Pan-Lancashire Child Death Overview Panel
Annual Report 2014-15

Public – small numbers suppressed

Contents

Introduction

This is the 7th annual report since Child Death Overview Panels (CDOP) became statutory in April 2008 and the third 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 provides information on trends and patterns in child deaths reviewed:

- during the last reporting year (2014-15)
- on all deaths reviewed since the panel began in April 2008

It also makes recommendations to the three LSCBs based on the analysis.

Members and Attendance

During 2014/15 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 representatives 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 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 (6 meetings)		**Case Discussion Meetings (6 meetings)**		**Neo-natal Review Meetings (5 meetings)**	
Agency	**% Attendance**	**Agency**	**% Attendance**	**Agency**	**% Attendance**
Chair	67% (4 of 6)	Chair	83% (5 of 6)	Chair	80% (4 of 5)
Lancashire Constabulary	83% (5 of 6)	Lancashire Constabulary	100%	Lancashire Constabulary	80% (4 of 5)
Children's Social Care	67% (4 of 6)	Children's Social Care	100%	Children's Social Care	100%
Public Health	100%	Public Health	100%	Public Health	100%
Designated Doctor for SUDC/ Lead Nurse for SUDC	100%	Named Nurse for Safeguarding	100%	Named Nurse for Safeguarding	80% (4 of 5)
SUDC Prevention Chair	83% (5 of 6)	Named Midwife	100%	Named Midwife	100%
SUDC Stake Holders Rep.	100%	Paediatrician	100%	Paediatrician and/or Neonatologist	100%
B'pool LSCB Business	67% (4 of 6)	SUDC Service	83% (5 of 6)	SUDC Service	80% (4 of 5)

Manager					
BwD LSCB Business Manager	100%	Education (School/ Early Years Rep)	75% (3 of 4)	Neonatal Specialist	67% (2 out of 3 meetings invited to)
Lancs LSCB Business Manager	83% (5 of 6)	Observers	15	Observers	3
CCGs	100%				
Acute	83% (5 of 6)				
LCFT	83% (5 of 6)				

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

83% of business meetings had all geographical representation, the exception was August when 3 Blackpool representatives had to send apologies. Additionally, throughout the reporting year the Panel has had 18 observers of primarily the case discussion meeting with a few observing the neonatal case discussion meetings.

Recommendation for Blackpool Board: identify a Blackpool education and/ or early year's representative to be a member of the CDOP.

CDOP priorities for 2014/15

Year	Priority	RAG Rating	Comments
	CDOP Database	Amber	The Panel has submitted its second business enquiry with BTLS which is the 2nd phase of finding a solution. Currently it is proposed the scoping out of a solution will take approximately 22 full days, the Lancashire Constabulary are pulling together a list of information security requirements to inform this stage. The Panel would like the implementation of a database to be completed by March 2016.
	Monitor the Safer Sleep Campaign	Green	The SUDC Prevention Group had a small budget (£15,000) this year to maintain the campaign while a report was produced to consider other appropriate bodies to coordinate this piece of work. It was agreed to maintain the campaign using the current governance arrangements. The SUDC prevention group has now started developing a risk assessment tool and agreement has been given to plan safer sleep training for the workforce provided by The Lullaby Trust.
	Commission an evaluation of the SUDC Service	Amber	The Panel have been unable to commission an evaluation of the service within the £5000 budget allowance advised by the LSCBs. However, the Panel have completed a self-assessment and included the rapid response process (which the SUDC Service lead on) within this assessment. A Public Health Specialist Registrar, who is not connected with the service, has been identified to undertake an evaluation.
	Launch SUDC Protocol	Green	Completed and the updated protocol has been disseminated and put on the LSCB websites. The SUDC service has been completing training for health and police colleagues. For 2015/16 the Lancashire LSCB are organising SUDC Protocol training which will be multi-agency.
	Review cases and make recommendations to the Boards	Green	Completed. The Panel reviews child deaths every month and provides the LSCB with bi-monthly reports.

	Review and update the Safer Sleep Guidance	Amber	This was delayed pending the release of updated NICE guidelines (Addendum to Clinical Guideline 37, Postnatal Care) in December. Prof. Helen Ball has been consulted on how we should update our guidance, the amendments are now in the process of being made.
	CDOP Development Day	Green	Took place 26/03/15. This was positively evaluated and helped inform the annual plan.
	CDOP to QA the consistency of decision making	Green	Results from previous cases were re-presented at the development day on 26/03/15 and it was noted that the Panel had been more consistent than it was anticipated with similar decisions and categorisations being made, even without specialists (e.g. neonatologists) being present.
	Develop a multi-agency destruction and retention policy	Green	LSCBs are taking this forward. CDOP TOR agreed without this included until further advice available.
	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.	Green	Data analysis sub group has been set up and will provide CDOP advice and recommendations as how to progress the analysis of data, in subsequent years.
2015/16	An analysis of the impact of service provision in areas of higher deprivation on child deaths.		CDOP's data analysis sub-group is reviewing the data and will make recommendations on how to progress.
	In depth analysis of Category 3 deaths		CDOP's data analysis sub-group is reviewing the data and will make recommendations on how to progress.
	In depth analysis of Category 7 deaths		CDOP's data analysis sub-group is reviewing the data and will make recommendations on how to progress.
2016/17	Update analysis already completed on the neonatal deaths by completing a review of the category 8 deaths		CDOP's data analysis sub-group is reviewing the data and will make recommendations on how to progress.
April 2014 – March 2017	Disseminate messages and information to the multi-agency workforce and public (as appropriate)	Green	Newsletter/ Safer Sleep Campaign/ Contribution to briefings and training.
	Take part in the academic research to evaluate safer sleep campaigns, materials and policies and the effect on families and professionals	Green	A number of children's centres within pan-Lancashire have been approached by Prof. Helen Ball to help with identifying parents/ carers to contribute to research.

Table 2, update on CDOP priorities for 2014/15

2013/14 Annual Report Recommendation Update:

The Panel have reflected upon the recommendations identified in the 2014/15 report and below are the updates:

- Health visiting providers (Lancashire Care Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust) to provide assurances to their respective LSCB that safer sleep information is discussed with parents/ carers at the antenatal and primary contacts.
  Update: Safer sleeping advice has been added to the service specification as part of The New Baby Review (Universal Services). "SIDS prevention including promoting safe sleep - active promotion of the pan-Lancashire safer sleeping messages including the use of jointly produced materials". Additionally the CDOP Chair has written to the providers for Health Visiting Services to request assurances that safer sleep is being discussed with parents/ carers.

- 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.
  Update:
  Lancashire Health and Wellbeing Board has commissioned a piece of work to review the commissioning of CAMHS services.

  Action plans have been developed by Lancashire and Blackburn with Darwen Health and Wellbeing Boards to improve emotional health and wellbeing for children and young people.

  Blackpool has a Joint Health and Wellbeing Strategy and within the 'developing well' section have a number of actions to improve emotional health and wellbeing in 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.
  Update: CDOP has developed a data analysis sub group which is attended by the pan-Lancashire CDOP Public Health Consultants and 4 Intelligence Specialists. The group is reviewing the current data and will make recommendations to CDOP on how to develop the data analysis and thematic reviews.

- 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.
  Update:
  Lancashire LSCB have received two reports in relation to tobacco control/ smoking cessation and alcohol and Substance Misuse which provided the necessary assurance.

  Blackburn with Darwen has submitted a Joint Health and Wellbeing Strategy with a recommendation that Public Health commission a smoking cessation service.

