Southend, Essex and Thurrock

Child Death Review Annual Report

1st April 2015 – 31st March 2016

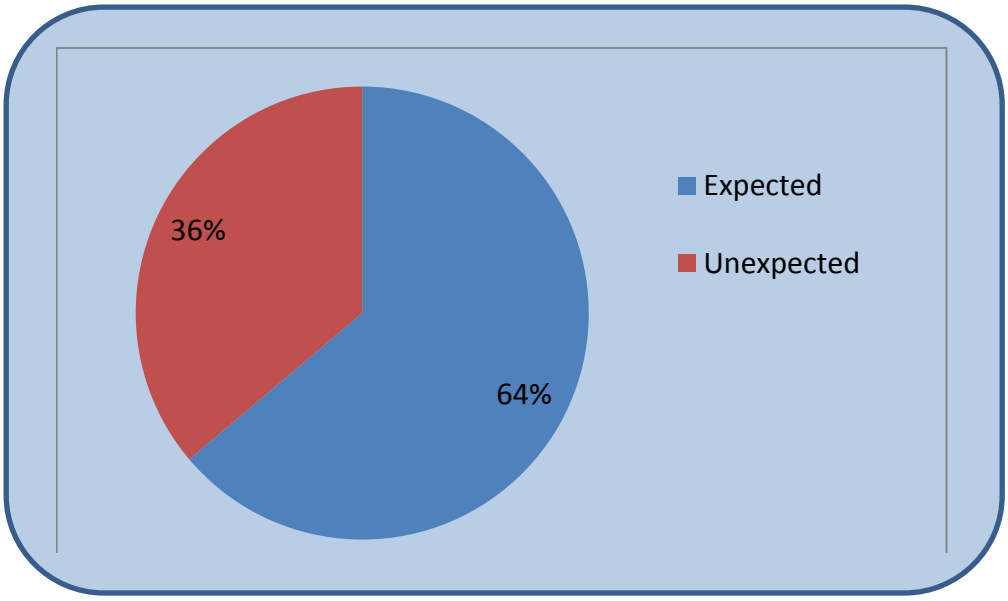
We hope that you will find this Report useful and informative.

We are continually trying to improve the information provided and would appreciate your taking the time to complete the following very short survey.

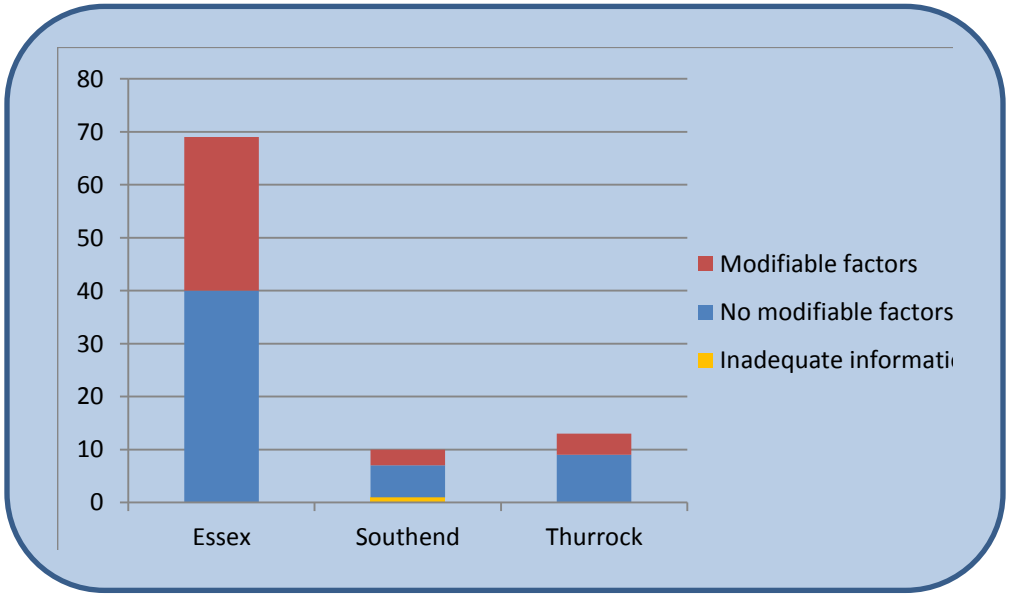
Please send your response to:- cdr@essex.gov.uk.

