Merseyside Child Death Overview Panel

Annual Report
1st April 2016 – 31st March 2017

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Mike Leaf
Independent Chair
Merseyside CDOP
August 2017
Section 1: Executive Summary

The Merseyside CDOP is a sub-group of the five Local Safeguarding Children Boards (Knowsley, Liverpool, Sefton, St. Helens, Wirral LSCBs) and has a statutory responsibility to review the deaths of all children up to the age of 18 years old (excluding infants live-born following planned, legal terminations of pregnancy and stillbirths) resident within the five Local Authority areas. The focus of CDOP should be on identifying any modifiable factors that may help prevent unnecessary future child deaths or harm.

The purpose of this Annual Report is to:
- Clarify and outline the processes adopted by the Merseyside CDOP
- Assure the five Merseyside LSCBs that there is an effective inter-agency system for reviewing child deaths across Merseyside
- Provide an overview of information on trends and patterns in child deaths reviewed across Merseyside during the last reporting year (2016-17), and on all deaths reviewed since April 2008
- Highlight issues arising from the child deaths reviewed between April 2016 and March 2017
- Report on achievements and progress from last year's annual report
- Make recommendations to agencies and professionals involved in the children’s safeguarding system across Merseyside

Achievements during 2016-17

- A CDOP Business Meeting has been established to consider all issues outside individual case meetings
- A Memorandum of Understanding between the Merseyside LSCBs and CDOP support has been drafted for sign off by all parties.
- A CDOP action plan has been developed
- A Safer Sleep Audit has been undertaken with both professionals and parents to assess the uptake, awareness and delivery of safe sleep messages. Results will be presented to LSCBs once the review is fully completed.
- Improving information quality to identify issues.
- An independent CDOP Chair was appointed on a substantial basis from January 2017.
- CDOP Briefing Sessions to Merseyside agencies
- Sentinel Training and the trigger system has resulted in improvements in responses to requests for information within specified timescales
- CDOP Review recommendations have been implemented and will be kept under review.
  - CDOP membership has been reviewed and updated its terms of reference in accordance with the review recommendations to ensure consistency and “panel memory” between meetings.
  - The number of full panel meetings has been reduced, and the increased demand on each panel will be kept under review
- A standard reporting form has been developed providing consistent feedback on issues identified, action taken by CDOP and any potential action required of the relevant LSCB
✓ The SUDiC Joint Agency Protocol has been updated. The SUDiC Steering group will take responsibility for monitoring adherence to the protocol. An information leaflet for professionals has been produced.
✓ A SUDiC audit report was produced indicating good adherence to the protocol, outlining specific areas for improvement
✓ The relationship with Coroners continues to be positive, with ongoing conversations taking place
✓ Merseyside CDOP continues to play an active role in both regional and national networks, influencing programmes, and gaining insight into proposed changes to the CDOP function in the future
✓ Following last year’s Annual Report, a suicide prevention group has convened to consider the increasing number of suicides. The first meeting focused on a scoping exercise, and further exploration has been undertaken including the possibility of a conference to raise awareness and ‘train the trainer’ events to promote confidence amongst workers in discussing the issues.

Priorities for 2017-18:

✓ Memorandum of Understanding (MOU) to be completed and signed off
✓ Terms of Reference and Protocol to be completed and signed off
✓ The Performance Framework and action plan to be completed and signed off
✓ Launch of the revised SUDiC Protocol
✓ Ensure partner agencies with links to the SUDiC protocol undertake staff briefings to raise awareness of the revised protocol and for the LSCB to seek assurance that this has been done
✓ Safe Sleep Audit to be presented to LSCBs and partners. An action plan to be developed with the task and finish group to monitor progress

Summary of key points and themes:

Knowsley
• 84% of deaths reviewed during 2016/17 were completed within 12 months
• 58% of deaths were expected
• 58% of deaths were children under 1 year of age
• 47% of deaths had modifiable factors identified which is significantly higher than the national and regional average of 24%
• The most common modifiable factors identified were smoking, service provision, alcohol and substance misuse and safer sleep

