Merseyside and Isle of Man Child Death Overview Panel

Annual Report 2022 – 2023

Foreword from Merseyside and Isle of Man CDOP Independent Chair:

While fortunately infrequent in our society, the loss of a child is an exceptionally heart-wrenching event that deeply affects not only the child's immediate family but also their wider circle of loved ones and the communities they are a part of. Our unwavering commitment is to prioritise families and children in all our endeavours. As a society, it is imperative that we draw profound lessons from these tragic losses, scrutinize any areas where improvements can be made, and adopt better strategies to diminish the likelihood of similar tragedies in the future.

As of this moment, a verdict in the Lucy Letby case has been reached. Between June 2015 and June 2016, this former neonatal nurse was found guilty of murdering at least seven infants and attempting to murder at least six others under her care at the Countess of Chester Hospital. This shocking case has cast a glaring spotlight on the entire child death review process, particularly in relation to the deaths of babies within hospitals. The subsequent Independent Inquiry initiated by the Government will hopefully highlight how we can enhance child death review procedures further.

Throughout Merseyside, the number of child deaths and cases reviewed in any given year tends to fluctuate, and these numbers generally remain relatively small. This can make it challenging to draw definitive conclusions in a single reporting year. However, the National Child Mortality Database (NCMD) has now become a valuable source of comparative data. This data will be integrated into future reports and will continue to drive fresh research on child fatalities and strategies to reduce them.

Mike Leaf, Independent Chair, October 2023.

Useful links:

Previous CDOP Annual Report - Merseyside and Isle of Man CDOP Annual Report 2021-2022

Safeguarding Practice Review Process - Child Safeguarding Practice Review Panel Guidance for Safeguarding Partners September 2022

SUDiC Protocol – In subsequent reports there will be a link to the SUDiC Protocol and Portal – this is due to launch in December 2023.

Whilst it is imperative that we review all child deaths, it is essential that we do not lose sight of the fact that behind every statistic is a child, a family and a community who have experienced a bereavement. As such, the report can make for difficult reading.

Purpose of CDOP:

The death of a child is a devastating loss which profoundly affects all those involved. Since April 2008, all deaths of children up to the age of 18 years, excluding still births and planned terminations are to be reviewed by a Child Death Overview Panel in line with the national guidance and statutory requirement set out in the Child Death Review Statutory and Operational Guidance published in October 2018. Child Death Overview Panels should "*review the deaths 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.*" Child Death Review Statutory and Operational Guidance published in October 2018.

Responsibility for reviewing child deaths across Merseyside and the Isle of Man sits with the following statutory partners:

- Knowsley Borough Council
- Liverpool City Council
- Sefton Borough Council
- St Helens Borough Council
- Wirral Borough Council
- Isle of Man
- Cheshire & Merseyside ICB (Integrated Care Board)
- Merseyside Police

Purpose of the Report:

The purpose of the Annual Report is to:

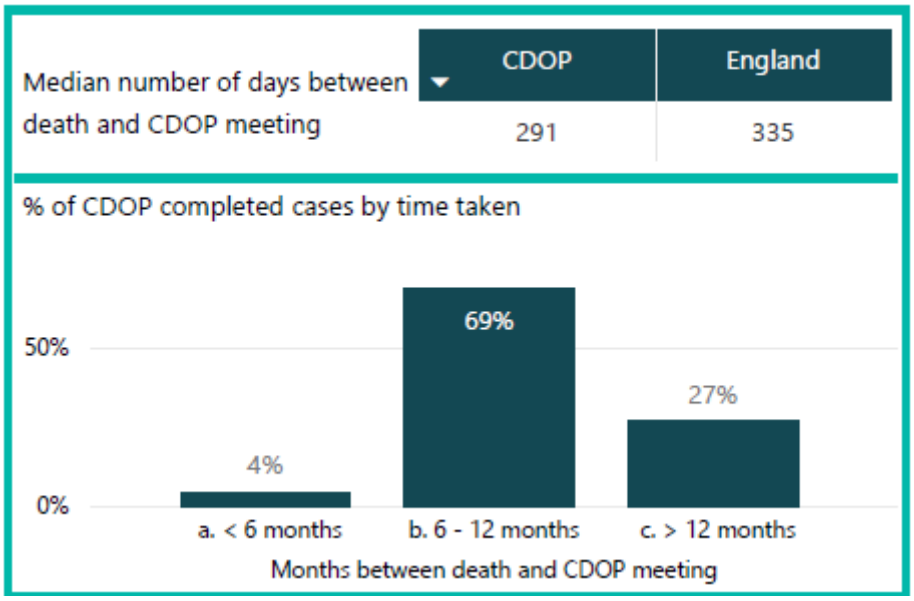
- Outline the processes adopted by Merseyside and Isle of Man CDOP
- Assure the Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across Merseyside and the Isle of Man which is in line with national guidance
- Provide an overview of information on trends and patterns in child deaths reviewed across Merseyside and the Isle of Man during 2022-2023
- Highlight issues arising from those reviewed child deaths – for the region as a whole as well as identifying pertinent issues in each Local Authority area.
- Report on progress from the issues identified in Merseyside and Isle of Man CDOP's last annual report
- Make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across Merseyside and the Isle of Man which may help to positively influence infant mortality across the region.

