Southend, Essex and Thurrock

Child Death Review Annual Report

1st April 2018 – 31st March 2019

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.notifications@nhs.net.

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

		CONTENTS	Page

Terminology and Definitions

CAIU	Child Abuse Investigation Unit
CCG	Clinical Commissioning Group
CPP	Child Protection Plan
CDOP	Child Death Overview Panel
Infant mortality	All deaths under 1 year
LCDRPs	Local Child Death Review Panels
LeDeR	Learning Disabilities Mortality Review
LSCB	Local Safeguarding Children's Board
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
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 occurrences 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 of Public Health

Foreword

Local Safeguarding Children Boards have a statutory responsibility to carry out a review of each death of a child or young person under 18 years of age and normally resident in their area.

The Safeguarding Children Boards of Southend, Essex and Thurrock (SET) share one Strategic Child Death Overview Board (SCDOP). This report is intended to summarise the work of the Southend Essex and Thurrock Strategic Child Death Overview Panel during 2018-2019 and should also serve as a resource to inform public health measures to promote child health, safety and wellbeing.

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.

Section 1 of this Report details the notifications of child deaths received during the period 1st April 2018 to 31st March 2019. Section 2 relates to the child death reviews completed during this year (which will include cases initially notified in previous years) and the findings from these reviews. Section 3 relates to outcomes and learning from completed reviews and the work of the Strategic Child Death Overview Panel and section 4 to priorities for the year 2019 – 2020.

Section 1

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

Notifications of Child Deaths received (1 April 2018 – 31st March 2019)

1.1 Number of notifications

During the year of this reporting period, notifications were received for 103 deaths of children resident in the Southend, Essex and Thurrock authority areas.

Notifications Received	2014/15	2015/16	2016/17	2017/18	2018/19
Southend	7	12	8	x	13
Essex	61	72	65	77	74
Thurrock	9	10	8	17	16
Out of area	X	X	X	X	x
Total	**77**	**94**	**83**	**100**	**103**

Per 100,000 population aged 0 – 17 years*, these figures equate to 24 for Essex, 33 for Southend and 37 for Thurrock.

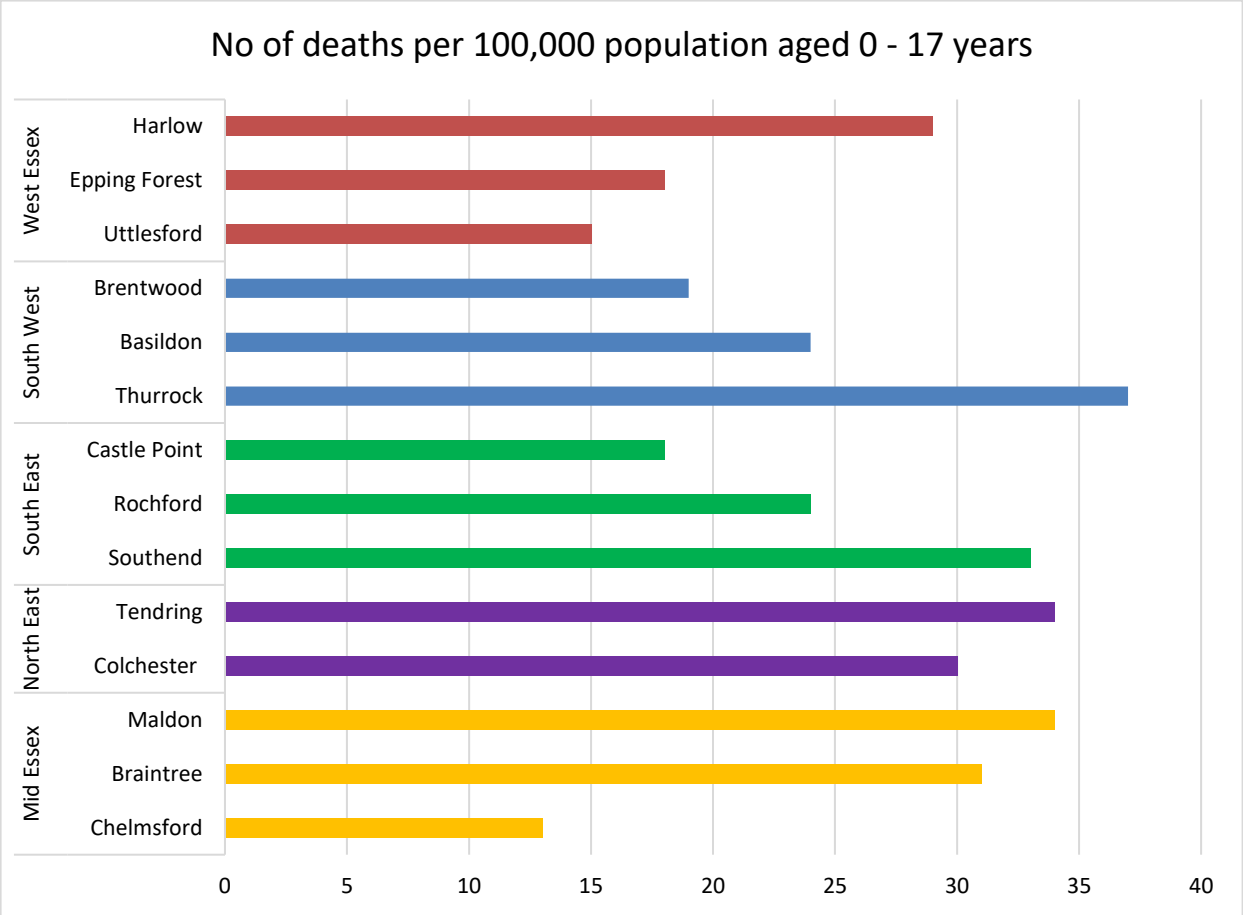
**Source ONS Population Estimates Mid 2017*

By Local Authority area, Thurrock had the highest number of cases.

