**Central Bedfordshire Safeguarding**

**Children Board**

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

## 1 April 2015 - 31March 2016

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## 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 2015-2016.

This is the 8th Annual Report of the Bedford Borough, Central Bedfordshire and Luton Child Death Overview Panel (CDOP). It gives a summary of the deaths reported to the panel during 2015-2016 and analysis of the data and emerging themes for 2009-2016.

During the period 1st April 2015 to 31st March 2016 the panel met on 8 occasions and completed full reviews on 40 children residing in Bedford Borough, Central Bedfordshire and Luton. These cases were from 2013-2014, 2014-2015 and 2015-2016. There can be a delay in reviewing cases as CDOP is not able to fully review a death until all information is gathered and other processes have been completed such as post mortem reports and coronial inquests.

During the period April 2015 until March 2016 there were 60 deaths reported across Bedfordshire. This consisted of 13 (21.6%) in Bedford; 31 (51.6%) in Luton and 16 (26.6%) in Central Bedfordshire. There was a 17.6% increase in the number of deaths in comparison to the previous year (60 compared to 51).

Unexpected deaths accounted for 32 (53.3%) of the total deaths in 2015-16, which is an increase from the previous year where only 25% (13/51) of the deaths were unexpected. 53.3% (32/60) of the reported deaths were of children less than 1 year

of age. Of the total reported deaths 40% (24/60) were female and 60% (36/60) were male.

The CDOP Panel reviewed the deaths of 40 children during 2015-16 and identified modifiable factors in 52.5% (21/40) of these cases. The modifiable factors identified included: consanguinity, smoking of one or both parents, co-sleeping and factors relating to service provision.

The number of deaths reported to CDOP in each LSCB area over the past 5 years, broken down by age is shown in Table 1. Numbers have varied across the period and there is no clear pattern. All LSCB areas have had an increase in child deaths compared to last year. As mentioned there was a high number of unexpected deaths this year with 8% of these caused by road traffic accidents and 25% of deaths reported this year were due to complications of prematurity. In line with National Figures the majority of deaths have continued to be in the first year of life.

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

| **LSCB Area** | **2011-2012** | **2012-2013** | **2013-2014** | **2014-2015** | **2015-2016** | **Total by Local Authority** |
|---|---|---|---|---|---|---|
| **Luton** | **22** | **31** | **20** | **25** | **31** | **130** |
| Aged < 1 year | 13 | 23 | 11 | 18 | 17 | 82 |
| Aged 1- 4 Years | 6 | 1 | 1 | 5 | 7 | 20 |
| Aged 5+ | 4 | 7 | 8 | 2 | 7 | 28 |
| **Central Bedfordshire** | **17** | **24** | **10** | **13** | **16** | **80** |
| Aged < 1 year | 11 | 16 | 6 | 8 | 5 | 46 |
| Aged 1- 4 Years | 3 | 4 | 1 | 1 | 6 | 15 |
| Aged 5+ | 3 | 4 | 3 | 4 | 5 | 19 |
| **Bedford Borough** | **19** | **11** | **16** | **12** | **13** | **71** |
| Aged < 1 year | 15 | 9 | 12 | 7 | 10 | 53 |
| Aged 1- 4 Years | 2 | 1 | 1 | 0 | 3 | 7 |
| Aged 5+ | 2 | 1 | 3 | 5 | 0 | 11 |
| **Total** | 58 | 66 | 46 | 51 | 60 | 281 |

## 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 as 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 2015)

- **3,515** Reviews completed by Child Death Overview Panels in the year ending March 2015 – a year on year decrease from 4,061 in 2011.
- **24%** the percentage of child death reviews (827 reviews) identified as having modifiable factors, an increase from 20% in 2011.
- **33%** the percentage of deaths reviewed which were due to a perinatal/neonatal event; this is broadly consistent with previous years.
- **64%** the percentage of deaths reviewed that were for children under one year old in the year ending March 2015; this compares with 67% in 2011.

Source: Statistical First Release – Department for Education July 2015.

### Reported deaths and cases reviewed

During the period April 2015 until March 2016 there were 60 deaths reported across Bedfordshire, this is an increase of 17.6% on the previous year which is inconsistent with national data which shows a year by year decrease in child deaths. Unexpected deaths accounted for 53.3% of the total deaths reported which is an increase from the previous year where only 25% of the deaths were unexpected.

