Pan-Lancashire Child Death Overview Panel
Annual Report 2013-14

Public – small numbers suppressed

Contents

Introduction

This is the sixth annual report since Child Death Overview Panels (CDOP) became statutory in April 2008 and the second as a pan-Lancashire Panel. The pan-Lancashire CDOP is a sub-group of the three Local Safeguarding Children Boards (LSCBs) and has a statutory responsibility to review the deaths of all children up to the age of 18 years old (excluding infants live-born following planned, legal terminations of pregnancy) resident within the three Local Authority areas.

This report will provide information on trends and patterns in the deaths reviewed during the last reporting year (2013-14), on all deaths reviewed since the panels began in April 2008 and make recommendations to the LSCBs or other relevant bodies (e.g. Health and Wellbeing Boards) based on the analysis.

Members and Attendance

During 2013/14 the panel had representation from the three Boards for Lancashire Constabulary, SUDC Service, Children's Social Care, the Local Safeguarding Children Boards, Community Health Services, Midwifery, Paediatrics, Public Health, Neonatology & Obstetrics (co-opted for review of early neonatal deaths) and Education and Early Years representative were provided by Lancashire and Blackburn with Darwen, respectively.

In an attempt to ensure equal representation across the three areas a rota system has been utilised for case discussion meetings which aims to ensure:

1. All three areas are represented
2. All agencies are represented
3. It is equitable for all: number of meetings attended is based proportionately on to number of child deaths per area

The table below documents the attendance by each agency/ area of expertise for business and case discussion meetings.

Business Meetings				**Case Discussion Meetings**			
Agency	**Invited**	**Attended**	**% Attendance**	**Agency**	**Invited**	**Attended**	**% Attendance**
Chair	6	6	100%	Chair	12	12	100%
Lancashire Constabulary	6	6	100%	Lancashire Constabulary	12	12	100%
Children's Social Care	6	4	67%	Children's Social Care	12	10	83%
Public Health	6	6	100%	Public Health	12	12	100%
Midwifery	6	6	100%	Midwifery	12	12	100%
SUDC Service	6	6	100%	SUDC Service	12	12	100%
Paediatrics	6	5	83%	Paediatrics	12	12	100%
SUDI Prevention	6	5	83%	Community Health	12	11	92%

Chair				Services			
LSCB's	6	6	100%	Neonatology & Obstetrics	3	3	100%
Designated Nurses	6	5	83%	Early Years	2	1	50%
				Education	2	1	50%

Table 1, the attendance by each agency/ area of expertise for business and case discussion meetings

CDOP priorities for 2013/14

CDOP Priority	Status (RAG rating)	Comments
1. Review cases and make recommendations regarding themes to the Board		The Panel has an ongoing responsibility to review cases and make recommendations as appropriate; the CDOP reports to the Boards bimonthly, quarterly (with statistics) and annually.
2. Undertake a detailed review to identify themes / trends in deaths categorised as caused by perinatal / neonatal events.		This report has been completed and the recommendations have been put into the CDOP work programme and will be monitored in 14/15.
3. Monitor Safer Sleep Campaign		There is regular bi-monthly reporting to the CDOP Business Meeting and all evaluation reports/ proposals are considered by the Panel.
4. Ensure and monitor the review of the SUDC Protocol		The SUDC Protocol has been completely reviewed and updated. It was finalised by all Boards in January. The Panel we now monitor the SUDC Protocol Launch the SUDC Stake Holders Group are overseeing, which is a priority for 14/15.
5. Finalise the multi-agency e-learning and make available to professionals front line multi-agency professionals		The CDOP e-learning has been completed and the link has been disseminated widely, the Panel will monitor completion rates bi-monthly.
6. Disseminate messages and information to the multi-agency workforce and public (as appropriate)		This is completed by the Safer Sleep Campaign, the CDOP e-learning and contributions to briefing/ training sessions. The Panel considered how to improve this at the development day and will continue to keep this as a priority for 14/15.
7. CDOP to implement a new database/ IT system which will improve reporting particularly in relation to specific modifiable factors identified by the Panel		This has not been completed. Another business enquiry has been submitted to OneConnect (now BT Lancashire Services) to try and resolve the identified issues with security. This will remain a priority for 14/15.
8. CDOP Development Day		This took place on Friday 21st March.

Table 2, CDOP priorities for 2013/14

Update on identified Recommendations for 2013/14:

The Panel have reflected upon the recommendations identified in the 2012/13 report and acknowledges these needed to be more concise; the CDOP have tried to improve on this in the present report. Below are the updates for the recommendations identified from the 2012/13 annual report:

The three LSCBs should reiterate to all agencies, which provide CDOP with information, the importance of completing agency report forms as fully as possible, particularly ethnicity, asylum seeker and parental demographic details**. The percentage of unknown/ not stated responses to the ethnicities has been reduced from 6% of the cases reviewed in 2012/13 to 2% in the cases reviewed during 2013/14. This means of the cases which were reviewed by CDOP in 2013/14, fewer than 5 children and young people's ethnicities were unknown.**

The three LSCBs should recommend to the Health and Wellbeing Boards in their area to note the information contained within this report and ask them to clarify whether any research and/or planning of services work is being undertaken on any of the themes/trends or issues raised, in particular for:

i. The Blackpool LSCB to consider research and/or planning of services on the theme of deprivation identified in child deaths under 28 days;
ii. The Lancashire and Blackburn with Darwen Boards to consider the themes of ethnicity and deprivation linked with deaths categorised under the category of 'chromosomal, genetic and congenital anomalies'.

In seeking the clarifications from the Health and Wellbeing Boards, the LSCBs should be assured that local action is being taken, and that this action is effective, in preventing future such deaths: **The CDOP annual report was shared with all three Health and Wellbeing Boards and it was noted there is already work being undertaken in relation to 'Starting Well' and 'Developing Well'. Additionally, the Pennine Lancashire Infant Mortality Group is monitoring the implementation of the neonatal mortality review recommendations.**

The LSCBs should recommend to the Health and Wellbeing Boards that representatives should attend the CDOP development day: **Unfortunately it was not possible for any representatives to attend the development day. The CDOP should consider how to develop links with the three Health and Wellbeing Boards.**

CDOP to explore learning opportunities with other CDOPs across the country: **Pan-Lancashire CDOP is represented at the Regional CDOP meeting; the CDOP coordinator and Chair attend national conferences and training.**

All three Boards should continue to support the Safer Sleep Campaign: **The three Boards agreed to fund the Campaign during the 2013/14 reporting year. An options paper will be developed to consider the delivery of the current programme and will be presented to the three LSCB Chairs in November 2014.**

The three LSCBs should circulate the anonymised report widely. **The report was anonymised, circulated widely and uploaded onto the LSCB websites.**

CDOP Key Successes 2013/14

Safer Sleep Campaign: The Campaign has continued to supply professionals with materials to support them in providing consistent messages to parents/ carers across pan-Lancashire. The Campaign aims to inform parents/ carers of the risks associated with safer sleeping arrangements to help them make an informed decisions in relation to bed sharing, and consequently make children within pan-Lancashire safer. The Safer Sleep campaign and associated material for parents and practitioners has continued to be successfully received and on page 9 a summary is provided from the campaign's most recent evaluation. The evaluation highlights that parents find the material useful, that the majority of respondents have received and read the advice. Where the evaluation identifies areas of further work to improve the reach of the safety messages, the SUDC Prevention Group will incorporate into their 2014-15 work.

