Lincolnshire Child Death Overview Panel (CDOP) Annual Report 2021/22

Julian Saggiorato – Chair of Child Death Overview Panel

April 2022

Introduction

The death of a child is a tragedy that affects families and communities. They will often want to know: Why did my child die? Could this have been prevented? What can we learn from it?

The Lincolnshire Child Death Overview Panel (CDOP) reviews the death of every Lincolnshire child to see if any lessons can be learned. We are aiming to prevent future deaths where we can and to improve care and support for children, their families and communities.

This annual report contains the summary of cases discussed by CDOP in 2021/22, as well as recommendations made by the panel.

Purpose of the Child Death Overview Panel

The Lincolnshire Child Death Overview Panel was established on 1st April 2008. It is a sub-group of the Lincolnshire Safeguarding Children Partnership (LSCP).

The National Child Mortality Database (NCMD) launched on 1 April 2019 and collates data collected by CDOPs in England from reviews of all children, who die at any time after birth before their 18th birthday. There is a statutory requirement for CDOPs to collect this data and to provide it to the NCMD.

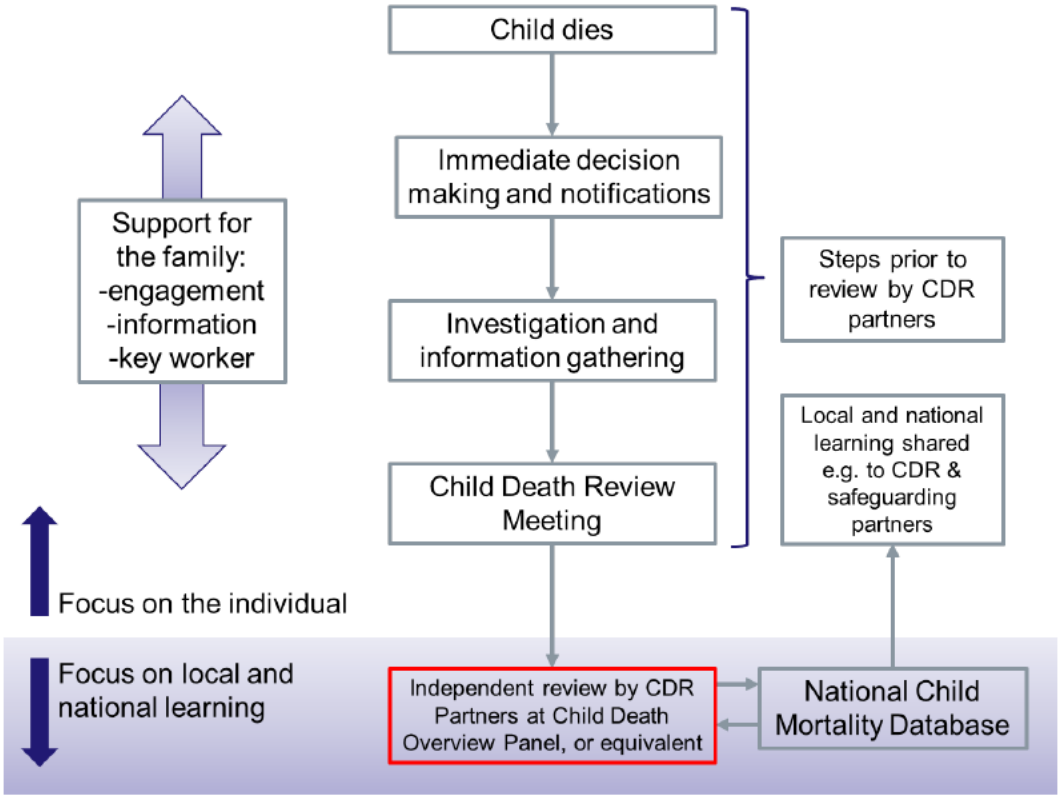
The purpose of CDOP is:

- To review all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy
- To confirm the cause of death and determine any contributing factors
- Identify learning that may prevent future child deaths
- Make recommendations to organisations (including the LSCP) where actions have been identified that could prevent future child deaths or promote the health, safety and wellbeing of children
- Where a suspicion arises that neglect or abuse may have been a factor in a child's death, referring a case back to the LSCP chair to consider whether a local Child Safeguarding Practice Review is required
- To produce an annual report on local patterns and trends of child death
- To contribute to local, regional and national initiatives to improve learning from Child Death Reviews

Examples of other work resulting from the process are working groups to review local policy or local awareness raising campaigns, which are coordinated with the support of the Safeguarding Children Partnership, expert groups, national charities and frontline children's health and care services in the area.

