Merseyside Child Death Overview Panel

Annual Report
1st April 2017 – 31st March 2018

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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:

- Provide an outline of 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 (2017-18), and on all deaths reviewed since April 2008
- Highlight issues arising from the child deaths reviewed between April 2017 and March 2018
- Report on progress from last year’s annual report
- Make recommendations to agencies and professionals involved in the children’s safeguarding system across Merseyside

Achievements during 2017-18

- A Memorandum of Understanding between the Merseyside LSCBs and CDOP support has been signed off by all parties.
- The CDOP action plan is regularly updated and maintained
- Terms of Reference and Protocol signed off
- The Performance Framework and action plan signed off
- Launch of the revised SUDiC Protocol
- The results of the Safer Sleep Audit have been presented to LSCBs and follow up action developed to improve outcomes
- Further audits progressed with a plan to ensure respective agencies progress regular audits
- Improving information quality to identify issues.
- Sentinel training and the trigger system has continued to improve responses to requests for information within specified timescales
- 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
- The Chair became a member of the Cheshire and Mersey Suicide Prevention Board
- Collaboration between Cheshire and Wirral Partnership (CWP), Merseyside Youth Association (MYA) and Young Persons Advisory Service (YPAS), as part of the Suicide Prevention Group, to produce materials for suicide prevention training for the children’s workforce.
- Active collaboration with the public health teams
Priorities for 2017-18:

- Manage a smooth transition of the Child Death Review process from Local Safeguarding Boards to new governance arrangements
- Further develop the relationship with CHAMPS suicide prevention network
- Ensure that the new guidance is implemented including:
  - Ensuring all child death review meetings (e.g., perinatal mortality; hospital mortality; etc.) inform the CDOP process in a standardised/structured manner
  - Implementation of any changes to the reporting processes e.g., Forms A, B, and C
- Ensure that there is a stronger link with the neonatal network
- Ensure all agencies understand the new guidance and relevant processes
- Ensure that safer sleep messages are being promoted in a consistent way across Merseyside
- Collect data for Adverse Childhood Experiences (ACEs), and explore links between ACEs and child deaths
- Collect and disseminate information on child suicides and children with learning disabilities as part of national guidance
- Finalise and pilot the suicide prevention programme

Summary of key points and themes (2016/17 figures in [brackets]):

Knowsley
- 100% of deaths reviewed during 2017/18 were completed within 12 months [84%]
- 57% of deaths were expected [58%]
- 50% of deaths occurred in neonatal intensive care units [75%]
- 66% of deaths were children under 1 year of age [58%]
- 55% of deaths had modifiable factors identified [47%]
- The most common modifiable factors identified were smoking in pregnancy, service provision, alcohol and substance misuse, domestic abuse and poor parenting

Liverpool
- 92% of deaths reviewed during 2017/18 were completed within 12 months [92%]
- 70% of deaths were expected [69%]
- 73% of deaths were children under 1 year of age [79%]
- 35% of deaths had modifiable factors identified [35%]
- The modifiable factors identified were smoking in pregnancy/household, service issues, poor parenting, obesity, domestic abuse, concealed pregnancy, parental mental health and unsafe sleep

Sefton
- *73% of deaths reviewed during 2017/18 were completed within 12 months [92%]
- 65% of deaths were expected [63%]
- 64% of deaths were children under 1 year of age [56%]
- 45% of deaths had modifiable factors identified [19%]
- The modifiable factors identified were service issues, safer sleep, poor parenting, criminality and knife crime but service provision also featured

*An increased number of deaths this year have been subject to an inquest process which impacts on time
St Helens
- 100% of deaths reviewed during 2017/18 were completed within 12 months [92%]
- 85% of deaths were expected [13%]
- 55% of deaths were of children under 1 year of age [46%]
- 55% of deaths had modifiable factors identified [23%]
- The modifiable factors identified were smoking in pregnancy, service provision and poor parenting

Wirral
- 95% of deaths reviewed during 2017/18 were completed within 12 months [97%]
- 71% of deaths were expected [76%]
- 85% of deaths were children under 1 year of age [57%]
- 35% of deaths had modifiable factors identified [22%]
- The modifiable factors identified were smoking in pregnancy, unsafe sleeping, alcohol/substance use and domestic abuse

Merseyside
- 91.9% of deaths reviewed during 2017/18 were completed within 12 months [93%]
- 70% of deaths were expected [65%]
- 72.1% of deaths were of children under 1 year of age [64%]
- 40.7% of deaths had modifiable factors identified [38%]
- The most common modifiable factors identified were smoking in pregnancy/household, service provision, poor parenting (including supervision/missing appointments, domestic abuse, substance/alcohol use

