BOLTON, SALFORD AND WIGAN CHILD DEATH OVERVIEW PANEL ANNUAL REPORT 2017/18

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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 currently 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 2017/18 known as 'notifications' but the main focus is on cases concluded by the CDOP during 2017/18 referred to as 'closed' and any trends which can be identified during that period or through analysis of cases from that year and previous years.

It is important to recognise that not all notifications received in 2017/18 are dealt with in that 12 month period. Notifications received later in the year require information to be gathered which means they are normally considered in the next 12 month period. However 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 73 notifications to the BSW CDOP but 83 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 Children 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.

Therefore Section 3 should not be circulated beyond CDOP, LSCBs and those professionals involved in safeguarding children.

1.2 The Panel and its functions.

Up until 2018 Government advice was 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 (first breath up to 18th birthday) with the aim of understanding how and why children in Bolton, Salford and Wigan die. The cause of death or gestation of the child is irrelevant and all cases (other than planned terminations) are dealt with by the panel. 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 Changes to CDOP

One of the main changes since 2016/17 is that oversight of the process has moved from the Department for Education to the Department of Health.

Following a review of the child death review process (CDRP) and subsequent consultation process, several changes are expected to be made on how child death overview panels operate.

At present there is no minimum number of deaths each year for a CDOP to consider; it is expected that a minimum number of 60 notified deaths will be proposed.

There will be an additional tier prior to the current CDOP meeting. This additional meeting will be made up from professionals who have dealt with the child and will then provide details of that meeting to the CDOP. The CDOP will continue to be made up of professionals but they will have had no direct dealings with the child.

At present it is not clear who will administer the new tier or how these meetings will be co-ordinated.

It is expected that the new CDRP guidance will be published in September or autumn.

The creation of a national database has finally been agreed and the contract awarded. However, in practical terms CDOPs have been told not to expect any meaningful information for at least 2 years whilst the contract holders develop and test the database.

In the meantime this CDOP, along with others in Greater Manchester and the North West, continue to collaborate with regular meetings to establish consistent practices and produce joint annual reports using common data sets. Work continues with partners in Public Health to identify good practice to tackle infant mortality. This has resulted in action plans being formulated across the region and all 10 areas within Greater Manchester. The action plans relevant to this CDOP are in Section 2 of this report.

1.4 Childhood deaths and key issues in 2017/18.

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 focusses on trends rather than individual cases. The GM report has been written by a member of Public Health and is available to be read alongside this annual report. This local report will identify and analyse several themes and

trends but in general terms the ongoing issues 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.

1.5 Numbers of Childhood deaths.

There were a total of 73 childhood deaths notified to the CDOP in 2017/18. Since 2007/8 there have been a total of 836 child deaths across the 3 areas. As might be expected there are year on year variations, although the last 3 years have been remarkably similar at 72, 72 and 73 respectively.

Of 73 child deaths notified in 2017/18 the panel concluded 31 (42%) of those cases in 2017/18. In 2016/17 this figure was (35%). The panel closed 83 cases in 2017/18. Of those, 60 (72%) were closed within 12 months of the death being notified to the CDOP manager. In 2016/17 a total of 68 cases were concluded, of which 58 (87%) closed within 12 months of the death taking place.

1.6 Ages of children.

2016/17 saw a continued downward trend since 2013 in both notified and closed cases of children under 1 year old. 2016/17 was also the first year that the percentage was below the GM average for children under 1 year old.

In 2017/18 there was a percentage increase of deaths under 1 year of age from 54.5% to 59%. The percentage of notified deaths under 1 year old dropped from 58% in 2016/17 to 45%. As in 2016/17 the percentages for 2017/18 were below the average for Greater Manchester.

Following previous CDOP annual reports Greater Manchester CDOPs and Public Health have initiated a sector led improvement plan across the North West in 2017 targeting infant mortality rates. Bolton Salford and Wigan are all actively engaged in this initiative which will be commented on in Section 2 of this report.

