

BUCKINGHAMSHIRE CHILD DEATH OVERVIEW PANEL (CDOP)

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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 ninth annual report by the CDOP and it focuses on the work of the panel during 2016-17 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:

A:	Executive Summary	Page 5
B:	Background	Page 7
C:	Child Death Review Panel Activity 2015-16	Page 10
D:	Analysis of Child Death Review Data and Findings	Page 13
E:	Actions Taken by CDOP	Page 22
F:	Progress and Achievements	Page 23
G:	Recommendations	Page 23
Appendix 1: Actions to reduce Child Death		Page 25
Appendix 2: Child death review process in Buckinghamshire		Page 30

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 2016-17 CDOP was notified of 29 deaths of children aged 0-17 in Buckinghamshire and reviewed a total of 58 cases.

Review time:

- Of the 58 cases reviewed in the year ending 31 March 2017, 29% (17 cases) were completed in less than 6 months which is an improvement from 19% in 2015-16 and 8% in 2014-15.
- 74% (43 cases) were completed within 12 months of the notification compared with 30% in previous year. This is above the national average of 70% in 2015-16.
- 26% (15 cases) took longer than a year to review compared with 69% in previous year. This is well below the national average of 30% in 2015-16.

Number of deaths reviewed by age group, gender and ethnicity:

- Of the 58 cases reviewed, 35 cases (60%) were 0-27 days old at the time of death compared with 43% nationally (2015-16). A further 12 cases (21%) were aged between 28 and 364 days which is similar to the national average for that age group (2015-16).
- Overall, 81% (47 cases) were in children aged 0-1 year old which is higher than the national average of 64% (2015-16).
- 5% of cases were in 1-5 year olds which is lower than the national average of 10% for these age groups (2015-16). 8 cases (14%) were in 5-17 year olds compared with 23% nationally.
- 28 cases (48%) were male and 30 cases (52%) were female, compared with the national average of 57% and 42% respectively (2015-16). Nationally, boys' deaths have consistently accounted for over half of deaths reviewed since the year ending 31 March 2011 (2015-16).

- In 10 cases (17%) information on ethnicity was either unknown or not stated compared with 10% nationally (2015-16). This is an improvement from 32% of cases with unknown/not stated ethnicity in previous year.
- 20 deaths (33%) were in children of White (Any White) ethnic background compared. 22 deaths (38%) were in children of any Asian/mixed Asian background compared. A small proportion of deaths were in children of any black and mixed black background. 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. It is therefore not possible to benchmark these figures against the national average.
- One child was subject to any child protection plan or statutory order and no case was identified as an asylum seeker.

Category of death as determined by CDOP

- Perinatal/neonatal deaths were the top category of death in Buckinghamshire (27 cases, 47%) compared with 32% nationally (2015-16), followed by chromosomal/congenital abnormalities (16 cases, 28%) compared with 26% nationally (2015-16).

Events that caused the death as determined by CDOP:

- In 34 cases (59%) the cause of deaths was determined as neonatal deaths compared with 41% nationally (2015-16). In 7 cases (12%) the cause of death was determined as 'known life-limiting conditions' compared with 27% nationally (2015-16).
- In 42 cases (72%) Acute Hospitals were the place of death followed by 10 cases (17%) in the normal residence of the child. Nationally, 67% of the deaths reviewed occurred in an acute hospital and 22% in the normal residence of the child.
- Modifiable factors were identified in 9 (16%) cases compared with 17% in the South East, and 24% nationally (2015-16). (Issues identified and lessons learnt are presented in section E). Nationally the number and percentage of reviews which were assessed as having modifiable factors has increased from 20% in 2012 to 24% in 2016. In Buckinghamshire the figure for this year is similar to last year's figure.