Please note that we must use the data in this report with caution. It cannot be taken as indicative of the events/number of deaths/issues experienced of a particular year. The data contained within covers deaths which have taken place over a number of years and therefore whilst useful, should not be used to draw firm conclusions for any fixed period of time.

Merseyside and Isle of Man Data:

In 2022/2023 Merseyside and Isle of Man CDOP reviewed 93 children and 92 deaths occurred. Due to the various processes, for example Police or Coronial investigations, Practice Learning Reviews, which take place following the tragic death of a child, most of the child deaths we are notified of, will not be reviewed in the same year they occurred. The deaths reviewed in any given year are likely to have occurred several months before being discussed at Panel. In 2022/23, three deaths were reviewed from 2019-2020, 9 deaths reviewed were from 2020-2021, 68 of the deaths reviewed were from 2021-2022 and 13 of the deaths reviewed happened in 2022-2023.

The National Child Mortality Database compares Merseyside and Isle of Man CDOP's performance against other CDOPs across England:



In 2022-2023, Merseyside and Isle of Man CDOP reviewed deaths 44 days earlier than the median review time of other CDOPs in England. The majority of deaths were reviewed between 6-12 months after the child had died.

Each Local Authority area covered by Merseyside and Isle of Man CDOP had completed child death reviews in 2022-2023:

Local Authority Area	Number of Child Deaths Reviewed
Isle of Man	<5
Knowsley	8
Liverpool	46
Sefton	14
St Helens	9
Wirral	15

There were 46 male children (49.5%), 46 female children (49.5%) and 1 child (1%) of indeterminate gender reviewed.

As per previous years, the largest number of deaths reviewed were White British children who were 0 – 27 days old, followed by 28 days – 1 year old. For a breakdown of the ages and ethnicity of the children reviewed at CDOP, please see the table below:

Completed CDOP reviews by ethnic group and age group

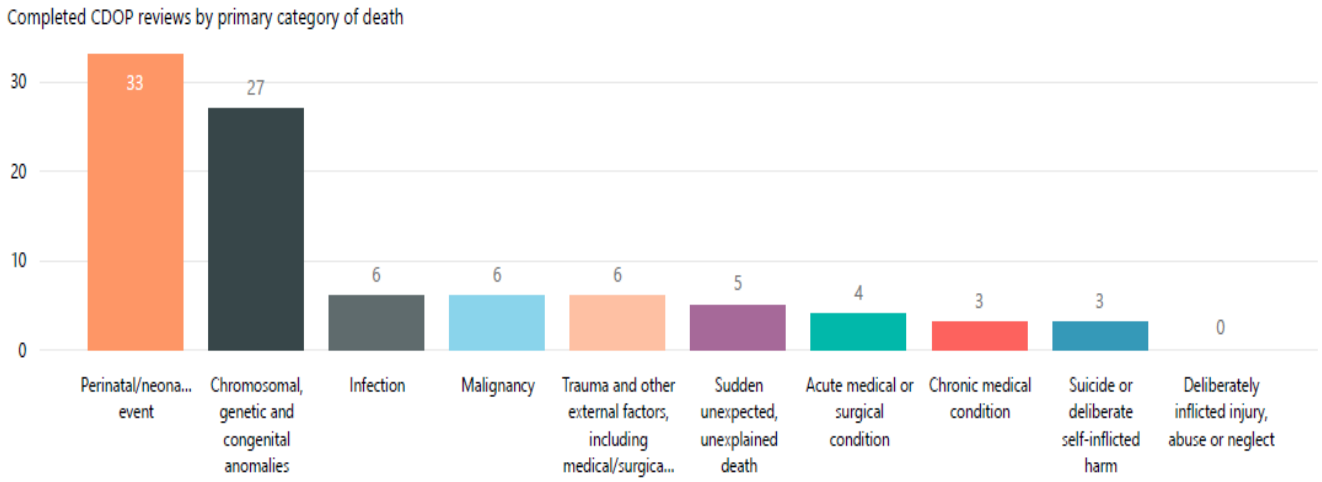
Ethnic Group	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	Total
White	37	13	10	6	8	6	**80**
Unknown	0	0	0	0	0	0	**0**
Other	3	1	0	1	1	0	**6**
Mixed	2	0	0	0	0	0	**2**
Black or Black British	1	0	0	0	0	0	**1**
Asian or Asian British	0	1	1	2	0	0	**4**
Total	**43**	**15**	**11**	**9**	**9**	**6**	**93**

Panel identified modifiable factors in 45 of the 93 cases reviewed – this equates to 48% of the cases reviewed by Merseyside and Isle of Man CDOP. In comparison, 39% of cases reviewed at other CDOPs across England were found to have modifiable factors.

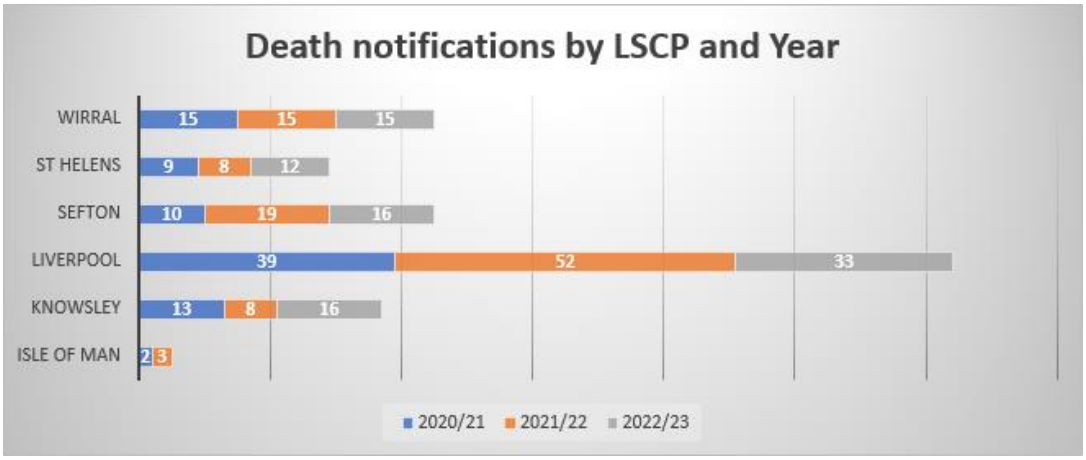
% of cases where modifiable factors were identified by age group

