Child Death in Lambeth and Southwark

A rapid review

Southwark's Joint Strategic Needs Assessment

Public Health Division

Place and Wellbeing Department

April 2019

GATEWAY INFORMATION

Report title:	**CHILD DEATH IN LAMBETH AND SOUTHWARK: A RAPID REVIEW**
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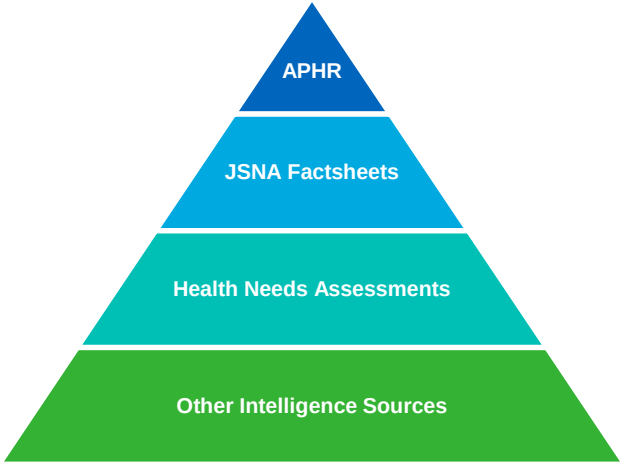
Health Needs Assessments form part of Southwark's Joint Strategic Needs Assessment process

BACKGROUND

The Joint Strategic Needs Assessment (JSNA) is the ongoing process through which we seek to identify the current and future health and wellbeing needs of our local population.

- The purpose of the JSNA is to inform and underpin the Joint Health and Wellbeing Strategy and other local plans that seek to improve the health of our residents.
- The JSNA is built from a range of resources that contribute to our understanding of need. In Southwark we have structured these resources around 4 tiers:



Tier I: The Annual Public Health Report provides an overview of health and wellbeing in the borough.

Tier II: JSNA Factsheets provide a short overview of health issues in the borough.

Tier III: Health Needs Assessments provide an in-depth review of specific issues.

Tier IV: Other sources of intelligence include Local Health Profiles and national Outcome Frameworks.

- This document forms part of those resources.
- All our resources are available via: www.southwark.gov.uk/JSNA

This needs assessment aims to identify core themes in local child injury and death across Lambeth and Southwark

AIMS & OBJECTIVES

The aim of the project is to conduct a thematic analysis of the historical caseload of Lambeth and Southwark child deaths to identify core themes in local child death. The project will inform an action plan for local improvements in service delivery and practice for children and young people spanning wider public health initiatives.

The objectives of the project are to:

- Summarise the national and local policies around child death
- Identify local patterns of child death, both in terms of category and groups affected
- Identify potential opportunities for preventative, cross-cutting public health work
- Make recommendations for future, specific pieces of work and topic areas for in-depth needs assessments

The scope of this project is to evaluate the caseload of historical cases of child death for children up to 18 years in the London boroughs of Lambeth and Southwark.

Clear terminology around child death is essential to the child death review process

TERMINOLOGY

Term	Definition
Child	Any person under 18 years of age. For the purposes of this document, this includes the death of any live-born baby where a death certificate has been issued. This does not include stillbirths (a baby born without signs of life after 24 weeks gestation), late foetal loss (where a pregnancy ends before 24 weeks gestation, or terminations of pregnancy of any gestation.
Child Death Overview Panel (CDOP)	A multi-agency panel set up by CDR partners to review the deaths of all children normally resident in their area to learn lessons and share any findings for the prevention of future deaths.
Child Death Review Meeting (CDRM)	The stage of the review process that precedes the independent multi-agency panel arranged by CDR partners. All matters relating to the child death are discussed at this meeting, and it should be attended by all professionals directly involved in the care of the child during his/her life and any professionals involved in the investigation.
Child Death Review (CDR) partners	As defined in 16Q of the Children Act 2004, the local authority and any CCG for an area any part of which falls within the local authority area
Child Death Review process	The entire process for reviewing the death of a child with which professionals must engage

References
1. Child Death Review: Statutory and Operational Guidance. 2018.

Clear terminology around child death is essential to the child death review process

TERMINOLOGY

Term	Definition
Designated Doctor for child death	A senior paediatrician, appointed by CDR partners, responsible for coordinating responses and health input to the child death review process
Joint Agency Response (JAR)	A coordinated multi-agency response by a lead health professional (a doctor, senior nurse, or on-call senior attending paediatrician) including a police investigator and duty social worker. Formerly known as the Rapid Response Meeting (RRM) this response is triggered if a child's death: ▪ Is or could be due to external factors; ▪ Is sudden and there is no immediately apparent cause (including SUDI/C); ▪ Occurs in custody, or where the child was detained under the Mental Health Act; ▪ Where 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
National Child Mortality Database (NCMD)	A repository of data relating to all children's deaths in England.
Neonatal Death Overview Panel (NDOP)	A multi-agency panel set up by CDR partners to review the deaths of all neonates (aged 0—28 days) normally resident in their area to learn lessons and share any findings for the prevention of future deaths.

References
1. Child Death Review: Statutory and Operational Guidance. 2018.

CONTENTS

Each child death is reviewed to identify factors that can mitigate future child injuries, accidents or death

INTRODUCTION

The death of a child is a tragic event that profoundly affects the community.

- Key local partners (see slide 14) have a statutory responsibility to review the deaths of all children normally resident in their local area.
- The review is conducted to determine whether any factor(s) related to the death impact, or have the potential to affect, the health and wellbeing of local residents and to identify recommendations and actions that may mitigate future child injuries, accidents, or death.

A comprehensive analysis of the historical caseload of child death provides insight into the efficacy of recommendations made from the review of a single case.

- Additionally, a review of all cases has the potential to highlight any trends or threats that may not be apparent on an individual basis.
- The understanding gained from this review can elucidate actions to promote the welfare of children, or refine recommendations which can lead to service or practice improvements.

CONTENTS

Child death review partners have a statutory responsibility to review all deaths of children from the local area

NATIONAL POLICY CONTEXT

The 2018 'Child Death Review: Statutory and Operational Guidance' establishes best practice for the child death review (CDR) process in England.

- The primary aim of this guidance is to standardise national practice and enable local thematic learning.
- This guidance is one of several documents resulting from the 2016 Wood Report evaluating the role and functions of Local Safeguarding Children Boards.

The CDR guidance incorporates statutory functions related to national policies around child death as per sections 16M – 16P of the Children's Act 2004 and is intended to be used in conjunction with other relevant documents including:

- ***Working Together***, statutory guidance around the legislative responsibilities for child inter-agency safeguarding services and local child safeguarding partners.
- ***Sudden unexpected death in infancy and childhood: multi-agency guidelines for care and investigation***, the operational guidance for some of the statutory duties involved in a Joint Agency Response.
- ***National Guidance on Learning from Deaths***, an NHS Trusts and Foundation Trusts framework for learning from deaths and improving work, particularly for inpatients and persons with learning disabilities and serious mental health conditions.

References
1. Child Death Review: Statutory and Operational Guidance. 2018.
2. Wood Report :Review of the role and functions of Local Safeguarding Children Boards. 2016.

Prior to the 2018 Child Death Review Guidance, the CDR processes varied considerably across England

NATIONAL POLICY CONTEXT

The 2018 Child Death Review guidance introduced several changes in an attempt to clarify processes and establish high level principles for CDR partners.

