Annual Child Death Overview Report

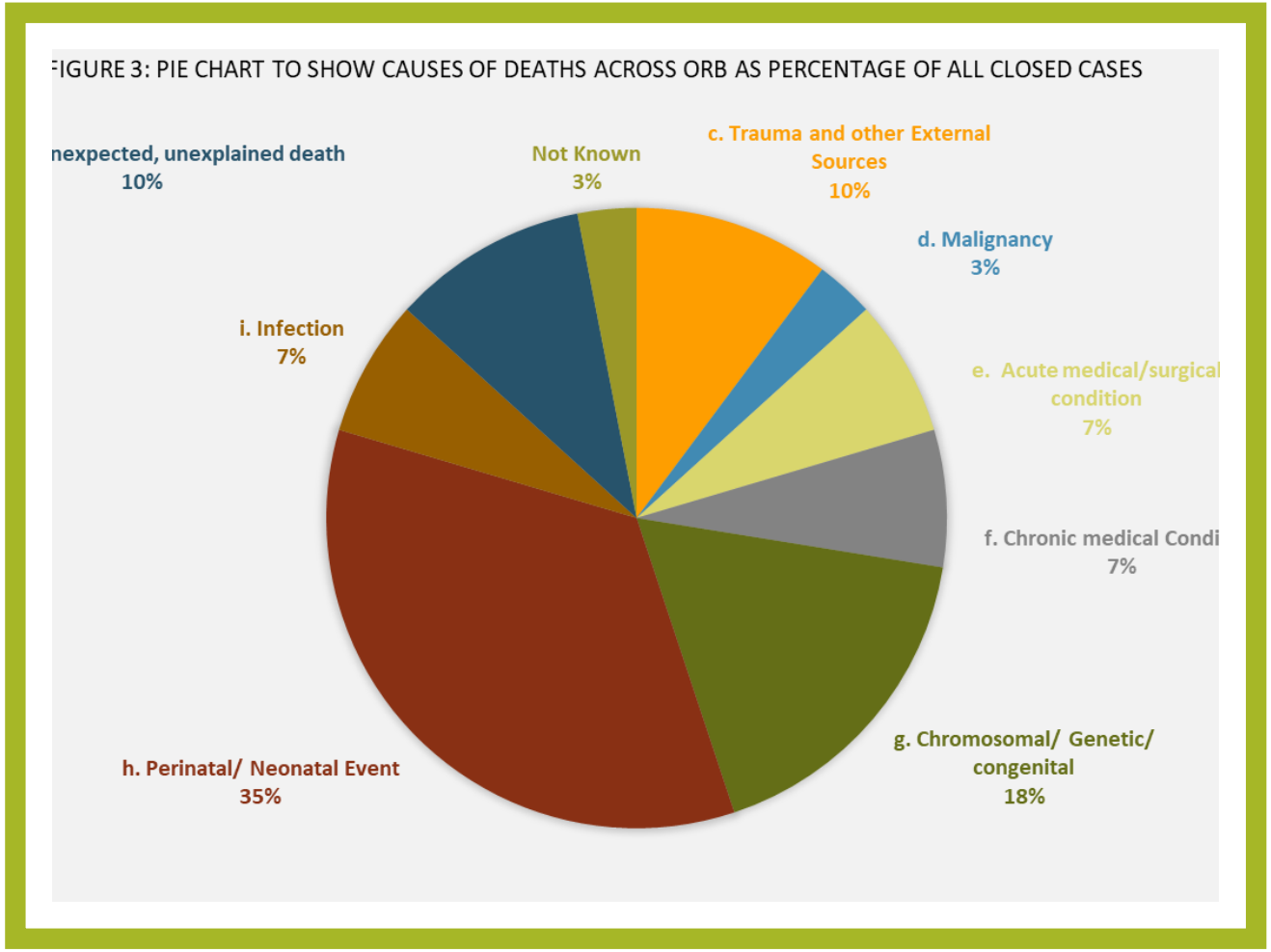
The Child Death Review Process

- All deaths of children and young people aged under 18 must be reviewed in a timely manner
  - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf
  - Initially Child Death Review Meetings must be held soon after death – usually led by the Acute Trust involving professionals
  - Following all other reviews and investigations, Child Death Overview Panels gather reports from services involved with the family to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified.

