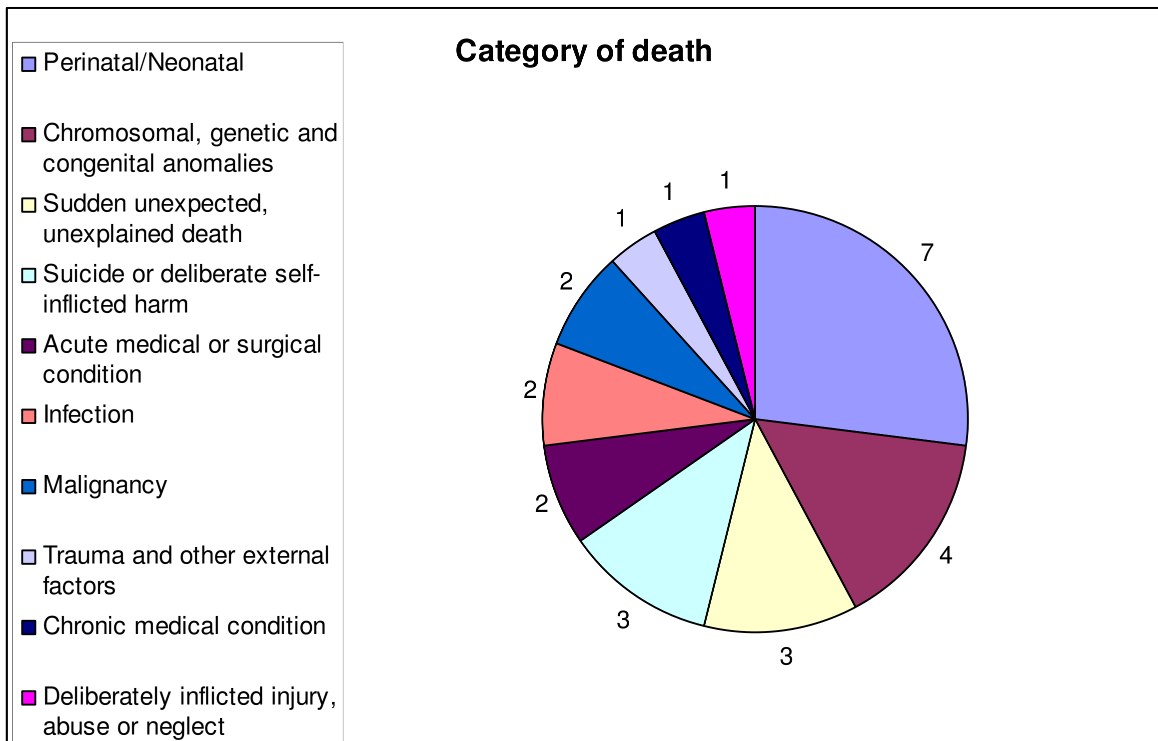
3.1 Neonatal deaths

Just over one-quarter of the 26 cases reviewed by the CDOP were deaths occurring within the first 28 days of life (7, 27%) and over half (15, 58%) occurred within the first year of life. Almost half of deaths, (7, 47%) 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, bronchopulmonary dysplasia and post-haemorrhagic hydrocephalus irrespective of age at death.

The CDOP classified a fifth of deaths occurring within the first year of life (3, 20%) as due to chromosomal, genetic and congenital abnormalities and a fifth due to sudden unexpected, unexplained deaths (3, 20%). The other two cases were due to infection and malignancy.

Two thirds (10, 66%) of the reviewed deaths of children under 1 year were in males.

Figure 3.1 Category of death classified between 1st April 2013 and 31st March 2014



3.2 Gestation at birth

Of the fifteen deaths that occurred before the first year of life, the gestation of six (40%) were under 25 weeks, the other nine (60 %) being between 36-41 weeks gestation. Of the seven ‘Perinatal/Neonatal’ deaths, six (86%) of these were under 25 weeks gestation with one (14%) being born at 40 weeks gestation.

