Southend, Essex and Thurrock

Child Death Review Annual Report

1st April 2016 – 31st March 2017

We hope that you will find this Report useful and informative.
We are continually trying to improve the information provided and would appreciate your taking the time to complete the following very short survey.

Please send your response to:- cdr@essex.gov.uk.

- **How did you see this Report?**
- **Did you find it valuable?**
- **Is there anything further you would like included?**

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Terminology and Definitions

CAIU	Child Abuse Investigation Unit
CCG	Clinical Commissioning Group
CPP	Child Protection Plan
CDOP	Child Death Overview Panel
DfE	Department for Education
Infant mortality	All deaths under 1 year
LCDRPs	Local Child Death Review Panels
LSCBs	Local Safeguarding Children's Boards
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MCCD	Medical Certificate of Cause of Death
Modifiable death	Where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths
Neonatal mortality	Deaths up to 28 days
ONS	Office for National Statistics
OOA	Out of Area
Perinatal mortality	Still births and deaths under 1 week
PHE	Public Health England
RTC	Road Traffic Collision
SCDOP	Strategic Child Death Overview Panel
SCR	Serious Case Review
SET	Southend, Essex and Thurrock
SI	Serious Incident
Sudden Unexpected Death in Infancy (SUDI)	All unexpected deaths of infants up to 1 year of age at the point of presentation. Description rather than a diagnosis. Following investigation, will be divided into those with a clear diagnosis (explained SUDI) and those with no diagnosis (SIDS)
SUDC	Sudden Unexpected Death in Childhood - the sudden and unexpected death of a child over the age of 12 months, which remains unexplained after a thorough case investigation is conducted

Chair's Introduction

The death of a child is always tragic and we must strive to minimise these occurences where we can. Improving our understanding about why these deaths occur and what we might do to prevent them is important but often difficult work. I am immensely grateful for and constantly impressed by the hard work of the dedicated range of professionals involved in this endeavour across Southend, Essex and Thurrock. As always the pivotal role of Janet Levett in this work cannot be underestimated.

Dr Mike Gogarty
Chair of Strategic Child Death Overview Panel
Director for Public Health

Introduction

This report is intended to summarise the work of the Southend Essex and Thurrock Strategic Child Death Overview Panel during 2016-2017.

The Report contains information on the numbers of Child Death Reviews completed in SET, the recommendations made by the panel to prevent future child deaths and the actions taken to implement those recommendations.

The report should also serve as a resource to inform public health measures to promote child health, safety and wellbeing.

NB. To protect identify of individual cases, all numbers of 6 or less have been replaced with x

1. Notifications of Child Deaths received (1 April 2016 – 31st March 2017)

Working Together to Safeguard Children (2015) states that Safeguarding Children Boards are responsible for ensuring that a review of each death of a child or young person under 18 years of age and normally resident in their area is undertaken by a Child Death Overview Panel. The Safeguarding Children Boards of Southend, Essex and Thurrock share one Strategic Child Death Overview Panel.

The objective of the reviews is to learn lessons to help prevent further deaths.

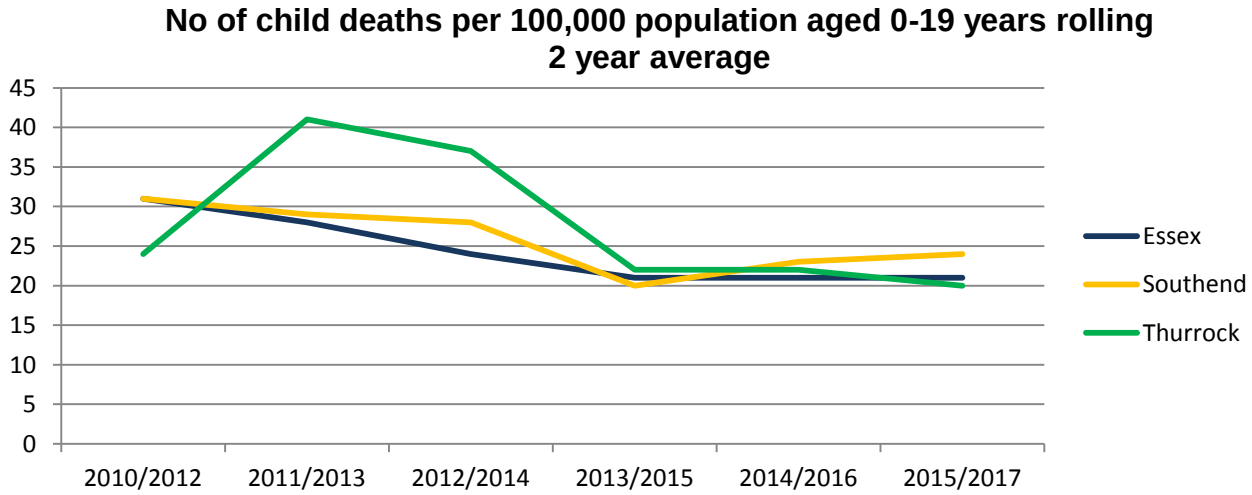
1.1 Number of notifications

83 notifications were received during this year. 81 notifications related to children who were resident in Southend, Essex or Thurrock. 2 of the notifications related to children who had been briefly associated with addresses in Essex and Thurrock but where all information relating to the case was held by a London Borough. Both of these were unexpected deaths which occurred outside of the SET areas. Following discussions it was agreed that the London Borough would undertake these Reviews and the outcome and learning would be shared with us.

