

# SANDWELL CDOP CHILD DEATH OVERVIEW PANEL



## ANNUAL REPORT 2017 - 2018



**Authors: Jaki Bateman, Debbie Brown**

**Sandwell CDOP is a sub-group of Sandwell Safeguarding Children Board**

Metsec Building, Broadwell Road, Oldbury, B69 4HE  
0121 569 4800  
[cdop.sandwell@nhs.net](mailto:cdop.sandwell@nhs.net)

# Foreword – CDOP Chair

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*Welcome to the tenth Annual CDOP Report which reflects activity from April 1<sup>st</sup> 2017 to March 31<sup>st</sup> 2018.*

*The Panel has met eight times in the reporting period and successfully reduced the number of deaths to be reviewed in preparation for upcoming changes in legislation.*

*38 deaths in total were reviewed in 2017-18 reflecting the hard work undertaken over the last two years and both myself and the CDOP Coordinator, Jaki Bateman, would like to thank the Panel for their commitment to providing high quality child death reviews and discussions.*

*I would like to take this opportunity to thank Sandwell Safeguarding Children Board (SSCB) for their support and recognition of the importance of CDOP over the last ten years as we enter into a new era of review arrangements.*

*The primary function of CDOP is to learn from child deaths, and Sandwell Safeguarding Children Board has given a platform for the dissemination of learning through the passion of panel members and investment of time and resources.*

*Following the publication of amendments to Working Together 2018 CDOP is looking to the future and is prepared to embrace any future change.*



**Debbie Brown**

**Sandwell CDOP Chair**

If you have any questions or queries about this report please contact:

Jaki Bateman, Child Death Coordinator, [Jaki\\_bateman@sandwellchildrenstrust.org](mailto:Jaki_bateman@sandwellchildrenstrust.org) 0121 569 4801

Debbie Brown, CDOP Chair, [debbie.brown2@nhs.net](mailto:debbie.brown2@nhs.net) 0121 612 2065

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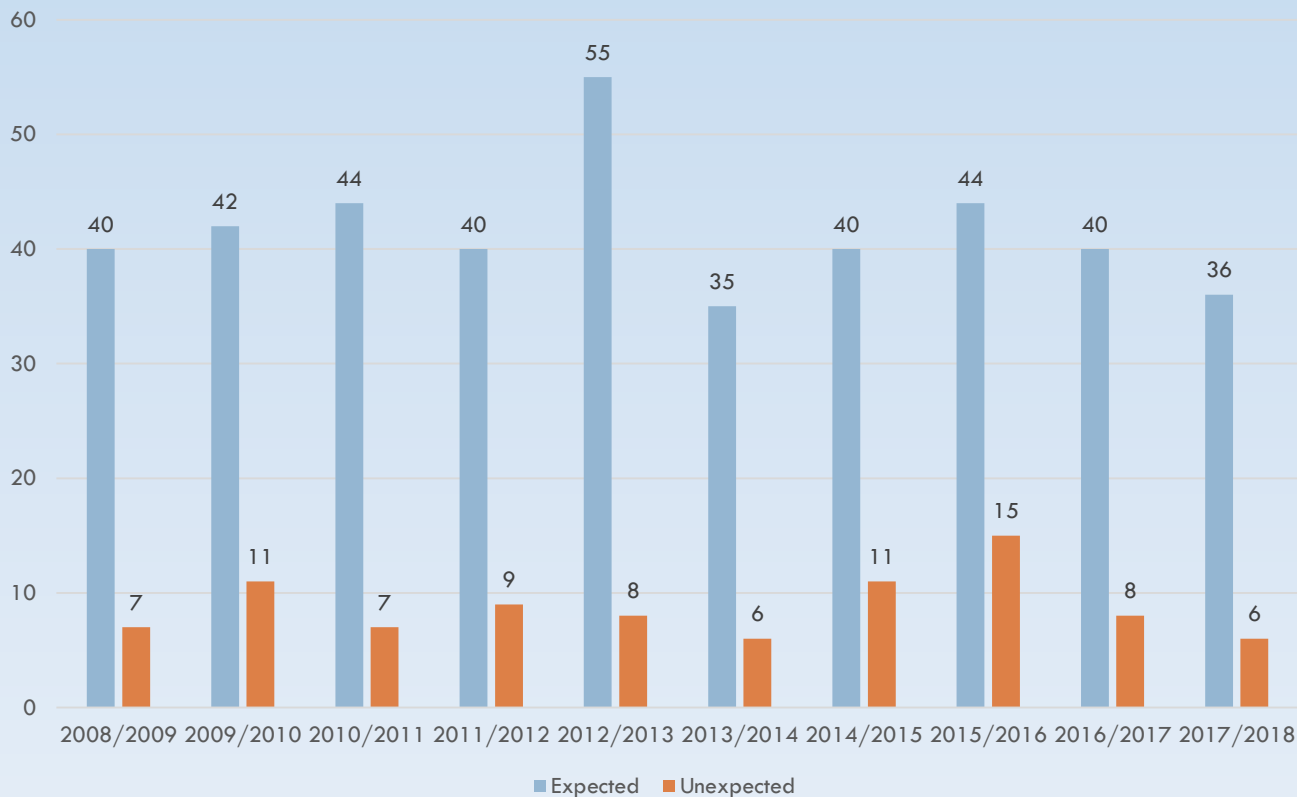
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## Part One - Child Deaths reported to CDOP during 2017-2018

