Annual Report of the

Pan Cheshire Child Death Overview Panel

2023/24

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Introduction

Each child death is a tragedy.

"The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. Families experiencing such a tragedy should be met with empathy and compassion. They need clear and sensitive communication. They also need to understand what happened to their child and know that people will learn from what happened. The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths[1].

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.

At the time of writing this 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 of murder and attempted murder of babies at the hospital[2].

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.

This current report focuses on children whose deaths were either notified to the Pan Cheshire Child Death Overview Panel during 2023/24, or whose reviews concluded during 2023/24.

As a panel, we are dedicated to ensuring our families are supported following the death of their child, and that any learning from these heartbreaking losses is fully acknowledged and shared across our the Pan Cheshire area and beyond.

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[1] HM Government (2023) Working Together to Safeguard Children 2023. A guide to multi-agency working
to help, protect and promote the welfare of children. Available from: Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk) (Accessed 24 June 2024).
[2] Thirlwall Inquiry. Available from: https://thirlwall.public-inquiry.uk/ © Crown Copyright 2024 (Accessed 13 September 2024).

The Pan Cheshire Child Death Overview Panel footprint and process

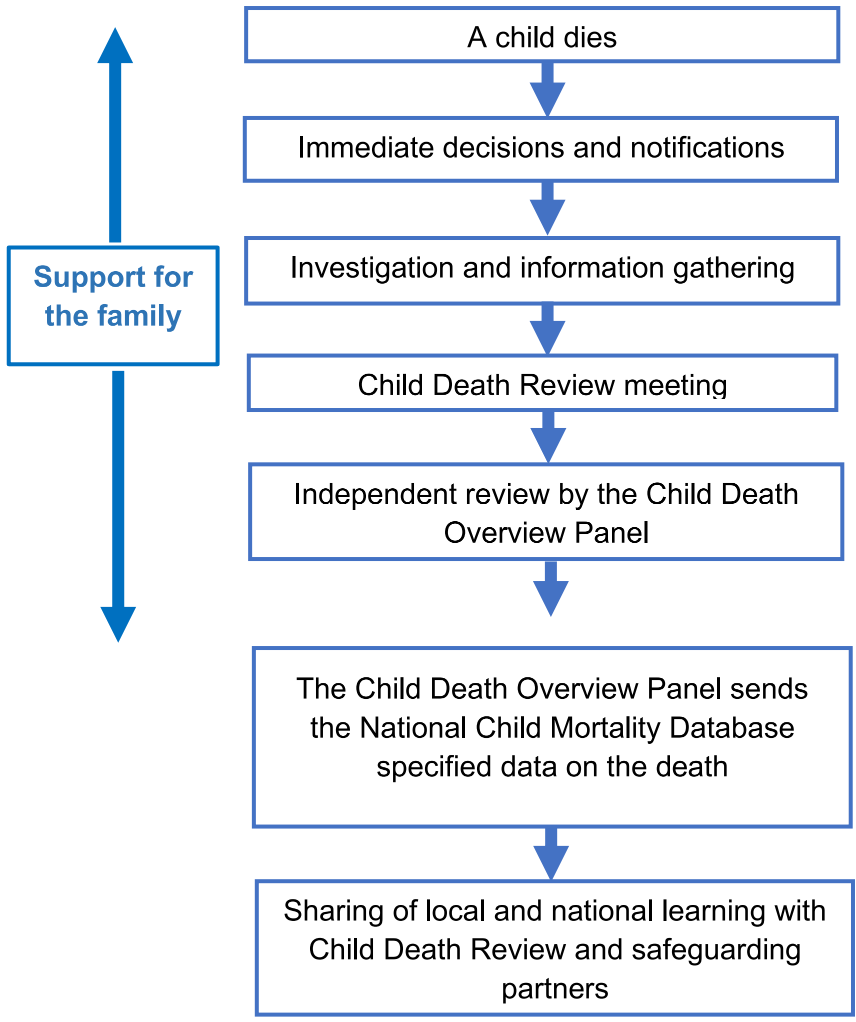
Child Death Review partners include the local authorities and the NHS Cheshire and Merseyside Integrated Care Board.

The Cheshire Child Death Overview Panel includes representatives from across:

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

The child death review process is outlined in statutory guidance: Working Together to Safeguard Children 2023 and Child Death Review Statutory and Operational Guidance (England) 2018.

When a child dies, the process undertaken is illustrated in the figure below.



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.

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.

Supporting families with child bereavement

At the centre of every child death are families and friends experiencing devastating loss. An important role of the Child Death Overview Panel is to ensure they have the support and importantly, the compassion and sensitivity that is so greatly needed in such distressing circumstances. Child Bereavement UK has produced guidance to support professionals with this important role.

"Working with families who are grieving can feel daunting…

Nothing we can do or say can take away the pain of bereavement, but families tell us of the importance of sensitive care. Poor care can intensify and prolong a family's distress, whilst care that is sensitive and appropriate can help families in their grief. The effects of this are positive and long-lasting…

Supporting bereaved families includes good communication, responding to their needs in a timely way, and being emotionally self-aware"[3].

The guidance states:

"Listening to others means using all our senses to pick up on what the person is communicating, and it involves much more than just what we are hearing.

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[3] Child Bereavement UK. Supporting bereaved families. Available from: https://www.childbereavementuk.org/Listing/Category/working-with-bereaved-families (Accessed 15 July 2024

Good communication involves:

- Having the right environment, preferably where you will not be disturbed.
- Being compassionately clear about the time the person or family can have with you to talk. This creates a safe environment where they know what they can expect, and it avoids the interaction ending abruptly.
- Listening to the words, the tone of voice and the feelings being conveyed.
- Observing body language and facial expressions, and noticing what is not being said as well as what is said.
- Showing your interest and empathy through good eye contact, your tone of voice and body language.

Checking with the person that you have both heard and understood the key messages."[4]

Purpose of the Child Death Overview Panel Annual Report

As outlined in the statutory guidance, the purpose of the Annual Report is:

- 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] [4] Child Bereavement UK. Supporting bereaved families. Available from: https://www.childbereavementuk.org/Listing/Category/working-with-bereaved-families (Accessed 15 July 2024

Key trends in child death notifications

As described in the statutory guidance, when a child dies, a number of notifications should also be made, including: to the child's GP and other professionals; to the Child Health Information System; the relevant Child Death Review partners and the Child Death Overview Panel. This helps to guide how to support the family. It also helps to identify whether Joint Agency Reviews, NHS serious investigations, or referrals to the coroner are required. Across the Pan Cheshire footprint:

- 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[5].
- The rate of notifications across England as a whole was 3.18/10,000 during 2022/23[6].
- 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.

It is difficult to discern a pattern of seasonal variation due to the very small numbers involved.

Key trends in reviews of child deaths completed by the Child Death Overview Panel during 2023/24

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 during another.

The length of time between notification and final review can vary considerably depending on circumstances and other review processes. The reasons for delays can include awaiting further investigation through neonatal reviews, post-mortems and inquests.

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[5] Based on ONS 2022 mid-year population estimates. ONS (2024) Population estimates for the UK, England, Wales, Scotland, and Northern Ireland: mid-2022. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest (Accessed 14 June 2024

[6] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

The deaths of 57 children were reviewed by 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.

Key trends in modifiable factors during 2023/24

Each child death is reviewed to understand if there were any ways children, young people or their families could be supported differently, which 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 have included:

- Mental health issues in a co-habiting parent, care giver or other family member, in 39% of all completed reviews.
- Substance or alcohol misuse in a co-habiting parent, care giver or other family member, in 20% of all completed reviews.
- Obesity (body mass index ≥30), in 20% of all completed reviews.
- Smoking, in 16% of all completed reviews.
- Parental separation, in 16% of all completed reviews.
- Domestic abuse, in 15% of all completed reviews.

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%)[7].
- 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:

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[7] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP Report created on: 23/05/2024. Quarter 4 2023/24

- Trauma and other external factors, including medical/surgical complications or error.
- Perinatal or neonatal events.
- 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)[8].

Progress during 2023/24 and achievements

Significant progress has been made against the recommendations in the 2022/23 Child Death Overview Panel Annual Report (see Progress against 2022/23 annual report recommendations during 2023/24) for further details.

