Title of Report:	Pan Cheshire Child Death Overview Panel Annual Reports 2022/23 and 2023/24
Date of meeting:	21 January 2025
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Health & Wellbeing Board Lead:	Helen Charlesworth May and Theresa Leavy

Executive Summary

Is this report for:	Information x	Discussion ☐	Decision
Why is the report being brought to the board?	The purpose of this report is to inform the Health and Wellbeing Board of findings and recommendations from the Pan Cheshire Child Death Overview Panel Annual Reports 2023/24 and 2022/23		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Creating a place that supports health and wellbeing for everyone living in Cheshire East ☒ Our children and young people experience good physical and emotional health and wellbeing. ☒ Improving the mental health and wellbeing of people living and working in Cheshire East ☒ Enable more people to live well for longer ☐ All of the above☐		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above ☒		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	The Health and Wellbeing Board (HWB) is asked to: • Note the findings and recommendations within the Pan Cheshire Child Death Overview Panel Annual Reports. • To advocate for sustained focus on approaches to address the commonly associated modifiable and vulnerability factors amongst local children and families.		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	This report has been considered by the Cheshire East Public Health Senior Management Team, it has also been shared specifically with the Executive Director for Adults, Health and Integration and the Executive Director for Children and Families		
Has public, service user, patient feedback/consultation informed the recommendations of this report?	n/a		

If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	Adoption of the recommendations within the reports, by the Pan Cheshire Child Death Overview Panel and where appropriate, the wider Cheshire East system could improve outcomes amongst children and young people, and prevent future child deaths. It could also lead to improved support for those affected by child deaths.

1. Report Summary

1.1. Every child death is a tragedy with huge impacts for the family, friends and professionals that surround and care for that child during their lives. Child Death Overview Panels exist to ensure that each child death is systematically reviewed, so that any learning from these tragic events can be identified and widely shared with the goal of preventing future deaths, wherever possible. The purpose of this Health and Wellbeing Board report is to update the Health and Wellbeing Board on the findings and recommendations within the Pan Cheshire Child Death Overview Panel Annual Reports for 2022/23 and 2023/24.

1.2. Due to external pressures and pressures across the Pan Cheshire Child Death Overview Panel and Pan Cheshire Child Death Overview Panel Business Group, the annual report for 2022/23 was finalised in March 2024, shortly after which, planning of the 2023/24 annual report commenced. The 2023/24 annual report was finalised in November 2024. As such, both reports are being presented to the Health and Wellbeing Board at the same time.

1.3. The 2022/23 Annual Report is included in Appendix A. Key findings and recommendations from the 2023/24 report build on those in the 2022/23 report and are summarised in Appendix B. Further details are included within the full 2023/24 report in Appendix C.

1.4. The reports include a routine update on the number of notifications for the respective year and the numbers of child deaths reviewed by the Child Death Overview Panel. Child deaths are reviewed by the Child Death Overview Panel only after all other review processes are undertaken. Therefore, a child death may be notified during one year and reviewed in another. The Panel consider recurrent themes associated with the deaths reviewed. Findings in relation to modifiable factors are particularly important for the Health and Wellbeing Board to consider. Each child death case is reviewed to understand if there were any ways children, young people or their families could be supported differently that may prevent future deaths. These are known as modifiable factors. Due to the small numbers of child deaths seen each year, it can be helpful to take a longer term view to understand common modifiable or vulnerability factors.

Between 1 April 2022 and 31 March 2024, the leading modifiable (or vulnerability) factors associated with reviews completed by the Pan Cheshire Child Death Overview Panel area have included:

- Mental health issues in a co-habiting parent, care giver or other family member
- Substance or alcohol misuse in a co-habiting parent, care giver or other family member
- Obesity (body mass index ≥30)
- Smoking
- Parental separation
- Domestic abuse

Certain causes of death are more frequently associated with modifiable factors that if addressed, may prevent further deaths in the future. During 2023/24, all completed reviews with a primary category of deliberately inflicted injury, abuse or neglect, and sudden unexpected, unexplained death involved modifiable risk factors. As such, promotion of safe sleep guidance and the ICON programme (which provides information about infant crying, including how to support parents or carers to cope, reduce stress and prevent injuries) remain important interventions.

Modifiable factors were also linked to the majority of completed reviews with the following primary categories of death:

- Trauma and other external factors, including medical/surgical complications or error
- Perinatal or neonatal events
- Suicide or deliberate self-inflicted harm.