B. BACKGROUND

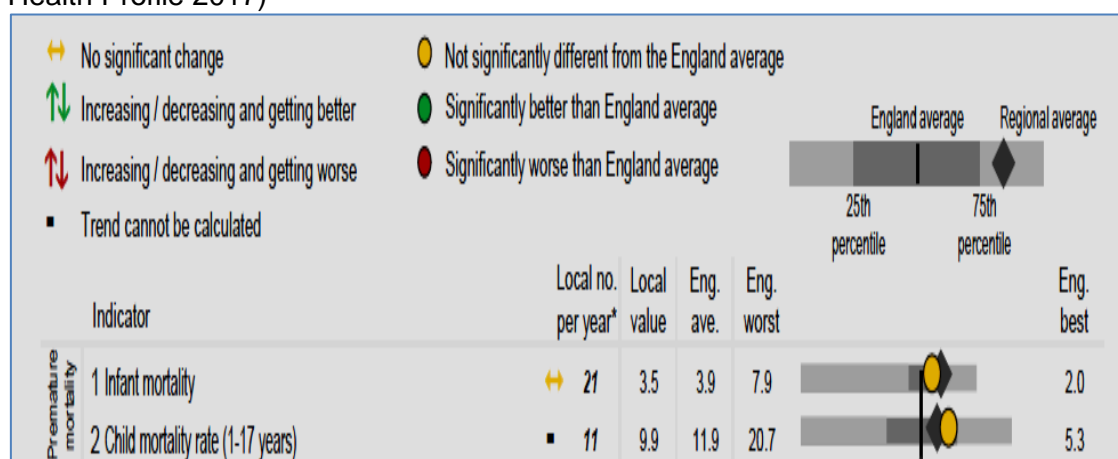
Table 1 below gives an overview of the total number of children aged 0-17 in Buckinghamshire between 2010 and 2015.

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

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

The health and wellbeing of children in Buckinghamshire is generally better than the England average. Infant and child mortality rates are similar to the England average. The figure below shows how child mortality 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 black line indicates the England average. The key to the colour of the circles is shown in the figure.

Figure 1: Infant and Child Mortality Rates in Buckinghamshire 2013-15 (PHE, Child Health Profile 2017)