The number of child deaths in Lincolnshire notified to CDOP between 1st April 2021 and 31st March 2022 was 33, compared to 31 the previous year. Lincolnshire CDOP has completed 21 child death reviews during this period.

The child death review process includes the whole pathway from the initial response to provide care for the child and their family, and undertake initial investigations, any detailed reviews or investigations, through to the 'child death overview' which takes a summary view of all the factors and seeks to capture any learning that could benefit the whole population of children in future. This is best explained by the diagram below, taken from the Child Death Review statutory and operational guidance.



Changes to national and local processes

Following the publication of the new arrangements that were published in Lincolnshire to meet *Working Together to Safeguard Children 2018,* Lincolnshire's child death overview panel has continued to operate in line with statutory guidance to manage an effective Child Death Review process.

The arrangements for reviewing child deaths within the county of Lincolnshire are working well, with clear governance and accountability through the LSCP. The CDR process:

- works within the legislative and guidance frameworks.
- meets the needs of families whose child has died, whilst maximising learning from any child's death to reduce the likelihood of similar occurrences where possible in the future
- allows agencies involved in the process to make a meaningful contribution within their available resources
- maximises learning from children's deaths both locally and nationally

Lincolnshire Child Death Overview Panel Members

Member	Organisation
Dr Julian Saggiorato - Chair	Designated Doctor for Safeguarding Children, Looked After Children and Adults, Lincolnshire CCG
Dr Mujeeb Pervez - Vice Chair	Consultant in Community Paediatrics/SUDIC Lead, United Lincolnshire Hospitals Trust
Lucy Gavens	Lincolnshire County Council Public Health
Dr Margaret Crawford	Named Doctor, United Lincolnshire Hospitals Trust
Gemma Cross	Named Nurse, Lincolnshire Community Health Services NHS Trust
Libby Grooby	Interim Head of Midwifery & Nursing, United Lincolnshire Hospitals Trust
Deborah Flatman	Lead Children's Nurse – Transformation, United Lincolnshire Hospitals Trust
Perce Bosworth/Jane Parks	Lincolnshire Police
Dr Amulya Nadkarni	Named Doctor, Lincolnshire Partnership NHS Foundation Trust
Jo Casey	Lincolnshire County Council Children's Services
Claire Saggiorato	Lincolnshire County Council Children's Health
Liz Cudmore	East Midlands Ambulance Service
Stacey Waller	Business Manager, Lincolnshire Safeguarding Children Partnership
Steven Batchelor	Lincolnshire Road Safety Partnership
Jill Chandar-Nair	Lincolnshire County Council Education
Hannah Page/Erica Coney	Lincolnshire County Council Administrator

Data analysis

1. **Number of child deaths notified in Lincolnshire during 2021/22**
   33 child deaths were notified during the period from 01 April 2021 until 31 March 2022.

2. **Cases reviewed at panel 2020/21**
   The number of child deaths reviewed by the Lincolnshire Child Death Overview Panel between 01 April 2021 and 31 March 2022 was 21.

   6 out of the 21 cases took more than a year to reach the final determination. The main reasons for delay of review were other on-going investigations such as Coroner's inquest, serious case review (now Child Safeguarding Practice Review) or criminal proceedings.

   There are currently 34 cases that remain open, 16 of these awaiting the outcome of a coroner's inquest (the CDOP process awaits this before closing a case at panel).

