LSCB
Analysis of child deaths for 2011-2012

Deaths of Cumbrian Children and Young People
April 2011-March 2012

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UPDATE FROM CDOP July 2014:

Recommendations
The CDOP considered the report at its meeting on 15 July and agreed that the recommendations should be removed and that Public Heath consider the remaining outstanding data for 12-13 and 13-14, collate into report and an overall report should be produced that looks at the data across all the available years with a view to making recommendation based on a much wider set of information.

The LSCB is asked to endorse this approach.

Introduction

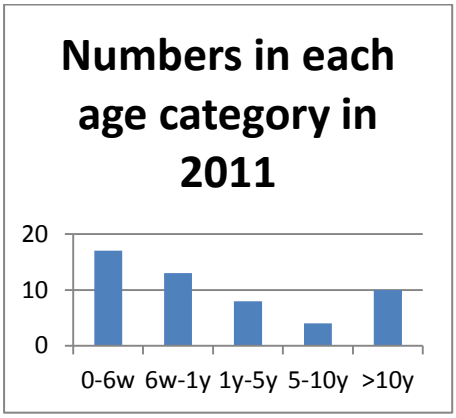
This is the second annual report from the Child Death Review Process in Cumbria and covers the deaths of children and young people in Cumbria in 2011-12. The previous report, covering 2010-11, highlighted a number of issues relating not only to the deaths of children and young people but also their life experience. Key issues which were highlighted included the need for Advance Care Planning for children and young people with life threatening and life limiting conditions, an issue which Cumbria CCG is currently exploring; the experience of mental health, domestic abuse, child abuse and neglect that many families in Cumbria experience and which the Cumbria LSCB "Early Help" initiative will begin to address; and the contributing and modifiable factors for Sudden Infant Death, already highlighted as a national issue.

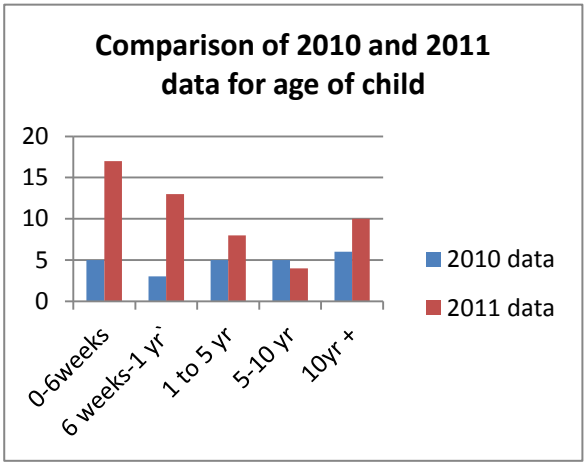
In this report the themes identified above are recurrent through the years data and the recommendations from 2010-11 are carried through with some modifications relating to the themes arising from analysis of 2011-12.

Demographic Data Analysis

There was an increase in the number of deaths in children and young people from 2010-11 (23) to 2011-12 (52). On closer analysis, this increase specifically involves deaths in the neonatal period as well as deaths from congenital, genetic and chromosomal conditions. Review of alternative data sources would suggest that rather than the 2011 data representing an increase in these specific categories, 2010 involved the underrepresentation of neonatal deaths and early deaths from genetic conditions. A look forward to the 2012-13 data would support this conclusion. However, it is important to note that the 2011-12 data included cases reviewed in detail as part of the investigation into maternity and children's services in Morecambe Bay. Thus while the increase in cases of neonatal deaths may be explainable, it is still of great importance to continue to review neonatal cases across the county in detail to ensure that the quality of neonatal care is of a high standard.

