

HEALTH AND WELLBEING BOARD

28 OCTOBER 2014

Title: Update on the Barking & Dagenham Child Death Overview Panel Annual Report 2013/14	
Report of the Director of Public Health	
Open Report	For Information
Wards Affected: All	Key Decision:
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Sponsor: Matthew Cole, Director of Public Health	
Summary: <p>The Child Death Overview Panel Annual Report was presented to the Health and Wellbeing Board at its meeting on 29th July 2014. The Board requested that the Director of Public Health update the Board on the following actions:</p> <ul style="list-style-type: none">• To give the Board an in-depth understanding of Sudden Unexpected Death in Infancy and how it can be prevented• An update on the outcomes of the cases relating to maternity services and the London Ambulance Service with modifiable Factors / recommendations to child death reviews 2013-14• Update on the further analysis on the relationship with ethnicity and child death rates through examining the deaths across the boroughs of north east London.	
Recommendation The Health and Wellbeing Board is asked to note the report.	

Reason(s)

There is a requirement to present an annual Child Death Overview Panel (CDOP) report to the Local Safeguarding Children Board who recommends its findings to the Health and Wellbeing Board as part of the process of influencing health and social care commissioning priorities. Under Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, set out the function of the Local Safeguarding Children Board (LSCB) in relation to child deaths, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

- a) collecting and analysing information about each death with a view to identifying:
 - any case giving rise to the need for a review mentioned in regulation 5(1)(e);
 - any matters of concern affecting the safety and welfare of children in the area of the authority;
 - any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
- b) establishing procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Barking and Dagenham CDOP is asked to categorise the likely cause of death, record the event that caused the death and any modifiable factors.

1. Background and Introduction

- 1.1 Child Death Reviews are undertaken on behalf of Local Safeguarding Children Boards for every child that dies under the age of 18, and data is published annually. The statutory responsibility to review child deaths was introduced on 1 April 2008.

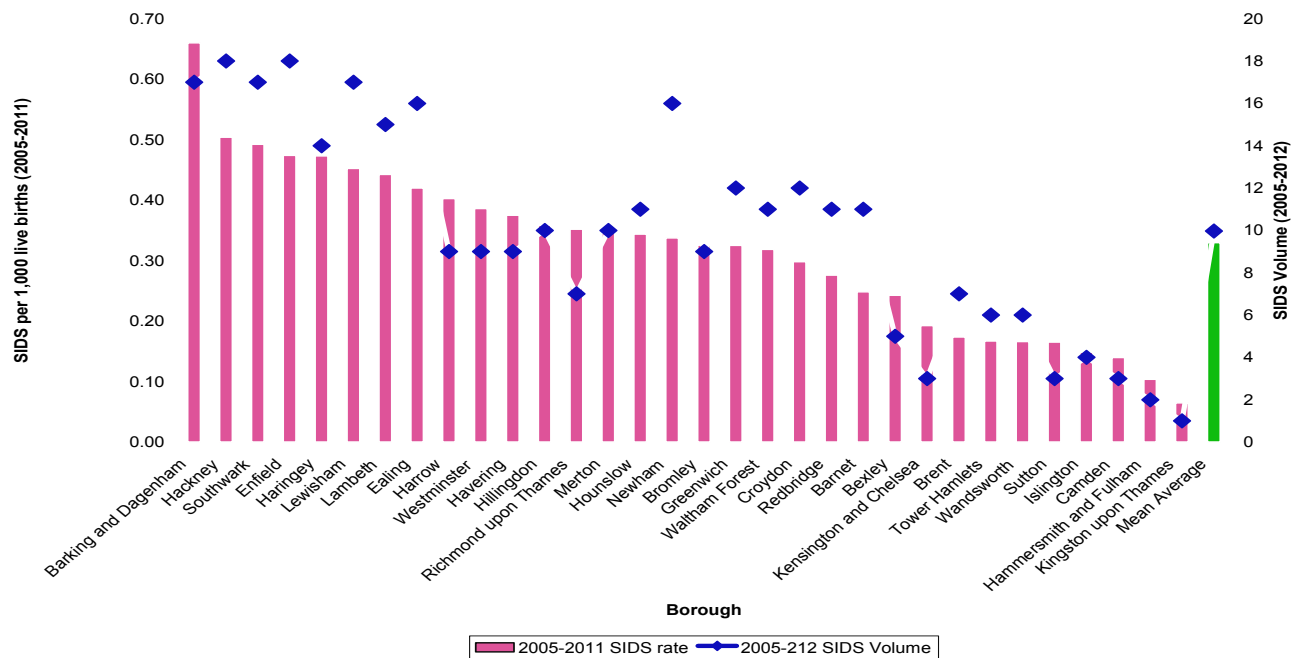
2. Sudden Unexpected Death in Infancy in Barking and Dagenham

