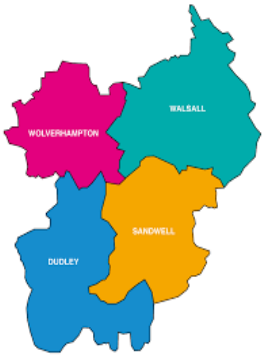
Black Country Child Death Overview Panel

Annual Report 2021 - 2022



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BLACK COUNTRY CHILD DEATH COORDINATOR
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BLACK COUNTRY CHILD DEATH OVERVIEW PANEL

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1. Foreword – Independent Chair

Losing a child is the most devastating thing that can happen to a parent.

I continue to be amazed at the dedication and professionalism of those on the front line, and panel members who strive to make sure that we can learn something from each death, so that we can prevent future deaths and reduce risks to children. The global pandemic continued to interrupt and impact on child death review processes across all four areas of the Black Country, much as it does across much of the country.

This report aims to not only reflect the cases the panel has considered throughout 2021-22, but also the achievements of the partnership, future priorities for action, and issues related to the implementing the statutory child death review processes. The National Child Mortality Database, for which we provide data, is now able to provide more meaningful comparative reports, which will help support the agenda of children's safeguarding and health and wellbeing.

I would like to thank all the Panel members, for their continued commitment and hard work, to what is a particularly emotive subject. I would also like to thank Jaki Bateman and Michelle Mincher for the hard work that goes on behind the scenes to ensure that the Panel runs smoothly and keeps pace with the changing landscape.

Mike Leaf

Black Country Independent Chair

2. Introduction

This is the third report of the Black Country Child Death Overview Panel. The Black Country Death Overview Panel (BC CDOP) is an inter-agency forum for Child Death Reviews comprising of organisations from Sandwell, Dudley, Walsall, and Wolverhampton.

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 a statutory body and are accountable to their respective Local Authorities and Clinical Commissioning Groups. Every child death is a devastating loss that profoundly affects the family involved.

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. This is grounded in respect of the rights of the child and their family, with the objective of preventing child deaths.

Learning lessons from Child Death cases is a priority, and will have a positive impact on the safety, health and wellbeing of children and young people, and to ensure the learning is shared widely across the area, as well as regionally and nationally. This report explores the statistical and qualitative conclusions from the Child Death Overview Panel Reviews in the Black Country during the reporting year April 2021 to March 2022.

Purpose

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, to learn lessons and share findings for the prevention of child deaths.

The Child Death Overview Panel review is intended to be the final scrutiny over a child's death. 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.

Statutory Framework and Governance

Chapter 5 of the Child Death Overview Panels Statutory and Operational Guidance (2018), sets out the key features of a good Child Death Review (CDR) process to be followed by all organisations involved with the process of child death reviews as of 1st April 2019. The Department of Health & Social Care have taken over statistical analysis of Child Death Review data from the Department for Education as of April 2019. Greater regionalisation of child death reviews was encouraged, and further work undertaken to develop a national database. The Department of Health will disseminate relevant learning to Local Safeguarding Children's Partners.

Operational Overview

The Black Country Child Death Overview Panel membership is made up of senior multi-agency professionals who have knowledge and expertise in fields such as public health, children's social care, paediatrics, police, education etc. The panel consists of representation from a range of organisations who can make a valuable contribution when undertaking a child death review. Each professional provides information and advice to enable a thorough review and analysis, with the aim of identifying relevant factor, modifiable factors, and emerging themes.

The purpose of a review and analysis is to identify any matters relating to the death(s), that are relevant to the welfare of children in the area or to public health and safety, to consider whether action should be taken. The aim of the child death review process is to ensure that information is systematically captured for every death to enable learning and prevent future deaths. The Child Death Overview Panel publishes an annual report which provides an overview of local patterns and trends and evidence what has taken place because of the child death review arrangements and how effective the arrangements are in practice.

Themed Panel Meetings

Some child deaths are reviewed at the Themed Panel meeting to discuss a particular cause or group of causes. The Black Country Child Death Overview Panel holds Themed Panel meetings to review neonatal deaths (<28 days of life). Such arrangements allow for the attendance of appropriate professional experts and independent scrutiny from a neighbouring authority neonatal unit, to inform discussions and allow easier identification of themes.

Child Death Review Meetings

The Black Country Child Death Overview Panel is informed by the referral of a standardised report analysis form from the Child Death Review Meeting (CDRM). The meetings are attended by professionals who were directly involved in the care of the child during their life, and any professional involved in the review of their death. At this meeting, all matters relating to the individual child death are discussed. The composition of professionals at the CDRM varies according to the circumstances of the child death and is not limited to medical staff. The focus of this meeting is:

- To review background history, treatment, and outcomes of investigations to determine as far as possible the likely cause of death
- To ascertain any contributory or modifiable factors from the death
- To describe any learning from the death, and, where appropriate to identify any actions that should be taken arising from the death
- To review the support provided to the family and to ensure families are provided with a plain explanation of why their child died
- To ensure that the Child Death Overview Panel and, where appropriate, the coroner is informed of the outcomes of any investigation into the child's death
- To review the support provided to staff involved in the care of the child

The National Child Mortality Database (NCMD)

The National Child Mortality Database (NCMD) is a repository of data relating to all child deaths in England. The NCMD was 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 Child Death Overview Panels across England submit data via the NCMD. The Black Country continues to use a web-based system that submits the required data and reports are received on a quarterly basis summarising submitted data.

Black Country eCDOP Database

The eCDOP system is being used across England and feeds into the National Child Mortality database. The eCDOP Database management with Quality Education Systems continues to be used for meaningful data collection, consolidation, and analysis of data from panel reviews. The annual contract was renewed for the financial year April 2022 to March 2023.

The eCDOP system provides an online procedural structure for notifications, reporting and meeting protocol for the areas that form the Black Country Clinical Commissioning Partnership, and supports coordination of interaction between the two parts of a child death review as required under the new working arrangements for Child Death Overview Panels.

Strategic Partnership

Strategic partners, including police and safeguarding partnerships meet on a quarterly basis to ensure the statutory function of Child Death Overview Panel being robustly implemented and to highlight any concerns for escalation.

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

Process: Relevant Factors & Modifiable Factors

Information is collated using the Department of Health and Social Care (DHSC) national Child Death Overview Panel reporting forms. Completed forms are presented during the Child Death Overview Panel meeting to assess the death. As part of the child death review process, the Child Death Overview Panel is responsible for analysing information to determine the categorisation of death (see appendix 2), relevant factors and modifiable factors. Such modifiable factors are defined as factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Information is collated and categorised using the four domains:

Domain A: Factors intrinsic to the child:

Factors in the child (and in neonatal deaths, in the pregnancy) relating to the child's age, gender and ethnicity; any pre-existing medical conditions, developmental or behavioural issues or disability, and for neonatal deaths, the mother's health and wellbeing.

Domain B: Factors in social environment including family and parenting capacity:

Factors in family structure and functioning and any wider family health issues; provision of basic care (safety, emotional warmth; stimulation; guidance and boundaries; stability); engagement with health services (including antenatal care where relevant); employment and income; social integration and support; nursery/preschool or school environment.

Domain C: Factors in the physical environment:

Factors relating to the physical environment the child was in at the time of the event leading to death, and for neonatal deaths, the mother's environment during pregnancy including poor quality housing; overcrowding; environmental conditions; home or neighbourhood safety; as well as known hazards contributing to common childhood injuries (e.g., burns, falls, road traffic collisions)

Domain D: Factors in Service Provision:

Factors in relation to service provision or uptake including any issues relating to identification of illness, assessment, investigations, and diagnosis; treatment or healthcare management; communication or teamwork within or between agencies; and organisational or systemic issues. Consider underlying staff factors, task factors, equipment, and work environment, education and training, and team factors.

For each of the four domains, Black Country Child Death Overview Panel determines the level of relevance (0-2) for each factor, relating to the registered cause of death and to inform learning of lessons at a local, regional, and national level. The categories are:

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

As part of the review, the Child Death Overview Panel is responsible for identifying modifiable factors, although categorising a death as having modifiable factors does not necessarily mean the Child Death Overview Panel regards the death in question as preventable, but that there may be emerging trends which could reduce the risk of future child deaths.

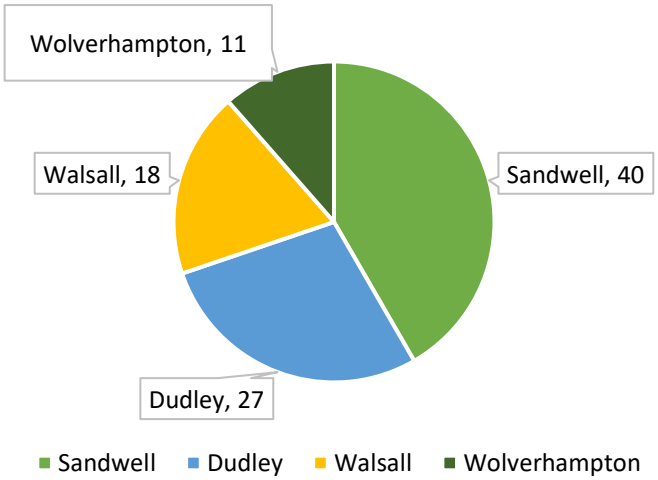
Modifiable factors identified: The review has identified one or more factors across any domain which may have contributed to the death of the child, and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future child deaths.

No modifiable factors identified: The review did not identify any modifiable factors or inadequate information upon which to make a judgement: The review was unable to identify if any modifiable factors were present.

