

North West London
Child Death Review Team

Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon,
Hounslow, Kensington and Chelsea, Westminster



North West London

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Child Death Review

Annual Report 2022/2023

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North West London (NWL) Child Death Review (CDR) **Annual Report 2022/2023**

Introduction

This report provides an overview of the work done by the NWL Child Death Review (CDR) Service, which coordinates the statutory CDR process for children who are usually resident in NWL. The service works closely with a range of partner organisations across NWL including, London Ambulance service, children's social care, the police, primary and secondary healthcare agencies, education and local safeguarding children partnerships.

Reviews are carried out on the deaths¹ of any child normally resident in the area by collecting and analysing information about each death with a view to identifying:

- any case giving rise to the need for a serious incident notification²,
- any matters of concern affecting the safety and welfare of children in the area of the relevant local authority,
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area.

The NWL Services that Contribute to the CDR Process

Table 1 illustrates the NHS and local council services that contribute to the CDR process.

The NHS and local councils are the statutory agencies, responsible for the CDR process, but schools, London Ambulance Service, the Metropolitan Police and a range of third sector bodies also make a very important contribution.

¹ It does not review cases of stillborn or the planned termination of pregnancies which happen when healthcare staff are present.

² When a child dies (or is seriously harmed) and there is neglect or abuse known or suspected to be part of the child or family history the relevant local authority is required to send a serious incident notification to the Department for Education. Occasionally a baby might die in circumstances of neglect or abuse which prior to the CDR process were unknown to the local authority.



Figure 1

We are:

65,000 NHS employees
1,500 Adult social care staff
1,500 Voluntary organisations
1,300 (FTE) GPs
350 GP practices
276 Care homes
45 Primary Care Networks
9 NHS Trusts – four acute trusts, 4 community and mental health trusts, 1 ambulance trust
8 London Councils
8 Boroughs
1 NHS Clinical Commissioning Group (until ICS/ICB established)



Acute trusts
Chelsea and Westminster NHS Foundation Trust

Imperial College Health Care NHS Trust

London North West University Healthcare NHS Trust

The Hillingdon Hospitals NHS Foundation Trust

Community and mental health trusts
Central and North West London NHS Foundation Trust

Central London Community Health Care NHS Trust



Hounslow and Richmond Community Healthcare NHS Trust

West London NHS Trust

Other NHS organisations
London Ambulance Service NHS Trust

National Institute of Clinical Research Network North West London

NHS England/London

NHS Health Education North West London

NHS North West London Clinical Commissioning Group

Table 1

The Geography and the People of NWL

The service covers the eight boroughs of NWL: Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster. (Figure 1). NW London is a diverse area with a population³ of 2.1 m people from many different ethnicities.

³ ONS 2021

Health Inequalities

There are significant health challenges and inequalities in health status and life expectancy across NWL.

- 1 in 10 people have diabetes or non-diabetic hyperglycaemia (NDH) (1 in 16 nationally).
- 1 in 5 adults (18+) has two or more long-term conditions compared to 1 in 4 nationally.
- Alcohol admissions in Ealing are above the average in England, with 2,200 admissions a year per 100,000 people (England 1,815).
- Rates of emergency hospital admissions for self-harm are twice as high in Hounslow as they are Harrow.
- 1 in 4 of our 10-11 year-olds are obese (1 in 5 nationally).
- 17.1% of people in Hillingdon smoke, versus 9.2% in Ealing (13% across NW London - 14% nationally).
- 38,000+ (11%) children and young people aged between 5 and 18 years have a mental health disorder (12% nationally).

Social and Economic Inequalities

There are wide differentials in the economic circumstances and available social support experienced in various families and communities in NWL.

- 28.6% of people do not have English as first language (8% nationally).
- 8.7% households are overcrowded (3.5% nationally).

Variation Within and Between Boroughs

- Kensington and Chelsea has the greatest income inequality in London.
- While 13.9% of children in Harrow are in low income families 29% of children in Westminster are (16% nationally).
- Nearly four times as many children live in poverty in Hammersmith and Fulham's poorest ward 45% as in the richest ward 12.2% (30% nationally).
- On the index of multiple deprivation (where 1 is the most deprived) Brent numbers 65 and Harrow 156 (out of 317 local authorities).

The Diversity and Age Profiles of NWL's Children

The table below shows the breakdown in the ethnicity, gender and age of children 0-17 years across NWL.

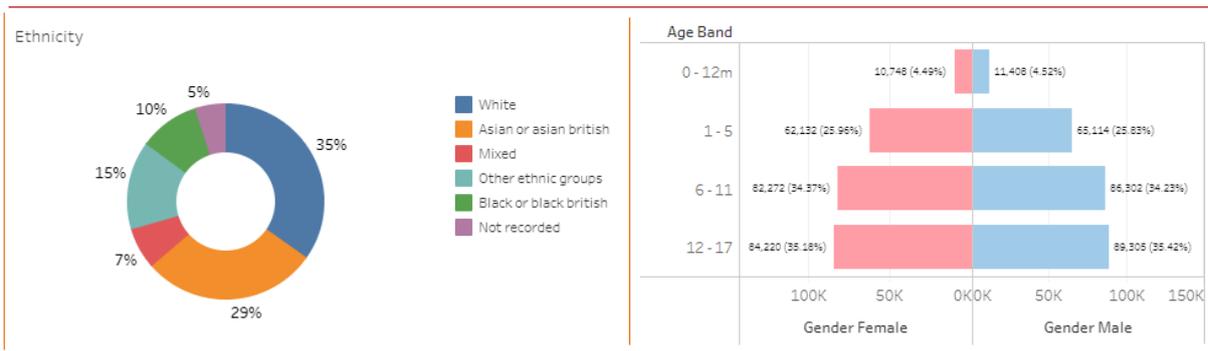


Table 2

Aim of NWL CDR Team

The aim of the Service is to ensure families are appropriately supported following the death of their child and that any learning to prevent future child deaths is identified and actioned both locally and nationally. We also seek to work with partner agencies across NWL to ensure the statutory guidelines are adhered to in a systematic way.

Objectives

The service objectives are to:

- Ensure a key worker is allocated to all families normally resident in NWL whose child has died.
- Ensure families are signposted to specialist bereavement support and are fully informed of the CDR process.
- Support staff responding to the death of a child within NWL.
- Develop staff training around child death and bereavement support.
- Promote local and national learning following child deaths.

Staffing

The NWL CDR team comprises five full time staff. They coordinate and manage the CDR process and work closely with NWL designated doctors for child death who have a statutory responsibility for child deaths.

The CDR team provide expertise in Joint Agency Response⁴ meetings (JAR) and Child Death Review Meetings⁵ (CDRMs). The team also supports the final stage of the process at the monthly Child Death Overview Panels (CDOP).

⁴ These are multi agency meetings which respond to unexpected child deaths

⁵ These are multi agency meetings which are attended by staff with knowledge of the child which discuss the circumstances of every child death.

In April 2022 during normal office hours in cases involving unexpected deaths the team began supporting multi agency joint home visits as part of the Key worker role to ensure bereaved parents and families have a single point of contact.

NWL CDR Team Structure (See Figure 2 Below)

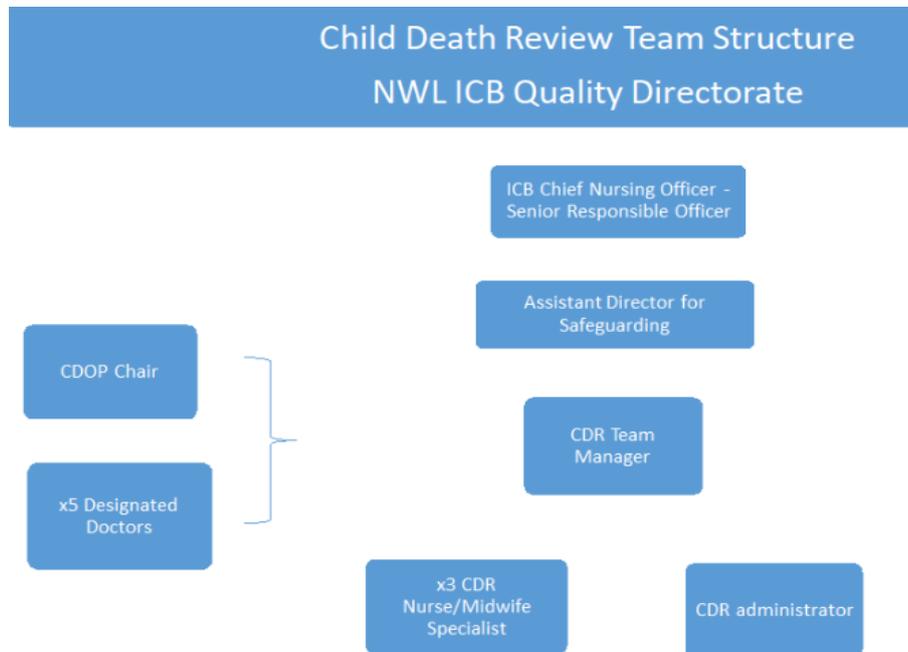


Figure 2

The CDR Team Achievements for 2022/23

As well as running an effective service, we seek also to spread learning, improve practice and raise understanding of how professionals and the public can contribute to reducing child mortality. Over the past year we have

- Developed a CDR website which publicises upcoming training events, contains informative newsletters, and provides learning from deaths with seven minute briefings. It also explains how the service works and provides contact information. This can be accessed at:

<https://www.nwlondonicb.nhs.uk/professionals/children-and-young-people/child-death-reviews>

- Run a London learning event focusing on falls from heights – See seven-minute briefing on our website.

