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 2017 – 31 March 2018

Contents

Executive Summary

Since April 2008 Local Safeguarding Boards (LSCBs) 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 LSCBs websites.

The aim of this report is to summarise the work of the Bedford Borough, Central Bedfordshire and Luton Child Death Overview process during 2017-2018.

This is the 10th 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 2017-2018 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 2017 to 31st March 2018 the panel met on 9 occasions and completed full reviews on 66 children residing in Bedford Borough, Central Bedfordshire and Luton. These cases included deaths from 2015-2018 as there can be a delay in reviewing cases due to other processes such as coronial inquests and toxicology reports.

During the period April 2017 until March 2018 there were 57 deaths reported across Bedfordshire. This was made up of 15 in Bedford Borough; 25 in Luton and 17 in Central Bedfordshire. There was an increase in the number of deaths from 54 in 2016-17 to 57 in 2017-18.

Unexpected deaths accounted for 21% of the total deaths reported in 2017-18, which is a decrease from the previous year where 31% of the deaths were unexpected. 63% of the reported deaths were of children less than 1 year of age. Of the total reported deaths 39% were female and 61% were male. There were no significant differences in the proportions of unexpected deaths by gender, with 18% for female and 23% for male.

During 2017-18 Bedfordshire CDOP reviewed and closed 66 cases at panel meetings. Modifiable factors were identified in 39% of these cases; this is lower than last year where modifiable factors were found in 57% of cases heard at panel. Similarly to previous years, the modifiable factors identified included service provision, consanguinity, maternal BMI and smoking. There were also cases that found modifiable factors of substance misuse and road safety factors.

The number of deaths in each LSCB area over the past 5 years is shown in Table 1. This shows that Luton has had a decrease in child deaths this year 25 compared to 28 whilst Central Bedfordshire and Bedford Borough have each had an increase of 3 deaths on the previous year.

Table 1: Deaths reported 2013/14 – 2017/18

LSCB Area	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	Total by Local Authority	Average 2013/2018
Luton	**20**	**26**	**31**	**28**	**25**	**130**	**26**
Central Bedfordshire	**10**	**13**	**16**	**14**	**17**	**70**	**14**
Bedford Borough	**16**	**12**	**13**	**12**	**15**	**68**	**13.6**
Total	**46**	**51**	**60**	**54**	**57**	**268**	**53.6**

Changes to CDOP and National Data Collection

Due to the changes recommended in the Wood Review (Review of the role and functions of Local Safeguarding Children's Boards March 2016), including departmental responsibility for the oversight of the Child Death Review Process moving from the Department for Education to the Department of Health there has been a delay in the collection of the National Data for 2017-18. CDOPs nationally have been advised to await further instruction as to how the annual returns for reviews completed during this period are to be undertaken. In order to avoid further delaying this annual report it has been agreed with the members of Bedfordshire CDOP panel that this report will use last year's national data for comparison. This is in line with what other CDOPs have also decided.

Key Areas of Note from 2017-18:

- The CDOP Panel have increased the number of cases reviewed and closed this year by 22%.
- Bedfordshire CDOP had a decrease in the number of modifiable factors being identified (39% compared to 57%) bringing us closer to the national percentage of 27%.
- Bedfordshire CDOP have worked hard to ensure that cases reach panel in a more timely manner; this has meant that the number of cases completed within 12 months of the child's death has increased from 62% to 71% which brings us much closer to the national percentage of 76%. It is worth noting here that reviews often taken longer if modifiable factors have been identified and Bedfordshire are still identifying a higher number of modifiable factors in comparison with national data.
- 45% of cases closed at panel were reviewed within 6-12 months of the child's death, a small increase on the previous year. 24% of cases closed at panel were reviewed under 6 months from the child's death which is the same as the previous year.

