Triborough Annual Report 2022-23

Suppressed version

Child Death Overview Panel

Bexley, Greenwich, and Lewisham Child Death Review Partnership

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The deaths of 73 Bexley, Greenwich & Lewisham children under the age of 18 were notified between 1 April 2022 and 31 March 2023. The standardised mortality ratio for the triborough area was 124.5 (95%CI 97.6-156.6), meaning there were more deaths than might be expected compared to England as a whole, but not significantly so.[1]

Table 1. Child deaths notified, by borough (number and rate per 100,000), 2022/23

Borough	Notifications	Population ages 0-17	Rate (per 10,000)	95% Confidence Interval	
				Lower	Upper
Bexley	23	56,706	40.6	25.7	60.9
Greenwich	26	65,839	39.5	25.8	57.9
Lewisham	24	64,740	37.1	23.7	55.2
Triborough total	73	187,285	39.0	30.6	49.0
England (2021/22)[2]	3,428	11,774,602	29.1	28.1	30.1

Source: Lewisham and Greenwich NHS Trust, National Child Mortality Database, ONS Census 2021

23 deaths were notified for children in Bexley, 26 in Greenwich, and 24 in Lewisham. There is little difference between the rate of death per population in each borough, and although the crude mortality rates are higher than England, again the difference is not significant.

Place of residence

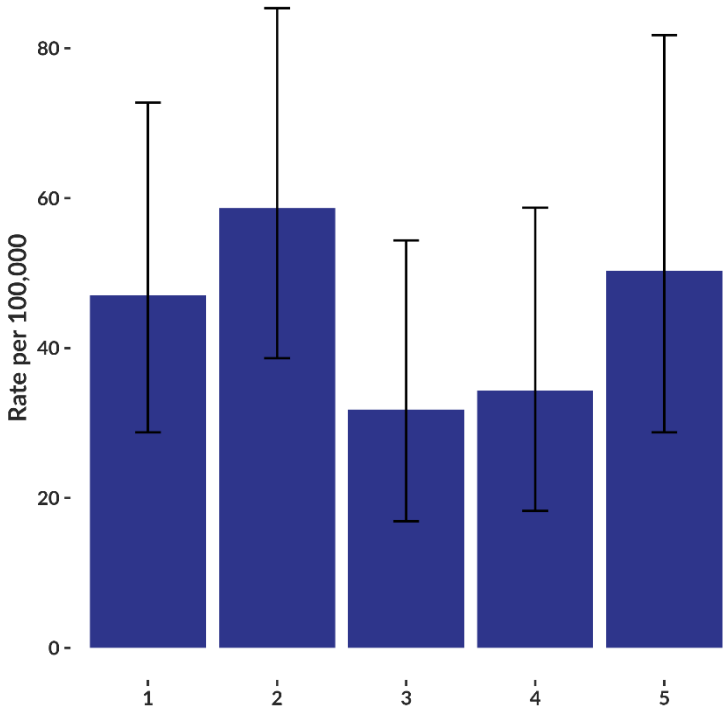
At England level, child mortality follows a deprivation gradient, with twice the rate of death in the most deprived quintile compared to the least deprived. The local data does not follow this pattern. Although there were almost three times as many notifications from areas in the most deprived quintile compared to the least deprived, this difference is due to the population at risk being more likely to live in these areas. After adjusting for population size, the rate of

[1] Throughout this report the significance of any difference in rate or proportion is determined by non-overlapping 95 per cent confidence intervals, in accordance with the Association of Public Health Observatories *Technical Briefing 3.* <https://webarchive.nationalarchives.gov.uk/ukgwa/20170106081144/http://www.apho.org.uk/resource/item.aspx?RID=48457>

[2] National Child Mortality Database, *Child Death Review Data: Year ending 31 March 2022* <https://www.ncmd.info/wp-content/uploads/2022/11/Child-death-review-data-release-2022.pdf>

death shows no clear association with level of deprivation, and nor are there any significant differences between the rates experienced in any two quintiles:

Figure 1. Child deaths notified, by deprivation decile (rate per 100,000), 2022/23

