SOUTH WEST LONDON CHILD DEATH OVERVIEW PANEL

Annual Report

April 2019 – March 2020

A report on organisational arrangements, operations, statistical analysis and commentary

A collaboration of the activities of South West London CCG Partnership Child Death Overview Panels of Croydon, Kingston and Richmond upon Thames, Merton, Sutton, and Wandsworth

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I also wish to thank the Local Child Death Overview Panels who have merged to form the regional panel in South West London, comprising the Designated Doctors, Designated Safeguarding Nurses, Children Social Care, Acute and Community Providers, Primary care (GP Practices) , Metropolitan Police Service, London Ambulance Service, Mental Health (CAMHS) Hospices, Bereavement Support Specialist Nurses, Directors of Public Health, Quality Directorate and all services who have participated in meetings and contributed to the information presented in this report. As a multi-agency body all worked diligently to implement the new operating procedures for child death reviews.

Finally, thank you to the Director of Nursing Leadership & Quality, Regional Lead for Safeguarding (London) from NHS England for her assistance and support in the implementation of the statutory and operational framework processes for child death reviews.

CHAPTER ONE: INTRODUCTION

1. Executive Summary

The Child Death Review process is a systematic analysis of deaths of children who die in England from birth to 18 years of age. Child Death Overview Panels are a statutory body and are accountable to their respective Local Authorities and Clinical Commissioning Groups. Every child death is a devastating loss that profoundly affects the family involved.

CDOP operates under the principle that an appropriate balance should be kept between medical, forensic, and social requirements and the family need for support. This is grounded in respect of the rights of the child and their family, with the objective of preventing child deaths. Learning lessons from CDOP activity is a priority to have a positive impact on the safety, health and wellbeing of children and young people, and to ensure the learning is shared widely across the area, as well as regionally and nationally. In addition to providing support to families and carers, staff involved in the care of the child should also be considered and offered appropriate help.

The South West London Child Death Overview Panel (SWL CDOP) is an inter-agency forum for Child Death Reviews comprising the boroughs of Croydon, Merton, Kingston Upon Thames, Richmond upon Thames, Sutton, and Wandsworth.

This report explores the statistical and qualitative conclusions from the Child Death Overview Panel Reviews in South West London during the reporting year April 2019 to March 2020.

1.1 Purpose

The South West London Child Death Overview panel has a duty to retrospectively review the findings of the child death review meetings of all children normally resident in South West London, and if appropriate and agreed with Child Death Review Partners, deaths of non-resident children who die in South West London, in order to learn lessons and share findings for the prevention of child deaths.

The Child Death Overview Panel Review is intended to be the final scrutiny over a child's death. The purpose of a child death review is to identify any matters of concern affecting

the safety and welfare of children relating to the death or deaths and to consider any actions or recommendations that can be taken based on a death, or a pattern of deaths.

1.2 Statutory Framework and Governance

Chapter 5 of the new working arrangements for Child Death Overview Panels statutory and operational guidance (2018), sets out the key features of a good Child Death Review (CDR) process to be followed by all organisations involved with the process of child death reviews as of 1st April 2019. A consultation concluded that for CDOP's to be effective, reviews need to cover a sufficiently wide geographical area to produce meaningful data on the cause and demographics on child deaths. South West London CDR partners implemented this guidance and started regional operations in September 2019. The Terms of Reference, and requirements of governance processes are complete. Clinical Commissioning Groups, Local Authorities, and regulatory bodies are required to review and follow the procedures set out in the guidance.

The geographical 'footprint' of child death review partners has been locally agreed and cover a child population that typically reviews a minimum of at least 60 - 120 deaths per year. The amalgamation of panels is to provide a larger cohort of information to enable better detection of themes, analysis of trends, and learning to prevent future child deaths.

The Department of Health & Social Care have taken over statistical analysis of Child Death Review data from the Department for Education as of April 2019. Greater regionalisation of child death reviews was encouraged, and further work undertaken to develop a national database. The Department of Health will disseminate relevant learning to child protection agencies and multi-agency partners.

CHAPTER 2

OPERATIONAL OVERVIEW

2.1 Membership of South West London Child Death Overview Panel

The panel has a multi-agency membership of Child Death Overview Panel Partners from the consolidated Child Death Overview Panels of Merton, Wandsworth, Sutton, Kingston, Richmond, and Croydon. The panel developed clear plans outlining the administration and logistical processes for child death reviews. All six south west London boroughs are represented on the Panel.

The core membership and representation of the South West London Child Death Overview Panel as of 1st September 2019 – March 31st, 2020 are as follows: -

- Independent Consultants in Public Health – Chairs (Croydon / Sutton)
- Consultant Paediatricians, Designated Doctors for Child Deaths (Croydon, Merton & Sutton, Wandsworth, Kingston & Richmond)
- Children's Social Care representatives (all South West London boroughs)
- Metropolitan Police / Child Abuse Investigation Team (CAIT) covering South West London
- Designated Nurses for Safeguarding Children (all South West London Boroughs)
- Single point of Contact CDOP Panel Coordinators and SWL Senior Manager across South West London

As required on a case by case basis, other participants are invited to contribute to panel meetings. This may include agencies with relevant involvement or knowledge. Tertiary and acute services, London Ambulance Service, Midwifery, Community Nursing, Mental Health, South West London Commissioning Partnership, forensic specialist on a case by case / thematic basis, Directors of Quality, Education and National Clinical Agencies may be asked to contribute in an advisory capacity.

The arrangements for the conduct of the meetings has been agreed as follows: -

- Chairing will take place on a rotational basis, drawn from the two local CDOP Chairs across South West London for a period of one year
- Where necessary, a Deputy Chair will be arranged by the local area, who are currently hosting
- The panel meets monthly
- Provision will be made for ad hoc or extraordinary meetings as required based on caseload and complexity of cases

