Bedford Borough, Central Bedfordshire and Luton Child Death Overview Panel

Annual Report

1 April 2023 – 31 March 2024

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Annual Report Bedfordshire CDOP
1st April 2023 – 31st March 2024

Chair's Foreword

I have the honour of chairing the Bedfordshire Child Death Overview Panel and of publishing this annual report, my third as chair of the panel. I continue to be proud of the panel we have in Bedfordshire of the professionalism of the panel members in the collaborative yet challenging discussions, and of the time and commitment each panel member gives to ensure that we can give appropriate scrutiny of each child's sad death, so that we can take away learnings and improvements.

The purpose of this process is always to learn and improve systems, taking recommendations and actions back into the system. There have again been a number of follow ups and improvements actioned through the course of the last year based on case review findings.

The annual report is a key element of the work of the panel – enabling us to look at trends. This oversight enables system recommendations and actions to be developed, that we have a responsibility to ensure are taken away and enacted on.

We hope again that the findings in this report will continue to drive change and improvements, tackling risk factors and service improvement approaches to reduce ongoing risks of child death.

1. Executive Summary

1.1 Introduction

The death of a baby or child is a devastating loss, and although an uncommon event, the death represents a tragedy that profoundly affects the family, friends, and all those involved.

The child death process is a statutory requirement, with the purpose of each Child Death Review (CDR) process, to learn from child deaths, and identify potentially modifiable factors, which may prevent future deaths from occurring. A modifiable factor is defined as factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

The Children Act 2004, requires Integrated Care Boards (ICBs) and local authorities (child death review partners) to make local arrangements, to undertake these statutory reviews.

There is a requirement to produce an annual report, outlining the work of the CDOP, including relevant learning from the cases reviewed, local patterns and trends in child deaths and the effectiveness of the wider Child Death Review Process. Findings and recommendations identified inform the priorities for the CDR Partners (Local Authorities and BLMK ICB), the Safeguarding and Public Health agendas.

An overarching aim of the Child Death Review Process is to ascertain why children die and to support improvements as identified, in the health, safety and wellbeing of children and young people in the local area. The aim is to reduce risk of future child deaths and to inform local practice as required. This includes active engagement and contribution with Regional and National initiatives to align processes and the sharing of wider learning.

1.2 Key findings

Deaths occurring between 1st April 2023 and 31st March 2024

48 children died across the area in 2023-24. The largest proportion 33/48 (68.7%) of deaths occurring were infants, with most dying before 28 days (Neonatal) 22/33 (66.6%). 22/48 (45.8%) of these were born prematurely. 14/48 deaths were unexpected.

Infant Mortality rates

In 2021 there were 2,179 infant deaths (aged under one year) in England and Wales; the infant mortality figure was lower than the previous year (2,411). 6

Deaths were higher in boys (34/48) to girls (14/48). The highest proportion were White-British and Black British - African. The largest proportion of deaths (40) occurred in hospital of which 15 occurred in centres away from the child's area of residence. 1 died in the hospice. Of the 7 deaths occurring at home, 4 were unexpected.

Deaths reviewed between 1st April 2023 and 31st March 2024

The panel reviewed 54 deaths. These deaths were reviewed during the year but occurred between 2020 and 2023. Out of the deaths reviewed, 17 (31%) of the reviewed child deaths had modifiable factors, which is lower than the previous year and lower than the national figure 43% NCMD[2].

29 (53.7%) of the child deaths were infants.

The greatest number of deaths were in Category 7 - Chromosomal/Genetic/ Congenital (18/54, 33.3%). The next highest was in Category 8 Perinatal/Neonatal (12/54, 22.2%).

Nationally the category of Perinatal/Neonatal event was recorded for the largest proportion of deaths reviewed (34%) by Chromosomal, genetic and congenital anomalies (24%), Malignancy *(*9%) *and* Sudden unexpected and unexplained death (7%). These patterns were similar to previous years.

The greatest number of deaths were amongst Asian-Asian British and White – British with both reported as (23/54).

One death reviewed, which was the subject of a Child Safeguarding Practice Review (CSPR).

The category of death for children where a modifiable factor found was below in figure 1.0

Figure 1.0

% of cases where modifiable factors were identified by category of death

Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Trauma and other external factors, including medical/surgical complications/error	1	1	100%
Suicide or deliberate self-inflicted harm	3	2	67%
Sudden unexpected, unexplained death	2	2	100%
Perinatal/neonatal event	12	2	17%
Malignancy	6	1	17%
Infection	3	1	33%
Deliberately inflicted injury, abuse or neglect	1	1	100%
Chronic medical condition	4	3	75%
Chromosomal, genetic and congenital anomalies	18	1	6%
Acute medical or surgical condition	4	3	75%
Total	**54**	**17**	**31%**

Modifiable factors were identified locally and are listed in order:

1. Quality of Service Delivery (Missed Opportunity to Delivery Earlier, referrals, recognition of condition, recognition of deterioration of condition and following guidelines)
2. Consanguinity
3. Risky behaviour including substance and/or drugs abuse and other risky behaviours
4. Challenges with access to services/triage
5. Gang Involvement
6. Smoking by parent or carer
7. Unsafe sleeping arrangements
8. Poor communication/information sharing

Nationally the third Annual NCMD report[2] (ending 31st March 2023) noted that modifiable factors continue to rise with 39% of deaths reviewed in the year ending 31 March 2023. The Deaths categorised as deliberately inflicted injury, abuse or neglect had the highest proportion of reviews with modifiable factors (81%), followed by Sudden unexpected and unexplained death (76%), Trauma or other external factors (71%) *and* Suicide or deliberate self-inflicted harm (50%)

1.3 Recommendations

1. Panel notes that once again higher infant mortality rate in our area. This highlights the need to continue to promote public health strategies to reduce risks of premature birth to reduce numbers of babies dying in infancy or neonatal period, including smoking cessation, healthy lifestyles, and heathy weight in mothers and access to services.
2. CDR partners continue to assure themselves that the findings from previous child death reviews where there were service modifiable factors have been addressed and used to reduce risk of future deaths.
3. Continue to promote safe sleeping and smoking cessation to reduce the risks of deaths in infancy.
4. Promote the learning from local and National CDRs in multiagency training.
5. Share findings and learnings across BLMK ICB and CDR partners including findings from CSPRs.
6. The ICB has not been able to fund the Key Work or Home Visitor role.
7. Share our findings with CDR partners and services regarding deprivation indices which show that child deaths are associated with deprivation.
8. Continue to share and be assured that Maternity and Public Health messages and referrals are used widely across the whole children, young people and family's workforce.
9. Promote awareness of housing issues which impact on infant safety to all multiagency partners who visit families in their home. Homes must provide adequate space for babies under 6 six months to have a cot in their parents' bedroom.
10. The Panel will analysis our Infant Mortality data in detail to see if there are any thematic issues underlying our high IMR.
11. Panel promote the Close Relative Marriage Project in our training and with services who can make relevant referrals.
12. A number of modifiable factors were identified that related to Service Provision and Information Sharing. Learning from these will be shared through our Multi-Agency Training in addition to the Action Plans owned by individual services in relation to CSPR, HSIB, SI Reports.

