Health and Wellbeing Board
25 January 2022

Agenda item 11

Black Country Strategic Child Death Overview Panel

1. Purpose

1.1 The purpose of this report is to

- Update the Walsall Health and Wellbeing Board on activity within the Black Country Strategic Child Death Overview Panel (BC CDOP) 2020 to 2021
- Outline some of the challenges, issues and responses seen in Walsall relating to child deaths
- Provide a summary of data from 2020 – 2021

2. Recommendations:

2.1 The Health and Wellbeing Board partners are asked to:

- Note the below update and challenges
- Accept future reports from the Strategic Child Death Overview Partnership and any accompanying recommendations for learning.
- Relate relevant learning and suggested recommendations in point 13.1 and 13.2 to their organisations and make changes accordingly
- To report on organisational actions undertaken as a result of this CDOP report at future HWBB meetings with particular reference to whole organisation actions around to reducing inequalities and promoting of safe sleep

3. Report Detail

3.1 Background and Context

3.2 The purpose of a CDOP is to identify the cause of child deaths in an area and to learn and share lessons that may prevent future deaths. Its role is also to consider whether action should be taken in relation to any matters identified. Where it is identified that action should be taken by a person or organisation, they are informed.

3.3 The responsibility for ensuring child death reviews are carried out is held by 'child death review partners', who, in relation to a local authority area in England, are defined as the local authority for that area and any clinical commissioning groups (CCGs) operating in the local authority area as set out in the Children Act 2004 (the Act), as amended by the Children and Social Work Act 2017.

3.4 The processes to be followed when a child dies are currently outlined within "Working Together to Safeguard Children 2018: Chapter 5 Child Death Review Processes and Child Death Review: Statutory and Operational Guidance 2018" https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

3.5 The Black Country Child Death Overview Panel

3.6 In the Black Country the child death review partners are the Black Country Local Authorities and Clinical Commissioning Groups:

- Wolverhampton Council; Sandwell Council; Walsall Council; Dudley Council
- Wolverhampton CCG; Sandwell and West Birmingham CCG; Walsall CCG; Dudley CCG all of whom are combining into one strategic CCG.

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

3.8 The Black Country CDOP works alongside each of the Safeguarding Boards in the Black Country and each share learning and base actions on recommendations made in each agency's reports and from individual child death reviews.

Appendix 1 describes the review process for the Black Country and its oversight by the Black Country Child Death Strategic Partnership.

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

4.1 **Black Country CDOP Achievements**

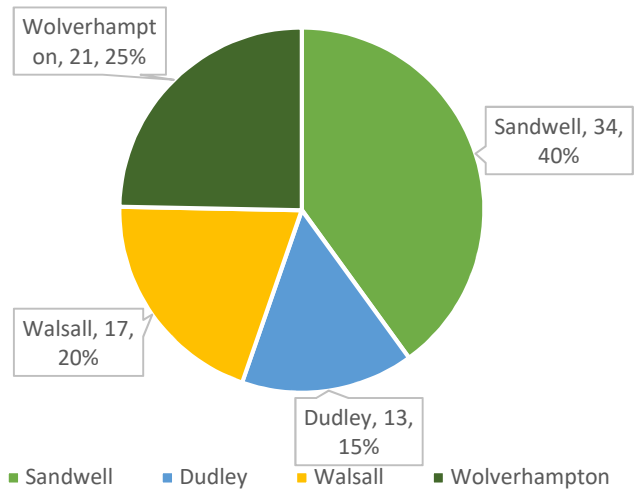
- The role of the Independent Chair into the Strategic Partnership and Operational Panels has now been embedded and has had a positive impact ensuring consistency and progress
- The Key Worker Role has been developed but is still work in progress to ensure the voice of the child/parent is reflected
- Assurance has been received that there is bereavement support for professionals working within the child death arena
- Progress has been made with developing a CDOP section on the new CCG website allowing for wider dissemination of learning and raising the profile of the child death review process
- CDOP has provided data and links for developing and contributing to strategies such as Safe Sleeping, ICON and Suicide Prevention

