Reducing child mortality in London

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Background

• Although there have been significant reductions in child deaths in the past three decades in England, too many children are still dying unnecessarily

• If the UK had the same childhood mortality for children aged 0-14 years as Sweden there would be five fewer child deaths every day and about 1,951 fewer child deaths every year

• In 2014, almost one in three child deaths in England and Wales was avoidable

• In 2015, about one in four child death reviews in England was identified by CDOPs as having a modifiable risk factor

• 675 children and young people (CYP) aged 0-19 years died in London in 2014
Key child mortality statistics for CYP in London

675 deaths registered in 2014

- Under 1 years: 53% (393 deaths, 47%)
- 1-4 years: 54% (87 deaths, 46%)
- 5-9 years: 51% (53 deaths, 49%)
- 10-14 years: 55% (38 deaths, 45%)
- 15-19 years: 62% (104 deaths, 38%)

Source: ONS
Key child mortality statistics for CYP in London (2011-13)

**Infant mortality**

- 3.8 per 1,000 live births of infants under one year of age in London compared with the England average of 4.0.

**Child mortality**

- 12.2 per 100,000 people aged one to 17 years in London compared with the England average of 11.9.

**Children killed or seriously injured in road traffic accidents**

- 13.7 per 100,000 people from 0-15 years in London compared with the England average of 19.1.

Source: www.fingertips.phe.org.uk
Causes of deaths (%) of CYP in London (2014)

- **Neonatal (<28 days)**: 68.4%
- **Congenital**: 8.7%
- **Perinatal**: 7.6%
- **Unexplained**: 4.3%
- **Other**: 11.0%
- **< 1 year**:
  - Cancer: 16.1%
  - Nervous system: 14.9%
  - External e.g. road traffic injuries, unintentional injuries, drowning, assault, suicide: 10.3%
  - Endocrine: 9.2%
  - Cardiovascular: 8.0%
  - Respiratory: 5.7%
  - Other: 3.8%
  - Unexplained: 2.6%
  - Congenital: 1.3%
- **1-4 years**:
  - Cancer: 15.1%
  - Nervous system: 13.2%
  - External e.g. road traffic injuries, unintentional injuries, drowning, assault, suicide: 13.2%
  - Endocrine: 7.5%
  - Cardiovascular: 7.5%
  - Respiratory: 5.3%
  - Other: 3.8%
  - Unexplained: 2.6%
  - Congenital: 1.3%
- **5-9 years**:
  - Cancer: 18.4%
  - Nervous system: 18.4%
  - External e.g. road traffic injuries, unintentional injuries, drowning, assault, suicide: 18.4%
  - Endocrine: 7.9%
  - Cardiovascular: 7.9%
  - Respiratory: 5.3%
  - Other: 3.8%
  - Unexplained: 2.6%
  - Congenital: 1.3%
- **10-14 years**:
  - Cancer: 23.7%
  - Nervous system: 23.7%
  - External e.g. road traffic injuries, unintentional injuries, drowning, assault, suicide: 23.7%
  - Endocrine: 6.7%
  - Cardiovascular: 6.7%
  - Respiratory: 6.7%
  - Other: 3.8%
  - Unexplained: 2.6%
  - Congenital: 1.3%
- **15-19 years**:
  - Cancer: 26.9%
  - Nervous system: 12.5%
  - External e.g. road traffic injuries, unintentional injuries, drowning, assault, suicide: 7.7%
  - Endocrine: 6.7%
  - Cardiovascular: 6.7%
  - Respiratory: 4.8%
  - Other: 3.8%
  - Unexplained: 2.6%
  - Congenital: 1.3%

Number of deaths:
- < 1 year: 393
- 1-4 years: 87
- 5-9 years: 53
- 10-14 years: 38
- 15-19 years: 104

Source: ONS
Avoidable child deaths in England and Wales in 2014

In 2014 almost 1 in 3 child deaths in England and Wales was avoidable*

72 years of potential life is lost on average for each person aged 0 to 19 who died from avoidable* causes

Top six causes of avoidable* deaths in children and young people (aged 0 to 19 years)

- Accidental injuries 13.5%
- Complications of perinatal period 13.3%
- Suicide and self-inflicted injuries 12.6%
- Transport accidents 12.2%
- Infectious diseases 11.2%
- Congenital malformations of the circulatory system 9.9%

The leading causes of avoidable deaths in children and young people were non-chronic conditions

*Avoidable deaths are all those defined as preventable (could be avoided by public health interventions), amenable (could be avoided through good quality healthcare) or both, where each death is counted only once

ONS (2016) Avoidable mortality in England and Wales 2014
The following chart shows the number of reviews for each category of death together with the proportion of these deaths with modifiable risk factors.

