



**Coventry, Solihull & Warwickshire  
Safeguarding Children Boards**

# **CHILD DEATH OVERVIEW PANELS**

## **ANNUAL REPORT**

**2010 - 2011**

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## 1 Work undertaken during 2010 – 2011

The focus for 2010-2011 continued very much on the same theme as the previous year by aiming to review cases in a timely manner, finalise outstanding areas of work, progressing actions arising from reviews and continually reviewing and improving the process as a whole.

## 2 Work of local CDOPs during 2010-2011

19 local panels were held during 2010-2011 and 93 deaths (compared to 64 in 09-10) were reviewed:

LSCB	Panels held	Deaths Reviewed
Coventry	6	33
Solihull	6	15
Warwickshire	7	45
<b>Total</b>	<b>19</b>	<b>93</b>

- 2.1 Of the 93 deaths reviewed, 18 were from 2008-2009, 44 from 2009-2010 and 31 from 2010-2011.

### Recommendations and actions arising from local CDOPs during 2010-2011

## 3 Coventry CDOP

17 actions were identified during 2010-2011, an example of some are listed as follows:

- 3.1. GP Practice vaccination procedures were looked into when swine flu was found to be a contributory factor in vulnerable groups.
- 3.2 Following an action from 2009-2010 to research what work has been conducted with regards to genetic disorders where parents are consanguineous, a report was presented to Coventry Safeguarding Children's Board highlighting the number of reviews conducted where parents are consanguineous, i.e. blood related. Coventry LSCB recommended that the report be raised and discussed at the Equality and Diversity Theme Group of the Local Strategic Partnership.
- 3.3 Although Coventry has seen a reduction in deaths due to Sudden Infant Death Syndrome (SIDS) the panel recommended that the SIDS preventative campaign continue and funding was obtained to purchase additional room thermometers displaying the safe sleep messages, to hand to parents of newborns during 2011.
- 3.4 A gap in service provision was identified in the previous year for psychological support for children and young people with life limiting or chronic medical conditions. Following dialogue with the relevant services, the Children and Adolescent Mental Health Service (CAMHS) has agreed to provide psychological support to children and adolescents with a life limiting or long term illness.
- 3.5 Ascertaining agencies' protocols for referral when an expectant mother discloses domestic abuse.
- 3.6 Clarify if families have been offered genetic counselling where children have died from a chromosomal, genetic or congenital anomaly.

## **4 Solihull CDOP**

- 4.1 **24** actions were identified during 2010-2011, an example of some are listed as follows:
- 4.2 Heart of England NHS Foundation Trust to formalise a process for debriefing staff following a death.
- 4.3 Facilitate information exchange between internal mortality review meetings held in Heart of England NHS Foundation Trust hospitals and deaths reviewed at CDOP, to maximise learning opportunities.
- 4.4 CDOP to link in with the West Midlands Newborn Network which is looking to implement a standardised review process for neonatal deaths across the region.
- 4.5 Clarify capacity/escalation policy in Midwifery Units within Heart of England NHS Foundation Trust Hospitals.
- 4.6 Develop a Suicide Prevention Strategy for Solihull.
- 4.7 Explore current legislation and guidance relating to residential swimming pools and water safety in general.
- 4.8 A number of actions were also identified to obtain further information relating to the specific management of a case and to acknowledge good practice.

## **5 Warwickshire CDOP**

- 5.1 **24** actions were identified during 2010-2011, an example of some are listed as follows:
- 5.2 Community Midwifery Service to revisit their policy of not plotting weights in the child health record, i.e. 'red book'.
- 5.3 Community Midwifery Service to review their growth monitoring protocols to encourage flexibility and use of professional judgement if concerns are noted.
- 5.4 Clarify if Paediatricians record post natal checks conducted prior to discharge, in the child health record (red book).
- 5.5 Re-circulate to Head Teachers information on how the Critical Incident Support Group can support schools.
- 5.6 The Education Psychology Service to consider giving regular inputs to Head Teacher Induction Training, in line with good practice identified in Coventry.
- 5.7 Raise awareness amongst health professionals on bowel conditions in young infants.
- 5.8 Medical research to be conducted into 'twin to twin transfusion' to ascertain what has been published, how the condition is identified and what the prognosis is.
- 5.9 Monitor future deaths from congenital diaphragmatic hernia.
- 5.10 Continue with the SIDS preventative campaign. Funding was obtained to purchase additional room thermometers displaying the safe sleep messages, to hand to parents of newborns during 2011.

5.11 A number of actions were also identified to obtain further information relating to the specific management of a case and to acknowledge good practice.

## **6 Generic themes identified in categories of deaths reviewed during 2010-2011.**

### **6.1 Neonatal deaths**

Neonatal deaths were the highest category of deaths reviewed during 2010-2011. Contributory factors of smoking, drinking or recreational drug use were identified in 10% of cases. Where smoking was a contributory factor CDOP reviewed smoking cessation referral policies and whether appropriate referrals were made.

6.1.2 Actions from the Perinatal and Neonatal Mortality Review (PNMR) meetings held at University Hospitals Coventry and Warwickshire identified a number of learning points such as incorrect plotting on customised growth charts, the use of partograms (graphic representation of the progress of labour) and reinforcing fetal movement advice to expectant mothers.

### **6.2 Sudden and Unexpected Deaths**

**20** rapid response investigations under the Sudden and Unexpected Deaths in Children (SUDC) Protocol were conducted across the sub-region during 2010 – 2011 and **1** police investigation following a fatal road traffic collision, making the total **21**. Further detail with regards to cause and age is detailed in paragraph 13.1.

#### **6.2.1 Medical cause:**

In some cases where a medical cause of death was ascertained following a sudden and expected death, issues around early recognition and response to acute medical conditions and communication between GP's and hospital staff was identified. Learning points were also identified and acted upon by hospitals following an internal review which have been shared with and endorsed by CDOP. CDOPs have recommended that training/ awareness sessions be considered for health professionals from acute and community services, either within protected learning slots or 'stand alone' sessions to share learning.

6.2.2 Where H1N1 Swine Flu or seasonal flu was found to be the cause of death or a contributory factor, vaccination procedures were reviewed, particularly for vulnerable groups.

#### **6.2.3 Sudden Infant Death Syndrome**

Of the 7 deaths reviewed during 2010-2011 (2 from year 2009-2010 and 5 from year 2010-2011) which were categorised as SIDS, 6 featured one or more of the following risk factors; co-sleeping with an adult, incorrect sleeping position, smoking, prematurity or a hot environment. In all cases the 'Sleep Safe' merchandise was given and although the evaluation of the safe sleep campaign showed that parents' knowledge of safe sleeping practice improved, it is recognised that we need to keep reinforcing the messages particularly with vulnerable families.

6.2.4 An audit on rapid response investigations is being conducted, the findings of which will be available towards the end of 2011.

### **6.3 Malignancy and Chronic Medical Conditions**

In the deaths reviewed there was much evidence of good multi-agency working between acute and community services, in particular the dedication and commitment of the Palliative Care team which ensured patients and families were supported out of office hours when required.

## **7 Sub-Regional Strategic Child Death Overview Panel**

Following a review in October 2010, it was agreed that the Sub-Regional Strategic CDOP would cease and be replaced by a CDOP Annual Event where local CDOP members, former sub-regional strategic CDOP members and other interested parties would convene and analyse aggregated sub-regional data. The first annual event took place in June 2011.

## **8 CDOP Working Group**

The CDOP Working Group, formed in 2007 to progress the operational elements of the child death review process met 3 times during 2010-2011 with the Chair and venue rotating across the sub-region.

## **9 Work Completed during 2010 – 2011**

- 9.1 The Sub-Regional Information Sharing Protocol was ratified by respective LSCBs.
- 9.2 All outstanding neonatal deaths from years 2008-09 and the majority from 2009-10 have been reviewed. Those outstanding from year 2009-10 will be completed during 2011-12.
- 9.3 Dialogue continued with regards to purchasing an 'on line' notification system, however on review it was agreed to pursue an alternative option of utilising secure e-mail to receive notifications, request and receive additional information and for the dissemination of panel papers. The use of secure e-mail has been in operation since early 2011 and is proving to be practical and cost effective.
- 9.4 The 'Sleep Safe!' SIDS preventative campaign was launched in Solihull in November 2010, with Health Visitors handing out the 'Sleep Safe' merchandise to new parents at the primary visit. Arrangements are in hand to evaluate the campaign later in 2011.
- 9.5 An evaluation of the 'Sleep Safe!' SIDS preventative campaign, launched in Coventry and Warwickshire in January 2010 was conducted mid 2010 and the evaluation showed that in both areas parents' knowledge of safe sleeping practice improved after receiving the 'Sleep Safe' merchandise. Feedback was also received on what items parents found most useful and the vast majority indicated the room thermometer, hence the decision to purchase additional thermometers.
- 9.6 Contact has been made with all Registrar offices across the sub-region and all are providing child death registrar information into the child death review process. This is proving to be a very useful source of information as there have been a number of instances, albeit small, where registrar information has alerted the child death review process of a death.

