Title of paper:	Child Death Overview Panel	
Report to:	Nottingham Children's Partnership Board	
Date:	26th January 2011	
Director(s)/Corporate Director(s):	Satinder Gautam	**Wards affected:** All
Contact Officer(s) and contact details:	Dr Liz Didcock, Consultant Paediatrician and CDOP Chair Hayley Frame, Child Death Manager, NCSCB	
Other officers who have provided input:		

Relevant Children and Young People's Plan (CYPP) objectives(s):	
Safeguarding and Early Intervention - Children, young people and families will benefit from early and effective support and protection to empower them to overcome difficulties	X
Strong families - More families will be strong and healthy, providing an enjoyable and safe place for children to grow up	
Healthy and positive children and young people - Children and young people will be healthier, fitter, more emotionally resilient and better able to make mature decisions	X
Achievement - All children and young people will leave school with the best skills and qualifications they can achieve and will be ready for work or further learning	
Economic well-being - Child poverty will be significantly reduced	

Summary of issues (including benefits to customers/service users):

The Child Death Overview Panel (CDOP) would wish to report annually to the Children's Partnership Board (CPB), and ask the CPB to note the findings of the child death review process and consider any implications for their agencies.

Recommendations:	
1	That the CDOP report to the CPB yearly
2	That the CPB note and promote the review of bed and breakfast accommodation to promote safe sleeping for infants
3	That the CPB note the public health campaign in respect of neonatal herpes simplex
4	That Senior Officers ensure that headlines from child death review are fed into relevant commissioning intentions in the future, to ensure that services commissioned are fit for purpose and improve safeguarding and quality across the partnership

1. BACKGROUND AND PROPOSALS
(Explanatory detail and background to the recommendations)

Since 1st April 2008, it has been a statutory requirement for all Local Safeguarding Children Boards to undertake a review of all deaths in childhood up to the age of 18 years occurring within the LSCB area. This is in accordance with "Working Together to Safeguard Children 2010" and Local Safeguarding Children Board regulation 6.
This function is completed via:

- Rapid Response to unexpected child deaths
- Child Death Overview Panel

Rapid Response to Unexpected Child Deaths

The purpose of this process is to ensure an early multi-agency response to all unexpected deaths of children in order to:

- understand the reasons for the child's death;
- address the possible needs of other children in the household and of all family members;
- identify those deaths that may be as a result of abuse or neglect and ensure an appropriate response;
- consider any lessons to be learned about how best to safeguard and promote the welfare of children in the future including consideration of any wider public health implications.

For the purposes of this procedure 'unexpected deaths' of children and young people are defined as " the death of a child that was not anticipated as a significant possibility for example 24hrs before the death, or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death."

Nottingham has a well resourced rapid response Consultant led health team, with a dedicated Lead Nurse post. There are robust working relationships with Police and Social Care following an unexpected child death. City PCT Commissioners receive an Annual Performance Report, and quarterly monitoring reports re both the rapid response and CDOP data.

Child Death Overview Panel

The purpose of the Child Death Overview Panel (CDOP) is to ensure that through a process of multidisciplinary review of child deaths, NCSCB will better understand how and why children in our local authority area die. By using the collective findings of child deaths in the local authority area, the CDOP will take action to prevent deaths and improve the health and safety of all children in our communities.

The CDOP primary functions are:

- to review all deaths of children normally resident within Nottingham City;
- to overview deaths of children not normally resident in Nottingham City but who die within the City boundary;
- to quality assure the Rapid Response Process in relation to unexpected deaths of children;
- to identify preventable deaths, where modifiable factors may have contributed to the death.
- collect and collate an agreed minimum data set of information on all deaths of children normally resident in Nottingham City. This will include deaths that occur abroad and in other local authorities
- identify significant risk factors and trends in individual child deaths and overall patterns of child deaths in Nottingham. This will include relevant environmental, social, health, cultural and service provision aspects of each death and any systematic or structural

factors affecting children's well being to ensure a thorough consideration of how such deaths might be prevented in the future.
- identify any public health issues and consider, with the Directors of Public Health, other provided services and commissioning bodies how best to address these and their implications for both provision of services and for training.
- inform work aimed at increasing public awareness of issues that affect the health and safety of children.
- monitor the information, support and assessment services offered to families of children who have died, by those professionals involved with the family.

All information considered by the CDOP is anonymised.

Parents and family members should be informed that their Child's death will be reviewed and will be provided with literature that explains the review process. Parents and family members should be assured that the objective of the review process is to learn lessons in order to improve the health, safety, and wellbeing of children, and ultimately to prevent future child deaths.

The DofE have published their annual figures following the statutory CDOP returns for the data collected during 2009/10. The national key findings are:

- 3,450 child death reviews were completed by Child Death Overview Panels (CDOPs) in the year ending 31 March 2010.
- Of the child death reviews completed in the year ending 31 March 2010, 150 were assessed as preventable.
- Each year there are approximately 5,000 child deaths registered in England, so approximately 10,000 children have died since the statutory responsibility to review child deaths was introduced on 01 April 2008. Approximately 57 per cent of these child deaths had their child death review completed by 31 March 2010.
- Voluntary data indicates that the majority of deaths which were assessed as preventable in the year ending 31 March 2010 were due to trauma and other external factors (54 per cent). And the most common event which resulted in the death being assessed as preventable was a road traffic accident (representing over a quarter of all preventable child deaths).
- CDOPs assess if a child's deaths was preventable, potentially preventable or not preventable and voluntary data indicates that 15 per cent of child deaths were assessed as potentially preventable in the year ending 31 March 2010 (i.e. there were modifiable factors extrinsic to the child). And the most common cause of death which was assessed as potentially preventable was sudden unexplained death in infancy (27 per cent).

