

**HARINGEY CHILD DEATH
OVERVIEW PANEL**

ANNUAL REPORT 2008/09

Chair's Introduction

This report marks the culmination of the first year that Haringey's Child Death Review Panel has been operating, as part of the substructure of the Local Safeguarding Children Board. Because of this, the statistics contained in the report are not measured against any data from previous years and the conclusions are not comparative. This does not make them any less interesting or the review process less important.

The more we understand how and why children die, the better equipped we will be, through learning, to influence and potentially reduce the numbers of child deaths in the future. The information gathered from reviews of the way children die is also be useful in the identification of any trends or patterns that may be occurring in particular areas of the borough. Although these trends will only be come evident in time, this report provides a very useful benchmark.

Eleanor Brazil
Deputy Director, Children & Families
Chair, Haringey Child Death Review Panel

1. The Context

- 1.1 It has been a legal requirement since April 2008¹ for the circumstances surrounding the death of any child resident in the borough to be reviewed. This is in order to identify:
- Any case that indicates a need to consider a Serious Case Review;
 - Any concerns about the safety and welfare of children in the local area; and
 - Any wider public health or safety concerns arising from a particular death or pattern of deaths in the area.
- 1.2 The requirement applies to children aged between 0 and 18 years. It is the responsibility of Local Safeguarding Children Boards (LSCBs) to ensure that the requirement is carried out.
- 1.3 Introduced at the same time was an obligation to put in place a process for ensuring a coordinated and rapid response to any unexpected death.

2. Local Arrangements

- 2.1 Haringey's Local Safeguarding Children Board established a Child Death Overview Panel (CDOP) in March 2008, having agreed terms of reference for the Panel in January. Terms of reference are attached to this report as Appendix 1.
- 2.2 The CDOP is a multi-agency Panel and meets quarterly. Standing membership is currently:

¹ Local Safeguarding Children Boards Regulations 2006, 6(1)

- Eleanor Brazil, Deputy Director Children's Social Care (Chair)
- Dr David Elliman, Great Ormond Street Hospital, Designated Doctor for Child Death
- Jin Lim, Assistant Director, Public Health
- Suzanne Dale, Named Nurse NHS Haringey
- Jo Carroll, Named Nurse Whittington Hospital
- Detective Inspector Noel McHugh, Police Child Abuse Investigation Team
- Sarah Peel, LSCB Manager and Single Point of Contact for child death
- Donna Jones, LSCB Child Death Administrator

2.3 Information about children and the circumstances in which they died is presented to the Panel in reports required from any agency that had been involved with the child and family. The CDOP also considers the outcome of post-mortems and information gathered in Confidential Enquiry into Maternal and Child Health (CEMACH) reports, in coming to a collective view has to whether or not the child's death might have been preventable.

2.4 It is the job of the CDOP to consider all reports, in order to be clear about:

- What caused the child's death;
- Whether there was an appropriate response from agencies if the death was unexpected;
- Whether there is any public health risk;
- What kind of support was offered to the child's family;
- What, if anything, might have prevented the child's death?

- 2.5 The CDOP produced two leaflets in September 2008 – one for families and one for professionals – in order to provide information about the process of child death review.
- 2.6 In November 2008 Haringey CDOP agreed to sign up to the London Safeguarding Children Board Child Death Overview Panel Procedure.

3. Regional Arrangements

- 3.1 Haringey is a member of the North Sector CDOP, with Barnet, Camden, Enfield and Islington. More complex cases are referred to this regional forum to benefit from a completely independent overview. Meetings were held and attended by Haringey representatives in May and July 2008 and in March 2009.

