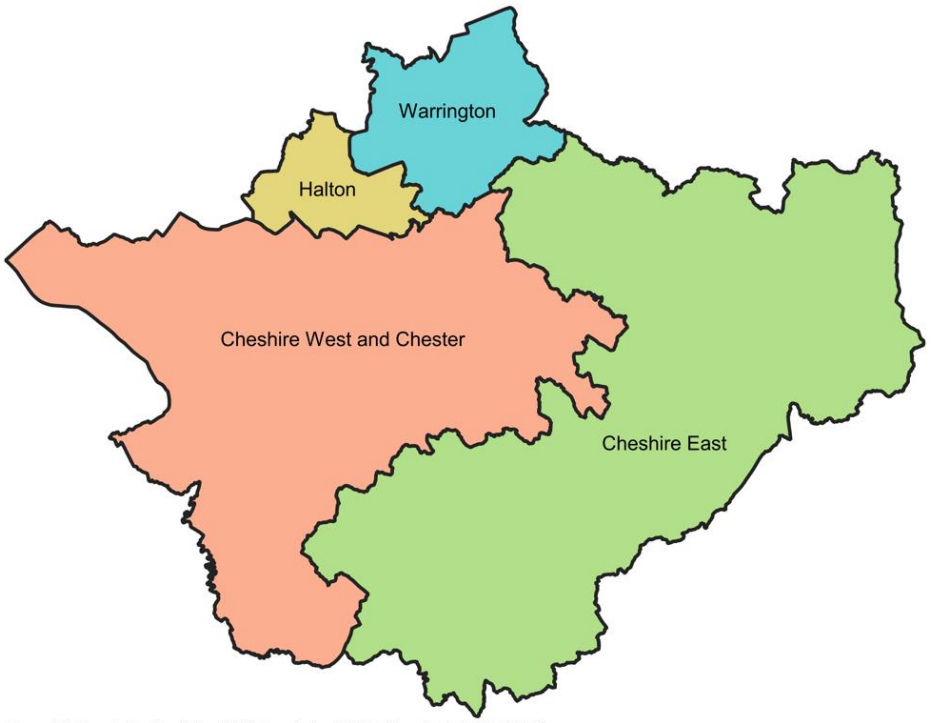
Pan Cheshire Child Death Overview Panel (CDOP)

Annual Report 2022-23



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Executive Summary

The purpose of this Annual Report is to:

- Clarify and outline some of the CDOP processes directed by national guidance
- Assure the Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across Cheshire.
- Provide an overview of information on trends and patterns in child deaths reviewed across Cheshire during the last reporting year (2022-23) and highlight issues arising from the child deaths reviewed.
- Report on achievements and progress.
- Make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across Cheshire.

Key findings from this annual review were:

- Of deaths reviewed:
    - The majority of those child deaths reviewed occurred within the first year of life, particularly the neonatal period.
    - The majority of deaths reviewed were children from a white British background.
    - Smoking in pregnancy or the household, mental health and maternal excess weight were the highest modifiable factors identified in infant deaths (the largest group).
- During 2022-23, considerable progress has been made in: strengthening CDOP governance approaches; improved recording and use of eCDOP (An electronic paperless software system for managing all child death data), improved processes after death and the number of cases reviewed compared to the number of notifications received.
- Local actions that have followed child death reviews have focussed on the following themes: safe sleep; promotion of the ICON programme (a programme to prevent baby shaking); water safety; fire safety; anaphylaxis management; drugs and alcohol; infection control and prevention; and more general accident prevention.
- At the end of the 2022-23 reporting year, 68 deaths were still to be reviewed by panel. CDOP was awaiting completion of other processes e.g. coroner's inquest and neonatal network reviews, which delayed them coming to CDOP.

Key recommendations as a result of this annual review are for system partners to:

- Take ownership of these findings, share them with relevant forums, and ensure that local strategies are underpinned by these, and other core intelligence.
- Actively promote joint strategies to minimise the impacts of significant modifiable factors such as: mental health; maternal smoking; smoking in the home; substance and alcohol misuse; maternal excess weight.
- Continue to promote awareness in relation to the ICON programme, safe sleep and water and fire safety.
- Work with CDOP to build upon understanding of local longer-term trends.
- Work with CDOP to ensure it has robust capacity for coordinating and administrating the various elements of the child death review system, including CDOP itself.

Contents

1. Introduction from CDOP Chair

Each child death is a tragedy.

As a society, it is vital that we learn from the heartbreaking losses of children and young people so that we can understand where we can reduce the likelihood of similar tragedies occurring in the future. While infrequent It is imperative that we glean lessons from these heartbreaking losses, pinpoint any aspects we can change, and adopt improved approaches to reduce the likelihood of similar future tragedies.

Whilst this report covers the year 2022-23, at the time of writing, the verdict of the Lucy Letby case had been concluded, where the former neonatal nurse was convicted of murdering infants in her care within the Countess of Chester Hospital. The Independent Inquiry announced by the Government, will provide an opportunity to improve child death review processes. The events have had a significant impact on the community, and the staff that care for young children.

In any one year, the number of deaths notified and reviewed across Cheshire remain relatively small in number, which makes it difficult to make any firm conclusions in a single reporting year. The National Child Mortality Database (NCMD) is now able to provide meaningful comparative data, which will form part of future reporting.

I would also like to take the opportunity to thank all those professionals behind the scene who make CDOP and the Child Death Review processes work, including the production of this annual report. In particular, a special mention goes to Anne Barber, who came out of retirement to provide interim support and experience through transition.

Mike Leaf, Independent CDOP Chair

Links to additional information:

Pan-Cheshire Child Death Pathway
https://www.cheshirewestscp.co.uk/wp-content/uploads/2015/06/pathway-following-the-death-of-a-child-under-18.pdf
Pan-Cheshire Child Safeguarding Practice Review Process
https://www.Pan-Cheshire.gov.uk/media/2106570/gscp-safeguarding-practice-review-process-april-2021-v11.pdf
SUDI/SUDIC Guidelines
https://www.cescp.org.uk/pdf/sudic-2021/pan-cheshire-sudic-documentation-proforma-and-guidance-april-2023.pdf

2. Background to the Child Death Review Process

There is a requirement for the statutory partners to "*...make arrangements to carry out child death reviews. These arrangements should result in the establishment of a Child Death Overview Panel (CDOP), or equivalent, to review the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children*." Child Death Review Statutory and Operational Guidance published in October 2018.

The statutory responsibilities for child death review (CDR) partners are set out in Chapter 5 of Working Together to Safeguard Children (2018) and further clarified in Child Death Review Statutory and Operational Guidance published in October 2018.

The statutory partners are:

- **Halton Borough Council**
- **Warrington Borough Council**
- **Cheshire East Borough Council**
- **Cheshire West and Chester Council**
- **NHS Cheshire and Merseyside Integrated Care Board**

Under this guidance, Child Death Review Partners are required to establish a process to review all child deaths within the geographical boundaries of the local authorities. The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified.

A range of information is collected using statutory forms and the case discussed by professionals involved in the child's life prior to death, at a Child Death Review Meeting (CDRM). Following the CDRM, all information and details of discussions and other reports e.g. post mortems, coronial inquiry etc is collated by the CDOP administrator in preparation for the Panel discussion, with data anonymised.

The CDOP aims to identify those factors in the course of a child's life, and leading to the child's death, which might have directly led to the child's death or increased their vulnerability, and which might have been amenable to modification, and make recommendations which may prevent similar deaths occurring in the future.

Understanding the difference between expected and unexpected deaths

Unexpected child deaths are defined as the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death. This includes children and young people with disabilities or life limiting illnesses, children and young people who die in road traffic accidents, by drowning etc. and children who are admitted to a hospital ward and subsequently die unexpectedly in hospital.