- Delivered a range of multi-agency events. One of NWL’s designated doctors for child death, the police and a bereavement charity help us deliver wide ranging and in-depth learning. We intend to include children’s social care and a coroner in sessions where their expertise will prove invaluable and we continue to develop the content as a result of attendee feedback.
- Supported acute trusts to deliver effective and timely Child Death Review Meetings. Our staff attend this hospital led meetings and provide feedback to ensure consistency and improvement.
- Reduced a backlog of aging cases. Some cases get “stuck” for a number of reasons and we have focused on ensuring that the oldest cases in the system receive additional attention.
- Worked with a donor charity to enable community health teams to have access to cooling blankets so that families can spend time at home with their child after they have died. Three cooling blankets have been funded by the Stefanou Foundation⁶ and now are available for use in NWL.
- Worked with local bereavement charities across NWL to ensure that CDR staff and partners understand what is available for families.
- Highlighted to NCMD and to England’s Chief Medical Officer a cluster of deaths linked to the failure of central venous catheters. This is now being investigated by the Deputy Chief Medical Officer for Patient Safety.
- Published a quarterly newsletter.
- Strengthened our relationships with partner agencies by having quarterly meetings with the police, local safeguarding children partnerships, community health teams and local authority children’s social care teams.

Child Death Notifications

NWL received 145 notifications of child deaths in the past year. Table 3 shows these by borough and how this year’s figure compares with the previous three years.

⁶ More details can be found at <http://www.stefanoufoundation.org>

Death notifications by LSCB and year

LSCB name	2019-20	2020-21	2021-22	2022-23
Brent	17	32	21	18
Ealing	23	29	24	23
Hammersmith and Fulham	8	7	10	13
Harrow	26	13	22	25
Hillingdon	19	24	14	25
Hounslow	28	18	11	16
Kensington & Chelsea	9	4	4	9
Westminster	20	4	11	16
Total	150	131	117	145

Table 3 (taken from the National Child Mortality Database)

There were fewer deaths in the Covid pandemic years 2020/2022 but numbers have returned to where they were before the pandemic. The situation in NWL was similar to what was reported nationally.

Ealing has the largest population of the eight NWL boroughs and also the highest population of 0-17 year olds and Ealing consistently has the highest number of deaths.

Borough Specific Issues

These points of note are issues to be kept under review. The numbers for each borough remain relatively small and therefore it takes time before it is possible to discern trends of note as opposed to normal statistical variations.

- Westminster has seen a rise in child deaths since mid-2021
- Hammersmith and Fulham previously had a downward trend between April 2019 and February 2022 but since then has seen an upturn
- Brent, Ealing and Hounslow have experienced a downward trend since 2019-2020.
- Kensington and Chelsea, had no reported child deaths in Quarter 4 January-March 2023
- Hillingdon has only had two child deaths in the first four months of 2023, compared with 13 in the same period in 2022
- Child deaths in Hounslow in 2023 are more than double for the same period in 2022.

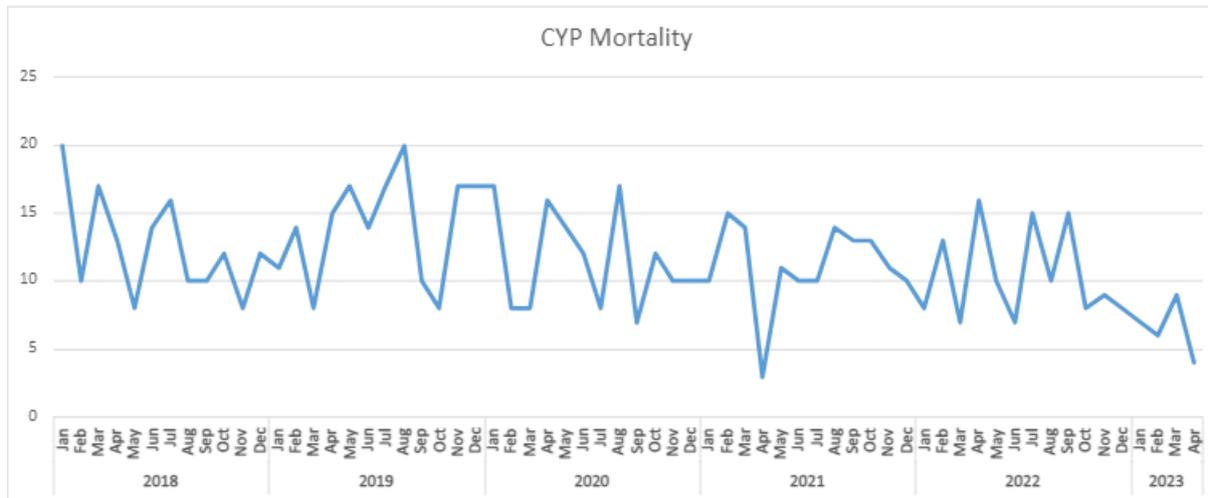


Figure 3

Child Deaths in NWL

Figure 3 shows the wide fluctuations in child death reports month by month. In some months 20 are reported and in others 3. The median is 12.

There are seven CDOPs in London. North West London, which has the largest resident population also has the highest number of child deaths in all age categories (Table 4).

1.3.2: Total child deaths by age group - 3 years

CDOP	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years
North Central London	86	62	30	19	19	33
North East London (Barking, Dagenham, Havering & Redbridge)	63	40	25	5	14	16
North East London (Waltham Forest, East London & the City)	129	56	28	14	18	28
North West London	188	67	45	21	40	36
South East London (Bexley, Greenwich & Lewisham)	104	41	26	10	10	17
South East London (Bromley, Lambeth & Southwark)	72	37	12	11	11	13
South West London	91	53	29	20	14	32
Total	733	356	195	100	126	175

Table 4 (three years of child death in London)

Joint Agency Response (JAR)

A JAR is a multi-agency meeting attended by any agency that has been involved with a child in a meaningful way prior to their death and it takes place if a child's death:

- Is or could be due to external causes;
- Is sudden and there is no immediately apparent cause (incl. SUDI/C);
- Occurs in custody, or where the child was detained under the Mental Health Act;
- Occurs in such a way that the initial circumstances raise suspicions that the death may not have been natural; or
- (In the case of a stillbirth) takes place with no healthcare professional in attendance.

In 2022/23 the CDR Team held and chaired 58 JAR meetings. Figure 4 shows how over four years, while the number of notifications are now back to pre-pandemic levels, the number of JARs has doubled suggesting an increase in unexpected deaths. It is also possible that some of this increase is due to better reporting and a more responsive system.

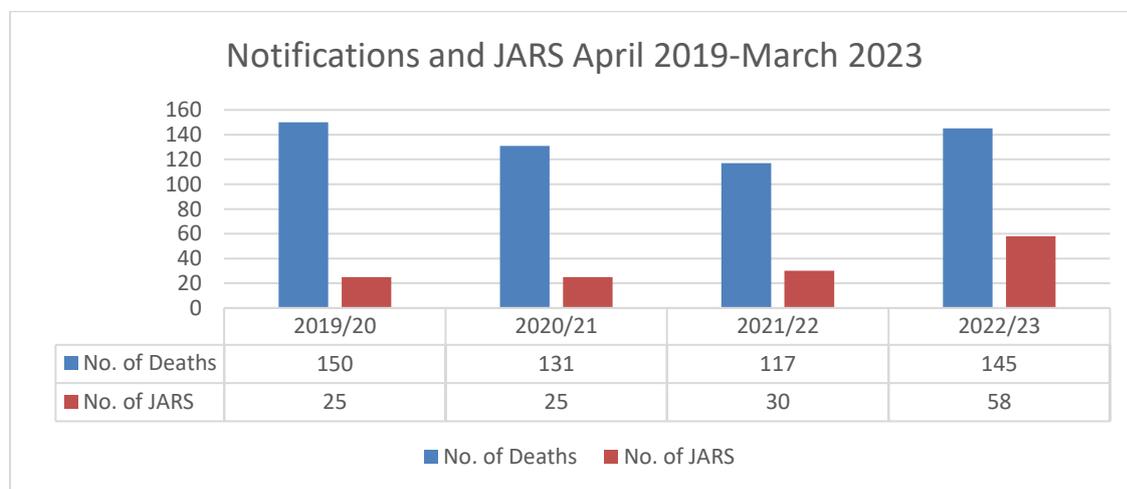


Figure 4

Unexpected and Expected Deaths Yearly Comparison 2019-2023

Of 543 death notifications received over the last four years, 25% of them are unexpected. These have doubled since 2019. Expected deaths are mainly neonatal or happen among children with chronic health needs like cancer or with chromosomal or congenital anomalies. These expected deaths have declined since 2019. This is shown by Figure 5.

