Buckinghamshire
BSCB
Safeguarding Children Board

BUCKINGHAMSHIRE CHILD DEATH OVERVIEW PANEL (CDOP)

EIGHTH ANNUAL REPORT
APRIL 2015 – MARCH 2016

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CHILD DEATH REVIEW PROCESS

In April 2008 Child Death Overview Panels (CDOPs) became mandatory in England with every Local Authority required to operate a CDOP and to produce an annual report for its Local Safeguarding Children Board (LSCB).

The overall aim of the child death review processes is to understand why children die and to put in place interventions to help improve child safety and welfare and to prevent future avoidable deaths.

A key function of CDOP is to identify if a child's death was preventable. Government guidance defines preventable child deaths *as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.*

There are two interrelated processes for reviewing child deaths as explained below. **Appendix 1** further explains the local review processes:

1. Rapid Response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death. Unexpected death in childhood is defined as 'the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to, or precipitating the events that led to the death'

2. An overview of all deaths up to the age of 18 years (excluding both those babies that are stillborn and planned terminations of pregnancy carried out within the law) which happens at a later stage as part of a multidisciplinary panel discussion (CDOP). CDOP is a confidential review in which professionals from the services involved discuss cases and the circumstances leading to the death.

The purpose of a rapid response service is to ensure that the appropriate agencies are engaged and work together to:

- Respond quickly to the unexpected death of a child.
- Ensure support for the bereaved siblings, family members or members of staff who may be affected by the child's death.
- Identify and safeguard any other children in the household that are affected by the death.
- Make immediate enquiries into and evaluate the reasons for and circumstances of the death, in agreement with the coroner when required.
- Preserve evidence in case a criminal investigation is required.
- Enquire into and constructively review how each organisation discharged their responsibilities when a child has died unexpectedly and determine whether there are any lessons to be learnt.
- Collate information in a standard format when collecting information about child deaths
- Co-operate appropriately post-death, maintaining contact at regular intervals with family members and other professionals who have ongoing

responsibilities to the family, to ensure that they are appropriately informed (unless such sharing of information would place other children at risk of harm or jeopardise police investigations)

- Consider media issues and the need to alert and liaise with the appropriate agencies
- Maintain public confidence

The rapid response begins at the point of death and ends when the final meeting has been convened and chaired by the designated paediatrician or equivalent. Any records of the meeting should be forwarded to the CDOP at the time of the review.

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 may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- Making recommendations to the LSCB 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 LSCB;
- Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether a Serious Case Review (SCR) is required;
- Agreeing on 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.

The aggregated findings from all child deaths should inform local strategic planning, including the local Joint Strategic Needs Assessment, on how to best safeguard and promote the welfare of children in the area. Each CDOP should prepare an annual report of relevant information for the LSCB. This information should, in turn, inform the LSCB annual report.

This report is the eighth annual report by the CDOP and it focuses on the work of the panel during 2015-16 and reports on the activity and the findings from the analysis of data collected locally and of the annual return to the national government. This report consists of the following six sections:

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A. EXECUTIVE SUMMARY

- Children and young people under the age of 18 years make up 23% (120,643) of the population of Buckinghamshire (2015).

- Child mortality rates in Buckinghamshire are similar to the England average; however, there is a large disparity between the most and least deprived populations in Buckinghamshire.

- In 2015-16 CDOP was notified of 42 deaths of children aged 0-17 in Buckinghamshire and reviewed a total of 49 cases.

Of the 49 cases reviewed in the year ending 31 March 2016:

- 19% were completed in less than 6 months which is an improvement from 8% in 2013 and 2014.

- 15 cases (31%) were completed within 12 months of the notification compared with 70% nationally. 34 cases (69%) took longer than a year to review compared with 30% nationally.

- 20 cases (41%) were 0-27 days compared with 43% nationally and a further 11 cases (23%) were aged between 28 and 364 days at the time of death compared with 21% nationally. Overall, 63% were in children aged 0-1year old which is similar to the national average of 64%.

- 5 cases (10%) were in 1-5 year olds which are similar to the national averages for these age groups. 13 cases (27%) were in 5-17 year olds compared with 23% nationally.

- 29 cases (59%) were male and 18 cases (37%) were female, compared with the national average of 57% and 42% respectively. Two cases did not include information on gender.

- 19 deaths (38%) were in children of White (Any White) ethnic background compared with 61% nationally. 8 deaths (16%) were in children of Asian (any Asian and mixed Asian background) compared with 15% nationally. 8% were in children of any black and mixed black background compared with 7% nationally. In 16 cases (32%) information on ethnicity was either unknown or not stated compared with 10% nationally.

- No children were subject to any child protection plan or statutory order and no case was identified as an asylum seeker.

- Perinatal /neonatal deaths are the top category of death in Buckinghamshire ((14 cases, 29%) compared with 32% nationally), followed by chromosomal/ congenital abnormalities ((9 cases, 18%) compared with 26% nationally).

- In 17 cases (35%) the cause of deaths was determined as neonatal deaths compared with 41% nationally. In 10 cases (20%) the cause of death was determined as ‘known life-limiting conditions' compared with 27% nationally.

- In 28 cases (57%) Acute Hospitals were the place of death followed by 13 cases (27%) in the normal residence of the child and 5 cases (10%) in public places. Nationally, 67% of the deaths reviewed occurred in an acute hospital, 22% in the normal residence of the child and 4% in public places.

- Modifiable factors were identified in 8 (16%) cases compared with 17% in the South East, and 24% nationally (2015-16). (Issues identified and lessons learnt are presented in section E).

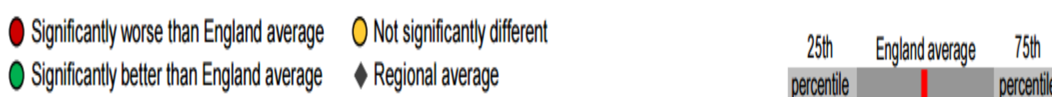
B. BACKGROUND

Table 1: Population of children aged 0-17 in Buckinghamshire 2010-15

<table>
<tr><th>Age</th><th>2010</th><th>2011</th><th>2012</th><th>2013</th><th>2014</th><th>2015</th></tr>
<tr><td>0-27 days</td><td rowspan="2">6,033</td><td rowspan="2">6,299</td><td rowspan="2">6,261</td><td rowspan="2">6,056</td><td rowspan="2">5,938</td><td rowspan="2">6,287</td></tr>
<tr><td>28-364 days</td></tr>
<tr><td>1-4 years</td><td>25,233</td><td>25,619</td><td>26,434</td><td>26,737</td><td>26,845</td><td>26,977</td></tr>
<tr><td>5-9 years</td><td>30,788</td><td>31,030</td><td>31,924</td><td>33,057</td><td>33,945</td><td>34,940</td></tr>
<tr><td>10-14 years</td><td>32,820</td><td>32,510</td><td>32,271</td><td>32,085</td><td>32,209</td><td>32,481</td></tr>
<tr><td>15-17 years</td><td>19,969</td><td>20,047</td><td>19,988</td><td>19,948</td><td>19,972</td><td>19,958</td></tr>
<tr><td>Total</td><td>114,843</td><td>115,505</td><td>116,878</td><td>117,883</td><td>118,909</td><td>120,643</td></tr>
</table>

The health and wellbeing of children in Buckinghamshire is generally better than the England average. Infant and child[1] mortality rates are similar to the England average. The table below shows how children's health and wellbeing in this area compares with the rest of England. The local results for each indicator are shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown in the table.