1. Age of child at death

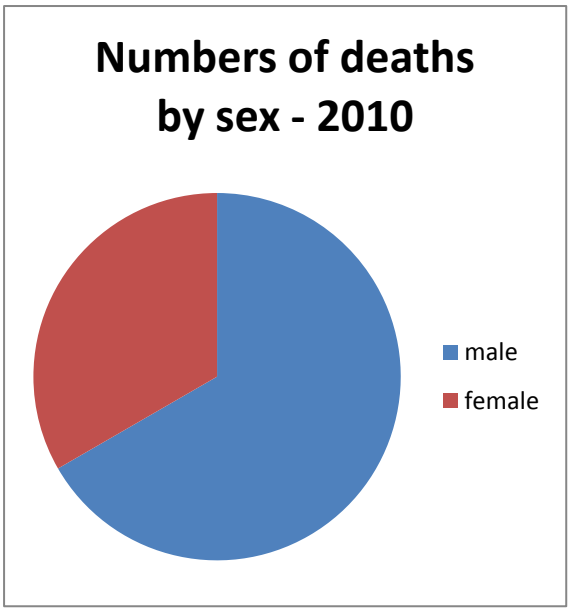


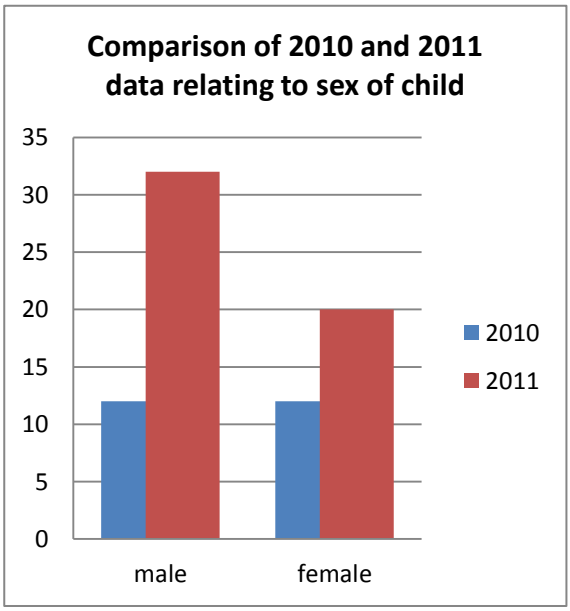


The pattern of deaths in each age category follows the national pattern with relatively higher deaths in the neonatal period (0-6 weeks) and infancy (6 weeks – 1 year) reflecting the high mortality from prematurity, genetic and congenital disorders as well as SUDI. The main comparison with 2010 involves the greater increase in numbers of deaths in children overall as well as specifically in these age categories as discussed above.

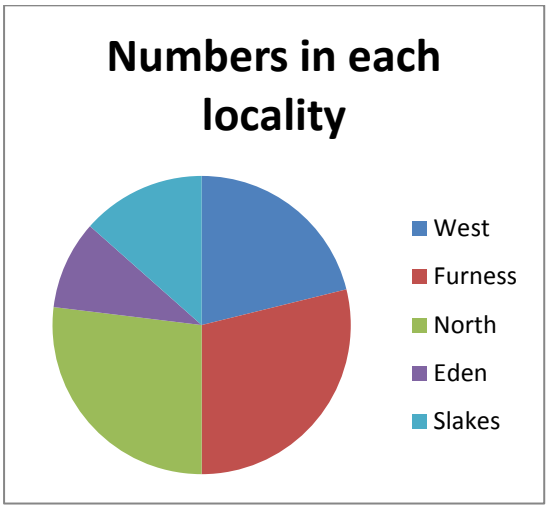
2. Sex of the child

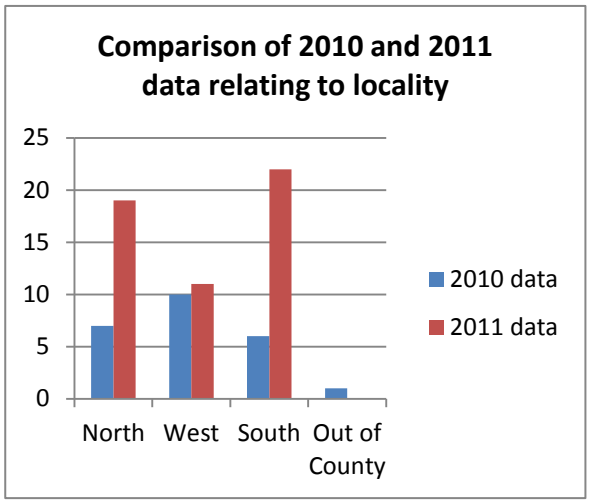
In line with national figures there was a preponderance of deaths in male children and young people over 2011, a difference from 2010 where there were equal numbers. Deaths in males were across all categories.





