



**Cambridgeshire and Peterborough Child Death
Overview Panel**

Public Annual Report 2014 - 2015

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June 2015

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1. Introduction

- 1.1 The aim of this report is to summarise the work of the Cambridgeshire and Peterborough Child Death Overview Panel (CDOP) during 2014-15.
- 1.2 It gives a summary of the deaths reported to and reviewed by the panel during the last year together with an analysis of the data and emerging themes from 2008 when figures were first collected through to March 2015.
- 1.3 Fortunately it is rare for children to die in this country and therefore the number of child deaths in any particular age range within a local area is small in number. However, this means that generalisations are rarely appropriate and for lessons to be learned data needs to be collected and reported on nationally and over a number of years. Current methods of data collection mean that accurate regional and national comparisons are not readily available, but where relevant, they are included in this report.
- 1.4 Because the number of child deaths is small it may be possible to identify individual children. All text, data, tables and figures in this public version of the report where they represent individual children have been removed. This excludes information relating to two individual children whose deaths were subject to a Serious Case Review, as the full review reports have been published. The full version of the report is available to professionals on request. Please contact the CDOP Coordinator via capccg.cdop@nhs.net

2. Background

Child Death Overview Panels (CDOP) were established in April 2008 as a new statutory requirement as set out in Chapter 7 of 'Working Together to Safeguard Children' 2006.¹ Their 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 the area aged under 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 Local Safeguarding Boards of Cambridgeshire and Peterborough form a single Child Death Overview Panel.

¹ 'Working Together to Safeguard Children' has been revised and was reissued in March 2015. The responsibilities of Child Death Overview Panels are set out in chapter 5 and remain unchanged.

2.1 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 the death was preventable.
- 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.
- Monitoring the response of professionals to an unexpected death of a child
- Referring to the Chairs of the local Safeguarding Children Boards (LSCB) any deaths where the panel considers there may be grounds to consider a serious case review.
- Monitoring the support services offered to bereaved families.
- Identifying any public health issues and considering, with the Director of Public Health, how best to address these and their implications for the provision of both services and training

3. 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

4. The Process

4.1 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.

4.2 During 2014-15, the CDOP has met four times to review anonymous information about child deaths. The panel is chaired by the Cambridgeshire LSCB chair and has members from all relevant agencies.

- 4.3 A separate panel which reviews neonatal deaths is chaired by the Designated Doctor for Death in Childhood. Neonatal deaths are reviewed separately because the reasons such young babies die is almost always health related and the added value of attendance by agencies such as the police and children's social care services is very limited. This meeting, therefore, is multi-disciplinary rather than multi-agency and reports any relevant issues to the main CDOP.
- 4.4 The administration of the CDOP process is hosted by NHS Cambridgeshire and Peterborough Clinical Commissioning Group and funded jointly with the Peterborough and Cambridgeshire Children's Services Departments.

5. The National Picture

- 5.1 Every year it is estimated that 1,951 additional children - around 5 a day - die in the UK compared to Europe's best performing country for child mortality, Sweden. The key areas where the UK rates appear to be relatively high are infant deaths and deaths among children and young people who have chronic conditions.² The UK infant mortality rate (deaths of babies aged under 1 year per 1000 live births) in 2013 was 3.8, the lowest ever recorded in England and Wales. Sweden and Norway have the lowest rates in Europe with an infant mortality rate of 2.6 and 2.5 deaths per 1000 births.
- 5.2 Babies who die under the age of one tend to be from deprived households, have a low birth weight and have parents who smoked. Between the ages of one and five, deaths are mostly linked to injuries, accidents and serious diseases.
- 5.3 The number of child death reviews completed has decreased year on year from 4061 in the year ending March 2011 to 3658 in the year ending March 2014. The percentage of child death reviews identified as having modifiable factors increased slightly from 20% in the year ending 31 March 2011 to 22% in the year ending 2014.
- 5.4 Nearly two thirds of child deaths in England and Wales in 2013 were of children aged under one year with the main causes of death perinatal events and

² *Why Children Die: Death in Infants, children and young people in the UK*. Royal College of Paediatrics and Child Health and National Children's Bureau 2014.

chromosomal, genetic and congenital abnormalities. Congenital related conditions and cancers remain the most common form of death for children aged under 16 years.³ External factors such as road traffic accidents, drowning and assault are the main cause of death of young people aged 15-19 years.