## **10 Work in progress 2010 - 2011**

- 10.1 The sub-regional 'task and finish' group set up in 2010 to formulate policy on involving families in the child death review process met twice during 2010-2011. A draft policy has been subject of two consultations and following feedback a local information leaflet is being produced and further consultation will include bereaved parents. It is acknowledged that this area of work requires a sensitive and co-ordinated approach to ensure contact with bereaved parents is timely and proportionate.
- 10.2 A retrospective audit of rapid response investigations commenced in the latter part of 2010 and should be completed by the end of 2011.

- 10.3 It was also agreed that final local case discussion meetings under the Sudden and Unexpected Death in Children (SUDC) Protocol will complete the Rapid Response Audit Tool.

## 11 CDOP Budget

### 11.1 Expenditure 2010 – 2011

CDOP expenditure for 2010- 2011 is broken down as follows:

£59,742.00	Salary and on-costs for CDOP Manager and Clerical Support Officer
1,400.00	Hardware (computers, desk charges, office telephones)
700.00	CDOP Conference/Event
600.00	Supplies and services (hosting costs)
500.00	Postage and carriage
400.00	Mobile Phones
250.00	Printing
230.00	Stationery and paper
63,822.00	Total

### 11.2 Income for 2011-2012

In line with the formula agreed by sub-regional partners, contributions to the budget for 2011-2012 are:

£24,800.00	Coventry
13,000.00	Solihull
24,800.00	Warwickshire
62,600.00	Total

- 11.3 Expenditure for 2011-2012 will be brought into line with the income by a reduction in expenditure on postage, printing and stationery following the implementation of the secure electronic mailing system and a reduction in cost for the CDOP Annual Conference in 2011.

## 12 Sub-Regional Data 2010 – 2011

- 12.1 During 2010-2011, **85** deaths were notified to the Child Death Review Process across the sub-region. This is a slight reduction compared to the **88** deaths notified in year 2009-2010 and a reduction on 2008-2009 where **108** deaths were notified.
- 12.2 The annual report for 2009-2010 makes reference to the cross matching of data with the West Midlands Perinatal Institute where it transpired that 33 deaths had not been notified to the child death review process between 2008 -2010. The majority of these were early neonatal deaths and a lot of work has been conducted over this year in raising awareness with Obstetric and Neonatal teams.
- 12.3 The same process was conducted for 2010–2011 which ascertained that 5 deaths reported to the West Midlands Perinatal Institute had not been notified to the child death review process. These deaths all occurred within the first half of the reporting year and it is encouraging to note that there is no discrepancy on notifications for the latter half of 2010-2011 which is a significant improvement.
- 12.4 The figures given in paragraph 12.1 for years 2008-2009 and 2009-2010 include the additional 33 deaths identified by the West Midlands Institute and the first graph in paragraph 15 on page 11 reflects the true figure. However the further breakdown of aggregated sub-regional data on pages 11-13 does not include the 33 deaths as these

figures were obtained retrospectively with insufficient detail available. The aggregated data on pages 11 – 13 therefore only refers to the **86** deaths notified to the child death review process in 2008-2009 and **77** deaths notified in 2009-2010.

12.5 Data relating to 2010-2011 does includes the 5 deaths reported to the West Midlands Perinatal Institute.

12.6 Categories of deaths used in the data provided are defined as follows:

**Neonatal** – babies that die within 28 complete days of life

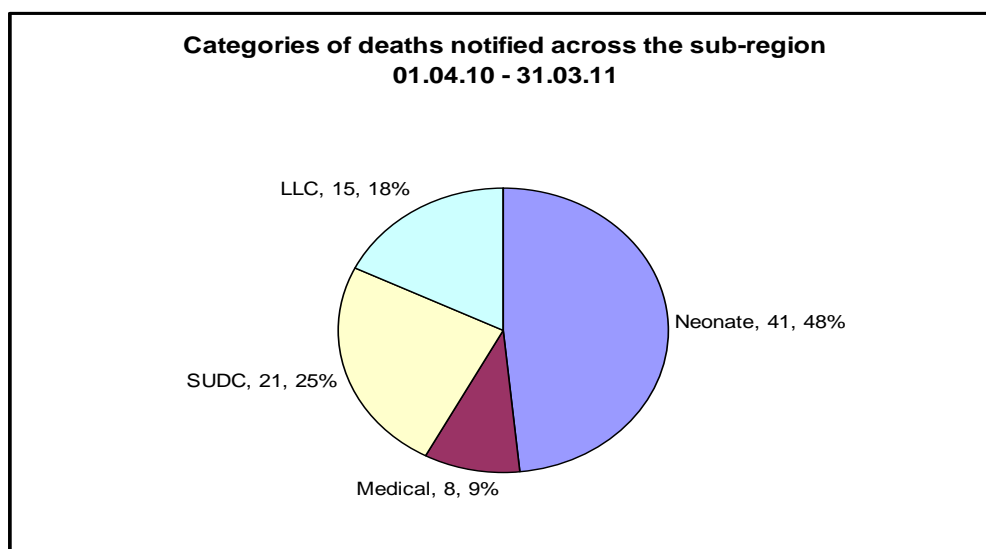
**Medical** – unexpected death but the cause is known at the time and a death certificate is issued.

**SUDC**- sudden and unexpected death in children where the cause is not known and a rapid response investigation under the Sudden and Unexpected Death in Children (SUDC) Protocol is instigated **or** a police investigation is conducted such as in a death resulting from a road traffic collision.

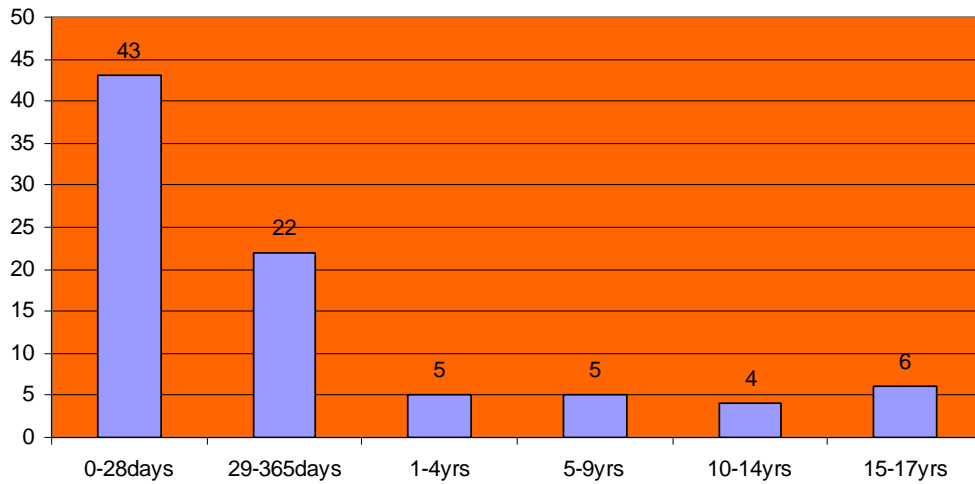
*N.B. In years 2008-09 and 2009-10, sudden and unexpected deaths subject of a rapid response investigation, where a medical cause of death was identified, were included in the 'medical' category. However for 2010-2011, all sudden and unexpected deaths have been grouped together and the outcome categorised. The SUDC category for 2010-2011 also includes all unexpected deaths from external factors where a rapid response and/or police investigation is conducted and will no longer be depicted as a separate category. This change has been made to reflect more accurately the number of sudden and unexpected deaths requiring an investigation and the resource implications associated with such investigations.*

**LLC** – expected deaths of children known to have a life limiting condition and where a death certificate is issued.

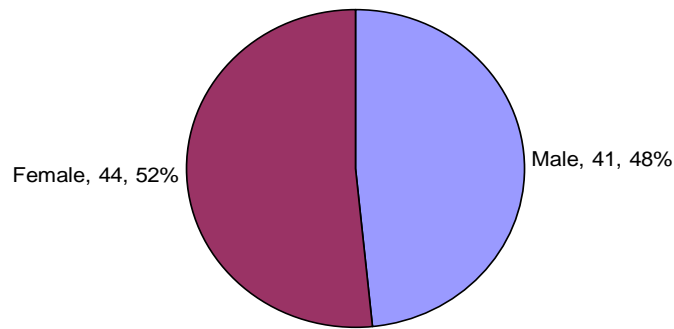
13 **Data relating to deaths notified across the sub-region during 2010 – 2011.**  
**Total number of deaths notified: 85**



