Herefordshire and Worcestershire Child Death Overview Panel

Annual Report

01 April 2019 to 31st March 2021

Contents

1. Foreword

I am pleased to introduce this first annual report from the joint H&W CDOP.

As you will see, 'annual' report is something of a misnomer because the report covers the first two years of the newly constituted joint panel. It also covers the period during which the world has been responding to the challenge of COVID-19.

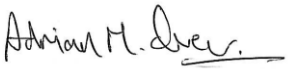
I was delighted to be invited to take on the role of independent chair of the panel from February 2020, just a few weeks before the first lockdown. To date, I have therefore only chaired panel meetings virtually and very much look forward to meeting my CDOP colleagues in person!

I am from a safeguarding background, initially as a frontline social worker; then managing residential family assessment facilities; before leading the implementation of the Common Assessment Framework, acting as Local Authority Designated Officer and safeguarding adviser to schools.

I am honoured to chair a panel of excellent and committed professionals, who bring a range of experience and expertise from across the spectrum of services for children and families to the process of reviewing the deaths of children.

The death of a child is always tragic. I am struck by that every time I read the documents for the review of each death. In overseeing the child death review process, our commitment is to honour each child who has died and their families by seeking to identify any learning that might prevent future deaths.

This report summarises the lessons that have been identified in that endeavour during the last two years. I hope you find it useful and instructive.



Adrian Over

Herefordshire and Worcestershire Child Death Overview Panel Independent Chair

2. Introduction

The death of a child is a devastating loss that profoundly affects the bereaved parents as well as extended family, friends and professionals who were involved in caring for the child. The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families, with the intention of preventing future child deaths. Every family has the right to have their child's death sensitively reviewed in order, where possible, to identify the cause of death and to learn lessons that may prevent future deaths.

The Children Act 2004 requires child death review (CDR) partners to make arrangements to carry out child death reviews. These arrangements should result in the establishment of a Child Death Overview Panel (CDOP), or equivalent, to review the deaths of all children normally resident in the relevant local authority area. The reviews should be conducted in accordance with the Child Death Review Statutory Operational Guidance, published by the Department of Health and Social Care in 2018, and Working Together to Safeguard Children also published in the same year. The guidance outlined changes to the bodies responsible and the process of reviewing child deaths. All CDR partners are required to gather information from every agency that has had contact with the child, during their life and after their death, including health and social care services, law enforcement, and education services. This is done using a set of statutory CDR forms. This process combines best practice with statutory requirements.

In line with the new guidance Herefordshire and Worcestershire CDR partners made arrangements for all deaths of children normally resident in both counties to be reviewed by a single CDOP. From September 2019 the Herefordshire & Worcestershire (H&W) CDOP began operating as a combined CDOP and provided the structural framework for the independent review of all child deaths. The geographical and population 'footprint' covers the child population that will typically review between 46 – 55 child deaths per year.

In the counties of Herefordshire and Worcestershire the current child death review partners are:

- Herefordshire Council (Public Health)
- Worcestershire County Council (Public Health)
- NHS Herefordshire and Worcestershire Clinical Commissioning Group

2.1 Transfer to New Responsibilities and Panel Development

In light of new national guidance a Herefordshire and Worcestershire Child Death Review procedure was established to align practice in both areas and to address the changes outlined in the guidance. This was a very large piece of work which involved mapping the separate processes in each area and understanding how these could be brought together to ensure consistency and good practice.

The new guidance also included the introduction of the National Child Mortality Database (NCMD), an NHS-funded project that collates data collected by CDOPs in England, with the aim of learning lessons from child deaths to save lives in the future. There has been a statutory requirement for CDOPs to submit copies of completed forms to NCMD electronically since April 2019. This was a large shift in practice. Furthermore, during the pandemic a new legal requirement to notify all deaths to NCMD within 48 hours emerged. The enhanced data submitted to NCMD during the pandemic has supported the national surveillance of the effect of COVID-19 and informed national strategy.

H&W CDOP held the first combined Panel meeting in September 2019 and began reviewing cases in November 2019. H&W CDOP is an independent multi-agency panel whose role is to carry out an anonymised secondary review of each child's death to learn lessons and share any findings for the prevention of future deaths. One of the responsibilities of H&W CDOP is to produce an annual report on behalf of the statutory partners. The report provides a descriptive analysis of all completed child death reviews, highlighting the most frequent modifiable factors and how to address them locally. H&W CDOP also integrates local learning and actions with information from national reports to improve outcomes.

NCMD reported that the number of completed reviews in 2019-20 decreased by 16% from the previous year. This is potentially due to fewer CDOP meetings taking place whilst working under transitional arrangements. However, H&W CDOP continued to review a consistent number of cases during 2019-20 and 2020-21.

2.2 Response to Covid-19 Pandemic

It is important to acknowledge the impact of coronavirus (COVID-19) and that the first combined Herefordshire and Worcestershire Child Death Overview Panel (H&W CDOP) annual report has been written during a global pandemic. The Panel has continued to review the deaths of children from across Herefordshire and Worcestershire so any lessons learned and recommendations can inform future preventative activity and may prevent child deaths. The Panel agreed that the report would cover a two-year period which would incorporate reviews completed during the creation of the new joint panel and COVID-19 pandemic.

During the pandemic H&W CDOP continued to meet virtually at the usual non-pandemic intervals of every other month. Since April 2019 H&W CDOP has reviewed a total of 61 cases. This is a significant achievement as the CDR partners were also continuing to embed the new child death review process while addressing the constant challenges of the pandemic. There was a requirement to amend the local Joint Agency Response (JAR) guidance across the two counties, provide communication to all Trusts and partner agencies on our position in continuing to support the CDR process and respond to the government's request to use an enhanced CDR notification form with additional COVID-19 questions.

Hospital Trusts were also advised to cancel all meetings not relating to COVID-19 so there was no requirement for them to hold child death review meetings (CDRMs) during the pandemic. However, virtual CDRMs continued to be held in Herefordshire and Worcestershire to ensure there was no additional delay to the child death review process.

3. Data Summary

3.1 Child Death Notifications in Herefordshire and Worcestershire 2019-2021

- Between 1st April 2019 and 31st March 2021, a total of **103** child death notifications were received for Herefordshire and Worcestershire resident children.
- 52% of notifications were male and 48% were female.
- 67% of the deaths were expected and 33% were unexpected

3.2 Child Death Notifications in Herefordshire 2019-2021

- Between 1st April 2019 and 31st March 2021, a total of **27** child death notifications were received for Herefordshire resident children.
- 48% of notifications were male and 52% were female.
- 56% of the deaths were expected and 44% were unexpected.

