Somerset Local Safeguarding Children’s Board

Child Death Overview Panel

2015-2016 Annual Report
Foreword from CDOP Chair:

We are fortunate that a child death is a rare event in our society; however, each death represents a tragedy for the family. The panel of professionals that work together to ensure that each death is reviewed holistically and respectfully to identify any learning or service improvement take this responsibility very seriously. I would like to take this opportunity, as chair of the panel, to thank each and every member of the panel for their dedication, hard work and professionalism. I would also like to thank all the professionals who have supported Somerset children nearing the end of their life or at the time of death. We thank you for your care and input to the multiagency reviews hosted by our dedicated designated doctors and for your written submissions, that enable a thorough review of all aspects of the child’s life.

I would also like to thank both the child death administrator and the Associate Nurse for Safeguarding for all their hard work over the last year.

Finally as a panel we welcome the Wood Review’s recommendations regarding child death overview panels and will work to ensure, that, over the coming year our data collection locally will contribute nationally to a better understanding of the reasons why children die.
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1.0 INTRODUCTION

1.1 Background to the Child Death Review Process

1.1.1 The overall purpose of the child death review process is to understand how and why children and young people die, identify any interventions or improvements to services which may help to prevent future deaths and/or improve experiences for children and families receiving services.

1.1.2 The process of the child death review is to:

- document the cause of death for the child or young person
- recognise any factors which may require a more in-depth review by agencies and/or make recommendations for review of service provision
- identify any pattern of deaths within the local community to enable recognised modifiable factors to be reduced

1.1.3 Since 2008, when the Child Death Review process became a statutory function of the Somerset Safeguarding Children’s Board (SSCB), has had an organised process in place, to both:

- respond to the unexpected death of a child, through a rapid response team jointly staffed by local paediatricians and a police officer from the constabulary’s Investigation Team
- and to gather information and systematically review the child’s life and care they received prior to and at the time of their death

1.1.4 In March 2015 revised Working Together to Safeguard Children guidance was published. In essence the responsibility for Child Death Review process has remained the same, there have been small clarifications regarding how the process should be running.

1.1.5 This guidance states the functions of the CDOP include:

- reviewing all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law
- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members
- discussing each child’s case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family
• determining whether the death was deemed preventable, that is, those deaths in which modifiable factors for example, in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level to reduce the risk of future child deaths.

• making recommendations to the SSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible

• identifying patterns or trends in local data and reporting these to the SSCB

• where a suspicion arises that neglect or abuse may have been a factor in the child’s death, referring a case back to the SSCB Chair for consideration of whether a Serious Case Review is required

• agreeing local procedures for responding to unexpected deaths of children; and

• cooperating with regional and national initiatives – for example, with the National Clinical Outcome Review Programme – to identify lessons on the prevention of child deaths

1.1.6 In reviewing the death of each child, the CDOP should consider modifiable factors, for example, in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level.

1.1.7 The responsibility for determining the cause of death rests with the coroner (in coronial cases) or the doctor who signs the medical certificate where the death is not referred to the coroner. In both cases the Cause of Death is not the responsibility of the Child Death Overview Panel (CDOP).

1.2 The Somerset Child Death Review Process

Rapid Response

1.2.1 The Rapid Response describes a process of communication, collaborative action and information sharing following the unexpected death of a child. Its purpose is to ensure that agencies work together:

• to respond promptly to the unexpected death of a child

• make immediate enquiries into the reasons for and circumstances of the death, in agreement with the Coroner and Police

• undertake enquiries that relate to the current responsibilities and actions of each organisation when a child dies unexpectedly, to include the collation of information to enable future case analysis
• ensure ongoing support and communication with family members and relevant professionals to share information as appropriate

1.2.2 The Somerset process following all unexpected deaths includes:

• a strategy meeting as immediate as possible, including Police, Paediatrician and liaison in person or by telephone with Children Social Care

• examination of the deceased child by the police and paediatrician, including collection of Kennedy samples (as described in the paediatric protocol) so that examination of tissues is enabled promptly to ascertain the cause of the child’s death

• a joint visit to the child’s home by a senior police officer and paediatrician to view the family home; hear the narrative of events from the family, as well as advising them of the process of the review. The joint visit allows for a fuller in depth analysis of events leading up to the child’s death

1.2.3 The Rapid Response Protocol was followed for all 5 unexpected deaths for children in Somerset during 2015 – 2016. This represents 13% of all child deaths reviewed.