4. Summary of the work of the Panel, 2008 - 2009

- 4.1 Haringey's Child Death Overview Panel met four times between March 2008 and April 2009, in March, June, October and February. The meeting in March was a planning meeting, to test readiness to begin operating from April as required by legislation. There have therefore been three meetings over the financial year at which cases were reviewed.
- 4.2 25 Haringey children died between April 2008 and March 2009. The CDOP reviewed 19 of these within the same timescale². However there is enough information available to draw conclusions on all, although in the light of fuller information that may become available, some conclusions

² The CDOP generally allows 3 months between the date of death and the review of the case.

may need revision. It should also be borne in mind that this covers one year and the numbers are small. As the data accumulates, more definite patterns may emerge with more robust conclusions being possible.

General Features of Cases

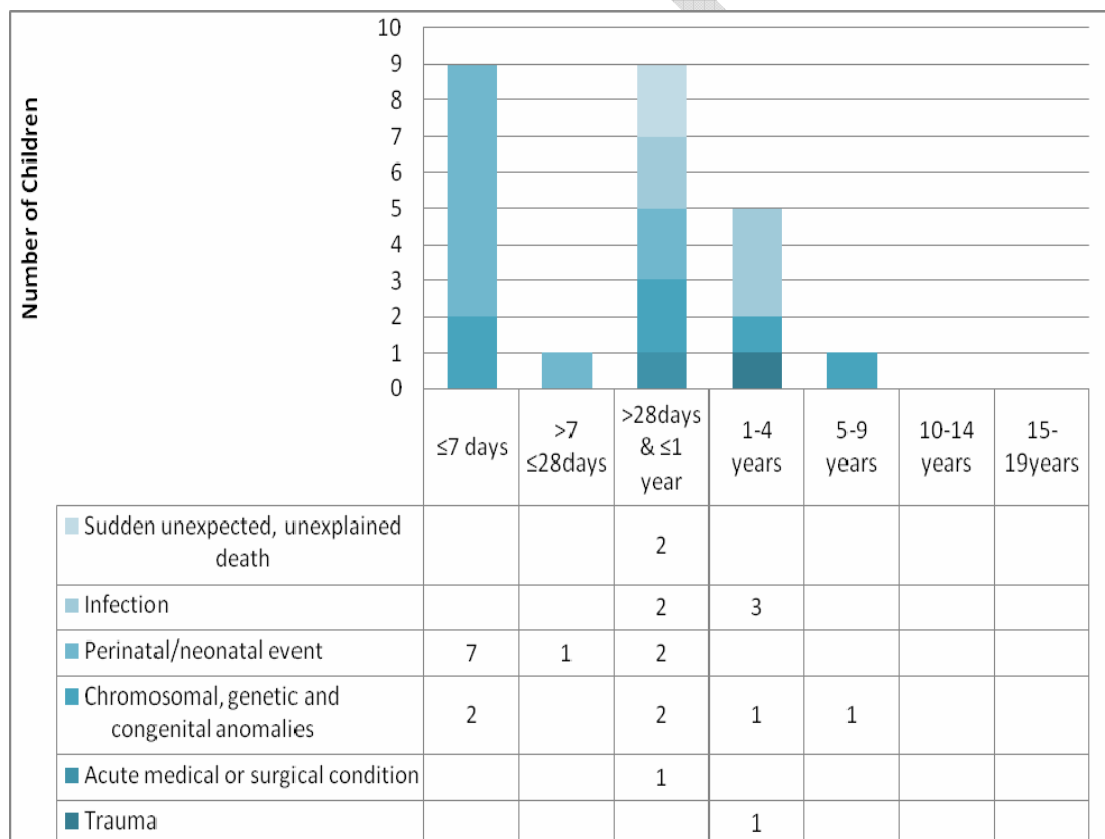
- 4.3 There were 13 boys and 12 girls. Nine were less than one week old, ten less than 28 days (40%), 19 less than one year old and only six older. There were no teenage deaths. CEMACH also found 40% of cases dying at or before 28 days.
- 4.4 Based on a birth rate of 4026 (2005 figures), the neonatal and infant mortality rates are 2.5 and 4.7/1,000 live births, respectively. The neonatal death rate in 2005 was 5.2 compared to 3.8 in 2003 and the infant mortality was 7.7 per 1,000 live births up from 5.4 in 2003. This fluctuation is due to the small numbers involved.
- 4.5 As would be expected, the overwhelming number of deaths were related to perinatal or congenital factors (see over and Appendix 2 for definitions).

