Camden Safeguarding Children Board

London Borough of Camden Child Death Overview Panel (CCDOP)

Annual report - 2013/2014

Contents

Executive Summary

In 2013/14 there were 12 deaths of Camden residents who were under 18 years of age: six female and six male. We are still awaiting the final report of one of these child deaths, which will be included in the next year's annual report.

The 3 were preventable deaths and the lessons learnt were as follows: -

Sudden Infant Death Syndrome (SIDS) - The baby who died from SIDS had 2 risks factors: - smoking and co sleeping and the existing recommendation is to avoid both as there is evidence that these factors lead to an increased risk of cot death. Health visitors should give sleeping advice to new mothers.

Neonatal pneumonia - There was a preventable death following neonatal pneumonia and the internal hospital review recommended more vigilance when neonates start to show signs of respiratory distress as this baby did. He rapidly became very ill and antibiotics were thought to have been given too late. Some stringent recommendations will be implemented in the hospital where he was born birth.

Head trauma at delivery - (full hospital report awaited). - In this preventable hospital death a review is currently taking place in order to identify areas that can be improved in the management of new-born babies. CDOP will report next year.

Nine were not preventable: -

- 1 was a very premature baby.
- 5 had very complex congenital problems incompatible with life.
- 3 children had known life-threatening diseases.

In 2012, a 15 year old girl committed suicide. The inquest into her death was opened in February 2013 and the full Coroner's report is awaited.

The Camden CDOP aims to continually learn from the tragic incidences of child deaths both in the borough and nationally. Our learning and achievements in 2013/14 include:

- Improved reporting from hospitals relating to the deaths of infants
- Reviewed and improved understanding regarding CDOP categorization methodology
- Every death of a child is a tragedy and a very difficult time for a parent. In 2013 /14 the CDOP reviewed support offered to parents who have lost a child. Improvements implemented meant that in 2013/14, 100% of parents in Camden whose children died received bereavement support
- Continued use and promotion of NICE fever guidelines.
- We have focused on cot safety and researched what information parents receive from manufacturers and health settings on this issue. We will continue this work and take forward actions and recommendations in 2014/15.
- Work and learning continued following the tragic death of TW including improving awareness of safeguarding issues with regard to social networking has resulted in relevant training being given and improving strategies with schools to notify and support children, friends and parents.

1. Introduction

This report concerns the activities of the Camden Child Death Overview Panel between April 2013 and April 2014. It is the fifth such report for the Camden LSCB *(Local Safeguarding Children's Board).*

2. Purpose of the Child Death Overview Panel and Statutory Duties

In April 2008 Child Death Overview Panels (CDOPs) became mandatory in England with every local authority required to have a CDOP and to produce an annual report for its Local Safeguarding Children Board (LSCB).

The overall aim of child death review processes is to understand why children die and to put in place interventions to help improve child safety and welfare and to prevent future deaths.

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 death.

Each death of a child is a tragedy and enquiries should keep an appropriate balance between forensic and medical requirements and supporting the family at a difficult time. Professionals supporting parents and family members should assure them that the objective of the child death review process is not to allocate blame, but to learn lessons.

3. Membership of the panel

Membership of Camden's Child Death Overview Panel (CCDOP) consists of the following core members:

- Chairperson - Dr Deborah Hodes – Named Doctor, Camden Provider Services, Central and North West London NHS Trust
- Deputy Chairperson - Dr Ben Lloyd, Consultant Paediatrician, Royal Free Hospital NHS Trust
- Single Point of Contact (SPOC)- Bodil Mlynarska, London Borough of Camden
- Designated Nurse for Safeguarding Children - Jackie Dyer, NCL Camden
- Bereavement Midwife – Lyn Gilbert, University College London Hospital
- Bereavement Services Manager – Rachel Cooke, Great Ormond Street Hospital
- Head of Camden and Islington CAIT team – DI Anthony McKeown, Metropolitan Police
- Public Health Strategist – Alison Wall, St. Pancras Hospital, NHS Camden
- Public Health – Jenny Gough, NHS Camden

When needed other relevant professionals are invited , such as the Coroner.

4. Identifying, managing and analysing Camden child deaths

4.1. Identifying Camden child deaths

A system for notification of all Camden child deaths has been in place since 1st April 2008. A cross-check with a list of child deaths from the registrar's office is made to ensure the fullest ascertainment of cases.

4.2. Managing and analysing Camden child deaths

The Camden Child Death Overview Panel Rapid Response Protocol, first written in 2008, was reviewed and updated in 2012.

