Bedford Borough, Central Bedfordshire and Luton Child Death Overview Process Panel Annual Report 1 April 2018 – 31 March 2019

Contents

Executive Summary

Since April 2008 Local Safeguarding Boards (LSCBs) have had a statutory responsibility to review deaths of all children resident in their area. As recommended in the new guidance from 'Working Together' 2018, child death review partners will continue to comprise of both Local Authorities and Clinical Commissioning Groups (CCGs) locally. In Bedfordshire and Luton a single Child Death Overview Panel will remain. Operational policies and terms of reference have been written in readiness for the changes which commence from September 2019. The new arrangements will be available to view on the safeguarding partner websites (formerly LSCBs) in Luton, Central Bedfordshire and Bedford Borough.

The aim of this report is to summarise the work of the Bedford Borough, Central Bedfordshire and Luton Child Death Overview process during 2018-2019.

This is the 11th 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 2018-2019 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 2018 to 31st March 2019 the Panel met on 7 occasions and completed full reviews on 37 children residing in Bedford Borough, Central Bedfordshire and Luton. These cases included deaths from 2015-2019 as there can be a delay in reviewing cases due to other processes such as coronial inquests, criminal investigations and toxicology reports.

During the period April 2018 until March 2019 there were 71 deaths reported across Bedfordshire. This was made up of 21 in Bedford Borough; 30 in Luton and 20 in Central Bedfordshire. There was a notable increase (24.5%) in the number of deaths from 57 in 2017/18; over 50% of the 71 deaths this year occurred in the neonatal period, with a significant number related to extreme prematurity.

Unexpected deaths accounted for 22% of the total deaths reported in 2018-19, which is similar to the previous year where 21% of the deaths were unexpected. Of these unexpected deaths, 62% of the total reported deaths were of children less than 1 year of age, with an even divide between male and females. Of the total reported deaths, 54% were female and 46% were male; this is contrary to national and prior local data, whereby there are usually more male than female deaths.

During 2018-19 Bedfordshire CDOP reviewed and closed 37 cases at Panel meetings. Modifiable factors were identified in 32% of these cases; this is lower than last year where modifiable factors were found in 39% of cases heard at Panel. Similarly to previous years, the modifiable factors identified included service provision, consanguinity

and maternal BMI. Service provision featured as a modifiable factor in 19% of all cases reviewed and BMI in 11. Due to the small numbers it is not possible to comment on the localities where modifiable factors were identified.

Changes to CDOP and National Data Collection

In line with national changes to CDOP, a large piece of work was undertaken in March 2019, as part of the NHS Digital data collection. Data relating to child deaths and cases heard at CDOP panel in Bedfordshire over the last 4 years was shared in the anticipation that trends and themes can be identified locally and nationally. Due to some errors in the collection data nationally, there has been a delay in publishing statistics so the information has not yet been updated since March 2017.

Key Areas of Note from 2018-19:

- The number of deaths has varied over the last five years. There was an increase in the number of deaths across Bedfordshire and Luton in 2018-19.
- The CDOP have reviewed and closed 56% fewer cases this year than in the previous year. There are a number of contributing factors including CDOP Manager vacancy between substantive post holder leaving and interim commencing; time for interim to establish systems and embed in role; notable increase in child deaths in the time period, with associated increase in workload data collecting; establishing new statutory processes and national data systems.
- Bedfordshire and Luton CDOP had a decrease in the number of modifiable factors being identified (32%) compared to 39% last year (57% in 2016-17) bringing us closer to the national percentage of 27%.
- Whilst pursuing data collection returns and deaths with known modifiable factors can delay cases coming to Panel, Bedfordshire CDOP continue to strive hard to present cases to panel in a timely way. This year demonstrates a slight decrease (67%) of cases completed within 12 months of the child's death compared to the previous year of 71%, which was much closer to the national percentage of 76%.
- A high proportion (43%) of cases closed at Panel were reviewed within 6 months of the child's death; this is notably higher than in each of the previous 2 years when only 24% of cases closed in this time period, and is above the national average (32%).
- Chromosomal, Genetic and Congenital anomalies (Category 7) made up 32% of the reviewed cases. This is an increase on the previous 2 years where 30% of cases in 2017-18 and 24% of cases in 2016-17 closed under this category. This is also higher than the national average of 25%.
- The number of deaths closed under the category of Perinatal/Neonatal events (Category 8) decreased slightly this year to 30%, compared to 32% in 2017-18, although higher than the 2016-17 figure of 26%. The national average is similar at 34%

- The third highest category for child deaths reviewed this year is Acute, Medical or Surgical conditions (Category 5) which accounted for 16% of closed cases. This is higher than the percentage of national cases which is 6%.
- In Central Bedfordshire there were 20 deaths; an increase of 3 deaths this year as in the previous year. There was also significant decrease in unexpected deaths at 10% compared to 18% in 2017-18 and 36% in 2016-17. Ward level data depicts a varied spread, although more deaths were reported in Dunstable localities.
- In Bedford Borough there were 21 deaths; this is an increase of 6 deaths from 2017-18 and 9 from 2016-17. 43% of these deaths were unexpected, a slight increase from 2017-18 when 40% were unexpected and significant increase from 2016-17 (25%). Ward level data depicts a varied spread, although Queens Park and Wilshamstead account for 43% of the deaths.
- In Luton there were 30 deaths; this is an increase of 5 deaths on the previous year and 2 from 2016-17. The proportion of unexpected deaths has varied in recent years, 23% in 2018/19 compared to 12% in 2017-18, and 32% in 2016-17. Ward level data depicts a varied spread, with Round Green and Saints having the greatest number of deaths.
- Whilst it would be helpful to have a breakdown of deaths in ward areas and linked to Indices of Multiple Deprivation, numbers are too low in this period to breakdown to this extent.
- Maternal obesity remains a significant modifiable factor and the delivery of the maternal weight management programmes through maternity services remains a priority.
- The proportion of deaths with consanguinity as a modifiable factor decreased, however this remains a priority.

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*
- From 2019 to commence inputting of data from outstanding CDOP cases into the National Child Mortality Database (NCMD) to provide more accurate reporting of local/national trends and data
- 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.

