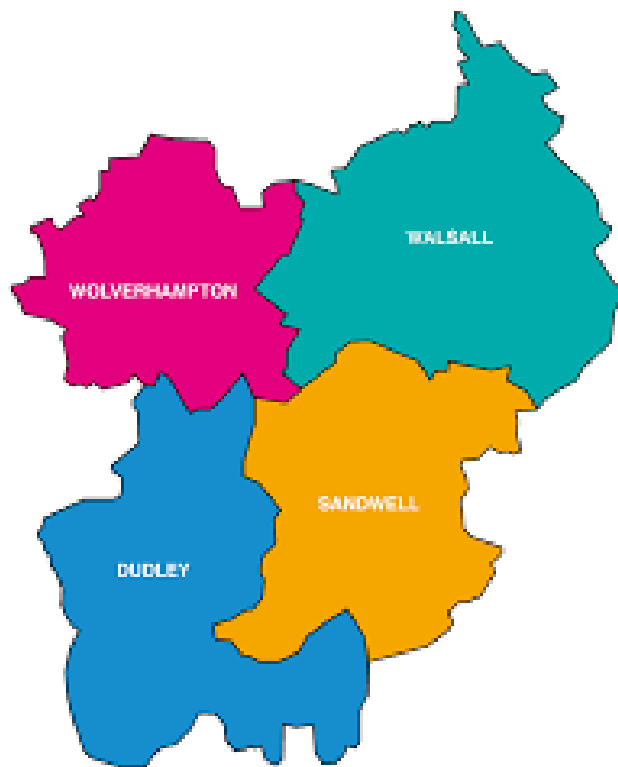


# Black Country Child Death Overview Panel

Annual Report  
2019 – 2020



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This year's CDOP annual report has been written during the unprecedented times of a global pandemic of coronavirus. The pandemic has impacted many services and seen tragedies through the loss of family and friends to the virus and condolences are sent to all those affected. The Panel has continued to review the deaths of children from across the Black Country and have embraced technology to discharge the duties of the panel in a safe and appropriate way, giving due consideration to each child and their family and carers so that any lessons learned and recommendations may contribute to mitigating risks to children where possible.

## **1. Introduction and Background to the Child Death Review Processes:**

**1.1** The death of a child is a devastating loss that profoundly affects all those involved. The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths. Every family has the right to have their child's death sensitively reviewed in order, where possible, to identify the cause of death and to learn lessons that may prevent future deaths.

The majority of child deaths in England arise from medical causes. Enquiries should keep an appropriate balance between forensic and medical requirements and supporting the family at a difficult time.

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 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.

**1.2** In the Black Country the 'child death review partners' are:

Black Country Local Authorities:

Wolverhampton Local Authority; Sandwell Local Authority; Walsall Local Authority; Dudley Local Authority

Black Country Clinical Commissioning Groups:

Wolverhampton CCG; Sandwell and West Birmingham CCG; Walsall CCG; Dudley CCG.

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.

The Black Country Local Authorities and CCG's have combined and agreed that their areas be treated as a single area for the purpose of undertaking child death reviews.

'The Partners' have arrangements in place for the analysis of information from all deaths reviewed.

**1.3** The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. Where 'the partners' find action should be taken by a person or organisation, they will inform them. In addition, 'the partners': will prepare and publish an annual report on:

- What they have done as a result of the child death review arrangements in their area; and
- How effective the arrangements have been in practice.

'The Partners' may request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process - the person or organisation must comply with the request, and if they do not, 'the partners' will consider legal action to seek enforcement.

**1.4 Responsibilities of 'the partners'**

The child death review process covers children: a child is defined in the Act as a person under 18 years of age, regardless of the cause of death.

The Black Country has a combined Child Death Overview Panel (CDOP) which will provide the structural framework to review child deaths.

The geographical and population 'footprint' of child death review partners has been locally agreed and covers a child population such that CDOP will typically review at least 60 child deaths per year. It also takes into account networks of NHS care, and agency and organisational boundaries in order to reflect the integrated care and social networks of the area.

'The Partners' have established designated doctors for child deaths for Wolverhampton, Sandwell, Walsall and Dudley who are senior paediatricians who have a lead role in the review process. The designated doctors are spread across the 4 hospital trusts and are supported in Sandwell by a Designated Nurse and in Dudley a Lead Nurse.

The organisation where the child's death is declared (usually the acute hospital) is responsible for carrying out a child death review meeting (see below).

This includes the death of any live-born baby where a death certificate has been issued. In the event that the birth is not attended by a healthcare professional, child death review partners may carry out initial enquiries to determine whether or not the baby was born alive. If these enquiries determine that the baby was born alive the death must be reviewed.

*For the avoidance of doubt, it does not include stillbirths, late foetal loss, or terminations of pregnancy (of any gestation) carried out within the law.*

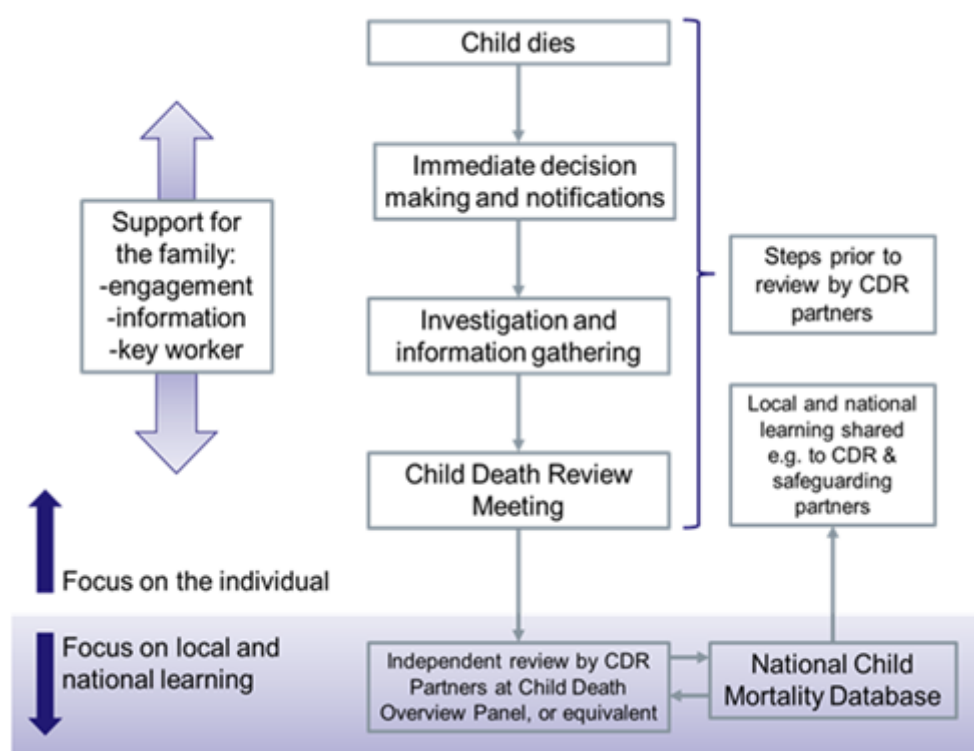
- Stillbirth: baby born without signs of life after 24 weeks gestation;
- Late foetal loss: where a pregnancy ends before 24 weeks gestation.