- 2.1 Sudden Unexpected Death in Infancy (SUDI) is defined as the sudden death of an infant, which is unexpected by history and remains unexplained after a thorough forensic autopsy and detailed death scene investigation.
- 2.2 Data for the year ending 31 March 2013 shows that the event which caused the child's death in 374 cases was sudden unexpected death in infancy, out of a total of 3857 child deaths that were reviewed. These deaths were 9.7% of the child deaths reviewed and modifiable factors were identified in 57% of the deaths. In spite of the difference in some cases between year of death and year of review, and some lack of clarity about whether rates are based on deaths under the age of one year or under the age of two years, the rate per 1000 live births, at local and higher levels is published as a means of comparison between areas. In 2011 the rate for England was 0.34 per 1000 live births, with London having the lowest regional rate at 0.29.

- 2.3 Data on child deaths is complicated by the difference in timing between the date of death and the date of the child death review being completed. For example, of the 3954 children in England who died in the year ending 31 March 2013, only 38% of the child death reviews had been completed. This may be due to the complexity of on-going investigations, or simply lack of resources or meeting dates. In Barking and Dagenham in 2012-13, 46 child death reviews were completed. Of these 13 deaths occurred in 2012-13, 27 in 2011-12 and 6 in 2010-11. In 2013-14, 27 deaths were reported, of which one was reported as occurring in 2012. 18 reviews were completed, of which 9 related to the year of the report and 9 to the previous year.
- 2.4 Data on child deaths is therefore confused by the potential for the death to occur one year and the review to be completed in a different year. This is particularly important with the small numbers of deaths that occur in a rare circumstance like SUDI, and in a small geography like a London borough. In Barking and Dagenham, SUDI numbers have varied between 0 and 5 per year. In both 2008 and 2010 no SUDI deaths were reviewed. Both years were followed by higher numbers of reviews in the subsequent year, as can be seen from the table, which also shows the annual rate per 1000 live births. The table also shows slight differences between the deaths reported by the Metropolitan Police Service and by the Child Death Overview Panel Report, which may reflect a difference in timing between the date of death and the date of review, but which impacts on the rate in the relevant years, depending on the data source.

Year	Number of live births	SUDI deaths as reported by MPS		SUDI deaths reported by CDOP	
		Number	Rate	Number	Rate
2005	2985	2	0.67	2	0.67
2006	3208	4	1.25	4	1.25
2007	3384	2	0.59	2	0.59
2008	3619	0	-	0	-
2009	3624	5	1.38	4	1.1
2010	3729	0	-	0	-
2011	3688	3	0.81	4	1.08
2012	3957	1	0.25	1	0.25
Total 2005-12	28194	17	0.6	17	0.6
2013	N/A	N/A		1	

- 2.5 In spite of all the data issues, taking the period 2005-2012 it is clear that Barking and Dagenham has experienced a high number of SUDIs, and has the highest SUDI rate in London. Data is collected and analysed by the Metropolitan Police Service as 'Project Indigo', from which it is possible to see London borough comparisons.
- 2.6 The graph below, taken from the Project Indigo report published in 2013, shows the numbers and rates per 1000 live births for SUDI for all London boroughs.



2.7 At borough level, although the aggregate number of SUDIs is comparatively high, the numbers are small from an epidemiological perspective. This means that no analysis can demonstrate whether any specific characteristic of an individual case has occurred by chance or indicates a trend or risk that should be addressed. In addition, details of cases that could lead to identification of the infant or family cannot be published as this would break confidentiality. This means that, while information about any modifiable factors related to the death are published, demographic data cannot be published, and due to the small numbers no meaningful conclusions can anyway be drawn from demographic data.

