



Croydon Child Death Overview Panel

Eleventh Annual Report 2018-2019

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1. INTRODUCTION

- 1.1. This is the eleventh annual report of the Croydon Child Death Overview Panel (CDOP). The report provides a summary of the deaths reviewed by CDOP during 2018-2019.
- 1.2. 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 borough¹.
- 1.3. Due to the very small numbers of child deaths reviewed, associations and significance cannot be applied to the findings. Details of cases have also been omitted where these would breach confidentiality.

2. EXECUTIVE SUMMARY FOR 2018-2019

- 2.1. Statistically speaking, Croydon had similar rates of mortality to both London and England in 2015-2017. The child mortality rate in Croydon is slightly lower than London and England. Both the infant mortality rate and the neonatal mortality rate in Croydon is slightly higher than the London rate but slightly lower than the national rate.
- 2.2. 26 deaths of children resident in, or the responsibility of, the London Borough of Croydon were notified to Croydon's Child Death Overview Panel (CDOP) between April 2018 and March 2019 as per the CDOP's terms of reference. Less than five of these deaths were of babies born below 24 weeks gestation and were therefore not reviewed by CDOP as per the panel's terms of reference.
- 2.3. Rapid Response meetings were convened for six deaths of children notified between April 2018 and March 2019. Please see appendix A for more details about the rapid response process.
- 2.4. 32 CDOP reviews were completed during 2018-2019. The following information in this report relates to cases reviewed in 2018-2019, regardless of the year of death. Deaths that occurred in 2018-2019 but have not yet been reviewed will be included in a future report following CDOP review.

¹ <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

- 2.5. Of the deaths reviewed in 2018-2019, 14 cases had required a post mortem and none were subject to a Serious Case Review.
- 2.6. Of the deaths reviewed in 2018-2019 less than five of the cases were identified as Children in Need at the time of their deaths and / or had a previous or current statutory order². Less than five had previously been subject to a child protection plan and less than five were identified as an asylum seeker.
- 2.7. Just under half of the children whose deaths were reviewed were living in areas classified as the 40% most deprived areas of the county.
- 2.8. Less than five deaths were classified as a Sudden Unexpected Death in Infancy (SUDI).

3. BACKGROUND

- 3.1. 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.
- 3.2. Child Death Overview Panels were established in 2008 as a new statutory requirement and updated in 2015. These arrangements are being replaced in 2019 by new arrangements as described in *Working Together to Safeguard Children (2018)* and the *Child Death Review: Statutory and Operational Guidance (2018)*. Under the existing guidance (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.
- 3.3. The CDOP has specific functions laid down by the existing statutory guidance which include:
 - 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.

² Statutory orders include: Police Powers of protection, Emergency Protection order, Interim Care order, care order, supervision order, residence order, section 20, antisocial behaviour order, other

- 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.
- Making recommendations to the CSCB regarding any deaths where the CDOP considers there may be grounds for a serious case review.
- Monitoring and offering support services given to bereaved families.
- Identifying any trends that can be analysed and deliver 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 to mitigate these factors.

3.4. The principles 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.

3.5. See the appendix for organisation of the CDOP and the Terms of Reference.

4. DATA

4.1. National mortality rates

According to the Department of Education³, the number of deaths of children registered in England has continued to decline, dropping from 3,857 in 2013 to 3,575 in 2017. The majority of these deaths were due to perinatal / neonatal event (34% of deaths reviewed in 2017) and chromosomal, genetic and congenital anomalies (25% of deaths reviewed in 2017).

The national publication of statistics for year ending 31 March 2018 has been postponed and will be published by NHS Digital as the child death review policy transferred from the Department for Education to the Department of Health and Social Care in July 2018.