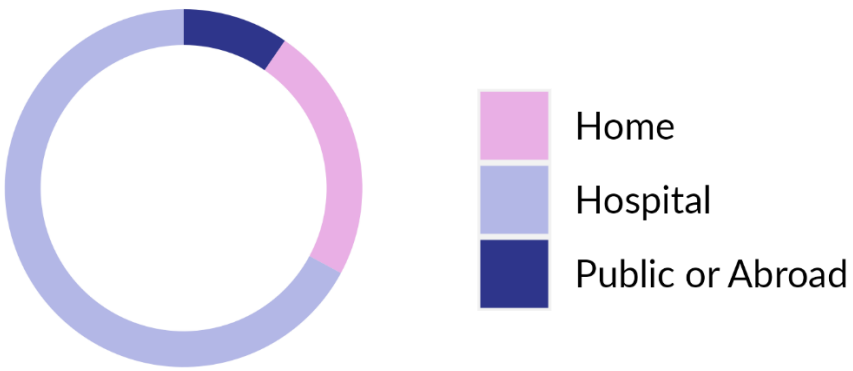


Source: Lewisham and Greenwich NHS Trust, English Indices of Deprivation, SAPE23DT2

Place of death

Of the 73 notifications, 7 children died in a public place or abroad, 17 at home, and 49 either in a hospital or hospice.

Figure 2. Child deaths notified by place of death (proportion of total), 2022/23

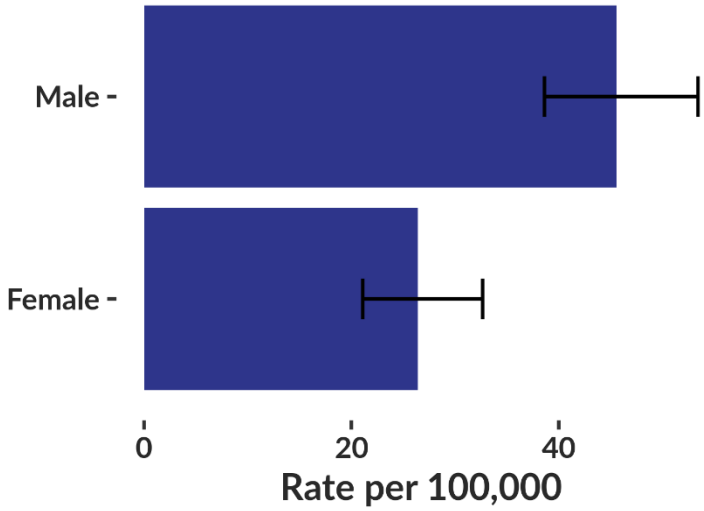


Source: Lewisham and Greenwich NHS Trust

Gender

The rate per 100,000 population for males (50.4) was almost twice that of females (26.1). There has been a consistent excess of male deaths over the last three reporting periods, with a statistically significant difference across the pooled period:

Figure 3. Child deaths notified by gender (rate per 100,000), 1 October 2019 – 31 March 2023



Source: Lewisham and Greenwich NHS Trust, ONS Census 2021

The same pattern has been observed nationally[3], with males experiencing a higher rate of death across all age ranges. Nationally, the largest absolute contribution to the difference is from deaths in the 0-27 days age bracket, not because this age bracket experiences the widest inequality, but because this age group contains 42% of all child deaths. The most pronounced inequality occurs in the 15-17 years age range, where males were 1.67 times more likely to die than females at England level.

[3] National Child Mortality Database, *Child Death Review Data: Year ending 31 March 2022* <https://www.ncmd.info/wp-content/uploads/2022/11/Child-death-review-data-release-2022.pdf>

Age

As above, nationally 42% of child deaths in occur in the first 27 days of life, and locally the figure for this reporting period is 37%, with 63% occurring at less than one year of age:

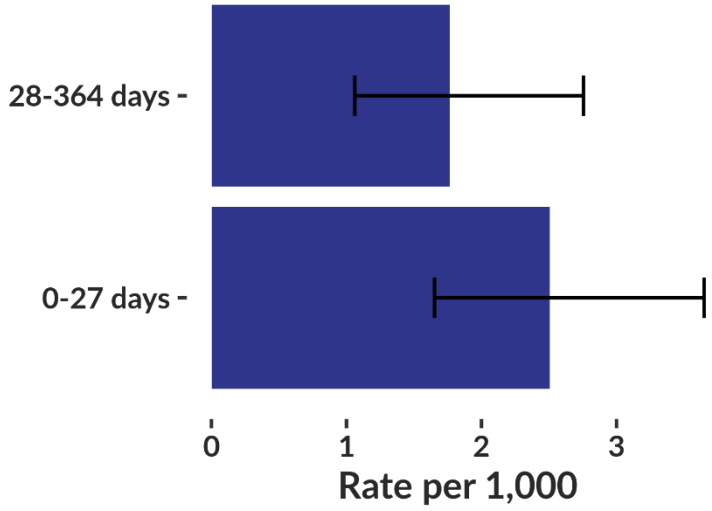
Table 2. Child deaths notified by age group, 2022/23