3.3 Child Death Notifications in Worcestershire 2019-2021

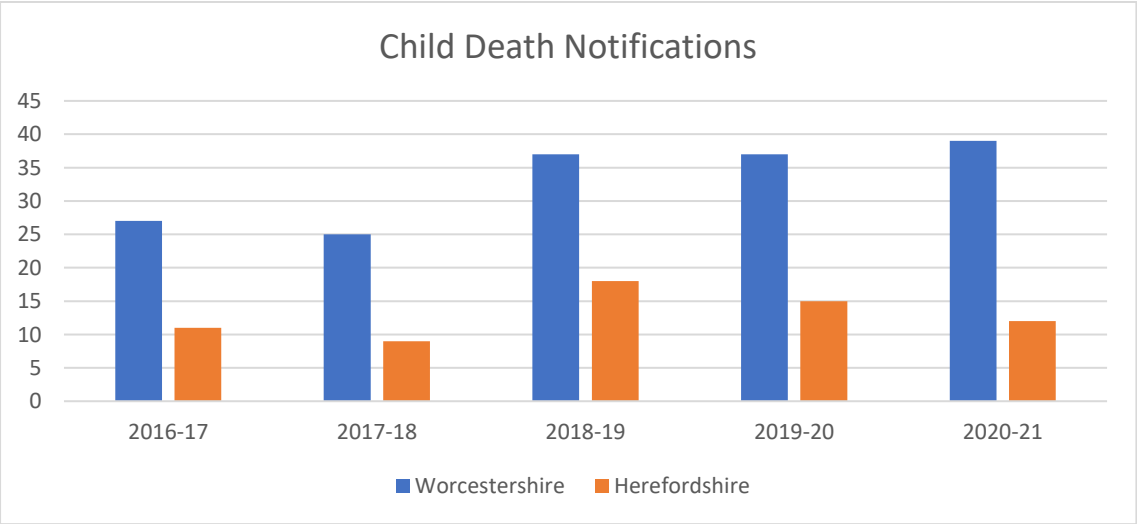
- Between 1st April 2019 and 31st March 2021, a total of **76** child death notifications were received for Worcestershire resident children.
- 54% of notifications were male and 46% were female.
- 71% of the deaths were expected and 29% were unexpected.

Nationally over half of child death notifications were male. The child death rate for males remains higher than the child death rate for females. This difference is consistent with what is reported by ONS every year and observed in most countries in the world.

Data source: NCMD 1st April 2019 to 31st March 2020

Figure 1. Number of child death notifications received by year of notification and area of residence

Data source H&W CDOP 2019-2021

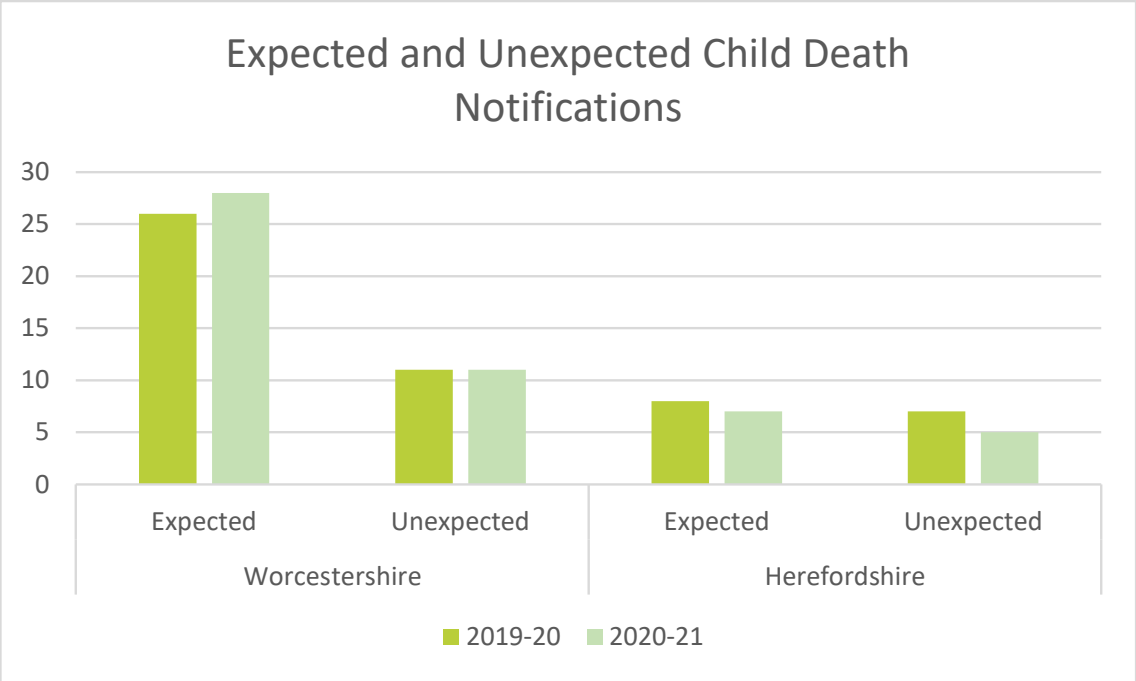


Nationally NCMD received 3,347 notifications of child deaths from CDOPs in England where the date of death of the child was between 1 April 2019 and 31 March 2020.

Data source: NCMD 1st April 2019 to 31st March 2020

Figure 2. Number of child death notifications received by expected and unexpected death by year of notification and area of residence.

Data source H&W CDOP 2019-2021



An unexpected death involves cases in which there is death (or collapse leading to death) of a child, which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent. There is a requirement to perform further investigations for children who die where the cause is unknown. This process is referred to as a Joint Agency Response (JAR).

A Joint Agency Response should be triggered if a child's death:

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

3.4 Cases reviewed by Herefordshire and Worcestershire Child Death Overview Panel

- Between 1st April 2019 and 31st March 2021, a total of **61** cases were reviewed by H&W CDOP.
- In 2019-20 26% of cases were reviewed in the same year as the child's death and 74% of reviews were where the child died in the preceding years.
- In 2020-21 15% of cases were reviewed in the same year as the child's death and 85% were reviews where the child died in the preceding years.

H&W CDOP reviews are not always completed in the same year as the notification of death. Most cases are reviewed in the years following the child's death. The timescale for secondary review at CDOP relies on the collection and analysis of information requested from professionals. Where deaths of resident children occur out of county a CDRM will be completed before local review.

Some child deaths may involve a coronial investigation, post-mortem, child safeguarding practice review, Healthcare Safety Investigation Branch investigation, Serious Incident investigation or Police investigation which all have varying timescales for completion.

Nationally 27% of child death reviews were of children who died within the same year and 73% were reviews where the child died in the preceding years.

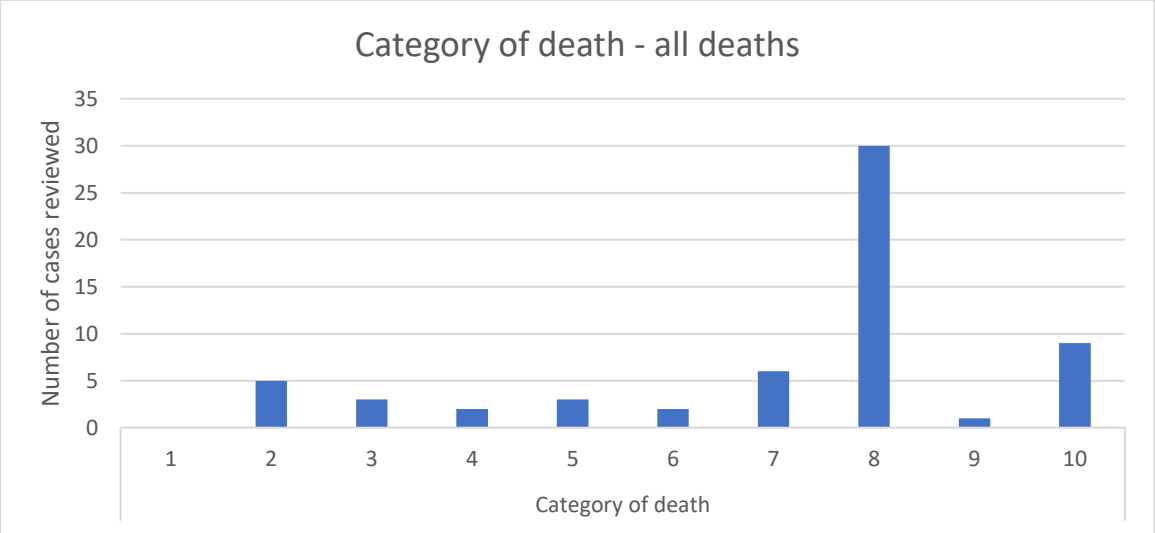
Data source: NCMD 1st April 2019 to 31st March 2020

