Report to:	**Health and Wellbeing Board**
Relevant Officer:	Delyth Curtis, Director of People, Blackpool Council
Relevant Cabinet Member	Councillor Ivan Taylor, Cabinet Member for Children's Services
Date of Meeting:	28th January 2015

CHILD DEATH OVERVIEW PANEL REPORT 2013/2014

1.0 Purpose of the report:

1.1 The Child Death Overview Panel has a responsibility to review the deaths of children and young people resident within the three local authority areas with the aim of identify themes, trends and recommendations in an attempt to prevent future child deaths. This is their annual report for 2013/2014.

2.0 Recommendation(s):

2.1 To note the information contained within this report and ask for further clarification from the Blackpool Safeguarding Children Board with regards to the recommendations in the report and how they are to be implemented.

3.0 Reasons for recommendation(s):

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

This report will provide information on trends and patterns in the deaths reviewed during the last reporting year (2013-2014), on all deaths reviewed since the panels began in April 2008 and make recommendations to the Local Safeguarding Children Boards or other relevant bodies (e.g. Health and Wellbeing Boards) based on the analysis.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

None, the Board should consider the report of the Panel.

4.0 Council Priority:

4.1 The relevant Council Priority is:

- Safeguard and protect the most vulnerable
- Improve health and well-being especially for the most disadvantaged

5.0 Background Information

5.1 The Child Death Overview Panel (CDOP) is a multi-agency group responsible for reviewing all child deaths occurring within Lancashire, Blackburn with Darwen and Blackpool. The Panel is a sub group of the three Local Safeguarding Children Boards.

5.2 The deaths of all live-born children 0-18 (excluding infants live-born following planned, legal terminations of pregnancy or still births), are reviewed by the Child Death Overview Panel in line with Working Together to Safeguard Children (2013). This report will provide information in relation to trends and patterns from deaths reviewed and identify recommendations for the Local Safeguarding Children Board or other relevant bodies to prevent future child deaths where possible.

5.3 **Key points to note are**:
From April 2008 – March 2014 the Panel has completed 770 child death reviews consisting of 68 Blackpool, 121 Blackburn with Darwen and 578 Lancashire. Of these deaths:

- 23% of pan-Lancashire deaths had modifiable factors (24% Lancashire, 17% Blackburn with Darwen, 25% Blackpool and 22% national)
- Nationally 72% of cases are completed within 12 months; 80% of pan-Lancashire deaths have been completed within 12 months of the deaths occurring between April 2008 and March 2014 (79% Lancashire, 88% Blackburn with Darwen and 72% Blackpool)
- 63% of pan-Lancashire deaths reviewed are of children under 1 year of age (62% Lancashire, 66% Blackburn with Darwen and 63% Blackpool) this is slightly below the national figure of 66% · 59% of pan-Lancashire deaths were of male children and young people (56% national, 60% Lancashire, 59% Blackburn with Darwen, and 47% Blackpool)
- The largest categories of pan-Lancashire child deaths are perinatal/ neonatal event (34.2%), chromosomal, congenital and genetic abnormalities (24.5%) and sudden unexpected, unexplained deaths (8.7%)

- Sudden unexpected, unexplained deaths are particularly noticeable in children aged 28-364 days old. Examples of modifiable factors in this category relate to safer sleep.
- The largest category of death with modifiable factors in Blackpool is sudden unexpected, unexplained deaths (41%), perinatal/ neonatal event in Blackburn with Darwen (48%) and perinatal/ neonatal event Lancashire (23 %)
- The categories of death with the largest proportion of modifiable factors (pan-Lancashire) were Deliberately inflicted injury, abuse or neglect (89%), Trauma and other external factors (63%), Suicide or deliberate self-inflicted harm (52%), and Sudden unexpected, unexplained death (52%)
- The most common risk factors identified from the pan-Lancashire cases identified to have modifiable factors are:
    1. 35% service provision (including access to health care, prior medical intervention e.g. misdiagnosis or missed testing etc , communication e.g. cross boundary issues, interagency communication or internal issues and/or access to other services e.g. housing)
    2. 31% smoking (includes smoking in pregnancy and in the household by parent or carer)
    3. 31% alcohol/ substance misuse by parent, carer and/ or child

5.4 **Recommendations**

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

5.5 Does the information submitted include any exempt information? No

5.6 **List of Appendices:**

Appendix 7a: Annual Report Executive Summary

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None