Pan-Lancashire Child Death Overview Panel
Annual Report 2015-16

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Contents

Introduction

This is the 8th annual report since Child Death Overview Panels (CDOP) became statutory in April 2008 and the fourth 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 (2015-16)
- 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 2015/16 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	6 (100%)	Chair	6 (100%)	Chair	6 (100%)
Lancashire Constabulary	6 (100%)	Lancashire Constabulary	6 (100%)	Lancashire Constabulary	6 (100%)
Children's Social Care	6 (100%)	Children's Social Care	6 (100%)	Children's Social Care	5 (83%)
Public Health	6 (100%)	Public Health	6 (100%)	Public Health	6 (100%)
Designated Doctor for SUDC/ Lead Nurse for SUDC	6 (100%)	Named Nurse for Safeguarding	6 (100%)	Named Nurse for Safeguarding	6 (100%)
SUDC Prevention Chair	2 (33%)	Named Midwife	6 (100%)	Named Midwife	5 (83%)
		Paediatrician	6 (100%)	Paediatrician and/or Neonatologist	6 (100%)

B'pool LSCB Business Manager	5 (83%)	SUDC Service	6 (100%)	SUDC Service	5 (83%)
BwD LSCB Business Manager	6 (100%)	Education (School/ Early Years Rep)	5 (83%)	Neonatal Specialist	2 (50%)[1]
Lancs LSCB Business Manager	4 (67%)	Observers	19	Observers	8
CCGs	6 (100%)				
Acute	2 (33%)				
LCFT	3 (50%)				

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

100 % of business meetings had all geographical representation, with a member from each area being in attendance at each meeting. Additionally, throughout the reporting year the Panel has had 27 observers. Most of these observers attended the case discussion meetings with 8 observing the neonatal case discussion meetings. It should be noted that due to change it staffing at Lancashire County Council the SUDC Prevention Chair only attended two of the six business meetings. A new chair of this group has been in place since April 2016.

CDOP priorities for 2015/16

Year	CDOP Priority	RAG Rating	Comments
2015/16	Identify a new chair for January 2016	Green	Dr Sakthi Karunanithi, Director of Public Health and Wellbeing for Lancashire became CDOP Chair in April 2016.
	CDOP Database	Amber	Work on the CDOP database is ongoing and will be implemented in the 2016/17 reporting year. Database implementation has been added to the 16/17 work programme.
	Review and update the Safer Sleep Guidance	Green	Amendments were made to the Safer Sleep Guidance and these were ratified by CDOP members. The final guidance was disseminated to the pan-Lancashire workforce and was recognised by NICE as an example of good practice and shared on their learning website. It has automatically been entered into the NICE annual award.
	Review of SUDC Service	Amber	A Public Health registrar was identified and a first draft of the review was submitted to the April 2016 business meeting. A further report will be ready for August 2016 with recommendations being added to the 2016/17 work programme.
	CDOP to complete thematic review/s into specific types of death.	Amber	These thematic reviews were not undertaken and will be carried forward into the work programme for 2016/17.

[1] Although there were six neonatal meetings, the neonatal specialists were only invited to four out of the six meetings and attended two.

	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	
	CDOP to QA the consistency of decision making	Amber	QA cases have been reviewed in case discussion meetings in 2015/16 and it is evident that CDOP members are more consistent in their decision making. The findings will be explored at the CDOP Development Day.
	Hold CDOP Development Day/s	Amber	A CDOP Development Day did not take place in 2015/16. One is due to take place in October 2016.
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 were approached by Prof. Helen Ball to help with identifying parents/ carers to contribute to research.

Table 2, update on CDOP priorities for 2015/16

2014/15 Annual Report Recommendation Update:

Blackpool LSCB:

- Identify a Blackpool education/ early year's representative to be a member of the CDOP.
  Update: *An early year's representative was identified and has since attended several case discussion meetings.*

- 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.
  Update: *Two Children's Centres representatives were identified and sit on the meetings on an alternate basis. Both members are included on the circulation list and kept up to date with minutes and any arising issues.*

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.

Update: *A Children's Centre representative was identified and has attended every meeting since April 2015.*

Pan-Lancashire LSCBs:

- Determine a revenue stream amongst partners to continue with the safer sleep programme
  Update: *A revenue stream was identified through the Public Health Collaborative of £15,000 as well as the £15,000 annual contribution from the CDOP itself and was allocated to the safer sleep programme. This contributed towards an order of materials, development of the risk assessment tool and safer sleep training for professionals across 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.
  Update: *A reminder was cascaded to professionals across Pan-Lancashire. Missing information on AB forms continues to be an issue and this will remain as a recommendation. A seven minute briefing on completing AB forms will be cascaded across the Pan-Lancashire workforce.*

- 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
  Update: *A response has been sought from the health and wellbeing boards in order to assure CDOP that coordinated strategies have been developed by partners and an update will be provided to the three boards once a response has been received.*

- Pan-Lancashire independent LSCB Chairs to identify a marketing representative for the SUDC Prevention Group: ***Update:*** *It was agreed by business members that the CDOP coordinator would contact a marketing representative as and when needed.*

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.
  Update: *This is discussed further in the SUDC Report on page 7*

CDOP Key Successes 2015/16

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. A pharmacy campaign was also commissioned across pan-Lancashire in November with Public Health colleagues. A bulk order of the materials was placed with regional colleagues buying into the campaign, this significantly reduced the cost for pan-Lancashire and provided regionally consistent messages and reduced cross-border differences particularly for acute trusts.
The group developed a family friendly risk assessment tool that encompasses a checklist for risks around the home for children up to the age of two. This is being disseminated pan-Lancashire with frontline workers.

Safer Sleep Guidelines: The Safer Sleep Guidelines were amended and ratified by CDOP members and the final guidance was disseminated to the pan-Lancashire workforce. The guidance was recognised by NICE as an example of good practice and shared on their learning website.

Public Health Data Analysis Report: Public Health analysts from Pan-Lancashire local authorities undertook a data analysis of CDOP data from April 2008-March 2014. The recommendations drawn from the report will be added to the 2016/17 priorities.

Development of learning briefs: The CDOP developed several learning briefs throughout the year and will continue to do so when issues are identified. These will be circulated Pan-Lancashire.

Northwest Sector Led Improvement Self-Assessment: CDOP contributed data and supporting information to the Northwest Sector Led Improvement Self-Assessment on infant mortality. Subsequently, action plans are being developed across Pan-Lancashire public health teams. This will be made as an additional item to the 2016/17 CDOP priorities.

CDOP Sub Group Updates

SUDC Service

The Sudden Unexpected Death in Childhood (SUDC) service is a unique Nurse-led service that has provided the health element of the Pan- Lancashire Multi-agency rapid response process to a sudden, unexpected death of a child since September 2008. The service responds to approximately 1 death per week providing a bespoke service that exceeds statutory requirements.

The Service is hosted by Lancashire Care Foundation Trust and consists of two Senior Nurses, a Lead Nurse and a Specialist Nurse. One of the main aims of the commissioned Lancashire SUDC team is to ensure that any unexpected child death receives a multi-agency coordinated response; in addition to, leading on the response from a health perspective (fulfilling the role of the designated SUDC Paediatrician described in Working together to Safeguard Children 2015). Since the inception of the service 8 years ago, the number of unexpected deaths that the service has responded to each year has remained fairly consistent. The overall total number across the Pan-Lancashire footprint for 2015-2016 was **49**. It did initially appear that there would be a significant reduction in the total number of unexpected child deaths for the year 2015-2016, however, during the latter part of quarter 4 the service experienced an unprecedented number of deaths amounting to 21 in total. In addition, many of these deaths had a significant safeguarding element to them thereby raising the complexity of the response and subsequent processes.
The service has continued to develop and modernise in response to changes within the NHS and partner organisations. The publication of the forthcoming service review may suggest areas for further improvement and development.

