Pan-Cheshire Child Death Overview Panel

Annual Report

1st April 2017 – 31st March 2018

Forward

Section 1:

Executive Summary

Section 2:

Overview and Processes:

Section 3:

Mike Leaf
Independent Chair
Pan-Cheshire CDOP
August 2018

Forward from the Independent CDOP Chair

This is my second report as Independent Chair for the Pan-Cheshire CDOP, which comes at a time of tremendous change in terms of Safeguarding and the Child Death Review processes. The report aims to not only reflect the cases the panel has considered throughout 2017/18, but also the achievements of the partnership, and the future priorities for action.

We anticipate significant changes to the CDOP arrangements following the publication in March 2016 of the Wood Review. The Report recognises that over 80% of child deaths have a medical or public health causation, and therefore recommends that ownership of the arrangements for supporting CDOPs should move to the Department of Health from the Department for Education, which retains responsibility for children's safeguarding arrangements. Moving forward we need to recognise the importance of continuing the development of well-established relationships with the children's safeguarding partners. Currently, we are still awaiting details about how this transfer will take place and the potential implications that this will have on the workings of CDOP.

I see part of my role as ensuring that the current processes we have developed across Cheshire are robust and fit for purpose and provide the necessary assurances to the current and future safeguarding partners and arrangements, however they are organised. I see another part of the role to have an eye on the future, to ensure that child death reviews are undertaken in the most effective way, and are in line with the latest guidance, and within the resources available.

I would like to thank all the Panel members, for their continued commitment and hard work, and in particular, to Anne McKenzie and Rosie Lyden for the hard work that goes on behind the scenes to ensure that the Panel runs smoothly, and keeps pace with the changing landscape.

Mike Leaf

Independent Chair

Pan-Cheshire CDOP

August,2018

Section 1:
Executive Summary

The Pan-Cheshire CDOP is a sub-group of the four Local Safeguarding Children Boards (Cheshire East, Cheshire West and Chester, Halton and Warrington LSCBs) and has a statutory responsibility to review the deaths of all children up to the age of 18 years old (excluding infants live-born following planned, legal terminations of pregnancy and stillbirths) resident within the four Local Authority areas. The focus of CDOP should be on identifying any modifiable factors that may help prevent unnecessary future child deaths or harm.

The purpose of this Annual Report is to:

- Clarify and outline the processes adopted by the Pan-Cheshire CDOP
- Assure the four Cheshire LSCBs and future Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across Cheshire, which meets national guidance
- Provide an overview of information on trends and patterns in child deaths reviewed across Cheshire during the last reporting year (2017-18)
- Highlight issues arising from the child deaths reviewed between April 2017 and March 2018
- Report on achievements and progress from last year's annual report
- Make recommendations to agencies and professionals involved in the children's safeguarding system across Cheshire

Achievements during 2017-18

- ✓ Active participation in the North West Directors of Public Health Sector Led Improvement programme on child deaths under one year old
- ✓ A positive relationship with the coroner's office has been developed further
- ✓ Pan-Cheshire CDOP continues to play an active role in both regional and national networks, influencing programmes, and gaining insight into proposed changes to the CDOP function in the future
- ✓ Active participation in the organisation of the National CDOP Conference
- ✓ Engagement with other CDOPs across the NW and nationally and sharing good practice
- ✓ Quarterly Newsletter developed
- ✓ Processes have been reviewed in the light of the neo-natal ongoing neonatal enquiry at the Countess of Chester Hospital. All numbers of child death notifications from hospital are monitored
- ✓ Development of top tips to infant safer sleep
- ✓ CDOP Study/ Development day delivered
- ✓ Chair is now a member of the Cheshire and Merseyside Suicide Prevention Board

Summary of key points and themes:

Of those deaths reviewed [2016-17 percentage in square brackets]:

- 36.2% of the deaths occurred before the child reached 28 days (21 deaths)[38%]
- 58.6% of the deaths occurred before the child reached one year of age (34 deaths)[56.7%]
- 8.6 % of the deaths occurred in Children aged 1 year to 4 year (5 deaths) [16%]

- 8.6% of the deaths occurred in Children aged 5 years to 9 years (5 deaths) [9%]
- 8.6% of the deaths occurred in Children aged 10 years to 14 years (5 deaths)[8%]
- 15.5% of the deaths occurred in Children aged 15 years to 17 years (9 deaths) [10%]
- 53.4% of the deaths were male (deaths)
- 43% were Perinatal/Neonatal events (25 Deaths) [35%]
- 24% of deaths were classed as 'unexpected' (22 deaths) [11%]
- 40% of deaths reviewed had 'modifiable factors' (23 deaths) [18%]

Priorities for 2018-19:

- ✓ Manage a smooth transition of the Child Death Review process from Local Safeguarding Boards to new governance arrangements
- ✓ Further develop the relationship with CHAMPS suicide network
- ✓ Ensure that the new guidance is implemented including:
    - Ensuring all child death review meetings (e.g.perinatal mortality; hospital mortality; etc) inform the CDOP process in a standardised/ structured manner
    - Implementation of any changes to the reporting processes e.g. Forms A, B, C
- ✓ Ensure that there is a stronger link with the neonatal network
- ✓ Ensure all agencies understand the new guidance and relevant processes
- ✓ Deliver a multi-agency learning event
- ✓ Ensure that safer sleep messages are being promoted in a consistent way across Cheshire
- ✓ Update the Pan-Cheshire CDOP protocol in accordance with the new guidance
- ✓ Ensure that data is collected for ACEs, Suicides and Children with learning disabilities
- ✓ Explore the observed rise in deaths per u18 population in Cheshire East
- ✓ Ensure that children's deaths are categorised in accordance with the new guidance in terms of either place of local authority residence, or GP registration. Figures will be verified by the panel at the end of the reporting year

Update on action plan/ priorities identified

- ✓ Develop a Memorandum of Understanding (MOU) between CDOP and LSCBs *In view of the proposed changes in governance arrangements as part of national guidance, it is felt that this would be no longer relevant. The Pan-Cheshire CDOP protocol will be updated in accordance with the new statutory guidance which will describe the new relationship*
- ✓ Revise and update Terms of Reference *Terms and Conditions were revised during the year*
- ✓ Provide assurance that agreed Safer Sleep protocols are being implemented across all relevant agencies *Information has been cascaded and LSCBs have be asked for assurance. CDOP has not specifically endorsed the Baby Box initiative due to the lack of evidence of effectiveness.*
- ✓ Explore suicide prevention initiatives, particularly with other existing PH networks eg CHAMPs *The Cheshire and Merseyside Public Health network presented at the CDOP development day. CDOP is assured that there are sufficient multi-agency plans and activity in place, without the need to create other structures/ initiatives. Formal links have now been made in terms of representation on various groups. The Chair is a member of the Cheshire and Merseyside Suicide Prevention Board. The Cheshire Coroner's office and CDOP have undertaken a review of fatal self-harm in children and adolescents*
- ✓ Consider the implications of the emergent national CDOP Database *Due to late award of the national contract, the implications have not yet been clarified. This will form part of the work during 2018/19. It is unlikely that there will be any significant implications until 2019-20.*

- ✓ Develop a Memorandum of Understanding between CDOP and Coroner's office. *A Senior Coroners Officer sits on the CDOP and is very pro-active in developing strong links and exploring opportunities with the coroners office.*
- ✓ Explore how we can improve the notification of deaths of children living outside of Cheshire *Discussions with neighbouring CDOPs and Welsh colleagues have taken place. Further clarification of responsibilities will be included in the new guidance, and ongoing dialogue with Wales will continue.*
- ✓ Support the delivery of the recommendations of the NW Sector-led improvement programme. *Pan-Cheshire CDOP has played an active role in this programme, and will be collecting data on Adverse Childhood Experiences form June 2018*
- ✓ Establish an agreed budget for CDOP *A budget for CDOP was established and details are included within this report*

Update on recommendations for Local Safeguarding Partners in the annual report 2016-17

LSCBs were asked to:

Thematic reviews - Suicide Prevention

1. Assure themselves that existing multi-agency strategies aimed at reducing the incidence of mental health issues, include issues relevant to children and young people, in particular:
   - suicide and self-harm prevention;
   - training for various staff groups on management of suicidal behaviour and self-harm;
   - active engagement of children and young people in strategy development;

A comprehensive overview has been provided by Cheshire West and Chester at Appendix 2, some of which covers the other three LSCB areas.

