BLACK COUNTRY CHILD DEATH OVERVIEW PANEL

2020 - 2021 Black Country Child Death Overview Panel

Annual Report

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Contents

1. Foreword – Independent Chair

The period April 2020 to March 2021 reflects an historical year for everyone, in which we have had to deal with the pressures of managing a global pandemic, whilst continuing the process of reviewing child deaths. All of the public sector were directly involved in responding to unprecedented demands and changes in roles, which was clearly going to have an impact on child death review processes. Remarkably, the impact on the processes has been managed incredibly well, with delays restricted to relatively few cases.
The report aims to not only reflect the cases the panel has considered throughout 2020/21, but also the achievements of the partnership, future priorities for action, and issues related to the implementing the statutory child death review processes, during a year affected by Covid 19.

I would like to thank all the Panel members, for their continued commitment and hard work, and in particular to how they switched swiftly to virtual working, without compromising the quality of the panel meetings. I would also like to thank Jaki Bateman and Alex Davy for the hard work that goes on behind the scenes to ensure that the Panel runs smoothly and keeps pace with the changing landscape.

Mike Leaf
Independent Chair

2. Introduction

In October 2018, HM Government published the revised Child Death Review: Statutory and Operational Guidance (England) for Clinical Commissioning Groups and Local Authorities as Child Death Review Partners (CDR Partners). CDR Partners are identified as Local Authorities and any Clinical Commissioning Groups for the local area as set out in the Children and Social Work Act 20173. The guidance sets out the full process that follows the death of a child, who is normally resident in England and builds on the statutory requirements set out in Working Together to Safeguard Children (2018)4. The revised guidance clarifies how individual professionals and organisations across all sectors, involved in the child death review process, contribute to reviews in order to improve the experience of bereaved families and professionals involved in caring for children.

The Government produced the Working Together: Transitional Guidance (published July 2018) and provided CDR Partners up to 12 months (from 29 June 2018) to agree arrangements for the review of all child deaths normally resident in their area, including arrangements for the analysis of deaths reviewed. At the 12-month period, CDR Partners then had up to three months to implement the arrangements ensuring at the latest, that the new child death review arrangements were in place by 29 September 2019. The implementation of the guidance prompted changes to the way in which child deaths are reviewed such as the introduction of the Child Death Review Meeting (CDRM).

The Child Death Review Meeting (CDRM)

The Child Death Review Meeting (CDRM) is a multi-professional meeting where all matters relating to an individual child death are discussed by the professionals directly involved in the care of the child during life and any investigation after death. The nature of the meeting varies according to the circumstances of the child's death and the practitioners involved. The CDRM can take place in the form of a final case discussion following a Joint Agency Response (JAR); a perinatal mortality review group meeting in the case of a baby who dies in a neonatal unit; a hospital based mortality review meeting following the death of a child in a paediatric intensive care unit; or similar case discussion. In all cases, the aims of the CDRM are:

- to review the background history, treatment, and outcomes of investigations, to determine, as far as is possible, the likely cause of death;
- to ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment, and service delivery;
- to describe any learning arising from the death and, where appropriate, to identify any actions that should be taken by any of the organisations involved to improve the safety or welfare of children or the child death review process;
- to review the support provided to the family and to ensure that the family are provided with:
    - the outcomes of any investigation into their child's death;
    - a plain English explanation of why their child died (accepting that sometimes this is not possible even after investigations have been undertaken) and any learning from the review meeting;
- to ensure that the CDOP and, where appropriate, the Coroner is informed of the outcomes of any investigation into the child's death; and
- to review the support provided to staff involved in the care of the child.
- Information, reports and notes of the CDRM are shared with the appropriate CDOP.

The Child Death Overview Panel (CDOP)

CDR Partners have a legal responsibility to ensure that the deaths of children normally resident in their area are reviewed. This function is carried out by the Child Death Overview Panel (CDOP) to ensure that a review is undertaken for all child deaths age 0-17 years, excluding babies who are stillborn, late foetal loss and planned terminations of pregnancy carried out within the law.
In reviewing the death of each child, the CDOP considers relevant factor and modifiable factors in the family environment, parenting capacity and service provision. The CDOP identifies what action could be taken locally, regionally or at a national level with the aim of preventing child deaths and to improve the health and safety of children and young people.

The functions of the CDOP are:

- to collect and collate information about each child death, seeking relevant information from professionals;
- to analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;
- to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and well-being of children;
- to notify the Child Safeguarding Practice Review Panel (CSPR) and Local Safeguarding Partnership (LSP) when it suspects that a child may have been abused or neglected;
- to notify the Medical Examiner and the Doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;
- to provide specified data to the National Child Mortality Database (NCMD);
- to produce an annual report for child death review partners on local patterns and trends in child deaths, any lessons learnt, and actions taken, and the effectiveness of the wider child death review process; and to contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

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

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

Themed Panel Meetings

Some child deaths are reviewed at the Themed Panel meeting to discuss a particular cause or group of causes. The Black Country CDOP holds Themed Panel meetings to review neonatal deaths (<28 days of life). Such arrangements allow for the attendance of appropriate professional experts and independent scrutiny from a neighbouring authority neonatal unit, to inform discussions and allow easier identification of themes. There are plans to join with West Midlands Regional CDOP's to review deaths on a regional basis where small numbers of deaths from each area can be reviewed on a greater footprint to extract robust learning.

The National Child Mortality Database (NCMD)

The National Child Mortality Database (NCMD) is a repository of data relating to all child deaths in England. The NCMD was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and is delivered by the University of Bristol, in collaboration with the University of Oxford, University College London (UCL) Partners and the software company QES. The NCMD enables more detailed analysis and interpretation of all data arising from the child death review process, to ensure that lessons are learned, that learning is widely shared and that actions are taken locally and nationally, to reduce child mortality. The introduction of the NCMD aims to learn lessons that could lead to changes to improve outcomes for children.

As of the 1 April 2019, it became a statutory requirement that CDOPs across England submit data via the NCMD. The Black Country CDOP has purchased a web-based system that submits the required data and reports are received on a quarterly basis summarising submitted data.

Covid Response and Impact

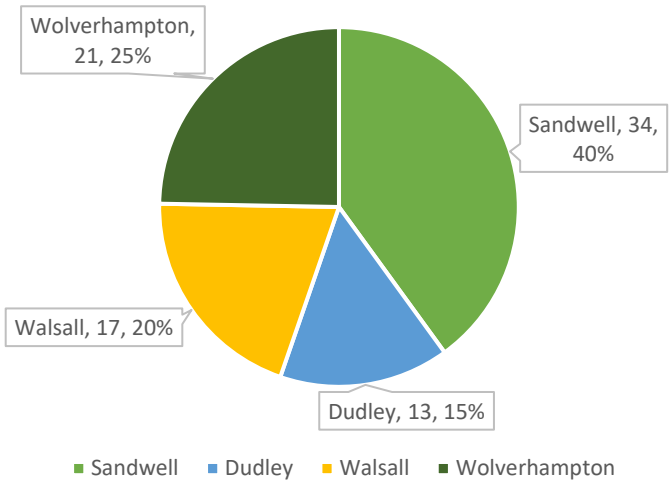
CDOP shifted fairly seamlessly to remote working and continues to be well-placed to capture some of the effects of COVID on children as well as operational changes to the delivery of the process. Reviews of those deaths that have taken place during Covid-19 may highlight some public anxiety leading to delay in accessing health treatment and this will be reported on in 2021 – 2022.

