LLR Child Death Overview Panel Annual Report 2021/22

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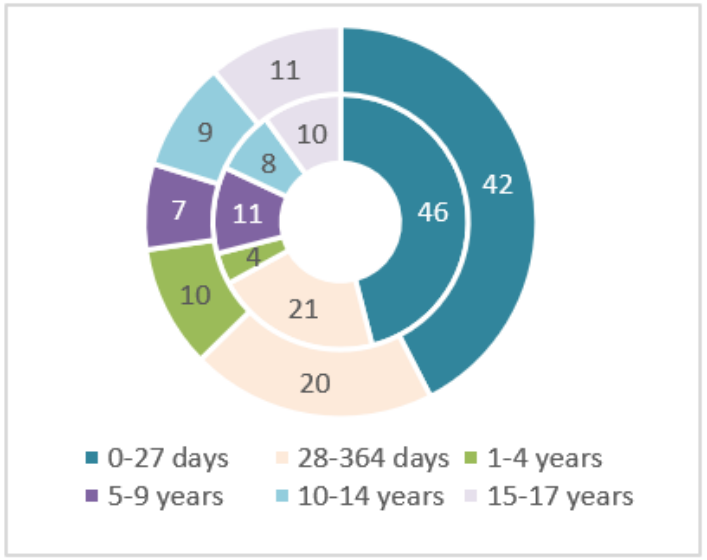
Notifications 2021/22

Death notifications by Local Authority 2017/18 to 2021/22

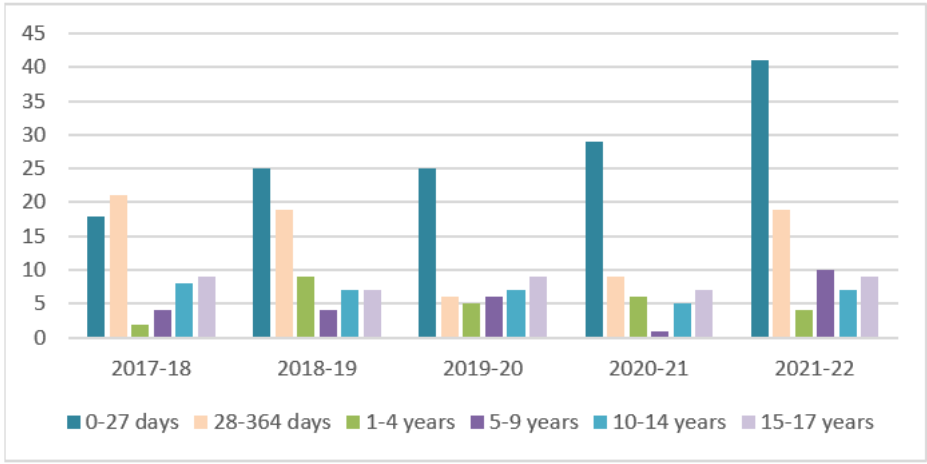
	2017/18	2018/19	2019/20	2020/21	2021/22
Leicester City	33	36	24	30	48
Leics & Rutland	29	35	34	27	42
Total LLR	**62**	**71**	**58**	**57**	**90**

