



CHILD DEATH OVERVIEW PANEL (CDOP)

ANNUAL REPORT 2017-18

A review of the child deaths in the London
Borough of Barking and Dagenham

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Message from CDOP Chair

Welcome to the 2017/18 Child Death Overview Panel (CDOP) Barking and Dagenham Annual Report.

The process of reviewing child deaths was established in April 2008 has continued to develop over that time. Working Together 2015 sets a clear remit for the work of the CDOP and incorporates requirements from the Health and Social Care Act 2012. Nationally, the NHS has set out an ambition to halve the rates of stillbirths by 2030, with a 20% reduction by 2020. It is envisaged that the work of the Panel, as demonstrated in this report, will help improve outcomes for children and young people in Barking and Dagenham by continuing to identify areas for reducing the risk of preventable death.

The Children and Social Work Act 2017 requires significant changes to the processes and structures associated with safeguarding Children and Young People and especially child death review processes currently delivered by local CDOPs. We are now in a period transition and this report outlines the requirements of the new statutory system and identifies the key agenda areas, issues and timescales that need to be considered and decisions taken to enable local CDOPs to migrate to the new child death review working arrangements.

The CDOP Chairs of Barking and Dagenham, Havering and Redbridge have met to consider the new requirements and draw together options for their senior officer colleagues and Local Safeguarding Children Board (LSCB) to consider.

This report will provide information to our Local Safeguarding Children's Board to inform LSCB partners in respect of preventable child deaths and risk factors which impact on safeguarding children and young people. The LSCB will report on CDOP activity within the LSCB Annual Report to demonstrate on how we have made a difference to the lives of children and young people. The CDOP Annual Report is a powerful resource for driving public health action and promoting child safety and well-being.

Matthew Cole

Director of Public Health and Chair of Child Death Overview Panel
Barking and Dagenham

Chapter 1:

1. Introduction to Barking and Dagenham CDOP

The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

- (a) collecting and analysing information about each death with a view to identifying -
 - (i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);
 - (ii) any matters of concern affecting the safety and welfare of children in the area of the authority;
 - (iii) any wider public health or safety concerns arising from a particular death, or from a pattern of deaths in that area; and
- (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 death¹.

1.1 Terms of Reference

Through a comprehensive and multi-agency review of child deaths, CDOP aims to understand how and why children die in Barking and Dagenham (LBBD) and use the findings to take action to reduce the risks of future child deaths and to improve the health and safety of the children in the area.

The CDOP will gather and assess data on the deaths of all children from birth (excluding those babies who are stillborn) up to their 18th birthday who are normally resident in the area.

The reviews will include neonatal deaths, expected and unexpected deaths in infants and in older children.

Where a child normally resident in another borough, dies within our area, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident in LBBD, dies outside the area, the CDOP should be notified. In

¹ Working Together to safeguard Children: A Guide to inter-agency working to safeguard and promote the welfare of children (2015)

both cases, an agreement should be made as to how the two CDOPs will report to each other.

1.2 Core Membership

To ensure a multi-agency child death case review process is undertaken, the following members are selected for their fields of expertise within Public Health, Paediatrics and Child Health, Children’s Social Care, Child investigations, Nursing and General Practice.

The CDOP are also supported by a coordinator who acts as the Single Point of access (SPOC) for all notifications and communications.

Matthew Cole	Director of Public Health and CDOP Chair
Dr El-Hassan Magid	Designated Paediatrician for CDOP
Ann Graham	Operational Director, Children’s Care and Support
Paul Archer (P) Kate Byrne	Designated Nurse Safeguarding, BD CCG
Dr Junaid Solebo	Consultant Paediatrician & Named Doctor for Safeguarding Children & Young Adults. Barking Havering Redbridge University Hospitals NHS Trust
Kevin Jeffery Sean Treweek	Detective Inspector, Child Abuse Investigation Team, Metropolitan Police Service
Ruth Gardner	Safeguarding Paediatric Liaison Nurse, Barking Havering Redbridge University Hospitals NHS Trust
Dr Richard Burack	Named GP for Safeguarding
Liz Winnett	LSCB Business Manager & CDOP Co-ordinator.

Additional members are invited to the meeting, as required.

Following a decision at the end of the financial year 2015-16, the CDOP coordinator post was reduced from a full-time position, to part time. With effect from 1 April 2016, the BDSCB Business Manager has undertaken these duties in addition to a substantive post. This cover arrangement continues in 2017-18.

1.3 Definitions of child death categories

The following definitions are the areas CDOP will provide commentary on reviewed cases in this report.

- 1.3.1 **Neonatal death** is a death of a live born infant within the first 28 days of life. The CDOP review all registered live births. However, the CDOP will not review stillbirths and planned terminations.
- 1.3.2 **Sudden Unexpected Death in Infancy (SUDI)** is marked by the sudden death of an infant, under 2 years old. The death is unexpected by history and remains unexplained after a thorough forensic autopsy and detailed death scene investigation. Many of these deaths are from natural causes such as extreme premature birth and its complications, congenital anomalies, infection, and malignancy. Others relate to road traffic injuries. Only around 1% of such deaths can be directly attributed to abuse and neglect².
- 1.3.3 **Unexpected Death** is a death of an infant or child (up to but including 18 years old) which: was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death³. All notified unexpected deaths trigger the Rapid Response process.
- 1.3.4 **Expected Death** is an expected death defined as: a death where the patient's demise is anticipated as a significant possibility 24 hours before the death and plans have been put in place and the cause of death is known. There are no suspicious circumstances to suggest that anything untoward has occurred and the decision that death is expected will be clearly documented in clinical notes. This will be separate from a "do not resuscitate order".
- 1.3.5 **Modifiable factors** are where there are factors which 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 the risk of future child deaths.