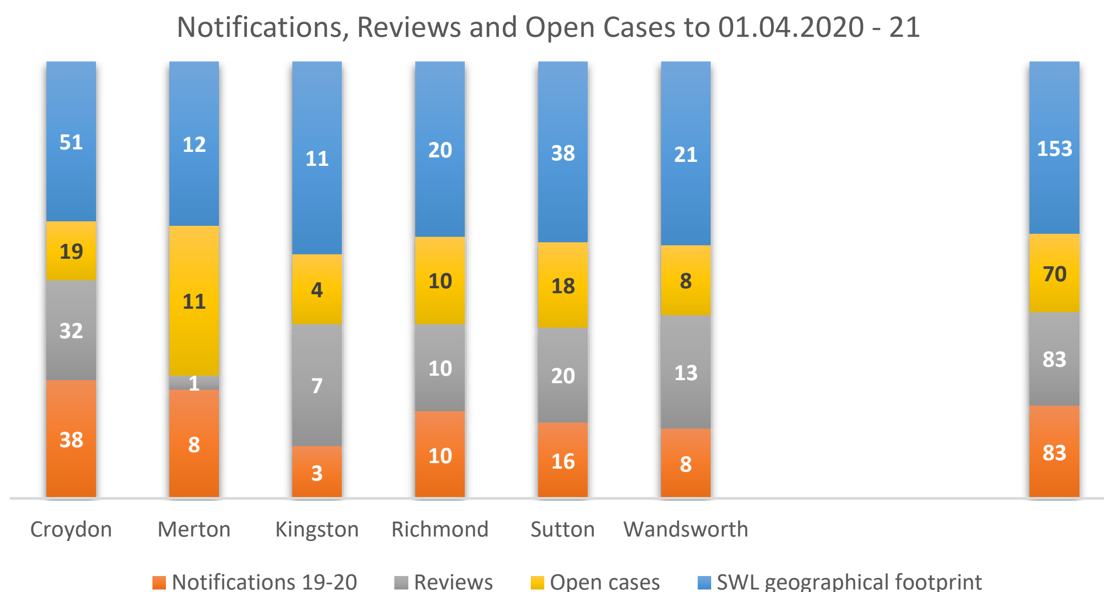
The arrangements for management of CDOP operation follows national guidance and has met all the requirements of quoracy, membership, and attendance. Case discussions are led by the Chair, who invite members to contribute where relevant resulting in agreement of learning, or recommendations to be taken forward for implementation by local, regional, and national agencies. Those agencies are required to provide assurance that organisational improvements have been applied. The final completion of the analysis form with recommendations from the Panel are recorded and the case is closed.

The organisation of the CDOP is shared by the Single Points of Contact (SPOCs) for each area at the Child Death Review meeting level, supported by a Manager for the South West London Child Death Overview Panel.

2.2. Summary of South West London Child Death Overview Panel Caseload

This information was submitted as part of the returns for South West London CDOP Panel to the National Child Mortality Database for 2019-20. During this reporting period, there were 83 notifications of death, and 83 child death reviews. As of 1st April 2020, there are 70 open cases remaining making a total of 153 cases recorded on the South West London Child Death Overview Panel database.

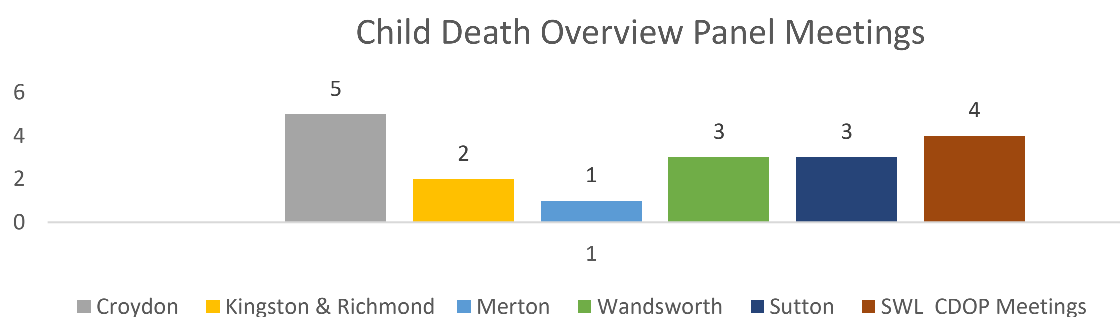
Graph 1.



2.3. Child Death Overview Panel Reviews

To date, 14 local child death overview panel meetings completed 73 of the 83 case reviews to December 1st, 2019. The balance of 10 cases were completed by the South West London Child Death Overview Panel.

Graph 2.



2.4 Aims of the South West London Child Death Overview Panel

The focus of the South West London Child Death Overview Panel is an objective independent review of the findings of the Child Death Review meeting to learn lessons, to share any findings and recommendations to prevent future child deaths which includes: -

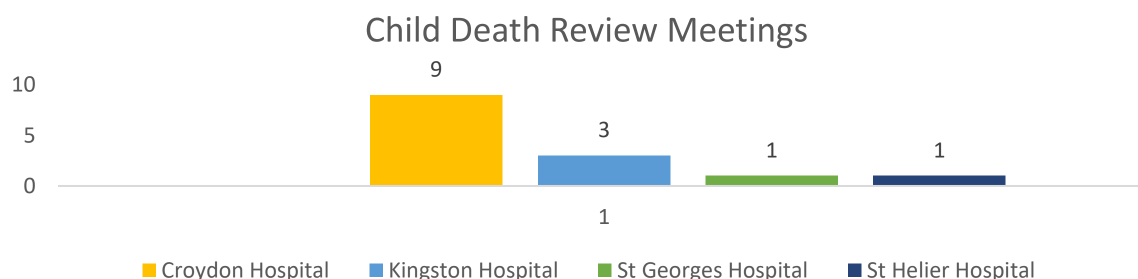
1. Analysis of the information obtained, including the reports from the Child Death Review Meeting, to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths.
2. Make recommendations to all relevant organisations where actions have been identified which may promote the health, safety, and wellbeing of children.
3. Notify the Medical Examiner and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction of a death certificate.
4. Provide specified data to the National Child Mortality Database and to produce an annual report for Child Death Review partners.
5. Provide data and analysis for the South West London Child Death Overview Panel to allow patterns, themes, and trends to be analysed on a wider footprint to enable learning.
6. Contribute to local, regional, and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the statutory requirements of data protection.

2.5 Child Death Review Meetings

The South West London Child Death Overview Panel (SWL CDOP) is informed by the referral of a standardised report analysis form from the Child Death Review Meeting (CDRM). The Panel (SWL CDOP) conducts an independent multi-agency scrutiny of the report from the Child Death Review Meeting partners by senior professionals with no named responsibility for the care of the child during their life with representation from all six boroughs.

To date fourteen Child Death Review Meetings have been completed under the new working arrangements.

Graph 3



An initial Child Death Review Meeting (CDRM) is held as an independent multi-professional meeting at an Acute Hospital in the local area, or any Acute Hospital that has the most information on a child who is resident in South West London at the time of death. Locally, Acute Hospitals are in the process of implementing appropriate arrangements for reporting and referral of reviewed cases to the Chid Death Overview Panel for South West London as follows: -

(1) Merton & Wandsworth: St Georges Hospital

(2) Sutton: St Helier Hospital

(3) Croydon: Croydon University Hospital

(4) Kingston & Richmond: Kingston Hospital

The meetings are attended by professionals who were directly involved in the care of the child during their life, and any professional involved in the review of their death.

At this meeting, all matters relating to the individual child death are discussed. The composition of professionals at the Child Death Review Meeting varies according to the circumstances of the child death and is not limited to medical staff. The focus of this meeting is:

- To review background history, treatment, and outcomes of investigations to determine as far as possible the likely cause of death
- To ascertain any contributory or modifiable factors from the death
- To describe any learning from the death, and, where appropriate to identify any actions that should be taken arising from the death
- To review the support provided to the family and to ensure families are provided with a plain explanation of why their child died
- To ensure that the Child Death Overview Panel and, where appropriate the Coroner is informed of the outcomes of any investigation into the child's death,
- To review the support provided to staff involved in the care of the child
- To refer the completed cases to the regional South West London Overview Panel for final scrutiny of learning, actions taken for further recommendations at a regional or national level

2.6. South West London eCDOP Database

For meaningful data collection, consolidation and dissemination, the Panel amalgamated local case management systems. The eCDOP Database management contract negotiated by NHS England for the service with Quality Education Systems Ltd was renewed by South West London Clinical Commissioning Partnership for the financial year April 2020 to March 2021. The South West London eCDOP database went live in November 2019.

