Herefordshire and Worcestershire Child Death Overview Panel

Annual Report

1st April 2021 to 31st March 2022

worcestershire
county council

Contents

1. Foreword 3

2. Introduction 4

3. Data Analysis 6

3.1 Child Death Notifications in Herefordshire and Worcestershire 2021-2022 6

3.2 Child Death Notifications in Herefordshire 2021-2022 6

3.3 Child Death Notifications in Worcestershire 2019-2021 6

3.4 Cases Reviewed by Herefordshire and Worcestershire Child Death Overview Panel 7

4. Cause of Death 9

5. Health inequality 11

6. Modifiable Factors 13

7. Achievements 14

8. Priorities 17

9. Appendices 18

Acknowledgements 21

1. Foreword

I am very pleased to introduce the annual report for the joint H&W CDOP for the period 1st April 2021 to 31st March 2022.

Last year's report reflected themes and developments in both counties leading up to and following the establishment of the new joint panel in late 2019. This is therefore the first report that specifically focuses on completed activity in the review of children's deaths for a single year and provides information for Child Death Review (CDR) partners on local patterns and trends in the deaths of children, lessons learned and modifiable actions identified.

In reflecting on my foreword to last year's report, some of my comments then - when the world was in the midst of the COVID-19 pandemic - are just as pertinent now:

- The death of a child is always tragic. It is essential that in seeking to identify factors that, if modified, might have prevented a child's death or might prevent future deaths, we never lose sight of that or the life-changing impact of losing a child on parents, siblings, extended families and friends.
- Working remotely seems to have become routine and I am still to meet many of my CDOP colleagues in person. Nonetheless, an excellent group of professionals from across the CDR partnership demonstrate a high level of ongoing commitment to meeting remotely and ensuring that a thorough analysis of the CDR process is undertaken in respect of the death of every child normally resident in Herefordshire or Worcestershire.

The findings of the report speak for themselves. Although the number of deaths reviewed is relatively low, modifiable factors were identified in 57% of deaths reviewed. That is significant for two reasons:

- The identification of those factors underlines the importance of CDOP's work
- Thorough analysis of 43% of the deaths reviewed led to a conclusion that nothing whatsoever could have been done to prevent the deaths of those children. In looking for lessons, themes and trends, we have to recognise that the deaths of some children are utterly unpreventable but no less tragic for that.

I should like to thank all members of the wider CDR process for their hard work and commitment in notifying CDOP when a child dies; convening and attending child death review meetings; and completing and submitting analysis forms. Huge thanks also to all members of CDOP for their diligent attendance and participation in panel meetings. Analysing the deaths of children is an emotionally as well as intellectually demanding task, which should never be underestimated.

In thanking everybody, I feel as chair that it is particularly important to acknowledge the wonderful contribution of our designated doctors in preparing and presenting case information for analysis. CDOP benefits enormously from their dedication, diligence and expertise.

Finally, my special thanks to CDOP Co-ordinator Polly Lowe for her tireless efforts in co-ordinating the panel's work, standardising the CDR process across the two counties and chasing up information and responses to identified actions; to Jayne Williams for her patient and consistent work in providing administrative support to the panel; and to Hayley Durnall and Polly for all their work in writing this report.

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.

Herefordshire & Worcestershire Child Death Overview Panel (H&W CDOP) operates as a combined CDOP. In the counties of Herefordshire and Worcestershire (H&W) the current child death review (CDR) partners are:

- Herefordshire Council (Public Health)
- Worcestershire County Council (Public Health)
- NHS Herefordshire and Worcestershire

