Merseyside Child Death Overview Panel and Isle of Man Annual Report

1st April 2021 – 31st March 2022

Foreword

This is my sixth report as Independent Chair for the Merseyside CDOP and reflects another historical year in which we have had to deal with the pressures of the Covid pandemic, with a series of restrictions which left an impact on all partners involved in child death reviews. Inevitable there have been some impacts on the processes leading to some delays, particularly those involving coroners' inquests and neonatal deaths.

At the time of writing, the NHS is in the midst of a major reorganization which will see the disappearance of CCGs and the emergence of Integrated Care Boards/systems; local government facing severe financial challenges; and local communities facing inflationary pressures due to rising energy costs. We need to ensure that despite these challenges, the child death review processes remain robust, with the appropriate oversight, to ensure that we maximise the opportunity to learn from every child death and reduce future risks.

I would like to thank all the Panel members, for their continued commitment and hard work, and in particular to how they switched swiftly to virtual working, without compromising the quality of the panel meetings. I would also like to thank Irene Wright, Helen Fleming-Scott and Vicki Kinsley for the hard work that goes on behind the scenes to ensure that the Panel runs smoothly and keeps pace with the changing landscape.

Mike Leaf
Independent Chair
Merseyside CDOP
Autumn 2022

Section 1: Executive Summary

There is a legal requirement for the statutory partners to *make arrangements to carry out child death reviews. These arrangements should result in the establishment of a Child Death Overview Panel (CDOP), or equivalent, to review the deaths (excluding infants live-born following planned, legal terminations of pregnancy, and stillbirths) of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children*. The focus of CDOP should be on identifying any modifiable factors that may help prevent unnecessary future child deaths or harm.

Across Merseyside, during 2021/22, responsibility for reviewing child deaths sat with the following:

- NHS Liverpool Clinical Commissioning Group (CCG)
- NHS Knowsley CCG
- NHS South Sefton CCG
- NHS Southport and Formby CCG
- NHS St Helens CCG
- NHS Wirral CCG
- Knowsley Borough Council
- Liverpool City Council
- Sefton Borough Council
- St Helens Borough Council
- Wirral Borough Council
- Isle of Man

It has been agreed as part of a MOU that Merseyside CDOP will:

- provide oversight and assurance of the new Child Death Review processes and ensure that it meets the required statutory standards.
- review all infant and child deaths under 18 years of age. This includes neonates where a death certificate has been issued, irrespective of gestational age.
- identify and highlight any modifiable factors, and bring these to the attention of strategic partners, including Health and Wellbeing Boards, Local Children's Safeguarding Partnerships and Community Safety Partnerships where necessary.

The purpose of this Annual Report is to:

- Clarify and outline the processes adopted by the Merseyside CDOP
- Assure the Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across Merseyside, which meets national guidance
- Provide an overview of information on trends and patterns in child deaths reviewed across Merseyside during the last reporting year (2021/22)
- Highlight issues arising from the child deaths reviewed
- Report on achievements and progress from last year's annual report
- Make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across Merseyside

Achievements during 2021/22 (*Update from last year's priorities in italics)*

- ✓ Improve the quality and frequency of analysis forms from CDRM meetings
  Both the quality and content of feedback from CDRM meetings has improved since covid pressures began to ease, and in particular the numbers of analysis forms being received. There is still, however, much room for improvement. Merseyside is not an outlier as other CDOPs have found it challenging to ensure all relevant parties are involved and contribute.
- ✓ Re-evaluate the role of virtually held panels and meetings following the covid pandemic
  Whilst there were a mixture of views from various professionals, panel and business meetings have reverted to face to face meetings. The group will continue to keep this under review.
- ✓ Provide assurance that multi-agency partner strategies are in place to address modifiable factors
  A communication has been sent to all Chairs of the Health and Wellbeing Boards and Children's Safeguarding Partnerships requesting a clarification of what assurance they will be seeking to ensure that there is a coordinated strategic approach to addressing:
    - *Smoking in pregnancy and at the time of delivery (SATOD)*
    - *Substance misuse*
    - *Issues relating to high or low Body Mass Index (BMI) before pregnancy*
    - *Alcohol misuse*
    - Unsafe sleeping
- ✓ Improve information provision from GPs
  There has been an improvement in information being provided by GPs, although it recognised there is still a long way to go. Merseyside CDOP is not an outlier as many CDOPs up and down the country recognise this as an ongoing issue.
- ✓ Develop use of the Sentinel system for Isle of Man participants
  There have been personnel changes in IoM, and still needs to be developed.

In addition, CDOP has:

- ✓ Managed and maintained oversight of the Child Death Review processes during major disruption to services due to the global Covid 19 pandemic
- ✓ Engaged with other CDOPs across the NW and nationally, and sharing good practice e.g. Safe sleep messaging, preventing shaking baby (ICON)
- ✓ Circulated good practice, learning and tools across Merseyside e.g. seven minute briefings including new partners
- ✓ Ensured that exceptional care is recognised by writing to providers where care has gone beyond that which might be expected.
- ✓ Supported Trusts in developing robust child death review meetings (e.g. Perinatal mortality; hospital mortality; etc) to inform the CDOP process in a standardised/ structured manner
- ✓ Continued to collect data for Adverse Childhood Experiences (ACEs), and analyze patterns and links between ACEs and child deaths

Priorities for 2022/23 (some rolled over from previous year):

- ✓ Review the current processes with a purpose of identifying areas of improving effectiveness and efficiency
- ✓ Improve the quality and frequency of analysis forms from CDRM meetings
- ✓ Re-evaluate the role of virtually held panels and meetings following the covid pandemic
- ✓ Provide assurance that multi-agency partner strategies are in place to address modifiable factors
- ✓ Improve information provision from GPs
- ✓ Develop use of the Sentinel system for Isle of Man participants
- ✓ Re-establish a lay representative to panel meetings.
- ✓ Undertake a review of the CDOP and CDR arrangements, including appointment and development of a new CDOP Manager following retirement of existing staff

Summary of key points and themes (2020/21 figures in [brackets]):

<u>Knowsley (14 deaths reviewed)</u>

- 78.6% of deaths reviewed during 2021-22 were completed within 12 months [45.5%]
- 75% of deaths were expected [84.6%]
- 85.7% of deaths were children under 1 year of age [72.7%]
- 50% of deaths had modifiable factors identified [36.4%]

Most prevalent modifiable factors (greater than one) included: Maternal BMI; Smoking/smoking in pregnancy; Alcohol/substance abuse; Domestic abuse/violence

<u>Liverpool (43 deaths reviewed)</u>

- 65.1% of deaths reviewed during 2021/22 were completed within 12 months [68.2%]
- 52% of deaths were expected [82.1%]
- 72.1% of deaths were children under 1 year of age [77.3%]
- 44.2% of deaths had modifiable factors identified [68.2%]

Most prevalent modifiable factors included: Service issues; Maternal BMI; Smoking/smoking in pregnancy; Alcohol/substance abuse; Engagement with health services; Domestic abuse/violence; Unsafe Sleeping; Housing/home conditions; Maternal health

Sefton (13 deaths reviewed)

- 61.5% of deaths reviewed during 2021-22 were completed within 12 months [70%]
- 68% of deaths were expected [100%]
- 53.8% of deaths were children under 1 year of age [65%]
- 38.5% of deaths had modifiable factors identified [35%]

Most prevalent modifiable factors included: Maternal BMI; Smoking/smoking in pregnancy; Unsafe Sleeping

St Helens (5 deaths reviewed)

- 20% of deaths reviewed during 2021/22 were completed within 12 months [80%]
- 71% of deaths were expected [100%]
- 80% of deaths were of children under 1 year of age [30%]
- 60% of deaths had modifiable factors identified [20%]

Most prevalent modifiable factors included: Service issues; Maternal BMI

Wirral (12 deaths reviewed)

- 58.3% of deaths reviewed during 2021/22 were completed within 12 months [69.2%]
- 71% of deaths were expected [42.9%]
- 83.3% of deaths were children under 1 year of age [53.8%]
- 33.3% of deaths had modifiable factors identified [23.1%]

Most prevalent modifiable factors included: Neglect; Unsafe Sleeping; Housing/home conditions

Merseyside (91 deaths reviewed including IoM)

- 61.5% of deaths reviewed during 2021/22 were completed within 12 months [66.7%]
- 68.3% of deaths were expected [80%]
- 72.5% of deaths were of children under 1 year of age [63.2%]
- 42.9% of deaths had modifiable factors identified [39.7%]

The most frequently occurring modifiable factors in ranked order include:

  - *Service issues (19%) [22%]*
  - *Maternal Body Mass Index BMI (15%) [4%]*
  - *Smoking/smoking in pregnancy (15%) [6%]*
  - *Alcohol/substance abuse (11%) [22%]*
  - *Engagement with health services (11%) [0%]*
  - *Domestic abuse/violence (8%) [4%]*
  - *Neglect (5%) [3%]*
  - *Unsafe Sleeping (5%) [4%]*
  - *Housing/home conditions (4%) [0%]*
  - *Physical environment (4%) [0%]*
  - *Maternal health (3%) [0%]*
  - *Mental health (1%) [5%]*

There has been a marked increase in the proportion of reviewed cases that have modifiable factors that were identified at panel with the information provided.

There were 4 deaths reviewed in the Isle of Man.

Recommendations for Strategic Partners

Local Safeguarding and Health and Wellbeing partners are asked to:

1. Note the contents of this annual report, and note that Merseyside has robust processes for oversight and undertaking child death reviews;
2. Continue to assure themselves that through the various strategic partnerships that there is an adequate coordinated approach to reducing:

    - Smoking in pregnancy and at the time of delivery (SATOD)
    - Substance misuse
    - Issues relating to high or low Body Mass Index (BMI) before pregnancy
    - Alcohol misuse
    - Unsafe sleeping

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 Manager
- Merseyside Police
- Education
- Public Health
- Consultant Paediatricians
- Lay Members
- Legal Services
- Named GPs
- Mental Health Trust
- Local Children's Safeguarding Partnership representative
- Safeguarding Nurse/Named 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. A Memorandum of Understanding has been compiled and incorporates the terms of reference and membership.

Lay Membership

Previously CDOP had Lay member participation in non-neonatal meetings from Liverpool and Sefton LSCPs and an ex CDOP member. Since the start of the Covid pandemic, CDOP has not had any Lay membership. During 2022-23, we will endeavour to re-establish this arrangement.

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. It is planned that there will be four meetings of each type per year.

Agency Representation at Meetings

There is a consistent membership for both neonatal and non-neonatal processes to promote greater collective memory and the advantages of a dedicated membership. Membership will be continually reviewed to ensure that there continues to be representation from all professional perspectives and geographies. The Business meeting continues to develop a more strategic focus and will ensure that it receives the input from relevant organisations. The transition group established to oversee the transition to the new Child Death Review processes continues to meet and provides senior level involvement.