- The number of deaths closed under the category of Perinatal/Neonatal events (Category 8) increased this year to 32% compared to 26% last year.
- Chromosomal, genetic and congenital anomalies made up 30% of the reviewed cases this is an increase on the previous year where 24% of cases were closed under this category.
- The third highest category for child deaths in Bedfordshire this year is Malignancy with 11% of deaths reviewed closed under this category. This is higher than the percentage of National Cases which is 7% although this is a variance of less than 3 deaths.
- In Bedfordshire the proportion of cases reviewed and closed under the perinatal/neonatal category increased by 4% percentage points on the previous year (30% compared to 26%) however this is still lower than the national percentage of 43%.
- In Central Bedfordshire there were 17 deaths; this is an increase of 3 deaths on the previous year. There was also a decrease in unexpected deaths of 18% compared to 36% last year. Due to low numbers ward level data cannot be fully reported, however more deaths occurred in Flitwick ward than any other.
- In Bedford Borough there were 15 deaths; this is an increase of 3 deaths on the previous year; 40% of these deaths were unexpected. Due to low numbers ward level data cannot be fully reported, however more deaths occurred in Queens Park, Eastcotts and Kingsbrook wards than others.
- In Luton there were 25 deaths; this is a decrease of 3 deaths on the previous year. There was also a decrease in the proportion of unexpected deaths 12% compared to 32% the previous year. Due to low numbers ward level data cannot be fully reported, however more deaths occurred in Northwell and Dallow wards than others.

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 2 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

As previously mentioned due to delays in the National Data this Annual Report will use 2016-17 data for comparison.

The National Picture (Year ending March 2017)

- **3,575** Reviews completed by Child Death Overview Panels in the year ending March 2017. This had fallen slightly from 3,665 in 2015-16. Bedfordshire CDOP have increased the number of cases reviewed over the past 2 years.
- **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 higher percentage of modifiable factors being identified (39%) 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 30% 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 (63%).

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

Mortality Rates

Table 2 shows the mortality rates for each authority compared with the national average and statistical neighbours. Central Bedfordshire has a relatively low infant mortality rate and Luton has significantly worse rates than the England average for both infant mortality rates and child mortality rates. Luton's child mortality rate is also the worse performing out of all its statistical neighbours.

Please note that these figures cover the period 2014/16 and therefore do not directly relate to the data in the remainder of this report.

Table 2: Infant mortality rate and Child mortality (1-17 years) rate 2014-16

Bedford and its CSSNBT statistical neighbours

Compared with benchmark Better | Similar | Worse | Not compared

* a note is attached to the value, hover over to see more details

Recent trends: – 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 - Medway
Infant mortality	2014 - 16		3.9	4.1	3.5	4.3	3.0	6.0	4.4	5.2	4.4	2.8	4.7	3.8
Child mortality rate (1-17 years)	2014 - 16		11.6	10.8	7.4	12.4	14.9	13.5	9.9	14.5	12.2	7.6	9.6	11.0

Central Bedfordshire and its CSSNBT statistical neighbours

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

Recent trends: – 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	2014 - 16	3.9	2.2	3.0	4.7	3.3	3.9	3.5	4.9	3.9	3.1	1.6	3.7
Child mortality rate (1-17 years)	2014 - 16	11.6	12.5	9.8	9.6	8.6	11.2	7.4	9.4	11.1	8.4	*	*

Luton and its CSSNBT statistical neighbours

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

Recent trends: – 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 - Wolverhampton	10 - Oldham
Infant mortality	2014 - 16	3.9	5.4	7.9	5.8	4.2	5.9	7.1	3.2	2.0	6.0	5.6	6.2
Child mortality rate (1-17 years)	2014 - 16	11.6	22.4	16.9	15.7	18.5	17.8	10.3	11.9	15.7	13.5	9.7	20.0

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 2014 to 2016. The comparators used are from Fingertips and are Children's Services Statistical Neighbour Benchmarking Tool (CSSNBT).

Reported deaths and cases reviewed

During the period April 2017 until March 2018 there were 57 deaths reported across Bedfordshire; this is an increase on the previous year which is inconsistent with national data which shows a year by year decrease in child deaths. Unexpected deaths accounted for 21% of the total deaths reported which is a decrease from the previous year where 31% of the deaths were unexpected.

The CDOP panel met on 9 occasions during this period and completed full reviews on 66 children residing in Bedford Borough, Central Bedfordshire and Luton. This is an increase of 22% 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 2017-2018, some will have occurred in the previous or earlier years. There is generally a gap of several months between a reported death and the final review at the panel 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.

71% of child deaths reviewed in2017-18 were completed within 12 months of the child's death. This is an increase from the previous year (62%) which brings us closer to the National Percentage of 76%. However reviews often take longer if modifiable factors have been identified and Bedfordshire has a higher percentage of cases being identified as having factors that are modifiable. 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.