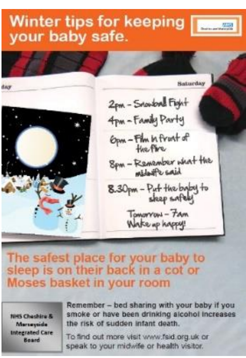
ICON Week
25 - 29 September 2023

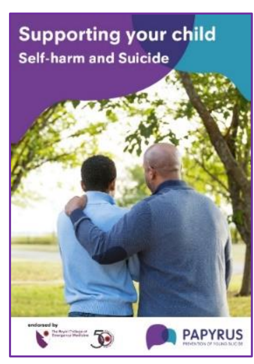
Key achievements include:

- 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.

A Christmas Button Battery Safety Message
What should I do if my child swallows a button battery?

Winter Water Safety
Royal Life Saving Society UK issues winter water safety advice
Urgent Winter Water Safety Message

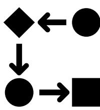




[8] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

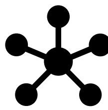
Priority recommendations for 2024/25

The priorities for 2024/25 include:



- 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.



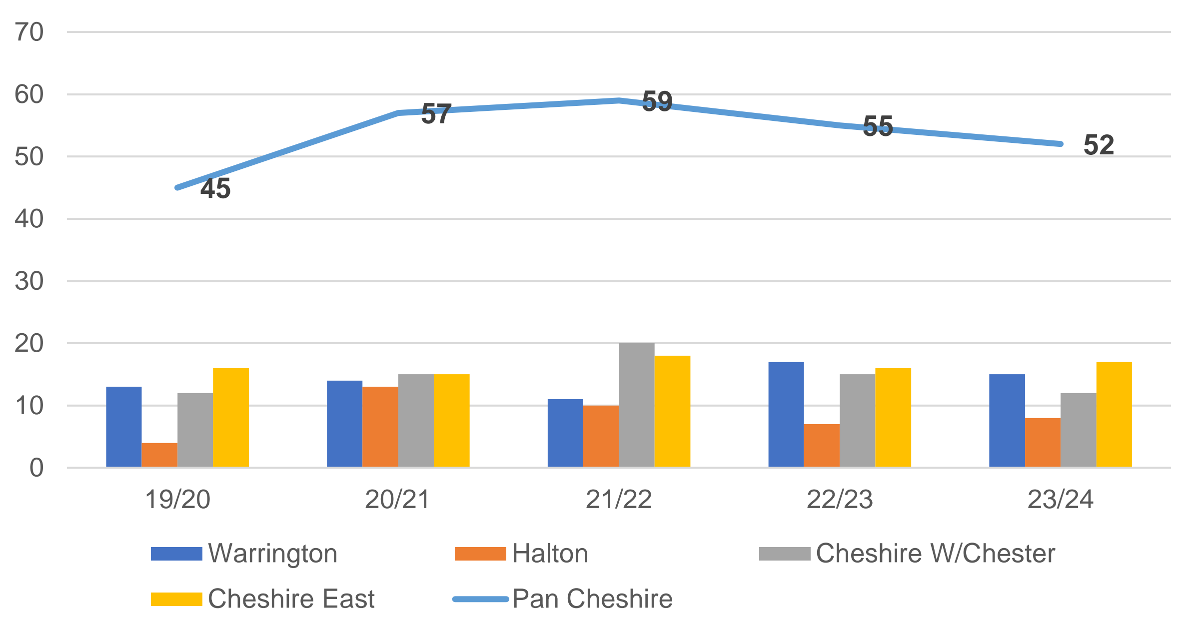
- To continue to support partners contributing to the Thirlwall Inquiry, await the recommendations from the Inquiry and to champion them amongst stakeholders.

A Child Death Overview Panel business plan has been developed for 2024/25 to facilitate progress against these priorities.

Appendices

Number of notifications to the Pan Cheshire Child Death Overview Panel

Natural variation in the number of deaths notified to Child Death Overview Panels is to be expected from year to year. Between 2019 and 2024, the number of child death notifications across the Pan Cheshire footprint has varied from 45 to 59. There were 52 notifications during 2023/24 across Pan Cheshire. This is 3 fewer than during 2022/23. During 2023/24, the highest numbers of death notifications were seen in Cheshire East and then Warrington.

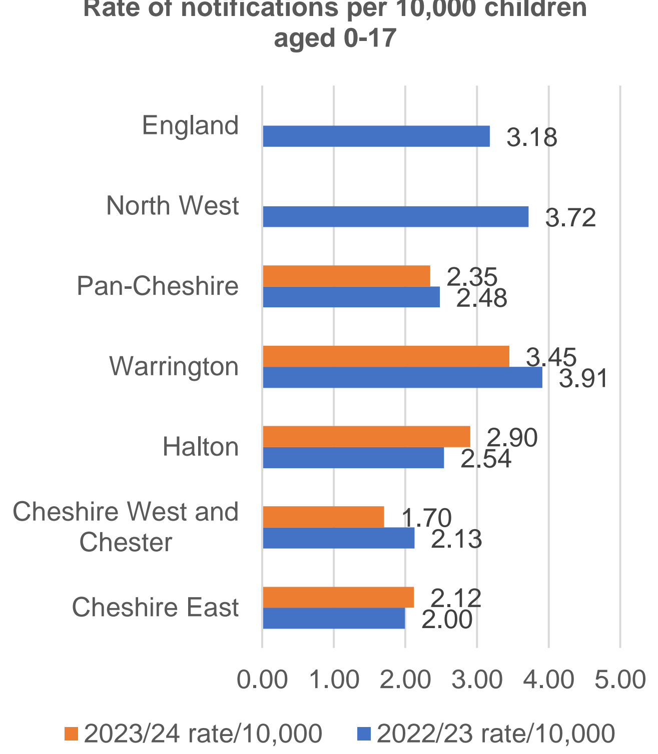


Rate of notifications to Pan Cheshire Child Death Overview Panel (per 10,000 children aged 0-17years)[9]

During 2023/24, the rate of notifications to the Pan Cheshire Child Death Overview Panel was 2.35/10,000 children aged 0-17 years. At time of writing, the national death notification rate for 2023/24 is not currently published. However, the death

[9] .Based on ONS 2022 mid-year population estimates. ONS (2024) Population estimates for the UK, England, Wales, Scotland, and Northern Ireland: mid-2022. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest (Accessed 14 June 2024).

notification rate across England for 2022/23 was 3.18/10,000 children aged 0-17. This was higher than the Pan Cheshire rate for 2022/23 (2.48/10,000)[10] (although the statistical significance of this difference has not been determined). The regional notification rates for 2022/23 ranged from 2.42/10,000 in the South West to 4.11/10,000 in the West Midlands[11]. The rate across the North West was 3.72/10,0004[11].



During 2023/24, the highest notification rate was seen in Warrington where there were 3.45 notifications/10,000 children aged 0-17 years. Warrington also had the highest rate during 2022/23. The rate for 2023/24 is lower than that for 2022/23. Single year rates are subject to significant random variation. Statistical analysis has determined that the Warrington rate of notifications for 2023/24 was not statistically significantly different to the rate of the other local authorities[11].

On reviewing rolling 3 year average rates of infant mortality in Warrington (2001-22) and of child mortality in Warrington (1-17 years old) (2010-2022), rates have been consistently similar to the England average[12]. In addition, the 3 year average child

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[10] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