Table 2: Infant and Child Mortality Rates in Buckinghamshire 2012-14 (PHE, Child Health Profile 2016)



	Indicator	Local no.	Local value	Eng. ave.	Eng. Worst		Eng. Best
Premature mortality	1 Infant mortality	23	3.9	4.0	7.2		1.6
	2 Child mortality rate (1-17 years)	12	10.9	12.0	19.3		5.0

1 Mortality rate per 1,000 live births (age under 1 year), 2012-2014
2 Directly standardised rate per 100,000 children aged 1-17 years, 2012-2014

Table 3: Number of deaths in children aged 0-17 in Buckinghamshire 2010 -14

<table>
<tr><th>Age</th><th>2010</th><th>2011</th><th>2012</th><th>2013</th><th>2014</th><th>Total 2010-14</th></tr>
<tr><td>0-27 days</td><td>16</td><td>11</td><td>20</td><td>13</td><td>7</td><td>67 (37%)</td></tr>
<tr><td>28-364 days</td><td>9</td><td>9</td><td>7</td><td>10</td><td>11</td><td>46 (26%)</td></tr>
<tr><td>1-4 years</td><td>7</td><td rowspan="4">11</td><td>7</td><td rowspan="4">10</td><td rowspan="4">8</td><td rowspan="4">67 (37%)</td></tr>
<tr><td>5-9 years</td><td>6</td><td rowspan="3">11</td></tr>
<tr><td>10-14 years</td><td rowspan="2">7</td></tr>
<tr><td>15-17 years</td></tr>
<tr><td>Total</td><td>45</td><td>31</td><td>45</td><td>33</td><td>26</td><td>180</td></tr>
</table>

Source: Primary Care Mortality Database (PCMD) 2010-14.

[1] Infant : aged under 1 year , child: Age 1-17 year

Table 4: Trend in Infant Mortality Rates[2] in Buckinghamshire 2010-14

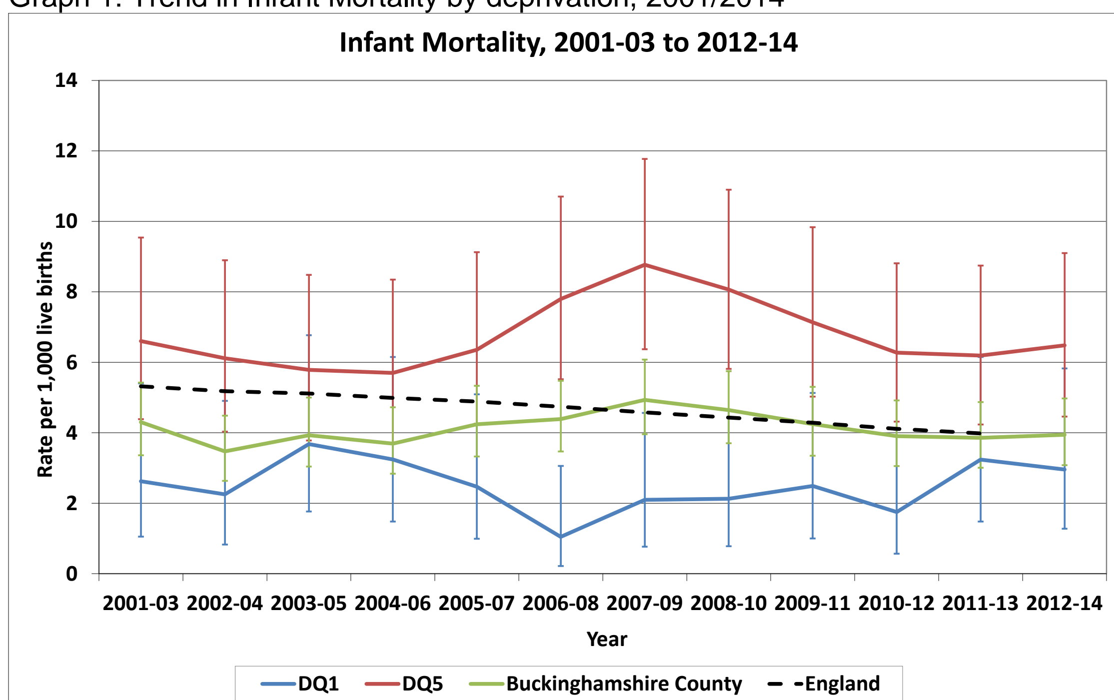
Crude infant mortality rate per 1000 population (0-1 y)					
Year	2010	2011	2012	2013	2014
0-1 year	4.1	3.2	4.3	3.8	2.9

Crude child mortality rate per 10,000 population (<18 y)					
Year	2010	2011	2012	2013	2014
<18s (Total)	3.92	2.68	3.85	2.80	2.20

Source: Primary Care Mortality Database (PCMD) 2010-14.

While the number of deaths is small and fluctuates year on year, data suggests that the overall trend in child deaths in all age groups shows a downward trend.

Graph 1: Trend in Infant Mortality by deprivation, 2001/2014



Source: ONS Annual District Birth and Death Extracts and Public Health Outcomes Framework (PHOF)

There is a wide gap in Infant Mortality between the 5th most deprived population (Deprivation Quintile 5 (DQ5)) (6.5/1,000 live birth) and the least deprived population (Deprivation Quintiles 1(DQ1)) (3.0/1000 live birth) in Buckinghamshire (2012-14), however due to small numbers the differences are not statistically significant.

Table 5 below shows the number and percentage of pre-term births in Buckinghamshire. The differences in the proportion of preterm births between the two CCGs and the Buckinghamshire average are not statistically significant.

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[2] Infant mortality rate: the number of infants dying before their first birthday per 1,000 live births

Table 5: Pre-term[3] birth in Buckinghamshire 2014 & 2015.

