Abridged version of Annual Report for the Joint Child Death Overview Panel for Kingston and Richmond

April 2017 – March 2018

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1. Introduction

This abridged report reflects the content of the second annual report of the Child Death Overview Panel (CDOP) for Kingston and Richmond, and covers the year 1 April 2017 to 31 March 2018. The report has been redacted to ensure identifiable data is removed.

The purpose of CDOP 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 is to learn lessons in order to improve the safety and well-being of children. It is not about culpability or blame.

The full CDOP Annual Report has been prepared for the respective LSCBs as per the requirement of Working Together 2015. Unlike the LSCBs' Annual Reports, in which the work of the CDOP is summarised, the CDOP Annual Report is not a public document, therefore this abridged version within which statistical reporting has been suppressed to avoid possible identification has been developed to share lessons.

Three CDOP meetings were held during 2017-18. The meetings were chaired by an Independent Chair, appointed by the Local Safeguarding Children's Board (LSCB) Chair for Kingston and Richmond.

The number of deaths across Kingston and Richmond boroughs has decreased, with a total of 21 deaths for 2017-18, compared with 25 for 2016-17, comprising 10 in Kingston and 11 in Richmond.

A total of 16 case reviews were completed during 2017-18 comprising 9 Kingston and 7 Richmond. This is a decrease from 2016-17 when 15 Kingston and 12 Richmond cases were reviewed, totalling 27 across the two boroughs.

In 2017-18, of the 16 deaths reviewed 2 were thought to have modifiable factors present, representing 13% of the reviews completed. This is a decrease from last year when 30% of reviews completed for Kingston and Richmond were found to have modifiable factors.

Key themes and issues identified are described later in the report.

2. Introduction to CDOP

2.1 Terms of reference

The review of deaths of children under 18 years old is a statutory requirement, and a Child Death Overview Panel must be established to fulfil this duty. The main functions of the CDOP are set out in Chapter 5 of Working Together 2015. The panel evaluates all deaths of children resident in the two boroughs to identify any issues of concern and lessons to be learnt. It also aims to identify any risk factors and trends in the local pattern of child deaths, with a view to informing the ongoing development of policies and procedures across all agencies and advising the LSCB on resources and training required to improve responses to child deaths and reduce preventable deaths.

One of the functions of LSCBs set out in the Children Act 2004; regulation 6, in relation to the deaths of any children normally resident in their area is as follows:

(a) Collecting and analysing information about each death, with a view to identifying-

- *Any case giving rise to the need for a review mentioned in reg 5(1)(e) (i.e. Serious Case Review)*
- *Any matter of concern affecting the safety and welfare of children in the area of the authority, and*
- *Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area*

(b) Putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death

Working Together to Safeguard Children 2015 and LSCB Guidance (DCSF 2006) set out the regulations and guidance for reviewing these child deaths.

Two inter-related processes were established:

- A rapid response by a team of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child
- An overview of the deaths of all children (birth up to 18th birthday, excluding stillborn and planned terminations) normally resident in each LSCB area

From April 2008 each LSCB has a responsibility for convening and maintaining a CDOP with members drawn from key organisations represented on the LSCB. CDOPs are accountable to the LSCB.

The CDOPs functions are to:

- Collect and collate information on each child's death, seeking relevant information from professionals and, where appropriate, family members;
- Discuss each child's case and provide relevant information or any specific actions related to individual families to those professionals who are involved with the child's family so that they, in turn, can convey this information in a sensitive manner to the family;
- Ensure that families are appropriately informed and involved with the child death review processes including rapid response, where applicable, and that they are enabled to contribute should they wish to;
- Determine whether the death is deemed preventable, that is those deaths in which modifiable factors[1] may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- Make recommendations to the LSCB(s) or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- Identify patterns or trends in local data and report these to the LSCB(s);
- Provide regular subgroup updates to the LSCBs as per their requirements;
- Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case to the relevant LSCB Chair for consideration of whether a serious case review is required;
- Agree local procedures for responding to unexpected deaths of children;
- Cooperate with regional and national initiatives to identify lessons on the prevention of child deaths;
- Provide an annual report of relevant information to the LSCBs to inform their annual reports; and
- Provide anonymised information on behalf of the LSCBs to the Department for Education to enable the Department to commission research and publish nationally comparable analyses of these deaths.

The joint CDOP and rapid response arrangements have been in place since April 2008. The Terms of Reference are reviewed annually and reflect Working Together to Safeguard Children 2015.

[1] Modifiable factors are identified as those which, by means of national or local interventions, the risk of future child deaths could be reduced. Factors should be considered in domains including, family environment, parenting capacity and service provision.

2.2 Core membership

Membership has been established to reflect statutory requirements, with core members at a senior level from each borough as follows:

- Designated Paediatrician for child deaths;
- Public Health Consultant;
- Health safeguarding representatives such as Designated Nurse/ Named Nurse, from CCG and providers;
- Local Authority Safeguarding managers; and,
- Detective Inspectors from Child Abuse Investigation Teams and Borough Police

For the meeting to be quorate there has to be at least one representative from each of the five core service areas. This is a local agreement and not a statutory requirement.

