Croydon
Child Death Overview Panel

Seventh Annual Report 2014/2015

Contents

Tables

Figures

1 Introduction

Welcome to the seventh annual report of the Croydon Child Death Overview Panel (CDOP) which sets out the activities of the CDOP from 1st April 2014 – 31st March 2015.

The aim of this report is to provide a summary of the work of the CDOP during 2014/2015. The numbers in this report refer to the child deaths that have been reviewed within this time period.

Recommendations and learning points from the overview of deaths are provided within this report to which the CSCB (Croydon Safeguarding Children Board) has a responsibility to respond and take action; ensuring that they are included in future education and interventions that could help prevent future child deaths, or improve the safety and welfare of children within the borough.

Due to the small numbers of child deaths reviewed, associations and significance cannot be applied to the findings. Details may also be omitted as these would breach confidentiality.

2 Background

Each child death is a sad and serious event but fortunately, it is rare for children to die in this country.

The primary function of the CDOP is to undertake a local review of all child deaths under the age of 18 (excluding stillbirths and terminations of pregnancy carried out within the law). This process is undertaken locally for all children who are normally resident in Croydon. The deaths reviewed by the panel are not about allocating blame; it is about learning and putting in actions in place to prevent future deaths. Working Together to Safeguard Children [1]was revised in March 2015 however, the responsibilities of the child death overview process remains unchanged.

The CDOP has specific functions laid down by statutory guidance:

- Meet regularly to review the available information on all child deaths to determine whether the death was preventable.
- Collecting, collating and reporting on an agreed national data set for each child who has died.
- Identify lessons to be learnt or issues of concern relating to the safety and welfare of children in Croydon
- Make recommendations to the CSCB regarding any deaths where the panel considers there may be grounds for a serious case review
- Monitoring the support services offered to bereaved families

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf accessed 29.10.15

- Identify any trends that can be analysed and deliver interventions in response
- Report any immediate concerns to the CSCB that require a co-ordinated response to ensure the safety and well-being of all children in Croydon

See Appendix 1 for CDOP Terms of Reference.

3 Organisation for Croydon CDOP

3.1 The Process

The death of each child is notified to the Child Death Review Co-ordinator (CDRC) who is also the SPOC (Single Point of Contact) via a telephone call or other verbal/electronic means; this is followed with "Form A" giving initial details about the death. The designated paediatrician will then consider whether the death was unexpected and if deemed to be so, will initiate a rapid response.

See Appendix 2 for Rapid Response Meeting Terms of Reference.

For all children who die, whether expectedly or unexpectedly, an information gathering process is initiated. The completion of "Form B" (data collection form) is requested from all agencies and services involved in the death in order to provide as full a picture as possible of the circumstances directly and indirectly leading to the death.

Whilst using information from a number of existing forms and sources e.g. neonatal unit summary/ discharge summary, hospital death summary, police forms, post mortems and rapid response meeting minutes has helped to improve the available information. In addition, this year a number of the form B's have been reviewed to be agency specific to encourage completion, however, a number of on-going difficulties still remain in obtaining a completed Form B from some of the agencies.

CDOP meetings are convened regularly at which the review of a child death will be included if the information gathered is felt to be as complete as expected and where relevant a post mortem, coroner's report and rapid response meeting report, have been returned.

The CDOP core members are invited to attend every meeting; invites to additional agency representatives are made where the panel feel this would be essential or advantageous for the review of a case.

The CDOP discuss each case and, using "Form C" (Analysis Proforma) and the discussions are recorded based on the information provided in the Form B and other supporting documentation, to give an overview of the findings of the case.

Data from Form C is entered onto a spreadsheet to support analysis of the data, points of interest for the CSCB and to inform this report.

Any identified learning and recommendations from the case reviews are communicated to the agencies involved, setting out the concerns and requesting feedback from the agency to confirm what actions have been/are being taken to address the concerns.

3.2 Panel Meetings

During 2014/2015, CDOP met seven times to review anonymous information about child deaths. The panel is chaired by Public Health with members from relevant agencies.

The CDOP has a fixed core membership of experts drawn from the key organisations represented on the Croydon Safeguarding Children Board who should be present at each meeting. Other members are co-opted to contribute to the discussion of certain types of death when they occur.

