Agenda Item 12

Health and Wellbeing Board

13 June 2024

Child Death Overview Panel Annual Report

For Information

1. Purpose of paper.

- Update the Walsall Health and Wellbeing Board on activity and data for the statutory Black Country Child Death Overview Panel (BC CDOP) for the period 1.4.2022 to 31.3.2023.
- Outline the challenges, issues and responses seen in Walsall relating to child deaths in this period.

2. Recommendations

That the Health and Wellbeing Board

- Note the update.
- Agree to receive future reports and any accompanying recommendations for learning from the Strategic Child Death Overview Panel process.
- Agree that board members will disseminate the learning and recommendations across their respective organisations and implement these as relevant.

3. Report detail

Background and Context

3.1 The Child Death Review process is an analysis of deaths of children who die in England from birth to 18 years of age. Child Death Overview Panels are statutory bodies and are accountable to their respective Local Authorities and Integrated Care Boards. Every child death is a devastating loss that profoundly affects the family involved.

3.2 In addition to providing support to families and carers, staff involved in the care of the child should also be considered and offered appropriate help.

3.3 The Black Country Child Death Overview Panel is a multi-agency panel set up to conduct the independent scrutiny on behalf of the local Child Death Review partners on the reviews of deaths of children normally resident in the Black

Country. With an independent Chair and representatives from all commissioner and provider organisations across the Black Country, its aim is to learn lessons and share findings around the prevention of child deaths.

3.4 Learning lessons from CDOP activity is a priority and will have a positive impact on the future safety, health and wellbeing of children and young people, ensuring that learning is shared widely across the area, as well as regionally and nationally.

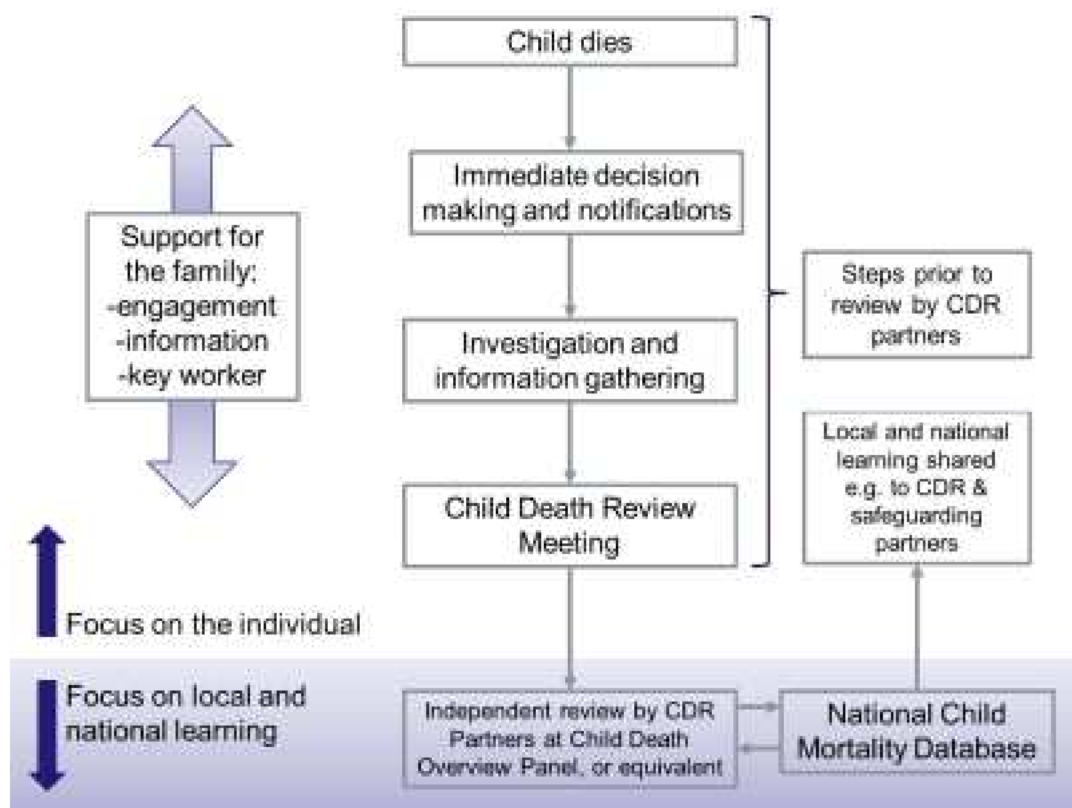
3.5 This report details the statistical and qualitative conclusions from the Child Death Overview Panel Reviews in the Black Country during the reporting year April 2022 to March 2023. The full annual report of the BCCDOP is appended.

