Wandsworth
Child Death Overview Panel

Year End Report
April 2012 – March 2013
1. INTRODUCTION TO CDOP

As of 1st April 2008 all LSCBs must have arrangements in place to respond to and review child deaths in their borough, as outlined in Working Together To Safeguard Children 2013, Chapter 5. These arrangements are to include:

- An overview of all child deaths (under 18 years, excluding those babies who are stillborn) in the LSCB area undertaken by a panel (para 5.8 – 5.9); and
- A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child (para 5.12-5.20).

The overall principles are that in all cases enquiries should seek to understand the reasons for the child’s death, address the possible needs of other children in the household, the needs of all family members, to monitor the support services offered to families and, also to consider any lessons to be learnt about how best to safeguard and promote the children’s welfare in the future. All families should be treated with sensitivity, discretion and respect at all times, and professionals should approach their enquiries with an open mind.

1.1 TERMS OF REFERENCE

The Wandsworth Child Death Overview Panel was duly set up in April 2008 and has agreed Terms of Reference. These include the purpose of the panel, their objectives and scope, the membership of the panel, importance of confidentiality and information sharing, accountability and reporting arrangements.

1.2 CORE MEMBERSHIP

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Peter Green</td>
<td>Designated Dr Child Safeguarding, Wandsworth CCG</td>
<td>CDOP Chair</td>
</tr>
<tr>
<td>Dr Serena Haywood</td>
<td>Consultant Paediatrician Developmental Paediatrics, SGH</td>
<td>Designated Paediatrician for Child Death</td>
</tr>
<tr>
<td>Ileen Ashitey</td>
<td>Designated Nurse, Wandsworth CCG</td>
<td></td>
</tr>
<tr>
<td>Dr Ravi Balakrishnan</td>
<td>Director of Public Health, Wandsworth CCG</td>
<td></td>
</tr>
<tr>
<td>Jacque Burke</td>
<td>Manager Safeguarding Standards, WBC</td>
<td></td>
</tr>
<tr>
<td>Anji Reynolds</td>
<td>WSCB Manager, WBC (interim)</td>
<td></td>
</tr>
<tr>
<td>Pete Paterson</td>
<td>Children’s Social Care, SGH</td>
<td></td>
</tr>
<tr>
<td>Dr Sarah Thurlbeck</td>
<td>Named Doctor/ Consultant Paediatrician, SGH</td>
<td></td>
</tr>
<tr>
<td>Dr Helen Morgan</td>
<td>Named GP, Wandsworth CCG</td>
<td></td>
</tr>
<tr>
<td>DI Joanne Belton</td>
<td>Metropolitan Police, CAIT team</td>
<td></td>
</tr>
<tr>
<td>Marion Louki</td>
<td>Safeguarding Midwife, SGH</td>
<td></td>
</tr>
<tr>
<td>Geraldine Fraher</td>
<td>Named Nurse Safeguarding, SGH</td>
<td></td>
</tr>
<tr>
<td>Kelly Slade</td>
<td>CDOP Manager/SPOC, SGH</td>
<td>SPOC</td>
</tr>
<tr>
<td>Paula Steele</td>
<td>CDOP Bereavement Co-ordinator, SGH</td>
<td></td>
</tr>
</tbody>
</table>

**Single Point of Contact / CDOP Manager**

The SPOC is the designated person who receives all notifications for children who die anywhere in Wandsworth, and for children with a residential address within Wandsworth. These are then collated onto a spreadsheet. When the child lives outside the Borough the SPOC will forward the information to the appropriate local authority SPOC.

For Wandsworth resident children, the SPOC will then disseminate the notification to various agencies including Health, Community Child Health, Metropolitan Police, Children’s Safeguarding Standards Unit and the Coroner’s Office.
The SPOC will then request information from agencies who have been involved with the child / family. This is collated to prepare for the child death review.