The eCDOP system provides an online procedural structure for notifications, reporting and meeting protocol for the boroughs that form the South West London Clinical Commissioning Partnership, and supports coordination of interaction between the two

parts of a child death review as required under the new working arrangements for Child Death Overview Panels.

Consolidation of the eCDOP database has facilitated better joint working between panels, better shared cover of resources for notification of child deaths, improved monitoring, and information sharing. The eCDOP system is being used across England and feeds into the National Child Mortality database. In the future, this will also generate improved information to support local policies and national agencies.

2.7 Timing of Reviews

During the 2019-20 reporting year, Inquests and Serious Incident (SI) Investigations delayed conclusion of reviews due to the time required to conduct these independent processes. In addition, the transition between child death reviews under the former local borough systems and the consolidation of the panels to a regional panel caused some delay in concluding reviews, with all boroughs working to review as many cases as possible before the 1st November 2019. It is important to note that a few of the 83 deaths reviewed during 2019-20 occurred in previous years. It is also noted that a number of CDR Meetings were for children who died in out of area Hospitals, who had not yet started conducting reviews under the new working arrangements for child death reviews . The following figures and commentary include reviews of deaths in this reporting year.

Across South West London, the average time taken was 270 days.

2.8 Out of Area Notifications

Hospitals in South West London notified Boroughs of 47 child deaths across London and 20 other area CDOP's of child deaths in this area. A total of 27 notifications were received from other boroughs across London for South West London Child Deaths. One notification was received from abroad for South West London for this reporting year.

CHAPTER 3

COMMENTARY ON REVIEWED CASES

3.1 Expected deaths.

The former statutory guidance on child death reviews required the notifying professionals to classify if deaths were expected or unexpected (with unexpected deaths defined as those 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 that led to the death). The updated guidance for child death reviews now require professionals to indicate if deaths require a Joint Agency Response (JAR).[1] As this report contains reviews completed under both versions of statutory guidance, we have retained these headings. For clarity, the deaths referred to as expected here, are those that a rapid response meeting or JAR was not indicated.

Chronic illness, disability, and life limiting conditions account for a large proportion of child deaths, which may be expected. However, while children with life limiting or life-threatening conditions may die prematurely young, it is not always easy to predict when, or in what manner they will die and therefore be unexpected. The death of a child with a long-term life limiting condition is managed as any other unexpected death, to determine the cause of death and any contributory factors. Seventy-four per cent of child deaths were expected in South West London during the 2019-20 reporting year.

3.2 SUDI's (Sudden Unexpected Death in infancy/childhood)

SUDI/C is a term used to describe the sudden unexpected death of a baby child or young person where no immediate cause of death has been identified by post-mortem. There were seven per cent (7%) of deaths classified as SUDI/C in South West London. More information is provided in chapter 4 analysis of the report.

[1] (Please see criteria for information on page 14 of this report).

3.3. Neonatal child deaths

Neonatal / Perinatal child deaths are the largest category. Thirty per cent of neonatal deaths were reviewed in this period. Average gestation is 30 weeks, with the lowest recorded at 19 weeks gestation. Sixty percent were live birth/child deaths between 25 to 38 weeks' gestation. Forty per cent of live birth/child deaths were between 19 to 24 weeks gestation. Sixteen per cent of these deaths were multiple births, which carry a 50% higher risk of preterm birth, and result in increased demand for specialist neonatal resources. This is higher than the national average of three percent per 1,000 births [2]. The average maternal age is 34 years, which is higher than national statistics of 28.6 years.[3] More information on this category is in chapter 4 of this report.

3.4 Unexpected Child Deaths

An 'unexpected' child death: is defined as the death of an infant or child which was not anticipated as a significant possibility, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which led to the death. Unexpected child deaths amounted to 26% of all deaths in South West London during the 2019-20 reporting year.

3.5 Rapid Response / Joint Agency Response Meetings

Under the new CDOP working arrangements the Rapid Response process has been replaced by the the Joint Agency Response (JAR) Meeting. Under this process one or more multi-agency meeting can be convened before the Hospital's Child Death Review Meeting. This is a coordinated multi-agency response that should be triggered if a child's death: -

- Is or could be due to external causes
- Is sudden, and there is no immediately apparent cause (including SUDIC)

[2] https://www.nice.org.uk/guidance/qs46/chapter/introduction
[3] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsbyparentscharacteristicsinenglandandwales/2015

- Where the initial circumstances raise any suspicions that the death may not have been natural, or
- In the case of a stillbirth where no healthcare professional was in attendance

Across South West London during the 2019 - 20 reporting year, thirty-one (31) Rapid Response / Joint Agency Response meetings were held.

The following graph shows the number of meetings for each borough.

Graph 4

3.6. Post-mortem Reports

Post-mortems provide more information on cause of death. All parents are offered the service which many parents choose to decline. Post-mortems are conducted at the request of parents, or the Coroner. Across South West London 30% of child deaths had Post-mortem reports completed, of which 87% of those reports provided sufficient information to confirm the cause of death without further investigations.

3.7. Coroners Inquests

Coroners are independent judicial officers, responsible for investigation of violent, unnatural, or sudden deaths of an unknown cause. Thirteen percent (13%) of deaths were subject to Inquests to confirm the cause of death. One case had a Coroners Act Regulation 28 Prevention of Future Death notice issued with recommendations to reduce future child deaths.

3.8 Modifiable Factors

"Modifiable Factors" is selected when: "The CDR meeting identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths".

"No Modifiable Factors" is selected when: "The CDR meeting have not identified any potentially modifiable factors in relation to this death".

In South West London, eighteen per cent (18%) of reviewed cases had modifiable concerns. This compares favourably to the National Child Mortality Database statistics for England with an average of 30% of modifiable concerns noted in child death reviews. An additional two cases were recorded as having inadequate details to reach an agreement if there were modifiable actions that could have reduced the likelihood of child death and CDR Meeting level.

While modifiable issues are noted under agencies in Chapter 5 learning outcomes and recommendations, others noted for consideration included the following issues:

- Learning from Vulnerable adolescents' review – highlighting missed opportunities for earlier interventions. Risks of gang violence, misadventure, self-harm
- Reiteration of dangers of co-sleeping, substance abuse
- Smoke alarms and the importance of regular maintenance of devices
- Pictogram / visual information on how to help a choking child in a community where several languages are spoken
- Indicators of induced fabricated illness
- The complexity of allergens and Asthma management in young people

3.9. Serious Case / Learning Reviews

Two child deaths were the subject of serious case reviews. Both were in the category 1 (deliberately inflicted child death). Safeguarding issues, domestic violence, and all categories of child abuse were raised in the reviews. One case was referred for a Learning Review based on the background of three child deaths as a vulnerable adolescents' review. Issues of adverse childhood experiences, fractured family background, difficult

childhoods, school exclusions, early contact with the social care and criminal justice system, learning difficulties and gang related exploitation were highlighted themes in the reviews.

