SANDWELL CHILD DEATH OVERVIEW PANEL (CDOP)

ANNUAL REPORT 2016 - 2017

Sandwell Safeguarding Children Board

Sandwell CDOP is a sub-group of Sandwell Safeguarding Children Board

Sandwell Child Death Overview Panel

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Foreword – CDOP Chair

Welcome to the ninth Annual CDOP Report which reflects activity from April 1st 2016 to March 31st 2017.

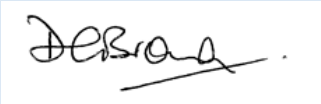
The Panel has continued to meet six weekly and also in this period met one extra time in order to decrease the amount of outstanding deaths requiring review.

66 deaths in total were reviewed in 2016-17 which is a slight increase on the previous year which has enabled the panel to keep the number of outstanding reviews at a low number, and I would once again like to extend sincere thanks to Jaki Bateman, Child Death Co-ordinator for her commitment to providing high quality child death processes.

Attendance at meetings by panel members in the last year has once again been excellent, providing the opportunity for robust partnership discussions and assurance that learning is taken back to individual organisations.

The primary function of CDOP is to learn from child deaths, and I am happy to report that CDOP was invited to present the learning from Sandwell child deaths to over 400 students at Sandwell College. We also held a very successful CDOP development day where frontline practitioners were given the opportunity to explore modifiable factors that CDOP had identified. We were very pleased to enable a bereaved parent of a Sandwell child to attend this event to share their experience.

Following the publication of the Wood Review CDOP is looking to the future and is prepared to embrace any future change.



Sandwell CDOP Chair

If you have any questions or queries about this report please contact:

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Debbie Brown, CDOP Chair, debbie.brown2@nhs.net 0121 612 2065

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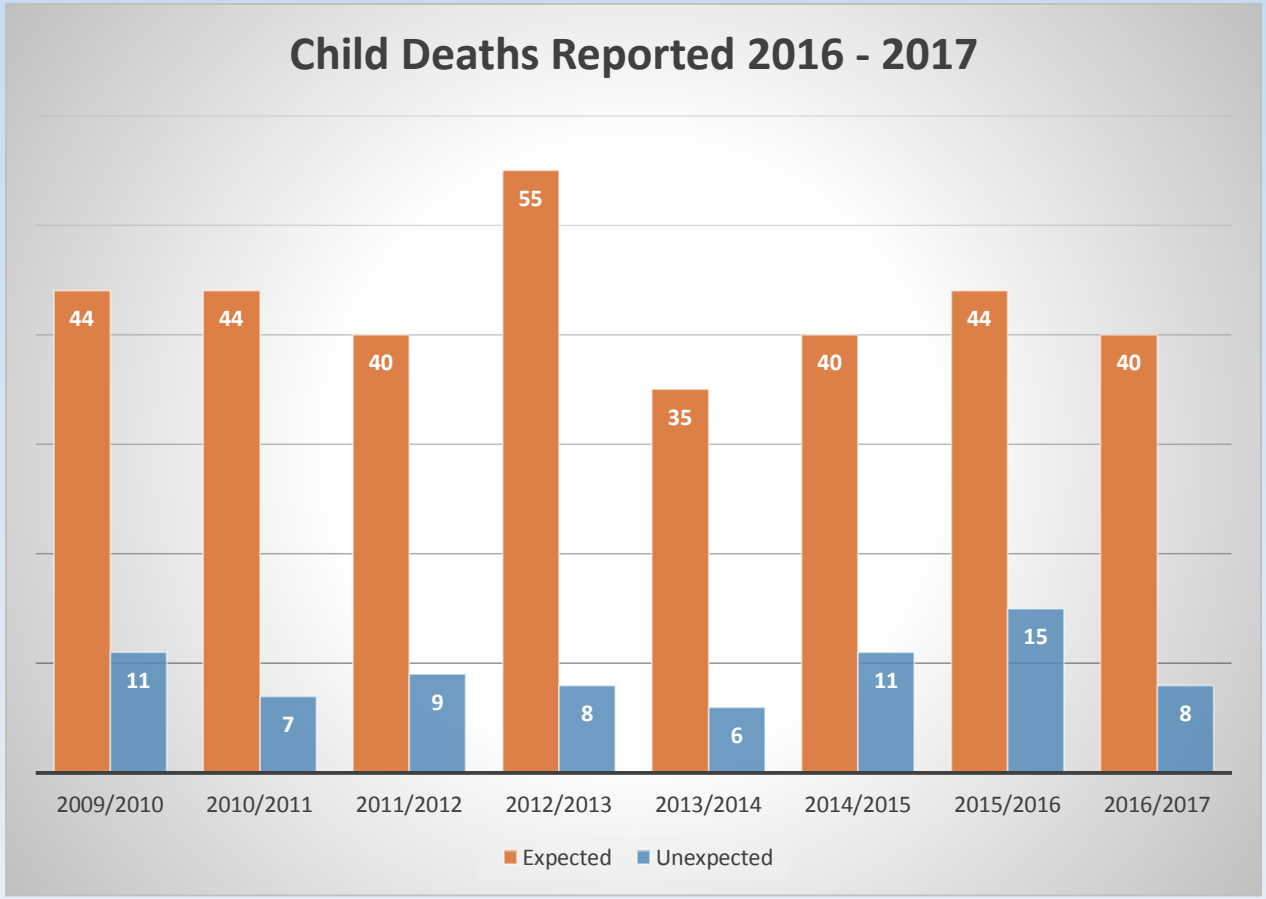
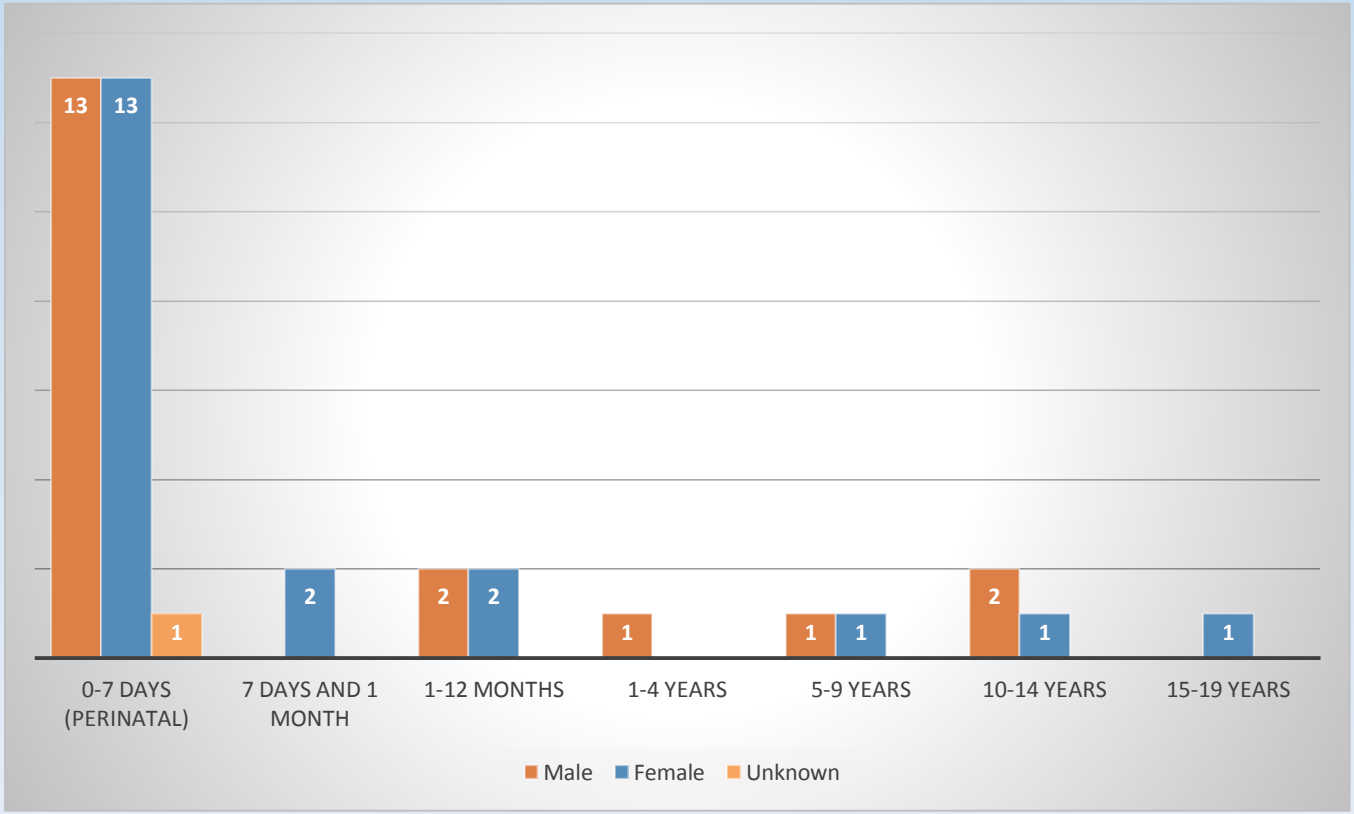
Child Deaths reported to CDOP during 2016-2017



