Southend, Essex and Thurrock

# Child Death Review Annual Report

1st April 2014 – 31st March 2015

**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

| | |
|---|---|
| CAIT | Police Child Abuse Investigation Team |
| 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 |
| 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 |
| Post-neonatal mortality | Deaths between 28 days and 1 year |
| 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 |
| Unexpected death | Death of a child which was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death. Includes Sudden Unexpected death in Infancy and unexpected deaths in older children |

# CHAPTER 1

## Chair's Introduction

Please find attached this year's Annual Report of the Strategic Child Death Overview Panel. I hope that you find it of value and interest and I would be very keen to hear your thoughts so please email any comments to the Email address on the preceding page.
This year we have focussed on reviewing the Rapid Response process and early signs suggest the new system with an Essex wide response is working very well.
We tried to engage the DH and Public Health England in to support central, perhaps legislative action to require fencing around swimming pools as is the law in some parts of Europe, the United States and Australia but were not successful. We continue with a local campaign.
The dedication, partnership hard work of all professionals in this area is inspirational and I would like to thank all involved. I would particularly want to thank Janet Levett, the Child Death Review Manager whose dedication and hard work has been key in all that we have done.

Dr Mike Gogarty
Chair of Strategic Child Death Overview Panel
Director for Public Health
June 2015

## Purpose of this Report

This report is intended to summarise the work of the Southend Essex and Thurrock Child Death Overview Panel during 2014-2015.

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 5 or less have been replaced with x**

# CHAPTER 2

# Demographics of SET areas

**2.1 Child Population** *(source: PHE Child Health Profiles, March 2014)*

| Essex | Southend | Thurrock | England |
|---|---|---|---|
| Live births 2012 | | | |
| 16,860 | 2,345 | 2,476 | 694,241 |
| Children (age 0 to 4 years), 2012 | | | |
| 83,600 (5.9%) | 11,400 (6.5%) | 12,200 (7.7%) | 3,393,400 (6.3%) |
| Children (age 0 to 19 years), 2012 | | | |
| 329,500 (23.4%) | 41,600 (23.9%) | 47,300 (26.5%) | 12,771,100 (23.9%) |
| Children living in poverty (age under 16 years), 2011 | | | |
| 16.8% | 23.5% | 22.0% | 20.6% |
| School children from minority ethnic groups, 2013 | | | |
| 12.6% | 20.5% | 27.9% | 26.7% |

**2.2 Infant and Neonatal Mortality Rate** [source ONS Mortality Statistics 2013]

The infant mortality rate (rate of deaths of children under 1 year) in 2013 was 3.9 per 1000 live births in England and Wales, which is the lowest rate ever recorded. Within SET the infant mortality rates were 3.5 within Essex, 3.9 within Thurrock and 4.9 within Southend areas per 1000 live births.

The national rate for neonatal deaths (deaths of children aged under 28 days) in 2013 was 2.7 deaths per 1000 live births. Within Essex the rate was 2.4 deaths, the rate in Thurrock was 2.6 deaths and in Southend 4 deaths were registered per 1000 live births

Due to the low numbers of child deaths in the Southend area the higher rates for neonatal and infant deaths are unlikely to be of significance.

| Essex | Southend | Thurrock | England |
|---|---|---|---|
| Infant Mortality (per 1000 live births) | | | |
| 3.5 | 4.9 | 3.9 | 3.9 |
| Neonatal mortality (per 1000 live births) | | | |
| 2.4 | 4.0 | 2.6 | 2.7 |

# CHAPTER 3

## Child Death Notifications

The deaths of children in SET authority areas are reviewed by the LCDRP covering the area in which the child was considered resident irrespective of whether the death occurred in SET or in another local authority area. For further information relating to the structure of the SET Local Child Death Review Panels please see Appendix 1

Not all deaths which occurred in the year ending 31st March 2015 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

