Southend, Essex and Thurrock

Child Death Review Annual Report

1st April 2017 – 31st March 2018

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
DoH	Department of Health
Infant mortality	All deaths under 1 year
LCDRPs	Local Child Death Review Panels
LeDeR	Learning Disabilities Mortality Review
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
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 for Public Health

Introduction

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 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 2017-2018 and should also serve as a resource to inform public health measures to promote child health, safety and wellbeing.

The structure of the Southend, Essex and Thurrock (SET) SCDOP is attached at appendix 1.

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 has been prepared in three sections. Section 1 details the notifications of child deaths received during the period 1st April 2017 to 31st March 2018. 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.

Section 1

Notifications of Child Deaths received (1 April 2017 – 31st March 2018)

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

1.1 Number of notifications

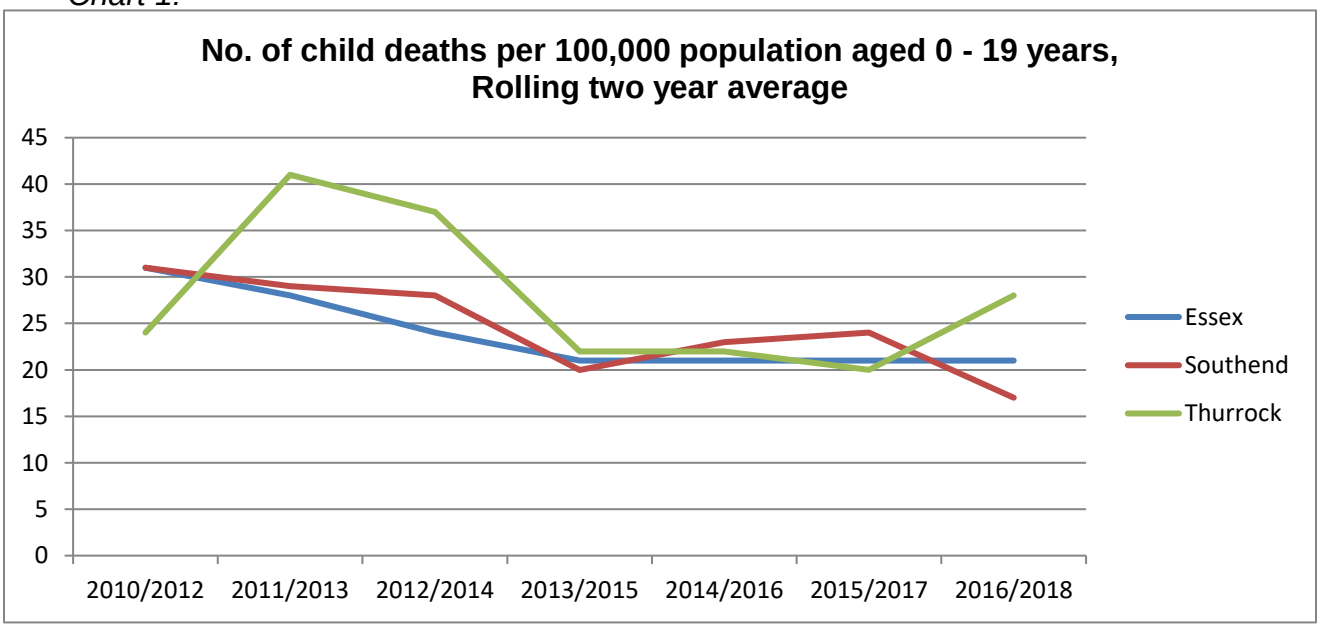
There were 100 notifications of deaths of children and young people resident in the Southend, Essex & Thurrock area this year. This is the highest yearly figure since 2012. The increase was seen in both Essex and Thurrock areas, with a small decrease in Southend.

Table 1:

Notifications Received	2013/14	2014/15	2015/16	2016/17	2017/18
Southend	9	7	12	8	X
Essex	77	61	72	65	77
Thurrock	10	9	10	8	17
Out of area	X	X	X	X	X
Total	**98**	**77**	**94**	**83**	**100**

When viewed as a two year rolling average, the number of deaths of Essex children has remained level since 2014, whilst Thurrock has seen an increase and Southend a small decrease in numbers.

Chart 1:



1.2 SET Mortality Rates and statistical neighbours

Child Mortality = Rate per 100,000 population aged 1 – 17 years
Infant Mortality = Rate of deaths in infants aged under 1 year per 1000 live births

	Infant mortality	Child mortality
Essex	**3.3**	**8.6**
Southend	**3.6**	**11.2**
Thurrock	**3.3**	**10.4**
England	3.9	11.6

Statistical neighbours
(Source: Public Health England, Child Mortality Data 2014-2016)

	Infant Mortality	Child Mortality
Essex	**3.3**	**8.6**
Kent	3.5	7.4
Worcestershire	4.9	9.4
Central Bedfordshire	2.2	12.5
Staffordshire	5.2	12
West Sussex	3.1	8.4
South Gloucestershire	3.5	7.4
Warwickshire	4.7	9.6
Leicestershire	3.9	11.2
North Somerset	3.2	9
East Sussex	3.4	12.7

	Infant Mortality	Child Mortality
Southend	**3.6**	**8.6**
Swindon	3	14.9
Plymouth	2.6	6.8
Medway	3.8	11
Bournemouth	3	*
Kent	3.5	7.4
Sheffield	5.2	14.5
Isle of Wight	3.5	*
Telford and Wrekin	5.3	10.4
East Sussex	3.4	12.7
Poole	1.9	*