3.6 The purpose of a child death review is:

(a) to identify any matters of concern affecting the safety and welfare of children relating to the death or deaths.

(b) to consider any actions or recommendations that can be taken based on a death, or a pattern of deaths to identify trends that require a multidisciplinary response to enable learning and prevent future death.

The CDOP process is summarised as follows:



Black Country Child Death Overview Panel - Operational Overview

3.7 The Black Country CDOP comprises senior multi-agency professionals who have knowledge and expertise in fields such as children's social care, paediatrics, police, public health and education. Each professional provides information and advice to enable a thorough review and analysis, with the aim of identifying relevant factors, modifiable factors and emerging themes.

3.8 In the Black Country, the child death review partners are the Black Country Local Authorities and the Integrated Care Board.

3.9 Each of the four Black Country areas contribute a pro rata amount of funding to support the work of the Black Country CDOP Coordination team and fund actions based on learning across the whole area. Walsall contributes £14,145 per annum.

Governance

3.10 The CDOP process is overseen by a Strategic group consisting of partner agencies, including police, public health consultants and safeguarding partnerships. The steering group meets on a quarterly basis to ensure the statutory function of CDOP is being robustly implemented and to highlight and address any concerns.

3.11 Elements of good practice, learning and modifiable factors are identified at this meeting and reported to Child Death Review partners through Multi-agency Safeguarding Partnerships and Health and Wellbeing Boards as appropriate. The Strategic partnership is also responsible for setting the budget, structure and making recommendations to agencies where concerns are highlighted.

3.12 Further information is provided on a quarterly basis from CDOP to the Walsall Safeguarding Performance, Quality & Assurance Group for action and review.

The National Child Mortality Database (NCMD)

3.13 The National Child Mortality Database (NCMD) is a repository of data relating to all child deaths in England commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and is delivered by the University of Bristol, in collaboration with the University of Oxford, University College London (UCL) Partners and the software company QES. The NCMD enables more detailed analysis and interpretation of all data arising from the child death review process, to ensure that lessons are learned, that learning is widely shared and that actions are taken locally and nationally, to reduce child mortality. The introduction of the NCMD aims to learn lessons that could lead to changes to improve outcomes for children.
As of the 1 April 2019, it became a statutory requirement that CDOPs across England submit data via the NCMD. The Black Country CDOP continues to use

a web-based system that submits the required data and reports are received on a quarterly basis summarising submitted data.

3.14 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 has been identified as potentially relevant 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.

3.15 CDOP reviews are held regularly, reviewing both deaths of children 28 days to 18 years and a themed Panel addressing all Neonatal cases (0-27 days) in 2 separate meetings. 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.

4. Progress over the past year within the Black Country CDOP

4.1 Black Country CDOP Achievements

- Child Death Review partners have supported the priorities and deliverables from the Local Maternity and Neonatal System, a body established to oversee work within the maternity services system and ensure national and regional guidance is adopted. CDOP have engaged further in sub-groups to ensure a more joined up way of working.

- CDOP has led on embedding the Dudley Safe Sleep Protocol across the whole of the Black Country which has been shared with all partners in the health, social care and voluntary sector working with infants.

- In response to the data regarding deaths involving traumatic head injury, CDOP provided each Black Country area with12 “shaken baby” dolls for practitioners to use in advice work with new parents.

- Bleed kits have also been provided to each Black Country area to be sited alongside defibrillators. Once placed, these will provide equipment for immediate use by members of the public and agencies in cases of sharp trauma in public places. The locations in Walsall are being coordinated by the Walsall community safety team.

- Positive Recognition - In order to recognise and encourage good practice, or where agencies have gone above and beyond their expected duties, CDOP continue to send letters commending good practice. Whilst it is the panel's responsibility to identify learning and trends from child deaths across the Black Country, the panel feel it is important to recognise the excellent care that professionals provide for the children and families that they work with. As an example, a letter was sent to Walsall Healthcare Trust for the support set in place to allow a child to die at home.

