Bedford Borough, Central Bedfordshire and Luton Child Death Overview Process Annual Report April 2012-March 2013

Bedford Borough Safeguarding Children Board &

Central Bedfordshire Safeguarding Children Board

Working together to Safeguard Children

Luton Safeguarding Children Board

Contents

1.0 Executive summary

1.1 Since April 2008 Local Safeguarding Boards (LSCB's) have had a statutory responsibility to review all deaths of children resident in their area. In Bedfordshire the LSCBs of Luton, Central Bedfordshire and Bedford Borough form a single Child Death Overview Panel. Operational policies and terms of reference have been written and implemented and these are updated as required. These are available on the LSCB's websites.
The CDOP managers post is hosted by Bedfordshire Clinical Commissioning Group (BCCG) and this post is line managed by the Designated Nurse for Safeguarding Children & Young People.

1.2 This is the 5th Annual Report of the Bedford Borough, Central Bedfordshire and Luton Child Death Overview Panel (CDOP). It gives a summary of the deaths reported to the panel and analysis of the data and emerging themes for 2009-2013.

1.3 During 2012-2013 the panel met on 8 occasions and completed full reviews on 78 children residing in Bedford Borough, Central Bedfordshire and Luton. These cases were from 2010-2011, 2011-2012 and 2012-2013. CDOP is not able to fully review a death until all information is gathered and other processes have been completed such as post mortem reports and coronial inquests. A new legal framework launched by the Ministry of Justice in June 2013 means that most inquests in England will be completed within 6 months of the death. This will speed up the process for CDOP to review those deaths subject to a Coroners Inquest.

1.4. 66 children died across Bedfordshire between 1st April 2012 and 31st March 2013. 77% (51/66) of the deaths were expected. 24% (16/66) of the children died outside of Bedfordshire at tertiary centres where these children were receiving specialist care. 9% (6/66) died in a hospice.

1.5 45% (30/66) of the children who died were under 1 month of age. 36% (24/66) were as a consequence of perinatal complications (mostly extreme prematurity). CDOP are required to review the deaths of all babies regardless of gestational age at delivery if they are registered as live births. The age of viability is 24 weeks gestation but many of the neonatal deaths are babies born before the age of viability but have a heart rate present for some time after delivery. 9% (6/66) were in children with congenital or chromosomal conditions. 6% (4/66) children were classified as Sudden Unexpected Deaths in Infancy.

1.6 The Bedfordshire and Luton CDOP reviewed and closed 78 cases between 1st April 2012 and 31st March 2013

- 33% (26/78) were classified as dying as a consequence of a perinatal/neonatal event. 32% (25/78) were classified as dying from chromosomal/genetic or congenital anomalies.
- 10% of the deaths were sudden, unexpected and unexplained deaths

The CDOP Panel identified modifiable factors in 50% of the cases. These included, smoking, raised maternal body mass indexes, unsafe sleeping practices, consanguinity and factors related to service provision.

A modifiable factor is one 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.

1.7. The number of deaths in each LSCB area over the past 4years is shown in Table 1.

Table 1

LSCB Area	2009-2010	2010-2011	2011-2012	2012-2013	Total by Local Authority
Luton	44	33	22	31	130
Central Bedfordshire	16	14	17	24	71
Bedford Borough	12	16	19	11	58
Total	72	63	58	66	259

Table 2

Infant Mortality Rates (IMR)

IMR is defined as the number of deaths of children less than one year of age per 1000 live births.

Local Authority	Infant Mortality Rate (CHIMAT 2009-2011)	England Average (CHIMAT 2009-2011)
Bedford Borough	5.8/1000	4.4/1000
Central Bedfordshire	2.5/1000	4.4/1000
Luton	7.2/1000	4.4/1000

As can be noted the rates in Bedford Borough and Luton appear higher than the England average whilst Central Bedfordshire rate is lower.

Table 3

Child Mortality Rates (0-17yrs)

The child mortality rate is rate of deaths per 100,000 children aged 1-17yrs (CHIMAT 2009-2011)

Local Authority	**Child Mortality Rate** (CHIMAT 2009-2011)	**England Average** (CHIMAT 2009-2011)
Bedford Borough	11.5/100000	13.7/100000
Central Bedfordshire	13.8/100000	13.7/100000
Luton	19.9/100000	13.7/10000

Luton has a relatively high rate, the Central Bedfordshire rate is similar to the national average and Bedford Borough is slightly lower.

2.0 Background to the Child Death Review Process

Since April 2008 Local Safeguarding Children Boards have had a statutory responsibility for child death review processes. The relevant legislation can be found within the Children's Act 2004 and applies to children from 0 to 18 years. The process is outlined in Working Together to Safeguard Children (DfE 2013).

The overall purpose of the child death review process is to understand how and why children die and identify interventions which may help to prevent future deaths.

The overall review process will

- Document the cause of death for each child
- Identify any pattern of deaths within the local area so that modifiable factors can be recognised and reduced
- Recognise any factors in the child's death which necessitates referral for consideration as a Serious Case Review.

There are 2 processes:
A **rapid response meeting** where professionals come together to review the circumstances leading to an unexpected death and a review of all child deaths at the **Child Death Overview Panel meeting.**

In Bedfordshire there are 3 Local Safeguarding Children Boards (Luton, Central Bedfordshire and Bedford Borough) that form a single CDOP responsible for reviewing all the deaths of children in the 3 Local Authorities. The membership of the panel (Appendix 1) ensures there is the appropriate level of knowledge and expertise to fully review each child's death. The CDOP Terms of Reference and Working Policies and Procedures have been reviewed and updated and are available on the LSCB websites.