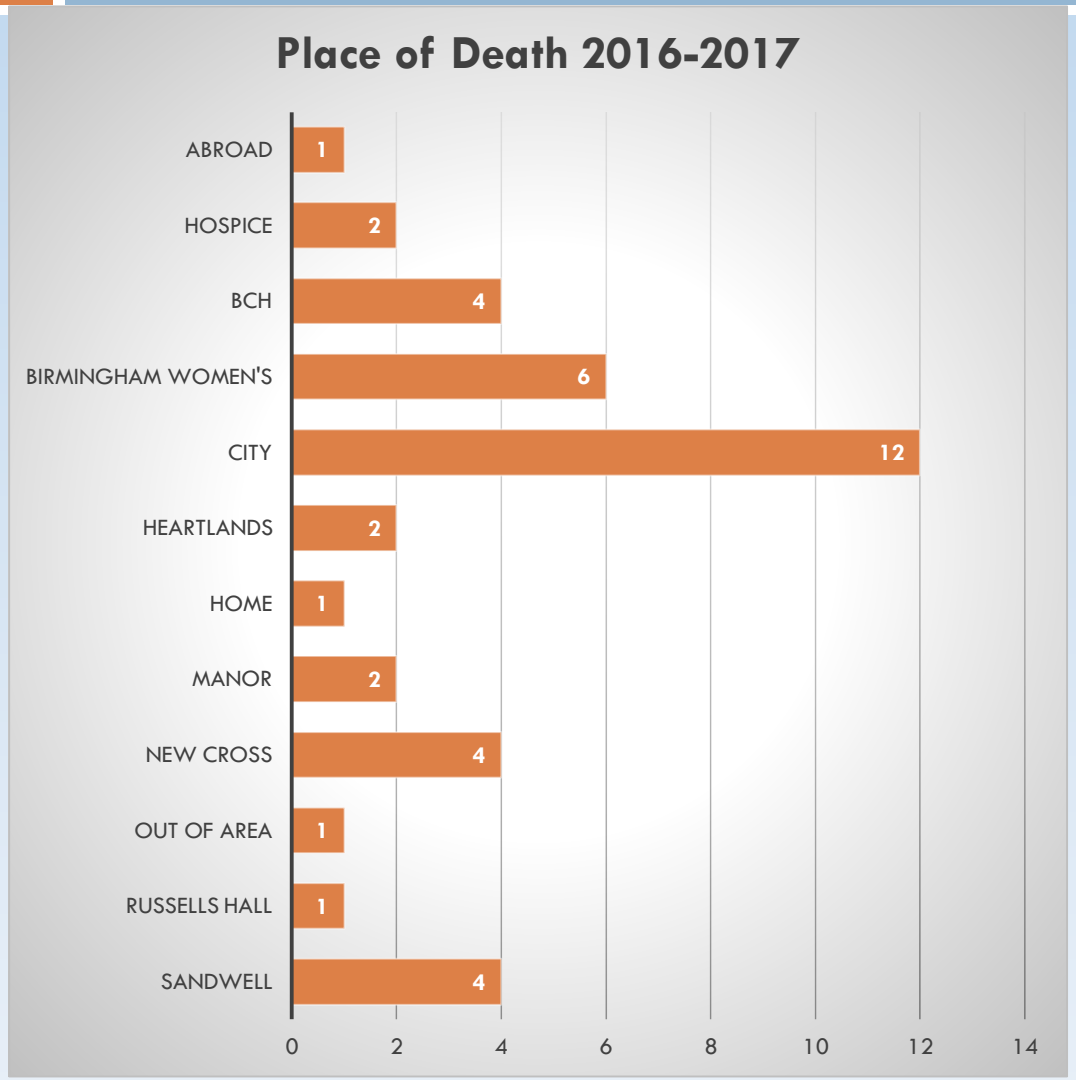
There were 40 child deaths reported to Sandwell CDOP in the year 2016-2017. Of these, 8 were deemed unexpected. Working Together 2015, Chapter 5 guidance gives the definition of an unexpected child death as: 'the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death'

Reported deaths 2016-17 – Gender and Age band



33 of the deaths in 2016-2017 occurred in the first year of life (82.5%). These deaths will be reviewed in more detail in the Infant Mortality Section of this report

Reported deaths 2016-17 – place of death



As with previous years the majority of child deaths occur in a health care setting.

For those child deaths that occur abroad it remains a challenge to gather information. However in 2016-2017 guidance was issued giving a named point of contact in the Foreign and Commonwealth Office to aid this process.

Reported deaths 2016-17 - Ethnicity

The number of 0-18 year olds in Sandwell in 2011 was 74,376.

