city & hackney safeguarding children board

Child Death Overview Panel
Annual Report 2015/16

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

Contents

Message from the Chairperson

The death of a child touches the lives of the child's family, friends, those who worked with the child and the broader community. I would like to offer my condolences to the families, carers and friends of those children and young people whose deaths occurred during this reporting period.

Complementary to any judicial process, it is a statutory requirement that, when a child dies, the factors around the death, including services provided to the child, will be comprehensively reviewed and evaluated.

The City and Hackney Child Death Overview Panel (CDOP) is the 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. This enquiry is carried out in a manner which promotes learning and transparency and, in order that future lives are protected, identifies and addresses risks and makes recommendations, locally and nationally, to change or improve services.

The City and Hackney CDOP became active on the 1st of April 2008, since when it has reviewed the deaths of 235 children and young people. All recommendations made by the CDOP have been implemented or are in the process of being implemented.

This year's Annual Report of CDOP reports on the processes and findings. During the 2015-16 reporting period the CDOP reviewed the deaths of 22 children and young people.

All cases are scrutinised by an independently appointed panel with expertise in the fields of public health, paediatrics and child health, neonatology, mental health, children's social care, child protection, nursing, midwifery, general practice, child safety (police), education, youth crime reduction and other relevant 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.

I would like to take this opportunity to thank the members of CDOP for their contribution to the review process. They have brought a wealth of experience, commitment, challenge and support over the last year. I trust the information in this report will continue to be useful to all those involved in protecting children and promoting their wellbeing.

My particular thanks go to Kerry Littleford for her unfailing commitment, and efficient support to myself and the panel.

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

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

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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* (2015).

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, mental health, children's social care, investigations and child protection, nursing, midwifery, child safety (police), education, youth crime reduction and other members who can otherwise make a valuable contribution.

A coordinator supports the work of the CDOP to ensure it fulfils its statutory requirements and acts as Single Point of Contact (SPOC) for all child death notifications.

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 completes a statistical data return for annual submission to the Department for Education and produces this annual report.

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. The CDOP has also agreed to monitor, but not review, the deaths of infants that are born under 23 weeks gestation.

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]

[3] HM Government, *Working Together to Safeguard Children* (2015) 85.

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

Whenever a child dies unexpectedly, a rapid response team constituted by a group of professionals from different key agencies comes together for the purpose of assessing all information, enquiring into and evaluating the death.

The purpose of the rapid response is to ensure that the appropriate agencies are engaged and work together to:

- respond without delay to the unexpected death of a child;
- ensure support for the bereaved family members, as the death of a child will always be a traumatic loss – the more so if the death was unexpected;
- 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 2015 to the 31st of March 2016, there were 21 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 2016 from the Child and Maternal Health Observatory (Chimat) *Child Health Profile* is 15.8 in Hackney and City of London compared to a national average of 12 per 100,000 children.[4] The infant mortality rate is 5.6 per 1000 births compared to a national average of 4.0. Both rates remain higher locally. You can see rates locally and nationally from 2010 – 2016 in table 2.1.

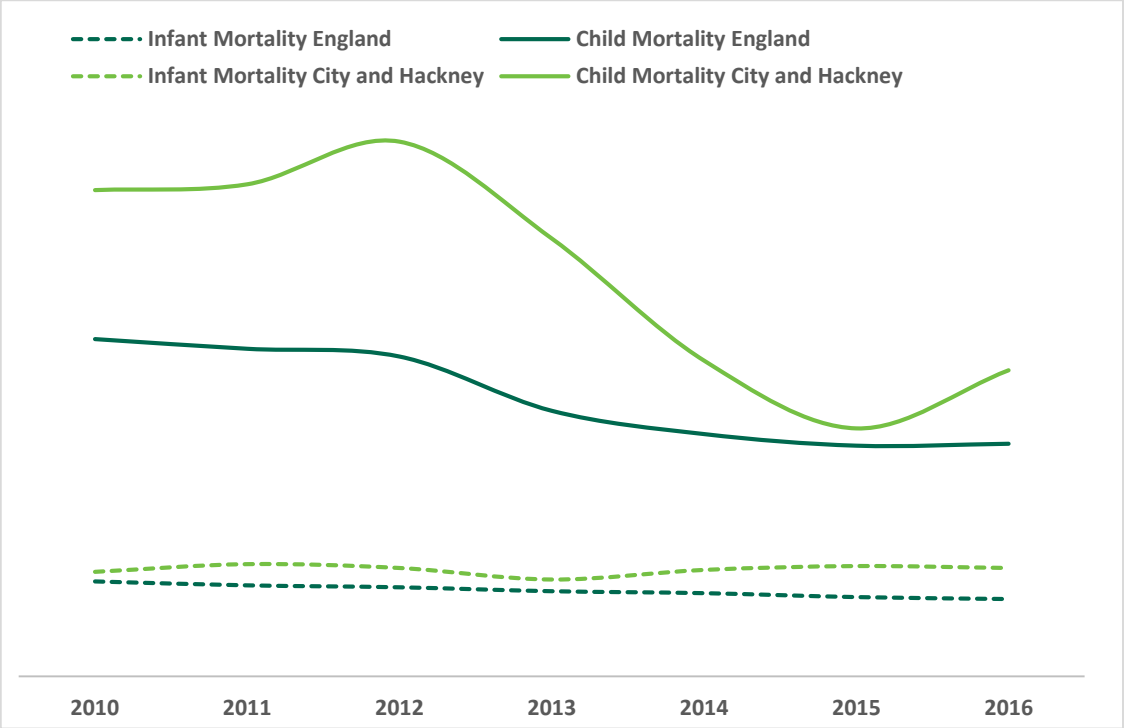
Between 2010 and 2016 there has been a steady downward trend in mortality rates nationally both for infants and children. City and Hackney have seen increases in the earlier years, followed by a decline and ending in 2016 with a small increase again. In particular it is worth noting the sharp decrease in child mortality rates in the City and Hackney from 2013 shown in figure 2.1. Please note that these figures have been taken from Chimat where aggregated data for the previous 3 years make up each year's figure.