Table 1: Panel member attendance at CDOP meetings 2014/2015

Child Death Overview Panel Attendance							
	2014					2015	
	12th May 2014	23rd June 2014	21st July 2014	29 Sept 2014	24th Nov 2014	26 Jan 2015	9 Mar 2015
Public Health (Chair)	✓	✓	✓	✓	✓	✓	✓
Designated Doctor for CP & Child Death review process	✓	✓	✓	✓	✓	✓	✓
Designated Nurse for Child Protection CCG	✓	✓	✓	✓	✓	✓	✓
Named Midwife for Safeguarding	✓	×	×	✓	✓	✓	×
Named Nurse for Child Protection	×	✓	✓	✓	✓	✓	×
CSCB Child Death Review Co-ordinator	✓	✓	✓	✓	×	✓	✓
QA Manager (LADO) (Deputy Chair)	×	✓	✓	✓	×	✓	×
CSCB Manager	×	×	×	✓	✓	×	✓
Child Abuse Investigation Team Police CAIT	×	×	×	✓	×	✓	✓
CSCB Administrator					✓	✓	✓
Deputy Designated Nurse for CP CCG (Observer)				✓			

3.3 Administration

The administration of the CDOP process is amalgamated with the Rapid Response Meetings and is hosted within Croydon Health Services whilst being funded by CSCB through the contributions of partner organisations.

3.4 Representation

To ensure local, pan London and national co-ordination of, and input into, the CDOP processes, the CDOP Chair provides Croydon representation through local membership on the CSCB, the CSCB Executive Group and Health sub-groups and attendance at the London CDOP Chairs' meetings. In addition, there is now increased partnership working with SPOCs in South West London to improve meaningful data collection and share learning.

4 Definitions and categories of child death

4.1 Neonatal Death

The death of a child under 28 days of age, including premature births but excluding stillbirths.

4.2 Sudden Unexpected Death in Infancy (SUDI)

The sudden death of an infant under one year that is unexpected by medical history and remains unexplained after a thorough post mortem examination and a detailed death scene investigation [(then referred to as Sudden Infant Death Syndrome (SIDS)].

4.3 Expected Deaths

An expected death is that which was anticipated 24 hours before the death.

4.4 Unexpected Deaths

The death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility 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.[2]

4.5 Modifiable death

A modifiable death is defined as where there are factors which may have contributed to the death. These factors are identified as those which by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

5 National Picture

According to the Department of Education[3], the number of deaths of children registered in England has continued to decline, with just over 4000 child deaths a year. The majority of these deaths were due to perinatal/ neonatal or perinatal events and chromosomal, genetic and congenital anomalies.

Nationally in 2014/2015, 24% of all child deaths reviewed (827) reviews were identified as having modifiable factors; this is an increase from 20% in 2011.

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[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf accessed 28.10.15

[3] https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2015 accessed 28.10.15

In the year ending 31 March 2015, deaths in an acute hospital had a lower percentage of modifiable factors (19%) than deaths in other locations. Whilst the number of child deaths in other locations, are relatively small, modifiable factors were identified in 43% of the cases.

6 Local Picture

6.1 Number of deaths in CDOP area

Between April 2014 and March 2015 there were 30 deaths to children resident in Croydon. This is a decrease from 37 deaths in 2013/2014.

Table 2: Child deaths, Croydon residents and cases reviewed 2010/2011 – 2014/2015

	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015
Child deaths	39	28	34	37	30
Cases reviewed	39	30	24	36	33

Thirty-three cases were reviewed and of these, 14 were children who died in 2013, 19 were children who died in 2014.

For this time period there were 13 cases awaiting review, 9 of these, for children who died in 2014 and 4 cases for children who died in 2015.

6.2 Time from death of the child to CDOP review

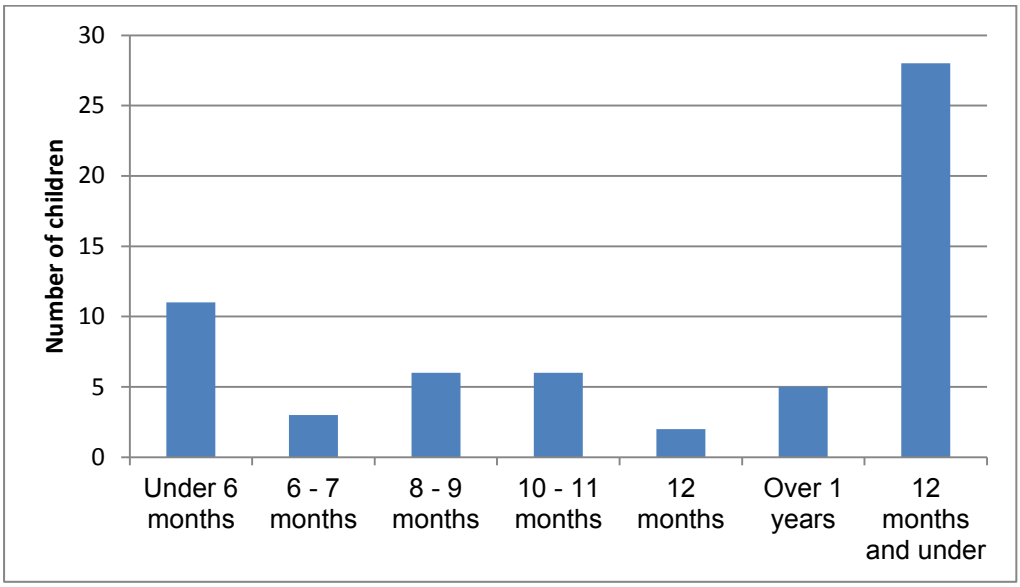
11 cases were reviewed within the first 6 months following the death, 17 in the period 6-12 months and 5 after one year of the death.

