

# Analysis of Child Deaths 2010 (1 April 2010 to 31 March 2011)

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## Introduction

In 2008 CEMACH (Confidential Enquiry in to Maternal and Child Health) published a report from a pilot study undertaken in 2006 in 6 areas within England, Wales and Northern Ireland. This study titled “ Why children die” set out to look at all children’s deaths from 6 weeks of age to 17 years and 364 days of age and identify key themes in cause of death, issues raised in expected versus unexpected deaths and whether there were any preventable factors in those deaths.

The report identified preventable factors in 26% of cases and potentially avoidable factors in a further 43%. The most significant avoidable factors were the recognition of severity of illness in children, compliance with appointments, poor communication within health and between agencies. These issues applied across all aspects of health care, from primary to tertiary care.

From 1st April 2008 LSCBs had a statutory responsibility to use the aggregated findings from all child deaths, collected according to a nationally agreed data set, to inform local strategic planning on how best to safeguard and promote the welfare of children in their area.

In Cumbria the LSCB Child Death Overview Panel has begun to analyse the historical deaths to establish the demographic issues and identify any key themes.

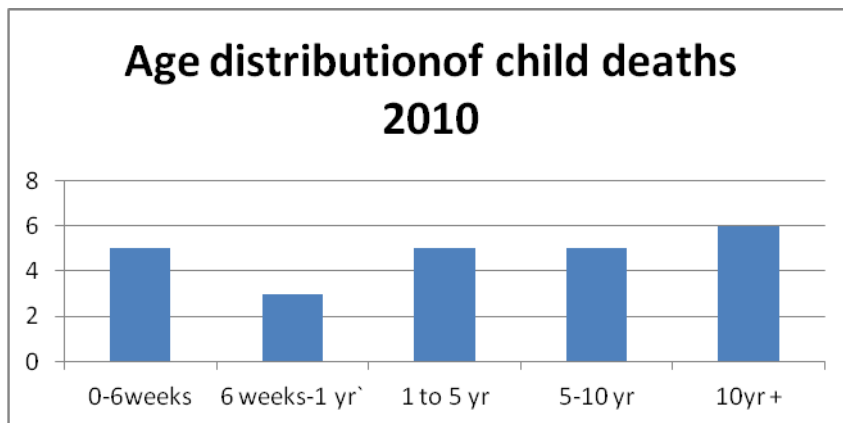
This report summarises that analysis. It includes unexpected and expected deaths of children aged 0 to 17 years + 364 days which occurred in 2010.

Although the focus is on the 2010 deaths, a preliminary analysis has begun of the 2011 and 2012 deaths and, where there are common themes which seem to cross the year data set, these have been identified and recommendations produced for the LSCB to consider. The issues arising from the information submitted to the Panel can best be summarised in narrative form as the numbers are relatively small for each issue raised.

## Demographic data

### Age Distribution

During the period 2010 to 2011 the Child Death Overview Panel considered 24 cases of child death. The age distribution of these deaths is in figure 1. The majority of deaths occur in the neonatal age group and in the first year of life, with a second peak in the adolescent age group. This data is consistent with national data and also with the Cumbrian annual data for 2011 and 2012.

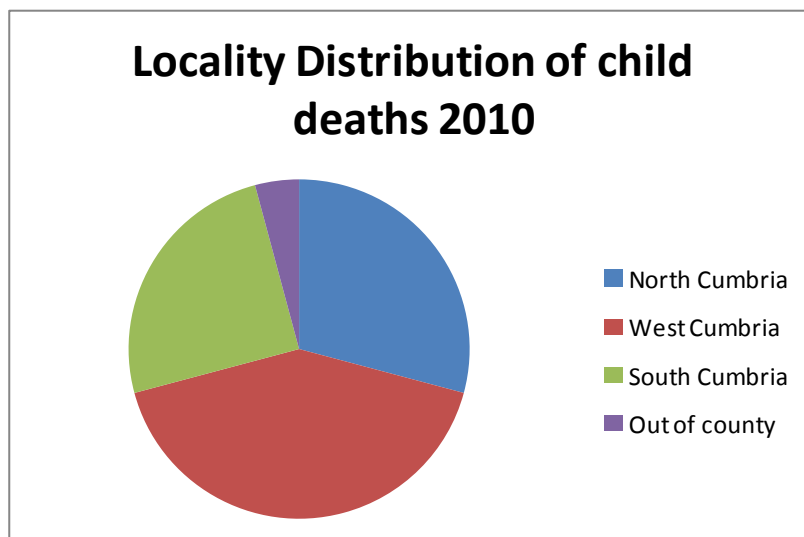


### Sex

There were an equal number of male and female deaths. The numbers of deaths in this annual cohort is low but the National data would usually comprise an overrepresentation of males in child deaths.