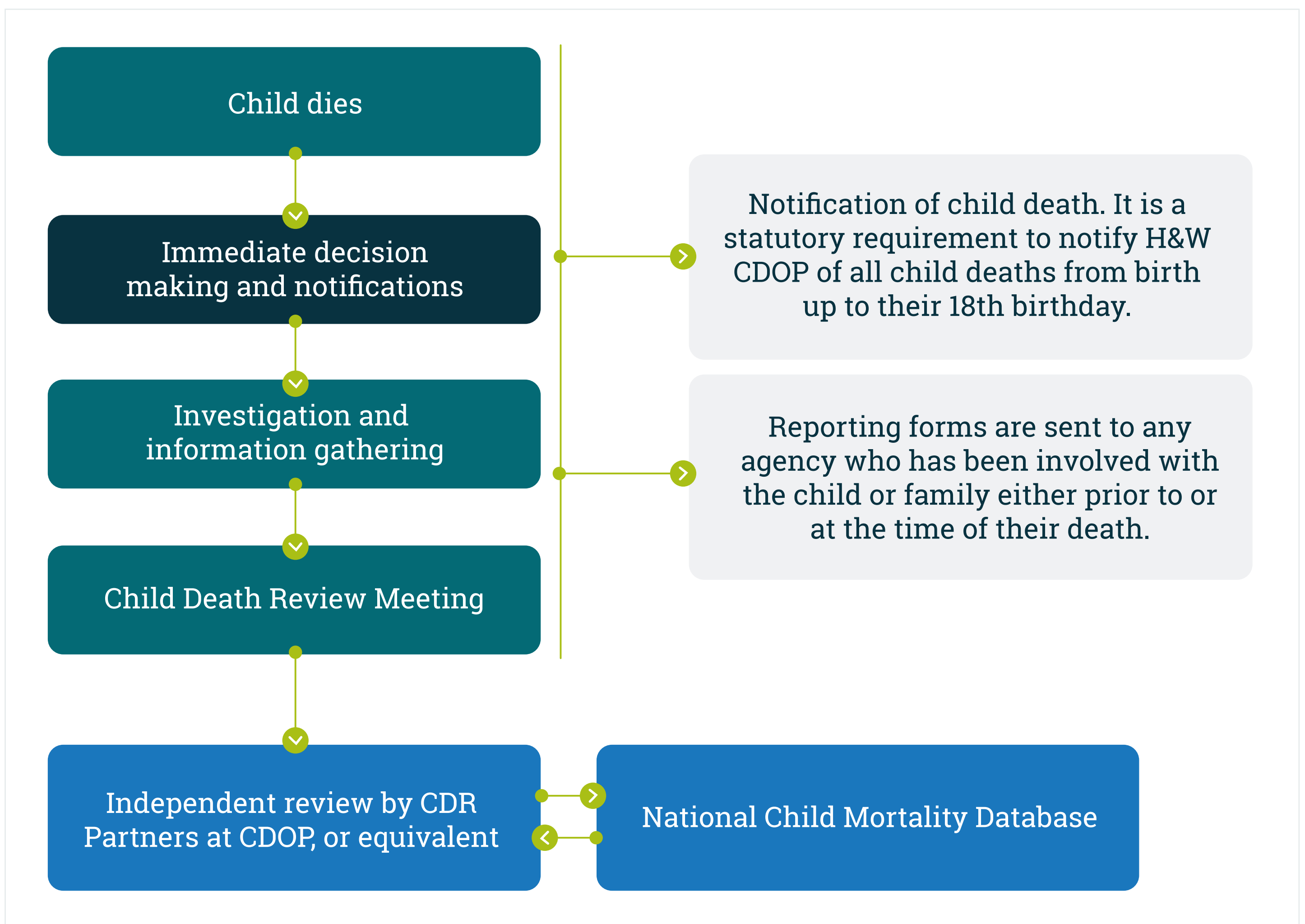
H&W CDOP is an independent multi-agency panel whose role is to carry out an anonymised secondary review of each child's death to learn lessons and share any findings for the prevention of future deaths. One of the responsibilities of H&W CDOP is to produce an annual report on behalf of the statutory partners, which is reported to both Herefordshire and Worcestershire's Health and Wellbeing Boards and the Integrated Care Board. The report may also be shared, as appropriate, with other key strategic partnerships. The report provides an overview of all completed child death reviews, highlighting the most frequent modifiable factors. Analysing the data by varying categories often results in very small numbers. Therefore, data has been summarised in proportions throughout this report to prevent an individual child being able to be identified from the analysis.

Overview of CDOP Process

There is a statutory obligation to notify a child death to Child Death Overview Panel (CDOP) However, CDOP reviews are not always completed in the same year as the notification of death. 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. 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.

Before the death of a child can be reveiwed at CDOP it must be reviewed by the Child Death Review Meeting (CDRM) process. The Child Death Review Meeting CDRM is a multi-professional meeting where all matters relating to an individual child's death are discussed. A Joint Agency Response is triggered if a child dies unexpectedly and is reviewed using SUDIC (Sudden Unexpected Death in Infants and Children) guidelines. These guidelines ensure that all unexpected child deaths are reviewed in detail to identify any learning or actions that should be taken to improve the safety or welfare of children or the child death review process. An initial CDRM is usually held within 14 days of the child's death to ensure that the correct information surrounding the circumstances of the death is collected and that family members and others who were close to the child are being appropriately supported. A final CDRM will be held once any investigations have concluded and any reports from key agencies and professionals have been received.

There is a statutory requirement that all child deaths are independently reviewed so following the CDRM each case will then be taken to H&W CDOP. The Panel will make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children.



About Herefordshire and Worcestershire

Herefordshire and Worcestershire are two separate counties located in the West Midlands in the heart of England towards the south and southwest of the West Midlands Region. The two counties border Shropshire, Staffordshire, the West Midlands Metropolitan Area, Warwickshire, Gloucestershire and Wales to the west. The two main administrative cities are Worcester City in Worcestershire and Hereford in Herefordshire. Worcestershire consists of 6 districts, namely Bromsgrove, Malvern Hills, Redditch, Worcester City, Wychavon and Wyre Forest

In terms of population, almost 791,000 people live across the two counties. Worcestershire had approximately 604,000 people resident and Herefordshire had a little over 187,000 as at the 2021 census. The overall population in Worcestershire has increased by 6.6% since 2011 which is a similar rate to England. However, Herefordshire has had a slower rate of growth at only 2%.

By area, both counties are largely rural with almost 85% of Worcestershire and 95% of Herefordshire classified as rural areas. However, almost three quarters of the population of Worcestershire and almost half of the population of Herefordshire is defined as living in urban areas.

Despite being seen as relatively affluent counties, 5% of Worcestershire and 1% of Herefordshire's population live in areas which are amongst the 10% most deprived in England. Approximately 9% of children aged under 18 years in Herefordshire and nearly 17% in Worcestershire are living in income deprived households in areas which are classed as amongst the poorest 20% in England.