2. Assure themselves that existing mental health services that care for children and young people with MH issues (e.g. CAMHS and third sector) include:
   - an appropriate level of provision to match the need;
   - appropriate ease of access;
   - effective inter-agency working;
   - active engagement of children and young people in service development;

A comprehensive overview has been provided by Cheshire West and Chester at Appendix 2, some of which covers the other three LSCB areas.

Thematic reviews - Sudden unexpected deaths in infancy

3. Assure themselves that all agreed policies and guidance designed to reduce the risk of Sudden Unexpected Death in Infancy are being adhered to by all relevant staff groups. These include:
   - Safer Sleep (Unsafe sleeping; safe sleep environment)
   - Local guidance on Care of Next Infant (CONI)
   - Escalation policies to ensure concerns are heard
   - Graded Care Profile and Signs of Safety Neglect assessments
   - Observation protocols for early identification of sick infants and children
   - Repeated clinic non-attendance protocols
   - Smoking in pregnancy

A comprehensive overview has been provided by Cheshire West and Chester at Appendix 2, some of which covers the other three LSCB areas.

4. Assure themselves that there are effective multi-agency strategies in place to reduce:
    - Smoking around children
    - Substance / alcohol misuse
      Domestic abuse

A comprehensive overview has been provided by Cheshire West and Chester at Appendix 2, some of which covers the other three LSCB areas.

Recommendations for Local Safeguarding Partners

Local Safeguarding Partners are asked to:

1. Note to contents of this annual report
2. Ensure that the new Safeguarding arrangements maintain strong links with the child death review processes as they evolve, and in particular, ensure full involvement of the relevant partners
3. Work collaboratively to ensure that lessons learned from the COCH neonatal review are effectively cascaded across all appropriate networks, and ensure that robust processes are in place to establish unusual patterns of unexpected child deaths in hospitals.

Mike Leaf

Independent Chair

Pan-Cheshire CDOP

August, 2018

Overview and Processes

CDOP Panel Meetings

CDOP Membership

Pan-Cheshire CDOP has a core membership of:

- Independent Chair
- CDOP Coordinator
- Designated Nurse for Safeguarding Children (Warrington and Halton)
- CDOP Nurses x 3 (Cheshire East, Cheshire West and Warrington)
- Special Midwife (Cheshire West)
- Designated Doctor for Child deaths x 3 (Cheshire East, Cheshire West, Warrington/Halton)
- Police Representative from PPU Directorate
- Local Authority Service Manager, Safeguarding Unit
- Local Authority Service Manager, Children's Social Care
- Education Representative from Safeguarding in Education Team.
- LSCB Business Manager x1
- Co-opted Advisory Member (Paediatrician/Deputy Coroner)
- North West Ambulance Service (where needed in cases of unexpected deaths)

The Pan-Cheshire CDOP has permanent representatives drawn from the key professional areas represented on participating LSCBs. Members of the CDOP attend the meetings as representatives of their profession/designation rather than representing their employing organisation. Members have a responsibility to disseminate recommendations and learning to agency representatives on the Boards in the other Pan Cheshire LSCB areas. Other members may be co-opted to contribute to the discussion of certain types of death when they occur.

Quoracy

A representative from the police, one Doctor, one Nurse and a minimum of one LSCB Business Manager will ensure that a meeting is quorate.

Frequency of Meetings

The panel currently meet on a quarterly basis and for a whole day. It has been agreed that this frequency will remain to unless there was a significant number of cases to review.

Agency Representation at Panel Meetings

The Pan-Cheshire CDOP met on four occasions between April 2017 and March 2018. Attendance is monitored on a regular basis to ensure quoracy and effective representation. On occasions there are times where professional demands have to take priority, and members, in these cases are expected to provide a replacement. Representation has been consistent throughout the year.

Table 1: Agency representation

Sector	Role
Chair	Independent CDOP Chair
Health	Designated Doctor CE

	Designated Doctor CWAC
	Designated Doctor (Warrington/ Halton)
	Cheshire East Specialist CDOP Nurse
	Cheshire West Specialist CDOP Nurse
	Warrington Designated Nurse Safeguarding
	Designated Nurse Halton CCG
	Supervisor of Midwives CWAC
	Warrington Safeguarding Nurse
Local Authority	Coroner Officer
	Cheshire East Head of Service – Children's Safeguarding
	Public Health Consultant (Cheshire W. and Chester)
	LSCB Business Manager for Warrington Borough Council
Police	Public Protection Unit

Processes/ Networks/ Reviews and Sub-groups

Notification Process

The notification process via paediatric liaison and hospital/hospice staff functions well. By cross-referencing with the annual DfE return (regarding notifications from Registrars to DfE), CDOP is now confident that it is notified of all child deaths.
When Cheshire child deaths occur out of area, CDOP is often notified by Cheshire agencies, as well as by the CDOP contact in the respective area where the death occurred. This demonstrates effective communication between local organisations and CDOP.
It has been identified in preparing this year's annual report that the small number of deaths per year from Vale Royal have been counted in East Cheshire's figures, and this is the same for this year (5 in total). These figures have been corrected for this and all previous years. Notifications for areas within Cheshire will in future be aligned to the definitions contained within the new guidance, and any subsequent organisational restructuring.

SUDiC Protocol

Currently, Cheshire is not fully compliant with *Working Together to Safeguard Children 2015* and the *Baroness Kennedy Report 2016*, in that not all children receive a joint visit. A decision to undertake a joint home visit by Police and a Health professional following SUDIC is made on a case by case basis, based on need and added value, in the interests of effective utilisation of resources. Technology in the form of videos and photographs of the scene of death is often used to inform rapid response procedures in cases of SUDIC, in some parts of Cheshire and has been found to be useful. The provision of photographs of the 'scene' for the strategy meeting participants to assist with the identification of risk factors is included in the revised protocol, and has been considered sufficient at present and will be kept under review. A briefing paper highlighting these processes was prepared for partners, and CCGs were asked if they were happy to accept these risks. CDOP will continue to ensure that the protocol is delivered consistently across all agencies, and reviewed as necessary.

Links to Coroners and Registrars

Within Cheshire there is an excellent working relationship with the Coroners offices, with senior coroner's officer representation, and specific investigatory work being undertaken e.g. a *review of fatal self-harm in children and adolescents*.