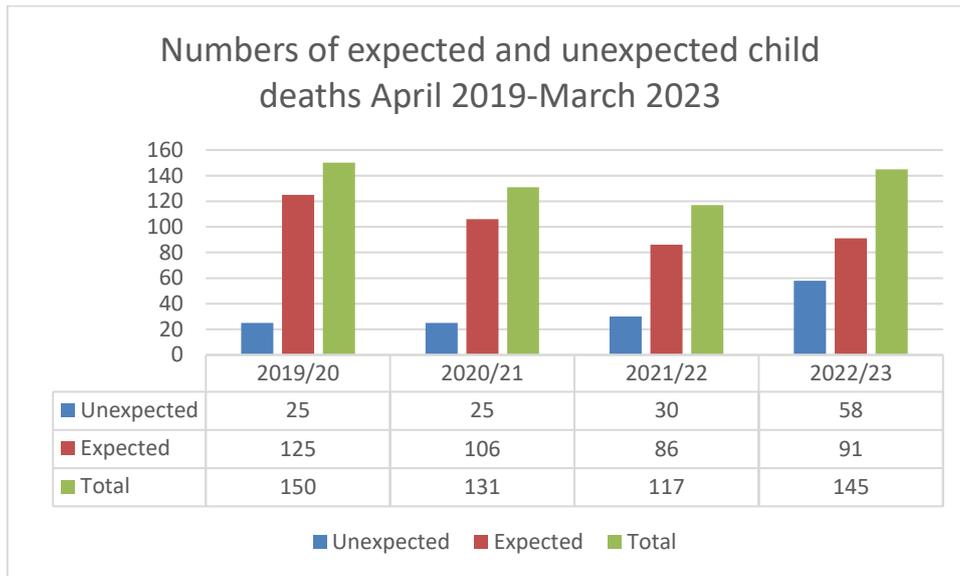


Figure 5

Age

The highest number of deaths occur among children aged 0-27 days (36%) and 28-364 days (22%). Table 4 above shows that this pattern is similar across London. NWL’s pattern of death by age of child is broadly similar to the national picture. The Tables below (copied from NCMD reports) show how NWL compares with England as a whole. Neonatal and infant mortality are close to the England average, while mortality among children aged 1-17 is slightly higher in NWL than in England.

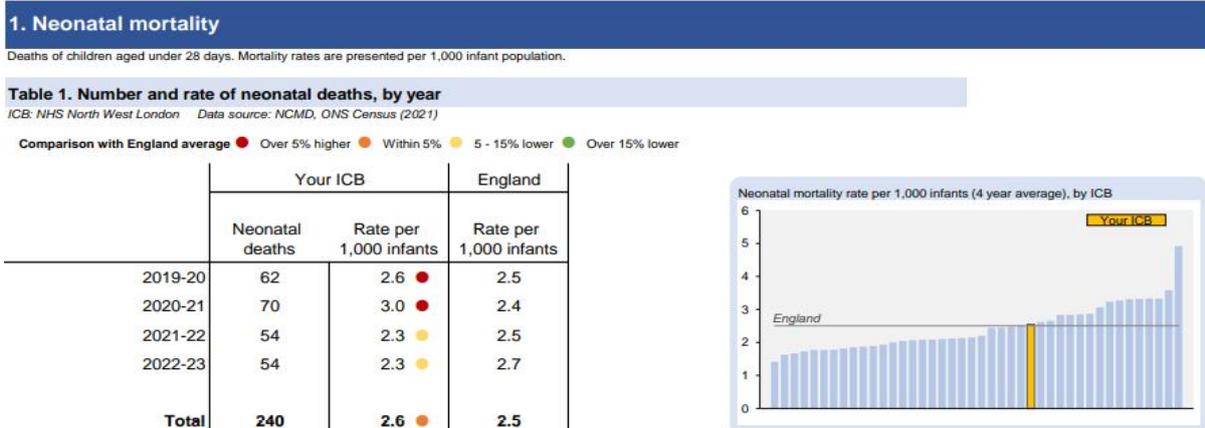


Table Showing Neonatal Mortality

2. Infant mortality

Deaths of children aged under 1 year. Mortality rates are presented per 1,000 infant population.

Table 5. Number and rate of infant deaths, by year

ICB: NHS North West London Data source: NCMD, ONS Census (2021)

Comparison with England average ● Over 5% higher ● Within 5% ● 5 - 15% lower ● Over 15% lower

	Your ICB		England
	Infant deaths	Rate per 1,000 infants	Rate per 1,000 infants
2019-20	90	3.8 ●	3.7
2020-21	89	3.8 ●	3.4
2021-22	73	3.1 ●	3.7
2022-23	85	3.6 ●	3.8
Total	337	3.6 ●	3.7

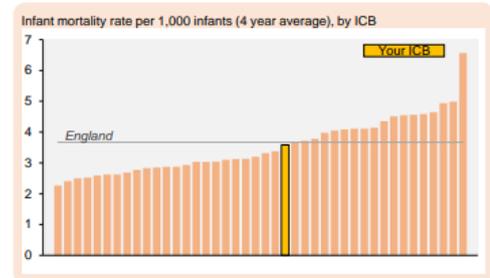


Table Showing Infant Mortality

3. Mortality rate of children aged 1 - 17 years

Deaths of children aged between 1 and 17 years. Mortality rates are presented per 100,000 population of children the same age.

Table 9. Number and rate of deaths of 1-17 year olds, by year

ICB: NHS North West London Data source: NCMD, ONS Census (2021)

Comparison with England average ● Over 5% higher ● Within 5% ● 5 - 15% lower ● Over 15% lower

	Your ICB		England
	Deaths of 1 - 17 year olds	Rate per 100,000 population	Rate per 100,000 population
2019-20	56	13.6 ●	11.3
2020-21	42	10.2 ●	9.6
2021-22	45	10.9 ●	11.7
2022-23	60	14.6 ●	13.6
Total	203	12.3 ●	11.5

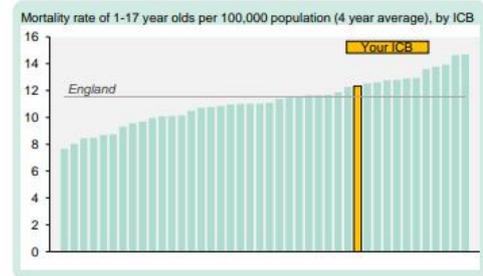


Table Showing Child Mortality

Sex

Of the 145 notifications received 78 (53%) were Male and 64 (44%) were Female. Three notifications were received where the sex of the child was not determined. These were babies born under 23 weeks with no post mortem carried out.

Number and rate of deaths of 1-17 year olds between 01/04/2019-31/03/2023 (4 years), by sex

North West London Data source: NCMD, ONS Census (2021)

	Your ICB		England
	Deaths of 1 - 17 year olds	Rate per 100,000 population	Rate per 100,000 population
Female	88	11.0	9.8
Male	113	13.4	13.1

The table above shows that the proportion of male deaths at 56% involving children aged 1-17 and at the rate of 13.1 per 100,000 is higher than the National average.

National Reports

A recent National Child Mortality Database's (NCMD) report⁷ on sudden and unexpected deaths in infancy and childhood (SUDIC) highlighted that in 27% of cases where a SUDIC occurs with a child aged 1 - 17 there is often a family history of convulsions (27%).

Even when their deaths are fully explained by an underlying medical condition the same family history is often found. The NWL CDR Team is reviewing these deaths across NWL to see whether this issue is found in NWL. This could have an impact on how children attending GPs and Accident and Emergency following febrile convulsion are assessed. The NCMD report recommends that research on sudden unexpected and unexplained deaths of children over one year of age be prioritised to identify modifiable factors so professionals can work to prevent these deaths.

The report also highlights that more deaths occur in males and among vulnerable infants with lower birth weight.

The Lullaby Trust⁸ has identified that 63% of unexplained deaths were among boys in 2020. This could be for biological reasons⁹.

Other Investigations

There are a number of different ways in which learning is obtained from child deaths; some mandatory, others not. The CDR process is mandatory. From time to time the CDR process runs in parallel with other investigations.

Learning Disabilities Mortality Review (LeDeR)

Every child over the age of four, who has a learning disability and who dies should have their case referred for a LeDeR. In the past year ten cases have been referred.

⁷ Accessed at https://www.ncmd.info/wp-content/uploads/2022/12/SUDIC-Thematic-report_FINAL.pdf

⁸ <https://www.lullabytrust.org.uk>

⁹ [Gender bias in under-five mortality in low/middle-income countries | BMJ Global Health](#) Costa et al 2017

Main Issues that have Arisen from LeDeR from NWL Cases

- A child with Learning Disabilities (LD) was managed by an adult resuscitation team which was not aware of the child's complex background.
- The LAS should consider coding as high priority addresses occupied by children with LD and complex needs in view of their potential for rapid deterioration.
- The impact of COVID and the effect the Visiting Policy had on a family who could not be with their child at time of death.
- COVID made services less accessible for children with complex needs
- There are issues with communication from hospital trusts to community health teams on the child's or young person's discharge.
- Best practice would always be the use of interpreters.
- Importance of supporting the LeDeR programme by reporting the death of child aged four and above with a learning disability.