1.5. Significant progress has been made against the recommendations in the 2022/23 Child Death Overview Panel Annual Report (please see the full annual report document at Appendix C for further details). Key achievements include:

- Awareness raising regarding
    - Safe sleep
    - The ICON programme
    - Water safety
    - Button battery safety
    - Suicide prevention
    - Bereavement support
    - Child death processes
- Further development of child death review processes to reflect national guidelines and local learning.

1.6. Key priorities for 2024/25 are:

- Child Death Overview Panel reviews to promote greater reflection of the scrutiny of services provided by partner agencies and follow up on actions taken after learning has been identified through partner agency reviews.

- Further developing child death review processes to reflect national guidelines and local learning.

- To promote the findings from the Child Death Overview Panel Annual Report 2023/24 to wider partners.

- To continue to support partners contributing to the Thirlwall Inquiry, await the recommendations from the Inquiry and to champion them amongst stakeholders.

1.7. A new Independent Chair of Pan Cheshire Child Death Overview Panel joined during November 2024. She has a commitment to progressing the priorities and recommendations of the Child Death Overview Panel and to share learning from child deaths widely, to help prevent further deaths in the future wherever possible.

2. Recommendations

2.1. The Health and Wellbeing Board is asked to:

- Note the findings and recommendations within the Pan Cheshire Child Death Overview Panel Annual Reports.

- To advocate for sustained focus on approaches to address the commonly associated modifiable and vulnerability factors amongst local children and families.

Reasons for Recommendations

2.2. The Health and Wellbeing Board is a key forum through which to deliver further improvements in wider health and wellbeing that could lead to the prevention of further child deaths in the future.

3. Impact on Health and Wellbeing Strategy Priorities

3.1. The production of the Pan Cheshire Child Death Overview Panel Annual Report supports the following outcomes from the Health and Wellbeing Strategy 2023-28:

- Cheshire East is a place that supports good health and wellbeing for everyone.
- Our children and young people experience good physical and emotional health and wellbeing.
- The mental health and wellbeing of people living and working in Cheshire East is improved.

4. Background and Options

4.1. Each child death is a tragedy. Child Death Overview Panels exist to ensure the independent and systematic review of the death of every child, so that lessons can be learned from these tragic events and shared effectively to prevent future deaths, wherever possible.

4.2. Child Death Review partners include the local authorities and the NHS Cheshire and Merseyside Integrated Care Board. The Pan Cheshire Child Death Overview Panel includes representatives from across:

- Cheshire East
- Cheshire West and Chester
- Halton
- Warrington

4.3. The review by the Child Death Overview Panel is intended to be the final, independent review of a child's death by senior professionals from different specialities and organisations with no responsibility for providing care to the child during their life. The information gathered may help identify factors that could be altered to prevent future deaths.

4.4. The Pan Cheshire Child Death Overview Panel consists of varied experts including: public health representatives, the Designated Doctor for Child Deaths for the local area; social services; police, the Designated Doctor or Nurse for Safeguarding; nursing and/or midwifery; and other professionals that Child Death Review partners consider should be involved. Additional professionals may be asked to contribute reports in relation to individual cases.

4.5. The purpose of the Child Death Overview Panel Annual Report is outlined in the statutory guidance. The report is produced:

- To clarify and outline some of the Child Death Overview Panel processes directed by national guidance.

- To assure the Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across the Pan Cheshire Child Death Overview Panel footprint.

- To provide an overview of information on trends and patterns in child deaths reviewed across the Pan Cheshire Child Death Overview Panel footprint during the last reporting year (2023/24) and highlight issues arising from the child deaths reviewed. This could include deaths of children who were resident in the Pan Cheshire Child Death Overview Panel footprint, or who died in the footprint.

- To report on achievements and progress.

- To make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across the Pan Cheshire Child Death Overview Panel footprint.

4.6. At the time of writing the most recent annual report, the live hearings at the public Thirlwall Inquiry have commenced. This inquiry has been set up to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby for murder and attempted murder of babies at the hospital. The Pan Cheshire Child Death Overview Panel continues to support partners contributing to the Thirlwall Inquiry. Once the Inquiry concludes, the Panel is committed to championing the recommendations that result.

4.7. Key findings the 2022/23 annual report 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 most frequently identified modifiable factors in infant deaths.

During 2022-23, considerable progress was made in: strengthening the Child Death Overview Panel 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 the panel. The Child Death Overview Panel was awaiting completion of other processes e.g. coroner's inquest and neonatal network reviews, which delayed them coming to

the Child Death Overview Panel.