Deaths are often categorised into three groups;

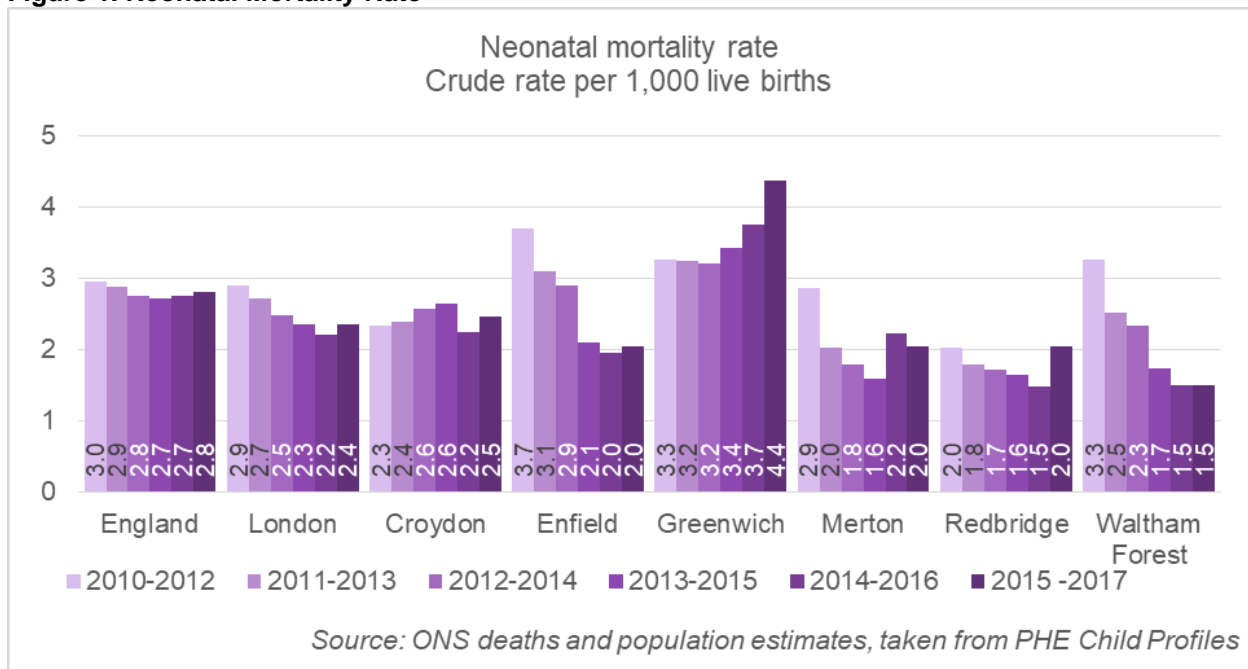
³ <https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2017>

- A 'neonatal death' is defined as the death of a child less than 28 days of age; this includes premature births but excludes stillbirths.
- An 'infant death' is defined as the death of a child within the first year of their life, but aged 28 days or over at time of death.
- A 'child death' is defined as the death of a child aged between 1 and 17.

4.1.1. Neonatal mortality rate

The rate of deaths in the 0-27 days old age group in Croydon rose slightly in the most recent year. In 2015-2017, Croydon had the second highest neonatal mortality rate (equal to the London rate but lower than the England rate) when compared to its statistical neighbours.⁴