- The aim of these changes is two-fold:
  - To improve the experience of the bereaved families and professionals after the death of a child
  - To ensure information from the CDR process is systematically captured to enable local learning and inform changes in policy and practice

The changes incorporated into the 2018 guidance include:

1. Change in responsibility for the CDR process from Local Safeguarding Children's Boards to local Child Death Review Partners, formed of the local authority and CCG for a geographical area
2. Merger of existing Child Death Overview Panels to represent a geographical footprint of a minimum of 60 deaths per annum
3. Establishment of local multi-agency Child Death Review Meetings involving professionals directly involved in the child's care and investigation of the death
4. Introduction of a 'key worker' role to act as a single point of contact with the bereaved family for the duration of the death review process
5. Submission of child death data to the National Child Mortality Database beginning 1 April 2019

Plans to address these changes must be published by 29 June 2019 and implemented by 29 September 2019, yet a number of logistical and resource challenges have arisen as a result

- The processes described on the following pages detail best practice according to 2018 guidance, rather than current practice, whilst local hospital trusts and the local CDR partners undergo a transformation and establish plans for implementation.

References
1. Child Death Review: Statutory and Operational Guidance. 2018.

National guidance sets best practice for reviewing child deaths to promote learning and service improvement

NATIONAL POLICY CONTEXT

The recommended child death review process is comprised of four main stages after a child has died to promote learning and service improvement.

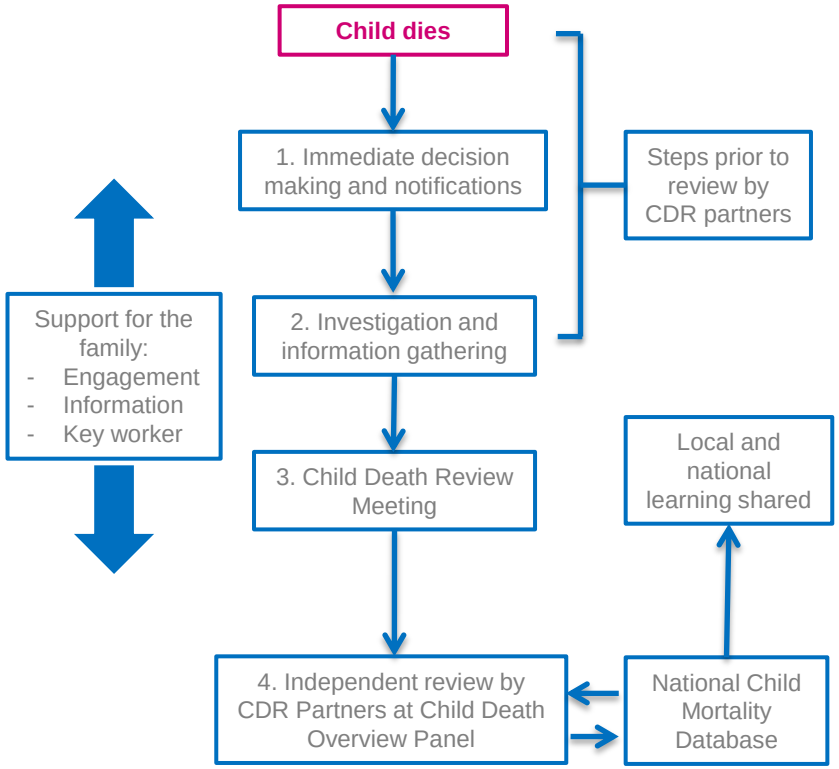
- All children should be brought to A&E unless planned and managed with palliative or hospice care.
- Additionally, the organisation where the child was certified dead must identify a **key worker** for the family to serve as a point of contact and provide information on the CDR process and signpost services for support.

Reviews are conducted to identify any matters relevant to child welfare or public health and safety in the area.

- The **Child Death Review Meeting (CDRM)** should be held within 3 months and only include professionals directly involved the child's care or investigation to ensure local learning and to inform CDOP.
- This differs from the review of child deaths at the **Child Death Overview Panel (CDOP)**, an independent, multi-agency group.

CDR partners are defined as the local authority and any CCG for an area or any part of which falls within the local authority area.

- This includes both professionals directly involved in care and independent case reviewers.



References

1. Child Death Review: Statutory and Operational Guidance. 2018.
2. Children's Act 2004, Section 16Q.
3. Child Death Overview Panels Programme. Annual Report 2016/17.

Southwark Council
southwark.gov.uk

CDOP aims to identify recommendations for actions and learning that will improve child welfare and prevent death

NATIONAL POLICY CONTEXT: CDOP

The Child Death Overview Panel (CDOP) is a multi-professional panel which reviews the deaths of all children normally resident in the area to identify factors that may improve child welfare or prevent future deaths.

- Nationally there are 90 CDOPs, 28 of which are in London.
- It is recommended that senior representatives from public health, social services, the police, safeguarding teams, primary care, nursing and/or midwifery and the Designated Doctor for child deaths attend CDOP meetings to ensure effective, collaborative working across all agencies involved. Information on the roles and responsibilities of panel members is detailed on the following slide.
- At a minimum, quoracy should demand attendance by lead professionals from relevant health teams and the local authority.

The aim of the CDOP review meeting is to identify any modifiable factors that may have contributed to a child's death and recommend actions and share lessons learnt to prevent future deaths of children in similar circumstances, both locally and nationally.

- Information discussed at CDOP should be informed by a standardised report from the Child Death Review Meeting (CDRM).
- Panels can make recommendations for action and report to the local Safeguarding Children's Board.

As of April 2019, information from CDOP meetings is collected at the national level by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and fed into the National Child Mortality Database (NCMD).

- Data from local case reviews will help develop an understanding of patterns, trends and risks relating to child death at a regional and national level to support opportunities for public health intervention.

References

1. Child Death Review: Statutory and Operational Guidance. 2018.
2. Child Death Overview Panels Programme. Annual Report 2016/17.
3. Southwark and Lambeth Child Death Overview Panel Annual Report: 2016-17.

CDOP is a multi-professional panel with membership from a range of representatives from several agencies

NATIONAL POLICY CONTEXT: CDOP

Roles and responsibilities of CDOP members

Chair	Manager / Administrator	Designated Doctor for Child Deaths	Health Professional	Police	Children's Social Care & Safeguarding	Education
•Ensure CDOP operates effectively and meets statutory requirements •Coordinate meetings, agenda, action plan and annual report •Coordinate with Public Health and assist in evaluating patters and trends	•Serve as POC and ensure effective notification and data management and collection •Record CDOP conclusions and submit data to NCMD	•Be responsible for the CDR process •Advise CDOP on modifiable factors •Liaise with regional clinical networks •Assist Public Health with strategies to reduce child deaths	•Assist CDOP in interpreting medical information •Advise CDOP on medical issues including injuries and causes of child deaths	•Provide information on criminal investigations as appropriate •Advise on law enforcement practices and investigations •Liaise with other police departments as necessary	•Help CDOP evaluate issues relating to the family and social environment •Interpret social care needs of the child and family •Identify child protection needs	•Interpret information about educational needs and service for the child and other impacted children

References
1. Child Death Review: Statutory and Operational Guidance. 2018.

NDOP aims to identify recommendations for actions and learning specifically aimed at neonates

LOCAL POLICY CONTEXT: NDOP

Depending on the caseload, local authorities may elect to review neonatal deaths independently from children aged over 28 days.