3. **Breakdown of demographic characteristics**

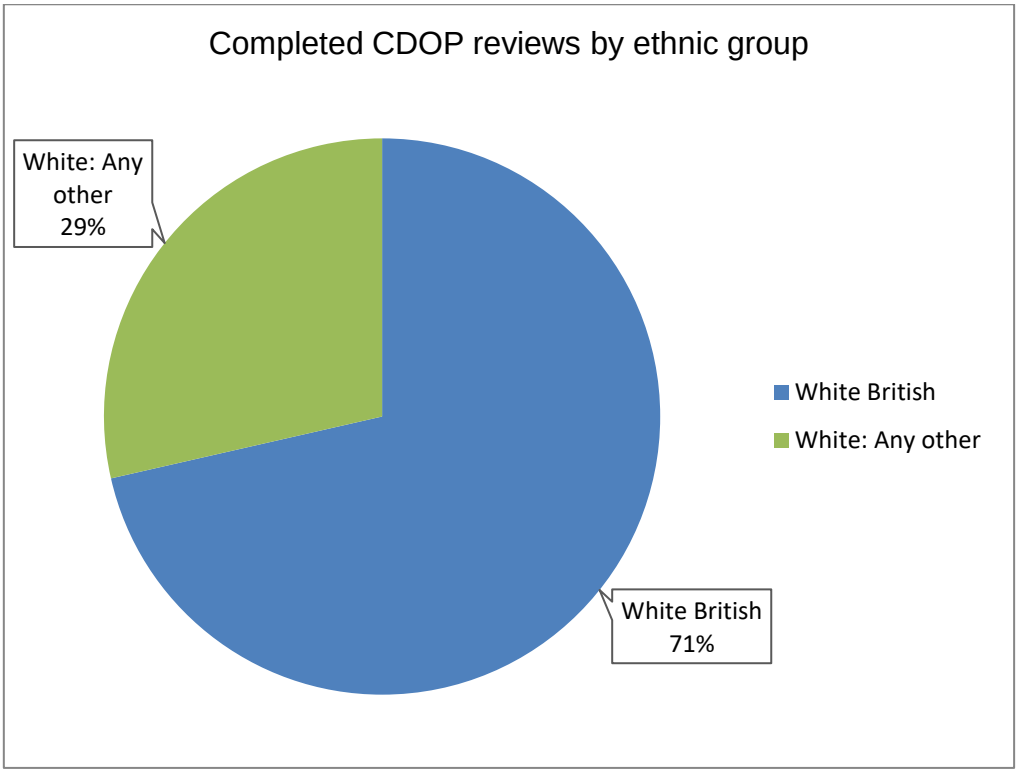
   Although the number for one year are small and therefore must be interpreted with caution, the characteristics broadly reflect that seen in England the previous year.

3.1. Age and gender

Completed CDOP reviews by gender. 62% of all deaths reviewed were Male, 38% were Female.

Age group	Female	Male	Total
0 - 27 days	4	5	9
28 - 364 days		2	2
1 - 4 yrs		1	1
5 - 9 yrs	3	1	4
10 - 14 yrs	1	3	4
15 – 17 yrs		1	1
	8	13	**21**

3.2. Ethnicity of children



3.3. Geographical residence of child

Authority Area	Total
Boston	5
South Holland	5
East Lindsey	5
South Kesteven	4
Lincoln	2
West Lindsey	0
North Kesteven	0
Total	**21**