Table 2 shows how these figures compare to those over the previous five years and shows a five year high in the number of unexpected deaths in Luton and Central Bedfordshire.

**Table 2: Unexpected Deaths over the past 5 years by LSCB Area**

| Luton | | | | | |
|---|---|---|---|---|---|
| **Year** | **2011-12** | **2012-13** | **2013-14** | **2014-15** | **2015-16** |
| **Total Deaths** | 22 | 31 | 20 | 25 | 31 |
| **Unexpected Deaths** | 7 | 6 | 9 | 5 | 15 |
| **Bedford Borough** | | | | | |
| **Year** | **2011-12** | **2012-13** | **2013-14** | **2014-15** | **2015-16** |
| **Total Deaths** | 19 | 11 | 16 | 12 | 13 |
| **Unexpected Deaths** | 8 | 3 | 4 | 4 | 6 |
| **Central Bedfordshire** | | | | | |
| **Year** | **2011-12** | **2012-13** | **2013-14** | **2014-15** | **2015-16** |
| **Total Deaths** | 17 | 24 | 10 | 13 | 16 |
| **Unexpected Deaths** | 4 | 6 | 5 | 4 | 11 |

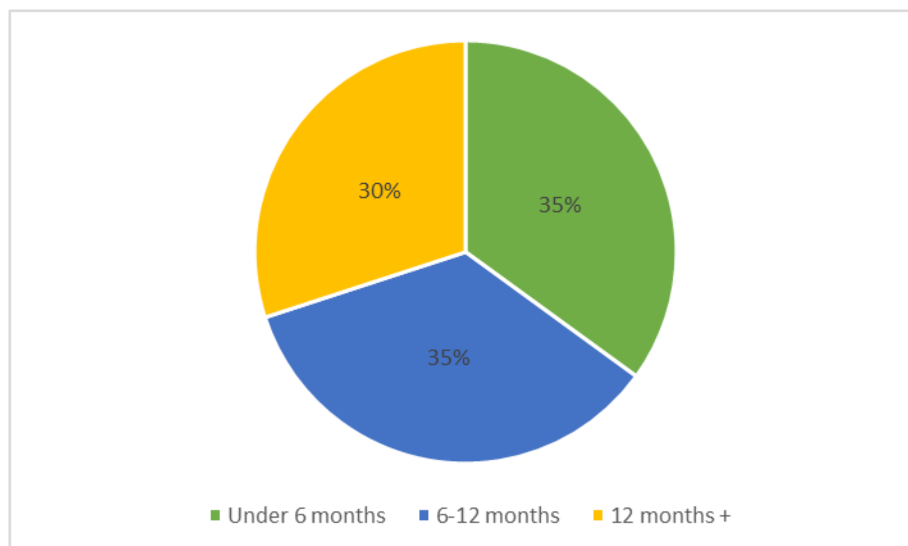
The CDOP panel met on 8 occasions during this period and completed full reviews on 40 children residing in Bedford Borough, Central Bedfordshire and Luton. The number of completed reviews is less than the previous year which is consistent with national data which has shown a year on year decrease in the number of cases reviewed annually.

Not all of the deaths reviewed occurred in 2015-2016, 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.

65% of child deaths reviewed in the year were completed within 12 months of the child's death which is slightly lower than the national data of 70%. 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.

**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 majority of cases in 2015-16 were closed under the category of Chromosomal, genetic and congenital anomalies (Category 7) these accounted for 37.5% of the total reviews this is an increase of 7.5% from the previous year. Perinatal/Neonatal events (Category 8) made up 22.5% of the reviewed cases which

is a decrease from 2014-15 where 43% of the cases reviewed were closed under this category.