Category of death

- 49% of cases reviewed had a primary category of perinatal/neonatal event.
- 15% of cases reviewed had a primary category of sudden unexpected, unexplained death.
- 10% of cases reviewed had a primary category of chromosomal, genetic and congenital anomalies.

A primary category of perinatal/neonatal event was recorded for the largest proportion of deaths, followed by sudden unexpected, unexplained death and then chromosomal, genetic and congenital anomalies. The rarest category was infection. Nationally a primary category of perinatal/neonatal event was recorded in 31% of cases reviewed. H&W CDOP reviewed a higher proportion of cases in this category.

Figure 3 The number of child deaths reviewed by category of death for Herefordshire and Worcestershire.
Data source H&W CDOP 2019-2021



CDOPs are required to assign a category to each death during the review. The classification of categories is hierarchical, where the uppermost selected category will be recorded as the primary category, should more than one category be selected. A description of these categories can be found below:

Category	Name & description of category
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.

3	**Trauma and other external factors, including medical/surgical complications/error** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death.
4	**Malignancy** Solid tumours, leukaemia's & lymphomas, and 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, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Includes cerebral palsy with clear post-perinatal cause.
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral palsy without evidence of cause and includes congenital or early-onset bacterial infection (onset in the first postnatal week).
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.
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).

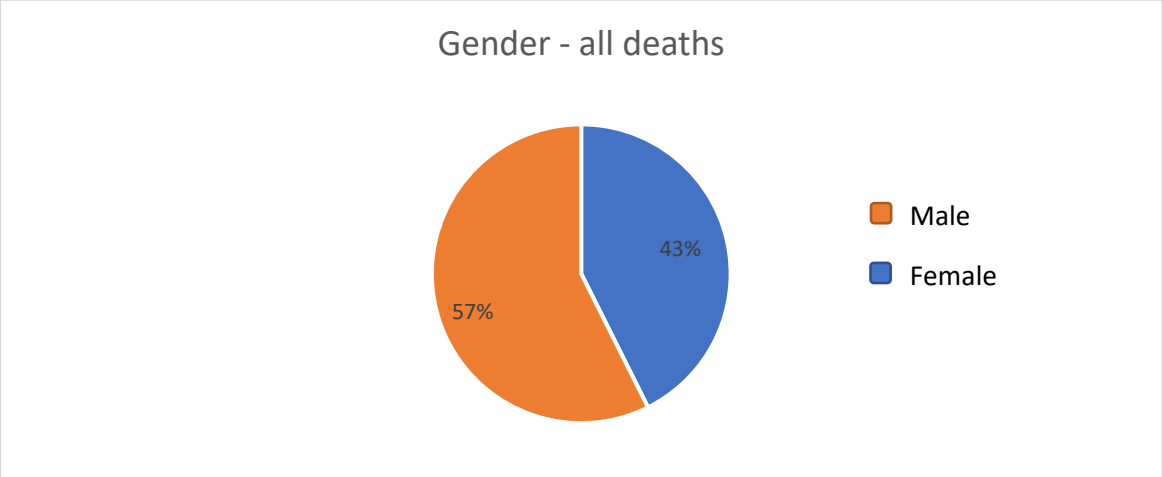
Nationally a primary category of Perinatal / Neonatal event was recorded for the largest proportion of deaths (31%). 25% recorded a primary category of Chromosomal, genetic and congenital anomalies and (8%) of deaths reviewed were categorised as Sudden unexpected and unexplained.

Data source: NCMD 1st April 2019 to 31st March 2020

Gender

- 57% of cases reviewed were male and 43% female.

Figure 4 The number of child deaths reviewed by gender for Herefordshire and Worcestershire.
Data source H&W CDOP 2019-2021



Nationally the child death rate for males remained higher than the child death rate for females. This difference is consistent with what is reported by ONS5 every year and observed in most countries in the world.

Data source: NCMD 1st April 2019 to 31st March 2020

Age

- 39% of the deaths reviewed were under 1 day old.
- 57% of the deaths reviewed were under 1 month old.
- 79% of the deaths reviewed were under 1 year old.

A large proportion of deaths reviewed were in the first month of life. 8% of the cases reviewed were assigned a category of suicide and these involved older teenagers between the age of 16 and 17 years.

Figure 5. The number of reviews completed by H&W CDOP by age group, 1st April 2019 to 31st March 2021
Data source: H&W CDOP 2019-2021