6. Local Overview

Reported Deaths

- 6.1 Infant and child mortality rates are slightly below the England average in Cambridgeshire and slightly higher than average in Peterborough, although not significantly different (see appendix A, mortality rates by Council area).
- 6.2 Over the last year, the deaths of 43 children were reported to the CDOP across Cambridgeshire and Peterborough, 30 in Cambridgeshire and 13 in Peterborough. This is the lowest number since 2008 when data was first collected and below the average of 55 deaths per year. 58% of these children were babies under one year old and 49% died due to a perinatal or neonatal event irrespective of their age. The majority died in the neonatal period however never having left hospital. 8 unexpected deaths were reported in Cambridgeshire this year (26% of child deaths) and none in Peterborough.
- 6.3 Last year's number of reported deaths has been modified from 53 to 56. After comparing the child deaths reported to CDOP in 2013-14 to the Registrar General data set it was found three deaths had not been reported to the CDOP (one Cambridgeshire child and two Peterborough children). This has been brought to the attention of the organisations responsible for notification and aggregate data sets and graphs have been updated to reflect this higher number of deaths.
- 6.4 15 (35%) of children died from a known life limiting condition this year, spread across all age groups.
- 6.5 Chart 1 below shows a similar pattern of deaths across the age groups since data was first collected. See appendix A for deaths reported by council area.

³ *Childhood, Infant and Perinatal Mortality in England and Wales, 2013*. Office for National Statistics March 2015

Chart suppressed: Chart 1 - Deaths reported to Cambridgeshire and Peterborough CDOP 2008 - 2015 by age group

Chart suppressed: Chart 2 - Deaths reported to Cambridgeshire and Peterborough CDOP 2014-15 by cause

Deaths reviewed

- 6.6 A total of 53 deaths were reviewed in 2014/15; 36 Cambridgeshire children and 17 Peterborough children. 28 deaths were reviewed by the main CDOP Panel and 25 by the Neonatal Panel.
- 6.7 One of the purposes of the child death review process is to identify 'modifiable' factors for each child that dies. That is, any factor which, on review, might have prevented that death and might prevent future deaths. There were nine child deaths last year where a modifiable factor was identified by the panel (seven by the main panel, two by the neonatal panel) and these are described in more detail below.
- 6.8 Not all of the deaths which were reviewed occurred in this year, some will have occurred the previous year or even earlier. There is generally a gap of several months between a reported death and that death being reviewed to enable all relevant information to be gathered. CDOP is unable to review a death until other processes have been completed such as NHS Trusts Serious Incident Investigations, Serious Case Reviews, post mortem reports and Coronial inquests. The table below shows that 38% of the deaths reviewed this year actually occurred the year before. 60% of deaths reviewed this year also occurred in 2014-15. 94% of cases reviewed this year were completed within 12 months. Last year, 2013-14 78% of deaths were reviewed within 12 months which is more in line with the national figure of 72% of reviews being completed within 12 months of the child's death, which has decreased year on year from 78% in the year ending March 2011. The DfE acknowledges that reviewing child deaths is an extremely complex task and these figures are not used as a performance measure.

Table suppressed: Table 1 - Deaths reviewed by year of death, Cambridgeshire and Peterborough 2014-15

- 6.9 As in previous years the majority of children whose death was reviewed were less than a year old; 62% for both areas, 58% for Cambridgeshire and 71% for Peterborough.
- 6.10 In both areas the next highest age range was young people aged 15 - 17 years, 14% for Cambridgeshire and 17% for Peterborough.
- 6.11 The main causes of death reflected similar years, with 43% of deaths being the result of perinatal or neonatal difficulties and 36% of the children dying from known life limiting conditions. See appendix A for charts by council areas.