The CDOP is managed on a day to day basis by the CDOP manager and this post is hosted by Bedfordshire Clinical Commissioning Group (BCCG). There is daily contact between the Designated Nurse and the CDOP manager in order for any safeguarding issues [i] that may be associated with child deaths to be discussed.

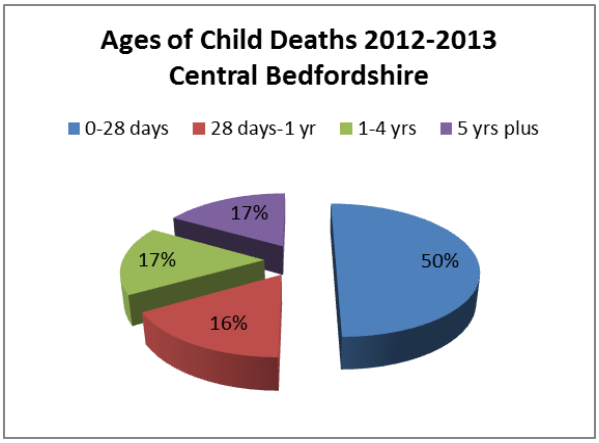
2.1 Serious Case Reviews (SCR)

Where a suspicion arises that neglect or abuse may have been a factor in the child's death, CDOP is responsible for the case to be referred to the LSCB Chair for consideration of whether an SCR is required.

3.0 Central Bedfordshire Child Death Review

Deaths Reported 1st April 2012-31st March 2013

During the period 1st April 2012 to 31st March 2013 a total of 24 child deaths occurred amongst children residing in Central Bedfordshire. Although numbers are small, this is an increase of 7 deaths on the previous reporting year (2011-2012) and above the average number of deaths reported in the previous 4 years which was 18 deaths per year.

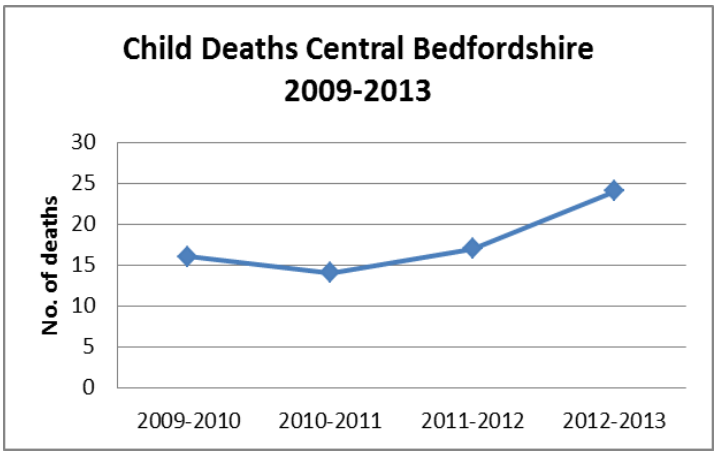


Half of the deaths were in the first month of life and 67% in the first year of life. 6 of the deaths reported were unexpected deaths i.e. the death was not anticipated in the 24 hours before the child died. There was no common factor identified to explain the suggested increase.

3.1 Central Bedfordshire Review of Data April 2009- March 2013

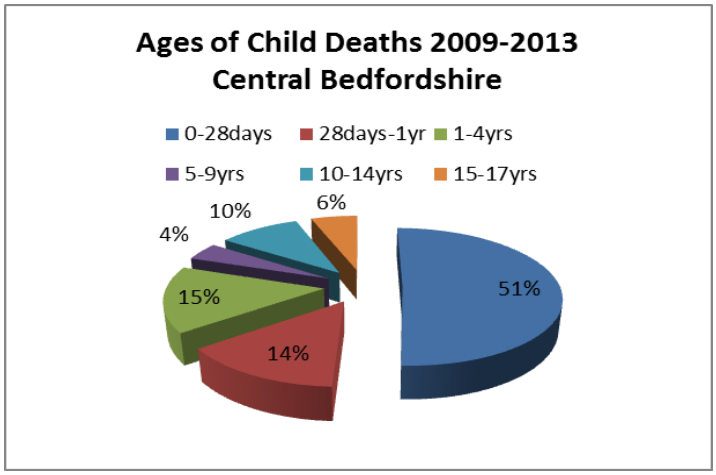
Number of Child Deaths

In the period 1st April 2009 to 31st March 2013 a total of 71 child deaths were reported in Central Bedfordshire.



3.2 Ages of Children

65% were aged less than 1 year similar to the national average of 66% for the total number of deaths reviewed in England during the year 2011-2012.



3.3 Gender of Children

58% male

42% female

This is the same as the figure for England 2011-2012 for deaths reviewed in this time period.

3.4 Cause of Death in cases reviewed and closed 2012-2013

When reviewing cases CDOP panels are required to categorise the death into categories and identify any modifiable factors. Table 4 sets number of cases reviewed and closed during 2012-2013 and the percentage of cases for which modifiable factors were identified. The data in the third column is taken from the Statistical Release published by the Department for Education (DfE) in July 2013. This is the analysis of all data submitted by CDOPs to the DfE on cases reviewed and closed during 2013-2013. This table gives a comparison between local data on modifiable factors as compared to national data. As some of the numbers are small caution should be taken with comparisons.