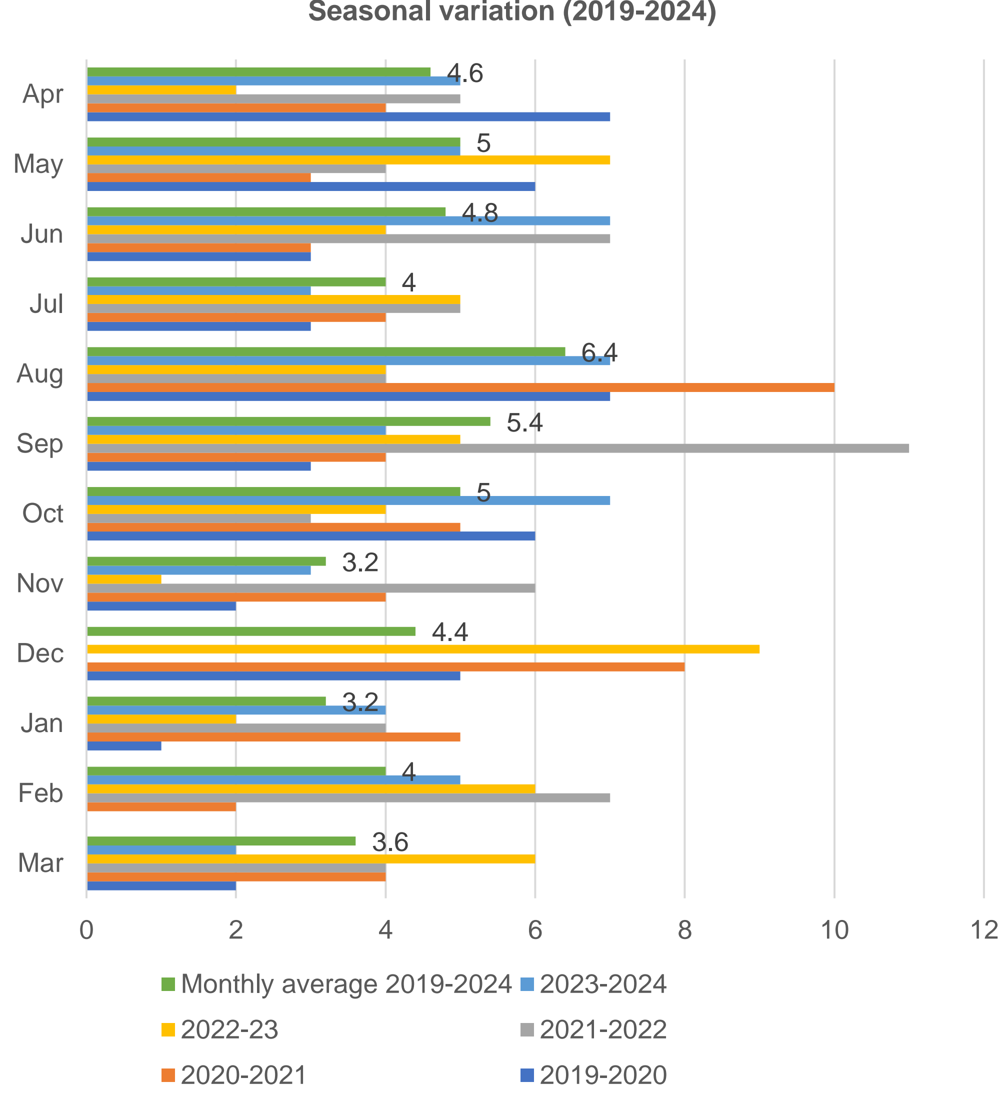
[11] Cheshire East Council Public Health Intelligence Team (2024). Chi-squared testing was undertaken to determine whether there is a significant difference between the expected frequencies and the observed frequencies in one or more categories with null hypothesis that any differences are due to chance. Childhood deaths are similar across all Cheshire local authorities.

[12] Office for Health Improvement & Disparities. Public Health Profiles. (Accessed 14 June 2024) https://fingertips.phe.org.uk © Crown copyright (2024).

death notification rate (2021-2024) for Warrington (3.3/10,000) was more similar to Halton (3.1/10,000) than the single year rate for 2023/24.

Variation in notifications by month

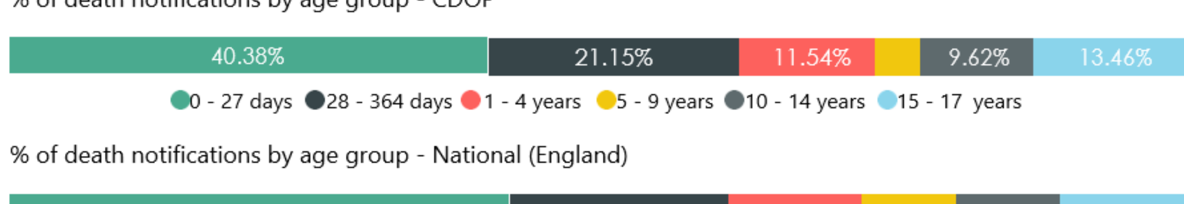
Seasonal variation in notifications to the Pan Cheshire Child Death Overview Panel are provided in the graph below. Monthly numbers of notifications varied from 0 in December to 7 in June, August and October. It is difficult to discern a pattern in terms of seasonal variation as the numbers for each given month vary from year to year. However, the month with the highest average rate over the last five years was August, followed by September[13]. The statistical significance of this finding has not been determined and this could be due to chance variation.



[13] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP. Report created on: 23/05/2024. Quarter 4 2023/24

Variation in notifications by age during 2023/24

The age distribution of notifications to Pan Cheshire Child Death Overview Panel was very similar to the England average, with the majority being deaths in the first year of life (62%) (see bar chart below)[14].



Numbers of reviews of child deaths completed by the Child Death Overview Panel

Child deaths are reviewed by the Child Death Overview Panel only when all information has been provided, and once all other review processes are completed. This is to ensure a final independent review by senior professionals to make sure all learning is identified and to ensure this learning will then be shared with wider relevant professionals to try and prevent future deaths, where possible.

The length of time between notification and review can vary considerably depending on circumstances and other review processes. The reasons for delays can include awaiting further investigation through neonatal reviews, post-mortems and inquests.

57 reviews of child deaths were completed by the Child Death Overview Panel during 2023/24 (compared to 76 during 2022/23) The year of death of the cases reviewed ranged from 2016/17 to 2022/23:

- 53% had died during 2022/23
- 23% had died during 2021/22

Of the reviews of child deaths completed, the highest numbers related to children resident in Cheshire East and Cheshire West and Chester, followed by Warrington. As at 31 March 2024, there were 63 cases with reviews ongoing (compared to 68 as at March 2023), and therefore could not as yet be reviewed by the Child Death Overview Panel. Cheshire East had 22 ongoing cases, Warrington 17, Cheshire West and Chester 14 and Halton 10.

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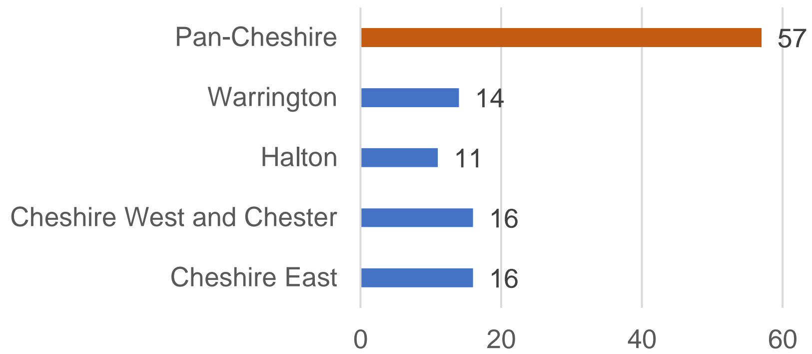
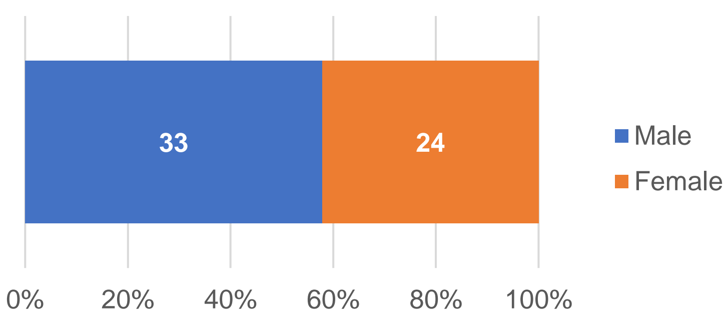
[14] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP. Report created on: 23/05/2024. Quarter 4 2023/24