Cause of Death	Number of children
Deliberately inflicted injury, abuse or neglect	0
Suicide or deliberate self-inflicted harm .	0
Trauma and other external factors	1
Malignancy	0
Acute medical or surgical condition	1
Chronic medical condition .	0

Chromosomal, genetic and congenital anomalies	6
Perinatal/neonatal event	10
Infection	5
Sudden unexpected, unexplained death	2

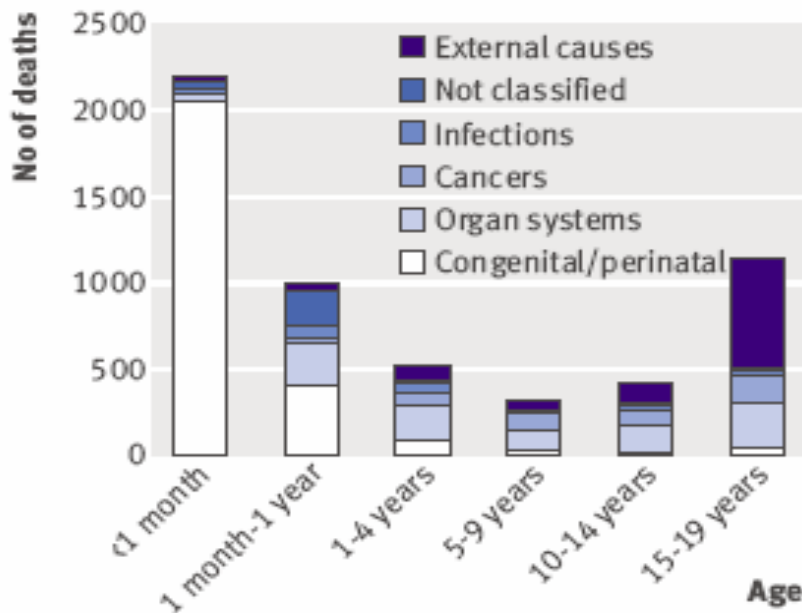
4.6 Age at Death and Classification of Cause

As would be expected, the majority of deaths in those under a week old were due to perinatal events (8/10) and the remainder due to congenital anomalies. In older children, other disorders become commoner, however the oldest child to die, did so from a genetic disorder. Below is the experience in Haringey for the period in question.



4.7 Causes and age at death in Haringey Children 2008-9

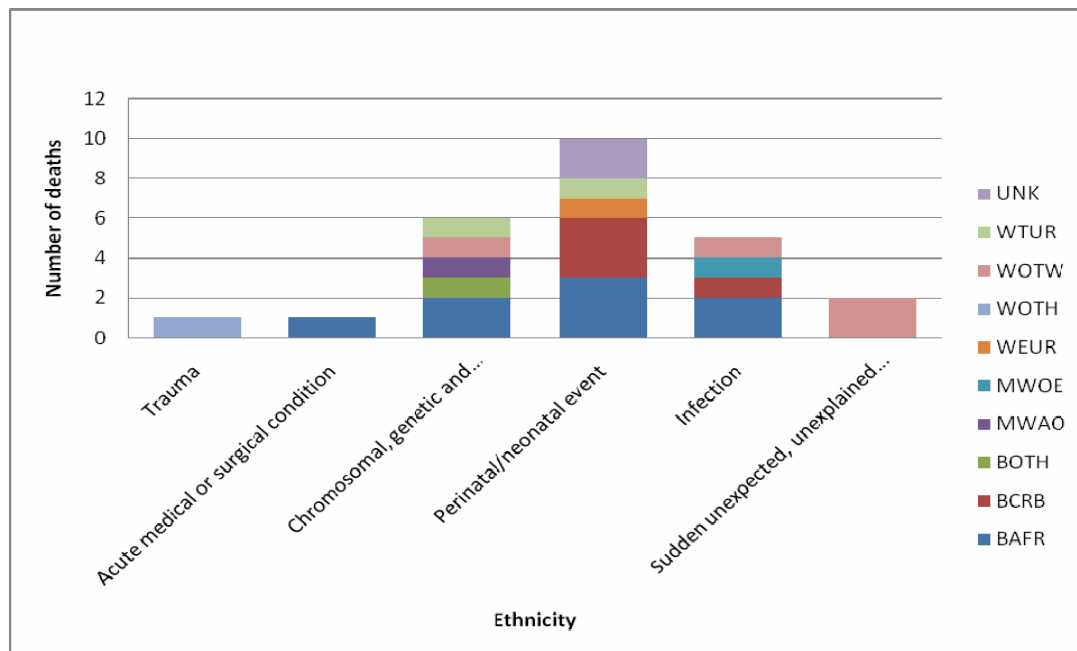
For comparison below is data from 2004 for England and Wales. The absence of deaths in children over 10 in Haringey is probably a statistical quirk.