During 2014/2015 as part of the CSCB dashboard, an indicator in line with Department for Education annual data collection, was set to work towards achieving 40% of case reviews by 6 months; this is not seen as a performance indicator as there is often a time lag between a death and the review whilst all relevant information needed for the review is gathered.

The various reasons for the delays are:

- slow returns of Form Bs (data collection forms)
- time taken for the post mortem or coroner's autopsy reports to be released
- awaiting the findings of criminal proceedings or Serious Case Reviews (SCR)
- where the panel requested further information

Figure 1: Length of time to complete reviews 2014/2015



(source: Croydon Child Death Overview Panel data)

In 2014/2015, whilst numbers are small, 33% of cases were reviewed by six months, an increase from 25% in 2013/2014; just over 84% were reviewed within 12 months following the death of the child.

6.3 Neonatal Deaths

Similar to the national picture, a large proportion of all neonatal deaths are accountable to maternal and neonatal factors; 13 (39.3%) of all deaths were to babies less than 28 days of age. Eight of these babies were born prematurely (<37 completed weeks' gestation), and three of these babies were born at 26 weeks' or less gestation.

Out of the neonatal deaths, there were six females and seven males.

6.4 Expected and Unexpected Deaths

19 of the 33 child deaths reviewed could have been expected 24 hours before they occurred and the majority of these (13) were in children under 1 year of age. Seven of the fourteen unexpected deaths occurred in children under one year of age.

Figure 2: Expected and unexpected child deaths reviewed by age, 2014/2015 (Figure removed for disclosure control and replaced with a table)

	Expected	Unexpected
less than 28 days	**10**	**3**
28 - 364 days	**3**	**4**
1 - 4 years	**4**	**<3**
5 - 9 years	**<3**	**<3**
10 - 14 years	**<3**	**<3**
15 - 17 years	**<3**	**3**

(source: Croydon Child Death Overview Panel data)

6.5 Sudden Unexpected Deaths in Infancy (SUDI)

There were four cases reviewed where "sudden unexpected deaths in infancy" was classified by the post mortem as sudden infant death syndrome. All the infants were male; none of them were born premature. Three of the mothers were under 21 years of age and were amongst the most deprived. Whilst there were no modifiable factors identified, factors that were present in one or all the cases that may or may not have contributed to the death were smoking, housing, domestic violence and co-sleeping.

6.6 Modifiable factors

Of the 14 unexpected deaths, three were identified as having modifiable factors.

6.7 Serious Case Reviews

None of the children whose deaths were reviewed in this period were the subject of a SCR.

6.8 Age and gender

As expected, most of the deaths reviewed were to infants under one year of age: n= 20 (60.6%).

Figure 3: Child deaths reviewed by age 2014/2015 (Figure removed for disclosure control and replaced with a table)

Age at death	Number of children
0-27 days	**13**
28-364 days	**7**
1-4 years	**6**
5-9 years	**<3**
10-14 years	**<3**
15-17 years	**4**

(source: Croydon Child Death Overview Panel data)

Table 3: Child deaths reviewed in 2014/2015 by gender and age

Age at death	Female (n)	Male (n)	Total (n)
<28 days	6	7	13
28 days - <1 year	<3	5	7
1 - 4 years	<3	5	6
5 - 9 years	<3	<3	<3
10 – 14 years	<3	<3	<3
15 - 17 years	<3	3	4

(source: Croydon Child Death Overview Panel data)

During 2014/15, twice the number of males to females died in the cases reviewed.

