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# BLACKBURN WITH DARWEN, BLACKPOOL & LANCASHIRE CHILD DEATH OVERVIEW PANEL

## Annual Report 2019-20

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# Contents

Foreword by the Independent Chair ..... 3
Part 1 - CDOP Business Update ..... 4
Introduction ..... 4
Members & Attendance ..... 4
CDOP Priorities for 2019/20 Update ..... 5
Annual Report Recommendation Update 2019/20 ..... 6
CDOP Reporting Arrangements ..... 6
CDOP Key Successes 2019/20 ..... 6
CDOP Sub group updates ..... 7
CDOP Priorities for 2020/21 ..... 12
Part 2 - Data Analysis ..... 13
Summary of the cases notified to panel between April 2019 and March 2020 ..... 13
Completed CDOP reviews by ethnic group and age group ..... 13
Completed CDOP reviews by primary category of death ..... 14
Modifiable factors ..... 14
Category of death and modifiable factors ..... 15
Recommendations ..... 17
Appendix 1: National Child Mortality Database Monitoring Report ..... 18
Appendix 2: Department of Health & Social Care category of death descriptions ..... 19
Appendix 3: Recognised Adverse Childhood Experiences (ACEs) and definition ..... 20

## Foreword by the Independent Chair

This is my fourth report as Independent Chair for the Blackburn with Darwen, Blackpool and Lancashire CDOP. The report follows implementation of new Safeguarding and Child Death Review (CDR) processes, and the first year in which the National Child Mortality Database (NCMD) has reported on its first set of data which the CDOP has contributed to. The NCMD report features as a main part of this annual report to minimize duplication.

This is the first year of a new relationship between CDOP and the Statutory Partners of Child Deaths Review processes (Clinical Commissioning Groups and Local Authorities) which is outlined within a Memorandum of Understanding to clarify the expectations of each. As Chair, I will continue to ensure that CDOP not only reviews deaths of children, but provides oversight and assurance of the child death review processes, and highlight any issues that may need to be resolved.

At the time of writing, Covid-19 is having a severe impact into all walks of life, and it is unclear what the impact will be on child deaths and the CDR processes. What we do know, is that the efforts of all CDOPs in England, have been instrumental in providing timely notifications to the centre (NCDM), which has resulted in changes to government policy.

The report aims to not only reflect the cases the panel has considered throughout 2019/20, but also the achievements of the partnership, and the future priorities for action.

I would like to thank all the Panel members, for their continued commitment and hard work, and in particular, to Rachel Rimmer, Becky Gill and Victoria Gibson for the hard work that goes on behind the scenes to ensure that the Panel runs smoothly, and keeps pace with the changing landscape.

Mike Leaf
Child Death Overview Panel Chair
Blackburn with Darwen, Blackpool & Lancashire

# Part 1 - CDOP Business Update

## Introduction

This is the twelfth annual report since the Child Death Overview Panels (CDOP) became statutory in April 2008. It is the eighth report as a pan-Lancashire Panel and the first year of a new relationship between CDOP and the Statutory Partners (Clinical Commissioning Groups and Local Authorities). CDOP 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 of Blackburn with Darwen (BwD) Council; Blackpool Council; and Lancashire County Council (LCC). It includes any infant death where a death certificate has been issued, irrespective of gestational age.

This report provides information on trends and patterns in child deaths reviewed:

- During the last reporting year (2019-20)
- Over the last five years (2015-20)
- Involving the Pan-Lancashire SUDC Service (2019-20)

It also makes overarching and individual recommendations to partners across the three local safeguarding areas based on the analysis.

## Members & Attendance

During 2019/20 the CDOP had representation from Lancashire Constabulary, the Sudden Unexpected Death in Childhood (SUDC) Service, Children's Social Care, the Children's Safeguarding Assurance Partnership, Community Health Services, Midwifery, Paediatrics, Clinical Commissioning Groups, Public Health, Education and Early Years, North West Ambulance Service and representation from the Learning Disabilities Mortality Review Programme (LeDeR).

