Bedford Borough Safeguarding Children Board

Central Bedfordshire Safeguarding Children Board

Luton Safeguarding Children Board

Bedford Borough, Central Bedfordshire and Luton Child Death Overview Process Panel Annual Report

1 April 2014 - 31March 2015

Contents

Executive Summary

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 aim of this report is to summarise the work of the Bedford, Central Bedfordshire and Luton Child Death Overview process during 2014-2015.

This is the 7th 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 during 2014-2015 and analysis of the data and emerging themes for 2009-2015.

During 1st April 2014 to 31st March 2015 the panel met on 8 occasions and completed full reviews on 44 children residing in Bedford Borough, Central Bedfordshire and Luton. These cases were from 2012-2013, 2013-2014 and 2014-2015. There can be a delay to reviewing cases as 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.

During the period April 2014 until March 2015 there were 51 deaths reported across Bedfordshire. This is made up of 12 (24%) in Bedford; 26 (51%) in Luton and 13 (25%) in Central Bedfordshire. Unexpected deaths accounted for 13 (25%) in 2014 / 2015. The number of deaths was 10 % greater than the previous year (46 against 51), but less than each of the previous 4 years.

25% (13/51) of the deaths were unexpected, which was a decrease on the previous year where 39% were unexpected. 66% (34/51) of the children died at local hospitals,

21% (11/51) of the children died outside of Bedfordshire at tertiary centres where these children were receiving specialist care. 12% (6/51) children died either at home or in a hospice. 77% (33/51) of the deaths were in children less than 1 year of age.

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

The number of deaths in each LSCB area over the past 5 years is shown in Table 1. This shows a decline in child deaths over the past 5 years

Table 1: Deaths reported 2010/11 - 2014/15

LSCB Area	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	Total by Local Authority
Luton	**33**	**22**	**31**	**20**	**26**	**132**
Central Bedfordshire	**14**	**17**	**24**	**10**	**13**	**78**
Bedford Borough	**16**	**19**	**11**	**16**	**12**	**74**
Total	**63**	**58**	**66**	**46**	**51**	**284**

Serious Case Reviews

Local safeguarding children boards (LSCB) commission serious case reviews when a child has died or been seriously harmed through abuse or neglect. The purpose of the serious case review is to ensure that lessons are learned which help to better protect children in the future. CDOP may refer a case to its LSCB chair if it considers the criteria for a SCR may be met and a SCR has not been initiated.

One Serious Case review has been published in the past year following a child death.

1.0 Background

Child Death Overview Panels (CDOP) were established in April 2008 as a statutory requirement as set out in Chapter 5 of 'Working Together to Safeguard Children' (2015). The primary function (as required by the Local Safeguarding Boards Regulations 2006) is to undertake a comprehensive and multiagency review of all deaths of children normally resident in Bedford Borough, Central Bedfordshire and Luton aged 0-18 years of age, in order to understand better how and why they die and to use the findings to take action to prevent other deaths and to improve the health, wellbeing and safety of children and young people. The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate of the cause of death (Working Together, 2015, p81).
The CDOP has specific functions laid down in statutory guidance, including:

- Reviewing the available information on all deaths of children up to 18 years (including deaths of infants aged less than 28 days) to determine whether there were any modifiable factors identified
- Collecting, collating and reporting on an agreed national data set for each child who has died.
- Meeting regularly to review and evaluate the routinely collected data on the deaths of all children, and thereby identifying lessons to be learnt or issues of concern.
- Referring to the Chair of the Local Safeguarding Children Board (LSCB) any deaths where the panel considers there may be grounds to consider a serious case review.
- Identifying any public health issues and considering, with the Directors of Public Health, how best to address these and their implications for the provision of both services and training.
- Identifying patterns or trends in local data and reporting these to the LSCB.
- Informing local Joint Strategic Needs Assessments and the work of Health and Wellbeing board.

The local CDOP Panel covers the 3 Local Safeguarding Children's Boards of Bedford Borough, Central Bedfordshire and Luton.

