Croydon
Child Death Overview Panel

Eighth Annual Report 2015/2016

Anonymised version

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1 Introduction

Welcome to the eighth annual report of the Croydon Child Death Overview Panel (CDOP) which provides a summary of the deaths reviewed by CDOP from 1 April 2015 to 31 March 2016.

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 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[1].

Due to the very small numbers of child deaths reviewed, associations and significance cannot be applied to the findings. Details and some charts have been 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 therefore the number of child deaths in any particular age range within a local area is small in number. This means that generalisations are rarely appropriate and for lessons to be learnt from the deaths reviewed, data needs to be collected and reported on nationally over a number of years. Current data collection methods mean that accurate regional and national data are not readily available.

Child Death Overview panels were established in 2008 as a new statutory requirement and updated in 2015. It is the responsibility of the Local Safeguarding Board to ensure that a comprehensive review of every death of a child normally resident in Croydon under the age of 18 years is undertaken to understand better, how and why they die, to detect trends and / or specific areas which would appear worthy of further consideration.

The CDOP has specific functions laid down by statutory guidance including:

- Reviewing the available information on all deaths of children up to the age of 18 years (excluding stillbirths and terminations of pregnancy carried out within the law) to determine whether the death was preventable
- Meeting regularly to review and evaluate the routinely collected data on all child deaths to identify lessons to be learnt or issues of concern relating to the safety and welfare of children in Croydon
- Collecting, collating and reporting on an agreed national data set for each child who has died

[1] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2 Accessed 20.06.2016

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

In reviewing the death of each child, the CDOP should consider modifiable factors, for example, in the family environment, parenting capacity or service provision and consider what action could be taken locally and what action could be taken at a regional or national level.

The principals underlying the overview of all child deaths are:
- Every child death is a tragedy
- Learning lessons
- Joint agency working
- Positive action to safeguard and promote the welfare of children

See Appendix 1 for CDOP Terms of Reference

3 Organisation of the 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) by telephone or email; this is followed with “Form A” giving initial details about the death. The Designated Paediatrician will then consider whether the death triggers a Rapid Response (RR) meeting which looks in greater detail at the deaths of children who die unexpectedly.

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 to provide as full a picture as possible of the circumstances directly and indirectly leading to the death.

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. However, it is still a challenge obtaining completed Form Bs from some agencies.

CDOP meetings are convened regularly where the review of a child death will be included if the information gathered is determined to be as complete as possible.

Each case is discussed and recorded using “Form C” (Analysis Proforma) based on information provided in the Form B and other supporting documentation. The data are entered on a child deaths database 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 Rapid Response

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

Rapid Response meetings were convened for 12 unexpected deaths of children notified during the period 1 April 2015 – 31 March 2016.

RR meetings are considered a priority to be convened, where possible, within 5 working days of the child’s death. 81.8% of the RR meetings achieved this time scale

A log of the Rapid Responses is maintained and reported to the CDOP meetings.

See Appendix 2 for Rapid Response Terms of Reference

3.3 Panel Meetings

During 2015/2016, CDOP met six times to review anonymous information about child deaths.

The CDOP has a fixed core membership of experts drawn from the key organisations represented on the Croydon Safeguarding Children Board. 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 2015/2016

Child Death Overview Panel Attendance						
	2015			2016		
	18th May 2015	17th August 2015	16th November 2015	18th January 2016	29th February 2016	21st March 2016
Public Health (Chair)	✓	✓	✓	✓	✓	✓
Designated Doctor for Child Protection & Child Death review process	✓	✓	✓	✓	✓	✓
Designated Nurse for Child Protection CCG	✓	✓	✓	✓	✓	✓
Named Nurse for Child Protection	✓	✓	✓	✓	✓	✓
CSCB Child Death Review Co-ordinator	✓	✓	✓	✓	✓	✓
Quality Assurance Manager (LADO) [2] (Deputy Chair)	✓	✓	✓	×	✓	×
CSCB Manager	×	✓	✓	✓	✓	×
Child Abuse Investigation Team Police CAIT	✓	✓	✓	×	×	×
CSCB Administrator	✓	✓	✓	✓	✓	✓
Specific Case Attendance						
Consultant Paediatrician			✓			
Team Leader Special School Nurses			✓			

3.4 Administration

The administration of the CDOP process is amalgamated with the Rapid Response Meetings and is hosted and funded by London Borough of Croydon.

3.5 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-group and attendance at the London CDOP Chairs' meetings.

[2] Local authority Designated Officer

4 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.