Deaths of Children Living Outside Cheshire

Whilst CDOP is responsible for the review of child deaths resident in Cheshire, there is an expectation that it should receive notification of child deaths for children who live out of area, but have died within the boundary. As Cheshire borders Wales, where there is a different process for reviewing child deaths, the numbers of these children may be significant. CDOPs across the country should routinely notify the CDOP where the child died, and visa versa. Any deviations from this process are followed up.

Communicating with Parents, Families and Carers

Leaflets and a letter are made available to any parent following the death of a child. The national Lullaby Trust leaflet: 'The Child Death Review, A Guide for Parents and Carers' is a more detailed explanation of many of the processes associated with a child's death. A new leaflet is being developed by the Department of Health, in conjunction with the Lullaby Trust, which will be launched when the new guidance is launched.

Deaths involving Serious Case Reviews/ Critical Incident Reviews

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

Regional/ National Links/ Updates:

North-west meetings
Pan-Cheshire CDOP continues to be represented at the north-west CDOP meetings. A common dataset was agreed for all north-west annual reports to allow for the compilation of an overview report covering the area. A north-west CDOP report is produced annually, although falls out of sequence from local CDOP annual reports.

National Network
Some Cheshire CDOP members form part of the national network group which advises on issues of national interest, including the transfer of the CDOP responsibilities to the Department of Health. Panel members attend the national event and feed back to panel.

National Database Development Project
Pan-Cheshire CDOP continued to participate, by invitation, on the working group to determine the need for a national CDOP database. The database has now been commissioned and is in its early stages of development. The national database will be able to access CDOP data through data extraction rather than needing input into two systems, but will not be extracting data for at least one year.

Funding

Contributions

Each LSCB and PH department contributes £1625 (£13000pa total) with additional population-based contributions to cover the CDOP Business Administration costs (Table 2). Establishing a budget for the new arrangements will form a priority for 2018/19, within the context of revised national guidance.

Table 2: Contributions to CDOP process for 2017-18 by LSCB area

	Warrington	Halton	Cheshire West and Chester	Cheshire East	Total
20% for panel admin	£1,169.40	£1,169.40	£1,169.40	£1,169.40	£4,677.59
80% for child deaths	£3,924.74	£2,410.79	£5,545.65	£6,829.21	£18,710.40
Total	**£5,094.14**	**£3,580.19**	**£6,715.05**	**£7,998.61**	£23,387.99

Issues Identified

Missing Data

There has been an improvement on the details provided on the forms, but the failure to provide consistent information can create issues. For example, the lack of details of the father/significant male/other parent in the family, is particularly relevant in relation to necessary checks regarding domestic violence. This forms part of an ongoing dialogue with representatives and remains under scrutiny. These processes will be strengthened with the new child death review processes.

Modifiable Factors

A modifiable factor is one *which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths*. Overall the modifiable factors identified for Cheshire include:

- domestic abuse
- High maternal Body Mass Index (BMI)
- alcohol/ drug misuse
- unsafe sleeping

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

Unsafe sleeping practices continue to remain an issue, and it is important to gain assurance that Safe Sleep initiatives are being implemented and applied in a consistent way across the Cheshire footprint. It is important that partners are assured that safer sleeping messages are being conveyed in a consistent manner.

Allocation of notified deaths by location

In preparation for this Annual Report, it became evident that a small number of the death notifications had been historically assigned to the wrong LSCB. This has now been corrected, and this report contains accurate historical data, and the process for assignment clarified. This has not affected any of the issues, priorities or recommendations of previous reports.

Gestational Age

Prior to 2017, babies who died under 22 weeks gestation were not reviewed by CDOP, which was outside the Working Together Guidance. 2017/18 was the first year that all baby deaths (excluding infants live-born following planned, legal terminations of pregnancy and stillbirths) were reviewed, which included 5 East Cheshire cases and one West Cheshire case, that would not have been reviewed in previous years.

National annual statistical data

The LSCBs are required to collect a considerable amount of data following the death of every child and then submit an annual return to the Department for Education. The CDOP Co-ordinator is responsible for this function on behalf of each of the four LSCBs. The Department for Education, in turn, consolidates the returns and publishes a statistical release in July. At the time of writing, no data has so far been collected.

Priorities for 2018-19:

- ✓ Manage a smooth transition of the Child Death Review process from Local Safeguarding Boards to new governance arrangements
- ✓ Further develop the relationship with CHAMPS suicide network
- ✓ Ensure that the new guidance is implemented including:
    - Ensuring all child death review meetings (e.g.perinatal mortality; hospital mortality; etc) inform the CDOP process in a standardised/ structured manner
    - Implementation of any changes to the reporting processes e.g. Forms A, B, C
- ✓ Ensure that there is a stronger link with the neonatal network
- ✓ Ensure all agencies understand the new guidance and relevant processes
- ✓ Deliver a multi-agency learning event
- ✓ Ensure that safer sleep messages are being promoted in a consistent way across Cheshire
- ✓ Update the Pan-Cheshire CDOP protocol in accordance with the new guidance
- ✓ Ensure that data is collected for ACEs, Suicides and Children with learning disabilities
- ✓ Explore the observed rise in deaths per u18 population in Cheshire East
- ✓ Ensure that children's deaths are categorised in accordance with the new guidance in terms of either place of local authority residence, or GP registration. Figures will be verified by the panel at the end of the reporting year

Section 3: Data and Analysis

It should be noted that it is often difficult to make clear conclusions from analysing data from a relatively small number of cases reviewed each year. The learning from each individual case is noted at each CDOP meeting, with the appropriate action taken at that time. Where reviews have already been undertaken e.g. hospital mortality reviews, action has usually already been taken. Cheshire's figures are amalgamated with other CDOP data across the NW to provide opportunities for identifying more reliable trends. Notified deaths are categorised according to place of residency using postcodes.

Number of Deaths

The Pan Cheshire CDOP met on four occasions between April 2017 and March 2018. The total number of child deaths notified across the Pan Cheshire footprint was 53. The total number of child deaths reviewed by the panel during this period was 58 (Cheshire East (27), Cheshire West and Chester (16), Halton (6) and Warrington (9)).

End of Year Case	
Was awaiting inquest	9
Subject to SCR	2
Additional paperwork required	2
Cases less than 6 months old at 31/03/2018	10
TOTAL	**23**

At the end of 2017-18 there were 23 child deaths outstanding which have not yet been considered by CDOP. A total of 11 were subject to additional processes including inquests and serious case reviews.

