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CDOP Newsletter

Luton Safeguarding Children Board

NHS
The NHS in Bedfordshire and Luton

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

Every child's death is a tragedy for his or her family including any siblings. Only a small minority of unexpected deaths are as a consequence of abuse or neglect

Child Death Overview Process-what is it?

The Child Death Overview Process (CDOP) is a statutory function introduced in 2008 whereby areas have to investigate all child deaths (0-18 yrs) (Working Together to Safeguard Children 2006& 2010). This process is accountable to the Local Safeguarding Children Boards (LSCB) for Luton, Bedford Borough & Central Bedfordshire. If the child dies in another area it is usually the CDOP in the area where the child was normally resident who will take the lead in investigating the child's death

A data set of information is collected on all child deaths with a focus on **unexpected** deaths. If a child dies unexpectedly an information sharing meeting is held as soon as possible with all agencies who knew the child & family to:

- determine the circumstances leading up to the death,
- to ensure the family are supported,
- that there are no safeguarding concerns for other children in the family &
- should the case be referred to the LSCB for consideration a as Serious Case Review.

The police are always involved when a child dies unexpectedly to look at all circumstances to ensure there are no suspicious elements to the death.

When a full data set of information has been collected the case is presented to the CDOP Panel

CDOP Panel

The CDOP panel meets approximately every 6 weeks. It is chaired by Gerry Taylor who is also Director of Public Health in Luton. There are 2 Paediatricians for the panel, Dr Catherine Kearney who takes a lead with child deaths in Luton and Dr Salma Rehman her counterpart for deaths in Bedford Borough and Central Bedfordshire. Other panel members include the police, designated nurses for safeguarding children in Luton & Bedfordshire, representatives from social care and LSCB business managers. Luton have a Lead Nurse for Child Death Reviews, Anita Wilson, who offers bereavement support following the death of a child and ensures that all families are informed about the child death review process and are given a chance to contribute to or receive feedback from the review process. The process is overseen and managed on a day to day basis by the CDOP manager whose post is hosted by NHS Bedfordshire.

Sub group meetings have been held at the Luton & Dunstable Hospital to discuss neonatal deaths with the expertise of a consultant neonatologist.

Child Death data 2008-2011

During this period a total of 183 child deaths were reported across Luton and Bedfordshire with 71 of these being unexpected deaths.

Around 44% of the deaths reviewed are in babies under 1 year of age. The main causes of these deaths are complications of prematurity with some of the babies being born at a very early gestational age or even pre viable but they were registered as a live birth as a heart rate was present for a short time after delivery. Other causes of deaths are due to chromosomal or congenital anomalies- in some cases parents have been aware of these problems but elected to continue with the pregnancy.

8% (15) of the deaths were Sudden Unexpected Deaths in Infancy (SUDI) with age range being 10 days to 8 months.

In Luton over the 3 year period 31% of the children who died were from a Pakistani background which appears to be an over representation of about 10 percent according to the school census. In Central Bedfordshire all the children who died were White British and in Bedford Borough 46% of children were white and 22% were Asian (Pakistani and Indian)

Modifiable factors *-these may have contributed to the death & which by means of locally or nationally achievable interventions could be modified to reduce the risk of future child deaths*

Modifiable Factors & Public Health Messages

For each death modifiable factors are considered. These factors may have contributed to the child's death.

For neonatal cases the mother's social, medical, obstetric history as well as current antenatal history is reviewed.

In many cases it is noted that the mother was a smoker & had continued to do so during pregnancy. Evidence shows that women have an increased risk pre tem delivery & low birth weight babies if they smoke as well as an increased risk of 'cot death' some cases

It has also been noted in some cases of neonatal deaths especially where the baby was born at a very early gestation that the mothers BMI was raised. Research shows that women with a high BMI are at increased risk of miscarriage, preterm delivery & neonatal death

Consanguinity (1st cousin marriages) has been noted as a modifiable factor in 20% of the cases reported in Luton and NHS Luton will be working with partners to understand the inter-generational attitudes and beliefs toward consanguineous relationships, the general awareness & risk perceptions & to openly discuss these sensitive issues.

When reviewing SUDI's the panel have also noted modifiable factors in some of the cases such as smoking in the home environment, drug/alcohol misuse and unsafe sleeping practices.

Messages therefore for any agency coming into contact with women of child bearing age, pregnant and newly delivered mothers is to offer referral to smoking cessation, discuss weight management and ensure that new mothers are aware that babies should be placed on their backs to sleep in their own cot and especially if there are risk factors such as smoking or drug/alcohol misuse

Contact Details

For further information or if you have a group of staff who would like some in depth information/training please contact CDOP manager Shirley Whiterod on 01234 292955.

The CDOP annual report can be found on the LSCB websites:
www.bedfordshirelscb.org.uk

www.lutonlscb.org.uk