1.1 The Principles

The principles underlying the overview of all child deaths are:
1. Every child's death is a tragedy
2. Learning lessons including referring cases for in depth review/scrutiny such as Serious Case Review

3. Joint agency working and informing service provision.
4. Positive action to safeguard and promote the welfare of children

1.2 The Process

Child deaths are reviewed through two interrelated processes; a paper based review of all deaths of children under the age of 18 years and a rapid response service which looks in greater detail at the deaths of children who die unexpectedly, an unexpected death is one where it was not anticipated within the previous 24 hours. During 2014-2015, the CDOP panel met on eight occasions to review anonymised information about child deaths. The panel is chaired by the Director of Public Health for Luton and has members from all relevant agencies.

The administration for the CDOP process is hosted by Bedfordshire Clinical Commissioning Group and funded via the 3 Local Authorities (Bedford Borough, Central Bedfordshire and Luton) and the 2 Clinical Commissioning Groups (Luton and Bedfordshire).

2.0 The National Picture year ending March 2014

3,658 Reviews completed by Child Death Overview Panels in the year ending 31 March 2014 – a year on year decrease from 4,061 in the year ending 31 March 2011.

22% The percentage of child death reviews (823 reviews) identified as having modifiable factors, a slight increase from 20% in the year ending 31 March 2011.

72% The percentage of child death reviews completed in the year ending 31 March 2014 that were reviewed within 12 months of the death, which has shown a year on-year decrease from 80% in the year ending 31 March 2011.

66% The percentage of deaths reviewed relating to children under one year old in the year ending 31 March 2014. This percentage is consistent with the previous three years.

56% The percentage of child death reviews for boys (2,015) compared to 44% for girls (1,587). The majority of reviews have been for boys' deaths for in each of the last four years.

67% The percentage of serious case reviews related to a child death where modifiable factors were found.

Source: Statistical first release Department for Education (statistics at DfE website)

2.1 Local Picture

Locally the number of deaths in Central Bedfordshire, Bedford Borough and Luton for children under 1 year of age was greater than the national picture (77%) compared to 66% nationally. However, it should be noted that national figures relate to the year 2013 / 2014 which is the most recent published data. In 2014 – 2015 modifiable factors were identified in 40% of cases, which is higher than the national picture in 2013 -2014 of 22%. Unsafe sleeping, smoking, raised maternal body mass index and consanguinity were identified as modifiable factors.

Consanguinity is a major risk factor for congenital anomaly. CDOP Panels nationally continue to be concerned that inter-family couples do not have sufficient understanding of the increased risks of having a child with a disability or of having a child die under the age of 5. In 2% of the deaths reviewed nationally consanguinity may have contributed to vulnerability, ill-health or death and in a further 1% consanguinity provided a completed and sufficient explanation for the death. Whilst across Bedfordshire this is represented as 4.5% of deaths reviewed by the Panel to have consanguinity as a factor, within Luton this is represented as 7.6% of the deaths, which is lower than in 2013 / 2014. Within Luton targeted action has been taken with considerable community engagement to improve awareness in high risk communities.

It should be noted that it is not possible to directly compare the national picture with the local picture due to the publication timescales of national data.

