CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT 2023 - 2024

CDOP annual report on partnership arrangements and trends/patterns highlighted in child deaths reviewed across the Blackburn with Darwen, Blackpool and Lancashire region during the reporting period 1st April 2023 – 31st March 2024.

Child Death Overview Panel
CDOP
Blackburn with Darwen, Blackpool & Lancashire

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MESSAGE FROM OUR CHAIR

In the face of unprecedented challenges, the Blackburn with Darwen, Blackpool & Lancashire Child Death Review (CDR) process, including the Child Death Overview Panel (CDOP) has demonstrated resilience. Despite immense pressures on public sector services, the commitment to safeguarding children has remained steadfast. This report reflects the hard work and professionalism of all involved, as well as the significant strides made during a time when many families are facing economic hardships.

Several key successes have been achieved this year. Our collaborative approach has led to improved processes and better outcomes for children and families across Lancashire. Notably, the national recognition of the Sudden Unexpected Death in Children (SUDC) service stands as a testament to our commitment to excellence. Additionally, the partnership with Trading Standards to highlight the dangers of certain products has been instrumental in safeguarding children.

The professionalism and dedication of the staff are the cornerstones of our success. Their ability to work under pressure, maintain high standards, and continually strive for improvement is commendable. Everyone involved in the child death review process plays a vital role in the collective aim to protect and support the children and families of Lancashire.

Looking to the future, there is a continued commitment to learning, adapting, and improving. The challenges ahead are significant, but with the dedication of the staff and the support of partners, there is confidence in the ability to make a positive impact.

Gratitude is extended to everyone who has contributed to these efforts over the past year. The hard work and dedication are deeply appreciated and make a real difference in the lives of many.

INTRODUCTION

The death of a child is a devastating loss that profoundly affects all those involved. Since 1st April 2008, there has been a legal requirement across England that Child Death Overview Panels (CDOP) conduct a review for all child deaths. Child Death Review (CDR) partners have a statutory responsibility to review the deaths of all children up to the age of 18 years old (excluding babies who are stillborn, late foetal loss and planned terminations of pregnancy carried out within the law) it includes any infant death where a death certificate has been issued, irrespective of gestational age.

The statutory partners are:

- Blackburn with Darwen Council
- Blackpool Council
- Lancashire County Council
- Lancashire and South Cumbria Integrated Care Board (ICB)

This report outlines the analysis of cases derived from panels held across Blackburn with Darwen, Blackpool & Lancashire and provides information on trends and patterns in child deaths reviewed:

- During the reporting year (2023-2024)
- Over the last five years (2019-2024)
- Involving the pan-Lancashire SUDC Service (2023-2024)

The aim of the child death review (CDR) process is to ensure that information is systematically captured for every death to enable learning and prevent future deaths and share learning with colleagues regionally and nationally, so the findings have wider impact.

MEMBERSHIP & ATTENDANCE

Membership is made up of senior multi-agency professionals who have knowledge and expertise in fields such as public health, primary care, children's social care, paediatrics, police, and education. Panel meetings comprise of two separate panels, a specialist neonatal panel and an all-age panel.

The group provides oversight and challenge to statutory partners and other relevant strategic partnerships, in relation to any identified issues relating to the death, or deaths that are relevant to the welfare, public health and safety of children across pan-Lancashire. The business group continues to meet bi-monthly and maintain oversight and assurance of the whole child death review (CDR) process.

During 2023/24, the CDOP panel met on 10 occasions (5 neonatal panels, 5 all age panels). The table below lists the agencies represented at each panel.

Business Meetings	Case Discussion meetings	Neo-natal Review meetings
Chair	Chair	Chair
Lancashire Constabulary	Lancashire Constabulary	Lancashire Constabulary
Children's Social Care	Children's Social Care	Children's Social Care
Public Health	Public Health	Public Health
Lead Nurse, SUDC Service	Named Nurse for Safeguarding	Named Nurse for Safeguarding
SUDC Prevention Chair	Named Midwife	Named Midwife
Paediatrician	Paediatrician	Paediatrician
Integrated Care Boards	SUDC Service	SUDC Service
Lancashire and South Cumbria Foundation Trust	Education (School/Early Years Rep)	Neonatal Specialist
HCRG Care Group	HCRG Care Group	HCRG Care Group
Lay Member	Lay Member	Lay Member
Acute Trust Representation	North West Ambulance Service	North West Ambulance Service

WHAT HAS CDOP ACHIEVED IN 2023/24

ICON Babies cry, you can cope! Pan-Lancashire Subgroup

To mark ICON Week 25 – 29 September 2023, the ICON subgroup arranged for the famous Blackpool Tower to be lit up in the ICON colours. The entrance to Royal Preston Hospital Maternity Unit, and the Preston Flag Market were also illuminated.

Footballers from Preston North End, Burnley F.C. and Blackburn Rovers also got involved and the players recorded a message to help reach more male caregivers. The local press covered their story with: PNE and Burnley F.C. players help share important health message this ICON week and our Safeguarding Midwife, Lancashire Teaching Hospitals Trust, also engaged with That's TV. Additionally, there was a local learning from reviews session which attracted 70+ delegates, and Morecambe Bay Hospital Trust created a YouTube VLOG discussing ICON, with a focus on moving towards destigmatising parents feeling unable to cope and needing some time to calm down.

Members of the subgroups also linked in with senior lecturers at the University of Cumbria and the University of Central Lancashire, ICON is now part of the core training programme for trainee midwives. The subgroup is now working on phase two of the campaign which will consider how we build on phase one, reach wider audiences and include a roll-out to schools and GPs.

SUDC Prevention Strategic Group

The SUDC prevention group met regularly to review activity across the system, particularly in relation to the work of the subgroups, Safer Sleep, and ICON. Both groups function very well and have made great progress with their work plans.

Ongoing activity to update the strategic action plan included a development day which was held in March 2023. The day was well attended, and guest speakers spoke about childhood suicide and childhood deaths related to infection; priorities were reassessed, and future activity defined. There were some challenges due to several services undergoing transformation, particularly the business unit and ICB, which did impact slightly on the organisation of the group at times.

Links between The Royal Society for the Prevention of Accidents (RoSPA) and the Child Accident Prevention Trust (CAPT) have been maintained through the CDOP coordinator and messages are shared out to all partners through the network and major national campaigns have been supported.

Drowning Prevention Week 17- 24 June 2023 saw communication messages go across all agencies to launch the start of the summer safety messages. In August 2023 one of our Specialist SUDC Nurses attended a water safety awareness engagement day at a local reservoir near Rivington.

Learning from local cases and safeguarding reviews remains a focus, hence the activity around Safer Sleep and ICON being of high importance. Members have also been signposted to national learning through the National Child Mortality Database (NCMD) thematic reports and webinar links.

Safer Sleep Campaign

The Safer Sleep subgroup was re-established in May 2023 to review the pan-Lancashire safer sleep guidelines. A task and finish group formed to review the current guidance and a countywide consultation and engagement took place with staff and public on the refresh of the safer sleep guidance. The pan-Lancashire guidance has been updated and is now in line with the current guidance offered by the Lullaby Trust and NICE, furthermore our guidance has since been endorsed by the Baby Sleep Information Source (BASIS).

To mark Safer Sleep Week 11th March - 17th March 2024, the safer sleep subgroup engaged with local radio stations Rock FM and BBC Radio Lancashire and interviews took place to help raise awareness of sudden infant death syndrome (SIDS). Championship top-scorer, Blackburn Rovers Sammie Szmodics also backed the campaign by recording an exclusive video sharing safer sleep advice. Additionally, members of the safer sleep subgroup held a webinar during Safer Sleep Week which attracted 50+ delegates, the webinar focussed on the theme 'safest place' which was in line with the national campaign messages.

Through CDOP, members of the safer sleep subgroup raised their concerns with regards to five unsafe sleeping products, CDOP referred the items to Trading Standards and the products were removed from sale.

A media briefing pack was distributed to all partners to help raise awareness of safety messages over the festive period, we also used this opportunity to provide support and advice to families over the winter months. In addition to the comms brief, a winter newsletter was shared offering advice to caregivers over the winter months, acknowledging the challenges faced by many families to keep rooms warm, especially with the rising cost of fuel bills.

LEARNING FROM REVIEWS

A subgroup (Continuous Learning & Improvement Group) has been introduced during the reporting period with a focus on continuous improvement to strengthen the Child Death Review (CDR) processes. The group reports into and is accountable to the pan-Lancashire CDOP & CDR Business Group.