CDR Activity 2015-2016

94 Notifications received



92 Reviews completed



		CONTENTS	Page
		Terminology and Definitions	5
		Chair's Introduction	6
		Purpose of this Report	7
1		**Notifications of Child Deaths received Apr 2015 - Mar 2016**	8
	1.1	Number of notifications	8
	1.2	Area of residence	9
	1.3	Age and gender	9
	1.4	Neonatal deaths	10
	1.5	Unexpected deaths	12
2		**Completed Reviews (Apr 2015 – Mar 2016)**	12
	2.1	Modifiable factors	12
	2.2	Completed cases by Local Authority area	13
		2.2.1 Southend	13
		2.2.2 Thurrock	13
		2.2.3 Essex	14
	2.3	Completed Reviews by year of notification	15
	2.4	Neonatal deaths	15
	2.5	Sudden unexpected, unexplained deaths	16
		2.5.1 SUDI 2015-2016	16
		2.5.2 SUDI 2011 - 2016	17
	2.6	Suicide or deliberate self-inflicted harm	18
	2.7	Ethnicity	18
	2.8	Child Protection Plans and Statutory Orders	19
3		**SCDOP Activity 2015 - 2016**	20
		3.1 Child Safety Campaigns	20
		3.2 CDR Development Day	21
4		**Plan for 2016 - 2017**	22
		Appendices	
	1	Overview of SET CDOP Structure	23
	2	Flow chart – Response to unexpected deaths	25

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

Purpose of this Report

This report is intended to summarise the work of the Southend Essex and Thurrock Child Death Overview Panel during 2015-2016.

The aim of the report is to provide information on the total numbers of child deaths reviewed 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

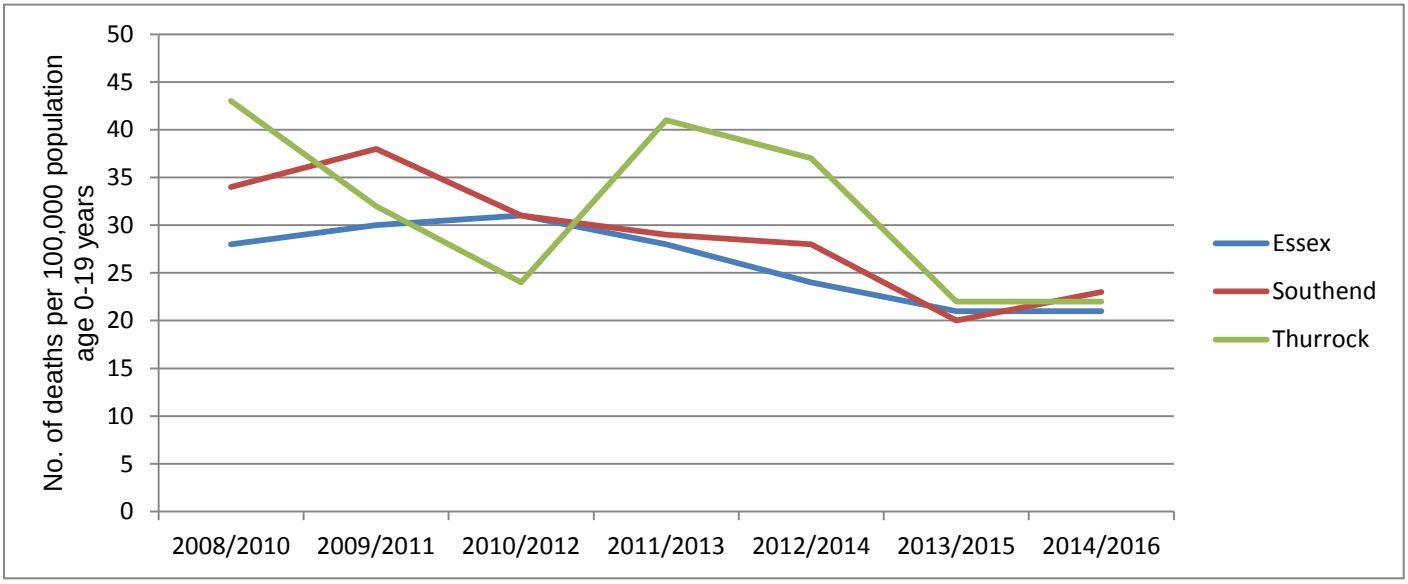
1. Notifications of Child Deaths received (1 April 2015 – 31st March 2016)

1.1 Number of notifications

In total 94 notifications of child deaths were received during this year. 72 children were resident in Essex, 12 in Southend and 10 in Thurrock.

This equates to a figure of 22 for Essex, 29 for Southend and 23 for Thurrock per 100,000 population aged 0-19 years for this year.