² Royal College of Paediatrics and Child Health: <http://www.rcpch.ac.uk/news/new-guidelines-investigation-sudden-unexpected-death-infancy-launched>

³ HM Government, Working Together to Safeguard Children (2015)

Chapter 2: Overview of child death reviews

2.1 National Context

In 2015-16 HM Government, commissioned Alan Wood to undertake a review of Local Safeguarding Children Boards (LSCB) and Child Death Overview Panels (CDOP). Following Wood's recommendations, and numerous consultation periods, changes were proposed to the Children & Social Work Bill. These changes came into effect from 1 April 2017 when the Children and Social Work Act received Royal Assent.

Following Royal Assent, HM Government commenced a revision of Working Together to safeguard Children: A Guide to inter-agency working to safeguard and promote the welfare of children (2015).

A revised Child Death Review (CDR) guidance is still awaited. This guidance is currently being discussed in Parliament. It is expected the release date will be May/June 2018, following Parliamentary Elections.

2.2 Barking and Dagenham demographics

Approximately 208,200 people live in Barking and Dagenham, of whom around 61,800 are under the age of 18.⁴ Children therefore represent almost 30% of Barking and Dagenham's population, the highest proportion among all UK local authorities.

Barking and Dagenham also has the highest fertility rate in England and Wales, with 3,973 live births in 2016.⁵ This is a rate of 86.5 live births per 1,000 women aged 15–44; more than one in every twelve women in this age group had a baby in 2016.

The children and young people's population is projected to continue to grow.⁶ Between 2018 and 2023, the 0–19 population is estimated to increase by 11%, which is similar to the overall population increase projected for the borough (10%). Within this, the largest increase is estimated to come from the 15–19 age group, which is projected to increase by 25%.

⁴ Office for National Statistics (ONS) licensed under the Open Government Licence, 2016 mid-year estimates, revised March 2018.

⁵ ONS licensed under the Open Government Licence, Birth Summary Tables, England and Wales 2016.

⁶ Greater London Authority (GLA) interim 2015-based Borough Preferred Option (BPO) population projection, 2017.

Table 1: Population projections 2018 and 2023, Barking and Dagenham

	2018	2023	Difference (count)	Difference %
0–4	20,000	21,600	1,600	+7.8%
5–9	19,700	20,000	300	+1.6%
10–14	16,500	19,200	2,600	+15.8%
15–19	13,300	16,600	3,300	+24.7%
All 0–19	69,500	77,300	7,800	+11.2%

Note: Difference (as count and percentage) based on unrounded figures. Source: Greater London Authority (GLA) interim 2015-based Borough Preferred Option (BPO) population projection, 2017.

The borough is ethnically diverse; approximately 36% of the 0–17 population is White, 30% is Black, 23% is Asian, 9% is Mixed and 2% are from another ethnic background.⁷

Within this, White British is the single largest ethnic group (26%), followed by Black African (23%), Other White (10%), Bangladeshi (7%), and Pakistani (7%). In total, 64% of 0–17 year olds are from a Black and Minority Ethnic (BME) background, compared with 52% across Barking and Dagenham of all ages.

Barking and Dagenham is a deprived borough and ranks 11th highest in England and 4th in London for income deprivation affecting children.⁸

In 2014–16, the infant mortality rate (deaths in those aged less than 1 year per 1,000 live births) was 4.0 per 1,000 live births.⁹ The small numbers of deaths in this age group in Barking and Dagenham (46 deaths across 3 years, an average of 15 per year) means that the rate is vulnerable to the effects of chance. However, we can quantify this statistically by giving a range of values in which we expect the true rate to lie (in this case, between 3.0 per 1,000 and 5.4 per 1,000).¹⁰ For this reason, it is not straightforward to claim that Barking and Dagenham’s value (4.0 per 1,000) is higher than the national (3.9 per 1,000) or London (3.2 per 1,000) figures for the same period; however, a significance test would need to be performed to confirm that there is no significant difference.

⁷ GLA housing-led ethnic group projections, 2016 round © GLA, 2016-based demographic projections, 2017.

⁸ Income Deprivation Affecting Children Index (IDACI) - Average score, English indices of deprivation 2015, Department for Communities and Local Government.

⁹ Public Health Outcomes Framework [<https://fingertips.phe.org.uk/profile/public-health-outcomes-framework>].

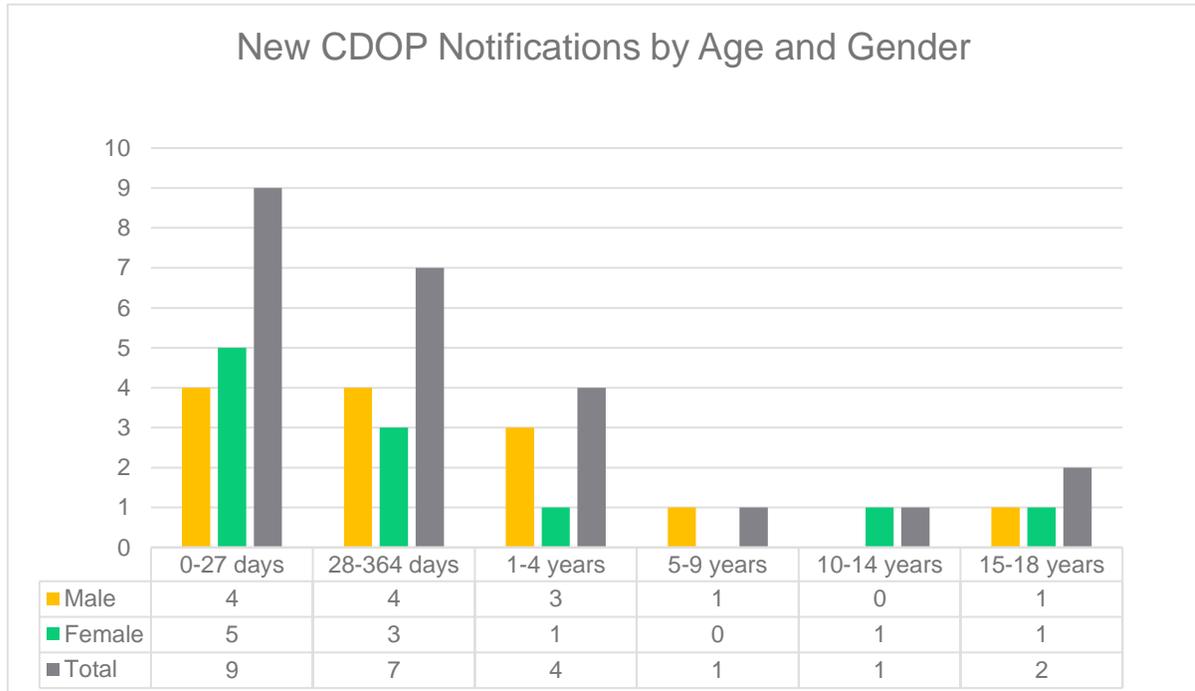
¹⁰ 95% confidence intervals.

