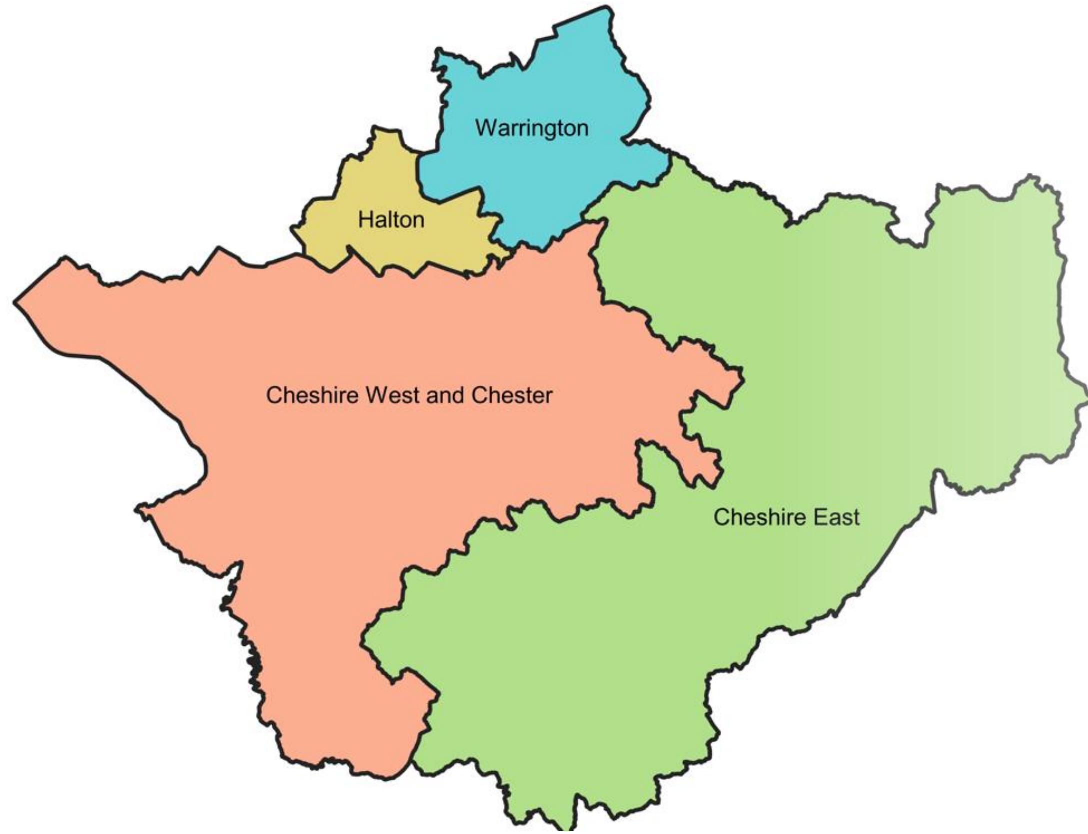

Annual Report of the

Pan Cheshire
Child Death Overview Panel

2023/24

November 2024

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1. 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.

