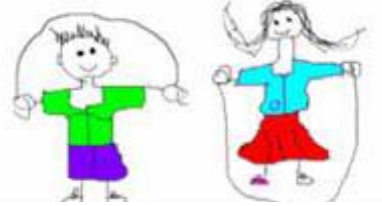




*Working Together
to Safeguard Children*



**BEDFORDSHIRE & LUTON
CHILD DEATH OVERVIEW
PROCESS
ANNUAL REPORT
2009-2010**

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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)*. 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 (2006)* 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.

1.1 Terms of Reference & Objectives

Bedfordshire & Luton CDOP aims to meet the functions set out in paragraph 7.4 of *Working Together to Safeguard Children* in relation to the deaths of any children normally resident in Bedfordshire and Luton, namely collecting and analysing information about each death with a view to identifying –

- i. any case giving rise to the need for a Serious Case Review;
- ii. any matters of concern affecting the safety and welfare of children in Bedfordshire and Luton;
- iii. any wider public health or safety concerns arising from a particular death or from a pattern of deaths in Bedfordshire and Luton.

The objectives of Bedfordshire & Luton CDOP for the 2009/2010 were:

1. To implement, in consultation with HM Coroner, procedures and protocols in line with the guidance in *Working Together to Safeguard Children (2006)* on enquiring into unexpected deaths and evaluating these together with information about all deaths in childhood.
2. To collect and collate an agreed minimum data set and where relevant seek information from professionals and family members

3. To make recommendations to the LSCBs for any additional data to be collected locally.
4. To evaluate the routinely collected data on the deaths of all children and evaluate specific cases in depth to ensure a thorough consideration of how such deaths might be prevented in the future
5. To review reports produced by the Rapid Response Team on each unexpected death of a child, making a full record of this discussion and provide the professionals with feedback on their work. Where there is an ongoing criminal investigation the Crown Prosecution Service and Senior Investigating Officer should be consulted as to what is appropriate for the panel to be considering and what actions it might take in order not to prejudice any criminal proceedings.
6. To identify lessons to be learnt or issues of concern for particular agencies, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children
7. To identify wider safety and public health concerns arising from a particular death or pattern of deaths.
8. To provide relevant information to professionals involved with the child's family, so that they can convey this information in a sensitive and timely manner to the family.
9. To refer to the chairs of the LSCBs any deaths where the panel considers there may be grounds to undertake further enquiries, investigations or conduct a Serious Case Review and explore why this had not previously been recognised.
10. 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.
11. To inform the chairs of the LSCBs where specific new information should be passed to HM Coroner or other appropriate authorities.
12. To monitor the support and assessment services offered to families of children who have died.
13. To monitor the appropriateness of the response of professionals to unexpected deaths of children.
14. To monitor and advise the LSCBs on the resources and training required 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 DCSF (Department for Children, Schools & Families).
16. To cooperate with regional and national initiatives to identify lessons on the prevention of unexpected child deaths.

1.2 Core Membership

As per guidance from *Working Together to Safeguard Children* 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 including the Coroners Office.:

- 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
- Sally Stocker, Business Manager, Bedfordshire Local Safeguarding Children Board
- Catherine Barrett, Business Manager, Luton Local Safeguarding Children Board
- Sarah Millett, Coroner's Officer
- Sue Ioannou, Central Bedfordshire Children's Services
- Sika Smith, Bedford Borough Children's Services
- Richard Fountain, Luton Children's Services
- Jayne Cowell, Police Child Abuse Investigation Unit
- Sandra James, Public Health Manager for Children & Young People, NHS Bedfordshire
- Shirley Whiterod, Manager Bedfordshire & Luton CDOP
- Lay representative (to be identified)

8 meetings have been held during the past year all have been quorate and attendance by all panel members has been excellent. The panel have invited other professionals such as road traffic police officers and a consultant paediatrician to give their expert opinion when the panel have been discussing particular cases.

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.

2. Overview of CDOP operation

2.1 Number of deaths in Bedfordshire & Luton 2009-2010

During the period 1st April 2009 to 31st March 2010 a total of 71 child deaths were reported to the Bedfordshire and Luton Child Death Overview Panel.

11 of the child deaths were of children residing in Bedford Borough, 16 of the deaths were of children living in Central Bedfordshire and 44 of the child deaths were of children living in Luton. Appendix 1

This is an increase of 28% compared to the same period last year. This however represents in part an improved reporting of neonatal deaths.