Chart suppressed: Chart 3 - Deaths reviewed by Event, Cambridgeshire and Peterborough 2014-15

Chart suppressed: Chart 4 - Deaths reviewed by Category, Cambridgeshire and Peterborough 2014-15

CDOP Main Panel – Modifiable Factors

- 6.12 The main CDOP panel met four times and reviewed the deaths of 28 children. Modifiable factors were identified in seven cases.
- 6.13 The learning and actions arising from these cases include:
- Learning to feed into the county wide Suicide Prevention Group which has developed a joint Cambridgeshire and Peterborough prevention strategy.
 - An issue with the arrangements for prescribing, monitoring and review of medication was raised with NHS England.
 - The report *Why Asthma Still Kills - National Review of Asthma Deaths* (Royal College of Physicians, 2014) was brought to the attention of the CCG Quality and Patient Safety Director. The work of the Regional Asthma Forum in redesigning paediatric asthma care pathways was noted and updates on the project were received by the panel.
 - The CDOP has shared learning around working with doulas and drawn attention to the Local Supervising Authority Midwifery Officers guidance on this subject to local Maternity Services Providers.

- 6.14 Chart 4 provides a breakdown by category for deaths where modifiable factors were identified over the seven years in which figures have been collected. See appendix A for modifiable deaths charts by council area.

Chart suppressed: Chart 4 - Deaths where modifiable factors were identified by Cambridgeshire and Peterborough CDOP 2013-14 by category of death.

Neonatal Panel - Modifiable Factors

- 6.15 The Neonatal CDOP met twice over the course of 2014-15 and completed a review of 25 deaths. The deaths reviewed were of babies who died in the neonatal period (0 - 27 days) or shortly after and who had never left hospital. The CDOP is required to review the deaths of all babies if they are registered as live births, regardless of gestational age at delivery. This excludes terminations of pregnancy carried out within the law but includes miscarriages as early as 19 weeks gestation.
- 6.16 The age of viability is 24 weeks gestation but many of the neonatal deaths that have been reviewed are babies born before the age of viability, who had a heart rate and sometimes other signs of life present for some time after delivery. 7 (28%) of the neonatal deaths reviewed were non-viable babies. These deaths are often the result of complex antenatal causes and inclusion of them in the statistics may not paint an accurate picture of the neonatal death rate.
- 6.17 Modifiable factors were identified by the Neonatal panel in cases where the deaths were already reported and investigated as a Serious Incident by the relevant Trust. These reports were reviewed and no further recommendations were made.

7. Action Taken in Response to Modifiable Factors and Trends Identified

- 7.1 Children's Services in Peterborough were inspected by Ofsted this year and the work of the joint Cambridgeshire and Peterborough Child Death Overview Panel was reviewed as part of this inspection. The following was noted in the inspection report:

'The CDOP has been effective in analysing local information on child deaths, identifying patterns and trends, and developing and rolling out two good awareness-raising programmes focusing on the risks of swimming in rivers and of adults co-sleeping with young babies. The CDOP has not identified any preventable deaths

and has not felt it necessary to refer any cases to the LSCB because of concerns about professional practice'.

Safer Sleeping Campaign

- 7.2 During 2013 a Safer Sleeping task and finish group was set up; with a view to exploring how infant deaths could be reduced across Cambridgeshire and Peterborough. Sadly a number of infant deaths had been attributed to parents not being aware of the risks of sleeping with their babies and in some cases there were contributory factors such as parental alcohol behaviours (Serious Case Review Cambridge 2012). The group proposed a number of actions which have been implemented during this year.
- 7.3 The Safer Sleeping Campaign was formally launched in April 2014 and a programme of six workshops and additional talks took place during 2014. The workshops were facilitated by the Designated Doctor for Death in Childhood, LSCB Training Managers, Health Visiting leads and DAAT.
- 7.4 A number of leaflets have been purchased and downloaded (different languages) from the lullaby trust. The Safer Sleeping leaflet and lessons learned briefing, from a Cambridgeshire Serious Case Review, has been distributed amongst the LSCB agencies, across Peterborough and Cambridgeshire, Local Practice Groups and the LSCB Committees. Safer sleeping and the 'lessons learned' regarding parental alcohol behaviours have been written into all relevant LSCB training courses.
- 7.5 Prior to the Christmas holidays, at a time when alcohol becomes a celebratory factor, all General Practitioners across both areas have been written to by the Chairs of the LSCB's, about the campaign and a number of leaflets for parents and professionals have been included for distribution within their surgeries. Additionally 'Night Time Economy' leads (Pubs / Clubs / Councils and supermarkets) have agreed to be part of the campaign and have distributed the leaflets within the public arena (i.e. in the bar, reception areas and public toilets (male and female).
- 7.6 It is positive to note that the target audience for which the workshops were aimed attended (these included nursery nurses, midwives, health visitors, children centre staff and family workers - those practitioners who would have the most contact with families and babies). However there were few social care staff present for whom the

