Central Bedfordshire Safeguarding Children Board

Bedford Borough, Central Bedfordshire and Luton Child Death Overview Process Annual Report April 2013-March 2014

CDOP Annual Report 2013-2014 Final
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Contents

1.0	**Executive Summary**	4
2.0	**Background**	8
3.0	**Central Bedfordshire Child Death Review** 3.1 Deaths reported April 2013-March 2014 3.2 Review of Central Bedfordshire Child Death Data April 2009-March 2014 3.3 Ages of children 3.4 Gender of children 3.5 Cause of death in cases reviewed and closed 3.6 Perinatal/neonatal deaths 3.7 External factors 3.8 Ethnicity of children 3.9 Modifiable factors identified 3.10 Area of residence	10
4.0	**Bedford Borough Child Death Review** 4.1 Deaths reported April 2013-March 2014 4.2 Review of Bedford Borough Child Death Data April 2009-March 2014 4.3 Ages of children 4.4 Gender of children 4.5 Cause of death in cases reviewed and closed 4.6 Perinatal/neonatal deaths 4.7 Ethnicity of children 4.8 Modifiable factors identified 4.9 Area of residence	16
5.0	**Luton Borough Child Death Review** 5.1 Deaths reported April 2013-March 2014 5.2 Review of Luton Child Death Data April 2009-March 2014 5.3 Ages of children 5.4 Gender of children 5.5 Cause of death in cases reviewed and closed 5.6 Chromosomal, genetic & congenital anomalies 5.7 Perinatal/neonatal deaths 5.8 External factors 5.9 Ethnicity of children 5.10 Modifiable factors identified 5.11 Area of residence	20
6.0	**Consanguinity: Community Consultation Luton**	25

7.0	**Child Death Overview Panel meetings**	27
8.0	**CDOP Training Sessions**	28
9.0	**Key Actions taken**	29
10.0	**Plans for 2014-2015 (Taken from Work Plan)**	30

1.0 Executive Summary

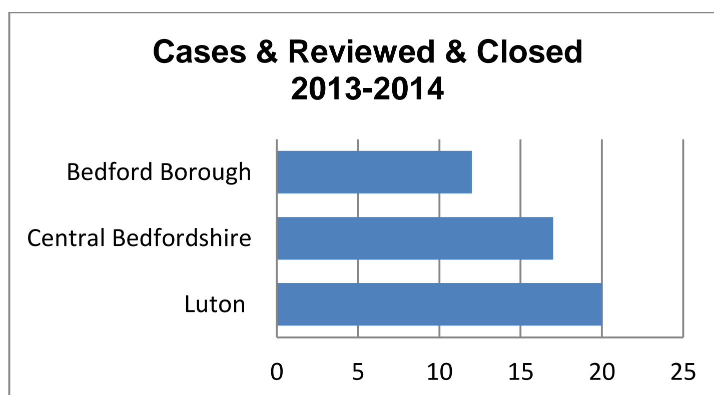
1.1 Since April 2008 Local Safeguarding Boards (LSCB's) have had a statutory responsibility to review all deaths of children resident in their area. In Bedfordshire the LSCBs of Luton, Central Bedfordshire and Bedford Borough form a single Child Death Overview Panel. Operational policies and terms of 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 Bedfordshire and Luton Child Death Overview process during 2013-2014

The CDOP manager's post is hosted by Bedfordshire Clinical Commissioning Group (BCCG) and this post is line managed by the Designated Nurse for Safeguarding Children & Young People.

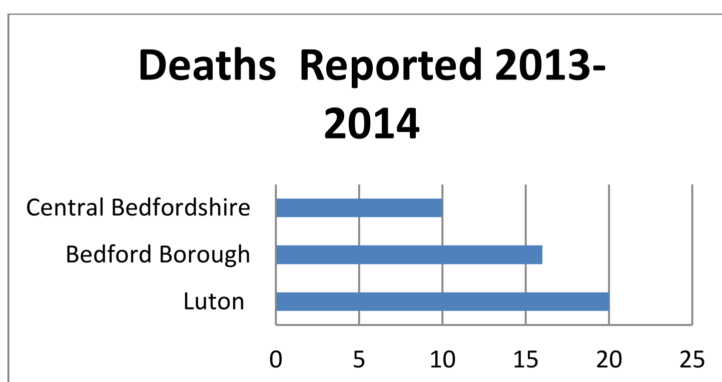
1.2 This is the 6th Annual Report of the Bedford Borough, Central Bedfordshire and Luton Child Death Overview Panel (CDOP). It gives a summary of the deaths reported to the panel during 2013-2014 and analysis of the data and emerging themes for 2009-2014.

1.3 During 2013-2014 the panel met on 8 occasions and completed full reviews on 49 children residing in Bedford Borough, Central Bedfordshire and Luton. These cases were from 2011-2012, 2012-2013 and 2013-2014. There can be a delay to reviewing cases as CDOP is not able to fully review a death until all information is gathered and other processes have been completed such as post mortem reports and coronial inquests.



1.4. 46 children died across Bedfordshire and Luton between 1st April 2013 and 31st March 2014. This is was a significant reduction of 30% compared to 2012-2013. The most significant reduction is in the number of deaths reported in the 0-28 day age range where

there has been a 50% reduction in the number of deaths. However although numbers are small, there has been an increase of 15% in the deaths in the 10-17 year age range.



