Merseyside Child Death Overview Panel (CDOP)

Annual Report
1st April 2015 – 31st March 2016

Merseyside CDOP Report
1st April 2011 – 31st March 2016
Foreword

The Merseyside Child Death Overview Panel (CDOP) has completed its 5th year of operating as a combined panel. During this time a systematic process has been embedded within all agencies involved in CDOP. This has ensured the quality of information provided enables panel members to engage in meaningful analysis of all child deaths across Merseyside. Modifiable factors are identified, where relevant, and recommendations for change are proposed that aim to prevent future deaths in similar circumstances. Additionally, patterns and trends are beginning to emerge that enable CDOP to propose actions to address.

This report will be divided into two sections:
Section 1: annual report for 2015 -16
Section 2: data established relating to Merseyside deaths from 2011 - 2016

During the functioning of Merseyside CDOP panel members have maintained their commitment to the process. The number of deaths during 2015-16, at 115, unfortunately, increased by a substantial number of 27, predominantly neonatal deaths.

The first section of this report describes the work of the panel throughout this year and identifies the key factors that impact on the wellbeing of children across the Merseyside region.

Section two will highlight the key aspects of the data established over the past five years and identify areas for focus in the future.

In continuing to support the work of the CDOP process appreciation is extended to Carly Gebhardt, Knowsley LSCB Administrator, Helen Fleming-Scott, Merseyside CDOP Administrator, Donna Atkinson, Sefton LSCB Administrator, Bernadette Pitchford, St Helens LSCB Administrator, and Jo Smith, Wirral CDOP Administrator for their efforts within their respective LSCBs; the continued excellent input of paediatric liaison staff and hospital staff who engage extremely well with the process and without whom it would not be possible to function as it does; panel members for their continued and ongoing commitment to CDOP, and to all staff who have contributed through their hard work and completion of agency reports.

Appreciation is also expressed to Stephen Knuckey and his team, St Helens Public Health, and Mike Owen, Liverpool Strategic Intelligence Team, for their input relating to deprivation data and mapping of child deaths respectively.

Acknowledgement of all those who have resigned from Merseyside CDOP during this year is offered with an appreciation for their commitment, efforts and what they helped to achieve, and a welcome is extended to those members who have joined the process during 2015-16.
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>1</td>
</tr>
<tr>
<td>List of tables and figures 2015-16</td>
<td>3</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>5</td>
</tr>
<tr>
<td><strong>Section 1:</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 Background and process</td>
<td>7</td>
</tr>
<tr>
<td>Membership</td>
<td>7</td>
</tr>
<tr>
<td>Frequency of meetings</td>
<td>8</td>
</tr>
<tr>
<td>Notification process</td>
<td>8</td>
</tr>
<tr>
<td>Rapid response</td>
<td>9</td>
</tr>
<tr>
<td>SUDiC Implementation Group</td>
<td>9</td>
</tr>
<tr>
<td>Links to Coroner and Registrar</td>
<td>9</td>
</tr>
<tr>
<td>Sentinel database</td>
<td>10</td>
</tr>
<tr>
<td>Process for children living outside who die in Merseyside</td>
<td>10</td>
</tr>
<tr>
<td>Communicating with parents, families and carers</td>
<td>10</td>
</tr>
<tr>
<td>Deaths involving Serious Case Reviews/Critical Incident Reviews</td>
<td>11</td>
</tr>
<tr>
<td>Regional/national links</td>
<td>11</td>
</tr>
<tr>
<td>1.2 Funding</td>
<td>12</td>
</tr>
<tr>
<td>1.3 Analysis</td>
<td>13</td>
</tr>
<tr>
<td>Child population</td>
<td>13</td>
</tr>
<tr>
<td>Number of deaths</td>
<td>13</td>
</tr>
<tr>
<td>Child death notifications by year</td>
<td>13</td>
</tr>
<tr>
<td>Child deaths by area</td>
<td>14</td>
</tr>
<tr>
<td>Timespan from notification to categorisation</td>
<td>15</td>
</tr>
<tr>
<td>Modifiable/non-modifiable re child deaths categorised</td>
<td>17</td>
</tr>
<tr>
<td>Child deaths age categories perinatal/neonatal/1 month to 1 year and 1 to 18 years</td>
<td>19</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>19</td>
</tr>
<tr>
<td>Child deaths reviewed by age (DfE categorisation)</td>
<td>20</td>
</tr>
<tr>
<td>Age range of notifications</td>
<td>21</td>
</tr>
<tr>
<td>Category of child death</td>
<td>21</td>
</tr>
<tr>
<td>Cause of child death</td>
<td>23</td>
</tr>
<tr>
<td>Age of mother</td>
<td>24</td>
</tr>
<tr>
<td>Birth weight of child</td>
<td>24</td>
</tr>
<tr>
<td>Gender</td>
<td>24</td>
</tr>
<tr>
<td>Expected versus unexpected deaths</td>
<td>25</td>
</tr>
<tr>
<td>Risk factors</td>
<td>26</td>
</tr>
<tr>
<td>Location of child death</td>
<td>27</td>
</tr>
<tr>
<td>Incidence of statutory involvement</td>
<td>28</td>
</tr>
<tr>
<td>Child deaths across Merseyside by locality</td>
<td>29</td>
</tr>
<tr>
<td>Deprivation</td>
<td>30</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>35</td>
</tr>
<tr>
<td>1.4 Issues identified</td>
<td>37</td>
</tr>
<tr>
<td>1.5 Achievements during 2015-16</td>
<td>42</td>
</tr>
<tr>
<td>1.6 Planned work for 2016-17</td>
<td>44</td>
</tr>
<tr>
<td>Appendices</td>
<td>46</td>
</tr>
<tr>
<td><strong>Section 2:</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 Data from child deaths reviewed 2011-12 to 2015-16</td>
<td>49</td>
</tr>
</tbody>
</table>
List of Tables

Tables:

Table 1: Contributions to CDOP process for 2015-16 by LSCB area
Table 2: CDOP expenditure in 2015-16
Table 3: Child population per respective Merseyside area
Table 4: Child death notifications per year across Merseyside 2008-2016
Table 5: Duration from notification to categorisation by LSCB area 2015-16
Table 6: Comparison of Merseyside and National timescales
Table 7: Age range of child death notifications
Table 8: Number of expected/unexpected child deaths relating to LSCB areas
Table 9: Parental/carer risk factors relating to child deaths for 2015-16
Table 10: Statutory interventions for child deaths reviewed by LSCB area
Table 11: Number of child deaths by LSCB areas according to local quintiles
Table 12: Percentage of child deaths by LSCB areas according to national deciles
Table 13: Number of child deaths by LSCB areas per quintile nationally
Table 14: Percentage of child deaths by LSCB area per quintile nationally
Table 15: Ethnicity of child deaths categorised 2015-16
Table 16: Agency representation at CDOP meetings
Table 17: CDOP team contact details
List of Figures:

Figure 1: Child deaths occurring April 2015 – March 2016 by LSCB area
Figure 2: Duration from notification to categorisation by LSCB area 2015-16
Figure 3: Child deaths reviewed by LSCB area and presence of modifiable factors
Figure 4: Child deaths reviewed identifying number by definitive ages per LSCB area as specified by DfE
Figure 5: Age of child at death by LSCB area for reviewed cases 2015-16
Figure 6: Category of child death by LSCB area 2015-16
Figure 7: Cause of death by LSCB area 2015-16
Figure 8: Number of categorised child deaths by gender per LSCB area
Figure 9: Number of child deaths occurring in hospital per LSCB area
Figure 10: Number of child deaths occurring outside hospital per LSCB area
Figure 11: Child deaths across Merseyside by locality
Figure 12: Number of child deaths by deprivation quintile of local authority
Figure 13: Number of child deaths by national deprivation quintile of local authority
Figure 14: Injury deaths rates per year per 100,000 children 0-15 years
Figure 15: Ethnicity of child deaths categorised for Merseyside 2015-16
Figure 16: Child deaths notified 2011-12 to 2015-16 by LSCB area
Figure 17: Category of child death for all categorised 2011-12 to 2015-16
Figure 18: Categories of child deaths in Knowsley 2011-16
Figure 19: Categories of child deaths in Liverpool 2011-16
Figure 20: Categories of child deaths in Sefton 2011-16
Figure 21: Categories of child deaths in St Helens 2011-16
Figure 22: Categories of child deaths in Wirral 2011-16
Figure 23: Child deaths involving the ‘toxic trio’
Figure 24: Number of child deaths notified by gender per LSCB area 2011-12 to 2015-16
Figure 25: Child deaths notified by gender 2011-12 to 2015-16
Executive Summary

Merseyside CDOP has accumulated detailed information about child deaths over five years and during that time has identified some similarities in the pattern of deaths for each year, for example the greatest number of deaths always occurs in the neonatal/under 1 year age groups.

During 2015-16 there were 115 notifications with 115 child deaths reviewed and 113 categorised. Consistently, the greatest number of deaths occur in the neonatal age group, and when combined with infants under 1 year accounts for more than 60% of child deaths each year.

Lifestyle factors are sought which has identified that smoking, domestic abuse, raised BMI and mental health are significant features in at least 35% of the deaths reviewed. Efforts to assist adults with smoking cessation have been applauded by the Lullaby Trust in the past but in these pressing times this focus may shift. Merseyside CDOP would propose that this would be a retrograde step and one that would be likely to severely impact on the wellbeing of children’s futures, given the impact of smoking on children’s lives from pre-birth into adulthood.

The ability to explore whether domestic abuse is a feature in families’ lives is dependent upon having access to information relating to all adults within the household. Once again, this year, missing information relating to fathers/other parents has meant that establishing data regarding lifestyles is substantially impacted upon. It is imperative that this is addressed by agencies to ensure CDOP is provided with meaningful information on which to analyse and draw accurate conclusions.