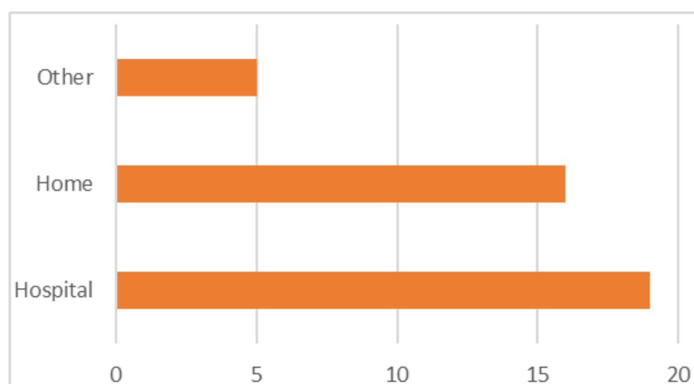
**Table 3: Categories with highest percentage of deaths 2015-16**

| Category of closed case | Number of Local Cases |
|---|---|
| Chromosomal, genetic and congenital anomalies (Category 7) | 37.5% |
| Perinatal/neonatal event (Category 8) | 22.5% |
| Malignancy (Category 4) | 10% |
| Acute medical or surgical condition (Category 5) | 10% |
| Sudden unexpected, unexplained death (Category 10) | 10% |

## Location of death

In line with the national data the majority of children (47.5%) died following an admission to hospital. 40% of the deaths reviewed occurred in the child's usual place of residence and in line with national statistics the number of deaths in public spaces is relatively small at 12.5%.

**Figure 2: Location of deaths**



**Modifiable Factors**

In 2015-2016 modifiable factors were identified in 52.5% of cases reviewed which is significantly higher than the national picture of 24%. The modifiable factors identified included: consanguinity, smoking of one or both parents, co-sleeping, obesity and factors relating to service provision.

Consanguinity is a major risk factor for inherited disorders and 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. Within Luton targeted action has been taken to improve awareness in high risk communities and this work needs to be ongoing as this year there was a three year high in the percentage of cases reviewed that were closed under the category of Congenital Anomalies or Chromosomal Defects, however not all of these will have been as a result of consanguinity.

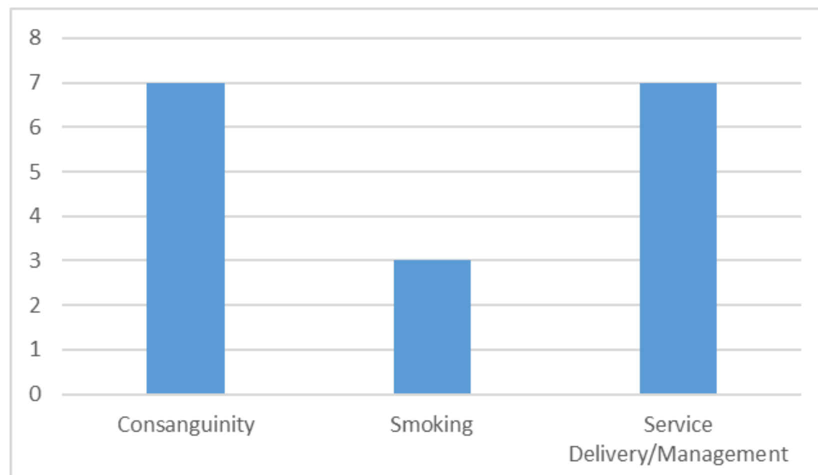
**Table 4: Cases closed under Category 7: Chromosomal, Genetic and Congenital Anomolies**

| Year | Percentage of cases closed under Category 7 |
|---|---|
| 2011-12 | 29% |
| 2012-13 | 32% |
| 2013-14 | 21.3% |
| 2014-15 | 30% |
| 2015 - 16 | 32% |

Consanguinity was identified as a modifiable factor in 17.5% of the cases reviewed in 2015-16, this is an increase from the 2014-2015 data a where 12% of cases were closed with consanguinity as a modifiable factor. Not all of the cases reviewed were children who died during 2014-15 so this may have an impact on this figure however it is clear that this is an area that requires ongoing attention. All of the cases with consanguinity as a modifiable factor were children that resided in Luton.

CDOP aims to raise awareness of modifiable factors identified in order to prevent future deaths, CDOP is working with Public Health to ensure pathways are in place for pregnant women to promote healthier lifestyle choices. Women with a raised BMI are offered access to information and support to make healthy living choices and weight management in pregnancy. For pregnant women who smoke, access to stop smoking services and campaigns to raise awareness of the risk of smoking in pregnancy. Service delivery or service management were identified as modifiable factors in 17.5% of cases reviewed this year. Learning from serious incident reports and independent reviews have been shared with relevant agencies and professionals to enable interventions to be put in place.