2.3 Number of Child Deaths in LBBB.

During the period from 1 April 2017 through to 31 March 2018, Barking and Dagenham CDOP were notified of 24 deaths of children and young people.

The 24 new notifications received can be broken down further by gender: 54% Male (13) and 46% Female (11).

Diagram 1: Notifications broken down by Age and Gender



88% (21) of notifications were received in a timely manner (less than 5 working days), an increase from 81% in 2016-17. Three (3) notifications were received between 5-8 working days which is outside expected guidelines. On these three occasions, the CDOP Coordinator worked with agencies to ensure that these issues were resolved.

Timeliness of notifications continues to be monitored within 2018-19.

2.3.1 Expected and Unexpected deaths

The categorisation of expected child deaths in Barking and Dagenham, continues to follow the same trend as previous years and remains higher than Unexpected deaths.

It is expected that these categorisations are to be removed within the revised Child Death Review guidance, when released in May/June 2018, but we await confirmation of this.

A breakdown of information can be found in the table 2 below:

Table 2: Breakdown Expected and Unexpected Deaths over 5 years.

Financial Year	Expected Deaths	Unexpected Deaths	Percentage difference
2017/2018	16	8	50%
2016/2017	14	7	50%
2015/2016	16	4	25%
2014/2015	15	8	53%
2013/2014	17	10	58%

2.4 Number of meetings held

During 2017-18 the CDOP held quarterly panel meetings, all Chaired by the Director of Public Health:

- April 2017
- July 2017
- October 2017
- January 2018

Meetings were held at within Barking Town Hall. All meetings were scheduled for 2 hours. The PA support to the Director of Public Health facilitates the taking of minutes for the meeting. These are then circulated following agreement by the Chair and Designated Doctor.

Attendance levels by Panel members, or their representatives, are recorded in Table 3 below:

Table 3: Attendance levels by members to CDOP Panel 2017-18

CDOP Panel Member	Attendance %
Director of Public Health and CDOP Chair	100
Designated Paediatrician for CDOP	100
Children's Care and Support LBBD	100
Designated Nurse Safeguarding, BD CCG	75
Consultant Paediatrician for Safeguarding Children & Young Adults (BHRUT)	50
Detective Inspector, Child Abuse Investigation Team, Police	100
Safeguarding Paediatric Liaison Nurse (BHRUT)	25
Named GP for Safeguarding, BD CCG	25
CDOP Coordinator	100

It was identified that representation from Midwifery was a missing cohort from the membership of CDOP. Invites were extended to include the Named Midwife from October 2017 meeting onwards. It is hoped that with the appointment of a Named Midwife at BHRUT, attendance will be secured within 2018-19.

At each meeting, Panel members review details of each child death by accessing information captured within the National Template, Form C. Reviewing these forms, the Panel consider the categorisation of death; modifiable factors; learning points; and recommendations. Form C pulls together all information known on the child and family into one template. This is based on Form B information, provided by partners, and collated by the CDOP Coordinator. All forms are anonymized before being shared with Partners ahead of the meeting. This information is manually collated by the CDOP Coordinator, however once implemented, eCDOP will automatically collate this information.

Over the course of the four CDOP meetings, the Panel reviewed 26 cases. 96% (25) cases reviewed, were closed during this period, with the remaining one (1) case open, awaiting the outcome from Inquest.

Of these closed cases, one (1) case was from the period April 2015-March 2016, 12 cases were from April 2016 – March 2017 and 12 cases were from period April 2017 -March 2018. 12 cases remain open to CDOP at the end March 2018, one (1) from 2016-17 and the remaining were received within this reporting period.

It should be noted that deaths that have been notified to the Barking and Dagenham CDOP are not all reviewed and closed during the same year of notification. The Department of Education recognise it may take a number of months (or years in some

cases) to gather sufficient information to be able to fully review a child’s death. This can be due to criminal proceedings, autopsies, coroners’ reports, serious incidents (SIs) and serious case reviews (SCRs). Barking and Dagenham CDOP will await the conclusion of these investigations before a review is undertaken.

The following table (Table 4) provides a five-year breakdown of new notifications received by CDOP versus the number of cases in the same year. This shows numbers of new notifications to CDOP remain constant, with an average of 23 being received each year.

Table 4: Breakdown of new notification received

Financial Year	New notifications	Closed cases
2017- 2018	24	25
2016/2017	21	24
2015/2016	20	11
2014/2015	23	27
2013/2014	27	18

2.4.1 Rapid Response Meetings

A Rapid Response meeting is set up on behalf of the CDOP, when a notification for an unexpected death (see 1.3.3) has been received.

The Designated Doctor, following consultation with the lead clinician, is responsible for making the final decision on whether a death is unexpected.¹¹

Of the 24 new cases notified to CDOP, seven (7) Rapid Response meetings were held. All Rapid Response meetings were held within 5 working days of notification, across two Hospital settings. All meetings were held at the Hospital where the child had died. This enabled medical staff involved with the care of the child to attend and share information known. We did not hold a Rapid Response in relation to one case, as no suspicious circumstances were raised by any partner involved.

