



## **ANNUAL REPORT OF THE CHILD DEATH OVERVIEW PANEL**

### **FOR THE REPORTING PERIOD 1<sup>ST</sup> APRIL 2009 TO 31<sup>ST</sup> MARCH 2010**

The Child Death Overview Panel (CDOP) process commenced 1<sup>st</sup> April 2008. CDOP works in partnership across Walsall and Wolverhampton Safeguarding Children Boards and its function is to establish procedures to ensure a coordinated response to all child deaths, namely:

- reviewing the available information on all child deaths of children aged up to 18 years (including deaths of infants aged less than 28 days but excluding those deaths set out in paragraph 7.1b) to determine whether the death was preventable.
- implementing, in consultation with the local coroner, local procedures and protocols that are in line with this guidance on enquiring into unexpected deaths, and evaluating these as part of the information set held on all deaths in childhood;
- collecting and collating an agreed minimum data set on each child who has died and, seeking relevant information from professionals and family members;
- meeting frequently to review and evaluate the routinely collected data on the deaths of all children, and thereby identifying lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children;
- having a mechanism to evaluate specific cases in depth, where necessary, at subsequent meetings. This may involve revisiting child deaths after the outcome of other types of investigations is known (for example, outcomes from SCRs or criminal proceedings);
- monitoring the appropriateness of the response of professionals to an unexpected death of a child, reviewing the reports produced by the rapid response team on each unexpected death of a child, including the extent to which the team has brought together any recorded wishes and feelings of the child, making a full record of this discussion and providing the professionals with feedback on their work. Where there is an ongoing criminal investigation, the Crown Prosecution Service must be consulted as to what it is appropriate for the Panel to consider and what actions it might take in order not to prejudice any criminal proceedings;
- referring to the Chair of the LSCB any deaths where, on evaluating the available information, the Panel considers there may be grounds to undertake further enquiries, investigations or a SCR and explore why this had not previously been recognised;
- informing the Chair of the LSCB where specific new information should be passed to the coroner or other appropriate authorities;

- providing relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family;
- monitoring the support and assessment services offered to families of children who have died;
- advising and monitoring the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths;
- organising and monitoring the collection of data for the nationally agreed minimum data set, and making recommendations (to be approved by LSCBs) for any additional data to be collected locally;
- identifying any public health issues and considering, with the Director(s) of Public Health, how best to address these and their implications for both the provision of services and for training; and
- co-operating with regional and national initiatives – for example, by the Centre for Maternal and Child Enquiries (CMACE)<sup>133</sup> – to identify lessons on the prevention of child deaths.

Copies of all Child Death Review processes and procedural documentation are available on the Walsall Safeguarding Children Board website ([www.wlscb.org.uk](http://www.wlscb.org.uk)).

### Data Collection

National Data Collection Forms have been revised in November 2009 and March 2010 to reflect the recently published revisions made in Chapter 7 (Working Together to Safeguard Children) March 2010. Data forms have been distributed to all agencies across both Walsall and Wolverhampton to assist in the collation and compilation of child death information.

### Networking

Good links have been established with the following.

- CDOP contacts across the West Midlands Regional Network
- Coroner's Office
- Registrar
- Child Health Information Services
- Palliative Care
- Acorns Hospice
- Bereavement Services Helplines
- Neighbouring LSCBs

### CDOP Briefing Sessions

Briefing sessions are held throughout the year to inform agencies about the Child Death Review process and reporting requirements.