6.9 Ethnicity

Table 4 removed for disclosure control.

Table 5 shows that the Black and Asian Minority Ethnic (BAME) population represented 39.4% of the children 0-17 years who died compared to 44.5% in 2014/2015. This is below the GLA ethnic group population projections for 2014[4] that show that 61.06% of Croydon's population aged 0-17 years are from BAME groups. Compared with 2012/2013, there has been a percentage increase in mixed and white ethnic groups.

Table 5: Child deaths reviewed by ethnicity 2014/2015

Ethnicity	2012/2013 (%)	2013/2014 (%)	2014/2015 (%)
White	20.8	27.8	45.5
Mixed	8.3	25.0	6.0
Asian	29.2	13.9	24.2
Black	33.3	30.6	15.2
Other	8.3	2.8	9.1

6.10 Cause of death

The majority of reviewed deaths aged under one year, were due to perinatal or neonatal events including prematurity and/or hypoxia at birth and chromosomal, genetic and congenital abnormalities. Of the deaths to children over 1 year, most were related to existing long term conditions.

Figure 4: Child deaths reviewed by CDOP in 2014/15, by cause and child age (Figure removed for disclosure control)

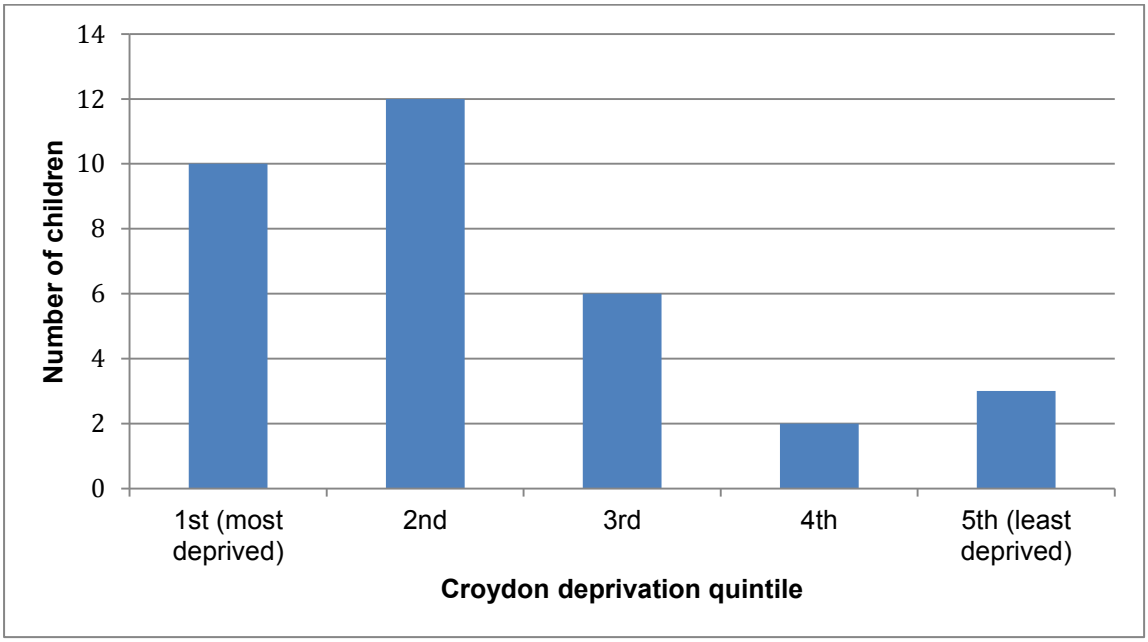
[4] 2014 Round Ethnic Group Projections - SHLAA Final © Greater London Authority, 2015

6.11 Deprivation

The index of multiple deprivation (IMD) is a method of ranking areas according to their level of deprivation by combining different indicators into a single score. It is calculated by combining different scores on a range of indicators relating to income, employment, health, education, housing and access to services. The most deprived fifth (quintile) of the population is described as “quintile 1” and the least deprived quintile is described as “quintile 5”

As seen in Figure 5, there are a greater number of children whose deaths were reviewed were subject to increased levels of deprivation. No neonates reviewed were in the least deprived quintile.

Figure 5: Child deaths reviewed by CDOP in 2014/15, by Croydon deprivation quintile



(source: Croydon Child Death Overview Panel data)

The greater proportion of children living within the lower IMD may be due to differences in factors affecting the determinants of health: personal, social, economic and environmental conditions or it may partly reflect the over representation of children within the most deprived population quintiles

6.12 Place of death

Figure 6: Child deaths reviewed by CDOP in 2014/15, by place of death (Figure removed for disclosure control)

As would be expected the majority of children died in hospital, often following an event or deteriorating condition that took place at home. This reflects the high proportion of child deaths which were neonatal deaths and are likely to be children who have not left hospital since their birth.