A substantial number of deaths during this year have occurred out of the SUDC Nurses working hours. (See below). This is the first year that this has been analysed which has been prompted by the service review. All information is then passed on to the SUDC team by the Constabulary during their next working day as outlined in the service specification. This can raise issues for families who have experienced the loss of their child in relation to both the multi-agency investigation, (Kennedy Principles) and the development of relationships with parents from the outset. This in turn can then affect the quality of the ongoing bereavement support provided and communication processes with the families involved.

Numbers removed to maintain confidentiality.

A service review has been commissioned by the Pan-Lancashire Child Death Overview Panel

(CDOP). This is the first review and it is anticipated that the long awaited findings will highlight areas that may require further investment from Commissioners to ensure the Service remains compliant with the statutory requirements within Working together to Safeguard Children (2015)[2]. The review will also provide the CDOP with recommendations for improving working practices and provide evidence of service compliance with statutory processes in addition to, outlining areas of good practice. The final report is expected to be available in August 2016. The service has also worked with Commissioners in securing 15 hours equivalent of dedicated administration support to assist the service, an increase of 7.5 hours. Training has been incorporated into the LSCB training programme, the SUDC Team delivered 4 sessions across Lancashire and 3 within the Blackpool locality. This increases awareness and supports application of the SUDC protocol into practice. In addition, the lead SUDC nurse is a consistent and only 'frontline' member of the Child Death Overview Panel. This provides an 'operational perspective' to the review of all child deaths in Lancashire.

Themes

Unsafe or inappropriate sleeping arrangements have emerged as a recurrent theme during this year in a significant number of the deaths pan Lancashire (**numbers removed**). This trend appears to be rising year on year. In view of this, one of the work streams of the CDOP panel was to carry out a thematic analysis of deaths. The SUDC Nurses have contributed to as members of the SUDC prevention group. They have been able to utilise their knowledge and insight gained from these deaths to contribute to the SUDC prevention agenda.

Numbers removed to maintain confidentiality.

The SUDC service continues to receive positive feedback from both professionals and bereaved parents 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. The service continues to develop as a result of the learning and response to each death and is constantly striving to improve and act upon feedback both from service users and partner agencies. The SUDC Nurses are also making links with similar services to share best practice and ideas.

SUDC Prevention Group

The SUDC Prevention Group is coordinated by the pan-Lancashire CDOP and is funded by the CDOP budget (£15,000) and contributions from the pan-Lancashire Public Health Collaborative (£15,000). The funding maintains the supply of materials to agencies pan-Lancashire and in 2015/16 funded the delivery of Safer Sleep training. In 2016/17 the group undertook a SUDI thematic review into the sudden and unexpected deaths of infants 2012-2015. The recommendations from this report are to be added to the 2016/17 CDOP recommendation log.

Priorities for 2016/17:

- Maintain a supply of materials to agencies pan-Lancashire
- Establish a revenue stream from partners for the additional funding of materials
- Commission in-house training on safer sleep
- Design and implement a new campaign based around messages from older generations
- Proactively use social media to promote campaigns
- Update the TOR and membership of the group and maintain attendance from key partners

[2] http://www.workingtogetheronline.co.uk/chapters/chapter_five.html

Recommendations:

1. Determine a revenue stream amongst partners to continue with the materials
2. Have in place a contingency plan for future engagement campaigns for the changes afoot in key frontline services and if future funding is cut
3. LSCBs to endorse the priorities for 2016/17 identified above

Part 2 – Data Analysis

Analysis of deaths reviewed between April 2015 and March 2016

This section of the report considers the child deaths data reviewed between April 2015 and March 2016 only.

During the 2015/16 reporting year, CDOP was notified of 127 child deaths (12 Blackpool residents, 20 Blackburn with Darwen (BwD) residents, 95 Lancashire residents) which were in line with Working Together to Safeguard Children (2015) definition and therefore considered by the pan-Lancashire CDOP.[3] Twenty additional notifications were outside the statutory guidance and therefore not reviewed including 14 cases out of area (reviewed by the CDOP in their area) <5 terminations of pregnancy and <5 stillborn deaths.

Figure 1 below shows the number of statutory notifications received in each reporting year since CDOPs became statutory in April 2008.

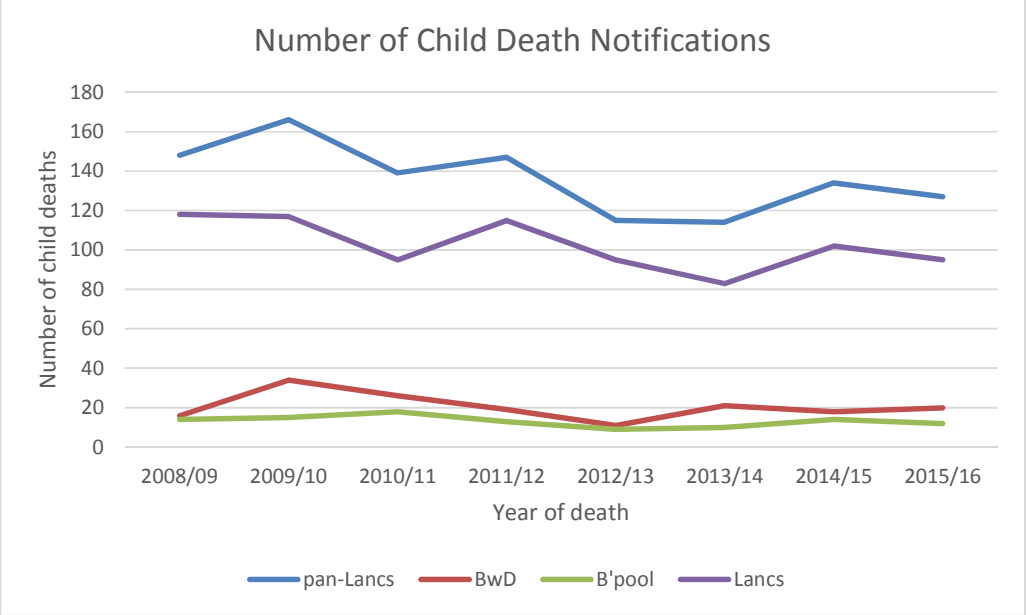


Figure 1: Number of child death notifications by child's local authority and year of child death

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 deaths reported from Blackburn with Darwen.

In the reporting year ending March 2016 the Panel completed 112 reviews (13 BwD reviews, 13 Blackpool reviews and 86 Lancashire reviews) compared to, 117 reviews in 2014/15. Of the 112 completed this year 61 were expected and 48 unexpected with a further three reviews classed as unexpected but meeting exclusion criteria.[4]

[3] Please see the link on page 9

[4] Where a child dies within 24 hours of birth or shortly thereafter **and** has never left hospital **and** there is a clear medical explanation for the death, falls within the exclusion criteria for a Rapid Response. Any death that falls within this criteria is unexpected but a rapid response is not required.