	Notifications received
Chelmsford	x
Braintree	10
Maldon	x
Colchester	12
Tendring	9
Southend	13
Rochford	x
Castle Point	x
Thurrock	16

Basildon	10
Brentwood	x
Uttlesford	x
Epping Forest	x
Harlow	x

A more balanced view can be shown by comparing the numbers by the rate per 100,000 population, aged 0 – 17 years across the Local and Unitary Authorities within the SET SCDOP area.



1.2 Mortality Rates

Child mortality rates are calculated using the following formula, based on 2015 – 2017 ONS figures:

Neonatal Mortality Rate per 1000 live births (age 0 - 28 days)

Infant Mortality Rate per 1000 live births aged under 1 year
Child Mortality Rate per 100,000 children aged 1 - 17 years

Rates within Southend, Essex and Thurrock remain lower than the national rates for neonatal, infant and child deaths.

Figures for the closest demographic neighbours for each of the SET authorities are shown below:-

Compared with the national figure: Better Similar Worse

	Neonatal	Infant	Child
Essex	**2.14**	**3.1**	**9.5**
Kent	2.74	3.8	8.2
Worcestershire	3.06	4.1	8.1
Central Bedfordshire	2.13	2.6	11.4
Staffordshire	4.2	5.5	11.8
West Sussex	1.93	2.7	9.1
South Gloucestershire	2.33	3.5	8.7
Warwickshire	3.39	4.2	9.9
Leicestershire	2.72	3.7	10
North Somerset	2.01	2.9	9.8
East Sussex	2.37	3.2	10.8
England	2.8	3.6	11.2

	Neonatal	Infant	Child
Southend on Sea	**2.38**	**3.4**	**8.5**
Swindon	2.58	3.4	13.7
Plymouth	2.36	3.1	*
Medway	2.94	3.7	14.1
Bournemouth	3.04	3.8	*
Kent	2.74	3.8	8.2
Sheffield	3.26	4.8	12.4
Isle of Wight	2.45	3	*
Telford and Wrekin	3.85	4.8	9
East Sussex	2.37	3.2	10.8
Poole	1.28	1.9	*
England	2.8	3.6	11.2

*Value cannot be calculated as number of cases is too small

	Neonatal	Infant	Child
Thurrock	**2.27**	**3.1**	*****
Medway	2.94	3.7	14.1
Bexley	1.93	3.1	9.1
Havering	1.39	1.9	9.3
Dudley	3.84	5.4	14.5
Telford and Wrekin	3.85	4.8	9
Swindon	2.58	3.4	13.7
Southend-on-Sea	2.38	3.4	8.5
Sheffield	3.26	4.8	12.4
Peterborough	3.22	4.3	17.1
Derby	4.16	6.2	*
England	2.8	3.6	11.2

*Value cannot be calculated as number of cases is too small

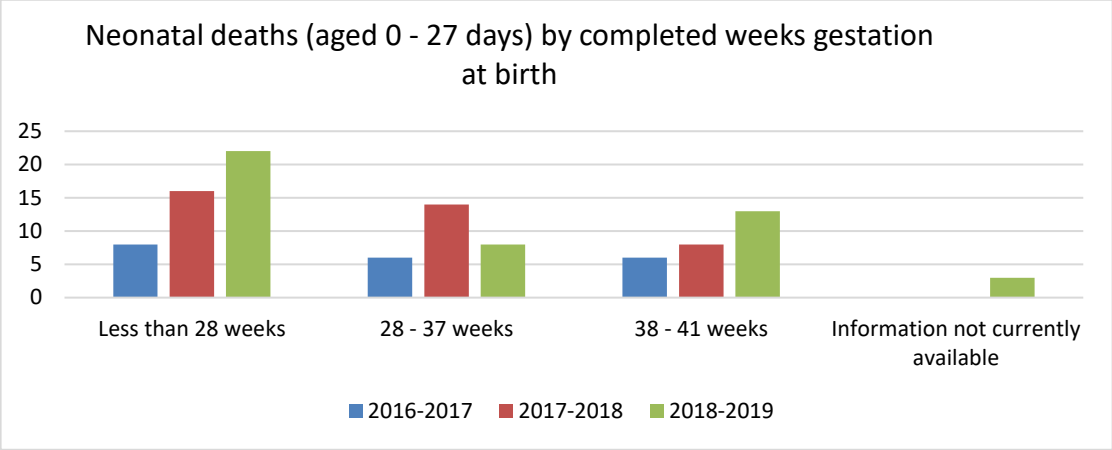
1.3 Profile of Child Death Notifications 2018 - 2019

1.3.1 Age and gender

	Southend	Essex	Thurrock	Total	Male	Female
0 - 27 days	x	31	10	**46**	31	15
28 days - 364 days	x	14	x	**18**	10	8
1 - 4 years	x	x	x	**x**	x	x
5 - 9 years	x	12	x	**13**	x	7
10 - 14 years	x	7	x	**11**	x	x
15 - 17 years	x	x	x	**9**	7	x
	13	74	16	**103**	62	41

1.3.2 Neonatal deaths

There has been an increasing number of notifications of deaths of babies aged 0 - 27 days. One reason for this is the increase in notifications received for extremely pre-term births, i.e. less than 28 weeks gestation.



Nationally, the neonatal mortality rate has been increasing since 2015. One reason for this could be the increasing numbers of live births recorded below the age of viability. Survival of babies born at less than 24 weeks gestation is now less unusual, but mortality rates are high.