** To be known as 'safeguarding partners' in response to the aforementioned arrangements in paragraph 1 of the Executive summary, page 3*

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. An 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'. Whilst the rapid response process and meeting is managed by the CDOP Manger currently, this will cease to happen from September 2019 when the new statutory

arrangements commence. Under the new arrangements, the local health professional declaring the death will be responsible for facilitating the meeting(s) which will be required for all child deaths (both expected and unexpected).

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 reporting by NHS Digital, 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. Whilst Bedfordshire CDOP had increased the number of cases reviewed in 2016-17 and 2017-18, there has been a decline of 56% in number of reviews in this reported period to March 2019.
- **27%** of child death reviews identified modifiable factors, an increase from 24% last year and an increase of 6% over the last 5 years. Bedfordshire CDOP identified a higher percentage of modifiable factors (32%) in 2018-19, although this is a reduction from previous year (32%). Further detail can be found in the Modifiable Factors section of this report.
- **43%** of deaths reviewed were due to a perinatal/neonatal event; this is broadly consistent with previous years. In Bedfordshire and Luton the proportion was lower, with 30% of cases reviewed being closed under this category in both 2017-18 and 2018-19.

- **64%** of deaths reviewed were for children under one year old in the year ending March 2017; this is consistent with previous years and similar to the Bedfordshire and Luton rate (62%).

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

Mortality Rates

The data for child mortality rates up to age 17 years have not been updated since 2016. However, data has been updated to 2015 - 2017 pertaining to infant mortality rates as detailed below; this is particularly relevant as over 50% of the deaths reviewed across Bedfordshire and Luton are of those under 1 year old.

Bedford Borough

	Infant mortality rates 2017 - Bedford Borough & it's CSSNBT Statistical neighbours (deaths per 1,000 live births)	**Infant mortality rates 2014 - 2016 Bedford Borough & it's CSSNBT Statistical neighbours (deaths per 1,000 live births)**
England	**3.9**	**3.9**
Bedford	**4.1**	**4.1**
Derby	6.2	6
Milton Keynes	4.5	4.4
Sheffield	4.8	5.2
Leeds	4.2	4.4
Hertfordshire	2.8	2.8
Warwickshire	4.2	4.7
Kent	3.8	3.5
Northamptonshire	4.5	4.3
Swindon	3.4	3
	Similar	
	Worse	
	Better	

Central Bedfordshire

	Infant mortality rates 2015- 2017 Central Bedfordshire & it's CSSNBT Statistical neighbours (deaths per 1,000 live births)	Infant mortality rates 2014 - 2016 Central Bedfordshire & it's CSSNBT Statistical neighbours (deaths per 1,000 live births)
England	**3.9**	**3.9**
Central Bedfordshire	**2.6**	**2.2**
Hampshire	3.5	3
Warwickshire	4.2	4.7
Essex	3.1	3.3
Leicestershire	3.7	3.9
South Gloucestershire	3.5	3.5
Worcestershire	4.1	4.9
Cheshire East	3.4	3.9
West Sussex	2.7	3.1
Bracknell Forest	2.8	1.6
West Berkshire	4.2	3.7
	Similar	
	Worse	
	Better	

Luton

	Infant mortality rates 2015-2017 Luton & it's CSSNBT Statistical neighbours (deaths per 1,000 live births)	Infant mortality rates 2014 - 2016 Luton & it's CSSNBT Statistical neighbours (deaths per 1,000 live births)
England	**3.9**	**3.9**
Luton	**5.6**	**5.4**
Birmingham	7.8	7.9
Sandwell	6.5	5.8
Slough	5.3	4.2
Bradford	5.8	5.9
Walsall	6.2	7.1
Enfield	3.2	3.2
Hillingdon	2.9	2
Derby	6.2	6
Wolverhampton	5.8	5.6
Oldham	5.9	6.2
	Similar	
	Worse	
	Better	

Refs: https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/3/gid/1938133232/pat/6/par/E12000006/ati/202/are/E10000015/iid/92196/age/2/sex/4

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsregisteredbyareaofusualresidenceenglandandwales

Reported deaths and cases reviewed

The number of deaths in each LSCB area over the past 5 years is shown in Table 1. Reflecting an overall increase in child deaths this year, each area had an increase in child deaths. Luton has seen an increase of 5; Central Bedfordshire of 3 and Bedford Borough of 6. Both Central Bedfordshire and Bedford Borough have had the highest number of deaths reported this year than in any of the previous 4 years.

Table 1: Deaths reported 2014/15 – 2018/19

LSCB Area	2014-2015	2015-2016	2016-2017	2017-2018	2018 - 2019	Total by Local Authority	Average 2014/2019
Luton	**26**	**31**	**28**	**25**	**30**	**140**	**28**
Central Bedfordshire	**13**	**16**	**14**	**17**	**20**	**80**	**16**
Bedford Borough	**12**	**13**	**12**	**15**	**21**	**73**	**14.6**
Total	**51**	**60**	**54**	**57**	**71**	**293**	**58.6**

During the period April 2018 until March 2019 there were 71 deaths reported across Bedfordshire; this is a notable increase on the previous year. It is not possible to comment on this trend in comparison to national data as figures have not been released since 2017. Unexpected deaths accounted for 22% of the total deaths reported which is similar to the previous year where 21% of the deaths were unexpected, but a notable decrease from 2016-17 where 31% were in this category.

