Healthier Futures
Black Country Integrated Care System

Black Country
Child Death Overview Panel

Black Country Child Death Overview Panel

2022/2023 Annual Report

Healthier place Healthier people Healthier futures

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Foreword

Each child death is a tragedy. As we reflect upon another year of dedicated efforts and collaboration, I am immensely proud of the commitment demonstrated by our panel members and the strides we have taken to fulfil our crucial role in safeguarding children and promoting their well-being.

Whilst this report covers the year 2022-23, at the time of writing, the verdict of the Lucy Letby case had been concluded, where the former neonatal nurse was convicted of murdering infants in her care within the Countess of Chester Hospital. The Independent Inquiry announced by the Government, will provide an opportunity to improve child death review processes.

Our foremost commitment is to provide reassurance through adherence to the legislative framework that governs our work. In this regard, we remain steadfast in our compliance with the "Working Together" framework, ensuring a coordinated approach to safeguarding and promoting the welfare of children.

The CDOP Statutory Guidance and Kennedy Guidelines continue to be our compass, guiding our actions and decisions as we navigate the complex landscape of child safeguarding and child death review processes. With these guidelines in mind, we endeavour to maintain the highest standards of practice and uphold the principles that underscore our responsibility to protect vulnerable young lives.

Addressing Sudden Unexpected Death in Infancy and Children (SUDIC) remains a key focus of our efforts. The CDOP process plays a pivotal role in ensuring that notifications are managed with the utmost care and sensitivity, and that data is accurately and promptly submitted to the National Child Mortality Database (NCMD). This diligence ensures that our collective knowledge and insights contribute to the broader understanding of child mortality trends and inform policy decisions at the national level.

I would like to thank all the dedicated panel members who bring a wealth of expertise and passion to the process and in particular, Keren Hodgson and Michelle Mincher, who manage, coordinate, and administrate the processes behind the panel, which often go unseen.

This year, we will emphasise the importance of parent engagement and ensuring that families receive the right bereavement support. It is crucial that we approach our work with empathy, recognising the profound impact that the loss of a child has on families. Additionally, we must focus on the key worker role, striving to confirm that all families have equitable access to the support they need at a local level.

To enhance our effectiveness, we must further develop how learning is shared among panel members and stakeholders. The continuous improvement of our processes and practices is essential in our quest to provide the best possible outcomes for children and their families.

Lastly, let us strengthen our collaborative efforts with partners to support initiatives addressing infant mortality. By working closely with other agencies and organisations, we can contribute to comprehensive strategies that tackle the multifaceted challenges associated with child mortality.

Mike Leaf

Independent CDOP Chair

Executive Summary

Child deaths are tragic, and thankfully uncommon. Comprehensive reviews of child deaths undertaken by the Child Death Overview Panel (CDOP) serve as an opportunity to learn from these devastating events.

It is important to recognise the Child Death Review is a statutory process and this Black Country CDOP Annual Report for 2022/2023 hopefully demonstrates how local services and multi-agency partnerships have contributed to the review of deaths, in an open and transparent way, and recognise the need to take the learning forward.

This report is divided into five core areas:

⇒ Child Death Notifications during 2022/2023 - 128 deaths were notified.

⇒ Child Death Reviews during 2022/2023 - 96 deaths were reviewed.

⇒ Learning arising from the completed reviews.

⇒ An overview of Child Deaths in the Black Country with data from 2019-2023.

⇒ Priorities and recommendations.

From the key themes identified as a result of deaths reviewed between 2022-2023 in the Black Country the recommendations for Partners are:

⇒ To note the data shared within this report.

⇒ To share feedback from parents/families following the death of a child to inform the Child Death Review process.

⇒ To share with CDOP; Where actions/changes to practice are as a result of learning shared in this report and Examples of good practice in individual areas/services already happening that can be reflected in other areas/services.

⇒ To highlight initiatives developed as a result of this learning to the Child Death Overview Panel that reduce the prevalence of modifiable factors including Safer sleeping, Smoking, High Maternal BMI.

⇒ For partners to consider an area specific deep dive into deprivation and ethnicity.

Introduction

This is the fourth Annual Report for the Black Country Child Death Overview Panel (BCCDOP). This report will explore the statistical and qualitative conclusions from child death data across the Black Country which includes, Dudley, Sandwell, Walsall, and Wolverhampton from 1st April 2022 – 31st March 2023.

The Child Death Overview Panel (CDOP) publishes this Annual Report to provide an overview of local patterns and trends related to child deaths and to share recommendations as a result of the Review process for local Partners to action.

Every child death is a devastating loss that profoundly affects the family involved. The teams involved with the Child Death Review (CDR) process would like to share their thoughts and sympathy with the family and friends of all those children who died during 2022-2023.

Strategic Partnership

The Strategic Partnership meets four times a year to ensure the Statutory function of the Child Death Overview Panel (CDOP) and the whole local Child Death Review process is effective and highlights any concerns for escalation.

The Strategic Partnership is Chaired by an Independent Chair and supported by the Child Death Overview Panel Coordinator. The Strategic Partnership are responsible for setting the budget, structure, and making recommendations to specific services in response to the data, good practice, learning and modifiable factors that are shared from the Child Death Overview Panel.

Child Death Review Process

The Child Death Review (CDR) process is an analysis of deaths of children who die in England from birth up to 18 years of age. There is a statutory requirement for the statutory partners to make arrangements to conduct child death reviews. In the Black Country, the Statutory Partners refer to;

City of Wolverhampton Council

Dudley Metropolitan Borough Council

Sandwell Metropolitan Council

Walsall Metropolitan Borough Council

Black Country Integrated Care Board (BCICB)

The aim of the Child Death Review (CDR) is to ensure the information is systematically captured for every death to enable learning and prevent future deaths.

The purpose of a CDR is to identify any matters of concern affecting the safety and welfare of children relating to the death(s) and to consider any action or recommendations that can be take or developed based on a death, or a pattern of deaths to identify trends that require a multidisciplinary response.

The roles within the Black Country Child Death Review Team and Child Death Overview Panel can be found in Appendix one.

Process when a Child Dies

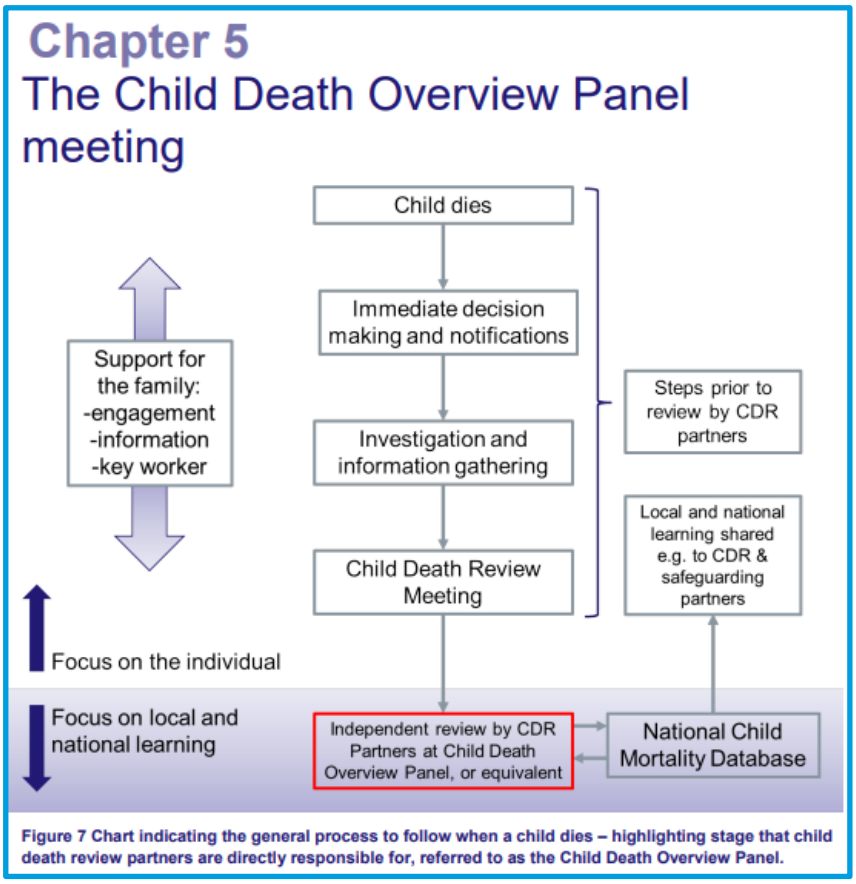

Figure 7 Chart indicating the general process to follow when a child dies – highlighting stage that child death review partners are directly responsible for, referred to as the Child Death Overview Panel.

Child Death Review Statutory and Operational Guidance (England) (publishing.service.gov.uk)

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Child Death Notification

Following the death of a child, a formal notification of the death should be shared with the CDOP Team as soon as possible, ideally within 48 hours. A child death notification can be completed by any professional involved with the death of a child. For ease, the notification form is accessible online as a public facing document.

To notify a child death please use: www.ecdop.co.uk/BlackCountry/Live/Login

Joint Agency Response

A Joint Agency Response (JAR) would be triggered when a child's death, or the collapse leading to death would not have been expected to occur 24 hours previously.

Criteria for a JAR includes the following:

⇒ The death is or could be due to external causes.

⇒ The death is sudden and there is no immediately apparent cause.

⇒ The death occurs in custody or where the child has been 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.

Any death that is both sudden and unexpected might be referred to as Sudden, Unexpected Death of an Infant/Child (SUDIC) at the point where the child dies. Following a Post Mortem and full investigation, these deaths might go on to be explained by for example infection, cardiac or metabolic condition or even homicide. At the point of review, the death would be categorised as the appropriate cause of death.

If after full investigation, the death remains unexplained, it would be referred to as Sudden Unexplained Death in Infancy (SUDI) or Childhood (SUDC). Infancy refers to a child being under the age of one at the time of death and childhood refers to those who are over the age of one at the time of death.

Child Death Review Meeting

Child Death Overview Panel is informed by the referral of a standardised report completed during a Child Death Review Meeting (CDRM). The meetings are attended by professionals who were directly involved in the care of the child during their life, the parents' life and/or siblings and any professional involved during the child's death.

At this meeting, a formal agenda is followed to ensure all matters related to the child are discussed. The professionals in attendance at the CDRM vary dependent on the circumstances of the child death and is not limited to medical staff.

During this meeting any contributory factors, which are categorised into four domains (see Appendix two) are discussed and modifiable factors are identified. The learning and any actions as a result of the learning will be highlighted and support available for those within the meeting. The support the family have received, accessed, or been offered is explored.

An important part of the CDRM is the opportunity for professionals to share any comments or questions on behalf of the parents/family that may have been raised at the time of death or during the CDR Process. Parents would not attend the CDRM, but they should be informed that

the meeting is taking place and given the opportunity to share their feedback into the Child Death Review Process.

Child Death Overview Panel

The Child Death Overview Panel (CDOP) is a multi-agency panel set up to conduct the independent scrutiny on behalf of the local Child Death Review (CDR) partners on the reviews of all deaths of children who are normally resident in the Black Country to learn lessons and share findings for the prevention of future child deaths.

The review at CDOP is intended to be the final scrutiny over a child's death. The CDOP membership includes representation from a range of organisations with knowledge and expertise in fields such as Public Health, Childrens Services, Police, Education, Paediatrics etc.

Members support the review of each case that is referred into CDOP and factors relevant to the child's vulnerability or death are agreed within each of the four domains and a level of relevance is agreed for each factor;

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

At CDOP for each case a category of death is agreed, this may be one category of death or multiple categories dependent on the final cause of death (see appendix four).

Modifiable Factors

The CDOP is responsible for identifying modifiable factors. These modifiable factors would not mean the death was preventable, but there may be emerging trends that could reduce the risk of future child deaths. Where a factor in one of the domains has been identified as an increase to the child's vulnerability or contributed to the child's death, the Panel can discuss if there is a local and/or national intervention in place or that could be recommended to reduce the risk of future child deaths.

Learning from Child Deaths

Learning lessons from child deaths cases is a priority for BCCOP to ensure this learning is shared widely across the Black Country as well as Regionally and Nationally. With Child Deaths being reviewed across the Black Country footprint, there may be an opportunity to highlight emerging themes.

CDOP is held on a regular basis, with a themed Panel addressing all Neonatal cases (0-27 days) on a bi-monthly basis. This arrangement allows for Obstetricians and Neonatologists to be invited from neighbouring areas to provide an independent scrutiny of cases as well as inform the discussions during the review process and highlight themes and learning locally. The Panel on the alternate month reviews cases of child death from 28 days of age up to 18 years old.

National Child Mortality Database

The National Child Mortality Database (NCMD) records comprehensive data standardised across the whole country (England), on the circumstances of children's deaths. The purpose of collating information nationally is to ensure that deaths are learned from, that learning is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die.

The NCMD programme was established and is delivered by the University of Bristol, in collaboration with the University of Oxford's National Perinatal Epidemiology Unit (NPEU), University College London (UCL Partners) and the software company QES. It also includes representation from bereaved families through the NCMD charity partners: Child Bereavement UK, The Lullaby Trust, and Sands. The programme is funded by NHS England and commissioned by Healthcare Quality Improvement Partnership (HQIP).

eCDOP

From 1st April 2019, it has been mandatory for Child Death Review Partners to input data on all child deaths into the NCMD. In the Black Country, the programme used to support the Child Death Review process is eCDOP which is a programme developed by QES (a software company). QES provide eCDOP to 99% of the areas involved in the Child Death Review process in England.

eCDOP supports the CDR process by allowing agencies to share information following the death of a child, to ensure appropriate action and processes are followed then reviewed and cases are then referred to CDOP for final oversight and scrutiny of every child death. eCDOP allows notifications of a child death in real-time, without sharing confidential information over email, to ensure no delay in the transfer of information and triggering of the process required on receipt of a child death notification.

Data presented in this report

This report will not highlight any one specific death and following guidance from the West Midlands Child Death Review Network (WMCDRN) where data is less than 5, this has been removed to ensure no information is identifiable.

Data presented in this report has been collated from eCDOP and reports shared by NCMD to compare Black Country data to neighbouring areas in the Region and England data. In regard to any population data presented in this report, this will be rounded up/down to the nearest 5.

Data - Death Notifications in 2022 – 2023

Child Deaths notified in 22/23

From 1st April 2022 – 31st March 2023 there were 128 deaths notified across the Black Country for children under the age of 18 years of age.

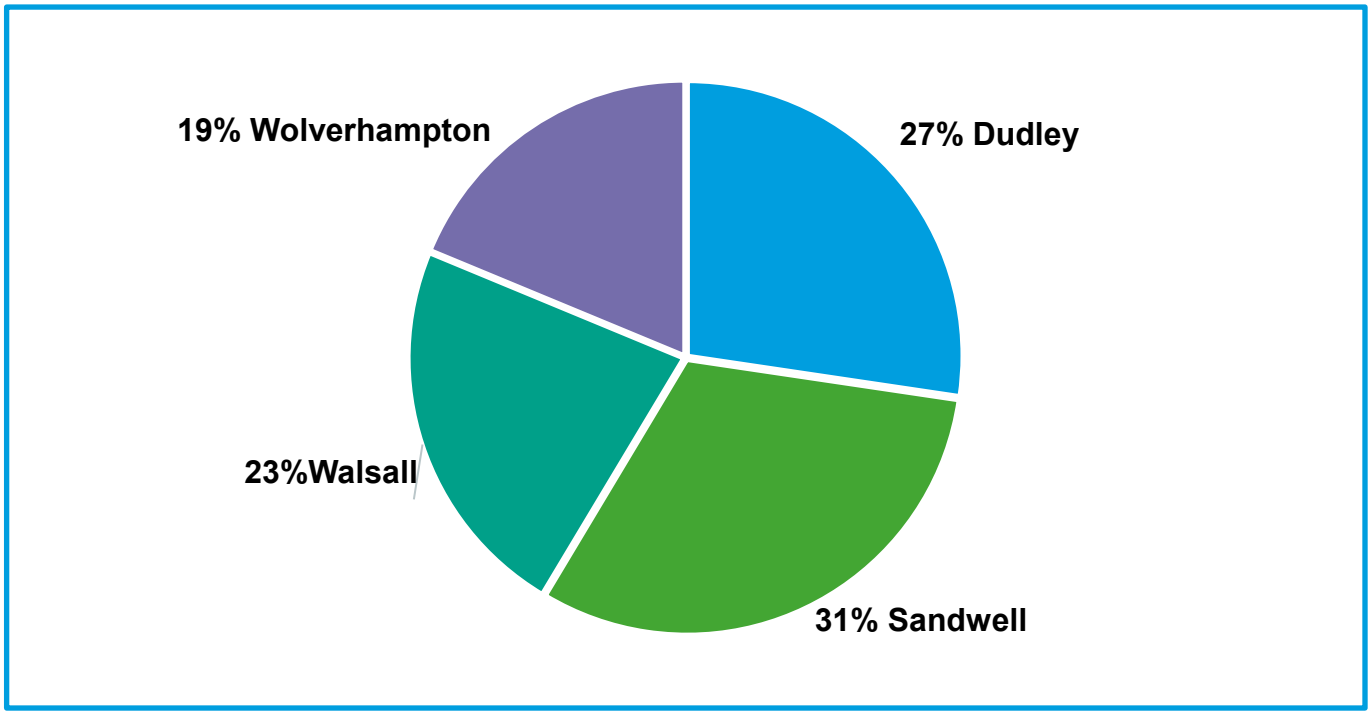
The number of child death notifications had increased by 25% since the previous year 2021-2022 in the Black Country (96 child death notifications in 2021/2022).