13 of the 46 neonatal death notifications were for babies of less than 24 weeks gestation.

Details of the profile of completed reviews of neonatal deaths is included in Section 2 of this Report.

1.3.3 Unexpected Deaths and Rapid Response

Of the 103 notifications received this year, 34 (33%) were classed as unexpected, ie the death was not anticipated as a significant possibility 24 hours before the death or there was a similarly unexpected collapse leading to or precipitating the events which led to the death.

Of the 34 deaths classed as unexpected the rapid response process was initiated in 32 cases. The remaining two cases were medically explained deaths in hospital.

A joint home visit was made by the Rapid Response Team Health and Police CAIU in 25 of the 34 cases. In 6 cases the death was a medically explained death in hospital. 2 cases were subject to a Police investigation and a joint home visit was not appropriate. In 1 case the death resulted from an incident in a public place. The Rapid Response Team met with the family at the hospital, but a home visit was not deemed necessary.

1.4 Learning Disabilities Mortality Review (LeDeR)

8 deaths notified during this year will also be subject to a LeDeR Review.

The Rapid Response Team Health will undertake the home visit and prepare a report on each case. This report is then considered and finalised by the Child Death Review panel when completing the CDR.

The Rapid Response Team Health will then submit the finalised report to the LeDeR Programme.

Section 2

Completed Child Death Reviews (April 2018 – March 2019)

Area of Residency:	Number of Reviews:
Southend	8
Essex	73
Thurrock	13

94 Child Death Reviews were completed during this year. Initial notifications for these deaths were received between April 2016 and March 2019.

- In 37 cases the child died at a tertiary hospital
- 17 children died at their home address
- 8 children died in a Children's Hospice
- 2 deaths occurred in a public place
- 2 reviews related to children who died whilst outside of the UK

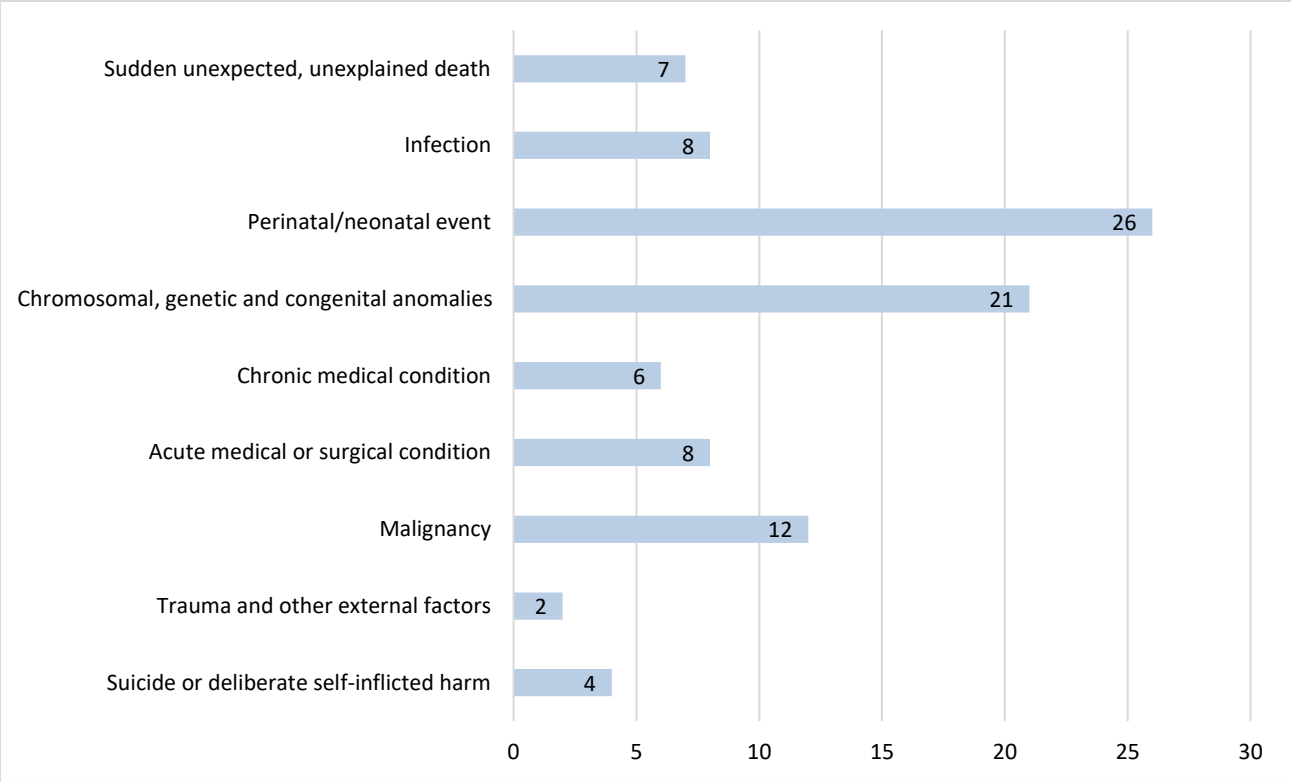
2.1 Category of death

At completion of the Child Death Review the Local Panels are required to categorise each death according to the following scheme:-

1	Deliberately inflicted injury, abuse or neglect
2	Suicide or deliberate self-inflicted harm
3	Trauma and other external factors
4	Malignancy
5	Acute medical or surgical condition
6	Chronic medical condition
7	Chromosomal, genetic and congenital anomalies
8	Perinatal/neonatal event
9	Infection
10	Sudden unexpected, unexplained death

This list is hierarchical and if more than one category could reasonably be applied, the highest up the list is marked.