E-learning & SCR Briefings: The CDOP finalised and went live with their e-learning package during the latter part of this reporting year, by the 31st March 2014 69 people had completed the course. The CDOP will continue to raise awareness to the package and monitor the completion rates by agency throughout 2014/15. The CDOP Coordinator contributes to the SCR briefings which are half day, multi-agency information sessions. 196 professionals have attended these briefings in the 2013/14 year. The CDOP presentation has been developed to include more detail regarding Safer Sleep for Baby, group work to consider deaths as a result of the young person's own actions and the findings from the suicide thematic report.

SUDC Protocol: CDOP have successfully overseen the review and update of the pan-Lancashire SUDC Protocol, a multi-agency document to inform professionals of their responsibilities following the unexpected death of a child/ young person. The three Boards ratified this document in March 2014 and it was widely disseminated. The protocol training within the Lancashire Constabulary, Acute Trusts and Children's Social Care will be rolled out throughout 2014/15.

Suicide Thematic Report: This report was completed in March 2013; through 2013/14 the report was widely disseminated and the recommendations have been adopted by the multi-agency workforce. Work undertaken includes a review of the provision for Children and Young People suffering with emotional distress, Lancashire's Children and Young People's Health and Wellbeing Board have completed "flash mobs" raising awareness to emotional health in young people. Multiple training courses are now available to support professional's to develop their skills, when dealing with emotional stress amongst Children and Young People. This work is a good example of concise multi-agency working with effective dissemination and ownership of recommendations.

Neonatal Mortality Report: This report considered the modifiable factors associated with neonatal deaths from the pan-Lancashire CDOP data. There were a number of recommendations identified from this report which are now being overseen and

monitored by the Pennine Lancashire Infant Mortality Group. The report has been anonymised, circulated and uploaded on to the LSCB websites.

CDOP Sub Group Updates

SUDC Service
The Sudden Unexpected Death in Childhood (SUDC) service is a nurse-led service that has been providing the health element of the multi-agency rapid response process to sudden unexpected deaths of infants and children across pan-Lancashire since September 2008.

The SUDC Nurses have worked closely with the CDOP Coordinator and partner agencies to revise the SUDC protocol, to ensure that it fully complies with the requirements of Chapter 5 (Working Together, 2013). Amendments to the existing protocol have been made with revisions to the Medical Proforma and SUDC history record. The aim is that both of these documents will become generic records for all involved. This will improve communication, standardise practice and act as an aid memoir for thorough, seamless information gathering.

Training has been developed to support practitioners embed the new protocol into practice and ensure all professionals involved with unexpected child deaths are clear of their roles and responsibilities within the Rapid Response process.

The training will be rolled out as a ‘train the trainer’ style course aimed at key departments within Acute Trusts, Lancashire Constabulary and Children's Social Care. The Local Safeguarding Children Boards have requested all agencies sign up to an expectation document and will seek assurances regarding the following:

- learning is disseminated within teams
- ensure staff are kept up to date and new starters receiving SUDC Protocol training
- local procedures are in place in the event of an unexpected child death

The ongoing issue in relation to expected deaths continues to place an increasing demand on the service. Within this reporting year the SUDC service has been involved in 22 expected deaths. This may be attributed to a lack of clarity as to classification of the child death or merely a misunderstanding by the notifier of the SUDC Service function. It is anticipated that the ‘roll out’ of the new Protocol will assist in addressing these issues which demands a significant amount of the SUDC Nurse’s time and capacity.

From 2008 when the SUDC Service started up to the 2011/12 reporting year there was an increase year on year on the number of unexpected deaths reported to the Service (2009/10 – 50; 2010/11 – 58; 2011/12 – 65). During the last two reporting years the Service has seen a reduction in the number of unexpected deaths notified with 46 in 2012/13 and 41 in 2013/14.

Of the 41 deaths notified in 2013/14, 15 were infants and 26 children, compared to the previous year when the number of infants (25) was greater than the number of children (21). It is also apparent that a significant amount of the deaths had a

safeguarding element to them, of which the SUDC Nurse's expertise and contribution has been invaluable to partner agencies.

Table 3 provides information on unexpected death rates for the number of children who died unexpectedly in the 2013/14 reporting year. The information provided in this table is based on very small 'actual numbers' and therefore the data is not statistically significant.

	Blackburn with Darwen	Blackpool	Lancashire
2013/14	1.65	1.24	1.05
2012/13	1.18	1.24	1.09

Table 3; unexpected child death rate per 10,000 child population

The number of infants dying in pan-Lancashire where co sleeping or unconventional sleeping arrangements were a factor was slightly higher in 2013/14 (7) than 2012-13 (less than 5) although these numbers are small. The SUDC Nurses have utilised their insight and knowledge gained from responding to these deaths to contribute to the SUDC Prevention Group and will be a part of the task and finish group reviewing the Safer Sleeping Guidance in 2014/15.

Additionally, in response to the suicide thematic review last year, the SUDC Service was invited to participate in a research study carried out by Manchester University. The purpose of the study was to develop a parental bereavement training pack to guide health professionals on how to respond and care for parents who had either a suicide, open or narrative verdict returned for their child. The study's main aim was to identify the needs and vulnerabilities of both parents and NHS Staff responsible for caring for these families. It was identified that many health care professionals had received no training on how to respond to those bereaved by suicide and felt anxious about doing so. One of the key findings is that health professionals have stated that they would like to attend multi-disciplinary workshops to learn specific skills on how to respond to bereaved parents. It is also anticipated that a directory, endorsed by the Department of Health, will be produced that will list all available resources for parents bereaved by suicide.

The SUDC service has received positive feedback from both professionals and bereaved families regarding the individual support provided by the SUDC Nurses. This has included supporting parents at inquest, facilitating meetings and accompanying to appointments with paediatricians where appropriate. This has served to improve links with paediatricians and relationships with coroner's officers.

The SUDC service also co-ordinates the end of case discussion meetings (ECDM). Challenges remain in ensuring these are undertaken within the required timescale; the service will continue to monitor and explore solutions. The lessons learnt from ECDMs and the rapid response process continues to formally feed into the CDOP case reviews.

SUDC Prevention Group
The pan-Lancashire SUDI Prevention Group is a sub group of CDOP and has responsibility for planning and coordinating the 'Safer Sleep for Baby' campaign.

During the 2013/14 reporting year the SUDC Prevention Group have re-distributed materials across pan-Lancashire to support frontline professionals have detailed discussions with families regarding Safer Sleep for Baby.

The Group has disseminated the information in the following ways:

1. Media coverage such as radio advertisements, posters in shopping centres and bus advertisements to highlight the risks associated with co-sleeping particularly smoking and/ or consumption of alcohol and substances.
2. Resources for professionals to share with parents to raise awareness of safer sleep messages have been distributed to children's centres, health visitors, midwives, day nurseries, GP's, neonatal units, childminders and registrars on a pan-Lancashire basis. The resources include A4 posters, door hanger room thermometers, safer sleeping magazine, downloadable display materials, postcards and cot cards.
3. The messages are also given during the 'From Bump to Birth and beyond' programme (and the Blackburn with Darwen and Blackpool equivalents) delivered by children's centre, health visitors and midwives in the antenatal period.