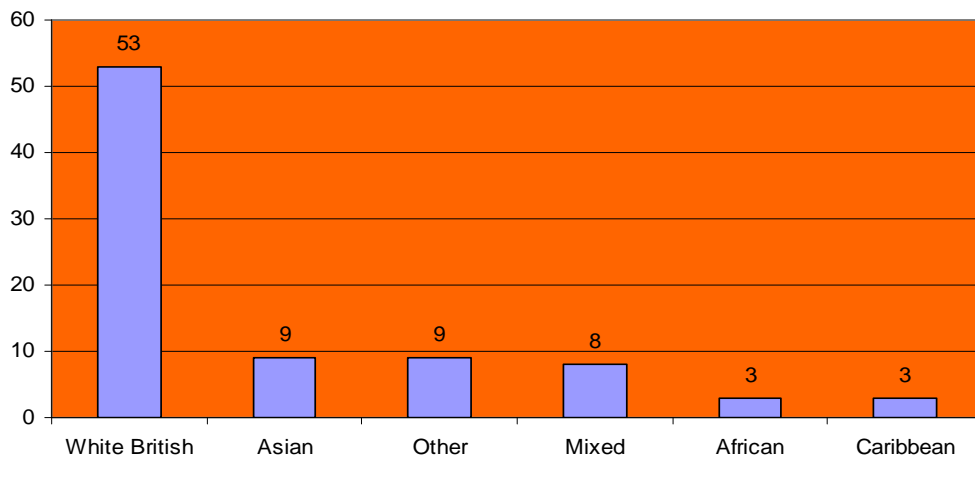
**Breakdown by age of deaths notified across the sub-region  
01.04.10 - 31.03.11**



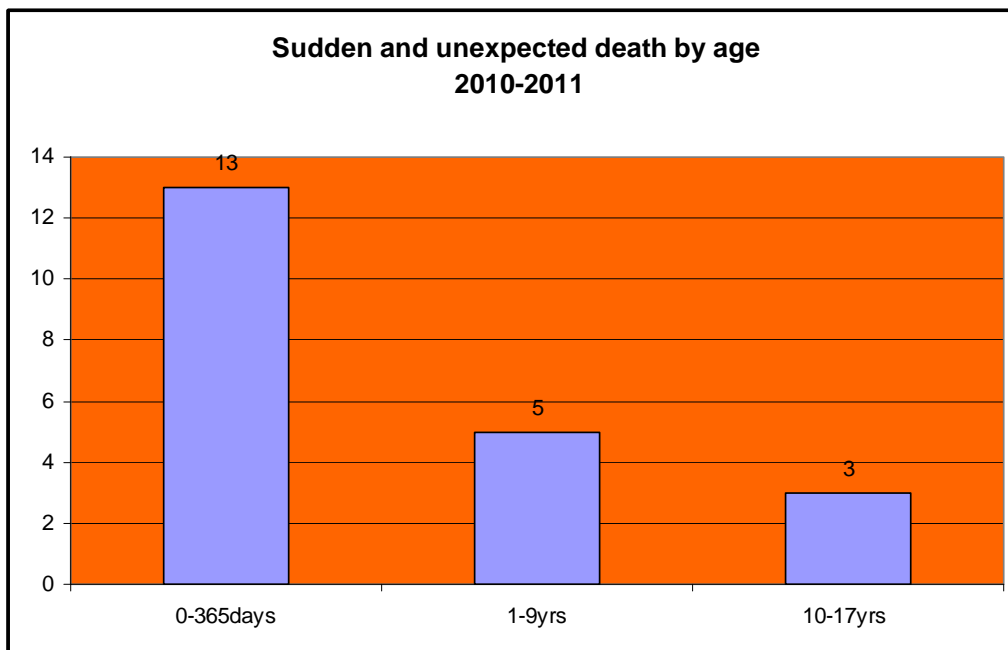
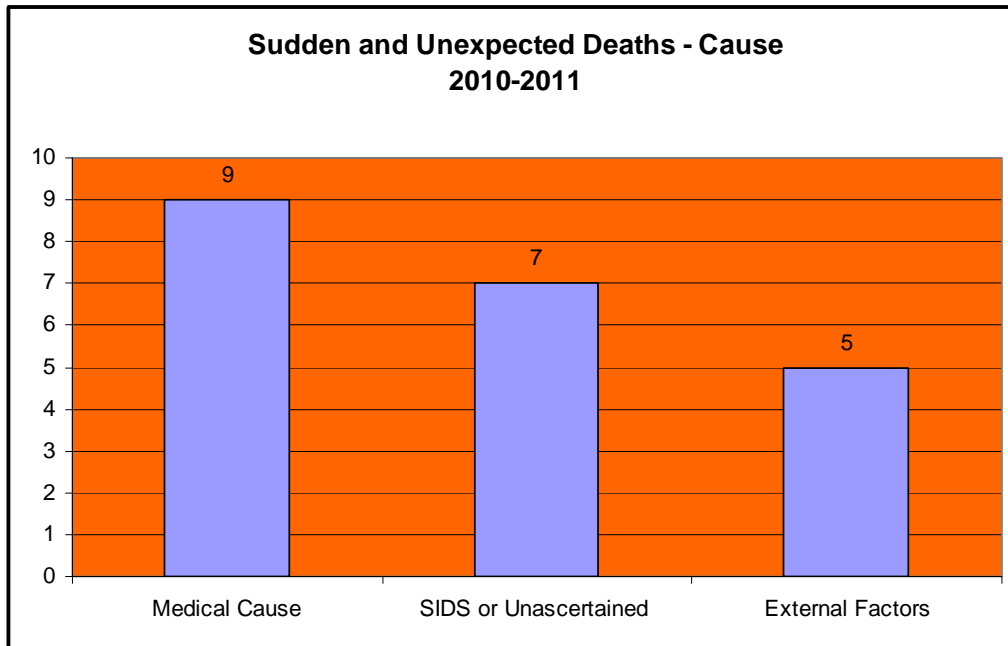
**Breakdown by gender - sub-regional deaths  
01.04.10 - 31.03.11**



**Breakdown by ethnicity sub-regional deaths  
01.04.10 - 31.03.11**



### 13.1 Breakdown of sudden and unexpected deaths (21 in total)



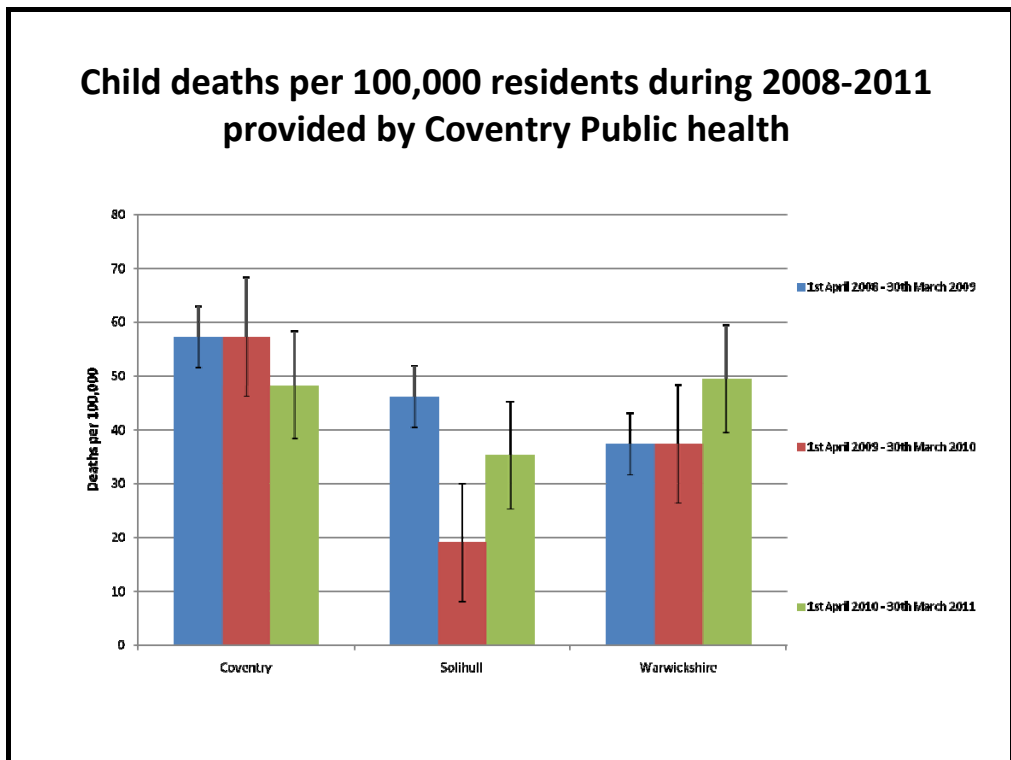
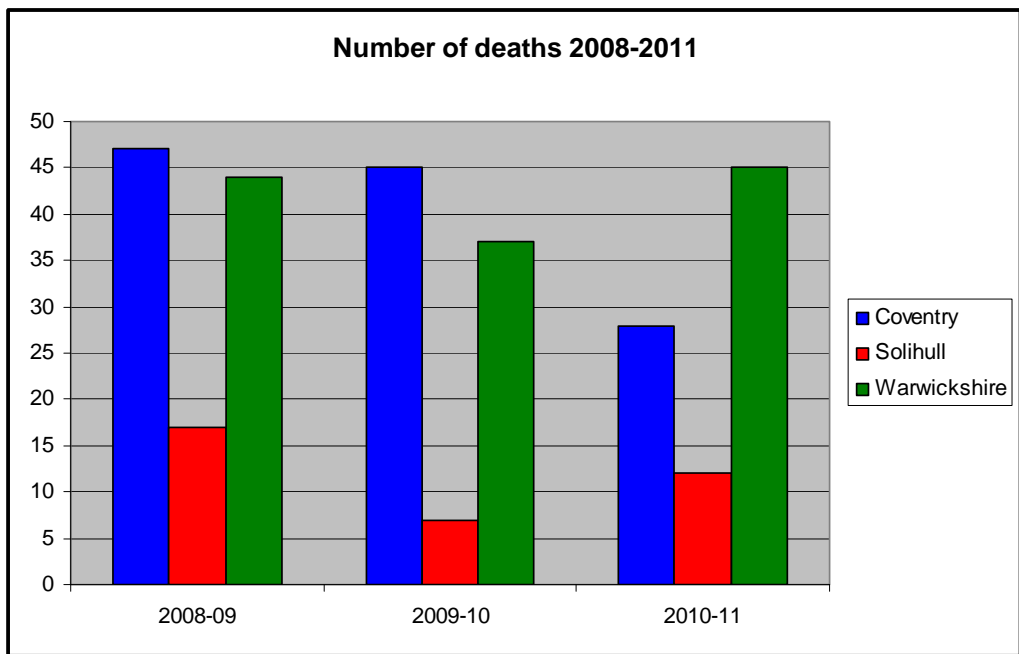
## 14 Summary of 2010 – 2011 data

