Bedford Borough Safeguarding Children Board &
Central Bedfordshire Safeguarding children Board
Working together to safeguard children

BEDFORDSHIRE & LUTON

CHILD DEATH OVERVIEW

PROCESS

ANNUAL REPORT

2010-2011

Gerry Taylor

Director of Public Health, Luton PCT

Independent Chair

Bedfordshire & Luton CDOP

Shirley Whiterod

Manager

Bedfordshire & Luton CDOP

		Page
	Executive Summary	3
1.	**Introduction to Child Death Overview Process**	5
2.	**Overview of Child Death Overview Process operation**	5
	2.1 Numbers of deaths in Bedfordshire & Luton 2010-2011	
	2.2 Meetings held & reviews conducted 2010-2011	
	2.3 Organisation & resourcing of Child Death Overview Process	
3.	**Role of Lead Nurse for Child Death Reviews in Luton**	7
4.	**Rapid Response Information Sharing Meetings**	8
5.	**Luton Cases reported & reviewed 2010-2011**	9
	5.1 Luton Neonatal deaths	
	5.2 SUDI's	
	5.3 Other unexpected deaths	
	5.4 Expected deaths	
6.	**Central Bedfordshire Cases reported & reviewed 2010-2011**	11
	6.1 Central Bedfordshire Neonatal deaths	
	6.2 SUDI's	
	6.3 Other unexpected deaths	
	6.4 Expected deaths	
7.	**Bedford Borough Cases reported & reviewed 2010-2011**	12
	7.1 Bedford Borough Neonatal deaths	
	7.2 SUDI's	
	7.3 Other unexpected deaths	
	7.4 Expected deaths	
8.	**Modifiable factors noted in child deaths**	13
9.	**Actions taken as a result of enquires by CDOP 2010-2011**	13
10.	**Recommendations for 2011-2012**	14
	9.1 Training	
	9.2 CDOP Newsletter	
	9.3 Review by Professor Eileen Munro	
11.	**Summary of CDOP 2008-2011**	17
12.	**Appendices**	20
	Appendix 1 Purpose, terms of Reference & Objectives	20
	Appendix 2 Operational Arrangements of CDOP	24
	Appendix 3 Comparison of Statistical Data	28
	Appendix 4 Cases reported 2010-2011	31
	Appendix 5 Ethnicity of children	32
	Appendix 6 Age profile of children	33
	Appendix 7 Gender of children	34
	Appendix 8 Summary of all Luton cases reviewed	35
	Appendix 9 Summary of all Central Bedfordshire cases reviewed	36
	Appendix 10 Summary of all Bedford Borough cases reviewed	37

Executive Summary

The Child Death Overview Process (CDOP) is a process which has been a statutory requirement since April 2008. (Working Together to Safeguard Children 2006 & 2010)

There is one CDOP across Bedfordshire and Luton as it is recommended that there should be one CDOP for every 500,000 head of population. CDOP is accountable to the 3 Local Safeguarding Children Boards (LSCB) of Luton, Bedford Borough and Central Bedfordshire

Membership of CDOP is made up as per Chapter 7 of Working Together to Safeguard Children and is managed on a day to day basis by a full time manager. This post is hosted by NHS Bedfordshire on behalf of the 3 LSCB's and managed by the Designated Nurse for Safeguarding Children and Young People in Bedfordshire. The CDOP panel is chaired by an independent chair who is also Director of Public Health for NHS Luton. The panel meet every 6 weeks and all child deaths are reviewed. Bedfordshire and Luton CDOP have robust terms of reference and objectives. These can be accessed on the Bedfordshire LSCB website

If the child dies unexpectedly a rapid response/information meeting is held as soon as practicably possible after the death with all agencies and professionals who knew the child and family. The purpose of this meeting is to enquire into the circumstances of the death, to establish who will support the family and ensure there are no safeguarding concerns for other children in the family.

During the period 2010-2011, 7 meetings have been held with 2 addition sub group meetings held with a neonatologist and senior nurses and midwives from the Luton & Dunstable Hospital. In total the panel have reviewed and closed 69 cases. Just over half of these deaths occurred in the period 2009-2010 with 7.2% dying in the period 2008-2009 and the remainder during the current reporting year.

During the current year 2010-2011 63 child deaths were reported to the Child Death Overview Panel. This is a decrease of 11% on the previous year. Nearly 40% of these cases have been reviewed and closed

The panel has to determine if, when reviewing the deaths, there were any modifiable factors 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 deaths.

The panel has identified in 28% of the cases reviewed and closed some modifiable factors particularly in relation to neonatal deaths especially when babies have been born at a very early gestational age. Factors include maternal smoking and obesity. Other factors in unexpected deaths relate to unsafe sleeping practices and parental smoking. One of the recurring factors observed in neonatal deaths where babies have been born with congenital anomalies is that the parents have been related. When this factor is identified the lead paediatrician will write to the GP to suggest that genetic counselling is offered to these parents in order for them to make informed decisions about future pregnancies.

1. Introduction to Child Death Overview Process

Bedfordshire & Luton Child Death Overview Panel (CDOP) was convened in February 2008 in accordance with statutory guidance detailed in *Working Together to Safeguard Children (2006 & 2010).* The child death review functions became compulsory from 1st April 2008. This panel is a sub committee of the Local Safeguarding Children's Boards and as such is accountable to them and reports to them on a 6 monthly basis.

Due to population numbers and the recommendations in Working Together to Safeguard Children (2010) there is one Child Death Overview Process for Bedfordshire and Luton.

Through a comprehensive and multidisciplinary review of child deaths, the Bedfordshire and Luton Child Death Overview Panel (CDOP) aims to better understand how and why children in Bedfordshire and Luton die and use our findings to take action to prevent other deaths and improve the health and safety of our children. Throughout this process the CDOP aims to ensure that families are treated with sensitivity and respect at all times and that cases are reviewed with an open mind.

Appendix 1-The purpose, terms of reference and objectives

Appendix 2 Operational arrangements of CDOP

2. Overview of CDOP operation

2.1 Number of deaths in Bedfordshire & Luton 2010-2011

During the period 1st April 2010 to 31st March 2011 a total of 63 child deaths were reported to the Bedfordshire and Luton Child Death Overview Panel.

16 of the child deaths were of children residing in Bedford Borough, 14 of the deaths were of children living in Central Bedfordshire and 33 of the child deaths were of children living in Luton. 2 of these deaths were of children who had died in the previous reporting year. Appendix 3

This is decrease of 11% compared to the same period last year.

25 of these cases have been reviewed by the CDOP panel and closed. 9 cases were deemed by the panel to have modifiable factors.

Working Together to Safeguard Children (2010) states that all child deaths, excluding stillbirths should be reported to CDOP. A large proportion of the reported deaths, (38%) were neonatal deaths which include extremely pre term babies, some of whom

delivered before or at the edge of viability and some with lethal congenital anomalies who died very shortly after birth or within the first week of life.

2.2 Meetings held & reviews conducted 2010-2011

7 meetings have been held during the past year. All have been quorate and attendance by all panel members has been excellent. One meeting was given over to discussing neonatal deaths and a neonatologist, senior neonatal nurse and senior midwife attended from the Luton and Dunstable Hospital. As a consequence and due to large numbers of neonatal deaths 2 sub group meetings have been held at the Luton and Dunstable Hospital with the neonatologist, senior neonatal nurse and senior midwife to discuss these cases

In total during 2010-2011, 69 cases have been reviewed and closed. 7.2% of these cases were babies or children who died during the period 2008-2009, 56.5% dying in the period 2009-2010 with the remainder 36.3% dying during the period 2010-2011.

Of the 69 cases reviewed, 43% of these deaths were reviewed at panel within 6 months of the child's death.

In total 78% of cases were reviewed within 1 year of the child's death. The cases which took longer than 12 months to come to the panel were due to internal investigations by other agencies and waiting for completion of coroners inquests.

There are no outstanding cases for 2009-2010 to be reviewed.

20 (29%) of the 69 deaths reviewed were considered by the panel to have modifiable factors. These factors include parental smoking, maternal drug misuse, raised maternal BMI, unsafe sleeping practices and consanguinity.