Table 2.1 Child and Infant Mortality 2010-2016 (Chimat)

	2010	2011	2012	2013	2014	2015	2016
Infant Mortality (England)	**4.9**	**4.7**	**4.6**	**4.4**	**4.3**	**4.1**	**4.0**
Infant Mortality (City & Hackney)	**5.4**	**5.8**	**5.6**	**5.0**	**5.5**	**5.7**	**5.6**
Child Mortality (England)	**17.4**	**16.9**	**16.5**	**13.7**	**12.5**	**11.9**	**12**
Child Mortality (City & Hackney)	**25.1**	**25.4**	**27.6**	**22.6**	**16.3**	**12.8**	**15.8**

[4] *Child Health Profile: Hackney and City of London,* CHIMAT, March 2016.

Figure 2.1 Child and Infant Mortality 2010-2016 (Chimat)



2.2 Number of meetings held and reviews conducted

The CDOP has reviewed 23 cases and completed 22 cases during the period from the 1st of April 2015 to 31st March 2016. The 22 cases completed included 7 outstanding case from the period covering 1st April 2014 to 31st March 2015 and 15 cases from the current year, 1st of April 2015 to 31st March 2016.

One case is pending review of the CDOP, which requires actions to be completed 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;
- modifiable factors 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.

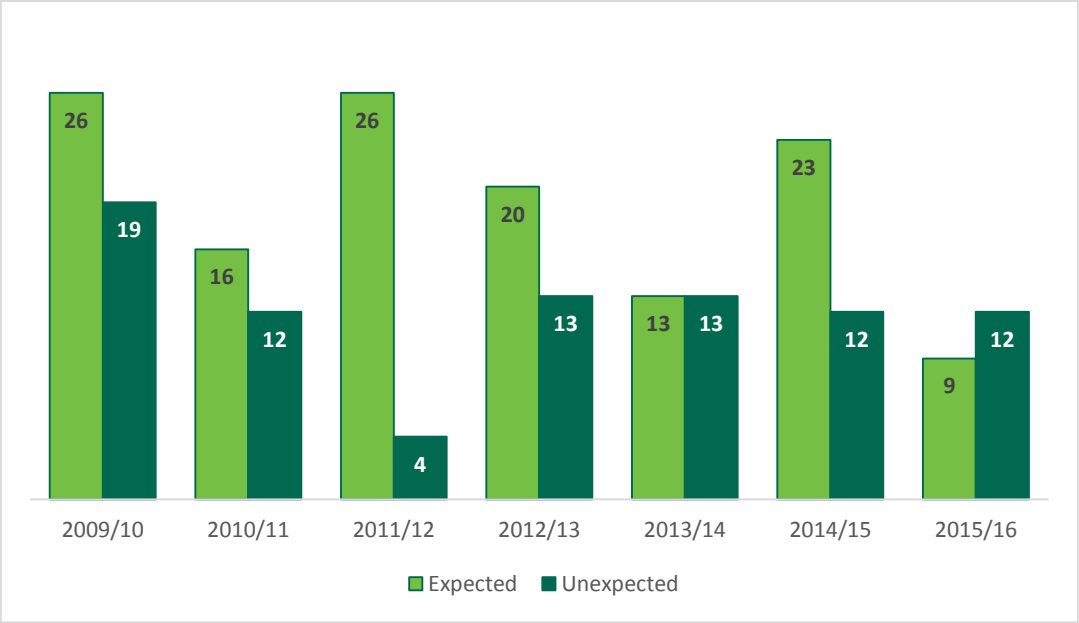
2.2.1 Rapid response group

The rapid response group, which is monitored by the CDOP, has considered the unexpected deaths of 12 of the 21 children and young people notified during the period 1st of April 2015 to 31st March 2016. This is the first year unexpected deaths were higher than expected (as shown in figure 2.2). Expected deaths have seen a

steady decline since 2009 with a sharp decline in the last year. Unexpected deaths declined rapidly between 2010 – 2012 but have remained fairly constant since 2012.

The findings of rapid response meetings which may require further review are discussed at the monthly Serious Case Review sub-committee. One of the sudden deaths reviewed by the rapid response group during 2015-16 was recommended to be subject to a Serious Case Review.

Figure 2.2 Expected and Unexpected deaths 2009-16



The venue of each rapid response meeting will depend on where the child has died. During 2015-16, 7 of the rapid response meetings took place at the Homerton University Hospital, 2 took place at Hackney Service Centre, 1 took place at Newham University Hospital, and 2 at Royal London Hospital. See table 2.1 for a breakdown of all rapid response venues during the last year.

Table 2.2 Venues of rapid response meetings

Venue	Number of meetings held
Homerton University Hospital	7
Hackney Service Centre	2
Royal London Hospital	7
Newham University Hospital	1
Total	12

2.2.2 Preventability / Modifiable factors

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 one of the 22 completed case reviews (4.5%).

The City and Hackney CDOP is confident that all cases are reviewed comprehensively, and that professional challenge remains a central part of the review process.

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 2015-16:

- 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;
- presenting to front-line staff on recommendations made by the CDOP;
- 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 2015 to March 2016 - during this period, there were four meetings.

Table 2.3 Agency attendance at CDOP meetings

Organisation	% of meetings attended
Chair – Public Health	75%
Child Death Overview Panel & Rapid Response Co-ordinator – CHSCB / Public Health	100%
Child Abuse Investigation Team - Metropolitan Police Service • Detective Inspector	25%
Children's Social Care – Hackney Council	

• Head of Safeguarding • Head of Children in Need	0% 100%
City and Hackney Safeguarding Children Board Team • Professional Advisor/Board Manager	 75%
City of London • Children's Social Care	 0%[5]
City of London Police • Detective Sergeant	 0%
Clinical Commissioning Group • Named GP • Designated Nurse Safeguarding Children & Young People	 50% 75%
East London NHS Foundation Trust • Named Professional for Safeguarding Children	 50%
Education – Hackney Learning Trust • Head of Wellbeing and Education Safeguarding	 50%
Hackney Borough Police – Metropolitan Police Service • Detective Inspector	 75%
Homerton University Hospital – NHS Trust • Consultant Paediatrician & Named Doctor • Consultant Neonatologist and Lead Clinician • Consultant Midwife – Public Health & Named Midwife for Safeguarding • Consultant Community Paediatrician, Designated Doctor for Child Deaths • Named Nurse Child Protection	 75% 100% 100% 100% 75%
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 learnings to health care professionals. The most recent presentations took place in February 2015 to health visitors and midwives on safe-sleeping, April 2014 to the Community Paediatricians, and in November 2013 to GPs.