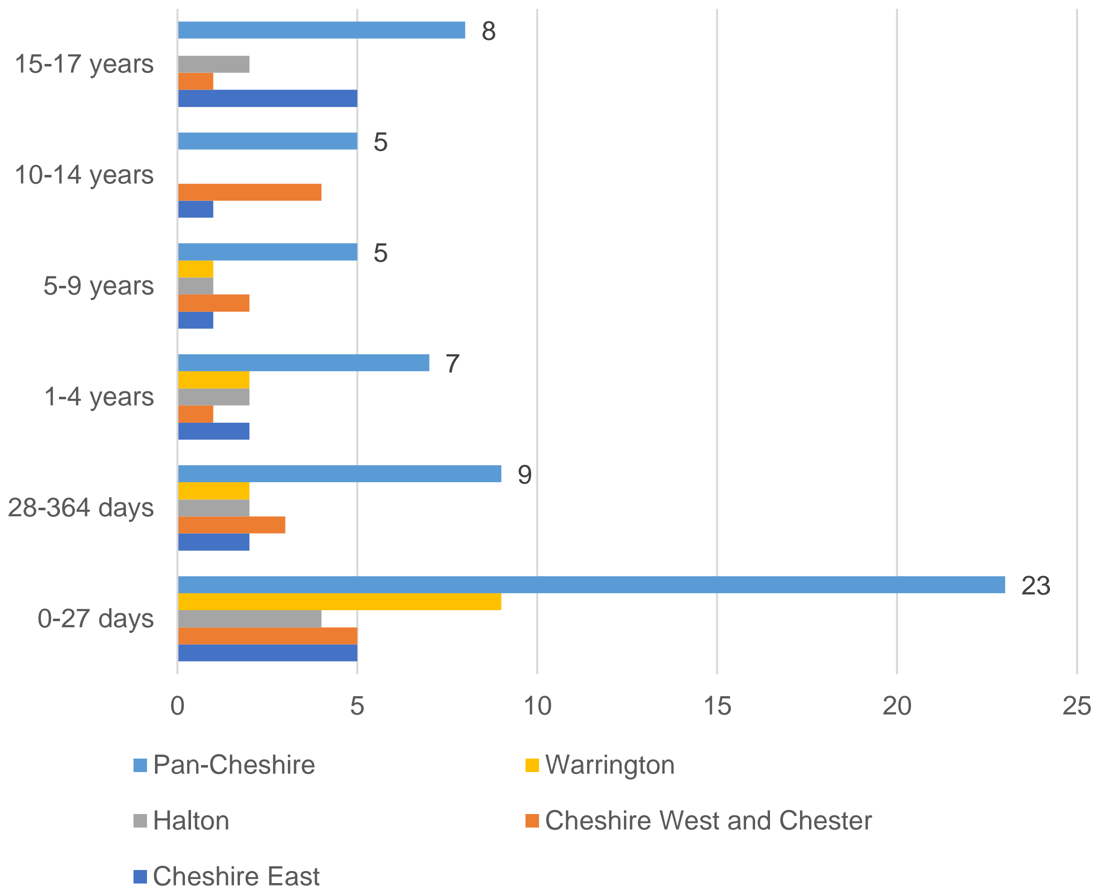


More males were reviewed than females.



Variation of reviews of child deaths completed by the Pan Cheshire Child Death Overview Panel by age and area (2023/24)

The highest numbers of child deaths reviewed related to death during the neonatal period (23/57,40%). 56% (32/57) of child deaths reviewed related to death within the first year. The next highest proportions of reviews related to 1-4 year olds (12%) and 15-17 year olds (14%) (see graph below).



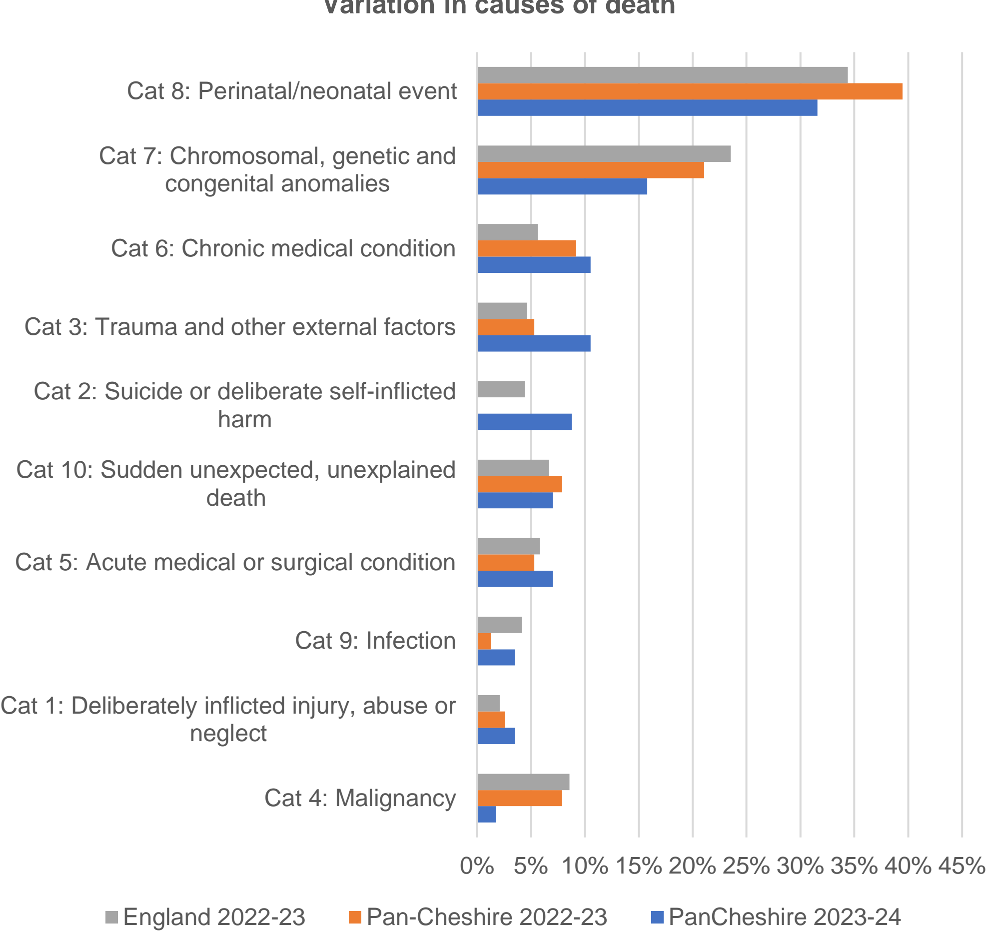
Causes or categories of death amongst reviews of child deaths completed by the Pan Cheshire Child Death Overview Panel (2023/24)

The most frequent causes of death amongst completed reviews were

- Perinatal/neonatal events (32%)
- This was followed by chromosomal, genetic and congenital anomalies (16%), chronic medical conditions (11%) and trauma and other external factors (11%)
- Suicide or deliberate self-inflicted harm was the category in 9% of cases (5/57)
- Sudden unexpected death was noted as a category of death in 7% of cases (4/57).

Whilst there is significant variation from year to year (due to the small numbers involved) and statistical significance has not been determined, the distribution of the

causes of death are fairly similar in the Pan Cheshire Child Death Overview Panel footprint to the England average[15].



Variation in ethnicity of reviews of child deaths completed by the Pan Cheshire Child Death Overview Panel (2023/24)

The majority of closed cases were of “white” ethnicity (51/57, 89%), this was similar to 2022/23 where 87% of closed cases were of “white” ethnicity.

According to the School Census, 83% of children and young people were “White British” across the Pan Cheshire area. However, the classification of ethnicity may be slightly different. The numbers of closed cases are comparatively very small

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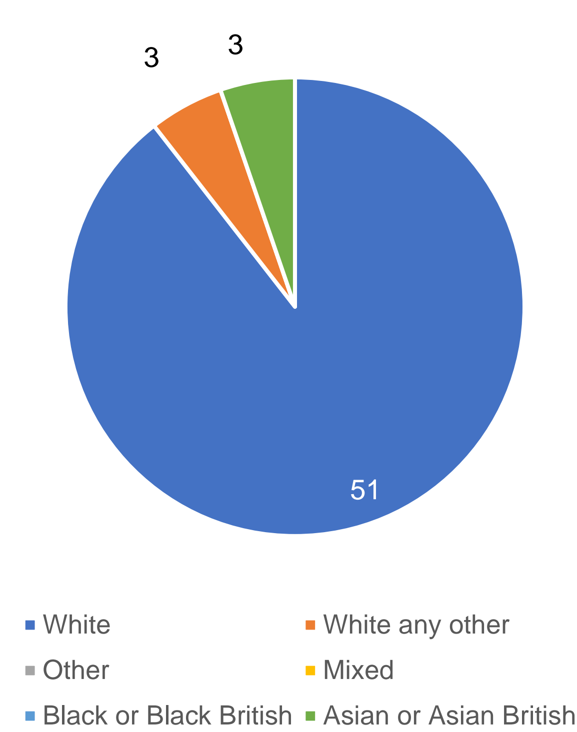
[15] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

compared to the entire population. However, those from ethnicities other than White British do not appear to be significantly over represented[16].