3. Deaths Notified in 2021 – 2022

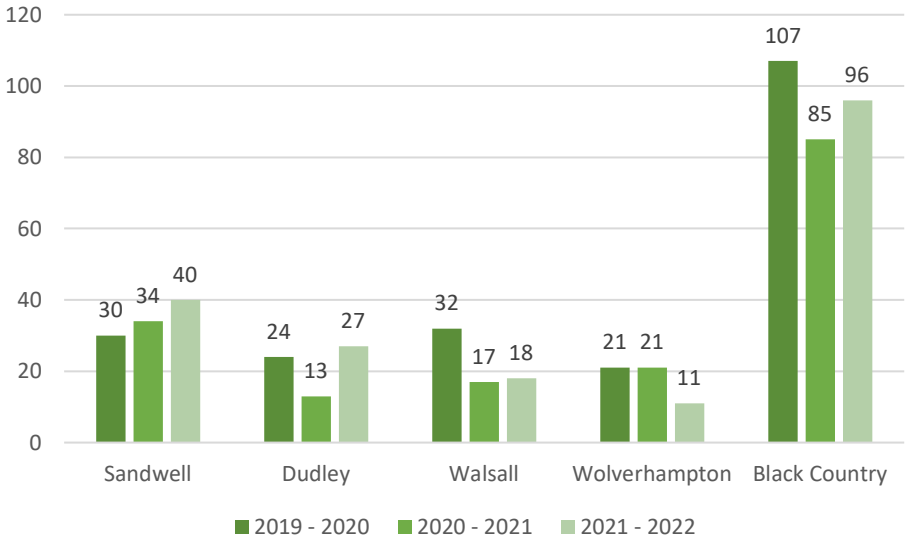
96 deaths in total were notified across the Black Country between April 2021 – March 2022. Nationally, the NCMD reports 3,470 Child Death notifications by CDOP's between April 2021 – March 2022. This is an increase of 396 child deaths nationally from the previous year, 2020-2021, where there was a significant reduction in child death notifications.

Chart 1: Black Country Death notifications by area - 2021-2022



In 2021-2022 there were 96 child deaths notified in the Black Country with 42% in the Sandwell, 28% in Dudley, 19% in Walsall and 11% in Wolverhampton.

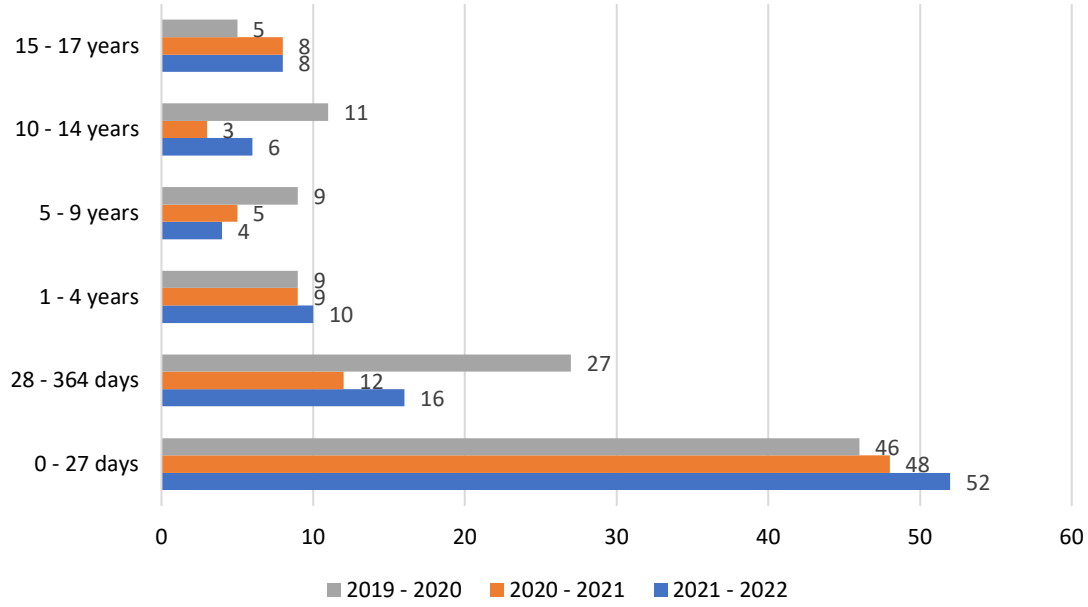
Chart 2: Black Country Death Notifications for each area – 3-year comparison 2019-2022



The chart above shows a 3-year comparison using data collected consistently from across the Black Country since the new arrangements in April 2019. Sandwell, Dudley, and Walsall have seen an increase since 2020 – 2021, where Wolverhampton has seen a 52% decrease in numbers. Overall,

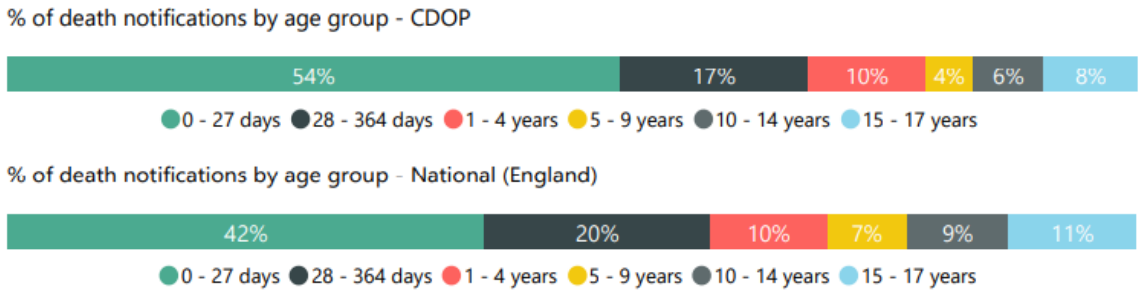
the Black Country has seen a 13% increase in child deaths from 2020 – 2021, although numbers are not as high as they were in 2019 - 2020.

Chart 3: Black Country Death Notifications by Age Group - 3 Year Comparison 2019-2022



Overall, deaths have increased in the 0 - 27 days, 28 – 364 days, 1 – 4 years and 10-14 years age groups since 2020-2021. There has been a slight decrease in the 5 – 9 years age groups and death notification have remained the same in the 15 – 17 years age group as 2020 – 2021. The pattern of notifications by age is similar to the national pattern.

Chart 4: Black Country and England Death Notifications by Age Group - 2021-2022



In 2021 – 2022, the proportion of deaths in the 0-27 days age group is 28% more in the Black Country when compared to the National (England) data. In summary the infant mortality (under one year) remains higher in the Black Country than nationally, and accounts for 69.8% of all deaths over the 3 years 2019-22. The proportion of deaths in the other age groups appears slightly lower than the National (England) figures although the notification of death for 1-4 years is at the same level.

Black Country Death Notifications by age – 2019 – 2022 – 3-year comparison for each area

Care should be taken in attempting to establish trends over time when dealing with small numbers, as they are likely to fluctuate from year to year.

Chart 5: Dudley - 3-year Comparison of Death Notifications by Age

In Dudley in 2021/2022, deaths have reduced in the 10 – 14 years age group. All other age groups have increased apart from the 5 – 9 years age group which remains the same as in 2020 – 2021. The greatest increase is in the neonatal age group, 0 – 27 days where this has more than doubled from the previous two years.

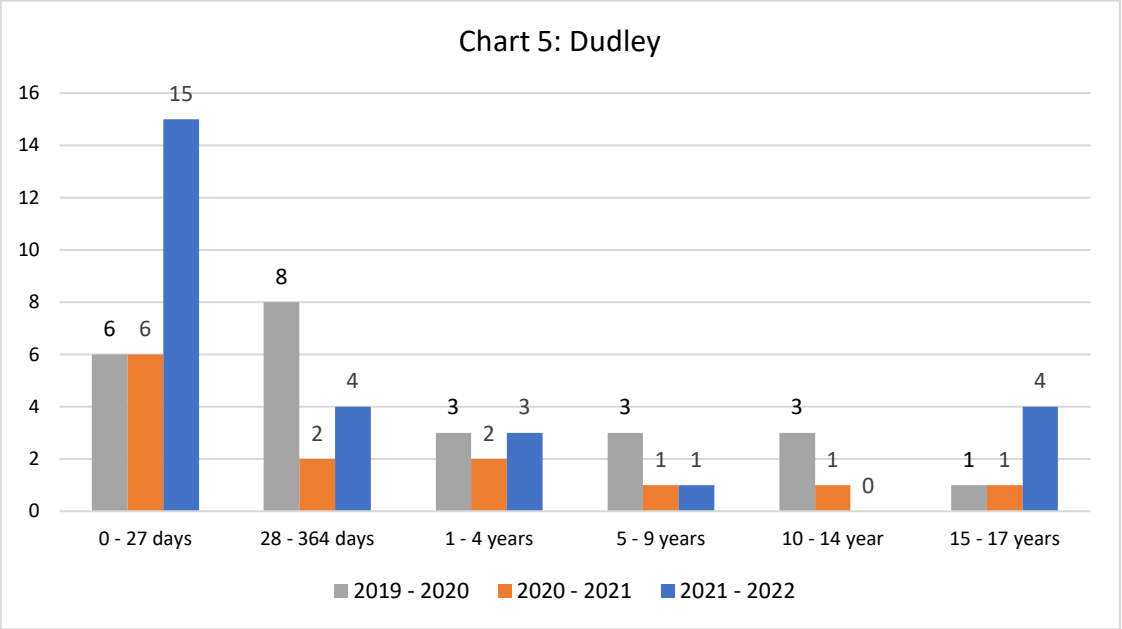


Chart 6: Sandwell - 3-year Comparison of Death Notifications by Age

In Sandwell in 2021/2022, deaths have reduced in the 5 - 9 years and 15 - 17 years age groups. However, deaths have increased in all other age groups, although numbers are small. The largest increase was in the 10 – 14-year age group.

