Sandwell Health & Wellbeing Board

18 October 2023

Subject:	Child Death Overview Panel report 2021 /22
Presenting Officer and Organisation	Interim Director Public Health, Liann Brookes-Smith Sandwell Council Liann_Brookes-Smith@sandwell.gov.uk
Purpose of Report	Information

1 Recommendations

1.1 That the findings of the Child Death Overview Panel 2021/ 22 are understood and support is made to make a change within the current system.

2 Links to the following Board Priorities

Priority 1	**We will help keep people healthier for longer**
Priority 2	**We will help keep people safe and support communities**
Priority 3	**We will work together to join up services**
Priority 4	**We will work closely with local people, partners and providers of services**

4. Context and Key Issues

4.1. This is the third report from the Black Country Child Death Overview Panel, an interagency forum for Child Death Reviews. Deaths are reviewed from birth to 18 years of age. This is a statutory body, accountable to the Local authority and ICB. Learning from Child deaths is a priority and has an impact on safety and child health and wellbeing

4.2. Data for 22/23 will be available in January 2024

4.3. In 2021/22 there were 40 deaths in Sandwell which was the highest in the black country and double our Black Country neighbours. Cases have been increasing since 2019-2020 but decreasing in Dudley, Walsall and Wolverhampton.

4.4. Half (20) deaths were in the under 27 days. 7 were 29- 264 days, 5 were 1-4 years, 0 were 5-9 years, 5 were 10-14 years and 3 were 15-17 years. Most age groups have seen an increase in deaths.

4.5. Themes that have emerged from the Infant mortality (death under 1 year are

- Smoking in pregnancy
- Obesity
- Concealed pregnancy
- Working with high risk fathers

Following delivery are:

- Monitoring
- Awareness of risk factors
- Adequate staffing in high-risk deliveries.

4.6. LMNS 2022/23 Transformation - Priorities/Deliverables for Best Start Work Stream

- To ensure that every Provider has a Pre-term Birth Clinic
- To ensure that at least 85% of women who are expected to give birth at less than 27 weeks gestation can do so in a maternity unit with appropriate on-site NICU
- To halve the rates of stillbirths, Neonatal deaths, Maternal deaths, and serious intrapartum brain injuries by 2025
- To reduce the national rate of pre-term births from 8% to 6%
- LMNS' should continue to work with Neonatal Operational Delivery Networks to implement local Neonatal improvement plans with a particular focus on
- Maternity and Neonatal services working together to ensure that at least 85% of births at less than 27 weeks take place at a Maternity unit with an onsite NICU and together undertake a review of all births not in the right place. Data from these reviews should be collated at the regional level to support thematic analysis and inform targeted actions.
- Identifying routes to escalate requirements for capital investment in Neonatal services through the relevant ICS routes

4.7. Other lessons learned:

4.8. What the Public Health team are doing:

- Working to put in place a healthy pregnancy service
- Infant mortality deep dive to understand the rates of death in children compared to other areas, i.e. do we have more deaths of the same type compared to other areas.
- working to decrease obesity
- Universal best start vitamins.

5 Engagement

No Public Engagement has occurred

6 Implications

Resources:	It is funded via Public Health grant funding.
Legal and Governance:	Ensuring we are reducing risk and encouraging the best practice in our maternity units and midwifery teams.
Risk:	Raising the profile of the out comes and working with our Local Maternity and Neonatal Systems (LMNS)
Equality:	Working to tackle poorer outcomes in women from minority backgrounds.
Health and Wellbeing:	Improving infant mortality outcomes.
Social Value:	Improve the outcomes for our children and families.
Climate Change:	No climate change implication directly arising from this report.
Corporate Parenting:	Improve the outcomes for our children and families

6 Appendices

Appendix 1 - Black Country Child Death Overview Panel: Annual Report 2021- 2022

7. Background Papers

None