55.5% of this population were White British, however, only 25% of reported child deaths in 2016-17 were from this ethnic background. As with previous years this is in contrast to those children from a BME background where there was a higher percentage of reported child deaths compared to the population size (0-18yrs).

http://www.sandwelltrends.info/themedpages/Census2011/Ethnicity_Hub

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

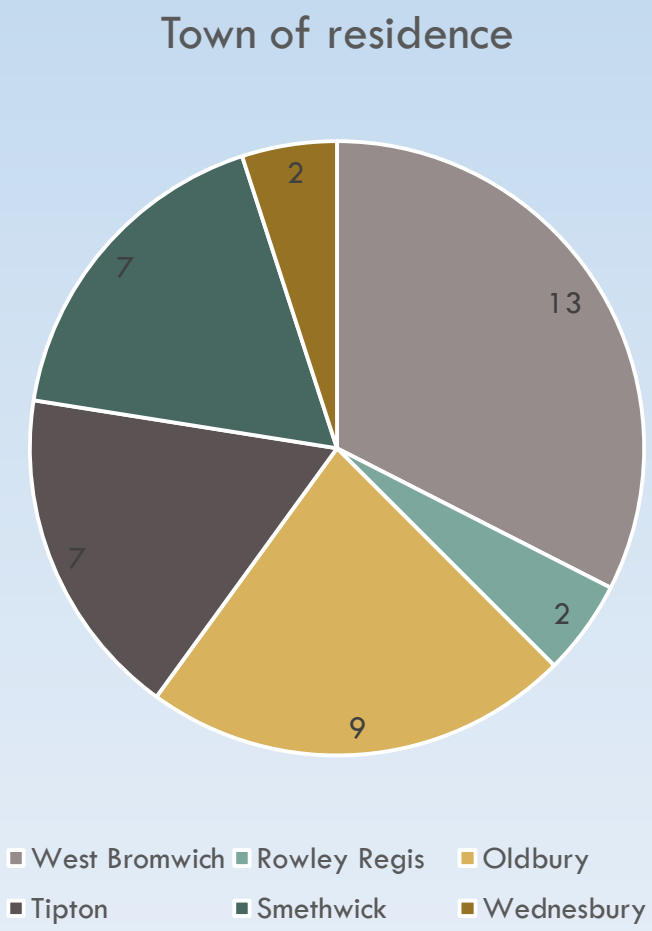
	2011 Census 0-18 yrs	%	Deaths 2016-17	%
White British	41249	55.5%	10	25.0%
White Other	2475	3.3%	4	10.0%
Mixed Multiple Ethnic Group	5786	7.7%	7	17.5%
Asian British Indian	7584	10.2%	4	10.0%
Asian British Pakistani	5773	7.8%	3	7.5%
Asian British Bangladeshi	2840	3.8%	4	10.0%
Asian British Chinese	227	0.3%	0	0.0%
Other Asian	1913	2.6%	2	5.0%
Black British African	1623	2.2%	2	5.0%
Black British Caribbean	2552	3.4%	3	7.5%
Black British Other	1019	1.4%	0	0.0%
Other Ethnic Group/Not recorded	1335	1.8%	1	2.5%
Totals	74376	100.0%	40	100.0%

Reported deaths 2014-2017 (3 year comparison) - Ethnicity

	2011 Census 0-18 yrs	%	Deaths 2014-2017	%
White British	41249	55.5%	42	34%
White Other	2475	3.3%	8	6.50%
Mixed Multiple Ethnic Group	5786	7.7%	16	13%
Asian British Indian	7584	10.2%	11	9%
Asian British Pakistani	5773	7.8%	14	11%
Asian British Bangladeshi	2840	3.8%	7	5.50%
Asian British Chinese	227	0.3%	0	0%
Other Asian	1913	2.6%	4	3%
Black British African	1623	2.2%	8	6.50%
Black British Caribbean	2552	3.4%	6	5%
Black British Other	1019	1.4%	1	1%
Other Ethnic Group/Not recorded	1335	1.8%	7	5.50%
Totals	74376	100.0%	124	100%

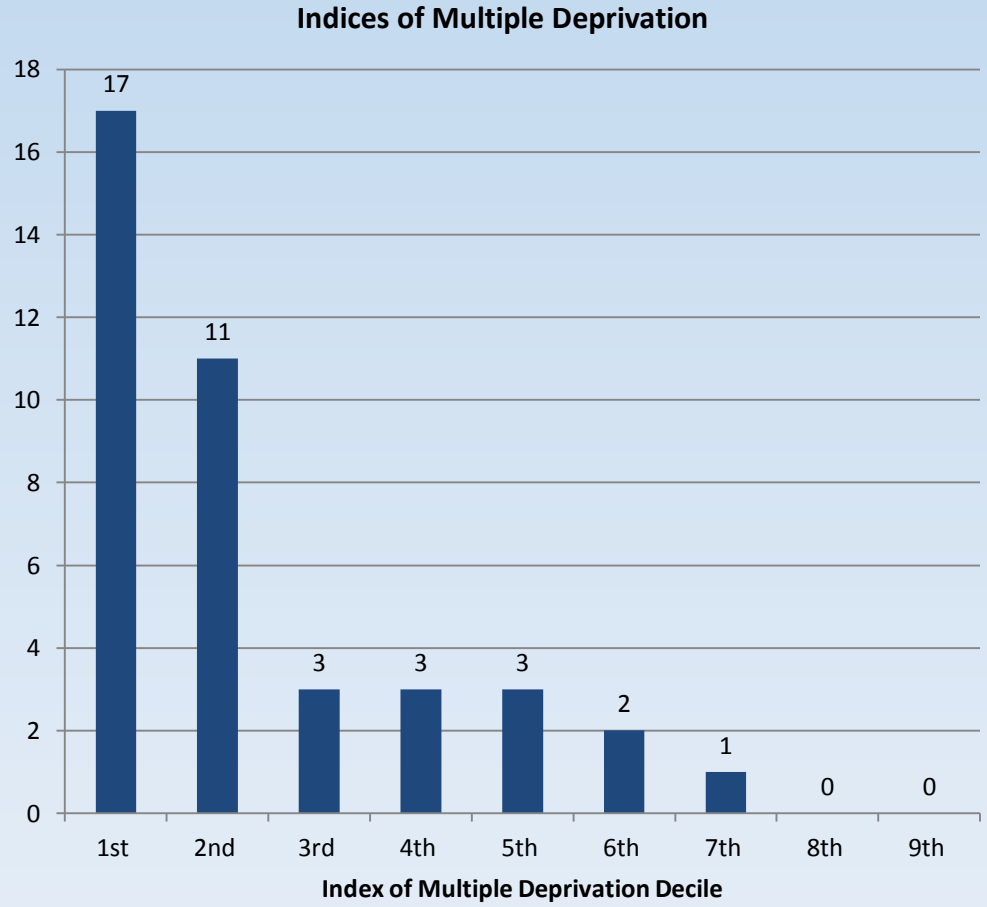
Considering 3 years data gives us a clearer picture of issues around child death and ethnicity and confirms the disproportionate number of deaths in children 0-18 years from a BME background.

Reported Deaths 2016-2017 – Town of Residence



The number of deaths, albeit small would appear to reflect population levels within the 6 towns, with the exception of Rowley which consistently has a lower number of deaths than would be expected based on population. Smethwick has a higher than expected number of deaths based on population, but it is of note that the area has a higher number of deprived wards than other towns in Sandwell. Of the seven deaths that occurred in Smethwick there is no particular theme.

