South West London Integrated Care System

SOUTH-WEST LONDON CHILD DEATH OVERVIEW PANEL ANNUAL REPORT 2023-2024

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

South-West London Integrated Care System
Consolidated SWL CDOP Panels of Croydon, Kingston and Richmond upon Thames, Merton, Sutton, and Wandsworth

Contents

Acknowledgments

This is an objective report that collates the main themes, issues, and recommendations to be shared first as a local region and to assist learning across health and social care agencies that contribute to panel reviews.

Many thanks to Panel members including local coordinators also known as Single Points of Contact (SPOCs), Designated Doctors for Child Death, Designated Nurses

for Safeguarding Children, Children's Social Care, Acute and Community Providers, Primary Care (GP Practices), Metropolitan Police Service, London Ambulance Service, Child and Adolescent Mental Health Services (CAMHS), Hospices, Bereavement Support Specialist Nurses, Public Health, SWL Quality Directorate and all services who contributed to the reviews and information presented in this report.

Message from Independent Chair, Kelly Williams South-West London Child Death Overview Panel

Having been the independent chair for this panel for over two years, I remain in admiration of how multi-disciplinary teams can work across different boroughs to learn from the deaths of children and ensure that changes are made to services to prevent future deaths. Such learning is apparent within this report, and I appreciate the time taken by all those who will read and disseminate the information within it.

There has been an increase in number of notifications of child deaths for 2023-24 compared to the previous year, and the focus of this report is on the seventy deaths that were reviewed over the last year. The panel met monthly to review these deaths, and all were quorate whilst containing appropriate discussion when reviewing the lives and deaths of these children.

After reviewing each death, the panel considers if recommendations should be made, and these actions are compiled within the report. I would like to highlight the continued work undertaken by the Integrated Care Services (ICS) for safe sleep advice to new parents, sadly South-West London remains higher than the national rate for sudden unexpected deaths in infancy, and a few of these deaths have had unsafe sleep practices as a modifiable factor.

There have also been deaths of older children due to suicide, self-inflicted harm, deliberately inflicted harm, or trauma through misadventure. A common thread through these deaths was access to mental health services and how to facilitate continued engagement with young people and families, and this is a recommendation from the

panel. In addition to maintaining multi-agency communication when there are stakeholders involved in a child's care. After reading these recommendations, and the others, in the report, please consider how these can be implemented in your area of work.

I wish to offer my profound gratitude to the multi-agency panel members and to Lorraine Beckford, who led this comprehensive report and diligently supports all areas of child death reviews in South-West London. I am about to commence a year of maternity leave and begin my absence knowing that the panel will continue to maintain the highest standards.

Finally, I would like to acknowledge the impact each child's death has on the family, friends, staff, and broader society, as this cannot be underestimated. There is a responsibility as a panel to learn from child deaths and ensure that bereavement support has been provided. Third-sector organizations such as Child Bereavement UK and Sands offer help not only to families but also to professionals affected by the death of a child. Please continue to signpost families and staff to such organizations for support, in addition to looking after yourselves.

KELLY WILLIAMS
Independent Chair
South-West London Child Death Overview Panel

Chapter One:

Introduction

1.1 Executive Summary

- The SWL CDOP serves as an inter-agency forum for Child Death Reviews in the boroughs of Croydon, Merton, Kingston / Richmond upon Thames, Sutton, and Wandsworth.
- Its primary purpose is to examine why children die, identify opportunities for prevention, and improve health and social services to reduce the risk of similar deaths in the future.
- The panel operates as a statutory body and is accountable to the SW London Integrated Care Board and the respective Local Authorities mentioned above.
- The Child Death Overview Panel has complied with the Child Death Review Statutory and Operational Guidance (England) from October 2018.
- The report presents statistical conclusions drawn from reviews conducted between 1st April 2023 and March 31st 2024 and borough-wide data on child death notifications.
- The findings and recommendations from child death reviews inform policy, practice, and training interventions.
- The aim is to prevent future child deaths by improvements in service provision, quality, and sharing key learning and priorities from Child Death Reviews:-

1.2 Purpose

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 death, or a pattern of deaths to identify trends that require a specific agency, or multidisciplinary response.

1.4 Statutory Framework and Governance

The Department of Health & Social Care is responsible for the statistical analysis of child death review data. The Child Death Overview Panels Statutory and Operational guidance (2018) is an expansion of the revisions of Chapter 6 of the 'Working Together to Safeguard Children' guidance (2023) on child death reviews. The National Child Mortality Database (NCMD) is an NHS-funded programme. The NCMD is tasked with the responsibility of gathering information on all children who die in England from child death reviews so that improvements can be made to save children's lives in the future.

Chapter 2

Operational Overview

2.1 Membership of South-West London Child Death Overview Panel

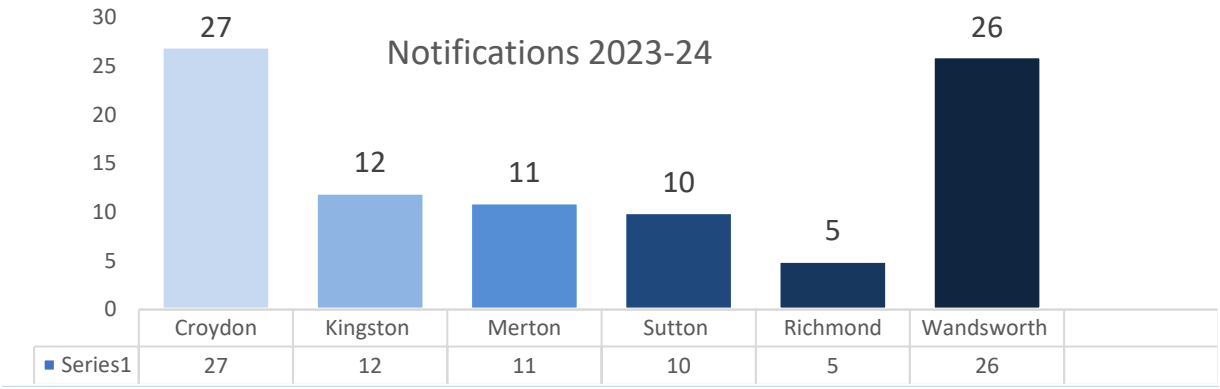
- The Child Death Overview Panel (CDOP) has members from health, social care, police, and public health, representing all six South West London boroughs of Croydon, Merton, Kingston/Richmond Upon Thames, Sutton, and Wandsworth.
- The panel meets monthly on a rota basis to ensure quoracy and is chaired by an Independent Chair appointed by the SW London Integrated Care System. All meetings have been quorate.
- Designated Doctors for Child Deaths for Kingston/Richmond, Croydon, Sutton, and Merton, with a vacancy in Wandsworth which has continued for the past three years. All boroughs have representatives from Children's Social Care, Metropolitan Police/CAIT, Designated Nurses for Safeguarding Children, and Midwifery. Other experts are invited as needed.
- The panel emphasizes the importance of inviting agencies with relevant expertise to contribute to panel meetings on a case-by-case basis such as the London Ambulance Service. Neonatology, Community Nursing, Education, and Patient Safety Incident Reporting representatives.
- National agencies like the National Child Mortality Database (NCMD) and the Coronial Service are asked to contribute as needed. The London CDOP Chairs Network also contributes to national concerns that have been identified as contributory factors in child deaths. This approach ensures a comprehensive review of child mortality cases by incorporating diverse perspectives and expertise.

- There is an ongoing discussion about the need to provide psychological support and/or restorative supervision for panel members due to the distressing nature of case review content, with the panel hoping for implementation in the 2024-25 reporting year.
- The administration is managed by four Single Points of Contact (SPOCs), supported by a manager who also supports as SPOC for Merton. Recruitment of a Single point of contact (SPOC) for Merton is anticipated in the next reporting year.
- There is a system of cross-cover for borough notifications, with shared access to case files and the use of eCDOP software for joint management involving two boroughs.
- The joint working arrangements are generally satisfactory from an operational standpoint.
- It is acknowledged that increased notifications of child deaths exceed current capacity for the time allocated for child death review case processing, with Wandsworth, in particular, experiencing capacity issues and considerable administrative strain due to extra paperwork processing that is required. St George's Hospital is a tertiary Hospital involved with child deaths in several other boroughs as well as South-West London. These notifications are almost as much as those managed by SW London by themselves, totalling fifty-one for other boroughs outside South-West London for children who died in the Wandsworth area/St George's Hospital.