In an attempt to ensure equal representation across the three areas a rota system has been utilised for case discussion meetings which aims to ensure:

1. All three areas are represented
2. All agencies are represented
3. It is equitable for all: number of meetings attended is based proportionately on number of child deaths per area

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

| **Business Meetings (6 meetings)** | | **Case Discussion Meetings (5 meetings)** | | **Neo-natal Review Meetings (4 meetings)** | |
|---|---|---|---|---|---|
| **Agency** | **Attendance** | **Agency** | **Attendance** | **Agency** | **Attendance** |
| Chair | 6 (100%) | Chair | 5 (100%) | Chair | 4 (100%) |
| LANCON | 5 (83%) | LANCON | 5 (100%) | LANCON | 4 (100%) |
| Children's Social Care | 5 (83%) | Children's Social Care | 5 (100%) | Children's Social Care | 4 (100%) |

| Public Health | 6 (100%) | Public Health | 5 (100%) | Public Health | 4 (100%) |
|---|---|---|---|---|---|
| Lead Nurse for SUDC | 6 (100%) | Named Nurse for Safeguarding | 4 (80%) | Named Nurse for Safeguarding | 3 (75%) |
| SUDC Prevention Chair | 6 (100%) | Named Midwife | 5 (100%) | Named Midwife | 4 (100%) |
| Paediatrician | 6 (100%) | Paediatrician | 5 (100%) | Paediatrician | 4 (100%) |
| CSAP Business Manager | 6 (100%) | SUDC Service | 5 (100%) | SUDC Service | 4 (100%) |
| CCGs | 6 (100%) | Education (School/ Early Years Rep) | 2 (40%) | Neonatal Specialist | No rep |
| LCFT | 6 (100%) | North West Ambulance Service | 3 (60%) | Virgin Care | NA |
| Virgin Care | 3 (50%) | Virgin Care | 1 (20%) | Observers | 5 |
| Observers | 4 | Observers | 10 | | |

100% of business meetings had all geographical representation, with a member from each area being in attendance at each meeting. Additionally, throughout the reporting year the panel has had 19 observers. Most of these observers attended the case discussion meetings with 5 observing the neonatal case discussion meetings. It should be noted that Virgin Care only started attending part-way through the reporting year which accounts for the low numbers.

## CDOP Priorities for 2019/20 Update

| CDOP Priority | RAG rating | Comments |
|---|---|---|
| Ensure the smooth transition into the 7-day SUDC service and oversee and monitor the updates to the SUDC Protocol. | | The SUDC seven-day nurse-led service commenced in January 2019; the team have recently completed their first year. The SUDC Protocol was completed in October 2019 and was due to launch in December 2019. The launch was delayed and the Protocol will now launch in June 2020. |
| To implement the recommendations from the reviews into trauma and infection | | A summary of the actions from the thematic review(s) are included in this report. A redacted version will be published on the board(s) website if agreed. Recommendations have been transferred to the recommendation log. |
| To undertake a suicide thematic review, including cases from South Cumbria and also make links into the Strategic Suicide Prevention Group. | | Recommendation rolled over to 2020/21. CDOP Chair to make a recommendation to the Suicide Prevention Oversight Group to undertake a suicide thematic review, including cases from South Cumbria. Several members of CDOP now sit on the Suicide Prevention Oversight Group so there is an established link. |
| Engagement with GPs | | CDOP Chair and CDOP Coordinator attended several GP Safeguarding Lead Forum & Training Sessions during March 2020. GPs have started completing the reporting |

| | | |
|---|---|---|
| | | proforma and this is being monitored by the business group. |
| To implement the recommendations from the ACE Audit | | A summary of the actions included in the body of this report. |
| BwD Death by Ethnicity | | Recommendation carried over to the recommendation log. If, following the review of the 2019/20 data, further analysis is required this will be picked up during 2020/21. |

## Annual Report Recommendation Update 2019/20

Local Safeguarding and health and wellbeing Partners are asked to:

- Ensure all professionals providing information to CDOP to ensure that forms are returned within the statutory three week deadline and are completed as fully as possible before they are submitted; 20% of cases reviewed during 2018/19 did not have the child's ethnicity recorded.
- Ensure that the CDR processes remain embedded in the new safeguarding arrangements until at least April 2020.

*CDOP continued to report to LSCB and CSAP. New reporting arrangements have been agreed with CSAP mainly on an exception basis, with quarterly meetings held between CSAP/CDOP Chairs to discuss issues.*

- Transfer the responsibility for CDR/CDOP to Health and Wellbeing Boards at some point after April 2020.

*Agreed arrangements with Directors of Public Health who will receive quarterly reports from CDOP through the PH Collaborative and relevant issues to be taken to Health and Wellbeing Boards by them.*

## CDOP Reporting Arrangements

The three local authorities have delegated the responsibility of the child death review arrangements to their respective Directors of Public Health (DsPH). The eight CCGs maintain accountability and have delegated the same responsibility to their Health Executive Group who will co-ordinate with NHS England.

The Pan-Lancashire CDOP will be accountable to the statutory partners and will report to each at appropriate intervals, and by exception. Relevant reports will go to statutory strategic partnerships including the Blackburn with Darwen, Blackpool & Lancashire Children’s Safeguarding Assurance Partnership (CSAP), Health and Wellbeing Boards and the Community Safety Partnership.