Child Death Reviews by Age

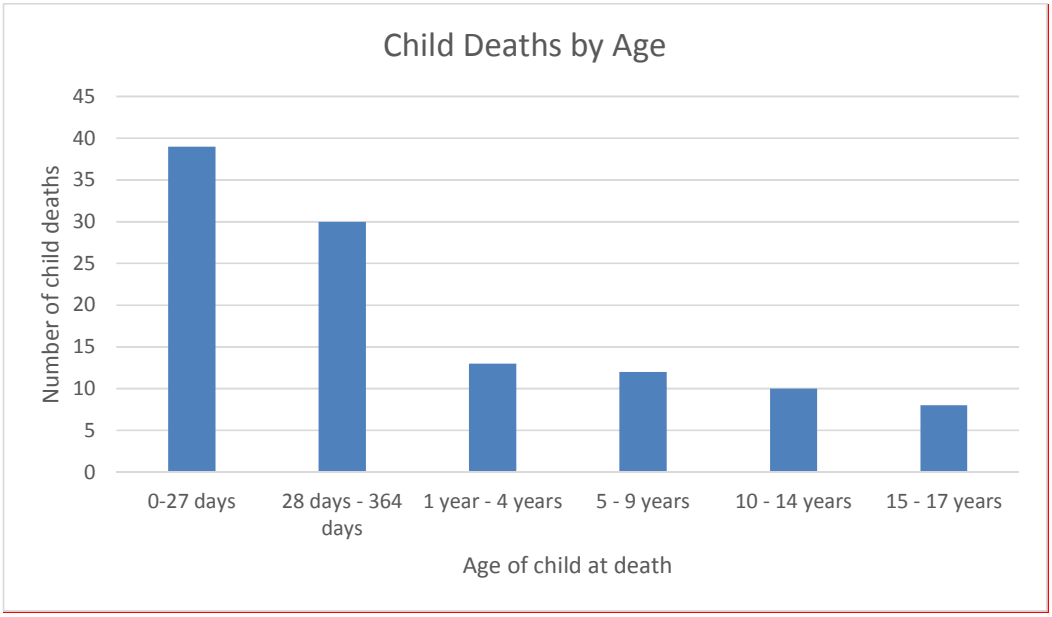


Figure 2, child deaths reviewed in 2015/16 by the age at death

The pattern of deaths by age seen in figure 2 is similar to that seen nationally with the highest number of deaths occurring in children of neonatal age 0-27 days old (35%). Of the 112 deaths reviewed in 2015/16 62% of deaths occurred in children under 1 year of age, these figures are comparable to previous reporting years and the trend seen nationally.

Child Death Reviews by Ethnicity

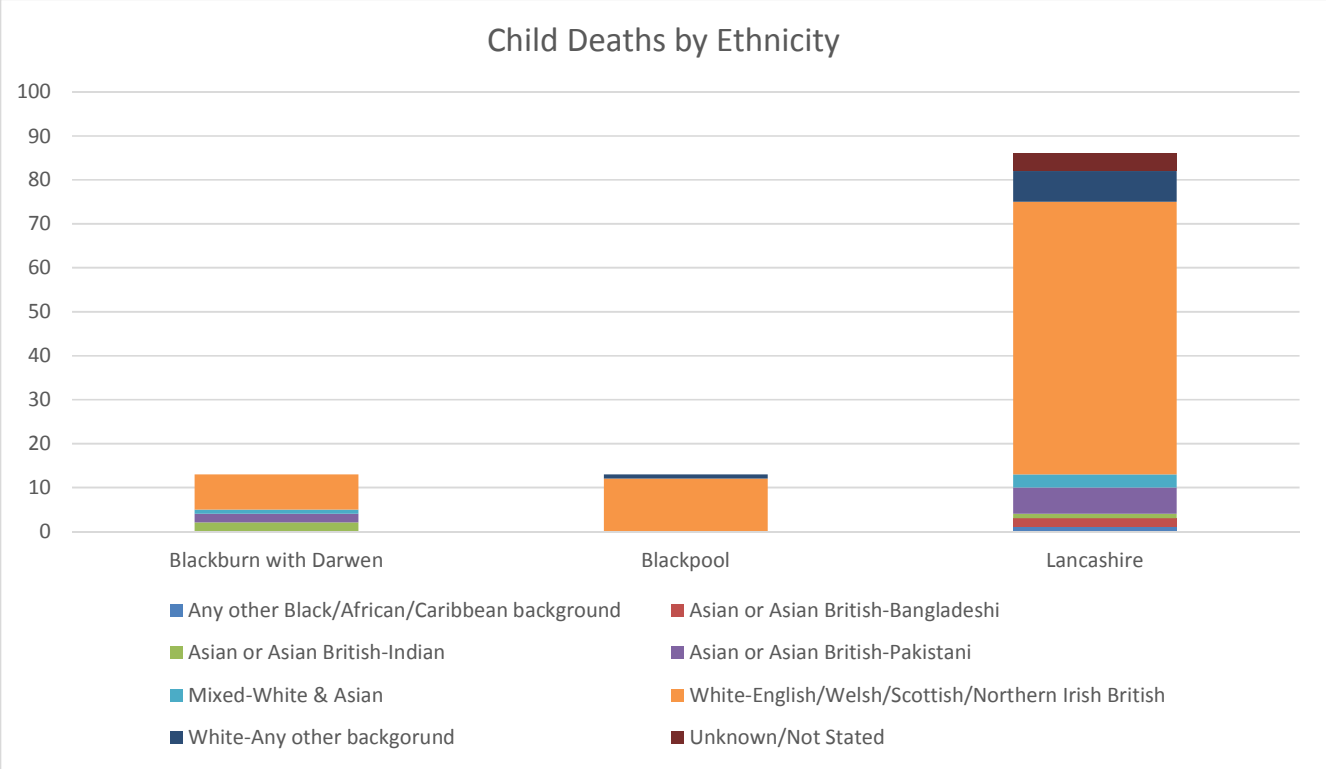


Figure 3, child deaths reviewed in 2015/16 by the child's local authority and ethnicity

Figure 3 highlights that in the deaths reviewed in 2015/16 the majority of deaths for the three local authorities was White-English/Welsh/Scottish/Northern Irish/British making up 72% of the deaths. The data shows that Lancashire had small gaps in information relating to ethnicity. This again highlights the importance of ensuring that professionals complete as much information as possible when filling out AB forms.

Category of Death

Figure removed to maintain confidentiality

Figure 4, child deaths reviewed in 2015/16 by category of death as defined by the Department for Education[5]

The most common category of death for cases reviewed during 2015/16 was chromosomal, genetic and congenital anomalies (38%), with perinatal/neonatal events accounting for the second most common category (22%). In comparison in 2014/15 the most common category of death was perinatal/neonatal events (33%), this is also comparable to what is seen nationally. Since 2008 perinatal/neonatal events have been the most common cause of death categorised with the exception of 2011/12 when both perinatal/neonatal events and chromosomal, genetic and congenital anomalies both being the most common category with 30% respectively (figure 5 below).

Figure 5 removed to maintain confidentiality

Figure 5, category 7 and 8 deaths by the Department for Education

As can be seen in figure 5 the number of cases that have been categorised as chromosomal, genetic and congenital anomalies have slowly risen with perinatal/neonatal events peaking in 2012/13 and slowly declining from 2013-16. However, the numbers of deaths reviewed are small and it is only the second time since 2011 that category 7 deaths have been the most common category. Figure 6 below shows the category of death broken down into year reviewed. Other categories remain fairly consistent across the years.

Figure 6 removed to maintain confidentiality

Figure 6, category of death by year reviewed 2008-16

Location of death

The table below 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. 19% 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	BwD	B'pool	Lancs	Total
Acute hospital - Adult intensive care unit			<5	<5
Acute hospital - Emergency Department	<5	<5	7	11
Acute hospital - Neonatal Unit	<5	<5	20	26
Acute hospital - other	<5		12	13
Acute hospital - Paediatric Intensive Care Unit	<5	<5	14	18
Acute hospital - Paediatric Ward	<5	<5	7	12
Acute hospital - unknown	<5			<5
Home of normal residence		<5	17	21
Hospice			<5	<5
Other (specify)			<5	<5
Other private residence			<5	<5
Public Place		<5	<5	<5
All locations total	13	13	86	112

[5] DfE category of death descriptions can be found in Appendix 1 on page 33

Table 1, child deaths reviewed in 2015/16 by the child's local authority and the place where they died

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).