For the same time period, 1st April 2022 – 31st March 2023, in the West Midlands there were 531 child death notifications (24% from the Black Country), and in England there were there were 3,743 child death notification (3.4% from the Black Country).

Child Death notifications by area

From 1st April 2022 – 31st March 2023, of the 128 child death notifications across the Black Country, 40 of these were Sandwell cases, 35 were from Dudley, 29 were from Walsall and 24 cases from Wolverhampton.

Data Chart 1 – Breakdown of Child Death Notifications across the Black Country by area.



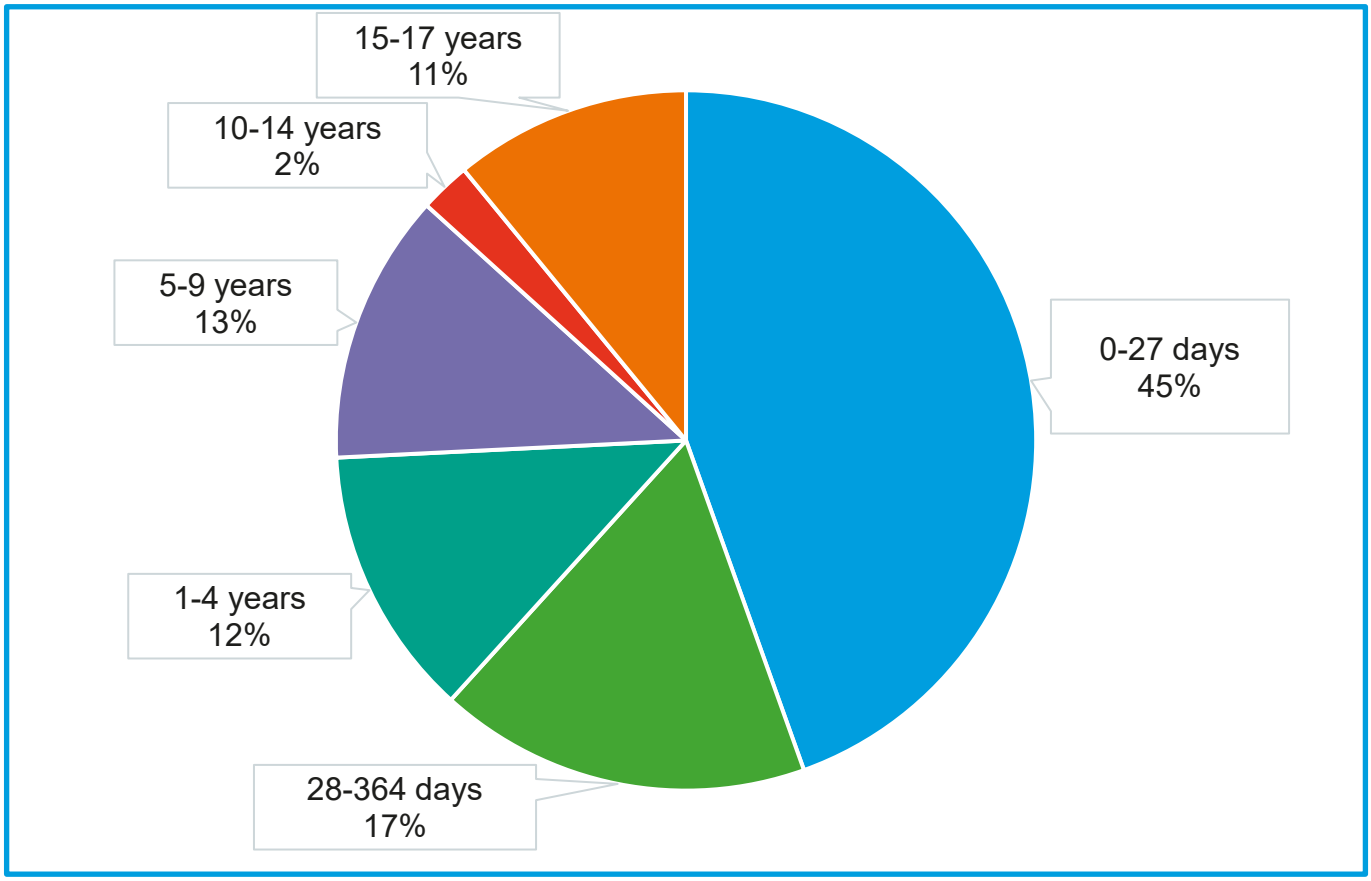
Dudley, Walsall, and Wolverhampton all had an increase in child death notifications during 2022- 2023 compared to the previous year, 2021-2022. Sandwell had the same number of child death notifications during 2021/2022 and 2022/2023.

Age Breakdown for notified Child Deaths

From 1st April 2022 – 31st March 2023, of the 128 child death notifications across the Black Country, 57 of these were aged 0-27 days, 22 were aged 28-364 days, 16 were in the 1-4 years age range and 16 were aged 5-9 years. 17 notified child deaths were children aged 10 years and over.

79 child death notifications were under the age of one year old (62% of child death notifications).

Data Chart 2 – Breakdown of Child Death Notifications by age.

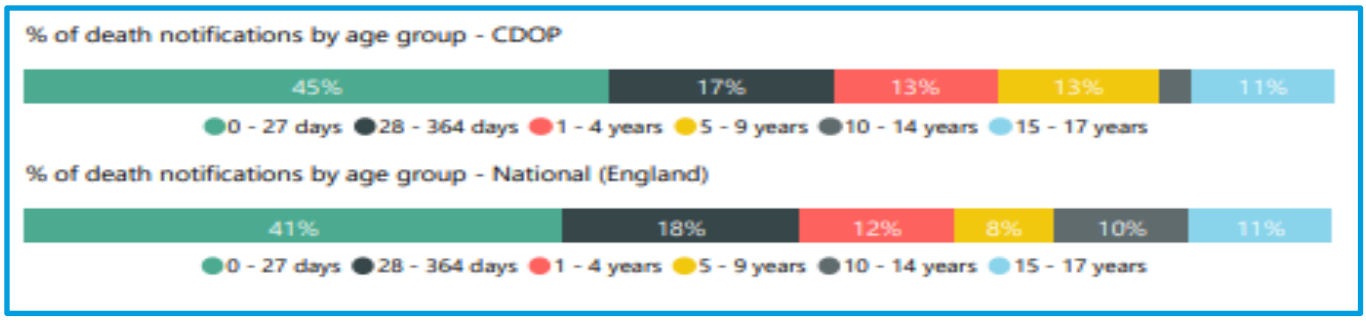


Data Chart 3 below has been presented by the National Child Mortality Database (NCMD) to highlight the breakdown of child death notifications by age during 2022-2023 compared to England data.

62% of all child death notifications are under one year of age in the Black Country, compared to 59% across England.

The child death notifications in the 10-14 years age appears to be lower in the Black Country when compared to the England data.

Data Chart 3 – Breakdown of Child Death Notifications by age (Black Country & England)



Ethnicity breakdown for notified Child Deaths

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

Data Chart 4 – Breakdown of Child Death Notifications by ethnicity.

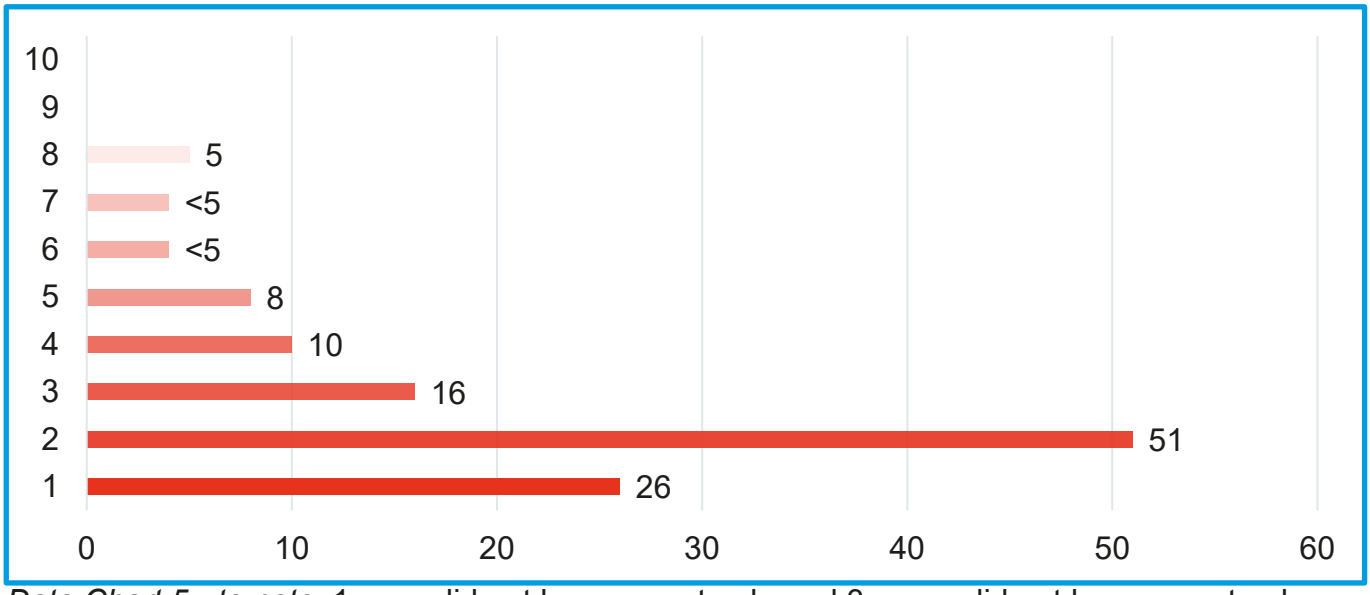
Data Chart 4 - to note: 113 of 128 Child Death notifications are illustrated in Data Chart 4. Less than 5 cases were identified in the remaining 15 cases in the following ethnicity categories; Black or Black British – any other, White Irish, Mixed – white and Black African, Other ethnic group – Arab, Other ethnic group – Chinese and Not known/not stated and not applicable.

Deprivation breakdown for notified Child Deaths

Of the 128 Child Death Notification during 2022-2023, 124 cases had an identifiable postcode that could be checked against the Index of Multiple Deprivation Decile (2019).

Of these 124 cases, 103 (83%) lived in the 40% most deprived areas. There were 77 (62%) child deaths in the 20% most deprived areas.

Data Chart 5 – Breakdown of Child Death Notifications by Index of Multiple Deprivation Decile.

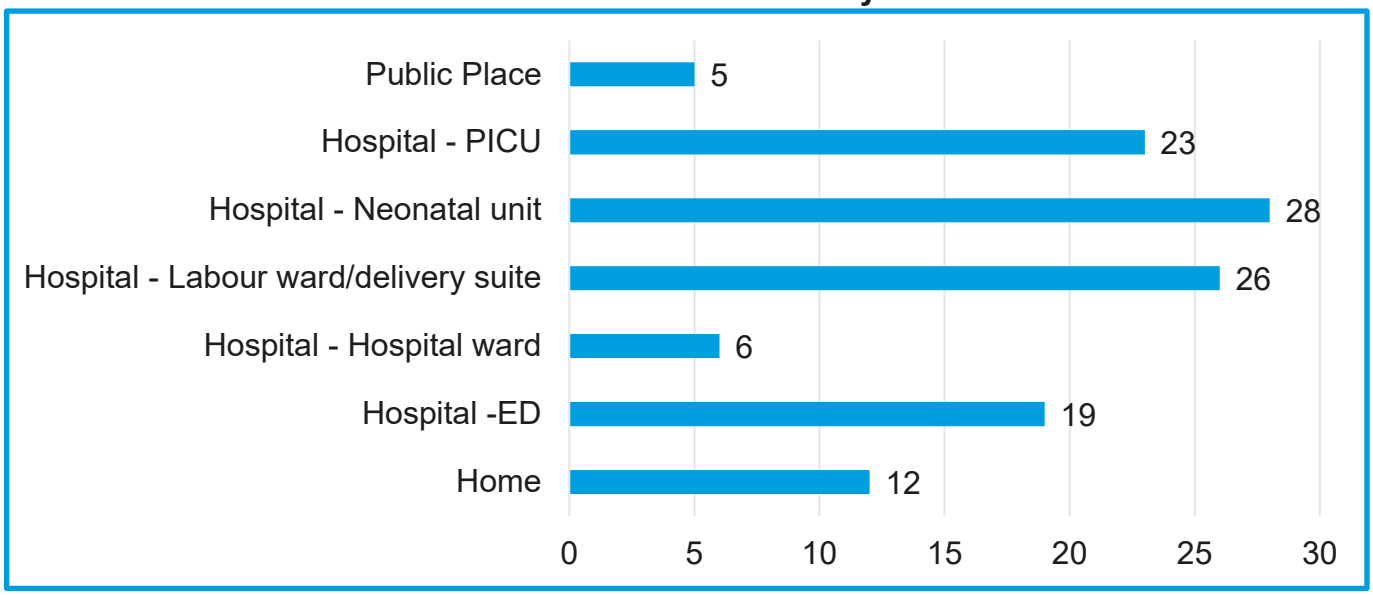


Data Chart 5 - to note: 1 case did not have a postcode and 3 cases did not have a postcode that was recognised on the Index of Multiple Deprivation Decile (2019).

Place of Death breakdown for notified Child Deaths

Of the 128 notifications of child death, 106 child death notifications identified the location of death in a hospital or Hospice. 54 of these cases where the hospital was the location of death were in the Neonatal unit or Labour/ward/delivery suite.

Data Chart 6 – Breakdown of Child Death Notifications by Location of Death



Data Chart 6 - to note: Figures less than 5 have been removed from this data, therefore 119 of 128 cases are illustrated above and the remaining 9 notifications not included above had a location of death; abroad, hospice, hospital (Adult Intensive Care Unit (AICU) or other residence (childcare/family address).

Data – Deaths Reviewed in 2022-2023

From 1st April 2022 – 31st March 2023, 96 Child Deaths were reviewed at Black Country Child Death Overview Panel.

