Blackburn with Darwen

lancashire safeguarding children board

Blackpool Safeguarding Children Board

Pan-Lancashire Child Death Overview Panel
Annual Report
2012/13

Contents

Introduction

At the start of the 2012/13 reporting year the Lancashire and Blackburn with Darwen Child Death Overview Panel (CDOP) merged with the Blackpool Panel to become a pan-Lancashire tripartite CDOP. The pan-Lancashire CDOP is a sub-group of the three Local Safeguarding Children Boards (LSCBs) with responsibility for reviewing the deaths of all children resident within the local area.

The deaths of all live-born children under 18 years (excluding infants live-born following planned, legal terminations of pregnancy) were reviewed by the panel in line with Working Together to Safeguard Children (2010). This report will provide information on trends and patterns in the deaths reviewed during this reporting year (2012-13) and also on all deaths reviewed since the panels began in April 2008. It will also provide assurance to the LSCBs that the CDOP is meeting its statutory obligations.

The first section of the report provides updates in relation to CDOP priorities 2012/13, successes during 2012/13, updates from the sub-groups of CDOP and outlines the 2013/14 priorities for CDOP and the rapid response service. The second section focuses on the deaths reviewed in 2012-13 including data on the timeliness of the reviews completed in the period. The third section analyses all deaths reviewed between April 2008 – March 2012 by year of death in an attempt to provide a more meaningful and useful approach to looking at the trend data. The fourth section analyses all deaths reviewed by the panel between April 2008 and March 2013 and reviews the causes of death, whether any modifiable factors were identified, and considers the broader context of the child death data such as demographic and population characteristics. The final section documents emerging themes, trends and recommendations to the respective Boards.

Changes in Statutory Guidance

March 2013 saw the publication of the revised statutory guidance *Working Together to Safeguard Children* (HM Government 2013). Although there are no significant changes in respect of the Child Death Overview Panel (CDOP) processes, as anticipated, the rapid response to unexpected deaths in childhood remains a paediatrician led model. The pan-Lancashire rapid response service has operated very effectively using a nurse-led model since its inception in September 2008; therefore, a priority for the CDOP for 2013/14 is to commission a review of the model to evaluate its effectiveness in delivering on the requirements detailed in *Working Together* (HM Government 2013).

Members and Attendance

During 2012/13 the panel had representation from Lancashire Constabulary, Children's Social Care the Local Safeguarding Children Boards, Community Health Services, Midwifery, Paediatrics, Education (Blackpool and Lancashire), Early Years (Blackburn with Darwen), Public Health, SUDC Service and Neonatology & Obstetrics (co-opted for review of early neonatal deaths).

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 on number of child deaths per area

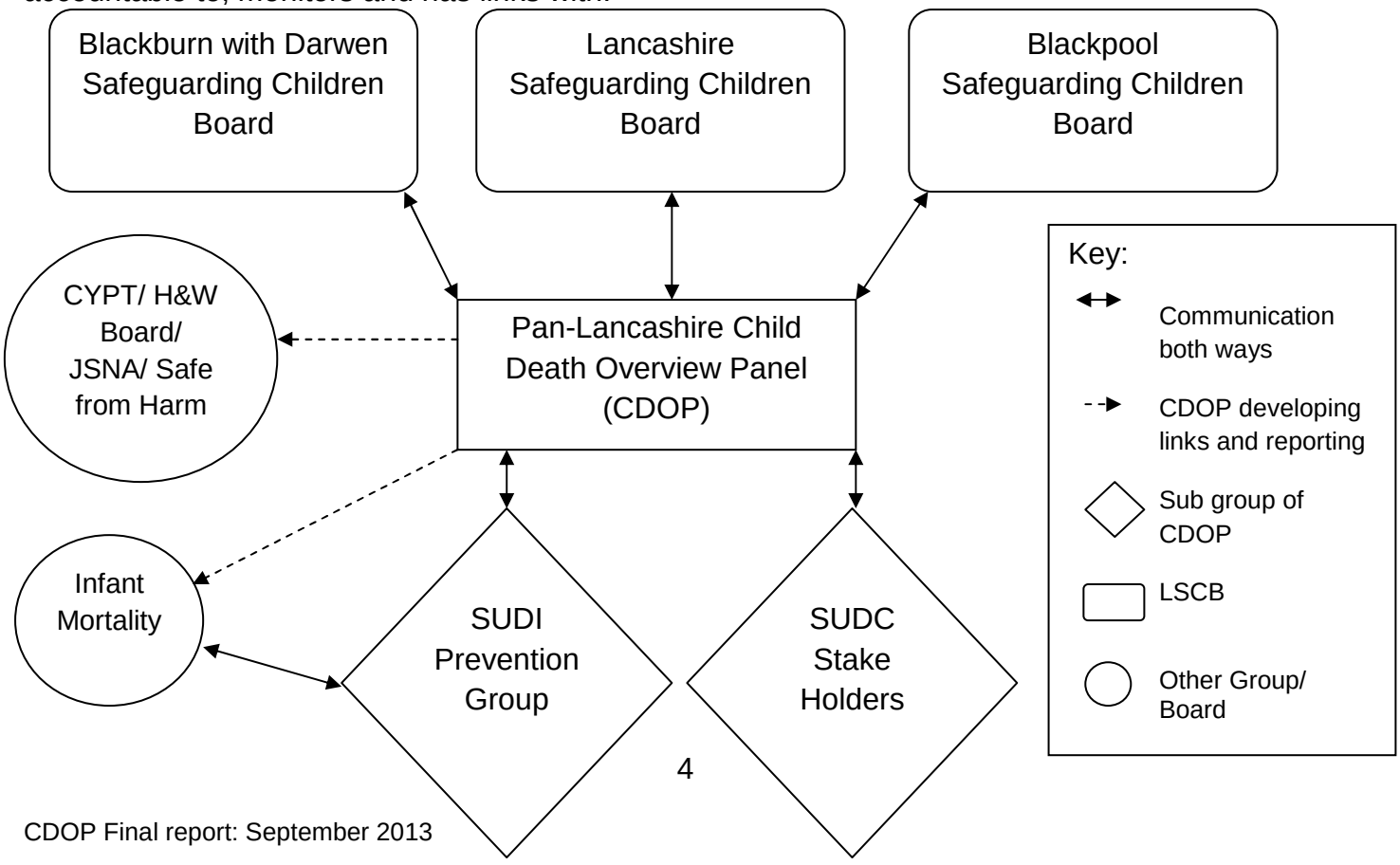
The table below documents the attendance by each agency/ area of expertise for business and case discussion meetings.

	Business Meetings			Case Discussion Meetings			
Agency	**Invited**	**Attended**	**% attendance**	**Agency**	**Invited**	**Attended**	**% attendance**
Chair	6	6	100	Chair	12	12	100
Lancashire Constabulary	6	5	83	Lancashire Constabulary	12	12	100
Children's Social Care	6	4	67	Children's Social Care	12	11	92
Public Health	6	3	50	Public Health	12	10	83
Midwifery	6	6	100	Midwifery	12	12	100
SUDC Service	6	6	100	SUDC Service	12	10	83
Paediatrics	6	3	50	Paediatrics	12	12	100
SUDI Prevention Chair	4	1	25	Neonatology & Obstetrics	5	3	60
SUDC Stake Holders Chair	6	5	83	Community Health Services	12	12	100
Community Health Services	6	3	50	Education	5	4	80
LSCBs	6	6	100	Early Years	2	1	50
Designated Nurses	6	5	83				

Table 1, annual attendance at Business and Case discussion meetings from April 2012 – March 2013

CDOP Structure

Below is the CDOP structure chart which shows which Boards and/or Groups CDOP is accountable to, monitors and has links with.



CDOP priorities for 2012/13

CDOP Priority	Status (RAG rating)	Comments
1. The Panel will review cases and make recommendations regarding themes to the Board		The Panel has an ongoing responsibility to review cases and make recommendations as appropriate; the CDOP reports to the Boards bimonthly, quarterly (with statistics) and annually.
2. CDOP will develop links with other Local Safeguarding Children Board Sub-Groups particularly the Safe from Harm Group		The CDOP Coordinator sits on the pan-Lancashire Infant Mortality Group, has presented the Annual Report and Suicide Thematic Report to the Safe from Harm Group, the annual report has also been shared with the CYPT Chairs Meeting, the LSCB locality groups and the JSNA managers for the 3 local authority areas.
3. With Public Health department investigate apparent mis-match in numbers of deaths between CDOP and ONS data.		Mismatch of data identified inherent problems with the comparison of the two datasets because they work on different parameters – gestation viability, pending inquest/ criminal investigation.
3b. Further detailed review work to identify themes / trends in deaths categorised as caused by perinatal / neonatal events.		The initial findings have been presented to CDOP the final report is awaited.
4. The Panel will monitor the re-launch of the Give Me room to Breathe (GMRTB) Campaign		The SUDI Prevention Group have updated and re-launched the Campaign; the Boards have approved funding for the second/ third phase of the Campaign.
5. CDOP will ensure the Safer Sleeping Guidance is reviewed		The Guidance was approved by the Board in March 2013 and is being widely disseminated to all frontline professionals.
6. Ensure and monitor the review of the SUDC Protocol		The review of the Protocol was delayed pending the release of the new statutory guidance. This is a priority for 2013/14.
7. Finalise the multi-agency e-learning and make available to front line multi-agency professionals		The e-learning has been re-written to be more user friendly; this remains a priority for 2013/14.
8. Develop a Pan-Lancashire communications strategy for disseminating messages and information on a multi-agency basis		The CDOP developed a task and finish group to look at this; however, it was decided a specific sub-group/ strategy was not required and the CDOP would develop an 'events calendar' to enable CDOP to recommend to the Boards time press releases.
9. Monitor Multi-Board CDOP Budget and develop action plan for utilising the under spend.		The Boards approved funding for the safer Sleep campaign. The CDOP still has a budget for 2013/14 which has some under spend from 2012/13. The CDOP now monitor their budget at each bi-monthly Business Meeting.
10. Update the data recording/ analysis systems to improve reporting on specific modifiable factors identified by the Panel		The current reporting spreadsheet has been updated to enable some reporting on modifiable factors while a CDOP database is scoped out.