Within the older age group, of note this year, has been the increase in deaths of young people in the 15-18 years age range following a pattern of reduction since 2012-13. Tragically, there has been a significant increase in deaths from suicide. The gradual increase year on year, combined with the national figures, has led Merseyside CDOP to put forward for consideration a proposal relating to training focused on preventative action.

The timescales relating to the CDOP process are considered within the report. It is acknowledged that it has not been possible to meet, to any great degree, the four month timespan from notification to categorisation and with respect to this it is proposed that this target is extended in line with DfE timescales.

The independent review of Merseyside CDOP suggested a consistent membership and fewer meetings as some of the recommendations and Merseyside CDOP has adopted these and pursued the implementation of the changes to assist with improving what is already an effective and committed process, supported by all those involved.

It is regrettable that requests for public health input into the analysis of this report could not be met but it is anticipated that a further report focused on data analysis can be provided during 2016-17, in which we would hope to secure participation by public health colleagues.
Merseyside CDOP team would most certainly welcome the input to ensure there is greater emphasis regarding the significance of the data.

Merseyside CDOP experienced a greater number of deaths this year, mirroring the number that occurred in the first year of CDOPs’ operation. The majority of the increase was linked to neonatal deaths so the issues impacting upon the wellbeing of pregnant women and the safe delivery of their babies as near to term as possible, has to be an area for consideration, to improve the infant mortality rates and reduce the impact of bereavement on the lives of families and the wider communities that are affected.
Section One:

1.1 Background & Process

Child Death Overview Panels (CDOP) remain a statutory requirement, as defined in Chapter 5 of Working Together to Safeguard Children 2015. CDOP analyses any deaths occurring in children, aged from new-born up to eighteen years old, (excluding stillbirths and planned terminations of pregnancy carried out within the law) and identifies any modifiable factors that could highlight areas for future improvement. This includes babies of any gestation, irrespective of whether their birth was deemed viable, as it is felt there may be important lessons to be learnt within the antenatal and birth period.

Merseyside Child Death Overview Panel (CDOP), formed in April 2011, continues to involve all five Merseyside LSCBs. Knowsley joined Liverpool, St. Helens, Sefton and Wirral in April 2014.

This section of the report reflects the work of the Merseyside CDOP from April 2015 to March 2016. Further information relating to the CDOP process can be found within the Merseyside CDOP protocol, which was revised following the implementation of Working Together 2015 and is applicable to all five Merseyside LSCBs. For a copy of the full protocol, contact Helen Fleming-Scott (CDOP Administrator) at helen.flemingscott@liverpool.gov.uk or Irene Wright (CDOP Manager) at irene.wright@liverpool.gov.uk

An independent review of the CDOP process was progressed during 2015 concluding with recommendations (appendix 1), that included the development of a core membership, and reducing the frequency of meetings. Whilst there were a number of members who attended all meetings those representing paediatricians, children’s social care, education, legal and LSCB business managers participated in a rota. There will be a decrease in the number of meetings being held per year from April 2016 but during 2015-16 they remained monthly. The change in frequency from monthly to quarterly will eradicate the need for a rota system, thus providing a totally consistent membership to improve on collective memory. Implementation of the actions from the review commenced in 2015-16, and will continue into 2016-17.

Membership

Merseyside CDOP had a core membership that consisted of:

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

*Denotes participation in a rota system from April 2015 – November 2015, which then ceased.
**Since the resignation of the previous co-chairs, who were both public health representatives, there has been no public health involvement with the process. This issue has been raised in quarterly reports, and is being highlighted again in this annual report as it requires addressing.
***Neonatal panel participants only

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

The rota ceased to operate at the end of 2015. There will now be identified representatives that will attend all four quarterly meetings. A separate smaller process has been agreed for neonatal deaths with outcomes feeding into the main meetings for ratification. Terms of reference have been compiled in 2016 for both processes.

**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**

The CDOP panel met monthly throughout this year. The number of reviews per meeting increased with a maximum number of 16 cases for review per meeting agreed. The dedicated neonatal panel met on alternate months and the presence of two consultant neonatologists greatly assisted the process, in addition to a consultant obstetrician attending on occasions.

**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 child deaths not reported. These are few in number, but when occurring have been pursued, establishing the births had either occurred on the delivery suite and lived for a very short time, or related to therapeutic abortions. This, in addition to cross-referencing with the annual DfE return CDOPs receive (regarding notifications from Registrars to DfE) enables Merseyside CDOP to be confident they are notified of all child deaths.
The effectiveness of the notification process is also borne out when Merseyside child deaths occur out of area as we are often notified on these occasions through Merseyside agencies rather than the CDOP contact in the respective area where the death occurred.

**Rapid Response**

Despite awareness that Merseyside was not totally compliant with Working Together to Safeguard Children 2015, in that no joint visits involving health and police took place for their rapid response arrangements, local clinicians expressed a view through the respective Clinical Commissioning Groups (CCGs) that the arrangements within the Merseyside SUDI/SUDC protocols (since merged to become the SUDiC protocol (2015)) were sufficient to satisfy the guidance. The provision of photographs of the 'scene' to strategy meeting participants assists with the identification of risk factors. This has addressed the shortfall in part but this issue requires focusing on again in the future.

**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.

An audit relating to adherence with the SUDiC protocol was undertaken during this year and a report was presented to LSCBs. This identified compliance with the SUDiC protocol in the majority of cases, highlighting where this had not occurred. A recommendation was made that LSCBs assured themselves that strategy meeting chairs utilised the appropriate documentation. This should ensure adherence to the agenda and include the necessary information within the recordings of the meetings. It would also greatly assist the information gathering and provide evidence to confirm compliance during future auditing processes.

Evidence of scene photographs being provided at strategy meetings will be included in future audits.

**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 2015-16 203 notifications were received, of which 115 related to Merseyside, 88 were external to Merseyside. The number of external notifications this year was similar to the number from the previous year of 81, but the number of Merseyside child deaths increased by 27.

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

The implementation of the trigger system to encourage completion of agency reports within the given timescale of 15 working days has improved the response. The subsequent three 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 agencies.

The inputting of Knowsley historical data from 2008 to 2014 commenced during this year. This was inputted by the Merseyside CDOP Administrator and Manager.

Deaths of Children Living Outside Merseyside

88 child deaths were reported to Merseyside CDOP regarding children who had died in this area but had lived in areas external to Merseyside. Merseyside CDOP, in these circumstances, converts the notification from the Sentinel database to a word document. This is securely e-mailed to the respective CDOP contact for the LSCB area. Merseyside CDOP team undertakes to convey this information within 24 hours or as soon as practically possible if a secure method of conveyance is required. 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.

There were a number of Merseyside child deaths that occurred out of the area. Merseyside CDOP, in most circumstances, was informed by agencies in Merseyside once they had received notification, rather than the CDOP lead in the area where the child had died. This suggests that other areas do not progress a definitive system for informing other areas as soon as possible.

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

The Merseyside CDOP Manager has had contact with two families relating to the CDOP process, subject to their request, during this year. At the point at which their child’s death was reviewed both families contributed to the process.

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

Child deaths that have been the subject of Serious Case Reviews, Critical Incident Reviews or any learning review were previously considered at panel once all relevant investigations and reports had been completed. This was a consistent approach exercised across the north-west. However, following an indication from one LSCB that this led to a protracted process Merseyside CDOP are now complying with reviewing the child deaths as soon as possible unless an inquest, serious case review (SCR) process or criminal investigation is occurring. For these child deaths the review will commence once the additional processes have concluded.

**Regional/National Links:**

**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 north-west. This has been adhered to in the compilation of this report, as in previous years.

**Infant Mortality Workshop – regional initiative**
There was also representation from Merseyside CDOP at the Infant Mortality Workshop planning sessions, relating to an event that took place later in 2016. The focus of the workshop was intended to be identifying best practice with an aim of reducing the number of infant deaths in the north-west, given we have a considerably high infant mortality rate.

**National Network**
Merseyside CDOP forms part of the national network group established by Nisar Mir, Consultant Paediatrician at Warrington Hospital. This group focused upon proposed changes to the documentation as one of the short-term goals and the development of a CDOP website as a longer term goal and both have been achieved, albeit the revised forms remain in draft awaiting consideration through the respective overseeing body.

**National Database Development Project**
Merseyside CDOP has also continued to represent CDOPs, by invitation, on the working group to establish if a national CDOP database is required. The necessity has been confirmed and is to progress with a tendering process beginning in 2016. The desired completion date for development is in 2017. The national database will be able to access Merseyside CDOP data through a ‘sucking up’ process that will not warrant input into two systems. Merseyside CDOP was the only panel represented from the beginning.
1.2 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 2015-16 the amounts for contributions and expenditure were:

<table>
<thead>
<tr>
<th>Area</th>
<th>Amount from Public Health</th>
<th>Amount from LSCB</th>
<th>Total from area</th>
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<tbody>
<tr>
<td>Knowsley</td>
<td>£10,733.53</td>
<td>£5,000</td>
<td>£16,100</td>
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<td>Liverpool</td>
<td>£29,632.47</td>
<td>£5,000</td>
<td>£32,750</td>
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<tr>
<td>Sefton</td>
<td>£17,753.10</td>
<td>£5,000</td>
<td>£23,500</td>
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<td>St Helens</td>
<td>£12,022.23</td>
<td>£5,000</td>
<td>£17,950</td>
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<tr>
<td>Wirral</td>
<td>£22,358.67</td>
<td>£5,000</td>
<td>£27,200</td>
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<td><strong>TOTAL</strong></td>
<td><strong>92,500</strong></td>
<td><strong>£25,000</strong></td>
<td><strong>£117,500</strong></td>
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*Table 1: Contributions to CDOP process for 2015-16 by LSCB area*