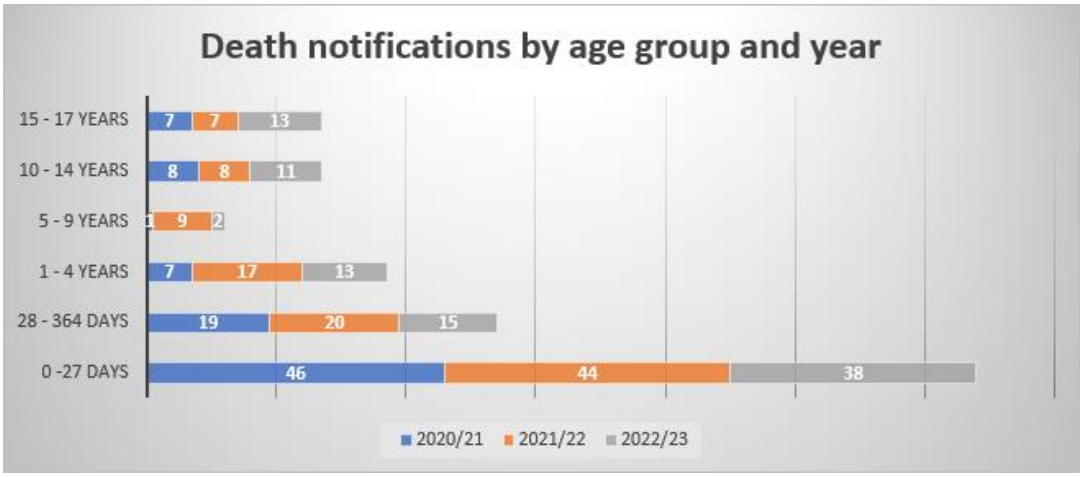
Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	43	24	56%
28 - 364 days	15	8	53%
1 - 4 years	11	5	45%
5 - 9 years	9	2	22%
10 - 14 years	9	2	22%
15 - 17 years	6	4	67%
Total	**93**	**45**	**48%**

For the Local Authorities covered by Merseyside and Isle of Man CDOP, the highest proportion of deaths fell into the category of 'perinatal or neonatal events', followed by 'chromosomal, genetic, and congenital anomalies', which fits with the neonatal age group being when most deaths occur. The other categories of death have relatively small numbers in comparison, please see the table below for details:



In terms of trends with our notification data, the table below shows the number of notifications of child death by the Local Authority (LSCP – Local Safeguarding Children's Partnership) in which the child was usually resident and the child's age when they died:





This illustrates that as would be expected, with the largest population, Liverpool has the highest number of child deaths of all the areas covered by our CDOP and that our highest number of deaths fall into the neonatal (0 - 27 days) period of a child's life, with 38% of reviewed deaths in 2022/23 falling into this category.

Modifiable Factors:

Modifiable factors are defined as one or more factors across any domain which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future child deaths. We have examined the most frequently occurring modifiable factors in 2022-2023 for all Local Authority areas, where there was more than one case:

Modifiable Factor	2022 - 2023	2021 - 2022	**2020 - 2021**
ervice Issues	26%	19%	22%
noking during pregnancy/at me of delivery	13%	15%*	6%*
gh maternal BMI	11%	15%	4%
noking in Household	10%	15%*	6%*
bstance use	8%	11%**	22%**
nsafe Sleep	5%	5%	4%
cohol use	4%	11%**	22%**
omestic Violence	4%	8%	4%
ngagement with health rvices/attendance at health ppointments	4%	11%	0%
eglect	4%	5%	3%
rental mental health	2%	1%	5%
ck of adherence to health dvice	2%	Not previously included in report	ot previously included in report
ild's substance use	2%	Not previously included in report	ot previously included in report
um's health & wellbeing	2%	3%	0%

* - previously smoking/smoking during pregnancy

** - previously alcohol/substance abuse

From the deaths reviewed in 2022-2023, there was an increase in Service Issues which has consistently been one of the most frequently occurring modifiable factors identified at Merseyside and Isle of Man CDOP. Alcohol and substances were reported on separately for the first time this year, which it is hoped will make the differentiation between the two easier to identify. When combined, the numbers appear to have remained quite consistent with 2021-2022, which was a reduction from the reviews completed in 2020-2021.

More positively, it appears that this year there has been some reduction in the number of reports of smoking during pregnancy/smoking at the time of delivery/smoking in the household as well as engagement with health services and attendance at health appointments from the previous year.