The most recently released child mortality rate (age 1-17 years) as at March 2016 from the Child and Maternal Health Observatory (CHiMat) Child Health Profile for Croydon[4] is 10.8 per 100,000 children in 2012/2014 down from 11.4 per 100,000 children in 2011/ 2013. In 2012/2014, Croydon was lower than England and London and Croydon's statistical neighbours (Table 2).

Table 2: Comparison of directly standardised mortality rate per 100,000 children aged 1-17 years, 2010-2012, 2011-2013, 2012-2014

Local Authority	2010-2012	2011-2013	2012-2014
	Rate per 100,000		
England	12.5	11.9	12.0
London	13.7	12.2	12.0
Croydon	11.3	11.4	10.8
Enfield	12.0	13.7	15.3
Greenwich	13.9	11.9	12.6
Merton	18.5	14.1	11.0
Redbridge	9.9	8.5	11.9
Waltham Forest	14.9	11.5	13.5

Source: Child Health Profiles for Local Authorities, ChiMat 2016

[3] https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2015 accessed 20.06.2016
[4] http://www.chimat.org.uk/resource/view.aspx?QN=PROFILES_STATIC_RES&SEARCH=C* Accessed 20.06.2016

The infant mortality rate is the number of deaths under one year of age per 1,000 live births. Table 3 compares the Infant Mortality Rate (IMR) in Croydon against our statistical neighbours and England and London. The IMR for 2012-2014 was 4.0 per 1000, live births. In Croydon, this rate has been consistent and is equal to the England rate (Table 3).

Table 3. Infant Mortality Rate 2010/2012 – 2012/2014

Local Authority	2010-2012	2011-2013	2012-2014
	Rate per 1,000 live births		
England	4.3	4.1	4.0
London	4.1	3.8	-
Croydon	4.0	4.0	4.0
Enfield	5.6	4.6	4.0
Greenwich	4.3	3.9	4.2
Merton	4.4	3.6	3.1
Redbridge	3.8	3.0	2.6
Waltham Forest	5.4	4.6	3.8

Source: Child Health Profiles for Local Authorities, ChiMat 2016 & Children & Young people health Benchmarking tool

5 Local Picture

5.1 Number of deaths in CDOP area

Between April 2015 and March 2016, 32 deaths of children resident in Croydon were notified to CDOP. In 2015/2016, 29 cases were reviewed and of these, 12 were children who died in 2014/2015 and 17 were children who died in 2015/2016 (Table 4).

For this time period there are 8 cases awaiting review.

Table 4: Child deaths, Croydon residents and cases reviewed 2010/2011 – 2015/2016

	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
Child deaths	39	28	34	37	30	32
Cases reviewed	39	30	24	36	33	29

Source: Croydon Child Death Overview Panel data

The 32 child deaths reported to CDOP in 2015/2016 equate to a mortality rate of 34.65 per 100,000 children aged 0-17 years (using the ONS 2014 mid-year population estimates); the number of deaths reported is a small percentage (0.03%) of the overall child population.

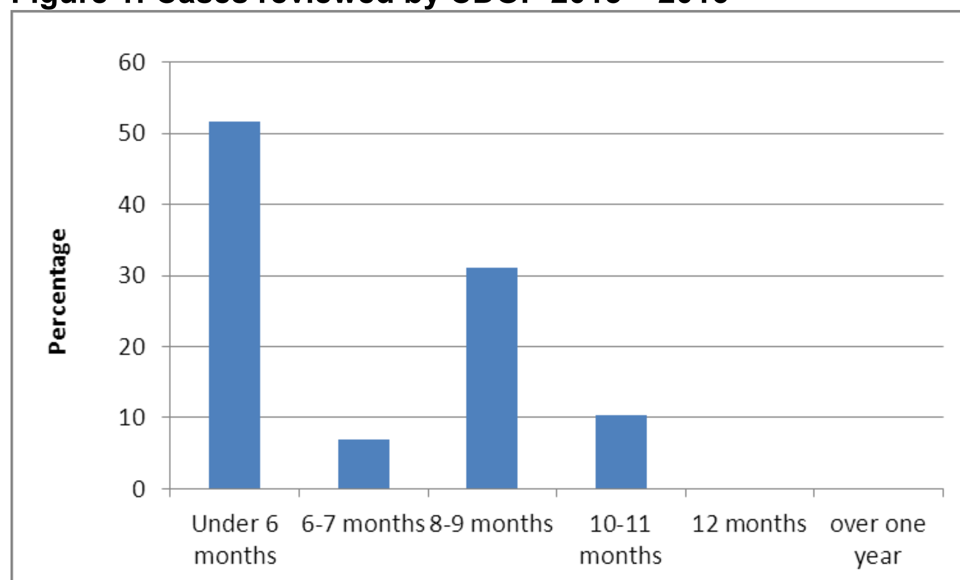
5.2 Time from death of the child to CDOP review

Just under two-thirds of deaths are notified to the SPOC within two days.