Modifiable/vulnerability factors in reviews completed during 2022-24 across the Pan Cheshire Child Death Overview Panel footprint

Modifiable factors are factors across domains specific to the child, the social and physical environment, and service delivery that could be altered to prevent future deaths[17]. During 2022-24, the leading associated modifiable (or vulnerability) factors across the Cheshire Child Death Overview Panel area have included:

- Mental health issues in a co-habiting parent, care giver or other family member, in 39% of all completed reviews
- Substance or alcohol misuse in a co-habiting parent, care giver or other family member, in 20% of all completed reviews

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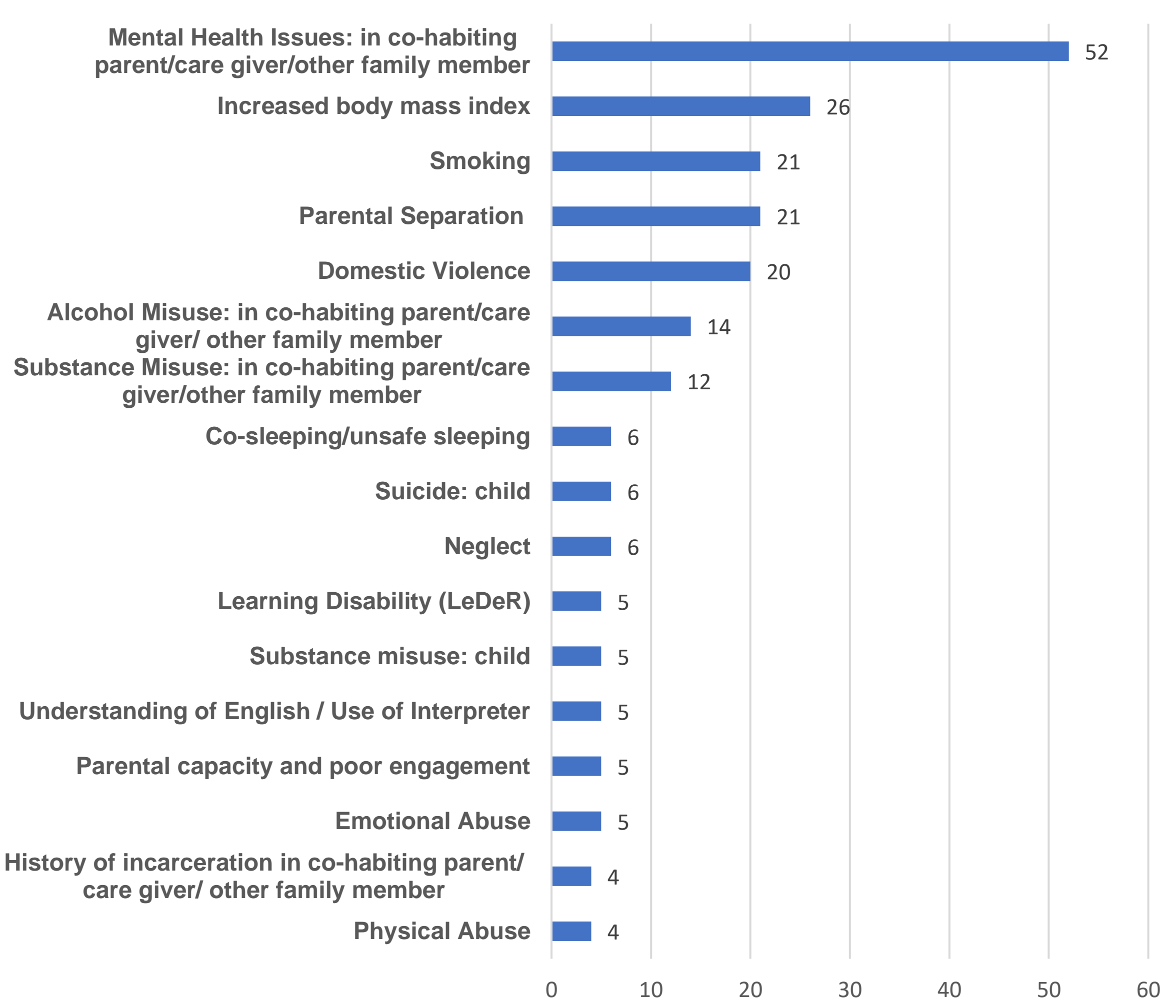
[16] Gov.uk (2024) Academic year 2023/24. Schools, pupils and their characteristics. Available from: https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics (Accessed 14 June 2024).
[17] Gov.uk (2018) Child death review: statutory and operational guidance (England). Available from: Child death review: statutory and operational guidance (England) - GOV.UK (www.gov.uk) (Accessed 13 September 2024).

- Obesity (Body mass index ≥30), in 20% of all completed reviews
- Smoking, in 16% of all completed reviews
- Parental separation, in 16% of all completed reviews
- Domestic abuse, in 15% of all completed reviews

As well as child death data, other sources of data demonstrate the wider public health challenges of smoking and obesity across the Pan Cheshire population. According to the most recently available data, Halton and Warrington had significantly worse rates of mothers smoking at time of the birth of their babies than the England average. Cheshire West and Chester and Halton had a significantly higher prevalence of excess weight (people experiencing overweight or obesity) than the England average[18]



[18] Office for Health Improvement & Disparities. Public Health Profiles. Available from: https://fingertips.phe.org.uk © Crown copyright [2024].(Accessed 18 June 2024).

In addition to the modifiable and vulnerability factors that were recorded as part of a systematic framework, for 2023/4, some additional comments were recorded as more free-form text, including relating to the following themes:

- Equipment safety issues (2)
- Service development/provision issues (7).

Variation of modifiable risk factors across pan Cheshire Child Death Overview Panel by cause of death

During 2023/24, 32 out of 57 completed reviews were linked to modifiable risk factors. This represents 56% of all completed reviews 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 had modifiable risk factors.

Modifiable factors were also linked to the majority of closed cases 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.

The category of deaths with the highest numbers of cases with modifiable factors identified was for perinatal/neonatal events (see table on next page). These findings are similar to the national picture presented for child deaths during 2022-23, similar analysis for 2023-24 is not yet available[19].

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[19] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

Primary category of death (CDOP)	Modifiable Factors Identified (%)	Modifiable Factors Identified (absolute numbers)
Malignancy	0%	0
Chronic medical condition	0%	0
Acute medical or surgical condition	0%	0
Chromosomal, genetic and congenital anomalies	33%	3
Infection	50%	1
Suicide or deliberate self-inflicted harm	60%	3
Perinatal/neonatal event	78%	14
Trauma and other external factors, including medical/surgical complications/error	83%	5
Deliberately inflicted injury, abuse or neglect	100%	2
Sudden unexpected, unexplained death	100%	4

Variation in modifiable risk factors by cause of death across England (2022-23)

The picture in Pan Cheshire during 2023/24 was similar to the England picture during 2022/23[20].

