



**Central Bedfordshire Safeguarding
Children Board**

Bedford Borough, Central Bedfordshire and Luton Child Death Overview Process Panel Annual Report 1 April 2016 – 31 March 2017

Contents

	Description	Page Number
	Executive Summary	3
1.	Background and Functions	6
2.	The Principles and Process	7
3.	Bedfordshire data in comparison with National Data <ul style="list-style-type: none">- Reported deaths and cases reviewed.- Duration of reviews.- Category and location of death.- Modifiable factors.- Age, Gender and Ethnicity.	8
4.	Learning from the reviews and actions taken <ul style="list-style-type: none">- CDOP training	15
5.	Positive areas of note	16
6.	Areas for development and future plans	17
7.	Appendices	
	Appendix 1: Summary Central Bedfordshire.	18
	Appendix 2: Summary Bedford Borough	20
	Appendix 3: Summary Luton	22

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 2016-2017.

This is the 9th 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 as well as those reviewed by the panel during 2016-2017 and analysis of the data and emerging themes. Due to low numbers it needs to be noted that figures which may look significant may not be statistically significant nor meaningful.

During the period 1st April 2016 to 31st March 2017 the panel met on 9 occasions and completed full reviews on 54 children residing in Bedford Borough, Central Bedfordshire and Luton. These cases included deaths from 2013-2017 as there can be a delay in reviewing cases due to other processes such as coronial inquests and toxicology reports.

During the period April 2016 until March 2017 there were 54 deaths reported across Bedfordshire. This was made up of 12 in Bedford; 28 in Luton and 14 in Central Bedfordshire. There was a decrease in the number of deaths, in all boroughs, in comparison to the previous year 54 compared to 60.

Unexpected deaths accounted for 31% of the total deaths reported in 2016-17, which is a decrease from the previous year where 53% of the deaths were unexpected. 61% of the reported deaths were of children less than 1 year of age. Of the total reported deaths 54% were female and 46% were male. Looking at the female deaths 67% were expected deaths compared to 68% of expected male deaths and 33% were unexpected deaths compared to 32% of male deaths so there does not seem to be a significant difference.

54% of the girls deaths were infants under the age of 1 compared to 63% of boys, 25% of the girls were aged between 1-10 years compared to 18% of boys and 21% of girls were aged between 10-18 years compared to 18% of boys.

During 2016-17 Bedfordshire CDOP reviewed and closed 54 cases at panel meetings. Modifiable factors were identified in 57% of these cases, this is higher than last year which is in line with National Data which shows that the percentage of reviews with modifiable factors has increased. Similarly to previous years, the modifiable factors identified included Maternal BMI, Consanguinity, Neglect and Service Provision.

CDOP Annual Report 2016 / 2017

Gerry Taylor CDOP Chair / Karis Venables CDOP Manager

The number of deaths in each LSCB area over the past 5 years is shown in Table 1. This shows that all LSCB areas have had a decrease in child deaths compared to the previous year. The number of deaths was particularly high in 2012/13 in Luton and Central Bedfordshire. Although there has been some variation since then, partly due to small numbers, the number of deaths has remained lower than they were in 2012/13.

Table 1: Deaths reported 2012/13 – 2016/17

LSCB Area	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	Total by Local Authority	Average 2012/2017
Luton	31	20	26	31	28	136	27.2
Central Bedfordshire	24	10	13	16	14	77	15.4
Bedford Borough	11	16	12	13	12	64	12.8
Total	66	46	51	60	54	277	55.4

Key Areas of Note:

- The number of deaths from chromosomal, genetic and congenital anomalies appears to have decreased this year. However work is still ongoing to ensure that where consanguinity has been identified as a modifiable factor CDOP will contact the family’s GP to request that genetic counselling is offered to parents. There is an ongoing action plan in place around consanguinity in Luton.
- The CDOP panel have slightly increased the number of cases reviewed throughout the year.
- Bedfordshire CDOP had an increase in the number of Modifiable Factors being identified and have a much higher percentage of modifiable factors (57%) than National Data (27%).
- In Bedfordshire the proportion of cases reviewed and closed under the perinatal/neonatal category (26%) was lower than the national percentage (43%).
- 62% of child deaths reviewed in the year were completed within 12 months of the child’s death which is lower than the national percentage of 76%. However reviews often take longer if modifiable factors have been identified and there has been an increase in the percentage of deaths reviewed with modifiable factors both locally and nationally.
- Compared to the previous year Bedfordshire CDOP closed 9% more cases in 6-12 months than the previous year.