In February 2014 the Group commissioned an evaluation of the Campaign, this was completed by requesting parents/ carers to complete a survey and in return they were entered into a prize draw. In total, 421 questionnaires were returned.
The key findings from the evaluation were:

1. Almost all respondents (96%) agree with the statement, 'The Safer Sleep for Baby campaign will help parents provide safer sleep for their baby'
2. More than nine in every ten respondents (93%) agree that the safer sleep for baby information is useful. Almost three-fifths (58%) strongly agree.
3. Almost three-quarters of respondents (73%) have received advice about how their newborn baby should be sleeping from health professionals.
4. Almost three-fifths of respondents (59%) had seen or heard about the safer sleep for baby campaign before visiting the registrar.
5. Over half of respondents (54%) had heard of the safer sleep for baby campaign from a health professional. Half of respondents (50%) had heard of or seen the safer sleep for baby campaign at a children's centre.
6. Over three-fifths of respondents (63%) had picked up or been given either a cot hanger thermometer, teddy bear postcard or a safer sleep for baby booklet before visiting the registrar.
7. Around two-fifths of respondents (44%) said that they could recall seeing the safer sleep for baby poster somewhere, and around two-fifths (41%) said they couldn't.
8. Over two-thirds of respondents (67%) do not remember hearing adverts on local radio promoting the safer sleep for baby campaign. However, almost a quarter (24%) does remember hearing them.

The evaluation found it is particularly important to engage health professionals in promoting the Six Steps to Safer Sleep. It was therefore decided to remove the radio advertising from the Campaign and concentrate on providing frontline staff particularly health professionals (acute and community) and children's centre staff with materials.

At the end of the 2013/14 reporting year the Group recommended to CDOP that their remit was increased to cover Sudden Unexpected Death in Childhood up to 2 years of age, as the Group envisaged the Campaign progressing to incorporate safety within the home. Moreover, the Group was targeted by the University of Durham to take part in a study to look at the effectiveness of local safer sleep campaigns, this large piece of national research will start during 2014/15.

Analysis of deaths reviewed in 13/14

During the 2013/14 reporting year CDOP was notified of 113 child deaths (9 Blackpool residents, 21 Blackburn with Darwen (BwD) residents, 83 Lancashire residents) which were in line with Working Together to Safeguard Children (2013) and therefore will be considered by the pan-Lancashire CDOP. There were an additional 18 notifications to the Panel which were outside of the statutory guidance and therefore will not be reviewed by the pan-Lancashire CDOP, these were: 10 cases out of area and therefore reviewed by a different Panel, 7 were stillborn or terminations of pregnancy and 1 young person was 18 years of age.

In the figure below the number of notifications received in each reporting year since CDOPs became statutory in April 2008 can be seen (this graph does not include data outside of statutory guidance).

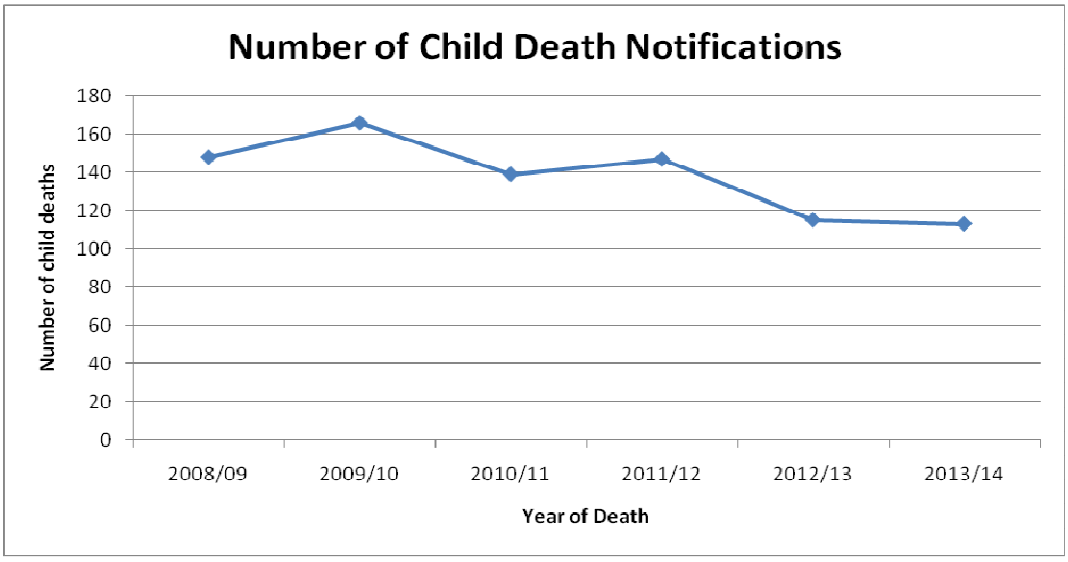

Figure 1, Number of child death notifications by year of child death

Figure 1 shows there is a gradual decline in the number of child deaths over the last six years. The Panel receives a report from the Department for Education (DFE) of every child death registered within the Local Authority area as a check that no notifications have been missed; therefore, the data within the figure above is accurate rather than this being an apparent decline due to missed notifications.

Modifiable Factors

In the reporting year ending March 2014 the Panel completed 137 reviews (22 BwD reviews, 10 Blackpool reviews and 105 Lancashire reviews). Table 4 below identifies the number of deaths that were deemed to have modifiable factors and whether the deaths were expected or unexpected.

	Resident of which Locality	Modifiable factors	No modifiable Factors	Grand Total
Expected	Blackburn with Darwen	<5 (13%)	13 (87%)	15
	Blackpool	<5 (33%)	<5 (67%)	6
	Lancashire	13 (20%)	52 (80%)	65
Expected Total		17 (20%)	69 (80%)	86
Unexpected	Blackburn with Darwen	<5 (43%)	<5 (57%)	7
	Blackpool	<5 (50%)	<5 (50%)	<5
	Lancashire	15 (37%)	25 (63%)	40
Unexpected Total		20 (39%)	31 (61%)	51
Grand Total		37 (27%)	100 (73%)	137

Table 4, Total number of deaths reviewed by expected/ unexpected and whether modifiable factors were identified

Table 4 illustrates more modifiable factors are identified in the unexpected deaths compared to the expected deaths, which is what would be expected. Nationally 22% of cases are deemed to have modifiable factors, based on the 2013/14 reporting year the pan-Lancashire CDOP identified 27% of the cases reviewed to have modifiable factors. This may be attributed to the very subjective nature of identifying modifiable factors. More detail is provided on modifiable factors later in this report where the aggregated data is analysed (page17).