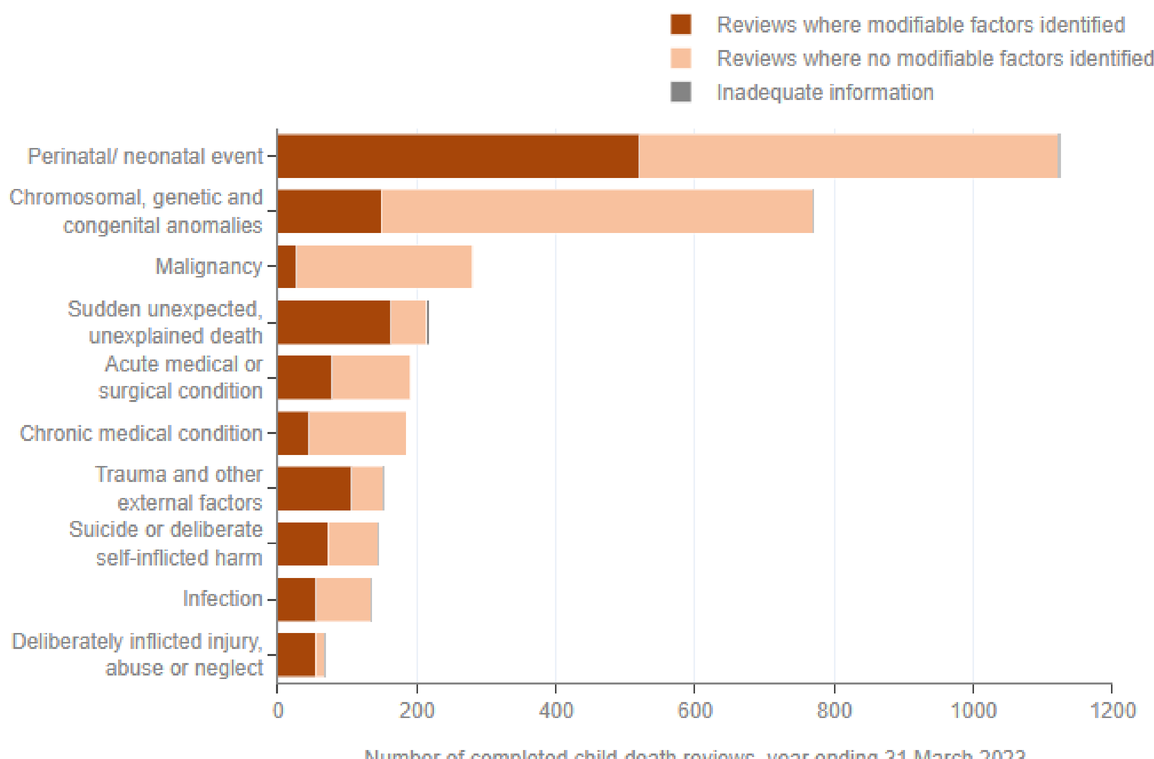
Categories of death where modifiable factors were most frequently identified in child deaths across England included:

- Deliberately inflicted injury, abuse or neglect (81%).
- Sudden unexpected and unexplained death (76%).
- Trauma or other external factors (71%).
- Suicide or deliberate self-inflicted harm (50%).

(See graph on next page).

[20] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

Number of reviews completed by the Child Death Overview Panel by primary category of death and whether modifiable factors were identified, year ending 31 March 2023



Data Source: NCMD
www.ncmd.info/cdr23/

Adverse childhood experiences in cases of child death

Adverse Childhood Experiences (ACEs) are a set of adverse events or environmental factors occurring in a person's life under the age of 18. It has been shown that ACEs can negatively affect people's health and opportunities throughout their life, however in many cases ACEs are preventable[21].

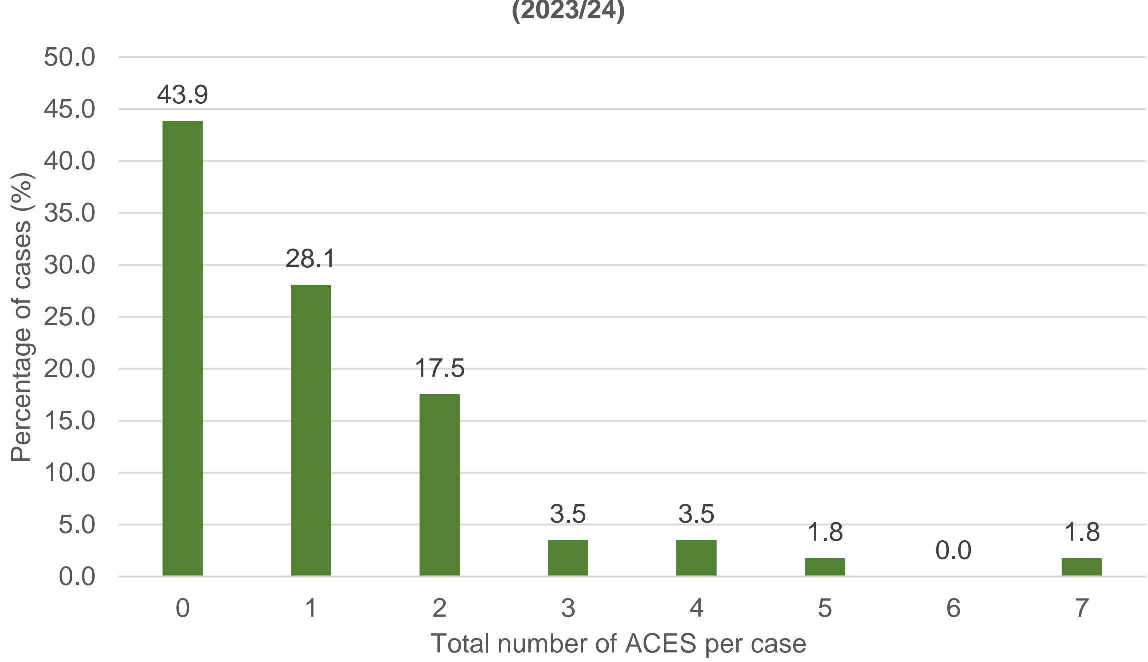
Across the Pan Cheshire Child Death Overview Panel area between 2019/20 and 2022/23 the most common ACEs present in child death cases were:

- Household mental health issues (present in 41 cases)
- Parental separation (present in 25 cases)
- Household domestic violence (present in 24 cases).

[21] CDC (2024) Adverse Childhood Experiences. Available from: https://www.cdc.gov/aces/about/index.html?CDC_AAref_Val=https://www.cdc.gov/violenceprevention/aces/preventingace-datatoaction.html (Accessed 13 September 2024).

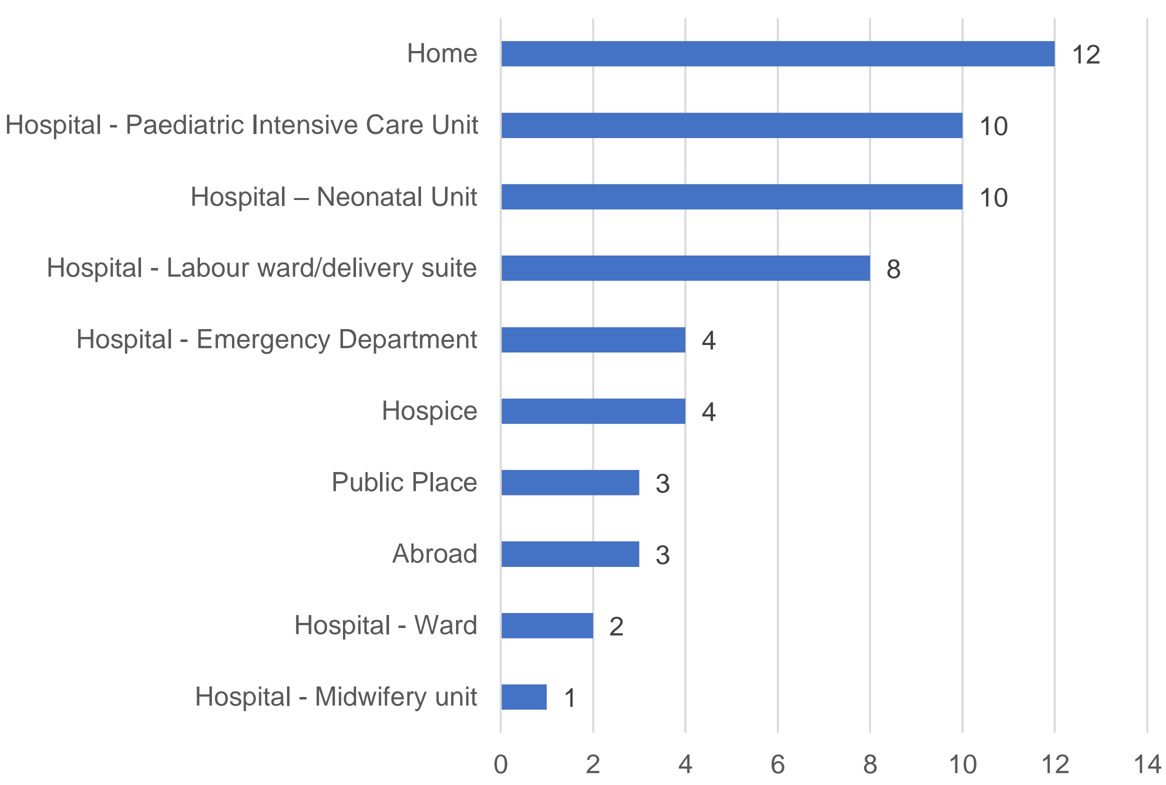
However, children experiencing neglect have the highest mortality rates of all the ACEs (245 per 100,000 children experiencing neglect).