39% (18/46) of the deaths were unexpected. 50% (23/46) of the children died at local hospitals, 37% (17/46) of the children died outside of Bedfordshire at tertiary centres where these children were receiving specialist care. 11% (5/46) children died either at home or in a hospice

1.5 61% (28/46) of the deaths were in children less than 1 year of age, with 10% of these deaths recorded as Sudden Unexpected Deaths in Infancy

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

A modifiable factor is defined as one which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions could be modified to reduce the risk of future child deaths Working Together to Safeguard Children DfE (2013)

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

Table 1 Deaths reported 2009/10-2013/14

LSCB Area	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	Total by Local Authority
Luton	44	33	22	31	20	150
Central Bedfordshire	16	14	17	24	10	81
Bedford Borough	12	16	19	11	16	74
Total	72	63	58	66	46	305

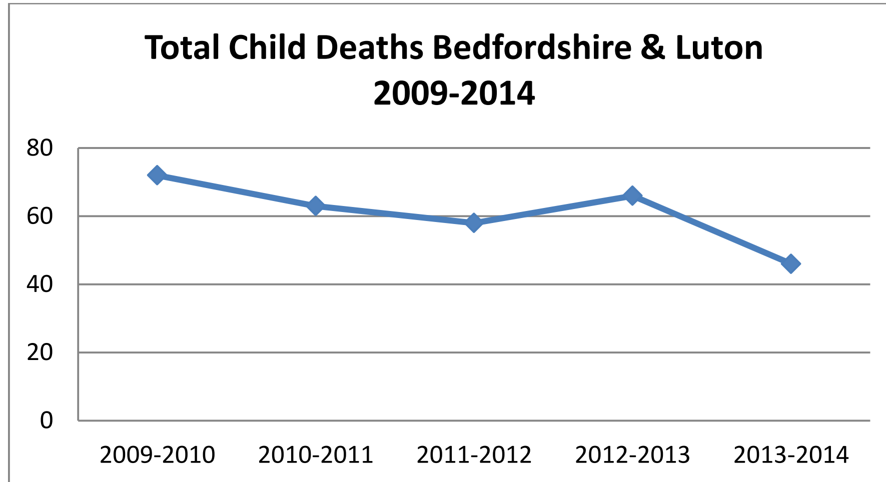


Table 2

Infant Mortality Rates (IMR)

IMR is defined as the number of deaths of children less than one year of age per 1000 live births.

Local Authority	Infant Mortality Rate (CHIMAT 2010-2012)	England Average (CHIMAT 2010-2012)
Bedford Borough	5.9/1000	4.3/1000
Central Bedfordshire	3.4/1000	4.3/1000
Luton	5.4/1000	4.3/1000

The IMR for Central Bedfordshire increased slightly in the period 2010-2012 from the previous figure of 2.5/1000 live births, but remains below the national average whilst the figure for Luton has decreased from the previous figure of 7.2/1000 live births. The IMR for Bedford and Luton remain above the national average.

Table 3

Child Mortality Rates (0-17yrs)

The child mortality rate is rate of deaths per 100,000 children aged 1-17yrs (CHIMAT 2010-2012)

Local Authority	Child Mortality Rate (CHIMAT 2010-2012)	England Average (CHIMAT 2010-2012)
Bedford Borough	8.8/100000	12.5/100000
Central Bedfordshire	10.3/100000	12.5/100000
Luton	19.4/100000	12.5/10000

The Child Mortality rates have fallen across all 3 areas since the previous data published by CHIMAT 2009-2011 most significantly in Bedford Borough. Luton's rate remains above the national average.

1.8 Serious Case Reviews

3 cases have been referred to the Local Safeguarding Children Boards for consideration as Serious Case Reviews. 2 are nearing completion and the third review is to be start in the near future.

2.0 Background

2.1 Child Death Overview Panels (CDOP) were established in April 2008 as a new statutory requirement as set out in Chapter 5 of 'Working Together to Safeguard Children' (2013). The primary function (as required by the Local Safeguarding Boards Regulations 2006) is to undertake a comprehensive and multiagency review of all deaths of children normally resident in Bedford Borough, Central Bedfordshire and Luton aged 0-18 years of age, in order to understand better how and why they die and to use the findings to take action to prevent other deaths and to improve the health, wellbeing and safety of children and young people.

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

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

2.2 The Principles

The principles underlying the overview of all child deaths are:

1. Every child's death is a tragedy
2. Learning lessons
3. Joint agency working
4. Positive action to safeguard and promote the welfare of children

2.3 The Process

Child deaths are reviewed through two interrelated processes; a paper based review of all deaths of children under the age of 18 years and a rapid response service which looks in greater detail at the deaths of children who die unexpectedly. During 2013-2014, the CDOP panel met on eight occasions to review anonymised information about child deaths. The

panel is chaired by the Director of Public Health for Luton and has members from all relevant agencies.