Staff at the Hospital for Sick Children, Great Ormond Street, which admits children from all over the UK and internationally, have written their own procedures for managing unexpected child deaths.

We remain concerned that there is still no national analysis of child deaths in England. It is clearly a missed opportunity to share lessons learnt.

4.3 The recommendations made in the 2012/2013 work plan

- ***Recommendation:*** *Redouble our efforts to promote review of all deaths by the treating team which is currently not done in all hospitals or if it is done, is not always reported to us.*

  Action*:* We have received more reports on babies whose neonatal course have needed review and are keeping a close eye on this aspect of our work.

- ***Recommendation:*** *Improve categorisation of all child deaths.*

  Action: We consider that our categorisation of child deaths is now satisfactory. However there will always be somewhat border line cases in relation to whether there were modifiable factors or preventable factors.

- ***Recommendation:*** *Continue to monitor whether or not bereavement support services were offered*.

  Action: We can report 100% of families whose children died in 2013/14 had bereavement counselling.

- ***Recommendation:*** *Continue to monitor and implement the lessons can be learnt from all child deaths*.

  Action: We continue to do this and report to the Camden LSCB.

- ***Recommendation:*** *The accidental death of a 10 month old baby who fell from his cot was classified as preventable as the mattress was not lowered appropriately. As a result of this death, a project was carried out on behalf of CDOP by Dr Satar and Ms Tania Aly, supervised by Dr Hodes.*

  Action: The quality improvement question was to find out what parent information is given by:

  1. Manufactures on cot safety
  2. Child health settings in Camden on cot safety and general information and recommendations

on child safety at home.

A cot safety poster was produced and presented nationally at the British Association of Community Child Health (BAACH) annual scientific meeting in 2013. The poster outlined the following lessons.

1. Include advice on preventing falls from a cot within general advice on accident prevention.
2. Verbal advice and posters to show relationship between developmental stages and accidents for all primary care staff and in Children's centres.

This quality improvement project will be presented to the LCSB with a recommendation that they should advise on its dissemination. We also recommend that health settings continue to offer cot safety advise and that the Camden LSCB write to manufacturers to ensure they are providing information on cot safety with their products.

5. Camden child deaths between April 1st 2013 and March 31st 2014

5.1 Summary of the clinical course and causes of Camden child deaths between April 1st 2013 and March 31st 2014

There were 12 deaths.

C1. 10 weeks old baby who died from Patau Syndrome.

This death was not preventable.

C2. 30 weeks old baby with Down Syndrome who died from congenital heart disease.

This death was not preventable.

C3. 16 year old who died suffering from Cerebral Palsy, epilepsy and Microcephaly

This death was not preventable.

C4. 26 weeks old baby who had Lissencepahy and died from respiratory failure.

This death was not preventable.

C5. 25 weeks old baby who died from Meningococcal disease.

This death was not preventable

C6. 2 day old baby died from head trauma at delivery.

This death was preventable.

C7. 21 weeks gestation baby died on second day of life from complications of extreme prematurity.

This death was not preventable.

C8. 25 weeks gestation baby died with severe congenital anomalies.

This death was not preventable.

C9. 39 weeks gestation baby died from a pulmonary haemorrhage.
This death was preventable.

C10. 1 day old baby died from Thanatophoric dysplasia.
This death was not preventable.

C11. 17 weeks old baby who died at home from Sudden Infant Death Syndrome (SIDS)
This death was preventable.
There was a criminal investigation as drugs were found at the premises. Blood tests on the parents did not find any drugs or alcohol. Hence no criminal prosecution as parents were not under the influence of drugs or alcohol. The conclusion of SIDS is confirmed.

C12. 6 month old baby who died from Posterior Fossa Tumour.
This death was not preventable.

5.2 Categorisation of Camden child deaths between April 1st 2013 and March 31st 2014

5.2.1 Categorisation according to broad cause of death

	Name and description of category of lead cause of death	**n**	**Preventable (P), non – preventable (NP) potentially preventable (PP)**
1	Deliberately inflicted injury, abuse or neglect	0	
2	Suicide or deliberate self-inflicted harm	0	
3	Trauma and external factors	0	
4	Malignancy	1	NP – C12
5	Acute medical or surgical condition	0	
6	Chronic medical condition	0	
7	Chromosomal, genetic and congenital anomalies	6	NP – C1 NP – C2 NP – C3 NP – C4 NP – C8 NP – C10

8	Perinatal/neonatal event	3	P – C6 NP – C7 P – C9
9	Infection	1	NP – C5
10	Sudden unexpected, unexplained death	1	P – C11

5.2.3 Gender

There were 6 male and 6 female children.