# Child Deaths reported to CDOP during 2017-2018

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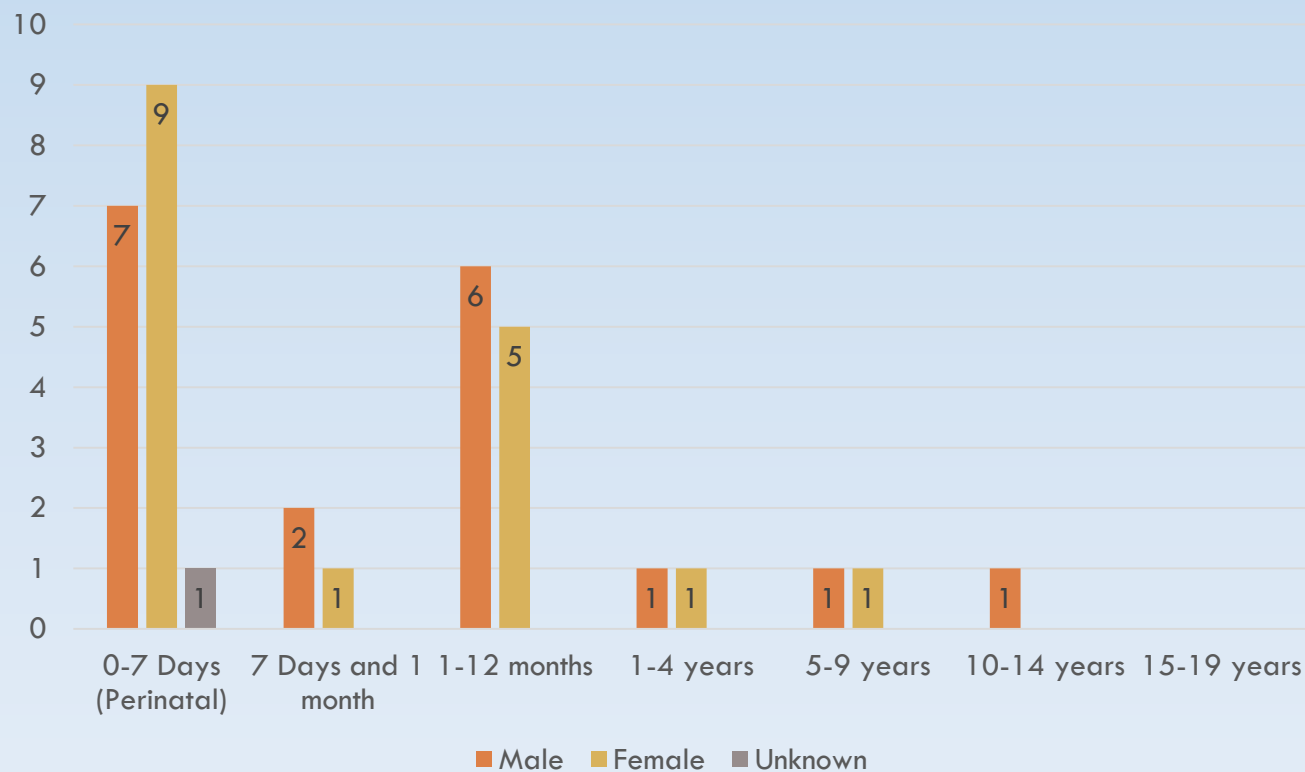
Child Deaths Reported  
2008 - 2018



There were 36 child deaths reported to Sandwell CDOP in the year 2017-2018. Of these, 6 were deemed unexpected. Working Together 2015, Chapter 5 guidance gives the definition of an unexpected child death as: 'the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death'

# Reported deaths 2017-18 – Gender and Age band

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31 of the deaths in 2017-2018 occurred in the first year of life (86.1%). These deaths will be reviewed in more detail in the Infant Mortality Section of this report.

When a child is born with abnormalities, and their gender is uncertain, this has been recorded as 'unknown'.

# Ethnicity Comparison 2017-2018

	2011 Census 0-18 years	%	Deaths 2017- 18	% rounded up
White British	41249	55.50%	13	36.11%
White Other	2475	3.30%	3	8.34%
Mixed Multiple Ethnic Group	5786	7.70%	3	8.34%
Asian British Indian	7584	10.20%	3	8.34%
Asian British Pakistani	5773	7.80%	4	11.08%
Asian British Bangladeshi	2840	3.80%	3	8.34%
Asian British Chinese	227	0.30%	0	0.00%
Other Asian	1913	2.60%	2	5.55%
Black British African	1623	2.20%	3	8.34%
Black British Caribbean	2552	3.40%	1	2.78%
Black British Other	1019	1.40%	1	2.78%
Other Ethnic Group/Not recorded	1335	1.80%	0	0.00%
Totals	74376	100.00%	36	100.00%

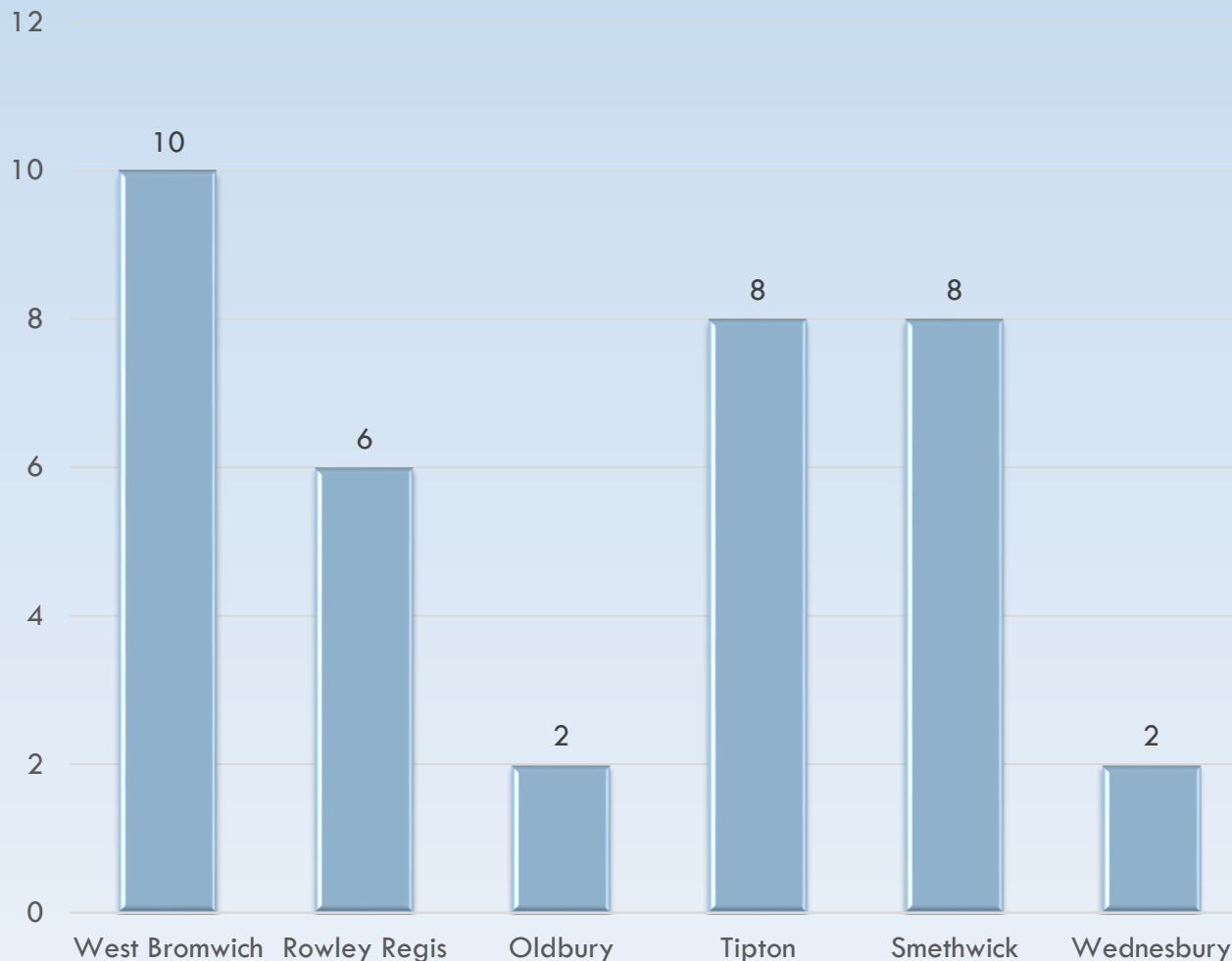
55.5% of 0 – 18 year olds in 2011 population were White British, however, only 36% of reported child deaths in 2017-18 were from this ethnic background. As with previous years, this is in contrast to those children from a BME background where there was a higher percentage of reported child deaths compared to the population size (0-18yrs).

