Lancashire Health and Wellbeing Board
Meeting to be held on Tuesday, 7 May 2024

Corporate Priorities:
Delivering Better Services

Director of Public Health Child Death Overview Panel (CDOP) Annual Report

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Brief Summary

The Child Death Overview Panel (CDOP) Annual Report outlines the analysis of cases derived from panels held across Blackburn with Darwen, Blackpool and Lancashire and provides information on trends and patterns in child deaths reviewed during the reporting year (2022/23) and notified deaths (2022/23). The report also highlights key achievements and priority areas for 2023/24.

Recommendations

The Health and Wellbeing Board is asked to:

(i) Review and comment on the key findings including modifiable factors associated with child deaths.
(ii) Seek assurance on the progress being made through the Best Start in Life priority workstream.

Detail

The Pan Lancashire Child Death Overview Panel (CDOP) Annual Report provides an analysis of cases derived from panels held across Blackburn with Darwen, Blackpool and Lancashire and provides information on trends and patterns in child deaths reviewed during the reporting year (2022/23) and notified deaths (2022/23). The main purpose is to ensure that information is systematically captured for every death to enable learning and prevent future deaths and share learning with colleagues regionally and nationally, so the findings have wider impact.

Background

The publication of the Child Death Review Statutory and Operational Guidance in 2018 built on the requirements set out in Chapter 5 of Working Together to Safeguard Children 2023 and details how individual professionals and organisations across all sectors involved in the Child Death Review should contribute to guided

standardised practice nationally and enable thematic learning to prevent future child deaths.

Child Death Review partners, the Local Authorities, and the Integrated Care Board (ICB) for the local area hold responsibility for the delivery of the Child Death Review Process as set out in the Children Act 2004, as amended by the Children and Social Work Act 2017.

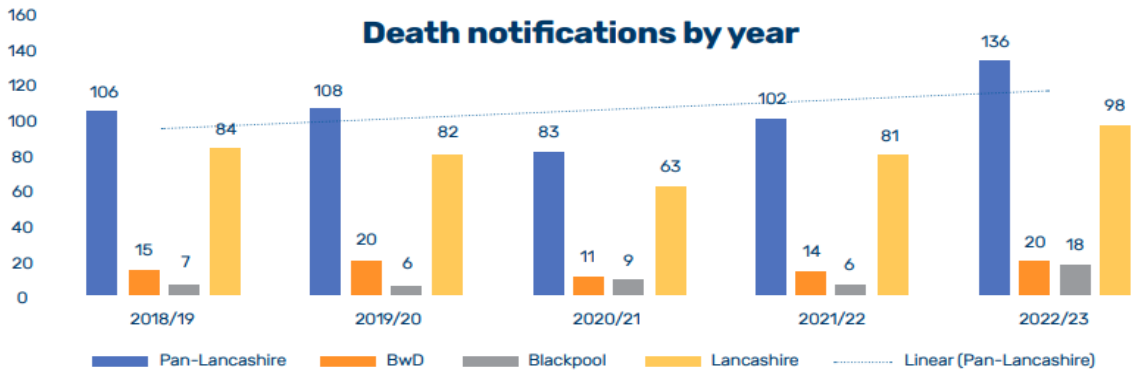
The aim of the Child Death Review (CDR) process is to ensure that information is systematically captured for every death to enable learning and prevent future deaths and share learning with colleagues regionally and nationally, so the findings have wider impact.

The Pan Lancashire Child Death Overview Panel (CDOP) annual report provides the Health and Wellbeing Board an analysis of cases derived from panels held across Blackburn with Darwen, Blackpool and Lancashire and provides information on trends and patterns in child deaths reviewed during the reporting year (2022/23) and notified deaths (2022/23).

