# HEALTH AND WELLBEING BOARD

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| **TO:** | Health and Wellbeing Board |
| **FROM:** | Cath Taylor, Acting Consultant in Public Health |
| **DATE:** | 20/06/2022 |

**SUBJECT: Child Death Overview Panel (CDOP) Annual Report 2020-21**

## 1. PURPOSE

To update the Health & Wellbeing Board on the work undertaken by the pan-Lancashire Child Death Overview Panel (CDOP) set out in the annual report 2020/21. This includes key findings from child death data, progress made on last year's recommendations (2019/20), partnership achievements and recommendations for 2021/22.

## 2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

Health and Wellbeing Board partners are asked to:

a. Note the content of this report, and in particular the CDOP priorities and recommendations for 2021/22 (paragraph 5.11-12).

b. Note the contribution that Blackburn with Darwen partners are currently making towards CDOP priorities and recommendations (paragraph 5.13).

## 3. BACKGROUND

The independently chaired pan-Lancashire Child Death Overview Panel (CDOP) has a statutory responsibility to review the deaths of all children in Lancashire. Local authorities and Clinical Commissioning Groups are statutory partners and must support the review process in line with national guidance (Child Death Review Statutory and Operational Guidance, 2018). This includes requirements for individual professionals and organisations to contribute to standardised national practice and undertake learning to prevent future child deaths.

CDOP reports to each statutory partner individually (at appropriate intervals and by exception) and also to statutory strategic partnerships including the pan-Lancashire Children's Safeguarding Assurance Partnership (CSAP), Health and Wellbeing Boards and the Community Safety Partnership.

The CDOP annual report provides the mechanism for this reporting and reports on both child death notifications for the previous year, and also the findings of the review panels. It should be noted that the review panels are often undertaken over a year after a child's death is notified and therefore these two data sets are reported separately. The annual report is not for public distribution, and therefore has not been attached to this report, as it contains small numbers which could potentially lead to a child death's being identifiable. A redacted version of the report will be published on the CSAP website shortly.

Children are defined as those up to the age of 18 years old resident within the three Local Authority areas of Blackburn with Darwen (BwD) Council; Blackpool Council; and Lancashire County Council

(LCC). There are a number of exceptions include babies who are stillborn, late foetal loss and planned terminations of pregnancy carried out within the law.

**3.1 CDOP Membership**

The Pan-Lancashire CDOP membership is made up of senior multi-agency professionals from a range of organisations who can make a valuable contribution when undertaking a child death review. During 2020/21 the CDOP had representation from Lancashire Constabulary, the Sudden Unexpected Death in Childhood (SUDC) Service, Children's Social Care, the pan-Lancashire Children's Safeguarding Assurance Partnership (CSAP), Community Health Services, North West Ambulance Service, Lancashire & South Cumbria NHS Foundation Trust (LSCFT), Midwifery, Paediatrics, Clinical Commissioning Groups, Public Health, and Education and Early Years.

During 2020/21, the CDOP panel met on 12 occasions (6 neonatal panels, 6 all age panels). 100% of business meetings had geographical representation from all Lancashire upper tier local authorities and CCGs, with a member from each area being in attendance at each meeting. Additionally, throughout the reporting year the panel has had 15 observers.

CDOP is supported by Children's Safeguarding Business Managers, the SUDC Prevention Group, the Child Death Investigation Group, and the SUDC Service, and all have significant roles in leading, supporting and informing the developmental and prevention work with partners across pan-Lancashire.

**3.2 Progress on 2020/21 priorities**

CDOP successfully completed four out of the eight priorities which were identified for 2020/21, following the 2019/20 annual report. This includes to:

- Improve the quality and outputs of the child death review processes, including reducing missing information and maximising the potential of eCDOP database to improve efficiency.
- Monitoring the delivery of the 7-day SUDC service, and continuing to provide oversight of the SUDC service as well as advocating change where appropriate.
- Support on producing a Covid Impact thematic review.
- Ensuring the reduction of infant/child deaths forms part of integrated multi-agency strategies.

Progress has also been made on the remaining four priorities, but this is on-going and will carry over to 2021/22 priorities (see Section 5.11).

**3.3 CDOP key achievements 2020/21**

The following campaigns have been developed and successfully delivered across pan-Lancashire to promote key messages based on learning gained from child death reviews:

- Positive recognition - letters acknowledging good practice where agencies have gone above and beyond their expected duties.
- Safer Sleep briefing sessions raising awareness of SUDCs to over 280 local stakeholders.
- Safer Sleep Assessment & Action Plan Tool launched in April 2020 to be completed with parents during home visits to improve awareness of safer sleeping.
- Blackburn with Darwen, Blackpool and Lancashire Child Death Overview Panel e-learning course delivered.