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

	Infant Mortality	Child Mortality
Thurrock	**3.3**	**10.4**
Medway	3.8	11
Bexley	2.8	9.6
Havering	1.7	7.6
Dudley	5.5	12.9
Telford and Wrekin	5.3	10.4
Swindon	3	14.9
Sheffield	5.2	14.5
Peterborough	3.7	18.3
Derby	6	13.5

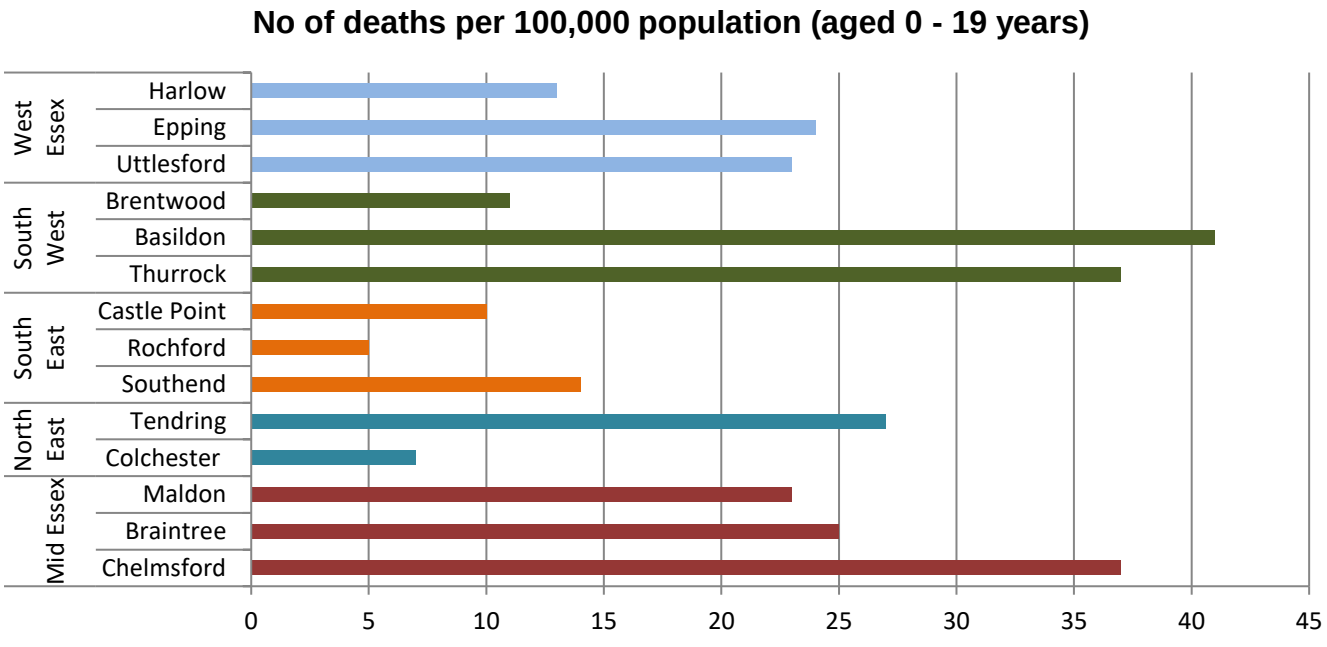
1.3 Age and Gender

	Southend	Essex	Thurrock	Total	Male	Female
0 - 27 days	X	28	7		21	17
28 days - 364 days	X	11	X		X	8
1 - 4 years	X	10	X		7	X
5 - 9 years	X	X	X		X	X
10 - 14 years	X	7	X		X	X
15 - 17 years	X	17	X		8	11
	6	77	17	**100**	50	50

There has been an increase in the number of deaths in each age category compared to last year, apart from the 5 – 9 years old group.

1.4 Area of Residence

Basildon received the highest number of notifications during this year, followed by Thurrock and Chelmsford.



1.5 Unexpected Deaths and Rapid Response

An unexpected death is defined as the 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.

Of the 100 notifications of child deaths received this year, 43 were classed as unexpected.

For each of these 43 unexpected deaths the Rapid Response process was initiated. A home visit was made in 37 cases.

The Health rapid response team offer ongoing bereavement support to families

For details of the SET rapid response process see flowchart attached at Appendix 2.

2 Child Death Reviews

76 Reviews have been completed during this year.

Of the deaths reviewed, 54 out of 76 (71%) had a medical cause.