Expenditure

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<thead>
<tr>
<th>Area of expenditure</th>
<th>Amount spent</th>
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<tbody>
<tr>
<td>CDOP Independent Chair</td>
<td>£2,000 (November to March)</td>
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<tr>
<td>CDOP Manager</td>
<td>£53,477 (including on-costs)</td>
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<tr>
<td>CDOP Administrator</td>
<td>£27,628 (including on-costs)</td>
</tr>
<tr>
<td>Sentinel database</td>
<td>£6,746.62 annual licence</td>
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<tr>
<td>Sentinel complex triggers</td>
<td>£3,450 (inc. VAT)</td>
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<tr>
<td>Printing – parents leaflets</td>
<td>£595.20 (inc. VAT)</td>
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<td>Safer Sleep campaign materials</td>
<td>£15,317.20 (inc. VAT)</td>
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<td>Safer Sleep Briefing Sessions</td>
<td>£1049.60</td>
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<tr>
<td>Attendance at conferences</td>
<td>£59</td>
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<td>Rail travel</td>
<td>£288.32</td>
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<td>Alder Centre support for panel members</td>
<td>£900 (limit order £1,500)</td>
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<tr>
<td>Equipment</td>
<td>£41.91</td>
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<tr>
<td>Stationary</td>
<td>£12.95</td>
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<tr>
<td>Clarity Assurance (independent review)</td>
<td>£2,400</td>
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<td><strong>TOTAL EXPENDITURE</strong></td>
<td><strong>£113,965.80</strong></td>
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*Table 2: CDOP expenditure in 2015-16*

* £126.13 claimed back from University of Oxford (in relation to travel on 3/3/16 and cancelled meeting on 4/3/16*
1.3: Analysis of Child Deaths

Child Population

<table>
<thead>
<tr>
<th>LSCB Area</th>
<th>Total Population</th>
<th>Under 18 Population</th>
<th>U18 as % of total</th>
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<tbody>
<tr>
<td>Knowsley</td>
<td>147,231</td>
<td>32,486</td>
<td>22.1%</td>
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<tr>
<td>Liverpool</td>
<td>470,780</td>
<td>89,902</td>
<td>19.1%</td>
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<tr>
<td>Sefton</td>
<td>273,707</td>
<td>56,566</td>
<td>20.7%</td>
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<tr>
<td>St Helens</td>
<td>177,612</td>
<td>36,279</td>
<td>20.4%</td>
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<tr>
<td>Wirral</td>
<td>320,295</td>
<td>71,406</td>
<td>22.3%</td>
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<tr>
<td>Total for Merseyside</td>
<td>1,389,625</td>
<td>286,639</td>
<td>20.9%</td>
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*Table 3: Child population for Merseyside areas*


Number of Deaths

During the period 1st April 2015 to 31st March 2016, 115 child deaths were notified to CDOP across the five LSCB areas. This figure corresponds to that experienced in 2008-2009 but is an increase on the intervening years and is substantially greater than the 88 that were experienced in 2014-15. Prior to this the number of deaths that occurred each year from 2009 to 2015 had been relatively stable.

Child Death Notifications by Year for Merseyside

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<tbody>
<tr>
<td>No. of deaths</td>
<td>115</td>
<td>97</td>
<td>93</td>
<td>80</td>
<td>94</td>
<td>87</td>
<td>89*</td>
<td>115</td>
</tr>
</tbody>
</table>

*Table 4: Child Death Notifications per Year*

*This figure includes one death that CDOP became aware of very late, after the completion of the annual report and the submission of the DfE return.*
Child Deaths by Area 2015-16
Figure 1 shows the breakdown of the child death notifications received for 2015-16 by areas.

![Total number of child deaths 2015/16](chart.png)

**Figure 1: Child deaths occurring April 2015 – March 2016 by LSCB area**

During this year a total of 115 deaths were reviewed by the panel and 113 were categorised. There were two deaths deferred, 1 from Liverpool and 1 from Wirral, for further information.

The numbers categorised for each area were:
- Knowsley: 12
- Liverpool: 41
- Sefton: 20
- St Helens: 22
- Wirral: 18

At the end of 2015-16 there were 6 child deaths outstanding from 2014-15 that had not been presented to CDOP as they were subject to additional processes. The remainder outstanding are from 2015-16. The total categorised during the year included:

- 1 from 2011/12;
- 1 from 2012/13;
- 8 from 2013/14;
- 49 from 2014/15; and
- 54 from 2015/16.
The delay in reviewing the older deaths was linked to their involvement with additional processes.

The Department for Education Statistical First Release for year ending March 2015 identified that nationally there were 2,188 reviews completed where the death had occurred prior to the start of that year, and 1,327 reviews of deaths that had occurred in that year.

**Timespan for completion of CDOP process from notification to categorisation**

![Time taken to complete reviews in 2015/16](image)

**Figure 2: Duration from notification to categorisation by LSCB area for 2015-16**

<table>
<thead>
<tr>
<th>LSCB Area</th>
<th>Under 4 months</th>
<th>Under 6 months</th>
<th>6 or 7 months</th>
<th>8 or 9 months</th>
<th>10 or 11 months</th>
<th>12 months</th>
<th>Over 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowsley</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Liverpool</td>
<td>10</td>
<td>7</td>
<td>11</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Sefton</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>St Helens</td>
<td>1</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Wirral</td>
<td>1</td>
<td>6</td>
<td>3</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>26</td>
<td>29</td>
<td>17</td>
<td>6</td>
<td>3</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage completed within timescale</th>
<th>12.4%</th>
<th>23%</th>
<th>25.7%</th>
<th>15%</th>
<th>5.3%</th>
<th>2.7%</th>
<th>15.9%</th>
</tr>
</thead>
</table>

**Table 5: Duration from notification to categorisation by LSCB area for 2015-16**

In total 81.4% were completed in less than one year, which is an increase on 77.29% in 2014-15. The DfE Statistical Release of Child Death Reviews for the year ending March 2015 highlighted a percentage of 70% for that year, indicating this had shown a year on year...
decrease from 80% in 2011. This has shown Merseyside to have achieved a better than average score with regard to timescales for both years.

<table>
<thead>
<tr>
<th>Timescale and %</th>
<th>Up to 4 months</th>
<th>4-6 months</th>
<th>6 or 7 months</th>
<th>8 or 9 months</th>
<th>10 or 11 months</th>
<th>12 months</th>
<th>Over 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merseyside 2014-15</td>
<td>31.8%</td>
<td>15.9%</td>
<td>14.8%</td>
<td>14.8%</td>
<td>Not available</td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>Merseyside 2015-16</td>
<td>12.4%*</td>
<td>23%*</td>
<td>25.7%</td>
<td>15%</td>
<td>5.3%</td>
<td>2.7%</td>
<td>15.9%</td>
</tr>
<tr>
<td>Nationally 2015-16</td>
<td>Does not exist</td>
<td>32%*</td>
<td>14%</td>
<td>11%</td>
<td>10%</td>
<td>4%</td>
<td>30%</td>
</tr>
</tbody>
</table>

*Merseyside had a total of 35.4% completed in under 6 months compared to the national figure of 32% and can be seen to have improved on the percentage of 31.8% for this timescale from 2014-15.

A standard of six months from notification to categorisation was proposed by CDOP. LSCBs requested that this figure was reduced to four months. The implemented four months timescale has proven to be a significant challenge and not achieved for the majority of reviews as can be seen by the figures in Table 5.

The first category of timescale nationally is up to 6 months:
- Merseyside achieved 35.4% in this timescale compared to the national figure of 32%
- 76.1% of reviews were completed on Merseyside in a period of up to 9 months compared to the national figure of 57%
- A further 8% of reviews were completed in under 12 months compared to 14% nationally and the reviews taking over one year were almost half the national figure of 30%, at 15.9%

The table shows that Merseyside is performing well relative to the national picture. The majority of reviews taking the lengthier periods of time were associated with inquests, serious case reviews or additional review processes.

It is anticipated that there is greater potential for an improvement on the timespan for reviews progressing due to:
- The maximum number of child deaths reviewed per meeting doubled from 8 to 16 during this year;
- The trigger system operating on Sentinel that sends reminders prompting agency representatives to complete their report at 13 days, in advance of the 15 working day timescale, and thereafter at 18; 23 and 28 working days;
- Monthly reporting to LSCBs regarding status of cases and identifying outstanding agency reports;
- Variation in practice that has resulted in CDOP reviews not being progressed only if there is a serious case review, criminal process or inquest ongoing: all other reviews can feed into the CDOP process on completion and variations to CDOP outcomes will be considered if necessary.
Having identified the progress made there is, however, the need for caution as the timescales are likely to be impacted upon by the reduction in the number of meetings. The proposal from the independent review was to have four meetings per year but this was based on a model where the number of deaths was less than half of those experienced by Merseyside CDOP. As a consequence, it has been suggested that to aim to continue the positive focus on reducing the number of outstanding deaths and conclude them as quickly as possible quarterly neonatal meetings will also take place involving a smaller group. The outcomes from this process will be fed into the main meeting for ratification. Safeguards have been incorporated in that if agreement on outcomes cannot be reached at a neonatal meeting the child’s death will be reviewed at a quarterly meeting alongside non-neonatal reviews.

**Child deaths categorised in 2015/16**

![Child deaths categorised 2015/16](image)

**Figure 3: Number of child deaths categorised identifying number with modifiable factors per LSCB area.**

- The number of notifications and child deaths reviewed and concluded for Knowsley were the same at 12.
- There were 42 notifications received for Liverpool and 42 child deaths reviewed, deferring one, hence 41 categorised.
- Sefton experienced 16 deaths and 20 child deaths were categorised.
- St Helens experienced 14 deaths throughout this year and 22 deaths were categorised.
- Wirral had a substantial increase in their number, 31 notified compared to 11 last year, 18 were categorised.

The fewer numbers for Wirral were due to other processes impacting in addition to the CDOP administrator being off ill and unable to put forward any child deaths for one
panel meeting. The latter issue has been addressed as the final reports are now forwarded to the CDOP manager as they are completed so that should any emergency situation occur in the future it will not prevent Wirral reports being presented to panel.