Cases where there is a live birth after a planned termination of pregnancy carried out within the law are not subject to a child death review.

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>

Process to follow when a child dies:



## **2. Executive Summary**

### **2.1 Data related to Child Death Notifications**

- 107 child deaths were notified to the Black Country between 1st April 2019 and 31st March 2020 (Data collected in previous years is not consistent and therefore it is not possible to compare this with previous years.).
- 68% of deaths occurred during the first year of life, 8% of deaths were of children ages 1-4, and rates then slightly increase in mid-childhood to 10% but then drop in ages 15-17.
- 32% of deaths were seen to be 'unexpected' and had a Joint Agency Response.

### **2.2 Data from cases reviewed by the Child Death Overview Panel**

- The Black Country CDOP reviewed 84 cases in detail between 1st April 2019 and 31st March 2020
- The majority of deaths reviewed were in the first year of life.
- CDOP identified 'modifiable factors' in 33% of cases. Modifiable factors are defined as 'one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths'.
- Modifiable factors were identified more in the 15 – 17 year age group.

### **2.3 Service improvement**

CDOP has taken forward actions arising from cases which include contacting Local hospital Trusts, CCGs, Road Traffic Police and Local Authorities.

Hospital Trusts are now complying with legislation around Child Death Review Meetings (CDRM) enabling learning to be disseminated locally in a shorter timeframe.

### **2.4 Themes**

Certain themes have emerged from reviewing children's deaths in the Black Country this year including lower completion rate of new eCDOP Reporting Forms and the need to prompt to complete particularly from neighbouring authorities and trusts; the consistency of response from Education Authorities with regards to the death of a pupil and siblings across the Black Country; and supporting professionals following the death of a child, both medics and non-medics.

### **2.5 Achievements and Future Priorities**

These included plans to improve sharing of learning across CDOPs, recruitment of an Independent Chair, development of the Key Worker role and the multi-agency approach to reducing Infant Mortality.

COVID is likely to dominate the coming year's work, and CDOP is well-placed to capture some of the effects on children as well as resulting in operational changes to the delivery of the process.

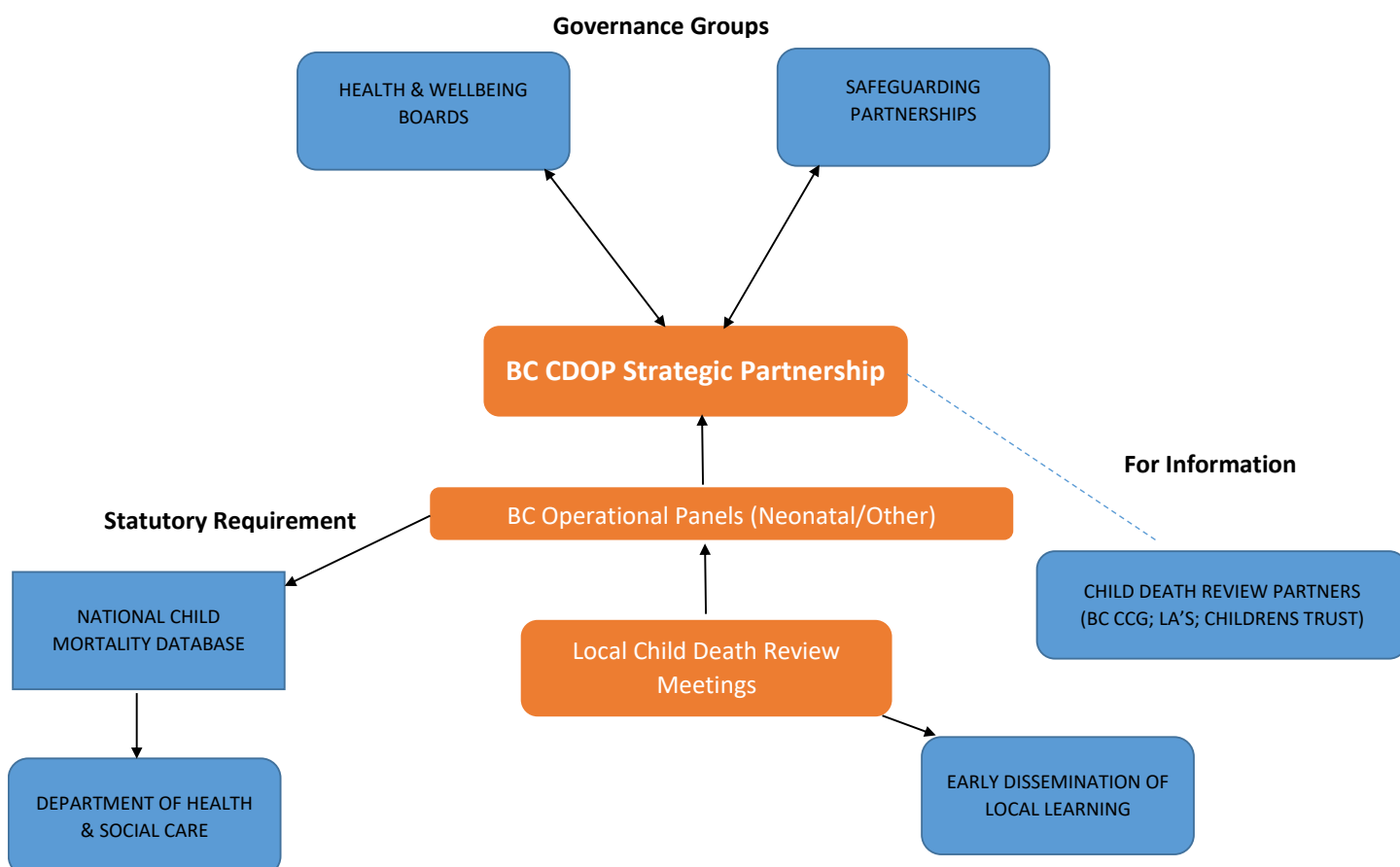
## 2.6 Progress towards 2018-2019 Annual Report Targets

This is the first combined Annual Report undertaken by the Black Country. Separate reports were published last year by Sandwell, Dudley, Walsall and Wolverhampton as processes were not joint at this point. However, each area had the same forward priorities for 2019-2020:

- Continue to embed and strengthen the joint working arrangements within CDOP.
- Contribute to the development of the Black Country Strategic CDOP in order to:
  - provide good quality data on causes of death and modifiable factors in domains related to the child and the wider system;
  - develop novel approaches to linking hospital mortality review processes to CDOP reviews and undertaking thematic reviews.