6.13 Location at the time of event or condition

Most of the events leading to the deaths occurred in hospital, the majority in babies aged under 0-27days and all were expected.

Table 6: Location at time of event or condition cases reviewed 2014/2015 (Table amended for disclosure control)

Location at time of event or condition	Under 28 days		Over 28 days	
	Expected	Unexpected	Expected	Unexpected
	(%)	(%)	(%)	(%)
Hospital	66.6	0.0	33.3	0.0
Home	0.0	27.3	27.3	45.4

(source: Croydon Child Death Overview Panel data)

33.3% of events where the deaths were unexpected, occurred in the home. The majority of these being due to chromosomal, genetic and congenital anomalies, and sudden unexpected, or unexplained deaths.

6.14 Asylum Seekers

The reviews indicated that no deaths occurred in children seeking asylum.

6.15 Post mortem examinations

Of the 33 deaths, 17 had a post mortem carried out.

6.16 Child Protection

Of the children whose deaths were reviewed in this period none were subject to a current or previous child protection plan.

7 Rapid Response

The arrangements for a rapid response to the death of a child and review are well established in Croydon.

There were 12 deaths between 1st April 2014 and 31st March 2015 for which a rapid response meeting was held.

Following last year's review of the rapid response terms of reference, it was agreed that RR meetings will be considered as a priority and be convened within 5 working days where possible, of the child's death.

The majority of the rapid response meetings were convened within 5 working days, 58%; 75% of these were convened in six days and the remainder were convened between 7 and 11 working days.

A log of the rapid responses is maintained and reported to the CDOP meetings.

See Appendices 3 and 4 for the rapid response agenda and process.

8 Bereavement services for families

A bereavement midwife Croydon University Hospital (CUH) supports families whose babies die whilst receiving care in the neonatal unit.

The updated CSCB CDOP bereavement leaflet that provides information about specific sources of support and advice which is given to all parents at the earliest appropriate opportunity after the child's death, was disseminated in April 2014.

9 Directly standardised mortality rates

Table 7 provides comparative information about the directly standardised mortality rates of children aged 1 – 17 years in the London Boroughs which are deemed to be statistically close to Croydon. As deaths of children are rare it is more appropriate to provide rates for a number of years rather than on an annual basis. The rates for 2010-2012 and 2011-2013 have remained static.

Table 7: Comparison of directly standardised mortality rate per 100,000 children aged 1-17 years, 2010-2012, 2011-2013

Local Authority	2010 – 2012		2011-2013	
	Count	Rate	Count	Rate
England	-	12.5	-	11.9
London	-	13.7	-	12.2
Croydon	30	11.3	31	11.4
Enfield	27	12.0	31	13.7
Greenwich	24	13.9	22	11.9
Merton	23	18.5	18	14.1
Redbridge	20	9.9	18	8.5
Waltham Forest	27	14.9	25	13.9

Source: Child Health Profiles for Local Authorities, ChiMat 2015

10 Risk Factors

During this year, the database was updated to record risk factors where they may have contributed to the death, or provide a sufficient explanation for the death. Each case might have had one or a number of risk factors (Table 8).

Table 8: Risk factors – contribution to death

Risk factor	May have contributed to death	Provided a complete and sufficient explanation for the death
Acute/ Sudden onset illness	1	6
Asthma	0	1
Epilepsy	2	1
Other Chronic illness	1	4
Learning Disabilities	1	0
Motor Impairment	1	1
Sensory Impairment	1	1
Other disability or impairment	1	1
Allergies	1	0
Alcohol/substance misuse by child	0	1
Emotional/behavioural/mental health condition in a parent/carer	1	0
Alcohol/substance misuse by a parent/carer	1	0
Smoking by parent/carer in household	3	0
Smoking by mother during pregnancy	3	0
Housing	2	0
Domestic Violence	2	0
Co-Sleeping	2	0
Gang/ knife crime	0	1
Consanguinity	1	0
Poor Parenting/supervision	0	1

(source: Croydon Child Death Overview Panel data)

The most common risk factors identified are Acute/Sudden onset of Illness, Epilepsy, Other Chronic illnesses and Smoking.