As part of the CSCB dashboard, an indicator in line with Department for Education annual data collection was set for 40% of cases to be reviewed by six 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. This delay may be due to slow returns of Form Bs (data collection forms), the 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) or where the panel requested further information.

In 2015/2016, whilst numbers are small, over half of the cases (51.7%) were reviewed within six months of the child's death. This is an increase of 18.4% from 2014/2015 and 26.7% from 2013/2014. By 11months, all 29 cases (100%) had been reviewed (Figure 1).

Figure 1: Cases reviewed by CDOP 2015 – 2016



Source: Croydon Child Death Overview Panel data

Table 5: Time taken for cases to be reviewed by panel 2013 – 2016

Time taken for cases to be reviewed by panel	2013/2014	2014/2015	2015/2016
	%	%	%
Under 6 months	25.0	33.3	51.7
6-7 months	25.0	9.1	6.9
8 - 9 months	8.3	18.2	31.0
10 - 11 months	13.9	18.2	10.3
12 months	5.6	6.1	0.0
Over one year	22.2	15.2	0.0
Total: under one year	**77.8**	**84.8**	**100.0**

Source: Croydon Child Death Overview Panel data

5.3 Neonatal Deaths

A Neonatal Death is defined as the death of a child less than 28 days of age; this includes premature births but excludes stillbirths.

Just over a quarter (8, 27.6%) of the 29 cases reviewed were deaths occurring in the first 28 days of life.

5.4 Infant deaths

Infant death refers to all deaths in the first year of life. Just over half (16, 55.2%) of all deaths reviewed, occurred within the first year of life.

5.5 Expected and Unexpected Deaths

An expected death is that which was anticipated 24 hours before the death; an unexpected death is where it 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.

16 (55.2%) of the 29 child deaths reviewed in this period were defined as unexpected deaths

Of the expected deaths, the majority were in children under 1 year of age.

Figure 2: Expected and unexpected child deaths reviewed by age, 2015/2016 (Figure removed for disclosure control and replaced with a table)

Number of Children	Expected	Unexpected
Less than 28 days	7	<3
28 - 364 days	4	4
1 - 4 years	<3	<3
5 -9 years	<3	<3
10 - 14 years	<3	<3
15 - 17 years	<3	6

Source: Croydon Child Death Overview Panel data

5.6 Sudden Unexpected Death in Infancy

The term SUDI is 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.

There were five cases reviewed where “sudden unexpected death in infancy” was classified.

Four of the mothers were amongst the most deprived in Croydon; In the five cases reviewed, the mental health of the parent/carer, alcohol, smoking, housing concerns, co-sleeping, domestic violence, poor parenting and child abuse/neglect were noted. (See Section 6 for definition of Modifiable Factors).

5.7 Serious Case Reviews

Information removed for disclosure control.

5.8 Age and gender

As expected, most of the deaths reviewed were to infants under one year of age: n= 16 (55.2%).

Figure 3: Child deaths reviewed by age 2015/2016
(Figure removed for disclosure control and replaced with a table)

Age at death	Number of children
0-27 days	8
28-364 days	8
1 - 4 years	3
5-9 years	<3
10-14 years	<3
15-17 years	6

Source: Croydon Child Death Overview Panel data

Table 6: Child deaths reviewed in 2015/2016 by gender and age

Table 6 removed for disclosure control

Of the 29 deaths reviewed in 2015/2016, 13 (44.8%) were in males and 16 (55.2%) in females

5.9 Ethnicity

Table 7 removed for disclosure control.

The Black and Asian Minority Ethnic (BAME) population represented 44.8% of the children 0-17 years who died compared to 39.4% in 2014/2015. This is below the GLA ethnic group population projections for 2015[5] that show that 62.7% of Croydon's population aged 0-17 years are from BAME groups.

Table 8: Child deaths reviewed by ethnicity 2012/2016

Table 8 removed for disclosure control

[5] http://data.london.gov.uk/dataset/2014-round-ethnic-group-population-projections/resource/21cc8aba-acf7-4bb0-ae9a-8186d5fdd705
Accessed 20.06.2016

6 Categories of death

The panel reviews cases and decides on the category of death that should be classified. There are two categories into which each death is classified: "Modifiable Factors" (Preventable) and "No Modifiable factors" (Not preventable)

Modifiable factors identified: Where the panel identifies one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions could be modified to reduce the risk of future child deaths.