Child Deaths 2016-2017 – Indices of deprivation



It is clear from this graph that in 70% of the child deaths reported in 2016-2017 the family resided in the most deprived areas of Sandwell.

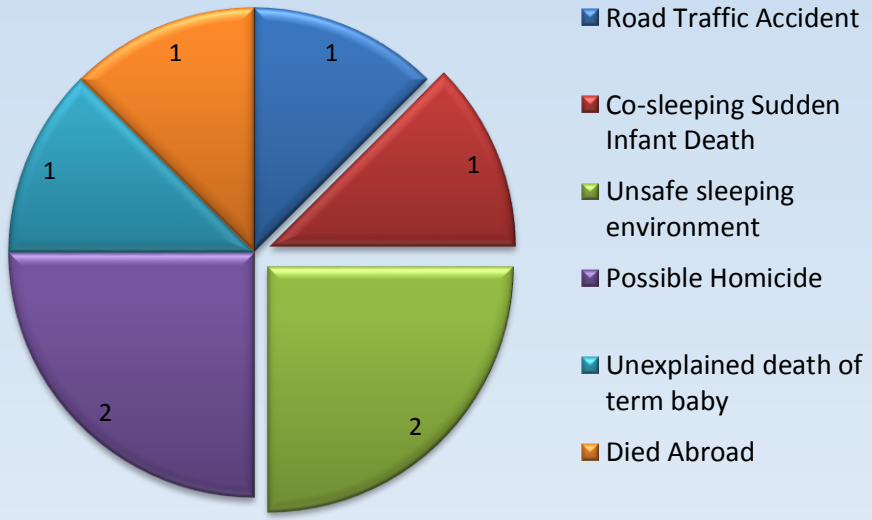
The relationship between poverty, deprivation and child death is cited by the Royal College of Paediatrics and Child Health

http://www.rcpch.ac.uk/improving-child-health/state-child-health/report-glance/state-child-health-report-glance

Unexpected Deaths reported 2016-17

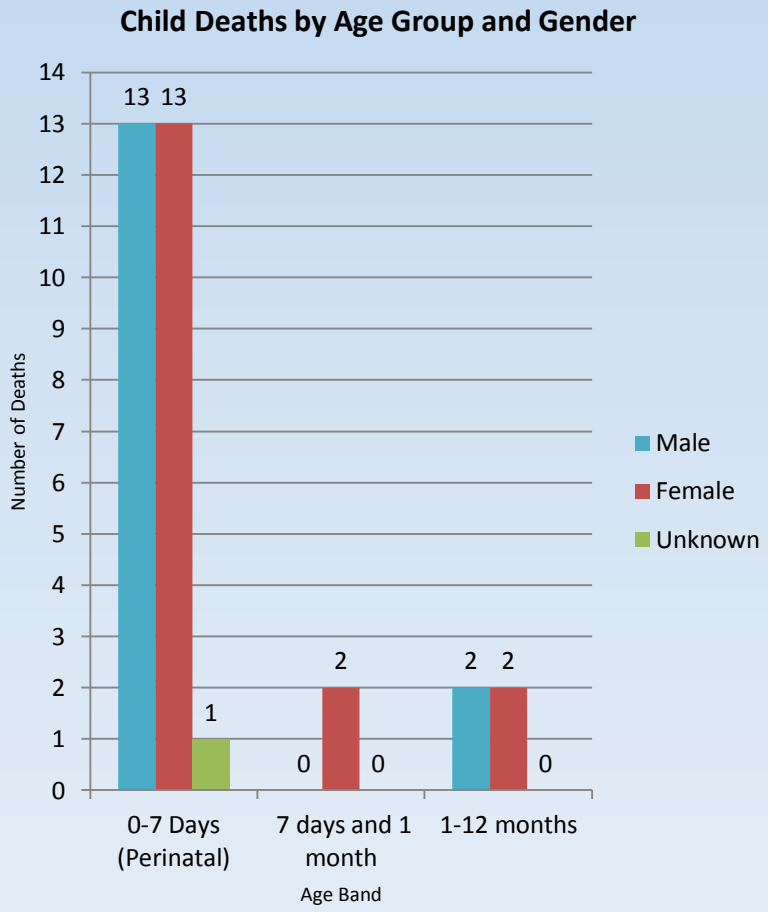
The percentage of unexpected deaths decreased back to expected levels in comparison to the large increase we saw last year.

There has been a slight reduction of infant deaths of where co-sleeping was identified as a contributory factor. In 2015-2016 there were 5 deaths compared to 1 death in 2016-2017 where a baby was sharing a sleeping place with an adult and/or other children. It is of note however that in 2016-2017 2 deaths were notified where babies were sleeping in an unsafe environment (adult bed, breastfeeding pillow).



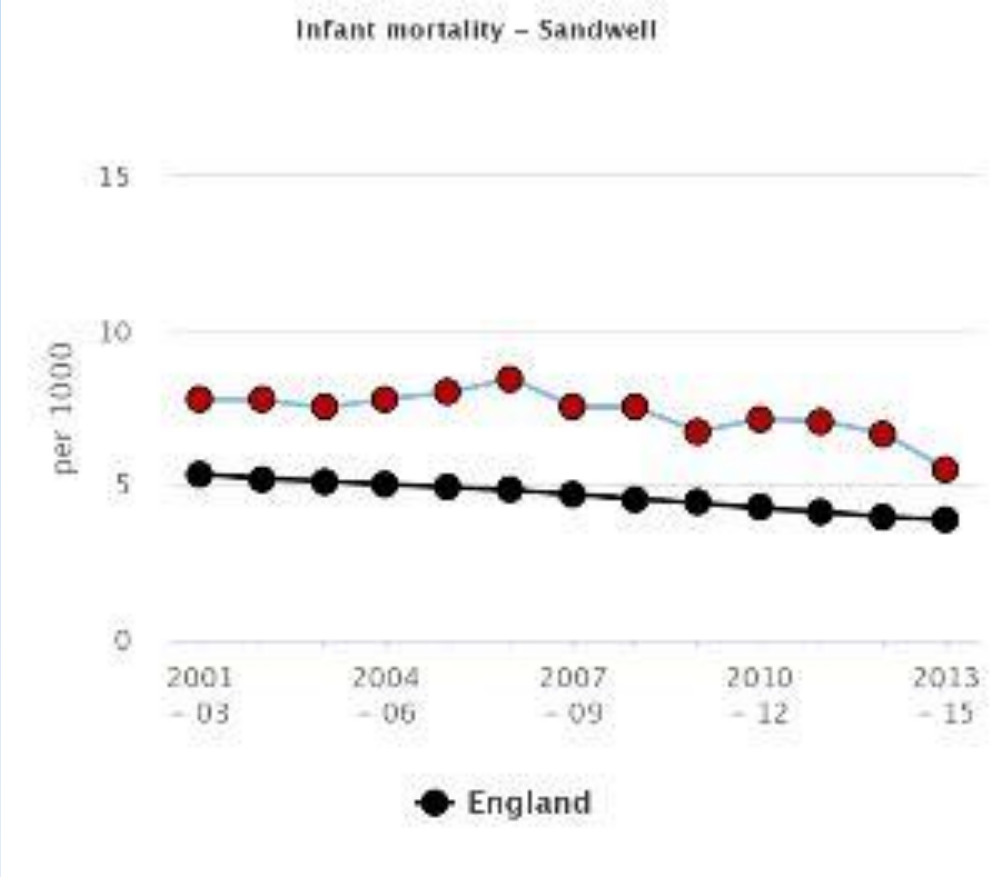
Part Two – Infant Mortality Deaths Reported to CDOP 2016-2017