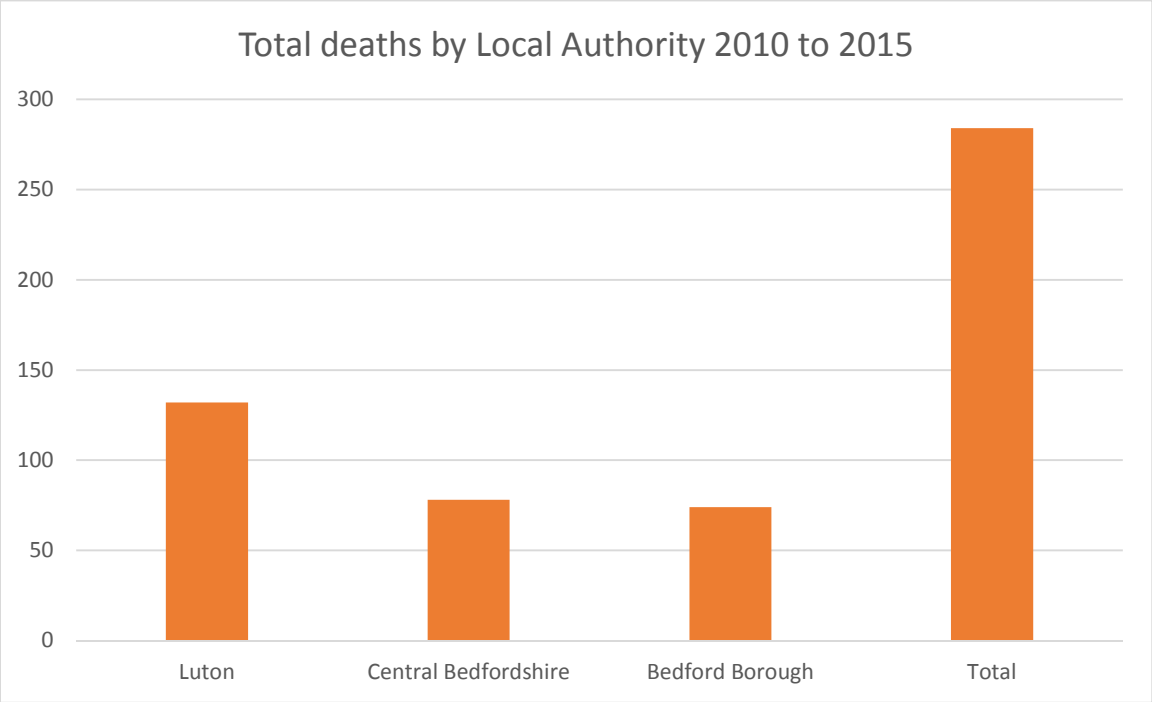
3.0 Reported deaths

During the period April 2014 until March 2015 there were 51 deaths reported across Bedfordshire. This was made up of 12 (24%) in Bedford Borough; 26 (51%) in Luton and 13 (25%) in Central Bedfordshire. Unexpected deaths accounted for 13 (25%) in 2014 / 2015. The number of deaths was 10% greater than the previous year (46 against 51), but less than each of the previous 4 years. In the annual report, April 2013-March 2014 it states that 39% of deaths were unexpected. This suggests a reduction of 14 percentage points.

Table 1 Deaths reported 2010/11 - 2014/15

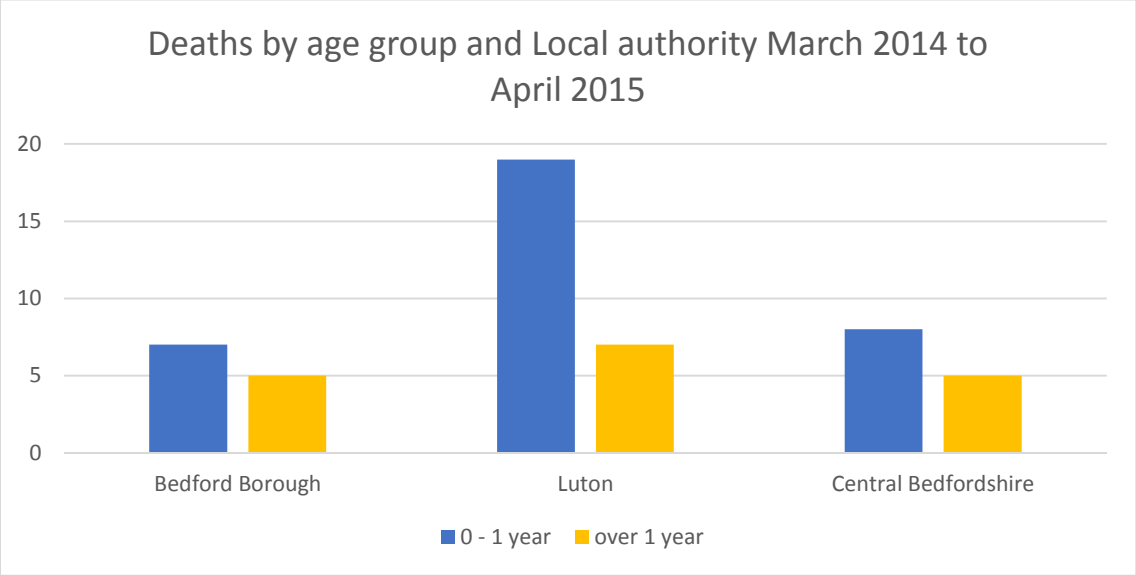
LSCB Area	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	Total by Local Authority
Luton	33	22	31	20	26	132
Central Bedfordshire	14	17	24	10	13	78
Bedford Borough	16	19	11	16	12	74
Total	63	58	66	46	51	284