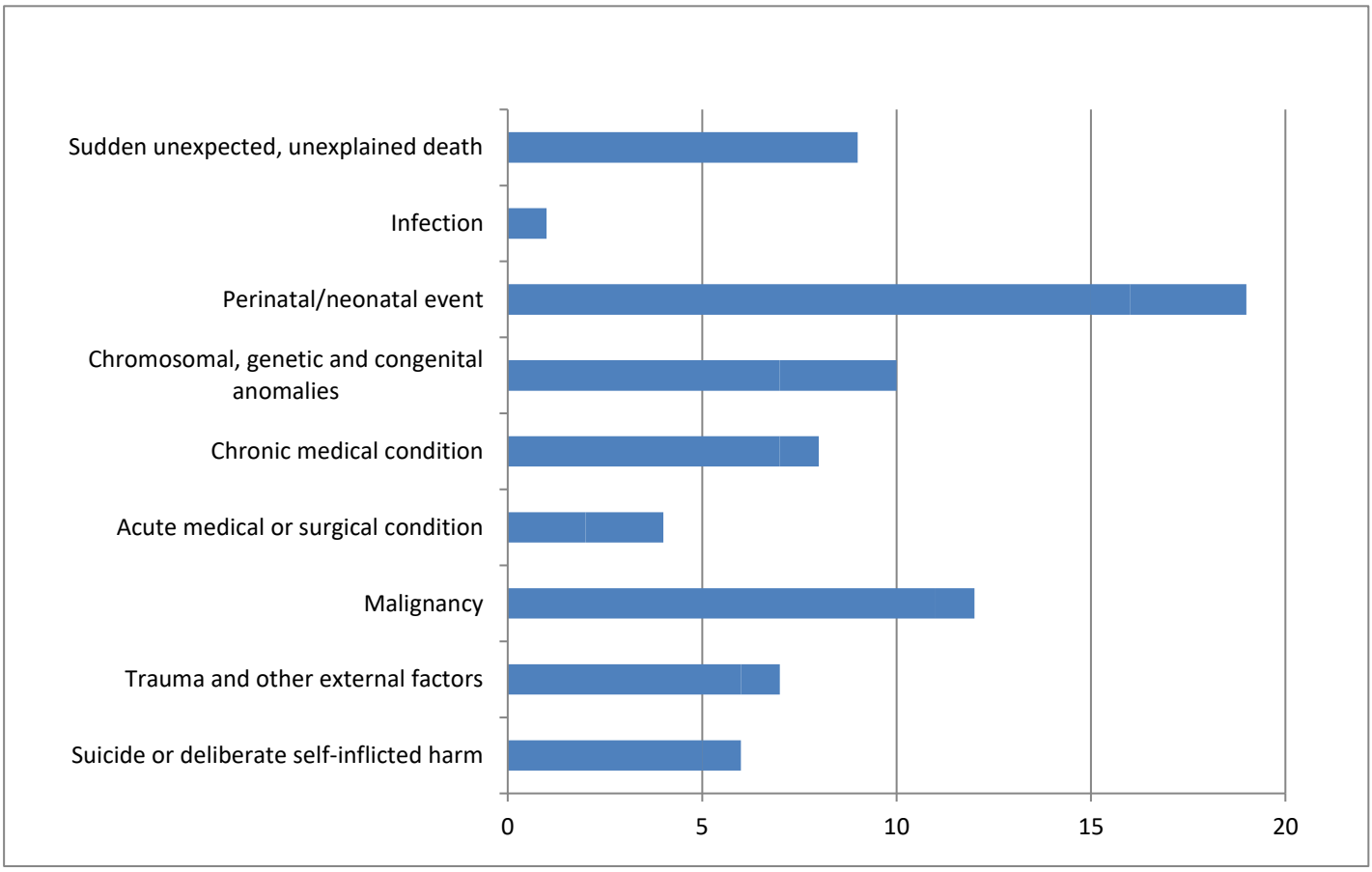
2.1 Category of death

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 Reviews completed this year were categorised as follows:-

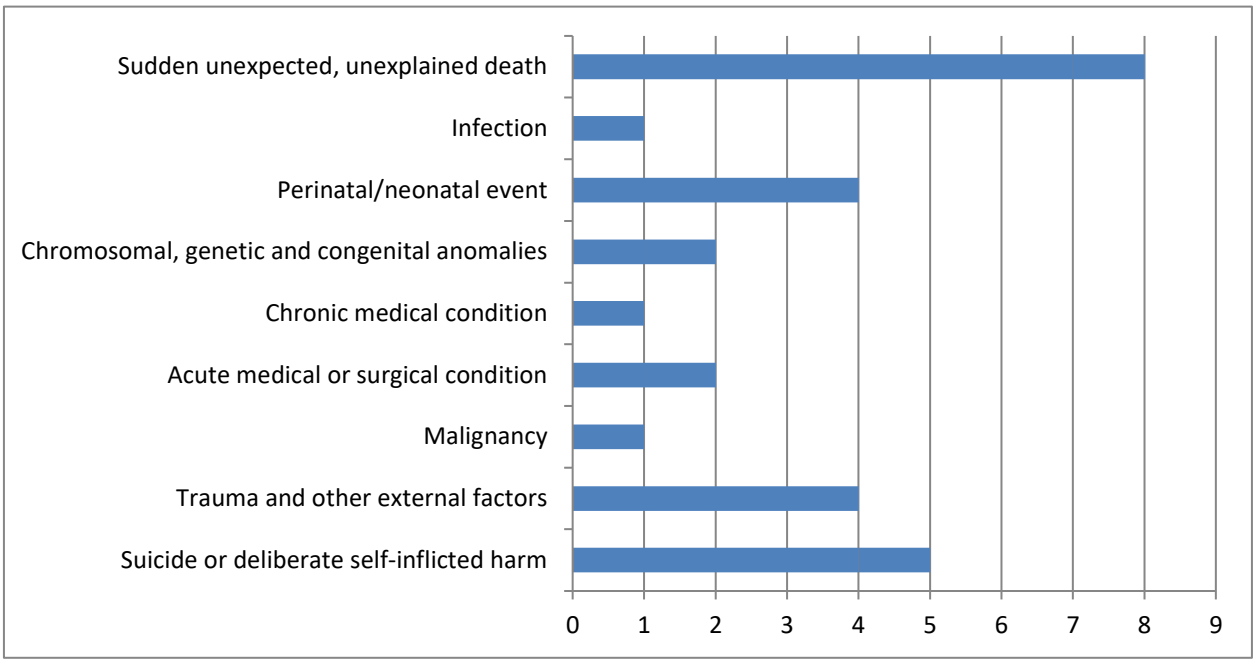


2.2 Modifiable Factors

As well as categorising each death the Local Panels are required to establish whether there were any modifiable factors which may have contributed to the death.