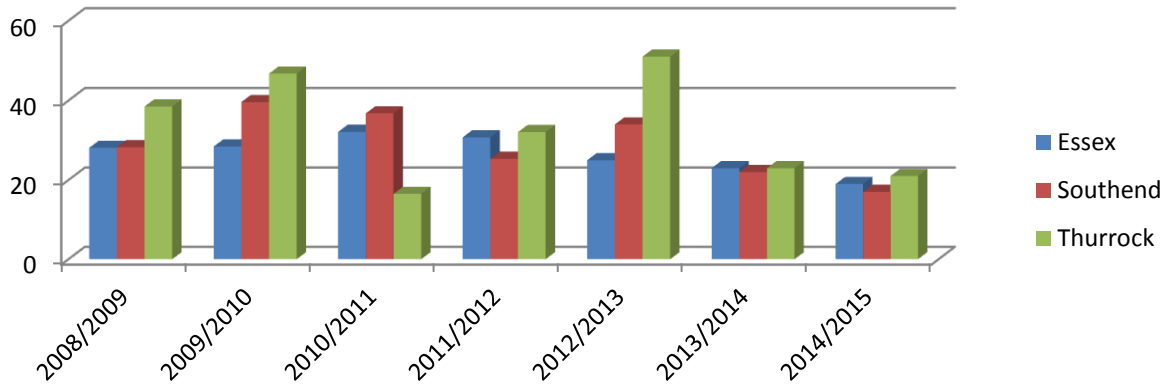
### 3.1 Number of notifications received

77 notifications of deaths of children resident in the SET areas were received during the year 1 April 2014 to 31 March 2015. This is the lowest number since the start of the CDR process in 2008 and continues a decrease in numbers over the past five years.

| Child death notifications received | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|
| Southend | 13 | 9 | 12 | 9 | 7 |
| Essex | 96 | 92 | 75 | 77 | 61 |
| Thurrock | 6 | 12 | 19 | 10 | 9 |
| Out of Area | 5 | 0 | 2 | 2 | 0 |
| **Total** | **120** | **113** | **108** | **98** | **77** |

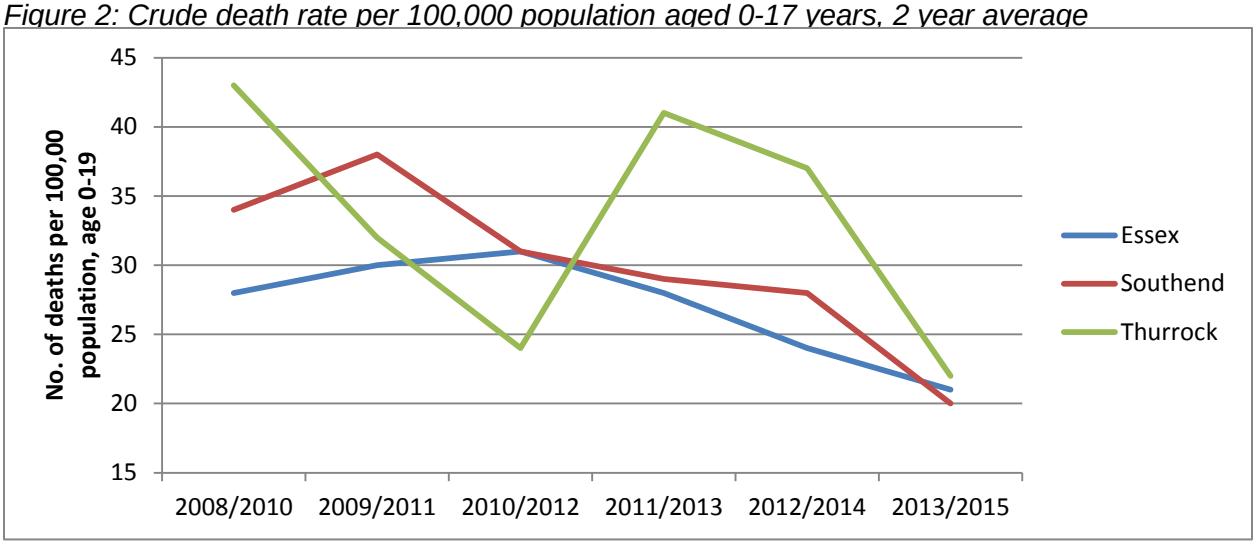
A clearer picture is shown when the figures are adjusted as a crude rate per 100,000 population age 0 – 19 years* as follows:
**population figures from PHE Child Health Profile 2014*