Table 2 removed to maintain confidentiality

Table 2- Total number of deaths reviewed in 2015/16 by expected/unexpected and whether modifiable factors were identified, one death in Lancashire had insufficient information and could therefore not be categorised.

The table above identifies the number of deaths reviewed in 2015/16 by the child's local authority that were considered to have modifiable factors and whether the deaths were expected or unexpected. During 2015/16 35% of cases reviewed pan-Lancashire had modifiable factors, compared to the 2014/15 reporting year 30% of cases reviewed had modifiable factors. This could be a reflection of the panel improving how they identify modifiable factors; it will be interesting to see if the figure increases again in the next reporting year.

Category of death and Modifiable Factors

The largest category of deaths pan-Lancashire in 2015/16 with modifiable factors was perinatal/neonatal events (31%). The second largest category to have modifiable factors was sudden unexpected, unexplained deaths (18%) and the third was chromosomal, genetic and congenital anomalies and trauma and other external factors both with 12% each. In 2014/15 chromosomal, genetic and congenital anomalies had no modifiable factors identified. However, with the increase in the number of chromosomal, genetic and congenital anomalies being categorised this year it could be expected that modifiable factors would be identified.

There were no modifiable factors for deaths caused by malignancy.

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 2015 and March 2016

Category of death by local authority and modifiable factor

Table 3 removed to maintain confidentiality

Table 3- Category of death by local authority and modifiable factor

The most common category of death to have been deemed to have modifiable factors in Lancashire is Perinatal/neonatal event with sudden, unexpected, unexplained deaths being ranked second which is comparable to that of Pan-Lancashire. The most common category to have modifiable factors identified in Blackpool is deliberately, inflicted injury, abuse and neglect which could be expected with such a category of death. However, as these numbers are only small they should be treated with caution.

Length of time to complete the review

The 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 is a criminal case involved. Of the

127 cases notified to the Panel in this reporting year, 35% (45) of reviews were completed and 65% (82) were ongoing at 31st March 2016. In comparison, of the cases notified to panel in the last reporting year (14/15) 51% were completed by March 2015. The CDOP will continue to monitor how many cases it completes and is in the process of increasing the number of cases it takes to the review panel.

Recommendation: LSCB members are to reiterate to all agencies about their statutory responsibility of returning AB forms on time as this can put a delay in the CDOP process.

Figures 8-12 removed to maintain confidentiality.

Figure 8 Length of time taken to complete review BwD 2015/16

Figure 9 Length of time taken to complete review Blackpool 2015/16

Figure 10, Length of time taken to complete review East Lancs, 2015/16

Figure 11, Length of time taken to complete review Central Lancs, 2015/16

Figure 12, Length of time taken to complete review N.Lancs 2015/16

Analysis of child deaths reviewed from April 2008 – March 2016

This section of the report will look at the aggregated child death data reviewed between April 2008 and March 2016.

In total the Panel has been notified of 1090 deaths (excluding out of area children and including 7 terminations of pregnancy which were pre March 2010) since April 2008 through to 31st March 2016 and has completed 999 Cases. Table 6 below identifies the number of cases (10%) currently awaiting review by year of notification and resident of locality.[6]

[6] This numbers differ to the 2014/15 annual report due to the CDOP being made aware of missed notifications in the DfE registrar data deaths.

Table 4 removed to maintain confidentiality

Table 4, 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 2013 have been reviewed and completed. The small numbers of cases from April 2013 – March 2014 requiring review are complex cases with outstanding criminal or coronial investigations.

Of the 999 cases reviewed 93 were Blackpool residents, 155 were Blackburn with Darwen residents and 751 Lancashire residents including 3 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 will be included for comparison once available.

	Lancashire	Blackburn with Darwen	Blackpool	Pan - Lancashire	National
Expected	* (53%)	* (68%)	* (47%)	* (55%)	Not reported
Unexpected	* (44%)	* (30%)	* (53%)	* (42%)	Not reported
Male	* (58%)	* (60%)	* (46%)	* (57%)	57%
Female	* (41%)	* (40%)	* (54%)	* (42%)	42%
Modifiable	* (25%)	* (20%)	* (33%)	* (25%)	24%
No Modifiable	* (74%)	* (79%)	* (67%)	* (74%)	76%

*numbers removed to maintain confidentiality Table 5, comparison of local data (2008-2016)

In 7% 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 4 do not equal 100%.

It should be noted that of the 155 Blackburn with Darwen deaths reviewed from 2008-2015 68% were expected, this is marginally higher than Blackpool (47%) and Lancashire (53%). When analysing the Blackburn deaths it can be seen that the most common category of death was chromosomal, genetic and congenital anomalies amounting to 40%, this correlates to there being more expected deaths.

Category and Age of Child Deaths

Perinatal/ neonatal events (category 8) and chromosomal, genetic and congenital anomalies (category 7) are the cause for the majority (59%) of child deaths as seen in figure 13.

Figure 13 removed to maintain confidentiality

Figure 13 Number of child deaths by category of death 2008-2016

The pattern of deaths by age seen in figure 14 below is similar to that seen in previous annual reports. The largest number of deaths occurred in children aged 0 - 27days (38%) with the fewest deaths in children aged 5-9 years (6%). Numbers for 2015/16 remain incomplete because of ongoing cases

Figure 14 removed to maintain confidentiality

Figure 14, child deaths by cause of death and age of death 2008-16

Child deaths reviewed between April 2008 and March 2016 by locality and ethnicity are shown in Figure 16 (page 22). Blackburn with Darwen, Preston, Pendle and Burnley have the most diverse populations. Of the 999 deaths reviewed between April 2008 and March 2016 the two largest ethnicities were White British 58% with 11% of an Asian or Asian British (Pakistani) ethnic origin. 6% 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.

