SOUTH-WEST LONDON CHILD DEATH OVERVIEW PANEL

Annual Report
April 2020 – March 2021

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

Lorraine Beckford, CDOP Senior Manager South-West London Clinical Commissioning Partnership
lorraine.beckford@swlondon.nhs.uk

Table of Contents

Chapter 1: Executive Summary

1.1. Purpose ……………………………………………………………………………………3

1.2 Statutory framework and governance …………………………………………………4

Chapter 2: Operational Overview

2.1. Membership………………………………………………………………………………… 5

2.2. Overview of SW London Child Death Review Panel Cases………………………………...7

2.3. Child Death Overview Panel Reviews…………………………………………………… 8

2.4 Aims of the SW London Child Death Overview Panel…………………………………… 9

2.5 Child death Review Meetings…………………… ……………………………………… 10

2.6. SW London eCDOP Database…………………………………………………………... 11

2.7 Timing of Reviews……………………………………………………………………….. 11

Chapter 3: Commentary on case activity 2020-21

3.1 Modifiable/Non modifiable child deaths ……………………………………………… 12

3.2 SUDI's (Sudden Unexpected Death in an Infant)………………………………………... 13

3.3 Neonatal child deaths…………………………………………………………………13-14

3.5 Joint Agency Review Meetings…………………………………………………………... 15

3.6 Post-mortem Reports……………………………………………………………………. 16

3.7 Coroners Inquests………………………………………………………………………. 16

3.9 Serious Case/Learning Reviews………………………………………………………… 16

3.10 Children with Disabilities……………………………………………………………… 16

3.11 Commentary on deaths – location ……………………………………………………. 17

Chapter 4: Statistical Overview: Analysis of Child Deaths 2019-20

4.1. Completed Child Death Reviews by Category of Death……………………………… 18

4.2 Generic Themes from completed reviews……………………………………… 19 - 21

4.3 Completed Reviews by Child's age……………………………………………………… 22

4.4 Gender……………………………………………………………………………………. 22

4.5 Ethnicity…………………………………………………………………………………… 23

4.6 Asylum Status……………………………………………………………………………. 23

4.7 Factors in the Child……………………………………………………………………… 23

4.8. Factors in the family and environment………………………………………………… 25

4.9. Factors in Service Provision…………………………………………………………… 26

4.10 Bereavement……………………………………………………….……………………. 26

4.11 Parent's and carers feedback to the Child Death Overview Panel………………..……. 27

Chapter 5 Learning from Child Death Reviews

5.1 Learning Themes and Recommendations …………………………………………..…… 28

5.2 Promotion in Community Education ………………………………………………...… 29

5.3 Improvements in organisational practice……………………….……………………… 30

5.4 Educating / Training /Communication: Local Partner agencies…………………….30-31

5.5 Influencing Policy and Legislation……………………………………...……… …… 32

Chapter 6 Moving Forward 2021 – 2022

6.1 Plan………………………………………………………………………….………... 33

6.2 Goals for next Reporting year 2021-22………………………………………………... 33

Summary…………………………………………………………………………….……34

Appendix 1

Statutory and Regulatory legislation ……………………………………………………….. 35

Acknowledgements

Thanks to the SW London Child Death Overview Panel comprising Local Coordinators, (SPOCs) 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, for their efforts in panel review contributions, information gathering, research and collation of statistical data which are essential components of this report.

On behalf of the panel, many thanks to the Director of Nursing Leadership & Quality, Regional Lead for Safeguarding (London) from NHS England for her assistance and support covering the role of the Chair due to the redeployment of Public Health leads during the NHS response to the COVID 19 Pandemic to continue operational management of child death reviews during the reporting year 2020-21.

Chapter ONE:

INTRODUCTION

1. Executive Summary

This is the second report of the South-West London Child Death Overview Panel

The SW 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.

The Child Death Review process is an 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.

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. 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 , and will 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.

This report explores the statistical and qualitative conclusions from the Child Death Overview Panel Reviews in SW London during the reporting year April 2020 to March 2021.

1.1 Purpose

The SW London Child Death Overview panel is a multi-agency panel set up to conduct the independent scrutiny on behalf of the local Child Death Review partners on the reviews of deaths of children normally resident in SW London, and if appropriate and agreed with Child Death Review Partners, deaths of non-resident children who die in SW London, 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:-

(a) to identify any matters of concern affecting the safety and welfare of children relating to the death or deaths,

(b) to consider any actions or recommendations that can be taken based on a death, or a pattern of deaths to identify trends that require a multidisciplinary response.

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.

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 Local Safeguarding Childrens 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 terms of reference for the administration and logistical processes for child death reviews in 2019-20 which has continued in 2020-2021. All six south West London boroughs are represented on the Panel.

The core membership and representation of the SW London Child Death Overview Panel has been affected by re-deployment of the Public Health Chairs, due to the national response to the COVID 19 Pandemic. The Panel has operated without representation from Public Health during this reporting year. The panel continues to meet monthly. Meetings were suspended for two months due to the national health response to the Covid 19 Pandemic in April and May 2020 and resumed meetings online in June 2020 to date.

The status of key membership roles are as follows.

- The role of the Chair, which was formerly held by Public Health as Chair continues to be filled by interim representation from NHS England which will end in July 2021. The role of the Independent Chair is now in the process of recruitment and appointment will follow shortly.
- Consultant Paediatricians, Designated Doctors for Child Deaths: Two Designated Doctors (Kingston/Richmond, Croydon) are active members of the Panel . There are two vacancies for this role that remain unfilled to date.
- Children's Social Care representatives: all boroughs are represented.
- Metropolitan Police / Child Abuse Investigation Team (CAIT) covering SW London : all boroughs are represented.
- Designated Nurses for Safeguarding Children :all boroughs are represented.

- Midwifery Risk and Bereavement Midwives: all four acute Hospitals in SW London are represented.
- Single point of Contact CDOP Panel Coordinators and SWL Senior Manager across SW London : all boroughs are represented.

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, Neonatology, Community Nursing, and Mental Health have attended meetings to contribute to case reviews . A Director of Quality has been in regular attendance to represent the Quality and Commissioning aspects of the regional partnership that is in place. Other agencies, such as Education and National Clinical Agencies are asked to contribute an advisory capacity as the need arises.

It is proposed that future arrangements for meetings will include as follows: -

- An independent Chair is being recruited to chair Panel meetings for an agreed term across SW London for a period of two years
- That as working arrangements return to normal as COVID 19 restrictions improve, Independent Public Health representation will re-join active membership to the panel.
- Representation by Neonatology/Obstetrics) will be identified to expand the resource of multi-borough Neonatal/Perinatal clinical contribution of panel reviews.
- The financial resource to cover Independent Chairmanship, and Lay Membership of the Panel is to be identified.
- Provision will be made for ad hoc or extraordinary meetings as required based on caseload and complexity of cases

For the reporting year 2020-21, The arrangements for management of CDOP operation continued to follow 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.

During 2020-21, A rota system was implemented to ensure all agencies were represented at panel meetings, to facilitate efficient use of meeting time for membership. Representatives from agencies such as the Police, Designated Safeguarding Nursing, Social Care and Midwifery have nominated two delegates each month to join the meetings to ensure all agencies are represented and meetings are quorate.