4.2 Black Country CDOP Challenges:

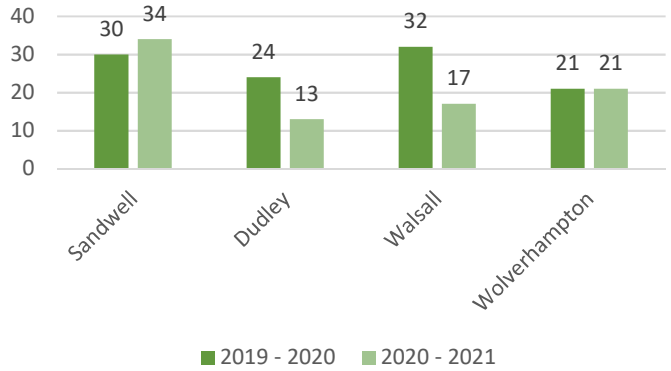
4.3 Extra challenges were encountered in 2020/2021 due to the restrictions brought about by Covid-19. However, CDOP continued to function in this period despite these challenges. Health professionals were supported to complete reviews in a timely manner.

5. Summary of Local Data 2020 – 2021

Black Country Deaths Notified 2020 – 2021



2 Year Comparison



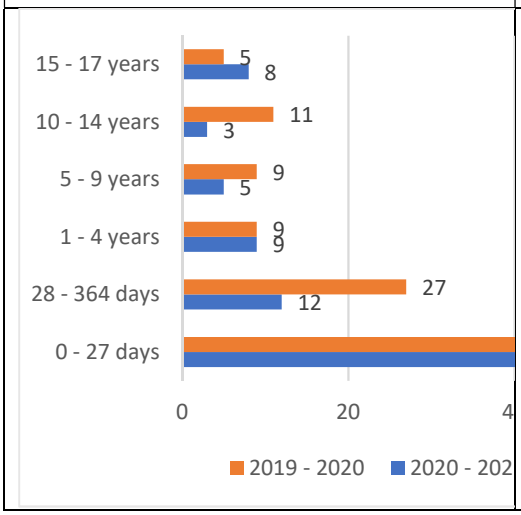
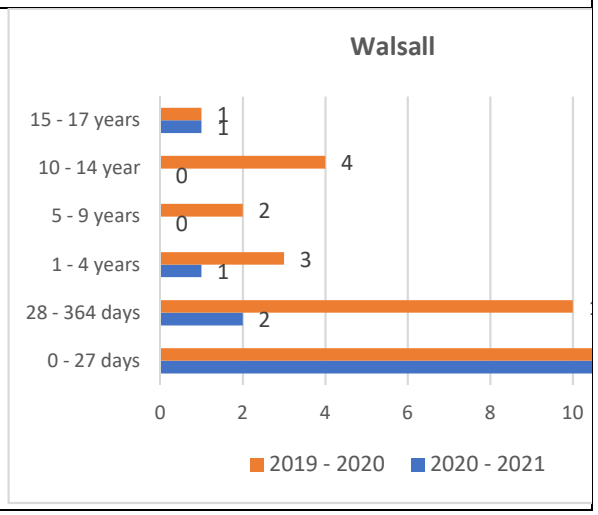
85 deaths were notified in total in the Black Country in 2020 – 2021.

17 of these deaths were reported to be Walsall residents which made up 20% of the total deaths reported in the Black Country.

Out of the 85 deaths notified to the Black Country in 2020 – 2021, 23 were unexpected and required a Joint Agency Response (JAR). 1 of these was a Walsall death

Although CDOP have not had national figures at point of reporting, it is believed that the Black Country has followed the general pattern of reduction in child deaths notified in the reporting period 2020 – 2021. Early analysis of this pattern has found that due to the reduction of social interactions, deaths from infections and deaths as a result of elective surgeries have significantly reduced.

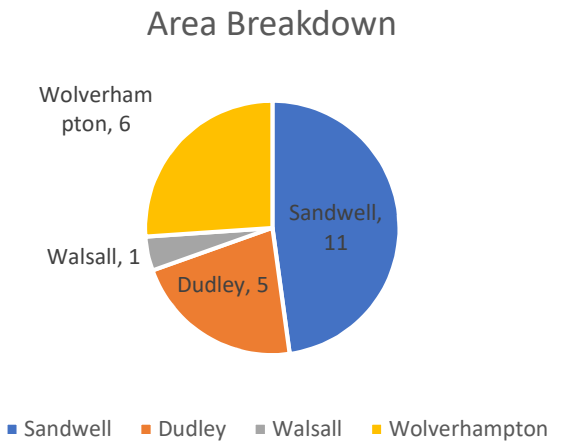
Walsall has seen a 53% reduction in child deaths from 2019 – 2021.