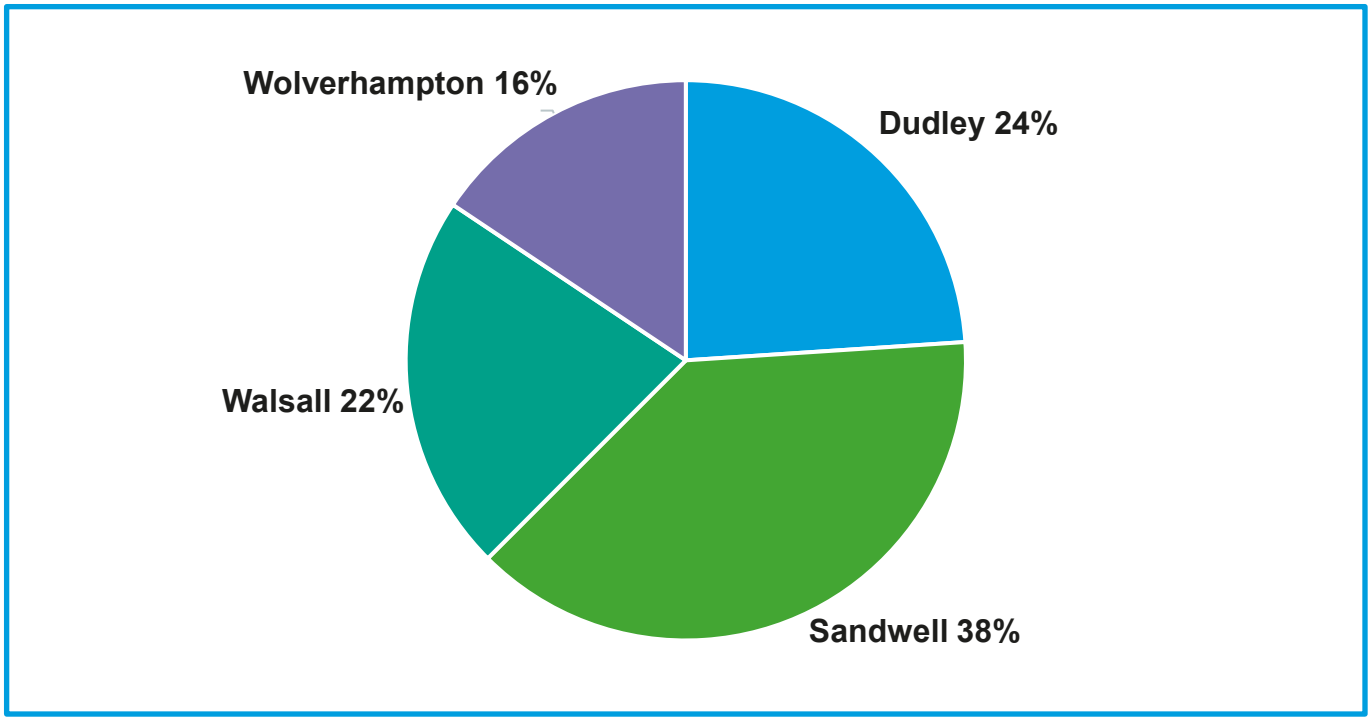
For the same time period, in the West Midlands, 452 Child Deaths were reviewed.

There were 8 Child Death Overview Panels that took place during 2022/2023, with 4 of these being a Neonatal themed panel.

Area breakdown for Child Death Reviews

From 1st April 2022 – 31st March 2023, of the 96 Child Deaths that were reviewed at Black Country Child Death Overview Panel, 37 cases that were reviewed at Panel were child death notifications with a Sandwell postcode, 23 had a Dudley postcode, 21 had a Walsall postcode and 15 cases had a Wolverhampton postcode.

Data Chart 7 – Breakdown of Child Death Reviews by area



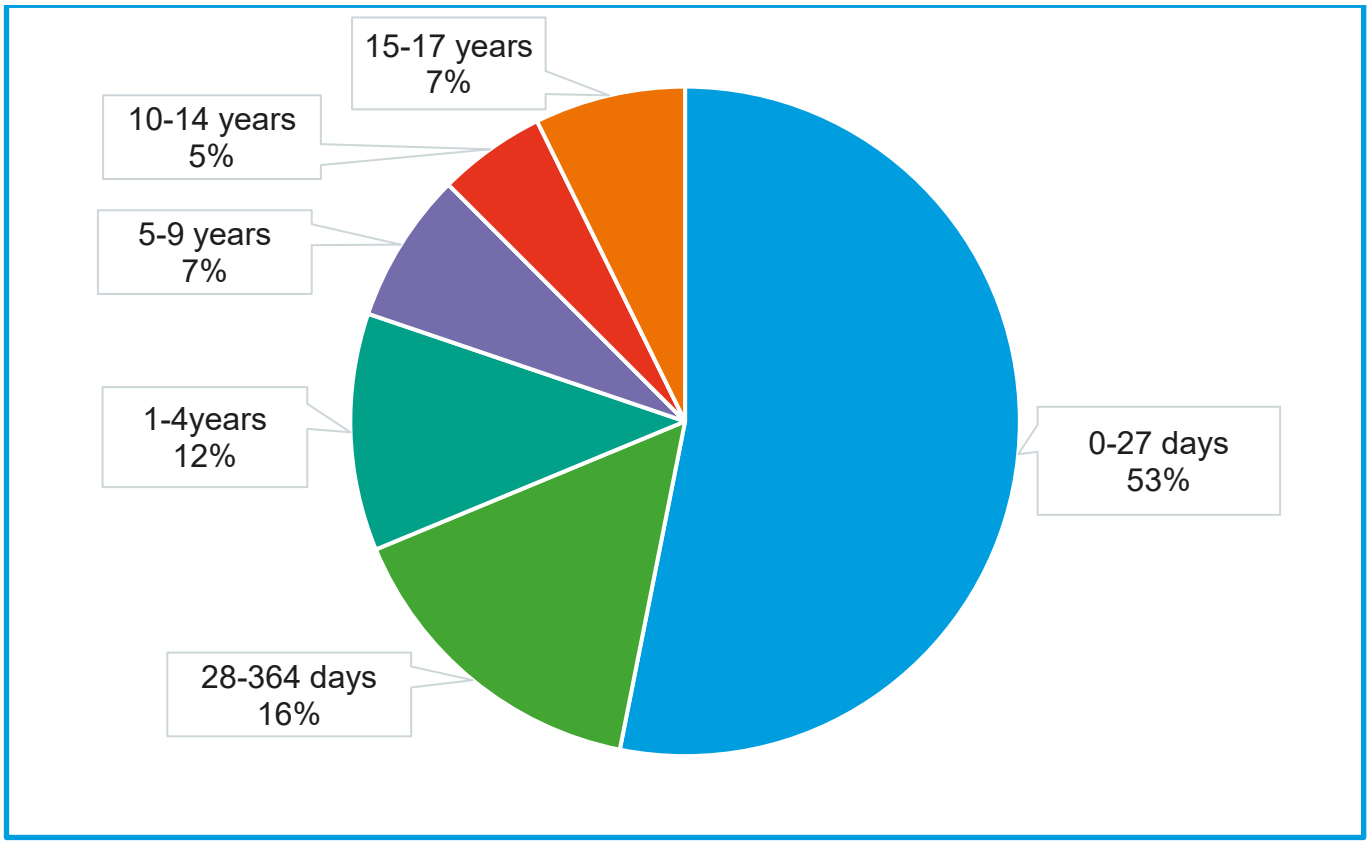
Age breakdown for Child Death Reviews

Of the 96 Cases reviewed by BCCDOP, 51 cases were of babies in the 0-27 days range, these were reviewed at the four Neonatal themed Panels that took place during 2022/2023.

A further 15 cases were aged between 28 days and a year old, therefore a total of 66 cases that were reviewed were under the age of one years old.

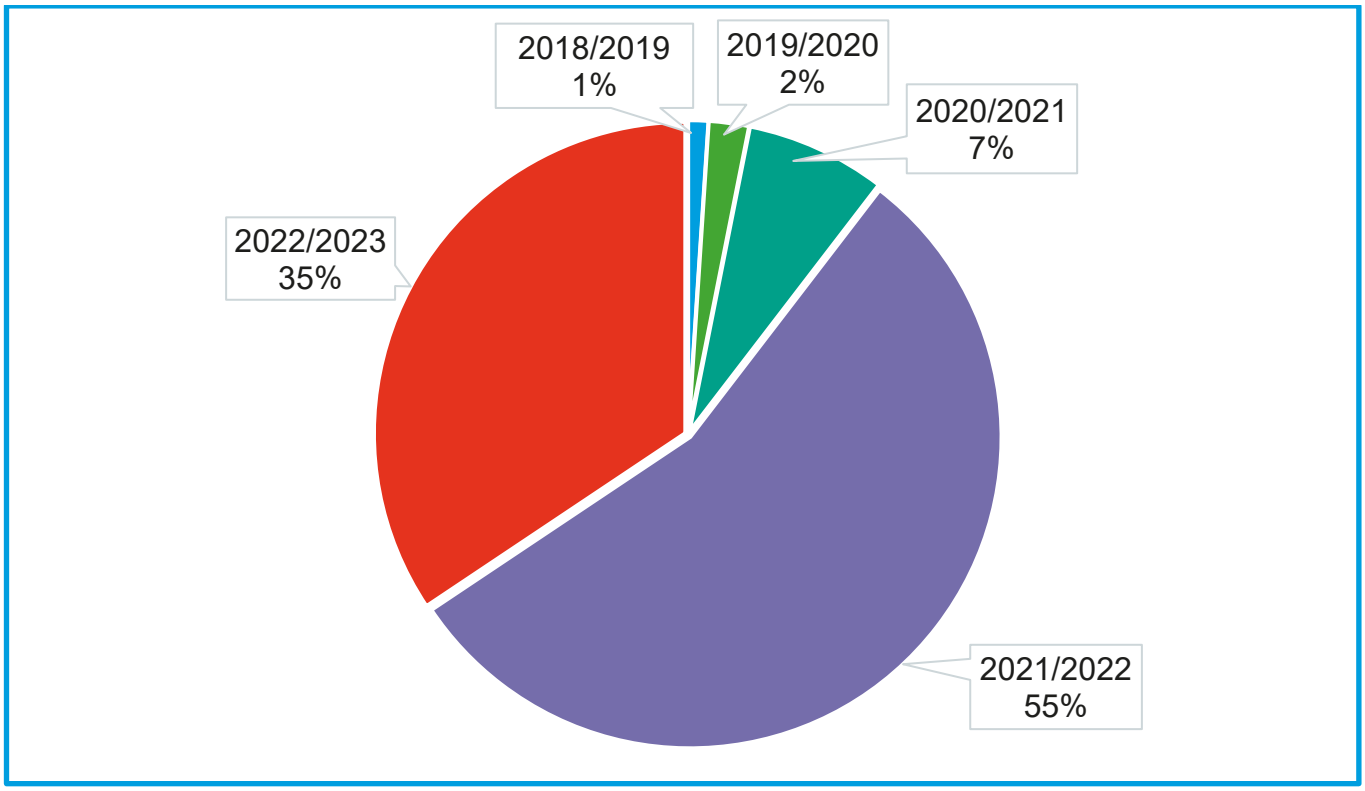
Of the 96 cases reviewed, 11 cases were 1-4 years old, 7 cases were in the 5-9 years age group, 5 cases in the 10-14 years age group and 7 cases in the 15-17 years age group.

Data Chart 8 – Breakdown of Child Death reviews by age



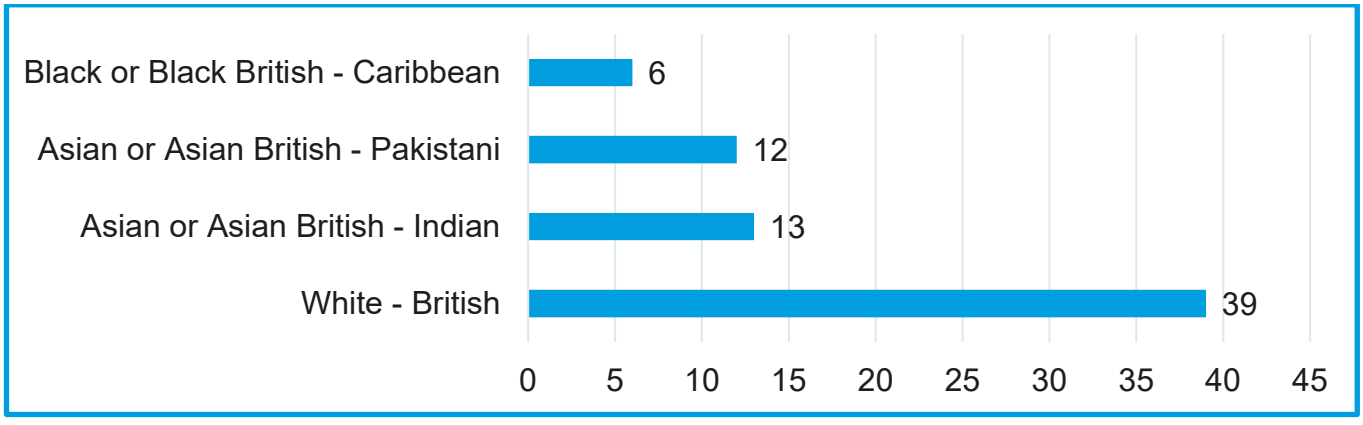
Of the 96 cases that were reviewed by BCCDOP during 2022/2023, 33 of these had the death notified within the same year. 53 cases that were reviewed during 2022/2023 were death notifications from the previous year (2021/2022). Data Chart 9 illustrates the breakdown of reviews that took place during 2022/2023 and which financial year the death was notified. The majority are the previous year which is to be expected as often we are required to wait a significant amount of time for any investigations or reviews before a case is ready for review at CDOP.

Data Chart 9 – Breakdown of reviews by financial year of death



Ethnicity breakdown for Child Deaths Reviews

Data Chart 10 – Breakdown of reviews by ethnicity



Data Chart 10 - to note: Data Chart 9 illustrated 70 cases of the 96 cases reviewed during 2022/2023 the remaining 26 cases fall into the following categories: Mixed - Any other mixed background, Mixed - White and Black African, Mixed - White and Black Caribbean, Other ethnic group - Any other ethnic group, Other ethnic group – Arab, White - Any other White background, White – Irish, Black or Black British – African, Black or Black British - Any other Black

background, Asian or Asian British - Any other Asian background, Asian or Asian British – Bangladeshi.

Category of Death for Child Death Reviews

At CDOP, members are expected to agree on the category of death (see Appendix four). Of the 96 cases reviewed, 59 cases had one category of death agreed, Perinatal/Neonatal event.

Some cases may have more than one category of death identified.

Of the 96 cases reviewed 28 cases had 2 categories of death, 6 cases had 3 categories of death and there were 3 cases that identified 4 categories of death.

Data Chart 11 – Category of Death identified during the Child Death Review

Data Chart 11 - to note: The following categories of death: Malignancy, Suicide or deliberate self-inflicted harm and deliberately inflicted injury, abuse or neglect had less than 5 cases.

Data Chart 11 - to note: Recently we have had further guidance regarding the category of death at the time of Panel. During 2022/2023, some deaths at the time of CDOP may have included SUDIC as a category of death, at the time of notification, these were identified as SUDIC. However, following a Post Mortem and full investigation, those same deaths might go on to be explained by for example infection, cardiac or metabolic condition or even homicide. At the point of review, the death should be categorised as the appropriate cause of death and not include 'Sudden, unexpected, unexplained' even though this would have been the case to begin with.

Modifiable Factors identified in Child Death Reviews

The modifiable factors are determined by Panel members during the BCCDOP meeting as each Domain is discussed. Of the 96 Child Death cases that were reviewed, 42 cases had no modifiable factors identified. 53 cases had modifiable factors identified and 1 case had modifiable factors not known.

Of the 53 cases with modifiable factors, 36 of these had one modifiable factor identified, 17 had multiple modifiable factors.

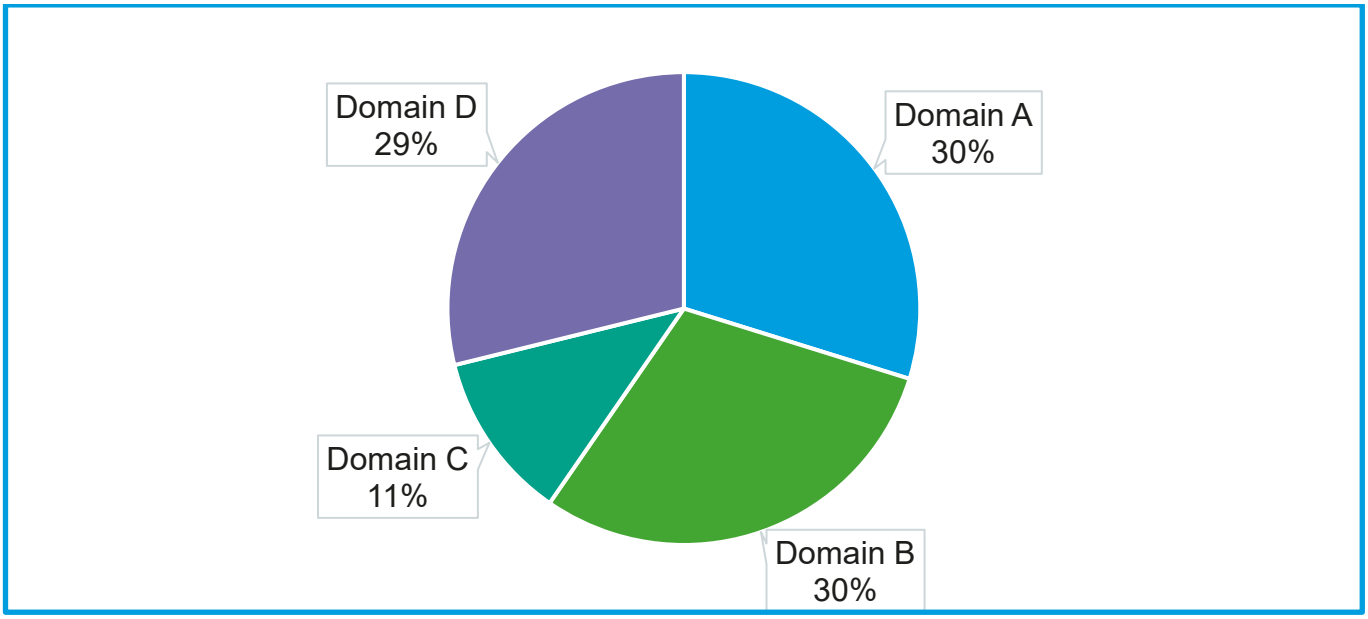
Less modifiable factors were identified in Domain C, factors in the physical environment than the other three domains.