Data on all child deaths is reported annually to the Department for Education.

When reviewing a number of cases (3) issues around processes and clinical care were highlighted by the panel and requests made through NHS commissioners for a further review or consideration for the case to be flagged as a Serious Incident.

The DCSF undertook a statistical analysis of all data received for the period 2009-2010. The Bedfordshire and Luton CDOP compared their data to the national picture and our panel operation compared very favourably with the national picture. See Appendix 1.

2.3 Organisation & resourcing of CDOP

The day to day management of the CDOP process is undertaken by the CDOP manager. She is employed by NHS Bedfordshire, who host the post on behalf of partner organisations and is line managed by the Designated Nurse for Safeguarding Children and Young People in Bedfordshire.

Child deaths in Luton are reviewed by a lead paediatrician who is employed by Luton Community Health Services- now Cambridge Community Services Trust and child deaths in Bedford and Bedfordshire are reviewed by a lead paediatrician who is employed by NHS Bedfordshire.

The CDOP process across Luton and Bedfordshire is currently funded by partner organisations from monies given by Central Government:

- NHS Bedfordshire
- NHS Luton
- Luton Borough Council
- Central Bedfordshire Council
- Bedford Borough Council

Monies given by Central Government for the CDOP process are no longer ring fenced. However, funding for the CDOP process has been agreed from all the above agencies for the period 2011-2012.

3. Role of Lead Nurse for Child Death Reviews in Luton

In May 2010 Luton Community Health Services employed Anita Wilson as the Lead Nurse for Child Death Reviews in Luton. She is a paediatric nurse by background and the main purpose of her role is to be a link between the family and child death review process, by making enquiries into the death, offering bereavement support and two way feedback.

The main aspect of the role is to offer early bereavement support to families and signpost them to appropriate bereavement counselling services. She rapidly responds to unexpected deaths and where possible makes joint home visits with the Police, to make further enquiries about the circumstances surrounding the death and if applicable to observe the environment the child died in. She will inform all families of the child death review process, explaining that multi-agency information about the child and family will be occurring. She offers families the opportunity the ask questions or make comments about their child's death or medical care they received and represent them when the case is discussed by CDOP.

From October 2010- March 2011, the lead nurse visited 21 families, 10 following unexpected deaths and 11 following expected deaths.

As some families require follow up bereavement visits, the total number of home visits made in this period was 36. (24 following unexpected deaths, 12 following expected deaths).

The Lead Nurse for Child Death Reviews tends to visit families instead of the health visitor. Most families do not receive support from any other health service in the community, usually because the families do not actively seek bereavement support.

Other aspects of her role include;

- Training GPs & LCS Community Staff about the child death review process
- Organised for the Foundation for Sudden Infant Death to deliver their seminar entitled 'Better Beginnings for Vulnerable Teenage Parents and Their Babies' for Luton Community Staff
- Collaborative working with Keech Hospice Care, resulting in a change to their Palliative Care Plan, which now incorporates discussing the child death review process with parents, prior to the death
- Member of Bedfordshire's Bereavement Forum

There is no such comparable role for child deaths in Bedford Borough or Central Bedfordshire.

4. Rapid Response/Information Sharing Meetings

A number of rapid response information sharing meetings were held in response to unexpected deaths. These meetings were held either on the day of the child death or within 48 hours. All such meetings are chaired by the Lead Paediatrician for the CDOP panel and are attended by all professionals who knew the child and family. This purpose of these meetings is to establish facts around the circumstances leading to the child's death, to take a decision on who will be supporting the family and offering bereavement support and to discuss if there are any safeguarding concerns for other children in the family.

Following 2 of the unexpected deaths concerns were raised by the police and these cases were the subject of a forensic post mortem. The Local Safeguarding Children Board was informed of concerns raised and consideration was given to whether the cases met the threshold for a serious case review.

5. Luton Cases reported/reviewed 2010-2011 (*Appendix 2*)

In total 33 deaths were reported to the Bedfordshire and Luton Child Death Overview Panel. However 2 of these deaths were late reporting and the children had died in the period 2009-2010

This compares with 44 reported in 2009-2010.

During the period April 2010 to March 2011 60% of the reported deaths were of children under the age of 1 year with 50% of these being early neonatal deaths (deaths occurring within the first week of life)

Ethnicity

All Children

Of the 33 child deaths reported in Luton 45% of those were from the Pakistani community with 80% of these being deaths in children under 1 year of age.

15% of deaths were Black African and 12% of deaths were White British. The breakdown of the remaining deaths can be seen in Appendix

5.1 Luton Neonatal deaths

During the period 1st April 2010 to 31st March 2011 a total of 9 neonatal deaths (deaths occurring during the 1st 28 days of life) were reported for babies whose parents reside in Luton.

44% of these babies died within the first few hours of life either from complications of extreme prematurity or as a result of known congenital anomalies where parents had chosen to continue with the pregnancy.

The remaining 5 babies died aged between 1 day and 27 days due to complications of prematurity, congenital anomalies and complications of surgery.

8 of these cases have been reviewed and closed. 2 sub group meetings were held during 2009-2010 with a Consultant Neonatologist, senior nurse and midwife from the Luton and Dunstable Hospital.

A large number of neonatal deaths from the preceding reporting year as well as cases from this year were reviewed and closed.

When modifiable factors for all these neonatal deaths were discussed it was noted that a significant number of babies died as a consequence of chromosomal and congenital anomalies. These babies' parents were predominantly from an Asian background and the parents were noted to be consanguineous. The population risk for any couple of having a child with a serious or lethal medical condition is around 2% (1 in 50). The excess risk for a couple who are related as first cousins, in the

absence of a known genetic disease in the family, is in the order of 3% (1 in 30). Some of these families have already had a child with a similar life limiting condition. Genetic counselling is recommended for these families so that they can make informed decisions about future children.

5.2 SUDI's

2 Sudden Unexpected Deaths in Infancy (SUDI) were reported. In both cases the age of death was 2 months. At the time of this report post mortem findings are not available and it is possible that a cause of death will be established.

5.3 Other unexpected deaths

There were 10 further unexpected deaths. To date only 1 of these cases has been reviewed and closed. The delay in reviewing these cases is due to ongoing hospital investigation, police investigations and awaiting post mortem reports and coroners inquests

Two of the children were known to have life limiting conditions but their death was not expected at the time. However there were no suspicious circumstances noted in these deaths.

Two children died abroad and despite letters to the hospitals were they died it has not been possible to gain a full data set of information but it appears that there were no suspicious circumstances surrounding the deaths.

One of the deaths is being investigated by the Bedfordshire & Hertfordshire Major Crimes Unit. One child died as result of a road traffic collision in a neighbouring county and is still under investigation. One death was an unexpected neonatal death for which there is an ongoing investigation

One child died as a result of an undiagnosed condition and for the other 2 deaths a cause of death is awaited.

.5.4 Expected deaths (excluding neonatal deaths)

12 expected deaths were reported to the CDOP during 2010-2011.

50% of these deaths were in children aged 1 year and under and were the result of chromosomal /congenital anomalies or as a consequence of prematurity.

Two children were aged between 1 and 4 years and the remaining 3 were teenagers with known life limiting conditions.

50% of these cases have been reviewed and closed.

6. Central Bedfordshire Cases reported/reviewed 2010-2011

A total of 14 child deaths were reported from April 2010 to March 2011 for children in Central Bedfordshire Council.

71% of these deaths occurred in children under 1 year of age with 70% of these deaths being neonatal deaths (occurring in the 1st 28 days of life)

The remaining deaths of which there were 4 were reported in the ages 1 to 17 years.

7 of the deaths were classified as unexpected deaths- that is they were not anticipated in the 24 hours prior to the death

Ethnicity

All Children

All the children who died in Central Bedfordshire were White British

6.1 Central Bedfordshire

Neonatal Deaths

During the period 1st April 2010 to 31st March 2011 a total of 7 neonatal deaths were reported for babies whose parents reside in Central Bedfordshire.

Of these all 71% died within the first few hours or days of life either from complications of extreme prematurity or as a result of known congenital anomalies where parents had chosen to continues with the pregnancy.