Figure 1: Duration of Reviews

<u>Categories of reviewed and closed cases</u>

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 2017-18 were closed under the category of Perinatal/Neonatal events (Category 8). These accounted for 32% of the total reviews this is an increase on the previous year where 26% of cases were closed under this category. 43% of the cases closed under this category were found to have modifiable factors, including service provision, maternal BMI and maternal smoking.

Chromosomal, genetic and congenital anomalies made up 30% of the reviewed cases; this is an increase on the previous year where 24% of cases were closed under this category. It is also important to note that the third highest

category for child deaths in Bedfordshire this year is Malignancy with 11% of deaths reviewed closed under this category. This is higher than the percentage of national cases which is 7% however, it is worth remembering that we are dealing with very small numbers.

Table 3: Categories with highest percentage of deaths 2017-18

Category of closed case	Percentage of Local Cases	Percentage of National Cases (2016-17)
Perinatal/Neonatal Event (Category 8)	32%	34%
Chromosomal, genetic and congenital anomalies (Category 7)	30%	25%
Malignancy	11%	7%

Modifiable Factors

In 2017-2018 modifiable factors were identified in 39% which is lower than the previous year where 57% of cases reviewed were found to have modifiable factors; however this is still 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, factors relating to service provision and BMI. It is also worth noting that not all CDOP panels define consanguinity as a modifiable factor.

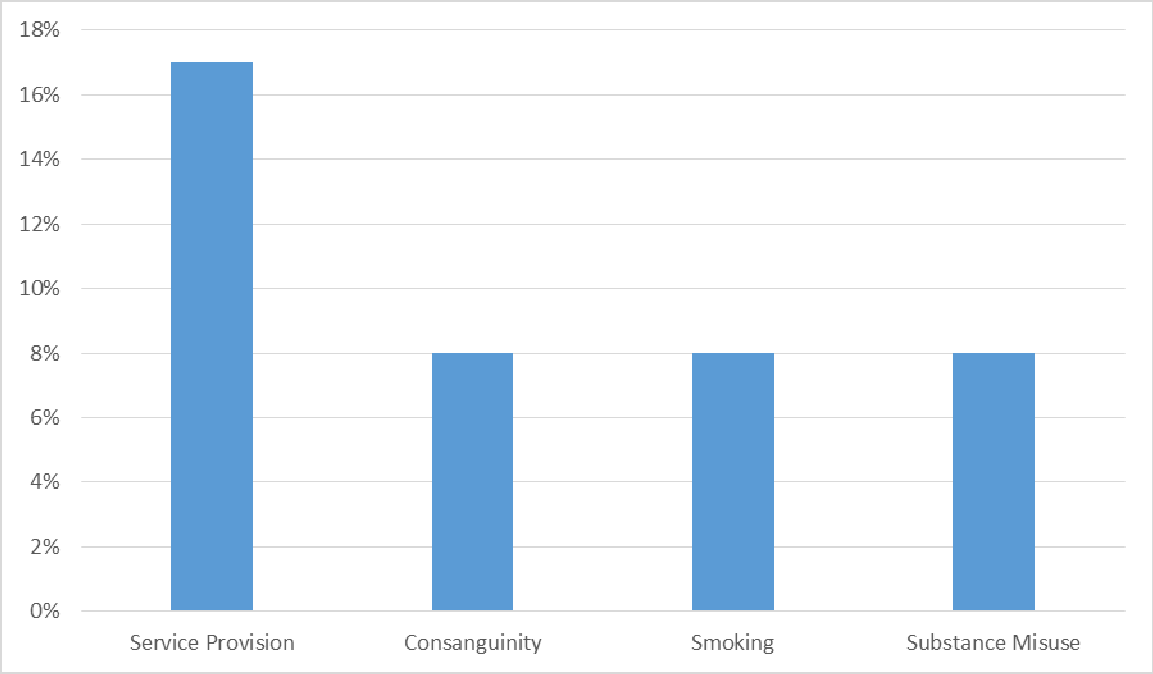
Consanguinity, where parents are related to each other, is a major risk factor for congenital anomaly. CDOP panels nationally continue to be concerned that inter-family couples do not have sufficient understanding of the increased risks of having a child with a disability or of having a child die under the age of five. Although consanguinity was identified as a modifiable factor in a number of cases reviewed in 2017-18, there has been a decrease from the 2015-2016 data which is positive. However, the fact that it is still being identified as a modifiable factor in child deaths shows that work still needs to be ongoing to ensure that families where parents are related are fully aware of the risks.