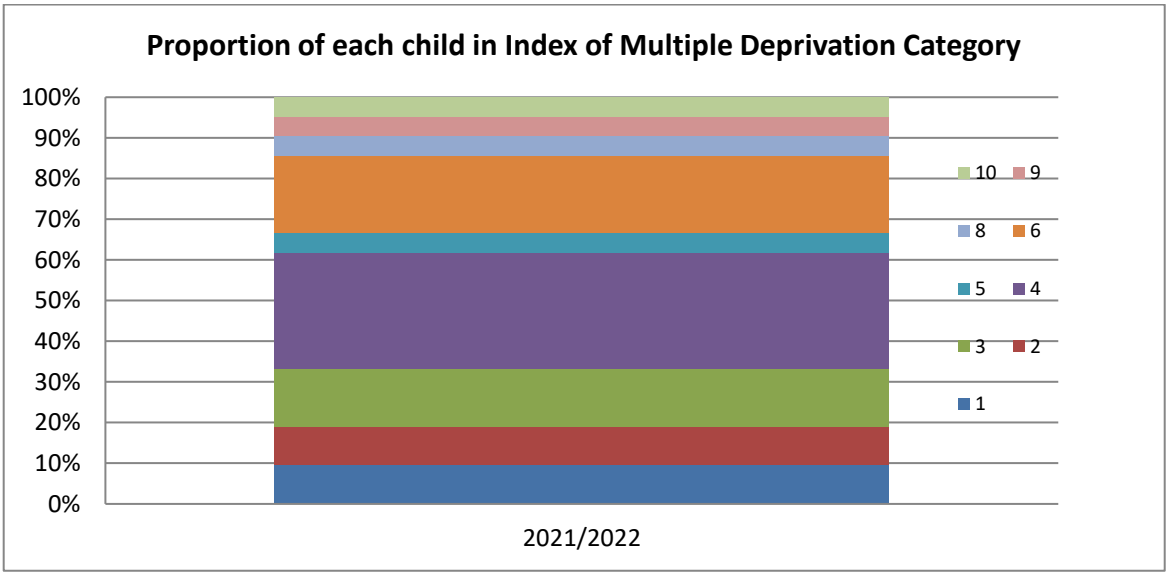
3.4. Deprivation decile

The figure below shows the proportion of child deaths that occurred in each of the deprivation deciles (calculated by full postcode of residence). Decile 1 represents the most deprived tenth of the population and 10 is the least deprived.

This shows that over 60% of child deaths occur in the 4 most deprived deciles.

The NCMD report *Child Mortality and Social Deprivation* (May 2021) found a clear association between the risk of child death and the level of deprivation (for all categories of death except cancer). It more specifically states that over a fifth of all child deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived – which translates to over 700 fewer children dying per year in England.

It is to be hoped that those involved in planning and commissioning public health services as well as health and social care professionals pay attention to this data to develop, implement and monitor the impact of strategies and initiatives to reduce social deprivation and inequalities.



3.5 Social Care and Early Help

Out of the 21 deaths reviewed in 2021/22, there were 4 children who were known to social care at the time of their death. For Lincolnshire, this represents 19% of child

deaths which is comparable to the national average of 23% (NCMD 2nd Annual Report, June 2021).Of these, 50% had modifiable factors identified in the review. 1 child was on a Child Protection Plan (CPP) at the time of death, and the 3 others were known to social care as a Child In Need (CIN).

3.6 Children with a Learning Disability

Out of the 21 deaths reviewed in 2021/22, there were 4 children who were known to have a disability. Those child deaths have been notified to the Learning Disabilities Mortality Review Programme (LeDeR) by CDOP to assist with their review and share learning of the deaths of children with disabilities.

4. Brief summary of the SUDIC process and how it aligns to CDOP

The majority of sudden unexpected deaths in infancy or childhood (SUDIC) have natural causes and are unavoidable tragedies. The incidence of unexpected deaths in infancy or childhood is highest in infancy. About 600 babies die suddenly each year in the UK.

Professionals from a number of different agencies and disciplines will become involved following an unexpected death in infancy or childhood to try to establish the cause of the death and support the family.

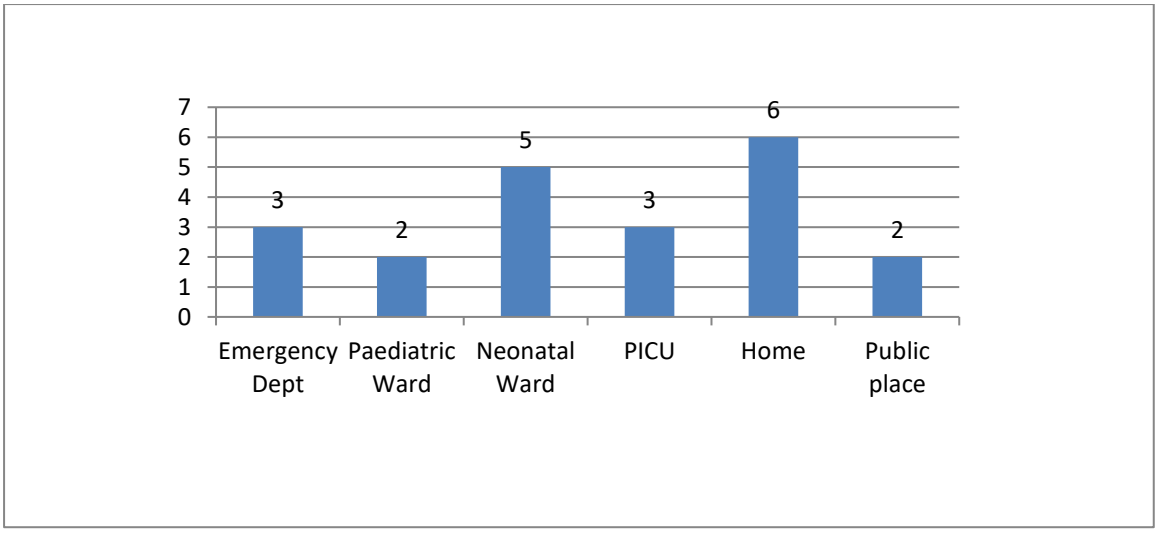
United Lincolnshire Hospitals NHS Trust established a designated SUDIC service team in May 2011. All professionals involved strike a balance between managing the sensitivities of a bereaved family and identifying and preserving anything that may help to explain why the child died. It is as important to absolve a family from blame and to recognise medical conditions, especially hereditary disorders, as to identify unnatural deaths or homicides.