Child Deaths, England and Wales 2004. (Sidebotham P, Pearson G. Child deaths: how to respond and what can we learn. *BMJ* 2009; 338: 575-6.)

4.8 Cause of Death and Ethnicity

In the 2001 census, of the 0 - 15 year olds, 51.5% were white, 10.3% were Black Caribbean and 15.4%. This contrasts with the deaths we report, of which 8/21 (38%) were Black African, 4/21 (19%) were Black Caribbean and only 8/21 (38%) were white. In the CEMACH study of Child Deaths there were disproportionately high death rates in Black African and Pakistani children, but not in Black Caribbean children.



Ethnicity and cause of death (For Key, see Appendix 3)

4.9 Potentially avoidable factors

4.10 In one case of sudden unexpected death in infancy, the environment in which the baby slept was very hot. This may have contributed to the death as it is a well known factor in SUDI. Information about prone sleeping and environmental temperature is given to all mothers, but increased efforts should be made to ensure that they fully understand its importance.

4.11 At the inquest of the death of a two year in a road traffic accident outside a children and young person's centre, the coroner made some recommendations in relation to road layout. These included further barriers along the stretch of road directly outside the community centre, double yellow lines preventing vehicles from parking along that stretch of road and a recommendation that the speed limit be reduced to 20 mph.

5. Recommendations from reviews

- 5.1 Advice to new mothers on the avoidance of cot deaths should be strengthened and reinforced at all opportunities.

- 5.2 Road safety measures outside centres attended by children should be reviewed.

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Appendix 1: CDOP Terms of Reference

Child Death Overview Panel Terms of Reference

Purpose

Through a comprehensive and multidisciplinary review of child deaths, the Haringey Child Death Overview Panel (CDOP) aims to better understand how and why children between the ages of 0-18 years in Haringey die and use our findings to take action to prevent other deaths and improve the health and safety of our children.

In carrying out activities to pursue this purpose, the CDOP will meet the functions set out in paragraph 7.4 of *Working Together to Safeguard Children* in relation to the deaths of any children normally resident in Haringey; namely collecting and analysing information about each death with a view to identifying –

- (i) any case giving rise to the need for a Serious Case Review
- (ii) any matters of concern affecting the safety and welfare of children in Haringey
- (iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in Haringey

Objectives

1. To ensure, in consultation with the local Coroner, that local procedures and protocols are developed, implemented and monitored, in line with the guidance in Chapter 7 of *Working Together* on enquiring into unexpected deaths.
2. To ensure the accurate identification and consistent reporting of the cause and manner of every child death.
3. To collect and collate an agreed minimum dataset of information on all child deaths in Haringey and, where relevant, to seek additional information from professionals and family members.