Expected child deaths often involve children with a life limiting condition (often with an Advanced Care Plan) or in a hospital/hospice and are anticipated to die.

Neonatal deaths are defined as babies that die within 28 days of birth of any cause or for the purposes of this process a baby who dies that has not left hospital since birth (excluding live born terminations).

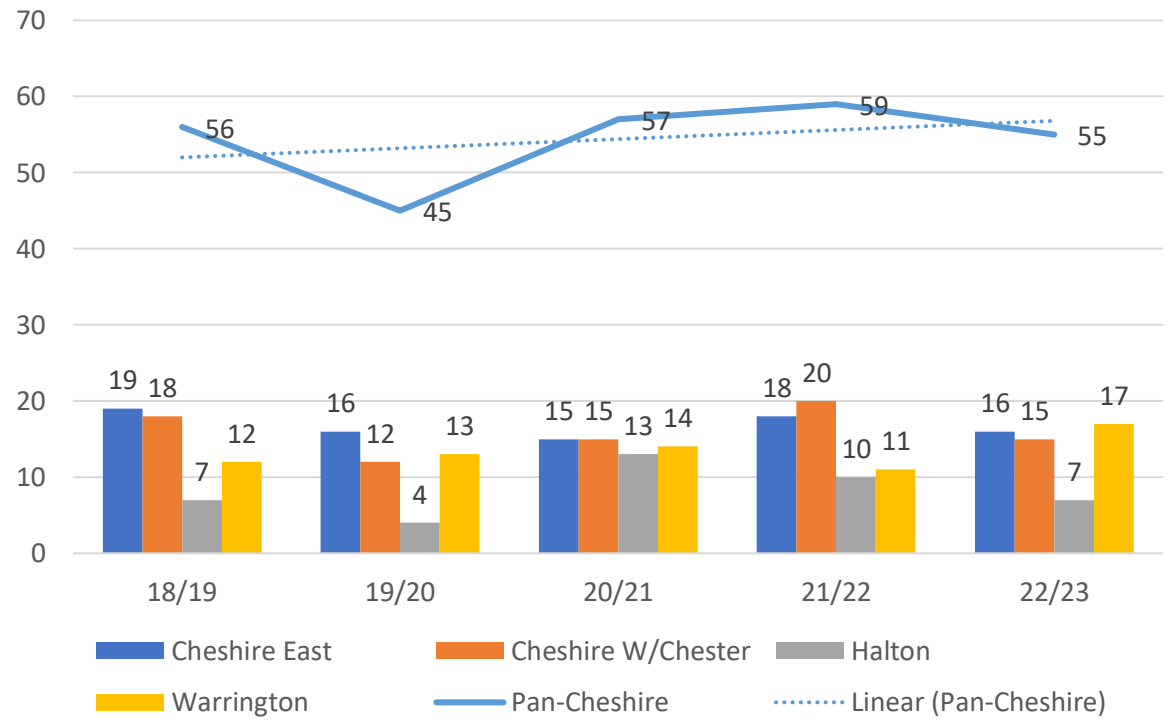
3. Notification and Case Management

Throughout the twelve months this report covers (April 2022–March 2023), Cheshire were notified of 55 deaths who were resident in the four Local Authority boundaries (Halton, Warrington, Cheshire East, and Cheshire West and Chester). Comparative data for the last five years has also been included. (**NOTE: MOST DEATHS NOTIFIED IN THE REPORTING YEAR WILL NOT BE REVIEWED BY CDOP IN THE SAME YEAR** – this is because other reviews/ investigations need to be concluded before scheduled onto a panel e.g. internal reviews, Perinatal Mortality Review Tool (PMRT), coroner's inquests, criminal prosecutions etc.)

Notifications by Year

There are yearly fluctuations within each area, which is expected in view of the relatively small numbers involved (Figure 1). During the last five years, there is a very slight upward trend in death notifications, however, this is very difficult to determine in view of the small numbers.

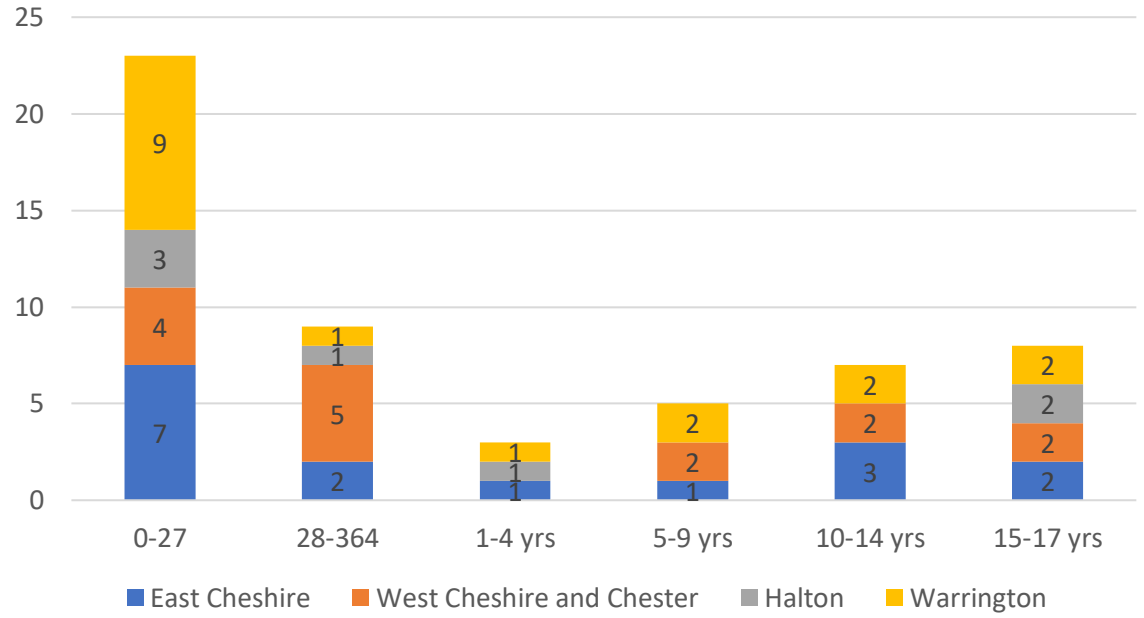
Figure 1-Number and trends of notifications 2018-23



The highest numbers of death notifications are seen in infants (

Figure 2). This picture is consistent across all local authorities. (**Error! Reference source not found.**) and is also consistent with the national.

Figure 2-Notifications by age and local authority



The local authority with marginally the highest number of deaths notified in the year was Warrington (Figure 3), and it has a significantly lower under 18 year old population than Cheshire East and Cheshire West and Chester Councils (Figure 4).