Child Death Overview Panel Chair
The Chair is responsible for chairing the CDOP meetings and encouraging all panel members to participate appropriately, ensuring that statutory requirements are met, maintaining a focus on preventative work and ensuring that the Child Death Overview process operates effectively.

Designated Paediatrician
The Designated Paediatrician has the responsibility to determine whether a child death is unexpected. The Designated Paediatrician also Chairs all multi-agency response meetings, presents cases at panel meetings and works closely with the CDOP Manager.

1.3 WORDING AND DEFINITIONS USED IN CDOP PROCESS

Neonatal Death
Death of a newborn child under 28 days old – includes premature births but excludes still births.

Sudden Unexpected Death in Infancy (SUDI)
Unexpected death of a child under two years of age, including those less than 28 days if discharged home.

Expected Death
Death of a child who was expected to die within 24 hours of actual death. This may be due to illness or planned palliative care.

Unexpected Death
An unexpected death is defined as the death of an infant or child (less than 18 years of age) 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.

*Working Together To Safeguard Children 2013 (para. 5.12)*

Modifiable Factors Identified
The panel 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.

*Form C – Analysis Proforma*

2. OVERVIEW OF CDOP OPERATION

2.1 NUMBER OF DEATHS IN CDOP AREA

There were a total of 64 deaths reported to the Wandsworth Single Point of Contact from 1 April 2012 to 31 March 2013. 23 (36%) of these deaths are Wandsworth resident children and are to be reviewed by the Wandsworth Child Death Overview Panel, the remaining 41 were children resident in other areas and these were passed onto the relevant local authority SPOC.

There are a high number of child deaths from neighbouring boroughs due to St George’s Hospital role as a large tertiary referral hospital. The neighbouring boroughs include the following CDOP areas:
Merton and Sutton
Lambeth
Richmond, Hounslow and Kingston
Kensington and Chelsea
Westminster

| Total number of child deaths reported to Wandsworth SPOC | 64 |
| Number of deaths to be reviewed by Wandsworth CDOP | 23 |
| Number of deaths forwarded to other SPOCs | 41 |

### 2.2 NUMBER OF MEETINGS HELD AND REVIEWS CONDUCTED

The Wandsworth Child Death Overview Panel met four times during the data year, 1st April 2012 to 31st March 2013, on the following dates:

Wed 23 May 2012
Wed 4 July 2012
Wed 12 December 2012
Wed 27 March 2013

During these meetings a total of 23 cases were reviewed.

The chart / graph below gives the total number of cases reviewed at each CDOP meeting and a breakdown of when those cases were first notified to the SPOC. This shows the timeframe from initial notification to case review. The panel are now completing reviews in a shorter timeframe (in line with CDOP’s priority to reduce the time it takes to review cases) but this is still dependent on the gathering of information from agencies.
In the 2011/2012 annual report it was reported that there was a year on year decrease in the number of cases being reviewed and closed at each meeting. This year (2012/2013) there has been an increase in the number of cases reviewed even though the CDOP met fewer times in the last 12 months.

Reasons for this include:

- Fewer delays in receiving information from various agencies
- Better completion of agency forms
- New leadership in the panel now embedded in their roles

The CDOP Manager continues to forge good relationships with other agencies to enable this process to work efficiently.

### 2.3 ORGANISATION AND RESOURCING OF CDOP

The Wandsworth Child Death Overview Panel has been joined by:

- The Named GP for Child Safeguarding
- A specialist Bereavement Counsellor, which is an innovative appointment.
Other membership changes have been due to staff / leadership changes in various agencies i.e. Wandsworth Safeguarding Standards Unit and Metropolitan Police CAIT team.

The Wandsworth CDOP now has a dedicated Bereavement Counsellor / Co-ordinator in post. The postholder will make contact with families following the death of a child to offer counselling as well as guidance on bereavement matters.