Figure 1: Number of notified deaths by geography 17/18

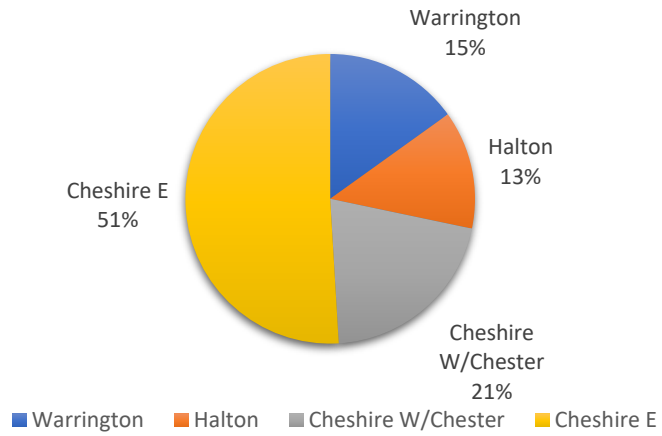
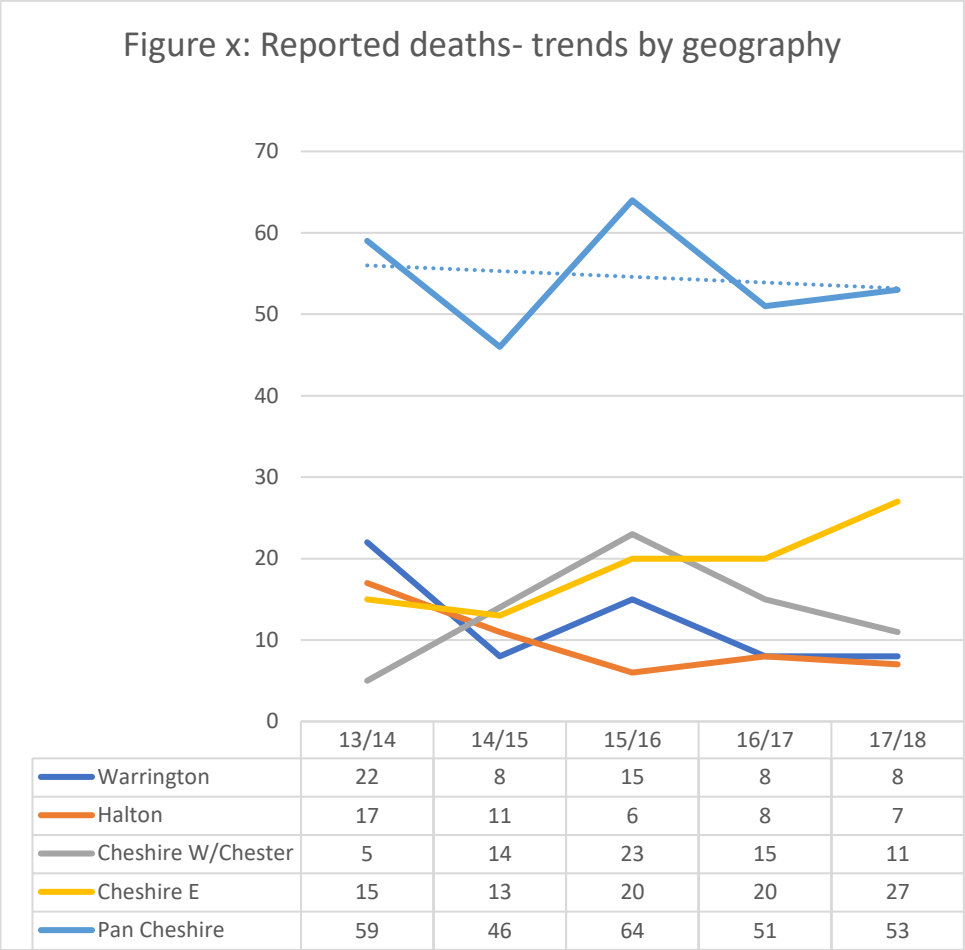


Figure 1 shows the percentage split of the numbers of notified deaths, by local authority area. Cheshire East accounted for just over half of all notifications, but has a larger population than the others (see below). A small increase or decrease in notifications can cause significant swings in these proportions each year, and it is sometimes more useful to consider trends over a period of time.

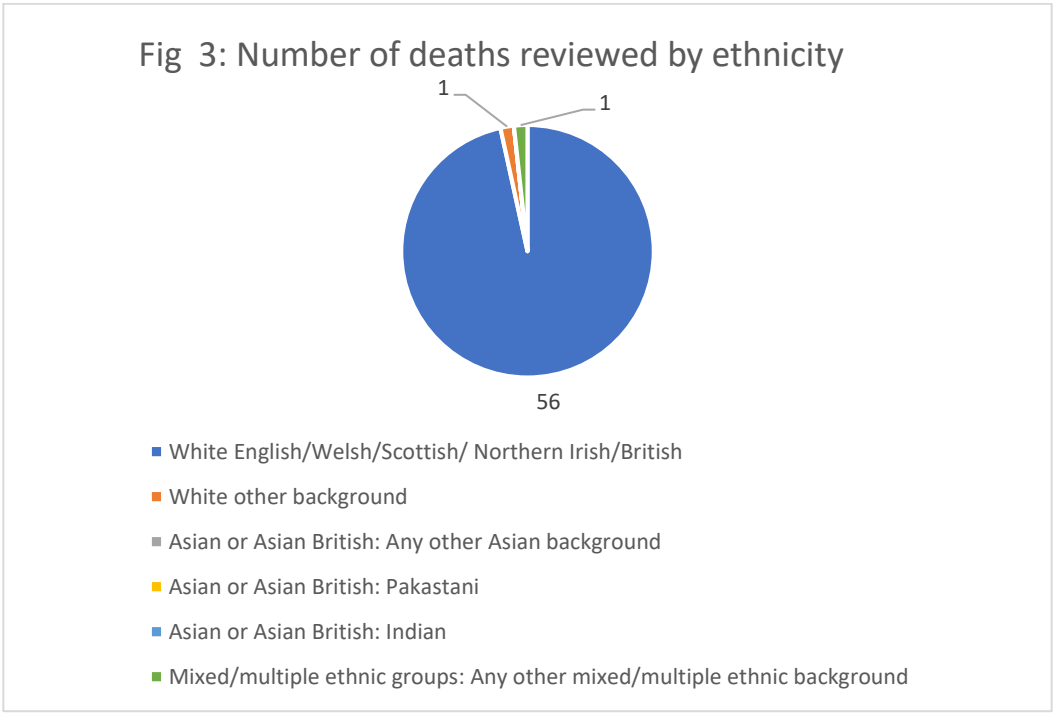


	13/14	14/15	15/16	16/17	17/18
Warrington	22	8	15	8	8
Halton	17	11	6	8	7
Cheshire W/Chester	5	14	23	15	11
Cheshire E	15	13	20	20	27
Pan Cheshire	59	46	64	51	53

Figure 2 shows that there is a very slight downward trend in child death notifications over the last four reporting years, but this is unlikely to be of any significance, because of the small numbers involved. Cheshire East has seen a small rise in notifications over the same period (see trend line). The mean average number of notifications over the last 5 years is 54.6.

Ethnicity of the child

Figure 3 shows that the vast majority (96.6%) of the child deaths reviewed during 2017-18 were of 'British White' ethnicity.



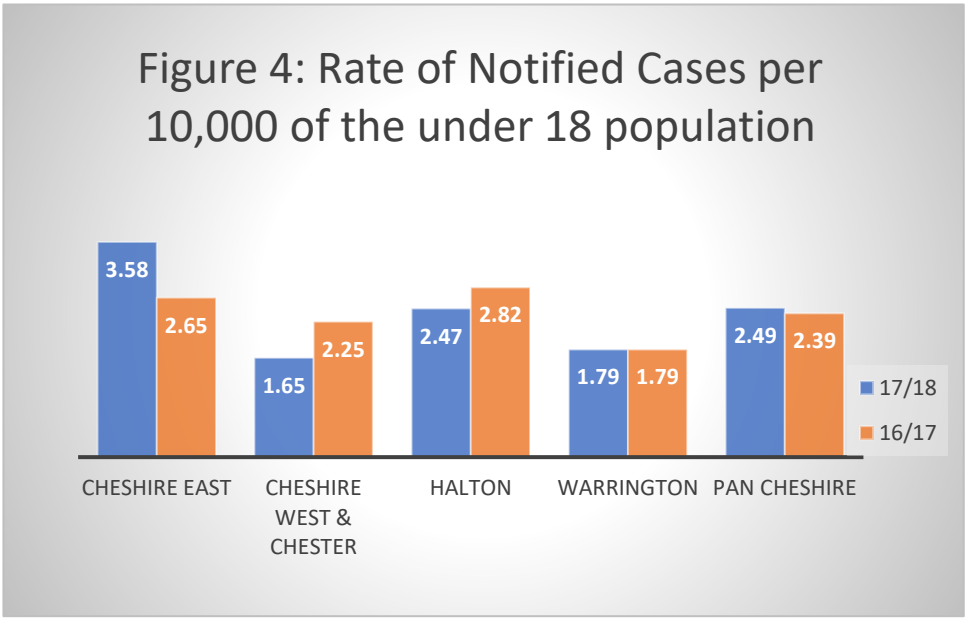
Child Population

The child population estimates in each of the four LSCB areas is detailed in the following table 4.

