



Child Death
Overview Panel

ANNUAL REPORT

1st April 2009 – 31st March 2010



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Executive Summary

1. The publication of Working Together to Safeguard Children (HM Government, 2006) set out the process to be followed for Local Safeguarding Children Boards (LSCBs) to review all child deaths. This has set the scene for England to become the first country in the world to have national standards and procedures for the investigation and management of unexpected child deaths and the overview of all child deaths.
2. The Panel (appendix I) have met on a monthly basis during the period 1st April 2009 to 31st March 2010. During this time there have been several changes to the Child Death Overview Panel (CDOP), namely the employment of a CDOP Manager and a change of Chair.
3. During this year, 4 LSCB CDOP were notified of 138 child deaths. Of these deaths, 48% were female and 52% were male. CDOP reviewed 144 child deaths in-depth. To assist in this process, deaths were themed according to their cause of death. At each meeting, a theme of child deaths were reviewed i.e. malignancy, road traffic collisions, sudden unexpected deaths, etc. A detailed list of the meetings and themes of the meetings can be found in appendix II.
4. From the 144 deaths reviewed, 21% were children from Southampton, 61% were from Hampshire, 8% were from the Isle of Wight and 10% were from Portsmouth.
5. The majority of children's deaths reviewed (79%), occurred within the first year of life. Infants who died within the first 28 days of life accounted for 58% of cases. The number of child deaths reported to CDOP decreases until adolescence. During adolescence the numbers start to increase again, with 10% of cases reviewed, being of children between 10 to 14 years of age.
6. The Panel identified 5 from the 144 deaths reviewed as being preventable deaths, and 18 as potentially preventable deaths. The majority of child deaths were not preventable (78%). Not preventable deaths indicate that the deaths were caused by intrinsic or extrinsic factors, with no modifiable factors identified.
7. The majority of not preventable deaths occurred within the first year of life and were categorised as perinatal/neonatal deaths or chromosomal, genetic or congenital anomalies. The children who have died at ages 15 to 17 years had an equal amount of preventable and potentially preventable deaths.
8. The highest number of preventable deaths occurred within the deliberately inflicted injury, abuse or neglect category.
9. Within the sudden unexpected/unexplained deaths, 33% were considered preventable. A large number of these cases had co-sleeping as a factor.
10. Within the 4 LSCBs, 70% of children's deaths were expected deaths and 25% of children's deaths were unexpected deaths. As stated within Working Together (2010) a rapid response process should be followed for any child who dies unexpectedly.

11. From reviewing the 144 deaths in-depth some recurring themes emerged; bereavement support for families, water safety in the home environment, palliative care services for children, engagement of older children with services and the importance of the need to continue to promote the 'Safer Babies' campaign. All of these themes have been fed back to the LSCBs.
12. Learning points have been identified from individual cases around the following areas:
 - Health
 - i. the need for health visitors to attend professional meetings where the permanent address of the child is not known
 - ii. that health visitors should always see the home environment and that a pre-birth meeting should be in place if deemed necessary and there is a need to identify which professional should call it
 - iii. an audit tool should be used for substance misuse in pregnancy in order to access treatment/interventions
 - iv. robust inter-agency assessments should be in place where there is evidence of significant alcohol consumption
 - v. a multi-agency discussion should occur if there is evidence of rejection of professional support and there are concerns about vulnerability
 - vi. that an out of hours service should have a paediatrician or nurse with paediatric experience should be on duty at all times (recommendation from CMACE report: Why Children Die, 2008)
 - vii. robust procedures in place for when a child 'Was not Brought' to health appointments.
 - Parents
 - i. LSCBs need to review services and support packages for bereaved families; professionals must be sensitive in communicating with bereaved parents and sending any documentation in a timely manner.
 - Neonatal deaths
 - i. request to the DCSF to gather National data on babies born from egg donor births with congenital anomalies and also babies born to mothers who suffer from cystic fibrosis
 - ii. more efficient documentation in conjunction with CMACE to assist with benchmarking and obtaining the additional information from all neonatal units.
 - Training
 - i. all drivers and escorts commissioned by agencies to transfer children should be competent in First Aid.
 - Education
 - i. should ensure schools have good pastoral support in schools after a pupil has die
 - ii. ensure the recent changes in PSHE cover aspects of self-harm.
 - Children Services

- i. to ensure there is a strong interface between Child Services Departments and the MAPPA process.
 - Transport
 - i. to ensure appropriate signage for 'Live Rail' on train stations and railway lines to deter children from walking across the lines.
 - Governance
 - i. to review panel membership to ensure representation from localities and agencies and to serve for a 2 year time period
 - ii. advise CDOP on how to attract lay persons to attend the meetings
 - iii. letters sent to one LSCB Chair should be sent to all LSCB Chairs for information.
13. There was an Annual Presentation of the CDOP work and progress in the summer months. The data is collected; themes and learning points are presented to an audience of up to 125 multi-agency professionals.

Introduction.

- 1.0 This is the second Annual Report of the 4 LSCB (Southampton, Hampshire, Isle of Wight and Portsmouth) Child Death Overview Panel (CDOP). It provides a summary of the work undertaken by the Panel since 1st April 2009 until 31st March 2010, setting out the priorities for future development to address the principle strategic objective of reducing child deaths and learning lessons from child deaths. Accountability is to each of the Local Safeguarding Children Boards (LSCBs), and this is co-ordinated by the 4 Chairs from the LSCBs. Stronger links have been developed in presenting a quarterly data report, and detailed Business Plan, financial reports and attendance by the CDOP Manager at Board meetings on request by each LSCB.
- 1.1 CDOP is a statutory requirement and works closely with each of the LSCBs to inform about data and learning from child deaths. It is important to recognise the high level of co-operation required from all the agencies involved with children and families. Without the information being provided by these agencies, the child death overview process would not happen and we thank the numerous professionals who have completed the review forms for the panel. A special thank you must be given to the parents, who under such difficult circumstances have felt able to share with CDOP, their thoughts and feelings about the time prior to and after their child's death.
- 1.12 The death of any child is a tragedy for all those involved. It is the intention that the work of the 4 LSCB CDOP can contribute to a greater understanding of the reasons for those deaths and to ensure that, as far as possible, such tragedies can be avoided or prevented in the future.

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Background to the Child Death Overview Panel.

- 2.0 Since 1st April 2008 it has been a statutory requirement for LSCBs to review the deaths of all children from birth (excluding still born babies) up to their 18th birthday as stipulated within chapter 7 of Working Together to Safeguard Children (2006). This is completed by the CDOP, a sub-committee of the LSCB. The Working Together document was revised in March 2010 and provides the necessary guidance on how to review child deaths.
- 2.1 The overall purpose is to understand why children die and to put into place any necessary interventions to improve child safety and welfare and to prevent future deaths. The objective of this process is to learn lessons in order to improve the safety and well-being of children. It is not about culpability or blame. This is achieved by collecting and collating information from those professionals who were involved in the care of the child, both before, during and immediately after the child's death.
- 2.2 The 4 LSCBs decided to have just one CDOP for their four areas. This means that as a CDOP we cover a wide geographical area and a population of 1.89 million, with 374,500 children and young people. Working Together (2010) highlights that panels' responsible for reviewing deaths from a total population greater than 500,000 gain experience more quickly.
- 2.3 The child death review process remains a public health initiative, with its main purpose being to collect and analyse information about all child deaths (from 0 until their 18th birthday) to enable the panel to identify:
- any cases giving rise to the need for further investigation, including the need for a serious case review;
 - any matters of concern affecting the health, safety and welfare of children within the area; and
 - any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area.
- 2.4 The panel is able to achieve this by meeting regularly to review and evaluate the routinely collected data on the deaths of all children within the 4 LSCB areas. From this data, any lessons to be learnt or issues of concern are identified with a particular focus on effective inter-agency working. The CDOP process is documented in appendix III.
- 2.5 Through this process, the Panel will record any modifiable factors that have been identified. It is these factors, which will lead to the overall aim of locally and nationally, improving the safety and well-being of all children.
- 2.6 An interrelated process of this is to put into place procedures for ensuring that there is a co-ordinated response to the unexpected death of a child. These procedures are known as the rapid response procedures and can be found at www.4lscb.org.uk. This is a very detailed and lengthy document so a flow chart for quick reference has been produced by the CDOP Manager for use by the professionals involved with the rapid response process and this can be found in appendix IV. An unexpected death is defined within Working Together (2010) as the death of an infant or child (up until their 18th birthday) which:

- was not anticipated as a significant possibility for example, 24 hours before death; or
- where there was a similarly unexpected collapse or incident leading to or precipitating the events that led to the death.