30 of these cases have been reviewed by the CDOP panel and closed. 1 case was deemed by the panel to be preventable and 5 cases deemed to be potentially preventable.

Working Together to Safeguard Children (2006) states that all child deaths, excluding stillbirths should be reported to CDOP. A large proportion of the reported deaths, 53%, 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 2009-2010

The Bedfordshire and Luton Child Death Overview Panel have met 8 times in the period 1st April 2009 to 31st March 2010. On each occasion the panel has been quorate.

In total during 2009-2010, 51 cases have been reviewed and closed. 41% of these cases were babies or children who died during the period 2008-2009 with the remainder dying during the period 2009-2010.

Of the 51 cases reviewed, 59 % of these deaths were reviewed at panel within 6 months of the child's death.

In total 94% of cases were reviewed within 1 year of the child's death. 3 cases took longer than 12 months to come to the panel. This was due to internal investigations by other agencies which prevented all information being available to the panel for their consideration.

There are still 2 outstanding cases from 2008-2009. These will not be reviewed by the panel until the inquests have been held.

Of the 51 cases reviewed, 3 of the deaths were considered by the panel to be preventable, all 3 being categorised as due to trauma or other external factors. 6 deaths were considered to be potentially preventable; factors included parental smoking and safe sleeping arrangements.

This data is reported annually to the Department for Children, Schools and Families.

1 case had been initially reported as a Serious Untoward Incident (SUI) but the case had been closed prior to all investigations being concluded. Following investigation by the CDOP panel the local PCT was contacted and the case was reopened. The organisation where concerns with practice were identified has conducted an internal review and made changes to policies and procedures as a result.

There has been joint collaborative working with colleagues in the Child Abuse Investigation Unit of Bedfordshire Police on a further case to investigate and exclude serious safeguarding concerns.

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 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

The final year of this guaranteed funding is 2010/2011

2.4 Operation 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 DCSF 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 (2006) 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 the 'preventability' of the death

Preventable – Modifiable factors where if a particular action had been taken the death would have been prevented

Potentially preventable – potentially modifiable factors extrinsic to the child

Not preventable – Death caused by intrinsic or extrinsic factors with no identified modifiable factors

There is a category where there is inadequate information on which to make a judgement but panels are advised that that category should be used very rarely.

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.

There was an issue with a tertiary hospital who was reluctant to share any information with CDOP panels unless it was a suspected non accidental injury case. CDOP panels in the Eastern Region raised the matter with the Safeguarding Advisor in the local GO EAST Government office. Through negotiations with the hospital their understanding of the statutory process of CDOP has led to full co operation with the CDOP process.

Issues about information sharing with parents/carers

The CDOP panel had devised an information leaflet for parents and reviewed a number of leaflets currently in use but the DCSF have produced a very comprehensive leaflet in recent months which the Bedfordshire & Luton CDOP panel plan to adopt.

The panel has not yet implemented robust feedback mechanisms for discussing findings of investigations with parents but the revised Chapter 7 of Working Together to Safeguard Children (2010) offers clear guidance and this piece of work is included in the actions for CDOP for 2010-2011

3. Luton Cases reported/reviewed 2009-2010 (Appendix 2)

In total 44 deaths were reported to the Bedfordshire and Luton Child Death Overview Panel. This compares with 21 reported in 2008-2009. However during that period there were very few neonatal deaths reported to CDOP. During the period 2009-2010 there has been improved reporting of neonatal deaths including those pre viable babies who had a heart rate present for a short time after birth and consequently the birth was registered as a live birth. There has also been improved contact with the Registrar of Births and Deaths to ensure all child death data is collected by CDOP. Furthermore the Department for Children, Schools and Families have also forwarded data received by the Registrar for Births and Deaths. This has acted as a fall back mechanism for checking that all deaths have been notified.

During the period April 2009 to March 2010 75% of the reported deaths were of children under the age of 1 year with 64% of these being early neonatal deaths (deaths occurring within the first week of life) and a further 9% were late neonatal deaths (deaths occurring between 7 days and 28 days).

Infant mortality

Infant mortality is defined as death of children during the first year of life and expressed as deaths per 1000 live births (Office of National Statistics ONS).

The infant mortality rate for **2008** was reported as 5.6/1000 live births compared to an East of England rate of 4.4/1000 live births and the rate for England was 4.7/1000 live births. (National Centre for Health Outcomes Development NCHOD)

Childhood death rates (Appendix 3)

Childhood deaths as expressed per 100,000 population of the same age. The ONS publishes mortality data for children under the age of 15 years.

