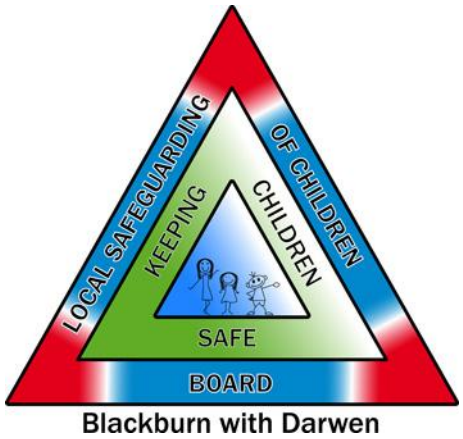
Blackburn with Darwen and Lancashire Safeguarding Children Boards

Child Death Overview Panel

Annual Report

2010-11

CDOP Chair
CDOP Coordinator
CDOP Administrator



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Introduction

The Child Death Overview Panel (CDOP) is a multi agency group responsible for reviewing all child deaths occurring within Lancashire and Blackburn with Darwen. The Panel is a sub group of the Local Safeguarding Children Boards.

The Panel meets on a monthly basis, one month to review information provided in relation to each death and alternate months to manage the business and develop the CDOP and spend a further half day reviewing information in relation to each death.

The deaths of all live-born children 0-18 (excluding infants live-born following planned, legal terminations of pregnancy), are reviewed by the Child Death Overview Panel in line with Working Together to Safeguard Children (2010). This report will provide information in relation to trends and patterns in the childhood deaths reviewed and assurance to the LSCBs that the CDOP is meeting its statutory requirements.

The Lancashire & Blackburn with Darwen CDOP has representation from Lancashire Police, Children's Social Care (both Lancashire & Blackburn with Darwen), Local Safeguarding Children Board (both Lancashire & Blackburn with Darwen), local Primary Care Trusts, Midwifery, Paediatrics, Neonatology & Obstetrics (for review of early neonatal deaths), Mental Health Trust, Early Years (Blackburn with Darwen), Public Health and SUDC Team.

The report initially presents some background information around the numbers of child deaths occurring, being notified and reviewed by the CDOP. Secondly, the report highlights the characteristics and factors in deaths which have been reviewed during the period April 2008 to March 2011 including analysis of the causes of death and whether modifiable factors were identified. The third part of the report focuses on the analysis of deaths reviewed in 2010-11 including data on the timeliness of reviews in the period. The fourth section considers the identification of themes and trends in the deaths considered by the Panel. The fifth section considers the functioning of the CDOP and Rapid Response in relation to the guidelines set out in Chapter 7 of Working Together to Safeguard Children (2010). This is followed with a summary of the national picture in relation to CDOP. The final part of the report outlines the priorities for CDOP and Rapid Response for 2011-12 and recommendations to respective Boards.

Child Deaths Notified to CDOP in Lancashire & Blackburn with Darwen 2008-2011
Background

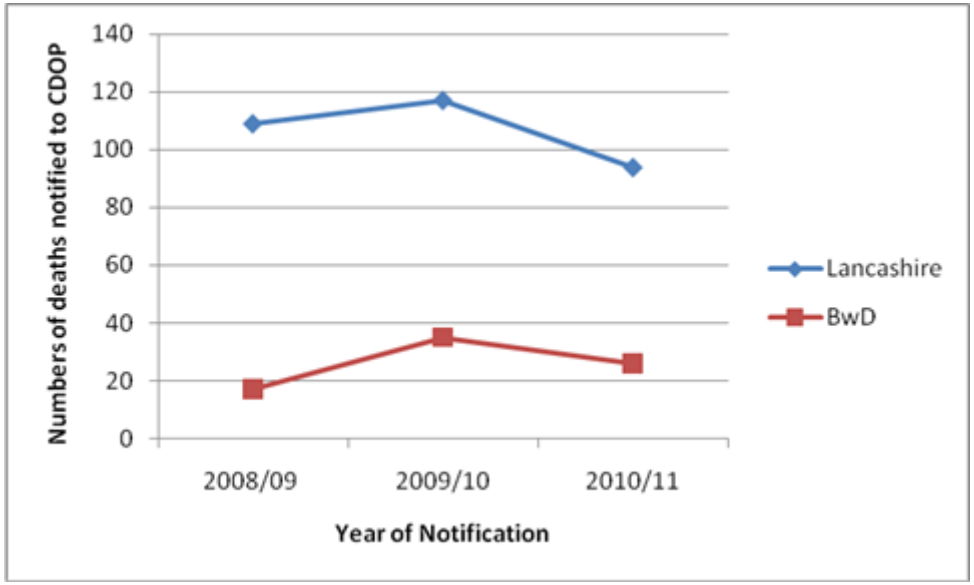

Figure 1; the total number of child deaths notified by locality and year between April 2008 and March 2011

Figure 1 shows the numbers of deaths notified in each year, (126 on 2008/09, 149 in 2009/10 – plus under 5 planned terminations which at that time we were required to review, 120 in 2010/11). There are some inconsistencies between this data and that available from the Office of National Statistics which is being investigated at present. Additional notifications may yet be received from the Department for Education later in 2011 (which may amend the totals from 2010/11) if some deaths have been missed. This additional notification mechanism was not available in 2008/09 and therefore, due to the immaturity of the processes, it may also be possible that some deaths have not been notified to the Coordinator. The figure shows an apparent peak in notifications in 2009/10 and the panel are working with Public Health colleagues to investigate this further.

Child Deaths Reviewed between April 2008 – March 2011

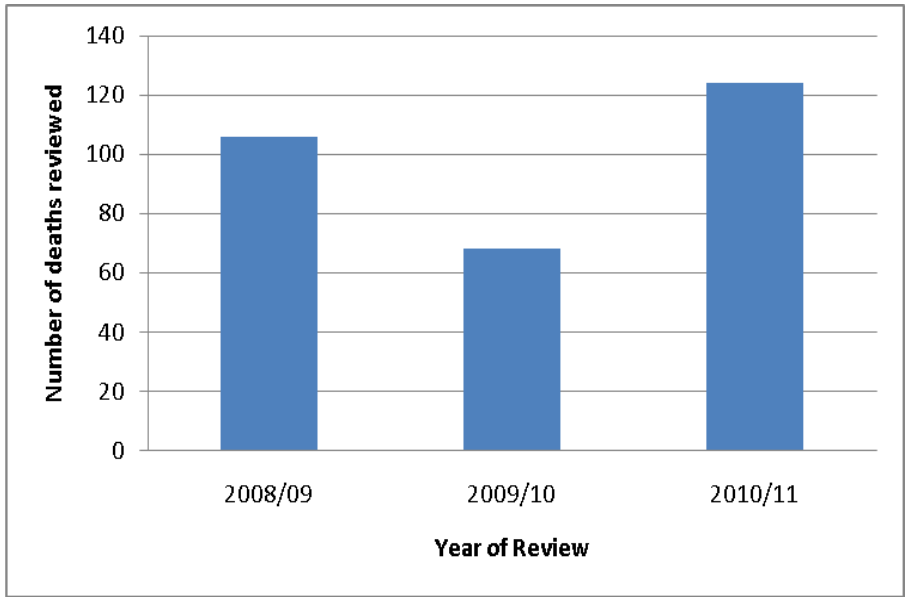

Figure 2 shows the numbers of deaths which have been reviewed by the Lancashire & Blackburn with Darwen CDOP over the 3 years since the Panel was established. The panel have reviewed 298 deaths in three years. 2009-10 clearly shows a marked decrease in the number of reviews, and this can be explained by the decision to tighten up CDOP processes and information gathering during the year. These changes have now been adopted on a widespread basis and the quantity and quality of information collected on behalf of the Panel has improved significantly. As a consequence the decision making process for the Panel has been better informed and the number of reviewed deaths have showed a substantial increase in 2010-11.