Table 1:

Notifications Received	2013/14	2014/15	2015/16	2016/17
Southend	9	7	12	8
Essex	77	61	72	65
Thurrock	10	9	10	8
Out of area	x	X	X	x

It can be seen from the graph below that the number of deaths in SET areas per 100,000 population remains below numbers seen in 2010 to 2014



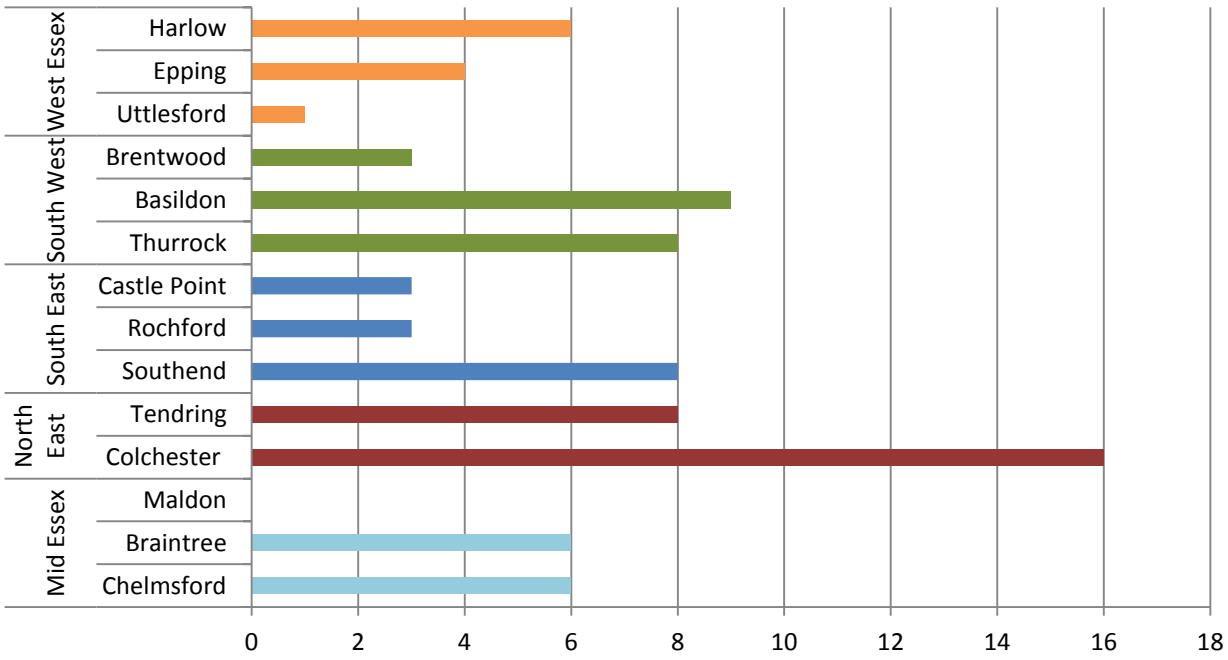
1.2 Age and Gender

59% of the notifications received were for children under one year of age.

	Southend	Essex	Thurrock	Total	Male	Female
0 - 27 days	x	17	x	**20**	13	7
28 days - 364 days	x	20	x	**27**	15	12
1 - 4 years	x	7	x	**11**	x	x
5 - 9 years	x	8	x	**9**	x	8
10 - 14 years	x	x	x	**x**	x	x
15 - 17 years	x	9	x	**10**	7	x
	8	65	8	**81**	43	38