The CDOP continues to highlight the importance of attendance at both CDOP meetings and rapid response meetings to partners. The CHSCB Board Manager recently highlighted this to the City of London following decreased attendance.

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/).

[5] Note:There were 0 deaths in City of London residents 2015/16. City representatives on the panel are only requested when there are cases to be discussed.

Chapter 3

Commentary on the 22 cases reviewed & completed by the CDOP

This chapter refers to the 22 cases reviewed and completed by the CDOP during the period 1st of April 2015 to 31st March 2016.

3.1 Neonatal deaths

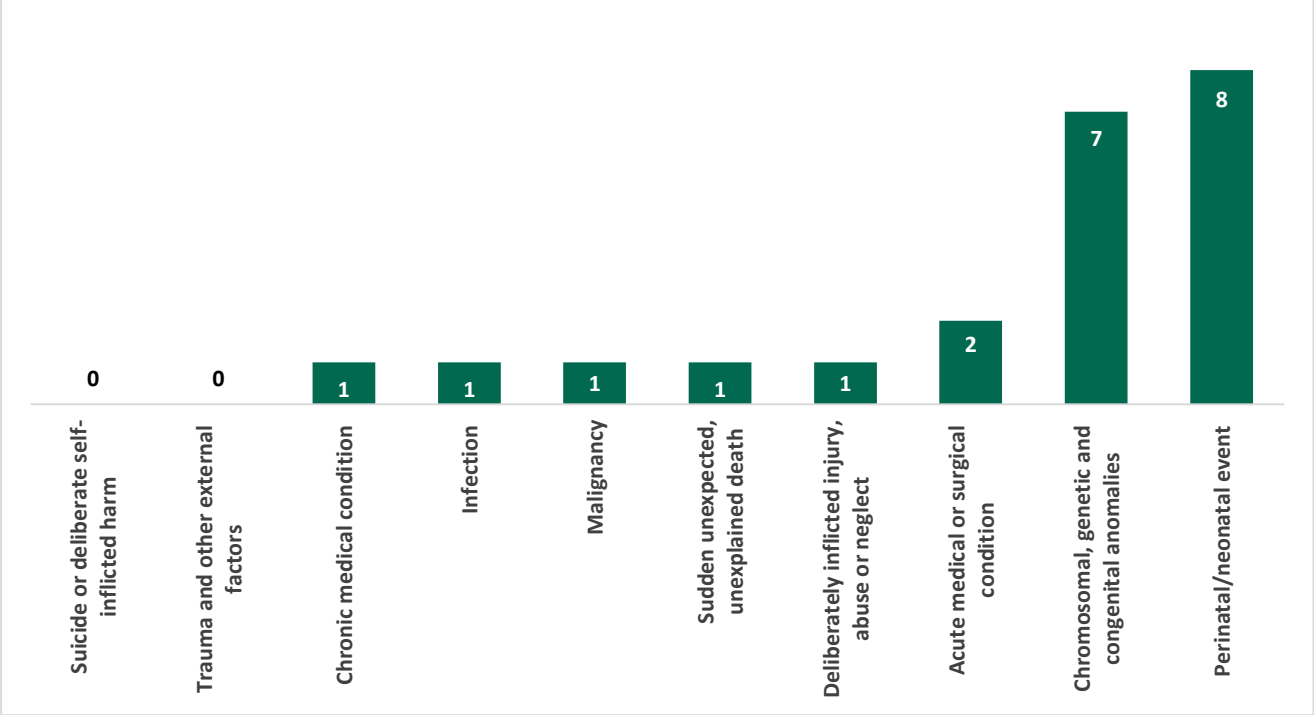
Half (50%) of the 22 cases reviewed by the CDOP were deaths occurring within the first 28 days of life (up from 47% last year and 27% the year before) and nineteen (86%) occurred within the first year of life (up from 68% last year and 58% the year before).

Almost half of deaths, (8, 42%) 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 over a third (7, 37%) of deaths occurring *within* the first year of life as due to chromosomal, genetic and congenital abnormalities. The other four cases (21%) were due to; sudden unexpected, unexplained death; infection; malignancy; and deliberately inflicted injury, abuse or neglect.

Eleven (58%) of the reviewed deaths of children under 1 year were in females. This is a shift from 61% of males last year.

Figure 3.1 Category of death classified between 1st April 2015 and 31st March 2016