- In Central Bedfordshire there were 14 deaths, this is a decrease on the previous year and there was also a decrease in unexpected deaths. Due to low numbers ward level data cannot be fully reported, however more deaths occurred in Dunstable Manshead ward than any other.
- In Bedford Borough there were 12 deaths, this is a decrease on the previous year and there was also a decreased in the number of unexpected deaths. Due to low number ward level data cannot be fully reported, however more deaths occurred in Goldington ward than any other.
- In Luton there were 28 deaths, this is a decrease on the previous year and there was also a decrease in unexpected deaths. Due to low numbers ward level data cannot be fully reported, however more deaths occurred in Biscot and Farley wards than any other.

Background and Functions

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 better understand 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 CDOP has specific functions laid down in statutory guidance, including:

- Reviewing the available information on all deaths of children up to 18 years of age, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law. This includes the death of infants who are less than 28 days old.
- 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.

The Principles and Process

The principles underlying the overview of all child deaths are:

- Every child's death is a tragedy.
- Learning lessons including referring cases for in depth review/scrutiny such as Serious Case Review.
- Joint agency working and informing service provision.
- Positive action to safeguard and promote the welfare of children

There are two interrelated processes for reviewing child deaths

- 1) A rapid response service which is used to investigate unexpected deaths.
- 2) A paper based review of the deaths of all children under the age of 18.

Rapid Response

The rapid response service involves a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death. Unexpected death in childhood is defined as 'the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to, or precipitating the events that led to the death'.

The purpose of the rapid response is to ensure that the appropriate agencies are engaged and work together to:

- Respond quickly to the unexpected death of a child.
- Ensure support is put in place for bereaved siblings, family members or members of staff who may be affected by the child's death.
- Identify and safeguard any other children in the household.
- Make immediate enquiries into and evaluate the reasons for and circumstances of the death in agreement with the coroner where required.
- Preserve evidence in case a criminal investigation is required.
- Constructively review the case to determine whether there are any lessons to be learnt.
- Collate information in a standard format.

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). The CDOP panel is chaired by the Director of Public Health for Luton and is made up of members from all relevant agencies including Police, Social Care and Health.

Bedfordshire data in comparison with National Data

The National Picture (Year ending March 2017)

- **3,575** Reviews completed by Child Death Overview Panels in the year ending March 2017 this has fallen slightly from 3,665 last year. Bedfordshire CDOP have increased slightly the number of cases reviewed.
- **27%** the percentage of child death reviews identified as having modifiable factors, an increase from 24% last year and an increase of 6% over the last 5 years. Bedfordshire CDOP have a much higher percentage of modifiable factors being identified (57%) and further exploration of this can be found in the Modifiable Factors section of this report.
- **43%** the percentage of deaths reviewed which were due to a perinatal/neonatal event; this is broadly consistent with previous years. In Bedfordshire the proportion was lower, with 26% of cases reviewed being closed under this category.
- **64%** the percentage of deaths reviewed that were for children under one year old in the year ending March 2017; this is consistent with previous years and similar to the Bedfordshire rate.

Source: Statistical First Release – Department for Education July 2017.

Mortality Rates

Table 2 shows the mortality rates for each borough compared with the national average and statistical neighbours. For most measures Bedfordshire and Luton rates are in line with the national average and statistical neighbours. Central Bedfordshire has a relatively low infant mortality rate.

Bedford and its CSSNBT statistical neighbours

Compared with benchmark: Better Similar Worse Low High Not compared * a note is attached to the value, hover over to see more details

Recent trends: (in development) - Could not be calculated ↑ Increasing / Getting worse ↑ Increasing / Getting better ↓ Decreasing / Getting worse ↓ Decreasing / Getting better → No significant change ↑ Increasing ↓ Decreasing

Indicator	Period	England	Bedford	1 - Kent	2 - Northamptonshire	3 - Swindon	4 - Derby	5 - Milton Keynes	6 - Sheffield	7 - Leeds	8 - Hertfordshire	9 - Warwickshire	10 - Merton
Infant mortality	2013 - 15	3.9	4.4	3.0	4.3	3.0	5.8	5.3	4.7	4.1	2.6	4.4	3.6
Child mortality rate	2013 - 15	11.9	9.4	8.3	12.0	15.5	12.3	11.7	15.1	12.1	9.8	9.3	13.8

Central Bedfordshire and its CSSNBT statistical neighbours

Compared with benchmark: Better Similar Worse Low High Not compared * a note is attached to the value, hover over to see more details