Modifiable factors were identified in 28 of the 76 cases reviewed.

Reviewed cases with identified modifiable factors:-



2.2.1 Modifiable factors – themes by category of death

- **Factors in the child, ie, alcohol/substance misuse; emotional/behavioural or mental health condition of the child**

  7 cases were noted to have modifiable factors in the child. 2 cases noted alcohol/substance misuse by the child; 3 cases noted emotional/ behavioural/ mental health condition in the child and 2 cases were noted to have both of these factors.

  All 5 of the suicide or deliberate self-inflicted harm cases with modifiable factors noted emotional, behavioural or mental health condition in the child.

- **Factors in Parenting capacity**
  9 cases reviewed were found to have modifiable factors related to parenting capacity. These were in the trauma; suicide; acute medical or surgical condition and sudden unexpected, unexplained death categories.

- **Factors in the Family & Environment**

  (i) <u>Alcohol/substance misuse by a parent/carer.</u>
  Alcohol/substance misuse by a parent or carer was identified as a modifiable factor in 7 of the reviewed cases:

- 4 of these were sudden unexpected, unexplained deaths,
- 2 were categorised as trauma and other external factors and
- 1 case was categorised as suicide or deliberate self-inflicted harm.

In each of these 7 cases alcohol /substance misuse was not the only modifiable factor identified. There was at least one other factor identified in each case. The 4 cases in the sudden unexpected category also noted co-sleeping as a modifiable factor.

Both of the cases in the trauma category also noted modifiable factors in alcohol/substance misuse by the child and poor parenting/supervision.

(ii) Smoking during pregnancy or in the household

Smoking was identified as a modifiable factor in 8 cases. 6 of these cases were in the sudden unexpected, unexplained death category; 1 case was a perinatal/neonatal event and 1 case was in the chromosomal, genetic and congenital anomalies category.

(iii) Co-sleeping

Co-sleeping was identified as a modifiable factor in 7 cases, each of which was classed as a sudden unexpected, unexplained death.

(iv) Other family & environment factors

Bullying was a factor in one death by suicide or deliberate self-inflicted harm
Issues around housing were noted in another case of suicide.
Pet or animal assault was a modifiable factor in one case classed as trauma.

- **Factors in service provision**

Modifiable factors relating to service provision were noted in 10 cases. This could relate to gaps in identified services or issues in relation to service provision or uptake.
These 10 cases were in the following categories:- trauma; suicide; acute medical or surgical event; sudden unexpected, unexplained death; perinatal/neonatal event; chromosomal, genetic and congenital anomalies; infection; and malignancy.

2.3 Analysis of completed Child Death Reviews by Local Authority Area

2.3.1 Southend

Modifiable factors identified in the reviews completed for Southend area children included the following:

(i) **Trauma and other external factors**:-

- Alcohol/substance misuse by the child and by a parent/carer;
- poor parenting, supervision; and
- Service provision around education reporting to social care.

(ii) **Chronic medical condition**:-

- Service provision, re access to healthcare and prior medical intervention

(iii) **Infection**:-

- Service provision, re access to healthcare and prior medical intervention

2.3.2 Essex

61 cases were reviewed for Essex resident children.

Modifiable factors were identified in 21 cases:

(i) Suicide or deliberate self-inflicted harm (4 cases)

- Emotional/behavioural/mental health condition in child
- Alcohol/substance misuse by the child
- Poor parenting/supervision
- Family relationships
- Housing
- Bullying
- Access to healthcare
- Prior medical intervention

(ii) Trauma and other external factors (3 cases)

- Alcohol/substance misuse by the child
- Poor parenting/supervision;
- Child abuse/neglect
- Alcohol/substance misuse by parent or carer
- Pet/animal assault
- Service provision

(iii) Malignancy (1case)

- Access to healthcare; prior medical intervention

(iv) Acute medical or surgical condition (1 case)

- Parenting capacity; family &environment; access to healthcare

(v) Chromosomal, genetic and congenital anomalies (1case)

- Access to healthcare; prior medical intervention; prior surgical intervention

(vi) Perinatal/neonatal event (4 cases)
- Smoking during pregnancy or in the household
- Access to healthcare, prior medical intervention; prior surgical intervention

(vii) Sudden unexpected, unexplained death (7 cases)
- Poor parenting, supervision; child abuse/neglect;
- Overwrapping or adult bedding;
- Alcohol/substance misuse by a parent or carer
- Smoking during pregnancy or in household
- Co-sleeping
- Access to healthcare

2.3.3 Thurrock

10 cases were reviewed for Thurrock resident children.