Figure 1. Neonatal Mortality Rate

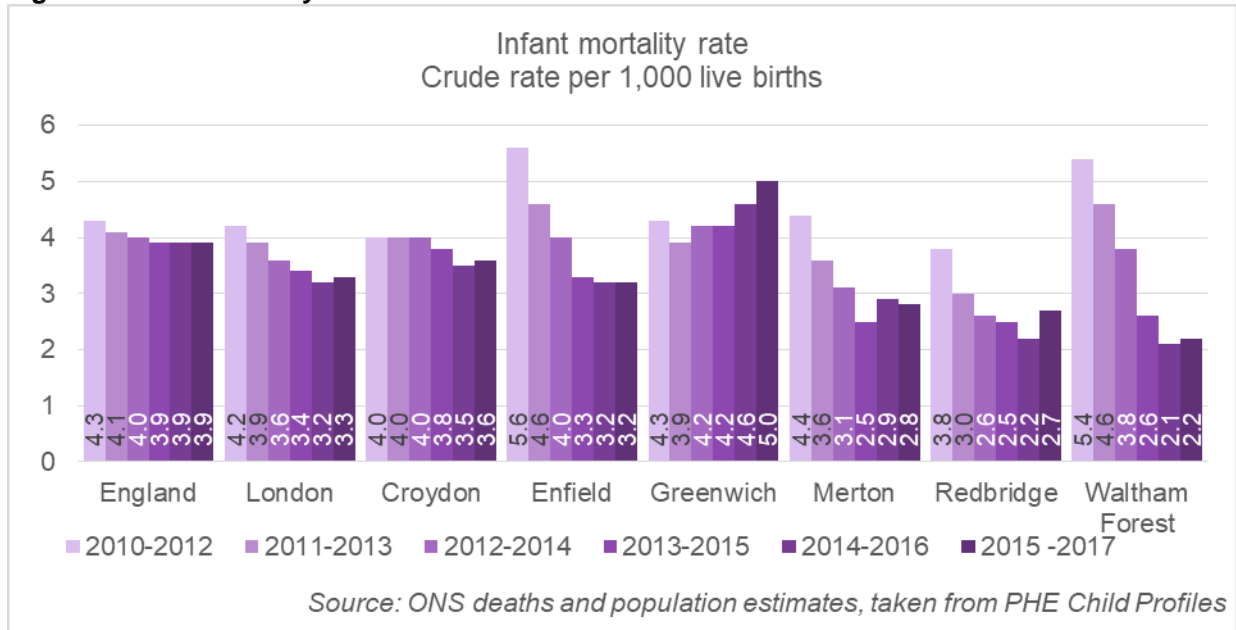


4.1.2. Infant mortality rate

The rate of deaths in the 0-1 year old age group in Croydon remained fairly level in 2015-2017 at 3.6 deaths per 1000 live births. This rate remains higher than the London rate and the rates of four out of five statistical neighbours.

⁴ <https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-overview>

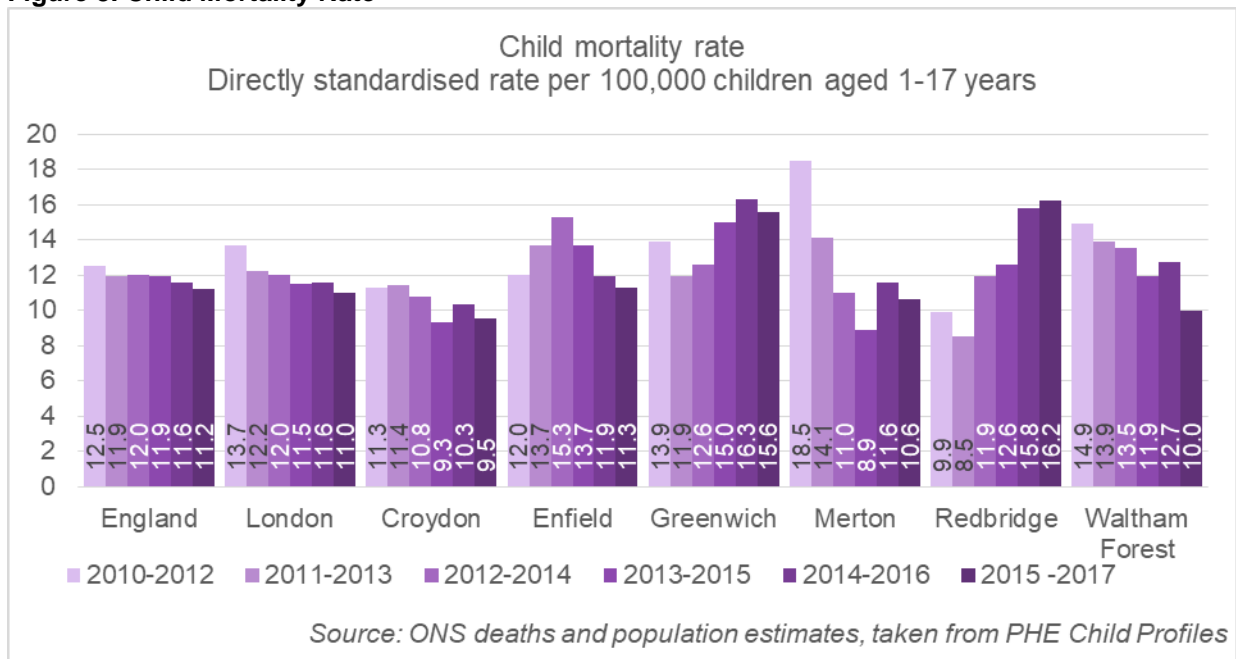
Figure 2. Infant Mortality Rate



4.1.3. Child mortality rate

In 2015-2017, Croydon had the lowest child (1-17 age groups) mortality rate when compared to its statistical neighbours, London and England.