% of notifications by age group

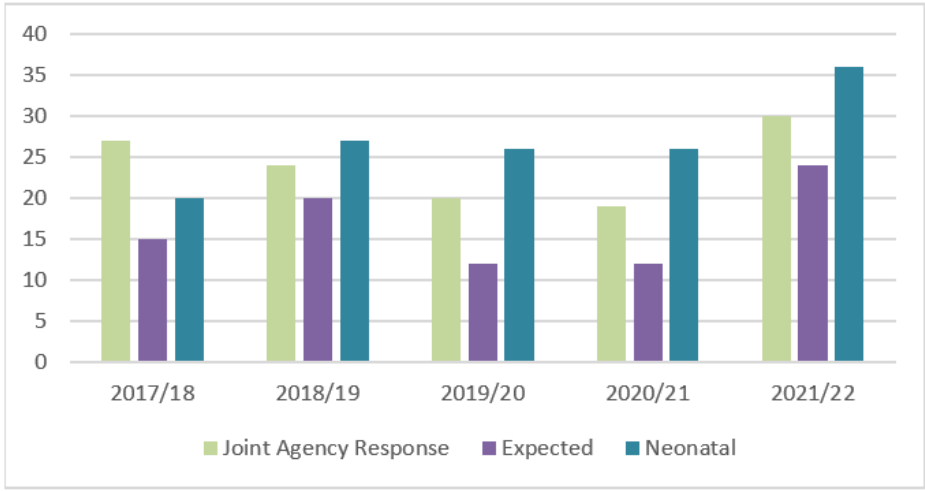
Inner ring LLR, Outer ring England



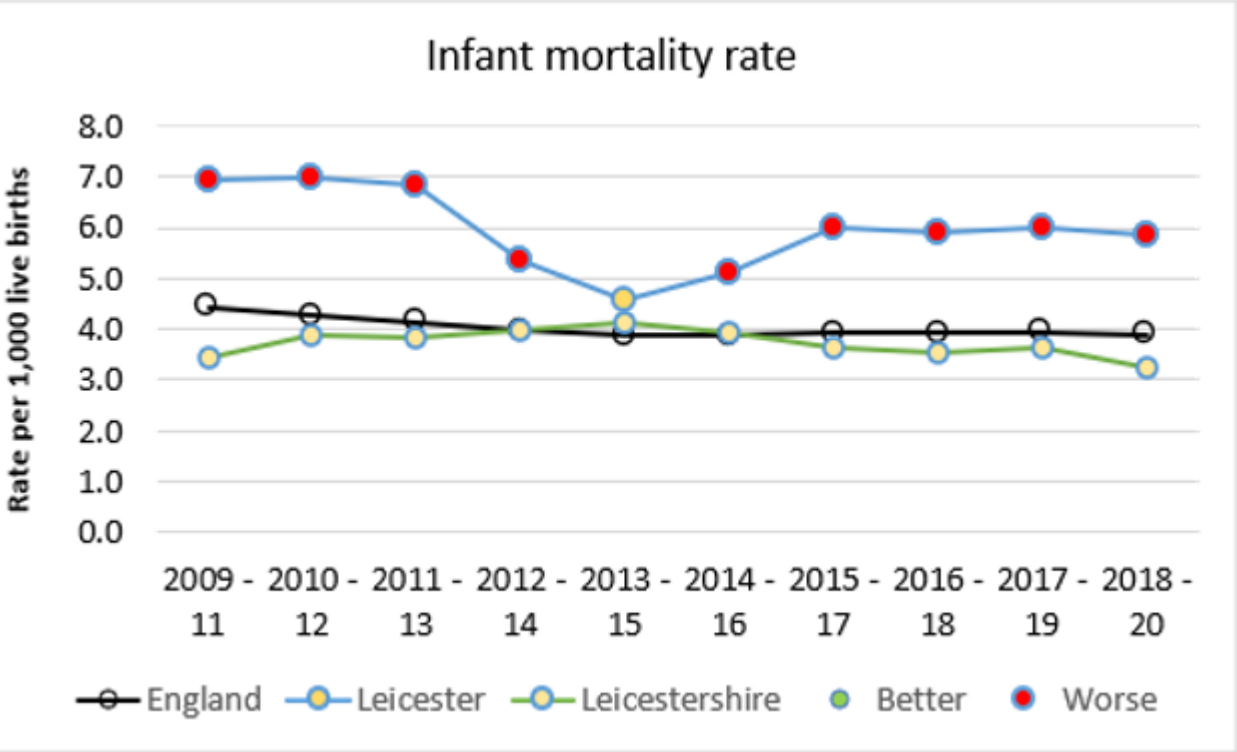
Notifications by age group & year

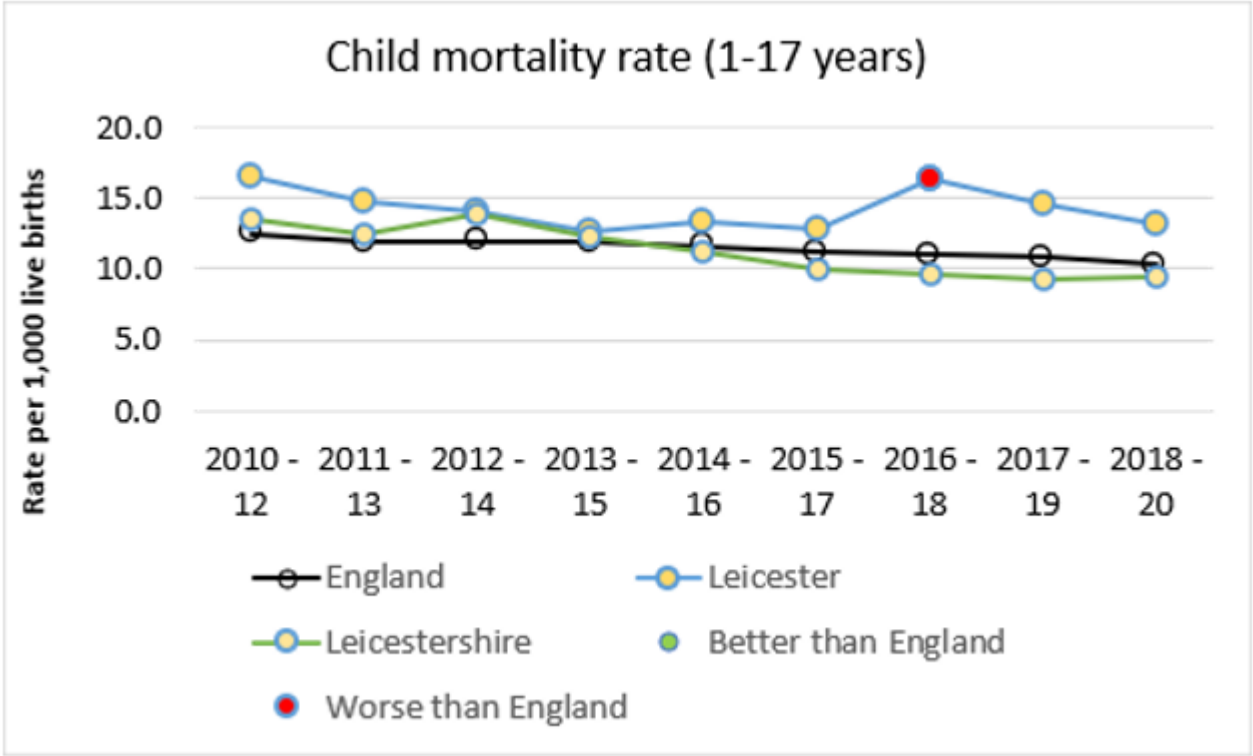


Notifications by category of response 2017/18 to 2021/22

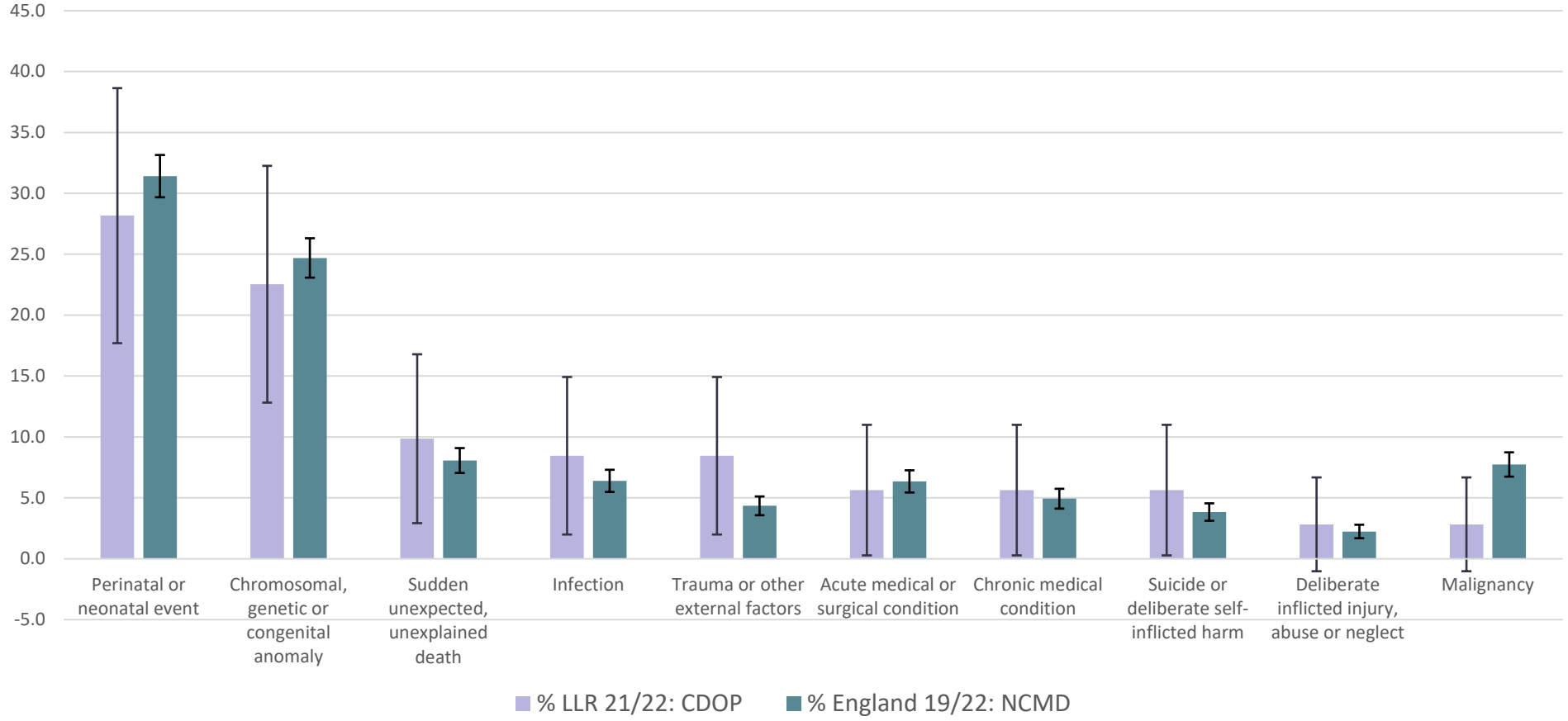


Summary Statistics





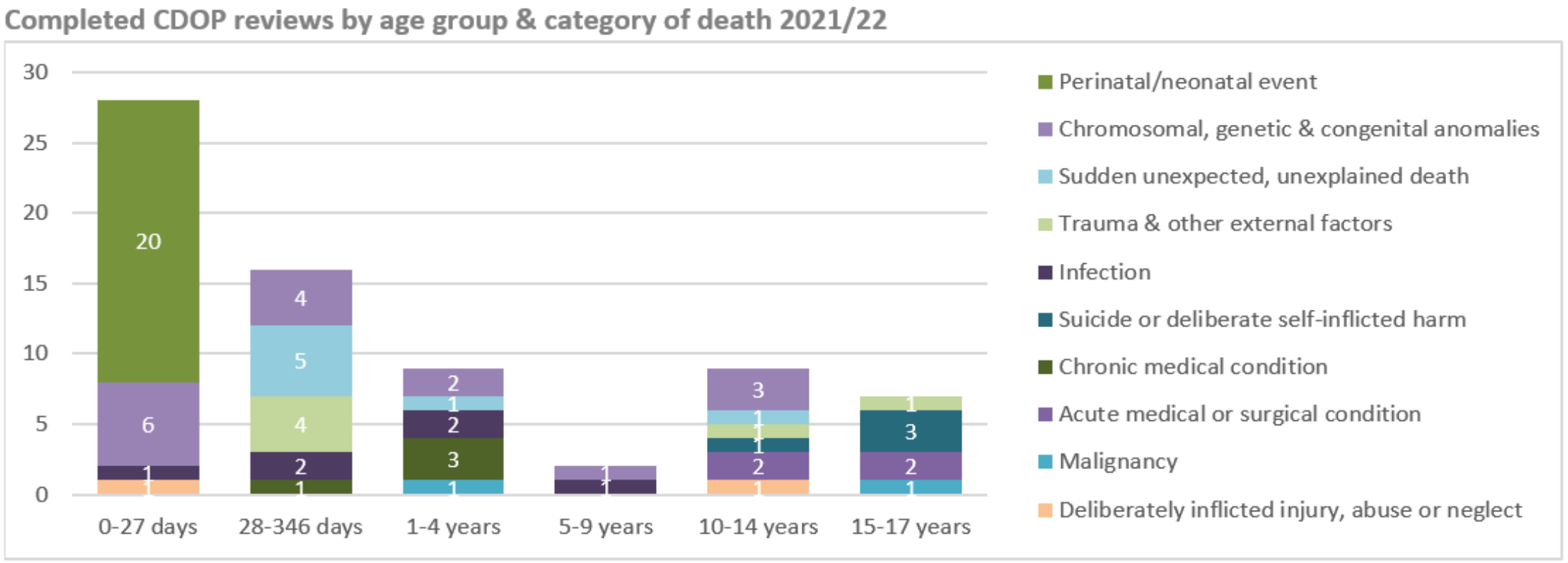
Completed Reviews 2021/22



Completed reviews by year of death 2021/22

Year of death	Cases
2017-18	2
2018-19	4
2019-20	22
2020-21	40
2021-22	3
Total	**71**

Completed Reviews 2021/22



Modifiable Factors 2021/22

Cases where modifiable factors were identified by category of death 2021/22