Figure 3.2 Gestation of baby whose death occurred before the first year of life, reviewed between 1st April 2013 and 31st March 2014

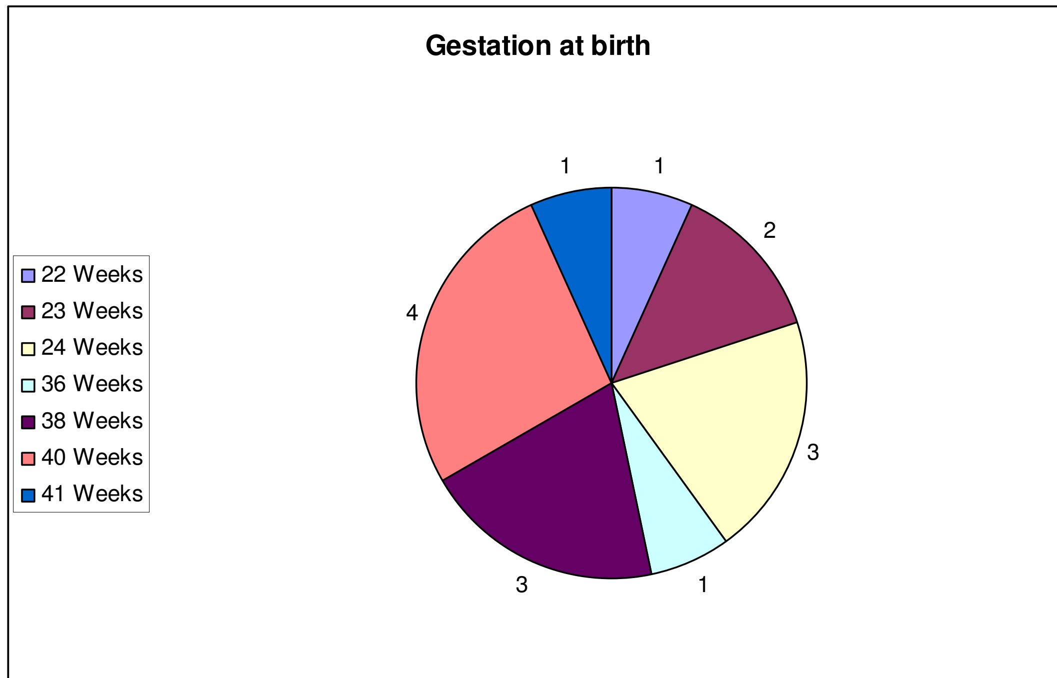
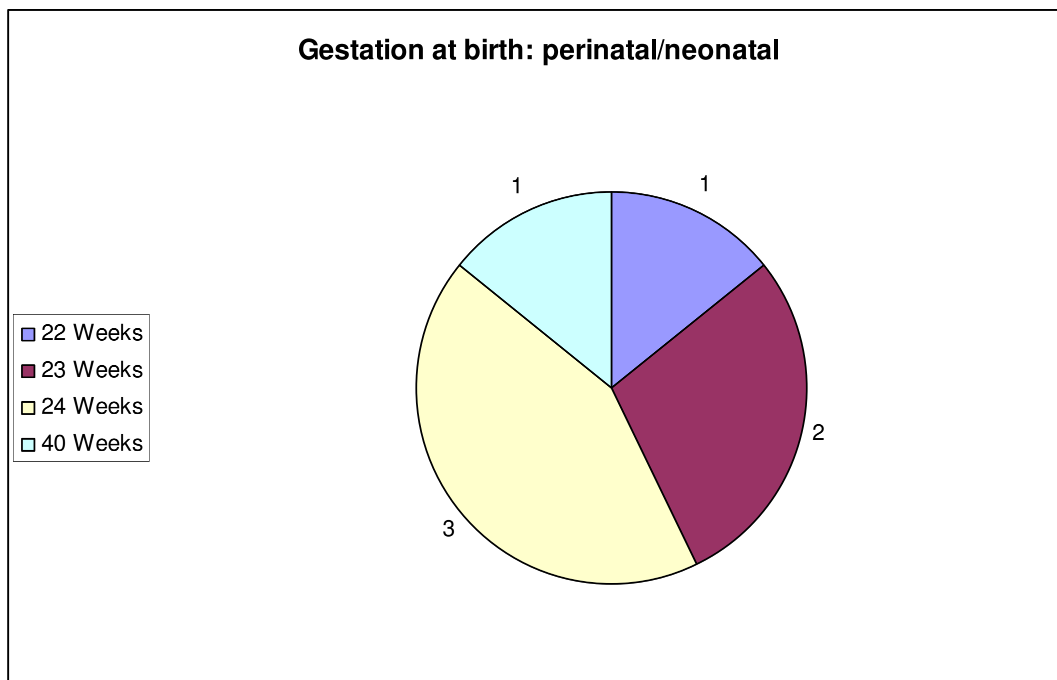