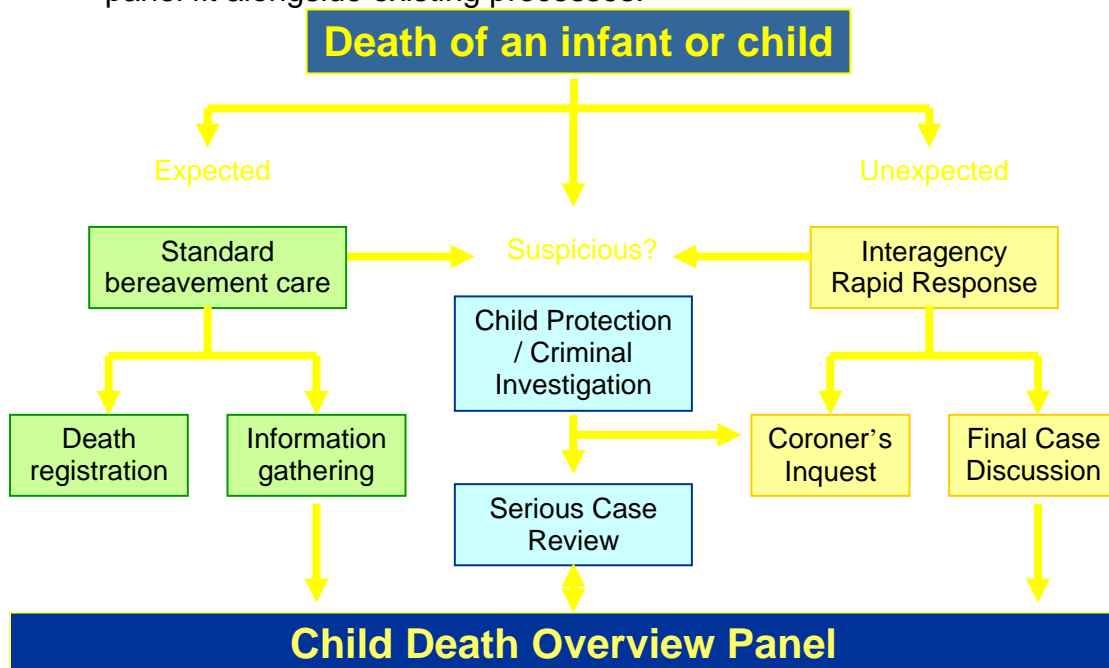
2.7 Further training is necessary to ensure that all professionals are aware of their role and the role and responsibilities of the other professionals within the rapid response process.

2.8 The overall purpose of the rapid response procedures is to ensure that the relevant professionals work together in a co-ordinated way. This will minimise duplication, and ensure that any lessons learnt will contribute to safeguarding and promoting the welfare of children in the future.

2.9 The joint responsibilities of the professionals involved within the rapid response process are to:

- respond quickly to the unexpected death of a child;
- make immediate enquiries into and evaluate the reasons for the circumstances of the death, in agreement with the coroner;
- undertake the types of enquiries/investigations that relate to the current responsibilities of the respective organisations when a child dies unexpectedly;
- collect information
- provide support to the bereaved family and referring if necessary to specialist bereavement services; and
- follow the child's death through and maintain contact at regular intervals with family members and other professionals who have ongoing responsibilities for the family, to ensure they are informed and kept up-to-date with information about the child's death.

2.10 Below is a diagram that shows how the rapid response and the child death overview panel fit alongside existing processes.



Scope of the reviews.

3.0 The Child Death Overview Panel review all child deaths whether they were expected deaths or unexpected deaths from birth up until the child's 18th birthday. This includes perinatal, neonatal and infant deaths. The definitions of which are:

- perinatal deaths – occurring during the first 7 days of life
- neonatal deaths – occurring during the first 28 completed days of birth
- infant deaths – occurring during the first year of life
- live births - refers to the complete expulsion or extraction from the baby's mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life - e.g. beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles - whether or not the umbilical cord has been cut or the placenta is attached.

3.1 The CDOP does not review terminations or stillbirths. This is clarified in Working Together (2010):

Reviews of deaths which follow a planned termination under the law (Abortion Act 1967) should not be carried out by Child Death Overview Panels even in instances where a death certificate has been issued. If the LSCB has general concerns about local procedures relating to planned terminations, it should contact the Care Quality Commission. All other deaths (i.e. excluding those deaths which follow a planned termination of pregnancy under the law) which have been registered as live with the General Registrar's Office, should be reviewed by the Child Death Overview Panel.'

3.2 The 4 LSCBs are responsible for reviewing the deaths of children who are normally resident within Southampton, Hampshire, Isle of Wight and Portsmouth. Any deaths that occur within these areas, but where the child actually resides within another local authority are noted by the 4 LSCB CDOP, but are referred on to the CDOP covering their locality. The CDOP has strong links with other CDOPs to facilitate the flow of information.

Data

Notifications for 2009-2010.

4.0 The, Southampton, Hampshire, Isle of Wight and Portsmouth CDOP were notified of 138 deaths during the period 1st April 2009 and 31st March 2010. Of these, 32 cases related to deaths 'out of area'. This means that the child's home address was not within the 4 LSCB geographical areas and therefore, the notification was passed on to the CDOP covering the area in which the child resided.

4.1 Table 1 below shows the number of deaths reported to CDOP for each quarter by locality, including out of area.

Table 1 Number of notifications per quarter for each LSCB

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Southampton	5	2	3	10	20
Hampshire	16	17	16	17	66
Isle of Wight	3	1	1	2	7
Portsmouth	5	4	3	1	13
Out of area	7	10	5	7	32
Total					138

Chart 1 Notifications received by CDOP for each LSCB.

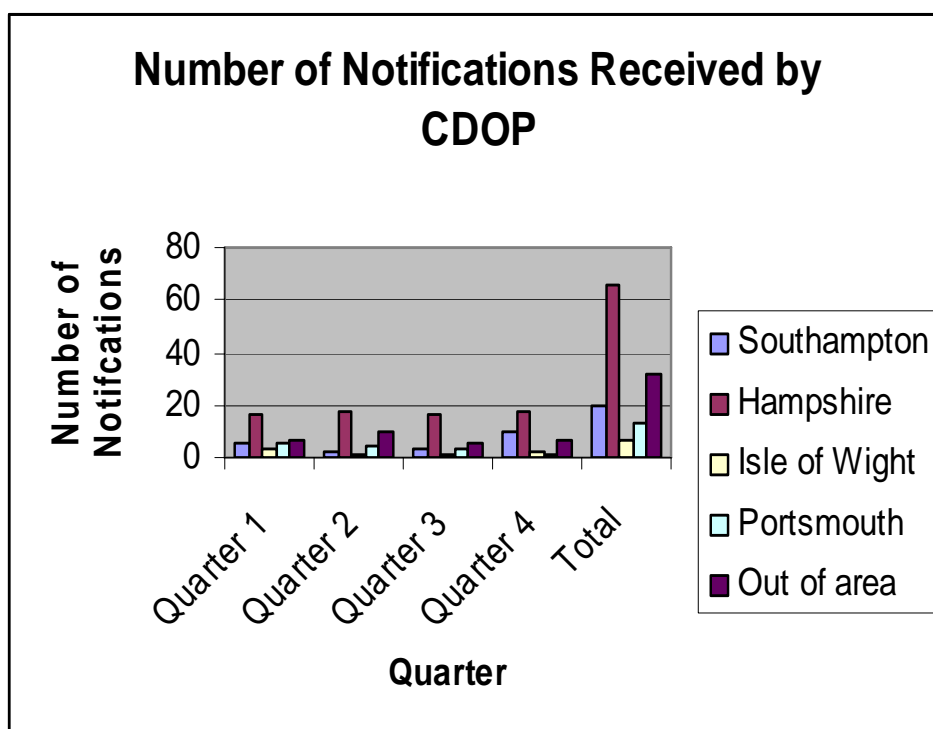
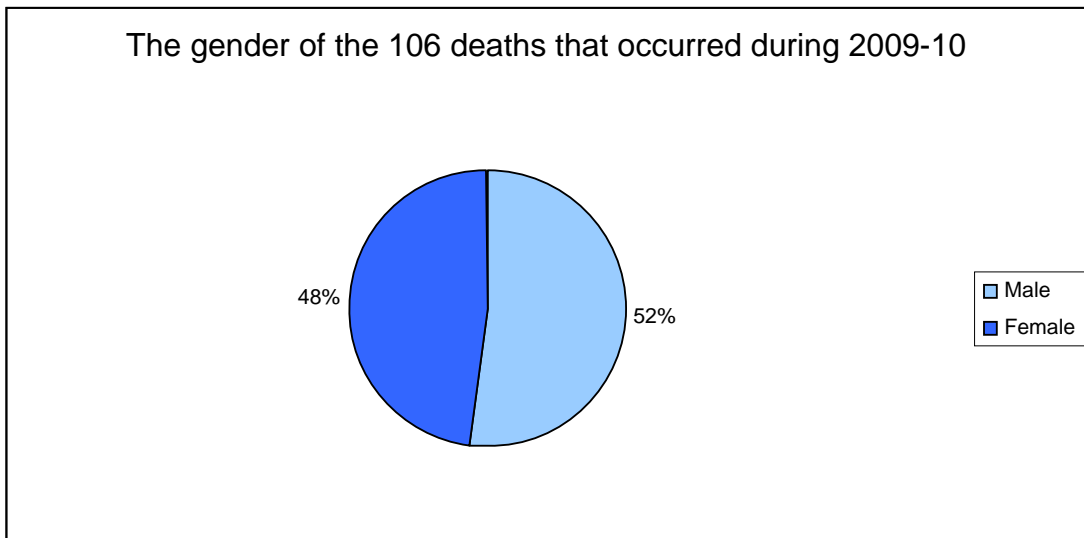


Table 2 Population of children per LSCB and the number of deaths per 1000 of the population.

