Healthier Futures
Black Country Integrated Care System

Black Country
Child Death Overview Panel

Black Country Child Death Overview Panel

2023/2024 Annual Report

Signed off at Mortality Review Group – 5/6/2025

Healthier place Healthier people Healthier futures

Contents

Foreword

Child deaths are among the most tragic events any family, community, or society can face. As the Independent Chair of the Black Country Child Death Overview Panel (BCCDOP), I am deeply aware of the profound impact each loss has on those left behind. This annual report for 2023/2024 reflects our collective commitment to understanding these tragedies, learning from them, and taking meaningful action to prevent future deaths wherever possible.

The BCCDOP, supported by a dedicated multi-agency partnership, continues to uphold its statutory duty to review child deaths with care, compassion, and rigor. This report highlights key data, trends, and learning from the past year, alongside recommendations aimed at improving outcomes for children and families across the Black Country.

I extend my heartfelt condolences to all families who have experienced the loss of a child, and a big thank you to all the professionals who engage in supporting the families and undertaking their respective roles within these traumatic events.

Mike Leaf

Independent CDOP Chair

Executive Summary

Child deaths are tragic, and thankfully uncommon. Comprehensive reviews of child deaths undertaken by the Child Death Overview Panel (CDOP) serve as an opportunity to gain experience from these devastating events.

It is important to recognise the Child Death Review is a statutory process and this Black Country CDOP Annual Report for 2023/2024 hopefully demonstrates how local services and multi-agency partnerships have contributed to the review of deaths, in an open and transparent way, and recognise the need to take the learning forward.

This report is divided into five core areas:

1. Child Death Notifications during 2023/2024 - 136 deaths were notified.
2. An overview of Child Deaths notified in the Black Country with data from 2019 to 2024.
3. Child Death Reviews during 2023/2024 - 127 deaths were reviewed.
4. Learning arising from the completed reviews.
5. Priorities and recommendations.

The recommendations to Partners across the Black Country from this CDOP Annual Report for 2023/2024 include:

- To note the data shared within this report.
- To note the disparity in the number of deaths between ethnic groups and share initiatives and interventions to address this.
- To improve the allocation of a key worker for every family who experiences a child death.
- To share with CDOP where actions/changes to practice are as a result of learning shared in this report.
- To share with CDOP examples of good practice in individual areas/services already happening that can be reflected in other areas/services.
- To highlight initiatives developed as a result of this learning to the Child Death Overview Panel that reduce the prevalence of modifiable factors including;
    - Safer sleeping
    - Smoking
    - High Maternal BMI
    - Poverty and Deprivation

Introduction

This is the fifth Annual Report for the Black Country Child Death Overview Panel (BCCDOP). This report will explore the statistical and qualitative conclusions from child death data across the Black Country which includes, Dudley, Sandwell, Walsall, and Wolverhampton from 1st April 2023 to 31st March 2024.

The Child Death Overview Panel (CDOP) publishes this Annual Report to provide an overview of local patterns and trends related to child deaths and to share recommendations as a result of the Review process for local Partners to action.

Every child death is a devastating loss that profoundly affects the family involved. The teams involved with the Child Death Review (CDR) process would like to share their thoughts and sympathy with the family and friends of all those children who died during 2023/2024.

Black Country Child Death Review Strategic Partnership

The Strategic Partnership meets four times a year to ensure the Statutory function of the Child Death Overview Panel (CDOP), and the whole local Child Death Review process is effective and highlights any concerns for escalation.

The Strategic Partnership meeting is Chaired by an Independent Chair and supported by the Child Death Overview Panel Coordinator. The Strategic Partnership are responsible for setting the budget, structure, and making recommendations to specific services in response to the data, good practice, learning and modifiable factors that are shared from the Child Death Overview Panel.

Child Death Review Process

The Child Death Review (CDR) process is an analysis of deaths of children who die in England from birth up to 18 years of age. There is a statutory requirement for the statutory partners to plan to conduct child death reviews. In the Black Country, the Statutory Partners refer to;

City of Wolverhampton Council

Dudley Metropolitan Borough Council

Sandwell Metropolitan Council

Walsall Metropolitan Borough Council

Black Country Integrated Care Board (BCICB)

The aim of the Child Death Review (CDR) is to ensure the information is systematically captured for every death to enable learning and prevent future deaths.

The purpose of a CDR is to identify any matters of concern affecting the safety and welfare of children relating to the death(s) and to consider any action or recommendations that can be

taken or developed based on a death, or a pattern of deaths to identify trends that require a multidisciplinary response.

The process when a child dies can be found in Appendix one. The roles within the Black Country Child Death Review Team and Child Death Overview Panel can be found in Appendix two.

National Child Mortality Database

The National Child Mortality Database (NCMD) records comprehensive data standardised across the whole country (England), on the circumstances of children's deaths. The purpose of collating information nationally is to ensure that deaths are learned from, that learning is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die.

The NCMD programme was established and is delivered by the University of Bristol, in collaboration with the University of Oxford's National Perinatal Epidemiology Unit (NPEU), University College London (UCL Partners) and the software company QES. It also includes representation from bereaved families through the NCMD charity partners: Child Bereavement UK, The Lullaby Trust, and Sands. The programme is funded by NHS England and commissioned by Healthcare Quality Improvement Partnership (HQIP).

eCDOP

From 1st April 2019, it has been mandatory for Child Death Review Partners to input data on all child deaths into the NCMD. In the Black Country, the programme used to support the Child Death Review process is eCDOP which is a programme developed by QES (a software company). QES provide eCDOP to 99% of the areas involved in the Child Death Review process in England.

eCDOP supports the CDR process by allowing agencies to share information following the death of a child, to ensure appropriate action and processes are followed then reviewed and cases are then referred to CDOP for final oversight and scrutiny of every child death. eCDOP allows notifications of a child death in real-time, without sharing confidential information over email, to ensure no delay in the transfer of information and triggering of the process required on receipt of a child death notification.

Data presented in this report

This report will not highlight any one specific death and following guidance from the West Midlands Child Death Review Network (WMCDRN) where data is less than 5, this has been removed to ensure no information is identifiable.

Data presented in this report has been collated from eCDOP and reports shared by NCMD to compare Black Country data to neighbouring areas in the Region and England data. In regard to any population data presented in this report, this will be rounded up/down to the nearest 5 or presented as a percentage.

Data: Child Death Notifications

Child Deaths notified in the Black Country in 2023/2024

From 1st April 2023 to 31st March 2024 there were 136 deaths notified across the Black Country for children under the age of 18 years of age.

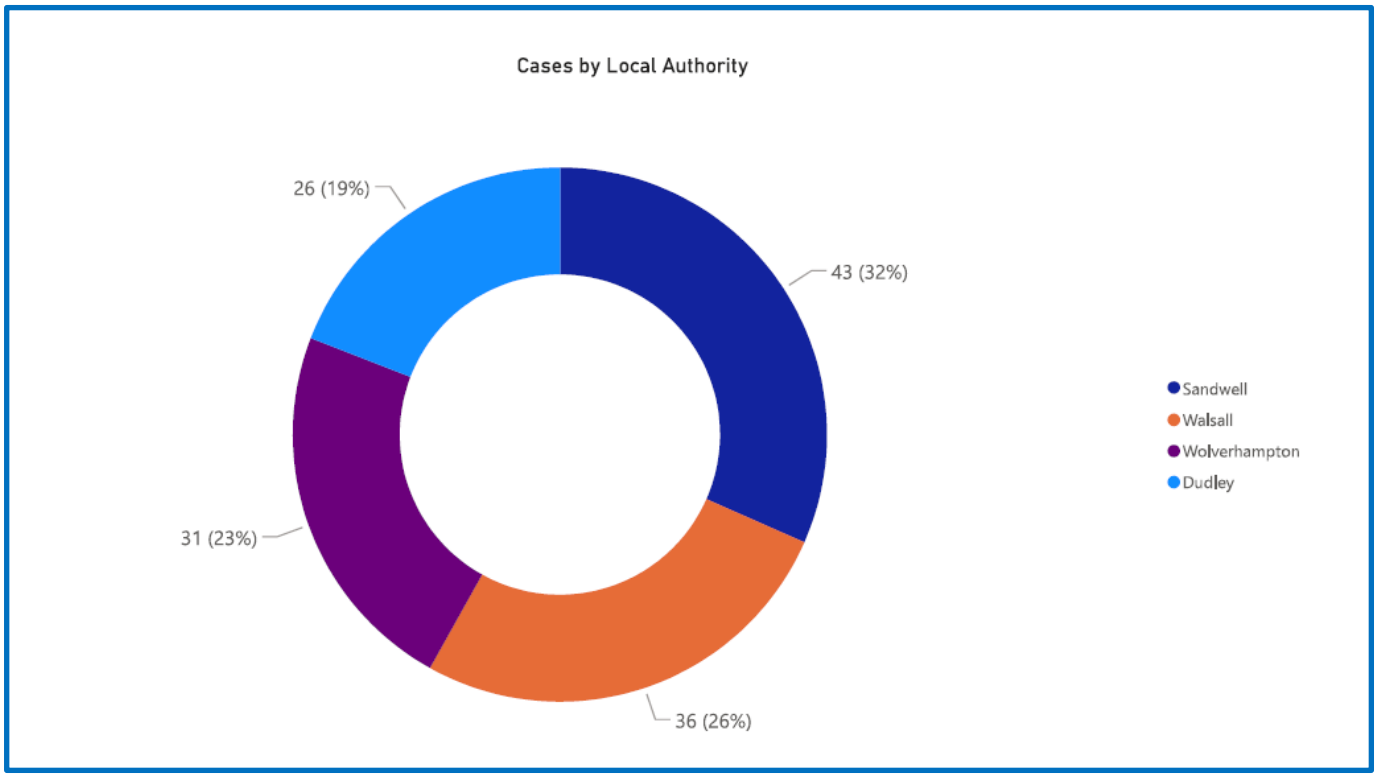
The number of child death notifications had increased by 6% since the previous year 2022/2023 in the Black Country (128 child death notifications in 2022/2023).

For the same time period, 1st April 2023 to 31st March 2024, in the West Midlands there were 539 child death notifications (25% from the Black Country), and in England there were there were 3,577 child death notification (3.8% from the Black Country).

Child Death notifications by Area in 2023/2024

From 1st April 2023 to 31st March 2024, the proportion of the 136 child death notifications across the Black Country is identified in Figure 1 below.

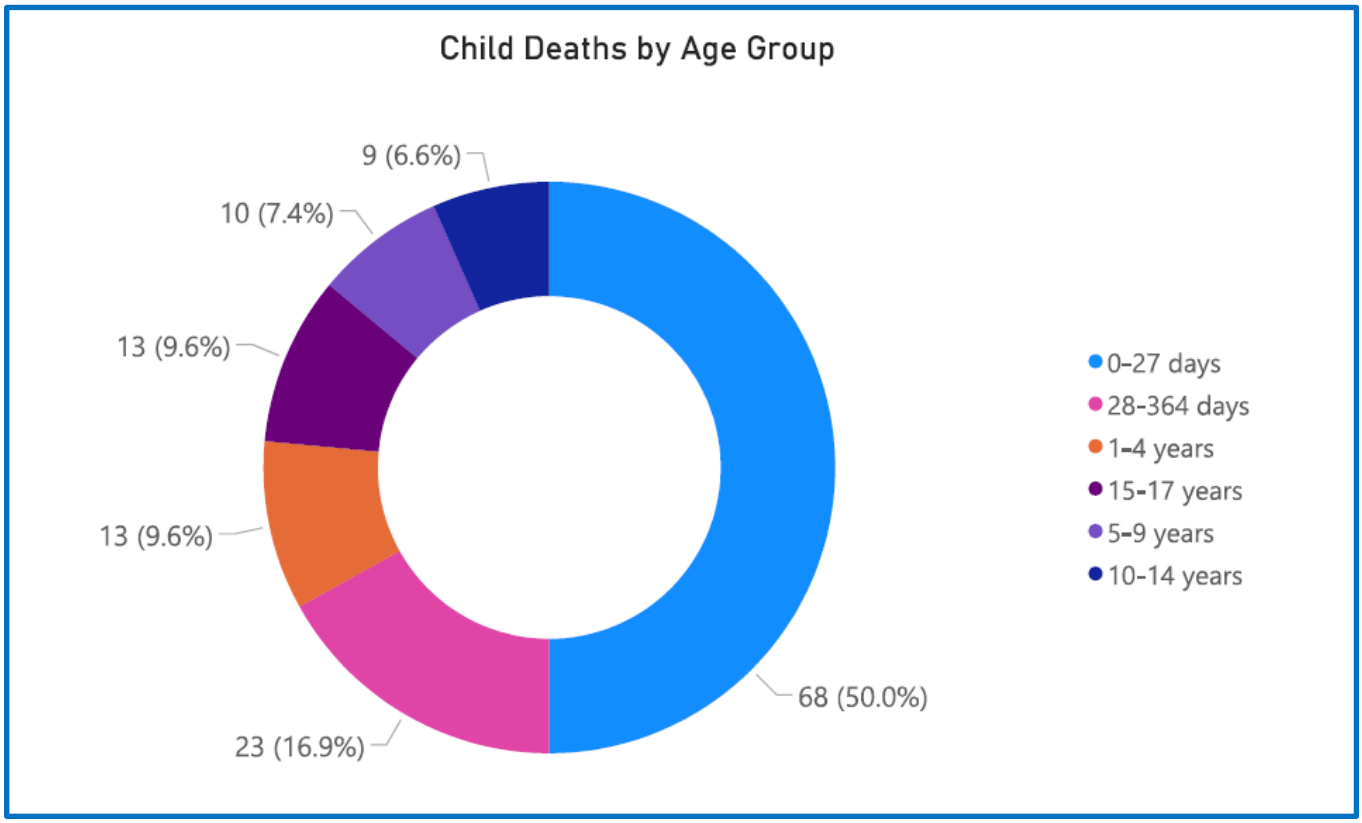
Figure 1 – Child Death Notifications by Local Authority 2023/2024



Child Death notifications by Age Group in 2023/2024

From 1st April 2023 to 31st March 2024, of the 136 child death notifications across the Black Country, 68 of these were aged 0-27 days, 23 were aged 28-364 days, 13 were in the 1-4 years age range and 10 were aged 5-9 years. 22 notified child deaths were children aged 10 years and over.

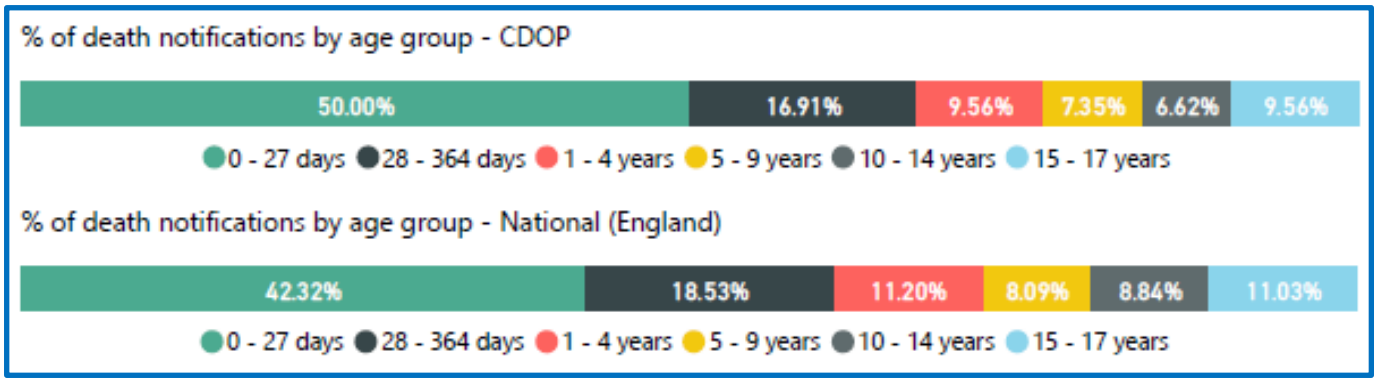
Figure 2 – Child Death Notifications by Age Group 2023/2024



In 2023/2024 of the 136-child death notification, 91 child death notifications were under the age of one year old. This is 66.91% of child death notifications during 2023/2024.

Figure 3 below has been presented by the National Child Mortality Database (NCMD) to highlight the breakdown of child death notifications by age during 2023/2024 compared to England data. This highlights the death notifications of under one year of age for the Black Country at 66.91% compared to 60.85% across England.