Figure 1



Figures 1 and 2 show the number of deaths in each local authority; numbers being the highest in Luton. Number of deaths were higher in the <1 age range for all three local authorities.

Figure 2



4.0 Infant Mortality rates (IMR)

IMR is defined as the number of deaths of children less than one year of age per 1000 live births, whilst the Child Mortality rates is the rate of deaths per 100,000 children aged 1-17 years (CHIMAT 2011-2013). Table 2 below shows the most up to date information available at the time of writing this report.

Table 2 Infant Mortality

Local Authority	Infant Mortality Rate 2010/2012	Infant mortality rate 2011/2013	England Average IMR	England worst	Comments
Bedford Borough	5.9 / 1000	5.6/1000	4.1 / 1000	7.5/1000	Above national average, but lower than the England worst; Lower than previous data
Luton	5.4 / 1000	5.1/1000	4.1 / 1000	7.5/1000	Above national average, but lower than the England worst: lower than previous data
Central Bedfordshire	3.4	3.1/1000	4.1 / 1000	7.5/1000	Lower than the national average; decrease on previous data

Table 3 shows that child mortality rates were relatively high in Luton, but had decreased.

Table 3 Child Mortality

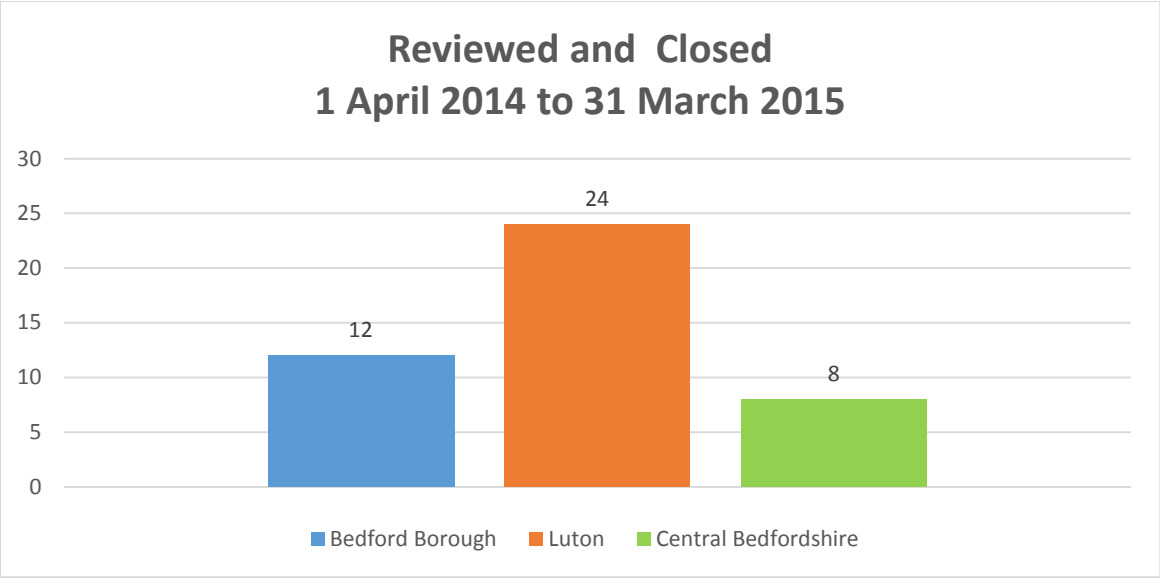
	Child Mortality Rate 2010-2012	CMR 2011-2013	England average	England worst	
Bedford Borough	8.8 / 100,000	9.7	11.9	22.8	Lower than the England average, increase on previous data
Luton	19.4 / 100,000	16.5	11.9	22.8	Above England average; decrease on previous data
Central Bedfordshire	10.3 / 100,000	11.2	11.9	22.8	Similar to the England average, increase on previous data