workshop would have been beneficial in terms of networking, sharing important information about safer sleeping for families and improving safeguarding practice. Overall all of the groups were well received and entailed much discussion from practitioners.

- 7.7 Safer Sleeping is contained within health visitor's breast feeding policy and clinical care packages. A small sample audit was undertaken and found that most health visitors recorded the discussion with parents around safer sleeping and that a leaflet had been put in the red book. It has been enlightening to see a number of children centre and family worker staff who attended the workshops and are displaying the leaflets within their establishments. Midwives also attended the event within the hospital along with specialist foster carers (working with babies of families who have alcohol / substance misuse issues) - both of which were eager to take the messages back to new mums and dads.
- 7.8 The Safer Sleeping Campaign has been a success in terms of promoting awareness and the safeguarding messages to practitioners working with families about safer sleeping, combined with highlighting other impacting factors on infant death such as parental alcohol behaviours. Success should also be measured in terms of how many leaflets have been distributed and are visible and available to parents.
- 7.9 The safe sleeping campaign has been re-launched for 2015 and a further two workshops have been planned for early help workers, early years, locality teams and children's centres across the region. Further evaluation of the campaign (e.g. single agency audits of records of discussions with parents, discussions with professionals around how the campaign has influenced their practice) will be undertaken in 2015-16.

End of Life Care

- 7.10 From the review of a number of deaths of children with a life limiting illness it appears that some families are not receiving consistent end of life care. The panel was struck by the different level of service provided to different families.
- 7.11 The Cambridgeshire and Peterborough area is fortunate to have within its health economy a well-developed children's hospice service which offers 24/7 specialist symptom management support. There is also access to a Managed Clinical Network which provides out of hours medical advice. The Children's Community Nursing is

currently not able to provide 24/7 nursing support on a consistent basis although staff does participate in ad-hoc rotas to support specific children. There is also a small Paediatric Palliative Care Team in the tertiary centre which primarily focuses on children with cancer.

- 7.12 There seems to be an inconsistent approach to discussing the need for palliative care input and hence engagement in the more specific end of life element of palliative care. Direct feedback from families is difficult to obtain in these very distressing circumstances but feedback from professionals at multi-agency debrief meetings suggest that the experiences of families can be variable.
- 7.13 The Designated Doctor for Death in Childhood has written to the Director of Quality, Cambridgeshire and Peterborough Clinical Commissioning Group, to highlight this issue and ask the CCG to consider how best to raise these issues with acute providers to ensure they understand their responsibility to appropriately refer in a timely manner children living with a life limiting illness (to facilitate anticipatory planning) and those nearing the end of their life.

Water Safety

- 7.14 Following a number of deaths from drowning the CDOP held a water safety campaign last year. The panel will continue to highlight water safety especially before May and summer holidays.

8. Serious Case Reviews

- 8.1 Two deaths that were subject to a serious case review were considered by CDOP in 2014/15.
- 8.2 Child H (Cambridgeshire LSCB) was a 2 year old girl who was murdered by her mother's teenage boyfriend in November 2013. The boyfriend is currently serving a life sentence. The conclusion of this SCR is that there is no evidence that the child's death could have been either predicted or prevented by the professionals who came into contact with her and her family. There was nothing in the mother's boyfriend's past that indicated that he would perpetrate the level of violence that resulted in her death. The SCR identifies some areas where practice could be improved but these did not contribute to the child's death. However the window onto the system this review has allowed has identified some learning which has been

implemented by the LSCB in Cambridgeshire. No modifiable factors were identified by the CDOP panel.

