BURY, ROCHDALE & OLDHAM

Child Death Overview Panel

Annual Report

April 2011 – March 2012

Contents

1. Introduction & Summary

The Bury, Rochdale and Oldham Child Death Overview Panel (CDOP) would like to welcome you to the fourth annual report, which reviews cases referred to the panel between 1 April 2011 – 31 March 2012.

In April 2008 Bury, Rochdale and Oldham joined to form a tripartite arrangement following the recommendation made by the Department for Education (DfE) that CDOPs require a total population of 500,000 or higher. The joint working of the three local authorities provides a wider data set to conduct analysis and investigate emerging trends.

As a subgroup of the Local Safeguarding Children Board (LSCB), the CDOP reports information and themes back to each LSCB via the annual report and on an ad hoc basis

The CDOP Annual Report in 2010/11 made mention of proposals to create a Greater Manchester database to allow the 4 CDOP's to collate data. This proved a challenging piece of work in terms of time and commitment for several organisations and the 4 CDOP Administrators. In particular Trafford should be thanked for creating a role within their existing structure to provide an individual with the skill, knowledge and energy to see the project through. As a result each CDOP now has access to anonymised data from across Greater Manchester. This should allow identifications of trends and patterns using the Greater Manchester 'footprint'.

The CDOP Chairs in Greater Manchester continue to meet and share good practice working with the Greater Manchester Partnership and Rapid Response Team.

On a wider field this Chair has also attended the Nottingham Regional CDOP Workshop and been part of the Regional CDOP with representation from Merseyside and Lancashire. It is clear from this joint working that even with local variations many of the themes in this report are replicated across the country.

As a result of feedback from CQC inspections renewed effort has been made to raise awareness of CDOP and its role. A short generic document has been produced and approved by CDOP members for distribution by LSCB members within their own organisations and agencies.

The involvement of parents and their awareness of the CDOP process is a challenge that all CDOPs have wrestled with. Whilst all child deaths involve personal tragedy conveying the appropriate information to parents at the correct time is not always straightforward. As a result of work with Registrars of Births, Marriages and Deaths this CDOP has recently agreed to distribute an FSID leaflet at Registrars offices. The leaflet will be handed to the person registering the death by Registrar staff which ensures the information is given at an appropriate time by a person well used to dealing with the grieving process. The leaflet provides appropriate information about CDOP work and whilst generic has a local contact within CDOP to provide further information if requested by a parent.

Following a recommendation in the 2010/11 Annual; Report Oldham SCB set up a working group looking at the issue of consanguinity in Oldham. This group includes CDOP and LSCB members as well as representatives from Health, Faith group members and workers and local councillors. This group has produced a leaflet providing statistical and general information on consanguinity.

As a result of contact with the national charity Foundation for the Study of Infant Death (FSID) a local representative has been contacted and available when required is available for advice and attending the Bury, Rochdale and Oldham CDOP.

There were a total of 85 notifications (child deaths) made to the CDOP in 2011/12. Of these 41 have were closed. The remaining 44 remained open for additional information or whilst other enquiries were on-going by the police or coroner.

The CDOP met 6 times between April 2011 and March 2012 and closed a total of 57 cases. These were a combination of 2011/12 cases and those carried over from previous years where inquests or police investigations had been concluded.

The report that follows will detail that safe sleeping arrangements, smoking by parents, deaths in children under 1 year are the main factors considered by this CDOP in 2011/12. These are consistent features across Greater Manchester and Nationally (see page 24)

In addition the report will provide data and explanations concerning the main issues regarding age of children, ethnicity given the diverse population of the CDOP area, categories of death and modifiable factors, which if addressed should assist in preventing similar deaths in the future.

NB This report was originally written in August 2012. However, at the request of each LSCB there was additional consultation with LSCB business managers and subsequently members of Rochdale Public Health who in 2013 have assisted in the analysis of data contained in this report.

2. Functions of the Child Death Overview Panel (CDOP)

The CDOP has a list of processes and functions to address which are laid out in Chapter 7 of Working Together 2010 but in summary they are as follows:

- Consist of a fixed core membership to review cases, with the flexibility to co-opt other relevant professionals as and when appropriate.
- Review the available information on all child deaths of children aged up to 18
- Review the appropriateness of professional's responses and give thorough consideration how such deaths might be prevented in the future.
- Maintain a database to collate an agreed minimum data set.
- Identify any patterns or trends in the local data.
- Refer to the chair of the LSCB any case where it is felt there may be grounds to undertake further investigations or a Serious Case Review (SCR) and explore why this had not previously been recognised.
- Identifying any public health issues and considering, with the Director(s) of Public Health, how best to address these and their implications for both the provision of services and for training.
- Develop a work plan approved by the LSCB.
- Identify modifiable factors which may reduce the number of child deaths in the future. These are factors which, by means of nationally, locally achievable interventions, could be modified to reduce the risk of future child deaths.

3. Data Collection

It has been recognised locally and nationally that data collection by the CDOP is a challenging area and there are several reasons for this. Some agencies continue to be slow or even reluctant to provide information requested. Cutbacks mean that some agencies have no identified individual to provide information and therefore its significance is not recognised. There are occasions where the information requested on the Form B is not available or is clearly not relevant and therefore when not provided is not pursued by CDOP. Examples of this might be birth weight of a child aged 17 years or whether a parent smoked when a teenager is killed in a road traffic collision.

It is national advice that unless information is vital to the panel coming to an objective decision there must be a pragmatic approach to balancing a complete data set with the ability to conclude a case.

However, it must remain a priority for CDOP to collect and analyse as much data as possible and as the process develops year on year so the data collection process improves. For example in the 2010/11 report only 66% of cases contained ethnicity of the child. This area has been targeted by CDOP and the figure in 2011/12 is now 94%

Below is a table showing some key areas comparing this CDOP to Greater Manchester in 2011/12 and figures from the North West collected in 2009/10 by CEMACE. The figures show the percentage of cases where the information was provided by agencies which has improved year on year.