### Locality of deaths

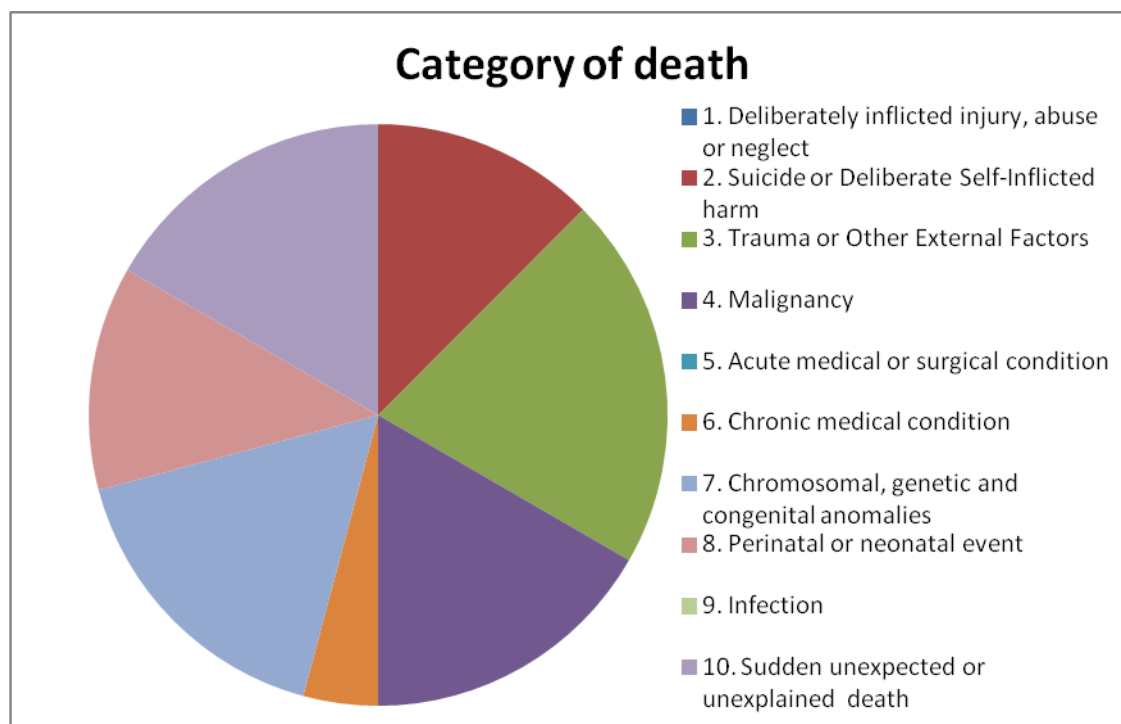
While a cursory look at the pie chart in Figure 2 might suggest equal distribution of deaths across localities, closer analysis of the area these children were normally resident in identified Carlisle, Whitehaven, Workington and Furness as the key sites. This data is repeated in subsequent years' analysis and would therefore benefit from closer epidemiological scrutiny.



### Place of Death and Expectation of death

The majority of children (15) died in a hospital setting, a minority (5), mostly expected deaths, died at home. Of the remaining (4) child deaths, 2 occurred on a public road, 1 on a riverbank and 1 in a private residence which was not that child's usual place of residence. Although 4 children died at home whose death was expected there were a total of 10 children in whom death was expected (definition of expected death being that the death could be predicted more than 24 hours previously). This implies that for some children there were acute deteriorations which led to their parents bringing the child to hospital. The CEMACH report "Why children die" also identified this issue and speculated that there needed to be better end of life planning and support for families of children expected to die and provision of hospice places for those families where some medical or nursing input was required at the time of death.

### Cause of death



There were no deaths in categories 1, 5 or 9. The deaths from chromosomal, genetic and congenital anomalies, and perinatal or neonatal events occurred in the younger age group while deaths from malignancy were in the older age groups. A significant number of deaths were from suicide or deliberate self harm and these were all in the over 10 years of age.

### Safeguarding Issues

Safeguarding issues were identified in 4 cases, 2 of which (cases A and B became serious case reviews). The following table lists in narrative form the

safeguarding issues identified and considered by the CDOP and the Serious Case Review Panel.

Case A	Case B	Case C	Case D
A long history with Children's Services - CP Plan, in and out of care. Was homeless and baby was taken into care. Disclosed physical/sexual abuse. Chaotic lifestyle, drug abuse.	Child hanged themselves. Was being treated for depression, ADHD, enuresis and on high doses of medication. Witnessed DV, moved house/school number of times. Previous suicide attempt and self harmed.	Child from out of county visiting. Previous concerns of neglect and home conditions and more recent concerns regarding mother's new relationship.	Child hanged themselves. Witnessed DV and no longer had contact with dad. Mum stated child had behavioural problems and was referred to CAMHS. Was well motivated at school. All information came from mum, no-one spoke to child.

## Analysis of Themes

Analysis of the themes is provided in narrative form as there are small numbers of children in each category. Those themes which cross over subsequent years are identified and there are year specific themes which are dealt with later in the report. The CDOP considers the form Cs completed after the death has been reviewed and identifies recommendations to be made on a locality, county, regional or national basis to commissioners, public health, LSCB or single agency recommendations.