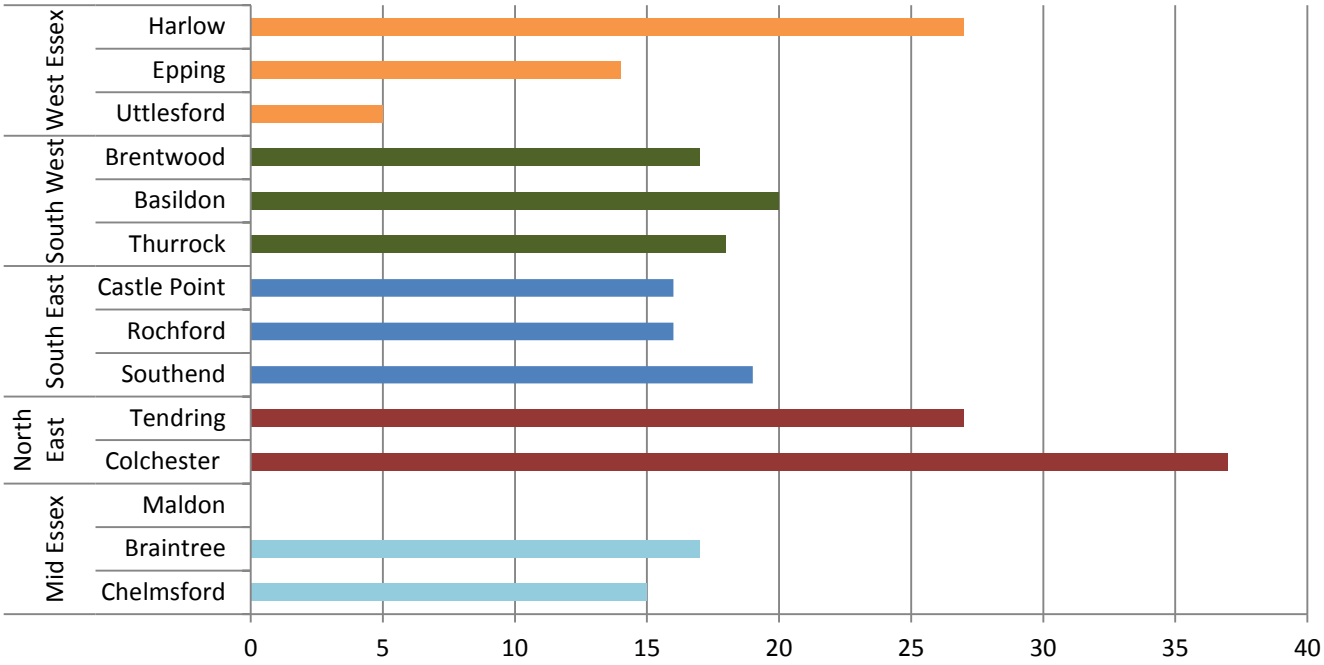
1.3 Area of Residence

When considered by area of residence North East Essex had the highest number of notifications this year.



When these figures are adjusted to a figure per 100,000 population aged 0-19 years, it can be seen that Colchester has received the highest number of notifications of child deaths during this year, followed by Harlow.

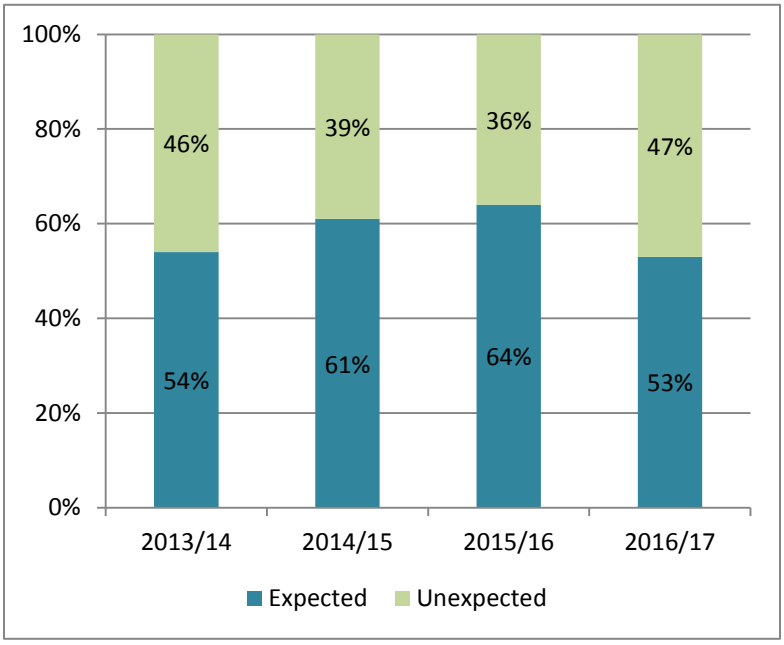
No of deaths per 100,000 population aged 0 - 19 years



1.4 Unexpected deaths

Of the 81 notifications received this year, 38 were classed as being unexpected, i.e. the death was not anticipated as a significant possibility for example, 24 hours before the death, or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.

The decision as to whether a death is classed as unexpected is made by the Paediatrician at the Hospital Emergency Department. In the event that the death is considered unexpected, the Paediatrician will contact the on-call Detective Inspector at Essex Police and a strategy meeting will be arranged, including a member of the Health Rapid Response Team and Social Care if required. The SET response to unexpected deaths procedure will then be followed (See Appendix 2)



This year 47% of deaths have been classed as unexpected. This is an increase over past years.

In 19 of these cases (50%) the child was aged under one year.

1.5 Rapid Response

Of the 38 unexpected deaths, the SET CDR Rapid Response procedure was initiated in 37 cases.

A home visit was undertaken by Police and a member of the Health Rapid Response team in 31 of the 37 cases.

2. Completed Child Death Reviews (1st April 2016 – 31st March 2017)

98 Reviews have been completed during the year 1st April 2016 to 31st March 2017.

2.1 Local CDR Panel Activity

Each of the five Local CDR Panels meets quarterly to undertake the reviews of deaths of children who were resident in their area. The outcome of the reviews is then fed back to the Strategic Overview Panel who oversee and monitor the CDR process and review and endorse any recommendations made.

The panel activity for the year 2016/17 was as follows:-

Local CDR Panel	Number of Meetings	Cases completed
Mid Essex	4	21
North East Essex	4	22
West Essex	3	9
South East Essex	3	17
South West Essex	5	29

2.2 Modifiable Factors

On completion of each Child Death Review the Local Panels consider whether there were any modifiable factors in the death, i.e. any factors which may have contributed to the death and which, by means of locally or nationally achievable interventions could be modified to reduce the risk of future child deaths.