Liverpool
• 92% of deaths reviewed during 2016/17 were completed within 12 months
• 69% of deaths were expected
• 79% of deaths were children under 1 year of age
• 35% of deaths had modifiable factors identified which is significantly higher than the national and regional average of 24%
• The most common modifiable factors identified were smoking including smoking in pregnancy, high BMI, substance misuse, domestic violence and safer sleep

Sefton
• 92% of deaths reviewed during 2016/17 were completed within 12 months
- 63% of deaths were expected
- 56% of deaths were children under 1 year of age
- 19% of deaths had modifiable factors identified
- The most common modifiable factors identified were safer sleep but service provision also featured
- The most common modifiable factors were smoking, safer sleep, service provision and alcohol/substance misuse by a parent/carer

**St Helens**
- 92% of deaths reviewed during 2016/17 were completed within 12 months
- 13% of deaths were expected
- 46% of deaths were of children under 1 year of age
- 23% of deaths had modifiable factors identified
- The most common modifiable factors identified were smoking, service provision and safer sleep

**Wirral**
- For the last 2 years, the ratio of child deaths in relation to the under 18 population is above the Merseyside figure, despite having lower indices of multiple deprivation
- 97% of deaths reviewed during 2016/17 were completed within 12 months
- 76% of deaths were expected
- 57% of deaths were children under 1 year of age
- 22% of deaths had modifiable factors identified
- The most common modifiable factors identified were smoking in pregnancy, service provision, parental lifestyle and safer sleep

**Merseyside**
- 93% of deaths reviewed during 2016/17 were completed within 12 months
- 65% of deaths were expected
- 64% of children were aged under 1-year old when they died
- 38% of deaths had modifiable factors identified
- The most common modifiable factors identified were smoking including smoking in pregnancy, high BMI, domestic violence, substance misuse and safer sleep

**Recommendations for LSCBs**

1. Note the priorities identified for the coming year and the themes identified
2. In view of the recurring modifiable factors which may have contributed to the deaths of children, all LSCBs should assure themselves, through partners, that there are suitably rigorous strategic multi-agency approaches to reduce smoking (particularly in pregnancy), high BMI, substance and alcohol misuse, and domestic violence. In particular, there should be a continued focus on evidence-based initiatives to reduce suicides, as Merseyside has the highest rates within the North West. (Whilst it is recognised that there is no single organisation or partnership that has ultimate responsibility for addressing these issues, all local strategic partnerships should be aware of the effects these issues have on the wellbeing of children, and should ensure that there are plans in place to reduce risks.)
Section 2: Overview and Processes

CDOP Panel Meetings

CDOP Membership

Merseyside CDOP has a core membership of:

- Independent CDOP Chair
- CDOP Manager & Administrator
- Children's Social Care/Safeguarding
- Merseyside Police
- Education
- Public Health
- Consultant Paediatricians
- Lay members
- Legal services
- Named GPs
- Mersey Care
- LSCB Business Managers
- Safeguarding Nurse
- Designated Nurses
- Consultant Neonatologists
- Consultant Obstetrician

Other members can be co-opted as and when necessary.

Dedicated agency representatives were identified to ensure consistency between panel meetings. Revised terms of reference for the CDOP and business meetings were compiled in 2016.

Lay Membership

Lay member representation has continued and provides a very positive input with effective scrutiny and challenge. The lay members have remained consistent throughout the period Merseyside CDOP has been functioning.

Frequency of Meetings

CDOP operates 3 types of meeting: neonatal panel (0-27 days); non-neonatal panel (28 days up to 18 years); and a newly established business meeting. The CDOP panel met on 11 occasions to review child deaths and held 2 dedicated business meetings during this period. There are now quarterly meetings for neonatal cases, non-neonatal cases, and business meetings. The practical limit for the number of reviews per meeting has been set at 16 cases per meeting, and this will be kept under review.