Rapid Response meeting venues are recorded in table 5 below:

¹¹ CDOP Rapid Response Procedure to Unexpected deaths

Table 5: Meeting venues for Rapid Response meetings 2017-18

Meeting venue	Number of meetings held
Newham General Hospital	1
Queens Hospital	6
Total	7

Following one case reviewed, the Rapid Response meeting recommended to the Safeguarding Children Board (LSCB) that the case be considered for a Serious Case or Practice Learning Review.

On reviewing the details of this case, the SCR panel agreed that this case did not meet the threshold for Serious case review, as detailed within Working Together 2015, however it was agreed that a Practice Learning Review would be commenced. An Independent Author to undertake this review was being commissioned at the point of writing this report.

2.5 Preventability/modifiable factors

As part of the robust reviewing of cases, CDOP are required to consider whether there are modifiable factors that could have contributed to the death of the child, thus reducing risks further in the future.

Of the 25 closed cases, only one case (4%) was identified as having modifiable factors. This case was also reviewed by the Safeguarding Children Board as part of their wider Serious Case Review (SCR) processes. Following publication, the SCR report was presented to the CDOP Panel, and recommendations were adopted.

It is expected that preventability or modifiable factors will no longer be reported with the revised Child Death Review guidance, however we await a fully ratified version in 2018-19.

Chapter 3: Child death statistics

This section provides a detailed breakdown and analysis of the 24 child deaths closed by Barking and Dagenham CDOP over the period April 2017 through to March 2018.

London recorded the highest rate of 137 offences involving a knife per 100,000 population in 2016/17, an increase of 20% from 2015/16¹².

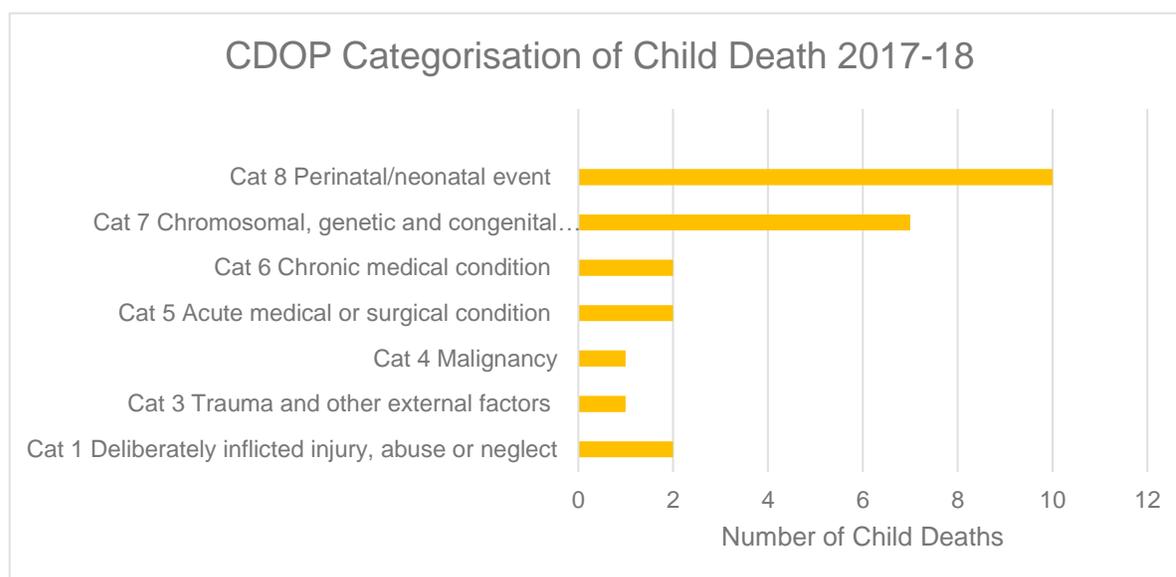
compared to 2015-16, Barking and Dagenham CDOP have only reviewed one.

3.1 Categorisation of Death

There are ten categories available to the CDOP to ascertain likely cause of death.

Diagram 1 below shows the number of cases closed to CDOP (25) over this reporting period, along with the category assigned to each closed case.

Diagram 1: CDOP Categorisation for closed cases during 2017-18



¹² <https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN04304>

3.1.1 Deliberately inflicted injury, abuse or neglect (Category 1)

Two cases reviewed by CDOP in 2017-18 were identified as Category 1. Both deaths were unexpected and notified to CDOP in 2016. One case referred in Q3, related to a 4 month old female, and one Q4 related to a 17 year old male.

Both deaths were referred to the Safeguarding Children Board for consideration of a Serious Case Review (SCR), by the CDOP Panel. Following review of the case by the SCR Panel, it was agreed that one case met threshold for SCR. The other case did not meet the threshold for serious case review.

During this time, criminal processes were running in parallel to the CDOP review in both cases. CDOP were unable to complete their review on either case until these processes had been resolved.

3.1.2 Trauma (Category 3).

This unexpected death was notified to CDOP in June 2017 in respect to an 8 year old boy. Following the conclusion of the Post Mortem, CDOP reviewed and closed this case.

Whilst it was clear that this death could not have been prevented, the Panel recommended that Health Partners, Education Health Care and Special Need School establishments, should be reminded to supervise Children when bathing.

3.1.3 Malignancy (Category 4).

CDOP reviewed one case within this category during 2017-18 in respect of a 14 year old female.

3.1.4 Acute Medical or surgical condition (Category 5)

Two (2) cases were closed and classified under Category 5 during this period. Both cases were notified within 2016-17, one within 28-364 day category, and one within age 1-4 years.

One case was an unexpected death, and the Rapid Response processes were implemented.

One death occurred overseas and therefore out of our jurisdiction. Liaison with the Foreign Commonwealth Office was commenced, however information shared was limited. Mother provided medical information and death certificate for the review.

The CDOP Panel recommended that GP communicate with Mother, to reiterate the need for surviving children to be immunised.