Table 4

Causes of death

	Cases reviewed & closed	Modifiable Factors Identified	National data with modifiable factors (2012-2013)
Trauma & other external factors	8.3%	40%	58%
Malignancy	6.7%	25%	
Acute medical or surgical condition	8.3%	20%	29%
Chromosomal, genetic & congenital anomalies	22%	7%	7%
Perinatal/neonatal event	36.6%	45%	15%
Sudden unexpected, unexplained death	8.3%	100%	63%
Other	9.8%		

Data supressed where <3 instances

3.5 Perinatal/Neonatal deaths

These are defined as deaths ultimately related to perinatal events, e.g. such as bleeds within the brain, difficulties with lung function due to immature lungs and problems with the gastrointestinal tract due to prematurity. The majority of these cases were therefore related to prematurity, 71% of these babies were delivered between 19 and 27 weeks gestation.

3.6 Ethnicity of Children

89% of the children who died were White British. This is in line with the Census 2011 that showed that in Central Bedfordshire 88.1% of the child population are White British.

3.7 Modifiable factors identified

As part of the review of child deaths the Child Death Overview Panel must determine if there were any modifiable factors identified. These are 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 child deaths.

In total 85% of the child death cases reported during this 4 year period have been reviewed and closed. Of these modifiable factors were identified in one third of the cases.

Factors include:

- Unsafe sleeping arrangements for babies
- Smoking

- Raised BMI
- Clinical care

CDOP ensure are aware of the modifiable factors and are working with Public Health to ensure pathways are in place for pregnant women to promote healthier lifestyle choices. Women with a raised BMI are offered access to information and support to make healthy living choices and weight management in pregnancy. For pregnant women who smoke, access to stop smoking services and campaigns to raise awareness of the risk of smoking in pregnancy.

The Public Health team is also is working jointly with Public Health in Luton to deliver workshops to health and social care staff concerning safe sleeping messages for front line staff.

3.8 Area of residence

Table 6 shows the number of deaths per ward

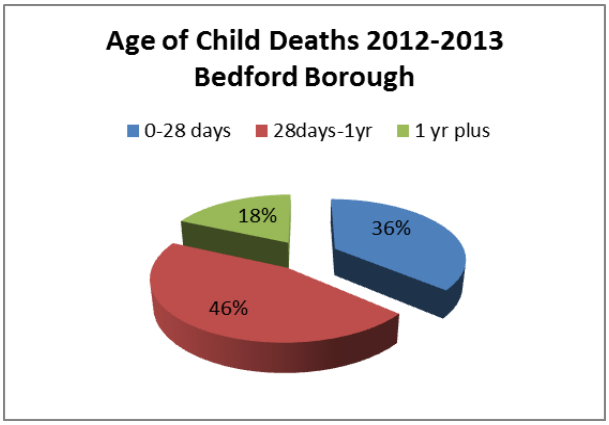
Wards with highest number of deaths	
Leighton Buzzard North	9.8% (7)
Leighton Buzzard South	8.4% (6)
Houghton Hall	8.4% (6)
Sandy	7% (5)
Dunstable Manshead	7% (5)
Dunstable Northfields	5.6% (4)
Flitwick	5.6% (4)
Cranfield & Marston	5.6% (4)
Biggleswade South	4.2% (3)
Parkside	4.2% (3)
Linslade	4.2% (3)
Heath & Reach	4.2% (3)

As can be seen from the table, the highest percentages of deaths are in the wards where there are areas of deprivation including Leighton Buzzard North, South and Houghton Hall.

4.0 Bedford Borough Child Death Review

Deaths Reported

During the period 1st April 2012 to 31st March 2013 a total of 11 child deaths occurred amongst children residing in Bedford Borough. This is a decrease of 8 deaths on the previous reporting year (2011-2012) and is comparable to the average number of deaths reported in the previous 4 years of approximately 14 deaths per year. The majority of deaths were in the first year of life.

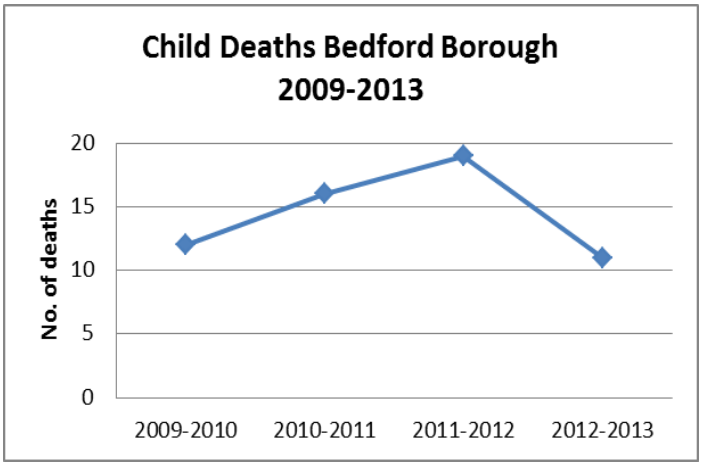


3 of the deaths reported were unexpected deaths i.e. the death was not anticipated in the 24 hours before the child died.