Number of notifications of child deaths per 100,000 population (age 0-19), rolling two year average:

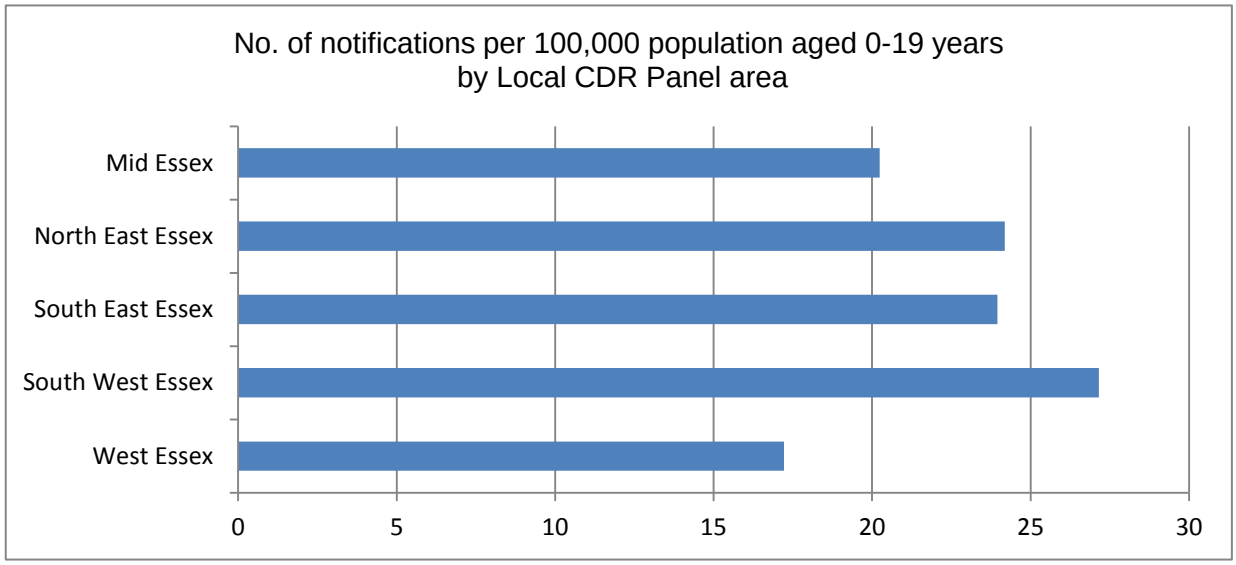


Not all deaths which occurred in the year ending 31st March 2016 had a completed review within this year as some may take many months to complete. For example, in cases where there are Coroners' reports, criminal proceedings, serious case reviews or other further investigations

1.2 Area of Residence

The number of deaths per 100,000 population aged 0-19 years by area of residence and local Child Death Review Panel area are shown below

.



1.3 Age and Gender

- 56% of child deaths this year were male
- 61% of deaths were for children under 1 year old.

	Southend	Essex	Thurrock	Total	Male	Female
0 - 27 days*	x	28	x	**41**	24	16
28 days - 364 days	x	15	x	**16**	8	8
1 - 4 years	x	9	x	**14**	6	8
5 - 9 years	x	7	x	**9**	x	x
10 - 14 years	x	x	x	**x**	x	x
15 - 17 years	x	7	x	**8**	x	x
	12	72	10	**94**	53	40

The Infant (aged 0 - 364 days) mortality rate per 1000 live births for England is 3.9. Rates for SET areas are slightly below this.

	Infant mortality rate per 1000 live births*
Essex	**3.6**
Southend	**3.6**
Thurrock	**3.4**
England	3.9
Essex comparator authority areas:	
Lancashire	3.9
Kent	3.1
Hampshire	2.8
Surrey	2.6
Herts	3.2

**Source: ONS Death Registrations (2014)*

1.4 Neonatal Deaths (0 – 28 days)

41 deaths (43%) occurred in the neonatal period, ie within the first 28 days of life.

The rate per 1000 live births for Essex is equal to the national figure of 2.7. The rate for Southend is lower than the national figure and for Thurrock the figure is higher.

	Neonatal mortality rate per 1000 live births*
Essex	**2.7**
Southend	**2.3**
Thurrock	**3.0**
England	2.7
Essex comparator authority areas:	
Lancashire	2.3
Kent	2.1
Hampshire	2.2
Surrey	2.0
Herts	2.1

**Source: ONS Death Registrations (2014)*

The MBRRACE-UK Perinatal Mortality Report[1] covering births from January to December 2014 states the stabilised and adjusted neonatal mortality rate [2] by CCG area as follows:-

Clinicial Commissioning Group (CCG)	Neonatal Deaths per 1000 births in 2014
Basildon & Brentwood	1.88
Castle Point & Rochford	1.75
Mid Essex	1.76
North East Essex	1.66
Southend	1.54
Thurrock	1.79
West Essex	1.79

By local NHS Trust the stabilised and adjusted rate of neonatal deaths for births in 2014 > 22 weeks gestation is as follows:-

NHS Trust	Neonatal Deaths per 1000 births in 2014 > 22 weeks gestation
Basildon & Thurrock University Hospital Trust	1.22
Mid Essex Hospital Trust	1.28
Princess Alexandra Hospital	1.10
Colchester Hospital University Foundation Trust	1.13
Southend University Hospital Foundation Trust	1.13

[1] https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK-PMS-Report-2014.pdf
[2] The stabilised & adjusted mortality rate provides a more reliable estimate of the underlying mortality rate, accounting for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity and gestational age at birth.