Data collection figures on National CDOP Form B

Category	CDOP 2011/12	G. Man 2011/12	N. West 2009/10
Father smokes %	52	36	24
Mother smokes %	84	74	41
Domestic Violence %	95	73	45
Mother substance abuse %	94	73	45
Ethnicity %	94	93	70
Child Protection Plan %	93	90	75
Birth weight %	93	88	55
Gestation %	89	86	58

It will be noted that information regarding smoking by father is significantly lower than the other categories. This tends to be repeated in all areas about the father. Enquiries reveal there are various reasons for this including the mother choosing not to give the information about father, the father not being present or in some cases the father not being known.

4. Demographic Profiles

The information provides a breakdown of the three local authorities' population, age and ethnicity. This data has been used to analyse the make up of each of the three local authorities to provide accurate statistics and identify trends across the three boroughs.

Data relating to population, gender and age has been extracted from the 2011 Census.

It is estimated that the total number of children in England under the age of 18 is 11,336,600, making up 21.3% of the total population.

The CDOP covers three local authorities with an estimated total population of 621,700. Oldham having the highest number of children 0-19 years (62,300) followed by Rochdale (56,200) and Bury (46,200). 26.4% (164,700) of the 3 local authorities population is made up of children ages 0 – 19 years which is 5.1% higher than the national figure.

In 2011, there were 3.5 million children under five in England and Wales, 406,000 more than in 2001.

Number of children in age ranges across CDOP and England -2011

Area	0 – 4		5 – 9		10 – 14		15 – 19		All Ages
Bury	12,200	6.6%	11,100	6.0%	11,400	6.2%	11,500	6.2%	185,100
Rochdale	14,800	7.0%	13,100	6.2%	13,900	6.6%	14,400	6.8%	211,700
Oldham	16,500	7.3%	15,400	6.8%	15,300	6.8%	15,100	6.7%	224,900
Greater Manchester	181,200	6.8%	158,500	5.9%	160,300	6.0%	176,300	6.6%	2,682,500
North West	432,100	6.9%	392,200	6.2%	412,400	6.4%	456,800	6.6%	7,052,200
England	3,318,500	6.1%	2,972,600	5.6%	3,080,900	5.8%	3,340,300	6.5%	53,012,500

There were 43,500 children under 5 years in Bury, Rochdale and Oldham making up 7% of the total population, the rate being higher than GM, NW and England.

There were 39,600 children aged 5-9 years (6.4%) the rate being higher than GM, NW and England.

There were 40,600 children 10-14 years (6.5%) the rate being higher than GM, NW and England.

There were 41,000 young people aged 15-19 years (6.6%), the rate being equivalent to GM and NW and higher than England.

In 2011 Oldham had the highest number of children and young people, 62,300 (27.7%) followed by Rochdale 56,200 (26.5%) with Bury having the lowest number 46,200 (25.0%).

4.1 Population by broad ethnicity

	England		Greater Manchester		Bury		Oldham		Rochdale	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
ALL	53012456	-	2682528	-	185060	-	224897	-	211699	-
WHITE	45281142	85.4%	2246123	83.8%	165092	89.2%	174825	77.5%	172874	81.7%
MIXED	1192879	2.3%	50710	2.3%	3355	1.8%	4057	1.8%	3556	1.7%
ASIAN	4143403	7.8%	272173	10.1%	13457	7.2%	43155	19.2%	31555	14.9%
BLACK	1846614	3.5%	74097	2.8%	1823	1.0%	2757	1.2%	2770	1.3%
OTHER	548418	1.0%	27428	1.0%	1358	0.7%	552	0.2%	855	0.4%

All three areas have an ethnically diverse population.

89.2% of the population of Bury are from a White background, higher than Greater Manchester and England as a whole.

Rochdale has the second highest rate (81.7%) followed by Oldham (77.5%), both these rates are lower than both Greater Manchester and England.

People of Asian or British Asian background make up the largest minority ethnic groups, the largest being in Oldham (19.2%) followed by Rochdale (14.9%) and Bury (7.2%).

Bury has lower percentages of minority ethnic groups than both Greater Manchester and England, whereas and Rochdale and Oldham have higher rates.

Life Expectancy at Birth 2008-10

Area	Male	Female
England	78.6	82.6
Greater Manchester	76.4	80.8
Bury	77.5	81.2
Oldham	75.7	80.5
Rochdale	76.3	80.6

In terms of life expectancy for males, Bury has the highest across the 3 areas (77.5 years) higher than Greater Manchester but lower than England as a whole. Oldham has the lowest life expectancy for males (75.6 years), lower than both Greater Manchester and England.

5. Total Child Death Notifications

The term 'notifications' has a specific use within CDOP and refers to a child death being 'notified' to the CDOP administrator.

When the CDOP was set up in 2008 it was decided the date on which a death was notified to the CDOP Administrator would be the factor that decided which year that death was recorded in the Annual Report. The Annual Report would cover the period between 1st April and 31st March. For example if a child died on the 30th March 2010 but the CDOP were not informed until 2nd April 2010 the case would be recorded in the 2010/11 Annual Report.

Total notifications from 1 April 2011 to 31 March 2012

Bury:	21	25%
Rochdale:	28	33%
Oldham:	36	42%
Total	**85**	

Total Notifications from April 2008 to March 2012

2008 – 2009:	45
2009 – 2010:	67
2010 – 2011:	75
2011 – 2012:	85
Total	**272**

Total cases referred since April 2008 – March 2012:

Bury:	60	22%
Rochdale:	88	32%
Oldham:	123	45%
Out of Area:	2	1%

Bury

60 child deaths = 22% of the total number of notifications. Bury has 28% of the CDOP population under 19 years of age based on the 2011 census. Whilst Bury has the lowest number of children across all ages in the CDOP (p 7) it also has the highest life expectancy in the CDOP and above the average for GM but below the average for England (p 8).