2.2 Summary of SW London Child Death Overview Panel caseload 2023-24

Notifications of child deaths 2023-24

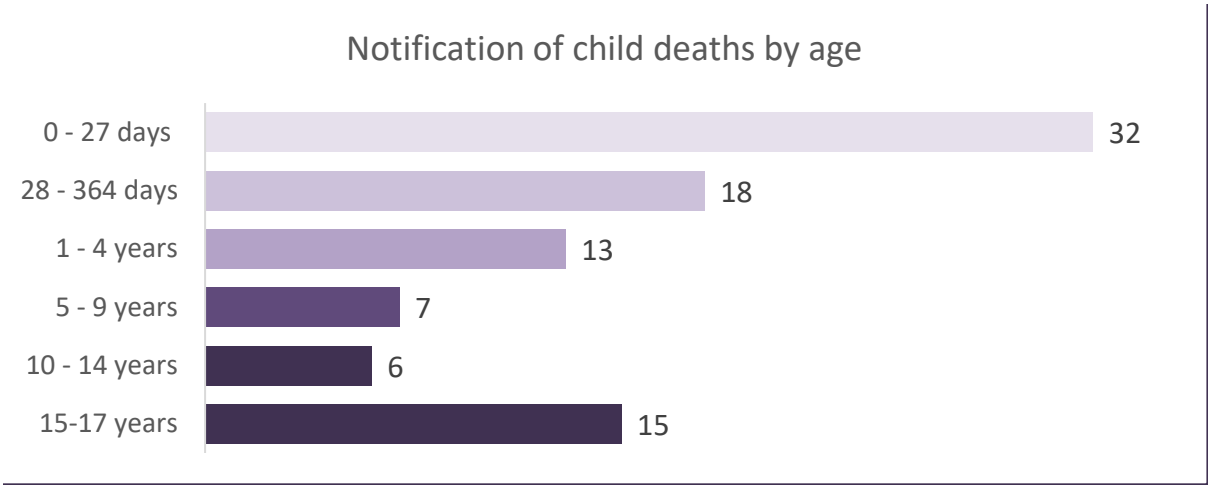
Graph 1



In the reporting year 2023-24, SW London received ninety-one new notifications of child death.

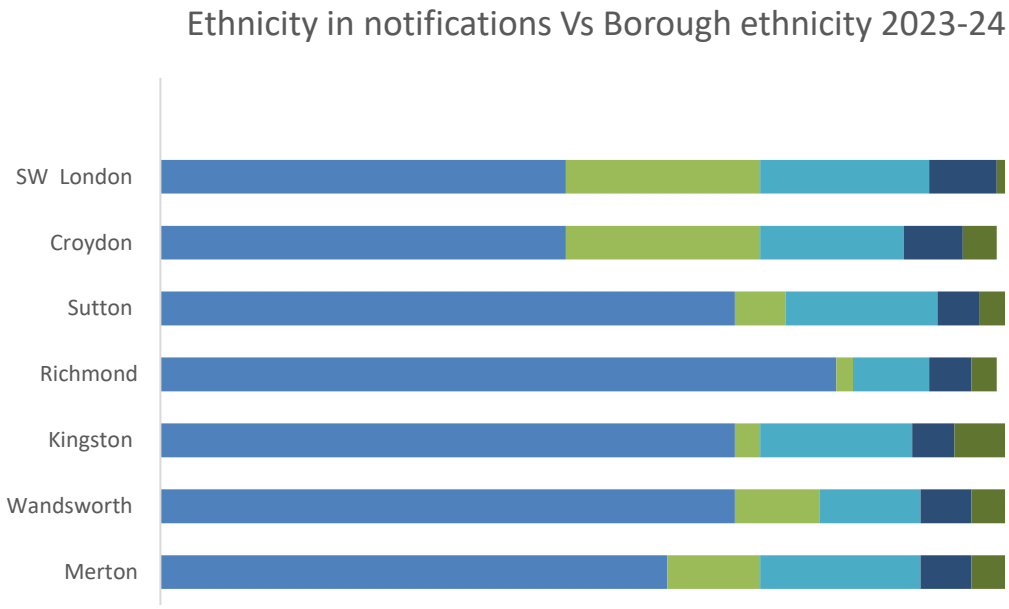
For 2023-24 children under 1 year old formed the largest category of child deaths. Regarding gender, fifty-three were male, and thirty-seven were female with one indeterminate.

Graph 2



As regards ethnicity, fifty-two percent of the notifications for 2023-24 are for ethnic minorities.

Graph 3



	Merton	Wandsworth	Kingston	Richmond	Sutton	Croydon	SW London
White	60%	68%	68%	80%	68%	48%	48%
Black	11%	10%	3%	2%	6%	23%	23%
Asian	19%	12%	18%	9%	18%	17%	20%
Mixed	6%	6%	5%	5%	5%	7%	8%
Other	4%	4%	6%	3%	3%	4%	1%

1

- For information, in the year ending 31 March 2023, there were 3,743 child deaths in England among children aged 0 to 17 years.
- The estimated rate was 31.8 deaths per 100,000 children.
- This represents an 8% increase compared to the previous year (2021-22).
- It is noted that the 2022-23 year was the highest number of child deaths in a single year, since the National Child Mortality Database began collecting data in 2019, under the new working arrangements for child death reviews.[2].

1 https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/populationestimatesbyethnicgroupandreligionenglandandwales/2019

2 Child death data release 2023 | National Child Mortality Database (ncmd.info)

- In London, the child death rate increased from twenty-five per 100,000 in 2022 year to thirty per 100,000 in 2023.
- The rate ranged from 24.2 to 41.1 deaths per 100,000 population of 0–17-year-olds.
- Most regions experienced an increase in child deaths compared to the previous year. [2].

2.3 Aims of the SW London Child Death Overview Panel

- The SWL CDOP reviews information obtained from Child Death Review Meetings.
- The goal is the final scrutiny of the reason the child died.
- Robust scrutiny ensures multiple perspectives are considered in determining contributory factors.
- The panel identifies learning points from the child death review process and makes recommendations to prevent future child deaths.
- These actions aim to:
    - Promote health, safety, and well-being of children.
    - Improve agency responses to child deaths.
    - Facilitate targeted bereavement support to the family including siblings.
    - If errors or deficiencies are identified or if an individual child's cause of death is unclear, the Medical Examiner can provide a second opinion to agree on a cause of death, and if there are questions requiring clarity on the cause of death, referral of further tests and to the coroner. This ensures proper discussion consensus and agreement on the cause of death on a death certificate.
    - The SWL CDOP provides specified data to the National Child Mortality Database.

- The panel produces an annual report for Child Death Review partners. The panel offers data and analysis to allow patterns, themes, and trends to be analyzed on a wider footprint. This broader perspective enables learning and informs future prevention efforts.
- The SWL CDOP advocates for local, regional, and national changes in (a) Policy, (b) Legislation, and (c) Initiatives to prevent future child deaths.

2.4 Local Child Death Reviews by Borough

The focus of the Child Death Review meeting (CDRM) is:

- To review background history, treatment, and outcomes of investigations to determine as far as possible the probable 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 coronial office, are informed of the outcomes of any investigation into the child's death,
- Refer the completed cases to the regional South-West London Overview Panel for final scrutiny of learning and actions taken for further recommendations at a regional or national level.

For deaths of children resident in SW London occurring between 1st April 2023 and 31st March 2024, 128 Child Death reviews were held in local hospitals and/or in conjunction with three specialist hospitals outside the area. In addition to sixty-eight meetings for SW London, local CDRM panels, particularly Wandsworth, conducted an additional sixty meetings for other areas for children who died in the local area. This

included fifty-one by Wandsworth, three by Kingston, four by Croydon, and two by Sutton CDRM Panels.

This is twice the number of meetings done in previous years and in the case of Wandsworth, who has St George's Hospital on their patch, three times the normal amount managed at this level by that area.

2.5 SW London Child Death Overview Panel Database (eCDOP)

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 fiscal year April 2023 to March 2024 at an increased cost. The London Chairs CDOP Meetings are in discussion with Quality Education Systems (the owners of the software) to support a London-wide re-negotiation of the contractual arrangements for financial savings to be agreed upon by a London-wide consolidation of the contract in the London region.

2.6 Out-of-Area Notifications

Regarding child deaths that occurred in SWL hospitals for other areas, in 2023-24 SWL CDOP notified other areas of 24 out-of-borough notifications, which were sent to the child's borough of home residence for case processing.

2.7 Length of time taken to review.

It is important to note that the deaths reviewed in a reporting year may not always coincide with the year of notification.