Figure 3.3 Gestation of baby whose death was classified as ‘Perinatal/Neonatal’, reviewed between 1st April 2013 and 31st March 2014



3.3 Unexpected deaths

Thirteen (50%) of the 26 cases reviewed by the CDOP in the period of this report were defined as unexpected deaths. Morbid conditions accounted for 5 deaths (38.5% of the unexpected deaths); external causes accounted for 5 deaths (38.5%) including accidental strangulation and self-inflicted injury; and 3 (23%) cases were classified by the CDOP as a sudden unexpected death of an infant (SUDI).

Table 3.1 Unexpected child deaths reviewed by the CDOP 2013-14

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

* Sudden unexpected death of an infant.

The CDOP considered that modifiable factors may have contributed to the child death in 2 (15%) 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

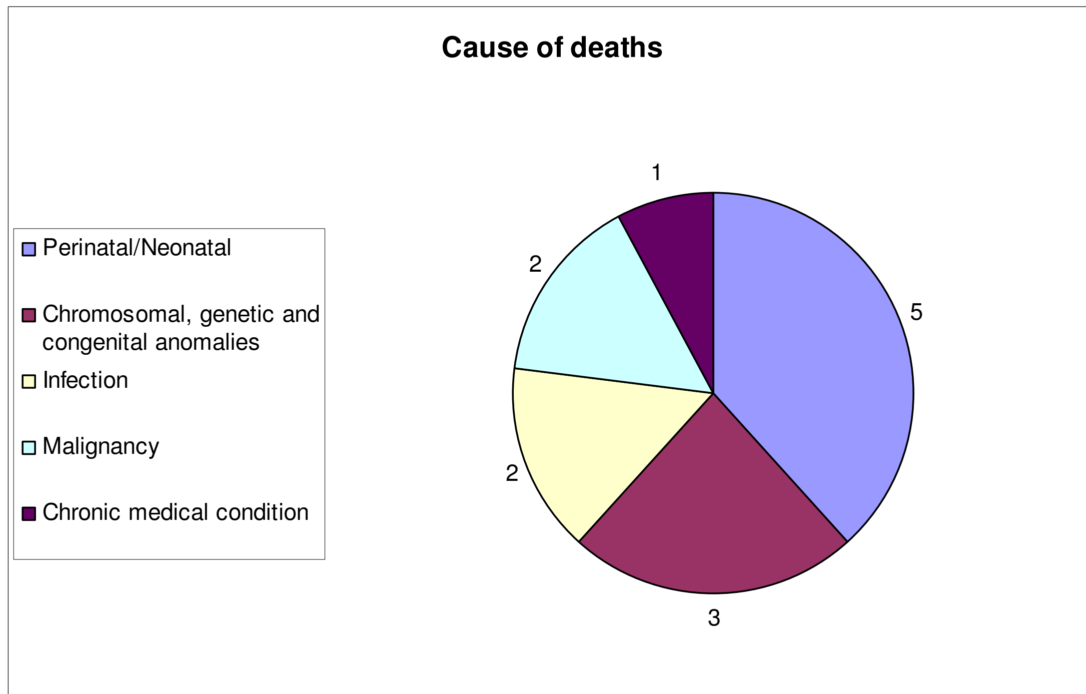
Three infant deaths reviewed by the CDOP were classified as sudden unexpected, unexplained death and by the Coroner as: one Sudden Unexpected Death in Infancy (SUDI), and two Sudden Infant Death Syndrome (SIDS) – all were noted as natural causes with the exception of one which was noted as 50/50 between natural causes and accidental.

It was evident in the last case from the history provided, that the baby died whilst sleeping in bed with their mother (co-sleeping). The CDOP noted that bed-sharing is a serious risk factor for sudden infant deaths of babies under four months of age. Co-sleeping has also been recognised as a national problem and continues to be addressed through dissemination of information.

3.5 Expected deaths

Thirteen (50%) of the 26 reviews completed by the CDOP were defined as expected deaths. All of these cases were caused by Morbid Conditions. 5 of these cases (39%) were classified as ‘perinatal/neonatal events’; 3 (23%) were classified as ‘chromosomal, genetic and congenital anomalies’; 2 (15%) were classified as infection; 2 (15%) were classified as malignancy; and 1 (8%) was due to chronic medical condition.