- 8.3 Child A (Peterborough LSCB) was a nine week old baby who died of severe head injuries and had also sustained other non-accidental injuries. The baby's father has been convicted for murder and sentenced to life imprisonment. The Serious Case Review report concluded that the death of the child could not reasonably have been predicted by any agency or individual who knew her or had any information about her. No professional, nor any family member, had any child protection concerns for the child during her short life. The period covered by the review included the three days following the child's death and made two recommendations regarding the Rapid Response Process. The first recommendation was that the PSCB should seek reassurance by way of quality assurance activity quality assurance of timings and meetings as part of child death procedures are fully compliant with WT2013 and has been taken forward by the Quality and Effectiveness sub group of the PSCB. The second recommendation was that the Multi Agency Protocol for the Management of Unexpected Deaths is reviewed by a task and finish group from both CSCB and PSCB. This task and finish group was chaired by the CDOP Chair and had representation from Police, CSCB, PSCB and Health. Both the Multi Agency Protocol for the Management of Unexpected Childhood Deaths and the CDOP Protocol and Terms of Reference were reviewed in light of the Serious Case Review learning and was amended to ensure compliance with Working Together 2013. The revised protocols were distributed to partners and published on the CSCB and PSCB websites.

9. Unexpected Deaths / Rapid Response Service

Arrangements for home visits

- 9.1 The Police representation on the joint on call rota remained the same this year. The Health representation on the rota has changed; two members have given their notice this year which has increased the frequency of on call periods for the remaining five members. The on call element of the Health Rapid Response Service will be reviewed in the coming year.
- 9.2 Eight children died unexpectedly in Cambridgeshire this year; there were no unexpected deaths in Peterborough. An unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility for example,

24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death.

10. East of England Regional Child Death Overview Network

- 10.1 This network of CDOP Coordinators and Managers met twice in the last year and provides a forum for sharing data across the region, identify trends and issues, facilitate the sharing and dissemination of learning and preventative approaches identified by the CDOP process, and share information about local operational and procedural issues.
- 10.2 The group collated the percentages of modifiable factors per category for the panels in the region in the year ending 31 March 2014. The percentage of reviews where modifiable factors were identified varies significantly for Child Death Overview Panels in different areas. From this and previous discussions around issues such as antenatal smoking and consanguinity it appears the different CDOP panels in the region have a different understanding of what constitutes a modifiable factor. For example, some panels class every neonatal death where the mother smoked during pregnancy as modifiable whereas other panels would only do so where a direct link is identified between the mother's smoking and cause of death. Some panels judge consanguinity of the child's parents to be a modifiable factor whereas others do not if the family were provided with genetic counselling.
- 10.3 A standardized approach for reviewing child deaths is encouraged by the use of the DFE data collection templates but it seems, despite the clear definition of modifiable factors provided, that different panels make different decisions when reviewing child deaths with similar features. Although CDOP Panels were established to have a local focus for the national annual data return to be meaningful more detailed guidance is needed regarding interpreting case factors and identifying those which are modifiable. The Child Death Review Manager for Cambridgeshire and Peterborough has written to the Department of Education on behalf of the Network but no reply has been received to date. One of the objectives on the CDOP Business Plan for 2015/16 is to reach regional agreement on modifiable factors for similar types of child death to achieve more meaningful data to compare on a regional level.

11. CDOP Training

11.1 The two LSCB's have jointly run three training sessions this year entitled 'Understanding the Impact of Serious Case Reviews and the Child Death Overview Process'. The sessions were attended by 10 - 13 people per session with participants from various agencies including Police, Health Providers, Social Services and Children's Services. Four sessions were planned; one was cancelled due to lack of attendance. Two more sessions are planned in the next training year. The sessions were well received; some of the comments from the course evaluation forms are included here:

- It was excellent, really informative, and I thoroughly enjoyed it.
- Really good course, tragic cases covered. Trainers were very knowledgeable and conveyed difficult information in empathetic and down to earth way.
- Very engaging, informative and well planned course.
- Excellent course
- Very useful and well presented
- Best Training I have been to in several years.