Death Notifications by Age Group Black Country, 2 Year Comparison	Death Notifications by Age Group Walsall, 2 Year Comparison
	

In Walsall in 2020/2021, deaths have reduced from 32 in 2019/20 to 17 in 2020/21.

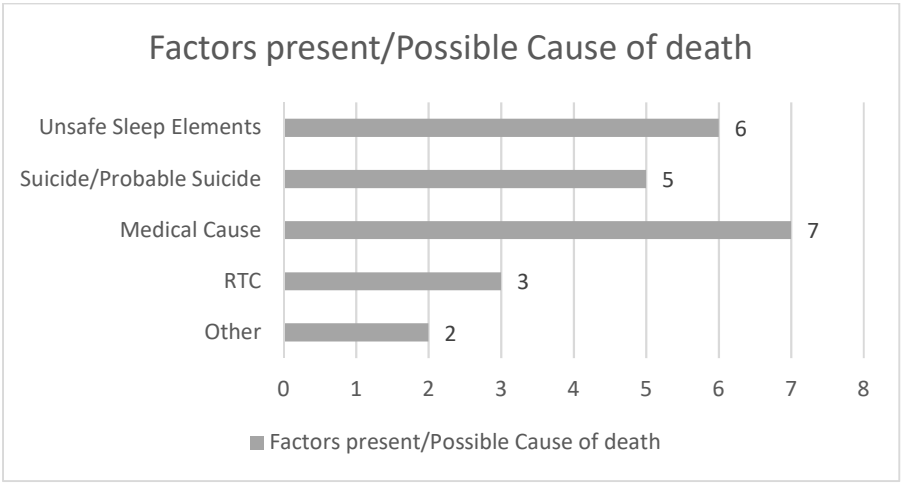
Child deaths in the 28 – 364 days, 1 – 4 years, 5 – 9 years and 10 – 14 years age groups have reduced. However deaths increased slightly in the 0 – 27 days age group moving from 12 to 13 deaths notified.

6. Unexpected Deaths across the Black Country



Out of the 85 deaths notified to the Black Country in 2020 – 2021, 23 were unexpected and required a Joint Agency Response (JAR). The summary of these deaths is as follows

6.1 Breakdown of unexpected deaths by category:



6.2 Unexpected death in Walsall

The unexpected Walsall death is thought to be a death due to suicide, but as this has not completed the coronial process yet, it can only be described as a probable suicide. This death was reported to Safeguarding Partnership in Walsall who decided to carry out a Child Safeguarding Practice Review (CSPR).

6.3 Analysis of Unexpected Deaths

6.4 The analysis of all unexpected deaths across the Black Country (**6.1**) showed that the following social and agency factors contributed to the death:

Social factors:

- Unsafe sleeping practices
- Parental misuse of drugs or alcohol
  Disguised compliance
- Neglectful home conditions/ Chaotic household
- Smoking in the household
- Unsafe sleeping practices
- Overcrowding

Agency factors

- Not born in appropriate level hospital
- Non engagement with services
- Pregnancy related factors
- Parental smoking during pregnancy
- Consanguinity
- Delay in induction of labour

7. Unexpected NeoNatal Deaths

7.1 Over half of neonatal deaths reviewed were caused by immaturity-related conditions such as respiratory and cardiovascular disorders. Congenital anomalies, such as heart and neural tube defects, account for approximately 30% of the total, followed by antepartum infections, which account for approximately 10%. Other neonatal deaths result from causes during or shortly after labour (intrapartum), or in the postnatal period.

7.2 Black Country and Walsall Response to Neonatal Deaths

7.3 As a result of this analysis, a region wide focus group was formed to address these issues. Work is taking place in Walsall and across the Black Country to focus on the following areas:

- Safer Sleeping
- Maternal smoking during pregnancy
- Smoking in the household
- Consanguinity
- Late booking and as a consequence to this delay of support services
- Maternal obesity
- Deprivation
- Neglect

7.4 In addition, a preconception campaign has been taken forward in primary care to support parents to enter pregnancy as healthily as they can be.

