



LLR Child Death Overview Panel Annual Report 2021/22

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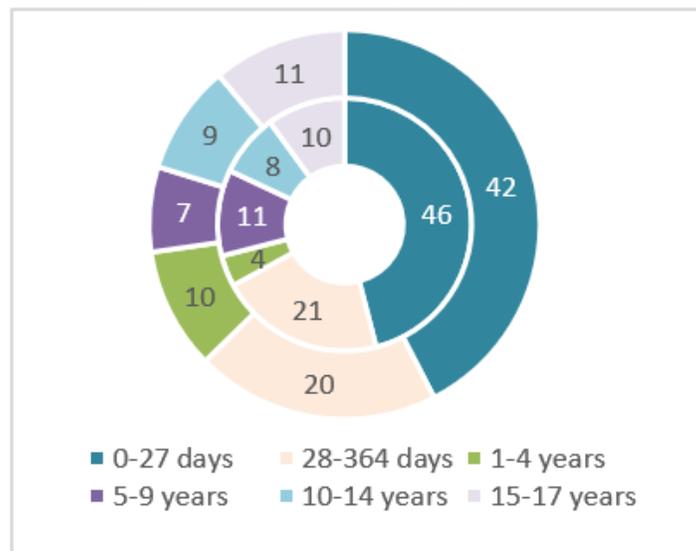
Notifications 2021/22

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

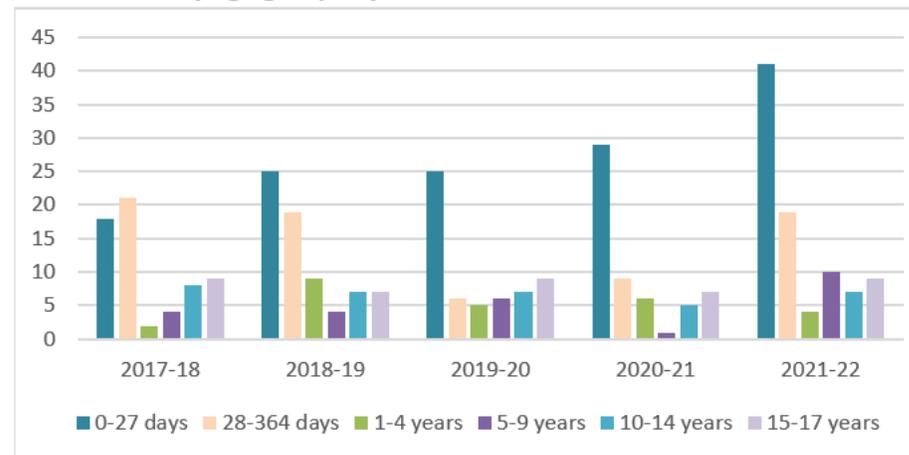
	2017/18	2018/19	2019/20	2020/21	2021/22
Leicester City	33	36	24	30	48
Leics & Rutland	29	35	34	27	42
Total LLR	62	71	58	57	90