2.4 The National Picture

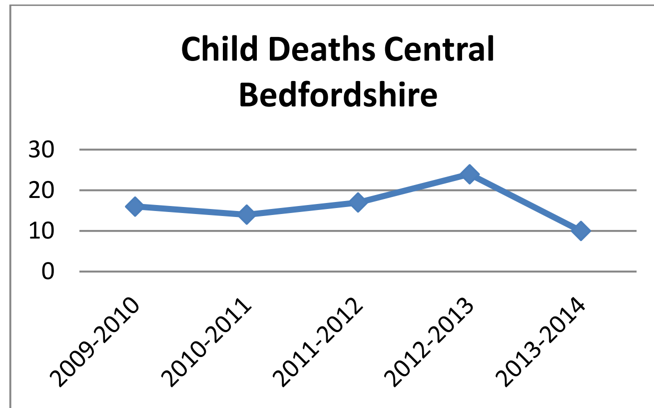
Nationally the number of child death reviews completed has remained relatively stable over the past 3 years, as has the proportion of deaths where modifiable factors were identified. The main causes of death nationally continue to be neonatal or perinatal events and chromosomal, genetic and congenital anomalies. This reflects the fact that nearly two thirds of deaths nationally were children who were aged less than 1 year. Factors present in the deaths reviewed have been collected nationally for the first time, these show that issues such as co-sleeping, smoking in the household and poor parenting/supervision contribute to a number of child deaths. (DfE July 2013)

Locally the number of deaths in Central Bedfordshire, Bedford Borough and Luton is similar to the national picture where just over two thirds of the deaths are in children under 1 year of age and similarly the main cause of death is associated with neonatal/perinatal events of deaths due to chromosomal, genetic or congenital anomalies. Modifiable factors identified are similar to the national picture with unsafe sleeping and smoking identified. Additional features are raised maternal body mass index and consanguinity.

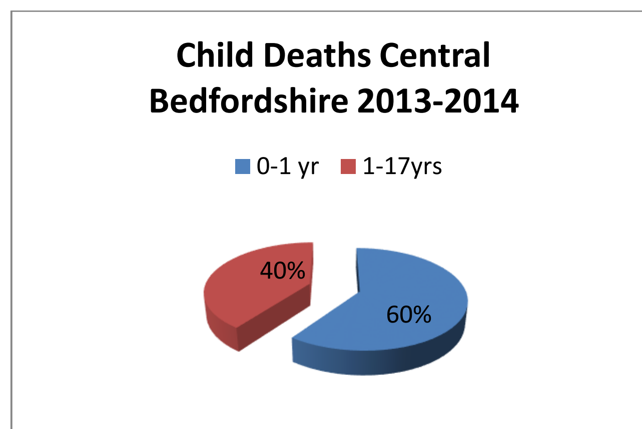
3.0 Central Bedfordshire Child Death Review

3.1 Deaths Reported 1st April 2013-31st March 2014

During the period 1st April 2013 to 31st March 2014 a total of 10 child deaths occurred amongst children residing in Central Bedfordshire. This is a reduction of 58% on the previous year, when there had been a higher than average number of deaths.



As detailed in the graph below, 60% of the deaths occurred in the first year of life. Of the deaths reported 50% (5/10) were unexpected deaths i.e. the death was not anticipated in the 24 hours before the child died.



3.2 Review of Central Bedfordshire Child Death Data

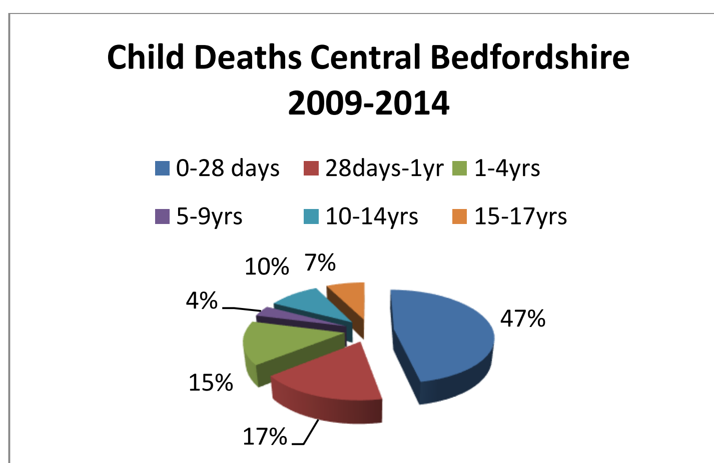
April 2009- March 2014

Number of Child Deaths

In the period 1st April 2009 to 31st March 2014 a total of 81 child deaths were reported in Central Bedfordshire. 92% of these cases have been reviewed and closed.

3.3 Ages of Children

64% were aged less than 1 year. This similar to the national average of 66% for the total number of deaths reviewed in England during the year 2012-2013.



3.4 Gender of Children

58% male

42% female

This is the same as the figure for England 2012-2013 for deaths reviewed in this time period.

3.5 Cause of Death in cases reviewed and closed 2009-2014

When reviewing cases CDOP panels are required to categorise the death into categories and identify any modifiable factors. Table 4 sets number of cases reviewed and closed during the period 2009-2014 and the percentage of cases for which modifiable factors were identified. The data in the third column is taken from the Statistical Release published by the Department for Education (DfE) in July 2013. This table gives a comparison between local data on modifiable factors as compared to national data. As some of the numbers are small caution should be taken with comparisons. However, the rate of modifiable factors appears higher in Central Bedfordshire for perinatal/neonatal events.

Table 4

Causes of death

	Cases reviewed & closed	**Modifiable Factors Identified**	**National data with modifiable factors (2012-2013)**
Trauma & other external factors	8% (7)	33%	58%
Malignancy	5.3% (4)	0%	
Acute medical or surgical condition	8% (7)	50%	29%
Chromosomal, genetic & congenital anomalies	21.3% (17)	6.3%	7%
Perinatal/neonatal event	41.3% (33)	41.9%	15%
Sudden unexpected, unexplained death	6.6% (5)	100%	63%
Other	9.5% (8)		

3.6 Perinatal/Neonatal deaths

These are defined as deaths ultimately related to perinatal events, e.g. such as bleeds within the brain, difficulties with lung function due to immature lungs and problems with the gastrointestinal tract due to prematurity.