	Population 0-18 years	Total No. of deaths	per 1000
Southampton	42,800	20	0.47
Hampshire	275,500	66	0.24
Isle of Wight	27,500	7	0.26
Portsmouth	38,700	13	0.34

- 4.3 The above table shows the population of under 18 year olds as projected by the ONS for each area and the number of notifications of deaths received by CDOP. From these figures, the final column shows the number of child deaths per 1000 of the population. It is important to remember that this is based on the number of notifications received by CDOP, which may be different from the actual number of deaths. A comparison with the registrar records and the notifications needs to take place, to confirm these figures are correct.
- 4.4 Of the 106 notifications that were for the Southampton, Hampshire, Isle of Wight and Portsmouth area there were 51 (48%) female and 55 (52%) male deaths. This is shown in chart 2. This corresponds with last years data. This also correlates with the national picture of 56% of all child deaths being male.

Chart 2



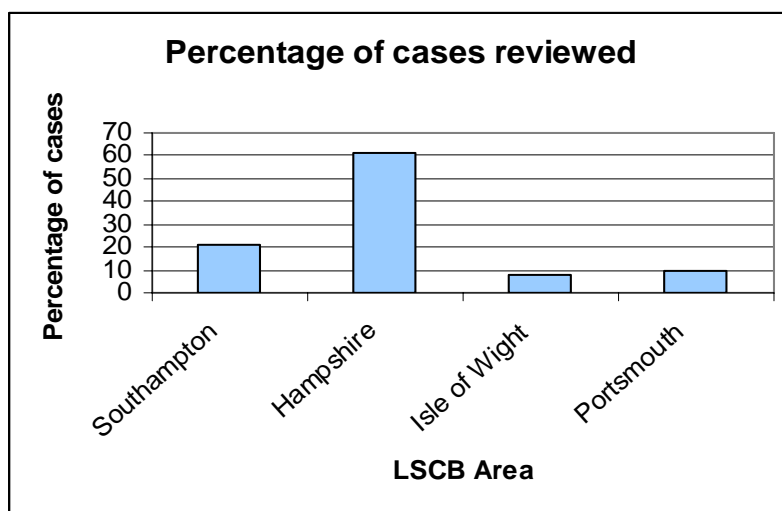
Cases reviewed by CDOP.

4.5 The 4LSCB CDOP reviewed 144 deaths during the period 1st April 2009 until 31st March 2010. The deaths were reviewed retrospectively allowing any other processes to be completed, for example serious case reviews, inquests and criminal proceedings. Therefore, some of the deaths reviewed are children who died in the previous year. Tables 3 and chart 3 detail the number of cases reviewed by CDOP from 1st April 2009 to 31st March 2010 by the year in which the child died, and the location within which the child resided.

Table 3 Cases reviewed by the 4 LSCB CDOP during 2009-2010.

	Number of cases reviewed from 08-09	Number of cases reviewed from 09-10	% of reviewed
Southampton	18	13	21
Hampshire	50	37	61
Isle of Wight	7	4	8
Portsmouth	10	5	10
Total	85	59	100

Chart 3 Percentage of cases reviewed from each LSCB.



4.6 Age at time of death.

The majority of the 144 children's deaths reviewed occurred within the first year of life. The number of children's deaths decrease until adolescence when the numbers of deaths start to increase again. This fits within the National picture of child deaths.

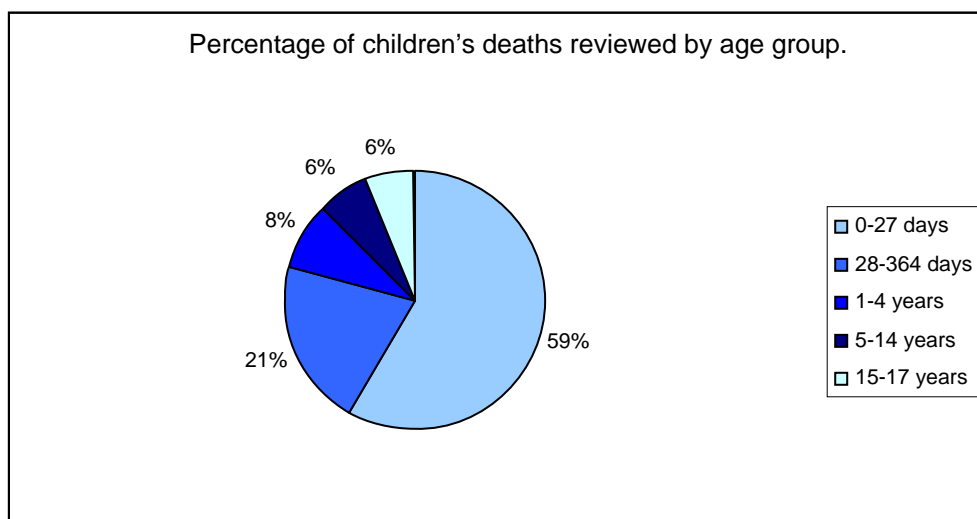
4.7 Table 4 shows the number of child deaths reviewed by CDOP. It details both the number of cases and the percentage of cases within the age range.

Table 4 Number and percentage of children’s deaths reviewed by CDOP.

Age at time of death	No. of children’s deaths	Percentage of children’s deaths
0-27 days	84	58
28-364 days	30	21
1-4 years	12	8
5-14 years	9	6
15-17 years	9	6

4.8 The pie chart (chart 4) demonstrates the largest age group reviewed within the 144 deaths, were children who died within the first 27 days of life (59%). The 28 to 364 day old children (21%), and then the 1 to 4 year olds (8%) follow this.

Chart 4



4.9 Preventability.

As part of the review process, the Panel have to reach a consensus as to whether the child’s death was preventable, potentially preventable or not preventable. This provides an opportunity to identify any factors that may enable any future child deaths occurring within the same circumstances, and not to allocate blame. The revised Working Together document (2010) dictates that the term preventable has now been changed, and the panel will have to make an alternative assessment based on whether there were any ‘modifiable factors’ identified that may have contributed to the death of the child. Working Together (2010) defines this as follows:

‘For the purpose of producing aggregate national data, this guidance defines preventable child deaths as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce risk of future child deaths.’

4.10 The DCSF have provided definitions for each category:

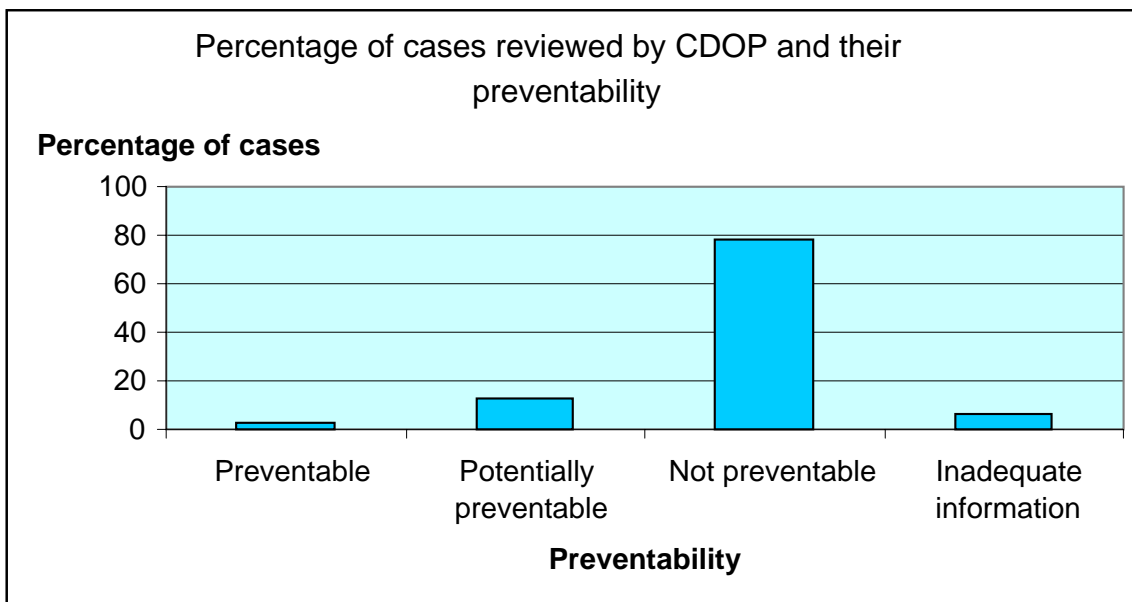
- Preventable – identifiable failures in the child’s direct care by any agency, including parents; latent, organisational, systemic or other indirect failure(s) within one or more agency. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths
- Potentially preventable – potentially modifiable factors extrinsic to the child
- Not preventable – death caused by intrinsic or extrinsic factors, with no identified modifiable factors.