Rochdale

88 child deaths = 33% of the total number of notifications. Rochdale has 34% of the CDOP population under 19 years of age based on the 2011 census.

Oldham

123 child deaths = 45% of the total number of notifications. Oldham has 38% of the CDOP population under 19 years of age based on the 2011 census. Oldham has the highest number of children across all ages in the CDOP and therefore would be expected to have the highest number of deaths. However, there is a disparity in the percentage of deaths within the CDOP. Oldham has the lowest life expectancy in the CDOP and is below the average for both GM and England. (See section 10 on consanguinity for a possible explanation)

Case Status

The CDOP met 6 times in 2011/12 and 'closed' a total of 57 cases. The outcomes and analysis of the 57 cases are covered in Section 11 (p23). The numerical data for the number of cases 'closed' by the CDOP is covered below.

CDOP consider a case 'closed' when it has been fully considered by panel members, all appropriate issues dealt with and consideration given to any 'modifiable factors' as defined on page 5.

Of the total 85 child death notification referred to the CDOP between 1 April 2011 – 31 March 2012:

Cases Closed:	41	48.2% (closed between 1 April 2011 – 31 March 2012)
Open:	44	51.7%

The cases that remain open will be for a variety of reasons –

- The date of notification was close to the 'year- end' therefore basic information has still to be collected.
- The case is subject to Coroners Inquest, SCR or criminal investigation. (CDOP will not normally deal with such cases until these processes have been completed.)
- The case has been considered by CDOP but panel members require additional information in order to reach a conclusion.

6. Child's Gender

Gender of deaths 2011/12

Area	Female	%	Male	%
Bury (21)	10	47.6	11	52.3
Oldham (36)	15	41.6	21	58.3
Rochdale (28)	11	39.2	17	60.7
Total (85)	36	42.3	49	57.6

In 2011/12 there were 85 child death notifications across the CDOP of which 36 (42%) were female and 49 (58%) were male. This is consistent with the percentages across Greater Manchester (GM) over the same period - 250 child death notifications made up of 103 (41%) females and 147 (59%) males.

Gender of deaths 2008 - 12

	2008/09		2009/10		2010/11		2011/12	
	Female	Male	Female	Male	Female	Male	Female	Male
Bury	1	4	8	7	10	9	10	11
Rochdale	8	15	11	14	8	10	11	17
Oldham	10	7	11	16	9	28	15	21
Total	19	26	30	37	27	47	36	49
%	42.2	57.8	44.8	55.2	36.5	63.5	42.4	57.6

It can be seen that other than a slight variation in 2010/11 the percentages have remained almost constant through 2008-12. Over that period the average is Female 41.5%, Male 58.5%

Population aged 0-19 by gender 2011

	Total Male Population	Male Under 19s Population	Total Female Population	Female Under 19s Population
Bury	90,600	23,900	94,500	22,400
Oldham	110,200	31,900	114,700	30,400
Rochdale	103,600	28,900	108,100	27,300

The total population of all ages for male and female residents is the same across the 3 local authorities and is:
49% Male 51% Female

The population of male and female residents under 19 years of age is the same across the 3 local authorities and is: 51% Male 49% Female

The total population of all ages for male and female residents in the UK based on the 2011 census is:
51% Male 49% Female.

7. Childs Age at Death

Ages and number of children who have died in CDOP area 2011/12

Age	Bury	%	Oldham	%	Rochdale	%
0 - 27 days	9	42.8	24	66.6	13	46.4
28 - 364 days	5	23.8	3	8.3	6	21.4
1 - 4 years	5	23.8	3	8.3	0	0
5 - 9 years	0	0	2	5.5	2	7.1
10 - 14 years	0	0	2	5.5	3	10.7
15 - 17 years	2	9.5	2	5.5	4	14.2

Ages and numbers of children who have died in CDOP area 2008-12

Age	2008/9	2009/10	20010/11	2011/12	Total
0 – 28 days	16 (36%)	28 (41%)	30 (40%)	46 (54%)	120
29 – 365 days	14 (31%)	9 (13%)	13 (18%)	14 (17%)	50
1 – 4 years	9 (20%)	16(24%)	10 (13%)	8 (9%)	43
5 – 9 years	0 (0%)	7 (10%)	4 (5%)	4 (5%)	15
10 – 14 years	3 (7%)	3 (5%)	8 (11%)	5 (6%)	19
15 – 17 years	3 (7%)	5 ((8%)	10 (13%)	8 (9%)	26
Totals	45	68	75	85	273

Ages and numbers of children who have died in Greater Manchester 2011/12

(2011/12) Age	Number	%
0–28 days	112	45%
29–364 days	61	24%
1–4 years	25	10%
5-9 years	14	6%
10-14 years	14	6%
15-17years	24	9%

In 2011/12 neonatal deaths and those under 1 make up the majority of notifications in the CDOP area – 60 (71%) and 170 (61%) over the period 2008-12.

In 2011/12 in Greater Manchester there were 250 notifications of which 173 (69%) were under 1.

Nationally in 2011/12 children under 1 represented 66% of the total number of notifications.

Therefore in percentage terms the figures for the CDOP are in keeping with those across GM and Nationally.

7.1 Neonatal Deaths (0-28 Days of Age) in 2011/12

A neonatal death is defined as the death of an infant within the first 28 days of life. The child must have been born alive (drawn breath) irrespective of gestation unless it was an authorised termination. In 2011/12 there were 46 (54%) neonatal death notifications in this CDOP and 112 (45%) across Greater Manchester.