As of 1st July 2023, LeDeR policy relating to the deaths of children and young people under the age of 18 is changing. There will no longer be any requirement for deaths of children with a learning disability to also be notified to LeDeR.

LeDeR are making this change because it is important that the deaths of children with a learning disability are reviewed by the national mandated processes that look at the deaths of all children.

Previous or Current Social Care Involvement

In 42 cases there had been prior to death some involvement of children's social care with either the deceased child or a sibling. In 14 of these cases modifiable factors were identified:

- Safe Sleeping Concerns.
- Better understanding of CAMHS and the neurodiversity pathway.
- Alcohol and smoking around a new born baby.
- Mother's mental health needs not assessed with the father being invisible to the case.
- Out of date EpiPen and importance of schools knowing how to use them.
- Clear child allergy plans to be shared between Health and School.
- Supportive mechanisms for parents where child has a mental health condition without a diagnosis.
- Education on using additional unsuitable aids to sleep; e.g. battery powered sleep aids.

- Unbooked pregnancy/missed opportunities in pregnancy e.g. attending Emergency Department when pregnant, mother had no GP, Maternity services involved and attended child protection conference but mother remained unbooked for pregnancy.

London Ambulance Service (LAS) Learning from JARS/CDRM/CDOP

- LAS now have paediatric saturation probes on all ambulances and body worn cameras are being rolled out across London. The LAS Hazardous Area Response Team now have longer reach poles following learning raised at the CDRM related to the death of a child by drowning.
- LAS have revised their mapping system so that children with particular needs are taken to the right hospital. Through this system LAS crews can ensure that children receive the specialist treatment they need.

NWL Child Death Review Process

Child Death Review Meetings (CDRM)

These meetings precede the CDOP and focus on the operational delivery of services to the deceased child and family prior to death, identifying areas of good practice and opportunities for improvement. The CDR team have worked hard to ensure CDRMs have been carried out where possible in a timely manner.

The Child Death Overview Panel (CDOP)

NWL convenes three different CDOPs:

- A neo natal panel for all babies under 28 days old (neonates)
- Flute panel which reviews children resident in Brent, Harrow, Hammersmith and Fulham, Kensington and Chelsea and the City of Westminster.
- Triangle panel which reviews children resident in Hounslow, Ealing and Hillingdon.

Last year the three panels closed 117 cases (compared with 65 in the previous year).

Panel members consist of paediatricians, public health experts, social care representatives, police officers, and a Designated Nurse for Safeguarding Children. Recently we have added a bereavement charity representative.

For neonatal panels we have an obstetrician, a neonatologist and a midwife. We plan to hold themed panels in the future where specialist services can offer specific expert advice in cases involving SUDI, suicide, trauma and cancer.

Delays to the CDOP panel

Cases being presented at CDOP can have delays due to outstanding investigations such as post mortem reports, police investigations, PMRT¹⁰ reports, serious incident reports¹¹, HSIB¹² reports.

Last year's report had an objective to ensure the CDR team worked with partner agencies to enable cases to progress. This was done by carrying out teaching on the CDR process, supporting trusts with CDRMs, and building relationships with the coronial services to ensure timely reports are shared and by attending PMRT meetings.

¹⁰ The Perinatal Mortality Review tool; this is the review of every baby death from 22 weeks' gestation up to death 28 days after birth.

¹¹ These are commissioned and completed by hospital trusts when any serious safety incident occurs

¹² These are reports conducted by the Healthcare Safety Investigation Branch into the deaths of babies up to 6 days after birth born as a result of labour, which began on or after 37 weeks' gestation.

Cases by Borough

Table 9 shows completed cases by borough, age, category of death and gender.

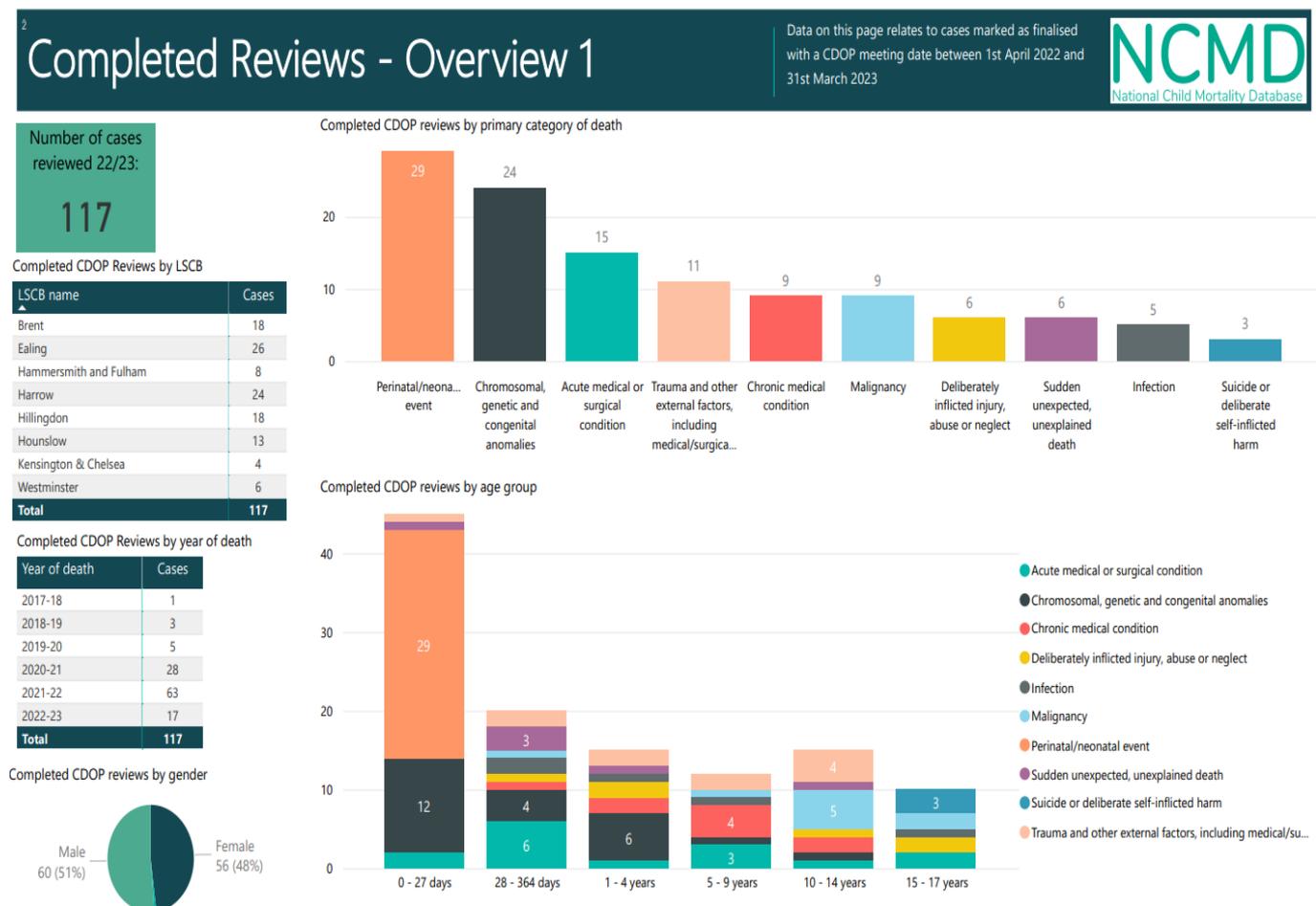


Figure 6

Modifiable Factors

Modifiable factors are things that could be done differently to prevent future child deaths. Figure 7 highlights that during 2022/23, 22% of cases (26/117) had modifiable factors. The national average is 39%. Modifiable factors were found in a higher proportion of cases involving families from minority ethnic communities (although our data needs to be improved as a high % of cases were unknown). Modifiable factors were also present in deaths relating to trauma, Suicide, SUDI, and deliberately inflicted abuse and neglect cases.

Across all boroughs modifiable factors included:

- Communication between agencies especially on discharge of children with complex/chronic illnesses.

- Use of interpreters to ensure the family understand what is being told and advised.
- Accident prevention information when giving advice on weaning (the risk of choking from sweetcorn kernels and the like).
- Basic life support in the community and
- Parent’s knowledge on where and how to call for medical help.
- Missing documentation on ethnicity and family dynamics, especially invisibility of the father.

