BOLTON, SALFORD AND WIGAN

CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT 2013/14

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1.1 Introduction.

Child Death Overview Panels (CDOP'S) are a multi-disciplinary sub-group of Local Safeguarding Children Boards that work across Local Authority boundaries based on population numbers. The CDOP reviews the deaths of all children aged from birth to under the age of 18years old (excluding still births and planned terminations carried out under the law) who normally reside within the geographical boundaries of that CDOP.

There are 4 CDOP's across Greater Manchester 3 of which are 'tri-partite' such as Bolton, Salford and Wigan (BSW) with one CDOP covering the area of Manchester City Council. This report provides information on the child deaths which have occurred in 2013/14 known as 'notifications' and cases concluded by the CDOP referred to as 'closed'. The first two sections of this report outline the functions of the Panel and summarises its key findings. In turn these key findings support the recommendations which are made to each of the three Local Safeguarding Boards (LSCB's) named above. These first 2 sections do not contain any identifiable data and can be made public. A more detailed analysis of the data in Section 3 for consideration by professionals involved in child safeguarding may contain identifiable information and therefore has a restricted circulation.

1.2 The Panel and its functions.

Government advice is that Child Death Overview Panels should cover populations of at least 500,000 and it was for this reason that the three authorities of Bolton, Salford and Wigan came together from 1st April 2009. The CDOP carries out a multi-disciplinary review of child deaths (0-17 years inclusive) with the aim of understanding how and why children in Bolton, Salford and Wigan die. Panel members consider whether there are any factors which could have been modified to prevent or reduce the chances of a similar death in future.

1.3 Childhood deaths and key issues.

One of the significant challenges for the Panel is to draw conclusions from a (thankfully) relatively small number of cases each year. CDOPs have been gathering data since 2008 and the collection of data from various agencies has improved year on year. The main issues for the CDOP are to consider the number of deaths and the reasons for those deaths with a view to detecting trends and/or specific areas which would appear worthy of further consideration.

1.4 Numbers of Childhood deaths.

There were a total of 48 childhood deaths notified to the CDOP in 2013/14. Since 2008/9 there are a total of 456 child deaths across the 3 areas. As might be expected there are year on year variations. From 2008-14 Bolton has recorded the highest number of deaths (172) but in 2013/14 recorded the lowest number across the CDOP (15). Wigan has recorded the lowest number of deaths between 2008-14 (135) but in 2013/13 recorded the highest number (26)

1.5 Ages of children.

In 2013/14 61% of deaths in this CDOP were children under 1year old and this figure has been consistent over recent years. Of the 61% there is a higher incidence of children under 27 days which ranges year on year between 25% in Bolton and 53% in Wigan. Whilst there is a significant range in this period the overall figures are generally in keeping with local and national trends. In the main this can be explained by premature births where the infant is too under developed or because of severe life limiting conditions when the child is at its most vulnerable.

1.6 Ethnicity.

In the early years of CDOP data around ethnicity was not always collected in a robust manner which limits year on year comparisons. Equally when broken down into local authority areas in individual years the relatively small numbers must carry a warning about their statistical significance. The CDOP report for 2012/13 identified that both Bolton and Salford have disproportionate percentages of BME deaths when compared to the ethnic population in those 2 areas. In 2013/14 this has been continued although the rate in Salford has seen a reduction.

1.7 Sudden Unexplained Death in Infancy (SUDI)

Over the past 3 years the CDOP has commissioned research into safe sleeping across the 3 areas. This has now been concluded and the results are being considered by each of the 3 LSCB's. In the 5 year period up to 2012/13 there had been 33 SUDI in the CDOP. In 2013/14 there were 2 such deaths – one each in Bolton and Wigan. There were a total of 10 deaths recorded as SUDI across Greater Manchester. In 2012/13 there were 20 such deaths across Greater Manchester. The common features in these cases are that parents smoke and/or have been co-sleeping with their child in bed or on a settee. (See modifiable factors at 1.8)Research shows that the North West and Wales have the highest rate of sudden unexplained deaths in England and Wales.