Figure 3 – Child Death Notifications by Age Group (Black Country & England)

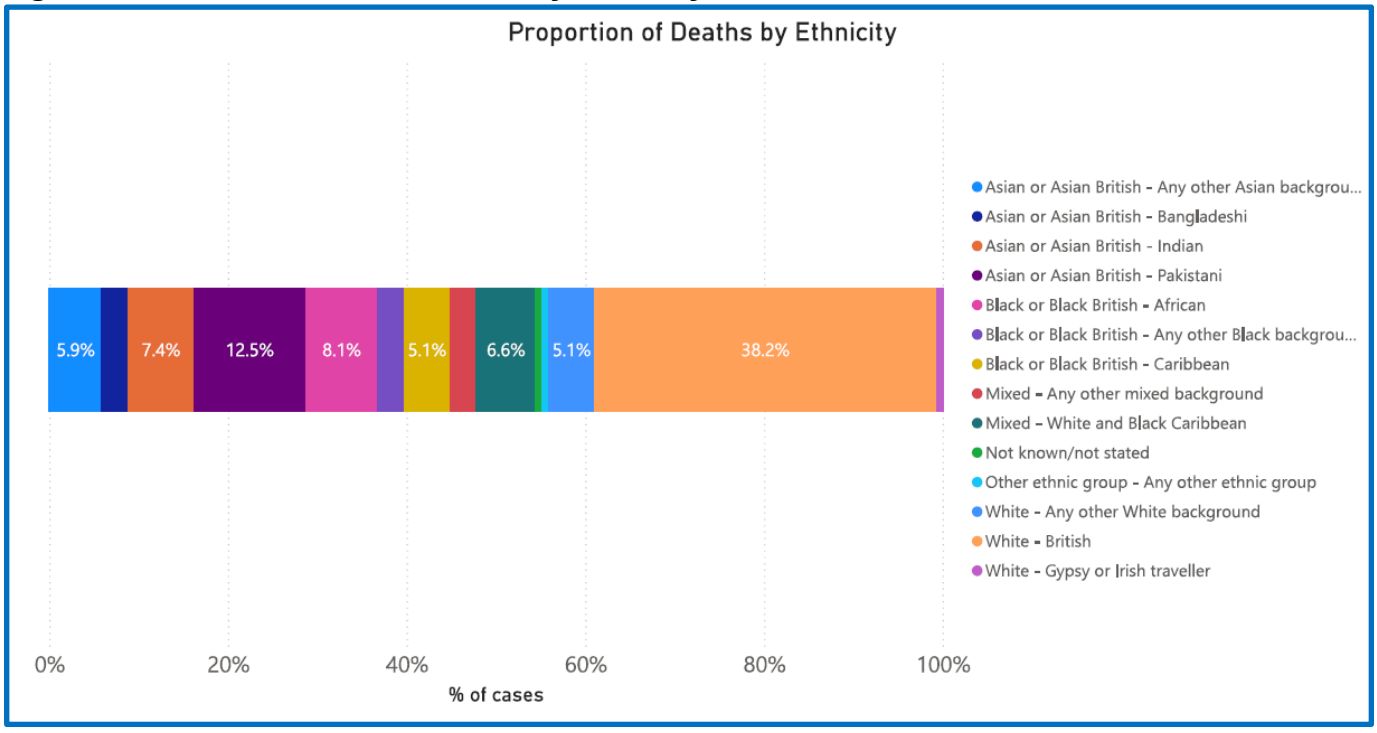


The child death notifications for all age groups 28 days up to 17 years is lower in the Black Country when compared to the England data, with 0–27-day notifications of death higher at 50% when compares to England data of 42.32%.

Child Death notifications by Ethnicity in 2023/2024

From 1st April 2023 to 31st March 2024, of the 136 child death notifications across the Black Country, 52 cases were White British background 39 were of an Asian or Asian British background, 22 cases were Black or Black British background. Thirteen different ethnic groups were identified.

Figure 4 – Child Death Notifications by Ethnicity 2023/2024

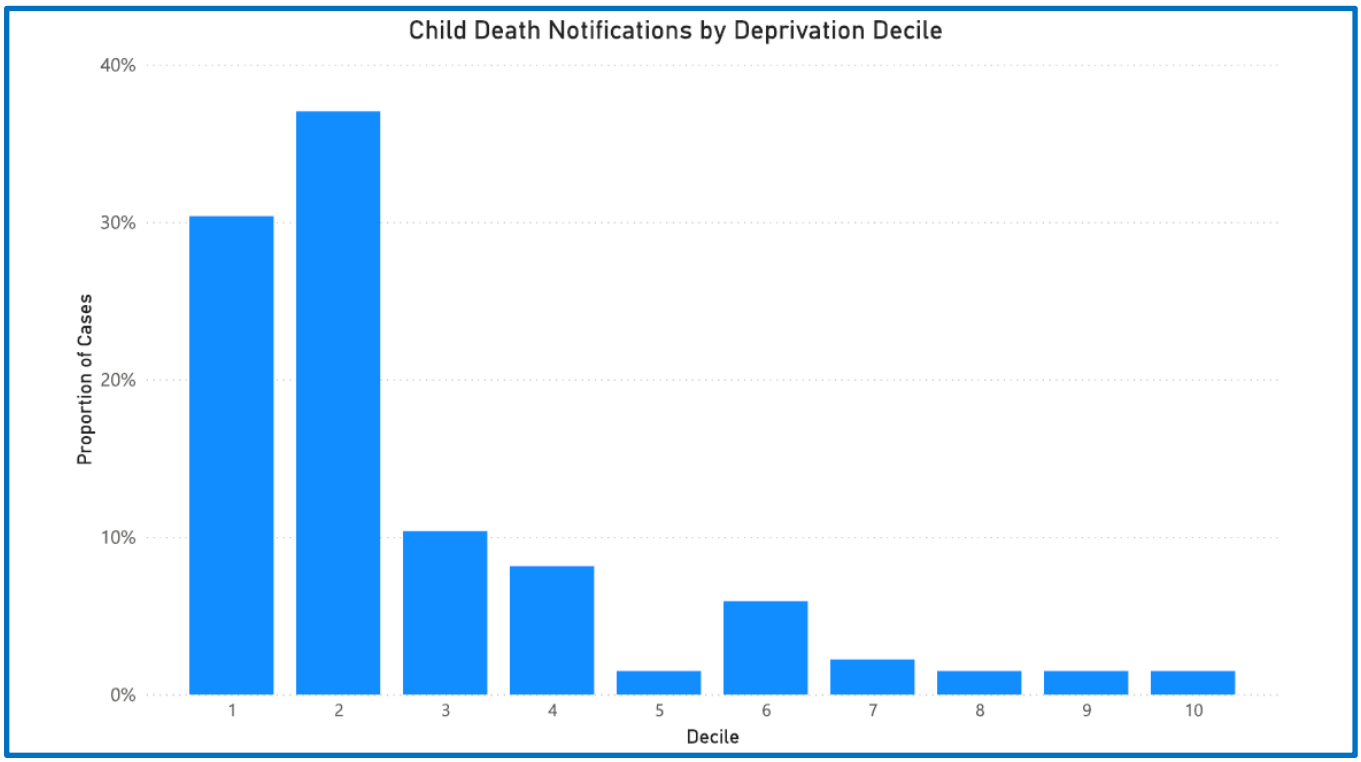


Child Deaths notifications by Deprivation in 2023/2024

Of the 136-child death notification during 2023/2024, 134 cases had an identifiable postcode that could be checked against the Index of Multiple Deprivation Decile (2019).

Of these 134 cases, 115 children resided (85.8%) in the 40% most deprived areas. There were 91 children (67.9%) who resided in the 20% most deprived areas.

Figure 5 – Child Death Notifications by Index of Multiple Deprivation Decile 2023/2024

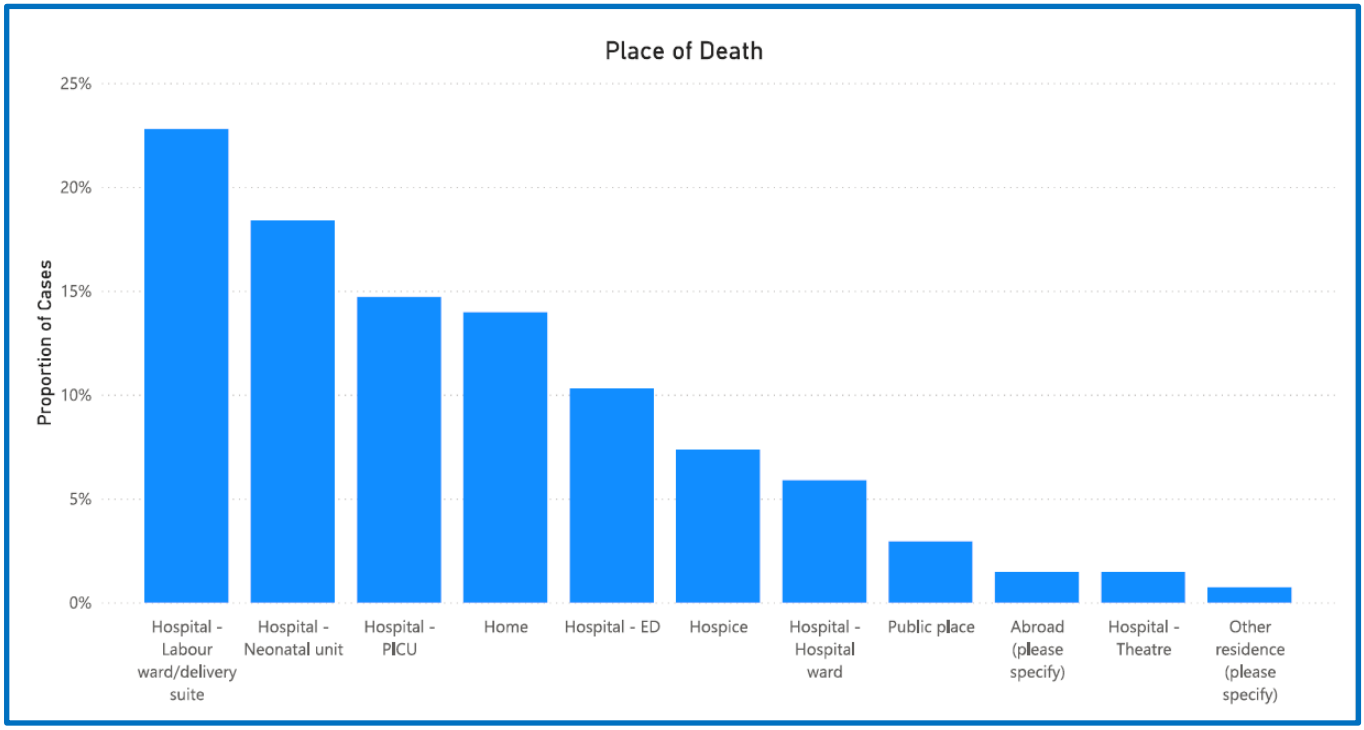


Child Deaths notifications by Location of Death in 2023/2024

Of the 136 notifications of child death, 107 child death notifications identified the location of death in a hospital or Hospice.

56 of these cases where the hospital was the location of death were in the Neonatal unit or Labour/ward/delivery suite.

Figure 6 – Breakdown of Child Death Notifications by Location of Death



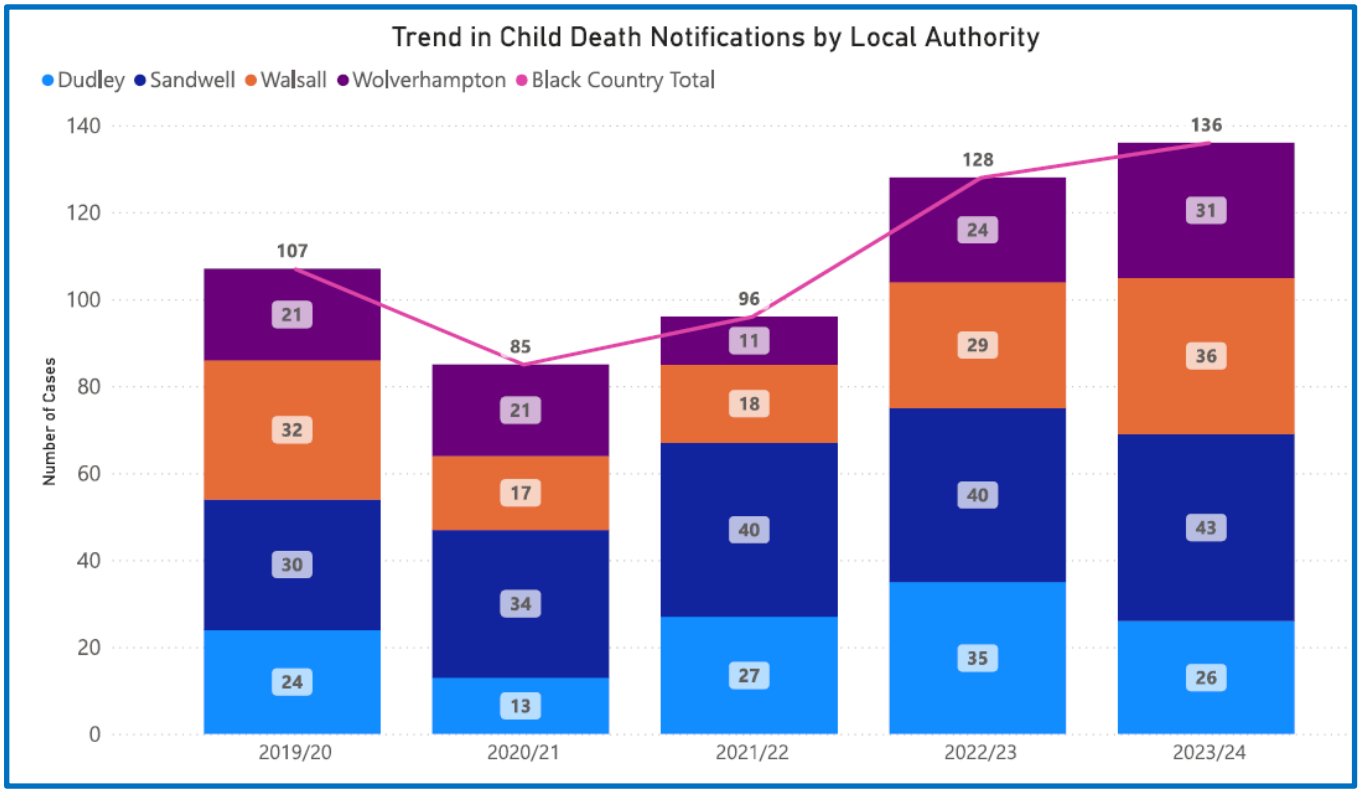
Data: Child Deaths 2019-2024

Child Deaths notified between 2019-2024

Over a five-year period, a total of 552 Child Death notifications have been received within Black Country CDOP. There has been a gradual rise in notifications over the last three years.

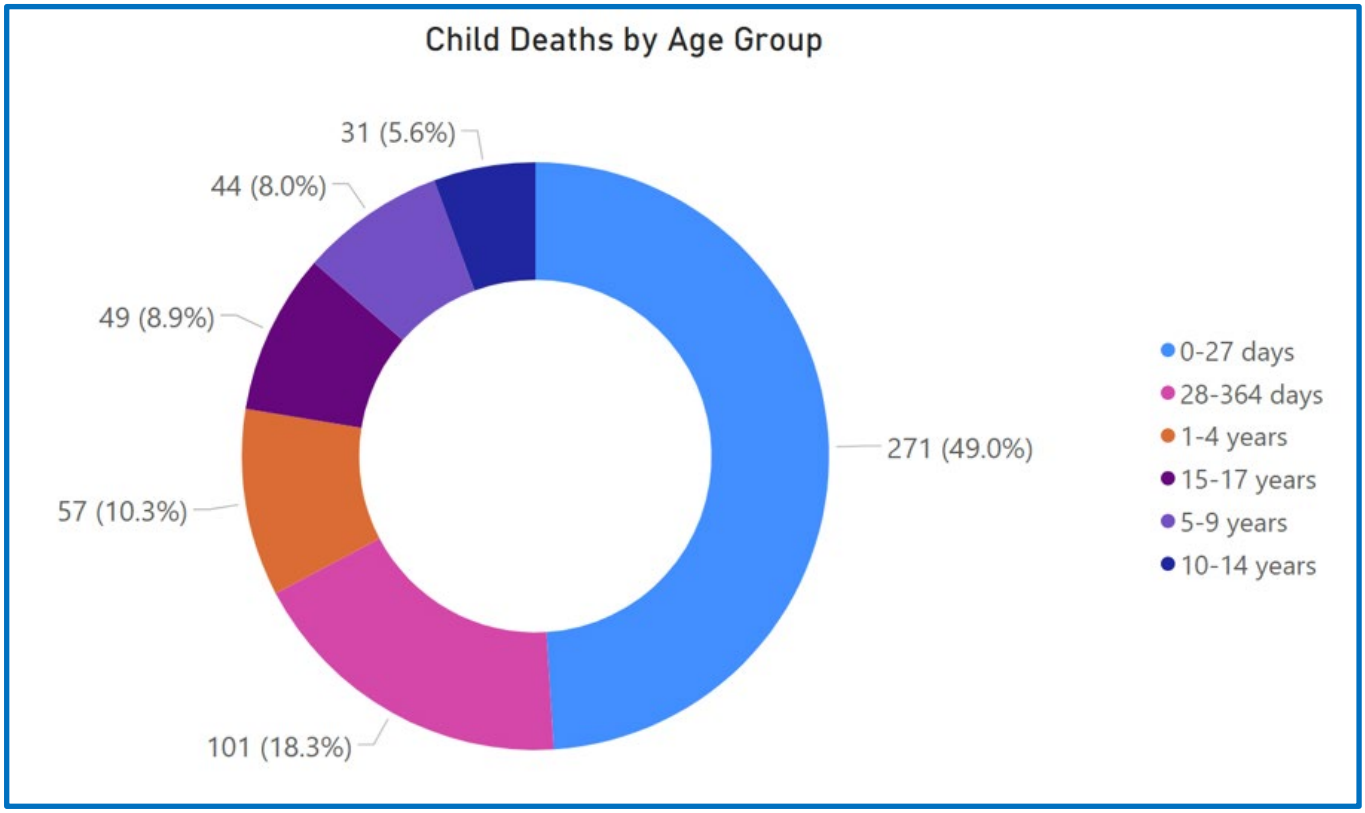
Child Death notifications by Local Authority 2019-2024