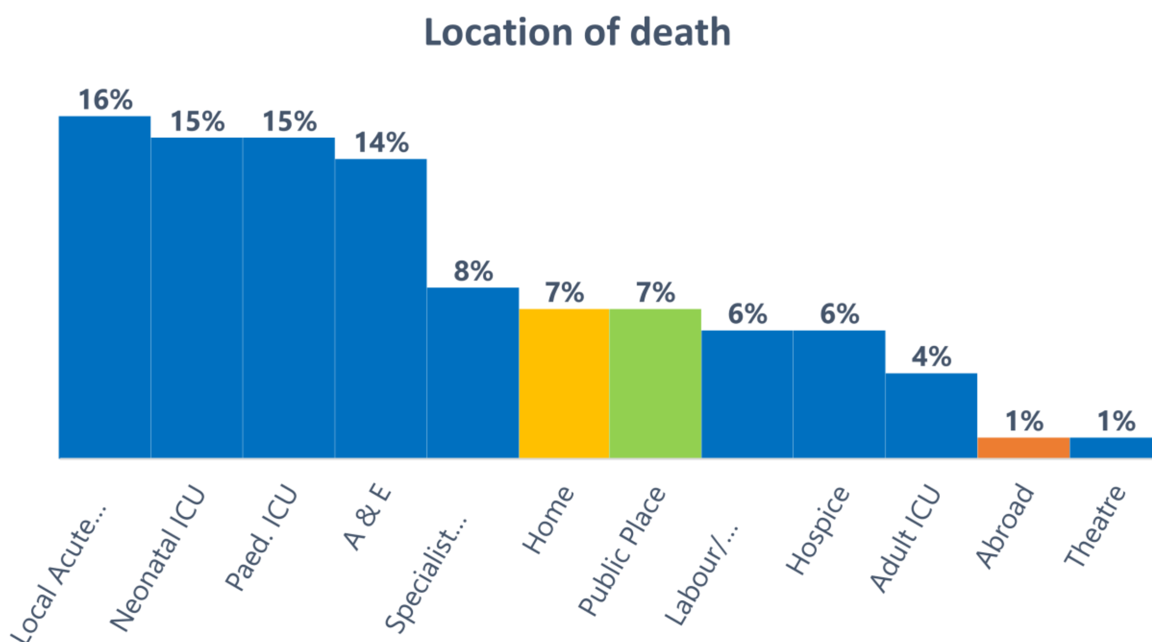
3.10 Children with Disabilities

The Learning Disabilities Mortality Review (LeDeR) programme is a review process for the deaths of people aged 4 years and over with learning disabilities in England. The Child Death Review process is the primary review process for children with learning disabilities. During this reporting year, four child deaths were referred to LeDeR for review on conclusion of their child death reviews.

3.11. Commentary on deaths – location

Seventy seven percent of child deaths were confirmed in a Hospital setting of which eight percent were other nearby specialist hospitals involving more than one hospital in the child's care, or circumstances where the child was transferred to tertiary hospitals. Seven percent of children were confirmed dead at home and seven percent of children were confirmed dead in a public location. Six percent of children died in hospices.

Graph 5



CHAPTER 4

STATISTICAL OVERVIEW:

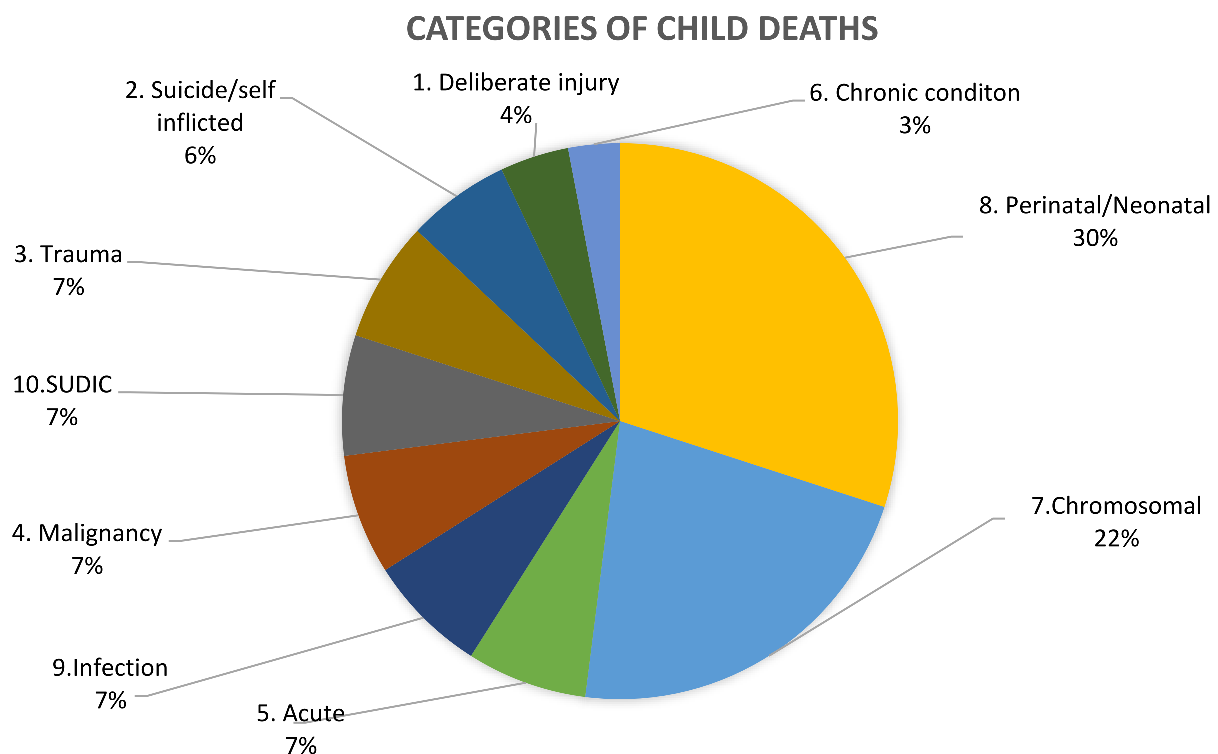
ANALYSIS OF CHILD DEATHS FOR 2019 – 2020

This chapter provides an analysis of eighty-three (83) child death cases reviewed and completed by the Individual and joint CDOP Panels in South West London during 2019 – 2020 reporting year. Caution needs to be taken in interpretation of the data because of the small numbers involved in each category. The information provided in 4.2 Category of deaths has been further pseudonymised by conversion and rounding up of the count to percentages for confidentiality.