Nationally an estimated 25 children are likely to have died of SARS-CoV-2 infection between 1 March 2020 and 28 February 2021, with an estimated mortality rate of 2 per million children per year. (NCMD Report Child death data release 2021 | National Child Mortality Database (ncmd.info))

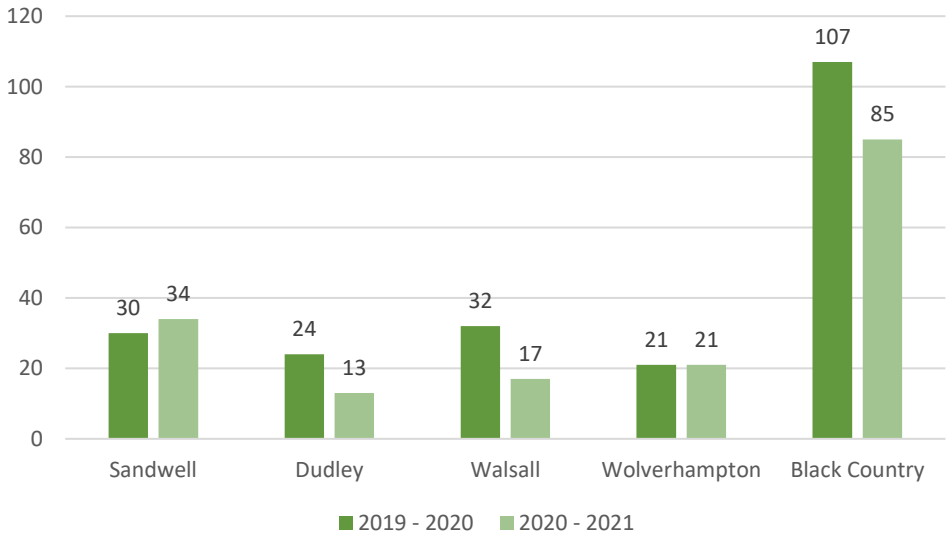
3. Deaths Notified in 2020 – 2021

85 deaths in total were notified across the Black Country between April 2020 – March 2021. Nationally, the NCMD received 3,068 notifications of child deaths from CDOPs in England where the child died between 1 April 2020 and 31 March 2021. This is 361 fewer deaths than the previous year. The reduction of deaths is apparent over winter months, which may be due to social distancing and other public health measures put into place in response to the COVID-19 pandemic.

The breakdown for 2020 – 2021 for the Black Country is as follows:



The chart below shows a 2 year comparison using data collected consistently from across the Black Country since the new arrangements in April 2019:

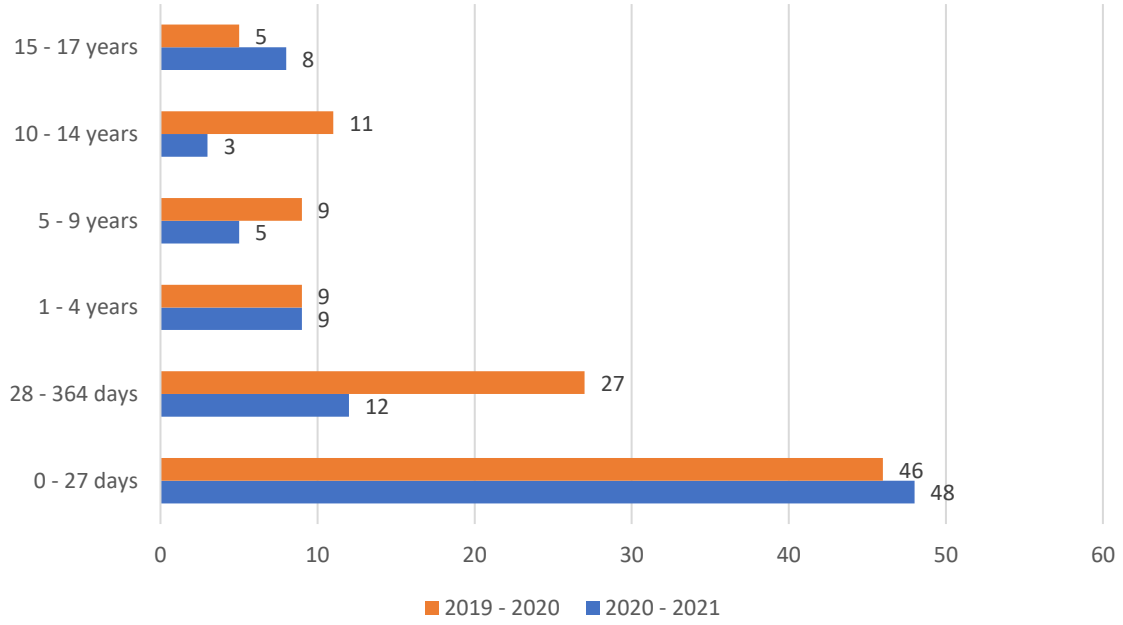


Dudley and Walsall have seen a 54% and 53% respectively reduction in deaths compared to deaths from 2019 – 2020, while Sandwell has seen a 13% increase and Wolverhampton deaths have remained the same. Overall, the Black Country has seen a 20% reduction in child deaths from 2019 – 2020.

It can be seen that the Black Country has followed the general pattern of reduction in child deaths notified in the reporting period 2020 – 2021. Early analysis of this pattern has found that due to the reduction of social interactions, deaths from infections and deaths as a result of complications following elective surgeries have significantly reduced.

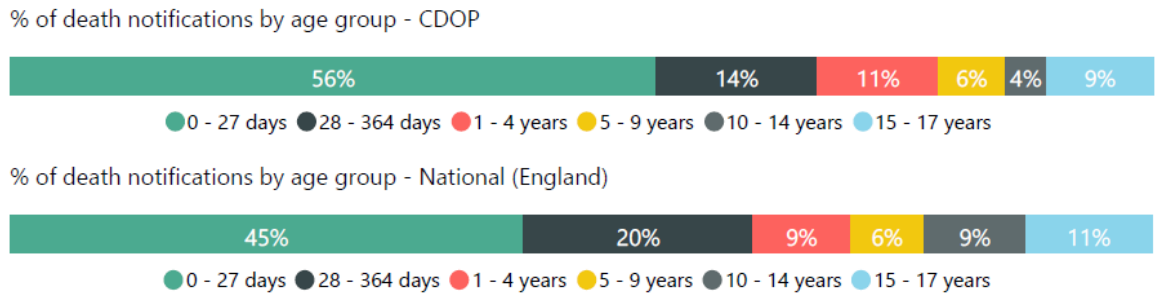
Death Notifications by Age Group

Black Country, 2 Year Comparison



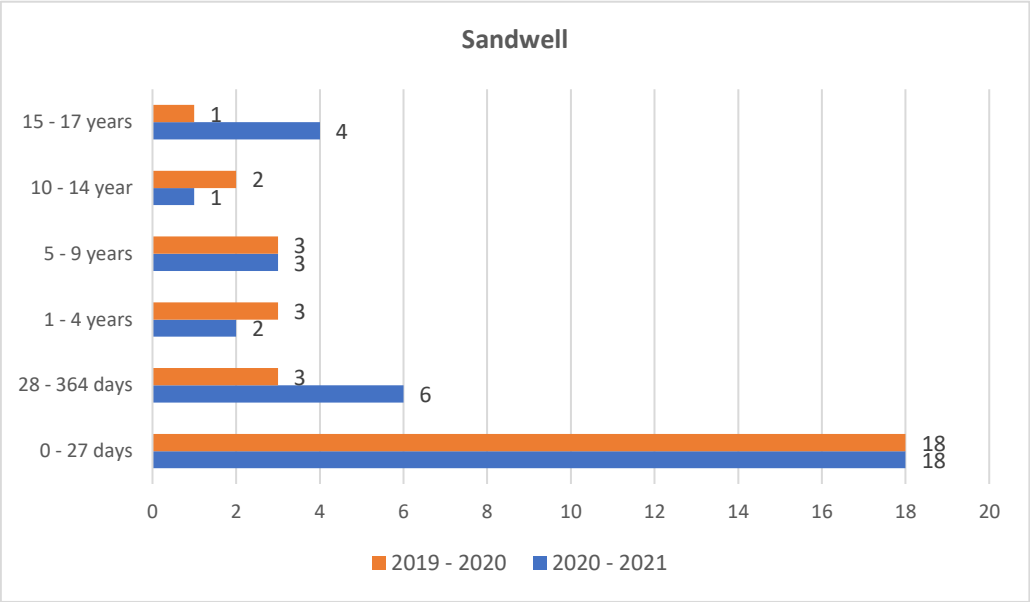
Overall, the greatest reduction in deaths has been in the 28 – 364 days (55%) and 10 – 14 years (73%) age groups and a slight increase in the 0 – 27 days (4%) and 15 – 17 year age groups.