Modifiable factors were identified in 4 cases:

(i) Acute medical or surgical condition
- Poor parenting, supervision
- Access to healthcare; prior medical intervention

(ii) Suicide or deliberate self-harm
- Emotional/behavioural/mental health condition in the child
- Alcohol/substance misuse by the child
- Poor parenting; supervision
- Access to healthcare

(iii) Sudden unexpected, unexplained death
- Poor parenting; supervision
- Child abuse/neglect
- Emotional/behavioural/mental health condition in parent or carer
- Alcohol/substance misuse by parent or carer
- Smoking by parent or carer in house or during pregnancy
- Co-sleeping
- Access to healthcare

(iv) Chromosomal, genetic and congenital anomalies
- Smoking by parent or carer in house or during pregnancy
- Factors in family & environment

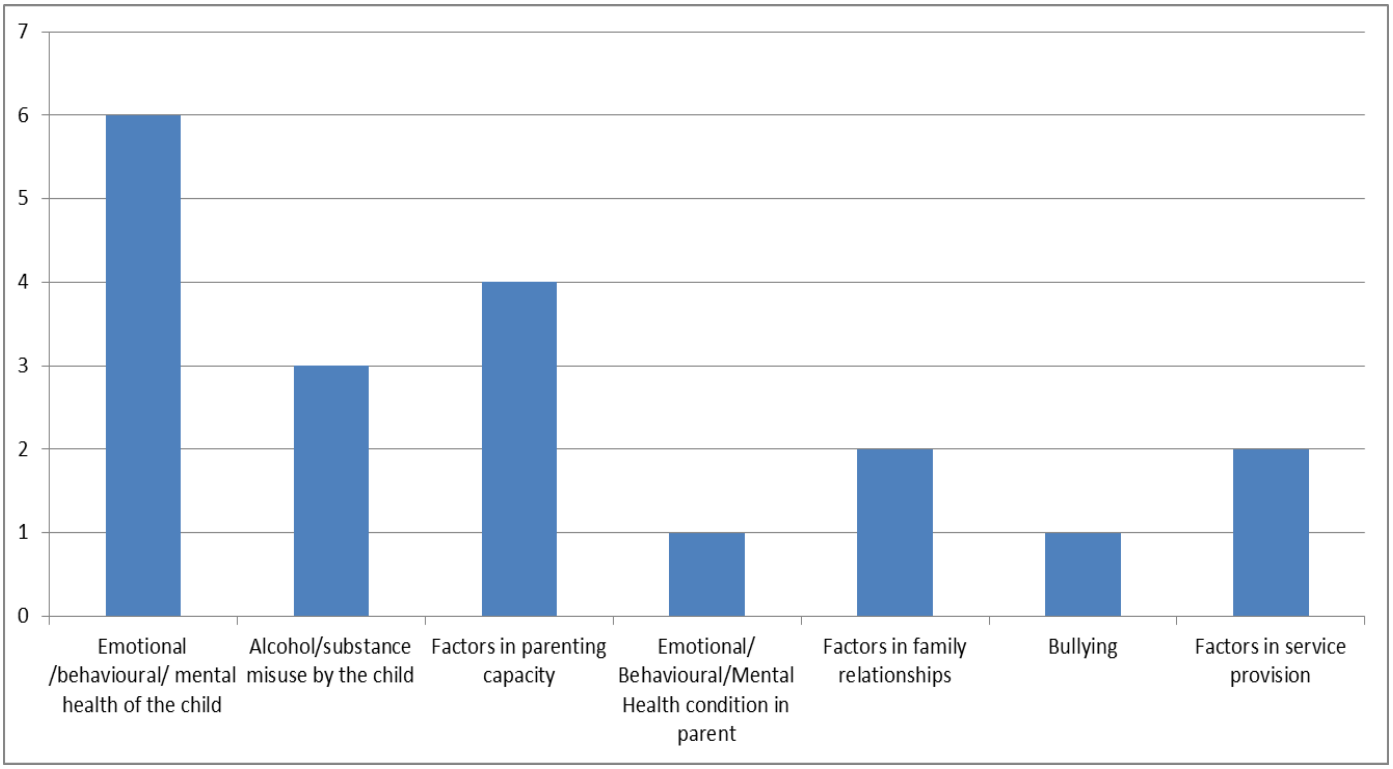
2.4 Categories of child deaths 2017-2018

2.4.1 Suicide or deliberate self-inflicted harm

During the year of this Report, 6 cases were reviewed where the categorisation of the death was found to be suicide or deliberate self-inflicted harm. The age range is from13 to 17 years old. 4 cases were male and 2 female.

It should be noted that during the year April 2017 to March 2018 10 notifications were received of Essex resident children and young people who died by suicide.
.
Only 1 of the completed cases was found to have no modifiable factors.

Each of the 6 cases was noted to have 2 or more factors which may have contributed to the death, as follows:-



2.4.2 Trauma and other external factors

7 cases were categorised as Trauma and other external factors. Modifiable factors were identified in 3 of these cases.

The events that led to these deaths were :-

- Road traffic collision
- Fire/burns
- Pet/animal assault

The deaths due to a road traffic collision were all males, aged between 15 and 17 years.

Alcohol/substance misuse by the child was a factor in the death of 66% road traffic collision deaths.