This year issues with service provision were identified as modifiable factors in 17% of all cases reviewed. This is a decrease on last year where 28% of cases were categorised with service provision as a modifiable factor. Learning from Serious Incident Reports, Serious Cases Reviews and Independent Reviews are shared with relevant agencies and professionals as well as with the families of the children that have died. An audit is in progress 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 the Public Health teams 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 (>30)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 run 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 (8%) and compared to last year there has been a 10% decrease in the number of cases that identified maternal BMI as a modifiable factor. However, obtaining accurate information from acute trusts on referral to weight management services for pregnant women with a BMI >30 remains a challenge.

The Modifiable factors identified most often in 2017-18 are shown in Figure 2 below.

Figure 2: Modifiable factors identified



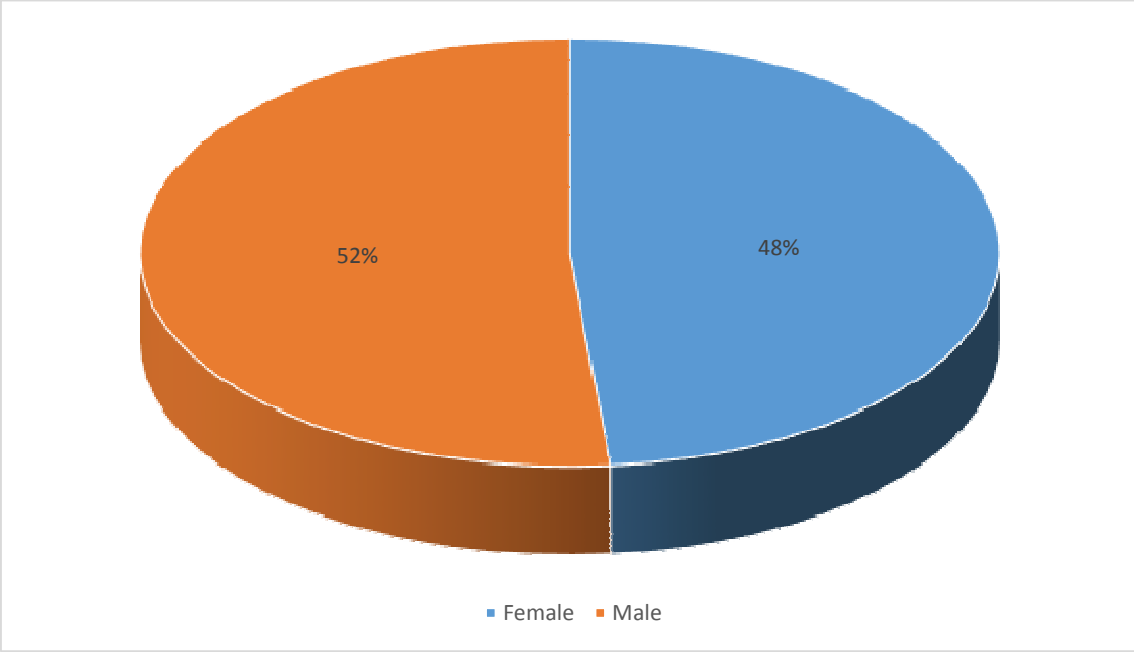
(Percentages of total cases reviewed in 2017/18)

Age, Gender and Ethnicity

In Bedfordshire the number of deaths of children under 1 year of age reviewed during 2017-18 was 65%; this is a 10% increase on the previous year. The National Data (2016-17) found that the percentage of these deaths with modifiable factors has steadily increased to 28% from 15% in March 2013. Of the Perinatal/Neonatal deaths in Bedfordshire this year 35% were felt to have modifiable factors, which is higher than the national data. However this is a decrease on the previous year where 59% were identified with modifiable factors.

Of the deaths reviewed at panel this year 52% were male and 48% were female; this a change from last year where 74% were male and 26% were female. The national data shows that boys' deaths account for over half of the deaths reviewed (56%). National data has also shown that CDOP panels were marginally more likely to identify modifiable factors in reviews of boys' deaths (28%) than in girls' deaths (27%). This is out of line with that was found in Bedfordshire this year where the CDOP panel identified modifiable factors in 35% of boys' deaths and 44% of girls' deaths.