5.2.4 Age

1st month of life (neonate): 5

1st Year of life (infant) – 1 month to 12 months: 5

Older than 12 months (child): 2

5.2.5 Ethnic breakdown (using the classification as given to CDOP)

White: English/Welsh/Scottish/Northern Irish/British	**5**
White: Irish	
White: Gypsy or Irish Traveller	**1**
White: Any Other White background	
Mixed: White & Black Caribbean	
Mixed: White & Black African	
Mixed: White & Asian	
Mixed: Any other mixed/multiple ethnic background	
Asian or Asian British: Indian	
Asian or Asian British: Pakistani	
Asian or Asian British: Bangladeshi	**4**
Asian or Asian British: Chinese	
Asian or Asian British: Any other Asian background	**1**
Black: Caribbean	
Black: African	**1**
Any other Black/African/Caribbean background	
Other: Arab	
Other: Any other	
Unknown/not stated	
Total:	**12**

5.2.6 Bereavement

Referral for counselling or a follow up appointment with the paediatrician team was documented in 12 of the 12 cases. This year we reviewed and monitored our bereavement offer and are satisfied there is a wide menu of available services, which reached 100% of families.

5.3 Bereavement services

The services that support the bereaved families originate from the hospital, police, coroner and health visitor. We have discussed this provision with a view to ensuring that all parents are offered the service and there is documentation in the records that this has been done.

6. Further update on TW.

As a response to the death of TW there were five extraordinary meetings of the panel and external agencies in October 2012, December 2012, April 2013, November 2013 and January 2014.

As a consequence of these meetings good inter agency links were created. The school in particular felt very supported and sought much help from the members. The CCG (Camden Commissioning Group) supported the family's requests for counselling outside the borough.

The Coroner's final report is still outstanding and as such the CDOP cannot determine whether the death was 'preventable' however following the Coroner's interim report and the CDOPs assessment to date which included the Tavistock clinic's own review these were the issues of concern, lessons learnt and the actions that followed.

6.1 Issues of concern, lessons learnt and actions

1. Increased awareness amongst Camden professionals on the use of internet sites by young people. This led to the implementation of multiagency training for health, social care and education on this matter.

2. The importance of a school strategy to support and inform parents and their children following such a traumatic event.

3. The importance of drafting a statement for the press that had a consistent message across all agencies. This was achieved by good communications across all agencies: - social care, health, police and education.

4. The final meeting discussed the importance of having a gagging order around the inquest, particularly as TW was under 18 years of age and the information would adversely affect other young people.

5. British Transport Police (BTP) did attend the CDOP meetings and shared information. They analysed the social networking sites that TW used but they did not support the suggestion that the Lucy Faithfull Foundation should also analyse TW's use of social networking sites.

7. Further discussion of the deaths and their preventability

7.1 Non preventable deaths

The majority of child deaths in Camden in 2013/14 were not preventable, being from chromosomal, genetic disease and congenital abnormalities or complications of these conditions.

The rapid response meeting and a further meeting following a death from meningococcal disease generated much discussion. A detailed report from Harmoni the GP out of hours service satisfied the group that the NICE fever guidelines had been followed. It was reasonable (with current guidelines) that she was not sent up to hospital. In summary the CDOP concluded that it was a difficult case which was managed appropriately. It was a most unfortunate death for which no more preventative steps could have been taken.

7.2 Preventable deaths and local action

The baby who died from SIDS had 2 risks factors: - smoking and co sleeping and the existing recommendation is to avoid both as there is evidence that these factors lead to an increased risk of cot death. Health visitors should continue to give sleeping advice to new mothers.

There was a preventable death following neonatal pneumonia and the internal hospital review recommended more vigilance when neonates start to show signs of respiratory distress as this baby did. He rapidly became very ill and antibiotics were thought to have been given too late. Some stringent recommendations will be implemented in the hospital where he was born birth.

In the third preventable hospital death a review is currently taking place in order to identify areas that can be improved in the management of new-born babies. CDOP will report next year.

8. Future activity and recommendations

Areas of focus for the Camden CDOP in 2014-2015 include:

- Strengthen membership by inviting the Coroner to one CDOP meeting a year, Public Health to Chair CDOP as recommended and inviting a neonatologist to one meeting a year.
- Take forward the recommendations regarding cot safety and monitor improvements
- Continue to focus on awareness regarding social networking sites (with the CSCB e-Safety Sub-Group)
- Progress outstanding child death reviews