Table 4: Child Populations by local authority

LSCB area	Child population size* (0-17 years)
Cheshire East	75,423
Cheshire West & Chester	66,571
Halton	28,337
Warrington	44,662
Pan Cheshire	**213,258**

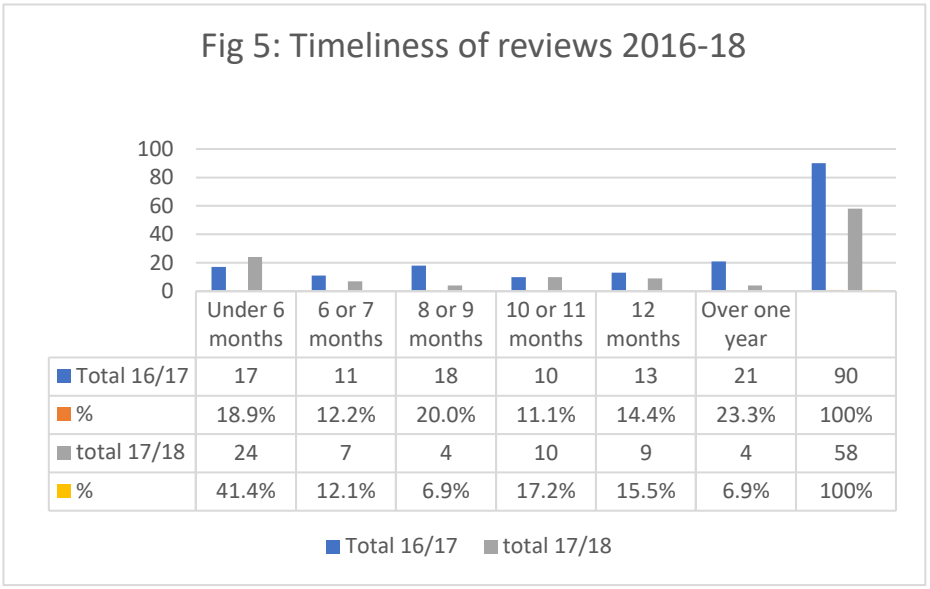
* Source: ONS mid-Year Population Estimates, 2016



Local child populations are useful when comparing local areas. Normally, one would expect to see the numbers of deaths in each geography, to be proportionate to the number of under 18-year olds living in each, but there may be differences according to deprivation levels. Figure 4 shows the rate of deaths per 10,000 0-18 years population over the last 2 years, and highlights that Cheshire East appears to have a disproportionately higher number of child death notifications relative to its under 18 population. Following a change in policy, notifications for babies born below 22 weeks gestation were included for the first time, to bring Pan-Cheshire in line with national guidance. There are four Cheshire East cases (14.8% of East Cheshire cases), and one in Cheshire West (9%). These would not have been included in previous years. This may go some way to explain the higher rate but may require further data analysis to determine whether this is significant, or due to other factors.

Review Completion

Figure 5 provides a breakdown of the time taken to complete the reviews during this period. It shows that during 2017/18, 41.4% of reviews were completed within 6 months compared to 18.9% in the previous year and 93.1% within 12 months, compared to 77% previously. This is a significant improvement. CDOP is confident that unnecessary delays in the process are being kept to a minimum and will keep the matter closely under review.



	Under 6 months	6 or 7 months	8 or 9 months	10 or 11 months	12 months	Over one year	
Total 16/17	17	11	18	10	13	21	90
%	18.9%	12.2%	20.0%	11.1%	14.4%	23.3%	100%
total 17/18	24	7	4	10	9	4	58
%	41.4%	12.1%	6.9%	17.2%	15.5%	6.9%	100%

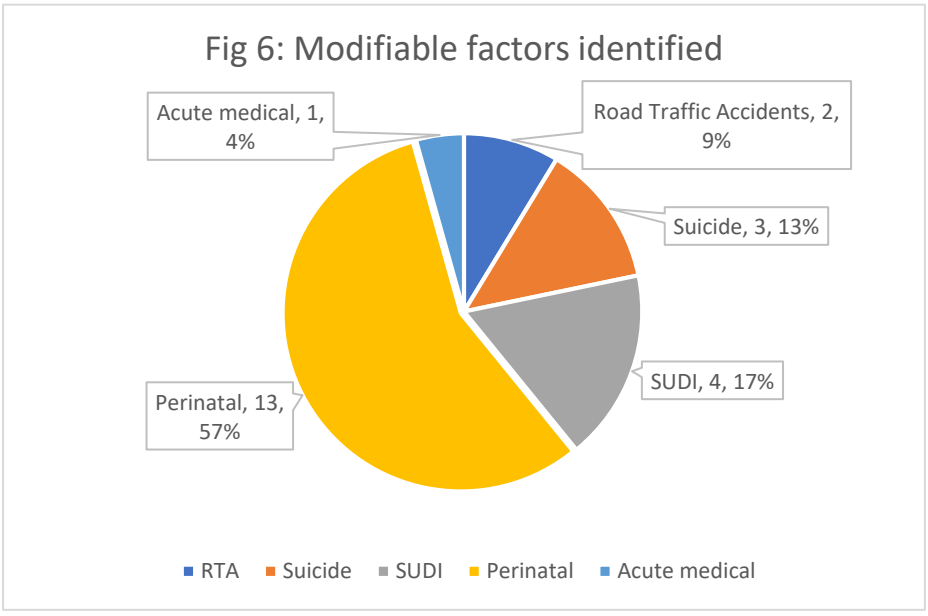
Deaths by gender

From April 2017 – March 2018 of the 58 child deaths reviewed by the CDOP, 31 were male (53.4%) and 27 were female (46.6%).

Deaths reviewed by CDOP with modifiable factors

A key purpose of the CDOP review process is to identify modifiable factors contributing to the death. Modifiable factors are defined *as one or more factors, which may have contributed to the death of the child and which by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths (DfE 2014).* 39.6% of reviewed cases had modifiable factors.

