Lancashire Health and Wellbeing Board
Meeting to be held on Tuesday, 3 November 2020

Blackburn with Darwen, Blackpool and Lancashire Child Death Overview Panel Annual Report 2019-20

Contact for further information:
Ruksana Sardar-Akram, Lancashire County Council, Tel: 01772 537839, Ruksana.Sardar-Akram@lancashire.gov.uk

Executive Summary

The purpose of this report is to update the members of the Health & Wellbeing Board of the work undertaken by the pan-Lancashire Child Death Overview Panel (CDOP) during 2019/20, which includes key findings from child death data, progress made on last year's recommendations (2018/19), partnership achievements, and priorities and recommendations for 2020/21.

During the 2019/20 reporting year, CDOP was notified of 108 child deaths (20 Blackburn with Darwen (BwD) residents, six Blackpool residents and 82 Lancashire residents) that were in line with Working Together to Safeguard Children definition and therefore considered by the Pan-Lancashire CDOP. An additional 14 notifications were received which fell outside the statutory guidance and therefore not reviewed. The total number of unexpected deaths in 2019-20 was 36. The Sudden Unexplained Death in Childhood (SUDC) Service has recorded the lowest number of deaths in 2019-20, since the service began (apart from 2008 when the service began in September and the figures were recorded for a six month period only).

Recommendations

The Health and Wellbeing Board is recommended to:

i) Note the update and priorities identified.

ii) Seek confirmation from each organisation that Child Death Overview Panel (CDOP) forms are returned within the statutory three week deadline and are completed as fully as possible, including details of father or other male carers in the household, before they are submitted to CDOP. (The CDOP Business group monitors this on a monthly basis. Whilst there have been measureable improvements over the course of the year, there are still gaps in information which are being followed up).

iii) Assure themselves that there are relevant interagency initiatives in place to reduce the prevalence of modifiable factors, identified in the under one population including:
- Safe sleeping
- Risk factors for reducing premature births including:
- High body mass index (BMI) (including healthy diet and physical activity)
- High blood pressure (linked to high BMI)
- Smoking
- Alcohol use
- Substance misuse
- Domestic violence
- Mental health

Lancashire County Council

- Diabetes (often linked to BMI)
- Lack of physical activity

Background

There is a statutory requirement for the statutory partners to make arrangements to carry out child death reviews. The three local authorities have delegated the responsibility of the child death review arrangements to their respective Directors of Public Health (DsPH). The eight Clinical Commissioning Groups (CCGs) maintain accountability and have delegated the same responsibility to their Health Executive Group who will co-ordinate with NHS England.

The Pan-Lancashire CDOP will, on behalf of the statutory partners will review all infant and child deaths under 18 years of age, with a view to identifying modifiable factors that may reduce future deaths or risk of harm.

Progress on 2019/20 priorities

CDOP successfully completed four out of the six priorities for 2019/20

- Monitor the delivery of the 7-day Sudden Unexplained Death in Childhood (SUDC) service.
- To implement the recommendations from the reviews into trauma and infection - A summary of the actions from the thematic review(s) are included in the report.
- Engagement with GPs - GPs have started completing the reporting pro-forma and this is being monitored by the business group.
- To implement the recommendations from the Adverse Childhood Experience (ACE) Audit – a summary of actions are contained within the full report.

Progress has been made on the remaining two priorities, but as this is on-going, these will carry over to 2020/21 priorities.

Child Death Overview Panel (CDOP) Key Successes 2019/20

- Safer Sleep Campaign: this year's campaign has seen a revision in the materials to consider hard to reach parents, guidance about the suitable sleeping environment up to the age of two years. The campaign work has also promoted the need for more professional curiosity and questioning when parents are being asked about where their child sleeps.
- CDOP Development Day: at which members discussed the CDOP priorities for 2019/20 and some of the challenges CDOP have faced over the past twelve months transitioning to the new Child Death Review Process.
- Positive Recognition: In order to recognise and encourage good practice, or where agencies have gone above and beyond their expected duties, CDOP continue to send letters of good practice where good practice has been identified.
- Pharmacy Campaign: The campaign, which ran throughout November 2019 coincided with the Safer Sleep Christmas messages designed to warn parents of the dangers of falling asleep with baby after drinking alcohol.
- Water Safety Campaign: The CDOP Panel were heavily involved in supporting Lancashire Fire and Rescue and the Royal Life Saving Society promote drowning prevention week which took place in June 2019.