Age	Notifications
0-27 days	27
28-364 days	19
1-4 years	9
5-14 years	12
15-17 years	6

Source: Lewisham and Greenwich NHS Trust

The 0-27 day mortality rate per 1,000 births was 2.5, or just under 1 per every 400 livebirths. The 28-364 day mortality rate was lower at 1.8 per 1,000, or around 1 per every 567 livebirths. The overall infant mortality rate was 2.1 per 1,000, around 1 per 468:

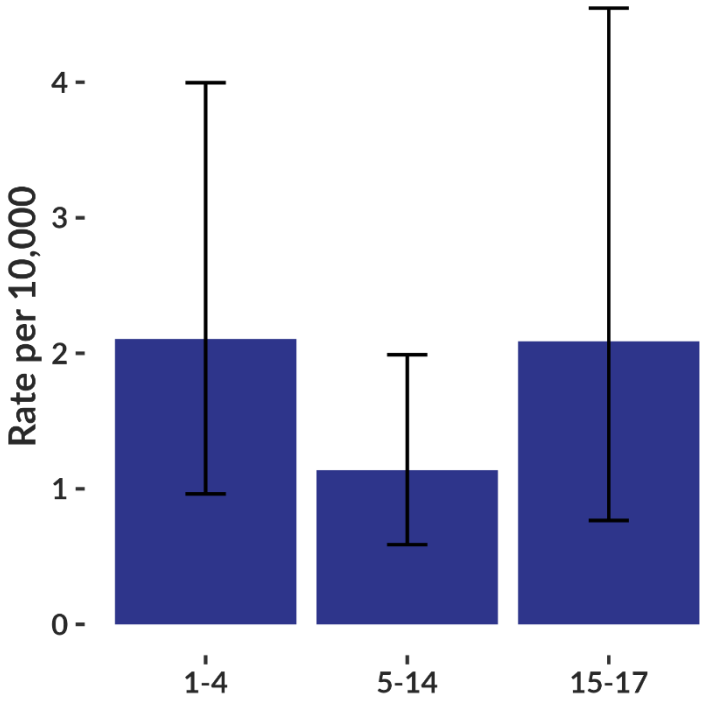
Figure 4. Child deaths notified under one year by age group (rate per 1,000 live births), 2022/23



Source: Lewisham and Greenwich NHS Trust, ONS Birth Statistics

The rate of death for 1-4 years olds (2.1 per 100,000) was very similar to that of 15-17 year olds (2.1 per 100,000), with the lowest rate seen in the 5-14 age bracket:

Figure 5. Child deaths notified one year and over by age group (rate per 100,000), 2022/23