Recent trends: (in development) - Could not be calculated ↑ Increasing / Getting worse ↑ Increasing / Getting better ↓ Decreasing / Getting worse ↓ Decreasing / Getting better → No significant change ↑ Increasing ↓ Decreasing

Indicator	Period	England	Central Bedfordshire	1 - Hampshire	2 - Warwickshire	3 - Essex	4 - Leicestershire	5 - South Gloucestershire	6 - Worcestershire	7 - Cheshire East	8 - West Sussex	9 - Bracknell Forest	10 - West Berkshire
Infant mortality	2013 - 15	3.9	2.0	2.9	4.4	3.5	4.1	3.5	4.8	4.2	3.4	2.2	3.2
Child mortality rate	2013 - 15	11.9	9.0	12.6	9.3	9.7	12.3	10.9	11.5	11.1	8.2	7.1	6.6

Luton and its CSSNBT statistical neighbours

Compared with benchmark: Better Similar Worse Low High Not compared * a note is attached to the value, hover over to see more details

Recent trends: (in development) - Could not be calculated ↑ Increasing / Getting worse ↓ Increasing / Getting better ↓ Decreasing / Getting worse ↓ Decreasing / Getting better → No significant change ↑ Increasing ↓ Decreasing

Indicator	Period	England	Luton	1 - Birmingham	2 - Sandwell	3 - Slough	4 - Bradford	5 - Walsall	6 - Enfield	7 - Hillingdon	8 - Derby	9 - Weoburnhampton	10 - Oldham
Infant mortality	2013 - 15	3.9	5.0	7.5	6.5	4.1	5.9	6.8	3.3	3.3	5.8	5.6	5.1
Child mortality rate	2013 - 15	11.9	15.8	16.8	12.9	15.5	18.3	13.5	13.7	12.8	12.3	14.5	20.5

Infant (less than one year) and childhood (0-17 years) mortality

Source data are from ONS mortality data sourced from PHE Fingertips and are shown for the combined 3 years 2013 to 2015. The comparators used are from Fingertips and are Children's Services Statistical Neighbour Benchmarking Tool (CSSNBT).

Reported deaths and cases reviewed

This section focuses on the deaths reviewed during 2016/17, many of which did not occur during this time frame. During the period April 2016 until March 2017 there were 54 deaths reported across Bedfordshire, this is a decrease on the previous year which is consistent with national data which shows a year by year decrease in child deaths. Unexpected deaths accounted for 31% of the total deaths reported which is a decrease from the previous year where 53.5% of the deaths were unexpected.

The CDOP panel met on 9 occasions during this period and completed full reviews on 54 children residing in Bedford Borough, Central Bedfordshire and Luton, this is an increase of 27% since last year this is inconsistent with national data which shows that the number of child death reviews has fallen slightly in the last year. The following sections relate to reviewed deaths.

Not all of the deaths reviewed occurred in 2016-2017, 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 ensure that all relevant information is available for the review. CDOP is unable to review a death until all other processes have been completed for example if there is a Serious Case Review or a Coroner's Inquest.

62% of child deaths reviewed in the year were completed within 12 months of the child's death which is lower than the national percentage of 76%. However reviews often take longer if modifiable factors have been identified and there has been an increase in the percentage of deaths reviewed with modifiable factors which is in line with

national data. The cases closed this year also consisted of a number of cases that had been subject to Serious Case Reviews and Criminal Investigations which mean that the case takes longer to be ready to present to the CDOP panel. A breakdown of the duration of reviews is shown in Figure 1. Compared to the previous year Bedfordshire CDOP closed 9% more cases in 6-12 months than the previous year.

Figure 1: Duration of Reviews



Categories of reviewed and closed cases

The child death review process aims to categorise the death and identify any modifiable factors for each child that dies and establish whether any lessons can be learned at a local or national level.

Table 3 shows that the highest proportion of cases in 2016-17 were closed under the category of Perinatal/Neonatal events (Category 8) these accounted for 26% of the total reviews this is an increase on the previous year where 22.5% of cases were closed under this category. Of the cases closed under this category 64% were male and 74% were under 30 weeks gestation. 57% of the cases closed under this category were found to have modifiable factors, BMI in 36% and service provision in 43% of cases.

Chromosomal, genetic and congenital anomalies made up 24% of the reviewed cases, this is a significant decrease on the previous year where 37.5% of cases were closed under this category. Other important figures to note is that there has been an increase this year in cases closed under the categories of sudden unexpected, unexplained death (13%) and trauma and other external factors (13%), these are both higher than nationally where 7% of all child deaths were categorised under the sudden unexpected death category and 6% were categorised under trauma and other external factors.