  Blackpool Health and Wellbeing Board have received reports on the Alcohol Strategy and Tobacco Control Strategy which have been refreshed during the year. A Drug Prevention Strategy will be developed and presented to the Health and Wellbeing Board during 2015/16. An exercise to re-commission specialist smoking cessation services has recently been completed and a new service will be in place by October 2015. This

service will include targeted work to support pregnant women to stop smoking, and to promote smoke-free homes. Reports on the Alcohol Strategy and on a commissioning review of drug and alcohol treatment services have been presented to Blackpool's LSCB. Blackpool's LSCB performance subgroup has carried out deep dive audits of safeguarding arrangements in drug and alcohol service providers with a view to strengthening interagency safeguarding procedures.

CDOP Key Successes 2014/15

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. There are plans to:

- develop the materials with a risk assessment tool
- commission a pharmacy campaign with Public Health
- commission training from the Lullaby Trust for front line professionals

There has also been regional interest in the materials which is very positive and will help in providing regionally consistent messages. It will also reduce cross-border inconsistent practice particularly for acute trusts which are accountable to more than one LSCB. During the forthcoming year we will look to place a bulk order of materials with Merseyside and Cheshire East, this will benefit pan-Lancashire by reducing the unit price of materials. Discussion is ongoing with other LSCBs to further reduce costs and promote consistency.

The pan-Lancashire Safer Sleep Guidance is in the process of being updated and reviewed by Professor Helen Ball, it will then be submitted to NICE for their shared learning database as an example of good practice.

CDOP Newsletter
The Panel produced its first CDOP newsletter to raise awareness to particular issues and dangers in December 2013. The feedback received was very positive and more are planned for 2015/16.

CDOP Development Day
A half day development day was held in March 2015. There were discussions regarding:

- The effectiveness of CDOP sub-groups
- Panel member responsibilities
- 2015/16 priorities
- A Quality Assurance review of consistency (see next point for detail)

Quality Assurance
The Panel undertook an exercise throughout 2014/15 in an effort to ensure decision-making consistency. The Panel re-considered 7 randomly selected deaths which had previously been concluded, originally reviewed between 2010 and 2013. The Panel were unaware they had previously considered these deaths. At the CDOP development day the decisions made at the original review and the QA review were compared.

The exercise highlighted that CDOP are quite consistent in their decision making in terms of identifying modifiable factors, issues and contributory factors within the deaths. Furthermore, it was noted that issues relating to information sharing and multi-agency communication remain areas for improvement; however, the group noted the small sample size in this exercise was a limitation. Anecdotally, the CDOP feel they are now recognising more family and environmental factors as

modifiable e.g. maternal health, smoking and BMI for neonatal and perinatal deaths which may explain why the pan-Lancashire CDOP is seeing an increase in modifiable factors.

SUDC Protocol Launch
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 has been widely disseminated. The multi-agency protocol training will be available throughout 2015/16.

National CDOP Network
The Pan-Lancashire CDOP Chair has been invited to sit on the National CDOP network, established with support from the National Chief Coroner.

Self-Assessment Tool
The Panel completed a self-assessment tool based on Working Together (2013), the Terms of Reference and additional factors that provide extra value to the CDOP. All items are RAG rated green with the exception of 3 which are amber and further work is ongoing.

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 response process to sudden unexpected deaths of children across pan-Lancashire since September 2008. The service has seen a change in personnel with the appointment of a new lead nurse in April 2014 and specialist nurse in April 2015.

During 2014/15 the SUDC service has been notified of 47 sudden, unexpected deaths an increase of 6 on the 2013/14 reporting year. The number of deaths the service has been notified of in previous years is seen in the table below.

Year of notification	2009/10	2010/11	2011/12	2012/13	2013/14
Number of Deaths	50	58	65	46	41

Table 3, number of deaths notified to the SUDC Service by reporting year.

The figure below show the number of unexpected child deaths by the child's resident Local Authority district area for 2013/14 and 2014/15. It is clear from the charts that East Lancashire have experienced the highest number of unexpected deaths during 2014/15; however there does not appear to be any obvious themes or trends emerging from these deaths.

Figure 1 removed to maintain confidentiality

Figure 1, unexpected deaths by child's resident Local Authority area during 2013/14 and 2014/15 reporting years.

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 inquests, facilitating meetings and accompanying them to appointments with paediatricians (where appropriate). This has served to improve links with paediatricians and relationships with coroner's officers. The formal reporting of client feedback is an area in need of further development and the service is currently examining innovative ways of obtaining this given the emotive nature of the subject matter.

Recommendation for SUDC Service – to ascertain the most appropriate way to gather parental feedback and provide an overview of the responses in the next CDOP annual report.

The final part of the rapid response culminates with the end of case discussion meetings (ECDM). Challenges remain in ensuring these are undertaken within the required timescale, which is governed by the timely sharing of the final post mortem report. The SUDC team, together with the CDOP chair and co-ordinator, have met with each district coroner and some coroner's officers to discuss issues that might be hindering the process. The service will monitor this and formally raise any issues and lessons learnt from ECDMs with CDOP.

During 2014/15 there were 11 infant deaths within pan-Lancashire where co – sleeping or unconventional sleeping arrangements were noted, this is an increase of 4 compared with 2013/14. The SUDC nurses have utilised their insight and knowledge gained from responding to these deaths to contribute to the SUDC Prevention Group. The number of deaths reported highlights the need for ongoing multi agency work to develop innovative ways of ensuring that parents are empowered to act upon safer sleep messages.

Priorities for 2015/16:

- To participate in the evaluation of the service
- To explore innovative methods of obtaining final post mortem reports
- To explore methods of obtaining client feedback
- To work with partner agencies in sharing information obtained from working with families who have experienced a sudden unexpected death of their child to contribute to the safer sleep group
- To work with IT colleagues to develop the recording of information to ensure a more efficient system that is fit for purpose
- To continue to establish links with coroners and their officers

SUDC Prevention Group

In April 2014 the SUDC Prevention Group was provided with £15,000 to maintain the supply of materials to agencies whilst an options paper was developed to review the most appropriate reporting and funding streams for the Safer Sleep Campaign. The options paper was presented to the pan-Lancashire Independent LSCB Chairs meeting in December 2014 and it was agreed the Safer Sleep Campaign should be coordinated by the SUDC Prevention Group and consequently overseen by the CDOP a sub group of the three LSCBs. The Directors of Public Health for Lancashire, Blackburn with Darwen and Blackpool agreed to fund £15,000 for one year (15/16) with the CDOP contributing £15,000.

Priorities for 2015/16:

- Identify a new Chair by January 2016
- Develop a family friendly risk assessment tool
- Work with Public Health teams on a pharmacy campaign to target high risk areas and grandparents
- Commission The Lullaby Trust to provide training for frontline staff
- Complete a bulk order of materials for multi-agency frontline professionals to cover approximately 47000 live births across pan-Lancashire, pan-Merseyside and Cheshire East
- Maintain a supply of materials to key agencies within pan-Lancashire

To allow the SUDC prevention group to achieve their priorities for 2015/16 attendance and membership at the group needs to improve. During 2014/15 there were 4 planned meetings, 1 had to be cancelled due to the number of apologies and so 3 actual meetings were held.

100% attendance has been recorded for the Chair, Infant Feeding Specialist and CDOP Coordinator. Representation from BwD Public Health, BwD Children's Centres, Blackpool Children's Centres, SUDC service and Lancashire Constabulary could all be improved. Unfortunately, Lancashire County Council can no longer provide a communications or marketing representative and this makes it very difficult to develop new materials, review old materials and place orders as the relevant professionals with specialist knowledge are not present.

Recommendations:

1. Determine a revenue stream amongst partners to continue with the programme
2. Blackpool and Blackburn with Darwen LSCBs to identify a suitable representative for the SUDC prevention group ideally a professional from either Children's Centres, Public Health and/ or midwifery
3. Pan-Lancashire independent LSCB Chairs to identify a marketing representative for the SUDC Prevention Group
4. LSCBs to endorse the priorities for 2015/16 identified above

Part 2 – Data Analysis

Analysis of deaths reviewed between April 2014 and March 2015

This section of the report considers the child deaths data reviewed between April 2014 and March 2015 only.

