Newsletter Date: August 2014

CDOP Newsletter

Luton Safeguarding Children Board

Bedford Borough Safeguarding Children Board

Central Bedfordshire Safeguarding Children Board

The Child Death Overview Panel (CDOP) became a statutory function in 2008 & meets every 6 weeks to review all child deaths & share lessons to prevent future deaths. The panel consists of representatives from the 3 Local Safeguarding Children Boards across Bedfordshire & Luton i.e health, public health, the police, social care, LSCB Business managers & a lay representative. Deaths across the county are analysed and modifiable factors identified which by means of local or national interventions may prevent deaths in the future

Why Children Die Report May 2014

This report from the RCPCH (Royal College of Paediatrics & Child Health & NCB (National Children's Bureau), calls for the withdrawal of the spending cap, a national data base on child mortality, minimum unit alcohol pricing & 20mph zones in built up area in a bid to reduce to reduce the UK's 'tragic child mortality rates'.

The report reviewed existing UK evidence on child deaths & their causes, & found that:

- In 2012 over 3000 babies died before 1 year of age & over 2000 children and young people died between 1 & 19
- Over half of deaths in childhood occur during the 1st year of a child's life, and are strongly influenced by pre-term delivery& low birth weight; with risk factors including maternal age, smoking & disadvantaged circumstances
- Suicide remains the leading cause of death in young people in the UK & the number of deaths due to intentional injuries & self-harm have not declined in 30 years in the 10-17 year age group.
- After 1 year of age, injury is the most frequent cause of death; over three quarters of deaths due to injury in 10-18 year olds are related to traffic incidents.

Further information can be found at:

http://www.ncb.org.uk/whychildrendie

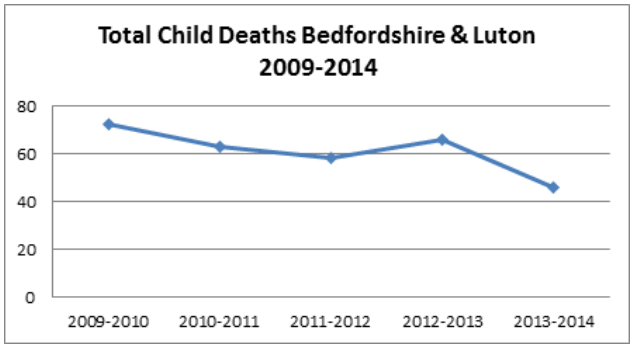
CDOP Annual Report 2013-2014

46 children died across Bedfordshire and Luton between 1st April 2013 and 31st March 2014.

This is was a significant reduction of 30% compared to 2012-2013.

The most significant reduction is in the number of deaths reported in the 0-28 day age range where there has been a 50% reduction in the number of deaths.

However although numbers are small, there has been an increase of 15% in the deaths in the 10-17 year age range.



- 39% (18/46) of the deaths were unexpected.
- 50% (23/46) of the children died at local hospitals, 37% (17/46) of the children died outside of Bedfordshire at tertiary centres where these children were receiving specialist care.
- 11% (5/46) children died either at home or in a hospice

- 61% (28/46) of the deaths were in children less than 1 year of age, with 10% of these deaths recorded as Sudden Unexpected Deaths in Infancy
- The panel have to identify modifiable factors these are defined as ones 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 Working Together to Safeguard Children DfE (2013)
- Modifiable factors included, smoking, raised maternal body mass index, unsafe sleeping practices, consanguinity and factors related to service provision.
- The panel is chaired by the Director of Public Health in Luton and met on 8 occasions in the period 2013-2014
- CDOP has a comprehensive workplan which demonstrates achievements & has been refreshed for 2014-2015. Plan is owned by CDOP panel members & will be monitored & updated on a quarterly basis

The annual report can be found at:
http://lutonlscb.org.uk/pdfs/cdop.doc
http://www.centralbedfordshirelscb.org.uk/publications/annual_reports

Statistical Review of Child Death data by Department for Education

Each year CDOP is required to send data to the DfE on the number of child deaths reviewed in the previous 12 months. A comparison of national and local data showed that whilst nationally 22% of deaths had modifiable factors, locally that figure was 33%. . The difference could be due to a lack of consistency in local CDPOPs as to whether factors such as smoking and consanguinity are identified as modifiable factors.