The functions of the group have included:

- Review and monitor of child death review processes in line with guidance.
- The development of learning pathway to support dissemination of learning to improve practice.
- Consideration of learning from local / national reviews via NCMD including thematic learning working in collaboration with partners.
- Strengthening system networks across partners.

A workshop held in March 2024 has supported the development of a workplan with a view to strengthening assurance processes. Priority areas for the workplan 2024/25 include: a two-year cycle of audit activity, thematic reviews, and other potential project work; these will be progressed over the next reporting year.

During the review process, if the panel identifies a matter of concern arising from a death or from a pattern of deaths in the area, action is taken, and recommendations are made.

Areas of focus across pan-Lancashire CDOP during 2023/24 were:

Pan-Lancashire thematic review of Category 2 deaths in children and young people

Suicide in children is a serious public health issue. The tragic loss of a child due to suicide has far reaching consequences for family, friends, their peers, and the rest of society. While the causes of suicide in CYP are multifactorial and complex, experience of potentially traumatic events in childhood have a significant influence, and that any factors which initiate or exacerbate these traumas may provide targets for prevention.

There has been concern regarding recent cases of suicide in young people across pan-Lancashire and this was identified as a key priority area for further investigation, a review of category 2 deaths (including deaths due to suicide or deliberate self-inflicted harm) was commissioned. The learning points and recommendations from the review are highlighted on the next page:

Workforce & Training

1. To ensure that those who work with CYP are appropriately trained in suicide awareness and prevention

Prevention and Early Intervention

2. To improve awareness of mental health, self-harm, and suicides in CYP among the general population of pan-Lancashire and services.
3. To promote awareness and assessment of suicide risk for younger children (aged 14 or under) to ensure prevention and early intervention.

Targeted Support for Priority Groups

4. To improve awareness of the impact of household functioning breakdowns by addressing risk factors such as mental health of parents, substance misuse, and conflict at home (including the impacts of domestic abuse) on CYP mental health, self-harm, and suicide.
5. To ensure support and clear pathways for CYP with existing mental health including transition from child mental health services to adult services.
6. To ensure children and young people at risk are considered as part of contextual safeguarding

Bereavement Support

7. To ensure timely information and support is provided to parents, carers, families and education settings following bereavement.
8. To ensure there is timely information sharing and support for staff working with pupil mental health issues, and for staff and pupils following bereavement.

Policy

9. To provide assurance that current national policies and guidance are being implemented locally.
10. To ensure the findings and recommendations from this review are included within local self-harm and suicide prevention strategies and action plans.
11. To provide assurance that schools have implemented effective anti-bullying and self-harm policies.

Improving Data & Evidence

12. Improving data and evidence to ensure that effective, evidence-informed and timely interventions are developed and adapted.
13. To review and develop policies on information sharing and escalation.
14. To assess the available data related to mental health conditions, self-harm, suicidal thoughts, deprivation, drug use, sleep issues, and prevalence of other factors identified in this review.
15. To carry out a Health Needs Assessment in CYP pan-Lancashire.

The areas highlighted require a systematic approach given some of the findings and recommendations which cut across various areas such as prevention, early intervention, education, management, and NHS treatment/specialist services.

Next steps

We are to consider the recommendations with key partners and stakeholders in order to understand the current situation and inform the development of an action plan so key partners take ownership of their appropriate areas. Scoping has been undertaken to assess the current situation with regards to the priority areas identified. This has identified some positive areas of work as well as some areas for further development which will inform the next steps and action plan. The action plan will inform the wider suicide and self-harm prevention strategies and plans across Lancashire.

Local response to NCMD publications

The National Child Mortality Database (NCMD) is a national data collection and analysis system which records comprehensive and standardised data for England, on the circumstances of children's deaths. The purpose of collating information nationally is to ensure learning from deaths is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die. Data from the pan-Lancashire CDOP panel is fed into the NCMD via the eCDOP system.

During 2023/24 NCMD have produced a number of publications which pan-Lancashire CDOP has responded to through direct action and distribution of information and learning to relevant partners.

NCMD Guidance on Consanguinity was produced in January 2023 and sets out how CDR professionals and CDOPs should record information on consanguinity and close relative marriage, including modifiable factors. During 2023/24, pan-Lancashire CDOP has taken steps to implement this guidance, including improved pathways for gathering information related to any genetic testing undergone by affected families at local genomics services, and reference to the 'decision-making tool for determining modifiability' during panel reviews.

Deaths of children and young people due to traumatic incidents was released by NCMD in July 2023. The report and its recommendations have since been presented to each of the Children's Safeguarding Boards across Lancashire by the lead CDOP Paediatrician and Consultant in Public Health for each local authority area. In Blackburn with Darwen to further work has been undertaken map current activity in relation to traumatic incidents and develop a response to any gaps identified.

Infection-related deaths in children and young people was produced by NCMD in December 2023. The report has been presented to the three Health Protection Boards across Lancashire, alongside local data in relation to childhood infections. In Blackburn with Darwen and Blackpool this has prompted a further session across the system and with the 0-19s Healthy Child Programme service and the provider of immunisations in local schools to consider further opportunities to work together to promote uptake of childhood vaccinations.

Further work by the Continuous Learning and Improvement Group is planned for 24/25 to consider the impact of race and ethnicity on child deaths in Lancashire

following the publication of the following review, **Race and Ethnicity, Deprivation, and Infant Mortality in England**, based on NCMD data.

Pan-Lancashire CDOP will continue to review forthcoming NCMD publications, particularly those relevant to trends seen in child deaths locally.

Reducing the risk of sudden unexpected death in infancy

Over the years, there has been a significant reduction of sudden unexpected death in infancy (SIDS) deaths, largely due to an increase in evidence-based knowledge and practice. The Office for National Statistics (ONS) states that although the number of SIDS deaths have followed a general pattern of decline since records began in 2004, the rate has remained stable overall since 2014 . Unsafe sleeping arrangements are a feature in the majority of SIDS deaths across pan-Lancashire.

In 2022, the National Child Mortality Database (NCMD) published their fourth thematic report, Sudden and Unexpected Deaths in Infancy and Childhood . There was a strong link between sudden, unexpected infant deaths and sleeping arrangements. Modifiable factors were identified by CDOPs in 87% of the reviews. The most common modifiable factors reported were unsafe sleeping arrangements, smoking in pregnancy or in the household and alcohol or substance use by a parent or carer.

Key learning from points from Child Safeguarding Practice Reviews (CSPR) include:

- Read assessments in full when they are received and ensure that you do not summarise outcomes and recommendations using simplistic language which may mean that important points are lost when discussing the case with others.
- Commence placement planning early and as soon as possible where planned assessments are taking place.
- Ensure that risk assessments are completed and updated when there are any changes.
- If co-sleeping is identified as an issue in a case where the placement is to be a mother and baby placement, ensure that everybody knows of the risk.
- There should be a document which outlines how the risk is being managed and what steps should be taken by the foster carers in the placement if co-sleeping is observed or suspected.
- Identify as soon as practicable when a member of staff is due to leave and ensure that there is a transition period and handover in place so that cases can move from one practitioner to another. Cases should not be left without an allocated worker.

Assurance is being monitored through the Performance, Assurance, and Impact (PAI) subgroup .

TRAINING & EDUCATION

SUDC UK

SUDC is the Sudden and Unexpected Death of a Child aged 1-18 where the cause of death remains unexplained despite a thorough investigation. There is limited awareness across health and other professionals, and limited research to understand SUDC. Currently no-one can predict or prevent these deaths that devastate families.

SUDC UK (www.sudc.org.uk) has set up a team who have structured a learning and awareness session aimed at professionals who could interact with a suddenly bereaved family; is involved in a child death review; or is interested in sudden death research. The team is made up of Nikki Speed (CEO SUDC UK); Joanne Birch (Lead NHS SUDC Nurse for Lancashire); and Brian Topping (a bereaved grandfather) and the sessions are delivered remotely throughout Lancashire.

These sessions cover topics such as:

- The epidemiology, research and the challenges and opportunities related to SUDC.
- The relevant guidelines, national reports, recent events, and national recommendations for SUDC.
- A family's story.
- How to access national and local resources.

The sessions are important as they are designed not only to inform but also inspire professionals to deal appropriately and sensitively with bereaved parents and wider family members. In raising awareness, there is an inherent agenda to heighten the need for excellent data collection through child death review and more research. Only here can a path be established to save lives through the prevention of SUDC. These positive sessions have been delivered to a variety of audiences across Lancashire including:

- CDOP
- Paediatric hospital staff including consultants
- A&E staff
- Grand Round at teaching hospitals
- Bereavement Nurses
- Coroner's Office

Plans are in place to deliver to other groups, namely: Police; NWAS; PCNs and GPs; Safeguarding teams; and Community groups (e.g., Family Hubs). Lancashire is held in highest regard across the country regarding its approach and support to families who are experiencing a SUDC tragedy. This learning and awareness work also has a wider aim to capture a comprehensive model of engagement and how each group can be influenced.