[http://www.sandwelltrends.info/themes/pages/Census2011/Ethnicity\\_Hub](http://www.sandwelltrends.info/themes/pages/Census2011/Ethnicity_Hub)

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

# Reported Deaths 2017-2018 – Town of Residence

## Town of Residence



In this reporting period, as for last year, the majority of deaths have occurred in the West Bromwich area, reflecting the population levels within the six towns.

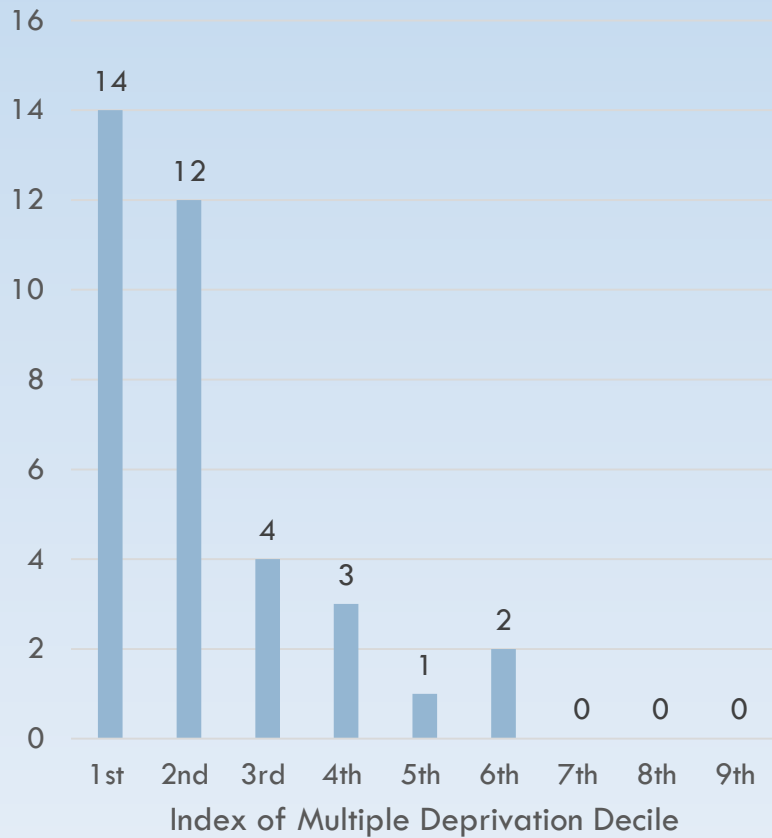
Population estimates for 2017 for all 0-18 year olds indicate that West Bromwich has 23% of the total population and 28% of total deaths.

However, this year only 5.5% of deaths occurred in Oldbury where the percentage of 0-18 population is 16%, indicating a dip in deaths for this area.



# Child Deaths 2017-2018 – Indices of deprivation

### Indices of Multiple Deprivation



Once again this year, as illustrated in the graph, it can be seen that in 72% of the child deaths reported in 2017-2018, the family resided in the most deprived areas of Sandwell.

The relationship between poverty, deprivation and child death is cited by the Royal College of Paediatrics and Child Health

<http://www.rcpch.ac.uk/improving-child-health/state-child-health/report-glance/state-child-health-report-glance>

# Unexpected Deaths reported 2017-18

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## Baby girl

Uncomplicated delivery at 38 weeks  
(induced as baby had stopped growing)

Given to mum for skin to skin contact

Checked 30 minutes later – found  
deceased

## Baby boy

2 months old

Large family – older siblings subject to CPP (physical abuse)

Baby found deceased by mother early morning– told  
professionals baby was in moses basket

Beds had been stripped at rapid response visit

Mother later gave different account to police – had been co-  
sleeping

## Baby Boy

Died aged 1 month

Mother, and children rehoused from Refuge

Flat in poor condition

Household smoking

Baby failing to thrive

Post mortem - SIDS



# Unexpected Deaths reported 2017-18, cont...

14 year old boy

Killed in RTC



Male Baby

Full term C/Section

Not registered at GP

Died aged 6 weeks

Post mortem - Unexplained Sudden Unexpected Death of an Infant

Coroners Conclusion-Natural Causes

Female baby - died aged 2 months

Co-sleeping

Police Investigation due to substance abuse

Complex history

Disguised compliance

Over optimism by ALL agencies

Serious Case Review

# Child Deaths Reported - Summary

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- 2017-2018 reported deaths saw a drop in comparison to previous years
- 86.1% of these deaths occurred in the first year of life reflecting national data which reports that the infant mortality rate increased to 3.8 deaths in 2016 compared to 3.7 in 2015. Infant mortality rates in the West Midlands remain the highest in England and Wales.
- Once again this year, child death numbers are concentrated in the highest areas of deprivation. This is recognised in a National Report, 'Why Children Die'

*Poverty, inequality and where a family live are risk factors for death in childhood.....'*

<https://www.ncb.org.uk/>

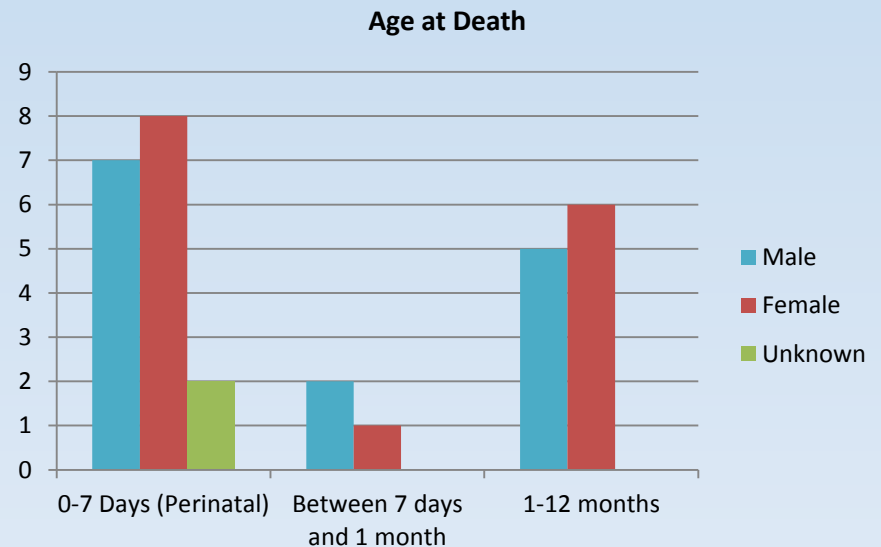
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**Part Two – Infant Mortality Deaths Reported to CDOP  
2017 - 2018**

# Infant Mortality – age at death 2017-2018

Infant mortality is the death of infants under the age of 1 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.