Primary category of death (CDOP)	Completed reviews	Modifiable factors identified	Modifiable factors identified (%)
Deliberately inflicted injury, abuse or neglect	2	2	100
Sudden unexpected, unexplained death	7	6	86
Trauma and other external factors	6	4	67
Infection	6	3	50
Suicide or deliberate self-inflicted harm	4	2	50
Perinatal/neonatal event	20	6	30
Acute medical or surgical condition	4	1	25
Chromosomal, genetic or congenital anomaly	16	2	13
Chronic medical condition	4	0	0
Malignancy	2	0	0
Total	**71**	**26**	**37**

Modifiable Factors cont'd

Most frequently recorded modifiable factors 2021/22

No of cases	Most frequently recorded modifiable factors:
9	Parental smoking
6	Maternal obesity
6	Service provision - education
5	Unsafe sleeping practices
4	Service provision - communication
4	Service provision - local/national commissioning
2	Safeguarding
1	Public safety
1	Vehicle/transport related
1	Service provision - human factors
1	Child physical condition
1	Child mental health condition

Cases with modifiable factors recorded by domain (some cases had factors identified in multiple domains) 2021/22

Domain	Cases where modifiable factors were identified by LLR CDOP	% of cases where modifiable factors were identified by LLR CDOP	% of cases where modifiable factors were identified England (2019/20)*
A: Factors intrinsic to the child	2	7	11
B: Factors relating to the family or social environment	16	62	61
C: Factors relating to the physical environment	7	27	27
D: Factors relating to service provision	11	42	35

Key Theme: Infant Mortality

Categories of death for children under 1 year – completed reviews

Category of death	No of cases	% of cases	Modifiable factors identified (%)
Perinatal/neonatal event	20	46	30
Chromosomal, genetic or congenital anomaly	10	23	10
Sudden unexpected, unexplained death	5	11	100
Trauma or other external factors	4	9	50
Infection	3	7	33
Deliberately inflicted injury, abuse or neglect	1	2	100
Chronic medical condition	1	2	0
Total	**44**		