Recommendations for Local Safeguarding Partners

Local Safeguarding Partners are asked to:
1. Note the contents of this annual report
2. Ensure that the new safeguarding arrangements maintain strong links with the child death review processes as they evolve, and in particular, ensure full involvement of the relevant partners
Section 2: Overview and Processes

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 business meeting. The CDOP panel met on 7 occasions to review child deaths and held 2 dedicated business meetings during this period. Quarterly meetings for neonatal cases, non-neonatal cases, and business meetings are held. The practical limit for the number of reviews per meeting has been set at 16 cases per meeting, and this has often been met, with further cases ready.

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>7</td>
<td>7</td>
<td>100%</td>
</tr>
<tr>
<td>Consultant Paediatricians</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Consultant Neonatologists</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Consultant Obstetrician</td>
<td>4</td>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td>Mersey Care</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Designated Nurses</td>
<td>7</td>
<td>6</td>
<td>85.7%</td>
</tr>
<tr>
<td>Named GP</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Social Care</td>
<td>7</td>
<td>7</td>
<td>100%</td>
</tr>
<tr>
<td>Education</td>
<td>3</td>
<td>2</td>
<td>66.7%</td>
</tr>
<tr>
<td>Legal Services</td>
<td>7</td>
<td>5</td>
<td>71.4%</td>
</tr>
<tr>
<td>Merseyside Police</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>LSCB Business Managers</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Safeguarding Specialist Nurse</td>
<td>7</td>
<td>5</td>
<td>71.4%</td>
</tr>
<tr>
<td>Public Health</td>
<td>3*</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Lay members</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 1: Agency representation and attendances at 2017-18 CDOP meetings

*A public health representative was identified during the year and attended all meetings thereafter which was 3 of the 7 held.

There is 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.

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.

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 good communication between local organisations and CDOP within Merseyside.

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. This will be kept under review, particularly in the light of new national guidance for Child Death Review.

**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 2017/18, 179 notifications were received, of which 115 related to Merseyside, 64 were external to Merseyside (76 external in 2017/18).

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 continued to improve timely responses. 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**

64 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. This is currently been updated.
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.

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, and the Chair and Manager are members of the Executive Committee.

National Database Development Project
Merseyside CDOP participated, by invitation, on the working group to determine the need for a national CDOP database. The National Database development has been awarded to a collaborative group that includes Bristol University, Oxford University, UCL partners and QES. The funding for development commenced in April 2018 and continues for 4 years.

Merseyside CDOP has been assured that they can continue to input their data into the Sentinel database and the national database will access it from there.

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 2017-18 there were no contributions in order to use up the excess. The amounts for contributions for 2018-19 were agreed at the rate from previous years:

<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><strong>TOTAL</strong></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 2017-18 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</td>
<td>£16,800</td>
</tr>
<tr>
<td>CDOP Manager and administrator incl on-cost</td>
<td>£86,540.15</td>
</tr>
<tr>
<td>Sentinel database</td>
<td>£7,800 annual licence</td>
</tr>
<tr>
<td>Refreshments for CDOP Meetings, Business Meetings and Suicide Prevention Meetings</td>
<td>£406.15</td>
</tr>
<tr>
<td>SUDIC Launch</td>
<td>£435.60</td>
</tr>
<tr>
<td>Translation of safe sleep materials</td>
<td>£216 (inc. VAT)</td>
</tr>
<tr>
<td>Attendance at conferences</td>
<td>£178</td>
</tr>
<tr>
<td>Rail travel</td>
<td>£223.12</td>
</tr>
<tr>
<td>Alder Centre support for panel members</td>
<td>£900 (limit order £1,500)</td>
</tr>
<tr>
<td>Equipment</td>
<td>£0</td>
</tr>
<tr>
<td>Stationary</td>
<td>£51.75</td>
</tr>
<tr>
<td>Total</td>
<td>£113,550</td>
</tr>
</tbody>
</table>

Table 3: CDOP expenditure in 2017-18

Issues Identified

Missing Data
There has been an improvement on the details provided on the forms, but the failure to record details of father/male household figures and ethnicity continues to be an issue in some cases. 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 and ethnicity recording enables monitoring to determine any patterns as well as quality of service provision. 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 in pregnancy/household (7)
- Poor parenting (including supervision/missing health appointments) (7)
- Service provision (7)
- Domestic abuse (4)
- Alcohol/Drugs (4)
- Obesity (3)
- Unsafe sleep (2)
- Concealed pregnancy (2)
- Criminality (including gang/ knife crime) (1)
- Parental mental health (1)
- Overcrowding (1)
- Social integration (1)
In addition to the modifiable factors identified, Merseyside CDOP is made aware of any outcomes from serious case reviews, single and multi-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 2018/19**