Table 2, CDOP priorities for 2012/13

CDOP Key Successes for 2012/13

Safer Sleep Campaign
The SUDI Prevention Group, a sub group of CDOP, updated and re-launched the Safer Sleep Campaign (previously Give Me Room to Breathe). The Campaign will provide professionals with a consistent message and materials to give parents/ carers for discussing safer sleep. The Campaign aims to inform parents/ carers of the risks associated with safer sleep for babies to help them make an informed decision in relation to bed sharing, and consequently make children within pan-Lancashire safer.

Safer Sleeping Guidance
The CDOP monitored the update and review of the Safer Sleeping Guidance which has been ratified by the three LSCBs and has informed the development of the Safer Sleep Campaign. This was a challenging piece of work which provides frontline staff across pan-Lancashire with clear and consistent evidence based information to support them in having open and honest discussions with parents/ carers about safer sleeping choices.

Suicide Thematic Review
The Panel set up and monitored the Suicide Thematic Task and Finish Group which completed an in depth review of the child deaths which were deemed to be as a consequence of the child/ young person's own actions. The group identified recommendations to be considered by the LSCBs and the report has been shared widely on a multi-agency basis.

CDOP Posters
The CDOP developed posters for professionals and GPs to advise them who to contact to initiate the rapid response and who to notify should a child die in a manner that was expected. This will improve the notification process, ensure relevant systems are initiated and parents/ carers/ families are supported in a timely manner.

Bereavement services
The Panel has completed a survey of available bereavement services within the pan-Lancashire area; this information is being distributed to GPs and will be included in the updated SUDC Protocol.

Tri-partite CDOP
The CDOP have successfully completed their first year as a tri-partite Panel utilising a rota system for Acute Trusts professionals, Community Health colleagues, Public Health, Children's Social Care and Education representatives.

Neonatal Research
CDOP commissioned a piece of research to provide an analysis of modifiable risk factors associated with neonatal mortality in pan-Lancashire using routine data collected by CDOP of children that died between April 2008 and March 2011. Modifiable risk factors were broadly defined as those factors that may be changed through lifestyle choices. 110 records were included as meeting the study' criteria. The research has identified the following initial findings and recommendations pending the final report, CDOP could:

- Consider further analysis and explore evidence base around pre-term births including late preterm
- Review definitions used by CDOP for cause of death and look at other ways of providing more detail
- Look at the feasbility of reporting the weight for gestational age for infant mortality cases

- Look at ways of calculating neonatal mortality rates adjusted for maternal age and deprivation
- Explore the apparent excess of mortality associated with consanguinity in Blackburn with Darwen as part of the larger scale public health genetics programme of work
- Review local weight management pathways and initiatives
- Examine the factors that may contribute to low recording of maternal weight.
- Examine factors that may contribute to low recording of substance misuse issues.

The research also took into consideration data quality and means to extract statistics from the information CDOP collates. The initial findings noted that although individual case records contained a wealth of information around maternal health and obstetric notes this level of information is not included in the current CDOP spreadsheets. Furthermore, it was noted that data quality is improving over time; however, there are still significant gaps and there is significant under-reporting across a number of data fields. The following recommendations have also been identified:

- Reporting agencies should be reminded of the importance of completing all data fields
- CDOP may consider a data validation exercise to provide assurances that all infant deaths are reviewed. This would involve data matching with another routine mortality data source such as death registration records
- Most importantly CDOP should consider investing in a comprehensive database that can be used to analyse trends and generate hypotheses for further study

CDOP Sub Group Updates

SUDC Service

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

With the publication of Working Together (March 2013) the Pan–Lancashire SUDC Protocol is currently under review, with the SUDC Nurses working closely with the CDOP Coordinator and partner agencies to ensure a document ‘fit for purpose’ that fulfils the requirements of chapter 5.

In November 2012, the SUDC Service successfully, alongside the Lancashire Constabulary, developed and delivered a multi-agency Continuous Professional Development (CPD) event for police staff. This was well evaluated and the feedback was impressively positive with many staff reporting that they had learnt something new about the rapid response and CDOP processes and would definitely change their practice. This hopefully will improve better information sharing and practices.

The SUDC service co-ordinates the end of case discussion meetings (ECDM). Challenges remain in ensuring these are undertaken within the required timescale; the service will continue to monitor and explore solutions. As part of the ECDM process the service has developed a more formal way of collating parent and multi-agency feedback on their experience of the rapid response process and is giving practitioners and parents an expectation that any feedback regarding the response will be welcomed as a means of improving the service further. The lessons learnt from ECDMs and the rapid response process now formally feed into the CDOP case reviews and are recorded on the AB forms.

An increasing demand on the SUDC service has been generated by the number of notifications they receive in respect of expected deaths. Although the service is only commissioned to respond

to unexpected deaths, they are often informed of child deaths where the referrer is unsure of the classification of the death. After discussion and information gathering these deaths are then classified as expected. The initial response into these deaths consumes a significant amount of the SUDC Nurse's time and capacity.

The SUDC Lead Nurse and the CDOP Coordinator organised a 'Suicide Thematic Task and Finish Group' on behalf of CDOP to review data available on the children and young people taking their own lives across Lancashire. This resulted in the publication of, a 'Suicide Thematic Review Report' identifying themes/ trends, gaps in service provision and recommendations. Although the review did not evidence a 'spike' in the numbers of children dying as a result of their own actions, issues were raised about gaps in service on offer to young people 16-18 year olds suffering emotional distress.

The number of unexpected deaths reported to the SUDC service has seen an increase year on year since the service started in 2008 (2009/10 – 50; 2010/11 – 58; 2011/12 – 65), however, for the period 2012/13 the service has seen a reduction reporting 46 unexpected deaths in this period. 25 of these were infants and 21 children, compared to the year before when the number of children (40) far exceeded the number of infants (25) that died unexpectedly. Figure 1 below shows the number of unexpected child deaths by Clinical Commissioning Group (CCG) area for April 2012 – March 2013.

The number of infants dying in pan-Lancashire where co – sleeping or where unconventional sleeping arrangements were a factor was slightly less than the previous year, less than 5 in 2012-13, compared to 5 in 2011-12. Whether this can be attributed to the raised profile of the 'Safer Sleep for Baby' campaign can be debated. However, the SUDI prevention group (SUDC Nurses being members of this group) has worked with LCC Media department to market the safer sleep campaign and develop resources to be used with families.

The SUDC Service has utilised their insight and knowledge gained from responding to these deaths, and has contributed to reviewing and revising the LSCB 'Safer Sleep for Infants – guidelines for professionals' which is being disseminated across Lancashire integrated workforce.

Figure one removed to maintain confidentiality

CCG	SUDC rates per 10,000 child population
Chorley & South Ribble	1.62
East Lancs	1.58
Blackpool	1.24
Lancashire North	1.22
Blackburn with Darwen	1.18
Greater Preston	0.56
Wyre & Fylde	0.26
West Lancs	0

Figure 1 and Table 3, number of unexpected child deaths between April 2012 and March 2013 by CCG area and Sudden Unexpected Death in Childhood rates per 10,000 child population

SUDI Prevention Group

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

During 2012/13 the SUDI Prevention Group held a large multi-agency workshop to review the Give Me Room to Breathe Campaign, Safer Sleeping Guidance and information currently provided to parents/ carers on a pan-Lancashire basis. The Group also coordinated a number of focus groups held at children's centres within different localities across pan-Lancashire to review the Give Me Room to Breathe materials with parents/ carers.

The feedback from the workshop with professionals and focus groups was invaluable in updating the Campaign. Particularly with the current climate of financial constraint and constant change which has required the SUDI Prevention Group to develop strategies to effectively get key messages to our audiences such as utilising twitter and our internet page at Christmas received 185 unique visitors and 353 visits.

The Campaign heavily relies on frontline professionals to disseminate the information to parents/ carers in a way that is understood; in an attempt to help professionals have these crucial conversations with parents' new materials and designs (following feedback from focus groups) have been developed (see images below).

The revised Campaign was renamed to Safer Sleep for Baby and is underpinned by the Safer Sleeping Guidance for professionals. The SUDI Prevention Group is aware of the complex nature of the safer sleep information and therefore, the key messages for the general public are simply the Six Steps to Safer Sleep. These are:

1. Keep baby away from smoke, before and after birth.
2. Put baby in a cot, crib or moses basket to sleep - never fall asleep with them on a sofa or chair.
3. Never fall asleep with baby after drinking or taking drugs/medication.
4. Put baby to sleep on their back with their feet to the foot of the cot.
5. Keep baby's head and face uncovered and make sure they don't get too hot.
6. Breastfeed your baby - support is available if you need it.

The secondary message for the campaign is:

- We know that every baby is different and if you have any questions, you can speak to your:
  - Midwife
  - Health visitor
  - Local Children's Centre
  - Or you can call the Lullaby Trust Helpline.

The Group plan to have a more targeted approach to disseminating materials for the 2013/14 phase of the Campaign, resulting in more parents/carers receiving consistent messages from the integrated workforce across pan-Lancashire at key contacts.