Next Steps

This model will be of help to other health authorities around the country and has helped launch SUDC UK's new 'EVERY' campaign with the support of NHS England's CYP team. At meeting on 1st August 2024, Joanne Birch will join SUDC UK, NCMD and the Designated Doctor for Child Death from Oxfordshire to ask leaders of Integrated Care Boards to sign and pledge that they will implement professional training on SUDC and effective key worker resource by the end of 2025.

"The SUDC Team was an amazing support; Jo was our voice in a time of crisis and supported me. It was so hard, I got PTSD, but Jo was here for me throughout, because of her involvement we have gone on to discover that two of our children don't have the mutation."

Learning from Child Deaths Study Day

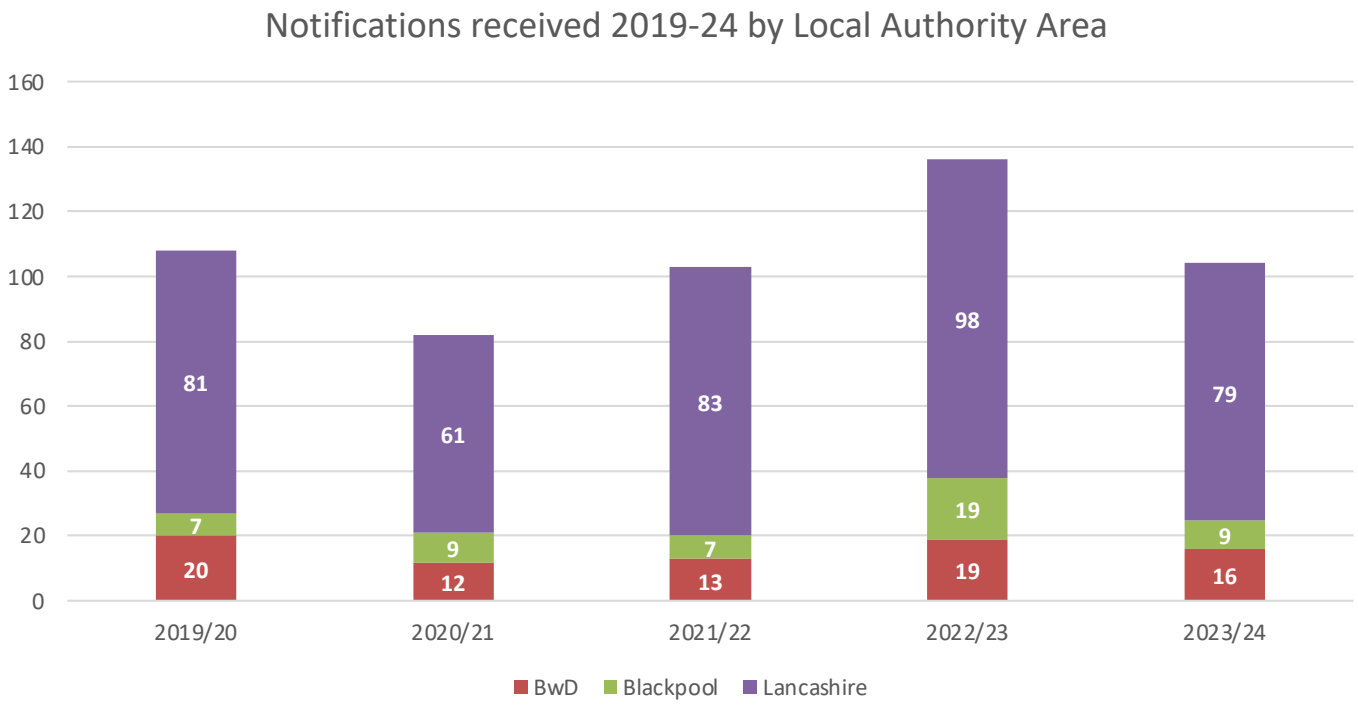
Our designated doctor for child death and the lead SUDC nurse delivered two separate presentations at a Learning from Child Death study day covering the role of the SUDC nurse and the child death review process. The event was hosted by the Senior Coroner for Lancashire & Blackburn and Darwen and was designed for healthcare workers interested in understanding the learning processes around child deaths.

DATA ANALYSIS

Deaths that occurred between 1 April 2023 and 31 March 2024
This section of the report focuses on the number of deaths and provides analysis on the demographics of children who died between 1 April 2023 and 31 March 2024 compared to the previous year. The data presented here represents the child deaths that were notified to the pan-Lancashire CDOP for review.

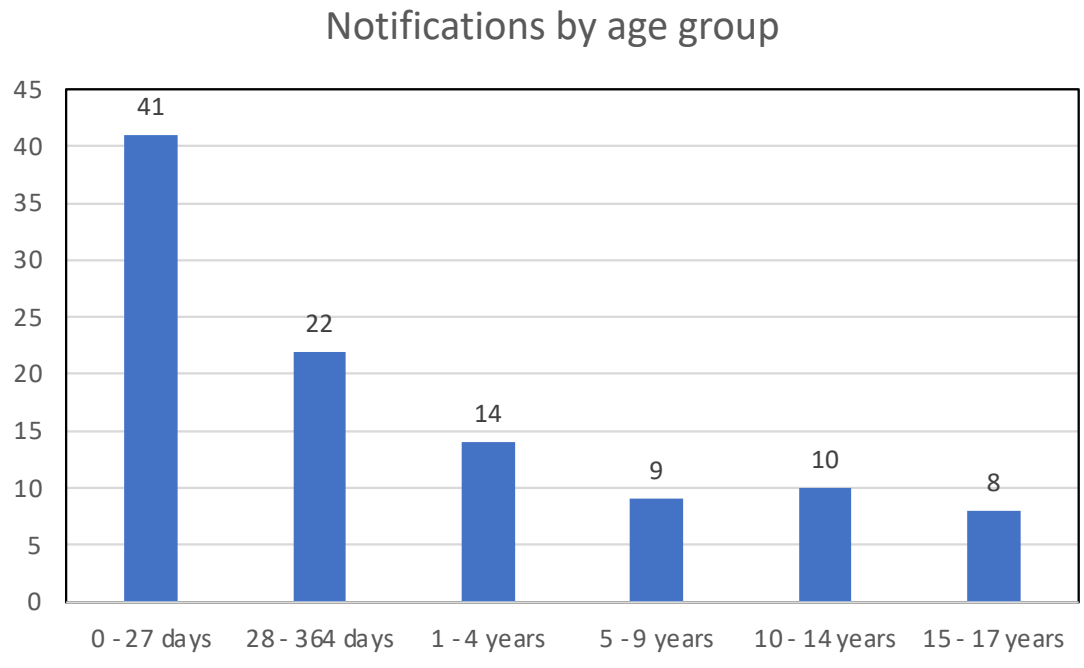
The number of death notifications
Between 1 April 2023 and 31 March 2024 the Blackburn with Darwen, Blackpool and Lancashire CDOP were notified of 104 child deaths (16 Blackburn with Darwen residents, 9 Blackpool residents and 79 Lancashire residents) that were in line with Working Together 2023. This represents a decrease of 32 deaths, compared to the previous year when we received 136 notifications. The figure is similar to 2021/22 when we received 103 notifications and lower than numbers pre-pandemic.

An additional 20 notifications were received for children who were not normally resident in Lancashire. These notifications were passed on to the respective CDOP.