**4. RATIONALE**

As set out in paragraph 3.0, the local authority and CCG are statutory partners within the pan-Lancashire Child Death Overview Panel (CDOP). The panel reports annually to the Health & Wellbeing Boards, and into the wider pan-Lancashire Children's Safeguarding Assurance Partnership (CSAP) (of which CDOP forms part).

## 5. KEY ISSUES

### 5.1 Findings from data analysis 2020-21

Between 1st April 2020 to 31st March 2021, CDOP received 83 child death notifications which met the criteria for review (11 Blackburn with Darwen (BwD), 9 Blackpool, and 63 Lancashire residents). There has been a downward trend in child death notifications over the last 10 years, with a notable reduction of child deaths in 2020/21, with 25 fewer deaths compared to the previous reporting year. This is in line with national trends, and may be due to social distancing and other public health measures put into place in response to the COVID-19 pandemic.

The Panel completed 80 reviews of child deaths during 2020/21. Eleven ongoing cases were subject to a Serious Case Review (SCR) or Child Safeguarding Practice Review (CSPR). It should be noted that Child Safeguarding Practice Reviews have now replaced the previous requirement for Local Safeguarding Children Boards to complete Serious Case Reviews (SCR).

### 5.3 Age

Of the 80 cases reviewed, the highest proportion of deaths (64%) that occurred were in children under one year of age, with 20% aged 1-9 years, and 16% 10-17 year olds.

### 5.6 Place

The majority of children died within a hospital setting (72%), with 18% of children and young people dying at home, which includes unexpected deaths and children on end of life care plans.

### 5.4 Ethnicity

Of the 80 cases reviewed in 2020/21, 67 (84%) had an ethnicity recorded. The ethnicity of the majority (69%) of child deaths reviewed across Lancashire were White-British. However, 11% of child deaths were children of South Asian heritage (including Asian/Asian British Pakistani (9%), Asian/Asian British Indian (2%), and Asian/Asian British Bangladeshi) which is a slight over representation for this ethnic group based on the 2011 Census for Lancashire's South Asian population (9%).

### 5.5 Category

The most common category of death across pan-Lancashire for cases reviewed during 2020/21 was 'perinatal/ neonatal event' (30%) with 'chromosomal, genetic and congenital anomalies' accounting for the second most common category (28%). This is consistent with national data where perinatal and congenital causes are the most common, especially in neonates (less than 4 weeks old). When comparing the latest 3 years data, to the previous 3 years, the number and proportion of reviewed deaths due to perinatal/neonatal events across pan Lancashire have increased.

### 5.2 Modifiable factors

Part of the review process is to understand which child deaths involved modifiable factors that could have reduced the risk of death. A modifiable factor is defined as: 'one or more factors, in any domain, which may have contributed to the death of a 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 the proportion of reviews that identified modifiable factors remained the same compared to the previous reporting year, with 43% of all deaths reviewed during 2020/21 identifying one or more modifiable factor. Since 2015/16 the proportion of cases identified with modifiable factors has risen by 8 percentage points. This may be due to improved reporting and consistent inclusion of significant risk factors such as smoking or obesity in pregnancy, which has ensured modifiable factors are in line with other CDOP's and national figures. Nationally the percentage of deaths considered to be 'modifiable' increased from 24% in 2015 to 31% in 2020.

The most common modifiable factors identified (including expected and unexpected deaths) across pan-Lancashire in 2020/21 were smoking by parents/carer in the household (44%), followed by unsafe sleeping arrangements (29%).

**5.7 Expected and unexpected deaths**

In 2020/21, just under two thirds (63%) of all reviewed child deaths were expected compared with 30% that were unexpected. 8% were reviewed as unexpected but met exclusion criteria.
An unexpected death is defined by Working Together (2018) as 'the death of an infant or child which was not anticipated as a significant possibility 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'.

The majority of deaths that occurred within the first year of life were expected and attributed to complications relating to prematurity or chromosomal, genetic/congenital abnormalities. In older children deaths tended to be unexpected. Between 1st April 2020 and 31st March there were 45 unexpected deaths, which triggered a Joint Agency Response. Deaths related to unsafe sleeping practices accounted for 10 of these cases (22%).

Sadly, there were 3 deaths reviewed in 2020/21 due to suicide or deliberate self-inflicted harm across pan-Lancashire. This compared to 3 in 2019/20 and 7 in 2018/19. The majority of these deaths were children already known to services. Lancashire and South Cumbria Integrated Care System is leading a comprehensive logic model action plan to reduce the number of suicides, including support for those who self-harm, and to improve outcomes for those affected by suicide.