1.5 Unexpected Deaths

Of the 94 notifications of child deaths received this year, 34 were classed as unexpected, ie. the death was not anticipated as a significant possibility for example, twenty four hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.
For all unexpected deaths the SET Rapid Response procedure will take place (See Appendix 2) .

A Rapid Response Team home visit was undertaken in 27 of the 34 unexpected deaths.

2. Completed Reviews (Apr 2015 – Mar 2016)

92 Child Death Reviews were completed during this year by the five Local Child Death Review Panels which are based in the Acute Trust areas, Mid, North East, South East, South West and West Essex. (Please see Appendix 1 for details of the SET CDOP structure)

In total the Local Panels met 19 times and the activity by panel area is as follows:-

Panel Area	Number of meetings	Cases completed
Mid Essex	3	12
North East Essex	3	12
West Essex	4	19
South East Essex	3	15
South West Essex	6	34

Not all reviews will be completed in the year of the notification received, especially where there is an Inquest or crminal proceedings.

2.1 Modifiable Factors (Factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths)

The Local Child Death Review Panels are asked to determine whether there were any modifiable factors and to decide what, if any, actions could be taken to reduce the risk of such deaths in the future.

Of the 92 completed cases in the year April 2015-March 2016, 55 cases were deemed to have no modifiable factors; In 36 cases modifiable factors were identified.

In 1 case the panel decided that inadequate information was available for a judgement to be made. This was a case from 2013 relating to an unexpected death where the child died in an out of area hospital two weeks after the incident. Due to the time between the incident and the death the rapid response process was not undertaken and the panel felt that they were, therefore, lacking sufficient information from the incident to be able to determine whether there were any modifiable factors. It should be noted that due to the change in the SET rapid response process since this time, this situation would no longer occur. All notifications of child deaths submitted from tertiary centres where the initial collapse was unexpected are now notified to the health Rapid Response team.

2.2 Completed cases by Local Authority area

2.2.1 Southend

10 Reviews were completed for children resident in the Southend Local Authority area. In 6 of these cases no modifiable factors were identified and the deaths were deemed to be not preventable.

In 3 cases modifiable factors were identified:-

Modifiable factors in the deaths classified as perinatal/neonatal events included maternal smoking and factors related to service provision and possible earlier surgical intervention. No specific recommendations were made following these reviews as the panel were satisfied that the issues had been identified by a Root Cause Analysis Report. The local hospital Head of Midwifery attended the CDR Panel to reassure the panel members that all recommendations from Root Cause Analysis had been implemented.

Parental smoking during pregnancy and in the household were noted as modifiable factors for the death in the Chromosomal, genetic & congenital anomalies category.

2.2.2 Thurrock

13 Reviews were completed for children resident in the Thurrock Local Authority area. In 9 of these cases no modifiable factors were identified and the deaths were deemed to be not preventable.

In 4 cases modifiable factors were identified:-

Modifiable factors were noted in two cases in the Suicide or deliberate self-inflicted harm category relating to parenting capacity, supervision and family & environment. In one case the emotional/behavioural/mental health of the child was the only factor identified and this case was classed as not preventable.

Co-sleeping was noted in the death classified as sudden unexpected unexplained.

Modifiable factors relating to service provision were noted in a death classified as chronic medical. This related to service provision at a tertiary hospital. The Panel were satisfied that appropriate recommendations had been made in a Serious Incident report but a letter was sent to the tertiary hospital seeking clarification of some further points. No other recommendations were felt necessary

2.2.3 Essex

69 Reviews were completed for children resident in the Essex Local Authority area. In 40 of these cases no modifiable factors were identified and the deaths were deemed to be not preventable.

Modifiable factors were identified in 29 cases.

In both the Trauma and the Suicide or deliberate self-inflicted harm categories modifiable factors were found including factors in family & environment, substance misuse by a child and behavioural or mental health condition in a parent or carer.

All of the deaths classified as sudden unexpected, unexplained deaths were found to have modifiable factors. In 6 out of 10 of these cases co-sleeping was noted. Smoking was a factor in 8 out of the 10 cases. Other modifiable factors in this category included sleeping surface or position, parenting capacity and family & environment.

Modifiable factors in the perinatal/neonatal deaths category were as follows:-

- Smoking during pregnancy

- Factors relating to prior medical intervention and service provision. In two cases hospital investigations were shared with the panel so that they could be reassured that all relevant recommendations had been made and implemented and no further investigation was needed by the CDR Panel.

- In one case a Local Manager from the East of England Ambulance Service was asked to attend the Local Panel meeting to discuss a service provision concern raised by the panel. The concerns have been fed back to the Ambulance Service who are now looking into the possibility of purchasing additional equipment.

The death classified as Infection included modifiable factors in parenting capacity, family & environment, co-sleeping and also service provision.