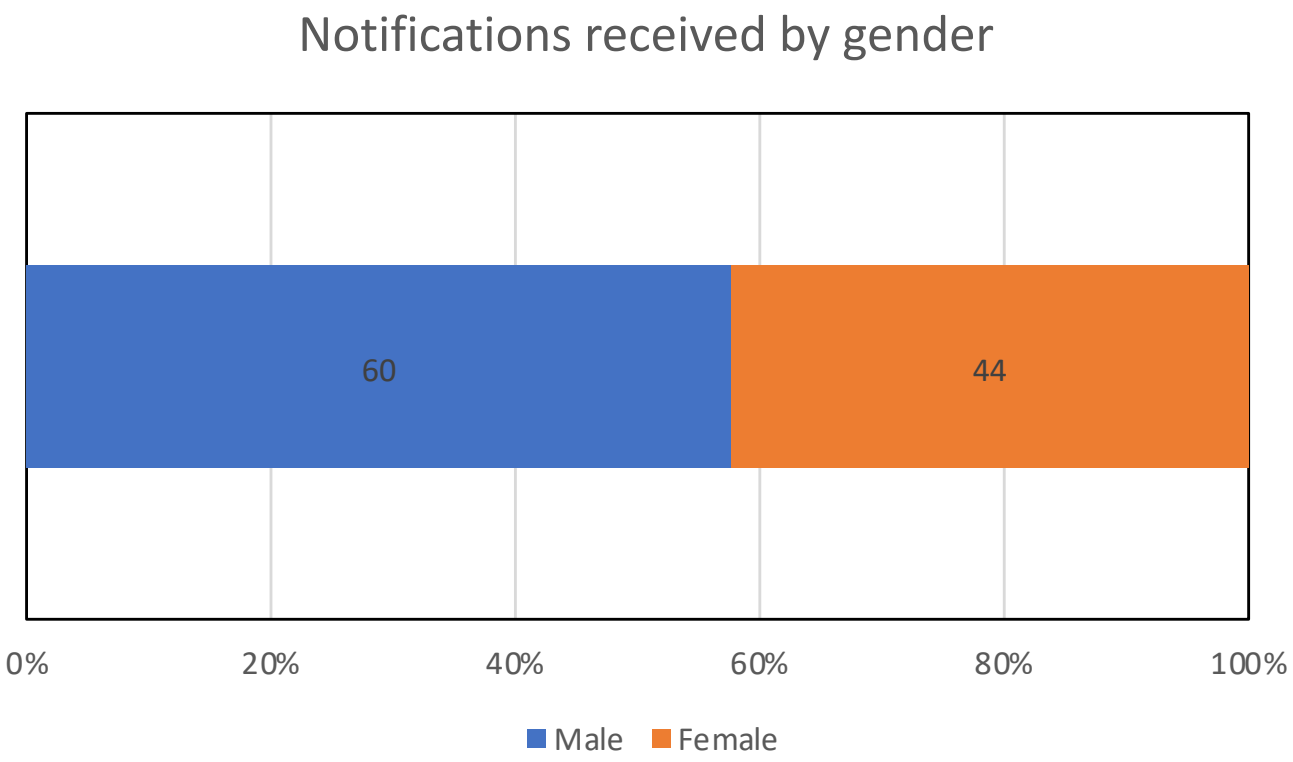


Death notifications by age group and gender

Out of the 104 pan-Lancashire notifications received during 2023/24, 63 (60.5%) were infants under one year old. Of these, (65%) occurred within the first 27 days of life. The following figure shows the age distribution of deaths, highlighting that the largest proportion occurred in the 0-27 days age group.



The following figure shows the split between male 60 (58%) and female 44 (42%) deaths in the year.



Deaths reviewed between 1 April 2023 and 31 March 2024

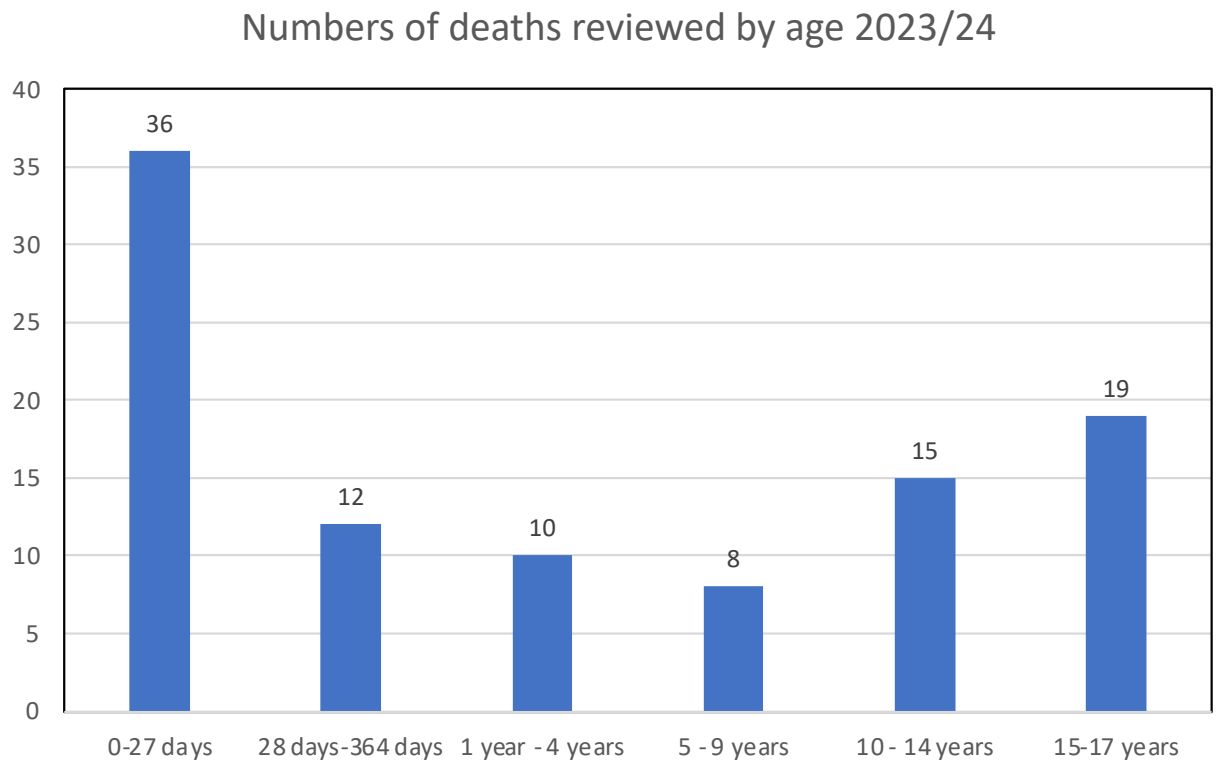
This section of the report presents the number of child death reviews completed by the pan-Lancashire CDOP between 1 April 2023 and 31 March 2024. It is important to note that the CDOP review of the child death may not be completed in the same year as when the death occurred.

In 2023/24, pan-Lancashire CDOP reviewed 101 child deaths (13 Blackburn with Darwen (BwD) residents, 14 Blackpool residents, 74 Lancashire residents). Of these, 10% (n=10) of cases were children who died between 1 April 2023 and 31 March 2024, and 90% (n=91) of cases were children who died during previous years.

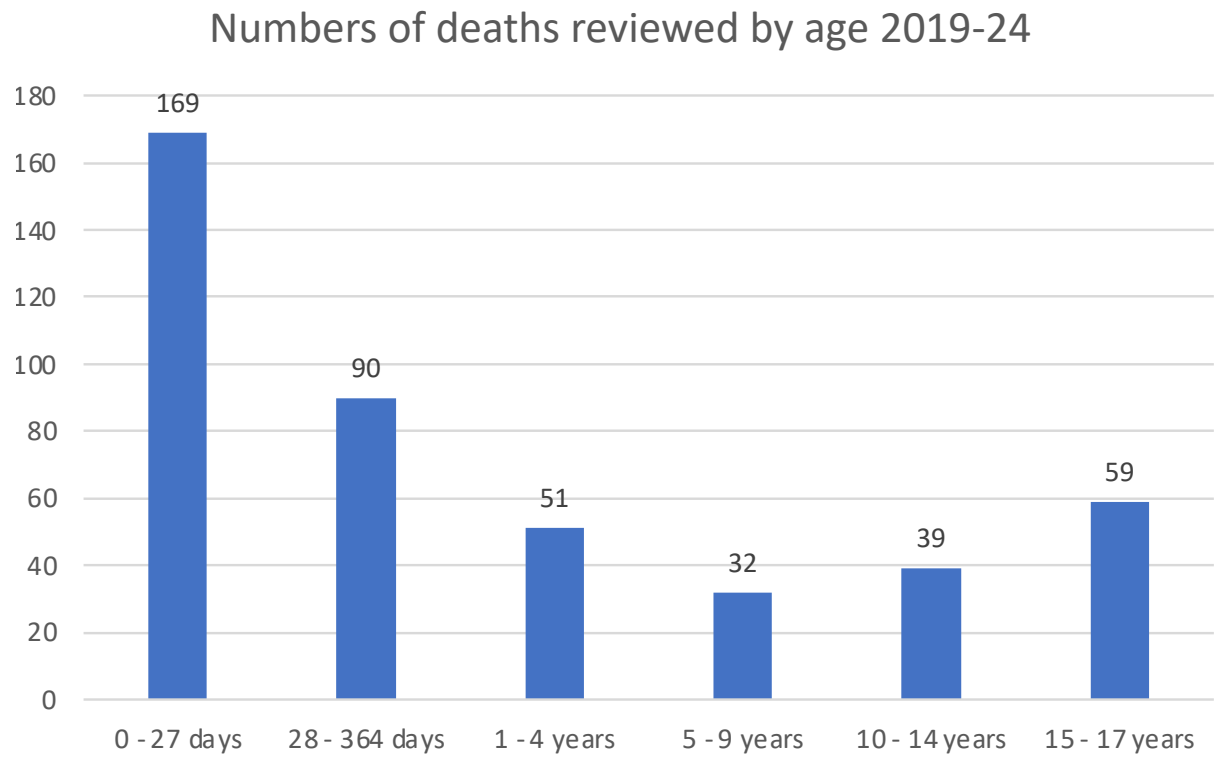
Local Authority Area	Cases
Blackburn with Darwen	13
Blackpool	14
Lancashire	74
Total	**101**

Reviewed Deaths by Age

By far the largest number of deaths (47.5%) of deaths occur in the under 1 age groups. This pattern follows the national pattern and follows a similar pattern to those deaths that occurred during the year.