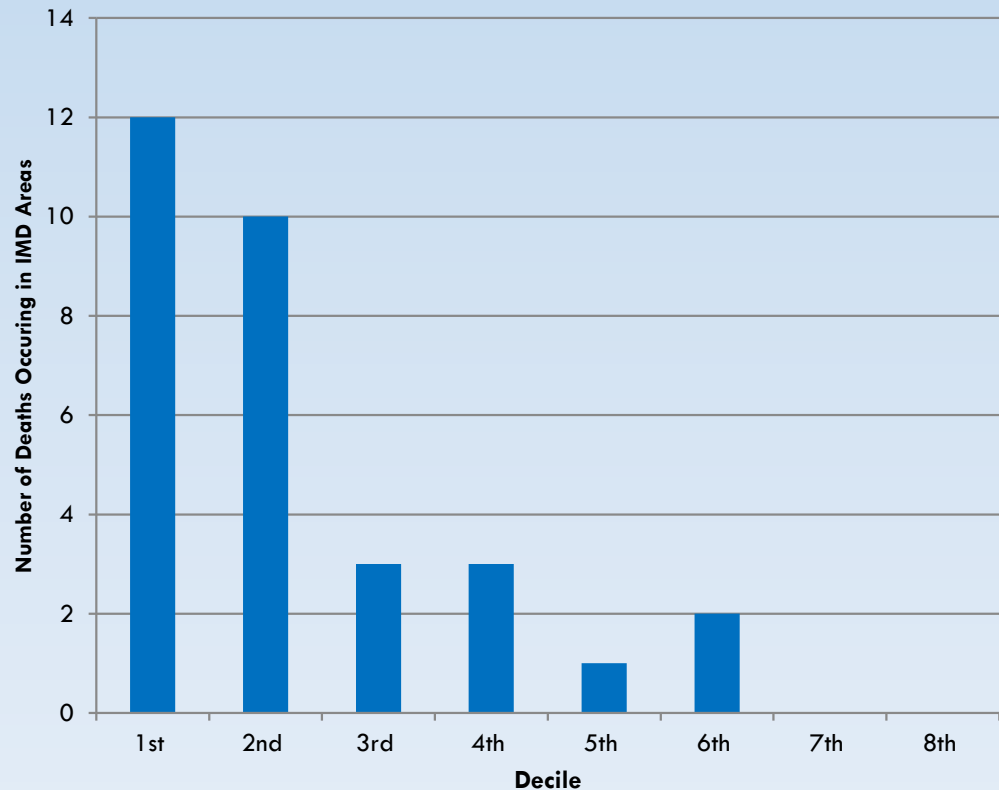


# Infant mortality and deprivation

## 2017-18 data

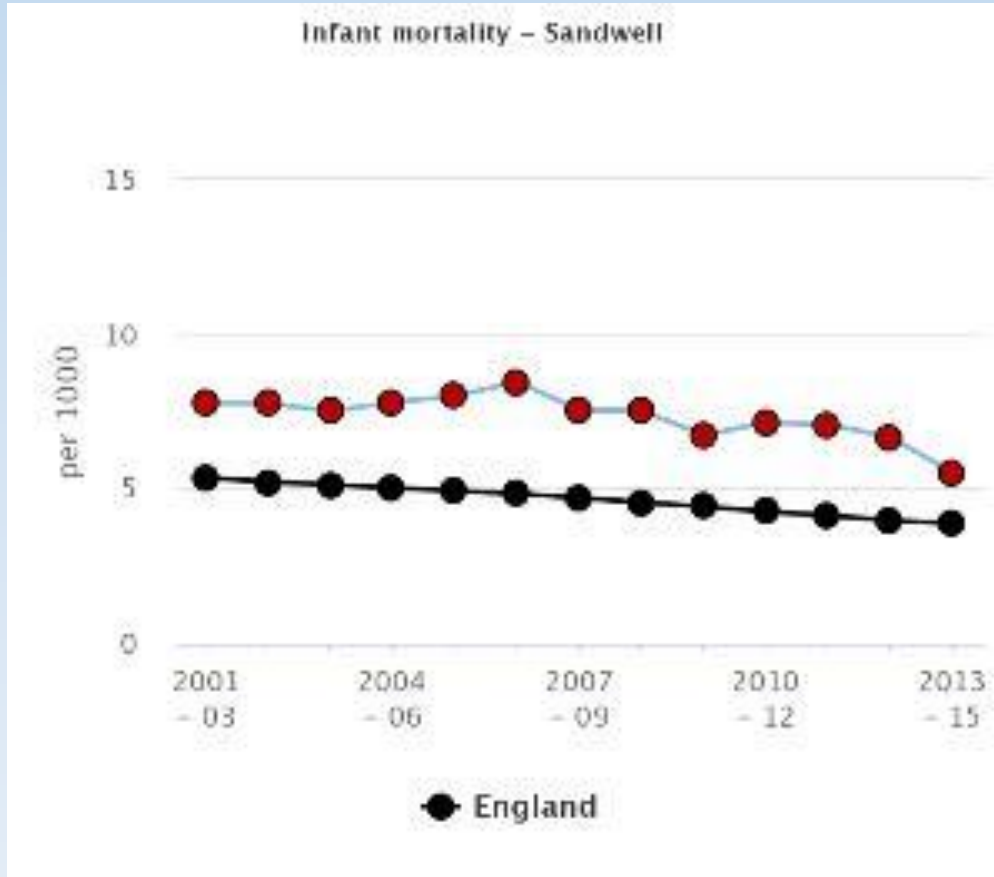
This chart describes infant deaths by deprivation decile. The highest proportion of infant deaths were to mothers living in the most deprived deprivation quintiles in Sandwell.

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/465791/English\\_Indices\\_of\\_Deprivation\\_2015\\_-\\_Statistical\\_Release.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465791/English_Indices_of_Deprivation_2015_-_Statistical_Release.pdf)



# Reduction in Infant Mortality

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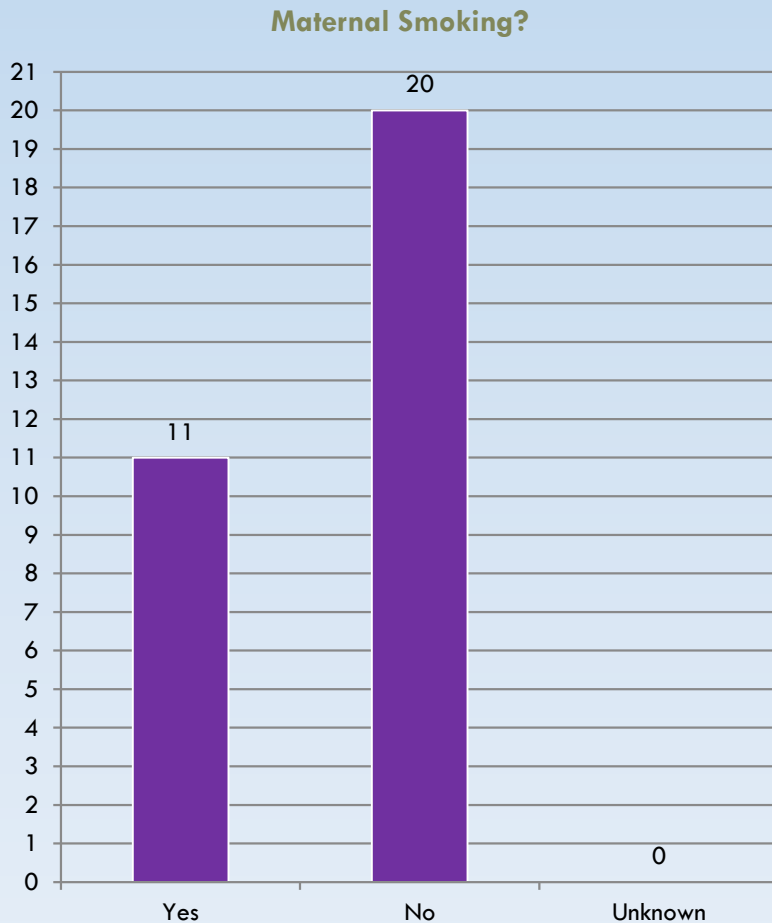
- The trend from 2001 -15 showed a slow reduction for Sandwell in infant mortality
- In March 2017 in Sandwell the figure was estimated at 5.5/1000 births compared to 6.7/1000 births in March 2016.
- This compared to the average England figures of 3.9/1000 births in 2014-2016