Four of these cases have been reviewed and closed. The panel did not consider that there were any modifiable factors in these cases.

6.2 SUDI's

Three Sudden Unexpected Deaths in Infancy (SUDI) was reported to the panel. In 2 of the cases there was no cause for the death found at post mortem. Therefore the cases can be classified as Sudden Infant Death Syndrome. Smoking and unsafe sleeping practices were noted as modifiable factors by the panel.

For the remaining case the post mortem result is awaited.

6.3 Other unexpected deaths (excluding SUDI's)

There were 4 other unexpected deaths reported in Bedfordshire. 3 of these cases have been reviewed and closed. There were no common features in any of the deaths and no modifiable factors were identified. Due to small numbers it is not possible to give further details as no child should be identifiable.

6.4 Expected deaths (excluding neonatal deaths)

One expected death was reported of a child with a life limiting conditions.

7. Bedford Borough Cases reported/reviewed 2009/2010

In total 16 child deaths were reported to the panel for children who reside in Bedford Borough. This represents an increase of 5 (45%) from the previous years reporting

78% of these deaths occurred in children under 1 year of age with 45% of these deaths occurring in the early neonatal period. The remaining 5 deaths were reported in the age range 1 to 11 years.

Four of the deaths were unexpected deaths – that is the death was not anticipated within the previous 24 hours.

Ethnicity

Children aged 0-4 years

38% of the children who died were White British, with 19% of Indian ethnicity. The remaining children were of Pakistani, Bangladeshi, and Black African and White other backgrounds.

7.1 Bedford Neonatal deaths

During the period 1st April 2010 to 31st March 2011 a total of 5 early neonatal deaths were reported for babies whose parents reside in Bedford Borough. These babies died within the 1st week of life from complications of prematurity and congenital anomalies.

7.2 SUDI's

2 SUDI's were reported to the panel. The conclusion of one post mortem was SUDI but modifiable factors identified were associated with unsafe sleeping practices. The post mortem result is awaited on the other case.

7.3 Other unexpected deaths

There were 2 other unexpected deaths. Information is currently being reviewed on one case and the other case has been flagged as a serious incident at 2 local hospitals. The date of the inquest for this death is not yet known.

7.4 Expected deaths (excluding neonatal deaths)

Six expected deaths were reported of children with life limiting conditions. 2 of this case were babies under 1 year of age who died as result of complications of prematurity the other 4 case were of children with life limiting conditions 3 cases have been reviewed and closed and the others will be reviewed in the coming year.

8. Modifiable factors noted in child deaths

Smoking, unsafe sleeping practices & consanguinity

From reviews of child deaths undertaken it is clear that smoking both in pregnancy and in the home may have been a contributory factor in a number of neonatal deaths. The CDOP panel will continue to recommend to public heath and health care professionals that awareness is raised through discussion with families of the serious consequences of smoking to both unborn babies and children. Midwives and health visitors continue to reinforce the message of safe sleeping practices to newly delivered mothers.

Consanguinity has been noted in a large proportion of deaths that have been reviewed. The panel have deemed this as a modifiable factor and recommended that where parents are related genetic counselling is offered to these parents to ensure they are aware of the potential risks and can make informed decisions about future pregnancies.

9. Actions taken as a result of enquiries by CDOP 2010-2011

- Discharge procedure from local NNU reviewed and amended and information leaflet given to parents updated
- Recommendations concerning medicine management for vulnerable children in the community investigated as a result of enquiries by CDOP
- Case taken forward as Serious Incident following discussion at CDOP panel. Action plan now in place and being monitored by Designated Nurse for Safeguarding Children in Luton.
- Recommendations that all babies children who die as a result of chromosomal abnormalities where it is known that consanguinity is a factor, GP's are contacted and asked that genetic counselling be offered to parents.
- Enquiries made to local public health commissioners to ascertain work in progress around obesity pathways for pregnant women
- Communication strengthened with Child Health Departments to ensure they are aware of every child death CDOP is notified of.
- Cover for annual leave of Lead Paediatrician in Bedford now in place.

10. Recommendations for 2010/2011

10.1 Addressing Consanguinity:

The link between infant mortality and genetic inheritance is real but the ability to openly discuss and tackle the risks is hampered by cultural sensitivities, preconceptions and misconceptions regarding marriage and family relationships.

Consanguinity is recognised as a significant contributory factor to infant mortality in Luton as evidenced through the panel findings. There are gaps in information regarding consanguinity in Luton that need to be filled to inform targeted interventions:

- Number of consanguineous relationships in the south Asian and other communities such as travellers and Irish community
- The degree of consanguinity between the partners in the relationship and whether the risk of infant mortality is linked in Luton and there is a strong genetic risk of autosomal recessive conditions within extended families.

NHS Luton will be working with partners to understand the inter-generational attitudes and beliefs towards consanguineous relationships, the general awareness and risk perceptions and to openly discuss these sensitive issues sensibly. Key actions planned are:

- Focused cultural awareness training of health professionals to deliver consistent and evidence based information that is not hampered by concerns regarding cultural sensitivities. In order to get past the barriers Luton needs to have health professionals who are trained and empowered to:
  - communicate in ways that resonate with families experience and observations to help them make informed choices about marriage and children
  - Provide a balance between giving scientifically evidenced information that does not become a catalyst for undermining cultural beliefs
  - Focus on the facts – the way in which genetics influences hereditary diseases
  - Ensure information is widely available through general practices, Asian media and community organizations in appropriate languages which signpost women to services
- Target community groups where consanguineous relationships are more common so that information is available before marriage and conception regarding associated risk and the extended family is engaged to support decision making

- Too few couples and mothers who may be planning or already within a marriage that is considered consanguineous and parents in consanguineous marriages who have suffered a child death or have a child with a birth anomaly are given information regarding risk to their children. Health professionals need to signpost families to genetic screening and counselling services.
- Genetic screening and counselling services are available locally but the scale of need in Luton for these services is not known. Services need to be extended and accessible

Other modifiable factors – work in progress:

The CDOP investigations also reinforce the need to promote healthy behaviour ideally pre-conception but certainly during the early antenatal period of pregnancy such as maternal smoking, drug misuse and raised maternal BMI. NHS Luton with partner organisations have prioritised:

- Reducing smoking in pregnancy – working with the Tobacco Control Collaborating Centre stop smoking advisors and midwives are currently being trained to deliver the 'baby clear' programme as part of the maternity care pathway
- Implementing NICE 'weight management before, during and after pregnancy' with maternity services
- Commissioning services is for vulnerable women and parents with children who do not routinely access services to support education and better parenting skills

10.2 Training

Further multi agency training will be undertaken to ensure that all agencies that interface with children and their families are aware of the working of the Child Death Overview Panel and understand their statutory responsibility when a child known to them dies.

10.3 Communication

CDOP will continue to liaise with Community Health Services and hospital trusts to ensure any safety messages identified through the review of child deaths are communicated in a timely manner for dissemination by midwives, health visitors and school nurses as appropriate.

10.4 CDOP newsletter

During 2011-2012 a CDOP newsletter will be developed to inform all professionals and agencies who complete data collection forms of general themes and outcomes arising from reviews of child deaths.

10.5 Review by Professor Eileen Munro

Professor Eileen Munro was commissioned by the Government in June 2010 to undertake a review of the Child Protection. In her interim report she states that the review has been made aware of a lack of a national mechanism for systematically analysing, collating and disseminating local learning. The review intends to consider how this might be achieved.

Further more she is reviewing how the Serious Case Review process and Child Death Review Process fit together and if there is scope for reducing duplication by aligning the 2 processes together.

It is understood that Working Together to Safeguard Children (2010) will be revised.

When Professor Munro's report is published, the Bedfordshire and Luton Child Death Overview Process will consider and implement her recommendations in respect of the Child Death Review Process.

11. Summary of CDOP 2008-2011

The Child Death Overview Process has been a statutory process since April 2008 and the process has evolved and reporting of child deaths has become more robust.

There is a commitment for all agencies feeding into the process and CDOP meetings are well attended.