2.8 Of the six Child Death Reviews included in the 2012/13 and 2013/14 Child Death Overview Panel Reports that confirmed the death was a SUDI, in five cases there were modifiable factors and in one there was not. Of the five with modifiable factors, in two there were pre-existing medical conditions where more active clinical intervention might have influenced the situation, and in one inappropriate feeding was identified, which might have been modified with more feeding advice from the midwife or health visitor. In the other two, classic factors associated with SUDI were present – co-sleeping, alcohol use and the sleeping position of the baby. Again, more advice from the midwife or health visitor might have resulted in better appreciation of the risks and more appropriate care of the infant. In the single case where there were no modifiable factors, it is assumed that none of the factors known to be associated with SUDI were present, and the death was completely unexplained.

3. Sudden Unexpected Death in Infancy in London

3.1 Project Indigo reviews all SUDI cases in London and due to the larger numbers is able to give some indication of demographic and other circumstances. Between 2005 and 2012 there were 319 cases and they found that:

- 56% of children were under 12 weeks of age at the time of their death
- 11% were born underweight

- 18% experienced major health problems prior to their death
- 42% of children were white
- 32% of children were black

3.2 Importantly Project Indigo data shows that in around 50% of SUDI cases the mothers were smokers, between 40 and 50% feature a household where one of both parents have a record on the Police National Computer, co-sleeping is a factor in one-third of cases and co-sleeping where the adult had consumed cigarettes or alcohol prior to sleeping a factor in one in ten cases. There is some indication from the small numbers for which additional housing data is available that co-sleeping may be associated with over-crowded households, and that SUDI cases are more likely in socially or privately rented households rather than owner-occupied (83% of 12 cases were in rented accommodation).

3.3 This more local data adds to the picture that we have from national statistical analysis and research over the years. SUDI was found to be associated with sleeping position and the incidence has reduced sharply since the introduction of the 'Reduce the Risk' campaign in 1991 which advised that babies should be laid on their back for sleep. 80% of SUDIs occur between 28 days and one year of age. They are more common in boys, in births that are registered by the mother only, in babies born to young mothers, in those that are not breastfed, and in those from routine and manual socio-economic classifications. The highest proportion occurs over the winter period from December to February, which is thought to be due to overheating with bed covers or central heating at night. SUDI is associated with exposure to tobacco smoke both during pregnancy and after birth.

4. What action can we take in Barking and Dagenham to reduce the number of SUDI deaths

4.1 Following completion of a Child Death Review, any failings or potential improvements in care that may influence modifiable factors are communicated to the health and care professionals involved, and where appropriate will result in changes in care policy or practice. The Child Death Overview Panel reports provide details of the recommendations arising from each Review.

4.2 In considering what further action to take in Barking and Dagenham, as many as possible of the 18 cases that have occurred since 2005 could be further assessed to ensure that all recommended actions have been implemented. In addition, any new cases should be rapidly reviewed for modifiable factors and recommendations. With such small numbers in recent years (one each in 2012 and 2013) it is possible that the local position is improving, but the aggregate data will demonstrate a high local rate for some years to come. On an annual basis, the difference between being above or below that London and national average is the difference between 0, 1 or 2 cases in the year, which could be artificially impacted on by whether the Child Death Review was completed in the same year as the year of death or not. Future Child Death Overview Panel reports should clearly report the relationship between the date of death and date of completion of Child Death Review in order to ensure accurate assessment of the local position on SUDI rate.

4.3 From the Public Health perspective, continuing to focus on sleeping position together with emphasising the risks of smoking in pregnancy and around the infant are the priority actions. Although it is assumed now to be well known that babies should be

laid on their back to sleep, inappropriate sleeping position was a factor in two of the recent local SUDIs and midwives and health visitors should be asked to continue to give advice on sleeping position and co-sleeping. The biggest single factor which could make a difference is to avoid smoking in pregnancy and around the infant.

- 4.4 Although 2013/14 data published on smoking at the time of delivery shows that the percentage of mothers who smoke has reduced from 15% in 2012/13 to 9.3% in 2013/14, there is no data on the percentage of mothers, fathers and other carers who smoke around the infant. Research demonstrates that infants of mothers who smoke may have up to five times the risk of SUDI than infants of mothers who do not smoke. The greatest risk is smoking during pregnancy, but the risk continues after the child is born. Although the evidence on exposure to tobacco smoke from other people is less clear, there is evidence of that the risk increases with the number of smokers in the household or the number of hours in the day that the infant is in a smoke-filled environment. A renewed drive to reduce smoking during and after pregnancy by both the mother and family members could help to reduce the number of SUDIs locally as well as bring health benefits to all those who stop smoking.