Some of the deaths reported are babies delivered at a pre viable gestation (before 24 weeks gestation) but had a heart rate present at birth and therefore were registered as live births. Some of these gestations are as early as 20 weeks. Modifiable factors were identified in over 40% of these neonatal deaths primarily maternal smoking and raised body mass index

A data set of information on the mother's antenatal history is requested from the midwives to determine if there are any wider health determinates of the mother that may have pre disposed to the pre-term /pre viable delivery.

3.7 External Factors

Some of the deaths were as a result of trauma and external factors. This will include isolated head injury, trauma, burn injury drowning and other extrinsic factors and for the purpose of this analysis death by probable /definite homicide has been included.

8% of the deaths reviewed were due to this classification. 57% of these deaths were in children under 5 years of age. No common factor was identified.

3.8 Ethnicity of Children

90% of the children who died were White British which is in line with the Census 2011 that showed that in Central Bedfordshire 88.1% of the child population are White British.

3.9 Modifiable factors identified

As part of the review of child deaths the Child Death Overview Panel must determine if there were any modifiable factors identified. These are factors, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.

In total 93% of the child death cases reported in Central Bedfordshire during the 5 year period, 2009-2014, have been reviewed and closed. Of these modifiable factors were identified in one third of the cases.
Factors include:

- Unsafe sleeping arrangements for babies
- Smoking in pregnancy
- Raised maternal BMI
- Clinical care

CDOP ensure through awareness raising that midwives are aware of the modifiable factors and are 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 are in place.

In some of the cases where clinical care has been identified as a modifiable factors these issues have been identified by the care provider who has reported the event as a Serious Incident to the Primary Care Trust (PCT) or from April 2013 to the relevant Clinical Commissioning Group (CCG). CDOP has liaised with the PCT/CCG to ensure a copy of the report and action plan has been made available for review and discussion at panel meetings. On occasions the author of the report has been invited to attend the panel meeting to give an overview and report on actions taken. CDOP will also approach the CCG for an update on the monitoring of the action plan.

There have been a number of occasions were the care provider has been asked to review an issue and this has also been flagged with the CCG to ensure any actions can be taken forward and reviewed at through quality monitoring arrangements.

3.10 Area of residence

Table 6 shows the number of deaths per ward and the index of deprivation for the ward

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

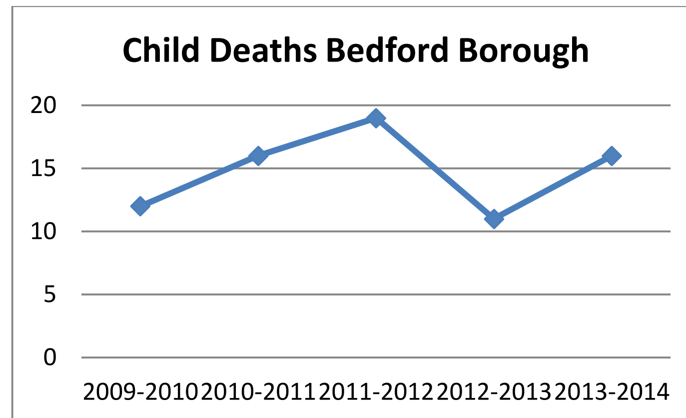
Table 6 Area of residence

Wards with highest number of deaths		Index of Deprivation
Leighton Buzzard North	8.6% (7)	13.7
Leighton Buzzard South	7.4% (6)	9.6
Houghton Hall	7.4% (6)	20.1
Sandy	7.4% (6)	14.2
Dunstable Manshead	6.1% (5)	24.6
Dunstable Northfields	4.9% (4)	22.5
Flitwick	4.9% (4)	7.1
Cranfield & Marston	4.9% (4)	5.8
Biggleswade South	4.9% (4)	10.5
Parkside	4.9% (4)	26.3
Shefford	4.9% (4)	7.5

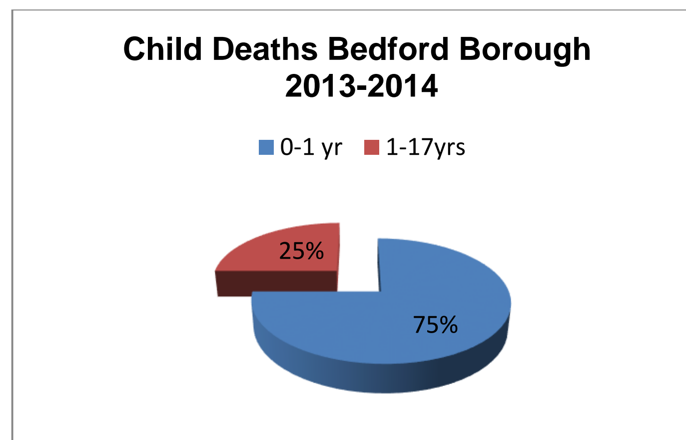
4.0 Bedford Borough Child Death Review

4.1 Deaths Reported

During the period 1st April 2013 to 31st March 2014 a total of 16 child deaths occurred amongst children residing in Bedford Borough. This is an increase of 5 deaths on the previous reporting year (2012-2013) and is comparable to the average number of deaths reported in the previous 5 years of approximately 14 deaths per year. The majority of deaths were in the first year of life.