- Whilst some local authorities review neonatal deaths as themed CDOP meetings or with all child deaths, a separate Neonatal Death Overview Panel (NDOP) is used locally for neonates (0-28 days) in addition to CDOP meetings for children (aged 28 days – 18 years).

The Neonatal Death Overview Panel (NDOP) is a multi-professional panel which reviews the deaths of all children aged 0-28 days normally resident in the area to identify factors that may improve child welfare or prevent future deaths.

- NDOP also requires multi-agency collaboration with input from senior representatives from public health, social services, the police, safeguarding teams, primary care, nursing and/or midwifery and the Designated Doctor for child deaths.
- NDOP does not review cases of stillbirths. A stillbirth is defined as an infant born without signs of life after 24 weeks gestation.

Similar to CDOP, the aim of the NDOP review meeting is to collate and analyse information surrounding a neonatal death and to identify any modifiable factors that may have contributed.

- A key outcome of the meeting is to recommend actions and learning to prevent future deaths of children in similar circumstances both locally and nationally, or to influence care related to maternal health.

References
1. Child Death Review: Statutory and Operational Guidance. 2018.
2. Southwark and Lambeth Child Death Overview Panel Annual Report: 2016-17.

The LeDeR progamme was developed to aid the review of cases for children with learning disabilities

LOCAL POLICY CONTEXT

The Learning Disabilities Mortality Review (LeDeR) programme was developed following the 2018 Child Death Review guidance to review the deaths of people with learning disabilities aged 4 years and older in England.

- Currently the LeDeR programme serves the London region exclusively with information collated and analysed by Bristol University.

According to the programme, a learning disability is defined to include:

- A significantly reduced ability to understand new or complex information and to learn and new skills (impaired intelligence) with;
- A reduced ability to cope independently (impaired social functioning), which;
- Started in childhood with a lasting effect on development.

If the death meets the criteria for the LeDeR programme, the LeDeR Local Area Contact will attend the CDOP meeting at which the death of the child with learning disabilities will be discussed.

- In Southwark and Lambeth, the Local Area Contact also reviews child LeDeR cases with the LeDeR Steering group which discusses deaths of all persons with learning disabilities aged over 4 years (including adults) to make recommendations or gain learning to improve service delivery across the lifespan.

Any learning, recommendations or actions relating to the death of the child with learning disabilities will be reviewed by the regional LeDeR Programme team at Bristol University.

- Oversight of actions is the responsibility of the CDOP Chair and LeDeR Local Area Contact.

References
1. Southwark and Lambeth Child Death Overview Panel Annual Report: 2016-17.
2. Learning Disabilities Mortality Review Programme. Available at: www.bristol.ac.uk/sps/leder/

CONTENTS

Lambeth and Southwark have large, diverse and deprived populations of children and young people

DEMOGRAPHICS OF LAMBETH AND SOUTHWARK

Children and young people (CYP) under the age of 20 years make up approximately one fifth of the population in Lambeth and Southwark.

- 21% (68,200 children) of the Lambeth population is under the age of 20 years.
- 23% (70,800 children) of the Southwark population is under the age of 20 years.

The population under 20 in both boroughs is much more ethnically diverse than the rest of London.

- Over 60% of the CYP population in Lambeth and Southwark are from Black or other minority ethnic groups.

Southwark and Lambeth are in the 2nd highest quintile in England for deprivation for primary and secondary school aged children.

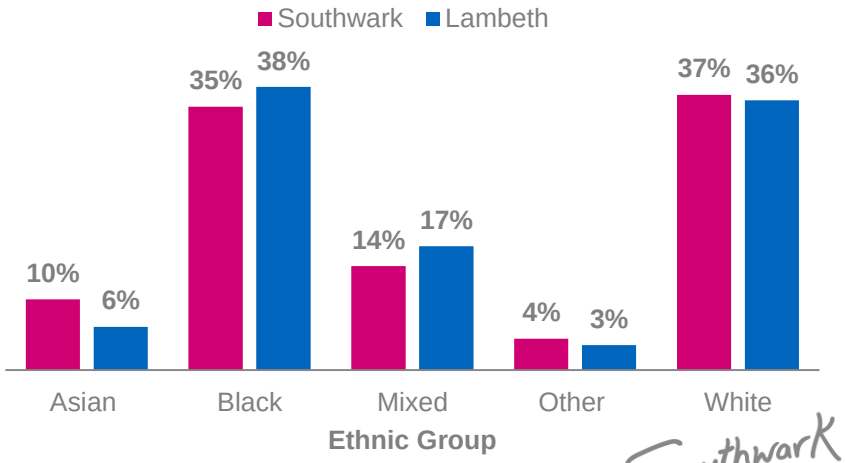
- Around 12,000 children (23%) in Lambeth and 15,000 children in Southwark (28%) in Southwark aged under 16 live in low income families.

Further information about the demographics and wider determinants of Lambeth and Southwark populations are available from the JSNA pages for each local authority.

Figure 1: Children and young people in Lambeth and Southwark, 2017

Age	Southwark	Lambeth
0-4	21,100	19,700
5-9	19,100	18,300
10-14	15,700	15,900
15-19	14,900	14,200
Under 20	**70,800**	**68,200**

Figure 2: Ethnicity of children and young people in Lambeth and Southwark, 2016



References

1. GLA 2016-based Central Trend Ethnic Group Population Projections.

Southwark Council
southwark.gov.uk

Neonatal and child mortality rates in Lambeth and Southwark are similar to regional and national rates

MORTALITY IN LAMBETH AND SOUTHWARK

Local all cause mortality rates are statistically similar to both regional and national rates for neonates (children aged 0-28 days) and children aged <15 years.

- Despite high levels of deprivation among primary and secondary school-aged children, mortality rates for both age cohorts over the 2013-2015 period in Lambeth and Southwark are not statistically different from London and England all-cause mortality rates.

Although the infant mortality rate (IMR) for Lambeth (4.7) is statistically greater than the London value (3.3), the IMR for Southwark (3.8) is not statistically different to the region, and the rates for both boroughs have been trending down.

- Infant mortality rate is defined as the mortality rate of children under 1 year per 1,000 live births.

The NCMD will help provide further detailed analysis on child mortality at the national and regional level beyond only all-cause mortality by age and sex.

Figure 3: Neo-natal mortality rate per 1,000 in 2013-15

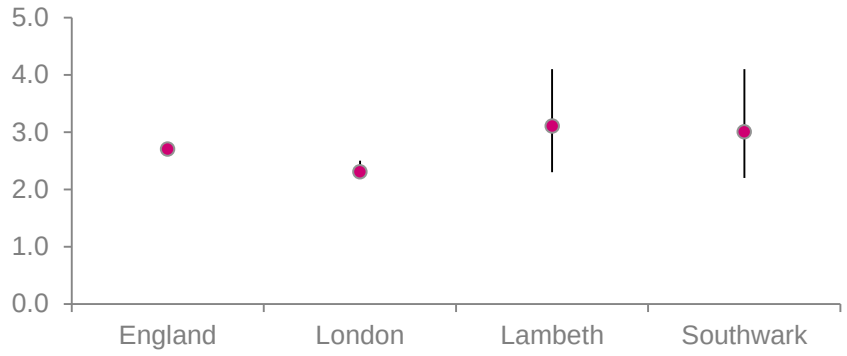
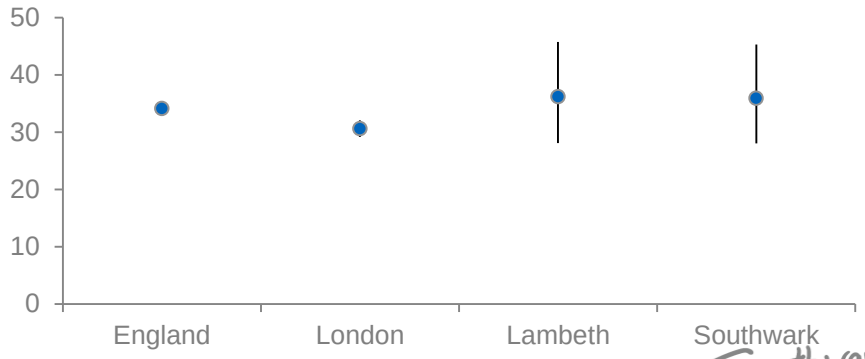