Notification Process

The notification process via paediatric liaison and hospital/hospice staff continues to function well. The contact for this within the Isle of Man at present is a public health officer. 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 has sometimes been notified by hospitals and CDOP contacts out of the area, as well as Merseyside agencies. This continues to demonstrate 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. Feedback from the SUDiC Implementation Group is now a standing item on the CDOP business meeting agenda.

Links to Coroners and Registrars

There continues to be an excellent working relationship with the Coroners for Liverpool and Wirral and the Coroner for Knowsley, Sefton and St Helens within Merseyside, as well as good engagement with Merseyside Registrars. This enables issues and queries from both perspectives to clarified and resolved in a timely manner.

Deaths of Children Living Outside Merseyside

104 child deaths were reported to Merseyside CDOP regarding children who had died in this area with some having lived in areas external to Merseyside. Notification of the death of a child who

lives outside of Merseyside is securely e-mailed to the respective CDOP contact for the Local Authority area within 24 hours, or as soon as practically possible.

Communicating with Parents, Families and Carers

The Merseyside CDOP leaflet, 'What we have to do when a child dies' is distributed by the registrars to families, along with a list of support resources to enable them to exercise some choice if they want to pursue bereavement support. Many will already have had contact with bereavement support resources through the hospitals, but the opportunity to access alternative/additional support is enabled through the provision of this information.

When a Child Dies – A Guide for Parents and Carers is a newly compiled leaflet and should be provided to all bereaved families or carers: https://www.lullabytrust.org.uk/wp-content/uploads/parent-leaflet-child-death-review.pdf The leaflet provides a detailed explanation of many of the processes associated with a child's death and remains available on LOCAL AUTHORITY and NHS Trust websites.

Deaths involving Child Safeguarding Practice Reviews/Critical Incident Reviews/North-West Neonatal Network.

Child deaths are considered at panel once all relevant investigations and reports have been completed. These include deaths that have been the subject of a child safeguarding practice review (previously a serious case review (SCR)), 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. During the Covid 19 pandemic, there have been delays to this process, and whilst there have been some improvements, delays continue to be a feature. Referral pathways have been developed.

Transition Group

Meetings with senior representatives from Childrens Safeguarding (DCS), public health (DPH), NHS (Director of Nursing) and the CDOP team was established in 2018 to initially oversee transition of CDOP from Local Childrens Safeguarding Boards in light of new guidance. Issues discussed include the development of a job description for a Merseyside Designated Doctor for Child Deaths.

Regional/National Links/ Updates:

North-West meetings

Merseyside CDOP continues to be represented at the North-West CDOP meetings. During the Covid 19 pandemic, it has not been possible to secure the required public health analytical support to produce the usual annual report for the NW, which Merseyside CDOP contributes to. It is envisaged that the annual report will be re-constituted once the covid pressures are resolved. At the time of writing Covid rates were significantly high.

National Network

Merseyside CDOP forms part of the National Network group that advised on issues of national interest, and the Manager remains a member of the Executive Committee. Issues such as themed reviews and reviewing out of area child deaths will be explored at the national network. This has not met through the pandemic.

National Database Development Project

Data collected by the National Database is now being collated and is released on a quarterly basis, with the second annual set of data released for 2021/22 included in this Merseyside CDOP annual report for the third time.

Funding

Contributions

The proportion of funding that each area contributes from Public Health funds, 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 Local Authority contributions (including the Isle of Man) provide a budget for campaigns and contribute to the running costs. The amounts for contributions for 2021-22 were agreed at the rate from previous years:

FINANCE

Income

	Knowsley	**Liverpool**	**Sefton**	**St Helens**	**Wirral**	**IoM - total**
PH contribution - £	7,076	20,069	11,468	7,869	14,518	10,246
CCG contribution		*£61k – split between all Merseyside CCGs				

*Liverpool CCG pays the total amount then invoices the respective areas

Expenditure

- Salaries: inclusive of on-costs
    - Independent Chair: £11,364.84
    - CDOP Manager: £63,673.43
    - Admin 1: £19,676.72
    - Admin 2: £8,601.17
- £9.62 – IT equipment
- £31.80 – stationery
- £161.00 – Life Bank room booking and refreshments

Table 3: CDOP expenditure in 2021/22

Issues Identified

Missing Data
There is a statutory responsibility for agencies and professionals to provide information to CDOP, and this will form part of the oversight programme. There has been an improvement on the details provided on the forms, but the failure to record details of father/male household figures continue to be an issue in some cases. CDOP continues to flag these issues as they arise, and will be working through regional and national networks, to identify good practice from other areas.

GP Engagement
Like many other areas, CDOP is still experiencing a lack of information from GPs upon request, although there is evidence that this is improving. Through safeguarding leads CDOP aims to improve these processes.

Covid Issues
Inevitably, the Covid 19 pandemic has had an impact on deaths. These include:

- Delays in accessing services
- Missed opportunities to view the home by professionals e.g. where baby sleeps, bonding
- Children learning remotely therefore not being seen by agencies

The National Child Mortality Database is informed of all deaths where covid may have been an issue and will produce a report in due course.

Service Issues
Invariably, as the majority of cases die in hospital, service issues continue to be picked up during reviews carried out prior to and at CDOP panel. These issues will be fed back to individual organizations where organizational learning is needed, or through established clinical networks e.g. maternity, paediatric, obstetric etc.

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:

- Service issues (19%) [22%]
- Maternal Body Mass Index BMI (15%) [4%]
- Smoking/smoking in pregnancy (15%) [6%]
- Alcohol/substance abuse (11%) [22%]
- Engagement with health services (11%) [0%]
- Domestic abuse/violence (8%) [4%]
- Neglect (5%) [3%]
- Unsafe Sleeping (5%) [4%]
- Housing/home conditions (4%) [0%]
- Physical environment (4%) [0%]
- Maternal health (3%) [0%]
- Mental health (1%) [5%]

In addition to the modifiable factors identified, Merseyside CDOP is made aware of any outcomes from Child Safeguarding Practice 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. On occasions, CDOP will flag issues up through regional and national networks where universal learning can be highlighted.

Priorities for 2022/23 (some rolled over from previous year):

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Mike Leaf
Independent Chair
Autumn 2022
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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.

This section (a) describes trends over several years, followed by (b) the narrative to accompany the National Child Mortality Database (NCMD) data contained in Appendix I, which is its second annual data output.

(a) Trends

When dealing with relatively small numbers, there can be wide fluctuations year on year. By considering number over time, one can look at trends in the figures.

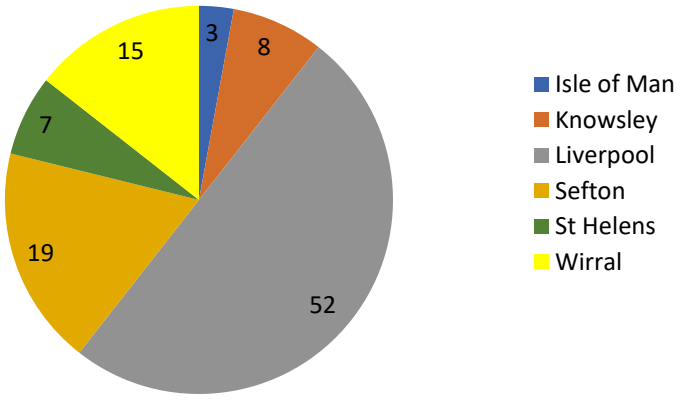
Child death notifications over time

Number of Deaths

Figure 1 shows the numbers and percentage split of the numbers of notified deaths.

During the reporting period 1st April 2021 to 31st March 2022, 104 child deaths were notified to CDOP across the five Local Authority areas (See Figure 1) and 3 for the Isle of Man (IoM). This is an 18% increase on the previous year. At the end of 2021/22 there were 109 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. Seven CDOP meetings were held during the year.

Figure 1: Total number of child deaths occuring in 2021-22



The “Heat map” in Figure 2 shows the relative locations of all notified deaths throughout Merseyside 2021-22, and the areas of greatest concentrations. (The Isle of Man figures are not included in the heat map in view of the small numbers which might be identifiable.)