Delays in post-mortems, inquests, and other medical or legal investigations can impact the timing of reviews. From the seventy cases reviewed in 2023-24,

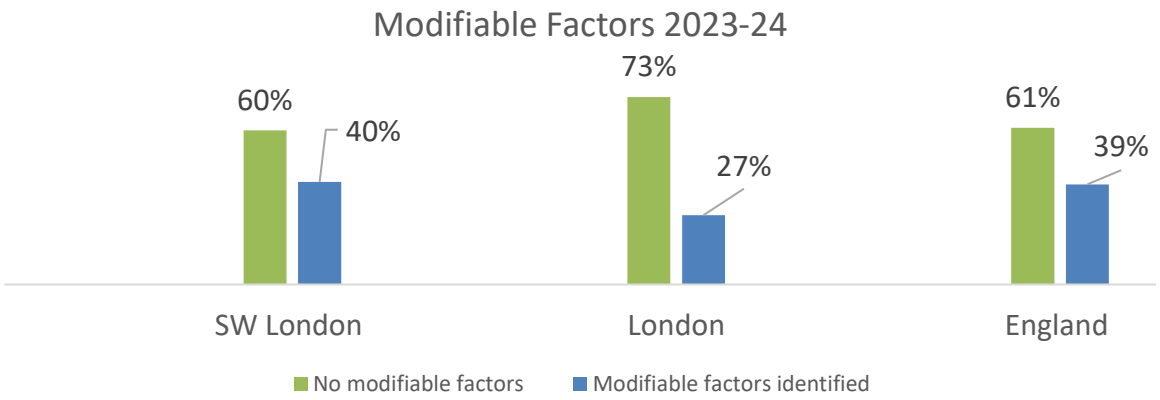
- Two percent were from the 2019-20 reporting year.
- Three percent were from the 2020-21 reporting year.
- Eleven percent were from the 2021-22 reporting year.

- Sixty-six percent were from the 2022-23 reporting year.
- Eighteen percent were from the 2023-24 reporting year.

A total of 18% of cases were completed in 6 months which is a decrease from 21% of child death reviews completed in the previous year. A total of 31% were completed in 12 months which is also less than 52% in the previous year. As a result of a delay in conclusion of inquests, 49% were over one year old at the time of review.

2.8 Modifiable Factors

Graph 4



- No Modifiable Factors:
  - When the CDR (Child Death Review) meeting does not identify any potentially modifiable factors concerning vulnerability, factors in the child or family, or as a result of issues with service delivery, a child's death, the category of "No Modifiable Factors" is selected.
  - This implies that the circumstances surrounding the child's death do not reveal any specific factors that could have been modified to prevent the death.
  - In 2023-24, 42 out of seventy reviewed cases (60%) had no modifiable factors identified on review.

- Three cases had inadequate information provided to conclusively state if there were modifiable factors.

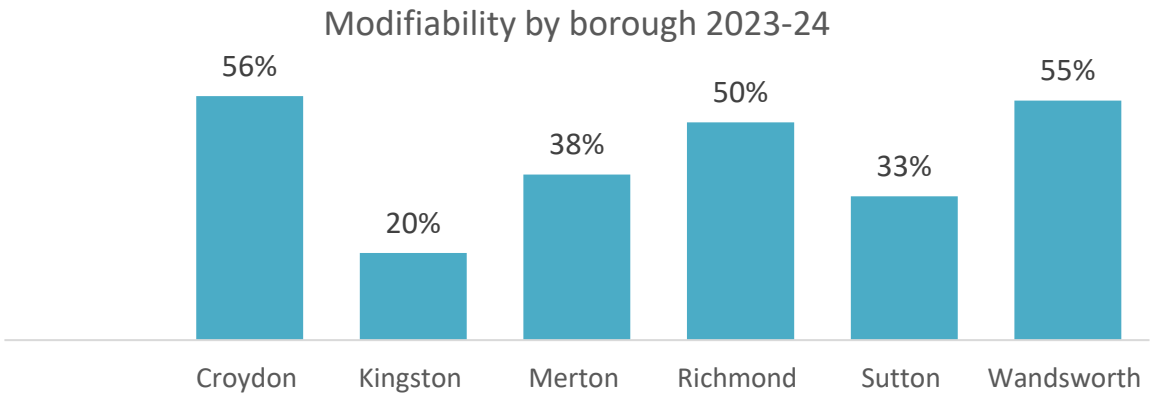
- Modifiable Factors

The category of “Modifiable Factors” is selected when the CDR or CDOP meeting identifies one or more factors that may have contributed to vulnerability or death.

These factors, across various domains, could be modified through locally or nationally achievable interventions to reduce future child deaths. In 2023-24, 28 cases had modifiable factors identified in the case reviews.

Reviewed cases that had modifiable factors by borough show the following picture of modifiable factors identified in reviews. The twenty-eight cases had modifiable factors in one or more domains. As a result, Graph 5 should be interpreted with caution as this does not change the overall figure in Graph 4 above as reflective of the total modifiable factors identified in reviews across SW London. The statistics indicate that there are more cases with modifiable factors this year than the 19% reported in 2022-23 in SW London.

Graph 5

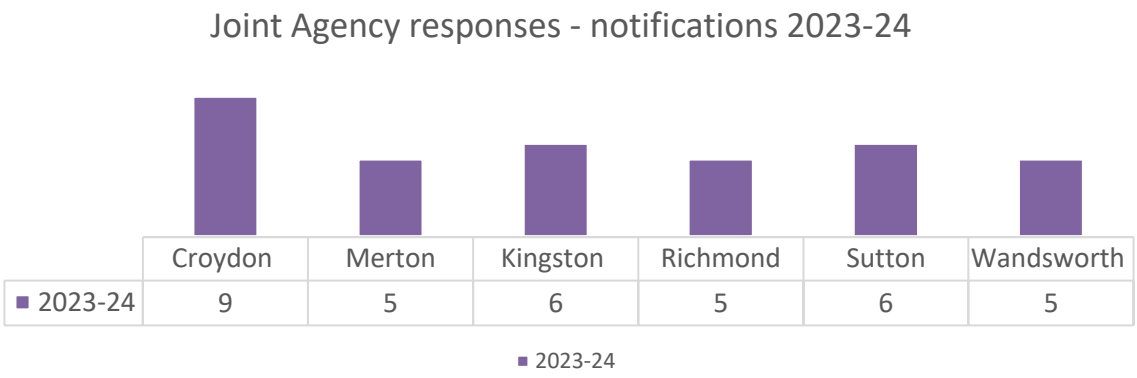


- For Domain A, factors in the child modifiable factors included, mothers’ pregnancy and delivery complications, mothers not accessing antenatal care, substance misuse, risk-taking behaviour by young people, and consanguinity.

- For Domain B, Factors in the family modifiable factors included parents' substance misuse and domestic violence.
- For Domain C factors in the home environment, modifiable factors included co-sleeping with babies and overcrowding of families living in cramped and deprived conditions.
- For Domain D, factors in service delivery, most of the modifiable factors included concerns raised on service delivery in labour wards, neonatal care, and postnatal care, which were subject to serious incident investigations. Staff shortages during levels of high activity in the labour ward negatively affecting care and overall oversight of clinical activity. Other factors included confusing advice from the NHS 111 service, and concerns raised by parents about mental health services on a child's safety in the community. More detail on the modifiable issues raised in the domains are provided in Chapter 3 (7-10) of this report.

2.10 Joint Agency Response

Graph 6



1. A Joint Agency Response is a coordinated multi-agency effort triggered when a child's death meets specific criteria.
2. These criteria include situations where:
    - The death may be due to external causes.

- The death is sudden, and there is no immediately apparent cause (including SUDI/C).
- "A Joint Agency Response should also be triggered if such children are brought to hospital near death, are successfully resuscitated, but are expected to die in the following days. In such circumstances, the Joint Agency Response should be considered at the point of presentation and not at the moment of death."
- The death occurs in custody or when the child was detained under the Mental Health Act.
- Initial circumstances raise suspicions that the death may not have been natural.
- In the case of a stillbirth, where no healthcare professional was present.

3. For new child death notifications that occurred during 2023-24, thirty-six Joint Agency Responses were held. This is 33% of all notifications received, and higher than the twenty-six Joint Agency Responses held in 2022-23 which was 20% of the notifications last year.
    - For the period 2022-23, Joint Agency Responses formed 40% of all notifications in London and 42% of all notifications in England [3]

2.11 Post-mortem Examinations and Reports

Post-mortems provide more information on the cause of death. Parents are routinely offered this service, but some parents choose to decline. Post-mortems are conducted at the request of parents, or the coroner. Of the seventy reviewed cases, twenty-five cases had a coroner's post-mortem completed, and another six cases had a hospital post-mortem done. In thirty-nine cases the cause of death was agreed upon without the need for a post-mortem examination.

[3] London NCMD Regional Report 2022-23. Please note that 2023-2024 figures have not yet been released.