Figure 3.4 Expected child deaths reviewed by the CDOP 2013-14



Chapter 4

Child death statistics

This chapter refers to the 26 deaths in children and young people that the CDOP was notified of during the period 1st of April 2013 to 31st of March 2014.

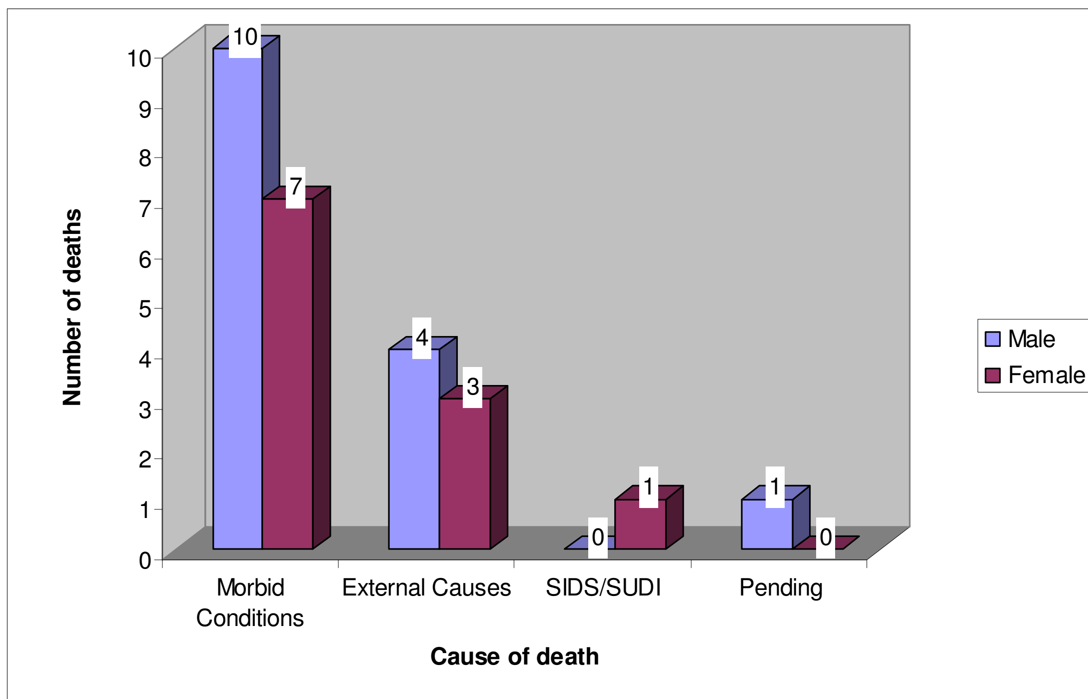
4.1 Cause of death

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 (17, 65%) 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 7 deaths (27%), 1 (4%) death was classified as SIDS/SUDI and the cause of death is currently pending in 1 (4%) case due to an outstanding inquest.

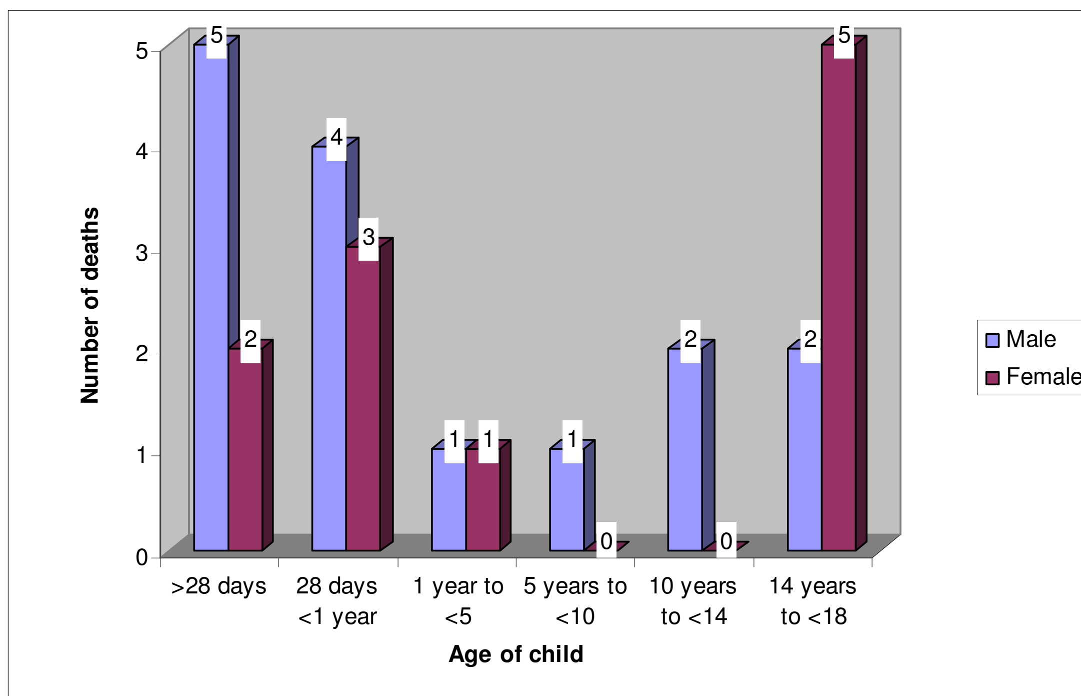
Figure 4.1 Child deaths in City and Hackney in 2013-14 by cause of death



