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HEALTH AND WELL-BEING BOARD
15 FEBRUARY 2022

ANNUAL REPORT OF THE HEREFORDSHIRE AND WORCESTERSHIRE CHILD DEATH OVERVIEW PANEL

Board Sponsor
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Adrian Over, Herefordshire and Worcestershire Child Death Overview Panel Independent Chair

Priorities	
Mental health & well-being	Yes
Being Active	Yes
Reducing harm from Alcohol	Yes

Safeguarding	
Impact on Safeguarding Children	Yes
Impact on Safeguarding Adults	No

Item for Decision, Consideration or Information
Consideration

Recommendation

1. **The Health and Well-being Board is asked to:**

   a) **note the new arrangements for the statutory revised child death review process and Child Death Overview Panel for Herefordshire and Worcestershire;**
   b) **receive the first annual report of the Panel noting the numbers and patterns of child deaths reviewed and the thematic learning to prevent future deaths; and**
   c) **support the recommendations of the panel, and to ask the Children and Young People's Strategic Partnership to progress the actions identified.**

Background

2. The death of a child is a devastating loss that profoundly affects all those involved. Since 2008, there has been a statutory requirement for a Child Death Overview Panel (CDOP). The Children and Social Work Act (2017) introduced changes to improve and gain consistency to local child death review processes and

the experience of bereaved families. Responsibility moved from Safeguarding Boards to Local Authorities and Clinical Commissioning Groups as Child Death Review (CDR) Partners to take joint ownership of child deaths within their area. Changes were made to the review mechanism and family support functions. CDR partners are expected to review 60 cases annually and for thematic analysis to be undertaken.

3. The Herefordshire and Worcestershire local authority areas have been combined to undertake child death reviews and a new Herefordshire and Worcestershire CDOP established in September 2019. The CDR partners are Herefordshire Council (Public Health), Worcestershire County Council (Public Health) and the NHS Herefordshire and Worcestershire Clinical Commissioning Group.

4. The CDR partners must arrange to review every death of a child aged 0-17 years normally resident in the area and give bereaved families a named key worker for information on the processes and who can signpost them to support. A multi-professional Child Death Review Meeting must be held, attended by professionals involved in the care of the child during life and any involved in the investigation after death. All deaths are then reviewed at an independent multi-agency CDOP, who have not been involved with the child's care, in order to learn lessons and share any findings for the prevention of future deaths. The CDOP should be chaired by someone independent of key providers in the area. The CDOP records the outcomes of their independent reviews on a standardised Final Analysis Form which is submitted to a National Child Mortality Database. The CDOP is required to produce an annual report for CDR partners on local patterns and trends and any lessons learnt.

5. This is the first report of the new two county CDOP which covers the two-year period from April 2019 to March 2021. During this period the CDR partners have reviewed, aligned and embedded the new required child death review processes across both counties. The CDOP continued to review cases during Covid-19 pandemic and responded to the requirements of enhanced notification.

Patterns, Modifiable Factors and Themes

6. There were 103 child death notifications during the two-year period. 27 from Herefordshire, 76 from Worcestershire. Of these notifications 67% were expected deaths and 33% unexpected (not expected 24 hours previously). The number each year were not significantly different than in previous years.

7. The CDOP reviewed 61 deaths during the two-year period. Of the cases reviewed, 49% had a primary category of perinatal/neonatal event; 15% sudden unexpected or unexplained death and 10% had a primary category of chromosomal, genetic and congenital anomalies.

8. Modifiable factors (one or more factors) which may have contributed to the death were identified in 44% of deaths reviewed. The most frequent modifiable factors identified were smoking, unsafe sleeping arrangements, substance/alcohol misuse, maternal obesity, poor communication and information sharing, quality of service delivery and domestic abuse.

9. A thematic analysis was completed for all deaths reviewed in the two counties during the previous five years to inform the work of the panel. This identified that most of the children who died either had complex social needs, or a diagnosed physical or mental health condition. Smoking was a factor across all categories of death. Mental health (predominantly maternal mental health) and complex family or social factors were evident in sudden infant deaths and suicides.

Recommendations

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

1. Herefordshire and Worcestershire 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 Child Death Review Meeting.
- Recommend CDOP review the number of cases discussed at each Panel meeting.
Responsibility for action: **Herefordshire and Worcestershire CDOP**

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 and 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

11. This is the first CDOP report presented to the CDR partners and the Health and Well-being Board. A variety of recommendations are presented for different boards and associated agencies. CDOP suggests the appropriate next step is for the recommendations to be considered and progressed by the Worcestershire Children and Young Peoples Strategic Partnership.

Legal, Financial and HR Implications

1. Legal, funding and HR implications would be considered as the various recommendations detailed within this report are progressed.

Privacy Impact Assessment

There is no required privacy impact assessment at this stage

Equality and Diversity Implications

An Equality Relevance Screening has been completed in respect of these recommendations. The screening did not identify any potential Equality considerations requiring further consideration during implementation.

Contact Points

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Specific Contact Points for this report
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Supporting Information

- Herefordshire and Worcestershire Child Death Overview Panel Annual Report 01 April 2019 to 31st March 2021 (Available online)

Background Papers

In the opinion of the proper officer (in this case the Director of Public Health) there are no background papers relating to the subject matter of this report.