The chart below gives a comparison between the Black Country and Nationally by age group;

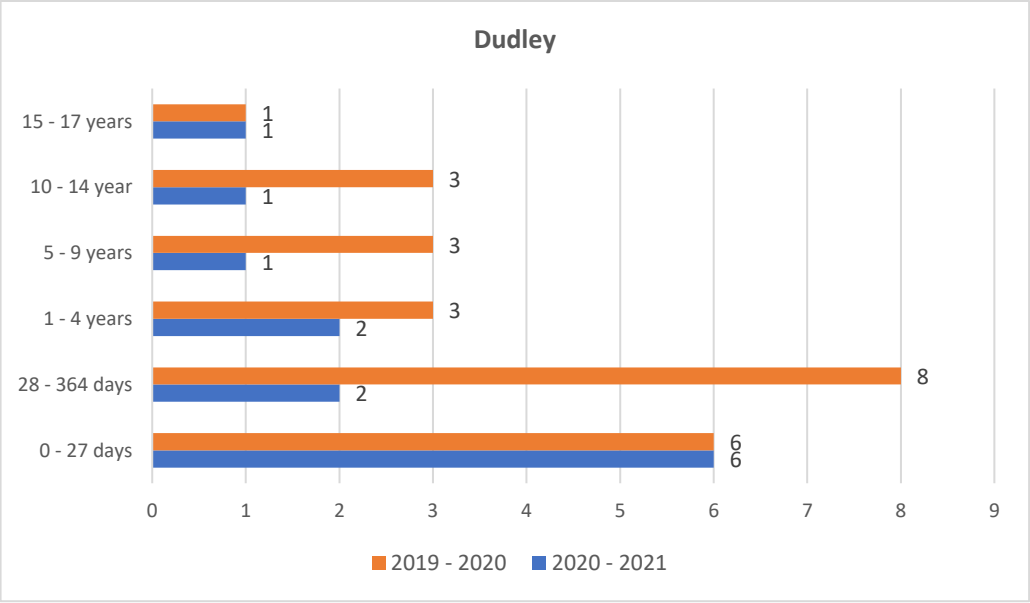


In 2020 – 2021, the Black Country saw 11% more deaths than the National figures in the 0 – 27 days age group and 2% more than National figures in the 1 – 4 years age group. However, the Black Country has shown lower death figures than the National figures in the 28 – 346 days, 10 – 14 years and 15 – 17 years age groups.

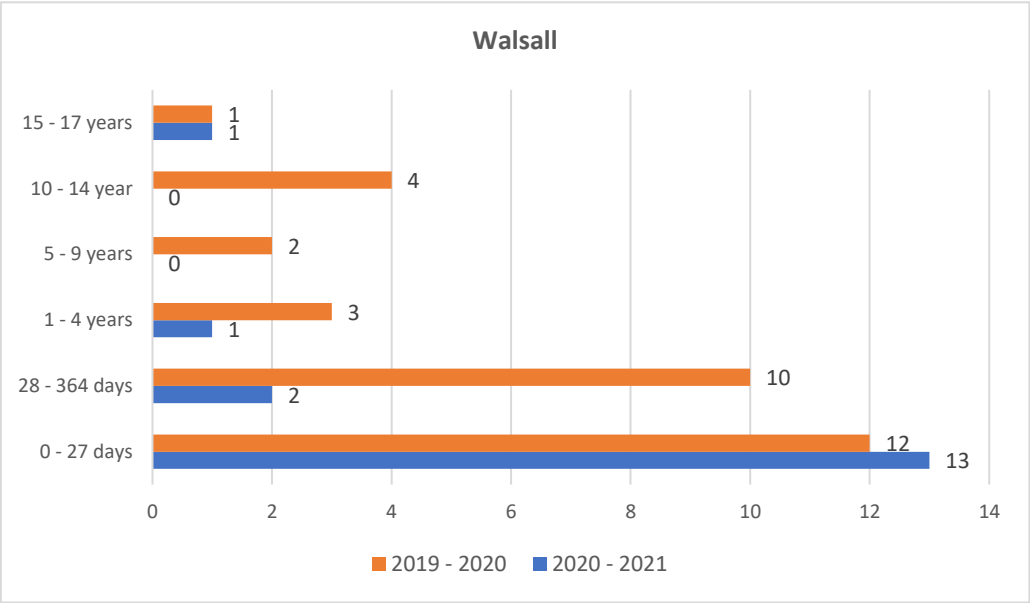
Area Breakdown, 2 year comparison



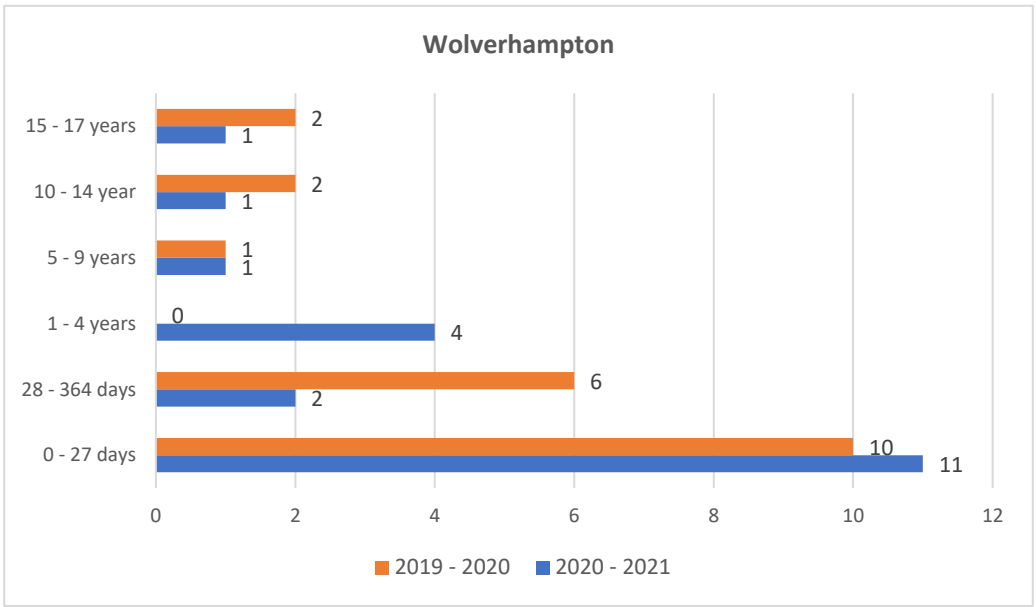
In Sandwell in 2020/2021, deaths have reduced in the 1 – 4 years and 10 – 14 years age groups. However, deaths increased in the 28 - 364 days and 15 - 17 years age groups.



In Dudley in 2020/2021, deaths have reduced in the 28 – 364 days, 1 – 4 years, 5 – 9 years and 10 – 14 years age groups. The greatest reduction is in the 28 – 364 day age group with the reduction being 75%.



In Walsall in 2020/2021, deaths have reduced in the 28 – 364 days, 1 – 4 years, 5 – 9 years and 10 – 14 years age groups. However, deaths increased slightly in the 0 – 27 days and 1 – 4 years age groups.



In Wolverhampton in 2020/2021, deaths have reduced in the 28 – 364 days, 10 – 14 years and 15 – 17 years age groups. However, deaths increased slightly in the 0 – 27 days and 1 – 4 years age groups.