3.1.5 Chronic Medical Condition (Category 6)

Two cases (2) were reviewed by CDOP under this category. Both cases reviewed related to age cohort 1-4 years. In both cases, the young people had long term medical conditions, but sadly died of Respiratory failure.

3.1.6 Chromosomal, genetic, and congenital anomalies (Category 7)

There were seven (7) cases classified as Category 7, cause of death was attributed to Neonatal deaths in three (3) cases; three (3) cases attributed to Life Limiting conditions; and one (1) categorised as Other.

All cases were classified as Expected deaths.

Age range categories were 0-28 days (3), 28-364 days (3) and 5-8 years (1)

3.1.7 Neonatal Death (Category 8)

40% (10) of all cases reviewed and closed by CDOP were deaths classified as a 'Perinatal/Neonatal' event. These are deaths ultimately related to perinatal events e.g. prematurity. Congenital abnormalities can also be attributed to Neonates; however, these are classified within Category 7 above.

Six (6) of the ten (10) cases reviewed occurred within 24 hours of birth (0-28days), with the remaining cases occurring within first 30 – 90 days (28-364 days).

Neonatal deaths however continue to be the highest categorisation of deaths within Barking and Dagenham.

3.1.8 Expected Deaths

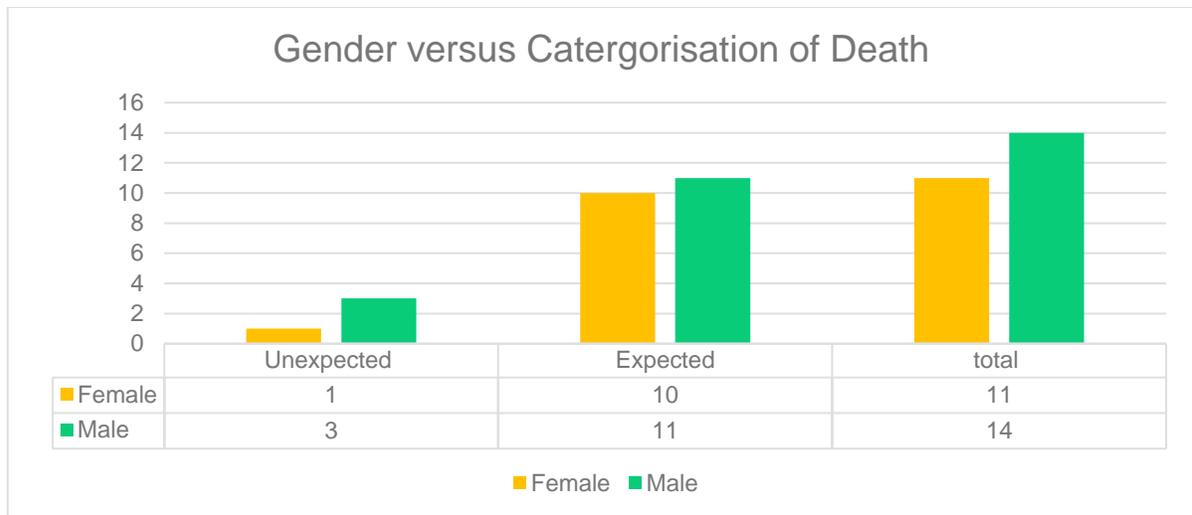
Of the 25 cases closed to CDOP during 2017-18, 21 were expected deaths (84%). Of these expected deaths, 13 (62%) were attributable to neonatal deaths.

3.1 Categorisation by Age and Gender

The following chart (Diagram 2) shows a breakdown of the 25 closed cases, split to show gender and categorisation of death, i.e. Expected or Unexpected.

The ratio of notifications for Male and Female is split 56% to 44% respectively. This is the first year that the Male cohort is higher than Female. There is no emerging theme currently, however this will continue to be monitored.

Diagram 2: Gender breakdown via categorisation



Age categories are reported within six age bands, as detailed within the chart (diagram 3) below.

Diagram 3: Gender breakdown by age

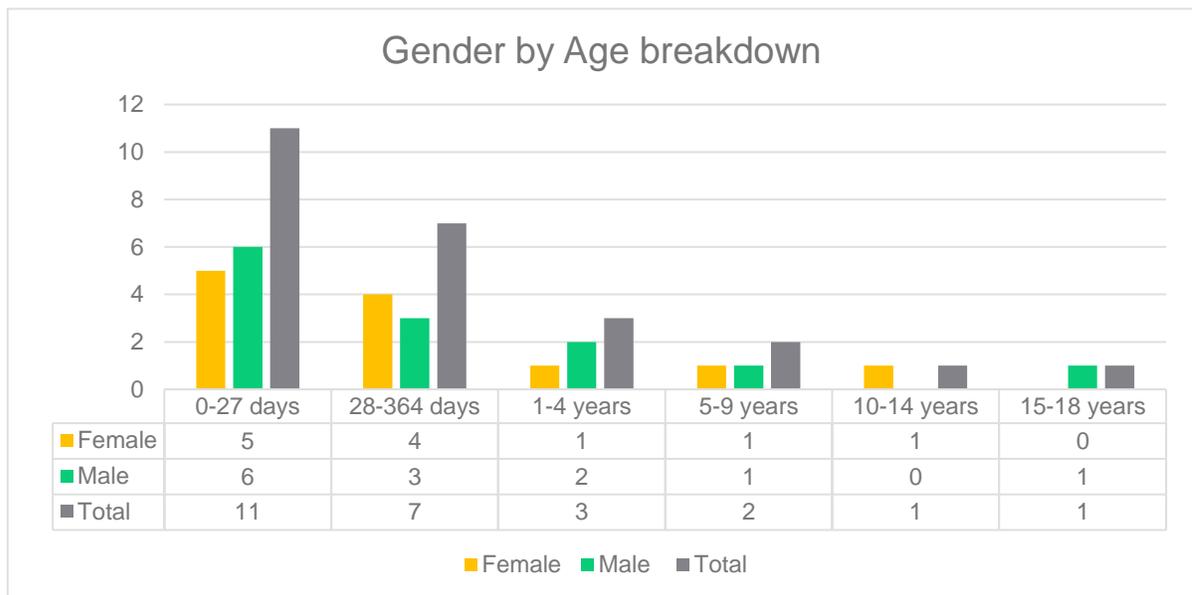


Diagram 3 above shows that neonatal age bracket (0-27days) remains the highest proportion of deaths (44%), which mirrors previous years reported figures. Children under the age of 1 year sadly represent 72% of total child deaths reviewed by CDOP over 2017-18.