35 (36%) Reviews completed this year were found to have modifiable factors. As seen in previous years this number is higher than the national rate of 24% of deaths assessed as having modifiable factors. (*DfE Statistical Release, CDRs year ending March 2016)*

Southend	
12 Reviews completed	4 with identified modifiable factors

Thurrock	
10 Reviews completed	3 with identified modifiable factors

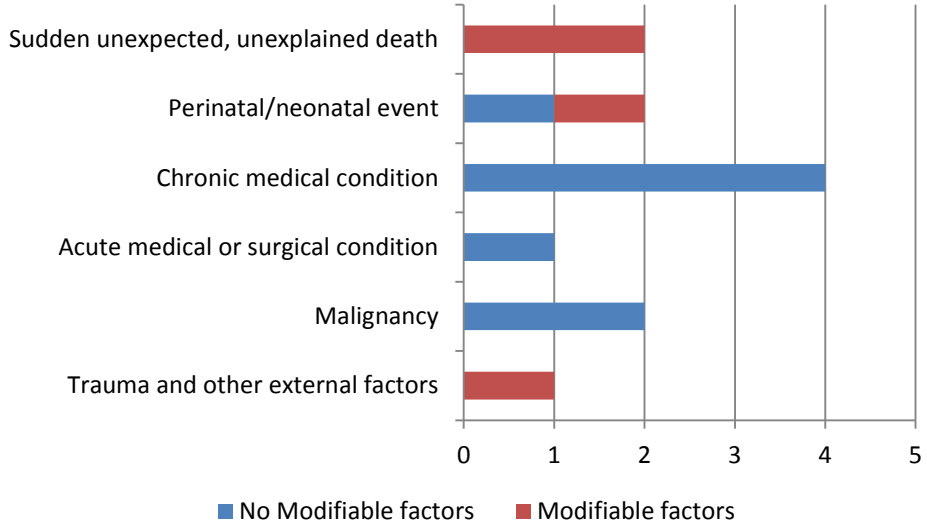
Essex	
76 Reviews completed	28 with identified modifiable factors

2.3 Completed cases by Local Authority Area and category

The Local Panels are asked to categorise each death on completion of the Review. The details of the categories are included at appendix 3.

2.3.1 Southend

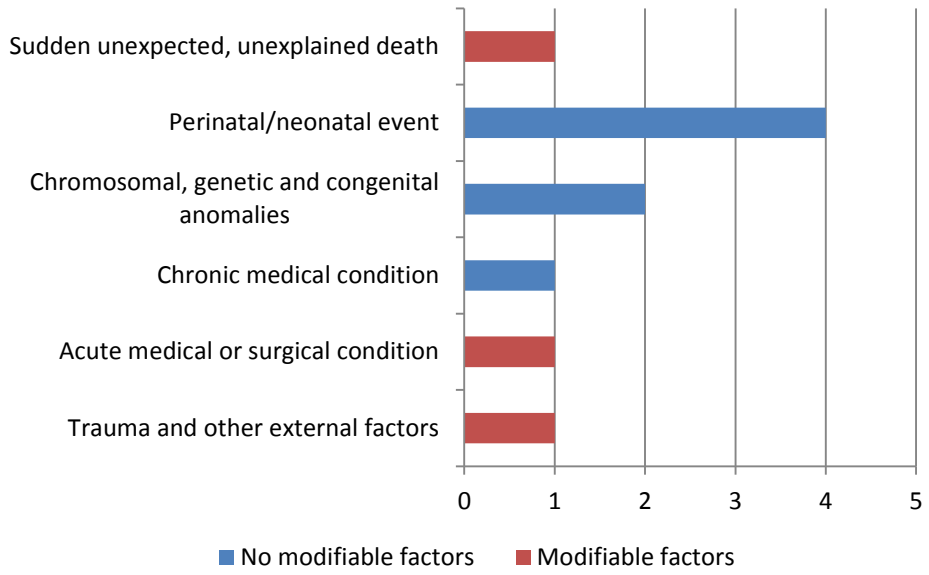
The 12 Reviews completed for children resident in Southend Local Authority area were categorised as follows:-



Category	Modifiable factors identified
Sudden unexpected, unexplained death	- Co-sleeping; parental smoking - Parental smoking
Perinatal/neonatal event	- Parental smoking; parental alcohol/substance misuse
Trauma	- Poor parenting/supervision

2.3.2 Thurrock

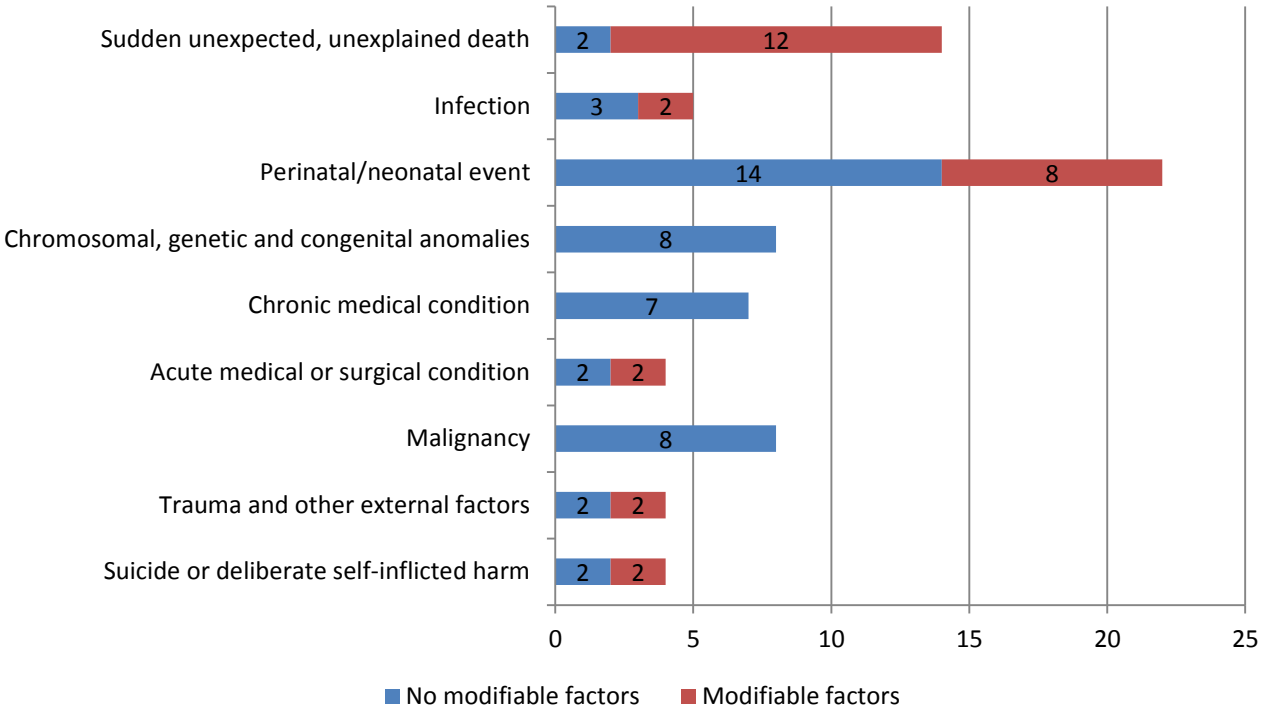
The 10 Reviews completed for children resident in Thurrock Local Authority area were categorised as follows:-