During the 2014/15 reporting year, CDOP was notified of 131 child deaths (14 Blackpool residents, 17 Blackburn with Darwen (BwD) residents, 100 Lancashire residents) which were in line with Working Together to Safeguard Children (2013[1]) definition and therefore considered by the pan-Lancashire CDOP. Seventeen additional notifications were outside the statutory guidance and therefore not reviewed including 13 cases out of area and (reviewed by a different Panel) and <5 were stillborn or terminations of pregnancy.

Figure 2 below shows the number of statutory notifications received in each reporting year since CDOPs became statutory in April 2008.

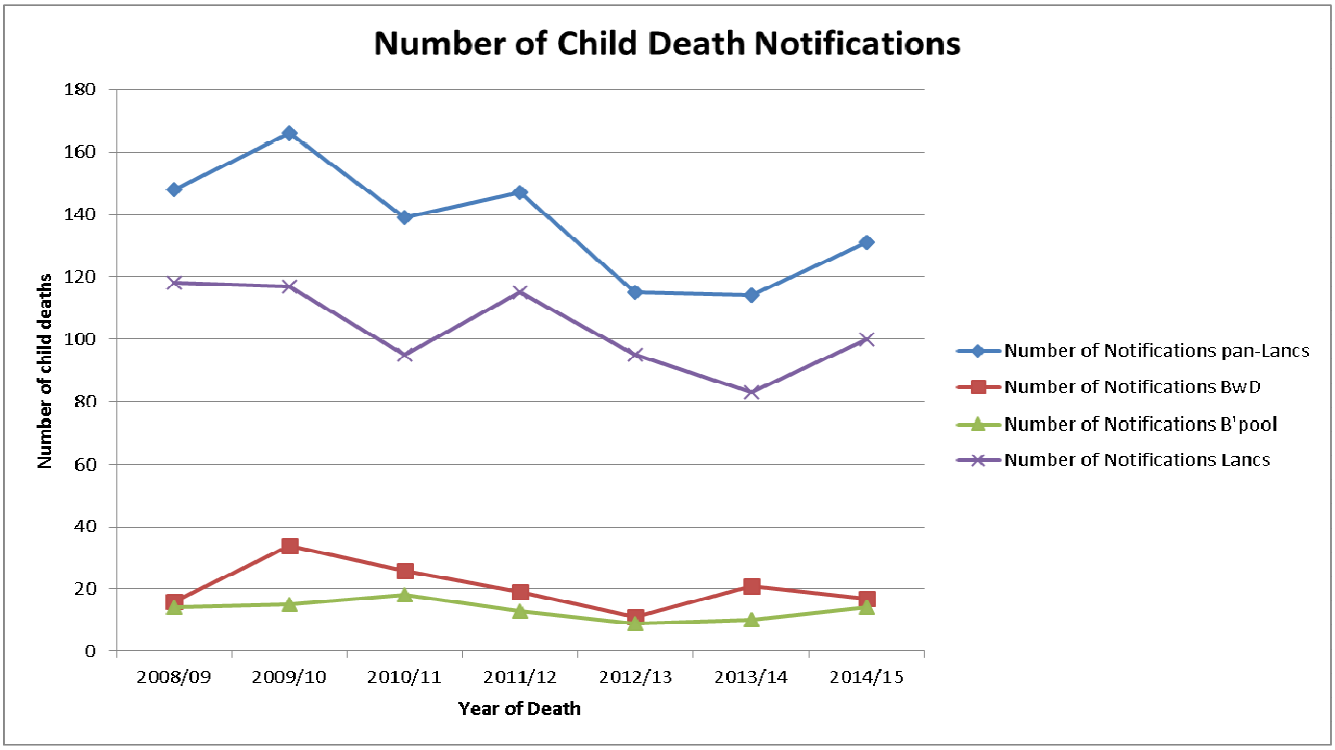

Figure 2, Number of child death notifications by child's local authority and year of child death

Overall there is a gradual decline in the number of reported child deaths over the last six years, despite a slight increase this year in Lancashire.

In the reporting year ending March 2015 the Panel completed 117 reviews (21 BwD reviews, 12 Blackpool reviews and 84 Lancashire reviews) compared to, 137 reviews in 2013/14. Of the 117 completed this year 73 were expected and 44 unexpected.

[1] Working Together was updated in March 2015

Child Death Reviews by Age

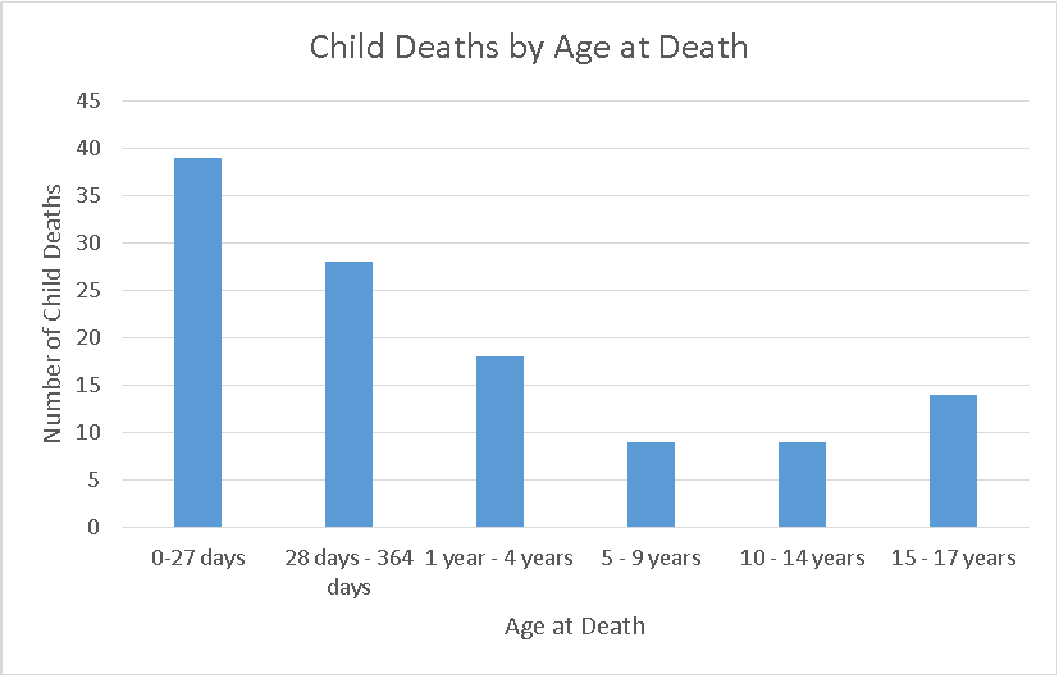

Figure 3, child deaths reviewed in 2014/15 by the age at death

The pattern of deaths by age seen in figure 3 is similar to that seen nationally.