Raising awareness of the CDOP process is often discussed at panel meetings. Most agencies have their own tools for raising awareness e.g. induction training. The panel is working with the Local Authority to set up a CDOP workshop for schools in the borough to be run in the Autumn 2013.

2.4 COMMENTARY ON CDOP OPERATION

CDOP Meetings

Attendance at panel meetings continues to be consistently high. The panel meets four to six times a year depending on case load and panel member availability, and will usually review at least 5 cases per meeting IF all information is available.

Cases awaiting review are as follows:

<table>
<thead>
<tr>
<th>DATA YEAR</th>
<th>NO. OF CASES STILL TO BE REVIEWED</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/04/2008 – 31/03/2009</td>
<td>0</td>
<td>All reviews completed</td>
</tr>
<tr>
<td>01/04/2009 – 31/03/2010</td>
<td>0</td>
<td>All reviews completed</td>
</tr>
</tbody>
</table>
| 01/04/2010 – 31/03/2011| 1                                 | • The one outstanding case has been taken to the panel for review but it was decided further information was required to enable the panel to make an informed decision.  
• This case will be on the agenda at the next CDOP meeting. |
| 01/04/2011 – 31/03/2012| 4                                 | • One of these cases were taken to the panel for review but it was decided further information was required  
• Three cases are still awaiting information |
| 01/04/2012 – 31/03/2013| 15                                | • Four of these cases have been taken to the panel for review but require further information  
• Two of these cases are subject to an Internal Management Review  
• One of these cases is subject to an overseas criminal investigation  
• Eight of these cases still require further information |
| 01/04/2013 – 30/06/2013 CURRENT YEAR | 4                                 | • All four cases are relatively new and require further information before review. |

Concerns:
1. It is not unknown for coroner’s post mortem reports to take several months to be released. The SPOC continues to liaise with the coroner’s officers on this matter.
2. Insufficient information on Agency Forms. This matter of practice is believed to relate to the process which is still a novelty in parts of the Health economy.
Multi-Agency Response Meetings

A response meeting is required for unexpected deaths with a view to ensuring any investigation and support is appropriate from the beginning. All agencies / professionals who have been involved with the child / family are expected to attend. The multi-agency response process is now working well. The meetings are generally held within one week of the death being notified and attendance is always very good. These meetings continue to be a very valuable way of sharing information, identifying any additional investigative actions and arranging support for the family.

London Chairs of CDOP Group

The London Chairs of CDOP Group is scheduled to meet bi-annually. However, unforeseen circumstances means that there has not been a meeting in the past 18 months.

SPOC Group

There have been fewer SPOC Group Meetings this year due to role changes in many areas. The Wandsworth SPOC attends these meetings as often as possible.

CDOP Leadership Meetings

The CDOP Manager / SPOC, Designated Paediatrician and Chair now meet fortnightly to discuss any issues and matters arising. These meetings have been a valuable source for information sharing and decision making.

3. CHILD DEATHS REVIEWED 01/04/2012 to 31/03/2013 – CHARTS AND GRAPHS

There were a total of 23 cases reviewed by the Wandsworth Child Death Overview Panel during the period 1 April 2012 to 31 March 2013.

There have been a number of instances where a case has been taken to the panel for review and not closed as panel members have raised questions that were not able to be answered by the information in the case file. In these circumstances the CDOP Manager aims to have the answers to questions raised available for the next panel meeting so that the case can then be closed.

The table / graph below shows how the 23 cases reviewed have been categorised.

<table>
<thead>
<tr>
<th>Category</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Deaths</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
At the review meetings deaths are categorised under one of the following:

This classification is hierarchical: where more than one category could reasonably be applied, the highest up the list is marked.

<table>
<thead>
<tr>
<th>Category</th>
<th>Name &amp; description of category</th>
</tr>
</thead>
</table>
| 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 inflicted injury (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, neurodegenerative 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, 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). |
The panel are also required to categorise the presence of modifiable factors in the death as follows:

| Modifiable factors identified | The panel 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 identified | The panel have not identified any potentially modifiable factors in relation to this death |
| Inadequate Information | Inadequate information upon which to make a judgement.  
> NB this category should be used very rarely indeed. |

The table / graph below shows how the 23 deaths modifiable factors was categorised.