The 94 reviews completed this year were categorised as follows: -

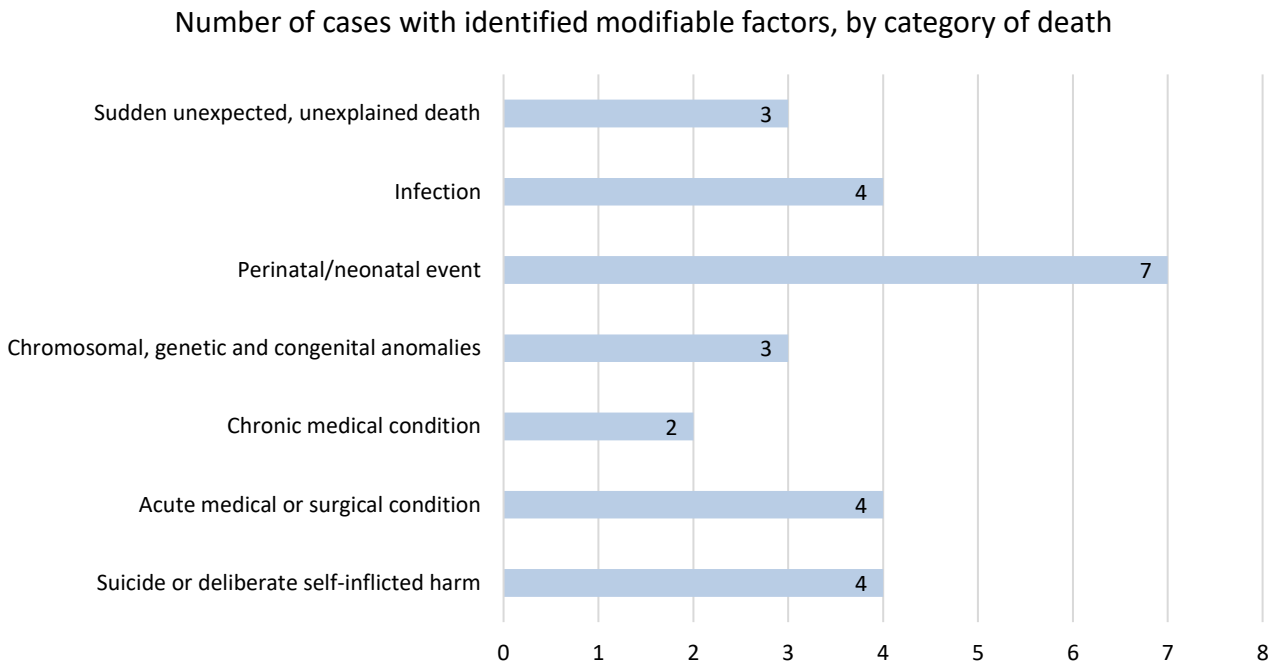


2.2 Modifiable Factors

The Child Death Review Panels are required to categorise the 'preventability' of each death by identifying whether there were any modifiable factors in the four domains below, which by locally or nationally achievable interventions, could reduce the risk of future child deaths.

- Intrinsic to the child
- Parenting capacity
- Family and environment
- Service provision

Modifiable factors were identified in 27 (29%) of the completed reviews during this period



Modifiable factors were noted within the following domains:

Acute medical or surgical condition

- Service provision
- Parenting capacity
- Family and environment

Suicide or deliberate self-inflicted harm

- Intrinsic to the child
- Parenting capacity
- Family and environment
- Service provision

Chronic medical condition

- Parenting capacity
- Family and environment
- Service provision

Chromosomal, genetic and congenital anomalies

- Intrinsic to the child
- Family and environment
- Service provision

Perinatal/neonatal event

- Service provision
- Parenting capacity
- Family and environment
- Service provision

Infection

- Family and environment
- Service provision

Sudden unexpected, unexplained death

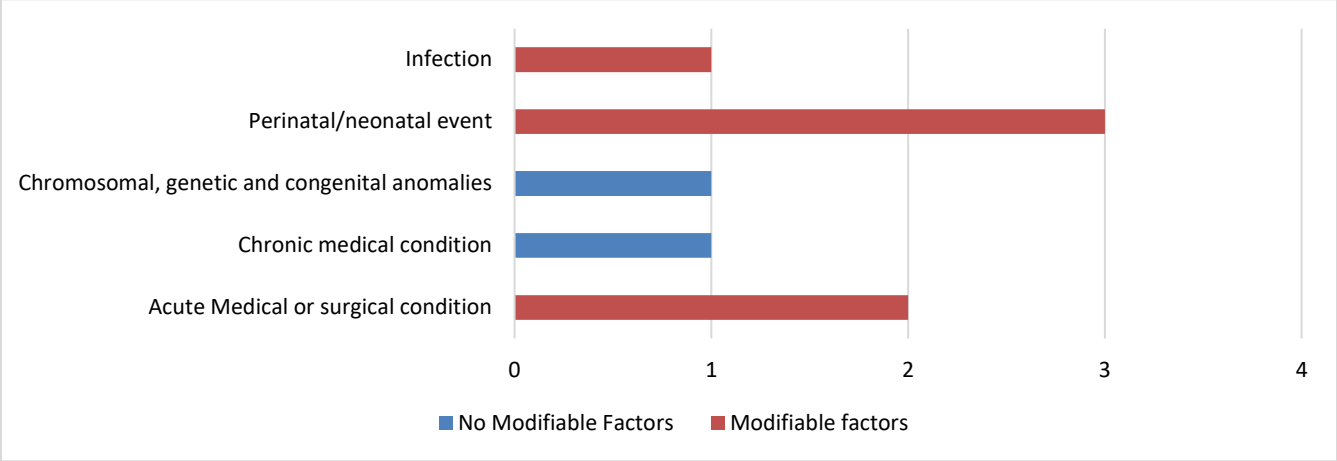
- Parenting capacity
- Family and environment
- Service provision

2.3 Profile of Reviews by Local Authority area

2.3.1 Southend Reviews completed

8 reviews were completed for Southend resident children.