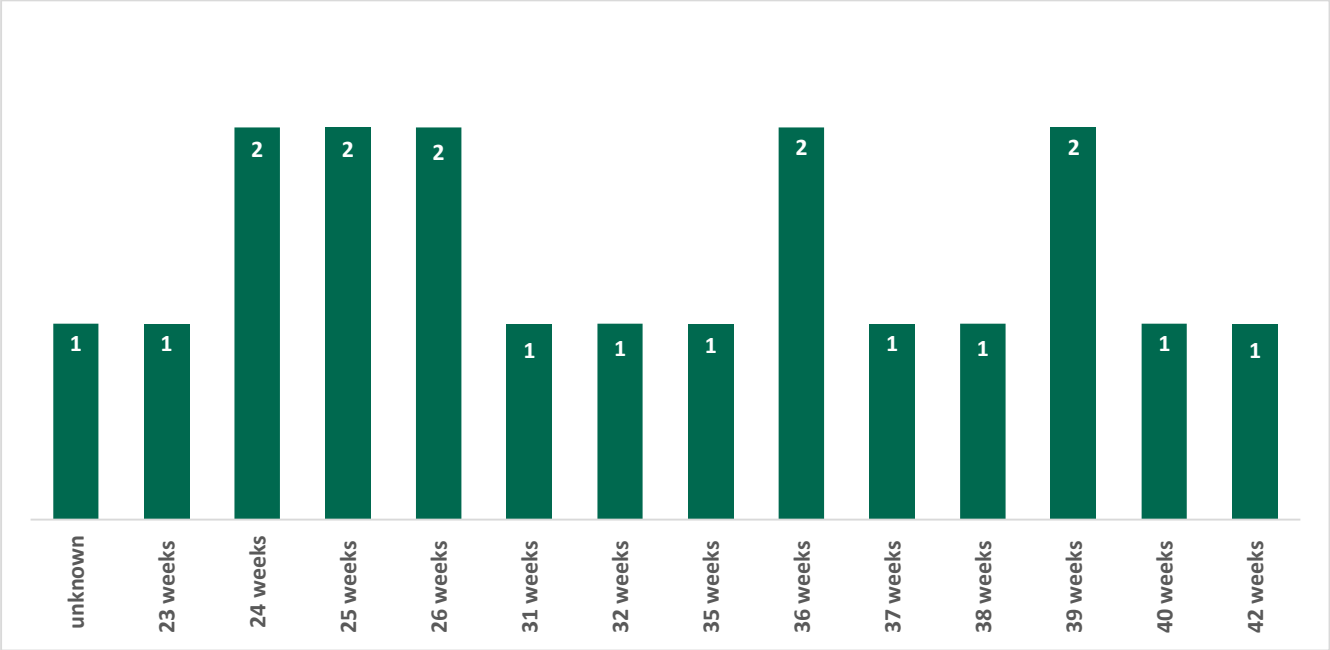


3.2 Gestation at birth

Of the nineteen deaths that occurred before the first year of life, the gestation of three (16%) were under 25 weeks (down from 39% last year), fifteen (79%) being between 26-42 weeks gestation and one was unknown (5%).

Of the eight 'Perinatal/Neonatal' deaths, three (37.5%) of these were under 25 weeks gestation (down from 82% last year) with the other five born at 25 weeks (2), 26 weeks (2) and one born at 32 weeks gestation.

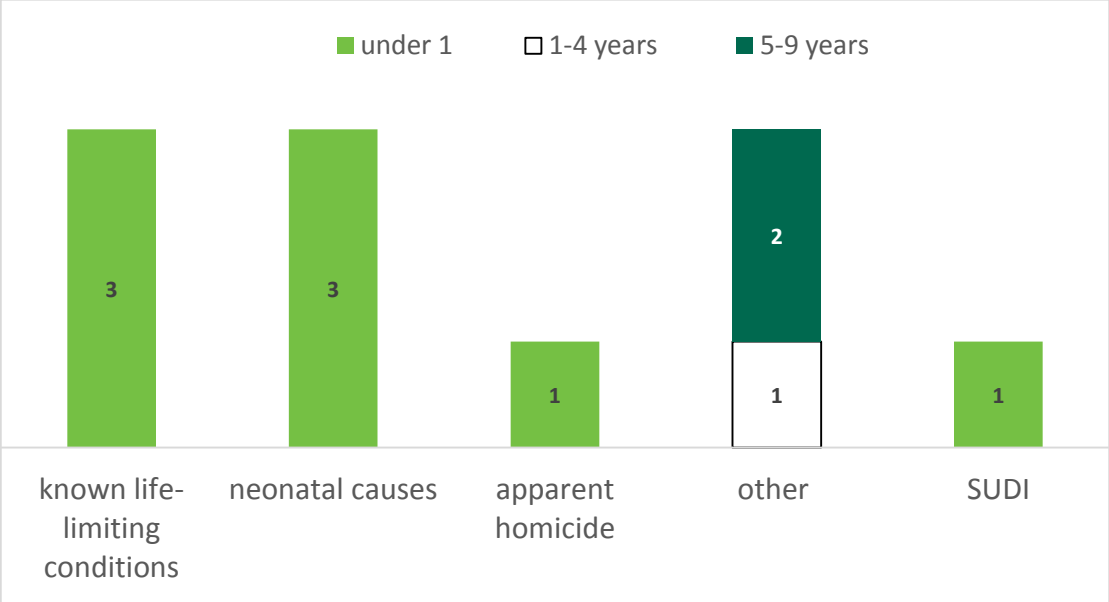
Figure 3.2 Gestation of baby whose death occurred before the first year of life, reviewed between 1st April 2015 and 31st March 2016



3.3 Unexpected deaths

Eleven (50%) of the twenty-two cases reviewed by the CDOP in the period of this report were defined as unexpected deaths (an increase from 38% last year). Of these unexpected deaths 'known life-limiting conditions' accounted for 3 (27%); 'neonatal causes' accounted for 3 (27%) there was one 'apparent homicide' (9.5%), one 'sudden and unexpected death in infancy' [SUDI] (9.5%), and 3 (27%) cases were classified by the CDOP as 'other' (two of these being due to an acute medical or surgical condition and one due to a chronic medical condition).

Figure 3.4 Unexpected child deaths reviewed by the CDOP 2015-16



The CDOP considered that modifiable factors may have contributed to the child death in 1 (9%) of the deaths classified as unexpected; this means that locally or nationally achievable interventions could reduce the risk of future child deaths. Although this is below the national average of 24%[6] classed as having modifiable factors, the numbers locally are small (one death = 9%) and so this is not statistically significant.

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.

3.4 SUDIs

One infant death reviewed by the CDOP was classified as sudden unexpected, unexplained death and by the Coroner as: Sudden Unexpected Death in Infancy (SUDI), noted as natural causes.