Factors identified in the Chromosomal, Genetic and Congenital Anomalies and the Acute Medical categories included:-

- Parenting capacity, family & environment, parental smoking, domestic violence and consanguinity

- Factors were identified in relation to access to healthcare and prior medical intervention. Learning points from these cases have been shared locally and, in one case, nationally.

2.3 Completed Reviews by year of notification

During the period covered by this report Child Death Reviews were completed in relation to notifications received from 2011 to 2015.

In general Child Death Reviews are completed between 3 months and 18 months of notification, depending on the complexity of the case and the amount of information to be collated. However, in some cases this time can be longer if other investigations are ongoing, eg Inquest, Hospital Investigation or Police investigation.

2.4 Neonatal deaths

Local details

In total there were 30 reviews of neonatal deaths during the year April 2015 – March 2016 in the SET area.

- 16 of these deaths were boys and 13 were girls. 1 child was of indeterminate gender.

- 20 of these deaths occurred in out of area, tertiary hospitals or specialist neonatal units.

- 13 deaths occurred of children born before 28 weeks gestation

- In x cases the mother's age was less than 20 years

.

- Maternal smoking was noted as a factor in x deaths

- Modifiable factors in relation to service provision were noted in x cases. These issues were addressed and recommendations made by hospital Root Cause Analysis or Serious Incident investigations and no additional recommendations were made by the Local CDR Panels.

National picture

In November 2015 the Government announced an ambition to half the rate of stillbirths, neonatal and maternal deaths in England by 2030. Following this in February 2016 the National Maternity Review, Better Births, Improving outcomes of maternity services in England was published. *(https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf)*

This Review set out a number of recommendations for improvements to maternity services including: the establishment of a national standardised investigation process when things go wrong to encourage rapid learning and ensure that families receive the help they need quickly. It is intended that this will be in place by the end of 2016/17.

2.5 Sudden Unexpected, Unexplained Deaths

2.5.1 Sudden Unexpected, Unexplained Deaths 2015-2016

11 cases were classified as Sudden Unexpected, Unexplained deaths.

- 64% of these deaths occurred between one month and twelve months of age.
- Co-sleeping was noted as a factor in 8 out of the 11 cases.

2.5.2 SUDI deaths Apr 2011 – Mar 2016

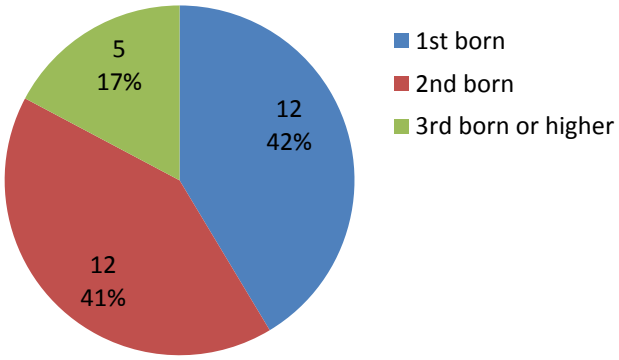
During this five year period 29 deaths were classified as Sudden Unexpected, Unexplained deaths.

Risk Factors

➢ **Bed sharing**	Bed sharing or sleep surface was a factor in 19 deaths	**65%**
➢ **Birth weight**	Low birth weight (less than 2.5 kg) was a factor in 9 deaths	**31%**
➢ **Prematurity**	Prematurity (less than 37 weeks gestation) was a factor in x deaths	**21%**
➢ **Smoking**	Smoking in the household was noted as a factor in 21deaths, 72%	**72%**
➢ **Alcohol or substance misuse**	Alcohol or substance misuse was noted as a factor in x cases	**17%**

Birth Order

- 42% of the SUDI deaths in this five year period occurred in first born children
- 58% in those children who were second or higher birth order.