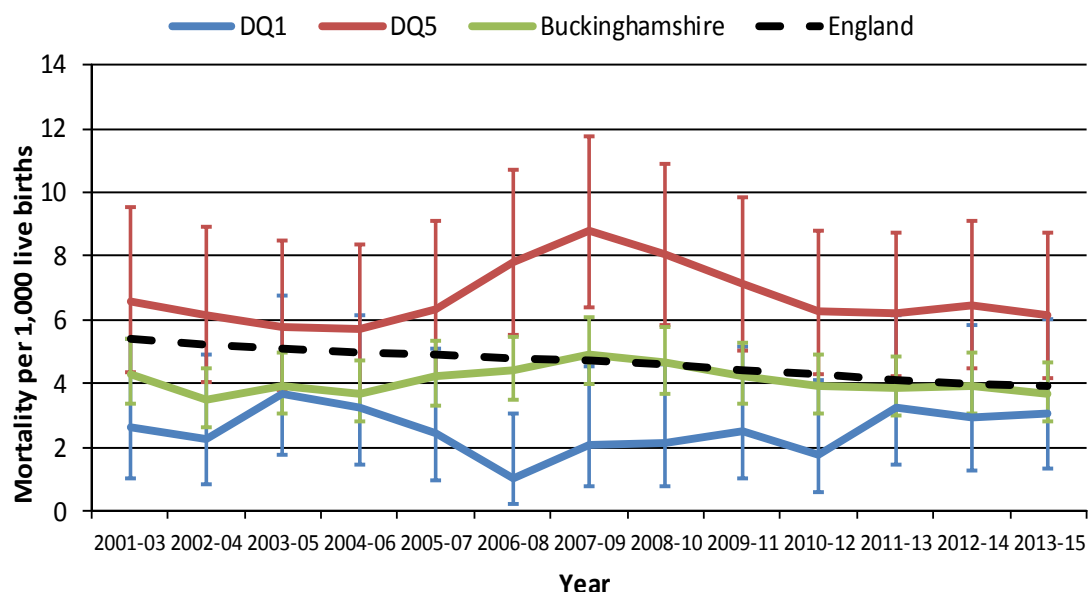


1 Mortality rate per 1,000 live births (age under 1 year), 2013-2015

2 Directly standardised rate per 100,000 children aged 1-17 years, 2013-2015

Figure 2 below shows the trend in infant mortality by deprivation quintiles in Buckinghamshire. The data suggests that, while the number of deaths is small and fluctuates year on year, the overall trend in child deaths in all age groups shows a downward trend. Infant mortality in Buckinghamshire has been approximately 4 deaths per 1,000 live births since 2001-03 (Figure 1).

Figure 2: Trend in Infant Mortality by deprivation, 2001-2015

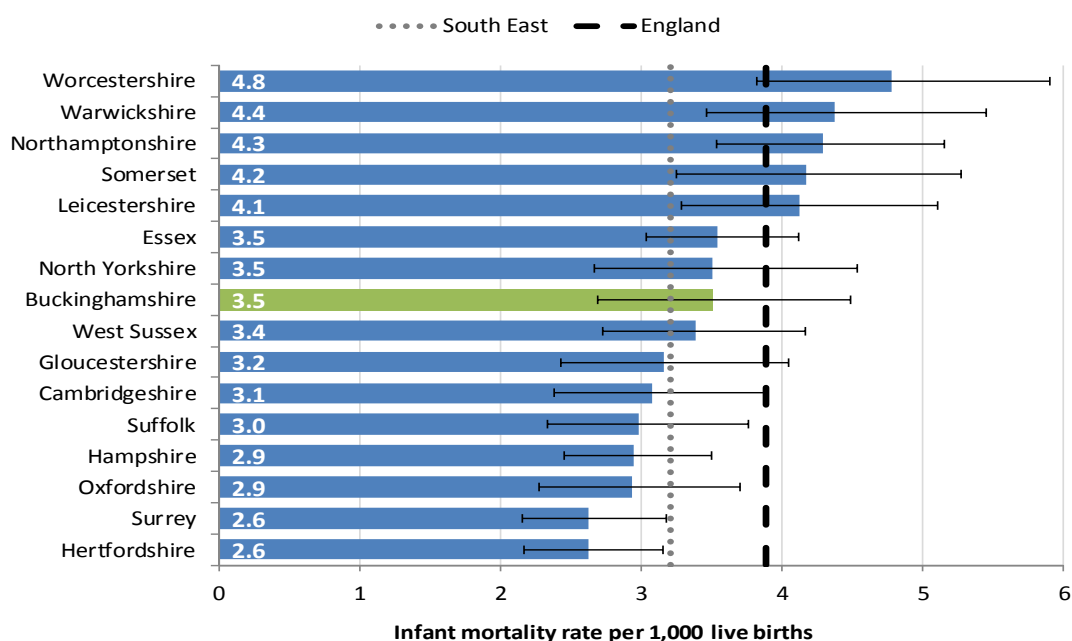


Source: Office for National Statistics Primary Care Mortality Database (PCMD) and Annual Public Health Birth Files.

The above data shows a wide gap in Infant Mortality between the 5th most deprived population (Deprivation Quintile 5 (DQ5)) and the least deprived population (Deprivation Quintile 1(DQ1)) in Buckinghamshire (2013-15), however due to small numbers the differences are not statistically significant.

Buckinghamshire's infant mortality rate for 2013-15 was higher than many of its CIPFA peers, as shown in figure 3 below; however, the differences are not statistically significant.