The themes identified from all unexpected child deaths in 2020/21 included the following, largest to smallest:

- Underlying health conditions/ Complex health needs (joint first)
- Co-sleeping/Unsafe sleeping arrangements (joint first)
- Neonatal cases (joint first)
- Accidental
- Murder investigations (joint third)
- Suicides (joint third)
- Unresponsive / unascertained (joint third)
- Concealed and denied pregnancy

**5.9 Complex social circumstances**

Of the unexpected deaths in 2020/21, just over one third were known to Children's Social Care. Key themes identified at the time or death or following death, included: Domestic violence between parents/carers (8); parental mental health problems (15); and parental alcohol/ substance misuse (10). These cases highlight the complex social circumstances, chaotic family dynamics and environmental factors that these children were living in at the time of their deaths. CDOP continues to collect data on Adverse Childhood Experiences with a view to making recommendations to partners.

**5.10 Summary of Blackburn with Darwen specific data**

The annual report presented a summary of data specific to deaths of children in BwD which were reviewed in 2020/21. Please note that some of this data contains small numbers and therefore some caution should be used within interpretation.

- 69% of deaths reviewed were completed within 12 months of the child's death
- 77% of deaths reviewed were expected, and 23% were unexpected
- Where ethnicity was recorded, 44% of deaths were of South Asian heritage – Asian/Asian British Pakistani (11%), Indian (22%) or Bangladeshi (11%). Based on the 2011 Census, this is disproportionately high, compared to BwD's under 18 South Asian population (38%).
- For 31% of deaths reviewed, the ethnicity was either not known or not recorded.
- 54% of deaths reviewed were male.
- 31% of deaths reviewed had modifiable factors identified.

- There were four cases deemed to have modifiable factors, of which smoking and raised BMI were identified in three.
- The most common category of death 'chromosomal, genetic and congenital anomalies' (39%) and 'perinatal/ neonatal event' accounting for the second most common category (20%).

**5.11 CDOP Priorities for 2021/22**

During the forthcoming year CDOP will maintain its current priorities as follows:

1. Deliver the SUDC Prevention group priorities including provision of materials to partner agencies, continued roll-out of current safer sleep and other campaigns and embedding use of the sleep assessment tool.
2. Improve the quality and outputs of the child death review processes.
3. Maximise the potential of the CDOP Database.
4. Continue to collect data for Adverse Childhood Experiences (ACEs) and analyse patterns in links between ACEs and child deaths.
5. Ensure that any preventive strategies and initiatives link with any existing health and wellbeing/ clinical workstreams.
6. Monitor the delivery of the 7-day SUDC service.
7. Ensure that the reduction of infant/ child death forms part of integrated multi-agency strategies.
8. Ensure all agencies and professionals provide input to the processes at the appropriate time.

**5.12 CDOP Recommendations for 2021/22**

The annual report made the following recommendations for CDOP during 2021/22:

- A review of the modifiable factors and actions/response to these to be integrated into existing work-streams across the (CDOP) Public Health team and with core partners.
- For each (upper tier) locality area to have an Infant Mortality Strategy and Action Plan with an identified Group that leads, or it reports to, which is then accountable to the appropriate Health and Wellbeing Board. To be developed over the next 12 months.
- Annual/6 monthly validation checks of CDOP data (carried out by an analyst) to minimise discrepancies prior to the production of routine annual CDOP analysis/reports.
- Ensure data is recorded/captured around genetic condition type (X-linked/autosomal recessive/autosomal dominant etc) where possible for Category 7 deaths (chromosomal, genetic and congenital anomalies) – currently not routinely or consistently recorded as part of the CDOP dataset.
- To continuously improve data completeness, partners must ensure all professionals providing information to CDOP complete the forms as fully as possible before they are submitted.

**5.13 Blackburn with Darwen programmes**

Whilst many of the CDOP priorities and recommendations are taken forward at a pan-Lancashire level by the CDOP team, BwD partners continue to make a significant contribution to this work, for example, through the following initiatives.

***Infant mortality strategy***

BwD Public Health team has started work to develop an Infant mortality strategy and associated action plan. The strategy will cover a broad range of risk factors associated with infant mortality including community genetics, smoking in pregnancy, safer sleep and childhood accidents. It will bring together a range of activities already underway and new initiatives within a strategic logic model framework, currently under development at ICS level.