Figure 3. Child Mortality Rate



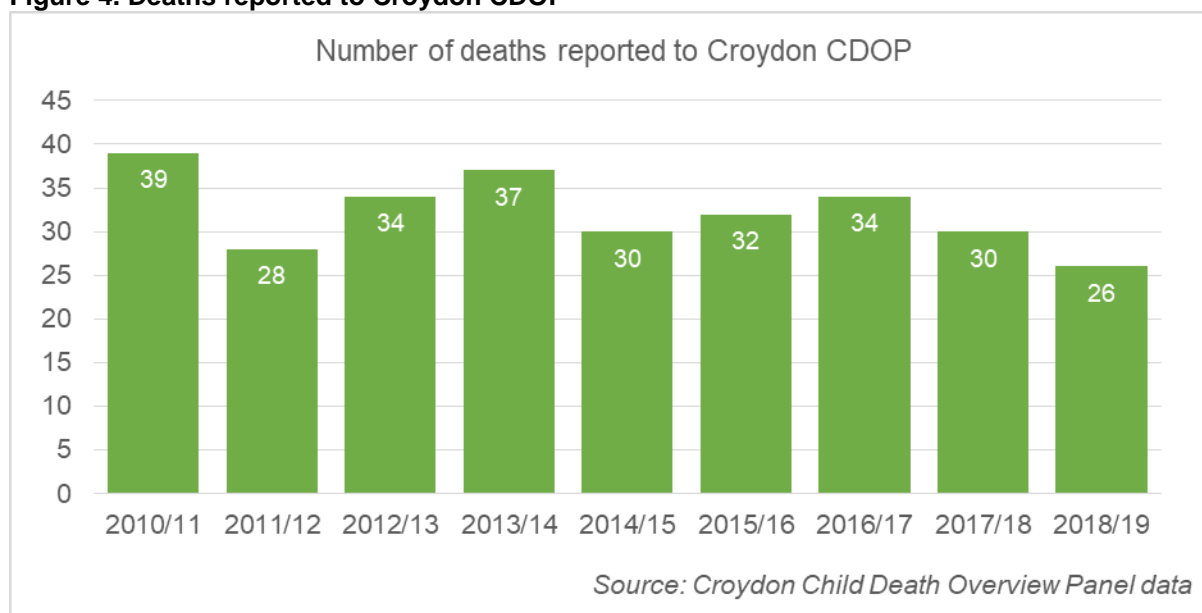
4.2 Number of child deaths in Croydon in 2018-2019

During 2018-2019, Croydon CDOP was notified of 26 child deaths. Of these:

- 12 deaths were initially on the Form A as unexpected. The Designated Doctor reviewed them all and identified six of them as being unexpected and rapid response meetings were held for these six. Please see appendix A for further information about the rapid response process.
- 14 of these deaths were expected.
- 11 cases had a post-mortem.
- Less than five inquests were held.
- Less than five were subject to a Serious Case Review.

The below graph shows the number of deaths per year notified to Croydon CDOP since 2010-2011.