New Safer Sleep Campaign Materials

CDOP priorities for 2013/14

CDOP Priority	Task	Lead	Timescale
1. Review cases and make recommendations regarding themes to the Board	Continue to gather information in relation to all child deaths in pan-Lancashire.	CDOP Team	Ongoing
	Identify themes / patterns in these reviews	CDOP Meeting	Ongoing
	Discuss 13/14 Annual Report content Prepare draft Annual Report Final Annual Report ratified by Panel	CDOP Coordinator/ Vice Chair	April Business Meeting June Business Meeting August Business Meeting
	Share Annual Report and themes identified with LSCB to inform planning.	CDOP Meeting	Sep-13
	Upload the Annual report to the LSCB websites and share with Safe from Harm Theme Group, HWB, CYPT and establish how it will link with the JSNA	CDOP Co and Chair	Dec-13

2. Undertake a detailed review to identify themes / trends in deaths categorised as caused by perinatal / neonatal events.	Public Health Specialty Registrar to present initial findings to CDOP Business meeting	Public Health Specialty Registrar	April Business Meeting
	Final report to be shared with CDOP Business Meeting	Public Health Specialty Registrar	October Business Meeting
3. Monitor Safer Sleep Campaign	SUDI Prevention Group to plan 2013/14 Campaign and request funding from CDOP.	SUDI Prevention Group	April Business Meeting
	LSCBs to approve CDOP funding recommendation	LSCBs	May Boards
	Summer Campaign to be started and planning for Winter to be initiated	SUDI Prevention Group	May-13
	Monitor development of training materials for Safer Sleeping Guidance	Cath Topping	Dec-13
4. Ensure and monitor the review of the SUDC Protocol	SUDC Nurses to update the Protocol in line with new guidance	SUDC Nurses	May-13
	6 week consultation period	CDOP Co	Jul-13
	Task and Finish Group to be developed to review the feedback	CDOP Co and SUDC nurses	Aug-13
	Guidance to be updated, draft document to be circulated to agencies and presented to SUDC Stake Holders Group	CDOP Co and SUDC nurses	Oct-13
	(Pending agreement by CDOP to agree evaluation of SUDC Service) The SUDC Service evaluation report to be considered and SUDC Protocol to be updated as appropriate.	SUDC Stake Holders	Nov/ Dec - 13
	Final Draft SUDC Protocol to be presented to CDOP	CDOP Co and SUDC nurses	Dec-13
	Final SUDC Protocol to be ratified by the 3 Boards	CDOP	Jan-14
	SUDC Protocol training and awareness raising	CDOP	Jan- 14 onwards
5. Finalise the multi-agency e-learning and make available to professionals front line multi-agency professionals	E-learning slides to be updated with Training Co-ordinator to put into appropriate language	CDOP Co	Jun-13
	E-learning to be approved by CDOP	CDOP Business Members	Jun-13
	CDOP Coordinator to request e-learning is uploaded Moodle and 10 volunteers to be identified to test the e-learning, any further amendments to made.	CDOP Co, LCC project officer and CDOP Business Members	October Business Meeting
	E-learning package live on the Children's Trust web site.	CDOP Co & LCC project officer	Nov-13
	CDOP Members to disseminate message to relevant professionals e-learning is now available.	CDOP Business Meeting	Nov-13 onwards
	Regular reports will be provided to CDOP Business Meetings to enable CDOP to monitor which agencies are completing the training.	CDOP Business Meeting	December 13 onwards

6. Disseminate messages and information to the multi-agency workforce and public (as appropriate)	CDOP Business Meeting to develop 'events calendar' of key multi agency campaigns	CDOP Co	June Business Meeting
	Business Meeting to identify campaigns and time press releases to raise awareness to particular issues.	CDOP Business Members, CDOP Co, LCC Media Team	Ongoing
	CDOP to share themes/ trends with the Health and Wellbeing Boards and CYP Trusts	CDOP & LSCBs	As and when appropriate
7. CDOP to implement a new database/ IT system which will improve reporting particularly in relation to specific modifiable factors identified by the Panel	CDOP Coordinator to scope out a costing for a database and present options to Panel	CDOP Co	Apr-13
	Request for funding to be approved by the Boards	CDOP Busi Meeting	May-13
	CDOP Coordinator to meet with Sentinel and confirm no licence contract term.	CDOP Co	Jun-13
	CDOP Coordinator to clarify with all agencies Vantage Technologies IT governance and security levels are sufficient.	CDOP Co	Aug-13
	CDOP Coordinator to initiate development of database with Sentinel following June Business Meeting update.	CDOP Co	Sept-13
	Development of the database, progress monitored by CDOP	CDOP Co/ Busi Meeting	Apr-13 onwards
8. CDOP Development Day	LSCBs to appoint new CDOP Chair	LSCBs	URGENT
	Date to be decided and draft programme to be developed.	CDOP Chair, CDOP co and Training Co	TBD
	Hold Development Day	CDOP Chair, CDOP co and Training Co	TBD

Table 4, CDOP priorities for the 2013/14 reporting year

Analysis of deaths reviewed in 2012/13

During the 2012/13 reporting year CDOP was notified of 129 child deaths (8 Blackpool residents, 11 Blackburn with Darwen (BwD) residents, 93 Lancashire residents and 17 out of area). In the same reporting year the Panel completed 150 reviews (15 BwD reviews, 11 Blackpool reviews and 124 Lancashire reviews).

In the figure below it can be seen that the number of notifications received this reporting year is significantly less than in previous years (this graph does not include out of area notifications).

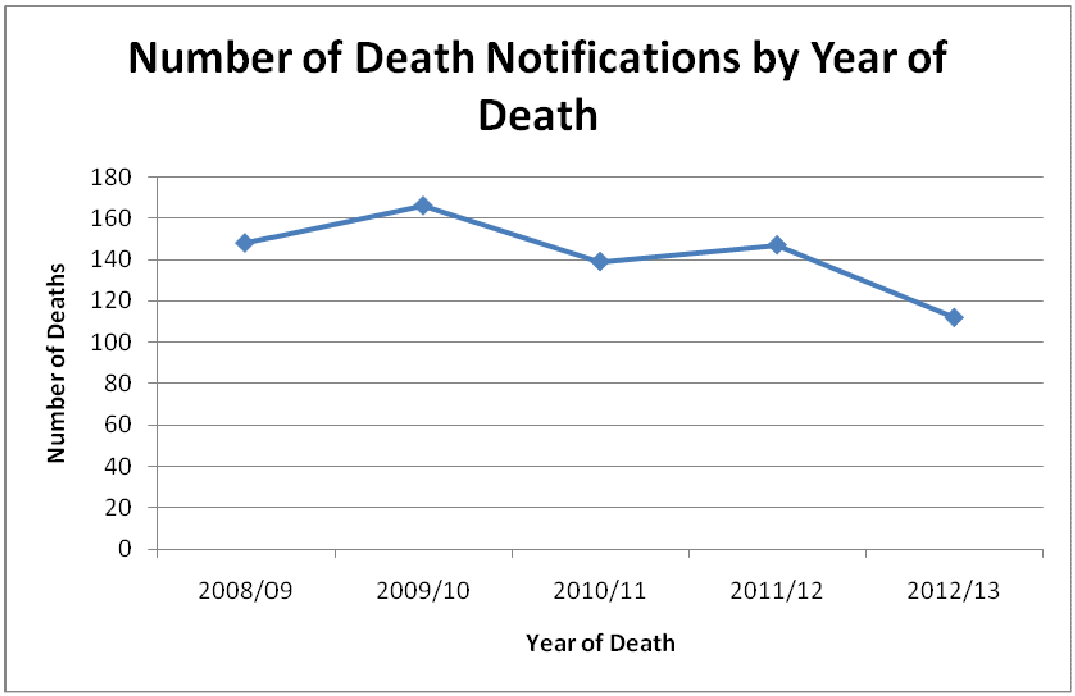


Figure 2, number of death notifications each reporting year from April 2008 – March 2013

Modifiable Factors

Of the 150 child deaths reviewed this reporting year table 5 below shows the number of deaths that were deemed to have modifiable factors and whether the deaths were expected or unexpected.

Expected?	Locality	Modifiable factors	No modifiable Factors	Grand Total
Expected	Blackburn with Darwen	<5	9	10
	Blackpool	0	<5	<5
	Lancashire	5	66	71
Expected Total		6	79	85
Unexpected	Blackburn with Darwen	<5	<5	5
	Blackpool	5	<5	7
	Lancashire	23	30	53
Unexpected Total		30	35	65
Grand Total		36	114	150

Table 5 Total number of deaths reviewed by expected/ unexpected and whether modifiable factors were identified