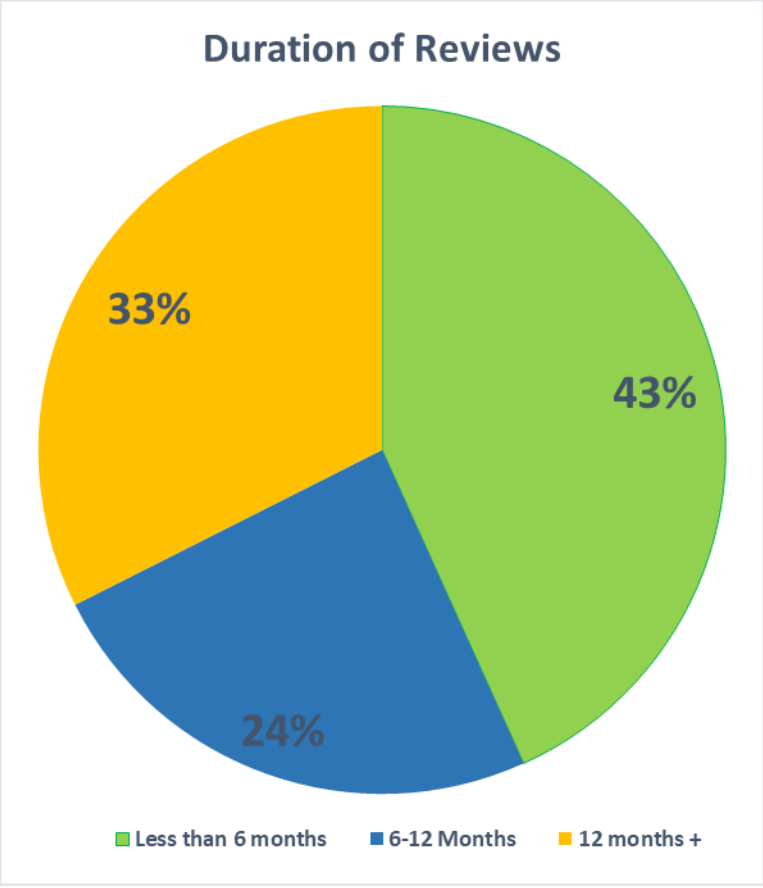
The CDOP panel met on 7 occasions during this period and completed full reviews on 37 children residing in Bedford Borough, Central Bedfordshire and Luton. This is a decrease of 56% since last year as discussed on page 4 ‘ Key areas

of note from 2018-19'. The latest national data shows that, whilst the number of child death reviews fell slightly in a year period, it was not of this magnitude. The following sections relate to reviewed deaths.

Not all of the deaths reviewed occurred in 2018-2019, 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.

67% of child deaths reviewed in 2018-19 were completed within 12 months of the child's death. This is a slight decrease from the previous year (71%) and is slightly less than 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 incident investigation, 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



Categories of reviewed and closed cases

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

Table 3 shows that the highest proportion of cases in 2018-19 were closed under the category (7) of Chromosomal, genetic and congenital. These accounted for 32% of the total reviews, which is an increase on the previous 2 years where 30% of cases in 2017-18 and 24% of cases in 2016-17 closed under this category. Of the cases closed under this category, 25% were found to have modifiable factors, predominantly maternal BMI, with consanguinity featuring less this year.

Perinatal/Neonatal events (Category 8) accounted for 30% of the reviewed cases. This is similar to previous years, slightly less than 2017-18 (32%), although higher than the 2016-17 figure of 26%. Only 18% of the cases closed under this category were found to have modifiable factors, comprising of maternal BMI and service provision.

The third highest category for child deaths reviewed in Bedfordshire this year was for Acute, Medical or Surgical conditions (Category 5) which accounted for 16% closed under this category. This is significantly higher than the percentage of National Cases which is 6%, although it is worth remembering that we are dealing with very small numbers. 17% of this category had modifiable factors identified (service provision).

Table 3: Categories with highest percentage of deaths 2018-19

Category of closed case	Percentage of Local Cases	Percentage of National Cases (2016-17)
Chromosomal, genetic and congenital anomalies (Category 7)	32% (n=12)	25%
Perinatal/Neonatal Event (Category 8)	30% (n=11)	34%
Acute, Medical or Surgical conditions (Category 5)	16% n= 6)	6%

Modifiable Factors

In 2018-2019 modifiable factors were identified in 32% of cases which is lower than the previous 2 years where 39% of cases reviewed in 2017-18 and 57% in 2016-17 had modifiable factors. However, whilst still higher than the national picture of 27%, it is more similar. Modifiable factors identified this year included consanguinity, factors relating to service provision and maternal BMI. It is also worth noting that not all CDOP panels define consanguinity as a modifiable factor.

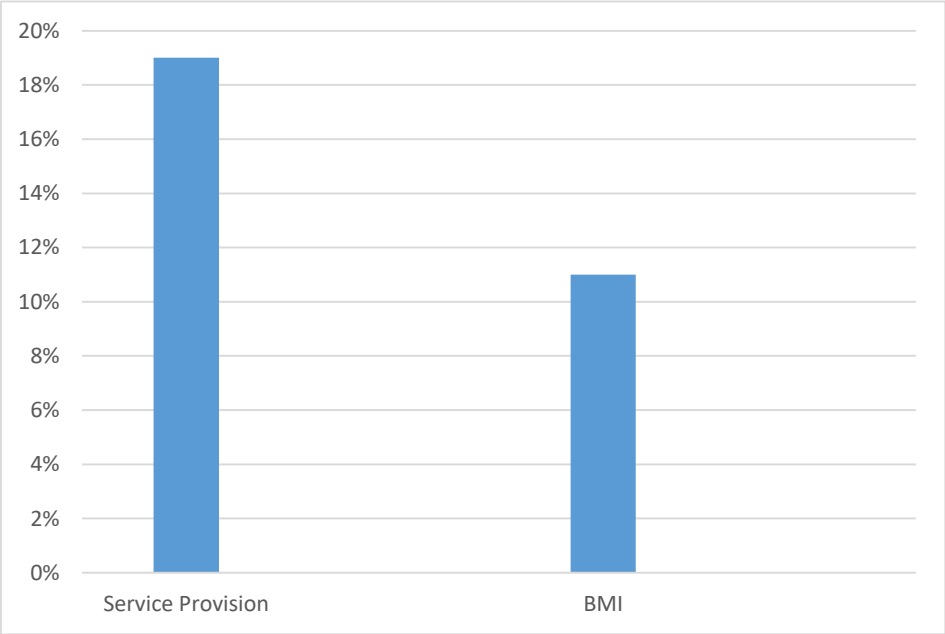
Consanguinity, where parents are related to each other, is a major risk factor for congenital anomaly. CDOP panels nationally continue to be concerned that inter-family couples do not have sufficient understanding of the increased risks of having a child with a disability or of having a child die under the age of five. Although consanguinity featured less often in cases as a modifiable factor this year, it remains a priority within Luton and Bedfordshire to ensure that related parents are fully aware of the risks. In recognition of this identified need, a programme of work is underway in Luton and an event was hosted by Luton Public Health in March 2019 to raise awareness of consanguinity to professionals and families. It is anticipated that further information sharing events will be developed.