Infant Mortality Deaths by age and gender 2016 - 2017



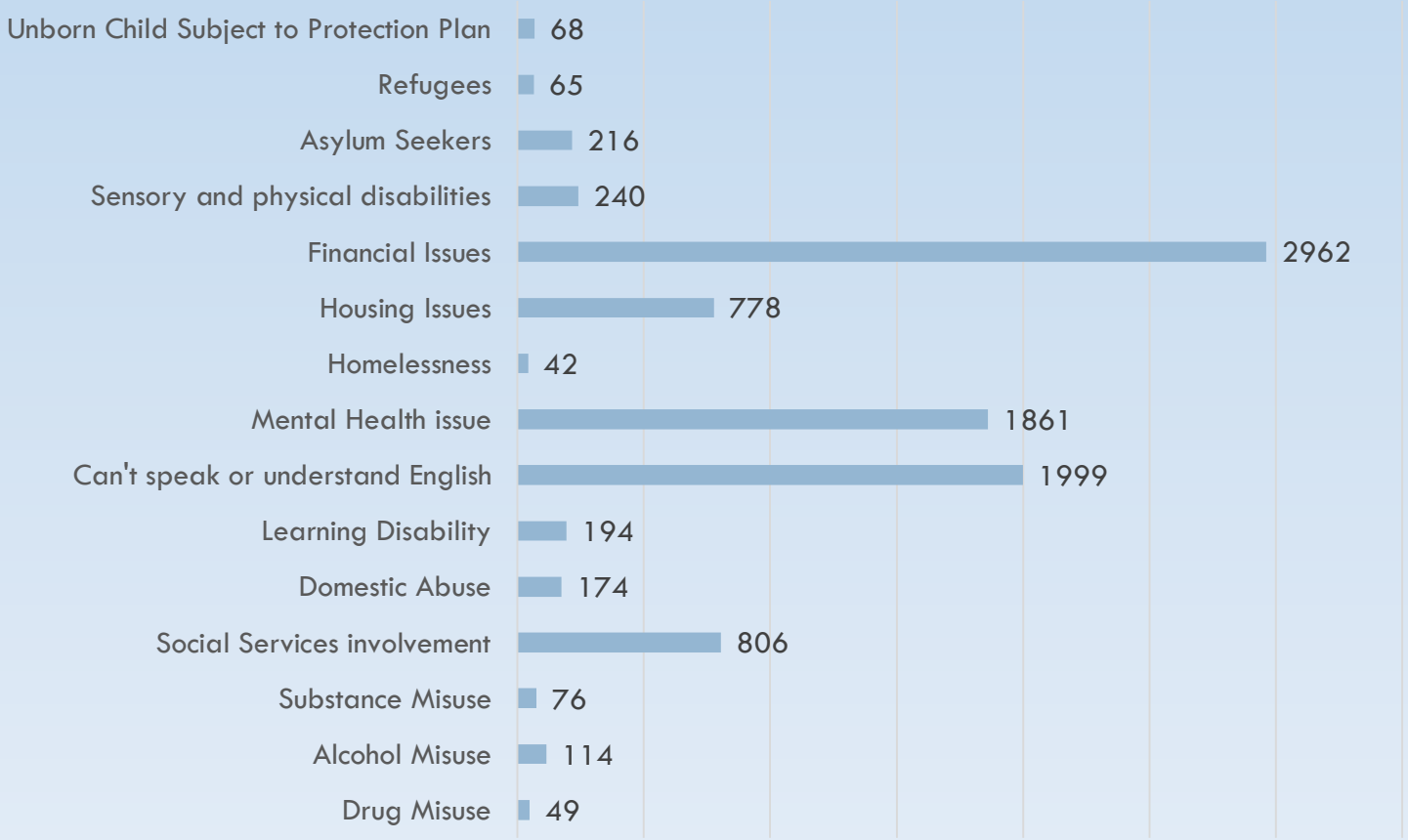
- 33 of the 40 deaths of Sandwell resident babies (82.5%) were under the age of 1 year. This represents a percentage increase on the previous year where this figure was 70% in 2015-16, and 62.5% in 2014-15.
- There is a clear significant increase in the last 3 years in the percentage of Sandwell child deaths that occur in the first year of life.
- Reducing infant mortality in Sandwell remains a Public Health and CCG priority

Reduction in Infant Mortality



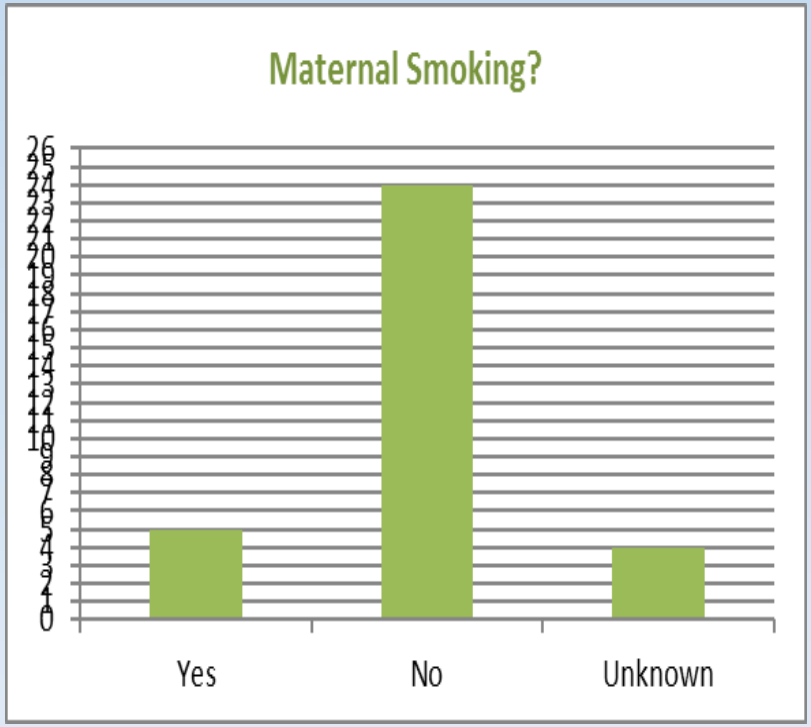
- The trend from 2001 -15 showed a slow reduction for Sandwell in infant mortality
- Between 2016 -17 we have again seen a reduction in infant mortality for Sandwell. In March 2016 the figure was 6.7/1000 births compared to 5.5/1000 births in March 2017. This compares to the average England figures of 4.0/1000 births in March 2016 and 3.9/1000 births in March 2017
- Child Health Profile Data March 2017