4.1 Bedford Borough Review of Data April 2009- March 2013

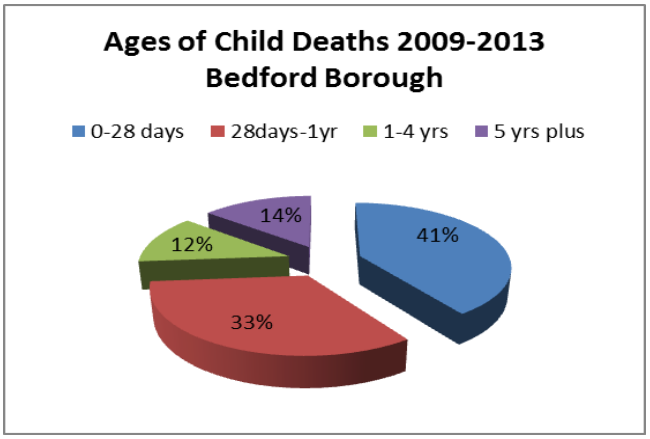
Number of Child Deaths

In the period 1st April 2009 to 31st March 2013 a total of 58 child deaths were reported in Bedford Borough.



4.2 Ages of Children

74% of deaths were in children under 1 year of age with 41% being under 28 days.



4.3 Gender of Children

55% male

45% female

This is similar for the figure for England for deaths reviewed in 2011-2012

4.4 Cause of Death in cases reviewed and closed 2012-2013

When reviewing cases CDOP panels are required to categorise the death into categories and identify any modifiable factors. Table 7 for the number of cases reviewed and closed during 2012-2013 and the percentage of cases for which modifiable factors were identified. The data in the third column is taken from the Statistical Release published by the Department for Education (DfE) in July 2013. This is the analysis of all data submitted by CDOPs to the DfE on cases reviewed and closed during 2012-2013.

Table 7 gives a comparison between local data on modifiable factors as compared to local data. However as some of the numbers are small caution should be taken with comparisons.

Table 7

	Cases reviewed & closed	**Modifiable factors identified**	**National data with modifiable factors (2012-2013)**
Malignancy	11.8%	0	x
Acute medical or surgical condition	7.8%	25%	29%
Chromosomal, genetic & congenital anomalies	25.4%	7.7%	7%
Perinatal/neonatal event	37.2%	26.3%	15%
Infection	9.8%	0	26%

Sudden unexpected, unexplained death	5.9%	100%	63%
Other	2.1%		

Data supressed/grouped where <3 cases

4.5 Perinatal/Neonatal deaths

These are defined as deaths ultimately related to perinatal events, e.g. such as bleeds within the brain, difficulties with lung function due to immature lungs and problems with the gastrointestinal tract due to prematurity.

89% of these babies were delivered between 22 and 26 weeks gestation

4.6 Ethnicity of Children

Table 8 shows that there appears to be an over-representation of child deaths among the Pakistani, White Other and Black African populations of Bedford Borough compared to the resident population and an under-representation of White British**.**

Table 8

Ethnicity	**% died in BBC**	**% child population in BBC**	**% Population England**
White British	45%	64.2%	79.8%
White Other	14%	6.8%	4.6%
Indian	7%	5.5%	2.6%
Pakistani	15%	3.2%	2.1%
Bangladeshi	5%	3.8%	0.8%
Black African	10%	2.4%	1.8%
Black Caribbean	4%	1.4%	1.1%

Census 2011

4.7 Modifiable factors identified

As part of the review of child deaths the Child Death Overview Panel must determine if there were any modifiable factors identified. These are 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 child deaths.

In total 90% of the child death cases reported during this 4 year period have been reviewed and closed. Of these modifiable factors were identified in 33% of the cases.

Factors include:

- Unsafe sleeping arrangements for babies
- Smoking

- Raised BMI
- Clinical care

CDOP are working with Public Health to ensure there are pathways in place to promote healthier lifestyle choice for pregnant women. Women with a raised BMI are offered access to information and support for weight management in pregnancy and for pregnant women who smoke, access to stop smoking services and campaigns to raise awareness of the risk of smoking in pregnancy.

The Public Health teams have also delivered workshops to health and social care staff concerning safe sleeping messages for front line staff.

4.8 Area of Residence

Table 8 shows the number of deaths per ward

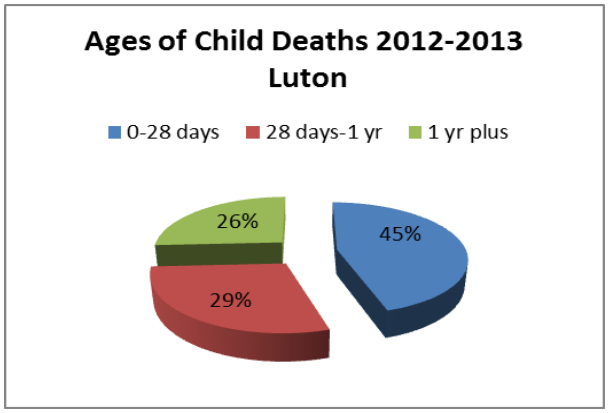
Wards with highest number of deaths	
Queens Park	21% (12)
Castle	10% (6)
Harpur	10% (6)
Cauldwell	9% (5)
Kingsbrook	7% (4)
Goldington	5% (3)

As can be seen from the table, the highest percentages of deaths are in the wards where there are areas of deprivation including Queens Park and Castle wards.

5.0 Luton Borough Child Death Review

Deaths Reported

During the period 1st April 2012 to 31st March 2013 a total of 31 child deaths occurred in children residing in Luton. This is similar to the average of the number of deaths reported in the previous 4 years (30).