6 out of the 8 cases had identified modifiable factors



- Infection
  - Co-sleeping
  - Smoking by the parent or carer during pregnancy or in the house

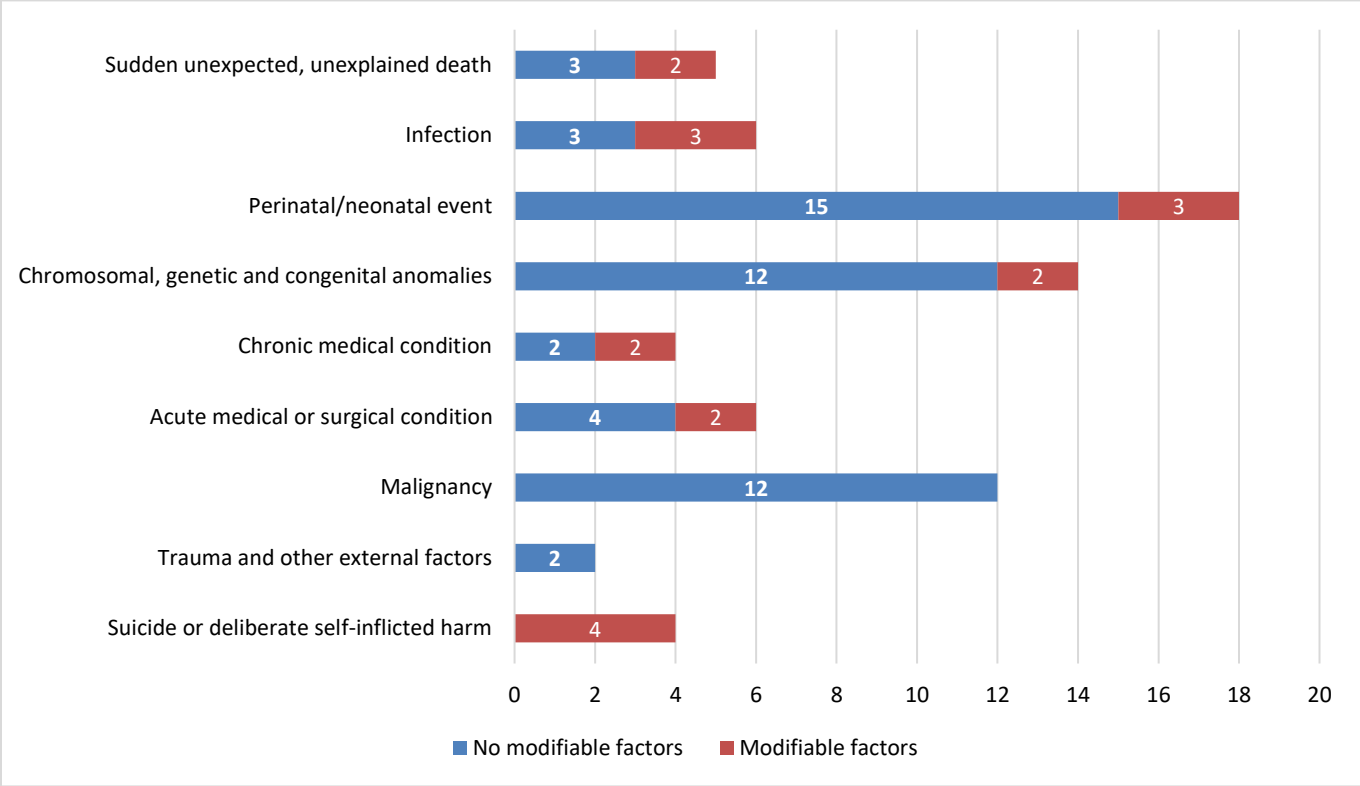
- Perinatal/Neonatal event
  - Alcohol/substance misuse by parent or carer
  - Smoking by parent or carer during pregnancy or in the house
  - Prior medical intervention, including identification of fetal distress and interpretation of CTGs.

- Acute medical or surgical condition
  - Prior surgical intervention; rare complications of surgery

2.3.2 Essex Reviews completed

73 reviews were completed for Essex resident children.

18 cases were found to have modifiable factors



The factors identified included:

- Sudden unexpected, unexplained death
  - Co-sleeping or sleep surface
  - Smoking by parent or carer during pregnancy or in the household
  - Mental health condition in a parent
  - Co-ordination of referral to social care and concerns raised not being progressed to assessment

- Infection
  - Smoking by parent or carer in household
  - Access to healthcare and advice given re safe sleeping
  - Prior medical intervention and quality of care received in hospital

- Perinatal/Neonatal event
  - Smoking by parent or carer during pregnancy or in the household
  - Domestic violence
  - Housing conditions

    - Access to healthcare and co-ordination of care

- Chromosomal, genetic and congenital anomalies
    - Alcohol/substance misuse by the child
    - Access to healthcare and hospital procedures

- Chronic medical condition
    - Parenting capacity
    - Smoking by parent or carer in the household
    - Domestic violence
    - Prior medical intervention