*Figure 1: Number of deaths per 100,000 population aged 0 – 19 years*



As a two year rolling average the downward trend can be clearly seen across the three SET areas

*Figure 2: Crude death rate per 100,000 population aged 0-17 years, 2 year average*




The number of notifications received per quarter is shown in fig 1 which shows an increase in the summer months and over the winter period

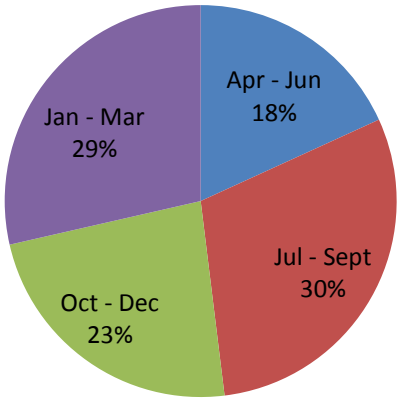



*Figure 3: Child death notifications received 2014-2015 per quarter*

### 3.2 Characteristics of Notifications received

#### 3.2.1 Age and Gender

47% of notifications received during this year were neonatal deaths, ie within the first 0 – 28 days of life and 27% of deaths occurred between 28 days and 364 days of age. 74% of all deaths notified during this year occurred within the first year of life.

The ratio of male to female deaths is slightly higher at 60% male to 40% female

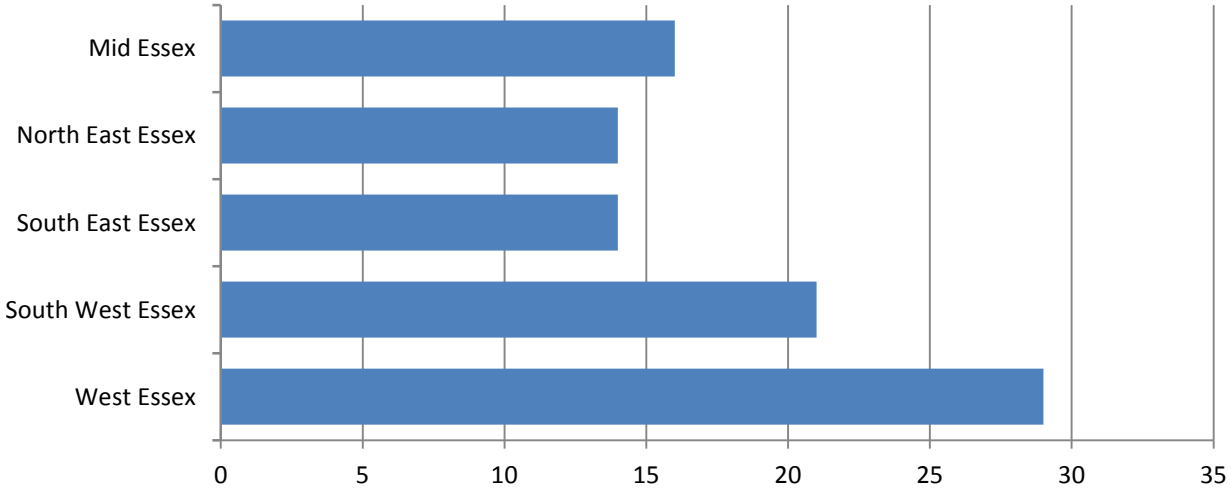
*Summary table of child deaths by gender, age band and SET area, 2014-2015*

| | Southend | Essex | Thurrock | Total | Male | Female |
|---|---|---|---|---|---|---|
| **0 - 27 days** | x | 29 | x | **36** | 22 | 14 |
| **28 days - 364 days** | x | 16 | x | **21** | 10 | 11 |
| **1 - 4 years** | x | x | x | **5** | x | x |
| **5 - 9 years** | x | x | x | **5** | x | x |
| **10 - 14 years** | x | x | x | **4** | x | x |
| **15 - 17 years** | x | x | x | **6** | x | x |
| | 7 | 61 | 9 | **77** | 46 | 31 |

### 3.2.2 Area of residence

By area of residence there has been a larger number of child deaths in the South West and West Essex areas in this year.