### Future Developments

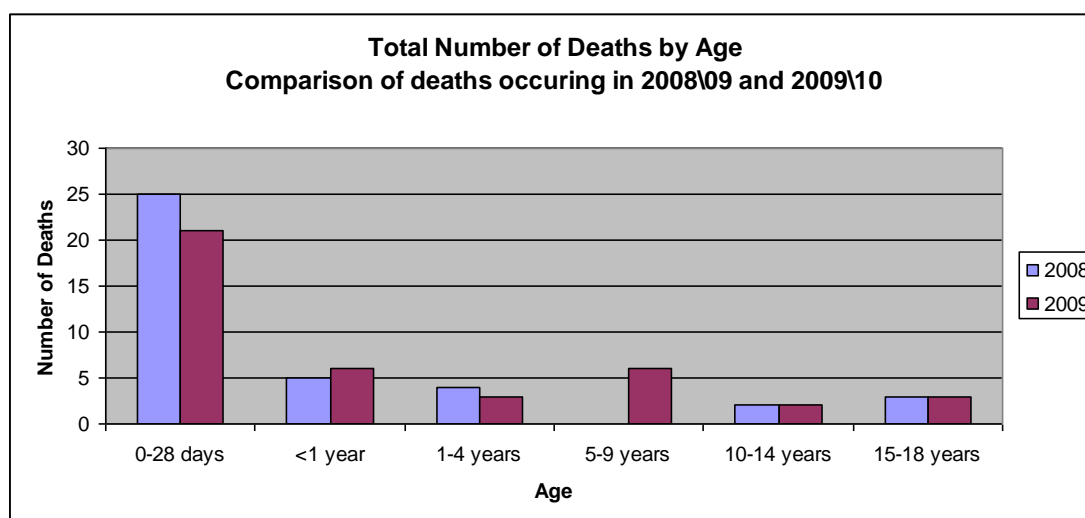
- Guidance notes have now been received from the DCSF for the completion of child death preventable data collection for the year 2009\10 and LSCBs are required to submit relevant data by 28 May 2010.
- Further CDOP briefing sessions to be held 2010.
- Contributing to the development of a national computerised child death database scheduled to be implemented in 2011

### Child Death Data

Reports of all child deaths are submitted to the Panel for review on a quarterly basis. These reports are also submitted to both Walsall and Wolverhampton Safeguarding Children Boards for monitoring outcome purposes.

## Wolverhampton Child Death Data and Trend Analysis

### Total Number of Deaths



The total number of child deaths occurring in Wolverhampton for the period is 41, broken down as follows:

Expected deaths	=	27 (66%)	(2008 = 32 (82%))
Unexpected Deaths	=	14 (34%)	(2008 = 7 (18%))

The total number of unexpected child deaths occurring in this period has almost doubled in comparison to 2008. This is mainly due to a more robust approach to reporting child deaths and processes and procedures being firmly established.

### Unexpected Deaths

Of the 14 unexpected child deaths, 2 deaths have been reviewed on behalf of Sandwell as the children concerned were receiving short term respite care and died whilst temporarily residing in Wolverhampton, under the care of the Sandcastle Project managed by Barnardos.

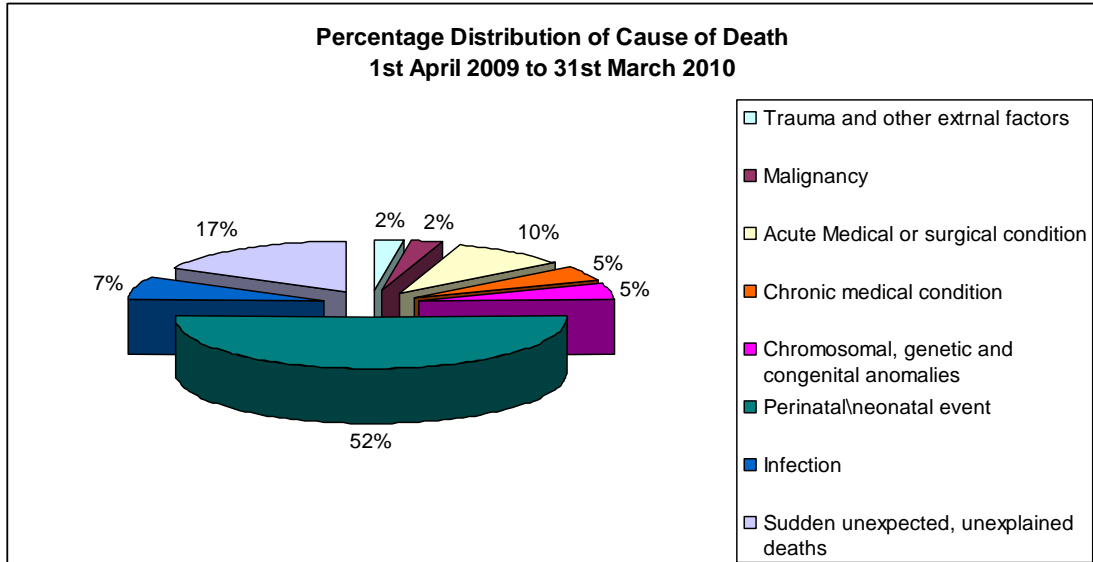
3 unexpected child deaths have been reviewed by the Child Death Overview Panel and the outcome of these reviews has been determined as follows:

- 1 death was determined as unascertained but in keeping with co-sleeping. Panel determined the death as potentially preventable.
- 2 deaths occurred overseas however, Panel were unable to determine preventability due to inadequate information upon which to make a judgement

Postmortem results and Coroner's verdict on the cause of death are still outstanding on 9 unexpected child deaths. Currently, outcomes from postmortems are usually made available within 6 months from the date of death and the scheduling of Coroner's Inquests can take a further month to

finalise the cause of death. These timescales do have a marked impact upon the timing of rapid response review meetings and ultimately results in delays in submission of final reports to the Child Death Overview Panel.