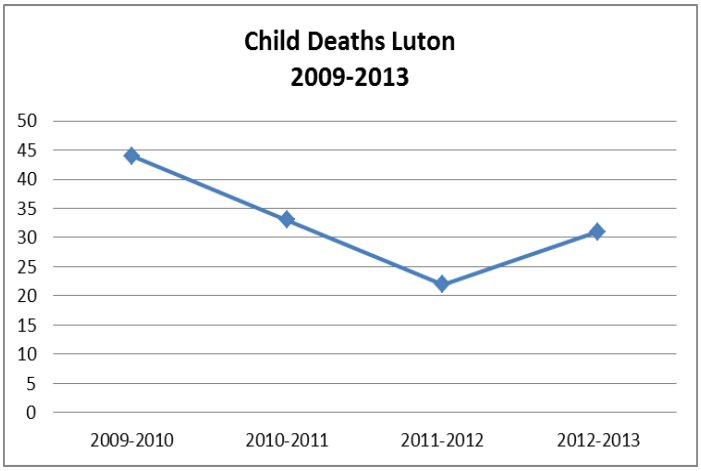


6 of the deaths reported were unexpected deaths i.e. the death was not anticipated in the 24 hours before the child died. There was no common factor identified in these deaths.

5.1 Luton Borough Review of Data April 2009- March 2013

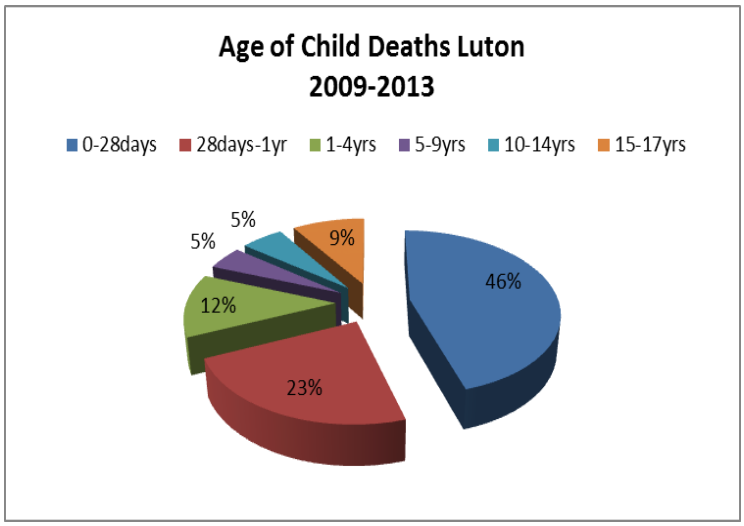
Number of Child Deaths

In the period April 2009 to March 2013 a total of 130 child deaths were reported in Luton



5.2 Ages of Children

69% of deaths were in children under 1 year of age, the largest proportion, 46%, being under 28 days.



5.3 Gender of Children

61% male

39% female

A review of deaths was carried out to identify an explanation for the over-representation of boys. It was agreed by CDOP that all boy deaths in Luton would be reviewed to identify any common themes associated with these deaths. The review of these cases did not highlight any specific explanation for this higher rate of boy deaths or any new action required by CDOP.

5.4 Cause of Death in cases reviewed and closed 2012-2013

When reviewing cases CDOP panels are required to categorise the death categories and identify any modifiable factors. Table 10 sets out the number of cases reviewed and closed during 2012-2013 with the percentage of cases for which modifiable factors were identified. The data in the third column is taken from the Statistical Release published by the Department for Education (DfE) in July 2013. This is the analysis of all data submitted by CDOPs to the DfE on cases reviewed and closed during 2012-2013. This table gives a comparison between local data on modifiable factors as compared to local data. As some of the numbers are small caution should be taken with comparisons.

Table 10

	Cases reviewed & closed	Modifiable factors identified	National data with modifiable factors (2012-2013)
Malignancy	3.4%		x
Acute medical or surgical condition	6.8%	40%	29%
Chronic medical condition	6.8%	25%	16%
Chromosomal, genetic & congenital anomalies	35.9%	66%	7%
Perinatal/neonatal event	25.6%	35%	15%
Infection	6.8%	37.5%	26%
Sudden unexpected, unexplained death	11.1%	100%	63%
Other	3.6%		

Data supressed/grouped where <3 cases

5.5 Chromosomal, genetic & congenital anomalies

It has been noted from the review of deaths and previous annual reports that hereditary conditions and associated genetic anomalies have a significant impact on child deaths, especially infant deaths in Luton. A significant contributory factor identified though CDOP may be due to the high incidence of consanguineous marriages predominantly affecting the British Pakistani community in Luton.

5.6 Perinatal/Neonatal deaths

These are defined as deaths ultimately related to perinatal events, e.g. such as bleeds within the brain, difficulties with lung function due to immature lungs and problems with the gastrointestinal tract due to prematurity.

90% of these babies were delivered between 20 and 27 weeks gestation.

5.7 Ethnicity of Children

Table 11 shows that there is an over-representation of deaths in the Pakistani and Black African communities in Luton compared to the resident population.

Table 11

Ethnicity	% died Luton	% child population in Luton	% Population England
White British	28.4%	32.5%	79.8%
White Other	5.3%	6.2%	4.6%
Pakistani	44%	22%	2.1%
Bangladeshi	6.9%	10.4%	0.8%
Black African	8.4%	5.7%	1.8%
Black Caribbean	3.8%	3.3%	1.1%
Mixed	6.1%	9.3%	

5.8 Modifiable factors identified

As part of the review of child deaths the Child Death Overview Panel must determine if there were any modifiable factors identified. These are 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 child deaths.