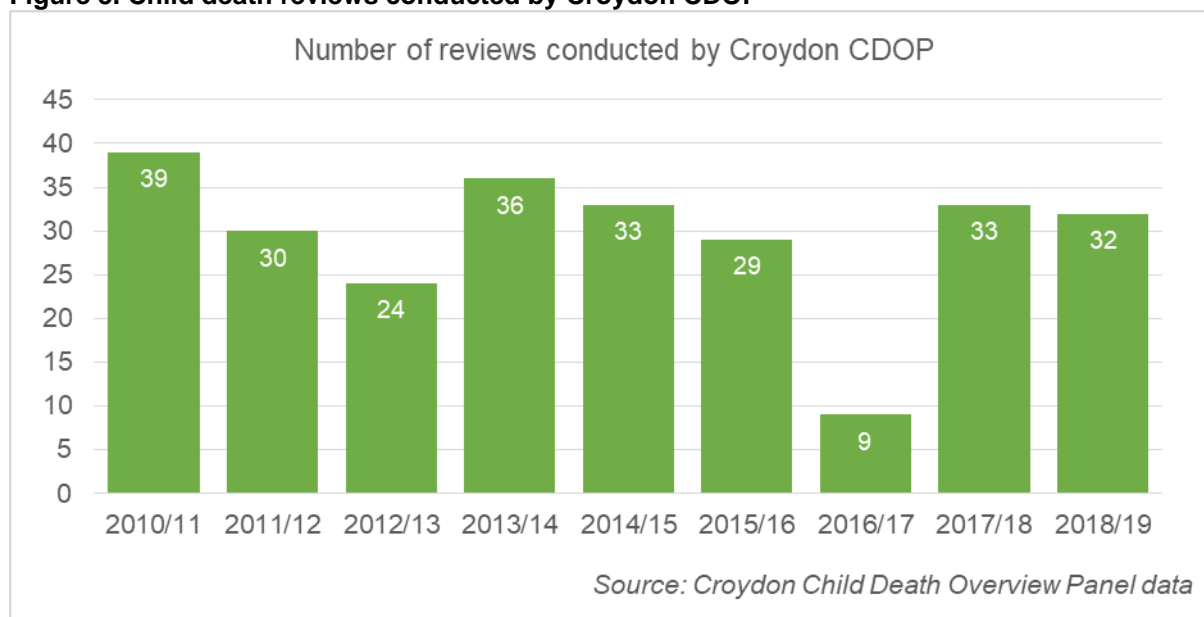
Figure 4. Deaths reported to Croydon CDOP



4.3 Child deaths reviewed during 2018-2019

32 deaths were reviewed in 2018-2019. 11 of these deaths occurred in 2018-2019 while the rest were reviews of deaths that occurred in previous years.

Figure 5. Child death reviews conducted by Croydon CDOP



As part of the CSCB dashboard and in line with Department for Education annual data collection, an indicator of 40% was set for cases to be reviewed within six months of a death. Table 1 shows the numbers reviewed within six months for the last two years.

This is not a performance indicator as there is often a necessary time gap between a death and the review whilst all required information needed for the review is gathered. We note, however, that in 2018-2019, 11 (34%) of the deaths were reviewed within six months and 75% within a year which is a significant improvement from 2017/2018. (Table 1). This is a positive reflection on the management and administration of the recent CDOP process. As of March 2019 there were 13 outstanding cases awaiting review compared to 22 in March 2018.

Table 1

Timing of the CDOP review	2018-2019	2017-2018
Cases reviewed	32	33
Number of cases reviewed within six months	11	0
Number of death reviewed within twelve months	24	17
Cases awaiting review at the end of March	13	22

Where there are delays between a death and the CDOP review the following factors contribute:

- 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 investigations into Serious Incidents or where the CDOP requested further information.

4.4 Rapid Response, Referrals to the Coroner, Post Mortems and Serious Case Reviews

Table 2 shows the numbers of deaths reviewed in 2018-2019 which had required a rapid response, referral to the coroner, post mortem or serious case review.

All rapid responses were convened within 9 days. Rapid response meetings are considered a priority to be convened, where possible, within 5 working days of the child's death.

Table 2

Of the deaths reviewed in 2018-2019	Numbers
Unexpected deaths reported on the Form A	12
Required a rapid response following review of the Form A by the Designated Doctor	6
Referrals to the coroner	12
Post Mortems	14
Serious Case reviews	0

4.5 Demographics of the deaths reviewed in 2018-2019

4.5.1 Place of Death

Three quarters of all deaths reviewed in 2018-2019 occurred in hospital (24 of 32).

4.5.2 Gestation date and age at death

Nine of the children who died as neonates (0 to 27 days) or infants (28 to 364 days) were born prematurely (less than 37 completed weeks of gestation).

4.5.3 Age

Two thirds of the child deaths reviewed in 2018-2019 were less than one year old when they died (21 of 32).

4.5.4 Gender

19 of the deaths reviewed were male and 13 were female.