The terms of reference stipulate that where possible, the panel will have a representative of a bereavement agency or similar. In this regard, the panel have been very fortunate to have a member from Shooting Star Chase Children's Hospice. This member assists the panel with regard to best practice in bereavement support and end of life care, as well as ensuring information sharing in relation to individual children and their families who have received care and support from the hospice.

From October 2016 the panel was joined by the lay member for Richmond LSCB. The perspective of a lay member has supported the panel in shaping processes, learning and recommendations.

From October 2017 the panel meetings have also had representation from the local borough police and this has been a helpful addition to the expertise from the Child Abuse Investigation Team Detective Inspector panel members, as many deaths will not fall under their remit which includes sudden unexpected deaths of children under two years old, or others specific to their remit.

2.3 Definitions used for child deaths

- Neonatal – death of a newborn child under 28 days old - includes premature births but excludes stillbirths.
- Sudden Unexpected Death in Infancy (SUDI) – unexpected unexplained death of a child under one year of age, including those less than 28 days if discharged home.

- Expected – describes a death that was anticipated and did not arise from an unexpected cause or complication. Expected deaths may be due to known illness, and include those with a palliative care plan.
- Unexpected – the death of a child (up to 18 years) 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. Unexpected deaths may be due to a child who dies sooner than expected from a pre-existing condition, or who experiences external trauma, such as accident or homicide.

The responsibility of deciding whether a death is defined as unexpected rests with the designated paediatrician for child deaths. Unexpected deaths will trigger a rapid response process.

3. Overview of CDOP operation

3.1 Meetings held and reviews conducted

The CDOP met three times this year. The meetings have been 3 hours in duration. As in previous years, the CDOP devoted one meeting to the review of neonatal deaths, to which guest experts were co-opted from a range of disciplines across several NHS Trusts.

A total of 16 case reviews were completed during 2017-18. The number of cases awaiting review at 31st March 2018 was 19.

3.2 Organisation and resourcing

National guidance allows for the establishment of combined CDOPs, depending on population size. The three LSCBs for Hounslow, Kingston and Richmond agreed to establish a joint CDOP with pooled funding for coordination and administration. This shared arrangement was in place from April 2008 to March 2016. From April 2016 Kingston and Richmond have operated a joint panel without Hounslow.

In October 2016 the LSCB Chair appointed an Independent Chair, who has continued to chair the CDOP since this time.

The CDOP coordinator has provided business support to the panel since 2010 and is the single point of contact for child death notifications and other communications to the CDOP and has responsibility for coordinating the relevant processes involved in the panel reviews including rapid response in conjunction with the respective Designated Paediatricians. The panel is managed and administered in Richmond and information (including the database) is stored there in accordance with London Borough of Richmond upon Thames

procedures (as per their Shared Staffing Arrangement with the London Borough of Wandsworth).

Common issues across London are discussed at the London CDOP Chairs & Designated Paediatricians group. CDOP Coordinators are welcome to attend the CDOP Chairs and Designated Paediatricians groups, and the local CDOP Coordinator has attended several of these meetings. These network meetings also provide a useful opportunity to discuss issues relating to good practice. Additionally during 2017-18 there has been a programme of work coordinated by the Healthy London Partnership for London CDOPs involving a number of network events which have been attended by several panel members.

The costs of management and administration of the CDOP including the coordinator post are funded by the LSCBs for Kingston and Richmond. The funding for the Kingston designated paediatrician is included in the acute contract for Kingston Hospital NHS Foundation Trust. The designated paediatrician post is funded by Richmond's Clinical Commissioning Group and as of October 2016 this post is now a direct appointment rather than through the previous arrangement with Hounslow and Richmond Community Healthcare Community Paediatrics Service.

3.3 Operation

CDOP members are expected to review the papers of CDOP meetings (circulated a week in advance) irrespective of attendance and ensure that any contribution is made in a timely way by means of correspondence with their nominated counterpart, for those members who rotate their attendance, or via the CDOP Chair, Coordinator or relevant Designated Paediatrician.

The panel has continued to have at least one meeting per calendar year dedicated to reviewing neonatal deaths with the contribution of guest obstetricians, neonatologists, midwives and key support staff. This has increased the general knowledge of the panel as to neonatal and obstetric matters. It also allows the panel to defer the review of any complex cases which it is felt would benefit from the additional expertise available at this dedicated panel.

3.4 Training and Development

The CDOP did not hold a specific development session during 2017-18; however, the panel has changed the structure of the meetings to incorporate development activities into each meeting. CDOP members also undertook a range of external development and learning activities:

- Attendance at a number of workshops organised by the Healthy London Partnership including the following:

  - *HLP CDOP Programme Sustainability and Transformation Plan (STP) Footprint Process Mapping workshop*
  - *Tackling Asthma Deaths*
  - *Understanding and Tackling Neonatal Deaths*
  - *Bereavement Support in the London CDOP System*
  - *Working with London Coroners*
- Attendance at London CDOP Chairs and Designated Paediatricians Meetings (September 2017 & March 2018)
- Continued dialogue with Coroner over rapid response protocols
- Training on CDOP and learning identified to LSCB pool of Safeguarding trainers
- Organisation and attendance of some panel members at the local Learning from Child Deaths Conference
- Participation in Public Health review of services in respect of Risky Behaviours
- Peer support to neighbouring CDOPs
- Participation in suicide prevention meetings coordinated by Public Health
- Presentation of CDOP Annual Report for 2016-17 to Health and Wellbeing Boards in Kingston and Richmond
- Presentation of CDOP Annual Report for 2016-17 to joint LSCB Meeting and subsequent impact report presentation.
- Responding to government consultation on new arrangements and guidance
- eCDOP training
- Attendance at CDOP meeting staff member from Public Health England to observe local approach
- Attendance at CDOP meeting staff member from Momentum, a local charity working with bereaved families
- Received presentations of relevant serious case reviews
- Revision of leaflet for parents based on parental feedback

3.5 Rapid response to unexpected deaths

There were 9 unexpected deaths across the two boroughs during 2017-18. For 7 of these deaths, formal meetings were held as part of the rapid response process.