The 0-4 population in the two counties has decreased since 2011, by 5% in Worcestershire and 13% in Herefordshire. Comparatively, the figure was a 7% decrease in England as a whole. At a district level Redditch has a notably higher proportion of children than is seen nationally.

3. Data Analysis

Child Death Notifications

It is a statutory requirement to notify the relevant CDOP of all child deaths from birth up to their 18th birthday. H&W CDOP now use the below link for notifications of child deaths:
www.ecdop.co.uk/WestMercia/Live/public

3.1 Child Death Notifications in Herefordshire and Worcestershire 2021-2022

- Between 1st April 2021 and 31st March 2022, a total of **43 child death notifications** were received for Herefordshire and Worcestershire resident children.
- **49%** of notifications were male and **51%** were female.
- **67%** of the deaths were expected and **33%** were unexpected

3.2 Child Death Notifications in Herefordshire 2021-2022

- Between 1st April 2021 and 31st March 2022, a total of **9 child death notifications** were received for Herefordshire resident children.
- **67%** of notifications were male and **33%** were female.
- **56%** of the deaths were expected and **44%** were unexpected.

3.3 Child Death Notifications in Worcestershire 2021-2022

- Between 1st April 2021 and 31st March 2022, a total of **34 child death notifications** were received for Worcestershire resident children.
- **45%** of notifications were male and **56%** were female.
- **71%** of the deaths were expected and **29% were** unexpected.

Figure 1. Number of child death notifications received by year of notification and area of residence
Data source H&W CDOP 2021-2022

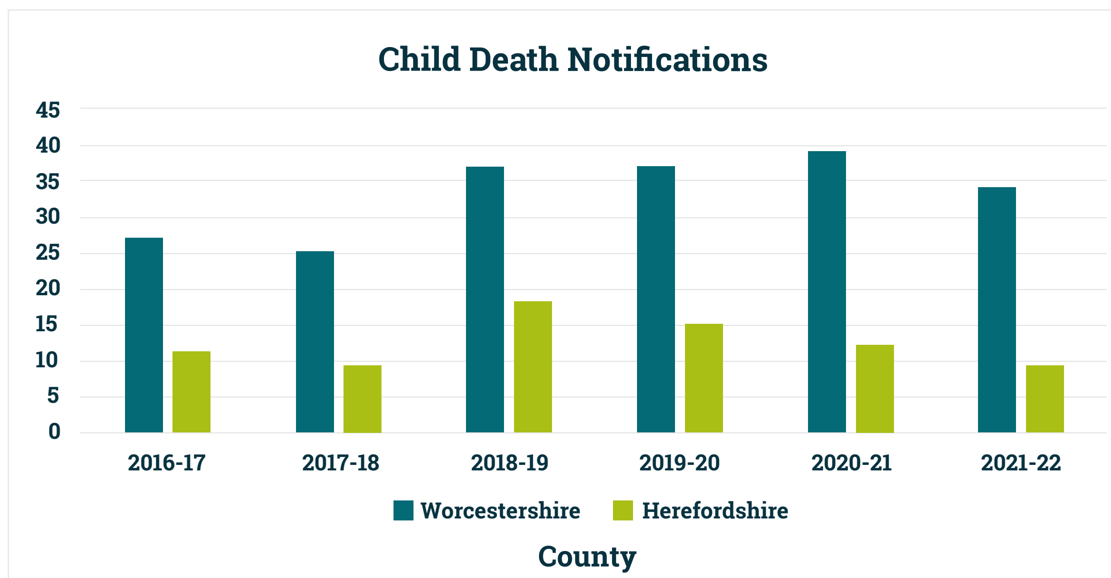
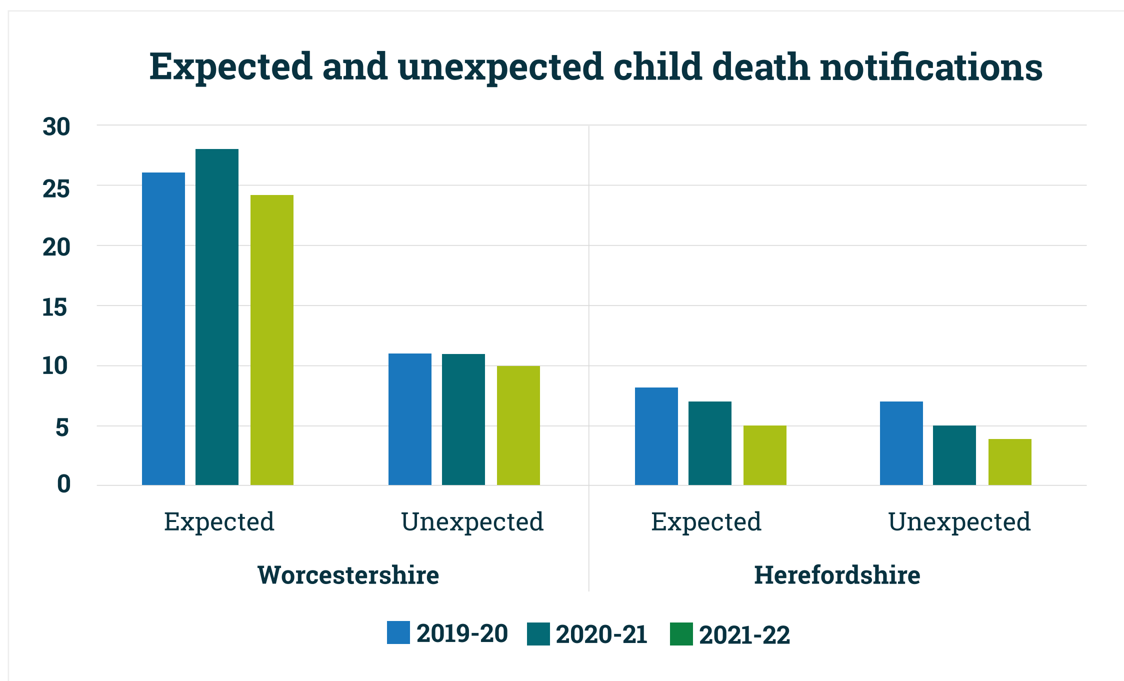