The ratio of child deaths having modifiable factors compared to those having no modifiable factors was:
Knowsley: 33% (4:8)
Liverpool: 24% (10:31)
Sefton: 20% (4:16)
St Helens: 18% (4:18)
Wirral: 28% (5:13)

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

The national picture shows 24% for England and 24% for the north-west. Merseyside figures show Sefton and St Helens to be below the national figure, Liverpool the same as and Knowsley and Wirral to be above.

Specific modifiable factors relevant to an area have been highlighted in each of the quarterly reports but overall the modifiable factors identified for Merseyside were:

- Risk of overheating in babies
- Parental alcohol/substance misuse, unsafe sleeping practices
- Domestic violence and associated stress
- Potential co-sleeping/parental smoking
- Maternal smoking/substance misuse and lack of engagement during pregnancy
- Maternal smoking
- Possible damage to cervix
- Maternal health conditions
- High maternal BMI
- Negligent care in service provision as a potential contributory factor
- Delay in presentation at hospital
- Risk taking behaviour
- Lack of supervision
- Safety of environment
- Substance misuse by parent
- Failing in service provision
- Service accessibility
- Lack of parental supervision
- Failure to assess impact of issues that resulted in greater urgency regarding a referral for a service
- Use of written agreements and lack of clarity for agencies

In addition to the modifiable factors identified Merseyside CDOP has been made aware of the outcomes from serious case reviews, multi and single agency reviews and internal review processes that occur within agencies. In these circumstances the modifiable factors, implementation of any action to address 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 led to the launch of a Safer Sleeping campaign in December 2015.

**Child deaths categorised - perinatal v neonatal, 1 month to 1 year and 1 year to 18 years**

![Child deaths reviewed 2015/16 by age](image)

**Figure 4: Number of child deaths reviewed identifying number by definitive ages as specified by DfE per LSCB area.**

The proportion of reviews for perinatal, neonatal and infant deaths reflects the greater number of notifications received in these age ranges which have consistently been the larger number of child deaths since 2011. The Statistical First Release (DfE 2015) highlights perinatal and neonatal events accounting for 33% of the deaths reviewed and confirms this as broadly consistent with previous years, Merseyside’s perinatal and neonatal events account for 50.4% compared to last year at 47.7%, thereby showing an increase.

**Infant Mortality**

Infant mortality is an area of concern for the north-west and in particular Merseyside. Greater Manchester Public Health began planning a north-west workshop to be held in 2016. CDOPs were largely unrepresented although it was information from one of the Greater Manchester CDOP Chairs that instigated the interest and henceforth the planned work. The aim of the workshop is to share best practice with a view to substantially reducing the infant mortality rate.

The Merseyside CDOP Manager was approached for data to complete the documents provided for use at the workshop. It was as a consequence of this that the Merseyside CDOP manager became aware of this work and became involved.

Rough et al (Chapter 3: Inequalities in Child Health BMA Rough E; Goldblatt P; Marmot M; Nathanson V [https://www.bma.org.uk/-improving%20health/child520health/growingupinuk_m]) indicates that whilst there are a range of established risk factors associated with infant
mortality, low birth weight (under 2,500g) and prematurity are the most significant in terms of strength of association and consistency. The two factors are highly associated with socioeconomic status and deprivation. The percentage of categorised neonatal child deaths that had low birth weight as a feature on Merseyside was 63.2%, many of which were born prematurely.

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

![Child deaths reviewed 15/16 by age (DfE categorisation)](image)

**Figure 5: Age of child at death by LSCB area for reviewed cases 2015-16**

Figure 5 shows the numbers reviewed during 2015-16 and when compared to 2014-15 figures identifies:
- an increase in neonatal deaths reviewed from 35 to 57
- an increase in under 1 year deaths from 17 to 19
- an increase in the 1-4 years age group from 8 to 10
- an increase in the 5-9 years age group from 7 to 10
- an increase in the 10-14 years age group from 4 to 7
- fewer 15-18 years age group reviewed by 1

49.6% of the child deaths reviewed related to the 0-28 days age group, this rose to 66% when the under 1 year category was added. This is slightly higher than the national percentage of 64% but considerably higher than the figure of 59% for 2014-15
Age range of notifications received during 2015-16

The age range of notifications received during this year identifies clearly that the largest number of deaths reported were in the neonatal and under 1 year age range.

<table>
<thead>
<tr>
<th>LSCB/AGE RANGE</th>
<th>0-28 days</th>
<th>29 days-1 year</th>
<th>1-4 years</th>
<th>5-9 years</th>
<th>10-14 years</th>
<th>15-18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowsley</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Liverpool</td>
<td>21</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Sefton</td>
<td>9</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>St Helens</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Wirral</td>
<td>12</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>23</td>
<td>9</td>
<td>7</td>
<td>5</td>
<td>16</td>
</tr>
</tbody>
</table>

Table 6: Age Range of Notifications during 2015-16

Table 6 highlights that the largest number of notifications related to neonatal deaths which accounted for 47% of the child death notifications. When combined with the under 1 year notifications it equates to 67% which is greater than the 2014-15 figure of 60%. The next biggest is the 15-18 years age group which is consistent with previous years and other north-west areas.

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 (0)
- Category 2: Suicide or deliberate self-inflicted harm (6)
- Category 3: Trauma and other external factors (2)
- Category 4: Malignancy (9)
- Category 5: Acute medical or surgical condition (4)
- Category 6: Chronic medical condition (5)
- Category 7: Chromosomal, genetic and congenital anomalies (30)
- Category 8: Perinatal/neonatal event (41)
- Category 9: Infection (9)
- Category 10: Sudden unexpected, unexplained death (7)

It can be seen in Figure 6 below that the greatest proportion of deaths relate to the perinatal/neonatal event (category 8) with Liverpool and Wirral having the greatest numbers, and chromosomal, genetic and congenital anomalies (category 7) with Liverpool and St Helens having the same number, and Sefton having one less death in this category.
Figure 6: Category of child death for by LSCB area 2015/2016

Figure 6 above highlights the concluded categories of the reviews conducted during 2015-16. It can be seen that there were no deaths from deliberately inflicted injury, abuse or neglect compared to one last year and the number of deaths associated with trauma has decreased from 8 to 2. However, deaths due to suicide or deliberate self-inflicted harm have doubled. Deaths due to malignancy have increased but acute and chronic conditions have slightly decreased. The most significant increase relates to category 7, chromosomal, genetic and congenital anomalies, up from 12 in 2014-15 to 30 this year and category 8, perinatal/neonatal events, has increased from 30 to 41. Deaths from infection have increased from 5 to 9 but sudden unexpected unexplained deaths have reduced from 11 to 7.

The DfE Statistical Analysis indicates that 33% of the reviews progressed nationally were due to a neonatal/perinatal event, Merseyside had 41 of the 113 reviews relating to a perinatal/neonatal event, category 8, which constitutes 36.3%.

The number of death notifications linked to suicidal acts, behaviour that may be construed as suicide but without the definitive proof of intention, increased substantially in 2015-16. The numbers from 2008 to 2016 indicated there had been 24 over this period but 7 of these notifications had been received in 2015-16 (appendix 2) This was flagged up with LSCB Business Managers for discussion with the LSCB Chairs.

An independent review of suicides within a given timescale was proposed but concluded with it being progressed by Liverpool only.
**Cause of Death**

![Chart](image)

**Figure 7: Cause of child death 2015/2016**

‘Other’ refers to child deaths not covered by supplementary forms B2 – B12 that relate to specific conditions.

There are several supplementary forms linked to certain types of deaths:
- 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

With the exception of the B2 form the supplementary form should be completed in addition to the agency report form. It was determined that it was not necessary to complete the B2 neonatal form as it does not provide sufficient information as a stand-alone form and agencies were requested to continue completing the agency report form (Form B).

**Cause of Infant Deaths**

Immaturity-related conditions, for example, respiratory and cardiovascular disorders, were deemed the most common cause of infant deaths in 2013 according to the Office for National Statistics, with 44% due to these causes.
Given the majority of neonatal deaths on Merseyside are linked to prematurity and associated immaturity related conditions this would appear to be applicable.

Within Merseyside, of the 113 deaths categorised during 2015-16, it was identified that there were 30.3% of all infant deaths categorised as chromosomal, genetic and congenital anomalies, category 7. 21.4% of post neonatal deaths and 31.6% of all neonatal deaths were category 7. However, caution needs to be exercised regarding these figures as they cover more than congenital anomalies and many are linked to chromosomal factors, with some related to congenital issues.

This leads to identification of the need to separate out the data into specific causes and can be equally applicable to other categories where a multiple outcome applies.

**Age of Mother**
The infant mortality rate for all infant deaths linked to their corresponding birth registration record was 3.8 deaths per 1,000 live births in 2013. For these linked deaths, infant mortality rates were lowest for babies of mothers aged 25 to 29 years (3.4 deaths per 1,000 live births) and highest for mothers aged under 20 years (6.1 deaths per 1,000 live births).

In 2015-16, of the 57 neonatal deaths, there were four mothers aged 20 years or less and one mother of a similar age whose baby died at one month old.

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

There were 5 mothers aged 20 years and under and of these 5 the birth weight of 2 was fine, a further one was slightly under and 2, both premature, had low birth weights.

**Gender**
The number of categorised deaths identified by gender was 46 females, 67 males.
Figure 8: Number of child deaths by gender for 2015/2016

Figure 8 shows the breakdown of child deaths by gender for each LSCB area for the year in question. It can be seen that the greater number of deaths relate to males with the exception of Sefton who have had a greater number of female deaths. This is contrary to previous years where the greater proportion of male deaths has been a constant feature. This is also reflected in national and international statistics. Infant mortality is higher in boys than girls 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 boys than girls.

Expected v unexpected deaths

The 115 child deaths notified in 2015-16 consisted of 84 expected child deaths and 31 unexpected child deaths. This ratio is fairly consistent with previous years.