Table 1 Summary of all child deaths April 2008-March 2011

Ages	2008-2009		2009-2010		2010-2011	
# child deaths	Total deaths	# Unexp	Total deaths	# Unexp	Total deaths	# Unexp
Bedfordshire	29	14	28	6	30	11
Luton	21	6	44	13	33	12
Total unexp.		20		18		33
Total deaths	50		72		63	

Data reporting of neonatal deaths especially of those babies born at a very early gestation with a heart rate for some time that are classified as live births but are in fact pre viable fetuses has improved over the past 2 years. These deaths were not captured during the first year of reporting. Closer links established with the Registrars of Births and Deaths across the county have also ensured that all deaths are captured. Deaths occurring outside of the county are reported to CDOP via local CDOP managers and co ordinators whilst deaths occurring in Bedfordshire and Luton of non residents are reported to CDOP leads in the area where the child resided.

Luton 3 Year Data Analysis

Between April 2008 and March 2011 a total of 98 Luton deaths were reported.

Ages of children

39% of these were neonatal deaths with many dying in the first hours or days of life from complications of prematurity and known anomalies but where the parents had opted to continue with the pregnancy.

In total almost 66 % of all deaths reported were in children under the age of 1 year

Of the total deaths reviewed to date from April 2009 to March 2011 consanguinity was a modifiable factor identified in 20% of the deaths reported in Luton.

Other modifiable factors include maternal smoking, drug misuse and raised maternal BMI.

Ethnicity

A breakdown of ethnicity shows that:

31% of children were Pakistani
28% of children were White British
11% of children were Bangladeshi
9% of children were Black African
6% of children were Black Caribbean
From Luton school census data of 2010 there appears to be an over representation by 10 percentage points of children dying from a Pakistani background. There is also an over representation of Black African children of 3.2 percentage points as compared to the school census data.

Area of residence

On reviewing the ward where these children have died, **15%** of children lived or their parents reside in Dallow Ward. Dallow ward is in the top 20% most deprived in Luton and according to the Index of Multiple Deprivation it is also a Super Output Area in the top 20% of most deprived in England (IMD, 2007). Dallow is an area of high deprivation with poorer health outcomes; Dallow is one of two wards in Luton with the highest percentage of children under the age of 5. It also has the highest percentage of Asian community at 55.1% (Census 2001)

Central Bedfordshire 3 year Data Analysis

When the CDOP process was set up in April there was only 1 local authority across Bedfordshire. There became a unitary split in April 2009 when Central Bedfordshire and Bedford Borough Local Authorities were formed.

Data collected for Bedfordshire during 2008-2009 has been reviewed and children who lived in what is now Central Bedfordshire have been included in the data with Central Bedfordshire children from the 2 subsequent years.
In total 45 children's deaths were reported to CDOP in the period 2008-2011

Ages of children

In total 64 % of all deaths reported were in children under the age of 1 year.

Ethnicity

100% of the children who died in this 3 year period were White British. The ethnic population of Central Bedfordshire for 2007 recorded that 89% of the population of Central Bedfordshire were White British.

Area of residence

24% of deaths occurred in children living in North and South Leighton Buzzard wards. Parts of the Leighton Buzzard North Ward are in the 50% most deprived in England with a large proportion of single parent families. One third of children live in income deprived households. Leighton Buzzard South Ward does not have any significant deprivation.

Nearly **12%** o the deaths occurred to children or families living in Sandy. Sandy has a high proportion of single parent families and is the 8th most deprived Lower Super Output Area in Central Bedfordshire. One third of children live in income deprived households.

Other deaths are spread throughout differing wards in Central Bedfordshire.

Bedford Borough 3year Data Analysis

In total 42 children's deaths were reported were reported to CDOP in the period 2008-2011

Ages of children

In total 66 % of all deaths reported were in children under the age of 1 year.

Ethnicity

46% of children who died in the 3 year reporting period were White British this compares to 78.4% of the population of Bedford Borough being White British in 2007.

7.3% were White other; this is roughly the same as the population of White other in 2007. 22% of children were Asian (Pakistani and Indian) compared to just 8.4% of the population being of this ethnicity in 2007. 15% of children were Black (Black African and Black Caribbean) as compared to just 3% of the population being from this background.

Area of residence

21.5% of the children who died lived in the Queens Park Ward. This ward is in the top 10% areas in England for income deprivation with 50 % of children living in an income deprived household.

In this ward 30% of children are aged 0-15 and over half of the population is from an ethnic minority group. A further **14%** of children or their parents lived in the Cauldwell Ward. This ward is in the top 10-20% deprived in England for child poverty. Health outcomes area particular concern with high mortality rates.

Other deaths are spread throughout differing wards in wards in Bedford Borough

12. Appendices

Appendix 1

1.1 Purpose, Terms of Reference & Objectives

The CDOP terms of reference and policies and procedures were reviewed and updated in November 2010 in response to the revised publication of Working Together to Safeguard Children (2010)

Purpose

Through a comprehensive and multidisciplinary review of child deaths, the Bedfordshire and Luton CDOP aims to better understand how and why children in Bedfordshire and Luton die and use our findings to take action to prevent other deaths and improve the health and safety of our children.

In carrying out activities to pursue this purpose, the CDOP will meet the functions set out in paragraph 7.13 of *Working Together to Safeguard Children (2010)* in relation to the deaths of any children normally resident in Bedfordshire and Luton;

(a) collecting and analysing information about each death with a view to identifying

1. any case giving rise to the need for a review mentioned in Regulation 5 (1) (e)
2. any matters of concern affecting the safety and welfare of children in Bedfordshire and Luton
3. any wider public health or safety concerns arising from a particular death or from a pattern of deaths in Bedfordshire and Luton

(b) putting in place procedures for ensuring there is a co-ordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Objectives

1. To ensure, in consultation with the local Coroner, that local procedures and protocols are developed, implemented and monitored, in line with the guidance in Chapter 7 of *Working Together to Safeguard Children (2010)* on enquiring into unexpected deaths.
2. To ensure the accurate identification of and uniform, consistent reporting of the cause and manner of every child death.
3. To collect and collate an agreed minimum data set of information on all child deaths in Bedfordshire and Luton and, where relevant, to seek additional information from professionals and family members.

4. To evaluate data on the deaths of all children normally resident in Bedfordshire and Luton, thereby identifying lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children.
5. To evaluate specific cases in depth, where necessary to learn lessons or identify issues of concern.
6. To improve agency responses to child deaths through monitoring the appropriateness of the response of professionals to each unexpected death of a child, reviewing the reports produced by the rapid response team and providing the professionals concerned with feedback on their work.
7. To identify significant risk factors and trends in individual child deaths and in the overall patterns of deaths in Bedfordshire and Luton, including relevant environmental, social, health and cultural aspects of each death, and any systemic or structural factors affecting children's well-being to ensure a thorough consideration of how such deaths might be prevented in the future.
8. To refer to the chairs of the LSCBs any identified safety or public health issues for consideration, with the Director of Public Health or any other relevant agency, of how best to address these and their implications for the provision of services and training.
9. To identify any public health issues and consider, with the Director(s) of Public Health and other provider services how best to address these and their implications for both the provision of services and for training.
10. To increase public awareness and advocacy for the issues that affect the health and safety of children
11. Where concerns of a criminal or child protection nature are identified, to ensure that the police and coroner are aware and to inform them of any specific new information that may influence their inquiries; to notify the Chair of the LSCB of those concerns and advise the chair on the need for further enquiries under section 47 of the Children Act, or of the need for a Serious Case Review
12. To provide relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family
13. To monitor the support and assessment services offered to families of children who have died

14. To monitor and advise the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths
15. To organise and monitor the collection of data for the nationally agreed minimum data set and the arrangements for providing data to bodies commissioned by the Department for Education (DfE)
16. To co-operate with any regional and national initiatives – e.g. Centre for Maternal & Child Enquiries (CMACE)
17. To make recommendations to the LSCBs for any additional data to be collected locally.
18. To inform the chairs of the LSCBs where specific new information should be passed to HM Coroner or other appropriate authorities.
19. To monitor the appropriateness of the response of professionals to unexpected deaths of children.
20. To prepare an annual report to the LSCBs on the work of the CDOP to include local data.