4.2 Age and gender

Of the 26 deaths that took place in the period covered by this report, fifteen were in males (58%) and eleven in females (42%); 14 deaths (54%) occurred within the first year and half of them (7, 27%) occurred within the first 28 days of life.

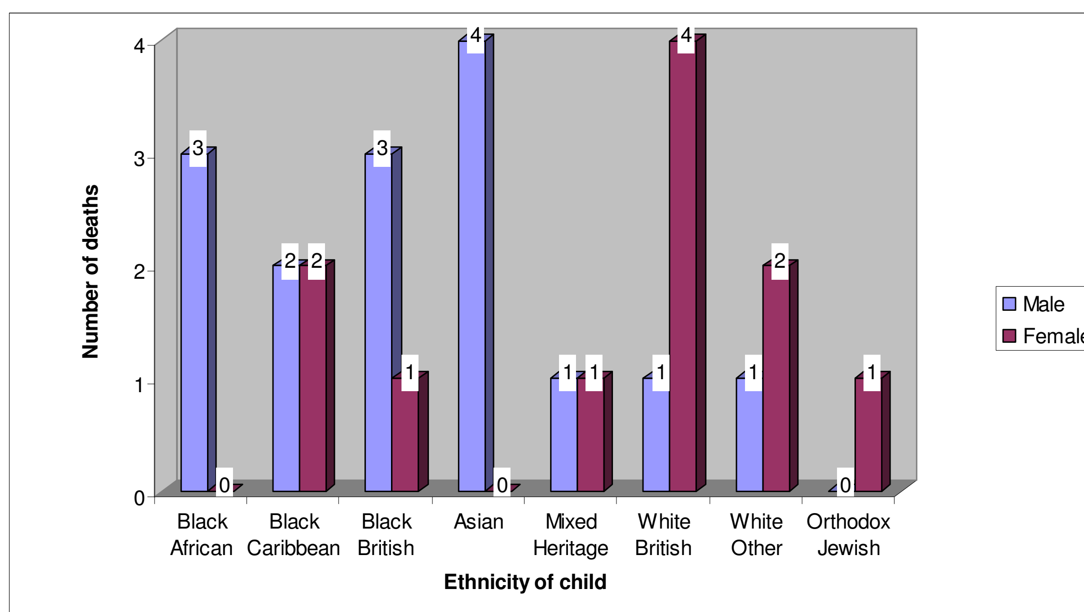
Figure 4.2 Age and gender of child deaths that occurred between 1st April 2013 and 31st March 2014



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 11, 43% (these groups represent 21% of the total City and Hackney population);[5] 4 (15%) in Asian children; 8 (31%) in White children; 2 (7%) children of mixed heritage and 1 (4%) in Orthodox Jewish children.