Notifications across both genders follow the same trend as last year.

Overall numbers recorded within Barking and Dagenham CDOP continue to be low, making it difficult to perform a detailed analysis of any trends or themes occurring. As detailed within Section 2.1, a review of the CDOP is currently underway. These potential changes may address these issues in the future.

3.3 Breakdown by Ethnicity

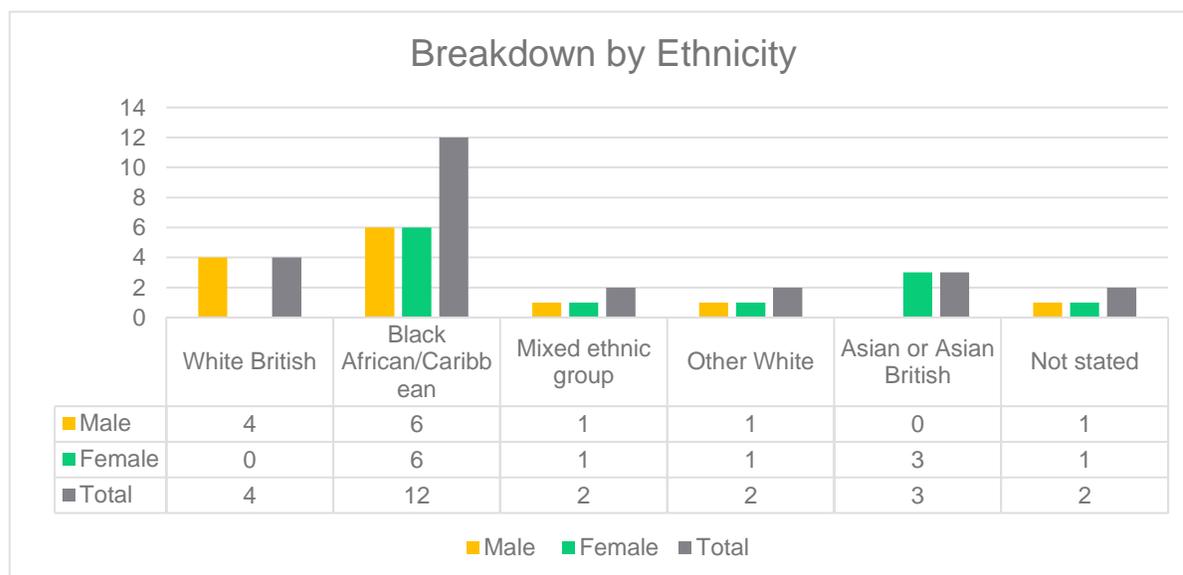
Diagram 4 details the ethnic breakdown of all the 25 cases reviewed by CDOP in 2017-18.

Child deaths within the Black African ethnic group continue to be highest cohort recorded. In 2017-18, there were 12 deaths reviewed (48%), six (6) male and six (6) female. This is a percentage point increase of 33% on figures recorded in 2016-17.

Black African is the second largest ethnic group within Barking and Dagenham at 23%, behind White British at 26%.

NICE are currently developing guidance to promoting health and preventing premature mortality in BAME groups, which is expected in May 2018.

Diagram 4: Breakdown of reviewed cases by Ethnicity

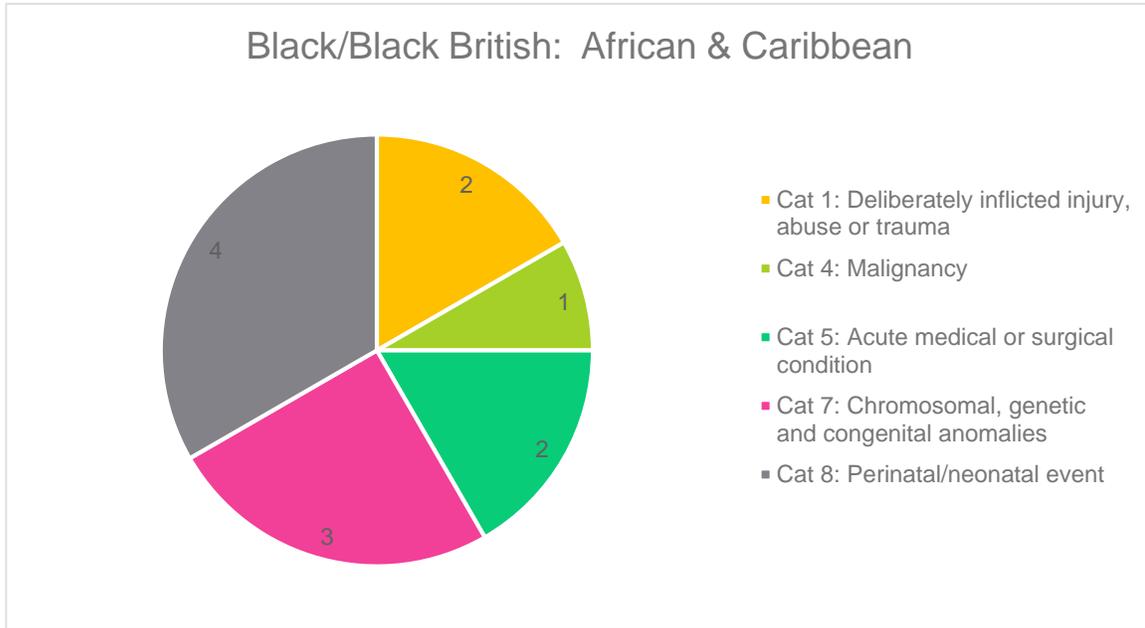


83% of children’s cases reviewed, who were identified as Black African (10), were aged between 0-4 years.