11 Summary of child deaths review 2014/2015

- 33 Child death reviews were completed by the CDOP
- 13 cases are outstanding awaiting review
- 58% of the rapid response meetings were convened within 5 working days
- 33% of cases were reviewed by 6 months
- 39.3% of cases reviewed are of children under 28 days
- 60.6% of cases reviewed are of children under 1 year
- 19 child deaths could have been expected.
- Four Sudden Unexpected Deaths in Infancy

- Twice the number of males to females died in the cases reviewed.
- Three cases were identified as having modifiable factors
- 39% of child deaths reviewed were from Black and Minority Ethnic groups
- Most of the deaths in those children under one year were due to perinatal/neonatal events and chromosomal ,genetic and congenital anomalies
- The most deprived geographical areas in Croydon have the highest number of child deaths.
- The most common risk factors noted were Acute/sudden onset of Illness, Epilepsy, Other Chronic illnesses and Smoking.
- There were no SCRs

12 Issues identified

- Croydon CDOP requested and received reassurance about fetal anomaly screening and detection rates as part of the national screening programmes**.**
- SUDI number of cases – agreed this would be included in the 2008-2015 analysis attached to this report

12.1 Learning points

- Discussion was had regarding the need for a greater awareness of pushchair safety

- It was noted that it would be helpful if medication requirements requested by a consultant for a patient this should be highlighted at the beginning of any correspondence with the GP.

12.2 Good practice

The CDOP have agreed that good practice should be acknowledged at each review and summarised in the annual report to ensure positive sharing and learning within Croydon's agencies.

For 2014/2015 the CDOP acknowledged:

- The excellent support to a family where agencies worked supportively together through effective communication and the parents chose to stay at the hospice as they felt well supported.

- Health Visitor was very thorough in her care with this family.

- The family were well supported by the family services at Royal Brompton Hospital. The family were from Eastern Europe and translators were provided for all conversations regarding planning of treatment. The family were to be invited to the Annual Paediatric Remembrance Service at the hospital held each year in October.

13 Feedback on outstanding issues from previous report 2013/2014

There were no outstanding issues from the previous report 2013/2014.

14 CDOP network England and London

Croydon CDOP was alerted to:

- the use of baby slings. Further information was obtained which was disseminated to midwives, health visitors and Children Centres.
- Information on encountering dangerous dogs; this information was disseminated to midwives, health visitors and Children Centres and made available on the CSCB website
- Croydon CDOP supported a letter to the DfE highlighting the difficulties that occur in obtaining information when a child dies abroad
- Child safety update - child drowning and use of bath seats: Advice for Children and Young People (CYP) stakeholders published by ROSPA in conjunction with PHE was disseminated

15 Actions completed for 2014/2015

- arrangements for cover for annual leave and days off for the SPOC/ Child Death Review Co-ordinator
- CDOP Annual Report and 2008-2015 analysis completed
- Statutory child death data returns for Department of Education submitted
- Partial completion of the revision of Agency Specific Form Bs (data collection form)
- CDOP child death database data quality review and transfer of six years written records to electronic database
- Visit to Coroner's office to increase partnership working, understand processes and support timely return of information

16 Actions for 2015/16

Action
From 2014.2015 annual report and 2008-2015 analysis, develop action plan to address the emerging issues.
Complete the revision and piloting of Form B for remaining agencies to ensure that agencies understand and are able to complete the forms to support achieving CSCB performance indicator.
Statutory child death data returns for Department of Education
Review Terms of Reference for both CDOP and RR meetings
Continue to build on partnership working to improve data collection and shared learning
Attendance at London CDOP Chairs meetings to encourage partnership working and learning
Monitor CSCB dashboard indicator; develop actions to mitigate risks
Observe other CDOPs in sector to improve learning of how other panels function
Look at how CDOP can increase awareness of issues identified at panel to

support improving child outcomes
Review and distribute Croydon Bereavement Leaflet to ensure that parents receive the correct information following the death of their child. Ensure alignment with CUH Maternity Bereavement leaflet.
Encourage an improved working relationship with Health to support improved information returns.
Continue to work with pan London to understand trends.
Complete and report 2015/2016 annual report and 2008/2016 analysis

17 Appendices

17.1 Appendix 1: Child Death Overview Panel Terms of Reference

The Child Death Overview Panel is a sub-group of the Croydon Safeguarding Children Board (CSCB) and oversees the Rapid Response Meeting. This document should be read in conjunction with "Working together to Safeguard Children" Chapter 5 (2013) HM Government.