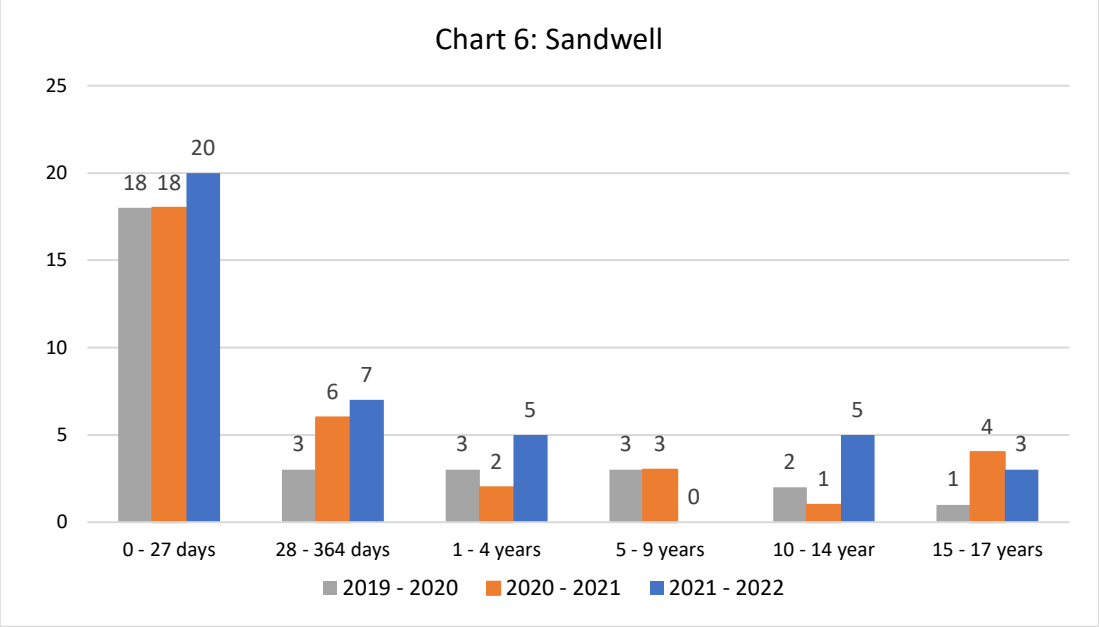


Chart 7: Walsall - 3-year Comparison of Death Notifications by Age

In Walsall in 2021/2022, deaths have increased in the 5 – 9-year age group and 28 – 364 days age group. The largest reduction in deaths was see in the 0 – 27 days age group. The other age group deaths remained the same as 2020-2021.

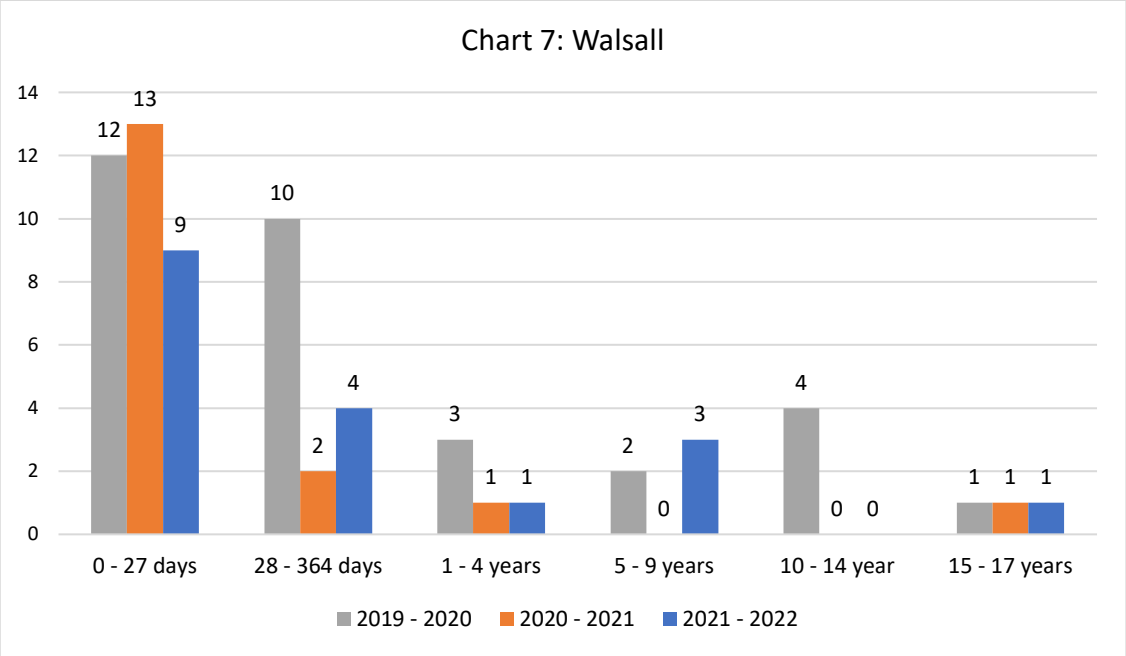


Chart 8: Wolverhampton - 3-year Comparison of Death Notifications by Age

In Wolverhampton in 2021/2022, deaths reduced in every age group, except for the 10 – 14 years age group where it remained the same as 2020-2021.

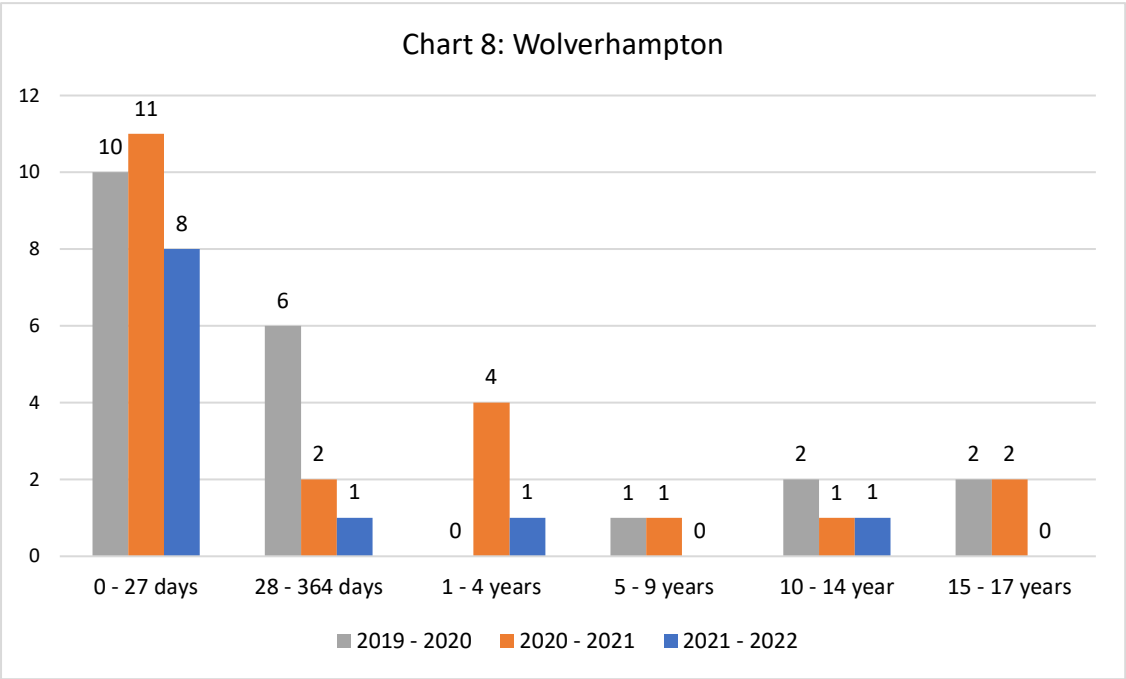


Chart 9: Black Country Death Notifications by Ethnicity – 3-year Comparison 2019 - 2022

Ethnicity	2011 Census 0-18 years	%	2019 – 2020 Notified Deaths	2019 – 2020 %	2020 – 2021 Notified Deaths	2020-2021 %	2021 – 2022 Notified Deaths	2021-2022 %
White British	41249	55.50	43	**40.19**	29	**34.12**	43	**45**
White Other	2475	3.30	5	**4.67**	8	**9.42**	5	**5**
Mixed Multiple Ethnic Group	5786	7.70	18	**16.82**	2	**2.35**	3	**3.5**
Asian British Indian	7584	10.20	8	**7.48**	9	**10.59**	12	**12.5**
Asian British Pakistani	5773	7.80	12	**11.21**	7	**8.23**	9	**9.5**
Asian British Bangladeshi	2840	3.80	3	**2.80**	2	**2.35**	5	**5**
Asian British Chinese	227	0.30	4	**3.74**	0	**0.00**	0	**0**
Other Asian	1913	2.60	0	**0.00**	4	**4.70**	3	**3.5**
Black British African	1623	2.20	4	**3.74**	7	**8.23**	4	**4**
Black British Caribbean	2552	3.40	4	**3.74**	3	**3.53**	5	**5**
Black British Other	1019	1.40	0	**0.00**	6	**7.06**	2	**2**
Other Ethnic Group/Not recorded	1335	1.80	6	**5.61**	8	**9.42**	5	**5**
Totals	74376	100%	**107 notified deaths in 2019-2020**	100%	**85 notified deaths in 2020-2021**	100%	**96 notified deaths in 2021-2022**	100%

Most deaths notified in 2021 – 2022 were from children identified as 'White - British' (45%). The second largest ethnic category of deaths notified within this reporting year was 'Asian or Asian British – Indian' (12.5%). As with previous years, this contrasts with those children from a Black, Asian or Minority background where there was a higher percentage of reported child deaths compared to the population size (0-18yrs). Hopefully this data will be more reliable and take into consideration population migration next year when new census data should be made available.

Nationally, the Ethnic group was recorded in 3,330 (96%) death notifications. Of these, 64% of deaths were of children who were recorded as being from a White ethnic group, 18% of deaths were of children from an Asian or Asian British background, 8% were from a Black or Black British background, 7% were from a mixed background and 3% were from any other ethnic group. These proportions were like the previous year.

The National Child Mortality Database highlighted the improvement in completeness of ethnicity records compared to previous years and this should help ensure mortality differences by ethnicity can be measured accurately in future years.