The newly developed Black Country Child Death Arrangements structure has led to the strengthening of the joint working arrangements.

### Black Country Child Death Structure



Data is now collected on a quarterly basis to support identifying patterns and themes in conjunction with the National Child Mortality Database. This data is shared with different workstreams working across child mortality to enable joined up working resulting in consistency of approach.

Child Death Review Meetings are held in every hospital trust across the Black Country in differing formats but with the same output of quicker local learning and the production of an analysis form to take to Child Death Overview Panels. In the case of neonates, this meeting takes the form of the Perinatal Mortality Review meeting which identifies good practice and opportunities for learning which is shared across the Black Country. An example of this is the development of a rota for those consultants needing advice and support from a higher level neonatal unit when it is not possible to move mum or baby. This means that the best possible care can be offered with a positive outcome.

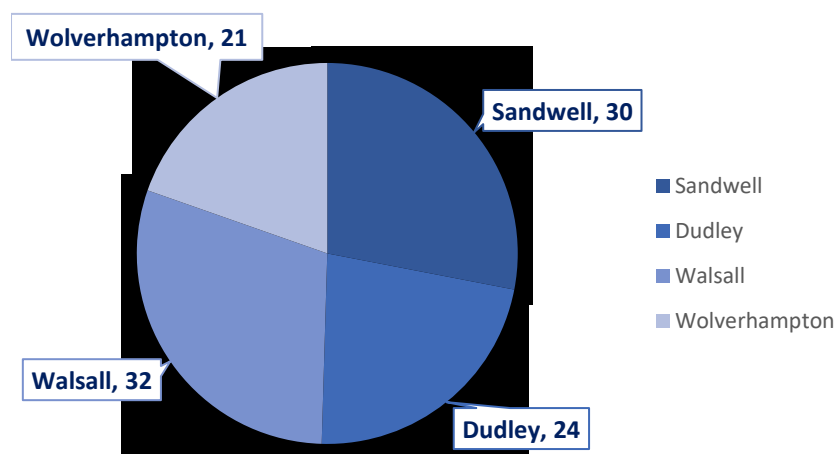


### 3. Deaths Notified in 2019 – 2020

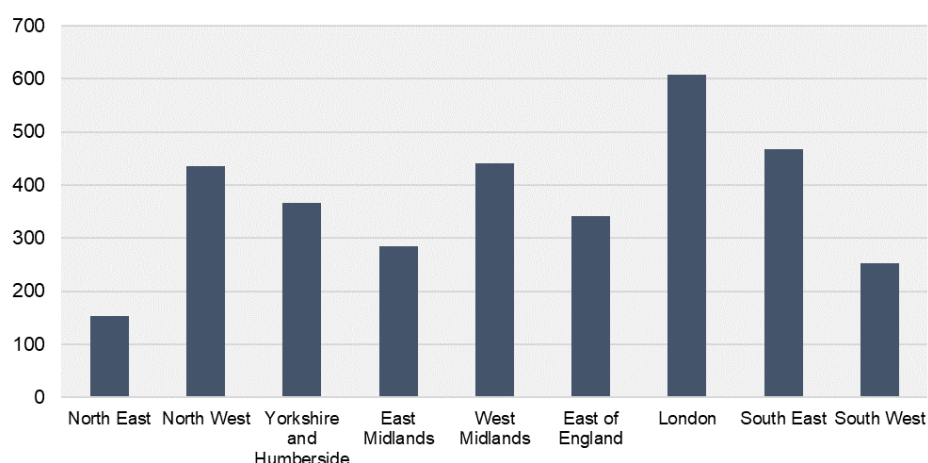
107 deaths in total were notified across the Black Country between April 2019 – 2020. Nationally, 3347 deaths were reported to the National Child Mortality Database (NCMD).

The breakdown for 2019 – 2020 for the Black Country is as follows:

#### 3.1 Notified deaths

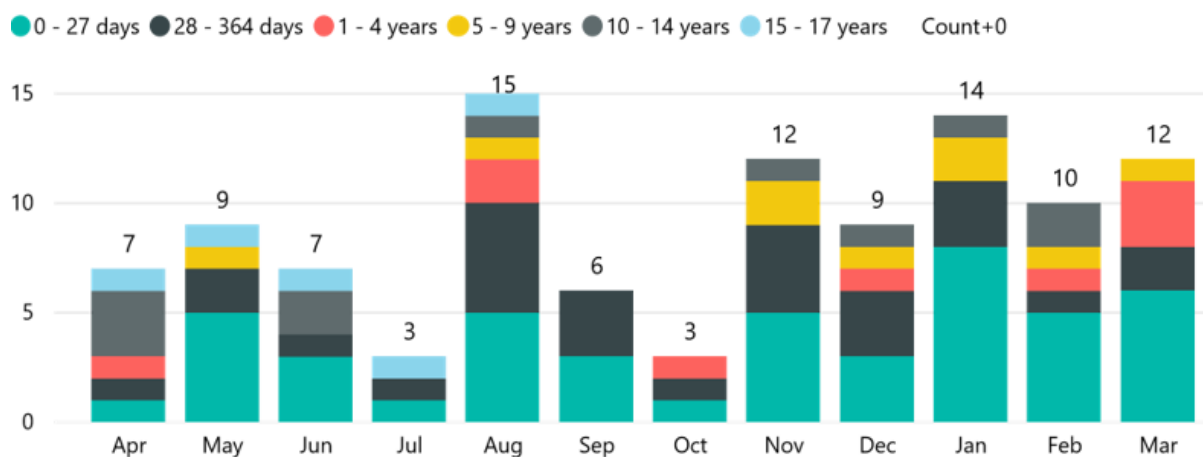


*(Data collected in previous years is not consistent and therefore it is not possible to compare this with previous years.)*