Figure 2; the total number of child deaths reviewed between April 2008 and March 2011

The data in figure 2 relates to deaths reviewed and completed by the Panel each year. The difference between this data and the total number of deaths notified within the year is often due to an inherent backlog in the gathering of information and waiting for the completion of Post Mortems, Inquests or Criminal Proceedings. Over the three year period the number of deaths which had taken 6 months or longer to review and complete peaked during 2009/10 and is gradually being reduced from this point.

Categorisation by Cause of Death (reviewed between April 2008 – March 2011)

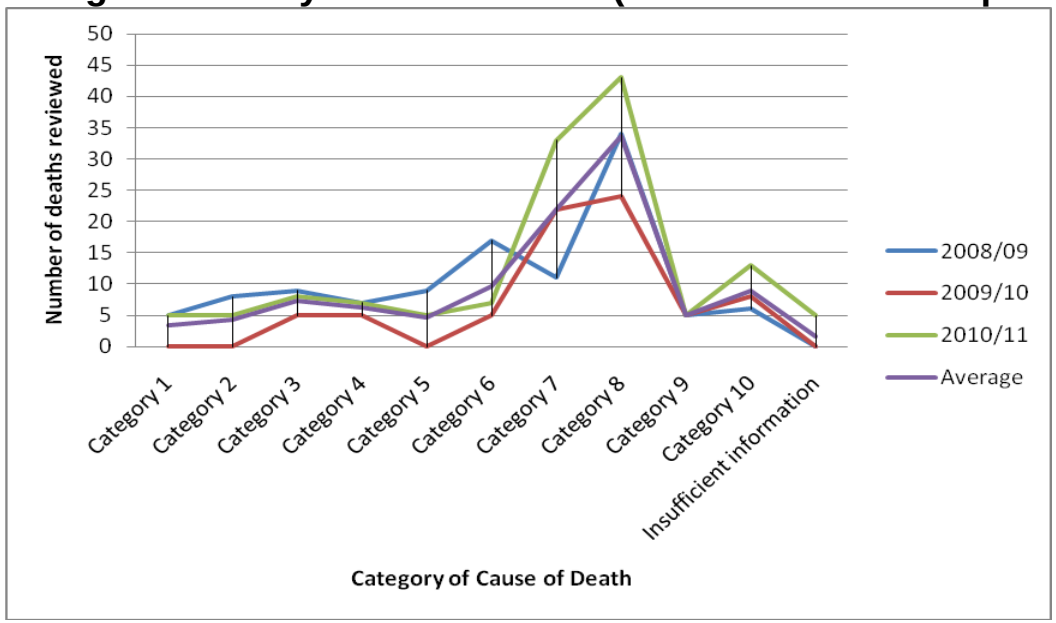

Figure 3; child deaths reviewed between April 2008 and March 2011 by category of cause of death

Figure 3 shows the patterns in categorisation of cause of death over three years. Each year shows a slight variation in the causes of death identified but the line which depicts the 3 year average follows a similar pattern to each individual year. Clearly the deaths reviewed in 2008-09 and 2009-10 show a closely matched pattern, with the highest number of deaths in Category 8 – Perinatal / Neonatal event. However, a lower number of reviewed deaths in 2008-09 which were categorised as Category 7 – chromosomal, genetic, congenital abnormality, is likely to be a result of the immaturity of the Panel reviews in identifying this cause of death.

Categories of cause of death (for further information please see Appendix 1)

1. Deliberately inflicted injury, abuse or neglect
2. Suicide or deliberate self-inflicted harm
3. Trauma and other external factors
4. Malignancy
5. Acute medical or surgical condition
6. Chronic medical condition
7. Chromosomal, genetic and congenital anomalies
8. Perinatal/neonatal event
9. Infection
10. Sudden unexpected, unexplained death

Categorisation by District (reviewed between April 2008 – March 2011)

