

BURY, ROCHDALE & OLDHAM Child Death Overview Panel



Annual Report

April 2014 – March 2015

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Section A: Introduction

The Bury, Rochdale and Oldham Child Death Overview Panel (CDOP) would like to welcome you to the seventh annual report, which reviews cases referred to the panel between 1 April 2014 and 31 March 2015.

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.

The Bury, Rochdale and Oldham CDOP is 1 of 4 CDOPs in Greater Manchester which are split into the Coroner's jurisdiction:

Manchester North	Bury, Rochdale and Oldham CDOP
Manchester South	Tameside, Trafford and Stockport CDOP
Manchester West	Bolton, Salford and Wigan CDOP
Manchester City	Manchester CDOP

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

In 2010 the Greater Manchester Child Death Database was implemented across the four CDOPs and continues to be populated by the CDOP Officers with information for each child death notification received. The database contains information regarding all deaths referred to the panel and is an extremely useful tool when extracting data to support the annual report and information requests from the DfE.

The CDOP continues to distribute information to parents via the Register Office. Registrars across Greater Manchester have agreed to distribute The Lullaby Trust leaflet '[The Child Death Review: A Guide for Parents and Carers](#)' to parents when registering a child death to ensure information is provided at an appropriate time. If parents have any queries they can put these in writing to the CDOP to request further information regarding the process. The Lullaby Trust (formally known as The Foundation for the Study of Infant Deaths, FSID) has recently revised the leaflet which will be continued to be distributed by the Registrar.

A Summary of the Key Findings

The report analyses the total number of child deaths reported to the CDOP between 1st April 2014 to 31st March 2015 and breaks these figures down into each borough to identify key themes locally.

- Since the CDOP was established on 1 April 2008 to 31 March 2015 there have been a total of 466 child death notifications reported to panel.
- Between 1 April 2014 and 31 March 2015 the CDOP received a total of 57 child death notifications.
- With 25 of the 57 child deaths, Oldham received the largest number of notifications totalling 44%. Of the 3 boroughs joint child population (149,281) Oldham has the largest child population (56,557) totalling 38%.
- Of the 81 cases closed 20 (25%) were categorised as having modifiable factors and 61 (75%) categorised as having no modifiable factors.
- Of the 20 modifiable cases the largest number of deaths were categorised as sudden unexpected, unexplained death (5 / 25%) and trauma and other external factors (5/25%) where a number of the children were involved in a road traffic collision, either as the driver of the vehicle or as a pedestrian. A number of the trauma and other external factors deaths also found that underage drinking had occurred whereby the consumption of alcohol and the use of illegal substances contributed to the death.
- Modifiable factors identified in perinatal/neonatal deaths included smoking during pregnancy, Mother not booking the pregnancy and as a result no antenatal care received.
- All three of the local authorities found the highest number of deaths occurred in neonates (deaths within 28 days of life) with a joint total of 47% of the overall deaths. Another large proportion of the deaths occurred in children aged 29 - 365 days, calculating 16%. If we combine the two categories this would indicate that 63% (36) of the 57 child deaths occurred within the first year of life.
- Of the 57 child death notifications 31 (54%) of these were male and 26 (46%) were female. The joint CDOP child population highlights a slightly higher percentage of males (51%) in comparison to females (49%).
- 29 (51%) of the 57 child deaths were of White English/Welsh/Scottish/N Irish/British ethnicity and 28 (49%) were from the Black Minority Ethnic (BME) community.
- Of the 28 BME child deaths across Bury, Rochdale and Oldham, 16 (28%) of these were of Pakistani heritage making this ethnic group the most prevalent within the BME deaths.
- Of the 28 BME deaths, consanguinity was relevant and directly linked to a number of deaths (less than 5). Of the 28 BME deaths, consanguinity was relevant and directly linked to 14% of the BME child deaths. These children lived in the areas of Rochdale and Oldham.
- Rochdale and Oldham have a much larger percentage of child deaths from the Pakistani community in comparison to Bury. This is expected as Rochdale (8,268) and Oldham (8,983) have more than double the Pakistani child population in comparison to Bury (3,442).
- Deaths directly linked to parents being first cousins making up 7% of the total deaths, all of which were of Pakistani heritage.
- Statistics from the Children with Disabilities Team highlighted a disproportionate number of children from the BME community known to the service in comparison to the BME child population. A common theme across the three local authorities is that children with disabilities of Pakistani heritage are the most prevalent ethnic group within the BME community. The figures suggest that there is a link between consanguinity and children with disabilities given that consanguineous relationship and cousin marriage is mostly practiced within the Pakistani community.
- Of the 57 child deaths the largest number of deaths occurred where the child/family resided in areas of deprivation (quintile 1 and 2) totalling 75% (43) of the total deaths. Of the 43 child deaths in quintile 1 and 2 a large percentage of the deaths occurred in neonates (17 / 40%).
- Co-sleeping on a sofa or in a parental bed was identified in a number of SUDI cases. There was various risk factors documented such as overheating, overlay and sleeping with multiple parents/carers and siblings in the same bed/sofa.

Section B: Functions of the Child Death Overview Panel (CDOP)

2. Roles & Responsibilities of the Child Death Overview

The Child Death Overview Panel (CDOP) operates in line with the [Chapter 5: Child Death Reviews of Working Together 2015](#)

The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

- a) collecting and analysing information about each death with a view to identifying -
 - (i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);
 - (ii) any matters of concern affecting the safety and welfare of children in the area of the authority;
 - (iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
- (b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

The functions of the CDOP include:

- reviewing all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
- discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
- determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- identifying patterns or trends in local data and reporting these to the LSCB;
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required;
- agreeing local procedures for responding to unexpected deaths of children; and
- cooperating with regional and national initiatives – for example, with the National Clinical Outcome Review Programme – to identify lessons on the prevention of child deaths.

In reviewing the death of each child, the CDOP should consider modifiable factors, for example, in the family 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.

The aggregated findings from all child deaths should inform local strategic planning, including the local Joint Strategic Needs Assessment, on how to best safeguard and promote the welfare of children in the area. Each CDOP should prepare an annual report of relevant information for the LSCB. This information should in turn inform the LSCB annual report.

3. Panel Membership

The Child Death Overview Panel (CDOP) membership is made up of multi-agency professionals from across the three local

Name	Position	Organisation	Representing the Local Authority
Andrea Fallon	CDOP Chair, Consultant in Public Health	Public Health	Oldham
Mike Bridges	Deputy CDOP Chair, Public Health Specialist	Public Health	Oldham
Abdul Rehman	SUDI Paediatrician	Pennine Acute Hospitals	Bury, Rochdale & Oldham
Alison Kelly	Named Nurse for Safeguarding Children & Adults	HMR Community Services	Rochdale
Amanda Smith	Child Safeguarding Lead	Pennine Care (Mental Health)	Bury, Rochdale & Oldham
Chris Howard	Paediatrician	Pennine Care	Oldham
David Devane	Safeguarding Lead for Education	Education	Oldham
Hazel Chamberlain	Designated Nurse - Children's Safeguarding	NHS Rochdale Clinical Commissioning Group	Rochdale
Laurene Mannix/Kim Gaskell	Named Nurse - Safeguarding Children	Pennine Acute Trust	Bury, Rochdale & Oldham
Maxine Lomax	Designated Nurse for Safeguarding (Children and Adults)	NHS Bury Clinical Commissioning Group (CCG)	Bury
Rob Rifkin	Designated Doctor for Safeguarding Children	Bury CCG and HMR CCG	Bury & Rochdale
Sandra Bruce	Children's Service Manager (Safeguarding Unit)	Social Care	Rochdale
Kirsty Leyden / Nicky Porter	Detective Sergeants	Greater Manchester Police	Bury, Rochdale & Oldham

4. Panel Attendance

The below table provides a summary of the 2014/15 attendance of panel members.



In attendance



No longer a CDOP member



Apologies or did not attend

Name	Organisation	September 2014	October 2014	February 2015
Andrea Fallon	Chair (Oldham Public Health)	✓	✓	A
Mike Bridges	Deputy Chair (Oldham Public Health)			✓
Abdul Rehman	SUDC Paediatrican	✓	✓	✓
Alison Kelly	Pennine Community Service	✓	A	
Amanda Smith	Pennine Care (Mental Health)	A	✓	
Chris Howard	Oldham, Pennine Care	✓	✓	✓
Clare Kelly	Pennine Care (Mental Health)			A
David Devane	Oldham, Education	✓	✓	✓
Hazel Chamberlain	Rochdale, Clinical Commissioning Group	✓		
Kim Gaskell	Pennine Acute Hospitals			A
Kirsty Leyden	Greater Manchester Police	✓	A	A
Laurene Mannix	Pennine Acute Hospitals	✓	✓	
Maxine Lomax	Bury, Clinical Commissioning Group	PM Only	✓	✓
Nicky Porter	Greater Manchester Police			✓
Rob Rifkin	HMR & Bury CCG	✓	✓	✓
Sandra Bruce	Rochdale, Social Care	A	A	A
Stephanie Davern	CDOP Officer	✓	✓	✓
Guests/Attendees on behalf of an absent panel member				
Claire Smith	Observer			✓
Donna Green	On behalf of Maxine Lomax	AM Only		
Eileen Mills	On behalf of Alison Kelly		✓	
Leila Dilamy	Observer	✓		
Lydia Bowden	Observer			✓
Tony Philbin	On behalf of Sandra Bruce	✓		✓

The position of the CDOP Officer was vacant for four months which led to the cancellation of a number of panel meetings.

Section C: Analysis

5. 2014/2015 Child Death Notifications to CDOP

From the 1 April 2014 to 31 March 2015 the CDOP received a total of 57 child death notifications aged 0 – 17 years of age.

Bury	10	17 %
Rochdale	22	39 %
Oldham	25	44 %
Total	57	

Child Death Rate per 10,000

Using the 2011 Census to review the child population and comparing this to the number of child deaths reported to CDOP in 2014/2015 highlights the number of child deaths per 10,000 children. Of the 3 areas Bury has the fewest number of child deaths per 10,000 which is anticipated as the borough is defined as an affluent local authority and has the smallest child population of the 3 boroughs.

	Child Deaths	Child Population	Rate per 10,000
Bury	10	41,952	2.38
Rochdale	22	50,772	4.33
Oldham	25	56,557	4.42
Greater Manchester	239	601,624	3.97

In comparison to the child population the number of deaths reported is a small percentage of the overall the child population:

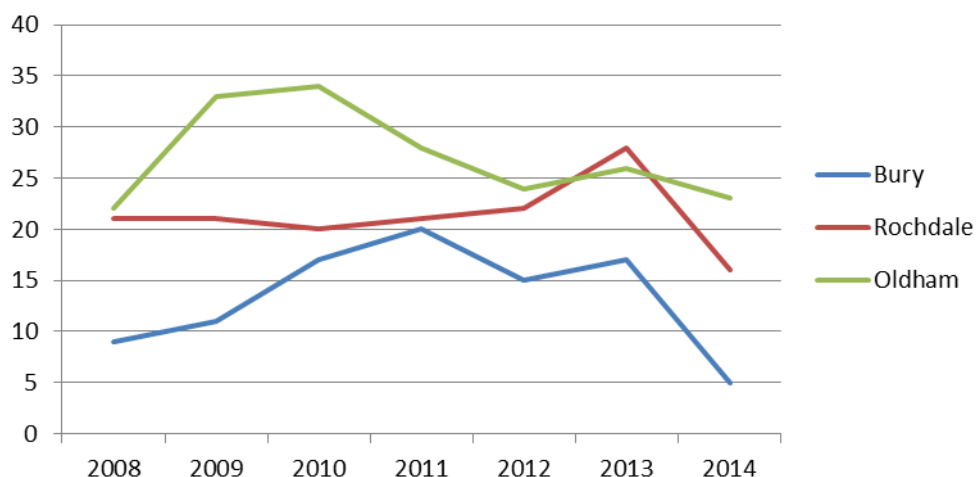
Bury	0.02 %
Rochdale	0.04 %
Oldham	0.04 %
Greater Manchester	0.04 %

Since the CDOP was established on 1 April 2008 to the 31 March 2015 there have been a total of 466 child death notifications reported to panel. The below table provides a breakdown of year on year data based on the year the death was notified to the CDOP.

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	Total
Bury	5	15	18	21	16	19	10	104
Rochdale	17	24	19	26	27	22	22	157
Oldham	23	27	37	36	22	33	25	203
Total	45	66	75	84	65	74	57	466

6. Data by Childs Year of Death

Each year the CDOP bases the Annual Report data set on the number of child deaths referred to the CDOP from 01 April to 31 March. The data below shows the number of child deaths categorised by the year the death occurred. These figures may change slightly if in future the panel receives a late notification from previous years. The data for 2015 will be included in the 2015/2016 CDOP Annual Report.



	Bury	Rochdale	Oldham	Total
2008	9	21	22	52
2009	11	21	33	65
2010	17	20	34	71
2011	20	21	28	69
2012	15	22	24	61
2013	17	28	26	71
2014	5	16	23	44
Total	94	149	190	433

The above statistics indicate the largest number of child deaths occurred in 2010 and 2013 whilst the fewest number of child deaths occurred in 2014. There was initially a discussion amongst CDOPs regarding notifications of infant deaths under 24 weeks gestation, until the Department of Education revised Working Together to Safeguard Children in 2010 to state that CDOPS are to discuss 'all child deaths up to the age of 18 years (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law)'.

Excluding 2013, Oldham has been the local authority with the largest number of child deaths year on year and has the largest child population of the three local authorities. Of the three boroughs Bury continues to have the lowest number of child deaths year on year and has smallest child population of the three local authorities.

From January 2015 to March 2015 there have been 13 child death notifications. Data for the total number of deaths which occurred in 2015 continues to be collated and will be provided in the 2015/16 Annual Report.

7. Cases Closed Between 1 April 2014 - 31 March 2015

From 1 April 2014 to 31 March 2015 the CDOP discussed and closed a total of 81 cases.

Bury	17	21 %
Rochdale	28	35 %
Oldham	36	44 %
Total	81	

Of the 81 cases closed 24 (30%) were notified to the CDOP in 2014/2015 and the remaining 57 (70%) cases were referred prior to 1 April 2014. A number of these cases were subject to investigations (such as Post Mortem Examination, Inquests, Police Investigation, Serious Case Reviews, Internal Review etc.) thus prolonging the discussion and closure of the cases.

Year Referred to CDOP	
2009/2010	1
2010/2011	1
2011/2012	1
2012/2013	8
2013/2014	46
2014/2015	24

As the Annual Report bases its data set on the number of notifications received, in-depth analysis for the 57 cases referred prior to 1 April 2014 is detailed in previous annual reports. Of the 57 cases referred to the CDOP between 1 April 2014 to 31 March 2015, 24 (42%) of these were closed within the same year and 33 (58%) remain open for discussion.

Under the revised Rule 8 of the Coroners (Inquest) Rules 2013, Coroners are now required to complete an inquest within 6 months of the date on which the Coroner is made aware of the death, or as soon as is reasonably practicable. The change in legislation will significantly reduce the length of time between the date of notification and date closed for cases subject to post mortem examination and/or inquisition.