Figure 4.3 Ethnic groups of deaths occurring during the reporting period

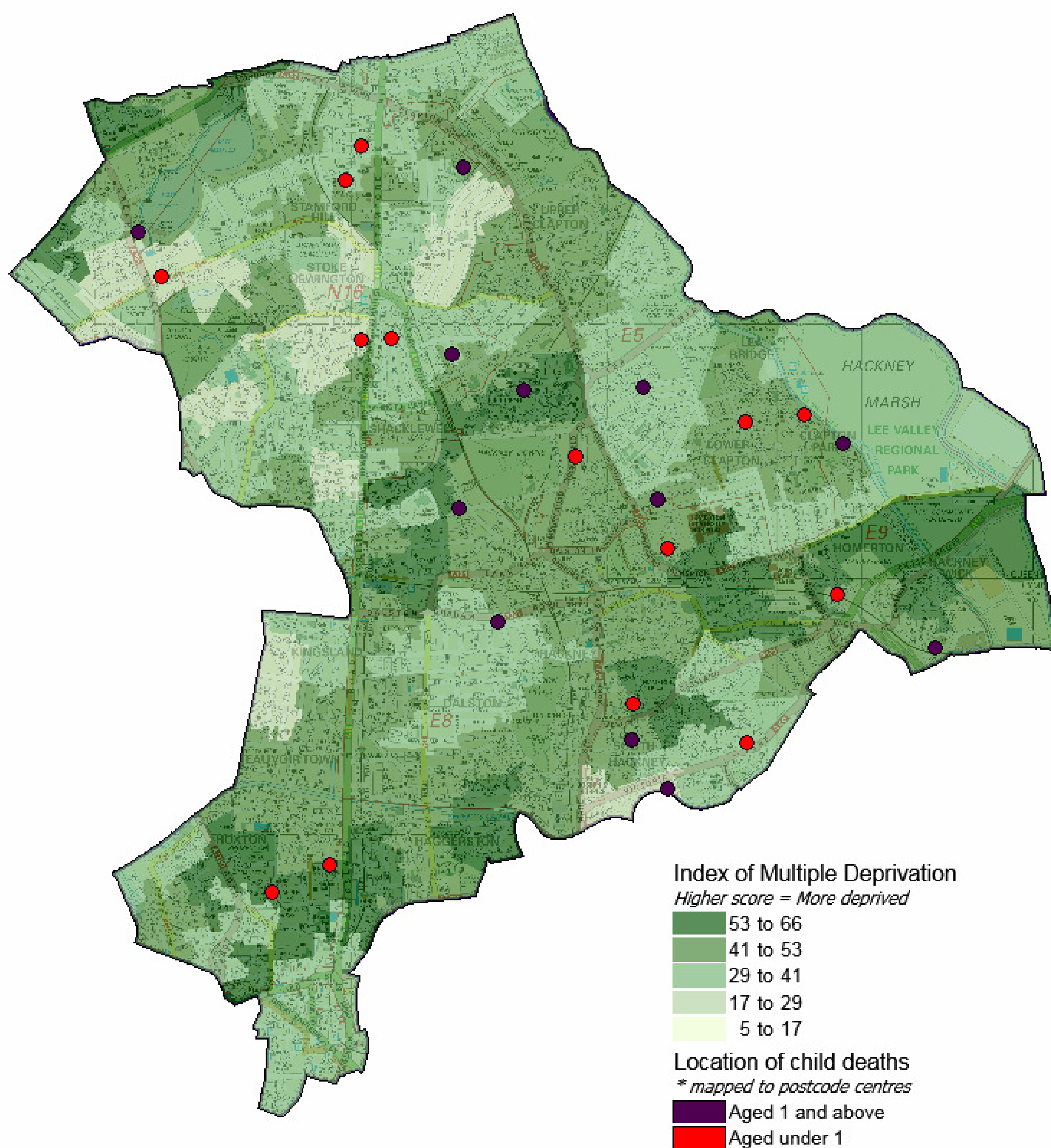


[5] NHS City and Hackney, *Health and Wellbeing Profile 2010/11: Our Joint Strategic Needs Assessment* (2010) 17.

4.4 Geographical distribution

Figure 4.4 shows the location of all child deaths occurring during the period covered by this report, mapped over an Index of Multiple Deprivation score within London Borough of Hackney and the City of London. There were no child deaths in the City of London; over half of the deaths occurred in the most deprived areas with the London Borough of Hackney.

Figure 4.4 Geographical location of child deaths in the London Borough of Hackney and the City of London 2013-14.[6]



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 three years.