Agency Representation at Panel Meetings

There is excellent commitment to agency participation in CDOP meetings shown in Table 1 below. Legal Services engaged in a rota and were clear that when they attended the meeting
they were not representing the area but providing legal advice/information to CDOP relative to the situation if required. Mersey Care previously participated but were unable to do so for some time but representation was achieved again towards the end of this year.

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>INVITED</th>
<th>ATTENDED</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Chair</td>
<td>7</td>
<td>7</td>
<td>100%</td>
</tr>
<tr>
<td>CDOP Manager*</td>
<td>11</td>
<td>11</td>
<td>100%</td>
</tr>
<tr>
<td>Consultant Paediatricians</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Consultant Neonatologists</td>
<td>6</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>Consultant Obstetrician</td>
<td>6</td>
<td>1</td>
<td>16.7%</td>
</tr>
<tr>
<td>Mersey Care**</td>
<td>5</td>
<td>3</td>
<td>60%</td>
</tr>
<tr>
<td>Designated Nurses</td>
<td>11</td>
<td>10</td>
<td>90.9%</td>
</tr>
<tr>
<td>Named GP</td>
<td>5</td>
<td>6</td>
<td>120%</td>
</tr>
<tr>
<td>Social Care</td>
<td>11</td>
<td>8</td>
<td>72.7%</td>
</tr>
<tr>
<td>Education</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Legal Services</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>Merseyside Police</td>
<td>5</td>
<td>6</td>
<td>120%</td>
</tr>
<tr>
<td>LSCB Business Managers</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Safeguarding Specialist Nurse***</td>
<td>5</td>
<td>3</td>
<td>60%</td>
</tr>
</tbody>
</table>

Table 1: Agency representation and attendances at CDOP meetings

There is now a consistent membership for both neonatal and non-neonatal processes to promote greater collective memory and the advantages of a dedicated membership. A permanent independent Chair has also been secured.

*CDOP Manager chaired the neonatal process until the appointment of the permanent independent Chair.

**Since identifying a new Mersey Care representative they have attended all non-neonatal meetings

*** There was some debate regarding attendance of the Safeguarding Specialist Nurse at neonatal meetings but this was confirmed in 2017 and since then there has been full attendance.

Processes/ Networks/ Reviews and Sub-groups

Notification Process

The notification process via paediatric liaison and hospital/hospice staff continues to function extremely well. The ability to cross-reference with information received through the Registrars and Coroner’s Officers, has led to identification of some child deaths not reported through the expected route. This, in addition to cross-referencing with the annual DfE return (regarding notifications from Registrars to DfE), ensures Merseyside CDOP are confident they are notified of all child deaths.

When Merseyside child deaths occur out of area, CDOP is often notified by Merseyside agencies, rather than by the CDOP contact in the respective area where the death occurred. This demonstrates effective communication between local organisations and CDOP.

SUDiC Implementation Group
The CDOP Manager and Administrator remain involved with the SUDiC Implementation Group meetings as chair and administrator respectively. The meetings continue to focus on ensuring the rapid response arrangements are working effectively and identifying any issues, as the more detailed information arising from sudden deaths is explored within the CDOP process.

Currently, Merseyside is effectively non-compliant with Working Together to Safeguard Children 2015 and the Baroness Kennedy Report 2016, in that no joint visits involving health and police take place for their rapid response arrangements. The provision of photographs of the ‘scene’ for the strategy meeting participants assists with the identification of risk factors, is included in the protocol, and has been considered sufficient. Following a discussion at the CDOP Business meeting, a paper outlining the position was presented to each LSCB. Audits of SUDiCs for rapid response will continue, and this process will be reviewed regularly.

An audit relating to adherence with the SUDiC protocol was undertaken during this year and a report was presented to LSCBs. This identified compliance with the SUDiC protocol in the majority of cases. A CDOP recommendation has been made for LSCBs to assure themselves that the chairs of strategy meetings utilise the appropriate documentation to ensure adherence to the agreed process. This will assist in the information gathering to provide assurance of correct processes being followed.