<https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133228/pat/46/par/E39000033/at/152/are/E38000144>



# Infant Mortality and Maternal Smoking 2017-2018

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- It is encouraging to see that the numbers of mothers not smoking at antenatal booking is higher than expected
- Where there is a death in the first year of life and smoking is a feature in the household, this is recorded as a modifiable factor at the Child Death Overview Panel (CDOP)
- This data is taken from Badgernet information on antenatal booking where women are tested for carbon monoxide levels as part of the booking procedure

**Part Two – Child Deaths Reviewed at CDOP during  
2017 - 2018**

# Child Deaths Reviewed at CDOP during 2017-2018 (By Year of Death)

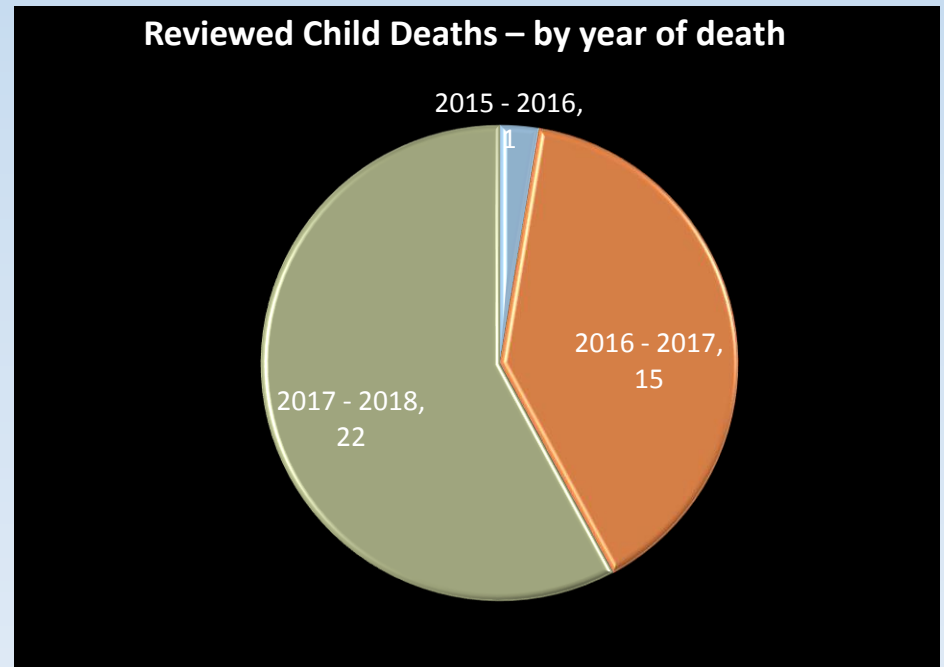
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The purpose of the CDOP is to collect and analyse information about each child death with a view to identifying any matters of concern affecting the safety and welfare of children in the area, any wider public health or safety concerns or pattern of deaths.

CDOP met a total of 8 times during 2017-2018 as a whole group and was Chaired by the Designated Nurse for Child Death in Sandwell.

In total, 38 child deaths were reviewed by the Child Death Overview Panel in 2017-2018, of which 10 were identified as having modifiable factors which will be explored later in the next slide

Two deaths remain outstanding from 2013 – 2014 as they are currently in litigation. Legal advice states we should not review until these proceedings have concluded.



# Preventing Child Deaths – Modifiable Factors

It is a primary function of CDOP to identify areas of practice, both operationally and strategically, to be developed as a result of reviewing child deaths. In 10 of the 38 deaths reviewed during 2017-2018, modifiable factors were identified by panel members. Facts of a modifiable nature were present across all age ranges

CDOP with partner agencies via regional briefings shares learning in terms of identifying and addressing the prevention of any similar deaths occurring in future.

These are available on the Local Safeguarding Board Website

**Sandwell Safeguarding Children Board  
Child Death Overview Panel  
Safety Briefing**

Within this newsletter we will raise awareness amongst frontline professionals, parents/carers and families about some of the risks to children that we have identified through our CDOP work. Can you cascade this information as widely as possible to colleagues, friends and contacts.

From Autumn 2017 the nasal flu vaccine will be offered free of charge to all children aged 2 and 3 years via their GP surgery, and all children in reception class and school years 1-4 via the school health team. Children aged from 6 months old who have certain long term conditions should also be vaccinated by their GP surgery.

The vaccine has been well tested and has an excellent safety record. The vaccine not only protects children against flu, but also helps to reduce its spread to other children, their parents and grandparents.

If you have any questions, please contact your GP surgery or school health team.

**Childhood Immunisations**  
"The two public health interventions that have had the greatest impact on the world's health are clean water and vaccines"

World Health Organisation

As a parent, you may not like seeing your baby or child being given an injection. However, vaccination will help protect them against a range of serious and potentially fatal diseases.

There are three good reasons to have your child vaccinated:

- vaccinations are quick, safe and extremely effective
- they help protect against a range of serious and potentially fatal diseases.
- if a child isn't vaccinated, they're at higher risk of catching serious diseases that can be either fatal or cause lasting damage to their health.

Premature babies have a higher risk of infection. They should follow the recommended schedule from two months after birth, no matter how premature they were.