This year, issues with service provision was identified as modifiable factors in 19% of all cases reviewed. This is similar to the previous year (17%), although a notable decrease from 2016-17 (28%). Learning from serious incident reports, serious cases reviews and independent reviews are discussed in depth at CDOP panels, and shared with relevant agencies and professionals as well as with the families of the children that have died. Due to the low numbers it is not possible to breakdown the service provision category or comment on the number subject to serious incident reviews, but the cases heard highlight service provision factors across statutory, primary and secondary health services.

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 smoking. Women with a raised BMI (>25) are offered access to information and support to make healthy living choices and weight management services in pregnancy. Events have commenced to engage Midwifery teams in assisting with the referral pathways, and a closer interface between public health teams and CDOP has commenced which aids understanding of the potential significance of maternal BMI on fetal outcomes. 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 did not feature as a modifiable factor in any CDOP case this year, and has followed a year on year decrease over 3 years.

The modifiable factors identified most often in 2018-19 are shown in Figure 2 below.

Figure 2: Modifiable factors identified



(Percentages of total cases reviewed in 2018/19)

Age, Gender and Ethnicity

In Bedfordshire and Luton the number of deaths of children under 1 year of age reviewed during 2018-19 was 67%; this is similar to the previous year (65%), but higher than in 2016-17 (55%).

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 26% were felt to have modifiable factors, which more closely reflects the national picture than the previous 2 years locally whereby 35% in 2017-18 and 59% in 2016-17 had modifiable factors.

Of the deaths reviewed at panel this year 54% were male and 46% were female, which is similar to last year whereby 52% were male and 48% female. This is a similar trend to the national data which 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, however, not in keeping with what has been found in Bedfordshire for 2 consecutive years; 25% of boys' deaths and 35% of girls' deaths in 2018-19; 35% of boys' deaths and 44% of girls' deaths in 2016-17 had modifiable factors.

Figure 3: Gender of cases reviewed 2018-19

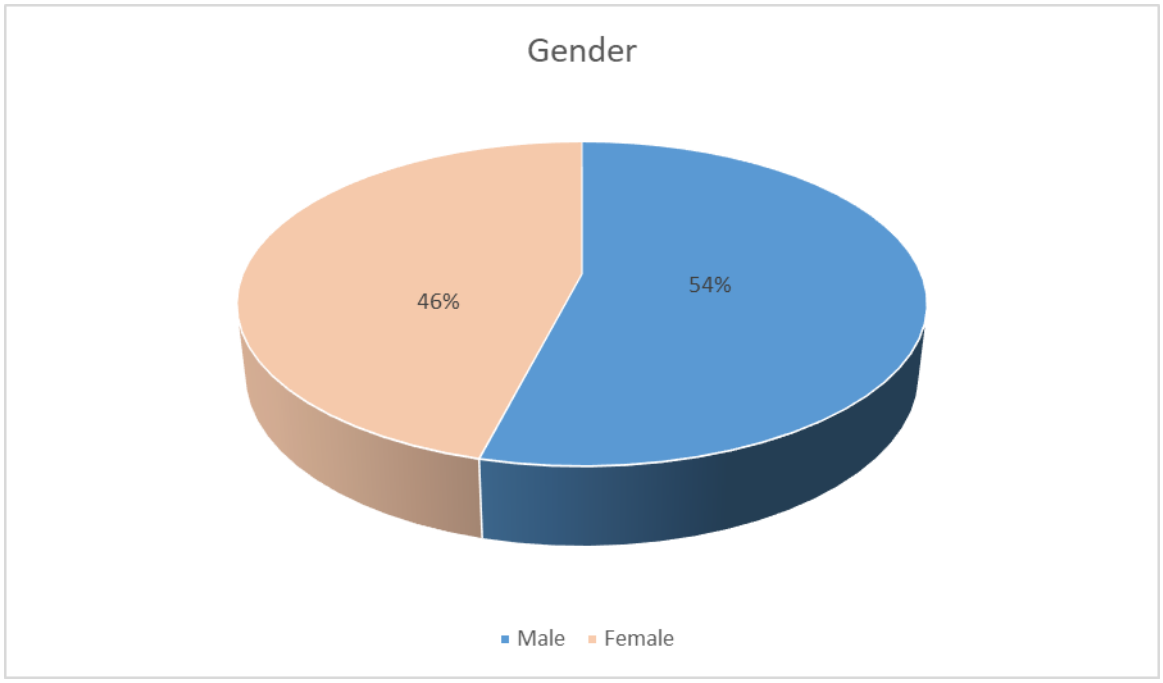
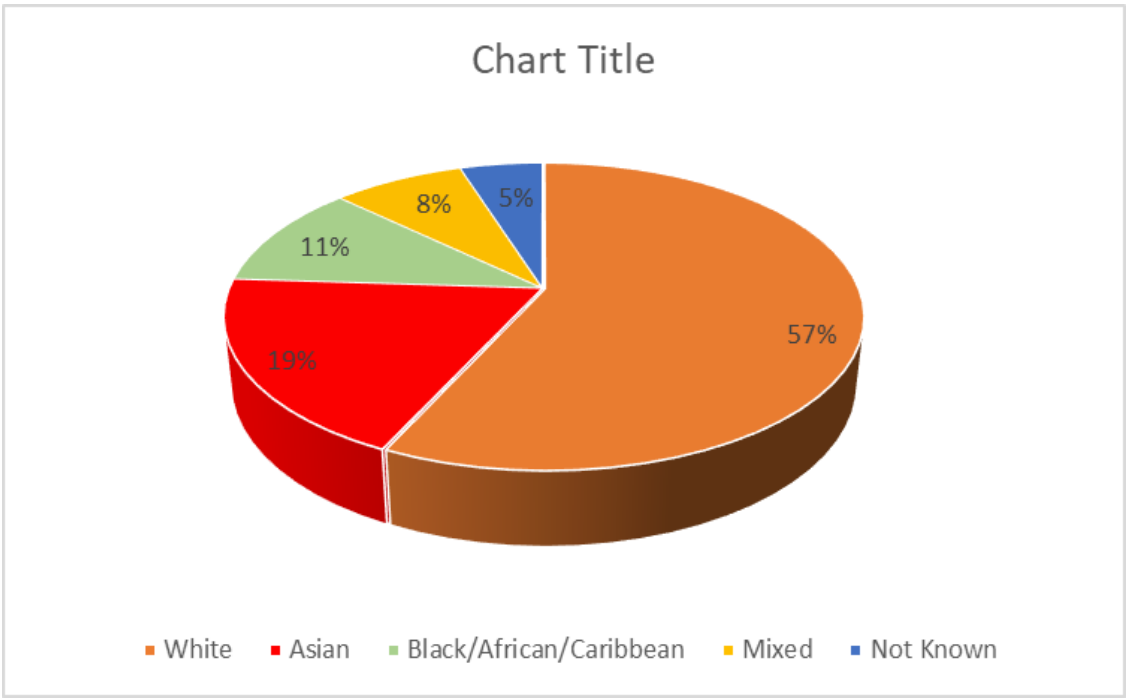