Factors intrinsic to the child (Domain A), Factors in Social Environment (Domain B) and Factors in service provision (Domain D) presented similar numbers of modifiable factors.

It is important to note here, with modifiable factors, where the Panel may have identified a modifiable factor, in some cases it would not be clear if the mother/family had been offered a service and refused this support, and/or the service is or is not available. As Black Country CDOP covers four Local Authorities, with four Hospital Trusts, it is important to note there is not a consistent offer/service in place in all four areas, therefore Panel members attempt to highlight the modifiable factors consistently to highlight to Partners potential areas to develop/improve and/or the opportunity provide reassurance to CDOP that there is a service in place.

For example: During review, it was not always clear where mom was smoking in pregnancy if the smoking cessation service was offered, and if it was offered, if mother declined or took this service up, and if the service was accessed if this was maintained.

Data Chart 12 – Breakdown of modifiable factors identified by Domain.



Data Chart 13 – Examples of the Modifiable factors identified in each of the Domains.

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

The full list of modifiable factors identified in each domain are highlighted in Appendix three.

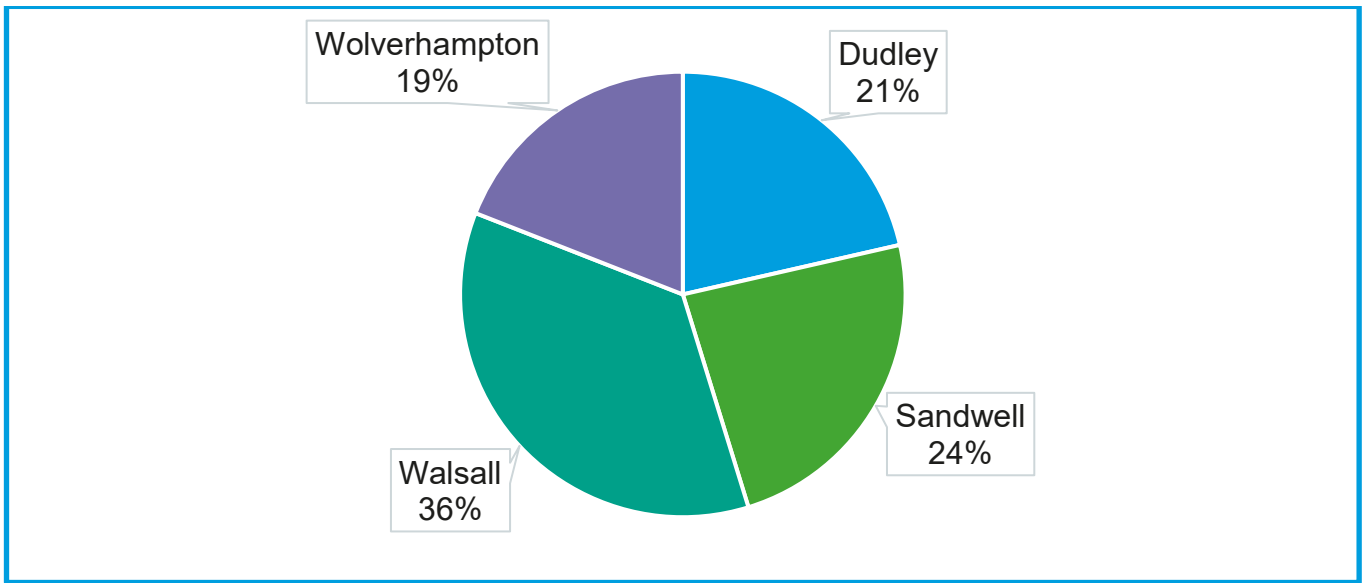
Joint Agency Response

In 2022/2023 in the Black Country there were 42 cases that required a Joint Agency Response (JAR). These would be referred to as SUDIC cases as the JAR is arranged as a result of a death that was sudden and not expected.

Of the 42 cases that required a JAR, at the time of this report*, 28 had been reviewed and closed. Of the 42 cases, at the time of this report*, 14 cases are still open and require further investigation and/or information to be shared before the case can be referred to CDOP for the final review.

There was a higher proportion of unexpected deaths requiring a JAR in Walsall (15 cases) compared to other areas. During 2022/2023, Wolverhampton had 8 cases that triggered a JAR, Dudley had 9 cases requiring a JAR and Sandwell had a total of 10 cases resulting in a JAR.

Data Chart 14 - Breakdown of Joint Agency Response by area



Of those 28 cases that triggered a JAR and have been reviewed at the time of this report* the following categories have been identified in 5 or more cases:

⇒ Sudden unexpected, unexplained death (10 cases)

⇒ Chromosomal, genetic, or congenital anomaly (7 cases)

⇒ Acute medical or surgical condition (6 cases)

⇒ Chronic Medical condition (6 cases)

⇒ Infection (5 cases)

*(At the time of this report*January 2024)*

Learning Disabilities Mortality Review

Learning from the lives and deaths of people with a learning disability and autistic people (referred to as LeDeR) is not an investigation but to lead on improvements in services for people with a learning disability and autistic people.

During 2022/2023, 11 child death notifications were notified to the LeDeR Manager, these have been included in the Black Country LeDeR Annual Report for 2022/2023.

Of the 11 deaths during 2022/2023 that were notified, 6 of these were under the age of 10 years old and 55% of the 11 deaths were not identified as White British.

CDOP recognises there are improvements to be made in regard to reviewing Child Deaths where a Learning Disability and/or Autism has been diagnosed/suspected and ensuring parents are able to feedback into the Child Death Review process.

Since 1st July 2023, child deaths that are notified and the child has been diagnosed to have a Learning Disability and/or Autism, they are no longer added to the LeDeR platform, but remain within the CDOP process.

However, the LeDeR Manager should be informed of all Child Deaths over the age of 4 years old where a Learning Disability and/or Autism is known, diagnosed and/or suspected and should be invited to all Joint Agency Response meetings and Child Death Review Meetings.

BCCDOP Monitoring

Child Death Overview Panels are monitored through eCDOP by NCMD to ensure local data is completed. In the regional report of data up to 31st March 2023 that is published by NCMD, each CDOP has been provided with a score against data completion of the mandatory fields within eCDOP and the timeliness of notifications and reviews.

Data Completeness

In 2022/2023 The Black Country had 100% in all data fields checked for completeness including the NHS number, Date of Birth, Date of Death, Gender, Ethnic group, Gestational age*, postcode, place of death and hospital specified. (*if a child is under one).

The Joint Agency Response had 53% completion, this is the highest in the West Midlands, and higher than the average across England. In the Black Country and many CDOP across England, the JAR area on eCDOP is not used in its full capacity.

The NCMD reported that Black Country achieved 100% in data completeness for cases that reached CDOP for review during 2022/2023.

Timeliness

In 2022/2023 the Black Country delivered 78% of Child Death notifications in 2 days. Although some work is required to ensure more Child Death notifications are shared within the 2 days following the death, it is important to note the average in the West Midlands was 73% and across England was 66% of notifications in 2 days.

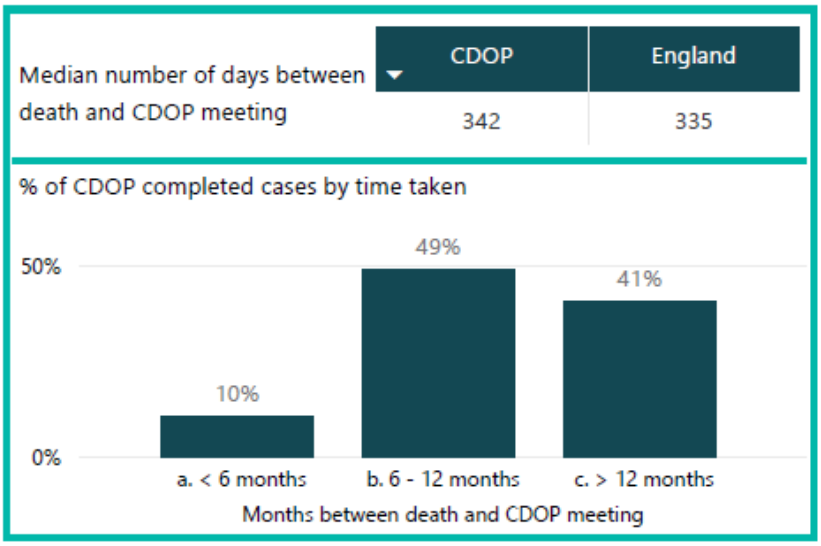
In 2022/2023 we can report that 98% of notifications were processed in 7 days. Across England 90% of notifications are processed in 7 days.

The child death notifications that may be delayed can be where a child has died abroad. It may take some time before the family return and share information, or the news of the death reaches the community or is shared with school and/or lead professionals. There is also hesitation by professionals to notify a death to CDOP without the full details or without formal confirmation that the child has died, and this can often cause additional delays.

Data Chart 16 is taken from the NCMD local monitoring report for the Black Country for 2022/2023 and illustrates the percentage of cases that are reviewed within 6 months, 12 months and over 12 months.

The time between the date of death and the case being reviewed (and closed) at CDOP during 2022/2023 was 342 median days. The Black Country has an average of 60% of cases being reviewed within 12 months. In 2022/2023 the West Midlands has an average of 52% of reviews in 12 months and England has an average of 45% of reviews within 12 months.

Data Chart 15 – Days between notification of death and CDOP meeting



Unfortunately, the delay for some cases to be ready for review is out of the control of CDR teams and CDOP. There is a national shortage of paediatric pathologists, and this is impacting on all Child Death Review teams across England.

Some families may be informed their child requires a Post Mortem, but this would result in the child being transported to areas out of the Black Country, for example, to Sheffield or Cambridge. CDOP understands for families the thought of their child being so far away from home can be incredibly difficult along with all the emotions already occurring following the death of their child.

We would hope the conversations between the coroner and family ease any concerns or fears family may have, and we hope to collaborate more closely with the coroner moving forward to understand the practicalities to ensure a Post Mortem takes place in a timely manner and capture feedback from families to further highlight the capacity of Pathologists.

Learning from deaths

Looking at all the deaths reviewed during 2022-2023, we have been able to collate the learning points into specific areas (For a more detailed version, please refer to Appendix five)

⇒ **Communication** – between services, with parents, note taking, telephone triage, language, and cultural barriers.

⇒ **Paediatric Palliative care** – inconsistent commissioning of services, importance of involving all professionals in a debrief, end of life care and Advanced Care Plans (ACP)

⇒ **Paediatric care** – missed opportunities, need for further clarification of roles and responsibilities, training for staff, reflection on cases to improve future practice, escalation, and consultation with colleagues.

⇒ **Maternity and risks identified during pregnancy** – missed opportunities, the impact of family history and previous experiences, lack of monitoring.

⇒ **Neonatal care** – Missed opportunities in the first 24 hours of care, importance of clear, informed and prompt decisions about care, training for staff, importance of monitoring.

⇒ **Genetic testing** – Missed opportunity or service not offered to the family.

⇒ **CDR process** – lack of information, delay in notification, delay or lack of information shared with appropriate agencies.

⇒ **Coroner** – Lack of or delay in contact with family, sharing of information with family without informing lead clinician to support the family appropriately, missed opportunities.

⇒ **Bereavement care** – Parents not supported to spend time with their child, lack of bereavement care/follow up, missed opportunity to support staff, lack of supervision.

⇒ **Multi-Agency learning** – unclear processes, missed opportunity to share relevant information, lack of invite to all professionals involved, incorrect gender used, key worker not identified, delay in follow up/contact following referral.

⇒ **Childrens Services** – timescales not clear, missed opportunities to invite the appropriate services, sharing information.

⇒ **Health Visiting** – Missed opportunities, lack of referral, lack of documentation, policy not followed.

⇒ **Housing** – not appropriate for the family's needs, not invited to appropriate meetings.

⇒ **Mental Health services** – missed opportunity, delay in referral/assessment time.

⇒ **Training and Education** – Lack of understanding of referral routes/thresholds, sharing information across educational settings.

⇒ **Information sharing** – Inconsistent, missed opportunity to share vital information, lack of details to build appropriate picture to determine risk, timely sharing of information.

Actions: shared at Panel

Below are some specific examples of actions that have been shared during the Child Death Review process, these may have been shared within the PMRT, CSPR or as a result of an investigation by the service or external organisation.

⇒ Employment of specific roles to support/focus on areas of care (e.g., Fetal Monitoring, Saving Babies Lives Midwife, ATAIN midwife)

⇒ Action plans to monitor progress.

⇒ Feedback directly to the clinician involved.

⇒ Feedback to the appropriate MDT meeting.

⇒ Risk Assessments to further support exacting standards of care.

⇒ Guidelines reviewed, updated, and shared with appropriate teams.

⇒ Policies and procedures reviewed, updated, and disseminated.

⇒ Inclusion of relevant documentation (e.g. Risk Assessments) into the Electronic Patient Record (EPR) and making these mandatory fields to complete.

⇒ Inclusion of information/reminders into a regular newsletter, safety briefings, learning summary, updates, reminders.

⇒ Noticeboards used to share information and good practice – posters to remind staff of key learning.

⇒ Refresh of information to ensure staff understand the referral process, criteria and point of contact.

⇒ Regular study days.

⇒ Team meetings to share updates and actions as a result of learning.

⇒ Education/teaching sessions for staff (at all levels) including education packages/workbooks.

⇒ Audits – regular monitoring to evidence compliance and spot checks once compliance met.

⇒ Retrospective recording in EPR records to ensure appropriate documentation.

⇒ Recording of calls and improvements to the storage and log of telephone conversations.

⇒ Proforma for telephone triage developed and implemented.

⇒ Referral to appropriate and available services to meet the child and/or family needs.

⇒ Improvements in documentation processes (signed to confirm a copy has been received).

⇒ Improvements to information (in a leaflet) shared with families to ensure a clear consistent message moving forward and checking information is understood by parents.

⇒ Promotion of local services to families.

⇒ Translation of leaflets/posters into the top languages for the specific area.

⇒ Escalation of learning to the appropriate service and/or leading programme of work (e.g., LMNS. ODN, WMP, WMAS)

Actions: suggested as a result of the learning

Below are some specific actions that were identified as a result of cases that had been reviewed at CDOP during 2022/2023;

⇒ Maximise the pivotal role of supervision across the system.

⇒ To ensure no duplication of work, one colleague to document the event at and soon after birth.

⇒ Ensure DNA appointments are checked daily and re-appointed.

⇒ If a woman has transferred care to another Trust to ensure all Clinical information has been shared.

⇒ Improved communication between services, with clear processes and sharing of information.

⇒ Improved communication with parents, to ensure information is clear, consistent, and understanding is checked.

⇒ When sharing information with families, this should include the risks and benefits faced by a particular course of action.

⇒ Bereavement teams/professionals need to work together to ensure the appropriate support is in place for families.

⇒ Improvements to telephone triage, including a proforma to ensure appropriate questions and record of conversation and recording of calls to audit and support training.

⇒ The correct people from the correct agencies need to be invited and around the table at every multi agency discussion (particularly related to children with complex needs)

⇒ Access to an interpreter should be considered at every opportunity to ensure parents are engaged with the process, fully understand care plans and their child's needs. This should be an external translator (not family members or staff).

⇒ Advanced care plans need to be reviewed by the entire team, reviewed at regular intervals, and shared with all relevant parties.