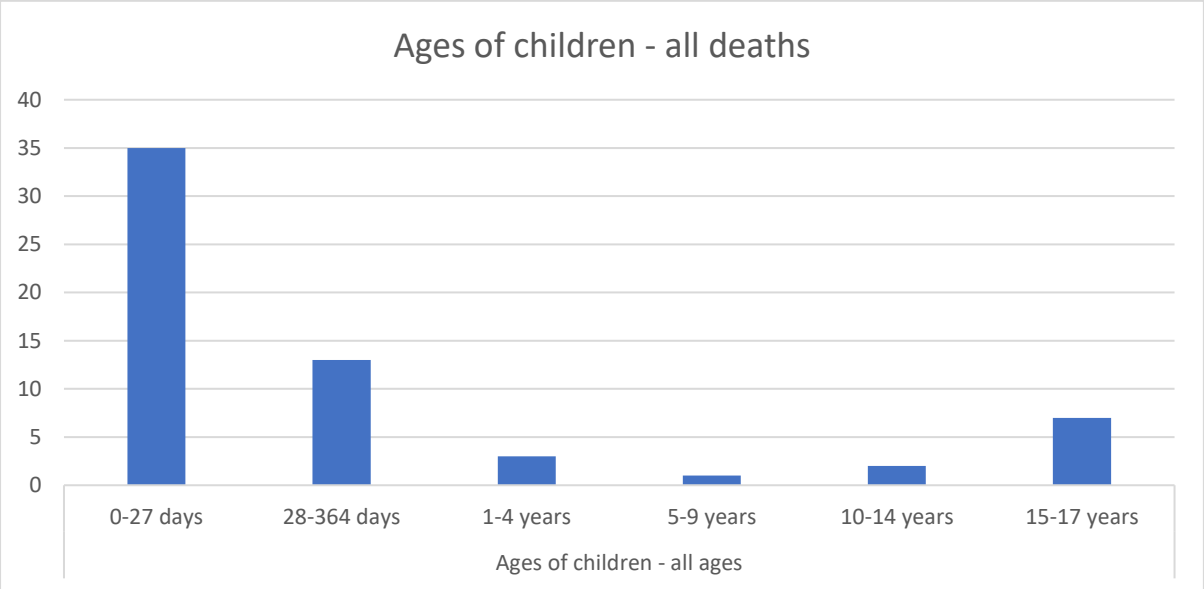
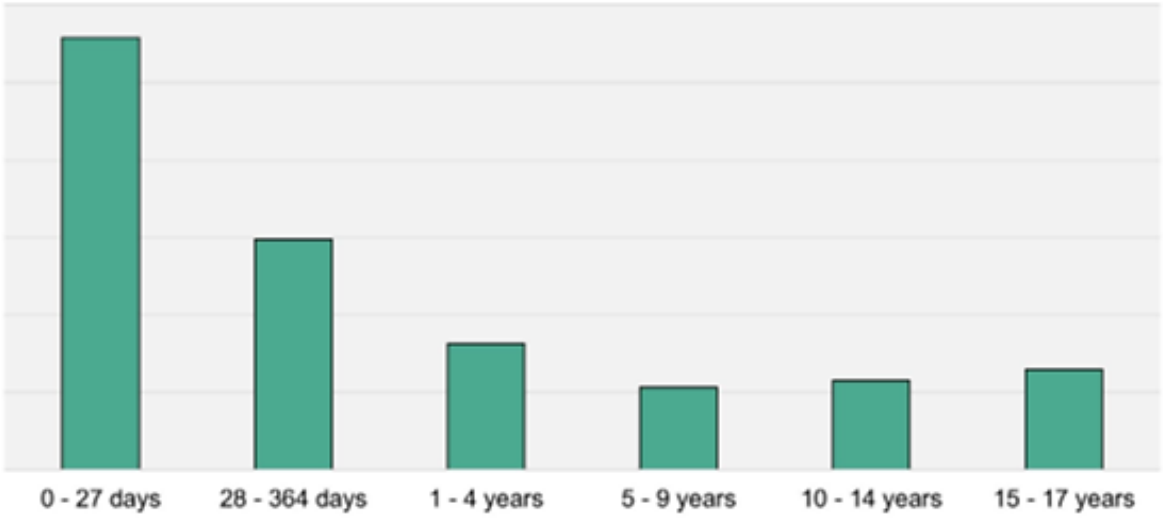


Figure 6. The number of reviews completed by all Child Death Overview Panels in England by age group, 1st April 2019 to 31st March 2020
Data source: NCMD



Nationally 65% of deaths reviewed where the child was aged under 28 days categorised as Perinatal/ neonatal event.

Data source: NCMD 1st April 2019 to 31st March 2020

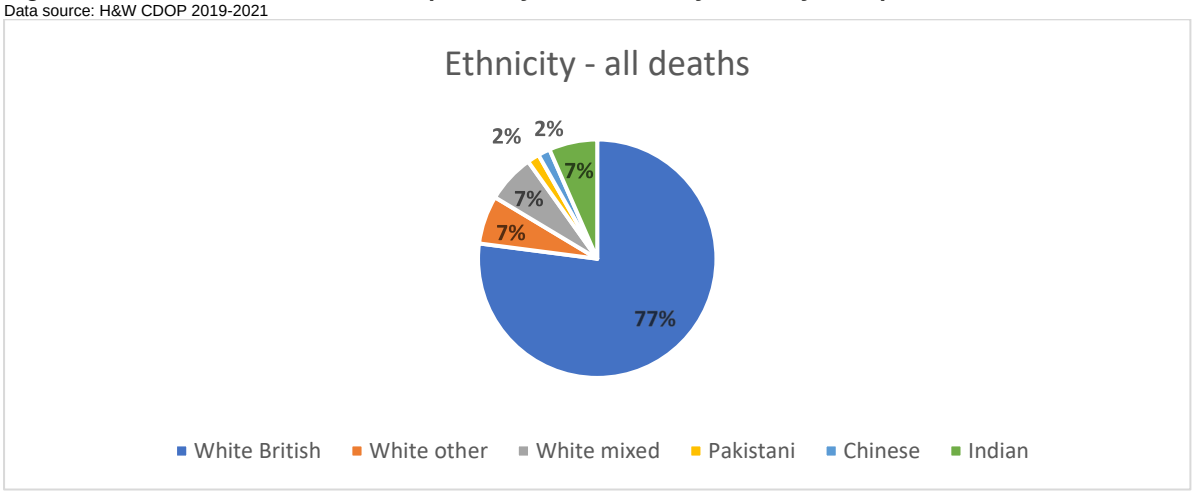
Nationally suicides were more common in older groups, 78% of the deaths in those aged between 15 and 17 years and 22% in those aged 14 and below were suicide.

Data source: NCMD 1st April 2019 to 31st March 2020

Ethnicity

- 77% of the deaths reviewed were White British

Figure 7. The number of reviews completed by H&W CDOP by ethnicity, 1st April 2019 to 31st March 2021
Data source: H&W CDOP 2019-2021



Nationally, where ethnicity was recorded, 62% were of children from a White ethnic group, 19% were from an Asian or Asian British background.