- 14.1 As in previous years, neonatal deaths remain the highest category of death.
- 14.2 The highest proportion of deaths (76%) occurred within the first year of life, which is consistent with findings from the previous two years.
- 14.3 Gender has remained consistent also with an even split, although in 2009-2010 there were slightly more males at 51% than females at 49%.
- 14.4 Recording of ethnicity has significantly improved compared to the start of the process and ethnicity has been captured in all deaths reported in 2010-2011. Children of White British ethnicity remains the highest category of deaths at 62%. Children from minority ethnic backgrounds account for 27% of the total. Consanguinity has been identified as a factor in some Asian ethnic groups.

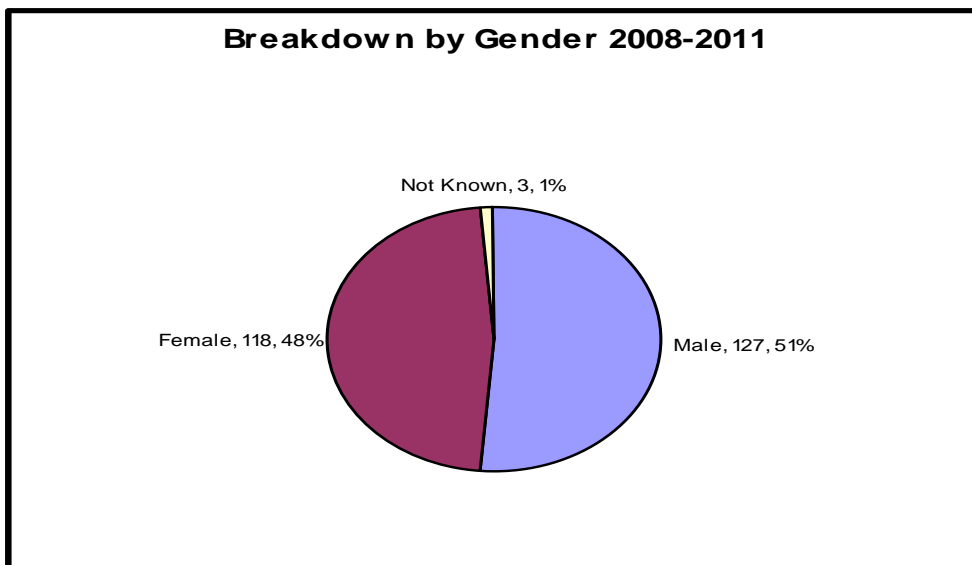
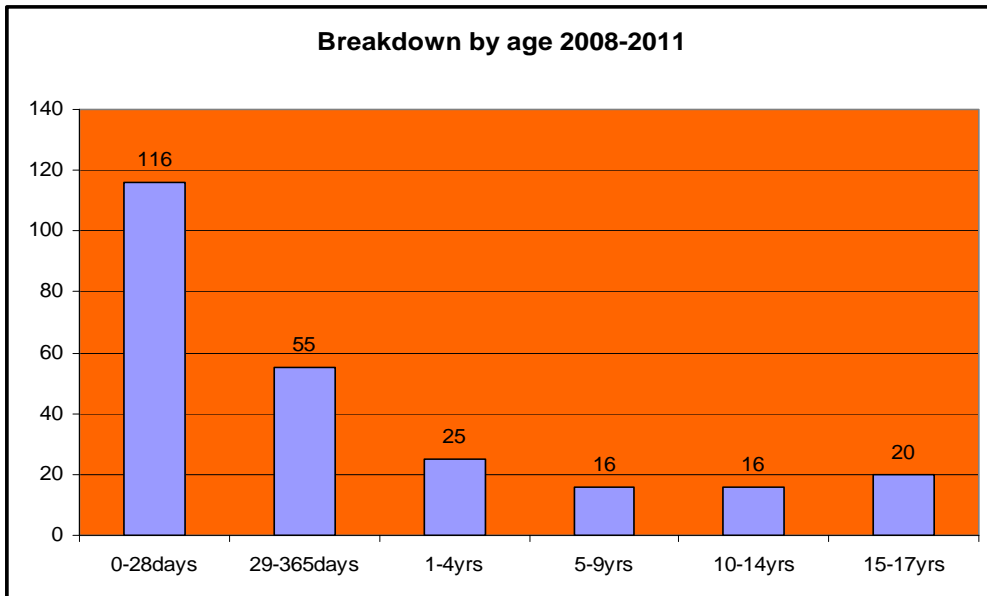
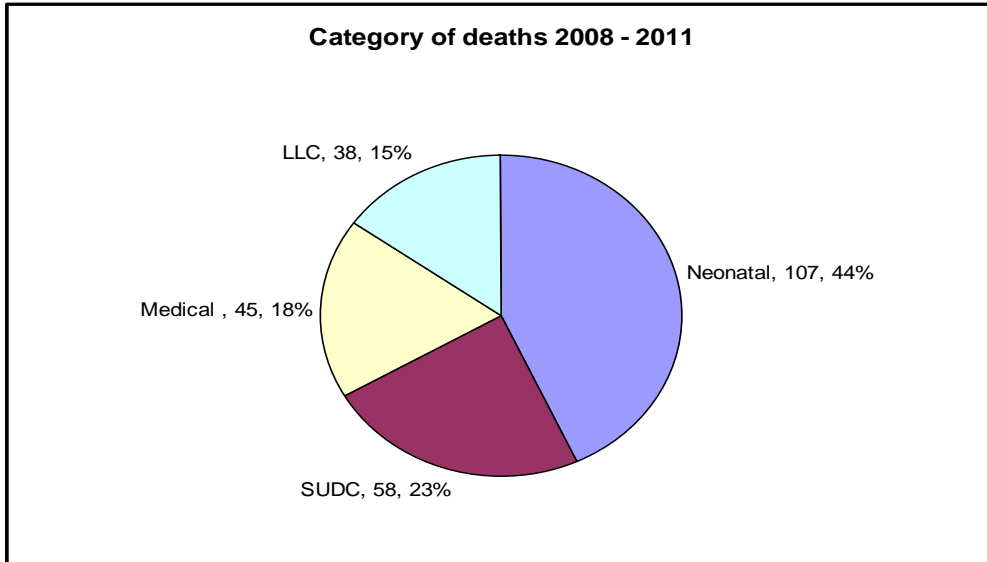
14.5 Deaths due to road traffic collisions has significantly reduced in 2010-2011 although sudden and unexpected deaths have increased compared to the two previous years with 20 rapid response investigations conducted in 2010-2011 compared to 14 in 2008-2009 and 14 in 2009-2010.