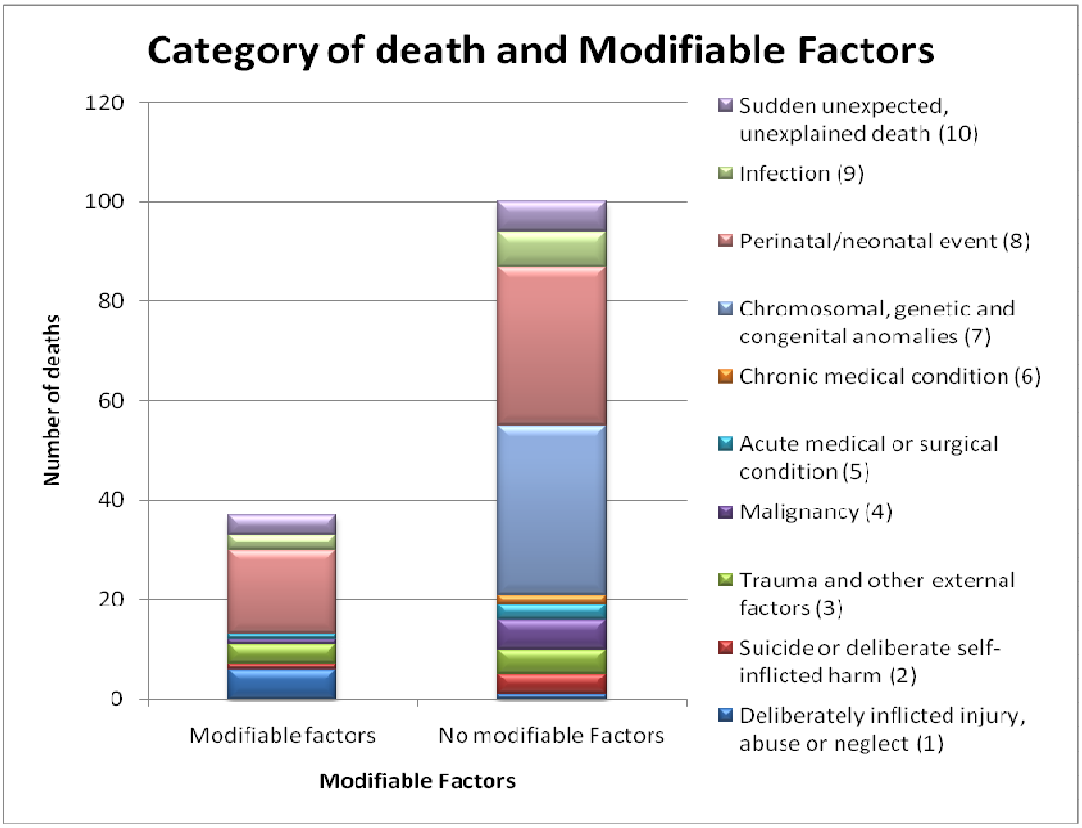

Figure 2, category of the child's death as defined by the Department for Education and whether modifiable factors were identified in reviews completed between April 2013 and March 2014

Of the cases reviewed in 2013/14 the largest categories of death which were deemed to have modifiable factors were perinatal/ neonatal event (46%) and deliberately inflicted injury, abuse or neglect (16.2%) (figure 2). Comparatively, in the reporting year ending March 2013, 33% of cases deemed to modifiable factors were due to a perinatal/ neonatal event and the second largest category was sudden unexpected, unexplained deaths (25%). Chromosomal, genetic and congenital anomalies and chronic medical condition did not have any deaths where modifiable factors were identified.

Length of time to complete the review

Of the 113 cases notified to the Panel in this reporting year 57% (64) of reviews were completed and 43% (49) were still ongoing at 31st March 2014. In comparison, of the cases notified to the Panel in the 2012/13 reporting year, 44% were completed and 56% were ongoing by 31st March 2013. This highlights the Panel has continued to improve its processes and agencies succeed in providing information promptly, to enable cases to be considered and completed within the same reporting year.

Of all the cases reviewed in 2013/14 85% of cases were reviewed within 12 months (84% Lancashire, 91% Blackburn with Darwen and 80% Blackpool). In comparison with the national picture, where 72% of cases were reviewed within 12 months, all areas of pan-Lancashire are completing more cases in less than a year. Similar to the national report, reviews take longer if modifiable factors are identified in the death. Of the deaths reviewed in under 6 months 16% had modifiable factors; however 67% of the reviews which took over 1 year to complete had modifiable factors.

The pie charts below (figures 3-7) show the time taken for reviews to be completed by CDOP from the point of notification. Blackburn with Darwen have completed the most reviews in less than 6 months with North Lancashire and Blackpool having the most cases take over 1 year to complete. For Blackpool this equated to 2 child deaths and both of these were due to no notification being received and the Department of Education (DFE) registrars report being used by the CDOP Coordinator as the notification mechanism. For North Lancashire there were 9 child deaths which took longer than 1 year to complete and this was due to 56% of cases having criminal trials/ other investigations, 44% being a late notification and 33% requiring further information for CDOP to complete.