Figure 4: All-cause mortality rate for <15s per 1,000 in 2013-15



References

1. NHS Digital, Compendium – Infant Mortality. 2017.
2. NHS Digital, Compendium – Mortality from all causes. 2018.

The London boroughs of Lambeth and Southwark have combined to deliver a joint child death review process

THE LOCAL CHILD DEATH REVIEW PROCESS

CDR partners are permitted to establish a localised structure and process for reviewing the deaths of children normally resident in the geographical area.

- Any local processes should align to general principles set out in national guidance.

According to the guidance and statutory requirements, child death review partners for two or more local authority areas may combine and agree that their areas be treated as a single area for the purpose of undertaking child death reviews.

- The recommended catchment population should be approximately 500,000 where at least 60 child deaths are reviewed each year to enable better thematic learning and meaningful population level analysis.

The London boroughs of Lambeth and Southwark jointly review deaths of children normally resident in the areas.

- The local NDOP meetings review deaths of neonates (0-28 days) across Lambeth and Southwark, whilst similarly CDOP meetings review deaths of children (aged 1 month – 18 years) also from both boroughs.
- The CDOP and NDOP meetings have been administered by Southwark Council since its inception in 2008 and has been chaired by the Public Health team since 2012.
- Beginning 2019 these panel meetings will also review deaths of children normally resident in the London Borough of Bromley.

References

1. Child Death Review: Statutory and Operational Guidance. 2018.
2. Child Death Overview Panels Programme. Annual Report 2016/17.
3. http://www.londonscb.gov.uk 2018.
4. Child Death Overview Panel Annual Report 2016/17

Improving the welfare of CYP in Lambeth and Southwark is at heart of the CDR process

THE LOCAL CHILD DEATH REVIEW PROCESS

CDOP/NDOP is expected to produce an annual report describing the local patterns and trends in child deaths and submit relevant statistics to the Department of Health.

- The annual report should include recommendations, actions that have been implemented and the impact of lessons learnt as a result of the CDR process.
- By aligning with national guidance and best practice, recommendations and actions should contribute to wider regional and national initiatives.

Recommendations and actions resulting from the Lambeth and Southwark CDOP and NDOP meetings are communicated to local and regional Safeguarding Children Boards.

- The Safeguarding Children Boards for Lambeth and Southwark are statutory partnerships responsible for coordinating and scrutinising local practice with the aim to improve safeguarding outcomes and the welfare of children and young people (CYP) in the area.
- The London Safeguarding Children Board seeks to enhance the safety and wellbeing of children in London by supporting regional organisations to fulfill statutory responsibilities for coordinating work and promoting child welfare.

References
1. Southwark and Lambeth Child Death Overview Panel Annual Report: 2016-17.

The child death review pathway in Lambeth and Southwark is a multi-layered, multi-agency process

THE LOCAL CHILD DEATH REVIEW PROCESS

Due to the complex nature of a child death, review meetings require a significant amount of investigation from a range of partners.

- The CDOP Single Point of Contact (SPOC) is integral to requesting and coordinating information from review partners.

A complete view of the child death review pathway for Lambeth and Southwark as of December 2018 is depicted in the following slide.

- Due to the amount of information that must be collected and corresponding procedures that must be followed, the length of time for case review (from death to case closing) at NDOP and CDOP usually ranges from 12 to 15 months.

Whilst the Statutory and Operational Guidance recommends holding CDRMs with professionals directly involved in the child's care or investigation prior to CDOP meetings, local capacity and logistical challenges have delayed implementation of this best practice.

- As of December 2018, routine child death review meetings with professionals directly involved in care usually occurred in the format of a Rapid Response Meeting (RRM), which is held for all unexpected deaths, or a Mortality and Morbidity (M&M) meeting.
- A series of regional meetings for relevant health professionals have been arranged for early 2019 to address logistical concerns and understand how to establish effective CDRMs.
- Partners are expected to establish plans for CDRMs by July 2019 with full implementation expected by September 2019.

References

1. Magnus, D. et. al. (2018) A service evaluation of a hospital child death review process to elucidate understanding of contributory factors to child mortality and inform practice in the English National Health Service

The majority of closed cases occurring in Lambeth and Southwark are expected deaths

THE LOCAL CASELOAD

As of December 2018, there are a total of 32 open cases in Lambeth and Southwark.

- Cases reviewed in full by CDOP and NDOP are deemed ‘closed’, and any remaining cases whereby additional information needs to be gathered or other processes have yet to be completed such as Inquests and Serious Case Reviews are classified as ‘open’.
- The panel has estimated that locally there will always be approximately 15 open cases per borough at any one time.
- In Lambeth, there are 5 open cases for neonates and 7 for children aged between 28 days and 18 years. In Southwark, there are 9 open cases for neonates and 11 for children aged between 28 days and 18 years.

Delays in information gathering from relevant partners is the primary reason for cases remaining open.

- Obtaining relevant documents from the key partners continues to cause delay, particularly for complex cases which may require investigation and liaison with multiple external agencies. However, allocated resources in recent years have improved the timeliness of case preparation and management.
- Examples of relevant documents necessary for discussion at panel meetings include a police investigation report, Rapid Response Meeting (RRM) minutes, Child Safeguarding Practice Review (CSPR) minutes and the Post Mortem (PM) report.

61% of the reviewed (closed) cases occurring between January 2016 – December 2018 have been expected deaths.

- An expected death is defined as a death that was expected or anticipated within 24 hours of the event.

References
1. Child Death Overview Panels Programme. Annual Report 2016/17.

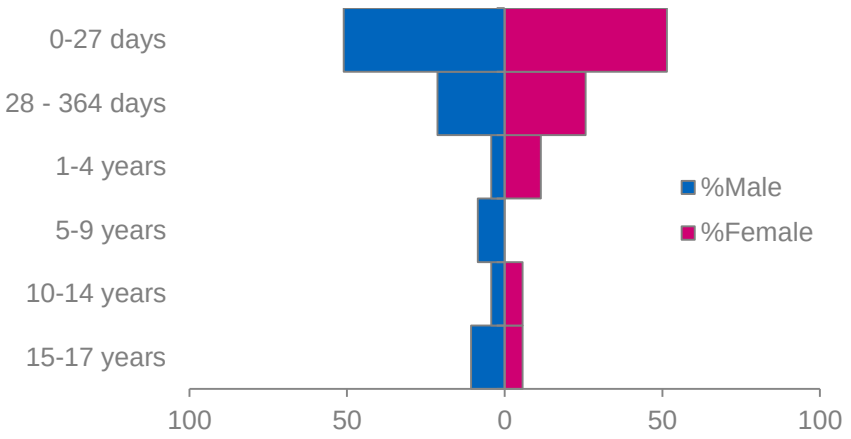
Infant death accounts for 75% of child deaths in Lambeth and Southwark

THE LOCAL CASELOAD: AGE & SEX

Expected deaths are much more common in neonates than in children aged between 28 days and 18 years.

