Messages from the CDOP

August 2015
Issue 1

Kirklees Safeguarding Children Board

Calderdale Safeguarding Children Board

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The Child Death Overview Panel:
Who are we and what do we do?

The death of any child is a tragedy. It is vital that all child deaths are carefully reviewed. This is so that we may learn as much as possible from them, in order to better support families and to try to prevent future deaths.

Chapter 5 of Working Together to Safeguard Children 2015 describes how the deaths of all children under the age of 18 must be reviewed by a Child Death Overview Panel (CDOP) on behalf of every Local Safeguarding Children Board. The CDOP is a group of professionals who meet 6 times a year to review the deaths of all children who ordinarily live in their area (including those who die abroad)

Kirklees and Calderdale SCB's hold a joint CDOP which includes representatives from both authorities. The Panel provides data and any recommendations re: lessons learned to the Local Safeguarding Children Boards, and cascades information and learning to individual agencies via their CDOP representative. Information is also shared with the Department for Education to inform a National Statistical Release.

Very positive professional relationships have been forged and CDOP meetings tend to be positive and informative despite the difficult subject matter.

Families do not attend Panel but are provided with information regarding the process. They can provide information to be shared at Panel if they wish to do so.

Who is on the Panel?

The Panel has representatives from:

- Public health
- Local child health and social care services
- Police
- Forget Me Not Children's Hospice
- LSCB's
- Other professionals may be invited to give specialist advice

Child Death Review Process

As mentioned overleaf, the statutory process for reviewing child deaths is set out within Chapter 5 of Working Together to Safeguard Children 2015. This chapter also describes the inter-related process of initiating a rapid response to sudden unexplained deaths in childhood (SUDIC). The lead professional for the SUDIC response in Kirklees and Calderdale is Dr. Eilean Crosbie, Consultant Paediatrician (and CDOP member).

CDOP coordinators are routinely notified of all child deaths (usually by hospital or hospice colleagues). By far the largest numbers relate to neonatal babies (less than 28 days old).

Overall, numbers are reassuringly low with on average, 45-50 deaths per year within the whole of Kirklees and between 15 and 20 in Calderdale.

Standard Department for Education information gathering templates are sent out to all agencies who may have had involvement with the child or family. The information returned is then collated into one report, anonymised and presented at CDOP. (Please be aware if you receive one of these forms that this is the process following all child deaths and is purely an information gathering exercise).

CDOP discusses each case at length and then determines and records:

I. a category in respect of the cause of death
II. whether the death was preventable
III. whether there were any "modifiable factors" which could have contributed in some way
IV. whether there are any specific lessons which could prevent future deaths

Examples of preventable deaths are accidents such as ingestion of toxic substances or suffocation due to unsafe sleeping arrangements. Modifiable factors include parental smoking / substance misuse and some inherited genetic conditions.

Reviews cannot be completed until all other processes such as inquests and Serious Case Reviews are concluded.

In Kirklees, professionals can access multi agency training "Lessons Learned: Using Reviews to Prevent Serious Harm to Children" for a broader overview of the local processes and statistical information.

Safety Messages

Window Blind Cord Safety

'Coroner warns parents of dangers of window blind cords after toddler becomes third child to be accidentally strangled this year' Mail Online, March 2012.

Between 1999 and the end of 2013, 27 children in the UK are known to have died as a result of becoming entangled in a blind or curtain cord or chain. Most of these deaths occurred in toddlers in their bedrooms when their parents believed them to be asleep. In Kirklees and Calderdale there have been 2 such deaths between 2008 and 2015.

From 2014 stringent new standards governing the manufacture, selling and installation of new blinds have come into effect with the aim of reducing such incidents.

The Child Accident Prevention Trust (CAPT) has worked with the British Blind and Shutter Association (BBSA), RoSPA , BSI, the UK Government and the EU to strengthen safety requirements. The new standards will mandate: safety devices for preventing any cords or chains from forming a hazard / the testing of all safety critical items of internal blinds / the testing of blinds using safety devices / the installation of safety devices on the product at the point of manufacture / maximum cord and chain lengths / warnings and instructions on packaging and point of sale information.

Further information is contained within this leaflet:

http://www.makeitsafe.org.uk/uploads/categories_11_53301a8518e5f.pdf

Other ongoing safety issues

Nationally, CDOP'S have recently been raising awareness of risks associated with

- Ingestion of button batteries
- Drowning following unsupervised use of baby and toddler bath seats
- Risk of suffocation from nappy sacks
- Unsecured or wrongly fitted large TV's
- Ingestion of liquitabs
- Suffocation due to unsafe sleeping arrangements and certain types of baby sling.
- Ingestion of nicotine refills from e-cigarettes

Further information regarding specific safety issues can be accessed via the website of the Child Accident Prevention Trust

LSCB e-learning

Every Local Authority area has a designated CDOP representative to act as a single point of contact for data collection and information sharing. In Kirklees, the designated person is Carol Rhodes and in Calderdale, Julia Caldwell. This enables safety messages to be collated and shared in respect of issues which have not necessarily arisen in our areas but could do so in the future.

Becki Hinchliffe, Learning and Development Officer for Kirklees SCB has developed an e-learning course in conjunction with Kirklees Accident Prevention Forum. Some of the safety messages gathered via the CDOP Single Point of Contact mechanism have been incorporated within the course which is free and can be accessed by anyone (including members of the public).

All of the KSCB e-learning courses can be accessed by creating an account on the Course Management System via the KSCB website.

Safeguarding Children Board Contacts

Kirklees

Caryn Hansom, Business Support Officer
Email: caryn.hansom@kirklees.gov.uk
Tel: 01484 225450

Calderdale

Julie Hartley, SCB Business Support Co-Ordinator
Email: julie.hartley@calderdale.gov.uk
Tel: 01422 394149

Websites and links to further Information

Kirklees Safeguarding Children Board
http://www.kirkleessafeguardingchildren.co.uk/

Calderdale Safeguarding Children Board
http://www.calderdale-scb.org.uk/

Forget Me Not Children's Hospice
http://www.forgetmenotchild.co.uk/

Child Accident Prevention Trust
http://www.capt.org.uk/?gclid=CKrlmZziu8UCFeiWtAodWmwAnw

Lullaby Trust (bereavement support)
http://www.lullabytrust.org.uk/

National CDOP contacts
https://www.gov.uk/government/publications/child-death-overview-panels-contacts