**Links to Coroners and Registrars**

Within Merseyside there is an excellent working relationship with the Coroners for Liverpool and Wirral and the Coroner for Knowsley, Sefton and St Helens.

There is also a good working relationship with Merseyside Registrars who distribute the parents leaflet on behalf of Merseyside CDOP at the point at which the child’s death is registered. For those children subject to inquest the leaflet is contained within the inquest pack and distributed by Coroner’s Officers.

**Sentinel Database**

Merseyside CDOP has continued to use the Sentinel database system for the collection of information relating to the CDOP process, in addition to external notifications of any child death that occurs in the area.

During 2016-17, 190 notifications were received, of which 112 related to Merseyside, 78 were external to Merseyside (88 external in 2015/16).

Quarterly meetings continue to be held involving the CDOP team and the LSCB/CDOP administrators from the respective areas to share information and address any emerging issues.

The implementation of the trigger system to encourage completion of agency reports within the given timescale of 15 working days has improved the response. The subsequent automatic reminders assist agencies to focus on completion of their report within the overall timescales of 28 working days. The progress of report compilation and the outstanding reports are highlighted to the LSCB and CDOP through provision of monthly spreadsheets that identify outstanding agency issues.

**Deaths of Children Living Outside Merseyside**
76 child deaths were reported to Merseyside CDOP regarding children who had died in this area but had lived in areas external to Merseyside. Notification of such a death is securely e-mailed to the respective CDOP contact for the LSCB area within 24 hours, or as soon as practically possible. In all circumstances efforts are made immediately to contact the relevant CDOP lead and inform them of the notification. This constitutes good cross-border practice.

**Communicating with Parents, Families and Carers**

In addition to the Merseyside CDOP leaflet that is distributed by the Registrars, there is a list of support resources provided to enable families to exercise some choice if they are not already aware of them and want to pursue bereavement support.

The national Lullaby Trust leaflet: *The Child Death Review, A Guide for Parents and Carers*’ is a more detailed explanation of many of the processes associated with a child’s death and remains available on LSCB and NHS Trust websites.

The Merseyside CDOP Manager has been contacted by two families, relating to the CDOP process, during this year. At the point at which their child’s death was reviewed both families contributed to the process.

**Deaths involving Serious Case Reviews/Critical Incident Reviews**

Child deaths are considered at panel once all relevant investigations and reports have been completed. These include those that have been the subject of Serious Case Reviews, Critical Incident Reviews or any learning review. This approach is consistent with that undertaken across the north-west and much of England. This may, on occasions, result in a delay between notification and completion that exceeds the specified six month timescale, CDOP will continue to monitor this process.

**Regional/National Links/ Updates:**

**North-west meetings**
Merseyside CDOP continues to be represented at the north-west CDOP meetings. A common dataset was agreed for all north-west annual reports to allow for the compilation of an overview report covering the area. This has been adhered to in the compilation of this report, as in previous years. A north-west CDOP report is produced annually.

**Infant Mortality Workshop – regional initiative**
There was representation from Merseyside CDOP at the Infant Mortality Workshop that took place in 2016. The focus of the workshop was identifying best practice with an aim of reducing the number of infant deaths in the north-west.

**National Network**
Merseyside CDOP forms part of the national network group which advises on issues of national interest, including the transfer of the CDOP responsibilities to the Department of Health.