**Notifications to NCMD Year ending 31 March 2020**

### 3.2 Death Notifications by Age Group



% of death notifications by age group - CDOP

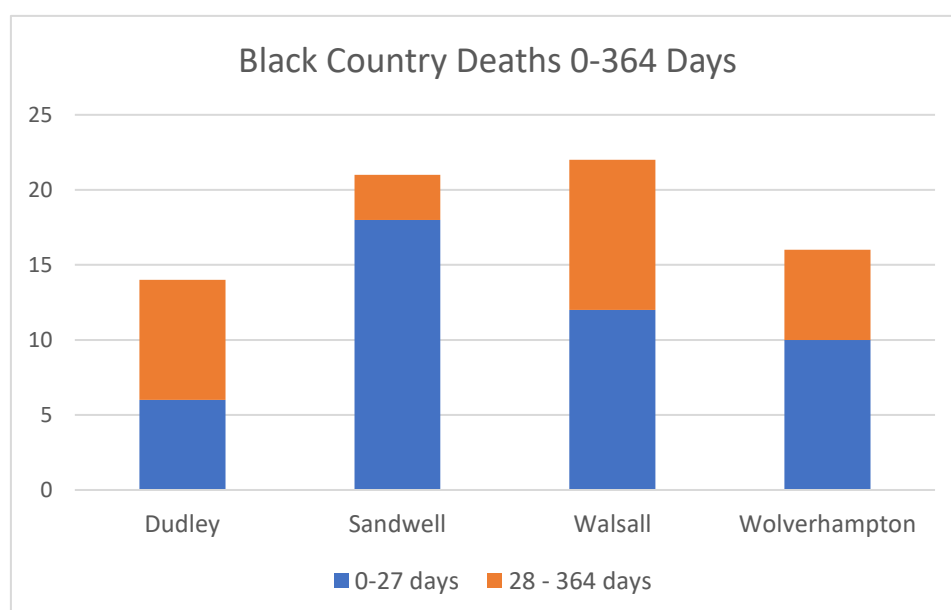


% of death notifications by age group - National (England)



It can be seen that, as a Black Country, the majority of deaths occur within the 0-27 day age group with 43%, which is slightly higher than the National average at 42%. This will be explored further in the [Infant Mortality](#) section of this report, but it has been recognised that this should be a priority for the coming year.

The following chart shows the breakdown of neonatal deaths in the Black Country



### 3.3 Deaths Notified – Ethnicity

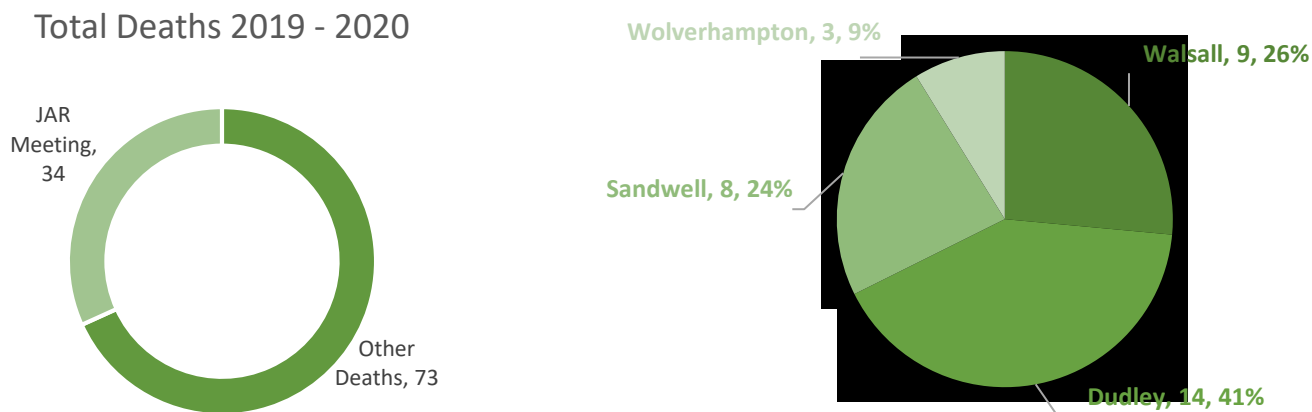
	2011 Census 0-18 years	%	2019 – 2020 Notified Deaths	%
White British	41249	55.50	43	40.19
White Other	2475	3.30	5	4.67
Mixed Multiple Ethnic Group	5786	7.70	18	16.82
Asian British Indian	7584	10.20	8	7.48
Asian British Pakistani	5773	7.80	12	11.21
Asian British Bangladeshi	2840	3.80	3	2.80
Asian British Chinese	227	0.30	4	3.74
Other Asian	1913	2.60	0	0.00
Black British African	1623	2.20	4	3.74
Black British Caribbean	2552	3.40	4	3.74
Black British Other	1019	1.40	0	0.00
Other Ethnic Group/Not recorded	1335	1.80	6	5.61
Totals	74376	100.00%	107	100.00%

<http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/pregnancyandethnicfactorsinfluencingbirthsandinfantmortality/2015-10-14#ethnicity>

55.5% of 0 – 18 year olds in 2011 population were White British, however, only 40% of reported child deaths in 2019-20 were from this ethnic background. As with previous years, this is in contrast to those children from a BME background where there was a higher percentage of reported child deaths compared to the population size (0-18yrs).

### 3.4 Deaths requiring a Joint Agency Response (JAR):

Nearly a third of the Black Country deaths that were notified to CDOP in 2019 – 2020 required a JAR.



Since the inception of the child death review process there has been a requirement to perform further investigations for children who die where the cause is unknown. This was previously called a Rapid Response but the terminology has been changed following the publication of the Child Death Review Statutory and Operational Guidance in 2018 and it is now referred to as a Joint Agency Response (JAR).

The criteria for triggering a JAR include:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy/childhood (SUDI/C);
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural; or
- in the case of a stillbirth where no healthcare professional was in attendance.

The full process for a Joint Agency Response is set out in the SUDI/C Guidelines.

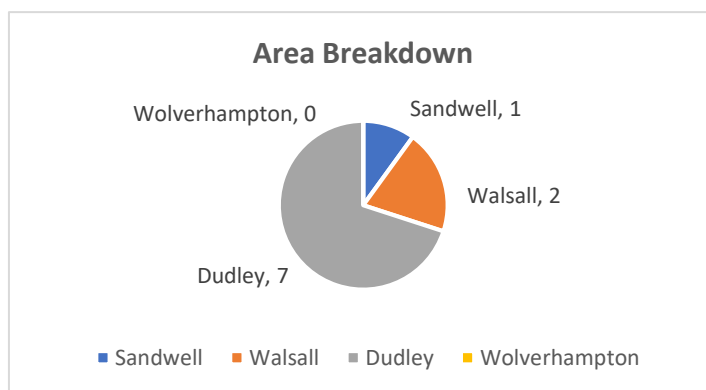
Prior to 2018, these criteria were not used, and the definition for an Unexpected Death was the death of an infant or child, which was not anticipated as a significant possibility 24 hours before the death or, where there was a similarly unexpected collapse or incident leading to or precipitating the events that led to the death. This was counted if recognised to be an unexpected death and a multi-agency Rapid Response was carried out.

**3.5** Out of the 34 unexpected deaths that were notified to the Black Country in 2019 – 2020, 10 had elements of Safer Sleeping identified. These were:

- 60% were co-sleeping
- 50% Mum taking medication for depression
- 60% Dirty/poor home conditions
- 90% 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

Breakdown of data for the 10 cases:

Age at death	
0, 1 ,2 months	6
3, 4,5 months	3
6,7,8, months	0
9,10,11 months	1



Strategic Partners agree that Safer Sleeping will be a priority for 2020-2021 and will be working with other areas across the Region to ensure consistency of messages and a joined-up approach.