Barking and Dagenham CDOP continues to request and record pregnancy and maternity information so factors like late bookings, birth gestation, birth weight and any high-risk factors can be considered in the review.

Diagram 5 below details the breakdown of all reviewed Black African deaths by Category. The highest number of notifications received are within the Perinatal/Neonatal events.

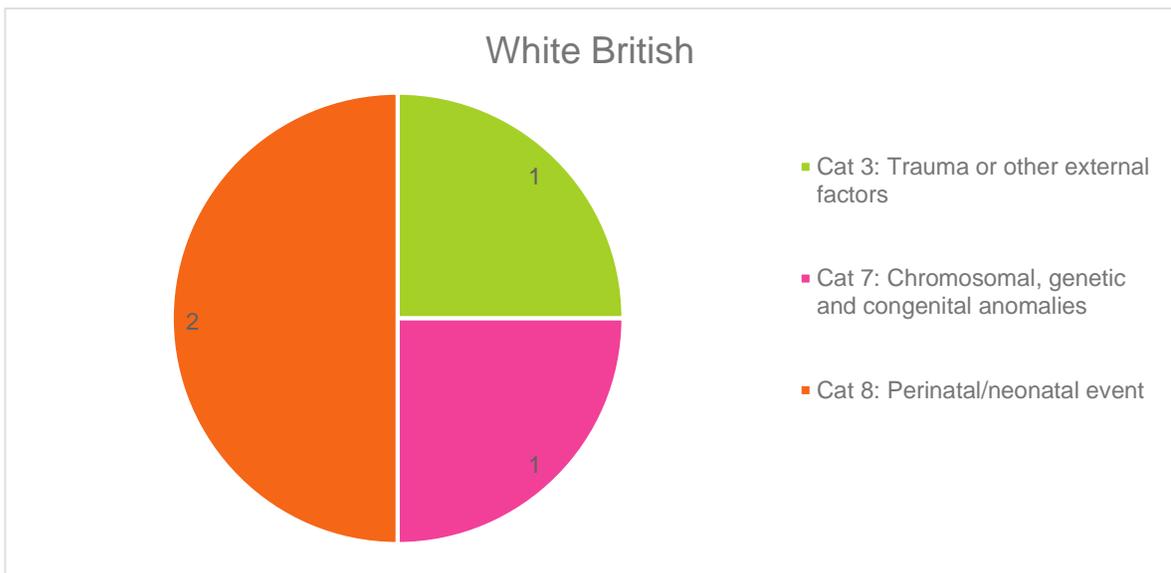
Diagram 5: Breakdown of Black African deaths



White British cohorts were next highest with 16% (4) each. This represents a small increase (one case) in White British child deaths on last year

Category breakdowns of each cohort are recorded within diagram 6.

Diagram 6: Breakdown of White British deaths



Increased recording of ethnicity continues to be an area for improvement. Some notifications are still being received with limited information recorded. Further investigation is then required to populate this field. On most occasions this information is obtained, however in 2017-18, two (2) cases were recorded as Not stated/Not known. This was an increase from last year's recording of one case.

Unfortunately, CDOP numbers are too small to be able to further analyse, however CDOP are committed to further analysing all deaths to use findings to inform change and reduce further risk to children.

3.4 Modifiable Factors

CDOP identified one (1) case (4%) with Modifiable factors during 2018-18, relating to an unexpected death.

This case was subject to a Serious Case Review, as detailed within 3.1.1. Whilst this child was not resident in this borough at the time of death, due to the information held in Barking and Dagenham, it was agreed that the CDOP would conduct the review, alongside the SCR being completed by the Safeguarding Children Board.

The Coroners Post Mortem report recorded the death as Head Injury.

Following completion of this review, an Overview report was published. CDOP adopted all recommendations listed within this report.

A copy of the full report can be found on the LSCB website - <http://newsite.bardag-lscb.co.uk/serious-case-review/>

Chapter 4: Learning outcomes, Networking, and Challenges

4.1 Learning outcomes

4.1.1 Local Learning:

CDOPs are required to review cases of child deaths and consider whether to make recommendations wider as detailed within Working Together 2015.

During the review of child death cases across 2017-18, recommendations for learning, or improved practice, have been highlighted by the Panel, and implemented by Partners. The table below details recommendations made.

Table 6: Learning recommendations

Reference Number	Learning points/recommendations/outcome
KG/16/238	<p>Stronger links with the Foreign Commonwealth Office (FCO) were raised as an issue. Following this case, information was discussed at various Healthy London Partnership events, and as part of the wider WT2018 consultations. Increased links and more detailed guidance are expected within the revised Child Death Review (CDR) processes, due for release in Summer 2018.</p> <p>The Child was also not fully immunised at Parents request. Recommendation from Panel was to write to GPs to gain assurance regarding surviving siblings health.</p>
KG/16/247	As detailed within 3.4
KG/17/260	It was acknowledged by Panel that this death could not have been prevented, however Panel felt a reminder should be circulated to all Health and Special Needs Educational establishments in borough, to remind Parents to supervise children whilst bathing.
KG/17/265	Panel recommended that BDCCG review this case, to assess Mother's care prior to child's birth. This sits outside of the CDOP Panel remit however this report will be shared with Panel.

Working relationships continue to strengthen between CDOP and the Coroner and her Officers. Bi-Annually meetings are facilitated by the Coroner for CDOP coordinators across the North East London network, to discuss any emerging issues.

All Regulation 28 notices from across the London network, continue to be shared with Barking and Dagenham CDOP, in order that lessons can be shared widely. No Regulation 28 notices have been issued in relation to Barking and Dagenham services within 2017-18.