Figure 2. Number of child death notifications received by expected and unexpected death by year of notification and area of residence. Data source H&W CDOP 2021-2022



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). Due to the small numbers of unexpected and expected deaths from each county it is difficult to comment on trends. However, both counties show a small reduction in expected and unexpected deaths in 2021-22.

3.4 Cases Reviewed by Herefordshire and Worcestershire Child Death Overview Panel

- Between 1st April 2021 and 31st March 2022, a total of **28** cases were reviewed by H&W CDOP.
- **57%** of cases reviewed were expected and **43%** were unexpected.
- **44%** of expected deaths were female and **56%** male.
- **58%** of unexpected deaths were female and **42%** male.

Figure 3. Number of child death reviews by area of residence.
Data source H&W CDOP 2021-2022

Figure 3 demostrates that of the 28 cases reviewed at H&W CDOP the majority during 2021-2022 were deaths of children from the Worcestershire area.

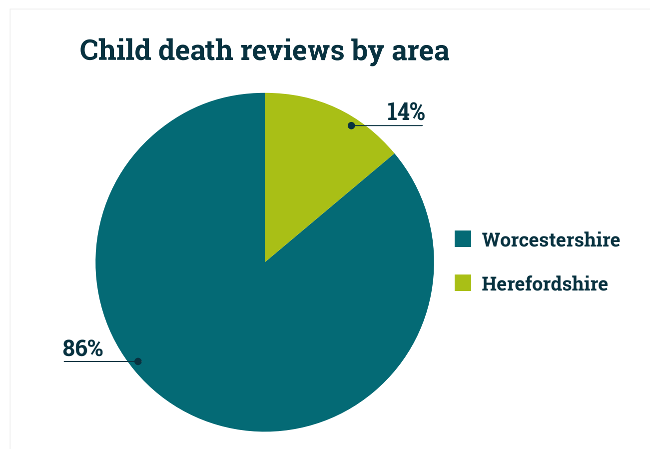


Table 1. Average number of months between CDRM and CDOP by expected and unexpected death
Data source: H&W CDOP 2021-2022

Average number of months between Child Death Review Meeting and H&W CDOP	All deaths reviewed	Expected	Unexpected
<3 months	50%	68%	25%
3-6 months	25%	13%	42%
6-12 months	21%	19%	25%
>12 months	4%	0%	8%

Table 1 shows that the majority of deaths are reviewed at CDOP within 3 months of the final CDRM. However, a larger proportion of expected deaths than unexpected deaths are reviewed within 3 months. The majority of unexpected deaths are reviewed between 3 and 6 months. This data highlights that generally unexpected deaths may take longer to be reviewed at CDOP.

4. Cause of Death

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. Further details can be found in Appendix A

Category	Name & description of category
1	**Deliberately inflicted injury, abuse or neglect**
2	**Suicide or deliberate self-inflicted harm**
3	**Trauma and other external factors, including medical/surgical complications/error**
4	**Malignancy**
5	**Acute medical or surgical condition**
6	**Chronic medical condition**
7	**Chromosomal, genetic and congenital anomalies**
8 (i) (ii) (iii) (iv)	**Perinatal/neonatal event** Immaturity/Prematurity related Perinatal Asphyxia (HIE and/or multi-organ failure) Perinatally acquired infection Other (please specify)
9	**Infection**
10	**Sudden unexpected, unexplained death**

- **39%** of cases reviewed had a primary category of perinatal/neonatal event.
- **21%** of cases reviewed had a primary category of chromosomal, genetic and congenital anomalies
- **11%** of cases reviewed had a primary category of acute medical or surgical condition
- **11%** of cases reviewed had a primary category of suicide or deliberate self-inflicted harm
- **7%** of cases reviewed had a primary category of sudden unexpected, unexplained death.
- All deaths in categories 2-5 were above the age of 1 year.
- All deaths in categories 7, 8 and 10 were under 1 year.

In England a primary category of Perinatal / Neonatal event was recorded for the largest proportion of deaths (34%). 23% recorded a primary category of Chromosomal, genetic and congenital anomalies and (7%) of deaths reviewed were categorised as Sudden unexpected and unexplained.

Data source: NCMD 1st April 2021 to 31st March 2022

The proportions of death by cause are broadly similar in Herefordshire and Worcestershire to those of England. Although, perinatal/neonatal events are higher, it must be considered that the number of deaths is very small. The 39% represents 11 cases reviewed by H&W CDOP. 10 of these cases were immaturity/prematurity related. Hence, the focus on prematurity in this report's priorities.