Figure 3-Notifications by local authority

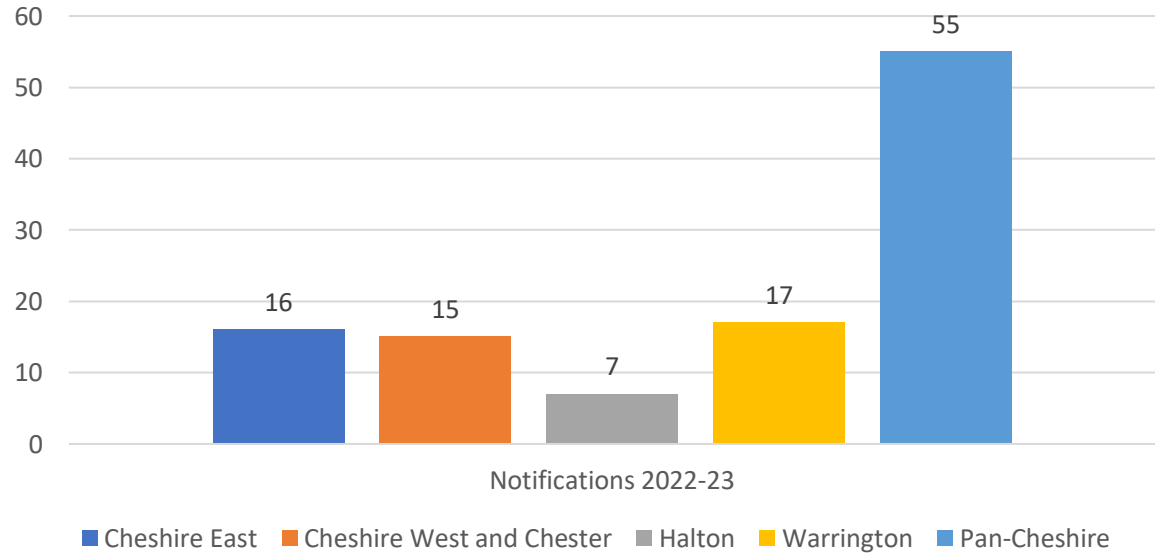
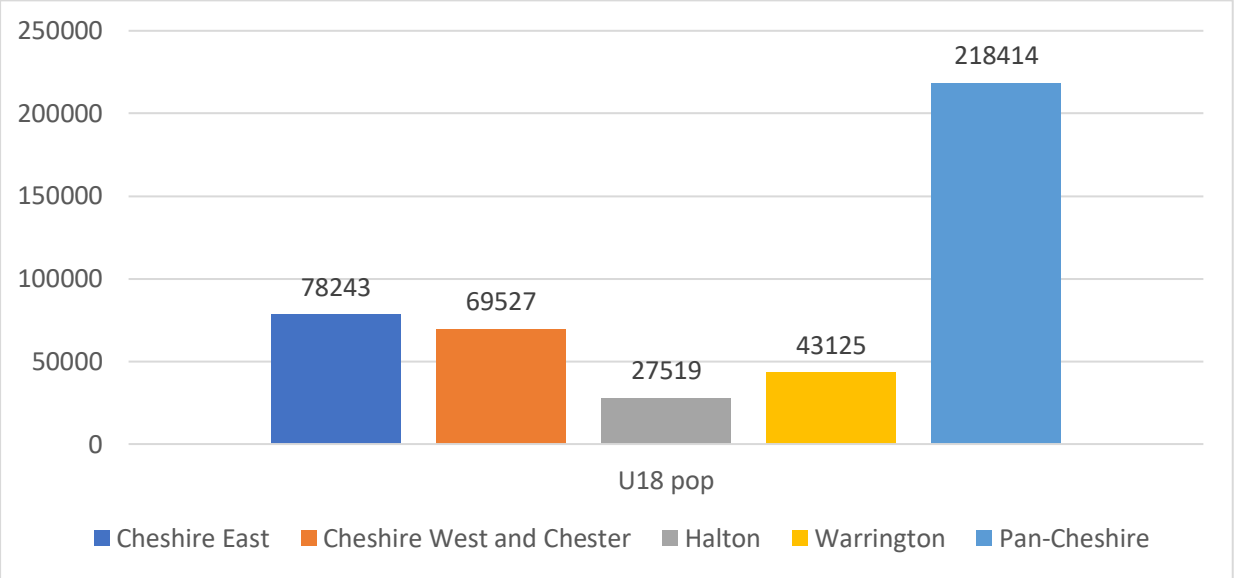


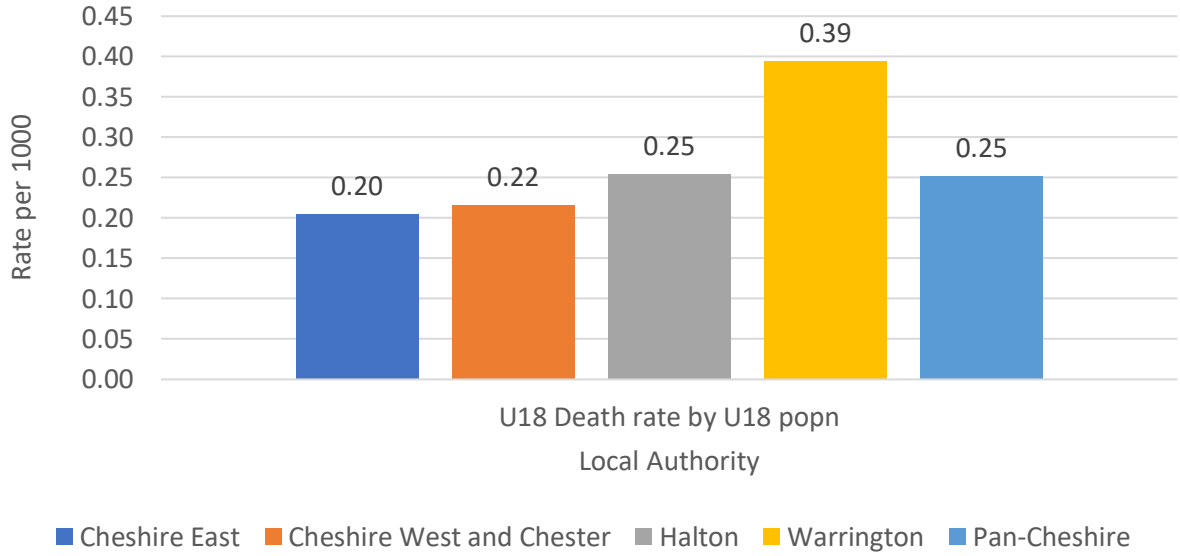
Figure 4-Numbers of residents under 18 years old



The under 18 populations vary between local authorities, so it is more relevant to consider number of child deaths of each local authority per population under the age of 18 years old (Figure 5). Warrington does appear to have relatively high number of deaths per under 18 population, compared to the other local authorities. However, due to the small numbers of child deaths seen across our local area, some random variation would be expected in the number of deaths seen. Statistical analysis confirms that the increase in deaths in Warrington falls within what we would consider to be chance (random) variation and is not statistically significantly different[1].

[1] Cheshire East Council Public Health Intelligence Team (2023). Chi-squared testing was undertaken to determine whether there is a significant difference between the expected frequencies and the observed frequencies in one or more categories with null hypothesis that any differences are due to chance. Childhood deaths are similar across all Cheshire local authorities. 27 September 2023.

Figure 5-Rate of death notifications per 1000 residents under 18 years old



As well as considering the current year's notifications, historical trends have also been taken into account. When looking at the 2021-22 notifications, Warrington had the lowest number of notifications across the Cheshire CDOP area. Furthermore, on reviewing rates of infant mortality (2001-21) and of child mortality (1-17 years) (2001-20) , rates have been consistently similar to the England average.[2] Whilst the undertaken statistical analysis and historical trends are reassuring, rates will continue to be monitored in future years, and duly explored should there be a trend towards higher numbers.

Deaths Reviewed by Local Authority (LA)

Please note that this information is different to the number of ***notifications*** by LA and is provided so that readers understand how the following findings relate to their LA area. In any reporting year, most of the deaths notified **will not** be reviewed at CDOP in the same year, as other reviews/ investigations need to be completed first, as highlighted above.