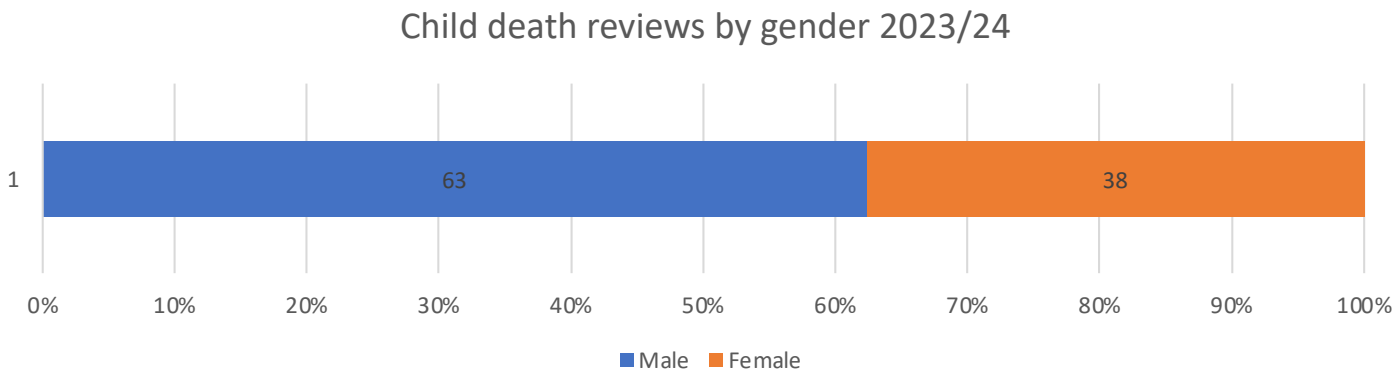


One can see that the pattern of deaths is similar over a longer timescale.



Deaths Reviewed by Gender

In 2023/24 there was a higher proportion of reviewed deaths in males 63 (62%) compared to females 38 (38%) which is similar to the national data, where this is also evident. In 2022/23 the proportion of reviewed deaths in males was (60%) compared to females (40%).



Reviewed Deaths by Category

The most common category of death across pan-Lancashire for cases reviewed during 2023/24 was perinatal/neonatal event (27%) with chromosomal, genetic and congenital anomalies accounting for the second most common category (26%). This correlates to the higher numbers of deaths occurring in children under one. This is consistent with England and Wales where perinatal and congenital causes are the most common, especially in neonates.

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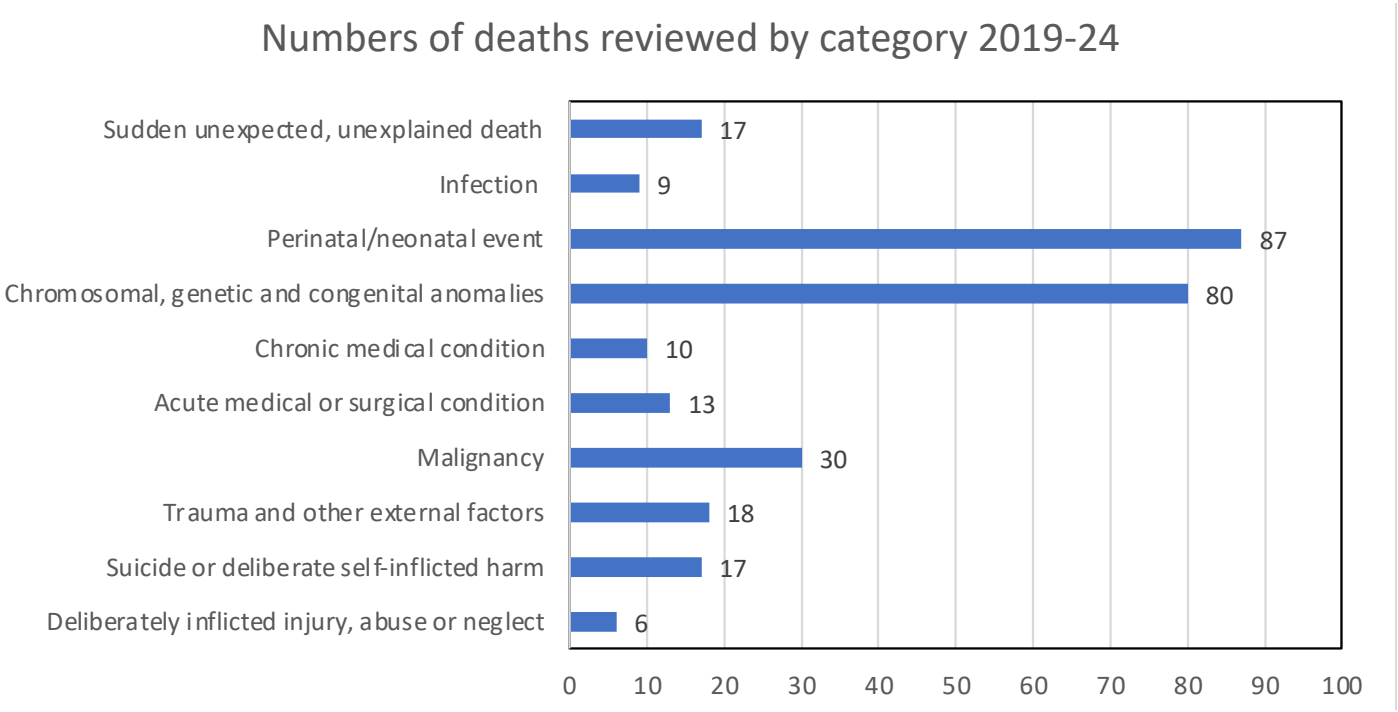
For comparison the following figures show the incidence of various categories over the year, and the similar pattern seen in the four years preceding it. One can see a very similar pattern between these years and the year contained within this report.



Location of death

Based on the child deaths reviewed in 2023/24, the table below highlights that the majority (72.3%) of children died within a hospital setting.