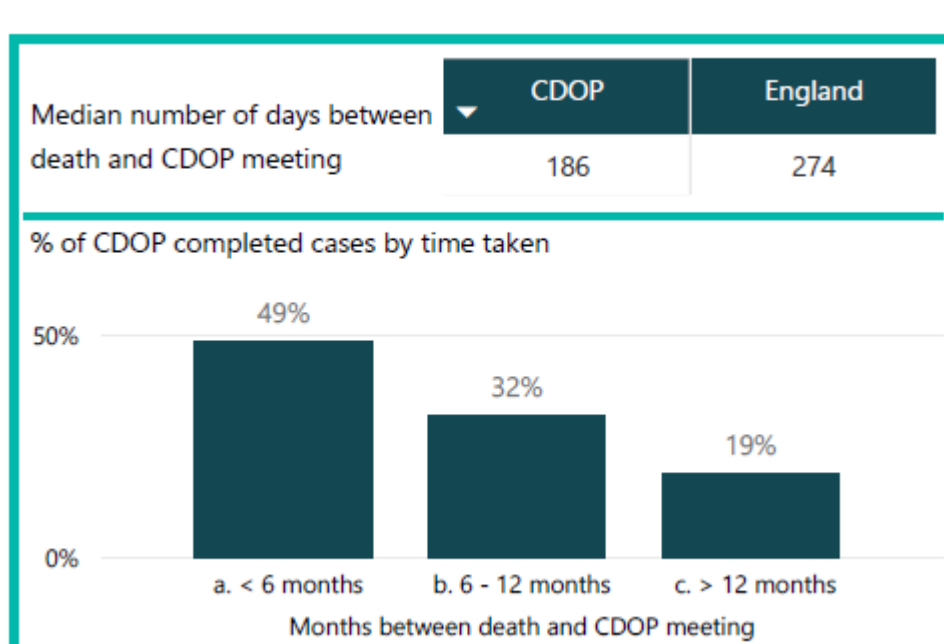
## 4. Deaths Reviewed 2019 – 2020

84 deaths in total from across the Black Country were reviewed in 2019 – 2020 at 13 CDOP meetings. These panels were made up of multi-agency professionals from across the health economy, Local Authorities, Children’s Services, Safeguarding Partnerships and Police.

Child Death guidance states that deaths cannot be reviewed until all investigations are completed, safeguarding reviews published and relevant information gathered. In 2019 – 2020, there was a responsibility placed on healthcare professionals to complete a draft analysis form following a Child Death Review Meeting (CDRM) which forms the basis of the final multi-agency review.

There is an inevitable time-lag (4-12 months) between notification of a child’s death and discussion at CDOP and there are various factors that contribute to this: the return of Reporting Forms from professionals, the completion of the final post-mortem report by the pathologist and receipt of the final report from the local child death review meeting. On occasions when the outcome of a Coroner’s inquest is awaited, there may be a delay of over a year before a case might be brought before CDOP. The undertaking of a criminal investigation or a Serious Case Review (now a Child Safeguarding Practice Review) will also affect a timely review.

The following chart shows the number of days (median) between the death and the CDOP review. The first chart shows that the Black Country reviewed deaths in a shorter period of time than the England average in 2019 - 2020.



4.1 Overview of reviewed deaths, 2019 – 2020

The following section gives a breakdown of the reviews completed in this year. It should be remembered that these reviews are of deaths from different years, as outlined in Chart 4.1b. As previously mentioned, from April 2019 there was a new requirement for health care professionals to arrange a Child Death Review Meeting to gather enough information to submit to the final CDOP review. There were inevitable delays as new processes were being set up which could explain why more deaths from previous years were reviewed as opposed to deaths occurring in 2019 – 2020 as there was no requirement to carry out a child death review meeting until April 2019.

Completed CDOP Reviews by LSCB

LSCB name	Cases
Dudley	16
Sandwell	28
Walsall	30
Wolverhampton	10
Total	84

Chart 4.1a – Breakdown of reviews completed by area of residency

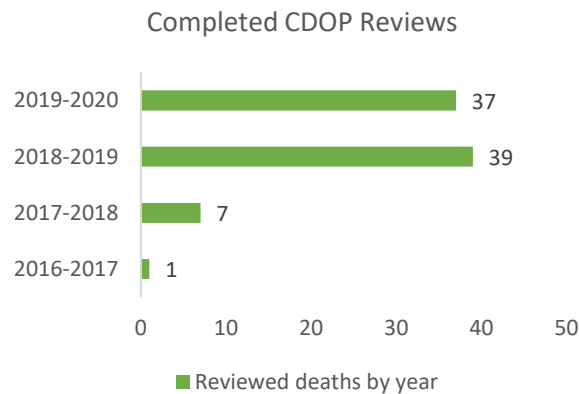


Chart 4.1b – Completed CDOP Reviews – Year of Death

Completed CDOP reviews by gender

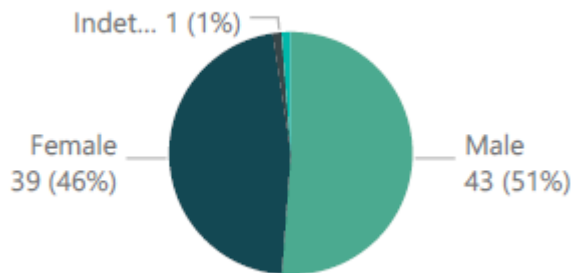
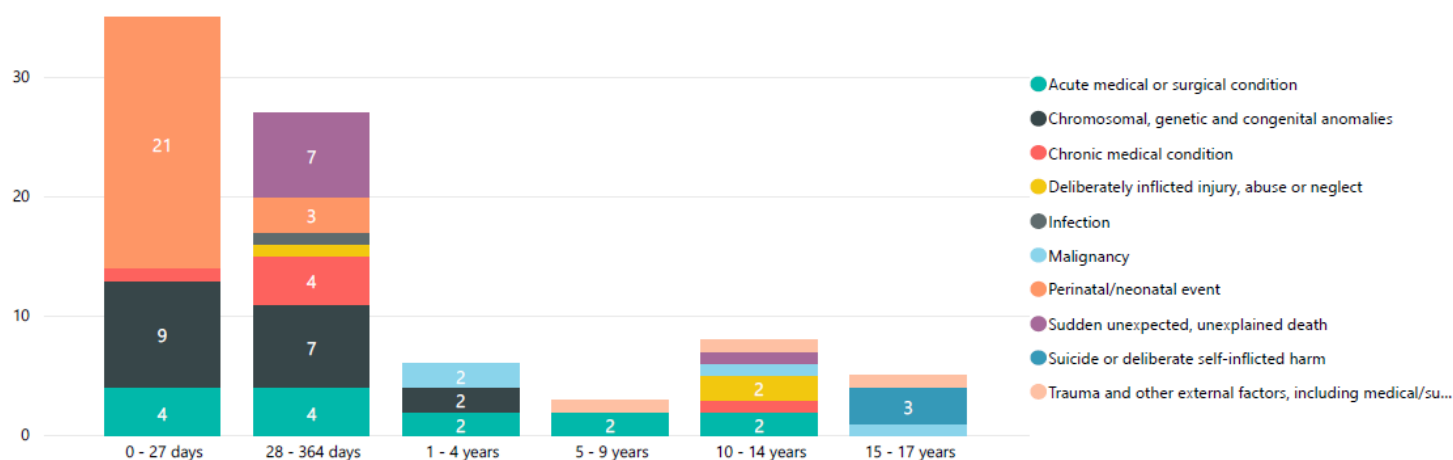