% of notifications by age group

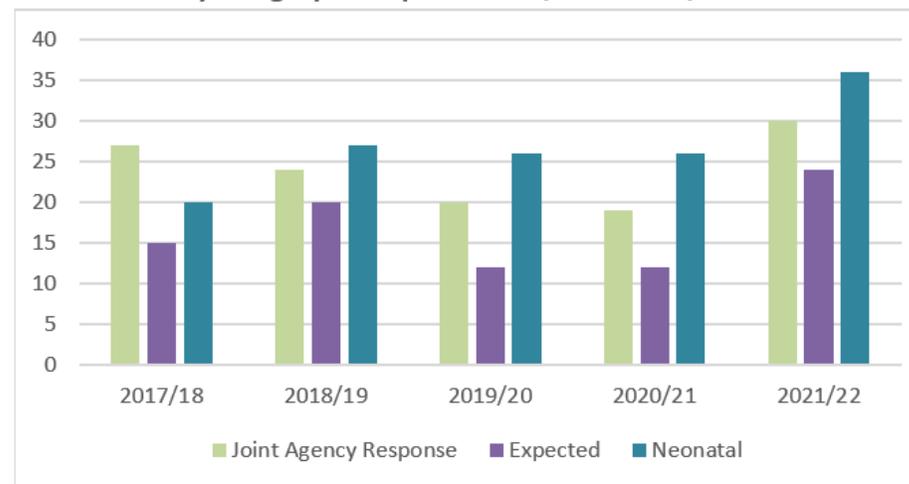
Inner ring LLR, Outer ring England



Notifications by age group & year



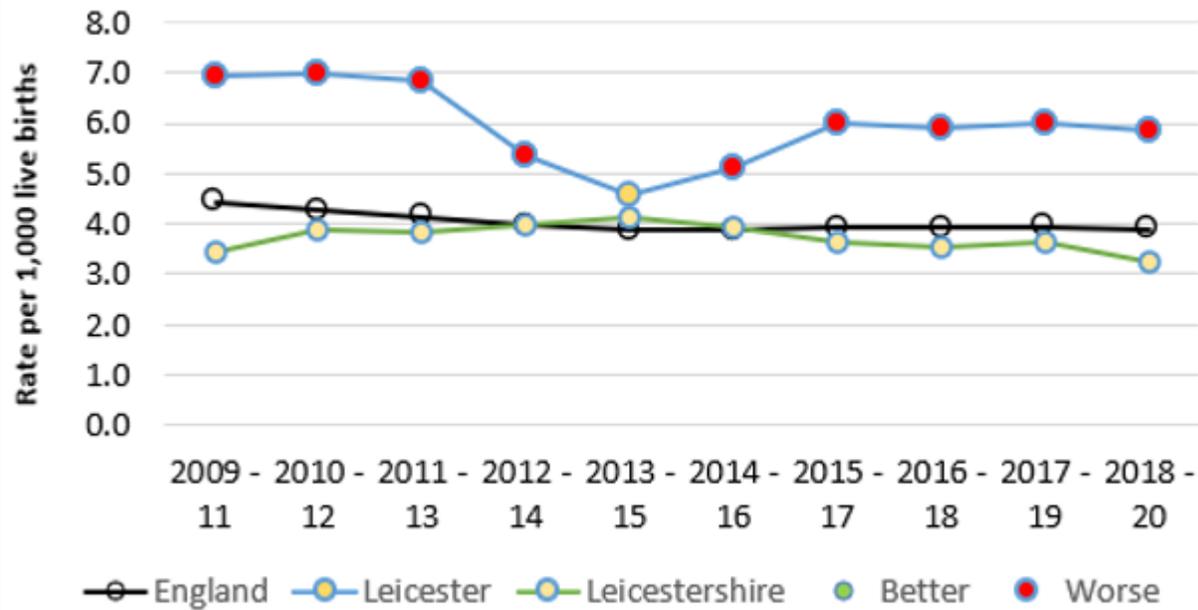
Notifications by category of response 2017/18 to 2021/22