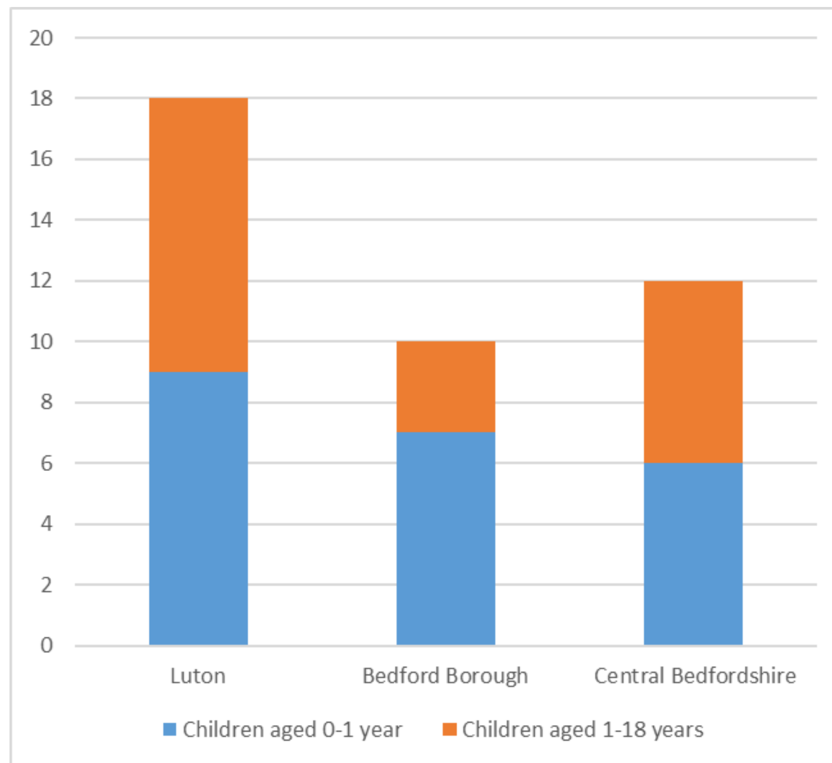
**Figure 3: Modifiable factors identified**




## Age, Gender and Ethnicity

In Bedfordshire the number of deaths of children under 1 year of age reviewed was 55% which is less than the national picture of 64%. However it should be noted that national figures relate to the year 2014/15 which is the most recent published data.

**Figure 4: Ages of children reviewed**




Of the deaths reviewed this year 60% were male this is in line with National Statistics in which boys deaths have consistently accounted for over half of those reviewed at panel.

**Figure 5: Gender of cases reviewed**

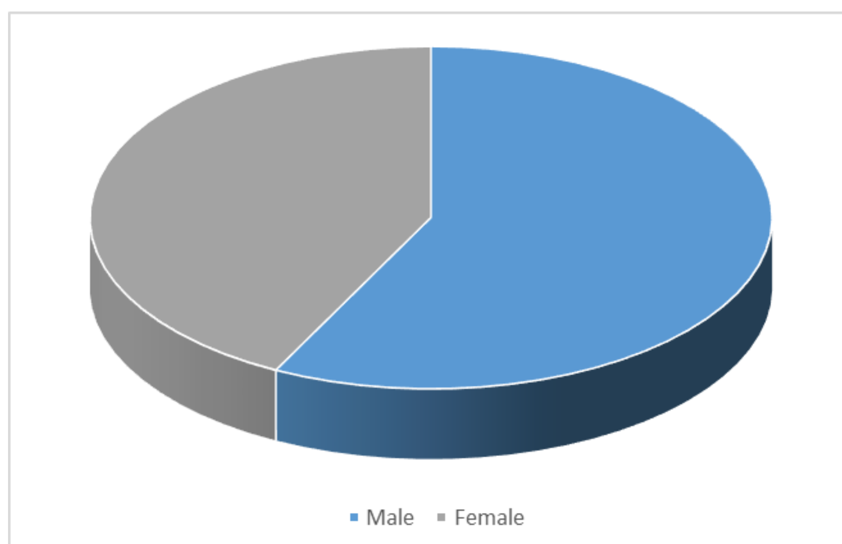


Table 5 gives an indication of the ethnicity of children where cases were reviewed in 2015/16. The data indicates that the majority of deaths reviewed were from a White British background at 52.5% which is consistent with national figures however this is actually lower than the proportion of children from a White British background in the Bedfordshire Population at 61.9%. However the data also shows that 27.5% of the deaths reviewed were from a Pakistani background at 27.5% which is higher than the proportion of children in Bedfordshire at 8.9%. The data also suggests an over-representation of children from Black African & Caribbean and white other backgrounds.