4.1 Completed Child Death Reviews by Category of Death

The following table are the agreed assigned category of death reviewed with percentages of child deaths in that category. The categories are considered in more detail.

Graph 6



4.2 Generic Themes from completed reviews

Category 1: Deliberately inflicted injury, abuse, and neglect.

Four per cent of deaths were agreed in this category, with ages ranging across the spectrum of 0 – 27 days to 14 years old. Of this category, 75% of children involved in these deaths were male and 75% deaths occurred in a public place, the remaining 25% at home. 50% had modifiable factors identified. The learning from these reviews are addressed in Chapter 5 of the report.

Category 2: Suicide or self-inflicted harm

Six percent of deaths were agreed in this category. All children were in the 15 – 17 age range. Of this category, 60% were Males and 80% occurred in a public place, the remaining 20% at home. 40% were known to children's social care in the past and had mild learning difficulties. Modifiable factors were recorded for these unexpected deaths. Thirty-three per cent of cases were witnessed by members of the public.

The learning from the cases are addressed in Chapter 5 in this report.

Category 3: Trauma and other external factors

Seven per cent of child deaths were agreed in this category. Ages ranged across the spectrum of 0 – 27 days to 15 – 17 years old. For this category, sixty per cent were female. Fifty five percent of these deaths occurred at home, 15% in a public place, 15% of deaths were confirmed in an Accident and Emergency acute setting and 15% occurred abroad.

All cases had modifiable factors identified and learning from the cases are addressed in Chapter 5 of this report.

Category 4: Chronic Medical Condition

Three per cent child deaths were agreed in this category. The children were in the age range of 1- 4 years to 10 – 14 years of age. Of this category all children had Cerebral Palsy with compromised respiratory systems, and cause of death included respiratory conditions. 50% children had 'do not attempt resuscitation' directives (DNAR's) in place at time of death. All were subject to emergency admission to hospital. While none of these

cases had modifiable concerns identified, a service delivery recommendation was agreed, addressed in chapter five of this report.

Category 5: Chromosomal, genetic, or congenital anomaly

Twenty-Two per cent child deaths were reviewed by local panels and agreed in this category of deaths. The children were in the age range of 0 – 27 days and 10 – 14 years of age. 53% children were male. A total of 63% were mixed ethnicity and BAME ethnic groups. 26% of children died in Hospices, and 74% children died in Paediatric Intensive Care Units and in hospital admissions. 5% of cases had modifiable concerns, addressed in Chapter 5 of this report.

Category 6: Infection

Seven per cent of deaths were agreed in this category. The children were between age ranges of 0 – 27 days and 5 – 9 years of age. In this category, 57% of causes of deaths included Respiratory (Pneumonia) infection, and with Streptococcal infections and Sepsis in the remaining 43%. While no modifiable concerns were identified, the panel made recommendations addressed in chapter 5 of the report.

Category 7: Sudden Unexpected Death of an Infant/Child (SUDI/SUDIC)

Seven per cent child deaths were reviewed by local panels in this category. Of these, while 50% were under one year old 30% were in the 15 – 17 and 20% in the 5 – 9 age range categories. Sixty-Six percent (66%) children died at home and 34% died in a public place. 16% of deaths had a modifiable concern in the home environment. Sixty-six per cent of cases had safeguarding concerns in the family, 34% of which learning difficulties were noted and all of which were subject to Rapid / Joint agency Response meetings.

Category 8: Acute medical / surgical condition

Seven per cent of child deaths were agreed in this category of deaths.

In this category, the age of children ranged from 1 – 4 years, to 10 – 14 years. In 50% of the deaths, the mode of death was by unsuccessful cardio-pulmonary resuscitation. No cases had modifiable concerns noted.

Category 9: Malignancy

Seven per cent of child deaths were agreed in this category. The children were in age range of 27 – 364 days and 10 – 14 years old. With reference to the category, 83% were Asian British, and all were male. Case management was by multiple specialist hospitals, supported by community paediatric and nursing care. Fifty per cent had agreed palliative care plans and fifty per cent of the children died at home supported by the end of life care teams.

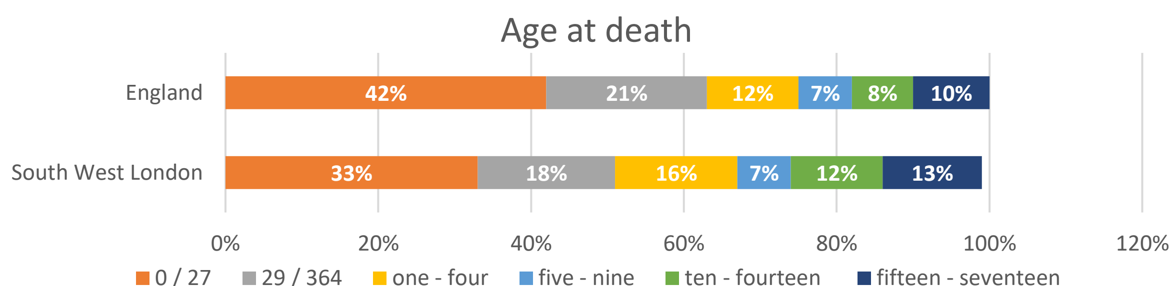
No modifiable factors were identified in service delivery or care.

Category 10: Perinatal / Neonatal event

Thirty percent of deaths were agreed in this category. The children were in the age range of 0 – 27 days and 27 – 364 days of age. In this category, 46% of children were male and 54% of children female. Thirty-six percent of deaths were in the delivery suite / Labour ward, and 64% in the Neonatal Units of local and regional hospitals. Fourteen percent of cases had modifiable concerns identified, addressed in chapter 5 of the report.

4.3 Completed Reviews by Child's age

Graph 7



The age of children at death in South West London is less than England average in the 0 – 27 days and 28 – 364 days age range. However, in the 1 - 4, 10 - 14 and 15 -17 years of age categories, the local amount is higher. The 5 – 9 age range are the same locally and nationally.[4]

[4] NCMD Annual Monitoring Report 2019-20 Merton, Sutton, Wandsworth, Kingston & Richmond Upon Thames, Wandsworth and Croydon.