- ✓ Manage a smooth transition of the Child Death Review process from Local Safeguarding Boards to new governance arrangements
- ✓ Further develop the relationship with CHAMPS suicide prevention network
- ✓ Ensure that the new guidance is implemented including:
  - o Ensuring all child death review meetings (e.g. perinatal mortality; hospital mortality; etc) inform the CDOP process in a standardised/structured manner
  - o Implementation of any changes to the reporting processes e.g. Forms A, B, and form C
  - o Ensure all agencies understand the new guidance and relevant processes
- ✓ Ensure that there is a stronger link with the neonatal network
- ✓ Ensure that safer sleep messages are being promoted in a consistent way across Merseyside
- ✓ Collect data for Adverse Childhood Experiences (ACEs), and explore links between ACEs and child deaths
- ✓ Collect and disseminate information on child suicides and children with learning disabilities as part of national guidance
- ✓ Finalise and pilot the suicide prevention programme
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 2017 to 31st March 2018, 115 child deaths were notified to CDOP across the five LSCB areas. (Knowsley 14, Liverpool 50, Sefton 17, St. Helens 13, and Wirral 21). At the end of 2017-18 there were 69 child deaths outstanding which had not yet been considered by CDOP. Many of these were subject to additional processes including inquests, criminal processes, post-mortem and internal review processes such as Serious Incident Reviews but there had also been two CDOP meetings postponed due to the inability of key professionals to attend. This was conveyed to CDOP at short notice.

Fig 1 : Total number of reported child deaths occurring in 2017/18

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Merseyside</td>
<td>115</td>
<td>97</td>
<td>93</td>
<td>80</td>
<td>93</td>
<td>87</td>
<td>89</td>
<td>115</td>
<td>112</td>
<td>115</td>
</tr>
</tbody>
</table>

*Difficulty confirming exact numbers

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.
The pattern of notified child deaths for 2017-18 is shown on the following map, figure 2.

Figure 2: Child deaths mapped by local authority 2017-18
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 fairly level, but with a very slight upward trend.

![Figure 3: Number of Notified Deaths per Year by Local Authority](image)

**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>148,560</td>
<td>32,930</td>
<td>22.2%</td>
</tr>
<tr>
<td>Liverpool</td>
<td>491,549</td>
<td>93,556</td>
<td>19.0%</td>
</tr>
<tr>
<td>Sefton</td>
<td>274,589</td>
<td>53,514</td>
<td>19.5%</td>
</tr>
<tr>
<td>St Helens</td>
<td>179,331</td>
<td>36,644</td>
<td>20.4%</td>
</tr>
<tr>
<td>Wirral</td>
<td>322,796</td>
<td>67,706</td>
<td>21.0%</td>
</tr>
<tr>
<td>Total for Merseyside</td>
<td>1,416,825</td>
<td>284,350</td>
<td>20.1%</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 for instance. The 2015/16 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.
Figure 4 shows the rate of deaths per 10,000 0-17 years population over the last two years. In last year’s annual report, it was commented on that Wirral appeared to have a disproportionately high rate of notifications compared to its U18 population, but in 2017/18 this has reversed to something that might have been more likely. Liverpool has the highest rate, with Wirral the lowest. As we are dealing in small numbers of notifications, fluctuations between years is more likely. Merseyside continues to have 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.

### Time taken to complete reviews in 2017/18

<table>
<thead>
<tr>
<th>LSCB Area</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 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowsley</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Liverpool</td>
<td>25</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sefton</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>St Helens</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Wirral</td>
<td>13</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

The table above shows that 84.95% (66.9%) of reviews were completed within 6 months and 91.9% (98.8%) completed in less than one year. 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 53 females, 62 males. Figure 6 shows the breakdown of child deaths categorised 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.

Child deaths categorised in 2017/18 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 51 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 (2016/17 % in [square brackets]) were:

Knowsley: 55% (5:4) [47%]
Liverpool: 35% (13:24) [35%]
Sefton: 45% (5:6) [19%]
St Helens: 55% (5:4) [23%]
Wirral: 35% (7:13) [22%]
Merseyside: 41% (35:51) [38%]
*Percentages are shown rounded up or down to whole numbers as occurs with the national picture

With the exception of Liverpool, in the cases that were reviewed at panel, all local authority areas showed increases in the proportion of deaths where modifiable factors were identified to reduce future risk. The national picture shows 24% for England and 24% for
the north-west (2016/17), so Merseyside as a whole, over the last two years, has reviewed a greater proportion of deaths where modifiable factors have been identified.