Purpose

Through a comprehensive and multidisciplinary review of child deaths, the Croydon Child Death Overview Panel (CDOP) aims to better understand how and why children in Croydon die, providing relevant knowledge and skills to interpret the information gained and use our findings to take action to prevent other deaths and improve the health and safety of our children.

Responsibilities of CDOP

- Review all child deaths up to the age of 18, excluding babies who are stillborn and planned terminations of pregnancy carried out within the law.
- Collect, collate and review information on each death to identify:
    - the need for a further review
    - any matters of concern affecting the safety and welfare of children in Croydon
    - wider public health or safety concerns arising from a particular death or from a pattern of deaths in Croydon
- Ensure the accurate identification of and uniform, consistent reporting of the cause and manner of every child death.
- Determine if the death was deemed preventable, where modifiable factors may have contributed to the death and decide whether any actions could be taken to prevent future deaths
- Make recommendations to CSCB and other relevant bodies promptly so that action can be taken to prevent future such deaths
- Identify significant risk factors and trends in individual child deaths including and report these to CSCB
- Refer to CSCB Chair any deaths where, from the available information, the panel considers there may be grounds to undertake further enquiries, investigations or a Serious Case Review.

- Identify 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.
- Evaluate specific cases in depth where necessary, to learn lessons or identify issues of concern.
- Identify significant risk factors and trends in individual child deaths and in overall patterns of deaths in Croydon, including relevant environmental, social, health and cultural aspects 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.
- Identify public health issues and consider, with the Director of Public Health and other provider services how best to address these and their implications for both provision of services and training.
- Identify and advocate for needed changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.
- Increase public awareness and advocacy for the issues which affect the health and safety of children.
- Where concerns of a criminal or child protection nature are identified, confirm that the police and coroner are aware and inform them of any specific new information that may influence their inquiries and inform the Chair of the CSCB
- 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.
- Advise CSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths
- Co-operate with any London-regional and national initiatives
- Collect a minimum dataset as required by the Department for Education and submit this annually for national data collection.
- Prepare an annual report for the Croydon Safeguarding Children Board who is responsible for disseminating the lessons to be learnt to all relevant organisations, and ensure that relevant findings inform the Children and Young People's Plan. They will also action any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children
- Develop and implement a work plan approved by Croydon Safeguarding Children Board.

Membership

Core attendees:

- Designated Doctor for Child Protection & Child Death Reviews
- Head of Safeguarding, Designated Nurse Children (Croydon Clinical Commissioning Group)
- Named Nurse Safeguarding and Child Protection (Croydon Health Services)

- Croydon Single Point Of Contact (SPOC) & Child Death Review Coordinator
- Public Health Principal (Chair)
- Police
- Quality Assurance Manager – Local Authority Designated Officer (LADO), Social Care And Family Support

Other members may be co-opted to contribute to the discussion of certain types of death when they occur.

Members may nominate a deputy to attend on their behalf, but must ensure that their deputy is fully briefed on their responsibilities

Confidentiality

- Information circulated and discussed at the meeting will be anonymised prior to the meeting and where possible all Form B information be amalgamated onto one form.
- Any reports, minutes and recommendations arising from the CDOP will be fully anonymised and steps taken to ensure that not personal information can be identified
- Any information that is being shared in the public interest for the purposes set out in Working together to Safeguard Children (2013) is bound by legislation on data protection.
- CDOP members will be required to sign a confidentiality agreement before participating in the CDOP and at the start of each meeting
- Any ad-hoc or co-opted members and observers will also be required to sign an attendance sheet, confirming that they have understood and signed the confidentiality agreement.

Accountability

- The CDOP is accountable to the chair of Croydon Safeguarding Children Board.

Frequency of Meetings

- CDOP will meet bimonthly with ad-hoc meetings convened as needed

- There must be a minimum of 2 agencies in attendance in addition to the Designated Doctor for Child Protection & Child Death Review

Relevant papers

Croydon Multi-agency Child Death Notification Protocol
Form A - Initial Notification of the death of a child
Form B – Agency Report Form
Form C – Analysis Proforma
CDOP Confidentiality Statement

March 2014

17.2 Appendix 2: Croydon Rapid Response Meeting Terms of Reference

(To be read in conjunction with 'Working Together to Safeguard Children' March 2015 HM Government)

The Rapid Response (RR) process applies when a child dies unexpectedly (birth up to 18th birthday), excluding babies who are still born or whether there is lack of clarity about whether the death of a child is unexpected.

An unexpected death is defined as the death of a child not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death.

Deciding on whether the death is unexpected and whether to implement the RR process is the responsibility of the designated paediatrician responsible for unexpected deaths in childhood.