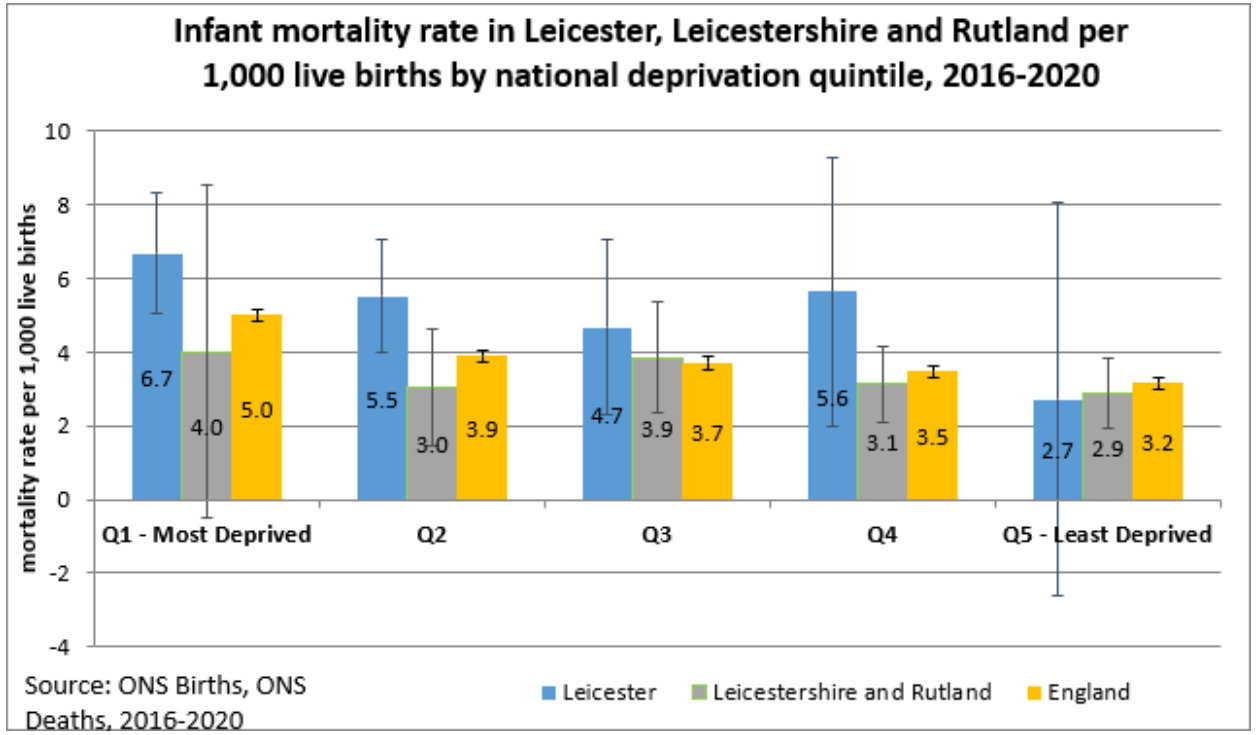
Sudden Unexpected Unexplained Deaths - Infant case characteristics – 5 year review

	2015/16 to 2020/21 (n=15)		2016/17 to 2021/22 (n=15)	
	N	%	N	%
Bottle fed	12	80 %	11	73 %
First born	4	27 %	6	40 %
Preterm	10	67 %	9	60 %
IMD 1&2	7	47 %	6	40 %
Birthweight <2.5kg	9	60 %	9	60 %
Mean maternal age	28.8 (20-36)		28.73 (20-36)	
Medical cause of death:				
'Unascertained'	12	80 %	11	73 %
'SIDS'	3	20 %	4	27 %
Modifiable Factors				
Unsafe sleeping	10	67 %	9	60 %
Parental smoking	9	60 %	9	60 %
One or more MF	13	87 %	13	87 %
More than one MF	10	67 %	11	73 %

Key Theme: Deprivation

NCMD Thematic Report: Deprivation & Child Mortality

- Clear association between risk of death and deprivation across all categories except malignancy.
- Relative 10% increase in risk of death between each decile of increasing deprivation.
- **More than 1 in 5 deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived.**



Key theme: Suicide & Self-inflicted Harm

- NCMD Thematic Report: Suicide in children & young people
  - Key findings:
    - Suicide not limited to certain groups
    - 62% had suffered significant personal loss in their life prior to their death
    - Over 1/3 had never been in contact with mental health services
    - 16% had a confirmed neurodevelopmental condition
    - Almost ¼ had experienced bullying (face to face or online)

- LLR Thematic review of suicide & self-inflicted harm in children & young people due 2022/23

Key theme: Children with learning disabilities

- Children 4yrs or over
- 2020/21-2021/22: 16 cases
  - Most common category of death
    - Chromosomal/genetic/congenital anomaly
    - Acute medical condition
    - Chronic medical condition
  - Modifiable factors: 3 cases
  - Good or excellent care: 9 cases
  - Care falling far short of expected good practice: 2 cases

- Key learning themes:

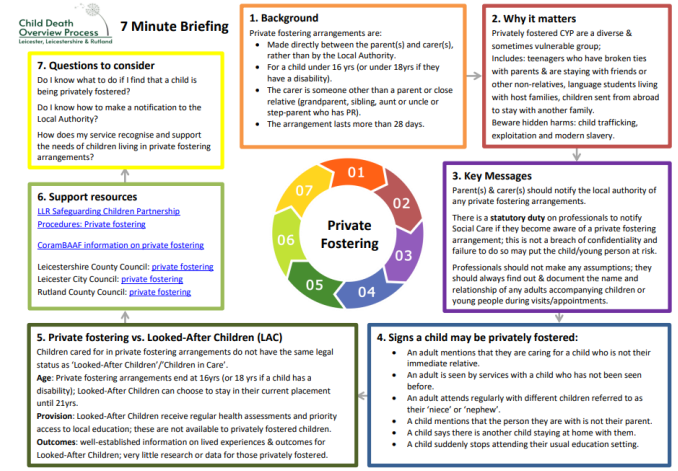
Communication is key

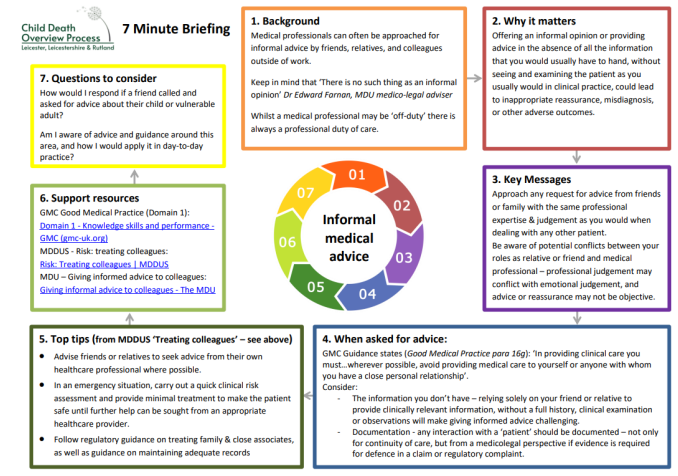
Care coordination & transition

Access to services

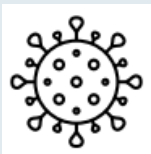
Learning from case reviews

Category of death	Total no of cases	Cases where learning identified	% of cases where learning identified
Sudden unexpected, unexplained death	7	7	100
Trauma or other external factors	6	6	100
Infection	6	6	100
Deliberately inflicted injury, abuse or neglect	2	2	100
Acute medical or surgical condition	4	3	75
Suicide or deliberate self-inflicted harm	4	3	75
Chromosomal, genetic or congenital anomaly	16	10	62.5
Perinatal/neonatal event	20	10	50
Chronic medical condition	4	2	50
Malignancy	2	1	50
Total	**71**	**50**	





Learning from case reviews cont'd

	More integrated IT systems would improve communication, information-sharing & recognition of emerging vulnerability.
	Early recognition of vulnerability is vital to provide appropriate support, advice and information.
	Timely communication & information sharing is key.
	Safer Sleep conversations need to include partners, help families identify risks and help families plan to mitigate those risks
	Covid-19 pandemic impacted on visibility & accessibility, and compounded existing challenges.

Recommendations

1. **Safer Sleeping**

   To develop multiagency guidance for all practitioners around infant safer sleep messaging embedded within systems & processes that support effective multiagency practice across the continuum of risk.

2. **Digital solutions to improve communication**

   To prioritise the development of integrated electronic records systems to support the appropriate sharing of information & communication between practitioners working with families, and identification of emerging vulnerabilities.

Recommendations cont'd

3. **Infant mortality**

   For the LLR Healthy Babies Strategy Group to use this report to refresh the strategy and action plan to address social determinants of infant mortality.

4. **Suicide & self-harm**

   For LLR CDOP to work with stakeholders to carry out a thematic report into deaths due to suicide and self-inflicted harm in children and young people, and to share the report & recommendations across LLR.

5. **LeDeR Reviews**

   For LLR CDOP to work collaboratively with the LLR LeDeR Programme to commence annual thematic reviews of cases, and to work together to generate clear SMART actions based on learning themes identified.

Further information

- Child Death Reviews: Statutory & Operational Guidance

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1120062/child-death-review-statutory-and-operational-guidance-england.pdf

- LLR CDOP Annual Report & 7 Minute Briefings

https://lrsb.org.uk/child-death-overview-panel-cdop

- National Child Mortality Database

www.ncmd.info