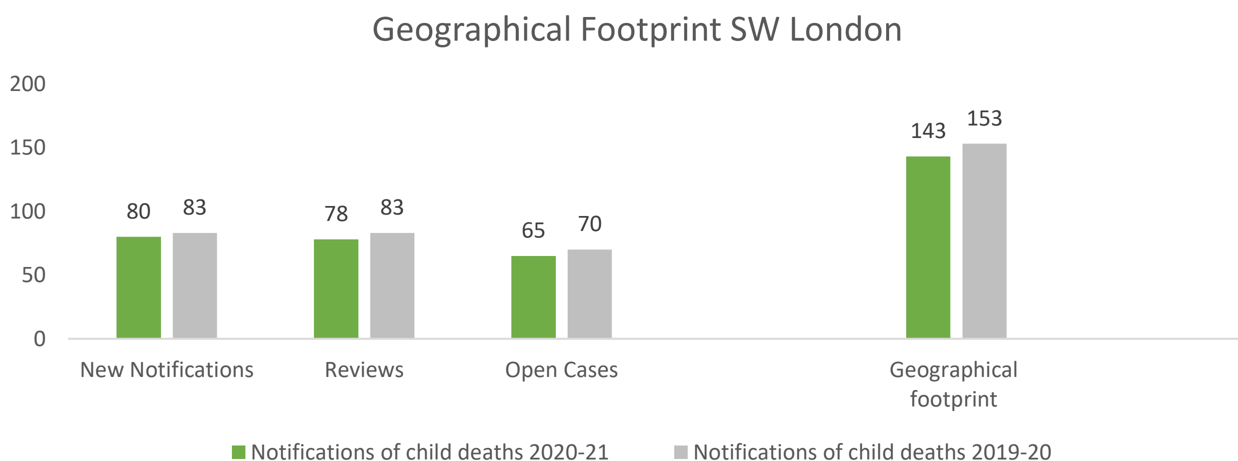
The organisation of the CDOP is shared by the Single Points of Contact (SPOCs) for each area at the Child Death Review meeting level, supported by a Manager for the SWLondon Child Death Overview Panel. The SPOC's have facilitated a cross-cover of each other's borough notifications by coordinated use of eCDOP software and greater information sharing of case files that involve two boroughs. SWL Coordinators have been instrumental in improvement of joint borough participation in Child Death Review Meetings.

From an operational standpoint the joint working arrangements are working well.

2.2. Summary of SW London Child Death Overview Panel Caseload 2020-21

The geographical footprint is an accumulation of new notifications during the year, reviews of existing cases and cases that remain open to the end of the reporting year. In 2020-21 there were 80 new notifications of child death, similar to 83 for 2019-20. There were 78 Child death Reviews. As of 1st April 2021, there were 65 open cases creating a geographical footprint of 143 cases. Comparatively, in 2019-20, there were 83 notifications of death, and 83 child death reviews. As of 1st April 2020, there were 70 open cases remaining making a total of 153 cases recorded on the SW London Child Death Overview Panel database.

Graph 1.



2.3 Aims of the SW London Child Death Overview Panel

The objectives of the SW London Child Death Overview Panel are to independently review the findings of the child death review meetings 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 Meetings, to confirm or clarify the cause of death, with robust scrutiny to provide other perspectives in determining 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, to contribute to the improvement of agency responses to child deaths, to protect siblings and to promote targeted bereavement support.

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.

7. To advocate for local, regional, and national changes in policy, legislation, and practices to prevent future child deaths.

2.4 Child Death Review Meetings

The SW 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).

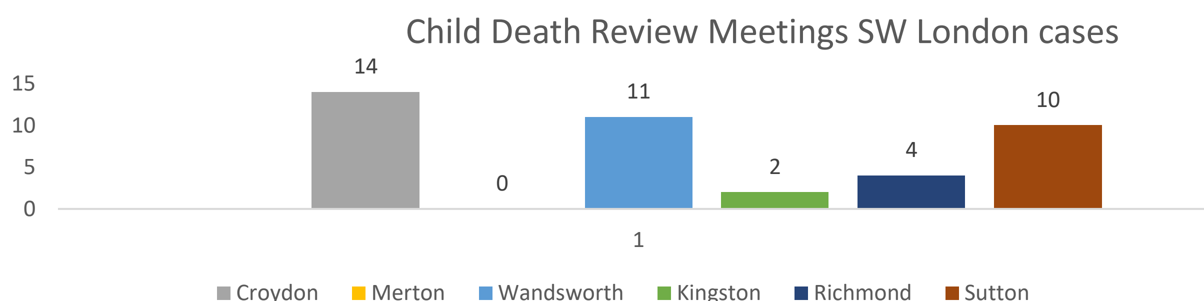
The meetings are attended by professionals who were directly involved in the care of the child during their life, and any professional involved in the review of their death.

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.

To date, 41 local Child Death Review Meetings were completed for SW London cases in 2020-21. An additional 24 reviews were completed by specialist hospitals for SW London cases or completed by local hospitals for out of borough cases. This is more than four times the amount completed for the year 2019-20 at 14. This shows the substantial increase in the clinical workload due to the addition of this meeting at hospitals as part of the new working arrangements for child death reviews.

Graph 2



2.5. SW London eCDOP Database

The eCDOP system is being used across England and feeds into the National Child Mortality database. The eCDOP Database management with Quality Education Systems continues to be used for meaningful data collection, consolidation, and analysis of data from panel reviews. The annual contract was renewed for the financial year April 2021 to March 2022. The use of eCDOP has been referred to the London Chairs Meetings to consider London-wide negotiation of the contractual arrangements in the future.

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.

A discussion is underway at a London CDOP Chairs Panel level for improved redesign of the software to improve efficiency in meeting interactions . The improvements proposed for the reporting year 2021-22 being advocated include:-

(a) Software improvements to facilitate joint Child Death Review meetings between Tier 3 and Tier 2 Hospitals, and joint access to case files by Single points of Contact when two boroughs are working on one case at Child Death Review Meeting level.

(b) Software improvements to facilitate joint borough Child Death and Perinatal Mortality Review meetings to reduce the need for two meetings to one.

(c) Software improvements to improve the quality and content of transferred information between forms.

2.6 Timing of Reviews

During the 2020-21, 26 cases representing one third (33%) of all reviews were completed in the six months completion requirement which is an improvement on the previous year. However, delayed Inquests and Serious Incident (SI) investigations which were suspended for a few months as a result of the COVID 19 pandemic, delayed conclusion of reviews. These investigations are independent processes and are required to conduct and complete Child Death Reviews. Nationally, 29% of reviews were completed in 6 months.

Across SW London, the average time taken for 52 cases which is two thirds (66%) of the current caseload of 78 cases was 317 days which was slightly longer than last years' overall assessment of 270 days. Nationally, 38% percent of reviews were completed in 365 days with 33% reviews taking more than 12 months to completion totalling 50% . [1]

2.7 Out of Area Notifications

In 2020-21, Hospitals in SW London notified other boroughs of 34 child deaths across London which is a reduction by 16 deaths of last year's notifications of 47 deaths. A total of 17 notifications, were received from other boroughs beyond SWL CDOP area for SW London child deaths . This was a reduction by 10 deaths from 27 deaths reported last year. One notification was received from abroad for SW London for this reporting year.