- 37 of 43 (86%) neonatal deaths are expected, compared to 14 of 40 (35%) child deaths.
- The high prevalence of expected neonatal deaths suggests problems resulting from maternal and perinatal health, whereas child death is comparatively more often a result of unexpected events.

Figure 5: Percentage of child deaths by age, 2016 to 2018



Furthermore, a closer look reveals that there are stark differences in child death across age ranges as infant death (0-364 days) accounts for 75% of child death in Lambeth and Southwark.

- Neonatal (0-28 days) death, makes up approximately half (43 of 83) of all local cases.
- After the age of 1 year, child death is much more variable by age.

From aged 0 – 364 days, child deaths in Lambeth and Southwark are generally equally distributed across males and females.

- After 1 year old, there is no clear age-related trend or pattern based upon sex of the child.

The majority of cases in Lambeth and Southwark occur among children from minority ethnic groups

THE LOCAL CASELOAD: ETHNICITY

Analysis of ethnicity has traditionally been limited, as reporting agencies do not reliably use the categories from the Department for Education (DfE) Child Death Data Collection Form.

- There is significant uncertainty around whether reporting agencies directly ask families to state their ethnic background or draw conclusions from appearances or limitations with data collection by category.

Despite uncertainty around the accuracy of reporting, caseload data from January 2016 – December 2018 indicates approximately 70% of NDOP and CDOP cases are children from BAME backgrounds.

- Specifically, half of all cases occur among children from a black ethnic background.
- The prevalence of cases among minority ethnic groups is unsurprising as it reflects the ethnic diversity of the local population, yet the finding suggests there may be challenges related to awareness, access, use and provision of healthcare services and information.

Figure 6: NDOP cases by ethnicity for Lambeth & Southwark 2016 to 2018

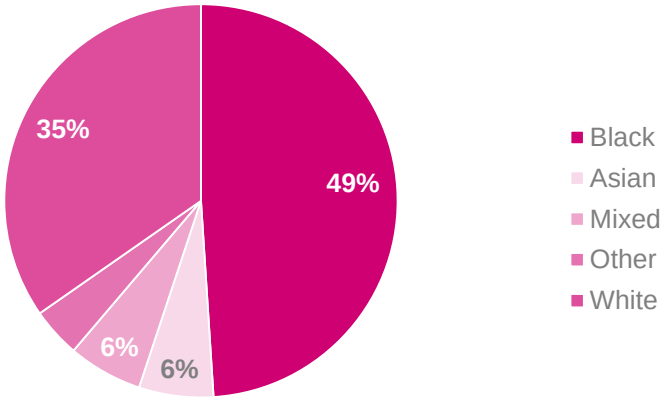
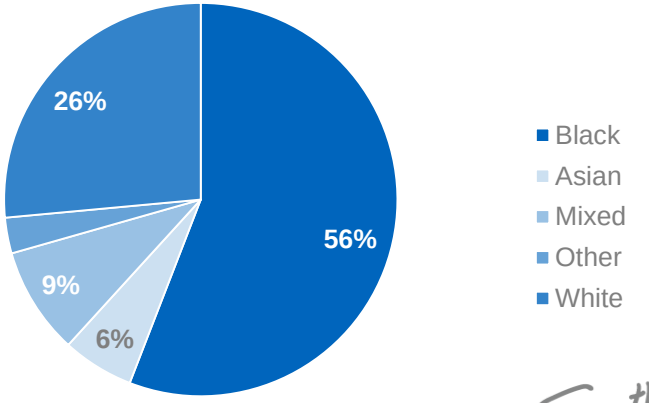


Figure 7: CDOP cases by ethnicity for Lambeth & Southwark 2016 to 2018



References

1. Child Death Review: Statutory and Operational Guidance. 2018.
2. Data Collection in the Field of Ethnicity. European Commission. 2017.

There is significant overlap in type of disability where disability is identified in a case

THE LOCAL CASELOAD: DISABILITY

Recording disability in CYP irrespective of any other diagnosis or syndrome is important for understanding equitable access, planning and use of health services.

- Disability is well-recorded in child death reporting and is categorised by learning disability, motor impairment, sensory impairment or other disability or impairment.

Disability (all cause) in CYP was identified in 18% (15 of 83) cases reviewed between January 2016 and December 2018.

- Only three cases were identified in neonates since disability, especially learning disability, can be difficult to identify in children younger than 4 years of age.

Most cases where disability was identified had more than one type of disability.

- Despite the high prevalence of multi-morbidity in cases where children were identified with a disability, only one case recorded poor parenting and another case found access to healthcare to be factors that may have contributed to the vulnerability, ill health or death of the child.
- This information suggests healthcare service provision and parenting capacity may not be a significant concern for this population.

The development of the LeDeR programme ensures factors relating to the death of children with learning disabilities are specifically considered within the context of this population

- This focus allows for lessons learnt to be translated into services for all persons with a learning disability where relevant

References
1. Child Death Review: Statutory and Operational Guidance. 2018.

The majority of neonatal deaths are due to perinatal / neonatal events, whereas child death is much more varied

THE LOCAL CASELOAD: CLASSIFICATION

Unsurprisingly, the majority (88%) of all neonatal deaths are due to perinatal / neonatal events, however the reason for expected and unexpected child deaths is much more varied.

- Whilst the caseload of neonatal death over the January 2016 – December 2018 time period was limited to categories 7, 8 and 9, at least one death occurred in each category for children aged over 28 days
- Further investigation into the perinatal / neonatal events could elucidate opportunities for intervention during pregnancy and the perinatal period to reduce neonatal death.
- Over one tenth of all cases were attributable to chromosomal, genetic and congenital anomalies. One of these cases involved consanguinity.

Sudden, unexpected unexplained death (category 10) accounts for approximately one fifth of the cases of child death (7 of 34) occurring over the January 2016 – December 2018 period.

- Of these cases, three involved unsafe sleeping practices.

Classification of Child Death

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

Almost half of all child deaths in Lambeth and Southwark happened in the home of normal residence

THE LOCAL CASELOAD: LOCATION

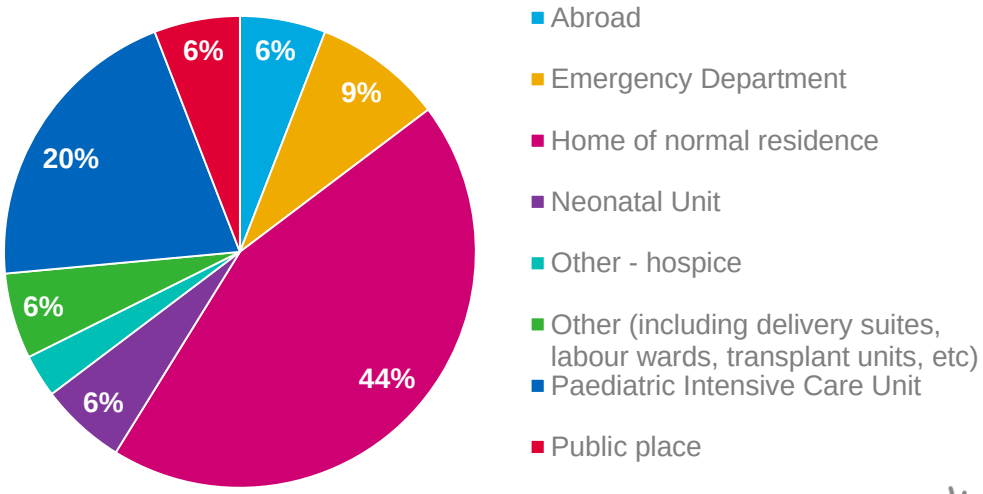
Although events leading to death often occur in locations that differ from the place of death, insight into the setting helps develop an understanding for the potential of any place-based interventions.