Identified Vulnerabilities



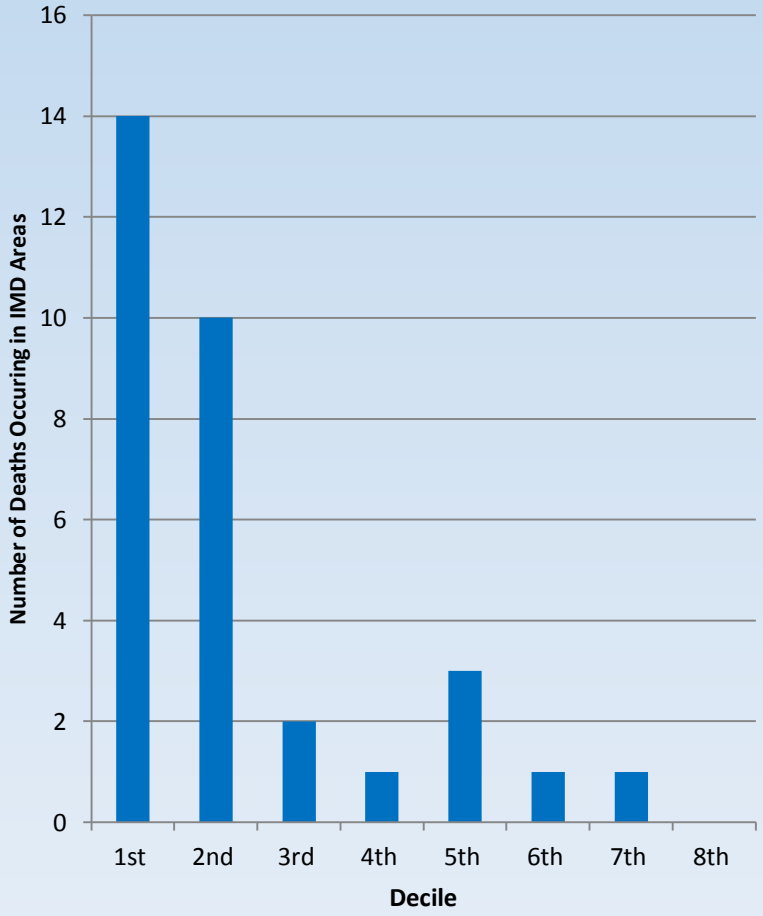
Of the 11,886 Women booked at City Hospital, Badgernet data would indicate that there was a significant number of women with 1 or more vulnerability.
(It is of note that this is total bookings undertaken by Sandwell and West Birmingham midwives and will include women from Sandwell and Birmingham)

Infant Mortality and Maternal Smoking 2016-2017



- It is encouraging to see that the numbers of mothers not smoking at antenatal booking is higher than expected
- Where there is a death in the first year of life and smoking is a feature in the household, this is recorded as a modifiable factor at the Child Death Overview Panel (CDOP)
- This data is taken from Badgernet information on antenatal booking where women are tested for carbon monoxide levels as part of the booking procedure

Infant Mortality and Deprivation 2016-2017



- For those deaths under the age of 1 year, as expected most deaths have occurred where families reside in areas of greatest deprivation
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465791/English_Indices_of_Deprivation_2015_-_Statistical_Release.pdf
- https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-overview/area-search-results/E08000028?place_name=Sandwell&search_type=parent-area

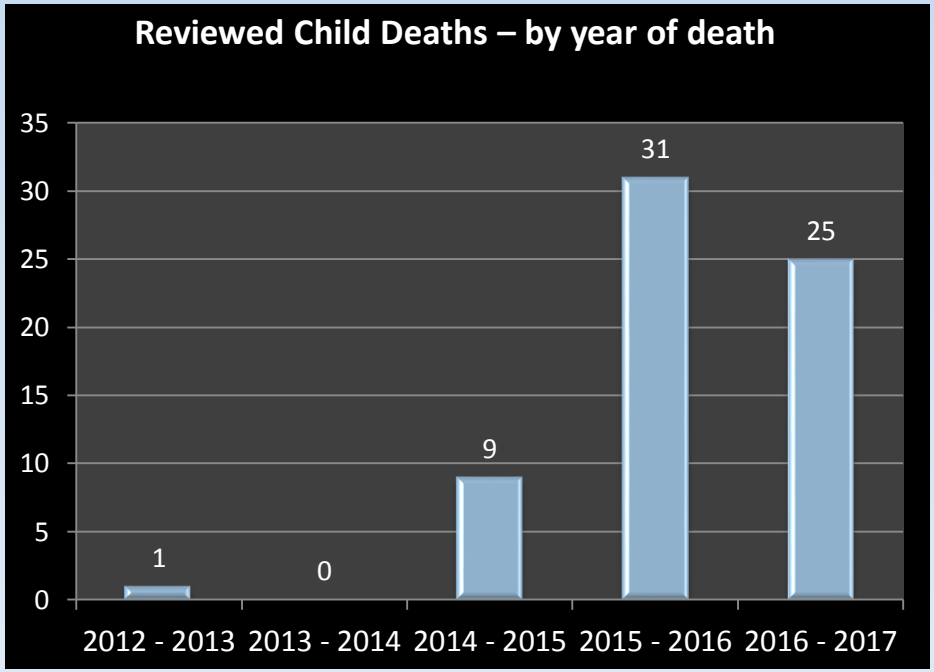
Part Two – Child Deaths Reviewed at CDOP during 2016-2017

PART TWO
Child Deaths Reviewed at CDOP during 2016-2017

The main focus of the Child Death Overview Panel (CDOP) is to review child deaths in order to evaluate practice and identify key areas for learning. Membership features senior representatives from all sector agencies who are able to influence policy and practice.

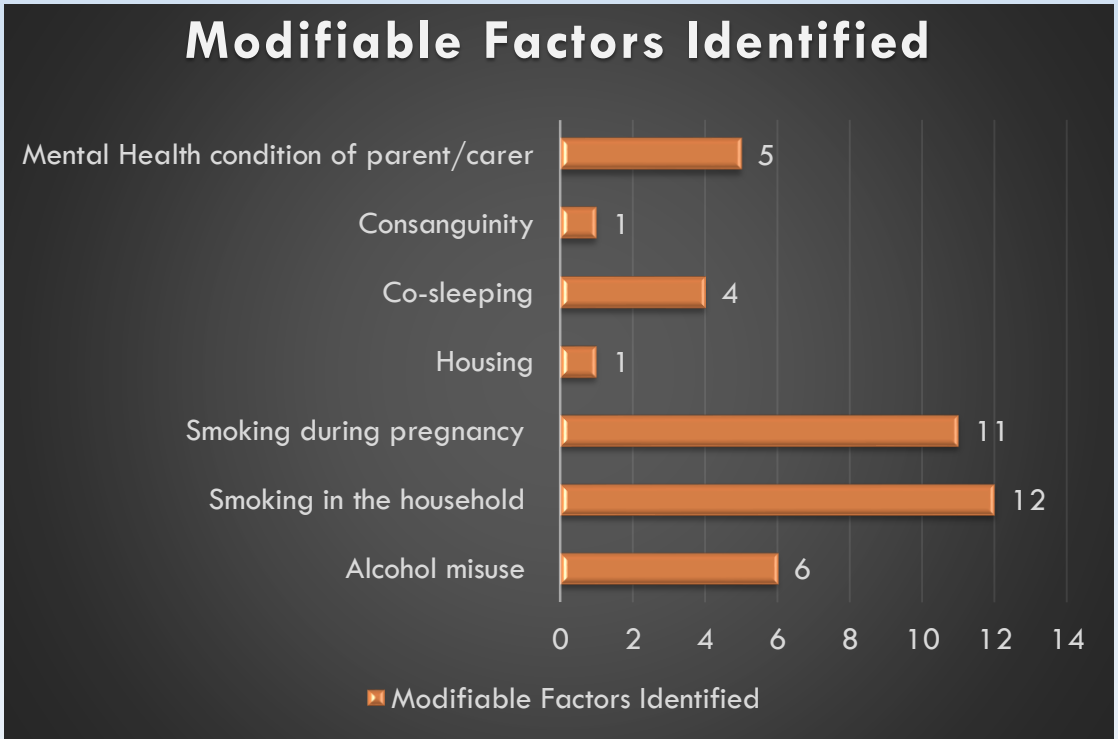
CDOP met a total of 9 times during 2016-2017 as a whole group and an extra-ordinary meeting was arranged in April 2016.

