BOLTON, SALFORD AND WIGAN

CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT 2014/15

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SECTION 1 - EXECUTIVE SUMMARY

1.1 Introduction.

Child Death Overview Panels (CDOPs) 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 18 years 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 CDOPs 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 annual report provides information on the child deaths which have occurred in 2014/15 known as 'notifications' and cases concluded by the CDOP referred to as 'closed'.

It is important to recognise that not all notifications received in 2014/15 are dealt with in that 12 month period. Notifications received later in the year require information to be gathered which means they will be considered in the next 12 month period. Equally some cases may result in coroner inquests, police investigations and in some cases Serious Case Reviews. The timescales of these investigations mean there will inevitably be significant periods between the notification to CDOP and the case being discussed and closed by CDOP.

This explains why there were 63 notifications to CDOP but 66 cases were closed.

The first two sections of this report outline the functions of the Panel and summarise its key findings. In turn these key findings support the recommendations which are made to each of the three Local Safeguarding Boards (LSCBs) named above. These first 2 sections do not contain any identifiable data and are therefore appropriate for wider circulation. 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 first came together in 2008. 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 in 2014/15.

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. In order to draw some conclusions this report includes some comparative year on year data. This means that larger numbers and longer terms trends can be analysed. The data collection process and analysis around CDOP has continued to develop both locally and across Greater Manchester. This has resulted in the production of a Greater Manchester CDOP annual report which is able to analyse trends using larger numbers. The GM report will be published in September 2015 but in general terms the ongoing issues will continue to be deaths in children under 1 year. These deaths have consistent themes around prematurity, parental smoking (particularly by mother during pregnancy), low birthweight and life limiting conditions when the child is at its most vulnerable.

1.4 Numbers of Childhood deaths.

There were a total of 63 childhood deaths notified to the CDOP in 2014/15. Since 2007/8 there have been a total of 519 child deaths across the 3 areas. As might be expected there are year on year variations .When the numbers of deaths 2007-2015 across the CDOP are compared to the Rate per 10,000 Pop 0-17years it can be seen that Wigan has the lowest rate at 2.51 with Bolton at 2.88 and Salford has the highest at 5.91. This compares to an average across Greater Manchester (GM) of 3.91.

1.5 Ages of children.

In 2014/15 of the 66 cases closed 69.7% were children under 1 year old. In 2013/14 this figure was 68.9. In both cases this was above the average for GM which in 2014/15 stood at 64.5%

In 2014/15 the rate for 0-27 days was 44% in this CDOP. The average across GM was 41.6. 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 on their statistical significance. In 2014/15 closed cases showed that in Bolton 50% of the deaths were children classified as white. In Salford this figure was 68% and in Wigan the figure was 85%. These figures can in some way be accounted for by the population make-up in the 3 areas. The BME community in Bolton comprise just under one third of the under 19 population. In 2014/15 the panel identified 4 cases where parents were 1st cousins. Of these it viewed that 2 of the deaths were linked to genetic anomalies

1.7 Sudden Unexplained Death in Infancy (SUDI)

In 2014/15 the CDOP identified 3 SUDI cases. Across GM there were 19 cases and only Bolton did not have at least 1 incident. The common features in these cases were that parents smoked and/or had been co-sleeping with their child in bed or on a settee (see modifiable factors at 1.9 below). Research shows that the North West and Wales have the highest rate of sudden unexplained deaths in England and Wales. Since 2011 BSW have run a joint campaign to highlight factors such as safer sleeping and the risks of parental smoking. Of the 66 cases closed in 2014/15 only 1 death involved safe sleeping issues with that case and 1 other featuring parental smoking.

1.8 Unexplained deaths in young people

The nature and intention of these deaths involving, in the main, adolescents, is often unclear and accordingly Coroners in GM rarely if ever record a finding of suicide. In 2014/15 CDOPs closed 9 such incidents in GM where children died and where illness was not the cause and there was no evidence of third party involvement. There were 3 such incidents in the CDOP area; none in Bolton. In addition to the work by all CDOPs research is being carried over the next 2 years at the University of Manchester into deaths of this nature.