48 deaths were reviewed by Bedfordshire & Luton CDOP in 2013-2014

In England reviews of deaths from a White background accounted for 3 out of 5 reviews completed. This is similar to the figure in Bedfordshire but for Luton the number of reviews for children from an Asian background was 3 out of 5

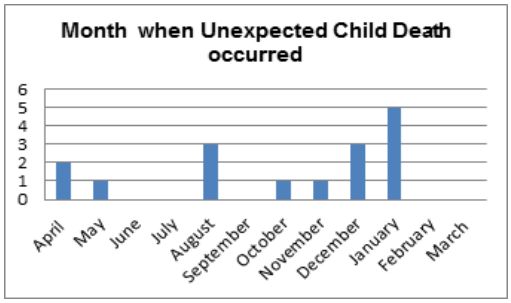
Audit of Unexpected Child Death Arrangements

Central Bedfordshire, Bedford Borough and Luton unexpected child death response arrangements are based on the statutory Working Together to Safeguard Children Guidance (2013) and were last updated in May 2014.

An audit was undertaken on the 16 unexpected child deaths that occurred from April 2013 to March 2014 to determine if the response from Bedfordshire and Luton CDOP is within the local documented arrangements and if multi agency working and response can be demonstrated within the process.

The audit has demonstrated that during the past year 81% of Rapid Response/Information Sharing meetings have taken place within the required time frame. Where this has not been possible there have been legitimate reasons for the non-compliance

There was a period in December2013-January 2014 when there was sadly a high number of unexpected deaths. This was a challenging period for all professionals.



It is appreciated that professionals/agencies make themselves available to attend the rapid response information and share information on the child and family to ensure an appropriate response to an unexpected death.

Safe Sleeping

Midwives & health visitors continue to deliver safe sleeping messages to parents and NICE have recently published a draft consultation on an addendum to the clinical guideline on Postnatal care on the association between co sleeping and Sudden Infant Death Syndrome (SIDS). This sets out recommendations to be given to parents & carers to help them reach a fully informed decision on the place of sleeping for their babies. It is expected that the guidance will come into effect in December 2014
https://www.nice.org.uk/guidance/gid-cgwave0699/resources/postnatal-care-update-addendum-consultation-document2

Baby Slings

Harrow CDOP have recently reviewed the sad & unexpected death of a month old baby who had been taken out by his parents in a 'mobi' style sling. On their return home it was found the baby was no longer breathing

At the inquest the Coroner deemed that the cardiac arrest was caused by positional asphyxia but no there was no evidence that the use of the sling was inappropriate or incorrect.

However 2 matters of concern were identified at the inquest:

- There appears to be a body of evidence that positional asphyxia can occur through the use of baby slings. However knowledge of this risk appears to be limited at present to academic circles & has not been widely researched
- If there is currently sufficient evidence to raise this risk to parents, then the information has not been publicised more widely,

The Royal Society for the Prevention of Accidents (RoSPA) advocates products that keep babies upright and allow parents to see their baby and to ensure that the face isn't restricted. Not all slings are dangerous. A carrier that keeps the newborn baby solidly against the parent's body, in an upright position, is the safest method. Parents should ensure that they keep their baby's chin off their chest, keeping the airways clear for breathing.

Tragically this is the 2nd unexpected death in Harrow involving a baby in a sling & Harrow LSCB requested that this information be shared with other CDOPs

CHUMS
Child Bereavement Trauma & Emotional Wellbeing Service

CHUMS was initially created to meet the needs of children and their families following the death of someone close, however they may have died.

They offer support in a variety of ways to children, young people and their families across Luton and Bedfordshire.

The Service is an organisation established from a wide range of experienced, trained professionals and volunteers throughout Bedfordshire.

Postal Address: CHUMS – Child Bereavement and Trauma Service, Wrest Park Enterprise Centre, Wrest Park, Silsoe, Bedfordshire MK45 4HS.

Telephone: 01525 863924

CDOP Information Sessions

Would you like to find out more about CDOP, emerging themes from the review of child deaths in our area and your role in the CDOP process if a child known to you dies?

2 sessions have been arranged:

Monday 1st December 2014
Meeting Room
Endeavor House, Wrest Park, Silsoe MK45 4HR
12.00-14.00

Thursday 4th December 2014
Room 207
Redgrave Gardens Children's Centre Luton LU3 3QN
14.30-16.30

Sessions will be facilitated by the Lead Pediatrician for CDOP

To book a place please contact CDOP Manager, Shirley Whiterod on
01525 864430 Ext 5878
Or email
Shirley.whiterod@bedfordshireccg.nhs.uk