Ethnicity

	2011 Census 0-18 years	%	2019 – 2020 Notified Deaths	%	2020 – 2021 Notified Deaths	%
White British	41249	55.50	43	40.19	29	34.12
White Other	2475	3.30	5	4.67	8	9.42
Mixed Multiple Ethnic Group	5786	7.70	18	16.82	2	2.35
Asian British Indian	7584	10.20	8	7.48	9	10.59
Asian British Pakistani	5773	7.80	12	11.21	7	8.23
Asian British Bangladeshi	2840	3.80	3	2.80	2	2.35
Asian British Chinese	227	0.30	4	3.74	0	0.00
Other Asian	1913	2.60	0	0.00	4	4.70
Black British African	1623	2.20	4	3.74	7	8.23
Black British Caribbean	2552	3.40	4	3.74	3	3.53
Black British Other	1019	1.40	0	0.00	6	7.06
Other Ethnic Group/Not recorded	1335	1.80	6	5.61	8	9.42
Totals	74376	100.00%	107	100.00%	85	100.00%

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

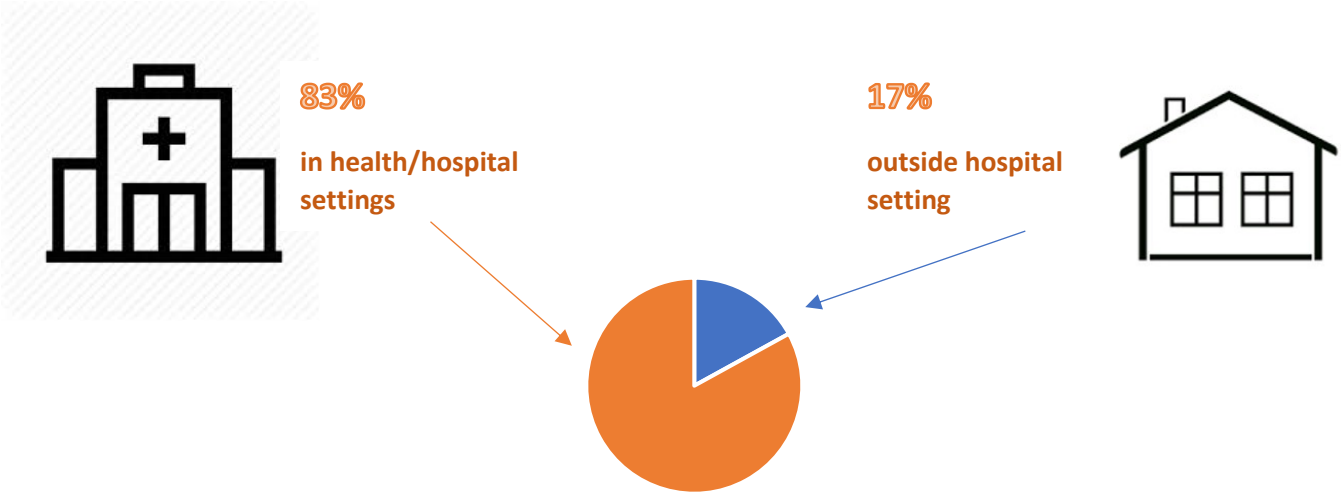
55.5% of 0 – 18 year olds in 2011 population were White British, however, only 34% of reported child deaths in 2020-21 were from this ethnic background. As with previous years, this is in contrast to those children from a BME background where there was a higher percentage of reported child deaths compared to the population size (0-18yrs). Hopefully this data will be more reliable and take into consideration population migration next year when new census data should be made available.

Nationally, the Ethnic group was recorded in 2,668 (87%) death notifications. Of these, 65% of deaths were of children who were recorded as being from a White ethnic group, 18% of deaths were of children from an Asian or Asian British background, 9% were from a Black or Black British background, 6% were from a Mixed background and 2% were from any other ethnic group. These proportions were similar to the previous year. There were significantly fewer deaths in 2020-21 for all ethnic groups apart from children from a Black or Black British ethnic background.

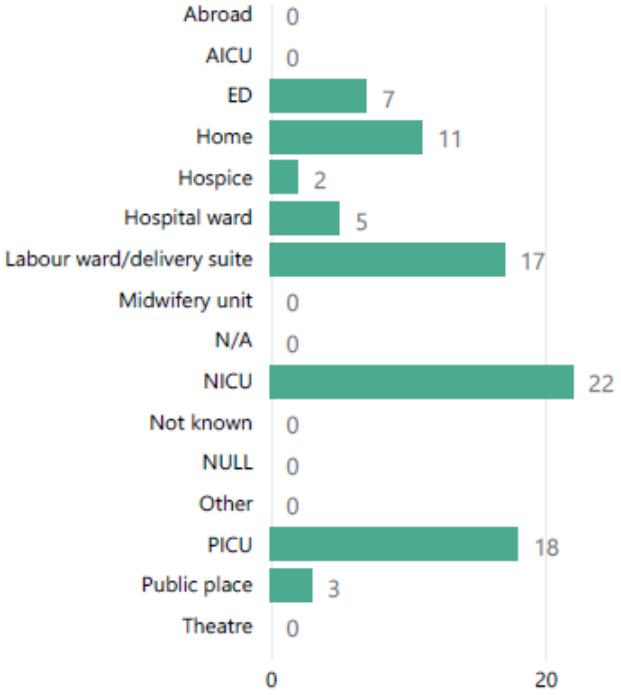
(Child death data release 2021 | National Child Mortality Database (ncmd.info))

Place of death

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



Black Country breakdown of place of death:



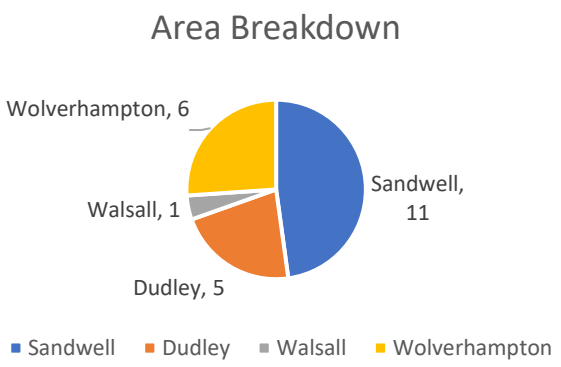
It makes sense that as the majority of deaths have occurred in the 0 – 28 days age group that the place of death reflects this with deaths occurring in the NICU and labour ward/delivery suite.

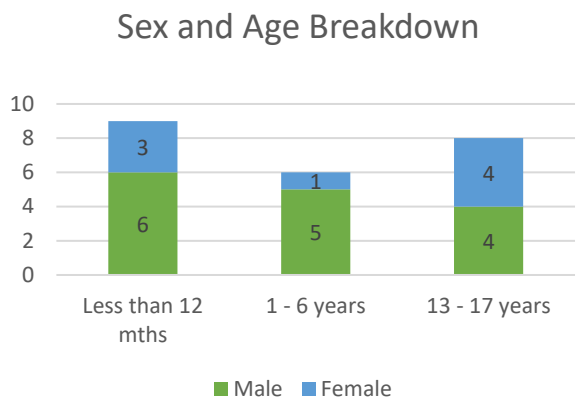
It is concerning, however, that large numbers of deaths have occurred at home, ED and public places. However, this corresponds to the unexpected death reported below.

Nationally, where the place of death was known, the majority (73%,) of deaths occurred in a hospital trust, consistent with the previous year. Deaths that occurred on neonatal units accounted for 800 (27%) deaths; the largest proportion of deaths across all locations recorded. Deaths reduced across most places of death in comparison to the previous year. However, there was an increase in the number of deaths where the place of death was recorded as the child's home.