**Multi-Agency Meeting**

1.2.4 The multi-agency meeting should be held as soon as practicable within two – three months after the child’s death, although this can be delayed due to outstanding post mortem reports and the availability of Consultant Paediatric Pathologists. One of the two Designated Doctors for Child Death Review chairs the meeting.

1.2.5 In essence, the multi-agency meeting can provide the story of the child, and ‘the child’s journey’. Parents have often by this stage contributed to the review through their contact with one of the key professionals who knows the child and family best. Following the meeting, feedback is then offered to the family by an appropriate professional who is known to the family, often the Paediatrician or the family GP.

1.2.6 Professional attendance at the multi-agency meeting varies between cases. Dependent on the health and social needs of the child, age of the child and whether the death was expected or unexpected. For children with chronic or complex health needs professional involvement may include out of county teams from the tertiary hospital. The importance of full professional attendance cannot be over emphasised and can provide both the specialist and local context to the child’s story, as well as fuller analysis and the opportunity to learn lessons. There has been a high level of participation at multiagency meetings, led by Designated Drs for child deaths and hosted in many cases by Primary Care. This enables a full holistic review of the child’s life.
### Table showing the range of professionals who may attend a Multi-agency meeting:

<table>
<thead>
<tr>
<th><strong>Chair</strong></th>
<th><strong>Designated Doctor for Child Death Review</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Co-ordinator</strong></td>
<td><strong>Child Death Review Team</strong></td>
</tr>
<tr>
<td><strong>Local Hospital</strong></td>
<td><strong>Consultant Paediatrician</strong>&lt;br&gt; <strong>Paediatric Dietician</strong>&lt;br&gt; <strong>Community Children’s Nurse</strong></td>
</tr>
<tr>
<td><strong>Integrated Therapy Services</strong></td>
<td><strong>Speech and Language Therapist</strong>&lt;br&gt; <strong>Occupational Therapist</strong>&lt;br&gt; <strong>Physiotherapist</strong></td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td><strong>GP</strong>&lt;br&gt; <strong>Health Visitor/School Nurse</strong></td>
</tr>
<tr>
<td><strong>Tertiary Centre</strong></td>
<td><strong>Consultant Paediatrician</strong>&lt;br&gt; <strong>Specialist Consultant Paediatrician</strong></td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td><strong>Care Co-ordinator</strong></td>
</tr>
<tr>
<td><strong>Children’s Social Care</strong></td>
<td><strong>Social Worker Disabilities Team</strong>&lt;br&gt; <strong>Family Support Worker</strong></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td><strong>Nursery/School representative</strong></td>
</tr>
<tr>
<td><strong>Police</strong></td>
<td><strong>If rapid response/unexpected death</strong></td>
</tr>
<tr>
<td><strong>Ambulance Service (SWAST)</strong></td>
<td><strong>Paramedics involved plus Safeguarding Lead</strong></td>
</tr>
</tbody>
</table>

### Parental Involvement

1.2.7 Every death of a child is a tragedy for family and friends. Enquiries should be appropriately balanced between the forensic and medical requirements, whilst supporting the family at a difficult time. This is, and has always been, recognised in the Working Together Guidance.

1.2.8 Professionals supporting parents and family members should assure them that the objective of the child death review is not to apportion blame, but to learn lessons where possible to prevent future child deaths.

1.2.9 Bereavement support information is included in the leaflet that is sent to the family. This includes details of a number of charities who provide listening services and/or on-line web pages. We will be updating this leaflet shortly. The Child Death Review team do not provide bereavement support to families; this is normally facilitated by the practitioner whom knows the family best, often the GP or through an organisation such as Cruse.