Child Death Reviews by Ethnicity

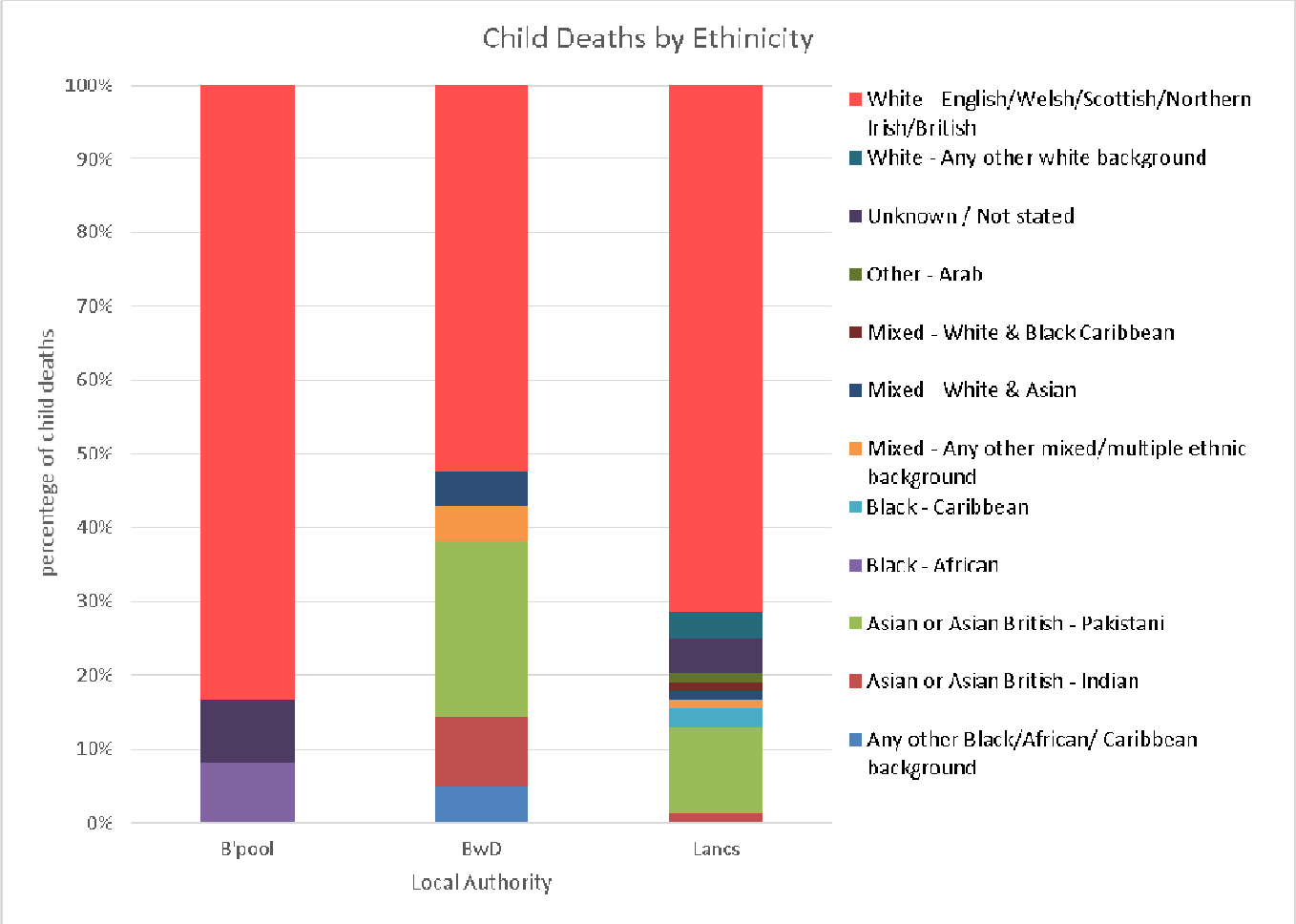

Figure 4, child deaths reviewed in 2014/15 by the child's local authority and ethnicity

Figure 4 highlights that Lancashire and Blackpool have small gaps in information relating to ethnicity for the deaths of children and young people reviewed this year.

Category of Death

Figure 5 removed to maintain confidentiality

Figure 5, child deaths reviewed in 2014/15 by category of death as defined by the Department for Education

The most common categories of death are perinatal/ neonatal events (33%) and chromosomal, genetic and congenital anomalies (24%). Sudden unexpected, unexplained deaths accounted for 11% of pan-Lancashire deaths reviewed in 2014/15 (figure 5). This pattern is similar to the national picture.

Location of death

The table below (table 4) highlights that the majority of children die within a hospital setting. This is expected due a large number of the deaths being due to neonatal and perinatal events, and chromosomal, genetic and congenital anomalies, which require medical support. 23% of children and young people died at home, including children who have end of life care plans in place, as well as children who have died unexpectedly.

Where was child at death[2]	B'pool	BwD	Lancs	Grand Total
Abroad			<5	*
Acute hospital - Adult intensive care unit	<5			*
Acute hospital - Emergency Department			5	5
Acute hospital - Neonatal Unit	<5	8	29	*
Acute hospital - other	<5	<5	6	*
Acute hospital - Paediatric Intensive Care Unit	<5	<5	10	*
Acute hospital - Paediatric Ward		<5	<5	*
Home of normal residence	<5	6	17	*
Hospice			<5	*
Other (specify - hotel)			<5	*
Other private residence		<5	<5	*
Public Place			8	8
Residential Care			<5	*
All locations (total)	12	21	84	117

Table 4, child deaths reviewed in 2014/15 by the child's local authority and the place where they died
* Figures removed to maintain confidentiality

Child Deaths by Deprivation

Figure 6 reinforces the link between child deaths and deprivation. Whilst numbers are small, there is a disproportionate over-representation from each of the 3 deciles with the highest deprivation.

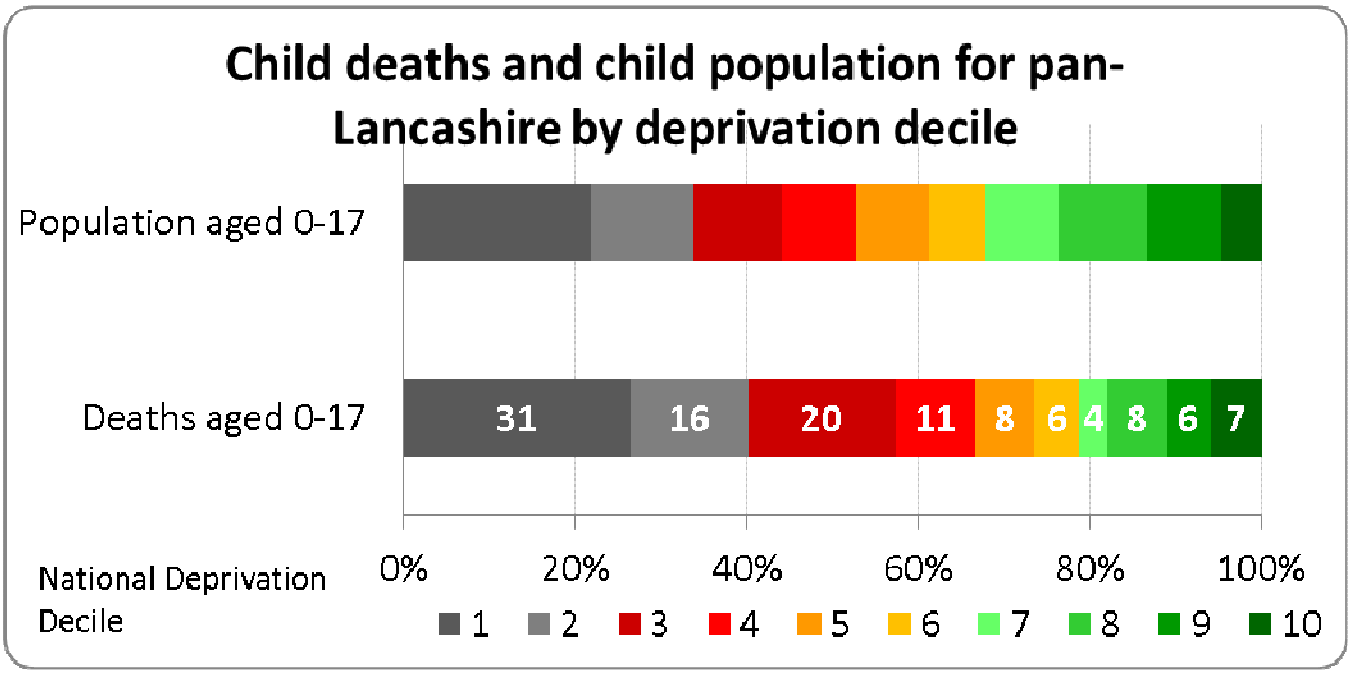

Figure 6, percentage of child deaths reviewed in 2014/15 by deprivation decile compared with child population percentage by deprivation decile.