## CDOP Key Successes 2019/20

**Safer Sleep Campaign**

This year a vast amount of time and effort has been put into the Safer Sleep task and finish group to revise the Safer Sleep materials and consider hard to reach parents. The task and finish group were asked to consider the findings of two Children's Safeguarding Practice Reviews that involved the deaths of toddlers. This has led to a revision of materials to address guidance about the suitable sleeping environment up to the age of two years. The campaign work has also promoted the need for more professional curiosity and questioning when parents are being asked about where their child sleeps. Special thanks is given to all those who were involved in the various task and finish groups throughout the year.

**CDOP Development Day**

CDOP held a development day on January 27 2020. The day started with a presentation from Ruksana Sardar-Akram, Public Health Consultant, Lancashire County Council. Ruksana presented the Infant Mortality Strategic Plan and the group discussed how CDOP could support the multi-agency plan to reduce infant mortality. During the afternoon, there was a presentation from The Learning Disabilities Mortality Review (LeDeR) Programme. Members discussed the CDOP priorities for 2019/20 and some of the challenges CDOP have faced over the past twelve months transitioning to the new Child Death Review Process. Priorities for 2020/21 were considered.

**Positive Recognition**

In order to recognise and encourage good practice, or where agencies have gone above and beyond their expected duties, CDOP continue to send letters of good practice where good practice has been identified. Whilst it is the panel's responsibility to identify learning and trends from child deaths across pan-Lancashire, the panel feel it is important to recognise the excellent care that professionals provide for the children and families that they work with.

**Pharmacy Campaign**

CDOP took part in the pharmacy campaign during November 2019, for the second consecutive year. The campaign is driven by Public Health England North West on behalf of the Cumbria and Lancashire Public Health Collaborative. The campaign, which ran throughout November coincided with the Safer Sleep Christmas messages designed to warn parents of the dangers of falling asleep with baby after drinking alcohol.

**Water Safety Campaign**

Pan-Lancashire Child Death Overview Panel were heavily involved in supporting Lancashire Fire & Rescue and the Royal Life Saving Society promote drowning prevention week which took place in June 2019. CDOP engaged partners to raise awareness of the strategic risk and ask them to support Lancashire Fire & Rescue Service, the Royal Life Saving Society and Royal National Lifeboat Institution explore what could be achieved if a Pan-Lancashire Water Safety Partnership was established.

## CDOP Sub group updates

**SUDC Prevention Group**

The SUDC Prevention Group is coordinated by the pan-Lancashire CDOP and is funded by the CDOP budget (£15,000). The funding maintains the supply of safer sleep materials to agencies across Pan-Lancashire.

This year a vast amount of time and effort has been put into the Safer Sleep task and finish group to revise the Safer Sleep materials and consider hard to reach parents specifically looking at the impact of substance misuse on baby deaths. CDOP raised concerns that 1) current materials are not "hard hitting enough" to reach the parents of babies and toddlers that are most at risk 2) not all GP practices/ clinics and professionals were aware of materials and campaigns available. The campaign took some time to devise as a balance was required between safe co sleeping when parents chose and unsafe co sleeping when parents make unsound choices having taken drugs or drink alcohol. The task and finish group worked hard on publicity materials that have now been launched, link to materials here.

We have retained a balance of materials but have adapted messages to ensure that the campaign is effective and that the materials are appropriate, and will stand up to scrutiny from Public Health England and Pan-Lancashire CDOP. In addition the task and finish group was asked to consider the findings of 2 CSPRs that involved the deaths of toddlers. This has led to a revision of materials to address guidance about the suitable sleeping environment up to the age of two years. The campaign work has also promoted the need for more professional curiosity and questioning when parents are being asked about where their child sleeps.

Our membership has increased and we have good representation from Children's Social Care that had previously been a gap. We have representation from Dad's Net which is vital and one of our priorities for this year is to work with partners on making sure all fathers are included in all aspects of ante natal and post-natal care.

During 2019/20 the SUDC prevention group was heavily involved in the ICON: Babies Cry, You Can Cope! Campaign and have had some nationally recognised outcomes with regard to this. We are 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.

The 2019-20 reporting year saw the second Pharmacy Campaign on Safer Sleep and this autumn will see the third. Some Pharmacies have reported that they will continue to support the campaign throughout the year.