Background: Infant Mortality Rates and Ethnicity

Substantial inequalities in infant mortality rates are known to exist between white and ethnic minority groups in England and Wales (Gray et al., 2009), and low gestational age is strongly linked to poor health (or mortality) (Kurinczuk et al., 2009). However, information about ethnicity and gestational age is not always collected at birth registration.

Since 2005 birth registration records have been linked with NHS birth notification records. This data is then linked to death registration records for babies who died before their first birthday. By linking the 3 data sources, figures can be reported for infant mortality by gestational age and ethnicity, as well as other risk factors including: birthweight, mother's age at birth of child, marital status, and socio-economic status (based on the most advantaged parent's occupation).

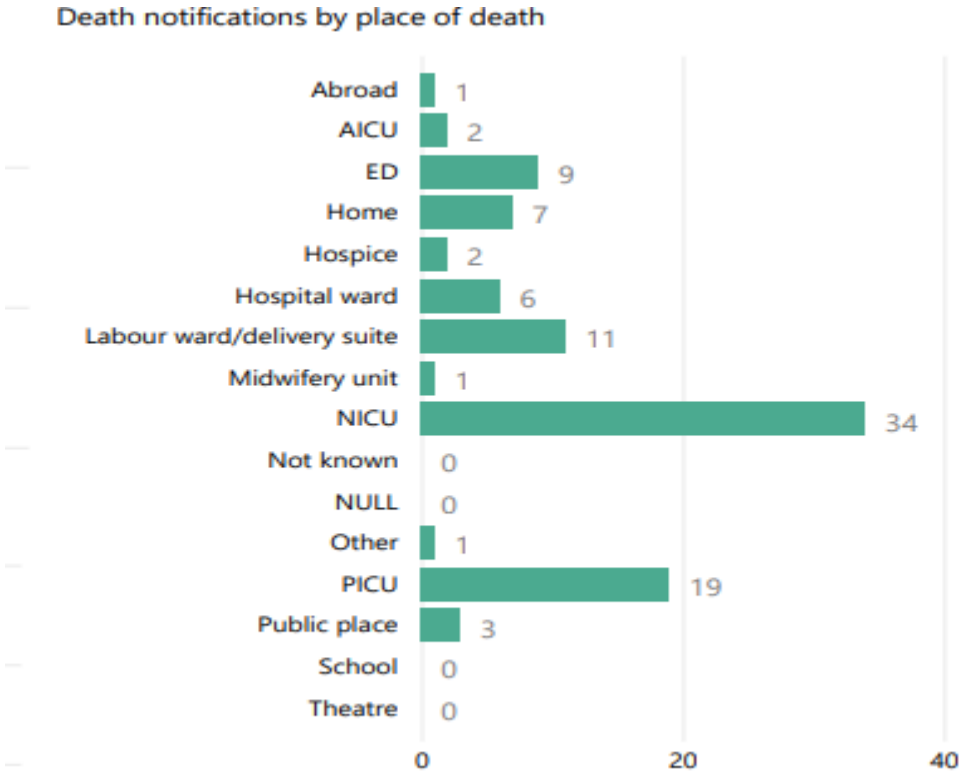
The NHS birth notifications system collects information about ethnicity to help organisations monitor their service delivery. Ethnicity is usually self-defined, for birth notifications the baby's ethnic group is defined by the mother.

Individuals may choose not to state their baby's ethnicity. In some areas with a very high proportion of "Not Stated" records opting-out may not be the sole reason for incomplete data, as the "Not Stated" response category also includes "not known", "missing" and "not asked".

Place of death

The place of death is defined at data collection as where the child is believed to have died regardless of where death was confirmed.

Chart 10: Black Country Death Notifications by place of Death – 2021-2022



It makes sense that as most deaths have occurred in the 0 – 28 days age group that the place of death reflects this with deaths occurring in the NICU and labour ward/delivery suite.

It is concerning, however, that the trend has continued from last year where large numbers of deaths have occurred at home, ED, and public places. However, as summarised last year, this also corresponds to the unexpected death reported below.

Nationally, where the place of death was known, the majority (74%,) of deaths occurred in a hospital Trust, consistent with the previous year. Deaths that occurred on neonatal units accounted for 869 (25%) of deaths; the largest proportion of deaths across all locations recorded. There was an increase in the number of deaths where the place of death was recorded as the child's home or a public place in 2021-2022 when compared to previous years.

Black Country Unexpected Deaths requiring a Joint Agency Response (JAR)

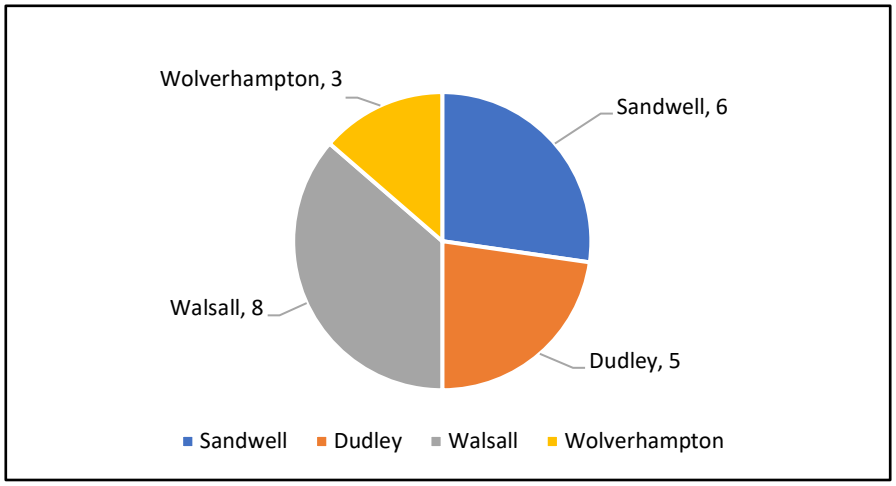
22 of the 96 (22.9%) deaths notified to the Black Country in 2021 – 2022, were unexpected and required a Joint Agency Response (JAR).

An unexpected death involves cases in which there is death (or collapse leading to death) of a child, which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent.

There is a requirement to perform further investigations for children who die where the cause is unknown. This process is referred to as a Joint Agency Response (JAR) and is a coordinated multi-agency response which is triggered if a child's death:

- is or could be due to external causes.
- is sudden and there is no immediately apparent cause (including 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.
- in the case of a stillbirth where no healthcare professional was in attendance.

Chart 11: Black Country Unexpected Deaths Requiring a JAR by area – 2021-2022



Overall, there was a higher proportion of unexpected deaths requiring a JAR in Walsall compared to the other areas.

Chart 12: Black Country Unexpected Deaths Requiring a JAR by gender – 2021-2022

Males represented 82% of unexpected child deaths across the Black Country.

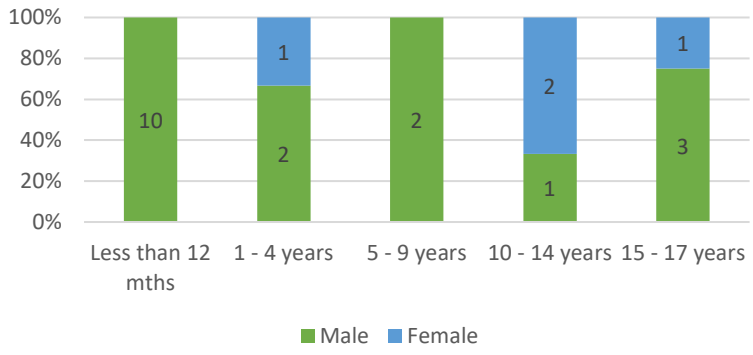
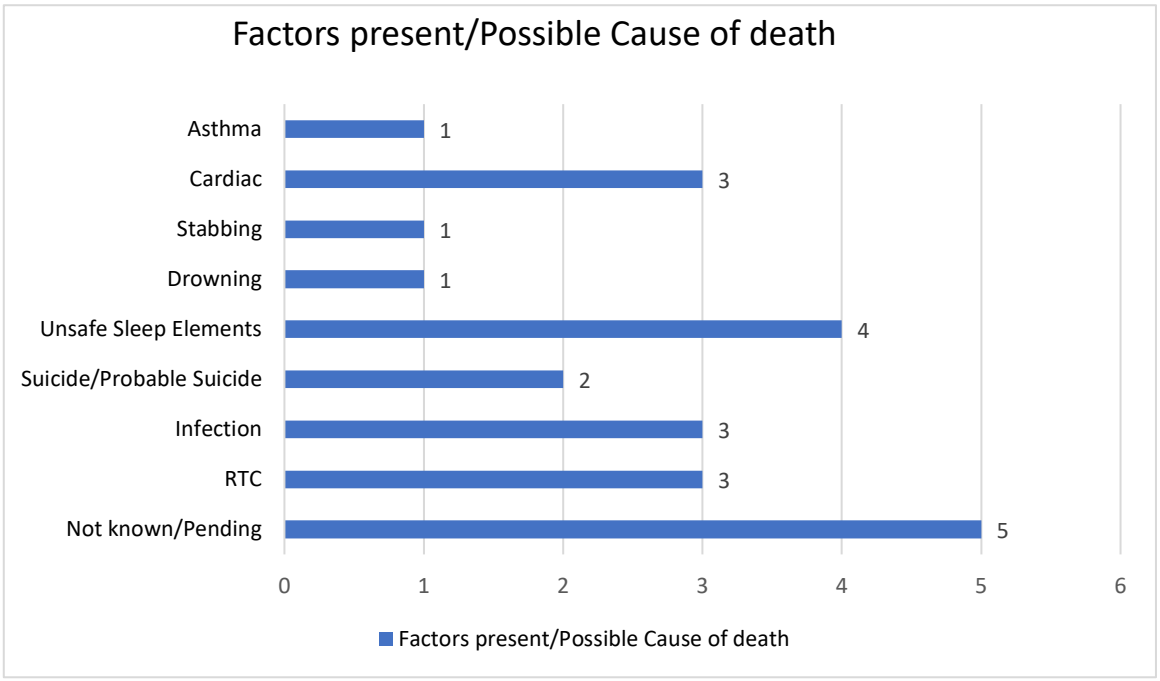


Chart 13: Black Country Unexpected deaths by category – 2021-2022



There has been a delay this year with obtaining results from the coroner due to an increased pressure on the service which is reflected in the 'Not known/Pending' section, which means that these deaths cannot be categorised. Out of the 3 infection deaths, 2 were known to be Covid-19 positive at the time of death. The cardiac cases were all children and young people over the age of 8.