Specific modifiable factors relevant to an area have been provided to the relevant LSCBs. Across Merseyside, the modifiable factors identified in rank order include:

- Smoking in pregnancy/household (7)
- Poor parenting incl supervision/missing health appointments (7)
- Service provision (7)
- Domestic abuse (4)
- Alcohol/ Drugs (4)
- Obesity (3)
- Unsafe Sleep (2)
- Concealed pregnancy (2)
- Criminality incl gang/ knife crime (1)
- Parental mental health (1)
- Overcrowding (1)
- Social integration (1)

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 (72.1%). This is higher than the figures for the last 3 years (54.5 %, 50.4% and 47.7%). Nationally, 60% of deaths (2016/17 figures) 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).
Annual shifts in these percentages are influenced by the timeliness of cases coming to panel, and delays due to other reviews that might be needed.

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 10 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 and in the previous years. This follows NW and national patterns.
Location of Child Death

The majority of deaths (70.9%) occurred within a hospital setting, the majority of these occurring in the neonatal units followed by paediatric intensive care units (Figure 11). This is unsurprising because, by their very nature, they provide care to the most vulnerable and poorly.

Figure 10: Category of child death 2017/18

Fig 11: Child deaths categorised 2017/18 occurring in hospital

Figure 12 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 13 on the next page shows the cause of death, with the majority (60%) occurring neonatally, followed by others with a known life-limiting condition (15.1%). ‘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 70% (65%) of deaths were expected, with 30% (35%) of deaths being unexpected. 13% (15%) SUDC [2 up to 18 years] and 17% (14%) SUDI [0 up to 2 years]. (Last year’s figures in brackets).

Ethnicity

Figure 15 shows that the vast majority, 71% of the child deaths categorised during 2017-18 were of ‘British White’ ethnicity, a decrease from 86% in 2016-17.
Although the recording of ethnicity has improved since the start of the Merseyside CDOP panel, there are further improvements required as there remains 12.8% of child deaths (11 deaths) where the ethnicity is unknown.

**Deprivation**
There is a recognised association between deprivation, poor health and premature death. Figures 16 and 17 demonstrate this relationship very clearly across Merseyside. Figure 16 shows that 92% (46 out of 50) of notified deaths in Liverpool occurred in areas that fell in the first and second most deprived quintiles nationally. This is a pattern repeated for each of the other LSCB areas: Wirral 73%, Sefton 53%, Knowsley 92%, St Helens 61%.

Similarly, figure 17 shows historical figures for Merseyside over the last 3 reporting years. It can be seen that the majority of death notifications occur in the most deprived communities, with relatively few in the least deprived. Again, there are many publications that relate to these types of inequalities, many of which have a strong correlation to premature death. *The State of Child Health Report 2017*, a report written by the Royal College of Paediatrics and Child Health (RCPCH), reaffirm the fact that socioeconomic
status is strongly associated with premature infant and child mortality. For example there is increasing risk associated with higher levels of maternal deprivation for infants.

The RCPCH recommends some key actions, some of which could be applied locally:

- Maximise health during pre-conception and pregnancy, including smoking cessation programmes, promotion of breastfeeding and promoting healthy weight in women of childbearing age
- Ensure provision of high-quality, evidence-based sex, relationships and reproductive health education in schools
- Protect and support early intervention services and strategies.
- Create safe environments, including access to information and safety equipment schemes to promote safety in the home.
- Reduce road speed limits in built-up areas to 20 mph. (This has been done successfully in other NW areas e.g. Lancashire)
- Improve adolescent mental health and wellbeing in the UK.
- Protect and support early intervention services and strategies.
- Promote healthy physical, mental and social health through statutory, comprehensive, evidence-based personal health and social education in all schools.

Clearly, in an ever-challenging financial squeeze on public sector finances, some of these actions may prove difficult to implement, but nonetheless worthy of consideration.
## 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>8</th>
<th><strong>Perinatal/neonatal event</strong></th>
<th>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).</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td><strong>Infection</strong></td>
<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>
</tr>
<tr>
<td>10</td>
<td><strong>Sudden unexpected, unexplained death</strong></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>
</tr>
</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).