Data source: NCMD 1st April 2019 to 31st March 2020

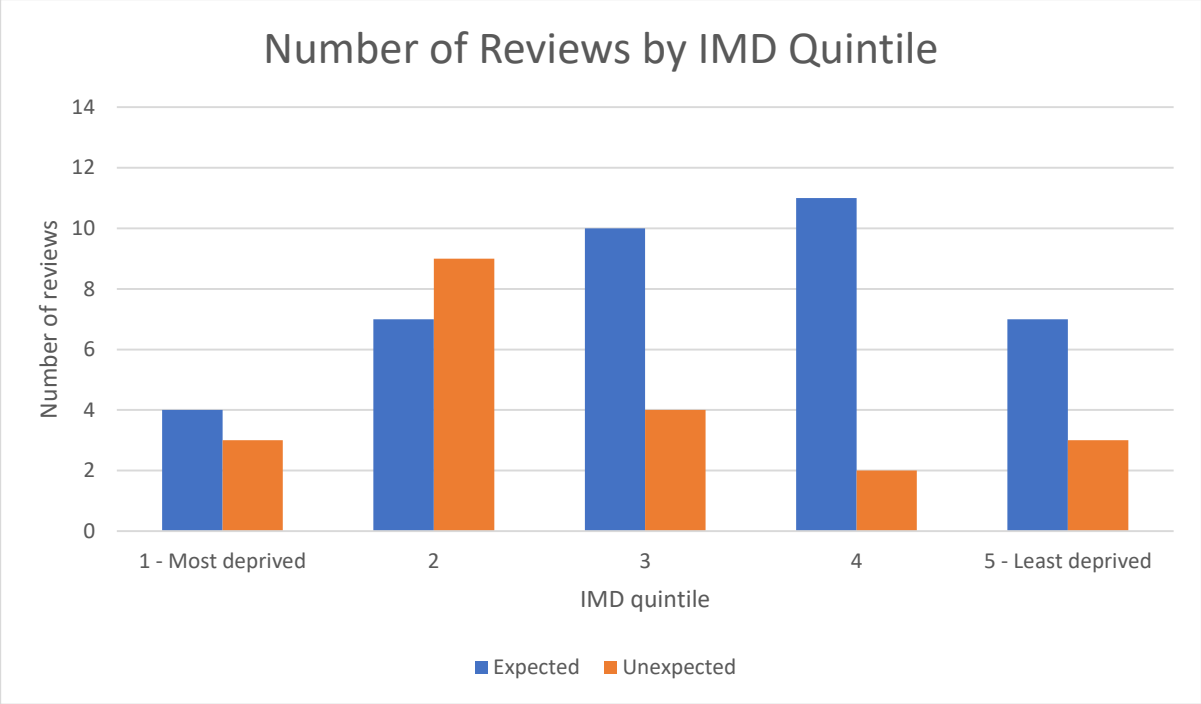
4. Significance of Social Deprivation

The Index of Multiple Deprivation (IMD) was used to identify the IMD quintile of a particular postcode. IMD is based on a set of factors that includes levels of income, employment, education and local levels of crime. Lower socio-economic groups, for example, tend to have a higher prevalence of risky health behaviours, worse access to care and less opportunity to lead healthy lives. IMD quintile 1 is the most deprived. Postcode information was not available for one of the cases reviewed therefore an IMD quintile could not be identified.

- The IMD quintiles of overall deaths reviewed were fairly evenly distributed, with a slightly higher number of child deaths in the least deprived postcodes compared to the most deprived postcodes.
- The IMD quintiles of deaths reviewed by expected and unexpected did not show any clear trends but there was a higher number of deaths in quintile 2.

Likely due to the small number of deaths reviewed by H&W CDOP in 2019-21, the data does not reflect a significant link with deprivation. However, there were a higher number of deaths categorised as sudden infant death syndrome (SIDS) in the most deprived postcodes.

Figure 8. Number of child deaths reviews completed by expected and unexpected death by IMD quintile, 1st April 2019 to 31st March 2021
Data source: H&W CDOP 2019-2021



Nationally there were approximately three times as many deaths for children who were resident in the most deprived neighbourhoods compared to the least deprived neighbourhoods.

Data source: NCMD 1st April 2019 to 31st March 2020

5. Sudden Infant Death Syndrome (SIDS)

- 15% of cases reviewed were categorised as SIDS.
- 55% of those infants were female and 45% were male.
- There were multiple themes or risk factors identified in almost all of the deaths reviewed.
- Smoking was the most common risk factor alongside social issues.

- Co-sleeping was also a common theme but this occurred alongside other risk factors such as adherence to safe sleep guidance, smoking and substance misuse.
- There was a higher proportion of child deaths in this category from the most deprived postcodes compared to the least deprived postcodes.

SIDS refers to the sudden and unexpected death of an infant under 12 months of age, with onset of the lethal episode apparently occurring during normal sleep, which remains unexplained after a thorough investigation including performance of a complete post-mortem examination and review of the circumstances of death and the clinical history.

Smoking during pregnancy is known to negatively impact pregnancy-related health and can include complications during childbirth, an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy.

NICE guidance strongly advises parents not to share a bed with their baby if their baby was low birth weight or if either parent:

- has had 2 or more units of alcohol
- smokes
- has taken medicine that causes drowsiness
- has used recreational drugs.

6. Perinatal Deaths

- 49% of all deaths reviewed were categorised as perinatal/neonatal deaths.
- 63% were male and 37% female.
- The most common themes identified were infection and multiple pregnancy, followed by maternal smoking and domestic abuse.
- The least common themes were poor service engagement, issues with clinical care and poor maternal physical health and mental health.
- There was a higher proportion of deaths in this category in the least deprived postcodes.

7. Modifiable Factors

Modifiable factors are defined as one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.

- H&W CDOP identified modifiable factors in 44% of deaths reviewed.
- The highest number of reviews with modifiable factors by category of death were:
  - Perinatal/neonatal event 41%.
  - Sudden unexpected, unexplained death 30%.

Modifiable factors identified in the case reviews included:

- Smoking (parent/carer) or in household.
- Unsafe sleeping arrangements (such as not adhering to safe sleep guidance, smoking and substance misuse).
- Substance/alcohol misuse (parent/carer).
- Maternal obesity during pregnancy.
- Poor communication and information sharing.
- Quality of service delivery.
- Domestic abuse.

Table1 Percentage of cases reviewed where modifiable factors were identified by category of death
Data source: H&W CDOP 2019-2021

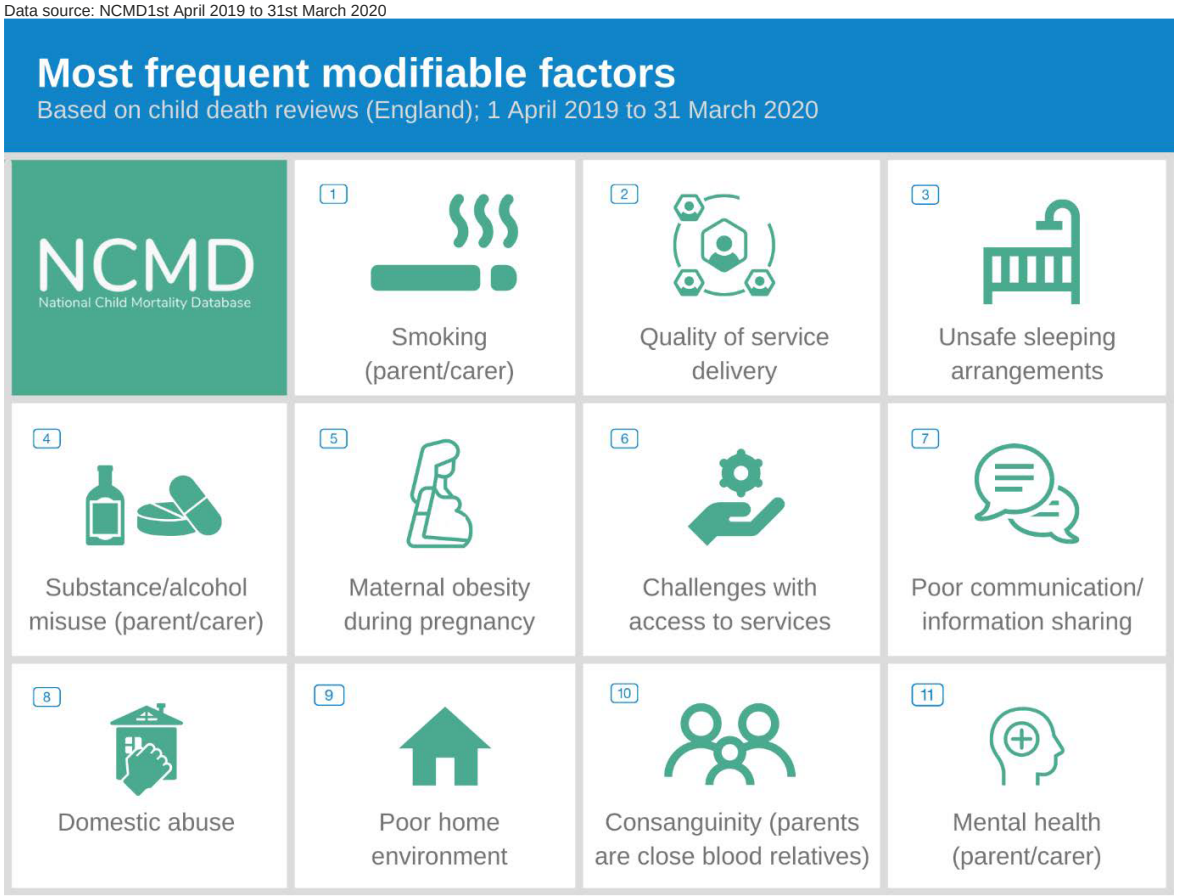
Primary Category of Death	All cases reviewed (%)	Modifiable Factors Identified (%)
Perinatal/neonatal event	**49%**	**37%**
Sudden unexpected, unexplained death	**13%**	**88%**
Chromosomal, genetic and congenital anomalies	**10%**	**0**
Suicide or deliberate self-inflicted harm	**8%**	**60%**