[1] NCMD Report y/e 31.03.2020 Table 3: Time between the death of a child and the completion of the CDOP review

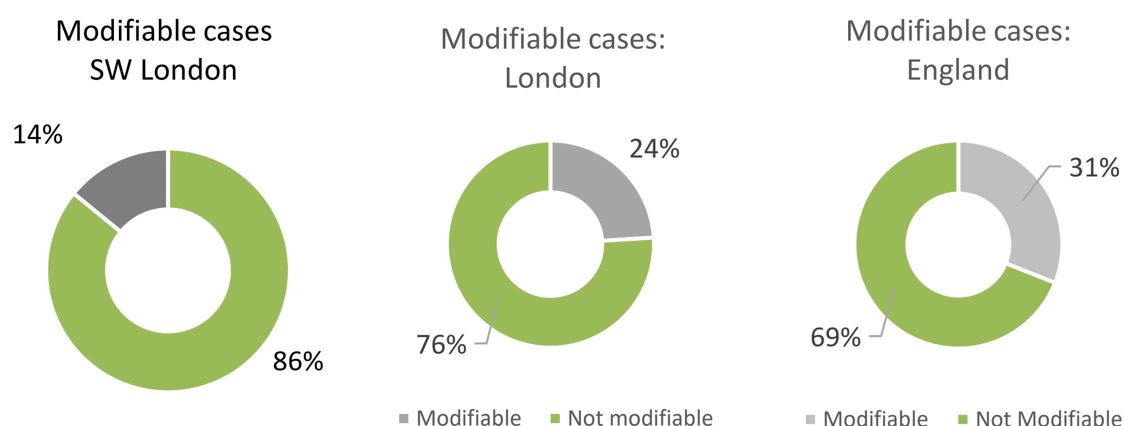
CHAPTER 3

COMMENTARY ON CASE ACTIVITY 2020-21

3.1 No modifiable Factors

"No Modifiable Factors" is selected when: "The CDR meeting have not identified any potentially modifiable factors in relation to this death". Chronic illness, prematurity, and life limiting conditions account for a large proportion of child deaths. The death of a child with a life limiting condition is managed as any other unexpected death, to determine the cause of death and any contributory factors.

For clarity, the deaths that are reviewed in this reporting year do not always coincide with the year of notification, due to delays in post-mortems, inquests and other medical or legal investigations.



In 2020-21, 84% of child deaths in SW London had no modifiable concerns which is a slight improvement on 74% per cent of child deaths during the 2019-20 reporting year.

3.2. Modifiable factors

"Modifiable Factors" is selected when: "The CDR or CDOP 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"

In SW London, 14% of reviewed cases had modifiable concerns. This is a slight improvement to 18% of reviewed cases that had modifiable concerns last year. This compares favourably to the National Child Mortality Database statistics for London at 24% and England with an average of 30% of modifiable concerns noted in child death reviews.

3.3 SUDI/C (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 eight per cent (8%) in 2020-21 which was a slight increase on seven per cent (7%) of deaths in 2019-20. More information is provided in chapter 4 analysis of the report.

3.4. Neonatal child deaths

Neonatal / Perinatal child deaths are the largest category in SW London. Thirty-two per cent (32%) of perinatal/neonatal child deaths as agreed from the analysis form were reviewed in 2020-21. Comparatively, In England, 63% of perinatal/Neonatal child deaths were reviewed in 2020-21 [2]

3.4.1 Themed Reviews: Perinatal/Neonatal Child Deaths

As part of the new working arrangements for child death reviews, periodical themed reviews are conducted for analysis of local indicators using a larger number of child deaths in a specific category. For an effective and measurable Child Death Overview Panel process, the objective of themed reviews are as follows:-

I. To identify trends in child deaths in the SW London area, by conducting reviews involving specialists on specific issues, such as Perinatal/Neonatal events.

II. 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.

III. Define measures of effectiveness arising from implementation of actions from recommendations made from child death reviews.

[2] NCMD 2nd Annual Report see appendix for link.

In October 2020, the SW London Panel conducted a themed review on the category of Perinatal/Neonatal child deaths. The meeting had representation from Neonatology and Obstetrics, SW London Commissioning, A medical examiner,(which is a new role now at all local hospitals as an integral part of child death reviews,) Clinical Leads and Regional GP Leads on the subject of Perinatal / Neonatal events.

Data was shared on analysis from reviewed child deaths in this this category from the 2019-20 reporting year. It was noted the emphasis of the Saving Lives Bundle is to reduce pre-term births. The importance of flagging anomalies identified antenatally was reiterated for decisions to be taken to mitigate risks or escalation to specialists best placed to address these issues. The questions raised at the themed review based on analysis of perinatal/neonatal child deaths from the 2019-20 annual report were as follows:-

1: There were no child deaths between 28 – 35 weeks gestation:-

Neonatology confirmed that this not an unusual developmental occurrence in antenatal observations in child deaths and stillbirths below 27 weeks gestation. For older babies, survival rates incrementally improve with lower rates of loss at 38 – 40 weeks gestation.

2: Significance of 43% of child deaths in ethnic minorities in SW London in 2019-20

It was agreed that while the statistic given is proportionally significant, each hospital should review their own child deaths involving ethnic minorities over a specified period to establish the reason for poor outcomes in pregnancy, utilising the results to inform local service development and pathways of care.

3. Antenatal flagging of mental health issues in expectant mothers:

It was noted that in the 'Saving Babies Care Bundle 2' report,[3] mental health issues have been flagged as a reason for poor outcomes, in stillbirth and pre-term births. It was confirmed that discussions were underway in SW London to arrange a package of mental health support for mothers in antenatal/postnatal care.

4. How learning and recommendations should be cascaded.

---

[3] https://www.england.nhs.uk/wp-content/uploads/2019/03/Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-Final-Version.pdf

It was recommended that a method of sharing information be agreed between Midwifery, Neonatology and Obstetrics that would not wait on an annual report but would be shared periodically arising from interim reporting on child reviews. This is to target specific areas for review to implement faster responses to learning and recommendations, or to provide assurance that systems and procedures are in place.

More information on this category of deaths is in chapter 4 of this report.

3.5 Joint Agency Response

A Joint Agency Response is a coordinated multi-agency response which is triggered if a child's death:-

• is or could be due to external causes.

• 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,

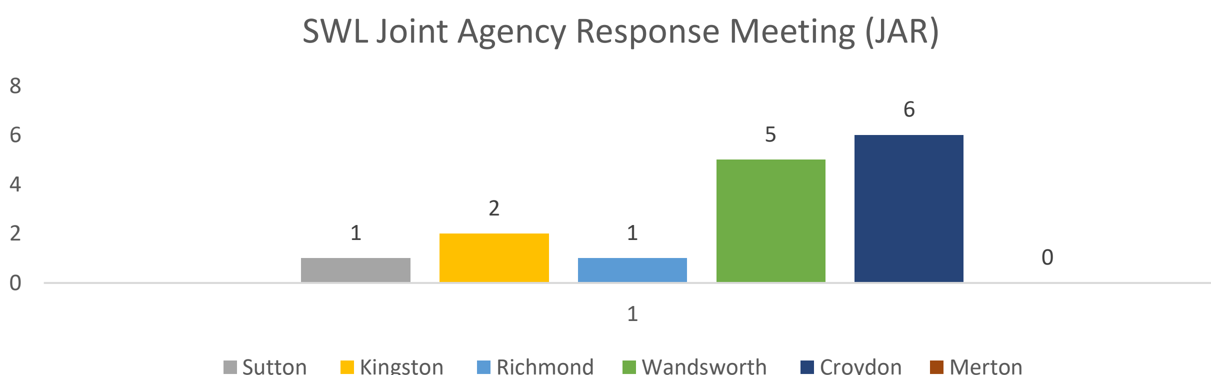
• where the initial circumstances raise any suspicions that the death may not have been natural; or

• in the case of a stillbirth where no healthcare professional was in attendance.