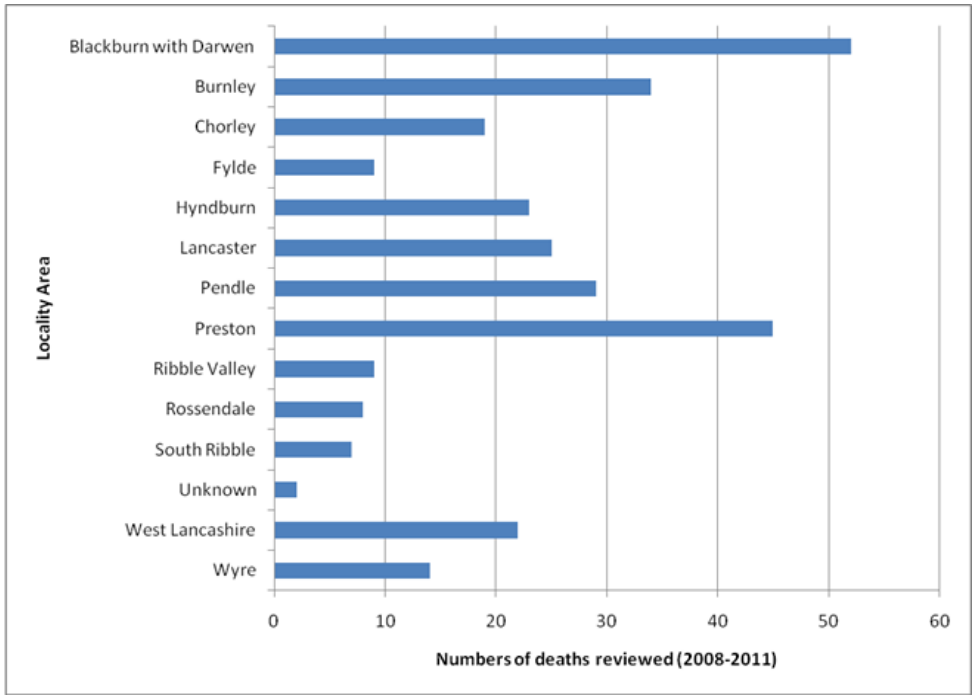

Figure 4; number of deaths reviewed for 2008 – 2011 per locality

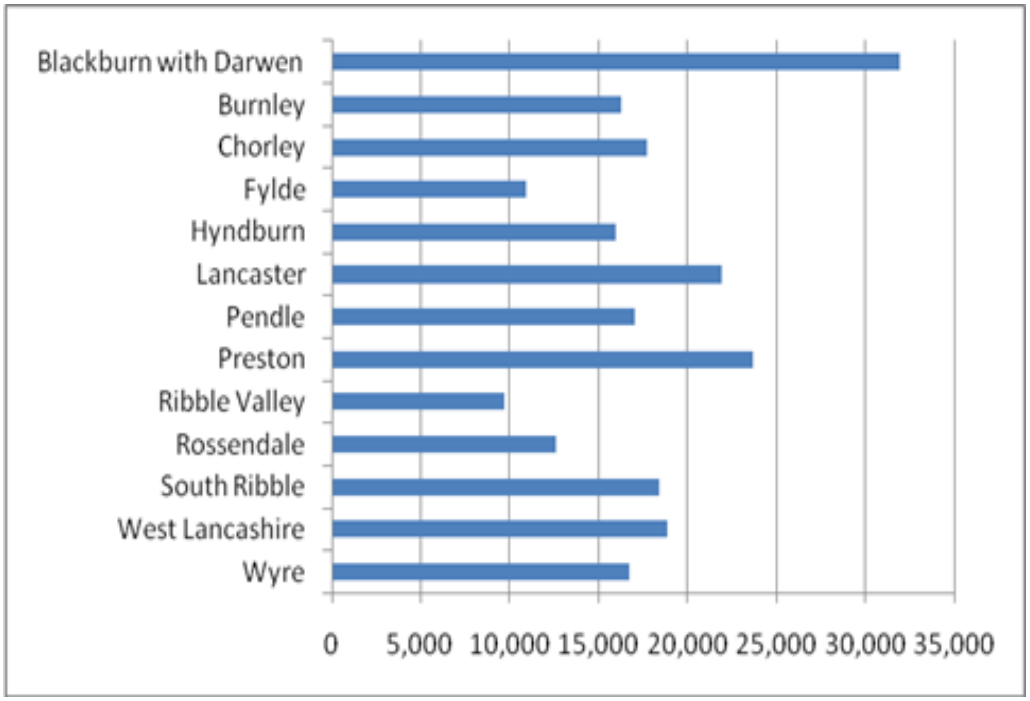

Figure 5; population which is aged 0-15 years per locality

Figure 4 represents the number of deaths reviewed by the Panel rather than all those which have occurred in each area (as 101 reviews from this period are still outstanding). The highest number of child deaths reviewed are from Blackburn with Darwen, followed by Preston and Burnley. For comparison, figure 5 above shows the number of children in each locality aged 0-15 years, (as this data is only 0-15years, the comparison of these data sets requires some caution). The areas of Lancashire with the highest child population are Blackburn with Darwen, Preston and Lancaster, which does not fully reflect the pattern of deaths reviewed. Further work is to be undertaken linking child deaths with deprivation indices and a consideration of patterns in incidence of deaths as further deaths are reviewed. Further details on this work will be shared in locality groupings at presentation of the Annual Report.

Number of Child Deaths where modifiable factors have been identified (reviewed between April 2008 – March 2011)

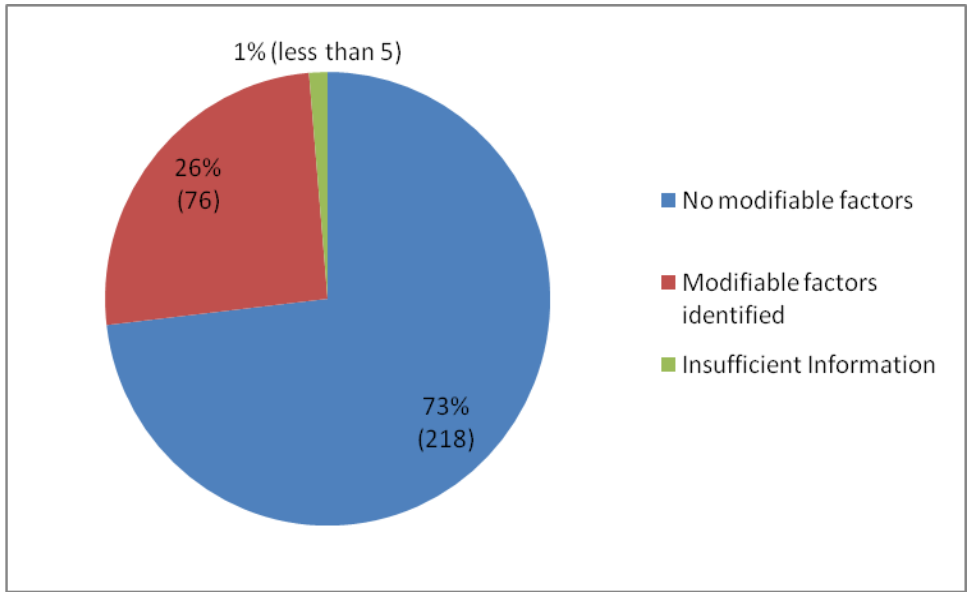

Figure 6 shows the number of deaths which have been reviewed by the CDOP since April 2008 where modifiable factors have been identified. During 2010-11 Working Together 2010 was published and the categories used for these decisions were amended. From April 2008 to publication of Working Together 2010 the categories 'not preventable', 'potentially preventable' and 'preventable' were used. However, at review these were amended to 'modifiable factors identified' and 'no modifiable factors identified'. Therefore the category for 'modifiable factors identified' includes all deaths which were previously categorised as 'preventable' or 'potentially preventable'.

Figure 6; percentage of child death reviewed during April 2008 – March 2011 with modifiable factors identified

Comparing this data to information released by the Department for Education (based on 2010-11 alone), Lancashire and Blackburn with Darwen's Panel have a slightly higher than average percentage of deaths where modifiable factors were identified (26% compared to a National Average of 20% and a NW regional average of 20%), However the national percentage does range from 10% in the South-East Region to 27% in Yorkshire and Humberside. This wide range suggests that reviews nationally are not consistent however, to improve the consistency of reviews on a Lancashire basis, the Panel have identified the need for a Development Day which will be discussed later in the report.

In 10 or more cases domestic abuse, co-sleeping (on a bed or sofa), substance misuse (of child or carer), alcohol use / misuse (of child or carer), child or adult mental health problems and road traffic collisions were identified as modifiable factors. Each of the factors identified may have been identified in conjunction with other modifiable factors. Other factors present in 6 or less deaths include chaotic home environments, overheating, life-limiting conditions (or children with complex needs), smoking in the household and bullying. A further 40 modifiable factors were identified that fall into three broad groupings:

- Access to medical advice – either carer's delay in seeking medical advice, advice not available or inappropriate at that time.
- Environmental Factors – such as security issues around water or child dying abroad where medical advice was not available
- Communication & information sharing between professionals – inter or intra-agency communication.

Number of Child Deaths where modifiable factors have been identified by cause of death (reviewed between April 2008 – March 2011)