Chart 4.1c – Breakdown of reviews completed by gender

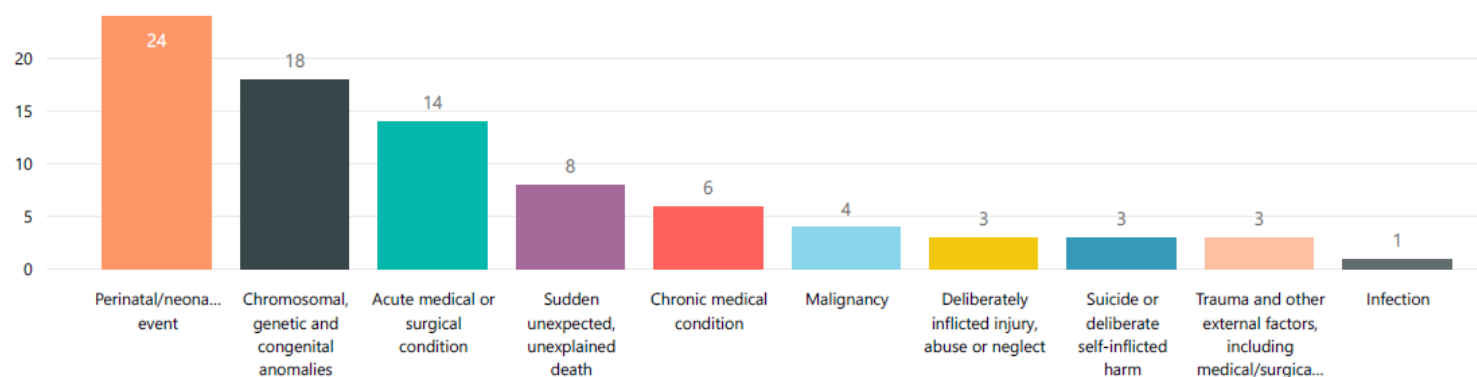
As has been commented previously, not all deaths reviewed are in the same year and so data needs to be understood within this context. It is not always the case that the figures show patterns as court cases could mean that reviews are assigned at different times meaning that all road traffic collision accidents could be reviewed in the same year, or that coroners have concluded their findings which means that SUDC deaths all come to review in the same year, therefore giving over-inflated data for co-sleeping deaths, for example. However, the gender split is roughly indicative of notified deaths for the year 2019-2020.

**Chart 4.1d/e – Completed Reviews by age group and category of death**

Completed CDOP reviews by age group



Completed CDOP reviews by primary category of death

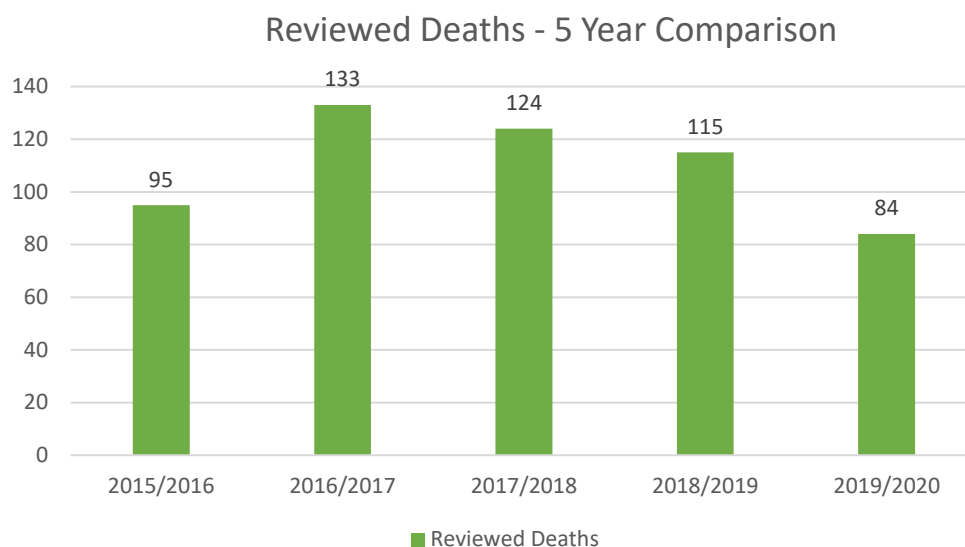


As in other years, the majority of reviewed deaths were of those in the first year of life, mirroring the majority of notified deaths for this age group. These reviews would have been following the completion of the required Perinatal Mortality Review Tool (if over the age of 24 weeks gestation) and any learning emerging from these reviews would be taken into consideration by the child death overview panel.

Eight deaths reviewed were categorised as being Sudden and Unexpected and they would have been reviewed following the completion of any serious case reviews, police investigations and inquests. These additional investigations would also have been taken into consideration when making any recommendations or actions.



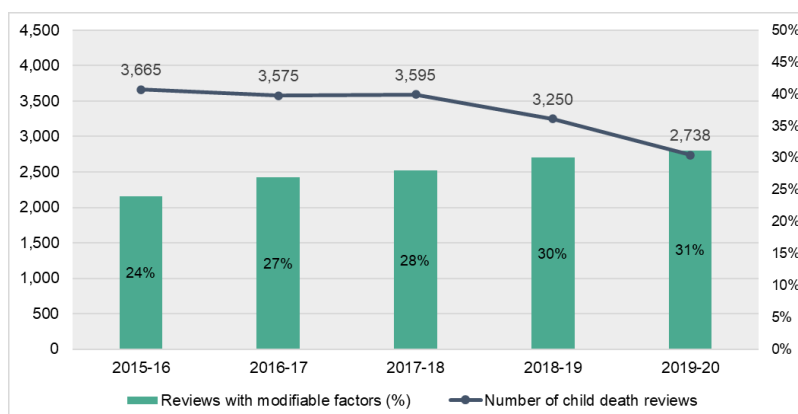
## 4.2 Comparison with other years



It is anticipated that between 80-100 deaths will be reviewed per year by the Black Country CDOP. As can be seen from the chart above, 84 deaths were reviewed, which is considerably lower than the previous year.