For deaths notified across SW London during the 2020 - 21 reporting year, fifteen Joint Agency Response (JAR) meetings were initiated for local SW London cases. In addition, thirteen Joint Agency Responses were held out of area for SW London boroughs, or local Hospitals held JAR's for out of area CDOP boroughs.

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

Graph 3



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 19% of child deaths had Post-mortem reports completed, of which all reports provided sufficient information to confirm the cause of death without further investigations. This is a reduction on the 30% cases subject to post-mortem reports last year.

3.7. Coroners Inquests

Coroners are independent judicial officers, responsible for investigation of violent, unnatural, or sudden deaths of an unknown cause. Fifteen percent (15%) of deaths were subject to Inquests to agree on the cause of death. Last year statistic was similar at 13%.

3.8. Safeguarding Practice Reviews

In 2020-21, one child death was the subject of a Child Safeguarding Practice review. This was in the category of suicide/self-harm case and was a child in need. Learning difficulties, self - perception concerns, non-engagement with mental health services, sleep disorders, and drug misuse were issues raised in the reviews. The review concluded the structure of the service provision generally for 16-18-year-old young people does not consistently fit the needs of this cohort.

A significant theme identified by the SPR, was that when children who are receiving SEN support, under a needs' assessment or health plan, a review by the SEND partnership should take place to address the issues holistically before decisions are taken. Nationally, 2% of cases were subject to safeguarding practice reviews in 2019-20.[4]

3.9. Children with Disabilities

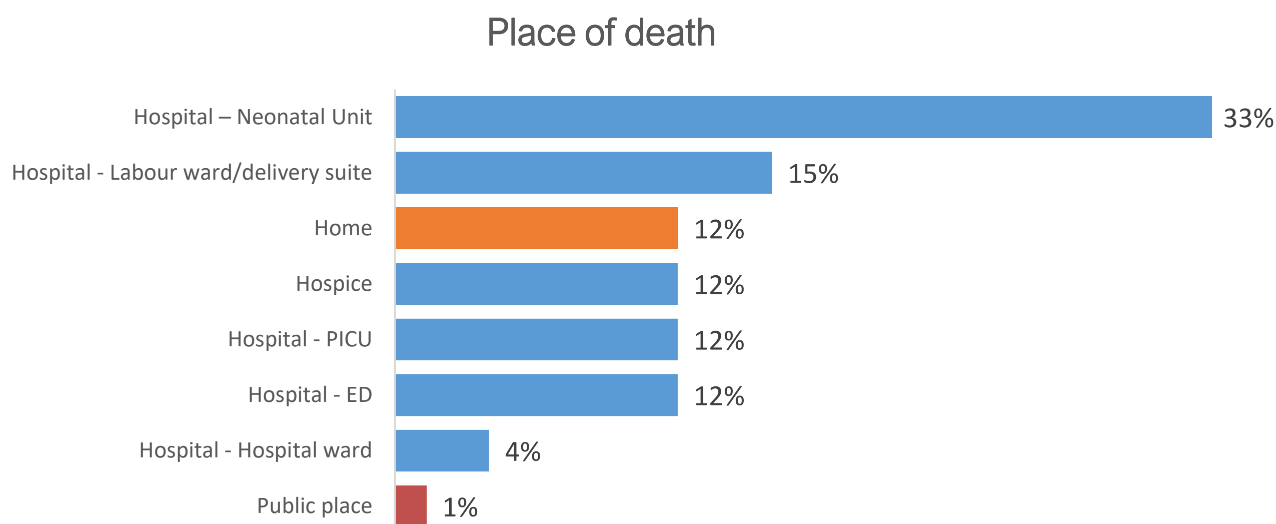
The Learning Disabilities Mortality Review (LeDeR) programme is a review process for the deaths of people aged 4 years and over with learning disabilities in England. The Child Death Review process is the primary review process for children with learning disabilities. During this reporting year, four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

[4] NCMD 2nd Annual Report for 2019-20 published June 2021. See appendix for link.

reviews. In two cases there was learning on the commissioning of, and access to therapies and education support in the community for school age children, who are unable to attend school for an extended period due to illness.

3.10. Commentary on deaths – location

Graph 5



Eighty-Seven percent (87%) of child deaths were confirmed in a clinical environment of which twelve percent (12%) 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. Twelve percent respectively were children who died at Hospices or at home. Nationally, 78% of child deaths occurred in a clinical setting, while 22% were in non-clinical locations .[5]

[5] NCMD 2nd Annual Report June 2021. See appendix

Chapter 4

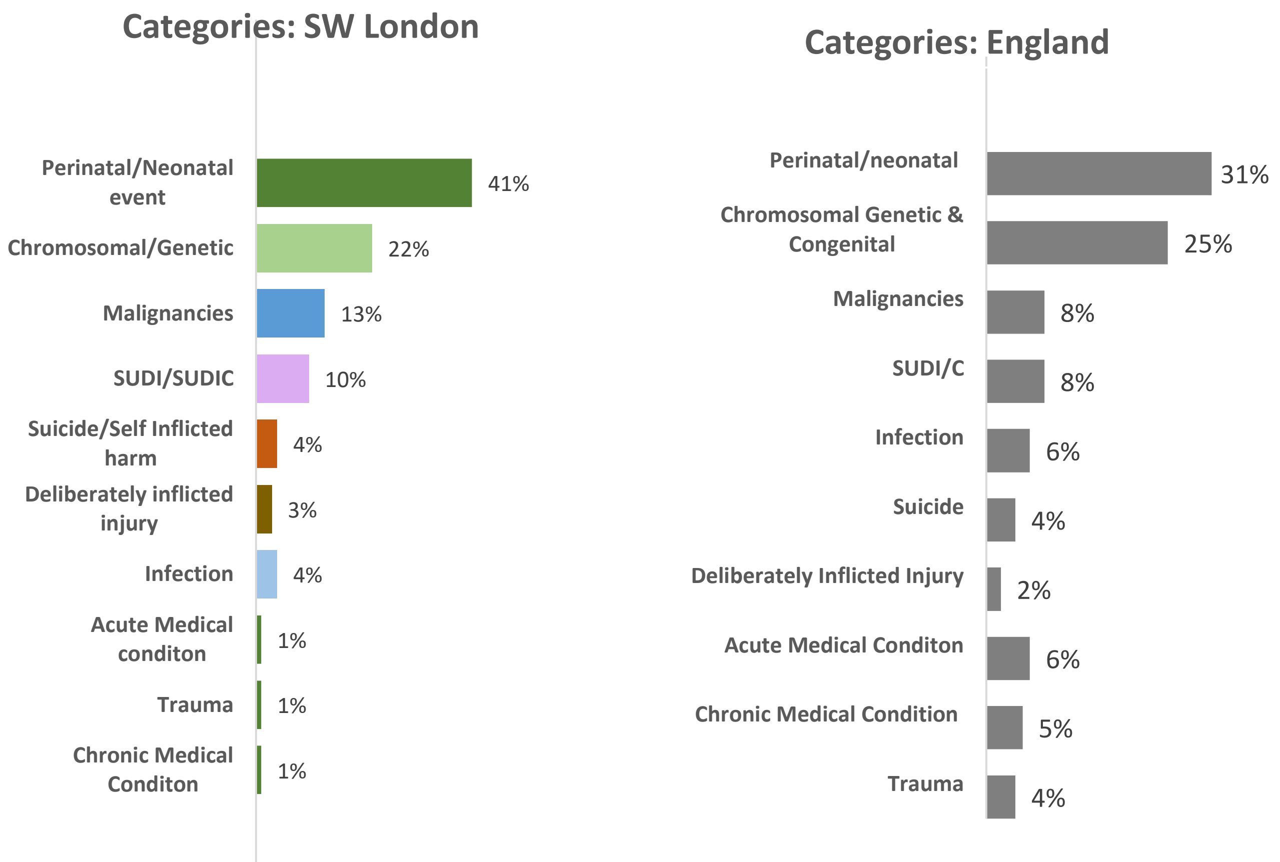
STATISTICAL OVERVIEW:
ANALYSIS OF CHILD DEATHS FOR 2020-2021

This chapter provides an analysis of Seventy-Eight (78) child death cases reviewed and completed by the Individual and joint CDOP Panels in SW London during 2020 – 2021 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 4.1 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 deaths reviewed in 2020-21 with percentages of child deaths in that category. The categories are considered in more detail.