2.12 Coroners Inquests

- Coroners are independent judicial officers responsible for investigating specific types of deaths.
- Coroners focus on deaths that are violent, unnatural, or sudden with an unknown cause.
- In the reporting period 2023-24 of the ninety-one new notifications of child deaths, thirty-three cases (30%) were referred for the coroners' investigation. This represents a 14% increase in coroners' inquests on those referred last year. Just over half (48 cases) required no coronial input.
- In the reporting period 2023-24 of the seventy reviewed cases, twenty-three cases required a coroner's inquest. In an additional five cases, the coroner discussed the death and agreed with the medical examiner to issue a death certificate. For forty-two cases, the deaths did not require coronial input, and a death certificate was issued by the medical team.
- All local coronial offices in South London, West London, and Inner West London that cover Inquests for South-West London face backlogs in concluding inquests.
- Adult and child inquests are combined, and there is no priority list for child inquests. All Inquests are listed based on the date of death and completion of the investigations to prepare the cases for Inquest. The cases cannot be reviewed until all investigations, including inquests, are completed.
- The SW London ICS Quality Directorate has been informed of anticipated delays in completing child death reviews while cases await inquests.
- As of April 2024, of the 117 open cases that await review, sixty-six have coronial involvement, which is 56% of the caseload. These cases are subject to coronial investigations and await decisions on whether to proceed to inquest, with most of them more than one year old.
- In 2022-23, out of ninety-seven open cases, 47% had coronial involvement.

2.13 Learning from Life and Death Reviews with a Learning Disability and Autism.

The Learning Disabilities Mortality Review (LeDeR) program is under new management and is now known as the ‘Learning from Life and Death Reviews for Persons with a learning difficulty and Autism” (LDRLDA) aged four and over as of 1st June 2021. The Child Death review process has taken over the child death review process for children with ADHD /ADD /Autism or possible neurodiversity under 18 years old as of June 2021 and then shares with the Learning from the reviews with the Learning from Life and Death review panel for SW London.

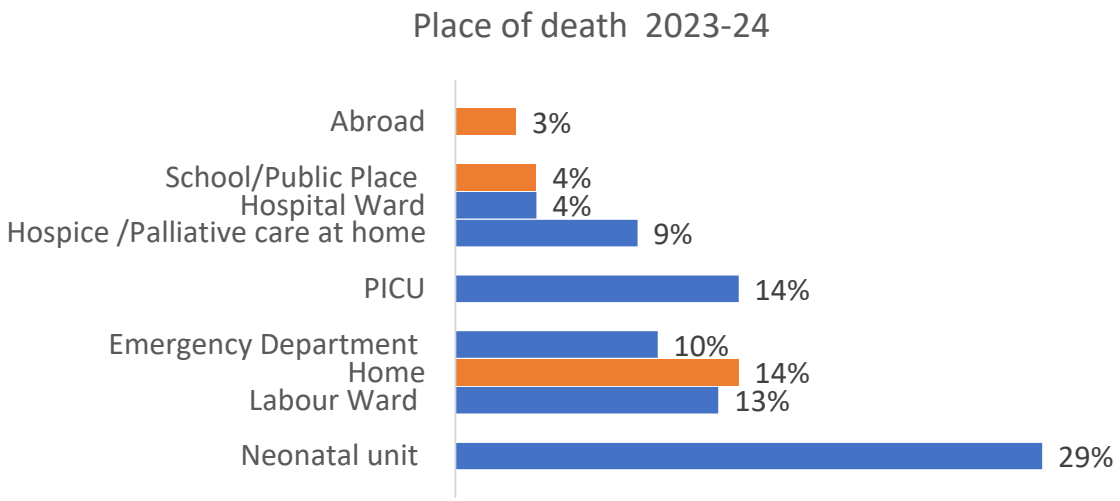
The child must have had a confirmed learning clinical diagnosis of Autism or learning difficulty recorded in their clinical records before their death. It is hoped that feedback on themes from these reviews will result in decreasing numbers of deaths, greater use of reasonable adjustments in health and care services for people with a learning difficulty and autistic people, and better outcomes for children as a result of local service improvement projects.

It has been noted by the panel in case reviews that there have been a few cases in older children where a learning difficulty was noted as suspected but not formally diagnosed at the time of death. The panel has reflected that once the question of a learning difficulty has been raised, an assessment should be prioritized for a formal diagnosis for support and to get a more accurate picture of levels of neurodiversity in older children.

The panel has shared themes on child deaths for children with difficulties with the SW London Statement of Educational Needs and Disabilities service (SEND) part of the Quality Directorate, of the SW London Integrated Care system, and a pilot project is currently underway to improve parity of service delivery across the area, in both health and social care provision.

2.14 Commentary on deaths – location

Graph 7:



In 2023-24, 79% of child deaths occurred in a clinical setting. This is lower than the 85% of child deaths that occurred in clinical settings in the previous year. There was an increase in the incidence of child deaths at home, abroad, or in a public place which at 21% was an increase of 12% that occurred in the previous year.

Chapter 3
Statistical Overview

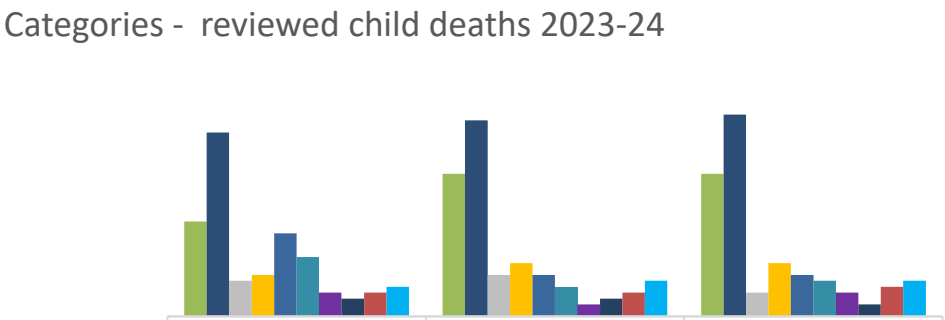
3.1 ANALYSIS OF CHILD DEATHS FOR 2023-24.

Seventy child death cases were reviewed and completed by the CDOP Panel during the 2023-24 reporting year. Caution is necessary when interpreting the data due to the small numbers involved. The pseudonymization process ensures privacy by converting and rounding up counts to the nearest percentages. South-West London statistical data is analyzed with London and England statistical data as comparators.

3.2 Completed Child Death Reviews by Category of Death

CDOP reviews cover a range of circumstances, including accidents, illnesses, and other factors. Ten main categories of death that are a culmination of several causes of death are presented in the graph below.

Graph 8



	South West London	London	England
Chromosomal/Congenital	16%	24%	24%
Perinatal/Neonatal	31%	33%	34%
Infection	6%	7%	4%
Malignancies	7%	9%	9%
Sudden Unexpected Child Death	14%	7%	7%
Chronic child death	10%	5%	6%
Self Harm child death	4%	2%	4%
Deliberately inflicted child death	3%	3%	2%
Trauma	4%	4%	5%
Acute child death	5%	6%	6%

Generic Themes from completed reviews.

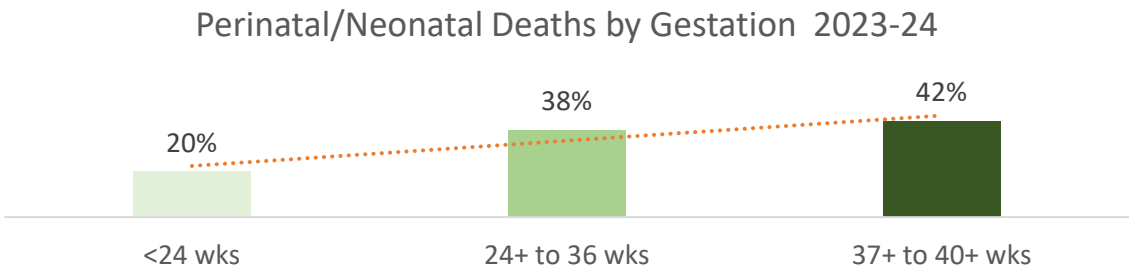
3.3.1 Perinatal/Neonatal event.

- Perinatal deaths occur during the perinatal period, which includes the time just before birth (usually the last few weeks of pregnancy) and the first week after birth.
- Neonatal deaths occur within the first 28 days of life (the neonatal period).
- These deaths can happen to both preterm and term infants.
- These deaths can be due to a range of factors, including complications during pregnancy, labour, or delivery.

In 2023-24, Perinatal/neonatal child deaths are the leading cause of child deaths in South-West London and, at 31%, is similar to the London and England averages of reviewed child deaths for this category.

Of this category, 20% of these cases were under 23+ weeks gestation, which is less than 31% of the same gestation last year. Thirty-eight percent (38%) of cases in this category were between 24 + to 36 weeks gestation which is also lower than last year at 56%. Term babies reviewed were 42% which was higher than the 13% reviewed last year. The panel continues to follow up on the difficulties in identifying learning from child death reviews for babies under 23+ weeks gestation from the London CDOP Network and NHS England for clarity on the terms of reference for the review of cases for this gestation.

