Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 23 January 2019

Subject: Manchester Child Death Overview Panel 2017-18 Annual Report

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

---

Summary

The Manchester Child Death Overview Panel (CDOP)- a subgroup of the Manchester Safeguarding Children's Board- reviews the deaths of children that are normally resident in the area of Manchester City, aged 0 - 17 years of age (excluding stillbirth and legal terminations of pregnancy) in line with Chapter 5 of Working Together to Safeguarding Children 2015. CDOP has a statutory requirement to produce a local annual report based upon cases closed and the findings

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 potential risk factors that are likely to contribute to Manchester's child death rate and 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	

Lead board member:

David Regan- Director of Population Health and Wellbeing, MHCC

Contact Officer:

Name: Barry Gillespie
Position: Consultant in Public Health
Telephone: 0161 234 3486
E-mail: b.gillespie@manchester.gov.uk

Background documents (available for public inspection):

- Previous CDOP reports;
- Manchester CDOP Annual Report 2016-17;
- GM CDOP Annual Report 2017-18;
- GM CDOP Annual Report 2016-17

available at:

https://www.manchestersafeguardingboards.co.uk/resource/child-death-overview-panel-cdop-information-practitioners/

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.

Introduction

1. The 2017/18 Child Death Overview Panel (CDOP) Annual Report is the tenth Manchester CDOP Annual Report. It is a summary of the key issues identified by the CDOP regarding all the deaths reviewed and closed between 1st April 2017 and 31st March 2018.

Background

2.1 The CDOP Manager, a member of the Manchester Safeguarding Team, works and liaises with a wide range of agencies to gather any relevant information following a reported child death. This will include information about the child, the family and the circumstances of the death to ensure a full picture of relevant clinical and social issues are available for the CDOP to consider.

2.2 A key element of our response to each sudden and unexpected death of a child (SUDC) is that we have in place an agreed Greater Manchester (GM) protocol for the rapid assessment of such deaths. A team of senior paediatricians provide cover via an on-call rota (24 hours per day, every day of the year) across GM, working in close collaboration with Greater Manchester Police, Children's Services, GM coroners and primary health care. Nationally this service provision is seen as the "gold standard".

2.3 The CDOP reviews all the information at a quarterly meeting and categorises the deaths, based on ten hierarchical categories, and identifies any potentially modifiable factors in the child's death. These modifiable factors (jointly agreed by the four Greater Manchester CDOPs to ensure consistency) are aggregated to identify factors that could reduce the risk of future deaths.

2.4 The work of CDOP is also closely linked to the Reducing Infant Mortality Strategy through identifying the key modifiable factors in the population including unsafe sleeping, housing conditions, reducing maternal smoking, and reducing maternal obesity. This Strategy will also be presented to the Health and Wellbeing Board on 23rd January 2019.

2.5 The 2017/18 CDOP Annual Report, and the 2017/18 GM CDOP and GM Rapid Response Team Annual Reports, were presented to the MSCB meeting in November 2018.

Future arrangements

3.1 A new Working Together to Safeguard Children was published in July 2018 and Local Safeguarding Boards are to be replaced with new multi-agency safeguarding arrangements which have to be established by September 2019. Given the robust CDOP system in place in Manchester (and GM) the recommendation is that we will continue with our current system.

3.2 Following the transfer of the child death review policy from the Department for Education (DfE) to the Department of Health and Social Care (DHSC) in July

2018 it is recommended that CDOP reports to the Health and Wellbeing via the Children's Board from 2019-20.