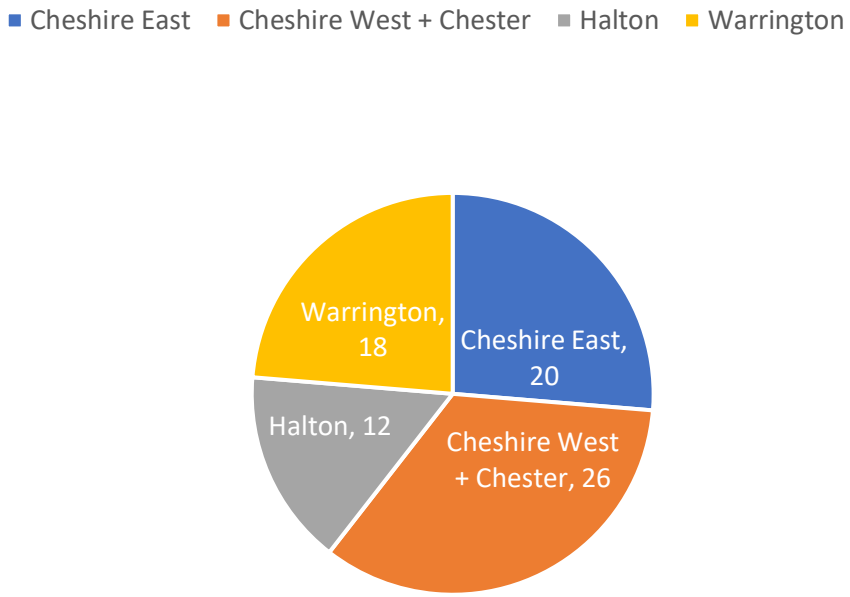
Deaths are brought to the Child Death Overview Panel (CDOP) panel only when all information has been provided, and after other review process have been completed. This means that the length of time between notification and review can vary considerably depending on circumstances and other review process. It is therefore difficult to identify particular patterns for any particular year, especially with relatively small numbers. Trends and themes, however, may be identified over several years.

In this reporting year (2022-23), as in the previous year, significantly more deaths were reviewed (76) than notified deaths (55), which helped reduce the number of deaths ready to be reviewed by the panel. Cheshire West + Chester accounted for 34% of deaths reviewed, Cheshire East 26%,

[2] Office for Health Improvement and Disparities (2023). Child and Maternal Health. Warrington. Available from: https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133228/pat/15/par/E92000001/ati/402/are/E06000007/iid/90801/age/177/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0 (Accessed 18 October 2023). Of note, neonatal and still birth rates and post-neonatal mortality rates have also been consistently similar to the England average.

Warrington 24% and Halton 16%. Deaths are brought to panel once all information is available, so the split by area will vary (Figure 6). At the end of the 2022-23 reporting year, 68 deaths remained outstanding. CDOP was awaiting completion of other processes e.g. In the majority of these deaths are coroner's inquest and neonatal network reviews.

Figure 6-Deaths reviewed by local authority



Birth Gender of Death Notifications and Reviews

As in previous years, there were more male than female deaths (Figure 7) and slightly more male deaths being reviewed (Figure 8) which follows a national pattern as highlighted by the National Child Mortality Database Q4 (Annual) report.

Figure 7-Notifications by gender

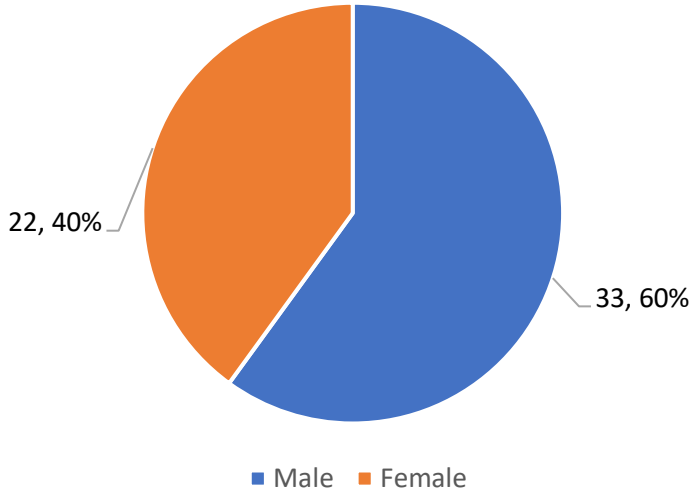
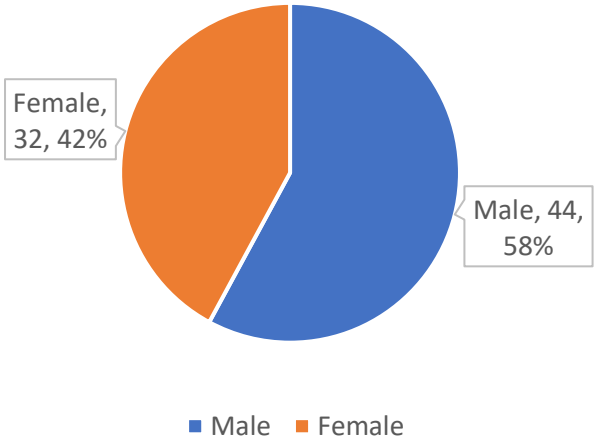


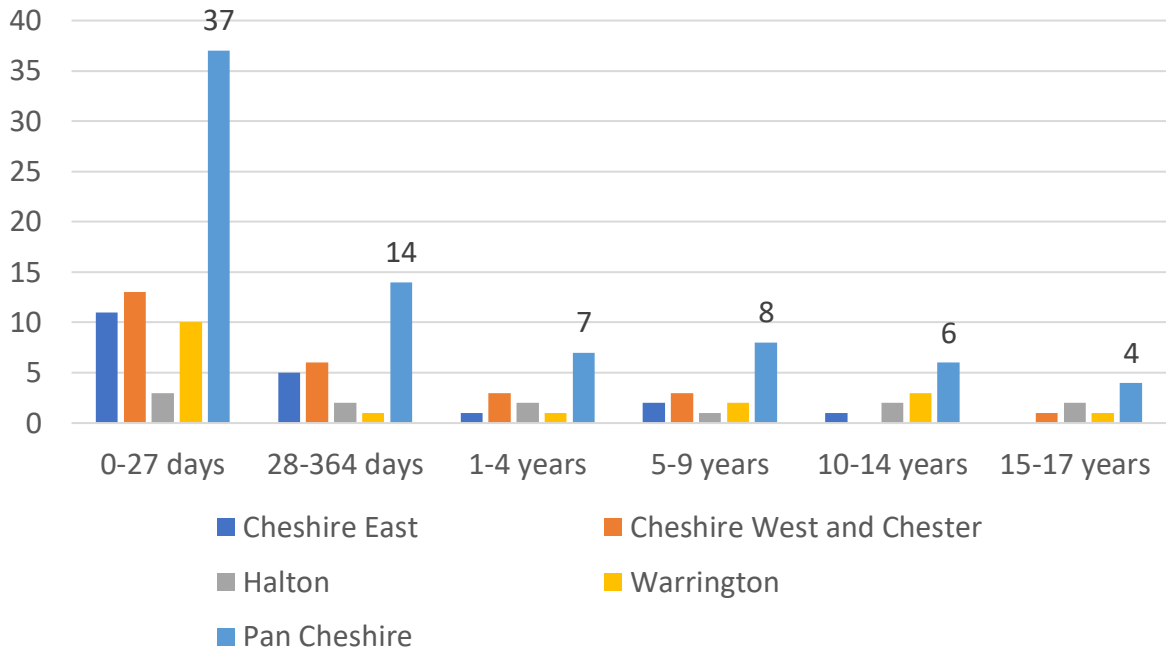
Figure 8-Cases reviewed by gender



Age of Reviewed Deaths

The majority (67.1 %) of all child deaths reviewed fell within the first year of life with neonatal deaths (less than 28 days) accounting for 48.7 % of the total child deaths reviewed (**Error! Reference source not found.**9).