**Child Death Investigation Group**

Lancashire Constabulary continue to host the monthly multi-agency Child Death Investigation Group which aims to promote best investigative practice, identify areas for development and continue the established partnership working in this critical area. Membership consists of police detectives, SUDC Nurses, Crime Scene Investigation Managers, Children's Social Care, the CDOP management team as well as the North West Ambulance Service (NWAS) Safeguarding Team. This group functions as a vibrant and engaged forum that enables frontline practitioners to exchange professional views on recent cases, facilitating professional challenge where needed, ensuring that policy and process is fit for purpose, striving for consistently high standards of response across all agencies.

A particular focus (and benefit) of the group is its ability to provide rapid access to the detail of recent SUDC cases as well as the experiences of the professionals involved. This continues to provide a vital link to CDOP, improving the review process through the enrichment of relevant data. In addition, this access is channelled towards staff development, informing training requirements and seeking sustained improvements in service delivery.

The Child Death Investigation Group also hosts a preventative work stream, with members also now attending the CDOP Safer Sleep Task & Finish group. Again, the immediate access to current and recent cases ensures that the latter group is dealing with the most topical presentations of risk and threat for children in our communities.

The group’s most significant achievement of the last 12 months is the production and delivery of an innovative interactive training product for front-line uniformed police officers. This module equips officers with the skills to deal effectively with the initial phases of a SUDC incident and fills a gap in training provision with investigative training focused previously on the role of detectives. This training product is now being reviewed by the national police training review group and is being considered for widespread adoption across UK forces.

**SUDC Service**

The Sudden and Unexpected Deaths in Children (SUDC) Service, is a unique nurse-led service that has provided the health element of the Pan-Lancashire multi-agency Rapid Response process to a sudden and unexpected death of a child since September 2008. In line with statutory guidance (Child Death Review, Statutory and Operational Guidance 2018, HM Government) the SUDC Nurse fulfils the role of the Lead Health Professional. When a child dies unexpectedly a Joint Agency Response is triggered and the SUDC Nurse is responsible for coordinating the health response to that death.

**Provision of a 7-day SUDC Service**

The SUDC Service commenced a 7-day service delivery model in January 2019. This has led to improved equity in the responses undertaken. The service have recently completed their first full year. During this time, 52.7% of the cases have had a SUDC Nurse present, meaning a joint health and Police investigation from the outset. This enriches the SUDC investigation in an increased number of cases. 47.2% of the cases occurred out of hours. Despite the SUDC Nurse not being present at the hospital for these, the SUDC Nurse has picked the case up promptly the following morning. Therefore, parents and carers have received improved support from the beginning of the investigation and throughout the child death process.

**Joint Agency Responses**

The East of the county has had the most child deaths with 13. The East had 10 deaths in total from April-March last year. There are no obvious themes of deaths within the East other than <5 co-sleeping/unsafe sleeping environment deaths and <5 suspected suicide cases. The co-sleeping figures in the East are similar to previous years, however, the suicide deaths have increased in the East of the county. The last suicide prior to 2019-20 in the East was in 2017.

Child Deaths by area 2019-2020

**Table removed to maintain confidentiality.**

The total number of unexpected deaths in 2019-20 was 36.

The SUDC Service has recorded the lowest number of deaths in 2019-20, since the service began (apart from 2008 when the service began in September and the figures were recorded for a six month period only).