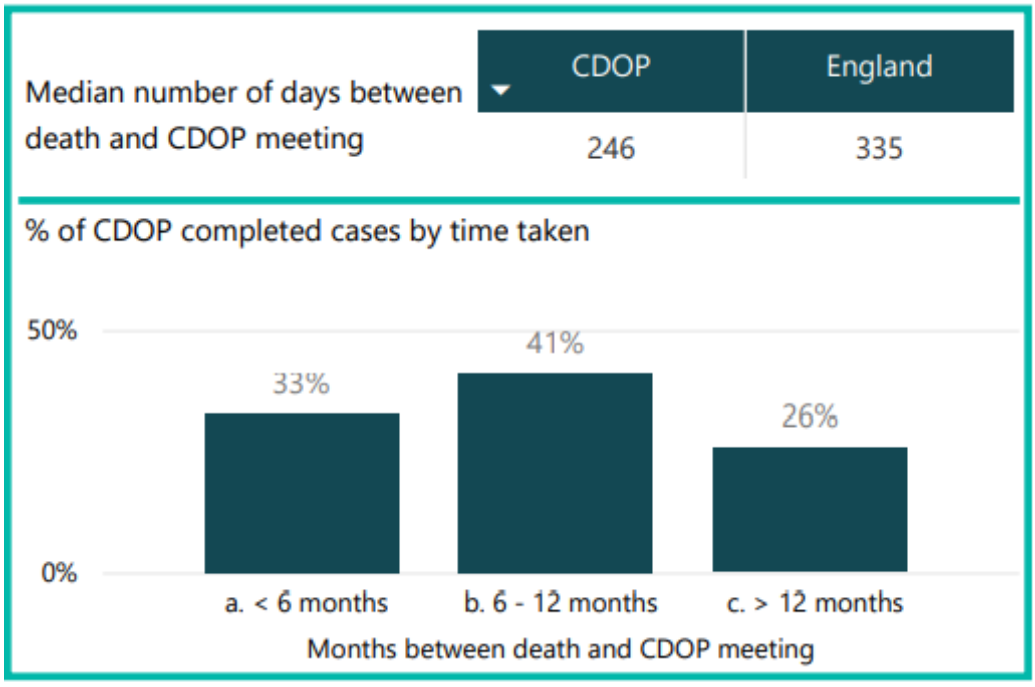
4. Deaths Reviewed 2021 – 2022

73 deaths in total from across the Black Country were reviewed in 2021 – 2022 at 8 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, representing their profession as well as their geography.

Child Death guidance states that deaths cannot be reviewed until all investigations are completed, safeguarding reviews published and relevant information gathered. Guidance in 2019 placed a responsibility 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 Child Safeguarding Practice Review (previously Serious Case Review) will also affect a timely review.

Chart 14: Black Country CDOP completed cases between death and CDOP meeting 2021-2022



The top chart shows that the Black Country continued to review deaths in a shorter period than the England average in 2021 – 2022. The bottom chart highlights the majority of CDOP completed cases take between 6-12 months from notification of death to CDOP meeting.

Chart 15: Black Country reviewed deaths by area and year of death – 2021-2022

Completed CDOP Reviews by LSCB

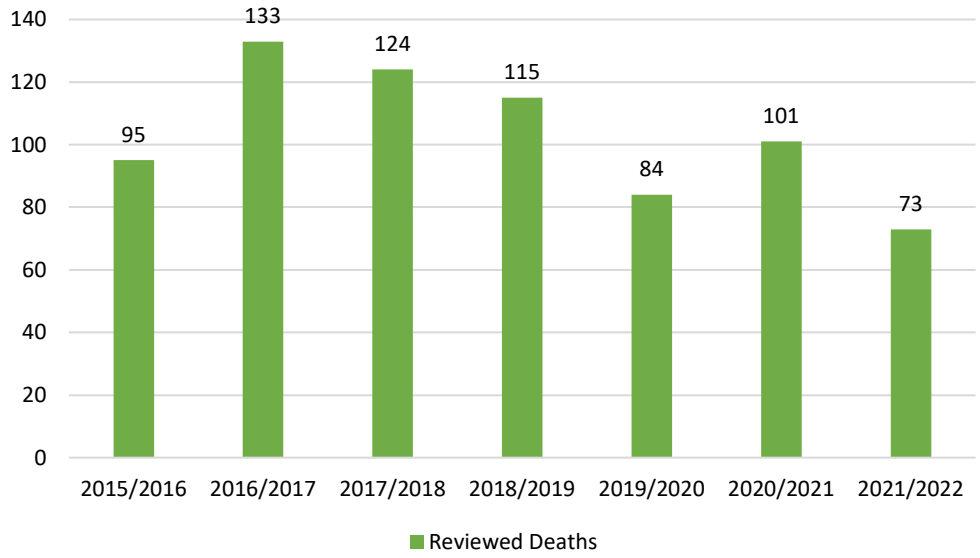
LSCB name	Cases
Dudley	16
Sandwell	33
Walsall	11
Wolverhampton	13
Total	**73**

Completed CDOP Reviews by year of death

Year of death	Cases
2018-19	1
2019-20	6
2020-21	39
2021-22	27
Total	**73**

Most deaths reviewed in 2021 – 2022 were from the previous year 2020 – 2021, where Child Death Review Meetings (CDRM) had been held and an analysis form completed as per the new process. Those deaths reviewed in earlier years were because of police and other investigations concluding.

Chart 16: Black Country Overview of reviewed deaths – 7-year comparison

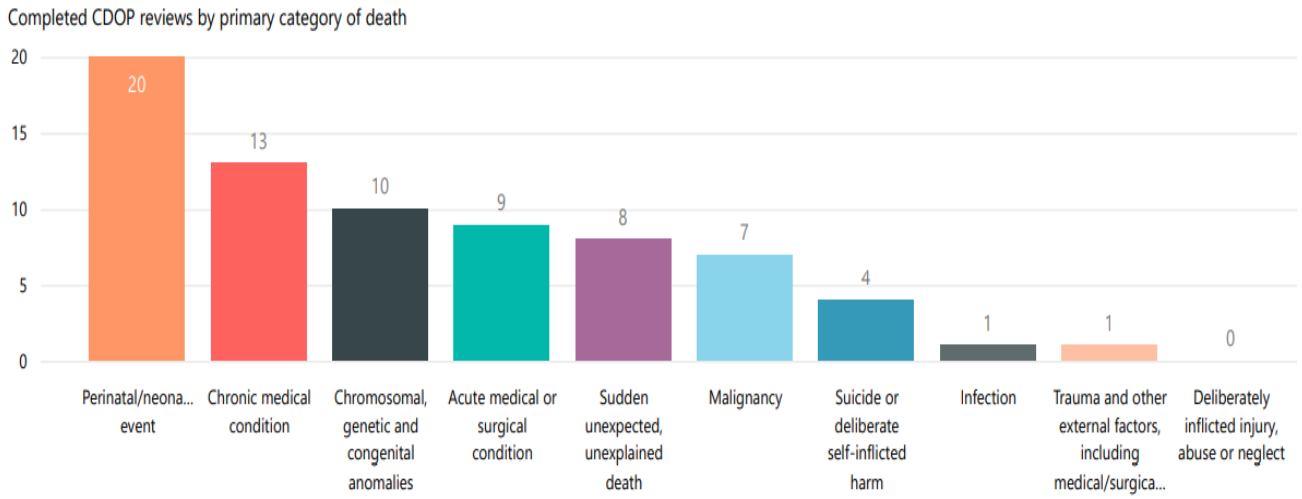


It is anticipated that between 80-100 deaths will be reviewed per year by the Black Country CDOP. In the year 2021 – 2022 only 73 deaths were reviewed which is the lowest in 7 years. This is partly explained by the continued impact of Covid-19 and in particular the unusual low number of child death notifications in the previous year (2020-2021) therefore fewer cases to review.

Nationally, 2,724 child deaths were reviewed by CDOPs in England between 1 April 2021 and 31 March 2022. Of these, 16% were reviews of children who died within the same year and 84% were reviews where the child died before 1 April 2021. This is a decrease from the previous year where 20% of reviews were of children who died within the same year.