Scope

The CDOP will gather and assess data on the deaths of all children and young people from birth (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) up to the age of 18 years who are normally resident in Bedfordshire or Luton. This will include neonatal deaths, expected and unexpected deaths in infants and in older children. Where a child normally resident in another area dies within Bedfordshire and Luton, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident in Bedfordshire or Luton dies outside of this area the Bedfordshire and Luton CDOP should be notified. In both cases an agreement should be made as to which CDOP (normally that of the child's area of residence) will review the child's death and how they will report to the other.

There will be a rapid response/information sharing meeting by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death

Confidentiality and Information Sharing

Information discussed at the CDOP meetings will be anonymised prior to the meeting, but it is still essential that all members adhere to strict guidelines on confidentiality and information sharing. Information is being shared in the public interest for the purposes set out in Working Together and is bound by legislation on data protection.

CDOP members will all be required to sign a confidentiality agreement before participating in the CDOP. Any ad-hoc or co-opted members and observers will also be required to sign the confidentiality agreement. At each meeting of the CDOP all participants will be required to sign an attendance sheet, confirming that they have understood and signed the confidentiality agreement.

Any reports, minutes and recommendations arising from the CDOP will be fully anonymised and steps taken to ensure that no personal information can be identified.

Accountability and Reporting arrangements

The CDOP will be accountable to the chairs of Bedford Borough, Central Bedfordshire and Luton Local Safeguarding Children Boards.

The CDOP is responsible for developing its work plan, which should be approved by the LSCB. It will prepare an annual report for the LSCB, which is responsible for publishing relevant, anonymised information.

The LSCB takes responsibility for disseminating the lessons to be learnt to all relevant organisations, ensures that relevant findings inform the Children and Young People's Plan and acts on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.

The LSCB will supply data regularly on every child death as required by the DfE to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.

These procedures include provision for cooperation with other LSCBs in collecting information and providing a coordinated response to unexpected child deaths in these circumstances

1.2 Core Membership

As per guidance from *Working Together to Safeguard Children (2010)* the panel is chaired by an Independent Chair not directly involved in the provision of services to children. Gerry Taylor, Director of Public Health at Luton PCT was appointed the Independent Chair and assumed responsibilities in March 2009.

The panel has an agreed fixed core multi agency senior membership from both Bedfordshire & Luton.

- Gerry Taylor, Director of Public Health, Luton PCT (Chair)
- Dr Salma Rehman, Lead Paediatrician & Designated Doctor for Safeguarding in Bedfordshire
- Dr Catherine Kearney, Lead Paediatrician for Luton
- Helena Hughes, Designated Nurse for Safeguarding for Bedfordshire
- Sue Steffens, Designated Nurse for Safeguarding for Luton
- Anita Wilson, Lead Nurse for Child Death Reviews Luton

- Sally Stocker, Business Manager, Bedfordshire Local Safeguarding Children Board
- Catherine Barrett, Business Manager, Luton Local Safeguarding Children Board
- Sue Ioannou, Central Bedfordshire Children's Services
- Caroline Brady, Bedford Borough Children's Services
- Keith Hill, Luton Children's Services
- Jayne Cowell, Police Child Abuse Investigation Unit
- Shirley Whiterod, Manager Bedfordshire & Luton CDOP

The panel meeting will be deemed to be quorate if there is representation from:

- A paediatrician
- Social care
- Police
- Designated nurse

The panel will meet approximately bi monthly

1.3 Definitions of Child Death Categories

- **Neonatal death**

  Death of a live born baby before the age of 28 completed days
- **Sudden Unexpected Death in Infancy (SUDI)**

  Sudden Unexpected Death of a baby or child under the age of 2 years
- **Unexpected death**

  Death of a child whose death was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death.
- **Expected death**

  Death of a child whose death was expected.

Appendix 2

Operational arrangements of CDOP

Referral/Reporting Arrangements

The CDOP Manager is notified of the death of any child, aged less than 18 years, normally resident in Bedfordshire or Luton or the death of any other child in, or consequent to an unexpected event in, Bedfordshire or Luton by:

- The senior police officer in Bedfordshire or Luton attending the unexpected death of a child or similarly unexpected event consequent to which a child had died, wherever the death occurred.
- The medical practitioner or paramedic confirming the fact of death of a child in Bedfordshire or Luton, whether the death was unexpected or not, unless the Police are involved in the investigation of that death

- Any professional made aware of the death, outside of Bedfordshire or Luton, of a child normally resident in one of the authorities. (This is particularly relevant to children receiving medical treatment at specialist centres, in out of county respite hospice or foster care placements or on holiday, including abroad)

Details of the deaths of children who are normally resident in Bedfordshire or Luton but who die outside of the county will be notified to the CDOP Manager by the CDOP manager/administrator in the area in which the child died.

Notification of child deaths is made using the appropriate form as set out by the DCSF. These forms are available for the Department of Children, Schools and Families (DCSF) website as well as on the Bedfordshire Local Safeguarding Children Board (LSCB) website.

If a child whose death is notified to the CDOP manager is normally resident outside of Bedfordshire or Luton the CDOP Manager will provide immediate notification of that death to the CDOP Manager/Administrator of the local LSCB either in writing/secure fax or secure email.

Operational Arrangements

The CDOP Manager will notify the Lead Paediatrician for either Bedfordshire or Luton about the death and if the death is unexpected she will consider the need for an urgent rapid response/information sharing meeting. If this is deemed appropriate the CDOP manager will co ordinate this process and the meeting will be held as soon as practicably possible and all professionals who knew the child and family will be invited as well as the relevant police officer from the Child Abuse Investigation Unit. The primary functions of this meeting is for all professionals to share information about the child and the family, to establish who will support the family and to ensure that there are no safeguarding issues for other siblings or children within the family. Consideration will be given as to whether the case should be referred to the Serious Case Review panel of the appropriate Local Safeguarding Children Board

Appropriate DfE data collection forms will be sent out to all professionals who knew the child or family whether the death was unexpected or expected in order for a core set of information to be available for the CDOP panel.

Case Review Processes

Each case will be reviewed at regular intervals by the appropriate Lead Paediatrician to assess the quality of the information received and to determine if further information or clarity is required on information received. The Lead Paediatrician may choose to discuss issues with those who have returned information and if appropriate that professional may be invited to the CDOP panel meeting to share their agency's involvement with the child or family.

For children whose death has been unexpected and where a rapid response/information sharing meeting has been held the Lead Paediatrician may wish to hold a Final Case Discussion meeting with those professionals who attended the initial meeting. The purpose of this meeting as set out in Chapter 7 of Working Together to Safeguarding Children (2010) is to review the information received and determine any actions arising from that information. The meeting will also focus on who will share information about the post mortem findings with the family and identify who will continue to support the family and other siblings. If any safeguarding issues have arisen these will be discussed and advice sought from Children's Services. Consideration will again be given if the case should be referred to the Serious Case Review panel of the appropriate Local Safeguarding Children Board.

Following completion of the data collection the CDOP manager collates the information and 1 week prior to the meeting sends a collated Form B to the panel members either via secure e mail or via recorded delivery/internal post.

Cases are discussed in full at the panel meeting using the DCSF Form C in which 4 domains are considered:

- **Factors intrinsic to the child**
- To include any known health needs; factors influencing health; development/educational issues; behavioural issues; social relationships; identity & independence; abuse of drugs or alcohol.

Factors in the family & environment
To include family structures & functioning; including parental abuse of drugs or alcohol; wider family relationships; housing; employment & income; social integration & support and community resources

- **Factors in the parenting capacity**
  To include issues around provision of basic care; health care (including antenatal care where relevant); safety; emotional warmth; stimulation; guidance & boundaries & stability

- **Factors in relation to service provision**
  To include any identified services (either required or provided); any gaps between child's or family members needs & service provision; any issues in relation to service provision or uptake.

Each of the 4 domains determines different levels of influence (0-3) for any identified factors:

0 - Information not available

1 - No factors identified or factors identified but are unlikely to have contributed to the death

2 - Factors identified that may have contributed to vulnerability, ill-health or death

3 - Factors identified that provide a complete and sufficient explanation for the death

This information informs the learning of lessons at a local level.