Figure 7 – Child Death Notifications over a 5-year period by Local Authority



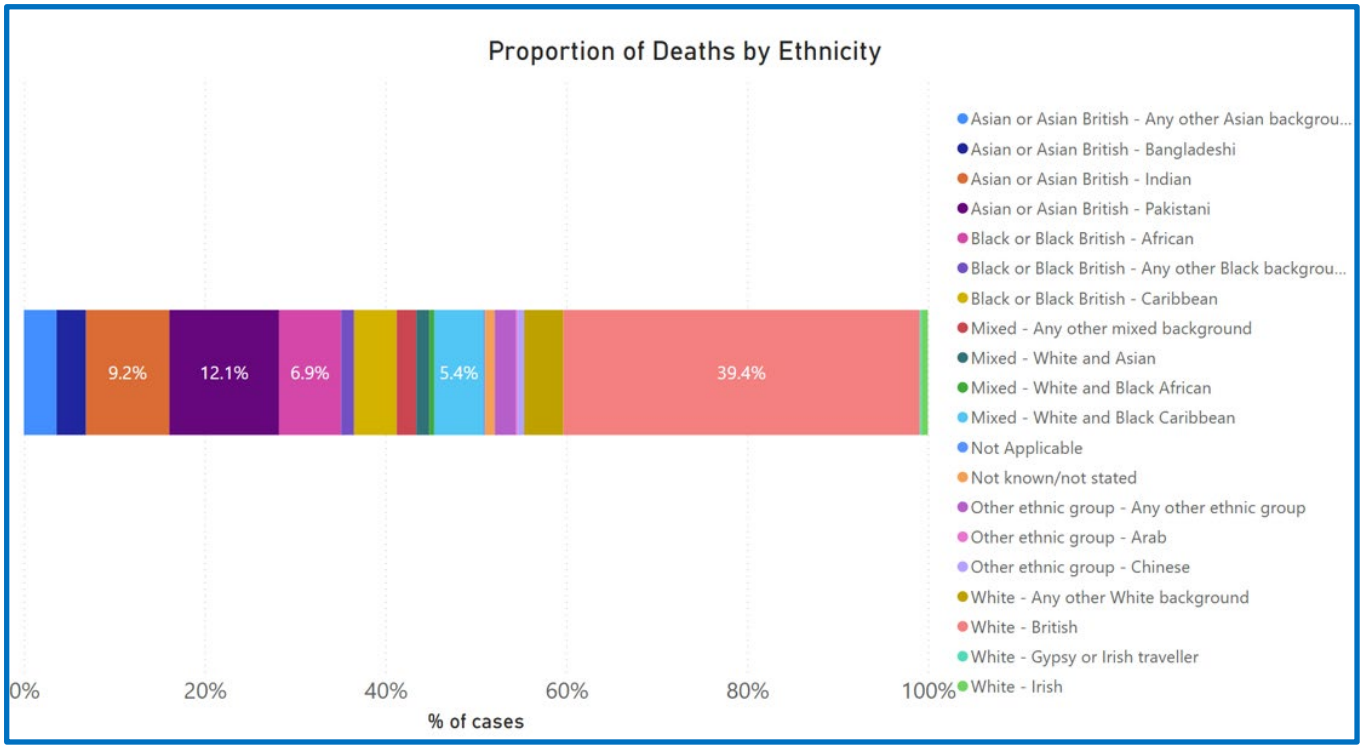
Child Death notification by Age Group 2019-2024

Figure 8 - Child Death Notifications over a 5-year period by Age Group



Child Death notification by Ethnicity 2019-2024

Figure 9 – Child Death Notifications over a 5-year period by Ethnicity



Data: Child Death Reviews

Child Death Reviews in 2023/2024

From 1st April 2023 to 31st March 2024, 127 Child Deaths were reviewed at Black Country Child Death Overview Panel. For the same time period, in the West Midlands, 400 Child Deaths were reviewed.

There were twelve Child Death Overview Panels that took place during 2023/2024, with six of these being a Neonatal themed panel.

Of the 127 cases that were reviewed by BCCDOP during 2023/2024:

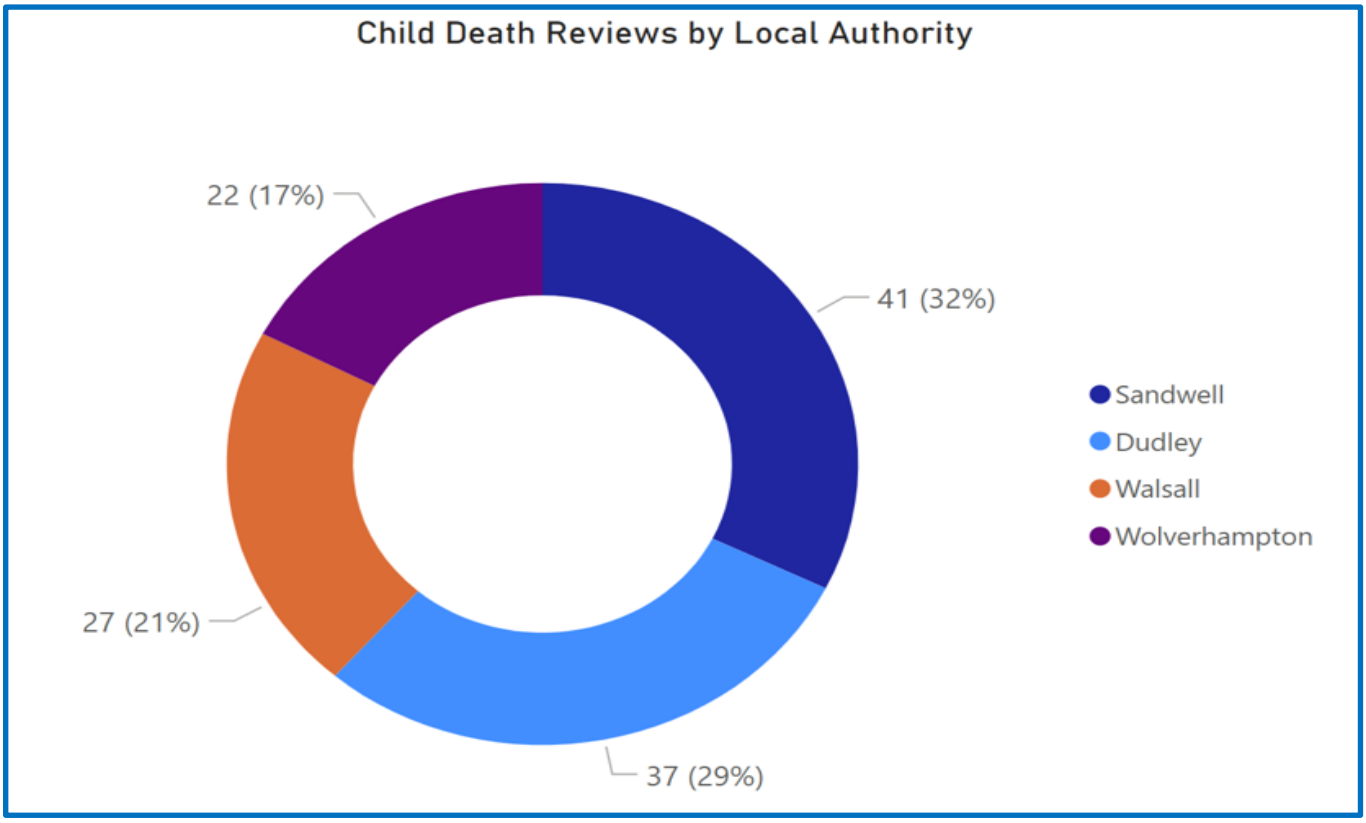
- 29 cases of these had the death notified within the same year.
- 82 cases were death notifications from the previous year (2022/2023).
- 16 cases were death notifications pre-April 2022.

The majority of child deaths that were reviewed are from the previous year, there is often a significant amount of time before a case is ready for review at CDOP.

Child Death Reviews by Local Authority in 2023/2024

From 1st April 2023 to 31st March 2024, of the 127 Child Deaths that were reviewed at Black Country Child Death Overview Panel, 41 cases that were reviewed at Panel were child death notifications with a Sandwell postcode, 37 had a Dudley postcode, 27 had a Walsall postcode and 22 cases had a Wolverhampton postcode.

Figure 10 – Child Death Reviews by Local Authority 2023/2024



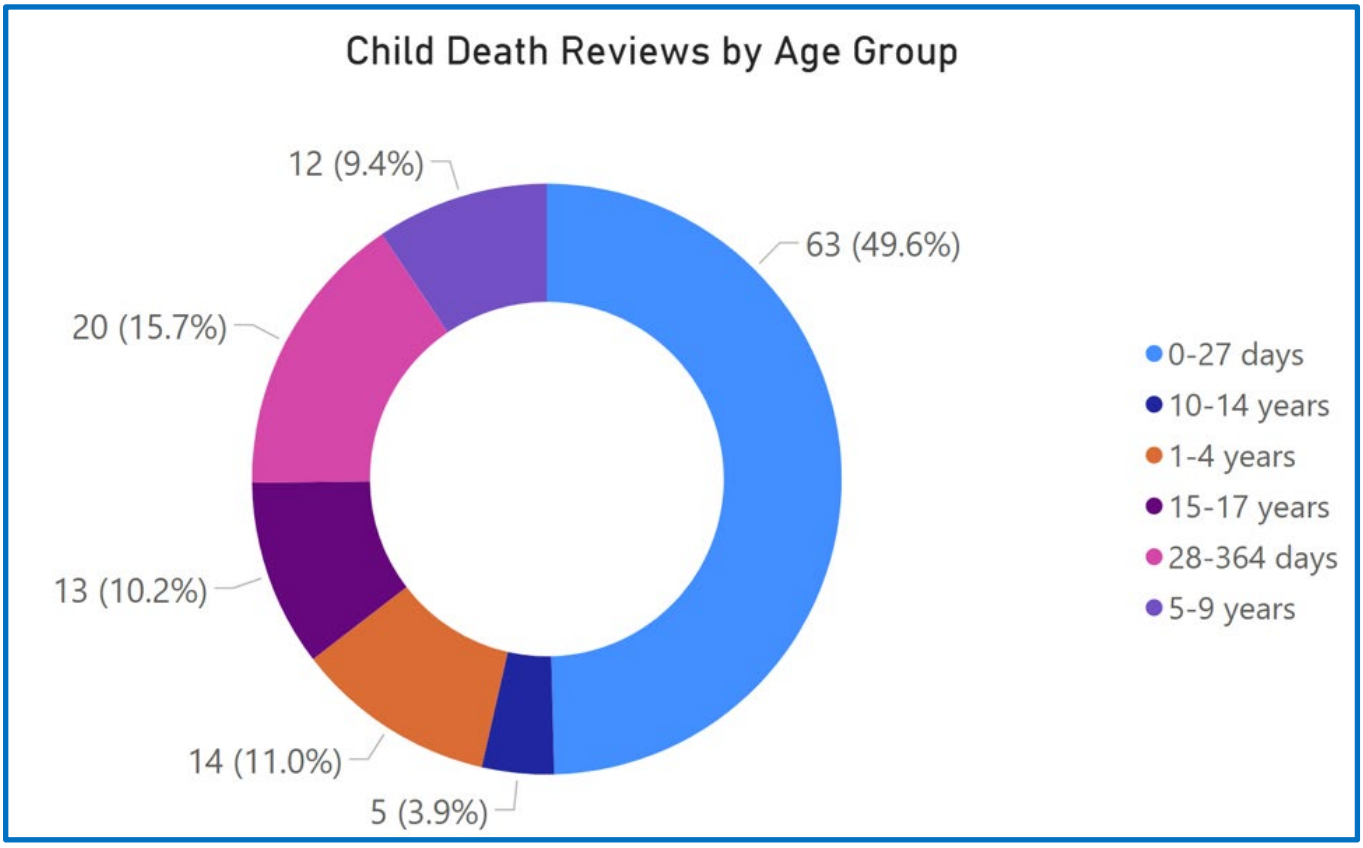
Child Death Review by Age Group in 2023/2024

Of the 127 cases reviewed by BCCDOP, 63 cases were of babies in the 0-27 days range, these were reviewed at the six Neonatal themed Panels that took place during 2023/2024.

A further 20 cases were aged between 28 days and a year old, therefore a total of 83 cases that were reviewed were under the age of one years old.

Of the 127 cases reviewed, 14 cases were 1-4 years old, 12 cases were in the 5-9 years age group, 5 cases in the 10-14 years age group and 13 cases in the 15-17 years age group.

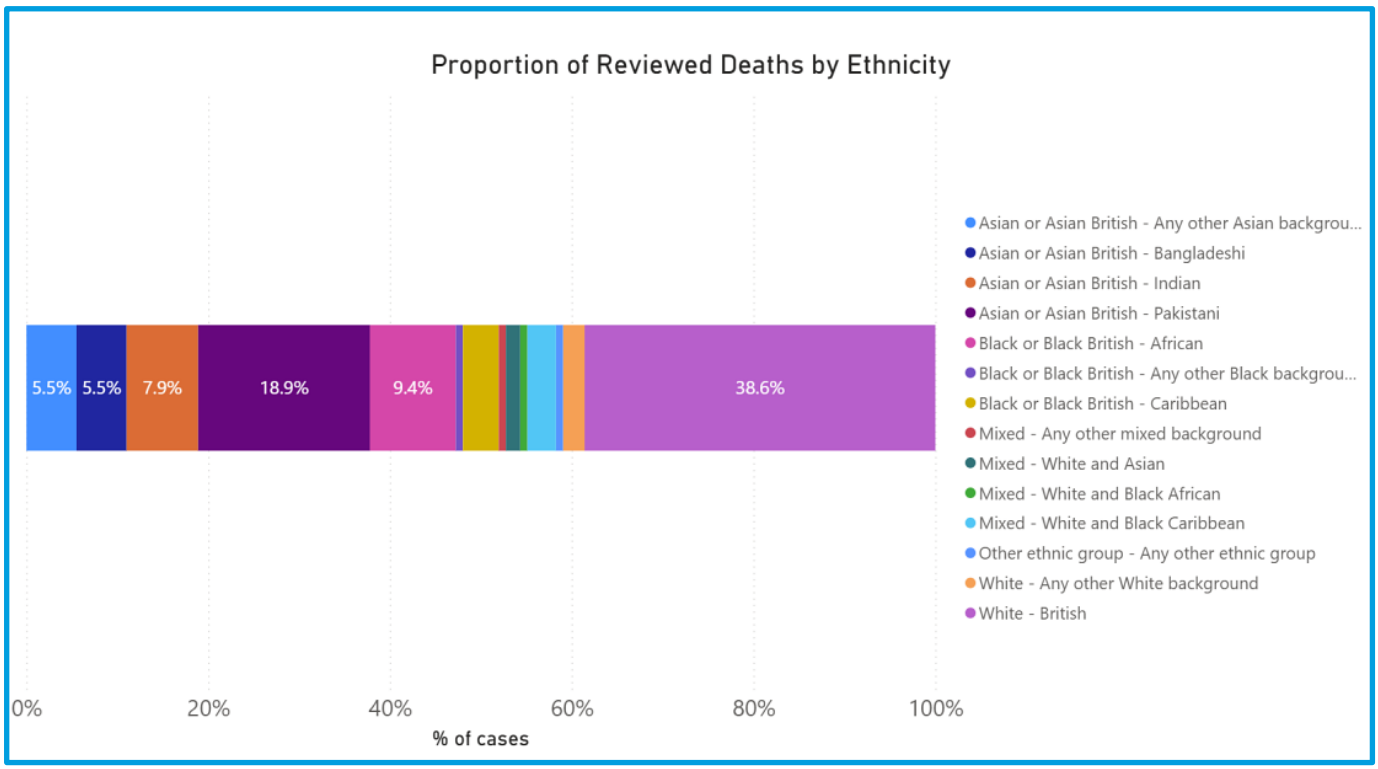
Figure 11 – Child Death reviews by Age Group 2023/2024



Child Death Review by Ethnicity in 2023/2024

Of the 127 cases that were reviewed, fourteen different ethnic categories were identified.