Purpose

The purpose of the RR meeting, which is an element of the RR process, is to have a multi-agency case discussion to share information about the cause of death or factors that may have contributed to the death and to plan future care of the family.

This meeting ensures that the appropriate agencies are engaged and work together to:

- Respond quickly to the unexpected death of a child in accordance with locally agreed procedures
- Ensure support for the bereaved families, as the death a child will always be a traumatic loss, more so if the death is unexpected.
- Ensure all relevant agencies are involved in the process and are aware of their roles and responsibilities
- Identify any safeguarding concerns around other children in the household or affected by the death
- Making immediate enquiries into and evaluating the reasons for and circumstances of the death , in agreement with the coroner as required
- Enquire and constructively challenge how each organisation discharged their responsibilities to an individual child's death, and whether there are any lessons to be learnt
- Collate information in the standard format
- Cooperate appropriately post death, maintaining contact at regular intervals with family members and other professionals who have on-going responsibilities to the family, to ensure that they are appropriately

informed (unless such sharing of information would place other children at risk of harm or jeopardise police investigations)

- Consider media issues and the need to alert and liaise with the appropriate agencies
- Consider bereavement support for any other children, family members or members of staff

Attendance at Rapid Response Meeting

Core attendees:

- Designated Doctor for Child Protection & Child Death Reviews
- Head of Safeguarding, Designated Nurse Children (Croydon Clinical Commissioning Group)
- Named Nurse Safeguarding and Child Protection (Croydon Health Services)
- Croydon Single Point Of Contact (SPOC) & Child Death Review Coordinator
- Paediatrician
- Social Care Operational Manager
- Deputy Designated Nurse, Commissioning on behalf of Independent Contractor Services
- Representation from the Health Visiting Team

Representation from other lead agencies or services that may be in attendance

- Hospitals where the child has died out of area
- Children's Hospital at Home (CHAH)
- London Ambulance Service (LAS)
- Police
- Child & Adolescence Mental Health Services (CAMHS)
- Education
- Croydon University Hospital (CUH) Paediatric Staff-A&E Matron & Clinical Nurse Manager

- Helicopter Emergency Medical Service (HEMS)
- Midwifery
- Speech & Language Therapy (SALT)
- Physiotherapy
- Family support services
- School Nurses
- Any other relevant agency/service

The meeting will be chaired by either the Designated Doctor for Child Protection & Child Death Reviews or the Head of Safeguarding, Designated Nurse Children (Croydon Clinical Commissioning Group).

Confidentiality

- All attendees will be required to sign a confidentiality agreement / attendance sheet before participating in the meeting to confirm that they have understood the requirements of confidentiality.
- Any confidential information will be transferred securely

Accountability

The RR team will report to the local Child Death Overview Panel who are accountable to the Croydon Safeguarding Children Board

Frequency of meetings

RR meetings will be considered as a priority and be convened within 5 working days where possible, of the child's death

A second meeting may be convened if required

Follow-up of actions

- Actions agreed and logged at the RR meeting will be followed up by the Croydon SPOC & Child Death Review Coordinator
- Any identifiable information will be anonymised prior to review by the local Child Death Overview Panel

The Terms of Reference will be reviewed annually

Relevant papers:

- Croydon Multi-agency Child Death Notification Protocol

- Croydon Rapid Response Flow Chart
- Form A - Initial Notification of the death of a child
- Child Death RR meeting Confidentiality Statement
- Child Death RR Meeting Agenda

March 2014

17.3 Appendix 3: Child Death Rapid Response Meeting Agenda

1. Welcome, introductions & apologies
2. Confidentiality Statement (signed)
3. Confirmation of Child's details
4. Confirmation of wider family details
5. Discussion of events immediately leading to the death
   - Agencies responding at the time
6. Potential causes of the death
   - Initial PM report
   - Medical reports
7. Background history & previous contact with agencies
   - Agency by agency reports
8. Have any professionals been omitted from the process that could provide relevant information?
9. Discussion regarding Child Protection
   - Risk of harm to others
   - Referral to SCR Panel
10. Plans for supporting the family
    - Who will take the lead
    - Who will discuss CDR process with the parents
    - Bereavement support for family & siblings
11. Plans to support community/school
12. Plans to support staff
13. Press involvement & communication strategy

14. Was the Bereavement Information Leaflet given to the family?
15. Form B requirements
16. Actions
17. Any other business

March 2014

17.4 Appendix 4: Croydon Rapid Response Process