HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Shirley Goodhew
DATE:	4th December 2019

SUBJECT: Child Death Overview Panel (CDOP) Annual Report 2018-19

1. PURPOSE

To update the members of the Health & Wellbeing Board of the work undertaken by the pan-Lancashire Child Death Overview Panel (CDOP) during 2018/19, which includes key findings from child death data, progress made on last year's recommendations (2017/18), partnership achievements, and priorities and recommendations for 2019/20.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

Local Safeguarding and Health and Wellbeing Board partners are asked to:

a. Note the content of this report, and in particular the priorities for 2019/20.

b. Ensure all professionals providing information to CDOP ensure that forms are returned within the statutory three week deadline and are completed as fully as possible before they are submitted; 20% of cases reviewed during 2018/19 did not have the child's ethnicity recorded.

c. Ensure that the Child Death Review (CDR) processes remain embedded in the new safeguarding arrangements until at least April 2020.

d. Transfer the responsibility for CDR/CDOP to Health and Wellbeing Boards at some point after April 2020.

e. Clarify what interagency initiatives are required 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
- Diabetes (often linked to BMI)
- Lack of physical activity

3. BACKGROUND

CDOP has an independent chair, who has a responsibility to review all child death cases within pan Lancashire, and provide oversight and assurance of the child death review processes, on

behalf of statutory partners. The Working Together to Safeguard Children (2018) guidance states local areas should have a clear child death review process in place, whereby a child is defined in the Act as a person under 18 years of age, regardless of the cause of death.

3.1 CDOP Membership
During 2018/19 the CDOP had representation from: Lancashire Constabulary, the Sudden Unexpected Death in Childhood (SUDC) Service, Children's Social Care, the three Lancashire Safeguarding Children's Boards (and new arrangements), Community Health Services, Midwifery, Paediatrics, Clinical Commissioning Groups, Public Health, and Education and Early Years representatives were provided by Lancashire County Council, Blackburn with Darwen (BwD) Borough Council, and Blackpool Council respectively.

All business, case discussion and neo-natal review meetings had excellent or good (80-100%) representation by agencies, and by geographical coverage; however the panel is still without an Education representative for Lancashire.

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 2018/19 priorities
CDOP successfully completed four out of the eight priorities for 2018/19:

- New improved database and quality assurance monitoring system aligned to national eCDOP system
- Smooth transition of new SUDC service and updated SUDC protocol
- Action plan developed to implement recommendations from thematic reviews on trauma and Infection
- Implemented the recommendations from the Adverse Childhood Experience (ACE) audit

Progress has been made on the remaining four priorities, but as this is on-going, these will carry over to 2019/20 Priorities (Section 5.11).

3.3 CDOP key achievements 2018/19
The following campaigns have been developed and successfully delivered across pan Lancashire to promote key messages based on learning gained from child death reviews:

- Safer sleep campaign
- Safer sleep for Grandparents campaign
- Positive recognition
- ICON – Babies Cry, You Can Cope!
- SUDC 10 Year Recognition event
- CDOP Development Day
- Adverse Childhood Experiences approach
- Pharmacy campaign
- Two thematic reviews (Infection and Trauma)

4. RATIONALE
The death of all children under the age of 18 must be reviewed by a Child Death Overview Panel (CDOP) on behalf of the relevant Local Safeguarding Children Board. The CDOP in this area covers Blackpool, Blackburn with Darwen and Lancashire and is known as, the Pan-Lancashire CDOP, which reports annually to the Health & Wellbeing Boards, and pan Lancashire Local Safeguarding Children's Board.

5. KEY ISSUES

5.1 Findings from data analysis 2018-19

Between April 2018 to March 2019, CDOP received 106 child death notifications (7 Blackpool, 15 BwD and 84 Lancashire residents) in line with the statutory guidance Working Together to Safeguard Children. There has been a slight downward trend in child notifications over the last 10 years, however BwD and Lancashire saw a slight increase, whilst Blackpool showed a decrease. The Panel completed 111 reviews during 2018-19 (18 BwD, 13 Blackpool, 80 Lancashire) of which 51% were expected deaths, 45% were unexpected deaths and 4% unexpected but meeting the exclusion criteria. Nine ongoing cases were subject to Serious Case Review.

5.2 Modifiable factors

It is recognised that a number of child deaths had 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 modifiable factors relating to child deaths accounted for around half (51%) of all deaths during 2018/19, which is an increase compared with 2017/18, whereby only 33% of cases reviewed had modifiable factors.

The most common modifiable factors identified (including expected and unexpected deaths) across pan Lancashire were smoking by parents/carer in the household (36%), high or low Body Mass Index (BMI) in mother (23%), followed by unsafe sleeping arrangements (7%).

5.3 Age

Of the deaths reviewed, the highest number of deaths (53%) that occurred were under one year of age, with 20% aged 1-9 years, and 27% 10-17 year olds.