Table 3: Categories with highest percentage of deaths 2016-17

Category of closed case	Percentage of Local Cases	Percentage of National Cases
Perinatal/Neonatal Event (Category 8)	26%	34%
Chromosomal, genetic and congenital anomalies (Category 7)	24%	25%
Sudden unexpected, unexplained death (Category 10)	13%	7%
Trauma and other external factors (Category 3)	13%	6%

Location of death

In line with the national data the majority of children (65%) died following an admission to hospital. 13% of the deaths reviewed occurred in the child’s usual place of residence, 7 % in a hospice. The national data found that deaths in a hospice and an acute hospital had lower percentages of modifiable factors (5% and 24% respectively) than deaths in other locations. In Bedfordshire 57% of deaths that occurred in acute hospitals and 25% of deaths in Hospices were found to have modifiable factors.

In line with national statistics, the number of deaths in public spaces was 15%, the majority of these (88%) were road traffic accidents. National data also found that although the number of deaths in public places is relatively small (148 deaths nationally) child death reviews identified modifiable factors in 51% of the cases. In Bedfordshire 87% of the deaths in public places were found to have modifiable factors.

Modifiable Factors

In 2016-2017 modifiable factors were identified in 57% of cases reviewed which is significantly higher than the national picture of 27%. The difference in the amount of modifiable factors may be due to the accidental deaths which had factors relating to driving and the number of cases reviewed that were subject to Serious Case reviews and internal reviews. Other modifiable factors identified this year included: consanguinity, smoking of one or both parents, neglect, and factors relating to service provision. Not all CDOP panels define consanguinity as a modifiable factor.

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 five. Although Consanguinity was identified as a modifiable factor in a number of cases reviewed in 2016-17, there has been a decrease from the 2015-2016 data which is positive. Cases where

consanguinity was felt to be a modifiable factor were children who resided in both Luton and Bedford Borough. Targeted action has been taken in Luton to improve awareness in high risk communities, so it is positive that a decrease has been seen, however work needs to be ongoing and work also need to be done with high risk communities in the Bedford Borough area.

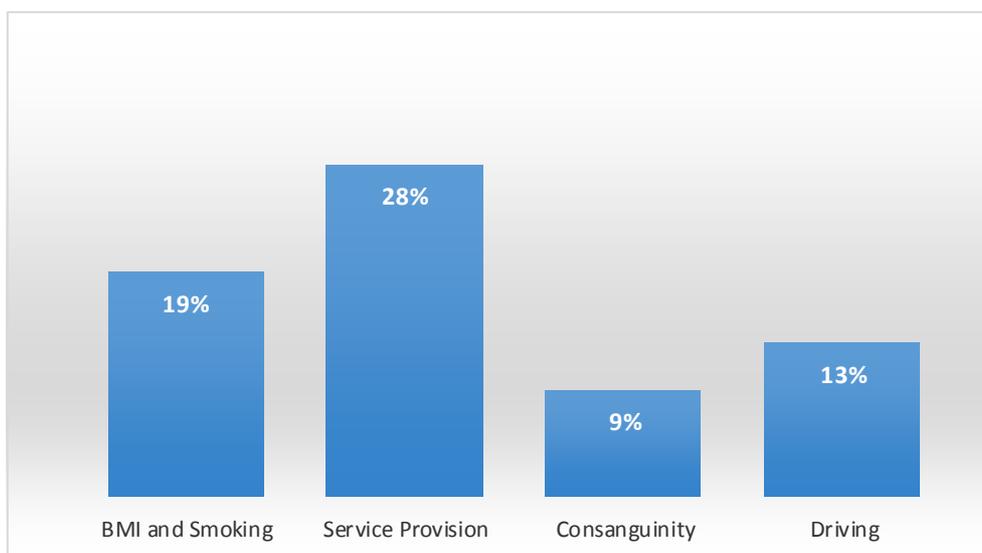
This year issues with service provision were identified as modifiable factors in 28% of all cases reviewed, this is an increase on last year where 17.5% of cases were categorised with service provision as a modifiable factor. Learning from Serious Incident Reports, Serious Cases Reviews and Independent Reviews have been shared with relevant agencies and professionals as well as with the families of the children that have died. An audit is being carried out on previous cases reviewed as having modifiable factors related to service provision.