2.0 Child Death Overview Panel

CDOP is a multi-agency panel set up by CDR partners to review the deaths of all children normally resident in Bedfordshire and Luton to learn lessons and share any findings for the prevention of future deaths. The panel review and analyse the anonymised data, as set out in the National Mortality Database, to utilise the findings as a means of informing this Annual Report. The panel met 7 times in 2023-24 with 1 meeting cancelled due to unforeseeable circumstances.

The collation and sharing of all learning from Child Death Reviews and the CDOP is managed by the National Child Mortality Database (NCMD) which became operational on 1st April 2019.

2.1 Panel Membership

- Public Health (Chair) (Core)
- Public Health Rep from each LA (Core)
- Designated Doctors for Child Deaths (Core)
- Hospital Clinician (Core – one Rep)
- Safeguarding (Designated Nurses) (Core - Rep)
- Lead Nurse for Child Deaths (Bedford and L&D Hospital, Hospice) (Core – one Rep)
- Children's Services – Beds, CBC and Luton (Core)
- Primary Care (Health Visitor) (Core)
- Lay Representation (as available)
- Nursing and/or Midwifery (as required)
- Police (as required)
- Ambulance Services (as required)
- Coroner's Office (as required)
- Education (as required)
- Housing (as required)

3.0 Deaths reported between 1st April 2023 and 31st March 2024

This section focusses on the number of children who died during the period 1st April 2023 to 31st March 2024 who were normally resident in the Bedfordshire and Luton area.

3.1 Number of child deaths notified in 2023-2024

The Luton and Bedfordshire CDOP received notifications of 48 child deaths where the child died between 01.04.2023 and 31.03.2024. Within that year, there were 35 expected deaths and 13 unexpected deaths. In previous years there had been 65 deaths in 2022-23 and 61 deaths in 2021-22 in the area covered by this panel.

In England NCMD received 3,743 child (0 – 17 years) deaths in England in the year ending 31 March 2023, an estimated rate of 31.8 deaths per 100,000 children. The number of deaths increased by 8% on the previous year and was the highest number of deaths in a year since NCMD started data collection in 2019 (Figure 1). Infant (children under 1 year) deaths increased by 4% on the previous year and deaths of children aged between 1 and 17 years increased by 16%.

There were 391 deaths during December 2022, the highest in any single month since 2019.

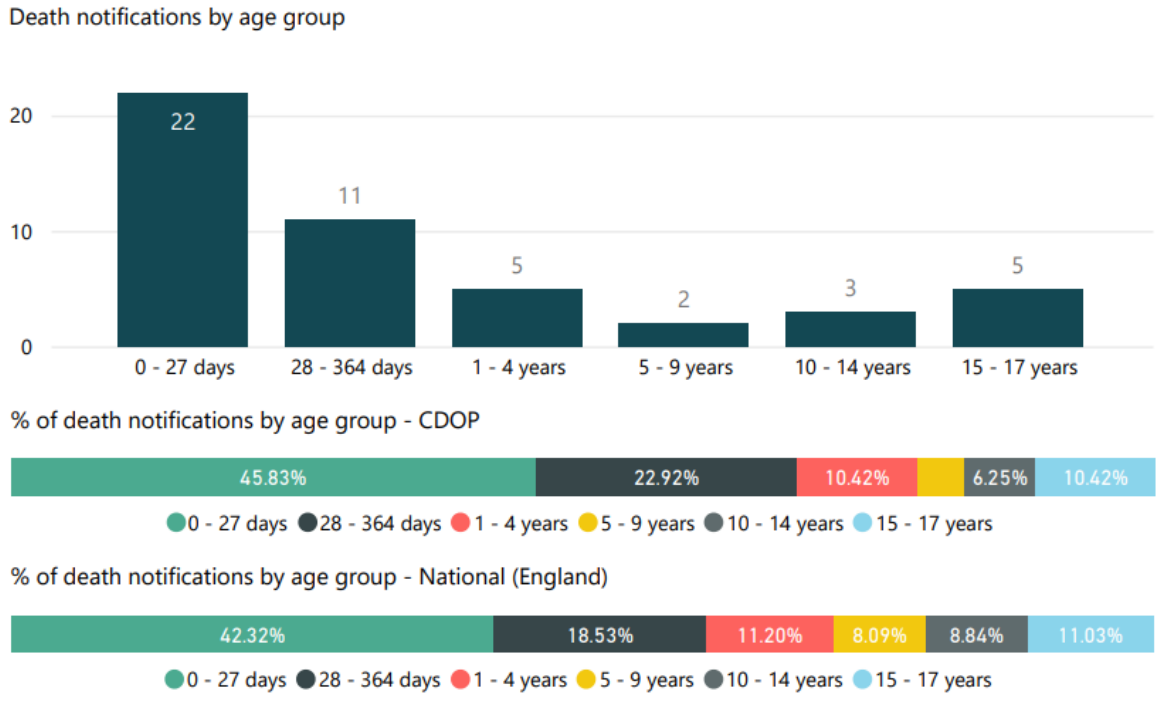
3.2 Age, sex and ethnic group

3.2.i Age of child deaths

Similar to Nationally, the greatest number of deaths occurring were amongst those under 1 year, with the largest proportion being perinatal deaths (45.8%). See figure 1 below.

45.8% death under 28 days old (22/48)
22.9% between 28 to 364 days old (11/48)
7.2% one year and over (15/48)