<table>
<thead>
<tr>
<th>Modifiable Factors</th>
<th>No Modifiable Factors</th>
<th>Inadequate Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 (22%)</td>
<td>18 (78%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>
Cases where Modifiable Factors have been found

Of the 23 child deaths reviewed – 5 deaths were found to have modifiable factors

Case 1  This child died in a house fire that was started through the use of candles due to no electricity supply. Parent known for alcohol / substance abuse.

Case 2  This child died in a boating accident at a birthday party. The case was highlighted in the national media. There are a number of recommendations from the investigation carried out by the Marine Accident Investigation Branch.

Case 3  This child died from the flu virus. There had been issues with developmental delay and not accessing services. This case was subject to an Internal Management Review - reports received from three agencies. Recommendations were made as a result of the review.

Case 4  This child had been ante-natally diagnosed with a heart condition. The child became unwell during transfer from one hospital to another following tests and sadly died. This case was subject to a Serious Incident Investigation by Acute Health. Recommendations were made as a result of the investigation.

Case 5  This family were known to services. Mum booked very late for ante natal care. It was felt earlier booking may have altered the outcome of premature delivery.

In the four cases where reviews / investigations took place. The resulting reports have been added to the case files. The agencies involved will ensure that all recommendations / actions are completed within set time frames.

Recommendations from reviews

6 of the 23 cases reviewed and closed had recommendations.

Case 1  Serious Case Review recommendations
Case 2  Recommendations relevant to case – to confirm families level of understanding
Case 3  Marine Accident Investigation Branch recommendations
Case 4  Internal Management Review recommendations
Case 5  Serious Incident Investigation recommendations
Case 6  Recommendation relevant to case - closer multi-agency working in future might help reduce risks exposed in this review

Agencies who have conducted investigations / reviews will ensure recommendations and actions are completed within set time frames.

The CDOP process is a nationally targeted, evidence gathering exercise. Local borough “themes” are not sought, nor expected, due to the statistically small numbers involved.

4. CHILD DEATHS REPORTED TO SPOC 01/04/2011 to 31/03/2012 – CHARTS AND GRAPHS

The Wandsworth Child Death Overview Panel has now been in operation for 5 years. The following charts / graphs will show comparisons for this entire period.

4.1 Deaths Reported to Wandsworth SPOC 01/04/2012 to 31/03/2013 shown by Expected / Unexpected

64 cases were reported to the Wandsworth SPOC during the data year 01/04/2012 to 31/03/2012 – 23 of these are Wandsworth resident children and will be reviewed by the Wandsworth CDOP

Of the 23 cases to be reviewed by the Wandsworth CDOP 8 were unexpected and 15 expected.

The table / chart below shows the expected / unexpected comparison for the last 5 years data of Wandsworth Child Deaths.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TOTAL</th>
<th>EXPECTED</th>
<th>UNEXPECTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>23</td>
<td>15 (65%)</td>
<td>8 (35%)</td>
</tr>
<tr>
<td>2011/12</td>
<td>26</td>
<td>16 (62%)</td>
<td>10 (38%)</td>
</tr>
<tr>
<td>2010/11</td>
<td>27</td>
<td>17 (63%)</td>
<td>10 (37%)</td>
</tr>
<tr>
<td>2009/10</td>
<td>13</td>
<td>7 (54%)</td>
<td>6 (46%)</td>
</tr>
<tr>
<td>2008/09</td>
<td>24</td>
<td>14 (58%)</td>
<td>10 (42%)</td>
</tr>
</tbody>
</table>
During the period 01/04/2012 to 31/03/2013, of the 8 reported unexpected deaths, multi-agency response meetings were held following 6. The Designated Paediatrician felt that a multi agency response meeting was not required for the other 2 unexpected deaths as these were extremely premature infants. In these situations it is felt more optimal to ensure good family support, where the Designated Paediatrician oversees the clinicians, than the minimal benefit that might accrue from multi agency working in the aftermath of a predicted death.