	2014		
	No of Preterm births	**Total No of births**	**% Pre- term births**
Aylesbury Vale Clinical Commissioning Group (AVCCG)	133	1,914	6.9%
Chiltern Clinical Commissioning Group (CCCG)	139	2,340	5.9%
Buckinghamshire County Council	**272**	**4254**	**6.4%**

	2015		
	No of Preterm births	**Total No of births**	**% Pre- term births**
Aylesbury Vale Clinical Commissioning Group (AVCCG)	131	1,998	6.6%
Chiltern Clinical Commissioning Group (CCCG)	150	2,298	6.5%
Buckinghamshire County Council	**281**	**4296**	**6.5%**

Source: Information Department, Buckinghamshire Healthcare NHS Trust

[3] Preterm birth is defined as babies born alive before 37 weeks of pregnancy are completed.

C. CHILD DEATH REVIEW PANEL ACTIVITY 2015-16

In March 2015 when the responsibility of chairing the CDOP was transferred to the Public Health Team, the panel had inherited a backlog of 48 cases going back to 2010-11. This meant that in 2015-16 the panel had to deal with 90 cases in total (48 old cases and 42 new notifications).

C.1. CDOP Membership

The Child Death Overview Panel is drawn from the key organisations represented on the LSCB.

Core members of CDOP in 2015-16 include:

- A Public Health Consultant (Chair)
- A consultant Paediatrician / Designated Doctor, Bucks Hospital Trust
- A named Nurse for Child protection, Bucks Hospital Trust
- A midwife, Bucks Hospital Trust
- An education representative
- A representative from Children's Social Care
- A representative from Thames Valley Police Child Abuse Investigation Unit
- A representative from the Coroner's Office
- The CDOP Coordinator

C.2. Number of child death notifications to CDOP 1.4.2015 - 31.3.2016

Between 1st April 2015 and 31st March 2016, CDOP was notified of 42 deaths of children aged 0-17 in Buckinghamshire.

Table 6 below shows historic data on the number of notifications received by the panel since 2008. On average CDOP receives 39 notifications and reviews 33 cases per year. While the number of deaths has fluctuated year on year, in 2015-16, CDOP has received a higher number of notifications of death in children in Buckinghamshire compared with 2014-15.

Table 6: Number of child death notifications to CDOP and number of reviews per year, April 2008- Mar 2016

	Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12	Yr 5 12/13	Yr 6 13/14	Yr 7 14/15	Yr 8 15/16	Total
No. of Notifications	34	48	44	30	50	37	28	**42**	**313**
No. of Reviews	14	23	40	21	39	38	39	**49**	**263**

C.3. Number of CDOP Review Meetings 1.4.2015 - 31.3.2016

The Multi-agency Child Death Overview Panel met six times a year during 2015-16 and completed a total of 49 reviews. The table below summarises the attendance of each agency at Panel meetings for the period 1.4.2015 to 31.3.2016.

Table 7: Number of CDOP meetings in 2015-16 and attendances by each agency

Agency	May	Jun	Sep	Nov	Jan	Mar
Public Health (Chair)	Yes	Yes	Yes	Yes	Yes	Yes
Education Representative	Yes	Yes	Yes	Yes	Yes	Yes
Social Care Representative	Yes	Yes	Yes	Yes	Yes	No
Designated Doctor/BHT	Yes	Yes	Yes	Yes	Yes	Yes
Named Nurse for Child Protection/BHT	Yes	No	Yes	Yes	Yes	Yes
Police	Yes	Yes	Yes	Yes	Yes	Yes
Coroner’s Representative	N/A	N/A	Yes	Yes	Yes	No
Midwifery	No	No	Yes	No	No	No

C.4. Number of reviews and review time

In 2015-16 the panel reviewed 49 cases in total. Of the 49 cases, 77% (38 cases) were old cases from previous years. Clearing the backlog and reducing the review time were the top priorities for the panel in 2015-16.
It is important to note that not all child deaths which occur each year will have their child death review completed by 31 March. This is mainly because it may take a number of months to gather sufficient information to fully review a child's death.

Table 8 below shows the year in which death occurred for the 49 cases that were reviewed in 2015-16.

Table 8: Year in which death occurred

Deaths occurred in					Total
Yr 3 10/11	**Yr 5 12/13**	**Yr 6 13/14**	**Yr 7 14/15**	**Yr 8 15/16**	
3	6	13	16	11	49

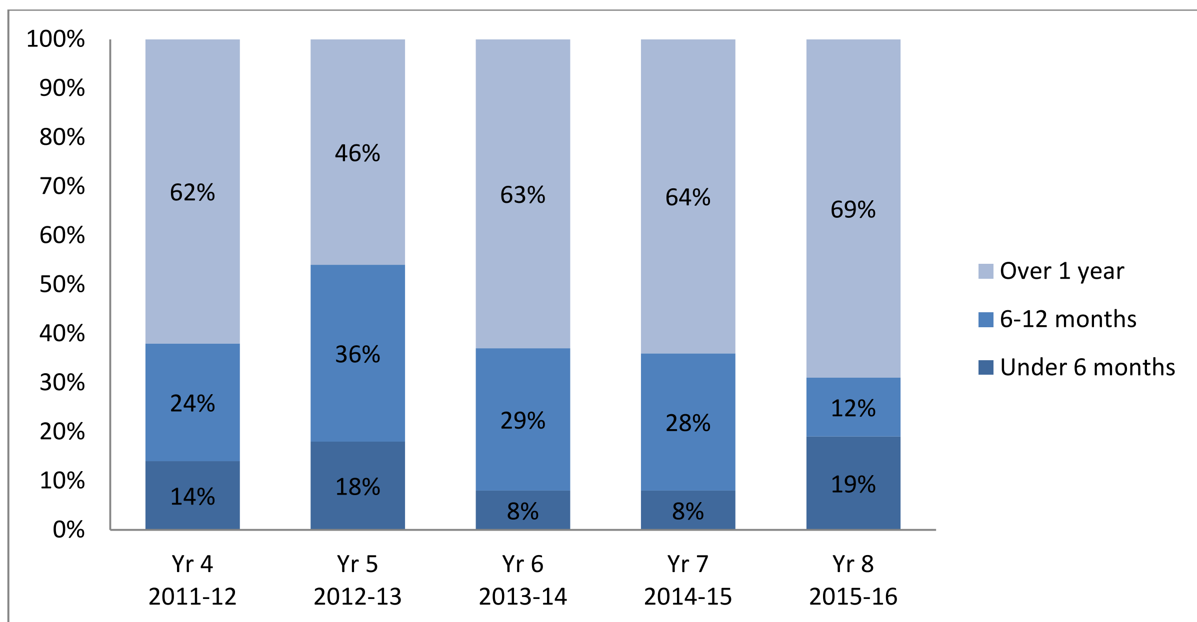
Table 9 and graph 2 below show the total number of reviews and review time in Buckinghamshire since 2008/09.
Of the 49 child deaths reviewed in the year ending 31 March 2016, 19% were completed in less than 6 months which is an improvement from 8% in 2013-14 and 2014-15.