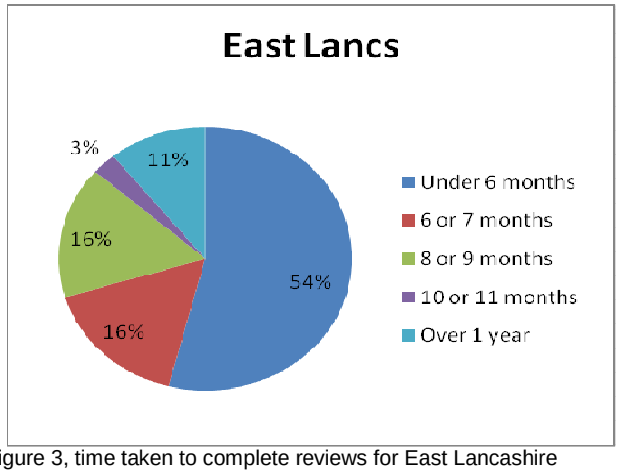

Figure 3, time taken to complete reviews for East Lancashire

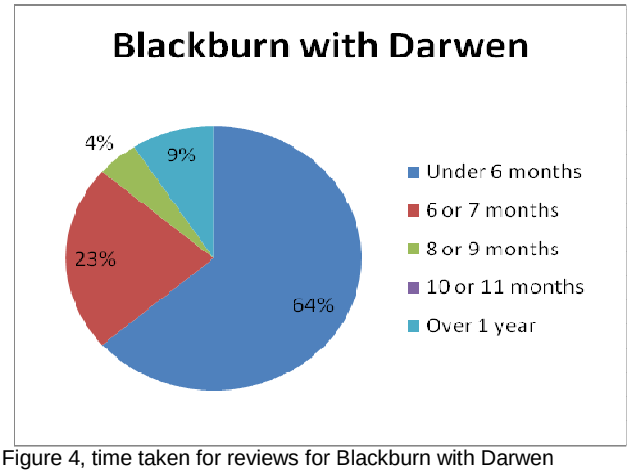

Figure 4, time taken for reviews for Blackburn with Darwen

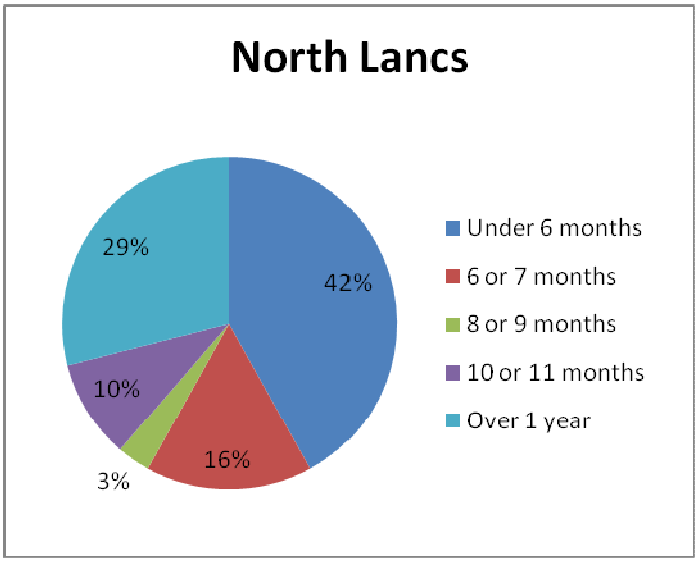

Figure 5 time taken to complete reviews for North Lancashire

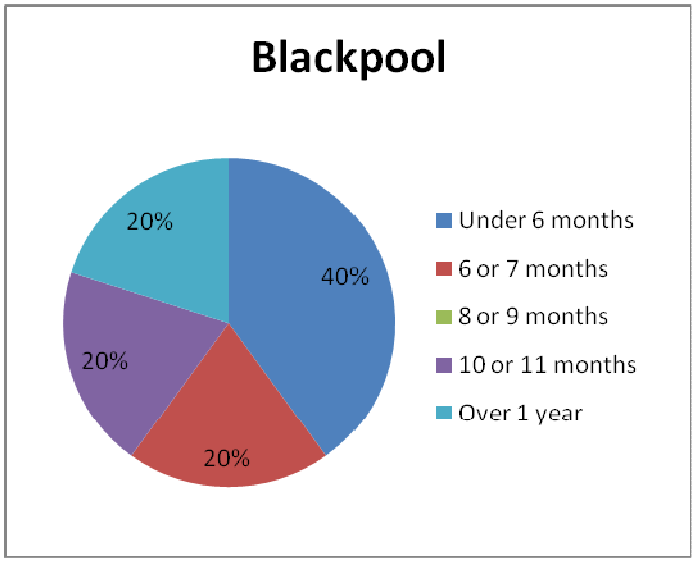

Figure 6 time taken to complete reviews for Blackpool

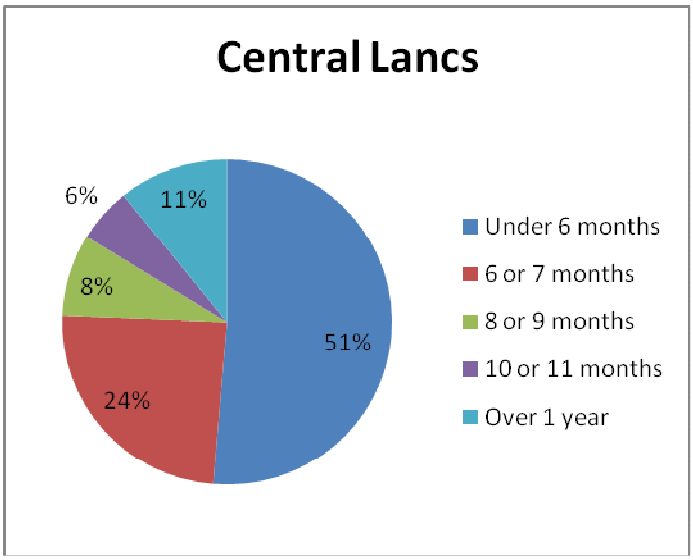

Figure 7 time taken to complete reviews for Central Lancashire

Analysis of child deaths reviewed from April 2008 – March 2014

In total the Panel have been notified of 828 deaths (excluding out of area children and including 7 terminations of pregnancy which were pre March 2010) since April 2008 through to 31st March 2014 and has completed 93%. The table below identifies the number of cases (7%) currently awaiting review by year of notification and resident of locality.

	2011/12	2012/13	2013/14	Total
Lancashire	<5	5	36	42
Blackpool	<5	<5	6	9
Blackburn with Darwen	0	0	7	7
Total	<5	6	49	58

Table 5, the number of cases awaiting review at 31st March 2014 by year of notification and resident of which locality

All cases notified to the Panel prior to April 2011 have been reviewed and completed. The small number of cases from 2011/12 and 2012/13 requiring review are complex cases with outstanding investigations such as criminal or coronial.

Of the 770 cases reviewed 68 were Blackpool residents, 121 Blackburn with Darwen residents and 578 Lancashire residents with 3 unknown/ out of area. 148, 166, 139, 144, 109, 64 died in 2008/09, 2009/10, 2010/11, 2011/12, 2012/13 and 2013/14, respectively (taking into consideration the three latter years are incomplete). The table below provides the local figures for deaths deemed to be expected/ unexpected, male/ female children and whether modifiable factors were identified; the national figures are included for comparison.

	Lancashire	Blackburn with Darwen	Blackpool	Pan - Lancashire	National
Expected	53%	69%	46%	55%	Not reported
Unexpected	44%	29%	54%	43%	Not reported
Male	60%	59%	47%	59%	56%
Female	40%	41%	53%	43%	44%
Modifiable	24%	17%	25%	23%	22%
No Modifiable	75%	82%	75%	76%	78%

Table 6, comparison of local data (2008-2014) with national figures (2013/14)

From table 6 above it can be seen that:

- Blackburn with Darwen has significantly more expected deaths than unexpected deaths and the least deaths with modifiable factors
- Lancashire, similar to Blackburn with Darwen, has more male deaths slightly higher than the national figure.
- Lancashire and Blackpool have slightly more deaths with modifiable factors than the national data
- Blackpool more unexpected deaths and more female child deaths, both are opposite to Lancashire and Blackburn with Darwen which have more expected deaths and male children who have died.

Category and Age of Child Deaths

Category	**Total**	**Percentage**
Deliberately inflicted injury, abuse or neglect (1)	19	2.5%
Suicide or deliberate self-inflicted harm (2)	25	3.2%
Trauma and other external factors (3)	54	7%
Malignancy (4)	47	6.1%
Acute medical or surgical condition (5)	26	3.4%
Chronic medical condition (6)	38	4.9%
Chromosomal, genetic and congenital anomalies (7)	189	24.5%
Perinatal/neonatal event (8)	263	34.2%
Infection (9)	41	5.3%
Sudden unexpected, unexplained death (10)	67	8.7%

Table 7, number of child death by category of death

From table 7 above it can be seen that perinatal/ neonatal events (8) and chromosomal, genetic and congenital anomalies (7) are the cause for the majority (58.7%) of child deaths within pan-Lancashire. Similar to last year, sudden unexpected, unexplained deaths (10) is the third most common category but it is a much smaller group than category 7 and 8 and has similar numbers to category 3.

Figure 8 below, illustrates the data shown in table 7 but separated into the year the child died. Taking into consideration there are still cases to be reviewed in 2012/13 particularly 2013/14, the pattern of the largest categories is very similar year on year. It appears there has been a reduction in category 1, 2, 3 and 10 deaths but this is likely to be because these deaths are awaiting review. This is because the CDOP can only review a child's deaths once all other investigations are complete and these types of death usually require further investigation.

Figure 8 removed to maintain confidentiality

Figure 8, Number of child deaths by year and category of death

The pattern of deaths by age seen in figure 9 below is similar to that seen in previous annual reports and reflects the national picture. The largest number of deaths occurred in children aged 0-27days (39%) with the fewest deaths in children aged 5-9 years (6%).

As anticipated a large number of deaths occurred in children aged 0-27days with the majority due to perinatal/neonatal events. 63% of all the child deaths between April 2008 and March 2014 were in children under 1 year and of these 78% died of

chromosomal, genetic and congenital abnormalities or perinatal/ neonatal events. Sudden unexpected, unexplained deaths particularly noticeable in children aged 28-364 days old and trauma and other external factors begins to emerge in this age category, becoming more prevalent in the teenage years along with suicide.

Figure 9 removed to maintain confidentiality

Figure 9, number of child deaths reviewed between April 2008 – March 2014 by age at death and category of death