⇒ Use of evidence-based assessment tools and frameworks (e.g., GCP2, hoarding tool) to highlight persistent neglect.

⇒ Guidelines based upon measurable items (such as the level of blood loss) should be considered in a form that women can use to report consistently.

⇒ Women with a Maternal BMI <18 should have a referral to the dietician.

⇒ Consideration to be given to undertake a "Test and Cure" when a woman has repeated

UTI's.

⇒ A partogram should be used to monitor uterine activity, fetal heart, and maternal observations.

⇒ The importance of understanding previous pregnancy history, as well as family history to ensure the appropriate level of care and/or referrals.

⇒ Referral to unborn vulnerable babies' network where appropriate.

⇒ Health Visitors should receive information about babies' progress when admitted for extended periods to hospital.

⇒ Ensure that Child in Need plans are robust and include - What support/services are needed to help the family achieve the changes. Who will do what, by when, setting out clear timescales for action (that are realistic and achievable), and review of the plan.

⇒ Clarity in documentation and the reasons when a referral has been stepped down.

⇒ Where a person identifies as a gender that is different to their birth gender, this should be reflected on their records and any correspondence.

⇒ Childhood experiences to adult outcomes indicator tools, for example The Adverse Childhood Experience and Resilience Scales, may strengthen the pathways across services related to young people.

⇒ All agencies/services to ensure access and sharing of current referral forms and pathways to avoid delay to safeguarding concerns being acted on.

⇒ To ensure the GP is included in any meetings and/or information about their patient.

⇒ Enhance information sharing and multi-agency engagement.

⇒ Early use of Advanced Care Plans.

⇒ Availability of a cold cot and arrangements made for families to spend time with their children.

⇒ If concerns are raised at scans, these are shared with Midwifery team and Consultants to share reassurance.

⇒ Highlight the importance of antenatal visits (Health Visiting and Midwifery).

⇒ Clinical judgement must be used alongside guidelines rather than be replaced by them.

⇒ Proforma used for all children attending the paediatric assessment unit.

⇒ To reinforce the sepsis screen de-escalation process to ensure patients are seen in person.

⇒ To promote recognition of serious illness with a surgical origin across all critical care.

Learning Shared by CDOP

Sharing learning is a key role for the CDOP team. CDOP is collaborating with colleagues across the region to understand how learning is shared and recorded to improve and develop this in the Black Country. CDOP is keen to formulate a formal process to record learning, identify where this has been shared and monitor the impact of the learning on practice.

CDOP has shared learning by:

⇒ Briefings - to highlight learning from Panel and where appropriate, specific briefings have been developed to target professionals in the field and highlight relevant learning.

⇒ Themes and trends - developed on a quarterly basis, shared with the Strategic Partnership and then the wider network.

⇒ Local Maternity and Neonatal System (LMNS) - learning and good practice shared quarterly at the Quality and Safety Work Stream relevant to Maternity and Neonatal colleagues across the Black Country and monthly attendance at the LMNS Best Start Work Stream.

⇒ CDOP contact list - members of the CDOP, Strategic Partnership and other Safeguarding and relevant colleagues across the Black Country.

⇒ Warnings - Following a case, it may be appropriate to highlight the dangers of an item and/or activity to specific areas/contacts.

⇒ Research – During Panel, members might highlight research relevant to the discussion.

⇒ Reminders - where a case has highlighted the importance of reiterating a process/action.

⇒ NCMD - Escalating learning from cases to the NCMD through eCDOP and/or directly.

⇒ ACDRP - Escalating learning/concerns to ACDRP through the Independent Chair or BCCDOP.

⇒ West Midlands Child Death Review Network (WMCDRN) – quarterly attendance

⇒ CDOPS across England - Sharing learning or responding to requests for information.

Recognising Good Practice

At Child Death Overview Panel, where good practice has been noted during the review of a case and staff have been recognised going above and beyond this has been highlighted to Panel members. The BCCDOP Independent Chair has shared a letter following Panel to acknowledge good practice and/or extend thanks to an individual and/or team.

For example, where a service which is not formally commissioned but is offered to support the family, or feedback from the family to how helpful and kind a team or member of staff were or the actions of a member of staff in an emergency situation.

Although the review sometimes highlights this good practice or recognition of staff going above and beyond, it is also evident there are many more who may not be recognised at the time of the review. CDOP would like to continue the emphasis on highlighting good practice and sharing thanks to those supporting the child who died and their family.

CDOP and many families depend on the kind, generous, compassionate, and diligent professionals and volunteers who engage in often complex, uncommon, unusual scenarios, and would like to share a ‘Thank you’ to every single one.

Data Overview - Child Death in Black Country

Infant Mortality in the Black Country

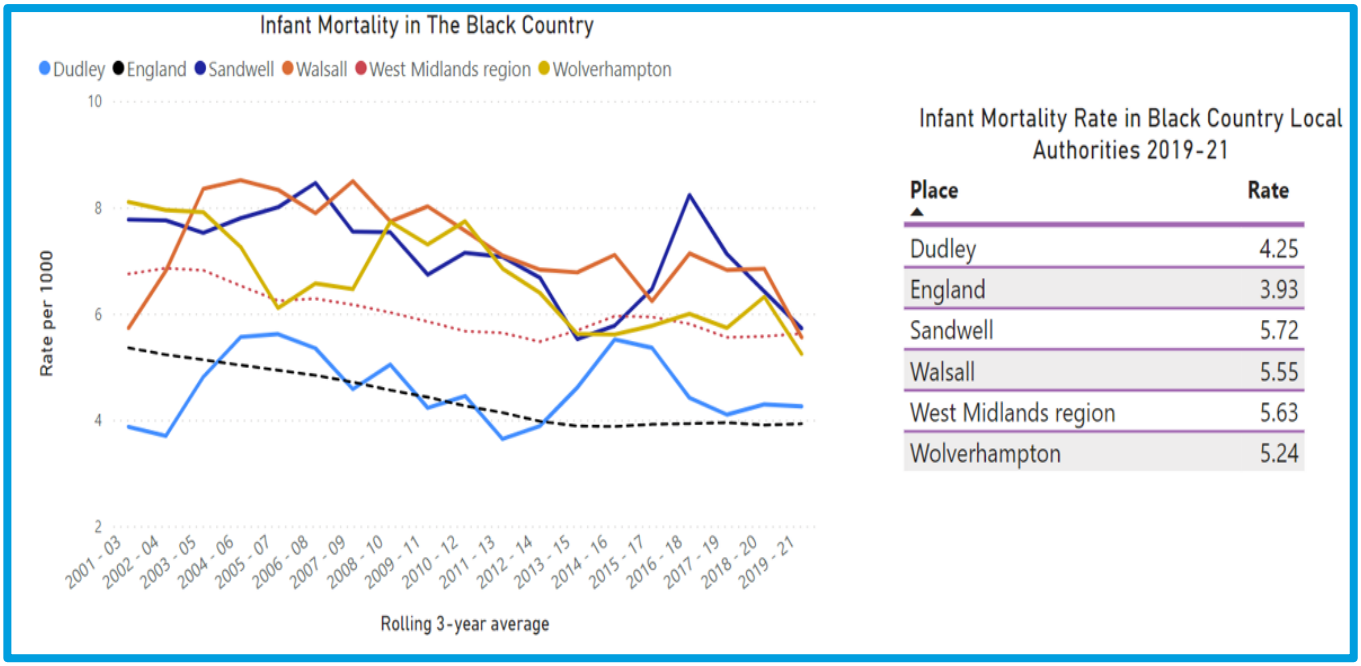
Infant Mortality refers to any child who dies and is under the age of one year old and the rate is the number of infant deaths for every 1,000 live births.

In 2022/2023 of the 128 Notifications of Child Death, 79 child death notifications were under the age of one year old (62% of child death notifications).

The Data Chart 16 below highlights the infant mortality rate per 1,000 for each of the areas over a 20-year period based on a rolling 3-year average, the specific figures have been included in a table (see Appendix six).This illustrates a significantly higher infant Mortality Rate in the West Midlands (red dotted line) when compared to England (black dashed line) and demonstrates a significantly higher infant mortality rate in the Black Country (four solid coloured lines)

In 2019-2021 the Infant Mortality rate across England was 3.9 (rate per 1,000 live births). This compares to a rate in of 4.3 (Dudley) up to 5.7 (Sandwell) per 1,000 live births.

Data Chart 16 – Infant Mortality in the Black Country for each area, compared to West Midlands and England Data based on 3 year rolling data.



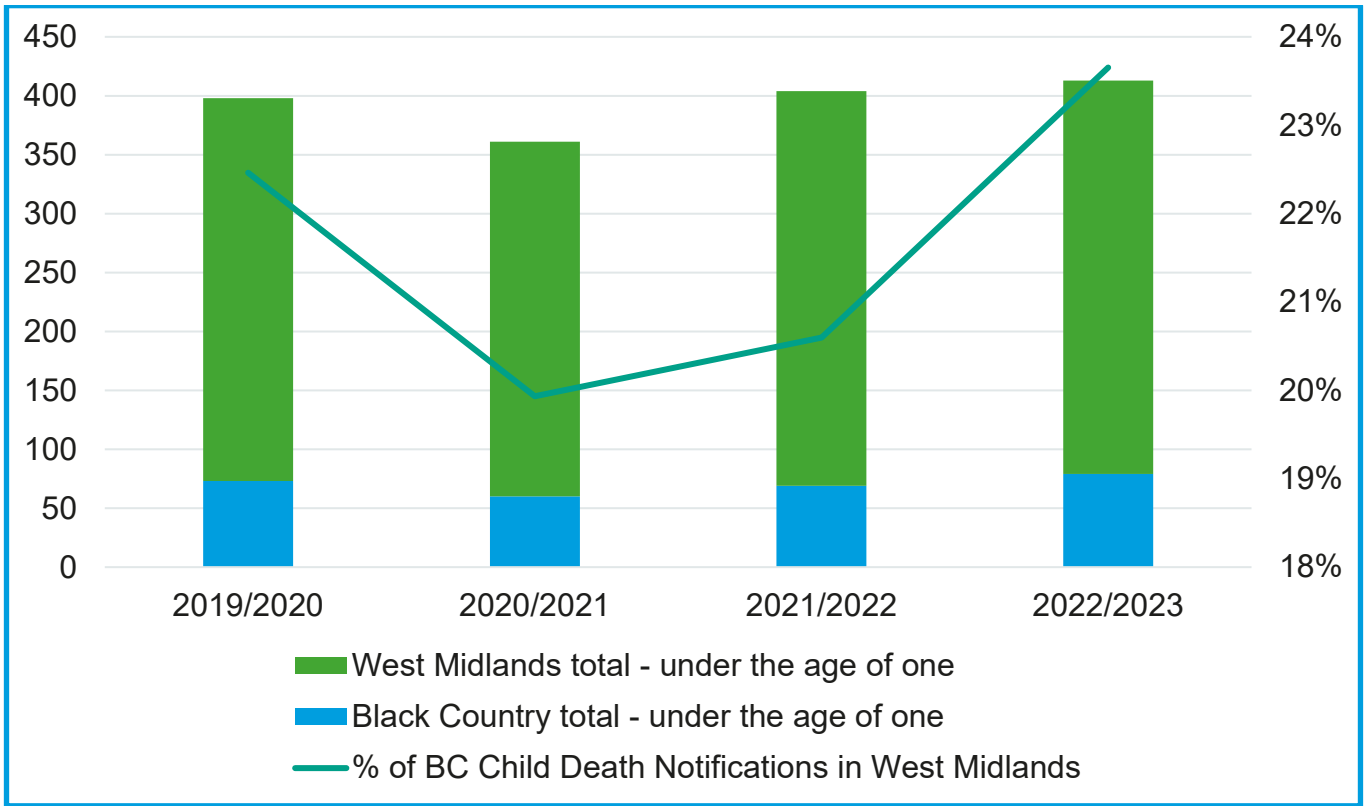
Infant Mortality Rate in Black Country Local Authorities 2019-21

Place	Rate
Dudley	4.25
England	3.93
Sandwell	5.72
Walsall	5.55
West Midlands region	5.63
Wolverhampton	5.24

To understand the overview in the Black Country over the last four years, data chart 17 illustrates the data for child death notifications under one years of age in the Black Country (blue block). And how many child deaths under one years of age were notified across the West Midlands (green and blue block together).

The line represents the Black Country figure in a % of West Midlands deaths under one year of age, with an average of 22% (282 notifications) of all West Midlands Child Death notifications (1295 notifications) under the age of 1 over the last four years (2019 – 2023).

Data Chart 17 – Infant Deaths in the Black Country compared to West Midlands data.



Infant Mortality and Ethnicity inequality

Although the figures for mortality are small statistically in, we have identified an increase in child death for some ethnicities when comparing the infant deaths against the live birth data as a percentage for each ethnic category. Data chart 18 illustrates data from 2021 and highlights some further work that could be considered by Partners moving forward.

From data chart 18 there is a clear difference with a higher proportion of infant deaths during 2021 occurring in both Asian or Asian British, Pakistani, and Bangladeshi communities and Black or Black British African or Caribbean.

In 2021 where the proportion of births for Asian or Asian British - Pakistani communities in 2021 was 7.9% for infant deaths in the same year sadly accounted for 13.9% of infant deaths.

There was also a significant difference in the proportion of infant deaths during 2021 for those infants in White – British or other White background.

In 2021 where White British children accounted for 48.5% of live births in 2021, 41.7% of deaths were White British infants, a significantly lower proportion.

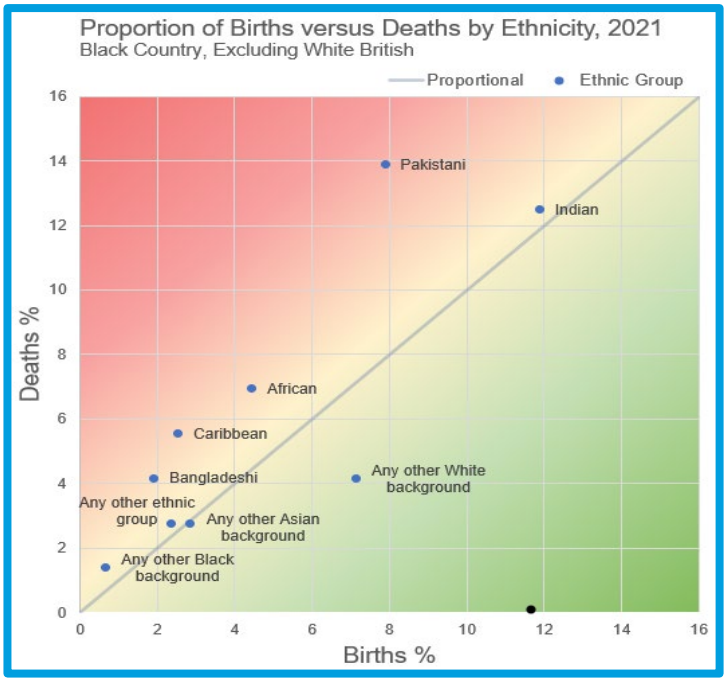
Data Chart 18 – Black Country % Live Births and % of infant deaths in 2021 and the difference between the proportion

	Proportion of Births in 2021 (%)	Proportion of Infant Deaths in 2021 (%)	Difference
Asian or Asian British - Any other Asian background	2.8	2.8	0.0
Asian or Asian British - Bangladeshi	1.9	4.2	2.3
Asian or Asian British - Indian	11.9	12.5	0.6
Asian or Asian British - Pakistani	7.9	13.9	6.0
Black or Black British - African	4.4	6.9	2.5
Black or Black British - Any other Black background	0.7	1.4	0.7
Black or Black British - Caribbean	2.5	5.6	3.0
Other ethnic group - Any other ethnic group	2.3	2.8	0.4
White - Any other White background	7.1	4.2	-3.0
White - British	48.5	41.7	-6.8

Data Chart 18 – to note: this is 2021 data.

Data Chart 19 illustrates the proportion of births against the proportion of child deaths in each of the ethnic groups.

Data Chart 19 – Black Country Births versus Deaths by ethnicity in 2021



Data Chart 19 – to note: this is 2021 data and White British has been excluded.

To explain data chart 19, for those ethnicities that are above the line, and in the red zone, this signifies a higher proportion of child deaths than corresponding births for this ethnic group. This is most pronounced in the Pakistani ethnic group.