In total 93% of the child death cases reported during this 4 year period have been reviewed and closed. Of these modifiable factors were identified in 46% of the cases with consanguinity being the highest modifiable factor in 20& of all the cases reviewed and closed.

Factors include

- Consanguinity
- Unsafe sleeping arrangements for babies
- Smoking
- Raised BMI
- Clinical care

Consanguinity was noted as a modifiable factor in 20% of all the cases reviewed and closed. Infant mortality and the genetic risk associated with cousin marriage has been a key priority for the Health and Wellbeing Strategy for Luton.

The risk associated with genetic anomalies most notably among the Luton Pakistani community has a major impact on child death. Many children die in early infancy however many children with life limiting conditions and profound disabilities survive into later childhood.

Work to address this issue has been a key extension to the infant mortality plan for Luton. In 2012 a genetics plan was agreed that focusses on increased awareness among community groups and health professionals of the risk and access to information and services to support family decision making.

During 2103/14 the Council scrutiny function has focussed on improving infant mortality. The recommendations from the Scrutiny Task and Finish Group are expected later this year.

Similar to the work being carried out in the other local authority areas, targeted work is being delivered to reduce maternal obesity and smoking in pregnancy. CDOP are working with Public Health to ensure there are pathways in place for pregnant women with raised BMI to access healthy living choices and weight management in pregnancy.

CDOP ensure Public Health are aware of the modifiable factors in relation to smoking and receive feedback on campaigns and pathways for pregnant women who smoke.

5.9 Area of Residence

Table 12 shows the number of deaths per ward

Wards with highest number of deaths	
Dallow	14% (18)
Saints	10% (13)
South	10% (13)
Biscot	9% (11)
Farley	8% (10)
Leagrave	8% (10)
Lewsey	8% (10)

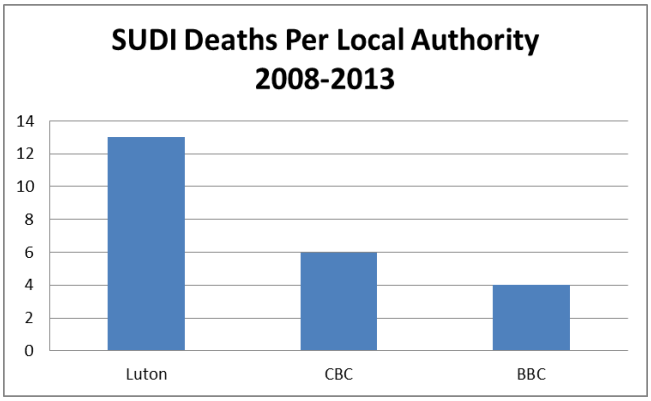
In 2011 when the Indices of Multiple Deprivation were published Luton was ranked as the 69th (out of 326) most deprived local authority.
Data published in the Research & Geospatial Information in August 2011 suggests that areas of Luton are becoming more deprived particularly Dallow, Biscot , South and Farley. These areas have higher numbers of child deaths as compared to other wards in Luton.

6.0 Sudden Unexpected Deaths in Infancy (SUDI) Central Bedfordshire, Bedford Borough & Luton 2008-2013

'Sudden Unexpected Death in Infancy' is the term used to describe the sudden and unexpected death of a baby or toddler that is initially unexplained. Some sudden and unexpected infant deaths can be explained by the post-mortem examination revealing, for example, an unforeseen infection or metabolic disorder. Deaths that remain unexplained after the post mortem are usually registered as 'sudden infant death syndrome' (SIDS). Sometimes other terms such as SUDI or 'unascertained' may be used. (Lullaby Trust 2013)

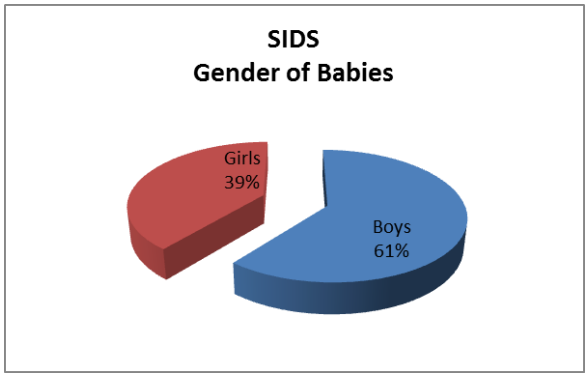
There are well known and documented risk factors associated with SIDS and these include unsafe sleeping practices, maternal/paternal smoking, drug misuse, alcohol misuse and overheating. Breast feeding is known to be a protective factor.

Between April 2008 and March 2013 across Central Bedfordshire, Bedford Borough and Luton there have been a total of 23 deaths of babies which were sudden and unexplained.



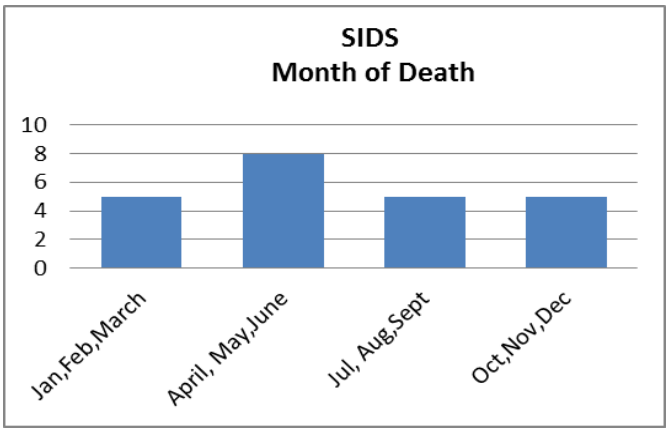
6.1 Gender of babies

14 of 23 babies who died were boys. This is in keeping with research which shows that boys appear to be more at risk than girls. (Epidemiology of SIDS and explained sudden infant deaths. CESDI SUDI Research Group .Leach CE, Blair PS, Fleming PJ, Smith IJ, Platt MW, Berry PJ, Golding J.)