4.5.5 Ethnicity

31% (10) of the deaths reviewed in 2018-2019 were of white British ethnicity. This is a change from 2017-2018, when 21% of deaths reviewed were of a white British ethnicity. **Because of the small numbers no inferences can be drawn from this data.**

4.5.6 Deprivation

There is a strong association in the literature between deprivation and poor mortality: 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 all areas is described as “quintile 1” and the least deprived fifth of areas is described as “quintile 5”.

In 2018-2019, just under half of the children whose deaths were reviewed were living in areas in the two most deprived quintiles nationally. **Due to small numbers of child deaths reviewed no inferences, trends or patterns can be identified from this data.**

4.6 Deaths reviewed in Croydon: Causes of death

4.6.1 Expected and Unexpected Deaths

An expected death is one that was anticipated 24 hours before the death. An unexpected death is where the death 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.

12 of the child deaths reviewed in this period were defined as unexpected deaths on the initial Form A. All these forms were reviewed by the Designated Doctor and the number revised to six unexpected child deaths. All of these deaths had a rapid response.

4.6.2 Sudden Unexpected Deaths in Infancy (SUDI)

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 less than five cases reviewed where “sudden unexpected death in infancy” was classified.

4.6.3 Modifiable factors and causes of death

The CDOP reviews cases and decides on the category of death that the case should be classified under. There are two categories under which each death is classified:

- Modifiable factors (preventable): The CDOP have identified 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 (unpreventable): The CDOP have 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 deaths reviewed, 19% of cases were identified as having modifiable factors. Due to confidentiality, further details cannot be made available in this report.

When looking at the known causes of death for all cases reviewed, the highest proportion of deaths were from perinatal/neonatal events followed by chromosomal, genetic and congenital anomalies.

4.6.4 Factors contributing to vulnerability, ill-health or death

CDOP reviews information on relevant environmental, extrinsic, medical or personal factors that may be present in the case and makes an assessment as to their contribution to vulnerability, ill-health or death of the child. In some case reviews, there may be more than one factor identified.

Of the 32 cases reviewed, the most common factor identified that may have contributed to vulnerability, ill-health or death of the child, or provided a full and sufficient explanation for the death, was other acute sudden onset illness.

5 ISSUES AND LEARNING POINTS

5.1 Issues and learning points identified from cases reviewed in 2018-2019

5.2.1 It is not possible to identify specific issues and learning points due to small numbers which prevents the drawing of conclusions and identification of trends. One of the aims of the new national arrangements, and the creation of CDOPs covering large areas is to enable issues and trends to be identified.

5.2.2 General issues which were followed up during 2018-2019 included:

- Access to specialist bereavement services for family friends and kinship groups. Implementation of the Working Together to Safeguard Children 2018 guidance which includes the establishment of a 'key worker' role to act as a single point of contact with the bereaved family for the duration of the death review process will help address this point.
- Awareness raising work with partners to broaden understanding of the work of CDOP and to improve the timeliness of Form B submissions is ongoing.

5.2 Good practice

5.2.1 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.

5.2.3 The CDOP has benefitted enormously from the efforts made by the current SPOC post holder to increase the timeliness of processes e.g. availability of Form Bs, numbers of reviews taking place within six months of a death and speedy arrangement of rapid response meetings.

5.3 CDOP network London and England

5.3.1 Croydon CDOP members have taken part in the London wide and South West London meetings about the implementation of the new Child Death Review processes. Under these new arrangements there will be one Child Death Overview Panel for South West London which includes Croydon CDOP as well as a number of other boroughs.

5.4 Actions completed during 2018-2019

The 2017/2018 annual report identified actions for 2018-2019.

5.4.1 Work closely with CCG, Safeguarding Board, South West London CDOP and Healthy London Partnerships in supporting the implementation of the proposed changes around the child death process. As noted in 5.3.1 above, members of the CDOP including the designated doctor and SPOC have been contributing to the

meetings at London and South West London levels about the new child death review arrangements.

5.4.2 Consider the recommendations of the review of CDOP processes and identify which to prioritise and implement, in the context of wider changes to child death review nationally.

- The CDOP has prioritised reviewing procedures In light of the national changes to the Child Death Review processes.