Figure 12 – Child Death reviews by Ethnicity 2023/2024



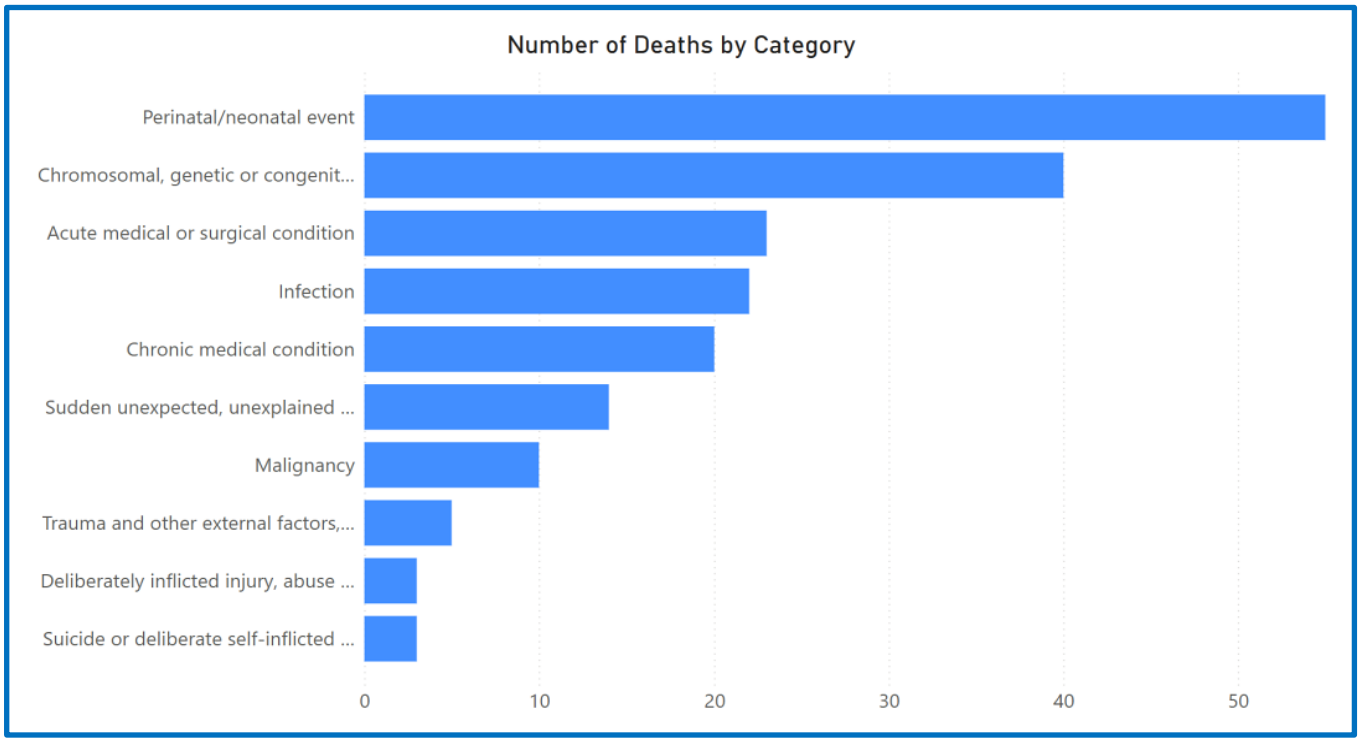
Category of Death identified in Child Death Reviews in 2023/2024

At CDOP, members are expected to agree on the category of death (see appendix five). Of the 127 cases reviewed, 34 cases had Perinatal/Neonatal event as the only category of death agreed, with a further 20 identifying Perinatal/Neonatal event and another one, two or three categories.

Some cases may have more than one category of death identified.

Of the 127 cases reviewed 24 cases had two categories of death, 18 cases had three categories of death and there were 2 cases that identified four categories of death.

Figure 13 – Category of Death identified during the Child Death Review 2023/2024



Modifiable Factors identified in Child Death Reviews

The modifiable factors are determined by Panel members during the BCCDOP meeting as each domain (Appendix three) is discussed. Of the 127 Child Death cases that were reviewed, 46 cases had no modifiable factors identified. 81 cases had modifiable factors identified.

Of the 81 cases with modifiable factors, 41 of these had one modifiable factor identified, 40 had multiple modifiable factors.

Less modifiable factors were identified in Domain C, factors in the physical environment than the other three domains.

The majority of modifiable factors are identified in cases where the child died before their first birthday, with 61 out of the 81 cases where modifiable factors were identified were cases where the child was between 0 days – 364 days.

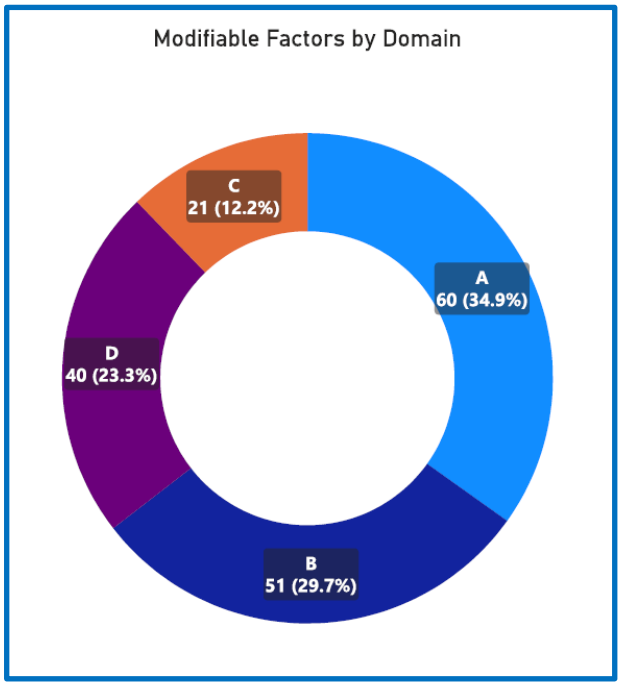
In Black Country CDOP during 2023/2024 64% of cases were identified with modifiable factors. In 2023/2024 across England 43% of cases had modifiable factors identified in cases that were reviewed.

It is important to note here, with modifiable factors, where the Panel may have identified a modifiable factor, in some cases it would not be clear if the mother/family had been offered a service and refused this support, and/or the service is or is not available. As Black Country CDOP covers four Local Authorities, with four Hospital Trusts, it is important to note there is not a consistent offer/service in place in all four areas, therefore Panel members attempt to highlight the modifiable factors consistently to highlight to Partners potential areas to develop/improve and/or the opportunity provide reassurance to CDOP that there is a service in place.

For example: During review, it was not always clear when a mother confirmed smoking in pregnancy; if the smoking cessation service was offered, and if it was offered, if mother declined or took this service up, and if the service was accessed if this was maintained.

The identification of modifiable factors has been highlighted to the National Child Mortality Database and there are some further discussions taking place between the ACDRP (Association of Child Death Review Professionals) and CDOP Chairs to identify a method to ensure consistency when discussing modifiable factors.

Figure 14 – Modifiable Factors identified by Domain in review of cases 2023/2024



Below are examples of the Modifiable factors identified in each of the Domains. See appendix 4 for a full list of modifiable factors identified in each domain.

Figure 15 - Modifiable factors identified by Domain in review of cases 2023/2024

Domain A: Factors intrinsic to the Child
High Maternal BMI (ranging from 30-63.1) Low Maternal BMI Smoking in pregnancy Father smoked in household Child known to use cannabis No healthcare professional present at the delivery Recently entered the UK and unclear the Expected Date of Delivery (EDD) Child was a victim of exploitation (county lines/gang affiliation)
Domain B: Factors in the Social Environment
Advance Maternal Age (Over 40) Smoking in the household (mother smokes, father smokes). Significant amount of alcohol and drug paraphernalia found at home Father was accessing a medication, not prescribed by GP, and not kept securely. Mother was Vitamin D deficient (association between Vit D deficiency and preterm birth) Short amount of time unsupervised to support sibling with complex needs Previous/historical domestic abuse (during previous pregnancy, from grandparents) Frequent non-attendance at health appointments

Domain C: Factors in the Physical Environment
Always slept in prone position for sleeping (thought this was for the best) Unsafe sleeping arrangements - Next to Me cot not used. Evidence of co sleeping. – with mother and father and/or mother and sibling Challenges for mother to supervise two children with complex needs Choked on a piece of food
Domain D: Factors in Service Provision
Missed opportunity to investigate further following previous pregnancies Missed opportunity to clarify sepsis Lack of consideration of an underlying problem on postnatal ward (assumed reluctant feeder) Escalation of concerns not made in a timely manner Lack of communication & reviews: Baby born in height of Covid/born on a bank holiday No documentation of inhaler technique being checked Delay in autism assessment due to moving from out of area. Issues for children transitioning from paediatric services into adult services. Different agencies/services use different IT and record keeping systems – lack of information sharing.

Joint Agency Response

In 2023/2024 in the Black Country there were 38 cases that required a Joint Agency Response (JAR). These would be referred to as SUDIC (Sudden Unexpected Death of an Infant or Child) cases as the JAR is arranged as a result of a death that was sudden and not expected.

There was a higher proportion of unexpected deaths requiring a JAR in Walsall (15 cases) compared to other areas. During 2023/2024, Sandwell had 11 cases that triggered a JAR, Wolverhampton and Dudley both had 6 cases that triggered a JAR.

Of the 38 cases that required a JAR, at the time of this report* 24 had been reviewed and closed. 14 cases are still open and require further investigation and/or information to be shared before the case can be referred to CDOP for the final review.

Of those 24 cases that triggered a JAR and have been reviewed at the time of this report* the following categories were agreed at Panel (some cases identified more than one category of death (see appendix five).

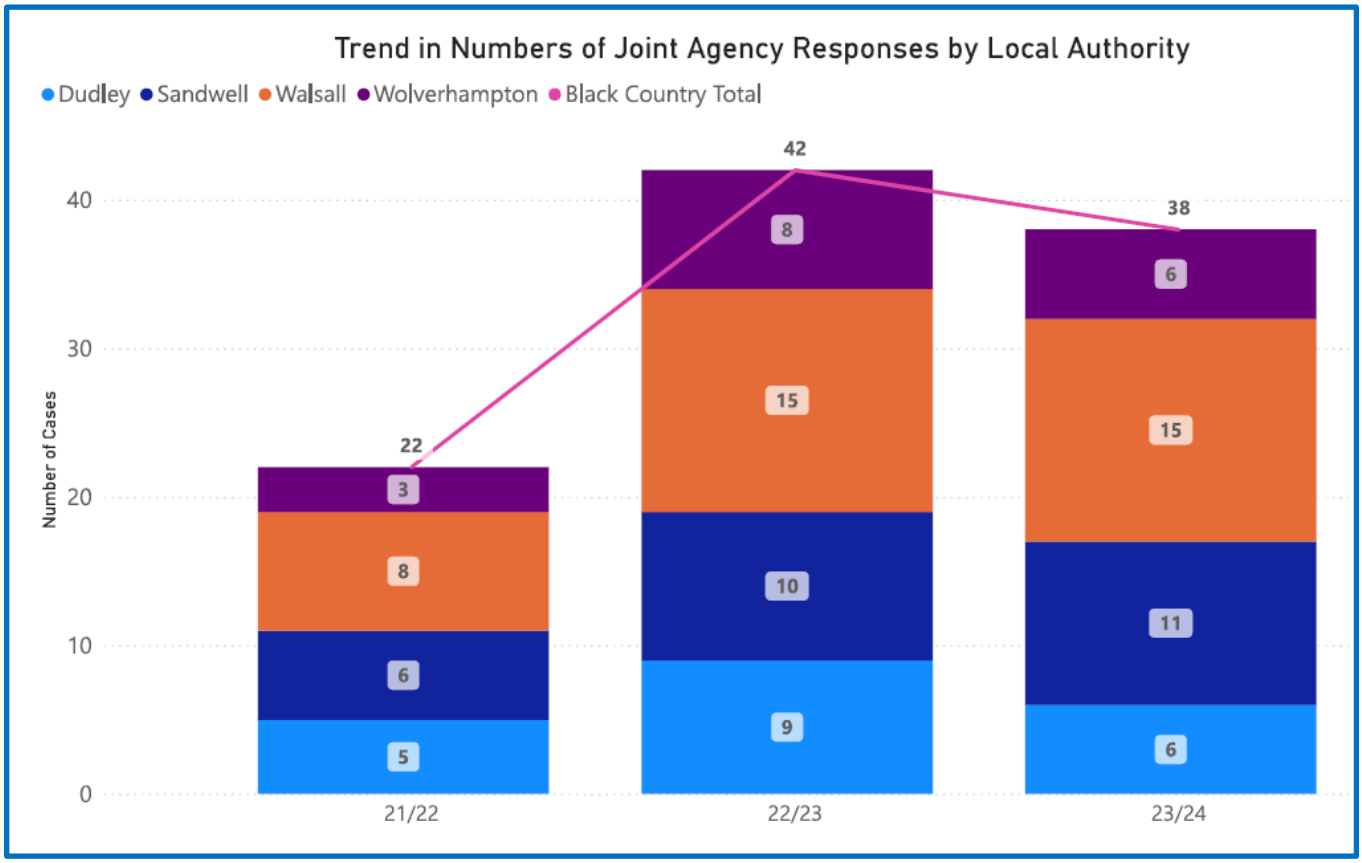
- Sudden unexpected, unexplained death (7 cases)
- Acute medical or surgical condition (7 cases)
- Chromosomal, genetic, or congenital anomaly (5 cases)
- Perinatal/Neonatal cases (5 cases)

Categories also identified, but in less than 5 of the cases;

- Chronic Medical condition
- Infection
- Trauma and other external factors, including medical/surgical complications/error.

(At the time of this report*January 2025)

Figure 16 – Joint Agency Response by Local Authority over a 3-year-period



Learning Disabilities Mortality Review

People with a learning disability often have poorer physical and mental health than other people and may face barriers to accessing health and care to keep them healthy. Too many people with a learning disability are dying earlier than they should, many from things which could have been treated or prevented.

The (LeDeR) programme (learning from deaths – people with a learning disability and autistic people) were set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and reduce health inequalities. By finding out more about why people died we can understand what needs to be changed to have influence on people's lives.

Since 1st July 2023, child deaths (where there has been a diagnosis of a Learning Disability and/or Autism) are no longer added to the LeDeR platform but remain within the CDOP process and the BCICB LeDeR Manager is informed and if invited to the Joint Agency Response if this was a Sudden, Unexpected Death of a Child or the Child Death Review Meeting.

During 2023/2024, 6 cases were highlighted to the LeDeR Manager.

The National Child Mortality Database has taken on board views from CDOPs to assist with the review of child deaths where a Learning Disability and/or Autism has been diagnosed/suspected. In the discussions locally, is evident there are a number of cases where a formal diagnosis was not in place, but there was suspected or known learning difficulties. Where possible, we are working with the LeDeR Manager to seek advice and oversight of these cases. Including those where the family member/carer has been identified to have known or suspected learning difficulties and/or learning disabilities.

BCCDOP Monitoring 2023/2024

Child Death Overview Panels are monitored through eCDOP by NCMD to ensure local data is completed. In the regional report of data (up to 31st March 2024) that is published by NCMD, each CDOP has been provided with a score against data completion of the mandatory fields within eCDOP and the timeliness of notifications and reviews.

Data Completeness

The Regional report for data completeness and timeliness in 2023/2024 the Black Country had 99%-100% in all notification fields in all 136 cases notified to CDOP.

In the 127 cases reviewed by CDOP, there was 100% completion of fields.

Timeliness

In 2023/2024 the Black Country delivered 83% of Child Death notifications in 2 days, this is an increase on last year (78%). It is important to note the average in the West Midlands was 72% and across England was 69% of notifications in 2 days.

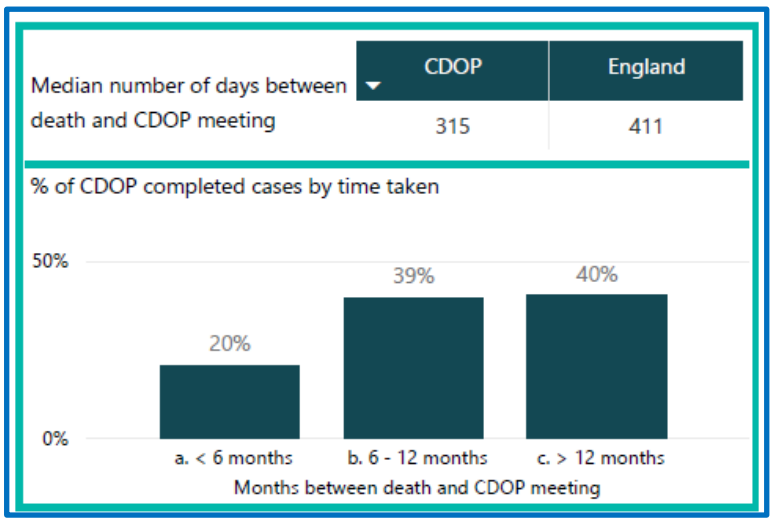
In 2023/2024, 96% of notifications were processed in 7 days. Regionally this is 95% and across England 93% of notifications in 7 days.

Further analysis of the data has identified the majority 126 cases were notified to CDOP within 0-3 days. Where the cases were not notified to CDOP within the 7 days, these were investigated and the reasons for the delay were shared with CDOP.

Figure 17 is taken from the NCMD local Monitoring report for the Black Country for 2023/2024. The median number of days between death and the CDOP meeting in the Black Country is 315 days, compared to 411 in England and an average of 350 days across the West Midlands.

The percentage of reviews in 12 months is 60% compared to 42% across England and an average of 53% in the West Midlands.

Figure 17 – Days between notification of death and CDOP meeting 2023/2024



It is important to note here that the delay in some of the cases to be ready for review is out of the control of the Child Death Review teams. There is a shortage of Paediatric Pathologists, and this is impacting on Child Death Reviews across England.

Where a child requires a Post Mortem, the family would be informed which area the child would be taken to for this to happen. This could be for a Post Mortem in Sheffield or Cambridge for example. CDOP acknowledges this is an additional cause of distress for the families, and it has been highlighted to Child Death Review Strategic Partnership who have assurance from the Association of Child Death Review Professionals (ACDRP) this is being discussed at a national level.

Learning from deaths 2023/2024

Learning from Child Deaths

Learning lessons from child deaths cases is a priority for BCCOP to ensure this learning is shared widely across the Black Country as well as Regionally and Nationally. With Child Deaths being reviewed across the Black Country footprint, there may be an opportunity to highlight emerging themes.

CDOP holds a panel meeting on a monthly basis. There is a themed Panel addressing all Neonatal cases (0-27 days) on a bi-monthly basis. This arrangement allows for Obstetricians and Neonatologists to provide an independent scrutiny of cases as well as inform the discussions during the review process and highlight themes and learning locally. The Panel on the alternate month reviews paediatric cases from 28 days of age up to 18 years old.

During 2023/2024 there have been twelve Panel meeting, six of these had a Neonatal theme.

Looking at all the deaths reviewed during 2023/2024, we have been able to collate the learning points into specific areas (For a more detailed version, please refer to Appendix six.)