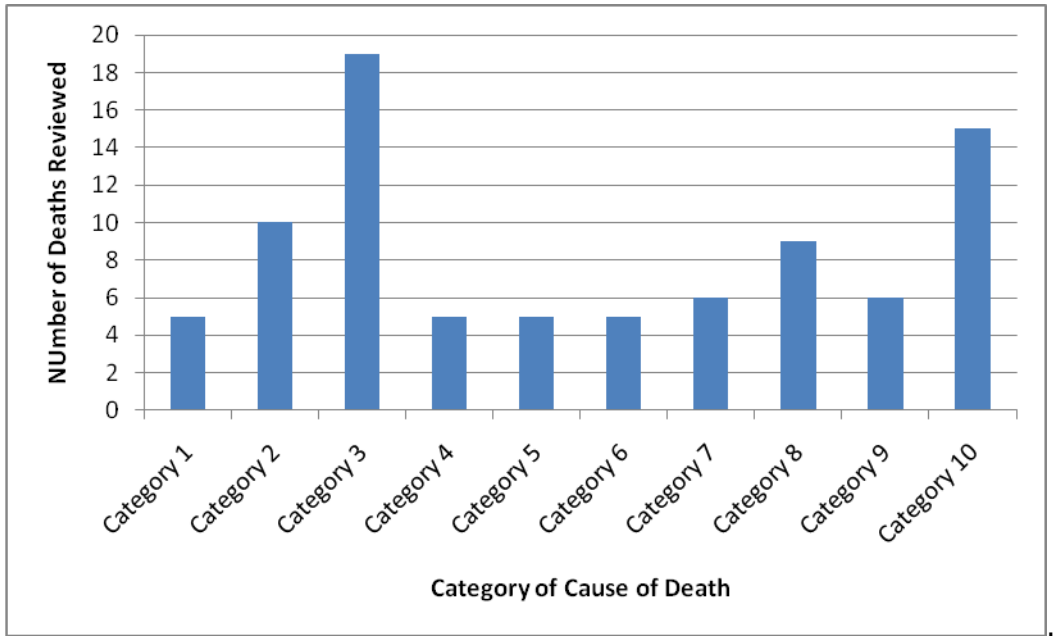

Figure 7 shows the 76 deaths between 2008 and 2011 where modifiable factors have been identified, grouped by category of cause of death. Over the three years deaths with modifiable factors predominantly fall into Category 3 – Trauma and Other External Factors, Category 10 – Sudden Unexpected, Unexplained Death and Category 2 – Suicide or self-inflicted or deliberate self-inflicted harm

Figure 7; number of child deaths with modifiable factors identified categorised by cause of death

Deaths categorised by age (reviewed between April 2008 – March 2011)

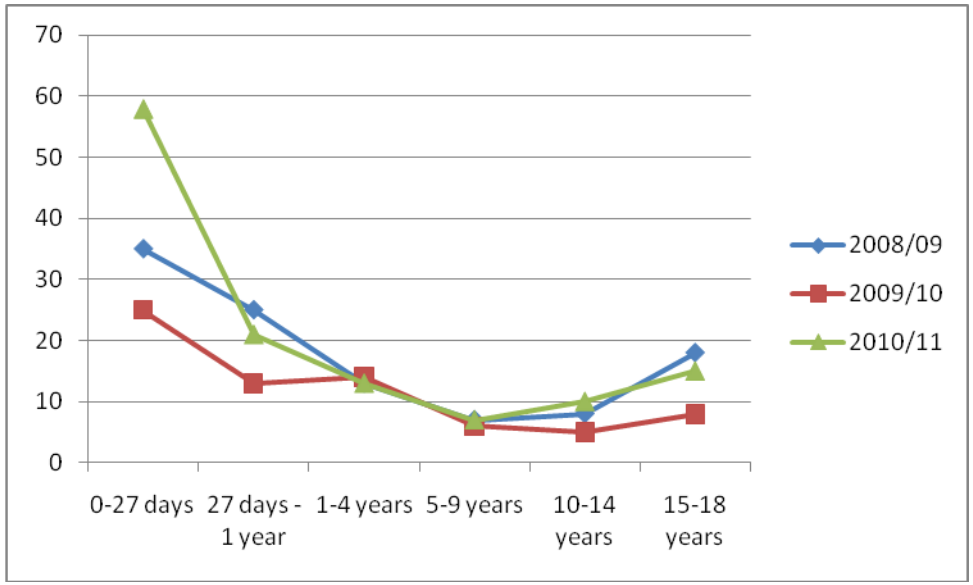

Figure 8; number of child deaths reviewed between 2008 – 2011 categorised by age

The graph above shows the numbers of deaths for each age category over a 3 year period. It is clear that the majority of the age groups follow a similar pattern through the three years of reviews although reviews completed in 2010/11 have included a higher proportion of deaths 0-28 days. This pattern is reflected on a national basis where 44% of all deaths reviewed in 2010-11 are of children 0-28 days old. For 2010-11 Lancashire & Blackburn with Darwen's reviews contained 47% at 0-28 days. Although slightly higher this does reflect the national picture. The process of the CDOP also means that the neonatal deaths may be brought to Panel more quickly than deaths of older children with the result that more deaths have been reviewed this year. This national data is not available for previous reviewing years as the collection of this information from CDOPs was not made compulsory until 2010-11.

CDOP Reviews 2010-11

The data included in this section of the report relates to the child deaths which have been considered and completed at Panel review from April 2010 to April 2011. The Panel have reviewed in total 124 deaths (of which 26 are children normally resident in Blackburn with Darwen). It is also important to note that the CDOP Coordinator has been *notified* of 128 deaths during 2010-11 (this includes 8 deaths of children normally resident elsewhere which will not be reviewed here but the team may contribute to the information gathering required for another CDOP to complete the review). During 2010/11 the Panel have reviewed sufficient deaths to halt the increasing backlog.

Time taken to complete reviews 2010-11

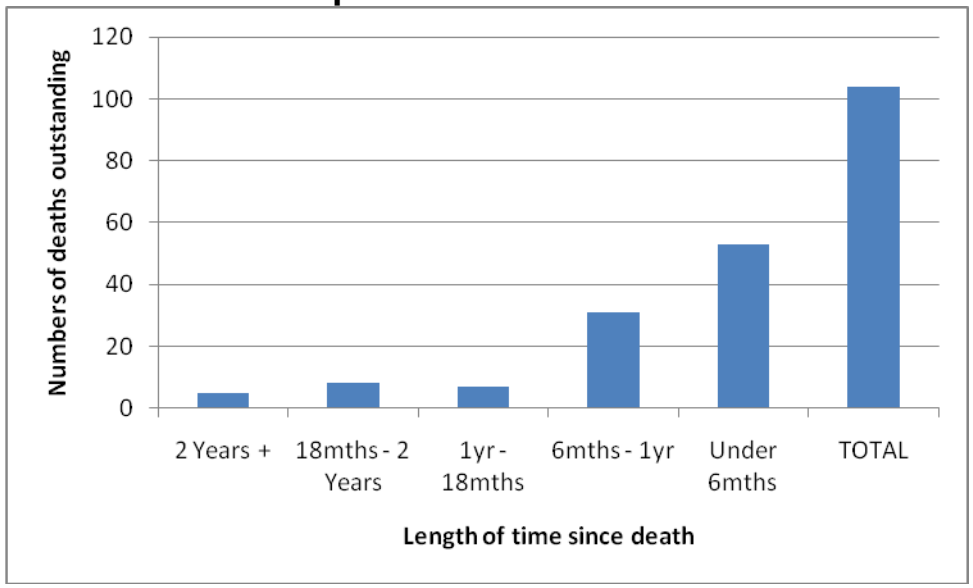

Figure 9; number of child deaths awaiting review categorised by the length of time since the death

Figure 9 shows the total number of deaths awaiting review at 1st April 2011. It also breaks down this information into how long it has been since the death to this date. As a result of the reviewing process, in 2008-09 almost all deaths which occurred in that year were also reviewed in that year. Very few reviews were outstanding at the beginning of 2009-10 recording year which meant that reviews in 2009-10 would have inherently shorter timescales. Information gathering systems were also amended in 2009-10. There were some difficulties in accommodation of the new arrangements which meant that a large proportion of deaths remained outstanding at the end of 2010. Although there will always be a delay in reviewing some deaths (i.e. those with Post Mortems, Inquests, Criminal Proceedings or Serious Case Reviews), the CDOP are taking steps to ensure that the backlog of all *other* deaths remains at a minimum.