Deaths can only be reviewed at CDOP when all investigations have been concluded and a child death review meeting has taken place. As previously explained, the child death review meeting is a new process for healthcare professionals and it has taken time to trial, adapt and revise these processes. New child death review teams have also been formed in three of the areas, which again may have contributed to the delay of providing analysis forms for consideration at the final child death overview panel.

Nationally, 2,738 deaths were reviewed in 2019-2020, 16% lower than previous years as can be seen below:



The Black Country reflects this drop in reviews which is thought nationally to be the impact of consolidating CDOP's (reduced from 72 to 58) and the embedding of the new National Guidance.

### 4.3 Modifiable Factors

Modifiable factors are defined as ‘one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths’. An example of a modifiable factor might be a death resulting from a vaccine preventable infection where the vaccine had not been given to the child. The Black Country has also regarded bed-sharing with parents known to be smokers to be a modifiable factor in cases of Sudden Infant Death Syndrome (SIDS).

In 28 of the 84 cases (33%) reviewed by the Black Country CDOP 2019 - 2020 modifiable factors were identified, which is in line with the National average which is 31%.

Modifiable factors identified by the Black Country panels for these cases were:

- Smoking in pregnancy or in the household
- Drugs/Substance misuse
- Co-sleeping/unsafe sleeping practices
- Consanguinity
- Late booking
- Maternal high BMI
- Disguised compliance
- Communication/processes between agencies
- Childhood obesity
- Vitamin D deficiency

% of cases where modifiable factors were identified by category of death

Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
▲			
Acute medical or surgical condition	14	2	14%
Chromosomal, genetic and congenital anomalies	18	5	28%
Chronic medical condition	6	1	17%
Deliberately inflicted injury, abuse or neglect	3	2	67%
Infection	1	1	100%
Malignancy	4	0	0%
Perinatal/neonatal event	24	6	25%
Sudden unexpected, unexplained death	8	7	88%
Suicide or deliberate self-inflicted harm	3	2	67%
Trauma and other external factors, including medical/surgical complications/error	3	2	67%
<b>Total</b>	<b>84</b>	<b>28</b>	<b>33%</b>

% of cases where modifiable factors were identified by age group

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	35	8	23%
28 - 364 days	27	13	48%
1 - 4 years	6	0	0%
5 - 9 years	3	1	33%
10 - 14 years	8	3	38%
15 - 17 years	5	3	60%
<b>Total</b>	<b>84</b>	<b>28</b>	<b>33%</b>

% of cases where modifiable factors were identified by ethnic group

Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
White	43	18	42%
Asian or Asian British	21	6	29%
Mixed	6	0	0%
Other	6	2	33%
Black or Black British	5	1	20%
Unknown	3	1	33%
<b>Total</b>	<b>84</b>	<b>28</b>	<b>33%</b>

Overall, in England 31% of reviews identified at least one modifiable factor. The NCMD annual report will include where these modifiable factors are being identified on a national level and link to further data to support learning and communication opportunities.

## 5. Infant Mortality

Infant mortality is the death of infants under the age of one year. This is measured nationally and internationally by the 'infant mortality rate', which is the number of deaths of children under one year of age per 1000 live births.

Premature birth is the biggest contributor to infant mortality.

When an infant dies before the age of 28 days this is called a 'neonatal' death and when death occurs in the first 7 days of life this is usually referred to as 'early neonatal' death.

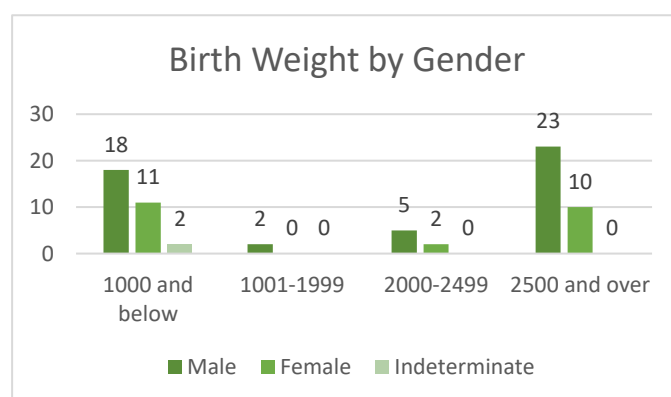
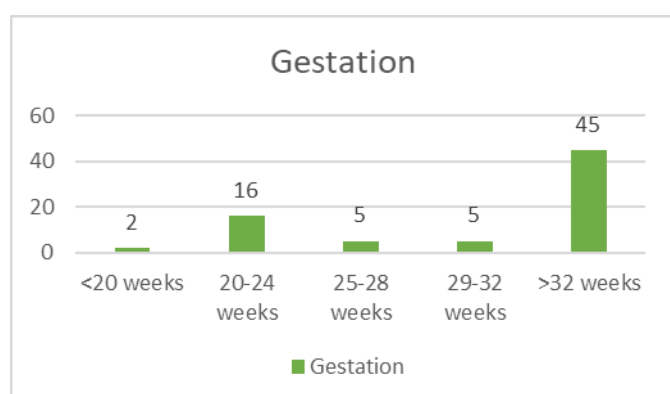
In 2019 – 2020 the Black Country has developed links with the Black Country and West Birmingham Local Maternity Services to support with their local vision:

*Through collaboration, we are committed to deliver high quality maternity services across the Black Country and West Birmingham shaped by the voices of local people. Our aim is to provide safe, personalised and responsive maternity services and ensure every woman and baby receives the best possible care.*

Data has been supplied around maternal smoking, mother's BMI, booking details, gestational age and weight to support with the several workstreams carried out by healthcare providers and local public health teams to reduce infant mortality rates where possible.

- 73 deaths in this age group were notified to Black Country CDOP in 2019 – 2020

### Infant Mortality in the Black Country by gestation and birthweight 2019 - 2020



It is important to highlight that more deaths happened in gestation >32 weeks and weight >2500grams. This could well be a perinatal event, chromosomal or medical/surgical diagnosis.

Of the 84 deaths reviewed in 2019-2020, 62 were under the age of one year. This equates to 74%. Modifiable factors identified were:

- Alcohol
- Drugs
- Co Sleeping
- Unsafe sleeping practices
- Consanguinity
- Late booking and access to services consequently
- Communication between healthcare professionals

Nationally, 63% of deaths reviewed were in this timeframe and age group. The NCMD annual report will include where these modifiable factors are being identified on a national level and will be available in the Spring of 2021 – later than planned due to the increased workload created by Covid-19.

In past years, deprivation has been a factor in infant mortality. This is seen to still be the case, however it has not been possible to report on this due to data collection methods. This has now been addressed and relevant data is now being collected. However, Child Death Review Partners recognise that deprivation remains a major factor in the deaths of Infants in the Black Country and the reduction of deaths in this age group will be another priority for 2020 – 2021. It is anticipated that the LMNS, Public Health and CDOP will combine their data and action plans to more effectively support the reduction of infant mortality in the Black Country.