CDOP aims to raise awareness of modifiable factors identified in order to prevent future deaths, CDOP is working closely with Public Health to ensure pathways are in place for pregnant women to promote healthier lifestyle choices, including reducing their BMI and not smoking. Women with a raised BMI are offered access to information and support to make healthy living choices and weight management advice in pregnancy. Pregnant women who smoke are given opportunities to access smoking cessation services, campaigns are also being done to raise awareness of the risk of smoking in pregnancy. It is positive that smoking was only picked up in a relatively small number of cases however maternal BMI was identified in 15% of cases reviewed.

This year there has been a fairly high percentage (13%) of deaths that were found to have factors relating to driving as a modifiable factor. Bedfordshire Police are part of the Bedfordshire and Luton Casualty Reducing Partnership which uses a multi-agency strategic approach with the aim of reducing casualties on the roads.

The Modifiable factors identified most often in 2016-17 are shown in Figure 2 below.

Figure 2: Modifiable factors identified



Age, Gender and Ethnicity

In Bedfordshire the number of deaths of children under 1 year of age reviewed during 2016-17 was 55%. The National Data found that the percentage of these deaths with modifiable factors has steadily increased to 28% this year from 15% in March 2013. However of the Perinatal/Neonatal deaths in Bedfordshire this year 59% were felt to have modifiable factors which is significantly higher than the National Data. As previously mentioned 36% of Perinatal/Neonatal deaths had BMI and 43% had service provision as modifiable factors.

Of the deaths reviewed at panel this year 74% were male and 26% were female, this is in line with national data where boy's deaths account for over half of the deaths reviewed (56%). This is an increase on the previous year in Bedfordshire where 60% of deaths reviewed were male. National data has also show that CDOP panels were slightly more likely to identify modifiable factors in reviews of boy's deaths (28%) than in girls deaths (27%) and this is in line with what was found in Bedfordshire where the CDOP panel identified modifiable factors in 60% of boy's deaths and 57% of girl's deaths.

Figure 3: Gender of cases reviewed

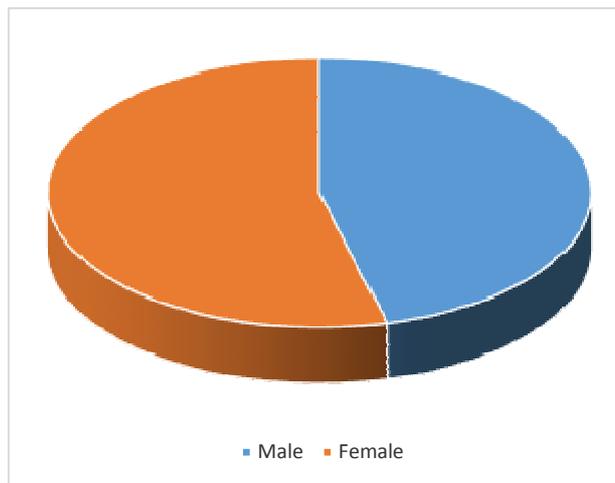
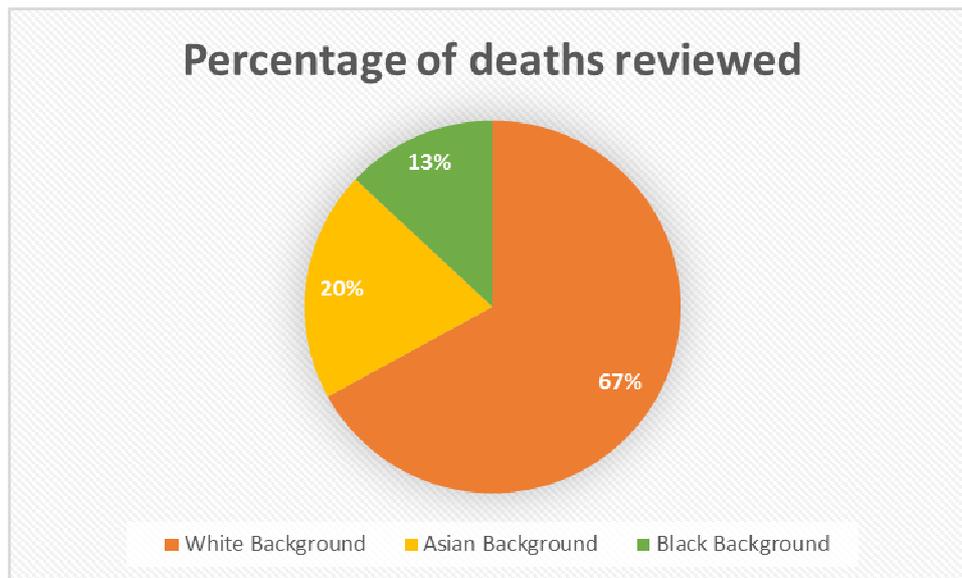


Figure 4 gives an indication of the ethnicity of children where cases were reviewed in 2016/17. The data is largely in line with the population data in Table 4. The percentage of deaths reviewed from Asian backgrounds was 20% which is slightly higher than the National data at 16%, however Bedfordshire and Luton have a high proportion of people of Asian origin.