For 2010-11 reviews completed the figures 10 - 13, break down the length of time to complete reviews into Primary Care Trust boundary areas.

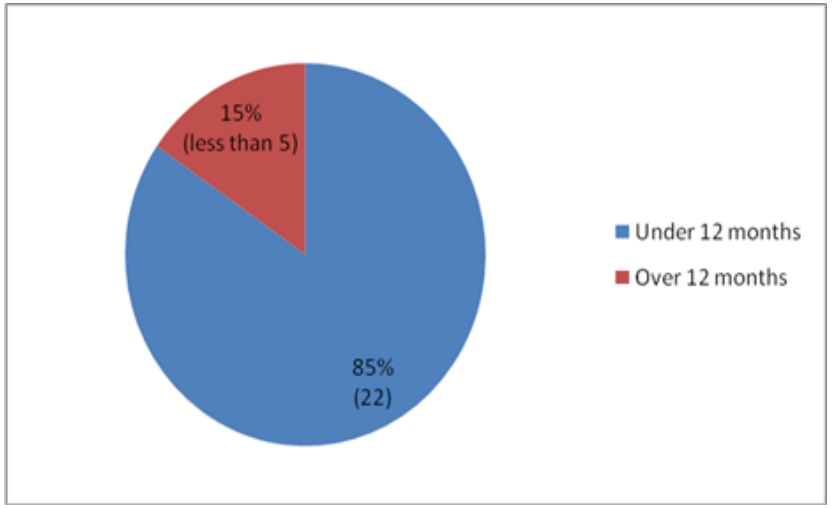

Figure 10; Blackburn with Darwen child deaths categorised by length of time to complete the review

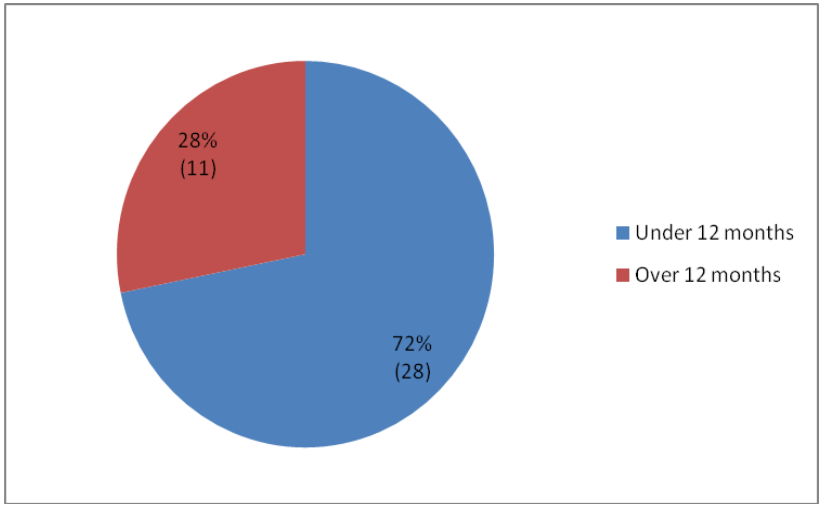

Figure 11; East Lancashire child deaths categorised by length of time to complete the review

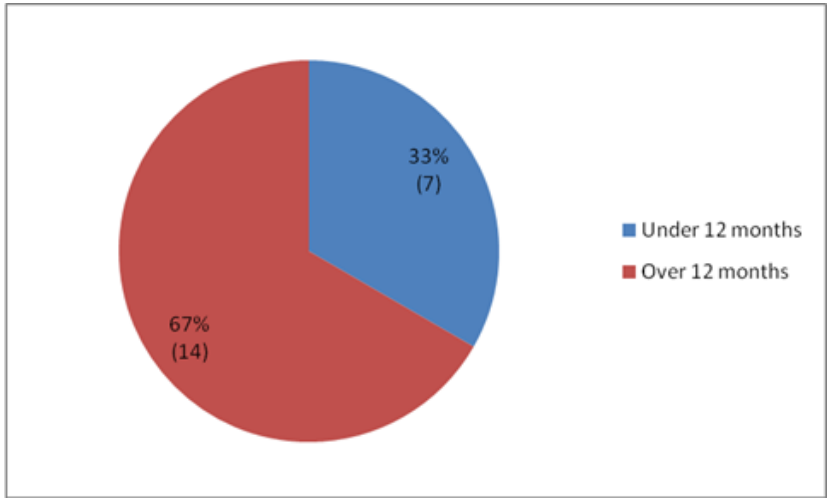

Figure 12; North Lancashire child deaths categorised by length of time to complete the review

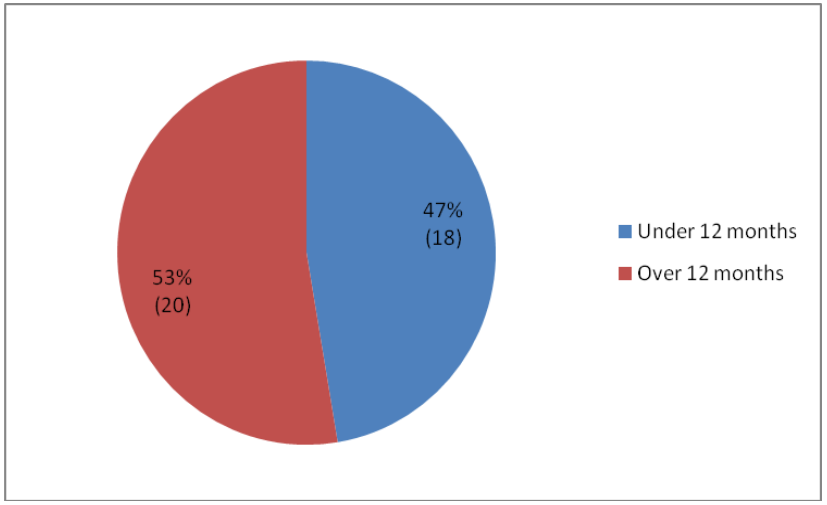

Figure 13; Central Lancashire child deaths categorised by length of time to complete the review

The figures above show that deaths in East Lancashire and Blackburn with Darwen PCT are reviewed in a shorter time scale than the other areas (figure 11 and 10).The majority of these deaths were reviewed in under 12 months. Figure 13 shows that areas under Central Lancashire PCT's footprint are approximately even for those reviewed under and over 12 months. In comparison North Lancashire has more deaths which take over 12 months to complete (figure 12). It is possible that the geographical differences are related to the system of information gathering in each area; however this process will be monitored closely as organisational changes come into force.

