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HEALTH AND WELLBEING BOARD
14 FEBRUARY 2023

ANNUAL REPORT OF THE HEREFORDSHIRE AND WORCESTERSHIRE CHILD DEATH OVERVIEW PANEL

Board Sponsor
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Priorities
This report is relevant to the following Joint Local Health and Wellbeing Strategy priorities:

- Healthy Living at All Ages

Safeguarding

This report has a direct impact on safeguarding children or adults.

There are themes and recommendations within this report that relate to the safeguarding of children, such as discussion of modifiable risk factors that cause harm or death. See full report for further detail.

Item for Decision, Consideration or Information:

This item is being brought for information.

Recommendation

1. **The Health and Wellbeing Board is asked to:**

    a. **Receive the 2021-2022 Herefordshire & Worcestershire Child Death Overview Panel (H&W CDOP) Annual Report noting the numbers and patterns of child deaths reviewed and the thematic learning to prevent future deaths; and**
    b. **Support the continued prioritisation of the system priorities of CDOP.**

Background

2. 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.

3. H&W CDOP operates as a combined CDOP. In the counties of Herefordshire and Worcestershire the current child death review partners are Herefordshire Council (Public Health), Worcestershire County Council (Public Health) and NHS Herefordshire and Worcestershire.

4. 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.

5. 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's and Worcestershire's Health and Wellbeing Boards and the Integrated Care Board. The report for the period April 2021 to March 2022 is attached for information at **Appendix A**. The report may also be shared, as appropriate, with other key strategic partnerships. It 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.

6. H&W CDOP continue to 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.

Patterns, Modifiable Factors and Themes

7. Between 1st April 2021 and 31st March 2022, a total of 43 child death notifications were received for Herefordshire and Worcestershire resident children. Of these notifications, nine were from Herefordshire and 34 from Worcestershire.

8. Between 1st April 2021 and 31st March 2022, a total of 28 cases were reviewed by H&W CDOP. Of these deaths 57% were expected and 43% were unexpected.

9. From the reviewed deaths the category of death that was most reported was perinatal/neonatal event, which was the primary category of death for 39% of cases.

10. 10 of the 28 deaths reviewed were related to prematurity.

11. Overall, 68% of the reviewed deaths were under one year old, 21% were between the ages of 15 and 17. 11% of the cases reviewed were assigned a category of suicide and these involved older teenagers between the age of 15 and 17 years.

12. Small numbers make it difficult to find a clear association with deprivation. However, the most deprived quintile of the population had the highest number of deaths overall and the highest number of expected deaths

13. H&W CDOP identified modifiable factors in 57% of the cases reviewed. The most commonly reported modifiable factors were smoking and neonatal care.

System Priorities

14. The number of deaths reviewed annually is small. However, some themes occur at H&W CDOP more often than others. From these the following priorities have been developed:

a) **Prematurity**- A focus on reducing modifiable factors linked to prematurity and clinical management of women who are at risk of preterm birth.

b) **Smoking**- A continued focus on reducing smoking in the preconception period, smoking during pregnancy and smoke free homes.

c) **Neonatal Care**- A local and regional focus on providing high quality neonatal care.

d) Complexity- Frontline workers to be continued to be supported with appropriate training and tools to identify complex family issues and develop professional curiosity.

Legal, Financial and HR Implications

15. Legal, funding and HR implications would be considered as the various system priorities detailed within this report are progressed.

Privacy Impact Assessment

16. There is no required privacy impact assessment at this stage.

Equality and Diversity Implications

17. 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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Background Papers

- Herefordshire and Worcestershire Child Death Overview Panel Annual Report 1st April 20201 to 31st March 2022