Graph 6



4.2 Generic Themes from completed reviews

Perinatal/Neonatal event.

This is the largest category of child deaths in SW London. Forty one percent (41%) of deaths were perinatal /neonatal child deaths, of which 32% were perinatal/prematurity related, 5% had a chromosomal/congenital element and 4% had an infection related to the death. This is an increase on the previous year of 30% .

84% of these deaths were babies that died within 28 days of birth, and 16% of babies died in the first year of birth. It is important to note that a total of 32% , or a third of this category of deaths were of extremely premature babies born under 23 weeks gestation, in a condition incompatible with life. The average gestation of the babies overall was 29 weeks with an average weight of 2,420 grams. Three percent of babies were over 38 weeks gestation at time of death. The gender of these babies were 56% male and 44% female. The ethnicity of these babies was 52% white, with 20% from black, 12% from Asian and 18% from mixed ethnicity/any other ethnic groups totalling 48% from all other ethnic groups. Sixteen per cent (16%) of these child deaths were one of twins which is the same as 2019-20. Twins have a 50% higher risk of preterm birth, resulting in increased demand for specialist neonatal resources. National child deaths involving twins were fourteen percent (14%) of total perinatal neonatal child deaths .

A total of 36% of mothers had risk factors identified antenatally. A total of 16% of these child deaths had modifiable concerns identified and were subject to serious incident investigations and HSIB reports. Issues included missed opportunities to identify risk factors in early stages of labour that increased risk status, requiring a change of decisions on management of labour, or change of delivery location to facilitate quick access to level 3 Neonatal Intensive Care Units.

Statistically, Merton, Wandsworth and Kingston Upon Thames have the lowest rates of child mortality per 1000 births in London. [6]

Chromosomal, Genetic and Congenital anomalies.

This is the second highest category of death in South-West London at 22%. Of this amount, 47% were 0-28 days of age and were between 26 – 38 weeks gestation, 32% below one year of age,

---

[6] https://www.trustforlondon.org.uk/data/infant-mortality-borough/ click link to view

and 14% under fourteen years of age. A total 38% of these child deaths were of white ethnicity, with 23% of Asian,14% black and 10% of any other ethnicity, with 14% not stated.

A total of 95% of these child deaths had no modifiable concerns identified, the remaining 5% were subject to a serious incident investigation and an inquest resulting in organisational changes to clinical procedure by the Hospital involved.

After discussion with parents on poor prognosis, Palliative care was arranged for children who had life limiting conditions. A total of 20% of deaths were in hospices, 14% had agreed palliative care plans supported by palliative care in the community at home at the request of the family and the 66% took place in hospitals.

Malignancy

Oncology conditions at 13% are the third highest cause of child deaths in South-West London. The ages of these children were across all age groups and ethnicities, with 36% being between the ages of 1 – 4 years old. A total of 73% of conditions were tumour related, and 27% were diagnosed as leukemias. Case management was by multiple specialist hospitals, supported by community paediatric and nursing care. Half of these children had agreed palliative care plans which were arranged for 36% of these children to remain in the family home, with the remaining 64% in specialist hospitals.

Sudden Unexpected Death of an Infant/child (SUDI/C)

Sudden unexpected deaths of infants and children are the fourth highest cause of death, and at 10%, is 3% higher than 7% reviewed in the 2019-20 reporting year. A total of 75% were babies under 1 year of age with 25% being between the ages of 1 and 15 years old. 87% occurred at home and 12% in a hospital environment and all were subject to post-mortems. Of these, 75% started life as premature babies with health issues at birth, with the remaining 25% born at 40 weeks gestation. Twenty Five percent (25%) of children had life chronic life limiting conditions and died unexpectedly at home. A total of 50% had issues that increased risk factors. For risks identified, 25% had factors related to co-sleeping/overlaying and 25% had maternal smoking/substance misuse noted in pregnancy. Social Care was involved with 50% of cases, but no safeguarding or abuse concerns were raised as a causal factor in the deaths. Social care involvement was limited to interventions for vulnerable mothers, including placements in supportive environments.

Infection

A total of 4% of child deaths had factors related to infections. 3% of these were related to Perinatal/Neonatal Deaths and 1% related to malignancy child deaths. All were bacterial infections, or life limiting complications caused by a positive COVID 19 diagnosis.

Suicide, Self-Inflicted harm

Four per cent (4%) of child deaths resulted from fatal self-inflicted incidents. All were young people between the ages of 15 – 17 years old. While these cases had no modifiable factors, common themes were issues with low self-worth and body image, previous attempts at self-harm, domestic violence in the home, and non-engagement with mental health services. Recommendations included the importance of standardising processes for emergency department admissions with safeguarding concerns to be flagged with primary care, health visiting and school nursing.

Deliberately inflicted deaths

Three per cent (3%) of child deaths resulted from fatal stab wounds. All were victims of knife crime, and subject to post-mortems, inquests, and criminal prosecutions. The files were endorsed with a narrative to the National Child Mortality Database noting that child deaths by knife crime would be monitored in this area and added to subsequent cases that involve knife crime. The trend of deliberately inflicted deaths of children by knife crime will be raised at a London-wide level as a preventable cause of death of children as a wider social and public health concern.

Trauma

A Serious Incident report completed by a Tertiary Hospital, made several procedural recommendations to improve practice in the surgical management of cases of children with known co-morbidities.

Chronic Medical /Chromosomal Genetic, and Congenital condition

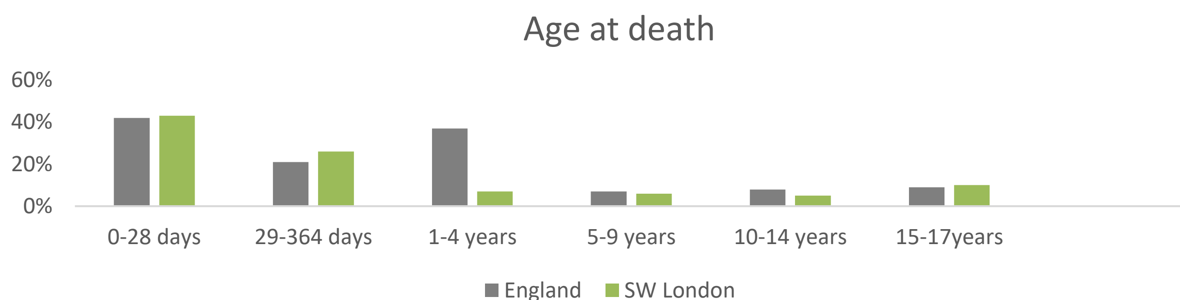
While the deaths in this category were unexpected, there were no care or service delivery issues of children with a long-term chronic health condition exacerbated by a chromosomal, and genetic condition.