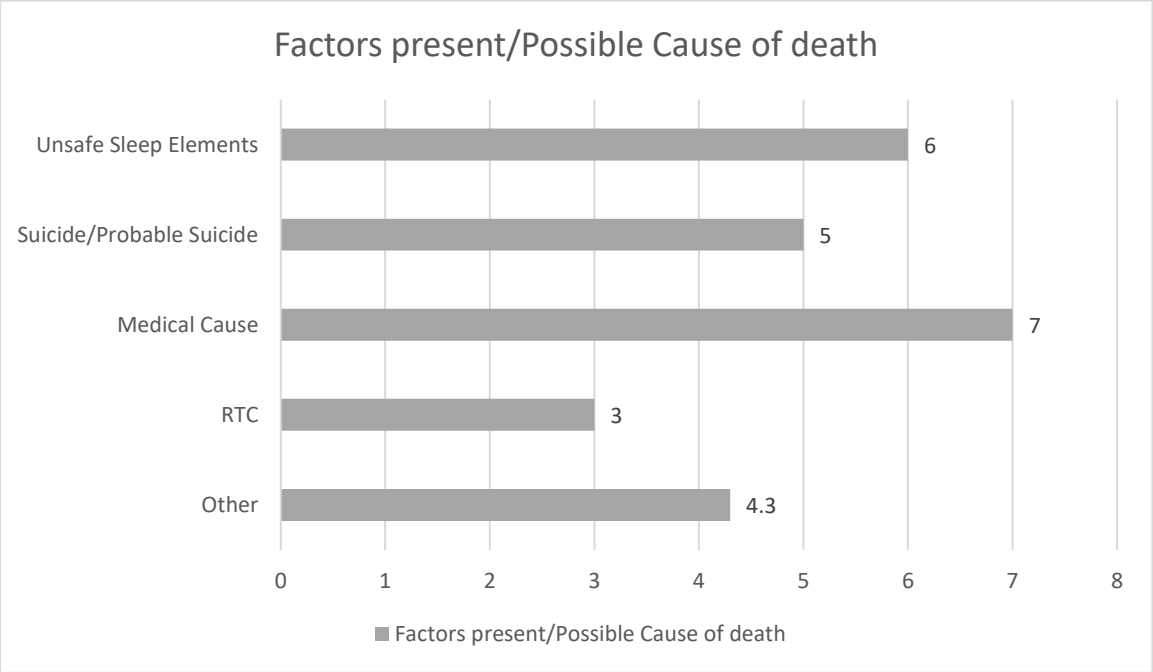
Unexpected Deaths requiring a Joint Agency Response (JAR):

Out of the 85 deaths notified to the Black Country in 2020 – 2021, 23 were unexpected and required a Joint Agency Response (JAR). The summary of these deaths is as follows:





Breakdown of unexpected deaths by category:



As a result of an increase in the number of suicides/probable suicides between October 2020 – March 2021, a deep dive was carried out by child death review partners to assess whether there were any patterns or trends highlighted for immediate action.

The report found that there were no obvious trends or patterns. It identified that few comparisons can be made with regards to age and gender, although more males than females have died by probable suicide. Three out of the five cases died by hanging, which may have some relevance as hanging, strangulation and suffocation are reported to be the most common suicide methods in young people.

It concluded that:

It needs to be recognised that, although unusual to the Black Country, the probable suicide deaths reported are still quite small and each case has unique elements, some of which are unknown, and could remain unknown.

The current Covid-19 situation also needs to be analysed more closely to assess whether it has had an impact on deaths in some way; whether this be social, emotional, limited/restrictive agency interactions or unknown factors yet to emerge.

Further consideration should also be given to the presence of ACEs in each child. This information is not fully available in all deaths but could hold possible comparisons.

Safeguarding within the CCG also carried out an analysis looking at the safeguarding element within the 5 cases and made several recommendations.

Recommendations included:

- Suicide prevention planning to be a joined up, governed approach to ensure that safeguarding is considered with a recommendation of regular audit and review of the processes due to the changing social circumstances that our children are encountering, particularly following the pandemic.
- Ensure professionals understand ACE's, the risk of cumulative harm and the impact of these adversities and for this approach to be applied within decision making, whether the child is seen to be coping or not (NSPCC 2020).
- Ensure professional practice involves obtaining and hearing the voice of the child and, within this, to consider the presence of isolation and loneliness as a safeguarding risk.

The West Midlands Child Death Review Network will be holding a Themed Review in 2021 – 2022 to review the findings from those deaths where suicide was found to be the cause of death by the Coroner, to highlight any possible area patterns and themes and to make recommendations to regional partners.

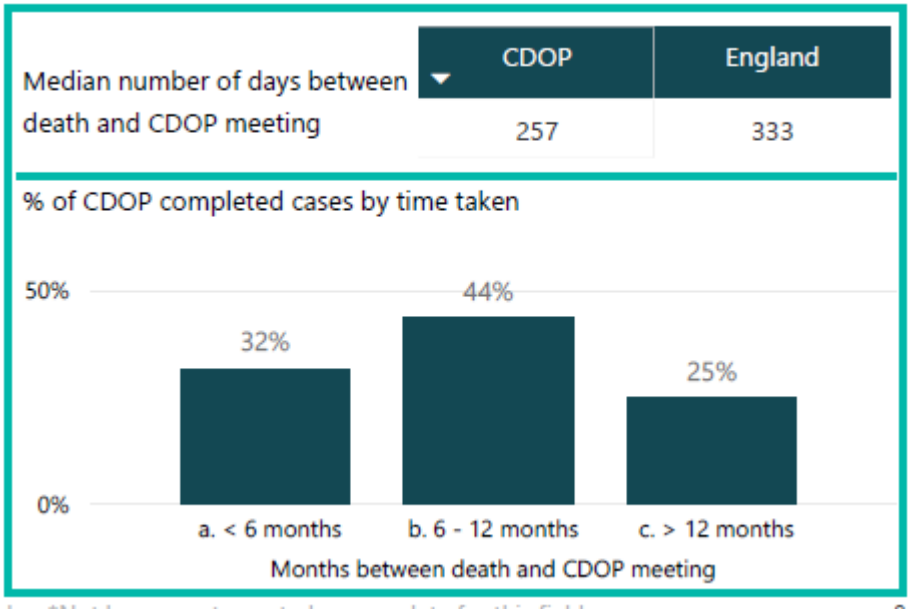
4. Deaths Reviewed 2020 – 2021

101 deaths in total from across the Black Country were reviewed in 2020 – 2021 at 10 CDOP meetings. These panels were made up of multi-agency professionals from across the health economy, Local Authorities, Children's Services, Safeguarding Partnerships and Police, representing their profession as well as their geography.

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

There is an inevitable time-lag (4-12 months) between notification of a child's death and discussion at CDOP and there are various factors that contribute to this: the return of Reporting Forms from professionals, the completion of the final post-mortem report by the pathologist and receipt of the final report from the local child death review meeting. On occasions when the outcome of a Coroner's inquest is awaited, there may be a delay of over a year before a case might be brought before CDOP. The undertaking of a criminal investigation or a Child Safeguarding Practice Review (previously Serious Case Review will also affect a timely review. In the year 2020 – 2021, there was also the added pressure of Covid-19 which saw healthcare professionals priorities being changed causing an inevitable delay with standard processes.

The following chart shows the number of days (median) between the death and the CDOP review. The first chart shows that the Black Country continued to review deaths in a shorter period of time than the England average in 2020 - 2021.



Overview of reviewed deaths, 2020 – 2021

Completed CDOP Reviews by LSCB

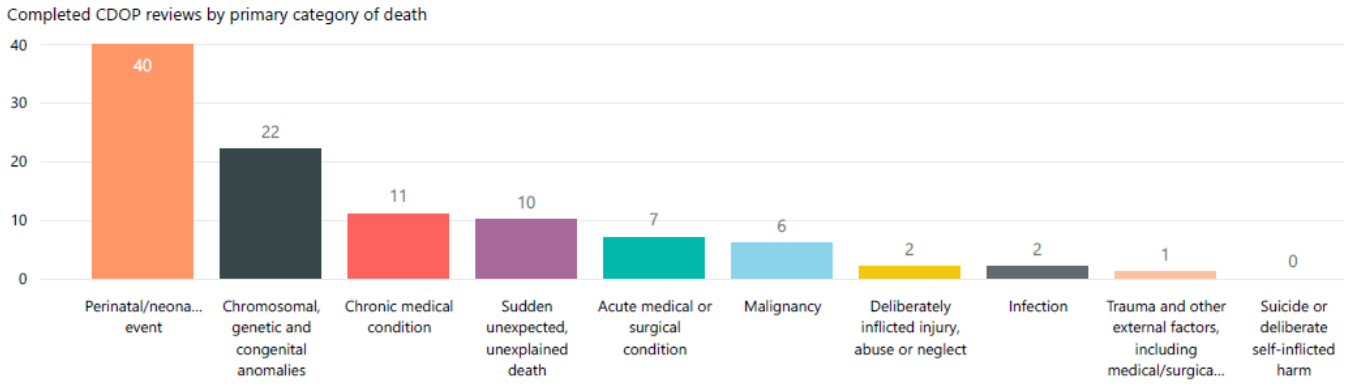
LSCB name	Cases
Dudley	24
Sandwell	23
Walsall	27
Wolverhampton	27
Total	**101**