31% (15 cases) were completed within 12 months of the notification compared with 70% nationally. 69% (34 cases) took longer than a year to review compared with 30% nationally. (This figure includes the 38 cases from the backlog).

Table 9: Total number of reviews and review time 2015-16

Duration	**Yr 1 08/09**	**Yr 2 09/10**	**Yr 3 10/11**	**Yr 4 11/12**	**Yr 5 12/13**	**Yr 6 13/14**	**Yr 7 14/15**	**Yr 8 15/16**	***National Benchmark 2015/16***
< 6 months	11 (79%)	11 (48%)	17 (43%)	3 (14%)	7 (18%)	3 (8%)	3 (8%)	9 (19%)	*29%*
6-7 months	0	8	4	1	5	3	5	1	*41%*
8-9 months	3	3	3	3	7	4	4	4	
10-11 months	0	0	6	1	2	4	1	1	
12 months	0	0	1	0	0	0	1	0	
Over 1 year	0 (0%)	1 (4%)	9 (22%)	13 (61%)	18 (46%)	24 (63%)	25 (64%)	34 (69%)	*30%*
Total	**14**	**23**	**40**	**21**	**39**	**38**	**39**	**49**	

Graph 2: Percentage of reviews and review time 2015-16



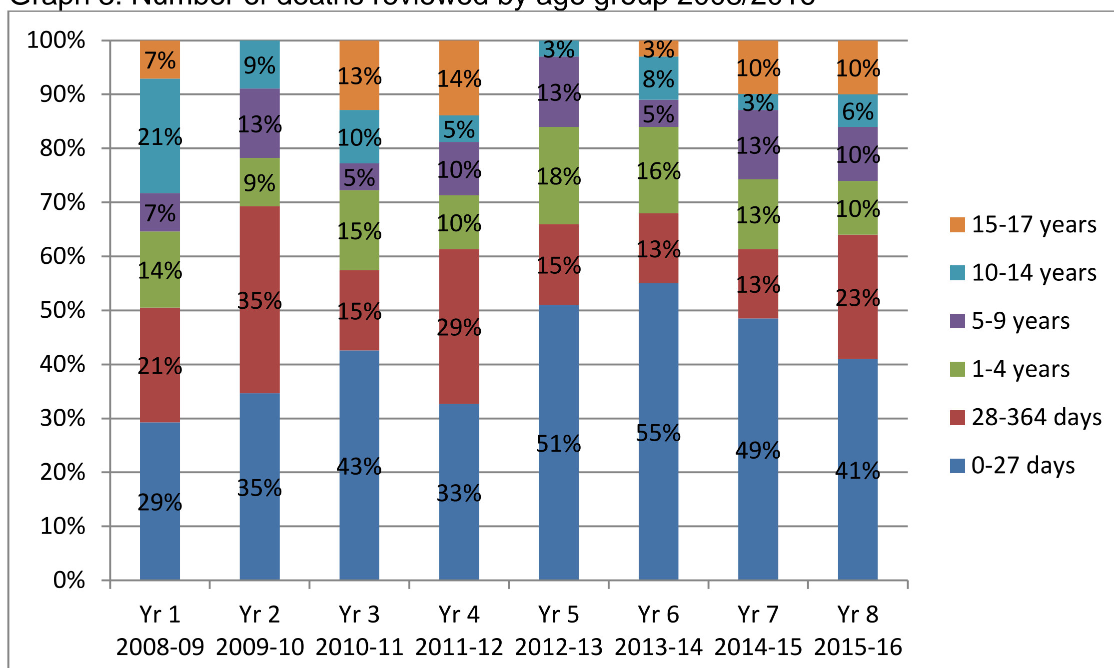
D. ANALYSIS OF CHILD DEATH REVIEW DATA & FINDINGS

D.1. Number of deaths reviewed by age group

Of the 49 cases reviewed, 20 cases (41%) were 0-27 days old at the time of death compared with 43% nationally and a further 11 cases (23%) were aged between 28 and 364 days compared with 21% nationally. Overall, 63% were in children aged 0-1year old which is similar to the national average of 64%.

5 cases (10%) were in 1-5 year olds which are similar to the national averages for these age groups. 13 cases (27%) were in 5-17 year olds compared with *23%* nationally.

Graph 3: Number of deaths reviewed by age group 2008/2016



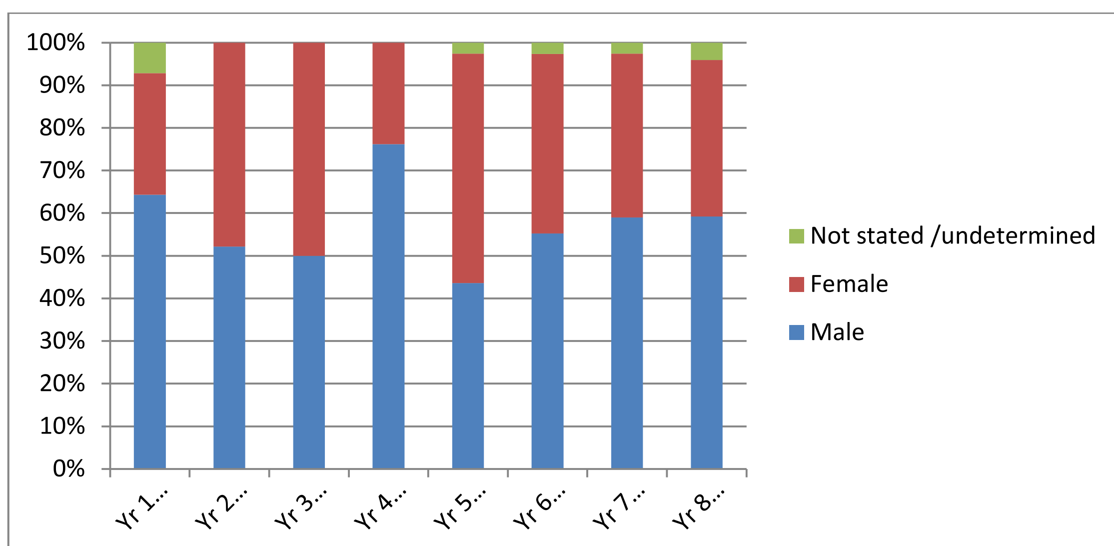
D.2. Number of deaths reviewed by gender:

Of the 49 cases reviewed in 2015-16, 29 cases (59%) were male and 18 cases (37%) were female (Table 10 & graph 4), compared with the national average of 57% and 42% respectively. Two cases did not include information on gender. Nationally, boys' deaths have consistently accounted for over half of deaths reviewed since the year ending 31 March 2011.