Time Taken for Completion & Closure of Cases

Of the 81 cases closed between 1 April 2014 and 31 March 2015 a large proportion of the cases were closed over 1 year after the date of notification. The majority of these cases were subject to some form of investigation such as post mortem, inquest, police investigation/CPS prosecution, serious case review, internal review etc. The CDOP does not review any death which is subject to investigation until these have concluded and reports are submitted to panel. This is to ensure that CDOP members have the appropriate level of information to categorise the death and identify any modifiable factors which may have contributed to the death.

Time taken to Close Cases		
Under 6 months	16	20 %
6 to 7 months	12	15%
8 to 9 months	19	23 %
10 to 11 months	10	12 %
12 months	2	3 %

Over 1 year	22	27 %
Total	81	

Categorisation of Cases

Once the CDOP has discussed a case and are in agreement that sufficient information has been collated, a Form C Analysis Profroma is completed by multi-agency professionals. The Department for Education national templates assist the panel to review the circumstances leading to death and identify any emerging trends.

The Department for Education requires CDOPs to allocate each child death under one of the following categories:

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 inflicted 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).

This classification is hierarchical: where more than one category could reasonably be applied, the highest up the list is marked.

Categorisation of Death	Bury	Rochdale	Oldham	Total	
Chromosomal, genetic and congenital anomalies	6	8	12	26	32 %
Perinatal/neonatal event	5	9	10	24	30 %
Sudden unexpected, unexplained death	<5	<5	<5	7	9 %
Trauma and other external factors	0	<5	5	6	7 %
Acute medical or surgical condition	<5	<5	<5	5	6 %
Infection	<5	<5	<5	5	6 %
Malignancy	<5	<5	<5	<5	5 %
Suicide or deliberate self-inflicted harm	0	<5	<5	<5	2 %
Chronic medical condition	0	<5	0	<5	1 %
Deliberately inflicted injury, abuse or neglect	0	0	<5	<5	1 %
Total	17	28	36	81	100

The largest number of deaths occurred in the category chromosomal, genetic and congenital anomalies with 26 (32%) of the 81 cases closed. Of the 26 deaths, consanguineous relationships was noted to be a contributing factor in 8 (31%) of the deaths.

Another large number of deaths were categorised as perinatal/neonatal with 26 (32%) of the 81 cases. Of the 26 perinatal/neonatal deaths 21 (81%) were born prematurely (<37 weeks gestation).

Categorisation of Preventability

For each case discussed and closed the CDOP professionals will determine the categorisation of preventability. In line with the Department for Education, the CDOP must categorise the case under one of the following:

1. Modifiable factors identified

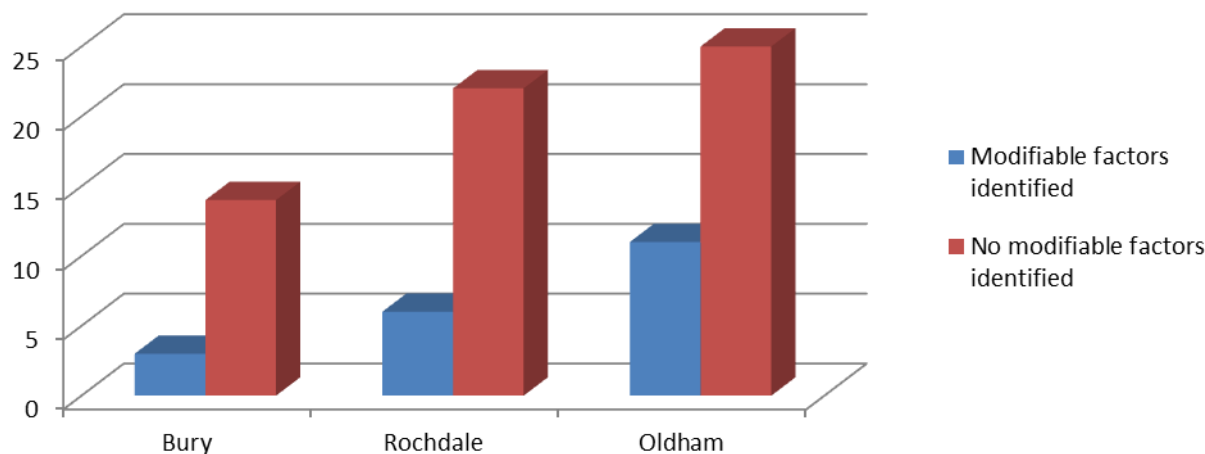
The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths

2. No Modifiable factors identified

The panel have not identified any potentially modifiable factors in relation to this death

3. Inadequate information upon which to make a judgement

NB this category should be used very rarely indeed.



	Modifiable factors identified		No modifiable factors identified	
Bury	<5	18 %	14	82 %
Rochdale	6	21 %	22	79 %
Oldham	11	31 %	25	39 %
Total	20	25 %	61	75 %

Of the 81 cases closed between 1 April 2014 and 31 March 2015 the panel identified modifiable factors in 20 (25%) of the deaths. The remaining 61 (75%) cases were categorised as having no modifiable factors.

Modifiable Factors and the category of death	Modifiable factors identified	
Trauma and other external factors	5	25 %
Sudden unexpected, unexplained death	5	25 %
Perinatal/neonatal event	<5	15 %
Chromosomal, genetic and congenital anomalies	<5	10 %
Acute medical or surgical condition	<5	10 %
Suicide or deliberate self-harm	<5	10 %
Deliberately inflicted injury, abuse or neglect	<5	5 %
Total	20	100 %

Of the 20 cases with modifiable factors the largest number of deaths were categorised as trauma/other external factors (5/25%) and sudden unexpected, unexplained death (5/25%). A number of the children were involved in a road traffic collision, either as the driver of the vehicle or as a pedestrian. A number of these deaths also found that underage drinking had occurred whereby the consumption of alcohol and the use of illegal substances contributed to the death.

Of the 5 sudden unexpected, unexplained deaths there were a number of contributing risk factors which panel members deemed as being modifiable:

- Co-sleeping in bed
- Co-sleeping on a sofa
- Family history of co-sleeping
- Overheating
- Alcohol consumption on the night of the death
- Parent/carer of child presented as intoxicated to professionals
- Maternal smoking during pregnancy
- Parental smoking and/or smoking within the family home
- Prone sleeping
- Parent/carer taking prescribed medication

8. Child Population across the Local Authorities

The below table provides information from the Office of National Statistics (ONS) 2011 Census, providing a breakdown of age across the child population for children aged 0 – 17 years.

Age		England	North West	Greater Manchester	Bury	Rochdale	Oldham	CDOP Total
Infants, Children & Young People	Age 0 to 4	3,318,449	432,091	181,245	12,235	14,754	16,491	43,480
	Age 5 to 9	2,972,632	392,166	158,523	11,108	13,148	15,422	39,678
	Age 10 to 14	3,080,929	412,407	160,304	11,361	13,925	15,337	40,623
	Age 15 to 17	1,964,950	265,375	101,552	7,248	8,945	9,307	25,500
Total		11,336,960	1,502,039	601,624	41,952	50,772	56,557	149,281
Adults	Age 18 to 19	1,375,315	191,462	74,759	4,297	5,480	5,749	-
	Age 20 to 24	3,595,321	489,640	203,899	10,688	14,005	14,586	-
	Age 25 to 29	3,650,881	466,582	200,933	11,622	14,111	15,177	-
	Age 30 to 44	10,944,271	1,394,536	560,081	37,977	42,914	44,945	-
	Age 45 to 59	10,276,902	1,397,119	500,860	37,272	41,147	42,055	-
	Age 60 to 64	3,172,277	439,644	150,623	11,712	12,454	12,875	-
	Age 65 to 74	4,552,283	627,742	211,280	16,292	16,642	18,280	-
	Age 75 to 84	2,928,118	394,596	129,230	9,623	10,367	10,465	-
	Age 85 to 89	776,311	99,316	32,995	2,397	2,632	2,760	-
Age 90 & over	403,817	49,501	16,244	1,228	1,175	1,448	-	
Total Population		53,012,456	7,052,177	2,682,528	185,060	211,699	224,897	621,656

The ONS data shows the total child population across the three local authorities as 149,281, with the highest number of children being aged 0 - 4 years at 29.1%.

Age 0 to 4	43,480	29.1 %
Age 5 to 9	39,678	26.6 %
Age 10 to 14	40,623	27.2 %
Age 15 to 17	25,500	17.1 %
Total	149,281	

The 2011 Census data compiled by the Office of National Statistics shows that Bury, Rochdale and Oldham have a combined population of 621,656 of which 149,281 (24%) are children under 18 years of age. Of the three local authorities Oldham has the largest percentage of children in its area.

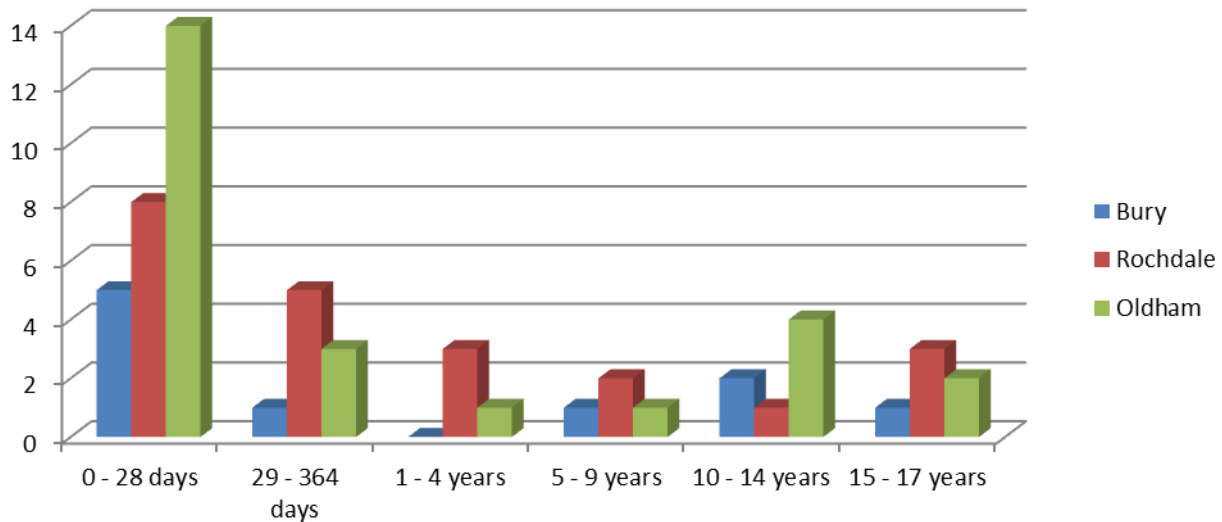
	Total Population	Child Population	
Bury	185,060	41,952	22.7 %
Rochdale	211,699	50,772	24.0 %
Oldham	224,897	56,557	25.1 %
Total	621,656	149,281	24 %

When comparing the 2001 Census and the 2011 Census there has been an increase in the total population across Bury, Rochdale and Oldham by 3.1 % from 603,226 to 621,656. Whilst the total population (all ages) has increased, the child population (0 – 17 years) has decreased by 2.2 % from 152,695 to 149,281. Of the three local authority's only Oldham saw a slight increase in child population of 0.7 % from 56,181 to 56,557.

	2001 Population		2011 Population	
	Child Population	Total Population	Child Population	Total Population
Bury	43,750	180,604	41,952	185,060
Rochdale	52,764	205,360	50,772	211,699
Oldham	56,181	217,262	56,557	224,897
Total	152,695	603,226	149,281	621,656

9. Childs Age at Death

The below graph contains information of the 57 child deaths referred to panel from the 1 April 2014 to the 31 March 2015 and provides an overview of the child's age at death.



Age at Death	Bury	Rochdale	Oldham	Total	
0 - 28 days	5	8	14	27	47 %
29 - 364 days	<5	5	<5	9	16 %
1 - 4 years	0	<5	<5	<5	7 %
5 - 9 years	<5	<5	<5	<5	7 %
10 - 14 years	<5	<5	<5	7	12 %
15 - 17 years	<5	<5	<5	6	11 %
Total	10	22	25	57	100 %

All three of the local authorities found the highest number of deaths occurred in neonates (deaths within 28 days of life) with a joint total of 47% (27) of the overall deaths. Another proportion of the deaths occurred in children aged 29 - 365 days, calculating 16% (9). If we combine the two categories this would indicate that 36 (63%) of the 57 child deaths occurred within the first year of life highlighting children under the age of 1 as the most vulnerable.

0 - 28 days	27	47 %
29 - 364 days	9	16 %
1 - 4 years	4	7 %
5 - 9 years	4	7 %
10 - 14 years	7	12 %
15 - 17 years	6	11 %

Of the total 466 child death notifications from 1 April 2008 to 31 March 2015, neonatal deaths make up 43% (202) and children who died between 29 - 365 days make up 21% (100) of the total deaths, thus highlighting that the majority of child deaths occurred within the first year of life (302, 65%).

Collating joint data based on the child's year of death and comparing this year on year highlights that babies under the age of 1 are those most at risk of reduced infant mortality. These figures may change slightly if in future the panel receives a late notification from previous years. The data for 2015 will be included in the 2015/2016 CDOP Annual Report.

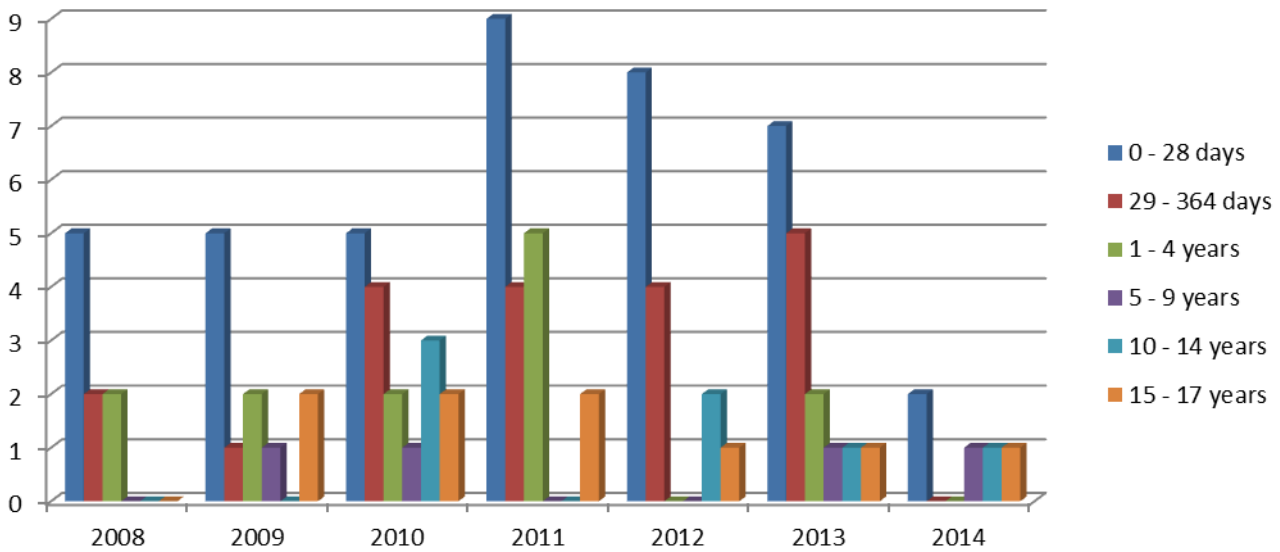
Age by Year of Death	2008	2009	2010	2011	2012	2013	2014	Total	
0 - 28 days	20	31	26	33	29	26	22	187	43 %
29 - 364 days	16	12	15	12	15	19	5	94	22 %
1 - 4 years	10	11	10	9	6	10	<5	59	14 %
5 - 9 years	0	<5	<5	<5	<5	7	<5	22	5 %
10 - 14 years	<5	<5	7	5	5	8	5	37	9 %
15 - 17 years	<5	<5	10	7	<5	<5	5	34	8 %
Total	52	65	71	69	61	72	44	434	100

Year on year the highest number of child deaths fall amongst children under the age of 1 as shown below:

2008	36	69%
2009	43	66%
2010	41	57%
2011	45	65%
2012	44	72%
2013	45	62%
2014	27	61 %

Breaking down the data into the three local authorities provides a detailed overview of the number of deaths in each age group across the boroughs. This data is based on the child's year of death.