Locality and Ethnicity

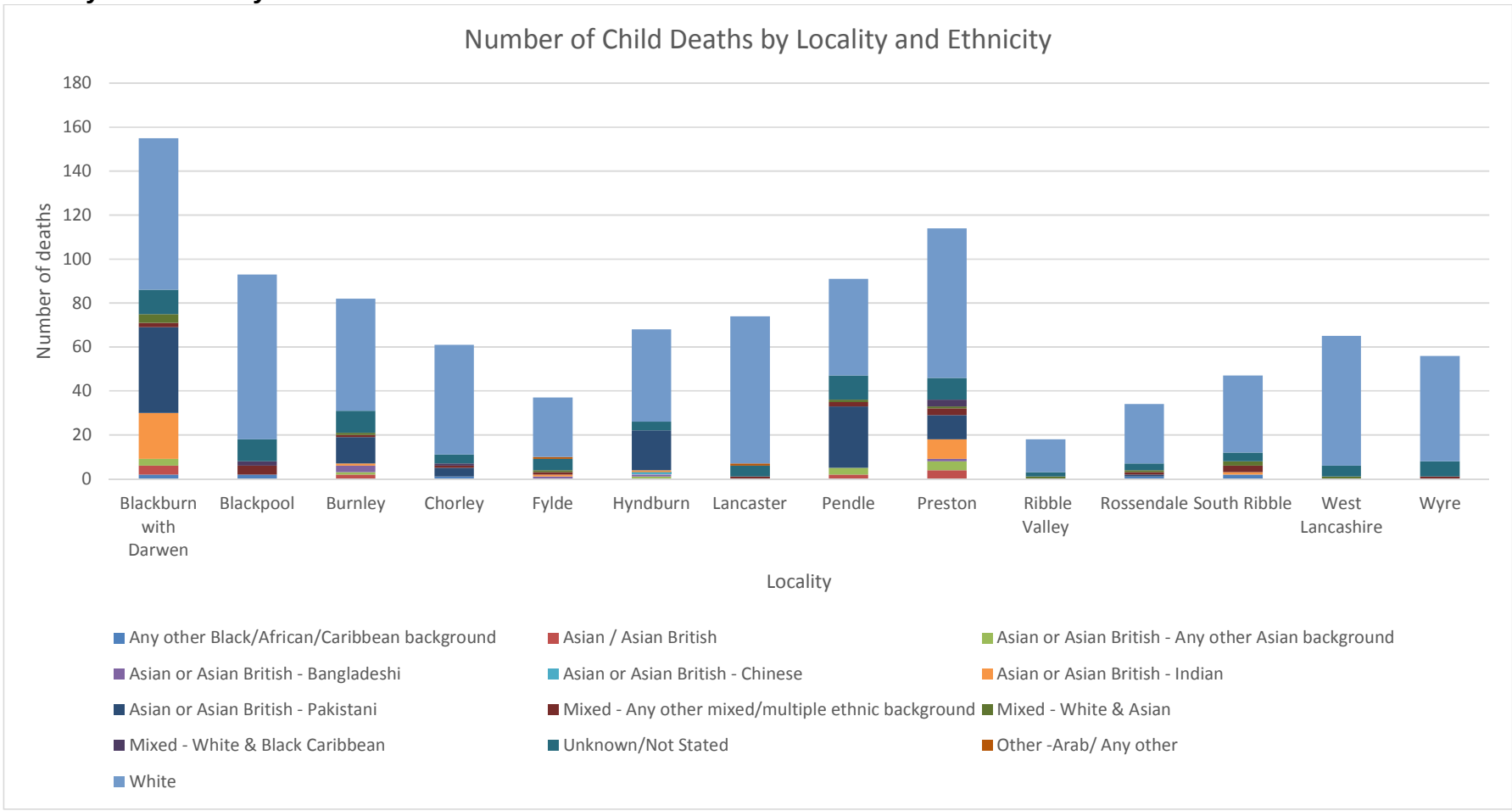


Figure 15, number of child deaths by locality and ethnicity

Modifiable Factors

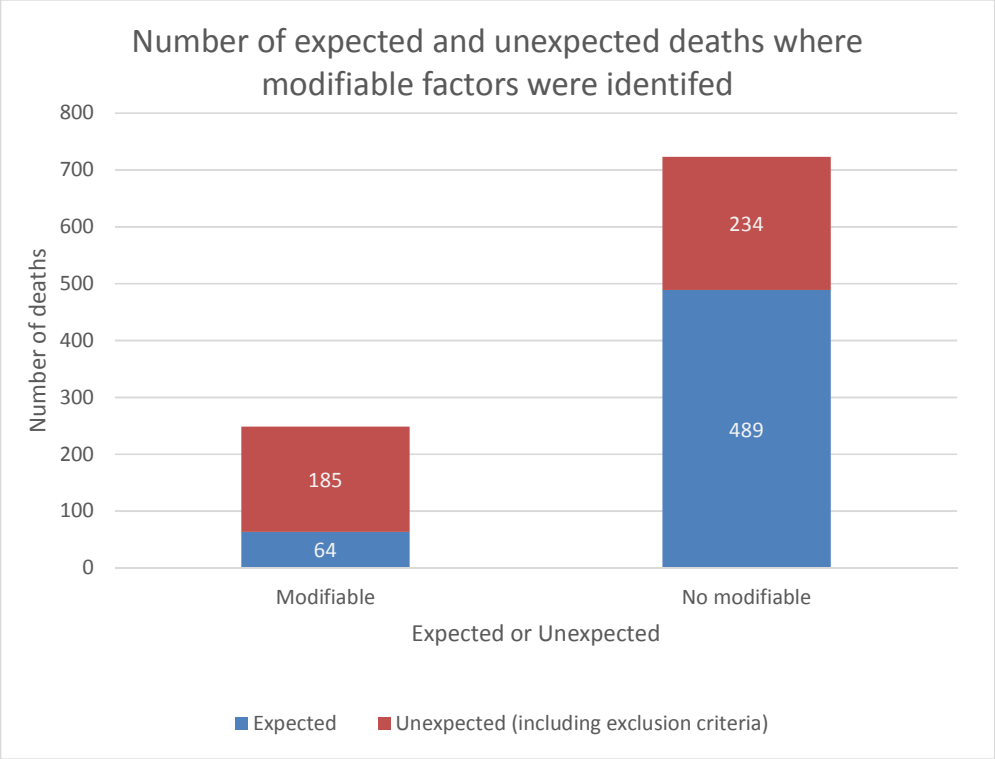


Figure 16, number of expected and unexpected child deaths reviewed, April 2008 – March 2016 and whether modifiable factors were identified (deaths which were not categorised as expected/ unexpected or where there was insufficient information have been omitted from this graph)

The data shown in table 6 (below) is based on cases reviewed between April 2008 and March 2016 and is broken down into Local Authority area. When reviewing this chart caution needs to be taken when considering very small numbers. As previously stated above in 7% of the pan-Lancashire deaths there was either insufficient information to determine whether there were modifiable factors/ no modifiable factors therefore some of the figures in table 5 do not equate to the number of deaths reviewed.

Pan-Lancashire has identified a much smaller percentage of deaths with modifiable factors which are categorised as 'medical' categories[7] in comparison to the non-medical categories of death.

84% 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.

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

Lancashire			
Category of Death	**Modifiable Factor**	**No modifiable factor**	**Grand Total**
Medical (4,5,6,7,8,9)	87 (14%)	496 (85%)	583
Sudden, Unexpected, Unexplained Death (10)	35 (56%)	27 (44%)	62
Trauma and Other External Factors (3)	35 (69%)	16 (31%)	51
Suicide or deliberate self-inflicted harm (2)	16 (53%)	14 (47%)	30
Deliberately inflicted injury, abuse or neglect (1)	* 79%	*21%	*
Blackburn with Darwen			
Category of Death	**Modifiable Factor**	**No modifiable factor**	**Grand Total**
Medical (4,5,6,7,8,9)	20 (15%)	112 (85%)	132
Sudden, Unexpected, Unexplained Death (10)	*	*	*
Trauma and Other External Factors (3)	*	*	*
Suicide or deliberate self-inflicted harm (2)	0	0	0
Deliberately inflicted injury, abuse or neglect (1)	*(100%)	0	*
Blackpool			
Category of Death	**Modifiable Factor**	**No modifiable factor**	**Grand Total**
Medical (4,5,6,7,8,9)	13 (20%)	52 (80%)	65
Sudden, Unexpected, Unexplained Death (10)	*	*	*
Trauma and Other External Factors (3)	*	*	*
Suicide or deliberate self-inflicted harm (2)	*	*	*
Deliberately inflicted injury, abuse or neglect (1)	*	*	*
National			
Category of Death	**Modifiable Factor**	**No modifiable factor**	**Grand Total**
Medical (4,5,6,7,8,9)	476 (16%)	2502 (84%)	2978
Sudden, Unexpected, Unexplained Death (10)	179 (65%)	97 (35%)	276
Trauma and Other External Factors (3)	104 (56%)	82 (44%)	186
Suicide or deliberate self-inflicted harm (2)	50 (42%)	69 (58%)	119
Deliberately inflicted injury, abuse or neglect (1)	34 (60%)	23 (40%)	57

Table 6, the number of deaths per each locality area including category of death and modifiable or no modifiable factors. (Deaths where there was insufficient information have been omitted from this table) *figures removed to maintain confidentiality

Figure 16 (below) 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'.

251 (25%) cases were identified to have modifiable factors. Of the deaths categorised as having modifiable factors:

- Blackburn with Darwen had 43% of deaths due to perinatal/ neonatal events
- Blackpool had 25% of deaths due to sudden unexpected, unexplained deaths, this is a reduction of 7% compared with last year. Perinatal/neonatal events also contributed to 25% of the deaths, this being a 2% reduction from last year.