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

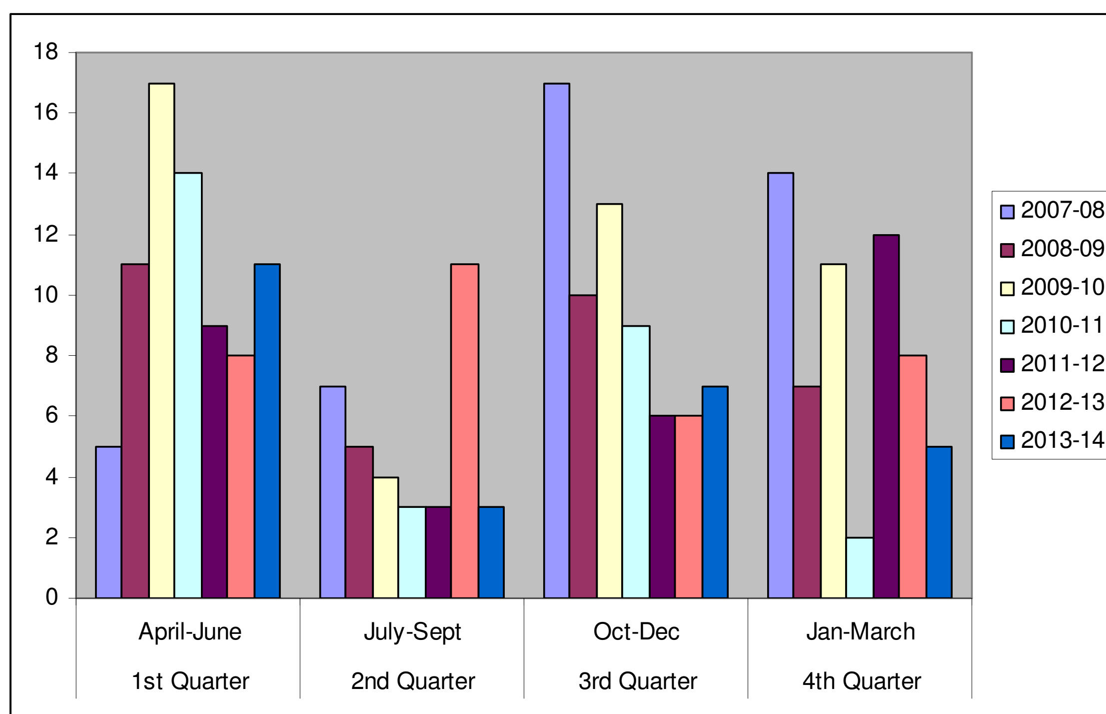
The infant mortality rate in Hackney and the City for 2010-2012 according to CHIMAT was 5.5 deaths per 1,000 live births or an average of 25 infant deaths per year[7]. The rate in Hackney and the City for 2013-2014 is 3.1 deaths per 1,000 live births or an average of 14 infant deaths per year, which sees a significant decrease in infant mortality and compliments the long-term trend in infant mortality decreasing.

Hackney and the City continue to see a trend in higher numbers of child deaths in the Black ethnic group, this year seeing 43% of deaths in these groups (they represent 21% of the population). This figure was 37% of deaths in 2011-12 and 2012-13, whilst representing 21% of the population.

4.5 Seasonal variability

Although the numbers are too small to discard random variation, death counts from 2007-08 until 2013-14 seem to show some degree of seasonal variation. The CDOP year runs from April 1st until March 31st so the quarters begin April 1st each year. In 2007-08 deaths in children and young people were more common in the 3rd and 4th quarters (Oct-Dec and Jan-March), whereas in the following years deaths seem to be more common during the spring and autumn months (1st and 3rd quarter). Quarter 2 (July-Sept) tends to see the least deaths. This is true for 2013-14 in which we saw 11 deaths in quarter 1 and 7 deaths in quarter 3. In general, deaths seem to be more common in the spring months (April-June). However, the figures are small and the differences are not statistically significant.

Figure 4.5 Deaths stratified by month of occurrence



7 *Child Health Profile: Hackney and City of London,* CHIMAT, March 2014.