Last year's priorities, (some which were rolled over from previous year) with update in italics:

- Review the current processes with a purpose of identifying areas of improving effectiveness and efficiency – *An Independent Review of CDOP was commissioned and completed alongside a new CDOP Manager coming into post, so many of the processes in place previously have been updated to enhance efficiency in terms of admin time as well as efficiency for professionals accessing CDOP.*
- Improve the quality and frequency of analysis forms from CDRM meetings and work to embed this in Trusts where these meetings are not taking place regularly and work to develop and fully establish the CDRM process in Trusts which have not yet embedded this practice – *This work is on-going with a view to an audit being completed in 2023, so will roll over in to 2023-2024 priorities.*
- Re-evaluate the role of virtually held panels and meetings following the covid pandemic – *The Independent Review also evaluated virtual and non-virtual meetings. As a result, it was agreed that Business Meetings etc. would take place virtually but that due to the nature of the discussions that take place at Panel meetings that on the most part, these would take place face-to-face with the option to run virtually, if necessary.*
- Provide assurance that multi-agency partner strategies are in place to address modifiable factors – *This work remains on-going, however CDOP has asked for and received specific assurances from Local Safeguarding Partners regarding issues relating to:*
    - *Dangerous Dogs*
    - *Safer Sleep Advice – with a Safer Sleep Conversation Tool in development for launch later in 2023*
    - *High/low maternal BMI*
    - *Smoking in pregnancy and at the time of delivery*
    - *Substance/alcohol use*
    - *Asthma and poor home conditions*
- Improve information provision from GPs – *Work was completed between CDOP and Named GPs to revise the forms requesting information from GPs for the purposes of Panel review, making them more relevant to GPs. The revised forms were launched in January 2023. This has resulted in an increase in the number of returns from GPs and will continue to be monitored into 2023/2024.*
- Develop use of the Sentinel system for Isle of Man participants – *Due to the reviews around efficiency completed by the new CDOP Manager, there will be a move to a new data system eCDOP, meaning that Sentinel use will be discontinued. Isle of Man professionals will be offered training in the new system alongside all Merseyside professionals when the new system launches in April 2023.*
- Re-establish a lay representative to panel meetings – *This work is on-going and so will be rolled over to 2023-2024 Annual Report for an update.*
- Undertake a review of the CDOP and CDR arrangements, including appointment and development of a new CDOP Manager following retirement of existing staff – *A new interim CDOP Manager was*

appointed in October 2022 and the Independent Review into CDOP was commenced in January 2023.

Priorities for 2023-2024:

- Launch the new online data system - eCDOP
- Train all staff across Merseyside and the Isle of Man in eCDOP
- Continue to monitor the effectiveness of the new forms for GPs to ensure that their vital information is being fed into the reports for Panel
- Re-establish lay member representation at Panel
- Improve quality and frequency of analysis forms from CDRM to Panel and embed the CDRM process
- Provide assurances that multi-agency partner strategies are in place to address modifiable factors and assist in the plans to tackle these where feasible
- Develop themed panels to assist with increasing our understanding of the issues across Merseyside and the Isle of Man as well as potential emerging issues and future planning for CDOP

Local Area Information

Isle of Man:

There were less than 5 deaths reviewed and no notifications received by Merseyside and Isle of Man CDOP for the Isle of Man in 2022 – 2023, as such there is limited scope in completing any further analysis as there is little data to support this.

In terms of modifiable factors identified, these were (listed in prevalence order):

- Service Issues
- Smoking in pregnancy

Knowsley:

There were 8 deaths reviewed and 16 notifications processed by Merseyside and Isle of Man CDOP for Knowsley in 2022 – 2023.

Of the 16 notified deaths, 69% (11) were considered to be expected.

5 of the 16 notifications (31%) were of children who were under 1 year of age.

In terms of modifiable factors identified for the 8 Knowsley children, which were reviewed at Panel were (listed in prevalence order):

- Service issues
- Smoking in pregnancy
- Child's substance misuse

Liverpool:

There were 46 deaths reviewed and 33 notifications processed by Merseyside and Isle of Man CDOP for Liverpool in 2022 – 2023.

Of the 33 notified deaths, 70% (23) were considered to be expected.

17 of the 33 notifications (52%) were of children who were under 1 year of age.

In terms of modifiable factors identified for the 46 Liverpool children, which were reviewed at Panel were (listed in prevalence order):

- Service issues
- Smoking within the household
- Smoking during pregnancy/time of delivery
- Substance use
- High maternal BMI
- Unsafe sleep
- Alcohol use
- Domestic abuse
- Engagement with health services
- Not adhering to health advice
- Child's substance use
- Maternal health
- Mental health

Sefton:

There were 14 deaths reviewed and 16 notifications processed by Merseyside and Isle of Man CDOP for Sefton in 2022 – 2023.