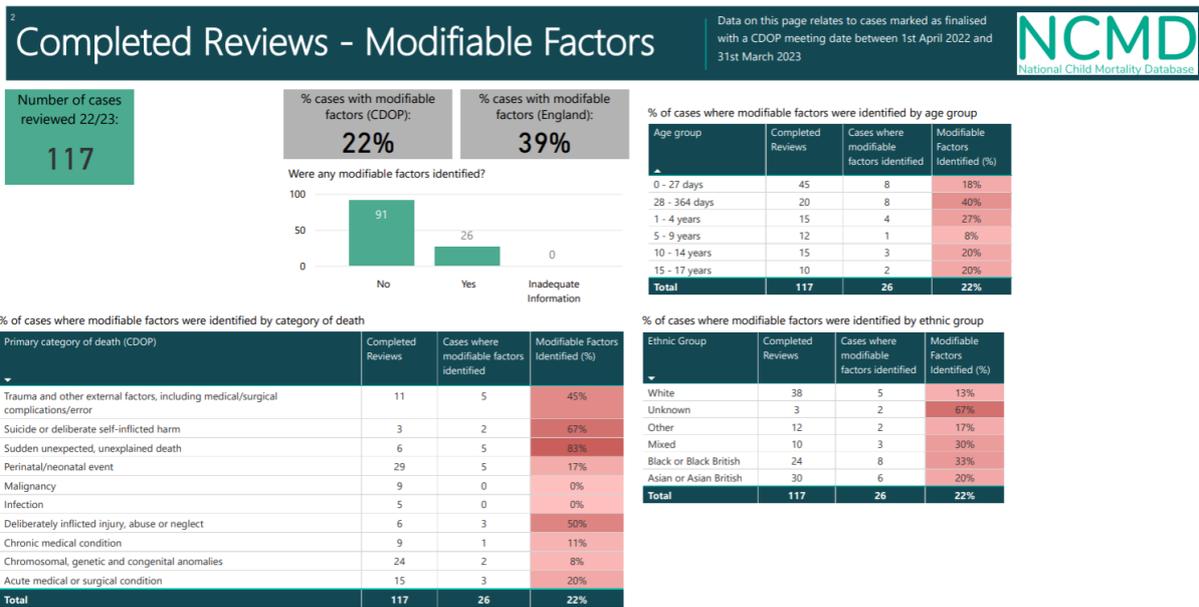


Figure 7

Case Reviewed at CDOP: Category of Death Over the Last 3 Years 2020-2023

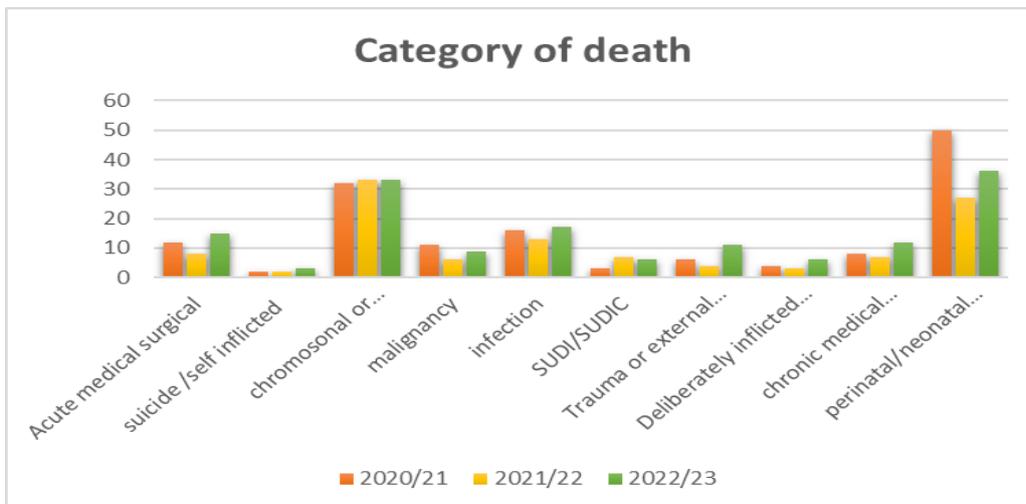


Figure 8

With unexpected deaths, we have noted an increase in acute medical/surgical and trauma/external deaths. The incidence of sudden unexpected deaths in infants (SUDI) declined in 2020/21 and has since risen 2021/22. (Figure 5).

Below is a summary of some themes we have collated from cases reviewed at CDOP over the past three years.

Significant Issues:

Consanguinity

Numerous studies have shown that higher rates of consanguinity in communities' correlates to higher rates of infant mortality. We notice high numbers of baby deaths born to consanguineous parents; significantly in excess of the rate of consanguineous partnerships in the community.

There is a need for preconception counselling within communities e.g. from religious leaders, consistency of interpreting services and a way of engaging missing fathers.

NWL CDR Proposal:

Collaborate with community and acute trusts as well as children's centres and pharmacies for QR codes and leaflets that have consistent information on use of interpreters and inclusion of fathers.

Action at community level may help people to understand and act on this advice; but this is only acceptable if information is balanced, non-stigmatising and offers families and communities realistic choices. NCMD suggests that pre-conception genetic counselling might prepare people for choices.

Asthma

No child should die as a result of asthma, but in NWL we have had four asthma deaths since 2020. A key theme is the need for consistency in follow up from GP and acute trusts as well as clinical nurse support via a core pathway across NWL.

NWL CDR Proposal:

Work is already commenced on ensuring consistent services are commissioned across NWL in terms of clinical nurse specialists and developing a collaborative core pathway.

Infection

46 cases identified the primary cause of death as Covid 19, sepsis, respiratory syncytial virus bronchiolitis. A key theme from the 46 deaths was the need to recognise an unwell child – and to ensure that parents knew who to contact when their child was unwell.

NWL CDR Proposal:

Undertake engagement with at risk cohorts across NWL; coproduce and deliver tailored services to address risk.

Sudden Unexplained Deaths of Infants/Children

16 cases, mostly aged between 28-364 days.

NWL CDR Proposal:

Consistent Safe Sleep advice from all agencies - Every Contact Counts especially when families are not in their usual environment or if they are attending a party or event with their child and there may be alcohol involved.

Suicides

7 cases; with the ingestion of sodium nitrate being the cause of death of two 17year olds and with two deaths by strangulation/hanging. Three of these cases have been reviewed at CDOP.

Key themes from the seven deaths over the last three years; low mood reported, but not all were known to CAMHS. All were still in education.

NWL CDR Proposal:

To work with the Children and Young People (CYP) Mental Health team to develop key messages and better communication approaches.

Trauma

21 deaths including two where children had choking episodes at home, two knife/ pointed instrument deaths, injuries from falls and car accidents and drownings. Key issues - In one case of choking episode the parents did not commence basic life support. In another case a child choked during feeding. Three cases involved falls from height and in one case two children died abroad in a car accident.

NWL CDR Proposal:

Feeding advice leaflets/videos concerning giving babies solids which include foods that have hard skin like grapes, sweetcorn, peas.

Basic life support in the community for parents/public.

Charity and local authorities offering swimming lessons to high school ages/ children who have arrived here from abroad.

Early intervention activities to reduce and prevent serious youth violence

Consistent information sharing from all agencies.

From the thematic review that the CDR Team conducted, it is clear that we need to collaborate with system partners to share these emerging themes. From these themes we can achieve change and reduce child deaths in our eight NW London boroughs.

Categories of Death by Borough

Table 11 shows completed reviews over a period of four years 2019-2023 by borough and by category of death.

Number of child death reviews where the death was reviewed between 01/04/2019 - 31/03/2023 (4 years)											
	Deliberately inflicted injury, abuse or neglect	Suicide or deliberate self-inflicted harm	Trauma and other external factors	Malignancy	Acute medical or surgical condition	Chronic medical condition	Chromosomal, genetic and congenital anomalies	Perinatal/neonatal event	Infection	Sudden unexpected, unexplained death	Total
Brent	5	3	0	4	3	2	26	15	5	3	66
Ealing	2	1	7	8	5	4	18	20	7	4	76
Hammersmith and Fulham	1	0	2	3	2	4	6	4	1	2	25
Harrow	1	0	4	2	6	5	15	24	3	1	61
Hillingdon	1	1	5	6	5	5	15	19	4	9	70
Hounslow	1	0	5	4	6	5	15	22	5	3	66
Kensington & Chelsea	1	3	0	1	2	2	3	7	2	0	21
Westminster	1	2	4	6	1	7	4	5	2	5	37
North West London	13	10	27	34	30	34	102	116	29	27	422
%	3%	2%	6%	8%	7%	8%	24%	27%	7%	6%	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. Data represents completed reviews between 01/04/2019 and 31/03/2023. The actual date of death may be before these dates.

Table 5

Ealing and Hillingdon have had the most deaths over the four-year period, Brent and Hounslow having the same number of deaths. Hillingdon have had the highest number of sudden unexpected, unexplained deaths with nine over the four-year period. Brent have had the highest number of deliberately inflicted deaths including, abuse or neglect (5) and Kensington and Chelsea and Brent have had the highest number of suicide/deliberate self-inflicted harm (3).

In each borough the highest number of deaths are due to chromosomal, genetic and congenital anomalies and perinatal/neonatal events.

Learning from Neonatal Panels – 2022/2023

NWL CDR team hold six neonatal panels a year. They consist of specialists in the childbirth continuum and the neonatal period including midwives, obstetricians and neonatologists. To ensure we capture the perspective of parents, we also have a representative from a baby loss charity as well as public health professionals. The cases reviewed at the neonatal panel are those where there are no safeguarding concerns.