The mortality rate for children in Luton aged 1 to 4 years is 8/100,000 children of the same age compared to a national average of 19/100,000 children of a comparable age.

For children in Luton aged 5 to 9 years the mortality rate is 14.5/100,000 as compared to a national average of 10/100,000

For children in Luton aged 10 to 14 years the mortality rate is high at 33/100,000 as compared to the national average of 9/100,000.

However in all the examples the numbers are small and therefore it is not possible to draw meaningful conclusions.

Ethnicity

Children aged 0-4 years *Appendix 4*

The **census of 2001** revealed that 55% of children between 0 & 4 years of age were white British. 16 of the children that died in 2009/2010 were of this ethnic origin which equates to 47% of the children in this age range. The other significant number of deaths was among Pakistani children were 10 children died. This over represents this ethnic minority that makes up 15% of the Luton population but the deaths equate to 29% of the deaths. It is anticipated that the percentage of children aged 0-4 years who are Pakistani is likely to have increased since the 2001 census.

Children aged 5-18 years *Appendices 4 & 5*

There is more recent data from **Luton Borough Council (2009)** on the ethnicity of school children aged 5-11years and 11 to18 years in Luton. However there were small numbers of deaths in these age ranges so it is not possible to draw any meaningful conclusions.

3.1 Luton Neonatal deaths

During the period 1st April 2009 to 31st March 2010 a total of 24 neonatal deaths (deaths occurring during the 1st 28 days of life) were reported for babies whose parents reside in Luton.

Of these 13 died within the first few hours of life either from complications of extreme prematurity or as a result of known congenital anomalies were parents had chosen to continue with the pregnancy.

The remaining 11 babies died aged between 1 day and 27 days due to complications of prematurity, congenital anomalies, SUDI and birth injury.

9 of these cases have been reviewed and closed. A Consultant Neonatologist has been approached to request his expertise in reviewing the remaining cases as some of the cases are babies who have been delivered at a non viable age but had a heart rate for some time after delivery. The panel need to have a full understanding of complications of extreme prematurity and what measures can be put in place to mitigate the risk of pre term deliveries. Recommendations if any can then be made to the Local Safeguarding Children Board

3.2 SUDI's

5 Sudden Unexpected Deaths in Infancy (SUDI) were reported. The age range for these babies was 19 days to 8 months.

All of these cases have been reviewed and closed. 3 of these deaths were deemed by the panel to be potentially preventable and factors identified were around unsafe sleeping practices and parental substance misuse.

A 'Keeping Baby Safe' campaign was launched in Luton with the aim of reinforcing the message given by other health professional around risk factors for sudden unexpected death in infancy. Similar risk factors were also identified in findings from deaths occurring in 2008/2009.

3.3 Other unexpected deaths

There were 8 unexpected deaths reported in Luton. 3 of these cases have been reviewed and closed.

The panel deemed that one case classified as trauma was preventable, 1 case was potentially preventable and the third case was not preventable. Both of these cases were classified as infection as the cause of death.

In one of the cases the panel has made recommendations to the Medical Directors with regard to prescribing

Of the 5 remaining cases 2 are the subject of police investigations, 1 child died in another area and the Coroners inquest is awaited and the remaining 2 cases have yet to be presented at CDOP panel.

3.4 Expected deaths (excluding neonatal deaths)

8 expected deaths were reported to the CDOP panel of these 4 have been reviewed and closed.

3 of the 4 deaths have been classified as death resulting from a chromosomal or genetic condition. A common factor in these 3 deaths as well as a neonatal death is consanguinity. This issue has been raised at the Infant Mortality strategy launched in Luton in 2009.

Where this factor has been identified in the child's death the lead paediatrician has written to the parents GP to ensure that genetic counselling is offered so that parents can make informed choices when planning a future pregnancy.

4. Central Bedfordshire Cases reported/reviewed 2009-2010 (Appendix 6)

A total of 16 child deaths were reported from April 2009 to March 2010 for children in Central Bedfordshire Council

46% of these deaths occurred in children under 1 year of age with 77% of these deaths being neonatal deaths (occurring in the 1st 28 days of life)

The remaining deaths of which there were 9 were reported in the ages 1 to 17 years.

Infant mortality is defined as death of children during the first year of life and expressed as deaths per 1000 live births (Office of National Statistics ONS). Parents resident in Central Bedfordshire may choose to deliver their babies at a number of local hospitals therefore it is not possible to calculate accurately the infant mortality rate for this area.