27% (4) of the deaths reported were unexpected deaths i.e. the death was not anticipated in the 24 hours before the child died.



4.2 Bedford Borough Review of Data April 2009- March 2014

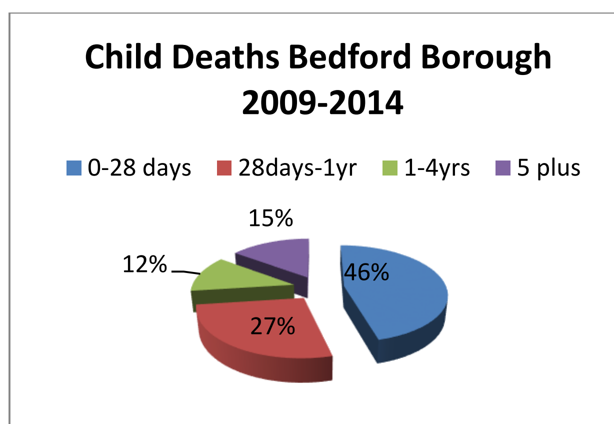
Number of Child Deaths

In the period 1st April 2009 to 31st March 2014 a total of 74 child deaths were reported in Bedford Borough.

When reviewing cases CDOP panels are required to categorise the death into categories and identify any modifiable factors.

4.3 Ages of Children

73% of deaths were in children under 1 year of age with 46% being under 28 days. This figure is slightly above the national average of 66% for the total number of deaths reviewed in England during the year 2012-2013.



4.4 Gender of Children

57% male

43% female

This is similar for the figure for England for deaths reviewed in 2011-2012

4.5 Cause of Death in cases reviewed and closed 2009-2014

Table 7 gives a comparison between local data on modifiable factors as compared to national data. However as some of the numbers are small caution should be taken with comparisons, but the largest number of deaths were recorded in the neonatal period.

Table 7 Modifiable Factors

	Cases reviewed & closed	Modifiable factors identified	National data with modifiable factors (2012-2013)
Malignancy	12.5% (9)	12.5%	Not published
Chromosomal, genetic & congenital anomalies	23% (17)	7%	7%
Perinatal/neonatal event	40% (30)	27%	15%
Infection	9% (7)	0	26%
Sudden unexpected, unexplained death	4.6% (3)	100%	63%
Other	10.9% (8)		

4.6 Perinatal/Neonatal deaths

These are defined as deaths ultimately related to perinatal events, e.g. such as bleeds within the brain, difficulties with lung function due to immature lungs and problems with the gastrointestinal tract due to prematurity.

Some of the deaths reported are babies delivered at a pre viable gestation (before 24 weeks gestation) but had a heart rate present at birth and therefore were registered as live births. Some of these gestations are as early as 20 weeks.

A data set of information on the mother's antenatal history is requested from the midwives to determine if there are any wider health determinates of the mother that may have pre disposed to the pre-term /pre viable delivery. Modifiable factors identified include maternal smoking and raised body mass index.

4.7 Ethnicity of Children

Table 8 shows that there appears to be an over-representation of child deaths among the Pakistani, White Other and Black African populations of Bedford Borough compared to the resident population and an under-representation of White British.

Table 8 Ethnicity of Children

Ethnicity	% died in BBC	% child population in BBC 2013
White British	49%	64.2%
White Other	12%	6.8%

Indian	9%	5.5%
Pakistani	12%	3.2%
Bangladeshi	4%	3.8%
Black African	8%	2.4%
Black Caribbean	4%	1.4%

Census 2011

4.8 Modifiable factors identified

As part of the review of child deaths the Child Death Overview Panel must determine if there were any modifiable factors identified. These are factors, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.

In total 86% of the child death cases reported during this 5 year period have been reviewed and closed. Of these modifiable factors were identified in 21% of the cases.

Factors include:

- Unsafe sleeping arrangements for babies
- Smoking
- Raised BMI
- Clinical care

CDOP are working with Public Health to ensure there are pathways in place to promote healthier lifestyle choice for pregnant women. Women with a raised BMI are offered access to information and support for weight management in pregnancy and for pregnant women who smoke access to stop smoking services and campaigns to raise awareness of the risk of smoking in pregnancy.

In some of the cases where clinical care has been identified as a modifiable factors these issues have been identified by the care provider who has reported the event as a Serious Incident to the Primary Care Trust (PCT) or from April 2013 to the relevant Clinical Commissioning Group (CCG). CDOP has liaised with the PCT/CCG to ensure a copy of the report and action plan has been made available for review and discussion at panel meetings. On occasions the author of the report has been invited to attend the panel meeting to give an overview and report on actions taken. CDOP will also approach the CCG for an update on the monitoring of the action plan.

There have been a number of occasions were the care provider has been asked to review an issue and this has also been flagged with the CCG to ensure any actions can be taken forward and reviewed at through quality monitoring arrangements.

4.9 Area of Residence

Table 8 shows the number of deaths per ward and the index of deprivation for the ward.