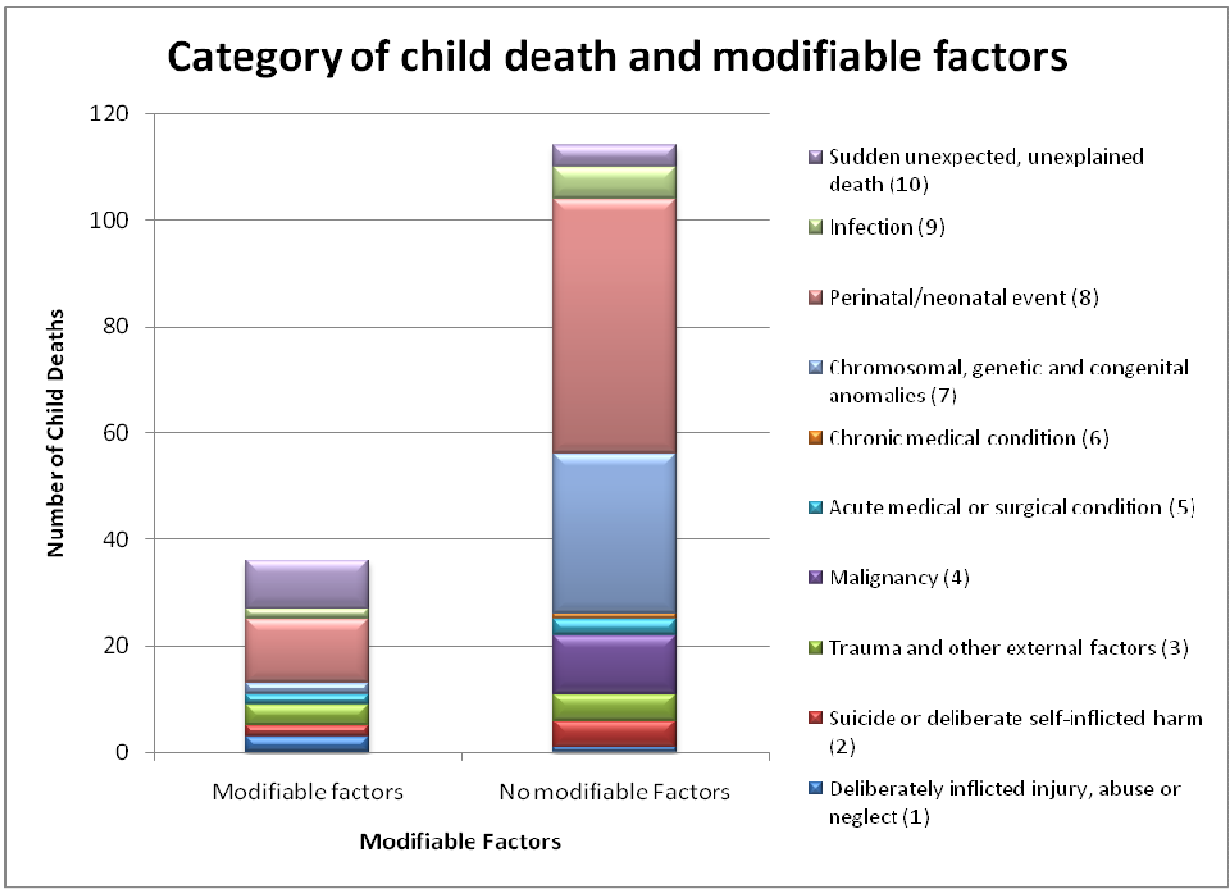


Figure 3, category of the child's death as defined by the Department for Education and whether modifiable factors were identified in reviews completed between April 2012 and March 2013

Of the cases reviewed in 2012/13 the largest categories of death which were deemed to have modifiable factors were perinatal/ neonatal event (33%) and sudden unexpected, unexplained death (25%) (figure 3). This was also seen nationally with 26% of deaths identified as having modifiable factors were due to perinatal/ neonatal event and a further 23% due to sudden unexpected, unexplained deaths.

Malignancy and chronic medical condition did not have any deaths where modifiable factors were identified.

Length of time to complete the review

Nationally, of the deaths notified to Panels in the year ending 31st March 2013, 62% of reviews were on-going at the end of the reporting year. In the same reporting year the pan-Lancashire Panel completed 44% of reviews and the remaining 56% were on-going at 31st March 2013.

The figure below (4) shows that the number of reviews completed in less than 6 months has reduced in comparison to the 2011/12 reporting year. Although, over half of reviews were still completed in 7 months or less; during 2011/12 137 reviews were completed whereas 150 reviews have been completed this reporting year. During 2011/12 and 2012/13 approximately 16% of cases took over 12 months to review, this is less than the national average of 25%.

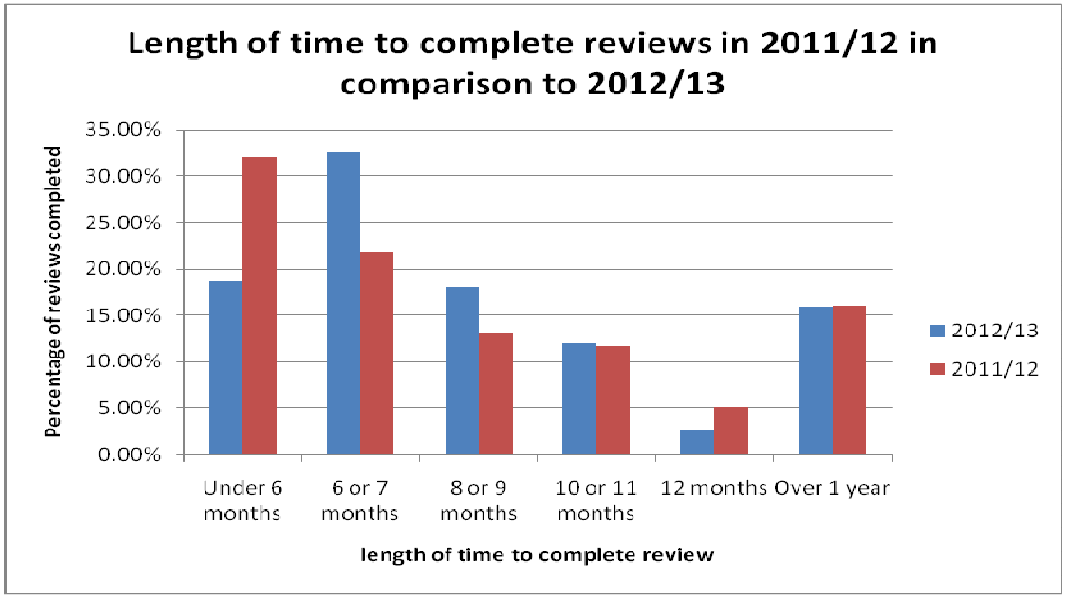


Figure 4, time taken to complete reviews in 2011/12 in comparison to 2012/13

Figure 5 shows the length of time taken for reviews to be completed this reporting year for each area; this information reflects the timeliness of information returned to the Panel by different agencies such as NHS, Lancashire Constabulary, Children's Social Care and the Coroner's. During 2012/13 the Panel completed 47% of Blackburn with Darwen reviews in under 6 months; in comparison 9% of Blackpool's cases were able to be reviewed in the same time period, 12% in North Lancashire, 16% in East Lancashire and 19% in Central Lancashire.

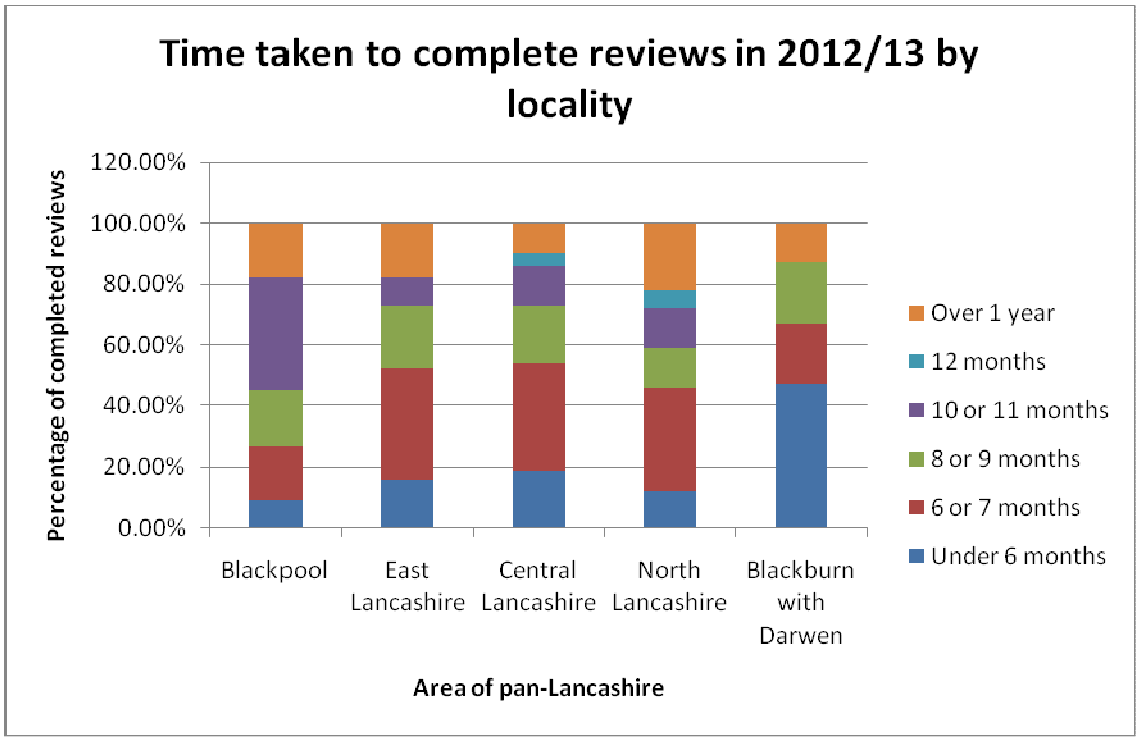


Figure 5, time taken to complete reviews during 2012/13 by are of pan-Lancashire

Analysis of data April 2008 – March 2012

This section of the report will consider the data by the year the child died which provides a more useful and meaningful approach for looking at trend data. 583 child deaths will be used in this section of the report and as 55% of child deaths which occurred in 2012/13 have yet to be reviewed, this section only contains data from April 2008 – March 2012. The Panel have recorded 148, 166, 138 and 131 child deaths in 2008/09, 2009/10, 2010/11 and 2011/12 respectively.