Oldham, Rochdale and Bury (ORB)

Method

- Oldham, Rochdale and Bury have a shared Child Death Overview Panel
- A review of the 29 closed cases in Oldham, Rochdale and Bury
- Data collected between 1st April 2019 -31st March 2020
- Analysis of:
  - CDOP process
  - General Demographics of closed cases
  - Modifiable Risk Factors
- Interventions



Report Findings

66% of closed cases were expected deaths

69% of closed cases occurred in a hospital setting

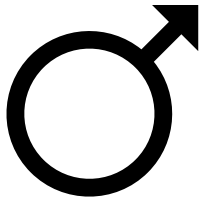
34% of closed cases occurred in the neonatal period

58% of closed cases occurred in the first year of life

Themes both Locally and Nationally

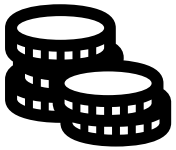
Prematurity

76% of child deaths under the age of 1 were born premature



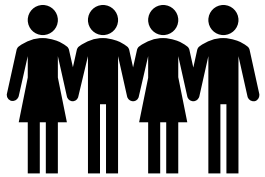
Gender

62% of closed cases were male



Deprivation

31% of closed cases were in the most deprived decile of the population



Ethnicity

Rochdale and Oldham have higher rates of closed cases in children of BAME ethnicity

Modifiable Risk Factors

Maternal Obesity

- Modifiable risk factor in 18% of closed cases under 1 year
- Intervention: Family centred health improvement and weight management service

Maternal Smoking

- Maternal smoking during pregnancy identified in 10% of cases
- Intervention: Baby clear, midwife led smoking cessation service

Risk Factors for Sudden, unexpected deaths in infants

- Risk factors include: Unsafe sleeping, parental smoking, drugs and alcohol
- Interventions: Safe sleeping advice, Risk Assessments, Lullaby Trust

Recommendations

- Consider other factors such as maternal age and breastfeeding
- Ensure data is recorded for unbooked pregnancy and concealed pregnancy
- Recognise the maternal obesity is a growing concern, and ensure that is recorded in child deaths under 1 year
- Acknowledge and address that children living in deprived neighbourhoods or of BME ethnicity are over-represented in child deaths
- Disseminate this report to the relevant departments within the health and wellbeing partnership to ensure shared learning

Greater Manchester CDOP Annual Report

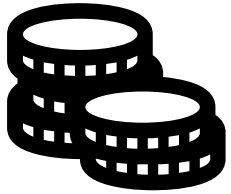
Greater Manchester CDOP Findings

- During 2019/20, there were 129 child death cases reviewed by GM CDOPs and 240 child death notifications
  - Bury, Rochdale & Oldham CDOP
  - Bolton, Salford & Wigan CDOP
  - Stockport, Trafford & Tameside CDOP
  - Manchester CDOP
- Reduction in number of cases reviewed across all CDOPs – mainly due to change in child death review process
- Potentially modifiable factors were identified in 40% of all closed cases

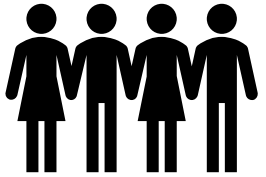
GM Findings - demographics

Age
64% of closed cases were in babies under the age of one

Cause
72% of closed cases were attributed to medical causes

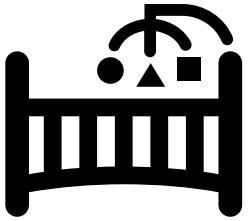


Deprivation
55% of the reviewed cases lived in the most deprived 20% of the population



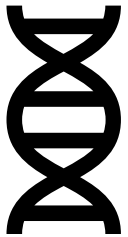
Ethnicity
There were higher rates of reviewed cases in children of BAME ethnicity

GM Findings – modifiable factors



Unsafe sleeping
in sudden and unexpected deaths in infants

Maternal obesity in pregnancy
in perinatal/ neonatal deaths



Consanguinity
In deaths related to chromosomal, genetic and congenital anomalies

Smoking
Smoking was identified as a modifiable factor in 10% of all cases closed

Recommendations

1. Local areas use the information on BAME communities being disproportionately represented, along with other local information, to inform work to address health inequalities
2. Continue to focus on smoking cessation in pregnant women
3. GM local authorities need to reduce levels of obesity throughout the population including women
4. GM CDOP Chairs to commission a 5 year GM CDOP analysis of cases
5. Local areas to consider real time data on suicides to inform more timely responses
6. Implement an electronic CDOP reporting system to improve the process

National Child Mortality Database Report (NCMD)

Key Findings

- The NCMD launched on 1 April 2019 and collates data collected by CDOPs in England. This is the first annual report.
- The NCMD received 3,347 child death notifications from CDOPs in England where the child died between 1 April 2019 and 31 March 2020.
- Decrease in the numbers of cases reviewed and closed nationally
- “Perinatal/neonatal event”, and “Chromosomal, genetic and congenital anomalies” combined represent over half (56%) of reviews completed. For 63% of deaths reviewed the child was aged under 1
- 31% of these reviews identified one or more modifiable factors
- Sudden, unexpected and unexplained deaths, deliberate injuries and trauma had the most modifiable factors identified