Whilst the CDOP does not have the depth of data nor the requirement to examine all cases in detail there are some consistent findings from the deaths of children under 29 days old, which are summarised below:

Summary

48% of the cases recorded the birth as extremely premature. Low birth weight was linked to this factor with 50% of children weighing less than 1kg. Across GM this was 54% and 49% respectively

Mothers who smoked during pregnancy are a feature in 20% of the deaths.

Just over half the deaths are classified as white. (54% in this CDOP and 59% in GM) The average percentage of white population of all ages across the CDOP is just under 87%.

Mothers in the 30-39 age range have the highest percentage (52%) of neonatal deaths. In GM this figure is 41%

Whilst only 7% of neonatal cases were identified as having modifiable factors the consistent features were around mothers smoking, safe sleeping and alcohol/drug abuse.

It will be seen in this age range that the percentages from this CDOP are similar to those across the cumulative percentages across Greater Manchester.

7.2 Deaths Aged 29 – 365 Days in 2011/12

There were 14/85 (30%) child death notifications in the CDOP and 61/250 (24%) child death notifications across Greater Manchester. The details are listed at Appendix 1

The main features were:

Summary

As with neonatal deaths this CDOP is in keeping with the overall percentages across Greater Manchester.

However, prematurity was less of a factor than with neonatal deaths (21% and 26% for 29-365 days) and 48% and 54% for neonatal deaths).

36% of deaths in this CDOP and 52% across Greater Manchester were classified as white. The average percentage of white population across the CDOP is just under 87%

Although a lower number (3) of cases had modifiable factors they formed a higher percentage (21%) of the cases. Again smoking and safe sleeping were the consistent features. This was also reflected in the figures across GM.

7.3 All Deaths under the Age of 1 in 2011/12

In 2011/12 there were 60 (71%) deaths in the CDOP and 173 (69%) across Greater Manchester.

Smoking was a consistent feature with 27% smoking during the pregnancy or after birth. The figure was 17% across GM.

38% of mothers had a BMI classified as obese. This was significantly lower across GM with 17% of mother classified as obese..

12% of cases recorded modifiable factors – safe sleeping and parental smoking. GM had 15% of cases with modifiable factors which again revolved around safe sleeping and parental smoking. (See recommendations – Section 15)

(A list of data covering 7.1 – 7.3 above can be found at Appendix 1)

8. Sudden Unexpected Death in Infancy (SUDI)

There were 4 (7%) such deaths in the CDOP from the 57 closed cases in 2011/12. Across Greater Manchester a total of 19 (6.9%) cases from the 274 closed cases in 2011/12 were recorded as SUDC.

All 4 were white.

3 were aged between 29 – 365 days. One of these being a female

1 was a white male aged 0-28 days.

In 3 of the deaths gestation was recorded as full term with birth weights in excess of 2.8kg. The fourth being 32 weeks with a birth weight of 1.1kg.

In 3 cases mother was between 20–29 years of age. In 1 case the mother was under 19 - This was not the child born at 32 weeks.

All 4 were single pregnancies. 3 had older siblings and in one case 6 siblings.

Mother smoked in all 4 cases.

2 of the cases were in Oldham with 1 in Bury and 1 in Rochdale.

The consistent themes were smoking by parents, consumption of alcohol and inappropriate sleeping arrangements such as too many blankets or sleeping with the infant. These factors may have been present individually or in a combination. One case recorded overcrowding as an issue.

The national charity The Lullaby Trust, formerly Foundation for the Study into Infant Deaths, (FSID) have a track record in analysing 'Sudden Infant Death Syndrome' (SIDS) and providing information on 'safe sleeping' based on that research. They have identified that significant risk factors such as bed sharing with parents who smoke, have consumed alcohol or taken drugs dramatically increases the chances of a child dying in circumstances classified as SIDS.. Similarly bed sharing with a baby of low birth weight (2.5kg or less) or a premature baby (37 weeks or less) is strongly linked to an increased risk of SIDS.

9. Ethnicity

As stated earlier in the report the collection of data around ethnicity has proved problematical. It is only in the last 2 years that the data gathered is sufficiently robust for any analysis to be made.

Number of child death notifications in 2011/12 based on ethnicity

	Bury		Rochdale		Oldham		Total	
	Number	%	Number	%	Number	%	Number	%
White	12	52.1	18	64.2	13	36.1	43	50.5
Mixed	2	9.5	2	7.1	4	11.1	8	9.4
Asian or Asian British	4	19	6	21.4	17	47.2	27	31.7
Black or Black British	0	0	0	0	1	2.7	1	1.1
Other	1	4.7	0	0	0	0	1	1.1
Not Known	2	9.5	2	7.1	1	2.7	5	5.8

Number of children in population under 19 years old based on ethnicity.

	England		Greater Manchester		Bury		Oldham		Rochdale	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
ALL	12712275	-	676383	-	46249	-	62306	-	56,252	-
WHITE	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
MIXED	639791	5.0%	32678	4.9%	1949	4.2%	[illegible]	[illegible]	[illegible]	[illegible]
ASIAN	1264221	9.9%	97731	14.4%	5075	11.0%	18997	30.5%	12,751	22.7%
BLACK	[illegible]	[illegible]	25487	[illegible]	593	[illegible]	803	[illegible]	[illegible]	[illegible]
OTHER	161042	1.3%	9267	1.4%	459	1.0%	152	0.2%	257	0.5%

9.1 Bury

Since 2008 there have been 60 child deaths in Bury which is 22% of the total number of CDOP notifications (272) since 2008. Bury has 28% of the CDOP population under 19 years of age based on the 2011 census and therefore the percentage of deaths is lower than might be expected. Bury has the highest life expectancy figures of the 3 areas in the CDOP.(p8)

In 2011/12 52% (12/23) of child deaths were classified a white. Based on the 2011 Population by Ethnic Group in 2011 the population of Bury 0-15 is 82.6 % white.