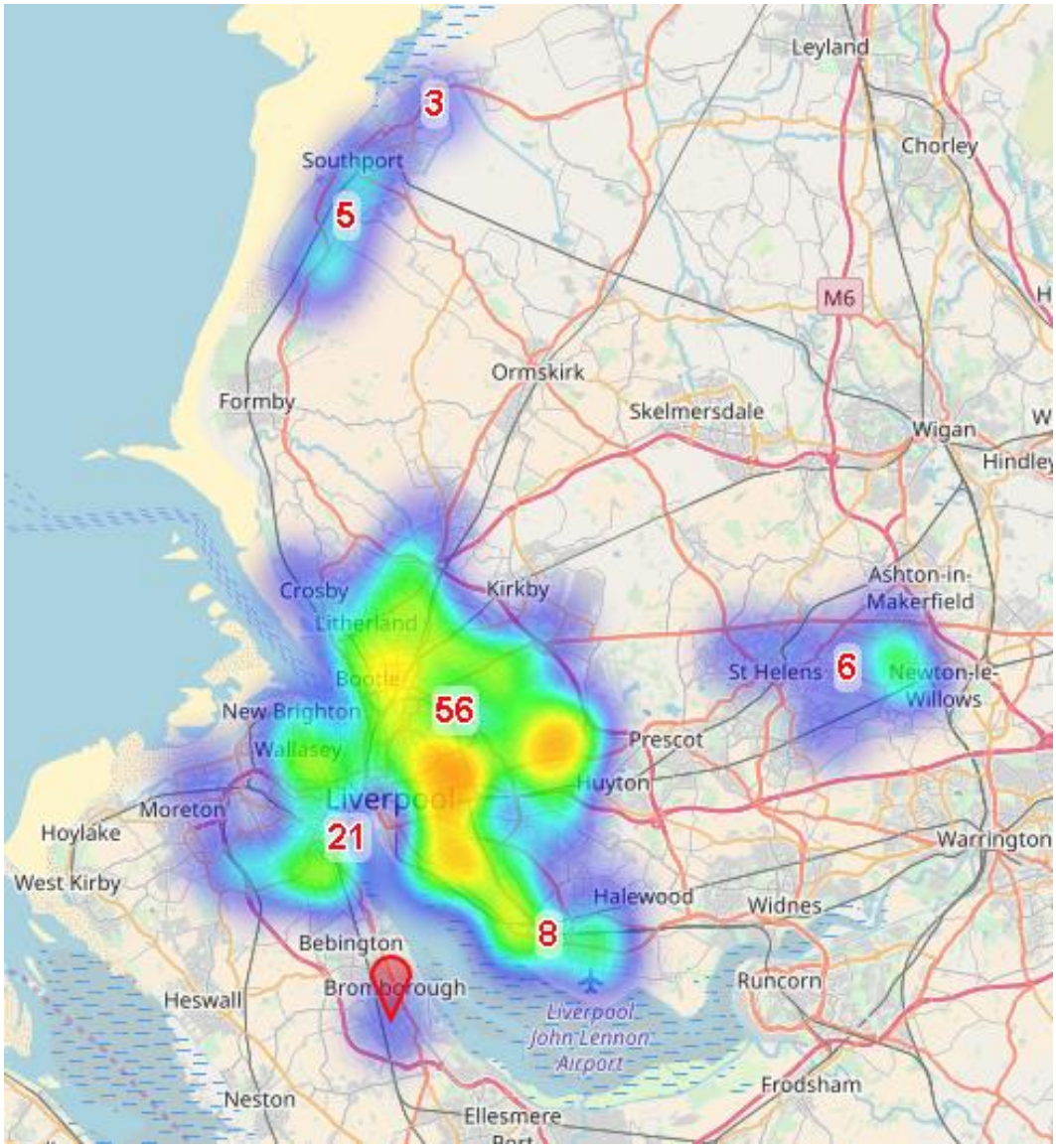
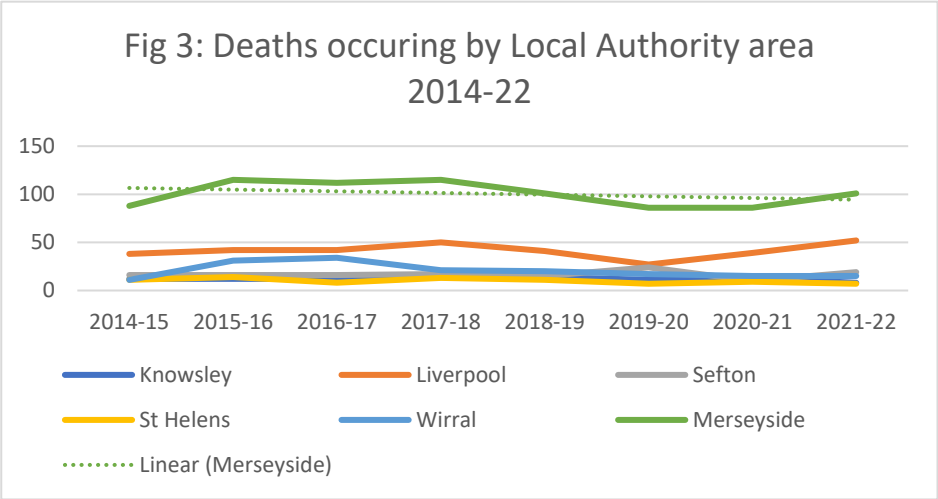


Figure 2

Figure 3 below shows the pattern of child death notifications over this period, for each of the Local Authority areas. One can see that the trend across Merseyside has decreased only slightly. In view of the relatively small number of notifications in the IOM, it is not possible to map the IOM deaths at this time as they may be identifiable.



Child Population

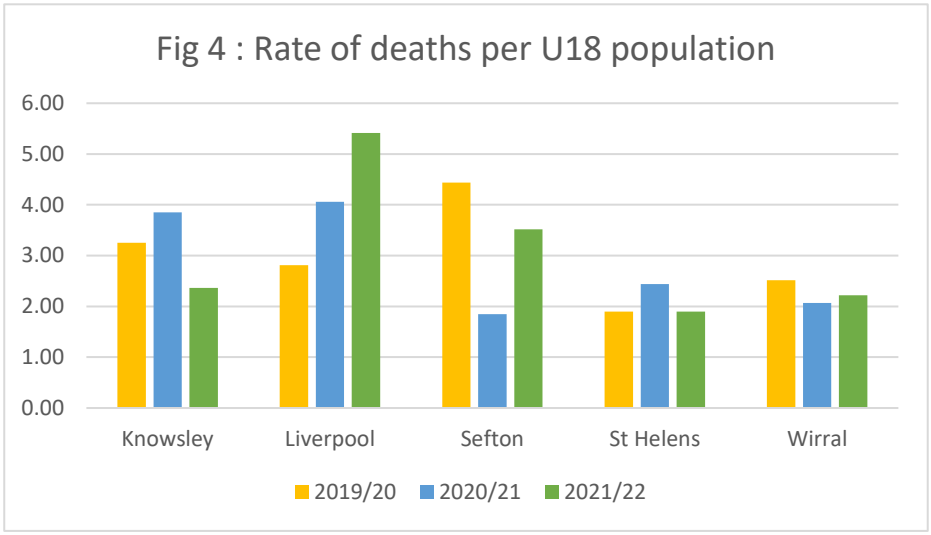
When considering relatively small numbers of deaths amongst the five Local Authority areas across Merseyside, it is appropriate to also consider the U18 population from each area and consider the rate per U18 population.

Local Authority Area	Total Population	U18 Population	U18 year olds as % of total
Knowsley	148,560	33,802	22.8%
Liverpool	491,549	96,052	19.5%
Sefton	274,589	54,057	19.7%
St Helens	179,331	36,868	20.6%
Wirral	322,796	67,508	20.9%
Total for Merseyside	1,416,825	288,287	20.3%

Table 4: Child population for Merseyside areas
Source: 2019 Mid-Year Population Estimates – Office of National Statistics (ONS)

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. Previous reports have 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 below shows the rate of deaths per 10,000 U18 years population over the last three years. Latest figures show that Liverpool has the highest rate, with St Helens the lowest. Liverpool appears to have seen an increase in this rate over the last three years, although small numbers mean that there can be wide annual fluctuations.



Merseyside CDOP, along with other CDOPs across the NW has been collecting information on the presence of Adverse Childhood Experiences (ACEs) on each death reviewed at panel. Research into adverse childhood experiences (ACEs) consistently shows that a set of 10 adverse experiences in childhood are associated with an increased risk of poor health and other problems in later life. Fig 5a provides a summary of the presence of ACEs identified throughout the reporting year, irrespective of the cause of death, or whether the death was expected or not. Care must be taken in attributing ACEs to deaths directly from this preliminary analysis, despite links identified between ACEs during childhood and increased vulnerability in adulthood.

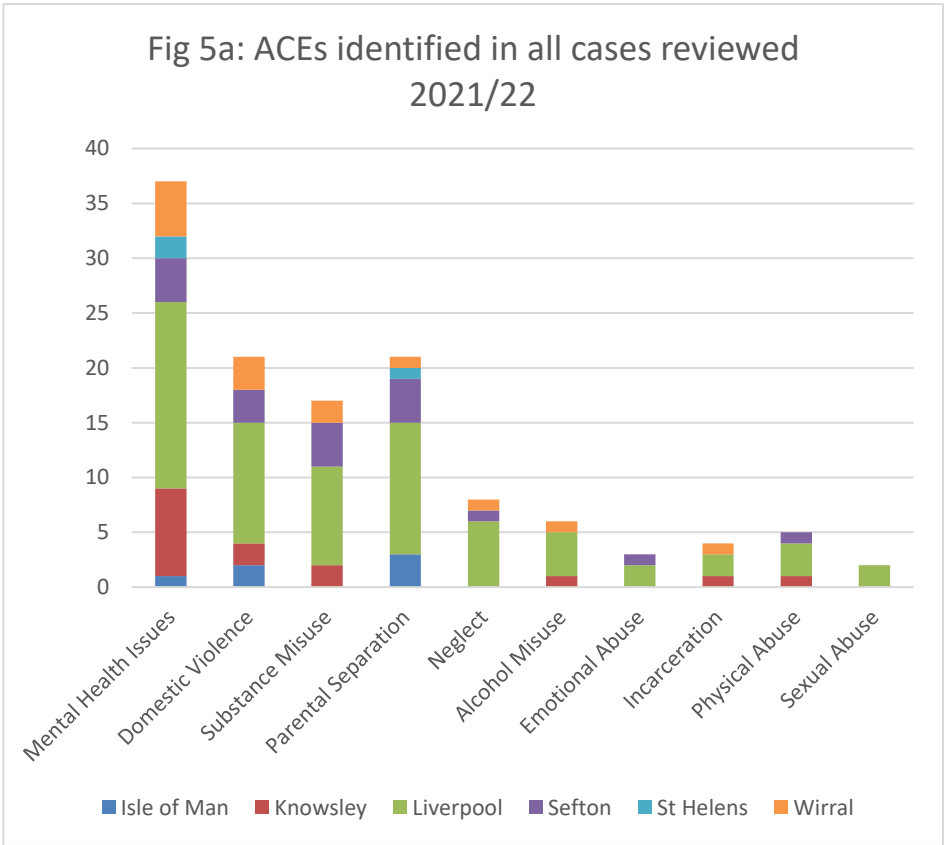
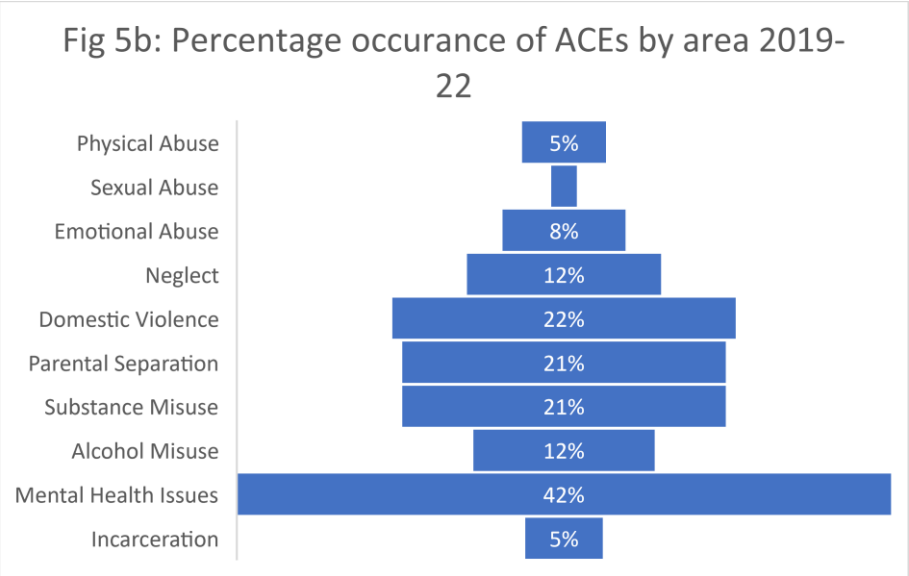


Figure 5b shows the occurrence of ACEs over the last three years for Merseyside as a percentage. The most common occurring ACEs include mental health issues, domestic violence, substance misuse and parental separation. What is clear is that the prevalence of ACEs amongst families where children have died appears high, although it is not clear without comparative data, whether this is any different to the general prevalence across Merseyside.



