Redbridge Health and Wellbeing Board

Date of Meeting	15th May 2017	**Classification**	Public Report
Report From	Gladys Xavier- Chair of the Child Death Overview Panel.		
Report Title	Child Death Overview Panel Annual summary Report: 2015/16		
This report is of interest to all Members			

1. Report Summary

1.1 The 2015-16 Redbridge Child Death Overview Panel (CDOP) Annual Report presents the 7 years cumulative findings following the review of deaths among Redbridge resident children (age 0-17 years) between 1st April 2008 and 31st March 2016. The report covers a brief background and overview of the operation of the CDOP and an analysis of child deaths in Redbridge in comparison to statistical and geographic neighbours. Emerging Modifiable factors, themes and trends, lessons to be learned, actions resulting from these reviews are presented. The report concludes with the recommendations to the LSCB for multi-agency service improvements to help children and young people in Redbridge remain safe and prevent child deaths.

2. Brief Background

2.1 Since the 1st April 2008, it has been mandatory for Local Safeguarding Children Boards (LSCB) to review all deaths of children from birth up to their 18th birthday. This applies to all children who are normally resident in the LSCB area even if they die abroad or in another LSCB area. Exemptions are stillborn babies and planned terminations carried out within the law. The LSCB functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004.

The key purpose of reviewing child deaths is to:

- Identify any modifiable factors that contributed to the death;
- Learn lessons in order to improve the health, safety and wellbeing of children;
- Reduce the number of child deaths in the future; and
- Ensure families receive necessary support.

2.2 **Overview of Redbridge CDOP Operation**

Redbridge LSCB established the CDOP in September 2006 to meet functions set out in paragraph 7.4 of Working Together to Safeguard Children (2006).

2.2.1 **Membership of CDOP**

The CDOP is chaired by the Deputy Director of Public Health and Vice Chair Consultant Paediatrician, Designated Doctor for Unexpected child deaths and the CDOP.

The core membership of the CDOP includes senior management representation from Redbridge Children's Services - Redbridge LSCB, Childrens Social Care; Police, Clinical Commissioning Group (CCG), Public Health (London Borough of Redbridge), Barking Havering and Redbridge University Hospitals Trust (BHRUT), and North East London Foundation Trust (NELFT). Multiagency participation is imperative to achieve thorough reviews of child deaths.

2.2.2 **Challenges to reviewing deaths**

Redbridge continues to experience improvements relating to data collection and response from agencies as the CDOP processes have become more understood. The Tri-borough CDOP work undertaken with Barking and Dagenham, Havering and Redbridge CDOPs has resulted in improved working agreements with the local Coroner along with the sharing of Serious Incidents (SIs) reports from local BHRUT hospitals.

There were no significantly late notifications (missed referral) of child deaths to the CDOP in 2015-16.

3. Summary of analysis of deaths between 2008 and 2016

3.1 During this period, Redbridge CDOP was notified of just over 200 child deaths of Redbridge resident children and has fully reviewed 80% of these. 25% of those reviewed had modifiable factors.

- 71% of the deaths reviewed were expected and 29% unexpected. There has been a roughly similar ratio of expected and unexpected deaths each year.
- 41% of deaths reviewed occurred amongst Neonates (age 0-27 days); 33% in childhood (age 1-17years) and 26% amongst Infants (age 28 days -364 days).Since 2010/11, there has been a steady decline in infant deaths with a small (4%) rise in deaths occurring during childhood.
- 55% of reviewed child deaths occurred among males and 45% in females. This is consistent with national trends. The DfE Child death reviews – year ending March 2016, reports that deaths in boys consistently accounted for over half of deaths reviewed and modifiable factors were more likely to be identified in reviews of boys' deaths (26%) than in girls' deaths (21%).

- 50% of child deaths reviewed were amongst children of Asian ethnicities. The highest numbers of deaths (18%) within this category were amongst children of Pakistani ethnicity who also had the highest rates of consanguineous parents (50%) and Modifiable factors (37%). There were no deaths amongst White Irish or the Mixed White and Black African ethnicities and only 1% equally amongst the Arab, Asian, Chinese and any other ethnic group.
- Perinatal or neonatal events (37%) and chromosomal, genetic or congenital anomalies (34%) resulted in the greatest proportion of deaths. These were followed, in consecutive order, by deaths due to Sudden Unexpected Deaths in Infancy (SUDI) (7%) and Acute medical/ surgical condition (7%), Malignancy, Infection and Trauma in combination made up the remaining.
- The majority of Redbridge resident child deaths occurred in hospitals (87%).