***Safer sleep campaigns and sleep assessment tool***

BwD sits on the pan-Lancashire Safer Sleep Task and Finish group to support the development

and growth of this work. Children's Services and the 0-19 Service have their own action plans to ensure that all staff receive training and deliver safer sleep messages to families at every contact. The BwD communications team links to national resources and campaigns including supporting Safe Sleep Week and the Lullaby Trust.

***ICON 'Babies cry, you can cope' campaign***

BwD Public Health team supports the pan-Lancashire ICON Task and Finish group and have been particularly involved in supporting the development of a lesson plan and resources as part of PSHE delivery in schools. The lesson plan, which is aimed at Y10 pupils, is now ready for its pilot phase. Secondary schools in BwD have been invited to take part in this and to roll out the resources during ICON week in September.

***Community genetics***

BwD have been actively involved in the commissioning of targeted support with regards to consanguinity and genetic risk for a number of years following data related to high numbers of infant deaths due to chromosomal abnormalities within the Borough. A Health Visitor Champions model is currently in place with ongoing training and supervision provided by a genetics specialist to support health visitors to identify and refer appropriate families to the genetics service for screening and counselling. An app is also being developed in partnership with Manchester University to supplement engagement with at risk families. BwD has also developed an education package that was previously delivered by a third sector provider in schools and colleges.

Recently BwD has been identified to take part in a national genetics programme after being identified as one of eight target areas of need across the UK.

***ACEs***

BwD Public Health team has developed a Systems Resilience Framework to support the early identification of Adverse Childhood Experiences and to mitigate the health and social impact related to the experiences of ACEs and trauma amongst the population. BwD 0-19 services use Routine Enquiry to ascertain risk associated with a pregnancy and make referrals where necessary to mental health support services, children's services and other third sector and community partners to support a family to break the cycle of adversity.

An early years (Start Well) network has been established in order to engage more awareness amongst core partners and to share good practice in this area. An extensive training offer has been established through the Lancashire Violence Reduction Network and a pledge of support has been signed to ensure that BwD is committed to becoming a Trauma Informed Borough.

**6. POLICY IMPLICATIONS**

The CDOP process is set out within the following national policy guidance documents:

- Child Death Review Statutory and Operational Guidance (England), October 2018.
- Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children (July 2018).
- Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation (2016).

**7. FINANCIAL IMPLICATIONS**

Alongside all statutory partners, Blackburn with Darwen make an annual contribution to funding the pan-Lancashire Children's Safeguarding Assurance Partnership of which CDOP forms part. In 2021/22 this figure was £166,817 (£50,000 from BwD CCG and £116,817 from BwD Borough

Council).

**8. LEGAL IMPLICATIONS**

A child death review partner in relation to a local authority area in England is defined under the Children Act 2004 as (a) the local authority, and (b) any clinical commissioning group for an area any part of which falls within the local authority area. The two partners must make arrangements for the review of each death of a child normally resident in the area and may also, if they consider it appropriate, make arrangements for the review of a death in their area of a child not normally resident there. They must also make arrangements for the analysis of information about deaths. The purposes of a review or analysis are (a) to identify any matters relating to the death or deaths that are relevant to the welfare of children in the area or to public health and safety, and (b) to consider whether it would be appropriate for anyone to take action in relation to any matters identified.

Extract from *Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children* (July 2018).

**9. RESOURCE IMPLICATIONS**

The child death review partners should consider the core representation of any panel or structure they set up to conduct reviews and this would ideally include: public health; the designated, doctor for child deaths for the local area; social services; police; the designated doctor or nurse for safeguarding; primary care (GP or health visitor); nursing and/or midwifery; lay representation; and other professionals that child death review partners consider should be involved. It is for child death review partners to determine what representation they have in any structure reviewing child deaths.

Extract from *Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children* (July 2018).

**10. EQUALITY AND HEALTH IMPLICATIONS**

The CDOP review process is compliant with the Equality Act 2010, outlined in Child Death Review Statutory and Operational Guidance (England), October 2018.

**11. CONSULTATIONS**

The CDOP Annual Report is consulted on and ratified by the:

- CDOP Business Group
- Pan-Lancashire Children's Safeguarding Assurance Partnership

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| **VERSION:** | **1.0** |
| **CONTACT OFFICER:** | Cath Taylor, Acting Consultant in Public Health<br><br>Saira Sharif, Public Health Knowledge Analyst |
| **DATE:** | 24.05.22 |
| **BACKGROUND PAPER:** | Pan-Lancashire Child Death Overview Panel Annual Report 2020-2021 (Not disseminated with this paper, due to risk associated with patient identifiable information). |