**Staying safe: Key messages for caring for the under 5's**

	1 to 6 weeks	6 weeks to 1 year	1 to 3 years	3 to 5 years
<b>Choking</b>	Never use a child's high chair or stroller until you have checked the manufacturer's instructions. Always use the correct harness for the child's age.	Always use your own child's high chair and stroller. Never use a second hand high chair or stroller. Always use the correct harness for the child's age.	Do not use old and worn food trays and do not use a second hand high chair or stroller.	
<b>Substitution and strangulation</b>	Do not use a child's high chair or stroller until you have checked the manufacturer's instructions. Always use the correct harness for the child's age.	Always use your own child's high chair and stroller. Never use a second hand high chair or stroller. Always use the correct harness for the child's age.	Do not use old and worn food trays and do not use a second hand high chair or stroller.	
<b>Falls</b>	Do not use a child's high chair or stroller until you have checked the manufacturer's instructions. Always use the correct harness for the child's age.	Always use your own child's high chair and stroller. Never use a second hand high chair or stroller. Always use the correct harness for the child's age.	Do not use old and worn food trays and do not use a second hand high chair or stroller.	
<b>Playthings</b>	Do not use a child's high chair or stroller until you have checked the manufacturer's instructions. Always use the correct harness for the child's age.	Always use your own child's high chair and stroller. Never use a second hand high chair or stroller. Always use the correct harness for the child's age.	Do not use old and worn food trays and do not use a second hand high chair or stroller.	
<b>Water and pools</b>	Do not use a child's high chair or stroller until you have checked the manufacturer's instructions. Always use the correct harness for the child's age.	Always use your own child's high chair and stroller. Never use a second hand high chair or stroller. Always use the correct harness for the child's age.	Do not use old and worn food trays and do not use a second hand high chair or stroller.	
<b>Firearms</b>	Do not use a child's high chair or stroller until you have checked the manufacturer's instructions. Always use the correct harness for the child's age.	Always use your own child's high chair and stroller. Never use a second hand high chair or stroller. Always use the correct harness for the child's age.	Do not use old and worn food trays and do not use a second hand high chair or stroller.	
<b>Motor Toys</b>	Do not use a child's high chair or stroller until you have checked the manufacturer's instructions. Always use the correct harness for the child's age.	Always use your own child's high chair and stroller. Never use a second hand high chair or stroller. Always use the correct harness for the child's age.	Do not use old and worn food trays and do not use a second hand high chair or stroller.	
<b>Hot Beverages</b>	Do not use a child's high chair or stroller until you have checked the manufacturer's instructions. Always use the correct harness for the child's age.	Always use your own child's high chair and stroller. Never use a second hand high chair or stroller. Always use the correct harness for the child's age.	Do not use old and worn food trays and do not use a second hand high chair or stroller.	

**Sandwell Child Death Overview Panel can be contacted on:**  
E-mail: [cdop.sandwell@nhs.net](mailto:cdop.sandwell@nhs.net)  
Phone: 0121 669 4801  
<http://www.sandwellcdo.org.uk>

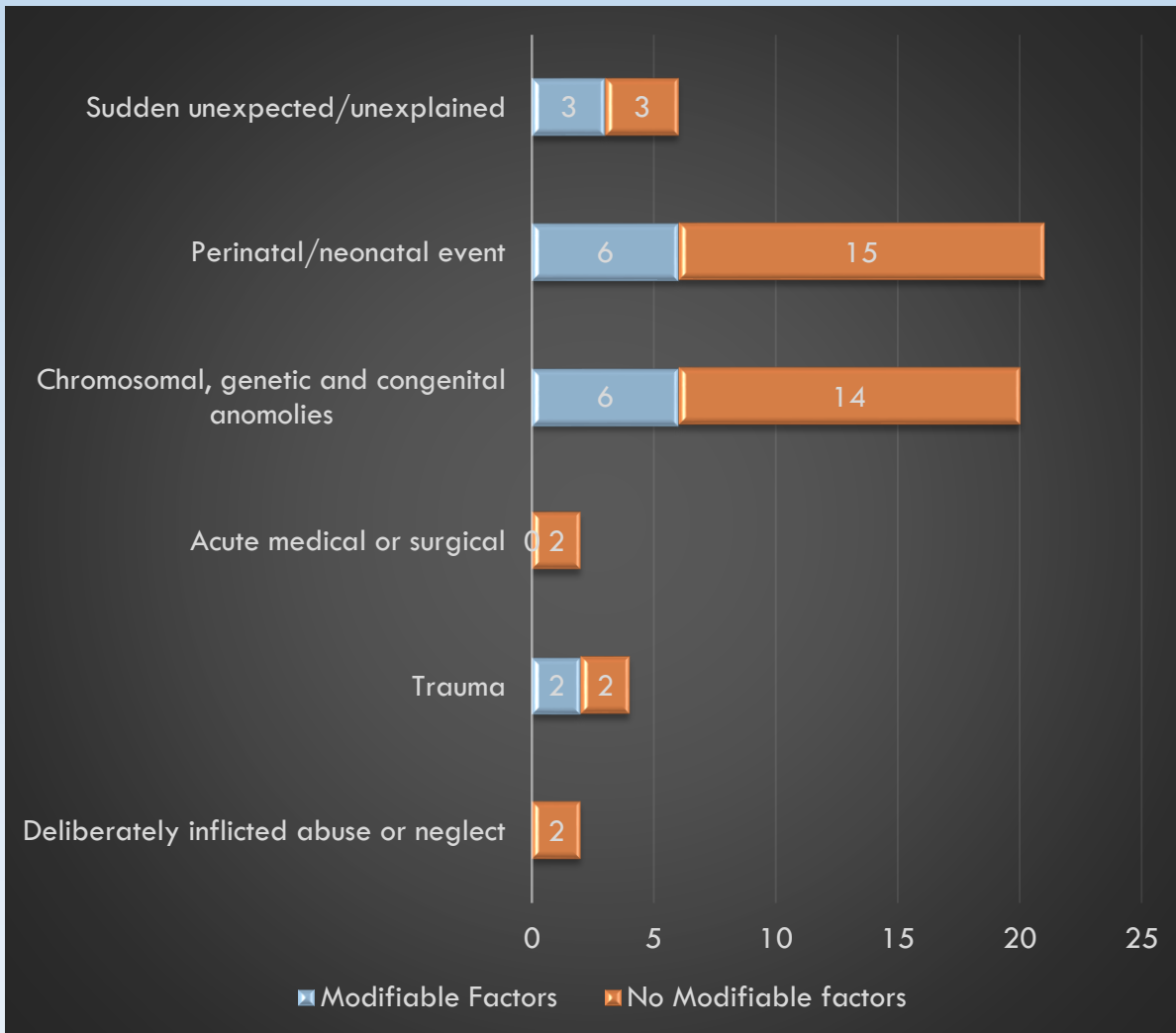
# Learning From Child Deaths

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At CDOP panel there has been much discussion and debate from all partners on both modifiable factors and service issues related to the cases discussed. Some of the recurring themes have included:

- ❖ Smoking in pregnancy and in the home - Smoking is a profound risk factor for neonatal death.
- ❖ Alcohol abuse in parents/carers
- ❖ Neglectful home conditions
- ❖ Domestic Abuse
- ❖ Obesity and high BMI in mothers to be
- ❖ Co-sleeping messages and the extent to which they are applied to extended family.
- ❖ Road traffic collisions (RTCs): road awareness and dangerous driving.
- ❖ Consanguinity - Cousin marriage increases the risk of a birth disorder (6% risk) compared to unrelated couples (3%), and most of this increase is linked to genetic conditions which may cause death or long-term disability.
- ❖ Maternal mental health
- ❖ Disguised compliance

# Category of Reviewed Deaths 2017-18



The greatest category of reviewed deaths for 2017-2018 was in the perinatal/neonatal event. No data was requested by DfE on a National level in this year so this cannot be compared with other CDOP's. However, this is in line with deaths reported for Sandwell.