Child Deaths by Locality

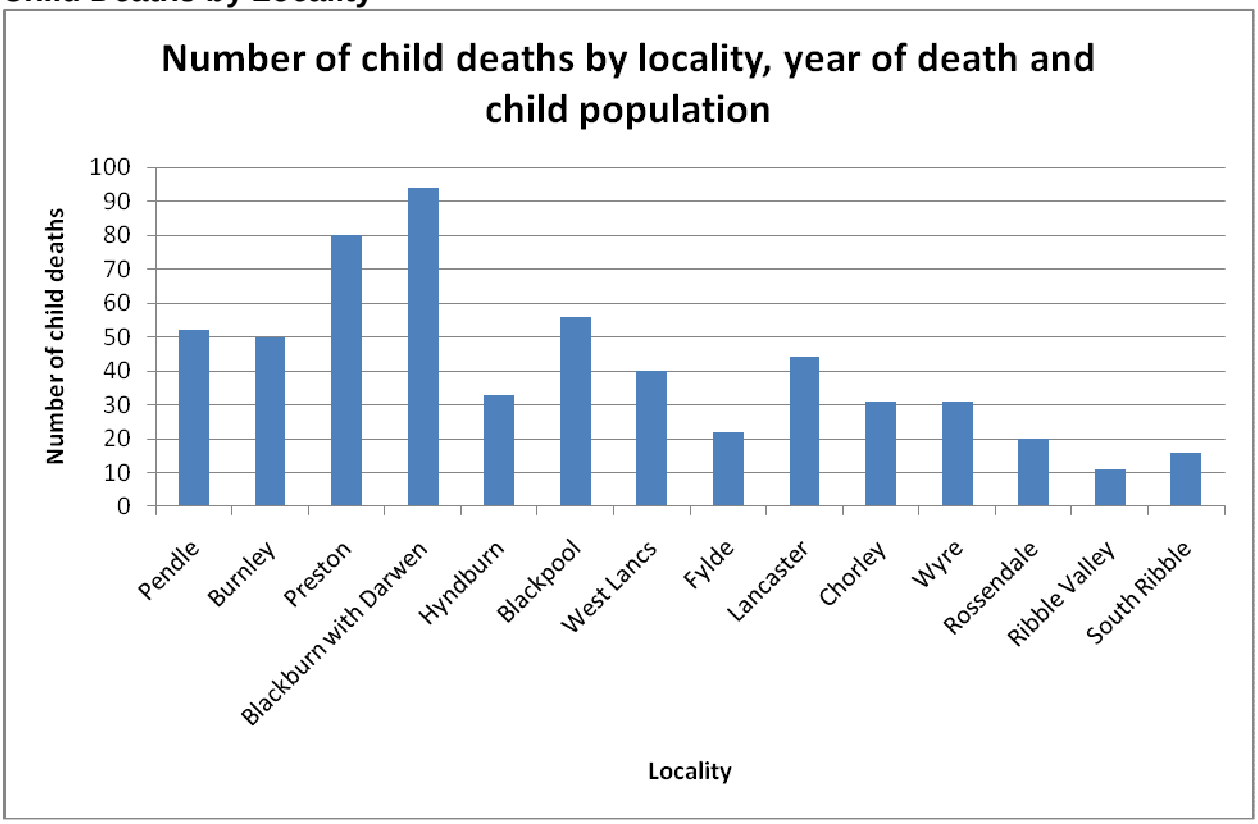


Figure 6, the number of child deaths per locality by year of death (this figure has been modified to maintain confidentiality)

It can be seen from figure 6 that Blackburn with Darwen, Preston, Pendle, Blackpool and Burnley have the highest number of deaths. Blackburn with Darwen, Hyndburn and Chorley had an increase in the number of deaths in 2009/10 with Ribble Valley not having any child deaths in 2010/11 and Preston having a relatively consistent number of deaths year on year.

Child Deaths by Gender and Age

From table 6 below it is seen that year on year more male children die than female children.

Gender	2008/09	2009/10	2010/11	2011/12
Female	41% (60)	39% (65)	42% (58)	42% (55)
Male	59% (87)	61% (100)	58% (80)	58% (76)

Table 6, child death by gender and year of death

The scarf charts on the next page represent child deaths between April 2008 and March 2012 by gender, age at death and year of death; the pattern of deaths by age, is what would be expected based on previous annual reports and the national data. The largest number of deaths occurred in

children aged 0-27days with the fewest deaths in children aged 5-9 years. This pattern is also seen on a year by year basis in the same figure.

Nationally, 66% of reviews completed in the year ending 31st March 2013 were for children aged under 1 year. Similar to the pan-Lancashire data, nationally there were more males (57%) children's deaths reviewed in comparison to females (43%).

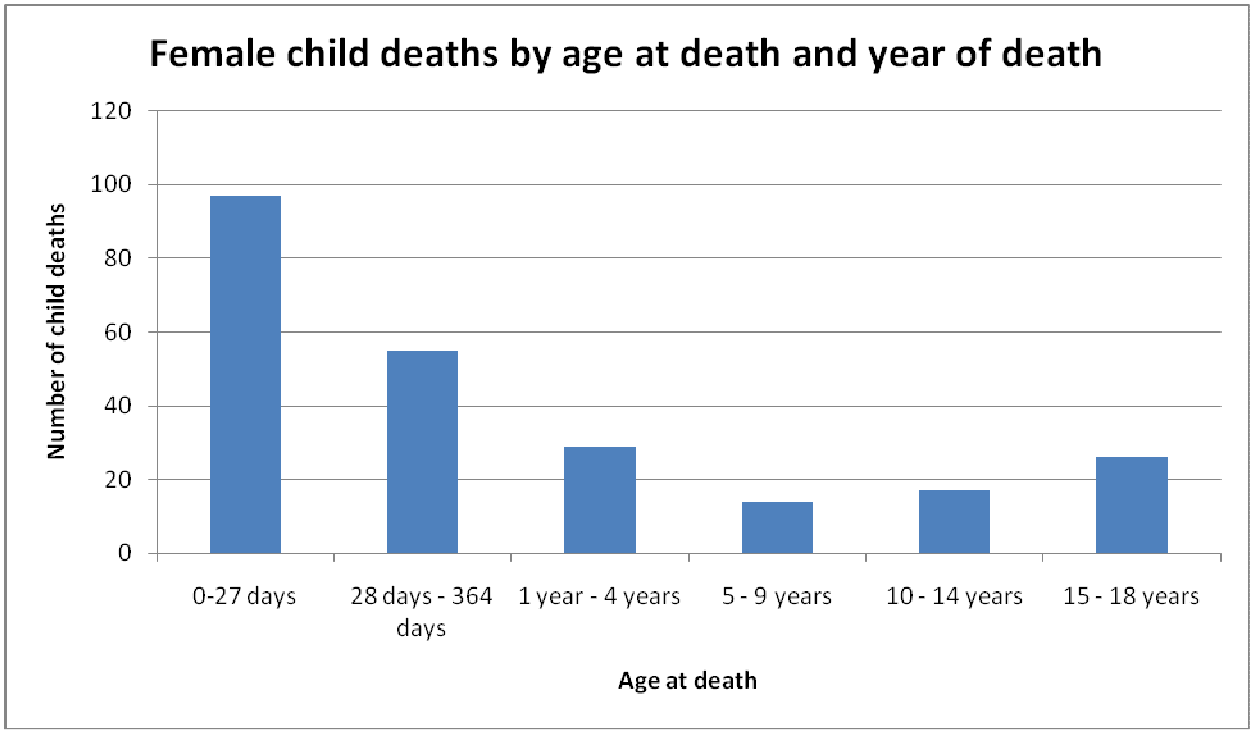


Figure 7, female child deaths by age at death and year of death (this figure has been modified to maintain confidentiality.)

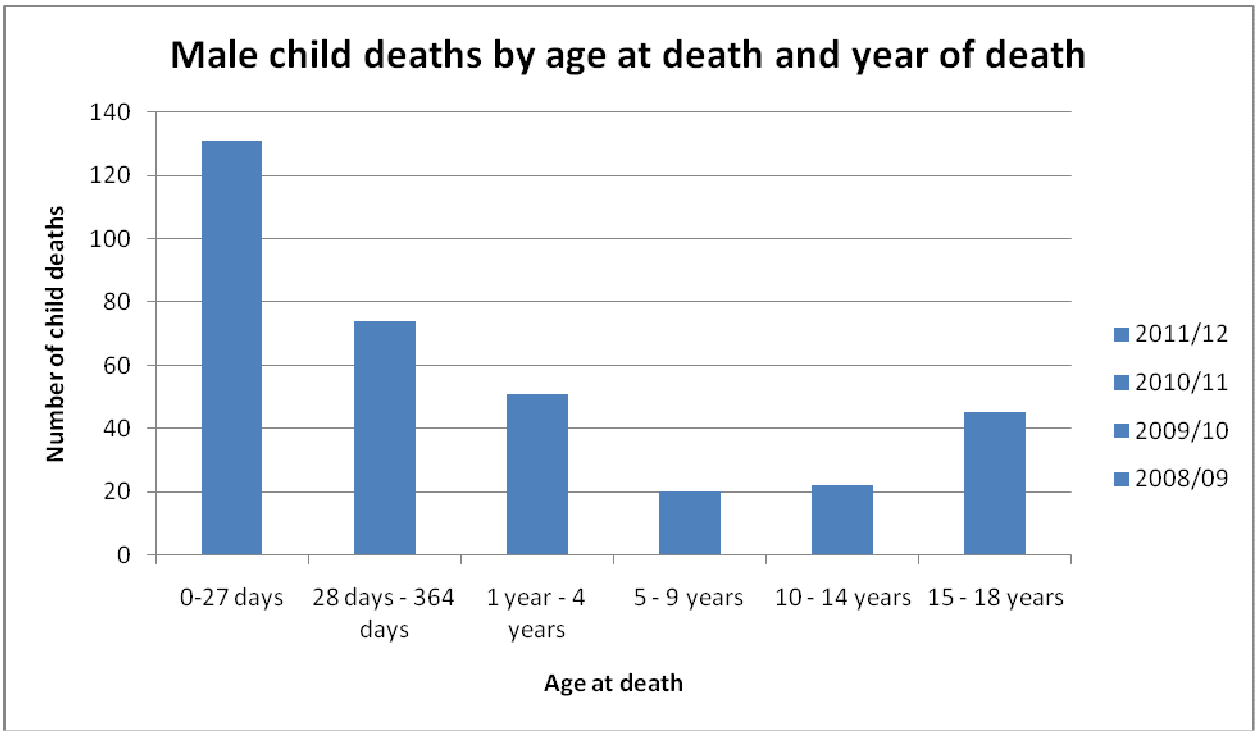


Figure 8, male child deaths by age at death and year of death (this figure has been modified to maintain confidentiality.)