Table 4: Ethnic Group for Total Population and under 18 Population

Age	Bedford				Central Beds				Luton			
	Total	Total %	0-17	0-17%	Total	Total %	0-17	0-17%	Total	Total %	0-17	0-17%
All Categories:												
Ethnic Group	157,479	100%	35,875	100%	254,381	100%	56,350	100%	203,201	100%	52,181	100%
White	126,846	80.50%	25,352	70.70%	238,722	98.80%	51,109	90.60%	111,079	54.70%	20,128	34.60%
Mixed/ multiple ethnic group	5,396	3.40%	3,107	8.70%	4,789	1.90%	2,708	5.00%	8,281	4.10%	4,856	8.00%
Asian/Asian British	17,982	11.40%	5,564	15.50%	6,402	2.50%	1,340	2.40%	60,952	30.00%	20,753	45.80%
Black/African/ Caribbean/ Black British	6,202	3.90%	1,585	4.40%	3,614	1.40%	981	1.50%	19,909	9.80%	5,775	10.40%
Other Ethnic Group	1,113	0.70%	267	0.70%	854	0.30%	212	0.50%	2,980	1.50%	669	1.20%

Figure 4: Ethnicity of deaths reviewed



Learning from the reviews and key actions taken in 2016/17

- When concerns relating to practise issues have been identified by either single or multi agencies during the review of cases, where appropriate CDOP have requested that these issues are investigated either through the Serious Incident process within the organisation or via a Local Safeguarding Children's Board case review. It is ensured that lessons learned and actions taken as a result of these reviews are fed back to the panel and are also fed back to those families involved.
- It has been noted in this report that the number of deaths from chromosomal, genetic and congenital anomalies has decreased this year. However work is still ongoing to ensure that where consanguinity has been identified as a modifiable factor CDOP will contact the family's GP to request that genetic counselling is offered to parents. There is an ongoing action plan in place around consanguinity in Luton.
- CDOP Information Sheets are produced on a biannual basis by the CDOP Manager and contain information regarding national and local issues identified, these are circulated to all Health and Social Care partner agencies to inform frontline practitioners such as GPs, Paediatricians, Health Visitors, Midwives and Social Workers.
- Multi-agency training is provided to staff locally by the CDOP Manager, Police and Paediatricians in order to ensure that they are fully aware of the CDOP process and allows for learning to be shared. CDOP training also makes up a part of the Level 3 Safeguarding Training for GPs in Bedfordshire, this has continued to work effectively and has received positive feedback.
- CDOP has a comprehensive work plan which demonstrates achievements and this has been refreshed for 2017-2018. This action plan will be owned by CDOP Panel members on behalf of their organisation and will be monitored and updated on a quarterly basis.

CDOP Training Sessions

CDOP training sessions are held throughout the year to ensure that frontline practitioners are informed about the CDOP Process. The length of these sessions is 2 hours and consists of a joint presentation by the CDOP Manager, Lead Paediatrician and Police. Further sessions will be arranged in 2017-2018 and invitations will be sent out to inform professionals and invite them to attend.

As many 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 such as maternal BMI and smoking. The training will also include learning coming out of Serious Incident Reports and Serious Case Reviews to ensure that findings are being shared and lessons are being learnt.

Positive Areas of Note:

- In March this year the CDOP Manager, along with the Designated Nurse for Safeguarding Children met with professionals who had flown over from Sweden to visit with sites of best practice in order to gain some understanding of how CDOPs are arranged and organised. These professionals were hoping to complete some research in order to look at setting up the CDOP process in Sweden and they gave very positive feedback as to how we were working as a panel and the work that is being done on a wider scale.
- Following some children that had sadly lost their lives in Asthma related incidents in Bedfordshire and the learning coming from the CDOP an Asthma Taskforce was set up which has now been a focus in Bedfordshire for around 18 months. The taskforce found that there was a variation in care received by people with Asthma throughout Bedfordshire and case studies from CDOP backed this up. The taskforce is using a coordinated approach involving children, parents/carers, primary care, school nurses, schools and hospitals. One of the targets set was to reduce hospital admissions for asthma by 10% in 2016/17 and this has been achieved.