However the infant mortality rate for Bedfordshire county in 2008 as a whole prior to the split into 2 unitary authorities was reported as 5.0/1000 live births compared to an East of England rate of 4.4/1000 live births and the rate for England was 4.7/1000 live births. (NCDOD)

Childhood death rates (Appendices 6 & 7)

Childhood deaths as expressed per 100,000 population of the same age. The ONS publishes mortality data for children under the age of 15 years.

The mortality rate for children in Central Bedfordshire aged 1 to 4 years appears to be high at 32/100,000 children of the same age compared to a national average of 19/100,000 children of a comparable age but with such small numbers it is difficult to draw conclusions from this data.

For children in Central Bedfordshire aged 10 to 14 years the mortality rate is 19/100,000 as compared to the national average of 9/100,000. Again with small figures it is difficult to draw any conclusions from this data.

Ethnicity

Children aged 0-4 years

The census of 2001 revealed that 94% of children between 0 & 4 years of age were white British. All 11 of the children that died in 2009/2010 were of this ethnic origin which is 100% of the children in this age range.

Children aged 5-18 years

There is more recent data from Central Bedfordshire Council (2009) on the ethnicity of school children aged 5-11 years and 11 to 18 years in Bedfordshire. However there were small numbers of deaths in these age ranges so it is not possible to draw any meaningful conclusions.

4.1 Central Bedfordshire Neonatal Deaths

During the period 1st April 2009 to 31st March 2010 a total of 7 neonatal deaths were reported for babies whose parents reside in Central Bedfordshire.

Of these all 7 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 continue with the pregnancy.

6 of these cases have been reviewed and closed. The panel deemed one case potentially preventable due to maternal smoking through out the pregnancy.

4.2 SUDI's

1 Sudden Unexpected Death in Infancy (SUDI) was reported to the panel. This case has been reviewed and closed. As a result of this case some changes have been made to the discharge process for babies at a local hospital. Parental smoking was noted as a factor in the parenting domain.

4.3 Other unexpected deaths

There were 5 unexpected deaths reported in Bedfordshire. 4 of these cases have been reviewed and closed. There were no common features in any of the deaths although one death was deemed to be potentially preventable. Due to small numbers it is not possible to give further details as no child should be identifiable.

4.4 Expected deaths (excluding neonatal deaths)

3 expected deaths were reported of children with life limiting conditions. No common themes were identified.

5. Bedford Borough Cases reported/reviewed 2009/2010

In total 11 child deaths were reported to the panel for children who reside in Bedford Borough.

81% of these deaths occurred in children under 1 year of age with 77% of these deaths occurring in the neonatal period. The remaining deaths were reported in the age range 1 to 4 years

Childhood death rates (*Appendices 8 & 9*)

Childhood deaths as expressed per 100,000 population of the same age. The ONS publishes mortality data for children under the age of 15 years.

The mortality rate for children in Bedford Borough aged 1 to 4 years is 2/100,000 children of the same age compared to a national average of 19/100,000 children of a comparable age but with such small numbers it is difficult to draw conclusions from this data.

5.1 Bedford Neonatal deaths

During the period 1st April 2009 to 31st March 2010 a total of 7 neonatal deaths were reported for babies whose parents reside in Bedford Borough. The age at which these babies died ranged from very shortly after birth up to 19 days. The babies died from complications of prematurity and congenital anomalies. 3 cases have been reviewed and closed.

5.2 SUDI's

None

5.3 Other unexpected deaths

None

5.4 Expected deaths (excluding neonatal deaths)

4 expected deaths were reported of children with life limiting conditions. 3 cases have been reviewed and closed with no common themes identified.

Ethnicity

Children aged 0-4 years

The census of 2001 revealed that 75% of children between 0 & 4 years of age were white British. 6 of the children that died in 2009/2010 were of this ethnic origin which equates to 54% of the children in this age range. The remaining 5 children were of different ethnic backgrounds and with such small numbers it difficult to draw

conclusions. It is recognised that there will be significant difference in ethnicity data when the census of 2011 is undertaken as there has been significant immigration from Eastern European countries in recent years.

6. Recommendations for 2010/2011

6.1 Working Together to Safeguard Children (2010)

Following the publication of the revised Working Together to Safeguard Children in April 2010 the Bedfordshire and Luton Child Death Overview panel will review this document to ensure that all actions and recommendations are embedded into practice and amend policies and protocols as necessary including a review of the terms of reference.