Physical rapid response meetings for four of these cases were held within 4-9 working days of the child's death. For three further cases, local case discussions were held 5-7 weeks from the death, as virtual information sharing had taken place in the time immediately subsequent to death (including for two deaths that occurred out of area and where the initial rapid response was overseen by the local authority where the death occurred, which is in line with statutory guidance).

In respect of a further two deaths, no physical meetings were held but information was gathered from the appropriate sources and the panel were satisfied that these deaths were not unexplained and that support was in place for families affected via the relevant hospital trusts.

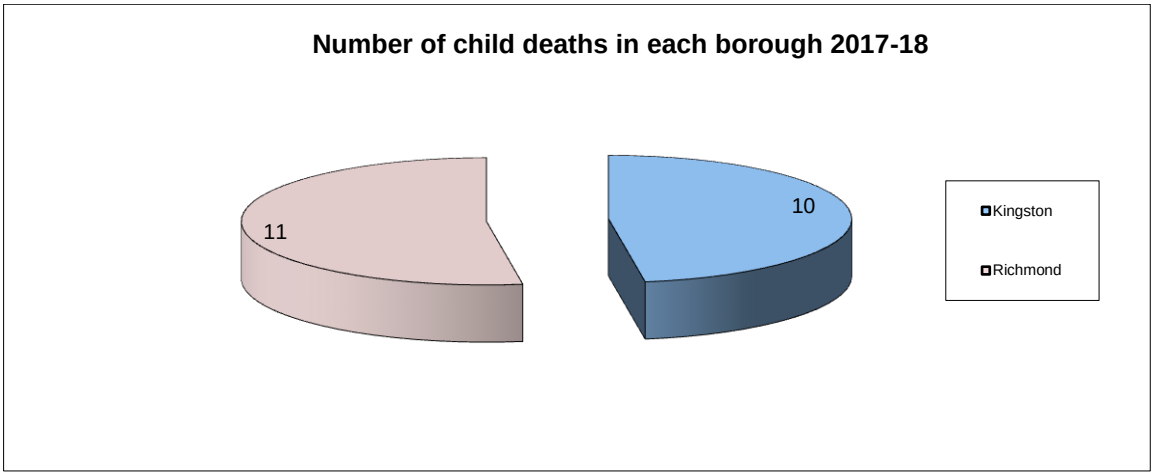
The rapid response meetings were generally well attended. There are some professionals such as GPs whose commitments make attendance problematic given the short notice. In these cases the panel requests summary information which can be shared on their behalf and they receive the minutes and action points.

For any deaths that are subject to a rapid response which are also being investigated by the coroner, the minutes of the rapid response meeting are sent to the relevant coroner for their information.

4. Child deaths in the area 2017-18

4.1 Number and characteristics of child deaths in Joint CDOP area

Figure 1 – Number of child deaths in each borough 2017-18



The number of deaths across Kingston and Richmond decreased to 21 for 2017-18 compared to 25 for 2016-17. Of the 21 deaths, 12 were expected, 7 in Kingston and 5 in Richmond. Richmond has a marginally greater proportion of unexpected deaths. Figure 2 in appendix iii shows the number of child deaths per year for each borough for the period 2008-18.

Whilst there may be variance between different CDOPs nationally as to their application of the definitions of expected and unexpected, it is important to note that this is not reported on nationally via the annual LSCB1 returns to the Department for Education. The definitions are used for local reporting and analysis, and to inform the need for a rapid response in cases of deaths classified as unexpected. It is anticipated that the forthcoming national guidance for the new arrangements for child death reviews will dispense with this distinction altogether, to allow further flexibility for a proportionate response on a case by case basis.

The majority of deaths across the Kingston and Richmond were male, 62%, but with in-borough variation; this is consistent with last year. Small numbers overall make it difficult to draw meaningful comparisons.

As in previous years, the highest proportion of deaths is in children aged up to 12 months cumulatively although there is in-borough variation. These deaths comprised 80% of deaths in Kingston and 55% of deaths in Richmond, with an average across the boroughs of 67% of the deaths overall occurring within the first year of life.

The proportion of neonatal deaths (all deaths under 28 days of age) overall across both boroughs is 33%. This is a notable decrease from last year's 60% and is more in keeping with the proportion of neonatal deaths notified in 2015-16, 37%.

It takes time to gather accurate ethnicity data as this is not always collected, recorded, and reported by different agencies particularly in the case of neonatal deaths; however, this year the panel have been able to establish ethnicity for all child deaths notified.