Key Findings

Death notifications between 1 April 2022 and 31 March 2023

- Pan-Lancashire Child Death Overview Panel (CDOP) received 136 notifications of child deaths within Lancashire, Blackburn with Darwen (BwD), and Blackpool, where the child died between 1 April 2022 and 31 March 2023.
- This represents an increase of 34 deaths, compared to the previous year.
- This appears to be in line with national trends as National Child Mortality (NCM) also recorded the highest number of deaths in a year (3,734) since the National Child Death Mortality Database (NCMD) started data collection in 2019 (ref - Child death data release 2023|National Child Mortality Database (ncmd.info))



Percentage of death notifications by age group pan-Lancashire

- Over the period of April 2022 - March 2023, most deaths occurred in infants under one year of age, and this follows the national pattern.
- Of the 136 cases notified to Pan-Lancashire Child Death Overview Panel in 2022/23, 78 (57%), compared to 64 (62%) in 2021/22 were deaths in infants under one year of age.

- Just over half (56%) of the deaths in 2022/23 were in the first 27 days, compared to the previous year where the proportion of deaths in infants aged between 0-27 days represented (65%) of all deaths in under one-year olds.

Joint Agency Responses 1 April 2022 and 31 March 2023

- There have been 65 unexpected deaths since April 2022. This is the highest recorded figure in the Sudden Unexplained Death in Childhood (SUDC) Service history over the last decade.
- There have been more deaths of boys in both the 0–1 year-old and 1–17 year-olds, with a slightly more equal split between boys and girls in the older age group.
- This is in line with national figures.

Deaths reviewed between 1 April 2022 and 31 March 2023

- It is important to note that most deaths notified in the reporting year will not be reviewed in the same year. This is because other reviews/investigations need to be concluded before being scheduled onto a panel e.g. internal reviews, Perinatal Mortality Review Tool (PMRT), coroner's inquests, criminal prosecutions etc).
- During the year 1 April 2022 – 31 March 2023 (2022/23), the pan-Lancashire Child Death Overview Panel (CDOP) reviewed 91 child deaths (13 (14.3%) Blackburn with Darwen (BwD) residents, 5 (5.5%) Blackpool residents, 73 (80.2%) Lancashire residents.
- Of the 91 reviews completed in 2022/23, were 58 (64%) expected deaths, and 33 (36%) were unexpected.
- The proportion of reviews that identified modifiable factors has increased slightly compared to the previous reporting year, with 54% of deaths reviewed during 2022/23 identifying one or more modifiable factors. This is higher than the national picture for England, where 39% of deaths identified modifiable factors in 2022/23.

Child Death Reviews by Gender

- In 2022/23 there was a higher proportion of reviewed deaths in males (60%) compared to females (40%) which is similar to the national data, where this is also evident.

Child Death Reviews by Ethnicity (2022/23)

- Of the 91 cases reviewed, over half (65%) of these deaths were in under one-year olds, and most were in the first 27 days.
- 35% of reviewed deaths were in children aged between 1-17 years old, which is lower compared to previous reporting years.
- Of the 91 cases reviewed in 2022/23, 90 (98.9%) had an ethnicity recorded (improvement from 91% of cases reporting year 2021/22).
- Of the 91 cases, just over half (57.1%) were White British, and (26.2%) were of South Asian heritage - including Asian/Asian British Pakistani (21%), Asian/Asian British Indian (5%). Other ethnic groups (including other Asian, and other White backgrounds) accounted for (15.3%) of deaths.

Category of death

- The most common category of death across pan-Lancashire for cases reviewed during 2022/23 was evenly split between chromosomal, genetic, and congenital anomalies (30%) and Perinatal/neonatal events (30%).
- This correlates to the higher numbers of deaths occurring in children under one year of age. By way of comparison in 2021/22 the most common category was chromosomal, genetic, and congenital anomalies (30%).
- Perinatal/neonatal events accounted for second most common category of death (23%).

Location of death (Based on the child deaths reviewed in 2022/23)

- The majority (81%) of children died within a hospital setting.
- This is expected due to many of the deaths occurring during neonatal and perinatal events, and chromosomal, genetic, and congenital anomalies, which require medical support.
- In 11 cases (12%) of children and young people died at home or other private residence, including children who had end of life care plans in place, as well as children who died unexpectedly.