Areas for development and future plans

- Increase GP and frontline staff awareness of CDOP and their role following a child death and implementation of learning from emerging themes.
- Reduce smoking in pregnancy and post birth.
- Continue to work with pregnant women with high BMI to ensure they are referred for weight management support and are aware of the risks for future pregnancies.
- Continue to raise awareness around the risks of consanguinity in Luton and also in Bedford Borough.
- Continue with a biannual publication of a CDOP Information Sheet to raise awareness of local themes and raise awareness of local and national issues.
- Incorporate professionals from Education into the CDOP process to ensure that safety messages and learning coming out of panel can be shared with young people throughout the Borough in the most effective way possible.
- An Audit of Service Recommendation factors will be carried out using 2016-17 data.
- CDOP would like to carry out a piece of work looking at the cumulative emerging themes over the past few years.

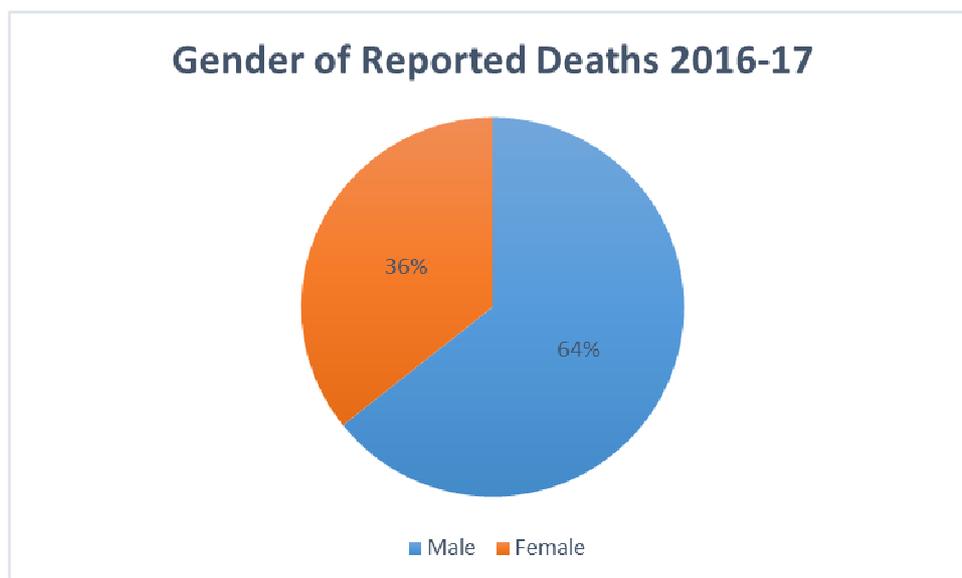
Appendix 1:

Summary for Central Bedfordshire LSCB of deaths reported

From 1st April 2016 to 31st March 2017 a total of 14 child deaths occurred amongst children residing in Central Bedfordshire. This is 2 less than the previous year. 57% of deaths were in the first year of life, this is an increase on the previous year where 31% of deaths were in children under one.

36% 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 the events which led to the death (Working Together to Safeguard Children (2015)). This is a decrease from the previous year where 68% of deaths were unexpected.

Of the deaths reported in 2016-17 64% were male which is similar to the previous year and in line with national data.



Due to small numbers it is not possible to provide a detailed breakdown of Ward level data, however there were more deaths in Dunstable Manshead Ward than in any other ward in Central Bedfordshire.

Actions undertaken during this year:

- High maternal BMI is being focused on with weight management services being signposted.
- Reductions in smoking during pregnancy and after birth with access to stop smoking services offered by all professionals.

CDOP Annual Report 2016 / 2017

Gerry Taylor CDOP Chair / Karis Venables CDOP Manager

- Where concerns relating to practice issues have been identified 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 Serious Case Review. Learning from these reviews and action plans put in place as a result are always fed back to the panel.
- Training on the CDOP process and learning from child deaths presented to professionals across Bedfordshire
- Publication of a CDOP Information Sheet to inform frontline staff and influence practice.

Areas for improvement 2017 /2018

- Explore ways of improving the dissemination of lessons learned from child death reviews.
- Aim to incorporate professionals from Education into the CDOP process to enable learning to be disseminated to young people in the Borough.

Appendix 2:

Summary for Bedford Borough LSCB of deaths reported

From 1st April 2016 to 31st March 2017 a total of 12 child deaths occurred amongst children residing in Bedford Borough, 1 less than the previous year (2015-2016). The majority of these deaths (75%) were in the first year of life which is in line with national data.

There was a decrease in 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 the events which led to the death (Working Together to Safeguard Children (2015)).