Communication – including note taking, documentation, phone calls, communication between services and families including the use of interpreting services.
Information sharing – cross boundary care and IT systems
Safeguarding – multi agency learning and professional curiosity.
Services:

- Maternity/Neonatal care – maternity record, antenatal care, neonatal care, transfer of care/tertiary unit, preterm labour/threatened preterm labour, obstetric care, community care, free birth terminology, foetal medicine, placental histology,
- Primary Care
- Childrens Services
- Mental Health Services
- Health Visiting
- Learning disabilities and/or autism
- Education
- Genetics
- Paediatric care – including asthma paediatric palliative care, transitional (paediatric into adult services)
- Urgent Treatment Centre
- Emergency Services – WMAS and 111/999

Areas of learning:

- Stabbing and youth violence
- Safer sleep

Child Death Review process – death abroad, post mortems, and support for families following a child death.
Staff Support – training and staff support following a child death.

Actions: Identified through the CDR process

Actions may be shared at the point the case is reviewed by CDOP. These may have been identified within the PMRT, CSPR or as a result of an investigation by the service or external organisation and shared/reviewed during the CDRM.

Some examples of the actions shared thought the Child Death Review process include:

- Specific staff training: To raise awareness of translating services within the organisation.
- Communication with teams: To ensure Midwifery/Neonatal units have a conversation with WMP following a sudden unexpected collapse on the unit.
- Introduction of a service: Open clinic - once a week for children with epilepsy
- Identifying a specific role: Employment of a Saving Babies Lives Midwife
- Refresh of guidelines: Preterm labour guideline and Fetal Monitoring Guideline updated.
- Update of Standard Operating Procedures: CT scanning for ventilated babies
- Follow up with the family: To ensure referral into the genetic service.
- Sharing feedback into appropriate groups/forums: Escalation into the Black Country Suicide Prevention Group.

Alternatively, towards the end of the review of a case at Panel, members in attendance may suggest or agree specific actions to address as a result of the learning from the case.

Some examples of actions agreed at Panel include:

- To remind services of the importance of utilising interpreters in cases where English is a second language.
- Recommendation of the funding of bleed kits across the footprint.
- To identify the inconsistency of an offer across the Black Country footprint and share this with the Strategic Partnership.
- To query if NCMD have been made aware of similar deaths from other areas.
- To highlight with NCMD/ACDRP the inconsistent formulation of a cause of death as SIDS or unascertained dependent on the Pathologist.
- To highlight a missed opportunity into a service for reassurance correct processes are in place moving forward.
- Raise the importance of accessing Vitamin D for babies/children.
- Raise awareness of key messages to reduce child/infant deaths, for example Safer sleep messages or to highlight the importance of community and neighbours knowing how to escalate a safeguarding concern (and not keep silent).

Learning Shared by CDOP

Sharing learning is a key role for the CDOP team. CDOP is collaborating with colleagues across the region to understand how learning is shared and recorded to improve and develop this in the Black Country. CDOP is keen to formulate a formal process to record learning, identify where this has been shared and monitor the impact of the learning on practice.

CDOP has shared learning by:

Briefings - to highlight learning from Panel and where appropriate, specific briefings have been developed to target professionals in the field and highlight relevant learning.

- GP scenario (July 2023)
- Water Safety Summer Briefing (July 2023)
- 111 service (Sept 2023)
- Safer Sleep and Infant Feeding (October 2023)
- Choking – Sharing the Learning (November 2023)
- Advance Care Plan (March 2024)

Themes and trends - developed on a quarterly basis, shared with the Strategic Partnership and then the wider network.
Local Maternity and Neonatal System (LMNS) - learning and good practice shared quarterly at the Quality and Safety Work Stream relevant to Maternity and Neonatal colleagues across the Black Country and monthly attendance at the LMNS Best Start Work Stream.
CDOP contact list (members of the CDOP, Strategic Partnership and other Safeguarding and relevant colleagues across the Black Country.)
Warnings - Following a case, it may be appropriate to highlight the dangers of an item and/or activity to specific areas/contacts.
Research shared during Panel relevant to the discussion.
Reminders - where a case has highlighted the importance of reiterating a process/action.
NCMD; Escalating learning from cases to the NCMD through eCDOP and/or directly.
NCMD; Sharing thematic reports with CDOP contacts.
ACDRP; Escalating learning/concerns to ACDRP through the Independent Chair or BCCDOP.
West Midlands Child Death Review Network (WMCDRN); quarterly attendance by CDOP.
CDOPS across England - Sharing learning or responding to requests for information.

Recognising Good Practice

Where good practice has been noted or where staff have been recognised going above and beyond, Panel members have highlighted this during the review. It has then been agreed to share a letter of thanks and acknowledgement to the team and/or individuals from the BCCDOP Independent Chair.

There may not be an opportunity to highlight the good practice or recognition of staff going above and beyond for every case, but CDOP would like to continue the emphasis on highlighting good practice and sharing thanks to those supporting the child who died and their family.

CDOP and many families depend on the kind, generous, compassionate, and diligent professionals and volunteers who engage in often complex, uncommon, unusual scenarios, and would like to take this opportunity to share a ‘Thank you’ to every single one.

Regional Overview – Infant/Child Mortality

The National Child Mortality Database released a regional report for the West Midlands in November 2024. This regional overview of Infant and Child Mortality uses the data from this NCMD Regional Report addressing data between 1st April 2019 and 31st March 2024.

Over the last 5 years, the majority of child deaths were identified in the most deprived areas on the index of multiple deprivation.

Infant Mortality in the West Midlands

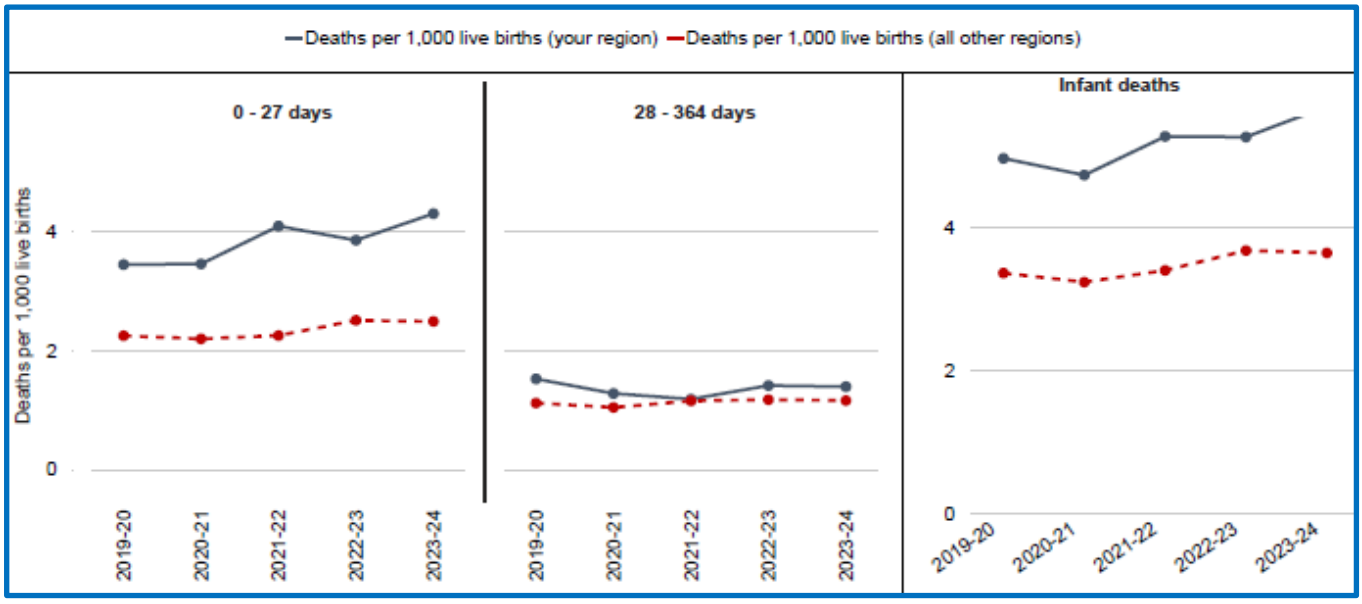
Infant Mortality refers to any child who dies and is under the age of one year old and the rate is the number of infant deaths for every 1,000 live births.

In 2023/2024 the total deaths per 1,000 live births was 5.7 in the West Midlands, compared to 3.6 in other regions. In 2023/2024 the Black Country infant mortality rate was approximately 6.1 deaths per 1,000 live births.

The rate of death of an infant (under the age of 1) by ethnicity is higher in the West Midlands when compared to all other regions, with a more significant increase in 2023/2024 for:

The Asian community with the rate of 7.9 deaths per 1,000 live births in the West Midlands compared to 4.9 across all other regions.
The Black community with the rate of 8.1 deaths per 1,000 live births in the West Midlands when compared to 6.6 across all other regions.
Those from Mixed backgrounds with the rate of 6.6 deaths per 1,000 live births in the West Midlands when compared to 3.4 across all other regions.

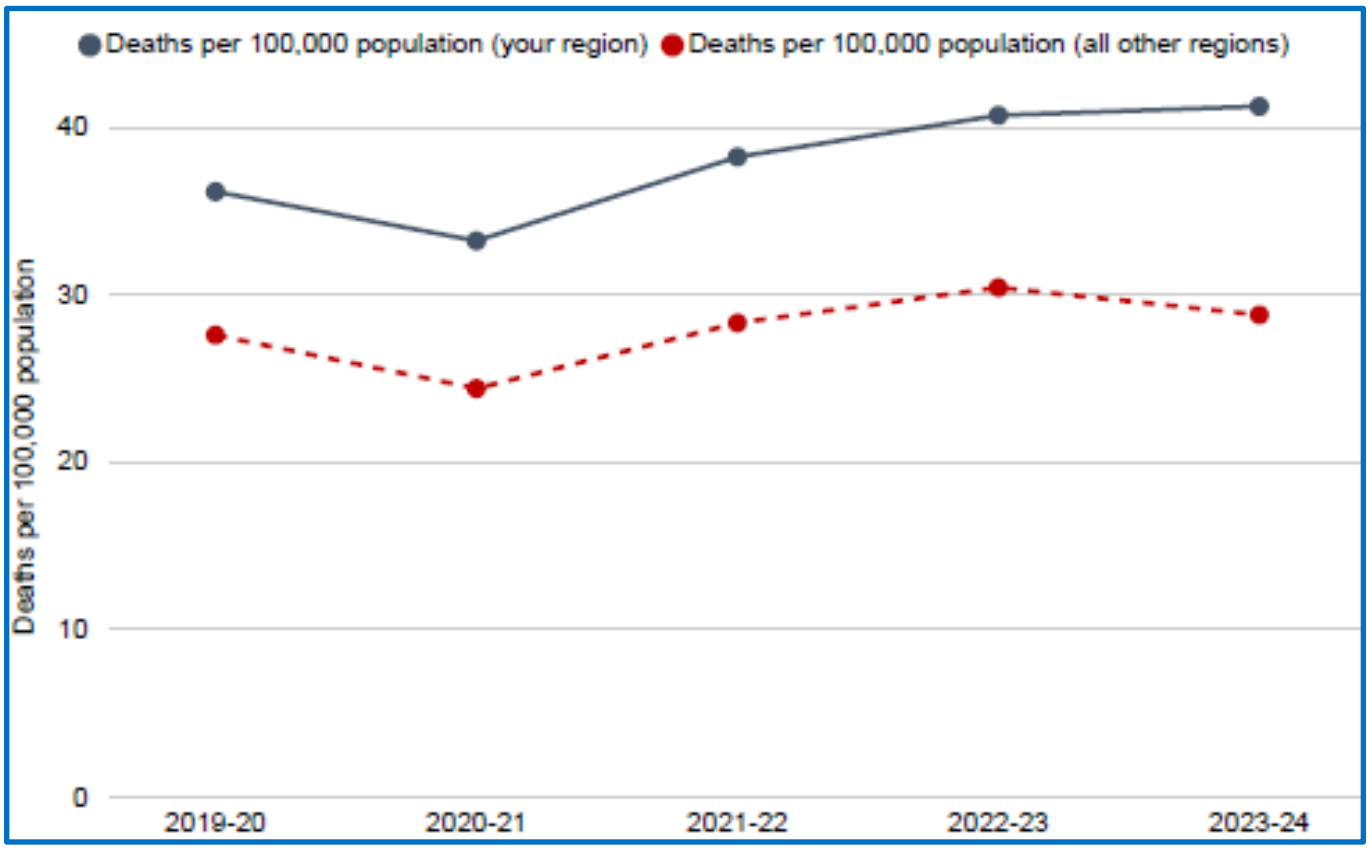
Figure 18 - Deaths per 1,000 live births: 0-27 days & 28-364 days. An overall rate of infant mortality in the West Midlands



Child Mortality in the West Midlands

Child mortality is the total number/rate of all child deaths (between 0-17 years) for every 100,000 population. Figure 19 highlights in the West Midlands 41.2 deaths per 100,000 population, compared to 28.7 deaths per 100,000 population across all other regions.

Figure 19 – Deaths per 100,000 population: 0-17 years in the West Midlands



In Figure 18 and Figure 19, the dark blue line represents West Midlands data, and the red dotted line represents all other regions.

Black Country overview – Infant/Child Mortality

Infant Mortality in the Black Country

Infant Mortality refers to any child who dies and is under the age of one year old and the rate is the number of infant deaths for every 1,000 live births.

Figure 20 – Infant Mortality in the Black Country by area compared to West Midlands and England from 2001 to 2023

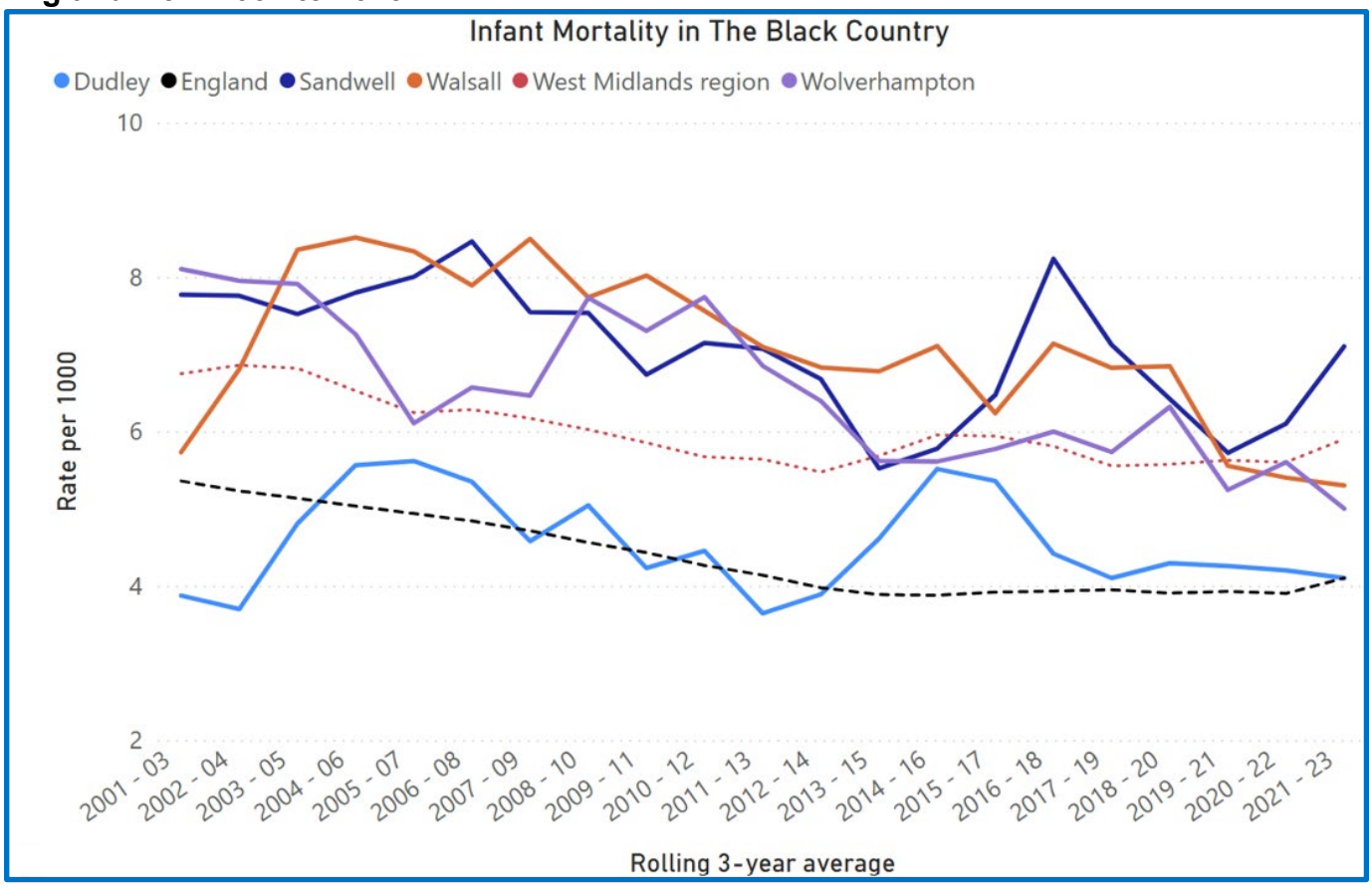


Figure 21 – Infant Mortality per 1000 live births (2021-2023: 3-year rate)

	Infant Mortality (per 1000 live births)
England	4.1
West Midlands Region	5.9
Dudley	4.1
Sandwell	7.1
Walsall	5.3
Wolverhampton	5.0

Child Mortality in the Black Country

Child Mortality refers to any child who dies and is aged between 0-17 years of age. The rate is the number of child deaths for every 100,000 of the population.