3. Locality child lived in:



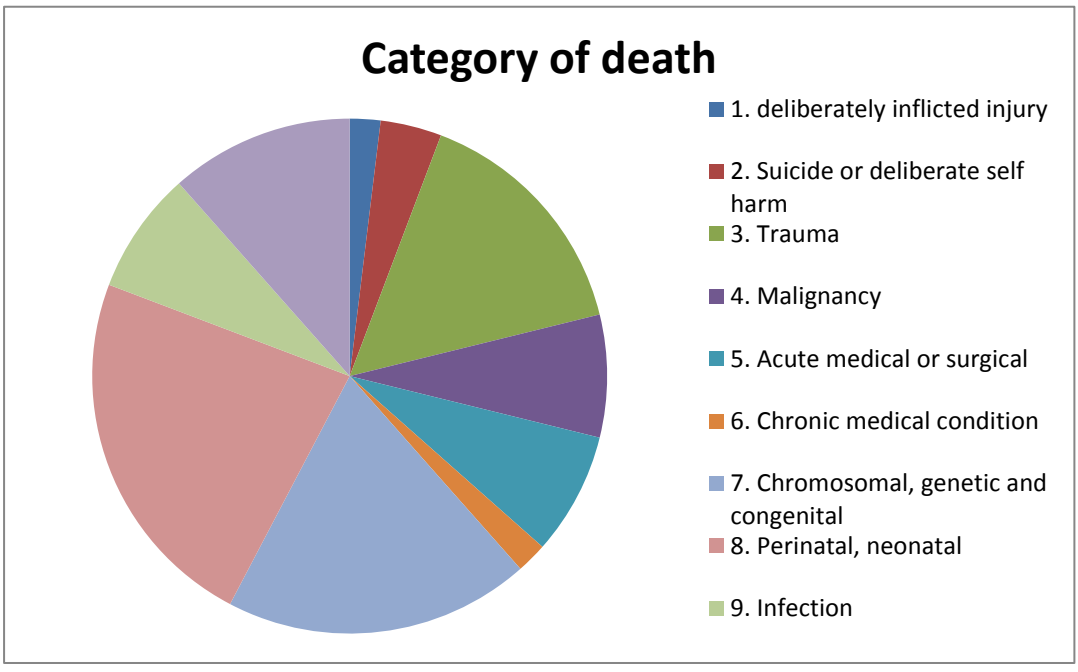


There were marked increases in deaths of children and young people usually resident in Carlisle and Barrow in comparison to 2010. A number of factors both modifiable and non-modifiable may contribute to this distribution and this needs to form part of a more detailed review of deaths in these areas.