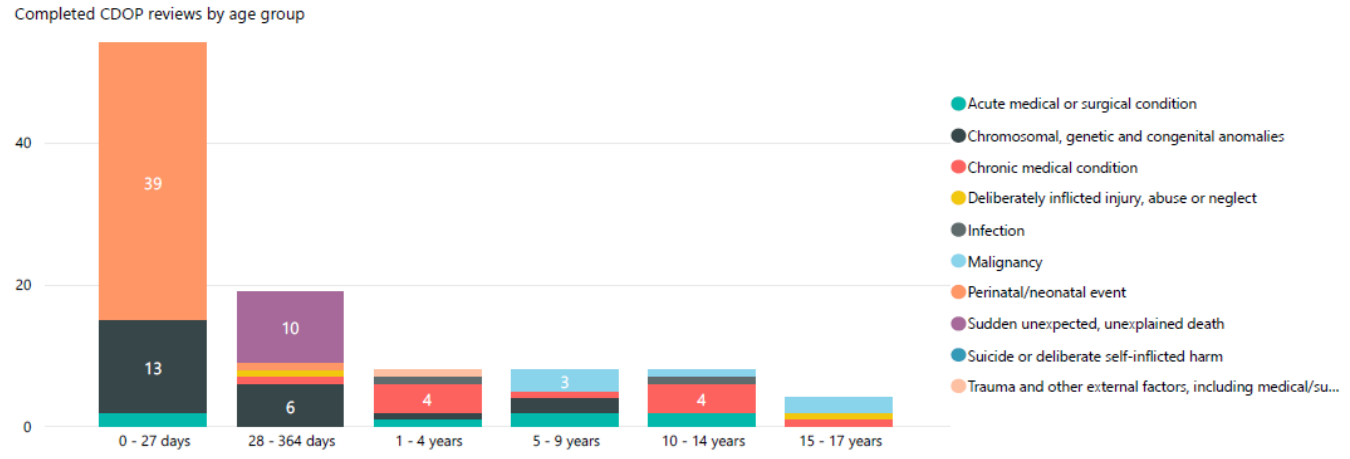
Completed CDOP Reviews by year of death

Year of death	Cases
2017-18	2
2018-19	4
2019-20	60
2020-21	35
Total	**101**

The majority of deaths reviewed in 2020 – 2021 were from the previous year 2019 – 2020, where Child Death Review Meetings (CDRM) had been held and an analysis form completed as per the new process. Those deaths reviewed in earlier years were as a result of police and other investigations concluding.

The fewest deaths reviewed were from Sandwell, who receive the majority of notifications. This is primarily due to the fact that deaths occur in neighbouring authority hospitals where child death review meetings are not yet established and mortality reviews take 6 -8 months to complete, leading to a delay in completing the necessary paperwork.

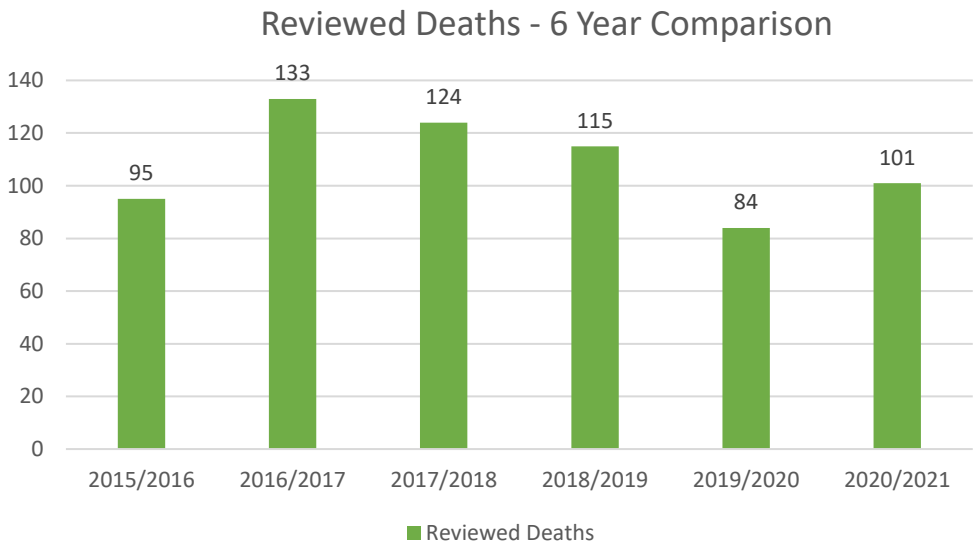




- Graphs above show that the majority of reviewed deaths were in the 0 – 27 days age group and have a primary category of death of a neonatal or perinatal event.
- Sudden, unexpected deaths reviewed were of children aged 28 – 364 days

Comparison with other years

It is anticipated that between 80-100 deaths will be reviewed per year by the Black Country CDOP.



Nationally, 2,575 child deaths were reviewed by CDOPs in England between 1 April 2020 and 31 March 2021. Of these, 20% were reviews of children who died within the same year and 80% were reviews where the child died before 1 April 2020. There were 176 (6%) fewer reviews compared to the previous year, likely because of the impact of the COVID-19 pandemic and fewer deaths occurring. The proportion of reviews that identified modifiable factors continues to rise each year with 34% of deaths reviewed during 2020-21 identifying modifiable factors.

Modifiable Factors

During the final review, the Child Death Overview Panel is responsible for identifying any modifiable factors in relation to the child's death. Such modifiable factors are defined as factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.
In 37 of the 101 deaths reviewed in 2020 – 2021, 37% were identified as having modifiable factors. This is slightly higher than the National figure at 34%.
The following tables give a breakdown with regards to primary category of death, age and ethnicity.

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

Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Acute medical or surgical condition	7	1	14%
Chromosomal, genetic and congenital anomalies	22	3	14%
Chronic medical condition	11	1	9%
Deliberately inflicted injury, abuse or neglect	2	1	50%
Infection	2	1	50%
Malignancy	6	0	0%
Perinatal/neonatal event	40	20	50%
Sudden unexpected, unexplained death	10	10	100%
Suicide or deliberate self-inflicted harm	0	0	0%
Trauma and other external factors, including medical/surgical complications/error	1	0	0%
Total	**101**	**37**	**37%**

% of cases where modifiable factors were identified by age group

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	54	20	37%
28 - 364 days	19	11	58%
1 - 4 years	8	1	13%
5 - 9 years	8	1	13%
10 - 14 years	8	2	25%
15 - 17 years	4	2	50%
Total	**101**	**37**	**37%**

% of cases where modifiable factors were identified by ethnic group

Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Asian or Asian British	24	9	38%
Black or Black British	5	2	40%
Mixed	13	6	46%
Other	5	3	60%
Unknown	3	0	0%
White	51	17	33%
Total	**101**	**37**	**37%**

Those deaths the panel placed in the category of sudden, unexplained or unexpected all had modifiable factors identified as detailed below. As these deaths were all in the 28 – 364 days, it makes sense that the table with a breakdown in ages, has the highest percentage of modifiable factors identified.