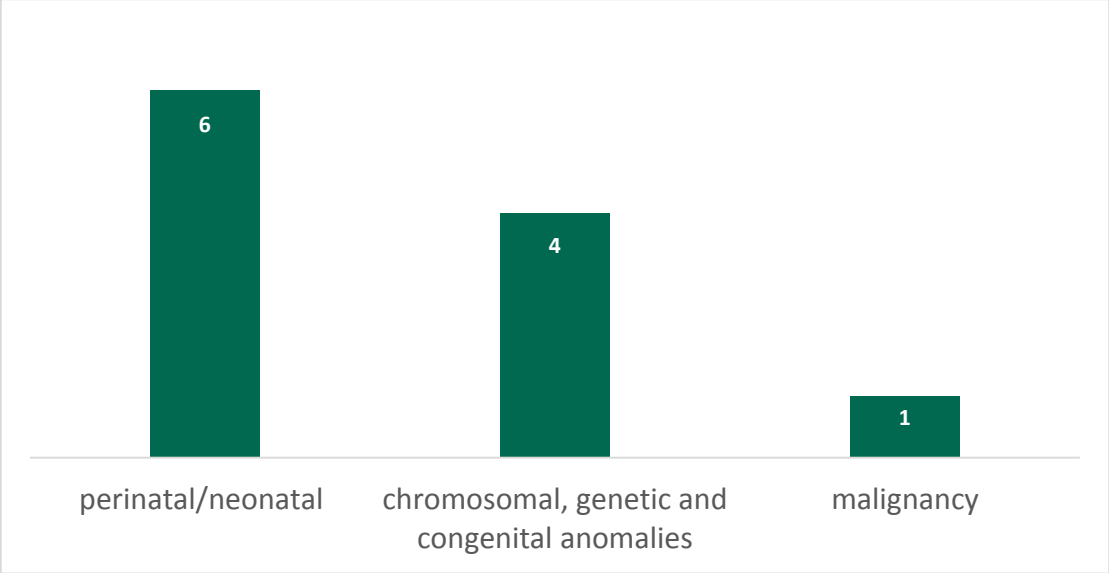
The CDOP would like to note that there were no deaths reviewed in this period where co-sleeping was a factor. The CDOP has been committed to raising awareness of this issue since 2008 as a serious risk factor for sudden infant deaths of babies under four months of age. Safer sleeping leaflets continue to be distributed at Children's Centres and safer sleeping seminars have been presented by the CDOP coordinator for front-line healthcare professionals. This continues a downward trend of co-sleeping as a factor for deaths in the borough.

[6] "Child death reviews: year ending 31 March 2015"; https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/444788/SFR23-2015.pdf

3.5 Expected deaths

Eleven (50%) of the 22 reviews completed by the CDOP were defined as expected deaths. Six of these cases (55%) were classified as 'perinatal/neonatal events'; four (36%) were classified as 'chromosomal, genetic and congenital anomalies'; and 1 (9%) was classified as malignancy.

Figure 3.5 Expected child deaths reviewed by the CDOP 2015-16



Chapter 4

Child death statistics

This chapter refers to the 21 deaths in children and young people that the CDOP was notified of during the period 1st of April 2015 to 31st of March 2016.

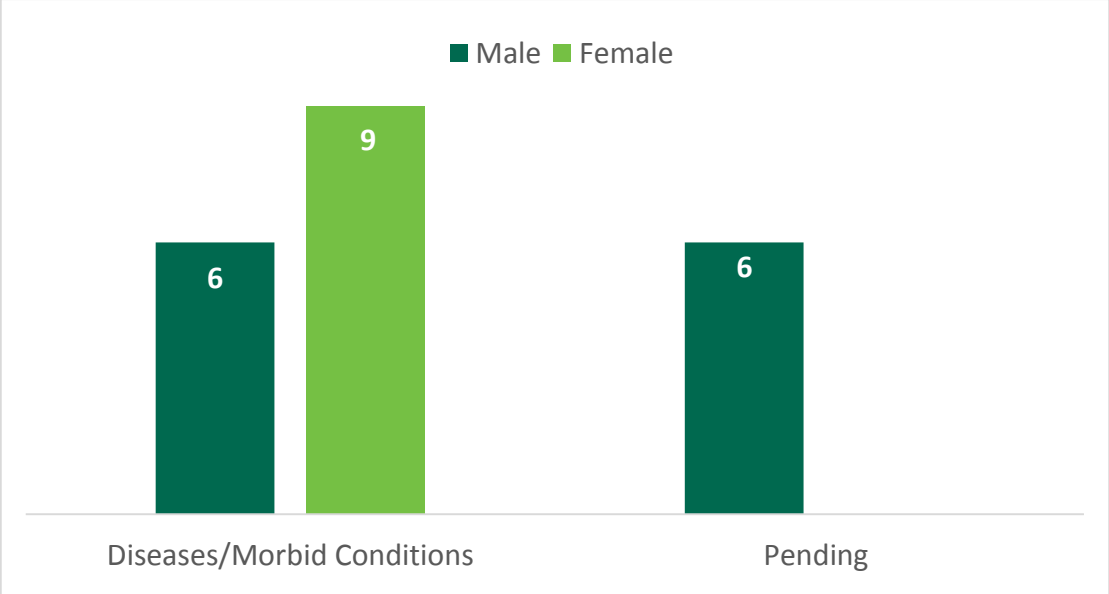
4.1 Cause of death

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 (15, 71%) 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.

The cause of death is currently pending in the other 6 (29%) cases due to either waiting to be reviewed at the next CDOP or outstanding Coroner inquests.