Figure 9 removed to maintain confidentiality

Figure 9, child deaths in 2008/09 by age and category of death

Figure 10 removed to maintain confidentiality

Figure 10, child deaths in 2009/10 by age and category of death

Figure 11 removed to maintain confidentiality

Figure 11, child deaths in 2010/11 by age and category of death

Figure 12 removed to maintain confidentiality

Figure 12, child deaths in 2011/12 by age and category of death

Category of Child Death

Figures 9-12 above show age at death by category of death by the year of death; as anticipated a large number of deaths occurred in children aged 0-27days with the majority due to perinatal/ neonatal events. 62% of all the child deaths between April 2008 and March 2012 were in children under 1 year and of these 76% died of chromosomal, genetic and congenital abnormalities or perinatal/ neonatal events. The increasing impact of trauma and other external factors and suicide is apparent in young people; with sudden unexpected, unexplained deaths particularly noticeable in children aged 28- 364 days old. See page 21 table 7 for all data reviewed by the Panel between April 2008 and March 2013 by category of death.

The analysis of the data by year of child death between April 2008 and March 2012 identified there were fluctuations in the number of deaths per category for each year as detailed below:

2008/09:

- Fewer deaths due to chromosomal, genetic and congenital abnormalities
- Increased number of deaths due to acute medical or surgical condition and chronic medical condition
- Slight increase in suicide or self inflicted harm and deaths due to infection

2009/10

- Similar number of deaths caused by perinatal/ neonatal events and chromosomal, genetic and congenital abnormalities
- Slightly higher number of deaths due to trauma and other external factors
- Fewer deaths as a consequence of suicide or self inflicted harm

2010/11

- The highest number of deaths due to perinatal/ neonatal events and chromosomal, genetic and congenital abnormalities
- Increased number of sudden unexpected, unexplained deaths
- Reduce number of deaths due to malignancy and suicide or deliberate self harm

2011/12

- Increased number of deaths due to perinatal/ neonatal events
- Fewer deaths due to chromosomal, genetic and congenital abnormalities and sudden unexpected, unexplained death
- Slight increase in deaths due to malignancy and suicide or deliberate self harm

The chart (figure 13) on the next page identifies the different causes of child death by the year the child died. Perinatal/ neonatal events and deaths as a consequence of chromosomal, genetic and congenital abnormalities are the main causes of child death from April 2008 – March 2012. See page 21 table 7 for all data reviewed by the Panel between April 2008 and March 2013 by category of death.

Figure 13 removed to maintain confidentiality
Please see page 21 table 7 for all data reviewed by the Panel between April 2008 and March 2013 by category of death.

Figure 13, number of child deaths by category of death and year the child died

Figure 14 depicts the number of child deaths with modifiable factors identified by category of death and year of death. During 2009/10 there was an increase in the number of deaths in which modifiable factors were identified this is likely due to the increased number of child deaths for this year; moreover there were specific increases in deaths due to trauma and other external factors and sudden unexpected, unexplained death during 2009/10.

There appears to be an increase in 2009/10 and 2010/11 in the deliberately inflicted injury, abuse or neglect; however, this type of death usually takes over a year to be reviewed by Panel. This is due to other investigations such as Serious Case Reviews (SCRs) or criminal investigations needing to be complete before the CDOP can review the information, therefore, the data for 2011/12 should be treated with caution. More deaths as a consequence of suicide or deliberate self-inflicted harm during 2008/09 were deemed to have modifiable factors.
It seems as though there are increasing numbers of deaths due to perinatal/ neonatal events being categorised as having modifiable factors. The Panel has commissioned further research into perinatal/ neonatal deaths and the final report will be released in 2012/13.
The differences in the number and category of deaths identified as having modifiable factors in 2008/09 and 2009/10 in comparison to 2010/11 and 2011/12 may be as a result of the following factors:

1. In March 2010 the statutory guidance was amended from each review being categorised as either 'not preventable', 'potentially preventable' or 'preventable' to 'modifiable factors identified' or 'no modifiable factors identified'. Therefore the category for 'modifiable factors identified' includes all deaths which were previously categorised as 'preventable' or 'potentially preventable.
2. The Panel has developed experience and understanding of the review process and discussions
3. The Panel members have changed which may have affected the decisions made

Figure 14 removed to maintain confidentiality

Figure 14, child deaths identified as having modifiable factors by category and year of death

Analysis of child deaths reviewed from April 2008 – March 2013

Since April 2008 – March 2013 the Child Death Overview Panel (Blackpool, Lancashire and Blackburn with Darwen) has been notified of 712 child deaths (excluding out of area children) and has completed 633 reviews (88.9%), nationally 81% of reviews have been completed since the statutory responsibility to review deaths was introduced in April 2008. Of the 633 cases reviewed 44% were unexpected deaths, 59% were male and 22% had modifiable factors.

From table 7 below it can be seen that perinatal/ neonatal events (8) and chromosomal, genetic and congenital anomalies (7) are the cause for the majority (58%) of child deaths within pan-Lancashire. Similar to last year, sudden unexpected, unexplained deaths (10) is the third most common category but it is a much smaller group than category 7 and 8 and has similar numbers to categories 3 and 4.

Category of Death	Number of Child Deaths	Percentage
Deliberately inflicted injury, abuse or neglect (1)	12	1.8%
Suicide or deliberate self-inflicted harm (2)	19	3.0%
Trauma and other external factors (3)	44	7.0%
Malignancy (4)	40	6.3%
Acute medical or surgical condition (5)	22	3.5%
Chronic medical condition (6)	36	5.7%
Chromosomal, genetic and congenital anomalies (7)	154	24.3%
Perinatal/neonatal event (8)	213	33.6%
Infection (9)	31	4.9%
Sudden unexpected, unexplained death (10)	57	9.0%

Table 7, number of child death by category of death

Expected/ Unexpected Deaths and Modifiable Factors

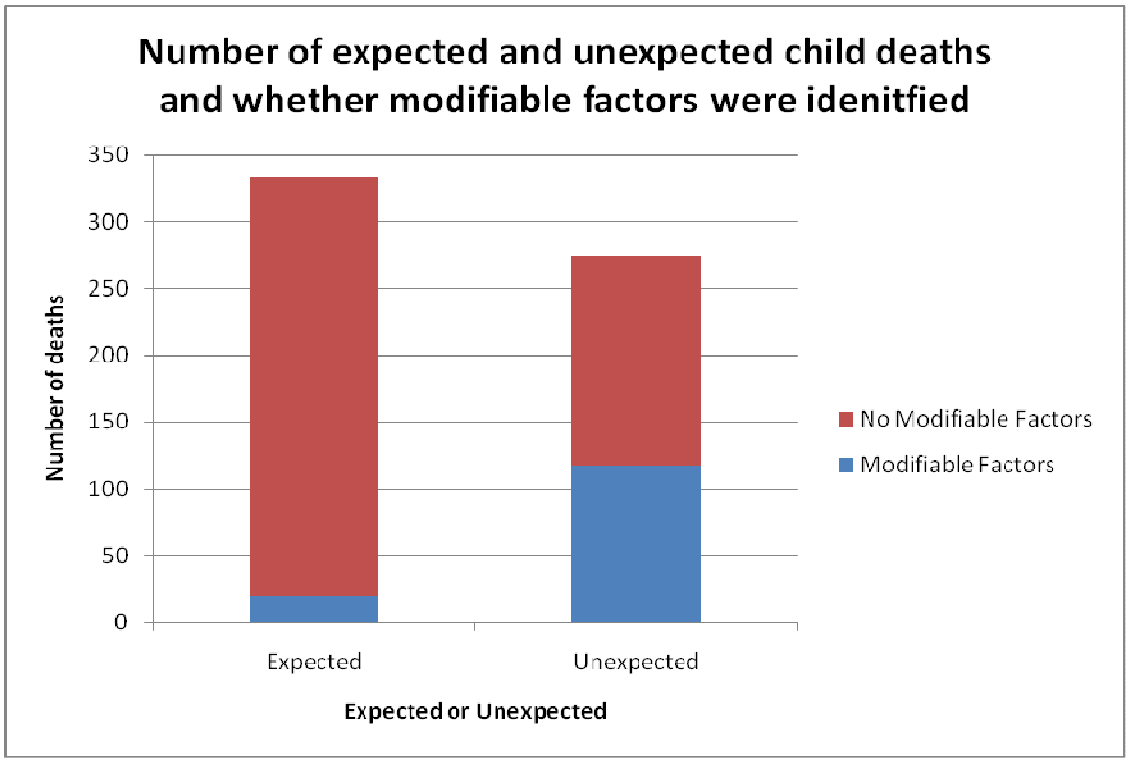


Figure 15, number of child expected and unexpected child deaths reviewed between April 2008 – March 2013 and whether modifiable factors were identified.

74% of the child deaths were deemed to have no modifiable factors; of the cases identified to have modifiable factors (22%) the majority were unexpected child deaths. No modifiable factors were identified in 94% of expected deaths and 57% of unexpected deaths. In 4% of the deaths there was either insufficient information to determine whether there were modifiable factors/ no modifiable factors or if the death was expected/ unexpected (figure 15).