The tables below show the proportion of deaths by ethnic group notified during 2017-18 against the ethnic distribution of the 0-17 population in the borough according to the data from the 2011 census.

Table 1 – Comparison of child deaths by ethnic group against 0-17 population ethnic mix in Kingston according to 2011 census data

Ethnic group	Percentage of child deaths in Kingston in this ethnic group during 2017-18	Percentage of 0-17 population in Kingston of this ethnic group according to 2011 census
White	70%	67%
Asian	0%	18%
Black	0%	3%
Mixed	30%	9%
Other	0%	3%
Not known	0%	N/A

Table 2 - Comparison of child deaths by ethnic group against 0-17 population ethnic mix in Richmond according to 2011 census data

Ethnic group	Percentage of child deaths in Richmond in this ethnic group during 2017-18	Percentage of 0-17 population in Richmond of this ethnic group according to 2011 census
White	73%	81%
Asian	9%	7%
Black	0%	1.5%
Mixed	9%	9%
Other	9%	1.5%
Not known	0%	N/A

The small numbers of deaths in each borough make it very difficult to provide meaningful comparisons of death rates across ethnic groups.

4.2 Deaths of children resident in other local authorities

There were 7 deaths during 2017-18 where the place of death was within Kingston and Richmond, i.e. at a local hospital or hospice but where the child was ordinarily resident in an out of area local authority (4 different local authorities in total). In each case the notification and any additional information received was forwarded to the relevant CDOPs.

The outcomes of the review at the respective CDOPs have been requested in respect of these 7 deaths and are reported in the next section where these have been concluded and shared.

5. Commentary on cases reviewed

In the period 2017-18 16 cases were reviewed. This compares to a total for Kingston and Richmond of 27 for 2016-17. The number of cases awaiting review at the end of the year has risen slightly due, in part to 9 deaths occurring in the final quarter of the year.

It is important to note that the deaths reviewed during 2017-18 did not all occur within this time period, due to a delay in cases having sufficient information available for review, and therefore also includes reviews of deaths occurring in previous years.

5.1 Categories of death and ‘preventability’

CDOPs categorise deaths using three sets of criteria: expected and unexpected, category of death, and modifiability. Category of death and modifiability are reported as part of the annual LSCB returns to the Department for Education

(which it is anticipated will transfer to the Department for Health imminently) - see appendix ii for further details of definitions.

In 2010-11 the CDOP was required to change the classification of deaths whereby all those for which it had identified possible 'modifiable factors' will be recorded in the annual reports to the Department for Education as 'preventable'. This change has the effect of increasing those deaths recorded in national annual LSCB returns as preventable. The CDOP has continued to make a judgement on the previous categorisation as well for comparison purposes across all years of the child death review process – so for all deaths with modifiable factors, the panel also records whether in their view they are preventable or potentially preventable.

Overall in 2017-18, 2 of the 16 deaths reviewed were thought to have modifiable factors present. This is 13% of reviews completed during 2017-18. This is a lower proportion than the national average according to the most recently available Statistical First Release of Child Death Reviews - Year ending 31 March 2017 (SFR 36/2017), in which overall 27% of deaths reviewed were found to have modifiable factors. The process for LSCB1 returns for reviews completed in 2017-18 has not yet been issued therefore the Statistical First Release of Child Death Reviews –Year ending 31 March 2018 is not yet available.

5.2 Deaths classified as the result of a neonatal or perinatal event

A total of 8 deaths reviewed were classified as due to a perinatal or neonatal event – 5 in Kingston, and 3 in Richmond. Unexpected deaths accounted for 3 of the total of deaths categorised as due to a perinatal or neonatal event.

All of the deaths classified as a death from a neonatal or perinatal event, occurred within the first 28 days of life.

Prematurity (birth before 37 weeks completed pregnancy) was indicated in the formal cause of death in a total of 6 cases. Of these 6 cases, 3 were extremely premature, (birth before 28 weeks of completed pregnancy).

One death was judged by the panel to have modifiable factors.

Five of the neonatal deaths reviewed were discussed (with four reviews completed therein) at the neonatal focused meeting held in June 2017 at which the panel were joined by guests specialising in obstetrics, midwifery and maternity risk management from relevant hospitals.

The panel monitor follow-up provided to mothers to ensure they have had access to advice regarding planning of possible future pregnancies, and to ensure that parents have had an opportunity to discuss the death of their baby and care received by their family.

5.3 Sudden Unexpected Death in Infancy

One death from Sudden Infant Death Syndrome was reviewed during this period.

5.4 Unexpected deaths

There were 6 unexpected deaths reviewed during the year. Of these, 2 were found to have modifiable factors.

5.5 Expected deaths

There were 10 expected deaths reviewed during 2017-18. Of these, 5 were due to a perinatal or neonatal event.

No expected deaths were found to have modifiable factors.