5.4.3 Explore possibilities for family involvement in the CDOP process.

- Family involvement in the CDOP process is a key element of the proposed new Pan London arrangements and Croydon will work within these recommendations.

5.4.4 Introduce eCDOP

- South West London will be implementing eCDOP as part of the new arrangements in 2019. In the meantime Croydon CDOP has continued to use its locally designed database however eCDOP has been implemented from April 2019.

5.4.5 Complete statutory child death data returns

- Data was submitted via the new NHS digital portal within the required timescales in March 2018.

5.5 Action plan for 2019-2020

5.5.1 Work closely with the CCG, Safeguarding Board, SWL CDOP and Healthy London Partnerships to implement the new Child Death Review processes and apply the learning that is reported from the review of child deaths across South West London.

APPENDIX A: CDOP Organisation and Terms of Reference

The Process

The death of each child is notified to the Child Death Review Co-ordinator who is also the SPOC (Single Point of Contact) by telephone or email; this is followed with a “Form A” giving initial details about the death.

Most unexpected child deaths are subject to the rapid response process; when a meeting is required as part of the process it is chaired by the Designated Doctor for Child Death Reviews or the Head of Safeguarding/Designated Nurse. All professionals/agencies involved with the child that died are invited to attend. The information from the meeting is shared with CDOP.

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 at the time of 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 in obtaining completed Form Bs from some agencies and the quality and detail of some remain poor.

CDOP meetings are provisionally scheduled monthly and go ahead when the information gathered for cases is felt to be as complete as possible, allowing the review of a child death to go ahead. Where insufficient cases are ready for review, meetings are stood down and case discussions are postponed to the following month.

Each case is discussed and recorded using a “Form C” (Analysis Proforma) based on information provided in the Form B and other supporting documentation. The data is entered on a local level 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.

Rapid Response

The arrangements for a rapid response to the unexpected death of a child are well established in Croydon, as described above and is monitored by the CDOP. Where an unexpected death is not believed to warrant a rapid response meeting, the rationale for this decision is logged.

Rapid response meetings are considered a priority to be convened, where possible, within five working days of the child's death. A log of the rapid response meetings is maintained and information is shared with the CDOP.

CDOP Meetings

During 2018-2019, Croydon CDOP met seven times to review information about child deaths.

The CDOP has a fixed core membership. Other members are co-opted to contribute to the discussion of certain types of death when they occur.

Administration

The administration of the CDOP process is completed by the CDOP Coordinator/SPOC.

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.

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.
- Refer to the SCR Panel 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 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.
- 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.

Membership

Core attendees:

- Director of Public Health (Chair)
- Designated Doctor for Child Protection & Child Death Reviews
- Head of Safeguarding, Designated Nurse Children (Croydon Clinical Commissioning Group)
- Named Professional Safeguarding and Child Protection (Croydon Health Services)
- Croydon Single Point Of Contact (SPOC)
- MET Police
- Social Care
- CSCB Business 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

- CDOP members will be required to sign a confidentiality agreement before participating in the CDOP and at the start of each meeting.
- 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 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.

Frequency of Meetings

- Croydon CDOP is scheduled monthly but subject to cancellation if business determines this appropriate.
- There must be a minimum of two agencies in attendance in addition to the Designated Doctor for Child Protection & Child Death Review for the meeting to be quorate.

Relevant papers

- Form A - Initial Notification of the death of a child
- Form B – Agency Reporting Form
- Form C – Analysis Proforma
- CDOP Confidentiality Statement

Rapid Response (RR) Meetings Terms of Reference

The Rapid Response (RR) process applies when a child dies unexpectedly (birth up to 18th birthday), excluding babies who are stillborn or where 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 doctor.

Purpose

The purpose of the Rapid Response (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.
- 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 those 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.
- 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.

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. Minutes will be password protected.

Frequency of meetings

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

Follow-up of actions

- Actions agreed and logged at the RR meeting will be followed up by the Croydon SPOC.
- Minutes will be distributed to all attendees (regardless of their attendance) by the Croydon SPOC. These will be password protected.

Relevant papers

- Form A - Initial Notification of the death of a child
- Child Death Rapid Response meeting; Confidentiality Statement
- Child Death Rapid Response meeting agenda
- Form B – Agency Reporting Form