1.9 Modifiable Factors.

National guidance defines potentially 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.

Cases can only be closed when all other processes such as Inquests, criminal investigations and Serious Case Reviews have concluded. In 2014/15 a total of 66 cases were closed by the panel. Of those, 17 (25.7%) were identified as having modifiable factors. In 2013/14 this figure was 17%.

In 2014/15 the 4 CDDOPs across GM identified modifiable factors in 63(24%) cases from 262 cases they closed. There was a wide variation in that Manchester identified 14% of cases and Stockport, Tameside and Trafford identified modifiable factors in 31% of cases.

Where modifiable factors exist consistent features are smoking by mothers in pregnancy, prematurity and associated low birth weight.

SECTION2 – RECOMMENDATIONS

The CDOP business plan containing the recommendations below has been e mailed to each of the 3 PH representatives following panel meeting and requests made at each CDOP meeting. E mails have also been sent requesting updates.

2.1 Update on the Recommendations in 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.

Salford - As part of the 0-25 review differentiated delivery models are being explored which would target additional services to areas of increased need; this would include deprived areas.

A detailed action plan for each area will be developed as part of a universal plus model. A strategic review of 0-25 provision is underway as part of the JSNA.

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 this high, Public Health should review current work and devise an updated action plan to address the areas identified.

Greater Manchester -Directors of PH have met and agreed the recommendations in the GM report. There was an initial meeting involving CDOP and PH where areas to be addressed were agreed. In April the GMSP agreed to support the recommendations made by PH.

3/ CDOPs 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 undertaken 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 whether 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 which need more support in reducing child deaths in their area.

Greater Manchester- Representatives from PH across GM met in March to agree ToR for the group. A number of key themes were identified in line with the recommendation above. Andrea Fallon has picked up key actions to progress.

2.2 - RECOMMENDATIONS BASED ON THE 2014/15 REPORT

Whilst the number of child deaths varies each year the overall numbers show little change since 2008. This report and previous CDOP annual reports provide evidence that there are key factors which could have a significant impact in reducing the number of child deaths.

In previous years recommendations have focussed on these key factors but with numbers in each area being thankfully small it has not proved possible to measure the effectiveness of any one factor in any one locality. This will prove even more difficult for each LSCB as the provision of services continues to move toward larger centres of excellence and reduction of smaller local services.

In the last 2 years great strides have been made by CDOPs working more closely with Public Health at local, GM and regional level. Public Health staff now play a vital role in analysing the data collected and collated by CDOPs and with that collaboration annual reports are now produced for each CDOP as well as Greater Manchester and, from last year, a regional report.

Many of the issues identified in this report are not specific to one local authority and whilst each LSCB should retain its autonomy and be held accountable it must fall to Public Health, working with CDOPs at a local, regional and national level to address the key issues identified in this and previous reports.

Updates provided from the recommendations made in 2013/14 provide evidence that Public Health is working to address these key factors but at this point several are either pilots or under review and no figures as to uptake or effectiveness have been produced. It is equally the case that Directors of Public Health across GM are aware of the 2013/14 recommendations contained in the GM CDOP Annual Report and have met on several occasions to discuss the best way forward.

It is the recommendation from this report that each LSCB ensure that Public Health take the lead in providing evidence of the work being carried out both locally and across GM that will have an impact on reducing the number of child deaths.

Based on the evidence in this report the areas which require specific focus are –

- Actions to prevent premature births which have a disproportionate effect on the child mortality rate.

- Actions to identify and then focus on groups where risk appears to be highest based on ethnicity and deprivation.

This will involve PH providing each LSCB with evidence of its action plans already in place to address the areas above and how these actions will be measured for outcomes.