Nottingham City Child Death Data Collection 2009/10:
Analysis of the data from 1/4/09 – 31/3/10 has shown that:

- Total number of child deaths: 39
- Total number of child deaths reviewed and ratified at CDOP: 39 (17 from 08/09 and 22 from 09/10)
- Total outstanding cases to be reviewed and ratified at CDOP: 17
- Preventability:
    - Preventable: 1 (2.5%)
    - Potentially Preventable: 7 (18%)
    - Not Preventable: 30 (77%)
    - Inadequate information to make a judgement : 1 (2.5%)
- Death Category:
    - 2 deaths as a result of deliberately inflicted injury or neglect (5%) – 1 death was preventable, 1 was potentially preventable.
    - 2 deaths as a result of trauma and other external factors (5%) – All of which were potentially preventable

    - 8 deaths as a result of chromosomal, genetic and congenital abnormalities (21%) – All of which were not preventable.
    - 18 deaths as a result of perinatal/neonatal events (46%) – All of which were not preventable.
    - 2 deaths as a result of sudden unexpected, unexplained death (5%) – All of which were potentially preventable.
- Age:
    - 56% of children were between 0 and 27 days old
    - 26% of children were between 28 and 364 days old
    - 5% of children were between 1 and 4 years old
    - 3% of children were between 5 and 9 years old
    - 10% of children were between 10 and 17 years old
- Gender:
    - 59% were male
    - 41% were female
- 1 child was subject of a child protection plan at the time of death. This child was also accommodated under S20 Children Act 1989 at the time of death.
- Ethnicity:
    - 54% of the children were white British
    - 13% of the children were Asian or Asian British Pakistani.

- Timescales:
    - 67% of deaths are reviewed and ratified at CDOP in under 6 months
    - 15% of deaths are reviewed and ratified at CDOP within 6-7 months

As the figures above show the majority of deaths are within the first 28 days, and mostly relate to prematurity. Infant deaths, those under 12 months, include a number of sudden unexpected deaths where the sleeping environment is a factor. We have had a small number of adolescent deaths including hanging.

Since April 1st 2010, there have been 19 deaths of children resident or ordinarily resident in Nottingham City and the CDOP has reviewed 6 of those deaths. The CDOP has also reviewed 11 deaths that occurred during 2009/10.

Learning from Child Deaths

The recommendations that lead to actions arising from the child deaths form the CDOP Action Log and evidence of completion of actions is required by CDOP. In complex cases, a sub group of the CDOP will be arranged to consider the evidence of the action taken following a child's death. This has recently taken the form of an audit Panel, to which the relevant agencies were invited to present their evidence, and proved to be a comprehensive and informative approach to auditing the implementation of the learning arsing from a child's death.

The recommendations made following a child's death are usually achievable within current service provision, and may relate to:

- improved staff training, e.g. the better recognition of a sick child
- the development of a guideline, e.g. management of a baby with hypothermia on a postnatal ward,
- a review of current arrangements, e.g. in a child with a life limiting illness, the review and adaptation of the assessment matrix in disability services for children with complex needs
- Some recommendations are interagency, and relate to safeguarding arrangements across the City. These are the responsibility of the LSCB and its sub groups. For example, the LSCB

will be launching a City/Countywide campaign to raise awareness of the dangers of shaking a baby (a leaflet has already been produced).

Other recommendations are broader, and are only achievable with cross City cooperation. It is these that CDOP requires assistance with from the CPB.

Suggested for Jan to June 2011 are:

- **a task and finish group to review all B and B/hostel accommodation across Nottingham to ensure there are safe sleeping arrangements for infants.**

- **a City/Countywide campaign, led by the Nottingham City Council Communications and Marketing section, to raise awareness of neonatal Herpes Simplex (the virus causing cold sores). HSV is an increasing cause of early neonatal deaths locally, and nationally.**

2. **RISKS**
   (Risk to the CYPP, risk involved in undertaking the activity and risk involved in not undertaking the activity)

   None

3. **FINANCIAL IMPLICATIONS**

   Financial implications of media/publicity campaigns recommended by CDOP

4. **LEGAL IMPLICATIONS**

   None

5. **CLIENT GROUP**
   (Groups of children, young people or carers who are being discussed in the report)

   Children age 0-18 years

6. **IMPACT ON EQUALITIES ISSUES**
   (A brief description on how many minority groups are being engaged in the proposal and how their needs are being met: This section includes traveller and refugee families. The themes of the Shadow Boards – children and young people; parents and carers; equalities issues and the voluntary and community sector should be considered here.

   None

7. **OUTCOMES AND PRIORITIES AFFECTED**
   (Briefly state which of the CYPP objectives and priorities will be affected)

   Safeguarding and Early Intervention
   Healthy and positive children and young people

8. **CONTACT DETAILS**

Hayley Frame , Child Death Manager , NCSCB, Loxley House, Tel 8764724

Dr Liz Didcock