Modifiable Factors and category of death (2022/23)

- 54% of cases reviewed across pan-Lancashire identified one or more modifiable factor.
- This is slightly higher compared to previous three reporting years. Nationally lower 39%.
- The most common modifiable factors identified across pan-Lancashire were inadequate service provision or treatment plan issues (45%), smoking by parent/carer (39%), maternal BMI (high/low) (29%) and alcohol/substance misuse (16%).
- The largest category of deaths in pan-Lancashire with modifiable factors was Category 8: perinatal/neonatal events (47%).
- The second largest category to have modifiable factors was Category 2: suicide or deliberate self-inflicted harm (12%).

What has Child Death Overview Panel (CDOP) Achieved in 2022/23

Sudden and Unexpected Death in Childhood (SUDC) Prevention

- The Sudden and Unexpected Death in Childhood (SUDC) Prevention Group continues to be coordinated by the pan-Lancashire Child Death Overview Panel (CDOP).
- The group has developed approaches to ensure work around ICON, Safer Sleep and the inclusion of fathers are interlinked.
- A national recognition was shared in parliament for the pan-Lancashire Sudden and Unexpected Death in Childhood (SUDC) Service for being outstanding.

- A national safeguarding star was awarded to one of the Sudden and Unexpected Death in Childhood (SUDC) Prevention Groups. (Award was presented by the NHSE National Safeguarding Team).

Safer Sleep

- An Early Years project in East Lancashire is being developed with pilots planned in Burnley and Hyndburn.
- A tool and a pathway have been developed to explore family trauma and determine the best plans to put in place to ensure babies sleep safely.
- Health visitors have all been trained on trauma informed practice, trauma informed language and conversation.
- Working closely with the third sector there will be an independent evaluation of the pilot after six months.
- The project is linked to a national programme of developing services.

ICON

- The ICON Task and Finish group was established to coordinate the local roll out of the ICON programme and 2022/23 saw the group became a permanent subgroup.
- The group aims to utilise information from the local Child Death Overview Panel (CDOP) and other sources to deliver the promotion of ICON messages throughout Lancashire.

Campaigns

- The Sudden and Unexpected Death in Childhood (SUDC) Prevention Group supported several campaigns during the reporting period, sharing key messages including Drowning Prevention, Farm Safety, ICON, and Safer Sleep.

Safety Alert

- The Child Death Overview Pane (CDOP) raised concerns regarding unsafe 'self-feeding' products, linking with Amazon and Trading Standards, resulting in an Urgent Safety Alert being issued by the Office of the Product Safety and Standards.
- In March 2023, the Child Death Overview Panel (CDOP) ran a three hour briefing session which provided insights into when and where deaths occurred.

Child Death Overview Panel (CDOP) Priorities for 2023/24

(i) Ensure that the reduction of infant/child death forms part of integrated multi-agency strategies.
(ii) Ensure that the Sudden and Unexpected Death in Childhood (SUDC) prevention is integral to relevant Public Health strategies across Lancashire.
(iii) Highlight risks and issues identified through child death reviews and provide intelligence for inter-agency partnerships.
(iv) To seek assurance that bereavement support services are readily available to children, young people, families, and communities across pan-Lancashire.

(v) Promote the safer sleep and ICON campaign and maintain a supply of materials to agencies across pan-Lancashire.
(vi) Raise the profile of the Child Death Overview Panel (CDOP) and the Child Death Review processes, by delivering multiagency training across the system.
(vii) Audit the safer sleep/ICON campaign and ensure the current materials and safer sleep guidelines. are in line with evidence-based research.
(viii) Reduce the variability of reporting forms and routinely missing information e.g. male partners.
(ix) Improve data completeness, with a focus on ethnicity.
(x) To undertake a thematic review of Category 2 deaths, pan-Lancashire (including deaths due to suicide or deliberate self-inflicted harm) occurring between 2013 and 2022) to help understand adolescent suicide risk factors and trends, which will inform early intervention and preventative strategies.

List of background papers

N/A