Figure 4: Ethnicity of cases reviewed 2018-19



Whilst in the year 2017-18 the percentage of deaths reviewed from Asian backgrounds was 33%, this year (19%) is similar to national trend of 15% (2017 statistic). Of note Asian ethnicity accounts for 5-10 % of children nationally in the under 18 age group (last census figure 2011).

Learning from the reviews and key actions taken in 2018-19

- 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.
- Whilst there has been a gradual decline in modifiable factors over 2 years, especially in neonatal deaths, the number of deaths from chromosomal, genetic and congenital anomalies has again increased this year, and is now the leading category of cases heard in Bedfordshire. However, the number of cases that have been closed at panel with consanguinity as a modifiable factor has significantly decreased.
- 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. A consanguinity learning event was held in Luton for professionals and families in March 2019.
- Whilst there has been an increase in numbers presented to panel exceeding a 2+ year period from the child's death, a greater number of cases have been heard within 6 months of a child's death.
- In response to an increase in suicides in under 18s in the County, with one suspected and one confirmed suicide in 2018-19, the CDOP Manger has been part of a wider working group helping to develop a more effective response and reporting process. An event to disseminate learning and processes with key partners is planned for Autumn 2019.
- 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.
- There has been a disappointingly lower number of CDOP panels held and cases heard in the period 2018-19. This could be attributed to a number of factors:
    - Period of CDOP Manager vacancy between substantive post holder leaving and interim commencing
    - Time for interim to establish systems and embed in role
    - Notable increase in child deaths in the time period by 25%, with associated increase in workload data collecting.
    - Time required to establish new statutory processes and share with key partners; inputting of national data and preparation to input to the new National Child Mortality Database (NCMD)

CDOP Training Sessions

- CDOP continues to be part of the Level 3 Safeguarding training for GPs in Bedfordshire and Luton. This has continued to work effectively and has received positive feedback.

- Formal CDOP training sessions have temporarily been put on hold whilst clarity and systems are established in response to the new child death reporting statutory guidelines from September 2019. However, individual and small group sessions have been facilitated in response to identified/requested need and in preparation for the changes.
- A suicide awareness event in the Autumn will feature a session on the new statutory guidelines and processes. The event has been organised in response to suicides in the locality in a two year period.
- More joint liaison with Public Health and Midwifery has commenced, with the purpose of increasing awareness of maternal high BMI risk factors.
- Once new statutory guidelines have been agreed locally, a training schedule will be designed to ensure wider learning across professions, with generic inclusion of learning from serious incident reports, and serious case reviews to ensure that findings continue to be shared and lesson learnt.

Areas for development and future plans

- For 2 consecutive years there have been more deaths with modifiable factors in females than males, contrary to national statistics. This could be an area to explore in greater depth in the future if the trend continues.
- It is evident that the number of cases presented to CDOP panels this year in Bedfordshire relating to acute medical/surgical conditions (Category 5) is three times the national average. This could provide an area for future development to analyse any underlying reasons.
- Following the initial consanguinity event for families and professionals in Luton, there are ongoing plans to continue the positive work that has been done to raise awareness around the risks of consanguinity in high risk areas, which will be included in the CDOP work plan.
- The report this year is the first occasion that ethnicity breakdown for each area has been included. It would be beneficial in the future to include further breakdown of ethnicity – for example a separate 'White other' category.
- Bedfordshire and Luton are in the procurement stage of implementing an electronic system for CDOP (E CDOP) which would assist in data collection and producing reports/identifying trends. E CDOP could, for example, assist in improving the response to 'ethnicity' on information returned as it is a mandatory field.
- Ongoing focus on reducing 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 and uptake information recorded.
- In response to the new statutory guidelines for child death processes, focused CDOP panels will be introduced. The first themed panel (Neonatal) has been organised for Autumn 2019.

- An Audit of Service Recommendation factors based on data since 2016 needs completing, so is recommended to be included in the CDOP work plan.
- Whilst it would have been beneficial to include the CDOP themes for our first 10 year period in this report, the aforementioned work load factors have prevented this from occurring, so will be included in the CDOP work plan.
- Whilst one of our Lead Paediatricians completed an audit to identify any emerging themes and learning from neonatal deaths 2016-18 with service modifiable factors, it would be beneficial to share findings to a wider audience with the purpose of enhancing good practice.

Appendix 1

Summary for Bedford Borough LSCB deaths reported

From 1st April 2018 to 31st March 2019 a total of 21 child deaths occurred amongst children residing in Bedford Borough; 6 more than the previous year and 9 more than 2016-17. 67% (n=14) of the deaths reported this year were in the first year of life which is in line with national data. As with the aforementioned County data, a significant

percentage of the deaths this year occurred in the neonatal period, with a significant number related to extreme prematurity.