**National Database Development Project**
Merseyside CDOP continued to participate, by invitation, on the working group to determine the need for a national CDOP database. The necessity was confirmed and a tendering process was expected to conclude in July 2016. The desired completion date for development is in 2017. The national database will be able to access Merseyside CDOP data through data extraction rather than needing input into two systems. Merseyside CDOP was the only panel represented from the beginning.
Funding

Contributions

The proportion of funding that each area contributes from Public Health funds is calculated using a formula linked to the population numbers of under 18 year olds and is based upon the amount needed to cover the two key support posts and running costs. The LSCB contributions provide a budget for campaigns and contribute to the running costs. The previous agreement that each LSCB would contribute £5,000 per year has continued. For 2016-17 the amounts for contributions and expenditure were:

<table>
<thead>
<tr>
<th>Area</th>
<th>Amount from Public Health</th>
<th>Amount from LSCB</th>
<th>Total from area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowsley</td>
<td>£10,733.53</td>
<td>£5,000</td>
<td>£16,100</td>
</tr>
<tr>
<td>Liverpool</td>
<td>£29,632.47</td>
<td>£5,000</td>
<td>£32,750</td>
</tr>
<tr>
<td>Sefton</td>
<td>£17,753.10</td>
<td>£5,000</td>
<td>£23,500</td>
</tr>
<tr>
<td>St Helens</td>
<td>£12,022.23</td>
<td>£5,000</td>
<td>£17,950</td>
</tr>
<tr>
<td>Wirral</td>
<td>£22,358.67</td>
<td>£5,000</td>
<td>£27,200</td>
</tr>
<tr>
<td>TOTAL</td>
<td><strong>92,500</strong></td>
<td><strong>£25,000</strong></td>
<td><strong>£117,500</strong></td>
</tr>
</tbody>
</table>

*Table 2: Contributions to CDOP process for 2016-17 by LSCB area*

Expenditure (to nearest £10)

<table>
<thead>
<tr>
<th>Area of expenditure</th>
<th>Amount spent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDOP Independent Chair (previous and present)</td>
<td>£8,690</td>
</tr>
<tr>
<td>CDOP Manager and administrator incl on-cost</td>
<td>£71,610</td>
</tr>
<tr>
<td>Sentinel database</td>
<td>£7,240 annual licence</td>
</tr>
<tr>
<td>Refreshments for CDOP Meetings, Business Meetings and Suicide Prevention Meetings</td>
<td>£330</td>
</tr>
<tr>
<td>Translation of safe sleep materials (inc. VAT)</td>
<td>£920</td>
</tr>
<tr>
<td>Safer Sleep campaign materials (inc. VAT)</td>
<td>£12,520</td>
</tr>
<tr>
<td>Attendance at conferences</td>
<td>£140</td>
</tr>
<tr>
<td>Rail travel</td>
<td>£770</td>
</tr>
<tr>
<td>Alder Centre support for panel members (limit order £1,500)</td>
<td>£900</td>
</tr>
<tr>
<td>Equipment</td>
<td></td>
</tr>
<tr>
<td>Stationary</td>
<td>£60</td>
</tr>
<tr>
<td>Total</td>
<td><strong>£103,180</strong></td>
</tr>
</tbody>
</table>

*Table 3: CDOP expenditure in 2016-17*

Issues Identified

Missing Data
There has been an improvement on the details provided on the forms, but the failure to provide consistent information can create issues. For example, the lack of details of the father/significant male/other parent in the family, is particularly relevant in relation to necessary checks regarding domestic violence. This forms part of an ongoing dialogue with representatives, and remains under scrutiny.
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. Overall the modifiable factors identified for Merseyside, and ranked in terms of frequency are:

- Smoking including smoking in pregnancy
- Unsafe sleeping practices
- Parental lifestyles including drug misuse, alcohol misuse and alcohol and substance misuse
- Issues with service provision including outcomes from serious case reviews and internal agency reviews
- High BMI
- Domestic violence
- Parental mental health
- Issues with agency functioning including delays in providing service
- Late booking in pregnancy including lack of access to antenatal care
- Failing to identify child’s needs appropriately

In addition to the modifiable factors identified, Merseyside CDOP is made aware of any outcomes from serious case reviews, multi- and single agency reviews and internal review processes that occur within agencies. In these circumstances implementation of any action to address the modifiable factors, and the monitoring of the progress rests with the agency or agencies identified within the reports and the specific sub-group identified by the LSCBs.