Bury



	2008	2009	2010	2011	2012	2013	2014	Total	
0 - 28 days	5	5	5	9	8	7	<5	41	44 %
29 - 364 days	<5	<5	<5	<5	<5	5	0	20	21 %
1 - 4 years	<5	<5	<5	5	0	<5	0	13	14 %
5 - 9 years	0	<5	<5	0	0	<5	<5	<5	4 %
10 - 14 years	0	0	<5	0	<5	<5	<5	7	7 %
15 - 17 years	0	<5	<5	<5	<5	<5	<5	9	10 %
Total	9	11	17	20	15	17	5	94	100 %

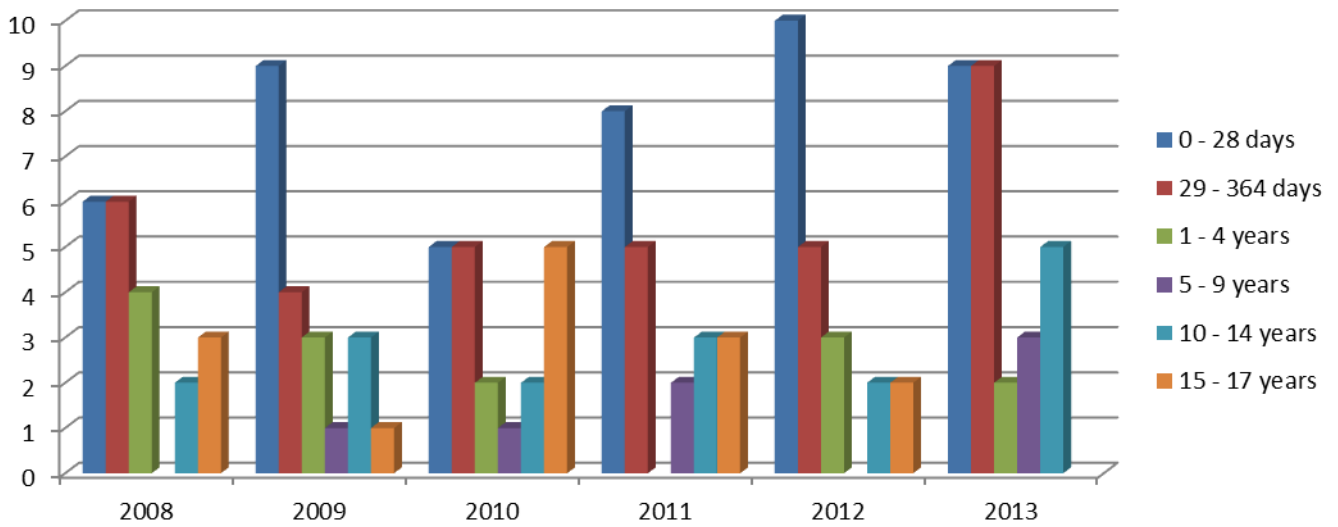
The largest number of child deaths in Bury occurred in children under the age of 1 totalling 61 (65%) of the 94 deaths. Of the 61 deaths under 1, 41 (44%) of these were neonatal deaths and 20 (21%) died between 28 - 365 days of life. Another vulnerable age group was identified in children aged 1 - 4 years with 13 (14%) of the 94 cases.

Of the three local authorities Bury has the least number of child deaths. From viewing year in year statistics there has been no drastic increase/decrease in specific age groups. Due to figures being so small an increase in 1 death can be viewed as a much larger percentage but remains insignificant.

The ¹Index of Multiple Deprivation (2010) score gave the local authority a national rank order of 119th most-deprived district out of 326 in England (1 being the most deprived). It would appear that there is an emerging link between the numbers of deaths where children lived within areas of deprivation. Of the three local authorities Bury is the most affluent borough and has much smaller pockets of deprivation in comparison to Rochdale and Oldham. Whilst Bury has the smallest child population (41,952) of the three local authorities, we can assume that a low level of deprivation is one of the reasons why Bury has a smaller number of child deaths in comparison to Oldham and Rochdale.

¹ ¹Department for Communities and Local Government <http://opendatacommunities.org/data/societal-wellbeing/deprivation/imd-rank-la-2010>
The dataset contains a summary measure of the Index of Multiple Deprivation 2010 at local authority district level. It puts the 326 Local Authority Districts into a rank order based the population weighted average rank of all LSOAs in the LAD. A rank of 1 is the most deprived.

Rochdale



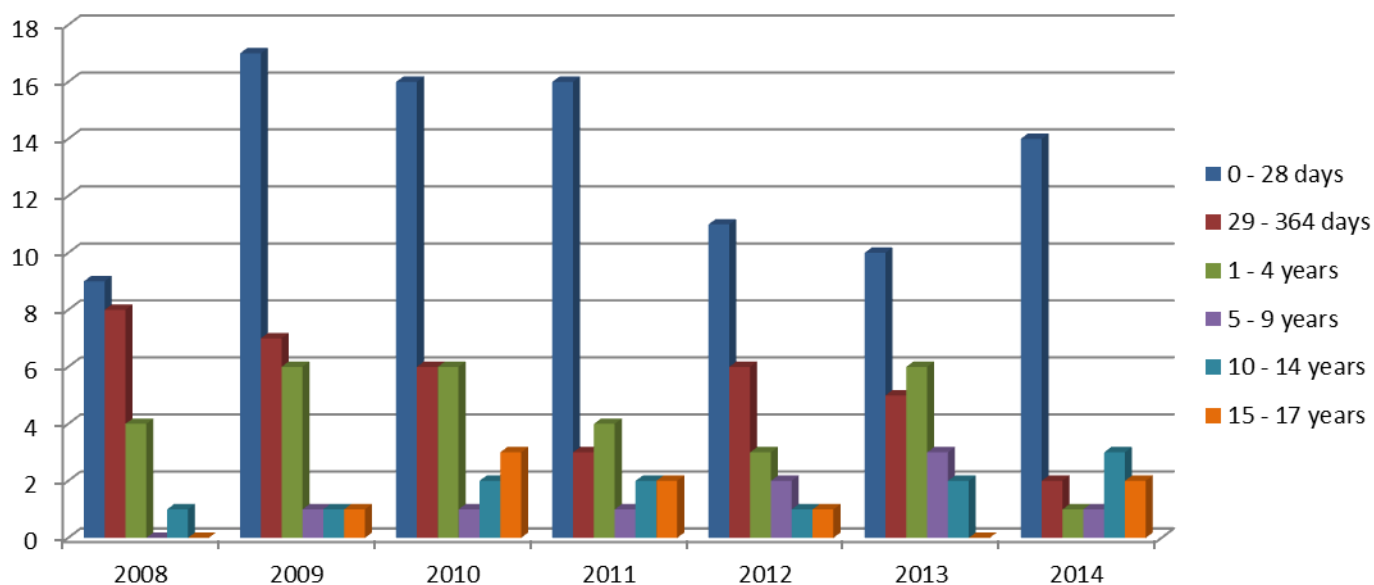
	2008	2009	2010	2011	2012	2013	2014	Total	
0 - 28 days	6	9	5	8	10	9	6	53	36 %
29 - 364 days	6	<5	5	5	5	9	<5	37	25 %
1 - 4 years	<5	<5	<5	0	<5	<5	<5	16	11 %
5 - 9 years	0	<5	<5	<5	0	<5	<5	9	6 %
10 - 14 years	<5	<5	<5	<5	<5	5	<5	18	12 %
15 - 17 years	<5	<5	5	<5	<5	0	<5	16	11 %
Total	21	21	20	21	22	28	16	149	100 %

The largest number of child deaths in Rochdale occurred in children under the age of 1 totalling 90 (61%) of the 149 deaths. Of the 90 deaths under 1, 53 (36%) of these were neonatal deaths and 37 (25%) died between 28 - 365 days of life.

Rochdale has had slightly more child deaths aged 10 – 14 years (18/12%) in comparison to Bury and Oldham. Of the total 18 deaths in children aged 10-14 years, the largest number of deaths occurred due to life limiting conditions.

The Index of Multiple Deprivation (2010) score gave the local authority a national rank order of 29th most-deprived district out of 326 in England (1 being the most deprived). Of the 3 boroughs Rochdale is the most deprived local authority and demonstrates a link between the numbers of deaths where children lived within areas of deprivation.

Oldham



	2008	2009	2010	2011	2012	2013	2014	Total	
0 - 28 days	9	17	16	16	11	10	14	93	49 %
29 - 364 days	8	7	6	<5	6	5	<5	37	19 %
1 - 4 years	<5	6	6	<5	<5	6	<5	30	16 %
5 - 9 years	0	<5	<5	<5	<5	<5	<5	9	5 %
10 - 14 years	<5	<5	<5	<5	<5	<5	<5	12	6 %
15 - 17 years	0	<5	<5	<5	<5	0	<5	9	5 %
Total	22	33	34	28	24	26	23	190	100 %

The largest number of child deaths in Oldham occurred in children under the age of 1 totalling 130 (68%) of the 190 deaths. Of the 130 deaths under 1, 93 (49%) of these were neonatal deaths and 37 (19%) died between 28 -365 days of life.

Of the 3 boroughs Oldham has the largest child population (56,557/25%) and has received the most child death notifications in total. There appears to be no significant increase/decrease in figures year on year in any particular age group.

The Index of Multiple Deprivation (2010) score gave the local authority a national rank order of 46th most-deprived district out of 326 in England (1 being the most deprived). As Oldham has been identified as an area of deprivation and has the largest child population of the 3 boroughs it is expected that Oldham has the largest number of child deaths.

10. Childs Deaths Under 1

Between 1 April 2014 to 31 March 2015 child deaths under the age of 1 made up 36 (63%) of the total 57 child death notifications. Of the 36 deaths under the age of 1, 9 (16%) of these occurred within the post neonatal period between 29 - 364 days of life.

Of the 9 child deaths the majority of the deaths were expected as the child had been diagnosed with a life limiting condition and had underlying medical conditions where the final event of death was infection.

Of the 9 deaths aged 29 days to 364 days:

- 6 (67%) of these were female and 3 (33%) male.
- 6 (67%) children were from the BME community, the majority of which were of Pakistani heritage
- Combining quintile 1 and 2 (most deprived) highlights a total of 7 out of the 9 deaths which occurred where the child was resident in an area of deprivation.

Neonatal Deaths

There are a number of contributing risk factors in neonatal deaths which include:

1. Smoking during pregnancy
2. Prematurity & birth weight
3. Multiple pregnancies

1. Smoking During Pregnancy

²Mothers that smoke during pregnancy are exposing their unborn baby to harmful gases like carbon monoxide and other damaging chemicals. There are a number of health risks when smoking during pregnancy which can include:

- increased complications in pregnancy
- less likely to have a healthier pregnancy and a healthier baby in comparison to those who do not smoke
- increased risk of stillbirth
- the baby is more likely to be born early and suffer additional breathing, feeding and health problems that often go with being premature
- the baby is more likely to be born underweight: babies of women who smoke are, on average, 200g (about 8oz) lighter than other babies, which can cause problems during and after labour, for example they are more likely to have a problem keeping warm and are more prone to infection
- increased risk of cot death
- children whose parents smoke are more likely to suffer from asthma and other more serious illnesses that may need hospital treatment.

³A study carried out by the [University College London](http://www.ucl.ac.uk) found that smoking during pregnancy increases the risk of birth defects, such as club foot and missing limbs. The report is based on a systematic review which assessed previous research on smoking during pregnancy to determine the risks of birth defects. It found that the risk of various birth defects increased for mothers who smoked, with the odds rising from between 9% and 50% for different abnormalities. The annual incidence of these sorts of defect is around 3 % to 5 % of births in the UK. Overall, this was a well-conducted study, and its findings are convincing evidence that smoking increases the risk of some birth defects.

² NHS <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/smoking-pregnant.aspx>

³ NHS <http://www.nhs.uk/news/2011/07/July/Pages/smoking-in-pregnancy-link-to-birth-defects.aspx>

Of the 27 neonatal deaths, Mothers smoking status was recorded in 24 cases, 3 recorded as not known. Of the 24 deaths where Mother smoking status was recorded, 5 Mothers (21%) when booking the pregnancy self-declared that they smoked during pregnancy and 19 Mothers (79%) stated they did not.

	Maternal Smoking	
Yes	5	21 %
No	19	79%
Total	24	100 %

Due to the health risks linked to smoking in pregnancy all CDOPs across Greater Manchester have agreed that for premature deaths, where Mother smoked during pregnancy, these would be categorised as having modifiable factors.

The NHS continues to work with Mothers that smoke during pregnancy to highlight the associated health risks posed to both Mother and baby. When a Mother declares at booking that she is a smoker, she is offered a referral to smoking cessation. This requires consent from the Mother and can be refused. Information is requested about other household members who smoke and advice is also provided to them about the benefits of stopping smoking/cessation. Parents are informed of the risks of smoking during pregnancy and once baby is born the midwife will go through safe sleeping arrangements which incorporates smoking. Information leaflets are provided to parents as well as verbal advice both before and after birth about the NHS Pregnancy Smoking Helpline.

2. Prematurity & Birth Weight

⁴About 1 baby in every 13 will be born prematurely. The chances of survival depend on many factors including the stage of the pregnancy, birth weight, inherited abnormalities, condition at birth and presence or absence of infection.

The NHS determines births at the gestation of 37 weeks and over as full term pregnancies. Any delivery under 37 weeks gestation is classified as a premature birth. Babies delivered under 26 weeks gestation are classified as extremely premature births.

⁵Babies born extremely prematurely have very immature organs. They are at increased risk of problems in later childhood even if they survive the neonatal period. These are some of the potential problems:

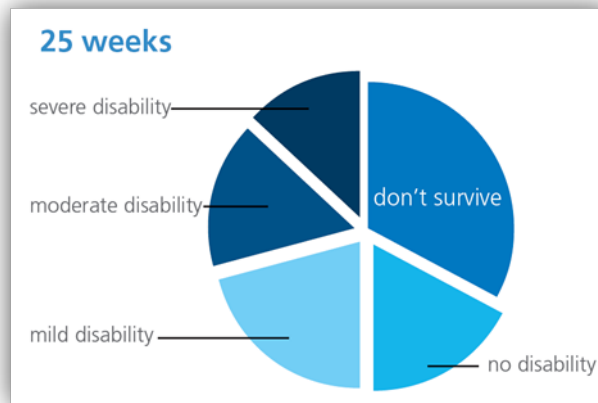
- Damage to their brain, such as cerebral parenchymal cysts (small “holes” in the brain) and hydrocephalus (too much fluid in the brain). These changes can cause cerebral palsy and/or learning difficulties.
- Damage to their eyes (retinopathy), which may affect their vision
- Hearing problems
- Damage to the lungs (chronic lung disease) causing breathing problems
- Problems with feeding and long term growth

⁴ NHS <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/premature-early-labour.aspx#close>

⁵ SUHT NHS Information:

<http://www.uhs.nhs.uk/Media/Controlleddocuments/Patientinformation/Pregnancyandbirth/Havinganextremelyprematurebaby-patientinformation.pdf>

⁶Babies who are born extremely premature have an increased rate of infant mortality:



- 25 weeks gestation: 6 - 7 in 10 survive, of whom 4 in 10 have moderate to severe disability
- 24 weeks gestation: 4-5 in 10 survive, of whom half have moderate to severe disability
- 23 weeks gestation: 2-3 in 10 survive, of whom two thirds have moderate to severe disability
- 22 weeks gestation: Only 1 in 100 babies survive with likely severe disability

The below data is based on the 27 neonatal deaths referred to the CDOP between 1 April 2014 to 31 March 2015. Of the 27 neonatal deaths the child's gestation was recorded in 26 of the cases. 21 (81%) babies were born prematurely and 5 (19%) were born full term.

