Report to:	**HEALTH AND WELLBEING BOARD**
Relevant Officer:	Liz Petch, Consultant in Public Health
Relevant Cabinet Member:	Councillor Jo Farrell, Cabinet Member for Adult Social Care, and Community Health and Wellbeing
Date of Meeting	5 October 2022

CHILD DEATH OVERVIEW PANEL (CDOP) ANNUAL REPORT 2020/21

1.0 Purpose of the report:

1.1 To update members of the Health and Wellbeing Board of the work undertaken by the Pan-Lancashire Child Death Overview Panel (CDOP) during 2020/21, which includes key findings from child death data, progress made on last year's recommendations (2019/20), partnership achievements; priorities and recommendations for 2020/21.

2.0 Recommendation(s):

2.1 To agree to undertake a review of the modifiable factors and actions/response to these to be integrated into existing work-streams across the Council's Public Health team and with core partners.

2.2 To agree that Blackpool as one of the (upper tier) locality area will develop over the next 12 months an Infant Mortality Strategy and Action Plan with an identified Group that leads, or it reports to, which is then accountable to the appropriate Health and Wellbeing Board.

2.3 To continuously improve data completeness, partners must ensure all professionals providing information to Child Death Overview Panel complete the forms as fully as possible before they are submitted. Improving this data will enable National Child Mortality Database to link with other data sets, leading to more comprehensive analysis in future.

3.0 Reasons for recommendation(s):

3.1 To ensure local actions are undertaken to reduce the risk of sudden unexpected deaths in children and young people in Blackpool.

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

4.0 Other alternative options to be considered:

4.1 An initial data review for infant mortality was undertaken for Blackpool in 2020/21. This included interviews with various stakeholders and partners to establish existing work, progress, gaps and opportunities; in order to prioritise future actions. This work has however been paused at the request of the Lancashire and South Cumbria Maternity and New-born Alliance Board in order that alignment is made with Lancashire, Blackburn and South Cumbria.

Partners await the results of this review before a suitable way forward is proposed for Blackpool.

5.0 Council priority:

5.1 The relevant Council priority is: "Communities: Creating stronger communities and increasing resilience".

6.0 Background information

6.1 The Child Death Overview Panel (CDOP) is managed and hosted by Lancashire County Council, alongside the Children's Safeguarding Assurance Partnership function, which helps maintain the important links between the two. The guidance is clear that the Child Death Overview Panel is now a parallel rather than a subgroup process.

The partners have identified that the requirement for analysis and the subsequent lessons emerging from Child Death Overview Panel are predominantly public health matters as opposed to safeguarding issues.

6.2 The functions for Health and Wellbeing Boards focus on the joint activity required between Local Authority and health partners to improve the health and wellbeing of the community they serve. Therefore, where preventable factors that may influence the death of a child can be identified, such as smoking, obesity and substance misuse for example, the Health and Wellbeing Board is the most appropriate place to address these matters on a population basis rather than being addressed via the current safeguarding mechanisms.

6.3 The themes and trends identified through the Child Death Overview Panel process should be placed within the context of the wider health and wellbeing data already considered at Health and Wellbeing Boards to inform their priorities and action, including joint commissioning.

The Children's Safeguarding Assurance Partnership would still be significant in leading on individual reviews where abuse or neglect is identified in a child death and being assured on the effectiveness of services responsible for supporting parents whose parenting capacity is compromised by their mental health, drug and alcohol abuse and / or domestic abuse**.**

6.4 The attached report, at Appendix 5a, provides information on trends and patterns in child deaths reviewed; during the reporting year (2020-21) and over the last five years (2015-21).

Child Death Overview Panel received 83 notifications of child deaths 2020/21, this was 25 fewer deaths than the previous year. The reduction of deaths was apparent over months where national lockdowns were in place, in response to the COVID-19 pandemic. This reduction is in line with the national picture.

1. Work around the impact of COVID-19 on child mortality has been performed and reviewed at a national level.
2. The number of deaths of children resident in the most deprived neighbourhoods across pan-Lancs was more than five times that of children resident in the least deprived neighbourhoods
3. In 2020/21, Pan-Lancashire Child Death Overview Panel reviewed 80 child deaths mostly due to the logistics of meeting via TEAMS, fewer reports coming through.
4. The most common category of death across pan-Lancashire for cases reviewed during 2020/21 was perinatal/neonatal events (30%), with chromosomal, genetic and congenital anomalies accounting for the second most common category of death (28%) – this is consistent with previous years
5. 43% of deaths reviewed in 2020/21 had modifiable factors identified
6. The most common modifiable factors identified between April 2015 and March 2021 were smoking, alcohol/substance misuse in parent/carer, high BMI, mental health, and service provision.
7. The largest category of deaths Pan-Lancashire in 2020/21 with modifiable factors was Category 8: perinatal/neonatal events (41%).

6.5 For Blackpool; 25% of deaths reviewed during 2020/21 were completed within 12 months of the child's death, compared to 71% in in the previous year.

1. 100% of deaths reviewed in 2020/21 were of White British ethnicity.
2. 75% of deaths reviewed in 2020/21 were female.
3. 25% of deaths reviewed in 2020/21 were unexpected.
4. 100% of deaths reviewed in 2020/21 were children are aged under 1 year old (25% under 28 days and 75% 28 – 364 days).
5. 50% of deaths reviewed in 2020/21 were due to chromosomal, genetic and congenital anomalies, 25% were due to trauma and other external factors, and 25% due to chronic medical condition.
6. 50% of deaths reviewed in 2020/21 had modifiable factors. The most common modifiable factors identified between April 2015 and March 2021 are: -

    - smoking,
    - alcohol/substance misuse in parent/carer,
    - domestic abuse/violence,

- safer sleep, and
- service provision

6.6 It has been agreed that Child Death Overview Panel priorities will remain as:

- Improve the quality and outputs of the child death review processes by ensuring all child death review meetings inform the Child Death Overview Panel process.
- Strengthening exiting pathways
- Reduce the variability of reporting forms and routinely missing information e.g. male partners.
- Demonstrate improvements against national standards through self-assessment.
- Continue to collect data for Adverse Childhood Experiences (ACEs) and analyse patterns in links between ACEs and child deaths.

6.7 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 Appendix 5a: Child Death Overview Panel Annual Report 2020/21 (redacted)

8.0 Financial considerations:

8.1 None.

9.0 Legal considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Equalities considerations:

11.1 None.

12.0 Sustainability, climate change and environmental considerations:

12.1 None.

13.0 Internal/external consultation undertaken:

13.1 None.

14.0 Background papers:

14.1 None.