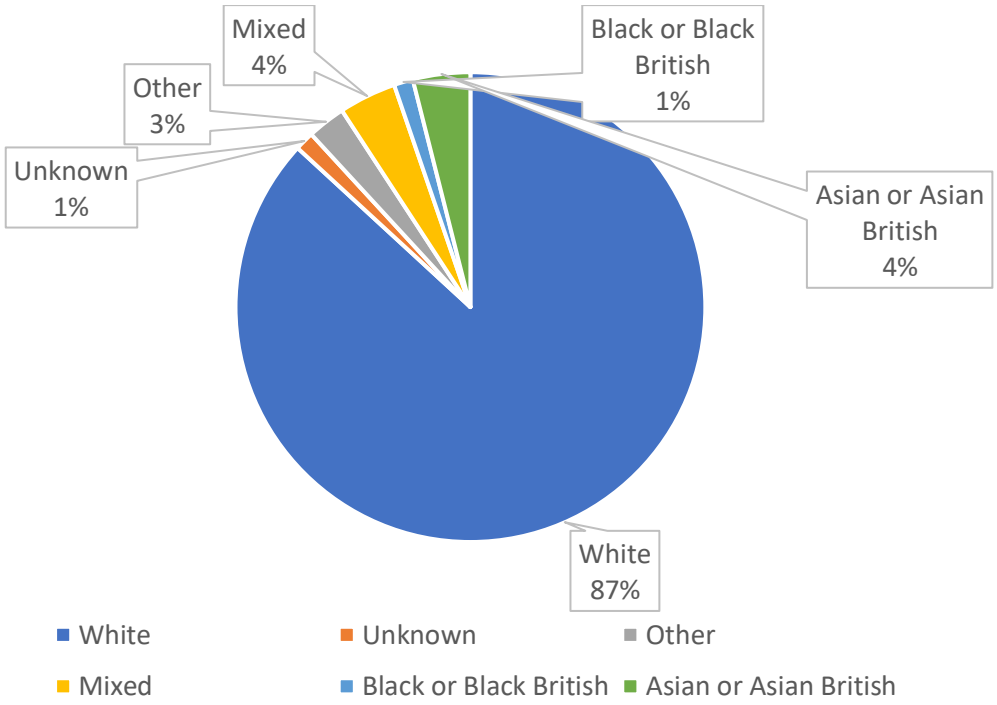
Figure 9-Reviewed deaths by age (2022-23)



Ethnicity of Reviewed Deaths

The ratios of deaths reviewed according to ethnicity are broadly comparable to those seen in the latest Census and School Census data[3,4]. 87% of deaths reviewed occurred in children of white ethnicity (Figure 10).

Figure 10-Cases reviewed by ethnicity



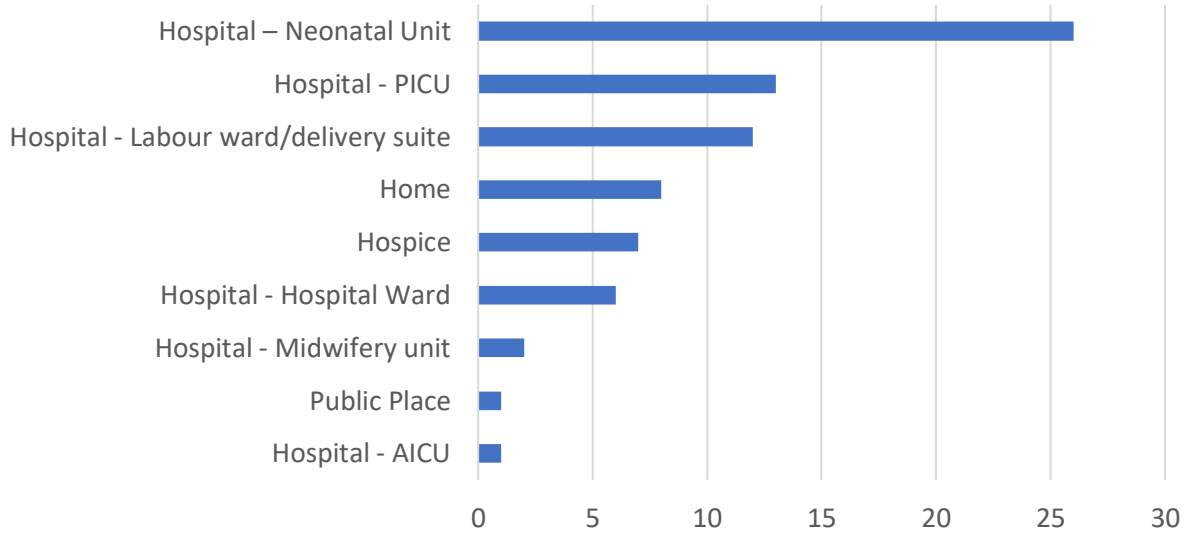
[3] Gov.UK. Explore Education Statistics (2023) Available from: https://explore-education-statistics.service.gov.uk/data-tables/fast-track/6d81afb6-3ec7-443c-ae84-d7454c9229eb%20 (Available from 19 October 2023).

[4] Office for National Statistics (2023) All data related to Ethnic group by age and sex, England and Wales: Census 2021. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicgroupbyageandsexenglandandwales/census2021/relateddata (Accessed 19 October 2023).

Place of Death

The majority (78.9%) of deaths reviewed occurred in hospital with 10.5% occurring in the home (Figure 11**Error! Reference source not found.**).

Figure 11-Cases reviewed by place of death



It is important to note that deaths that occur in Cheshire for a baby or child normally resident in another area e.g Wales, other local authority area, would not normally be reviewed by Pan-Cheshire CDOP, unless it was felt by all concerned, that the lessons learned would be more relevant to the Cheshire area.

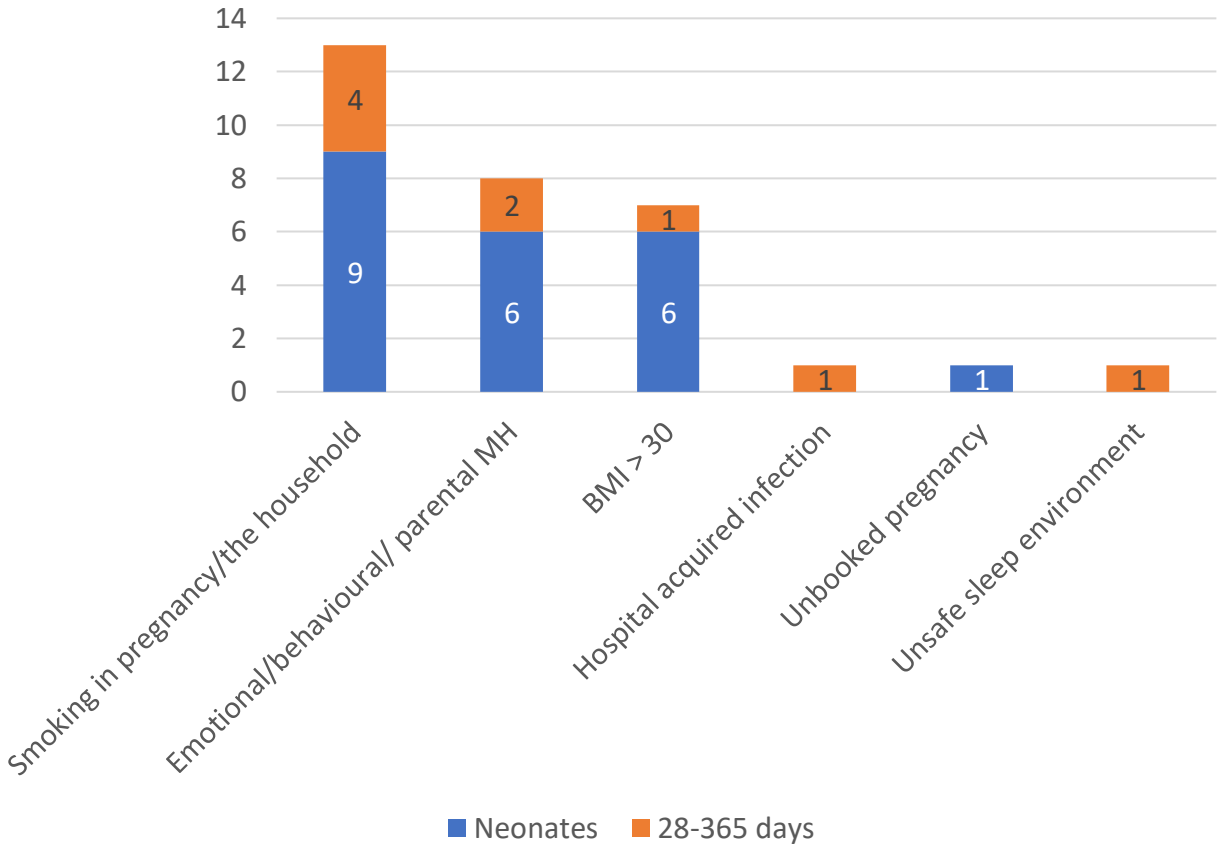
Modifiable Factors

A modifiable factor is one 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.