Gender

- **50%** of cases reviewed were male and **50%** female.
- There is no significant difference between males and female deaths or for 15-17 age group. However, the number of deaths is very small.

In England the death rate for males remained higher than that of females across all age groups. The largest difference in death rate between males and females can be seen in the 15-17 years age group.
Data source: NCMD 1st April 2021 to 31st March 2022

Age

- **35%** of the deaths reviewed were under 1 day old.
- **61%** of the deaths reviewed were under 1 month old.
- **68%** of the deaths reviewed were under 1 year old.
- There were no deaths reviewed for children between 1-4 years old.
- **7%** of the deaths reviewed were between 5-9 years old.
- **4%** of the deaths reviewed were between 10-14 years old.
- **21%** of the deaths reviewed were between 15-17 years old.

A large proportion of deaths reviewed were in the first month of life. 11% of the cases reviewed were assigned a category of suicide and these involved older teenagers between the age of 15 and 17 years.

In England, suicides were more common in older groups. The proportion of deaths due to suicide is higher in children between the ages of 15 and 17 compared to children aged 14 and below.

The NCMD has continued to monitor suicides of children and young people throughout the pandemic using a real-time surveillance system and has found no consistent evidence that suicide deaths in children and young people increased during the COVID-19 pandemic overall. While there were initial concerns that rates may have increased during the first UK lockdown, this was not statistically significant and baseline numbers remained low.

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.
Data source: NCMD Suicide in Children and Young People 1st April 2019 to 31st March 2020

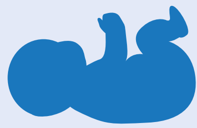
Ethnicity

- **82%** of the deaths reviewed were White British
- **10%** of the deaths reviewed were White Mixed
- **4%** of the deaths reviewed were White Other
- **4%** of the deaths reviewed were Pakistani

This reflects that Herefordshire and Worcestershire have a lower proportion of ethnic minority populations compared to England.

In England, where ethnicity was recorded, 64% were of children from a White ethnic group, 18% were from an Asian or Asian British background, 8% were from a Black or Black British background, 7% were from a Mixed background and 3% were from any other ethnic group.
Data source: NCMD 1st April 2021 to 31st March 2022

5. Health inequality



Birth rate

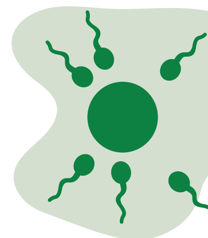
Birth rate has **decreased** in recent years, both nationally and in Herefordshire and Worcestershire.

Smoking in Pregnancy

Herefordshire and Worcestershire has a **higher** percentage than England but it has **decreased** in recent years. There is an association between deprivation smoking in pregnancy.

Maternal Obesity

Mothers living in the most deprived quintile are **more likely** to be obese than mothers living in the least deprived quintile.



Teenage Conceptions

In both counties the rate has been consistently **falling** and is **lower** than England.

Breast Feeding

Percentage of mothers initiating has **increased** over the last 18 months, with a similar percentage to England continuing to breastfeed at 6-8 weeks.

Premature Birth Rate

Premature Birth rate in Herefordshire & Worcestershire is significantly **higher** than that of England.

Infant Mortality

Infant Mortality Rate has **increased** in 2020 in both counties.

Low Birthweight

High percentage of low birthweight births in both counties due to preterm births.

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.

- Due to the small number of deaths reviewed by H&W CDOP in 2021-22, the data does not reflect a linear relationship with deprivation.
- The most deprived quintile of the population had the highest number of deaths overall and the highest number of expected deaths.
- No reviewed deaths in children under 1 were from the least deprived quintile.
- Although small numbers make it difficult to draw conclusions from the deprivation data, 90% of reviewed deaths due to prematurity are from quintiles 1-3.

The child death rate of children resident in the most deprived neighbourhoods in England was more than twice that of children resident in the least deprived neighbourhoods.

Data source: NCMD 1st April 2021 to 31st March 2022

6. 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 57% of the cases reviewed.
- The category of death where the highest proportion of deaths identified modifiable factors was sudden unexpected, unexplained death, followed by perinatal/neonatal event.
- The most commonly identified modifiable factors were smoking, which was identified in 8 of the 28 cases reviewed, and quality of neonatal care, which was identified in 7 of the 28 cases reviewed.
- Despite the number of modifiable factors in deaths due to suicide or deliberate self-inflicted harm being high, there were no common themes in modifiable factors between the deaths.
- Although prematurity is not considered a modifiable factor it was identified as a factor in 36% of reviewed cases.

Table 2. Percentage of cases reviewed where modifiable factors were identified by category of death.

Data source: H&W CDOP 2021-2022

Primary Category of Death	Proportion of all reviewed cases (%)	Proportion of cases by category of death where modifiable factors were identified (%)
Perinatal/neonatal event	39%	82%
Chromosomal, genetic and congenital anomalies	21%	33%
Acute medical or surgical condition	11%	67%
Suicide or deliberate self-inflicted harm	11%	67%
Sudden unexpected, unexplained death	7%	100%

In England deaths categorised as perinatal/neonatal have the highest number of reviews that identified modifiable factors.

