Health and Wellbeing Board
26January 2021

Agenda item 11

Black Country Strategic Child Death Overview Panel

1. Purpose

This report sets out to

- Update the Walsall Health and Wellbeing Board on progress of establishing a Black Country Strategic Child Death Overview Panel (BC CDOP)
- Outline some of the challenges that remain
- Provide a summary of data from 2019 – 2020

2. Recommendations:

The Health and Wellbeing Board partners are asked to:

2.1 Note the below update and challenges
2.2 Accept future reports from the Strategic Child Death Overview Partnership and any accompanying recommendations for learning.
2.3 Relate relevant learning from unexpected deaths to their organisations and make changes accordingly

3. Report Detail

3.1 Background and Context

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.Their 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.

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.

3.2 The Black Country Child Death Overview Panel

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.

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

3.3 Progress over the past yearwithin the Black Country CDOP

- An Independent Chair has been recruited to Chair both the Strategic Partnership and the Operational Panels
- An administrator has been recruited to support with the Child Death processes
- A budget for CDOP reviews and strategic/business functions has been secured on a partnership basis
- Two operational panels now review deaths on a Black Country footprint; neonatal and non-neonatal. An independent neonatologist attends the neonatal panel to offer an impartial view. This is reciprocated and a neonatologist from Wolverhampton attends Staffordshire's neonatal panel.
- A lay member has been recruited to the operational panels to offer a parental perspective.
- The operational panels are attended by professionals on a rota basis who feed back any learning and opportunities through professional networks. Members are expected to represent their geographical area and professional role.
- Panels are reviewing up to 15 deaths at each meeting.
- All four hospitals in the area are carrying out Child Death Review Meetings
- Peer audits have been scheduled to ensure legislation is being adhered to.
- The four CCGs are combining into one Black Country CCG, and so will be incorporating the child death review processes.
- The electronic notification and data collection system, eCDOP, has been embedded into practice. Data from eCDOP flows into the National Child Mortality Database and so contributes to a reliable national picture of child deaths.
- A combined Annual Report is available from 14 December 2020
- A Business Plan has been developed and progress is monitored by Strategic Partners such as safeguarding leads in the CCG and local authority.
- Learning is shared with partners and identified actions taken forward

- Through the National Child Mortality Database, the Black Country has fed into real time data supporting the national understanding of the impact of the current pandemic

3.4 Black Country CDOP Challenges:

The progress that has been made over the past 12 months during very difficult times has been enormous and has surpassed many expectations. However, the challenge now is to reflect upon processes and embed them into practice.

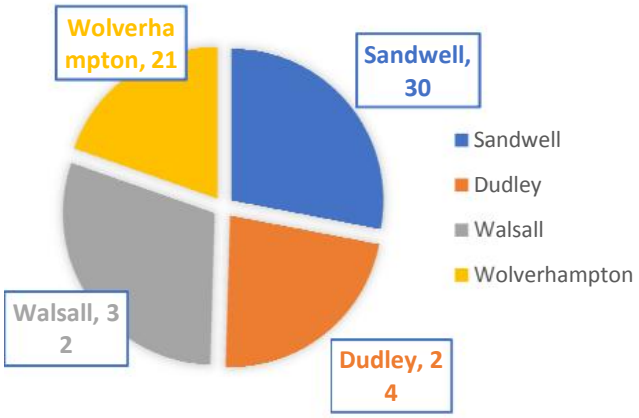
Challenges also remain with obtaining information from areas external to the Black Country, particularly Birmingham.This has been escalated to wider partners and strategies have been put in place to mitigate these and monitor progress.

There also needs to be consistency with the way the local areas support the child death review process. Wolverhampton has no administration support and at present this is being sourced from the central team which has implications on case progression and workload.