ACEs can have lasting, negative effects on health, well-being, as well as life opportunities such as education and job potential. These experiences can increase the risks of injury, sexually transmitted infections, maternal and child health problems (including teen pregnancy, pregnancy complications, and fetal death), involvement in sex trafficking, and a wide range of chronic diseases and leading causes of death such as cancer, diabetes, heart disease, and suicide.

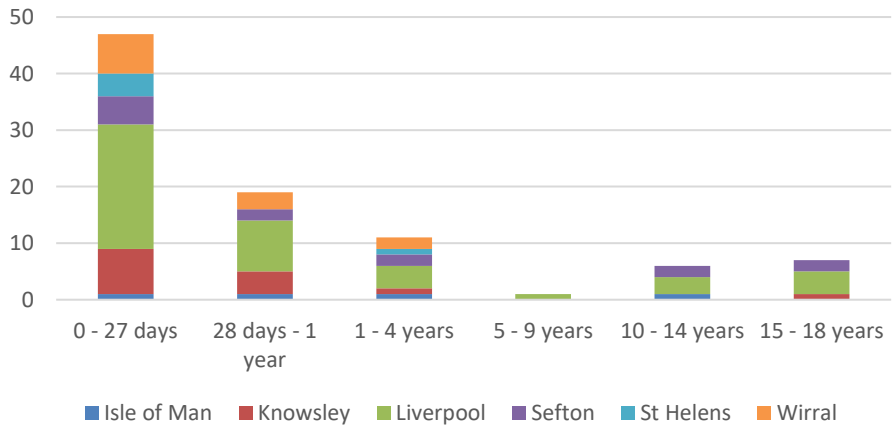
(b) National Child Mortality Database (NCMD) data (Appendix I)

The following narrative describes the various elements contained in Appendix I which is the third report from the NCMD. All tables described are included in Appendix I, with figures providing more nuanced outcomes included in the text below.

Deaths and Case Completions (Table A; Tables 1-4 – Appendix I)

There was a total of 104 deaths notified during the last year, and 91 cases closed (completed by CDOP including IoM). At 31st March 2022, 109 cases were ongoing. **Table 2** highlights the breakdown of closed and open cases by local authority area. Figure 7 shows how the Local Authority figures contribute to the age totals seen in Table 3. The number of closed/ open cases by age group covered in **Table 3** broadly reflects the expected distribution of deaths by age, with the majority occurring under the age of one year old. **Table 4** provides a breakdown of cases completed by local authority areas.

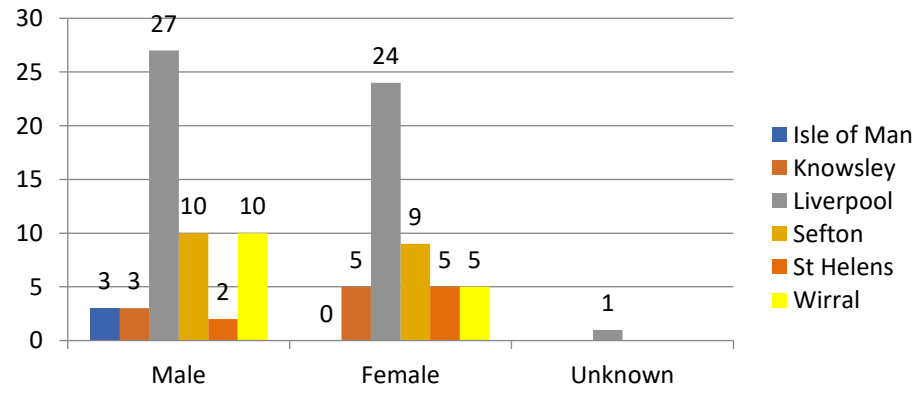
Fig 7: Reviewed child deaths by age and LA 2021/22



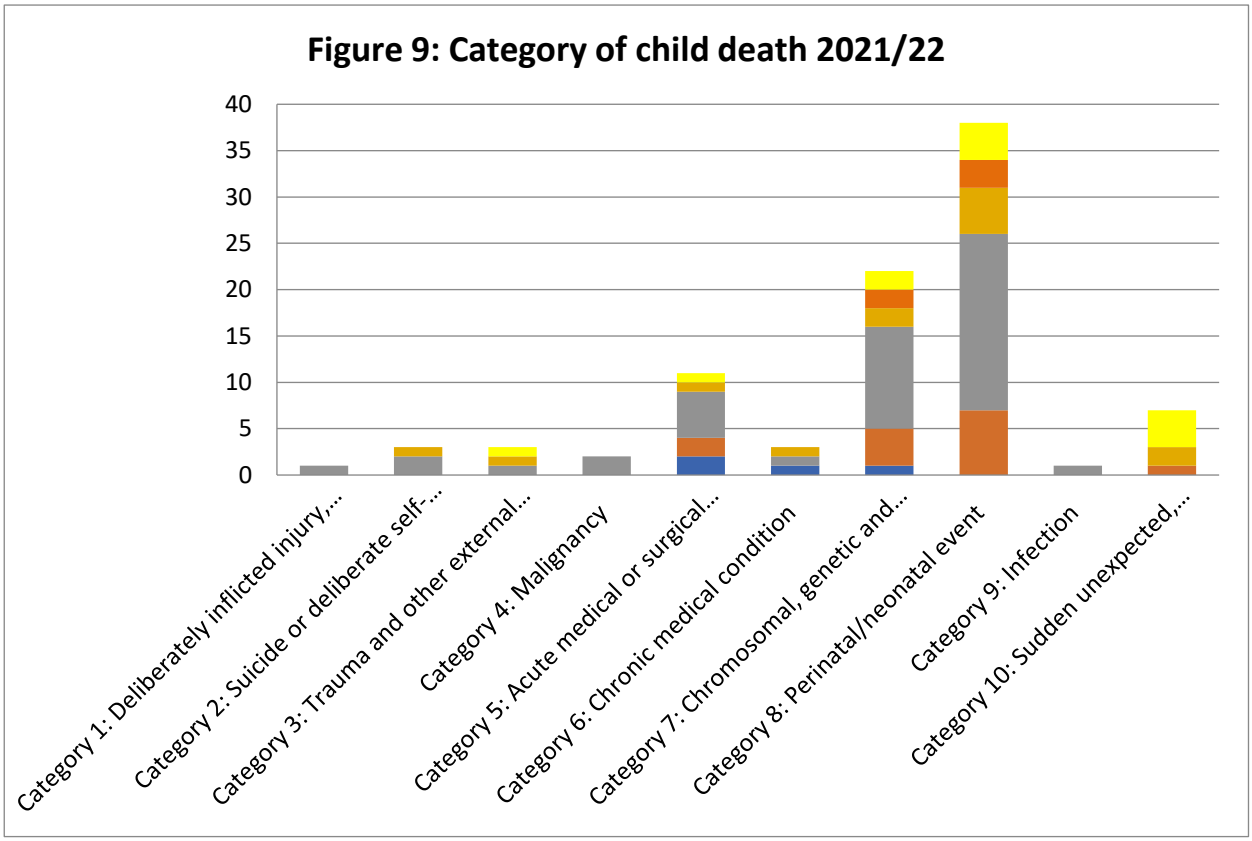
Deaths by Gender (Table 5)

From April 2021 – March 2022 of the 91 child deaths reviewed by the CDOP, 48 were male (53%) and 43 (47%) were female. The breakdown by local authority is provided below in figure 8.

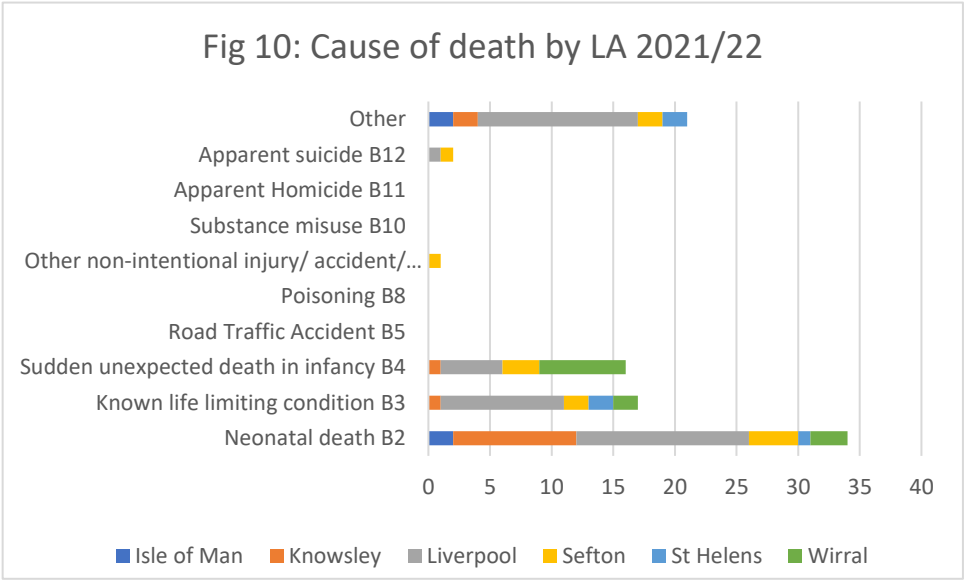
Fig 8: Child death occuring in 2021/22 by gender



Completed reviews by primary category of death and by age (Tables 6-7)
The majority of all deaths (67%) [61.5%] had a cause associated with chromosomal, genetic, congenital anomaly or as a result perinatal/neonatal event **(Table 6)**, and 72.5% [62.8%] of all deaths occurring under the age of one year **(Table 7).** A full description of the categories of death are provided at Appendix II, and the breakdown by area is provided in Figure 9.