Allowing for 9.5% (2 cases) where ethnicity was unknown there appears to be a marked difference in the percentage of deaths on white children and the percentage of white children in the population under 19.

9.2 Rochdale

Since 2008 there have been 88 child deaths in Rochdale which is 33% of the total number of notifications (272). Rochdale has 34% of the CDOP population under 19 years of age based on the 2011 census.

In 2011/12 64% (18/28) of child deaths notifications in Rochdale were classified as white. The figures for Rochdale show that 71.5% of the population under 19 are classified as white.

There have been 40 child death notifications in Rochdale in 2010-2012 of which at least 23 (57.5%) were white. The same period shows that of the 40 notifications at least 13 (32.5%) were classified as BME. In 4 (10%) cases the ethnicity data had not been collected.

When the data is collected using date of death rather than date of notification to CDOP the numbers vary slightly but with 10% unknown the percentage of deaths may well match the ethnic makeup of the under 19 population.

9.3 Oldham

Since 2008 there have been 123 child death notifications in Oldham which is 45% of the total number of notifications (272) since 2008. Oldham has 38% of the CDOP population under 19 years of age based on the 2011 census.

It is noted that Oldham has the highest population across the CDOP and therefore the actual number of deaths might be expected to be higher than the other areas. Oldham also has the lowest life expectancy figures across the CDOP and is below the average for both Greater Manchester and England.

Based on the figures in the table above it can be seen that 61.1% of the deaths are from the BME community of which 47.2% are recorded as Asian and 11.1% recorded as mixed. The 2011 Census show Asian children represent 30.5%. of the total population under 19. Similarly mixed race children represent 3.6% of the total population under 15 in Oldham.

It is recognised consanguinity could explain a number of these deaths within the Asian community. In the 2 years 2010-12 there have been 16 cases where the parents have been related. Between 2010-12 the total number of child deaths in Oldham is 73 of which 38 (52%) have been in the BME community. Therefore, if the 16 deaths linked to consanguinity are removed there have been 57 child deaths of which 22 (38.6%) are from the BME community. The BME population is 35.9% in the under 19 population in Oldham. (See Section 10)

NB. Data from previous reports has also been used to increase the number being compared. However, it is accepted that in statistical terms the numbers involved are, thankfully, low and therefore difficult to draw any solid conclusions at this time. (See recommendation 3, Section 15, p26)

10. Consanguinity

There were a total of 85 notifications in 2011/12 across Bury, Rochdale and Oldham:

Parents Related:	13	15%
Not Related:	47	55%
Not Known:	25	30%

If the 25 cases where consanguinity was not known are disregarded that would indicate that in the 60 remaining cases 21.6% (13/60) of parents were related.

	Related	Not Related	Not Known
Bury	2 (10%)	18 (85%)	1 (5%)
Oldham	8 (22%)	15 (42%)	13 (36%)
Rochdale	3 (11%)	14 (50%)	11 (39%)

In the number of cases where consanguinity was recorded Oldham saw the highest amount with 8 out of 23 cases (35%) of related parents, Rochdale had 3 out of 17 (18%) and Bury had 2 out of 20 (10%).

Of the total 13 consanguineous cases:

First Cousins	7	54%
Second Cousins	1	8%
Not Known	5	38%

All 13 cases of consanguinity were from the BME community:

Bangladeshi	2	15%
Pakistani	11	85%

The following religion was recorded:

Muslim	8	62%
Not Known	5	38%

The following factors were present:

Neonatal death (under 28 days)	7	54%
Child suffered life limiting condition	4	32%
Sudden Unexpected Death in Infancy	1	7%
Child suffered previous medical problems	1	7%

In 4 of the 13 cases it is known that Mother has previously suffered pregnancy loss either from miscarriage or the death of an infant. 6 of the cases it is not recorded if there had been previous pregnancies.

Oldham SCB have formed a multi- agency group involving local religious leaders to look at the issues around consanguinity and have launched several initiatives. They continue to look at the options to reduce deaths linked to this area.

11. Categorisation of Death (see below for explanation)

	Name & description of category
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Excludes Deliberately inflected injury, abuse or neglect. (category 1).
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Includes cerebral palsy with clear post-perinatal cause.
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease,cystic fibrosis, and other congenital anomalies including cardiac.
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral palsy without evidence of cause, and includes congenital or early-onset bacterial infection (onset in the first postnatal week).
9	**Infection** Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5).

Bury, Rochdale and Oldham

Category of Death and Closed Cases

Categorisation of death –explanation– This section is drawn from the National Form C which is the analysis pro-forma used by all CDOP's to conclude cases. The pro-forma divides all deaths into 10 specific areas and where there is doubt as the appropriate category the CDOP should use the category highest up the list.

Closed Case – explanation – It has previously been covered that when the CDOP is informed of a child death the terminology used is a 'notification'. A case remains open until the panel members are satisfied that sufficient information has been gathered to allow them to reach an objective conclusion. When the panel are satisfied the case is 'closed'.

In 2010/11 the CDOP 'closed' a total of 57 cases. Of these 41 were cases 'notified' to the CDOP in 2010/11. The 16 other case were from previous years.