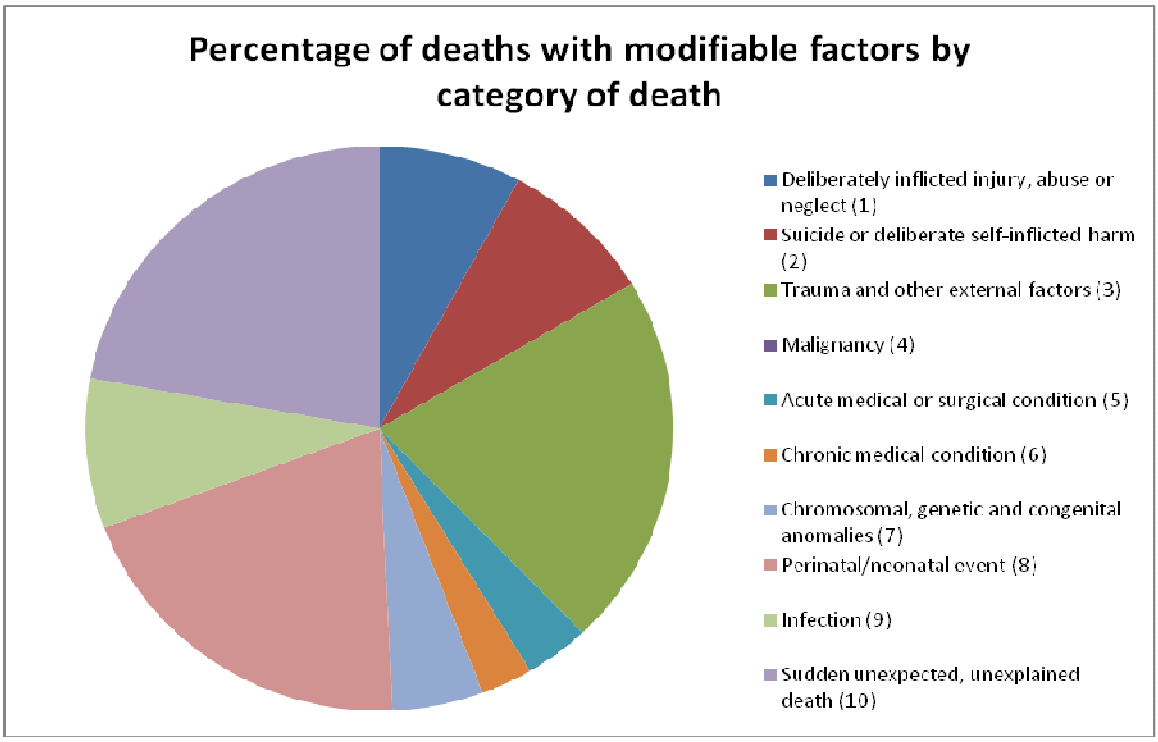


Figure 16, percentage of child deaths with modifiable factors identified by cause of death (this figure has been modified to maintain confidentiality.)

Figure 16 above shows 22% of deaths identified as having modifiable factors were sudden unexpected, unexplained deaths, 21% were due to trauma and other external factors and 20% were caused by perinatal/ neonatal event. No deaths due to malignancy were identified as having modifiable factors. Examples of modifiable factors relating to sudden unexpected, unexplained deaths, trauma and other external factors and perinatal/ neonatal events are issues relating to safer sleep, risk taking behaviours and smoking in pregnancy respectively.

The most common risk factors identified from the 140 cases deemed to have modifiable factors were:

- 32% of cases identified issues in relation to service provision including engagement with services, language barriers or access to services
- 28% of cases identified alcohol/ substance misuse by a parent or carer
- 24% of cases identified smoking by a parent/ carer
- 21% of cases identified issues relating to safer sleep for baby (80% also had either smoking, alcohol and/or substance misuse as risk factors)
- Other factors noted by CDOP included mental health of a parent/ carer, domestic violence, chaotic lifestyles and housing issue

Locality and Ethnicity

Figure 17, represents child deaths reviewed between April 2008 and March 2013 by locality and ethnicity. It can be seen that Blackburn with Darwen, Preston, Pendle and Burnley have the most diverse populations within pan-Lancashire and also have some of the highest numbers of deaths. Of the 633 deaths reviewed between April 2008 and March 2013 the two largest ethnicities were White British 60% and 12% of children and young people were of an Asian or Asian British (Pakistani) ethnic origin. 13% of the child deaths reviewed did not have an ethnicity listed because it was either not known or not stated.

Figure 14 removed to maintain confidentiality

Figure17, child deaths reviewed between April 2008 and March 2013 by locality and ethnicity

Figure 14 removed to maintain confidentiality

Figure18, child deaths reviewed between April 2008 and March 2013 by category and ethnicity
*the numbers on the y axis refer to the categories of death as follows: Deliberately inflicted injury, abuse or neglect (1), Suicide or deliberate self-inflicted harm (2), Trauma and other external factors (3), Malignancy (4), Acute medical or surgical condition (5), Chronic medical condition (6), Chromosomal, genetic and congenital anomalies (7), Perinatal/neonatal event (8), Infection (9), Sudden unexpected, unexplained death (10)

Figure 18 above depicts the child deaths reviewed between April 2008 and March 2013 by category of death and ethnicity. Each category of death has children of a White British heritage with the majority due to perinatal/ neonatal events. Of the children and young people who were of an Asian or Asian British (Pakistani) ethnic origin 52% died due to chromosomal, genetic and congenital anomalies and 28% perinatal/ neonatal events.

Analysis of the two largest ethnicities across pan-Lancashire by age of the child at death is seen in the table (8) below. Interestingly, the White British ethnicity follows a similar pattern to the combined data with 62% all the child deaths reviewed between April 2008 and March 2013 aged under 1 year, with fewest deaths in the 5-9 year category, and numbers increasing again in over 10 year olds. Comparatively, of the child deaths reviewed between April 2008 and March 2013 79% of Asian, Asian British (Pakistani) were under 1year of age and numbers plateau in the older age categories.

	0-27 days	28- 364 days	1-4 years	5-9 years	10-14 years	15-18 years	Totals
White British	155 (41%)	80 (21%)	49 (13%)	21 (6%)	27 (7%)	46 (12%)	378
Asian, Asian British (Pakistani)	33 (44%)	26 (35%)	6 (8%)	<5 (5%)	<5 (4%)	<5 (4%)	75

Table 8, two most common ethnicities across pan-Lancashire by the age of the child

Deprivation

From figure 19 below it can be seen that a high child population does not predispose an area to increased numbers of child death; therefore other social, economic and biological factors must be considered. Figure 20 identifies the areas which have the most deprivation also have far more child deaths than the least deprived areas of pan-Lancashire. This section of the report will look at mapping deprivation and child deaths reviewed between April 2008 and March 2013.