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

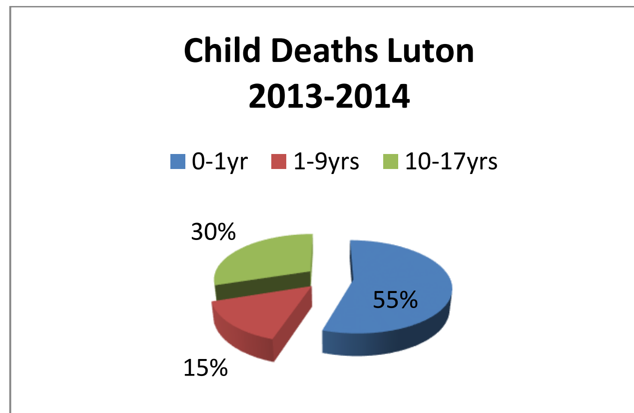
Table 9 Area of residence

Wards with highest number of deaths		Index of Deprivation
Queens Park	19% (14)	27.2
Harpur	9.5% (7)	26.3
Putnoe	8% (6)	10.0
Kingsbrook	8% (6)	30.3
Castle	7% (5)	26.6
Cauldwell	7% (5)	31.2

5.0 Luton Borough Child Death Review

5.1 Deaths Reported

During the period 1st April 2013 to 31st March 2014 a total of 20 child deaths occurred in children residing in Luton. This is a decrease of 35% from the previous reporting year.

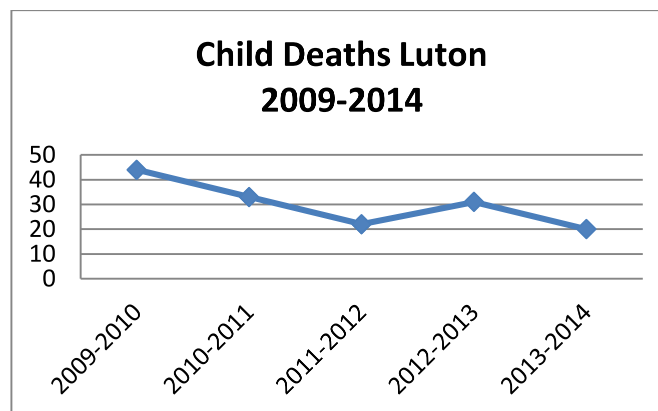


45% (9) of the deaths reported were unexpected deaths i.e. the death was not anticipated in the 24 hours before the child died. There was no common factor identified in these deaths.

5.2 Luton Borough Review of Data April 2009- March 2014

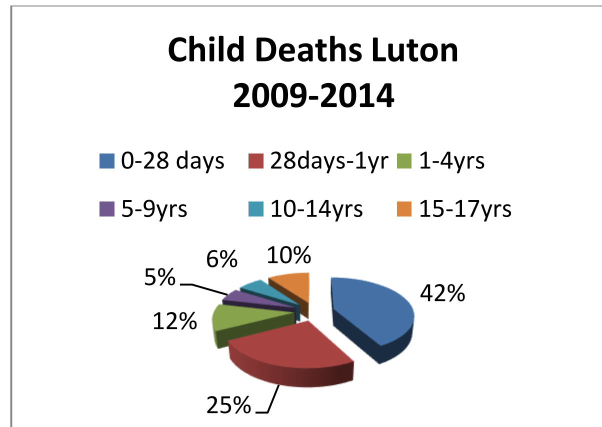
Number of Child Deaths

In the period April 2009 to March 2014 a total of 150 child deaths were reported in Luton



5.3 Ages of Children

67% of deaths were in children under 1 year of age, the largest proportion, 42%, being under 28 days. This similar to the national average of 66% for the total number of deaths reviewed in England during the year 2012-2013



5.4 Gender of Children

60% male

40% female

A review of deaths was carried out to identify an explanation for the over-representation of boys. It was agreed by CDOP that all boy deaths in Luton would be reviewed to identify any common themes associated with these deaths. The review of these cases did not highlight any specific explanation for this higher rate of boy deaths or any new action required by CDOP.

5.5 Cause of death in cases reviewed and closed

As part of the review of child deaths the Child Death Overview Panel must determine if there were any modifiable factors identified. These are factors, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.

In total 91% of the child death cases reported during this 5 year period have been reviewed and closed. Of these, modifiable factors were identified in 51% of the cases. This is shown in Table 10

Table 10 Modifiable Factors

	Cases reviewed & closed	Modifiable factors identified	National data with modifiable factors (2012-2013)
Malignancy	3%	0	Not published
Acute medical/surgical condition	7%	33%	29%
Chronic medical condition	7%	40%	16%
Chromosomal, genetic & congenital anomalies	36%	64%	7%
Perinatal/neonatal event	28%	33%	15%
Infection	6%	37.5%	26%
Sudden unexpected, unexplained death	9.5%	92%	63%

5.6 Chromosomal, genetic & congenital anomalies

It has been noted from the review of deaths and previous annual reports that hereditary conditions and associated genetic anomalies have a significant impact on child deaths, especially infant deaths in Luton. A significant contributory factor identified though CDOP may be due to the high incidence of consanguineous marriages predominantly within the South Asian community in Luton. This would account for the higher rate of modifiable factors for chromosomal, genetic & congenital anomalies in Luton. There are different opinions amongst CDOPs and not all consider and record these deaths as modifiable.

5.7 Perinatal/Neonatal deaths

These are defined as deaths ultimately related to perinatal events, e.g. such as bleeds within the brain, difficulties with lung function due to immature lungs and problems with the gastrointestinal tract due to prematurity.

Some of the deaths reported are babies delivered at a pre viable gestation (before 24 weeks gestation) but had a heart rate present at birth and therefore were registered as live births. Some of these gestations are as early as 20 weeks. Modifiable factors identified include maternal smoking and raised body mass index.