Figure 2.0: Age of death notified 01.04.2023 to 31.03.2024

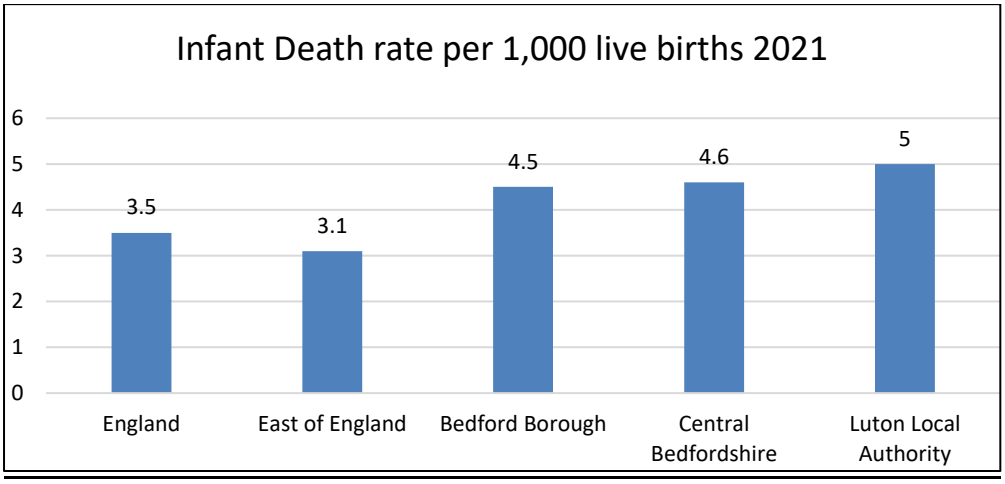


Infant, neonatal and post-neonatal mortality rates

The latest available data regarding infant mortality (IMR) in our locality is from the Office of National Statistics (ONS) in 2022 and shows that Bedford, Central Beds and Luton have a high IMR[1]:

Figure 3.0: Infant Death per 1,000 live births 2021

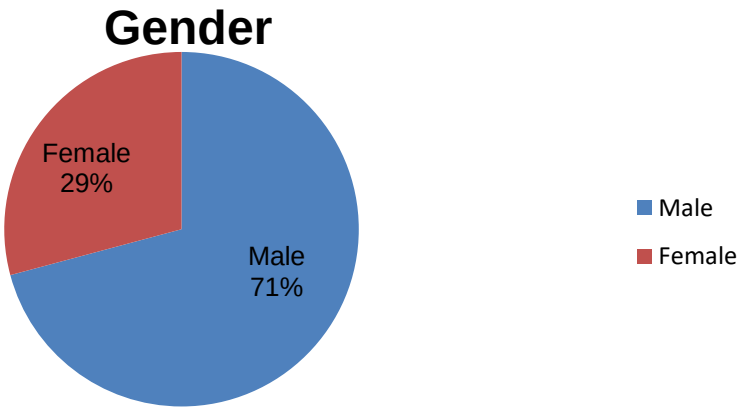
England IMR 3.5
Bedford IMR 4.5
Central Bedfordshire IMR 4.6
Luton IMR 5.0
East of England 3.1



3.2.ii Gender of child deaths

Due to the relatively small data set, we are not able to comment on if there are any significant differences in numbers of deaths by gender for each age group.

Figure 4.0: Gender of children dying between 01.04.2023 and 31.03.2024

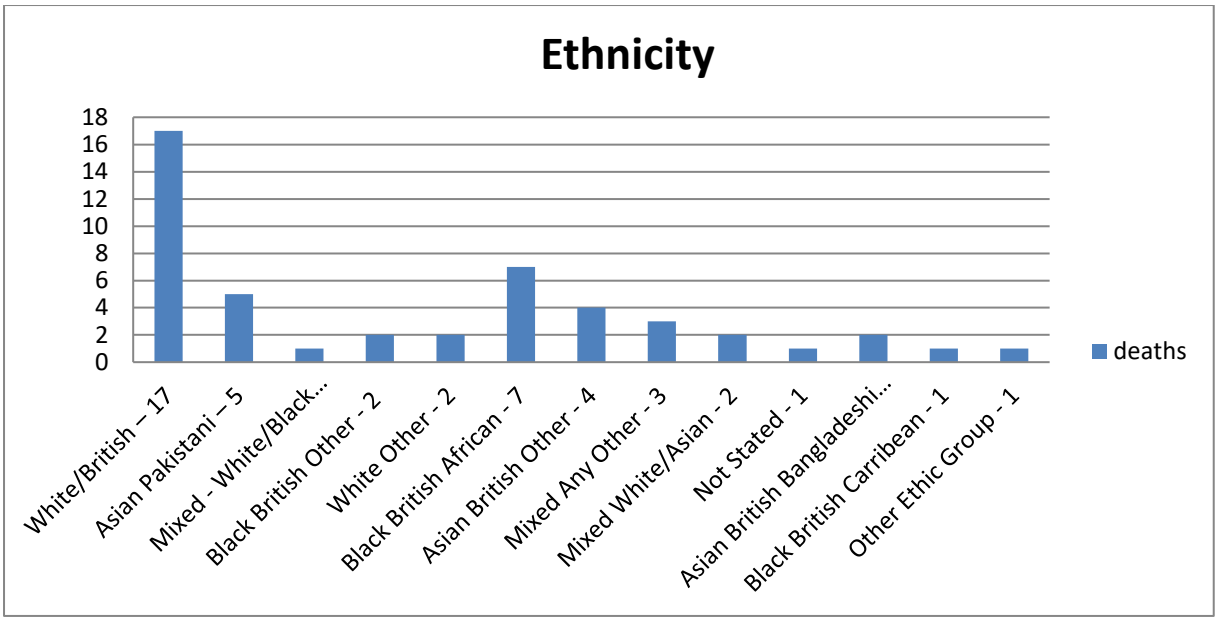


3.2.iii Ethnicity of child deaths notified 2023-2024

Locally

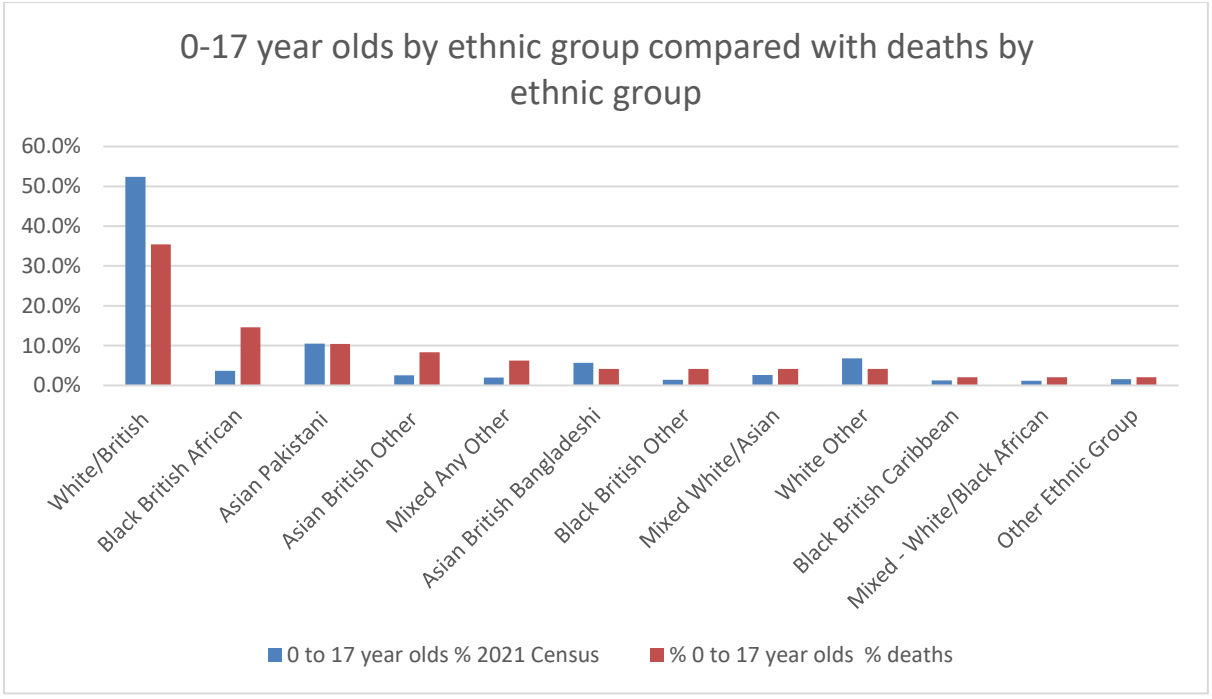
Data from 2023/24 child deaths notified locally shows the ethnicity of the largest proportion of the children that died was White - British with 17 deaths. The next highest ethnic group was Black British - African 7 deaths notified during the year. (Figure 5.0).