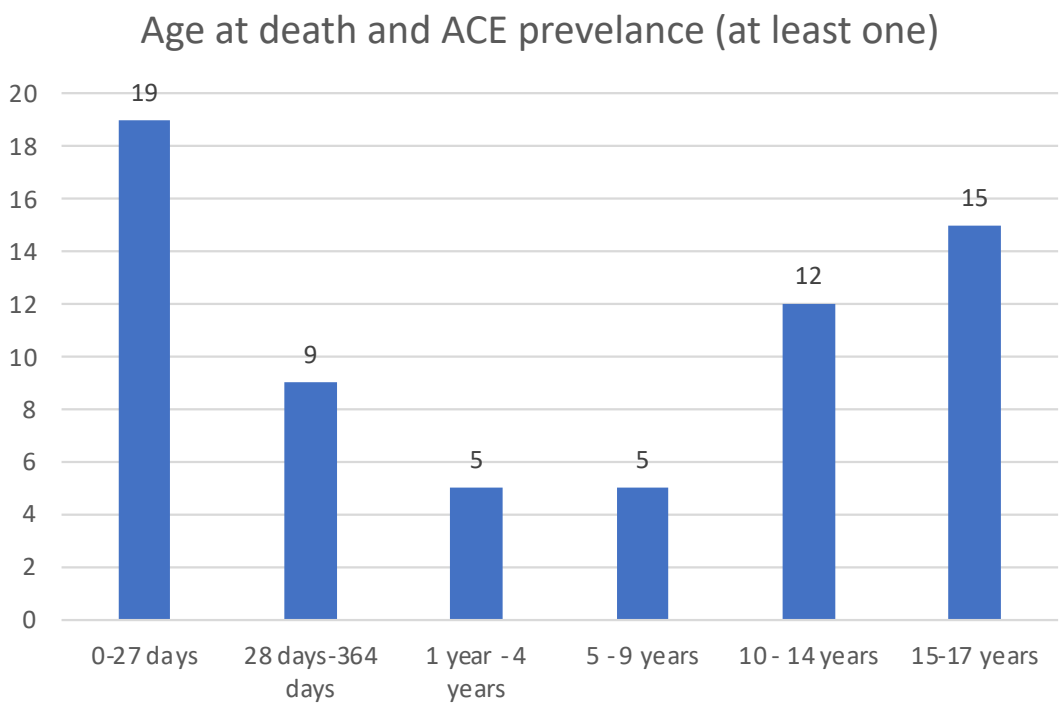
Location of death	Lancashire	BwD	B'pool
Acute Hospital-Emergency Department	16	<5	<5
Acute Hospital-Neonatal Unit	13	<5	<5
Acute Hospital-other	16	<5	<5
Acute Hospital-Paediatric Intensive Care Unit	7	<5	<5
Acute Hospital-Paediatric Ward	<5	<5	<5
Home or other private residence	13	<5	<5
Public Place	<5	<5	0
Hospice	<5	0	0
Abroad	<5	0	<5

Adverse Childhood Experience (ACE)

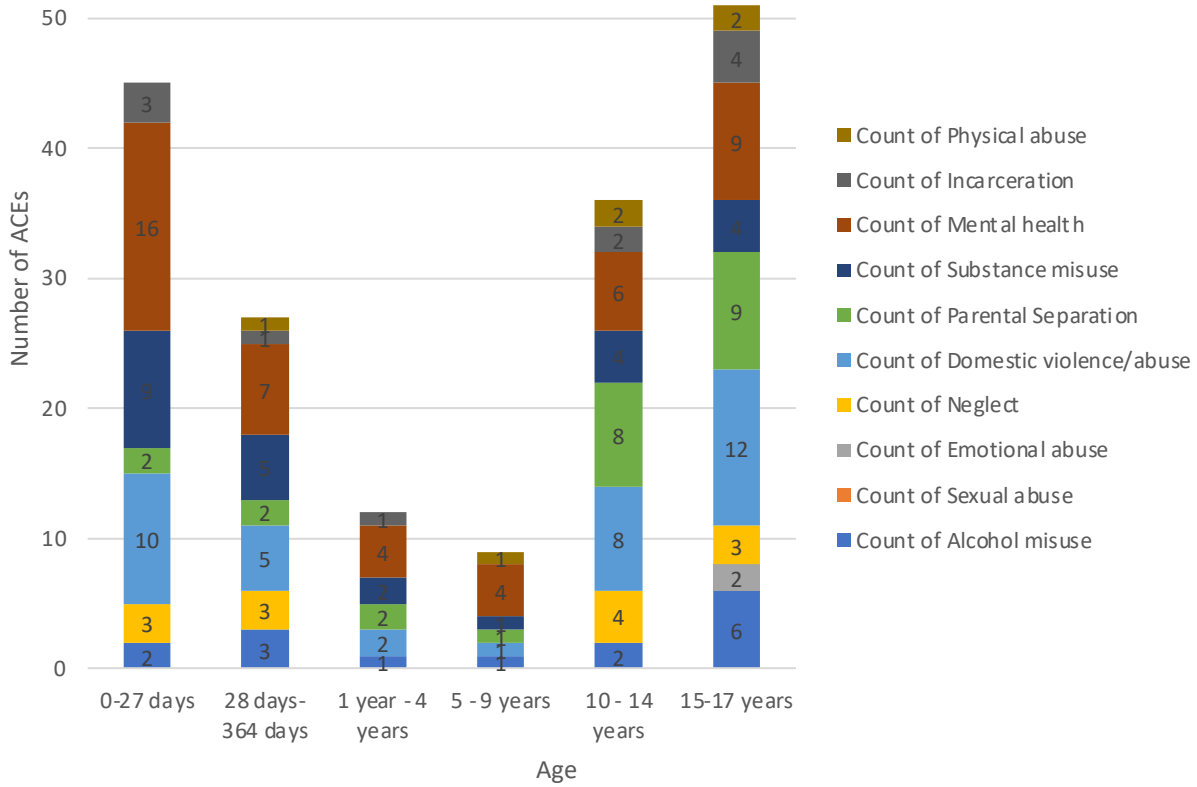
Adverse Childhood Experiences (ACEs) describe a wide range of stressful or traumatic experiences that may occur as a child is growing up. They can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust or bodily integrity .

Since August 2018, the pan-Lancashire CDOP has been collecting information on the occurrence of ACEs within the parents/carers/ caring environment of the child, in all deaths reviewed by the panel, including unborn babies.

Of the 101 cases reviewed by the pan-Lancashire CDOP, 65 cases (64%) had one or more ACE.



The figure below shows those ACEs occurring in the deaths reviewed 2023/24. The most common ACEs in pan-Lancashire include (in order of occurrences):



The most common ACEs identified in each local authority area include (in order of occurrences):

- Blackburn with Darwen domestic abuse, mental health, and neglect
- Blackpool mental health, domestic abuse, and substance misuse
- Lancashire mental health, domestic abuse and parental separation

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, 2023).

As shown in the table below, during 2023/24, (55%) of cases reviewed across pan-Lancashire identified one or more modifiable factors, which is slightly higher compared to previous reporting years. Nationally, this figure is much lower at (43%).

There has been an increase in the number of cases with modifiable factors across England. In 2022/23 39% of cases had one or more modifiable factors, in 2023/24 43% of cases reviewed had one or more modifiable factors identified.

	Expected Deaths		Unexpected Deaths	
Local Authority	**Modifiable Factors**	**No Modifiable Factors**	**Modifiable Factors**	**No Modifiable Factors**
Blackburn with Darwen	**0**	**7**	**<5**	**<5**
Blackpool	**<5**	**<5**	**9**	**<5**
Lancashire	**16**	**21**	**26**	**12**
Pan-Lancashire	**17**	**30**	**39**	**15**
% of cases with modifiable factors (CDOP)			**% of cases with modifiable factors (England)**	
55%			**43%**	

% of cases where modifiable factors were identified by LA area

Age group	Completed Reviews	Cases where modifiable factors identified
0 - 27 days	35	22
28 - 364 days	13	8
1 - 4 years	10	<5
5 - 9 years	8	<5
10 - 14 years	15	11
15 - 17 years	20	11

% of cases where modifiable factors were identified by age group

Deaths Reviewed by IMD

Looking at deaths by age broken down by Indices of Multiple Deprivation quintiles, where 1 represents areas within the 20 % highest deprivation quintile, and 5 the lowest, it can be seen that 50% or more deaths occur within the 20% most deprived communities.

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Using the same data, but presenting in a different way, one can see that over half of all deaths occur in families within the 20% most deprived areas.

Tables removed to maintain confidentiality.

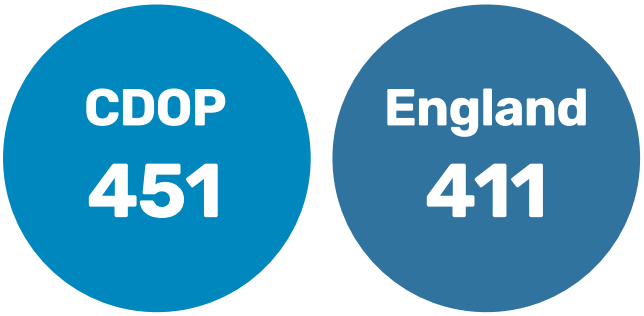
Reviewed Deaths by Ethnicity

The figure below illustrates the distribution of reviewed deaths by ethnicity and category. It highlights that the largest non-white group is Asian or Asian British – Pakistani, with genetic, chromosomal, or congenital abnormalities being the predominant cause of death in this group. Further investigation into ethnicity and childhood mortality is necessary and will be a key focus in the upcoming planning year (2024/25).