### Recurrent themes

#### *Risk factors for Sudden Unexpected death in Infancy (SUDI).*

Despite public health campaigns and involvement of universal services in parental education, the following risk factors can be identified in all cases categorised as SUDI:

1. Co-sleeping
2. Parental smoking
3. Prop feeding

There may need to be a re-evaluation of the public health campaign within Cumbria on this issue.

#### *Safeguarding Risk Factors*

Early identification of risk factors and early intervention is known to prevent the escalation of safeguarding issues.

While the following factors were not all contributory to the death of the children in this group, they were potentially avoidable factors.

1. Reference to a “chaotic” lifestyle
2. Substance misuse in a parent/carer
3. Domestic abuse in the household/family
4. Mental health issues in a parent/carer

The following were identified as childhood experiences in young people or in their families:

1. Experience of physical abuse
2. Experience of sexual abuse

Experience of recent or historic physical or sexual abuse is considerable and significant. Addressing these issues requires planning for the recognition and management of the longer term impact of abuse and neglect on children, young people and adults.

#### *Risk taking behaviour by the child/young person*

As with early intervention for safeguarding issues, it is important to have effective services to identify and intervene when young people are involved in risk taking behaviour such as alcohol use, drug use and teenage pregnancy.

#### *Emotional wellbeing and Mental Health Issues*

Emotional or mental health issues in children, young people or their parents and carers were either avoidable or potentially avoidable factors in a significant number of deaths. This is a cross-agency issue which requires clear planning and commissioning to address. It includes the provision of specific services for Children who are Looked After as a distinct and separate group within the wider concerns of children and young people.

#### *Bereavement*

In common with other CDOPs on a regional and national basis, the provision of bereavement services for parents, siblings, the extended family and the wider community was identified as being difficult to access, not available in all localities, and of variable quality. Further thought needs to be given to how this may be commissioned and provided in future.

#### *End of Life Planning and Palliative Care*

As described earlier, out of 10 expected deaths, only 4 occurred at home. Palliative care and end of life planning was identified by practitioners as being a significant issue for consideration. End of life planning needs to include the management of acute illness to enable and empower parents in the appropriate management of these events as well as ensuring that there is sufficient support for families at home when the terminal event occurs. The development of guidance to manage expected death needs to be written in conjunction with the regional tertiary specialists such as paediatric oncology, paediatric neurodevelopmental teams and county wide multi disciplinary and multi-agency partners.

Guidance is provided in “Deciding Right.” Written by health and social care professionals, “Deciding right” identifies the triggers for making care decisions in advance, complying with both current national legislation and the latest national guidelines. At its core is the principle of shared decision making to ensure that care decisions are centred on the individual and minimise the likelihood of unnecessary or unwanted treatment.

<http://www.cnne.org.uk/end-of-life-care---the-clinical-network/Decidingright/plusdocument>

#### *Service Specific Commissioning Issues*

For those children who either have an extended stay or die in tertiary unit at some distance to their home, we identified a need for support for families in the transport costs to and from hospital services.

#### **2010 Specific Themes and Issues**

Within each year of analysis there will be specific issues which may not occur in subsequent years but which may still raise important questions and have important lessons to be learned.

#### *Keswick Bus Crash*

In 2010 a school bus carrying children crashed outside of Keswick with the deaths of 2 children. Within the context of road traffic accidents this was a small number of deaths but the impact on the county population was significant and led to a community directed response for the surviving children, their teachers, their families and the wider community. This incident highlighted good practice in recognition and management of these issues.

#### *Illegal termination of pregnancy*

One case involved the purchase of Misopristol from the internet with the intention of termination of pregnancy. The young woman involved had a history of previous terminations. The case raises a number of issues. Firstly on a national perspective there is a responsibility for the national body, Medicines healthcare products Regulatory Authority (MHRA), to regulate how these drugs are obtained. From a regional perspective there is at least one other such case. The Cumbrian CDOP has therefore written to the MHRA asking what action they have taken to ensure these drugs are not freely available. On a locality basis, NHS Cumbria CCG is considering the issue of support for young women in their sexual health and contraceptive needs to ensure a non-judgmental approach to termination of pregnancy in the future.

## **Recommendations to Cumbria Local Safeguarding Children Board**

1. To commission an epidemiological assessment of the locality of child death to determine whether there are modifiable factors.
2. To consider all themes arising from the report on the analysis of Child Deaths in Cumbria in 2010.
3. The LSCB to receive assurance from Commissioners in respect of:
  - a) End of life and palliative care planning to be appropriately commissioned and developed within Cumbria.
  - b) The provision of transport or the provision of financial support with transport costs for families of children in tertiary centres.
4. The LSCB to receive assurance from Public Health in respect of:
  - a) Consideration to be given to a renewed public health campaign on the risk factors for SUDI, focussing on those issues identified from the child death analyses.