4.2 Child Death Notifications

4.2.1 From 1st April 2022 – 31st March 2023 there were 128 deaths notified across the Black Country for children under the age of 18 years. Out of these, 96 were reviewed by the Black Country CDOP. The remaining cases are still under the CDR review process and are taking longer due to the need for further investigations.

4.2.2 Over the four-year period of 2029-2022, a total of 416 Child Death notifications have been received within the Black Country CDOP with a gradual rise since 2020.

4.2.3 Dudley, Walsall, and Wolverhampton all saw an increase in child death notifications during 2022- 2023 compared to the previous year, whilst Sandwell had the same number of notifications (figure 1).

Figure 1 Child Death Notifications by area over 4-year period

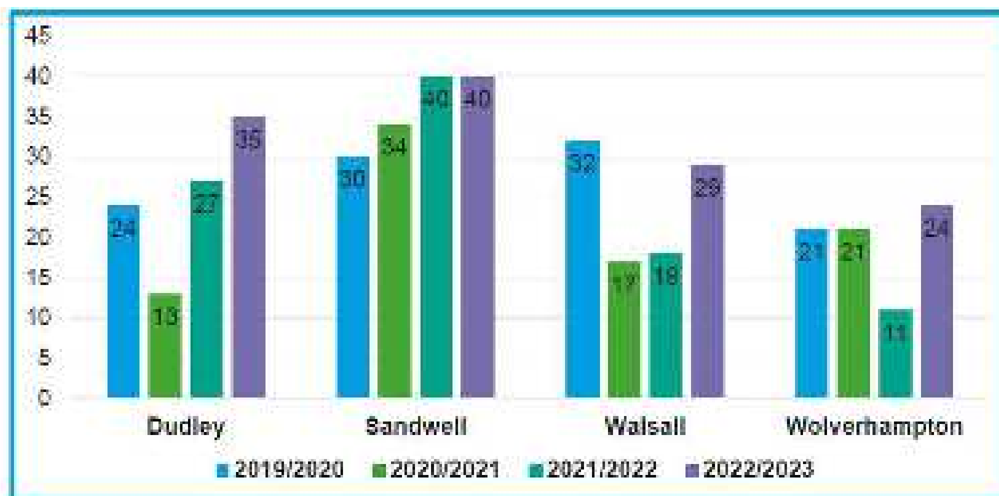
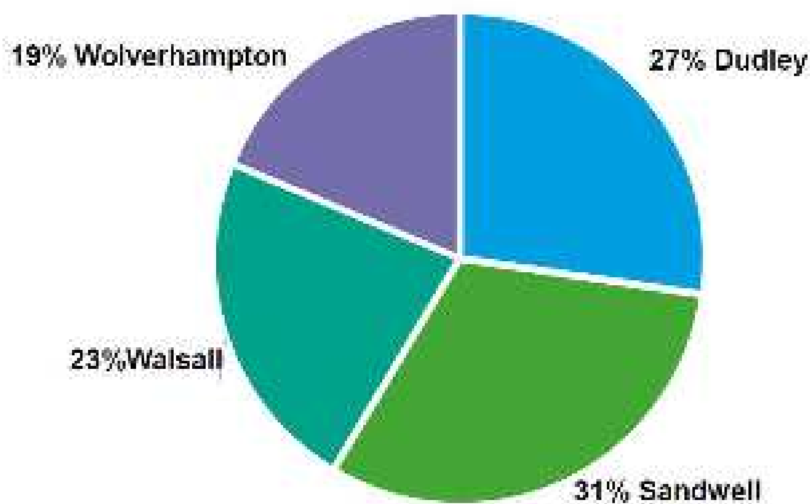


Figure 2 illustrates the percentage of child deaths in each Black Country local authority area.