Many of the modifiable factors identified related to unsafe sleeping practices and risk factors associated with alcohol, substance misuse, smoking and co-sleeping. The identification of this as a recurring feature supports the continuing involvement of the Safer Sleep programme. Results from professional and parental audits are expected shortly.

CDOP priorities for 2017/18

- Memorandum of Understanding (MOU) to be completed and signed off
- Terms of Reference and Protocol to be completed and signed off
- The Performance Framework and action plan to be completed and signed off
- Launch of the revised SUDiC Protocol
- Ensure partner agencies with links to the SUDiC protocol undertake staff briefings to raise awareness of the revised protocol and for the LSCB to seek assurance that this has been done
- Safe Sleep Audit to be presented to LSCBs and partners. An action plan to be developed with the task and finish group to monitor progress
- Continue to develop suicide prevention initiatives
Section 3: Data and Analysis

It should be noted that it is often difficult to make clear conclusions from analysing data from a relatively small number of cases reviewed each year. The learning from each individual case is noted at each CDOP meeting, with the appropriate action taken at that time. Merseyside’s figures are amalgamated to other CDOP data across the NW to provide opportunities for identifying more reliable trends.

Number of Deaths

During the reporting period 1st April 2016 to 31st March 2017, 112 child deaths were notified to CDOP across the five LSCB areas. (Knowsley 12, Liverpool 42, Sefton 16, St. Helens 8, and Wirral 34). At the end of 2016-17 there were 41 child deaths outstanding which have not yet been considered by CDOP, as 24 were subject to additional processes including inquests, criminal processes, post-mortem and internal review processes such as Serious Incident Reviews.

Figure 1 shows the percentage split of the numbers of notified deaths. Because we are dealing with small numbers, it is sometimes useful to consider trends. Table 4 shows the number of child death notifications since 2008-9.

Table 4: Child Death Notifications by Year for Merseyside

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of deaths</td>
<td>115</td>
<td>97</td>
<td>93</td>
<td>80</td>
<td>94</td>
<td>87</td>
<td>89</td>
<td>115</td>
<td>112</td>
</tr>
</tbody>
</table>
The pattern of notified child deaths for 2016-17 are shown in the following map, Figure 2.

Figure 3 below shows the pattern of child death notifications, over this period, for each of the LSCB areas. One can see that the trend across Merseyside is a gradual increase. An expansion in under 18 population might explain this, but this might be worthy of further investigation, to understand whether there are any other underlying features.
Child Population

When considering relatively small numbers of deaths amongst the five LSCB areas across Merseyside, it is appropriate to also consider the 0-17 year population from each area.

<table>
<thead>
<tr>
<th>LSCB Area</th>
<th>Total Population</th>
<th>0-17 year old Population</th>
<th>0-17 year olds as % of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowsley</td>
<td>147,231</td>
<td>32,486</td>
<td>22.1%</td>
</tr>
<tr>
<td>Liverpool</td>
<td>470,780</td>
<td>89,902</td>
<td>19.1%</td>
</tr>
<tr>
<td>Sefton</td>
<td>273,707</td>
<td>56,566</td>
<td>20.7%</td>
</tr>
<tr>
<td>St Helens</td>
<td>177,612</td>
<td>36,279</td>
<td>20.4%</td>
</tr>
<tr>
<td>Wirral</td>
<td>320,295</td>
<td>71,406</td>
<td>22.3%</td>
</tr>
<tr>
<td>Total for Merseyside</td>
<td>1,389,625</td>
<td>286,639</td>
<td>20.9%</td>
</tr>
</tbody>
</table>

Table 5: Child population for Merseyside areas

Normally, one would expect to see the numbers of deaths in each geography, to be proportionate to the number of under 18 year olds living in each, but there may be differences according to deprivation levels. Last year’s report highlighted the link between child deaths and Indices of Multiple Deprivation (IMD), where high IMD is linked to higher childhood mortality. This strong association continues across Merseyside and the NW, with higher child mortality in areas of higher deprivation.
Figure 4 shows the rate of deaths per 10,000 0-17 years population, and highlights that Wirral appears to have a disproportionately high number of child death notifications over the last two years of reporting, higher than Merseyside, despite having lower deprivation indices. This may be explained as two random events (small numbers), but it might also warrant further investigation, particularly if the same pattern is repeated next year. Merseyside has the highest number of notified deaths within its under 18 year population, across the NW.