**Percentage Distribution of Cause of Death**

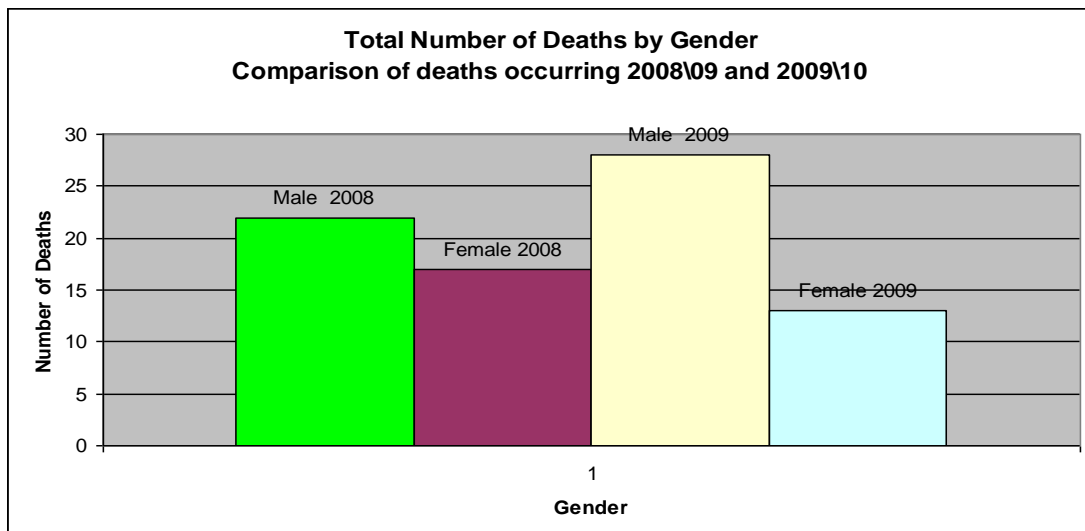


Perinatal\neonatal deaths equates to 52% of the total number of deaths reported during the year, compared to 63% recorded for 2008. A more detailed trend analysis for this age group is detailed below.

17% of deaths were determined as sudden unexpected death or unexplained death. Outcomes from postmortems on these deaths have determined cause of death to be SIDS (Sudden Infant Death Syndrome) or unascertained.

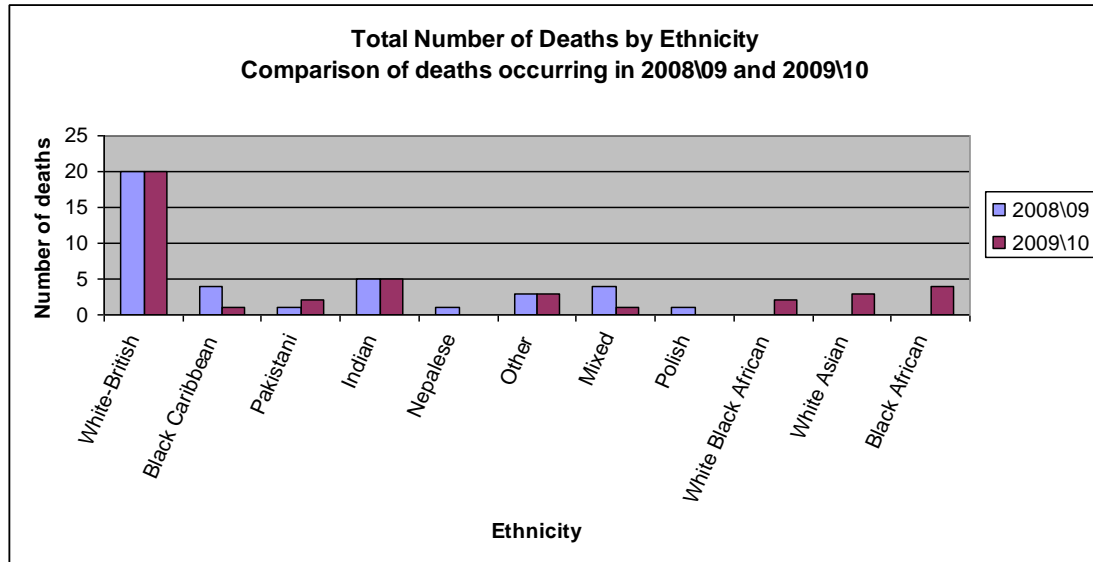
10% of deaths arising from acute medical or surgical condition i.e. acute nephritis and diabetic ketoacidosis.