Figure 22 – Child Mortality in the Black Country by area compared to West Midlands and England from 2001 to 2023

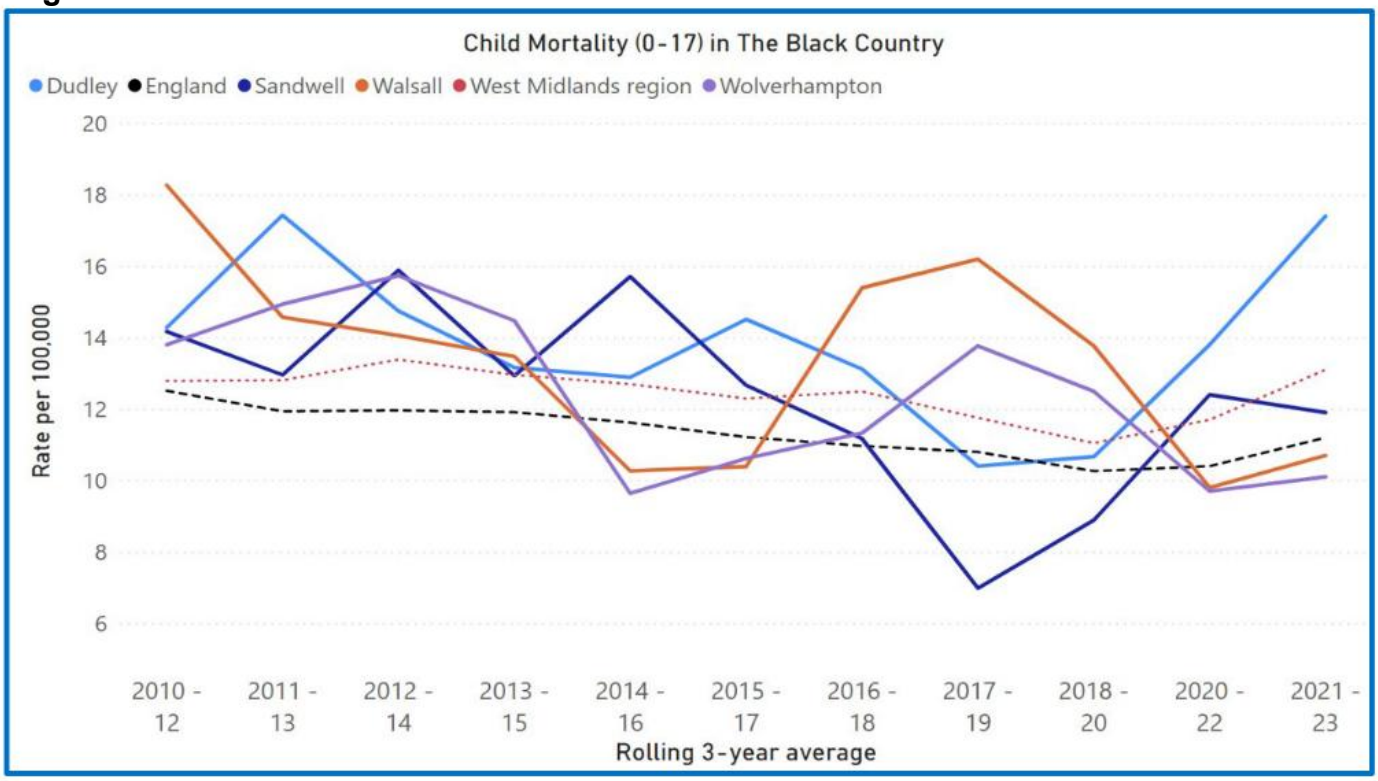


Figure 23 – Child Mortality (aged 0-17 years) per 100,000 population (2021-2023: 3-year rate)

	Child Mortality (per 100,000 population)
England	11.2
West Midlands Region	13.1
Dudley	17.4
Sandwell	11.9
Walsall	10.7
Wolverhampton	10.1

BCCDRSP & BCCDOP achievements during 2023/2024

BCCDR Strategic Partnership funding

During 2023/2024 the Partnership have agreed and facilitated funding for the following:

- Six months access to Lullaby Trust safer sleep training for anyone living/working in the Black Country.
- Implementation of Restorative Supervision for the CDOP team, BCICB Lead Nurses for Child Mortality and CDR administrator to access on a regular basis.
- Venue and refreshments to support Bereavement events hosted by the MNVP Coordinator across the Black Country.
- 48 Abusive Head Trauma models (Twelve models for each area) to be used in a variety of settings to facilitate sessions on the dangers of shaking a baby, promote the ICON campaign messages and demonstrate safer sleep messages. The use of these models is now monitored by the ICON implementation group.
- Lullaby Trust leaflets.
- Twelve Bleed kits to be placed across the Black Country (awaiting confirmation on some locations)
- Following an expression of interest, £2,500 provided to each Trust to purchase Pregnancy pillows to support safe sleep during pregnancy (over three hundred purchased, awaiting further feedback from Trusts)

Actions by the CDOP team

As well as the day-to-day activity by the CDOP team (for example: management of notifications, responding to queries, eCDOP review, monthly Panel meetings and quarterly Strategic Partnership meetings) the team have also actioned the following during 2023/2024:

- Development of an observer agreement to invite professionals and students to observe Panel.
- Coordination of the Safer Sleep training (Meeting with Lullaby Trust, registration process, email queries, certification, and evaluation).
- Lead Nurses for Child Mortality started to attend all Perinatal Mortality Review meetings across the four acute provider trusts.
- Visits to: Walsall Palliative Care Centre, West Midlands Air Ambulance Charity, Staff/Stoke CDOP Safer sleep training session.
- Training/info sessions: A teaching session at Wolverhampton University to Student Health Visitors and School Nurses to highlight the Child Death Review process, learning from reviews and invite to observe a Panel.

Regular Attendance at the following Black Country/System wide meetings:

- BCICS Mortality Review Group

  - BCICB Safety and Steering Group
  - BCICB Safeguarding Assurance Group
  - LMNS Quality and Safety Work Stream
  - LMNS Best Start Work Stream to share learning.
  - West Midlands Child Death Review meeting
- Monthly meetings implemented for CDOP and Area Administrators.
- Development of a web space on the BCICS website for CDOP arrangements and CDOP annual report to be made available.
- Development of a draft local bereavement directory.
- Initial meeting with the Black Country Coroner to engage in the CDR process and improve communication.
- Completion of a JAR audit to identify areas for improvement and a consistent process across the Black Country, including an update to the JAR agenda.
- Development of a Quality Assurance checklist for CDRMs.
- Formality of an Independent Chair to be employed by BCICB as host of CDOP from Wolverhampton Council.
- Development of an internal process to ensure the BCICB Quality and Safety Team are aware of SUDI cases uploading cases onto Datix.
- Facilitation of a data sharing agreement to develop a dashboard on Power BI with Walsall Public Health to provide data charts and identify themes and trends with Black Country data over the last 5 years.
- Dissemination of immediate learning/notifications to ensure rapid sharing of alerts or learning with the appropriate services/population.
- Improvement to the notification process to include appropriate partners including Safeguarding Partnership, Education, BCHFT and Childrens Services.
- Improvement to the notification process between CDOP and Child Health Information Service to ensure notifications are processed appropriately.
- Regular contact and initial discussions commenced with BWCH Governance Team once capacity allows to host CDRMs for those children who die at BWCH (to avoid delays local CDR teams are currently completing the CDRMs)
- Develop a process for notifying the LeDeR manager when a case identifies a diagnosed learning disability or suspected learning disability or learning difficulty.

Future Priorities for Black Country CDR Strategic Partnership

The CDOP team would like to highlight the following priorities to be addressed by the BCCDR Strategic Partnership as a result of the data shared in this annual report:

- To seek reassurance from partners to address the modifiable factors identified during the Child Death Review process to support a reduction in infant and child deaths.
- To highlight and share good practice across the Black Country.
- To improve sharing of learning across the Black Country with professionals.
- To improve the consistency for families in the allocation of a key worker.
- To improve the opportunity for families to feedback into the Child Death Review process.
- To provide high level data to individual areas to support targeted work using the Power BI.
- To update the Black Country SUDIC protocol with the release of the updated Kennedy Guidelines.
- To support Trusts who host the CDRM for a Black Country child outside of the Black Country can have access to Black Country eCDOP to support consistent reporting and collation of information to report up to NCMD.

Public Health Partners

NIHR Challenge Maternity Disparities Research – University of Birmingham

In 2024, one of the West Midland's key academic institutions, University of Birmingham was selected to be part of the new NIHR Challenge Maternity Disparities Consortium, with the aim of tackling inequalities in maternity outcomes. The research conducted by the consortium will focus on inequalities before, during and after pregnancy in the West Midlands. £50 million will be invested in the consortium over 5 years.

As key stakeholders, public health teams in the Black Country will be involved in influencing and designing the research and will use the findings of the Black Country CDOP report to do this. The research will help support professionals who plan and deliver services for women and babies across both health and social care.

Black Country Infant Mortality event

There is a jointly planned Black Country event between the LMNS, ICB and four public health departments. With support from OHID to look in detail at infant mortality strategies and current actions, and to agree on a set of joint priorities for all to progress. Whilst all areas and organisations have their own specific infant mortality reduction strategies, there are several themes of common interest that would be better tackled collectively.

Recommendations for Local Partners

On release of this report, CDOP would like to recommend the following items to Partners across the Black Country:

- To note the data shared within this report.
- To note the disparity in the number of deaths between ethnic groups and share initiatives and interventions to address this.
- To improve the allocation of a key worker for every family who experiences a child death.
- To share with CDOP where actions/changes to practice are as a result of learning shared in this report.
- To share with CDOP examples of good practice in individual areas/services already happening that can be reflected in other areas/services.
- To highlight initiatives developed as a result of this learning to the Child Death Overview Panel that reduce the prevalence of modifiable factors including;
    - Safer sleeping
    - Smoking
    - High Maternal BMI
    - Poverty and Deprivation

References

- NCMD | The National Child Mortality Database
- Census: Office for National Statistics (ons.gov.uk)
- Age by single year - Office for National Statistics (ons.gov.uk)
- English indices of deprivation 2019: Postcode Lookup (opendatacommunities.org)
- Live births by ethnicity and local authority, 2020 to 2021, Office for National Statistics (ons.gov.uk)
- https://www.blackcountryintelligencehub.co.uk/
- https://fingertips.phe.org.uk/profile/child-health-profiles
- Child and infant mortality in England and Wales - Office for National Statistics
- NHS England » Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)
- NCMD Regional Report – West Midlands, Data up to 31st March 2024
- NCMD Monitoring Report for CDOPs – Black Country, Quarter 4 2023/2024

Appendices

Appendix ONE – The Child Death Review Process

Process when a Child Dies

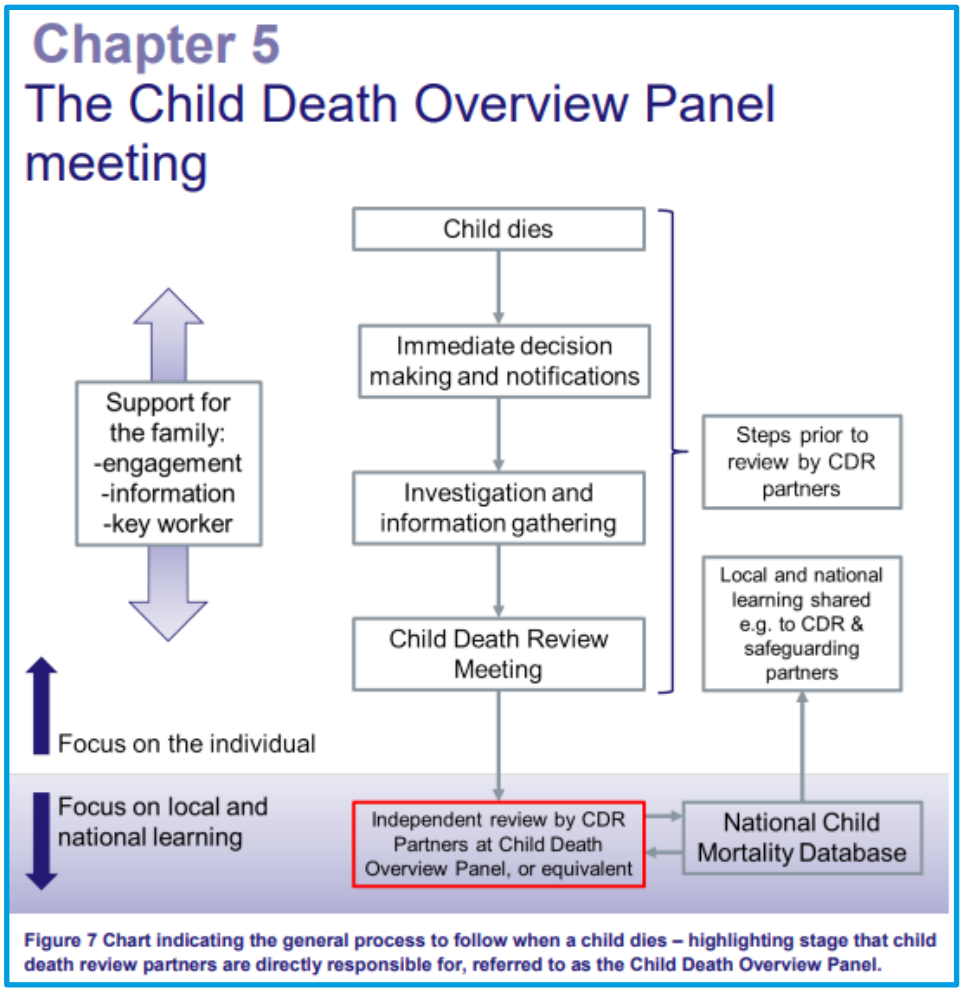


Figure 7 Chart indicating the general process to follow when a child dies – highlighting stage that child death review partners are directly responsible for, referred to as the Child Death Overview Panel.

Child Death Review Statutory and Operational Guidance (England) (publishing.service.gov.uk)

(Page33)

Child Death Notification

Following the death of a child, a formal notification of the death should be shared with the CDOP Team as soon as possible, ideally within 48 hours. A child death notification can be completed by any professional involved with the death of a child. For ease, the notification form is accessible online as a public facing document.

To notify a child death please use: www.ecdop.co.uk/BlackCountry/Live/Login

Joint Agency Response

A Joint Agency Response (JAR) would be triggered when a child's death, or the collapse leading to death would not have been expected to occur 24 hours previously.

Criteria for a JAR includes the following:

- The death is or could be due to external causes.
- The death is sudden and there is no immediately apparent cause.
- The death occurs in custody or where the child has been detained under the Mental Health Act.
- Where the initial circumstances raise any suspicions that the death may not have been natural.
- In the case of a stillbirth where no healthcare professional was in attendance.

Any death that is both sudden and unexpected might be referred to as Sudden, Unexpected Death of an Infant/Child (SUDIC) at the point where the child dies. Following a Post Mortem and full investigation, these deaths might go on to be explained by for example infection, cardiac or metabolic condition or even homicide. At the point of review, the death would be categorised as the appropriate cause of death.

If after full investigation, the death remains unexplained, it would be referred to as Sudden Unexplained Death in Infancy (SUDI) or Childhood (SUDC). Infancy refers to a child being under the age of one at the time of death and childhood refers to those who are over the age of one at the time of death.

Child Death Review Meeting

Child Death Overview Panel is informed by the referral of a standardised report completed during a Child Death Review Meeting (CDRM). The meetings are attended by professionals who were directly involved in the care of the child during their life, the parents' life and/or siblings and any professional involved during the child's death.

At this meeting, a formal agenda is followed to ensure all matters related to the child are discussed. The professionals in attendance at the CDRM vary dependent on the circumstances of the child death and is not limited to medical staff.

During this meeting any contributory factors, which are categorised into four domains (see appendix three) are discussed and modifiable factors are identified. The learning and any actions as a result of the learning will be highlighted and support available for those within the meeting. The support the family have received, accessed, or been offered is explored.

An important part of the CDRM is the opportunity for professionals to share any comments or questions on behalf of the parents/family that may have been raised at the time of death or during the CDR Process. Parents would not attend the CDRM, but they should be informed that the meeting is taking place and given the opportunity to share their feedback into the Child Death Review Process.

Child Death Overview Panel

The Child Death Overview Panel (CDOP) is a multi-agency panel set up to conduct the independent scrutiny on behalf of the local Child Death Review (CDR) partners on the reviews of all deaths of children who are normally resident in the Black Country to learn lessons and share findings for the prevention of future child deaths.

The review at CDOP is intended to be the final scrutiny over a child's death. The CDOP membership includes representation from a range of organisations with knowledge and expertise in fields such as Public Health, Childrens Services, Police, Education, Paediatrics etc.

Members support the review of each case that is referred into CDOP and factors relevant to the child's vulnerability or death are agreed within each of the four domains and a level of relevance is agreed for each factor;

0: Information not available
1: No factors identified, or factors identified but are unlikely to have contributed to the death
2: Factors identified that may have contributed to vulnerability, ill health, or death

At CDOP for each case a category of death is agreed, this may be one category of death or multiple categories dependent on the final cause of death (see appendix five).