4.11 Table 5 and chart 5 below detail the number of deaths within those categories, by the age of the child. The category of inadequate information is to be rarely used, and in the cases below each case classified as inadequate information available was a neonatal case, where limited information was available at the time of the review.

Table 5 The number and percentage of deaths reviewed by preventability.

Category of death	Total Number of deaths reviewed
Preventable	5
Potentially preventable	18
Not preventable	113
Inadequate information	8

Chart 5



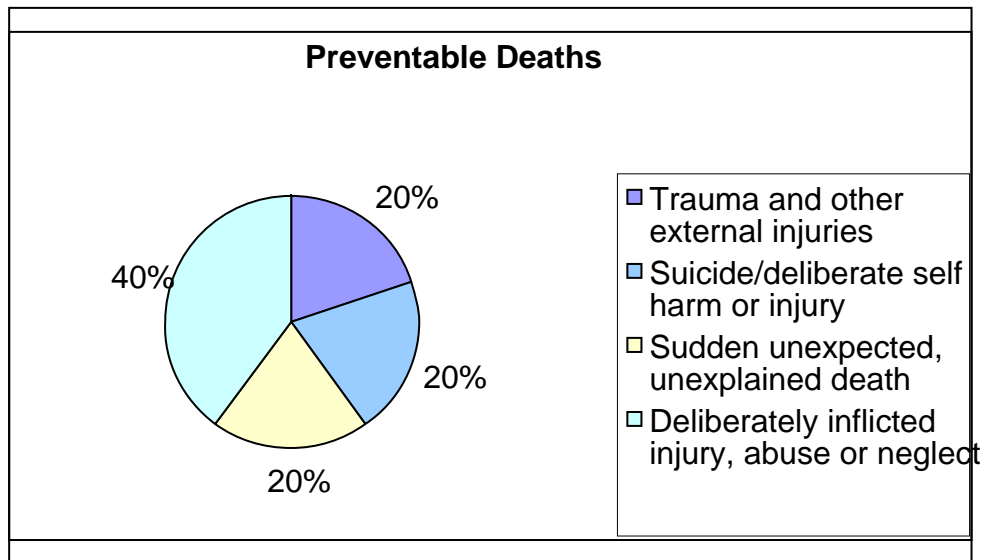
4.12 Table 6 shows that the majority of not preventable deaths reviewed by the panel are within the 0 to 364 days of age, with 0 to 27 days being the highest age category. The children who have died at ages 15 to 17 years had an equally amount of not preventable deaths (4) and potentially preventable deaths (4).

Table 6

	Preventable	Potentially Preventable	Not Preventable	Inadequate Information	Total
10-27 days	0	6	70	8	84
28-364 days	1	5	24	0	30
1-4 years	2	1	9	0	12
5-9 years	0	1	2	0	3
10-14 years	1	1	4	0	6
15-17 years	1	4	4	0	9
Total	5	18	113	8	144

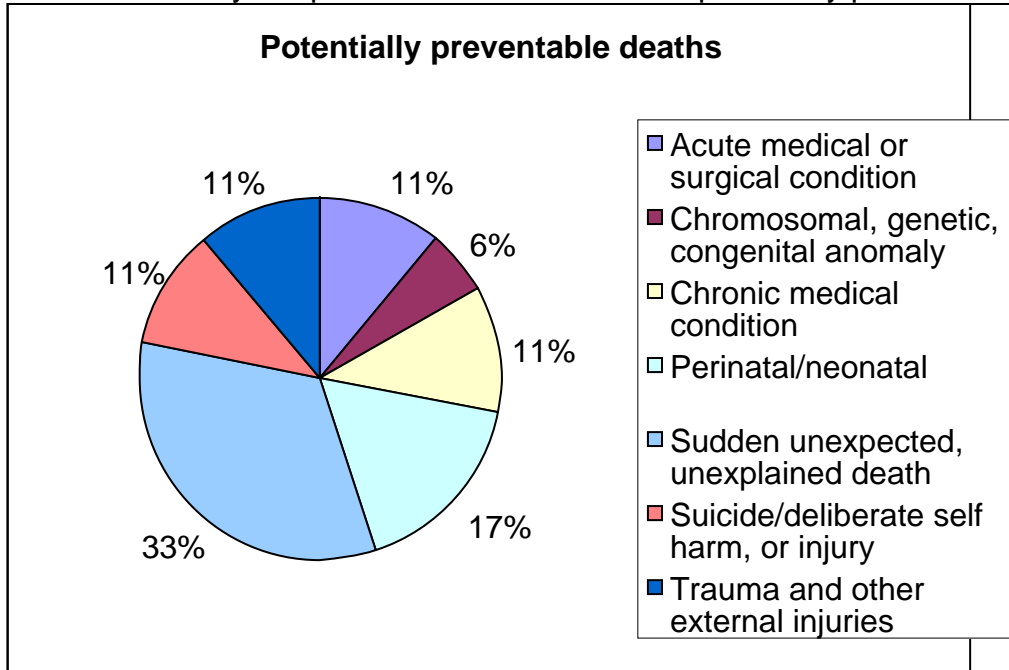
4.13 The following charts show the categories of death that were preventable, potentially preventable and not preventable. The highest numbers of preventable deaths are within the deliberately inflicted injury, abuse or neglect categorisation.

Chart 6



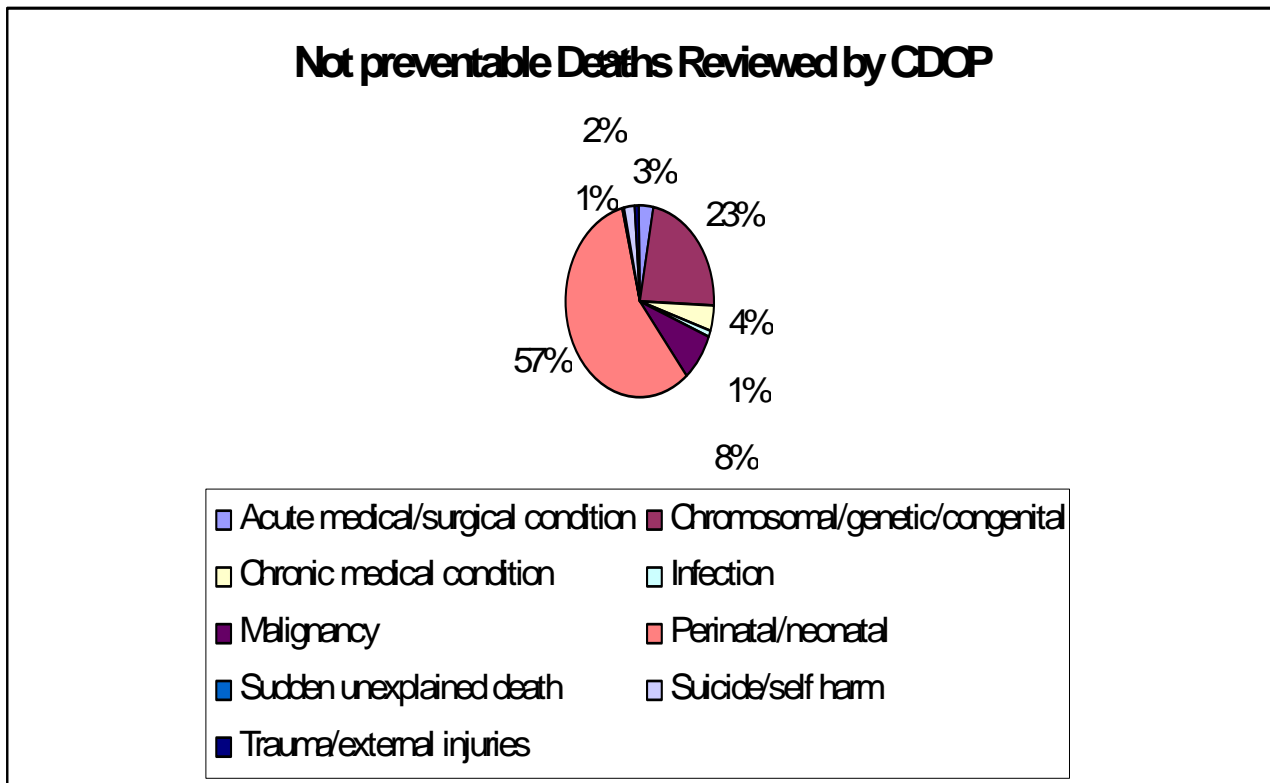
4.14 Chart 7 shows that 33% of sudden unexpected, unexplained deaths were described by the Panel as being potentially preventable. A large number of these are from co-sleeping, which has been highlighted as increasing the risk of sudden unexpected death in infancy greatly.