6.2 Preventable Child Deaths

The DCSF have amended the definition of preventable child deaths to encompass a broader definition:

- **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.

6.3 Training

Further multi agency training will be undertaken to ensure that all agencies who 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.

6.4 Communication with parents

Further work will be undertaken during 23010/2011 to ensure sensitive and effective communication with bereaved parents. The Department for Children, Schools and families have produced a parent information booklet about the Child Death Review process and these sets out for parents what processes will happen following their child's death.

6.5 Contributory factors noted in child deaths

Smoking & consanguinity

From reviews of child deaths undertaken it is clear that smoking both in pregnancy and in the home has been a contributory factor in a number of neonatal deaths. The CDOP panel will continue to recommend to public health and health care professionals that awareness is raised through discussion with families and local campaigns of the serious consequences of smoking to both unborn babies and children.

Consanguinity has been a factor noted in the expected deaths of some children with metabolic long term conditions. This factor has been noted by the Luton Infant Mortality strategy and it is hoped that awareness can be raised though working with community and faith groups of the potential consequences to children of first cousin marriages.

7. Challenges for 2010/2011

Funding was made available by the previous government for the setting up and functioning of the Child Death Overview Process for 3 years. During this time money was given to Local Authorities and the NHS to manage the process of setting up and maintaining the function of the Child Death Overview Process. With this funding ceasing this coming year Local Authorities and the NHS locally will need to incorporate funding for this statutory function in their business plans. The expectation was that Government would see a reduction in preventable child deaths as set out in Indicator 4 of Staying Safe Action Plan (2007)

8. Appendices

Appendix 1

Cases reported April 2009 – March 2010

	Bedford Borough	Central Bedfordshire	Luton
Cases Reported	11	16	44
Unexpected	0	6	13
Expected	11	10	31
0-28 days	7	7	24
1mth-1yr	8		9
1yr-4yrs			
5yrs-9yrs	0		3
10yrs-17yrs	5		8
14yrs-17yrs			

*Data has been combined where numbers were too small

Appendix 2

Age breakdown of children in Luton

Age range	2008 population mid year forecast	Deaths 2009-2010
0-1yr	3,600	33
1-4	12,200	*
5-9	13,800	*
10-14	12,100	*
15-19	13,100	*

* Numbers less than 6 therefore too small to be disclosed

Appendix 3

Luton Mortality Rates

Age range	2010 population mid year forecast	Deaths 2009-2010	Luton Mortality rate per 100,000 children	England Mortality rate per 100,000 children (ONS 2008)
1-4	12,600	*	8	19
5-9	13,800	*	14.5	10
10-14	12,100	*	33	9

* Numbers less than 6 therefore too small to be disclosed

Appendix 4

Proportion and number of children aged 0-4 by Ethnic Group in Luton 2001 census

Ethnic Group	Count	%	No: of child deaths	%
White - British	7,340	55.3	16	47
White - Irish	165	1.2		
White - Other	169	1.3	*	2.9
Mixed - White and Black Caribbean	544	4.1		
Mixed - White and Black African	86	0.6		
Mixed - White and Asian	220	1.7		
Mixed - Other	143	1.1	*	2.9
Asian or Asian British - Indian	405	3.1		
Asian or Asian British - Pakistani	2,032	15.3	10	29.4
Asian or Asian British - Bangladeshi	1,042	7.8	*	5.9
Asian or Asian British - Other	139	1.0		
Black or Black British - Black Caribbean	460	3.5	*	2.9
Black or Black British - Black African	365	2.7	*	8.8
Black or Black British - Other	83	0.6		
Chinese or other ethnic group - Chinese	47	0.4		
Chinese or other ethnic group - Other ethnic group	35	0.3		

* Numbers less than 6 therefore too small to be disclosed

Ethnic background of Luton's school children aged 5-11yrs (Jan 2009)

Ethnic Group	Count	%	No: of child deaths	%
White British	5149	33.2	*	66
White Irish	137	0.9		
White Traveller of Irish heritage	32	0.2		
White Gypsy/Roma	28	0.2		
White Turkish/Turkish Cypriot	54	0.3		
White Other	744	4.8		
Mixed White & Black Caribbean	541	3.5		
Mixed White & Black African	110	0.7		
Mixed White & Asian	246	1.6		
Mixed Any other mixed background	275	1.8		
Asian Indian	418	2.7		
Asian Pakistani	3404	22.0	*	33
Asian Bangladeshi	1750	11.3		
Asian Kashmiri other	385	2.5		
Asian other Asian	199	1.3		
Black Caribbean	673	4.3		
Black African	895	5.8		