Figure 5.0: Ethnicity of children dying between 01.4.2023 and 31.03.2024 in Luton and Bedfordshire



In Bedfordshire the latest available information on deaths aged 0-17 years and ethnicity is presented in the table below (2021 Census estimate, Office for National Statistics[3]). From this and the above findings from deaths in 2023-2024, the Black African population represent 4% of the population but accounted for 15% of deaths. Children of Black minority ethnic groups are overrepresented.

Figure 6.0: 0–17-year-olds by ethnic group compared with deaths by ethnic group, 2023-24



3.3 Number of child deaths by deprivation decile

Deprivation decile (2019) by number of child deaths, reported cases, 2023-24

Deprivation decile	Deaths	Percentage
1	3	6.5%
2	7	15.2%
3	8	17.4%
4	5	10.9%
5	7	13.0%
6	2	4.3%
7	5	10.9%
8	2	4.3%
9	4	8.7%
10	4	8.7%
Total	47	

Source: MHCLG Indices of Multiple Deprivation 2019, Deaths: NHS Bedfordshire 46 reported cases that had a postcode that could be matched with the indices of deprivation.
1= highest level of deprivation, 10 = lowest level of deprivation

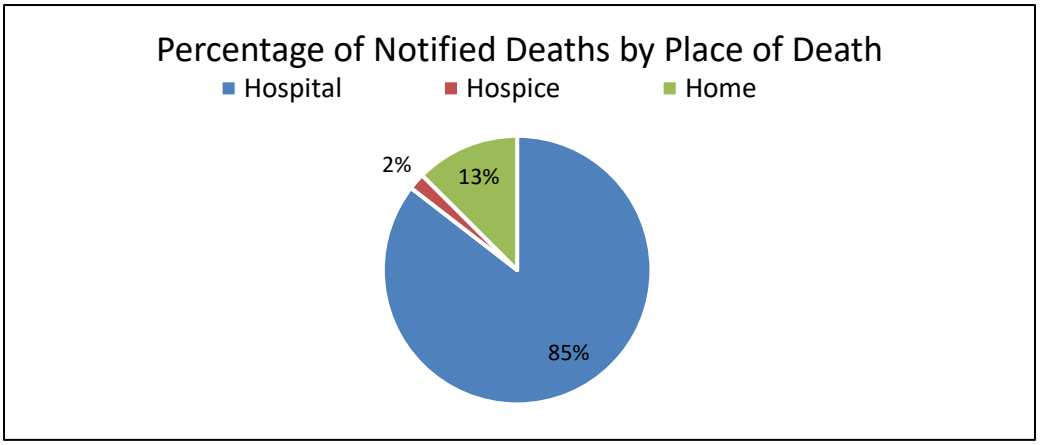
The postcodes of 47* reported cases of child deaths recorded by NHS Bedfordshire were linked to the 2019 indices of multiple deprivation. There were 30 (64%) cases above the 50th most deprived percentile i.e. above average deprivation with 17 (36%) cases below. There were 10 (21%) cases in the top 20 most deprived areas in the country.

**There was one case that didn't match with the deprivation data postcodes which is due to it being a postcode for newly built housing which was constructed after the deprivation data was published. The latest deprivation data are the 2019 data-set.*

3.4 Place of death

The place of death was recorded for all child deaths notified between 1st April 2023 and 31st March 2024. The greatest number of child deaths occurred in hospital (41/65). 6 deaths occurred at home, with 4 being unexpected and 2 being expected. Children also died in our local hospice.

Figure 7.0: Place of death for children dying between 01.04.2023 and 31.03.2024



3.5 Gestational ages for babies dying before 28 days and those aged 28-364 days

There were 22 deaths within 28 days of birth and 9 deaths within 28 – 364 days of birth.
Most babies dying in the first year of life were born extremely prematurely.

18 Babies dying before 28 days were born extremely prematurely (before 28 weeks gestation)
2 babies dying before 28 days were born prematurely (between 29 and 37weeks gestation).

2 babies dying between 28 and 364 days were born extremely prematurely.
0 baby dying between 28 and 365 days was born prematurely.

4.0 Deaths reviewed 01.04.2023 to 31.03.2024

This section focuses on data from the completed child death reviews by CDOP where the child death review took place between 1 April 2023 and 31 March 2024 (the child may have died in previous years). The panel reviewed deaths of children normally resident in the local area (Bedford Borough, Central Bedfordshire and Luton).

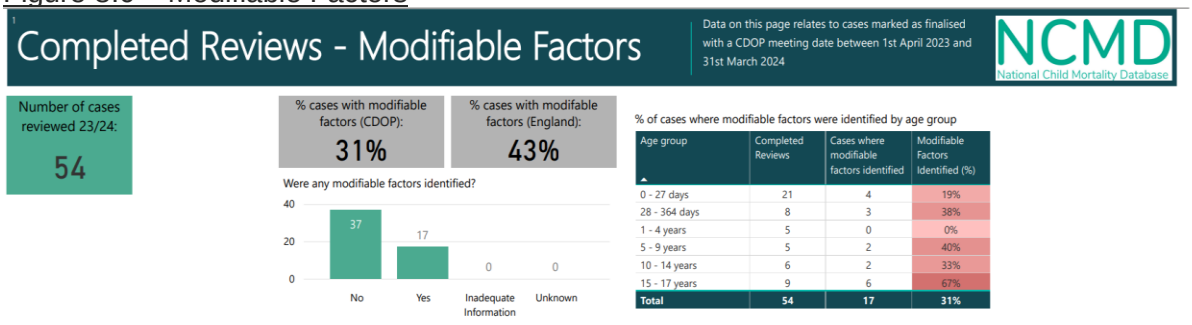
The panel reviewed the anonymous data relating to 54 deaths. These children had died between 2020 and 2023. There were 7 panels were held in the year. This compares to 44 reviews completed in the year up to 31.03.2023.