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

Social factors:

- Unsafe sleeping practices/ Co-sleeping with parents either on a sofa or bed
- Parental misuse of drugs or alcohol
- Disguised compliance
- Neglectful home conditions/ Chaotic household
- Smoking in the household
- Compliance with medication (young person)
- Young person high BMI
- Overcrowding

Service/agency factors:

- Place of birth – not born in the appropriate level hospital
- Non engagement with services
- Cross border communications

Pregnancy related factors:

- Maternal smoking during pregnancy
- Consanguinity
- Delay in induction of labour
- Parental smoking
- Maternal high BMI during pregnancy
- Late booking of pregnancy
- Poorly controlled gestational diabetes

5. Infant Mortality

Infant mortality is the death of infants under the age of one year. This is measured nationally and internationally by the 'infant mortality rate', which is the number of deaths of children under one year of age per 1000 live births. Premature birth is the biggest contributor to infant mortality. When an infant dies before the age of 28 days this is called a 'neonatal' death and when death occurs in the first 7 days of life this is usually referred to as 'early neonatal' death.

In 2020 – 2021 the Black Country has developed further links with the Black Country and West Birmingham Local Maternity Services to support with their local vision:

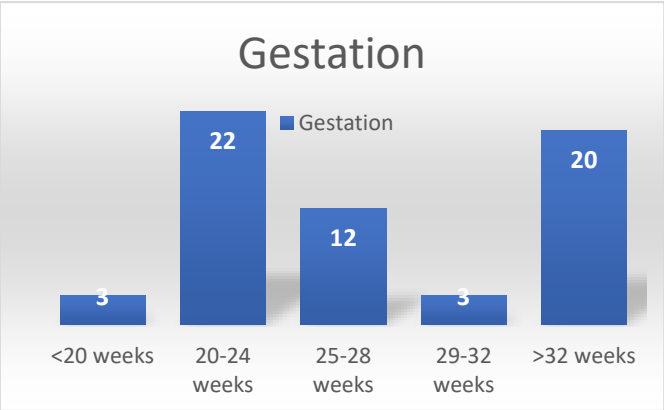
Through collaboration, we are committed to deliver high quality maternity services across the Black Country and West Birmingham shaped by the voices of local people. Our aim is to provide safe, personalised and responsive maternity services and ensure every woman and baby receives the best possible care.

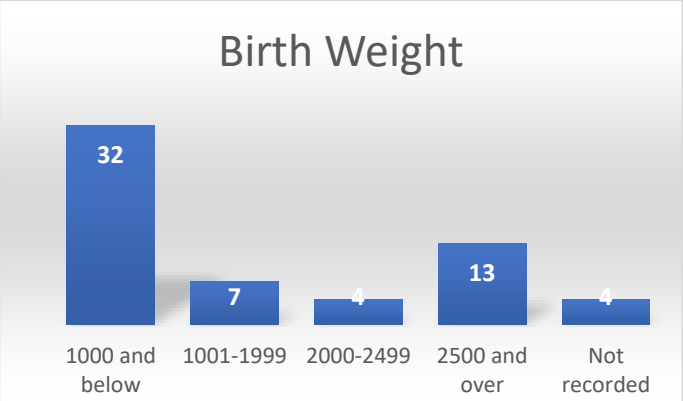
Data has been supplied around maternal smoking, mother's BMI, booking details, gestational age and weight to support with the several workstreams carried out by healthcare providers and local public health teams to reduce infant mortality rates where possible.

CDOPs and CDR professionals follow the statutory child death review guidance which states that all live births of any gestational age need to be reviewed and notified.

Infant Mortality
Notified Deaths 2020 - 2021

The number of infant death notifications received by Child Death Overview Panel by gestational age at birth in weeks and age group at death and weight, year ending 31 March 2021:





Out of the 48 deaths that occurred during the neonatal period (under 28 days of age),33 (69%) were born at an extremely preterm gestational age (before 28 weeks). An additional 7 deaths occurred at later preterm gestations (28+0-36+6 weeks); in total, 83% of infants dying in the neonatal period were born prematurely (before 37 weeks).

A low birth weight indicates a vulnerability to mortality, although there is a spike in those notified deaths where the birth weight is over 2500g. It was concerning that the weight of some deaths were not recorded and steps will be taken to improve this data collection in the coming months.

Infant Mortality
Reviewed Deaths 2020 – 2021

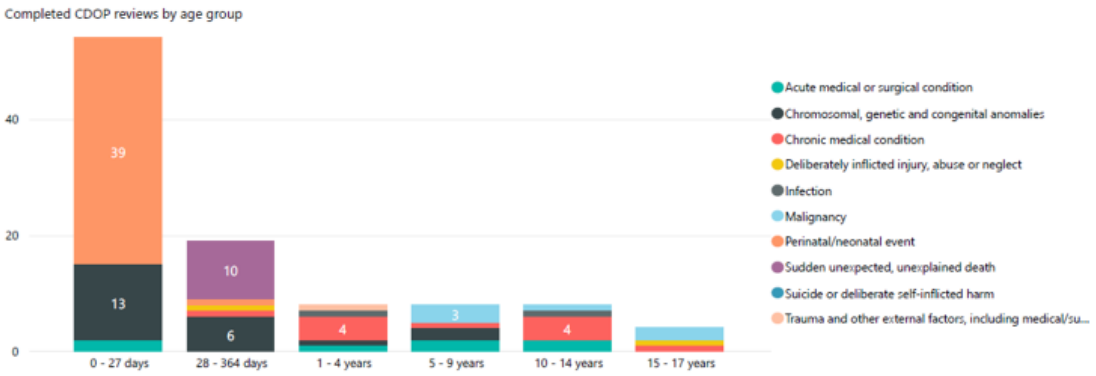
Perinatal/neonatal events

With deaths categorised as Perinatal/neonatal events being responsible for the largest proportion of death reviews in the Black Country, it has been crucial that relationships have been developed with the Local Maternity System (LMS) to ensure coordinated data analysis and approach.

Over half of neonatal deaths reviewed were caused by immaturity-related conditions such as respiratory and cardiovascular disorders. Congenital anomalies, such as heart and neural tube defects, account for approximately 30% of the total, followed by antepartum infections, which account for approximately 10% (Figure 6). Other neonatal deaths result from causes during or shortly after labour (intrapartum), or in the postnatal period.

Infant Mortality
Deaths Reviewed Chart 2020 - 2021

Of the 101 deaths reviewed, 73 deaths were for those that died under 12 months, as below:



6. Child Mortality and Social Deprivation

A key tool used in assessing deprivation in England is the Indices of Deprivation which combines data from across seven domains of deprivation to produce an overall relative measure of deprivation:

- Income: Measures the proportion of the population experiencing deprivation relating to low income

- Employment: Measures the proportion of the working age population in an area involuntarily excluded from the labour market

- Health Deprivation and Disability: Measures the risk of premature death and the impairment of quality of life through poor physical or mental health

- Education, Skills Training: Measures the lack of attainment and skills in the local population

- Crime: Measures the risk of personal and material victimisation at local level - Barriers to Housing and Services: Measures the physical and financial accessibility of housing and local services

- Living Environment: Measures the quality of both the indoor and outdoor local environment Each small area in England is ranked from 1 (most deprived) to 32,844 (least deprived).

Whilst designed to be a small-area measure, the data is also commonly used to describe higher level geographies, including Local Authorities, as demonstrated in this data table which provides an indication of the proportion of small areas within each Local Authority that fall within the 10% and 20% most deprived nationally along with a rank (out of 317 Local Authorities and 38 LEPS with '1' denoting 'Most Deprived')

Local Authority	% of SOA in 10% Most Deprived	% of SOA in 20% Most Deprived	IMD Ranking (lower number indicates higher deprivation)
Dudley	11	26	91 / 317
Sandwell	20	60	12 / 317
Walsall	26	5	25 / 317
Wolverhampton	21	4	24 / 317
Black Country	19	46	3 / 38