43% (n=9) unexpected deaths occurred this year, which is similar to the previous year of 40% (n=6). 'Unexpected' 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).

43% (n=9) of deaths reported this year in this area were male and 57% (n=12) were female.

Ward level data depicts a varied spread, although Queens Park and Wilshamstead account for 43% of the deaths.

Figure 5: Ethnicity of Bedford Borough child deaths 2018-19 comparative to local under 18 years

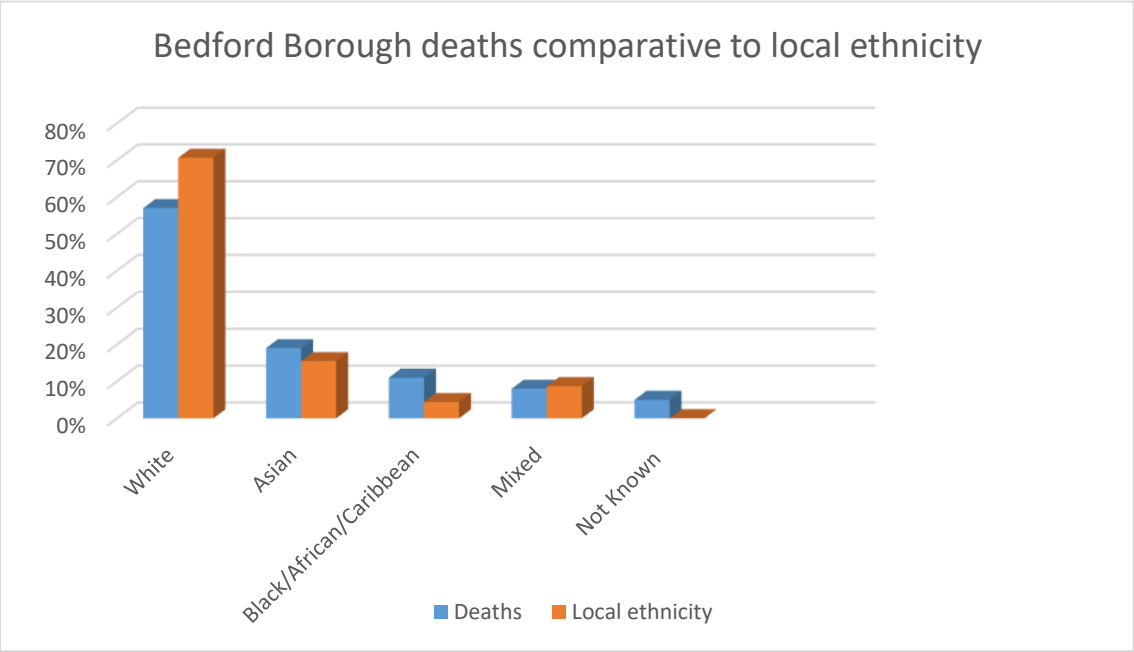
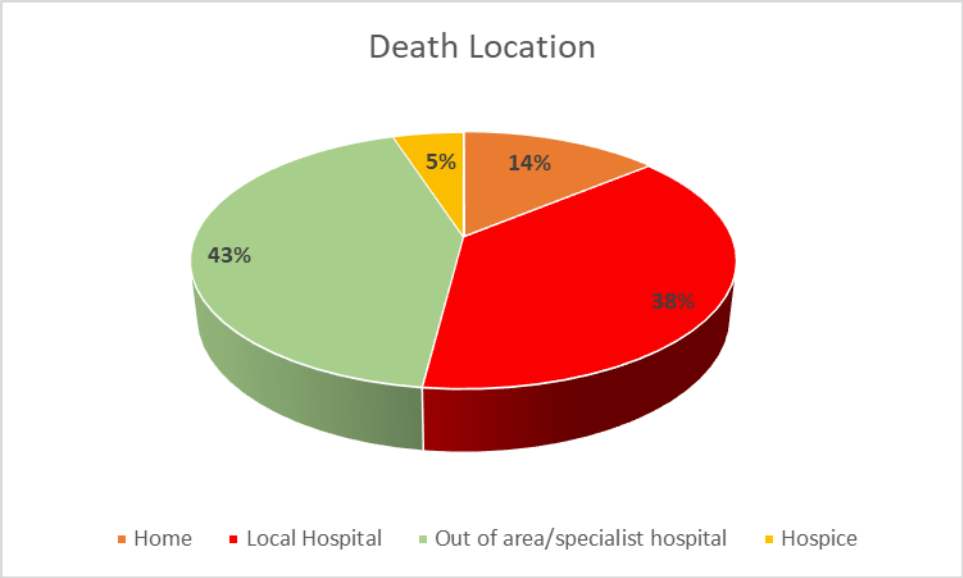


Figure 6: Location of Bedford Borough deaths 2018-19

As a significant percentage of the deaths this year occurred in the neonatal period, this will account for the number of deaths in specialist hospitals due to requirements for transfer out to tertiary centres for advanced treatment.



Actions undertaken:

- Ongoing professional referral to specialist services for maternal high BMI weight management and smoking cessation
- Development of a weight management service to assist maternity services when ladies are identified in pregnancy with high BMI.
- 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 reviewed panel.
- Development of a working group with key professionals who will be single point of contact for new statutory child death processes from September 2019.
- Development of work in relation to a pathway for schools in responding to suspected suicide of a pupil has progressed. Bedfordshire's 'Suspected Pupil Community action Plan' has now been produced, with an associated learning event scheduled for Autumn 2019

Appendix 2:

Summary for Central Bedfordshire LSCB deaths reported

From 1st April 2018 to 31st March 2019 a total of 20 child deaths occurred amongst children residing in Central Bedfordshire. This is 3 more deaths than the previous year and 6 more than in 2016-17. The first year of life

accounted for 80% (n=16) of deaths; this is a significant increase on the previous 2 years whereby 53% (n=9) in 2017-18 and 57% (n=8) in 2016-17 were of deaths in children under 1 year of age. As with the aforementioned County data, a significant percentage of the deaths this year occurred in the neonatal period, with a significant number related to extreme prematurity.