1.7 Ethnicity.

In the early years of CDOP data around ethnicity was not always collected in a robust manner which limits year on year comparisons. However, in recent years this data has been collected almost without exception. It is recognised that when broken down into local authority areas and in individual years the relatively small numbers should carry a warning on their statistical significance. In previous years the number of deaths of white children has always been lower than might be expected when set against the population makeup. The Bolton, Salford, Wigan percentage of white children is 77%, 86% and 95% respectively. In 2017/18 the percentage of white children in the 83 closed cases was 43%, 56% and 91% respectively. This is consistent with previous years and generally reflected across GM.

1.8 Sudden Unexplained Death in Infancy (SUDI)

In 2017/18 there were 5 identified cases (2 in Bolton, 1 in Salford and 2 in Wigan). This is in line with the previous 2 years when there were 5 and 6 deaths. In each of the previous 3 years each area has had at least 1 SUDI. In GM there has been a reduction in the number of SUDI cases although the percentages have remained fairly consistent at between 7-10% of total closed cases. The common features in these cases were that parents smoked, or had been co-sleeping with their child in bed or on a settee although by definition a cause cannot be ascertained. (see modifiable factors at 1.10 below) Research shows that the North West and Wales have the highest rate of sudden unexplained deaths in England and Wales. All professionals are aware of the factors associated to deaths of this nature and there is no doubt that parents are made aware of these factors. However, there are still incidents where the advice is not followed or in some cases tragic incidents just occur.

1.9 Unexplained deaths in young people

The intention of the individual in these deaths involving in the main, adolescents is often unclear and accordingly Coroners in GM rarely record a finding of suicide. There were 4 such incidents in the CDOP area (2 in Bolton and 2 in Wigan) where illness was not a factor nor was there any evidence of third party involvement. There is more detail on these cases in Section 3.

1.10 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 2017/18 29 (35%) of the 83 closed cases had modifiable factors. In 2016/17 the figure was 34%. The figure in 2015/16 was 37.5% which was the highest annual figure. In 2014/15 the figure was just 17% and the numbers rose from that year on until the last 3 years when they have levelled out. There is no definitive explanation for this rise in modifiable cases. A possible explanation may be that as the CDOP process continues to improve, a higher level of information is collected from a wider range of agencies, thus providing more detail for panels to consider. In 2017/18 10 of the 29 cases recorded a BMI of 30+ as a modifiable factor. This was first included as a GM wide modifiable factor in 2016/17

CDOP Chairs meet regularly and discuss consistency of decision making. Modifiable factors are always discussed and there is no evidence that a different decision making process exists.

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

SECTION 2 - RECOMMENDATIONS AND SECTOR LED IMPROVEMENT PLANS

Historically CDOP reports have made specific recommendations based on the annual figures available. However, the 2015/16 annual report for the BSW CDOP focussed on the trends and patterns that have become evident over the years. This was due to the production of an annual report covering the 4 CDOPs in Greater Manchester (GM) which was presented to the Directors of Public Health. That report highlighted trends and patterns across GM and linked in with the 4 local CDOP reports which highlighted local issues as well themes consistent across all areas in GM and across the region.

This led to joint working between CDOPs and Public Health and the creation of a Sector Led Improvement Plan (SLI) involving the 10 areas across Greater Manchester. This was recognised as good practice and quickly established across the North West.

The SLI focusses on the infant mortality rate and the work required to reduce deaths. Each area now has an action plan to address the areas highlighted in this report such as smoking during pregnancy, consanguinity, safe sleeping and low birth weight.

Bolton, Salford and Wigan have all produced action plans to target resources in these areas and prioritise work in line with local requirements. The resultant work around the SLI plan is relatively new and will no doubt continue to develop in the years ahead. It is important that the SLI action plans continue to be a priority in order to reduce the number of children who die before their first birthday.

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