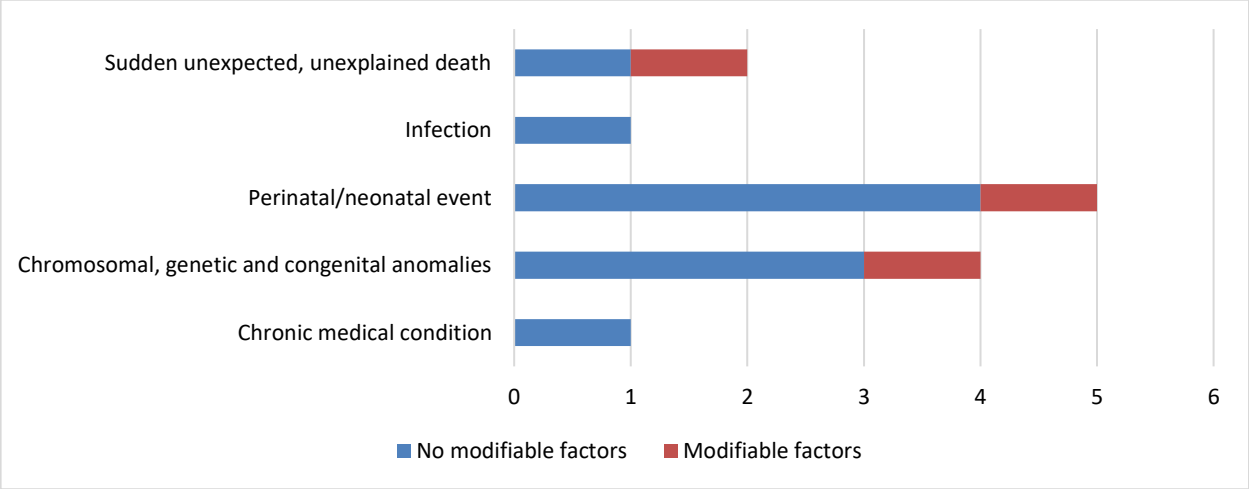
- Acute medical or surgical condition
    - Factors in parenting around supervision and child abuse/neglect
    - Access to healthcare; transfer of information between areas for children with chronic conditions; hospital procedures

- Suicide or deliberate self-inflicted harm
    - Emotional/behavioural and mental health of the child
    - Alcohol/substance misuse by the child
    - Emotional/behavioural and mental health condition in parent
    - Alcohol/substance misuse by parent/carer
    - Domestic violence
    - Bullying
    - Access to healthcare

2.3.3 Thurrock Reviews completed

13 reviews were completed for Thurrock resident children

3 out of the 13 cases had identified modifiable factors



- Sudden unexpected, unexplained death
  - Parenting capacity
  - Co-sleeping
  - Family and environment
  - Housing

- Perinatal/Neonatal event
  - Access to healthcare

- Chromosomal, genetic and congenital anomalies
  - Consanguinity

2.4 Categories of child deaths 2018 – 2019

2.4.1 Perinatal/Neonatal event

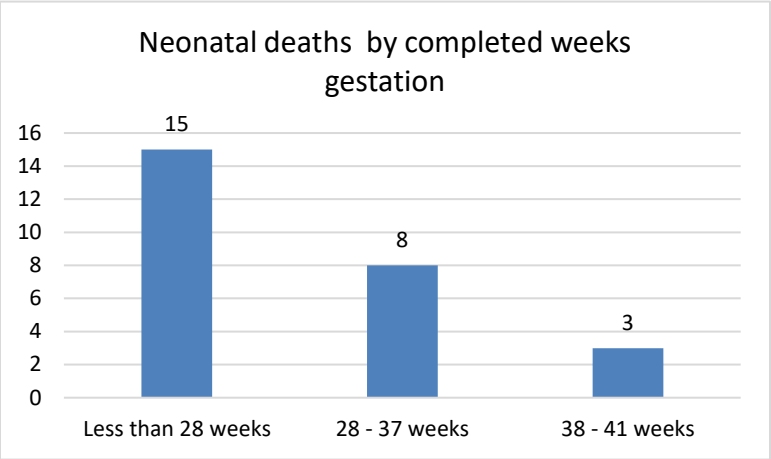
26 deaths were categorised as perinatal/neonatal event, i.e. the death was ultimately related to perinatal events. Not all deaths of babies aged 0 – 28 days will be included in this category as some cases may be classified under other domains, e.g. chromosomal, genetic and congenital anomalies.

The World Health Organisation defines preterm birth as follows:-

Preterm = born alive before 37 weeks of pregnancy are completed
Extremely preterm = less than 28 weeks gestation
Very preterm = 28 - 32 weeks gestation
Moderate to late preterm = 32 - 37 weeks gestation

23 (88%) of cases were preterm births.

15 (58%) of cases were extremely preterm



- In 25 of the cases reviewed the maternal age was between 20 and 39 years. In 1 case the maternal age was less than 20 years.
- In 23 cases (88%) the birth weight was less than 2.5kg
- 5 cases were following either twin or triplet pregnancies
- Maternal smoking during pregnancy was noted in 6 cases (23%)
- Paternal smoking in the household was noted in 5 cases (19%)

2.4.2 Chromosomal, genetic and congenital anomalies

21 deaths were included in this category.

- 16 cases (76%) occurred when the child was aged 0 – 364 days. In 3 cases the child was aged between 1 and 5 years. In 2 cases the child was over 6 years of age.
- 3 cases had identified modifiable factors. 1 related to consanguinity and 2 related to service provision and access to healthcare

2.4.3 Malignancy

12 deaths were included in this category of children aged between 1 and 17 years.

- None of the cases were found to have modifiable factors
- 6 deaths were due to brain tumours; 4 to other tumours and 2 to Leukaemia

2.4.3 Infection

8 deaths were recorded in this category.