Where the point is below the line, and in the green zone, there are a higher proportion of births than deaths in that ethnic group. This is most pronounced in the White Other group.

Data Table 20 – Correlation coefficient for a Chi-Square test looking at live births and deaths in each Ethnicity category.

	Death	Live
Asian or Asian British - Any other Asian background	0.43	-0.06
Asian or Asian British - Bangladeshi	0.71	-0.1
Asian or Asian British - Indian	1.11	-0.16
Asian or Asian British - Pakistani	1.1	-0.15
Black or Black British - African	1.48	-0.21
Black or Black British - Any other Black background	0.71	-0.1
Black or Black British - Caribbean	1.9	-0.27
Other ethnic group - Any other ethnic group	-1.8	0.25
White - Any other White background	-0.76	0.11
White - British	-1.03	0.14

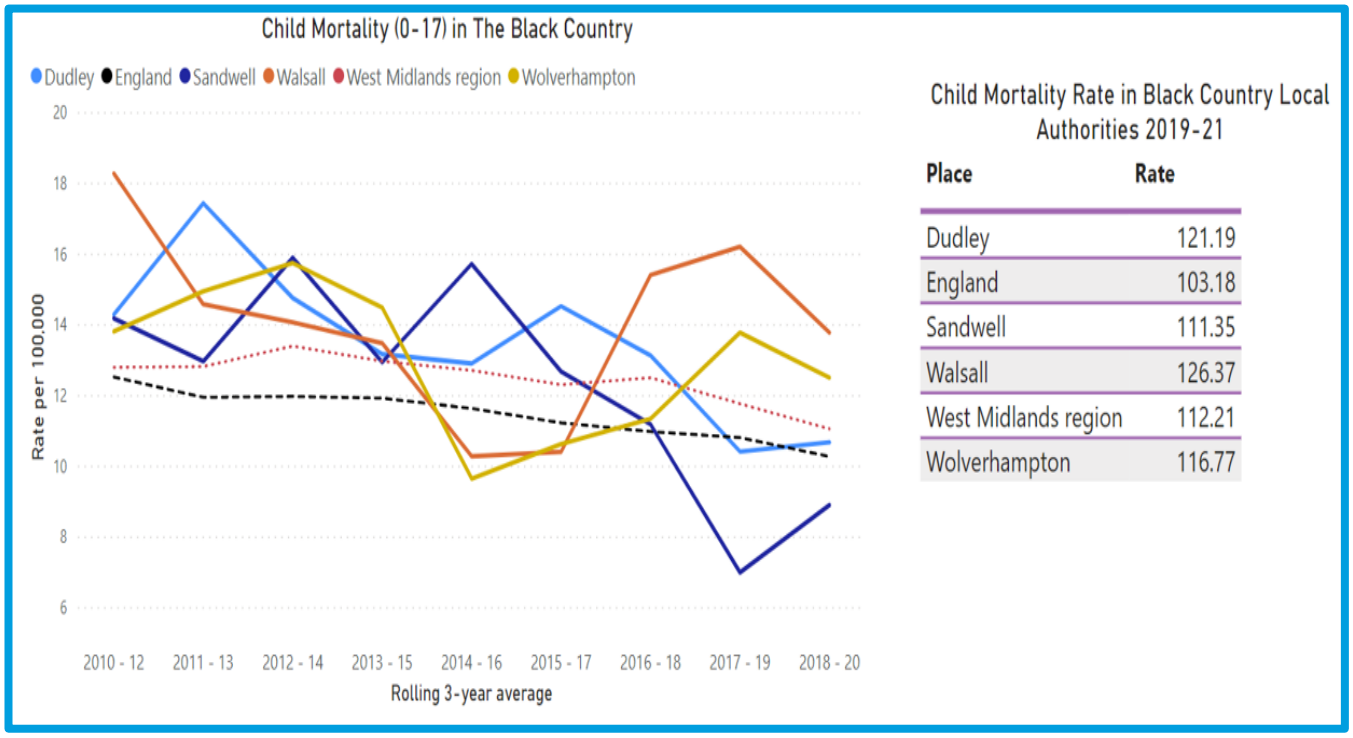
Colleagues within Walsall Public Health Business Intelligence Team have supported the Child Death Overview Panel Team with the deep dive into some of the data. The team noted although a small sample size there are indications of a positive correlation between the number of deaths and ethnicity. In data table 20 the purple shading suggests there are more observed instances of deaths than expected when calculated across all the ethnicities. The green shading suggests there were fewer deaths than would be expected in this group, based on the population data.

Child Mortality in the Black Country

The data chart below highlights the child mortality rate per 100,000 between the ages of 0-17. This illustrates a different trend to the infant mortality data, although spikes for individual areas, this suggests the Child Mortality rate in the Black Country on average is in line with West Midlands (red dotted line) and the England (black dashed line) Child Mortality rate.

Walsall and Wolverhampton have a slight spike in the recent years, particularly 2017-2019 followed by a decrease in more recent data, while Dudley and Sandwell had a significant decrease in 2017-2019 followed by a slight increase in 2018-2020.

Data Chart 21 – Child Mortality in the Black Country (Ages 0-17) for each area, compared to West Midlands and England Data based on 3 year rolling data



Child Mortality Rate in Black Country Local Authorities 2019-21

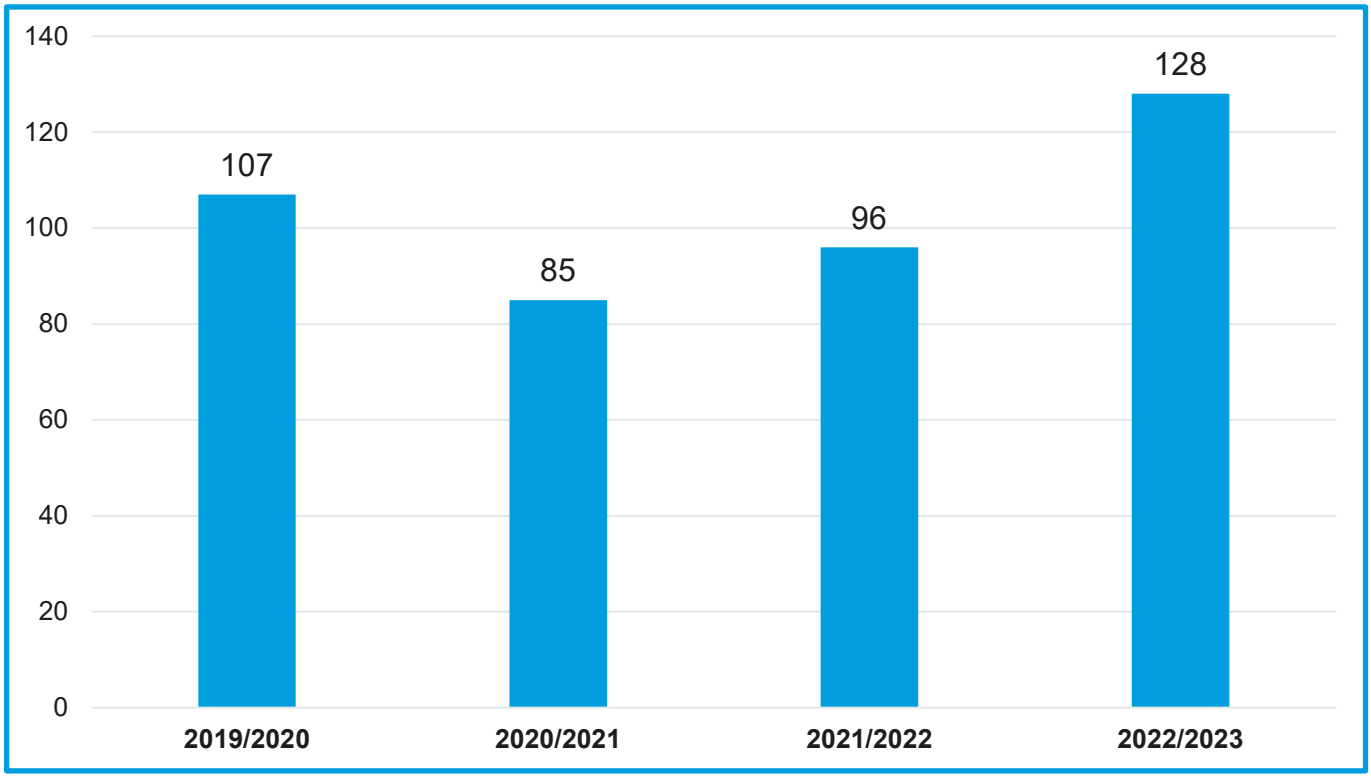
Place	Rate
Dudley	121.19
England	103.18
Sandwell	111.35
Walsall	126.37
West Midlands region	112.21
Wolverhampton	116.77

Deaths Notified 2019-2023

Over a four-year period, a total of 416 Child Death notifications have been received within Black Country CDOP. There has been a gradual rise in notifications over the last three years.

The data chart 22 illustrates the decrease in child death notifications during 2020/2021 and then an increase observed in 2021/2022 could be linked to lockdown imposed and then lifted due to the Covid-19 pandemic.

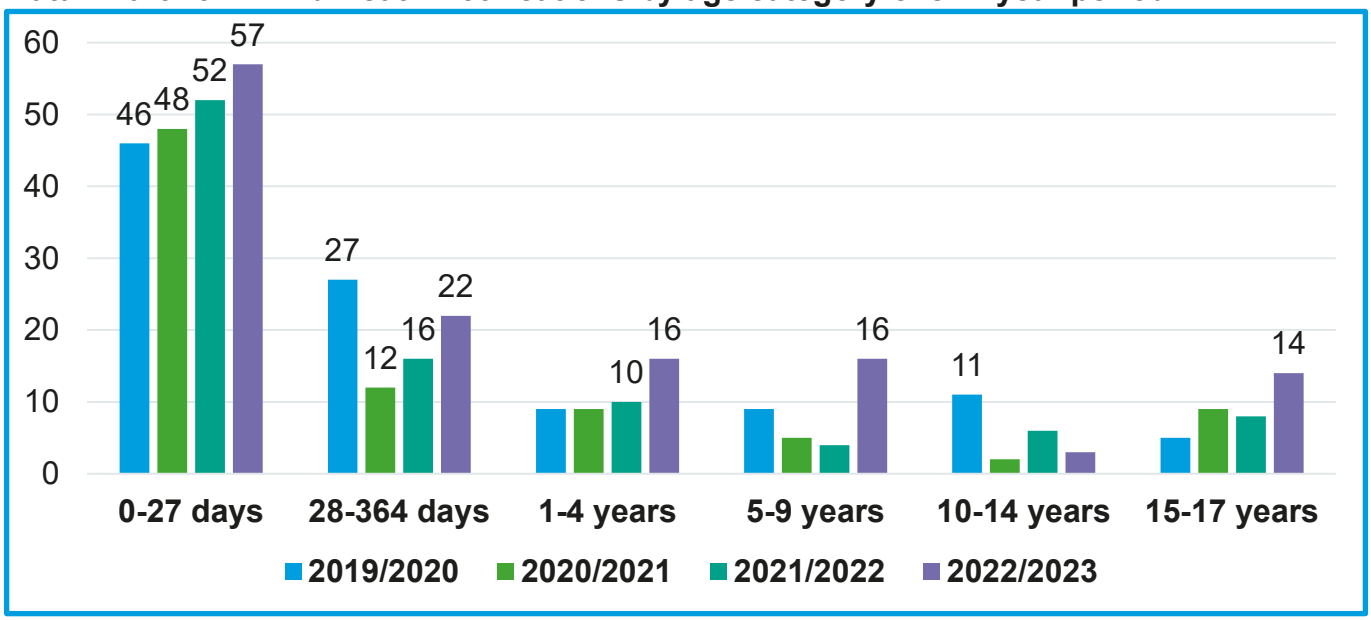
Data Chart 22 – Black Country Child Death Notifications over 4-year period



During lockdown, where people were out and about less, therefore an overall decrease in road traffic collisions and accidents in public places were observed during 2020/2021.

Also, less socialising, and risky activities which may explain the decrease illustrated in data chart 23 in the child death notifications between 2020-2022 in the older age groups.

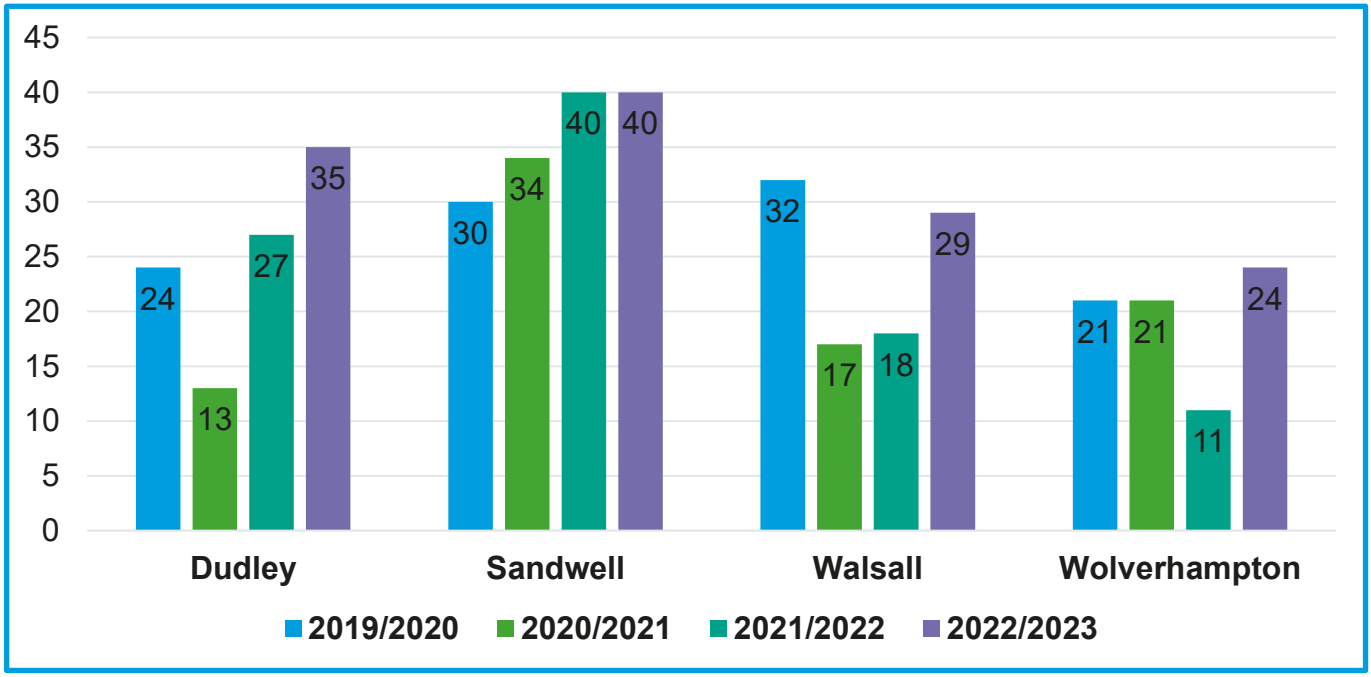
Data Chart 23 – Child Death Notifications by age category over 4-year period



Data Chart 23 – to note: figures below 10 have not been specified.

Over the last four years the notifications of child deaths in the 0–27-day age range has gradually increased, with the notifications of child deaths in the 10-14 years age range gradually decreasing since 2019-2020 while the other age groups all saw an increase in child death notifications in 2022/2023.