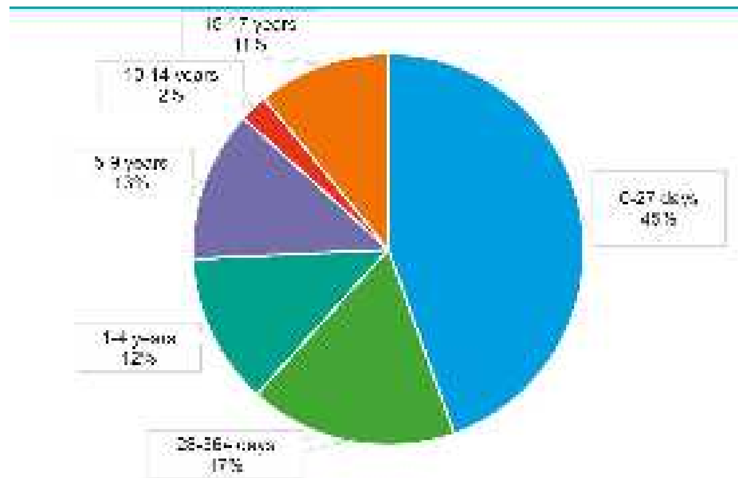
Figure 2 Percentage of child death notifications across the Black Country by area.



4.3 Age Breakdown for notified Child Deaths

4.3.1 Of the 128 child death notifications across the Black Country in 2022/23, 57 were in children aged 0-27 days, 22 were aged 28-364 days, 16 were in the 1-4 years age range and 16 were aged 5-9 years. 17 notified child deaths were in children aged 10 years and over (Figure 3).

Figure 3 Breakdown of child death notifications by age (Black Country)



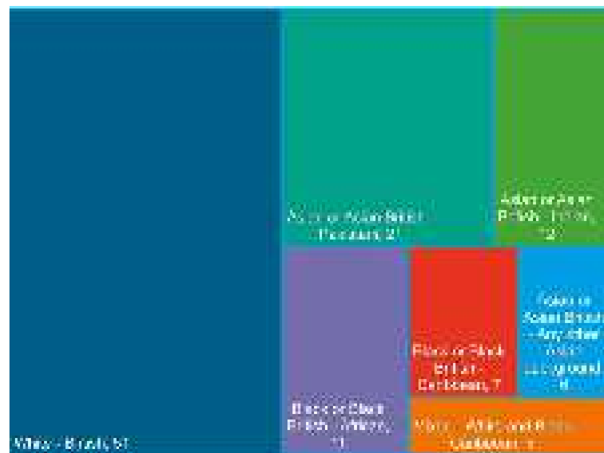
4.3.2 62% of all child death notifications are in children under one year of age in the Black Country, compared to 59% across England (figure 4). Deaths in children aged 5-9 are higher in the Black Country than in England

Figure 4 Child Death Notifications by age (Black Country & England)

4.4 Ethnicity breakdown for notified Child Deaths

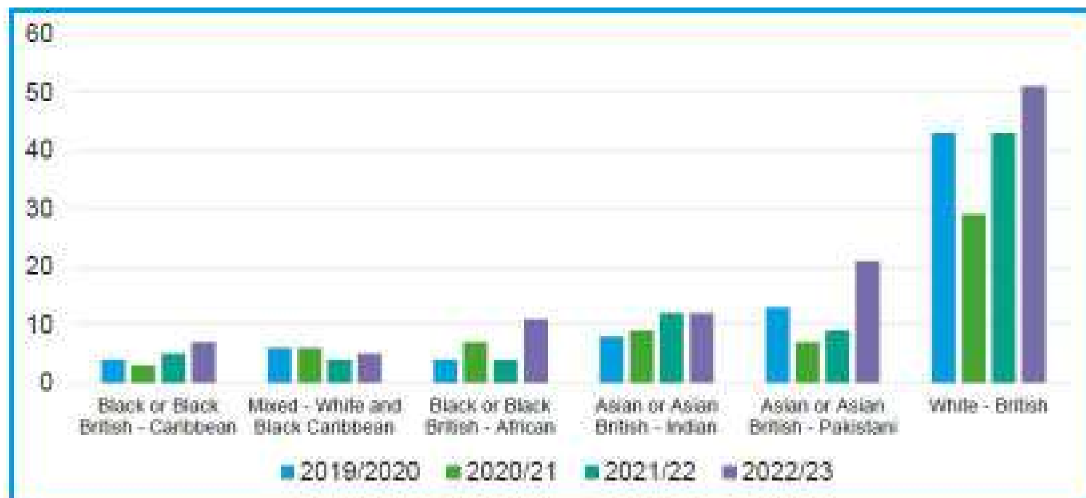
From 1st April 2022 – 31st March 2023, of the 128 child death notifications across the Black Country, 12 different ethnic groups were identified, although some were coded as not known/stated and not applicable (Figure 5).