Modifiable Factors

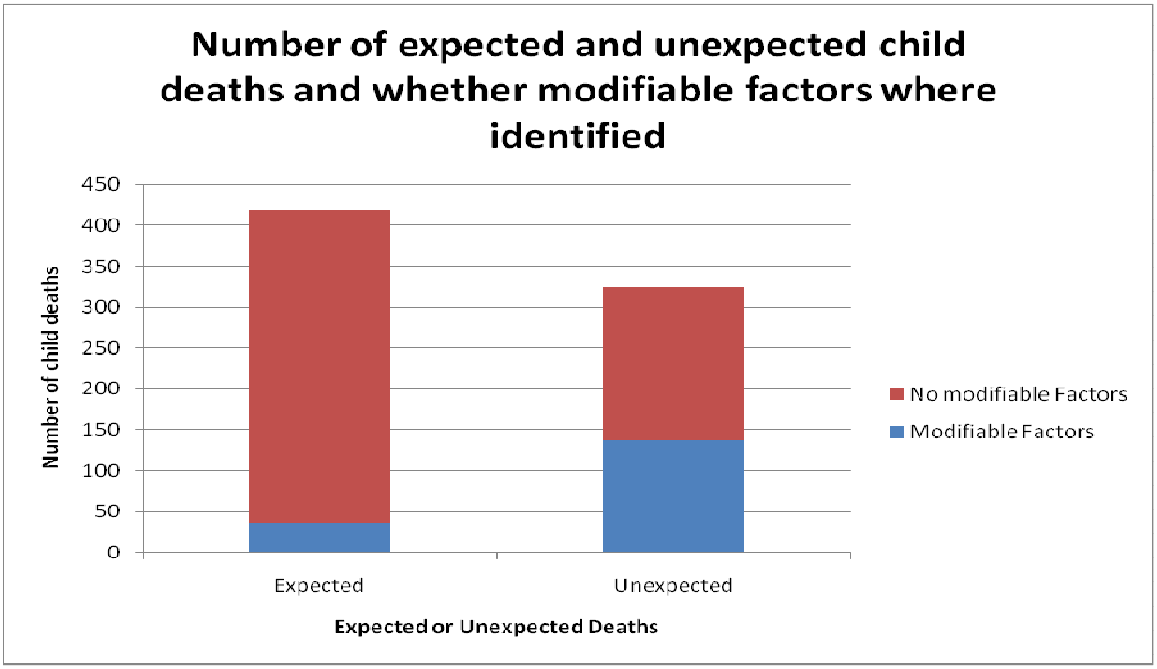

Figure 10, number of expected and unexpected child deaths reviewed between April 2008 – March 2014 and whether modifiable factors were identified.

76% of the child deaths were deemed to have no modifiable factors; of the cases identified to have modifiable factors (23%) the majority were unexpected child deaths. No modifiable factors were identified in 91% of expected deaths and 57% of unexpected deaths (figure 10).

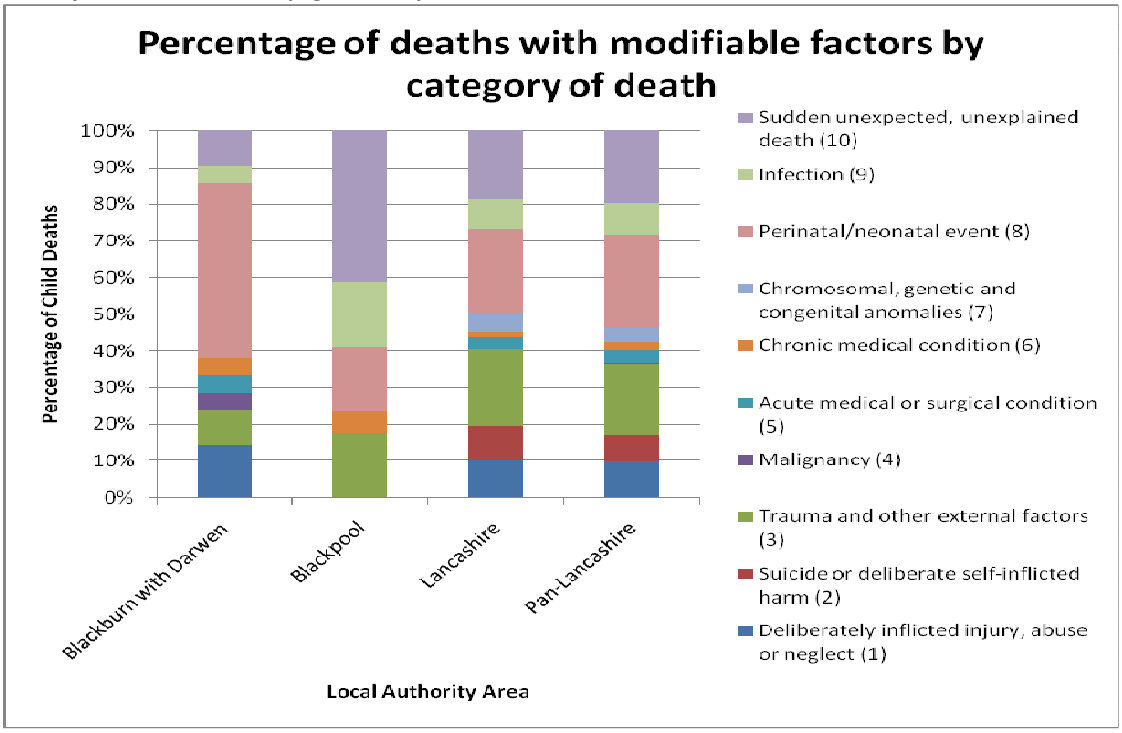

Figure 11, percentage of child deaths with modifiable factors identified by cause of death

177 cases were identified to have modifiable factors, figure 11 above illustrates Blackburn with Darwen to have a 48% of deaths with modifiable factors are due to perinatal/ neonatal events, Blackpool's largest category (41%) with modifiable factors are sudden unexpected, unexplained deaths. The following can be seen in the pan-Lancashire column:

- 25% of these deaths were caused by perinatal/ neonatal events,
- 20% were sudden unexpected, unexplained deaths and
- 19% were due to trauma and other external factors

Examples of modifiable factors relating to perinatal/ neonatal events, sudden unexpected, unexplained deaths and trauma and other external factors are issues relating to safer sleep, risk taking behaviours and smoking by someone in the household or smoking in pregnancy.

Category	Pan-Lancashire	National
Deliberately inflicted injury, abuse or neglect (1)	89%	47%
Suicide or deliberate self-inflicted harm (2)	52%	36%
Trauma and other external factors (3)	63%	59%
Malignancy (4)	2%	4%
Acute medical or surgical condition (5)	23%	29%
Chronic medical condition (6)	11%	15%
Chromosomal, genetic and congenital anomalies (7)	4%	9%
Perinatal/neonatal event (8)	17%	18%
Infection (9)	37%	22%
Sudden unexpected, unexplained death (10)	52%	68%

Table 8, percentage of child deaths identified to have modifiable factors per category

From the data displayed in the table above it can be seen that the cases reviewed between April 2008 – March 2014 that have been categorised as Deliberately inflicted injury, abuse or neglect (1), Suicide or deliberate self-inflicted harm (2) or Infection (9) are significantly higher than the national figures; whereas the Sudden unexpected, unexplained death (10) category is significantly less than the national data. This may be a reflection of national inconsistency of identifying modifiable factors or categorising deaths.

The most common risk factors identified from the cases deemed to have modifiable factors are seen in the table below.

	pan-Lancashire (177 cases)		Lancashire (139 cases)		Blackburn with Darwen (21 cases)		Blackpool (17 cases)	
Risk Factor	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Service provision including access to health care, prior medical intervention, communication and/or access to other services e.g. housing	62	35%	48	35%	9	43%	5	30%
Smoking (includes smoking in pregnancy and in the household by parent or carer)	54	31%	33	24%	10	48%	11	65%
Alcohol/ substance misuse by parent, carer and/ or child	55	31%	45	32%	5	24%	5	30%
Parenting capacity such as supervision, engagement with services, seeking medical help or compliance with medication	46	26%	30	22%	9	43%	7	41%
Parent, carer and/or child emotional/ behavioural/ mental health condition including a learning difficultly	46	26%	36	26%	8	38%	<5	12%
Safer sleep (including inappropriate sleeping surface, co-sleeping, temperature etc)	37	21%	28	20%	<5	10%	7	41%
Other risk factors (smoking, alcohol or substances) associated with the child deaths where safer sleeping issues were identified	30 (of the 37 above)	81% (of the 21% above)	22 (of the 28 above)	79% (of the 20% above)	<5	50% (of the 10% above)	7 (of the 7 above)	100% (of the 41% above)
Domestic abuse (including verbal, historical and low level)	37	21%	23	17%	8	38%	6	35%

Table 9, modifiable factors identified from cases reviewed between April 2008 and March 2014

Locality and Ethnicity

From figure 12 below it can be seen that child deaths due to perinatal and neonatal events are present across pan-Lancashire, this is similar to chromosomal, genetic and congenital anomalies, which is also the largest category of death for Blackburn with Darwen. Blackpool has the most deaths (10) due to trauma and other external causes followed closely by Preston which has 8. Preston has had the largest number of deaths (7) classified as suicide or deliberate self-inflicted harm. All the localities have had some sudden unexpected, unexplained deaths with Blackburn with Darwen, Blackpool, Burnley, Pendle and Lancaster having similar numbers (7- 10 deaths).