Chart 8. Deaths reviewed by the panel that were classed as potentially preventable.



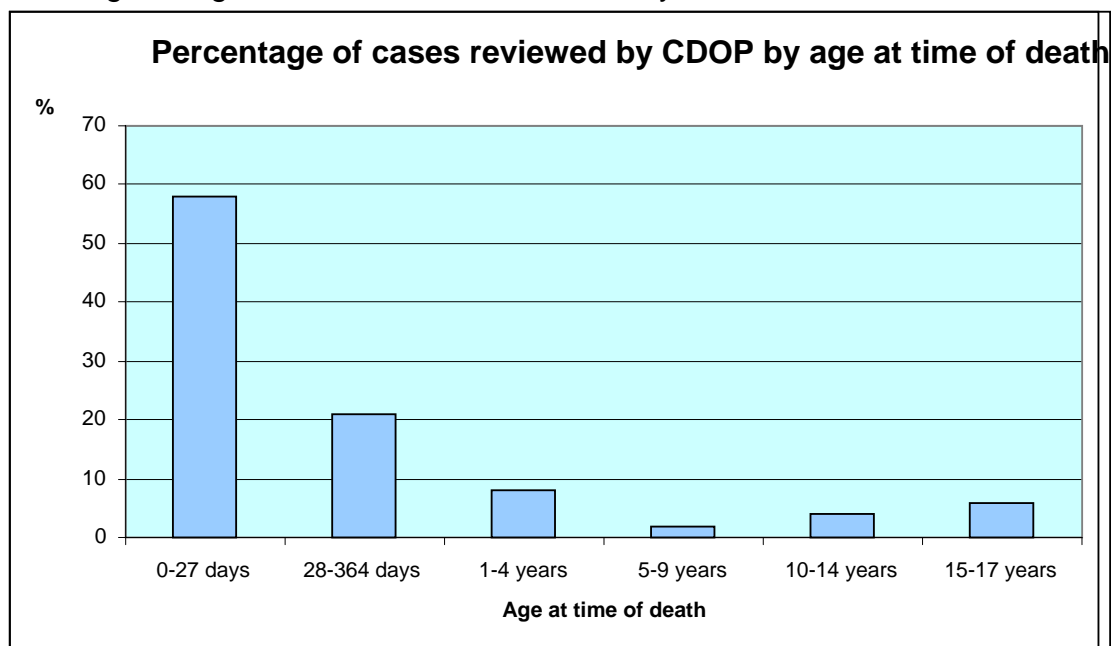
4.15 The chart below reinforces that the over half of the deaths (57%) reviewed by the panel were classified as non-preventable deaths and these occurred within the perinatal/neonatal category. This is followed by deaths due to chromosomal, genetic or congenital anomalies.

Chart 9 Deaths reviewed by the panel that were classed as not preventable.



4.16 The majority of deaths occurring within the first year of life were assessed as not preventable. This is because at the time of death there were no modifiable factors evident that would have prevented that child from dying. However, the panel is aware that there is a wide variety of circumstances prior to the birth of these babies. Far more information needs to be collected to perhaps identify factors, which can prevent babies being delivered pre-term, for example, demographic details, economic details, deprivation, etc. Ethnicity is an area, which has not been recorded regularly or consistently on the various forms, and therefore cannot provide the panel with any useful data to analyse at this time. This has been feedback to the DSCF and recognised as a significant point. The chart below summarises the age categories of all the children reviewed by CDOP, within all categories and theme.

Chart 10 The age categories of all children reviewed by CDOP



4.17 Category of deaths.

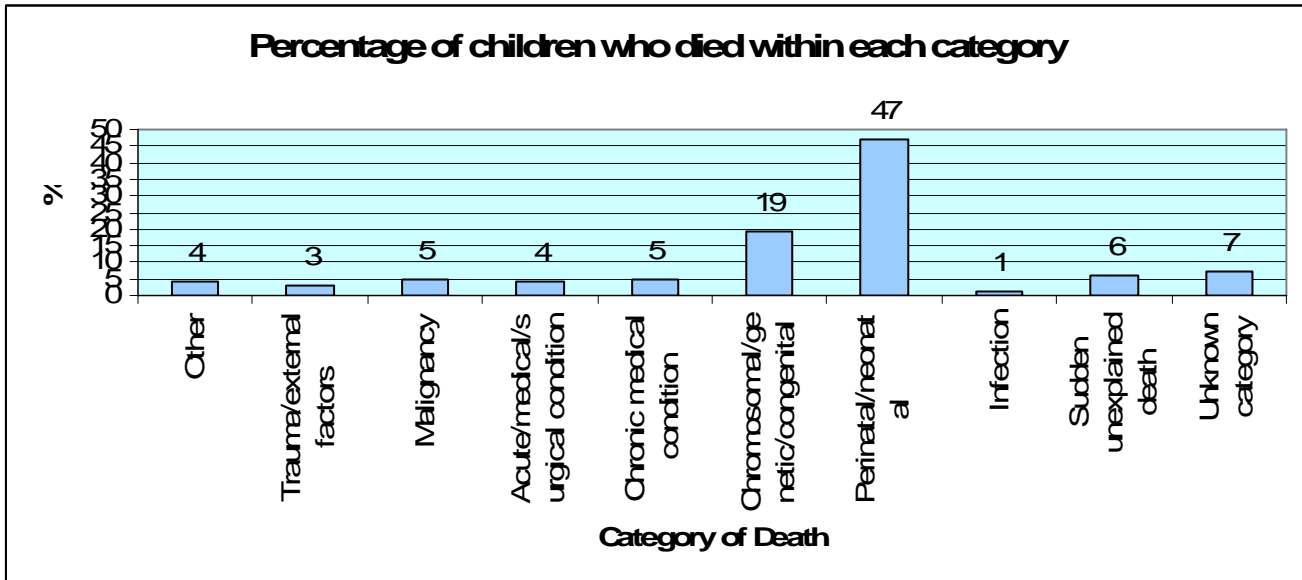
As a panel, there must also be a consensus on the category that the child's death can be classed as. The following table 7 and chart 11 details the age of the children at the time of death and the category of death, of all children reviewed by CDOP. This highlights that the largest number of deaths occur in the perinatal/neonatal period, followed by the children born with chromosomal, genetic or congenital anomalies.

Table 7 Number of child deaths within each DSCF category

DCSF No.	Category of Death	Number of deaths
1	Deliberately inflicted injury, abuse or neglect	0
2	Suicide or deliberate self inflicted harm	5
3	Trauma and other external factors	4
4	Malignancy	9
5	Acute medical or surgical condition	5

6	Chronic medical condition	7
7	Chromosomal, genetic and congenital anomalies	27
8	Perinatal/neonatal event	78
9	Infection	1
10	Sudden unexpected/unexplained deaths	8

Chart 11



4.19 The Panel also consider whether the death was an expected death or an unexpected death. Working Together to Safeguard Children has provided the definition of 'unexpected' as the death of an infant or child 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'.