**15 Sub-Regional Aggregated Data 2008 – 2011**

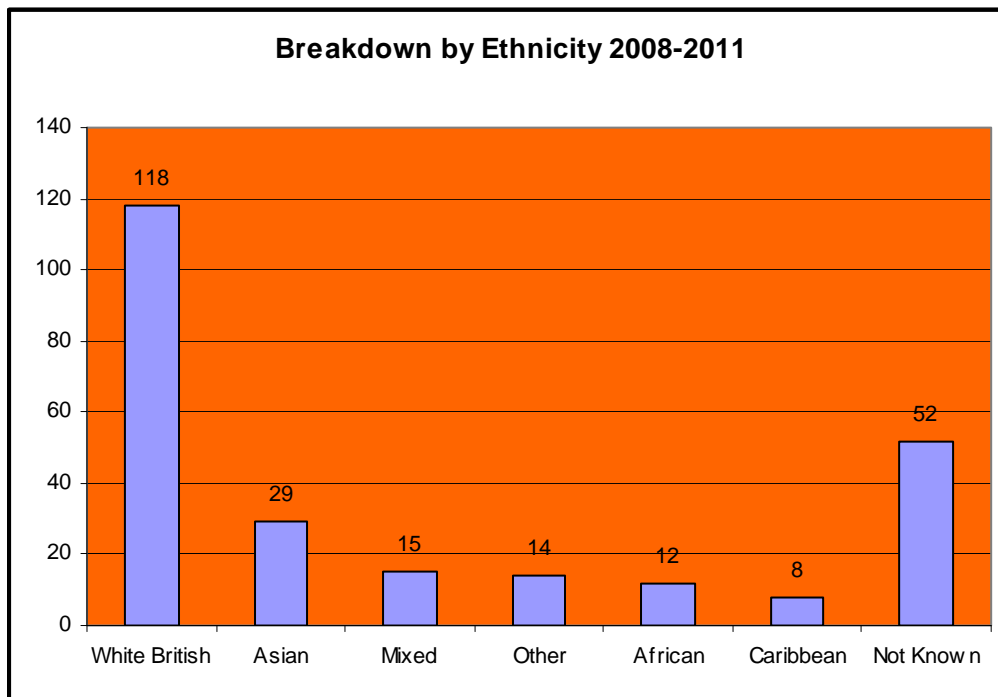
**(Total = 281, including the 33 notified by West Midlands Perinatal Institute)**



15.1 The below relate to 248 deaths notified to the child death process excluding the 33 notified to West Midlands Perinatal Institute.



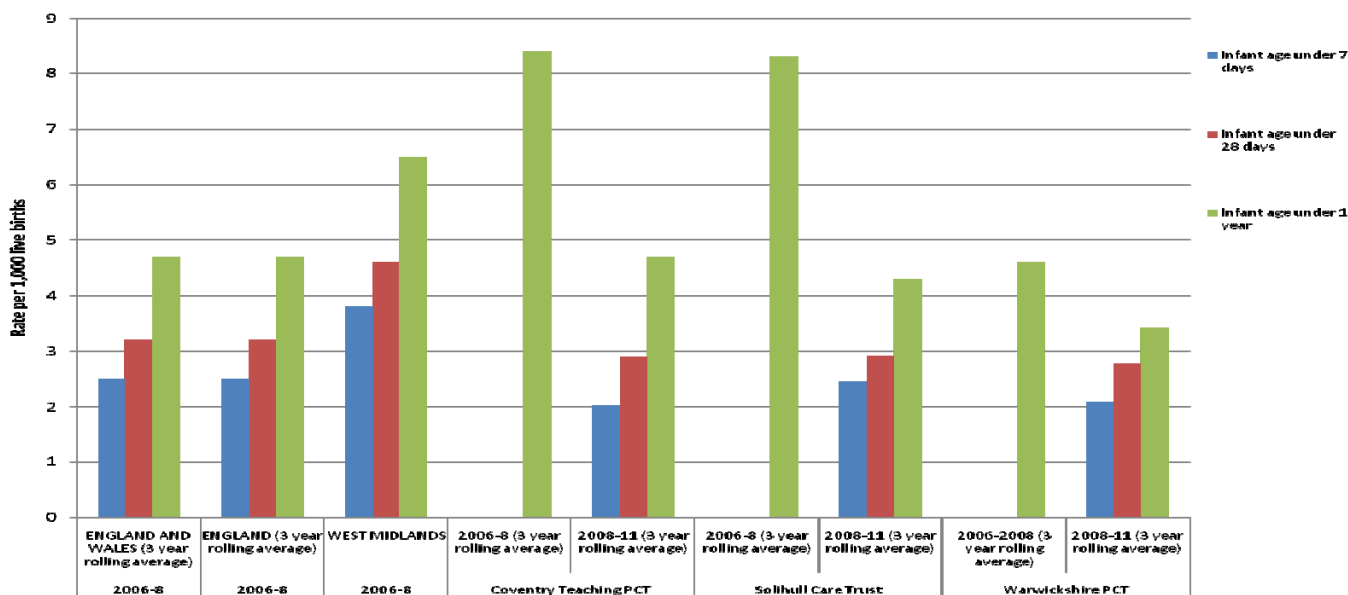
The 3 'not known' are from year 2008-2009 and were neonates.



15.2 Additional demographic information was sought from Coventry Public Health in relation to the geographical areas where deaths were more prevalent but this information could not be provided due to the relatively low number of deaths.

## 16 Neonatal Deaths

Deaths per 1,000 live births, data provided by Coventry Public health



- Infant mortality rates (less than 1 year of age) in Coventry, Solihull and Warwickshire have declined compared to 2006/2008 levels
- Rates in Coventry have declined over the last three years and are now comparable to national and regional rates
- Neonatal mortality rates have increased over 2008-2011 particularly in Warwickshire

**17 Sudden and unexpected deaths:**

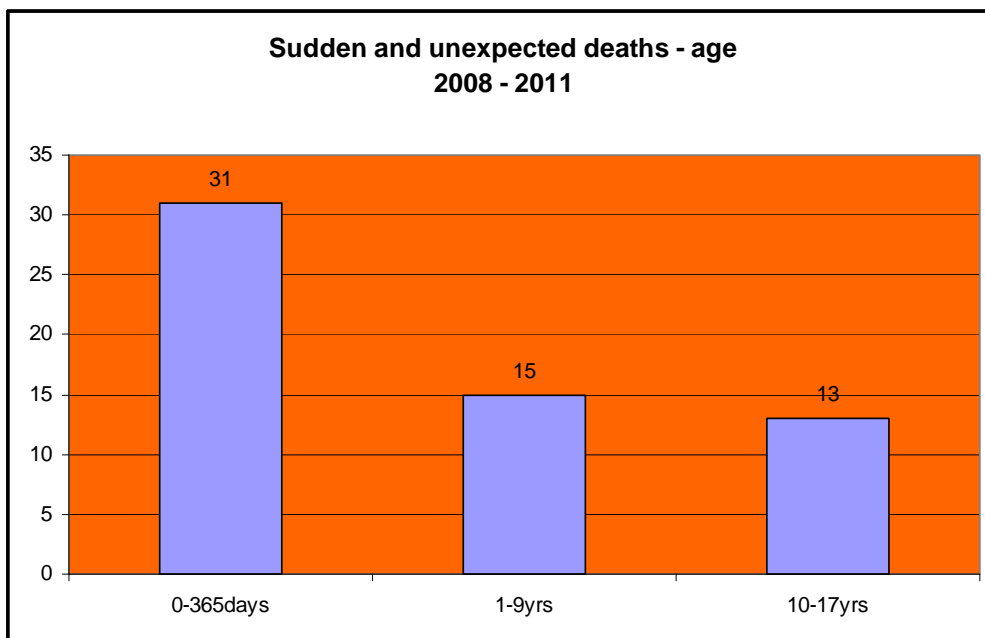
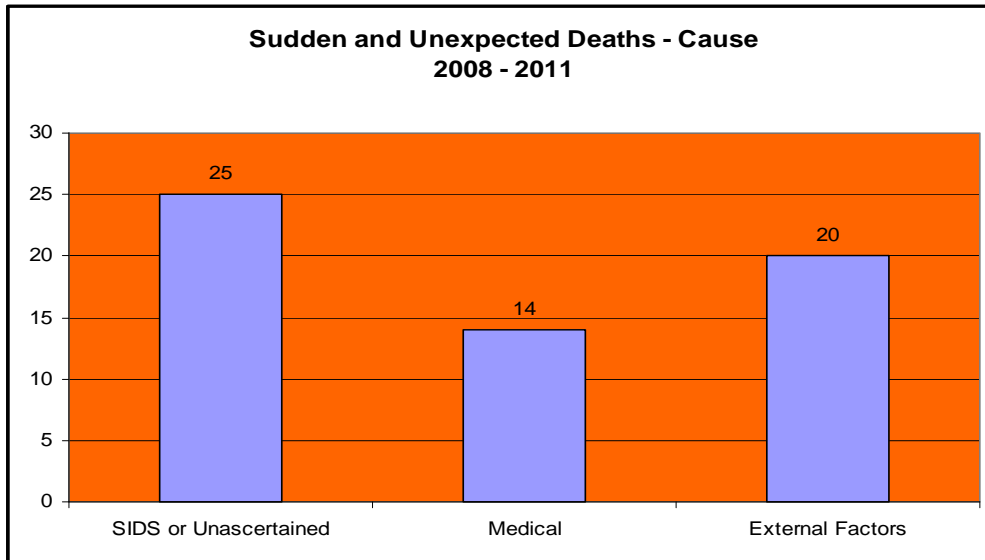
**48** Rapid Response investigations were conducted between 01.08.08 – 31.03.11:

**14** in 2008-2009: Coventry (7) Solihull (1) Warwickshire (6)

**14** in 2009-2010: Coventry (5) Solihull (1) Warwickshire (8)

**20** in 2010-2011: Coventry (8) Solihull (3) Warwickshire (10)

17.1 In addition to the above, **11** police investigations were conducted into deaths from road traffic collisions across the sub-region, taking the total of unexpected deaths to **59**. (8 deaths from road traffic collisions occurred in year 2008-2009 and the remainder in 2009-2010 and 2010-2011.) These are categorised as deaths due to external factors in the following graph. The remaining 9 in this category are a combination of choking, drowning, accidental asphyxia, suicide or a deliberately inflicted injury.