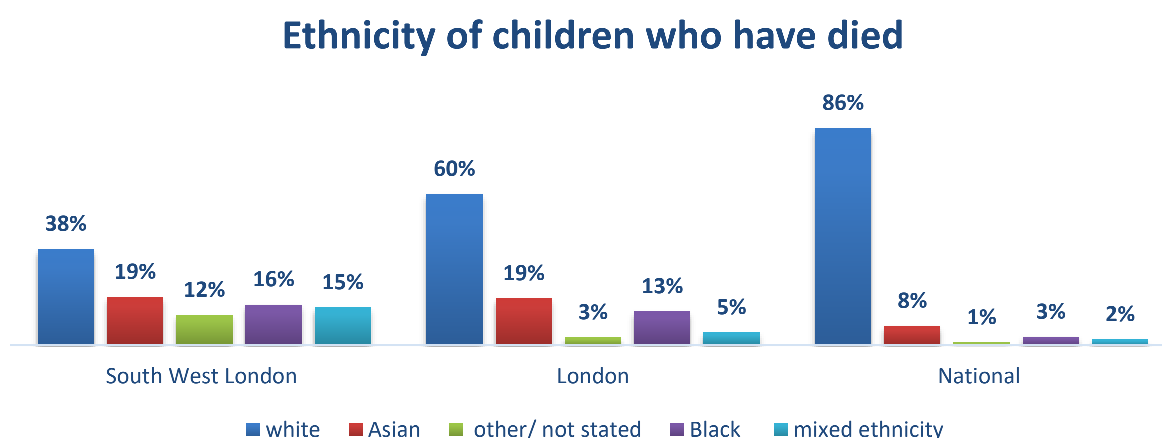
Demographic and Social Characteristics:

4.4. Gender

The gender breakdown of child deaths across all categories were 51% Male and 49% female

4.5. Ethnicity of children who have died.

Graph 8



All categories of ethnicity were grouped for reporting purposes as follows: -

White (Eastern European and other white background) 38% children

Black (Including Black African, Black Caribbean, Black British and Black – any other background) 16% children

Asian (Including Asian Indian, Asian Pakistani, British Asian and Asian – any other Asian background 19% children

Mixed Ethnicities (Black / White / Asian and other mixed ethnicities) 11%

Fifteen per cent (15%) of cases had no ethnicity recorded.

Proportionately (excluding those ethnicities not recorded), 46 % of child deaths in South West London are of are of Black, Asian and Mixed Minority ethnic categories.

In comparison with national statistics, the ethnicity of the population in London is more diverse, which proportionately, is evidenced in the local statistics in South West London.[5]

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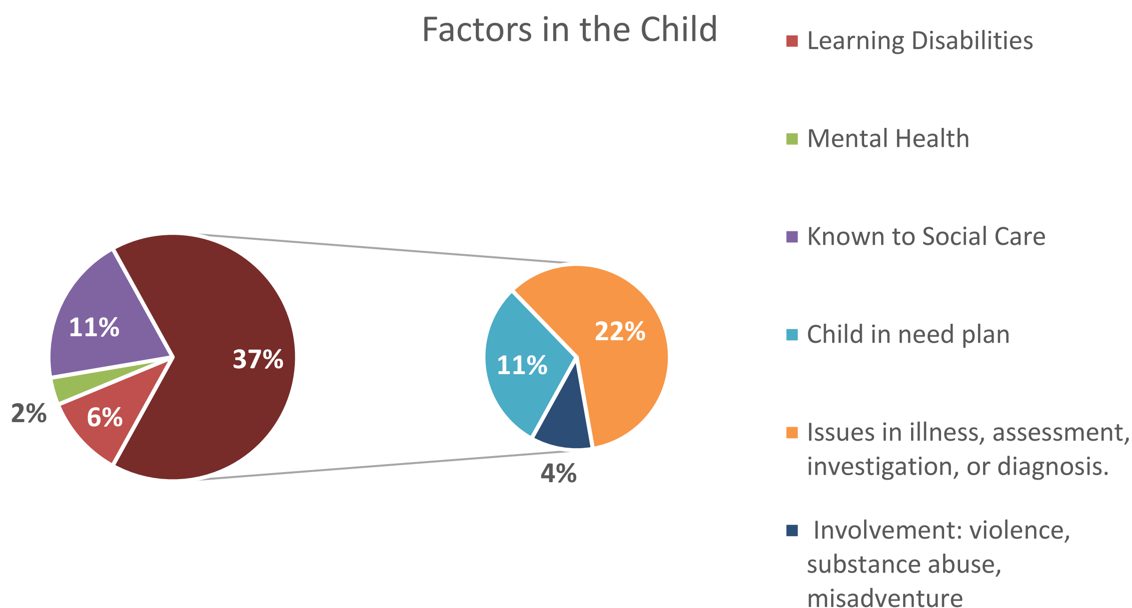
[5] Graph 8 - Ethnicity: Gov.uk Statistics https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest#by-ethnicity

4.6. Asylum status

No child or family was recorded as being the subject of an asylum application.

4.7. Factors in the Child.

Graph 9



Fifty six percent of child death cases had factors affecting the child recorded.

Six percent of children were recorded with learning disabilities. Twenty-two percent of child deaths had recorded issues in identification of illness, assessment, investigation, or diagnosis. Two of these were subjects of Hospital serious investigations.

Two percent of children had mental health concerns recorded.

Eleven percent children were known to Childrens' Social Care. Three percent of children had child in in plans in place at time of death, 8% of these children had child in need plans which were in place before death.

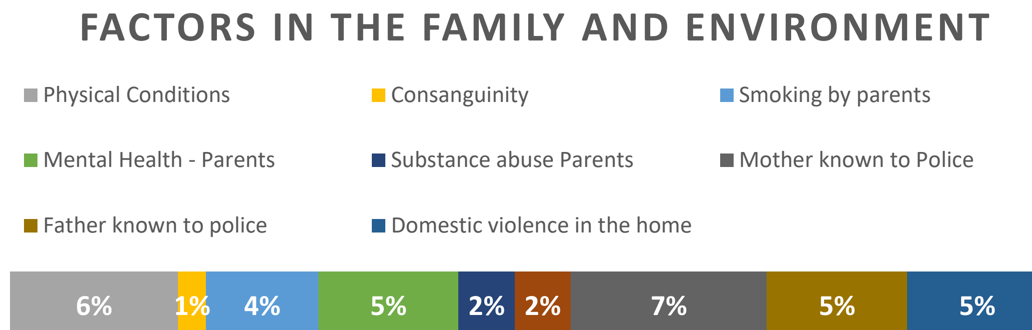
No children were on child protection plans at time of death.

Four percent of children were victims of violence, self-harm, fatal incidents, or accidents.

4.8. Factors in the Parents, Family and Environment.

In a few instances this was left blank in completion of the form B reporting, but the following was recorded for case analysis. Thirty Seven percent of children lived in environments where factors in the family were noted.

Graph 10



In four per cent of cases, parents smoked. Five percent of parents had mental health concerns recorded.

Seven per cent of mothers were known to the Police; it is not recorded if they are known as victims of crime. This compares with five per cent fathers being known to the Police.

Four percent of children lived in environments where domestic violence and substance abuse by a parent in the home is recorded. Co-sleeping is recorded in one per cent of cases.

4.9. Factors in Service Provision

The Serious Incident Framework undertakes the management of reporting safety incidents to deliver a high quality of identification and investigation of clinical incidents. This ensures the safety of healthcare. Serious Incident investigations (SI's) identify areas for improvement, retraining, policy revisions or procedural changes in provision of health care for children.