Table 10: Number of deaths reviewed by gender 2008/2016

Gender	Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12	Yr 5 12/13	Yr 6 13/14	Yr 7 14/15	Yr 8 15/16
Male	9 (64%)	12 (52%)	20 (50%)	16 (76%)	17 (44%)	21 (55%)	23 (59%)	29 (59%)
Female	4 (29%)	11 (48%)	20 (50%)	5 (24%)	21 (54%)	16 (42%)	15 (38%)	18 (37%)
Not stated /undetermined	1				1	1	1	2
Total	**14**	**23**	**40**	**21**	**39**	**38**	**39**	**49**

Graph 4: Number of deaths reviewed by gender 2008/2016



D.3. Number of deaths by ethnicity

Of the 49 cases reviewed, 19 deaths (38%) were in children of White (Any White) ethnic background compared with 61% nationally.

8 deaths (16%) were in children of Asian (any Asian and mixed Asian background) compared with 15% nationally. 10% were in children of any black and mixed black background compared with 7% nationally.

In 16 cases (32%) information on ethnicity was either unknown or not stated compared with 10% nationally. Table 11 below shows the ethnicity of cases reviewed since 2009.

Table 11: Number of deaths reviewed by ethnicity 2009-2016

Ethnicity	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Total
	09/10	10/11	11/12	12/13	13/14	14/15	15/16	
White: English/Welsh/ Scottish/Northern Irish/British	5 (22%)	18 (45%)	13 (62%)	16 (41%)	16 (42%)	18 (46%)	13 (26%)	99 (40%)
White: Gypsy or Irish Traveller &	0	0	x	0	0	0	0	x
White: Any Other White background	x	x	0	x	x	x	6 (12%)	17 (7%)
Mixed/multiple ethnic groups: White & Black Caribbean	0	0	0	x	0	0	x	5 (2%)
Mixed/multiple ethnic groups: White & Black African	x	0	0	0	x	0	0	x
Black/Black British: African	0	x	x	0	0	0	0	x

Mixed/multiple ethnic groups: White & Asian	0	x	0	0	0	0	0	x
Mixed/multiple ethnic groups	0	x	0	x	0	0	x	x
Asian or Asian British: Indian	0	0	0	x	x	x	x	6 (2%)
Asian or Asian British: Pakistani	x	10 (25%)	0 (0%)	11 (28%)	11 (29%)	9 (23%)	x	48 (19%)
Asian or Asian British: Any other Asian background	0	x	x	0	0	x	x	10 (4%)
Other: Any other	x	0	0	0	0	0	0	x
Unknown/not stated	9 (39%)	6 (15%)	3 (14%)	4 (10%)	7 (18%)	6 (15%)	16 (32%)	51 (20%)
TOTAL	**23**	**40**	**21**	**39**	**38**	**39**	**49**	**249**

X= numbers too small (<5) to report for reasons of confidentiality and data protection

It is important to note that data reported on ethnicity is unreliable due to inaccurate and incomplete data recording and the number of deaths is small overall which makes statistical analysis problematic.

D.4. Child deaths where the child was an asylum seeker 2015-16

Of the 49 deaths reviewed, while no case was identified as an asylum seeker, one case did not have a known status. Nationally, due to low numbers of deaths in children recorded as asylum seekers (around 10 deaths each year), this information has been removed from the national reports. There are no indications that the proportion of deaths of asylum seekers with modifiable factors is different from that of other children.

D.5. Child death reviews where the child was subject to a Child Protection Plan or any statutory orders 2015-16

Of the 49 deaths reviewed, no children were subject to any child protection plan or statutory order.

D.6. Category of deaths as determined by CDOP 2015-16

The Panel is required to classify the deaths into 10 categories and records the likely cause of death, the event which caused the death, the location of the death and whether any modifiable factors were identified. From April 2010 the focus moved away from the attributing preventability to the assessment of modifiable factors. The criteria now used nationally are:

- ‘Modifiable factors identified’ – where the Panel have identified one or more factors in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.

- No modifiable factors identified' – where the panel have not identified any potentially modifiable factor in relation to the child's death
- 'Inadequate information to make a judgement' – this category should be used very rarely indeed.

Perinatal /neonatal deaths[4] are the top category of death in Buckinghamshire (14 cases, 29%) compared with 32% nationally), followed by chromosomal/ congenital abnormalities (9 cases, 18%) compared with 26% nationally).

Table 12 below shows the category of deaths as determined by CDOP. Graph 5 below shows the trend in the category of deaths since 2008.

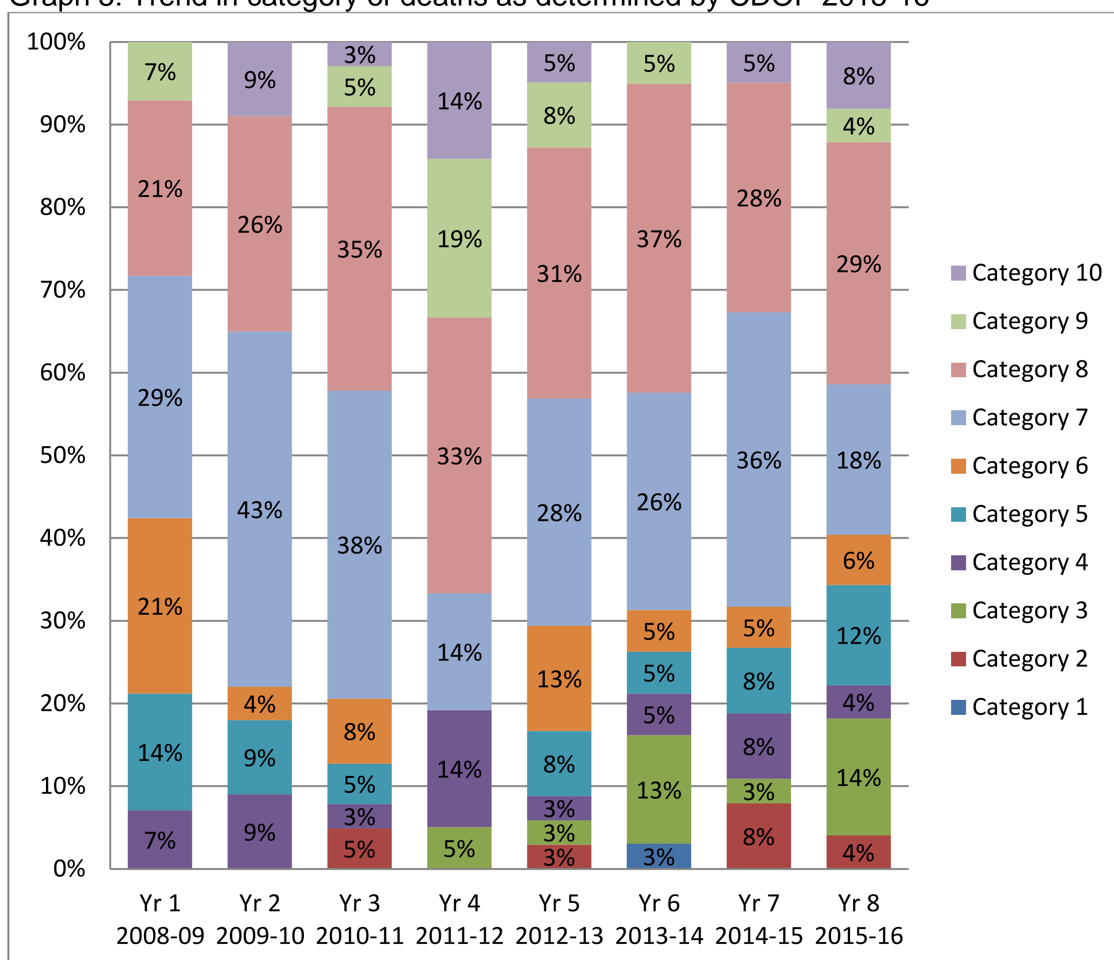
Table 12: Category of deaths as determined by CDOP 2015-16