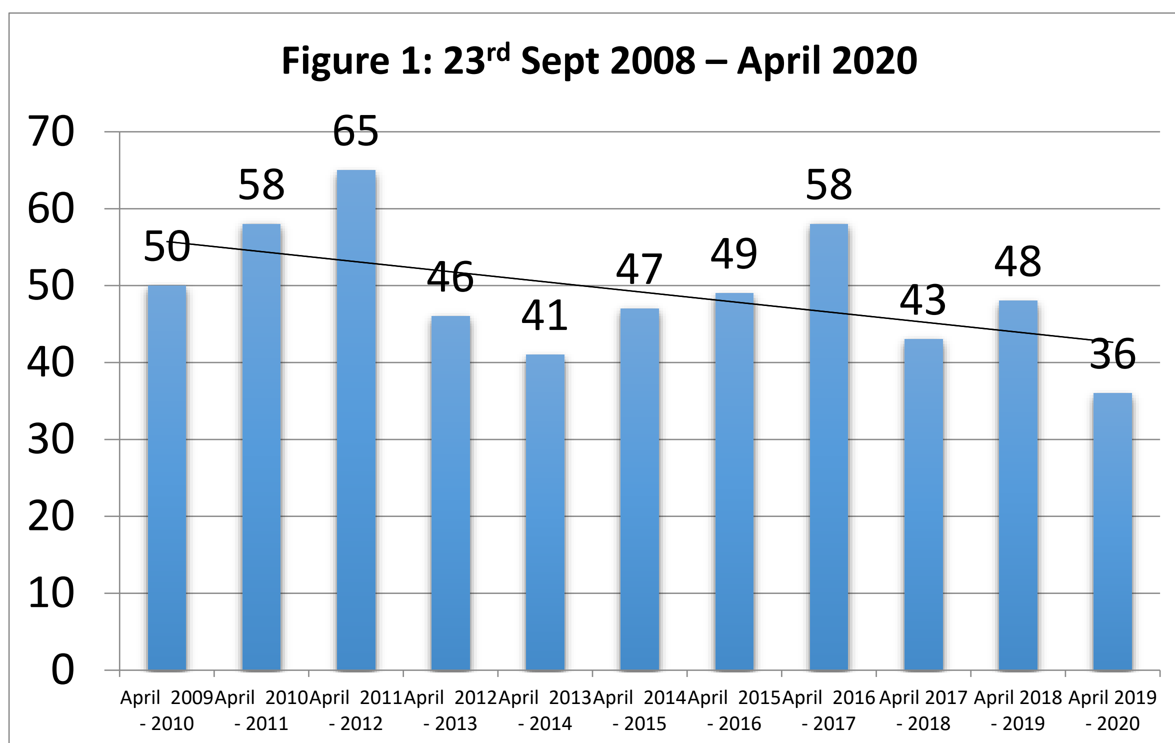


*Figure 1 Number of unexpected deaths since 2008*

**Themes**

Since April 2019 there have been 7 baby deaths where co-sleeping/inappropriate sleeping arrangements have been a feature. Alcohol and substance misuse has possibly been a contributory factor in some of these cases. The SUDC service has seen an increase in co-sleeping deaths in recent years. In 2018-19 there were 13 cases, so this year's figures of 7 show a significant and encouraging reduction.

Whether as a direct result of the increased work around safer sleep, or due to other more complex epidemiological/sociological factors, this decrease in co-sleeping figures is significant in terms of a reduction in infant deaths across Lancashire. Deaths of this nature will continue to be monitored alongside wider SUDC prevention strategies.

During 2019-20, <5 young people have ended their own lives.

**Figures removed to maintain confidentiality.**

In Lancashire and South Cumbria the ICS Suicide Prevention Logic Model has been developed to address short, intermediate and long term outcomes in order to reduce the number of suicides, the number that self-harm and to improve outcomes for those affected by suicide. The SUDC Nurses are involved in these preventative strategies.

During 2019-20 there was a slight increase in the number of children dying from medical related conditions, particularly those that have developed acute illnesses, such as gastrointestinal bleeds, asthma, allergies, infections and one child that died suddenly from an aneurysm. As the charts below show, there has been an increase from 27% in 2018-19 to 33.3% in 2019-20 (Figure 2) of children dying that were known to have complex health needs or underlying health conditions.

**Table removed to maintain confidentiality.**

Another possibility for the reduction in the overall numbers of deaths in 2019-20, may be that fewer 'unexpected but explained' deaths are being reported to the SUDC service. Examples of such deaths are neonatal cases and those children that die from meningitis/sepsis. We have seen a reduction in neonatal cases and no reported cases of sepsis in this reporting period. This is possibly because the hospitals are managing these as 'expected' deaths under the new Child Death Review Guidance. It won't be until these cases reach the CDOP panel that this may or may not become evident.

Since becoming a three-nurse SUDC Service (June 2018), the SUDC Nurses have been able to dedicate more time to public health work and have become more involved in preventative strategies. It is hoped that this has had some impact on both the reduction of co-sleeping and suicide deaths and has contributed to the overall reduction of unexpected child deaths in Lancashire in 2019-20.

Out of the 36 unexpected child deaths in 2019-20, Children's Social Care were involved (at the time of death or following death) in 47% of the cases. Domestic violence was reported between parents/carers in 25% of the cases. 27% of the parents were reported to have had mental health problems. In 16% of the cases, parents reported consuming alcohol/or taking substances on the night prior to their child's death. 19% of the cases were referred for CSPR consideration. 11% met the criteria for a CSPR. This evidences the significant number of complex social circumstances and chaotic family dynamics that some of these children were living in at the time of their deaths.

Figure 1 shows a gradual downward trend of unexpected deaths over the last decade.

**Multi-agency working**

The SUDC Nurses meet with Senior Police Officers monthly (Child Death Investigation Group). The purpose of these meetings is to discuss issues arising from individual cases, establish updates re: progress of criminal investigations, to promote best practice in child death investigations and staff development, and also to promote effective multi agency working by ensuring that the SUDC team maintain links with Police colleagues.