Category	Modifiable factors identified
Sudden unexpected, unexplained death	- Co-sleeping; parental smoking
Acute medical or surgical condition	- Parental alcohol/substance misuse; parental smoking; service provision re. access to health care
Trauma	- Poor parenting/supervision

2.3.3 Essex

The 76 Reviews completed for children resident in Essex Local Authority area were categorised as follows:-



Category	Modifiable factors identified
Sudden unexpected, unexplained death	- Prematurity and low birth weight Poor parenting/supervision - Parental alcohol/substance misuse Parental smoking - Co-sleeping - Service provision - access to healthcare
Infection	- Service provision – prior medical intervention - Parenting capacity
Perinatal/neonatal event	- Parental smoking - Poor parenting/supervision - Service
Acute medical or surgical condition	- Consanguinity - Parenting capacity/child abuse/neglect - Emotional/ Behavioural/Mental Health condition in parent - Service provision – access to healthcare; prior medical intervention
Trauma	- Emotional/Behavioural/Mental Health condition in child - Poor parenting/supervision
Suicide or deliberate self-inflicted harm	- Emotional/Behavioural/Mental Health condition in child

	- Alcohol/substance misuse by child - Poor parenting/supervision - Emotional/Behavioural/Mental Health condition in parent - Service provision – access to healthcare

2.4 Completed cases by year of notification

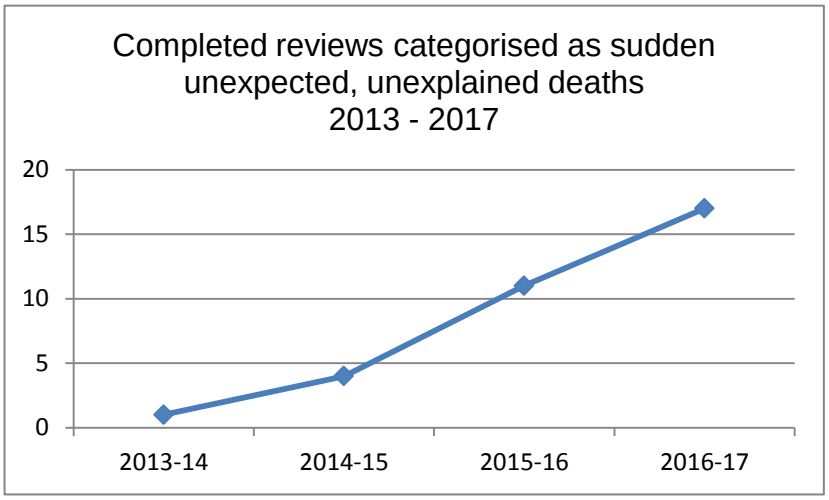
Not all reviews relate to notifications received during the same year as some cases take longer to conclude, for example where there is an Inquest, a Serious Case Review or a Police investigation.

By year of notification, the reviews completed this year were as follows:

	Southend	Essex	Thurrock
Apr 13 - Mar 14	x	x	x
Apr 14 - Mar 15	x	x	x
Apr 15 - Mar 16	9	54	x
Apr 16 - Mar 17	x	19	x

2.5 Sudden Unexpected, Unexplained Deaths

In the year April 2016 to March 2017 seventeen deaths were categorised as sudden unexpected, unexplained death. The number of deaths in this category has increased sharply over the past three years.



Two of these deaths were found to be not preventable, i.e. no modifiable factors were identified.

Factors noted in the 15 remaining deaths included:-

Parental smoking	(71%)
Alcohol/substance misuse	(18%)
Co-Sleeping	(59%)
Prematurity (< 36 weeks gestation at birth)	(12%)
Low birth weight (< 2.5kg)	(24%)

- **33% were noted to have 1 of the above factors**
- **66% were noted to have 2 or more of the above factors**

In three cases, modifiable factors were also noted relating to service provision

- A case from the year 2013-2014 was noted issues relating to care of mothers who misuse substances during pregnancy. Actions have since been taken to include commissioning and appointing of a specialist midwife for women who misuse substances during pregnancy. A clear pathway and guidance for the care of women who misuse drugs during pregnancy has been developed and disseminated to staff at acute trusts.