Gestation	Total	
Extremely Premature (<26 weeks)	16	62 %
Premature (26 weeks to <37 weeks)	5	19 %
Full Term (37+ weeks)	5	19 %

Low birth weight is defined as a birth weight of a live born infant of less than 2,500 grams (5.5 pounds) regardless of gestational age. This is another contributing factor for neonatal deaths as the earlier the gestation the lower the birth weight of the infant. The below data is based on the 27 neonatal deaths referred to panel from 1 April 2014 to 31 March 2015. Of the 27 neonatal deaths, birth weight was recorded in 25 of the cases.

Birth Weight	Total	
Low Birth Weight <2500 Grams	18	72 %
2500+ Grams	7	28 %

Of the 25 neonatal deaths where birth weight was recorded 18 of these (72%) were born with a low birth weight. Of the 18 cases recorded as having low birth weight all 18 of these babies were born prematurely.

⁶ The information in these charts comes from two large studies (EPICURE 1 in 1995 and EPICURE 2 in 2006), which assessed the outcome of large groups of babies that were born during these weeks of pregnancy in the U.K.
<http://www.uhs.nhs.uk/Media/ControlledDocuments/PatientInformation/Pregnancyandbirth/Havinganextremelyprematurebaby-patientinformation.pdf>

3. Multiple Pregnancies

⁷Many twins and triplets are born prematurely. The average delivery date for twins is 37 weeks and 33 weeks for triplets. Fewer than half of all twin pregnancies last beyond 37 weeks, and only 1.5% of triplet pregnancies go beyond this stage.

⁸There are a number of risks involving multiple pregnancies:

- half of all twins are born prematurely (before 37 weeks) and have a low birth weight of under 2.5kg (5.5lb); triplets have a 90% chance of being born prematurely and of having a low birth weight
- the risk of death for premature babies around the week of birth is five times higher for twins and nine times higher for triplets than single babies

Pregnancy	Total	
Single	22	81 %
Twin	5	19 %

Of the 27 neonatal deaths 5 (19%) of these were twin pregnancies. All 5 of these deaths were separate pregnancies all of which were twin 1 of 2.

Risk Factors

When reviewing neonatal deaths the CDOP gathers information regarding the pregnancy, antenatal care, labour, delivery and circumstances leading to death. The panel also reviews any contributing risk factors identified in parenting capacity, family and environment which could potentially contribute to the early onset of labour.

Of the 27 neonatal deaths:

- 13 Mothers had previously had a miscarriage, stillbirth or termination of pregnancy
- Domestic violence was recorded in 8 of the cases
- Maternal mental health issues were identified in a number of cases
- Mothers BMI at booking was recorded as obese in a number of cases

Year on year the CDOPs data set increases to incorporate additional data entry fields to help identify trends. The CDOP continues to monitor various risk factors that are potentially associated with prematurity and neonatal deaths such as:

- Chaotic lifestyles
- Late booking
- Concealed pregnancy
- Poor parenting capacity
- Lack of engagement with services (no antenatal care received)
- Missed medical appointments

⁷ NHS: <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/premature-early-labour.aspx#close>

⁸ NHS <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/twins-healthy-multiple-pregnancy.aspx>

11. Gender across the Local Authorities

The below table provides information from the Office of National Statistics (ONS) 2011 Census, regarding gender across the child population for children aged 0 – 17 years.

	Male		Female		Total
Bury	21,584	51 %	20,368	49 %	41,952
Rochdale	26,061	51 %	24,711	49 %	50,772
Oldham	28,799	51 %	27,758	49 %	56,557
CDOP	76,547	51 %	72,934	49 %	149,481

Each of the 3 local authorities' child population has a slightly higher percentage of males (51%) than females (49%).

Life Expectancy

⁹The below table provides information from the Office of National Statistics release: 2011-2013 Life expectancy at birth by local areas in England and Wales

	Male	Rank	Female	Rank
Bury	78.2	268	81.2	323
Rochdale	77.2	324	81.0	327
Oldham	77.6	312	81.2	320
Greater Manchester	77.7	-	81.3	-
North West	78.0	-	81.8	-
England	79.41	-	83.12	-

The ranking of local authorities is based on 1 being the highest and 346 being the lowest.

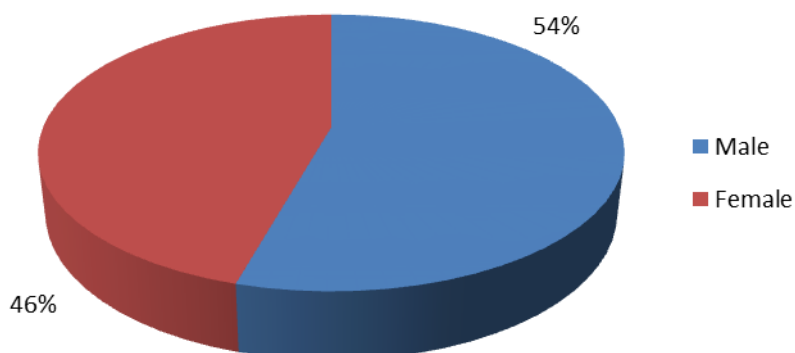
Life expectancy at birth in England and Wales (combined) increased between the periods 2007–09 and 2011–13, from 78.1 to 79.3 years for males and from 82.2 to 83.0 years for females. Life expectancy increased at a faster pace for males than females, causing the gap between the sexes to narrow from 4.1 years in 2007–09 to 3.7 years in 2011–13.

Life expectancy varies across English regions in each period examined and tended to be higher among those in the south than in the north and midlands. The distribution of life expectancy in England was characterised by a north-south divide, with life expectancy generally being lower among local areas in the north of the country.

⁹ ONS - Life expectancy at birth and at age 65 by local areas in England and Wales, 2011-2013
<http://www.ons.gov.uk/ons/rel/subnational-health/life-expectancy-at-birth-and-at-age-65-by-local-areas-in-england-and-wales/2011-13/index.html>

12. Gender of Child Deaths

The data below is based on the 57 child death notifications received from the 1 April 2014 to 31 March 2015. Of the 57 child death notifications 31 (54%) of these were male and 26 (46%) female.



	Male		Female	
	Count	Percentage	Count	Percentage
Bury	5	50 %	5	50 %
Rochdale	12	54 %	10	46 %
Oldham	14	56 %	11	44 %
Total	31	54 %	26	46 %

Breaking the figures down into each local authority indicates that whilst Oldham and Rochdale had more male child deaths to female, Bury had a 50/50 split. Given that each of the local authorities has a slightly higher male child population and females have a longer life expectancy it is anticipated that there is slightly more male child deaths each year.

Reviewing the child's gender by the year of death provides a more accurate overview when analysing the increase/decrease of gender. The data below is based on the year the death occurred. Of the 433 child deaths which occurred between 2008 – 2014 gender was recorded in 432 cases. The data for 2015 will be included in the 2015/2016 CDOP Annual Report.

	Bury		Rochdale		Oldham	
	Female	Male	Female	Male	Female	Male
2008	<5	6	12	9	8	14
2009	6	5	8	13	13	20
2010	8	9	8	12	9	25
2011	10	10	9	12	11	17
2012	8	7	9	12	13	11
2013	5	12	8	20	14	12
2014	<5	<5	8	8	11	12
Total	43	51	62	86	79	111
	46 %	54 %	42 %	58 %	42 %	58 %

Reviewing the statistics reflects that there have been a number for years where there have been more female deaths in comparison to male deaths within in each local authority. It's important to note that as figures are small that one death can significantly alter these statistics.

Collating the figures from 2008 to 2013 indicates that overall there are more male (248/57%) than female (184/43%) child deaths.

	Female		Male		Total
2008	23	44 %	29	56 %	52
2009	27	42 %	38	58 %	65
2010	25	35 %	46	65 %	71
2011	30	43 %	39	57 %	69
2012	30	50 %	30	50 %	60
2013	27	38 %	44	62 %	71
2014	22	50 %	22	50 %	44
Total	184	43 %	248	57 %	432

13. Ethnicity across the Local Authorities

The below table provides information from the Office of National Statistics 2011 Census, regarding ethnicity for the child population of children aged 0 – 17 years.

Ethnicity		England	North West	Greater Manchester	Bury	Rochdale	Oldham	CDOP Total
White	English/Welsh/Scottish/ Northern Irish/British	8,442,330	1,235,092	436,852	33,447	35,099	35,345	103,891
	Irish	33,889	3,574	1,980	123	89	79	291
	Gypsy or Irish Traveller	19,615	1,388	509	18	62	23	103
	Other White	407,479	26,630	12,105	969	780	451	2,200
	White: Total	8,903,313	1,266,684	451,446	34,557	36,030	35,898	106,485
Mixed/multiple ethnic group	White & Black Caribbean	206,044	17,693	11,250	663	445	983	2,091
	White & Black African	85,284	8,951	4,948	226	279	239	744
	White & Asian	171,250	16,080	8,402	617	743	714	2,074
	Other Mixed	127,439	10,219	5,663	283	271	281	835
	Mixed/multiple ethnic group: Total	590,017	52,943	30,263	1,789	1,738	2,217	5,744
Asian/Asian British	Indian	298,950	29,506	13,592	345	279	297	921
	Pakistani	403,323	70,100	47,524	3,442	8,268	8,983	20,693
	Bangladeshi	167,009	19,445	14,451	122	1,855	7,433	9,410
	Chinese	59,108	8,367	4,465	248	251	165	664
	Other Asian	207,903	12,951	8,245	495	1,062	657	2,214
	Asian/Asian British: Total	1,136,293	140,369	88,277	4,652	11,715	17,535	33,902
Black/African/Caribbean/Black British	African	327,168	19,520	15,502	400	850	580	1,830
	Caribbean	119,017	3,476	2,884	77	33	75	185
	Other Black	116,148	6,251	4,877	62	165	113	340
	Black/African/Caribbean/Black British: Total	562,333	29,247	23,263	539	1,048	768	2,355
Other ethnic group	Arab	68,840	8,230	5,329	168	118	39	325
	Any other ethnic group	76,164	4,566	3,046	247	123	100	470
	Other ethnic group: Total	145,004	12,796	8,375	415	241	139	795
Total: All Ethnic Groups		11,336,960	1,502,039	601,624	41,952	50,772	56,557	149,281

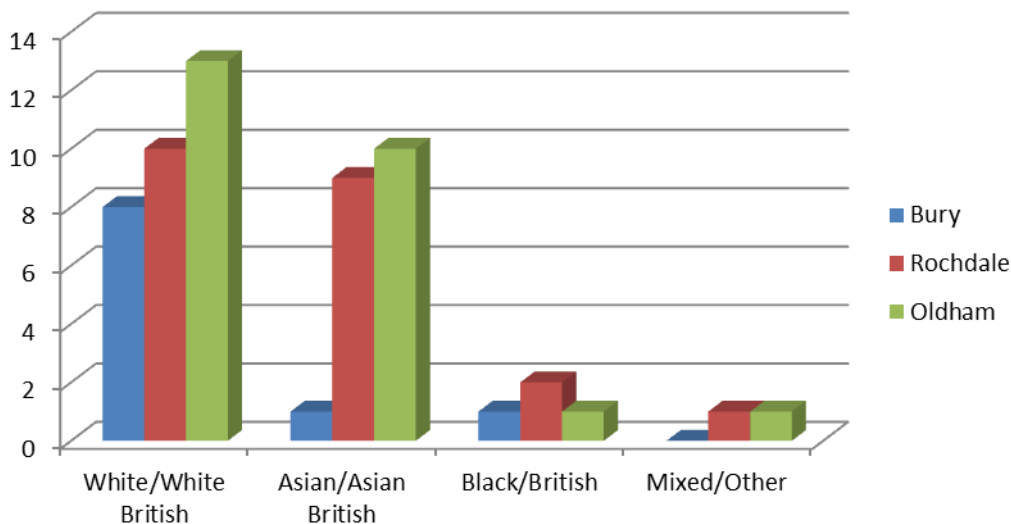
In all three of the local authorities child population in the White British community is the most represented with a total of (103,891) 70% of the CDOPs joint population. The BME community makes up 30% (45,390) of the joint population.

Bury BME	8,505	20 %
Rochdale BME	15,673	31 %
Oldham BME	21,212	38 %
CDOP BME	45,390	30 %
Greater Manchester BME	164,772	27 %
North West BME	266,947	18 %
England BME	289,4630	26 %

Of the three local authorities Oldham has the largest proportion of children from the BME community with 38% (21,212) of its child population. In comparison to the national and regional percentages Oldham and Rochdale have a higher BME community in comparison to the national average. Of Bury, Rochdale and Oldham's BME community the Pakistani community is the most prevalent in all three local authorities. In Bury the Pakistani community makes up 3,442 (40% of Bury's child BME community/8% of Bury's total child population), Rochdale 8,268 (53% of Rochdale's child BME community/16% of Rochdale's total child population) and Oldham 8,983 (42% of Oldham's BME community/16% of Oldham's total child population).

14. Ethnicity of Child Deaths

The below data is based on the 57 child death notifications received between 1 April 2014 to 31 March 2015. Of the 57 child death notifications received there was a 51% (29) of children were of White English/Welsh/Scottish/N Irish/British ethnicity and 49% (28) we from the Black Minority Ethnic community.



	Bury		Rochdale		Oldham		Total	
White/White British	8	80 %	10	45 %	13	52 %	31	54 %
Asian/Asian British	<5	10 %	9	41 %	10	40 %	20	35 %
Black/British	<5	10 %	<5	9 %	<5	4 %	<5	7 %
Mixed/Other	0	0 %	<5	5 %	<5	4 %	<5	4 %
Total	10	100 %	22	100 %	25	100 %	57	100 %

The figures indicate that overall Oldham and Rochdale had a large percentage of child deaths from the BME community. Breaking the figures down into specific ethnicities within each local authority identifies Oldham and Rochdale has having a much higher percentage of child deaths from the Pakistani community in comparison to Bury.