The SUDC Nurses also attend regular meetings with the Named Nurses across Lancashire. The purpose of the meetings are; to strengthen multi-agency working, to ensure the SUDC Protocol is embedded in practice; to discuss cases/issues in practice; to give updates; to identify themes and trends, and to advice of any SUDC Contingency arrangements.

The SUDC Team are involved in numerous ongoing multi-agency work-streams that are related to SUDC cases and public health strategies, and more recently Real Time Surveillance Group and the Suicide Prevention Oversight Group.

## CDOP Priorities for 2020/21

1. Deliver the SUDC Prevention group priorities including:
    a. maintaining a supply of materials to agencies across pan-Lancashire;
    b. promote the safer sleep campaign throughout pharmacies during November 2020;
    c. support the roll-out of phase 2 of the ICON campaign;
    d. ensure the sleep assessment tool is embedded in practice;
    e. undertake an evaluation of the safer sleep/grandparents campaign to ensure it is effective;
    f. ensuring fathers are included in all aspects of antenatal and postnatal care and are made aware of the safer sleeping campaign.
2. Improve the quality and outputs of the child death review processes by:
    a. ensuring all child death review meetings (e.g. perinatal mortality; hospital mortality; etc.) inform the CDOP process in a standardised and structured manner;
    b. ensure all agencies understand the new guidance and relevant processes;
    c. develop and oversee an implementation plan measured against national standards;
    d. reduce the variability of reporting forms and routinely missing information e.g. male partners;
    e. demonstrate improvements against national standards through self-assessment;
    f. evaluate the reporting and governance arrangements and make recommendations to partners as necessary;
    g. provide opportunities for continuing professional development e.g. development day.
3. Maximise the potential of the CDOP Database.
4. Continue to collect data for Adverse Childhood Experiences (ACEs), and analyse patterns in links between ACEs and child deaths.
5. Ensure that any preventive strategies and initiatives link with any existing health and wellbeing/ clinical workstreams.
6. Monitor the delivery of the 7-day SUDC service.
7. Support a suicide thematic review, including cases from South Cumbria.
8. Ensure that the reduction of infant/ child death forms part of integrated multi-agency strategies.
9. Ensure all agencies and professionals provide input to the processes at the appropriate time.

# Part 2 - Data Analysis

## Summary of the cases notified to panel between April 2019 and March 2020

This section of the report considers data pertaining to notifications received and cases reviewed by the panel between April 2019 and March 2020 only.

During the 2019/20 reporting year, CDOP was notified of 108 child deaths (20 Blackburn with Darwen (BwD) residents, 6 Blackpool residents and 82 Lancashire residents) that were in line with Working Together to Safeguard Children definition and therefore considered by the Pan-Lancashire CDOP. An additional 14 notifications were received which fell outside the statutory guidance and therefore not reviewed including 11 cases out-of-area (reviewed by the CDOP in their area), <5 terminations of pregnancy and <5 stillborn deaths.

Figure 3 below shows the number of statutory notifications received in each reporting year since CDOPs became statutory in April 2008.

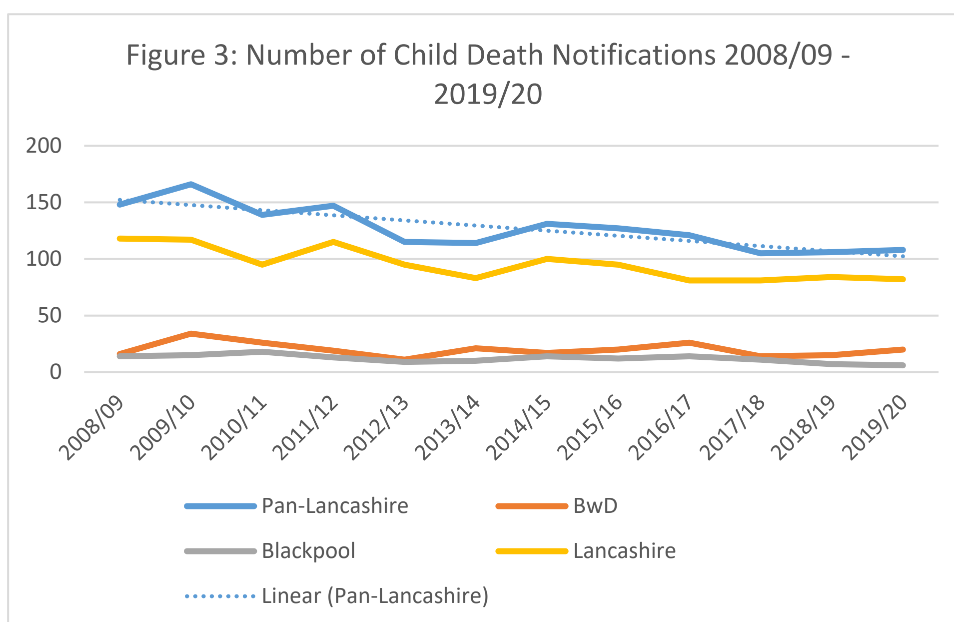


*Figure 2 Number of notifications since 2008*

Overall, from 2008 there has been a gradual downward trend in the number of reported deaths across Blackburn with Darwen, Blackpool and Lancashire.

