**Legislation**

The CDOP’s role, functions, governance and operations are set out in Chapter 5 of the statutory guidance “Working Together to safeguard Children” 2018 in relation to the death of any child resident in the local authority.

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**Reviewed cases at the Child Death Overview Panel**

- **23** Expected
- **8** Unexpected
- **31** reviewed cases

**Modifiable factors:**

- **52%** Chromosomal, genetic and congenital anomalies
- **32%** Perinatal / neonatal event
- **26%** Malignancy, Acute medical or surgical condition, Infection and Sudden Unexpected / Unexplained Deaths in Infancy (SUDI)

**Outstanding cases to 2019-20**

- **12** Post mortems / Inquests
- Serious / Critical Incidents
  - **5** Police investigations

**End to end completion of death to review:**

- **22** completed under 1 year
- **9** completed 1 year – 18 mths

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**Child death notifications 2018-19**

- **31** Child deaths
  - **22** Expected
  - **9** Unexpected

**Neonates**

- **12** children 1 year and over
  - **4** 28 - 364 days old
  - **15**

**Consanguineous families**

- **3**
- **7**

**Location of Death**

- **12** Walthamstow
- **5** Chingford
- **12** Leyton / Leytonstone

**Barts Health Trust place of death**

- **16**
- **15**

**Received voice of the parent to incorporate into CDOP review**

- **5**

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**Strategic developments**

- New Working Together 2018 Guidance brings transformations to the way CDOPs work
- WELC transformation group developed to merge the four CDOPs to review at last 60 child deaths per year in line with Working Together 2018
- eCDOP continues to progress incorporating new guidance and NCMC data
- CDOP awareness is broadened to further agencies
- Target awareness raising through various media to specific agencies and partners.

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**Number of deaths**

The last three years has shown child deaths in Waltham Forest increase year on year. However these deaths are mainly expected rather than unexpected as in the first five years.

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**Ongoing recommendations from 2017-18**

- Father’s details are not recorded. It is unknown if the question has been asked in the first instance
- Unsafe sleeping and safety in the home awareness to continue and be recorded
- Consanguinity related child deaths within WF remains constant – continue exploration of evidence based actions and awareness

**Recommendations from 2018-19**

- Awareness raising to agencies regarding the rights to access healthcare.
- Good practice of end of life care – praise given
- All partners and agencies to record data thoroughly, including responses to questions around national and local concerns such as “declined father’s details”
- All partners and agencies to be more robust in their referral policies and procedures to include vulnerable persons