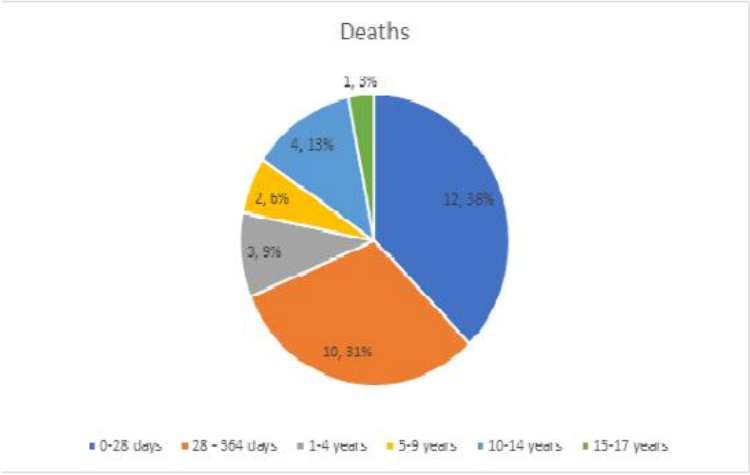
3.5 Summary of Local Data 2019 – 2020

3.5.1 In 2019/20 the Black Country saw 107 deaths. Out of these, Walsall saw 32 deaths. 12 of these were in the first 28 days. The majority of these deaths were seen in babies who were born a very low birth weight due to prematurity or with congenital anomalies This is lower than the national average for this age group at 42%.Deaths in children 28 to 365 days is however higher at 31% in Walsall as opposed to 21% nationally.

BLACK COUNTRY DEATHS NOTIFIED 2019 - 2020



Black Country Deaths (Figure 1)



Walsall Deaths(Figure 2)

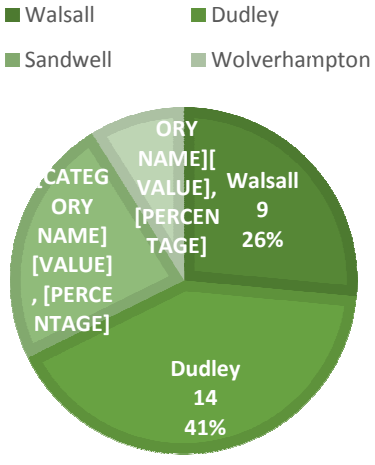
3.6.1 Unexpected Deaths

9 deaths notified in this timescale in Walsall were unexpected and a Joint Agency Response was carried out

Unexpected Deaths in Black Country(Figure 3

The analysis of all unexpected deaths across the Black Country (Figure 3)showed:

- 60% were attributed to co-sleeping
- 50% were intoMum taking medication for depression
- 60% in dirty/poor home conditions
- 90% in homes where there was maternal smoking/smoking in the home
- 30% Sofa sleeping
- 10% Alcohol abuse
- 30% Substance misuse



- 20% Low birth weight
- 20% Overcrowding
- 60% Child snuffly/ill previously
- 20% Bumpers/pillows in cot
- 10% Unsafe feeding practices

3.7Local Action resulting from the Black Country Analysis

As a result of this analysis, a region wide focus group has been formed to address theseissues. 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

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

Work is required by partners to raise awareness of these issues and their implication for the health of a child

3.8Planned Work

3.8.1 Safer Sleep Support

As seen in point 3.6.1 describing unexpected deaths, unsafe sleeping practices such as co sleeping, sofa sharing, alcohol abuse or bumpers and pillows were identified as major drivers for infant mortality. (10 of the 33)

From a recent national report, “Out of Routine” 2020, we have also gained new learning around the causes of infant mortality. These include insecure housing and parental stressors such as deprivation or domestic abuse. This highlights the requirement for new partners such as housing and landlords who have a role to play in preventing uncertain housing tenure to engage with the infant mortality reduction agenda.