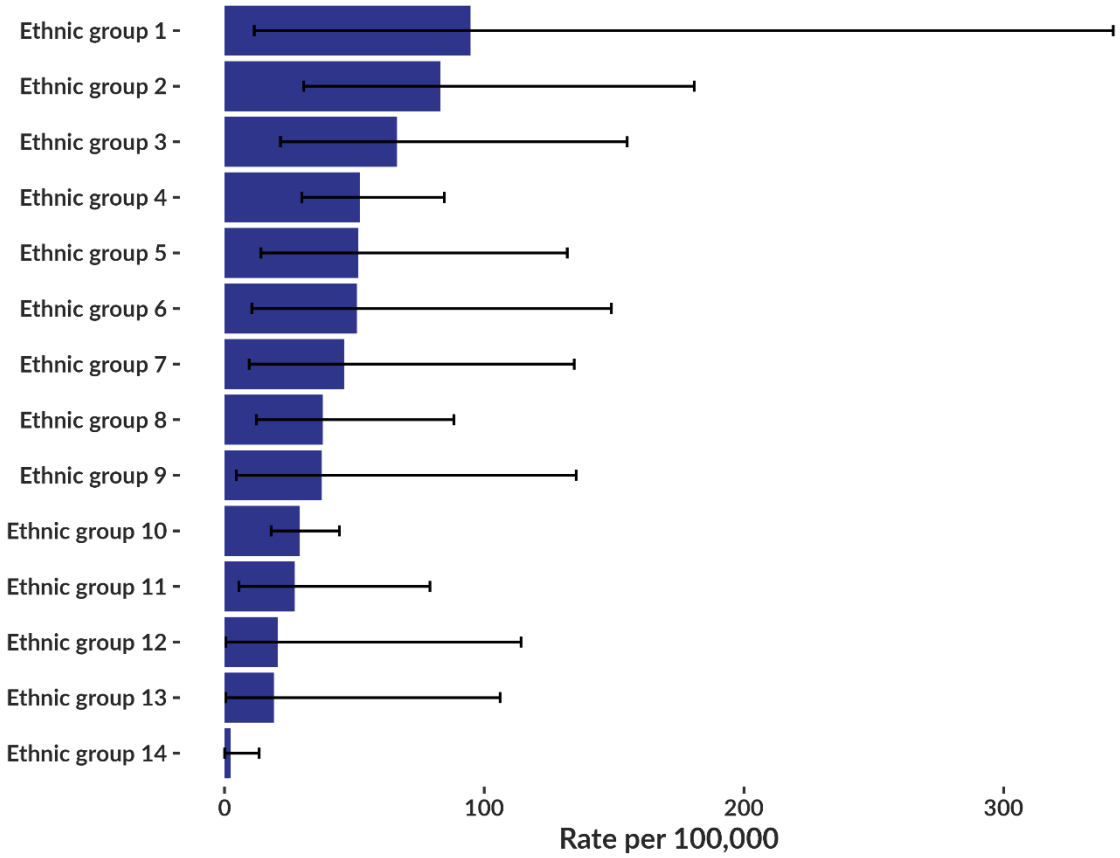


Source: Lewisham and Greenwich NHS Trust, ONS Census 2021

Ethnicity

Although there were no significant differences between ethnicity-specific rates of death, there was wide variation between ethnic groups. Making these kinds of comparisons is problematic due to the instability of rates based on the very small numbers involved. Only two deaths were notified for children in the group with the highest mortality rate, meaning small amounts of natural variation around the numerator can lead to dramatic changes to the rate per 100,000 population:

Figure 6. Child deaths notified by ethnicity (rate per 100,000), 2022/23



Source: Lewisham and Greenwich NHS Trust, ONS Census 2021

Outcome of case reviews

During the reporting period a total of 62 cases were reviewed, of which 34 were neonatal cases and 28 were for older children. Upon review, around half of the cases were found to have potentially modifiable factors, around half were found to have no modifiable factors, and less than 5 lacked the information to make a decision:

Table 3. Cases reviewed, by outcome of review, 2022/23

Category of death	Reviewed cases
Deliberately inflicted injury, abuse, or neglect	<5
Suicide or deliberate self-inflicted harm	<5
Trauma, other external factors (medical/surgical complications/error	<5
Malignancy	6
Acute medical or surgical condition	7
Chronic medical condition	<5
Chromosomal, genetic or congenital anomaly	8
Perinatal / neonatal event	29
Infection	<5
Sudden unexpected / unexplained death	7

Source: Lewisham and Greenwich NHS Trust

Following the same pattern as England as a whole, the most frequent outcome of review was "perinatal/neonatal event" and the second most frequent "chromosomal, genetic, or congenital anomaly".

90 cases remain open and awaiting review at the end of the reporting period. Of these more than 75% (around 71 cases) of the cases were awaiting:

- An inquest or decision by the coroner to discontinue the investigation (47 of the 90 cases - 52%)
- Police investigation (12 of the 90 cases)
- Other investigation (CSPR, serious incident investigation, HSIB (9 of the 90 cases)
- Child Death Review Meeting (CDRM), organised by the hospital where the child died (24 of the 90 cases).

Cases are not brought to CDOP until all other investigations have been concluded.

Family Support

The provision of support to families following the death of their child was a new element of the CDR function introduced in the 2019 guidance. This provides a crucial component of the tri-borough CDR response.

During the period 1 April 2022 – 31 March 2023, the tri-borough CDR team received 73 new notifications of families requiring support. All families received a letter including the booklet *When a child dies , a guide for parents and carers* and a letter from CDR team explaining the process.

25 new families were taken onto the caseload from the 1st April 2022 to 31st March 2023 and many other families have continued to receive support during this period (please note that the keyworker post is 0.5wte hours across the three boroughs).