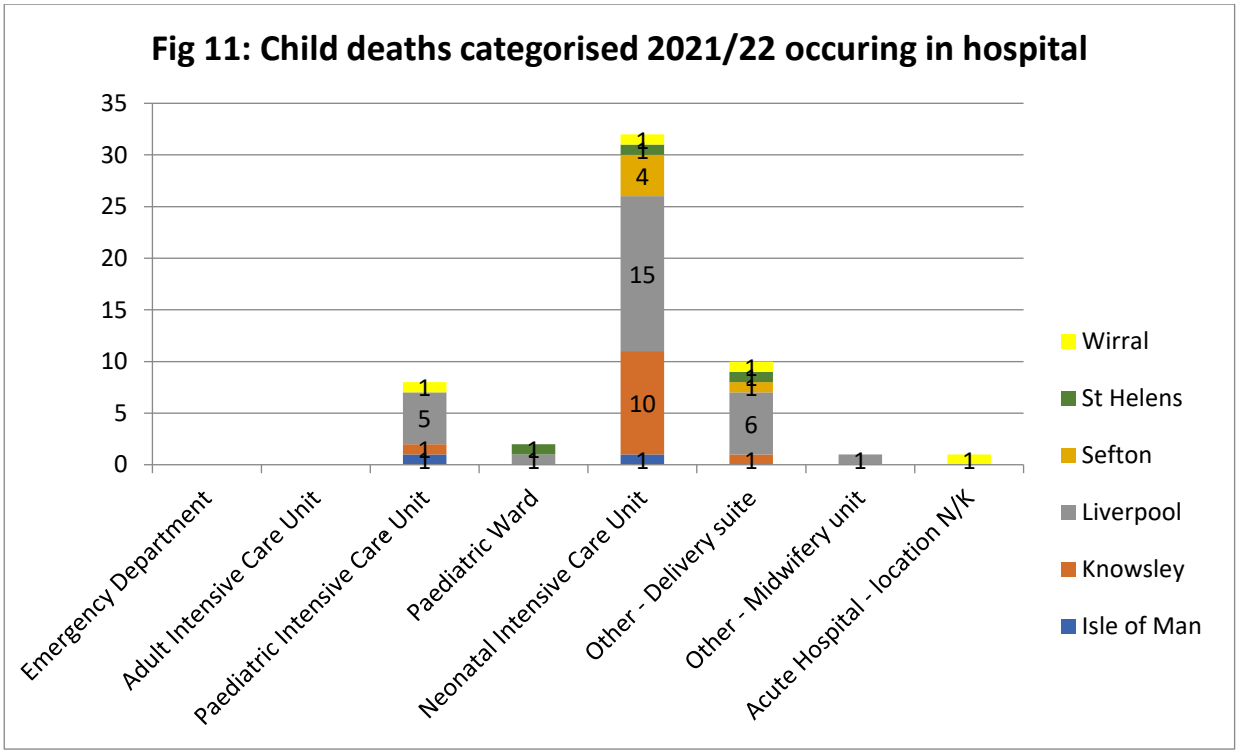


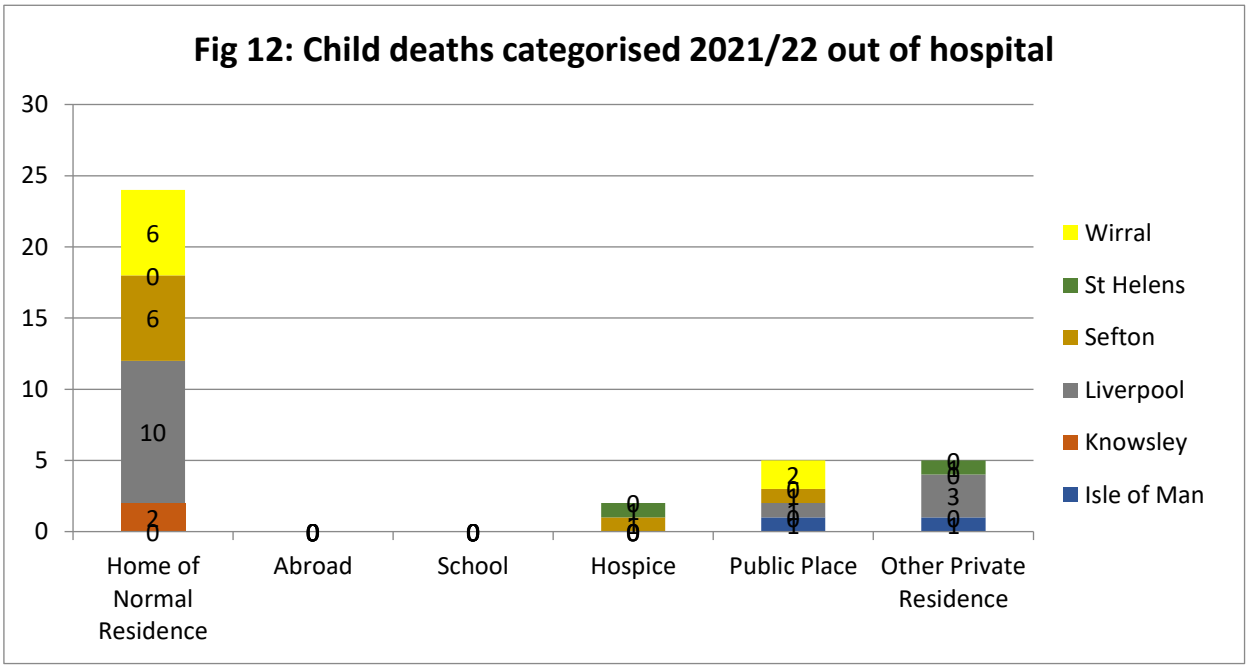
Causes of Child Death
Figure 10 shows the cause of death, with the largest proportion occurring neonatally, followed by a known life-limiting condition and Sudden Unexpected Deaths.



Completed reviews by place of death and onset of illness/incident (Tables 8-9)

As one might expect, the majority of deaths occur within a hospital **(Table 8)** and of these who die in hospital, the majority die in the perinatal/neonatal/maternity/labour units. Fig 11 and Fig 12: shows the make-up of these figures both inside and outside the hospital setting, by Local Authority area. It highlights 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. **Table 9** provides the breakdown of where the onset of illness or incident occurred, which is a new feature.

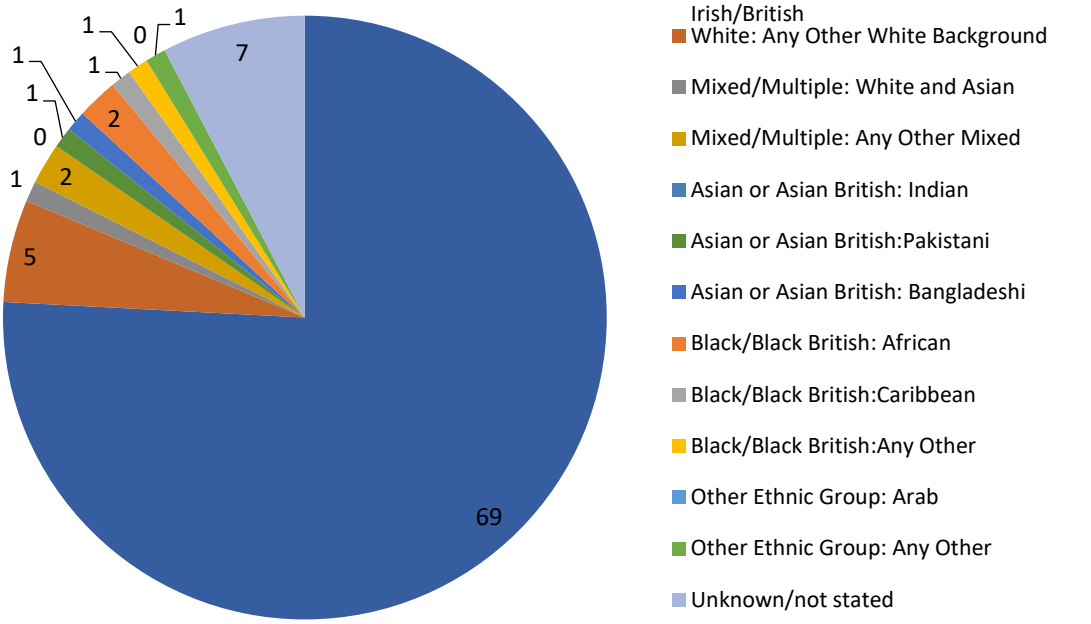




Ethnic groups and category of death (Tables 10-11)

61.5% (56) of those children who died where categorised as white, with 28% (26) having their ethnicity un-recorded **(Table 10).** CDOP will explore the reasons why so many cases do not contain ethnicity information. **Table 11** shows the primary category of death by ethnicity, although there appears to be no pattern in relation to category of death and ethnicity during one year. Fig 13 provides a population split by ethnicity.

Fig 13: Ethnicity of child deaths categorised 2021/22



Deaths reviewed by CDOP with modifiable factors (Tables 12-15)

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*.

It can be seen that from **Table 12**, 44% [40%] of cases reviewed (40) had modifiable factors identified, which is ***higher*** than the national average of 37%. Of these, 51% [59%] were linked to deaths under 28 days of age **(Table 14).** Fig 14 below shows the proportion of deaths where modifiable factors have been identified by Local Authority area.

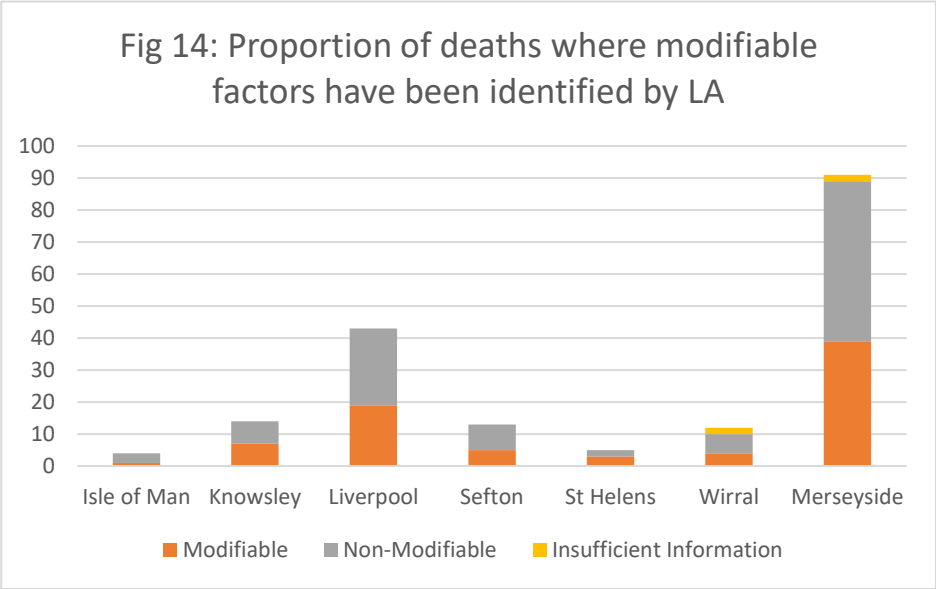
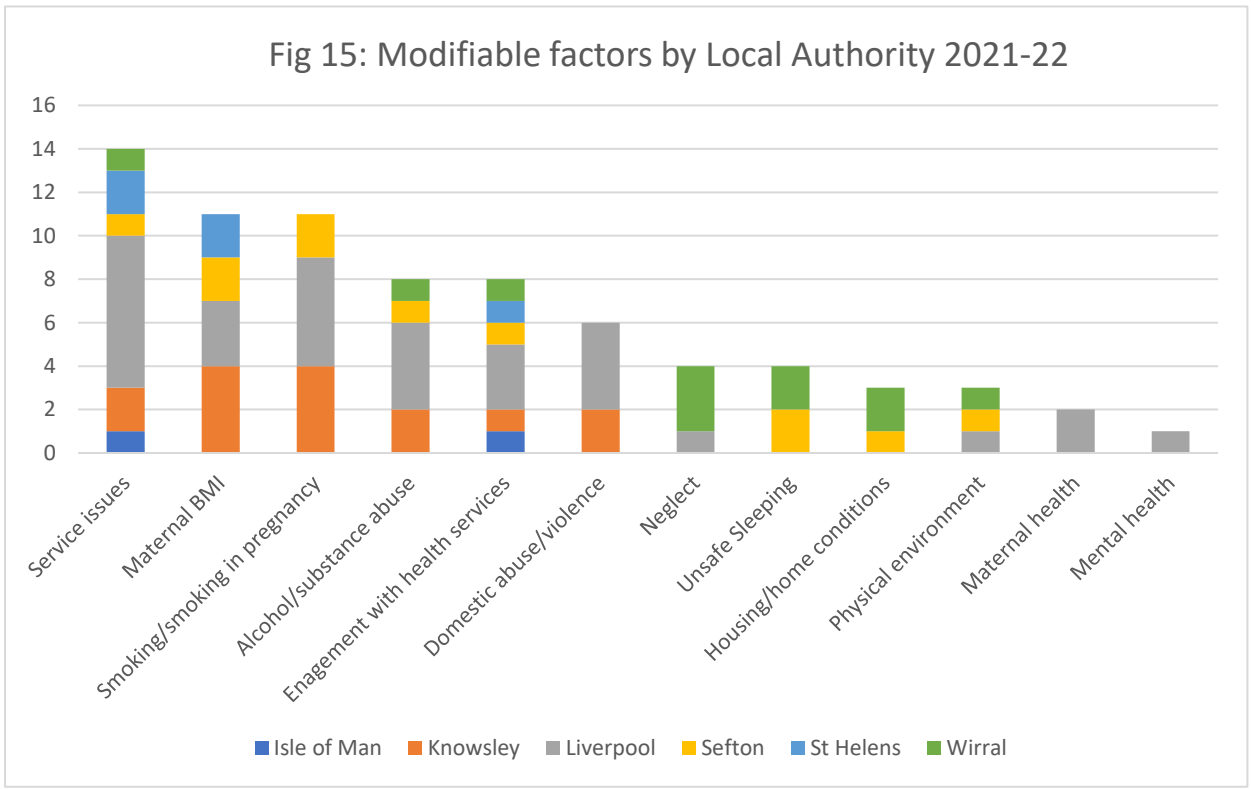