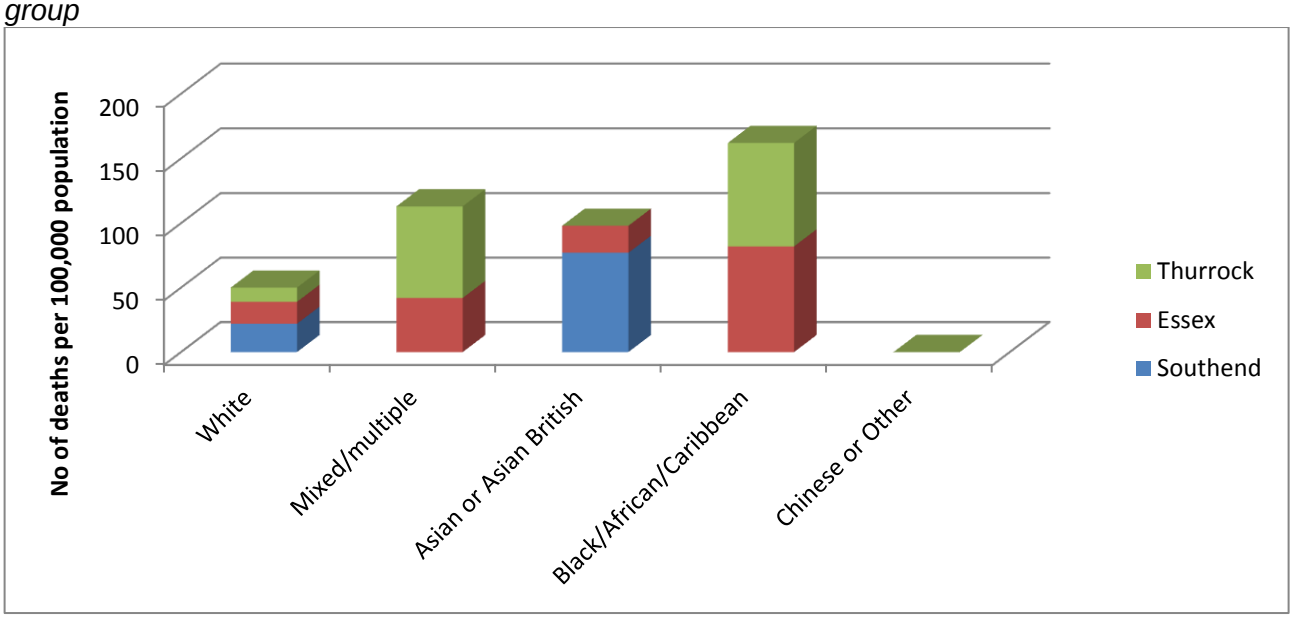
*Figure 4: Number of notifications per LCDR Panel area*



### 3.2.3 Ethnicity

The ethnicity group of child death notifications received this year is as shown adjusted to a rate per 100,000 population by ethnic Group aged 0-15 years:-

*Figure 5: Number of child death notifications per 100,000 population, aged 0-15 years, by ethinic group*




### 3.3 Unexpected deaths and Rapid Response

Of the 77 notifications received during the year April 2014 to March 2015, 30 were classed as unexpected deaths, ie not anticipated as a significant possibility 24 hours before the death or where there was an unexpected collapse leading to or precipitating the events which led to the death. There were x unexpected deaths in the Southend area, x in Thurrock and 23 in Essex.

The Rapid Response process was undertaken in 24 out of the 30 unexpected deaths. In the remaining six cases a decision was taken that the rapid response process was not appropriate either because the death was a neonatal death where the child never left hospital; as a result of a road traffic accident; or as a result of infection and the child having died in a tertiary hospital.

Of the 24 cases where a rapid response was initiated, a home visit was made in 20 cases. In four cases a decision was taken that no home visit would be made. Reasons for this included that the death had occurred out of area, eg in a tertiary hospital or public place; or that there had been a police visit at the time of the incident and no further visit was deemed necessary.

Child Death Review Rapid Response Service

There has been a major change in the way that SET Rapid Response process is undertaken in that the new county wide Health Rapid Response Service became operational on 1st March 2015.

This new service works with the Designated Doctors, paediatricians and health professionals and in partnership with the Police, Social Care and other partners. The service provides support to families, including bereavement counselling; and is a single point of contact for the Rapid Response process across the county.