7.5 In Walsall safe sleep is discussed by midwives and the Health Visitors with

all parents in the ante natal period and at every visit in the post-natal visit.

7.6 In addition, CDOP recommended that agencies should be aware of the importance of including fathers during the pandemic in scans and medical issues. Walsall now has two father's workers within the Walsall Health in Pregnancy team who are available to support all dads and who offer particular support vulnerable fathers.

8 Black Country Response to Suicides

8.1 Strategic Partners were concerned about the unusual number of deaths by probable suicide/confirmed suicide reported in 2020 – 2021 across the Black Country. As a result of an increase in the number of suicides/probable suicides between October 2020 – March 2021, a deep dive was carried out by child death review partners to assess whether there were any patterns or trends highlighted for immediate action.

8.2 The report found that there were no obvious trends or patterns in probable suicides across the Black Country. It identified that few comparisons can be made with regards to age and gender, although more males than females have died by probable suicide. Three out of the five cases died by hanging, which may have some relevance as hanging, strangulation and suffocation are reported to be the most common suicide methods in young people. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2019registrations

8.3 The report concluded that it needs to be recognised that, although unusual to the Black Country, the probable suicide deaths reported are still quite small and each case has unique elements, some of which are unknown, and could remain unknown.

8.4 The report also recommended that the current Covid-19 situation also needed to be analysed more closely to assess whether it had had an impact on deaths in some way; whether social, emotional, limited/restrictive agency interactions or unknown factors yet to emerge.

8.5 The BC CDOP also recommended that further consideration should also be given to the presence of ACE's (Adverse Childhood Experiences) in each young person. This information is not fully available in all deaths but could hold possible comparisons.

8.6 CDOP made a particular recommendation that agencies do not label a young person as hard to reach but try different ways to engage with a young person and their family

9. Walsall Action resulting from the Black Country Analysis into probable suicides

9.1 In response to the spike in suicides in young people 2020- 21, Walsall Public Health worked with the Black Country Mental Health Trust, Walsall Education team and young people to develop a Walsall suicide and self-harm prevention campaign titled "Let's Talk". This has resulted in a leaflet aimed at young people who are at risk of suicide or self harm, their friends and family and also a pathway document outlining what is available to support young people when issues first emerge and in the community and what support is available externally when issues become acute.

These are hosted on Walsall Childrens Services early help website

https://go.walsall.gov.uk/children_and_young_people/early_help/early_help_for_children_and_young_people/mental_health

9.2 A group is also meeting across the Black Country to develop Black Country support and resources which will benefit Walsall young people.

10 BC CDOP Next Steps and Objectives

10.1 In 2022 the Black Country CDOP team aims to;

- Further support the Black Country and West Birmingham CCG in maintaining consistent place-based child death review processes
- Develop and contribute to strategies to reduce Infant Mortality and suicide prevention
- Consolidate the role of the Key Worker
- Introduce a feedback letter for parents to ensure their voices are heard
- Continue to escalate issues where agencies are not providing timely information
- Submission and ratification of the third Black Country annual report
- To ensure there are good links with existing maternity and neonatal networks to improve outcomes
- Publish a Black Country multi-agency SUDIC protocol and ensure all areas of the Black Country are compliant

11 Health and Wellbeing Priorities:

11.1 The key Health and Wellbeing Board priority is to Maximise People's Health and Wellbeing and Safety and in particular the focus of this report is to Improve Maternal and New Born Health and to support young people's mental health.

11.2 Work 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.

12 Health Inequalities

12.1 Marmot's approach to addressing health inequalities as set out in Fair Society, Healthy Lives requires action across the social determinants of health and beyond the reach of the NHS. It also shows the importance of intervening in early childhood as well as addressing the social factors affecting health. Central to the Marmot Review is the recognition that disadvantage starts before birth and accumulates throughout life. Children born in disadvantage are more likely to be affected by infant mortality and accidents. See the Annual Report for the Black Country CDOP, 2020 – 2021 (**5.2**). Through actions undertaken as a result of CDOP learning, Marmot objective 1 will be achieved; Giving every child the best start in life.