4. Place of death and expectation of death

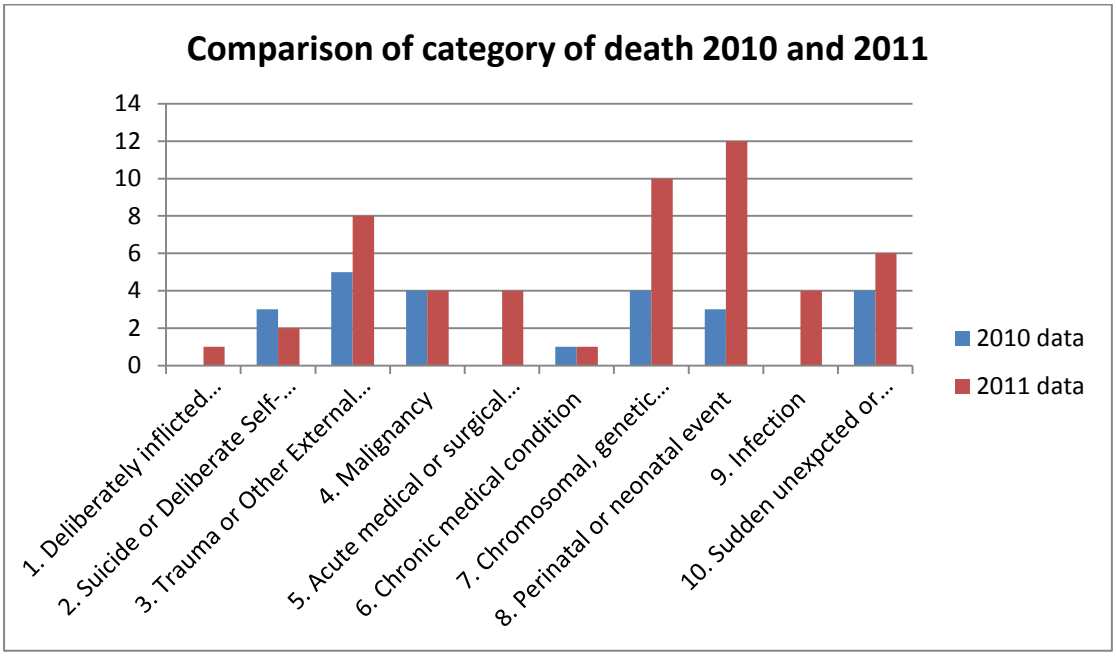
For those children where death was expected (12 children in total) there was a significant number of deaths occurring in hospital (8), most often tertiary centres with only 2 children dying at home and 2 dying in hospice. Deeper analysis of the form C data demonstrates that the reasons are varied but often included an admission following a significant deterioration. As advanced care planning becomes established within the county, it may be that this pattern changes in time and that more local support can be provided to these children and their families.

Cause of death



Of note for 2011 is the inclusion of a death as a result of abuse or neglect which was subsequently considered for serious case review and is currently under investigation in the criminal justice system.

Comparing the 2011 and 2010 data we can identify the marked increase in deaths from neonatal causes and those from genetic and congenital causes as discussed earlier. However, there is also an increase in deaths from infections and other acute medical conditions. Review of the form C information does not identify any common organism or type of condition, however a common theme involves the early recognition of the severity of illness in children and young people by professionals as well as parents. Work is ongoing through the "health builders" to promote competence amongst professionals in early identification of severity of illness. The inclusion of a public health programme to enable parents and carers to seek medical help early for children who are particularly vulnerable to sudden deterioration in their health would also be of benefit to the wider community of children and young people.



Serious case reviews / SCIE reviews

Two deaths in 2012 have been considered by the Serious Case Review Panel. One case was reviewed under the SCIE format with significant learning identified. A further death in 2012 was not identified as being due to abuse or neglect until the post-mortem report was received in 2013. Subsequent discussion raised the concern about the cause of death and the case is now under criminal proceedings. In addition, the SCR panel considered the case which is to be reviewed in two parts, firstly as a serious case review on events leading up to the death and secondly on the events following the death and subsequent investigation.

Life experiences

As with the deaths in 2010, the children and young people who died in 2011experienced a range of life experiences. In 18 deaths these experiences included parental issues such as mental health disorders, parental drug and alcohol use, parental disability and domestic abuse. In addition there were other safeguarding concerns such as neglect and non-attendance at appointments.

In a significant number of children or young people who died there were also a range of issues such as risk taking behaviour, poor engagement in disease management, drug and alcohol use, mental health and deliberate self-harm issues and physical and learning needs.

Other Themes

1. Parental Smoking

30% parents or carers smoked which is just more than the county average for the same period, however the cause of death in children who have one or both parents who smoked are almost all respiratory deaths or SIDS.

2. Increased numbers of trauma deaths

There were a number of trauma related deaths in 2012. Two cases of young men on motorbikes killed in road traffic accidents, 2 cases of deliberate hanging and a case of accidental hanging and 2 deaths from accidental drowning. The latter three cases were all in young children and relate to supervision of those children at the times of their deaths. All were tragic accidents.

A further death due to trauma occurred as a result of horse-riding. Again this was a tragic accident. However given the fact that Cumbria is a rural county with a number of residents as well as visitors interested in riding, the Child death overview panel feel it is important to establish the extent of injuries, and near miss events which occur from this activity so that appropriate support can be given to establishments which offer horse riding in order to explain and reduce risks.