Categorisation by Cause of Deaths (2010-11)

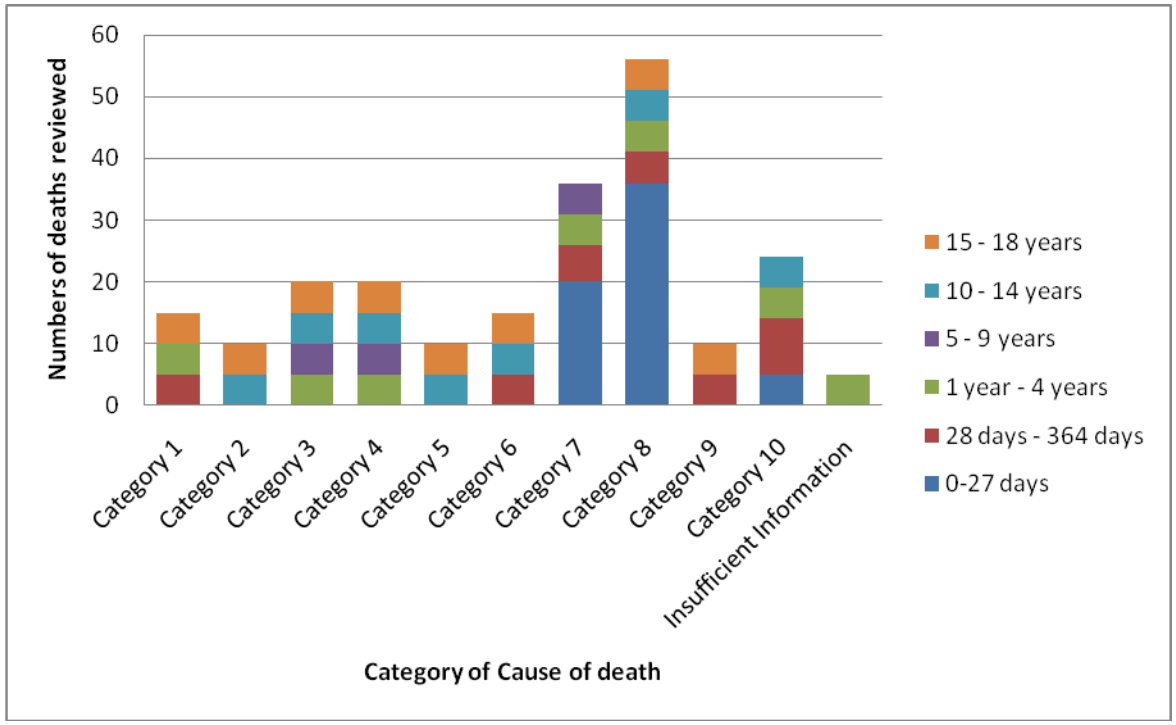

Figure 14; number of child deaths reviewed in 2010-11 categorised by cause of death

Figure 14 shows a breakdown of the deaths considered by cause of death and age. It can be seen there are clearly two categories of cause of death which have the highest total number of deaths; Chromosomal, genetic and congenital anomalies and perinatal / neonatal events. The Panel have begun to record maternal BMI, Domestic Violence and timings for intubation in order to try to better understand links between deaths in these categories. It is clear that although most deaths categorised as a result of perinatal / neonatal events or chromosomal, genetic or congenital abnormalities would be in children under 1year, a significant proportion of these deaths occur in older children as a result of long term life limiting conditions. One further category which has a higher number of deaths is sudden unexpected, unexplained deaths, these also contribute to deaths with high numbers of modifiable factors and will be discussed further later in the report

Modifiable Factors Identified in the Review (2010-11)

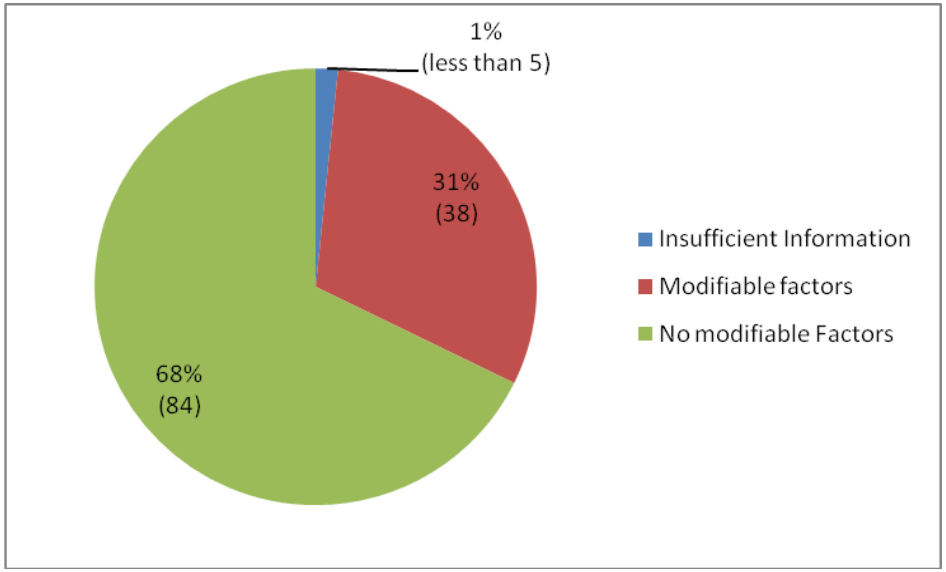

Figure 15 Deaths reviewed in 2010-11 where modifiable factors were identified

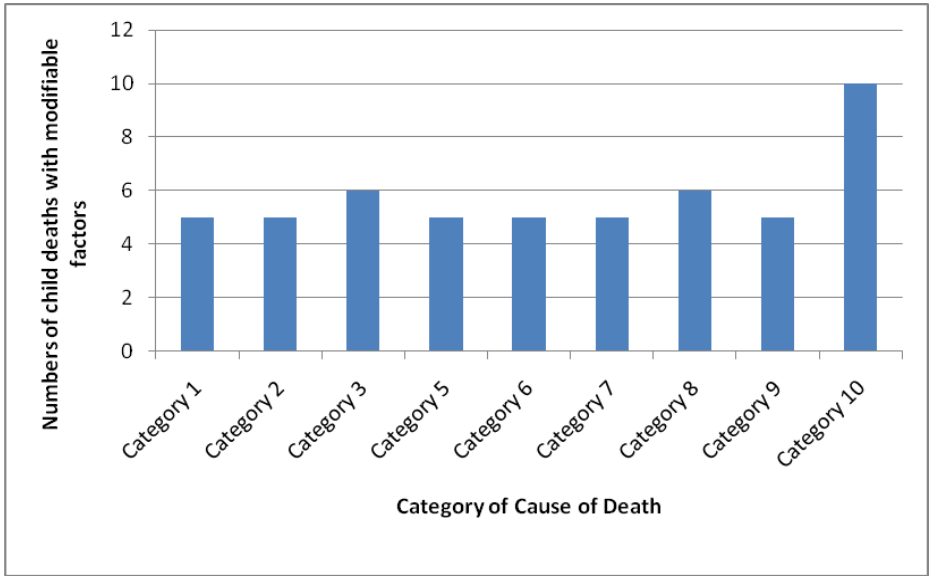

Figure 16 Deaths reviewed in 2010-11 where modifiable factors were identified, by cause of death

Figure 15 shows that of the deaths reviewed in 2010-11, 31% of the reviews identified some factors which may have been modifiable in the period leading up to the death. Figure 16 then shows the deaths where modifiable factors were identified by the category of cause of death. It is clear that most of the deaths where modifiable factors were identified are in Category 10, sudden unexpected / unexplained death. The remaining categories where most modifiable factors were identified are trauma and other external factors and chromosomal, perinatal / neonatal events and congenital and genetic abnormalities equally.

Children Who Die Overseas

Those deaths which were identified as having insufficient information included those where the child was normally resident in Lancashire or Blackburn with Darwen and died abroad (Figure 15). This is an area which is problematic on a national basis. As the child's body does not return to the United Kingdom, no coroner has jurisdiction and there is no compulsion to re-register the death in the UK. Therefore, as a CDOP, we cannot collect accurate information about cause of death or circumstances around the death.