10% (n=2) 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 2 years when 18% (n=3) in 2017-18 and 36% (n=5) of deaths were unexpected.

Of the deaths reported, where gender was determined, 56% (n=10) were male and 44% female (n=8), which is in line with national data.

Numbers of deaths indicate a varied spread across the wards, although a greater number occurred in Dunstable localities.

Figure 7: Ethnicity of Central Bedfordshire child deaths 2018-19 comparative to local under 18 years

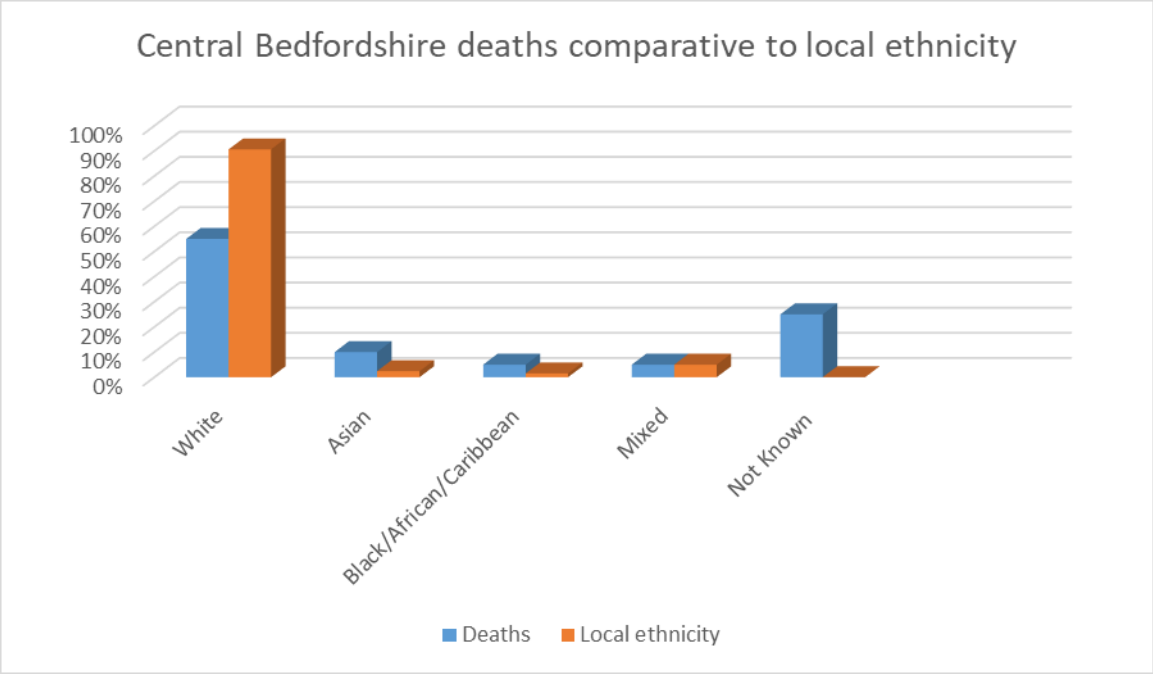
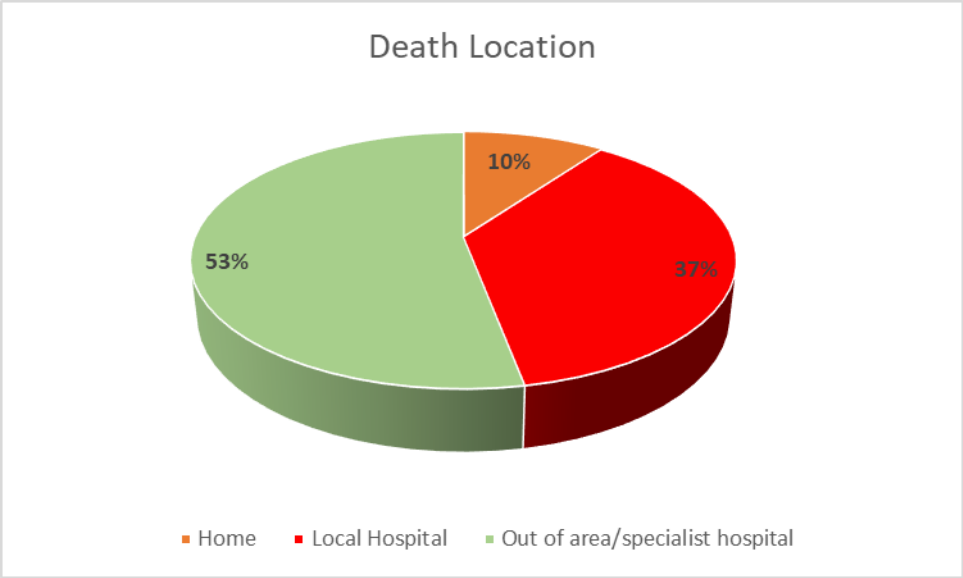


Figure 8: Location of Central Bedfordshire deaths 2018-19

As a significant percentage of the deaths this year occurred in the neonatal period, this will account for the number of deaths in specialist hospitals due to requirements for transfer out to tertiary centres for advanced treatment.



Actions undertaken during this year:

- Ongoing professional referral to specialist services for maternal high BMI weight management and smoking cessation
- Development of a weight management service to assist maternity services when ladies are identified in pregnancy with high BMI.
- 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 reviewed panel.
- Development of a working group with key professionals who will be single point of contact for new statutory child death processes from September 2019.
- Development of work in relation to a pathway for schools in responding to suspected suicide of a pupil has progressed. Bedfordshire's 'Suspected Pupil Community action Plan' has now been produced, with an associated learning event scheduled for Autumn 2019

Appendix 3:

Summary for Luton Borough LSCB of deaths reported

From 1st April 2018 to 31st March 2019 a total of 30 child deaths occurred amongst children residing in Luton. This is an increase of 5 deaths on the previous year, and an increase of 2 from the year prior (2016-17). 50% (n=15) of the deaths were in the first year of life; this is a decrease on the previous 2 years whereby 72% (n=18) in 2017-18 and

61% (n=17) in 2016-17 occurred in children under 1 year. As with the aforementioned County data, a significant percentage of the deaths this year occurred in the neonatal period, with a significant number related to extreme prematurity.