5.6 Time taken to review deaths

Table 3 - Time from date of death to review at CDOP 2017-18

Time from death to review	Expected	Unexpected	Total and %
Under 6 months	2	1	3, 19%
6-7 months	7	2 (1)	9, 56%
8-9 months	1	0	1, 6%
10-11 months	0	2	2, 13%
12 months	0	0	0, 0%
Over 1 year	0	1 (1)	1, 6%

Table 3 above shows the time taken from the date of death to the completion of the final review at panel for reviews completed during 2017-18. The time taken for the completion of reviews where modifiable factors were identified by the panel is indicated in brackets in the relevant columns. Of the 2 deaths found to have modifiable factors, 1 was reviewed within 6-7 months of the date of death while the other 1 took over a year to be finally reviewed at panel which was due to a delay in the coronial investigation being concluded and the outcome being shared with the CDOP; however, this case had previously been partially reviewed at the neonatal focused meeting to ensure learning was identified with guest experts at earliest possible opportunity.

The timeliness of reviews this year has increased from last year with 94% of reviews being completed in less than one year from the date of the child's death, and 75% of deaths being reviewed in 7 months or less from the date of death. This is better than the national average performance reported in the latest available statistic release, in which 76% deaths are being reviewed within one year (SFR 36/2017).

6. Key themes, issues & learning

6.1 Neonatal deaths

A significant proportion of the deaths notified and reviewed by the panel each year are a consequence of perinatal or neonatal events and/or in the neonatal period from life-limiting conditions. From the reviews conducted in respect of this category during 2017-18, the following issues were highlighted:

- Training need identified for staff around placement of probe on foot for post ductal readings*;
- Room temperature in SCBU*;
- Rotation of staff on units to assist in keeping skills up*;
- Planning for delivery of complex cases at tertiary centres*;
- Delayed recognition and therefore urgent escalation; earlier blood transfusion may have prevented death;
- Need for clarity and consistency of management where antenatal diagnoses may indicate conservative management*;
- Neonatal cot availability;
- Excellent practice in palliative care;
- Process for follow up of missed antenatal scanning appointments; and,
- Awareness-raising re end of life care support available at local hospice for neonates.

** raised in respect of out of area hospital units, but may have applicability to local hospital.*

The panel requested further information about any possible national mechanism for sharing learning between hospital trusts, where learning from individual Serious Incident Investigations would have wider applicability.

6.2 Communication

Two deaths reviewed during 2017-18 highlighted the need for consistent communication between all health professionals to ensure that discharge information is shared appropriately and local teams are aware of children's diagnoses and any appropriate monitoring that should be undertaken.

The CDOP has written to the relevant trusts, and has also shared their recommendation with NHS Improvement to request national dissemination of this learning.

6.3 Safer Sleep

The panel reviewed a sudden infant death in which the baby was sleeping within a sleep pod on parents' bed. There was no specific safety issues identified as regards the product itself in terms of the mechanism of death, however its use in

this context carried the risks associated with co-sleeping. The panel therefore wrote to Public Health England copying in the Lullaby Trust:

- to ascertain if other deaths have been associated with the use of these sleeping devices (either during co-sleeping or in baby's own sleeping area) and to recommend coordinated surveillance if this is not already in place
- to ascertain if there is any oversight of the marketing of these devices to ensure that parents are clearly advised that co-sleeping increases the risk of cot death?

Public Health England confirmed they have published a number of supporting resources *on unintentional injuries which include specific warnings related to safer sleep:*

- *Preventing unintentional injuries A guide for all staff working with children under five years (February 2017)*
- *Reducing unintentional injuries among children and young people: Action areas and data slide set for local authorities and their partners to help develop injury prevention strategies for children and young people; this includes a specific safety warning for sleep pods (first published 2014; updated March 2018*

Information Service for Parents: PHE provides information and tips for parents via the Start 4 Life Information Service for Parents and this includes specific information on safer sleep and the recommendations promoted by the Lullaby Trust. The link to the Start4Life site is https://www.nhs.uk/start4life

Workforce: PHE promotes child unintentional injury prevention in general through its professional leadership of the health visiting service who lead the delivery of the Healthy Child Programme. Guidance is provided to health visitors in the Healthy Child Programme: Pregnancy and the first years of life, the High Impact Area 5 publication 'Managing minor illness and reducing accidents (reducing hospital attendance/admissions)' and to commissioners in the commissioning guidance: "Best start in life and beyond: Improving public health outcomes for children, young people and families Guidance to support the commissioning of the Healthy Child Programme 0-19: Health visiting and school nursing services".
These documents do not specifically reference sleep pods, however practitioners are signposted to PHE Unintentional Injury resources outlined in the publications section above on the All Our Health online platform which has been developed to help healthcare professionals in England maximise the impact they can have on improving health outcomes and reducing health inequalities.

Unintentional Injuries data: PHE Fingertips site provides an interactive atlas of maps and data for a range of child and maternal health indicators and statistics over time, including 'Reducing unintentional injuries in and around the home among children under five years' These resources enable local areas to create a picture of local needs as well as benchmark performance against regional and national comparators. It is intended that the new centralised CDOP database will be used to generate intelligence which is

equally applicable for local and national action as appropriate. We understand that DHSC will in due course determine where in the system the responsibility for national intelligence gathering, dissemination and subsequent action will lie.

Other:

PHE work closely with a range of partners including The Child Accident Prevention Trust, ROSPA and the Lullaby Trust to promote safety messages to parents. Generally when child safety issues come to light from local deaths and injury reviews PHE bring these to the attention of PHE centres through the monthly PHE bulletin. As part of Safer Sleep Week (11th – 18th March), PHE have teamed up with Lullaby Trust to develop guidance to help new and expectant parents make safer choices when deciding on sleeping products for their baby. The guidance can be downloaded here https://www.lullabytrust.org.uk/about-us/safer-sleep-week-2018/ . It aims to provide parents with some key pieces of advice when choosing sleeping products.