Of the 16 notified deaths, 75% (12) were considered to be expected.

13 of the 16 notified deaths (81%) were of children who were under 1 year of age.

In terms of modifiable factors identified for the 14 Sefton children, which were reviewed at Panel were (listed in prevalence order):

- High maternal BMI
- Smoking during pregnancy/time of delivery
- Engagement with health services
- Service issues

St Helens:

There were 9 deaths reviewed and 12 notifications processed by Merseyside and Isle of Man CDOP for St Helens in 2022 – 2023.

Of the 12 notified deaths, 83% (10) were considered to be expected.

9 of the 12 notified deaths (75%) were of children who were under 1 year of age.

In terms of modifiable factors identified for the 9 St Helens children, which were reviewed at Panel were (listed in prevalence order):

- Smoking during pregnancy/time of delivery
- Service issues
- High maternal BMI
- Engagement with health services
- Substance use
- Domestic abuse
- Mental health

Wirral:

There were 15 deaths reviewed and 15 notifications processed by Merseyside and Isle of Man CDOP for Wirral in 2022 – 2023.

Of the 15 notified deaths, 67% (10) were considered to be expected.

8 of the 15 notified deaths (53%) were of children who were under 1 year of age.

In terms of modifiable factors identified for the 15 Wirral children, which were reviewed at Panel were (listed in prevalence order):

- Smoking in the household
- Smoking during pregnancy/time of delivery
- Substance use
- Alcohol use
- Domestic abuse
- Service issues

Responses to CDOP Data:

Merseyside and Isle of Man CDOP regularly share the data we are collecting and collating across multi-agency forums with all of the involved Local Authorities. This is done via Health and Wellbeing Boards, Safer Sleep Group meetings as well as the CDOP Business meeting and individual forums as and when the information is relevant.

As a result of the information gathered and shared by CDOP the following actions have taken place:

- The Parent Champion in the Community project ran from October 2021 – March 2022 and provided peer-led support to families in the most deprived areas whose babies are at risk of developing bronchiolitis. Hospital admission rates for bronchiolitis are twice the national average in Liverpool. The Project aimed to help address some of the health inequalities faced by many families, specifically relating to respiratory viruses which can impact mortality rates. The NCMD featured this project in its 'Sudden and Unexpected Deaths in Infancy and Childhood Thematic Report', which was published in December 2022. NCMD reported that: *"Qualitative evidence shows that Parent Champions working in these very deprived communities deliver effective health-related peer support to parents not only because of their communication skills and personal characteristics but also because they have similar life experiences to the parents; this means parents feel that they can be open with and trust the Parent Champions. In turn, this trust means other aspects of parents' lives have the potential to be changed".*
- Merseyside Police are planning a launch of a pilot of an app, developed by PC Craig Walsh which it is hoped will help to prevent of sudden infant death across Merseyside. Police officers as well as other frontline professionals were able to access training from The Lullaby Trust to ensure that they were able to spot unsafe sleep spaces and offer some safer sleep advice. Once the data is reviewed, if successful this app will be launched force wide.
- CDOP developed a Safer Sleep Conversations Tool which will be distributed to all areas which contains advice and guidance on how to start Safer Sleep Spaces conversations with families. The tool can be used by any frontline professional who might be visiting a family home and contains information on how to seek further advice from the local Health Visiting Team if this is needed.
- Safer Sleep Group are working on more consistent auditing tools to ensure that the right advice is being given to families at the right time regarding Safer Sleep advice.
- CDOP Team have initiated a review of the Pan-Merseyside SUDiC (Sudden and Unexpected Deaths in Childhood) Protocol. It is hoped that this will be launched in 2023-2024 alongside a web-based portal which will make it easier for all professionals who are dealing with a SUDiC to access the guidance within the protocol to ensure that the process is followed appropriately.
- CDOP Team are in the process of developing and launching an ALTE (Acute Life-Threatening Event) Protocol to stand alone from the current SUDiC Protocol to ensure that professionals have clear guidance when dealing with critically unwell children.