Figure 4.1 Child deaths in City and Hackney in 2015-16 by cause of death

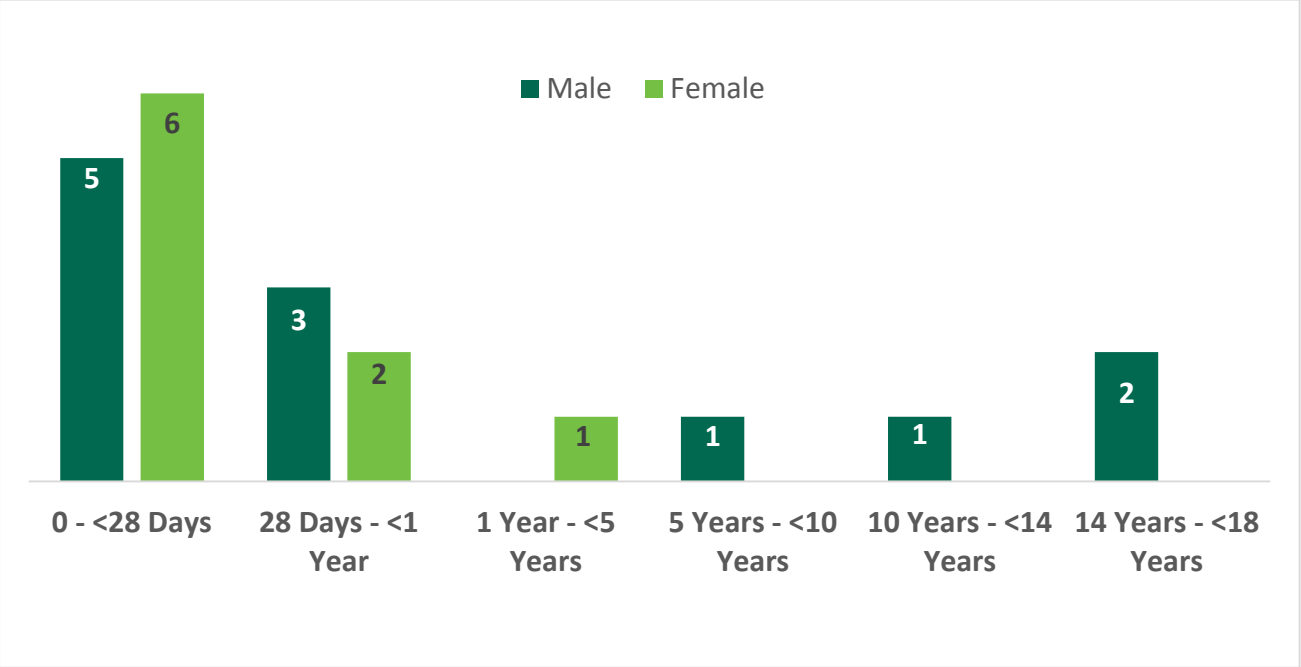


4.2 Age and gender

Of the 21 deaths that the CDOP was notified of in the period covered by this report, twelve were in males (57%) and nine in females (43%). The previous year was 60% and 40% respectively.

Three-quarters of all deaths (16, 76%) occurred within the first year and half of all deaths (11, 52%) occurred within the first 28 days of life (double the 26% last year).

Figure 4.2 Age and gender of child deaths that occurred between 1st April 2015 and 31st March 2016

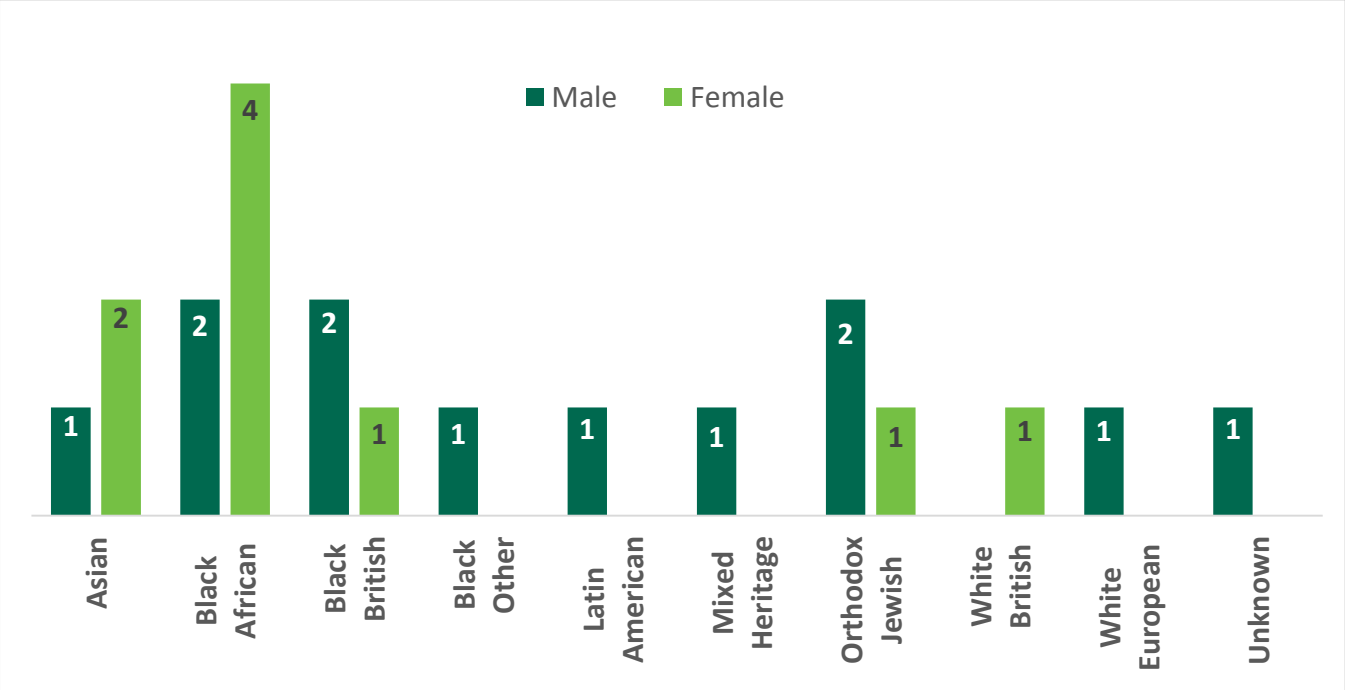


4.3. Ethnicity

When assessing the deaths by ethnic group, children from Black ethnic groups, including Black African, Black British and Black Other continue to be over-represented with 10 deaths (48%) of the total (these groups represent 23% of the total City and Hackney population).[7] This is up from 29% last year and 43% the year before. 3 deaths (14%) in Asian children; 2 (9%) in White children (down from 37% last year); 1 (5%) in children of Mixed heritage, 3 (14%) in Orthodox Jewish children and 1 (5%) in children from Latin America. The ethnicity of 1 young person was unknown.

[7] City and Hackney Health and Wellbeing Profile JSNA data update, January 2014, p26.