Acute Medical Condition

An inquest was held for one child death as the diagnosis, and short time of deterioration to death was considered unusual by Clinicians. The cause of death was confirmed as natural causes . The specialist hospital involved reflected on the delay in diagnosis, and a possibility was noted that there is medical evidence that suggests that viral infections such COVID 19 can conceal positive results in investigations of symptoms for other conditions.

4.3 Completed Reviews by Child's age

Graph 7



The above graph indicates that 69% of the child deaths reviewed in SW London were of children under one year of age. [7]

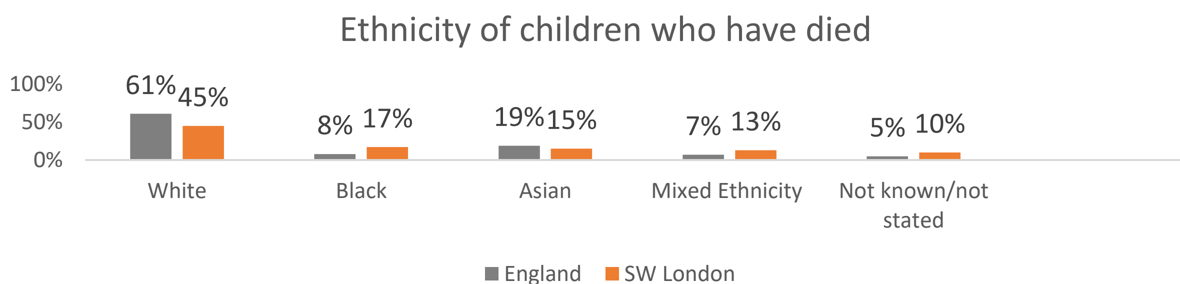
Demographic and Social Characteristics:

4.4. Gender

The gender breakdown of child deaths across all categories in 2020-21 was 56% male and 43% female, with one undetermined. This can be compared to 51% Male and 49% female in 2019-20. Nationally, the gender categories were 56% male and 43% female.

4.5. Ethnicity of children who have died

Graph 8



[7] NCMD Report 2020 Table 9 Child Deaths by age , gender and ethnicity

Proportionately, in South-West London (excluding those ethnicities not recorded), One half of all child deaths represented as 45 % are of are of Black, Asian and Mixed Minority ethnic categories.

At a national level, ethnic minorities total 31% of all child deaths.

Ten per cent (10%) of cases had no ethnicity recorded.

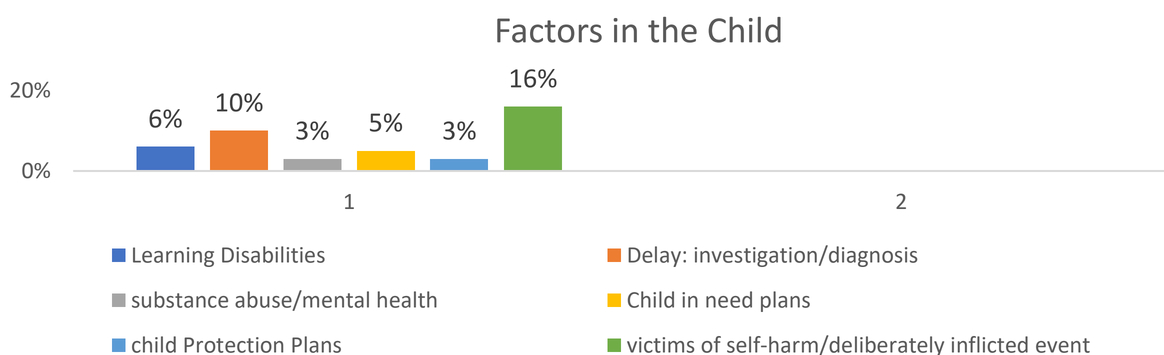
In comparison with national statistics, the ethnicity of the population in London is more diverse, which proportionately, is evidenced in the local statistics in SW London.[8]

4.6. Asylum status

4% of families were recorded as being the subject of asylum applications.

4.7. Factors in the Child.

Graph 9



Of the total of 78 child death reviews, forty three percent (43%)had factors that affected the child noted. Six percent of children were recorded with learning disabilities. Ten percent (10%) of child death reviews had recorded delays in identification of illness, assessment, investigation, or diagnosis .These child deaths were subject to serious investigations where recommendations were made for improvements in procedure for recognition of the sick child. This statistic is lower than 2019-20 at 22%. Three percent (3%) of children had mental health /substance abuse concerns recorded in the reviews. Eighteen percent (18%) of these children were known to Childrens' Social Care at varying levels which is an increase on 11% known to social care at time of death in 2019-20. Ten percent (10%) had a child in need plan which is an increase on 3% last year. Five percent of children had child in need plans in place at time of death

---

[8] Table 9 NCMD Report 2020 Reference Table 9 : Ethnicity – England. See appendix for link.

(a number were children with disabilities,) and an additional 5% % of these children had child in need plans previously in place before death.

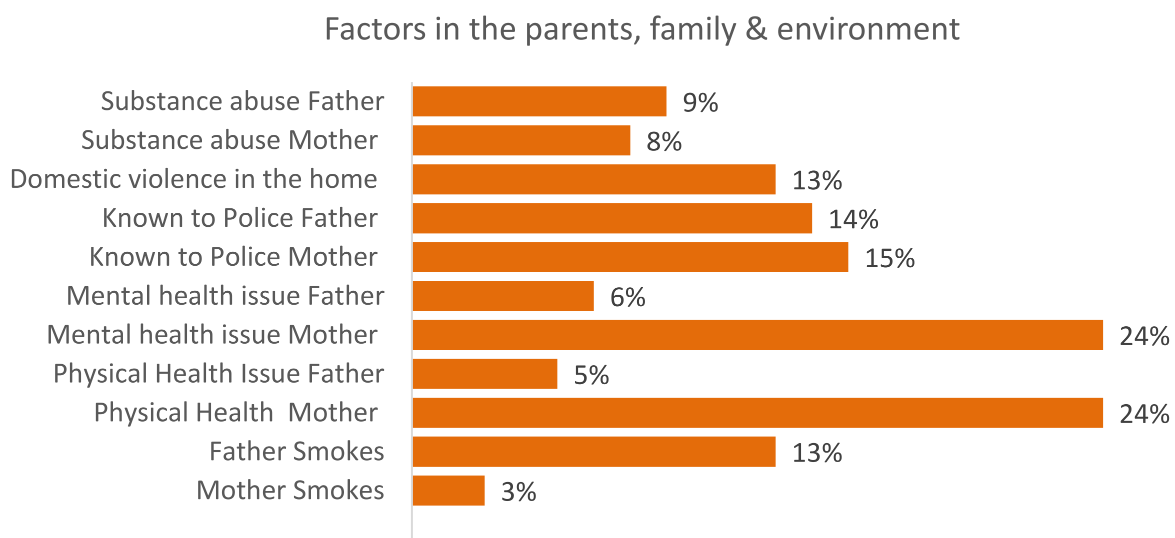
Three per cent (3%) children were on child protection plans at time of death, though the deaths themselves were not because of neglect or abuse. The child protection plans were put in place as an early help precautionary measure, to support parents where health needs or vulnerabilities were identified.

Sixteen percent (16%) of children were victims of violence, self-harm, fatal incidents, or accidents.