10% of total deaths overall, were the subject of Serious Incident investigations (SI). Seven SI's were for Hospital services to review service delivery issues or care incidents. Two

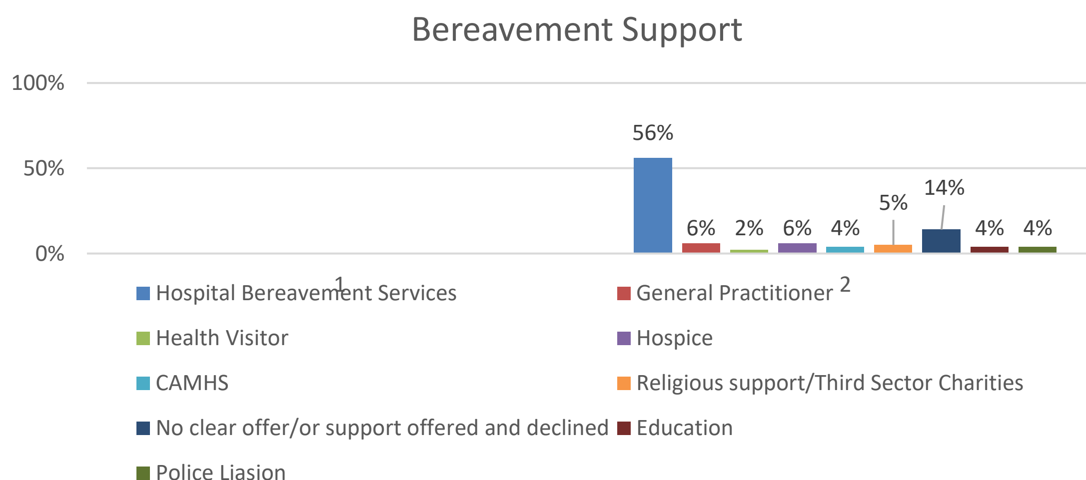
cases were subjects of Root Cause analysis to determine cause of in-hospital unexpected child deaths. While seven were in-hospital investigations, one Serious Investigation was done by London Ambulance Service, and one SI conducted by NHS 111 service. In a few local CDOP reviews, panels noted instances of best practice in acute services in interventions and care management by clinical and nursing teams.

A summary of the recommendations is highlighted in the Learning and recommendations in Chapter 5 of this report.

4.10: Bereavement

Bereavement support is initiated by identifying a key person best placed to support family, and Hospital bereavement nurse in acute settings decided on a case by case basis. Under S. 6.1 to S. 6.1.3 of the new working arrangements for child death reviews, the role of Key Worker acts as a single point of contact for the bereaved family, who communicates with the family on the child death review process, and who can signpost them to sources of support. To date, St Helier Hospital and Croydon University Hospital have their Key workers in post. They are Specialist Nurses who contact and support families who are recently bereaved. Kingston Hospital and St Georges Hospital are in the process of recruitment of Key Worker/Specialist Nurses.

Graph 11



The above graph represents deaths which local CDOP panels recorded specific agencies providing bereavement support. This should be interpreted with caution as for some

services, such as the GP and Health Visiting offers of support is likely to be under reported. Some agency partners often overlap each other, each offering support as a normal part of service delivery to recently bereaved parents and families. The main providers of bereavement support reported were Hospitals at 56%. Other sources include the School Community 4%, General Practitioner 6%, Hospice 6%, Police Liaison 4%, Health Visiting / Community Nursing 2%, CAMHS 4% and Third Sector Charities (including religious support) of 5%.

St Helier Hospital (Sutton) have launched the Perinatal Mental Health Network, linking services, including GP practices to improve communication and signposting of bereavement support.

The recent implementation of the 'Coordinate My Care' service in South West London is being used to share DNARs information between primary care, secondary care, and local ambulance services.

In a few cases the need for possible sources to signpost bereavement support for members of the public was noted.

4.11. Parents and carers feedback to the Child Death Overview Panel

In four cases, parents contacted the local panels to express concerns on antenatal care and provision of care for the child's needs by the local authority. In all cases, Clinicians met with parents to discuss issues raised by them. In two cases SI reports were done on service delivery issues which were shared with parents.

Instances of good practice and support were also noted. With reference to the chronic medical conditions, chromosomal conditions and malignancy categories, parents indicated they felt well supported by Hospices, and end of life care teams. Parents reported they felt their choice that their child should stay at home in their final days as part of the children's palliative care was considered and facilitated.

CHAPTER 5

LEARNING FROM CHILD DEATH REVIEWS

5.1. Learning Themes and Recommendations

Section 5.8.1. of Working Arrangements for Child Death Reviews require that a report of learning and actions that have been taken to prevent child deaths as follows:

- to identify gaps in service delivery to be addressed, and
- to recommend modifiable improvements that can be made.

This is to determine how effective the Child Death Review arrangements have been in practice, the key learning arising from the reviews and potential ways child death reviews may be enhanced at local, regional, and national levels.

The following recommendations and themes were made by local panels for a targeted range of actions by Agency partners, for effective ways to prevent future child deaths, and to improve service delivery for the health and wellbeing of children.

5.2: Promotion in community education

Recommendations from Child Death Review meetings with specific reference to Public Health were highlighted for the importance of reaching the widest sectors of the community to promote health and safety.

Table 1

Public Health	Wider sharing and review of communications strategy on suicide and self-harm
	Signposting importance of water safety
	Public Health communication/campaign on identifying signs of (a) meningitis/sepsis and (b) choking with easy to read picture information leaflets for families where English is not first spoken language.

5.3. Improvements in organisational practice

Recommendations from Serious Incident Investigations and Child Death Review Meetings were shared with partner agencies to adopt new working protocols to improve health and safety.

Table 2

Agency	Improvement
London Fire Brigade	Working with Housing to increase awareness of the importance of maintenance of smoke alarms
Local Authority	Endorsing licenced Landlords to ensure smoke alarms are working in regular inspections
London Ambulance Service	Consideration of a protocol for management of expected deaths of children with life limiting conditions in the community.
Acute Services	I. Pyrexia and suspected Chorioamnionitis Protocol Guideline development for care management
	II. Discussion with Anaesthetists and Haematologists on Trust protocol and major Obstetric Haemorrhage guidelines.
	III. Review of guidelines for adverse effects of Syntocinon infusion including hyperstimulation, its identification, and immediate actions to be taken should this occur.
Primary Care Services	GP Practices Development of a pathway for understanding and management of allergies/asthma in young people.
Local Authority: Education	Development of a School absence protocol to flag frequent absences in school attendance, as a safeguarding concern.

5.4 Educating / Training / Communication: Local partner agencies

Recommendations from Serious Incident Investigations, learning reviews and panel reviews resulted in actions taken to reach service providers. New policies, procedures, and training was implemented to upskill, reinforce, share, and promote learning by partner agencies, to improve communication to service providers and for improvements in service delivery.