Graph 9



1. Gender Distribution:
    - Among the babies, 64% were male, 32% were female, and 4% were indeterminate in gender.
    - Eighty-three percent of the deaths in this category were related to immaturity or prematurity. Perinatal asphyxia accounted for 27% of cases.
    - Twins accounted for 7% of child deaths. This is similar to last year. Twins often face a higher risk of preterm birth, which can result in increased demand for specialized neonatal resources.
    - Nineteen percent (19%) of the cases underwent serious incident investigations, similar to the previous year's 18%.
    - These investigations highlighted several areas of concern, including:
        - Antenatal, obstetric, or delivery risk factors in mothers accounted for 51% of cases.
        - Staffing shortages may be having an impact on the care of monitoring mothers during labour. The importance of ensuring adequate staffing during times of high activity in labour wards /delivery suites as a high-risk unit was noted in some Serious Incident Reports.
        - Ensuring effective pain management for mothers.
        - Antenatal concerns (e.g. maternal age, assisted conception, high/low maternal BMI, maternal smoking, etc) had an impact on poor outcomes.
        - Timely and accurate monitoring of fetal well-being.
        - Updating records and documentation promptly.

3.3.2. Chromosomal, Congenital, and Genetic Child Deaths

- Chromosomal abnormalities result from changes in the structure or number of chromosomes.
- Congenital anomalies (also known as birth defects) are structural or functional abnormalities present at birth.
- Genetic disorders result from changes or mutations in specific genes.

Chromosomal congenital and genetic disorders abnormalities can affect physical development, cognitive abilities, and overall health, and have poor outcomes. Chromosomal, congenital, and genetic child deaths were 16% of child deaths reviewed in 2023-24. Comparatively, in both London and England, 24% of child deaths were in this category. All cases had specific chromosomal, congenital, and genetic anomalies identified, some were related to prematurity, with heart and respiratory anomalies, and all families were referred for genetic testing to review to plan for future pregnancies.

In some cases, Hospices managed the child's final hours and last rites for the families and have been offered bereavement support. In one case a paediatric review initiated by the hospital, recommended consideration of the importance of a bridge between the community and acute teams jointly caring for children with life-limiting conditions to ensure there is appropriate support and parallel palliative care planning.

3.3.3 Infection

Infections can be caused by both bacteria and viruses.

Six percent (6%) of child deaths were in the category of infection, which is lower than 9% last year and lower than the London average of 7% but still higher than the England national average of 4%. Septicaemia, Myocarditis, and Meningoencephalitis were the most common infections identified.

Nearly all the cases in this category had either Perinatal Mortality reviews (PMRT) or Serious Incident investigations initiated. Local hospitals are closely monitoring all infections in children and the implementation and use of the Paediatric Early Warning

Sepsis Tool to assess infections in children has a national deadline for mandatory implementation in local hospitals by September 2024, as the risk of a sudden deterioration in a child's clinical condition is faster than an adult. The panel awaits assurance of plans for improvement in safety netting advice for parents who attend accident and emergency and urgent care treatment centres for children with a recent history of fever and temperature.

3.3.4 Malignancy

Childhood cancer is rare, with approximately 1,645 new cases diagnosed every year in the United Kingdom for children aged 0-14 years. Childhood cancers account for less than 1% of all cancers in the UK. The most common type of cancer in children is Leukaemia, which accounts for about a third of all cases in this age group. A further quarter of cancer cases are brain and spinal cord tumours. 1 in 10 are lymphomas.[4]

Oncology-related conditions in the case reviews were slightly lower this year at 7%. London and England's statistical data is at 9% which is the same as last year. These children were across all age groups and ethnicities. Leukaemia that was subject to previous bone marrow transplants and Tumours was featured for this category. As has become customary, there has been positive feedback from families on palliative care both by hospices and in the community by the Community Nursing Teams, Paediatric Oncology Shared Care Unit (POSCU), and Community Diagnostic Hub (CHAH) services. Parents have commended bereavement support. Siblings have also asked for and have been included in family bereavement support offers.

The commissioning of palliative care in the community across SW London was noted as different depending on the borough across the local area and is being considered by the SW London Integrated Care system to get a more equitable offer for parity in service provision across all boroughs in SW London.

[4] https://ukhsa.blog.gov.uk/2021/03/15/cancer-in-children-and-young-people-what-do-the-statistics-tell-us/

3.3.5 Chronic Medical Conditions

Chronic health problems in children are persistent conditions that may last for months or even indefinitely. These conditions can significantly impact a child's well-being and daily life.

In 2023-24, 9% of children in this category died as a result of complications from their complex medical conditions. This is higher than the 5% noted last year, but similar to London at 5% and England at 6%. All were children who despite severe physical and learning disabilities, continued to strive despite a limited life expectancy.

Issues raised at the reviews were the lack of a commissioned service for children's community nursing service for children with chronic conditions at weekends in Richmond and a need to have parity of service provision across the area. The need for a lead health professional overseeing the management of care of children with chronic conditions across the local area is now in the process of being implemented in SW London as part of a review of the components of the SEND services across SW London, and in a serious incident investigation, the importance of improved communication between hospital and community teams, on children with chronic conditions in the community that have a high risk of sudden deterioration at home.

3.3.6 Sudden Unexpected Death of an Infant/Child (SUDI/C)

Sudden unexpected deaths in infancy and childhood refer to tragic incidents where a child dies suddenly and unexpectedly, leaving no immediate cause apparent. These events have a profound impact on parents, families, and the community.

SUDIC-related child deaths are currently at 14%, which is twice the London and England average for this category. An alert noting an increase in notifications of child

deaths in this category was raised at the SW London ICS level in February 2024 to point out that this trend has not decreased to date.

All were babies under 2 years of age with half (50%) in the 28-364 days age group. . All of the SUDI deaths were discussed with the coroner and subject to post-mortems and 44% of the cases had Inquests completed. The remaining 66% had the cause of death agreed without Inquest after post-mortem. Two-thirds of the cases also had Serious Incident investigations completed and/or Perinatal Mortality Reviews.

Despite communication campaigns to reduce risk factors for SUDI, the most notable concerns identified are as follows:-

1) Ongoing issues of babies co-sleeping with parents (37%) and poor sleep environments/overcrowding in the family home (25%).

2) Increased risk for multiple births- three cases involved one of twins.

3) Housing issues, including a malfunction of heating/cooling systems in multi-story flats buildings with a previous history of a SUDI and delays in housing referrals.

4) Poor parental understanding of how to seek emergency assistance via 999 ambulances

5) Appropriateness of the response to 111 calls that involved the sudden collapse of babies at home requiring urgent action without complex and lengthy questioning

6) Delays in face-to-face new birth visits in two cases and communication issues in one case involving access to a GP appointment.

7) Babies who were recently discharged from the hospital with no apparent health issues before experiencing a sudden and unexpected collapse at home.

8) A few of the cases also had Perinatal Mortality Reviews done, which graded the baby’s care at level B.

3.3.7 Suicide, Self-Inflicted Harm

Suicide and self-harm are serious concerns affecting adolescents in SW London.

Four percent (4%) of child deaths in this category resulted from fatal self-inflicted harm, which was the same as last year and the year before. The young people were known to mental health services, and Serious Incident investigations were completed by that service. Common themes were substance misuse addiction and family breakdowns, i.e., parental separation, abuse, and domestic violence in the home. All children were between 15 and 17 years of age. Two cases were subject to Safeguarding Practice Reviews. This category is further discussed in Chapter 4 of this report.

3.3.8 Deliberately Inflicted Deaths

Deliberately inflicted child deaths refer to tragic incidents where a child's life is intentionally taken through abuse, neglect, or violence.

Three percent (3%) of child deaths were in this category, slightly higher than the previous year at two percent (2%). These were fatal stab wounds to male teenagers between the ages of 14 and 17 in a public place and resulted in convictions of perpetrators. Knife crime continues to be a serious cause of concern in this category and has been for the past 3 years. While community initiatives such as 'bleed kits' have been distributed in high-risk/incidence areas, the London Ambulance Service has reiterated that more first aid training in the community is most valuable to save lives.

3.3.9 Trauma

Trauma is defined as a stressful frightening and distressing event where in this instance, the outcome is fatal.

For the reporting year 2023-24, four percent (4%) of child deaths were in this category. These deaths included young people involved in tragic accidents while on holiday abroad, and others by misadventure involving local public transport. Two were known to mental health services before the incident. The Foreign and Commonwealth Coronial Liaison office assisted in following up and obtaining foreign post-mortems, police investigations, and inquest reports to assist in supporting the case reviews. Feedback from the local panel to the Foreign and Commonwealth Office on the learning from these reviews was communicated to them to share with their foreign counterparts. The rates of child deaths in this category are similar in London at 4% and England at 6%.