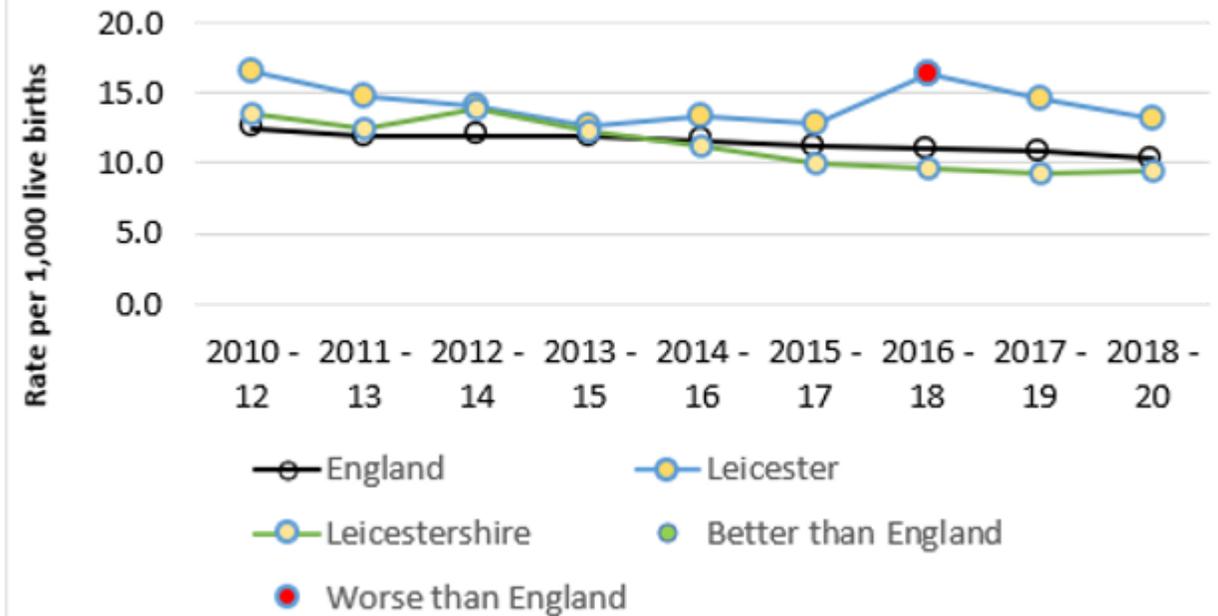
Summary Statistics



Infant mortality rate



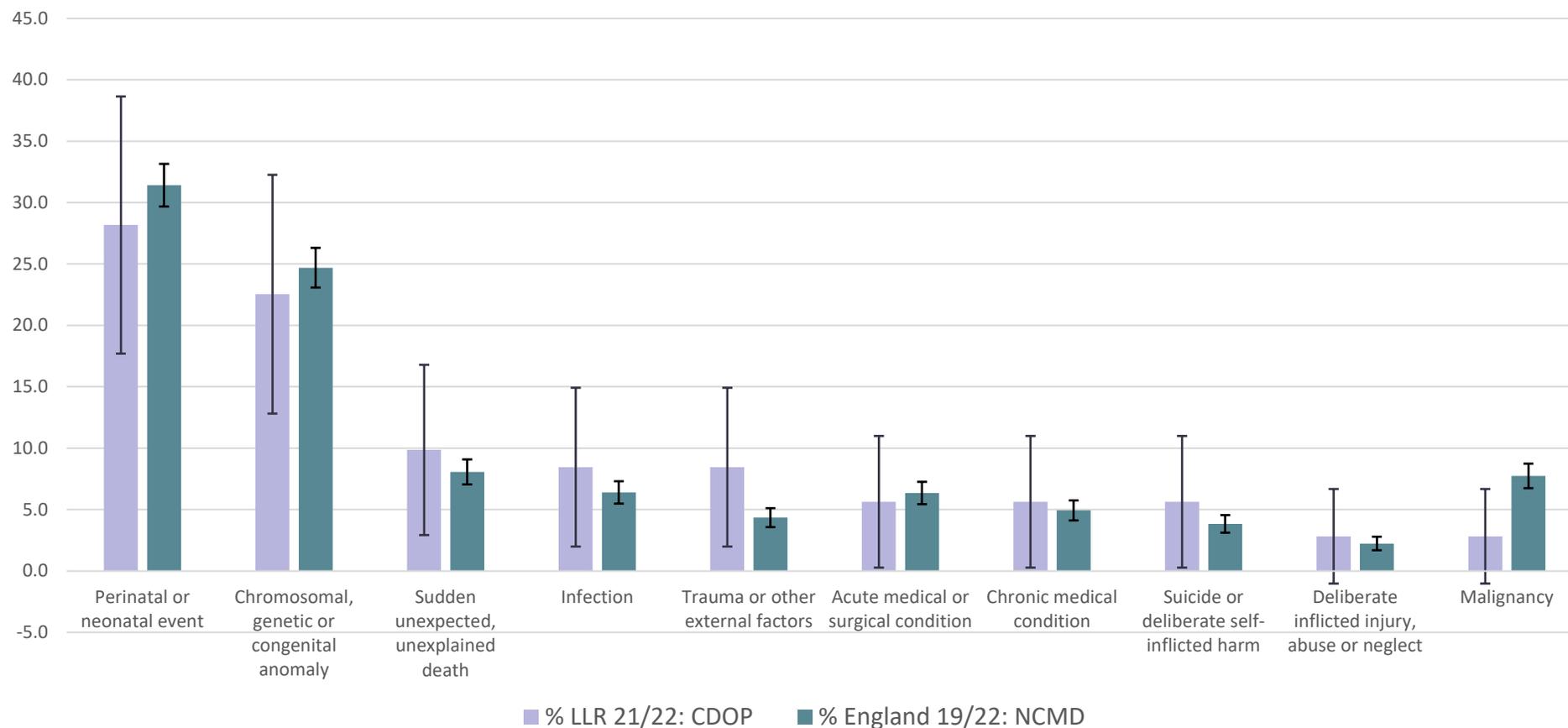
Child mortality rate (1-17 years)