Category of death	Number of deaths with modifiable factors	Number of deaths with no modifiable factors	Number of child deaths where there was insufficient information to assess if there were modifiable factors	Total
Deliberately inflicted injury, abuse or neglect (category 1)	0	0	0	0
Suicide or deliberate self-inflicted harm (category 2)	1	1	0	2
Trauma and other external factors (category 3)	5	2	0	7 (14%)
Malignancy (category 4)	0	2	0	2
Acute medical or surgical condition (category 5)	1	5	0	6
Chronic medical condition (category 6)	0	3	0	3
Chromosomal, genetic and congenital anomalies	0	9	0	9 (18%)

[4]Perinatal mortality rate: the number of stillbirths and deaths in the first six postnatal days per 1,000 total births
Neonatal mortality rate: the number of infants dying in the first 27 postnatal days per 1,000 live births
Post-neonatal mortality rate: the number of infants dying at 28 days and over but under one year per 1,000 live births

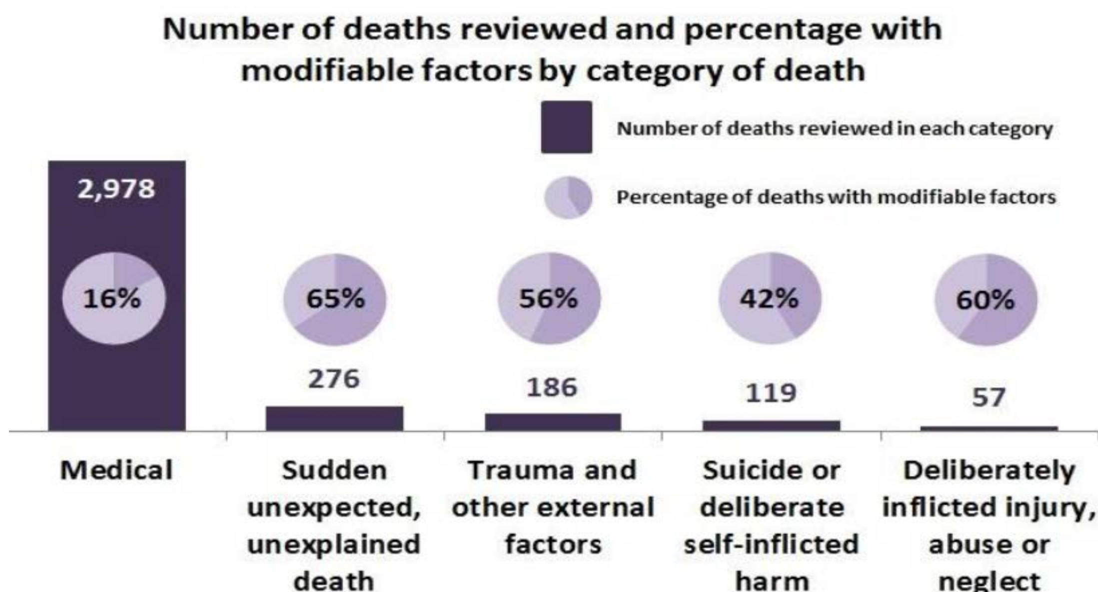
(category 7)				
Perinatal/neonatal event (category 8)	0	10	4	14 (29%)
Infection (category 9)	0	2	0	2
Sudden unexpected, unexplained death (category 10)	1	3	0	4
Total	**8 (16%)**	**37**	**4 (8%)**	**49**

Graph 5: Trend in category of deaths as determined by CDOP 2015-16



Graph 6 below shows the national figures on the number of reviews for each category of death together with the proportion of that category which had modifiable factors.

Graph 6: Number of deaths reviewed in each category, England 2015-16



D.7. Events that caused the death as determined by CDOP

Of the 49 cases reviewed, 17 cases (35%) were classified as neonatal deaths compared with 41% nationally. In 10 cases (20%) the cause of death was determined as 'known life-limiting conditions' compared with 27% nationally. In 8 cases modifiable factors were identified (see section D9 for more detail).

Table 13: Events that caused the death as determined by CDOP 2015-16

Category of death	No of deaths with modifiable factors	No of deaths with no modifiable factors	Total	National benchmark (2015/16)
Neonatal death	0	17	17 (35%)	*41%*
Known life limiting condition	0	10	10 (20%)	*27%*
Sudden unexpected death in infancy	0	1	1 (2%)	*10%*
Road traffic accident/collision	2	1	3 (6%)	*2%*
Drowning	2	0	2 (4%)	*0.7%*
Fire and burns	0	0	0	*x*
Poisoning	0	0	0	*x*
Other non-intentional injury/accident/trauma	0	0	0	*x*
Substance misuse	1	0	1(2%)	*2.4%*
Apparent homicide	0	0	0	*0.8%*
Apparent suicide	0	1	1 (2%)	*3%*
Other	3	11	14 (29%)	*12%*

D.8. Place of death

In 28 cases (57%) Acute Hospitals were the place of death followed by 13 cases (27%) in the normal residence of the child and 5 cases (10%) in public places. Nationally, 67% of the deaths reviewed occurred in an acute hospital, 22% in the normal residence of the child and 4% in public places.

D.9. Modifiability/Preventability

In Buckinghamshire, modifiable factors were identified in 8 cases (16%) compared with 17% in the South East and 24% nationally.
Nationally the number and percentage of reviews which were assessed as having modifiable factors has increased from 20% in 2012 to 24% in 2016.