5.0 Deaths Reviewed and closed during 1 April 2014 to 31 March 2015

The child death review process aims to identify any modifiable factors for each child that dies and to see at review if any lessons can be learned either at a local or national level. A total of 44 deaths were reviewed between April 2014 and March 2015 (Figure 3).

Not all of the deaths reviewed occurred in this year, some will have occurred in the previous or earlier years. There is generally a gap of several months between a reported death and that death being reviewed to enable all relevant information to be gathered. CDOP is unable to review a death until other processes have been completed for example if there is a NHS Serious Incident review, a Serious Case Review or Coroner's Inquest.

Figure 3



5.1 Demographics of the 44 deaths reviewed by the Bedford, Central Bedfordshire and Luton CDOP in 2014 / 2015

- 33 (75%) were children less than 1 year of age
- 11 (25%) were in children between 1 and 18 years of age

Nationally over the past 4 years the number of deaths in children under 1 was greater (66% year to 31/3/2014) than those over 1 year

- 23 (52%) were males
- 21 (48%) were females

Locally, boys deaths have consistently accounted for over half those reviewed, which is in line with national figures.

Table 4 gives an indication of the ethnicity of children where cases were reviewed in 2014/15. It has not been possible to provide a detailed ethnic breakdown due to small numbers. However, the data suggest an overrepresentation amongst the Pakistani, Mixed and Black African and Caribbean communities.

Table 4 Percentage of Childhood Mortality Compared with Population by Ethnic Group

		Bedfordshire* Population	
	Childhood Deaths	Less than 18	All Ages
Other	-	0.8%	0.8%
White British	43%	61.9%	70.1%
Pakistani	25%	8.9%	5.4%
Mixed	11%	7.4%	3.0%
Black African & Caribbean	9%	5.8%	4.8%
White other	7%	5.0%	7.4%
Asian	4%	10.3%	8.5%

Mortality data in CDOP, child deaths ethnicity

Under 18 population by Ethnic Group InFuse download for 3 LAs, aggregated on number and percentage calculated

All age population from 2011 Census data (www.statistics.gov.uk)

* Bedfordshire = Bedford, Central Bedfordshire and Luton Councils populations by ethnic group aggregated

5.2 Causes of deaths in cases reviewed and closed in 2014 / 2015

When reviewing cases CDOP panels are required to categorise the death into categories and identify any modifiable factors. That is, any factor which on review might have prevented that death and might prevent future deaths. Last year there were 18 deaths (40%) where a modifiable factors was identified.

Table 5 Analysis of cases reviewed and closed at CDOP Panel between April 2014 and March 2015

	Local Cases reviewed and closed	**Modifiable factors identified**	**National data with modifiable factors year ending 31/03/2014**	**Local picture against national**
Chromosomal, genetic and	13 (30%)	5 (38 %)	9 %	**Higher**

congenital anomalies				
Perinatal/neonatal event	19 (43%)	8 (42 %)	18%	**Higher**
Other	12 (27%)	5 (42%)		
Totals	**44**	**18 (40%)**		

5.3 Serious Case reviews

There was one serious case review considered by the Local Safeguarding Children's Board in Bedford Borough from the previous year which was published in Oct 2014. Lessons learned are currently being cascaded to front line practitioners across health and social care.