**Review Completion**

Figure 5 provides a breakdown of the time taken to complete the reviews during this period, by LSCB area.

**Table 6: Time taken to complete reviews in 2016/17**

<table>
<thead>
<tr>
<th>LSCB Area</th>
<th>Under 4 months</th>
<th>Under 6 months</th>
<th>6 or 7 months</th>
<th>8 or 9 months</th>
<th>10 or 11 months</th>
<th>Over 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowsley</td>
<td>4</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Liverpool</td>
<td>22</td>
<td>16</td>
<td>8</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Sefton</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>St Helens</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Wirral</td>
<td>14</td>
<td>13</td>
<td>9</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
<td>44</td>
<td>22</td>
<td>7</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Percentage</td>
<td>35.25%</td>
<td>31.65%</td>
<td>15.83%</td>
<td>5.04%</td>
<td>5.04%</td>
<td>7.19%</td>
</tr>
</tbody>
</table>
Table 6 above shows that 66.9% of reviews were completed within 6 months and 98.8% completed in less than one year, which is an increase on 81.4% in 2015-16. This is higher than the national average. Currently, CDOP is confident that there are no unnecessary delays in the process, but will keep the matter closely under review.

**Gender**

The number of notified deaths identified by gender was 48 females, 64 males. Figure 6 shows the breakdown of child deaths by gender for each LSCB area for the reporting period. Similar to last year, except for St Helens, there is a disproportionate number of deaths occurring within males. This is also reflected in national and international statistics. Infant mortality is higher in males in most parts of the world and has been explained in part by differences in genetic and biological makeup. Risk-taking behaviour has also been established as more prevalent in teenage males.

![Figure 6: Child deaths occurring in 2016/17 by gender](image)

**Child deaths categorised in 2016/17 identifying number with modifiable factors per LSCB area.**

Figure 7 shows the ratio of child deaths having modifiable factors compared to those having no modifiable factors (Modifiable: Non-modifiable). A total of 142 deaths were categorised during the reporting period. 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. For this reporting year, these percentages and ratios were:

- Knowsley: 47% (9:10)
- Liverpool: 35% (19:34)
- Sefton: 19% (3:13)
- St Helens: 23% (3:10)
- Wirral: 22% (9:32)
- Merseyside: 38% (43:69)

*Percentages are shown rounded up or down to whole numbers as occurs with the national picture

The national picture shows 24% for England and 24% for the north-west. Liverpool and Knowsley are significantly above these averages, which also inflates the overall Merseyside figure.
Specific modifiable factors relevant to an area have been highlighted in each of the quarterly reports provided to LSCBs.

**Child Deaths Reviewed by Age (DfE categorisation)**

Figures 8 and 9 show that the largest number of child deaths occurred within the first twelve months of life (54.5%). This is higher than last year's figures (50.4%) which was also higher than the year before (47.7%). Nationally, 60% of deaths in childhood occur during the first year of a child's life, and are strongly influenced by pre-term delivery and low birth weight; with risk factors including maternal age, smoking and disadvantaged circumstances (Wolfe and Macfarlan, 2015). Both figures also show the typical skewed “u-shaped” curve replicated at national level.
Figure 10 shows the numbers reviewed during 2016-17 according to age-band and when compared to 2015-16 figures identifies:

- a decrease in neonatal deaths reviewed from 57 to 53
- an increase in under 1 year deaths from 19 to 38
- an increase in the 1-4 years age group from 10 to 12
- a decrease in the 5-9 years age group from 10 to 8
- an increase in the 10-14 years age group from 7 to 8
- an increase in the 15-18 years age group reviewed from 10 to 23
Category of Child Death