The most common modifiable factors identified in infant death cases reviewed (the age group with the largest number of deaths) included: smoking by the mother in pregnancy/ in the household (25.5% of all infant deaths); emotional/ behavioural/ mental health condition in the parent (15.7% of all infant deaths); and a maternal Body Mass Index (BMI) greater than 30 (13.7% of all infant deaths) (Figure). Recent research published in the Lancet indicated that women with poor mental health have 50% higher risk of preterm birth, which increases the risk of infant death[5].

[5] Langham et al. (2023) Obstetric and neonatal outcomes in pregnant women with and without a history of specialist mental health care: a national population-based cohort study using linked routinely collected data in England. Lancet. 10 (10); 748-759.

Figure 13-Cases reviewed in children aged under 1 year where modifiable factors were identified (*MH-mental health and BMI-body mass index)*

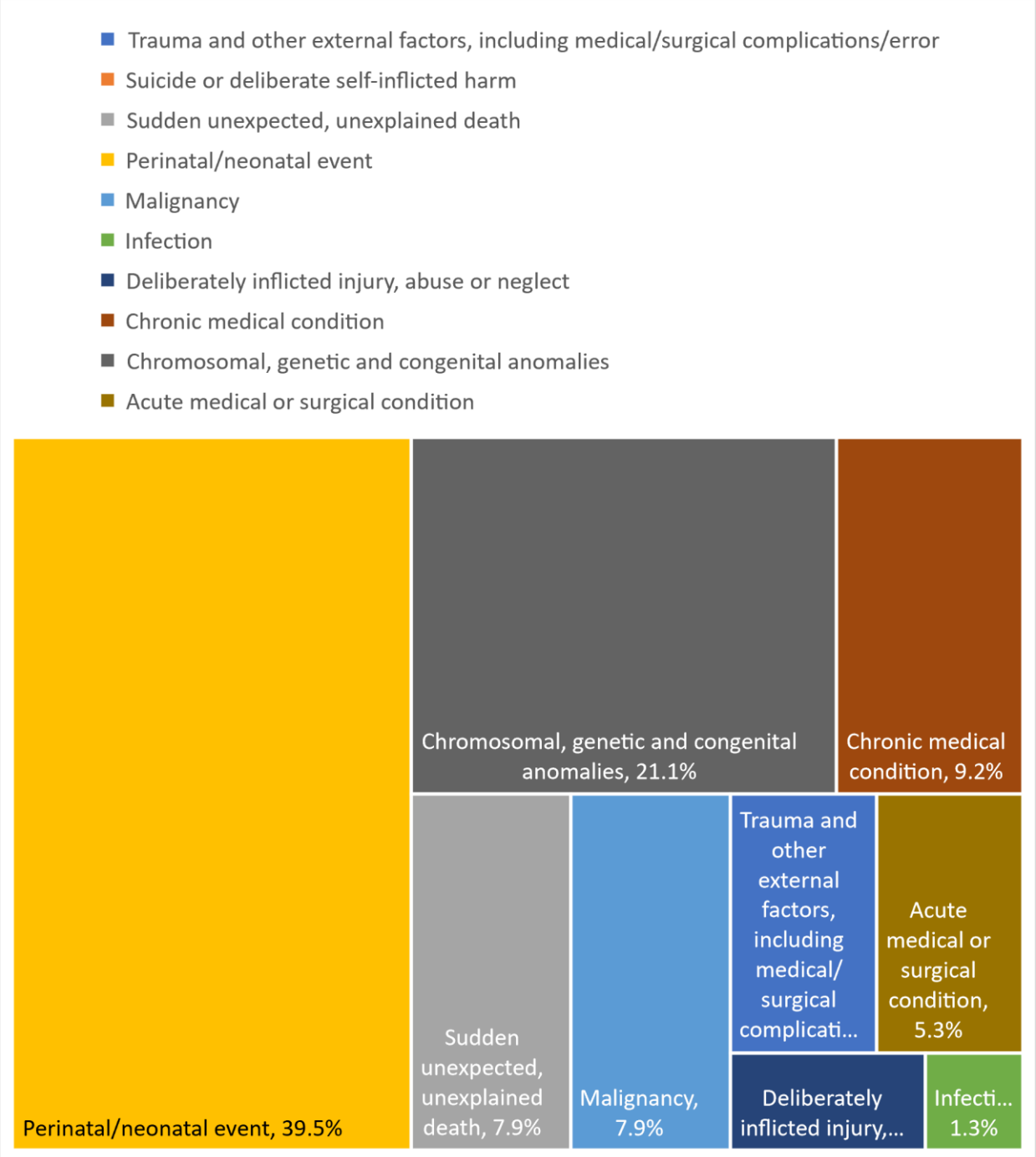


In addition, these child death reviews add further weight to the need for adequately resourced population level approaches to stopping smoking, promoting healthy weights and mental wellbeing, and reducing self-harm across our local population. All local authorities in our Cheshire CDOP area experience significantly higher than England average rates of emergency admissions for self-harm, three out of four local authorities experiencing significantly higher rates of women smoking at time of giving birth, and two out of four local authorities having significantly higher rates of adult overweight and obesity (see Appendix A). Whilst it could be argued that the extent to which these issues are experienced is not particularly higher in the group of child deaths than in the whole population, these factors are known to increase risk of child death and as such represent opportunities to prevent further such deaths in the future.

Category of Reviewed Deaths

The largest primary category of death accounting for nearly 40% of all deaths reviewed was perinatal/neonatal events. Modifiable factors were identified in 73.3% of these deaths (Figure 12).

Figure 12-Primary category of cause of death in the cases reviewed



4. Pan-Cheshire CDOP Achievements (2022-2023)

Assessing the effectiveness of the child death review process

Statutory guidance on child death reviews states that:

"The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If child death review partners find action should be taken by a person or organisation, they must inform them. In addition, child death review partners:

- *must, at such times as they consider appropriate, prepare and publish reports on:*
    - *what they have done as a result of the child death review arrangements in their area, and*
    - *how effective the arrangements have been in practice…"*[6].

Enhancements of the child death review process

The following improvements have been made to the enhance the child death review process across Cheshire:

- Achieving the ethnicity recording target– Every child's ethnicity should be identified to ensure if any minority groups are over-represented in child deaths. In 2021-22, only 85% of notified deaths and 87% of reviewed deaths had ethnicity recorded. For 2022-23, these figures were 100% and 99% respectively, which is a significant improvement.
- Achieving recording of Joint Agency Responses (JAR) – Every unexpected death should instigate a JAR. In 2021-22, only 76% of notified deaths and 83% of reviewed deaths had JAR information recorded. For 2022-23, both of these figures were at 100%.
- eCDOP is being used more widely for sharing papers in relation to Child Death Review Meetings which happen before CDOP panel.
- Governance arrangements have been strengthened through the introduction of a Business matrix which provides greater clarity over business actions, and member substitutes.
- Improvements in the quality of information reports for panel have been noted. CDOP will continue to re-enforce the importance of good quality reports from various professionals.