There was a small number of male deaths reported this year in Bedford Borough a significant decrease on the previous year where 75% of the deaths were male.

Due to small numbers it is not possible to provide a detailed breakdown of ward level data, however there were more deaths in Goldington Ward than in any other ward in Bedford Borough.

There was a decrease in deaths related to consanguinity which is positive, however as it was still identified as a modifiable factor in some cases work needs to be ongoing, particularly with high risk communities in the Bedford Borough area.

Actions undertaken:

- High maternal BMI is being focused on with weight management services being signposted.
- Reductions in smoking during pregnancy and after birth with access to stop smoking services offered by all professionals.
- Where concerns relating to practice issues have been identified 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 Serious Case Review. Learning from these reviews and action plans put in place as a result are always fed back to the panel.
- Training on the CDOP process and learning from child deaths presented to professionals across Bedfordshire
- Publication of a CDOP Information Sheet to inform frontline staff and influence practice.

Areas for improvement 2017 /2018

- Explore ways of improving the dissemination of lessons learned from child death reviews.
- Aim to incorporate professionals from Education into the CDOP process to enable learning to be disseminated to young people in the Borough.
- Continue work around Consanguinity and the associated risks within high risk communities in Bedford Borough.

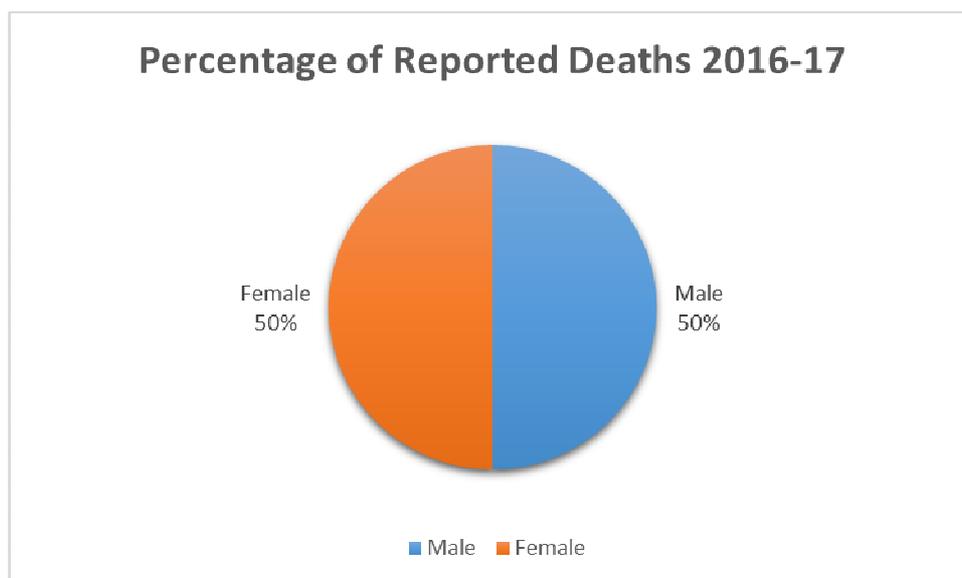
Appendix 3:

Summary for Luton Borough LSCB of deaths reported

From 1st April 2016 to 31st March 2017 a total of 28 child deaths occurred amongst children residing in Luton. This is a decrease of 3 deaths on the previous year (2015-2016). 61% of the deaths were in the first year of life this is an increase on the previous year where 48% of deaths occurred in children under one.

32% 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 the events which led to the death (Working Together to Safeguard Children (2015)). This is a decrease on the previous year where 48% of deaths reported were unexpected.

Of the deaths reported in 2016-17 50% were male and 50% were female. Which is not in keeping with national data where the majority of deaths were male. The reason for this is unclear, but may well be due to variation related to small numbers.



Due to small numbers it is not possible to provide a detailed breakdown of Ward level data, however there were more deaths in Biscot and Farley than in other wards in Luton.

Actions undertaken:

- High maternal BMI is being focused on with weight management services being signposted.

CDOP Annual Report 2016 / 2017

Gerry Taylor CDOP Chair / Karis Venables CDOP Manager

- Reductions in smoking during pregnancy and after birth with access to stop smoking services offered by all professionals.
- Where concerns relating to practice issues have been identified 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 Serious Case Review. Learning from these reviews and action plans put in place as a result are always fed back to the panel.
- Training on the CDOP process and learning from child deaths presented to professionals across Bedfordshire and Luton.
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Areas for improvement 2017 /2018

- Explore ways of improving the dissemination of lessons learned from child death reviews.
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