4.20 Any unexpected child death should initiate the rapid response processes as discussed earlier in this report.

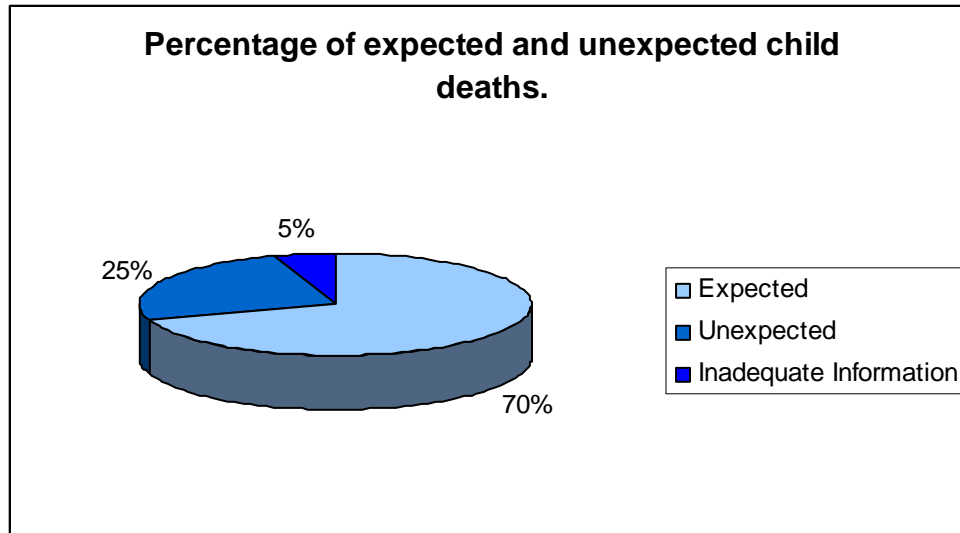
Table 8 Table detailing the numbers of expected and unexpected deaths for each LSCB from the cases reviewed for 2009 to 2010.

	Southampton	Hampshire	Isle of Wight	Portsmouth	Total Number
Expected	23	57	9	12	101
Unexpected	4	27	2	3	36
Inadequate Information	4	3	0	0	7

4.21 Table 8 identifies that there were 36 unexpected deaths that CDOP reviewed within the 4 LSCB region. As stated within working together any unexpected death of a child should have a rapid response initiated and followed. It is the responsibility of CDOP to monitor the appropriateness of the response of professionals to an unexpected child death. This is achieved by reviewing the reports produced by the rapid response team

on each unexpected death of a child, and providing the professionals with feedback on their work. Each LSCB is at different stages of being able to fully implement the rapid response process. This is an area that CDOP will be concentrating on in the following year, to ensure consistency across the areas and compliance with the protocol.

Chart 12



4.22 The majority of children's deaths remain expected death due to the number of perinatal/neonatal circumstances and chromosomal, genetic and congenital anomalies. This concurs with Working Together 2010, which states that,

'Chronic illness, disability and life limiting conditions account for a large proportion of child deaths.'

4.23 All of the deaths showing as inadequate information are perinatal/neonatal deaths for which the Panel felt there was not enough information to be able to make a true judgement as to whether the death was expected or not. The unexpected deaths account for a quarter of all the deaths the panel reviewed.

Recurring Themes

- 5.0 Working Together 2010 states that in all cases, whether the death was an expected or unexpected death,
- 'enquiries should seek to understand the reasons for the child's death, address the possible needs of other children in the household, the needs of all family members, and also consider any lessons to be learnt about how best to safeguard and promote children's welfare in the future.'*
- 5.1 It is from all the data collected above and the in-depth review of the cases that has enabled the panel to recognise some recurring themes and any areas that can be learnt from the tragic circumstances surrounding child death. This includes monitoring the support and assessment services offered to families of children who have died; advising and monitoring the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths; make recommendations for any additional data to be collected locally and identify any public health issues and consider how best to address these.
- 5.2 Any recommendations made by CDOP should be focused on the interventions that could help to prevent future child deaths, or improve the safety and welfare of children. Working Together highlights that recommendations will be few in number and need to be specific, measurable, achievable, relevant and timely.
- 5.3 The Panel have used recurrent themes to highlight any issues that have arisen whilst reviewing the children's deaths. Due to the small number of cases it is hard to make firm recommendations. These themes have been feedback to each LSCB during the annual study day provided by the CDOP, through quarterly reports and in person by the CDOP Manager attending each LSCB quarterly.
- 5.4 Bereavement.**
It has been highlighted from parents that there has been a lack of bereavement support for them at times when they have needed it. Further enquiries as to what services are available in each area and when they are available would be useful to gain a clear understanding of what is available. This would enable the LSCBs to see if there is a genuine lack of service or whether it is a lack of professionals informing families of the services that are there. It is becoming apparent that parents are not always aware of the services provided by non-NHS organisations, for instance FSIDS, Winston's Wish, SANDS, Bliss and Compassionate Friends. If counselling is needed, there can be a lengthy wait for an appointment through NHS organisations. CDOP do inform families of the FSID organisation and the other telephone lines that are available for them to talk to someone in their time of need that has experience in dealing with bereaved relatives.
- 5.5 Support for the family is crucial for the panel to consider. Parents receive a letter and leaflet from CDOP informing them of the CDOP process and they may need further support and help through this process. It may open up many feelings for the family, and informing the health visitor or GP that CDOP are about to review the child's case will allow them to offer support to the families during this time.

5.6 Water Safety

The CDOP area covers a large coastal area and yet despite this all the children who have died from drowning have actually died within the home. The drownings have all occurred in ponds. There are key messages about not leaving children unsupervised near water, fencing the pond off or covering the pond with a cover that will not allow the child to fall through. The Panel feel that a safer water campaign could be linked in with the safe sun campaign to increase people's awareness of the danger of water. This has been fed back to the LSCBs.

5.7 Palliative Care

Both professionals and families have commented on the lack of palliative services available for families whose child is in need of End of Life Care outside of the hospital environment. The care the children have received has been excellent, but this is because of the staff caring beyond their role and hours, sometimes being on-call 24 hours a day, if needed for the family. There does not appear to be a designated palliative care team for paediatrics.

5.8 Advanced care packages (ACP) are detailed documents describing how the family and child wished to be cared for during the end of life phase of their illness, including their chosen place of death. These ACP's appear to be used inconsistently across the 4 LSCB area, and this could be improved upon and communicated more effectively. This needs further investigation, as it is not clear as to whether these care packages are not being used, or perhaps it is just not being documented that an ACP was in use for the family.

5.9 Engagement

The older children are notoriously difficult to engage with any supportive services offered to them. This includes services from GP's, sexual health clinics, mental health services, etc. This has been noted by reviewing young people's deaths where services to support them and their individual needs had been offered, yet the young person did not attend. These children/young people are at the age where parents are unable to force them to attend appointments or seek help, and professionals need to find a way of engaging that person to enable them to seek the help and support they need. If these young people can access the support, it may prevent their deaths. Finding best practice on how to engage these children is essential, and an area that all LSCBs should be considering.

5.10 Safer Babies

The 'Safer Babies' campaign has been successful and needs to be continued throughout the 4 areas. Deaths from co-sleeping could be analysed into smaller categories. For example, was the death of the infant due to sleeping on a sofa death, or sharing the parent's bed were they breast fed or fed on formula milk, or had the parent consumed alcohol or drugs, was the parent a smoker etc.

5.11 Registering certain child births/deaths

The need to start a register of children who die, who have been born from a mother who has cystic fibrosis, should be considered. These females are now living longer and can have children, and there is little research as to whether the medications and the disease the mother has, has any effect on their unborn child. The numbers for this are very small and should be monitored further.

Learning Points

- 6.0 Learning points have been identified from individual cases around several areas and are detailed below. Specifics of individual cases cannot be detailed within this report due to confidentiality reasons, but are fed back to the LSCB in greater depth, although still anonymously.
- 6.1 Health issues highlighted are:
- the need for health visitors to attend professional meetings where the permanent address of the child is not known
 - that health visitors should always see the home environment and that a pre-birth meeting should be in place if deemed necessary, and there is a need to identify which professional should call it
 - an audit tool should be used for substance misuse in pregnancy in order to access treatment/interventions
 - robust inter-agency assessments should be in place where there is evidence of significant alcohol consumption; a multi-agency discussion should occur if there is evidence of rejection of professional support and there are concerns about vulnerability
 - that an out of hours service should have a paediatrician or nurse with paediatric experience on duty at all times (recommendation from CMACE report: Why Children Die)
 - there should be robust procedures in place for when a child 'Was not Brought' to health appointments.
- 6.2 Parent's issue highlighted are:
- LSCBs need to review services and support packages for bereaved families in their area as parents feel there is not enough support after their child has died
 - Professionals must be sensitive in communicating with bereaved parents and sending any documentation in a timely manner.
- 6.3 Neonatal death reviews highlight that:
- A request to the DCSF to gather National data on babies born from egg donor births with congenital anomalies and also babies born to mothers who suffer from cystic fibrosis
 - more efficient documentation in conjunction with CMACE to assist with benchmarking and obtaining the additional information from all neonatal units.
- 6.4 Training
- all drivers and escorts commissioned by agencies to transfer children should be competent in First Aid, to ensure if a child becomes unwell on route, basic first aid can be given, whilst awaiting an ambulance to arrive.
- 6.5 Education
- should ensure schools have good pastoral support after a pupil has died, to support their friends and colleagues
 - ensure the recent changes in PSHE cover aspects of self-harm to raise the awareness within pupils/students.