### Data Collection

1.2.10 The information collected for the Child Death Overview Panel includes mainly quantitative and some qualitative data. The collection of qualitative data provides the narrative of professionals who have been part of the
child’s life, supporting the analysis of the case review but also providing the basis for learning and service improvement.

1.2.11 Information collected from statutory Form Bs, local case review and multiagency meetings is consolidated onto the Form C, which is then reviewed by the Child Death Overview Panel. This enables review of each individual child’s death: the circumstances of the death; categorising the cause of death in accordance with the national dataset; identifying if there were any modifiable factors that may have prevented the death, and determining what lessons can be learnt and make recommendations either locally to one agency, through the SSCB, regionally or nationally.

1.2.12 Aggregated nationally defined anonymised data is submitted once each year to the Department of Education who report the year’s data centrally and publish an Official Statistical Release every year.

1.2.13 During the year April 2015 until March 2016, the Somerset Child Death Overview Panel reviewed 37 retrospective cases.

**Child Death Overview Panel**

1.2.14 The Child Death Overview Panel (CDOP) is a multi-agency group of professionals who are responsible for reviewing information collated on all child deaths, expected or unexpected, of children normally resident in Somerset. The panel considers every death of a child or young person under the age of 18 years.

1.2.15 The Panel is chaired by a Consultant in Public Health. The Child Death Administrator (supported by the Designated Nurse for Safeguarding Children from April 2015- November 2015) and Associate Nurse for Safeguarding Children (commenced post November 2015) have worked together to ensure the panel has run smoothly and families and professionals have been appropriately communicated with.

1.2.16 During this reporting year, the panel has met four times. There has been a fairly consistent senior representation and commitment from participating agencies, enabling discussions and agreement to be reached on modifiable factors, categorisation of deaths and to make specific recommendations to improve services for children, young people and their families in Somerset.

1.2.17 An impact of the Child Death Review Manager being absent from April 2015- November 2015 has been that there was less capacity to follow up on actions and recommendations made by the panel. The Chair of the panel had picked this up and from November 2015 the new Associate Nurse for Safeguarding Children has the Child Death Review Manager role as part of her responsibilities. The panel continue to explore how to share learning in a more effective manner with professionals.
1.3 Production of This Report

1.3.1 The CDOP is required to produce an annual report each year outlining the work of the panel and relevant learning from the cases reviewed to inform the priorities of the SSCB. This annual report is produced by the Associate Nurse for Safeguarding Children. This has been supported by the Designated Nurse for Safeguarding Children and the Consultant for Public Health. The data used is collected by the SSCB Child Death Administrator. Every year an annual return is submitted to the Department for Education (DfE) to capture the numbers of children who have died, how many of these deaths have been reviewed by CDOP and what themes or trends are evident. This annual report is based on data submitted to the DfE.

1.3.2 The whole multiagency panel has been involved with the production of this report and has signed off that it is a true reflection of their work over the year. They have all endorsed the recommendations made in this report.

2.0 CHILD DEATHS IN SOMERSET

2.1 It is important to put the Child Death review process into context. A child death is a tragic, but rare event. We are starting this year’s annual report with an overview of Child Deaths over time in Somerset, using 3 year rolling averages, to help reduce year on year variations associated with rare events. This allows better identification of longer term trends in childhood mortality before we analyse this at an individual child level.

2.2 Neonatal, Infant and Child Mortality Rates Over Time (statistics provided by Public Health)

2.2.1 A Neonatal death is defined as when a baby dies within the first 27 days after birth. Since 2008 Somerset’s rate has not been statistically different from the English or South West England Rate. For 2013-15 the neonatal death rate is expected to be 2.7/1000 live births (we do not yet have the complete 2015 dataset and so have estimated this based on three quarters worth of data and extrapolated,) we do not yet have comparable regional or national data.