- Examples of traditional place-based interventions within the community include information around road safety and creating safe home environments.
- Place-based interventions in healthcare settings could consist of activation of certain clinical protocol pathways, ensuring best practice is implemented and increasing the quality of end-of-life care.

Whilst all neonatal deaths occur in the acute hospital, almost half (15 of 34) of all child deaths in Lambeth and Southwark between January 2016 – December 2018 were in the home of normal residence.

- Two thirds (10 of 15) of the cases where the child died at home were unexpected deaths.
- Furthermore, of these unexpected deaths in the home, 70% were found to have modifiable factors suggesting there may be further public health opportunities for intervention in the community involving parents and other frontline workers.

Figure 10: Place of death for children aged 28 days to 18 years in Lambeth and Southwark, 2016 to 2018



The home of usual residence for almost 60% of cases was located in areas of the highest deprivation in the borough

THE LOCAL CASELOAD: RESIDENCE

Housing, and more specifically living conditions, was identified in 10% (8 of 83) of cases as a factor that partially or wholly contributed to the vulnerability, ill health or death of the child.

- Extreme clutter, high tenant occupancy or overcrowding, and unreliable accommodation are examples of relevant housing concerns.

Children living on council-owned housing estates across Lambeth and Southwark accounted for over a third of reviewed cases (36%).

- Whilst not all child deaths occurred at the home of normal residence, the proportion of child deaths among neonates (38%) was slightly higher than for children (33%) living on housing estates.

Approximately 60% of all cases from January 2016 – December 2018 were among children living in the first and second highest quintiles for deprivation in Lambeth and Southwark.

- Similarly, when separated by age, the home of normal residence for 60% of NDOP cases and 55% of CDOP cases was located in the top two quintiles of deprivation.

Reflecting national evidence, local data demonstrates that children living in areas of deprivation have a higher likelihood of mortality than children living in more affluent communities.

- In addition to addressing the direct causes of death, it is imperative to take a public health approach and continue tackling inequalities across the wider determinants of health that impact wider upstream factors such as poverty and deprivation.

References
1. Wolfe, I. et al. UK Child Survival in a European Context. 2015.
2. Social Inequalities in the Leading Causes of Early Death. 2015.

A key area of focus during the child death review process is to identify modifiable factors

THE LOCAL CASELOAD: MODIFIABLE FACTORS

All child deaths are assessed to determine whether any factors surrounding the circumstances of the child's death could have been modifiable.

- Often expected deaths lack preventability, however all unexpected deaths should present modifiable factors, although sometimes this does not hold true for certain situations.

MODIFIABLE FACTORS: 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.

- Understanding preventability is vital when exploring public health opportunities to improve child welfare or prevent child injury or death, although guidance encourages a focus primarily on modifiable factors.

Identification of modifiable factors is a key outcome of CDOP and NDOP meetings, however it is unclear whether specific actions resulting from assessing preventability have had real impact in improving child welfare or preventing death.

- Furthermore it is unclear how lessons learnt are communicated to relevant stakeholder groups due to a lack of systematic information sharing.

A significant majority of NDOP cases (47 of 49) were found to have no modifiable factors.

- This finding is unsurprising given the high proportion of expected neonatal deaths locally, however, further investigation into maternal and perinatal health may shed light on preventability during and before pregnancy, potentially leading to identification of modifiable behaviours to prevent neonatal death.

In contrast, 45% of CDOP cases (15 of 33) had no modifiable factors.

- Whilst one local case of child death had inadequate information to determine preventability, the majority (17 of 33) of CDOP cases were found to have modifiable factors.

References

1. Southwark and Lambeth Child Death Overview Panel Annual Report: 2016-17.

Four main themes emerged where modifiable factors were identified in the local caseload

THE PICTURE IN LAMBETH AND SOUTHWARK

Four main themes emerged where modifiable factors were present in the local caseload:

1. Unsafe sleeping environments, a lack of bathing supervision and poor appointment adherence were the main reasons attributable to parenting.

- Although generally local families seem to have good engagement with the midwifery and health visiting services, shared caring responsibilities across generations can result in the dilution of key messages such as information around safe sleeping practices. Where multiple carers are identified, it is vital for these messages to be reinforced.

2. Improvements in service provision involving the transition and coordination of care and the integration of services for the child and their family were recurring modifiable factors.

- Understanding the consequences and wider impact of poorly coordinated care would help highlight the importance of service integration, however it is unclear if the results of such instances are communicated to providers.

3. Inadequate identification of signs indicating ill-health, sepsis and sexual assault surfaced in the local caseload.

- Refreshed training especially for frontline professionals would ensure these skills are maintained.

4. Socio-environmental factors including parental consanguinity and domestic violence combined with environmental threats such as second-hand smoke, road safety and housing issues also contributed to preventability in the local caseload.

- Public health messaging particularly involving services relating to wider determinants of health could further instill best practice around child health and safety.

Reporting inconsistencies and data collection delays are the main barriers impeding effective child death reviews

CHALLENGES

A number of regional challenges were identified by the London Child Death Overview Panel Chairs as pan-London issues, significantly limiting the wider sharing of learning obtained from child death reviews including:

- Variation in data collection and reporting
- Variation in CDOP practice and procedures
- Insufficient administrative resource
- Inconsistencies in definitions of factors relevant to child death by CDR partners
- Inadequate sharing of learning and recommendations

Although reporting on the Department of Health Child Death Data Collection Form facilitates an understanding of inequalities in child deaths by assessing for age, sex, disability and ethnicity, there is room for improvement.

- Unless specifically documented by a reporting agency, information around religion or belief, gender reassignment, sexual orientation, pregnancy and maternity and marital status is all not systematically recorded.

Locally, despite system improvements in data collection and partner notifications following the adoption of the electronic database 'eCDOP', system functionality is limited.

- Whilst eCDOP is not a requirement of the 2018 CDR Guidance, the National Child Mortality Database (NCMD) will link directly into the system beginning April 2019 to improve reporting at the national level.
- Timeliness of returning relevant documents from CDR partners continues to be a challenge resulting largely from a lack of capacity in teams externally.

References
1. Child Death Overview Panels Programme. Annual Report 2016/17.

CONTENTS

The Healthy London Partnership CDOP programme has provided regional support to facilitate best practice

THE RESPONSE IN LONDON

The HLP CDOP Programme Objectives:

Identify and prevent common / important causes of death:

1. Enable collaboration between CDOPs to improve epidemiological understanding of child deaths
2. Facilitate the analysis and reporting of common and/or important causes of death in children
3. Facilitate the identification and delivery of London-wide measures to tackle these causes

Improve services

1. Identify and reduce variation in CDOP Operational practices and outcomes across London
2. Improve CDOP processes to maximise efficiency, resource use and outcomes, including opportunities for regional or sub-regional collaborations and networks
3. Enable sharing of best practice between CDOPs across London
4. Coordinate the input of London CDOPs to the National Review of Child Death Processes, and facilitate changes resulting from national policy and guidance.