<table>
<thead>
<tr>
<th>LSCB AREA</th>
<th>EXPECTED</th>
<th>UNEXPECTED</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SUDI</td>
<td>SUDC</td>
<td></td>
</tr>
<tr>
<td>Knowsley</td>
<td>9</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Liverpool</td>
<td>26</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Sefton</td>
<td>14</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>St Helens</td>
<td>12</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Wirral</td>
<td>23</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>84</td>
<td>20</td>
<td>11</td>
</tr>
</tbody>
</table>

Table 7: Number of expected/unexpected child deaths relating to LSCB areas

During this year 7 SUDIs (sudden unexpected deaths in infancy 0-2 years old) were reviewed, 6 had modifiable factors associated with unsafe sleeping practices and known risk factors
relating to smoking, alcohol consumption and drug misuse. There were 7 SUDCs (sudden unexpected death in childhood 2 up to 18 years), only 2 of these had no modifiable factors. The modifiable factors were associated with service provision/accessibility or risk taking behaviour.

**Risk factors**

Table 8 highlights some of the information on parental/carer ‘risk factors’ that is collected on the Agency Form B. It can be noted that smoking, domestic violence and mental health issues in particular are often present. All of these have been shown to have an association with miscarriage, low birth weight and deaths from co-sleeping.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Yes</th>
<th>No</th>
<th>Not known</th>
<th>No response/ambiguous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>35</td>
<td>61</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>Domestic abuse</td>
<td>34</td>
<td>66 (3 where it occurred in a previous relationship)</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol</td>
<td>13</td>
<td>86</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>8*</td>
<td>84</td>
<td>19</td>
<td>1</td>
</tr>
<tr>
<td>Raised BMI (above 25)</td>
<td>37</td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Low BMI (below 18.5)</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>BMI within normal range</td>
<td>29</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mental health issues</td>
<td>33</td>
<td>63</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>Physical health issues</td>
<td>24</td>
<td>69</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>Disability</td>
<td>6</td>
<td>91</td>
<td>15</td>
<td>1</td>
</tr>
</tbody>
</table>

*Table 8: Parental/carer risk factors relating to all deaths reviewed (113 deaths) for 2015-16*

In order to accurately identify issues likely to impact it is extremely important to have responses to the social factors, thereby reducing the figures in the not known/no response/ambiguous columns above.
Location of Child Death

Figure 9: Deaths occurring in hospital 2015-16

It can be seen in the chart above that the majority of deaths occurred in the neonatal units followed by paediatric intensive care units, which is unsurprising because, by their very nature, they provide care to the most vulnerable and poorly.

Figure 10: Deaths occurring outside hospital 2015-16

Deaths occurring in the home of normal residence include 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 want to die are adhered to and, only in exceptional circumstances, for clinical reasons, is it not achieved.
Incidence of Statutory Orders/Child Protection Plans/Child in Need Plans

There were no deaths of children on child protection plans (CPP) but for one child death in Liverpool there had been a previous child protection plan. This is the same child who was looked after at the time of death and had a life limiting condition. The remaining four areas had no child deaths relating to looked after children.

<table>
<thead>
<tr>
<th>LSCB AREA</th>
<th>Child Protection Plan</th>
<th>Looked after Child</th>
<th>Child in Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowsley</td>
<td>0</td>
<td>0</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Liverpool</td>
<td>0 (1*)</td>
<td>1*</td>
<td>2 (4)</td>
</tr>
<tr>
<td>Sefton</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>St Helens</td>
<td>0</td>
<td>0</td>
<td>5 (3)</td>
</tr>
<tr>
<td>Wirral</td>
<td>0</td>
<td>0</td>
<td>4 (1)</td>
</tr>
</tbody>
</table>

*Table 9: statutory interventions for child deaths reviewed 2015-16*

*Denotes looked after child with life limiting conditions
() Denotes previously

With regard to child in need status (CiN) it can be seen that all areas had child deaths with Sefton and St Helens having the most child deaths across Merseyside of children with this status. Liverpool and St Helens had the greater number of child deaths where a child in need status had previously applied. Knowsley and Wirral had the fewest deaths where child in need status previously applied.
The map identifies where the deaths have occurred in each of the respective Merseyside areas.

Figure 11: Child deaths by locality 2015-16
Deprivation

Table 11 and 12 identify the numbers and percentages of deaths relating to deprivation that occur in each local quintile.

LOCAL

<table>
<thead>
<tr>
<th>Count of local quintile</th>
<th>Most deprived in LA</th>
<th>2nd most deprived</th>
<th>3rd most deprived</th>
<th>2nd least deprived</th>
<th>Least deprived in LA</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowsley</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>St. Helens</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Sefton</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>Wirral</td>
<td>6</td>
<td>8</td>
<td>7</td>
<td>2</td>
<td>8</td>
<td>31</td>
</tr>
<tr>
<td>Liverpool</td>
<td>8</td>
<td>13</td>
<td>11</td>
<td>8</td>
<td>2</td>
<td>42</td>
</tr>
<tr>
<td>Grand Total</td>
<td>23</td>
<td>29</td>
<td>32</td>
<td>19</td>
<td>12</td>
<td>115</td>
</tr>
</tbody>
</table>

*Table 11: Number of child deaths per quintile locally relative to LSCB area*

<table>
<thead>
<tr>
<th>Percentage of local quintile</th>
<th>Most deprived 20% in England</th>
<th>2nd most deprived</th>
<th>3rd most deprived</th>
<th>2nd least deprived</th>
<th>Least deprived 20% in England</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowsley</td>
<td>33%</td>
<td>25%</td>
<td>42%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>St. Helens</td>
<td>14%</td>
<td>14%</td>
<td>36%</td>
<td>21%</td>
<td>14%</td>
<td>100%</td>
</tr>
<tr>
<td>Sefton</td>
<td>31%</td>
<td>19%</td>
<td>19%</td>
<td>31%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Wirral</td>
<td>19%</td>
<td>26%</td>
<td>23%</td>
<td>6%</td>
<td>26%</td>
<td>100%</td>
</tr>
<tr>
<td>Liverpool</td>
<td>19%</td>
<td>31%</td>
<td>26%</td>
<td>19%</td>
<td>5%</td>
<td>100%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>20%</td>
<td>25%</td>
<td>28%</td>
<td>17%</td>
<td>10%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Table 12: Percentage of child deaths per quintile locally relative to LSCB area*

It can be seen that 52 deaths occurred in the two most deprived quintiles which accounts for 45% of the deaths, compared to 31 deaths in the two least deprived quintiles, which represents 27%.
When Merseyside deaths are considered in the context of the national picture it is shown that 85, constituting 74% of child deaths, occurred in the two most deprived quintiles and only 13% featured in the two least deprived quintiles. This is a facet that has been known for many years by Merseyside CDOP but the data to confirm this situation is now evident in the annual reports from 2014-15 and 2015-16.

In an article entitled ‘Growing inequality in children’s health’ Nick Collins, Science Correspondent (Telegraph 29.5.2013) suggests 8% of parents with low income jobs determined their children were in poor general health in a survey in 2009. This compared to 2% of parents in the highest earning band. The figures, when compared with data from 10 years previously showed a decrease for low income children, aged 12 years, from 14% but a
more substantial decrease from 9% to 2% for children whose parents were in the higher earning brackets.

It is suggested by researchers that the figures show the gap between wealthy and disadvantaged children in Britain is widening despite general improvement in children’s health and government efforts to narrow it.

It is suggested that in 1999 a poor child was 60 per cent more likely to be in bad health than a wealthy one, but over the past decade the gap has grown almost seven times greater. It was highlighted in the report, by experts from University College London, that poorer children were 50 per cent more likely to have a long-standing illness or to be obese and 40 per cent more likely to have tried smoking.

The Marmot Review: Fair Society, Healthy Lives report led to the Marmot Indicators 2015, a new set of indicators of the social determinants of health, health outcomes and social inequality, which relate to the six policy recommendations proposed in this report:

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention

**Number of Deaths by Deprivation Quintile**

![Number by Deprivation Quintile of LA](image)

**Figure 12: Number of child deaths by deprivation quintile of local authority**
When determining the deaths using the national deprivation quintiles, as in figure 13, Merseyside has 65 out of 115 deaths in the most deprived 20% in England, and 20 in the second most deprived, equating to 56.5% and 74% respectively.

**Deprivation and Child Deaths**

Child Accident Prevention Trust (www.CAPT: accessed September 2016) indicates one in six children in the UK, a total of 2.6 million, are officially classified as poor. They specify that since 2010, there has been a 15% fall in the number of children in workless households, but a big rise in the proportion of poor children who are in families where someone is in work. Two thirds of poor children are now in working households.

Children living in poverty are almost twice as likely to live in bad housing. They indicate that this has significant effects on their physical health, mental wellbeing and educational achievement.

The overall number of accidental deaths has fallen in recent years, according to CAPT, but the percentage of deaths amongst the poorest children has risen. They indicate there are persistent and widening inequalities between socio-economic groups for childhood deaths from accidents.

Children from the most disadvantaged families, with parents who have never worked or are long-term unemployed, are 13 times more likely to die in accidents than children of parents in higher managerial and professional occupations as indicated in figure 14 below:
Figure 14: Injury death rates per year per 100,000 children aged 0-15 years by National Statistics Socio-Economic Classification (eight class NS-SEC), 2001-03, England and Wales

The socio-economic gradients for deaths vary considerably by accident type:
- for pedestrian deaths, the rate in families where parents have never worked or are long-term unemployed is 20 times higher than in families with parents in higher managerial/professional jobs
- for cycling deaths it is 27.5 times higher
- for fire deaths it is 37.7 times higher.

Other research confirms these variations, showing that childhood deaths from road and fire accidents are significantly higher in poorer households. Deaths from pedestrian accidents, suffocation and drowning also have a strong connection to socio-economic circumstances.

Research by the Joseph Rowntree Foundation, ‘Why poverty matters to us all’ (https://www.jrf.org/report/uk-poverty-causes-costs-and-solutions) identified in chapter 3 that children who grow up in low-income households have poorer mental and physical health than those who grow up in better-off families. With regard to social status children from disadvantaged families are more likely to have low birth-weight, with mothers who are less likely to breastfeed and more likely to experience depression.