No modifiable factors identified: Where the panel has not identified any potentially modifiable factors in relation to this death.

It is important to recognise that this categorisation is to inform efforts to reduce childhood deaths, it does not in itself carry any implication of blame on any individual party, but simply acknowledges where factors are identified, which had they been different may have resulted in the death being prevented.

Of the 29 deaths, three cases were identified as having modifiable factors. Two of these deaths were unexpected and one expected.
The modifiable factors in the three cases related to:

- Drugs taken in pregnancy where the effects were not well studied.
- Alcohol and Mental Ill-Health
- Sharing of information between professionals

7 Cause of death categories

CDOP categorises the likely/cause of death using the national hierarchical format.

Table 9: Breakdown of categories for the 29 deaths reviewed

Table 9 removed for disclosure control

Figure 4: Child deaths reviewed by CDOP in 2013/14 – 2015/2016, by cause and child age

Figure 4 removed for disclosure control

When reviewing the causes of death for all cases, the highest proportion of deaths were from the perinatal/neonatal events (27.6%) and Chronic Medical conditions (27.6%).

8 Deprivation

There is a strong evidence base which shows the strong association between deprivation and poor mortality outcomes: rates are lowest amongst the most advantaged families and highest in the most disadvantaged.

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”.

From the 29 deaths reviewed, there were a greater number of children who were subject to increased levels of deprivation.

Figure 5: Child deaths reviewed by CDOP in 2015/16, by Croydon deprivation quintile

Figure 5 removed for disclosure control

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.

9 Place of death

Figure 6: Place of death

Figure 6 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.

10 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 were all expected.

Table 10: Location at time of event or condition cases reviewed 2015/2016 (Table amended for disclosure control)

Location at time of event	Expected (%)	Unexpected (%)	Expected (%)	Unexpected (%)
Hospital	53.8	0	23.1	23.1
Home	0.0	10.0	0.0	90.0

Source: Croydon Child Death Overview Panel data

Of the 34.5% of events occurring in the home, all the deaths were unexpected.

11 Asylum Seekers

The review of data indicated that no deaths occurred in children seeking asylum.

12 Post mortem examinations

Of the 29 deaths, 16 had a post mortem.

13 Child Protection/Children in Need

Information removed for disclosure control

14 Risk Factors

CDOP reviews information on additional risk factors and while not considered to be the direct cause of death, may have contributed to the vulnerability in the child. In some cases, the children reviewed may have had more than one risk factor. Of the cases reviewed, 17 cases had a risk factor recorded, 12 had no risk factors recorded. Each case might have had one or more risk factors identified. (Table 11).

Table 11: Number of risk factors identified that may have contributed to the ill-health or vulnerability or death of the child

Risk factor	
Epilepsy	1
Other Chronic illness	2
Learning Disabilities	1
Motor Impairment	1
Sensory Impairment	1
Other disability or impairment	1
Emotional/behavioural/mental health condition in a parent/carer	4
Emotional/behavioural/mental health condition in the child	1
Alcohol/substance misuse by a parent/carer	2
Smoking by parent/carer in household	3
Smoking by mother during pregnancy	3
Housing	1
Co-Sleeping	2
Poor Parenting/supervision	0
Child Abuse/neglect	0

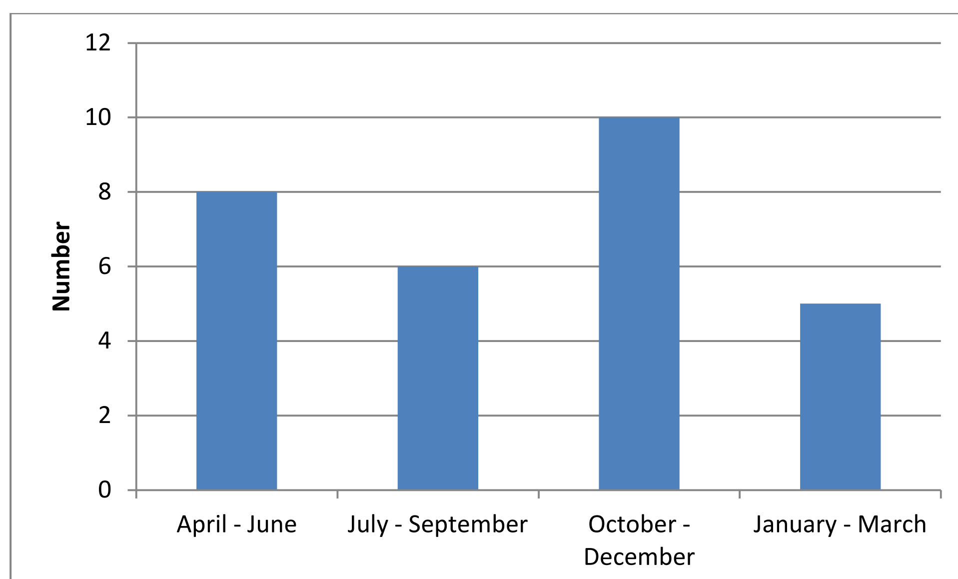
Source: Croydon Child Death Overview Panel data

The most common risk factors identified are the emotional/behavioural/mental health in a parent/carer and smoking.