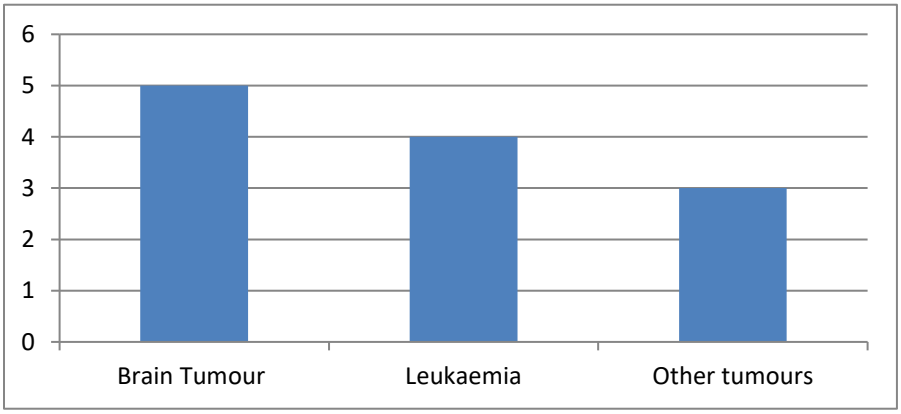
2.4.3 Malignancy

12 cases were classified in the malignancy category.

The age range of these cases was between 3 months and 15 months.

Only 1 case was found to have a modifiable factor, which related to early identification of symptoms by Primary Care.

The type of malignancy was as follows:



2.4.4 Perinatal/Neonatal deaths

19 deaths were recorded as perinatal/neonatal event during this reporting year.

- 13 cases (68%) were babies born at less than 36 weeks gestation
- 15 cases (79%) had a birth weight of less than 2.5kg

- 15 deaths were of babies aged 0 – 28 days. 4 of the deaths were of children aged 29 – 364 days where the death was found to be ultimately related to perinatal events.
- Infant mortality rates (Rate of deaths in infants aged under 1 year per 1000 live births) for SET areas are below the national rate of 3.9.

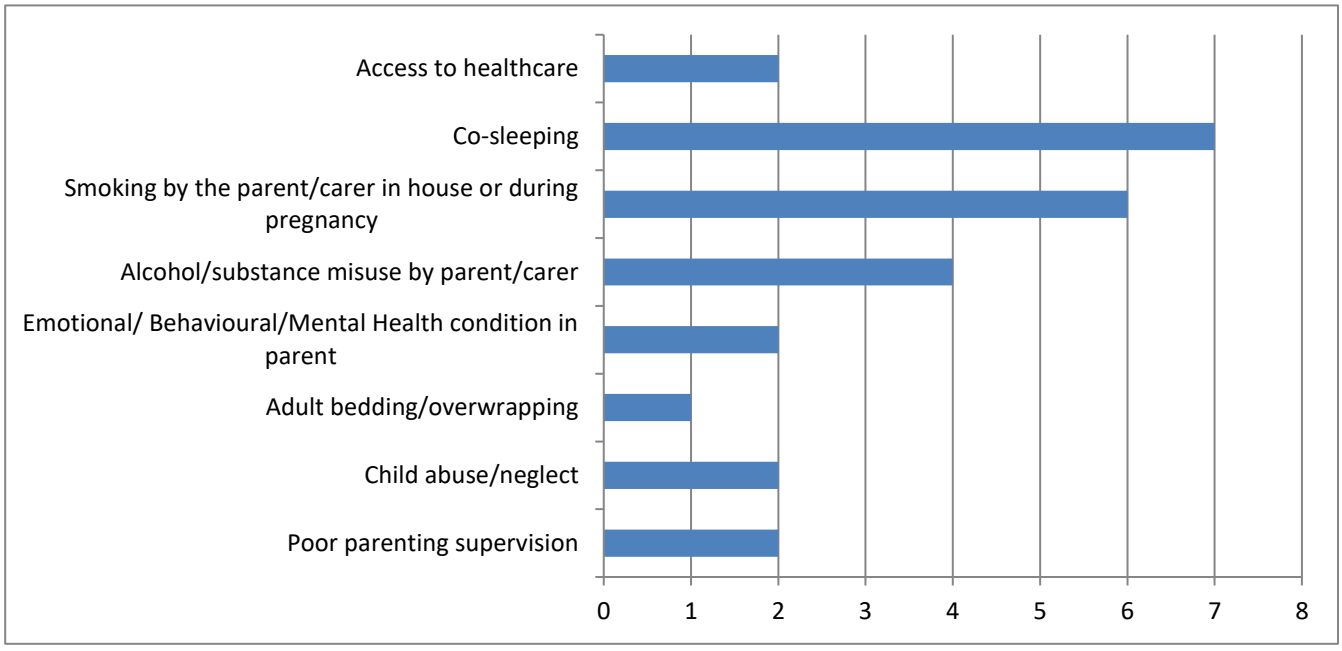
	Infant mortality Rate
Essex	**3.3**
Southend	**3.6**
Thurrock	**3.3**
England	3.9

2.4.5 Sudden unexpected, unexplained death

9 cases were classified as sudden unexpected, unexplained deaths.

The age range was between 6 months and 11 months.

Modifiable factors were identified in 8 of the 9 cases as follows:



The 8 cases reviewed each had between 1 and 7 of the above factors which may have contributed to the death.

It can be seen that co-sleeping and smoking during pregnancy or in the household continue to be significant factors in sudden unexpected deaths.

2.5 Child Protection Plans and Statutory Orders

None of the deaths reviewed this year were for children who were subject to a Child Protection Plan at the time of death.

3 cases had previously been subject to a Child Protection Plan.

3 Summary of work of the Strategic Child Death Overview Panel and Local Child Death Review Panels 2017 - 2018

The SET CDR Procedure was updated following the Royal College of Paediatrics and Child Health multi-agency guidelines for care and investigation of sudden unexpected death in infancy and childhood.