The death is then categorised into one of 10 categories as set out in the form.

The panel then categorises whether they consider there are any modifiable factors.

- **Modifiable factors identified**

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

- **No Modifiable factors identified**

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

The panel will continue to identify if any modifiable factors are present whether for individual families or at a more national level and make recommendations to Local Safeguarding Children Boards as appropriate.

Issues about sharing/gathering information from agencies

The CDOP manager has undertaken some training sessions to inform agencies who work with children and families of the statutory role of CDOP and the expectations of their agencies when a child dies. These sessions were extremely well attended and this improved communication with agencies has led to an improvement in information gathering.

The CDOP manager has identified key people within organisations to liaise with when a child dies either expectedly or unexpectedly and through excellent working relationships has established a robust process for gathering information.

When agencies or individual professionals fail to respond to requests for information a follow up request is made. If this fails to elicit the information required the CDOP manager will aim to discuss the matter in person with the individual or their manager.

It has proved informative when supplementary letters and discharge summaries accompany the data collection forms.

Issues about information sharing with parents/carers

The DfE have published an information booklet for parents entitled ‘The child death review processes. This booklet is given to bereaved parents at an appropriate time after the death to inform them about the Child Death Overview Proces

Appendix 3

The data is taken from a Statistical Report published by the Department for Education in July 2010.
Data was provided by all 145 LSCB's on behalf of 93 CDOP's
Additional data was provided on behalf of 123 out of 145 LSCB's. Bedfordshire and Luton CDOP contributed to this additional data collection.

Key points:

- 3,450 child deaths were completed by CDOP's in the year ending 31st March 2010 (some of these deaths occurred in 2008-2009)
- Of these completed reviews 150 were assessed as being preventable

National Figure		Bedfordshire & Luton Figure
Timing of review		
50%	Of reviews completed in 2009-2010 proportion were for deaths occurring in 2008-2009	41%
42%	Number of reviews completed within 6 months of death	59%
60%	Number of child deaths reviewed between 1st April 2008 to 31 March 2010	59%
75%	Number of child deaths that occurred in 2008-2009 that had been reviewed by 31st March 2010	94%
39%	Number of child death that occurred in 2009-2010 that had been reviewed by 31st March 2010	42%

Cause of death		
59%	Number of reviews completed were death recorded as neonatal, perinatal, chromosomal , genetic & congenital anomalies	59%
54%	Number of preventable child deaths due to trauma & other external factors (drowning, road traffic accidents & deaths due to fires)*	100%
27%	Number of potentially preventable child deaths due to sudden, unexpected, unexplained deaths	25%
19%	Number of potentially preventable deaths due to trauma & other external factors	12.5%
18%	Number of potentially preventable deaths due to neonatal or perinatal events	25%
Age of the child		
65%	Majority of child death reviews completed in 2009-2010 were for children under 1 year of age	61%
27%	Number of child deaths assessed as being preventable were for children aged 1-4years	0%
No data given	Number of child deaths assessed as being preventable were for children aged 5-9years*	33%
19%	Number of child deaths assessed as being preventable were for children aged 10-14 years*	66%

Gender of child		
56%	Male children	49%
44%	Female children	51%
Ethnicity of child		
60%	Majority of children were white	55%
Frequency of meetings		
9	Average number of meetings held	8
4	Reviews completed per meeting	6

Proportion of all completed child deaths reviewed which were assessed as preventable in the year ending 31st March 2010			
	National (England)	**East of England**	**Bedfordshire & Luton**
2009	5%	No data (numbers too small)	3%
2010	4%	6%	5.8%
Total 2009 & 2010	5%	4%	4.7%

* very small numbers only 3 preventable deaths

Appendix 4

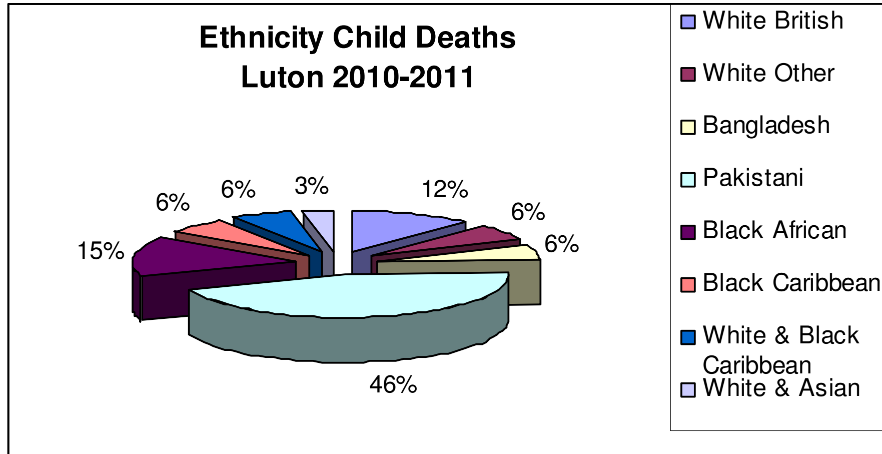
Cases reported April 2010 – March 2011

<table>
<tr><th></th><th>Bedford Borough</th><th>Central Bedfordshire</th><th>Luton</th></tr>
<tr><td>Cases Reported</td><td>16</td><td>14</td><td>33</td></tr>
<tr><td>Unexpected</td><td>4</td><td>7</td><td>12</td></tr>
<tr><td>Expected</td><td>14</td><td>7</td><td>21</td></tr>
<tr><td>0-28 days</td><td>5</td><td>7</td><td>10</td></tr>
<tr><td>1mth-1yr</td><td rowspan="2">7</td><td rowspan="2">5</td><td>10</td></tr>
<tr><td>1yr-4yrs</td><td rowspan="2">8</td></tr>
<tr><td>5yrs-9yrs</td><td colspan="2">3</td></tr>
<tr><td>10yrs-14yrs</td><td colspan="2" rowspan="2">3</td><td rowspan="2">5</td></tr>
<tr><td>14yrs-17yrs</td></tr>
</table>

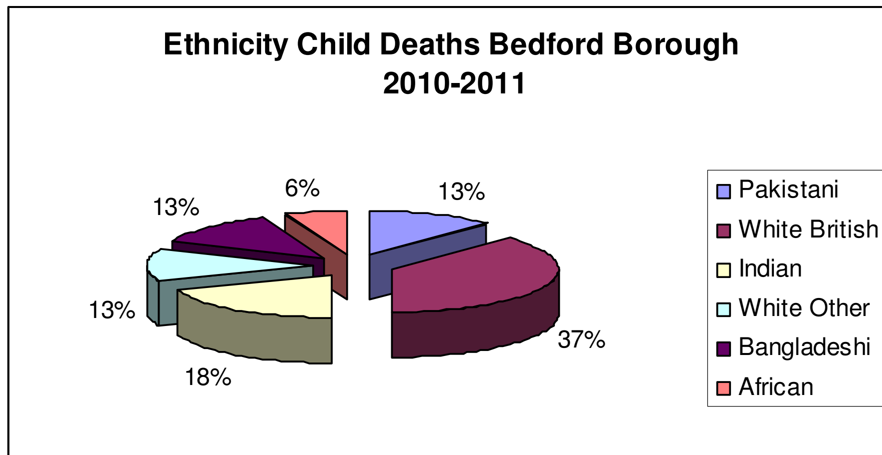
*Data has been combined where numbers were too small

Appendix 5

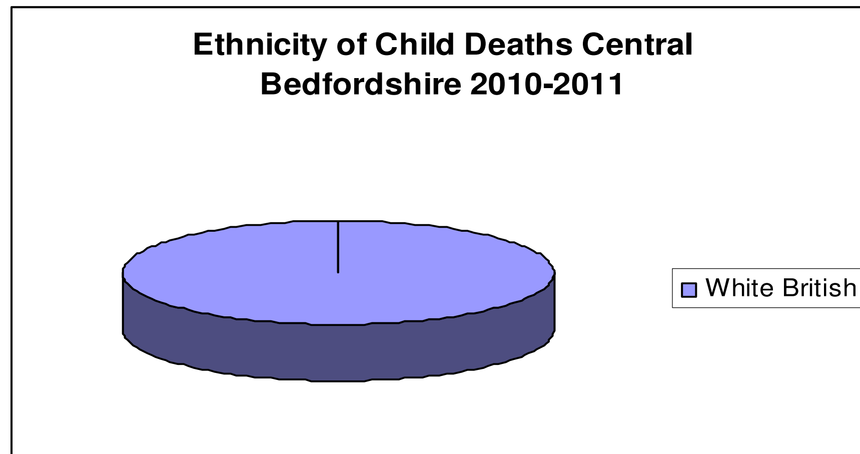
Ethnicity of child deaths in Luton 2010-2011