4.1 Modifiable Factor

During the review, the panel identifies any modifiable factors in relation to the child's death. Modifiable factors are defined as factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Our panel identified modifiable factors in 17/54 (31%) deaths. Nationally 43% of deaths reviewed identified modifiable factors. The number of deaths with modifiable factors identified will vary from year to year depending on the cases reviewed.

Figure 8.0 – Modifiable Factors



% of cases where modifiable factors were identified by age group

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	21	4	19%
28 - 364 days	8	3	38%
1 - 4 years	5	0	0%
5 - 9 years	5	2	40%
10 - 14 years	6	2	33%
15 - 17 years	9	6	67%
Total	**54**	**17**	**31%**

% of cases where modifiable factors were identified by category of death

Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Trauma and other external factors, including medical/surgical complications/error	1	1	100%
Suicide or deliberate self-inflicted harm	3	2	67%
Sudden unexpected, unexplained death	2	2	100%
Perinatal/neonatal event	12	2	17%
Malignancy	6	1	17%
Infection	3	1	33%
Deliberately inflicted injury, abuse or neglect	1	1	100%
Chronic medical condition	4	3	75%
Chromosomal, genetic and congenital anomalies	18	1	6%
Acute medical or surgical condition	4	3	75%
Total	**54**	**17**	**31%**

% of cases where modifiable factors were identified by ethnic group

Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
White	23	6	26%
Unknown	0	0	0%
Other	1	0	0%
Mixed	3	1	33%
Black or Black British	4	1	25%
Asian or Asian British	23	9	39%
Total	**54**	**17**	**31%**

4.2 Primary Category of Death and Modifiable Factor

During the review, the CDOP is responsible for noting the category of death and links this to the presence or absence of any modifiable factors in relation to the child's death.

Modifiable factors were grouped by domain - that is characteristics of the child, social environment, physical environment, and service provision.

Characteristics of the child these might include risk taking behaviour by child or young person. Panel reviewed cases where substance misuse, gang involvement and other risky behaviour contributed to the death and were deemed modifiable.

Social environment this might include for example parental smoking. In this domain the panel noted deaths with modifiable factors of close relative marriage and mental health of parent or carer.

Physical environment factors might include unsafe sleeping, smoking of parent or carer. The panel noted factors including unsafe sleeping.

Service provision this may include failure to follow guideline or pathway, lack of access to appropriate service, poor communication, difficulties with identifying deterioration or underlying condition or information sharing between professionals or with families. A total 9 cases had service modifiable factors which including quality of service.

4.3 Number of reviews completed by the CDOP by category of death

Figure 9.0

1. Deliberate inflicted injury, abuse or neglect	1
2. Suicide or deliberate self-inflicted harm	3
3. Trauma	
Vehicle collision	
Downing	1
Hanging	
4. Malignancy	6
5. Acute medical or surgical condition	4
6. Chronic medical condition	4
7. Chromosomal, congenital and genetic anomalies	18
8. Perinatal/neonatal event	
Immaturity/Prematurity related	11
Perinatal asphyxia	
Perinatally acquired infection	
Other	1
9. Infection	3
10. Sudden unexpected, unexplained death	2

The commonest category of death was Chromosomal, Congenital and genetic anomalies. The National NCMD report (2022-23) showed that the most common category of death was Perinatal /neonatal (34%).

The next highest category of death was Perinatal/neonatal event with 22% of deaths.

4.4 Social care and Child Safeguarding Practice Reviews

A Child Safeguarding Practice Review (previously Serious Case Review) in England is conducted when a child is seriously harmed, or dies, because of possible abuse or neglect as outlined in Working Together to safeguard children (2018). The review identifies how local professionals and organisations can improve the way they work together.

There were 1 Child Safeguarding Practice Reviews which the Panel reviewed in 2023/24. The following learning was identified:

In 2019, Luton Safeguarding Children's Partnership conducted a rapid review to consider the serious harm experienced by Lena through, sexual and criminal exploitation.

The rapid review concluded that there was scope for system learning from Lena's experiences and in improving safeguarding and welfare of young people exposed to similar risks.

A multi-agency practitioner event to be held to re-examine and debate the current potential (strengths and weaknesses) for collective local efforts to protect and support young persons in Lena's situation. Such an event could provide an opportunity to remind participants that maintaining accurate and timely records of contacts / judgements is vital.

The LSCP to explore the extent to which the required balance between medical confidentiality in GP Practice and Sexual Health Clinics and safeguarding of vulnerable individuals by Children's Social Care and Police is being maintained

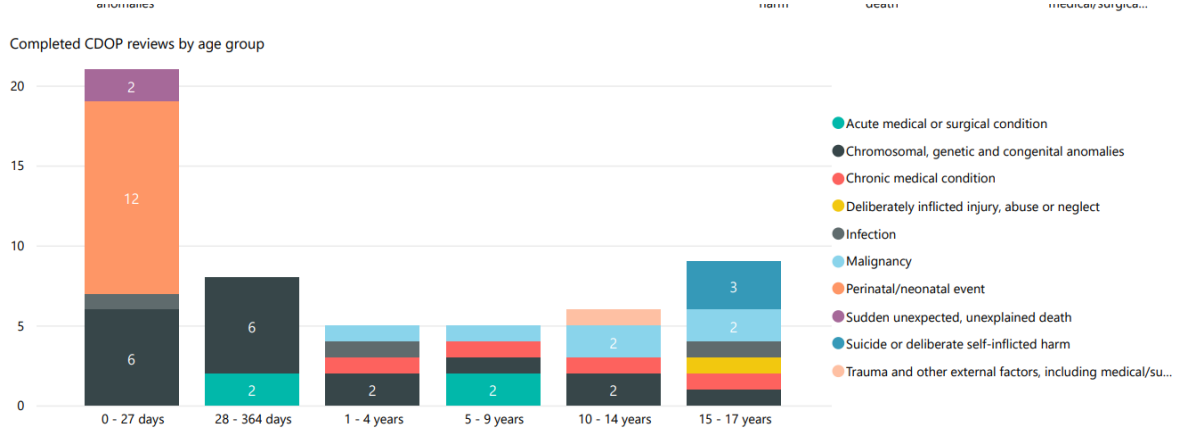
The ICB to consider what level of confidence and compliance with current policy / procedural expectations exists within local GP Practices

4.5 Age of death

20 (10.8%) of deaths reviewed occurred before 28 days.
8 (14.8%) of deaths occurred between 28 and 364 days of age
5 (2.7%) of deaths occurred between 1 and 4 years
5 (2.7%) of deaths occurred between 5 and 9 years
5 (2.7%) of deaths occurred between 10 and 14 years
11 (9%) of deaths occurred between 15 and 17 years.