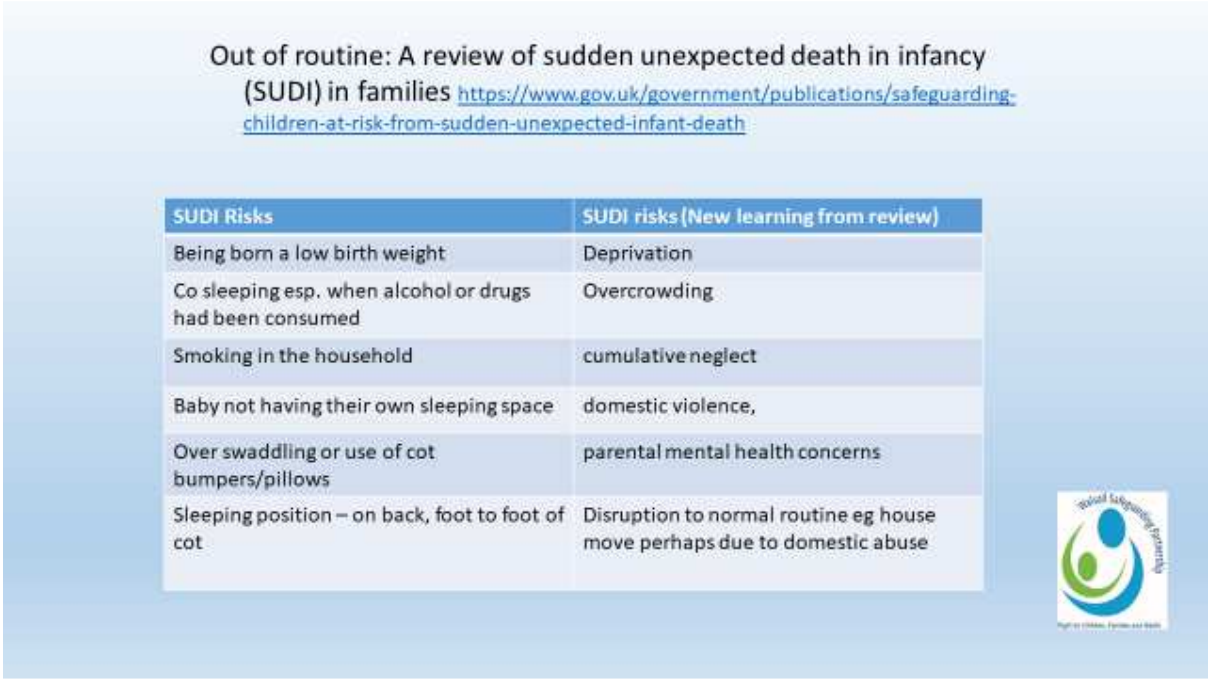


Figure 4 Out of routine A review of sudden unexpected death in infancy 2020

The Black Country Child Death Overview Panel are leading on a Black Country wide safer sleep campaign. A campaign will be developed with frontline staff such as maternity, health visitors, social workers and GPs to share best practice and ensure that information is given to parents, received and understood and followed up where needed.

Birmingham Safeguarding Partnership have recently released videos on social media called 'Who's in charge?' which highlight the risks of alcohol consumption when caring for a young child and contributes to awareness of safer sleeping practices.

https://www.bhamcommunity.nhs.uk/about-us/news/latest-news/whos-in-charge-video-campaign/

The links to these videos have been shared with Walsall safeguarding partners, the neglect steering group and neglect champions and Housing Groups.

3.9Regional Next Steps and Objectives

Over the next year, the Black Country Child Death Overview Partnership will seek to work with Walsall Health and Wellbeing Board Partner agencies to;

- take forward campaigns to combat child deaths and in particular to reduce infant mortality. This will also include developing, ratifying and implementing a the Black Country Sudden Unexpected Death protocol.
- Share regular awareness bulletins of unexpected child deaths. In 2020 – 2021 there are plans to develop a Black Country wide on call health response for unexpected deaths.
- Ensure professionals working within the child death arena have bereavement support so that parents are supported using best practice and the practitioners are supported in their role
- Disseminate learning from child deaths (e.g. team communications, social media or word of mouth)
- Support the consolidation of the new Black Country CCG
- Develop and contribute to strategies being developed and rolled out (Safe Sleeping/ICON)

In addition, they will work with the Walsall Safeguarding Partnership to submit and ratify the CDOP annual report.