3.2 Modifiable factors - Preventability of deaths reviewed between 2008 and 2016

(See full report appendices for definition of modifiable factors).

Between 2008 and 2016, 26% of deaths reviewed were found to have preventable/ modifiable factors. This is a similar proportion to the findings from reviews throughout England, which found modifiable factors in 24% of the cases reviewed (DfE child death reviews 2016).

Modifiable factors identified were associated with service provisions - poor access to hospital health care and untimely interventions, some degree of clinical incompetence leading to missed opportunity with diagnosis of pneumonia. Actions to address local service improvements were addressed soon after the reviews. Other modifiable factors included unintentional parental lapse in child supervision leading to accidental drowning and parental consanguinity.

3.2.1 Deaths due to suicide

Between 2008 and 2016, Redbridge reviewed <5 (values less than 5 are not presented so as to protect against identification of cases) deaths of young people which the Coroner concluded were due to suicide. Although not occurring in the same year, there were similarities in their lives which in retrospect, were antecedent suicide risks, based on recent research by the National confidential inquiry into suicide by people with mental illness (Suicide by children and young people in England, May 2016).

Similarities included gender, ages, no diagnosed history of mental illness. Suicide was not expected by those who knew them. They were achieving well academically and were socially popular amongst friends. In the past 6-10 months, they had experienced the death of a second parent (father), and from a young age had been living in the UK with their relative's family due to death/absence of their mother. They were reportedly well loved and accepted within the relative's family who along with school were unaware of any issues which may have led to their deaths. There were elements of risk taking related to alcohol and covert social media use.

3.2.2 **Parental consanguinity**

Redbridge has a diverse ethnic population and parental consanguinity is reflected in the cases reviewed amongst Roma and Irish Gypsy/travelling families and predominantly amongst Asian groups.

Deaths of children from parents who were known interfamily couples accounted for 19% of cases reviewed between 2008 and 2016. In 2009/10, Redbridge simultaneously recorded the highest numbers of consanguineous parents (8) with the 2nd highest cause of child deaths being Chromosomal, genetic or congenital anomalies. Since then, the numbers of consanguineous parents have decreased with the lowest record in 2014/15 since 2008/09. A corresponding decline in cause of child deaths from Chromosomal, genetic or congenital anomalies is also noted.

The DfE (July 2013) national CDOP findings on the issue of consanguinity states that 'Panels continue to be concerned that inter-family couples do not have sufficient understanding of the increased risks of having a child with a disability or of having a child die under the age of 5.

3.2.3. **Issues arising from reviews**

These pertained mainly to local service improvements so were addressed soon after the reviews.

A summary of actions taken in 2015-16 to meet the recommendations for service improvements along with the recommendations for 2016-17 with future actions planned are set out the Annual Report and will be taken forward by the LSCB.

In summary, there were a number of key priorities which emerged from the reviews and are as follows:

Key priorities:

- Preventing suicide in children and young people (CYP)
- In collaboration with LSCB partners and current government
- Programmes, contribute to learning reviews of disability service provision in the borough to reduce deaths.
- Continue with work already underway to address SUDIs, Childhood accidents and deaths resulting from disabilities associated with consanguineous unions.
- Improve or update CDOP electronic data collection system to achieve greater efficiency in identifying trends to help prevent future child deaths.

4. Fairness Implications

4.1 National evidence shows that childhood mortality is affected by a socio-economic gradient and that there are groups of children who are at greater risk of death. The CDOP Panel seeks to identify preventable trends in deaths among children resident in Redbridge and introduce action to prevent further mortality.

5. Financial implications for the Council - Comments of the Director of Resources, LBR

5.1 This report asks the Board to note the 2015/16 Child Death Overview Panel Report and to support the LSCB action plan.

5.2 At this stage there are no additional financial implications arising from the content of the report.

6. Recommendations for the Board

6.1 It is recommended that the Board note the Child Death Overview Panel Annual Report 2015/16 and support the LSCB in taking forward the action plan.

(The full report is available on request).

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