A data set of information on the mother's antenatal history is requested from the midwives to determine if there are any wider health determinates of the mother that may have pre disposed to the pre-term /pre viable delivery.

5.8 External Factors

Some of the deaths were as a result of trauma and external factors. This will include isolated head injury, trauma, burn injury drowning and other extrinsic factors and for the purpose of this analysis death by probable /definite homicide has been included.
3% of the deaths reviewed were due to this classification with the age range across the whole spectrum
No common factors were identified

5.9 Ethnicity of Children

Table 11 shows that there is an over-representation of deaths in the Pakistani community in Luton compared to the resident population.

Table 11 Ethnicity of Children

Ethnicity	% died Luton	% child population in Luton 2013
White British	26%	32.5%
White Other	4%	6.2%
Pakistani	44%	22%
Bangladeshi	6.7%	10.4%
Black African	7.3%	5.7%
Black Caribbean	4%	3.3%
Mixed	8%	9.3%

5.10 Modifiable factors identified

As part of the review of child deaths the Child Death Overview Panel must determine if there were any modifiable factors identified. These are factors, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.
In total 91% of the child death cases reported during this 5 year period have been reviewed and closed. Of these modifiable factors were identified in 51% of the cases

Factors include

- Consanguinity
- Unsafe sleeping arrangements for babies
- Smoking
- Raised BMI
- Clinical care

CDOP ensure Public Health are aware of the modifiable factors so that appropriate action can be taken to reduce risk. Needs info on what we are doing

In some of the cases where clinical care has been identified as a modifiable factors these issues have been identified by the care provider who has reported the event as a Serious Incident to the Primary Care Trust (PCT) or from April 2013 to the relevant Clinical Commissioning Group (CCG). CDOP has liaised with the PCT/CCG to ensure a copy of the report and action plan has been made available for review and discussion at panel meetings. On occasions the author of the report has been invited to attend the panel meeting to give an overview and report on actions taken. CDOP will also approach the CCG for an update on the monitoring of the action plan.
There have been a number of occasions were the care provider has been asked to review an issue and this has also been flagged with the CCG to ensure any actions can be taken forward and reviewed at through quality monitoring arrangements.

5.11 Area of Residence

Table 12 shows the number of deaths per ward and the index of deprivation for the ward
The Indices of Deprivation 2010 provide a relative measure of deprivation in small areas across England. The Indices of Deprivation 2010 is based on the concept that deprivation consists of more than just poverty. Poverty is not having enough money to get by on where as deprivation refers to a general lack of resources and opportunities. The domains used in the Index of Multiple Deprivation 2010 are income, employment, health, education, crime, access to services and living environment. An area has a higher deprivation score than another one if the proportion of people living there who are classed as deprived is higher. An area itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score. (Communities & Local Government: English Indices of Deprivation 2010)

Table 12 Area of Residence

Wards with highest number of deaths		Index of Deprivation
Dallow	13% (19)	38.1
Saints	11% (16)	25.7
South	10% (15)	35.2
Biscot	8% (12)	37.1
Farley	7% (11)	32.9
Leagrave	7% (11)	27.6
Lewsey	7% (11)	27.2
Northwell	7% (11)	38.1

6.0 Consanguinity: Community Consultation: Luton

In 2013 working with the University of Bedfordshire, LBC Public Health commissioned a community engagement exercise to explore Pakistani/Kashmiri and Bangladeshi views on consanguinity and access to universal and specialist services to inform the Luton Infant Mortality Plan particularly actions related to genetic risk.

Through a series of focus groups specifically targeting the Luton South Asian community which CDOP evidence shows to be the community group at risk of auto-recessive conditions the aims were to:

- Explore awareness of consanguinity (hereditary) risk and views on and types of intervention (s) needed related to genetic risk
- Examine barriers and facilitators towards accessing generic/specialist health services in Luton;
- Identify how access to generic/specialist services can be improved in Luton.

Twelve focus groups were planned with members of the Pakistani/Kashmiri and Bangladeshi communities. This approach was considered as the most appropriate for an engagement study of this type to allow access to a range of opinions and experiences relatively quickly, generate detailed descriptive information to understand of opinions, attitudes and beliefs. The focus groups were delivered in the groups preferred language and English.

Participants were voluntary and recruited by the university, and the groups had a mix across age bands to ensure a balance of opinion is obtained by including participants who are in cousin unions and those that are not. Separate groups were organised for men and women

to increase the likelihood of full and open group discussion. Dividing the focus groups by age and gender also allowed investigation of any generational and gender differences.

The final report will be available in June 2014 following which the IM action plan for Luton will be reviewed