Medical causes accounted for 82% of all deaths, 16% of these deaths had modifiable risk factors compared to non-medical causes, which accounted for 18% of all deaths but 57% of these deaths had modifiable risk factors.
Actions to reduce child death - overview

Risk factors for child deaths include:

**Factors intrinsic to the child**
- Prematurity
- Chronic illness

**Factors around parental care**
- Basic care of child
- Responding to health needs
- Parental smoking

**Environmental factors**
- Parental age
- Social class
- Housing

**Service need and provision**
- Unmet medical needs
- Inadequate health care
- Lack of support services

Actions to reduce child deaths

**Reduce** health inequalities

**Provide safe environments** for children and young people inside and outside their homes

**Optimise maternal physical and mental health** before, during and after pregnancy

**Increase uptake** of child immunisations

**Better training** of healthcare staff to improve the recognition of serious illnesses

**Communication** with families to spot the signs of illness or failing health

Useful resources

- Fraser J, Sidebotham P, Covington T et al The Lancet 2014:384;894-902 Learning from child death review in the USA, England, Australia and New Zealand
- Sidebotham P, Fraser J, Covington T et al The Lancet 2014: 384;915-927 Understanding why children die in high income countries
- Local authority child health profiles: atlas.chimat.org.uk/IAS/dataviews/childhealthprofile

References

- Department for Children, Schools and Families (2007) Patterns and causes of child deaths: Information sheet
- Department of Health (2007) Review of the Health Inequalities PSA Target
Actions to reduce child death - reducing infant mortality

Risk factors for infant mortality include:

- In 2014, the infant mortality rate (IMR) was **28x higher** for **low birth weight** babies than for babies of normal birth weight
- The IMR for babies born to **teenage mothers** is **44% higher** than mothers aged 20-39
- In 2014, the IMR was **2.5x higher** in babies in families in the **routine and manual** group compared with those in higher managerial and professional groups
- In 2014, the IMR of babies of mothers born in **Pakistan** was **2.1x higher** than babies of mothers born inside the UK

Actions to reduce infant mortality

- **Co-ordination and leadership**
  Vital for an effective cross-agency approach
- **Commissioning**
  Integrated commissioning to ensure a whole systems approach
- **Communication**
  Understand the preferences and needs of the local population
- **Care pathway development**
  Vital to support sustained improvements in service delivery and quality

Useful resources

- National Institute for Health and Care Excellence (2014) clinical guideline 37 Postnatal care
- National Institute for Health and Care Excellence (2014) NICE guideline PH26 Quitting smoking in pregnancy and following childbirth

References

Actions to reduce child death - improving communication

Good communication with families and between professionals is an **essential** component of high-quality care.

Factors contributing to poor communication include:

**Individual ability**
Human factors that influence the effectiveness of communication include skills and ability, attitude, stress, distractions.

**Team behaviours**
Role confusion and professional conflict.

**Organisational**
- Working arrangements creating barriers to effective communication
- A lack of staff and inadequate resources

**Actions to improve communication**

**Families**
Clear information given to families in a manner they can understand.

A clearly documented information 'passport' for children with long-term conditions.

**Organisational**
Make effective communication an organisational priority.

**Tools**
These include:
- The 'SBAR' (Situation, Background, Assessment, Recommendation) tool
- Clinical handover routines
- Safety briefings

**Useful resources**
- www.institute.nhs.uk/safer_care/safer_care/Situation_Background_Assessment_Recommendation.html

**References**
- Child Health Reviews UK (2013) Co-ordinating Epilepsy Care: a UK-wide review of healthcare in cases of mortality and prolonged seizures in children and young people with epilepsies
- National Children’s Bureau (2008): a shared responsibility safeguarding arrangements between hospitals and children’s social services
- Lim I (2014): effective communication among healthcare workers to improve patient safety and quality
- RCOG (2010): improving patient handover
### Actions to reduce child death - Improving quality