17.2 Of the 31 deaths in age group 0 - 365 days, death due to SIDS or death unascertained is the highest category (23 deaths - 74%) followed by a medical cause (8 deaths -25%)

- 17.3. Of the 15 deaths in age group 1-9yrs, death due to external factors is the highest category (7 deaths - 47%) followed by a medical cause (5 deaths – 33%)
- 17.4 Of the 13 deaths in age group 10-17years, death from external factors is the highest category (11 deaths – 73%)
- 17.5 Age categories could not be broken down any further due to the small numbers.

## **18 Summary of aggregate data – 2008-2011**

- 18.1 Neonatal deaths continue to be the highest category of deaths, accounting for nearly half of the total.
- 18.2 Infants under 12 months of age continue to be most at risk, accounting for 69% of the total.
- 18.3 Gender remains roughly equal with 51% males and 48% females (1% not known).
- 18.4 Children of White British ethnicity remains the highest category of deaths where ethnicity was recorded, accounting for 48% of the total, however no distinction can be made in relation to aggregate data due to the high number where ethnicity is not known.
- 18.5 Sudden and unexpected deaths have all increased across Coventry, Solihull and Warwickshire.
- 18.6 Road traffic collisions have reduced significantly.

## **19 Regional Data**

Three year data (2008-2011) for the West Midlands region is currently being collated and a report due in November 2011.

## **20 National Data**

Data collated by the Department for Education for 2010-2011 focuses on deaths reviewed during the year and not on deaths notified. National data on deaths reviewed can be found on the following link:

<http://www.education.gov.uk/rsgateway/DB/STR/d001015/index.shtml>.

**Author: Dara Lloyd**  
**Child Death Overview Panel Manager**  
**Coventry, Solihull and Warwickshire**

## Appendix 'A'

### Coventry Child Death Overview Panel

#### 1 Members:

John Forde, Consultant in Public Health (Chair)  
Jivan Sembi, Head of Safeguarding Children's Services (Vice Chair)  
Dr Supratik Chakraborty, Consultant Paediatrician  
Dr Miriam Wood, GP  
Detective Inspector Chris Hanson, West Midlands Police  
Lesley Cleaver, Paediatric Liaison Nurse, Coventry PCT  
Bridget Grove, Health Visiting Service  
Jayne Phelps, Lead Professional for Safeguarding, Midwifery Service, UHCW  
Andy Waugh, Integrated Service Manager, Children's Services  
Sandra Shipton, Senior Advisor for Education  
Jane Goodyear, Service Manager for Early Years

#### 1.1 Co-opted Members:

Dr Kate Blake, Consultant Neonatologist  
Dr Angela Thompson, Lead Paediatrician for Palliative Care

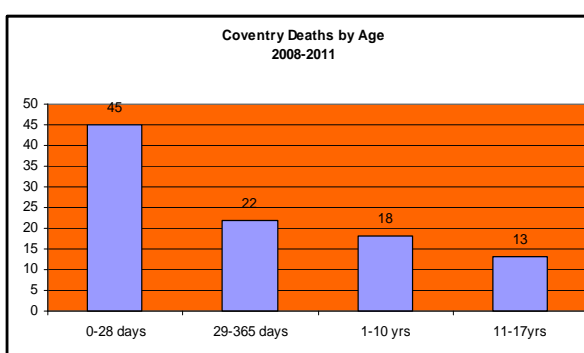
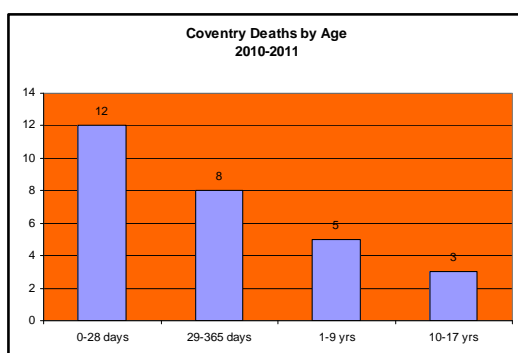
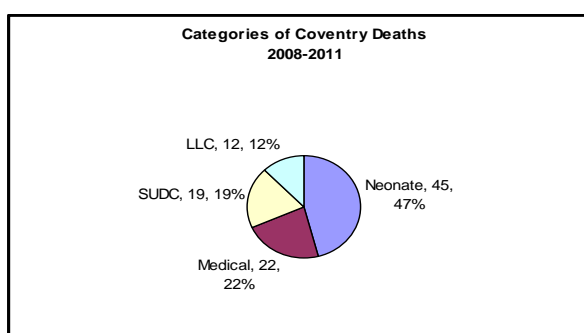
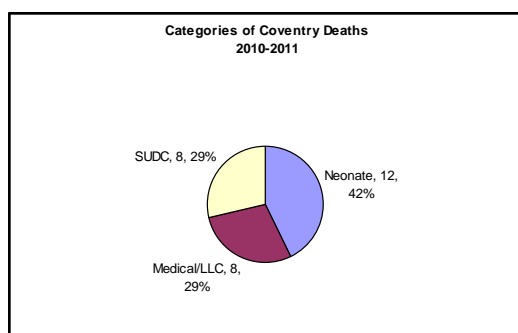
2 Coventry CDOP met **6** times throughout 2010-2011 and reviewed **33** deaths.

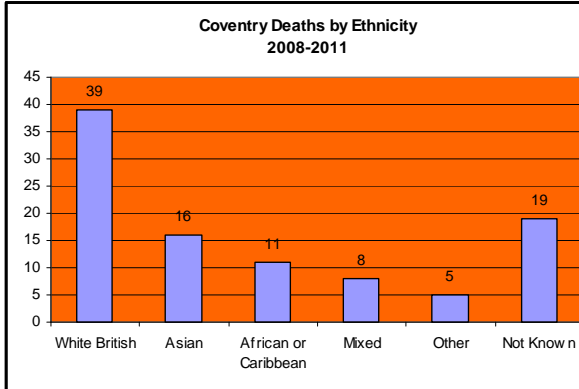
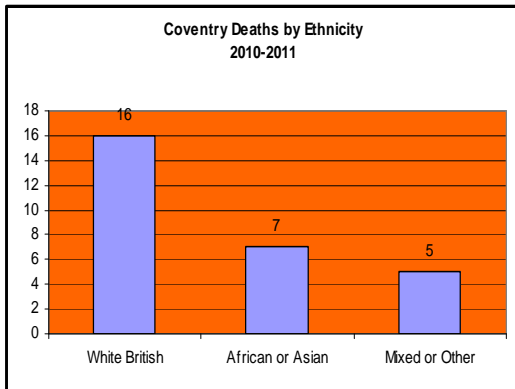
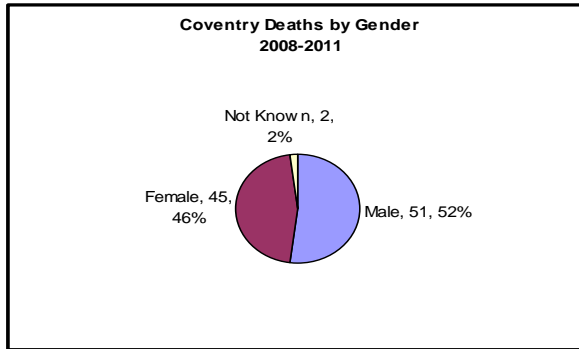
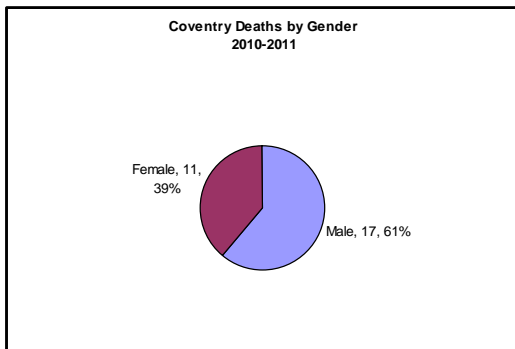
3 A summary of actions arising from Coventry CDOP, are contained in paragraph 3 on page 3.