The following can be seen in the pan-Lancashire column which is very similar to the Lancashire (12) column, these figures remain very similar to 2014/15:

- 29% of these deaths were caused by perinatal/ neonatal events
- 20% were sudden unexpected, unexplained deaths

- 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 include smoking by someone in the household or smoking in pregnancy, issues relating to safer sleep and risk taking behaviours, respectively. In the past reporting year maternal BMI has started to become a more common occurrence in being classified as a modifiable factor by the panel.

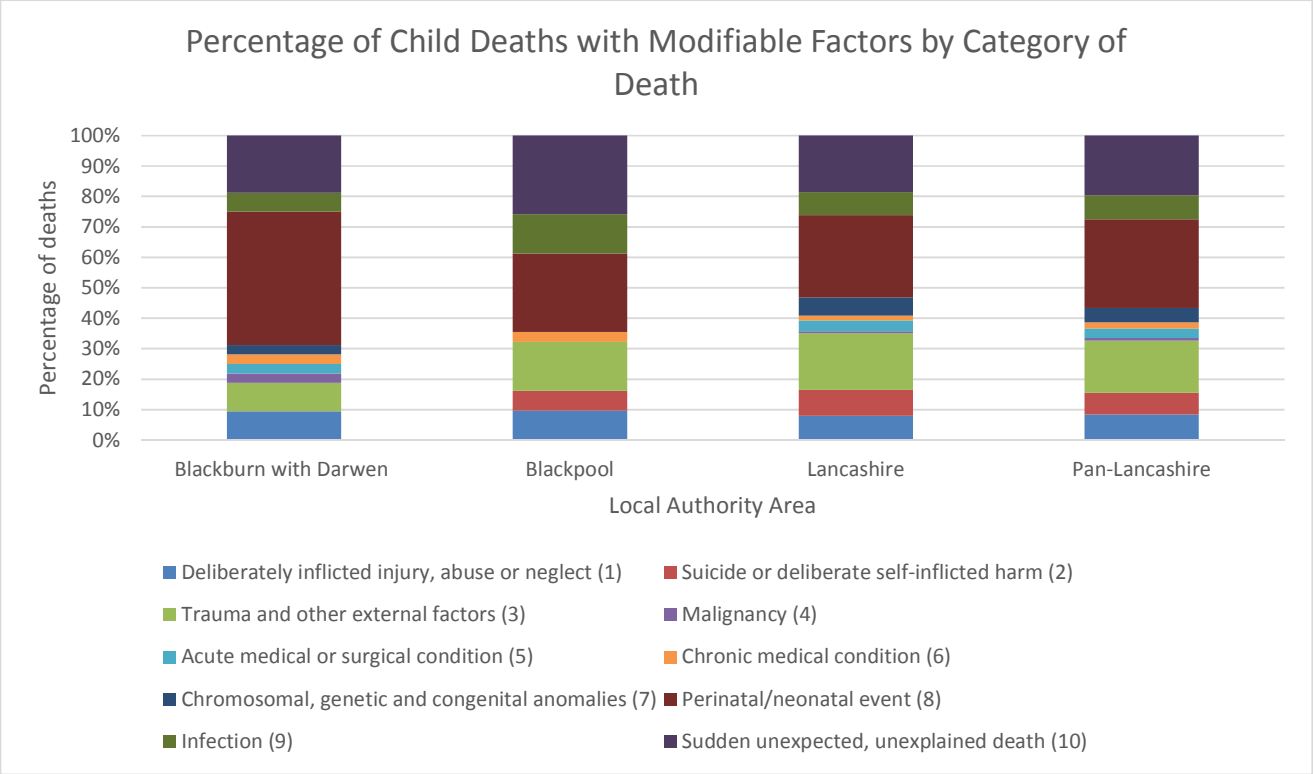


Figure 17, percentage of child deaths with modifiable factors identified by cause of death

Most common factors identified in deaths reviewed 2008-2016

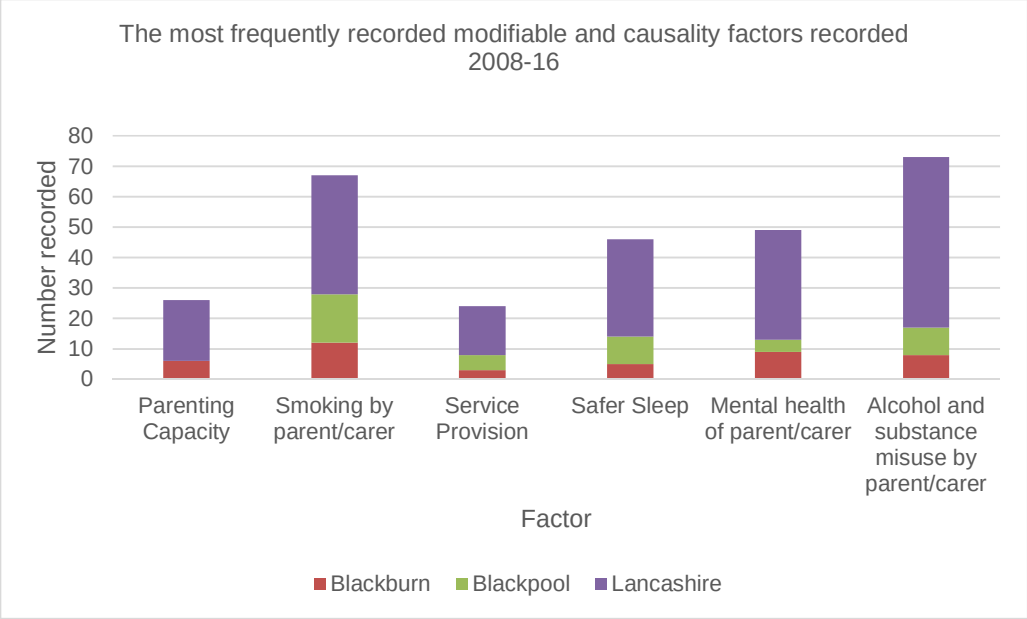


Figure 18, the most frequently recorded factors Pan-Lancashire 2008-2016

Figure 18 above shows the most frequent factors recorded in cases deemed to have modifiable factors. It should be noted that the above chart includes causative factors as well as modifiable factors. A further breakdown of factors by local authority is recorded below. Only the most frequent factors are shown; hence the numbers will not equate to the total number of factors recorded.

Table 7 removed to maintain confidentiality

Table 7, most frequent factors recorded by local authority 2008-16

Child Deaths by Deprivation[8]

The below data undertaken presents an in depth overview of child deaths by deprivation for the 3-year period April 2012 to March 2015.

There are five deprivation quintiles, quintile 1 being the 20% most deprived, nationally. Figure 19 shows the population aged 0-17 years by deprivation quintile compared to the national average. Figure 20 shows the proportion of deaths aged 0-17 by deprivation quintile.