All CYP are entitled to receive **appropriate** healthcare wherever they access it. In a national survey of CYP and their families:

- Of 8-15 year olds felt that staff did everything they could to help control their pain: **80%**
- Of 12-15 year olds were not fully involved in decisions about their care: **43%**
- Of parents and carers felt that staff were not always aware of their child’s medical history before treating them: **41%**
- Of parents and carers did **not** feel that staff ‘definitely’ knew how to care for their child’s individual or special needs: **29%**

### The six domains to improve quality

1. **Safe care** through training, continued education, strong leadership and sharing good, safe practice
2. **Effective care** through evidence-based practice
3. **Person-centred care** to ensure the person and their family are involved in decisions about their care
4. **Timely care** delivered at the right time, by the right person, with minimal delays
5. **Efficient care** to allow redistribution of resources to get greater value of the resources committed to delivering care
6. **Equitable care** to maintain the same quality of care regardless of the varying personal characteristics of patients

### Useful resources

- [www.improvement.nhs.uk](http://www.improvement.nhs.uk)

### References

- Care Quality Commission (2015) Children and young people’s inpatient and day case survey 2014
- RCPCH (2015) Quality improvement in child health: strategic framework
Actions to reduce child death - reducing SUDI

Every 11 days in London a baby dies from SUDI* risk factors include:

- **Low birth weight**: 5x higher risk
- **Smoking**: 5x higher risk
- **Deprivation**: 3.5x higher risk
- **Bed sharing**: 2.7x higher risk
- **Mothers <20 years**: 2.5x higher risk

**Actions to reduce SUDI**

- Ensure safer sleeping practice for babies
- Reduce parental smoking
- Encourage and support mothers to breastfeed
- Change knowledge and behaviour through clear communication of risk factors

**Useful resources**

- [www.bestbeginnings.org.uk/baby buddy](http://www.bestbeginnings.org.uk/baby buddy)
- [www.lullabytrust.org.uk](http://www.lullabytrust.org.uk)
- National Institute for Health and Care Excellence (2014) NICE guideline PH26 Quitting smoking in pregnancy and following childbirth

**References**


*SUDI: Sudden Unexpected Death in Infancy*
# Actions to reduce child death - reducing suicides

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<th>Actions to reduce suicide</th>
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<td>Reduce access to the means of suicide</td>
<td>• Family factors eg mental illness or history of suicide</td>
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<tr>
<td>Support the media in delivering sensitive approaches to suicide</td>
<td>• Physical illness and long-term conditions</td>
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<td>Support research, data collection and monitoring</td>
<td><strong>Psychological</strong></td>
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<td>Provide better information and support to those bereaved or affected by suicide</td>
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<td>• Mental ill health, self-harm and suicidal ideas</td>
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<td><strong>Environmental</strong></td>
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<td>• Abuse and neglect</td>
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<td>• Suicide-related internet use</td>
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<td>• Academic pressures related to exams</td>
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## Useful resources

- [www.supportaftersuicide.org.uk/](http://www.supportaftersuicide.org.uk/)
- [www.beatbullying.org/dox/resources/resources.html](http://www.beatbullying.org/dox/resources/resources.html)
- [www.stonewall.org.uk/at_school/education_for_all/default.asp](http://www.stonewall.org.uk/at_school/education_for_all/default.asp)

## References

- Butterworth S, Suicide and self-harm in young people: risk factors and interventions
- National Confidential Inquiry into Suicides and Homicides by People with Mental Illness (2016) Suicide by children and young people in England

149 children aged 10-19 years in England committed suicide in 2014, almost three children every week.
## Actions to reduce child death - home safety

Unintentional injuries in and around the home are a **leading** cause of **preventable** death and a **major** cause of ill health and disability.

- **Every year over 62 children** under 14 die as a result of an accident in the home.
- **Over 76,000 children** under the age of 14 are admitted for treatment.
- **Each year about two million children** under the age of 15 are taken to A&E after being injured in or around the home.
- **Risk factors for unintentional injuries** include age < 5 years, boys and deprivation.
- **£15.5-87 million** Estimated annual hospital costs of severe, unintentional injuries to children.

### Actions to improve home safety

#### Environment
Improvement in planning and design results in safer homes and leisure areas.

#### Education
Increasing the awareness of the risk of accidents in a variety of settings and providing information on ways of minimising these risks.