5.4 Actions taken in response to Modifiable factors and trends identified

Some of the deaths reported were babies delivered at a pre viable gestation (before 24 weeks gestation) but had a heart rate present at birth and therefore were registered as live births. Some of these gestations are as early as 21 weeks. A data set of information on the mother's antenatal history is requested from the midwives to determine if there are any wider health determinates of the mother that may have pre disposed to the pre-term /pre viable delivery. Modifiable factors were identified in 42% of these neonatal deaths primarily maternal smoking and raised body mass index.

5.5 Area of residence

The Indices of Deprivation 2010 provide a relative measure of deprivation in small areas across England. The Indices of Deprivation 2010 is based on the concept that deprivation consists of more than just poverty. Poverty is not having enough money to get by on whereas deprivation refers to a general lack of resources and opportunities. The domains used in the Index of Multiple Deprivation 2010 are income, employment, health, education, crime, access to services and living environment. An area has a higher deprivation score than another one if the proportion of people living there who are classed as deprived is higher. An area itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score. (Communities & Local Government: English Indices of Deprivation 2010).

For 2014 / 2015 it has not been possible to determine if there are higher numbers of deaths in areas of deprivation due to low numbers and the causes of death, it is not

possible to outline the areas of residence as it may then be possible to identify the child however for comparison purposes figures for 2009 to 2015 can be seen in the appendices.

5.6 Child Death Overview Panel Meetings

Eight panel meetings were held in the period 1st April 2014- 31st March 2015. Meetings are held approximately every 6 weeks and the duration of meetings is between three and four hours. All meetings were quorate.

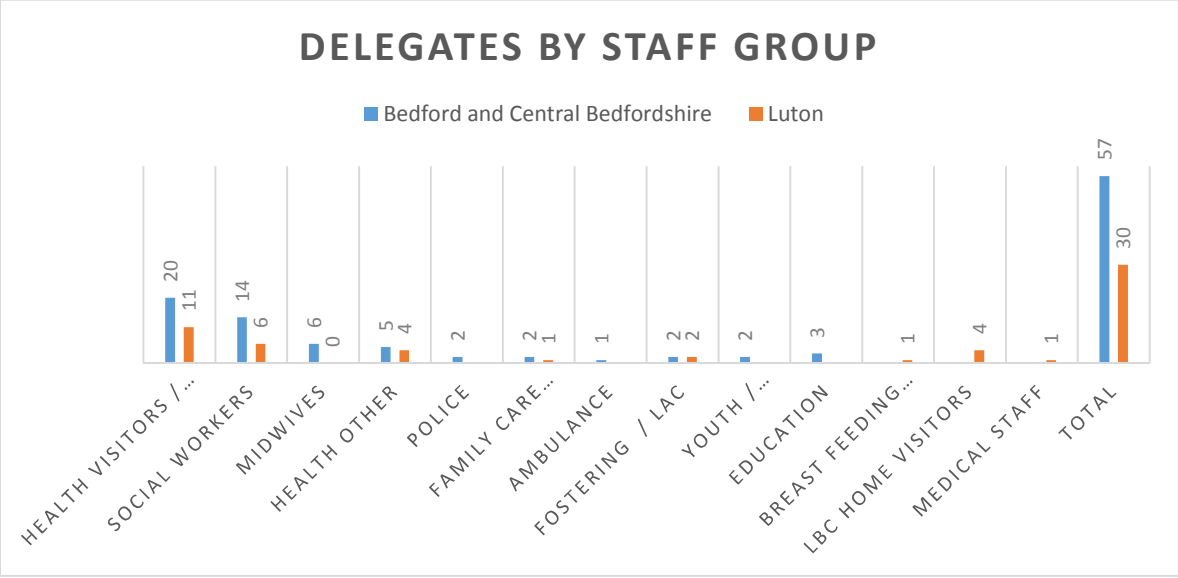
On occasions guests are invited to discuss particular cases and the Senior Coroner for Bedfordshire has been in attendance for one of the meetings held during this period.