## 6. Developments During 2019-2020

### Learning from child deaths



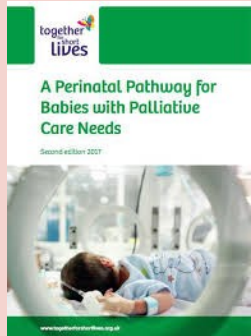
#### Consideration of antenatal Advanced Care Plans (ACP)

##### Advance Care Plan

A formal care plan that includes details about the baby's condition, decisions made with their parents or carers (for example, about managing symptoms), and their wishes and ambitions. This plan is a core element of their palliative care.

Parents are sometimes cautious about allowing an advanced care plan to be written and applied, especially antenatally.

Health practitioners are asked to approach this subject with care and sensitivity at diagnosis to help palliative care pathways.



#### Asthma Care Pathway

An asthma care pathway has been revised in line with NICE guidance to support admissions of this type to ensure consistency across age ranges 0-18.

(NICE guidance: <https://pathways.nice.org.uk> › pathways › asthma › managing-asthma)

#### Vitamin D Deficiency

3 deaths in the past 18 months have had vitamin D deficiency as a factor, either wholly or contributory. The Panel has identified that awareness needs to be raised by health practitioners to new mums and mums to be.

- Agencies need to have clear communication and referral pathways specifically with regards to urgent mental health cases
- Communication was identified as a learning point within agencies and across agencies. Agencies are asked to reflect on the ways in which they communicate with staff and parents to ensure consistency, sensitivity, clarity and accuracy.
- Staff working with child death need to have access to bereavement support and supervision
- Advanced Care Plans need to be kept up to date
- Communication between staff to be improved, specifically from hospital to hospital
- Professional Curiosity
- Pathways to adult mental health services to be more robust
- Consistent information to be given to parents

**Communication was identified as learning action points in each of the reviews; written and verbal.**

***Agencies are asked to reflect on the ways in which they communicate with staff and parents to ensure consistency, sensitivity, clarity and accuracy.***

- Where children have complex needs, it is important to assess the holistic needs of the family, including religious and cultural beliefs, to support effectively
- It is important to support young people to understand their medical conditions and how to make healthy choices, *i.e. the importance of taking medication regularly*
- Appointments need to be flexible to fit in with family commitments

Following each child death overview panel, learning was captured in a newsletter and sent to all panel members with the expectation they will disseminate widely within their agencies. Members are also urged to consider disseminating any learning from child deaths with Governance and Safeguarding colleagues.

In certain cases, the CDOP sought assurance that a particular action arising from a child's death had been addressed. As it is difficult on occasions to gain assurance on actions from Child Death Review meetings, it has been decided that healthcare professionals carrying out Child Death Review meetings should be responsible for following up specific actions.

## 7. Achievements

- Successful recruitment of a Black Country Co-ordinator (August 2019) and Black Country Administrator (February 2020). An Independent Black Country Chair will be recruited in the new financial year. Child Death Review partners have chaired in the interim period
- The North (Wolverhampton and Walsall) and South (Sandwell and Dudley) operating panels have merged for the final meeting of the year in March 2020 with the aim to have a Black Country combined operational panel in 2020 -2021, which has led to improved consistency and a more joined up approach to learning
- In December 2019, the first meeting of the Black Country CDOP Strategic Partnership took place. Members are made up of the Child Death Review Partners and are representative of professionals and geography. It has been established to:
  - Ensure that there is a strategic influence from child death reviews to reduce risk of death and future harm to children, within a changing environment
  - Provide oversight and assurance of the whole Child Death Review (CDR) and Sudden Unexpected Deaths in Children (SUDC) processes in accordance with the national child death review statutory and operational guidance 2018 and local child death review policies across the Black Country, to ensure consistency and quality
  - Consider what, if any, action should be taken in relation to any modifiable factors identified, and make recommendations to multi-agency safeguarding arrangements, health and wellbeing boards and other relevant strategic partnerships
- Child Death Review Meetings (CDRMs) have been successfully implemented across hospital trusts in the Black Country and these are evolving as lessons are learnt. This will effectively reduce the timescale when putting any local actions into place whilst staying compliant with legislation
- Relationships have been formed with the Local Maternity System to support with the reduction in infant mortality and this partnership will be developed further in the coming year
- 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
- Links with LeDer professionals across the Black Country have been embedded: The LeDer Programme covers the deaths of all people with a learning disability from the age of 4. As the deaths of children (up to age 17) are reviewed for the Child Death Overview Panel (CDOP) these deaths are not subject to an additional LeDer review. During a Child Death Overview Panel, any possible learning and recommendations related specifically to learning disabilities are discussed and submitted to relevant partners.



## 8. Future Priorities

- Recruitment of an Independent Chair and development of the role across the Strategic and Operational groups
- Training and support to new personnel to ensure high standards are maintained and new projects are taken forward
- Developing the role of the Medical Examiner and expanding to community and paediatric deaths
- Development, ratification and implementation of the Black Country SUDC protocol. In 2020 – 2021 there are plans to develop a *Black Country wide on call health response* for unexpected deaths
- Embedding of Black Country Panels to include members representing their profession on a rota basis and splitting panels into themed neonatal deaths and other deaths
- Development of and training for the Key Worker role to ensure the voice of the child/parent is reflected
- Explore the use of different methods of disseminating learning from child deaths (e.g. social media for the public, briefings for different workforces and changes to systems)
- Development and implementation of a campaign to promote safe sleeping practices and strategies to support the prevention of shaken babies
- Bereavement support for professionals working within the child death arena
- Linking more strongly with existing workstreams to support with the dissemination of learning
- Consolidating strategies to achieve a reduction in Infant Mortality across the Black Country

## 9. Response to Covid-19 Pandemic

The COVID crisis started just after the period covered by this Annual Report. However, given the time of publishing this report, it is important to acknowledge the impact of Covid at this time. Changes to CDOP work since April 2019 has included:

- Contribution to national working group chaired by the National Child Mortality Database to develop guidance for Joint Agency Responses (JAR) during this period
- Revised local JAR guidance issued in light of the COVID restrictions
- Liaison with the Incident Control Centres
- CDOP meetings have been carried out remotely
- Revised national Notification form to capture effects of COVID and lockdown on child deaths
- Letter to all Trusts and partner agencies to support continuation of CDR process with appropriate adaptations despite the shutdown of some other non-essential services

We will consider and monitor all child deaths that occur as a direct or indirect result of Covid-19 at the CDOP and ensure any actions which need to be implemented are recommended by the Panel. There will be a more in-depth commentary on this activity in the next annual report.