PHE does not currently have any role in product design or marketing of sleep pods. Further information on the regulations and British Safety Standards can be found at: ***Department for Business, Energy & Industrial Strategy*** *and* ***Office for Product Safety and Standards***

The Lullaby Trust responded to advise:

We did quite a bit of work on putting together a statement around positioners and pods a few months ago, and we have since been working on a further document on products which we plan to get out for safer sleep week in March. This has all been based around the statement that came from the U.S., and also the sheer volume of requests we have had for advice around these products and claims made by various manufacturers. We were aware of a few documents in different parts of the country raising concerns about these products following deaths, but without further information, and knowing how many are apparently being sold, we could not make any more assumptions about this.

The CDOP has promoted the Lullaby Trust resources and other relevant alerts for sleeping products via social media, the LSCB website and CDOP newsletters, likewise the PHE resource 'National learning in focus: Reducing unintentional injuries in and around the home among children under five years' has been promoted via a CDOP newsletter previously.

6.4 Suicide

The CDOP in reviewing deaths during 2017-18 highlighted the need to consistently promote mental health awareness and suicide prevention, as well as the need for effective response to suicides in communities including support for those affected and strategies to identify and limit possible clusters or contagion.

Papyrus, a charity focused on the prevention of young suicide, was one of the guest speakers at the Learning from Child Deaths Conference in July 2017. They emphasised that suicide is a preventable cause of death.

The panel has promoted mental health awareness and suicide prevention through their newsletter, twitter and participation in Walking out of Darkness an event.

The LSCB training offer continues to feature Mental Health First Aid Training in conjunction with Kingston's Public Health Team.

CAMHS provided training to professionals on suicidality in adolescence which was well received. It included role play with a formerly suicidal client, which was innovative and reported to be an extremely helpful learning method for this topic. Participants reported feeling empowered to use the techniques with young people they are in contact with.

The CDOP Coordinator and LSCB Professional Adviser have been working to support public health in Richmond in their coordination of a Suicide Community Action plan. The LSCB Professional Adviser also attends regular meetings of the Multiagency Suicide Prevention group in Kingston.

6.5 End of life care

In two of the deaths reviewed the panel noted there to have been positive practice in palliative care planning. This chimes with previous year's findings. The local area is extremely fortunate to have Shooting Star Chase Children's Hospice as a potential resource for children with life-limiting conditions.

In another review, the panel noted the need to ensure awareness of the potential for parallel palliative care planning and the potential for hospice for end of life care in respect of neonatal deaths. Various activities for example study days, have been undertaken at the local hospice and hospital to raise awareness of this potential pathway and the CDOP will also promote awareness where possible.

6.6 Risky Behaviours

During 2017-18 CDOP members contributed to the Public Health led review of Risky Behaviours Services. In previous years' reviews risky behaviours, and in particular substance misuse, have been contributory to a number of adolescent deaths, and parental substance misuse has also been noted as a risk factor in a number of sudden infant deaths. This remains a key area in which local and national awareness-raising may help to reduce the risk of preventable deaths.

6.7 Ethnicity

Information on the child's ethnicity was received for all of the deaths notified to the panel during 2017-18. For two of the deaths reviewed during this period, this information was not available. There is a trend for this information to be less readily available in the case of neonatal deaths, where both parents' ethnicity may not have been recorded and/or where the child and their ethnicity has not yet been recorded, for example where they have not yet registered with a GP. The CDOP will continue to actively pursue this information to ensure this is obtained in all possible cases and to remind professionals of the need to capture this.

The panel carefully considers any potential impact that ethnic and cultural background may have on individual children and their families, to ensure that any learning in this area is identified.

6.8 Ofsted

Ofsted reviewed the performance of Richmond LSCB as part of their inspection of the local authority's children's services from September-October 2017. Both were judged to be good. Their inspection findings can be accessed in full via the following link:

https://reports.ofsted.gov.uk/sites/default/files/051_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf

As part of the process the inspection team received the annual report, impact update prepared for the joint board, and CDOP meeting minutes, and met with the CDOP Chair and CDOP Coordinator. Their findings specific to the CDOP were as follows:

The joint Richmond and Kingston Child Death Overview Panel (CDOP) is highly effective. It reviews child deaths, identifying modifiable factors, and undertakes proactive work to reduce incidents of preventable child death. There has been considerable work to raise awareness of safe sleeping, water safety, and asthma and allergy management. Robust challenge of the chief coroner by the CDOP led to the development of national advice about signs of life.

7. Progress against work-plan for 2017-18

The CDOP work-plan for 2017-18 has been followed and the following achieved:

- The review of the terms of reference was completed and placed on LSCB website.
- Attendance has been monitored and membership reviewed.