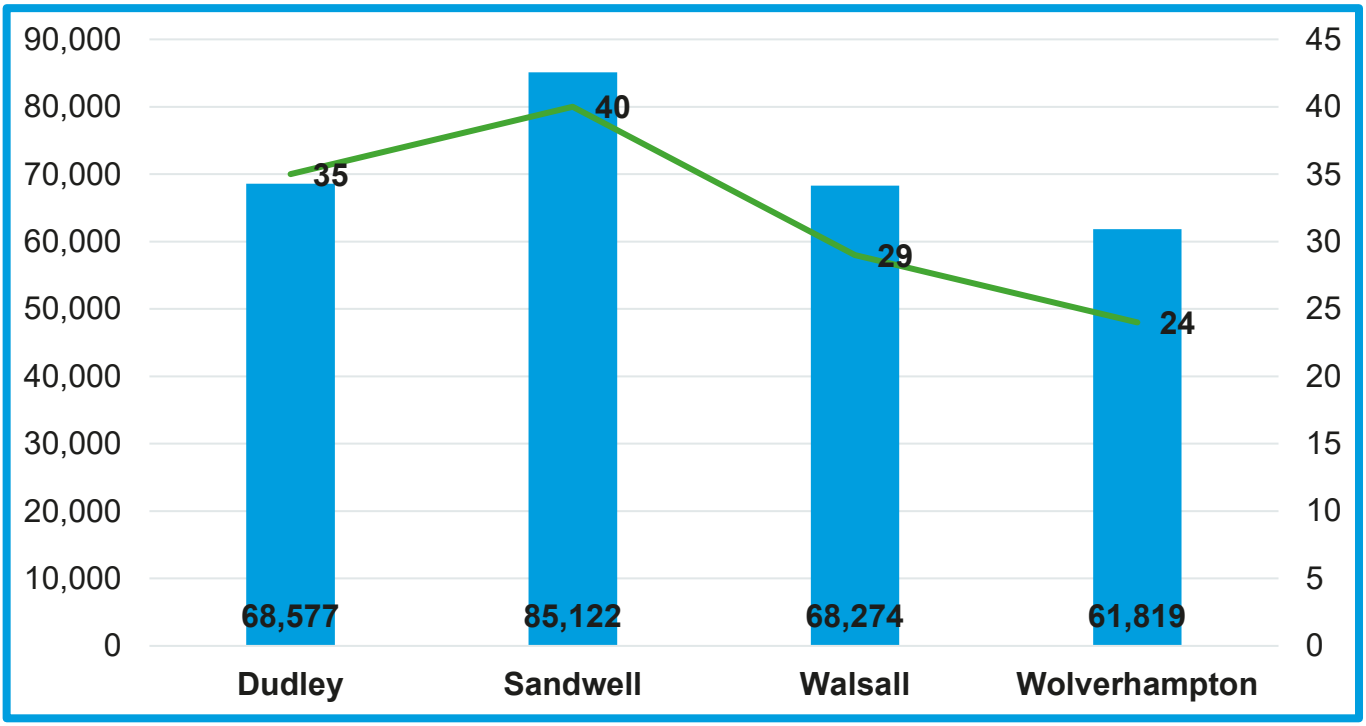
Data Chart 24 – Child Death Notifications by area over 4-year period



Dudley, Walsall, and Wolverhampton have all had an increase in child death notifications during 2022/2023. Sandwell, although a higher number of child death notifications, has stayed at 40 notifications during 2021/2022 and 2022/2023.

When comparing the child death notifications to the Census 2021 population data, data chart 25 below highlights the number of child death notifications for each area, with the individual area population.

Data Chart 25 – Child Death notifications in 2022/2023 and the population for 0–17-year-olds for each area.

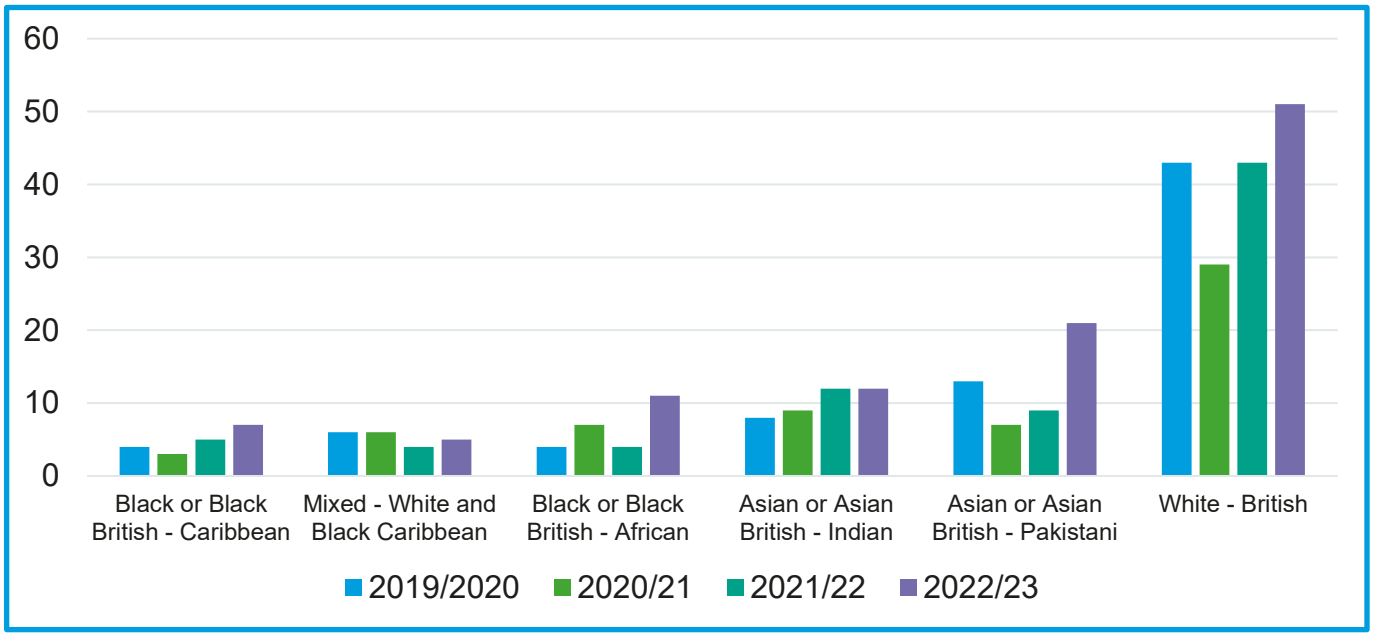


Data chart 25 – to note: population based on ONS data for 2021 for each area for ages 0-17 years old. This illustrates the total child death notifications next to the population for each area and is not illustrating a rate.

Data Chart 26 illustrates the significant increase in child death notifications for Black or Black British – African, Asian, or Asian British – Pakistani and White British communities in 2022/2023 compared to previous years.

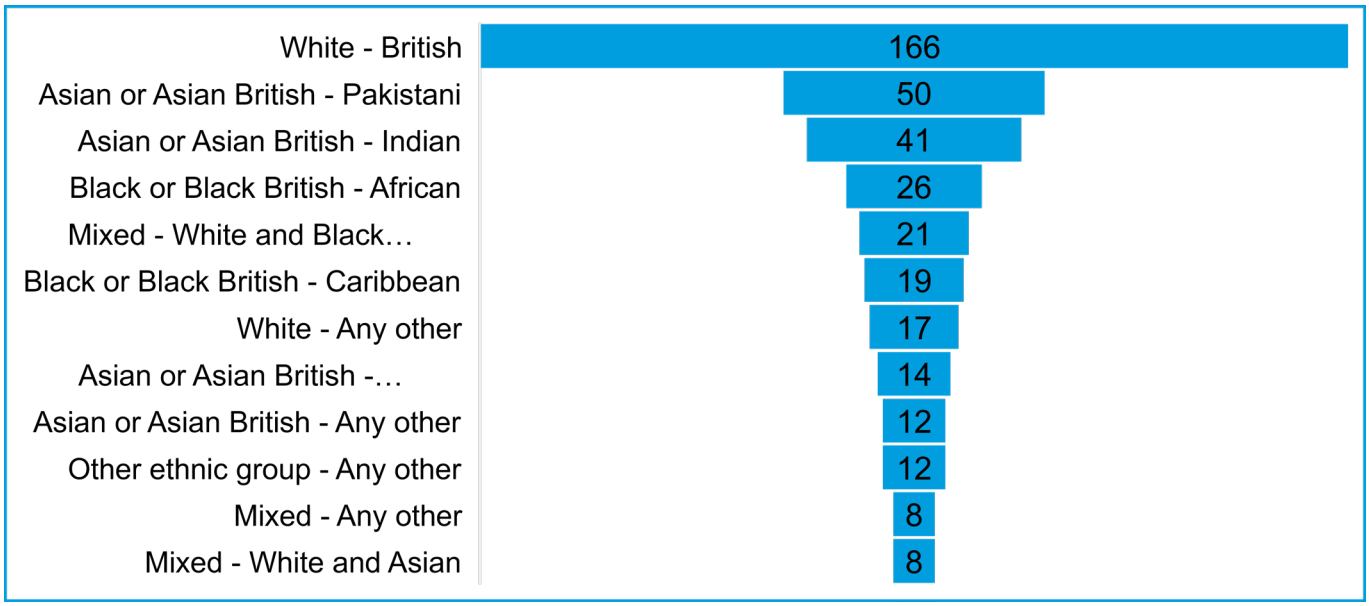
A gradual increase has been noted in child death notifications in the Black or Black British – Caribbean and Asian or Asian British – Indian communities during 2022/2023.

Data Chart 26 – Child Death Notifications by Ethnicity over a 4-year period



Of the total, 416 child death notifications received over a four-year period, data chart 27 illustrates the breakdown by ethnicity.

Data Chart 27 – Total Child Death notifications over a 4-year period by Ethnicity



Data chart 24 – to note: the following ethnic categories have not been included due to the small numbers; other ethnic group – Arab, not applicable, Mixed – white and Black African, White Irish, Other ethnic group – Chinese, Black, or Black British – any other, Not known/not stated.

Future Priorities for Black Country CDOP

The CDOP team would like to highlight the following priorities to be addressed by the BCCDOP Strategic Partnership:

⇒ Family/Parent engagement, to ensure understanding of the Child Death Review Process.

⇒ Feedback into the CDR process and appropriate support and services offered to parents, family, and siblings.

⇒ To consider an update to the Black Country SUDIC protocol on release of the updated Kennedy Guidelines.

⇒ To highlight and share Good Practice.

⇒ To implement a process for cases where a Learning Disability and/or Autism is suspected/diagnosed, following review, the learning is shared with the LeDeR Manager.

⇒ To establish a formal Governance structure to ensure oversight of Child Deaths across the Black Country.

⇒ To improve the sharing of learning across the Black Country and continue to develop the CDOP contact list.

⇒ To develop a surveillance model to allow further deep dive into the eCDOP data.

Recommendations for Local Partners

On release of this report, CDOP would like to recommend the following items to Partners across the Black Country:

⇒ To note the data shared within this report.

⇒ To share feedback from parents/families following the death of a child to inform the Child Death Review process.

⇒ To share with CDOP:

⇒ Where actions/changes to practice are as a result of learning shared in this report

⇒ Examples of good practice in individual areas/services already happening that can be reflected in other areas/services.

⇒ To highlight initiatives developed as a result of this learning to the Child Death Overview Panel that reduce the prevalence of modifiable factors including;

⇒ Safer sleeping

⇒ Smoking

⇒ High Maternal BMI

⇒ For partners to consider an area specific deep dive into deprivation and ethnicity.

References

- NCMD | The National Child Mortality Database
- Census - Office for National Statistics (ons.gov.uk)
- Age by single year - Office for National Statistics (ons.gov.uk)
- English indices of deprivation 2019: Postcode Lookup (opendatacommunities.org)
- Live births by ethnicity and local authority, 2020 to 2021 - Office for National Statistics (ons.gov.uk)
- https://www.blackcountryintelligencehub.co.uk/
- https://fingertips.phe.org.uk/profile/child-health-profiles

Appendix ONE – Roles within CDOP and CDR Teams

CDR and CDOP Roles (January 2024) – with names

	Mike Leaf Independent Chair		
	Keren Hodgson CDOP Coordinator	**Michelle Mincher** CDOP Officer	
Vacant (Jan 2024) Dudley/DGFT Area Administrator	**Taylor Miles** Sandwell Area Administrator	**Mindra Kumar** Walsall/WHT Area Administrator	**Gina Johnson** W'ton/RWT Area Administrator
	Dr Cath Williams SUDIC/Child Death BCICB	**Debbie Brown** Lead Nurse for Child Mortality BCICB	**Kerris Percival** Lead Nurse for Child Mortality BCICB
Dr Subra Mahadevan Designated Doctor **Bev Tinsley** Lead Practitioner for Child Death *DGFT CDR Team*	**Dr Charlotte Avann** Designated Doctor *SWBH CDR Team*	**Dr Bashir Muhammad** Designated Doctor **Dr Tamsin Lane** Lead for Child Death *WHT CDR Team*	**Dr Cath Williams** Designated Doctor **Dr Lorna Bagshaw** Lead for Child Death **Victoria Griffiths** Specialist Nurse for Child Death *RWT CDR Team*

CDR and CDOP Roles (January 2024) – without names

	BCCDOP: Independent Chair		
	CDOP Coordinator	**CDOP Officer**	
Dudley/DGFT Area Administrator	**Sandwell** Area Administrator	**Walsall/WHT** Area Administrator	**W'ton/RWT** Area Administrator
BCICB	**SUDIC/Child Death Lead**	**Lead Nurse for Child Mortality**	**BCICB**
DGFT CDR Team Designated Doctor Lead Practitioner for Child Death	**SWBH CDR Team** Designated Doctor	**WHT CDR Team** Designated Doctor Lead for Child Death	**RWT CDR Team** Designated Doctor Lead for Child Death Specialist Nurse for Child Death

Appendix TWO - Contributory Factors – Four Domains

Domain A Groups - Factors intrinsic to the child

- Child health history/medical conditions
- Risk factors in mother during pregnancy/delivery
- Child's developmental conditions/disabilities
- Emotional/behavioural factors
- Smoking/alcohol/substance use/misuse by the child
- Other

Domain B Groups - Factors in social environment including family and parenting capacity

- Smoking/alcohol/substance misuse/use by a parent/carer
- Challenges for parents with access to services
- Domestic or child abuse/neglect
- Household functioning, parenting/supervision
- Poverty and deprivation
- Social care
- Cultural factors
- Parent/carer's health
- School/peer groups
- Other

Domain C Groups - Factors in the physical environment

- Sleep environment
- Home safety/conditions
- Vehicle collision
- Public safety
- Other

Domain D Groups - Factors in service provision

- Initiation of treatment/identification of illness
- Following guidelines/pathway/policy
- Access to appropriate services
- Staffing/bed capacity/equipment
- Communication within or between agencies
- Communication with family
- Other

Appendix THREE – Modifiable Factors identified in each Domain – full list

Domain A – Factors intrinsic to the Child
• High Maternal BMI (ranging from 30.7- 54.9 • Low Maternal BMI (16.8 -17.8) • Smoking in Pregnancy. • Baby's sleep position. • Ability to meet the needs of the child. • No evidence a seatbelt was worn. • Co-sleeping • Drug paraphilia present in the house. • Child consuming alcohol and recreational drug user • Child was bullied online and at school. • Smoked cigarettes and vaped nicotine
Domain B – Factors in the Social Environment
• High Maternal BMI • Smoking in the household (mother smokes, father smokes). • Child not being supervised. • Mental Health – impact on mothers' attendance • Deay in presenting to Triage. • Overcrowding • No food in the house • Poor attendance at school of siblings • Drug taking paraphernalia in the bedroom. • Parental substance misuse. • Late booker to the Midwifery service • Concerns around Domestic Abuse • Emotional abuse • Negative behaviour towards the child
Domain C – Factors in the Physical Environment
• Smoking in the household. • Driving a vehicle illegally at an early age. • Confusing labelling on a product. • Overcrowded/busy household. • Poor home conditions observed – smoky environment, overflowing ashtrays, rubbish/clothes piled high, floor with animal/human excrement, mouldy food, dirty nappies, • Poor hygiene observed – child and siblings. • Household deemed unsafe by Fire. • Chaotic housing including co-sleeping. • Cot not used. • Evidence of co sleeping.