#### 4 Coventry Data:

**28** deaths were notified in 2010-2011 compared to **34** in 2008-2008 and **36** in 2009-2010, making the total over three years **98**.

Categories that have a total of 2 or less have been merged in accordance with disclosure control guidance issued by the NHS Information Centre for Health and Social Care.





## 5 Summary:

- 5.1 Neonatal deaths are the highest category as reflected in sub-regional data for 2010-2011, sub-regional aggregate data and Coventry aggregate data.
- 5.2 Children under 12 months of age have the highest number of deaths which is reflected in the sub-regional data for 2010-2011 and three year aggregated data.
- 5.3 There were more male than female deaths during 2010-2011 which is also reflected in the sub-regional aggregate data and Coventry aggregate data.
- 5.4 Children of White British ethnicity remains the highest category of deaths for 2010-2011, however no distinction can be made in relation to aggregate data due to the high number where ethnicity is not known.
- 5.5 Sudden and unexpected deaths have increased.

## Appendix 'B'

### Solihull Child Death Overview Panel

#### 1 Members:

Ian Mather, Consultant in Public Health (Chair)  
Paul Nash, Solihull LSCB (Vice Chair)  
Dr Alan Stanton, Consultant Paediatrician  
Carol Owen, Midwifery Services, Heartlands Hospital  
A/Detective Inspector Dave Amos, West Midlands Police  
Steve Martin, Chief Education Welfare Officer  
Eleni Prodromou, Solihull Children's Services  
Alison Frost, Solihull MBC Strategic Services

#### 1.1 Co-opted member:

Dr Richard Mupanemunda, Consultant Neonatologist, Heartlands Hospital.

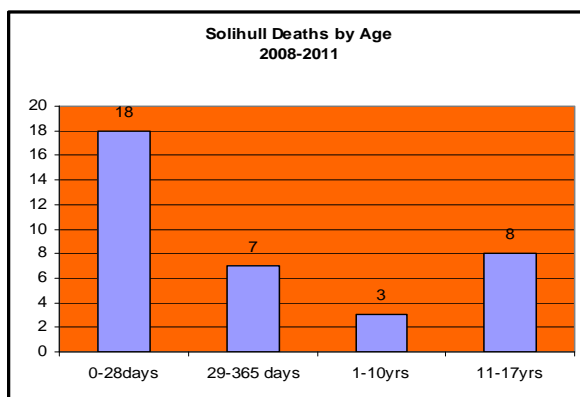
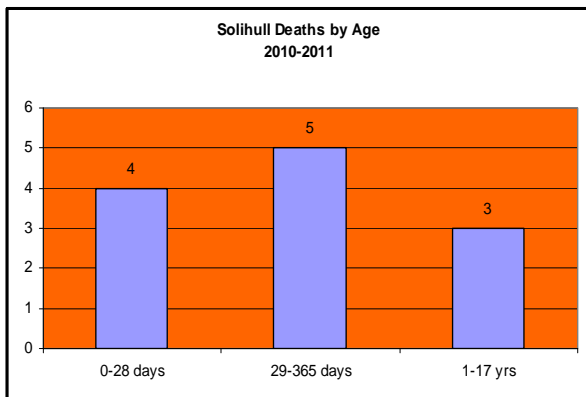
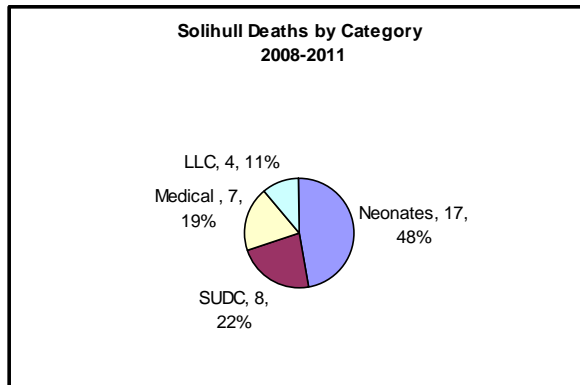
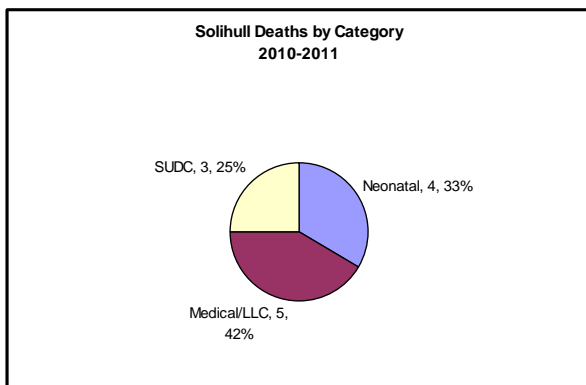
2 Solihull CDOP met **6** times during 2010-2011 and reviewed **15** deaths.

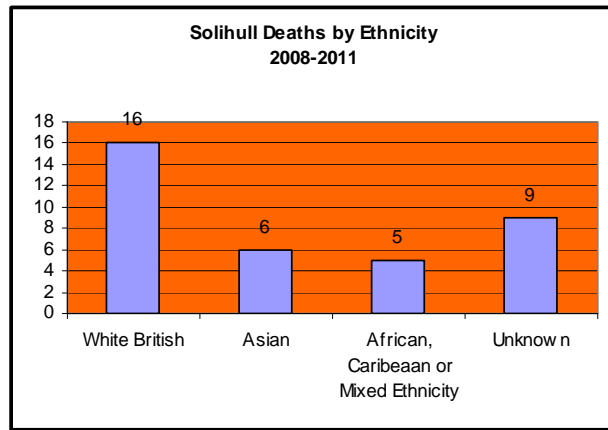
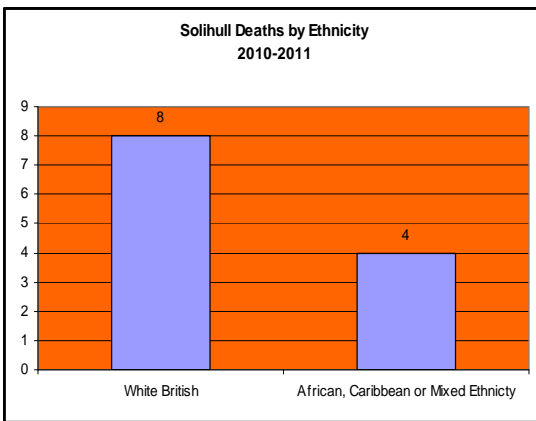
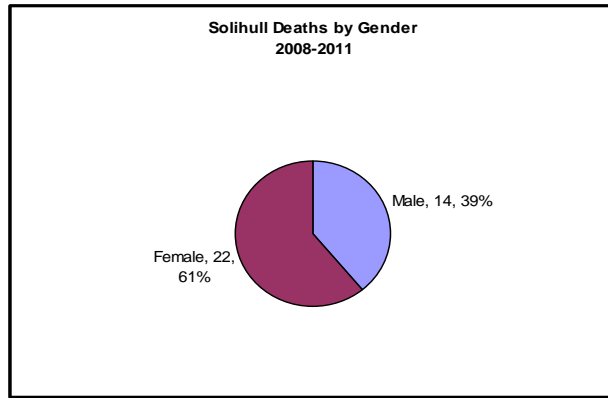
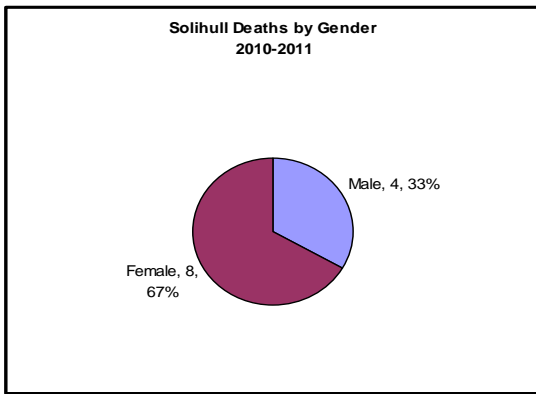
3 A summary of actions arising from Solihull CDOP are contained in paragraph 4 on page 4.

#### 4 Solihull Data:

**12** deaths were notified in 2010-2011 compared to **17** in 2008-2008 and **7** in 2009-2010, making the total over three years **36**.

Categories that have a total of 2 or less have been merged in accordance with disclosure control guidance issued by the NHS Information Centre for Health and Social Care.