No. of Days From Notification to Multi Agency Response Meeting Following an Unexpected Child Death during the period 01/04/2012 to 31/03/2013
The reasons behind the delay in the response for WW / 12 / 0007 are as follows:

- The child died at another hospital
- The notification was not received until two days following the death
- The doctor that had been involved with child’s care was on leave
- On return from leave the doctor’s availability was limited

Following the decision of the Designated Paediatrician the response meeting was finally held via conference call whilst the CDOP Manager took notes.

The timescale taken to arrange multi-agency response meetings continues to be an average of 3 working days following receipt of the death notification.

### 4.2 Deaths Reported to the Wandsworth SPOC 01/04/2011 to 31/03/2012 shown by Gender

During the reporting period 01/04/2012 to 31/03/2013, of the 23 cases to be reviewed by the Wandsworth – 11 are male and 12 female.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TOTAL</th>
<th>MALES</th>
<th>FEMALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>23</td>
<td>11 (48%)</td>
<td>12 (52%)</td>
</tr>
<tr>
<td>2011/12</td>
<td>26</td>
<td>10 (39%)</td>
<td>16 (61%)</td>
</tr>
<tr>
<td>2010/11</td>
<td>27</td>
<td>15 (56%)</td>
<td>12 (44%)</td>
</tr>
<tr>
<td>2009/10</td>
<td>13</td>
<td>5 (38%)</td>
<td>8 (62%)</td>
</tr>
<tr>
<td>2008/09</td>
<td>24</td>
<td>12 (50%)</td>
<td>12 (50%)</td>
</tr>
</tbody>
</table>

Comparison of Wandsworth Deaths Male / Female Ratio Per Year

[Graph showing the comparison of Wandsworth Deaths Male / Female Ratio Per Year]
4.3 Deaths Reported to Wandsworth SPOC 01/04/2010 – 31/03/2011 shown by Age Range

The table below shows the breakdown by age range, the deaths to be reviewed by Wandsworth, for each data year.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TOTAL</th>
<th>&lt; 1 yr</th>
<th>1 yr – 4 yrs</th>
<th>5 yrs – 14 yrs</th>
<th>15 yrs – 17 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>23</td>
<td>16 (70%)</td>
<td>1 (4%)</td>
<td>5 (22%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>2011/12</td>
<td>26</td>
<td>20 (77%)</td>
<td>2 (8%)</td>
<td>3 (11%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>2010/11</td>
<td>27</td>
<td>22 (81%)</td>
<td>0 (0%)</td>
<td>4 (15%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>2009/10</td>
<td>13</td>
<td>9 (68%)</td>
<td>1 (8%)</td>
<td>2 (16%)</td>
<td>1 (8%)</td>
</tr>
<tr>
<td>2008/09</td>
<td>24</td>
<td>9 (38%)</td>
<td>5 (21%)</td>
<td>7 (29%)</td>
<td>3 (12%)</td>
</tr>
</tbody>
</table>

The majority of Wandsworth resident child deaths reported to the SPOC between 1 April 2012 and 31 March 2013 are that of children under the age of 1 year. Out of the 16 children that died under the age of 1 year – 10 of these children died in the first 28 days of life.

This age group continues to be the highest each year due to premature births.

4.4 Deaths Reported to Wandsworth SPOC 01/04/2011 – 31/03/2012 shown by Ethnicity

The Form B section for ethnicity has a secondary level which should be completed, see below.