BURY	White English/Welsh/Scottish/N Irish/British	6 / 60 %	Black Minority Ethnic	4 / 40 %
ROCHDALE	White English/Welsh/Scottish/N Irish/British	10 / 45 %	Black Minority Ethnic	12 / 55 %
OLDHAM	White English/Welsh/Scottish/N Irish/British	13 / 52 %	Black Minority Ethnic	12 / 48 %

		Bury		Rochdale		Oldham		Total	
	White English/Welsh/Scottish/N Irish/British	6	60 %	10	45 %	13	52 %	29	51 %
Black Minority Ethnic	White: Any Other White background e.g. Polish, Slovakian, Hungarian, Portuguese	<5	20 %	0	0 %	0	0 %	<5	4 %
	Asian or Asian British: Bangladeshi	0	0 %	0	0 %	<5	4 %	<5	2 %
	Asian or Asian British: Pakistani	<5	10 %	9	41 %	6	24 %	16	28 %
	Asian or Asian British: Any other Asian background	0	0 %	0	0 %	<5	12 %	<5	5 %
	Black: African	<5	10 %	<5	9 %	<5	4 %	<5	7 %
	Mixed: White & Asian	0	0 %	<5	5 %	<5	4 %	<5	4 %
Total		10	100 %	22	100 %	25	100 %	57	100 %

White English/Welsh/Scottish/N Irish/British:	29	51 %
Black Minority Ethnic :	28	49 %
Total	57	

Reviewing specific ethnic groups highlights a disproportionate number of BME child deaths in comparison the BME child population. When reviewing the White English/Welsh/Scottish/N Irish/British child population (age 0 – 17 years) and comparing this to the number of deaths it would appear that this group are underrepresented.

Local Authority	White English/Welsh/Scottish/N Irish/British			
	Child Population		Child Deaths	
Bury	33,447	80 %	6	60 %
Rochdale	35,099	69 %	10	45 %
Oldham	35,345	62 %	13	52 %

Reviewing the percentage of the BME child population in comparison to the number of BME child deaths it would appear that this group is overrepresented.

Local Authority	Black Minority Ethnic			
	Child Population		Child Deaths	
Bury	8,505	20%	<5	40 %
Rochdale	15,673	31 %	12	55 %
Oldham	21,212	38 %	12	48 %

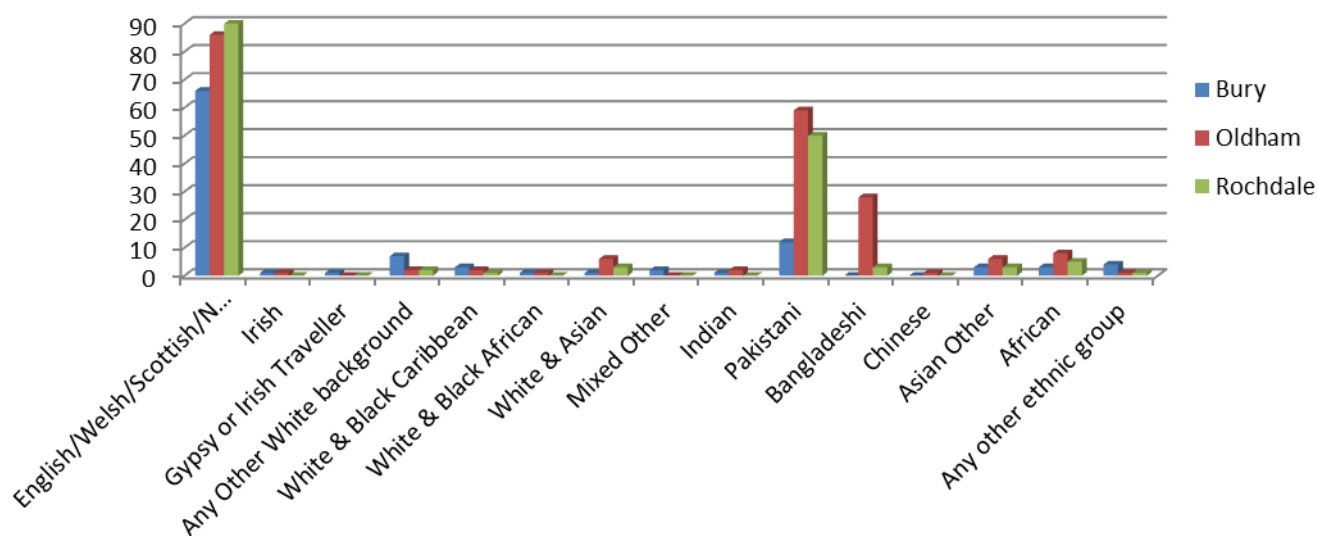
Of the 28 BME child deaths across Bury, Rochdale and Oldham, 16 of these were of Pakistani heritage totalling 57% of the BME child deaths making this ethnic group the most prevalent. Reviewing the nature of the 28 BME deaths highlights:

- The largest proportion of deaths occurred in children under the age of 1 with 71% (20) - 14 aged 0 – 28 days and 6 aged 29 – 364 days.
- 25 (89%) children were resident in an area of deprivation (quintile 1 and 2)
- The CDOP categorised consanguinity as a contributing factor in that in 6 (21%) of the child deaths (see Section 15: Consanguinity)

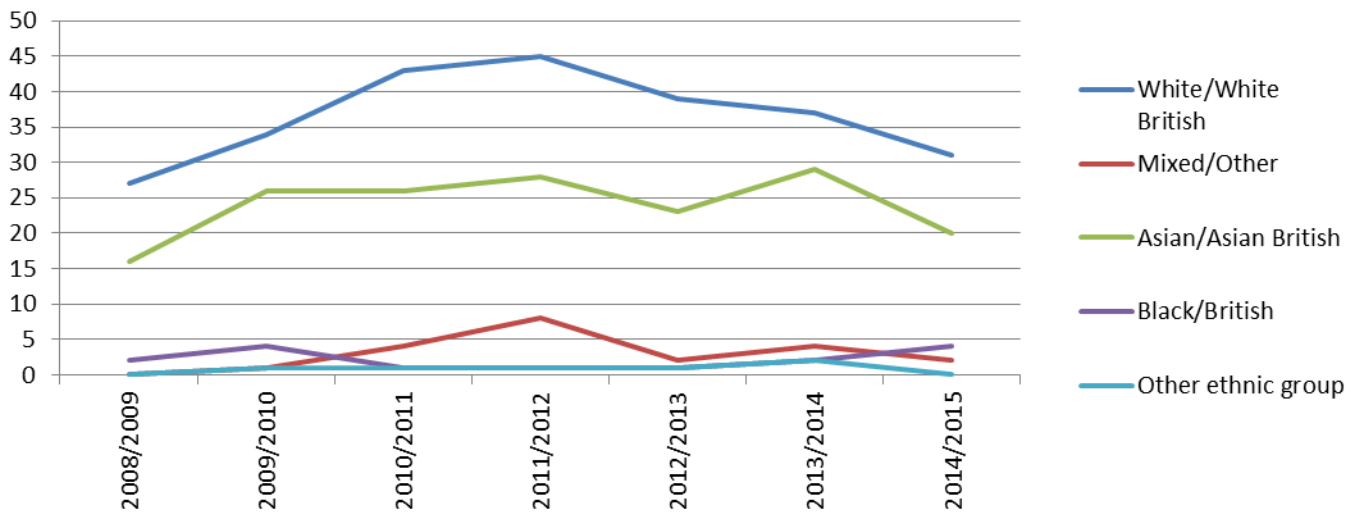
Reviewing statistics from previous year's annual reports highlights that year on year there has been a disproportionate number of BME child deaths in comparison to the BME child population.

	White English/ Welsh/ Scottish / N Irish / British		BME	
2014/15	29	51 %	28	57 %
2013/14	34	46 %	40	74 %
2012/13	36	55 %	30	66 %
2011/12	44	53 %	39	83 %
2010/11	39	52 %	36	75 %
2009/10	33	50 %	33	66 %
2008/09	27	60 %	18	45 %
Total	242	52 %	224	48 %

From the 1 April 2008 – 31 March 2015 there has been a total of 466 child death notifications to CDOP. The majority of the children were of the ethnicity English/Welsh/Scottish/N Irish/British making up 51% (242) of the total deaths. Within the BME community the largest number of deaths occurred in children of Pakistani heritage making up 26% (121) of the total deaths.



Ethnicity		Bury	Oldham	Rochdale	Total	
White	English/Welsh/Scottish/N Irish/British	66	86	90	242	51.9 %
	Irish	<5	<5	0	<5	0.4 %
	Gypsy or Irish Traveller	<5	0	0	<5	0.2 %
	Any Other White background	7	<5	<5	11	2.4 %
Mixed/multiple ethnic group	White & Black Caribbean	<5	<5	<5	6	1.3 %
	White & Black African	<5	<5	0	<5	0.4 %
	White & Asian	<5	6	<5	10	2.1 %
	Mixed Other	<5	0	0	<5	0.4 %
Asian/Asian British	Indian	<5	<5	0	<5	0.6 %
	Pakistani	12	59	50	121	26 %
	Bangladeshi	0	28	<5	31	6.7 %
	Chinese	0	<5	0	<5	0.2 %
	Asian Other	<5	6	<5	12	2.6 %
Black/African/Caribbean/Black British	African	<5	8	5	16	3.4 %
Other ethnic group	Any other ethnic group	<5	<5	<5	6	1.3 %
Total		105	203	158	466	



	White/White British	Mixed/Other	Asian/Asian British	Black/British	Other ethnic group
2008/2009	27	0	16	<5	0
2009/2010	34	<5	26	<5	<5
2010/2011	43	<5	26	<5	<5
2011/2012	45	8	28	<5	<5
2012/2013	39	<5	23	<5	<5
2013/2014	37	<5	29	<5	<5
2014/2015	31	<5	20	<5	0
Total	256	21	168	15	6

Reviewing the children's ethnicity by year of annual report indicates that year on year the largest number of child deaths occurs in children who are White/White British. This is expected given that White/White British children make up the majority of the child population within all three local authorities.

Section D: Current Areas of Interest

15. Consanguinity

Genetics & Consanguinity

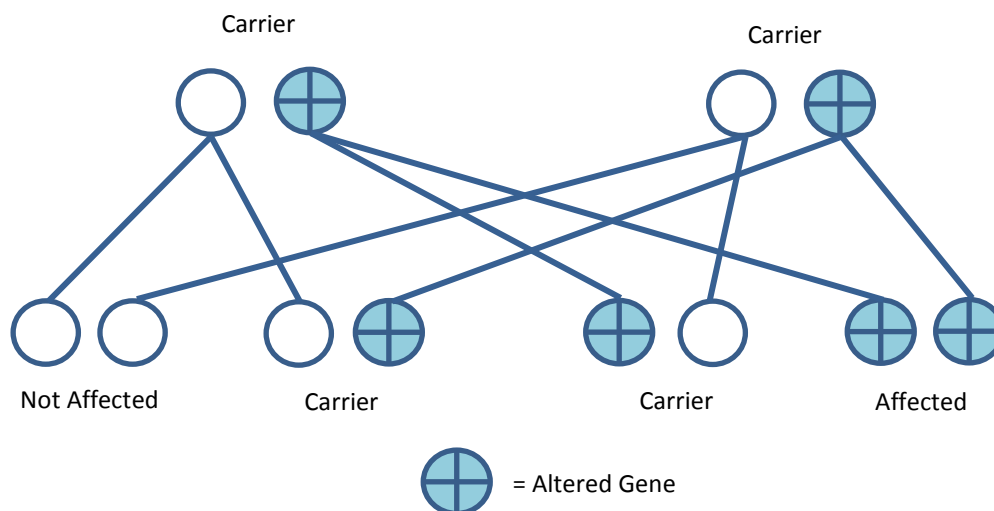
¹⁰Consanguinity refers to a relationship in which a couple are 'blood' relatives, i.e. they share a common ancestor. An example is a couple who are first cousins. Consanguinity is common in many cultures and most prevalent in the Asian community. Consanguinity is important because it increases the risk of genetic disorders called autosomal recessive disorders.

These are disorders which only occur if a child has a change (known as a mutation) in both copies of a particular gene. Because genes come in pairs it often doesn't matter if there one changed copy because the other copy is normal and can compensate for the changed gene. A parent with one changed copy is therefore called a 'healthy carrier'. For parent to have an autosomal recessive disorder he/she must have two changed copies of a particular gene.

For example, an individual with cystic fibrosis (a common autosomal recessive disorder in Europe) has two changed copies of the cystic fibrosis gene. Because one copy of each gene comes from Mother and one from Father, both parents of an individual with an autosomal recessive condition must have at least one changed copy of the gene causing the disorder. Therefore if two carriers have a child together there is a risk that their child could be affected by that disorder.

Parents, who are both healthy carriers of, for example cystic fibrosis, there are several possibilities for each of their children:

- A 1 in 4 (25%) chance that the child could be affected by cystic fibrosis.
- A 1 in 2 (50%) chance that the child could be a healthy carrier.
- A 1 in 4 (25%) chance that the child could have 2 normal copies of the cystic fibrosis gene and therefore would not be a carrier or affected.



With every pregnancy this chance stays the same, a bit like tossing a coin or throwing a dice. To put things into context unrelated parents have a risk of about 2 in 100 (2%) of having a child with a severe/lethal abnormality. Parents who are first cousins have an additional risk of about 3 in 100 (3%), giving them a total risk of about 5 in 100 (5%). Parents who are first cousins once removed or 2nd cousins have an additional risk of about 1 in 100 (1%) and therefore a total risk of about 3 in 100 (3%).

¹⁰ <http://www.scotgen.org.uk/documents/Consanguinity.pdf>

This means that when there is no family history of a recessive disorder, most children of first cousins and more distant relatives will be healthy (95% for first cousins, and 97% for first cousins once removed and second cousins). However, certain couples may be more closely related if there is a family tradition of cousin marriages going back generations. In this situation, the couple will have a higher risk of having a child with problems.

About half or 50% of these severe abnormalities are thought to be detectable by specialised ultrasound scanning at around 18 weeks of pregnancy. These scans can be easily arranged by a midwife, genetics department or GP.

Consanguineous Child Deaths

Of the 57 child death notifications in 2014/15 consanguinity status was recorded in 51 (89%) of the cases.

Consanguineous relationships	7
Non consanguineous relationships	44
Not known	6

There were 6 cases where parent's relationship status was recorded as not known, although in these deaths consanguinity was not a contributing factor linked to the cause of death. Of the 57 child deaths 7 families self-declared that they were in a consanguineous relationship. Of these 7 cases where it was recorded that Mother and Father were related a number of these death (less than 5) were directly linked to parents being first cousins accounting for 7% of the total 57 deaths in 2014/15.

- All of the children were of Pakistani heritage
- Of the 28 BME deaths, consanguinity was relevant and directly linked to 14% of the child deaths
- All children died under the age of 1
- The children lived in the areas of Rochdale and Oldham
- All families lived in an area of deprivation (Quintile 1 & 2)

Some of these inherited conditions include Neuro-Genetic Conditions, Neuro-regressive Disease, Cerebellar Pontine Hypoplasia, I Cell Disease, Congenital Abnormalities etc.

In many of the consanguineous deaths the final event contributing to the death was infection. The child's underlying congenital abnormality makes them more vulnerable and susceptible to forms of infection such as Bronchopneumonia and Sepsis. Once the child has contracted a form of infection, due to the complexity of some of the above inherited conditions, the child's immune system can be compromised making it much harder for the body to fight off the infection and recover ultimately contributing and leading to the death.

Consanguinity & the Associated Health Risks

Following the CDOP Annual Report and the links between cousin marriage and the increased risk of autosomal recessive disorders, in 2011 the Oldham Local Safeguarding Children Board (LSCB) created the Oldham Consanguinity Task and Finish Group. The group was established to review data and look at raising awareness of the associated health risks in the community.