According to the NICE guidelines, the neonatal period is from birth to 28 days of age, however the NCMD defines the neonatal period as being up to 27 days of age. The NCMD is the source of our data and so this report will include babies who have died up to 27 days old. The CDR Guidance¹³ requires all babies who are born with signs of life to be reviewed, unless born after a medical termination of pregnancy. This may also include babies who were stillborn in the absence of a medical professional.

In 2022/2023, the cases of 45 neonatal deaths were reviewed, 38% of all child deaths in NWL. Three had JAR meetings due to either birth trauma or SUDI. The majority of babies were female. There was one baby documented as indeterminate sex due to gestation at birth (Figure 9).

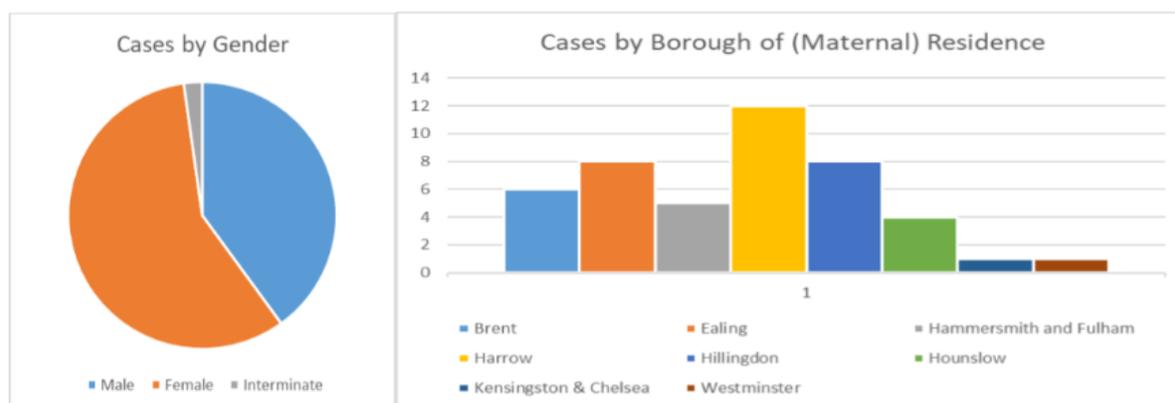


Figure 9

The largest number of babies who die in the neo natal period are black and Asian (Figure 10). The NWL CDR team have frequently flagged this to NCMD for further action. For example, it is known that Black African women are more likely to develop

¹³ Accessed at <https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england>

hypertension in pregnancy, leading to an increase of morbidity and mortality for both mother and baby. These women could be offered more frequent blood pressure monitoring during pregnancy to identify hypertensive complications at the earliest opportunity.

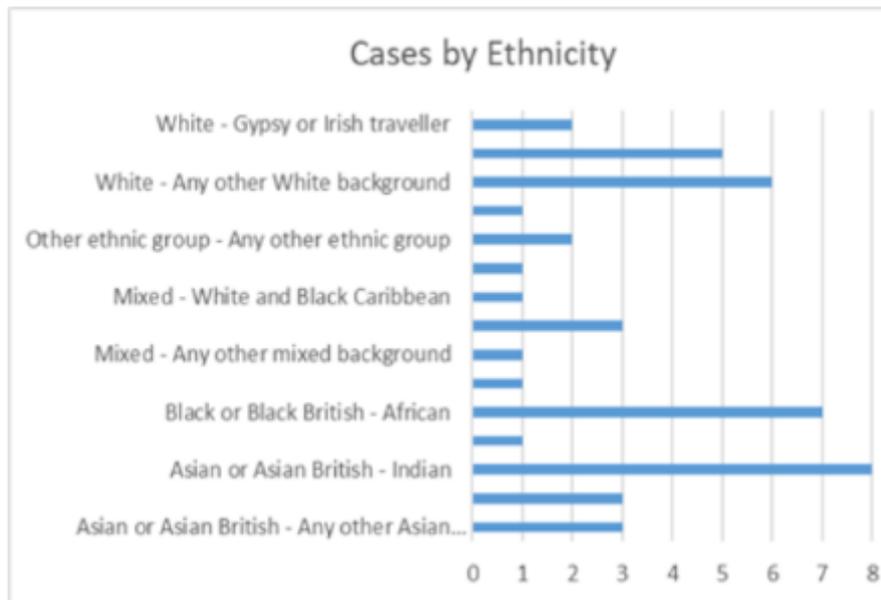


Figure 10

44% of the baby deaths were due to prematurity or as a result of the complications that arise from immaturity, whereas 8% died from infection. In the cases reviewed in 2022/2023, one neonate is recorded as having died as a result of Group B Streptococcus. The GBS3 trial¹⁴ may lead to changes to the prevalence of screening in the antenatal period.

We have noticed a trend where babies are being delivered earlier with signs of life. (Figure 11 and 12).

¹⁴ 71 hospitals in England and Wales are taking part in a randomised control trial; offering pregnant women GBS screening. This will report in 2024



Figure 11

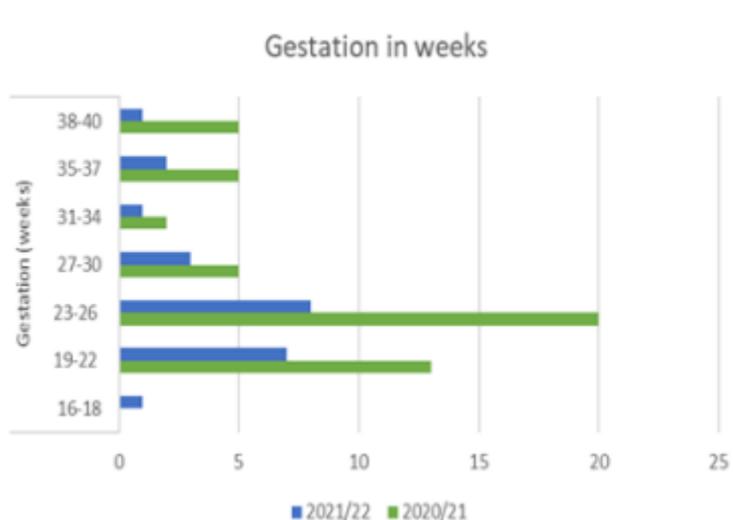


Figure 12

Some repeat themes arose during the Neonatal CDOPs. Interpreters were not used as often as they should have been and often family members were used. To address this, we have requested that all Trusts providing maternity care audit the use of interpreters.

We have also found there are a significant number of babies born to consanguineous parents. This data is currently collected by the maternity units, however greater understanding as to the degree of relationship is required. Work

with religious leaders and public health could provide communities with information about this risk.

The Neonatal CDOP has identified that a number of women whose babies have died, have undergone IVF abroad. However, data collection on this is poor. Next year we will work with Trusts to improve data collection about this.

The Neonatal CDOPs have gone from strength to strength in reviewing and understanding neonatal deaths, with invaluable insights from highly specialised experts.

Ethnicity and Deprivation

Child Mortality and Ethnicity

We want to understand better the link between ethnicity, deprivation and child mortality. Table 6 shows how over a four-year period the child mortality rate among black and Asian populations is higher in all eight NWL boroughs than it is for other ethnic groups.

	Number of child death notifications received where the death occurred between 01/04/2019 - 31/03/2023 (4 years)					Child death rate per 100,000 population of the same ethnic group per year				
	Asian or Asian British	Black or Black British	Mixed	White	Other	Asian or Asian British	Black or Black British	Mixed	White	Other
Brent	27	20	5	22	10	29.9	33.3	18.4	28.3	26.9
Ealing	43	14	6	22	10	43.5	33.6	16.9	20.7	25.3
Hammersmith and Fulham	5	8	5	12	4	46.6	36.8	26.3	18.5	36.4
Harrow	39	12	8	22	4	35.7	63.7	42.4	33.5	19.2
Hillingdon	36	8	5	24	4	34.1	27.6	18.9	23.1	19.3
Hounslow	30	13	3	17	5	30.3	49.7	11.5	18.1	25.1
Kensington & Chelsea	3	4	3	11	2	34.7	43.8	23.0	21.3	21.0
Westminster	9	7	1	12	20	42.2	53.0	5.8	24.9	87.9
North West London	192	86	36	142	59	35.3	39.1	19.6	23.2	32.5

Source: NCMD, ONS mid-year population estimates

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.
2. Population estimates for 2021 (census data) were used for all years. These data are available at <https://www.ons.gov.uk/datasets/create>

Table 6¹⁵

Table 7 compares child (age 1-17) mortality rates over four years by ethnicity within NWL ICB and contrasts them with rates in England over the same period. This shows that in NWL

¹⁵ When looking at Ethnicity and Deprivation we have used data from NCMD from notifications received as well as completed reviews over a period of 4 years (01/04/19-31/03/23). We have also used valuable data from the NWL ICB Analytics team.

Asian/ Asian British mortality rates are significantly below the English average and Black/ Black British mortality rates are slightly higher. The most significant discrepancy is among those children described as “other” This requires more research.