Domain D – Factors in Service Provision
• Thermal, respiratory, and fluid management could have been improved in the local Neonatal environment. • Misinterpretation of the CTG – delayed intervention during labour • Incorrect use of x-ray machine - misdiagnosis • Routine care for a health condition not delivered in another country. • Missed opportunities – transfer to a level 3 hospital, steroids, magnesium sulphate. • Communication difficulties and misunderstandings (checking parent level of understanding) • Delay in attendance – due to fetal movement and minimal bleeding. • Delay in results therefore delay in treatment. • Indicator of sepsis not acted on and de-escalation of sepsis pathway too soon. • Delay intervention due to lack of communication between team members. • Lack of information shared with services. • Differing opinions between clinicians/Trusts. • Surfactant administration delayed. • Missed opportunity to refer to unborn babies' network. • Missing/lack of records related to child's needs (allergy) • ACP not known by all services. • Lack of recognition of how sick the child is. • Missed opportunity to escalate to targeted support rather than universal care. • Assessment needed for suitability/parenting. • Impact of language barrier on acute illness. • Lack of record of phone calls and proforma used to take information on the phone. • Delay in intervention following diagnosis. • Missed opportunity to escalate care during labour. • Communication between Trusts – not being listened to. • Missed opportunity to share risks and benefits of home delivery to support an informed decision. • Information not shared between services/agencies. • Gaps in communication between services/agencies – lack of sharing information, reports, diagnosis etc.…

Appendix FOUR - Categorisation of Death

	Category	Description
1	**Deliberately inflicted injury, abuse, or neglect**	Includes suffocation, shaking injury, knifing, shooting, poisoning, and other means of probable or definite homicide; also, deaths from war, terrorism, or other mass violence; and severe neglect leading to death.
2	**Suicide or deliberate self-inflicted harm**	Includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. Will usually apply to adolescents rather than younger children.
3	**Trauma and other external factors, including medical/surgical complications/error**	Includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Includes proven medical & surgical complications or errors as the primary cause of death, excludes deliberately inflicted injury, abuse, or neglect (category 1).
	To include:	sudden unexpected deaths with epilepsy (SUDEP). *These deaths should not be categorised as Category 10 (Sudden unexpected, unexplained death)*
4	**Malignancy**	Solid tumours, leukaemia, and lymphomas as well as malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
5	**Acute medical or surgical condition**	For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.
6	**Chronic medical condition**	For example, Crohn's disease, liver disease and immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Also includes cerebral palsy with clear post-perinatal cause.
7	**Chromosomal, genetic, and congenital anomalies**	Trisomy, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.
8	**Perinatal/neonatal event**	Death related to perinatal events e.g., sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, and post-haemorrhagic hydrocephalus, irrespective of age at death. Also includes cerebral palsy without evidence of cause as well as congenital or early-onset bacterial infection (onset in the first postnatal week). This category includes four subcategories: immaturity/prematurity related, perinatal asphyxia, perinatally acquired infection, other perinatal/neonatal events.
	To include:	deaths caused by perinatal asphyxia. *These deaths should not be categorised as Category 3 (Trauma and other external factors)*– should include deaths related to cerebral palsy without evidence of cause. *Deaths due to cerebral palsy with clear post-perinatal cause categorised as Category 6 (Chronic medical condition)*
9	**Infection**	Any primary infection (i.e., not a complication of one of the above categories), arising after the first postnatal week or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.
	To include:	primary infection arising after the first postnatal week, or after discharge of a preterm baby. *Deaths where there was an early-onset bacterial infection in the first postnatal week should be categorised as Category 8 (Perinatal/neonatal event) and not as Category 9 (Infection)*
10	**Sudden unexpected, unexplained death**	Where the pathological diagnosis is either 'SIDS' or 'unascertained,' at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5).
	To include:	deaths at any age where pathological diagnosis is either 'SIDS' or 'unascertained.' *These deaths should not be categorised as Category 3 (Trauma and other external factors)*

Appendix FIVE – learning from deaths

Communication

Note Taking

Notes relating to the resuscitation of the baby were inappropriate and made it difficult to fully assess the quality of the resuscitation.

It is unclear if a debrief with staff involved in the resuscitation took place.

Staff involved in the care of the child were asked to provide retrospective entries into the notes.

Duplicating work and/or no one documenting the event.

Unclear if a blood transfusion was required and/or given in the correct volume during resuscitation of the baby.

Poor note keeping – lack of documentation, discharge summary, conversation with summary.

Communication between services

Lack of handover of information when a woman transferred her care and DNA policy not followed.

Poor communication between hospital services, health visiting, sonographer and midwifery, bereavement teams, Emergency Services.

Services not being informed of a Childs Death.

Staff not feeling listened to during the event.

Communication with parents

Unclear, inconsistent information being shared with family.

Lack of information to understand the risks and benefits to medication/action.

Not checking the information has been understood.

There was no early discussion with the parents on the neonatal unit about their baby's condition.

False reassurance is inappropriate and can result in an inadvisable decision being made between a patient and health care professional.

Decision passed over to patient in the absence of clear and direct professional advice.

Discussions at the hospital not involving all the teams involved in the care of the child.

Unclear if parents were kept informed about the progress of the resuscitation.

Parents found it difficult with receiving conflicting information from the medical team when this child was an inpatient.

To ensure clear information is shared with parents, particularly when there is a change in strength to medication.

Telephone Triage

No record of conversations or log of phone call to evidence care and information shared.

No recording of phone calls to clarify the conversation that took place.

No audit or standard template in place to monitor telephone triage.

Language and Cultural barriers

Unclear the impact of living in a traveller family setting and the relevant cultural practices impacted the child's support system.

Inconsistent access to language translation.

Reliance on family/friends to translate between staff and the patient.

The use of staff to interpret often inappropriate.

Translators not arranged for multi-Disciplinary meetings making it hard for parents to engage.

Hearing Monitors required in individual rooms.

Paediatric Palliative Care

Lack of 24-hour community paediatric provision to support end of life care in the community.

Unclear information relayed to parents, making it difficult to make an informed decision.

Hot debrief for all professionals involved would be helpful in complex cases where the death was expected.

End of Life Care

Missed opportunity to refer to a hospice.

Review of situation before intervention, in case a more peaceful death should be considered.

Challenge for timely verification of death, particularly at weekends/out of hours.

No out of hours contact meant the parents called 999 and a SUDI response was triggered.

Unnecessary distress for a family when the death of their child was expected.

Hospice unable to take emergency admissions.

Advanced Care Plans

Not always available during the acute admission.

Missed opportunity to develop an ACP.

Ignoring the ACP in place or not knowing the ACP was in place.

Inappropriate CPR and/or initiation of the SUDI process.

Review of the ACP has not taken place or not been done at regular intervals.

Paediatric care

Resuscitation trolley was not fit for purpose – lacking appropriate tools.

Surgical issues were not highlighted early enough.

Staff are unclear on the procedure to be followed after the death of a child in theatre.

The difference between verifying a death (the process of identifying that a person has died) and certifying (completing a medical certificate of cause of death) is not clear to all staff and the definitions should be included in the guideline.

Verification of death should be completed by medical staff and clearly documented in the notes in a place visible to other staff involved in the patient's care.

The patient may have benefited from a longer period on PICU, and earlier embolisation.

The child was not readmitted to PICU following clinical deterioration and there was some delay in performing the MRI and embolisation.

Not all staff have training and access to the appropriate electronic systems.

SEPSIS 6 pathway not always used for children presenting with fever.

Lack of recognition of dehydration in children.

When the child deteriorated there was no discussion with the on-call Neurology consultant overnight regarding the need for readmission to PICU.

As a plan for definitive treatment was already in place, this may have been the focus of care rather than recognition of the deteriorating clinical parameters.

To consider a second opinion if one team declines surgical intervention.

Maternity and risks identified during pregnancy

No evidence of an antenatal home visit.

Risk factors: Unsafe sleeping practices, drug and alcohol misuse in parents/carers, late booking in pregnancy, chaotic household.

History and background need to be taken into consideration during booking.

Missed opportunity to refer mother to the right care in the community following discharge.

Low Maternal BMI – no referral to dietician.

Missed opportunity to provide targeted support when a vulnerability had been identified.

Missed opportunity to use a neglect assessment tool appropriately.

This mother had pregnancy complications, but they were not recognised as requiring specific birth planning.

An intrauterine transfusion (IUT) was suggested but was not attempted.

Missed opportunity to screen for gestational diabetes, to transfer to obstetric led care during labour, referral to the preterm prevention clinic.

No Obstetric care or poor Obstetric care received.

Gap in care from community midwife.

Intrapartum Risk assessment not completed.

Missed opportunity to monitor the fetal heart with doppler or cardiotocography machine.

Misinterpretation of the CTG – therefore delay to intervention.

Mother's progress in labour was not monitored on a partogram.

This baby was resuscitated and delayed cord clamping did not take place.

Neonatal staff would have been required when the baby was born but were not called early enough.

Induction or elective delivery took place, but the timing of the induction/elective delivery was not appropriate.

Neonatal care

The management of the baby for the first 24 hours of arrival on the neonatal unit was not appropriate: *thermal management, fluid management, ongoing respiratory management, haematological management, infection management, skin care, drugs management, glycaemic management and hypoglycaemia prevention, metabolic management, and temperature management.*

During the first 24 hours of the baby's arrival on the neonatal unit appropriate lines were placed but their position was not radiologically confirmed.

Appropriate investigations were not conducted during the first 24 hours of the baby's arrival on the neonatal unit.

Clinician should recognise high lactate in the blood gas and should act timely and appropriately.

Transfer of the placenta should be sent with the baby if transferred.

Diagnosis of circumvallate placenta not acted on appropriately.

Importance of a completed published PMRT.

Unclear interpretation of blood loss when the woman is reporting to medical staff.

The decision to offer reorientation of care for the baby could have been considered sooner.

Close monitoring was required, but this baby was moved before a decision had been made that embolisation was not required in the immediate neonatal period.

Preterm

Not offered antenatal steroids and/or antibiotics and/or magnesium sulphate when they were indicated (in preterm labour)

Missed opportunity to monitor as the partogram would have picked up uterine activity, fetal heart, and maternal observations to inform staff she was in threatened preterm labour.

This mother was in preterm labour/threatened preterm labour but was not offered magnesium sulphate for fetal neuroprotection when this was indicated.

Reminder to team that BAPM guidance supports us in not attempting stabilisation/resuscitation of <23/40 babies.

Genetic testing

Missed opportunity to send off for further genetic investigations for genetic mutation.

Family was not offered chromosome analysis for baby.

Child Death Review Process

Lack of information received as the child died abroad.

Reliance on parents/carers to notify professionals following the death of a child abroad.

Delays in some services to notify to appropriate agency – PICU notifying the police of a SUDI, Delay in notification into CDOP.

Coroner

Coroners officer requested a death certificate to be completed by the paediatrician. This added pressure on the paediatrician despite not being comfortable with requested cause of death.

Lack of contact from Coroner to family.

Delay in the Coroner contacting the family with updates.

Delay to Post Mortem process not communicated with the family.

Sharing of Post Mortem documents with family without informing Clinician to support the family.

Missed opportunity to take the learning from the CDRM to feed into the inquest.

Bereavement Care

Family care

The opportunity to take their baby home was not offered to the parents.

Where families move between Trusts, the bereavement care can be missed and/or inconsistent.

A soundproof room was not available at the time required, therefore sounds on the unit could be heard, adding to the distress for the family.

Lack of availability for the cold cot.

The opportunity to spend time with their baby/child was not provided.

Staff Care

Lack of consistent care/supervision offered to staff.

Missed opportunity to invite all staff to a debrief following the death.

Staff involved with the child/family not offered or supported within their own organisation.

Multi Agency learning

Unclear process between Trusts and Social Care providers.

GP not involved in the multi-agency review and sharing information between services.

Some organisations not invited to the review meeting when they have been involved with the child and/or family.

Incorrect gender used when the child and family have informed services multiple times.

Missed opportunity to capture the voice and wishes of children and young people.,

Length of time for referral to be assessed is concerning for some services.

Missed opportunity to explore ACE's – Adverse Childhood Experiences and the impact of these on a child's behaviour.

Lead professional/Key worker not identified and assumption by others that role is theirs (over communication with family) or not theirs (lack of communication with family).

Safe and well checks to evaluate the safety of all the children – not all children had been seen.

Delay in follow up to a concern raised between services.

Childrens Services

Missed opportunity to include all the timescales for action into a Child in Need plan.

Housing providers not involved in MASH decision making.

Missed opportunity to share assessments with other services.

Learning identified following a rapid review and/or CSPR.

Health Visiting

Health Visiting service were not notified about pregnancy to trigger the appropriate response.

'Was Not Brought' WNB policy not followed.

Missed opportunity to escalate care from universal to targeted to ensure extra support in place for the family.

Hot temperature of the house noted on visit (25 degrees) but not challenged.

Missed opportunity to assess sleeping environment.

Lack of information in notes to evidence the sleeping environment was seen.

Late booking meant a referral to the HV team was missed.

The home conditions assessment was completed with a score generated but the template was not in the notes.

Missed opportunity to highlight other areas of concern from the home conditions assessment.

Housing

The family did not receive any housing benefit until 6 or 7 months of age.

Housing not appropriate for the family's needs.

Not invited/contacted to attend meetings as a professional with contact with the family.

Mental Health services

Lack of service level agreement in place between Trusts and Mental Health Providers.

Missed opportunity for CAMHS/ICAMHS clinicians to share information with the GP.

CAMHS Dialectical Behaviour Therapy and Non-Violent Restraint training referrals not prioritised when these are relied on as part of a care and risk plan.

Timeliness of assessment/child being seen by the service.

Training and Education

Thresholds for Early Help were not known.

Lack of risk assessment, particularly for those with more complex health needs.

Importance of sharing information between schools to ensure safeguarding of vulnerable children is in place.

Information sharing

Inconsistency surrounding Data Sharing/Information of children's health conditions and the sharing of this information between Independent Schools and 0-19 service.

Lack of information on partners details in Maternity notes.

Lack of information on living arrangements.

Concerns around vulnerability not discussed although professionals thought learning difficulties were presented but not recorded.

Timely sharing of information between MASH and Midwifery teams to ensure full picture before discharge.

Appendix SIX – Infant Mortality Rate: Black Country 2001-2021

Infant Mortality refers to the death of a baby that occurs before the first birthday. Infant Mortality is the number of infant deaths for every 1,000 live births.

Infant Mortality Rate in Black Country Local Authorities					
Period	**Dudley**	**Sandwell**	**Walsall**	**W'hampton**	**England**
2001 - 03	3.9	7.8	5.7	8.1	5.4
2002 - 04	3.7	7.8	6.8	7.9	5.2
2003 - 05	4.8	7.5	8.4	7.9	5.1
2004 - 06	5.6	7.8	8.5	7.3	5.0
2005 - 07	5.6	8.0	8.3	6.1	4.9
2006 - 08	5.3	8.5	7.9	6.6	4.8
2007 - 09	4.6	7.5	8.5	6.5	4.7
2008 - 10	5.0	7.5	7.7	7.7	4.6
2009 - 11	4.2	6.7	8.0	7.3	4.4
2010 - 12	4.5	7.1	7.6	7.7	4.3
2011 - 13	3.6	7.1	7.1	6.8	4.1
2012 - 14	3.9	6.7	6.8	6.4	4.0
2013 - 15	4.6	5.5	6.8	5.6	3.9
2014 - 16	5.5	5.8	7.1	5.6	3.9
2015 - 17	5.4	6.5	6.2	5.8	3.9
2016 - 18	4.4	8.2	7.1	6.0	3.9
2017 - 19	4.1	7.1	6.8	5.7	3.9
2018 - 20	4.3	6.4	6.8	6.3	3.9
2019 - 21	4.3	5.7	5.6	5.2	3.9

Highlighted – highest rate out of the four LA's

Appendix SEVEN - Acronyms

Within this document and/or may be used during the Child Death Review process.

AICU	adult intensive care unit
ACDRP	Association of Child Death Review Professional
ACP	Advanced Care Plans
BCCDOP	Black Country Child Death Overview Panel
BCICB	Black Country Integrated Care Board
BMI	Body Mass Index
CAMHS	Children and Adolescent Mental Health Services
CDOP	Child Death Overview Panel
CDR	Child Death Review
CDRM	Child Death Review Meeting
CICU	Cardiac Intensive Care Unit
CSPR	Child Safeguarding Practice Review
DD	Designated Doctor
ED	Emergency Department
eCDOP	Computer system that holds all the documents/data for child death.
EPR	Electronic Patient Record
HSIB	Healthcare Safety Investigation Branch
ICU	intensive care unit
IUT	Intrauterine transfusion
IVF	In Vitro Fertilisation
JAR	Joint Agency Response
LA	Local Authority
LeDeR	Learning Disabilities Mortality Review
LMNS	Local Maternity and Neonatal System
MCCD	Medical Certificate Cause of Death
MBRRACE-UK	Mothers & Babies: Reducing Risk through Audits & Confidential Enquiries
NCMD	National Child Mortality Database
NICU	Neonatal Intensive Care Unit
PICU	Paediatric Intensive Care Unit

PMRT	Perinatal Mortality Review Tool
PM	Post Mortem
SIDS	Sudden Infant Death Syndrome
SUDI	Sudden Unexpected Death in Infancy
SUDC	Sudden Unexpected Death in Childhood
SUDIC	Sudden Unexpected Death in Infancy/Childhood