Completed Reviews 2021/22



Completed reviews by primary category of death (%)



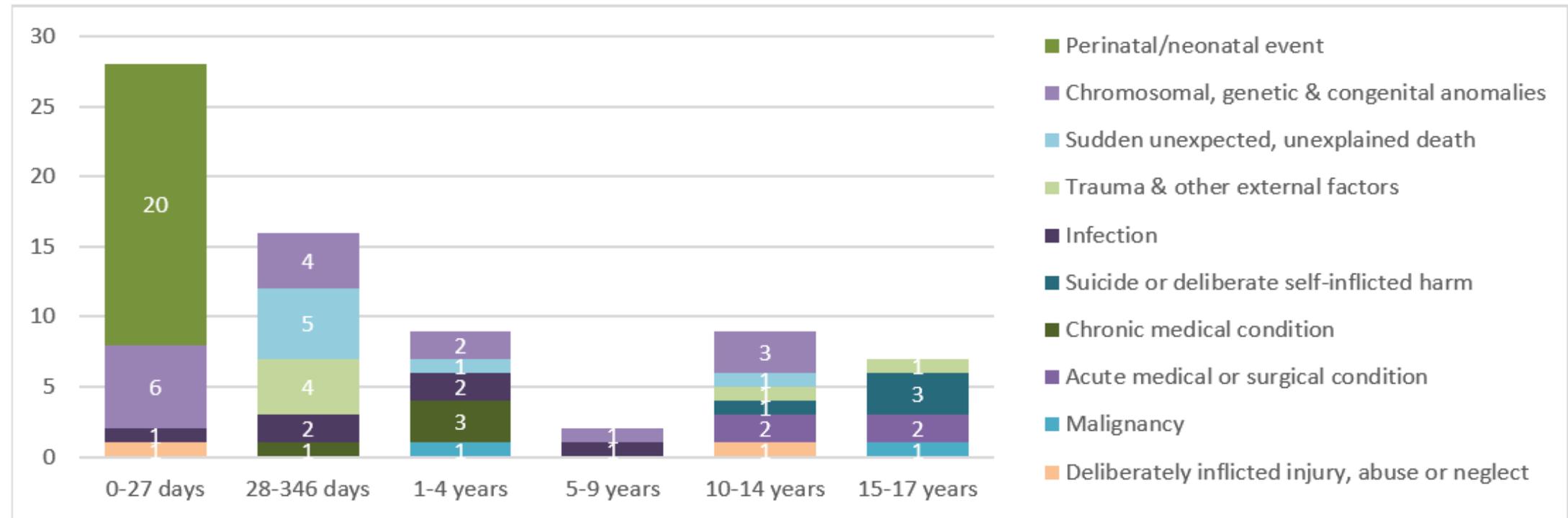
Completed reviews by year of death 2021/22

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



Completed CDOP reviews by age group & category of death 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, <u>abuse</u> 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, <u>genetic</u> 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](#)