- In 7 cases the initial collapse occurred at the child's home address; 1 death occurred in the paediatric intensive care unit

2.4.4 Acute medical condition and Chronic medical condition

14 cases were recorded in these two categories

- Modifiable factors relating to service provision were noted in 5 cases. Learning from these cases has been identified and shared and changes implemented.

2.4.5 Sudden unexpected, unexplained death

7 cases were recorded in this category

- In 3 cases the child was under 1 year of age
- Co-sleeping was noted in 2 out of the 3 cases under 1 year of age
- In 3 cases the child was between 1 year and 5 years of age. These deaths were due to Sudden Unexpected Death in Childhood (SUDC) and Sudden Unexpected Death in Cerebral Palsy
- 1 case related to a child who died whilst outside of the UK and insufficient information was available to identify the category of death or whether there were any modifiable factors

2.4.6 Suicide or deliberate self-inflicted harm

4 cases were reviewed in this category

- Alcohol/substance misuse by the child was noted in 2 cases
- Alcohol/substance misuse by parent or carer was noted in 2 cases
- Each of the cases had factors in the family and environment
- 1 case noted bullying as a factor
- 1 case noted domestic violence
- Each of the cases noted factors relating to access to healthcare

2.4.7 Trauma and other external factors

Each of the two deaths in this category were of a child aged 14 – 17 years.

- In 1 case the child died by drowning
- In 1 case the child died from other non-intentional injury/accidents/trauma
- No modifiable factors were identified in either case

2.5 Child Protection Plans and Statutory Orders

x of the deaths reviewed this year related to children who had previously been subject to a Child Protection Plan. None of the cases were subject to a Plan at the time of death.

Section 3

Summary of the work of the Southend, Essex & Thurrock Strategic Child Death Overview Panel and the Local Child Death Review Panels 2018 - 2019

During the year of this reporting period the Local Child Death Review panels met on 17 occasions, with each meeting completing an average of 5 or 6 cases.
The Strategic Child Death Overview Panel met 4 times.

Work completed this year included the following:-

Objective	Actions	Disseminated to
To provide an easy to read information leaflet for GPs to hand to parents to assist in recognition of a deteriorating child following a consultation.	Leaflet prepared 'Worsening signs of a sick child'	GPs within the SET area
To share learning across SET area re recognition of atypical presentation of congenital infection	Learning from Child Death Review template completed by Designated Doctor and agreed by SCDOP	Obstetricians, neonatologists and hospital microbiologists in SET acute trusts
To share learning across SET area regarding management of sickle cell disease	Learning from Child Death Review template completed by Designated Doctor and agreed by SCDOP	SET acute hospitals managing sickle cell disease

3.1 Review of SET CDR Process following changes to National Guidance

From 29 June 2018, the SET Local Safeguarding Children Boards began their transition from LSCBs to safeguarding partners and child death review partner arrangements as set out in Working Together to Safeguarding Children 2018. The responsibility for child death reviews will pass to the child death review partners, who are the Local Authorities of Southend, Essex and Thurrock and the seven CCGs covering the SET area.

The child death review partners were given twelve months from 29th June 2018 to agree arrangements for completing child death reviews, with a further three months to implement the arrangements.

In October 2018 the Government published national Child Death Review Statutory and Operational Guidance to standardise practice and enable thematic learning.

Following multi-agency discussions with representatives from Southend, Essex and Thurrock a proposal was developed and agreed for the revisions needed to the SET CDR procedure based on the new statutory guidance. The new arrangements will be in place by 1st October 2019 in line with the timescales set out in the Working Together: Transitional Guidance published in July 2018.

The revised SET Child Death Review arrangements are available on the ESCB web site;- http://www.escb.co.uk/working-with-children/child-death-reviews/

3.1.1. Changes to Local CDR Panel structure

The SET Local Child Death Review panel structure of 5 CDR Panels based in the Acute Trust areas of West, North, Mid, South West and South East Essex will be changed. The Local CDR Panels will be merged to form a single Child Death Overview Panel. A panel meeting will be held once a month (12 meetings per year) and will review and consider cases that are complete and ready for discussion, regardless of which SET area the child was resident in. This format commenced on 1st April 2019.