### 3.4 Co-sleeping

Eight of the notifications of deaths of infants (under 1 year) received during this year have noted co-sleeping as a possible factor in the deaths. The SET Strategic Child Death Overview Panel are continuing with the current Safer Sleeping campaign to try to raise awareness of this issue.

# CHAPTER 4

# Reviews Completed

## 4.1 Local CDR Panels

The five Local Child Death Review Panels met 20 times during the year and completed 98 reviews.

The activity of the panels is detailed as follows:-

| Panel | Meetings held | Reviews completed |
|---|---|---|
| Mid Essex | 5 | 14 |
| North East Essex | 5 | 26 |
| South East Essex | 4 | 21 |
| South West Essex | 2 | 15 |
| West Essex | 4 | 22 |

A change was made to the SET CDR Process during this year in that the Local Panel meetings are now chaired by Public Health representatives to ensure that appropriate independence and challenge can be evidenced. The Designate Paediatricians remain essential members of the Panel.

## 4.2 Modifiable Factors

Working Together 2015 defines modifiable factors as those where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced.

Of the 98 reviews completed in the year 2014-2015 modifiable factors were identified in 33 cases, ie 34%. This is higher than the national figure for reviews completed in the year ending March 2014 of 22%. This could be explained by a difference in the way that CDR Panels across the country classify what is a modifiable factor. For example, SET CDR Panels will always classify maternal smoking as a modifiable factor in the case of a neonatal death whereas SCDOPs in some areas of the country may not.

5 reviews were completed during this period where the panel found that there was inadequate information available to judge whether the deaths were preventable. This category is used very rarely and these five cases were all linked to the same event.

Of 81 reviews completed for Essex resident children, 25 were found to have modifiable factors. Of 9 reviews completed for Southend cases, 5 were found to have modifiable factors. For Thurrock cases, 8 reviews were completed and 3 were found to have modifiable factors.

Modifiable factors were identified in all cases in the trauma and external events categories. Factors identified included:-

- Emotional/behavioural or mental health of a parent/carer
- Child abuse/neglect/allegations of sexual abuse
- Access to healthcare and missed medical appointments
- Gang/knife crime

Modifiable factors found in cases categorised as chronic medical, acute medical, infection, malignancy and sudden unexpected death included the following:-

- Emotional/behavioural or mental health of a parent/carer
- Alcohol/substance misuse by a parent/carer
- Smoking by a parent/carer
- Factors relating to parenting capacity, eg supervision, immunisations not up-to-date, sleeping surface, feeding issues, co-sleeping, overwrapping, delays in access to healthcare
- Child neglect
- Difficulties in diagnosis of medical condition
- Consanguinity

## 4.3 Neonatal Reviews Completed

36 reviews were completed of children who died within the first 28 days. Not all of these deaths were classified as perinatal/neonatal. Other categories were infection; chromosomal, genetic and congenital anomalies and acute medical.

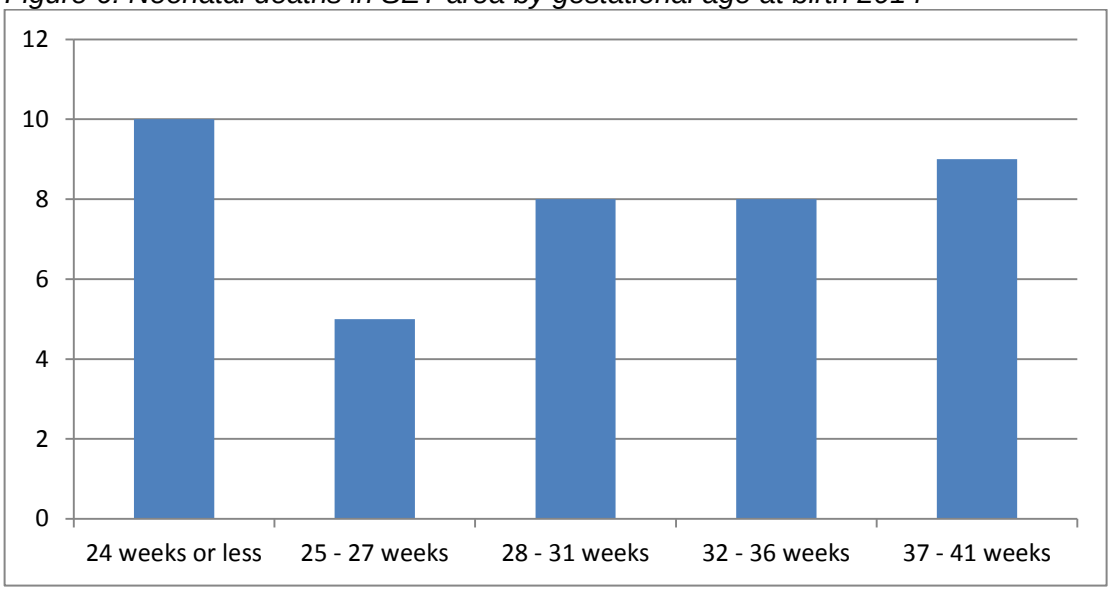
Modifiable factors were identified including:-