It is suggested that from an early age poverty has a negative impact on cognitive, social and behavioural development, with children from low income households more likely to exhibit behavioural difficulties, question their abilities and have little confidence or belief that they can make a difference in their lives. It is indicated that teenagers are unlikely to have access to technology within the home, and not likely to participate in extra-curricular activities or derive enjoyment from school. Overall, children from disadvantaged families have lower self-esteem as teenagers and are more likely to engage in risky or criminal behaviours.

It is highlighted in this report that a psychological research review into poverty determined it has an impact on the mental and physical health of adults and children and on children’s brain development. They suggest that the stress of poverty is associated with high levels of anxiety and depression. Children living in socio-economic disadvantage have as high a risk of
developing mental health issues as children of parents with mental health or substance misuse problems. It is indicated that poverty can be a factor contributing to a small minority developing problems with alcohol and drugs and can be a significant risk factor associated with child abuse and neglect, albeit the report author acknowledged that the vast majority of parents in poverty do not mistreat their children, and not all cases of abuse are related to poverty.

**Ethnicity**

Figure 15 and table 15 show that the vast majority, 72.6% (82) of the child deaths categorised during 2015-16 were of ‘British White’ ethnicity, a decrease from 84.1% in 2014-15. The DfE SFR 2015 identifies 3 out of 5 reviews, 60%, related to children from a White background. Merseyside had 85 from a White background that equates to 75.2%, considerably higher than the national figure.

The other ethnicities identified are represented to a much smaller degree

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>White: English/Welsh/Scottish/Northern Irish/British</td>
<td>82</td>
</tr>
<tr>
<td>White: Irish</td>
<td>1</td>
</tr>
<tr>
<td>White: Any Other White Background</td>
<td>2</td>
</tr>
<tr>
<td>Mixed/multiple ethnic groups: White &amp; Black Caribbean</td>
<td>1</td>
</tr>
<tr>
<td>Mixed/multiple ethnic groups: White &amp; Asian</td>
<td>4</td>
</tr>
<tr>
<td>Mixed/multiple ethnic groups: Any other mixed/multiple</td>
<td>3</td>
</tr>
<tr>
<td>Asian or Asian British: Indian</td>
<td>1</td>
</tr>
<tr>
<td>Asian or Asian British: Pakistani</td>
<td>1</td>
</tr>
<tr>
<td>Asian or Asian British: Chinese</td>
<td>1</td>
</tr>
<tr>
<td>Asian or Asian British: Any other Asian background</td>
<td>2</td>
</tr>
<tr>
<td>Black/Black British: African</td>
<td>4</td>
</tr>
<tr>
<td>Unknown/not stated</td>
<td>11</td>
</tr>
<tr>
<td>Total: 11 ethnic groups and unknown</td>
<td>113</td>
</tr>
</tbody>
</table>

*Table 15: Ethnicity of child deaths categorised 2015-16*
The North-West Child Death Overview Panel review report 2015-16 identified that interrogation of the ethnicity data against population estimates challenged the impression that most child deaths occurred in the White British population. It suggests that when the data is analysed against population estimates relatively more deaths occurred in the BME population, with a rate of 13 per 10,000 population.

Although the recording of ethnicity has improved since the start of the Merseyside CDOP panel, there are further improvements required as there remains 10% of child deaths (11 deaths) where the ethnicity is unknown. This is unacceptable and requires agencies to focus on the information they record. If recording systems do not request ethnicity it is suggested they should be amended in order to do so. Failure to do this results in an inability to determine if an equitable service is being offered across all ethnic groups within the community and is not complying with the requirements of legislation.

Figure 15: Ethnicity of child deaths categorised for Merseyside 2015-16
1.4 Issues Identified

Process Issues:

Missing Data

Once again, the failure to provide consistent details of the father/significant male/other parent in the family by most agencies continues to be an area of concern. This has repeatedly been highlighted in successive annual reports with requests to focus on this area for improvement. The lack of detail becomes particularly relevant in relation to checks regarding domestic violence as a lack of information about the father/significant male/other parent can prevent agencies, particularly Merseyside Police, from undertaking necessary checks.

It has become apparent recently that specific details relating to fathers are not requested by at least one hospital, possibly more, as the information regarding fathers from all hospitals is not as detailed as required. The lack of information has a detrimental impact and has to be addressed.

Requests for information relating to mother’s BMI commenced this year as panel became aware of this as a factor in premature births. It is important that the date the recording is determined is also provided but this very rarely occurs. The need to complete details for the other social factors also requires emphasis to enable CDOP to build up a clear picture of the social factors impacting on children and their wellbeing.

Agency Representation at Panel Meetings

The commitment to agency participation in CDOP meetings is evident from the figures shown in Table ? below. The agencies identified by an asterisk engaged in a rota and were clear that when they attended the meeting they were not representing the area but providing advice/information in relation to their profession. Given the changes to membership this is no longer applicable. Merseycare representation was not achieved during this year due to staffing issues but this has been addressed, therefore participation will recommence.

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>INVITED</th>
<th>ATTENDED</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-Chairs (Public Health)</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>Independent Chair</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>CDOP Manager</td>
<td>12</td>
<td>11</td>
<td>91.7%</td>
</tr>
<tr>
<td>*Consultant Paediatricians</td>
<td>6</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>Consultant Neonatologists</td>
<td>6</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>Merseycare</td>
<td>12</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Designated Nurses</td>
<td>12</td>
<td>11</td>
<td>91.7%</td>
</tr>
<tr>
<td>Named GP</td>
<td>12</td>
<td>9</td>
<td>75%</td>
</tr>
<tr>
<td>*Social Care</td>
<td>11</td>
<td>9</td>
<td>83.3%</td>
</tr>
<tr>
<td>*Education</td>
<td>6</td>
<td>5</td>
<td>83.3%</td>
</tr>
<tr>
<td>*Legal Services</td>
<td>12</td>
<td>12</td>
<td>100%</td>
</tr>
<tr>
<td>Merseyside Police</td>
<td>12</td>
<td>11</td>
<td>91.7%</td>
</tr>
<tr>
<td>*LSCB Business Managers</td>
<td>12</td>
<td>9</td>
<td>75%</td>
</tr>
</tbody>
</table>

Table 16: Agency representation at CDOP meetings
With effect from 2016-17 there will be a consistent membership for both neonatal and non-neonatal processes to promote greater collective memory and the advantages of a dedicated membership.

Issues arising from analysis of cases

The issues emerging from analysis of child deaths have been focused upon at stages within the report but are referenced again below.

The awareness of unsafe sleeping practices being a factor within a significant number of child deaths led to the launching of a Safer Sleeping Campaign:

**Safer Sleeping Campaign**

There are six messages consistently highlighted on each of five campaign tools. The messages are:

- Keep baby away from smoke, before and after birth
- Put baby in a cot, crib or moses basket to sleep – never fall asleep with them on a sofa or chair
- Never fall asleep with baby after drinking or taking drugs/medication
- Put baby to sleep on their back with their feet to the foot of the cot
- Keep baby’s head and face uncovered and make sure they don’t get too hot
- Breastfeeding your baby – support is available if you need it

The messages all appear on:

- Bookmarks – to be provided at the 20 week scan
- Teddy bear cot cards – to be provided following delivery by midwifery staff
- Door hanging thermometers – to be provided by community midwife at first postnatal visit
- Teddy bear postcard – to be provided by the health visitor
- Safer Sleep posters – disseminated widely for promotion by all agencies/resources

The campaign materials were purchased through Lancashire CDOP and are the same as those used by them. There was an attempt to promote a north-west campaign that has led to some areas of Cheshire purchasing the thermometers but the other areas have declined involvement. The progress of the campaign has been monitored through regular meetings of the task and finish group, and any emerging issues have been picked up and addressed.

There are also Safe Sleep banners containing the same messages and the logos of all five LSCBs.

There were 14 Safe Sleep Campaign multi-agency briefing sessions provided and an additional series of sessions specific to foster carers, family support workers and workers who engaged with families within their home.
Suicide

There have been 24 deaths from suicide since 2008 (appendix 2) but seven occurred in Merseyside during 2015-16. There were six deaths categorised as suicide in this year. It can be sometimes difficult to categorise deaths as suicide if the inquest outcome has determined ‘misadventure’ or ‘accidental death’ as the Coronial Service are required to use a criminal standard of proof.

Papyrus, in their newsletter (July 2016), indicate that in 2014 there were 1,556 young people who took their own life. They believe this figure to be an under reporting due to the Coroners’ use of the criminal standard, ‘beyond all reasonable doubt,’ to conclude that a death was a suicide.

Papyrus identify that young female suicides increased by 71% in the same year. They indicate that on average 4 young people end their lives each day, with many more attempting and thousands self-harming.

The categorised deaths for 2015-16 from Merseyside CDOP were 50% female and 50% male. A noticeable change has been the number of females dying through hanging. It is indicated by Papyrus that the reasons for suicide are complex but some of the contributory factors relating to the young people they identified were:

- 36% had a physical health condition
- 29% were facing exam results at the time of their death
- 28% were bereaved – 13% by the suicide of a family member or friend
- 25% were socially isolated or withdrawn
- For 22% there were reports of bullying, mostly face to face.

A report entitled ‘Suicide by children and young people in England’ (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, May 2016) identified ten common themes in suicide by children and young people:

- Family factors such as mental illness
- Abuse and neglect
- Bereavement and experience of suicide
- Bullying
- Suicide related internet use
- Academic pressures, especially related to exams
- Social isolation or withdrawal
- Physical health conditions that may have a social impact
- Alcohol and illicit drugs
- Mental ill health, self-harm and suicidal ideas.

The report highlights that there has been no national multi-agency investigative process focusing on suicide in children and young people and no national system for reporting suicide trends or recommending prevention priorities for this age group.