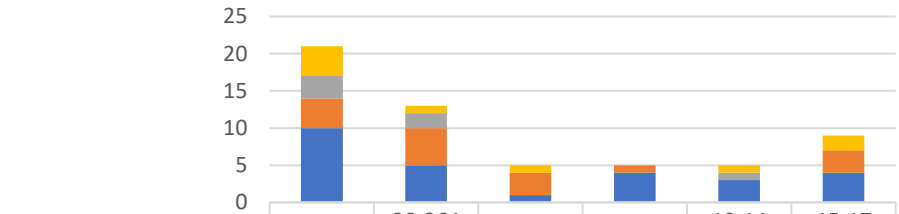
Figure 6 shows in which categories modifiable factors where identified, and included high Body Mass Index (BMI) in the mother (perinatal/SUDI), smoking during pregnancy, unsafe sleeping, alcohol/drugs and domestic violence (DV). Of the 58 deaths which were categorised during this reporting year, the ratio of modifiable: non-modifiable factors was 23:35 (39.6%), compared to 16:74 (17.8%) and 30% for the NW for 2016/17.



Child Deaths Reviewed by Age (DfE categorisation)

Figure 7 shows that the largest number of child deaths occurred within the first twelve months of life (55.6%). Nationally, 60% of deaths in childhood occur during the first year of a child's life, and are strongly influenced by pre-term delivery and low birth weight; with risk factors including maternal age, smoking and disadvantaged circumstances (Wolfe and Macfarlan, 2015).
Both figures also show the typical skewed "u-shaped" curve replicated at a national level.

Figure 7: Death by Age



	0-27 days	28-364 days	1-4 years	5-9 years	10-14 years	15-17 years
Warrington	4	1	1	0	1	2
Halton	3	2	0	0	1	0
Cheshire West/ Chester	4	5	3	1	0	3
Cheshire East	10	5	1	4	3	4

In Summary (last years' figures in [brackets]:

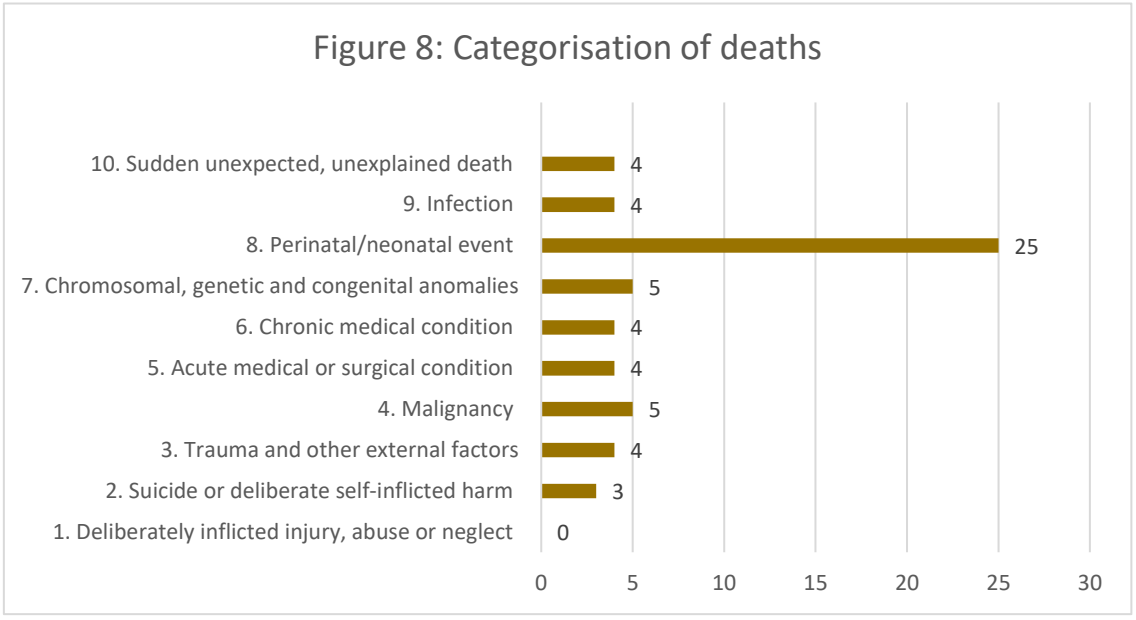
- 36.2% of the deaths occurred before the child reached 28 days (21 deaths)[38%]
- 58.6% of the deaths occurred before the child reached one year of age (34 deaths)[56.7%]
- 8.6 % of the deaths occurred in Children aged 1 year to 4 year (5 deaths) [16%]
- 8.6% of the deaths occurred in Children aged 5 years to 9 years (5 deaths) [9%]
- 8.6% of the deaths occurred in Children aged 10 years to 14 years (5 deaths)[8%]
- 15.5% of the deaths occurred in Children aged 15 years to 17 years (9 deaths) [10%]

Category of Child Death

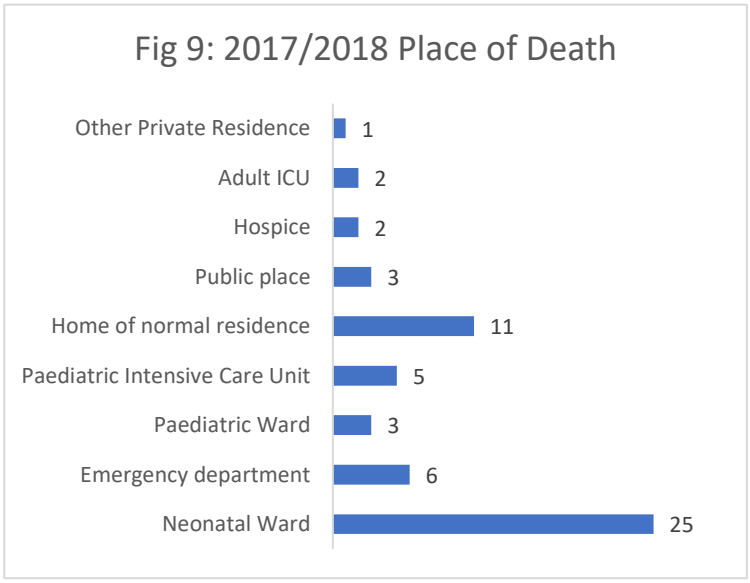
The CDOP panel is required to record each death against 1 of 10 nationally-set categories as follows:

Category 1: Deliberately inflicted injury, abuse or neglect (0)
Category 2: Suicide or deliberate self-inflicted harm (3)
Category 3: Trauma and other external factors (4)
Category 4: Malignancy (5)
Category 5: Acute medical or surgical condition (4)
Category 6: Chronic medical condition (4)
Category 7: Chromosomal, genetic and congenital anomalies (5)
Category 8: Perinatal/neonatal event (25)
Category 9: Infection (4)
Category 10: Sudden unexpected, unexplained death (4)

Further explanations can be found in Appendix 1. It can be seen in Figure 8 that the greatest proportion of deaths relate to perinatal/ neonatal event (category 8) which compares with the patterns seen in the NW and nationally. Chromosomal, genetic and congenital anomalies (category 7) is the second highest category, as it was for the last two years.