* Numbers less than 6 therefore too small to be disclosed

Source: Children and Learning, Luton Borough Council

Appendix 5

Ethnic background of Luton's school children aged 11-18yrs (Jan 2009)

Ethnic Group	Count	%	No: of child deaths	%
White British	4487	42.2	*	42.8
White Irish	162	1.5		
White Traveller of Irish heritage	*	*		
White Gypsy/Roma	*	*		
White Turkish/Turkish Cypriot	*	*		
White Other	366	3.4		
Mixed White & Black Caribbean	360	3.4	*	14.2
Mixed White & Black African	40	0.4		
Mixed White & Asian	116	1.1		
Mixed Any other mixed background	161	1.5		
Asian Indian	392	3.7		
Asian Pakistani	1861	17.5	*	14.2
Asian Bangladeshi	874	8.2	*	14.2
Asian Kashmiri other	300	2.8		
Asian other Asian	117	1.1		
Black Caribbean	527	5.0		
Black African	560	5.3	*	14.2
Black - any other Black background	86	0.8		
Chinese	25	0.2		
Any other ethnic group	77	0.7		
Information not available	17	0.2		
Prefer not to say	72	0.7		

* Numbers less than 6 therefore too small to be disclosed

Source: Children and Learning, Luton Borough Council

Appendix 6

Age breakdown of children in Central Bedfordshire

Age range	2008 population mid year forecast	Deaths 2009-2010
0-1yr	3,300	9
1-4	12,500	*
5-9	15,200	*
10-14	15,800	*
15-19	16,100	*

* Numbers less than 6 therefore too small to be disclosed

Source: Office for National Statistics, Mid Year Population Estimates 2008

Appendix 7

Central Bedfordshire Mortality Rates

Age range	2008 population mid year forecast	Deaths 2009-2010	Central Bedfordshire Mortality Rate per 100,00 children	England Mortality rate per 100,000 children (ONS 2008)
1-4	12,500	*	16	19
5-9	15,200	*	0	10
10-14	15,800	*	19	9

* Numbers less than 6 therefore too small to be disclosed

Appendix 8

Age breakdown of children in Bedford Borough

Age range	2008 population mid year forecast	Deaths 2009-2010
0-1yr	2,100	9
1-4	7,500	*
5-9	9,200	0
10-14	10,100	0
15-19	10,100	0