Other professionals have attended meetings as part of their induction process and for professional development.

6.0 CDOP Training Sessions

A total of 5 CDOP training sessions were held across Bedford Borough, Central Bedfordshire and Luton during 2014-2015 for all professionals who work with children and young people with a total of 87 delegates attending.

Figure 4



The length of the information session was 2 hours with a joint presentation by the CDOP Manager, Lead Paediatrician, Child Death Review Nurse and Police. Further sessions will be arranged in 2015-2016 and invitations will be sent out to professionals working with children across Bedfordshire, Central Bedfordshire and Luton.

As more deaths occur in the below one year age group we will be focusing training in Midwifery and Social Care to heighten the awareness of modifiable factors that can be altered during the antenatal period.

100% of delegates felt the training session met or exceeded expectations in relation to:

- The purpose of CDOP
- The delegates response to unexpected deaths
- An understanding of emerging themes
- How these themes can be integrated into practice

The delegates were asked how the training will impact on their role. Below are some of the responses:

- *I have been able to see the wider picture of why we do assessments and how it contributes to the public health picture*
- *Clearer focus on modifiable factors*
- *Emphasised the importance of safe sleeping advice*

7.0 Key Actions Taken 2014-2015

- When concerns relating to practice issues have been identified by either single or multi agencies during the review of cases, CDOP have requested that these issues are investigated either through the Serious Incident process within the organisation or via a Local Safeguarding Children Board case review. Lessons learned and actions taken are fed back to the panel.
- Safe sleeping promoted across maternity and early years services and an agreed consistent approach adopted.
- Water safety promoted through schools in response to drowning incidents, there has also been national Chief Fire Officer's drowning prevention and water safety weeks. In 2015 the campaign will be focusing on the issue of Cold Water Shock with the slogan "tell a friend, save a friend".
- Reduction in smoking during pregnancy with access to Stop smoking Services offered by all health professionals to parents during both ante natal and post natal periods.
- Focus on maternal BMI through setting targets with community and acute health providers.

- Management of crying infants following a serious case review.
- It has been noted that the number of deaths from chromosomal, genetic and congenital abnormalities is higher than the national average. It is known that nationally consanguinity has not been consistently recorded across CDOPs nationally until 2013. Locally where consanguinity is identified our paediatricians will contact the GP to offer genetic counselling to parents. There is an action plan around consanguinity in Luton.
- Newsletters are produced on a regular basis by the CDOP Panel and contain information regarding national and local issues identified, these are circulated to all Health and Social Care Partner agencies to inform front line practitioners such as GP's, Paediatricians, Health Visitors, Midwives, Social Workers, Children's Centre Staff and Nurses.
- Multi Agency training provided by the CDOP Manager, Police and Paediatricians is delivered to staff locally and this is another opportunity to pass on messages to practitioners.
- Review of evidence around neonatal deaths.
- CDOP has a comprehensive work plan which demonstrates achievements and has been refreshed for 2015-2016. The action plan will be owned by CDOP panel members on behalf of their organisation and will be monitored and updated on a quarterly basis.

8.0 Plans for 2015-2016

- Increase GP and frontline staff awareness of CDOP and their role 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 a Looked after Child (LAC).
- Reduce smoking in pregnancy and post birth.
- Provide information from CDOP to support evidence base for the quality schedule target for healthy weight management in pregnancy.
- Improve the dissemination of lessons learned from CDOP
- Ensure wide determinates of health are collected and recorded for child deaths.
- Deliver audit programme.
- Review local CDOP Process and procedures in line with Working Together to safeguard children (2015)
- Task and finish group to establish medications and pathways for school age children with asthma
- Publication of a CDOP Newsletter.