## 5 Summary

- 5.1 Neonatal deaths are the highest category in 2010-2011 as reflected in the sub-regional data for 2010-2011, sub-regional aggregate data and Solihull aggregate data.
- 5.2 Children under 12 months of age have the highest number of deaths which is reflected in the sub-regional data for 2010-2011 and three year aggregated data.
- 5.3 There were more female than male deaths during 2010-2011 which is also reflected in Solihull's three year aggregate data. (Coventry and Warwickshire have had more male than female deaths over the last 3 years.)
- 5.4 Children of White British ethnicity remains the highest category of deaths for 2010-2011, however no distinction can be made in relation to aggregate data due to the high number where ethnicity is not known.
- 5.5 Sudden and unexpected deaths have increased.

## Appendix 'C'

### Warwickshire Child Death Overview Panel

- 1 Members:  
Detective Inspector Nigel Jones, Warwickshire Police (Chair)  
John Sullivan, Safeguarding Children Manager for Education (Vice Chair)  
Jenny Butlin-Moran, Service Manager, Child Protection  
Dr Vic Tuck, Development Manager, Warwickshire LSCB  
Dr Peter Sidebotham, Consultant Paediatrician  
Victoria Gould, Young People Legal Services Manager, Warwickshire County Council  
Linda Watson, Locality Manager, Warwickshire Community Health  
Helen King, Consultant in Public Health  
DS Shane Barnes, Warwickshire Police

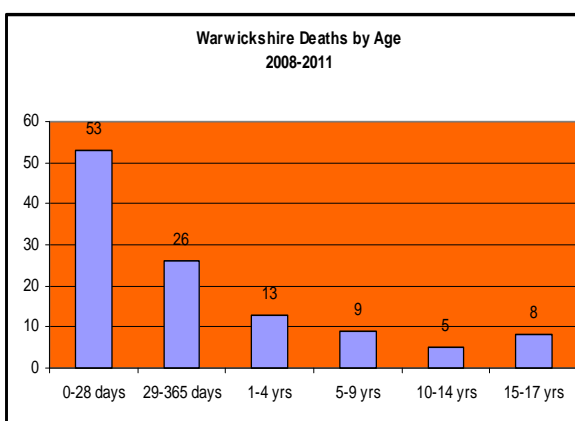
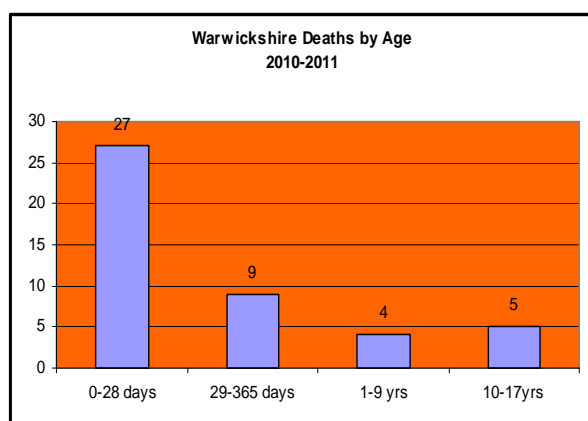
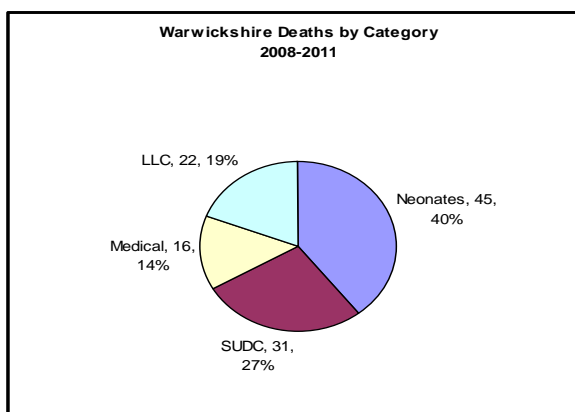
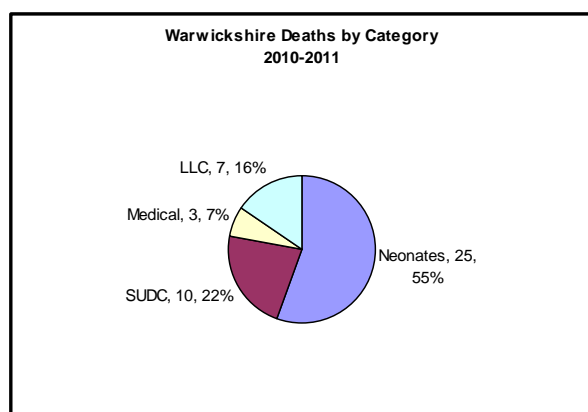
- 1.1 Co-opted Member:  
Dr Angela Thompson, Lead Paediatrician for Palliative Care

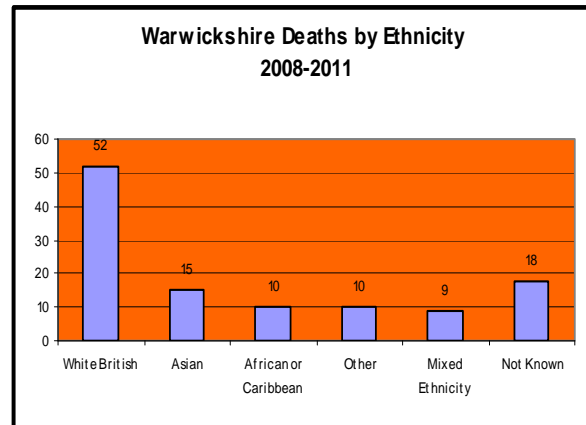
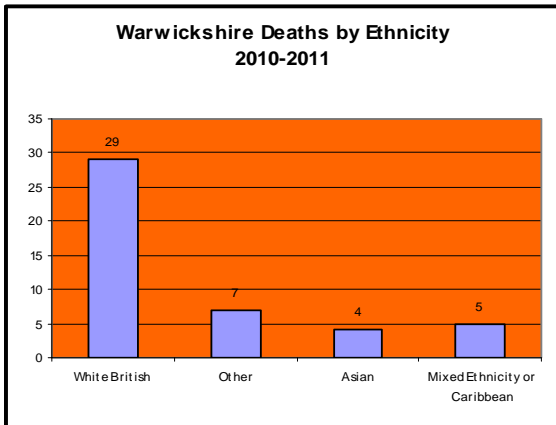
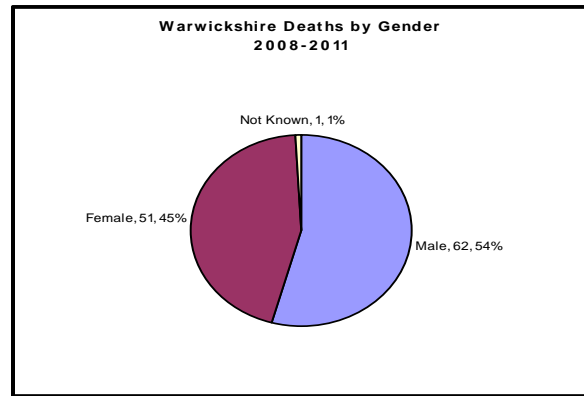
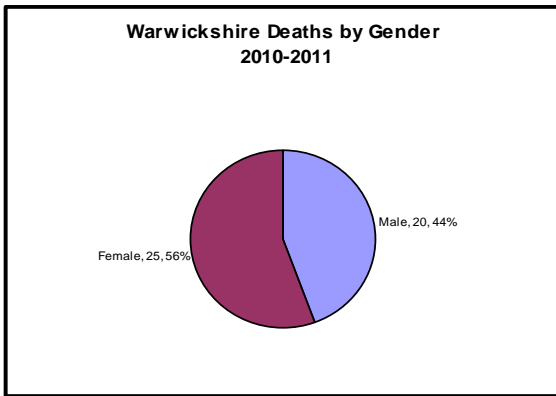
2 Warwickshire CDOP met **7** times throughout 2010-2011 and reviewed **45** deaths.

3 A summary of actions arising from Warwickshire CDOP are contained in paragraph 5 on pages 4-5.

4 Warwickshire Data:  
**45** deaths were notified in 2010-2011 compared to **35** in 2008-2008 and **34** in 2009-2010, making the total over three years **114**.

Categories that have a total of 2 or less have been merged in accordance with disclosure control guidance issued by the NHS Information Centre for Health and Social Care.





## 5 Summary

- 5.1 Neonatal deaths are the highest category in 2010-2011 as reflected in the sub-regional data for 2010-2011 and three year aggregate data.
- 5.2 Children under 12 months of age have the highest number of deaths which is reflected in the sub-regional data for 2010-2011 and three year aggregated data.
- 5.3 There were more female than male deaths during 2010-2011 but the aggregate data shows that more males than females have died over the three years in Warwickshire.
- 5.4 Children of White British ethnicity remains the highest category of deaths for 2010-2011, however no distinction can be made in relation to the aggregate data due to the high number where ethnicity is not known.
- 5.5 Sudden and unexpected deaths have increased compared to 2008-2009 and 2009-2010.
- 5.6 Deaths due to road traffic collisions have reduced significantly.