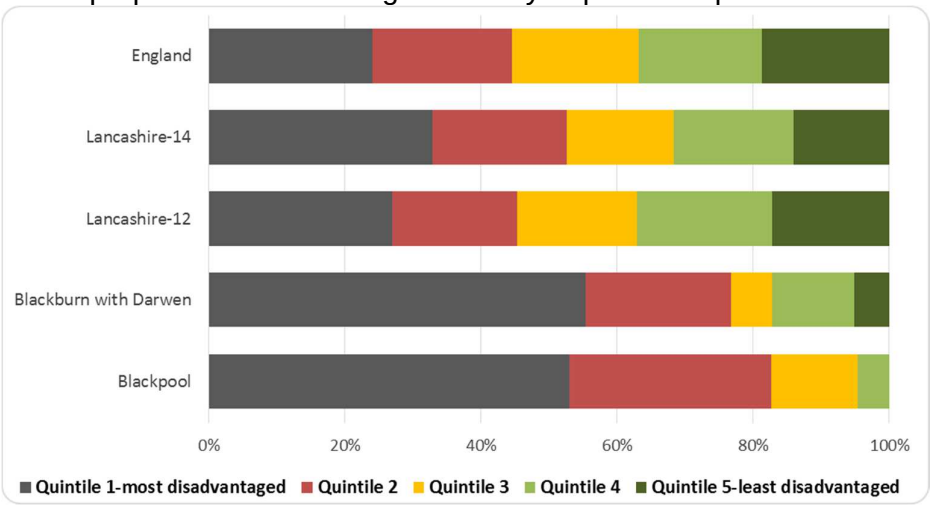


Figure 19, percentage of population aged 0-17 by deprivation quintile (IMD 2015)

[8] This data has been provided by the Pan-Lancashire Public Health Analysts. The Index of Multiple Deprivation data was released in September 2015 and therefore the data analysed only includes deaths reviewed until March 2015

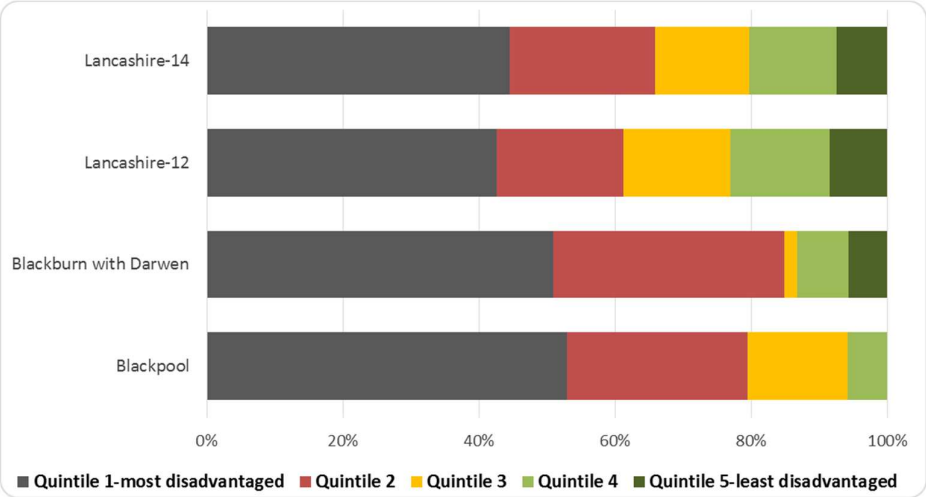


Figure 20, percentage of deaths aged 0-17 by deprivation quintile (IMD 2015)

In Lancashire-14, the death rate in quintile 1 is significantly higher than the overall death rate in Lancashire-12. In quintiles 4 and 5 the death rate is significantly below the Lancashire-14 rate. Quintiles 1 and 2 have a disproportionate amount of deaths compared to their populations and this is especially so in Lancashire-12, Over two fifths (42%) of deaths are from quintile 1 compared to 27% of the population. In Blackburn with Darwen and Blackpool the proportions of deaths and the 0-17 population are broadly similar.

Figure 21 shows the number and crude death rate for 0-17 year old deaths in each authority, broken down by deprivation quintile. Lancashire-12 has a significantly higher death rate in quintile 1 (68.4 per 100,000) compared to the overall Lancashire rate of 43.6.

	Population aged 0-17 years	Deaths aged 0-17 years	Crude rate per 100,000	95% CI Lower limit	95% CI Upper limit
Lancashire-14	**311,802**	**408**	**43.6**	**39.5**	**48.1**
Quintile 1	102,277	180	**58.7**	50.4	67.9
Quintile 2	61,925	86	46.3	37.0	57.2
Quintile 3	48,940	56	38.1	28.8	49.5
Quintile 4	54,606	52	**31.7**	23.7	41.6
Quintile 5	44,054	30	**22.7**	15.3	32.4
Lancashire-12	**244,755**	**320**	**43.6**	**38.9**	**48.6**
Quintile 1	65,812	135	**68.4**	57.3	80.9
Quintile 2	45,202	59	43.5	33.1	56.1
Quintile 3	42,995	50	38.8	28.8	51.1
Quintile 4	48,666	46	31.5	23.1	42.0
Quintile 5	42,080	27	**21.4**	14.1	31.1
Blackburn with Darwen	**38,237**	**54**	**47.1**	**35.4**	**61.4**

Quintile 1	21,193	27	42.5	28.0	61.8
Quintile 2	8,168	18	73.5	43.5	116.1
Quintile 3	2,291	1	14.5	0.4	81.1
Quintile 4	4,611	4	28.9	7.9	74.0
Quintile 5	1,974	3	50.7	10.4	148.0
Blackpool	**28,810**	**34**	**39.3**	**27.2**	**55.0**
Quintile 1	15,272	18	39.3	23.3	62.1
Quintile 2	8,555	9	35.1	16.0	66.6
Quintile 3	3,654	5	45.6	14.8	106.4
Quintile 4	1,329	2	50.2	6.1	181.2
Quintile 5	-	0	-		

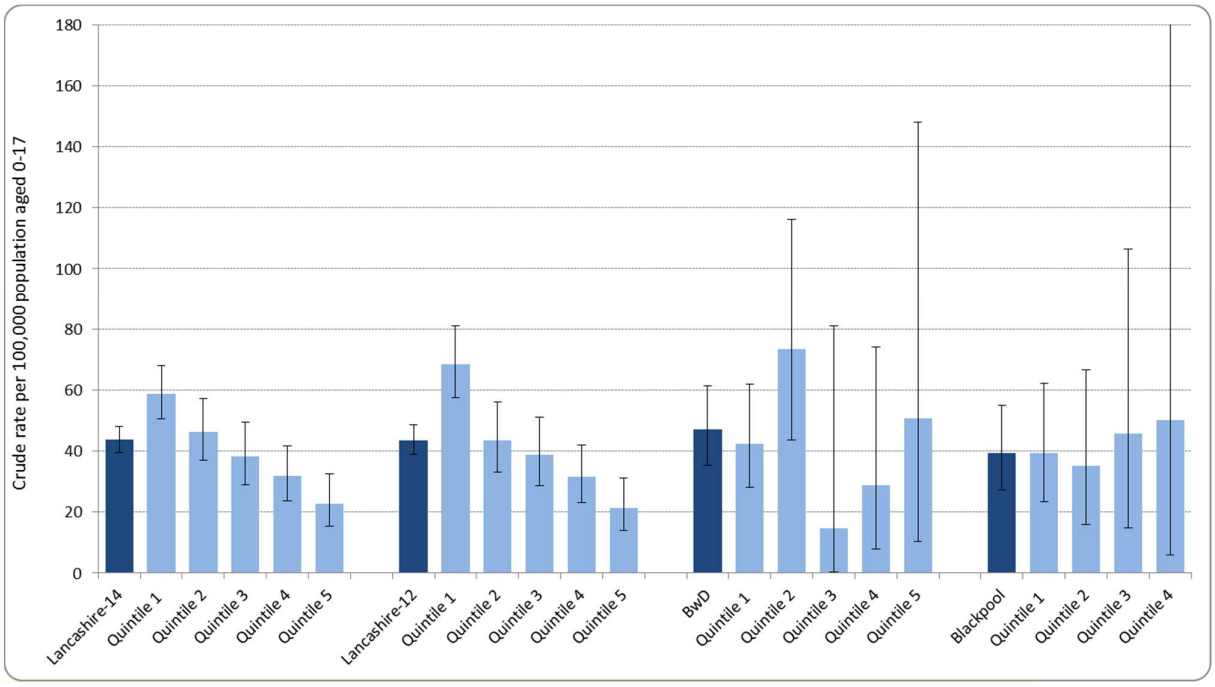
Figure 21, Crude mortality rate per 100,000 0-17 year olds in each IMD Quintile, nationally

Figure 22 (below) shows crude rate and confidence interval range in each quintile in a graphical format. It can clearly be seen that quintile 1 in Lancashire-14 and Lancashire-12 have significantly higher mortality rates. While quintile 2 in Blackburn with Darwen and quintile 4 in Blackpool have the highest rates in those authorities, they are not significantly higher than either the authority average or the Lancashire-14 average.