The Healthy London Partnership (HLP) CDOP Programme was established in 2016 to understand and address system-level concerns in the child death review process to prevent future child deaths

- The programme objectives were established to identify and prevent common / important causes of death and to improve services

The HLP works closely with and provides secretariat support for the London CDOP Chairs Group to facilitate close working with London CDOPs

- The CDOP chairs group supports the sharing of issues and best practice responses for London CDOPs

A series of themed workshops and seminars was designed to facilitate a culture of sharing and collaboration across the region

- The pan-London learning and sharing of best practice resulted in the collation of valuable resources including checklists, user guides, data sets and more.

The HLP CDOP Programme will continue to support area CDOPs at a regional level primarily with new legislation challenges

- HLP CDOP Programme support will be particularly valuable to local CDOPs during the transition to the new system involving CDRMs and key workers in 2019

References

1. Child Death Overview Panel Programme. Annual Report 2016/17.

The NCMD will enable further analysis, share lessons learnt and ensure actions are taken to reduce child mortality

NATIONAL CHILD MORTALITY DATABASE

The National Child Mortality Database (NCMD) was developed by the Healthcare Quality Improvement Partnership (HQIP) consisting of the University of Bristol, the University of Oxford, University College London and QES to be a national data repository for all children's deaths in England.

- The database aims to:
  - Enable more detailed analysis and interpretation of all data arising from the CDR process;
  - Ensure that lessons learnt following a child's death are widely shared;
  - Ensure actions are taken, locally and nationally, to reduce child mortality.

From 1 April 2019, all CDOPs in England will be required to provide data to the NCMD within 24 hours of receiving a notification of a child death.

- The electronic case management platform eCDOP will automatically transfer data from each CDOP to the NCMD when information is uploaded allowing for near-real time updates to the database.
- Whereas previously child death was commonly analysed by all-cause mortality rates, because 26 of 28 London CDOPs are already actively using eCDOP, information of this scale will facilitate a deeper understanding of regional trends, patterns and risk factors in child death previously unavailable in detail.
- Furthermore, regional data will allow for closer analysis of deaths by category and therefore provide greater insight into how to promote child health and welfare for specific circumstances.

The Healthy London Partnership has provided free usage of eCDOP to all London CDOPs through April 2020, however funding will need to be identified to continue using the electronic case management system.

- London CDOPs are expected to explain funding arrangements when submitting plans for implementing the new 2018 guidance.

References
1. Child Death Review: Statutory and Operational Guidance. 2018.
2. Healthy London Partnership: Information Pack: the new child death review requirements. 2019.

The CDOP Annual Report identifies key issues in child death and sets recommendations for the upcoming year

RECOMMENDATIONS FROM THE CDOP ANNUAL REPORT

The 2016-2017 Southwark and Lambeth CDOP Annual Report identified four main themes across the closed cases: Youth violence, asthma care, antenatal and new-born care and prematurity.

Five recommendations were developed to address these issues in 2017/2018.

- Good progress has already been achieved across both boroughs for the first three recommendations.

Recommendation 1: Adopt a public health approach to youth violence focusing on early intervention and prevention along the life course, with a focus on early years settings and schools.

- In Lambeth, the council is in the process of developing the borough's first 'Tackling Violence against Young People' strategy to take a public health approach to addressing the risk factors rooted in violence
- In Southwark, a youth violence JSNA is being developed to clarify and understand the determinants and causal pathway towards violence and identify opportunities for prevention using a public health approach.

Recommendation 2: The school nursing service should conduct an audit of healthcare plans to ensure children with long term conditions are supported at school.

- The re-commissioning of the school nursing service across Lambeth and Southwark is intended to incorporate this into the service requirement.

Recommendation 3: The Southwark and Lambeth CCGs should ensure that recommendations from the 2014 National Review of Asthma Deaths have been fully implemented locally.

- In addition to reinforcement from CCG partners, the Children and Young People's Health Partnership (CYPHP) has developed an Asthma Health Check to provide information and support resources to help asthma management and care in children aged 0-15 years.
- Southwark Public Health will also produce a JSNA on Asthma to ensure recommendations from the national review are targeted locally and to establish clear recommendations for further action.

References
1. Southwark and Lambeth Child Death Overview Panel Annual Report, 2016/17.
2. Tackling Violence against Young People: First Steps. 2018.

There is a clear need to address issues relating to neonatal and infant death

RECOMMENDATIONS FROM THE CDOP ANNUAL REPORT

Recommendations 4 and 5 reflect trends highlighted in the aggregate caseload from January 2016 – December 2018.

- Although the low number of deaths reviewed in a single fiscal year limits an accurate statistical interpretation or robust analysis of trends in an annual report, the identified issues parallel findings from the wider caseload.

Recommendation 4: Public Health should work with partners to improve the quality and continuity of antenatal and new-born care through closer working and integration of services involved.

- Communication between antenatal healthcare services was highlighted as a primary opportunity for improvement.
- The introduction of the CDRMs has the potential to facilitate conversation and coordinated care among health professionals by requiring all relevant stakeholders to review quality and care pathways for each case.
- Already both major NHS Foundation Trusts serving Lambeth and Southwark, Evelina London Children's Hospital (GSTT) and Kings College Hospital, are developing plans to implement CDRMs into the child death review process.

Recommendation 5: Public Health should look at the causes, risk factors, and effective interventions to prevent premature births to inform a work stream focusing on improving outcomes for babies born prematurely.

- A better understanding of the risks and vulnerabilities during the perinatal period could help prevent premature births and improve outcomes for infants.
- Improved communication and continuity of care would enable effective intervention to be implemented such that neonatal and infant deaths are reduced.

References
1. Southwark and Lambeth Child Death Overview Panel Annual Report, 2016/17.

There is an opportunity to integrate learning from CDOP into wider public health initiatives

THE PUBLIC HEALTH RESPONSE

In accordance with CDOP guidance, actions and learning identified in panel meetings from the review of each local case should be translated into practice where possible.

- Locally, however, understanding the impact of actions and information sharing has been limited due in large part to low capacity and a lack of systematic reporting.

There is a strong interest in linking the CDOP process with wider public health initiatives.

- A policy officer role within the Southwark Public Health team was created to identify opportunities for sharing learning and engaging different teams to improve service delivery based on CDOP reviews.

The data collected from case reviews has the potential to supplement local public health priorities.

- By demonstrating the consequences of potentially modifiable factors such as smoking, housing issues, poor parenting and integration of healthcare services, the lessons learnt from CDOP case reviews could improve child welfare and potentially prevent death through a proactive rather than reactive manner.

There are several opportunities to share learning from CDOP to ensure information is disseminated beyond panel members.

- CCG communications, local acute trust newsletters and safeguarding board meetings are a few outlets where both aggregate caseload statistics and anonymised case reviews could extend the lessons learnt from the child death review process.

Evidence-based policy underpins public health initiatives, and isolated instances make it challenging to justify change for a population level benefit. The review of the aggregate caseload combined with comprehensive scrutiny for individual cases, however, is a powerful mechanism to inform interventions to promote child health.