Table 2. Percentage of cases reviewed where modifiable factors were identified by age group
Data source: H&W CDOP 2019-2021

Age group	All cases reviewed (%)	Modifiable factors identified %
0-27 days	**57%**	**37%**
28-364 days	**21%**	**69%**
1-4 years	**5%**	**67%**
5-9 years	**2%**	**100%**
10-14 years	**3%**	**50%**
15-17 years	**12%**	**57%**

The most recent national NCMD report summarised the most frequent modifiable factors identified in child death reviews in the following graphic. H&W CDOP have begun to utilise the same descriptions.

Data source: NCMD1st April 2019 to 31st March 2020



8. Child Death Review Analysis

8.1 Thematic Review - all deaths

A H&W CDOP thematic review began in May 2021, completed by a Herefordshire Public Health Registrar. The review identified numerous themes in deaths of children resident in Herefordshire and Worcestershire, from April 2014 to March 2019 (five years), to inform the work of the panel and help identify appropriate preventive actions and interventions. The thematic review analysed all deaths and an additional analysis on sudden unexplained deaths in infancy.

The review found that most deaths over the five-year period had occurred in children who had a pre-existing medical condition, or who had some form of social or personal need, either as an individual, or within their family. The matrix below demonstrates the themes which were present in each category.

Table 3. Matrix of themes by category

Data source: Thematic Review April 2014 to March 2019

		Category							
		Prematurity	Neonatal	Sudden unexpected death in childhood	Sudden unexplained death in infancy	Suicide	Accidents	Genetic	Chronic or life-limiting conditions
Theme	Drug use								
	Alcohol use								
	Smoking								
	Mental health issues								
	Existing physical health condition*								
	Learning disability								
	Challenging family environment								
	Issues with clinical care								
	Phone/ social media use								
	Multiple factors								

Colour key:

- No cases have this theme
- Less than a third of cases have this theme
- More than a third but less than two thirds of cases have this theme
- More than two thirds of cases have this theme
- *Other than the condition the child died from

Learning points

- Interventions to reduce child deaths should be approached from a ‘life course’ perspective.
- Most of the children who died either had complex social needs, or a diagnosed physical or mental health condition.

- Safer sleep advice is being dispensed to the majority of pregnant women who engage with antenatal services but in some cases parental preference or parental lack of understanding of the advice results in safer sleep guidance not being adhered to.
- Smoking is a factor in almost every category of deaths; in premature, neonatal and infant deaths it is a direct contributor to the likelihood of death.
- Mental health issues, predominantly maternal mental health issues, are in some cases indicative of greater need, and a family that may be at higher risk of an infant death due to the association between mental health issues and smoking, substance abuse and complex family and social factors.
- The use of phones and social media were factors in two categories of unexpected deaths.

8.2 Thematic Review - Safer Sleep

Members of H&W CDOP worked alongside Herefordshire and Worcestershire CCG (H&W CCG), Herefordshire Safeguarding Children Partnership (HSCP) and Worcestershire Safeguarding Children Partnership (WSCP) to influence the 'Keep Me Safe' strategy. The strategy aims to reduce the numbers of children who die or are seriously injured across Herefordshire and Worcestershire. It also seeks to encourage and support partners in all agencies who care for or support families with babies and children to deliver clear consistent messages regarding child safety to families, including fathers and wider family members, and to their colleagues within their own organisation.

Guidance documents will be added to the strategy, as themes are identified, to inform local practice and learning. A 'Keep Me Safe… When I am Sleeping' guidance document is currently being co-produced by health professionals across Herefordshire and Worcestershire to ensure that partners in all agencies who have contact with families, infants and children feel confident to deliver the key messages about safe sleeping and these messages are led by evidence-based research. The content of the guidance documents will be led by the themes identified in the H&W CDOP annual report, NICE guidance and the thematic review learning from local Sudden Unexplained Deaths in Infancy (2014-2019) listed below.

Learning points

- Unsafe sleep practices predominantly occurred in families with complex social needs.
- Parents are not adhering to safer sleep advice because they either don't understand it or choose to go against it.
- Parental smoking was strongly implicit in deaths.
- Children with mild respiratory infections may be more at risk of death whilst unwell
- There is an association between maternal mental health issues and smoking, children being placed in unsuitable sleeping environment, drug and alcohol use.

8.3 Themed Meeting Review - Suicide

The 2018 Child Death Review Statutory and Operational Guidance suggests that '*Some child deaths may be best reviewed at a themed meeting. A themed meeting is one where CDR partners arrange for a single CDOP, or neighbouring CDOPs, to collectively review child deaths from a particular cause or group of causes. Such arrangements allow appropriate professional experts to be present at the panel to inform discussions, and/or allow easier identification of themes when the number of deaths from a particular cause is small*'. The guidance suggests suicide as a theme that might be reviewed at a regional level.

The guidance also states *'Themed panels will demand a customised approach and an experienced chair. Consideration might be given to experts attending from a neighbouring clinical network or region. Themed panels should occur within 12 months of the child's death. Designated doctors for child death should work together to decide which cases might best benefit from review at a themed panel.*'

At a meeting of the West Midlands Regional Child Death Review Network in December 2020, it was agreed to trial a regional themed review focusing on deaths by suicide. All CDOPs in the region were invited to submit cases for consideration with a view to identifying common themes across the region

and potential learning to prevent further deaths.

The themed panel met virtually on 29 April 2021. All CDOPs in the region were invited to send two representatives. The themed panel was attended by practitioners from mental health services, public health, paediatrics, education, children's safeguarding and a lay member. Three members of H&W CDOP attended.

The panel reviewed deaths of children aged less than 18 years from suicide or self-harm that had occurred across the West Midlands during 2019-2020 where a coroner's inquest had been completed. A total of nine deaths were reviewed, of which some were deaths of children in Herefordshire and Worcestershire. Two of the deaths reviewed had occurred during the COVID pandemic. Other deaths that had occurred during the pandemic could not be reviewed as inquests were awaited.