5. The outcomes of the cases relating to maternity services and the London Ambulance Service with modifiable Factors / recommendations to child death reviews 2013-14

- 5.1 The Performance and Quality Assurance Committee of the Barking and Dagenham Local Safeguarding Children Board is responsible for ensuring the recommendations of child death reviews are taken forward.
- 5.2 The September performance report to the Committee from CDOP is contained in Appendix 1 details progress to date.

6. The relationship with ethnicity and child death rates through examining the deaths across the boroughs of north east London

- 6.1 Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn. Reducing infant mortality overall and the gap between the richest and poorest groups are part of the Government's strategy for public health.
- 6.2 The small number of infant deaths at local authority level means that pooling over a number of years for robust levels of analysis is required. Even with pooled rates, however, numbers may still be small and large random fluctuations possible. With the exception of ethnicity, the rates are not standardised or adjusted to take into account any potential confounding variables. Whether or not such variables need to be considered depends on the purpose to which the indicator is being put.
- 6.3 There is a known association between infant mortality and deprivation, which combined with a relatively high proportion of those from ethnic minorities living in socially deprived areas compared to the white British population, could contribute to higher observed rates of infant mortality in non-white British populations in England.

- 6.4 The combined infant mortality rates across five of the six east London boroughs was 8.2 per 1,000 live births in black children, compared to 6.1 per 1,000 in other ethnic groups. With the data pooled over four years, totalling 167 deaths amongst Black children and 485 in all other ethnicities, this difference was found to be statistically significant. At borough level, the numbers are too small for reliable testing of significance.
- 6.5 Infant mortality is associated with a range of factors including congenital abnormality, low birth weight, young maternal age, sole registration of the birth, smoking and deprivation. For the east of London as a whole, the possibility that there is a relationship between mortality among Black infants and deprivation should be considered. Addressing avoidable factors and optimising support to families through health visiting and children's centres are some of a range of interventions to reduce childhood deaths.
- 6.6 While the current findings remain inconclusive, it is reasonable to be concerned that the local Black population is at higher risk of infant mortality, and to take steps to reduce those risks. The Public Health directorate will seek to undertake more detailed analysis of any available and relevant data so as to have a better understanding of issues that may be associated with the subject area.

7. Mandatory implications

7.1 Joint Strategic Needs Assessment (JSNA)

The JSNA has a section dedicated to the analysis of child deaths. The annual CDOP report is used to update this section of the JSNA annually.

7.2 Health and Wellbeing Strategy

The review of child deaths is an integral part of the safeguarding elements in our Health and Wellbeing Strategy. At this point there is no need to change the focus of the Health and Wellbeing Strategy as a result of this annual report.

7.3 Integration

The review of child deaths and the work of the Barking and Dagenham Local Safeguarding Board for Children is multi-agency and integrated in its approach.

7.4 Financial implications

There are no financial implications to this report and it is assumed that all CDOP training will be conducted by the CDOP Manger and not commissioned externally.

Implications completed by Patricia Harvey Interim Group Manager Children's Finance

7.5 Legal implications

There are no specific legal implications arising out of the recommendations in this report. The statutory provisions relating to the child death review processes have been set out in the body of this report. Legal services will continue to support the service delivery to achieve the improvements identified. In addition appropriate advice will be given on any changes to governance arrangements to ensure responsibilities are clearly defined and information exchanged to support the continued delivery of these improvements.

Panel is invited to note that child deaths and the review process can lead to interest from the media and other parties, such as the local community. Panel should be aware of the management of requests for information, from whatever source. Legal services shall support the appropriate marketing and communications team in managing such requests.

Implications completed by: Chris Pickering, Principal Solicitor - Litigation & Employment, Legal and Democratic Services

7.6 Risk management

The work of the CDOP links very closely into the Francis Report recommendations in respect of safeguarding and quality of care. The comprehensive and multi agency review of child deaths aims to understand how and why children die in Barking and Dagenham and use the findings to take action to reduce the risks of future child deaths and to improve the health and safety of the children in the area.

8. List of Appendices

Appendix 1 - September Performance Report