Child Poverty

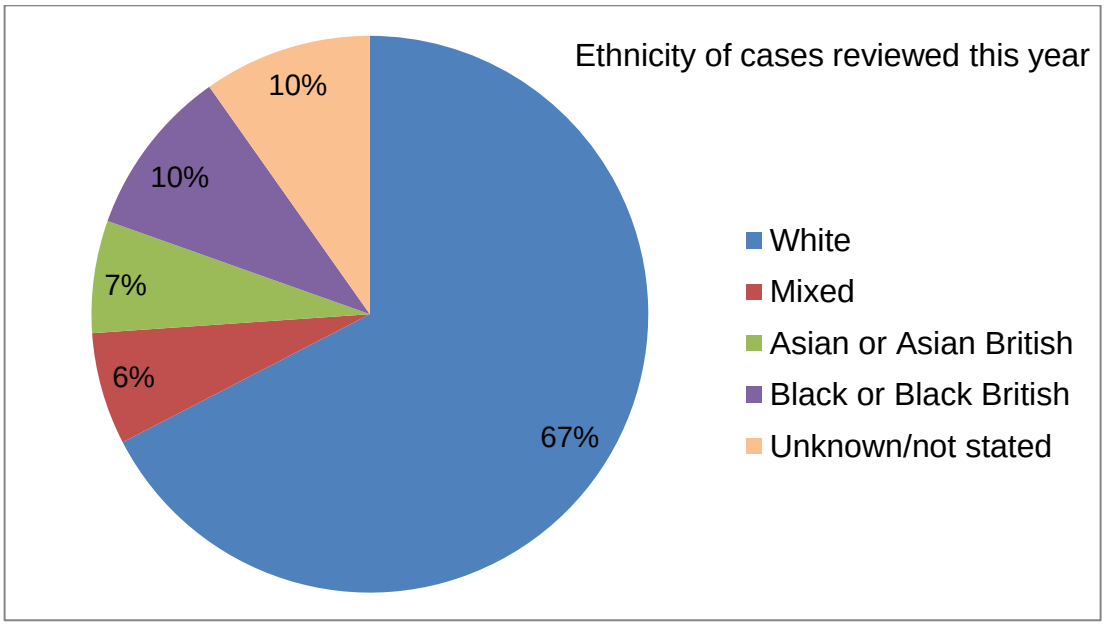
Nationally, areas of deprivation have been linked to a higher occurrence of SUDI. Within SET areas this does not appear to be the case. Authorities with a high rate of children living in poverty have had smaller numbers or in some areas, no cases at all.

2.6 Suicide or deliberate self-inflicted harm

A number of reviews were completed this year for children who had taken their own lives by suicide. These children were ranged in age between 13 and 17 years.

Following these reviews the Strategic Child Death Overview Panel will add work around reducing the risk of youth suicide to the Action Plan for 2016-2017 and will liaise with the Safeguarding Children Board to reduce vulnerability of children to factors identified in the reviews, including domestic violence, bullying, parental alcohol/substance misuse and deficits in parenting capacity.

2.7 Ethnicity



23% of reviews completed this year were for children from a minority ethnic background. Across the three SET areas the average percentage of school age children from minority ethnic groups is 21.5%. For the East of England the figure is 20.9% and for England the figure is 20.8%. The number of deaths reviewed for children from a minority ethnic background would appear to be slightly higher although numbers in these groups are very small.
(Figures obtained from Public Health Child Health Profiles, June 2015)

2.8 Child Protection Plan and Statutory Orders

One child for whom a review was completed this year was subject to a Child Protection Plan under the category of emotional abuse at the time of death. This was an expected death of a child with a life limiting condition. No modifiable factors were identified.

In three cases the child had previously been subject to a Child Protection Plan. In one of these cases modifiable factors were found in parenting capacity and family & environment. The death was categorised as Acute Medical.

None of the completed cases this year was subject to a Serious Case Review.

3. Strategic Child Death Overview Panel (SCDOP)Activity 2015-2016

During this year the SCDOP has continued to ensure that learning from child death reviews is shared locally, regionally and nationally as appropriate. For example, learning from a local hospital Serious Incident Report regarding diagnosis of a rare condition has been shared across SET area hospitals and nationally

3.1 Child Safety Campaigns

Posters and leaflets for all SET child safety campaigns have been circulated across SET areas and are available on the ESCB web site for families and professionals. They were also sent to Children's Centres and local Sport and Leisure Centres.

During school holidays information from all the SCDOP child safety campaigns has been on display and available for families at a local library.

Water Safety

The SET water safety campaign was launched in May 2015. During the campaign period May - June 2015 press coverage was included in several local papers as well as partner channels. Web hits increased significantly and saw over 300 visits to the ESCB water safety page during the month of June. (April 2015 – 17 hits)

The Facebook campaign ran from 23rd May to 23rd June. In this four week period we reached 12,670 people (this is the number of people that could have potentially seen the advert), there were 226 clicks to the ESCB website (water safety page) and the likes on our Facebook page increased from 51 to 81.
Twitter activity was purely organic (there was no paid advertising) however, there was still some noticeable increase in activity with the an audience reach in June of 3305 compared to a monthly average of around 2000.

Safer Sleeping

Child Safety was pushed again during Christmas 2015 and saw media coverage in several local papers as well as radio interview on Dream FM discussing the topic.
Child Safety Bulletin issues in December – Safer Sleep was most read article.
In December Safer Sleep was the third highest viewed page on the website, with 261 views.
In December the @EssexSafeguards twitter account had 5970 impressions (number of people to see the tweet) Normally this figure is about 1500. This doesn't include any promotion partner agencies may have also done

Furniture safety

In December 2015 the SCDOP commissioned posters and leaflets highlighting the dangers of falling furniture and recommendations for furniture safety in the home. This information has been circulated across SET areas, including Children's Centres and is available on the ESCB web site.