23% (n=7) 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 increase on the previous year where 12 % (n=3) of deaths were unexpected. However, the figure is smaller than the period 2016-17 where 32% (n=9) of deaths reported were unexpected.

Of the deaths reported, where gender was determined, 43% (n=12) were male and 57% female (n=16), which is not in line with national data as Luton has a greater percentage of female deaths than male.

Ward level data depicts a varied spread, with Round Green & Saints having the greatest number of deaths.

Figure 9: Ethnicity of Luton child deaths 2018-19 comparative to local under 18 years

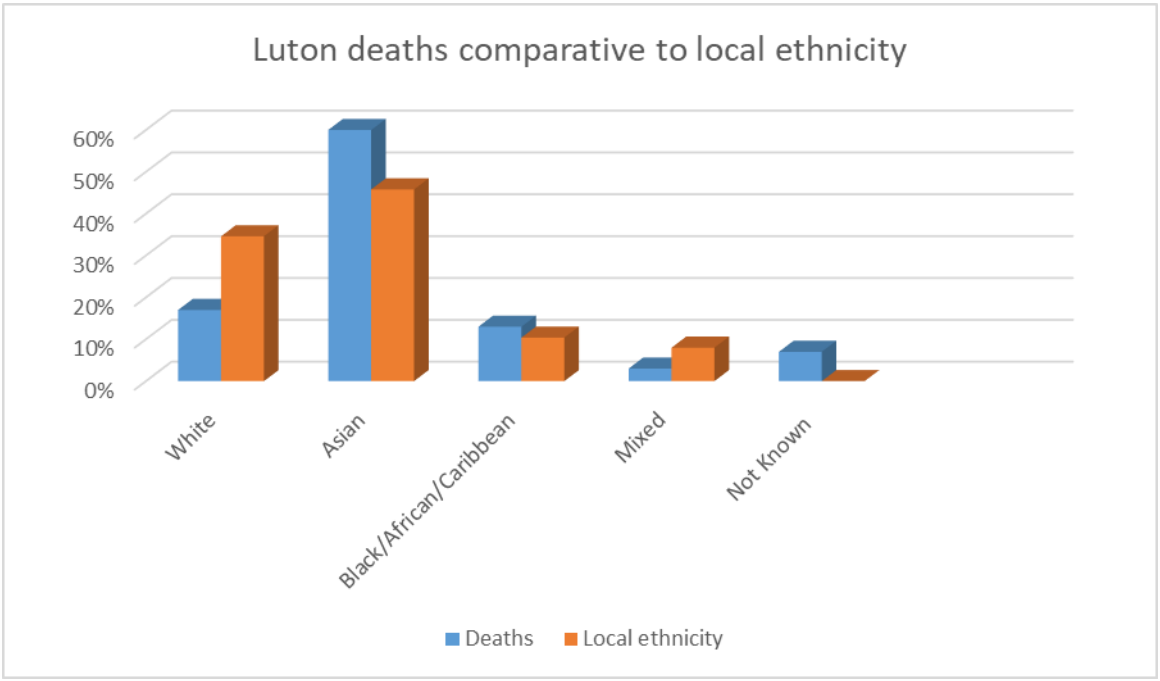
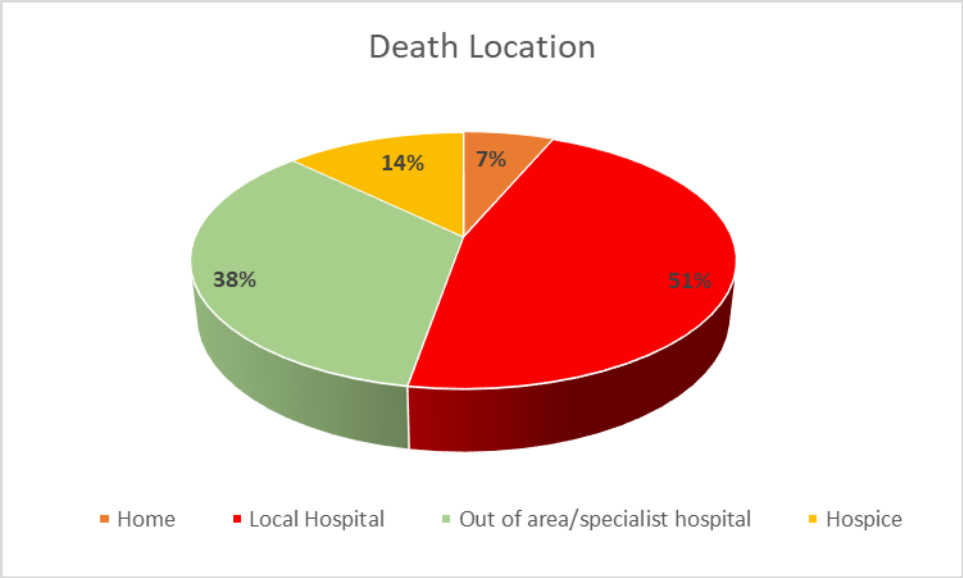


Figure 10: Location of Luton deaths 2018-19

As a significant percentage of the deaths this year occurred in the neonatal period, this will account for the number of deaths in specialist hospitals due to requirements for transfer out to tertiary centres for advanced treatment.



Actions undertaken during this year:

- Ongoing professional referral to specialist services for maternal high BMI weight management and smoking cessation
- Progression of a weight management service, including more work engaging professionals, to assist maternity services when ladies are identified in pregnancy with high BMI.
- In response to deaths relating to consanguinity, an event was hosted by Luton Public Health in March 2019 to raise awareness of consanguinity to professionals and families, with more development planned.
- 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 reviewed panel.
- Development of a working group with key professionals who will be single point of contact for new statutory child death processes from September 2019.
- Development of work in relation to a pathway for schools in responding to suspected suicide of a pupil has progressed. Bedfordshire's 'Suspected Pupil Community action Plan' has now been produced, with an associated learning event scheduled for Autumn 2019