#### Empowerment
Accident prevention initiatives, which have been influenced by the community, are more likely to reflect local need and therefore encourage greater commitment.

#### Enforcement
Child safety legislation. Local councils assess hazards to privately rented homes.

### Useful resources
- [www.chimat.org.uk/earlyyears/injuries](http://www.chimat.org.uk/earlyyears/injuries)
- [www.capt.org.uk/](http://www.capt.org.uk/)
- [www.rospa.com/](http://www.rospa.com/)

### References
- Department of Health (2012) Our children deserve better: prevention pays
Actions to reduce child death - reducing road traffic injuries (RTIs)

7 children are killed or seriously injured on Britain’s roads every day

15 people are seriously injured for every 1 person aged < 25 years who dies in a RTI

16 deaths or serious injuries to children under 16 years each week occur between 8am to 9am and 3pm to 7pm

547 million pounds is the estimated annual cost of child road deaths and injuries

936 fewer serious or fatal injuries to child pedestrians and child cyclists annually would occur if all children had a risk of injury as low as children in the least deprived areas

Actions to reduce RTIs

Improve safety for children travelling to and from school
Including developing school travel plans, education and engineering measures to physically change the road environment

Introduce 20mph limits in priority areas as part of a safe system approach to road safety
Supported by providing publicity, information and community engagement

Co-ordinate action to prevent traffic injury
Within local authorities to encourage active travel and create liveable streets

Useful resources

- [www.capt.org.uk/resources/road-safety](http://www.capt.org.uk/resources/road-safety)

References

- [www.makingthelink.net/tools/costs-child-accidents/costs-road-accidents](http://www.makingthelink.net/tools/costs-child-accidents/costs-road-accidents)
- PHE (2014) Reducing unintentional injuries on the roads among children and young people under 25 years
### About one in five

Children aged 11-17 years have been exposed to domestic abuse.

### About 130,000

Children live in households with **high-risk** domestic abuse.

### 62% of children

Exposed to domestic abuse are directly harmed.

### 80% of children

Exposed to domestic abuse are known to at least one public agency.

### Children suffer multiple

**physical** and **mental health** consequences because of living with domestic violence.

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### Actions to reduce domestic abuse

- Educating and challenging young people about healthy relationships, abuse and consent
- Earlier identification and intervention to prevent abuse
- Improving access to parenting programmes which specifically address domestic abuse
- Moving to an integrated model of family support
- Strengthening the role of health services and providing effective help through specialist children’s services
- Changing perpetrators’ behaviours to prevent abuse and reduce offending
- Building the evidence base in what works in early intervention and tackling perpetrators

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### Useful resources

- [www.caada.org.uk](http://www.caada.org.uk)
- [www.nspcc.org.uk](http://www.nspcc.org.uk)
- [www.ncdv.org.uk](http://www.ncdv.org.uk)

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### References

- CAADA (2014) In plain sight: effective help for children exposed to domestic abuse
- Radford L et al (2011): child abuse and neglect in the UK today
- Safe Lives (2015) Getting it right the first time
Bereavement support

1 in 20 children in England has been bereaved of a parent or sibling by the time they are 16 years old. In 2015, that was about 33,210 children aged five to 16 years in London.

Children from disadvantaged backgrounds are more likely to be bereaved of a parent or sibling.

Childhood bereavement may have both short and long-term impacts on children’s wellbeing and educational achievement.

Bereaved children are 1.5x more likely than other children to be diagnosed with ‘any’ mental disorder.

The death of a parent is associated with lower employment rates at the age 30.

Actions to support bereaved children

Support for families
Providing information about how children grieve, what can help and what services there are.

Support in schools
Developing a co-ordinated school approach such as staff training, school counselling services and peer support.

Specialist support
Providing outreach and specialist support for those who are vulnerable or traumatised.

Useful resources

- www.childhoodbereavementnetwork.org.uk
- www.cruse.org.uk
- www.griefencounter.org.uk
- www.hopeagain.org.uk
- www.tcf.org.uk
- www.winstonswish.org.uk
- www.nhs.uk/Livewell/bereavement/Pages/children-bereavement.aspx

References

- Aynsley-Green A, Penny A, Richardson S. BMJ Supportive and Palliative Care (2011) Bereavement in childhood: risks, consequences and responses
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