- A case from the year 2014-2015 noted issues around social care management of the case. The Local Panel asked for further clarification from Southend Social Care regarding actions taken.

- A case from 2014-2015 noted issues relating to access to healthcare and the level of support offered to single first time fathers.

2.6 Suicide or deliberate self-inflicted harm

Cases have been reviewed this year where a young person has died by suicide or deliberate self-inflicted harm.

The following factors were noted

- Alcohol/substance misuse by the child
- Emotional/behavioural/mental health of the child
- Poor parenting/supervision
- Emotional/behavioural/mental health condition in a parent

Each of the cases reviewed was noted to have at least three of the above factors.

In two of the cases the panel concluded that, although factors were present which may have contributed to vulnerability, ill-health or death, there was nothing which could have been modified to have prevented the death.

In one case a referral was made by the Local Child Death Review Panel for consideration of Serious Case Review. The Safeguarding Children Board considered the case and it was agreed that although the criteria for Serious Case Review was not met, a Partnership Learning Review would be undertaken. This Review is currently ongoing.

2.7 Neonatal Deaths

38 neonatal deaths were reviewed, i.e. where the infant was aged 0 – 28 days.

When shown as a rate per 1000 live births it can be seen that Southend, Essex and Thurrock have lower rates than either the East of England region or national figure.

	Rate per 1000 live births (2015)Source: ONS
Southend	0.9
Thurrock	2.4
Essex	1.8
East of England	8.8
England	9.1

Following the Child Death Review these 38 deaths were categorised as follows:-

- 24 - Perinatal/Neonatal event
- 8 - Chromosomal, genetic and congenital anomalies
- 5 - Sudden unexpected, unexplained deaths
- 1 - Death due to trauma and other external factors

<u>Perinatal/Neonatal Event</u>

Of the 24 reviews completed where the infant was aged 0 – 28 days and the category of death was perinatal/neonatal event:-

- 17 cases (71%) were born at less than 36 weeks gestation
- 15 cases (62%) were less than 2.5kg birth weight
- 8 cases were infants born following a multiple birth (twins or triplets)

- 2 cases noted modifiable factors relating to service provision. In each case the Panel considered a Serious Incident Report produced by the hospital and found that appropriate recommendations had been made and implemented.

4 deaths were reviewed of children aged between 29 and 364 days where the death was found to be ultimately related to perinatal events and these were also categorised as a perinatal/neonatal event.

2.8 Child Protection Plan and Statutory Orders

Three children whose death was reviewed this year were the subject of a child protection plan at the time of their death. Modifiable factors were identified in each of these three cases. Two of the deaths were categorised as sudden unexpected, unexplained death and one death as an acute medical or surgical condition.

One child whose death was reviewed this year was subject of a statutory order at the time of death. This death was categorised as a chronic medical condition and no modifiable factors were identified.

3. Summary of work of the Strategic Child Death Overview Panel and Local Child Death Review Panels 2016 - 2017

3.1 Shared Learning from SET Child Death Reviews

To enable learning from completed Child Death Reviews to be efficiently monitored by Strategic Child Death Overview Panel and then disseminated appropriately a standard template has been developed and implemented.

At the completion of a Review, if learning has been identified either the Local Panel Chair or the Designate Doctor representative on the Local Panel will complete a brief report outlining the case and identifying the issues raised, actions taken and conclusions. This is then presented at the next SCDOP meeting when it will be checked for anonymity and the appropriate pathways for sharing agreed.

This has made the process of sharing of learning from Child Death Reviews more efficient and streamlined.

3.2 Safer Sleeping Awareness

Due to the increase in numbers of sudden unexplained deaths in infancy SCDOP has undertaken further work to increase awareness of the risks associated with co-sleeping and to highlight safer sleeping information.

In December 2016 a questionnaire was circulated to professionals who work with families to gather information on what advice is currently being given; when this is given and to whom. 106 completed surveys were received and the data used to inform the planned revised safer sleeping campaign for 2017.

On 3rd January 2017 a 'Thunderclap' social media message was successfully launched. 135 agencies and individuals signed up to support the campaign which had a social reach of 489,024.

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3.3 Sharing of Essex CDR Process with other areas

Work has been undertaken to promote the SET Child Death Review process with other areas, including several London Borough CDOPs.

The SET CDR Process, together with the Rapid Response process has been acknowledged as 'gold standard' by other national CDOP areas.