1.8 Modifiable Factors.

National guidance defines preventable child deaths as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

A total of 48 cases were reviewed for modifiable factors prior to being closed by the panel in 2013/14. Cases can only be closed when all other processes such as Inquests, criminal investigations and Serious Case Reviews have concluded. Using that criterion 22 of these cases were notified to the CDOP prior to 2013/14. Of the 48 cases 9 were identified as having modifiable factors covering a wide range 7 of the 9 relating to parental smoking or issues around safe sleeping.

The percentage of cases identified as having modifiable factors was 19% which accords with the national average and significantly lower than the Greater Manchester average of 34%.

2 RECOMMENDATIONS

2.1 Recommendations from 2012/13 – updates requested

1/ The LSCBs should recognise the factors which contribute to neonatal and infant deaths e.g. poverty, infant nutrition, smoking in pregnancy, maternal and infant infections, obesity in mothers and early access to high quality, culturally sensitive maternity care. Vulnerable women should be identified and supported early in the pregnancy through early booking and the provision of appropriate support. Addressing these issues will require a partnership approach through local Health and Wellbeing Boards. Maternity services in Greater Manchester are commissioned collaboratively; therefore input at a city region level may also be required.

Updates from Salford -The findings from the NHS Salford CCG review of Maternity Services undertaken in 2013 resulted in a number of recommendations, one of which relates to the recording and sharing of information across Maternity, Primary Care and Community Services in order to identify and respond to additional needs at the earliest possible stage. The ongoing Salford CCG Maternity and Early Years Project Board and the Salford Post MiB Implementation Group Meetings will progress this recommendation.

The CDOP annual report was presented to the Safeguarding Board by the independent chair and to the Health and Well Being Board (HWB) by the Interim Assistant Director Specialist Services. Both boards have received and agreed the recommendations. Smoking in pregnancy is a key indicator within the HWB and is monitored through performance management this is led by Public Health. Salford have a City poverty strategy alongside the Childrens poverty strategy. The recommendations of the CDOP have been made available to the poverty group and work will be linked and monitored through the lead member for children.

2/ Bolton and Salford boards should work with the CDOP and public health colleagues to enhance understanding of the reasons for the disproportionate numbers of deaths in different sub-populations, categorised by e.g. ethnicity or deprivation. This may be done more effectively through the new GM database for CDOP panels.

Update - Following a meeting with Abdul Razzaq, the Director of Public Health for Trafford he produced a report in January 2014 highlighting some of the issues in the above recommendation. The report raised 5 actions for work across Greater Manchester, regionally and at a national level.

3/ The Sleep Safe Campaign needs to be evaluated to make a recommendation to the respective LSCBs as to whether the project should continue to receive funding.

Update – The Campaign has now been concluded and a paper submitted to each Board giving options for the continued work in this area. The final decision has yet to be confirmed by all 2 Boards but it hoped that the campaign will continue as a tri-partite process for at least the next 12 months.

2.2 Recommendations based on the 2013/14 report

1/ There is evidence of a disproportionate number of child deaths in Quintile 1(most deprived). Each Authority should assess the work currently in place to target vulnerable groups and an action plan should be developed to identify how the number of deaths can be reduced.

2/ It is a consistent feature, both locally and nationally, that children under 1 year old account for the majority of child deaths. These deaths have common features around low birth weight, prematurity and maternal smoking and associated issues of hypertension, diabetes and obesity and their links to poverty and infant nutrition. Given that year on year the percentage of deaths remains the high, Public Health should review current work and devise an updated action plan to address the areas identified.

3/ CDOP's have been in existence since 2008 and child deaths have remained relatively constant over this time period. It is recommended that a 5 years 'snapshot' is under taken across the 3 Authorities and GM to evaluate CDOP data in more detail. This would allow standardisation of the data sets, complete correlation to understand if there is a relationship between child deaths and areas such as smoking at time of delivery (SATOD), deprivation, and ethnicity. It would also allow robust benchmarking to take place across GM to highlight Local Authorities that need more support in reducing child deaths in their area.