Subgroups

Sudden Unexplained Death in Childhood (SUDC) Prevention Group

The SUDC Prevention Group is coordinated by the pan-Lancashire CDOP and is funded by the CDOP budget (£15,000). The funding maintains the supply of safer sleep materials to agencies across Pan-Lancashire.

Child Death Investigation Group

Lancashire Constabulary continue to host the monthly multi-agency Child Death Investigation Group which aims to promote best investigative practice, identify areas for development and continue the established partnership working in this critical area.

Sudden Unexplained Death in Childhood (SUDC) Service

The Sudden and Unexpected Deaths in Children (SUDC) Service, is a unique nurse-led service that has provided the health element of the Pan-Lancashire multi-agency Rapid Response process to a sudden and unexpected death of a child since September 2008.

Provision of a 7-day Sudden Unexplained Death in Childhood (SUDC) Service

The SUDC Service commenced a 7-day service delivery model in January 2019. This has led to improved equity in the responses undertaken. The service have recently completed their first full year.

The total number of unexpected deaths in 2019-20 was 36.

The SUDC Service has recorded the lowest number of deaths in 2019-20, since the service began (apart from 2008 when the service began in September and the figures were recorded for a six month period only).

Themes

There has been several baby deaths where co-sleeping/inappropriate sleeping arrangements have been a feature. Alcohol and substance misuse has possibly been a contributory factor in some of these cases. The SUDC service has seen an increase in co-sleeping deaths in recent years, however this year's figures show a significant and encouraging reduction. This decrease in co-sleeping figures is significant in terms of a reduction in infant deaths across Lancashire. Deaths of this nature will continue to be monitored alongside wider SUDC prevention strategies.

During 2019-20 a small number of young people have ended their own lives, however this year's figure represents a fifty percent reduction from the figures of last year and the previous two years.

During 2019-20 there was a slight increase in the number of children dying from medical related conditions, particularly those that have developed acute illnesses, such as gastrointestinal bleeds, asthma, allergies and infections. There has been an increase from 27% in 2018-19 to 33.3% in 2019-20 of children dying that were known to have complex health needs or underlying health conditions.

Out of the 36 unexpected child deaths in 2019-20, Children's Social Care were involved (at the time of death or following death) in 47% of the cases. Domestic violence was reported between parents/carers in 25% of the cases. 27% of the parents were reported to have had mental health problems. In 16% of the cases, parents reported consuming alcohol/or taking substances on the night prior to their child's death. 19% of the cases were referred for Child Safeguarding Practice Reviews (CSPR) consideration. 11% met the criteria for a CSPR. This evidences the significant number of complex social circumstances and chaotic family dynamics that some of these children were living in at the time of their deaths.

A modifiable factor is 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" (Working Together, 2018).

Across pan-Lancashire modifiable factors were identified in 43% of all deaths. Compared to 2018-19 where by 51% of cases reviewed had modifiable factors. The number of cases with modifiable factors across England is 30%. The most common modifiable factors identified in 2019-20 across pan-Lancashire were smoking and substances abuse (alcohol and/or drugs).

CDOP Priorities for 2020/21

- Promotion of the Safe Sleep Campaign throughout pharmacies during November 2020.
- Ensure the sleep assessment tool is embedded in practice.
- Ensuring fathers are included in all aspects of antenatal and postnatal care and are made aware of the safer sleeping campaign.
- Improve the quality and outputs of the child death review processes by ensuring all agencies understand the new guidance and relevant processes.
- Demonstrate improvements against national standards through self-assessment Continue to collect data for Adverse Childhood Experiences (ACEs), and analyse patterns in links between ACEs and child deaths.
- Ensure that any preventive strategies and initiatives link with any existing health and wellbeing/ clinical workstreams.
- Ensure that the reduction of infant/child death forms part of integrated multi-agency strategies.

List of background papers

A copy of the full Blackburn with Darwen, Blackpool & Lancashire Child Death Overview Panel Annual Report 2019-20 is available to members of the Health and Wellbeing Board upon request.