4.1.2 Shared Learning

The wider sharing of lessons learned is an important part of the reviewing process. Networks with other CDOPs and National bodies continued to be strengthened in 2017-18, assisting this process.

Social Media continues to be an effective way to share safeguarding messages with professional and the wider public.

Healthy London Partnerships continue to facilitate sessions of learning across London CDOPs. The HLP are leading on the development of a new Bereavement guidance, which should be released in 2018-19. It is expected that this guidance will provide consistency of bereavement services being offered to families. More information on HLP is detailed in 4.2.2.

4.2 Wider Networking

4.2.1 North East London CDOPs

The North East London CDOP support group remains in place during 2017-18. Whilst it has not been possible to meet face to face during this time, electronic communications continue to provide support and guidance across the group,

4.2.2 Healthy London Partnership

The Healthy London Partnership (HLP), in conjunction with NHS England, set up various networking conferences over the course of the last 12 months to once again support the London Child Death Overview Panel Programme: *Understanding Asthma, preventing suicide, Understanding Youth Violence, SUDI workshops, Bereavement and Consanguinity* were some of the topics addressed in 2017-18.

HLP have been charged with reviewing the circumstances and contexts for the death of an infant or child and are contributing to shaping and strengthening services and resources. Information collected from these workshops are fed wider into NHS England and assist in shaping the new guidance, process and National proformas that are scheduled for release in 2018-19.

Around 200,000 children and young people in London receive treatment for Asthma. Every year 65,000 emergency admissions occur but 75% of these admissions are

preventable¹³. In order to increase children and young people's care and experiences when dealing with Asthma, HLP developed the London Asthma toolkit - <https://www.healthylondon.org/resource/london-asthma-toolkit/> which has been shared widely with partners. This toolkit is for use by practitioners, parents and carers across London and endorsed by the Royal College of General Practitioners (RCGP) and the Royal College of Physicians (RCP).

In conjunction with Lewisham CCG, the HLP are currently liaising with QES, to provide eCDOP to all 28 London Boroughs. Negotiations are ongoing, but it is envisaged that eCDOP will be implemented across all London CDOPs with effect from 1st April 2018.

4.2.3 National Network CDOPs

Barking and Dagenham CDOP continues to network outside its neighbouring boroughs and link with the National Network CDOPs (NNCDOP).

London CDOPs have been invited to the NNCDOP Annual Conference 2018

4.3 Challenges

Resourcing issues within the London Ambulance Service (LAS) has been noted as a challenge within 2017-18. Non attendance was recorded at three Rapid Response meetings. This issue was escalated to Panel for wider discussion. It was agreed that monitoring across all partners would continue, should non attendance from LAS continue to be an issue, the Chair will escalate.

Obtaining timely information from General Practitioners continues to be an issue to the CDOP process. The Panel continues to work closely with the Named GP to eradicate these issues as information held by GPs are vital to the reviewing process.

The local Registrar has a responsibility to inform CDOPs of all registered deaths under the age of 18 years at time of death.¹⁴ Whilst these links appear to be robust within other boroughs, this appears to be a weaker link within Barking and Dagenham. The SPOC will continue to liaise with the Registrar to receive timely updates.

Under Coroner (Investigations) Regulation 2013, Regulation 24(1)¹⁵ Coroners must notify LSCBs within 3-7 days if a Post Mortem or investigation is being undertaken. Notifications are not being routinely received within Barking and Dagenham. The SPOC will continue to raise these issues within the meeting with the Coronial Office.

¹³ Asthma UK (2014) Time to take action on asthma

¹⁴ Working Together to Safeguard Children 2015

¹⁵ <http://www.legislation.gov.uk/ukxi/2013/1629/part/7/made>

4.4 Outcomes and next steps

4.4.1 Implementation of recommendations from 2017-18

With the changing landscape for CDOP, following ratification of legislation, partners will make changes to ensure policies and processes are fit for purpose:

- During 2017-18, consultation events took place with CDOP Partners, to discuss the draft Child Death Review guidance. Revisions to guidance have been submitted to Government. Changes are due to be discussed within Parliament shortly, and it is envisaged agreed guidance will be released in May/June 2018. Amended process and procedure will be incorporated into priorities for 2018-19.

Consideration to be given to procuring an eCDOP IT system, following NHS Child Death Mortality Database being rolled out:

- The National Child Mortality Database (NCMD) went out for tender in 2017. It is expected that implementation of this database will not be until 2019-2020, at the earliest.
- As referenced within 4.2.2, Health funding has been secured to fund eCDOP for all 28 London Boroughs. This is currently in early stages, with HLP facilitating contracts and implementation, with QES, eCDOP Provider. Implementation date is set from 1st April 2018, and training is currently being arranged to support this. Assurance has been received from QES, that eCDOP will link with the NCMD once implemented.

Continue to improve engagement and involvement with key partners especially GP and Coroner services:

- Engagement with all partners continued within 2017-18. Barking and Dagenham CDOP has secured attendance from the Named GP, but also the Named Midwife BHRUT. Attendances from both will continue to enrich discussions at CDOP meeting going forward.
- Liaison with Coronial services continued to be strengthened over the year. CDOP coordinators meet on a regular basis with the Coroner's office, to discuss any issues being found. The Coroner also continues to provide Regulation 28s to CDOPs for additional learning, as detailed within 4.1.

Continue to disseminate key messages to the wider partnership and engage in networking events

- Wider learning from CDOP reviews, locally and nationally, are shared as they arise. Any learning from Regulation 28s continue to be shared with partners.

4.4.2 Key priorities and challenges for 2018-19

- Following ratification of Child Death Review (CDR) guidance, embed the revised processes and policy, in conjunction with CDR partners: Local Authority and Clinical Commissioning Groups (CCG)
- Continue to develop CDOP in line with CDR Guidance, looking towards a BHR footprint for a shared CDOP and shared learning, in whatever format that looks like.
- Following evaluation of QES eCDOP, secure funding to continue with an electronic system, if deemed appropriate