Ethnicity of child deaths in Bedford Borough 2010-2011

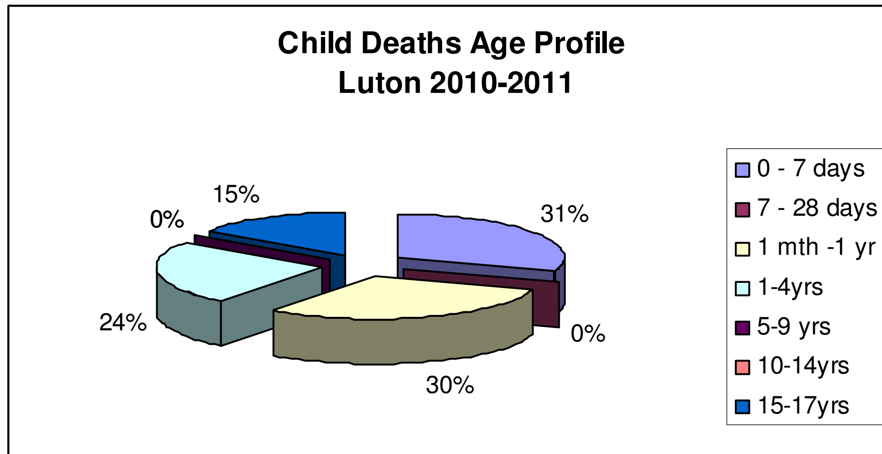


Ethnicity of child deaths in Central Bedfordshire 2010-2011

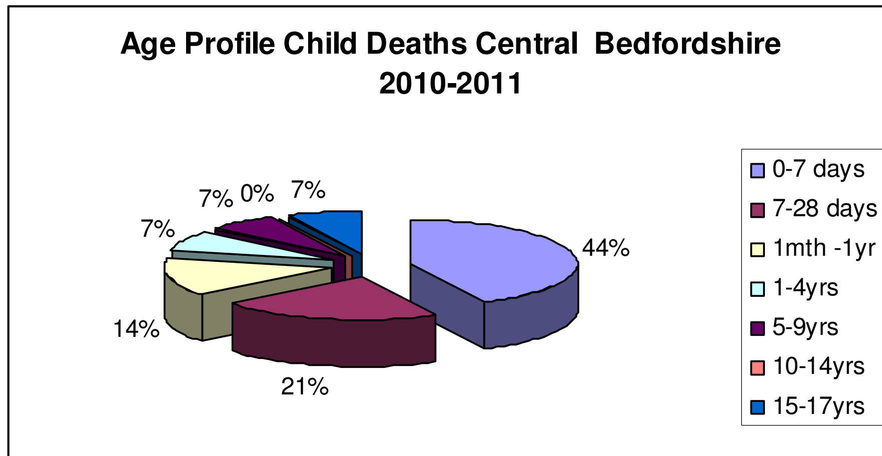


Appendix 6

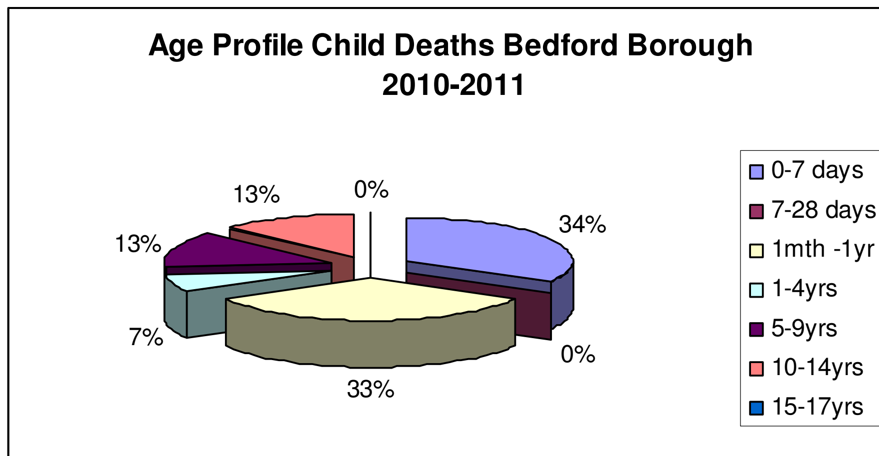
Age Profile Child Deaths in Luton 2010-2011



