Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 24 March 2021

Subject: Manchester Child Death Overview Panel 2019-20 Annual Report

Report of: Barry Gillespie, Consultant in Public Health, Chair of the Manchester Child Death Overview Panel

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Summary

The Manchester Child Death Overview Panel (CDOP), a subgroup of the Manchester Safeguarding Partnership (MSP), reviews the deaths of children aged 0-17 years of age (excluding stillbirths and legal terminations of pregnancy), that are normally resident in the area of Manchester City. In line with the Child Death Review: Statutory and Operational Guidance (England) published October 2018, the CDOP has a statutory requirement to produce a local annual report which provides a summary of the key learning and emerging trends arising with the aim of preventing future child deaths.

Recommendations

The Board is asked to note the report and its recommendations.

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	Identification of relevant factors and modifiable factors that are likely to have contributed to vulnerability, ill health or death of children in Manchester and to identify action that could be taken to address this.
Improving people's mental health and wellbeing	
Bringing people into employment and ensuring good work for all	
Enabling people to keep well and live independently as they grow older	
Turning round the lives of troubled families as part of the Confident and Achieving Manchester programme	
One health and care system – right care, right place, right time	
Self-care	

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

The following reports are available via the MSP CDOP webpage:

https://www.manchestersafeguardingpartnership.co.uk/resource/cdop/

- Manchester Reducing Infant Mortality Strategy (2019-24)
- Manchester CDOP Annual Report
- Greater Manchester CDOP Annual Report
- National Child Mortality Database (NCMD): Child Death Review Data: Year Ending 31 March 2020
- National Child Mortality Database (NCMD): Child Suicide Rates during the COVID-19 Pandemic in England: Real-time Surveillance

Introduction

1. The 2019/20 Manchester Child Death Overview Panel (CDOP) Annual Report provides a summary of the key factors and modifiable factors for cases closed between 1 April 2019 and 31 March 2020.

Background

2. Following the death of a child, the CDOP Coordinator liaises with a wide range of agencies to gather information. This includes information about the child, the family and the circumstances leading to death to ensure a full picture of relevant clinical and social issues are available for consideration at the CDOP.

3. The CDOP and Themed Panel (neonatal deaths less than 28 days) meetings are held on a quarterly basis to categorise the cause of death, highlight factors that may have contributed to vulnerability, ill health or death and identify modifiable factors which by means of a locally or nationally achievable intervention, could be modified to reduce the risk of future child deaths

4. The work of CDOP is closely linked to the Manchester Reducing Infant Mortality Strategy (2019-2024), within the broader context of First 1000 Days Priority of the Manchester Population Health Plan (2018-2027). The CDOP seeks to identify the key modifiable factors in the population such as unsafe sleeping arrangements, housing conditions, reducing maternal smoking, and reducing maternal obesity that can contribute to child deaths.

5. A key element of the child death review process is the response to sudden and unexpected deaths in infancy/childhood (SUDI/C) known as a Joint Agency Response (JAR). The Greater Manchester (GM) JAR Team conducts a rapid assessment of such deaths. A team of senior paediatricians provide 24/7 cover 365 days of the year, working in close collaboration with Greater Manchester Police, Children's Services, GM Coroner's Offices and health services. Nationally this service provision is seen as the "gold standard".

Future arrangements

6. The CDOPs national line of accountability transferred from the Department for Education (DfE) to the Department of Health and Social Care (DHSC). Published October 2018, the Child Death Review: Statutory and Operational Guidance (England) sets out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements set out in Working Together to Safeguard Children and clarifies how individual professionals and organisations across all sectors involved in the child death review should contribute to reviews. The guidance sets out the process in order to:

    - improve the experience of bereaved families, and professionals involved in caring for children
    - ensure that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths

7. The collation and sharing of the learning from reviews is managed by the National Child Mortality Database (NCMD) through the use of standardised forms. Following the introduction of the NCMD, there was an increase in data entry requirements and a number of changes were made to the national templates used by CDOP to gather information following a child death. To ensure that the CDOP supplies the necessary information to the NCMD, the four GM CDOP areas took a collaborative approach to purchasing the eCDOP system. The eCDOP system will go live on 1 April 2021 and once fully operational will automatically populate the NCMD.