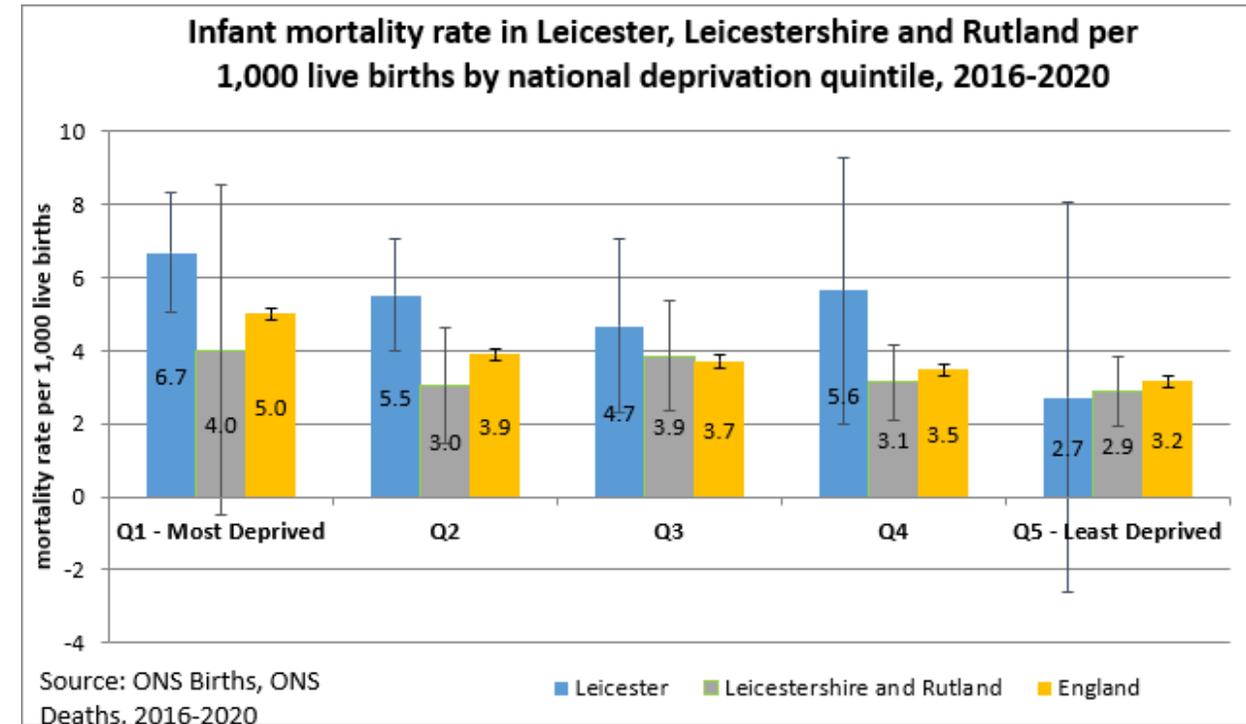
	2015/16 to 2020/21 (n=15)		2016/17 to 2021/22 (n=15)	
	N	%	N	%
Bottle fed	12	80 %	11	73 %
First born	4	27 %	6	40 %
Preterm	10	67 %	9	60 %
IMD 1&2	7	47 %	6	40 %
Birthweight <2.5kg	9	60 %	9	60 %
Mean maternal age	28.8 (20-36)		28.73 (20-36)	
Medical cause of death:				
‘Unascertained’	12	80 %	11	73 %
‘SIDS’	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	

Child Death Overview Process Leicester, Leicestershire & Rutland

7 Minute Briefing

7. Questions to consider

Do I know what to do if I find that a child is being privately fostered?
Do I know how to make a notification to the Local Authority?
How does my service recognise and support the needs of children living in private fostering arrangements?

1. Background

Private fostering arrangements are:

- Made directly between the parent(s) and carer(s), rather than by the Local Authority.
- For a child under 15 yrs (or under 18yrs if they have a disability).
- The carer is someone other than a parent or close relative (grandparent, sibling, aunt or uncle or step-parent who has PR).
- The arrangement lasts more than 28 days.