Location of Child Death

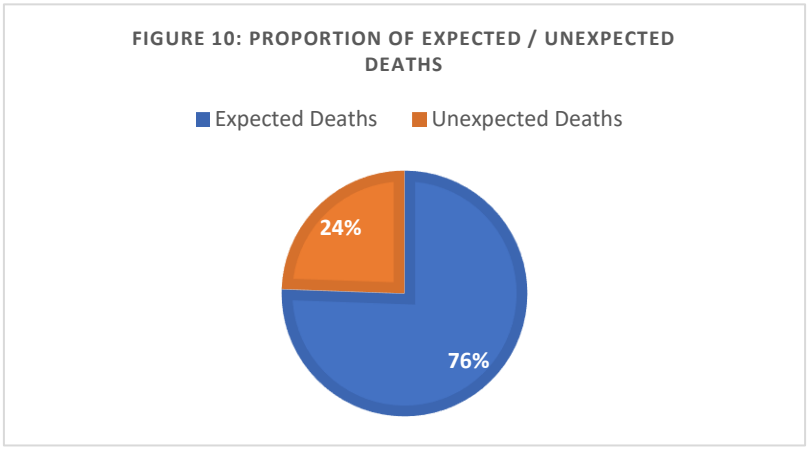


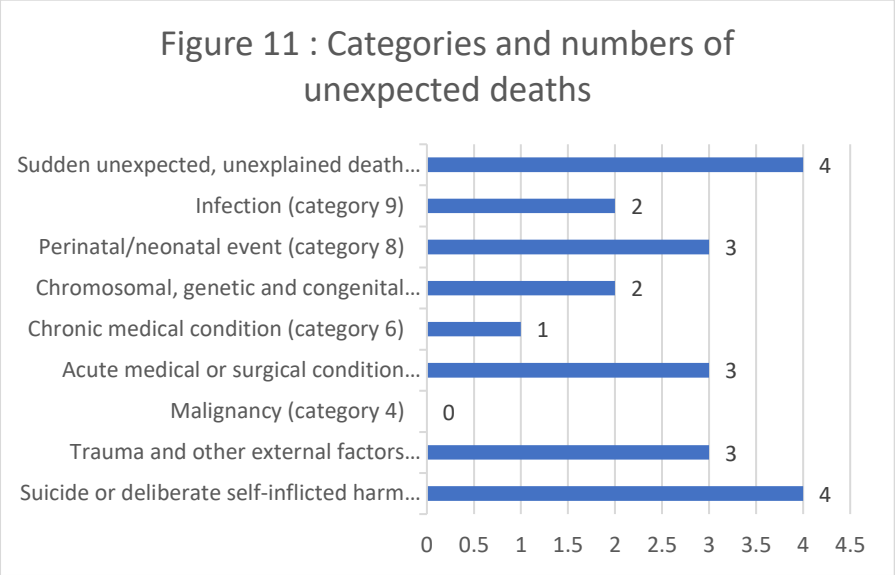
The majority of deaths (71.7%) occur within a hospital setting, the majority of these occurring in the neonatal units (Figure 9).

This is unsurprising because, by their very nature, these units provide care for premature babies and the most vulnerable/ at risk.

Expected / Unexpected deaths

An expected death refers to a death that could reasonably been foreseen by clinicians for a period of at least 24 hours before it occurred. An unexpected death is then defined as the death of an infant or child which was not anticipated as a significant possiblity 24 hours before the death or, where there was was an unexpected collapse or incident precipitating the events that led to that death. Between April 2017 and March 2018, there were 22 deaths (24%) that were classified as 'unexpected'.





The proportion of unexpected deaths has increased from 11% last year to 24% this year. Sudden unexpected and unexplained deaths, as well as deaths from suicide or deliberate self-inflicted harm form the most common categories of unexpected deaths (Figure 11), but numbers are too small to draw any firm conclusions. Deaths from suicide and deliberate self-harm are preventable but require effective inter-agency collaboration and partnership working.

Acknowledgements

As noted in the foreword much of the business of the CDOP is dependent on the continued support of panel members and the administrative support. I would like to take this opportunity to thank the panel members for their continued support and especially Anne McKenzie who ensures the panel runs smoothly.

Mike Leaf
Independent CDOP Chair
August 2018

Glossary of Terms

Term	Meaning
Child	A person aged 0-18th birthday
Expected death	A death that could have been reasonably predicted 24 hours before the death occurred or 24 hours before the immediate events leading to the death occurred
Infant	Aged less than 1 year of age
Modifiable factors	Factors associated with a death which by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths
Neonatal period	From birth until 28 days of life
Perinatal period	From viable gestation (around 23 weeks of pregnancy) until 7 days following birth
Unexpected death	A death that could not have been reasonably foreseen 24 hours before it occurs – or where there was an unexpected collapse or precipitating events leading to the death

Abbreviations

CDOP – Child Death Overview Panel

SUDI – Sudden Unexplained Death in Infants

LSCB – Local Safeguarding Children Board

Appendix 1: Classification of Death

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

Category	Name & description of category	Tick box below
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	☐
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.	☐
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury, abuse or neglect. (category 1).	☐
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	☐
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.	☐
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.	☐
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease,cystic fibrosis, and other congenital anomalies including cardiac.	☐

8	**Perinatal/neonatal event** Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).	☐
9	**Infection** Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.	☐
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	☐

The panel should categorise the 'preventability' of the death – tick one box.

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

Appendix 2
Cheshire West and Chester Response to the CDOP recommendations

Suicide Prevention - Assure themselves that existing multi-agency strategies aimed at reducing the incidence of mental health issues, include issues relevant to children and young people, in particular:	
Suicide and self-harm prevention	Self-Harm Audit was undertaken prior to this reporting year. Recommendations from the audit are being progressed. COCH have also undertaken a single agency self-harm audit which is yet to be reported to the Audit and Case Review subgroup
Training for various staff groups on management of suicidal behavior and self-harm;	Delivered 4 courses on working with children who self-harm of which 100 people from multi agencies attended – overall the programme evaluated well. CWP also delivered training on: Understanding Psychosis in Young People Brief intervention training for anxiety and depression LSCB delivered an event for parents – over 70 attendees that focused on Emotional Health and Wellbeing.
Active engagement of children and young people in strategy development	CYP have been engaged in the development of the Future in Minds Transformation Plan
Suicide Prevention - Assure themselves that existing mental health services that care for children and young people with MH issues (e.g. CAMHS and third sector) include	
An appropriate level of provision to match the need	June 2017 - Board received a presentation from (commissioners) on Children and Young People's Mental Health and Wellbeing Transformation Plan. June 2017 –Public Health delivered a presentation on CWAC Suicide Prevention: Local Perspective. The LSCB received assurance that: **Suicide strategy and suicide reduction action plan** Across Cheshire and Merseyside, the Champs Public Health Collaborative, led by the Directors of Public Health, coordinates joint actions for the sub-region to prevent suicide through the NO MORE Suicide Strategy. The Strategy and further details and can be found at www.no-more.co.uk. The NO MORE Suicide Strategy is an all-age suicide prevention strategy, recognising that suicide and suicidal risk varies across the life course and that prevention and age-appropriate interventions are particularly important. The 2017 refreshed Strategy has an increased focus on inequalities, men, children and young people, self-harm and safer care. Locally, the multi-agency Cheshire West and Chester Suicide Prevention Group is implementing the NO MORE Strategy. The group lead on the local suicide reduction action plan (S-RAP) which is based on national and regional suicide prevention strategies. The overarching aim of the S-RAP is to: • Reduce the rate of suicides (all ages) in Cheshire West and Chester • Provide better support for those bereaved or affected by suicide **Training**