The CDOP panel is required to record each death against 1 of 10 nationally-set categories as follows:

Category 1: Deliberately inflicted injury, abuse or neglect (3)
Category 2: Suicide or deliberate self-inflicted harm (8)
Category 3: Trauma and other external factors (8)
Category 4: Malignancy (7)
Category 5: Acute medical or surgical condition (4)
Category 6: Chronic medical condition (9)
Category 7: Chromosomal, genetic and congenital anomalies (42)
Category 8: Perinatal/neonatal event (48)
Category 9: Infection (8)
Category 10: Sudden unexpected, unexplained death (11)

Further explanations can be found in Appendix 1. It can be seen in Figure 11 below that the greatest proportion of deaths relate to perinatal/neonatal event (category 8) with Liverpool and Wirral having the greatest numbers. Chromosomal, genetic and congenital anomalies (category 7) is the second highest category, as it was last year.

Location of Child Death

The majority of deaths (79.5%) occurred within a hospital setting, the majority of these occurring in the neonatal units followed by paediatric intensive care units (Figure 12). This is unsurprising because, by their very nature, they provide care to the most vulnerable and poorly.
Figure 13 shows the breakdown of deaths occurring out of hospital, highlighting that the highest number of deaths occurring out of hospital occur in the home of normal residence, which includes children subject to palliative care plans as well as sudden deaths. With regard to palliative care the majority of family and child/ young person’s wishes as to where they wanted to die were adhered to and, only in exceptional circumstances, for clinical reasons, was this not achieved.

**Causes of Child Death**

Figure 14 on the next page shows the cause of death, with the majority (51%) occurring neonatally, followed by others with a known life-limiting condition (33%). ‘Other’ refers to child deaths not covered by supplementary forms B2 – B12 that relate to specific conditions:

B2: neonatal deaths
B3: death of a child with a life limiting condition
B4: sudden unexpected death in infancy (SUDI)
B5: road traffic accident
B6: drowning
B7: fire/burns
B8: poisoning
B9: other non-intentional injury
B10: substance misuse
B11: apparent homicide
B12: apparent suicide
Expected / Unexpected deaths

Figure 15 shows the breakdown of expected and unexpected deaths occurring in each of the LSCB areas. Across Merseyside 65% of deaths were expected, with 35% of deaths being unexpected (21% SUDC [2 up to 18 years] and 14% SUDI [0 up to 2 years]).

Birth-weight

Low birthweight, one of the known risk factors for infant deaths, was evident in 58 out of 113 categorised deaths. 20 of the 57 neonatal and 6 of 19 infant deaths had smoking within the household recorded as a factor. Mothers smoking is noted as a major risk factor contributing to low birth-weight. Babies born to women who smoke weigh, on average, 200g less than babies born to non-smokers. It is therefore imperative that we ensure the questions relating to social factors are completed as comprehensively as possible.
Ethnicity

Figure 16 shows that the vast majority, 86% of the child deaths categorised during 2016-17 were of ‘British White' ethnicity, an increase from 72.6% in 2014-15.

Although the recording of ethnicity has improved since the start of the Merseyside CDOP panel, there are further improvements required as there remains 5.3% of child deaths (6 deaths) where the ethnicity is unknown.
Appendix 1: Classification of Death

This classification is hierarchical: where more than one category could reasonably be applied, the highest up the list should be marked.

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

**The panel should categorise the ‘preventability’ of the death – tick one box.**

Preventable child deaths are defined in Chapter 5, paragraph 11 (p85) of Working Together to Safeguard Children (2015).

**Acknowledgements**

Thanks go to all those who have helped produce my first report, and in particular Irene Wright, CDOP Manager, and Helen Fleming-Scott, CDOP Administrator.

Mike Leaf
Independent CDOP Chair