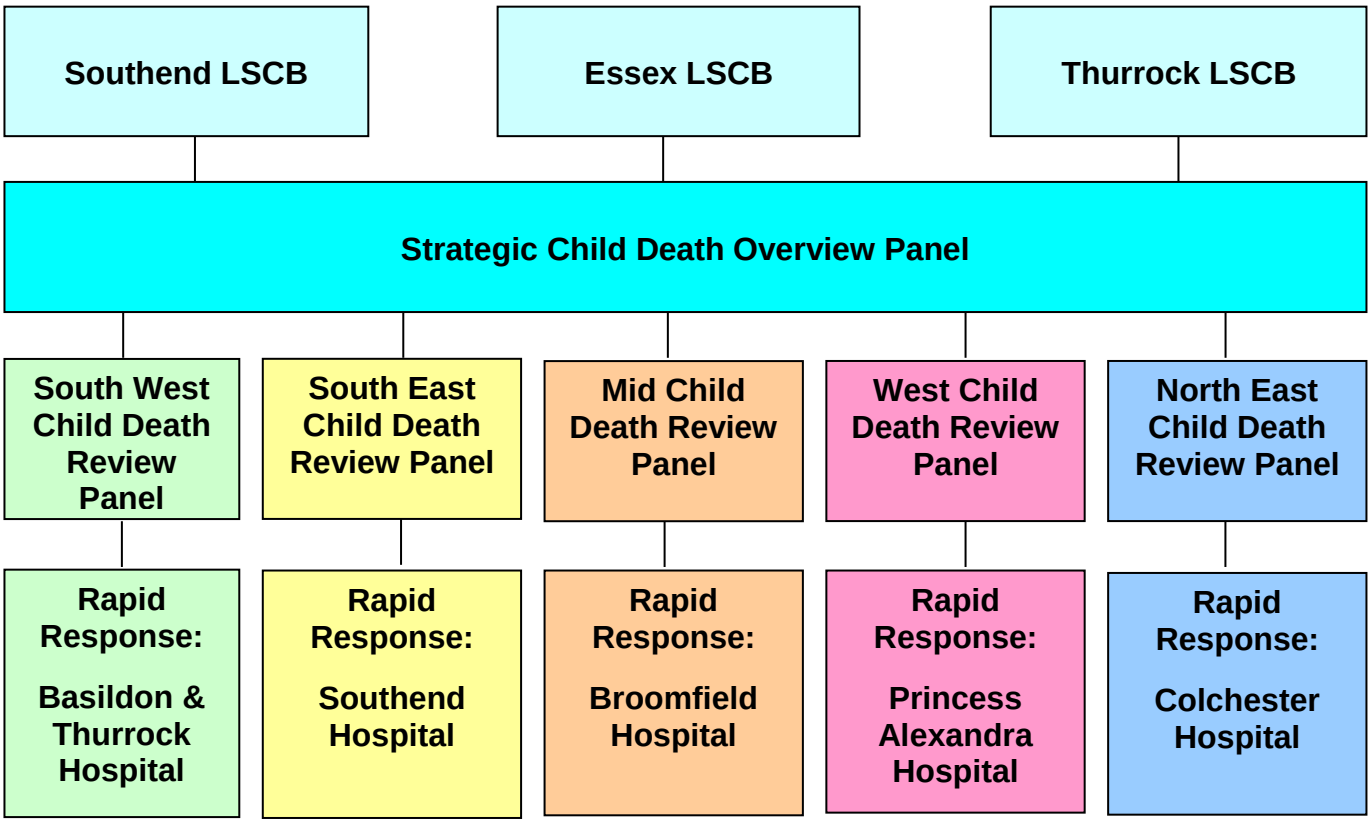
4. Priorities for 2017 - 2018

	Priority	How	By
1	To ensure that SCDOP meets its statutory requirements.	By reviewing all child deaths; To categorise the 'preventability' and identify any modifiable factors and to make recommendations for actions to prevent future deaths where possible	Ongoing
2	Re-launch the SET Safer Sleeping campaign	To raise awareness of the risks of co-sleeping; To promote safer sleeping for babies advice by production and circulation of posters. To also include media and social media to reach the maximum number of families and professionals	June 2017
3	To make any agreed changes to the SET CDR process necessary to gather information for the National Learning Disabilities Mortality Review Programme	By review and amendment of the current information gathering and notification forms	July 2017
4	To revise the SET CDR Procedure to reflect the Royal College of Paediatrics and Child Health multi-agency guidelines for care and investigation of sudden unexpected death in infancy and childhood	By review and amendment of the SET CDR Procedure, especially the appendices relating to initial assessment of an infant or child presenting unexpectedly dead or moribund (Appendices E and J)	August 2017
5	To identify any matters of concern affecting the safety and welfare of children in the SET authority areas	By monitoring of notifications and completed reviews to identify patterns or trends and to consider any actions needed	Ongoing

Appendix 1

Overview of SET CDOP structure

The Local Safeguarding Children Boards of Southend, Essex and Thurrock (SET) share a Strategic Child Death Overview Panel (SCDOP) with five Local Child Death Review Panels (LCDRPs).



The Strategic Child Death Overview Panel (SCDOP) meets quarterly and has a fixed core membership.

2.1 SCDOP Membership

Current SCDOP Membership is as follows:

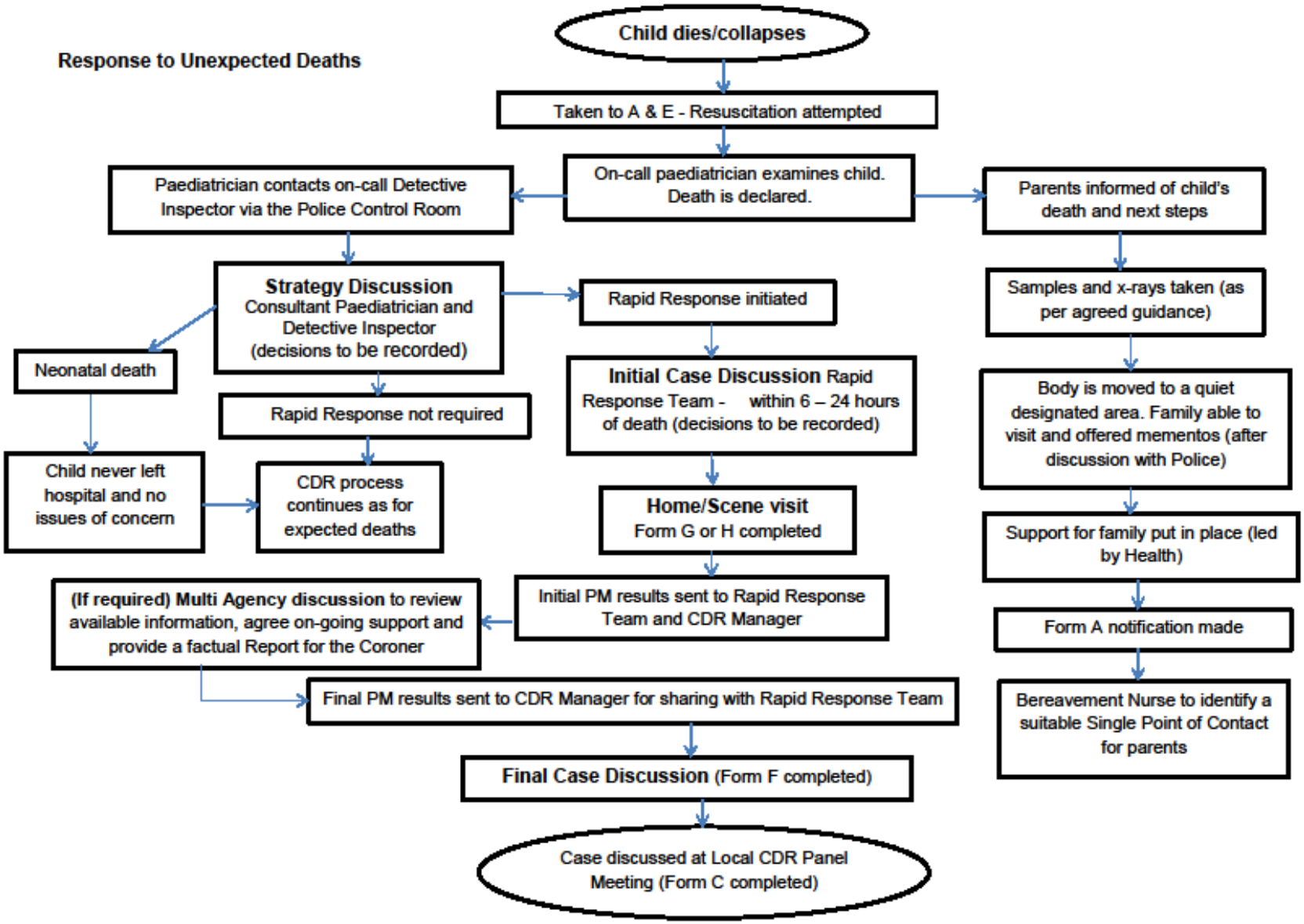
- Director of Public Health, (Chair)
- Detective Chief Inspector CAIU, Essex Police
- Designated Paediatrician for Deaths in Childhood, South Essex
- Designated Paediatrician for Death in Childhood - South Essex
- Designated Paediatrician for Deaths in Childhood – West Essex

- Designated Paediatrician for Death In Childhood – Mid Essex
- Designated Paediatrician for Deaths in Childhood - North East Essex
- HM Coroner – Essex
- Director of Quality Assurance & Safeguarding, Essex Social Care
- Southend Social Care/Education
- Child Protection Co-ordinator and LADO, Thurrock Council
- Health Rapid Response Service
- East of England Ambulance Service
- Assistant County Solicitor, People, Essex County Council
- Business Manager, Essex Safeguarding Children Board
- Business Manager, Thurrock Safeguarding Children Board
- Business Manager, Southend Safeguarding Children Board
- Designated Nurse Safeguarding Children

2.2 Local Child Death Review Panels

The LCDRP's are chaired by a Public Health representative. Professional membership of the panels includes; the Designated Paediatrician for Deaths in Childhood for each area; Essex Police, Children's Social Care, Midwifery Services, Primary Health Care. Other professionals may be invited to attend the panel meetings as required.

Appendix 2


Response to Unexpected Deaths
Child dies/collapses
Taken to A & E - Resuscitation attempted
On-call paediatrician examines child. Death is declared.
Paediatrician contacts on-call Detective Inspector via the Police Control Room
Parents informed of child's death and next steps
Strategy Discussion Consultant Paediatrician and Detective Inspector (decisions to be recorded)
Rapid Response initiated
Samples and x-rays taken (as per agreed guidance)
Neonatal death
Rapid Response not required
Initial Case Discussion Rapid Response Team - within 6 – 24 hours of death (decisions to be recorded)
Body is moved to a quiet designated area. Family able to visit and offered mementos (after discussion with Police)
Child never left hospital and no issues of concern
CDR process continues as for expected deaths
Home/Scene visit Form G or H completed
Support for family put in place (led by Health)
(If required) Multi Agency discussion to review available information, agree on-going support and provide a factual Report for the Coroner
Initial PM results sent to Rapid Response Team and CDR Manager
Form A notification made
Final PM results sent to CDR Manager for sharing with Rapid Response Team
Bereavement Nurse to identify a suitable Single Point of Contact for parents
Final Case Discussion (Form F completed)
Case discussed at Local CDR Panel Meeting (Form C completed)

Categories

Local Panels categorise deaths using the following scheme. This classification is hierarchical; where more than one category could reasonably be applied, the highest up the list is marked.

Category	*Name & description of category*
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 (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, cystic fibrosis, 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, 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 (i.e., 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).