5.4 Ethnicity

The ethnicity of the majority (53%) of child deaths reviewed for Lancashire were White-British. However, 11% of child deaths were children of South Asian heritage, which is an over representation for this ethnic group based on the 2011 Lancashire population census data (5.7%). For BwD, 22% of child deaths were of Asian or British Asian Pakistani heritage and 54% White British children. When compared to 2017/18, the latest data shows a decrease in proportion of Asian or British Asian Pakistani heritage (43%). However, caution is advised due to small numbers and this may be due to annual fluctuations.

5.5 Category

The most common category of death across pan Lancashire for cases reviewed was Perinatal/ neonatal event (29%) with chromosomal, genetic and congenital anomalies accounting for the second most common category (24%). This is consistent with England and Wales data where perinatal and congenital causes are the most common, especially in neonates (less than 4 weeks old). However, deaths from perinatal/neonatal events in Lancashire show a downward trend over the last 10 years, since 2008.

5.6 Place

The majority of children die within a hospital setting (77%), with 12% of children and young people dying at home, which includes unexpected deaths and children on end of life care plans.

5.7 Unexpected with modifiable factors

Due to the most common cause of child death in pan Lancashire being in perinatal / neonates and the small number of cases where modifiable factors are identified by Local Authority areas, it was not possible to identify one modifiable factor category, ie. BwD had 0-2 cases across the ten modifiable categories. Therefore, the second most common category of child deaths with modifiable factors identified across pan Lancashire included 'suicide or deliberate self-inflected harm' (13%), followed by 'trauma and other external factors' (9%). As the numbers are so small

they should be treated with caution.

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'. Generally, the majority of deaths occurred within the first year of life which were expected attributed to complications relating to prematurity or chromosomal, genetic/congenital abnormalities. In older children deaths tended to be unexpected. In 2018-19, over half (51%) of all child deaths were expected compared with 45% that were unexpected. 4% were reviewed as unexpected but met exclusion criteria.

Sadly, there were six young people who died by suicide in 2018-19 across pan Lancashire, which is consistent with the last two years (6 in 2016-17 and 6 in 2017-18). The majority of these suicides were children 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.

5.8 Themes

The themes identified from all 48 child deaths in 2018-19 included the following, largest to smallest:

- Complex medical needs (joint first)
- Co-sleeping/inappropriate sleeping arrangements (joint first)
- Road Traffic Collision / Drowning / Accidental (joint second)
- Suicides (joint second)
- Neonatal cases
- Unresponsive / unascertained
- Concealed and denied pregnancy

5.9 Complex social circumstances

Of the 48 deaths in 2018-19, 18 were known to Children's Social Care. Key themes identified at the time of death or following death, included: Domestic violence between parents/carers (7); parental mental health problems (7) and parental alcohol/ substance misuse (13). 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 Blackburn with Darwen data summary

- 75% of deaths reviewed during 2018/19 were completed within 12 months
- 45% of deaths were expected
- Of the BwD deaths reviewed, 22% were of Asian or Asian British Pakistani heritage
- 33% of deaths were female
- 50% of deaths had modifiable factors identified
- The most common modifiable factor identified was smoking

5.11 CDOP Priorities for 2019/20

1. Deliver the SUDC Prevention group priorities including:
    a. maintaining a supply of materials to agencies across pan-Lancashire;
    b. promote the safer sleep campaign throughout pharmacies during October 2019;
    c. raising awareness around water safety including cold water shock;
    d. auditing the safer sleep materials and create a harder hitting campaign;
    e. strengthen the current safer sleep materials and safer sleep guidelines; and
    f. support the roll-out of phase 2 of the ICON campaign.

2. Manage a smooth transition of the Child Death Review process from Local Safeguarding Boards to new governance arrangements and ensure that the new guidance is implemented including:

a. ensuring all child death review meetings (e.g. perinatal mortality; hospital mortality; etc.) inform the CDOP process in a standardised and structured manner;
b. ensure all agencies understand the new guidance and relevant processes;
c. ensure there is adequate resource to fulfill the new responsibilities;
d. Ensure all agencies understand the new guidance and relevant processes; and
e. Develop and oversee an implementation plan measured against national standards

3. Consider further analysis of the observed disproportionate Blackburn with Darwen deaths in certain population groups, and feedback to the LSCB and other partners

a. Implement the recommendations from the reviews into trauma (category 3) and infection (category 9)
b. Continue to collect data for Adverse Childhood Experiences (ACEs), and analyse patterns in links between ACEs and child deaths
c. Ensure that any preventive strategies and initiatives link with any existing health and wellbeing/ clinical workstreams.

6. POLICY IMPLICATIONS

- 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

Child death review partners should agree locally how the child death review process will be funded in their area. The SUDC Prevention Group is co-ordinated by the pan Lancashire CDOP and is funded by the CDOP budget (£15,000) within the Safeguarding partnership.

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.

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

- CDOP Business Group
- Pan Lancashire Local Safeguarding Children Board
- Health & Wellbeing Boards (BwD, Blackpool and Lancashire)

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CONTACT OFFICER:	Shirley Goodhew, Public Health
DATE:	13.11.19
BACKGROUND PAPER:	Pan-Lancashire Child Death Overview Panel Annual Report 2018-19 (Not for dissemination).