Category of Death by CDOP in 2011/12

Category		Bury	Oldham	Rochdale	Total	%
1	Deliberately inflicted injury, abuse or neglect	0	1	0	1	1.75
2	Suicide or deliberate self-harm	0	0	1	1	1.75
3	Trauma and other external factors	1	1	0	2	3.51
4	Malignancy	1	0	4	5	8.77
5	Acute medical or surgical condition	0	1	1	2	3.51
6	Chronic medical condition	1	1	0	2	3.51
7	Chromosomal, genetic and congenital anomalies	5	7	7	19	33.33
8	Perinatal/neonatal event	3	13	3	19	33.33
9	Infection	1	0	1	2	3.51
10	Sudden unexpected, unexplained death	1	2	1	4	7.02
	Total	13 (23%)	26 (45%)	18 (32%)	57	

Category of Death by CDOPs in GM 2011/12

	Category	Total	%
1	Deliberately inflicted injury, abuse or neglect	1	0.5
2	Suicide or deliberate self-harm	4	1.5
3	Trauma and other external factors	8	3
4	Malignancy	23	8
5	Acute medical or surgical condition	5	2
6	Chronic medical condition	11	4
7	Chromosomal, genetic and congenital anomalies	88	32
8	Perinatal/neonatal event	102	37
9	Infection	13	5
10	Sudden unexpected, unexplained death	19	7
	Total	274	100

There should be no significance attached to the difference in numbers from each of the 3 areas. As explained previously there can be a number of reasons why closed cased vary each year. It would be expected that Oldham would have the largest number of closed cases given they have the largest number of cases.

In 2011/12 the 2 largest categories of death in the CDOP and GM are Chromosomal, genetic and congenital anomalies (33% and 32% respectively) and Perinatal/neonatal events (33% and 37% respectively).

The average figures for the CDOP 2008-2012 show Chromosomal, genetic and congenital anomalies as 27% and perinatal/neonatal event 35%

Each local authority's highest category in 2011/12:

Bury:	Chromosomal, genetic and congenital anomalies	38.46%
Rochdale:	Chromosomal, genetic and congenital anomalies	38.89%
Oldham:	Perinatal/neonatal event	50.00%

In Bury the 5 deaths for Chromosomal anomalies were 2 classified as white and 3 classified as BME with 3 of the deaths being under 1 year of age and the remaining 2 deaths being under 3 years of age.

In Rochdale the 7 deaths for Chromosomal anomalies 4 were classified as white and 3 as BME. 5 of the children were under 1 year old and the other were older than 15.

In Oldham only 2 of the perinatal/neonatal deaths were classified as white with 11 (85%) being classified as BME. It is not possible to explain the difference in ethnicity at this time. (Recommendation 3, p26)
None of the 13 cases had any modifiable factors

12. Categorisation of Preventability

For every completed case, the CDOP will review the circumstances using the Department for Education (DfE) National CDOP Template Form C: Analysis Proforma. The template requires CDOPs to determine the 'preventability' of the death.

Definition of preventable child deaths – Working Together 2010.

"For the purpose of producing aggregate national data, this 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.

In reviewing the death of each child, the CDOP should consider modifiable factors, for example in the family and environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level."

Modifiable factors identified
The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths

No Modifiable factors identified
The panel have not identified any potentially modifiable factors in relation to the death

12.1 Issues Identified

Issues identified in cases categorised as having modifiable factors present

Bury

	Area	Sex	Age	Issues
Child 1	Bury	Female	0 – 28 days	Smoking
Child 2	Bury	Female	29-364 days	Co-sleeping, overcrowding, Smoking

Oldham

	Area	Sex	Age	Issues
Child 1	Oldham	Male	0 – 28 days	Co sleeping, alcohol. Smoking and drugs.
Child 2	Oldham	Male	15 – 17 yrs	Speed cameras, Local campaign – speed kills
Child 3	Oldham	Male	29-364 days	Overheating, Smoking

Rochdale

	Area	Sex	Age	Issues
Child 1	Rochdale	Female	0 – 28 days	Probable concealed pregnancy, Previous CPP with siblings
Child 2	Rochdale	Male	0 – 28 days	Engagement with Children services, Smoking
Child 3	Rochdale	Male	10 – 14 yrs	Suicide – SCR findings
Child 4	Rochdale	Male	29 – 365 days	Overheating, Smoking

In the CDOP there were 9 (15.7%) cases from 57 closed cases were identified as having modifiable factors.

7 (66.6%) of these cases were children under 1yr old.

8 (73%) were recorded as white, 2 recorded as Asian with 1 where the ethnicity was not recorded.

6 of the cases recorded smoking as a modifiable factor with 5 of the cases recording birth as premature or extremely premature.

5 (45%) of the cases showed a record of Domestic Abuse. Although based on the information provided to the CDOP there was no indication that this was a factor in the death it is felt the figure is sufficiently high to be worthy of mention.

Across Greater Manchester 44 (16%) cases from 274 were identified as having modifiable factors.

36 (82%) of these cases were children under 1year old of which 21 were under 28 days old.

30 (68%) were recorded as white, 10 (23%) recorded as BME and 4 (9%) where ethnicity was not recorded.

Where data was collected well over half of the cases listed parental smoking as a modifiable factor with at least 13 of these being classified as premature or extremely premature births.

13. National Picture

In July 2012 the Department for Education released statistical information based on the information submitted by CDOP's across England.

They listed a large range of recommendations made by CDOP's. The themes relevant to this CDOP are:

1. Safe Sleeping
There is a need for this to be embedded in practice rather than short lived campaigns.

2. Smoking
Continued work with pregnant women to highlight the risks of maternal smoking and the link to premature births and linked complications.

3. Health appointments
The importance of following up missed appointments. Both during and after pregnancy.

4. Consanguinity
The concern that parents do not have sufficient understanding of increased risk of children being born with disabilities.

14. 2010/11 Recommendations Update

Recommendation 1:

It is clear from the data in this report that consanguinity is an issue, particularly for Oldham, where 8 deaths (22%) are to parents who are known to be 1st cousins. Bury had 2 deaths (10%) Despite its diverse community there are no reports of similar cases in Rochdale. However, the relationship between parents was unknown in an average of 54% of cases. Oldham LSCB has formed a group to progress the issue of consanguinity and will have their first meeting in July 2011.