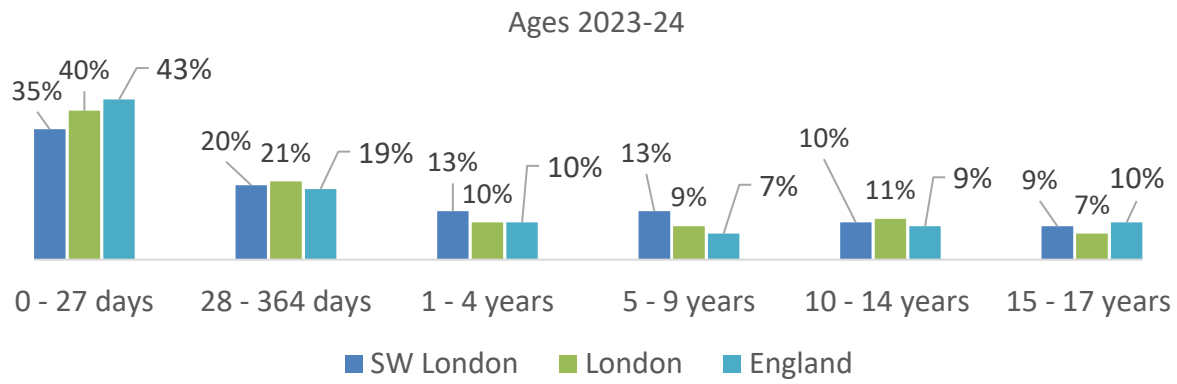
3.3.10 Acute Medical Conditions

An acute medical condition can be a sudden onset of illness of short duration which despite accessing medical attention in this instance has had a fatal outcome.

In the 2023-24 reporting year, 3% of child deaths were due to an acute medical condition due to the sudden collapse of a child who had an existing chronic medical condition that was unexpected. No issues were raised on service issues for these cases. London and England had 6% respectively for this category.

3.4 Completed Reviews by Child's Age

Graph 10



The above graph indicates that 55% of the child deaths reviewed in 2023-24 in South London were under one year of age which is less than last year at 69%.

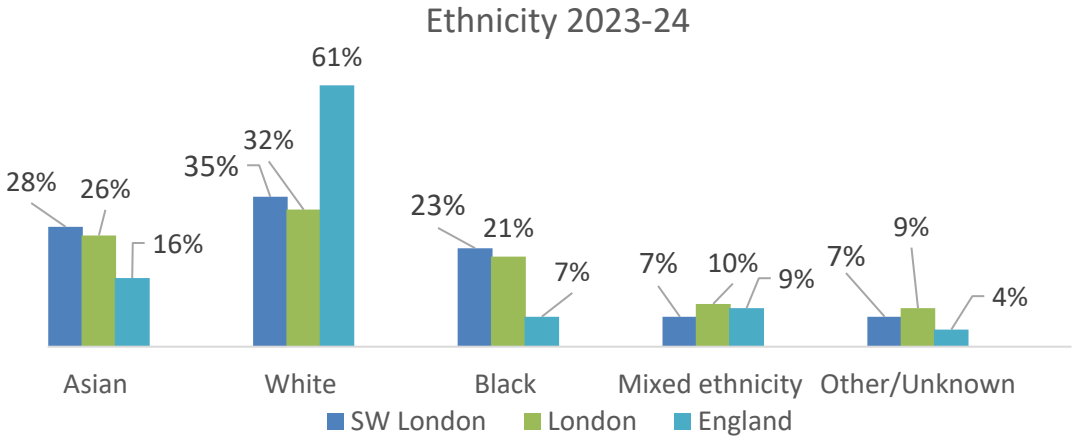
3.5 Demographic and Social Characteristics.

Gender

The gender breakdown of reviewed child deaths across all categories in 2023-24 is 45% male to 54% female, and one undetermined due to extreme prematurity. National gender rates are 42% female to 57% male and 1% undetermined due to prematurity.

3.6 Ethnicity of children who have died – Reviewed cases.

Graph 11:



Proportionately, in South-West London, as has been in previous years, 58% of the ethnicity of child death reviews was of Asian, Black, or mixed-ethnicity children which is higher than 43% of children whose deaths were reviewed last year. Proportionately, as a result of the ethnic diversity of London, the statistic is similar at 57%.

1. Infant Death Rates by Ethnicity: - national outlook.

    - Nationally, the estimated infant death rate varies significantly based on ethnicity.
    - The rate for infants of black or Black British ethnicity stands at 8.7 deaths per 1,000 live births.
    - In contrast, infants of white ethnicity have a lower rate of 3.0 deaths per 1,000 live births.
    - Infants of Asian or Asian British ethnicity fall in between, with a rate of 6.2 deaths per 1,000 live births.
    - Notably, the rate for Black infants is approximately three times higher than that for White infants.

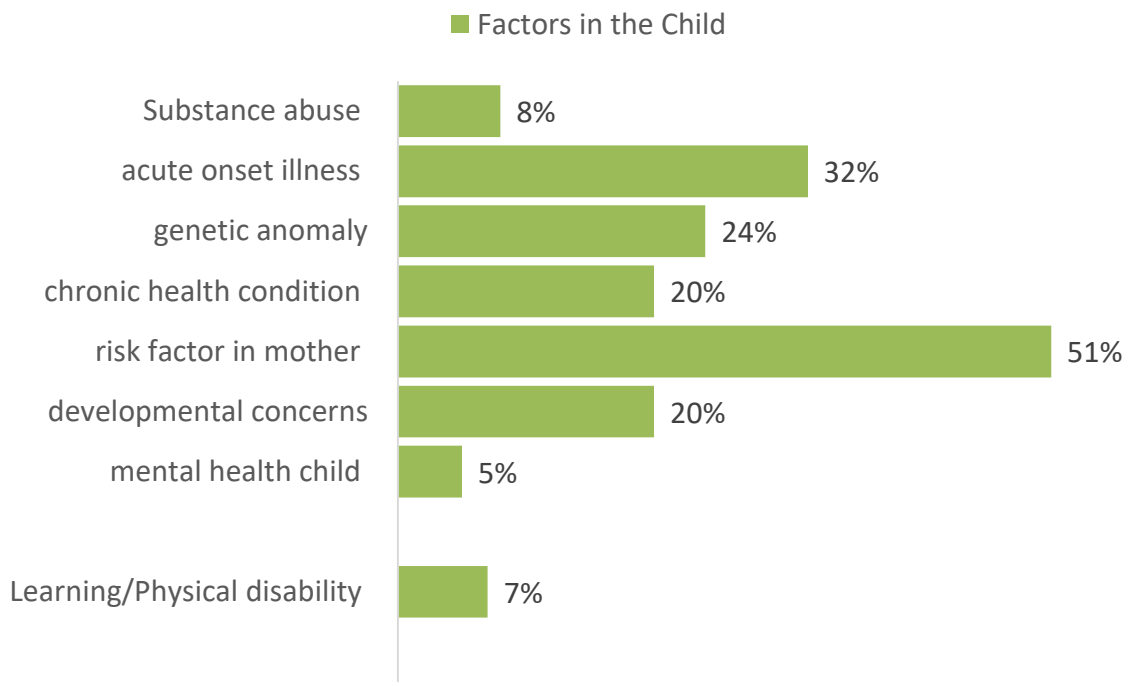
- The data indicates that infant death rates for those of Black or Asian ethnicity increased compared to the previous year.
- However, the rate of deaths for infants of white ethnicity decreased during the same period[5]

The panel has been monitoring the ethnicity of reviewed cases subject to serious incident investigations. Twenty-six percent of the seventy reviewed cases were subject to a serious incident investigation. In 2023-24, by ethnicity of reviewed cases subject to Serious Incident investigations, 77% were of White children, 11% of Black children, 11% of mixed ethnicities, and 5% of Asian children. Despite child deaths being 58%, referrals for serious incident investigations by ethnicity for minorities are at 27%. The disproportionality in terms of ethnicity in serious incident investigations in comparison to actual child deaths by ethnicity has continued as in previous years.