The new Procedure is available on the Essex Safeguarding Children Board web site: http://www.escb.co.uk/engb/workingwithchildren/childdeathreviews.aspx

Learning from Child Death Reviews completed at the Local Panels is monitored by SCDOP and any actions or recommendations are agreed.

During this year the following recommendations have been implemented:-

Objective	Actions	Disseminated to
To provide guidance for local hospital professionals regarding a procedure for rupture of FETO balloons	A Learning Brief was produced to accompany instructions obtained from Kings College Hospital	Acute Trust Paediatricians
To highlight issues and learning points re recognition of sepsis	Learning Brief produced explaining issues and learning points from a completed Child Death Review	Paediatric Consultants and Trainees, Senior Paediatric Nursing Staff
To undertake a Thematic Review of Teenage Suicides in Essex in 2017	Following a rise in the number of teenage suicides this year a Thematic Review was undertaken. The Report is currently being finalised. This Report will inform a multi-agency Learning Event for professionals around prevention of teenage suicides planned for June 2018.	SCDOP members and members of the Essex LSCB Serious Case Review Sub Committee

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The following projects are currently ongoing:

Objective	Actions	Disseminated to
For Paediatricians to consider the possibility of congenital infection in the case of unexplained maternal fever.	A Learning Brief has been produced highlighting issues raised in a completed Child Death Review. To be finalised by June 2018	Once finalised this will be circulated to obstetricians, neonatologists, hospital microbiologists.
Raise awareness of how to recognise a deteriorating child	A draft leaflet is being produced using a traffic light system that GPs could hand to families to assist in recognising a deteriorating child To be finalised by August 2018	General Practitioners

3.1 Learning Disabilities Mortality Review Programme (LeDeR)

The LeDeR programme commenced in SET areas in September 2017 for both expected and unexpected deaths of children with learning difficulties from age 4 – 17 years. This review is additional to the Child Death Review.

The Form A used for notification of child deaths has been amended to include an additional yes/no tick box as to whether the child had a learning disability.

The LeDeR programme requires a home visit and in view of the similar process already in place within SET for unexpected deaths it was agreed that the Health Rapid Response team would take on this additional process. The outcome of the LeDeR review is then fed in to the CDR Panel discussion.

A flow chart of the LeDeR process is attached at Appendix 3.