Activity/support related to the 25 new families is as follows:

- 8 referrals to Lullaby Trust for bereavement support packs
- 5 referrals to suicide support services
- 7 cases requiring links with family liaison officers due to ongoing police investigations
- 9 cases with CSC involvement (may include attending core group meetings or other multiagency meetings)
- 9 cases with family mental health concerns requiring referral to GP, home treatment team and 2 Helix service referrals
- <5 cases experiencing family breakdown and conflict post child death requiring additional listening visits
- <5 cases requiring immigration and home office support
- 5 cases requesting support with housing applications due to poor housing conditions and overcrowding
- 6 debrief meetings arranged with medical consultants
- 5 cases needed support with inquest process
- 9 cases requiring links with school services

Safeguarding

38 (52 per cent) of the 73 deaths notified were subject to a Joint Agency Response Meeting (JAR), an increase of 20.4 percentage points compared to 2021/22:

Table 4. Child deaths notified with a safeguarding need, 2022/23

Reporting period	Notifications	JAR	Proportion (%)	95% Confidence Interval	
				Lower	Upper
2022/23	73	38	52.1	40.8	63.1
2021/22	63	20	31.7	21.6	44.0
2019/21	108	42	38.9	31.1	49.6

Source: Lewisham and Greenwich NHS Trust

Police initiated 11 investigations and attended a further 19 deaths in order to gather information for submission to the coroner. A further 8 families had been involved with police in the past for offences including drug misuse, theft, sexual offences, and violence. No further data is currently available to determine if these were causative.

23 families were either currently involved or had been known to children's social care in the past. This may not mean that safeguarding contributed to these deaths. This data gives a picture of the complexity and vulnerability of the cases we are reviewing and refers to factors that *may* have contributed to ill-health, vulnerability or death. Those factors that might be directly causative relating to maltreatment are assessed in detail by the individual safeguarding partnerships and not included in this analysis.

Vulnerabilities

There was a history of parental mental health issues in 19 of the deaths notified, and special educational needs were known or suspected in five children who died and for five parents. Five of the children who died were either under CAMHS at the time of death or had been known to them in the past. It is likely these figures are an underestimation as this information was gathered following JARs and not all deaths meet the criteria. Two children had a diagnosed learning disability; LeDer referrals were made in both cases (to note that LeDer referrals will no longer be required going forward as per new processes).

Table 5. Child deaths notified with a safeguarding need, 2022/23

Safeguarding Need	Notifications
Child in Need Plans in relation to Complex Needs	5
Child in Need Plans in relation to Safeguarding Concerns	<5
Child Protection Plans	<5
Interim Care Orders	<5
Rapid Reviews:	10
Local Child Safeguarding Practice Reviews	*<5*
Joint Local Child Safeguarding Practice Reviews	*<5*
Joint Local Child Safeguarding Practice Reviews and Domestic Homicide Review	*<5*

Source: Lewisham and Greenwich NHS Trust

Learning from the deaths of children

A number of key themes have been identified from analysis of the cases reviewed as detailed below. For future years, data will be provided to quantify themes to enable prioritisation of actions.

Communication

- **Language barriers:** Reviews identified ad-hoc use of interpreters (for example, using only for complex discussions) or using relatives to interpret. Information, such as leaflets, was not always available in different languages, and there is a need for professionals to check understanding, particularly regarding treatment and medications.
- **Communication between agencies:** Reviews identified difficulties in information sharing between agencies, particularly where different IT systems are in place and where cross-border services are involved. A lack of lead professional was also highlighted, which would have provided oversight and accountability across multiple services or specialities.
- **Parents:** Parents reported that they were required to repeat information to different professionals, particularly in cases where children had complex needs. Disengagement from universal services was highlighted and there is a need to further support parents with a known or suspected learning disability in order to support their recognition of or coping mechanisms when a child is seriously unwell.
- **Professionals:** Parents have reported feeling like their concerns were dismissed or not taken seriously. The way in which professionals deliver bad news to families requires further consideration to ensure this is considerate and appropriate. Public health messages need to be more visible and widely shared, for example, around key home safety messaging.
- **Freedom of Information Requests, Record Access Requests and Information Sharing:** There have been several requests from legal teams acting on behalf of parents or local authorities to have the minutes of a Joint Agency Response (JAR) meeting sent to them or asking if these minutes can be shared with the parents. Whilst there is a guidance for issues such as this this i.e. *The Child Death Review Statutory and Operational Guidance England HM Gov 2018* It is evident from these requests that many professionals attending such meeting do not fully comprehend that such minutes are confidential, they are not owned by one agency and cannot be shared. These issues were shared by team with the London wide CDR professionals group.