2.2.2 In 2015-16 30% of the deaths reviewed by CDOP were neonatal deaths
An infant death is defined as the death of a baby within the first 364 days after birth. 35% of the children whose deaths were reviewed by CDOP in 2015-16 were infants. Although the local rate might appear to be increasing, the rates have not been statistically different from the English or South West England Rate, during this time period. For 2013-15 the infant mortality rate is expected to be 4.2/1000 live births (we do not yet have the complete 2015 dataset and so have estimated this based on three quarters worth of data and extrapolated,) we do not yet have comparable regional or national data.
Mortality statistics are only reported in 5 year age periods and so it is not possible to present child mortality data that is covered by the CDOP process (children aged 0-17 years) against national and regional comparison data. For this reason we have reported on child mortality for children aged 0-14 years in Figure 3. The local Under 15 year’s mortality rate is reducing, but again this rate has not been statistically different from the English or South West England Rate, during this time period. For 2013-15 the child mortality rate is expected to be 31.6/100,000 population (we do not yet have the complete 2015 dataset and so have estimated this based on three quarters worth of data and extrapolated,) we do not yet have comparable regional or national data.

Figure 3: Somerset Child Mortality (0-14years) Over Time Reported by 3 Year Rolling Average Rates

In conclusion our child, infant and neonatal mortality rates are not statistically different to either regional or national rates. We might want to revisit this when we have the full data set for 2015 to ensure we remain statistically comparable.
3.0 NOTIFICATIONS and REVIEWS

3.1 Analysis of Notifications

3.1.1 During this year April 2015 to March 2016, the Child Death Team has been notified of 26 deaths of children and young people normally resident in Somerset.

3.1.2 During this same time reporting period, the panel has reviewed the deaths of 37 children. Information regarding these child deaths is presented below; however, this is not robust for research purposes as it is based on small numbers. For 2016-17 we will be recording extra data so we will be able to analyse trends associated with modifiable factors over time.

3.2 Age at Time of Child’s Death

3.2.1 In Somerset during 2015-16 30% of cases reviewed were neonates (died before 28 days of age), 35% were aged 28-364 days and 35% were over 1 year of age.
3.3 Gender of Children Who Have Died

3.3.1 More boys died and more cases that were reviewed in 2015-16 were boys in Somerset. This continues to mirror national trend data for children that at all ages mortality rates among boys are higher than girls.
3.4 Ethnicity of Children Who Have Died

3.4.1 86% of children whose deaths were reviewed were from a white: English/Welsh/Scottish/Northern Irish /British ethnicity.

3.4.2 No reviews were undertaken on children who were known to be an asylum seeker at the time of death. 1 out of area death was reviewed where the child was Looked After (CLA) by Somerset but resided in a neighbouring county.

3.5 Proportion of Deaths That Were Unexpected

3.5.1 Of the 37 cases that were reviewed, 5 were unexpected, based on the Form A completed at the time of notification of death. This is according to the Working Together definition that death was not anticipated 24 hours prior to death.

4.0 CHILD DEATH OVERVIEW PANEL REVIEW DATA

4.1 Length of Time From Death To Review

4.1.1 In 2015-16 no children who died were reviewed within 6 months of their death. 73% of reviews occurred within 6-12 months of their death and 27% of reviews were conducted over a year after their death. It is important that when modifiable factors are identified these are promptly acted on locally, regionally or nationally. The process can take a long time, due to a variety of factors. Work has begun that aims to ensure that children who have died are brought for review as promptly as possible to the panel, following completion of a multiagency meeting. This multiagency meeting cannot proceed until the post-mortem report has been submitted to the local paediatrician. There has historically been a delay in the system, due to the delay in receiving post mortem results. The Chair of the Somerset panel signed a regional letter to highlight the delay in post mortems however there is now a paediatric pathologist in post in the South West region and this is now improving. The CDOP Chair and Associate Nurse are monitoring this and will take action if required.
4.2 Categorisation of Child Deaths Reviewed by CDOP

4.2.1 Part of the role of CDOP is to categorise each individual child death, according to the type of death. Where the numbers are less than 5 this is indicated as <5 to ensure individual children cannot be identified.