Of the deaths reviewed by CDOP during 2021/22, 9 went through the SUDIC process.

5. Factors surrounding deaths

5.1. Place and time of death

The place of death was recorded as below. The commonest place of death was Home.



5.2. Cause of death

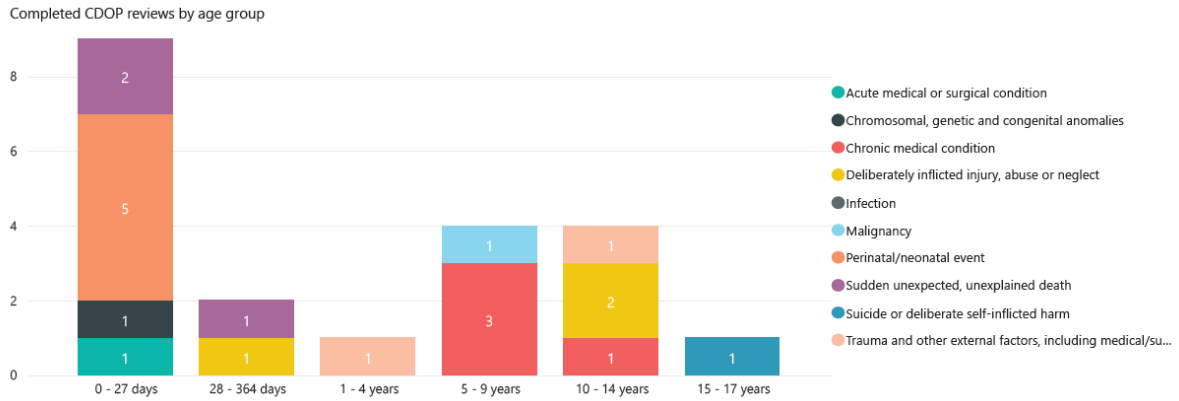
CDOP does not determine the cause of death, but records the category based upon reports such as Coroners' and other reports. The recorded causes of death for cases where a determination was reached are as below. Previous years are shown for comparison. It is possible for an individual death to be placed in more than one category should multiple factors be present

The relatively high figure of 2018/19 is due to a large number of cases being delayed for discussion due to outside factors, for example, coroner's inquests.

Category	Name & description of category	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	2021/ 20212
1	**Deliberately inflicted injury, abuse or neglect** Includes suffocation, shaking injury, knifing, shooting, poisoning and other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; and severe neglect leading to death.	1	0	0	0	**3**
2	**Suicide or deliberate self-inflicted harm** Includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. Will usually apply to adolescents rather than younger children.	0	1	1	1	**1**
3	**Trauma and other external factors, including medical/surgical complications/error** Includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis and other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary	1	3	3	8	**2**

	cause of death, but excludes deliberately inflected injury, abuse or neglect (category 1).					
4	**Malignancy** Solid tumours, leukaemias and lymphomas as well as malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	3	3	3	0	**1**
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.	1	2	7	6	**1**
6	**Chronic medical condition** For example, Crohn's disease, liver disease and immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Also includes cerebral palsy with clear post-perinatal cause.	3	4	1	5	**4**
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis and other congenital anomalies including cardiac.	4	13	6	6	**1**
8	**Perinatal/neonatal event** Death ultimately related to perinatal events e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis and post-haemorrhagic hydrocephalus, irrespective of age at death. Also includes cerebral palsy without evidence of cause as well as congenital or early-onset bacterial infection (onset in the first postnatal week). This category includes four subcategories: immaturity/prematurity related, perinatal asphyxia, perinatally acquired infection and other perinatal/neonatal events.	8	12	3	9	**5**
9	**Infection** Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.	1	2	0	2	**5**
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5).	1	2	0	2	**0**
	Total deaths reviewed	26	45	28	38	**21**

Cause of death can also be broken down by age:



6. *Modifiable Factors in Child Deaths*

6.1. Definition of modifiable factors

In reviewing the death of each child, the CDOP should consider modifiable factors, for example, in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level. Working Together to Safeguard Children defines preventable deaths as:

> *'Those in which modifiable factors may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced'.*

7 out of the 21 (33%) deaths reviewed in 2021/22 had modifiable factors identified, compared to 58% in 2020/21.