Deaths Categorised as Expected / Unexpected at Panel Review 2010-11

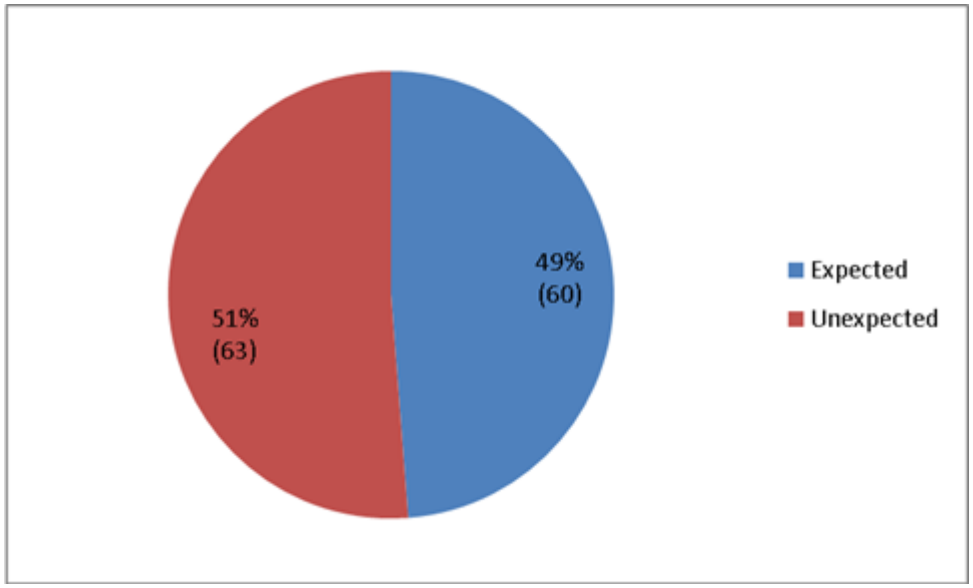

Figure 17; percentage of child deaths categorised as unexpected, at the CDOP Review

The definition of an unexpected death is a death which:

- was not anticipated as a significant possibility for example, 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.

The definitions are open to interpretation and have led to some inconsistencies by the Panel in classifying unexpected/expected deaths. Often, deaths which were originally categorised as expected at the time of death have been amended to unexpected by the Panel, once full information has been received for consideration. This issue will be revisited at the CDOP Development Day.

Late decisions on unexpected/expected deaths have also been problematic for the SUDC Service and will be improved in 2010-11. This is an aspect where increased awareness raising and training will support decision making at the time of death and help ensure appropriate involvement of the SUDC service in all unexpected deaths.

Identification of themes and trends

It is clear from the information presented above that there are obvious patterns of child deaths across Lancashire and Blackburn with Darwen. The highest numbers of deaths occur in the following three categories:

- perinatal / neonatal events,
- chromosomal, congenital and genetic abnormalities and;
- sudden unexpected, unexplained deaths.

Perinatal / Neonatal Events
Extreme prematurity sometimes of a non-viable gestation has remained a feature in this group of reviews. Domestic violence has also been noted as an aspect in a number of these deaths and will continue to be monitored. However, only a small number of these deaths have been found to have factors which, when modified, may have prevented the death.

Chromosomal, genetic and congenital abnormalities
Chromosomal, genetic and congenital abnormalities cause a high proportion of childhood deaths. The CDOP has throughout 2010-11 contributed to a scoping exercise undertaken by Public Health Blackburn with Darwen looking at the impact of consanguineous marriages on this group and this will be discussed in more detail later in the report.

Sudden unexpected, unexplained death
Sudden unexpected, unexplained death is the third highest category. A recent thematic review has considered the risk factors identified in this category and although they were not all present in all cases, the factors identified were: smoking, co-sleeping (on a bed), substance and alcohol misuse, and overheating (in infant deaths). This information and work will now further inform the direction and scope of the Give Me Room to Breathe campaign and Safer Sleeping Guidance for professionals.

Modifiable Factors
The deaths which have been identified as having 'modifiable factors' fit into slightly different categories:

- Sudden unexpected, unexplained deaths,
- Trauma and other external factors,
- Perinatal / neonatal events and;
- Chromosomal, congenital and genetic abnormalities.

The modifiable factors which have been most identified in these four categories include; domestic violence, co-sleeping (on a bed or sofa), substance misuse or alcohol use or misuse (in child or carer), child or carer's mental health problems and road traffic collisions.

Sharing Information
Information around co-sleeping and associated risk factors, including broad seasonal patterns, have been shared with the Give Me Room to Breathe group to inform planning of their future campaigns.
Information around self-harm, suicide and associated substance / alcohol use and misuse has been shared with Lancashire's Stay Safe Theme group in order to inform development of guidance for professionals around self-harm. It has also been shared with Blackburn with Darwen's Trust Performance Group and LCFT's monitoring group on their Mental Health/Suicide Protocol.
Road Traffic Collision deaths have not been significantly higher during 2010-11 however ongoing information is shared with relevant colleagues to inform their analysis of serious road injuries.

Issues linked to Information Gathering
Other recurrent issues identified by the review process included gaps in the completeness of information provided to the panel. These gaps included:

- Lack of parental information where available (specifically for fathers / other male adults in the household and their dates of birth)
- Lack of or incorrect information on ethnicity
- Incomplete information for 'Asylum Seekers'.

Information gathering documentation has been amended to make the required information clearer and data completeness will be monitored over the next reviewing year.

The Functioning of the CDOP during 2010-11

Rapid Response

Working Together 2010 requires that a rapid response should be completed by a group of key professionals who come together for the purpose of enquiring into and evaluating any unexpected death of a child, as a part of the processes to be followed by the Local Safeguarding Children Board.

The SUDC (Sudden Unexpected Death in Childhood) Service is nurse-led, and has been providing the health element of the Rapid Response process to unexpected deaths of infants and children up to 18 years of age, pan-Lancashire since September 2008. Lancashire Constabulary initiates a Rapid Response to unexpected deaths when no SUDC service is available (out of office hours, weekends & bank holidays).

The Service has developed valuable expertise in responding to and contributing to the joint investigations into sudden unexpected child deaths and in coordinating the multi-agency information gathering process. The Service provides individualised support for families and regularly refers families to specialised services, for example, genetic screening clinics or specialist bereavement services.

During 2010-11 the SUDC Service Specification has been modified and performance information will be reviewed by the CDOP on a bi-monthly basis in relation to End of Case Discussion Meetings, Coroner's reports prior to Inquest and numbers of deaths where Rapid Response was initiated.

It is hoped that the launch of the SUDC Protocol and revision of the Service Specification will strengthen the delivery of the service and will help to identify roles and responsibilities across Lancashire to support the Rapid Response process.

CDOP Priorities as Identified by 2009/10 Annual Report

During 2010/11, the CDOP has completed all priorities identified by the 2009/10 Annual Report. (Please see Appendix 2)

Future priorities for the year 2011/12 will be identified later in this report.