Figure 5 Breakdown of Child Death Notifications by ethnicity.



4.4.1 There has been a notable increase in child death notifications for Black or Black British – African, Asian, or Asian British – Pakistani and White British but not in Asian or Asian British Indian communities in 2022/2023 compared to previous years(Figure 6).

Figure 6 Child Death Notifications by Ethnicity over a 4-year period



4.4.2 Walsall Council's Business Insights Team supported the Child Death Overview Panel Team with a deep dive into data around ethnicity. The team noted although a small sample size there are indications of a clear correlation between the number of deaths and ethnicity with 60% of all deaths from non White-British communities.

4.4.3 Although the figures for mortality are small, a statistically significant increase in child death for some ethnicities was noted when comparing the infant deaths against the live birth data as a percentage for each ethnic category. For example in 2021, where White British children accounted for 48.5% of live births in 2021, 41.7% of deaths were in White British infants, a significantly lower proportion.

4.5 Deprivation breakdown for notified Child Deaths

Of the 128 Child Death Notifications, 124 cases had an identifiable postcode that could be checked against the Index of Multiple Deprivation Decile (2019). Of these 124 cases, 103 (83%) lived in the 40% most deprived areas. Sixty-two percent of child deaths (77 deaths) occurred in the 20% most deprived areas of the Black Country.

5 Modifiable Factors identified in Child Death Reviews

5.1 The modifiable factors are determined by Panel members during the BCCDOP meeting and categorised within domains (figures 7 and 8). Of the 96 Child Death cases that were reviewed (remaining cases still in the child death review process), 42 cases had no modifiable factors identified. 53 cases had modifiable factors identified and 1 case had modifiable factors not known. Of the 53 cases with modifiable factors, 36 of these had one modifiable factor identified with 17 having multiple modifiable factors.

Figure 7 .Modifiable factors in child deaths, grouped by domain

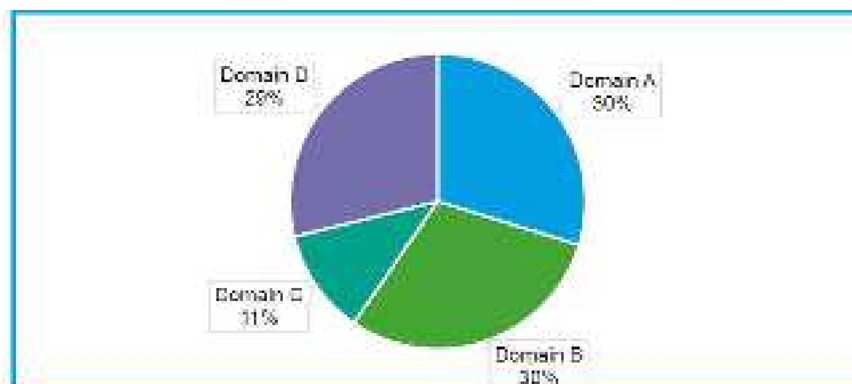


Figure 8. Examples of modifiable factors by domain

Domain A – Factors intrinsic to the Child	Domain B – Factors in the Social Environment
High Maternal BMI (ranging from 30.7- 54.9) Low Maternal BMI (16.8-17.8) Smoking in Pregnancy Baby's sleep position Ability to meet the needs of the child. Co-sleeping Risky behaviour -consuming alcohol, recreational drug user, smoking, vaping	Smoking in the household Domestic abuse/Emotional abuse Lack of supervision Mental Health (impact on mothers DNA) Delay in presenting to Triage. Overcrowding No food in the house Parental substance misuse Late booker to the Midwifery service
Domain C – Factors in the Physical Environment	**Domain D – Factors in Service Provision**
Smoking in the household Driving a vehicle illegally at a young age Inappropriate labelling on a product Overcrowded/busy/chaotic household. Poor home conditions observed. Poor hygiene observed. Evidence of co sleeping	Management of neonate in the first 24 hours. Missed opportunities to refer/transfer/escalate. Communication issues – language barrier Lack of information sharing between services Missing records Delays - attendance, results, treatment Differing opinions between clinicians/Trusts ACP not shared or known by all services