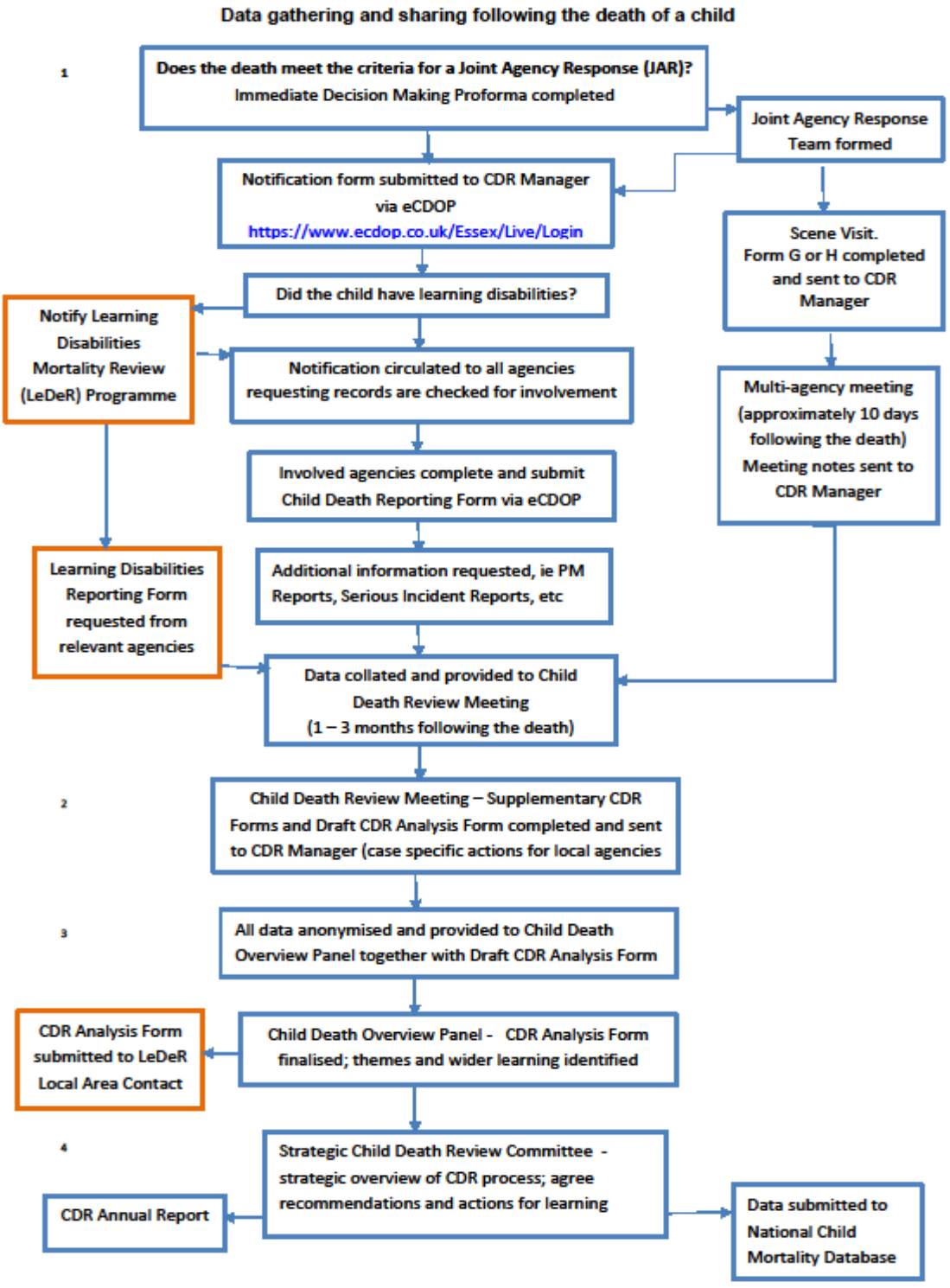
Section 4

Priorities for 2019 - 2020

	Priority	How	By
1	To ensure that SET SCDOP meets its statutory requirements	By reviewing all child deaths of children normally resident in the SET area and, if appropriate, any non-resident child who has died in the area; to identify any matters relating to the death that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified.[1]	Ongoing
2	The revised SET CDR Procedure to be implemented in line with the prescribed timescales	A flowchart of the proposed new Procedure is attached at Appendix 1	1st October 2019

[1] Chapter 5, Working Together to Safeguard Children, July 2018

Appendix 1


Data gathering and sharing following the death of a child
1
Does the death meet the criteria for a Joint Agency Response (JAR)?
Immediate Decision Making Proforma completed
Joint Agency Response Team formed
Notification form submitted to CDR Manager via eCDOP
https://www.ecdop.co.uk/Essex/Live/Login
Scene Visit.
Form G or H completed and sent to CDR Manager
Did the child have learning disabilities?
Notify Learning Disabilities Mortality Review (LeDeR) Programme
Notification circulated to all agencies requesting records are checked for involvement
Multi-agency meeting (approximately 10 days following the death)
Meeting notes sent to CDR Manager
Involved agencies complete and submit Child Death Reporting Form via eCDOP
Learning Disabilities Reporting Form requested from relevant agencies
Additional information requested, ie PM Reports, Serious Incident Reports, etc
Data collated and provided to Child Death Review Meeting
(1 – 3 months following the death)
2
Child Death Review Meeting – Supplementary CDR Forms and Draft CDR Analysis Form completed and sent to CDR Manager (case specific actions for local agencies
3
All data anonymised and provided to Child Death Overview Panel together with Draft CDR Analysis Form
CDR Analysis Form submitted to LeDeR Local Area Contact
Child Death Overview Panel - CDR Analysis Form finalised; themes and wider learning identified
4
Strategic Child Death Review Committee - strategic overview of CDR process; agree recommendations and actions for learning
CDR Annual Report
Data submitted to National Child Mortality Database

Data gathering and sharing following the death of a child

= Orange coloured boxes indicate process to be followed in the event of a death where the child was aged 4 years or over, had (or very likely to have had) learning disabilities, and was living in England

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[1] **Joint Agency Response** – Previously Rapid Response. To be undertaken in the case of a death due to external causes, or sudden with no apparent cause, or in custody, or suspicious circumstances, or stillbirth with no healthcare professional in attendance.

[2] **Child Death Review Meeting** – Multi-professional meeting where all matters relating to an individual child's death are discussed. Attended by professionals who were directly involved in the case of the child during his or her life, and any professionals involved in the investigation into his or her death. (source: CDR Statutory Guidance, October 2018) This meeting will be chaired by the Child Death Review Health Response Team, except where a case has been subject to a JAR when the meeting will be chaired by a Designated Doctor or by Social Care.

[3] **Child Death Overview Panel** – Previously Local Child Death Review Panel. This is a multi-agency panel who will conduct an independent anonymous scrutiny of each child death. These meetings will be held monthly and will be chaired by a Public Health representative

[4] **Strategic Child Death Review Committee** – Previously Strategic Child Death Overview Panel.