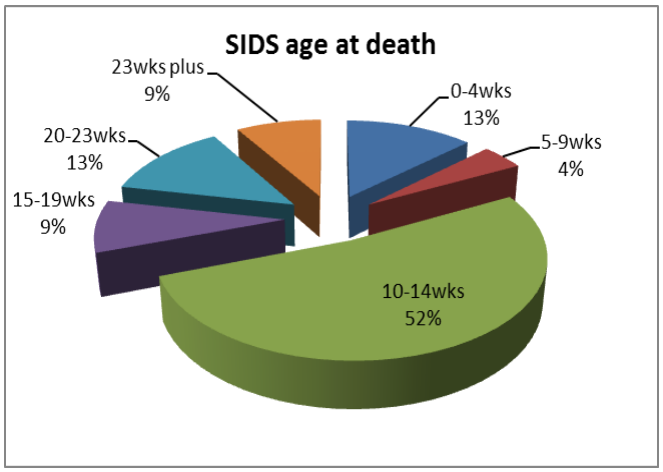
6.2 Month of Death

National statistics show that babies are more likely to die during cooler months however the data for Bedford Borough, Central Bedfordshire and Luton is fairly evenly spread throughout the year although a peak has been observed in the second quarter of the year.



6.3 Age at death

The age of the babies that died ranged from 2 weeks to 31 weeks with 52% of the deaths between 10 and 13 weeks.



6.4 Modifiable factors

Modifiable factors were identified in all 23 of the sudden unexpected deaths reported to CDOP. These include unsafe sleeping practices, smoking and drug/alcohol misuse. Midwives and health visitors offer advice to all parents in the ante and post natal period on factors associated with sudden unexpected deaths in infancy and measures parents should take to reduce the risk of this of tragedy. In some cases there was more than one modifiable factor identified.

6.5 Modifiable factors identified in relation to sleeping

The recommendations from UNICEF and the Lullaby Trust are that the safest place for a baby to sleep is in a cot on their back next to the parents for the 1st 6 months of a baby's life. It is strongly recommend that parents should never sleep with their baby on a sofa or armchair and that the baby should not be placed to sleep in the parent's bed if they smoke, drink, take drugs or are extremely tired.

In the review of the 23 unexpected and unexplained deaths the majority were not in a cot/Moses basket at the time of their final sleep.

6.6 Other modifiable factors identified

During pregnancy all mothers who disclose that they smoke are offered referral to smoking cessation. Advice and referral is also offered by midwives and health visitors in the postnatal period who discuss the risks to babies associated with smoking. Smoking was identified as a modifiable factor in 56% (13/23) of the cases.

These professionals also discuss risks associated with the use of alcohol and drugs especially if parents decide to place their baby in bed with them.

Other factors identified included a very hot environment and pre term delivery.

Actions being taken:

- Task group established led by Public Health Luton
- Frontline health staff survey carried out
- New mothers survey completed
- All information used by front line health staff (health visiting, maternity, infant feeding) and mode of information given reviewed
- Staff workshops carried out
- Planned evaluation of staff awareness planned for Sept/ Oct 2013

7.0 Neonatal Deaths

All neonatal deaths

In total 70 neonatal deaths from Central Bedfordshire, Bedford Borough and Luton have been reviewed and closed CDOP. These deaths were reported in the period 2009-2013.

Modifiable factors were identified in 38.5% of cases.

These include maternal smoking in pregnancy, raised maternal body mass index and drug/alcohol misuse.

Maternal smoking in pregnancy dramatically increases the rate of miscarriage and stillbirth. Midwives make routine enquiries at booking appointments regarding woman smoking status and if the woman discloses that she smokes, she is referred to the local smoking cessation service. Carbon monoxide monitoring also occurs at the booking of pregnancy and there is regular monitoring of smoking throughout pregnancy. Rates of smoking in pregnancy are monitored by Public Health and there are local targets to ensure a continued reduction in smoking in pregnancy.

Obesity is defined as a BMI over 30kgs/m^2 and is associated with and increased risk of serious adverse pregnancy outcomes including neonatal death. Public Health are working with midwives and other service providers to ensure there is consistent advice and interventions for women with a raised BMI.

8.0 Pre viable deaths

CDOP are required to collect a data set of information on all babies who are born with any signs of life and registered as live births regardless of the gestation. The current gestational age of viability is set at 24 completed weeks of pregnancy.

The World Health Organisation's definition of a live birth is when a fetus, whatever its gestational age, exits the maternal body and subsequently shows any sign of life, such as voluntary movement, heartbeat, or pulsation of the umbilical cord, for however brief a time and regardless of whether the umbilical cord or placenta are intact.

40% of the neonatal deaths reviewed and closed were of a gestation less than 24 weeks with the earliest gestation being 20 weeks.

Local hospital resuscitation guidelines outline processes/procedures to be undertaken depending on the gestational age of the baby.