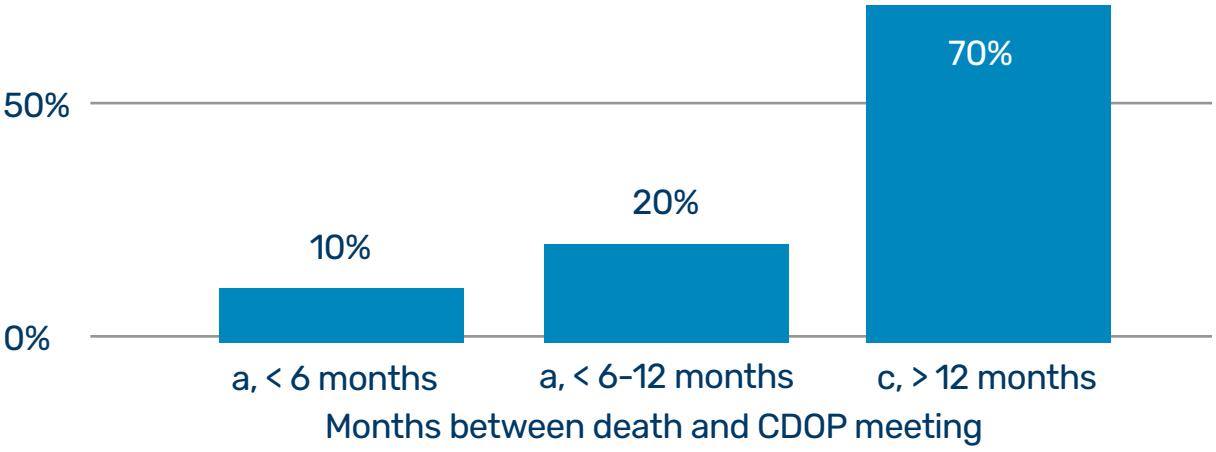
Tables removed to maintain confidentiality.

Length of time to review

Median number of days between death and CDOP meeting

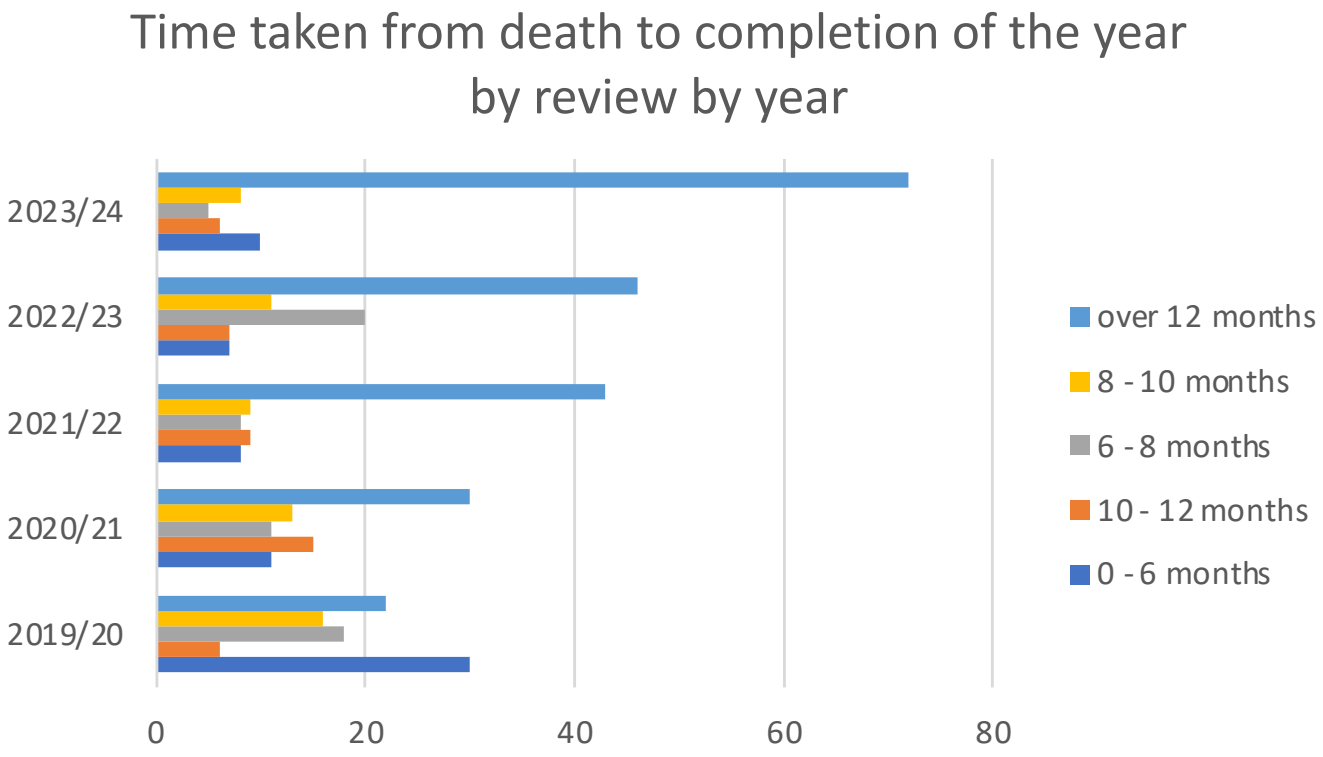


% of CDOP completed cases by the time taken



Of the 101 reviews completed by the pan-Lancashire CDOP, (10%) of the reviews were finalised within 6 months of the child's death, while (20%) were finalised within 12 months of the child's death.

The time taken for child deaths to come to panel has been increasing due to several factors, including delays in receiving the final post-mortem report, ongoing criminal investigations, or Child Safeguarding Practice Reviews (CSPR), and waiting for the final report from the local child death review meeting. A significant factor is the national shortage of forensically trained paediatric pathologists across England, leading to delays of up to 9 months for post-mortem reports. This shortage may partly explain why more cases are taking over 12 months to review. CDOP is working with partners to streamline the process and reduce the current delays improving the overall efficiency and effectiveness of the review process.



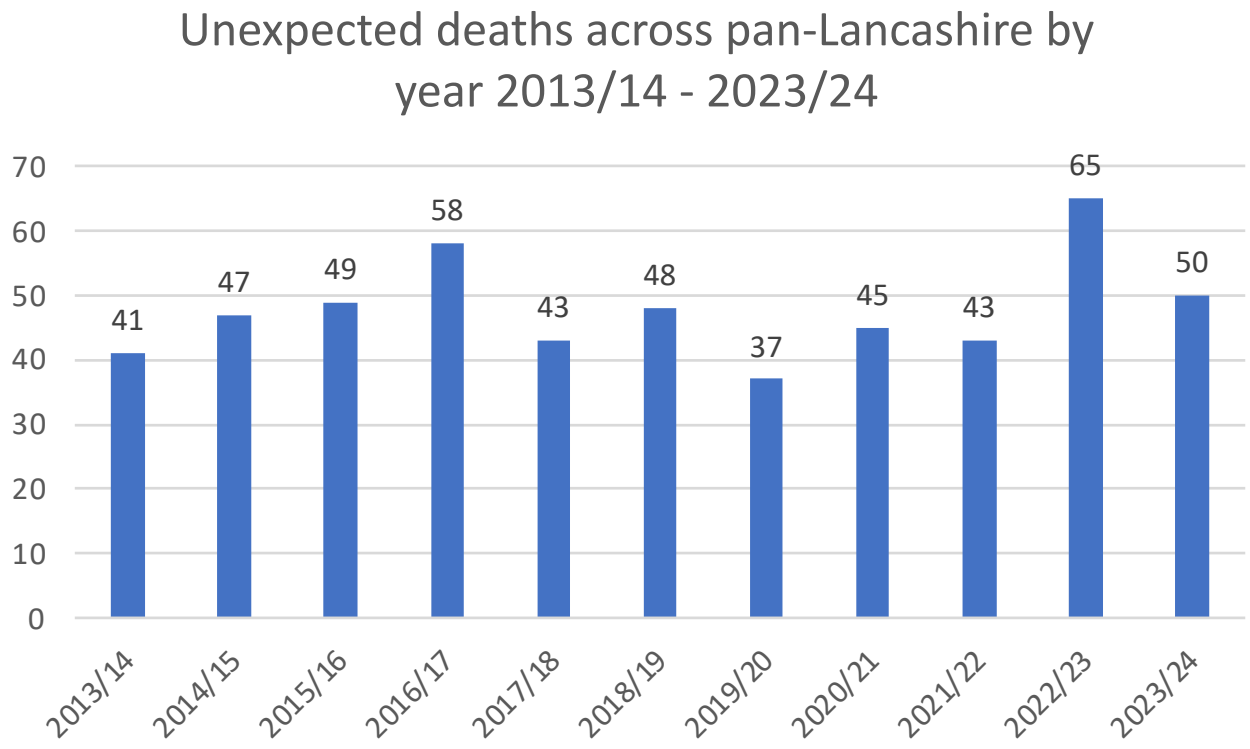
Joint Agency Responses 1 April 2023 and 31 March 2024