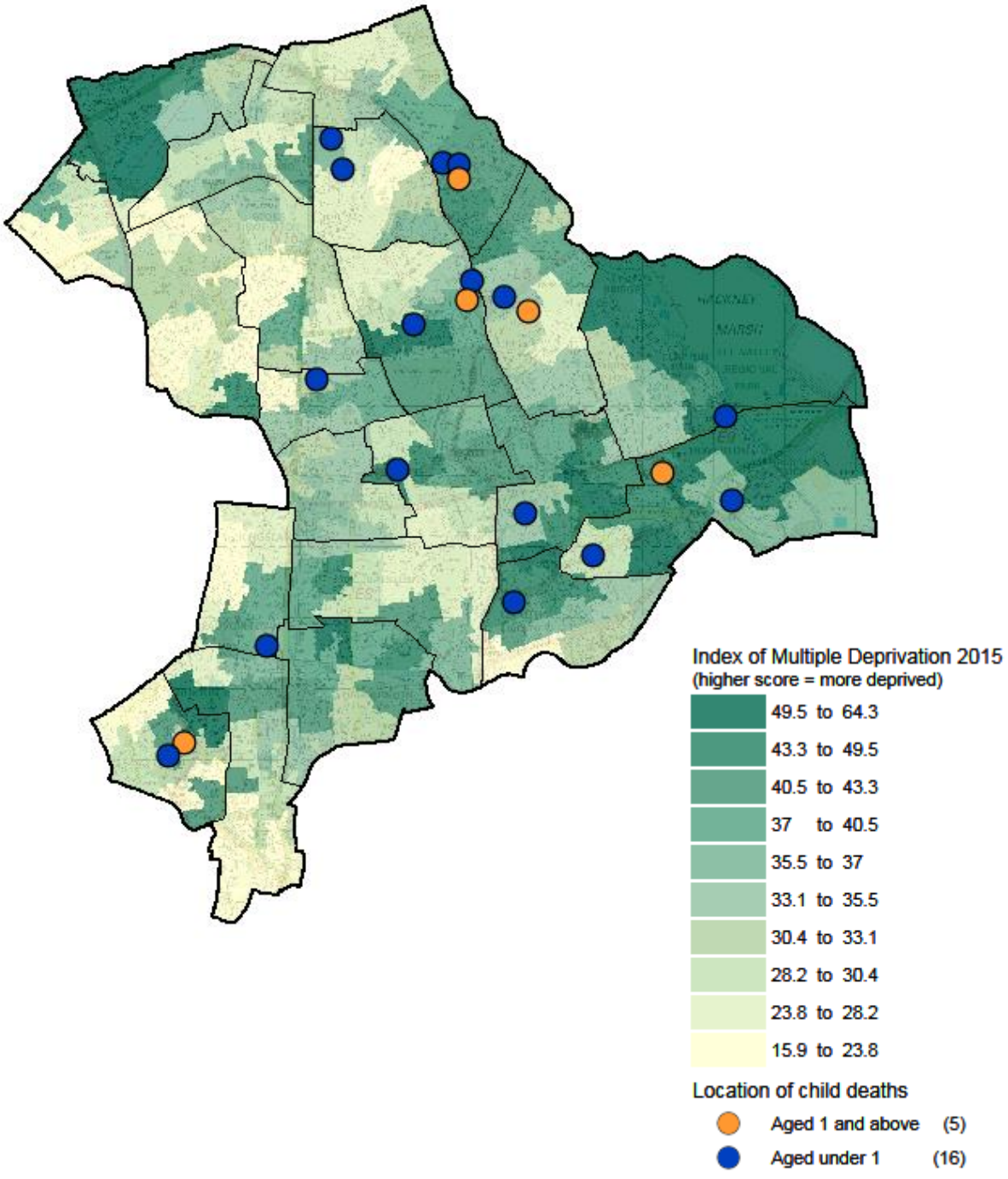
Figure 4.3 Ethnic groups and gender of deaths that occurred between 1st April 2015 and 31st March 2016



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 2015-16.[8]



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.

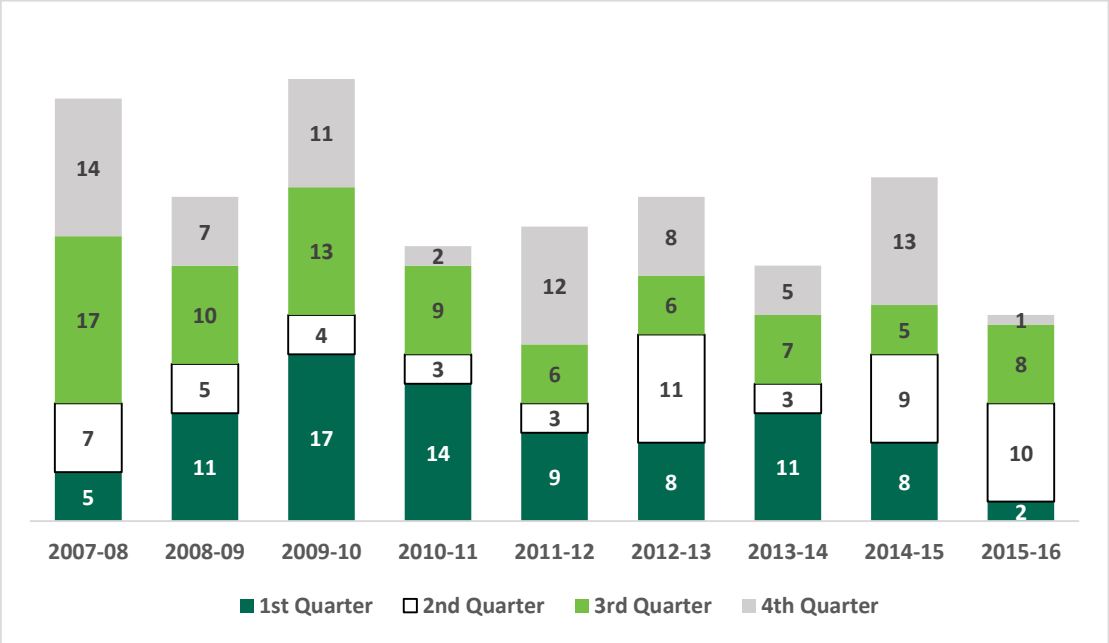
[8] Source: Indices of Multiple Deprivation 2015, Public Health, Child Death Overview Panel.

Hackney and the City continue to see a trend in higher numbers of child deaths in the Black ethnic group, this year seeing 48% of deaths in these groups (these groups represent 23% of the population). This figure was 29% in 2014/15, 43% in 2013/14, and 37% in 2011-12 and 2012-13 and so we are seeing an increase again following a decrease in 2014/15. It should be noted that 2015/16 recorded the lowest number of deaths overall in Hackney and the City since recording began in 2008.