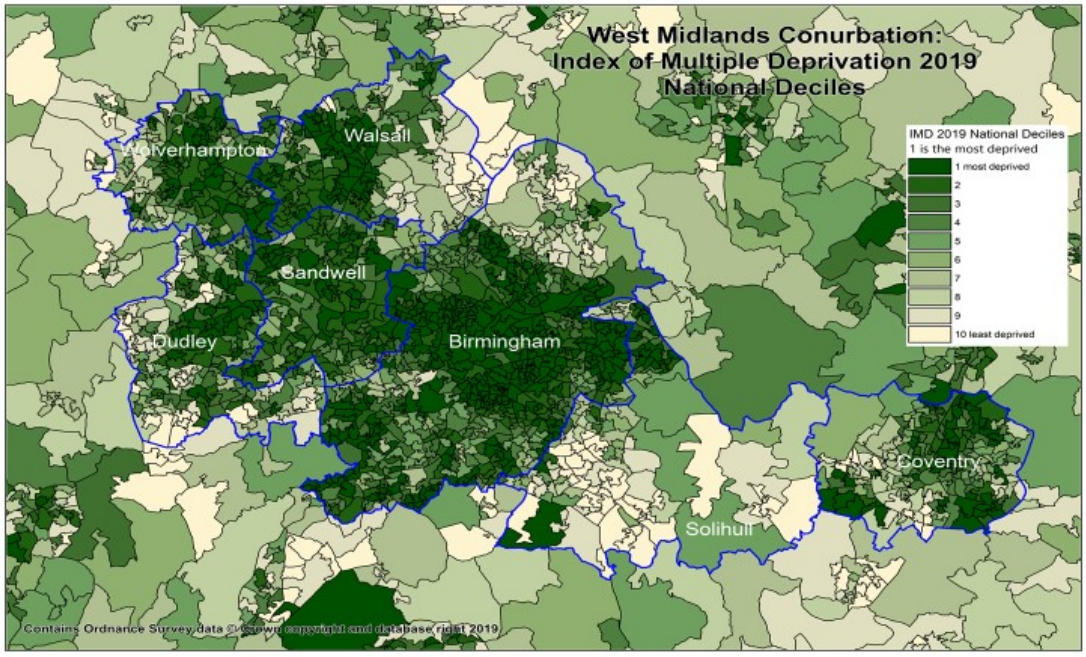
The Black Country has severe pockets of deprivation in each local authority. Sandwell is statistically the most deprived area, ranked 12th in the country, however all 4 authorities are within the poorest performing half of England for this indicator.

Indices of Multiple Deprivation, 2019 - ActiveBlackCountry

The following map shows this data highlighting how Sandwell in particular is surrounded by areas of deprivation.

Out of the 85 reported child deaths notified to the Black Country in 2020 – 2021, 57 (67%) were in the first or second Index of Multiple Deprivation Decile for the area, where 1 is the lowest. All were within the lowest 9 deciles.

English indices of deprivation 2019: Postcode Lookup (opendatacommunities.org)



Links to child mortality and deprivation

The Department for Education's triennial review of SCR's in 2019 found that

"One issue that came through more commonly in these reviews, however, was the impact of poverty on families' lives. Poverty can have a profound and a long-term negative impact on children's lives, but recognition of poverty and its impact is often missing from or only obliquely referred to in reviews"

About 700 child deaths could be avoided each year in England by reducing rates of social deprivation, according to an NHS England-funded report by NCMD.

REPORT: Child Mortality and Social Deprivation - National Child Mortality Database (ncmd.info)

The report, which analysed the records of 3,347 children who died in England between 1 April 2019 and 31 March 2020, identified a clear association between the risk of death and level of deprivation, for all categories of death apart from cancer.

It concluded that more than a fifth (23%) of all child deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived areas.

It is known already that children who grow up in poverty experience worse physical and mental health than their better-off peers and restricts opportunities in the future and the report goes on to highlight how living in deprivation can also increase the risk of child mortality.

It found that the majority (87.8%) of children who died lived in urban areas, and 63% of the deaths, were in infants less than one year old.

The team also scrutinised those child death records where deprivation was mentioned as a contributing factor. This revealed that problems relating to family debt or financial difficulties, homelessness in pregnant mothers, poor maternal nutrition, and mental health problems in either parent were the most frequently reported contributory factors.

Housing problems – such as a lack of cleanliness, unsuitable accommodation (including overcrowding), or maintenance issues such as damp or mould, or homes being in poor repair – were identified in 123 of the deaths reviewed.

Homelessness, either related to the father, mother, or child, featured in a further 33 deaths. This most commonly affected pregnant mothers, who went on to give birth to babies who subsequently died; families with young children; and young people leaving or being forced out of their family home.

A child's postcode can also influence their risk of traumatic death, such as being hit by a car while playing out on the street because there is nowhere else to play. Deaths from infections such as meningitis or pneumonia are also associated with social deprivation.

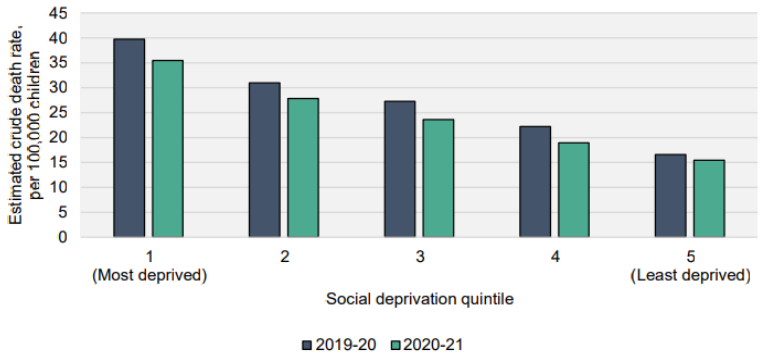
Social inequalities continue to have a marked impact on infant mortality. The risk of infant death increases with greater levels of maternal deprivation, reflecting the social gradient that exists across underlying risk factors such as preterm delivery, maternal health during pregnancy and uptake of recommended practices such as breastfeeding and safe infant sleeping positions. Infant mortality trends also show widening health inequalities, since 2010 there has been a rise in rates for the poorest children, compared to falling rates for more advantaged infants.

Infant mortality – RCPCH – State of Child Health

Nationally, the child death rate of children resident in the most deprived neighbourhoods in England (35.5 deaths per 100,000 children) was more than twice that of children resident in the least deprived neighbourhoods (15.5 deaths per 100,000 children).

Whilst the overall death rate was lower in 2020-21, the pattern of more deaths associated with children living in more deprived neighbourhoods remains consistent with previous year's data. The reduction of deaths across the two years was most marked for the more deprived neighbourhoods.

The national estimated crude child death rates per 100,000 population by social deprivation quintile



7. Black Country CDOP Progression In 2020 – 2021

- Each of the Trusts have provided assurance they are meeting Statutory and Operational requirements by completing a Self-Assessment Framework
- Positive Recognition - In order to recognise and encourage good practice, or where agencies have gone above and beyond their expected duties, CDOP continue to send letters of good practice where good practice has been identified. Whilst it is the panel's responsibility to identify learning and trends from child deaths across the Black Country, the panel feel it is important to recognise the excellent care that professionals provide for the children and families that they work with.
- In response to the data regarding deaths involving unsafe sleeping practices across the Black Country, a Safer Sleep 7 min briefing has been developed and widely shared locally, regionally and nationally.
- A training package has been developed around safe sleeping messages to be rolled out to front line practitioners
- Hospitals in the Black Country have developed robust Child Death Review Meeting procedures highlighting areas for learning and contributing to the final Child Death Overview Panel.

8. Future Priorities

Next Steps and Objectives

- Support the newly formed Black Country and West Birmingham CCG in establishing consistent place-based child death review processes
- Develop and contribute to strategies to reduce Infant Mortality and suicide prevention
- Consolidate the role of the Key Worker
- Introduce a feedback letter for parents to ensure their voices are heard
- Continue to escalate issues where agencies are not providing timely information
- Submission and ratification of the Black Country annual report
- To develop further good links with existing maternity and neonatal networks to improve outcomes
- Publish a Black Country multi-agency SUDIC protocol and ensure all areas of the Black Country are compliant
- Link with WM Regional CDOP to carry out themed review around confirmed suicide cases
- Liaise with Medical Examiners to explore the role and relationship with child death further
- Audit the effectiveness of dissemination of learning and impact on service provision
- Strengthen the Key Worker role

National Data taken from NCMD Report:

Child death data release 2021 | National Child Mortality Database (ncmd.info)