Modifiable Factors

The CDOP is responsible for identifying modifiable factors. These modifiable factors would not mean the death was preventable, but there may be emerging trends that could reduce the risk of future child deaths. Where a factor in one of the domains has been identified as an increase to the child's vulnerability or contributed to the child's death, the Panel can discuss if there is a local and/or national intervention in place or that could be recommended to reduce the risk of future child deaths.

Learning from Child Deaths

Learning lessons from child deaths cases is a priority for BCCOP to ensure this learning is shared widely across the Black Country as well as Regionally and Nationally. With Child Deaths being reviewed across the Black Country footprint, there may be an opportunity to highlight emerging themes.

CDOP is held on a regular basis, with a themed Panel addressing all Neonatal cases (0-27 days) on a bi-monthly basis. This arrangement allows for Obstetricians and Neonatologists to be invited from neighbouring areas to provide an independent scrutiny of cases as well as inform the discussions during the review process and highlight themes and learning locally. The Panel on the alternate month reviews cases of child death from 28 days of age up to 18 years old.

Appendix TWO – Roles within CDOP and CDR Teams

CDR and CDOP Roles (January 2025)

BCCDOP: Independent Chair			
CDOP Coordinator		**CDOP Officer**	
Dudley/DGFT Area Administrator	**Sandwell** Area Administrator	**Walsall/WHT** Area Administrator	**W'ton/RWT** Area Administrator
BCICB	**SUDIC/Child Death Lead**	**Lead Nurse for Child Mortality**	**BCICB**
DGFT CDR Team Designated Doctor Lead Practitioner for Child Death	**SWBH CDR Team** Designated Doctor	**WHT CDR Team** Designated Doctor Lead for Child Death	**RWT CDR Team** Designated Doctor Lead for Child Death Specialist Nurse for Child Death

Appendix THREE - Contributory Factors NCMD

Domain A Groups - Factors intrinsic to the child

- Child health history/medical conditions
- Risk factors in mother during pregnancy/delivery
- Child's developmental conditions/disabilities
- Emotional/behavioural factors
- Smoking/alcohol/substance use/misuse by the child

Domain B Groups - Factors in social environment including family and parenting capacity.

- Smoking/alcohol/substance misuse/use by a parent/carer
- Challenges for parents with access to services
- Domestic or child abuse/neglect
- Household functioning, parenting/supervision
- Poverty and deprivation
- Social care
- Cultural factors
- Parent/carer's health
- School/peer groups

Domain C Groups - Factors in the physical environment

- Sleep environment
- Home safety/conditions
- Vehicle collision
- Public safety

Domain D Groups - Factors in service provision

- Initiation of treatment/identification of illness
- Following guidelines/pathway/policy
- Access to appropriate services
- Staffing/bed capacity/equipment
- Communication within or between agencies
- Communication with family

Appendix FOUR – Modifiable Factors identified during reviews in 2023/2024 in each Domain – full list.

Domain A: Factors intrinsic to the Child

- High Maternal BMI (ranging from 30-63.1)
- Low Maternal BMI
- Smoking in pregnancy
- Father smoked in household
- Not tested for substances during pregnancy
- Mother smoked cannabis
- Child known to use cannabis
- Use of anabolic steroids
- Unsafe sleeping arrangements – mother and child/mother and child and sibling/parents and child.
- Lack of antenatal care
- Unbooked pregnancy
- Concealed pregnancy
- Declined antenatal care and health professional involvement from 16/40
- No healthcare professional present at the delivery
- Lack of Vitamin D
- Recently entered the UK and unclear the Expected Date of Delivery (EDD)
- Poor parental understanding of inhalers and late presentation when acutely deteriorating
- Hypoxic brain injury at birth (due to negligence - therefore modifiable)
- Child was a victim of exploitation (county lines/gang affiliation
- Knife/weapon was bought online.
- He struggled to make healthy relationships
- Socially unacceptable behaviour
- Victim of a fatal stabbing

Domain B: Factors in the Social Environment

- High Maternal BMI (including BMI under 30: over 27.5 BMI for South Asian, Chinese, other Asian, Middle Eastern, Black African, or African-Caribbean family background)
- Advance Maternal Age (Over 40)
- Smoke in pregnancy (reduced number of cigarettes during pregnancy)
- Declined smoking cessation services in pregnancy
- Father/Significant other known to smoke (20-a-day)
- Smoking in the household (mother smokes, father smokes).
- Significant amount of alcohol and drug paraphernalia found at home
- Parental alcohol misuse
- Parental substance misuse
- Father was accessing a medication, not prescribed by GP, and not kept securely.

- Mother was Vitamin D deficient (association between Vit D deficiency and preterm birth)
- Parental decision for free birth
- Previous traumatic birth experience (birth reflection had been offered and attended)
- Short amount of time unsupervised to support sibling with complex needs
- Previous/historical domestic abuse (during previous pregnancy, from grandparents)
- Domestic violence recorded with current partner
- Poor engagement with health services
- Frequent non-attendance at health appointments
- Child not being supervised (near canal)
- Child left alone at home from a young age
- Lack of nurturing support from family members
- Delay in parents calling an ambulance
- Exploited from an early age (previous victim and suspect with knife crime and robbery)
- Child involved in gang activity
- Aspired to be involved with gang activity

Domain C: Factors in the Physical Environment

- Always slept in prone position for sleeping (thought this was for the best)
- Unsafe sleeping arrangements - Next to Me cot not used. Evidence of co sleeping. – with mother and father and/or mother and sibling
- Co-sleeping suspected
- Challenges for mother to supervise two children with complex needs
- Difficulties for ambulance to find address
- Antisocial hot spot
- Choked on a piece of food

Domain D: Factors in Service Provision

- Lack of guidance for the transfer of care for mothers who received antenatal care in another country. (Slotted into ‘late booking’ pathway but ‘late bookers’ not included on the drop down as a risk factor and therefore consultant led care)
- Missed opportunity to investigate further following previous pregnancies
- Twin pregnancy: one twin with anomaly or genetic condition that should have been identified in Antenatal scan (allowing parents to prepare)
- Swab taken 3 weeks prior to birth was not reviewed therefore missed opportunity to treat and delay in prescription.
- The Neonatal team were not informed of the delivery, therefore limited preparation time
- Suboptimal views on anomaly scan, although concern raised about enlarged heart and malrotation.
- Not born in the right place – family declined in utero transfer
- Cardiovascular management of the baby in the first 24 hours was not appropriate.
- First 24 hours of arrival onto the neonatal unit appropriate lines were placed but their position was not radiologically confirmed.
- Baby was hypothermic following transfer from Maternity to NNU

- No clear leader when baby was admitted and stabilised
- Golden hour care was not achieved.
- The management of the baby in the first hour on the neonatal unit was not appropriate
- All babies admitted to the NNU should be examined and documentation completed.
- Baby required surgery but the local unit (BWCH was unable to accept due to capacity) therefore the child was transferred out of region. The review and intervention could have taken place earlier if the child had not been transferred.
- Missed opportunity to clarify sepsis.
- Incorrect entry of data into the KPSRC screening tool (missed opportunity for earlier detection of the clinical condition)
- Delay in completing the imaging alongside the sepsis screen – delayed identification of the child's deterioration
- Missing opportunity for investigation – paired blood cords could have provided an earlier diagnosis
- Missed opportunities – to give second course of medication, postnatal steroids
- Lack of consideration of an underlying problem on postnatal ward (assumed reluctant feeder)
- Issues as a result of HIE at birth (due to clinical negligence)
- Escalation of concerns not made in a timely manner
- Lack of communication & reviews: Baby born during height of Covid, Baby born over a bank holiday
- Confusion around the day/time of discharge and ensuring appropriate services are informed.
- Delay in communication between the Health Visiting team, Midwifery, and Social Care
- Parents had contacted a number of services, but none of these were linked - Health Visiting did not receive a notification of attendance from the Urgent Care Centre (UCC), GP attendance, or NHS 111 contact.
- Communication challenges – parents' difficulty to get through on the phone therefore delaying attendance
- WMAS missed opportunity to recognise how unwell the child was.
- Delay in Paeds response to ED request for review
- Difficulties contacting the BWCH liver team in a timely manner.
- Complication during diagnostic process (CVL insertion) resulting in cardiac puncture requiring urgent open cardiac surgery to fix the puncture.
- Although asthma suspected, a formal diagnostic process was not implemented/documented.
- Suspected asthma - SNOMED code not used on system.
- No documentation of inhaler technique being checked
- It is unclear if parents understood the importance to continue with 'Clenil' preventer inhaler when the child was well and respiratory issues had eased.
- Late presentation by parents due to lack of understanding to access an acute medical assessment due to continued maximum use of salbutamol.
- Services had a challenge to maintain engagement with the child. Family chose to

disengage with services.

- Parents did not understand when to seek emergency medical assessment with worsening wheeze, despite six acute episodes over the previous 9 months with GP/hub, out of hours and ED attendance.
- Delay in autism assessment due to moving from out of area (already on list in another area) as referral needs to be made through GP, therefore the process started again.
- Poor experience in hospital following an overdose (no beds available) may have put the child off accessing A&E when planning suicide.
- Support to family was offered but family declined – this impacted on further support as services withdrew, increasing the vulnerability.
- Issues for children transitioning from paediatric services into adult services. There should be an earlier discussion and transition process based on individual needs.
- No health psychology service available across the Black Country
- Different agencies/services use different IT and record keeping systems – lack of information sharing.
- Anxiety around social care had not been recognised; therefore no one was able to reassure the child.
- Lack of formal monitoring of exclusions for particular cohorts of children to ensure all children (particularly those who are vulnerable from Black and minority ethnic groups, are subject of an EHCP or SEND have fair and equal access to education)

Appendix FIVE - Categorisation of Death

	Category	Description
1	**Deliberately inflicted injury, abuse, or neglect**	Includes suffocation, shaking injury, knifing, shooting, poisoning, and other means of probable or definite homicide; also, deaths from war, terrorism, or other mass violence; and severe neglect leading to death.
2	**Suicide or deliberate self-inflicted harm**	Includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. Will usually apply to adolescents rather than younger children.
3	**Trauma and other external factors, including medical/surgical complications/error**	Includes isolated head injury, other or multiple traumas, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Includes proven medical & surgical complications or errors as the primary cause of death, excludes deliberately inflicted injury, abuse, or neglect (category 1).
	To include:	sudden unexpected deaths with epilepsy (SUDEP). *These deaths should not be categorised as Category 10 (Sudden unexpected, unexplained death)*
4	**Malignancy**	Solid tumours, leukaemia, and lymphomas as well as malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
5	**Acute medical or surgical condition**	For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.
6	**Chronic medical condition**	For example, Crohn's disease, liver disease and immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Also includes cerebral palsy with clear post-perinatal cause.
7	**Chromosomal, genetic, and congenital anomalies**	Trisomy, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.
8	**Perinatal/neonatal event**	Death related to perinatal events e.g., sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, and post-haemorrhagic hydrocephalus, irrespective of age at death. Also includes cerebral palsy without evidence of cause as well as congenital or early-onset bacterial infection (onset in the first postnatal week). This category includes four subcategories: immaturity/prematurity related, perinatal asphyxia, perinatally acquired infection, other perinatal/neonatal events.
	To include:	deaths caused by perinatal asphyxia. *These deaths should not be categorised as Category 3 (Trauma and other external factors)*– should include deaths related to cerebral palsy without evidence of cause. *Deaths due to cerebral palsy with clear post-perinatal cause categorised as Category 6 (Chronic medical condition)*
9	**Infection**	Any primary infection (i.e., not a complication of one of the above categories), arising after the first postnatal week or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.
	To include:	primary infection arising after the first postnatal week, or after discharge of a preterm baby. *Deaths where there was an early-onset bacterial infection in the first postnatal week should be categorised as Category 8 (Perinatal/neonatal event) and not as Category 9 (Infection)*
10	**Sudden unexpected, unexplained death**	Where the pathological diagnosis is either 'SIDS' or 'unascertained,' at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5).
	To include:	deaths at any age where pathological diagnosis is either 'SIDS' or 'unascertained.' *These deaths should not be categorised as Category 3 (Trauma and other external factors)*

Appendix SIX – Learning from Deaths

Communication

Note-taking

Clarity in discharge notes.

Lack of documentation to confirm if an ultrasound was requested to address the antenatal concerns of the reported looped bowel.

Lack of documentation of second dose for surfactant and rationale.

A documentation error led to a missed opportunity for this treatment.

Records of resuscitation were only partially adequate making it difficult to fully assess the quality of the resuscitation.

To ensuring all relevant clinical information, including previous conversations are recorded in the medical records.

Clear documentation on the cardiovascular management of the baby on NNU.

Phone Calls

Currently phone calls out of hours into the Trust are not documented (once EPR is implemented this will support recording of all interactions).

Education is needed within the Community team around recording and actioning messages.

Not being able to get through to Triage - to ensure communication with families if this is an issue, who else could be contacted.

Communication between Services

The Trust need to support staff to communicate effectively between teams.

Better communication between Children's Services and Adult Services.

Communication with families

When parents are not engaging with services efforts should be taken to understand the reason for non-engagement.

Language barrier and perception of families understanding.

Checking in on understanding – the team may feel the family understood but this might not be the case.

The family did not always want an interpreter – BUT it is important to make sure that the best support possible is available for families whose second language is English.

Increased access to interpreters and more consistent use of 'language line' or the 'Dora' interpreting system should be used when required.

Staff need to listen and acknowledge a parent fears and concerns.

Parents had not realised that sepsis is so serious, and it can lead to death – the importance of reiterating information particularly when emotions are high.

Use of interpreting service to ensure the mothers voice is captured through pregnancy.

Clear documentation on communication with parents.

Ensure parents are kept fully informed of their baby's condition, especially during resuscitation a designated member of staff should be identified.

Although the mother spoke and understood English, the reasons for her late booking and previous admission in her pregnancy were not documented.

No documentation of the mother's wishes, choices, or concerns.

Interpretation services need to be used during the antenatal period, induction of labour, when sharing information and making decisions.

Importance of following up from family comments.

Managing parents' expectations – although babies can now survive longer, clarity around mortality still being remarkably high.

Parents requested professionals listen to the family- when they report their child is not well for their concerns to be acknowledged rather than looking at clinical picture.

Information Sharing

Tertiary Hospitals needing to share notes/plans.

NHS record keeping systems are often separate therefore valuable information is not easily available.

Clinicians may not be aware of number of attendances child has had.

There are currently no alerts on EMIS or hospital system to highlight recent attendance.

Cross Boundary Care

Process issues with cross boundary care – GP gave the responsibility to the woman to refer herself.

To clarify the criteria that decides which local authority is responsible for Care Act Section 9 and Section 42 work where there is more than one locality involved.

Importance of sharing information across the border.

IT systems

To note, for chronology, that dates recorded on EMIS are the day of notification and not date of attendance. Each contact needs to be opened to clarify the date of attendance.

One attendance/date is counted as numerous attendances due to movement through departments.

There is a need for the appropriate system integration to allow clinicians to access the investigations/results from tests in a timely manner for review and action.

Safeguarding

Ensure appropriate safeguarding referrals are done where challenges/risks to siblings.

Oversight of action plans from Child Safeguarding Practice Reviews and ensure the focus moves from task to outcome.

Understanding Intrafamilial Child/Adult Sexual Abuse.

Agencies to look at the changes within MASH to see if the DA incident should have been reported to the GP and if the threshold for referral was met.

To empower the public to escalate/report safeguarding concerns.

More robust systems for transfer of safeguarding records between schools now in place ensuring current staff are aware of significant previous life events to monitor the child going forward.

Mapping exercise of all policies and procedures to ensure frontline workers receive clear and consistent messages to refer and support women when there are concerns.

Better communication between services to plan safe discharge of babies with social care concerns.

Despite identifying the child as substantial risk with multiple aces and despite involvements with multiple agencies there was still a tragic outcome. Agencies need to review their engagement with vulnerable groups.

Professional Curiosity

Check wider family records and information from school - Especially in cases of poor engagement from family, and history of previous involvement from social services.

Clinicians should ask about history over a few weeks rather than presenting episode to demonstrate professional curiosity.

The importance of trauma informed care and professional curiosity – all agencies should be using Trauma Informed approaches.

The importance of looking at the whole family and any previous concerns e.g. there had been previous issues/concerns raised about effective supervision of the children, a pattern of issues previously there would be a different discussion.

Multi Agency Learning

Acknowledge challenge of bank holidays/covid in contacting professionals.

Covid Impact - Agencies must record a clear rationale for not undertaking face to face contacts where there are concerns emerging, however low level those concerns may be.

All agencies need to look at process/pathways to ensure accurate recording & reporting.

Services

Maternity/Neonatal

Maternity record - BadgerNet/Sunrise

To seek assurance that only one account per person can be processed.

There is no notification/alert to advise a Cardiotocography (CTG) is not to be undertaken.

Importance of reviewing previous pregnancy notes on record/IT system when taking a booking history.

Antenatal Care

Importance of home antenatal visits.

The importance of antenatal care to prepare when there is a risk of a complex birth and further complications.

Estimated foetal weights from scans had not been plotted on a chart.

Missed opportunity for aspirin (risk assessment incorrectly completed) the woman required aspirin and growth scans due to smoking status and primigravida.

As the mother was not risk assessed there was also no referral to the screening team and dedicated vulnerable women's care team to provide additional care, information and support as needed.

Missed opportunity to conduct a robust antenatal risk assessment.

For a future pregnancy optimising blood pressure control before embarking on pregnancy would be important given the placental histology findings.

Specific guidance for the transfer of care for mothers who have received earlier antenatal care elsewhere in another country.

There should have been a discussion between the paediatric and obstetric team regarding utero-sepsis when considering induction of labour.