Of the 8 cases with modifiable factors:

- One case was related to a sudden unexpected, unexplained death for which a serious case review took place (see section D10 below for more information).
- One case was due to substance misuse (Ecstasy) by a 17 year old male attending an end-of- exams party.
- Two cases were due to road traffic accidents. In the first case, passengers had remained in a broken down vehicle which was hit by another vehicle and in the second case a child, who was a passenger on a tractor, had fallen off the tractor and was run over by it.
- Two cases were due to drowning. In the first case, a baby drowned in the bath and in the second case a teenager drowned while swimming in the River.
- One death was due to trauma during birth following a breech presentation and manual extraction. This case led to a coroner report under "Regulation 28" of the Coroner Act in order to prevent future deaths.
- One case was due to an acute medical condition where the seriousness of the condition was not recognised by the triage service. This case also led to a coroner report under "Regulation 28" of the Coroner Act in order to prevent future deaths.

D.10. Serious case reviews (SCR)

A Serious Case Review (SCR) must be undertaken by Local Safeguarding Children Boards (LSCBs) where –
a) abuse or neglect of a child is known or suspected; and
b) either – i) the child has died; or ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, the LSCB partners or other relevant persons have worked together to safeguard the child.

Out of the 49 cases reviewed, serious case reviews took place in 2 cases (4%), compared with 2% nationally. Both cases related to sudden unexpected, unexplained deaths of babies, one at 6 weeks and the other at 14 weeks.
More detailed information on these cases including the full reports and lessons

learnt can be found on http://www.bucks-lscb.org.uk/serious-case-review/.

E. ACTIONS TAKEN BY CDOP

One of the strengths of CDOP process is to understand the reasons why children die and to put in place interventions to help improve child safety and welfare and to prevent future avoidable deaths. This section summarises some of the actions that are taken following CDOP reviews. Information on individual cases from which the actions have been derived is not presented here as this is beyond the scope of this report.

- Dissemination of information about the safe use of bath seats
- Dissemination of the Water Safety Code through Independent Schools Forum, Schools Bulletin and BSCB Newsletter to raise awareness of safety around water prior to summer holidays
- Public awareness campaign around substance misuse by children and young people
- Public awareness campaign around road safety
- Promotion of the Lullaby Trust safer sleep campaign
- Review and reinforcement of procedures about the Rapid Response process following some instances where deceased children were taken directly to the mortuary instead of the A&E.
- Improvement in communications and notification of deaths to social care services due to concern over a lack of participation by children social care team in the Rapid Response process.

F. PROGRESS AND ACHIEVEMENTS IN 2015-16

- Good progress was made in clearing the backlog. An all-day panel meeting took place to tackle the oldest outstanding cases.
- Secured funding to purchase eCDOP for better administration and easier analysis of child death data
- Appointment of a dedicated coordinator for CDOP
- Active involvement of Coroner's Office on CDOP panel
- Improved links with the Serious Case Review (SCR) Sub Group to ensure all child deaths are quickly considered for an SCR or partnership review when appropriate
- Improved links with children social care in order to ensure appropriate involvement in the rapid response process.
- Linking in with National and Regional Network of CDOP's

G. RECOMMENDATIONS

Recommendations for CDOP

1. CDOP should improve the review time and aim to reduce the proportion of reviews that take more than 1 year in line with the national average.

2. CDOP to fully implement eCDOP in order to improve data recording and reporting process, and review and update all procedures in light of the implementation of eCDOP.

3. CDOP should analyse child death data over a number of years to get an accurate picture of deaths in children in Buckinghamshire.

Recommendations for Buckinghamshire LSCB:

1. Ensure close monitoring and surveillance of infant mortality continues and remains a top priority for all organisations in Buckinghamshire including the LSCB.

2. Buckinghamshire Care Trust's Mortality Review Group to include Child mortality review in their remit

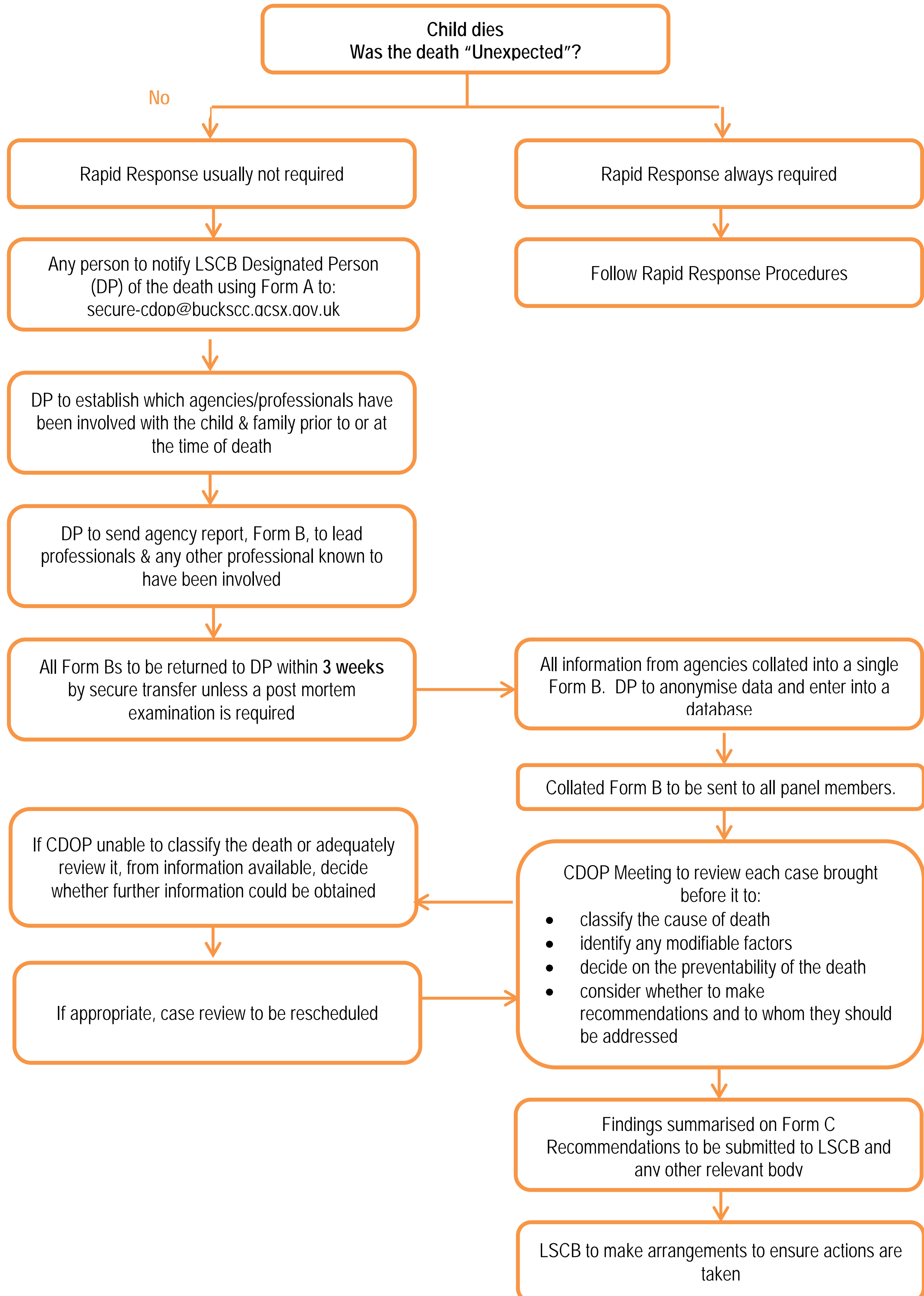
3. Ensuring there is a clear and agreed process in place for referring and sign-posting at-risk women to relevant services such as genetic screening and counselling, healthy lifestyle services and services that aim to prevent pre-term birth.