Merseyside CDOP engaged with this piece of research providing anonymised data for consideration.
Stephen Knuckey (Cheshire and Merseyside Suicide Audit Joint Report 2015) identified there were 145 suicides and probable suicides in young people aged under 25 in England between January 2014 and April 2015. 130 were included in the study, 66 were under 18 years, of which:

70% were males.
28% had been bereaved (13% by the suicide of a family member or friend).
36% had a physical health condition – most often acne and asthma
29% were suffering from academic pressure
22% were/had suffered from bullying (usually in the past) with the report identifying on-line bullying was less frequent than face-to-face.
25% were socially withdrawn or isolated.
23% had a history of suicide-related Internet use.
54% had a history of previous self-harm.
27% had expressed suicidal ideas in the week that they died.
43% were NOT known to any agency.
13% had a history of abuse (21% of under 18s)
3% had expressed concerns about their sexuality
Most antecedents of suicide – academic pressure, abuse, bullying, physical health conditions, and self-harm were more common in females that died.
Abuse, academic pressures and bullying were more common in the under-18’s.
63% of suicides were by hanging.

Bereavement, isolation, expression of suicidal ideas, and suicide related internet use were some aspects that were evident in the young people’s deaths on Merseyside.

It is suggested that in order to ensure a full assessment of young people accessing health services we need to continue to take comprehensive histories that, in addition to mental state examinations, include:

- Previous self-harm/suicide attempts
- Drug and alcohol use
- Histories of abuse in all of its forms
- Academic pressures such as exam stress
- Sexuality concerns
- Social withdrawal/isolation
- Bullying: face-to-face and on-line
- Accessing internet sites that promote suicide/self-harm
- Bereavement and loss
- Asking about suicidal thoughts and plans
- Family factors including mental illness
- Physical health conditions that can have a social impact e.g. acne

It is highlighted that if these predisposing factors are present, a full mental health assessment should be undertaken and referral to support services considered. If the assessment deems these risk factors not to be present at the time of assessment the information should be recorded and shared with the young person’s GP with a recommendation to continue to monitor the young person.
The three pieces of research referenced have identified very similar aspects and in light of the increase in numbers, albeit not particularly significant from a public health perspective, it would be pertinent to focus on preventative strategies from a CDOP perspective.

With regard to the multi-agency investigative process it should be emphasised that LSCBs have agreed that all sudden unexpected deaths in childhood (2 up to 18 years) should be subject to a multi-agency strategy meeting that considers the investigative process, any safeguarding of other children, support of the family and others, which in effect does address some element of the investigative process identified as necessary. It may be appropriate to suggest that the SUDiC strategy meeting incorporates information specific to the aspects identified above.

**Body Mass Index**

Awareness that the mothers in a significant number of neonatal deaths have high body mass index (BMI) led to the question being added into the agency report form with a request that agencies date the figure that is recorded regarding when it was calculated. This will assist CDOP to consider this over a greater period of time and identify whether this is a consistent feature in child deaths.

The emerging issue has been discussed at the North West CDOP meeting and it will be proposed at the next meeting that all CDOPs involved gather this data to aid analysis.

**Social Factors**

The need for greater reporting of social factors to assist in more detailed analysis has to be emphasised. It has been shown that it is important to have information relating to mothers, smoking and neonatal deaths but it is equally important to record whether other adults in the household smoke. Likewise, it is appropriate to know what family life experiences children have prior to their death to assist with engaging in informed scoring, categorisation and influencing any recommendations for change.
1.5 Achievements from 2015-16

Focus on Safe Sleep

As indicated the safe sleep campaign commenced in December 2015. Prior to this the multi-agency safe sleep pathway was introduced. Having conducted an extensive number of safe sleep briefing sessions in the previous year the Safe Sleep Task and Finish Group felt it was necessary to emphasise the Safe Sleep campaign and incorporate within the session the change in practice for midwives and health visitors. The change is identified within the multi-agency safe sleep pathway with regard to midwives and health visitors offering parents the opportunity to view where their baby sleeps and advise if appropriate.

There were 13 sessions progressed across Merseyside and 313 professionals registered to participate. Further sessions were progressed with foster carers, family support workers and any workers having contact with families within their homes.

Significantly, many private nursery staff participated and some concluded that they needed to focus more on safer sleeping and smoking with regard to their own staff members.

SUDiC protocol

Revision of the SUDiC protocol was commenced and completed but not disseminated as an issue arose that suggested further revision was necessary. This was to be resolved as quickly as possible to enable the protocol to be ratified by LSCBs.

CDOP Newsletter

There were two editions of the CDOP newsletter produced that focused on safe sleeping, the first was produced in hard copy as well as disseminated electronically, to assist in providing to parents and families. The second was disseminated to coincide with the launch of the Safe Sleep campaign. The copies went out electronically to all LSCB agencies and third sector partners.

Suicide report

A report relating to the incidence of suicide since 2008 was made available to LSCB Business Managers for consideration with the LSCB Chairs. Merseyside CDOP has experienced 24 suicides since 2008 but the greatest number occurred in this year.

Sentinel database

The input of Knowsley historical data commenced but was not completed during this year. 19 workers new to the CDOP process were trained to use Sentinel.

Independent CDOP Review

Focus on the implementation of the recommendations from the independent review led to discussions regarding how this could be achieved. Interim arrangements were made that
included the appointment of an independent chair, and further discussion led to a change in the process but this occurred later in 2016 and will feature in the next annual report.

**Monthly reports to LSCBs and CDOP**

This data report relates to the outstanding child deaths to be reviewed and identifies:

- Agencies yet to complete their report with particular reference to those over timescales
- Child deaths affected by additional processes

It is provided to all panel members with a view to LSCB business managers discussing with LSCB Chairs and the relevant agency lead if reports are outstanding.
Section 1.6: Planned Work for 2016-17

Timescales

Merseyside CDOP aims to meet the timescale requirements for presenting reports to panel meetings and categorising child deaths. This has proven very difficult with the implementation of a 4 month timescale and is not achievable in the majority of cases. This will be further impacted upon by the reduction in the number of meetings to four main meetings per year. Audits will be progressed to determine the degree of agency compliance with the process and the timescales.

LSCBs and DsPH are asked:

- to consider varying the timescale standard to 6 months to enable CDOP to achieve a greater compliance rate.
- support CDOP in its implementation of the ‘15 working day’ target for turnaround of agency information and also ‘28 working days’ exception reporting. The LSCB will be asked to intervene with any agency that is not complying with the set timescales.

Continued Drive to Improve the Quality of Information

Following the development of the good practice guidance and a continued drive by the CDOP team to improve the quality of agency information submitted to CDOP, there has been a noticeable improvement. However, there is a need to continue this progress, particularly with regard to information relating to fathers or all other adults in the household and social factors.

LSCBs and DsPH are asked to support the drive for more comprehensive reporting by:

- Liaising with local agencies wherever barriers have been identified.
- Requiring agencies to adapt their practice to ensure details of all household members are recorded as appropriate, and for maternity services ensuring the details of the father/other parent are recorded.

Safe Sleep

Further briefing sessions are to be arranged as requests have been made and there is evidence to suggest that co-operation with the campaign is not being fully achieved. It has also been suggested that the safe sleep messages are incorporated into the LSCB multi-agency training so that it occurs on a regular basis.

LSCBs and DsPH are asked to support this work by:

- Encouraging local attendance at forthcoming training sessions
• Promoting the safe sleep campaign whenever possible and endorsing the recommendation/key messages
• Multi-agency training to incorporate the messages from the safe sleep campaign

**Suicide Prevention**

Consideration is to be given to awareness raising and preventative measures that can be taken, potentially through the use of a ‘train the trainer’ event and engagement with the young advisors if appropriate.

**CDOP Newsletter**

The next edition of the newsletter, aimed at frontline staff and families, will focus on suicide prevention.

*LSCBs and DsPH are asked to continue to support the promotion and dissemination of the newsletter in local areas.*

**CDOP Briefing Sessions**

A further round of briefing sessions is to be planned for later in the year, as part of the ongoing work to share the learning of the panel.

*LSCBs and DsPH are asked to support CDOP in ensuring that these sessions are widely promoted and well attended by local practitioners.*

**Sentinel Training**

Training requirements in the use of Sentinel remain ongoing as staffing in agencies alters. This is met by either the Merseyside CDOP team or the Wirral administrator. The impact of the recently-introduced trigger system (for alerting agencies to missing information and missed deadlines) will also be evaluated:

*Audits are to be progressed to evaluate the compliance of agencies with the timescales*

**Subject matter for greater exploration**

The information provided in this report may benefit from greater analysis, therefore discussions will be held with Public Health departments once the report has been approved by LSCBs. This will be to consider areas that might benefit from more detailed exploration to inform LSCBs, Health and Wellbeing Boards and agencies involved.
Appendix 1: Merseyside CDOP Review Recommendations

1. Consideration should be given to developing a stable core membership of the CDOP. This would allow the development of collective memory, greater loyalty and deeper understanding of the process and the potential of CDOP.

2. LSCBs need to develop a greater understanding of the CDOP and its potential contribution. Ideally, there should be some overlap between LSCB membership and that of CDOP, so that there is better understanding within each committee of how the other operates. This would also allow the learning from the CDOP to become better integrated into the wider discussions of the LSCB, rather than usually only being included when the CDOP Annual Report is presented.

3. CDOP in collaboration with the LSCBs, should produce a standard reporting form so that reports can be sent back to the LSCBs. This should include
   a. Learning or issues from cases - relating to child death
   b. Learning or issues from cases – relating to wider issues
   c. Requests or suggestions for action from the LSCB(s)

   These reports should be anonymised so that they can be presented back to the LSCBs and others in an easily accessible manner, as currently, the need to log onto the system, while understood, is time consuming and can be off putting, especially when engagement with CDOP is a minor part of people’s jobs.