4.5 Seasonal variability

Although the numbers are too small to discard random variation, death counts from 2007-08 until 2015-16 seem to show some degree of seasonal variation. In 2007-08 deaths in children and young people were more common in the 3rd and 4th quarters whereas in the following years deaths seem to be more common during the spring and autumn months (1st and 3rd quarter). Quarter 2 tends to see the least deaths overall with a few exceptions more recently. This year (2015-16) saw deaths most common in quarters 2 and 3 (86%) which we have not seen before. It must be noted that the figures are small and the differences are not statistically significant.

Figure 4.5 Deaths stratified by month of occurrence



Chapter 5

Learning, recommendations and impact.

5.1 Learning points, recommendations and impact

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. Impact of these learning points and recommendations made through the CDOP process are shown in Appendix 1: Impact Log 2015-16.

5.2 Implementation of recommendations from 2014-15 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:

- assurance given by the Senior Coroner for better information sharing between the Coroner and the panel including sharing post mortem reports in a timely manner and sending Regulation 28 reports. Since the July 2015 meeting post mortem reports have been shared more readily and quickly and the one Regulation 28 report published was sent to the CDOP on the day of publication. The Coroner has also sent us the response from ELFT to that Regulation 28 Report;
- completion of the Suicide Audit by the Public Health team leading to a Public Health Suicide Prevention Action Plan. Once this is completed it will be brought back to CDOP for discussion;
- completion of the CDOP leaflet for parents sent over to Homerton to be incorporated into the bereavement pack;
- safe-sleeping and sling-safety leaflets being sent to new parents in Hackney with midwives and health visitors, following notification of increased deaths in other areas;
- 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;
- continuation of pursuing a challenge to the London Ambulance Service and the Senior Coroner to change LAS protocol for the removal of bodies of over 2's to be in line with Working Together 2015. LAS and London Coroners have fed-back that they are unable to support this motion with small numbers of cases related to safeguarding. The CDOP Coordinator is contacting all CDOPs to ascertain levels of prevalence for conflicting protocols nationally and its impact on child deaths.

5.3 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 2015-16 include:

- Highlighting the importance of information sharing between the CDOP and the Coroner's office, in particular, receiving Post Mortem reports in a timely manner to aid the rapid response process;
- Highlighting the need for thorough investigations into deaths including the need for Post Mortems where the cause of death is not fully known or understood, to the Senior Coroner, in particular in circumstances where cultural practice prefers not to have a Post Mortem;
- Highlighting the need for Regulation 28 reports to be shared with CDOPs upon release by the Senior Coroner to aid learning and to put measures in place to prevent future deaths;
- highlighting the need to collect more robust information on children who die abroad, by writing to the Foreign and Commonwealth Office and Department for Education and requesting a change in protocol;
- The CHSCB board manager has highlighted the need for City representatives to regularly attend CDOP meetings to aid learning and investigations.

5.4 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 2015-16 were:

- continuing to ensure in relevant cases that parents and siblings are referred to genetic screening and counselling;
- continuing 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;
- highlighting the need for additional safety nets in GP and Outpatient correspondence to advise school nurses of children who may need unexpected emergency care in the school setting;
- sending out choking safety posters to all nurseries, children's centers and childminders to highlight the dangers of toddlers choking on small food stuffs.

Appendix 1

Impact log: 2015/16

Date	Source[9]	Problem/Issue	Action	Impact
July 2015	CDOP Quarterly Meeting.	Disjointed working between CDOP and the Coroner – can be an obstacle to reviewing deaths, particularly with PM reports not being sent in a timely manner.	Senior Coroner Hassell to attend a CDOP meeting in July 2015. Coroner has agreed to share PM reports with the CDOP when the time is appropriate.	Information is now shared in a more timely manner which is assisting the CDOPs initial investigations.
July 2015	CDOP Quarterly Meeting.	Recommendations and learning from Coroner's inquests are not automatically shared with the CDOP.	Senior Coroner has agreed to copy the CDOP into all Regulation 28 reports upon release to aid learning and prevent future deaths.	The CDOP can chase and implement recommendations locally or to spread the message to a wider audience, preventing future deaths. The Senior Coroner sent a Regulation 28 report to the City and Hackney CDOP in June 2016.
October 2015	CDOP Quarterly Meeting.	Long-term health problems in children that are identified when they attend the GP or Out-Patients are not being notified to school nurses as there is currently	The CCG have raised this issue on their newsletter, sent to all GPs in the borough. Text states; "Children with long term health conditions should be managed appropriately at school with a care plan. However,	This will ensure an additional safety net for children who may need unexpected emergency care in the school setting, by allowing

[9] This refers to the source in which the issue was identified.

		no system in place. A&E send automatic notifications to school nursing, but GP and Out-Patients do not.	schools are not always aware of every child's health problems, either because parents do not pass on the information or from unintended gaps in notifications from health care professionals to school nursing. We would like to create a system whereby, with parental permission, GPs consistently and routinely notify the school nursing team of surgery attendances by children where a long term health condition presents, which would benefit from a care plan in a school setting. This would ensure an additional safety net for children who may need unexpected emergency care in the school setting, by allowing professionals to plan for and train to provide this."	professionals to plan for and train to provide this.
November 2015	CDOP Coordinator, through communication with other CDOPs nationally.	Toddlers in England are choking on small food products, this had led to some high-profile deaths recently.	Choking safety posters are being sent to all children's centres, nurseries, playgroups and child-minders in the borough.	There have been no deaths related to choking in Hackney but this action is to prevent deaths related to choking and to promote safety around food in settings where toddlers are.
March 2016	CDOP Coordinator	Regulation 28 reports present learning nationally: can the City and Hackney CDOP proactively learn from these?	The CDOP Coordinator regularly scrutinises all Regulation 28 reports nationally for child deaths and shares learning through the CDOP members' network locally.	The local CDOP will be able to learn from child deaths nationally and proactively put measures in place to prevent child deaths locally. At the

				time of writing this report learning from a Regulation 28 report has been shared but this will fall into 2016/17 impact log.