[5] https://www.ncmd.info/publications/child-death-data-2023/

3.7 Factors in the Child. (Domain A)

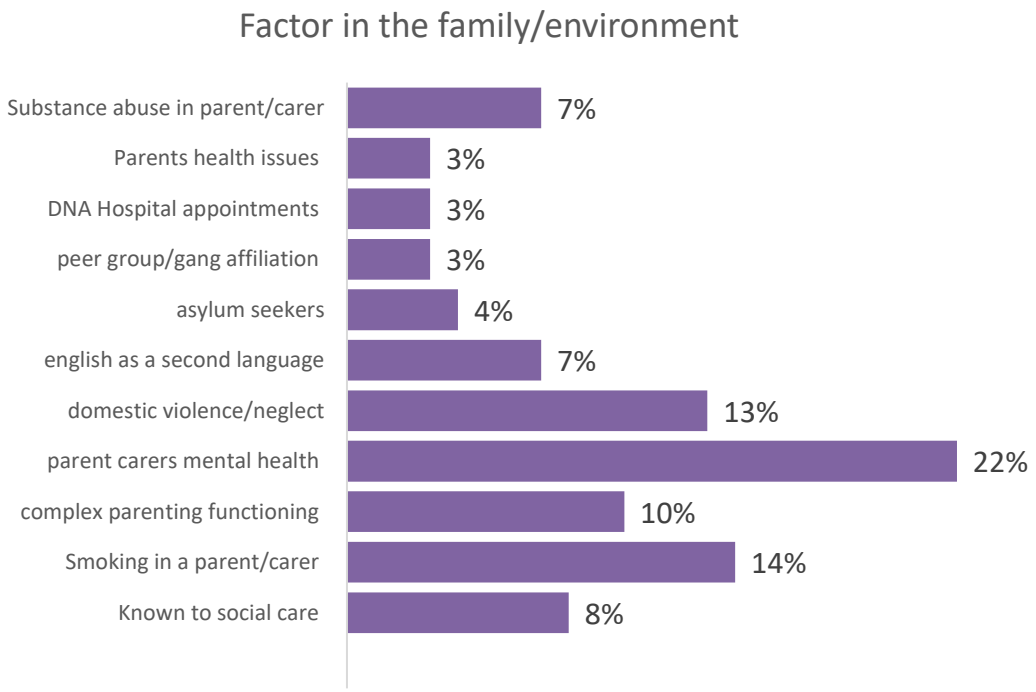
Graph 12



In the reporting year 2023-24 of 70 reviewed child deaths, half had a factor in the child noted which is similar to last year. While substance abuse, mental health concerns, and learning disability in a child accounted for 8%, 5%, and 7% respectively, risk factors in mothers antenatally and at birth accounted for 51% of vulnerabilities contributing to loss. Factors included maternal infection, and obstetric and delivery complications. Acute onset illness accounted for 32% of the deaths and chronic health conditions and genetic anomalies accounted for 20% and 24%, respectively.

3.8 Factors in the Parents, Family, and Environment (Domain B)

Graph 13

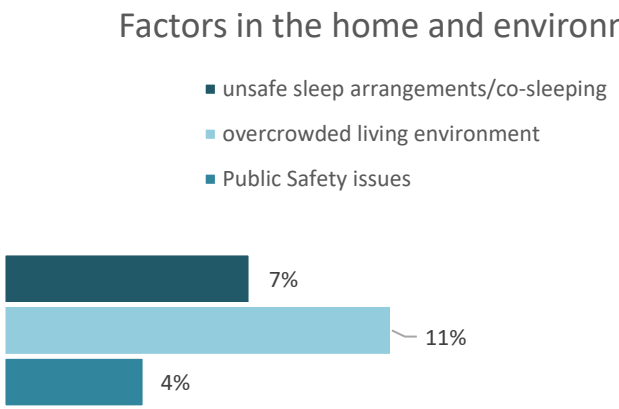


The following was recorded to support case analysis of child death reviews.

In SW London, reviewed cases that involve domestic violence fell to 13% from 24% last year. Mental health concerns (depression, anxiety, and learning disabilities) in parents are at 22%, down from 33% last year. Complex parenting environments were noted in 10% of the cases reviewed. Parents who speak English as a second language and communication issues were noted in 7% of cases. Substance misuse in parents/carers (drugs, alcohol) is at 7%, which is the same as in the previous year. Smoking by parents/carers in the home is up at 14% from 10% in the previous year. In 3% of cases, the child was not taken to their scheduled hospital appointment.

3.9 Factors in the Home and Environment (Domain C)

Graph 14



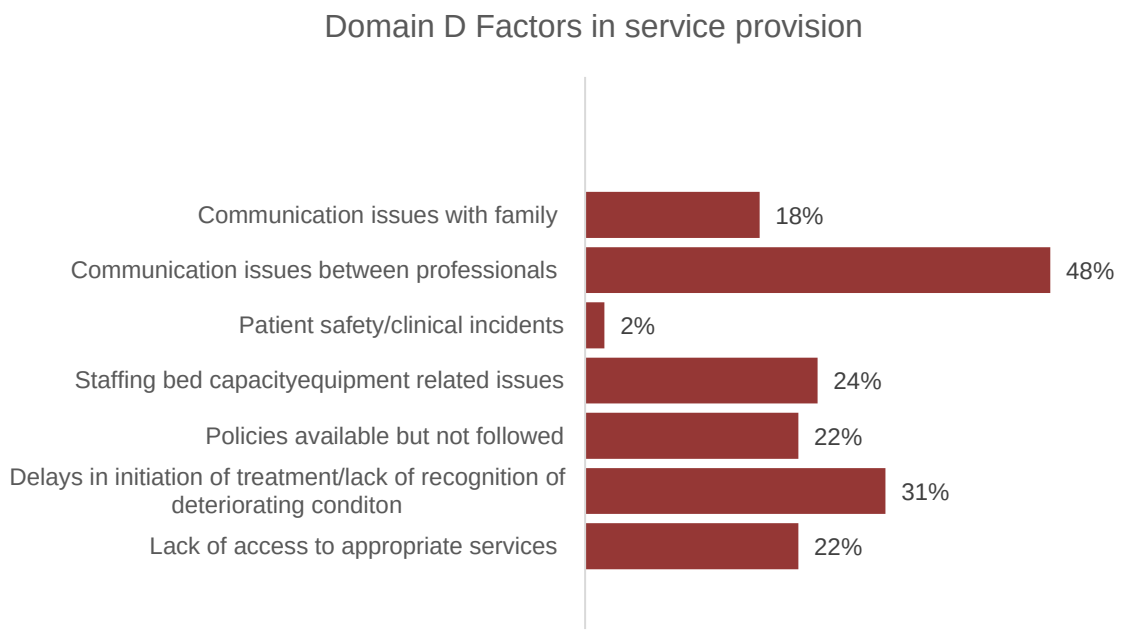
Overcrowded and unsuitable home conditions have been noted in 11% of cases, which is an increasing feature noted in child death reviews and is indicative of a shortage in the supply of adequate, affordable housing in London.

Young people accessing restricted areas of public spaces where they were at risk of harm was noted in 4% of cases.

Co-sleeping and unsafe sleep arrangements were noted in 7% of total deaths, including 37% of SUDI-related child deaths.

3.10 Factors in Service Provision (Domain D)

Graph 15



Of the 28 cases that had modifiable issues noted, 22 cases or eighty percent (80%) of these had concerns about service provision issues which is a substantial increase on the 34% noted in the previous year. These 28 cases had one or more of the following issues noted:-

- Delays in initiation of treatment, delays in recognition of a deteriorating child, and delays in escalation of care management were noted in 31% of the cases.
- Cases where there is a guideline or policy in place to respond to specific situations, which was not followed, featured in 22% of cases.
- Insufficient staffing levels at times of high activity, a shortage of specialist bed capacity, or defective or unavailable equipment were noted in 24% of cases.
- Poor communication between professionals, particularly in circumstances where more than one service was managing the care of the child, was particularly high in 48% of these cases.

- Eighteen percent of cases involved issues of communication with family, which included poor communication with parents by professionals to assist with understanding care management and expectations, parents' complaints on confusing advice given by 111 services, and inadequate access to interpreting services.
- For social care and services commissioned by the local authority, delays in access to appropriate services, where the required service is not commissioned, or commissioned to a third sector charity where accountability for service delivery is required, high attrition rates of staff in social care negatively affecting the quality-of-service provision, or for mental health, inadequate capacity to match the demand of referrals particularly as they relate to mental health/social care, and palliative care was noted as a factor in 22% of the cases reviewed.
- The Serious Incident Framework undertakes the management of reporting safety incidents to deliver a high-quality identification and investigation of clinical incidents. Serious Incident investigations (SI's) identify areas for improvement, retraining, policy revisions, or procedural changes in the provision of health care for children. There were 2% of cases that involved a clinical error, which was noted that it did not affect the outcome, but the panel has considered that cumulatively, patient safety may be negatively impacted by a culmination of all the factors in service provision noted above.

3.11 Serious Incident Investigations

Twenty-six percent (26%) or eighteen of the seventy reviewed child deaths were subject to Serious Incident investigations, which was an increase on the 16% subject to investigations in the previous year. Most involved perinatal/neonatal child deaths. This year, Croydon Hospital had ten Serious Incident Investigations, with Chelsea & Westminster and Kingston Hospitals with two each, St George's, Kings Hospital, and St Helier Hospitals with one each, and one by London Ambulance Service. St George's and the Maudsley Mental Health Trusts also conducted three Serious

Incident Investigations. A few of the issues arising have been covered in the Factors in Service Provision as all these cases had service provision issues which were referred to the serious incident process for investigation and recommendations made to address the issues raised.

3.12 Child Safeguarding Practice Reviews

In 2023-24 two reviewed cases were subject to Child Safeguarding Practice Reviews (CSPRs). They involved young people with complex safeguarding concerns and were subject to Mental Health Trust Investigations. For one, mental health struggles, family instability, education disruptions, trauma and loss, issues with navigating the complex system of support, poor self-esteem and identity, and transition to adulthood were all issues raised. On the other, the issues raised by the Inquest included missed opportunities to provide better responses to the young person's needs, struggles with emotional well-being and substance abuse, and a lack of engagement with professionals.