Figure 10.0

The number of reviews completed by Child Death Overview Panel by age group, year ending 31 March 2024

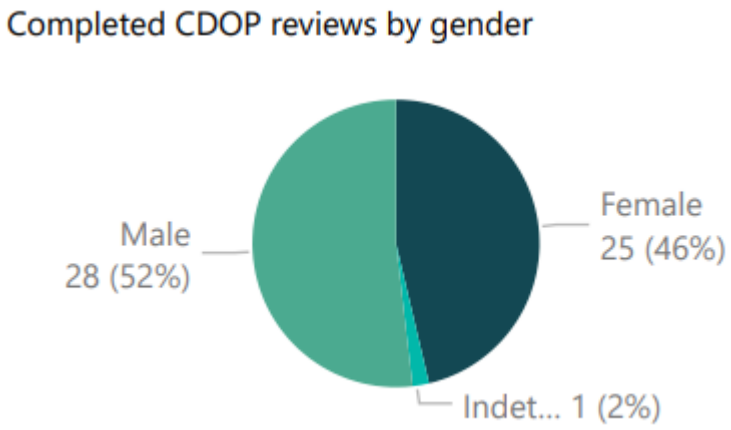


The greatest proportion of deaths was amongst infant and neonates. This is similar to the national picture.

4.6 Gender

The death in males was higher than females as shown in Figure 11.0 below.

Figure 11.0: Gender



4.7 Ethnicity

The ethnicity of child deaths reviewed is shown below. The highest proportion was Asian – Pakistani. With the second highest being White - British. Ethnicity data was complete which is an improvement on previous years and reflects use of eCDOP and its links to NCDM.

Figure 11.0: Ethnicity

Completed CDOP reviews by ethnic group and age group

Ethnic Group	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	Total
White	13	2	2	1	0	5	23
Unknown	0	0	0	0	0	0	0
Other	0	0	1	0	0	0	1
Mixed	0	1	0	0	2	0	3
Black or Black British	1	1	0	1	1	0	4
Asian or Asian British	7	4	2	3	3	4	23
Total	**21**	**8**	**5**	**5**	**6**	**9**	**54**

4.8 Number of child deaths by deprivation decile

Deprivation decile (2019) by number of child deaths, closed cases, 2023-24

Deprivation decile	Deaths	Percentage
1	1	1.9%
2	9	17.0%
3	11	20.8%
4	9	17.0%
5	10	18.9%
6	2	3.8%
7	3	5.7%
8	4	7.5%
9	2	3.8%
10	2	3.8%
Total	53	

Source: MHCLG Indices of Multiple Deprivation 2019, Deaths: NHS Bedfordshire 53 closed cases that had a postcode that could be matched with the indices of deprivation.
1= highest level of deprivation, 10 = lowest level of deprivation

The postcodes of 53 closed cases of child deaths recorded by NHS Bedfordshire were linked to the 2019 indices of multiple deprivation. There were 40 (75%) cases above the 50th most

There was one case that didn't match with the deprivation data postcodes which is due to it being a postcode for newly built housing which was constructed after the deprivation data was published. The latest deprivation data are the 2019 dataset.

5.0 Actions by CDOP during 2023-24

Review of CDR Process

BLMK ICB Head of Safeguarding, led on conducting a review of the CDR processes, across the whole of BLMK- ICB, with the support of the Designated Nurse who takes a lead on CDOP in Bedfordshire & Luton. The purpose of the review was to ensure that the Milton Keynes processes are aligned to those in Bedfordshire and Luton, within the newly formed BLMK -ICB footprint. Pathways were discussed and agreed with all partner agencies, and implementation date set for May 2024.

It is anticipated that specialist Safeguarding nurses would support the CDOP process, by being the single point of contact for families of children who died suddenly and unexpectedly. The single point of contact currently remains with the Child Death Office.

A new statutory medical examiner system is being rolled out across England and Wales to provide independent scrutiny of deaths, and to give bereaved people a voice. From 9 September 2024 all deaths in any health setting that are not investigated by a coroner will be reviewed by NHS medical examiners. The changes, which form part of the Department of Health's Death Certification Reforms, were announced by the government on 15 April 2024, and come into force on 9 September 2024.

Further exploration in 2024, to take place with police, to undertake joint visits with a health specialist (experienced in child deaths), when an unexpected child death occurs in the home. Currently a Joint Agency Meeting takes place for all unexpected child deaths. The purpose is to ensure that the appropriate agencies engage and work together to respond quickly to the unexpected death. Make immediate enquiries into and evaluate the reasons for and circumstances of the death, in agreement with the coroner. It is established at these meetings who should lead on supporting the family.

Scope service delivery options for joint home visits with Police and improved bereavement support for families with CDR partners

CDR processes have now been reviewed, with the aim, to align processes across the wider footprint of BLMK-ICB and to identify key workers to support families through the CDOP process, as a single point of contact and to signpost on to bereavement support as identified. The plan is for this role to be undertaken by the clinical specialist nurses, once recruitment opportunities have been finalised.

Medical Examiners pathway

Pathways established with Medical Examiner, Dr White for all non-coronial deaths which it is anticipated will become statutory in September 2024.

Skin Biopsy for SUDIC pathway update
Acute Paediatric service has agreed the medical components of the new pathway to ensure relevant unexpected deaths investigations include skin biopsy. APT service not currently able to offer 7 day a week coverage for taking the skin samples.

Close relative marriage project
Luton continues to be one of 10 areas with a culturally sensitive genetics project being offered to families. CDOP has worked closely with the link Genomics Associate to ensure all child deaths, where close relative marriage is noted, have a complete set of information to help judge if referral to clinical genetics is outstanding or has already occurred. This supports CDOP in using the agreed NCMD consanguinity guide.

Liaison with LA housing teams re Mouldy properties
The Panels Chair has sought reassurance from the three Local Authorities with regard to the management of mould in properties. Housing leads attended a CDOP meeting to discuss actions underway.

Thematic panels
Due to the large numbers of perinatal deaths to be reviewed, the Panel has convened additional neonatal themed panels for the year 2024-25 to address the backlog. 5 Neonatal panels were held between 2023-24. 20 cases were closed, and modifiable factors were identified in 3 cases.