Recommendation - Partners working across the children's health and wellbeing systems across pan-Lancashire should assure themselves that coordinated strategies to address the determinants of health in line with the Marmot principles are developed. The Marmot principles are:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all

[2] Place where the child is believed to have died, or where the event directly leading to death occurred.

- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

Modifiable Factors

A modifiable factor is defined as "*one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths*" (Working Together, 2015).

Expected/ Unexpected	LA	Modifiable Factors (2014/15)	Modifiable Factors **(Average 2008-14)**	No modifiable Factors (2014/15)	No modifiable **(Average 2008-/14)**
Expected	B'pool	* (43%)	* (6%)	* (57%)	* (94%)
	BwD	* (23%)	* (12%)	* (77%)	* (88%)
	Lancs	* (19%)	* (8%)	* (81%)	* (92%)
Expected Total		16 (22%)	6 (9%)	57 (78%)	63.8 (91%)
Unexpected	B'pool	* (40%)	* (40%)	* (60%)	* (60%)
	BwD	* (63%)	* (32%)	* (37%)	* (68%)
	Lancs	* (39%)	* (44%)	* (61%)	* (56%)
Unexpected Total		19 (43%)	23 (43%)	25 (57%)	31 (57%)
Grand Total		35 (30%)	29 (23%)	82 (70%)	94.8 (77%)

Table 5, Total number of deaths reviewed in 2014/15 by expected/ unexpected and whether modifiable factors were identified
* Figures removed to maintain confidentiality

The table above identifies the number of deaths reviewed in 2014/15 by the child's local authority that were considered to have modifiable factors and whether the deaths were expected or unexpected. The averages since 2008 are provided in bold for comparison. ***(Caution: small annual changes to numbers can lead to large percentage differences.)***

Nationally 24% of cases are deemed to have modifiable factors this has increased from 20% in 2011. During 2014/15 30% of the cases reviewed had modifiable factors, compared to the average for April 2008 – March 2014 of 23%.

Category of death and Modifiable Factors

The largest category of death with modifiable factors was perinatal/ neonatal event (46%). (See figure 7 below). The second largest category to have modifiable factors in 2014/15 was sudden unexpected, unexplained death (20%).

There were no deaths with modifiable factors identified due to chromosomal, genetic and congenital anomalies. There were no deaths caused by deliberately inflicted injury, abuse or neglect, that had modifiable factors identified

Figure 7 removed to maintain confidentiality

Figure 7, category of the child's death as defined by the Department for Education and whether modifiable factors were identified in reviews completed between April 2014 and March 2015

More detail is provided on modifiable factors later in this report (page 22-24).

Length of time to complete the review

CDOP is expected to review all deaths within a reasonable length of time, although the length of time varies depending a several factors, particularly if there a criminal case is involved. Of the 131 cases notified to the Panel in this reporting year, 51% (67) of reviews were completed and 49% (64) were still ongoing at 31st March 2015. In comparison, of the cases notified to the Panel in the last reporting year, 57% (64) were completed and 43% (49) were ongoing by 31st March 2014. This highlights that the Panel has maintained good processes and agencies have continued to succeed in providing information promptly, to enable over half of the cases to be notified and completed within the same reporting year.

Figure 8-12 below show that of the 117 cases reviewed in 2014/15, 91% were completed 12 months or less (89% Lancashire, 100% Blackburn with Darwen and 83% Blackpool) which is higher than the

national picture of 70%. All areas of pan-Lancashire have seen an increase in the proportion of reviews completed within 12 months of notification. This is a positive achievement.

Figures 8-12 removed to maintain confidentiality

Figure 8, time taken to complete reviews for East Lancashire

Figure 9, time taken for reviews for Blackburn with Darwen

Figure 10, time taken to complete reviews for North Lancashire

Figure 11, time taken to complete reviews for Blackpool

Figure 12, time taken to complete reviews for Central Lancashire

Analysis of child deaths reviewed from April 2008 – March 2015

This section of the report will look at the aggregated child death data reviewed between April 2008 and March 2015.

In total the Panel has been notified of 960 deaths (excluding out of area children and including 7 terminations of pregnancy which were pre March 2010) since April 2008 through to 31st March 2015 and has completed 92%. The table 6 below identifies the number of cases (8%) currently awaiting review by year of notification and resident of locality.

Table 6 removed to maintain confidentiality

Table 6, the number of cases awaiting review at 31st March 2015 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 numbers of cases from April 2011 – March 2014 requiring review are complex cases with outstanding criminal or coronial investigations.

Of the 887 cases reviewed 80 were Blackpool residents, 142 Blackburn with Darwen residents and 662 Lancashire residents with <5 unknown/ out of area. The table below provides the local figures for deaths deemed to be expected/ unexpected, by gender and where modifiable factors were identified; the national figures are included for comparison.

	Lancashire	Blackburn with Darwen	Blackpool	Pan - Lancashire	National
Expected	54%	68%	48%	55%	Not reported
Unexpected	43%	30%	52%	42%	Not reported
Male	59%	59%	45%	58%	55%
Female	41%	41%	55%	42%	43%
Modifiable	24%	20%	28%	24%	24%
No Modifiable	75%	79%	72%	76%	76%

Table 7, comparison of local data (2008-2015) with national figures (2014/15)

In 3% of the pan-Lancashire deaths there was either insufficient information to determine whether there were modifiable factors/ no modifiable factors or if the death was expected/ unexpected therefore some of the percentages in table 7 do not equal 100%.

Category and Age of Child Deaths

Perinatal/ neonatal events (8) and chromosomal, genetic and congenital anomalies (7) are the cause for the majority (58%) of child deaths as seen in figure 13. Causes of death by year are shown below in figure 14. (Figures for 2014/15 remain incomplete because of ongoing cases).