Table 13 shows the spread of modifiable factors across the category of death. 62% of the most common category (Perinatal/perinatal event) have modifiable factors. Fig 15 shows the modifiable factors identified for Merseyside as a percentage (%) [previous %] of all cases where modifiable factors were found:



Overall, the modifiable factors identified for Merseyside during 2021/22 (in order of prevalence) include:

- Service issues (19%) [22%]
- Maternal Body Mass Index BMI (15%) [4%]
- Smoking/smoking in pregnancy (15%) [6%]
- Alcohol/substance abuse (11%) [22%]
- Engagement with health services (11%) [0%]

- Domestic abuse/violence (8%) [4%]
- Neglect (5%) [3%]
- Unsafe Sleeping (5%) [4%]
- Housing/home conditions (4%) [0%]
- Physical environment (4%) [0%]
- Maternal health (3%) [0%]
- Mental health (1%) [5%]

Modifiable factors associated with Service issues remains the highest, partly due to the majority of deaths occurring in hospital, many before the age of one year old. Most of the learning from service issues are identified prior to coming to CDOP and are picked up through internal (and often external) reviews. Frequently, CDOP will identify additional learning that is fed back to individual services. Engagement with health services is likely to have been impacted by covid due to restrictions and anxieties regarding mixing.

Eleven cases reviewed identified maternal BMI as a modifiable factor, all of which were associated with perinatal/ neonatal events. BMI, smoking, alcohol, and substance misuse have a significant impacts on neonatal/ perinatal outcomes, as well as clinical care, which the NHS is leading. If we are to make a difference to the neonatal/ perinatal outcomes, we need to ensure that we have coordinated health and wellbeing as well as high quality clinical interventions. Representatives at CDOP panel have a responsibility to flag such issues up with their organisations and professional peers, but strategic partnerships e.g. Health and Wellbeing Boards and Childrens Safeguarding Partnerships should be assured that there are coordinated initiatives to reduce the impact of these factors. The CDOP annual report has flagged these issues in the past and this will be followed up.

Modifiable factors by ethnicity are shown in **(Table 15)**, but with such a significant proportion of ethnicity not being recorded, no conclusions can be made**.**

Death notifications (Tables 16 – 20)

CDOP can be notified of the death of a child by any organization or an individual. CDOP may receive several notifications for the same child, but where this occurs, it will be classified as a single notification. A breakdown of notifications by Local Authority area is provided in **Table 16** which broadly correlates to the relevant under 18 populations in each area.

Table 17 shows the number of Joint Agency Responses (JARs) undertaken. A JAR is a coordinated multi-agency response which is triggered if a child's death:

• is or could be due to external causes
• is sudden and there is no immediately apparent cause (including SUDI/C)
• occurs in custody, or where the child was detained under the Mental Health Act
• where the initial circumstances raise any suspicions that the death may not have been natural or
• in the case of a stillbirth where no healthcare professional was in attendance.

There has been a significant improvement in the number and percentage of death notifications where it was not clear whether a JAR had taken place, and CDOP will continue to monitor this to minimise this data gap. The Business Group will explore solutions to this.

Table 18 shows death notifications by month/age, where it can be seen that the highest number of notifications occurred in October, December, and February [July, September, and April], and this differs from the previous year when the top 3 months were October, January and March.

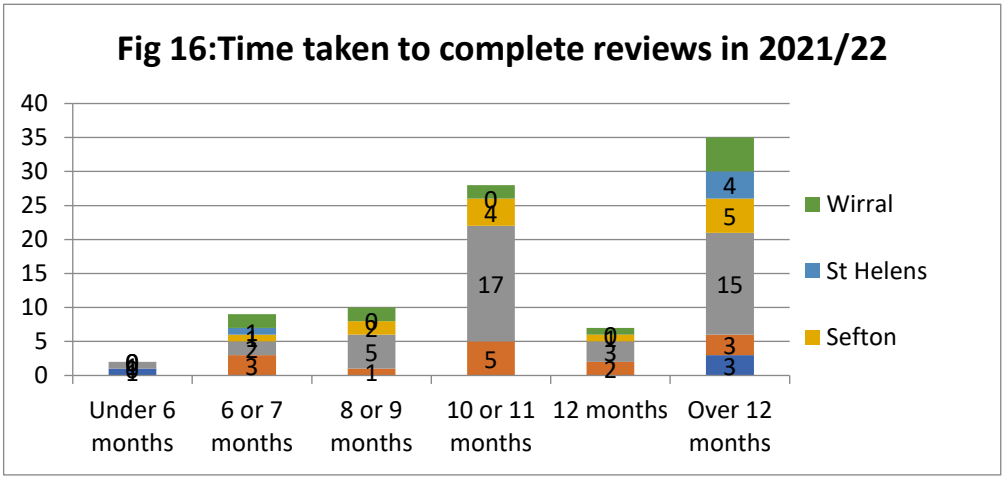
Table 23 illustrates that there appears to be no seasonal pattern developing. Notifications by age group feature in **Table 19** which clearly indicates that the majority of deaths occur the first year of life 69.2% [74%] compared to 60% nationally. The highest annual number of deaths occur neonatally (under 28 days), often as a result of complications through prematurity. Smoking, alcohol consumption, high maternal BMI, and domestic abuse all are known to increase the risk of prematurity and low birth weight, resulting in an increased level of vulnerability and risk of early infant death. It is important that all parts of the health and social care system reinforce messages that reduce risk of prematurity and low birth weight, especially during pregnancy. It can be seen from the **Table 19** that Merseyside has a similar pattern to national distributions for age, and lower rate for 15-15 year olds.

Table 20 shows death notifications by place of death with the majority occurring within a hospital setting.

Data completeness – Annual Comparison (Tables 21-23)
Tables 21 and 22 show the death notifications/age groups by year.

Data completeness- Notifications and Completed Reviews (Tables 24-27) (Previous years' figures in brackets)

The NCMD Report is a national repository for data from all CDOPs across England, and consequently provided an opportunity to provide comparative data. Clearly, there will be longer term benefits each year new data is gathered. In the first report, there has been an attempt to established national standards for completion of certain information.



Merseyside CDOP has tended to take less time to bring cases to panel from initial notification but this has now reversed with the cases taking an average of 344 [287] days compared to 335 [274], nationally. The significant increases in completion time both locally and nationally is partly due to delays in some of the processes as a result of covid. Local Authority comparisons are provided in Figure 16.

Acknowledgements

As noted in the foreword much of the business of the CDOP is dependent on the continued support of panel members and the administrative support. I would like to take this opportunity to thank the panel members for their continued support and especially Irene Wright, and Helen Fleming-Scott who ensure the panel runs smoothly.

Mike Leaf
Independent CDOP Chair
Autumn 2022
CDOPTeam@liverpool.gov.uk

APPENDIX I

NCMD
National Child Mortality Database

NCMD Monitoring Report for CDOPs

Merseyside CDOP

Report created on: 09/06/2022

Quarter 4 2021/22

This report contains confidential information which is intended for use by the CDOP named above for monitoring and data quality purposes. **This report must not be shared with anyone who does not have a role within the CDOP**. All data presented within this report is unvalidated and therefore should be interpreted with caution. Only data which has been submitted to NCMD is included within this report and therefore may not be representative of all child deaths within the area.

