Child Death Overview Process
Leicester, Leicestershire & Rutland

7 Minute Briefing

1. Background & why it matters

When a child dies, it is important to understand why they died, and whether there are any lessons to learn. LLR Child Death Overview Panel review all deaths of children (under 18yrs) usually resident in Leicester, Leicestershire & Rutland.

Aim: to identify factors contributing to child deaths that are relevant to the welfare of children in the area or public health & safety, and to consider whether any action should be taken to prevent future child deaths.

2. Panel Work 2020/21

1. Suicide in Children & Young People
Themed panel & report undertaken.
2. Infant Mortality
Consanguinity & risk, Safer Sleeping and work with Healthy Babies Strategy Group.
3. Learning Disability Mortality Reviews
Clustering of cases for themed learning, Local Area Contacts attending Panel.
4. Covid-19 Impact
Virtual multiagency meetings, data for NCMD real-time surveillance, ongoing monitoring.
5. Other Key Learning – 7 min briefings
Community defibrillators, epilepsy safety.

3. Case numbers 2020/21

Notifications

- 57 Notifications received for children usually resident in LLR.
- 33% met criteria for Joint Agency Response.

Completed Reviews

- 5 CDOP panels held.
- 64 case reviews completed.

4. Summary Statistics

Neonatal Mortality Rates

- Leicester City remains significantly higher than England (since 2014/16).

Infant Mortality Rates

- Leicester City remains significantly higher than England (since 2014/16).

Child Mortality Rates

- Leicester City remains higher than England but not significantly so.

5. Key Findings 2015/16 to 2020/21

- Reviews completed within 12 months of death: 57%
- Cases with modifiable factors:
  - 37% Leicester City
  - 34% Leicestershire & Rutland
- Cases occurring within first year of life: 44%
- Top 3 categories of deaths:
  - 34% Perinatal/Neonatal event
  - 26% Chromosomal/genetic/congenital anomaly
  - 9% Trauma and other external factors
- Top 3 categories with modifiable factors:
  - Suicide/self-harm - 75% of cases
  - Sudden unexpected, unexplained death - 73% of cases
  - Deliberately inflicted injury, abuse or neglect - 67% of cases
- Sudden unexpected, unexplained deaths:
  - 6% of all cases. For SUDIs:
  - Unsafe sleeping practices in 67%
  - Parental smoking in 60%

6. Recommendations

1. Continue workstreams (Suicide, Safer Sleeping, Learning Disability reviews).
2. Continue delivering multiagency training.
3. Work with key stakeholders around impact of Adverse Childhood Experiences.
4. Continue to review direct & indirect impact of Covid-19.
5. Continue to work with Healthy Babies Strategy Group to enhance safer sleep & ICON messaging.

7. Additional Resources

Full Annual Report:
LLR CDOP – Leics & Rutland SCP website
LLR CDOP – Leicester City SCP website

National Child Mortality Database

Child Death Review: Statutory & Operational Guidance (England) 2018