3.2 Child Death Review Development Day

In June 2015 a Child Death Review Development Day was held for professionals who may be involved in the Child Death Review or the Rapid Response process. The theme of this day was water safety to link with the SCDOP campaign to raise awareness of water safety in residential swimming pools.

45 professionals attended from across Health, Police, Social Care and Education agencies.

Presentations were given on the day by the SET Rapid Response Team, the Area Coroner, the Child Accident Prevention Trust, Child Bereavement UK and Little Havens Children's Hospice.

We were sent a personal message from Simon Martyn to introduce the film The Danger Age which he made, together with other families, following the death of his son by drowning.

4. Plan for 2016 - 2017

The priorities for the year are agreed by the Strategic Child Death Overview Panel based on findings from completed Child Death Reviews.

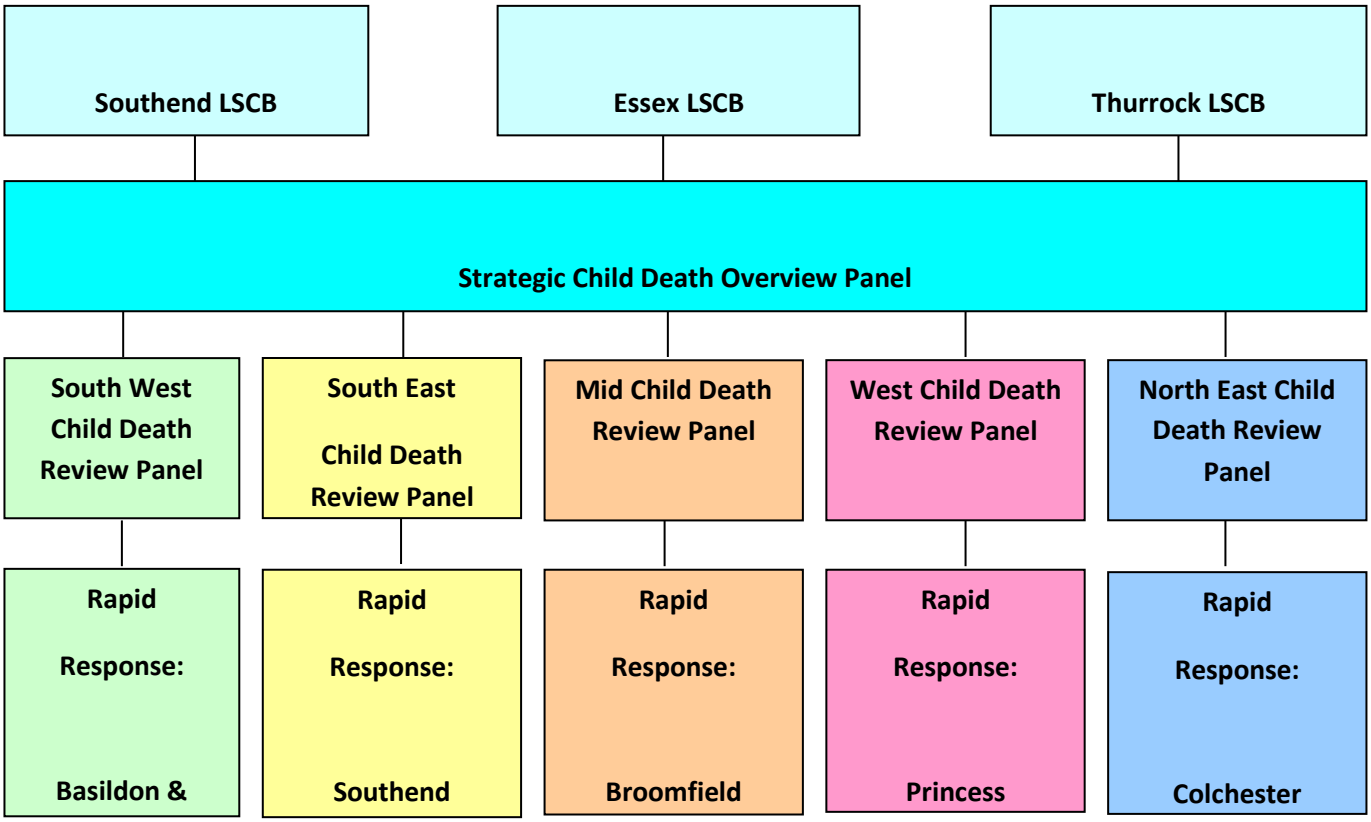
The following priorities have been identified:

	Priority	How	By
1	Reduce the risk of youth suicide	By working with the SET Suicide Prevention Workgroup to consider guidance currently available and whether any additional awareness raising campaign or resources are needed.	Dec 2016
2	Reinforce current SET Safer Sleeping campaign	To continue to highlight the risks of co-sleeping; To promote safer sleeping for babies advice and to consider any actions needed to ensure that this advice is reaching mothers and fathers	Ongoing
3	To continue to ensure that SCDOP meets its statutory requirements.	By reviewing all child deaths; Identifying patterns or trends in local data, determining whether the death was deemed preventable and making recommendations for actions to prevent future deaths where possible	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 local structure is set out below.