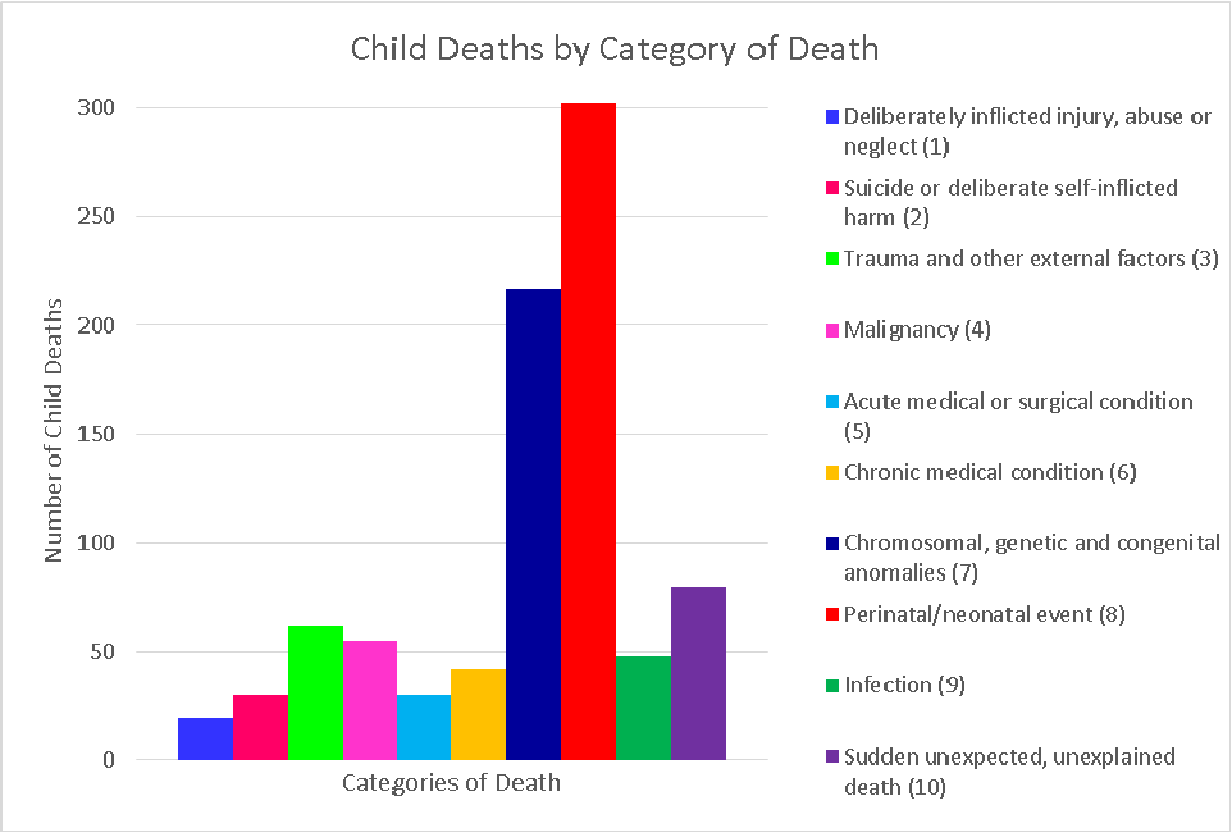

Figure 13, number of child deaths by category of death

Figure 14 removed to maintain confidentiality

Figure 14, cause of child death by year of death

The pattern of deaths by age seen in figure 15 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%). Interestingly, of the 99 deaths of young people in the 15-17 age group, 75% were unexpected and 65% of those were due to suicide/ self-inflicted harm or trauma/ other external factors. Based on the table in appendix 1 we know the modifiable factors for these categories of death are emotional health and wellbeing in young people and risk taking behaviours.

Figure 15 removed to maintain confidentiality

Figure 15, child deaths by age group at death and cause of death of cases reviewed between April 08 and March 15

Child deaths reviewed between April 2008 and March 2015 by locality and ethnicity are shown in Figure 16. Blackburn with Darwen, Preston, Pendle and Burnley have the most diverse populations. Of the 887 deaths reviewed between April 2008 and March 2015 the two largest ethnicities were White British 63% with 12% of an Asian or Asian British (Pakistani) ethnic origin. 10% of the child deaths reviewed did not have an ethnicity listed because it was either not known or not stated.

Based on information from the 2011 census (www.nomisweb.co.uk) the child population (0-17 years) for pan-Lancashire consists of 82% White British children and 6.8% Asian Pakistani children, which indicates the Asian Pakistani ethnicity is over-represented in the child death data.

Recommendation for pan-Lancashire LSCB Members – to cascade a reminder to all professionals providing information to CDOP to ensure the forms are completed as fully as possible before they are submitted, particularly relating to ethnicity.

Locality and Ethnicity

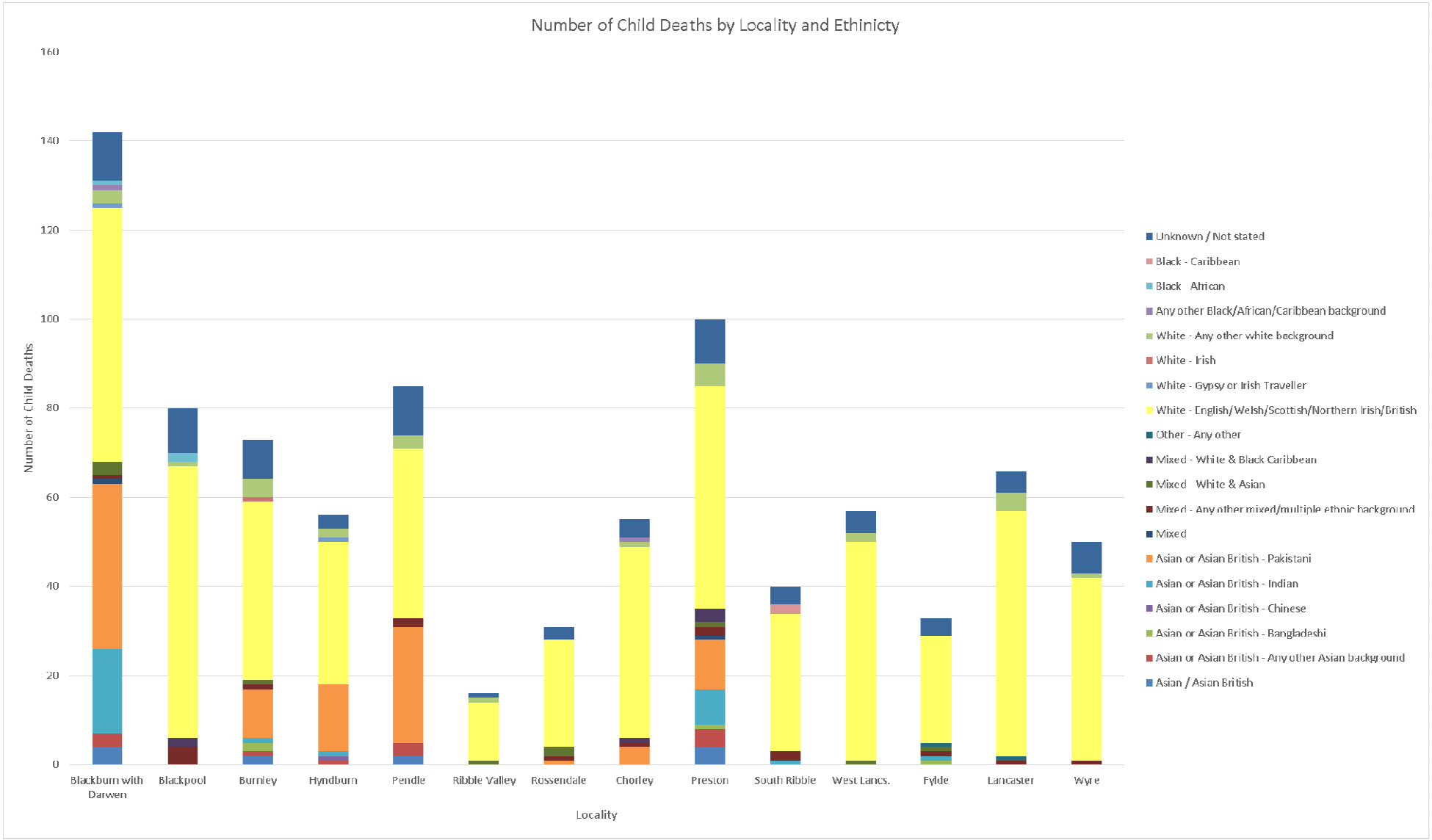

Figure 16, child deaths reviewed between April 2008 and March 2015 by locality and ethnicity