   These reports (or suggestions for action) would supplement the statistical data and themes emerging which would remain a major part of the Annual Report. The learning or issues from specific cases, together with the resulting requests or suggestions for actions, might form the basis of the Quarterly Reports to the LSCBs.

4. CDOPs should continue not to discuss cases until any SCR or critical incident process is complete. If they have a concern about a case and feel that it warrants an SCR or other review, the case should be passed back to the relevant LSCB. The CDOP is not an investigatory body.

5. The CDOP should aim to reduce the number of full panel meetings it holds each year. This would reduce the burden on attenders and would allow the development of a more expert panel with more consistent attendance. Some initial reviews of straightforward cases could take place outside the meeting and this could speed up the process. This would require safeguards, such as the ability of any member of the panel to call in a case for full review; and sufficient expertise, both clinical and regarding safeguarding, on the initial review panel, but this system is in place in other
areas and can work very well. With the number of cases in Merseyside, quarterly meetings might be sufficient.

6. The CDOP Annual report should include statistical information about the themes arising, and this should be presented at a Merseyside and a borough level. Any significant differences between areas should be flagged, as should areas of similarity. There should be a focus on interpretation and analysis as well as descriptions. The Annual Report should make recommendations for actions, underpinned by the evidence they have gathered and informed by the work of CDOPs across the North West and further afield, where relevant. The CDOP and the LSCBs may also wish to put pressure on the national bodies to ensure that there is more consistency in this area.

7. The funding arrangements for the CDOP need to be clearly understood, and the quality/consistency of the data collection service may need to be reviewed with the hospital. Individual LSCBs may wish to commission the CDOP to produce specific reports for them, or to produce material or data in a particular manner, but this may lead to additional costs which would then need to be picked up by the relevant LSCB. Ideally, the LSCBs need to agree on common formatting, reporting systems and processes.

8. A work plan should be agreed with the CDOP by the LSCBs, including the development of an action plan for delivery. Further to this, there should be evidence within the LSCB action plans of the influence of the CDOP, including specific actions to meet recommendations from the CDOP Annual Report.
## Appendix 2: Incidence of Suicide 2008-2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of deaths</th>
<th>3 Year Rolling Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-09</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2009-10</td>
<td>2 (Knowsley)</td>
<td></td>
</tr>
<tr>
<td>2010-11</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>2011-12</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>2012-13</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2013-14</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>2014-15</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>2015-16</td>
<td>7</td>
<td>18</td>
</tr>
</tbody>
</table>
Section 2

2.1 Data from child death reviews 2011-2016

The total number of child deaths notified to CDOP since the process began in 2008 has been 766. This section will focus on the deaths notified and subsequently categorised since Merseyside CDOP began in 2011. Figure 16 below indicates there has been a total of 464 notified since 2011 specific to:

- Knowsley: 54
- Liverpool: 176
- Sefton: 72
- St Helens: 52
- Wirral: 110

![Child deaths notified 2011/12 to 2015/16 by area](chart)

- Knowsley: a greater than 50% increase in 2013-14 and thereafter a slight decrease in 2015-16
- Liverpool: a 33% increase in 2012-13 and a continued increase to date with the exception of 2013-14 when there was a slight decline
- Sefton: a 70% increase in 2012-13 followed by a decrease the next year but consistent increases thereafter that do not reach the highest figure that occurred in 2012-13
- St Helens: a gradual increase year on year such that there is a 100% increase in 2015-16 compared to the figures in 2011-12
- Wirral displayed an ongoing decrease each year until 2015-16 when there was a substantial increase
Category of Death 2011-12 to 2015-16

| Category 1: Deliberately inflicted injury, abuse or neglect: 3 |
| Category 2: Suicide or deliberate self-inflicted harm: 13 |
| Category 3: Trauma and other external factors: 30 |
| Category 4: Malignancy: 37 |
| Category 5: Acute medical or surgical condition: 18 |
| Category 6: Chronic medical condition: 25 |
| Category 7: Chromosomal, genetic and congenital anomalies: 95 |
| Category 8: Perinatal/neonatal event: 169 |
| Category 9: Infection: 34 |
| Category 10: Sudden unexpected, unexplained death: 39 |
| Insufficient information to categorise: 1 |

Since 2011, 294 of the 464 child deaths notified have been categorised and a further 1 concluded that there was insufficient information to categorise.

The following diagrams will indicate the number of each category that occurred in specific years relevant to the Merseyside LSCB area.
Knowsley has experienced:

- No deaths from deliberately inflicted injury, abuse or neglect (category 1)
- 3 deaths due to suicide or deliberate self-inflicted harm (category 2), one per year from 2013-14 to 2015-16
- 3 deaths from trauma and other external factors (category 3)
- 3 deaths from malignancy (category 4)
- 4 deaths from acute medical or surgical condition (category 5) occurring on alternate years from 2011-12
- 8 deaths from a chronic medical condition (category 6) between 2013-14 and 2015-16
- 11 deaths from chromosomal, genetic and congenital anomalies (category 7), occurring each year
- 15 deaths from perinatal/neonatal event (category 8) occurring each year.
- 4 deaths from infection (category 9)
- 6 deaths from sudden unexpected death in infancy (category 10)

The most significant feature in figure 18 for Knowsley appears to be the number of deaths in categories 6, 7, 8 and 10. In addition, the identification of a death through suicide, category 2, occurring each year since 2013-14 is to be noted.
Liverpool has experienced:

1 death from deliberately inflicted injury, abuse or neglect (category 1)
6 deaths from suicide or deliberate self-inflicted harm (category 2)
16 deaths from trauma and other external factors (category 3)
14 deaths from malignancy (category 4)
2 deaths from acute medical or surgical condition (category 5)
5 deaths from chronic medical condition (category 6)
36 deaths from chromosomal, genetic and congenital anomalies (category 7)
75 deaths from perinatal/neonatal event (category 8)
18 deaths from infection (category 9)
16 deaths from sudden unexpected, unexplained death (Category 10)

2011-12 had a substantial number of category 8, with category 7 being the next highest. Categories 7 and 8 appear to reduce in 2012-13 and category 8 is lower again the following year but begins to increase by 2014-15. It continues to increase but does not reach the numbers recorded in 2011-12. Category 3 was at its highest in 2011-12.
Sefton has experienced:

No deaths from deliberately inflicted injury, abuse or neglect (category 1)
1 death from suicide or deliberate self-inflicted harm (category 2)
3 deaths from trauma and other external factors (category 3)
4 deaths from malignancy (category 4)
2 deaths from acute medical or surgical condition (category 5)
4 deaths from chronic medical condition (category 6)
18 deaths from chromosomal, genetic and congenital anomalies (category 7)
25 deaths from perinatal/neonatal event (category 8)
3 deaths from infection (category 9)
8 deaths from sudden unexpected, unexplained death (category 10)

There has been a gradual increase in categories 8 and 10 throughout the five year period in Sefton, with category 7 gradually increasing from 2013-14.
St Helens has experienced:

No deaths from deliberately inflicted injury, abuse or neglect (category 1)
1 death in 2015-16 from suicide or deliberate self-inflicted harm (category 2)
No deaths from trauma and other external factors (category 3)
8 deaths from malignancy with 5 categorised in 2015-16 (category 4)
2 deaths from acute medical or surgical condition (category 5)
3 deaths from chronic medical condition (category 6)
12 deaths from chromosomal, genetic and congenital anomalies (category 7)
13 deaths from perinatal/neonatal event (category 8)
4 deaths from infection (category 9)
4 deaths from sudden unexpected, unexplained death, all categorised in 2014-15 (category 10)

The most significant features for St Helens are the increase in categories 4 and 7 during the last year and the number of category 10 during 2014-15
Wirral

Figure 22: Categories of child deaths in Wirral 2011-16

Wirral has experienced:

2 deaths from deliberately inflicted injury, abuse or neglect category (category 1)
2 deaths from suicide or deliberate self-inflicted harm (category 2)
8 deaths from trauma and other external factors (category 3)
8 deaths from malignancy (category 4)
8 deaths from acute medical or surgical condition (category 5)
5 deaths from chronic medical condition (category 6)
18 deaths from chromosomal, genetic and congenital anomalies (category 7)
41 deaths from perinatal/neonatal event (category 8)
6 deaths from infection (category 9)
4 deaths from sudden unexpected, unexplained death (category 10)

Wirral experienced one death where it was felt there was insufficient information to categorise
**Figure 23: Identification by area of child deaths involving the ‘toxic trio’ from 2011-2016**

Each of the LSCB areas has experienced child death/s where the toxic trio, alcohol, substance misuse and mental health issues were evident. This only occurred in one child death in Wirral, two in Knowsley, three in St Helens but significantly more in Sefton at 6, and Liverpool, with the latter having the greatest number at 11.
The graph shows an increase over the years for both male and female child deaths, with a peak for female in 2012-13 and a rapid increase in 2015-16 for both genders but a steeper incline for males.
Knowsley: for males there were relatively lower numbers in 2011-12, that were particularly low in 2012-13. Increases occurred in 2013-14 that have remained higher since. Female deaths were very low in 2011-12 but substantially increased the following year. A slight decrease was experienced in 2013-14 which continued to reduce and was consistent for 2 years.

Liverpool: the figures for males have remained consistent for 2012-13; 2014-15 and 2015-16 with a lesser figure for 2011-12 and a slight dip in 2013-14. Female deaths have increased each year with the exception of 2013-14 which remained the same as the previous year.

Sefton: figures reduced slightly for males in 2012-13, increasing slightly in 2013-14 and remaining consistent thereafter. There was a substantial increase in 2012-13 for females from a low number in the first year. In 2013-14 the number almost halved but then increased by one third and remained consistent last year.

St Helens: the largest number for male deaths was 2015-16 with slightly less in 2013-14, the other years having similar numbers. In 2014-15 female deaths were the highest with 2012-13 having slightly less, and the other 3 years have fewer again.

Wirral: commenced with high numbers for both male and female in 2011-12, reducing each year until last year when they reached their highest.
# CDOP Team Contact Details

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