Age Profile Child Deaths in Central Bedfordshire 2010-2011

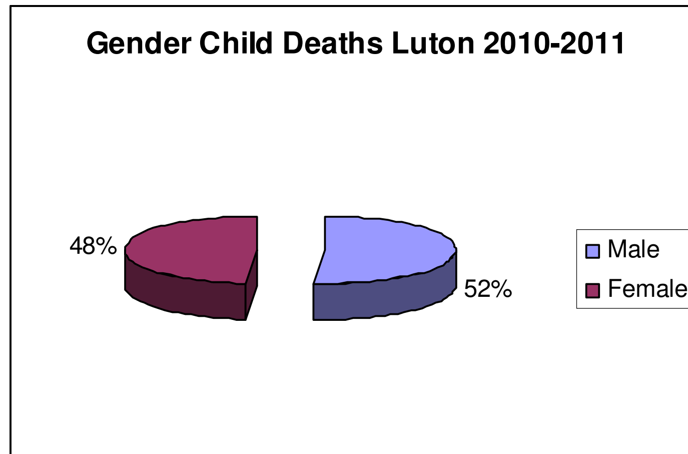


Age Profile Child Deaths in Bedford Borough 2010-2011

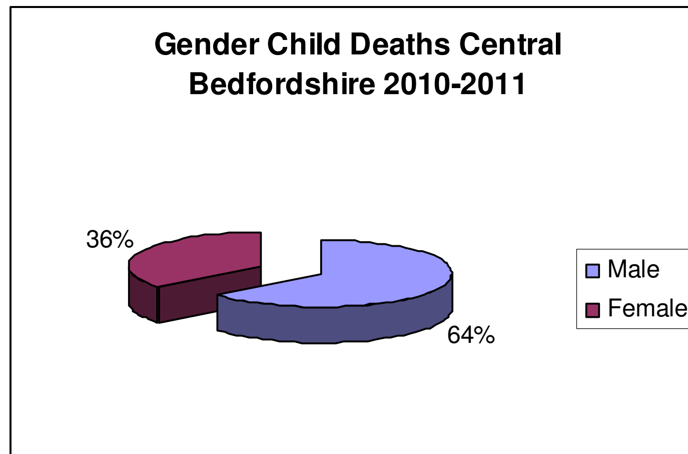


Appendix 7

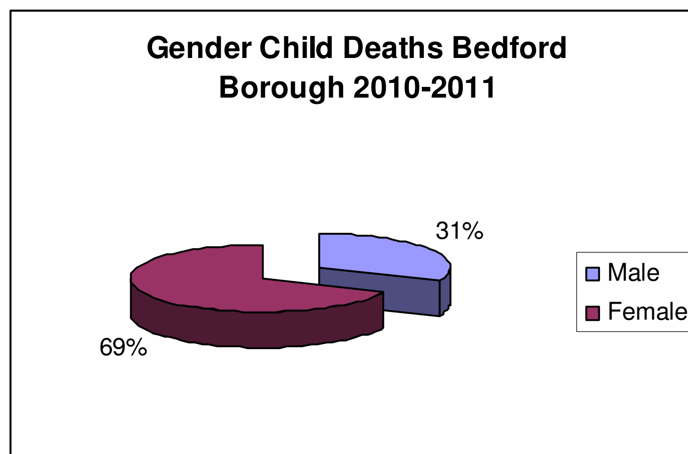
Gender Child Deaths in Luton 2010-2011



Gender Child Deaths in Central Bedfordshire 2010-2011

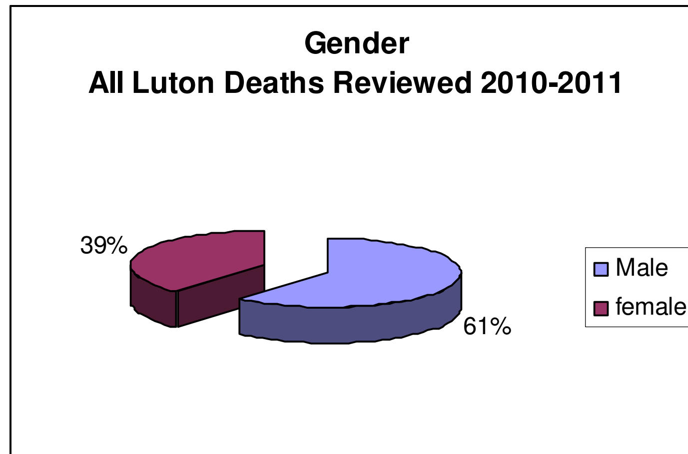


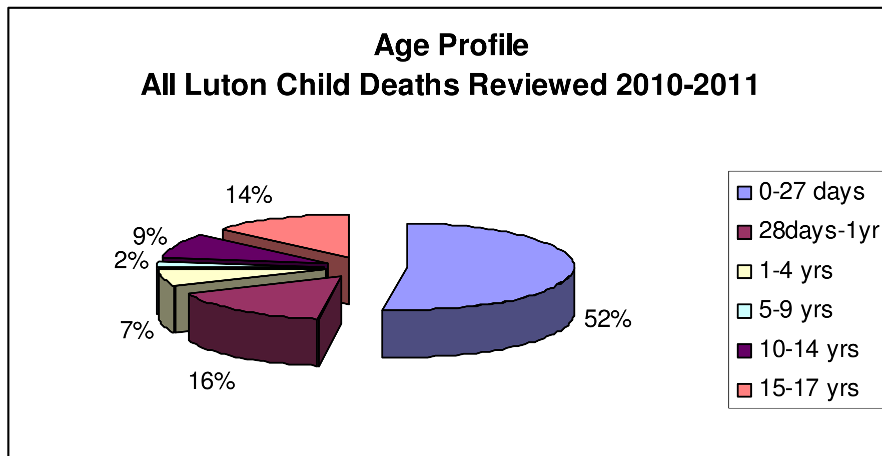
Gender Child Deaths in Bedford Borough 2010-2011

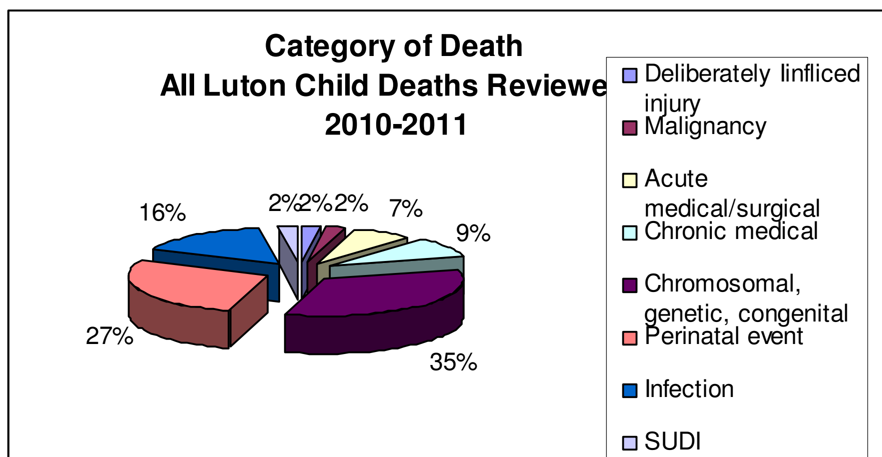


Appendix 8

Summary of all Luton cases reviewed in 2010-2011

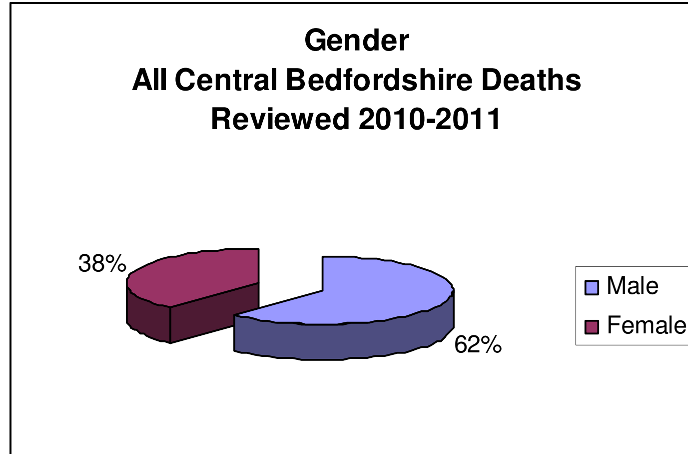


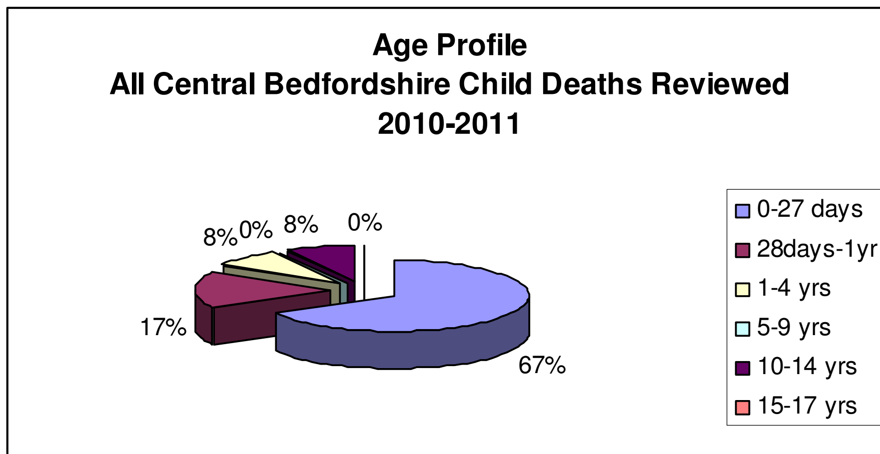


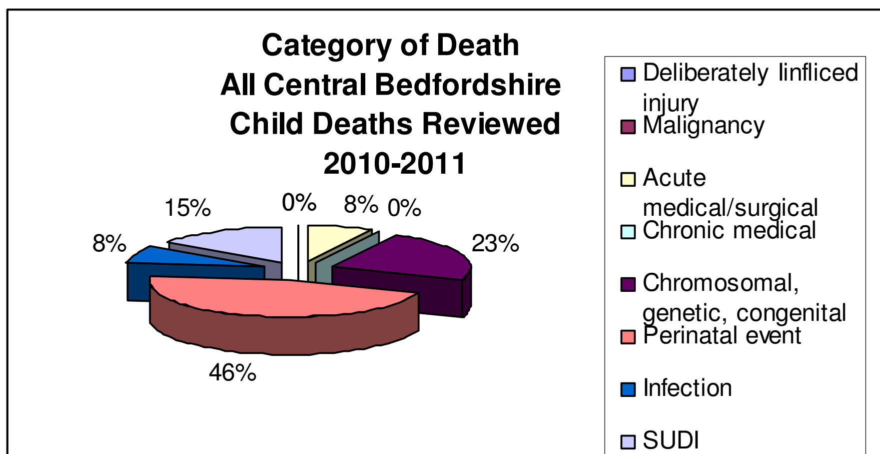


Appendix 9

Summary of all Central Bedfordshire cases reviewed in 2010-2011







Appendix 10

Summary of all Bedford Borough cases reviewed in 2010-2011