The proportion of reviews that identified modifiable factors continues to rise each year with 37% of deaths reviewed during 2021-2022 identifying modifiable factors. Modifiable factors are defined as factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

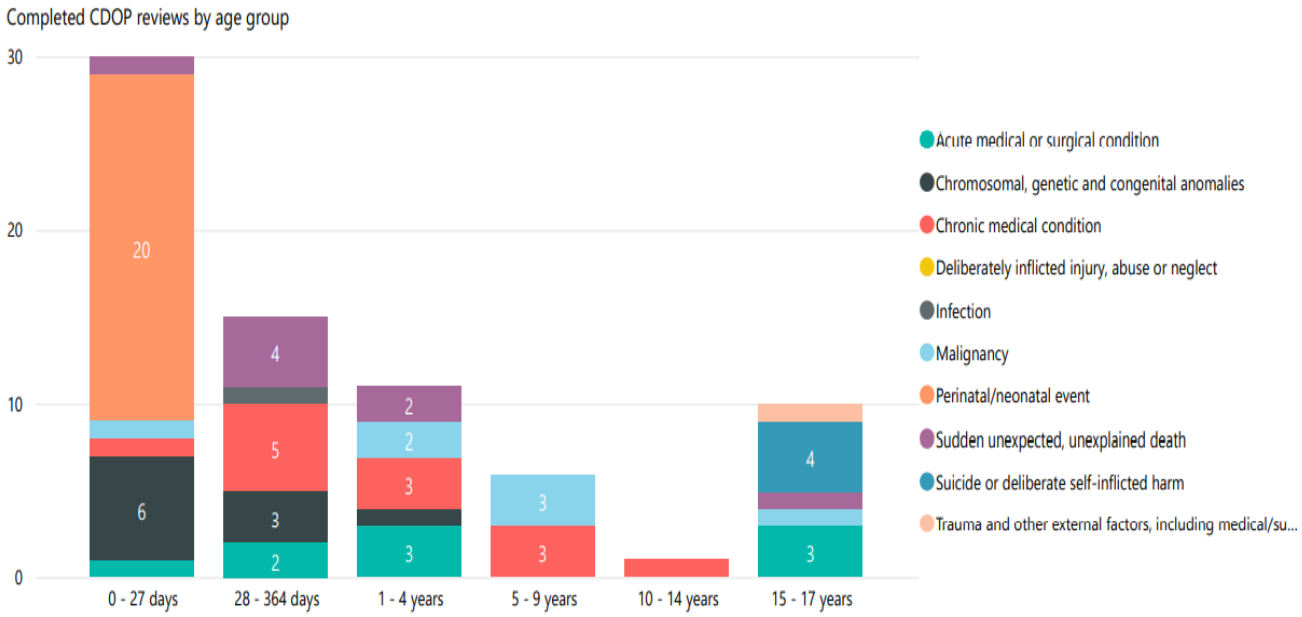
Chart 17: Black Country reviewed cases by primary category of death – 2021-2022



Of the 73 cases closed by the Black Country CDOP, the largest number of deaths were categorised as perinatal/neonatal event (27%) and chronic medical conditions (18%). Year on year, both categorises account for the largest proportion of child deaths and have remained stable overtime.

Most child deaths are due to medical causes which encompass multiple categories of death including acute medical or surgical, chronic medical, chromosomal, perinatal/neonatal event, malignancy, and infection. Small numbers were attributable to non-medical causes including trauma, deliberate harm/abuse/neglect, suicide/self-harm, and sudden unexpected/unexplained death.

Chart 18: Black Country reviewed cases by primary category of death and age group – 2021-2022



Most deaths reviewed in this period were deaths that happened for children under the age of one year and this is reflected in the greatest category of death, perinatal/neonatal event. CDOP also reviewed 10 deaths of children aged 15 – 17 years which included four suicides.

Chart 19: Black Country reviewed cases by Ethnic group and Age group – 2021-2022

Completed CDOP reviews by ethnic group and age group

Ethnic Group	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	Total
White	12	8	5	3	0	5	33
Unknown	1	0	0	0	0	0	1
Other	0	0	1	0	0	0	1
Mixed	3	3	2	0	0	2	10
Black or Black British	4	3	1	0	0	3	11
Asian or Asian British	10	1	2	3	1	0	17
Total	**30**	**15**	**11**	**6**	**1**	**10**	**73**

40% of reviewed neonatal deaths were reported as White British and 33% were reported as Asian or Asian British. This is in line with the Black Country demographics.

Nationally for child death reviews during 2021-2022, 34% of reviews recorded a primary category of Perinatal/Neonatal event and 23% recorded a primary category of Chromosomal, genetic, and congenital anomalies. Deaths categorised as Malignancy (8%) and Sudden Unexpected or Unexplained death (7%) were the next most frequent categories.

Chart 20: Black Country Reviewed Cases where modifiable factors were identified by category of death – 2021-2022

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

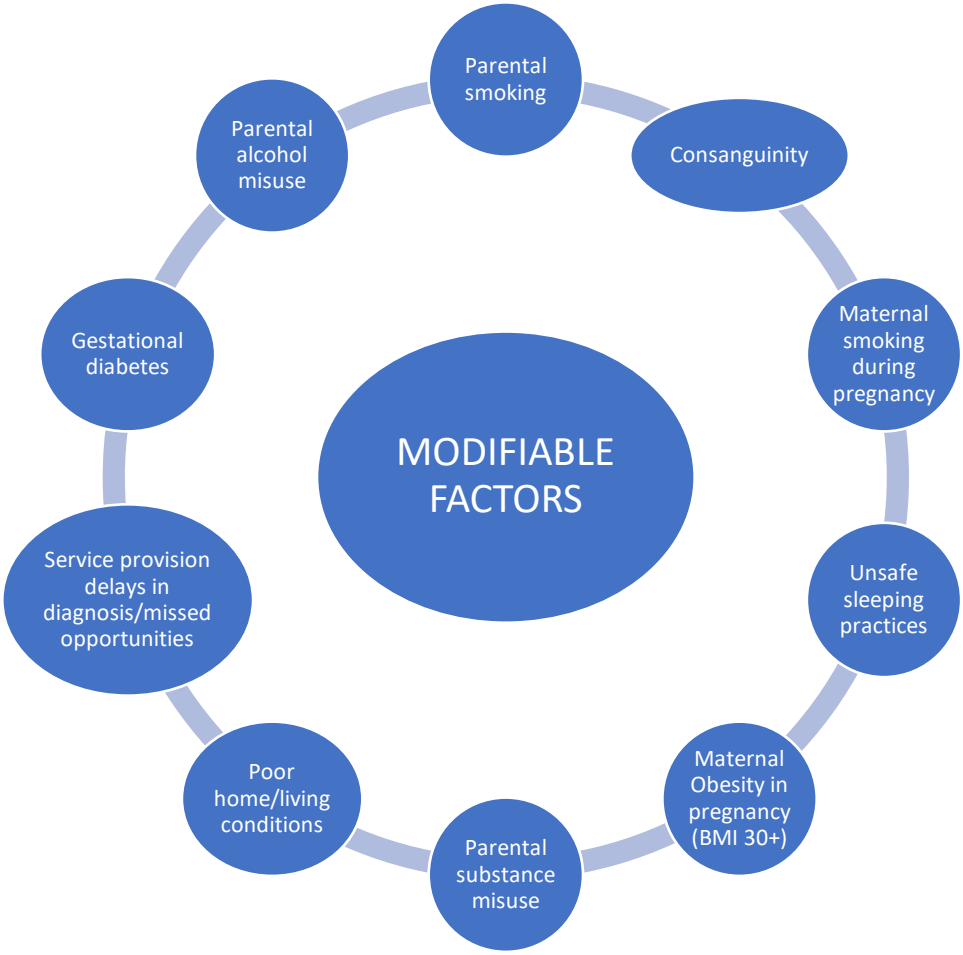
Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Trauma and other external factors, including medical/surgical complications/error	1	1	100%
Suicide or deliberate self-inflicted harm	4	0	0%
Sudden unexpected, unexplained death	8	5	63%
Perinatal/neonatal event	20	16	80%
Malignancy	7	0	0%
Infection	1	0	0%
Deliberately inflicted injury, abuse or neglect	0	0	0%
Chronic medical condition	13	3	23%
Chromosomal, genetic and congenital anomalies	10	5	50%
Acute medical or surgical condition	9	3	33%
Total	**73**	**33**	**45%**

33 (45%) of the 73 deaths reviewed in 2021 – 2022 were identified as having modifiable factors. This is considerably higher than the National figure at 37%.

These are factors where local or nationally achievable intervention could be modified to potentially reduce the risk of future child deaths. Of the 33 reviewed deaths with modifiable factors, 26 (79%) died before the age of one and 20 (61%) were during the neonatal period.

Some deaths feature multiple modifiable factors which vary depending on the circumstances leading to death and the cause of death ascertained. Modifiable factors act as multiplier effect, increasing the child's vulnerability where multiple factors are present.

Chart 21: Modifiable Factors



Smoking continues to 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 sudden unexpected, unexplained death. Maternal obesity, where mother has a raised body mass index (BMI) of 30+ during pregnancy is also a modifiable factor in perinatal/neonatal deaths, as is maternal alcohol and/or substance use during pregnancy. Multiple modifiable factors were also identified (antenatally and postnatally) in sudden unexpected, unexplained deaths the most common being unsafe sleeping arrangements including parental alcohol and/or substance use.

Though the numbers involved are relatively small, it emphasises that factors relating to smoking remain key modifiable factors for infant and child deaths. Despite ongoing efforts to reduce the rate of smoking, this continues to influence in the death of children and remains a steady modifiable factor. Further, the link between smoking and obesity strongly correlates with deprivation, meaning they represent a significant health inequality.

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.

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

CDOPs and CDR professionals follow the statutory child death review guidance which states that all live births of any gestational age need to be reviewed and notified. Many of the neonatal deaths are analysed using the Perinatal Mortality Review Tool (PMRT) which requires input from the antenatal and postnatal teams.

Themes that emerged from the PMRTs in the Black Country included:

- Antenatal
    - smoking in pregnancy
    - obesity
    - concealed pregnancy
    - high-risk fathers.

- Delivery
    - monitoring
    - awareness of risk factors requiring senior review
    - adequate staffing in high-risk deliveries

It remains challenging for staff to communicate with parents to ensure parents understand how unwell their child is and the chances of survival when they may not want to hear the message.

Infant Mortality in the Black Country

68 out of the 96 (70.8%) deaths notified during 2021-2022 were children under the age of one year old. Of these 68 notified deaths, 52 occurred before 28 days.