15 Seasonal variability

Although the numbers are very small deaths were slightly more common during October to December. (Figure 7)

Figure 7: Croydon child deaths by seasons, 2015/2016



Source: Croydon Child Death Overview Panel data

16 Summary of child deaths review 2015/2016

- 29 child death reviews were completed by the CDOP
- 8 cases are outstanding awaiting review
- Nearly 90% of the rapid response meetings were convened within 5 working days
- The child mortality rate is lower than England and London and our statistical neighbours
- The number of child deaths reported is a small percentage of the overall child population of Croydon
- 51.7% of cases were reviewed by 6 months, by 11 months all cases reviewed
- 27.6% of cases reviewed are of children under 28 days
- 55.2% of cases reviewed are of children under 1 year
- Just over half of the deaths were unexpected
- 5 Sudden Unexpected Deaths in Infancy
- 3 cases were identified as having modifiable factors
- 44.8% of child deaths reviewed were from Black and Minority Ethnic groups
- The highest proportion of deaths, were from the perinatal/neonatal events (27.6%) and Chronic Medical conditions (27.6%).
- The most deprived geographical areas in Croydon have the highest number of child deaths
- The most common risk factors identified are the emotional/behavioural/mental health in a parent/carer and smoking

17 Issues identified

The issues identified have been removed for disclosure control.

18 Learning points

National information was discussed at panel on:

- The need for a greater awareness of safety e.g. choking on grapes, suffocation by nappy sacs
- Safeguarding thresholds and supervision for staff caring for children with highly complex needs

19 Good practice

The CDOP members 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.

The acknowledgements by CDOP for 2015/2016 have been removed for disclosure control.

20 CDOP network England and London

Croydon CDOP was alerted to:

- The use of SSRI anti-depressant drugs in pregnancy and the low level of risk of birth defects
- Reports of the deaths of four young people in the USA dying from participating in 'The Choking Game' to experience a euphoric feeling
- Incidents of babies choking on nappy sacks

21 Challenges during 2015/2016

- Re-structure of Business Support
- Recruitment of Single Point Of Contact (SPOC)
- Ensuring robust process for handover and continuity.

22 Actions completed for 2015/2016

- 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 B (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
- Terms of Reference for both CDOP and RR meetings reviewed

- Croydon Bereavement Leaflet was aligned with Croydon University Hospital Maternity Bereavement leaflet and distributed to health services to ensure that parents receive the correct information following the death of their child

23 Action plan for 2016/17

Action
Identify emerging issues from 2015/2016 annual report
Identify how CDOP can increase awareness of issues identified at panel to support improving child outcomes
Raise awareness of safety issues in Child Safety Week (June 2016) and inclusion on CSCB website
Continue to achieve targets for cases reviewed at CDOP and RR meetings
Support the CSCB business plan working with the Health sub-group, and through Best Start improve early identification and outcomes for babies at significant risk of SUDI and support the development of pre-birth pathway
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
Complete statutory child death data returns for Department of Education
Continue to build on partnership working to improve data collection and shared learning
Attend 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
Encourage an improved working relationship with Health to support improved information returns
Continue to work with pan London CDOPs to understand trends
Work with CSCB Learning and Development team to include learning points identified at CDOP within the training programme

24 Appendices

24.1 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 (2015) 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 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
- Social Care Quality Assurance Manager

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 no 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 (2015) 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 is scheduled monthly but subject to cancellation if business determines this appropriate.

- 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

August 2015

24.2 Croydon Rapid Response Meeting

Terms of Reference

(To be read in conjunction with Chapter 5 '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 of 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
- Make 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

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
- GP
- Child & Adolescence Mental Health Services (CAMHS)
- Education
- Representation from the Health Visiting Team
- 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
- Hospice
- School Nurses
- Deputy Designated Nurse, Commissioning on behalf of Independent Contractor Services
- 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 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.

- Minutes will be distributed to all attendees and core members (regardless of their attendance).

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

August 2015