**Total Number of Child Deaths by Gender**



There is a higher ratio of male deaths compared to female deaths for the period 2009\10 (28:13). The number of male deaths arising in 2009\10 (28) has increased in comparison to those reported in 2008 (22). Conversely, the number of female deaths recorded for the period 2009\10 (13) has decreased in comparison to 2008 (17).

**Percentage Distribution of Child Deaths by Ethnicity**



Of the 41 child deaths, 49% had White-British ethnicity, 12% had Indian ethnicity, 9% had Black African ethnicity 7% White Asian ethnicity.

**Neonatal Deaths**

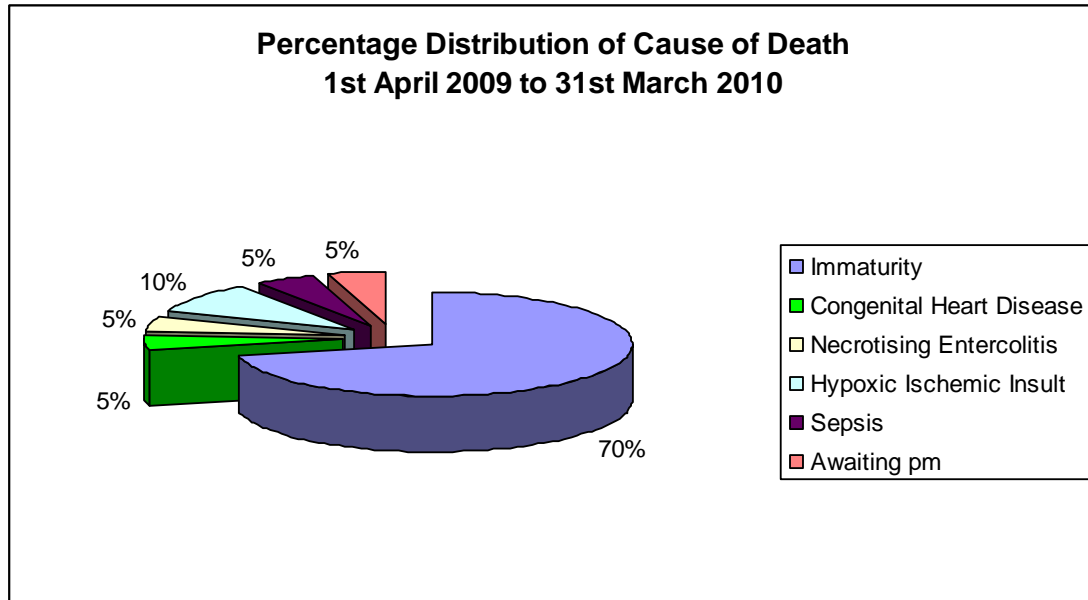
The highest number of reported deaths occurred in the age group 0-28 days (Neonatal).

There is a regional variation in registering live births according to gestational age category. For instance, an infant born at 20 weeks gestation may be regarded as a miscarriage in the North East but as a live birth and then subsequently a neonatal death in the West Midlands.

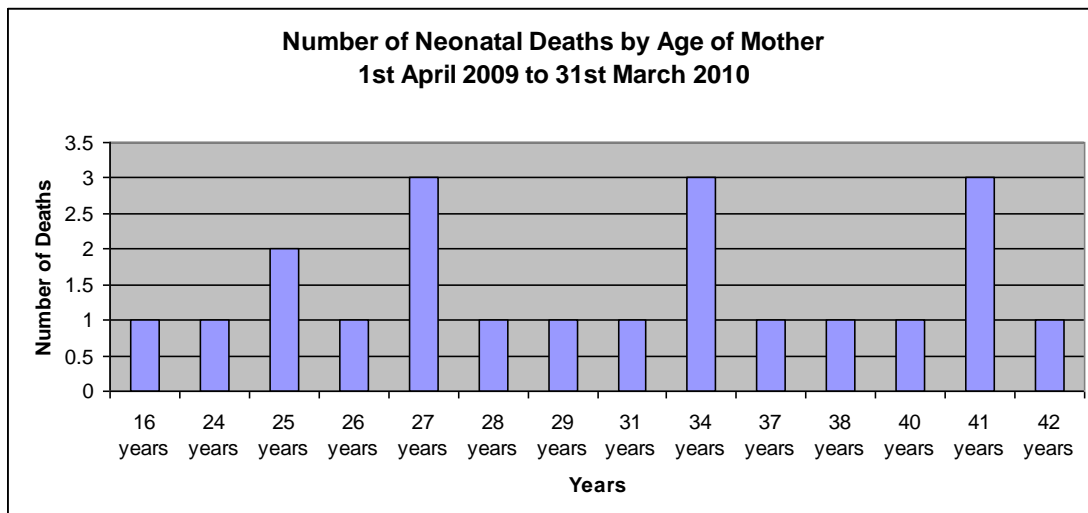
A live birth occurs when an infant shows some sign of life at birth, for example, breathes or shows evidence of life such as voluntary movement, heartbeat, pulsation of the umbilical cord or definite movements of voluntary muscles.