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

5.2 Smoking continues to be the most common modifiable factor identified by the Black Country CDOP, with maternal smoking in pregnancy and household smoking a factor in deaths categorised as a perinatal/neonatal event and in sudden unexpected, unexplained deaths i.e. in the youngest age groups. Walsall Public Health commissions local stop smoking in pregnancy services for pregnant smokers which in 2022/23 saw 311 clients with 133 quitting (39.3%). This is similar to previous year where the quit rate was 39.2%. A pilot project to support partners to quit has also been set in place funded by the Integrated Care Board to reduce the risk of maternal relapse after the baby's birth. More work needs to happen across the partnership however to encourage all women of childbearing age to quit smoking before pregnancy.

5.3 Maternal obesity, where the mother has a raised body mass index (BMI) of 30+ during pregnancy is also a modifiable factor in perinatal/neonatal deaths. The Health in Pregnancy service funded by Walsall Public Health has a programme to support women to manage their weight during pregnancy. Although it is ideal that women are a healthy weight before they enter a pregnancy, the support to eat healthily and maintain weight is key.

5.4 Maternal alcohol and/or substance used/misused during pregnancy is another factor identified. The Walsall Beacon offers particular support to women identified as using substances both in pregnancy and post birth.

5.5 Multiple modifiable factors were also identified (antenatally and postnatally) in sudden unexpected, unexplained deaths with the most common being unsafe sleeping arrangements where parental alcohol and/or substance misuse was a factor. The CDOP work across the Black Country to widely

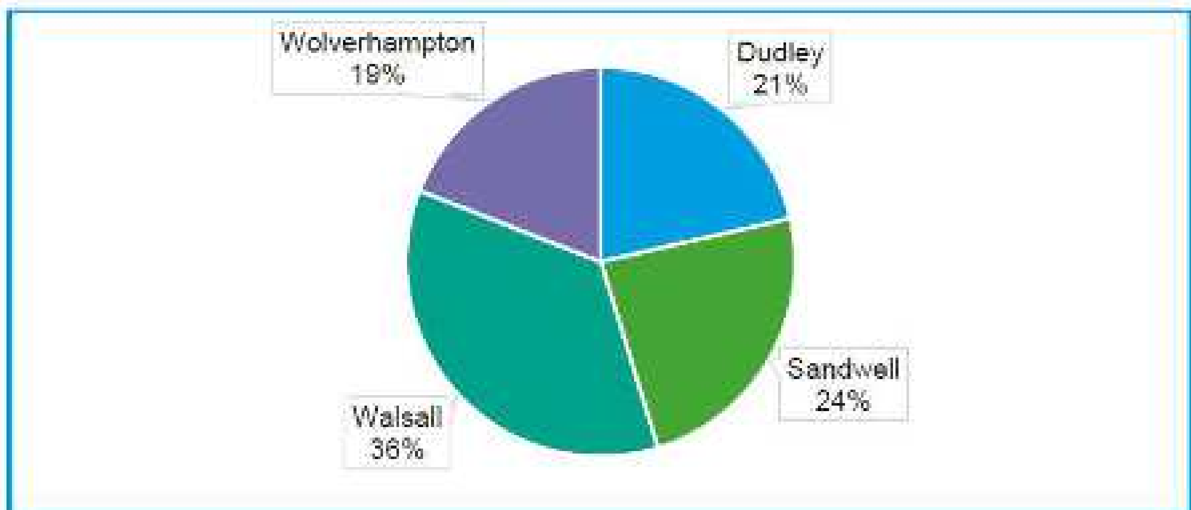
disseminate the Dudley Safe Sleeping Protocol is a positive response to this finding.