Appendix 1:
Summary for Central Bedfordshire LSCB

From 1st April 2014 to 31st March 2015 a total of 13 child deaths occurred amongst children residing in Central Bedfordshire. This is an increase of 3 deaths on the previous year (2013-2014). The majority (61%) of deaths were in the first year of life, with just under half (46%) of these deaths occurring in males. 30% were unexpected deaths which means that the death was not expected in the 24 hours before the death, or where there was an unexpected collapse or incident leading to or precipitating to the events which led to the death (Working Together to Safeguard Children (2015)

Actions undertaken:

- Safe sleeping has been promoted across maternity and early years services and an agreed consistent approach applied.
- Reductions in smoking during pregnancy and post Nataly with access to Stop smoking services offered by all professionals.
- Addressing high maternal BMI are being focused upon
- Management of crying infants, with information for parents following a serious case review
- Setting up a County wide group to look at Asthma management in children.
- Training on the CDOP process and learning from child deaths presented to professionals across Bedfordshire

Areas for improvement 2015 /2016

Increase GP and frontline staff awareness of CDOP and improve the dissemination of lessons learned from child deaths.

Central Bedfordshire

Wards with highest number of deaths 2009 to 2015		**Index of Deprivation**
Cranfield & Marston	4	5.8
Flitwick	5	7.1
Shefford	5	7.5
Leighton Buzzard South	7	9.6
Biggleswade South	4	10.5
Leighton Buzzard North	8	13.7
Sandy	6	14.2
Houghton Hall	7	20.1
Dunstable Northfields	5	22.5
Dunstable Manshead	6	24.6
Parkside	6	26.3

Appendix 2:

Summary for Bedford Borough LSCB

Child Death Overview Panel (CDOP)

From 1st April 2014 to 31st March 2015 a total of 12 child deaths occurred amongst children residing in Bedford Borough. This is a decrease of 4 deaths on the previous year (2013-2014). The majority (58%) of deaths were in the first year of life, with 71% of these deaths occurring in males.

Actions undertaken:

- Safe sleeping has been promoted across maternity and early years services and an agreed consistent approach applied.
- Reductions in smoking during pregnancy and post Nataly with access to Stop smoking services offered by all professionals.
- Addressing high maternal BMI are being focused upon
- Management of crying infants, with information for parents following a serious case review
- Setting up a County wide group to look at Asthma management in children.
- Training on the CDOP process and learning from child deaths presented to professionals across Bedfordshire

Areas for improvement 2015 /2016

Increase GP and frontline staff awareness of CDOP and improve the dissemination of lessons learned from child deaths.

Ward Level data

Bedford

Wards with highest number of deaths 2009 to 2015		Index of Deprivation
Putnoe	6	10
Harpur	7	26.3
Castle	6	26.6
Queens Park	17	27.2
Kingsbrook	6	30.3
Cauldwell	5	31.2

Appendix 3:

Summary for Luton Borough LSCB of deaths reported

During the period 1st April 2014 to 31st March 2015 a total of 26 child deaths were reported in children residing in Luton, this is an increase of 30 % (20 deaths 2013/14) over the previous year.

Five (19%) of the deaths in Luton were reported as unexpected and 16 (61%) were males which is in line with national statistics, however there has not been any specific explanation of why more boys die than girls.

Eighteen (69%) of the deaths were in children under 1 year of age, with a large majority being in the under 28 day age range. It has been noted that 9 (34%) are from the Pakistani community, however there were less cases this year than previous years registered as having modifiable factors of consanguinity.

Ward level data is provided below.

Luton

Wards with highest number of deaths 2009 to 2015		**Index of Deprivation**
Saints	18	25.7
Lewsey	13	27.2
Leagrave	13	27.6
Farley	16	32.9
South	15	35.2
Biscot	14	37.1
Dallow	22	38.1
Northwell	11	38.1