## Completed CDOP reviews by ethnic group and age group

Please refer to appendix 1, completed reviews (overview 2) for the complete breakdown of deaths reviewed by age and ethnic group. The pattern of reviews completed by age is similar to that seen nationally. Of the deaths reviewed during 2019-20, the highest number of deaths occurred in children under one year of age (68%) compared to 53% during 2018-19.

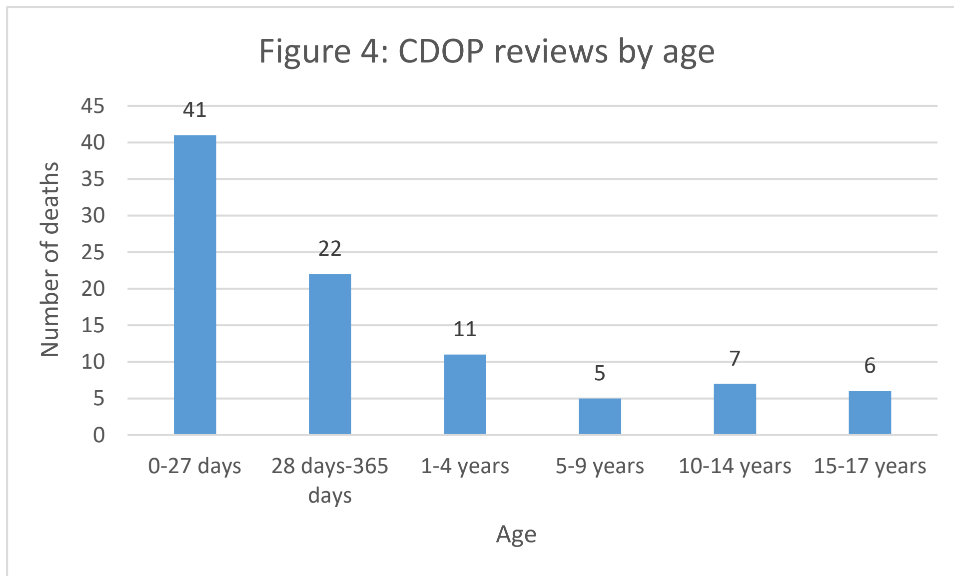


*Figure 3 CDOP Reviews by Age*

## Completed CDOP reviews by primary category of death

The most common category of deaths across pan-Lancashire for cases reviewed during 2019-20 was Perinatal/neonatal event (36%) with chromosomal, genetic and congenital anomalies accounting for the second most common category (28%). This is consistent with England and Wales where perinatal and congenital causes are the most common, especially in neonates. It is the tenth time since 2008 that perinatal/neonatal event has been the most common category of death.

**Table removed to maintain confidentiality.**

Figure 6 (below) shows the category of death broken down into year reviewed. Chromosomal, genetic and congenital anomalies (dark blue) and perinatal/neonatal event (maroon) are by far the biggest categories with the other categories remaining fairly consistent across the years.

**Table removed to maintain confidentiality.**

## 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, 2018).

**Table removed to maintain confidentiality.**

The table above identifies the number of deaths reviewed in 2019-20 by the child's local authority that were considered to have modifiable factors and whether the deaths were expected or unexpected. In deaths that are unexpected, it is not unusual that more modifiable factors are identified. Across pan-Lancashire modifiable factors were identified in 43% of all deaths. Compared to 2018-19 were by 51% of cases reviewed had modifiable factors. The number of cases with modifiable factors across England is 30%.

The most common modifiable factors identified in 2019-20 across pan-Lancashire were smoking and substances abuse (alcohol and/or drugs).

## Category of death and modifiable factors

Of the cases reviewed, the largest category of death across pan-Lancashire in 2019/20 with modifiable factors was perinatal/neonatal events (48%). There were no modifiable factors for deaths caused by malignancy for the third year running. 64% of cases where modifiable factors were identified fell under the 28-364 days age group.

**Table removed to maintain confidentiality.**

A further breakdown of data can be located under 'completed reviews - modifiable factors' on appendix 1 of this report.

## Summary of key points and identification of themes and trends

All data reported within this section is based on child deaths reviewed between April 2019 and March 2020 unless a different time period is stated.