[6] Cabinet Office (2018) Child Death Review Statutory and Operational Guidance (England). Available from: Child Death Review Statutory and Operational Guidance (England) (publishing.service.gov.uk) (Accessed 30 January 2024).

- eCDOP – Has now been embedded in practice and has become a more useful tool enabling more efficient use of data with lots of potential for the future. Papers for other meetings are to be made available in a confidential way, and CDOP will continue to explore wider uses of the system.
- Following discussion with relevant stakeholders, wording in the Pan Cheshire Sudden Unexplained Death in Children (SUDIC) documentation made clearer to emphasise the fact that on a case by case basis and in exceptional circumstances for example:
    - The Emergency Department is busy and there is lack of cubicles.
    - For SUDIC cases from the community, where there is a clear cut explanation for cause of death, for example, road traffic collision, and the child is pronounced dead at the scene with no suspicious circumstances, the infant or child may be transferred straight to the mortuary.

  All SUDIC procedures should still be followed by frontline staff.

Performance data from National Child Mortality Database and national comparisons

There are no longer any data completeness issues. The median number of days from time of death to completing the review was 433 days compared to the national average of 335 days. This year we have reviewed more deaths than notifications, but this remains a challenge.

(As highlighted by the National Child Mortality Database Q4 (Annual) report for 2022-23).

Local actions as a result of the child death review process

The following local actions have resulted from the child death review process or involved facilitation or promotion via CDOP panel members:

Safe sleep

- **Infant Safe Sleep and Cold Homes October 2022 (newsletter)–** sent on behalf of Pan Cheshire Child Death Overview Panel and disseminated to multi-agency partners via communication teams.
- **Safe Infant Sleep During the Colder Months October 2022 (newsletter) –** sent on behalf of the Lullaby Trust and disseminated to multi-agency partners via communication teams.
- **Infant Safe Sleep Advice in Emergency Situations October 2022 (newsletter)-** sent on behalf of the Lullaby Trust and disseminated to multi-agency partners via communication teams.
- **Infant Safe Sleep & Cold Rooms November 2022 (virtual lunch and learn professional development sessions)** in response to the fuel poverty crisis in the UK, and concerns that some parents/carers may as a result use unsafe infant sleep techniques during the winter months. This was a Pan Cheshire Multi-agency lunch and learn session which covered three key areas 'Infant Safe Sleep and Cold Rooms,' 'Out of Routine',

and 'Sudden Infant Death'. The event was delivered by the Pan Cheshire Child Death Overview Panel members (Cheshire East Safeguarding Midwife, the Child Death Review Nurse for West and East Place and the Sudden Unexpected Death in Infants and Childrens Nurse for Warrington) 66 professionals attended.

- **Safe Sleep week November 2022 (virtual lunch and learn professional development sessions)** in response to a number of safe sleep related deaths from the previous 12 months, these included sharing a bed with baby, inappropriate day time sleeping arrangements, sleeping with a bottle and sleeping on the sofa. This was a multi-agency safe sleep week supported by all 4 local authority areas, the police, and all of the acute and community providers. There was a QR code developed with links to all the latest up-to-date leaflets and information. There was also a combined social media campaign which had a "tweet of the day" pack and was shared by all agencies, safe sleep information was played in children centres, general practices and out patients, on TikTok and on Facebook. Safe sleep demonstrations were held in acute providers in antenatal waiting areas and in children's centres. There was an increased amount of hits on social media platforms.
- **Safer Sleep in Winter Lullaby Trust Resource Packs December 2022 (newsletter) –** were distributed via communication teams to multi-agency partners throughout Cheshire. This reiterated some of the safer sleep messages delivered during the lunch and learn session in November.
- **North West Regional SIDS (Sudden Infant Death) and Safer Sleep training programme January 2023 (regional learning event) –** Following extensive discussions with the key representatives from The Pan Cheshire Child Death Overview Panel working in collaboration with the North West Regional Safeguarding Nurses, this free training programme was delivered by The Lullaby Trust and was open to all staff working in the North West region and particularly those who have interaction with children and families. To prevent child deaths then safer sleep messages must be delivered by all professionals working across health, education (including early years and nursery providers), social care, voluntary and community organisations, police, housing officers and anyone who engages with families following the birth. Information and access to this training programme was disseminated multiple times throughout Cheshire. This was for a limited period of 6 months only.
- **Infant Safer Sleep Week 13-19th of March 2023 (national learning event)–** The Lullaby Trust key messages and resources were shared with multi-agency partners in Cheshire via communication teams. To ensure that professionals work together to provide consistent advice and information on infant safe sleep to families that is research/evidence based.

Accident prevention

- **Halloween October 2022 newsletter– (newsletter)** and a link to the Royal Society for the Prevention of Accidents (ROSPA) resource pack was developed and shared across Cheshire via Communication teams and the Child Death Overview Panel for professionals and agencies to share with families and carers.

Fire safety

- **Fire Surround Safety October 2022 (alert)-** NHS England asked if we would reshare the advice sent last year about Significant Injury and Death in Children Caused by Falling Fire Surrounds. Since the initial dissemination of this advice in October 2021, there had been a further 4 cases in the North West Region of children who had significant serious injuries after being injured by a falling fire surround. Out of 12 cases where the child was admitted to Alder Hey Children's NHS Trust - 2 children died and of the 10 remaining cases 7 required rehabilitation due to serious injury. This information was disseminated via communication teams and the Pan Cheshire Child Death Overview Panel.
- **Halloween October 2022 (newsletter)-** A Halloween and bonfire safety message for partner organisations was also shared on behalf of the Merseyside Fire & Rescue Service to Pan Cheshire multi-agency partners by the safeguarding teams.

Water safety

- **Drowning Prevention June 2022 – (virtual lunch and learn professional development sessions)** The Royal Life Saving Society (RLSS) provided a Cheshire multi-agency session on water safety. 56 professionals attended and following the presentation the guest speaker from the RLSS was contacted by a number of schools to deliver his presentation to a school audience. This event was planned prior to the summer holidays in response to a teenager drowning in Cheshire (a non-resident of Cheshire) during the previous year. During 2022, higher numbers accidental drownings took place between June and August, with more dying at inland water than at the coast according to the National Water Safety Forum[7].
- **Winter Water Safety December 2022 (alert) –** An urgent winter water safety message' was sent via Communication teams and the Child Death Overview Panel members to offer advice for winter water safety, with simple steps to keep safe during the winter. This was a newsletter for professionals to share with parents and families. It was sent out in response to national concerns following a number of out of area deaths of children who had died when playing on ice.
- **Royal Life Saving Society June 2022 (national learning event)– A** 'Drowning Prevention Week' was supported throughout Cheshire, resources and toolkits shared by communication teams to multi-agencies and social media platforms used to share daily messages throughout the week to raise awareness of water safety.

Drugs and alcohol use

- **Increased Use of Aerosol Abuse – information for professionals Feb 2023 (alert) –** The Contextual Safeguarding Hub had noted that a small number of children are reported to have misused aerosols. In light of the child death last year from apparent aerosol misuse, colleagues in Public Health and Westminster Drug Programme (WDP) were contacted who

[7] National Water Forum. WAID interactive report 2022. Available from: https://nationalwatersafety.org.uk/waid/waid-interactive-report (Accessed 31 January 2024).

reported that they had also been aware of a significant event involving a child who had misused aerosols. Although it is a small number of cases it is a cause for concern that they have come through in relatively quick succession. WDP prepared an alert for professionals, which was disseminated via Communication teams and the Pan Cheshire Child Death Overview Panel.

Infectious disease control and prevention

- **Advice on Managing Scarlet Fever for Schools/Parents December 2022 (alert) –** Following the Sudden and Unexpected Death of a child in Cheshire, letters and resources were shared for both professionals and parents in Cheshire & Merseyside following liaison with Public Health England. There had been more notifications of Group A Streptococcal infections (scarlet fever and invasive Group A Streptococcal infections) to UKHSA nationally than expected for the time of year. Both are notifiable diseases, practitioners and parents were reminded of the signs and symptoms and the actions to be taken.