Each LSCB should investigate the issue around marriage involving cousins to raise awareness and develop pro-active methods to reduce the incidences of genetic anomalies in children.

Outcome

Oldham has formed a group to look at the issue. This is made up of faith groups, community leaders, LSCB members and local councillors. Rochdale LSCB are monitoring the progress of work in Oldham. "Bury LSCB have developed links with Oldham LSCB in order to share their learning on consanguinity and will recommend to NHS Bury Public Health Department the adoption of key successful aspects of Oldham's action plan once this has been implemented."

Recommendation 2:

Figures locally, regionally and nationally support the case that the numbers of neonatal deaths form a disproportionate percentage of the overall child deaths. Over the past 3 years 74 children under 28 days who would reside in Rochdale, Bury and Oldham have died which represents 39.36% of the total number of deaths. This is lower than the North West Average (44%). Of the 30 neonatal deaths in 2010/11 14 (46.6%) were classified as white British and 12 (40%) as being from a BME group. The BME population of Rochdale is 14%, Bury 2.5% and Oldham 17% which is an average of just over 11% across the CDOP area.
However, the percentages are broken down there is a disproportionate number of deaths in the BME population.

Public health (Health and Well Being) should investigate the disproportionate representation of BME deaths in both neonates and the overall child death figures.

Outcome

The Chair has met with the representative of Oldham Public Health and started work in assessing the available information.
NHS Bury have noted the data and concluded that "the numbers are so small that it is neither possible to accurately statistically analyse the data further nor to draw any conclusions that are statistically significant."

Recommendation 3:

There continues to be a significant number of mothers who smoke during pregnancy and whilst the child is an infant. The panel feel strongly that this is a significant factor in neonatal deaths. There is also a consistent theme, albeit in small numbers, of parents who sleep with their infant or place the infant to sleep in inappropriate conditions. Whilst it is understood that any number of services inform parents about the above dangers there does not appear to be one consistent message that can be agreed by all. This may lead to confusion and uncertainty for parents.

Each LSCB and ideally the Greater Manchester Partnership should agree a common and consistent message for parents, particularly regarding safe sleeping.

Outcome

This has been discussed and monitored at the Greater Manchester Partnership and a significant change has now been made to the Personal Child Health Record for all new born in Greater Manchester. Bolton, Salford and Wigan CDOP have used available funds to promote a safe sleeping campaign. The results have yet to be analysed.

15. 2011/12 Recommendations

Recommendation 1

It is clear that consanguinity continues to be an issue. There were 60 deaths in 2011/12 where the relationship between parents was recorded of which 13 were identified as marriage between cousins (Bury 2, Rochdale 3, Oldham 8). Oldham has progressed by creating a working group to consider options and have produced a leaflet on the subject.

Oldham and Rochdale LSCB should investigate the cultural issue around 1st cousin marriages to raise awareness and investigate pro- active methods to reduce the incidences of genetic anomalies in children.

Recommendation 2

There were 5 SUDI deaths in the CDOP in 2010/11. There were 4 SUDI deaths cases in the CDOP in 2011/12. There were an additional 10 CDOP cases of children under 1 year old where parents smoked. There are 5 CDOP cases still open where the professionals involved believe them to be SUDI deaths. There were total of 19 SUDI deaths in the 274 closed cases across Greater Manchester. Parents and carers continue to place children in situations where the chances of a child dying are significantly increased.

Advice regarding parental smoking and safe sleeping should continue to be a mantra for all services.
Providers should ensure that pathways are in place to support pregnant women, their partners and families to stop smoking and these should be audited annually for effectiveness.

Recommendation 3

There continues to be a disparity in the ethnicity of children in the overall population and those who die in childhood. It is not clear if this is linked to issues around depravation, numbers of children in different ethnic groups or some other reason. It was agreed by each LSCB in 2010/11 that work in this area should be undertaken. Some information indicates that ethnicity percentages may be different for the child population compared to the overall population. However, reasons for this disparity in white and BME deaths are at this time inconclusive.

The numbers involved are thankfully small. However, given that this has now been a recommendation in 3 consecutive annual reports it is proposed that the CDOP and Public Health should continue to work together in all areas, particularly around ethnicity.

Appendix 1

Data on deaths of children under 29 days.

	CDOP		G. Man	
Mothers Age	0-28 days	%	0-28 days	%
19 or under	3	7	11	10
20-24	8	17	21	19
25-29	11	24	33	29
30-34	13	28	29	26
35-39	9	20	17	15
40 or over	1	2	1	1
Not Known	1	2	0	0
Grand Total	46	100%	112	100%

CDOP Birth weights ranged from 320g to 4900g.
G. Man Birth weight ranged from 275g to 3450g

CDOP 23 (50%) of the 46 cases weighed under 1kg.
G. Man 55 (49%) of the 112 cases weighed under 1kg

CDOP Mothers BMI was recorded as overweight or obese in 20 (43%) of the 46 cases. 53 (62%) of cases did not record mothers BMI.
G. Man Mothers BMI was recorded as overweight or obese in 39 (35%) of the 112 cases

CDOP 26 males and 20 females.
G. Man 61 males and 51 females.

CDOP 25 (54%) were recorded as white, 21 (46%) were recorded as BME.
G. Man 66 (59%) were recorded as white. 38 (34%) were recorded as BME with 8 (7%) cases where no ethnicity was recorded

CDOP 22 (48%) recorded as extremely premature (less than 30 weeks) with 14 (30%)) recorded as premature.
G. Man 61(54%) recorded as extremely premature (less than 30 weeks) with 18 (16%) recorded as premature.

CDOP 11 (24%) were recorded as under 24 weeks gestation.
G. Man 30 (27%) were recorded as under 24 weeks gestation.