**Blackburn with Darwen**

- 78% of deaths reviewed during 2019/20 were completed within 12 months
- 83% of deaths were expected
- Of the BwD deaths reviewed, 33% were of Asian or Asian British Pakistani heritage
- 50% of deaths were female
- 22% of deaths had modifiable factors identified
- The most common modifiable factor identified was smoking

**Blackpool**

- 71% of deaths reviewed during 2019/20 were completed within 12 months
- 86% of deaths were of White-English/Welsh/Scottish/Northern Irish/British
- 57% of deaths were unexpected
- 57% of deaths were male
- 86% of children were aged under one
- 57% of the deaths were deemed to have modifiable factors
- The most common modifiable factor was smoking

**Lancashire**

- 78% of deaths reviewed during 2019/20 were completed within 12 months
- 10% of deaths were of children from an Asian Pakistani heritage
- 63% of children were aged under 1 year old (43% under 28 days and 20% 28-364 days)
- 36% of deaths were due to perinatal/ neonatal events and 25% were due to chromosomal/congenital abnormalities
- 48% of deaths identified have modifiable factors
- 63% of the children were under one
- Of the 48% of deaths identified to have modifiable factors the most common category of death was perinatal neonatal events (16%). The second largest category to have modifiable factors was chromosomal/congenital abnormalities (7%) and sudden unexpected, unexplained death (7%)
- The most common modifiable factors was smoking

## Recommendations

Local safeguarding and health and wellbeing partners are asked to:

- Ensure all professionals providing information to CDOP to ensure that forms are returned within the statutory three week deadline and are completed as fully as possible, including details of father or other male carers in the household, before they are submitted to CDOP.
- *(The CDOP Business group monitors this on a monthly basis. Whilst there have been measureable improvements over the course of the year, there are still gaps in information which are being followed up)*
- Ensure that there are interagency initiatives to reduce the prevalence of modifiable factors identified in the under one population including:
  - Safe sleeping
  - Risk factors for reducing premature births including:
    - High BMI (including healthy diet and physical activity)
    - High blood pressure (linked to high BMI)
    - Smoking
    - Alcohol use
    - Substance misuse
    - Domestic violence
    - Mental health
    - Diabetes (often linked to BMI)
    - Lack of physical activity

# Appendix 1: National Child Mortality Database Monitoring Report

**Report removed to maintain confidentiality.**

## Appendix 2: Department of Health & Social Care category of death descriptions

| Category | Name & description of category | Tick box below |
|---|---|---|
| 1 | **Deliberately inflicted injury, abuse or neglect**<br>This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death. | ☐ |
| 2 | **Suicide or deliberate self-inflicted harm**<br>This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children. | ☐ |
| 3 | **Trauma and other external factors**<br>This includes isolated head injury, other or multiple trauma, burn injury, drowning, and unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury, abuse or neglect. (Category 1). | ☐ |
| 4 | **Malignancy**<br>Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc. | ☐ |
| 5 | **Acute medical or surgical condition**<br>For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy. | ☐ |
| 6 | **Chronic medical condition**<br>For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause. | ☐ |
| 7 | **Chromosomal, genetic and congenital anomalies**<br>Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac. | ☐ |
| 8 | **Perinatal/neonatal event**<br>Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week). | ☐ |
| 9 | **Infection**<br>Any primary infection (i.e., not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc. | ☐ |
| 10 | **Sudden unexpected, unexplained death**<br>Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5). | ☐ |

## Appendix 3: Recognised Adverse Childhood Experiences (ACEs) and definition

| ACE | Definition |
|---|---|
| Physical abuse | Intentional use of physical force against a child that results in, or has the potential to result in, physical injury. |
| Sexual abuse | Any completed or attempted sexual act, sexual contact with, or exploitation of a child by a caregiver. |
| Emotional abuse | Intentional caregiver behaviour that conveys to a child that they are worthless, flawed, unloved, unwanted, endangered, or valued only in meeting another's needs |
| Neglect | Failure by a caregiver to meet a child's basic physical, emotional, health, or educational needs—or a combination of these. |
| Domestic violence | Any form of verbal or physical violence between a caregiver and his or her adult partner or ex-partner |
| Parental separation | Divorce or separation between parents or caregivers |
| Substance misuse | Living with a parent, caregiver or other family member who misuses substances, including illegal drugs and prescription medications |
| Alcohol misuse | Living with a parent, caregiver or other family member who misuses alcohol |
| Mental health issues | Living with a parent, caregiver or other family member who is depressed, has other mental health problems or has ever attempted suicide |
| Incarceration | Living with a parent, caregiver or other family member who sentenced to serve time in a prison or youth offending institution |

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