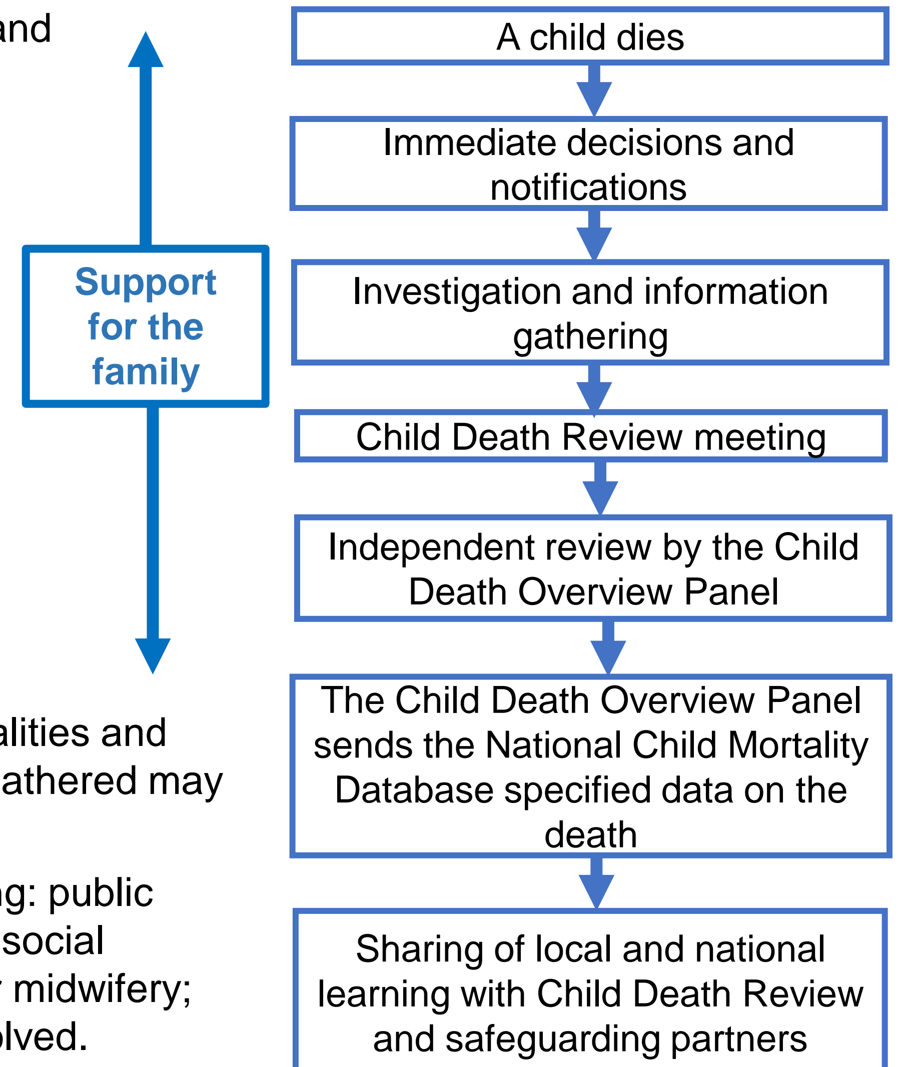
The Pan Cheshire Child Death Overview Panel continues to support partners contributing to the Thirlwall Inquiry. Once the Inquiry concludes, the Panel is committed to championing the recommendations that result.

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 the Pan Cheshire area and beyond.

2. 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 described in the figure to the right is undertaken. More detail is provided in the statutory guidance.
- 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 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.



3. 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 families have the support and importantly, 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"[1]

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.

5. 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 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*.
    - The rate of notifications across England as a whole was 3.18/10,000 during 2022/23[1].
- **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.

*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. 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 in during one year and reviewed in another.

- 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.

The deaths of 57 children were reviewed by 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.

7. Key trends in modifiable or vulnerability factors from 2022 to 2024

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**

More information on modifiable factors is provided on the next slide.

8. Causes of death associated with modifiable factors during 2023/24

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**
  - **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)[1].

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

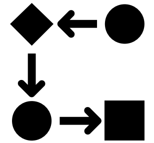
9. Progress during 2023/24 and achievements

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 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

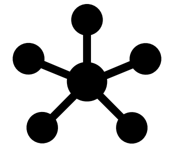
10. Priority recommendations for 2024/25

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.

Contributors to the report

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

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- Dr Rajiv Mittal, Designated doctor for Safeguarding and Child deaths, Countess of Chester Hospital
- Anne Barber, Senior Administrator, Pan Cheshire CDOP, Mid Cheshire Hospitals NHS Foundation Trust
- Jack Chedotal and Sara Deakin, Public Health Intelligence, Cheshire East Council