CDOP 10 (22%) recorded mother smoked during pregnancy. 32 (70%) recorded mother did not smoke with 4 not known.
7 (15%) recorded that father smoked. 17 (37%) recorded that father did not smoke. 22 (48%) did not record fathers smoking.
G. Man 24 (21%) recorded mother smoked during pregnancy. 79 (70%) recorded mother did not smoke with 9 not known.

CDOP 36 (78%) of the 46 neonatal cases notified in 2011/12 have been closed. Using the national Form C 21 (46%) are categorised as perinatal/neonatal events, 11 (24%) as chromosomal anomalies. There is 1 case recorded as SUDI.

G. Man 92 (82%) of the 112 neonatal cases notified in 2011/12 have been closed. Using the national Form C 58 (52%) are categorised as neonatal events and a further 30 (27%) as chromosomal anomalies. There are also 3 cases recorded as SUDI

CDOP 3 (7%) of the 46 cases had a record of domestic abuse involving parents.
G. Man 16 (14%) of the 112 cases had a record of domestic abuse involving parents.
There is no record of any case in the CDOP or Greater Manchester linking domestic abuse as a factor in a child death.

CDOP There were no Child Protection Plans in place for the 46 notifications in this CDOP. 2 CPP's were initiated as a result of the pregnancy.
G. Man 1 was in place for siblings and 2 were initiated as a result of the pregnancy.
CDOP did not identify any links to a CPP and notifications.

CDOP 4 (7%) cases were identified as having modifiable factors. These involved parental smoking, safe sleeping and 1 concealed pregnancy.
G. Man 13 (7%) cases were identified as having modifiable factors. The consistent features were around mothers BMI, smoking, alcohol abuse or substance misuse.

Deaths of children aged 28 – 365 days

Mothers Age	28-365 days	%	28-365 days	%
19 or under	3	21	6	10
20-24	2	14	15	25
25-29	3	21	13	21
30-34	5	37	15	25
35-39	1	7	9	15
40 or over	0	0	2	2.5
Not Known	0	0	1	1.5
Grand Total	14	100%	61	100%

CDOP Birth weights ranged from 572g to 3640g.
G. Man Birth weight ranged from 500g to 3670g

CDOP 2 (14%) of the 14 cases weighed under 1kg.
G. Man 17 (28%) of the 61 cases weighed under 1kg

CDOP Mothers BMI was recorded as overweight or obese in 3 (21%) of the 14 cases. 8 of the 14 cases did not record mothers BMI.
G. Man Mothers BMI was recorded as overweight or obese in 12 (20%) of the 61 cases. 36 (59%) of the cases did not record mothers BMI.

CDOP 9 males and 5 females.
G. Man 38 males and 23 females.

CDOP 5 (36%) were recorded as white, 9 (64%) BME.
G. Man 32 (52%) were recorded as white. 29 (48%) were recorded as BME with 1 case where no ethnicity was recorded

CDOP 3 (21%) recorded as extremely premature (less than 30 weeks) with 2 (14%) recorded as premature.
G. Man16 (26%) recorded as extremely premature (less than 30 weeks) with 10 (16%) recorded as premature.

CDOP. 1 (7%) was recorded as under 24 weeks gestation.
G. Man 4 (4%) were recorded as under 24 gestation.

CDOP 6 (43%) recorded mother smoked during pregnancy. 8 (57%) recorded mother did not smoke. 4 (29%) recorded that father smoked. 6 (42%) recorded that father did not smoke. 4 (29%) did not record if father smoked.
G. Man 17 (28%) recorded mother smoked during pregnancy. 32 (52%) recorded mother did not smoke with 12 (20%) not known.

CDOP 2 (14%) of the 14 cases had a record of domestic abuse involving the parents.
G. Man 18 (30%) of the 61 cases had a record of domestic abuse involving the parents.
None of the cases in the CDOP or Greater Manchester recorded Domestic Abuse as a factor in a child's death.

CDOP There was 1 Child Protection Plan initiated as a result of a pregnancy.
G. Man There was 1 previous Child Protection Plan in place for siblings.
CDOP did not identify any links to the CPP and the notification.

CDOP 9 (64%) of the 14 cases notified in 2011/12 have been closed. Using the National Form C of those closed 1 was classified as perinatal event, 5 as congenital anomalies and 3 SUDI cases.
G. Man 49 (80%) of the 61 cases notified in 2011/12 have been closed. Using the National Form C of those closed 13 have been classified as perinatal events, 23 as chromosomal anomalies, 9 as SUDI with the remainder comprised of malignancy, infection and trauma .

CDOP 3 (21%) cases were identified as having modifiable factors which related to mother smoking during pregnancy and alcohol misuse, co sleeping and overheating.
G. Man 13 (21%) of cases were identified as having modifiable factors. The common features were around mothers BMI, smoking, safe sleeping, alcohol abuse or substance misuse.

Combination of ages upto 365 days.

CDOP 16 (27%) mothers smoked during pregnancy or after the birth.
G. Man 30 (17%) mothers smoked during pregnancy or after the birth.

CDOP 23 (38%) mothers BMI classified as obese.
G. Man 30 (17%) mothers BMI classified as obese.

CDOP 23 (38%) cases recorded a gestation of less than 30 weeks.
G. Man 77 (45%) cases recorded a gestation of less than 30 weeks.

CDOP 6 (10%) cases recorded at least one incident of domestic abuse involving one or both parents. There was no evidence this was a factor in the death.
G. Man 34 (20%) cases recorded at least one incident of domestic abuse involving one or both parents. There was no evidence this was a factor in the death.

CDOP 7 (12%) cases recorded modifiable factors – safe sleeping and parental smoking.
G. Man 26 (15%) cases recorded modifiable factors – safe sleeping and parental smoking.