Continued promotion of safe sleeping
Sleeping arrangements for babies are routinely reviewed by the health visitors as part of the Healthy Child Programme. Safe sleeping is promoted using the Caring for your baby at Night information which is endorsed by The Lullaby Trust, UNICEF UK, RC of Midwives and institute of Health Visiting and NICE. Safe Sleeping information is part of the Bedfordshire and Luton Early Days booklet (also available digitally and on recite) which is given to all parents across Bedfordshire at maternity booking and new birth visit. In Luton the Tubes of Life programme is delivered by Early Years practitioners and Community Link Workers to parents-to-be and new parents as part of Safe at Home and Keeping Baby Safe sessions. The programme focusses on oxygen supply and positioning when sleeping. It supports health professionals including health visiting and maternity, through training to deliver key public health messages and support parents by raising awareness and improved understanding.

(https://www.cambscommunityservices.nhs.uk/docs/default-source/Beds---0-19-Team/early-days-booklet---beds---july-2022.pdf?sfvrsn=2)

Smoking cessation
This is an ongoing action for panel as women exposed to cigarette smoke during pregnancy are prone to premature birth, stillbirth, miscarriage, at greater risk of low birth weight and SIDS. Older children exposed to cigarette smoke are more prone to breathing problems such as exacerbations of asthma. Carbon monoxide monitoring was paused in March 2020 due to the coronavirus pandemic but gradually resumed at the start of 2021. Maternity Services in BLMK currently aim to monitor carbon monoxide levels in pregnant women at every antenatal appointment. Parents are offered access to smoking cessation services via Universal health services at all points of contact with midwives, GP's and health visitors. Information is given to mothers on risks of smoking in pregnancy and effects of second-hand smoke on children at antenatal appointments, new birth visits and development reviews. Pathways are in place to provide smoking cessation support to all pregnant women across BLMK via treating tobacco dependency advisors based within maternity services. Smoking cessation is a priority across BLMK ICB footprint especially within Luton and Bedfordshire. In Luton funding has been prioritised to tackle health inequalities and support pregnant women who opt into the Total well-being Luton stop smoking service to quit during pregnancy and successful long-term quitting, including financial incentives to quitting in the long term, and access to all stop smoking aids including e-cigarettes. The project aims to decrease the number of women recorded as smoking at the time of delivery to improve health outcomes for the mothers, fathers, newborns and whole family.

Latest NHS digital data shows that in 2023-2024 (year to date) 5.3% of woman across BLMK are recorded as smoking at the time of delivery. For 1.1% of women the smoking status is recorded as unknown[6]. This compares to 7.4% (year to date) women smoking at time of delivery across England with 2.3 % of unknown smoking status.

Close relative marriage and genetic risk

Panel noted some child deaths where consanguinity/close relative marriage was a contributory factor.
The designated Dr for Luton was a member of the NCMDs working group which wrote the NCMD Guidelines for CDR professionals and CDOPs on consanguinity[7]. Where families have a child affected by a genetic condition and they are in a close relative marriage, access to culturally sensitive clinical genetic services should be offered. Where this has not happened, this would be viewed as a modifiable factor in relation to service quality.

Luton has been recognised by NHS England as one of 9 High needs areas where access to clinical genetics required targeted support for underserved ethnic groups. The culturally competent genetic service is being developed in Luton with support from NHS E and will provide important support for families with increased genetic risks, including consanguinity.

It aims to:

- improve access to high quality genetics service for underserved groups with the addition of dedicated genomics associate for Luton families
- give families the opportunity to make informed reproductive decisions whilst respecting their culture, values and beliefs

The programme has four strands which will be developed throughout the year:

1. Raise genetic literacy at community level
    a. Appoint Community Link Worker locally to work with families and improve awareness update on current status
    b. Health promotion provided by NHSE
2. Educate and equip healthcare professionals
    a. Close relative marriage midwife appointed
    b. Training and e-learning available for professionals update
3. Improve access to genomic services for underserved groups
    a. Appointed Genomic Associate to support increased referrals
    b. Improve referral pathways
4. Continuously improve with national support

Maternal Obesity

Maternal obesity can result in negative outcomes for both women and their unborn children and increases risk of pregnancy complications and caesarean delivery. Maternal risks during pregnancy include gestational diabetes and pre-eclampsia and for child risks include stillbirth, congenital abnormalities, and neonatal deaths. Obesity in pregnancy can affect health later in life for both mother and child.

Support and information are provided by midwives and antenatal classes. Targeted support to help women manage their health and wellbeing through pregnancy is delivered by Total Wellbeing Luton (through a Healthy Lifestyles during Pregnancy programme) and MoreLife in Bedfordshire (MUMS2B and 4MUMS programmes). Referrals are often lower than desired, this might be because weight is an emotive and difficult topic to raise, particularly where a woman's Body Mass Index may not be recorded or shared with partners. Further work to look at pathways and develop actions continues to be taken forward.

The healthy weight services are continually offering support and advice to all professionals who need expertise in how to raise the subject of weight and how to refer in. MoreLife offer monthly lunchtime webinars on a wide range of weight related areas in a further drive to support professionals. It continues to be absolutely crucial for pregnant families to be offered support with their weight at all opportunities and for this to be recorded even if declined during their current pregnancy as we know that they may return for support in preparation for a following pregnancy.
Support from Total Wellbeing (Luton) and MoreLife (Bedford Borough & Central Bedfordshire) focuses on changing health behaviours and importance of living a healthy lifestyle. Support is delivered as a whole family approach to change and embed healthy behaviours and is linked with other public health messages in pregnancy such as smoking cessation. Work has started across BLMK around pre-conception advice and care. This is also focus for both the newly formed Family Hubs in Bedford Borough and Luton.

The Family Hub model which are becoming established in Bedford Borough and Luton will support families from conception, through the child's early years, to later childhood, up to the age of 19 (or 25 for young people with special educational needs and disabilities). They use a whole family approach to provide a single access point to family support services that is integrated across health (physical and mental health) and social care as well as voluntary and community organisations and education settings.

The Hubs will provide family support services early when families need them. These include universal and targeted services and can support all families, particularly in the first 1,001 days, but they are designed to be particularly accessible to families from lower socio-economic groups, families who have special education needs or a disability, or those from minority groups who are experiencing exclusion.

Family Hubs are not necessarily about creating new buildings but more of a focus on bringing services together and changing the way family help and support is delivered locally.

Safety
The panel has promoted public safety through working with local authorities and Highways teams to promote safety around beaches and other water ways and on roads. Water Safety awareness is promoted every year. We also share alerts though our newsletter regarding safety issues such as button batteries and cord blinds.

Suicide
BLMK has a joint suicide prevention strategic action plan. One of the objectives is to tailor approaches to improve mental health in children and young people and access to mental health services. Community Action plans and pathways are in place for educational settings for a response from Public Health to co-ordinate agencies to support following a death by suicide of a child or young person.

All schools have a policy and guidance in place to support them regarding not only what to do in the event of a suspected suicide but also a wealth of supporting information and links to services.