2. Why it matters

Privately fostered CYP are a diverse & sometimes vulnerable group:
Includes: teenagers who have broken ties with parents & are staying with friends or other non-relatives, language students living with host families, children sent from abroad to stay with another family.
Beware hidden harms: child trafficking, exploitation and modern slavery.

6. Support resources

L18 Safeguarding Children Partnership
Procedures: Private Fostering
CoramBAAF information on private fostering
Leicestershire County Council: [private fostering](#)
Leicester City Council: [private fostering](#)
Rutland County Council: [private fostering](#)

3. Key Messages

Parent(s) & carer(s) should notify the local authority of any private fostering arrangements.
There is a **statutory duty** on professionals to notify Social Care if they become aware of a private fostering arrangement; this is not a breach of confidentiality and failure to do so may put the child/young person at risk.
Professionals should not make any assumptions; they should always find out & document the name and relationship of any adults accompanying children or young people during visits/appointments.

5. Private fostering vs. Looked-After Children (LAC)

Children cared for in private fostering arrangements do not have the same legal status as 'Looked-After Children'/'Children in Care'.
Age: Private fostering arrangements end at 16yrs (or 18 yrs if a child has a disability); Looked-After Children can choose to stay in their current placement until 21yrs.
Provision: Looked-After Children receive regular health assessments and priority access to local education; these are not available to privately fostered children.
Outcomes: well-established information on lived experiences & outcomes for Looked-After Children; very little research or data for those privately fostered.

4. Signs a child may be privately fostered:

- An adult mentions that they are caring for a child who is not their immediate relative.
- An adult is seen by services with a child who has not been seen before.
- An adult attends regularly with different children referred to as their 'niece' or 'nephew'.
- A child mentions that the person they are with is not their parent.
- A child says there is another child staying at home with them.
- A child suddenly stops attending their usual education setting.

Private Fostering

Child Death Overview Process Leicester, Leicestershire & Rutland

7 Minute Briefing

7. Questions to consider

How would I respond if a friend called and asked for advice about their child or vulnerable adult?
Am I aware of advice and guidance around this area, and how I would apply it in day-to-day practice?

1. Background

Medical professionals can often be approached for informal advice by friends, relatives, and colleagues outside of work.
Keep in mind that 'There is no such thing as an informal opinion!' Dr Edward Fennan, MDU medico-legal adviser
Whilst a medical professional may be 'off-duty' there is always a professional duty of care.

2. Why it matters

Offering an informal opinion or providing advice in the absence of all the information that you would usually have to hand, without seeing and examining the patient as you usually would in clinical practice, could lead to inappropriate reassurance, misdiagnosis, or other adverse outcomes.

6. Support resources

GMC Good Medical Practice (Domain 1): [Domain 1 - Knowledge skills and performance - GMC \(gmc-uk.org\)](#)
MDDUS - Risk: treating colleagues:
[Risk: Treating colleagues | MDDUS](#)
MDU - Giving informed advice to colleagues:
[Giving informal advice to colleagues - The MDU](#)

3. Key Messages

Approach any request for advice from friends or family with the same professional expertise & judgement as you would when dealing with any other patient.
Be aware of potential conflicts between your roles as relative or friend and medical professional - professional judgement may conflict with emotional judgement, and advice or reassurance may not be objective.

5. Top tips (from MDDUS 'Treating colleagues' - see above)

- Advise friends or relatives to seek advice from their own healthcare professional where possible.
- In an emergency situation, carry out a quick clinical risk assessment and provide minimal treatment to make the patient safe until further help can be sought from an appropriate healthcare provider.
- Follow regulatory guidance on treating family & close associates, as well as guidance on maintaining adequate records

4. When asked for advice:

GMC Guidance states (Good Medical Practice para 16g): 'In providing clinical care you must... wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship'.
Consider:
- The information you don't have -- relying solely on your friend or relative to provide clinically relevant information, without a full history, clinical examination or observations will make giving informed advice challenging.
- Documentation - any interaction with a 'patient' should be documented - not only for continuity of care, but from a medico-legal perspective if evidence is required for defence in a claim or regulatory complaint.

Informal medical advice

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