**Manchester City Council**
**Report for Information**

**Report to:** Manchester Health and Wellbeing Board – 24 January 2024

**Subject:** Manchester Child Death Overview Panel 2022-23 Annual Report

**Report of:** Assistant Director of Public Health

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## Summary

The Manchester Child Death Overview Panel (CDOP) 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. The Annual Report is attached as Appendix 1.


## Recommendations

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

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**Wards Affected: All**

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| **Environmental Impact Assessment** -the impact of the issues addressed in this report on achieving the zero-carbon target for the city | No impact |
| **Equality, Diversity and Inclusion** - the impact of the issues addressed in this report in meeting our Public Sector Equality Duty and broader equality commitments | The inequalities issues associated with child deaths, both locally and nationally, relate to higher mortality rates in communities experiencing higher levels of health inequalities, and social and economic disadvantage. In addition, there have been higher rates of child deaths across non-white populations exacerbated, and added to, by social disadvantage. Given the levels of deprivation within Manchester and the ethnically diverse population the cumulative impacts of these factors contribute significantly to the child death rates in the city. |

| Manchester Strategy outcomes | Summary of how this report aligns to the Our Manchester Strategy/Contribution to the Strategy |
|---|---|
| A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities | This important work contributes significantly to our efforts to be a more progressive and equitable city. |
| A highly skilled city: world class and home-grown talent sustaining the city's economic success | |
| A progressive and equitable city: making a positive contribution by unlocking the potential of our communities | |
| A liveable and low carbon city: a destination of choice to live, visit, work | |
| A connected city: world class infrastructure and connectivity to drive growth | |

Full details are in the body of the report, along with any implications for:

- Equal Opportunities Policy
- Risk Management
- Legal Considerations

**Financial Consequences – Revenue**
None.

**Financial Consequences – Capital**
None.

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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.

- Manchester Reducing Infant Mortality Strategy (2019-24)
- Manchester CDOP Annual Reports 2011-22
- National Child Mortality Database (NCMD): Child Death Review Data
- National Child Mortality Database (NCMD): Child Suicide Rates during the COVID-19 Pandemic in England: Real-time Surveillance

***Additional reports are available via the Manchester Safeguarding Partnership CDOP webpage:***

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

## 1.0 Introduction

1.1 The 2022-23 Manchester Child Death Overview Panel (CDOP) Annual Report (Appendix 1) provides a summary of the key factors and modifiable factors for cases closed between 1 April 2022 and 31 March 2023.

## 2.0 Background

2.1 Following the death of a child, the CDOP Coordinator liaises with a wide range of agencies to gather information regarding the circumstances of the death- these includes factors in the child, their social environment (including family and parenting capacity), the physical environment, and service provision. This information gathering is to ensure a full picture of relevant clinical and social issues are available for consideration at the CDOP.

2.2 The main CDOP and a 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.

2.3 Manchester CDOP, similar to many CDOPs nationwide, has a backlog of cases due to a combination of factors including the implementation of the 2018 Statutory and Operational Guidance (see 6 below) and the pressures on public sector services resulting from the impact of the COVID-19 pandemic. In addition, the complexity of many of the cases in Manchester increase the timescales for closing cases resulting in lower numbers of cases closed in the last two years.

2.4 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".

2.5 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.

2.6 The collation and sharing of the learning from reviews is managed by the National Child Mortality Database (NCMD) using 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 Manchester uses the eCDOP system which automatically populates the NCMD.

## 3.0 Main issues

3.1 The annual number of death notifications has fluctuated in the last 3 years, with a downturn in 2020/21 and a similar upturn in 2022/23, when compared to the 10-year average of 60 deaths per year. Whether or not this negative direction will be maintained will need to be monitored in future years, as will the impact on age-groups (65% of child deaths are aged under one), ethnic groups (higher rates in non-white Black and Asian groups), and families living in socially deprived conditions (over 80% of child deaths in Manchester are experienced by families living in the most deprived wards).

3.2 The number of cases being reviewed and closed by CDOP is increasing as the overall governance system for the review of child deaths develops and improves. Despite the variation in numbers of cases closed the two main causes of death, year on year, are chromosomal, genetic and congenital anomalies, and perinatal/neonatal events.

3.3 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.

3.4 The work of Manchester CDOP is closely linked to the Manchester Reducing Infant Mortality Strategy (2019-2024)- with the information above informing the setting of priorities for the city- and the broader context of the Making Manchester Fairer Plan (2022-27).

3.5 The CDOP Manager will continue to work with Public Health colleagues in the development and delivery of the refreshed Reducing Infant Mortality Strategy

3.6 Manchester CDOP will continue to work with the other 3 Greater Manchester (GM) CDOPs, GM Association of Directors of Public Health, and the broader integrated care system leadership to initiate a change programme to create a sustainable and flexible workforce model hosted by an appropriate organisation within GM.

## 4.0 Recommendations

4.1 The board is asked to note the report and its recommendations.