Figure 12 removed to maintain confidentiality

Figure 12, child deaths reviewed between April 2008 and March 2014 by locality and category of death

Figure 13 (below), represents child deaths reviewed between April 2008 and March 2014 by locality and ethnicity. It can be seen that Blackburn with Darwen, Preston, Pendle and Burnley have the most diverse populations within pan-Lancashire and also have some of the highest numbers of deaths. Of the 770 deaths reviewed between April 2008 and March 2014 the two largest ethnicities were White British 62% and 12% of children and young people were of an Asian or Asian British (Pakistani) ethnic origin. 11% of the child deaths reviewed did not have an ethnicity listed because it was either not known or not stated.

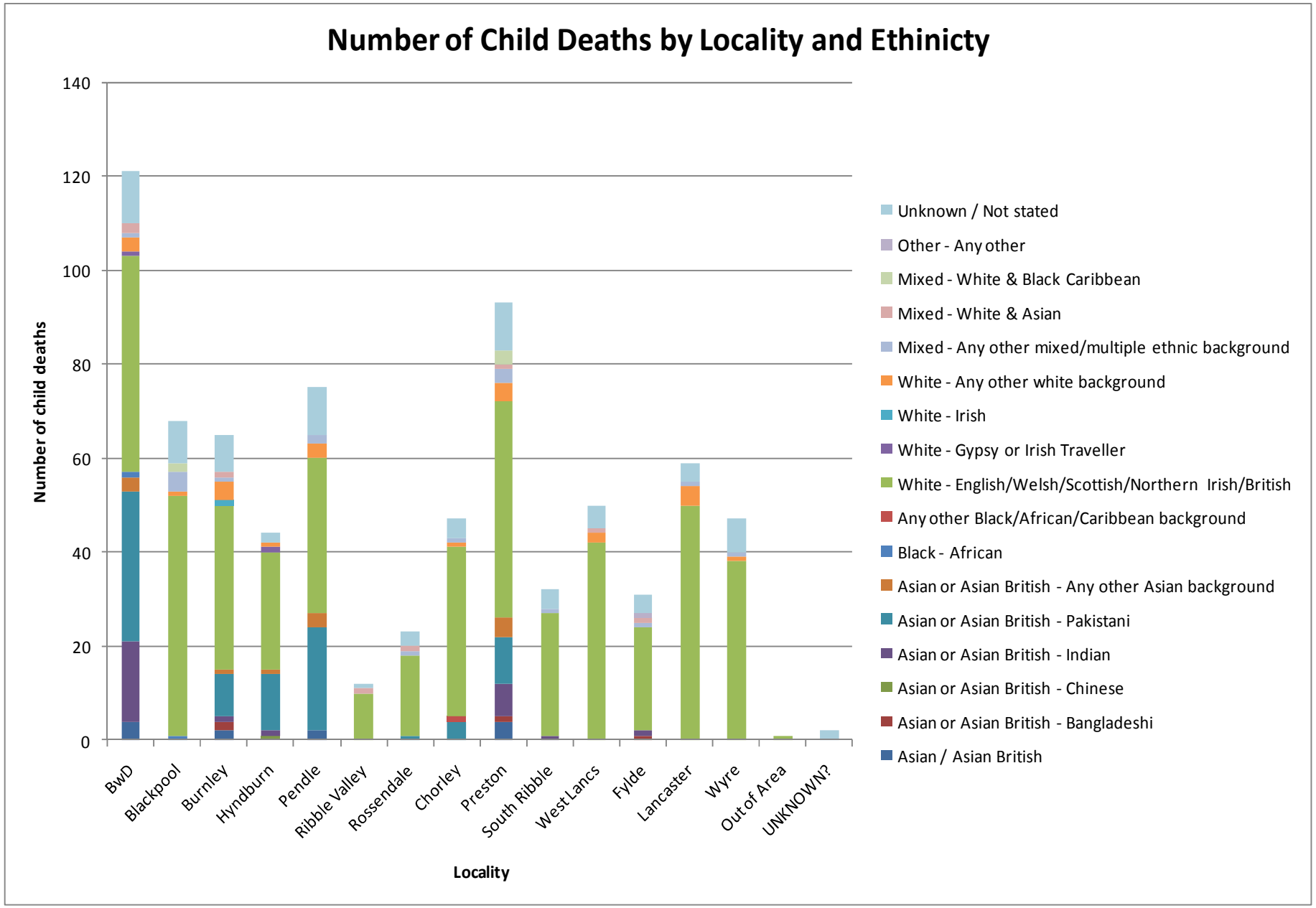

Figure13, child deaths reviewed between April 2008 and March 2014 by locality and ethnicity

Deprivation

This section of the report will look at mapping deprivation and child deaths reviewed between April 2008 and March 2014. The relationship between socioeconomic disadvantage and childhood morbidity is widely recognised in academic literature and from the figure below, it can be seen that the areas which have the most deprivation also have more child deaths.