Referral to haematology and immunology investigation was needed, in relation to poor pregnancy outcome.

When a woman has a history of adverse pregnancy outcome ensure the care in pregnancy is appropriate

Parents could opt for pre-implantation genetic testing and should seek advice from the fertility department for other options (e.g., gamete donation) with support from the team.

Birth options for this pregnancy were not discussed; pervious C-sections meant the woman should have been referred to VBAC.

The Fetal Movement Checklist should be used for each admission.

Smoking during pregnancy increased the risk for placental abruption.

Smoking during pregnancy can have an impact on congenital heart problems.

This mother missed some of her antenatal appointments but was not followed up according to the local DNA policy.

At 34+0 there was a missed opportunity for steroids.

The baby was not identified as IUGR, although small for gestational age at birth.

To take care during the antenatal scan at all times.

Drug testing should have been offered through pregnancy.

If the booking midwife had reviewed the previous pregnancy, there would have been an earlier referral to the Specialist Midwife for Vulnerable women.

Hypertension and maternal tachycardia were not adequately investigated.

Preterm Labour/Threatened Preterm

Not offered antenatal steroids when they were indicated or magnesium sulphate for fetal neuroprotection when this was indicated for preterm labour/threatened pre term labour.

There is a link between maternal mental health and increased risk in prematurity.

With extremely premature births, if the baby is born in good condition, it would be good practice to consider delayed cord clamping.

To explore practise within other Trusts in relation to the use of size 2 ET tubes for extremely preterm births. (team were unable to intubate the baby with a 2.5 ET tube and there was discussion around the use of a size 2 ET tube, but this would not allow the administration of any drugs).

Transfer of care/Tertiary unit

The decision to transfer the baby to another unit could have been made sooner.

Persistent high oxygen requirement post surfactant should be discussed with tertiary unit. At point of slow or non-response to surfactant - level 3 care is needed and babies should be transferred.

Did not give birth in a setting appropriate to clinical needs, although efforts were made to contact nearby units, they were unable to accept as IUT and mother then progressed rapidly.

Is it appropriate for babies with gastroschisis to be born at level 2 units? This was raised with the neonatal network and the gastroschisis guideline is in the process of being reviewed.

The mother should not have been referred from ED to an out of area hospital for maternity care when there is Maternity Triage available.

Neonatal

Baby should have been admitted to the neonatal unit sooner.

Examination and documentation must be completed for all babies admitted including a skin assessment.

The ongoing skin care of the baby on the neonatal unit was not appropriate.

The ongoing management of pain and/or sedation for the baby was not appropriate.

Umbilical lines must be secured before moving the baby from delivery theatre to NNU.

Fluid management of the baby during the first 24 hours of arrival was not appropriate.

Thermal management of the baby during the first 24 hours of arrival was not appropriate.

Nutritional management of the baby during the first 24 hours of arrival was not appropriate.

Respiratory management of the baby during the first 24 hours was not appropriate.

Cardiovascular management during the first 24 hours of was not appropriate.

During the first 24 hours of the baby's arrival, appropriate lines were placed but their position was not radiologically confirmed.

Importance of maintaining temperature following delivery and x-rays to confirm line positioning.

Detailed Neurological examinations to be undertaken on the Neonatal unit and to include examination of the pupils.

Cord gases to be processed within 1 hour of the baby’s birth.

During resuscitation of the baby appropriate drugs and fluids were given but one or more was given at an incorrect dose/volume.

Baby was resuscitated but delayed cord clamping was not instituted although this was indicated.

During resuscitation, the baby was given a blood transfusion (which was appropriate) but there was a delay in giving the blood (a process is needed to reduce time from request to receiving blood.)

In a resus situation where drugs are indicated preference is for central access UVC or if not able to obtain, IO access.

There is a need to provide management of thermal control when commencing Cooling in HIE babies, following Neonatal network guidelines and management of Cooling.

Baby had a haemodynamically significant PDA for which a second course of paracetamol would have been indicated.

Reinforce planning around Neonatal alerts, particularly those that involve airway guidance, to make sure that when teams deliver there may be a problem. If a facial anomaly had been identified, it will potentially be a difficult airway.

To ensure that all babies who are reluctant to feed are monitored using their reluctant feeder pathway.

Datix report to be completed when difficult airway policy is instigated.

Ensure medical & ANNP teams are aware of the requirement to sufficiently secure umbilical catheters prior to movement of the baby.

All staff must be aware of the escalations required when managing a difficult airway.

Obstetric Care

Assessment of the mother's risk status during labour.

Ensure local policies reflect need to administer surfactant in delivery room whenever possible.

All obstetric reviews to be documented.

To review the process for a central storage place for CTG's undertaken on the Maternity unit and Day Assessment Unit.

To screen for infection within the first hour if there are clinical concerns.

Community Care

Panel discussed boiling water being given, but as a breastfed baby, no cool boiled water should be given.

When the Baby identified as a reluctant feeder, emphasis was given to improving skin to skin contact and hand expressing breast milk -- this meant that there was not sufficient attention given to other causes of poor feeding.

The Did Not Attend (DNA) policy was not followed (should have been a home visit)

There was a missed opportunity to give postnatal steroids in the third week of life.

Free Birth - terminology

To clarify the terminology used; 'free birth' 'unassisted birth' 'born before arrival' are not confused with 'home birth.

When speaking about freebirth; to make it explicitly clear to families that the lack of ante-natal care means that potential risks to both the mother and baby may not be recognised and there is an increased risk of death with freebirths in these circumstances.

Foetal Medicine

To look at pathway when there is a discrepancy between initial anomaly scan and detailed fetal medicine scan (views were suboptimal)

To remind staff in foetal medicine to refer and investigate appropriately when women have abnormal observations.

Placental Histology

The placenta was destroyed before the opportunity to send placenta off for placental histology.

The importance of placenta being sent for histological examination.

The placenta was not sent for histological examination – missed opportunity to support family.

with future pregnancy plans.

Paediatric Care

To improve communication for patients with a poor medical prognosis who are not on a palliative pathway and therefore do not have an ACP.

To raise awareness of the need to check Liver Function Tests in patients on sodium valproate who develop gastrointestinal upset.

Endocrine have revised the advice they give to families regarding care after Bisphosphonates. This includes reminding the parents to give stress doses of steroids in children with pituitary insufficiency.

Delay in requesting an image meant a delay in identifying the issue and infant's clinical condition and decision making.

Long wait for tertiary review meant this child was not seen at the time of death (only by Junior doctors not the consultant)

NICE guidelines recommend consideration of a night monitor (the family were using a baby monitor) - Epilepsy monitors not available on the NHS at present.

Good practice would have been to have completed the screening at an earlier opportunity upon presentation to PAU and IV antibiotics considered at this point; however, the infant did not display the typical markers of sepsis.

E-Coli positive was resistant to all antibiotics.

Paediatric Epilepsy team to consult with Genetics colleagues to consider a formal testing protocol based on NICE guidelines (to reduce delays)

Raise awareness within the Paediatric and ED teams for a conference call via the KIDS team.

Error in completion of the initial KPSRC screening tool for sepsis. To ensure that all details of the seven parameters are inputted correctly and double checked for accuracy.

Patient journey in the hospital to be reviewed and improved if possible.

Asthma

Suspected Asthma needs regular review and clear information given to parents about use preventer inhalers.

Clear written wheeze plan for escalation of treatment and when to seek medical attention.

Inhaler technique needs to be checked during face2face contact.

Safety net information needs to be clearly documented in medical notes and coded.

Health Psychology Service

Importance of the need for health psychology for complex in-patients with chronic medical conditions.

Paediatric Palliative Care

Importance of an out of hours palliative care service in the community for families to have the option for end-of-life care at home.

There is currently no 24-hour palliative care/community nursing care available to families.

Parents could not be offered a choice around their discharge into the community.

A formal 24/7 palliative service would have benefited this child and other children with life limiting conditions.

To highlight the importance of referral to Acorns earlier, prior to death.

Importance of implementing an Advanced Care Plan document for palliative care neonatal cases.

Palliative patients wanting CPR need to be made aware that the SUDIC process is automatically triggered with an unexpected collapse/cardiac arrest.

Opportunity for parents to express their preferences about end-of-life care.

Early recognition & instituting parallel planning in a child with life-threatening/ life-limiting condition can help parents' understanding their values & prepare for a more seamless journey when care is redirected towards prioritising comfort vs curative.

Transition – Paediatric into Adult services

Transition between paediatric to adult services needs to be robust.

Establishment of smooth transition of care to adult team.

Importance of reminding hospitals of transition process/review of transition process.

Genetics

Better understanding of the genetic testing process.

Wide sharing of learning from this case to address awareness of POLG mutations.

To remember to send Cystic Fibrosis genetics in cases of meconium ileus.

Primary Care

GPs receive duplications of correspondence from NHS111 so risk overlooking valuable information.

Childrens Services

Look at developing information for family and young people when a referral is being made to Social Care (what to expect, what it means etc)

Completion of quality holistic assessments, which address all the needs of the individual child prior to sign-off.

Child in Need is timely, recorded and shared as per agency information recording and sharing policies.

Managers should be sighed on Child in Need cases where no progress has been made.

To challenge slow progress and escalating cases where insufficient progress has been made.

Concern' referrals are investigated with the same rigor as those for children subject of a Child Protection Plan or referred for the first time.

Maternal Grandparents should have had a further assessment for suitability to care for the baby.

Mental Health Services

There appeared to be little support offered by Adult Services, for mother, and the overall quality and depth of the Mental Capacity Assessment for mother.

There was no access to adult mental health services for the parents despite frequent escalations from the oncology team about concerns for their mental health.

Child was not seen for 14 days post discharge due to communication difficulties.

A recent move from paper to electronic system meant the risk assessment and care plan were not recorded in the correct place.

To address children with mental health conditions (on Ward 21) but under the care of the child and adolescent mental health service.

Clarity of Cognitive Learning Deficit assessment and diagnosis - where a person has been appointed for assessment and they then move area, the information should be forwarded to the new locality or that the referrer is informed.

Health Visiting

When parents reside in different addresses, it is good practice to visit both residential properties for evaluation.

The Was Not Brought (WNB) policy was not followed.

Health visitors should be recommending Vitamin D for under 4 years old. In some areas these are provided and in others they are not.

Care of Next Infant (CONI) Scheme was not available at the time of the new birth.

Importance of follow up of the missed 2-year development check in community.

Learning Disability And /Or Autism

A gap in service provision, including education psychology for autism post diagnosis (Exploring the Autism service across the Black Country)

Education

For schools to promote awareness of mental health issues, deliberate self-harm and suicide to encourage quicker escalation.

Impact of home learning and isolation from school (during Covid in this case) in child with difficult home circumstances.

Urgent Treatment Centre

All preschool children attendance to UTC should be notified to Health Visitor service - HV service not notified of NHS111 or UTC attendances.

Emergency Services

West Midlands Ambulance Service (WMAS)

Consider a flag system within to identify newly qualified to ensure Newly Qualified Paramedics re not dispatched as a solo response.

When choking is reported – to check the airway using the laryngoscope. Foreign Body Airway Obstruction should always be considered during paediatric cardiac arrest.

Basic Life Support should have commenced even if the child is unconscious to dislodge the foreign body.

That agreement take place on scene about who passes the alert to Trust/A&E.

Critical Care Paramedic to check with crews about assistance before any assumptions are made about travelling.

A team leader for clinical support and scene management should be considered in time critical situations to avoid delays on scene and should not be limited to cardiac arrest management.

Learning has been shared with the Ambulance service to ensure that under 18's are taken to ED.

111/999 service

The importance of experienced midwives (or appropriately trained clinicians) within the call centre.

To allow passive listening to call where early dispatch of enhanced care services would benefit patients and improve care outcomes.

Information from the caller had not been heard by the call assessor who had become task focussed. (Had the correct answer been selected the call assessor would have been presented with delivery instructions for a breech birth rather than for a normal delivery.)

Difficulties in family communication with WMAS may have led to delays.

Mother was not sure how to contact emergency services (new to the UK).

Specific areas of learning

Stabbing and youth violence

Effective assessment processes in use to consistently capture and consider social and structural factors in a child's life.

Training and workshops to provide further education and awareness raising about the role that social media plays in the amplification of issues that may culminate in violence.

Track and analyse the location and times of incidents to ensure that interventions are delivered at key times and in problematic locations.

Ensure all sectors are aware of the potential risks a child may be exposed to if they are known or suspected to be "freelancing.

Appropriate safety planning and intervention to respond to identified levels of risk.

Intelligence provided by parents, carers and the wider community need to be appropriately considered.

Equitable, consistent, and carefully considered messaging and awareness raising about serious youth violence and knife crime.

Importance of relatable practitioners with lived experience and ensure that children who lack positive male influence are able to access support and intervention from positive male role models.

Consistent, equitable and appropriate support and interventions are put in place to support and protect the families of victims and perpetrators.

Support and training to schools to enable practitioners to understand and respond to issues and complexities presented by the "peer paradox."

Debt is believed to have been the catalyst for the assault, and it is understood that debt between school peers is an increasing problem with a potential for violence as a result.

Safer Sleep

Although safer sleep campaign established and discussed with mother - this is still a public health issue that needs strengthening.

Child Death Review Process

Importance of Vitamin D testing to be included in SUDIC samples.

The SUDIC box in ED was not fully equipped – this is now in place and is on the nurses daily check list.

Staff were unfamiliar with the new chain of evidence forms and samples being taken to the lab.

The SUDIC process was delayed (one week later) and did not include the police to make an appropriately timed conversation.

Correct SUDC process needs to be followed for all children and young people with sudden unexpected deaths up to 18 years of age.

Police were not informed of child's death in a timely manner and were not present for top to toe examination.

Missed opportunity to initiate the SUDI process or take samples from the child in line with the SUDIC policy.

SUDIC joint home visit with WMP and Health is still not in place in one area.

Home visit not completed as felt to be a medical cause following a multi-agency discussion – highlighted the importance to ensure the documentation is clear that the immediate decision making with a multi-agency team.

Death Abroad

A death abroad can often provide little information, particularly the cause of death.

Access to a Post Mortem document is often limited in the case of a child death abroad.

A more unified approach is required, but this relies on the information provided to the foreign office at the time of death.

Coroner

Certification of death needs to be completed as close to the point of death as possible.

Post Mortems

At present there is a shortage of paediatric pathologists in relation to PM's taking place which is causing delays across the UK in process time, this did not have a significant impact, however the transporting of the body from A-B-C can have an impact on the status of the body.

Support for families following Child Death

Importance of a speedy referral for the family for a cardiac review for other family members.

There should be timely feedback to answering family questions in their preferred format; letter, verbal, face to face.

Lack of bereavement support available for both families and staff.

To support the family with answers when ready for that conversation.

Where bereavement support is declined, understanding the reason for the decline in support and identifying an alternative option for bereavement care to ensure a neutral offer.

Staff Support

Staff should be encouraged to challenge when procedures are undertaken by a colleague who is not trained to undertake.

Ensure all staff are competent with advanced skills.

Staff should know it is not acceptable to undertake a procedure for which they have not received training.

Staff need to listen to the parents' views.

To ensure there is supervision and managerial oversight or other overview of practice processes (whichever is relevant) is robust, of high quality and in line with relevant policies and best practice.

Following a Child Death

The importance of a debrief - moral distress from surgical team & PICU. It was important for the team to be reassured there was a dignified end.

A debrief should include all professionals.

A listening session for staff – a neutral platform to prepare & support frontline staff in managing challenging cases (empowering staff to manage moral distress and feeling listened)

Bereavement service access for all professionals when needed.

Staff Training

Perinatal postmortem consent training – there should be no more than two attempts at intubation and then to consider another clinician attempting.

Training for communicating sad news should be available for all staff.

A reminder of the requirement to achieve tasks within the golden hour.

SUDIC protocol training to highlight the new chain of evidence forms and samples being taken to the lab.

Adult Intensive Treatment Unit need to be aware of the SUDIC process for a child who is admitted into their care.

Appendix SEVEN - Acronyms

Within this document and/or may be used during the Child Death Review process.

AICU	adult intensive care unit
ACDRP	Association of Child Death Review Professional
ACP	Advanced Care Plans
BCCDOP	Black Country Child Death Overview Panel
BCICB	Black Country Integrated Care Board
BMI	Body Mass Index
CAMHS	Children and Adolescent Mental Health Services
CDOP	Child Death Overview Panel
CDR	Child Death Review
CDRM	Child Death Review Meeting
CICU	Cardiac Intensive Care Unit
CSPR	Child Safeguarding Practice Review
DD	Designated Doctor
ED	Emergency Department
eCDOP	Computer system that holds all the documents/data for child death.
EPR	Electronic Patient Record
HSIB	Healthcare Safety Investigation Branch
ICU	intensive care unit
IUT	Intrauterine transfusion
IVF	In Vitro Fertilisation
JAR	Joint Agency Response
LA	Local Authority
LeDeR	Learning Disabilities Mortality Review
LMNS	Local Maternity and Neonatal System
MCCD	Medical Certificate Cause of Death
MBRRACE-UK	Mothers & Babies: Reducing Risk through Audits & Confidential Enquiries
MNVP	Maternity and Neonatal Voices Partnership
NCMD	National Child Mortality Database
NICU	Neonatal Intensive Care Unit

PICU	Paediatric Intensive Care Unit
PMRT	Perinatal Mortality Review Tool
PM	Post Mortem
SIDS	Sudden Infant Death Syndrome
SUDI	Sudden Unexpected Death in Infancy
SUDC	Sudden Unexpected Death in Childhood
SUDIC	Sudden Unexpected Death in Infancy/Childhood