CONTENTS

New guidance will streamline some but not all local child death review processes

COMMUNITY & STAKEHOLDER VIEWS

Whilst this review was predominantly desktop-based, consultation with the local designated doctors for child death in the community and key stakeholders highlighted challenges that could be improved with implementation of the 2018 guidance.

- Locally, dedicated bereavement personnel in the clinical settings are extremely stretched. Assignment of a key worker as proposed by the 2018 guidance could alleviate the pressure and extend staff awareness of bereavement services more generally.
- Children who die in a public places are not routinely brought to A&E because of involvement in a crime scene or they are sent directly to a mortuary. New guidance clarifies all children should be brought to A&E unless otherwise arranged with palliative or hospice care.

Other wider system inconsistencies revealed significant variability in the practice following a child death.

- Despite the recognised value in sharing relevant information for CDOP meetings, resource limitations mean some clinical personnel do not have time or the correct training to input information. Additional dedicated administrative support could improve the timeliness of returned documents.
- Variability in sampling by pathologists can result in the loss of potentially valuable information that is extremely time specific. Consistency or established protocol would ensure relevant cultures are obtained correctly and routinely.

The purpose and impact of CDOP can sometimes get lost in the detail of closing cases.

- Routinely shared learning following each CDOP meeting via a newsletter or relevant outlets could extend learning beyond the panel members to various members of the acute trusts, public health and community and reinforce best practice and learning.

CONTENTS

The CDR process is valued by local stakeholders but lacks measurable impact in child protection

THE EVIDENCE BASE

Historically, stakeholders have felt reviews conducted by CDOP have provided meaningful learning, however there are opportunities for improvement through enhanced data collection and analysis at the national level.

- A call for a population-level approach to analysing child deaths was also recommended in the 2016 Wood Review investigating the CDR process as a function of Local Safeguarding Children's Boards.

Already data from CDOP meetings has proven valuable in identifying key issues and recognising trends, yet local evidence shows the potential to mitigate threats and share lessons learnt is not realised in practice.

- Despite the labour-intensive process of collecting data and conducting reviews, it is unclear whether findings led to further investigation or changes in policy as a response.
- Furthermore, research shows in-hospital Mortality and Morbidity (M&M) meetings have demonstrated limited impact in improving patient outcomes.

Best practice set forth by the 2018 guidance addresses several shortcomings previously identified with the CDR process, but gaps remain.

- Sharing of background information, delays in processing, public health involvement and improvements of data collection were identified as areas for improvements, some of which have already been addressed and integrated into CDR processes.
- Introduction of the NCMD in conjunction with eCDOP is a positive step toward addressing this limitation of the current reporting processes and meets recommendations first outlined in the 2016 Wood Review.
- Guidance continues to lack clarity around how recommendations are implemented in practice and what determines success.

References

1. Munro E. (2011) Department of Education: The Munro Review of Child Protection, Final Report.
2. Fraser, J. (2016) The morbidity and mortality meeting: time for a different approach?
3. Firth, C. et al. (2018) Infant deaths from congenital anomalies: novel use of Child Death Overview Panel data
4. Mazzola, F. (2013) How useful are child death reviews: a local area's perspective

CONTENTS

2018 CDR guidance will help develop processes and share learning

SUMMARY & KEY FINDINGS

This needs assessment analysed the caseload of Lambeth and Southwark child deaths occurring between January 2016 – December 2018 to identify core themes in local child death.

- This is the first time a multi-year, in-depth analysis has been conducted across both boroughs.
- Whilst there is significant value obtained in understanding local risks for an aggregate caseload, it is equally important to recognise the circumstances leading to any case of child death, even when trends or patterns are not presented, to promote child welfare whenever possible.
- Furthermore, because this review only investigated cases resulting in death, it is worth noting similar circumstances may lead to accident, injury or harm, and therefore add additional value for child welfare

Whilst the current CDR process effectively investigates factors intrinsic to the child, the child's physical and social environments, and the healthcare service provision, the lessons learnt must be shared with stakeholders beyond the CDOP panel.

- Due to the complexity of how these factors interact, a multiagency response is essential to translate the findings from information into intervention so that all public health initiatives can support child health.

Nationally and locally there are effective policies in place to improve the child death review process according to best practice.

- There is great potential for learning and a greater understanding of child death through a national database, and the introduction of the CDRMs will likely facilitate communication and learning among providers to promote the coordination of care and integration of services.
- Whilst the 2018 CDR guidance helps to standardise national practice, enable local thematic learning, and make recommendations for improvements in service delivery, existing challenges in resource capacity and logistical arrangements may impede implementation, and therefore the true impact of new procedures may not be realised for some time.

Locally, the coordination of care, social determinants and perinatal health are significant factors in child death

SUMMARY & KEY FINDINGS

The vast majority of deaths in Lambeth and Southwark occur in children aged 0-27 days.

- Since the majority of the local caseload consists of expected neonatal deaths, it suggests problems resulting from maternal and perinatal health, whereas child death is comparatively more often a result of unexpected events.

More than half of all cases of child death in Lambeth and Southwark are children of minority ethnic backgrounds and children living in areas of high deprivation.

- The historical caseload reflects the local demographic and reinforces the need to address disparities in the wider determinants of health.

Disability was identified in 18% (15 of 83) of cases reviewed between January 2016 – December 2018.

- Most cases where disability was identified had more than one type of disability, however healthcare service provision and parenting capacity may not be a significant concern for this population.

A significant majority of NDOP cases (47 of 49) were found to have no modifiable factors, yet the majority (17 of 33) of CDOP cases were found to have modifiable factors.

- In the local caseload, the main themes that emerged where modifiable factors were present included issues relating to poor parenting, inadequate service provision, inadequate identification of risk factors, and other social and environmental threats.
- There is potential for further public health intervention through place-based initiatives both in the community to address the high prevalence of unexpected deaths occurring in the home, and in healthcare settings through evidence-based practice for protocols and coordination of care.

The CDR process presents opportunities for further integrated work and information sharing

RECOMMENDATIONS & NEXT STEPS

Following this thematic review of historical cases, the following recommendations have been proposed:

Recommendation	Actions
Recommendation 1: Systematise information sharing and lessons learnt following CDOP meetings and disseminate findings with colleagues beyond panel members	▪ Connect with local outlets for information sharing including GP newsletters, CCG communications, local safeguarding newsletters etc. ▪ Information should also be regularly communicated with the local public health teams to ensure CDR findings provide evidence for public health initiatives addressing inequalities and wider determinants of health
Recommendation 2: Investigate the causes, risk factors and effective interventions to prevent premature births and ensure quality and continuity of care through the antenatal pathway	▪ Conduct a maternal health and perinatal Joint Strategic Needs Assessment to inform evidence-based recommendations and promote neonatal and infant health
Recommendation 3: Continue to collaborate and link in with national and regional initiatives to ensure a culture of sharing and collaboration is maintained	▪ Continue engaging with panels across London and nationally through the Healthy London Partnership CDOP network ▪ Maximise opportunities with the NCMD as a key resource for data and analysis when fully functional

The Public Health Policy Officer for CDOP shall oversee the implementation of recommendations under the guidance of the CDOP Chair for Lambeth and Southwark

- The efficacy and impact of these recommendations should be reported in the 2020 CDOP Annual Report

Find out more at
southwark.gov.uk/JSNA

Public Health Division

Place and Wellbeing Department