	Locally, Cheshire Wirral Partnership (CWP) takes the lead on training on behalf of the Suicide Prevention Group. For CWP mental health staff, there is an established programme of training, including mandatory elements pertaining to suicide. Within the CWP community services service, suicide awareness training has been delivered to a range of staff including community matrons, clinical case managers and other community staff. In the last three years, the Local Authority has commissioned training for its staff, particularly those in public-facing roles. PAPYRUS (Prevention of Young Suicide) have provided training in suicide awareness and suicide intervention training. PAPYRUS also plays a leading role in providing training for young people themselves and parents and carers. Wirral MIND was also commissioned to deliver a 'train the trainer' course on suicide prevention. The training programme was cascaded to frontline staff in the target groups identified in the NO MORE Suicide Strategy (alcohol and drugs service, social workers, self-harm support services DWP/CAB staff). CWAC have also commissioned Mental Health First Aid training for staff and will be commissioning further training for elected members in 2018. **Suicide bereavement support service (AMPARO)** Friends and relatives bereaved by suicide often experience severe effects on own lives and have an increased risk of attempting suicide themselves. As a preventative measure, Cheshire West and Chester Public Health therefore currently commission a service (AMPARO) for people (all ages) who have been bereaved by suicide. AMPARO also accepts self-referrals and can support communities, **schools** and workplaces in the event of a suspected or completed suicide.
Appropriate ease of access	Single Point of Access for the service. Professional consultation service was provided by CAMHS for discussion of individual cases.
Effective inter-agency working	The Term 2 (2017-18) LSCB multiagency audit focused on emotional wellbeing
Active engagement of children and young people in service development	As above
Sudden unexpected deaths in infancy - Assure themselves that all agreed policies and guidance designed to reduce the risk of Sudden Unexpected Death in Infancy are being adhered to by all relevant staff groups. These include:	
Safer Sleep (Co-sleeping; safe sleep environment)	The Lullaby Trust delivered 2 sessions of which 31 people from multi agencies attended – well evaluated. The Starting Well team advise on safe sleep, it is discussed at antenatal and post-natal visits and at any other opportunistic occasion. Information is given both verbally and written and is documented on EMIS and red book Midwifery teams also discuss safe sleep at antenatal contacts.
Local guidance on *Care of Next Infant* (CODI)	The COCH are starting to put together the CONI (Care of the next infant programme) which has not really existed in this area before

	as a detailed programme although there has always had access to Resuscitation training for parents/families who have experienced a loss of a child or have a close relative who has. The COCH are starting with a policy and then are rolling out safe sleep / CONI information in September 2018.
Escalation policies to ensure concerns are heard	Escalation Policy in place. No specific audits have been undertaken. Staff knowledge and understanding of the Escalation Policy is tested at Board front line visits – Board members visits to front line staff - overall there appears to be good understanding of the policy. However our case reviews show that it is not always effectively used.
Graded Care Profile and Signs of Safety Neglect assessments	CWC were subject to a JTAI on Neglect in September 2017. Over the findings were positive and there is a partnership action plan in place. The Inspection found that: *There is strong partnership working in Cheshire West and Chester and a clear and collective commitment to improving responses to children who suffer neglect. Collaborative and well-coordinated work at a strategic level to address neglect has been in place for some time and the impact is evident in effective partnership working at an operational level. This is resulting in many children receiving a timely and appropriate response to reduce risk and the impact of neglect.* In relation to the use of evidence based assessment tools – Graded Care Profile in CWC *'Practitioners across all health services use a range of risk assessment tools provided by the LSCB, alongside specific health assessment tools, to support them in assessing the risk of neglect and to inform decisions to refer to i-ART. This was seen, in cases, to help practitioners understand the specific needs of children and the impact of neglect on children across age ranges'.* This goes some way to provide the LSCB regarding the use of tools. CWC have also developed a Neglect screening tool specifically for use with teenagers – this will be rolled out in 2018-19
Observation protocols for early identification of sick infants and children	
Repeated clinic non-attendance protocols	A re-audit of DNA's was undertaken at the COCH and presented to the Audit and Case Review subgroup
Smoking in pregnancy	April 2018 – Public Health delivered an update presentation on North West Sector Led Improvement Plan: Infant Mortality – focused on smoking in pregnancy, this was an agreed priority area for CWC
Assure themselves that there are effective multi-agency strategies in place to reduce	
Domestic Abuse	**<u>Domestic abuse</u>** Cheshire West and Chester Domestic Abuse Partnership (CWACDAP) provides a forum for effective multi-agency strategy, action and networking on domestic abuse. The Partnership includes addresses domestic abuse priorities through the provision

	of specialist services and initiatives. The Domestic Violence and Abuse strategy vision is: *For everyone to have a safe and happy life outside an abusive relationship* The Vision will be delivered through 5 priorities: • Intervening earlier • Assessing risk • Providing services for victims • Providing services for children and young people • Challenging perpetrators and giving them effective support to change Link to strategy https://westcheshirelsab.co.uk/wp-content/uploads/2015/05/DVA-Strategy-2016-20.pdf The Partnership is Chaired by a member of the LSCB and reports to the Board by the Executive on an annual basis.
Smoking around children	**Tobacco control strategy - smoking around children** Prevention is at the heart of the tobacco control strategy, which sets out the steps we will take collectively to reduce smoking in the borough. The aim of the strategy states: *By 2022, cigarette smoking will be a much rarer sight on our streets and in our homes.* ***Hundreds more young people will have been protected from breathing second-hand smoke and starting smoking****. Thousands of our most vulnerable and dependent smokers will have accessed advice and support to quit smoking for good. Our shared dream is to achieve a smokefree generation by 2030.* There are three priority areas in the Strategy: • Preventing young people from taking up smoking and protecting them from second hand smoke • Ensuring a range of support is available to help people quit, whilst narrowing the smoking gap . This means taking action to address the much higher smoking rates we see in our more deprived communities compared to the rest to the borough • Creating an environment that provides the best chance of quitting forever
Substance / alcohol misuse	**Health improvement strategy – substance misuse** **a) Alcohol harm reduction** This multi-agency strategy outlines action across the life course (that is, from before birth through to older age), with a particular focus on prevention and protecting children and vulnerable groups from alcohol-related harm. The Starting Well chapter of the strategy includes the following key sections: • Promoting an alcohol free pregnancy • Protecting babies and toddlers from alcohol-related harm • Reducing alcohol-related harm in school age children

	The Living Well chapter of the Strategy is aimed at 16 years and older and includes: • Increase awareness of the harms of alcohol misuse • Work with employers to ensure they have effective and supportive alcohol misuse policies • Where appropriate, undertake targeted interventions with high risk groups of adults, such as: the lesbian, gay and bisexual community, homeless population, and offenders **Drug misuse** This strategy outlines action needed to reduce demand, restrict supply and build recovery, with a particular focus on prevention and protecting children and vulnerable groups from the harm caused by drug misuse. Key elements/recommendations include: • Personal, social and health education and school-based interventions • All services in contact with young people should identify those who are at risk of using drugs and refer them to services that can support them. • Information about drug use should be provided in settings where groups who use drugs, or who are at risk of using drugs may attend e.g. nightclubs or festivals, wider health services such as sexual and reproductive health services, primary care, supported accommodation, hostels for people without permanent accommodation, and gyms (to target people who are taking, or considering taking, image or performance enhancing drugs). • Activities aimed at preventing drug misuse should be delivered for at-risk groups through a wide range of existing statutory, voluntary or private services. Prevention activities can also be included in sexual and reproductive health services and drug and alcohol services. For young people, relevant services include the 0-19 children's and young people's services and community-based criminal justice services for adults, youth and families. • Routine appointments and other contacts with statutory and other services should routinely assess whether someone is vulnerable to drug misuse e.g. health assessments for children and young people who are looked after or care leavers, initial assessments and reviews with GPs, nurses, emergency departments (where contact is linked to drugs or alcohol), 0-19 children's and young people's service and the community criminal justice system.