**Table 5 Ethnicity and population**

| | | Bedfordshire Population* | |
|---|---|---|---|
| **Ethnicity** | **Deaths reviewed** | **Less than 18** | **All ages** |
| Other | - | 0.8% | 0.8% |
| White British | 52.5% | 61.9% | 70.1% |
| Pakistani | 27.5% | 8.9% | 5.4% |
| Mixed | 2.5% | 7.4% | 3.0% |
| Black African & Caribbean | 7.5% | 5.8% | 4.8% |
| White Other | 7.5% | 5.0% | 7.4% |
| Asian | 2.5% | 10.3% | 8.5% |

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

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

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

## Learning from the reviews and key actions taken

- When concerns relating to practise issues have been identified by either single or multi agencies during the review of cases, CDOP have requested that these issues are investigated either through the Serious Incident process within the organisation or via a Local Safeguarding Children'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. Two cases were referred for Serious Case Reviews in 2015-16.
- Safe sleeping practices continue to be promoted across maternity and early year's services and a consistent approach has been agreed and adopted.
- It has been noted that the number of deaths closed under the category of chromosomal, genetic and congenital anomalies has increased over the past 4 years. Where consanguinity has been identified as a modifiable factor our paediatricians will contact the family's GP to request that genetic counselling is offered to parents. There is an action plan in place around consanguinity in Luton.
- Information sheets are produced on a regular basis by the CDOP panel and contain information regarding national and local issues identified, these are circulated to all Health and Social Care partner agencies to inform frontline practitioners such as GPs, Paediatricians, Health Visitors, Midwives, Social Workers and Children's Centre Staff.
- 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.
- Regular targeted audits.
- Work on smoking and obesity.
- CDOP has a comprehensive work plan which demonstrates achievements and this is currently being refreshed for 2016-2017. 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**

During 2015-16 a total of 3 CDOP information sessions were held across Bedford Borough, Central Bedfordshire and Luton for all professionals who work with children and young people.

The length of the information session was 2 hours with a joint presentation by the CDOP Manager, Lead Paediatrician, Child Death Review Nurse and Police. Further sessions will be arranged in 2016-2017 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 smoking and raised maternal body mass index.

These sessions also aim to inform professionals of themes that are emerging from the CDOP review process and how learning from these can be integrated into their practice.

## Areas for development and future plans

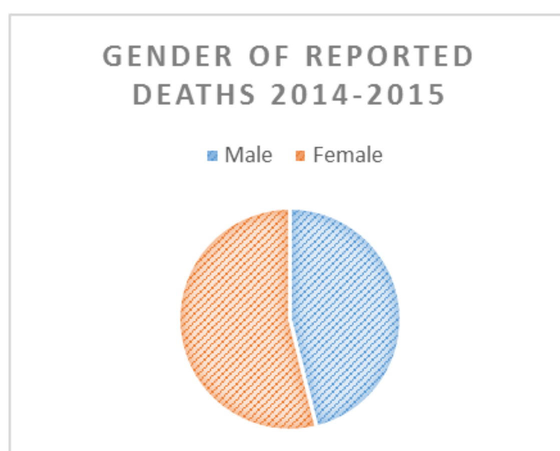
- Increase GP and frontline staff awareness of CDOP and their role following a child death and implementation of learning from emerging themes.
- Ensure safe sleeping messages are clear and parents are aware including foster carers when a baby is a Looked after Child (LAC).
- Reduce smoking in pregnancy and post birth.
- Continue to raise awareness around the risks of consanguinity.
- Provide information from CDOP to support evidence base for the quality schedule target for healthy weight management in pregnancy.
- Improve the dissemination of lessons learned from CDOP
- Ensure wide determinates of health are collected and recorded for child deaths in order to aid reviewing of cases.
- Review local CDOP Process and procedures in line with Working Together to safeguard children (2015)
- Regular publication of a CDOP Newsletter.
- Audit on deaths with modifiable factors around services.