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

The aim of the SCDOP is to:-

- oversee and monitor the implementation of the SET protocol for deaths in childhood,
- review aggregated and anonymised data on deaths occurring in SET,
- review and endorse recommendations made by the LCDRPS, and
- oversee the training and development program related to the CDR work

2.1 SCDOP Membership

Current SCDOP Membership is as follows:

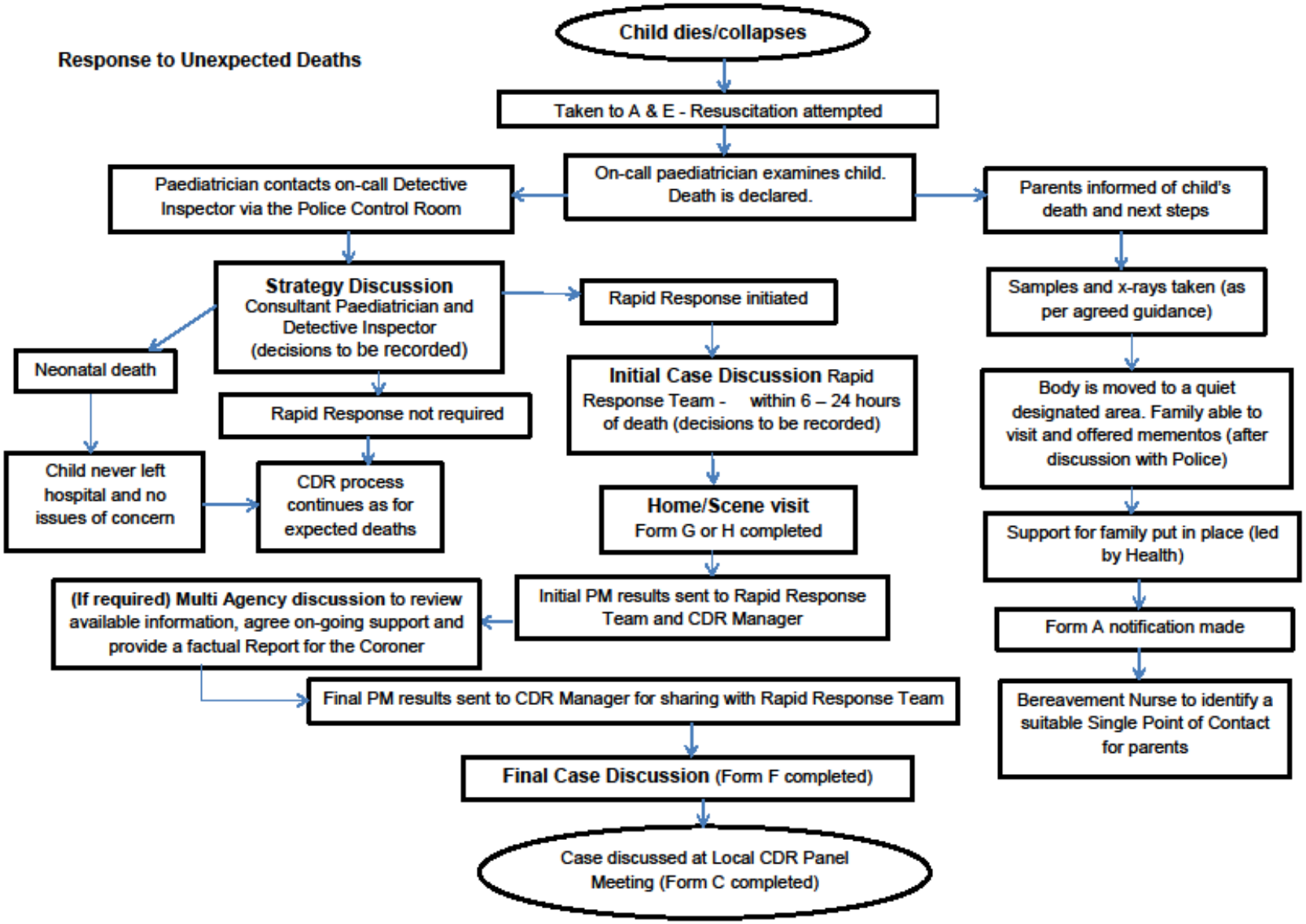
- Director for Public Health, (Chair)
- Detective Chief Inspector CAIU, Essex Police
- Designated Paediatrician for Deaths in Childhood, South Essex
- Designated Paediatrician for Death in Childhood - South Essex
- Designated Paediatrician for Deaths in Childhood – West Essex
- Designated Paediatrician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

The LCDRPs meet quarterly to assess gathered data on the deaths of all children in that area including both expected and unexpected deaths.

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)