# Child Death Reviewed - Summary

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- Of the 38 deaths reviewed in 2017 – 2018, 10 had modifiable factors. Facts of a modifiable nature were present across all age ranges.
- The most frequent category of death is Category 8, which describes the full range of perinatal and neonatal events which may result from complications of the pregnancy and delivery.
- Caution needs to be taken when analysing information regarding reviewed deaths due to the small numbers, but it has still been possible to extract learning for dissemination through briefings and training.

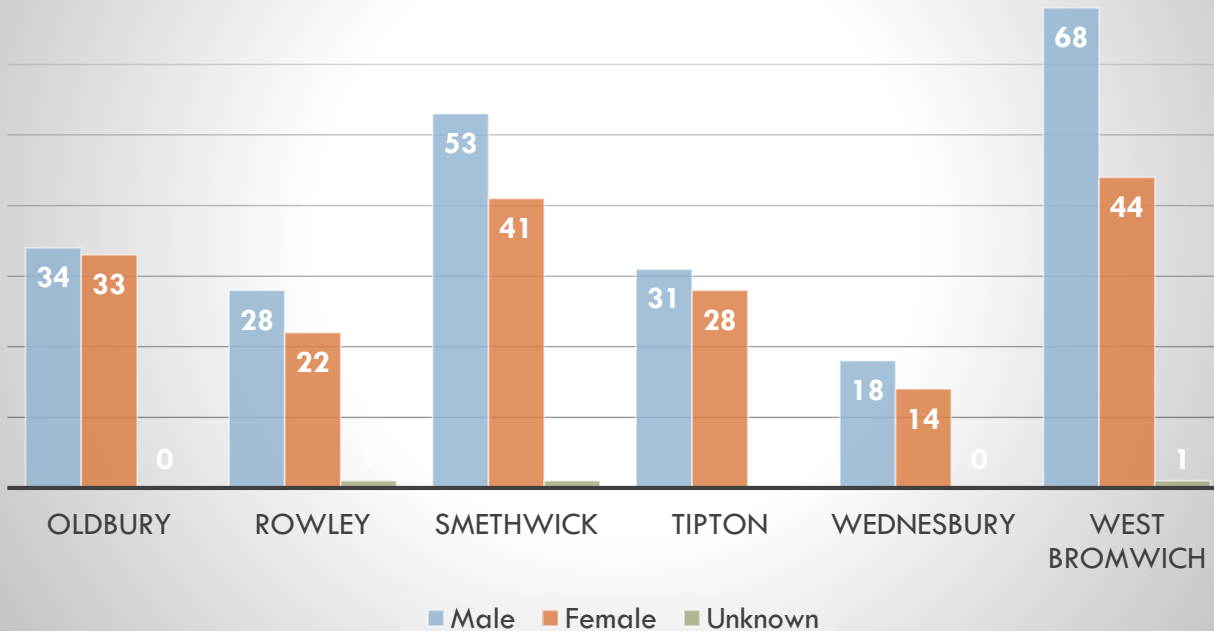
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## **Part Three – Looking Back 2008/09 – 2017/18**



# Total Deaths over 10 years by town

## Deaths by town and gender



Sandwell has had 416 deaths over the last 10 years. 56% of these deaths were male, 43% female and 1% unknown. West Bromwich has consistently had the most deaths over the 10 years reflecting the population value.

# Looking Back - Modifiable factors

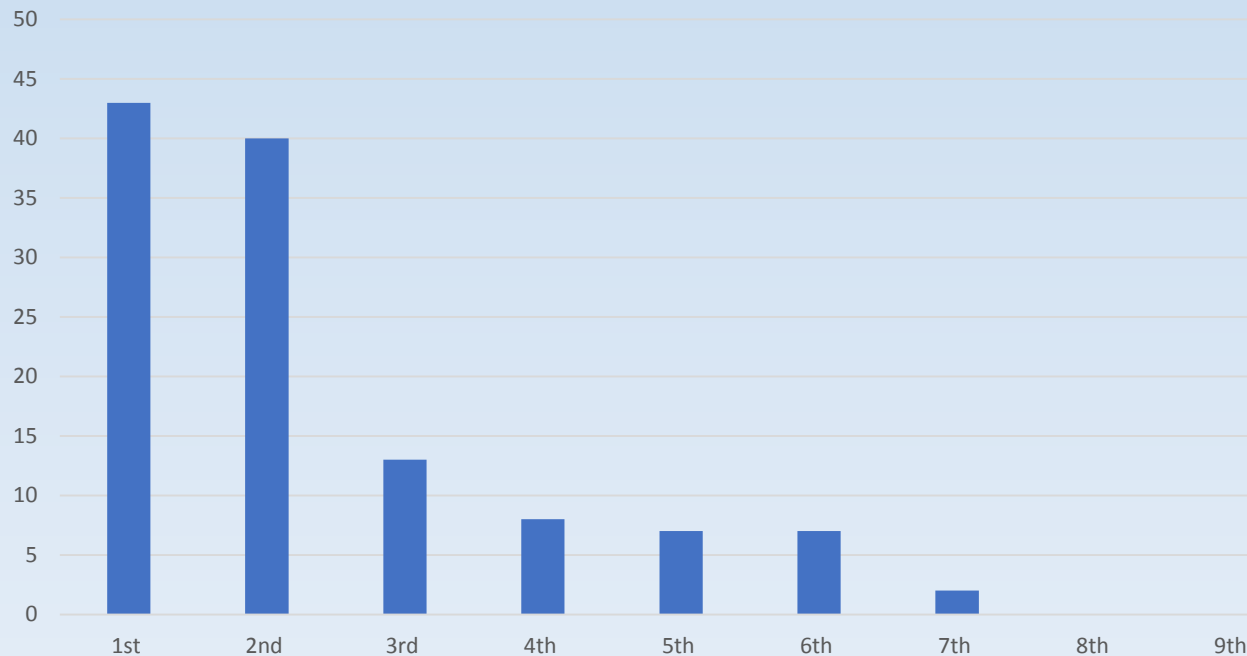
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Data from 2008 around modifiable factors was collected very differently to how it is collected presently. However, Annual Reports from this period, to the present day have recorded factors on:

- Safer Sleeping
- Solvent abuse
- Safety of infants in vehicles
- Asthma management in A&E
- Identification and management of strep B
- Road safety
- Smoking in the household
- Maternal smoking in pregnancy
- Alcohol abuse
- Housing conditions
- Consanguinity
- Mental health in a parent/carer

# Looking Back - Deprivation

Index of Multiple Deprivation Percentile  
2015-2018



Deprivation data was only collected robustly since 2015 around wards. It can be seen that the prevalence of deaths since 2015 have occurred in the top two most deprived areas as recorded through IDACI (Income Deprivation Affecting Children Index) <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015> This is consistent across all information gathered from 2015 to 2018.