4.8. Key recommendations of the 2022/23 annual report were 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 the Child Death Overview Panel to build upon understanding of local longer-term trends.
- Work with the Child Death Overview Panel to ensure it has robust capacity for coordinating and administrating the various elements of the child death review system, including the Child Death Overview Panel itself.

4.9. Key findings from the 2023/24 Annual Report were that across Pan Cheshire**:**

- Rates of child notifications were reasonably stable over the last three years.
- There were 52 child death notifications during 2023/24 compared to 55 during 2022/23.
- The rate of notifications across Pan Cheshire during 2023/24 was 2.35/10,000 0-17 year olds and 2.48/10,000 during 2022/23 compared to was 3.18/10,000 across England as a whole during 2022/23.
- The majority of notifications were in children under the age of 1 year (62%), this was a similar to the age distribution across England as a whole.
- The deaths of 57 children were reviewed by the Pan Cheshire Child Death Overview Panel during 2023/24, the majority of which died during 2021/22 or 2022/23 (76%). As at 31 March 2024, reviews of 63 children were ongoing (compared to 68 as at 31 March 2023) and therefore could not as yet be reviewed by the Child Death Overview Panel. Each child death case is reviewed to understand if there were any ways children, young people or their families could be supported differently that may prevent future deaths. These are known as modifiable factors. Due to the small numbers of child deaths seen each year, it can be helpful to take a longer term view to understand common modifiable or vulnerability factors. Between 1 April 2022 and 31 March 2024, the leading modifiable (or vulnerability) factors associated with reviews completed by the Pan Cheshire Child Death Overview Panel area have included:

    - Mental health issues in a co-habiting parent, care giver or other family member
    - Substance or alcohol misuse in a co-habiting parent, care giver or other family member
    - Obesity (body mass index ≥30)
    - Smoking
    - Parental separation
    - Domestic abuse
- Certain causes of death are more frequently associated with modifiable factors that if addressed may prevent further deaths in the future.
    - During 2023/24, 32 out of 57 competed reviews were linked to modifiable risk factors. This represents 56% of all deaths reviewed and is higher than the percentage across England as a whole (43%).
    - During 2023/24, all completed reviews with a primary category of deliberately inflicted injury, abuse or neglect, and sudden unexpected, unexplained death involved modifiable risk factors.
    - Modifiable factors were also linked to the majority of completed reviews with the following primary categories of death: trauma and other external factors, including medical/surgical complications or error; perinatal or neonatal events; and suicide or deliberate self-inflicted harm.The same factors were highlighted as the most commonly identifiable factors across England as a whole during the most recent national data release (relating to 2022/23 child deaths).
- Significant progress has been made against the recommendations in the 2022/23 Child Death Overview Panel Annual Report (please see the full annual report document at Appendix C for further details). Key achievements include:
    - Awareness raising regarding
        - Safe sleep
        - The ICON programme to provide information about infant crying including how to support parents/carers to cope, reduce stress and prevent injuries
        - Water safety
        - Button battery safety
        - Suicide prevention
        - Bereavement support
        - Child death processes
    - Further development of child death review processes to reflect national guidelines and local learning.

4.10. Key priorities for 2024/25 are:

- Child Death Overview Panel reviews to promote greater reflection of the scrutiny of services provided by partner agencies and follow up on actions taken after learning has been identified through partner agency reviews.

- Further developing child death review processes to reflect national guidelines and local learning.

- To promote the findings from the Child Death Overview Panel Annual Report 2023/24 to wider partners.

- To continue to support partners contributing to the Thirlwall Inquiry, await the recommendations from the Inquiry and to champion them amongst stakeholders.

There is a business plan with more specific objectives and recommendations for 2024/25 which the Pan Cheshire Child Death Overview Panel are progressing and coordinating through regular business group meetings.

4.11. During 2024/25, there has been an interim chair of the Child Death Overview Panel Business Group who led the production of this 2023/24 annual report. This followed the resignation of the previous Independent Chair earlier in the year and resulted in changes to the format of the 2023/24 report compared to the 2022/23 report. A new Independent Chair of Pan Cheshire Child Death Overview Panel joined during November 2024. She has a commitment to progressing the priorities and recommendations of the Child Death Overview Panel Annual Report and to share learning from child deaths widely to help prevent further deaths in the future, wherever possible. A responsibility of the new chair will also be the production of the 2024/25 Annual Report. This will include continued efforts to refine the report to ensure that it maximises impact both for the Child Death Overview Panel itself and the wider system.

Access to Information

4.12. The background papers relating to this report can be inspected by contacting the report writer:

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