At present the GP/hospital can refer a family to St Mary's Genetic Counselling Service where the Genetics Counsellor is based. However the current service does not have the capacity to extend this service and undertake further preventative work or general awareness raising within the community. A proposal was therefore set out for a programme of support for communities affected by consanguinity – to provide community based education and support.

The proposal was presented to the Health and Wellbeing Board to look at the next steps forward to increase capacity and continue working with families who are most at risk and raise awareness within the community by providing information in college settings regarding the associated health risks.

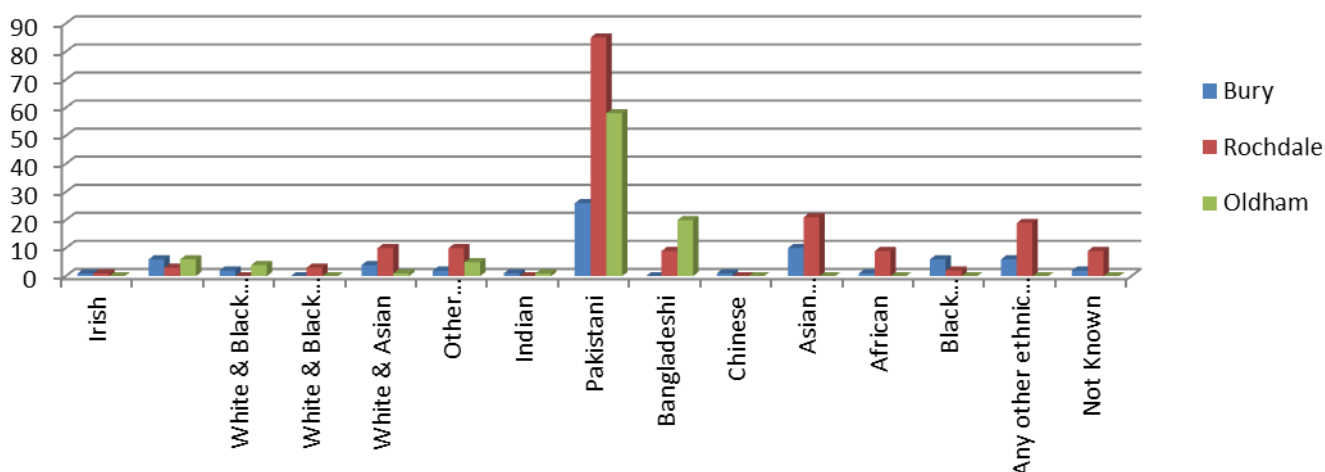
Oldham LSCB and Public Health suggested implementing the following proposal:

1. **Targeted work to raise awareness among communities at risk.** This needs to result in people understanding that, if there is a family history which raises concerns, they should seek specialist advice. The aim is to ensure that members of the public understand the associated health risks linked to consanguineous relationships to make informed decisions before considering marriage
2. **Raising awareness** amongst front-line health professionals about the issue enabling them to contribute to the awareness raising, provide the appropriate information and initiate referrals where needed
3. **Increasing the capacity of the St Mary's service** to provide genetic counselling, and to undertake community outreach work.

In addition, the CDOP reviewed other local authorities approach of how to raise awareness of consanguinity within the community and found the Sheffield leaflet [Cousin Marriage and Genetic Risk](#) a useful source of information. This has been adopted by Oldham. The relative success of the various initiatives in relation to consanguinity will be reviewed by Bury and Rochdale, who will look to implement proposals according to the needs of their respective populations.

Consanguinity & Children with Disabilities

A common theme across the three local authorities is that children with disabilities of Pakistani heritage are the most prevalent ethnic group within the BME community. The figures suggest that there is a link between consanguinity and children with disabilities given consanguineous relationships and cousin marriage is mostly practiced within the Pakistani community.



Bury

In Bury the most prevalent ethnic group within the BME child population are children from the Pakistani community (3,442). It would appear that children of Pakistani heritage who represent 8% (3,442) of the child population are slightly overrepresented with 12% (26) of children with disabilities.

Rochdale

In Rochdale the most prevalent ethnic group within the BME child population are children from the Pakistani community (8,268). It would appear that children of Pakistani heritage who represent 16% (8,268) of the child population are only slightly overrepresented with 17% (85) of children with disabilities.

Oldham

In Oldham the two most prevalent ethnic groups within the BME child population are Pakistani (8,983) and Bangladeshi (7,433). Children of Bangladeshi heritage represent 13% (7,433) of the child population and are underrepresented with 9% (20) of children with disabilities. Children of Pakistani heritage who represent 16% (8,983) of the child population are overrepresented with 26% (58) of children with disabilities.

16. Levels of Deprivation

¹¹The Department for Communities and Local Government produced a 2010 release update of the English indices of deprivation 2007. The English indices of deprivation measure relative levels of deprivation in small areas of England called 'lower layer super output areas'. The indices of deprivation are currently being updated for publication in summer 2015.

The Index of Multiple Deprivation 2010 contains seven domains when calculating deprivation:

- Income deprivation
- Employment deprivation
- Health deprivation and disability
- Education, skills and training deprivation
- Barriers to housing and services
- Living environment deprivation
- Crime

The level of deprivation is measured taking into account the above 7 areas and indicates where each borough sits of the total 326 local authorities.

Most Deprived	Rochdale	29/326
	Oldham	46/326
Least Deprived	Bury	119/326

Health Profile Demographics

¹² The profiles provide a snapshot overview for each local authority in England and are produced annually. The profiles present a set of indicators that show how each area compares to the national average.

Bury

The health of people in Bury is varied compared with the England average. Deprivation is lower than average, however about 17.9% (6,700) children live in poverty.

Life expectancy for both men and women is lower than the England average. Life expectancy is 11.5 years lower for men and 7.6 years lower for women in the most deprived areas of Bury than in the least deprived areas.

In Year 6, 19.3% (384) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 54.7 (rate per 100,000 population). This represents 23 stays per year. Levels of breastfeeding and smoking at time of delivery are worse than the England average.

In 2012, 21.0% of adults are classified as obese. The rate of alcohol related harm hospital stays was 616 (rate per 100,000 population). This represents 1,100 stays per year. The rate of self-harm hospital stays was 196.7 (rate per 100,000 population). This represents 368 stays per year. The rate of smoking related deaths was 354 (rate per 100,000 population), worse than the average for England. This represents 334 deaths per year. Rates of sexually transmitted infections and people killed and seriously injured on roads are better than average.

Rochdale

The health of people in Rochdale is generally worse than the England average. Deprivation is higher than average and about 26.7% (11,900) children live in poverty.

¹¹ English indices of deprivation 2010 <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2010>

¹² 2014 Public Health Profiles http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

Life expectancy for both men and women is lower than the England average. Life expectancy is 9.7 years lower for men and 7.9 years lower for women in the most deprived areas of Rochdale than in the least deprived areas.

In Year 6, 20.7% (487) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 was 68.3 (rate per 100,000 population), worse than the average for England. This represents 35 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.

In 2012, 29.9% of adults are classified as obese, worse than the average for England. The rate of alcohol related harm hospital stays was 727 (rate per 100,000 population), worse than the average for England. This represents 1,436 stays per year. The rate of self-harm hospital stays was 242.3 (rate per 100,000 population), worse than the average for England. This represents 524 stays per year. The rate of smoking related deaths was 366 (rate per 100,000 population), worse than the average for England. This represents 369 deaths per year. Estimated levels of adult excess weight and smoking are worse than the England average. The rate of hip fractures is worse than average. Rates of sexually transmitted infections and people killed and seriously injured on roads are better than average.

Oldham

The health of people in Oldham is generally worse than the England average. Deprivation is higher than average and about 26.8% (13,300) children live in poverty. Life expectancy for both men and women is lower than the England average.

Life expectancy is 11.2 years lower for men and 9.2 years lower for women in the most deprived areas of Oldham than in the least deprived areas.

In Year 6, 19.3% (536) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 70.1 (rate per 100,000 population), worse than the average for England. This represents 40 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.

In 2012, 25.2% of adults are classified as obese. The rate of alcohol related harm hospital stays was 650 (rate per 100,000 population). This represents 1,346 stays per year. The rate of self-harm hospital stays was 204.9 (rate per 100,000 population). This represents 468 stays per year. The rate of smoking related deaths was 370 (rate per 100,000 population), worse than the average for England. This represents 390 deaths per year. Estimated levels of adult excess weight, smoking and physical activity are worse than the England average. The rate of TB is worse than average. Rates of sexually transmitted infections and people killed and seriously injured on roads are better than average.

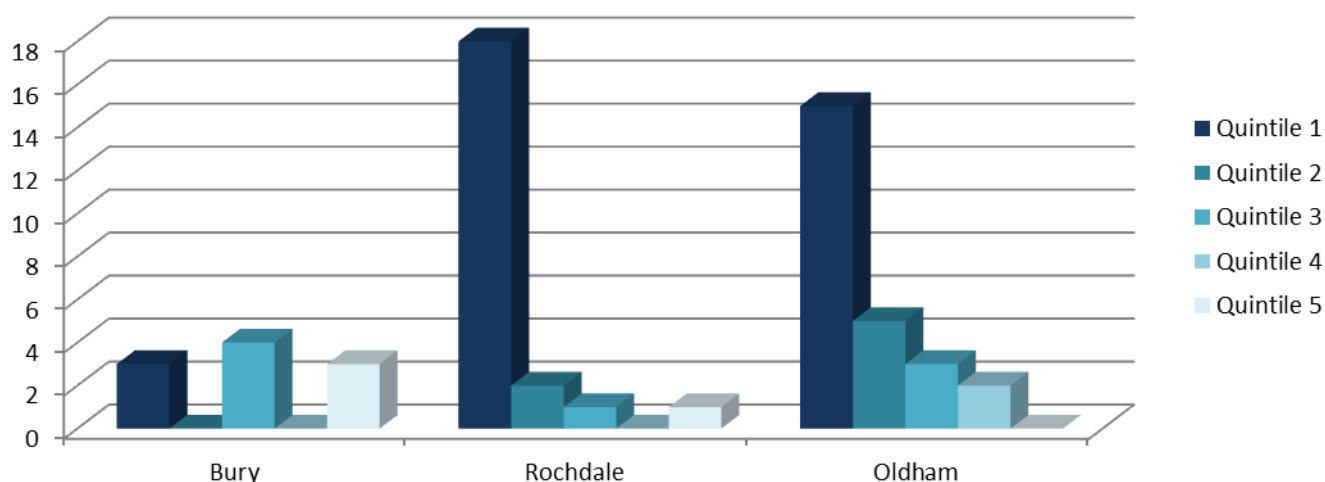
Quintiles

Each area within the local authorities is split into 1 of the 5 quintiles to determine the level of deprivation ranging from Quintile 1 as most deprived and Quintile 5 as the least deprived. Quintiles are based on statistical value of a data set that represents 20% of a given population.

The first quartile represents the lowest fifth of the data (1-20%); the second quartile represents the second fifth (21% - 40%) etc. The quintiles are broken down into:

- Quintile 1: Most deprived
- Quintile 2: 2nd Most Deprived
- Quintile 3: Mid Deprived
- Quintile 4: 2nd Least deprived
- Quintile 5: Least deprived

The below data is based on the 57 child death notifications received between 1 April 2014 and 31 March 2015.



	Bury		Rochdale		Oldham		Total	
Quintile 1 (Most Deprived)	<5	30 %	18	82 %	15	60 %	36	63 %
Quintile 2	0	0 %	<5	9 %	5	20 %	7	12 %
Quintile 3 (Mid Deprived)	<5	40 %	<5	5 %	<5	12 %	8	14 %
Quintile 4	0	0 %	0	0 %	<5	8 %	<5	4 %
Quintile 5 (Least Deprived)	<5	30 %	<5	5 %	0	0 %	<5	7 %
Total	10		22		25		57	

Of the 57 child death notifications received the largest number of deaths occurred where the child/family resided in areas of deprivation (quintile 1 and 2) totalling 75% (57) of the total deaths. Of these 43 child deaths in quintiles 1 and 2 a large percentage of deaths occurred in neonatal deaths (17, 40%) and life limiting conditions (15, 35%).

Bury

Unlike Oldham and Rochdale, Bury received the largest number of child deaths in quintile 3 (mid deprived) with 40% of the 10 deaths. Of the deaths in quintile 3 the majority of children were female and of White/White British ethnicity. Of the total 10 Bury child deaths reported to CDOP in 2014/15 the largest number of deaths occurred in the ward Tottington.

Rochdale

In Rochdale the largest number of deaths occurred in quintile 1 with 18 (82%) of the 22 deaths. Of the 18 deaths in quintile 1, 50% (9) of children were of Pakistani heritage and 39% (7) were of the ethnicity White English/Welsh/Scottish/N Irish/British. Data shows that there a 50/50 split in the number of male and female deaths in quintile 1. Of the 18 deaths in quintile 1 neonatal deaths (7/39%) and deaths due to a life limiting condition (8/44%) were the most represented. Of the 22 Rochdale child deaths reported to CDOP in 2014/15 the largest number of deaths occurred in the ward Kingsway (6/27%).

Oldham

In Oldham the largest number of deaths occurred in quintile 1 with 15 (60%) of the 25 deaths. Of the 15 deaths in quintile 1, the largest number of deaths with 47% (7) were Asian/ Asian British children. Overall the BME community was largely represented in child deaths within quintile 1 with 60% (9) of deaths. Of the 15 deaths in quintile 1 53% (8) were male and 47% (7) female. Of the total 25 Oldham child deaths reported to CDOP in 2014/15 the largest number of deaths occurred in the wards Hollinwood and Werneth.

17. Sudden Unexpected Death in Infancy (SUDI)

Sudden Unexpected Deaths in Infancy (SUDI) is the medical term used to describe the sudden and unexpected death of a baby or toddler that is initially unexplained. Some sudden and unexpected infant deaths can be explained by the post mortem examination revealing, for example, an unforeseen infection or metabolic disorder. Deaths that remain unexplained after the post mortem and the cause of death cannot be established are categorised as SUDIs.

The CDOP initially classifies a death as SUDI pending the outcome of the Coroner's investigation. If the cause of death is established from the post mortem examination and it identifies that the child died, for example, due to infection, the case would no longer meet SUDI criteria. Where it remains that the cause of death is unascertained, these cases are categorised as SUDI.

From the 1 April 2014 to 31 March 2015 the CDOP was notified of a number of SUDI child deaths (less than 5). The CDOP cannot be certain that the death was a SUDI until the conclusion of a post mortem examination and/or inquest where the Pathologist and Coroner confirm the cause of death as 'unascertained'.

Co-sleeping on a sofa or in a parental bed was identified in the majority of cases. There was various risk factors documented such as overheating, overlay and sleeping with multiple parents/carers and siblings in the same bed/sofa.

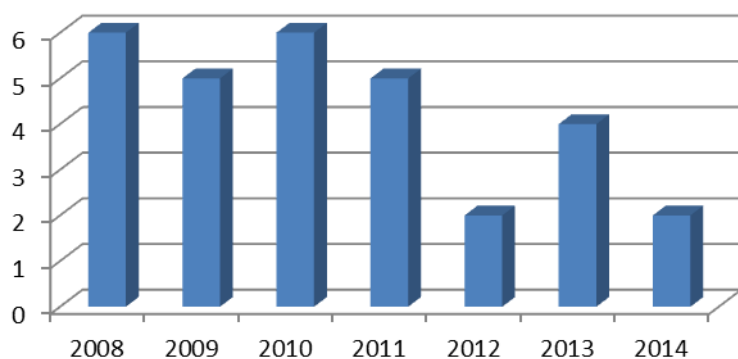
As numbers are small a breakdown of SUDI deaths year on year provides a more detailed overview of the emerging trends.