Compared to the previous analysis, (April 2008-March 2014)[9] the overall mortality rate has increased across Lancashire but decreased in both Blackburn with Darwen and Blackpool. Mortality in quintile 1 remains the highest for Lancashire-12 and Blackpool but once again, quintile 2 shows the highest mortality in Blackburn with Darwen. When comparing to the previous analysis by quintile it must be remembered that the new Indices of Multiple Deprivation was published in September 2015 and there are now more areas in quintile 1 across Lancashire than there were before.

Figure 22, number and crude rate of deaths to 0-17 year olds in each IMD Quintile

[9] This report was presented to the three Safeguarding Boards in 2014/15 with the recommendations from the report being included in the CDOP 2016/17 work programme.



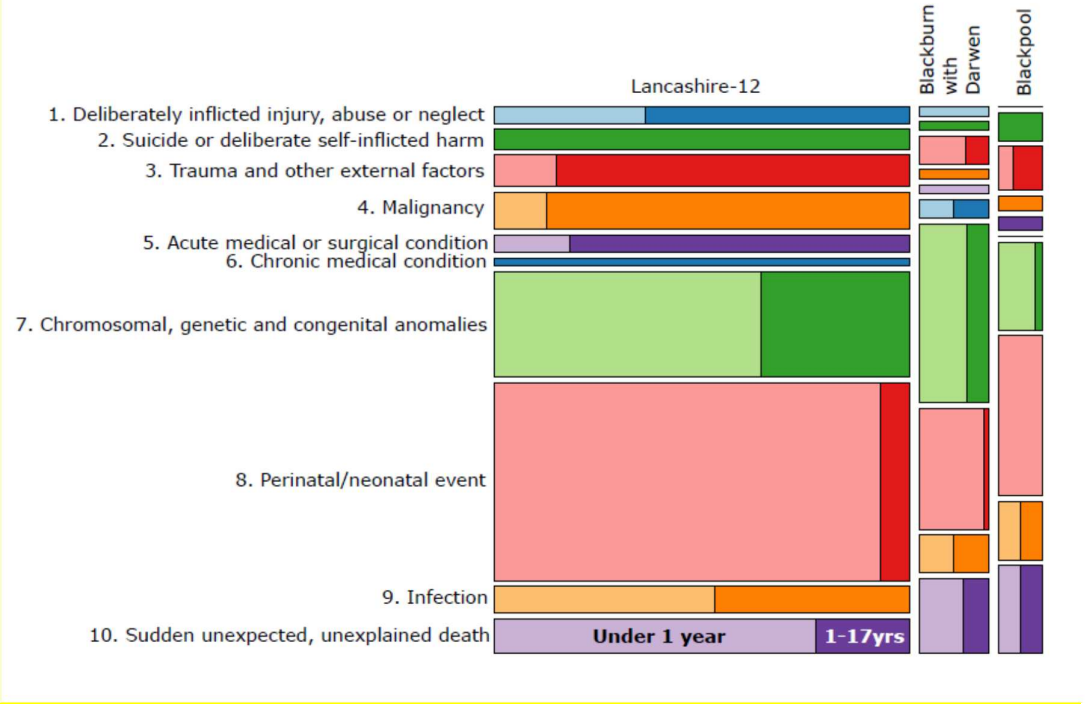


Figure 23, Graphical summary of deaths by Local Authority, Category and Age
(Light shades = Under 1 year, dark = 1-17 years)

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 2015/16 were completed within 12 months
- 68% of deaths are of children under 1 year of age (46% under 28 days and 22% 28 – 364 days)
- 25% of deaths are of children with an Asian Pakistani background, which appears dis-proportionately high compared with the child population of 18% in the 2011 census.
- 68% of deaths are expected
- 40% of deaths are due to chromosomal, genetic and congenital anomalies and 26% were due to perinatal/neonatal events
- 20% of deaths had modifiable factors identified
- The most common modifiable factors identified are smoking, service provision and safer sleep

Blackpool

- 54% of deaths reviewed during 2015/16 were completed within 12 months, of these cases 4 were SCRs and 2 had ongoing criminal investigations.
- 52% of deaths are unexpected
- 54% of deaths are female (43% nationally)
- 61% of children are aged under 1 year old (43% under 28 days and 18% 28 – 364 days)
- The most common category of death is perinatal/ neonatal event (27%) 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 (33%)
- The most common modifiable factors are smoking, safer sleep, service provision and alcohol/ substance misuse by a parent/ carer

Lancashire

- 82% of deaths reviewed during 2015/16 were completed within 12 months
- 7% of deaths are of children from an Asian Pakistani heritage, which appears dis-proportionately represented compared with the child population of 6% in the 2011 census
- 60% of children are aged under 1 year old (35% under 28 days and 25% 28 – 364 days)
- 38% of deaths are due to chromosomal, genetic and congenital anomalies and 23% were due to perinatal/ neonatal events.
- 31% of deaths are identified to have modifiable factors
- Of the 31% of deaths identified to have modifiable factors the most common category of death was perinatal neonatal events (33%). The second largest category to have modifiable factors was sudden, unexpected, unexplained deaths (22%)
- The most common modifiable factors are service provision, parenting capacity, alcohol/ substance misuse in a parent/ carer and smoking

Pan-Lancashire

- 82% of cases reviewed by the pan-Lancashire CDOP during 2015/16 were completed within 12 months
- 62% of child deaths are of children under 1 year old
- 58% of pan-Lancashire deaths are of male children and young people

- The two largest ethnicities are White British 58% and Asian or Asian British (Pakistani) 11%. 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 (26%) are the most common categories of death
- 48% of 15 – 17 year old's deaths are categorised as suicide or deliberate self - inflicted harm (24%) and trauma and other external factors (24%)
- 25% of deaths had modifiable factors identified
- Of the cases identified to have modifiable factors the most common categories of death are perinatal/ neonatal events (29%), sudden unexpected, unexplained deaths (20%) and trauma and other external factors (18%)
- The four most common modifiable factors identified are service provision, parenting capacity, smoking and alcohol/ substance misuse in a parent/ carer.

CDOP priorities for 2016/17

- Implement and embed the eCDOP Database
- Undertake thematic reviews around deaths due to infection and trauma
- Undertake an audit of CDOP cases relating to Adverse Childhood Experiences (ACEs)
- Undertake a case review of deprivation and the impact on child mortality
- Continue to contribute to the North West Sector-Led Improvement (SLI) self-assessment assisting public health teams across Pan-Lancashire
- Implement actions and recommendations from SUDC Service Review, SUDI Thematic Review and Public Health Data Analysis Report
- Await the decision of the Alan Wood Review of Local Safeguarding Boards through parliament and its implications on the CDOP

Recommendations for 2016/17

Pan-Lancashire LSCBs:

- LSCB members to cascade a message to all professionals providing information to CDOP to ensure that forms are returned within the statutory three week deadline and are completed as fully as possible before they are submitted
- LSCB members are to ensure that practitioners are fully aware of the child death notification process to try and minimise missed death notifications to the CDOP team
- Determine a revenue stream amongst partners to continue with the safer sleep programme and if this is not possible to have a contingency plan in place for the safer sleep programme and future engagement campaigns

Appendix 1 - 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).	☐