6.6 Children Services

- to ensure there is a strong interface between Child Services Departments and the MAPPA process.

6.7 Transport

- to ensure appropriate signage for 'Live Rail' on train stations and railway lines to deter children from walking across the lines.

6.8 Governance

- to review panel members to ensure representation from localities and agencies and to serve for a 2 year time period
- advise CDOP on how to attract lay persons to attend the meetings
- letters sent to one LSCB Chair should be sent to all LSCB Chairs for information.

Finance

7.0 The Local Authority Children Services Funding for 2008 - 2011 includes a grant for Child Death Overview Processes. Nationally the Child Death Review Process area based grant has increased over the last three years. This grant is hypothecated. There is a legal obligation under the Children Act 2004 Local Safeguarding Boards are required to review the deaths of all children in their area. In order to comply with this statutory obligation, to make use of limited resources and to gain insight into the learning from all deaths of children, all 4 Local Safeguarding Boards agreed to support one Child Death Overview Panel by pooling their allocated grants.

7.1 Historical Spend/Under spend 2008-2010

Table 13: DCSF Children Services Funding for Child Death Review Processes

	2008-9 Grant	Amount returned March 2010	2009-10 Grant	Amount returned March 2010	2010-11 Grant	Allocation Required for CDOP
Hampshire	£109,000	£82,686 (58.7%)	£112,000	£82,685	£116,000 (58.8%)	£55,919
Southampton	£32,000	£24,795 (17.6%)	£33,000	£24,795	£34,000 (17.3%)	£16,453
Portsmouth	£26,000	£19,654 (13.9%)	£27,000	£19,655	£28,000 (14.3%)	£13,600
Isle of Wight	£18,000	£13,829 (9.8%)	£19,000	£13,826 not allowed to be carried forward due to insufficient evidence	£19,000 (9.7%)	£9,225
Total	£185,000	£140,962	£191,000	£127,135	£197,000	£95,197

7.2 4 LSCB was set up during 2008 with a small team of a part time coordinator and an independent chair. The grant allocated for the panel to implement these two processes has historically returned to each Local Authority (see table1)

7.3 **The reasons identified for the under spend:**

7.4 Governance arrangements

- a) The CDOP was late in identifying the need for a full time manager with the appropriate skills to ensure delivery, the manager was appointed in late July 2009 (then absent for 5 months sick leave)
- b) CDOP made a decision to employ a part time coordinator when most areas with more than one local authority have a full time coordinator
- c) There has been minimal administration support to the panel

Lotty Smith CDOP Manager 4LSCB

- d) There has been no fully costed business plan identifying costs with outcomes and deliverables
- e) Financial planning has not been given a regular agenda item at CDOP meetings or reported to each LSCB
- f) Hosting of the coordinator were not fully costed

7.5 Rapid Response

- g) Minimum training of the Rapid Response Process across the 4 LSCB area has taken place and this had led to gaps in, joint visits and follow up visits with the appropriate professionals
- h) Limited implementation training of the Rapid Response Protocol for professionals in the community, acute hospitals and in interagency teams

7.6 Learning & Planning

- i) There has been limited accountability and reporting to the 4LSCB in the learning, outcomes and any practice developments which may have required resources
- j) There has been a delay in writing, publishing and distributing the annual plan 2008/9

Table 14: Summary of costs required by Child Death Overview Panel 2009/10.

	Costs for full year 2010/11
CDOP Support Officer	£30,416 – Full Year Non recurring costs £3,970 Total - £34,386
CDOP Manager	£51,394

Future

- 8.0 CDOP will be undergoing several exciting changes within the up and coming year. Mainly, the appointment of a new Chair, who has already Chaired a CDOP elsewhere in the country, so their ideas will be interesting to hear.
- 8.1 The CDOP Manager will be focusing on the rapid response process throughout the 4 LSCB areas. Currently, the process is not be followed through all the 3 phases in all areas. There needs to be training offered to the multi-agency teams who may be involved with the rapid response. This will include the police, nurses designated for rapid response and the designated doctor for rapid response. This will involve close linking with the Hampshire CAIU who are also responsible for all the 4 LSCB areas. Joint teaching will be arranged for the designated professional and ways to ensure the final inter-agency meeting happens and a smoother transition of this meeting with the CDOP process of reviewing the child deaths will be considered.
- 8.2 The processes involved in the completion of form B and notification is currently satisfactory. These forms are the forms completed by the professionals who were involved with the child or family and forwarded to CDOP to inform the review process. This could be far more efficient and ways of working with professionals and collecting and collating the forms will be considered.
- 8.3 With the current financial climate, the importance of providing an efficient and yet cost-effective process around child death review will be of up most importance and will be closely monitored. Both health and Local Authorities have a significant reduction in funding available to them, and therefore CDOP needs to be as cost-effective as possible whilst maintaining a high quality service.
- 8.4 Communication from CDOP with each of the LSCBs will be enhanced with written and verbal reports from. This will be via the CDOP Manager presenting quarterly reports to each individual LSCB and by attending 4 LSCB Chair and Manager's meeting that occurs quarterly.
- 8.5 CDOP are currently developing an induction pack and process for new panel members. CDOP has been functioning since April 2008 and it was initially decided that members should be in place for at least two years. As the two years has now passed, panel membership will be under review and new panel members will be joining CDOP as part of the core panel. An induction pack will make this transition a smoother process.
- 8.6 The CDOP Manager will continue to attend meetings with the South East CDOP Managers to share work practices and feedback best practice to the panel. This will also allow for data across a larger area to be reviewed which will highlight any issues to be learnt. This will increase the reliability of the data as there will be larger numbers of similar deaths to review.
- 8.7 CDOP will be producing another study day/presentation this year, which will be held at Netley Police Headquarters for multi-agency professionals to come and learn about the CDOP process and the rapid response process. It will enable professionals to gain an insight of the themes and learning points concluded from the reviews that CDOP have conducted during the previous year.

Further Reading and Links

- Every Child Matters Website:
<http://www.everychildmatters.gov.uk/socialcare/safeguarding/childdeathreview>
- London Safeguarding Children Board website:
http://www.londonscb.gov.uk/child_death
- Perinatal Mortality 2008 UK, Centre for Maternal and Child Enquiries. CMACE: London, 2010.
- Preventing Childhood Deaths – A Study of ‘Early Starter’ Child Death Overview Panels in England DCSF-RRO036 2008
- Working Together to Safeguard Children 2006 and 2010. HM Government. DSCF-00305-2010
- Warwick Medical School – Advanced Course:
http://www2.warwick.ac.uk/fac/med/study/cpd/subject_index/childhealth/sudc
- www.4lscb.org.uk
- www.FSID.org.uk
- www.DfE.gov.uk

Appendix I

Panel Membership

The Panel has a fixed core membership to review the child deaths and has the flexibility to co-opt other relevant professionals as and when appropriate. For example, when reviewing deaths of children that occurred because of road traffic collisions, the panel can co-opt a member from the British Transport Police to attend. This helps the panel as they hold specific knowledge regarding road traffic accidents and would be able to provide more detailed explanations.

The Panel also co-opts a neonatologist to provide expertise when reviewing neonatal/perinatal deaths.

The fixed core panel membership during 2009-10 has been:

Chair – David Parkinson and Donald McPhail

CDOP Manager – Lotty Smith

CDOP Co-ordinator – Kim White

	Representative	Deputy	2 nd Deputy
Health Designated Doctor	Dr Mike Tettenborn Hants LSCB	Dr Christopher Magier IOW LSCB	Dr Jean Price Southampton LSCB
Children Services Social Care	Sue Sevier * Southampton LSCB	Dave Watson Hants LSCB	
Children Services Education	Dr Julia Katherine	Barbara Piddington Hants LSCB	
Health Designated Nurse	Dr Catherine Powell Portsmouth LSCB	Karen Newham	
Public Health	Dawn Saunders Portsmouth LSCB	Stephanie Ramsey	
Police	D/Supt Kevin Walton	DCI Linda Dawson	DI Wendy Priston
Ambulance Service	Peter Warren (SCAS)	Dave Sherwood	

*Sue Sevier from Southampton Health and Social Care is the CDOP Training Coordinator.

There was a change to the Chairing arrangements as the previous Chair no longer sat on an LSCB and therefore, in accordance to Working Together (2010) should not be Chair of the CDOP.

The Panel will be chaired by the LSCB Chair or his or her representative, who will be a member of the LSCB. The Panel Chair should not be involved in providing direct services to children and families in the area.

With this revision it was necessary to have a temporary Chair. Donald McPhail fulfilled this role as he was familiar with the processes of CDOP, having Chaired CDOP's in other areas and is Chair for Southampton LSCB.