13 Safeguarding

13.1 Recommendations and actions arising from this report directly supports safeguarding and will benefit the most vulnerable sectors in the community.

14. Implications for Joint Working arrangements in Walsall:

14.1 In order to reduce unexpected deaths in Walsall, Health and Wellbeing Board partners are required to identify what actions they are able to take forward. In order to reduce child deaths, commitment is required from all agencies to reduce inequalities and promote safe sleep practices in 2022 and report to the Walsall Health and Wellbeing Board of activity undertaken.

14.2 Suggested commitments

- Walsall Housing providers to support reducing overcrowding or chaotic households and highlight the importance of not smoking in the household
- Maternity Service to promote Making Every Contact Count and ensure that women give birth in the appropriate level hospital
- All to work to reduce the impact of deprivation on young babies and children and young people
- Voluntary and community teams to support actions to identify and reduce neglect and support parenting.
- All including peer supporters to encourage safe sleep practices and increase breastfeeding.
- All to ensure that work is set in place to support young people's mental health.
- All to publicise the link to the Walsall "Let's talk" young people's suicide prevention and self-harm prevention resources

15. Background papers

15.1 National Child Mortality Database Monitoring Report - Walsall

Walsall - Black Country CDOP - NCM

15.2 The Annual Report for the Black Country CDOP, 2020 – 2021.Black Country

BCCDOPAR(JB)Final.pdf

15.3 Black Country CDOP, 2020 – 2021Walsall summary CDOP

BCCDOP Walsall Summary 20_21.docx

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Appendix 1

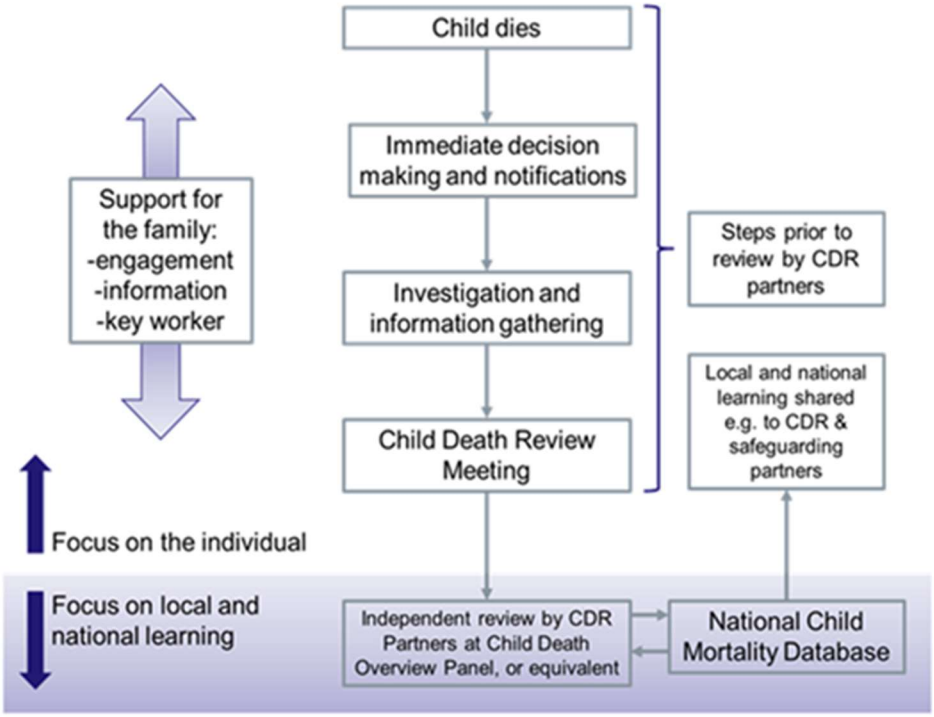
Black Country Child Death Overview Panel Process

The processes followed by the Black Country Child Death Overview panel are currently outlined within "Working Together to Safeguard Children 2018: Chapter 5 Child Death Review Processes and Child Death Review: Statutory and Operational Guidance 2018"

https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

The partners have made arrangements to review all deaths of children normally resident in the local area and, where it is considered appropriate, for any non-resident child who has died in their area.

They are summarised as follows:



The Strategic Child Death Overview Panel is responsible for ensuring that these processes and reviews are carried out as outlined in legislation.