- A range of training that relates to CDOP has been provided and resources updated
- A 'Learning from Child Deaths Conference' was held jointly with Wandsworth, Sutton and Merton LSCBs. There were speakers on drugs education, suicide prevention, safer sleep and bereavement. This was attended by approximately 100 multi-agency delegates. An evaluation was sent out to attendees and the responses have been collated and analysed to assess impact. A report has been shared with the panel and with the wider LSCBs including the Learning and Development subgroup.
- The database with review outcomes for 2016-17 is up to date and the LSCB1 return submitted to the Department for Education on time.
- The Annual Report for 2016-17 has been completed and presented to the LSCBs in June 2017. It was also presented to each of the borough's Health and Wellbeing Boards. It includes data and analysis of trends over
- The CDOP produced a report for the LSCBs in the autumn on the impact of work undertaken in respect of the learning identified and actions taken.
- The need for frontline practitioners to be sensitive to ethnic and cultural background has been raised with the Learning and Development Subgroup of LSCB. This was included in the June 2016 CDOP newsletter for learning focused on general practice. This has also been raised in training events.
- CDOP newsletters are circulated to the CDOP, LSCB Board Members, LSCB Team members for distribution to their networks, and other targeted professionals, for onward cascade to all Achieving for Children staff, schools, early years, local health professionals etc.
- A bulletin primarily aimed at Primary Care and Education colleagues regarding the need for asthma and allergy management plans has been produced and circulated in May 2017, as has a bulletin on water safety June 2017. The December 2017 newsletter featured items on suicide prevention, carbon monoxide poisoning, and safer sleep.
- The LSCB website and twitter have been used to promote safety campaigns and learning such as sepsis awareness, the asthma toolkit, Safer Sleep Week etc. Specific safety alerts in relation to cots have been circulated via email to partners recently and also tweeted and placed on the website.
- Partners' Communications teams have also promoted campaigns such as Safer Sleep Week.
- We have promoted learning specific to schools via our website: http://kingstonandrichmondlscb.org.uk/news-resources/information-and-guidance-for-schools-165/child-safety-and-life-saving-in-schools-234.php and targeted communications to state and independent schools, as well as via twitter. This has included advice from the London Ambulance Service as to best practice when contacting them in the event of an emergency.
- The CDOP/LSCB supported Walking out of Darkness in May 2017 to raise awareness of mental health and suicide prevention issues and will be promoting this again in 2018.

- For Child Safety Week in June 2017, the CDOP reproduced a newsletter with a poster on reducing the risk of accidents to under 5s, as well as sharing information on asthma and allergy management plans.
- Drowning Prevention Week in June 2017 was promoted on twitter and via the water safety bulletin.
- Road Safety Week in November 2017, was promoted through the LSCB Newsletter, website, twitter and partner's communications.
- The CDOP/LSCB and partners promoted Safer Sleep Week in March 2018, via twitter, the website and partners' communications.

8. CDOP work-plan for 2018-19

The CDOP will undertake the following:

- CDOP chair to review terms of reference and membership annually to take account of national development including emerging response to Wood report;
- CDOP chair to review attendance and contribution to CDOP panel meetings;
- CDOP members to influence the future development to new arrangements including exploration with key CCG leads and participation in relevant network meetings/consultations;
- Database is maintained to enable year on year trend analysis and identification of risks/issues more effectively;
- An annual report structure will be developed that will evidence child deaths over years identifying relevant patterns and trends. An executive summary will be prepared alongside this that can be shared with the public to ensure the learning is shared widely;
- CDOP engages with Warwick Study into review of SUDIs;
- CDOP Newsletters are distributed across LSCB partner agencies with learning identified, e-mail communications of key learning to ensure timely communication, and survey/audit of target audiences;
- CDOP members contribute to national campaigns and distribute learning across LSCB partner agencies; and,
- Designated professionals seek and consider the evidence available from health that best practice is complied with.

9. References

- HM Government (2015). *Working Together to Safeguard Children; A guide to inter-agency working to safeguarding and promote the welfare of children* accessed at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf published 25 March 2015 **WT2015**

- Statistical First Release: Child Death Reviews – Year ending 31 March 2017 (SFR 36/2017) accessed at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/537359/SFR24_2016_Text.pdf

- DC2101EW - Ethnic group by sex by age – ONS Crown Copyright Reserved from NOMIS accessed at: https://www.nomisweb.co.uk/census/2011/dc2101ew

- https://reports.ofsted.gov.uk/sites/default/files/051_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf

- https://www.hqip.org.uk/clinical-outcome-review-programmes/national-child-mortality-database/

Appendix (i) – Membership of the Joint CDOP as at 31/03/18

Representatives from the Royal Borough of Kingston upon Thames

- Designated Nurse for Safeguarding Children and Looked After Children, Kingston CCG
- Designated Paediatrician for Child Deaths, Kingston CCG (job-share)
- Associate Director of Public Health, Royal Borough of Kingston
- Detective Inspector, West Child Abuse Investigation Team
- Designated Paediatrician for Child Deaths, Kingston CCG (job-share)

Representatives from the London Borough of Richmond upon Thames

- Consultant in Public Health, London Borough of Richmond
- Designated Paediatrician for Child Deaths, Richmond CCG
- Detective Inspector, Feltham Child Abuse Investigation Team, Metropolitan Police Service
- Designated Nurse for Safeguarding Children, Richmond CCG
- Lay Member, Richmond LSCB

Shared:

- Professional Adviser to Kingston and Richmond Local Safeguarding Children Boards, London Borough of Richmond & Royal Borough of Kingston
- Head of Referral & Assessment, North East Cluster, Achieving for Children
- Social Worker, Shooting Star Chase Children's Hospice
- Detective Inspector, Community Safety Unit for Richmond and Kingston Boroughs, Metropolitan Police Service
- CDOP Coordinator, London Borough of Richmond

Appendix (ii) Categories used to classify child deaths

The Child Death Overview Panel should categorise the deaths according to the following scheme:

1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning and other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self harm. It will usually apply to adolescents rather than younger children.
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre school children, anaphylaxis and other extrinsic factors. **Excludes** Deliberately inflected injury (category 1).
4	**Malignancy** Solid tumours, leukaemias and lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis, sudden unexpected deaths with epilepsy.
6	**Chronic medical condition** For example, crohn's disease, liver disease, neurodegenerative disease, immune deficiencies, cystic fibrosis, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, and other congenital anomalies including cardiac.
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and includes congenital or early-onset bacterial infection (onset in the first postnatal week)

9	**Infection** Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5)

The panel should categorise the 'preventability' of the death – tick one box.

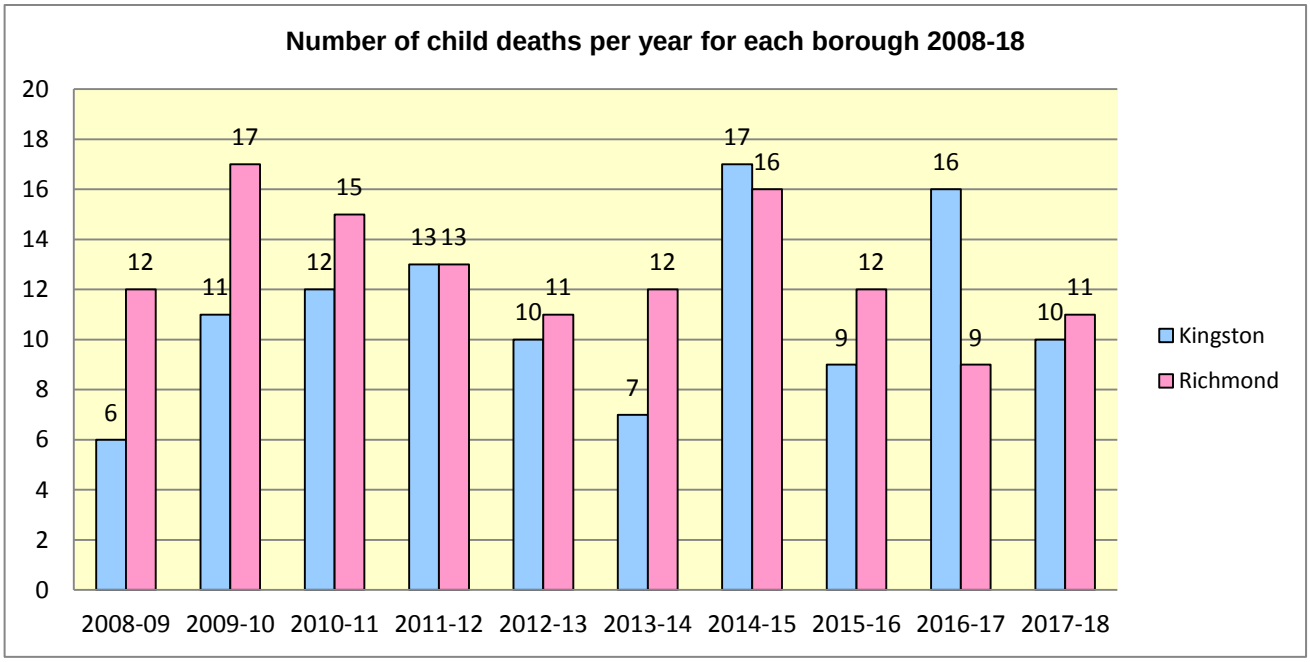
Modifiable factors identified	The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of local or national interventions, could be modified to reduce the risk of future child deaths	☐
No Modifiable factors identified	The panel have not identified any potentially modifiable factors in relation to this death	☐
	Inadequate information upon which to make a judgement. *NB this category should be used very rarely indeed.*	☐

* Note – previously the panel were asked to categorise the preventability of death as follows:

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.
Potentially Preventable	Potentially modifiable factors extrinsic to the child
Not preventable	Death caused by intrinsic or extrinsic factors, with no identified modifiable factors
	Inadequate information upon which to make a judgement. NB this category should be used very rarely indeed.

Appendix (iii) Child death figures April 2008-2018

Figure 2 – Number of child deaths per year for each borough 2008-18



From 2008-2018 there have been 111 child deaths in Kingston and 128 child deaths in Richmond. These are still relatively small numbers and accordingly difficult to attach significance to. The panel is of the view that this is best looked at in future on a regional or national basis for a more meaningful picture. It should also be noted that the only recent available data for comparison is from 2011.

A national child mortality database has now been commissioned (it's understood this will be operational from 2019). It is anticipated that once in operation, this database will support further analysis of this nature. You can read more about this here:

https://www.hqip.org.uk/clinical-outcome-review-programmes/national-child-mortality-database/