Table 3

Community Services	I. Review of the Perinatal/Maternity Pathway (questions asked about mental health) II. Reiteration of the vital role of the Health Visitor. III. Training to improve information sharing and transfer of medical information between acute services and community services, as well as private and public Hospitals IV. Communicating parents' choices for palliative care in the community. The Palliative Care Team may be involved in discussions for children with life limiting conditions before an end of life care plan has been agreed. V. Sharing information and continuity of care across borough borders particularly where safeguarding concerns have been identified.
Acute Services	**Antenatal Services:** I. Reiteration of communication on maternal smoking and risk of premature delivery II. Review of GAP protocol: Reiterate training to identify signs of a growth-restricted baby, with potential to change perinatal

	institute learning tool with an Imperial College Healthcare NHS Trust (ICHNT) specific eLearning package and face to face learning. <u>Obstetrics/Midwifery</u> I. Training for all midwifery and obstetric staff on new Chorioamnionitis guideline II. Importance to expedite delivery in cases of suspected sepsis once full dilation is confirmed III. Refresher training for recognition of deteriorating patient for Obstetric review IV. Key Messages to Multidisciplinary teams on when to initiate the Major Obstetric Protocol, allocation of team leadership and communication before, during and after delivery. Regular discussion on results and for sharing learning. V. Update of training annually for clinical staff in Continuous Cardiotocography (CTG) clinical risk factors and management, with competency testing. To share in teaching sessions and including Obstetricians and Junior Doctors. VI. The importance of an appropriate skill mix of Midwifery staff in rota planning, and reiteration of the importance of escalating concerns. VII. Ensuring nursing clinicians are aware of rare conditions and specialised instructions for care of specific patients when ward handovers are taking place. VIII. Department debriefs to understand barriers and develop solutions to prevent delays in contemporaneous record keeping. IX. Regular refresher resuscitation training in Neonatal Unit X. Training for having difficult conversations with parents for DNAR and palliative care options <u>Estates Management</u> I. Improvement of signage on hospital grounds.

Social Care	I. Improved communication between Social Care and Health when there are known safeguarding concerns, and where statutory orders have been issued. II. Addition of questions on sleeping arrangements and home environment in assessment of care plans for children with disabilities.
Local Authority	I. Support services as well as financial support options to be considered through assessment for migrants with children to ensure they know what they can access in the UK.
London Ambulance Service (LAS)	I. Clinical update and staff re-training on the correct use of pre-filled Adrenaline syringes. II. Audit of NHS 111 calls for London Ambulance Service response – to be aligned to modern style of NHS pathways audits, with individual feedback and learning workshops for 111 personnel. Appropriate learning to be shared with LAS staff. III. Training of London Ambulance Service Staff on the new working arrangements for Child Death Reviews, supported by Palliative Care Consultants and GP.
Metropolitan Police Service	I. Discussion: When responding to incidents at home, if no safeguarding concerns are identified, It is recommended that parents should travel with the child to the hospital or in the alternative follow behind in another vehicle that they arrive at the same time as their child to Hospital.

5.5 Influencing Policy and Legislation

Local Child Death Review panels, and partners, contacted the following national regulatory agencies and recommendations were made for strategies and to update existing policies to influence outcomes arising from child death reviews.

Table 4.

General Medical Council	1. Coroners' Regulation 28 Prevention of Future deaths notice for a national screening protocol for streptococcal infection to detect and interrupt ascending Chorioamnionitis infections. 2. Enquiry on regulations for anomaly scans for mothers with late antenatal bookings after 20 weeks gestation. The Council confirmed that no regulation exists. The learning would be shared for consideration on a case-by case basis if there is cause for concern.
Health and Safety Council	Review and update of iGAS guidelines for management of infections in Nursery and Primary care settings.
Nursing & Midwifery Council	Signposting membership to regulatory guidance for nursing professionals caring for relatives in Hospital
Mothers & Babies Reducing Risk by Audits & Confidential (MBRRACE)	Consultation on new guidelines for a clear definition of 'signs of life' for live births under 24 weeks gestation for Labour Wards/Delivery Suites.

CHAPTER 6:

CONCLUSION AND PRIORITIES FOR 2020-21

6.1. Plan

South West London Child Death Overview Panel is expecting to further develop its processes in line with the new Working Together statutory guidance. This is to move towards a more effective and measurable Child Death Overview Panel process that conforms to its statutory requirements of timely reviews, involvement of families and improvement of the process.

6.2 Goals for next Reporting year 2020-21

The panel will aim to: -

I. Support the acute Hospitals to implement their local systems and processes to commence local Child Death Review Meetings.
II. Reflect the regional footprint within reporting on child death reviews.
III. To identify trends in child deaths in the South West London area, to conduct themed reviews involving specialists on specific issues, such as reducing risk in vulnerable children that result in deaths due to self-harm, accident, or misadventure.
IV. To develop a formal system of feedback of learning from Child Death Overview Panel meetings to local, regional, and national agencies, to enable professionals to reflect on practice, and provide scope for improved collaborative learning, better health, and public safety provision.
V. Define measures of effectiveness arising from implementation of actions from recommendations made from child death reviews.
VI. To recommend improvements to the bereavement experience, to ensure all families are offered the assistance, and to measure the effectiveness of support in the local area.
VII. To improve feedback to families by way of notification of actions taken.
VIII. Complete recruitment of Key Worker Specialist Nurses across acute services in the South West London Partnership as advocates for the family after the child dies

and throughout the review process with information about the work of the Child Death Review process.

IX. Complete representation of Midwifery, Community Childrens Nursing and Mental health to panel membership.

X. To consider the recruitment of a Lay Person to panel membership for input from the public on the Child Death Review Process.

SUMMARY

In summary in 2019-2020

- Eighty-Three child deaths were reported to the South West London boroughs for the period 2019 – 20 and a total of Eighty-Three cases were reviewed by local borough child death overview panels and the South West London Child Death Overview Panel.
- There were fourteen Child Death Overview Panel Meetings across South West London and fourteen Child Death Review meetings under the new working arrangements for Child Death Reviews.
- Seventy-four percent (74%) of child deaths were classified as expected. Eighty Two Percent (82%) of these deaths had no modifiable factors identified. Twenty Four percent (24%) of child deaths were unexpected in South West London, and eighteen (18%) percent had modifiable factors identified. Thirty-one unexpected child deaths had Rapid Response/Joint Agency meetings held across South West London.

Recommendations and learning from panel reviews contributed to promotion in community education, improvements in organisational practice, improvements in education, training, and communication in local partner agencies, and learning that has had an impact on national government policy.

Appendix 1: Statutory and Regulatory Legislation

Child Death Review Statutory and Operational Guidance (England) (October 2018) These documents provide the statutory guidance for reviewing child deaths in England.

https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

Chapter 5 Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (July 2018)

http://www.workingtogetheronline.co.uk/chapters/chapter_five.html

The Child Death Review partners are local authorities and clinical commissioning groups for the local area as set out in section 16Q of the Children Act 2004 (the Act), as amended by the Children and Social Work Act 2017.

https://www.legislation.gov.uk/ukpga/2004/31/section/16Q

Appendix 2: NCMD Monitoring Reports (not attached to this document)

Croydon
Kingston Upon Thames
Richmond Upon Thames
Merton
Sutton
Wandsworth