Modifiable Factors

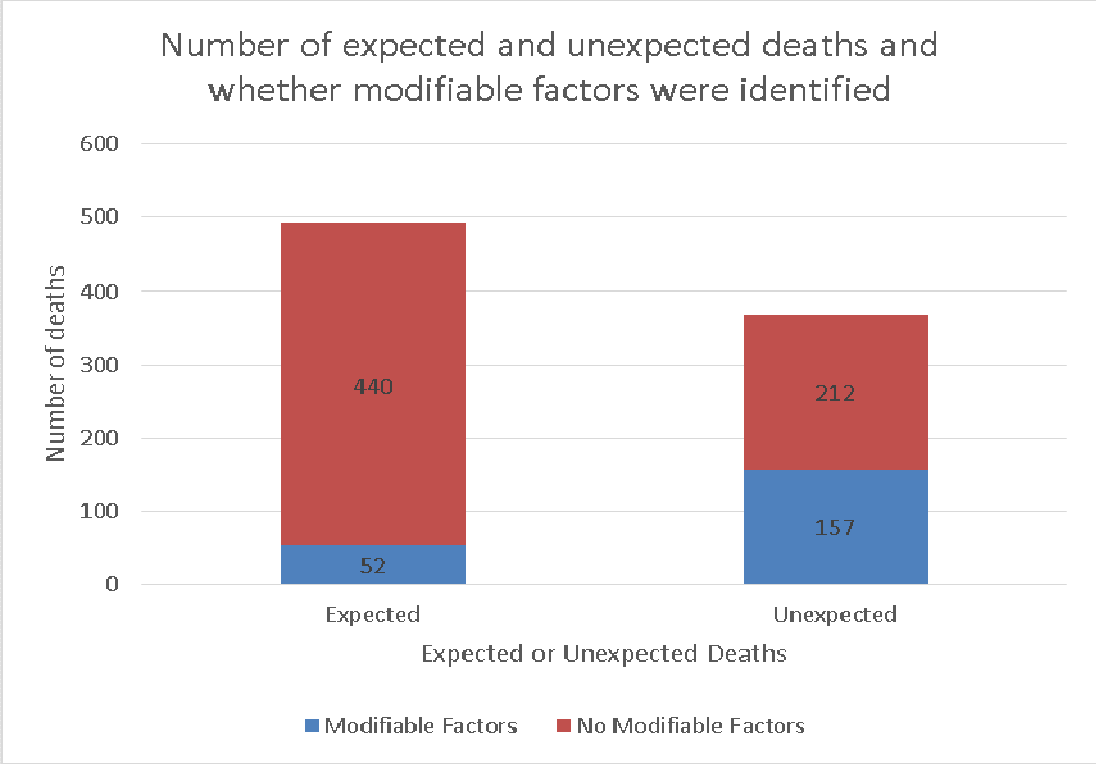

Figure 17, number of number of expected and unexpected child deaths reviewed between April 2008 – March 2015 and whether modifiable factors were identified (deaths which were not categorised as expected/ unexpected have been omitted from this graph)

The data shown in table 8 (below) is based on cases reviewed between April 2008 and March 2015 and is broken down into Local Authority area. When reviewing this chart caution needs to be taken when considering very small numbers. The table in appendix 1 has more detail on specific modifiable factors by category of death and Local Authority.

Pan-Lancashire has identified a much smaller percentage of deaths with modifiable factors which are categorised as 'medical' categories[3] in comparison to the non-medical categories of death. This is also seen in the Department for Education (DFE) statistical release for child deaths reviewed nationally throughout 2014/15.

85% of deaths reviewed and categorised as deliberately inflicted injury, abuse or neglect within pan-Lancashire have been identified to have modifiable factors. This is considerably higher than the DFE data; however, the majority of these will have been subject to Serious Case Review (SCR) where the learning will have been shared and extensive recommendations identified.

[3] The medical category includes perinatal/ neonatal event; chromosomal, genetic and congenital abnormalities; infection; malignancy; acute medical or surgical condition and chronic medical conditions.

	Category of Death	Modifiable Factors (Actual number)	No Modifiable Factors (Actual number)	Grand Total
Blackburn with Darwen	Medical (4,5,6,7,8,9)	14% (17)	86% (102)	119
	Sudden unexpected, unexplained death (10)	43% (6)	57% (8)	14
	Trauma and other external factors (3)	60% *	40% *	*
	Suicide or deliberate self-inflicted harm (2)	0	0	0
	Deliberately inflicted injury, abuse or neglect (1)	100% *	0	*
Blackpool	Medical (4,5,6,7,8,9)	19% (11)	81% (48)	59
	Sudden unexpected, unexplained death (10)	78% *	22% *	*
	Trauma and other external factors (3)	27% *	73% *	*
	Suicide or deliberate self-inflicted harm (2)	50% *	50% *	*
	Deliberately inflicted injury, abuse or neglect (1)	0	0	0
Lancashire	Medical (4,5,6,7,8,9)	14% (71)	86% (441)	514
	Sudden unexpected, unexplained death (10)	54% (29)	46% (25)	54
	Trauma and other external factors (3)	70% (32)	30% (14)	46
	Suicide or deliberate self-inflicted harm (2)	50% (14)	50% (14)	28
	Deliberately inflicted injury, abuse or neglect (1)	82% *	18% *	*
National	Medical (4,5,6,7,8,9)	11% (316)	89% (2554)	2,870
	Sudden unexpected, unexplained death (10)	63% (178)	37% (104)	282
	Trauma and other external factors (3)	57% (104)	43% (78)	182
	Suicide or deliberate self-inflicted harm (2)	44% (40)	56% (50)	90
	Deliberately inflicted injury, abuse or neglect (1)	53% (32)	47% (28)	60

Table 8, the number of reviews per Local Authority compared with national data for category of death together with the proportion of that category which had modifiable factors. * Figures removed to maintain confidentiality.

Figure 18 on page 24 illustrates the individual categories of death that the CDOP have a statutory obligation to allocate to each child death they review. This graph is helpful as it includes information on the individual categories of death the DFE have combined together under 'medical'.

211 (24%) cases were identified to have modifiable factors. Of the deaths categorised as having modifiable factors:

- Blackburn with Darwen had 45% of deaths due to perinatal/ neonatal events,
- Blackpool had 32% of deaths due to sudden unexpected, unexplained deaths, this is a reduction of 9% compared with last year; perinatal/ neonatal events (27%) was the next largest category.

The following can be seen in the pan-Lancashire column which is very similar to the Lancashire (12) column:

- 29% of these deaths were caused by perinatal/ neonatal events,
- 20% were sudden unexpected, unexplained deaths and
- 18% 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 smoking by someone in the household or smoking in pregnancy, issues relating to safer sleep and risk taking behaviours, respectively.