Table 12. Number and rate of deaths of 1-17 year olds between 01/04/2019-31/03/2023 (4 years), by ethnicity

ICB: NHS North West London Data source: NCMD, ONS Census (2021)

	Your ICB		England
	Deaths of 1 - 17 year olds	Rate per 100,000 population	Rate per 100,000 population
Asian or Asian British	66	12.8	16.4
Black or Black British	32	15.2	14.8
Mixed	14	8.2	9.0
White	46	8.0	10.0
Other	33	19.0	13.5

Table 7

	Number of child death notifications received where the death occurred between 01/04/2019 - 31/03/2023 (4 years)					Child death rate per 100,000 population of the same deprivation quintile per year				
	1 (most deprived)	2	3	4	5 (least deprived)	1 (most deprived)	2	3	4	5 (least deprived)
Brent	17	34	31	6	0	26.0	28.7	35.3	29.1	0.0
Ealing	17	44	22	12	5	27.3	37.4	28.8	25.4	28.0
Hammersmith and Fulham	11	11	13	2	1	40.1	31.0	39.3	7.3	25.3
Harrow	1	9	34	31	11	26.3	28.1	39.1	43.2	28.2
Hillingdon	6	33	25	9	9	43.8	29.6	36.8	20.1	18.9
Hounslow	4	39	27	3	0	15.6	35.6	28.0	9.5	0.0
Kensington & Chelsea	5	7	4	9	1	20.9	50.2	20.3	29.8	23.7
Westminster	8	11	6	9	13	31.5	30.4	27.7	36.4	91.5
North West London	69	188	162	81	40	27.9	32.7	33.0	27.2	31.0

Source: NCMD, ONS mid-year population estimates

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out
2. Population estimates for 2021 (census data) were used for all years. These data are available at <https://www.ons.gov.uk/datasets/create>

Table 8

Child Mortality and Deprivation

Table 8 provides some surprising data on the link between child mortality and deprivation. It appears to show that across NWL as a whole deprivation and child mortality do not

correlate in the same way as is seen at UK level¹⁶. The index of multiple deprivation provides us with a map of where communities collectively are deprived but we do not know if a family, who may live in a deprived community, is in fact deprived, or indeed if a family in a wealthy community is wealthy. This is an area to be explored further.

Table 9 shows how the different causes of death correlate with deprivation data and there is no clear link between any cause of death and deprivation, save for the fact that there are fewer deaths, of any type by number in the least deprived locations in NWL. This runs counter to the national picture and requires more analysis.

Number of child death notifications received where the death occurred between 01/04/2019 - 31/03/2023 (4 years)							
	1 (most deprived)	2	3	4	5 (least deprived)	Total	
Insufficient Info	2	0	1	1	1	5	1%
Infection	3	4	6	9	5	27	5%
Intrapartum or pre-natal event	2	5	12	4	1	24	4%
Malignancy	2	13	17	5	1	38	7%
Preterm	17	64	42	19	7	149	28%
SUDIC	8	23	11	13	2	57	11%
Suicide or Self Harm	0	5	3	2	0	10	2%
Trauma	6	10	12	4	3	35	6%
Underlying Health Condition	29	64	58	24	20	195	36%
Total	69	188	162	81	40	540	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths a

Table 9

The NWL Map of Child Death

Figure 13 shows where child deaths have occurred in NWL over the past four years, and the deprivation decile¹⁷ for each Lower Super Output Areas (LSOA) which the deaths occurred in. There are 1103 lower super output areas in NWL, each representing a community of about 2000 people. In the past four years there have been 515 child deaths in NWL. These are not spread evenly across the NWL footprint. Some small communities

¹⁶ See key findings from NCMD report on deprivation and child mortality – which headlines; ‘There is a clear association between risk of death and deprivation (except for malignancy)’; accessed at https://ncmd.info/wp-content/uploads/2021/05/NCMD-Deprivation-2019_20-Key-findings.pdf

¹⁷ The Index of multiple deprivation grades communities on a score of 1-10, where 1 means most deprived.

have experienced 8-10 deaths and others 1-2. By focusing on the few small areas that have a high number of deaths, we hope to improve child mortality in NWL in the future.

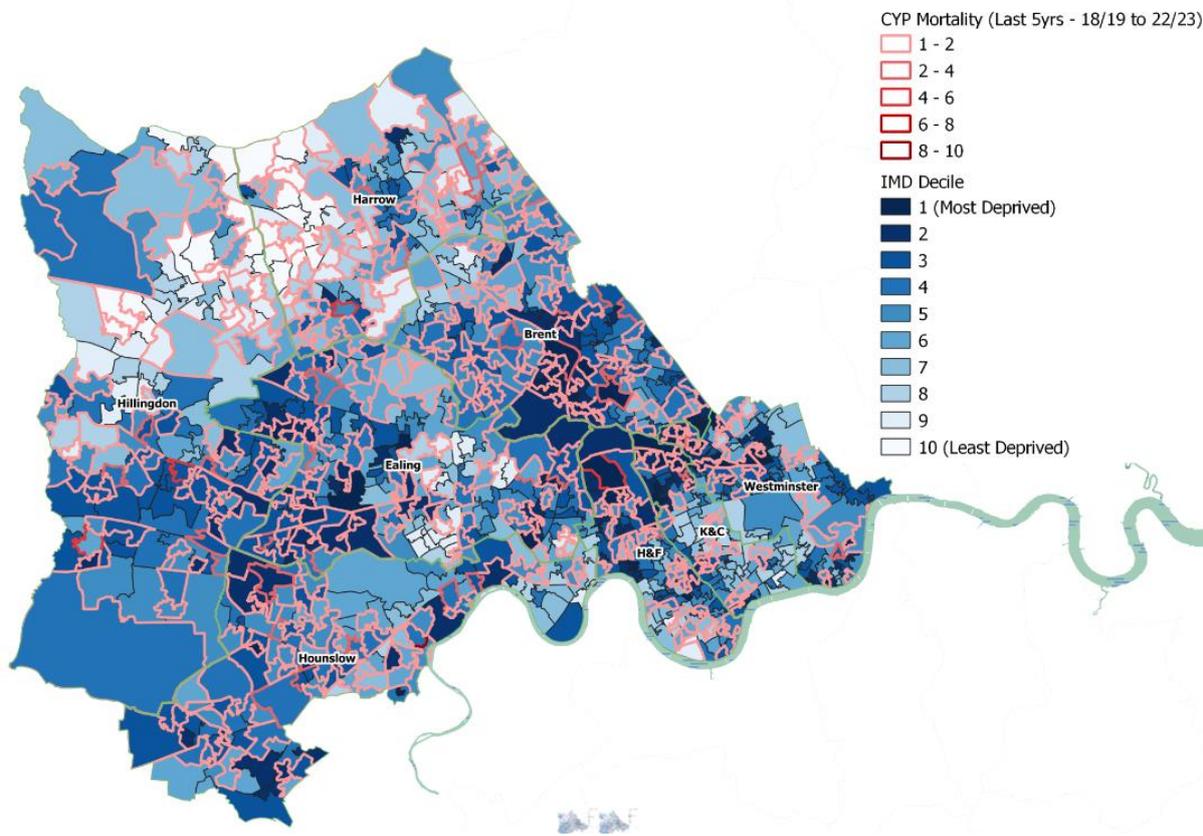


Figure 13

Deprivation by Borough

The tables below show the Lower Super Output Areas (LSOA) in each borough with the deprivation score and total number of deaths over the last 4 years 2018-2023. The CDR team would suggest the individual boroughs look in to these areas to see what health promotion/interventions may help in these areas to reduce infant mortality. Please see appendix 1 for the causes of death in each area which may help when considering what services are needed.

Brent

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01000498	Brent	4	4
E01000596	Brent	1	3
E01000497	Brent	4	3
E01000622	Brent	3	3
E01000640	Brent	3	3
E01000642	Brent	3	3
E01000643	Brent	1	3
E01000590	Brent	6	3
E01000587	Brent	6	3

Ealing

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01001366	Ealing	3	4
E01001238	Ealing	3	4
E01001336	Ealing	4	3
E01001337	Ealing	2	3
E01001356	Ealing	1	3
E01001294	Ealing	5	3
E01001369	Ealing	3	3
E01001322	Ealing	5	3
E01001195	Ealing	6	3

Hammersmith and Fulham

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01001876	Hammersmith and Fulham	1	7
E01001938	Hammersmith and Fulham	3	3
E01001852	Hammersmith and Fulham	5	3

Harrow

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01002238	Harrow	8	5
E01002213	Harrow	5	5
E01002126	Harrow	6	5
E01002181	Harrow	8	4
E01002203	Harrow	7	3
E01002118	Harrow	5	3
E01002117	Harrow	6	3
E01002234	Harrow	5	3

Hillingdon

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01002525	Hillingdon	6	5
E01002401	Hillingdon	3	5
E01002457	Hillingdon	3	4
E01002397	Hillingdon	3	4
E01002492	Hillingdon	5	3
E01033724	Hillingdon	8	3
E01002394	Hillingdon	5	3
E01002407	Hillingdon	3	3
E01002551	Hillingdon	4	3

Hounslow

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01002681	Hounslow	4	10
E01002650	Hounslow	4	5
E01002642	Hounslow	4	5
E01002568	Hounslow	3	4
E01002664	Hounslow	2	4
E01002684	Hounslow	4	3
E01002591	Hounslow	5	3
E01002622	Hounslow	5	3
E01002638	Hounslow	2	3
E01002626	Hounslow	5	3

Kensington & Chelsea

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01002830	Kensington and Chelsea	2	3

Westminster

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01004744	Westminster	3	3
E01004718	Westminster	2	3

Working with Bereaved Families Across NWL

From April 2023, the CDR Team will be acting as key workers for bereaved families, helping them navigate the many procedures that follow on from the death of a child and keeping them informed of developments. The CDR team will also during normal office hours be completing joint home visits. This entails working with police colleagues from the very beginning of an unexpected death. As well as helping families understand the coronial process the CDR team will signpost them to bereavement care.