Anaphylaxis management

- **Learning Following a Recent Child Death Due to Anaphylaxis March 2022 (virtual lunch and learn professional development sessions)** presented by a Consultant Paediatric Allergist from Royal Manchester Children's Hospital and contributed to level 3 safeguarding training. Over 213 professionals attended the event. There was a lot of positive feedback was received from the attendees including that the presentation was well delivered and very informative. This enabled schools to update their safety plans for the management of anaphylaxis, general practices were updated with the latest prescribing guidance and informed of the notification service when epipens expire for patients. Childminders also attended for information regarding food allergies.

Non-accidental injury prevention

- **DadPad September 2022 – (virtual lunch and learn professional development sessions).** The DadPad App was created because babies do not come with a set of instructions. Developed with the NHS, the DadPad gives new dads, partners, parents and dads-to-be the knowledge and practical skills necessary to be able to support themselves and their partner and give their baby the best possible start in life. This session was delivered by the founder Julian Bose and attended by 107 multi-agency partners across Cheshire & Merseyside. It contributed to Level 3 safeguarding training. This was in response to practice learning reviews which had highlighted the hidden male in non-accidental injuries sustained by children.
- **DadPad July 2022 (newsletter)-** sent via communication teams, to multi-agency partners throughout Cheshire & Merseyside, to announce the launch of the DadPad App and the availability of resources for new dads, partners, parents and dads-to-be.

- **ICON Week 26th - 30th of September 2022 (national learning event) –** The Infant Crying You Can Cope (ICON) programme is being implemented by health and social care organisations in the UK to provide information about infant crying. It includes how to cope, support parents/carers, reduce stress and prevent 'Abusive Infant Head Trauma'. Resources, toolkits, newsletters and information on daily webinars were shared to all agencies in Cheshire & Merseyside via the communication teams.
- **DadPad October 2022 (newsletter)–**for multi-agency partners throughout Cheshire & Merseyside was sent via communication teams, on how to access key resources locally.
- **DadPad November 2022 (poster)-** In collaboration with the founder of DadPad, the Specialist Child Death Review Nurse for West and East Place and Merseycare a personalised Cheshire & Merseyside DadPad Poster was designed complete with QR code to be displayed in public places. Details were sent out in a newsletter for professionals and shared via communication teams.

Comparisons in trends in modifiable factors since 2021-22

In addition to the important work identified apart. Other important modifiable risk factors associated with child death over 2021-22 and 2022-23 have included mental health, household smoking, substance misuse and excess weight. Integrated Care Board Place level arrangements in relation to these challenging issues are vital to ensure comprehensive, proactive system-wide responses. Dissemination of these latest CDOP findings can further inform these developments.

5. System-wide challenges

There are significant challenges facing the health and care system currently. These include:

- The ongoing impacts of the COVID-19 pandemic and cost of living crisis on families, with exacerbated inequalities and increased vulnerability in some children across the CDOP footprint.
- Budgetary constraints within the public sector, and subsequent system transformation, reorganisation have resulted in pressures across the health and care system, presenting risk of staff turnover. This results in the need to continue to reinforce CDOP messaging and processes.

6. Priorities for CDOP 2023-2024

Priorities for CDOP and the CDOP business team in 2023-4 have included to:

- Continue to share the Sudden Unexplained Death in Children (SUDC) processes within neonatal and maternity units for unexpected or unexplained collapses in hospital leading to deaths within them.
- Establish a system for monitoring notifications by hospital providers of neonatal and maternity care.

- Develop stronger relationships with the Coroner's office, particularly in relation to information sharing, post-mortem reports and child death review meetings.
- Strengthen the CDOP business support functions through additional investment and funding arrangements.
- Maintain Pan Cheshire CDOP compliancy with the National Child Mortality Database Report Key Performance indicators.
- Ensure that all parents whose child has died continue to have access to appropriate bereavement services.
- Ensure the potential of the eCDOP system can be accessed to improve processes and minimise additional administrative burdens across Cheshire.
- Ensure that all parents whose child has died are offered the opportunity to contribute to Child Death Review process.
- Raise the profile of CDOP and the Child Death Review processes, and highlight impacts, with Health and Wellbeing Boards, and children's safeguarding partners.
- Explore more alternative ways of presenting annual data to strategic partners.
- Reduce the number of outstanding deaths ready for review by the CDOP panel through additional meetings if required.
- Analyse trends and themes that will inform awareness raising/ training sessions as required.
- Cooperate and contribute as required to the Thirlwall Inquiry.
- Promote greater participation by partner agencies at Child Death Review Meetings (CDRM) in cases where there has been prior involvement during life.
- CDOP to enhance their scrutiny of whether key learning from partner-level child death reviews have been sufficiently comprehensive, and sufficiently actioned by partners.
- Evidence how the functions of CDOP has influenced policy and practice within the local health economy and its impact.

7. Recommendations to system partners

The Child Death Overview Panel asks system partners to:

- Take ownership of these findings, share them with relevant forums, and ensure that local strategies are underpinned by these, and other core intelligence.
- Actively promote joint strategies to minimise the impacts of significant modifiable factors such as: mental health; maternal smoking; smoking in the home; substance and alcohol misuse; maternal excess weight.
- Continue to promote awareness in relation to the ICON (reducing baby-shaking), safe sleep and water and fire safety programmes.
- Work with CDOP to build upon understanding of local longer-term trends.
- Work with CDOP to ensure it has robust capacity for coordinating and administrating the various elements of the child death review system, including CDOP itself.

8. Appendix A:

Summary of population health indicators across the Cheshire Child Death Overview Panel (CDOP) Footprint[8]

The indicators below summarise population level prevalence in relation to some of the modifiable risk factors highlighted through the CDOP case reviews. Although the data included relates to 2021-22 rather than 2022-23, it reflects the most recently available data at the time. In addition, sudden shifts in population-level prevalence are unlikely. Smoking status at time of delivery and emergency hospital admissions for self harm are significant issues for the local area. Adult overweight and obesity is also significantly worse than the England average in Halton and Warrington.

Indicator	Period	England	Cheshire CDOP	Cheshire East	Cheshire West and Chester	Halton	Warrington
Smoking Prevalence in adults (18+) - current smokers (APS) (Persons, 18+ yrs)	2022	12.7	-	9.4	8.9	13.3	9.9
Smoking status at time of delivery (Female, All ages)	2021/22	9.1	-	11.7	11.7	14.2	8.9
Self reported wellbeing: people with a high anxiety score (Persons, 16+ yrs)	2021/22	22.6	-	23.3	19.5	26.5	22.6
Self reported wellbeing: people with a low happiness score (Persons, 16+ yrs)	2021/22	8.4	-	10.3	11.2	9.5	8.2
Emergency Hospital Admissions for Intentional Self-Harm (Persons, All ages)	2021/22	163.9	-	249.3	216.2	282.0	224.5
Percentage of adults (aged 18 plus) classified as overweight or obese (Persons, 18+ yrs)	2021/22	63.8	-	62.5	65.4	71.2	70.6
Year 6: Prevalence of obesity (including severe obesity) (Persons, 10-11 yrs)	2021/22	23.4	-	19.4	20.1	25.4	22.0

Indicator	Period	England	Cheshire and Merseyside	Cheshire East	Cheshire West and Chester	Halton	Knowsley	Liverpool	Sefton	St. Helens	Warrington	Wirral
Percentage of adults (aged 18+) classified as obese (Persons, 18+ yrs)	2021/22	25.9	-	21.1	27.5	36.0	33.2	28.0	28.5	32.1	29.5	29.2

Better 95% | Similar | Worse 95% | Not compared

Display: Values | Trends | Values & Trends

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