12. Support to Bereaved Families

12.1 Prior to a child's death being reviewed, his or her family is normally written to, advised about the purpose of CDOP and encouraged to make contact if there is anything they think the panel should know about regarding the support they received following their child's death. One family chose to contact the panel this year. This is similar to the national picture with very few families, for understandable reasons, choosing to make contact with CDOPs. However, for unexpected deaths, the information sharing meetings, which are held in primary care settings, enable practitioners to coordinate bereavement support.

12.2 Reviewing the bereavement support offered to families and developing a bereavement support directory leaflet is one of the priority actions for the panel in the coming year.

13. Plans for the Year 2015-16

13.1 The 2015/16 business plan is attached as appendix B. The priority actions are summarised below:

- Review bereavement support for families and develop a leaflet listing support available
- Evaluate the Safe Sleeping campaign
- Reach regional agreement on identifying modifiable factors

Appendix A – Graphs and Tables

Mortality Rates by Council Area

1)

Infant Mortality Rate (deaths of babies aged under 1 year per 1,000 live births), 2011-2013⁴

Local Authority	Infant Mortality Rate (CHIMAT 2010-12)	England average
Cambridgeshire	3.4	4.1
Peterborough	4.4	4.1

2) **Child Mortality Rate (directly standardised rate per 100,000 children age 1-17 years), 2011-2013⁴**

Local Authority	Child Mortality Rate (CHIMAT 2010-12)	England average
Cambridgeshire	9.9	11.9
Peterborough	17.8	11.9

3) **Table suppressed: Reported Deaths by Gender 2014-15**

4) **Chart suppressed: Reported Deaths by Council Area, by age, 2008 - 2014**

5) **Chart Suppressed: Reported Deaths by Council Area, by Cause of Deaths, 2014-15**

6) **Chart Suppressed: Reviewed Deaths by Council Area, by Category 2014-15**

7) **Chart Suppressed: Reviewed Deaths by Council Area, by Event 2014-15**

8) **Chart Suppressed: Modifiable Deaths by Council Area, by Category 2008 - 2015**

⁴ Child Health Profiles for Local Authorities, National Child and Maternal Health Intelligence Network, chimat.org.uk

Appendix B – Business Plan for 2015-16

	Objective	Lead	Action and timescale	Outcome	Progress
1.	Review bereavement support for families	EL / KP	Describe the type & amount of support available across the County & identify gaps, good practice and variances. Sept 2015.	Better support for bereaved families as measured by feedback	On-going – carried over from 2014/15 Business Plan. KP is in the process of contacting NHS providers and charities to identify support available. The existing bereavement support directory will be updated with this information and will then be updated bi annually. This information will be available to families in leaflet form – content to be signed off at Sept 2015 Panel.
2.	Reach regional agreement on identifying modifiable factors	KP	Maternal smoking and consanguinity were identified as factors that are classed as modifiable by some CDOP panels and not modifiable by other panels. KP to raise this at the next EOE regional meeting. Identify any other	More meaningful data to compare on a regional level.	April regional meeting cancelled – to rearrange for June / July 2015.

			factors that may be interpreted differently and try to reach regional agreement on modifiable factors for similar types of child death.		
3.	Deliver CDOP multi agency training	SG / JB	Deliver the half day workshop 'Understanding the Impact of Serious Case Reviews and the Child Death Overview Process'. 11 Feb / 18 June / 05 Nov 2015, 12 May 2016	Enable (multi-agency) workshop participants to gain an understanding of the importance of serious case reviews and the child death overview process and how the findings from them impact on practice.	
4.	Evaluate 'Safe Sleeping' campaign	FS	Measure the impact of the Safe Sleeping campaign on practice of professionals.	Improve parental awareness of safe sleeping Reduce the numbers of SUDIs	
4.	Relaunch water safety poster	KP	Distribute water safety flyer before May half term and Summer holiday to partners and display on LSCB websites.	Greater public awareness of water safety issues	
6.	Ensure both LSCBs are kept informed of the work of CDOP	FS / KP	Annual report. July 2015	Lessons learned from CDOP shared with safeguarding partners.	