4.8. Factors in the Parents, Family and Environment.

The following was recorded for case analysis.

Graph 10



Across SW London 32% of all reviewed cases had one or more factors in the family noted as concerns. In SW London, in 13% per cent of reviewed cases, there was smoking in the home. Nationally, smoking in the home is the first most frequent modifiable factor.[9]

Locally, mental health ,(depression, anxiety) and physical health issues (including hypertension and obesity) for mother is the highest category of concerns noted in the family at 24% . This is a significant increase for this category which was noted at 5% in 2019-20 in SW London.

[9] NCMD 2nd Annual Report June 2021 see appendix for link.

Nationally, maternal obesity (which is recently being monitored by the National Child Mortality Database as a specific risk factor), and mental health are the 5th and 11th most frequent modifiable factor, respectively.

Nationally, domestic violence is the 8th highest most frequent modifiable factor. In SW London, domestic violence in the home is the 5th highest modifiable factor and has increased from 4% in 2019-20 to 13% in 2020-21.

In 2020-21, a total of 15% of parents are known to the police, though it is unclear if they are known as victims of crime. This is an increase on the 7% reported in 2019-20.

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. Serious Incident investigations (SI's) identify areas for improvement, retraining, policy revisions or procedural changes in provision of health care for children.

Eight percent (8%) of total deaths reviewed in 2020-21 were subject to Serious Incident Investigations or other internal investigations which is a decrease on the 10% of total deaths subject of Serious Incident investigations (SI) in 2019-20 . Four were serious incident investigations were for Hospital services to review service delivery issues or care incidents. Two cases were Healthcare Safety Investigation Branch reports to review patient safety incidents. One case referred to HSIB as a precautionary measure to assess service provision was returned with no recommendations, and confirmation that the correct procedure was followed. In a number of child death reviews, panels noted instances of best practice in acute services in interventions and care management by clinical and nursing teams. Also, on a national level, quality of service delivery, and challenges with access to services are the 2nd and 6th highest modifiable factors. [10]

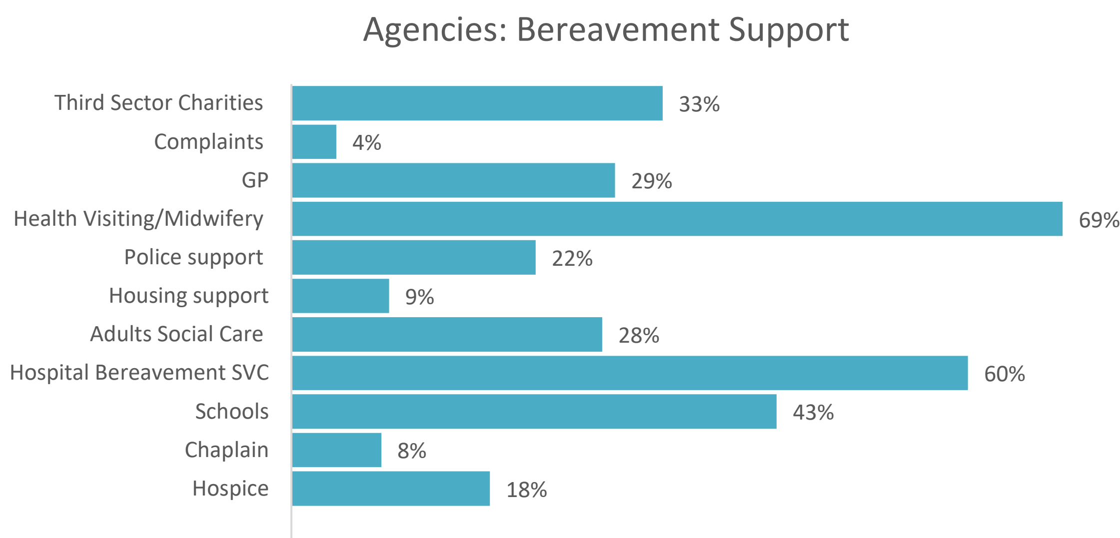
A summary of the recommendations is highlighted in the Learning and recommendations in Chapter 5 of this report.

[10] NCMD 2nd Annual Report June 2021. See appendix for link.

4.10: Bereavement

Bereavement support is initiated by identifying a key person best placed to support family, decided on a case-by-case basis. All SW London Hospitals now have their key workers, bereavement nurses and bereavement procedures in place across midwifery, neonatology, and paediatrics. Key workers are specialist nurses who contact and support families who are recently bereaved, as well as initiate the bereavement support process across other services in the hospital , and others across the community such as Heath visiting, community nursing and primary care.

Graph 11



There was 100% offer of bereavement support given to all families who had a child death across the area. The above agencies specifically provided support to those parents who agreed to use the services. It is noted that third sector charities, health visiting, and hospital bereavement services provided most of the support that was accepted by parents. There are several instances where more than one agency made offers of support to parents, therefore the offer 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.

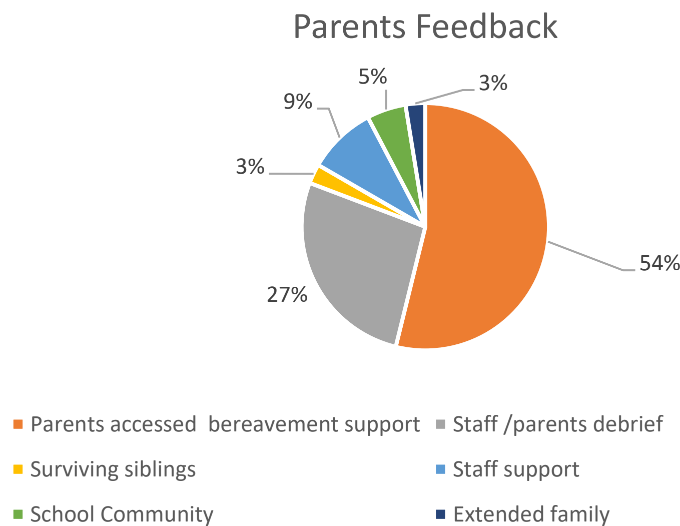
St Georges Hospital have developed a bereavement team to support the child deaths that occur at their hospital for local and other boroughs at their location as a tertiary hospital in SW London. The support that is offered from the bereavement team includes:-

- Reading and understanding PM reports
- Attending inquests
- Liaison with coroners
- Support with follow up meetings with consultants in hospital
- NNU post death meetings
- Bereavement support
- Assistance for results of genetic tests.

St Helier Hospital note that they also offered bereavement support to bereaved children who have lost a parent in the previous year due to the COVID 19 Pandemic and other issues. These children and their families have been offered practical advice and support, as well as signposting to specialist bereavement services and charities.

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

Graph 12



In the reporting year 2020-21, there has been an improvement in families accepting bereavement support offers with over 54% of all families accepting some form of bereavement support. Parents also accessed parent/staff debriefs to discuss the child deaths and to answer any questions parents may have. Staff have also accessed bereavement support. All local hospitals have reported incidents of calls, letters and cards being sent by parents thanking them for the support received and additional thank you cards sent on the anniversary of their child's death.

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

SWL CDOP/Local Authority	Monitoring knife crime as a specific cause of deliberately inflicted child deaths, indicators of an increasing trend, and strategies for reduction/prevention.
Public Health/ SW London Cdop/London Chairs CDOP/Coroner	Support to the London wide enquiry on actions to be taken on Regulation 28 Order– Pollution as a cause of death . Clean Air (Human Rights) Bill 2019 – 21 nicknamed 'Ella's Law'.