* Numbers less than 6 therefore too small to be disclosed

Appendix 9

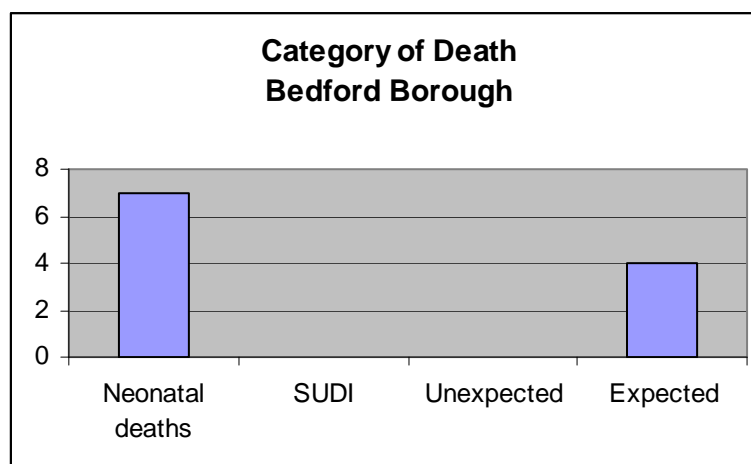
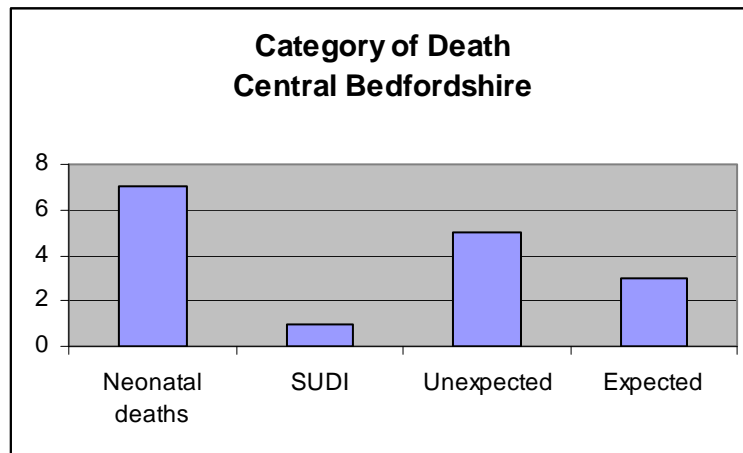
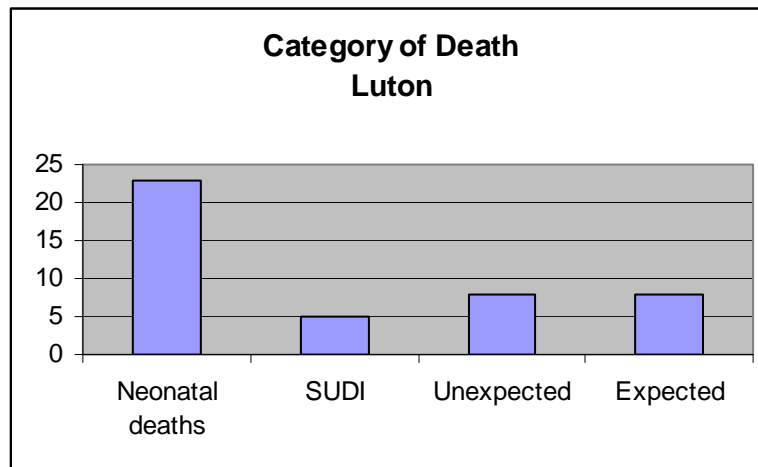
Bedford Borough Mortality Rates

Age range	2008 mid year forecast	Bedford Borough Mortality Rate per 100,000 children	England Mortality rate per 100,000 children (ONS 2008)
1-4	7,500	26	19
5-9	9,200	*	10
10-14	10,100	*	9

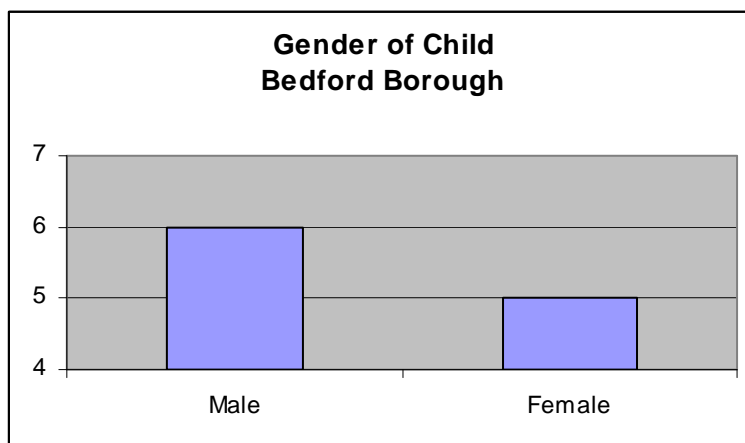
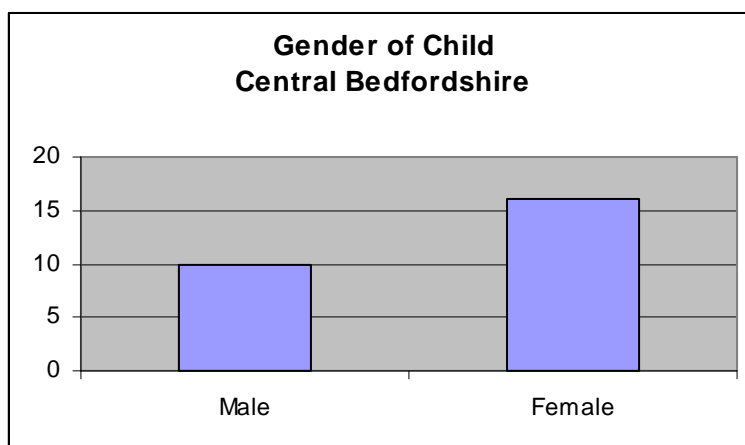
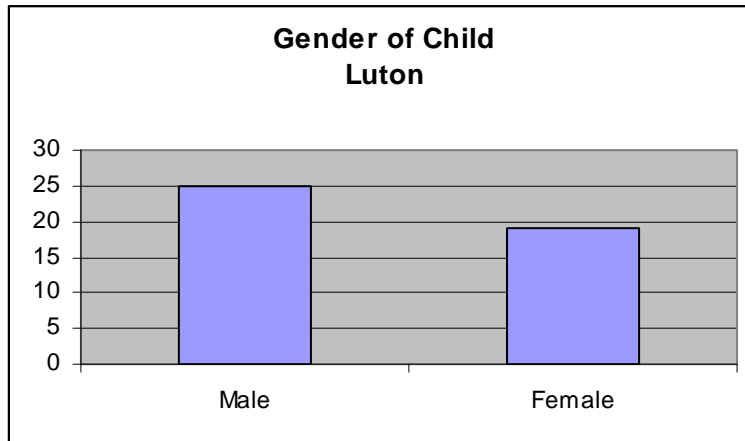
Source: Office for National Statistics, Mid Year Population Estimates 2008