In regard to emotional health and wellbeing support, the Local Offers on each Local Authority website provide a wide range of information on local and national information and services.

In education settings CAMHS provide Mental Health Support Team (MHST), Schools Mental Health Team (SMHT) or Behavioural Improvement Team (BIT) to support settings with all aspects of emotional and mental health.

Children and young people have access to digital support through the REFLECT text messaging service and Health Visitors and School Nurse team via Chat Health. This is alongside local voluntary support services and signposting to national organisations and information. There is a continuous offer of training regarding all aspects of mental health made available to all professionals working with children, young people and their families. Educational settings are also supported to review their health and wellbeing provision and advised on areas of improvement to guide their self-review work. They are encouraged to access information from recognised organisations such as the PSHE Association and the Sex Education Forum. The strategic action

plan also recognises that vulnerable children, especially those not in education or training, need to be reached. It is recognised that all children and young people need to be able to access support from a range of sources especially those who are not in formal education or training. Each Local Authority has a variety of channels that they use to access these young people and their families. This includes social media groups, newsletters, virtual school settings, voluntary organisation partnerships, text messaging services and close relationships with healthcare and mental health services.

East of England CDR Professional meetings

The designated Drs attended the Eastern CDR professionals meeting to ensure consistency in analysis of modifiable factors across the area. No outliers were found.

Local Training

During 2023-2024 we restarted the Multi-Agency Training across Bedfordshire, delivering two well attended sessions with positive feedback. Feedback received showed that attendees felt by using anonymised cases helped them to understand clearer their role within the process and how CDOP review those cases.

6.0 CDOP action plan 2024-25 All

This annual report will directly inform an action plan for Bedfordshire CDOP to have oversight of the coming year ahead. Panel has noted the following areas require action to reduce the risks of child deaths.

THEME OR ISSUE	Update from 2023-24	Action for 2024-25 for CDOP	Action for wider system
Deprivation is associated with higher number of child deaths locally and nationally		Share findings with Children's Trust Board or equivalent Continue to share annually	Findings incorporated into wider system plans around any additional service actions or focus on deprivation as a risk factor Luton 2040 - Vision 2023 to 2028
Close relative marriage leading to increased genetic risk and autosomal recessive conditions has been noted to be a contributory factor in child deaths		Continue to link with NHS England genetics project in Luton to enhance culturally sensitive genetic services provided to families, educate healthcare professionals to raise awareness, have sensitive conversations with parents and increase referrals to Genetics Service	Close relative marriage Midwife appointed Referral pathways established E learning training launch Face to face training for healthcare professionals Feedback from referrals to Genomic Associate Appoint Close relative neonatal nurse
Safe Sleeping	Continue to promote Lullaby Trust advice Promote findings from Out of routine	CDOP to receive an update report from 0-19 services on how safe sleeping is embedded	

	report in training delivery Continue to seek assurance that the 0-19 service promote at all contact points with families. Report to housing concerns that housing must give families space for a cot in the parent /carer bedroom for first 6 months	CDOP to receive a report from the three housing services on how this is to be embedded.	
Infant mortality higher than England for Beds Borough and Luton. Most infants that die are born prematurely. Smoking & obesity noted to be contributory factors.	Focused review on maternity pathways to be undertaken to ensure 1. Services are known about 2. Services are referred to 3. Referrals are recorded 4. Referrals are made in a health coaching and motivational interviewing approach. Maternity to provide assurance that all referrals into services are recorded, this can then be cross checked with provider services to determine uptake.	Pathway review with the hospital is ongoing, electronic patient record implementation will enable better referral tracking	
Access to skin Biopsy to complete SUDIC investigations recommended by Kennedy report	Designated Dr has worked with Acute Trust on a pathway. Acute Paediatrics have process in place, however currently there is not capacity within the mortuary and bereavement service serve to deliver out of hours	Designated Doctors to continue to support development of the pathways	Mortuary and Bereavement service e action to complete rota cover arrangements

	cover for skin biopsy sampling yet		
Themes from CDOP annual review understood by multiagency practitioner supporting families	Delivered 3 per year Feedback acted upon and integrated into the local safeguarding boards partnership arrangements. Feedback received showed that attendees felt by using anonymised cases helped them to understand clearer their role within the process and how CDOP review those cases.	Continue regular training sessions	
Joint statement of royal colleges regarding eye examination for SUDICs	Designated doctor developing pathway with Acute trust		Training planned by ophthalmology and Acute paediatrics to ensure key competencies met Acute Trust to update CDOP when process in place
There is a new toolkit to review best practices for supporting families via Key Workers where the death was not sudden or unexpected. https://www.ncmd.info/guidance/parents-cdr-toolkit/		Share toolkit with the ICB, Acute Trusts, Community Trust and Hospice	A keyworker is identified to support families
Health contribution for joint home visits as required with the Police.	ICB has initiated discussions with the Police		ICB considering models of delivery There are no joint visits in place presently
Key worker to be available for all families experiencing SUDICs.	Key worker not available for SUDICs. Bereaved families will still be allocated a Lead professional and under new regulations the Medical Examiners Officer will have contact with all families and ascertain if they	Further discussions with CDOP partners for funding for dedicated post holders	

	have any concerns about their child's care. All families are given a bereavement pack which contains the following: • Bereavement Support Officer - Business Card • Lullaby Trust - Business Card • Bereavement Support leaflet - Beds Hospitals • Information on the Child/Baby Memorial Book (kept in the Chapel). • What to do next - brochure • Lullaby Trust - Child death review booklet. • When a child dies - NHS England.		
A new statutory medical examiner system is being rolled out across England and Wales to provide independent scrutiny of deaths, and to give bereaved people a voice. From 9 September 2024 all deaths in any health setting that are not investigated by a coroner will be reviewed by NHS medical examiners.		The changes, which form part of the Department of Health's Death Certification Reforms, were announced by the government on 15 April 2024, and come into force on 9 September 2024	Work is on-going to ensure strong links/pathways are in place with CDOP Panel

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References:

1.https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/2021refreshedpopulations
2. https://www.ncmd.info/wp-content/uploads/2021/06/NCMD_2nd_Annual_Report_June-2021_web-FINAL.pdf
3. 2021 Census estimate, Office for National Statistics[3]
4. MHCLG Indices of Multiple Deprivation 2019, Deaths: NHS
5.https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf
6.https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-women-s-smoking-status-at-time-of-delivery-england/quarter-4-2021-22/data-tables
7.https://www.ncmd.info/wp-content/uploads/2023/01/NCMD-Guidance-on-Consanguinity.pdf
8.https://www.rcpath.org/uploads/assets/874ae50e-c754-4933-995a804e0ef728a4/Sudden-unexpected-death-in-infancy-and-childhood-2e.pdf)