The Panel is reviewed to ensure that it represents not only the necessary specialities, but also the geographical areas as well. The Panel membership is due a review in 2010 as most members have sat on the Panel since 2008, and it was felt that professionals should serve for 2 years.

Appendix II

The CDOP had regular meetings throughout the year and reviewed the child deaths within themes, to maximise the potential for learning from the cases.

Month (2009-10)	Theme of in-depth review
April	Deaths of Children requiring a rapid response
May	Deaths of children from cancer and life limiting conditions
June	Deaths of children which were not allocated to any other categories
July	Unexpected deaths in older children
August	Deaths of children by alleged suicide/murder
September	2 meetings 1. Administration meeting 2. Deaths of children with cardiac conditions
October	Deaths of children from choking, serious case reviews and murders
November	Deaths of children from cancer and life limiting conditions
January	Deaths of children requiring a rapid response
February	2 meetings 1. Administration meeting 2. Deaths of children from road traffic Collisions and sudden unexpected deaths
March	Perinatal and neonatal deaths

Appendix III

CDOP Process

Notification of a child death.

All child deaths that occur within Southampton, Hampshire, the Isle of Wight and Portsmouth are notified to a central email address – cdop.notification@hampshire.pnn.police.uk. These notifications are provided by a variety of professionals, for example, neonatologists, paediatricians, Emergency Department Consultants and nurses, midwives, Head teachers, coroners and registrar's. Also, if a child that resides within the 4 LSCB area has died in another local authority area, the CDOP co-ordinator from the area the child died will inform the 4LSCB CDOP to allow us to review the death. The majority of professionals complete the template provided by the DCSF called Form A.

The CDOP co-ordinator collects all the information provided and places the data onto a spreadsheet, allocating each case with a unique identifying number. The data includes the basic demographic details, the date, time and place of death and a summary of the events. It also indicates if the coroner or registrar has been notified. All agencies have a statutory duty to provide this information.

Registrars of Births and Deaths are required by the Children and Young Person Act 2008 to supply LSCB's, no later than 7 days from the date of registration, with information which they have about the deaths:

- of persons aged under 18 in respect of whom they have registered a death; or
- of persons in respect of whom the entry of death is corrected and it is believed that person was or may have been under the age of 18 at the time of death.

This is in respect of deaths occurring on or after 1st April 2009.

The Coroners Rules 1984 as amended by the Coroners (Amendment) Rules 2008 places a duty on coroners to inform the LSCB, for the area in which the child died, of the fact of an inquest or post mortem. It also allows the coroners to share information with the LSCB to enable the review of child deaths to be fulfilled.

Review

In order to be able to review all the child deaths, all the data is placed onto the spreadsheet, which the Panel review at each meeting. There will also be a number of deaths that will be reviewed in depth. For the deaths to be reviewed in depth, all the professionals that had involvement with the child and family are contacted and requested to complete a form template provided by the DCSF entitled 'form B'. This could include the GP, Emergency Department staff, midwives, obstetrics, neonatologists, health visitors, school teachers, social workers, , therapists, CAMH's, hospice workers, ambulance services, police services and voluntary organisations. The co-ordinator is responsible for ensuring the sending and receiving of these forms and collates all the information onto just one form allowing the Panel members to review this information. The form B records information about the child, family, environment, and service provision. Some causes of death require an additional form to be completed as well.

All of this collated information is sent to the Panel members prior to the meeting to allow the members to read and reflect on the information.

Case Analysis

This happens at the monthly meeting. The structured framework used to discuss each case is based on the template 'form C' provided by the DCSF. This allows a formal case discussion and analysis to happen. This format allows the panel to consider firstly, the factors which were intrinsic to the child, including any known health needs; factors influencing health; development/educational issues; behaviour issues; social relationships; identity and independence; abuse of drugs or alcohol; noting the strengths and difficulties.

Secondly, the factors in the parenting capacity including issues around the provision of basic care; health care (including antenatal care where relevant); safety; emotional warmth; stimulation; guidance and boundaries and stability.

Thirdly, factors in the family and environment including the family structure and functioning; parental abuse of drugs or alcohol; wider family relationships; housing; employment and income; social integration and support and community resources.

Finally, the panel are to consider factors in relation to service provision including any identified services (either required or provided); any gaps between child's or family member's needs and service provision and any issues in relation to service provision or uptake. It is important for the Panel to consider both the positive and negative aspects to any of the above to gain an overall impression.

The Panel form a consensus about the categorisation of the death using the scheme provided by the DCSF and to categorise the death as not preventable, potentially preventable, preventable or inadequate information upon which to make a judgement. The DCSF have altered this categorisation now to modifiable factors identified or no modifiable factors identified.

After reviewing all of the above the panel are able to highlight any reoccurring themes or recommendations from the deaths. These are fed back to the 4 LSCB's, who will consider them and take any necessary action.

The Panel also need to review the rapid response process if the death warranted a rapid response. This is able to be done through the Form D template provided by the DCSF. The CDOP Manager is responsible for overseeing the rapid response process.

All of the above information is treated as highly confidential and is subject to safe transfer. Following panel meetings all electronic copies of completed forms held outside of the CDOP office are deleted or destroyed. Any hard copies of the forms are shredded by the police department.

Parental Involvement

Parents are informed of the child death review process by the police personnel, if they were present at any stage and by letter sent from CDOP accompanied by the FSID leaflet. The

parents are asked to write to CDOP if they feel it is possible, with any information they would like us to know regarding the services provided prior to and immediately following their child's death. Any questions raised in this letter will be responded to.

Appendix IV

999 call 'Infant Collapsed'	<ul style="list-style-type: none"> Ambulance control will contact Police control and inform them of the incident CAIU DI will be notified immediately and will decide the Police response
Contact Police	<ul style="list-style-type: none"> If the child arrives and the Police have not been informed, the ED need to contact the Police
CAIU Detective Inspector informed	<ul style="list-style-type: none"> DI will inform the ED of their ETA DI will contact social care and the Nurse designated for rapid response as per the contact list
Detective Inspector attends the ED	<ul style="list-style-type: none"> DI liaises with the Duty Paediatrician to find out what has happened DI confirms samples taken, evidence collected and then the Police and Paediatrician perform a joint examination of the child The DI completes the Child Death Booklet The Nurse designated for rapid response completes the Health Professionals Booklet
Initial interview with family	<ul style="list-style-type: none"> Best practice, is that this is a joint interview away from the child with the Paediatrician, Police and the Nurse designated for rapid response, if available
Explanation of process	<ul style="list-style-type: none"> Professionals will share information with the parents about what happens next i.e. samples that are taken, that a post mortem will be necessary and perhaps a home visit It may be necessary to discuss funeral arrangements and counselling, but this may be better at a later stage
Parents spend time with their child	<ul style="list-style-type: none"> A professional must remain with the child and parents at all times At this time the initial strategy meeting can occur
Initial Strategy Meeting	<ul style="list-style-type: none"> Initial strategy meeting should take place away from the child and family. This includes phone calls to the GP, etc to gain relevant information. The professionals consider the need for a home visit and any safeguarding issues
Home Visit	<ul style="list-style-type: none"> The Police and Nurse designated for rapid response will do a joint home visit within the first 24 hours (usually within office hours) and collate the information using a standardised format It may highlight any suspicious circumstances and further interagency support may be required Information is given to the family about when their child's body will be released and if there is a need for an inquest, if not what the next steps in the process are, including the role of CDOP
Post Mortem	<ul style="list-style-type: none"> Police will attend the post mortem. This is usually within 48 hours of the coroner being notified
2nd Strategy Meeting	<ul style="list-style-type: none"> This usually happens within 5 to 7 days Designated Paediatrician will seek the initial post mortem results and convene the 2nd multi-agency meeting It is decided at this meeting who will return to the parents home and discuss any further information
2nd Home Visit	<ul style="list-style-type: none"> Best practice would be for the Police and the Nurse designated for rapid response to do this jointly, to enable any questions the family have, to be answered
3rd Strategy Meeting	<ul style="list-style-type: none"> within 2-3 months of the child's death multi-agency meeting organised by the CDOP Support Worker
Later Stage	<ul style="list-style-type: none"> The same professionals who visited the family throughout, return to the family to share any additional findings and answer any questions from this multi-agency discussion
Child Death Overview Panel (CDOP)	<ul style="list-style-type: none"> All minutes of these 3 meetings and any other documentation, are forwarded to cdop.notification@hampshire.pnn.police.uk

Appendix V

Abbreviations

CAIU	Child Abuse Investigation Unit
CAMHS	Child and Adolescent Mental Health Service
CDOP	Child Death Overview Panel
DCSF	Department for Children, Schools and Families
DfE	Department for Education
ED	Emergency Department
GOSE	Government Office of the South East
LSCB	Local Safeguarding Children Board
RR	Rapid Response
SCR	Serious Case Review