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

Local Authority /Education /Therapies		Improvements in actioning care plans including access to education and therapies in the community for children with disabilities while unable to attend a specialist school setting due to extended illness.
Acute Services	I.	Midwifery - Assessment of change of risk status management and escalation to Obstetric-led care during labour when required: ' just-in-case' plans for escalation of care (including change of location of birth) if risk status changes on admission in labour.
	II.	Policy: weighing newborn and management of excessive weight loss in the breastfed neonate born at term gestation.
	III.	Policy: Indicators to initiate major Obstetric Haemorrhage Protocol including assignment of a leader to the team response.
	IV.	Review and update of policies on management of Twin Pregnancies.
	V.	Cervical cerclage: Hospital Preterm Labour and Preterm Pre-labour Rupture of Membranes' Maternity Guideline to be reviewed to include a sentence that states if shortening of the cervical length is noted via USS, regardless of if it is <25mm the scan should be escalated and reviewed by a Consultant Obstetrician within a timely manner, that day / within a 72hr time frame.
	VI.	To support timely diagnosis (Oncology) : Revision of policy and procedure on constipation in children
	VII.	To support timely diagnosis (Oncology) : To ensure children are not discharged unless their observations have normalised (unless highlighted and discussed with a consultant). Vital signs should be repeated regularly for children undergoing a period of observation on

	the unit. A full set of observations including blood pressure should be performed on all children.
	VIII. (a) To support timely diagnosis (Infection) : PEWS charts need to be reviewed and should tally with the physiological observation ranges for age included in the sepsis screening proforma. (b) PEWS (observation) chart should have narrower age range for physiological parameters. (c) Importance of correct interpretation of physiological observations with respect to age of patient inclusive of measuring blood pressure with each set of observations.
	IX. To support the use of hospices for terminally ill children on a palliative care pathway when preferable.
	X. To recommend a specialist area locally to provide a 24 HOUR ASD crisis team for de-escalation of violent, disruptive behaviour in young people for psychological diagnosis and treatment at Tier 2 mental health levels, rather than using S.136 Suite at Springfield Hospital, paediatric wards or police station holding facilities.
	XI. Ethics support for clinicians in discussions with parents for escalation of care with consideration to religious and cultural practice.
	XII. The appropriate use of Syntocinon as per "Use of IV Oxytocin" guideline, use of an FSE and confirmation of fetal heart rate: Importance of recognising uterine hyperstimulation and assurance in quality of fetal heart monitoring , and if anomalies are identified, to expedite delivery in context of a pathological trace. (Syntocinon Hyperstimulation was also noted in 2019-20 CDOP Annual Report)

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

Acute Services	Antenatal Services: Importance of routine enquiry on domestic violence across the antenatal care period.(at one meeting, It was noted there was a rise in disclosures in the reporting year during the COVID 19 Response where mothers were seen alone.)
	Teaching sessions for the Sonographers to be provided by the Fetal Medicine Consultants on cervical length measurements.
	For expectant mothers: I. To resume CO2 testing suspended during recent COVID 19 service delivery restrictions. II. Life resuscitation training for parents to be incorporated as part of the antenatal pathway. III. Contact information for out of hours advice for mothers when reduced fetal movements are identified as part of the antenatal pathway.
	Paediatrics. (1)Education/Simulation for paediatric emergency department staff on recognition and management of SIRS, Sepsis, and Meningitis. (2)Staff training on GCS calculation and interpretation. (3) Training of the normal range for age of physiological observation parameters of heart rate, respiratory rate etc.
	Paediatrics/Emergency Department Improvements in flagging all Emergency Department admissions to Primary Care/Health Visiting/School Nursing, where safeguarding issues are identified.
	Neonatal Unit Regular refresher resuscitation training scheduling for neonatal team.

5.5 Influencing Policy and Legislation

The Chair of the South-West London Child Death Overivew Panel chaired the London Chairs Child Death Overview Panel for the year 2020-21 . The following national regulatory agencies were contacted, and recommendations were made for strategies and to update existing policies to influence outcomes arising from child death reviews.

Table 4.

SW London/London Cdop Chairs	Support for a local agreement for all London Coroners to authorise the taking of Kennedy Samples in sudden unexpected child deaths.
London CDOP Chairs/Metropolitan Police Service	Update of London Metropolitan Police Child Death Protocol under the new working arrangements for Child Death reviews
London CDOP Chairs	Highlight concerns on charging vulnerable women for antenatal/maternity care.
SW London CDOP/ London CDOP Chairs/Foreign & Commonwealth Office	Update of New working arrangements for child death reviews for UK Consulates worldwide, and implementation of a new UK based Coroner Liaison officer to support the Child Death review Process for children domiciled in the UK who die overseas.
SW London CDOP/London Ambulance Service	Improvements in arrangements for conveyance of children in palliative care plans for expected child deaths at home.

Chapter 6:

CONCLUSION AND PRIORITIES FOR 2021-22

6.1. Plan

South-West London Child Death Overview Panel has developed an effective and measurable Child Death Overview Panel process as part of an integrated care system (ICT) across South-West London that conforms to its statutory requirements of timely reviews, involvement of families and improvement of the process.

6.2 Goals for next Reporting year 2021-22

The panel aims are as follows: -

I. To continue to support the acute Hospitals to implement their local systems with improved joint working between local and specialist hospital panels to improve the quality of contributions from 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.

IV. To implement a system of feedback of shared learning from Child Death Overview Panel meetings as part of the CDOP's contribution to the organizational response to child deaths in the integrated care system. This will be compatible with the integrated care system and upcoming National Patient Safety Strategy . The purpose of this is to support 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 measure the effectiveness of support bereavement experience, and to continue to ensure all families are offered bereavement support in South-West London.

VII. To improve feedback to families by way of notification of actions taken.

VIII. Complete representation of panel membership with an Independent Chair, Neonatologist, and a Quality/Patient Safety Representative.

IX. 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 2020-2021,

- South-West London Child Death Overview Panel were notified of eighty new child deaths for the period 2020 – 21. Seventy-eight cases were reviewed by the SW London Child Death Overview Panel.
- There were forty-one local Child Death Review Meetings completed at SW London Hospitals and ten Child death Overview Panel Meetings under the new working arrangements for Child Death Reviews.
- Eighty Six percent (86%) of all reviewed deaths had no modifiable factors identified. Fourteen (14%) percent had modifiable factors identified. There were 15 local Joint Agency Response meetings in SW London and an additional 13 Joint Agency Responses held by local boroughs for out of borough child deaths, as well as at specialist hospitals for SW London child deaths.

Recommendations and learning from panel reviews and SW London leadership of the London Chairs Child Death Overview Panel in 2020-21 continue to contribute to promotion in community education, improvements in organisational practice, improvements in education, training, and communication in local partner agencies, and learning and has had a positive impact on national government policy.

Appendix 1: Statutory and Regulatory Legislation

NCMD 2nd Annual Report June 2021.

https://www.ncmd.info/wp-content/uploads/2021/06/NCMD_2nd_Annual_Report_June-2021_web.pdf

Saving Babies Lives care bundle 2 Report

https://www.england.nhs.uk/wp-content/uploads/2019/03/Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-Final-Version.pdf

Infant mortality Rate by London borough 2017-19

https://www.trustforlondon.org.uk/data/infant-mortality-borough/

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.

Appendix 2: NCMD Monitoring Reports 2020 21 (not attached to this document)

Croydon
Kingston Upon Thames
Richmond Upon Thames
Merton
Sutton
Wandsworth.