8. Child Death Statistics 2009-2010

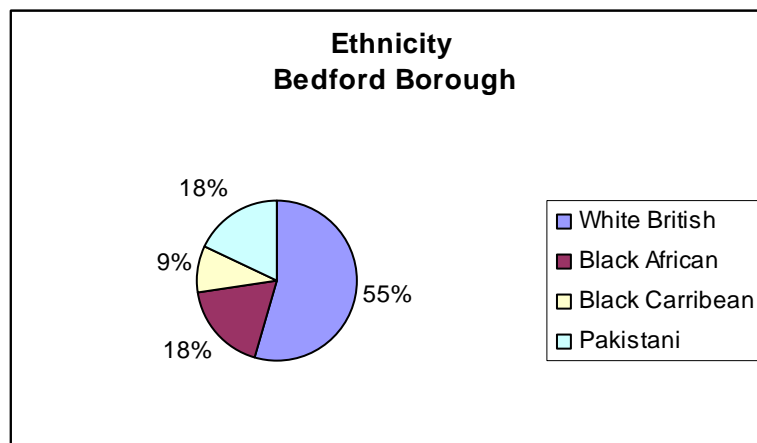
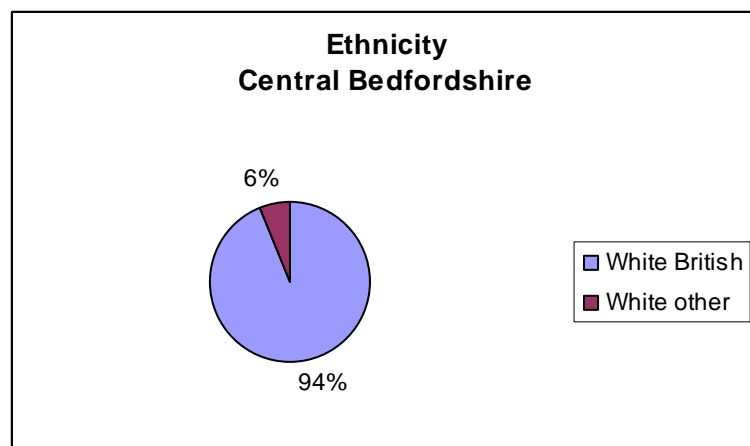
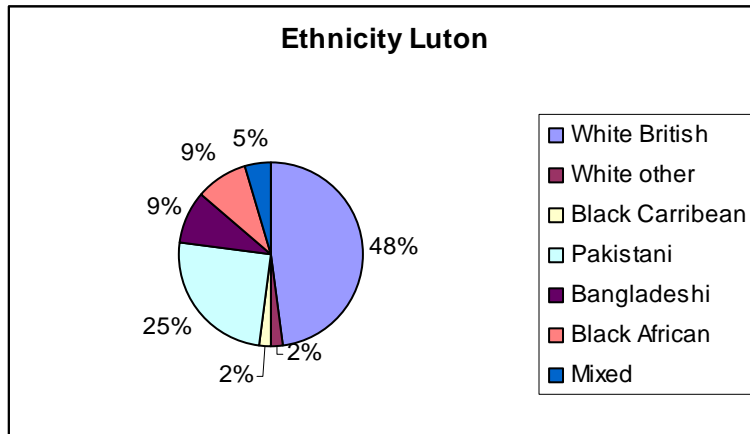
6.1 Category of deaths



6.2 Gender of children who died



6.3 Ethnicity of children who died



6.4 Cause of death for 2009-2010 cases reviewed and closed