21 (2008 = 25) neonatal deaths have occurred in Wolverhampton this year a slight decrease of 4 deaths in comparison to 2008. The main causes of death being due to immaturity related conditions (70%) and hypoxic ischemic insult (10%) with an average gestational age category of 24 weeks.

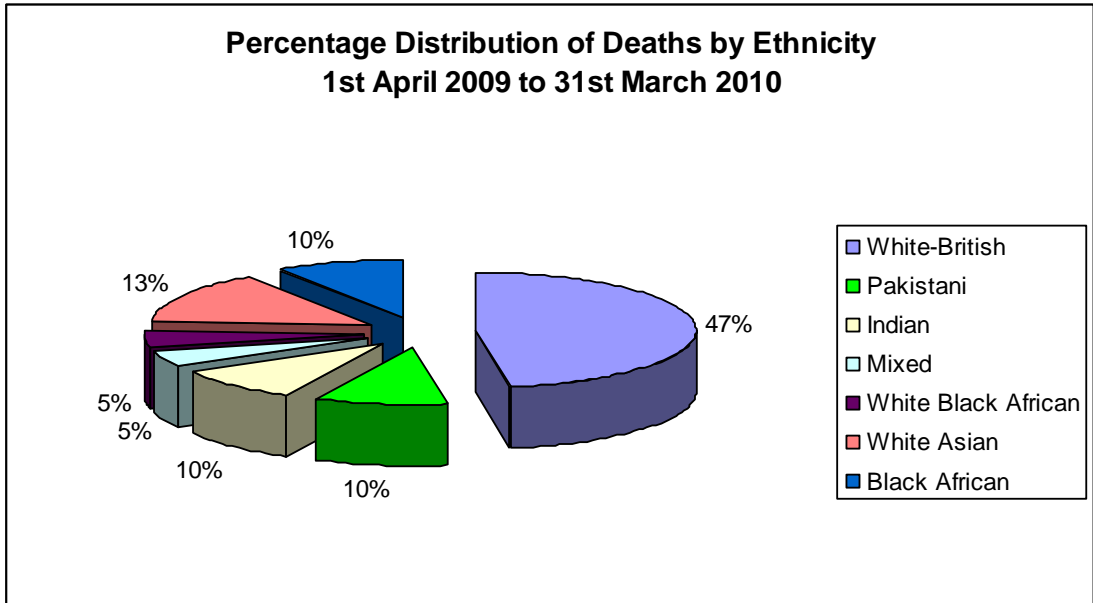
The percentage distribution of causes of neonatal deaths for 2009/2010 are reflected in the graph below. All neonatal deaths are ultimately related to Perinatal events e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus (see Page 5)



The highest proportion of these deaths (3 per age category) occurred in mothers aged 27 years, 34 years and 41 years respectively and 2 deaths recorded for mothers aged 25 years of age. Neonatal deaths for mothers aged under 20 years of age equated to 2%.



Of the total number of neonatal deaths 21 recorded (2008 = 25), 47% had ethnicity White-British (2008 = 44%), 10% ethnicity Pakistani (2008 = 4%), 13% ethnicity White Asian, 10% ethnicity Indian (2008 = 20%), 10% ethnicity Black African (2008 = 8%)



The geographic distribution of neonatal deaths is detailed below with the highest proportion of these deaths occurring in St Peters\Park\Ettingshall (WV2), Graiseley\Merry Hill (WV3), Blakenhall (WV4), Whitmore Reans\Dunstall (WV6), Heath Town (WV10) and Bilston East (WV14).