Sudden and Unexpected Death in Infancy (SUDI) Year on Year

Of the child deaths referred to the CDOP between 1 April 2008 and 31 March 2015 the panel has categorised and closed 30 cases as SUDI. There are a number of potential SUDI cases that are awaiting a cause of death from the Coroner's Office to confirm whether the death was a SUDI or due to an underlying medical condition or infection. The 30 cases are made up of:

Bury	10	33 %
Oldham	9	30 %
Rochdale	11	37 %
Total	30	

Reviewing the cases by the child's year of death provides an overview of the increase/decrease in the number of SUDI deaths year on year.



Year of Death	Number of Deaths
2008	6
2009	5
2010	6
2011	5
2012	<5
2013	<5
2014	<5
Total	30

Reviewing the cases highlighted:

- 13 (43%) of the deaths were female and the remaining 17 (57%) were male
- 21 (70%) deaths were of the ethnicity White English/Welsh/Scottish/N Irish/British and 9 (30%) from the BME community
- 6 (20%) of these deaths occurred in the neonatal period (<28 days), and 23 (77%) occurred post neonatal under the age of 1 (29 – 364 days)
- The majority of deaths occurred where the child was resident in an area of deprivation (Quintile 1 & 2 combined)
- Mothers smoking status was recorded in 25 of the 30 cases. It was recorded that Mothers smoked in 14 (56%) of the 25 cases and 11 (44%) Mothers stated that they were non-smokers.
- Co-sleeping with a parent, carer and/or sibling in bed or on a sofa was recorded in 19 (63%) of the deaths.
- It was noted in 9 (30%) of the cases that alcohol was consumed by parents on the evening/morning of death and that co-sleeping was also a factor in these 9 cases.
- The child's gestation was recorded in 29 of the 30 SUDI deaths. Of the 29 deaths where gestation was recorded 8 (28%) of the babies were born premature (<37 weeks gestation).
- Birth weight was recorded in 27 of the 30 SUDI deaths. Of these 27 cases the child's birth weight was recorded as low (<2500 grams) for 6 (22%) of the children.

Modifiable Factors & Sudden and Unexpected Death in Infancy

Of the 30 SUDI cases, the CDOP categorised 21 (70%) deaths as having modifiable factors. This is where 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.

Of the 21 cases where modifiable factors were identified one or more of the following risk factors were highlighted:

- Co-sleeping (with parents and/or other siblings in bed or on a sofa)
- A family history of co-sleeping
- Direct overlay on top of the baby by parent, carer or sibling
- Alcohol consumption by the parent/carers on the evening or morning of the event
- Ingestion of illegal substances by parent/carers (e.g. Cannabis)
- Parent/carers prescribed medication such as anti-depressants
- Maternal smoking during pregnancy
- Parental smoking within the family home
- Overheating
- Overwrapping
- Overcrowding housing arrangements
- Poor home conditions and family environment
- Chaotic lifestyles
- Lack of uptake to antenatal care/concealed pregnancy
- Lack of engagement with services such health services as GP and Health Visitors
- Late immunisations
- Parental refusal of immunisations
- Serious non-accidental injuries

The CDOP also highlighted a number of emerging themes such as:

- Parental mental health
- Domestic abuse
- Babies born prematurely premature (<37 weeks gestation)
- Babies with low birth weight (<2500 grams)
- Child suffered from cold/flu like symptoms prior to death
- Parents known to alcohol and substance misuse
- Parents known to Police for various offences

Year on year the CDOP reviews the number of SUDI cases and identifies any contributing factors. The CDOP requests information regarding resources provided to parents at various stages of pregnancy and birth including antenatally, birth (on the ward), discharge and home visits.

Antenatally there is a discussion with Mother at 36 weeks gestation when discussing the place of birth. Postnatally the information is provided:

- within the first few hours after delivery
- on the postnatal ward on transfer (if not done on labour ward)
- on the postnatal ward when being discharged home and
- on first visit by Community Midwife within 24 hours following discharge

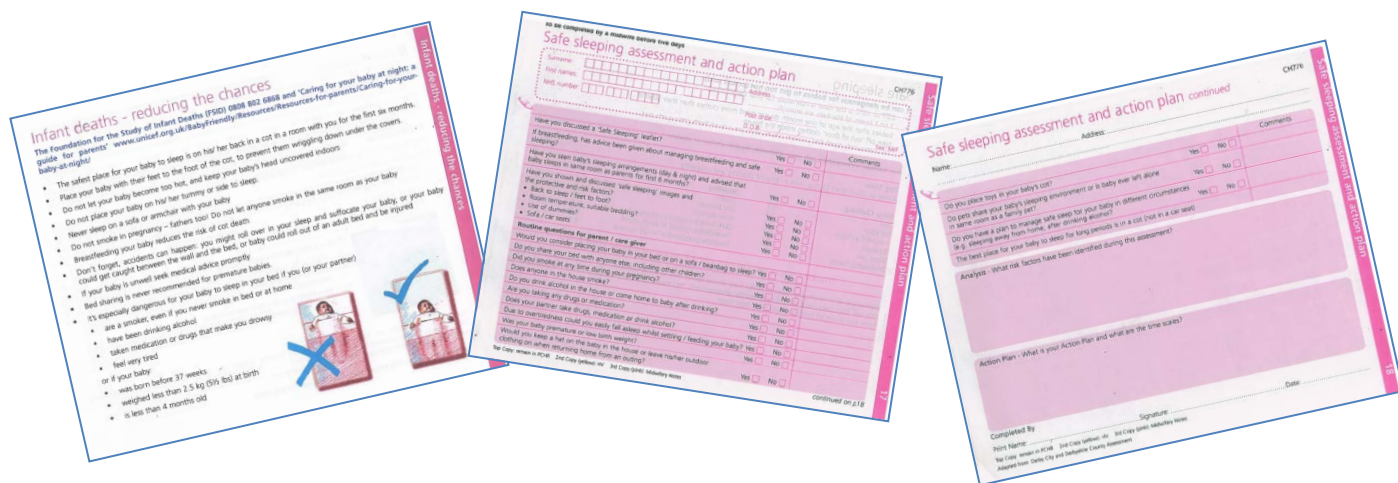
All women within the first few hours of delivery are given the 'safe sleeping' leaflet and have a conversation with their Midwife to discuss the key points. This allows the Mother to ask the Midwife any questions at this time. The Pennine Acute Hospital information guide 'Putting your baby down to sleep safely' advises that parents should:

Never sleep with your baby if either you or your partner

- has taken any legal or illegal drugs
- has been drinking alcohol
- is a smoker
- or if
- your baby was born small or premature

Do not put yourself, or allow others to be, in a position where there is a possibility of dozing off with the baby on a sofa or armchair, as this is one of the highest risk factors for sudden infant death.

The Personal Child Health Record (PCHR) 'Red Book' contains information SUDI information highlighting safe sleeping arrangements do's and don'ts stating that 'The safest place for your baby to sleep is on their back in a cot or a crib in the room with you for the first six months'. The PCHR is a record of a child's health, growth and development kept by the child's parent/ guardian, with contributions from various health professionals. The Personal Child Health Record contains material from the Healthy Child Programme, as well as information designed to promote active engagement with the health of a child from birth to age five.



Following the discussion the Midwife will then ask the routine questions located on page 21 of the PCHR, with the exception of 'have you seen the home surroundings'. In the hospital setting it is the delivering Midwife that initially provides this information to the Mother or if due to high labour activity where this is not possible, this discussion will take place on transfer to the postnatal ward by the postnatal ward Midwife.

Health professionals record the date, time and sign the postnatal record to safely document the discussions that have taken place. This information is then reiterated on the postnatal ward on transfer, at discharge and then by the Community Midwife at the first home visit following discharge. Pages 21 and 23 of the Personal Child Health Record are also completed on the first home visit.

If Mother has had a planned homebirth, unexpected home delivery or early discharge a postnatal record may not be started. In these cases the safe sleeping documentation will be recorded in the labour record located on page 22 of the PCHR.

The Safe Sleeping Assessment and Action Plan continue to be completed by the Midwife and contain questions regarding breastfeeding, safe sleeping, smoking and alcohol consumption. Any identified risk factors are highlighted and actions produced with timescales to address any concerns.

In November 2014 the Pennine Acute Trust completed the UNICEF internal audit which highlighted that 77 % of Pennine Acute Mothers received information and the risk assessment was completed on the postnatal ward in the early 12 hours post birth and the community audit increased this figure to 88 %. Work has taken place in the Pennine Acute Trust to ensure that Mothers receive the correct information regarding safe sleeping arrangements to improve consistency.

In early May and early June 2015 the Pennine Acute Trust completed the safe sleeping audit where postnatal notes and PCHR were audited to ensure that the information described above is being achieved. The audit showed that 93.5% of Pennine Acute Mothers received safe sleeping information and this was documented in the early 12 hours post birth. The community audit showed that 94.5% of Pennine Acute Mothers had their PCHR (Page 21 & 23) completed within 5 days.

The Lullaby Trust - Safe Sleeping Information

The Lullaby Trust www.lullabytrust.org.uk is nationally recognised organisation that provides useful safe sleep information such as videos, leaflets and quick tips for parents, carers and professionals:

Things to do

- Always place your baby on their back to sleep
- Keep your baby smoke free during pregnancy and after birth
- Place your baby to sleep in a separate cot or Moses basket in the same room as you for the first 6 months
- Breastfeed your baby, if you can
- Use a firm, flat, waterproof mattress in good condition

Things to avoid

- Never sleep on a sofa or in an armchair with your baby
- Don't sleep in the same bed as your baby if you smoke, drink or take drugs or are extremely tired, if your baby was born prematurely or was of low birth-weight
- Avoid letting your baby get too hot
- Don't cover your baby's face or head while sleeping or use loose bedding

The Lullaby Trust has developed the [Safe Sleep for Babies: A Guide for Parents](#) leaflet which provides a more detailed overview of how parents can reduce the risk of SUDI.

Parents who have suffered a sudden and unexpected death of a baby often feel anxious in future pregnancies. The Lullaby Trust has been working with the NHS to run a national health-visitor led service for bereaved parents the [Care of Next Infant \(CONI\)](#) programme, which supports families before and after the birth of their new baby. CONI is run in hospitals and community health centres and involves Health Visitors, Midwives, Paediatricians and GPs.

Through CONI, parents can:

- receive regular home visits by their health visitor, so they can talk freely about any worries and seek advice
- keep a symptom diary to record their baby's health, which they can then discuss with their health visitor
- use the Baby Check booklet to help decide when their baby should be examined by a doctor
- monitor their baby's growth with a weight chart and weighing scales, to detect changes quickly
- borrow apnoea (breathing) monitors which pick up movements as the baby breathes, and will ring an alarm if movements stop for longer than 20 seconds
- receive training on resuscitation
- receive a room thermometer and guidance on bedding and clothing

The CONI scheme is offered to parents across Bury, Rochdale and Oldham who present in pregnancy following a previous SUDI neonatal death or child death. The referral to CONI is usually completed by the Midwife or Health Visitor during the antenatal assessment once Mother reaches 28 weeks gestation. The scheme offers a more intense level of service to

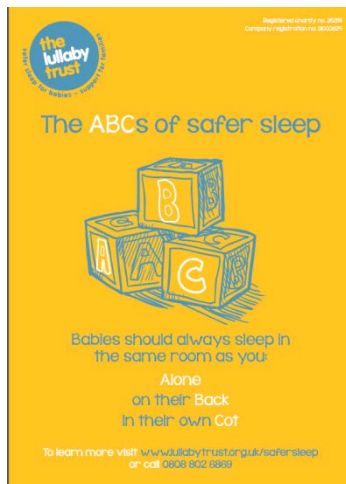
provide parents with additional support and reassurance during pregnancy. The core elements of the programme include regular contacts with a Health Visitor, symptom diaries, weight charts and apnoea (movement) monitors.

Raising Awareness of the Risks of Co-sleeping

Following a number of co-sleeping and overlay related SUDI deaths, the CDOP has taken a proactive approach in disseminating information regarding the risks associated with co-sleeping and other risk factors.

It was identified that whilst there is sufficient information provided antenatally and postnatally to parents, there were a number of co-sleeping deaths which involved siblings and family members. The CDOP agreed to utilise The Lullaby Trust poster 'The ABCs of Safe Sleep' to raise awareness amongst family members, friends and any other persons that may also care for a child.

In March 2015 the safer sleeping poster was sent to all GP surgery's and children's centres across Bury, Rochdale and Oldham. The CDOP requested that the poster be displayed in waiting areas to raise awareness within the community that babies should always sleep in the same room as you...



Alone
On their Back
In their own Cot

Safer Sleeping Training – Oldham Safeguarding Network Training

In November 2014, February and March 2015 the Local Authority Designated Officer held a number of training sessions for nursery workers and child minders in Oldham. Roughly 190 staff attended the training event where the CDOP Officer provided information regarding safe sleeping arrangements and the risks of co-sleeping. Staff were made aware of the do's and don'ts of co-sleeping and how to effectively communicate this message to parents. Staff were also provided with information from The Lullaby Trust website. Nursery workers and child minders present were requested to display the Safer Sleeping poster within their workplace to raise awareness amongst staff and parents/carers.

Oldham Council Team Briefing

In December 2014 the CDOP highlighted the potential risks of co-sleeping and overheating in the winter months. Oldham Local Safeguarding Children Board (LSCB) disseminated the 'Keep your baby safe this winter' message via the Oldham Council internal communications team briefing.

The team briefing was emailed to all Oldham Council staff to reinforce a consistent message regarding safe sleeping arrangements within the home:

When the weather is colder and you may be more likely to sleep with your baby in your bed, the LSCB is reminding parents and carers that the safest sleeping place for a baby is on their back in a cot or Moses basket. They should also be in the same room as you for the first six months.

The Oldham LSCB has also circulated information via the Team Briefing to raise awareness of The Lullaby Trust's Safe Sleep Week from 16th March 22nd March.

18. Suicide

From 1st April 2008 to 31 March 2015 there have been a total of 9 child deaths reported to CDOP following apparent suicide.

- 8 of the children were aged between 13 – 17 years of age
- The majority of the deaths occurred in 2012 (3/33%)
- 7 of the children died as a result of hanging at the parental home
- The largest number of deaths occurred where the children resided in the area of Bury with 56% (5)
- The majority of children were male (67%)
- 8 children were of the ethnicity White English/Welsh/Scottish/N Irish/British

The CDOP continues to monitor the number of suicides and works with neighbouring CDOPs across Greater Manchester to investigate emerging themes. In 2014 the CDOPs identified that there had been an increase across Greater Manchester in the number of child deaths following suicide. The Greater Manchester Safeguarding Partnership requested statistical data from the 4 Greater Manchester CDOPs to review key areas such as:

- Gender
- Age at Death
- Ethnicity
- Cause of Death
- Circumstances leading to suicide
- Any previous self-harm or indications they wanted to harm self
- Any mental health issues (incl. depression or anxiety)
- Any mental health issues known within family (parents or siblings)
- Previously known to services?
- Deprivation Quintile

The 4 CDOPs submitted data to the Greater Manchester Safeguarding Partnership to analyse the statistics and highlight any emerging themes. Whilst it was found that there was no significant emerging trend or link between the cases the CDOPs agreed to continue monitoring these figures and any issues are to be raised via the Greater Manchester CDOP Annual Report. This will provide the CDOPs with a much larger footprint to review and highlight any trends to potentially undertake collaborative working to reduce the number of suicides.