In total 66 child deaths were reviewed by the Child Death Overview Panel in 2016-2017, of which 22 were identified as having modifiable factors

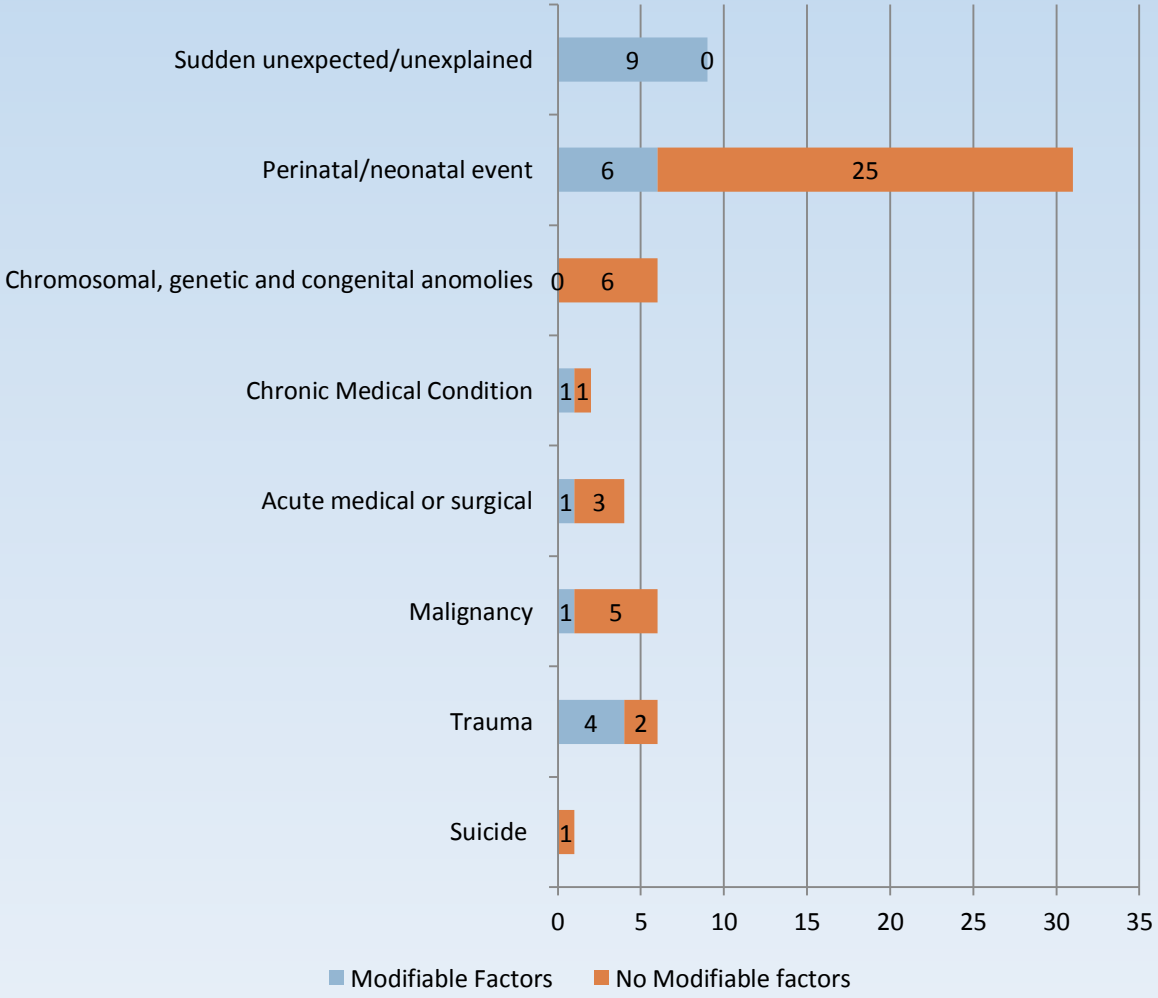


Preventing Child Deaths – Modifiable Factors

It is a primary function of CDOP to identify areas of practice, both operationally and strategically, to be developed as a result of reviewing child deaths. In 22 of the 66 deaths reviewed during 2016-2017 modifiable factors were identified by panel members. CDOP with partner agencies via regional briefings shares learning in terms of identifying and addressing the prevention of any similar deaths occurring in future. To ensure that respect and confidentiality of the children and families involved is maintained, the following information provides only a summary of the type of modifiable factors identified:



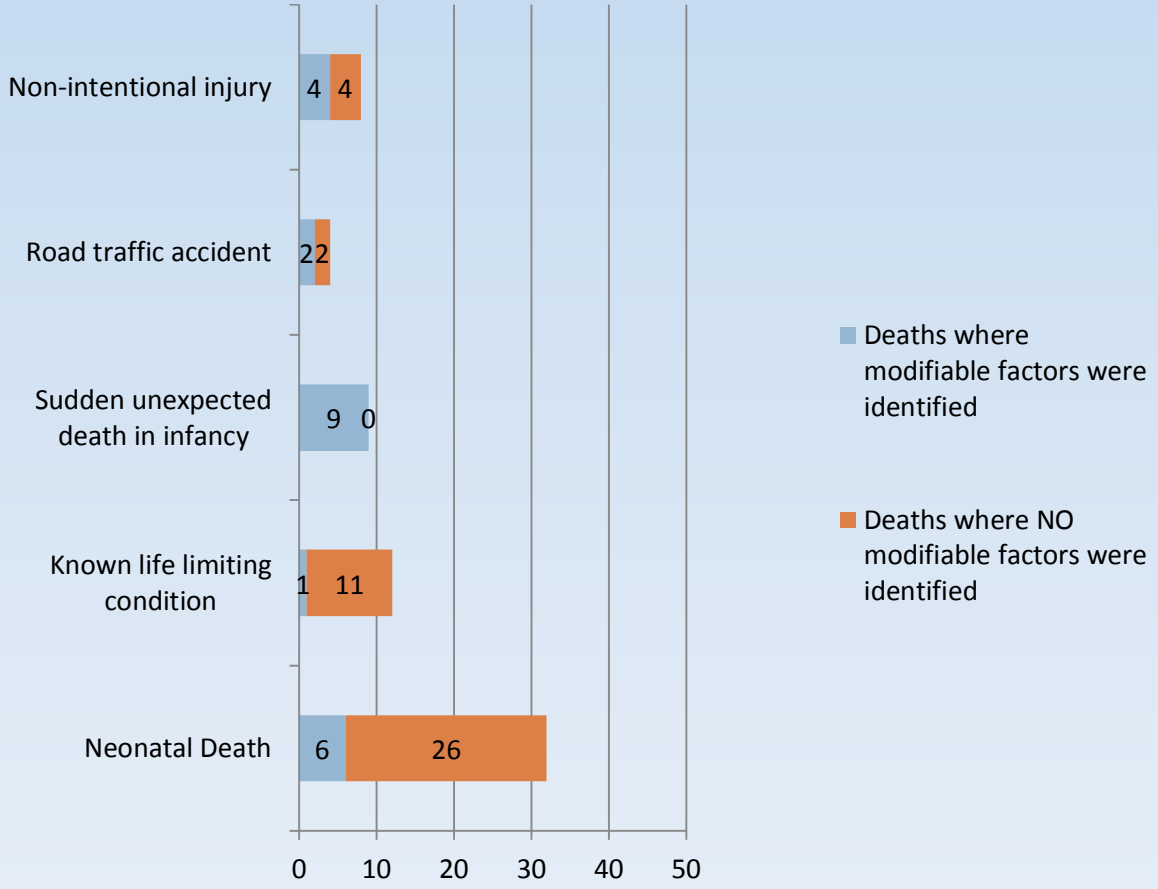
Category of Reviewed Deaths 2016-17



The greatest category of reviewed deaths for 2016-2017 was in the perinatal/neonatal event. DfE National Report on reviewed child deaths (July 2017) indicates that Nationally 39% of reviewed deaths in the year 2016-2017 were a neonatal death.

https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2017

Cause of Death 2016-17 Reviewed Deaths



In 2016-2017 the main cause of reviewed deaths was in the Neonatal death category which again is in line with National reviews. Nationally in this category 37% of deaths reviewed have modifiable factors. In Sandwell, 23% have modifiable factors

Part Three - CDOP Achievements 2016 - 2017

CDOP Achievements 2016 - 2017

Safer Sleeping:

The Baby Box initiative was launched in October 2016.
The Baby Box tradition, which originates from Finland, was credited with reducing their infant mortality rate from 65 infant deaths per 1,000 births in 1938 to 2.26 per 1,000 births in 2015. The UK has some of highest rates of infant mortality in Europe with 3.9 deaths per 1,000 births. (Child Health Profile 2017) The latest Sandwell value however is 5.5 per 1,000 births.
Families who have their baby at Sandwell and West Birmingham Hospitals NHS Trust were the first in the region to receive a Finnish-style Baby Box for their new-born to sleep in.

So far midwives have handed out in excess of 1200 registration cards to women. (The cards are given out at 16 week contact and boxes can be collected from 24 weeks gestation.) 489 women have registered and completed the programme so far.

CDOP Achievements 2016 - 2017

Dog Duck and Cat

In the latter half of 2016 the two new Dog Duck and Cat publications were launched – 'I Love my Car Seat' which promoted car and road safety and 'What's in my mouth', which educated children and their families about choking hazards including the dangers of button batteries.

Both these booklets are used to disseminate learning from local Sandwell deaths.

The books are actively used by health visitors, school nurses, children's centres and libraries in Sandwell

They are both available on line together with the complete range of safety and accident prevention booklets

http://www.ourguideto.co.uk/storybooks/

CDOP Achievements 2016 - 2017

❑ Development Day:

A highly successful CDOP development day, sponsored by Sandwell Public Health was held in conjunction with the Lullaby Trust, where 65 partners and stakeholders were invited to analyse modifiable data highlighted by CDOP and to look at possible strategies as to how these could be approached within different agencies. A moving presentation was given by the parent of a child who committed suicide in 2016, reminding attendees of the vital work carried out by the Samaritans.

❑ Co-sleeping child deaths:

CDOP undertook a detailed analysis of 9 co-sleeping deaths that occurred between 2014-2016. The findings from this analysis have now been embedded into child death training packages that have been delivered in a variety of settings. (Sandwell College, Health Visitor training, Designated Safeguarding Leads in schools)

CDOP Achievements 2016 - 2017

- Sandwell College Training Day

Over 400 young people were present during a training/information sharing event at a local college.

The content of the sessions covered three main topics – safer sleeping, road traffic deaths and suicide prevention and awareness. Local cases were discussed following agreement from the families involved who are keen for the learning from their children's deaths to be disseminated

Part Four - Planned Activity for 2017 - 2018

Planned Activity for 2017 - 2018

- Dog Duck and Cat stories will be merged into a combined booklet to amalgamate the 3 existing 0-5 stories and a new story that looks at Co-Sleeping. There will also be new information about road safety, burns and scalds and dog safety that we haven't previously had for the 0 – 5 age range to help support parents, carers and guardians to keep their child safe.
- The Family Nurse Partnership (FNP) will be replaced 2017 – 2018 by Best Start. CDOP will be working closely to support families around safer sleeping and the baby box distribution.
- Sandwell CDOP will be taking part in a second peer review with a neighbouring authority to ensure that decisions made during reviews around modifiable factors and allocation of specified grading is consistent.
- Impact assessment of CDOP Briefings to be completed

CDOP Membership

Name	Agency
Debbie Brown (Chair)	Sandwell and West Birmingham CCG
Dr Helen Grindulis (Vice Chair)	Sandwell and West Birmingham NHS Trust/ Sandwell and West Birmingham CCG
Jaki Bateman (Coordinator)	Sandwell Safeguarding Children Business Unit
Mel Jarvis	SMBC Sandwell Children Social Care
Eileen Welch	Sandwell and West Birmingham CCG
Sue Moore	SMBC Group Head, Education
DI Mick Spellman	West Midlands Police
Mary Molloy	Sandwell and West Birmingham NHS Trust
Peter Forth	SMBC Children's Centres
Sindy Manu	Sandwell and West Birmingham NHS Trust
Caroline Kovaks-Atkinson	Black Country Partnership NHS Trust

Name	Agency
Dr Shail Agarwal	Sandwell and West Birmingham NHS Trust/ Sandwell and West Birmingham CCG
Shawinder Basra-Dhillon	Birmingham Community Healthcare Trust
Randeep Kaur	Sandwell and West Birmingham NHS Trust
Jon Bull	SMBC DECCA
Cindy James	SMBC Public Health
Denise Hooper	SMBC Neighbourhoods
Nicola Ingram	Sandwell and West Birmingham NHS Trust (health visiting team)
Sheila Thomas	Sandwell School Nursing Team
Penny Gorton	Lay Member