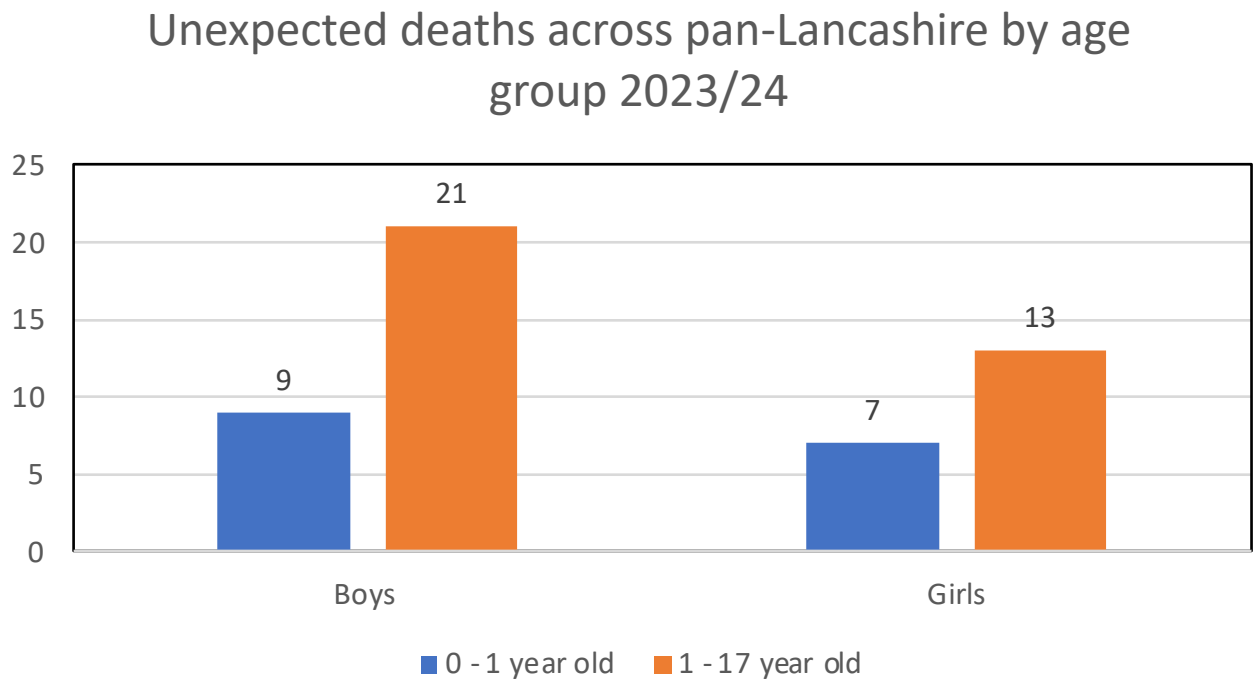
A joint agency response (JAR) is a coordinated multi-agency response for investigating and reviewing all sudden and unexpected child deaths. Across pan-Lancashire we have a Nurse-led SUDC Service. As of 29th January 2024, the service resumed a 7-day service, this has ensured a health response from the outset and the family have received the immediate support required.

There have been 50 unexpected deaths between 1 April 2023 and 31 March 2024. This is 15 fewer deaths than the previous reporting year and is more in line with the number of unexpected child deaths seen in previous years.

In 2023/24 a JAR was required in almost half (48%, 50/104) of all deaths.

There have been more deaths of boys in both the 0–1-year-olds and the 1–17-year-olds. This is consistent with previous years and in line with national figures. It is noted that there is usually there is a more of an equal split between boys and girls in the older age group. This year the gap between boys and girls is smaller in the <1 and larger in the older age group. One reason for this may be the increase in numbers of deaths that appear accidental in nature. Since April 2023 there have been 11 deaths in total that may be regarded accidental deaths (7 boys and 4 girls). Generally, the SUDC service would respond to between 4-7 accidental deaths per year, 11 is the highest number recorded since the service began. 8 of the 11 accidental deaths were road traffic/ vehicle related. All these incidents occurred in quite different scenarios and there do not appear to be any themes between them.





Out of the 50 unexpected child deaths since April 2023, 30 were known to CSC (before death, or opened at the time of death due to concerns); 20 were known previously or open to mental health services (parents); 15 cases had experienced domestic abuse issues; 10 parents admitted to drinking alcohol, taking substances or prescribed/un-prescribed medication prior to their child's death; 4 young people drank alcohol or took illicit substances prior to death. 8 young people were either known or previously known to mental health services prior to their death.

UPDATE ON CDOP PRIORITIES 2023/24

CDOP Priorities for 2023/24	Evidence	Progress
Ensure that the SUDC prevention is integral to relevant PH strategies across Lancashire.	Thematic review completed, support to deliver on the action plans will be overseen by the various boards and in particular the L&SC CYP Transformation and Delivery board.	
Highlight risks and issues identified through child death reviews and provide intelligence for inter-agency partnerships	Reports at quarterly intervals are shared with the local CSAPs and other key stakeholders. CDOP produces an annual report.	
To seek assurance that bereavement support services are readily available to children, young people, families, and communities across pan-Lancashire.	Consideration of family trauma and support for families to be explored further with bereavement nurses within trusts. The CLIG group will maintain oversight and is a priority on the workplan.	
Audit the safer sleep/ICON campaign and ensure the current materials and safer sleep guidelines are in line with evidence-based research.	The group recently undertook an audit to ensure compliance and identify any gaps. The pan-Lancashire guidance has been updated and is now in line with the national guidance.	
Raise the profile of CDOP and the Child Death Review processes, by delivering multiagency training across the system.	Virtual training has been provided and there are plans to provide targeted training to specific audiences. The Lead SUDC Nurse continues to provide training of the management of an unexpected child death and the JAR process.	
Reduce the variability of reporting forms and routinely missing information e.g., male partners, ethnicity.	CLIG has introduced a two-year cycle of audit activity, the first audit is underway to identify gaps in information of the notification form. CDOP is focussing on improving some key data fields to reach 100% completeness, a reminder has been issued to partners and is monitored through the business group.	
To undertake a thematic review of category 2 deaths, pan-Lancashire (including deaths due to suicide or deliberate self-inflicted harm).	A review was undertaken. The recommendations will form part of an action plan which will inform the wider suicide and self-harm prevention strategies and plans across Lancashire.	

CDOP PRIORITIES FOR 2024/25

1. Improve the quality and outputs of the child death review processes.
2. Support Local Thematic Reviews.
3. Ensure that the reduction of infant/child death forms part of multi-agency strategies.
4. Raise the profile of CDOP and the Child Death Review processes, by delivering multiagency training across the system.
5. Improve the quality and outputs of Child Death Review Meetings (CDRMs).
6. Reduce the impact of Vicarious Trauma.
7. To seek assurance that bereavement support services are readily available to children, young people, families, and communities across pan-Lancashire.
8. Support the work of the SUDC Prevention Group.
9. Highlight risks and issues identified through child death reviews and provide intelligence for inter-agency partnerships.
10. To undertake a focussed review of deaths by ethnicity

Recommendations
Strategic Partners to note the content of the annual report and promote the findings.

Next Steps
Take ownership of these findings, share them with relevant forums, and ensure that local strategies are underpinned by these, and other core intelligence.

Abbreviations

CDOP	Child Death Overview Panel
CDR	Child Death Review
CDRM	Child Death Review Meeting
CLIG	Continuous Learning & Improvement Group
CSPR	Child Safeguarding Practice Review
ICB	Integrated Care Board
JAR	Joint Agency Response
NCMD	National Child Mortality Database
NHS	National Health Service
ONS	Office for National Statistics
PMRT	Perinatal Mortality Review Tool
SIDS	Sudden Infant Death Syndrome
SUDC	Sudden Unexpected Death in Childhood

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Links to additional information:

The Management of Sudden and Unexpected Deaths in Childhood (SUDC)*
Blackburn with Darwen, Blackpool & Lancashire Guidelines sudden_death.pdf
(proceduresonline.com)

Children's Safeguarding Assurance Partnership Children's Safeguarding Assurance Partnership - Safeguarding information, advice & guidance
lancashiresafeguardingpartnership.org.uk

Child Death Overview Panel

CDOP

Blackburn with Darwen, Blackpool & Lancashire

NHS

Blackburn with Darwen Borough Council

Blackpool Council

Lancashire County Council