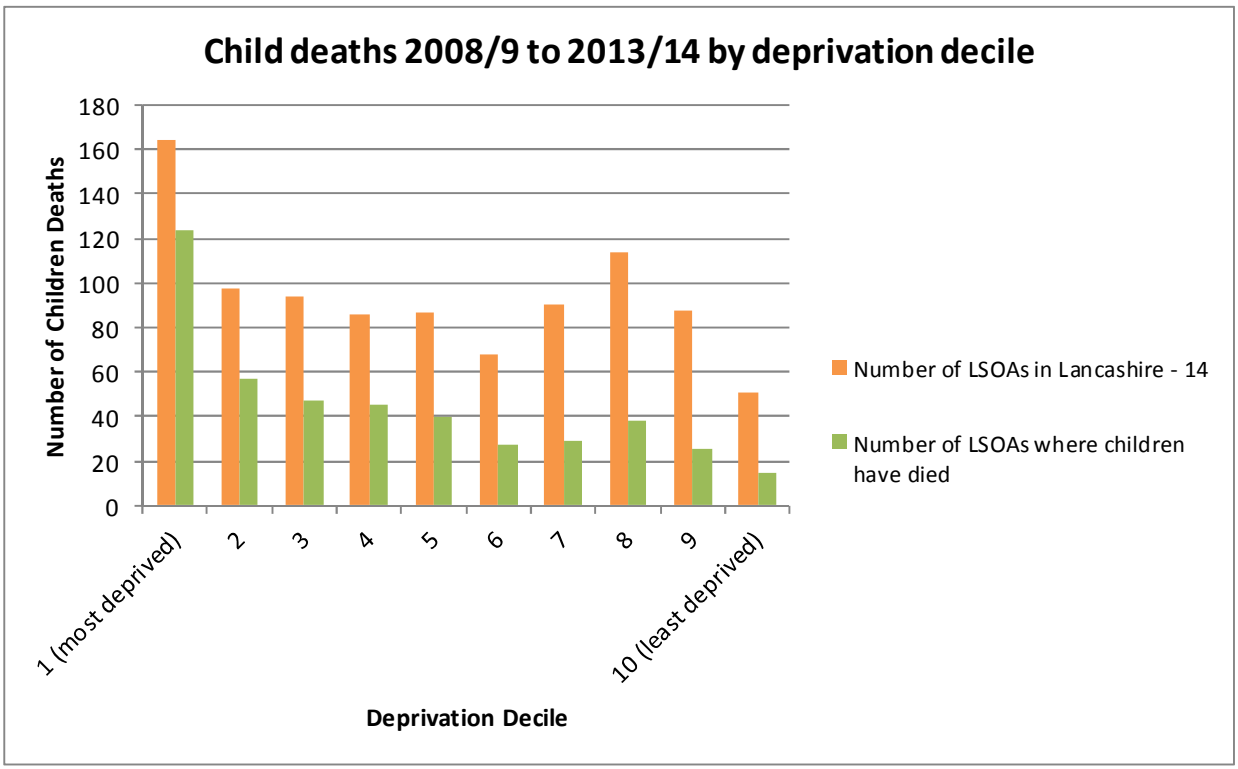

Figure 14, the number of child deaths reviewed between April 2008 and March 2014 by deprviation decile

Figure 14 above, shows the number of Lower Super Output Areas (LSOAs) across pan-Lancashire (referred to as Lancashire 14 in the graph) and the number of child deaths (reviewed April 2008-March 2014) for each decile category. There are more child deaths within the most deprived area, which gradually decreases from decile 2 – 10 with a slight increase in number for decile 8.

The map on the next page (figure 15) depicts the child deaths by index of multiple deprivation.

Figure 15 removed to maintain confidentiality

Figure 15 child deaths reviewed between April 2008 and March 2014 by deprivation and expected/ unexpected.

Identification of themes and trends

- There are significantly more deaths with no modifiable factors identified.
- Of the deaths deemed to have modifiable factors (23%) the largest categories of death in pan-Lancashire are perinatal/ neonatal events, sudden unexpected, unexplained deaths and trauma and other external factors
- Of the Blackburn with Darwen residents the largest category of death with modifiable factors identified was Perinatal/ neonatal events
- Blackpool's largest category with modifiable factors identified was sudden unexpected, unexplained deaths
- Pan- Lancashire have a significantly larger proportion of deaths with modifiable factors in the following categories compared to national figures: deliberately inflicted injury, abuse or neglect, suicide or deliberate self-inflicted harm, infection
- Pan- Lancashire have a significantly lower proportion of sudden unexpected, unexplained deaths with modifiable factors compared to the national data

- On a pan-Lancashire basis there are more expected deaths then unexpected deaths in line with the national picture; however, Blackpool has more unexpected deaths
- Deaths with modifiable factors take the longer to complete
- On a pan-Lancashire basis there are more male children than female children have died in line with the national picture; however, Blackpool has more female children who have died
- 63% of children who have died are under 1 year of age
- 62% of children who have died are of a White British ethnic origin
- Blackburn with Darwen, Preston and Pendle have the highest number of child deaths
- More children die in the most deprived areas of pan-Lancashire

Themes from other areas

There are a number of issues which continue to be a concern to panels nationally:

• Safe sleeping (including co-sleeping) - This continues to be a national issue and some panels have raised the need for safe sleeping messages to be shared with the wider family and anyone who may look after the child. In 3% of the deaths reviewed nationally co-sleeping may have contributed to vulnerability, ill-health or death and in a further 1% co-sleeping provided a completed and sufficient explanation for the death

• Language barriers - access to health services especially emergency services

• Consanguinity - Panels continue to be concerned that inter-family couples do not have sufficient understanding of the increased risks of having a child with a disability or of having a child die under the age of 5. Nationally, in 2% of the deaths reviewed consanguinity may have contributed to vulnerability, ill-health or death and in a further 1% consanguinity provided a completed and sufficient explanation for the death

• Bereavement support - including the support offered to children following the death of a parent, carer or sibling

• Smoking - A number of panels are working with pregnant women to highlight the risks of maternal smoking. They also continue to raise awareness of the risks of smoking in the home. Nationally, in 7% of the deaths reviewed smoking by the parent/carer in a household may have contributed to vulnerability, ill-health or death and in 5% smoking by the mother during pregnancy may have contributed to vulnerability, ill-health or death

• Road safety - this continues to be a main learning point for a number of panels. Actions ranged from improving links with the road safety teams to raising awareness of the importance of cycling helmets

A number of issues have become of increasing concern to panels across the nation within the recent year:

- Safe bathing - A number of panels raised concerns about unsafe bathing practices

- Suicide - The number of deaths due to suicide continues to be a concern to panels and they are taking actions in a number of areas, including working with the Samaritans and schools to offer support

- Domestic violence – Nationally, in 3% of the deaths reviewed domestic violence may have contributed to vulnerability, ill-health or death

- Early recognition of sick children - a number of panels reported that they are working closely with health professions to improve the early recognition of illnesses

- Ambulance procedures - a number of panels are reviewing procedures

- Parental supervision - A number of panels reported that parental supervision was a factor in accident related deaths and actions were being taken to address this. Nationally, in 4% of the deaths reviewed poor parenting/supervision may have contributed to vulnerability, ill-health or death and in a further 1% poor parenting/supervision provided a completed and sufficient explanation for the death

Limitations

The Panel have identified a number of limitations with the current report, primarily, the lack of an appropriate database to record information which also allows in depth analysis of the CDOP information. The lack of such a system results in difficulties analysing the data and ultimately impacts on making SMART recommendations; particularly in relation to modifiable factors, as the way the Panel has to reach a decision on this is very subjective.

The Panel have identified 3 thematic research areas for 2015/16 as priorities to help improve the recommendations made. Additionally, the Panel have identified areas for improving the annual report in terms of layout and format which will be utilised in the 2014/15 report.

CDOP 3 year priorities

Year	Priority
2014/15	CDOP Database
	Review where Safer Sleep Campaign should sit
	Commission an evaluation of the SUDC Service
	Launch SUDC Protocol
	CDOP to QA the consistency of decision making
	Review cases and make recommendations to the Boards
	Review and update the Safer Sleep Guidance
	Hold CDOP Development Days
	Develop a multi-agency destruction and retention policy which will be included within the CDOP TOR and will be approved by the three LSCBs by March 2015
2015/16	An analysis of the impact of service provision in areas of higher deprivation on child deaths.
	In depth analysis of Category 3 deaths
	In depth analysis of Category 7 deaths
2016/17	Add to analysis already completed on the neonatal deaths by completing a review of the category 8 deaths
April 2014 – March 2017	Disseminate messages and information to the multi-agency workforce and public (as appropriate)
	Take part in the academic research to evaluate safer sleep campaigns, materials and policies and the effect on families and professionals

Table 10, CDOP priorities for 2014/15

Recommendations for 2014/15

- Health visiting providers (Lancashire Care Foundation Trust and Blackpool NHS Foundation Trust) to provide assurances to their LSCB that safer sleep information is discussed with parents/ carers at the antenatal and primary contacts
- Given the frequency in the numbers of deaths caused as a result of own actions, the Health and Wellbeing Boards should assure themselves that there is evidence-based and effective early intervention/ preventive work for emotional health and wellbeing for children and young people
- Public Health teams to develop a set of recommendations based on more detailed analysis of historical data collected by CDOP (including the modifiable factors identified by CDOP) and any other relevant sources.
- The LSCBs & Health and Wellbeing Boards should seek assurances that there is effective interagency working to address the misuse of alcohol and substances and smoking cessation