Both young people were at the cusp of their 18th birthdays and were in a state of mental crisis at the time of death. Both cases received narrative verdicts from the coroners' inquest asking for improvements in risk information sharing between Children's Social Care, Mental Health, and the Police for vulnerable young people at risk of self-harm in the community. Links to the Safeguarding practice reviews are included in the appendix of this report.

3.13 Patient Safety Incident Reporting Framework

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents. Its purpose is to learn from incidents and improve patient safety.

The panel commenced reporting on feedback activity with the SW London Patient Safety Surveillance group on 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 (ICS).

The panel has sent the recommendations from case reviews on a six-monthly basis to local hospitals for assurance that changes from the Serious incident investigations and panel reviews have been considered and implemented. However, Kingston Hospital has been the only local hospital that has provided full assurance that recommendations have been met by engagement, system-based learning, and proportionate responses to patient safety concerns. The panel has concerns that there is a closer relationship between the factors in service provision and patient safety that has its learning being collected separately by the eCDOP /NCMD process when this could be viewed as one entity to get a true picture of the landscape of service delivery and its effect on patient safety. The national PSIRF system has released a recent report that the promised improvements in the implementation of PSIRF have not materialized[6] The panel looks forward to receiving similar assurances from St Helier Hospital, St George's Hospital, and Croydon University Hospital will follow with full compliance in this reporting year. [7]

3.14 Bereavement

Parents who have lost a child endure an incredibly painful and challenging experience. Coping with the death of a child is a unique and profound grief that can affect parents emotionally for years.

Under the operational arrangements for child death reviews, support of the surviving family is a core part of the procedures after child deaths. Bereavement support is initiated by identifying a key person best placed to support a family, decided on a case-

[7] Patient safety and the NHS staff survey results - Patient Safety Learning

by-case basis to assist with navigating services, funeral arrangements, and accessing counselling or psychological support.

There was a 100% offer of bereavement support given to all families who had a child's death across the area. Eleven families chose not to engage with services and parents were informed that arrangements could be made for support up to a year later if they felt they needed to access support at another time. It is noted that third-sector charities, health visiting, and hospital bereavement services provided most of the support that was accepted by parents.

For the seventy cases reviewed, Fifty percent (50%) of the children who died were survived by at least one sibling which was also similar to the previous year. Siblings who attend school were assigned bereavement support in the school setting.

The SW London Child Death Overview Panel would like to thank the key workers /bereavement nurses whose roles have been an essential and invaluable part of the bereavement process and the service is working well. Both grieving parents and clinical and other agency professionals are grateful for their leadership in the initial support of a family when a child dies.

Key workers are mainly specialist nurses who provide information on the child death review process and navigate the course of any investigations about the child, including consulting with the coroner's officer and any police family liaison officer, and signposting for specialist bereavement support, or securing documentation for funeral arrangements. Key workers keep the family informed and represent the 'voice' of the parents at professional meetings, to ensure that their questions are effectively addressed, to provide feedback to the family afterward; and to take feedback from parents who wish to contribute to child death reviews.

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 visitors offers of support are often unreported. All SW London Hospitals have their key workers, bereavement nurses, and bereavement procedures in place across Midwifery, Neonatology, Primary Care, and Paediatrics.

As a result of this, there is cross-checking across agencies to ensure every family that has a child's death, is offered appropriate support or signposting to third-sector charities for support. As always, Hospices provide an enhanced level of support that families can access up to three years after their child's death.

Metropolitan Police Service

There has been significant work to improve the partnership across all agencies when dealing with police involvement in child deaths.

As the Police are often the first point of contact with a family together with the London Ambulance Service and are conversant with the child death review process, Police officers have been invaluable in the provision of first responder perspectives of a scene of death as well as to provide immediate support to a bereaved family via a family liaison officer.

The Police contribute to scene of incident reporting as part of reviews. The relationship with the local hospitals and Police to contact hospitals pending arrivals to A & E via ambulance, to appropriately receive and triage grieving parents, has become an effective method of managing a devastating experience for both parents and staff. The police have also engaged in training sessions for their staff on the child death review process. This has meant better multi-agency collaboration and understanding with an enhanced prompt response in many instances.

Children's Social Care/Local Authorities

Likewise, Children's Social care has enhanced bereavement support in the community with more health visitor/key worker support. In a number of the cases reviewed, there has been more support to bereaved relatives through improved communication with the Key workers and Community Health Visitor services whose services are commissioned by the local authority. This ensures that bereavement support is immediately in place in the community and that teams work more closely together (health, police, and social care). Social care has provided bereavement support to siblings in school settings also via third-party providers.

3.14 Parents and Carers' Feedback to the Child Death Overview Panel

In most cases, parents want to understand why their child died. Parents are offered a meeting to discuss any questions they may have.

- In particular, comments from parents' discussions on the child death review process, parents did not like the term 'child death panels' as they considered the term insensitive to parents who are unfamiliar with a clinical environment. The term was explained to parents for clarity to make clear the name was a national term for a statutory function and the process was mandatory by law.

- In a few cases, parents raised concerns that they were not being listened to nor appropriately monitored while in Labour.

- Another concern raised was the lack of a monitored 24-hour helpline for midwifery. Parents raised concerns that there was not enough staff to care for babies. Staff were reminded of the importance of listening to parents and where there are concerns that they are appropriately escalated.

- Management of the post-natal units and returning mothers to an area where other nursing mothers and babies are when their child has died, was considered insensitive and asked for a procedure should be put in place when mothers have lost a baby that they do not return to the same area.

- There were a few inquiries about counselling for 'care of next infant (CONI) and the provision of a specialist pregnancy loss midwife for parents who want to try again for a baby, and the panel has been raised at the SW London ICS level as currently there is no commissioned service at present in the local area.

- A common question raised was whether there were delays in the initial treatment and if this made any difference to the outcome. It was explained to

the parents that in some circumstances in children deterioration is rapid and aggressive, and despite optimal treatment, the child did not survive. Genetic testing has helped identify anomalies in cases where there is initially no apparent reason their child did not survive.

- Other comments from parents included a suggestion for more direct communication regarding the end of a baby's life when Consultants know death is imminent.

- Out of a clinical setting, the importance of the appointment of a key worker to the child's parents as soon as possible after death was seen as essential to explain the procedural requirements of the child death review process, and social care and police input as part of the review.

- In a few instances, where automated text messaging reminding parents of immunization appointments continued when their child had died, the panel asked that this be corrected and communicated to the neonatal units to ensure that the primary care communication is updated with the notification of death promptly to ensure all automated messaging concerning future appointments are stopped immediately upon notification of death.

- There were also several messages from parents thanking the staff for the care their child received despite the poor outcome and efficient management of the release of documentation so that last rites, transfers to Hospices, or religious customs could be observed. One family raised funds and purchased a cold cot for the hospital involved and have started a foundation in their baby's name for the benefit of the hospital.

Chapter 4:

Conclusion and Priorities for 2025-26

4.1 Goals for next Reporting year 2025-26

The panel aims are as follows: -

I. To continue to identify trends in child deaths in the South-West London area, and to alert services regularly of trends in notifications of child deaths to flag issues that require immediate intervention.
II. To work with the SW London Patient Safety Surveillance group on shared learning from Child Death Overview Panel meetings as part of the CDOP's contribution to the organizational response to child deaths in the South-West London Integrated Care System (ICS).
III. To share learning and recommendations from child death reviews to support best practices across all services to reduce child deaths.

SUMMARY

The recommendations and learning from 70 panel reviews and the SW London Child Death Overview Panel in 2023-34, continue to contribute to the promotion of community education, improvements in organizational practice, improvements in education, training, and communication in local partner agencies, and learning and has had a positive impact on local practice, regional and national government policy.

Appendix 1: Statutory and Regulatory Legislation

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

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

Chapter 6 Working Together to Safeguard Children 2023 – Child Death Reviews

https://assets.publishing.service.gov.uk/media/65cb4349a7ded0000c79e4e1/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf

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.

Child Death Data Release 2023 | National Child Mortality Database (ncmd.info)

Ref.-414-NCMD-Child-Death-Reviews-data-yr-end-31-March-2023.pdf (hqip.org.uk)

jake-safeguarding-practice-review-2023_0.pdf (croydonlcsb.org.uk)

croydon_cspr_chloe_-_final_report_for_publication.pdf (croydonlcsb.org.uk)

NEW: Parents Safety Netting advice led by the Royal College of Paediatrics & Child Health

https://www.nenc-healthiertogether.nhs.uk/professionals/parent-advice-sheets

Appendix 2: NCMD Monitoring Reports 2023-24 (not attached to this document)

Croydon
Kingston Upon Thames
Richmond Upon Thames
Merton
Sutton
Wandsworth.

eCDOP London Annual Report statistical data 01.04.2023 – 31.03.2024 printed June 2024.

National Child Mortality Database London Regional Report to 1st March 2023