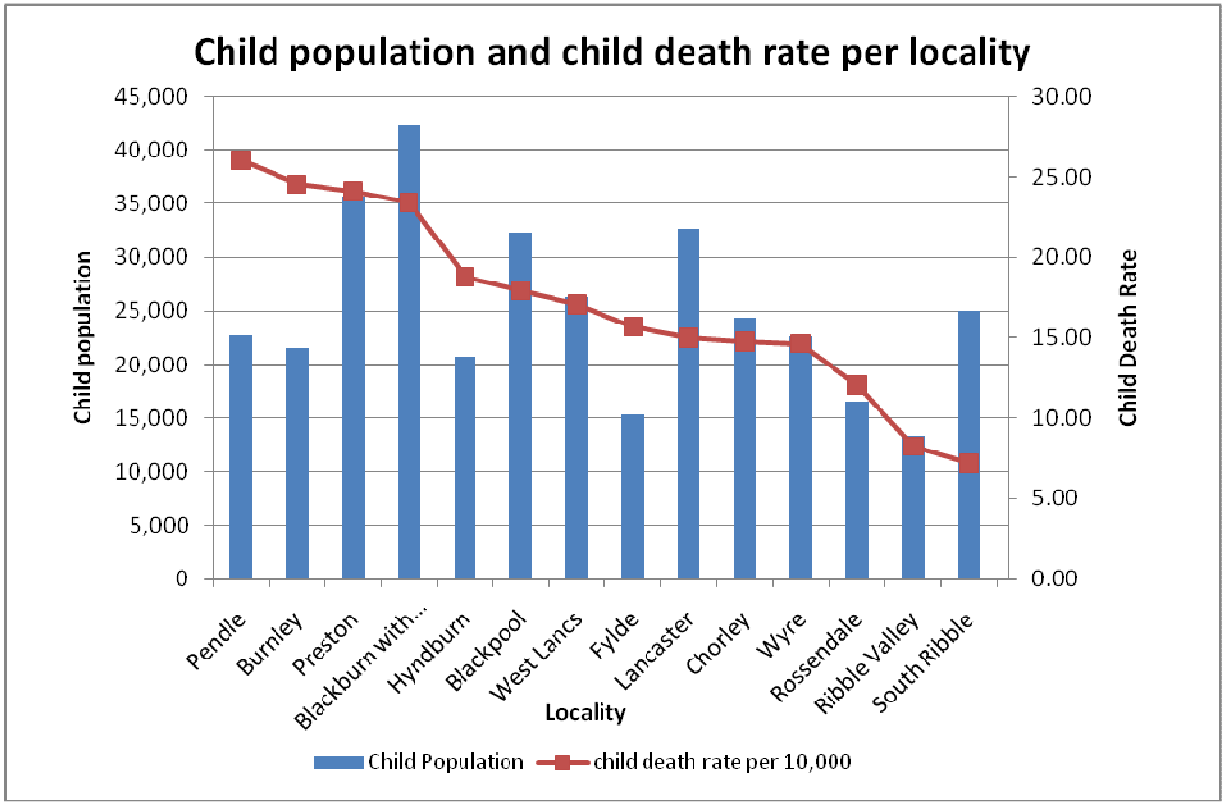


Figure 19, Child death rate per 10,000 of under 18 population

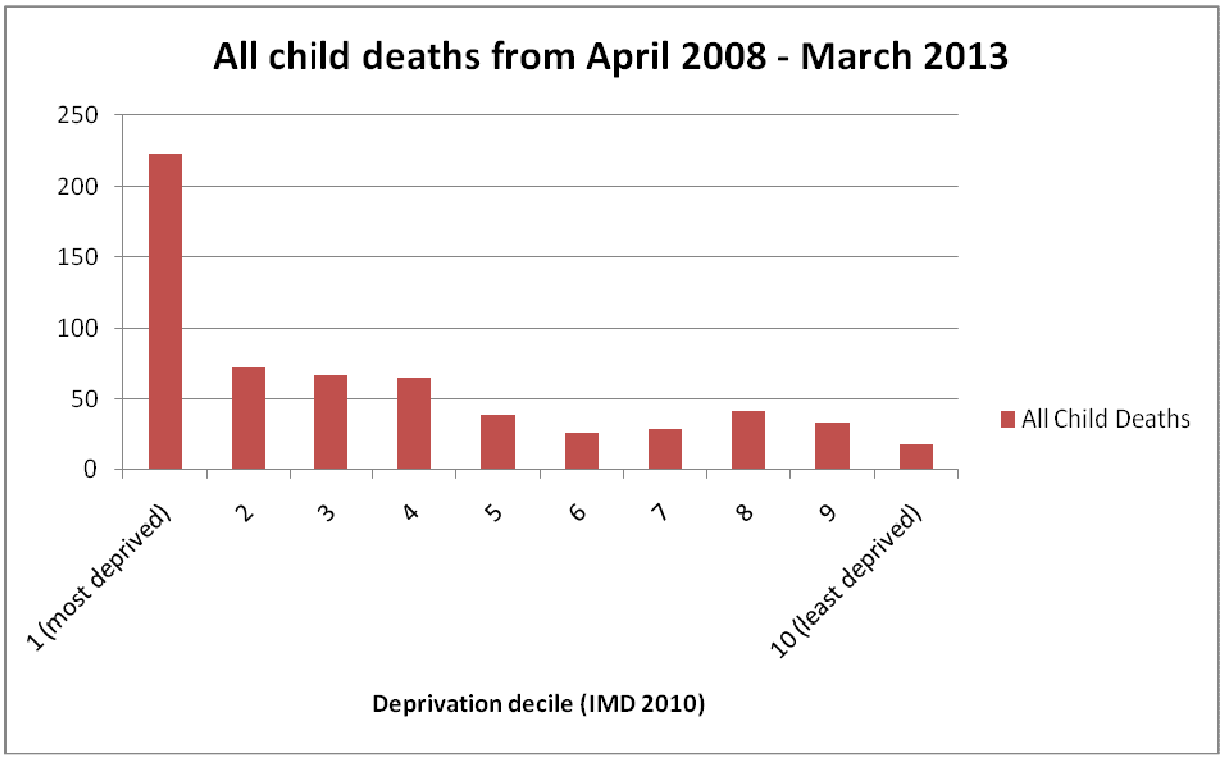


Figure 20, child deaths reviewed between April 2008 and March 2013 by deprivation decile.

Experian Mosiac Public Sector was used to profile all the child death data, it was identified that families from the following socio-economic backgrounds suffered more child deaths:

- lower income workers in urban terraces in often diverse areas
- families in low-rise social housing with high levels of benefit need

Further analysis idenified the following specific groups of being more at risk of child deaths :

- South Asian communities experiencing social deprivation
- Families living in older town centre terraces with transient, single populations
- Low income families occupying poor quality older terraces
- Vulnerable young parents needing substantial state support

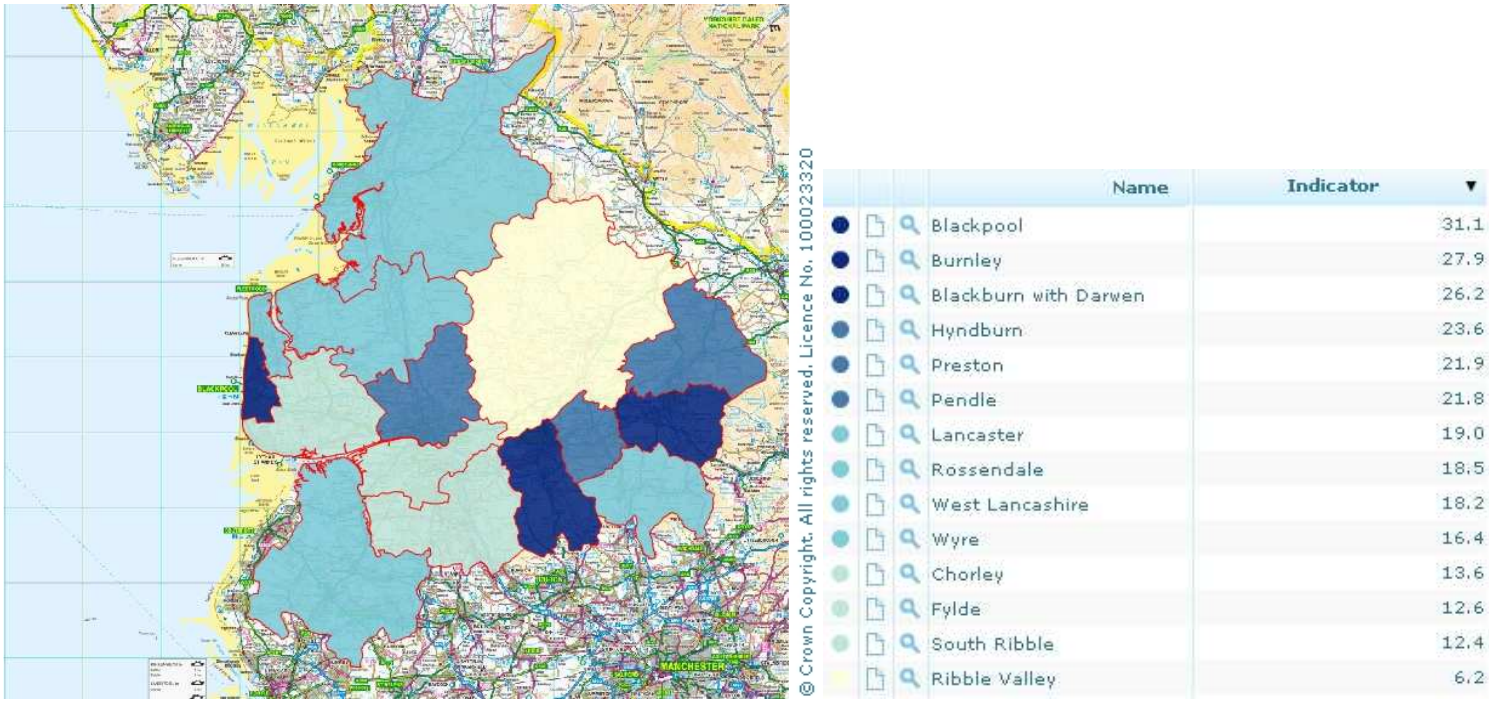


Figure 21, poverty of children and young people under 16 years old

When looking at the figure above (21) and the locality and ethincity scarf chart on page 23 the following trends/ themes can be seen:

- There are more child deaths in the districts with increased child poverty
- Ribble Valley, South Ribble and Fylde are the areas with the least child poverty also tend to have fewer child deaths.
- More diverse areas tend to have high levels of child deaths. However, Blackpool which has a large White British population also has high child death numbers, although this may be explained by the high deprivation rate for Blackpool.
- When looking at Lower Super Output Area (LSOA) and Ward level at the index of multiple deprivation 2010 and hotspot areas of under 18 conception rates per 1000 females aged 15-17 (2003-2005) (LCC interactive maps) there are higher conception rates in under 18s in areas of higher deprivation and there are also clusters of child deaths in these areas (CDOP Annual Report 2011/12).

Based on the mosiac analysis and the discussion above relating to deprivation/ child poverty, ethnicity and locality, families from BME communities experiencing social deprivation and families living in more deprived areas are more likely to experience a child death.

Identification of themes and trends

- The most common cause of all child deaths is perinatal/ neonatal events and chromosomal, genetic and congenital anomalies
- There are significantly more deaths with no modifiable factors identified; of the deaths deemed to have modifiable factors the largest categories of death are sudden unexpected, unexplained deaths, trauma and other external factors and perinatal/ neonatal events
- There are more expected deaths then unexpected deaths
- More male children die than female children
- 62% of all the child deaths between April 2008 and March 2012 were in children under 1 year and of these 76% died of chromosomal, genetic and congenital abnormalities or perinatal/ neonatal events
- The increasing impact of trauma and other external factors and suicide is apparent in young people; with sudden unexpected, unexplained deaths particularly noticeable in children aged 28-364 days old
- 60% of children who have died between April 2008 and March 2013 are White British
- Of the deaths reviewed 79% of Asian, Asian British (Pakistani) children were under 1year of age
- 80% of Asian, Asian British (Pakistani) child deaths were due to perinatal/ neonatal events and chromosomal, genetic and congenital anomalies
- Blackburn with Darwen, Burnley, Pendle and Preston have the most diverse populations within Pan-Lancashire, these areas also have the highest child death rates
- There are more child deaths in the districts with increased child poverty
- Families from BME communities experiencing social deprivation and families living in more deprived areas are more likely to experience a child death

Recommendations for 2013/14

- The three LSCBs should reiterate to all agencies, who provide CDOP with information, the importance of completing AB forms as fully as possible, particularly ethnicity, asylum seeker and parental demographic details
- The three LSCBs should recommend to the Health and Wellbeing Boards in their area to note the information contained within this report and ask them to clarify whether any research and/or planning of services work is being undertaken on any of the themes/trends or issues raised, in particular for:
  - The Blackpool LSCB to consider research and/or planning of services on the theme of deprivation identified in child deaths under 28 days;
  - The Lancashire and Blackburn with Darwen Boards to consider the themes of ethnicity and deprivation linked with deaths categorised under the category of 'chromosomal, genetic and congenital anomalies'.

  In seeking the clarifications from the Health and Wellbeing Boards, the LSCBs should be assured that local action is being taken, and that this action is effective, in preventing future such deaths
- The three Boards should be mindful that although the majority of cases do not have modifiable factors, this does not mean there were no risk factors identified. It may be appropriate to review in depth all the cases with no modifiable factors to identify common risk factors
- The LSCBs should recommend to the Health and Wellbeing Boards that representatives should attend the CDOP development day
- CDOP to explore learning opportunities with other CDOPs across the country
- All three Boards should continue to support the Safer Sleep Campaign
- The three LSCBs should circulate the anonymised report widely

Links

To access the Safer Sleeping Guidance for the integrated workforce, thematic reports and SUDC Protocol please follow this link LSCB - CDOP page
Please follow this link for the Safer Sleep for Baby Campaign