![Figure 7: Categorisation of each Individual Child Death, According to the Type of Death as recorded on the Form C](image)

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliberately inflicted injury, abuse or neglect (category 1)</td>
<td>0</td>
</tr>
<tr>
<td>Suicide or deliberate self-inflicted harm (category 2)</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Trauma or other external factors (category 3)</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Malignancy (category 4)</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Acute surgical or medical condition (category 5)</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Chronic medical condition (category 6)</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Chromosomal, genetic and congenital abnormalities (category 7)</td>
<td>9</td>
</tr>
<tr>
<td>Perinatal/neonatal event (category 8)</td>
<td>10</td>
</tr>
<tr>
<td>Infection (category 9)</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Sudden unexpected, unexplained death (category 10)</td>
<td>5</td>
</tr>
<tr>
<td>Unknown category</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>37</td>
</tr>
</tbody>
</table>
Figure 8: Category of Death for Somerset’s Children Reviewed During 2015-2016

4.3 Modifiable Factors identified

Definition of Preventable Child Deaths

4.3.1 For the purpose of producing aggregate national data, this guidance defines preventable child deaths as those in which modifiable factors may have contributed to the death. These are factors, where if actions could be taken through national or local interventions, the risk of future child deaths could be reduced.

Definition of an Unexpected Death of a Child

4.3.2 For the purpose of CDOP 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 an unexpected collapse or incident leading to or precipitating the events which lead to the death.
Figure 9: Percentage of Somerset Children Who’s Deaths Were Reviewed by CDOP 2015-2016 Where Modifiable Factors Were Found

<table>
<thead>
<tr>
<th>Percentage of modifiable and non modifiable factors identified in all child death cases 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Diagram showing 51% modifiable factors and 49% no modifiable factors." /></td>
</tr>
</tbody>
</table>

4.4 Social Factors in the Family and the Environment

4.4.1 Somerset’s strength as a panel is the holistic assessment they undertake regarding the factors that are present in children and young people’s lives at the time or prior to their deaths.

4.4.2 The chart below aims to capture if there are factors within the family and or environment of a child that may contribute to their vulnerability. This information is not complete for all children, particularly those who die in tertiary care in specialist centres outside of the county. However, this information provides an insight into modifiable / risk factors that all agencies can address. This might not affect the outcome that the child died, but may have contributed to their vulnerability whilst alive or in the case of housing improved quality of life or removed a stressor for parents caring for a child with a life limiting condition.
Figure 10: Factors Identified by CDOP in the Family and Environment of Children whose Deaths were reviewed during 2015-2016

Factors identified that provide a complete and sufficient explanation for the death = 3
Factors identified that may have contributed to vulnerability, ill-health or death = 2
No factors identified or Factors identified that are unlikely to have contributed to the death = 1
LESSONS LEARNT, ACTIONS TAKEN AND RECOMMENDATIONS AS A RESULT OF SOMERSET CDOP IN 2015-16

5.1 Action Taken

5.1.1 None of the child deaths that were reviewed were subject to a Serious Case Review (SCR) or recommended to be a SCR by the CDOP. No cases were referred to the Learning and Improvement sub-group of the SSCB for consideration as an SCR.

5.2 Emerging Themes and Actions Taken:

- The cases of sudden infant deaths we have reviewed in 2015-16 have in the majority occurred in an unsafe sleeping environment. We have seen a reduction in the number of sudden infant deaths this year but as numbers are small this cannot be proven as statistically significant. Public health have worked alongside the Lullaby Trust safe sleeping campaign and an example is the screening of safe sleeping information films in maternity waiting rooms of local hospitals. Safe sleeping information was also made available from Public Health to workers in the drugs and alcohol services.

- Smoking was prevalent in 35% of households where a child died. During panel discussions we have begun to differentiate between smoking during pregnancy and smoking in the household and capture this on Form Cs. Work continues across partner agencies in engaging families with smoking cessation, particularly by health as identified in previous annual reports.

- Maternal obesity (high Body Mass Index BMI) continues to factor in delivering safe maternity care and the risks for both mother and child and we are now capturing this in our modifiable factors data collection as recommended in last year’s report. Further consideration is needed in identifying potential issues with high BMI in pregnancy. The panel has discussed how to contribute to this in a meaningful way by sharing our findings and concerns regionally and nationally and work will continue in this area.