19. Asthma

¹³In the UK, 5.4 million people are currently receiving treatment for asthma. That is 1 in every 12 adults and 1 in every 11 children.

From 1st April 2010 to 31st March 2015 there have been a total of 8 asthma related child deaths. In 7 of the cases the child suffered from a sudden acute asthmatic attack prior to death. It's difficult to review information prior to 2010 as the Greater Manchester CDOP database was not established at this time.

The CDOP highlighted cases where the child was diagnosed with mild asthma but died from a sudden unexpected asthmatic attack. It was these cases where the CDOP discussed care management as the child did not have a history of frequent attacks but died following a sudden severe asthmatic episode. The CDOP felt it was these cases where children are most vulnerable and will continue to monitor the number of cases where asthma was a contributing factor to the death.

There were a number of cases where the panel identified modifiable factors. Some of the potential risk factors included:

- Poor compliance and frequently not attending for medical reviews and asthma appointments
- Inhalers/asthma medication not kept up to date nor available to the child due to missed appointments
- Lack of asthma medication thus presenting numerous time to Accident and Emergency for asthma related episodes
- Parental blame approach, lack of understanding of the severity of the child's condition
- Child protection concerns, child and/or siblings subject to child protection plans
- Chaotic home environment
- Domestic abuse within the home
- Parental smoking in the home
- Family pets

Oldham Asthma Audit

In May 2013 the Oldham Safeguarding Lead for Schools agreed to undertake an audit across primary and secondary schools. The survey was sent to all primary schools/primary academies in Oldham. A total of 59 primary schools out of 86 (68%) returned the questionnaire. All secondary school/academy asthma leads were also contacted to obtain details of procedures and practice across the secondary school sector.

Primary Schools

All primary schools were able to give data on the number of children in their school who were known asthma sufferers.

All schools that returned the survey confirmed that they had an asthma policy in place. Three primary schools reported that they had clear asthma procedures for staff contained within a 'Management of Medicines' or 'Pupil Medication' policy, rather than a stand-alone asthma policy. The majority of schools stated that they updated their asthma policy/procedures on an annual basis, usually after school staff have received updated training. 14 primary schools stated that this was not performed annually, 13 of which conceded that they had not updated their asthma policy for 3 years, or 5 years in 2 primary schools.

The majority of primary schools reported that staff received refresher management of asthma training on an annual basis. This was normally delivered by the School Health Advisor/School Nurse to all teachers and frontline school staff. 3 schools reported having received training via external providers (Skills Force, Elm First Aid Training). All primary schools who responded said that pupils bring inhalers into school.

¹³ NHS Information: <http://www.nhs.uk/conditions/asthma/Pages/Introduction.aspx>

Secondary Schools

All secondary schools and academies were contacted. Information was returned from 9 secondary school/academies (66%). All schools/academies who gave information have a designated first aider or pastoral manager who takes responsibility for keeping records of pupils with asthma. Parents are sent letters and asked to return slips to school with medical information.

All schools were able to say they have either an asthma policy or asthma guidance for staff and that staff receive regular training from the school nurse assigned to the school. It was established practice in most schools for all teaching and support staff to be given the names of pupils with asthma or made aware that this information is available on the school system. Several schools stated that they regularly sent an updated list of pupils with medical conditions to key pastoral staff. 1 school reported that they only kept a list of pupils with severe asthma. 2 schools commented that some parents only notify school that their child has asthmatic when they returned the permission slip for going on a school trip or outdoor activity.

Section E: Recommendations & Action Plan

20. 2014/15 Recommendations Update

In 2013/2014 the CDOP reviewed the findings from the Annual Report and produced recommendations and actions to in relation to:

1. Consanguinity and the Disproportionate Number of BME Deaths

Year on year the CDOP has highlighted an ongoing trend when comparing the number of BME child deaths to the BME child population. The CDOP continues to monitor and investigate the overrepresentation of child deaths within the BME community. This year the report suggested a link between BME child deaths, BME children with disabilities, consanguineous relationships and families that live in areas of deprivation.

Of the 37 BME child deaths referred to CDOP in 2013/14 it was identified that 10 (27%) of these deaths were directly linked to consanguinity, all of which are of Pakistani heritage thus accounting for a large proportion of the BME child deaths. Reviewing the ethnicity of the total 74 child deaths notifications in 2013/14 indicates that consanguinity accounted for 14% (10) of the overall deaths.

There is a clear link between consanguinity and the disproportionate number of children with disabilities and child deaths from the BME community. The Oldham Consanguinity Task Group has reviewed the existing processes in place to support the BME community via Saint Mary's Genetic Counselling and the support offered to families who are deemed most at risk. Oldham wishes to extend the services and information provided to the community and suggested a two strand approach

1. Reactive approach - To continue working with families that are at risk and increase the capacity by employing a specialist geneticist to undertake work in the community
2. Proactive approach – To raise awareness within educational settings to highlight the associated health risks of consanguineous relationships/marriages to ensure that the community has received appropriate information to make an informed decision.

As detailed in Section 15: Consanguinity of the annual report, year on year the CDOP is becoming more robust at collating data in relation to consanguinity. Section 15: Consanguinity of the report provides an overview of how consanguinity affects the population and raises questions regarding the cost implications this has for the NHS and Social Care. Calculating the cost implications and impact on the health service is difficult to estimate as every condition is varied and requires various sources of treatment and care depending on the child's diagnosis, the severity of their condition and the life expectancy of the child.

The Oldham Consanguinity Task Group reviewed local authority's campaigns such as Birmingham and Bradford who have also identified consanguinity as a risk factor regarding the associated health risks. Oldham reviewed the pros and cons of these campaigns to look at lessons learnt and establish what information is currently provided to the community and the best way forward. At present the GP/hospital may refer a family to Saint Mary's Genetic Counselling Service where a genetics counsellor works one day a week in Oldham. However they do not have the capacity to undertake any preventative work or general awareness raising within the community.

Oldham LSCBs drafted the consanguinity report which was presented to the Health and Wellbeing Board to look at the next steps forward to increase capacity and continue working with families who are most at risk and to raise awareness within the community by providing information in college settings regarding the associated health risks. Oldham LSCB wishes to implement the following proposal:

1. Targeted work to raise awareness within the communities at risk with the aim that people understand that, if there is a family history which raises concerns, they should seek specialist advice. The aim is to ensure that members of the public understand the associated health risks linked to consanguineous relationships to make informed decisions before considering marriage
2. Raising awareness amongst front-line health professionals about the issue enabling them to contribute to the awareness raising, provide the appropriate information and initiate referrals where needed
3. Increasing the capacity of the Saint Mary's service to provide genetic counselling, and to undertake community outreach work.

At present the report is to be presented to the Clinical Commissioning Group (CCG) to discuss resources to fund and employ a specialist genetics post who can carry out the proposal.

2014/15 Update

The Oldham LSCB and Public Health Consanguinity Report was presented to the Integrated Commissioning Partnership (ICP) to request funding from the Clinical Commissioning Group (CCG) to commission a programme of genetic counselling and awareness raising to reduce the impact of consanguinity in Oldham. The CCG have agreed to fund the post of a genetics worker who will:

- Continue to work with the St Marys Genetic Service to support affected families and families who are most at risk
- Train health professionals (GPs, Midwives, Health Visitors etc.) to gain knowledge of how to identify consanguineous families who are at risk of inherited genetic abnormalities and to refer these cases to the genetic service
- Undertake awareness raising work within the community
- Use and distribute suitable communication tools such as leaflets

The CCG is in the process of drafting a report detailing the expected costings to host the post of a community based genetic worker, communication tools, training and workforce development.

The Consanguinity Report recommends:

1. The Council and CCG are asked to agree the proposed financial contributions
2. ICP partners are asked to agree the actions set out in the report
3. NHS Oldham CCG is asked to nominate a lead contact for commissioning and procurement of the services indicated
4. The CCG lead the procurement of the proposed post, with support from Public Health colleagues

Once funding has been finalised and an appropriate candidate is appointed the actions outlined in the proposal can begin to take effect.

The CDOP reviewed the Sheffield NHS '*Cousin Marriage & Genetic Risk*' leaflet to look at adopting a similar document to raise awareness within the community of consanguinity and the associated health risks. Oldham NHS have agreed to adopt a leaflet containing similar content to the Sheffield document and work is ongoing in the NHS with the Health Visitor Development Lead and the Communication Department who are to review the content and draft an Oldham version. The leaflet has been discussed at the Bury SCB and was referred to the Health and Wellbeing Board for action. The leaflet has been raised at the Rochdale BSCB and it was agreed that the leaflet contained useful information and the LSCB Development Officer is to drive this forward.

It was agreed that initially the leaflet could be distributed via Midwives and Health Visitors. Once the genetics worker is in post they will also be responsible for distributing the leaflet to the GPS and within the community.

2. Continue Co-ordinating a Consistent Safe Sleeping Message

As part of the UNICEF audit the Pennine Acute regularly audit bed sharing information provided to Mothers in writing, the discussions held and risk assessments completed (Child Health Records).

The Pennine Acute Hospital continues to provide the information guide 'Putting your baby down to sleep safely' which advises that parents:

Never sleep with your baby if either you or your partner

- *has taken any legal or illegal drugs*
- *has been drinking alcohol*
- *is a smoker*

or if

- *your baby was born small or premature*

Do not put yourself, or allow others to be, in a position where there is a possibility of dozing off with the baby on a sofa or armchair, as this is one of the highest risk factors for sudden infant death.

The Pennine Acute Hospital policy states that the leaflet should be provided to every new Mother and discussed on the labour ward. Information is provided on the postnatal ward where notes are stamped, dated and signed to record the discussion held. The message is also reinforced at discharge and at the first home visit from the community midwife. An internal audit in Pennine Acute identified some gaps and that the service was not always fully compliant. Further work is required to ensure that all Mothers receive the correct information regarding safe sleeping arrangements to improve consistency. The Pennine Acute are in the process of updating action plans to achieve this.

The November 2014 audit showed that 77% of Pennine Acute Mothers received this information and the risk assessment was completed on the postnatal ward in the early 12 hours post birth. The community audit increased this figure to 88% of Mothers having this advice (links to early discharge). The Pennine Acute appreciate that further work is required to ensure that all Mothers receive the correct information regarding safe sleeping arrangements to improve consistency and are in the process of updating action plans to achieve this.

Information regarding safe sleeping and reducing the chances of infant death continues to be provided in the Personal Child Health Record (PCHR) also known as "the red book". The booklet contains information for parents highlighting safe sleeping arrangement do's and don'ts stating that '*The safest place for your baby to sleep is on their back in a cot or a crib in the room with you for the first six months*'.

The Safe Sleeping Assessment and Action Plan are completed by the midwife and contain questions regarding breastfeeding, safe sleeping, smoking and alcohol consumption. Any identified risk factors are highlighted and actions produced with timescales to address any concerns.

2014/15 Update

In 2014 the Pennine Acute Trust completed the UNICEF internal audit which identified some gaps and that the service was not always fully compliant. Further work has since taken place within the Trust to ensure that all Mothers receive the correct information regarding safe sleeping arrangements to improve consistency.

Whilst there are currently no plans for the Pennine Acute Trust to repeat the UNICEF audit work remains ongoing within the Trust to provide parents with appropriate and consistent information regarding safe sleeping arrangements. The Pennine Acute Trust continues to distribute the leaflet '*Putting your baby down to sleep safely*' which provides parents with useful information to reduce the risk of sudden and unexpected deaths in infancy.

The Pennine Acute Hospital policy states that the leaflet should be provided to all Mothers and discussed on the labour ward. Information is provided at birth on the postnatal ward where notes are stamped, dated and signed to record the discussion held. The message is also reinforced at discharge and at the first home visit from the community midwife.

Information regarding SUDI is also contained in the Personal Child Health Record (PCHR) also known as "the red book". The booklet contains information for parents highlighting safe sleeping arrangement do's and don'ts stating that '*The safest place for your baby to sleep is on their back in a cot or a crib in the room with you for the first six months*'.

The Safe Sleeping Assessment and Action Plan continues to be completed by the midwife highlighting specific factors such as breastfeeding, safe sleeping, smoking and alcohol consumption. Any identified risk factors are documented and actions produced with timescales to address any concerns.

In early May and early June 2015 the Pennine Acute Trust completed the safe sleeping audit where postnatal notes and PCHR were audited to ensure that the information described above is being achieved. The audit showed that 93.5% of Pennine Acute Mothers received safe sleeping information and this was documented in the early 12 hours post birth. The community audit showed that 94.5% of Pennine Acute Mothers had their PCHR (Page 21 & 23) completed within 5 days.

The CDOP continues to monitor the number of Sudden and Unexpected Deaths in Infancy (SUDI) year on year. When reviewing a SUDI child death the CDOP identifies specific risk factors in relation to the circumstances leading to death, the home environment and parenting capacity to determine whether the death was modifiable.

Co-sleeping is recorded in a number of SUDI cases where direct overlay onto the child has also occurred. Whilst the CDOP felt that appropriate and adequate information is provide to parents, there was potential for further awareness raising with friends and family members who also care for the child. The CDOP distributed The Lullaby Trust ABC Safer Sleep poster to all GP surgeries and children's centres across Bury, Rochdale and Oldham to reinforce the message:

Babies should always sleep in the same room as you:

Alone

On their back

In their own cot

The poster and safe sleeping advice for professionals and parents has also been distributed to nursery workers and child minders in Oldham. In 2014/2015 Oldham held a series of safeguarding network training events where roughly 190 staff were trained in the identifying the risks of co-sleeping and overlay. The training event also covered other contributing risk factors such as overheating, parental smoking, prescribed medication, substance misuse and alcohol consumption.

Staff were provided with useful leaflets detailing the do's and don'ts of co-sleeping and how to effectively communicate this message to parents. Nursery workers and child minders present were requested to display the safer sleeping poster within their workplace to raise awareness amongst staff, parents and carers.

21. 2014/2015 Action Plan

Following completion of the Annual Report, the key findings and emerging themes form the basis of the 2014/2015 Action Plan which highlights:

1. The associated health risks of consanguinity and the disproportionate number of BME child deaths

Year on the year the CDOP continues to highlight the disproportionate number of children with disabilities and child deaths within the BME community. Many of the issues raised within the report will remain ongoing pieces of work. The action plan specifies objectives which have been set for partner agencies to work together with the aim of reducing child death due to inherited autosomal recessive disorders.

2. Establishing links across the Greater Manchester CDOPs and Public Health to collaboratively identify themes and key actions

The Greater Manchester CDOP Network was established in 2014 and includes the attendance of the Greater Manchester Safeguarding Partnership Coordinator, CDOP Chairs, CDOP Officers and Public Health representatives. Meetings are held quarterly where key professionals review the child death process, statistical data and highlight emerging themes across Greater Manchester.

As good practice professionals will continue to meet and discuss findings from the annual report to implement an action plan with the support and assistance of the Department of Public Health.