Data source: NCMD 1st April 2021 to 31st March 2022

7. Achievements

The previous H&W CDOP Annual Report made a number of recommendations to itself and various Partnerships/Boards and systems across Herefordshire and Worcestershire. All of the recommendations have been implemented. Achievements are highlighted in the table below:

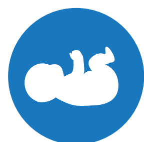
Recommendation		Responsibility for action	Agency Update
1	CDOP review the number of cases discussed at each Panel meeting.	Herefordshire and Worcestershire Child Death Overview Panel	In order to maximise the number of cases that can be reviewed at Child Death Overview Panels, H&W CDOP have extended the time allowed for each panel and have, when necessary, included additional panels to review additional cases.
2	Herefordshire and Worcestershire Safeguarding Children Partnerships implement the refreshed safe sleeping guidance and delivery of the 'Keep Me Safe' strategy to all relevant agencies.	Safeguarding Partnership	■ The 'Keep Me Safe when I'm Sleeping' guidance has now been completed. This provides consistent advice and messaging for all practitioners working with families with babies using references primarily from the Lullaby Trust. It covers all key risk factors such as sleeping position, bed sharing, smoking and when living arrangements change. It also provides guidance to support practitioners on how to approach discussing each of these areas with parents and carers. ■ This is available on the partnership website and has also been circulated across the partnership agencies. ■ The response of the Herefordshire Safeguarding Children Partnership (HSCP) and Worcestershire Safeguarding Children Partnership (WSCP) to H&W CDOP recommendations has also been guided by two National Child Safeguarding Practice Review Panel reports covering the similar areas as identified in the local recommendations. A 'Keep Me Safe' Strategy, has been developed, supported by the Child Safeguarding Practice Review Group of the WSCP. The Strategy incorporates learning from both the National Panel Review published in July 2020 entitled "Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm", and the later national report entitled 'The Myth of Invisible Men: Safeguarding children under 1 from non-accidental injury caused by male carers' (September 2021). ■ This work has been undertaken jointly with the Herefordshire Safeguarding Children Partnership and has been led by the Deputy Designated Nurse for Safeguarding, NHS Herefordshire and Worcestershire in collaboration with multi-agency partners from across Herefordshire and Worcestershire. The 'Keep Me Safe' Strategy outlines the agreed priorities, aims and objectives for the period 2022-2025. The first two themes to be addressed within this strategy are 'Keep Me Safe when I'm Sleeping' and 'Keep Me Safe when I'm Crying'.
3	There is a renewed focus on reducing smoking during pregnancy and ensuring smoke free homes to support mothers postnatally.	Herefordshire and Worcestershire Local Maternity and Neonatal System	■ A H&W wide deep dive into the smoking in pregnancy pathway and wider system was completed in Spring 2022 ■ This led onto the development of a H&W wide Smoking in Pregnancy action plan. A H&W wide multiagency Task and Finish group has been set up to deliver against this action plan. This meets every 6 weeks. ■ Within the action plan there is a focus on increasing awareness and access of smoking cessation support for families of infants admitted to the Neonatal Unit ■ Worcestershire has recently initiated a postnatal smoking service, delivered through the Starting Well service, focussing on a whole family approach. ■ A specific smoking in pregnancy dashboard, collating data across maternity care and smoking cessation service delivery, is nearing completion. Once set up this will monitor the progress and outcomes of the SIP task and finish group. ■ Key aims of the action plan include: » Increasing CO screening » Increasing referrals to cessation services » Improving service outcomes » Reviewing and ensuring equity of access and outcomes » Reducing rates of smoking at time of delivery. » Nicotine replacement therapy available whilst in hospital (links to the wider H&W initiatives)

Recommendation		Responsibility for action	Agency Update
4	Tackling maternal obesity becomes a key priority.	Public Health across Herefordshire and Worcestershire and the Herefordshire and Worcestershire Local Maternity and Neonatal System	■ A H&W wide multiagency task and finish group has been set up to identify key issues within service delivery and support and take action to reduce maternal obesity rates. ■ A systemwide deep dive was completed into pathways of care regarding maternal obesity- from preconception through to postnatal care. ■ Key aims of this group include: » Reviewing and strengthening referral and support pathways for women with a BMI over 30 at booking » Reviewing and strengthening the lifestyle service offer for pregnant women » Increasing training and support for midwives and health visitors to improve their confidence and skills to engage in conversations with pregnant women about their weight
5	Strengthening and expansion of programmes and interventions in educational settings for children and young people and staff to support emotional health & wellbeing	Herefordshire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board Worcestershire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board	■ Through the DMHL network meetings the whole school approach (Anna Freud Centre, Mentally Healthy Schools) has been recommended to settings. This is supported by services working in schools e.g. EPS, WEST. ■ Emotional Literacy Support Assistants (evidence-based programme to develop capacity in schools to deliver evidence-based interventions to support emotional health and wellbeing) is being offered to all settings (at a cost). ■ Schools are using DfE funding to access the Senior Mental Health Lead training. ■ Public Health is exploring preventative programmes ■ Thrive approach being used in some settings in Worcestershire. ■ WEST team in schools and due to expand in further Waves. ■ CAMHS CAST available for all settings. ■ Trauma Informed training available free to all settings. Over 50% have accessed this.
6	Improve 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	Herefordshire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board Worcestershire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board	■ Bereavement training forms part of the ELSA training for practitioners in schools. ■ Website being developed includes signposting to services that support with bereavement and loss as well as where to go for further support if concerned about CYP. ■ Guidance shared with headteachers about development of suicide safer policy as recommended by Public Health (Papyrus resource). ■ Anna Freud Centre Whole School approach shared with schools includes support to identify and respond to mental health and wellbeing concerns in settings.