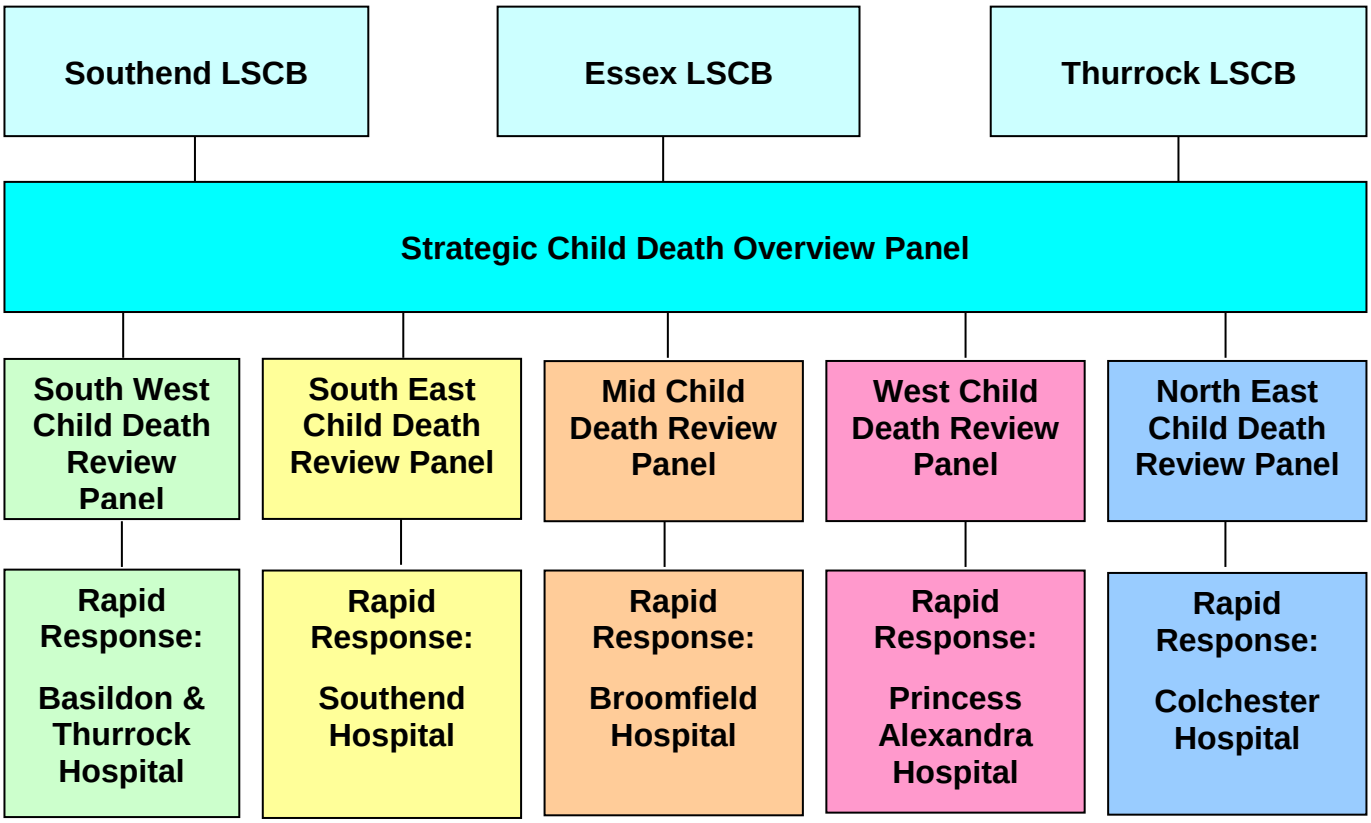
4 Priorities for 2018 - 2019

	Priority	How	By
1	To ensure that SCDOP meets its statutory requirements.	By reviewing all child deaths; determining whether the death was deemed preventable and making recommendations for actions to prevent future deaths where possible	Ongoing
2	To ensure the SET CDR process is compliant with any changes necessary following the Working Together to Safeguard Children: Changes to Statutory Guidance	By maintaining up to date knowledge and understanding of developments locally and nationally relating to the Child Death Review statutory process	Mar 2019
3	To continue current work to prevent teenage suicides	By working with multi-agency partners to promote learning from the Thematic Review of Teenage Suicides in Essex	
4	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:

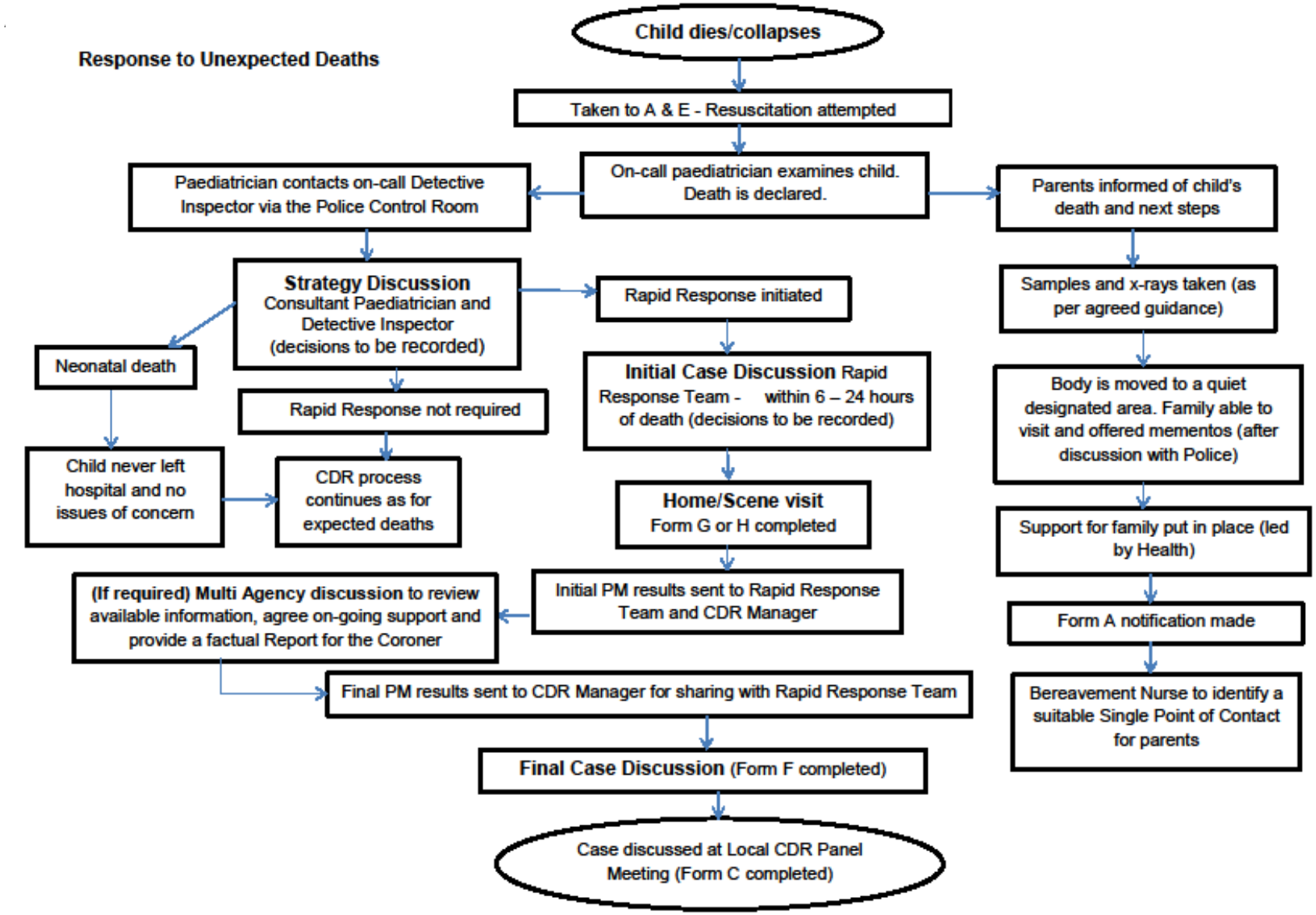
- Director for Public Health, (Chair)
- Detective Chief Inspector CAIU, Essex Police
- Designated Paediatrician for Deaths in Childhood, South Essex
- Designated Paediatrician for Death in Childhood - South Essex
- Designated Paediatrician for Deaths in Childhood – West Essex

- 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.

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)

Appendix 3

LeDeR Flowchart 2017