Just over 4 in 10 child deaths (25) in Pan Cheshire in 2022/23 had zero associated ACEs, and the number of ACEs for each child ranged between zero and seven of a possible ten. There were four children with four or more ACEs identified (7%).



Place of death of the reviews completed by the Pan Cheshire Child Death Overview Panel (2023/24)

49% (28/57) of deaths took place in either the hospital neonatal units, paediatric intensive care units, labour wards or delivery suites. 21% (12/57) of deaths were at home (see graph on next page).


Variation in place of death in completed reviews of child deaths (2023/24)
Home
Hospital - Paediatric Intensive Care Unit
Hospital – Neonatal Unit
Hospital - Labour ward/delivery suite
Hospital - Emergency Department
Hospice
Public Place
Abroad
Hospital - Ward
Hospital - Midwifery unit
12
10
10
8
4
4
3
3
2
1
0
2
4
6
8
10
12
14

Achievements during 2023/24

Non-accidental injury prevention

A national learning event took place regarding The Infant Crying You Can Cope (ICON) programme: 25th - 29th of September 2023

ICON Week

25 - 29 September 2023

WEBINAR PROGRAMME

Time	Session
Monday 25 September	
10:30-10:35	Sue Anslow, ICON Programme Manager - Welcome to ICON Week
10:35-10:50	Dr Suzanne Smith PhD ICON Founder & Programme Advisor - Introduction
10:50-11:00	Jane Scattergood – A few words from our Chair
11:00-11:15	Sue Anslow - Feedback from Audit
13:00-13:30	Joanna Garstang – Birmingham Videos
14:30-15:00	Laura Kefford and Monica Davis - Raising awareness of ICON and abusive head trauma within the multi-agency
Tuesday 26 September	
10:00-10:30	Craig Johnson – SCPHN/Clinical Advisor for School Health for SSAFA, based in British Forces Cyprus Delivering ICON to the teenage audience
11:00-11:30	Tilly Pillay and Vijay Jobanputra STORK Programme and ICON
13:30-14:00	Eleanor Marcham - Team Leader 0-19 service Locala's approach to ICON and male inclusivity
15:00-15:30	Fran Acharya – ReachDeck - An accessible website for all
Wednesday 27 September	
10:00-10:30	James Footitt Account Director, Bauer Media - Get Our Message Heard
11:00-11:30	Lois Fisher Deputy Clinical Lead- ICON - Update from 0-19 HCP across Cambridgeshire and Peterborough
13:30-14:00	Dr Giles Haythornthwaite - Consultant Paediatrician - Why the Major Trauma network in the UK are stakeholders in parent advice at birth and support the ICON message
15:00-15:30	Deborah Gibbons - Safeguarding Midwife, Carla Clarke – Named Midwife Safeguarding, and Karen Turzynski - Clinical Practice Lead ICON Developments in Lancashire
Thursday 28 September	
10:30-11:00	Krishoen Sawmynaden and Professor Anna Tarrant - Rethinking Dads
12:00-12:30	Emma Davis - Senior Probation Officer Warrington - Probation and ICON
13:00-13:30	Jonathan Hill Brown, Karen Tyson-Lee and Monica Davis - MECSH and ICON in Harrow Health Visiting
14:30-15:00	Dr Rachael Jolley - ICON in General Practice
Friday 29 September	
10:00-10:30	Kieran Anders - Dad Matters and ICON
10:45-11:30	Parents Ambassadors
11:30-12:00	Final thoughts and close from Dr Suzanne Smith

All webinars are on Microsoft Teams and available at this link www.iconcope.org/webinar-iconweek2023

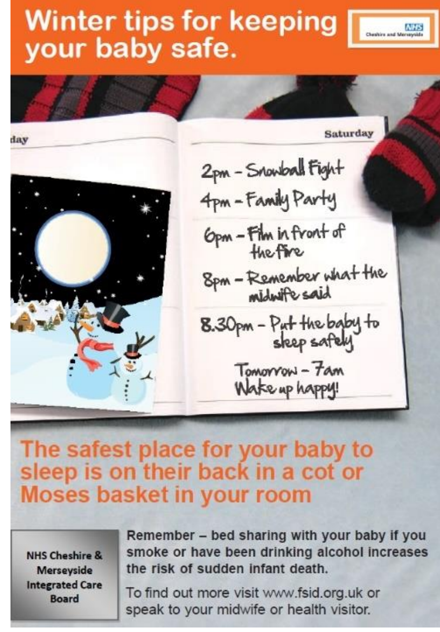
Full details are available on our website: www.iconcope.org/iconweek2023

The ICON programme is being implemented by health and social care organisations in the UK to provide information about infant crying. It includes how to support parents/carers cope, reduce stress and prevent 'Abusive Infant Head Trauma'.

Resources, toolkits, newsletters, and information on daily webinars were shared to all agencies in Cheshire via the communication teams.

Safe sleep: Winter tips for keeping your baby safe (December 2023)

Christmas is often a period when infants are more exposed to situational risks as often a safe sleep plan for baby has not been considered by parents/carers when 'out of routine', for example, staying at relatives or friends, consuming excessive alcohol.



Regional promotional material on safe sleep was widely circulated across Pan Cheshire Child Death Overview Panel professional networks during the lead up to Christmas.

A leaflet was designed by Designated Nurse for West Place Integrated Care Board as the Christmas festive season was approaching.

The leaflet also contained tips on the infant safer sleep during the winter months, as parents/carers

may choose unsafe infant sleep techniques/methods as their decisions are compounded by deprivation and prevailing fuel poverty.

The leaflet was shared complete with QR codes for further reading to all multi agencies in Cheshire via the communication teams, safeguarding nurse teams and by the Pan Cheshire Child Death Overview Panel members.

There were no child death notifications during December 2023.

Accident prevention

A Christmas Button Battery Safety Message Poster was developed and disseminated following Concerns Raised by UKHSA about ingestion by children of button batteries.

As the Christmas festive period was approaching, a poster was developed for professionals to alert parents/carers of the dangers, symptoms of ingestion and to seek immediate medical help if it is suspected a child has swallowed a button battery.

This poster was shared to agencies throughout Cheshire and Merseyside via the communications teams.

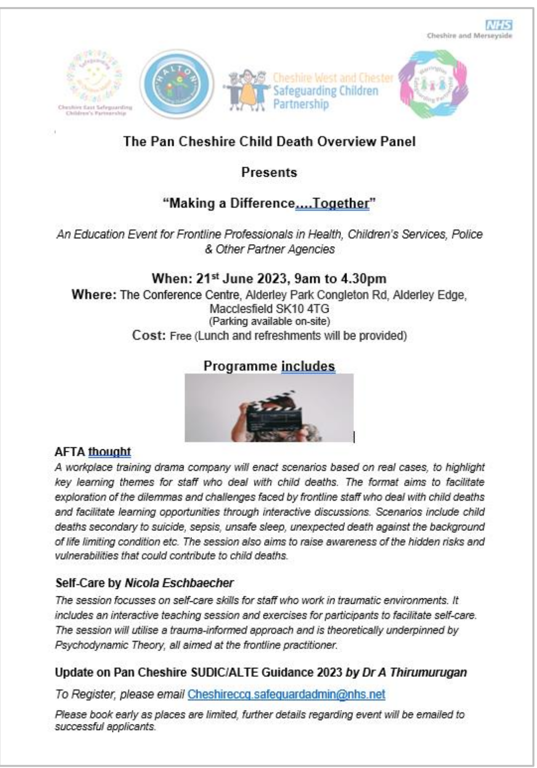
Enhancements of the child death review process

Plans were confirmed to move the administrative function of the Child Death Overview Panel to Mid Cheshire Hospitals NHS Foundation Trust and to expand capacity

The intention of moving the administrative function was to increase capacity for preparing cases for the panel and to increase resilience and pastoral support to those involved in the process.