Figure 3: Gender of cases reviewed 2017-18



The data around ethnicity is largely in line with the population data in Table 4 (2016-17). The percentage of deaths reviewed from Asian backgrounds was 33% which is higher than the national data, but also higher than the previous year at 20%. However Bedfordshire and Luton have a high proportion of people of Asian origin.

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

	Bedford				Central Beds				Luton			
Age	**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%

Learning from the reviews and key actions taken in 2017-18

- When concerns relating to practice 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 increased this year. However, the number of cases that have been closed at panel with consanguinity as a Modifiable Factor have continued to decrease. Work needs to continue to be ongoing in high risk areas ensuring that families are aware of the risks. 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 will be 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, School Nurses, 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.
- The CDOP panel continues to monitor and update their comprehensive work plan in order to demonstrate achievements; this will be refreshed 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. In 2017-18 there have been 2 training sessions that were well attended and the feedback received was positive. Further sessions will be arranged in 2018-2019 and invitations will be sent out to inform professionals and invite them to attend.

As many deaths occur in the below 1 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 from Serious Incident Reports and Serious Case Reviews to ensure that findings are being shared and lessons are being learnt.

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 midwifery services leads to ensure that pregnant women with high BMI are referred for weight management support , are aware of the risks for future pregnancies and referral information recorded.
- Continue the positive work that has been done to raise awareness around the risks of consanguinity in high risk areas.
- An Audit of Service Recommendation factors is in process based on 2016-18 data and this will be reported in 2018-19.
- It would be beneficial to do an audit looking at all neonatal deaths over the past few years to pick out any emerging themes and learning.

Appendix 1

Summary for Bedford Borough LSCB of deaths reported

From 1st April 2017 to 31st March 2018 a total of 15 child deaths occurred amongst children residing in Bedford Borough, 3 more than the previous year. 60% (n=9) of the deaths reported this year were in the first year of life which is in line with national data.

There was a 15% increase in unexpected deaths in Bedford Borough this year, with 40% (n=6) of deaths being unexpected 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 (2018).

67% (n=10) of deaths reported this year in this area were male and 33% (n=5) were female.

Due to small numbers it is not possible to provide a detailed breakdown of ward level data, however more deaths occurred in Queens Park, Eastcotts and Kingsbrook wards than others.

Actions undertaken:

- High maternal BMI continues to be 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

Appendix 2:

Summary for Central Bedfordshire LSCB of deaths reported

From 1st April 2017 to 31st March 2018 a total of 17 child deaths occurred amongst children residing in Central Bedfordshire. This is 3 more deaths than the previous year. 53% (n=9) of deaths were in the first year of life; this is a decrease on the previous year where 57% (n=8) of deaths were children under 1 year of age.

18% (n=3) 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 (2018). This is a decrease from the previous year where 36% (n=5) of deaths were unexpected.

Of the deaths reported in 2017-18 59% (n=10) and 41% (n=7) were female which is in line with national data.

Due to small numbers it is not possible to provide a detailed breakdown of Ward level data; however the ward with the highest number of child deaths this year was Flitwick.

Actions undertaken during this year:

- High maternal BMI continues to be 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
- Work has been done in liaison with Public Health around a pathway for schools in responding to the suspected suicide of a pupil.

Appendix 3:

Summary for Luton Borough LSCB of deaths reported

From 1st April 2017 to 31st March 2018 a total of 25 child deaths occurred amongst children residing in Luton. This is a decrease of 3 deaths on the previous year. 72% (n=18) of the deaths were in the first year of life this is an increase on the previous year where 61% (n=17) of deaths occurred in children under 1 year.

12% (n=3) 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 (2018).This is a large decrease on the previous year where 32% (n=9) of deaths reported were unexpected.

Of the deaths reported in 2017-18 60% (n=15) were male and 40% (n=10) were female, which is in keeping with national data.

Due to small numbers it is not possible to provide a detailed breakdown of Ward level data, however more deaths occurred in Northwell and Dallow wards than others.

Actions undertaken:

- High maternal BMI continues to be 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.
- Work continues to take place around consanguinity with high risk families in Bedfordshire. Where child deaths have occurred within consanguineous families the GP is asked to refer the family for genetic counselling.
- 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.
- Work has been done in liaison with Public Health around a pathway for schools in responding to the suspected suicide of a pupil.