Recommendation		Responsibility for action	Agency Update
7	An audit of educational providers on provision of mental health training and how this informs their awareness.	Herefordshire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board Worcestershire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board	■ Public Health tracking training provided to schools. ■ WASH surveyed about DfE training attended. ■ Anna Freud mentally health schools audit has been shared with settings through DMHL network. ■ CPD attendance monitored by Worcestershire Children First and audit kept.
8	Improved promotion of mental health crisis services and how to access them for children, young people, parents/carers and frontline practitioners working with them.	Herefordshire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board Worcestershire Children and Young People's Emotional Wellbeing & Mental Health Partnership Board	■ Services shared with DMHLs and headteachers through briefings and network events.
9	Training for frontline practitioners so they are supported to initiate difficult conversations with parents or carers.	Safeguarding Partnerships	Worcestershire ■ In support of practitioners who on occasions need to have difficult conversations with parents and carers on this subject and explore other areas of their life and relationships, often linked to a challenging family environment, in September 2022 WSCP published its updated guidance on 'professional curiosity' (WSCP - JTAI – Multi-Agency Inspection Briefing for Partners (safeguardingworcestershire.org.uk). Herefordshire ■ The Herefordshire Safeguarding Children Partnership (HSCP) is supporting frontline professionals to identify complex family issues and have difficult conversations with parents or carers through its training programme and guidance. The HSCP has embedded guidance on professional curiosity within its tools and training programme. HSCP courses also offer guidance on motivational interviewing, strengths-based approaches, and managing disclosures. Guidance on professional curiosity has been presented at Practitioner Forums, to a varied audience of multi-agency professionals, and in the virtual learning event about the murders of Arthur Labinjo-Hughes and Star Hobson (July 2022). A learning briefing for practitioners on professional curiosity has also been developed and will be published in 2023.

8. Priorities

As described in this report, a total of 28 deaths were reviewed during 2021-2022 by H&W CDOP. Due to the small number of deaths reviewed it is difficult to draw out commonalities between the deaths that can result in clear recommendations, as each tragic child death has its own distinct set of circumstances. After each panel meeting, recommendations will have been made to the relevant professionals. Also, because deaths usually occur in the years preceding their review at panel, organisations will look to learn and improve from a death immediately. Therefore, many of the issues seen at CDOP are already being prioritised by the relevant organisation. However, there were factors that presented more frequently than others during child death reviews. These themes are named below as system priorities for Herefordshire and Worcestershire for 2022-23.



Prematurity- The definition of prematurity is a baby that is born prior to 37 weeks gestation. Babies who are born prematurely are known to have poorer outcomes than babies born at term. Of the 28 deaths reviewed by CDOP, 10 cases were children who were born prematurely. This finding, in addition to the higher than England rates of prematurity in both Herefordshire and Worcestershire, re-enforce the need for prematurity to remain a priority of the Herefordshire ad Worcestershire Local Maternity and Neonatal System (LMNS). Both in clinical management of women who are at higher risk of preterm delivery and in the reduction of modifiable factors that are known to be linked to prematurity, including smoking in pregnancy.

Smoking- Smoking in pregnancy is widely understood to be linked to prematurity and poorer outcomes for babies. However, babies exposed to smoking postnatally are at higher risk of Sudden Infant Death Syndrome (SIDS) and increased risk of respiratory conditions such as asthma. Smoking was a modifiable factor noted in 7 deaths that were reviewed by CDOP. Although there was a mixture of smoking in pregnancy and household members that smoked, it was reported that some mothers had been offered smoking cessation during pregnancy and had refused. This finding, coupled with the levels of smoking in pregnancy being higher than England in both Herefordshire and Worcestershire allows the CDOP annual report to conclude that reducing smoking in pregnancy and supporting families to have smoke free homes should remain a priority for Herefordshire and Worcestershire, driven by system partners such as Public Health in Herefordshire and Worcestershire Councils, Public Health Nursing and the LMNS.

Neonatal Care- Neonatal care is often required to support babies who are born prematurely or are acutely unwell at or soon after birth. Quality of neonatal care was identified as a modifiable factor in 5 of the deaths reviewed at CDOP. Neonatal care is complex and the individual issues with quality of care identified were not homogeneous. However, due to the number of deaths where this factor was identified CDOP endorses the continued prioritisation of high-quality, safe neonatal care by the LMNS, including Worcestershire Acute Hospitals Trust and Wye Valley Trust and the work with the West Midlands Neonatal Network. The most common factors within neonatal care identified were medicine management, including the timely administration of antibiotics and thermoregulation on admission to the neonatal unit.

Complexity- Complex social factors were identified in 8 deaths and domestic abuse was in a number of these cases. When explored in further detail there were not any common themes between the circumstances. However, this is a reminder that families are complex and may experience a wide range of difficulties such as poor housing, economic difficulties, substance misuse and domestic abuse. Therefore, organisations that provide front line services should give their staff the tools to identify and support families as appropriate. Training and awareness of issues that families experience are important to front line staff and CDOP supports the continuation of a local focus on professional curiosity.