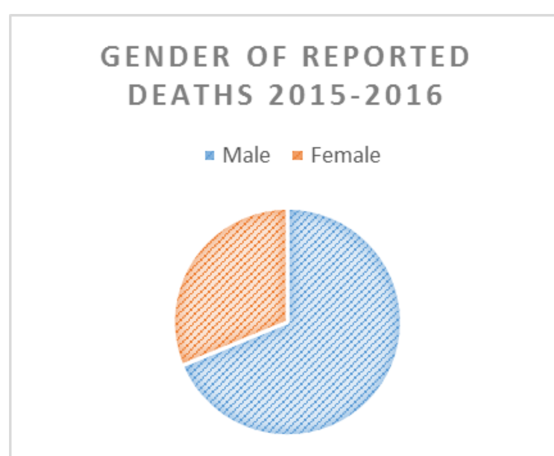
## Appendix 1:
## Summary for Central Bedfordshire LSCB of deaths reported

From 1st April 2015 to 31st March 2016 a total of 16 child deaths occurred amongst children residing in Central Bedfordshire. This is an increase of 3 deaths on the previous year (2014-2015). The minority of deaths (31%) were in the first year of life this is a change from the previous year where 61% of deaths occurred in children under one.

68% 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 an increase on the previous year where 30% of deaths were unexpected.

Of the deaths reported in 2015-16 68% were male which is also a shift from the previous year where just under half of the deaths in 2014-15 were male, but in line with national figures.






**Actions undertaken during this year:**

- Safe sleeping has continued to be promoted across maternity and early years services and a consistent approach to this has been agreed and applied.
- 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 by either single or multi agencies during the review of cases, CDOP have requested that these issues are investigated either through the Serious Incident process within the organisation or via a Local Safeguarding Children'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.
- Training on the CDOP process and learning from child deaths presented to professionals across Bedfordshire
- Publication of a CDOP newsletter to inform frontline staff.

**Areas for improvement 2015 /2016**

Increase GP and frontline staff awareness of CDOP and explore ways of improving the dissemination of lessons learned from child death reviews.

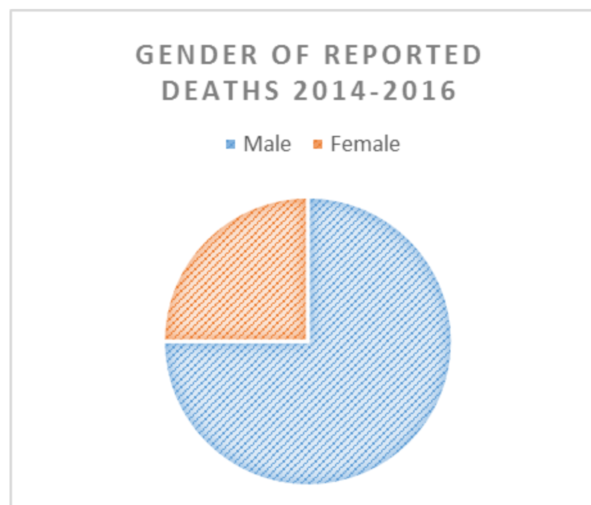
## Appendix 2:

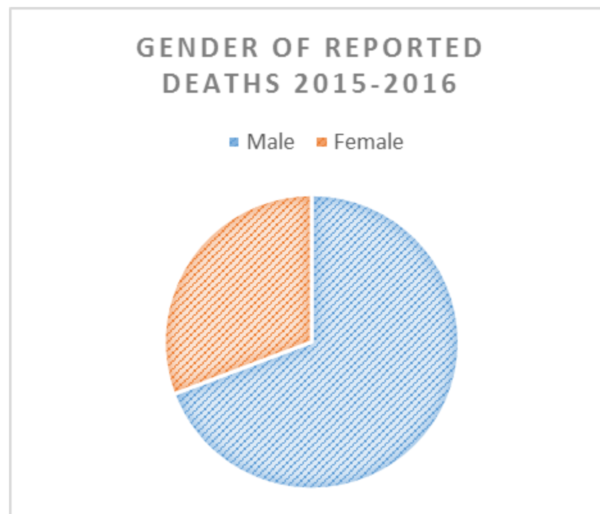
## Summary for Bedford Borough LSCB of deaths reported

From 1st April 2015 to 31st March 2016 a total of 13 child deaths occurred amongst children residing in Bedford Borough. This is an increase of 1 death on the previous year (2014-2015). The majority of these deaths (77%) were in the first year of life this is an increase from the previous year where 58% of deaths occurred in children under one.