Produced by National Child Mortality Database Programme Team. If you have any queries please contact ncmd-programme@bristol.ac.uk

1

Overview

Data on this page relates to deaths after 01/04/21 or where CDOP review was outstanding at 01/04/21, up to and including 31st March 2022

NCMD
National Child Mortality Database

Number of cases reviewed 21/22:	Total cases with review ongoing:
91	109

Number of deaths during 21/22:
104

Table A

Number of ongoing cases entered by LSCB

LSCB name	Cases
Isle of Man	4
Knowsley	11
Liverpool	53
Sefton	17
St Helens	8
Wirral	16
Total	**109**

Table 2

Number of ongoing cases by year of death and status of case

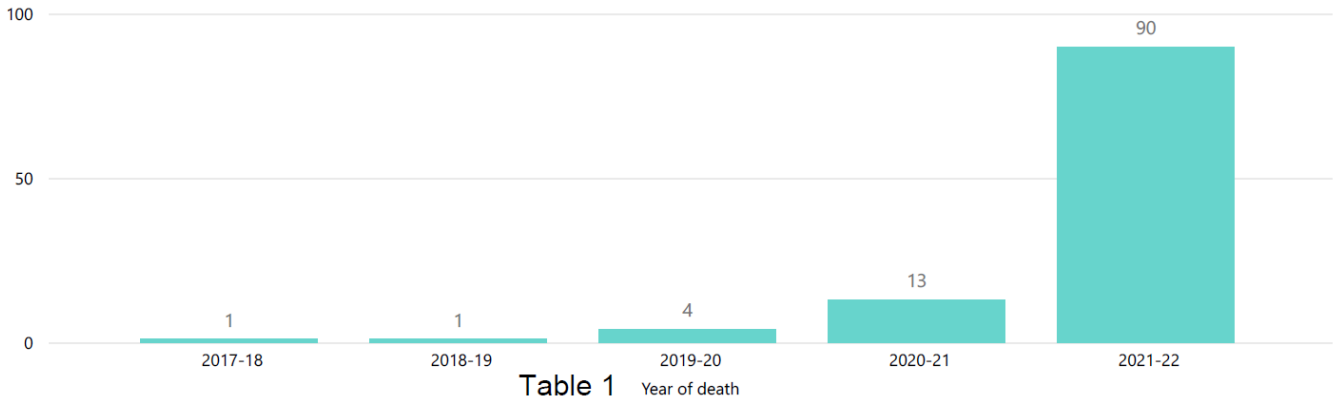


Table 1 Year of death

Number of ongoing cases by age group and status of case

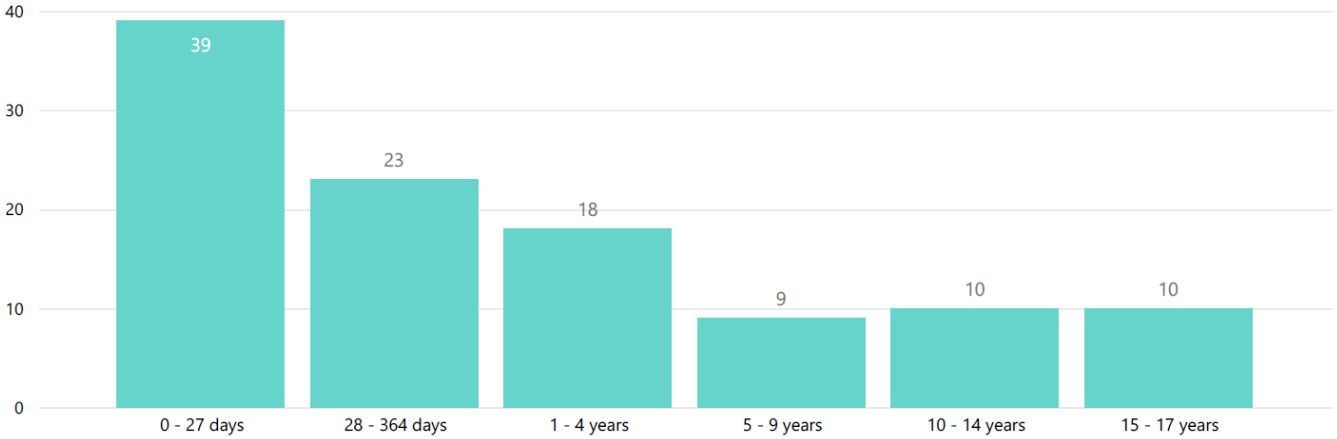


Table 3 Age group

1

Completed Reviews - Overview 1

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2021 and 31st March 2022

NCMD National Child Mortality Database

Number of cases reviewed 21/22:

91

Completed CDOP Reviews by LSCB

LSCB name	Cases
Isle of Man	4
Knowsley	12
Liverpool	45
Sefton	12
St Helens	5
Wirral	13
Total	**91**

Completed CDOP Reviews by year of death

Year of death	Cases
2018-19	3
2019-20	12
2020-21	62
2021-22	14
Total	**91**

Table 4

Completed CDOP reviews by gender

Table 5

Completed CDOP reviews by primary category of death

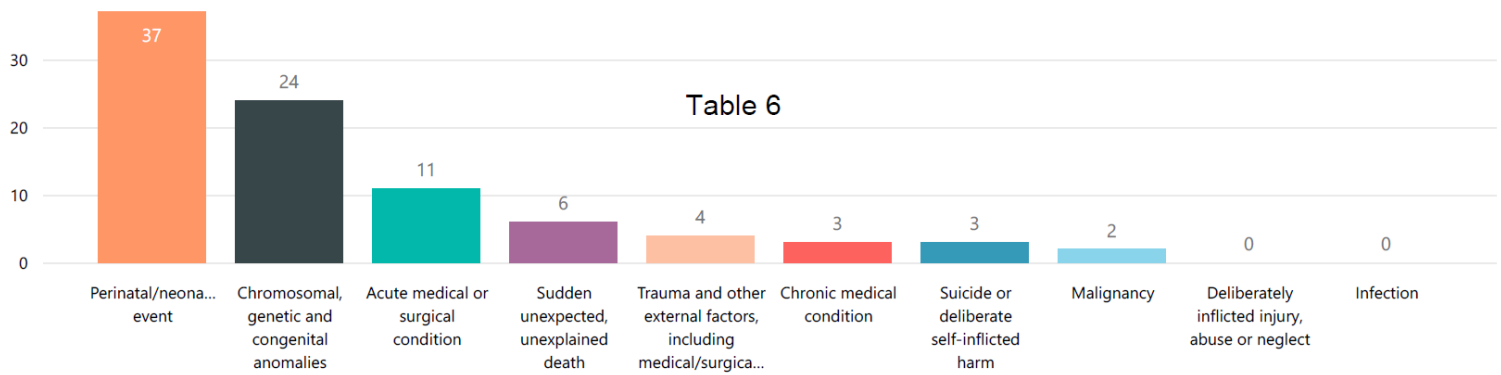


Table 6

Completed CDOP reviews by age group

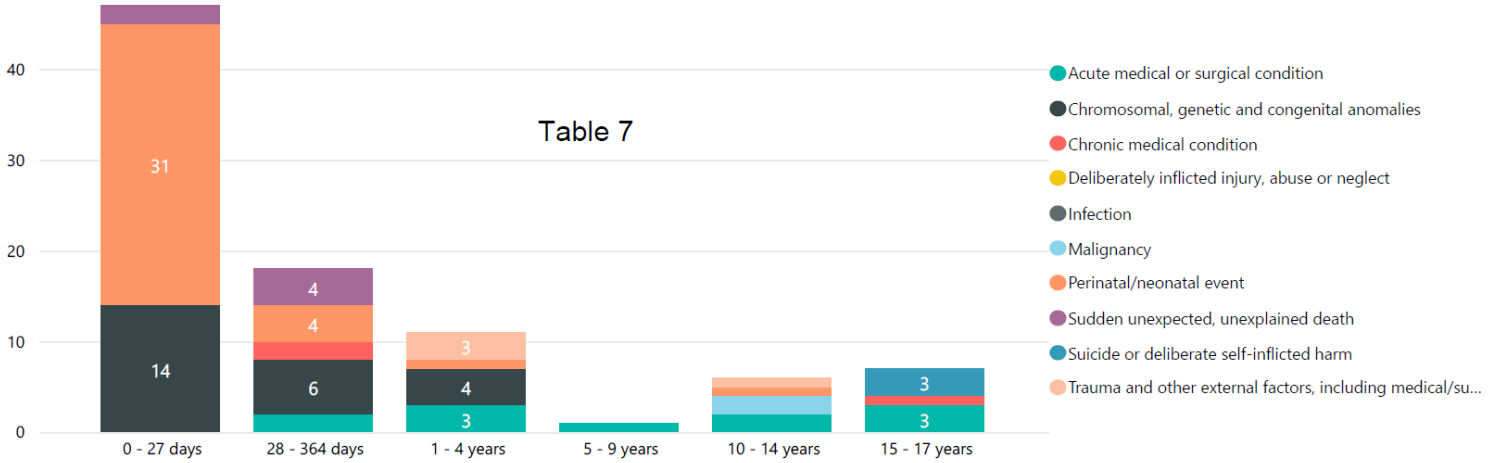


Table 7

Completed Reviews - Overview 2

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2021 and 31st March 2022

NCMD National Child Mortality Database

Number of cases reviewed 21/22:

91

Completed CDOP reviews by place of onset of illness/incident

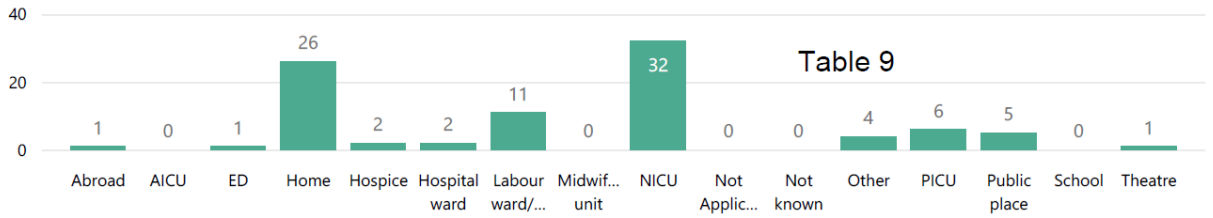


Table 9

Completed CDOP reviews by place of death

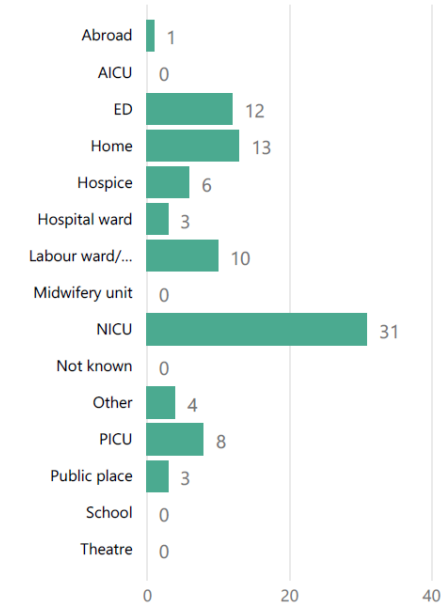


Table 8

Completed CDOP reviews by ethnic group and age group

Ethnic Group	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	Total
White	25	13	9	1	4	4	**56**
Unknown	17	4	1	0	2	2	**26**
Other	2	0	0	0	0	0	**2**
Mixed	0	0	0	0	0	0	**0**
Black or Black British	1	2	0	0	0	1	**4**
Asian or Asian British	2	0	1	0	0	0	**3**
Total	**47**	**19**	**11**	**1**	**6**	**7**	**91**

Table 10

Completed CDOP reviews by ethnic group and primary category of death

Ethnic Group	Acute medical or surgical condition	Chromosomal, genetic and congenital anomalies	Chronic medical condition	Deliberately inflicted injury, abuse or neglect	Infection	Malignancy	Perinatal/neonatal event	Sudden unexpected, unexplained death	Suicide or deliberate self-inflicted harm	Trauma and other external factors, including medical/surgical complications/error	Total
White	9	13	2	0	0	0	23	3	1	4	**55**
Unknown	1	7	1	0	0	2	10	3	2	0	**26**
Other	0	0	0	0		0	2	0	0	0	**2**
Mixed	0	0	0	0	0	0	0	0	0	0	**0**
Black or Black British	1	3	0	0	0	0	0	0	0	0	**4**
Asian or Asian British	0	1	0	0	0	0	2	0	0	0	**3**
Total	**11**	**24**	**3**	**0**	**0**	**2**	**37**	**6**	**3**	**4**	**90**

Table 11

Completed Reviews - Modifiable Factors

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2021 and 31st March 2022

NCMD National Child Mortality Database

Number of cases reviewed 21/22:	% cases with modifiable factors (CDOP):	% cases with modifable factors (England):
91	44%	37%

Were any modifiable factors identified?