- Alcohol/substance misuse by a parent/carer
- Smoking by a parent/carer during pregnancy or in the household
- Co-sleeping
- Service provision, eg inaccurate CTG interpretation; earlier medical intervention;
- Supervision of mothers in post natal ward

### 4.4.1 Gestational Age at Birth

- 77% of neonatal deaths reviewed during the year 2014-2015 occurred in children born before 38 weeks gestation.
- 37% occurred in children born before 28 weeks gestation.
- 60% of children born before 28 weeks died within the early neonatal period (the first week of life)

*Figure 6: Neonatal deaths in SET area by gestational age at birth 2014*




4.4.2 Characteristics of Reviewed Neonatal deaths

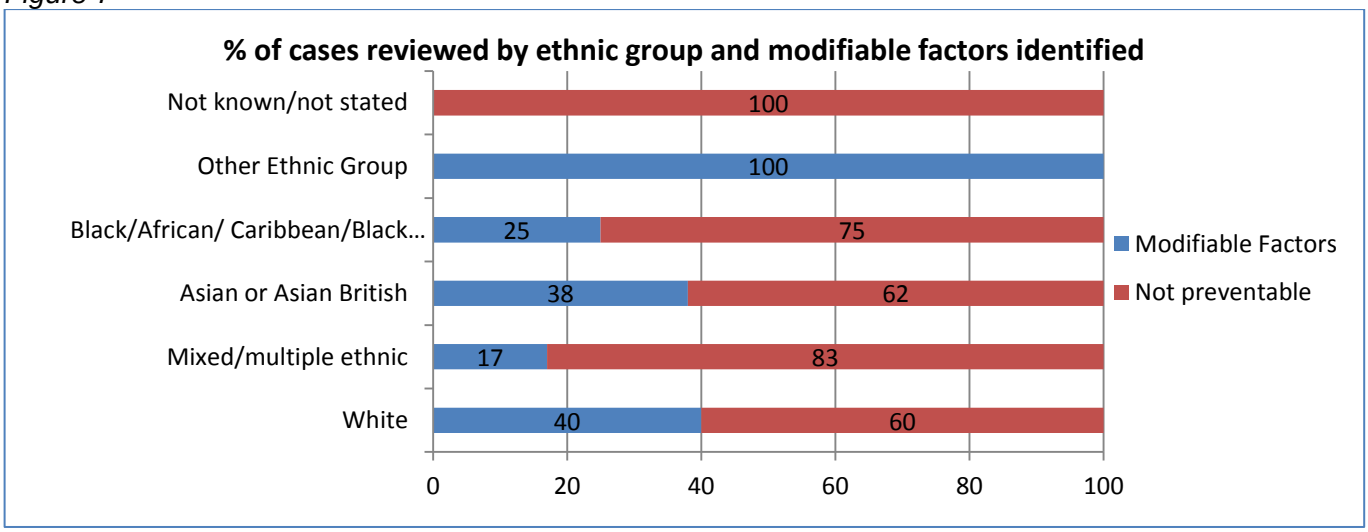
- Maternal smoking was an identified modifiable factor in 17% of neonatal deaths
- 10% of neonatal deaths reviewed in this period were multiple birth babies. Each of these babies had a recorded birth weight of less than 2 kgs.
- 7% of neonatal deaths occurred among women aged under 20.
- Maternal mental health issues were noted in 20% of reviewed neonatal deaths
- Maternal alcohol or substance misuse was noted in 5% of neonatal deaths

## 4.4 Ethnicity of reviewed deaths

71% of cases reviewed this year were for deaths of childen from a white background.