Chart 22: Black Country Notified Neonatal deaths by area – 2021-2022 (before the age of 28 days)

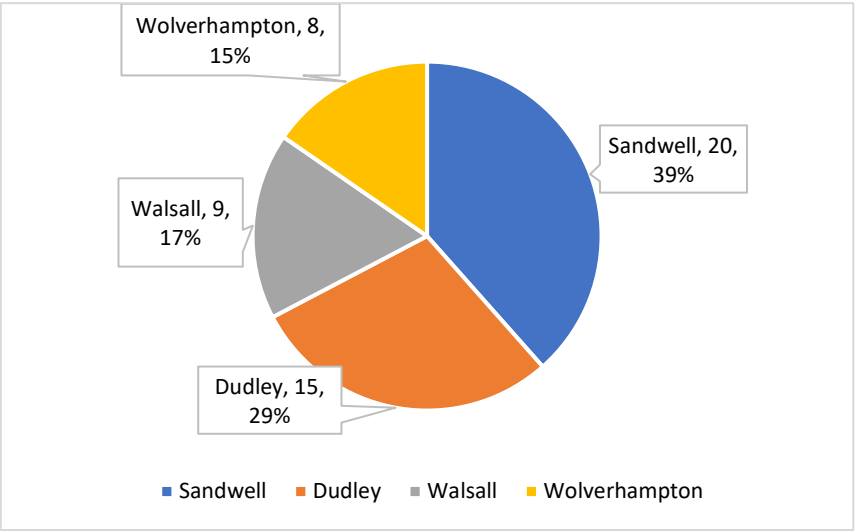
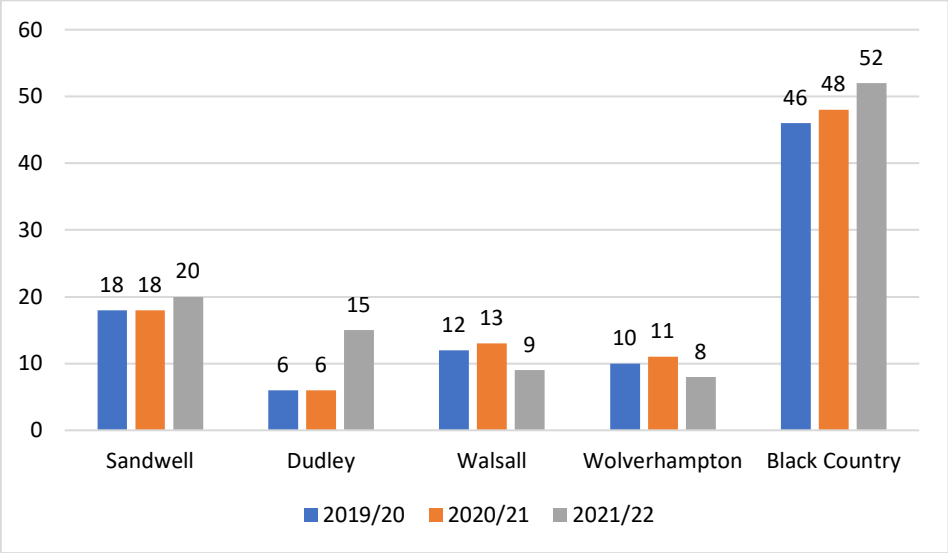


Chart 23: Black Country Notified Neonatal deaths by area – 2019-2022 - 3-year comparison



Across the Black Country there is a worrying upward trend for neonatal deaths and further analysis is needed to stop and reverse this trend.

Black Country Neonatal Deaths

Of the 52 neonatal deaths, 37 (72%) had a birth weight of less than 2500 grams, 33 of which were preterm deliveries (<37 weeks). Whilst prematurity impacts the infant's birth weight, low birth weight is also influenced by maternal lifestyle such as smoking.

When reviewing infant deaths, the Black Country CDOP identifies modifiable factors and relevant factors during pregnancy that increase the risk to both mother and baby. These factors may also contribute to an early onset of labour, leading to poorer outcomes. All the associated factors act as a multiplier effect increasing the risk of prematurity, or that the infant may not be born in the best possible condition.

Black Country Reviewed Perinatal/Neonatal events

Over half of neonatal deaths reviewed were caused by immaturity-related conditions such as respiratory disorders. Other neonatal deaths result from causes during or shortly after labour (intrapartum), or in the postnatal period.

Background: Low Birth Weight

Low birth weight is defined by the WHO as weight at birth less than 2500 g (5.5 lb). Low birth weight continues to be a significant health problem and is associated with a range of both short- and long-term consequences. Low birth weight is complex and includes preterm neonates, small for gestational age neonates at term and the overlap between these two situations. Typically, both preterm and small for gestational age neonates, have the worst outcomes.

The Royal College of Obstetricians and Gynaecologists defines small for gestational age to an infant born with a birth weight less than the 10th centile. Historically small for gestational age at birth has been defined using population centiles.

The use of centiles customised for maternal characteristics (maternal height, weight, parity, and ethnic group) as well as gestational age at delivery and infant sex, identifies small babies at higher risk of morbidity and mortality than those identified by population centiles.

Background: Maternal Obesity in Pregnancy

A modifiable and relevant factor highlighted by the Black Country CDOP is mother's raised body mass index (BMI) during pregnancy. For most adults, an ideal BMI is in the 18.5 to 24.9 range (healthy weight range).

The NHS defines the BMI categories as:

- below 18.5 – underweight
- between 18.5 and 24.9 - healthy weight range
- between 25 and 29.9 - overweight range
- between 30 and 39.9 - obese weight range
- 40 and over - severely obese weight range

Being overweight or obese increases the risk of complications for pregnant women and their babies. The higher a woman's BMI, the higher the chance of complications. Problems for baby can include being born prematurely and an increased risk of stillbirth (from an overall risk of 1 in 200 in the UK to 1 in 100 if mother has a BMI of 30 or more).

The increasing chances are in relation to:

- miscarriage - the overall chance of miscarriage under 12 weeks is 1 in 5 (20%); for women with a BMI over 30, the chance is 1 in 4 (25%)
- gestational diabetes - women with a BMI of 30 or above, are 3 times more likely to develop gestational diabetes than women who have a BMI below 25
- high blood pressure and pre-eclampsia - women with a BMI of 30 or above at the beginning of their pregnancy, have a chance of pre-eclampsia which is 2 to 4 times higher than that of women who have a BMI below 25
- blood clots - all pregnant women have a higher chance of blood clots compared to women who are not pregnant. For women with a BMI of 25 or above, the chance is increased further
- the baby's shoulder becoming "stuck" during labour (shoulder dystocia)
- heavier bleeding than normal after the birth (post-partum haemorrhage)
- having a baby weighing more than 4kg (8lb 14oz) - the overall chance of this for women with a BMI of 20 to 30 is 7 in 100 (7%); for women with a BMI of above 30, the chance is doubled to 14 in 100 (14%)
- women are more likely to need an instrumental delivery (forceps or ventouse), or an emergency caesarean section

Deaths categorised as a perinatal/neonatal event, where mothers BMI in pregnancy is recorded as underweight (BMI <18.5) or obese (BMI 30+), are deemed a modifiable factor by the Black Country CDOP.

Maternal obesity in pregnancy continues to be a relevant factor and features as a modifiable factor in deaths categorised as a perinatal/neonatal event. Infants born to women who begin pregnancy obese have a higher risk of premature death than children born to mothers at a healthy weight.

Black Country Local Maternity and Neonatal System

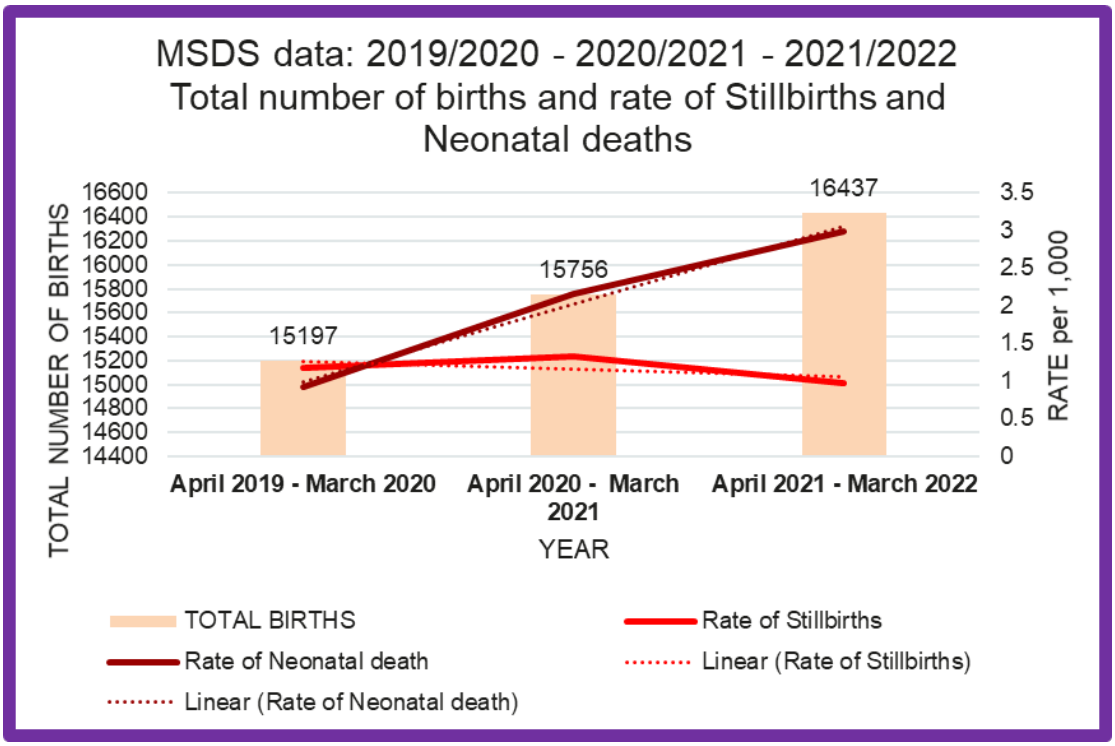
In 2021 – 2022 the Black Country continued to develop links formed with the Black Country and West Birmingham Local Maternity and Neonatal System (BCWB LMNS) to support with their local vision:

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.