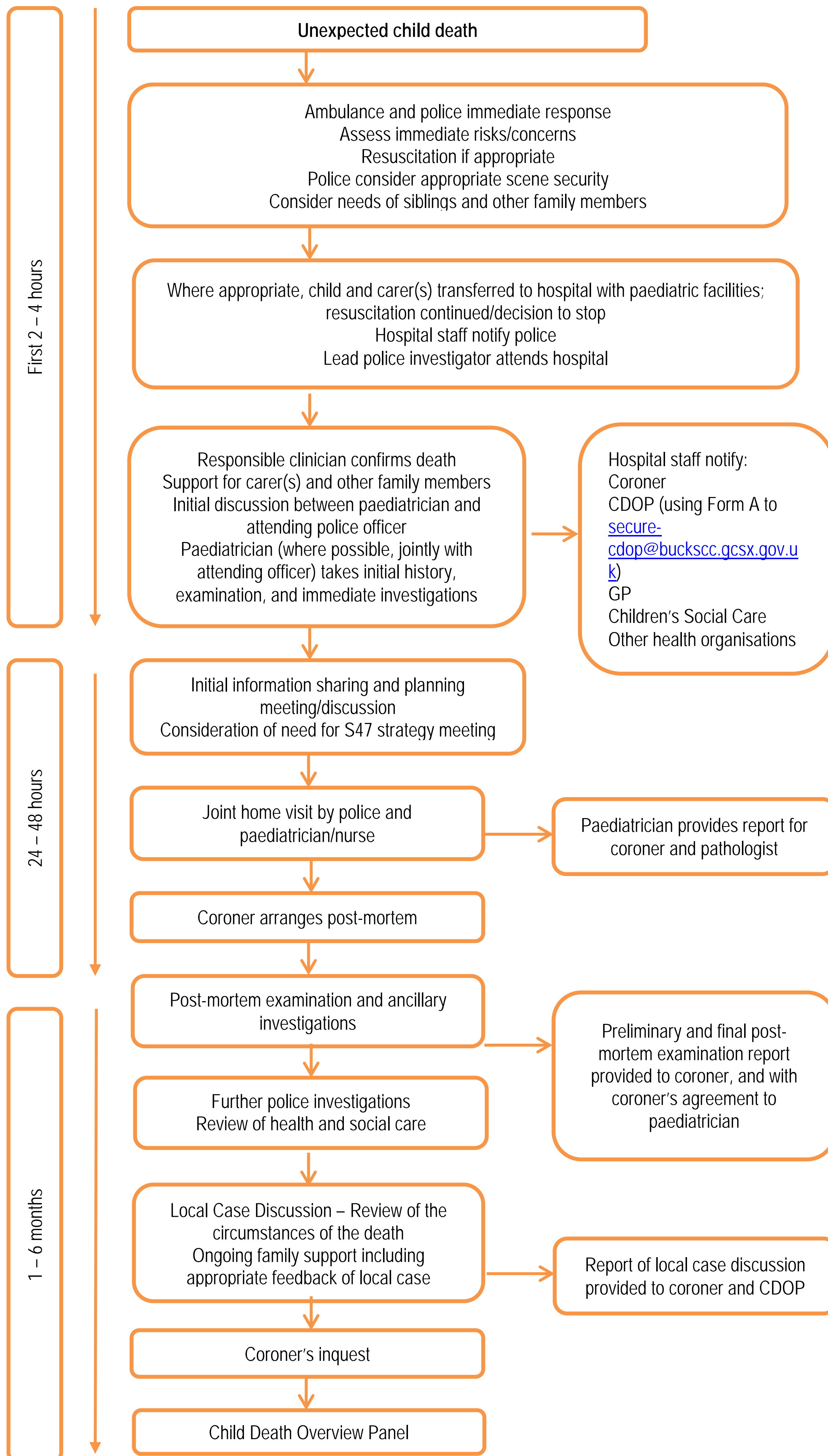
4. Ensure CCGs and NHS England improve early access to antenatal and maternity services for pregnant women particularly those from areas of social deprivation including ethnic minorities.

5. Ensure commissioners improve and enhance data collection on risk factors for child death in primary and secondary care settings through improved and robust contract and performance monitoring processes.

6. The LSCB should adopt these recommendations and request a progress report on them from commissioners by December 2017.

Appendix 1: Child death review process in Buckinghamshire




First 2 – 4 hours
24 – 48 hours
1 – 6 months
Unexpected child death
Ambulance and police immediate response
Assess immediate risks/concerns
Resuscitation if appropriate
Police consider appropriate scene security
Consider needs of siblings and other family members
Where appropriate, child and carer(s) transferred to hospital with paediatric facilities; resuscitation continued/decision to stop
Hospital staff notify police
Lead police investigator attends hospital
Responsible clinician confirms death
Support for carer(s) and other family members
Initial discussion between paediatrician and attending police officer
Paediatrician (where possible, jointly with attending officer) takes initial history, examination, and immediate investigations
Hospital staff notify:
Coroner
CDOP (using Form A to secure-cdop@buckscc.gcsx.gov.uk)
GP
Children's Social Care
Other health organisations
Initial information sharing and planning meeting/discussion
Consideration of need for S47 strategy meeting
Joint home visit by police and paediatrician/nurse
Paediatrician provides report for coroner and pathologist
Coroner arranges post-mortem
Post-mortem examination and ancillary investigations
Preliminary and final post-mortem examination report provided to coroner, and with coroner's agreement to paediatrician
Further police investigations
Review of health and social care
Local Case Discussion – Review of the circumstances of the death
Ongoing family support including appropriate feedback of local case
Report of local case discussion provided to coroner and CDOP
Coroner's inquest
Child Death Overview Panel