- White:
  - White other
  - White British (English, Scottish, Northern Irish, Welsh)
  - White Irish
  - White Gypsy or Irish Traveller
  - Any other White background

- Mixed:
  - White and Black Caribbean
  - White and Black African
The secondary level is not always completed so it is difficult to determine whether children are white British or white other etc. Therefore if a child is marked as Caucasian on the initial notification and no further information is available on the Form B the child will be recorded as white other.

The CDOP panel continues to seek ways to improve the means of getting such information and has developed an online form which has recently gone to use.

The table below shows the breakdown of ethnicity for the deaths to be reviewed by Wandsworth CDOP for the last 5 years.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TOTAL</th>
<th>White</th>
<th>Dual Heritage</th>
<th>Asian</th>
<th>Black</th>
<th>Other</th>
<th>Not Stated</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>23</td>
<td>9 (39%)</td>
<td>6 (26%)</td>
<td>3 (13%)</td>
<td>1 (4%)</td>
<td>0 (0%)</td>
<td>4 (17%)</td>
</tr>
<tr>
<td>2011/12</td>
<td>26</td>
<td>10 (38%)</td>
<td>1 (4%)</td>
<td>3 (12%)</td>
<td>7 (27%)</td>
<td>1 (4%)</td>
<td>4 (15%)</td>
</tr>
<tr>
<td>2010/11</td>
<td>27</td>
<td>12 (43%)</td>
<td>1 (4%)</td>
<td>5 (19%)</td>
<td>5 (19%)</td>
<td>0 (0%)</td>
<td>4 (15%)</td>
</tr>
<tr>
<td>2009/10</td>
<td>13</td>
<td>6 (46%)</td>
<td>4 (31%)</td>
<td>2 (15%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (8%)</td>
</tr>
<tr>
<td>2008/09</td>
<td>24</td>
<td>13 (54%)</td>
<td>1 (4%)</td>
<td>4 (17%)</td>
<td>1 (4%)</td>
<td>1 (4%)</td>
<td>4 (17%)</td>
</tr>
</tbody>
</table>
Comparison of Wandsworth Deaths By Ethnicity Ratio Per Year

The majority for each year falls under the ethnicity of “White”.

4.5 Deaths Reported to Wandsworth 01/04/2012 – 31/03/2013 – shown by Postal Code

The borough of Wandsworth is made up of nine postal codes. These are:

SW4 (part)  SW8 (part)  SW11 (all)  SW12 (part)  SW15 (part)  SW16 (part)  SW17 (part)  SW18 (all)  SW19 (part)

The table / graph below shows the 23 Wandsworth child deaths broken down into Wandsworth postal code areas. When comparing the last 5 years data there does not appear to be any trends in the parts of the borough child deaths occur.
4.6 Deaths Reported to Wandsworth 01/04/2012 – 31/03/2013 – shown By Quarter

The graph below shows the number of deaths in each quarter for the data year 01/04/2011 – 31/03/2012 compared to the data year 01/04/2010 – 31/03/2011.

The overall figures for each data year are very similar. The main differences appear to occur in the 3rd and 4th quarters.

CHART SHOWING QUARTERLY BREAKDOWN FOR LAST 5 YEARS DATA

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5. SUMMARY

Anecdotal benchmarking suggests that the Wandsworth Child Death Overview Panel review process continues to work effectively, with the recent introduction of the counsellor and the online form proving to be positive innovations.

The year (2010 / 11) remains the data year with the highest number of deaths since the Wandsworth Child Death Overview Panel came into operation.

Looking at the 5 years of data since the Wandsworth Child Death Overview Panel came into operation the average number of child deaths each year is 23.

Consideration for the future

1. Earlier release of pathology reports remains an objective, working collaboratively with H. M. Coroner’s office.

2. More timely reviews – the panel has set an objective for cases to be reviewed within 9 months of initial notification for this year dependent on pathology report availability.

3. Counselling evaluation to ensure family support is optimal.

4. Electronic data gathering

Report prepared by Kelly Slade, CDOP Manager, on behalf of Dr Peter Green, CDOP Chair