For all neonatal deaths a complete data set of information is collected on the mother's antenatal history which includes:

- maternal age
- parity
- gestation at booking
- medical and obstetric history including mental health problems
- any current pregnancy problems
- smoking status- referral to smoking cessation
- Body Mass Index (BMI)
- employment status
- ethnicity
- If the relationship is consanguineous
- any social/safeguarding concerns
- any history of domestic abuse

9.0 CDOP Training Sessions

CDOP information sessions have been held across Bedfordshire and Luton during 2012-2013 with a total of 80 delegates attending. These included midwives, health visitors, children's community nurses, hospital paediatric nurses, paramedics, nursery nurses and social workers.

The length of the session is 2 hours with joint presentations by the Lead Paediatrician, the Lead Nurse for Child Death Reviews (Luton), the Police and the CDOP manager.

The presentations are followed by group work in which child death scenarios are reviewed and discussed. This group work embeds the learning for the presentations and highlights the risk factors and themes which have emerged from the review of child deaths locally.

The CDOP manager has also delivered a short presentation at the Bedford Borough and Central Bedfordshire 2 day level 3 Safeguarding Children training and the Lead Nurse for Child Death Reviews (Luton) is actively involved in delivering CDOP training to health and social care professionals and delivers a presentation at the Luton Clinical Commissioning Group Safeguarding Children study day for level 3 staff.

3 GP Safeguarding Children education days were held in Central Bedfordshire and Bedford Borough with almost 200 GPs attending. A short presentation on CDOP and the GPs involvement in the process was delivered by the CDOP manager

10.0 Lead Nurse- Child Death Reviews (Luton)

The role of the Lead Nurse- Child Death Reviews is hosted by Cambridgeshire Community Services. The nurse visits all families in Luton following the death of a child, meeting the criteria for a child death review (CDR). This includes expected and unexpected deaths. The main purposes of the role are to ensure families are informed of the child death review process, to offer bereavement support and to signpost families to local bereavement counselling services.

The role forms part of the rapid response to unexpected deaths, involving a timely home visit to obtain pertinent information and may involve observation of the scene of death. This knowledge is disseminated at the multi-agency professional's information sharing meetings.

The lead nurse is a permanent member of CDOP and contributes additional information obtained from families regarding their child's death. The majority of parents do request feedback from the nurse following CDOP meetings. In some cases this discussion acknowledges the impact of parental health and lifestyle choices, such as smoking and obesity, for surviving siblings or to reduce the risks for future pregnancies.

It came to the attention of the lead nurse that some families had not received information on Serious Incidents conducted by health agencies following the unexpected death of their child. The nurse worked in collaboration with CDOP to ensure these families were offered the opportunity to receive feedback. The Clinical Commissioning Group is now looking at ways to improve communication between the investigators of Serious Incidents, CDOP and families.

11.0 Key Actions Taken 2012-2013

- Closer involvement with hospitals regarding Serious Incident reports to ensure CDOP are made aware of findings and actions taken to prevent reoccurrence

- Ensuring that where post mortem findings indicate a familial/genetic cause for the death that family members are appropriately signposted for specialist consultation

- Ensure genetic advice is offered to families where a child has died from a congenital/metabolic/chromosomal anomaly.

- Close liaison with Public Health has given assurance that there are pathways in place for referral to smoking cessation for pregnant women and newly delivered mothers.

- Public health have ensured clear pathways are in place for support for women with a raised BMI in pregnancy through referral to a local slimming support organisation.

- Design of a leaflet for bereaved parents whose child's death was expected informing them of the CDOP process and signposting them to appropriate support agencies.

- Audit of male deaths in Luton See section 5.3

- Staff education on reducing the risk of SIDS

12.0 Plans for 2013-2014 (taken from work plan for 2013-2014)

- Increase GP and frontline staff awareness of CDOP, and their role in data completion following a child death and implementation of learning from emerging themes

- Ensure safe sleeping messages are clear and parents are aware, including foster carers when a baby is LAC

- Evaluate work on safe sleeping.

- With Public Health aim to reduce smoking in pregnancy. Smoking is identified as a modifiable factor for Sudden Unexpected Death in Infancy and neonatal deaths.

- With Public Health reduce maternal BMI. Raised maternal BMI identified as modifiable factor in the review of neonatal deaths and babies born at a very early gestation

- Plan to reduce genetic related deaths in Luton-community consultation

- Identify data set for wider determinants of health and collect data.

Appendix 1

Child Death Overview Panel Membership

- Director of Public Health –Luton (Chair)
- Assistant Director of Public Health-Luton (Vice Chair)
- Head of Public Health - Children & Young People and Inequalities –Central Bedfordshire
- Lead Paediatrician for Child Death Reviews Central Bedfordshire & Bedford Borough
- Lead Paediatrician for Child Death Reviews Luton
- Designated Nurse for Safeguarding Children and Young People Bedfordshire Clinical Commissioning Group
- Designated Nurse for Safeguarding Children and Young People Luton Clinical Commissioning Group
- Manager Bedfordshire & Luton Child Death Overview Process
- Representatives from Children's Social Care Central Bedfordshire, Bedford Borough & Luton
- Lead Nurse for Child Death Reviews Luton
- Central Bedfordshire/Bedford Borough Local Safeguarding Children Board Business Manager
- Luton Local Safeguarding Children Board Business Manager
- Representative from Bedfordshire Police Safeguarding Unit
- Representative from East of England Ambulance Service
- Lay Member