% cases with modifiable factors (CDOP):	% cases with modifable factors (England):
33%	37%

% of cases where modifiable factors were identified by category of death

Primary category of death	Completed Reviews	Cases where modifiable factors identified	Modifiable factors identified (%)
Trauma and other external factors, including medical/surgical complications/error	2	1	50%
Suicide or deliberate self-inflicted harm	1		
Sudden unexpected, unexplained death	3	3	100%
Perinatal/neonatal event	5	3	60%

Malignancy	1		
Infection			
Deliberately inflicted injury, abuse or neglect	3		
Chronic medical condition	4		
Chromosomal, genetic and congenital anomalies	1		
Acute medical or surgical condition	1		
Total	21	7	33%

These were the most frequent modifiable factors identified;

- Parental smoking
- Maternal smoking during pregnancy (3 out of 7 cases)
- Substance/alcohol misuse by parent
- Broken window lock and restrictor
- Maternal body weight in pregnancy
- Unsafe sleeping arrangements (Co-sleeping, room temperature, and cot bumpers).
- Poor home environment (Clutter in house and lack of cleanliness)
- Socio economic deprivation in particular relating to financial difficulties and housing may have increased the risk to the child

This is in line with national data (NCMD 2nd annual report June 2021) where smoking by a parent or carer is the most frequent modifiable factor whilst parental substance misuse, maternal obesity during pregnancy, unsafe sleeping arrangements and a poor home environment are also in the top 10 national modifiable factors.

7. Themes and learning points

Since the 1st April 2016, the Lincolnshire panel notes up to three additional themes that have been present surrounding a child or family situation. These may or may not be identified as modifiable factors, and may or may not have a direct relationship to the death. Existing themes are used where possible, but new themes are identified as appropriate for each death.

Top 10 themes identified over the last six years in order of frequency;

Theme (1-3)	***Count of deaths April 2016 – March 2022***
Consequences of prematurity	*45*
Congenital abnormalities	*29*
Maternal Smoking in pregnancy	*24*
Life limiting condition	*15*
Chromosomal abnormalities	*14*
Maternal Body Weight in pregnancy	*12*
Smoking in household	*11*
Co-sleeping - with parent	*8*
Suicide	*5*
Delay in transport to hospital	*5*

8. 21/22 Recommendations made by the panel

1. 'ICON – Babies Cry, You can Cope' (ICON) is a programme designed to help parents and carers understand the normal crying pattern of young infants and to help them develop successful coping mechanisms. The goal is to reduce the incidence of abusive head trauma secondary to shaking of a baby. NHS Lincolnshire CCG have now rolled out the ICON programme across health, it has been offered to other LSCP partners and also promoted via a LSCP communications strategy.
2. Lincolnshire CDOP carried out its first themed panel looking at suspected teen suicides. Statistical analysis carried out by Public Health in 2018 showed that since 2001 there had been no change in suicide rates in Lincolnshire among 10-19 year olds and that since 2007, rates were lower than the national rates. On average, there is one child suicide in Lincolnshire per year.
   Lincolnshire CDOP receives notification of the death of every Lincolnshire child and from January 2021 to February 2022, it has been noted that there have been six deaths that are suspected to be suicides. Due to this apparent increase a themed panel was undertaken in order to recognise any themes to help inform policymakers, commissioners, those providing services to children and young people and those involved in reviewing deaths of children and young people. As a result of this, seven recommendations have been made to the Assurance Executive of the LSCP and sign off is awaited.
3. Following the death of a Lincolnshire child who fell from a window, CDOP asked the LSCP to share information about window safety. Nationwide, one child under five is admitted to hospital every day following a fall from a building. The NCMD has already produced a briefing which can be found at Open windows | National Child Mortality Database (ncmd.info) and this also contains links to RoSPA and CAPT.
   The Royal Society for the Prevention of Accidents (RoSPA) recommends that windows above the ground floor are fitted with restrictors to prevent children falling out. They also recommend that restrictors incorporating a child safely catch are best (as this avoids the complication of having to find keys in an emergency situation).

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