9. Appendices

Appendix A: HEREFORDSHIRE AND WORCESTERSHIRE CHILD DEATH OVERVIEW PANEL MEMBERSHIP

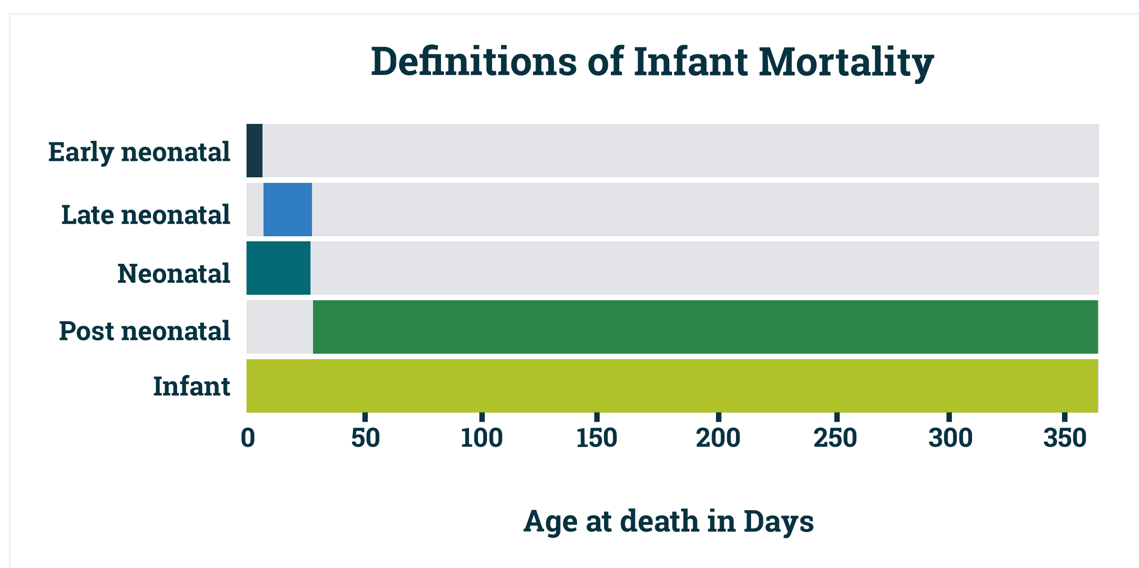
NAME	AGENCY / Contact Info
Liz Altay	Public Health Consultant, Worcestershire
Adrian Over	Independent Chair
Polly Lowe	H&W CDOP Co-ordinator
Jenny Edmunds	Designated Doctor for Child Death, Worcestershire
Julia Greer	SUDIC Coordinator, Worcestershire (Until December 2021)
Donna Steward	SUDIC Coordinator, 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
Denyse Ratcliff	MASH Head of Service, Children's Services, Herefordshire
Sue Rogers	Head of Service, Herefordshire Children's Services
Sharon Woodcock	Service Manager, Herefordshire Children's Services
Susan Smith	Quality Governance Manager (Midwifery), Worcestershire
Jez Newell	Deputy Designated Nurse, Adult Safeguarding Lead, NHS Herefordshire and Worcestershire
Heather Manning	Deputy Designated Safeguarding Nurse, NHS Herefordshire and Worcestershire
Sarah Dempsey	Deputy Designated Safeguarding Nurse, NHS Herefordshire and Worcestershire
Rebecca Pickup	Public Health Consultant, Herefordshire
Maria White	Assistant Director, Children's Services, Worcestershire
Jen Rogers	Case Progression Officer, Children's Services, Worcestershire

Appendix B: ANALYSIS PROFOMA CATEGORISATION OF DEATH

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).
(i) (ii) (iii) (iv)	**Immaturity/Prematurity related** Perinatal Asphyxia (HIE and/or multi-organ failure) Perinatally acquired infection Other (please specify)
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).

Appendix C: GLOSSARY

BMI	Body Mass Index
CAMHS	Child and Adolescent Mental Health Service
CAMHS CAST	Child and Adolescent Mental Health Service, Consultation Advice Supervision and Training
CO	Carbon Monoxide
CDOP	Child Death Overview Panel
CDRM	Child Death Review Meeting
CDR Partners	Child Death Review Partners
CPD	Continuing Professional Development
CYP	Children and Young People
DMHL	Designated Mental Health Lead
DfE	Department of Education
ELSA	Emotional Literacy Support Assistant
HSCP	Herefordshire Safeguarding Children Partnership
H&W	Herefordshire and Worcestershire
JAR	Joint Agency Response
JTAI	Joint Targeted Area Inspection
NCMD	National Child Mortality Database
SUDI/SUDC	Sudden Unexpected Death in Infancy/Childhood)
WSCP	Worcestershire Safeguarding Children Partnership



Acknowledgements

Thank you to the team who wrote and produced this report.

Hayley Durnall
Public Health Consultant

Polly Lowe
Herefordshire and Worcestershire Child Death Overview Panel Coordinator

Jan Harvey
Public Health Practitioner - Intelligence

worcestershire
county council