CDOP Successes 2010-2011

- *Chromosomal, Genetic and Congenital Abnormalities*
  One of the themes identified in the 2009/10 Annual Report was the issue of consanguinity or cousin marriage. This is acknowledged as a high contributory factor in child deaths categorised as due to chromosomal, genetic and/ or congenital abnormalities. Blackburn with Darwen Department for Public Health was commissioning research into this field to which the CDOP contributed. Blackburn with Darwen and East Lancashire has a high incidence of infants born with genetic disorders as a result of consanguinous marriage. The pilot study offered extended family members, as well as parents access to information and genetic carrier testing to inform their reproductive choices. Results showed that the vast majority of people offered the Service engaged and found it useful and the incidence of infants born with some genetic disorders was reduced.

- *Family Contact & bereavement training*
  During 2010-11 the CDOP has established systems for contacting parents to inform them of the CDOP processes. Following extensive discussion, the Panel have chosen to use a nationally agreed leaflet about Child Death Review (including the role of the Coroner, Post Mortems and the CDOP). The leaflet is given in person by a SUDC Nurse to families who have received a Rapid Response and by the Registration services in the bereavement pack which they supply. The leaflet is accompanied

by a letter from the Panel Chair and contact information for the Lancashire Safeguarding Children Board if parents have any further questions. In addition to this the Lancashire Safeguarding Children Board team have undertaken training for contacting bereaved parents, (provided by the Foundation for the Study of Infant Deaths). Contingency arrangements have also been agreed to cover any absence of the CDOP Coordinator.

- *Suicide or Deliberate Self-Inflicted Harm*
  Deaths due to 'Suicide or Deliberate Self-Inflicted Harm' have been identified in previous Annual Reports as an emerging theme. During 2010-11, a further review of this group of deaths has been undertaken, specifically in relation to the role which bullying may have played. The information from the review was presented to the CDOP and Safeguarding Children Boards and has subsequently been shared with the Lancashire Stay Safe Theme Group. This latter group is responsible for delivering the Stay Safe element of the Children's Plan and the information shared has been used to inform and support the development of Self-Harm Protocol and anti-bullying strategies. The Panel is represented on the Stay Safe Theme Group and also shares information on other deaths where there are potentially modifiable factors e.g., Road Traffic Collisions.

- *Sudden Unexpected, Unexplained Deaths*
  A review was also undertaken on the deaths categorised as 'Sudden unexpected, unexplained death'. It was identified that the risk factors associated with these deaths in infancy are smoking, co-sleeping (on a bed), substance and alcohol misuse and overheating. . It was also noted that deaths appear to be more prevalent during the Winter months (November, December & January) and that the highest proportion was in Blackburn with Darwen, Lancaster and Pendle.This information will inform the work of the Give Me Room to Breathe Group, in terms of key messages, locality focus and seasonality. During 2009/10 the SUDC service have also led the development of Safer Sleeping Guidance for professionals which has now been rolled out in each PCT locality.

- *Neonatal Deaths*
  As a result of the high number of neonatal deaths reviewed by the group in 2010/11, amendments to Panel processes are being trialled. The Panel have drafted a new A/B form for deaths of children 0-28 days, requesting specific information relevant to this group for example, ante-natal history, delivery details etc. This is being piloted in one hospital trust initially. In addition, the Panel will now review early neonatal deaths (under 7 days of age) in a separate, half day Panel meeting. The panel for this meeting will include an obstetrician, neonatologist, midwife and senior neonatal nurse who will represent hospital trusts across the LSCB areas to improve cross-border challenge and sharing of best practise. The first meetings will be held in June 2011.

- *SUDC Protocol*
  During 2010-11 the SUDC Service, on behalf of the CDOP, worked closely with the local Coroners and other agencies to develop and finalise the SUDC Protocol. The Protocol has now been ratified by the Lancashire & Blackburn with Darwen Safeguarding Children Boards (with the exception of a technical amendment in relation to pathology). This is an important step forward in ensuring that all families receive an exceptional and consistent service from all agencies involved in the Rapid Response process. The protocol will be launched in partner agencies to raise the profile of the Rapid Response process. This launch will take the format of a newsletter – including links to the Protocol, E-Learning Package amendment and cascading and additional slides to presentations of awareness-raising in relation to CDOP.

- *Links with Serious Case Review Findings*
  Findings from the CDOP reviews have recently been included in Pan-Lancashire Serious Case Review Briefings. The broad themes and trends support those identified during the SCR process in relation to 'Safer Sleeping', 'What harms teenagers', 'The Toxic Three – Mental Health, Substance Misuse and Domestic Violence' and 'Invisible Males'. The briefings are multi agency and delivered across Lancashire on a regular basis.

- The CDOP Coordinator continues to liaise with and visit other Panels to share best practise and identify future joint working opportunities.

- The efficiency and quality of information gathering for the Panel has significantly improved over the twelve month period. This has as a consequence, improved the quality of decisions and recommendations which the Panel are able to make.

The National Picture

The role of CMACE (Centre for Maternal and Child Enquiries)

The National Patient Safety Agency (NPSA) recently ran a competitive tendering exercise for the future provision of the National Confidential Enquiries from 1 April 2011. The work previously undertaken by CMACE was split into two programmes of work, maternal, newborn and child health. In late March 2011 the NPSA terminated the contract for the maternal and newborn confidential enquiry with immediate effect while a review of the way forward for this important work is conducted. The award of the child health contract to the RCPCH is unaffected.

As a consequence of these changes the CDOP will no-longer share information with CMACE, nor will they have access to the CMACE Perinatal Mortality forms formally supplied to the CDOP as a part of the information gathering process. To address this gap the CDOP have developed a form to be used for early and late neonatal deaths which incorporates some of the information which CMACE previously gathered.
With no annual CMACE regional report there is also no method of comparing information and performance across the region

Munro Review and CDOP
Although Professor Munro's review does not refer extensively to the CDOP, it is important to recognise the potential impact of her recommended changes on the CDOP processes. The review suggests that the findings from Serious Case Reviews and associated learning activities should be linked on a national level to the findings from the CDOP. She comments that there is evidence of good local learning from CDOP reviews, but no national mechanism for systematically analysing, collating and disseminating this learning. There is evidence that 'preventable deaths' will still remain a focus for central government. The review also identifies that the LSCB will have an extremely valuable role in the future and will remain uniquely positioned within local accountability structures.

Recommendations to LSCB

- The Board note the content of the CDOP report and support the planned actions for 2011/12
- The Training sub-groups of both Boards work with CDOP to develop robust single and multi-agency training to raise the profile of CDOP processes, procedures, notification processes and feedback to professionals from completed reviews.
- The Communications Sub-Group work with CDOP to develop a communication strategy for disseminating relevant learning from these reviews and the SUDC protocol to professionals and the public
- Members of the board are asked to share the themes identified in this report with relevant partners to inform future planning or services.

Appendix 1

Category of Cause of Death Descriptors:

1. **Deliberately inflicted injury, abuse or neglect**
   This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.
2. **Suicide or deliberate self-inflicted harm**
   This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.
3. **Trauma and other external factors**
   This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury, abuse or neglect. (category 1).
4. **Malignancy**
   Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
5. **Acute medical or surgical condition**
   For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.
6. **Chronic medical condition**
   For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.
7. **Chromosomal, genetic and congenital anomalies**
   Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease,cystic fibrosis, and other congenital anomalies including cardiac.
8. **Perinatal/neonatal event**
   Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).
9. **Infection**
   Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.
10. **Sudden unexpected, unexplained death**
    Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).