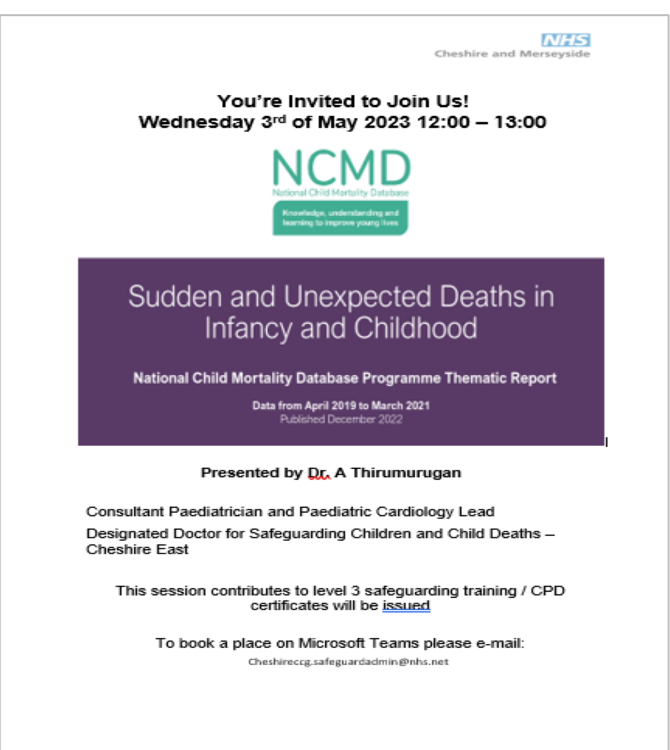
Pan Cheshire Child Death Overview Panel Education Event, 21 June 2023

Making a Difference together-This was an interactive learning event for agencies held at Alderley Park Conference Centre. There was an update of the Pan Cheshire Sudden Infant and Child Death/ Acute Life-Threatening Event Guidance, learning through case scenarios delivered by the acting company 'AFTA thought', 'Trauma Informed Self Care' session followed by interactive reflections. The case scenarios were developed to highlight some of the issues identified by the Pan Cheshire Child Death Overview Panel. Over 100 professionals attended. Feedback was positive.



The NCMD Sudden and Unexpected Deaths in Infancy and Childhood Thematic Report (virtual lunch and learn professional development session)

This session was presented by Dr Thirumurugan (Designated Dr for Child Deaths) on behalf of the Pan Cheshire Child Death Overview Panel to Multi agencies in Cheshire and Merseyside. Over 171 professionals attended. This report looked at vulnerabilities increasing susceptibility of sudden and unexpected deaths, modifiable factors and key learning points associated with the impact of the Covid -19 Pandemic and poor communication and information sharing, challenges in the child death response. It also affirmed the suspected risks associated with sudden and unexpected deaths infancy and the increased prevalence of convulsions in sudden and unexpected deaths in childhood.



'How is it relevant for me?' (virtual lunch and learn professional development session), 13 September 2023

This session was presented by Dr Mittal (Designated Doctor for Child Deaths) to Multi agencies in Pan Cheshire, over 66 professionals attended. This event was to raise professional awareness of the Child Overview Panel purpose and processes for both unexpected and expected deaths of children who are resident within the Cheshire locality.

Progress against 2022/23 annual report recommendations during 2023/24

Recommendation	Progress during 2023/24	Next steps
1. Continue to share the Sudden Unexplained Death in Children processes within neonatal and maternity units for unexpected or unexplained collapses in hospital leading to deaths within them.	Agreed to re-circulate the individual Self Assessment Frameworks to Trusts to update.	To work with partners to promote further awareness, particularly in hospital trusts. To seek assurance that this activity has occurred.
2. Establish a system for monitoring notifications by hospital providers of neonatal and maternity care.	A spreadsheet has been established that identifies death notifications by month and unit; unexpected/ expected.	To ensure this is a standing agenda item in Child Death Overview Panel business meetings.
3. Develop stronger relationships with the Coroner's office, particularly in relation to information sharing, post-mortem reports and child death review meetings.	A coroner's office representative now attends Pan Cheshire Child Death Overview Panel meetings where feasible. A discussion with the Coroner took place during Autumn 2023 to discuss ways of strengthening relationships, which resulted in an agreement to a regular annual meeting.	Annual meetings with the coroner to become part of routine Child Death Overview Panel business.

4. Strengthen the Child Death Overview Panel business support functions through additional investment and funding arrangements.	Mid Cheshire Hospitals NHS Foundation Trust have taken over employment of the administrative function of the Child Death Overview Panel and funding has been confirmed for 1.2 administrators.	A second part-time administrator to be recruited. To explore strengthening resilience of business administration across Cheshire and Merseyside.
5. Maintain Pan Cheshire Child Death Overview Panel compliance with the National Child Mortality Database Report Key Performance indicators.	Compliance with key performance indicators has been demonstrated in the quarter four 2023/24 National Child Mortality Database report which highlighted “good” levels of completeness for all indicators.	To maintain this good standard of completeness of reporting.
6. Ensure that all parents whose child has died continue to have access to appropriate bereavement services.	Bereavement support is monitored at panel and followed up if bereavement support is not recorded; work by a Child Death Overview Panel representative has been quite instrumental in ensuring bereavement support remains at the fore front of professionals. Anecdotally, the number of analysis forms being returned without information regarding bereavement support is limited.	Sustain this support and continue to monitor as part of business as usual.
7. Ensure that all parents whose child has died are offered the opportunity to contribute to Child Death Review process.	Parents are contacted by the Child Death Overview Panel administrator.	To audit this and utilise national resources to support parental involvement.
8. Raise the profile of Child Death Overview Panel and the Child Death Review processes, and highlight impacts, with Health and Wellbeing Boards, and children’s safeguarding partners.	A development day was delivered involving a wide range of professionals; circulating national reports; annual report presentations; circulation of National Child Mortality Database quarter 4 report; annual report; quarterly reporting to Integrated Care Board safeguarding; Reports were also taken to the Integrated Care Board.	Further delivery of development days for a wide range of audiences. Adapt the format of Child Death Overview Panel reports to optimise their use and ability to influence.
9. Explore more alternative ways of presenting annual data to strategic partners.		To establish and contribute to a Cheshire and

		Merseyside wide strategic group.
10. Reduce the number of outstanding deaths ready for review by the Child Death Overview Panel through additional meetings if required.	There has been a slight reduction in the number of outstanding reviews.	To continue with two monthly Child Death Overview Panel case review sessions and to extend sessions as needed.
11. Analyse trends and themes that will inform awareness raising/ training sessions as required.	Longer-term analysis of modifiable factors has been included in the 2023/24 annual report along with an in-depth review of adverse childhood experiences associated with child deaths. Circulate National Child Mortality Database quarterly reports; monitor themes emerging from panels and national reports, and provide recommendations; develop 7-minute briefings.	Exploration of the eCDOP system in relation to more comprehensive analysis of longer term trends.
12. Cooperate and contribute as required to the Thirlwall Inquiry.	All partners who have been asked to provide information for the Inquiry have complied.	To continue to support the public inquiry as required.
13. Clearing the backlog of cases pending Child Death Overview Panel review.	An open cases tracker has been developed and is a standing item on all business meeting agendas; modifiable reasons for delay are identified and followed up.	To continue with two monthly, rather than quarterly, case review meetings.
14. Promote greater participation by partner agencies at Child Death Review Meetings (CDRM) in cases where there has been prior involvement during life.	Invitation lists have been extended with regards to Sudden Unexplained Death in Children.	To seek assurance from partners in the case of expected deaths.
15. Promote greater reflection and scrutiny of services provided by partner agencies and any identified learning following child deaths from partner agencies' perspective,	Delivery of educational events and additional support from charities has been provided.	To continue with this provision and to explore obtaining further early years provision input.

at Child Death Overview Panel reviews.		
16. Evidence how the functions of the Child Death Overview Panel has influenced policy and practice within the local health economy and its impact.	We have explored alternative ways of presenting annual data to strategic partners; develop 7-minute briefings	To explore utilisation of the eCDOP system as part of this.

Contributors to the report

This report was produced through a collaborative multi-agency team including:

- Dr Susan Roberts, Consultant in Public Health, Cheshire East Council
- Janice Bleasdale, Specialist Child Death Review Nurse, Cheshire East Place & Cheshire West Place, NHS Cheshire and Merseyside Integrated Care Board
- Sue Pilkington, Designated Nurse Safeguarding Children and Children in Care, Cheshire West Place, NHS Cheshire and Merseyside Integrated Care Board
- Dr Rajiv Mittal, Designated doctor for Safeguarding and Child deaths, Countess of Chester Hospital
- Anne Barber, Senior Administrator, Pan Cheshire Child Death Overview Panel, Mid Cheshire Hospitals NHS Foundation Trust
- Jack Chedotal and Sara Deakin, Public Health Intelligence, Cheshire East Council
- The wider Pan Cheshire Child Death Overview Panel