4. Implications for Joint Working arrangements:

4.1 Within Walsall, our priority is to continue to reduce infant mortality. This requires commitment and activity from all partners who have contact with new parents to;

- Partners such as Childrens Services, GPs, Midwives and Health Visitors to embed and support safer sleeping practices
- The above but also police, housing teams and benefits support teams to reduce the impact of the issues which contribute to parental conflict and therefore neglect, for example financial or housing insecurity, parental mental health or domestic abuse
- Pharmacists, GPs and community teams to promote preconception care
- All agencies including the voluntary and community sector who meet with new parents to ensure that safer sleep and good parenting is promoted

4.2 Health and Wellbeing Priorities:

4.2.1 The key Health and Wellbeing Board priority is to Maximise People's Health and Wellbeing and Safety and in particular the focus of the report is to Improve Maternal and New Born Health.

4.2.2 Work to reduce child deaths and in particular infant mortality is a role for all in Walsall and not just the statutory sector. Voluntary and community teams are being asked to support actions to identify and reduce neglect and support parenting. Peer supporters are also supporting all work to encourage and increase breastfeeding.

4.2.3 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. Through CDOP learning, objective 1 will be achieved; Giving every child the best start in life

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

5 Background papers

BCCDOP AR 20192020 FINAL.pdf

The Annual Report for the Black Country CDOP, 2019 – 2020.Black Country

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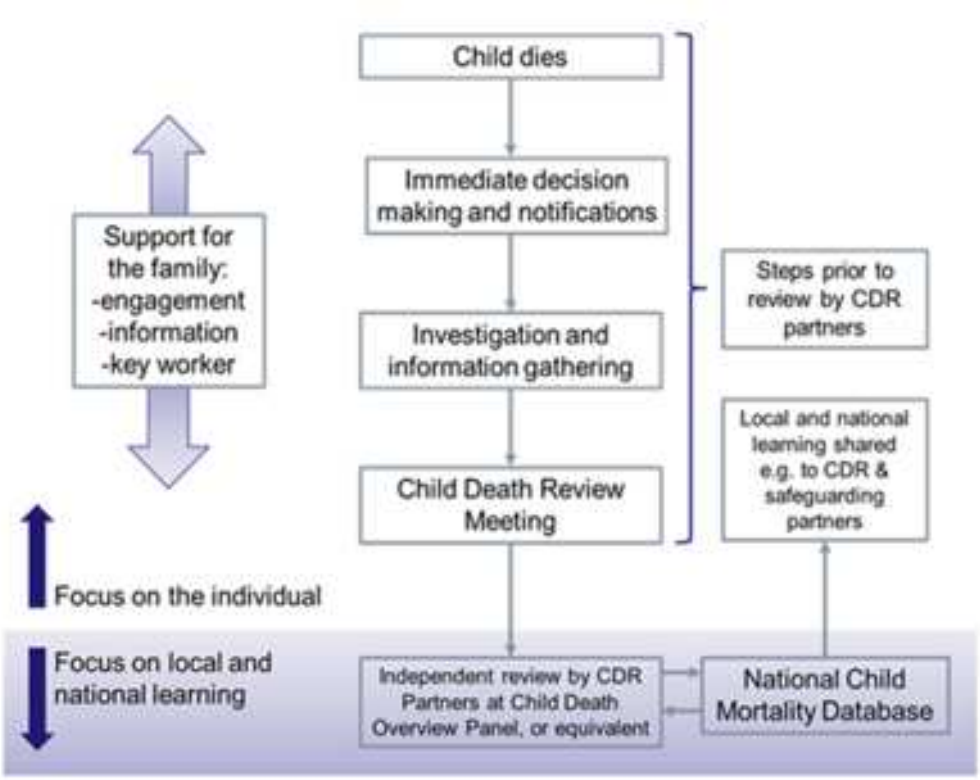
Appendix 1

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: (Figure 1)



The Strategic Child Death Overview Panel is responsible for ensuring that these processes and reviews are carried out as outlined in legislation. The local implementation of this national guidance is depicted in figure 2.

Figure 2 Black Country Child Death Governance Structure: (Figure 2)