46% 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 an increase on the previous year where 33% of deaths were unexpected.

Of the deaths reported in 2015-16 69% were male which shows a decrease on the previous year where 75% of the deaths were male.






**Actions undertaken:**

- Safe sleeping has continued to be promoted across maternity and early years services and a consistent approach to this has been agreed and applied.
- 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 by either single or multi agencies during the review of cases, CDOP have requested that these issues are investigated either through the Serious Incident process within the organisation or via a Local Safeguarding Children'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.
- 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.

**Areas for improvement 2015 /2016**

Increase GP and frontline staff awareness of CDOP and explore ways of improving the dissemination of lessons learned from child death reviews.

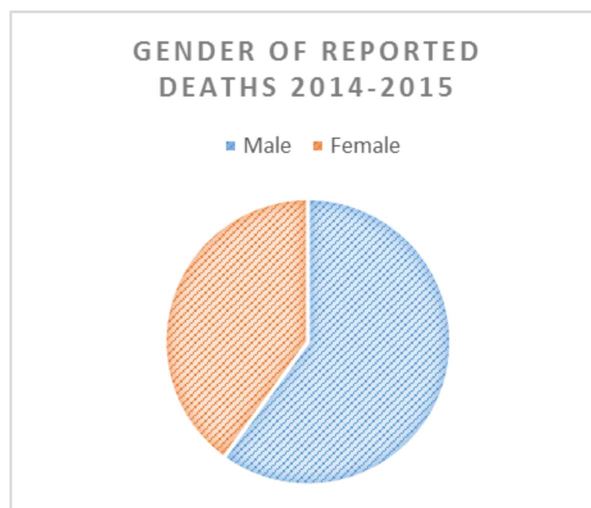
## Appendix 3:

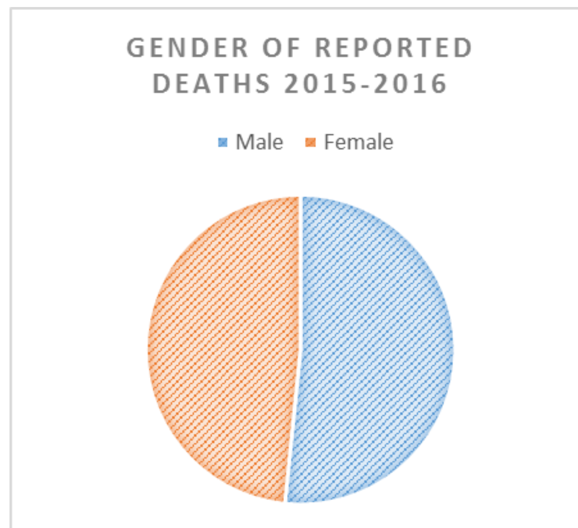
## Summary for Luton Borough LSCB of deaths reported

From 1st April 2015 to 31st March 2016 a total of 31 child deaths occurred amongst children residing in Luton. This is an increase of 5 deaths on the previous year (2014-2015). 48% of the deaths were in the first year of life this is a decrease from the previous year where 72% of deaths occurred in children under one.

48% 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 an increase on the previous year where 20% of deaths reported were unexpected.

Of the deaths reported in 2015-16 51% were male which shows a decrease on the previous year where 60% of the deaths were male.






**Actions undertaken:**

- Safe sleeping has continued to be promoted across maternity and early years services and a consistent approach to this has been agreed and applied.
- 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 by either single or multi agencies during the review of cases, CDOP have requested that these issues are investigated either through the Serious Incident process within the organisation or via a Local Safeguarding Children'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.
- 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.

**Areas for improvement 2015 /2016**

Increase GP and frontline staff awareness of CDOP and explore ways of improving the dissemination of lessons learned from child death reviews.