The following chart shows the per centage of cases reviewed by ethnic group where modifiable factors were identified. It should be noted that the numbers in these groups are very small.

*Figure 7*



# CHAPTER 5

## Summary of work of the Strategic Child Death Overview Panel and Local Child Death Review Panels 2014 - 2015

The comprehensive multi-agency reviews undertaken by the Local CDR Panels enable the SCDOP to identify any emerging trends or issues of concern affecting the safety and welfare of children in the SET areas and prioritise awareness raising campaigns where needed.

As a result of these reviews changes in practice in local hospitals and midwifery units have been recommended and implemented.

The following campaigns have been put in place during this year:-

**Safer Sleeping**

Work continues to highlight the risks of co-sleeping and to promote awareness of safer sleeping practices. Over 400 posters and Lullaby Trust information cards were distributed to Children's Centres across the SET areas.

Due to a number of notifications where co-sleeping or sleeping surface were a factor the campaign was increased over the Christmas 2014 period as follows:-

**Press coverage**

East Anglian Daily Times (page 12) 11th December 2014

Maldon and Burnham Standard 13th December 2014

**Radio coverage**

Dream 100 – SCDOP Chair phone interview - 11th December 2014

**Website**

The Safer Sleep page on Parents and Carers section of the ESCB website saw page views increase three-fold, going from 40 hits in November to 128 in December. People were also spending longer on the page from an average of 54 seconds in November to well over 2 minutes in December suggesting people were actually spending the time reading and accessing the information on the page. Additionally, entrances went from 2 in November to 62 in December, meaning that more people were entering the website on the Safer Sleep page (implying people got there via a direct link rather than navigating through from the homepage).

**Social media**

Twitter campaign was successful with 5600 impressions (numbers of times users saw the tweet on Twitter.) Of the 11 Safer Sleep tweets we posted (below) 12 people clicked the link through to our Safer Sleep page, 19 people re-tweeted our tweets and 2 people favourite them. Re-tweets included ECC, Association of LSCB Chairs and Hillingdon LSCB. We also gained 23 new followers during the period of the campaign which is more than we would normally expect in a month and could be due to increased twitter exposure.

## Keep Your Child Safe

SCDOP assisted the Essex County Council Keep your Child Safe campaign which was launched in Child Safety Week (23 – 29 June 2014) by distributing posters across SET Children's Centres on the following subjects:-

- Nappy sacks and the dangers of suffocation
- Button cell batteries
- Liquitabs
- Window blind cords

## Water Safety

Water safety leaflets and posters have been designed and printed in readiness for the launch of a summer water safety campaign to highlight the dangers of residential swimming pools.

## Furniture safety

A leaflet is currently being designed in relation to safety in the home, especially from falling furniture. This will be circulated as widely as possible, including children's centres, libraries, etc.

# CHAPTER 6

## Plan for 2015 - 2016

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

The following priorities have been identified:

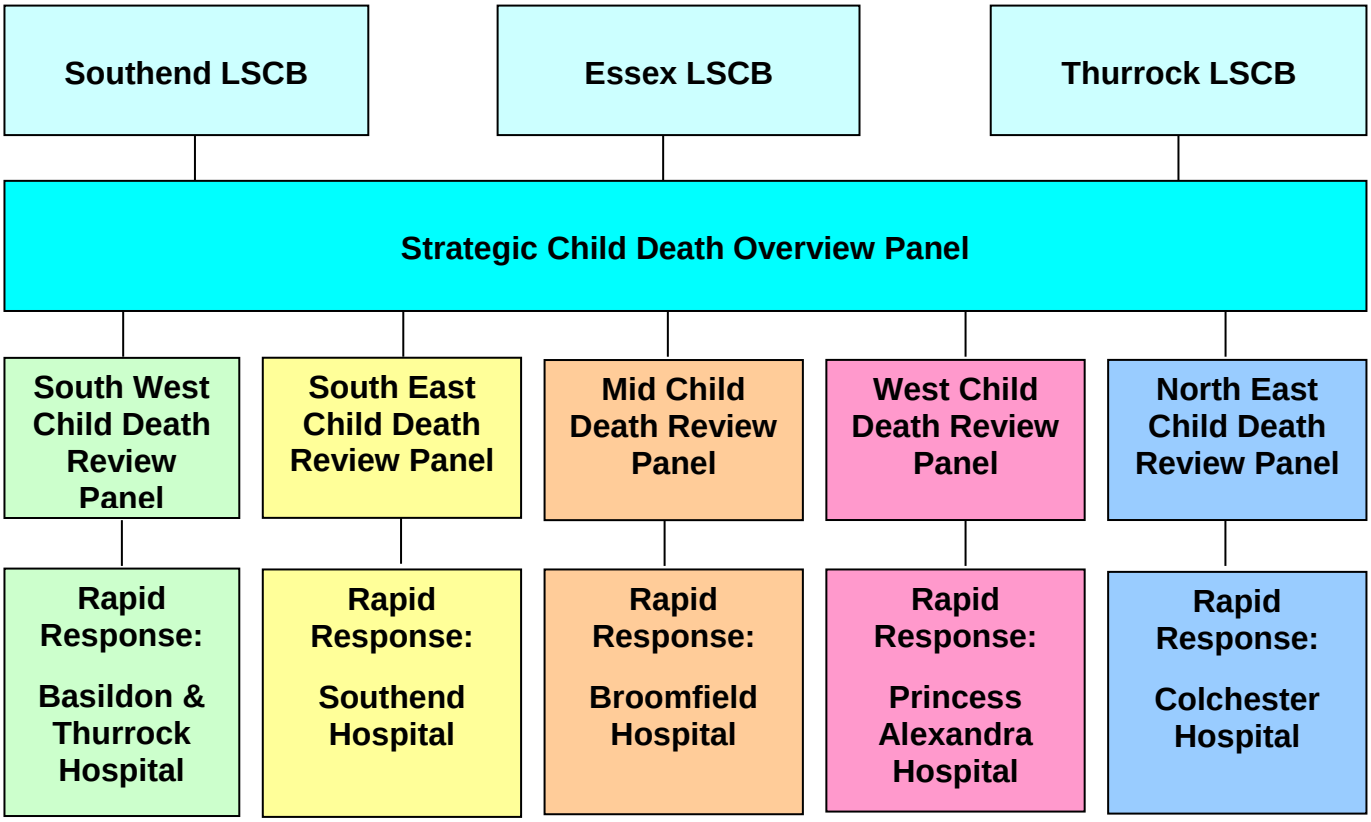
| | Priority | How | By |
|---|---|---|---|
| 1 | To raise awareness of the dangers associated with residential swimming pools and water safety | - Water safety campaign<br>- Posters and leaflets produced and circulated<br>- Media articles<br>- Social media adverts<br>- Web site<br>- CDR Development day themed around water safety | Campaign launched in May 2015 to coincide with school holidays |
| 2 | To ensure continuous development of panel members and professionals involved in the rapid response | - CDR Development Day to be held | June 2015 |
| 3 | To ensure the effectiveness of the child death review and rapid response process in SET | - Terms of Reference for both Local CDR Panels and SCDOP to be reviewed and updated<br>- SET Child Death Review process to be reviewed and updated | February 2016 |
| 4 | To highlight the dangers of falling furniture in the home, eg TVs, chests of drawers, etc. | - Leaflet and poster to be produced<br>- Media and social media to be used to publicise this issue | October 2015 |
| 5 | To reduce the number of infant deaths as a result of co-sleeping, sleep position and sleeping surface | - The ongoing campaign to raise awareness of safe sleep practices will continue | Ongoing |

**Appendix 1**

## Overview of CDOP operation

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.

*Figure 8: SET CDR Structure*




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
- Essex Fire and Rescue
- Coroners Officer - Essex
- 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, for example from the Collision Investigation Unit for discussions regarding road traffic accident cases.

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