Learning points identified by the regional themed panel were:

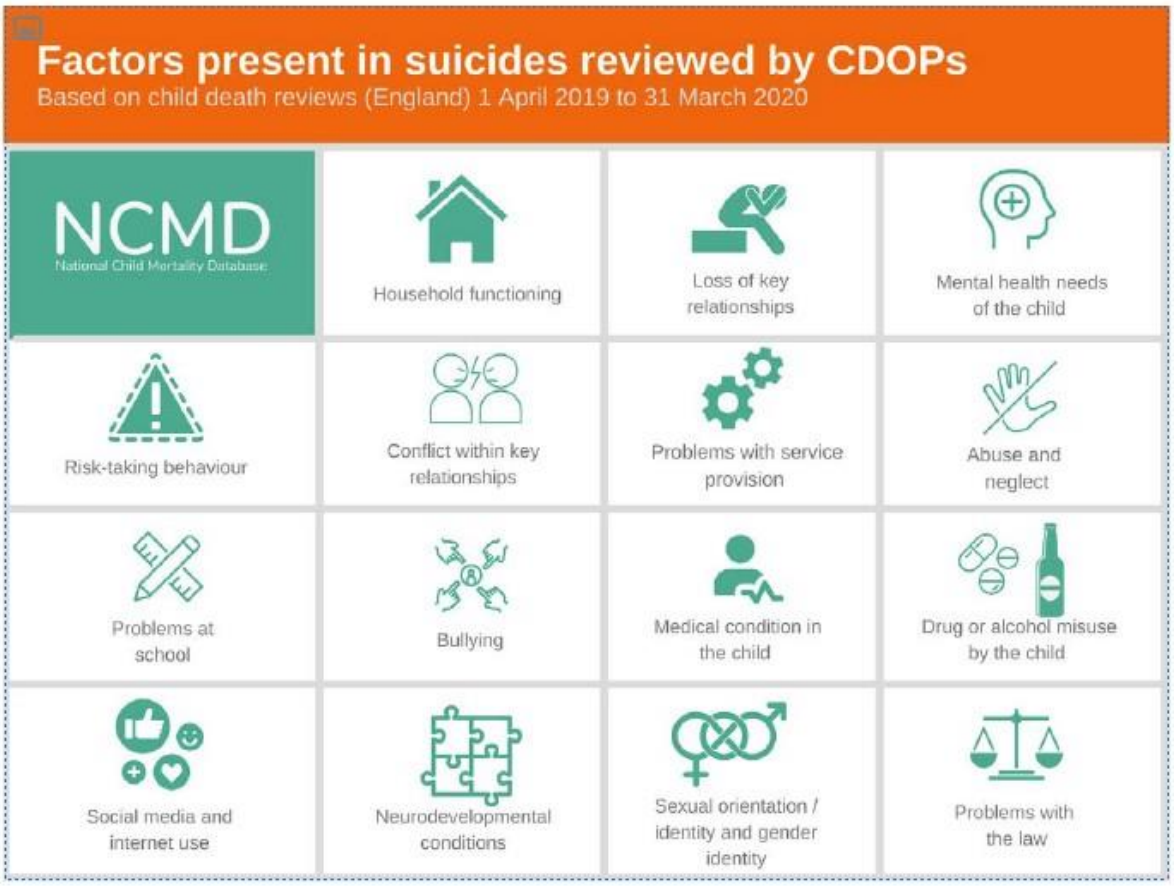
- Most of the young people whose deaths were reviewed had experienced adverse childhood experiences.
- Some appeared to be thriving at school and home while struggling with issues of self-identity and belonging. Family, friends and schools were unaware of some of the young people's turmoil.
- Several of the young people had not previously indicated any suicidal intent and their deaths were precipitated by a sudden crisis such as a relationship breakdown or argument.
- Some young people experienced difficulty in accessing and engaging with mental health services in a timely manner.
- CDOP and safeguarding reviews of suicides focus on more recent events leading up to deaths but those reviews may miss key information about children's earlier adverse experiences that may limit learning and prevention of further deaths.

The NCMD Programme published a thematic report in October 2021 which focussed on suicide in children and young people. The report aimed to identify the common characteristics of children and young people who die by suicide, investigate factors associated with these deaths and identify common themes to help inform policy makers, commissioners, those providing services to those involved in reviewing deaths of children and young people. It also aimed to contribute to the existing evidence base in this area to inform ongoing and future research into the mental health of children and young people.

Key findings from national review

- Suicide is complex, rarely caused by one thing, and suicide prevention is also complex.
- Childhood suicide is not limited to certain groups; rates of suicide were similar across all areas, and regions in England, including urban and rural environments, and across deprived and affluent neighbourhoods.
- Suicides were more common in older groups, with 78% of the deaths in those aged between 15 and 17 years.
- Suicides were more common in boys
- 79% of deaths were children or young people described as being from a white ethnic background.
- 61% of the likely suicides occurred within the home, 29% occurred in a public place and 12% occurred in another location.
- 9% of children or young people were reported to be ambitious, high achieving and successful but a specific adverse event e.g., test failure, argument with a parent, appeared to trigger the crisis prior to their death.
- Over one third of children and young people had never been in contact with mental health services and a third of children and young people were in current contact with mental health services.
- At least 62% of children or young people had suffered a significant personal loss in their life prior to their death, such as bereavement, loss of friendships and routine due to moving home or school or other close relationship breakdown.

Data source: NCMD Suicide in Children and Young People October 2021



9. Recommendations

The following recommendations have been identified from national and local learning to improve outcomes and reduce future child deaths.

1. H&W CDOP recognises that the timescales for completion of child death reviews could be improved to bring in line with national guidance. It is recommended that CDOPs should aim to review all children's deaths within six weeks of receiving the report from the CDRM.
   - Recommend CDOP review the number of cases discussed at each Panel meeting.

   Responsibility for action: **Herefordshire and Worcestershire Child Death Overview Panel**

2. The local thematic analysis identified inconsistencies in safer sleep guidance and the delivery of advice and guidance.
   - Recommend the Herefordshire and Worcestershire Safeguarding Children Partnerships implement the refreshed safe sleeping guidance and delivery of the 'Keep Me Safe' strategy to all relevant agencies.

   Responsibility for action: Safeguarding Partnerships

3. The local thematic analysis identified a high prevalence of maternal smoking associated with deaths.
   - Recommend there is a renewed focus on reducing smoking during pregnancy and ensuring smoke free homes to support mothers postnatally.

   Responsibility for action: Herefordshire and Worcestershire Local Maternity and Neonatal System

4. The local thematic analysis identified maternal obesity in pregnancy as a theme which can contribute to complications and premature births.
   - Recommend that tackling maternal obesity becomes a key priority.

   Responsibility for action: Public Health across Herefordshire and Worcestershire and the Herefordshire and Worcestershire Local Maternity and Neonatal System

5. It was identified from child death reviews there was a need for school and college mental health provision to be strengthened for children, young people and staff to support emotional health and wellbeing.
   - Recommend the strengthening and expansion of programmes and interventions in educational settings for children and young people and staff to support emotional health & wellbeing.