At the Black Country Oversight Quality Group in July 2022, Dawn Lewis, Chair of the Quality and Safety Work Stream within the Local Maternity and Neonatal System reported that overall, in year 2021-2022 stillbirth rate has reduced, however there has been a corresponding increase in early neonatal deaths. This has been shared and discussed further and noted by Public Health members that this is a commonly seen occurrence. The focus of the Work Streams will be to address inequalities and utilising the equity and equality strategy to achieve this.

COMPARISON from 2019/20 – 2021/22 – MSDS data

Chart 24: Total Number of births and rate of Stillbirths and Neonatal Deaths – 2019-2022 from MSDS data



The BCWB LMNS oversee a number of priorities/deliverables to support infant mortality and partners across the Black Country support the Best Start Work Stream.

LMNS 2022/23 Transformation - Priorities/Deliverables for Best Start Work Stream

- To ensure that every Provider has a Pre-term Birth Clinic
- To ensure that at least 85% of women who are expected to give birth at less than 27 weeks gestation can do so in a maternity unit with appropriate on-site NICU
- To halve the rates of stillbirths, neonatal deaths, maternal deaths, and serious intrapartum brain injuries by 2025
- To reduce the national rate of pre-term births from 8% to 6%
- To continue to work with Neonatal Operational Delivery Networks to implement local Neonatal Improvement Plans with a particular focus on;
    - Maternity and Neonatal services working together to ensure that at least 85% of births at less than 27 weeks take place at a Maternity unit with an onsite NICU and together undertake a review of all births not in the right place. Data from these reviews should be collated at the regional level to support thematic analysis and inform targeted actions.
    - Identifying routes to escalate requirements for capital investment in Neonatal services through the relevant ICS routes

Complex cases

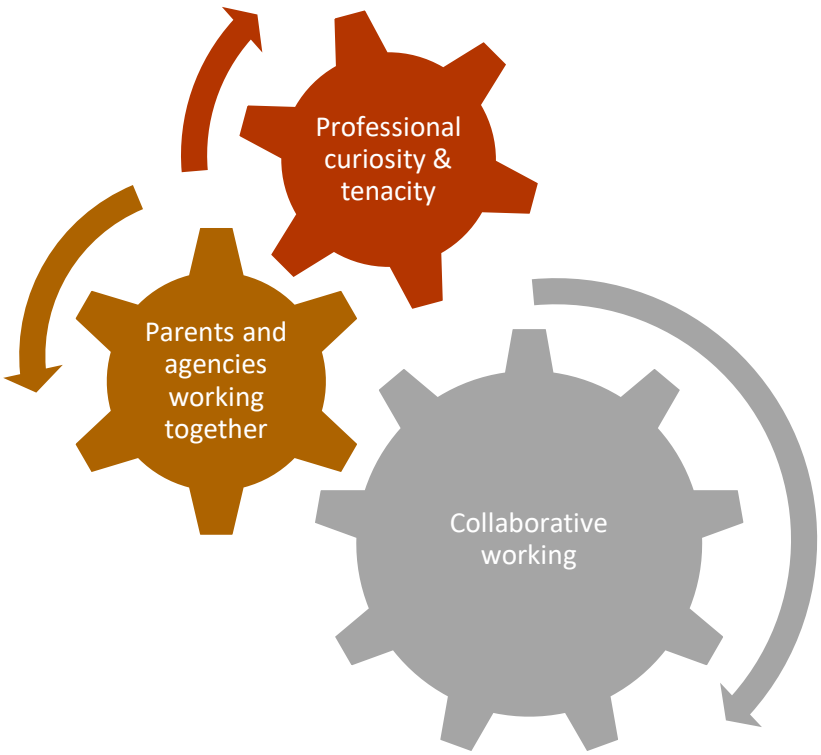
Most parents want the best for their children. However, there are some situations where families face such complex and challenging situations that they are unable to keep a child safe, and children are moved into the care of local authorities. Particularly if a child is removed at birth, support services to birth parents often cease. This is shown to exacerbate the already chaotic lives of parents, with increases in substance abuse, mental illness, and domestic violence. Evidence shows that many women who have had a child removed go on to have subsequent pregnancies, with the increased risks for both mother and child, including prematurity and low birth weight, in addition to neonatal abstinence syndrome. The 2022 MBRRACE report identified the high rate of suicide and death from substance misuse amongst women who had either had their child removed at birth, or who had been informed this would happen. In several cases, the woman's death also resulted in the death of her baby.

There are several programmes demonstrated to break this cycle, working intensively with women who have had a child removed at birth to improve their wellbeing and life satisfaction. These programmes aim to delay further pregnancies until the woman's life is in a better place to care for a child, although the evidence is many participants choose to avoid further pregnancy. Although this is a small cohort of families across the Black Country, this intervention is highly cost effective in preventing both health and social care costs and preventing trauma to families.

6. Additional Learning identified at CDOP:

- Dads and partners are often missed when giving bereavement support and when receiving crucial information from the health visitor and midwife.
- Co – sleeping advice needs to be consistent, repeated at every contact and include dads/partners
- Access for 24 hour palliative care within the community is crucial to enable a quality of life and death
- Parents expectations need to be carefully managed when babies are born with a poor prognosis or are given a diagnosis antenatally to support with the bereavement process
- Families should be assessed as a whole, looking at a cultural genogram to ensure the lived experience impact of the young person is assessed
- CAMHS assessment should be appropriate to age and concerns given as to whether there needs to be face to face
- It is important that agencies do not label young people as 'hard to reach' but try different ways to engage with a young person and their family, even if it means passing them on to another agency.
- Where there are numerous agencies involved with a child and family, there should be a key worker coordinating support
- There needs to be a greater awareness of the 'Dark Web'
- There needs to be effective communication with parents during treatment with a consistent management of expectations
- Palliation is not 'failure'
- Mums should be aware of the benefits of early booking and a healthy BMI
- Reviews need to be held together where there is more than one hospital involved to maximise learning.

7. Good Practice Identified at CDOP



A recurring theme throughout 2021 – 2022 has been the strong partnership working identified in reviews. This included:

- Excellent transfer planning where the specialist consultant went to local unit to meet baby/family.
- Evidence of some professionals going over and above their responsibilities, e.g., Community nurses using their own personal time to support families during palliative care
- Agencies approaching a chaotic, disturbing scene with professionalism and sensitivity
- Advice being available from a level 3 maternity unit where transfer is not possible

Other good practice identified included:

- Parents given the opportunity and encouraged to undertake memory making activities with their baby prior to death as part of the palliative care arrangements. They helped plan the last few days of his life
- Organ donation conversations held in a sensitive manner
- Children and young people have been included in their own ACP's giving a respectful quality of life

8. Black Country Child Death Review Progression In 2021 – 2022

- Child Death Review partners have supported the priorities and deliverables from the LMNS and have engaged further in sub-groups to ensure a more joined up way of working.
- In response to the data regarding deaths involving unsafe sleeping practices across the Black Country, 'Know More' posters were developed by Dudley Public Health and shared across the Black Country for display in public arenas to begin conversations around safer sleeping.

- Members from CDOP have supported a Black Country wide Suicide Prevention group contributing to training and data collection.

- The Black Country CDOP contributed to a regional themed review on suicides that had already been reviewed at CDOP. Findings were shared widely across different agencies for learning to be implemented.
- The Black Country SUDC Protocol was ratified and shared with relevant trusts and agencies across the Black Country and region.

BLACK COUNTRY MULTI-AGENCY SUDI/C PROTOCOL 2021

Guidance for the multi-agency management of Sudden Unexpected Death in Infancy/Childhood in the Black Country based on:
Working Together, 2018
Child Death Review Statutory and Operational Guidance, 2018
Sudden Unexpected Death in Infancy and Childhood: Multi-Agency Guidelines for Care and Investigation, 2016

- Positive Recognition - To recognise and encourage good practice, or where agencies have gone above and beyond their expected duties, CDOP continue to send letters of good practice where good practice has been identified. 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.
- Progression has been made to transfer the hosting responsibilities for CDOP across to the Black Country and West Birmingham CCG
- All areas in the Black Country now have an administrator and lead health professional at place level.

9. Future Priorities - Next Steps and Objectives

- CDOP MOU to be updated considering any changes since 2019
- Self-Evaluation Framework (SEF) to be completed by each hospital to identify areas for improvement
- Audits take place to ensure processes reported on in the SEF are being followed
- Implement and embed an eCDOP user group across the Black Country
- The Key Worker role to be strengthened across the Black Country including:
    - A Key Worker to be allocated to families following a child death
    - The Key Worker ensures the voice of the parent is captured in the CDOP review
    - Links made with PALS in each Trust to ensure parents have a way of reporting into the review process if not through a key worker
- Professionals engaged in any aspect of the CDR process have a robust supervision process in place
- Develop and contribute to strategies to reduce Infant Mortality and suicide prevention
- Continue to escalate issues where agencies are not providing timely information
- Continue to work towards reducing the time lag between notification of a child's death and discussion at CDOP
- Submission and ratification of the Black Country annual report
- To develop further good links with existing maternity and neonatal networks to improve outcomes
- Liaise with Medical Examiners to explore the role and relationship with child death further
- Audit the effectiveness of dissemination of learning and impact on service provision

10. Recommendations for Local Strategic Partners

Children's Safeguarding and Health and Wellbeing partners are asked to:

1. Note the contents of this report and in particular:
   a. The summary of achievements, key points and themes, and priorities for 2022-23

2. Ensure interagency initiatives are being monitored to reduce the prevalence of modifiable factors identified in the under one population including:
   - Safe sleeping
   - Risk factors for reducing premature births including:
     - High BMI (including healthy diet and physical activity)
     - High blood pressure (linked to high BMI)
     - Smoking
     - Alcohol use
     - Substance misuse
     - Domestic violence
     - Mental health
     - Diabetes (often linked to BMI)
     - Lack of physical activity

3. Support programmes which reduce the likelihood of babies being removed from mothers who live within complex and challenging situations where safeguarding challenges exist.

11. References

- National Data taken from NCMD Report: Child-death-review-data-release-2022.pdf (ncmd.info)

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