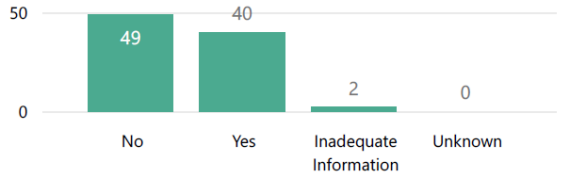


Table 12

% of cases where modifiable factors were identified by age group

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	47	24	51%
28 - 364 days	19	9	47%
1 - 4 years	11	3	27%
5 - 9 years	1	0	0%
10 - 14 years	6	2	33%
15 - 17 years	7	2	29%
Total	**91**	**40**	**44%**

Table 14

% of cases where modifiable factors were identified by category of death

Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Trauma and other external factors, including medical/surgical complications/error	4	3	75%
Suicide or deliberate self-inflicted harm	3	2	67%
Sudden unexpected, unexplained death	6	4	67%
Perinatal/neonatal event	37	23	62%
Malignancy	2	0	0%
Infection	0	0	0%
Deliberately inflicted injury, abuse or neglect	0	0	0%
Chronic medical condition	3	0	0%
Chromosomal, genetic and congenital anomalies	24	4	17%
Acute medical or surgical condition	11	3	27%
Total	**90**	**39**	**43%**

Table 13

% of cases where modifiable factors were identified by ethnic group

Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
White	56	28	50%
Unknown	26	10	38%
Other	2	0	0%
Mixed	0	0	0%
Black or Black British	4	0	0%
Asian or Asian British	3	2	67%
Total	**91**	**40**	**44%**

Table 15

1

Notifications during 2021/22

Data on this page relates to cases with a date of death between 1st April 2021 and 31st March 2022

NCMD National Child Mortality Database

Number of deaths during 21/22:

104

Death notifications by month of death

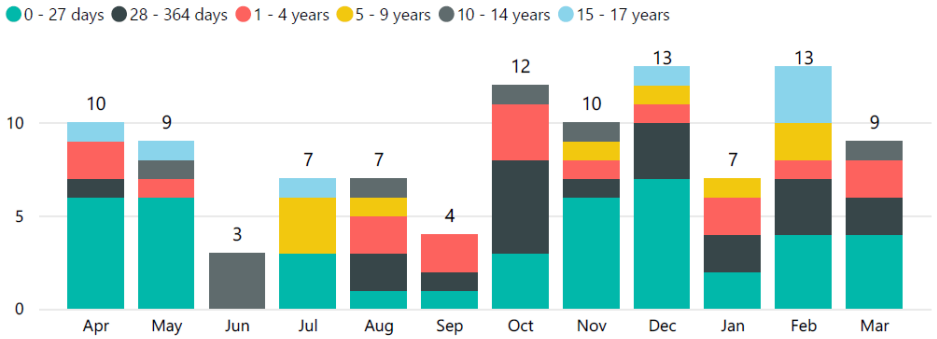


Table 18

Death notifications by place of death

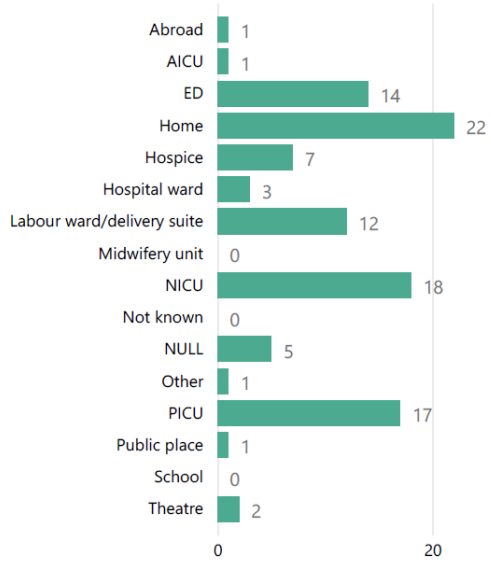


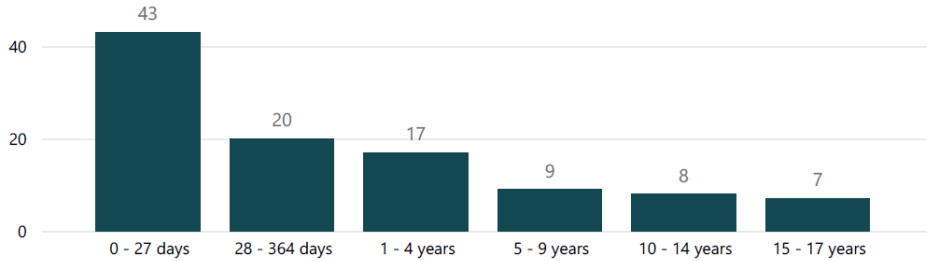
Table 20

Death notifications by LSCB

LSCB name	Cases
Isle of Man	3
Knowsley	8
Liverpool	52
Sefton	19
St Helens	7
Wirral	15
Total	**104**

Table 16

Death notifications by age group



% of death notifications by age group - CDOP

% of death notifications by age group - National (England)

Table 19

Is there to be a Joint Agency Response?

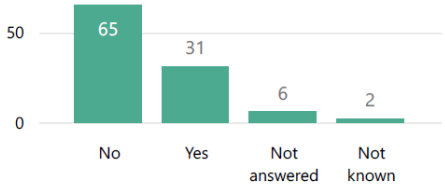


Table 17

Notifications - Annual comparison

Data on this page relates to cases with a date of death between 1st April and 31st March for all years. The table outlined in a blue box relates to all cases from 1st April 2019.

NCMD
National Child Mortality Database

Death notifications by LSCB and year

LSCB name	2019-20	2020-21	2021-22
Isle of Man	4	2	3
Knowsley	11	11	8
Liverpool	27	45	52
Sefton	24	8	19
St Helens	8	8	7
Wirral	17	14	15
Total	**91**	**88**	**104**

Table 21

Death notifications by age group and year

Age group	2019-20	2020-21	2021-22
0 - 27 days	35	46	43
28 - 364 days	20	19	20
1 - 4 years	19	7	17
5 - 9 years	4	1	9
10 - 14 years	4	8	8
15 - 17 years	9	7	7
Total	**91**	**88**	**104**

Table 22

All death notifications from 01/04/19 by month and year

Month of death	2019-20	2020-21	2021-22
Apr	3	10	10
May	7	3	9
Jun	5	7	3
Jul	6	13	7
Aug	7	4	7
Sep	10	11	4
Oct	11	2	12
Nov	6	8	10
Dec	9	8	13
Jan	11	8	7
Feb	5	7	13
Mar	11	7	9
Total	**91**	**88**	**104**

Table 23

1

Data Completeness - Completed Reviews

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2021 and 31st March 2022

NCMD National Child Mortality Database

Potential duplicates:	Cases with DoB/DoD errors:	Cases with CDOP meeting date not yet closed:
0	0	0

90 - 100% Good level of data completeness
< 90% Data completeness requires improvement

Notification fields - % completion of fields

CDOP Name	Cases	NHS No	DoD	Gender	Postcode	Suspected CoD	Place of Death	Hospital specified^	Joint agency response	Notification Details	Ethnicity	Gestational Age (Under 1s)	Investigated by Coroner	Post Mortem
Merseyside	91	96%	100%	100%	98%	100%	100%	100%	100%	100%	71%	97%	100%	100%

Table 24

Reporting fields - % completion of fields

CDOP Name	Cases	Events occurred selection	Circumstances of Death	Where at onset of illness	Known to social care	Subject to SCR	Mode of Death
Merseyside	91	100%	100%	100%	97%	93%	87%

Table 25

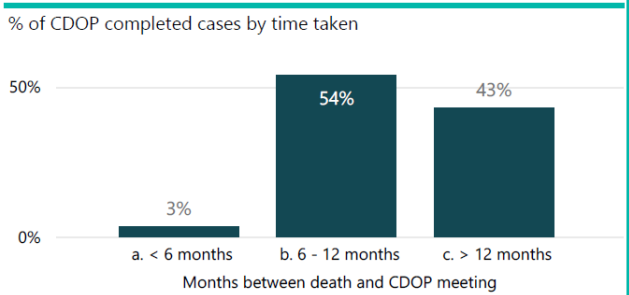
Analysis fields - % completion of fields

CDOP Name	Cases	CDOP category of death	CDOP meeting date	Cause of death	Domain factors recorded (at least 1)	Modifiable factors selection	Learning points text	Actions text
Merseyside	91	99%	100%	100%	100%	100%	100%	100%

Table 26

Table 27

Median number of days between death and CDOP meeting	CDOP	England
	344	335



^Where place of death was specified as hospital Not known or Not applicable not counted as complete

1

Data Completeness - 2021/22 Notifications

Data on this page relates to cases with a date of death between 1st April 2021 and 31st March 2022

NCMD
National Child Mortality Database

Potential duplicates:	Cases with DoB/DoD errors:	Cases with CDOP meeting date not yet closed:
0	0	0

90 - 100%	Good level of data completeness
< 90%	Data completeness requires improvement

Notification fields - % completion of fields (2021/22 notifications)

CDOP Name	Cases	NHS No	DoD	Gender	Postcode	Suspected CoD	Place of Death	Hospital specified^	Joint agency response	Notification Details	Ethnicity	Gestational Age (Under 1s)
Merseyside	104	98%	100%	96%	93%	100%	95%	97%	94%	100%	90%	95%

Appendix II: Category of Death

It is possible that deaths cover more than one category.

Category	Name & description of category	Tick box below
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 inflected 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.	☐

8	**Perinatal/neonatal event** Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).	☐
9	**Infection** Any primary infection (i.e., 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.	☐
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	☐

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).