4. To evaluate data on the deaths of all children normally resident in Haringey, thereby identifying lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children.
5. To evaluate specific cases in depth, where necessary to learn lessons or identify issues of concern.
6. To identify significant risk factors and trends in individual child deaths and in the overall patterns of deaths in Haringey, including relevant environmental, social, health and cultural aspects of each death, and any systemic or structural factors affecting children's well-being to ensure a thorough consideration of how such deaths might be prevented in the future.
7. To identify any public health issues and consider, with the Director(s) of Public Health and other provider services how best to address these and their implications for both the provision of services and for training.
8. To identify and advocate for needed changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.
9. To increase public awareness and advocacy for the issues that affect the health and safety of children
10. Where concerns of a criminal or child protection nature are identified, to ensure that the police and coroner are aware and to inform them of any specific new information that may influence their inquiries; to notify the Chair of the LSCB of those concerns and advise the Chair on the need for further enquiries under section 47 of the Children Act, or of the need for a Serious Case Review
11. To improve agency responses to child deaths through monitoring the appropriateness of the response of professionals to each unexpected death of a child, reviewing the reports produced by the rapid response team and providing the professionals concerned with feedback on their work.

12. To provide relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family
13. To monitor the support and assessment services offered to families of children who have died
14. To monitor and advise the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths
15. To co-operate with any regional and national initiatives – the Confidential Enquiry into Maternal and Child Health (CEMACH) – in order to identify lessons on the prevention of child deaths.

Scope

The CDOP will gather and assess data on the deaths of all children and young people from birth (excluding those babies who are stillborn) up to the age of 18 years who are normally resident in Haringey. This will include neonatal deaths, expected and unexpected deaths in infants and in older children. Where a child normally resident in another area dies within Haringey, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident in Haringey dies outside Haringey the Haringey CDOP should be notified. In both cases an agreement should be made as to which CDOP (normally that of the child's area of residence) will review the child's death and how they will report to the other.

Team Membership

The Child Death Overview Panel will have a permanent core membership drawn from the key organisations represented on the LSCB. Other members may be co-opted to contribute to the discussion of certain types of death when they occur.

Confidentiality and Information Sharing

Information discussed at the CDOP meetings will not be anonymised prior to the meeting, it is therefore essential that all members adhere to strict guidelines on confidentiality and information sharing. Information is being

shared in the public interest for the purposes set out in Working Together and is bound by legislation on data protection.

CDOP members will all be required to sign a confidentiality agreement before participating in the CDOP. Any ad-hoc or co-opted members and observers will also be required to sign the confidentiality agreement. At each meeting of the CDOP all participants will be required to sign an attendance sheet, confirming that they have understood and signed the confidentiality agreement.

Any reports, minutes and recommendations arising from the CDOP will be fully anonymised and steps taken to ensure that no personal information can be identified.

Accountability and Reporting arrangements

The CDOP will be accountable to Haringey Local Safeguarding Children Board.

The Child Death Overview Panel is responsible for developing its work plan, which should be approved by the LSCB. It will prepare an annual report for the LSCB, which is responsible for publishing relevant, anonymised information.

The LSCB takes responsibility for disseminating the lessons to be learnt to all relevant organisations, ensures that relevant findings inform the Children and Young People's Plan and acts on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.

The LSCB will supply data regularly on every child death as required by the Department for Children, Schools and Families to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.

Appendix 2: Categorisation of Cause of Death

Category	Name and description of category
1	Deliberately inflicted injury, abuse or neglect This includes suffocation, shaking injury, knifing, shooting, poisoning & 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 & other extrinsic factors. Excludes deliberately inflicted injury (category 1)
4	Malignancy Solid tumours, leukaemias & 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 Eg. Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy
6	Chronic Medical Condition Eg. 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-peri-natal 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, eg 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)

Appendix 3: Classification of Ethnicity of Child

BAFR	Black African
BCRB	Black Caribbean
BOTH	Any Other Black
MWAO	White & Any Other Asian Background
MWOE	White & Any Other
UNK	Unknown
WEUR	White European
WOTH	Any Other White Background
WOTW	White Other
WTUR	Turkish/ Turkish Cypriot

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