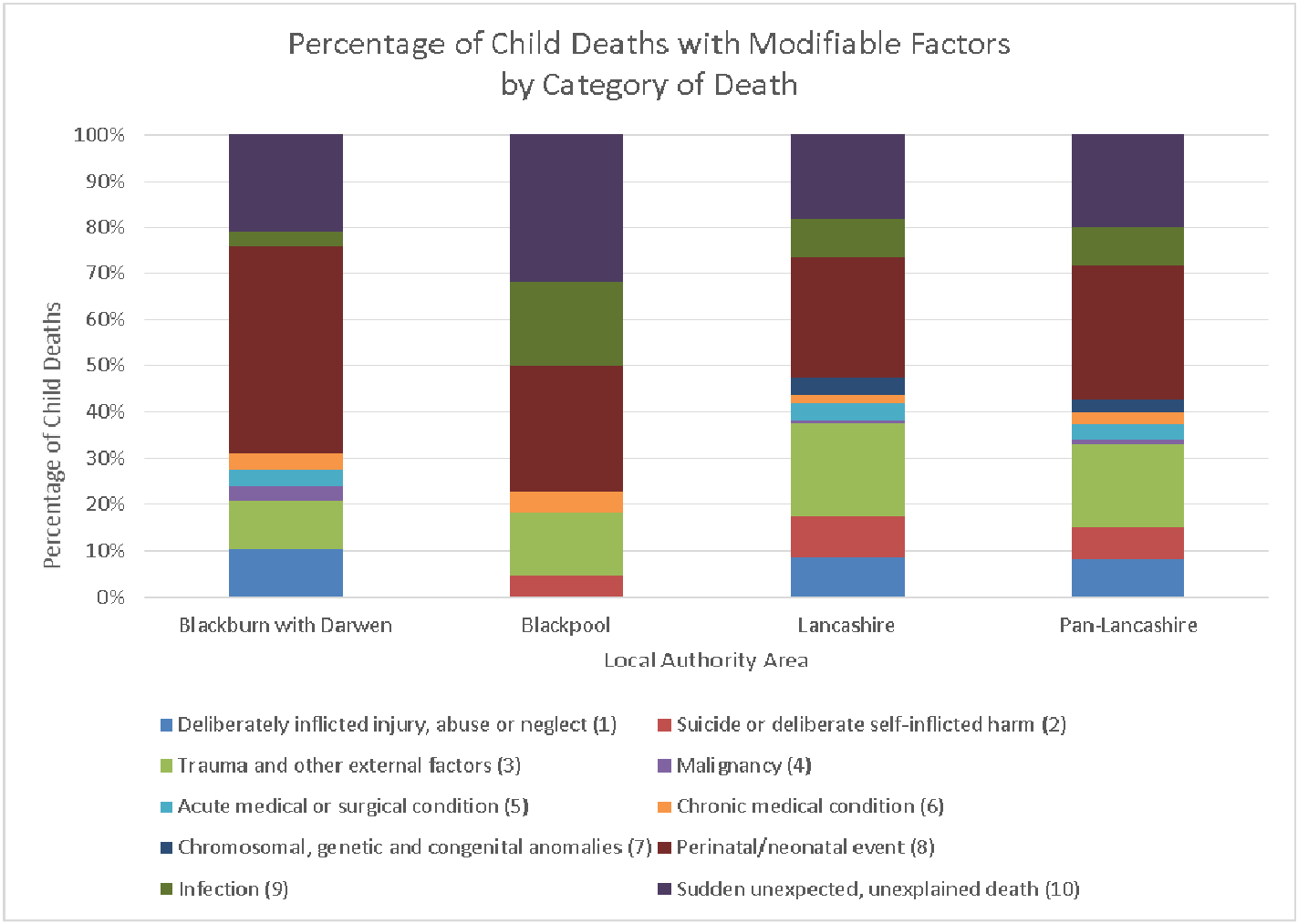

Figure 18, percentage of child deaths with modifiable factors identified by cause of death

Since 2008, the most common modifiable factors by Local Authority are (see appendix 1 for a detailed breakdown of modifiable factors by category and local authority):

Blackpool

1. Smoking (14)
2. Safer Sleep (8)
3. Service Provision (6)
4. Alcohol/ Substance misuse by parent/ carer (6)

Blackburn with Darwen

1. Parenting Capacity (15)
2. Smoking (13)
3. Service Provision (11)
4. Emotional/ behavioural/ mental health in parent/ carer (10)

Lancashire

1. Service Provision (53)
2. Parenting Capacity (48)
3. Alcohol/ Substance misuse by parent/ carer (43)
4. Smoking (39)

Pan-Lancashire

1. Service Provision (70)
2. Parenting Capacity (68)
3. Smoking (66)
4. Alcohol/ Substance misuse by parent/ carer (53)

Summary of key points and identification of themes and trends

All data reported within this section is based on child deaths reviewed between April 2008 and March 2015 unless a different time period is stated.

Blackburn with Darwen

- 100% of deaths reviewed during 2014/15 were completed within 12 months
- 26% of deaths were of children with Asian Pakistani heritage, which appears dis-proportionately high compared with the child population of 18% in the 2011 census.
- 68% of deaths are of children under 1 year of age (46% under 28 days and 22% 28 – 364 days)
- 68% of deaths are expected
- 39% of deaths are due to chromosomal, genetic and congenital anomalies and 27% were categorised as perinatal/ neonatal events
- 20% of deaths have modifiable factors identified
- 45% of deaths which had modifiable factors were due to perinatal neonatal events
- The most common modifiable factors are parenting capacity, smoking, service provision and emotional/behavioural/ mental health in a parent/ carer

Blackpool

- 83% of deaths reviewed during 2014/15 were completed within 12 months
- 52% of deaths are unexpected compared
- 55% of deaths are female (43% nationally)
- 61% of children were aged under 1 year old (46% under 28 days and 15% 28 – 364 days)
- The most common category of death is perinatal/ neonatal event (28%) followed closely by chromosomal, genetic and congenital anomalies (24%)
- 28% of deaths have modifiable factors.
- Of the deaths recognised to have modifiable factors, the most common category of death was sudden unexpected, unexplained deaths (32%)
- The most common modifiable factors are smoking, safer sleep, service provision and alcohol/ substance misuse by a parent/ carer

Lancashire

- 89% of deaths reviewed during 2014/15 were completed within 12 months
- 10% of deaths were of children from an Asian Pakistani heritage, which appears dis-proportionately represented compared with the child population of 6% in the 2011 census
- 61% of children were aged under 1 year old (36% under 28 days and 25% 28 – 364 days)
- 36% of deaths were due to perinatal/ neonatal events with 21% due to chromosomal, genetic and congenital anomalies
- 24% of death were identified to have modifiable factors
- Of the 24% of deaths identified to have modifiable factors the most common category of death was perinatal neonatal events (26%) the second largest category was trauma and other external factors (20%) whereas for pan-Lancashire it was sudden unexpected, unexplained deaths
- The four most common modifiable factors were service provision, parenting capacity, alcohol/ substance misuse in a parent/ carer and smoking

Pan-Lancashire

- Nationally 70% of deaths are reviewed within 12 months, 91% of cases reviewed by the pan-Lancashire CDOP during 2014/15 were completed within 12 months
- 62% of child deaths are of children under 1 year old, this is slightly below the national figure of 64%

- 58% of pan-Lancashire deaths were of male children and young people (55% nationally)
- The two largest ethnicities were White British 63% and Asian or Asian British (Pakistani) 12%. From the 2011 Census the child population was 82% White British and 7% Asian or Asian British (Pakistani)
- Perinatal and neonatal events (34%) and chromosomal, genetic and congenital anomalies (24%) are the most common categories of death
- 48% of 15 – 17 year old's deaths were categorised as suicide or deliberate self - inflicted harm (23%) and trauma and other external factors (25%)
- 24% of deaths had modifiable factors identified
- Of the cases identified to have modifiable factors the most common categories of death were perinatal/ neonatal events (29%), sudden unexpected, unexplained deaths (20% and trauma and other external factors (18%)
- The four most common modifiable factors were service provision, parenting capacity, smoking and alcohol/ substance misuse in a parent/ carer.

CDOP priorities for 2015/16

- Identify a new chair by January 2016
- Progress the development of the CDOP Database
- Complete the review and update the Safer Sleep Guidance
- Undertake a Review of SUDC Service
- Undertake a thematic review around unascertained and SUDI deaths

Recommendations for 2015/16

Blackpool LSCB:

- Identify a Blackpool education/ early year's representative to be a member of the CDOP.
- Blackpool LSCB to identify a suitable representative for the SUDC prevention group ideally a professional from either Children's Centres, Public Health and/ or midwifery

Blackburn with Darwen LSCB:

- Blackburn with Darwen LSCB to identify a suitable representative for the SUDC prevention group ideally a professional from either Children's Centres, Public Health and/ or midwifery

Pan-Lancashire LSCBs:

- Determine a revenue stream amongst partners to continue with the safer sleep programme
- LSCB members to cascade a reminder to all professionals providing information to CDOP to ensure the forms are completed as fully as possible before they are submitted
- Partners working across the children's health and wellbeing systems across Pan- Lancashire, should assure themselves that coordinated strategies to address the determinants of health in line with the Marmot principles are developed
- Pan-Lancashire independent LSCB Chairs to identify a marketing representative for the SUDC Prevention Group

Specific Agency:

- SUDC Service to ascertain the most appropriate way to gather parental feedback and provide an overview of the responses in the next CDOP annual report

Appendix One - specific modifiable factors by Local Authority and category based on cases reviewed between April 2008 and March 2015. (See appendix 2 for DFE category descriptions).

Appendix one removed to maintain confidentiality

Appendix Two - Department for Education category of death descriptions

Category	Name & description of category	Tick box below
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	☐
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.	☐
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury, abuse or neglect. (category 1).	☐
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	☐
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.	☐
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.	☐
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease,cystic fibrosis, and other congenital anomalies including cardiac.	☐
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).	☐
9	**Infection** Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.	☐
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	☐