6. Sudden Unexpected Deaths requiring a Joint Agency Response (JAR)

6.1 In 2022/2023 in the Black Country there were 42 child death cases notified that required a Joint Agency Response (JAR). These are referred to as Sudden Unexpected Deaths in Childhood (SUDIC) and undertaken when the death was unexpected

6.2 Of these 42 cases, 28 have been reviewed completely and closed. The other 14 cases are subject to ongoing investigations and/or information to be shared before the case can be referred to CDOP for the final review. Figure 9 illustrates the higher proportion of unexpected deaths requiring a JAR in Walsall (15 cases) compared to other areas (Wolverhampton 8 cases, Dudley 9 cases, and Sandwell 10). With small numbers, which fluctuate year on year, there are no straightforward conclusions to be drawn on numbers; however, for every review, CDOP ensures any modifiable factors are identified and recommendations to reduce these in the future are shared widely.

Figure 9. Joint area response (JAR) by area



6.3 Of the 28 cases in which a JAR has been completed, the following categories have been identified in 5 or more cases:

- Sudden unexpected, unexplained death (10 cases)
- Chromosomal, genetic, or congenital anomaly (7 cases)
- Acute medical or surgical condition (6 cases)
- Chronic medical condition (6 cases)
- Infection (5 cases)

7. Future Priorities for Black Country CDOP

The CDOP team has highlighted the following priorities to be addressed by the BCCDOP Strategic Partnership:

- Family/Parent engagement, to ensure understanding of the Child Death Review Process.
- Feedback into the Child Death Review process and appropriate support and services offered to parents, family, and siblings.
- Consider an update to the Black Country SUDIC protocol on release of the updated Kennedy Guidelines. (guidelines for professionals on being be sensitive to the needs of grief-stricken parents while also enabling investigations and explanations to be found when a child dies)..
- Highlight and share good practice and consider auditing implementation of good practice.
- Implement a process for cases where a Learning Disability and/or Autism is suspected/diagnosed, following review, the learning is shared with the LeDeR Manager.
- Maintain the formal Governance structure to ensure oversight of Child Deaths across the Black Country.
- Improve the sharing of learning across the Black Country and continue to develop the CDOP contact list.
- Develop a surveillance model to allow further deep dives into the CDOP data.

8. Health and Wellbeing Priorities:

8.1 The key Health and Wellbeing Board priorities are Children and Young People, Mental Health and Wellbeing and our Digital Approach. The focus in this report is;

- to improve maternal and new-born health
- to support young people's physical and mental health.

8.2 Working to reduce child deaths and in particular, infant mortality, is a role for all in Walsall and not just the statutory sector. The role of voluntary and community teams is also key in for example; delivering programmes to support women's health and wellbeing, provision of safe sleep messages at every opportunity and also ensuring support to maintain young people's mental resilience.

8.3 Walsall Public Health are working with partners to refresh the Walsall Infant Mortality Strategy and this will be brought to the Health & Wellbeing Board for ratification.

9. Health Inequalities

9.1 Addressing health inequalities requires action across all agencies and needs to cover the social determinants of health. Many of the contributing factors for child deaths are in the social and physical environment e.g. overcrowding, poor home conditions. Disadvantage starts before birth and accumulates

throughout life and children born in disadvantaged environments are at higher risk of child death.

9.2 Through actions undertaken as a result of CDOP learning, reductions in modifiable factors can be attained.

10. Safeguarding

10.1 Recommendations and actions arising from the CDOP annual report directly support child safeguarding and will benefit the most vulnerable people in our borough.

11. Implications for Joint Working arrangements:

11.1 In order to reduce unexpected deaths in Walsall, Health and Wellbeing Board members are asked to;

- Agree to disseminate the learning and recommendations from CDOP reviews across their respective organisations and implement these as relevant.

- Be willing to communicate with the HWBB any activities that their organisation has taken in response to the shared learning.

11.2 In particular, board members are asked to:

- Share the information within this report across their organisations
- Share feedback from parents/families following the death of a child to inform the Child Death Review process.
- Share with CDOP through the representatives on the steering group where actions/changes to practice are made as a result of learning from this report.
- Share with CDOP any examples of good practice in individual areas already happening that can be reflected in other areas/services.
- Highlight to CDOP initiatives delivered as a result of learning from the annual report, that reduce the prevalence of modifiable factors including;
    - Safer sleeping
    - Smoking
    - High Maternal BMI
- Consider their contribution to an area specific deep dive into deprivation and ethnicity

Background paper

Black Country Child Death Overview Panel Annual Report 2022-23

BCCDOP 2022-2023
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