- We have seen a small increase in the percentage of child deaths from non-white British ethnicity. We anticipate this may further increase if more refugees come to Somerset in the future and challenges can arise with supporting non English speaking families. An example of good practice is the sending of an interpreted letter in the family’s native language after the death of their child explaining the process and engaging professionals from their native country if appropriate to reduce language barriers.

- Our combined experience of reviewing the deaths of children, who commit suicide, is that the child’s peers are frequently aware of how
troubled they are even if services and schools are not. In response to this Public Health in conjunction with local young people have developed some ‘top tips’ for promoting mental health for young people and their peers and where to go for help. Additionally the police identified that by criminalising young people who were ‘sexting’ is a risk factor for teenage suicide. Therefore plans are in place to develop a local flowchart for Police use to enable prompt action and an early warning to young people undertaking this, to ensure they are not prompted to take extreme action whilst worrying about the consequences.

- Home Educated Children- the panel has discussed cases where children have been identified as being electively home educated. This may not have contributed to their death but is recognised as a vulnerability factor. There is an ongoing multi-agency task group led by Somerset's CDOP Chair considering how agencies can identify and share information regarding children not in mainstream education and ensure they are appropriately supported. It is well recognised that these children can be especially vulnerable, particularly in conjunction with others factors such as a disability and we will continue to develop good practice in this area with our partners.

5.3 Recommendations to the SSCB

5.3.1 Additionally the CDOP panel wish to seek endorsement from the SSCB for the following recommendations:

- For the SSCB to endorse this report and the work of the CDOP during 2015-16.

- For the CDOP to aim to reduce the length of time between child death and review at CDOP – to ensure modifiable factors are acted on as promptly as possible and follow up with pathologists to ensure local paediatricians receive copies of post mortem reports in a timely way.

- We need to ensure that professionals known to each child who dies are completing the case specific Form B, as endorsed by Working Together 2015, in a timely way, reminding them that this is about identifying lessons not apportioning blame. We have also launched bespoke Form Bs specific to individual agencies to reduce duplication of information and make it simpler for the form to be completed. The Associate Nurse is now supporting the administrator when there is a delay or no acknowledgment occurs. She follows up with professionals who have not provided the Form B information or if the information is not sufficient.
• Rapid response audit – The Detective Inspector as the police representative at child death overview panel, reviews the police response in each case ensuring that correctly trained Detective Officers are used to carry out Rapid Response. The Detective Inspector also delivers training on Rapid Response to all newly promoted Detective Sergeants on their Initial Management of Serious Crime Course and supervisors of all ranks who attend the week long Child Death Course run by Avon and Somerset Constabulary to maintain the highest professional standards in this area of work.

• Now that the Associate Safeguarding Nurse is in post, we are hoping to ensure more joined up work with tertiary care providers, who care for Somerset’s children. This has remained an area of concern, which has been escalated to the Chair of the SSCB and we are keen during 2016-17 to ensure local and regional processes join up – this will be helped by the recently published Wood review of LSCBs that included recommendations for child death reviews. We continue to find it challenging to receive input from Regional care providers to our local Somerset CDOP process when a Somerset child dies in their care. In one instance, the hospital is not responding to letters from the Chair of CDOP. The Associate Nurse had linked with a neighbouring CDOP who has arranged to meet with the Regional Provider later in the year to discuss how to overcome these issues.

• We are keen to ensure that lessons learned identified as part of CDOP are rapidly shared through multiagency partnership and request that the SSCB facilitates this through the business planning group and SSCB newsletter. In 2016-17 the CDOP team will begin to produce a regular bulletin/newsletter for distribution across partner agencies from the SSCB outlining lessons learned and emerging themes form CDOP.

• We note the recommendations made in the Wood report (published June 2016) relating to CDOP and welcome the recommendations around standardising data collection and analysis via the Department of Health and ensuring statistical analysis by working in larger geographical areas. However, we are keen to ensure that Somerset children and families are appropriately supported at this time and that learning identified through CDOP continues to reflect all aspects of the child’s health and social care, not merely the terminal event.