   Responsibility for action: Herefordshire and Worcestershire Mental Health Collaborative

6. The key findings from a national suicide in children and young people report identified there is a need to improve awareness of the impact a significant personal loss such as bereavement, loss of friendships and routine due to moving home or school or other close relationship breakdown.
   - Recommend improving the information and advice available to parents/carers, primary care and community services about identifying the early warning signs of vulnerability and support for children and young people. Including how to identify networks of trusted adults at home, in school and in the community who they might talk to in the event of concerns about themselves or any of their peers

   Responsibility for action: Herefordshire and Worcestershire Mental Health Collaborative

7. Local thematic analysis identified there was a need to improve awareness across the children's workforce of children who may have mental health needs that are masked by high academic performance and achievement so that those needs are identified and addressed effectively.
   - Recommend an audit of educational providers on provision of mental health training and how this informs their awareness.

   Responsibility for action: Herefordshire and Worcestershire Mental Health Collaborative

8. The key findings from the national suicide in children and young people report identified a need for improved support for children and young people in crisis.
   - Recommend improved promotion of mental health crisis services and how to access them for children, young people, parents/carers and frontline practitioners working with them.

   Responsibility for action: Herefordshire and Worcestershire Mental Health Collaborative

9. Local thematic analysis identified that a challenging family environment where complex social factors are present may indicate that there is higher risk of an infant death.
   - Recommend training for frontline practitioners so they are supported to initiate difficult conversations with parents or carers.

   Responsibility for action: Safeguarding Partnerships

10. Appendices

Appendix A: CDOP Thematic Review

CDOP thematic review 2014-2018 – summary

Introduction and purpose of review

The Child Death Overview Panel (CDOP) discusses all deaths of children under the age of eighteen years in Herefordshire and Worcestershire, with the intention of reaching a consensus on category of death and modifiable factors, and to identify learning points from the deaths to inform future preventative activity.
This review was conducted to identify common themes in deaths of children resident in Herefordshire and Worcestershire, from April 2014 to March 2019 (five years). The intention is that the findings of this review can be used to inform areas of focus for future interventions to reduce child and adolescent deaths in Herefordshire and Worcestershire.

Method

Notification forms, CDOP analysis forms and CDOP meeting minutes from both Herefordshire and Worcestershire were used to identify cases and relevant information surrounding the cases' death. Information was not uniformly available; the level of detail varied between cases, and in some cases (particularly those of expected deaths in Worcestershire between 2015 – 2017), there was very little detail available on the circumstances surrounding the death, aside from basic demographics and category of death. In these cases, attempts to identify missing information was made by reviewing Perinatal Subgroup data, which provided further information on a number of deaths.

Deaths were organised into relevant categories, and then themes within each category were identified through an iterative process of identification and coding. In some categories, such as sudden unexplained deaths in infancy, and suicide, the themes were organised into broad groups due to the larger number and detail of the themes in these categories.

Demographics were taken from notification forms. Postcodes were used to identify Index of Multiple Deprivation (IMD) quintile.[1] This identifies the IMD quintile of a particular postcode and therefore is not household-specific, but can give an indication of the socioeconomic status of the area the child is brought up in. IMD quintile 1 is the least deprived.

Results

224 deaths were reviewed, with information available for 212 deaths. Sixty-two deaths occurred in Herefordshire residents. 162 deaths occurred in Worcestershire residents. The matrix demonstrates the themes which were present in each category.

Conclusion and learning points

This report examined the deaths of 212 children over the period of the 2014-2018 financial years. The majority of deaths were within the premature deaths category. Although there are themes specific to each category, it is clear that there are overarching themes, such as mental health issues and challenging family environments, which are present in every category. Even if in some categories these factors do not have a direct impact on the child's death, they are indicative of the environment the child is raised in, and the level of support and supervision they receive from parents.
In certain categories, social factors in either the child or their parents is a directly attributable factor in the child's death, for example, parental smoking in unexpected infant deaths. This provides further evidence for local action to target these lifestyle behaviours. A clear finding from this report is that the majority of child deaths occur in children who are known to have (or have in retrospect), increased needs, whether that be due to physical or mental health conditions, learning disability, or social needs.

Learning points:

- Interventions to reduce child deaths should be approached from a 'life course' perspective; commencing with improving maternal lifestyle in pregnancy (reducing BMI, assisting in stopping smoking and consuming alcohol), and continuing throughout the child's life with increased recognition of those children who have risk factors for dying at a young age (mental health issues, risky behaviours, parents known to police or other services).

[1] IMD tool, Nuffield Department of Population Health. Available from: https://tools.npeu.ox.ac.uk/imd/

- The majority of deaths are not occurring in well children from a stable family. The majority of the children who died either had complex social needs, or a diagnosed physical or mental health condition (or both). Children with these factors should be identified as higher risk.
- Safer sleep advice is being dispensed to the majority of pregnant women who engage with antenatal services. In some cases, parental preference, or parental lack of understanding of the advice results in safer sleep guidance not being adhered to. Parents need to understand that co-sleeping applies to any situation where the child is sleeping in close proximity to the parent; this includes sofas.
- Smoking is a factor in almost every category of deaths; in premature, neonatal and infant deaths it is a direct contributor to the likelihood of death. In suicides, accidents, and deaths of older children, it contributes to overall poor-health of the child, and is often accompanied by alcohol use, substance misuse and wider risk-taking behaviour.
- Mental health issues (predominantly maternal mental health issues) are in some cases indicative of greater need, and a family that may be at higher risk of an infant death due to the association between mental health issues and smoking, substance abuse and complex family and social factors.
- The use of phones and social media were factors in two categories of deaths; accidents, where the adolescent was distracted by their phone at the time of death, and suicides, where the adolescent accessed inappropriate or suicidal content. Both schools and families have a role in monitoring social media use and supporting children and adolescents to use the internet safely and productively.
- Relevant CDOP recommendations should be embedded in regular clinical and non-clinical frontline staff training to ensure learning from CDOP continues to be disseminated widely.

Appendix B: Herefordshire and Worcestershire Child Death Overview Panel Membership

NAME	AGENCY / Contact Info
Liz Altay	Public Health Consultant, Worcestershire
Adrian Over	Independent Chair
Polly Lowe	H&W CDOP Co-ordinator
Jenny Edmunds	Designated Doctor for Child Death, Worcestershire
Julia Greer	SUDIC Coordinator, Worcestershire
Prakash Kalambettu	Consultant Paediatrician, Worcestershire
Tamar Thompson	CCG's LAY Representative
Julia Taylor	Detective Inspector, Herefordshire
Justin Taylor	Detective Inspector, North Worcestershire
Gareth Lougher	Detective Inspector, South Worcestershire
Simon Meyrick	Designated Doctor for Child Death, Herefordshire
Hayley Doyle	Area Safeguarding Officer, Children's Services, Worcestershire
WMAS	West Midland Ambulance Service
Amy Hanson	MASH Team Manager, Children's Services, Herefordshire

Susan Smith	Quality Governance Manager (Midwifery), Worcestershire
Jez Newell	Deputy Designated Nurse, Adult Safeguarding Lead, NHS Herefordshire and Worcestershire CCG
Sarah Dempsey	Deputy Designated Safeguarding Nurse, NHS Herefordshire and Worcestershire CCG
Rebecca Pickup	Public Health Consultant, Herefordshire
Maria White	Assistant Director, Children's Services, Worcestershire
Jen Rogers	Case Progression Officer, Children's Services, Worcestershire