Trauma and other external factors (including deliberately inflicted injury, abuse or neglect)

- **Overcrowding:** various issues were identified regarding overcrowding, including co-sleeping/sofa sleeping, a lack of housing stock, particularly for larger families who are

unable to secure a suitable sized property, and the associated impact on mental health. Where housing is a factor in the death of a child, the appropriate local authority housing leads will be informed.

- **Parental supervision:** reviews identified the need for further home safety information for parents, including consideration of risk in line with a child's developmental stage and ability.

Covid

Although less impact since the end of the pandemic, some themes have emerged, including:

- Delayed presentation to key services and parents managing for longer at home;
- The impact of virtual (primarily telephone) appointments including not seeing the home environment, reduced ability to pick up on body language and less observation of interaction between parents and children.

Perinatal/Neonatal

Examples of delayed presentation where there are concerning symptoms such as abnormal discharge or reduced fetal movements have been identified. Common factors such as maternal obesity and smoking, and domestic abuse continue to feature.

Chronic Conditions

Where chronic conditions occur, there is a need to raise awareness of parents in the need to attend appointments and recognition of how unwell a child can become. Communication issues have been identified where families travel abroad and specialist teams are not aware.

SUDIs

There are a number of common, recurring themes regarding SUDIs, including:

- Overcrowding
- Deprivation and poverty
- Parental mental health
- Overheating
- Excessive bedding
- Safeguarding and neglect
- Parental substance misuse, including cannabis
- Young parents
- Maternal smoking in pregnancy and exposure to cigarette smoke
- Co-sleeping and sleeping environment, where there are additional risk factors
- Baby put down to sleep on side or front

Programmes of Work Initiated/Supported by BGL CDOP in 2022/23

- The last two Annual Reports from CDOP have recommended the development of a South East London pre-conception strategy in recognition that many contributors to poor maternity and neonatal outcomes are better addressed in the pre-conception period. This is now a priority of the Public Health sub-group of the SE London Local Maternity and Neonatal System (LMNS) and work in this area has commenced locally and nationally.

- Analysis and learning from BGL SUDI deaths since 2019 and Lewisham SUDI deaths since 2008, have identified overheating as the most common risk factor in BGL babies followed by poverty and parental smoking. Following a high number of SUDIs in Lewisham, Lewisham Public Health identified funds to purchase 4,000 room thermometers from the Lullaby Trust to give out to Lewisham resident mothers in conjunction with safer sleep information. An audit conducted between the public health team and maternity and health visiting teams identified that over 80% of parents used the thermometer they were given. There is currently a business case in process for providing a further 2 year funding programme as part of a wider safer sleep initiative in Lewisham. Other initiatives have taken place in Bexley and Greenwich involving provider updates and public health messaging.

- The Safer Sleep staff briefing continues to be sent out on a bi-annual basis to all BGL staff in contact with expectant and new parents.

- Parental smoking is a contributory factor to a number of poor health outcomes for babies and children including SUDIs. CDOP panel members sit on the BGL Tobacco control meetings and the SUDI analysis has been used amongst other evidence in support of a business case for a stop smoking midwife on both the UHL and QE sites. These midwives are now in post and will ensure the best possible staff training and the initiation of a financial incentive scheme for parents wishing to stop smoking.

- In response to the number of deaths caused by accidents, there has been extensive outreach from universal services (including health visiting) regarding accident prevention in the home.

Recommendations

- This report will be presented to the SEL Integrated Care Board in November 2023 (TBC) prior to sharing more widely with BGL partners including public health and safeguarding partnerships.
- Ongoing work with public health and providers relating to SUDI and accidents.
- Continued engagement with providers regarding issues arising from the CDOP evaluations.
- Themes will be quantified in future annual reports.
- Discuss with neurodisability clinicians the risks relating to acceptance of ill health in disabled children, the need for a lead clinician, and consideration of how to strengthen input from universal services.
- Continue pre-conception strategies in SE London and develop local evaluations and initiatives.
- Child death manager and bereavement specialist to quantify workload and requirements for the local triborough.
- To re-launch information sharing guidance and partner information such that they are aware that information from JAR's is confidential, cannot be shared or wording changed once JAR minutes have been agreed.