## Events - 2018 Regional Conference

In March 2018, 200 delegates from across the West Midlands reflecting all agencies gathered for a Regional Conference:

### **'Learning From Child Deaths'**

The programme included presentations from:

- Dr Peter Sidebotham outlining future arrangements and National learning from child deaths and serious case reviews
- Dr Jo Garstang who gave a presentation on **Sudden Infant Death Syndrome, Co-Sleeping and Asphyxia**
- The Coroners office gave an overview of their work and how it interacts with the child death processes
- Walsall Healthcare Trust updated the conference of the **Bereavement Care Pathway pilot**
- Two bereaved parents gave very moving presentations of their own experiences with child death

Delegates were then asked to reflect on case studies to highlight modifiable factors and themes seen to be trends across the region.

## Events - 2018 Regional Conference

Evaluations were collected at the end of the conference to support with the planning for next year:

*'Truly multidisciplinary – was useful to have open dialogue among professionals'*

*'Would like to see more quantitative data from across the region'*

*'Parents perspectives very moving and will inform my future practice'*

*'I would like to see the police perspective and how their role interacts with families and professionals'*

*Dignity of the bereaved parents was inspirational thank you to the parents for sharing*

# The Journey of Dog Duck and Cat



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Dog Duck and Cat have been an integral part of the CDOP process and learning since 2015 and have been enjoyed by a variety of audiences including parents, children and professionals from all agencies.

Sadly due to the difficulties in obtaining funding to continue with the programme, in 2018 Sandwell Local Authority signed over the intellectual properties allowing the creation of a Dog Duck and Cat Trust which would allow Trustees to tap into other funding opportunities.

The Trustees agreed that Sandwell would still be able access resources through the Trust at no cost and Sandwell CDOP will continue to be a reference group for future publications.

It is recognised that:

***‘Giving children and their families the tools that they need is also critical ... we should prioritise prevention and equip children and young people with the knowledge .....’***

<https://www.ncb.org.uk/>

Dog Duck and Cat books and activities have enabled the practitioners in Sandwell to raise the profile of normally unspoken subjects and given them a platform for open, honest discussion.

# The Journey of Dog Duck and Cat

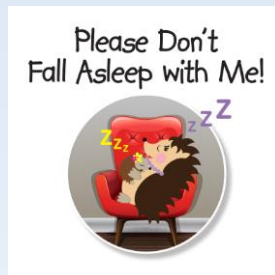
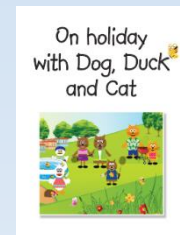
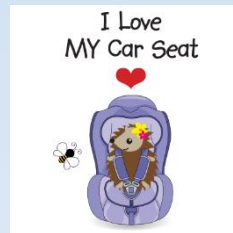


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Sandwell CDOP are extremely grateful to the creators of Dog Duck and Cat and would like to thank particularly the commitment, vision and insight given by Jon Bull.

Publications are available at:

[www.dogduckandcat.co.uk](http://www.dogduckandcat.co.uk)







## Looking Forward...

In 2016 the Wood Report recommended that ownership of the arrangements for supporting CDOPs should move to the Department of Health as over 80% of child deaths had a medical or public health cause. Working Together to Safeguard Children 2018 Guidance was published in July, following national consultation events.

One of the most prominent Working Together 2018 changes is the replacement of LSCBs with ‘*Safeguarding Partners*’. Under the new legislation, three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups) must make arrangements to work together with relevant and appropriate agencies to safeguard and protect the welfare of children in the area. The guidance also replaces the requirement for LSCBs to ensure that child death reviews are undertaken by a child death overview panel (CDOP) with the requirement for “**child death review partners**” (consisting of local authorities and any clinical commissioning groups for the local area) to make arrangements to review child deaths. LSCB’s must continue to ensure the review of every child death in their area is undertaken until the child death review partners arrangements are in place.

To increase the geographical footprint of statistical data collected, Sandwell and Dudley have joined their CDOP processes together.

## Looking Forward...

*Child Death Review Statutory and Operational Guidance (England)* was published in Oct 2018. The new guidance sets out key features of what a good child health review should look like and builds on the statutory guidance set out in Working Together.

April - May 2018 saw the launch and successful Black Country application to the DfE/DHSC/HO Safeguarding Reform Project Board Early Adopters Programme. The successful bid identified an aim of joining up the 4 Black Country CDOPs into a Strategic Black Country CDOP. The programme is time limited until the end of March 2019, with funding managed by Dudley Metropolitan Borough Council.

A Steering Group has been established to oversee the development and delivery of an action plan, with recommendations to be made to the key decision makers and networks. The Director of Public Health from City of Wolverhampton Council is the strategic lead for this piece of work.

# Looking Forward...

A set of principles have been designed to shape the work:

- Ensure that the review of every child death “*is grounded in deep respect for the rights of children and their families*” (CDR Guidance 2018)
- Be child, family and outcome focused to make a difference
- Maximise the use of limited resources, to maximise effectiveness and efficiency
- Learn from areas that already have regional child death arrangements
- Optimise the opportunity for review and learning on a sub-regional/STP footprint
- Nurture collaboration between partners and inform the development of local systems
- Strengthen links between child death review process and other mortality reviews

Stakeholders involved in the child death review processes and safeguarding arrangements are being engaged and consulted on the development of possible options. A stakeholder event is planned for 30th November which will provide an opportunity to inform the development of new ways of working across the Black Country footprint in relation to Child Death Reviews.

# CDOP Membership 2017 - 2018

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Name	Agency
Debbie Brown (Chair)	Sandwell and West Birmingham CCG
Dr Helen Grindulis (Vice Chair)	Sandwell and West Birmingham NHS Trust/ Sandwell and West Birmingham CCG
Jaki Bateman (Coordinator)	Sandwell Safeguarding Children Business Unit
Mel Jarvis	SMBC Sandwell Children Social Care
Eileen Welch	Sandwell and West Birmingham CCG
Sue Moore	SMBC Group Head, Education
DI Mick Spellman	West Midlands Police
Mary Molloy	Sandwell and West Birmingham NHS Trust
Peter Forth	SMBC Children's Centres
Sindy Manu	Sandwell and West Birmingham NHS Trust
Caroline Kovaks-Atkinson	Black Country Partnership NHS Trust

Name	Agency
Dr Shail Agarwal	Sandwell and West Birmingham NHS Trust/ Sandwell and West Birmingham CCG
Shawinder Basra-Dhillon	Birmingham Community Healthcare Trust
Randeep Kaur	Sandwell and West Birmingham NHS Trust
Jon Bull	SMBC DECCA
Cindy James	SMBC Public Health
Denise Hooper	SMBC Sandwell Homes
Nicola Ingram	Sandwell and West Birmingham NHS Trust (health visiting team)
Sheila Thomas	Sandwell School Nursing Team
Penny Gorton	Lay Member