7.0 Child Death Overview Panel Meetings

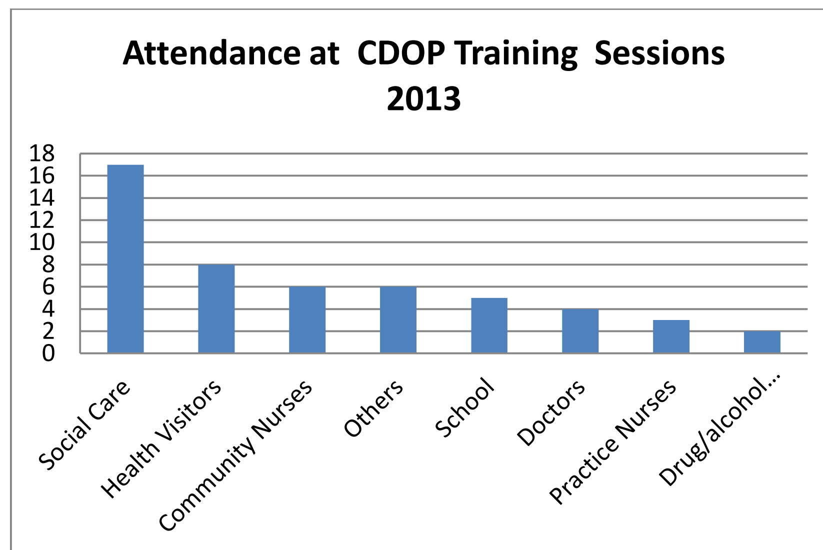
Eight panel meetings were held in the period 2013-2014. Meetings are held every 6 weeks and the duration of meetings is between three and four hours. All meetings were quorate and an average of 10 panel members attended each meeting.

On occasions guests are invited to discuss particular cases and the Coroners Officer has been in attendance for some of the meetings held during this period.

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

8.0 CDOP Training Sessions

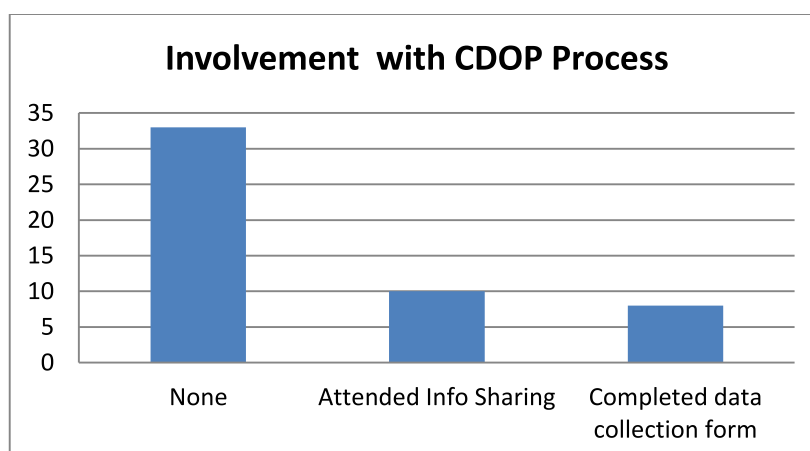
A total of 6 CDOP training sessions were held across Bedford Borough, Central Bedfordshire and Luton during 2013-2014 for all professionals who work with children and young people with a total of 51 delegates attending.



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 2014-2015 and all staff groups will be invited to attend.

This was followed by showing excerpts of DfE DVD entitled 'Why Jason Died'. This DVD reflects the multi-agency response to an unexpected death and builds on the presentation to reinforce the processes and procedures that must be undertaken when a child dies unexpectedly. It proved to be a useful basis for discussion about vulnerabilities and modifiable factors.



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

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

There was a similar response to the questions relating the content and length of the session.

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

- *Have more knowledge about process & services required to support bereaved families*
- *Will reinforces message regarding safe sleeping when parents bring children for their immunisations*
- *Will make me emphasise bed sharing/co sleeping messages and make me more aware of discussing safety with families*
- *Valuable to have training led by 3 people rather than 1*
- *Helpful to have insight into process when a child dies*
- *Found it very interesting will enable me to inform colleagues about CDOP process*
- *The importance of giving correct information to prevent the death of a baby*
- *Very interesting statistics*
- *Will cascade information to colleagues*
- *Assists with ongoing advice for families*
- *Found DVD very helpful*
- *Reinforce safe sleeping habits & health guidance*
- *Better understanding of CDOP process*
- *Greater awareness & understanding of reviews*
- *Insight into information required if requested to attend an information sharing meeting*
- *Reminder for practice- safe sleeping & emerging themes*
- *Understanding of process & will be able to give advice to families re sleeping arrangements*
- *Better prepared for future cases*

9.0 Key Actions Taken 2013-2014

- When concerns relating to practice issues have been identified by either single or multi agencies during the review of cases, CDOP have requested that these issues are investigated either through the Serious Incident process within the organisation or via a Local Safeguarding Children Board case review. Lessons learned and actions taken are fed back to the panel.
- CDOP Terms of Reference and working practices updated following publication of the updated Working Together to Safeguard Children 2013
- Leaflet developed for parents where their child's death is expected. This is sent to parents with a covering letter about one month after the death
- Public Health worked with Environmental Health to develop materials for schools for Drowning Prevention week in June 2014
- CDOP has a comprehensive work plan which demonstrates achievements and has been refreshed for 2014-2015. The action plan will be owned by CDOP panel members on behalf of their organisation and will be monitored and updated on a quarterly basis. It will be shared with the 3 LSCB's

10.0 Plans for 2014-2015 (Taken from Work Plan)

- Continue to raise awareness and dissemination of lessons learned from the Child Death Overview Process through training sessions and newsletters
- Ensure information on CDOP is contemporary and available on LSCB websites
- Continue to ensure that CDOP receive feedback that consistent messages on safe sleeping are given to parents by midwives and health visitors
- Audit work on SUDI's to include safe sleeping messages
- Work with Public Health to understand measures in place to reduce smoking in pregnancy strategies
- Receive information from Public Health concerning availability of weight management programmes for women with a raised BMI
- Audit themes from clinical care modifiable factors identified in cases reviewed and closed in 2013-2014