Along with this work the Shooting Star Hospice have been able to set up a project where they will be supporting all bereaved families whose child has died for long term support. This is an exciting project that will be monitored and assessed over the coming year. The aim is to ensure all families have the appropriate support required following the death of their child and includes family therapy as well as supported visits. The pilot will start with all child deaths apart from trauma and suicide deaths. This joined up working will also help when we are collecting data in terms of the child's lived experience, ethnicity, family situation.

Work for 2023/24

- Re introduce key working from April 2023 including letters to all parents explaining the CDOP process.
- Increase training events including teaching alongside police/trusts/community teams as well as our own events.
- Serious Youth Violence - Knife crime event in June 2023 with Pan London CDOP.
- Suicide and SUDI event planned for Q3/4.

- Increase awareness and collaboration within the ICB including Children and Young People transformation service (CYP).
- Better working relationships with our partner agencies.
- NWL CDR Team more visible in Trusts and Community settings.
- Collaborative working with hospice to provide bereavement support for families across NWL – for both expected and unexpected deaths including neonatal deaths.
- Work with public health and data analysts to further explore child deaths across NWL.
- Work with NCMD to improve our data collection.

Appendix A

Brent

Sum of Patients			
LSOA name	LSOA - Residence	Diagnosis	Total
Brent	E01000498	#N/A	1
		Sudden infant death syndrome without mention of autopsy	1
		Arthrogryposis multiplex congenita	1
		Heart disease, unspecified	1
	E01000640	Disorders of tyrosine metabolism	1
		Other bacterial sepsis of newborn	1
		Intentional self-harm by unspecified means	1
	E01000497	Fetus and newborn affected by multiple pregnancy	2
		Metabolic disorder, unspecified	1
	E01000642	Other ill-defined and unspecified causes of mortality	1
		Unspecified pulmonary haemorrhage originating in the perinatal period	1
		Status asthmaticus	1
	E01000643	Other sphingolipidosis	1
		#N/A	1
		Sepsis, unspecified	1
	E01000587	Extreme immaturity	2
		Congenital diaphragmatic hernia	1
	E01000622	Extreme immaturity	1
		Malignant neoplasm: Cortex of adrenal gland	1
		Fetus and newborn affected by oligohydramnios	1

Ealing

Ealing	E01001238	Sudden infant death syndrome without mention of autopsy	1
		Pedestrian injured in collision with railway train or railway vehicle	1
		Exposure to unspecified electric current	1
		Other cardiomyopathies	1
	E01001366	Sudden infant death syndrome without mention of autopsy	1
		Pneumonia, unspecified	1
		Motorcycle rider injured in collision with fixed or stationary object	1
		Persistent fetal circulation	1
	E01001356	Fetus and newborn affected by other forms of placental separation and haemorrhage	1
		Surgical operation with transplant of whole organ	1
		Fetus and newborn affected by placental transfusion syndromes	1
	E01001336	Acidosis	1
		Immunodeficiency, unspecified	1
		Extreme immaturity	1
	E01001195	Fetus and newborn affected by chorioamnionitis	1
		Neonatal cerebral leukomalacia	1
		Fetus and newborn affected by maternal hypertensive disorders	1
	E01001294	Malignant neoplasm: Pineal gland	1
		Persistent fetal circulation	1
		Necrotizing enterocolitis of fetus and newborn	1
	E01001322	Asthma, unspecified	1
		#N/A	1

Hammersmith and Fulham

Hammersmith and Fulham	E01001876	Other bacterial sepsis of newborn	2
		Unspecified intraventricular (nontraumatic) haemorrhage of fetus and newborn	1
		Sudden infant death syndrome without mention of autopsy	1
		Edwards' syndrome, unspecified	1
		Cerebral palsy, unspecified	1
		Lymphoedema, not elsewhere classified	1
	E01001852	Fetus and newborn affected by multiple pregnancy	2
		Respiratory distress syndrome of newborn	1

Harrow

Harrow	E01002213	Extreme immaturity	2
		Other and unspecified convulsions	1
		Unspecified diabetes mellitus	1
	E01002238	Fall from, out of or through building or structure	1
		Extreme immaturity	3
		Malignant neoplasm: Adrenal gland, unspecified	1
	E01002126	Fetus and newborn affected by chorioamnionitis	1
		Other specified degenerative diseases of nervous system	1
		Other specified chronic obstructive pulmonary disease	1
	E01002234	Extreme immaturity	1
		Malignant neoplasm: Brain, unspecified	1
		Fetus and newborn affected by chorioamnionitis	1
		Other disorders of nervous system, not elsewhere classified	1
	E01002117	Fetus and newborn affected by oligohydramnios	1
		Bronchopneumonia, unspecified	1
		Encephalopathy, unspecified	1
	E01002181	Congenital malformation of lung, unspecified	1
		Extreme immaturity	2
	E01002203	Glycogen storage disease	1
		Down syndrome, unspecified	1
		Other specified cerebrovascular diseases	1
		Hypoxic ischaemic encephalopathy of newborn	1

Hillingdon

Hillingdon	E01002525	Other secondary pulmonary hypertension	1
		Extreme immaturity	1
	E01002457	#N/A	1
		Malignant neoplasm: Spinal cord	1
		Other bacterial sepsis of newborn	1
	E01002397	Respiratory distress syndrome of newborn	2
		Slow fetal growth, unspecified	1
	E01002401	Necrotizing enterocolitis of fetus and newborn	1
		Malignant neoplasm: Adrenal gland, unspecified	2
		Pneumonia, unspecified	1
	E01002492	Bacterial sepsis of newborn, unspecified	1
		Toxic shock syndrome	1
		Fetus and newborn affected by other forms of placental separation and haemorrhage	1
		Fetus and newborn affected by multiple pregnancy	1
	E01002551	Fetus and newborn affected by oligohydramnios	1
		Fetus and newborn affected by prolapsed cord	1
		Muscular dystrophy	1
	E01002394	Malignant neoplasm: Connective and soft tissue of pelvis	1
		Fetus and newborn affected by multiple pregnancy	1
	E01002407	Hypoplasia and dysplasia of lung	1
		Fetus and newborn affected by placental transfusion syndromes	1
Malformation of coronary vessels		1	
Other medical procedures		1	
E01002407	Metabolic disorder, unspecified	1	
	Congenital malformation syndromes predominantly associated with short stature	1	
	Other disorders of branched-chain amino-acid metabolism	1	
		Necrotizing enterocolitis of fetus and newborn	1

Hounslow

Hounslow	E01002681	Extreme immaturity	3
		Termination of pregnancy, affecting fetus and newborn	2
		Other specified congenital malformations of brain	1
		Other preterm infants	1
		Edwards' syndrome, unspecified	1
		Down syndrome, unspecified	1
		Fetus and newborn affected by premature rupture of membranes	1
	E01002650	Fetus and newborn affected by chorioamnionitis	2
		Congenital diaphragmatic hernia	1
		Other accidental hanging and strangulation	1
		Fetus and newborn affected by multiple pregnancy	1
	E01002568	Metabolic disorder, unspecified	1
		Congenital malformation of heart, unspecified	1
		Assault by hanging, strangulation and suffocation	1
		Bronchopneumonia, unspecified	1
	E01002642	Intentional self-harm by hanging, strangulation and suffocation	1
		Fall from, out of or through building or structure	1
		Assault by drugs, medicaments and biological substances	1
		Extreme immaturity	1
	E01002684	Coarctation of aorta	1
		Pneumococcal meningitis	1
		Malignant neoplasm: Adrenal gland, unspecified	1
	E01002622	Congenital diaphragmatic hernia	1
		Unspecified intraventricular (nontraumatic) haemorrhage of fetus and newborn	1
		Extreme immaturity	1
	E01002638	Birth asphyxia, unspecified	1
		Wegener granulomatosis	1
		Ebstein anomaly	1
	E01002664	Cerebral palsy, unspecified	1
		Fetus and newborn affected by chorioamnionitis	1
		Extreme immaturity	1

Kensington and Chelsea/Westminster

Kensington and Chelsea	E01002830	Cardiomyopathy, unspecified	1
		#N/A	1
		Pneumonia, unspecified	1
Westminster	E01004744	Fetus and newborn affected by chorioamnionitis	1
		Unspecified drowning and submersion	1
		Hypoxic ischaemic encephalopathy of newborn	1
	E01004718	Fetus and newborn affected by maternal infectious and parasitic diseases	2
		Fetus and newborn affected by placenta praevia	1

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