Quarter	Months	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
1st Quarter	April-June	5	11	17	14	9	8	11
2nd Quarter	July-Sept	7	5	4	3	3	11	3
3rd Quarter	Oct-Dec	17	10	13	9	6	6	7
4th Quarter	Jan-March	14	7	11	2	12	8	5
Total		**43**	**33**	**45**	**28**	**30**	**33**	**26**

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 2013-14 were the:

- continued highlighting of the CDOP's concern regarding reviewing babies born pre 24 weeks gestation and the implication this has on infant mortality rates and abortion to the Department of Education;
- delivery of three presentations about the child death process (November and December 2013 and April 2014) by the Designated Doctor for Child Deaths to community paediatricians, health visitors, school nurses and general practitioners as part of their induction and development programmes;
- highlighting the importance of the child death enquiry, particularly rapid response (with a survey taken), to General Practitioners and encouraging their continued active participation;
- review of self-inflicted deaths by asphyxiation with emerging patterns among teenagers. Consideration of possible contribution from 'the choking game' popularised amongst young people.

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 child death case reviews identify issues that may indicate broader trends which with intervention could 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 2013-14 were:

- continuing to ensure in relevant cases that parents and siblings are referred to genetic screening and counselling;

- development of a robust rota system for attending medical emergencies in unregistered patients at a local GP surgery (see case study 1);
- implementation of a ‘doctor first’ system at a local GP surgery to correctly triage calls and ensure every patient is called back to determine if a doctor is needed;
- the addition of senior review for repeat presentations of infants to the Plastic Surgery outpatient service at Royal London Hospital;
- an obstetric review of invasive fetal monitoring during labour in women positive for blood-borne viruses;
- the London Ambulance Service introduced systems to improve response times following delayed response as reflected in Hackney and other London boroughs;
- the London Ambulance Service have held a review of dispatch work-load distribution and alterations to area and complex configurations to ensure that there are separate allocators for both Islington and City and Hackney complexes. There is also now a separate radio talk-group for each complex.
- 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. Looking at a date range of January – February 2014, Hackney saw a 78% take-up of Healthy Start vouchers, compared to a 76% take-up nationally. In terms of numbers of vitamins, there were 6469 collections for children and 5634 for adults between April 2013 and March 2014. Broken down by month, 2013-14 saw an increase in uptake from 940 collections in April 2013 to 1089 collections in March 2014, with a peak of 1188 in October 2013.

5.4 Case Study

Case Study

A 5 week old infant was seen for health screening by an allied health professional in a building housing multiple local GP practices. The infant began fitting and there was a delay in accessing emergency medical attention. The ambulance attended late and there was confusion around which doctor had responsibility to attend as the baby was not registered with any of the practices on site. Although a GP was found to carry out an assessment and the baby transferred to hospital, sadly he later died of sepsis related complications.
As a result of the review of this incident, a written policy was introduced by all the practices in that location to clarify a rota system for attending to emergencies involving unregistered patients on the premises.

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 palliative medicine and care; support for bereaved families and reducing infant mortality, identifying risk factors and the most effective preventative measures to reduce them. Therefore as listed below, the CDOP has during 2013-14 invited external speakers with expertise in those focus areas to present to the CDOP.

During 2013-14 the following presentations were delivered to the CDOP:

- The work of the Pause Project across Hackney, which looks at support given to mothers with successive removals of children, delivered by the Professional Advisor to the City and Hackney Safeguarding Children Team.
- Paediatric Palliative Medicine, delivered by the Consultant in Paediatric Palliative Medicine at Great Ormond Street Hospital.
- The work of Child Bereavement UK, talk from the leads at Child Bereavement UK.
- Talk from the Senior Professional Advisor to the City and Hackney Safeguarding Children Team regarding teenage deaths, and in particular deaths caused by accidental strangulation.

The CDOP has seen an alarming increase in the number of teenage deaths in 2013-14 (9), compared to previous years 2012-13 (4) and 2011-12 (2). The focus in the forthcoming year will particularly be on reviewing self-inflicted deaths by asphyxiation with emerging patterns among teenagers. It will also consider possible contribution from ‘the choking game’ which has become popularised amongst young people.

6.2 Implementation of recommendations from 2012-13 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 meeting was set up involving a presentation and survey for General Practitioners to determine their involvement in the rapid response process, and to highlight the importance of attendance from all agencies.
- A letter has been sent to the Department for Health 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.
- Awareness raising of safe sleeping messages continues to be a priority for the CDOP and all children’s centres were contacted to ensure access to material had been provided.
- continuation 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.

- The London Ambulance Service Quality and Nursing Director is in the process of writing to the Chief Coroner with a view to changing the direction for the removal of bodies of over 2's to be in line with Working Together.