Figure 3: Infant mortality rate among Buckinghamshire's CIPFA peers, 2013-15

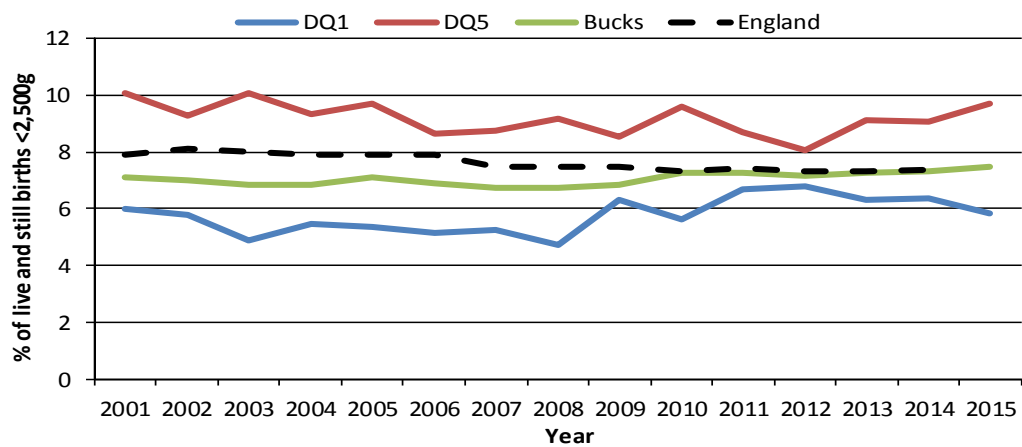


Source: Public Health England (PHE) Public Health Outcomes Framework, Indicator 4.01

Low birthweight is an important risk factor for infant mortality. Babies who have a very low weight (weighing <1.5kg) at birth have poorer outcomes and 1 in 5 die in their first year of life. In 2015, 453 babies or 7.5% of all babies (live and stillborn) born to mothers living in Buckinghamshire were born at a low birth weight. 326 babies or 7.6% of all live births (excluding stillbirths) born to mothers living in Buckinghamshire were born prematurely in 2015. The proportion of babies born prematurely has not changed significantly over the last four years.

Figure 4 below shows babies with low birth weight as a proportion of live and stillbirths by deprivation quintiles. The average value for Buckinghamshire is similar to the England average; however, rates are much higher in the most deprived areas (DQ5).

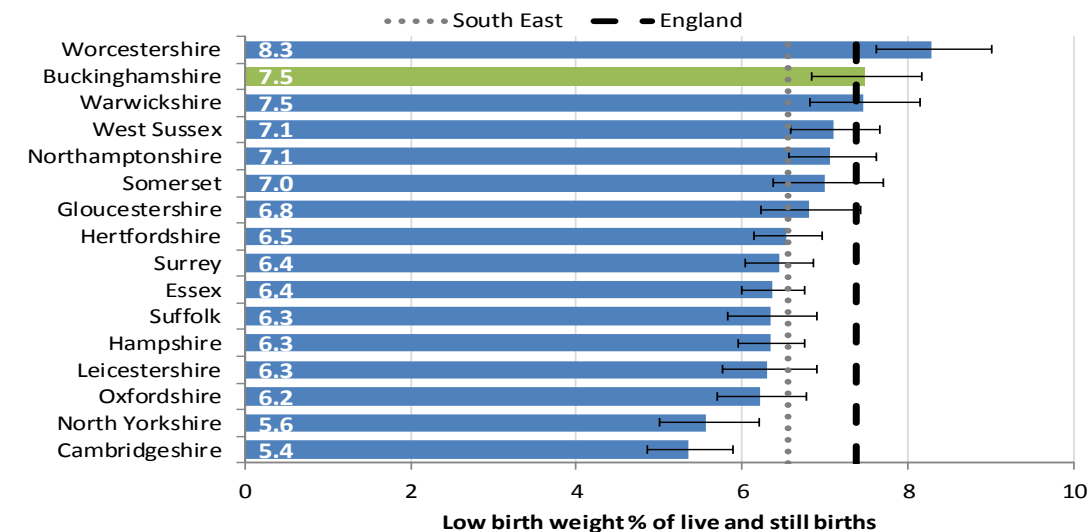
Figure 4: Low birth weight of all births in Buckinghamshire, 2001-15



Source: Office for National Statistics Annual Public Health Birth Files.

Buckinghamshire’s low birth weight rate for 2013-15 was higher than most of its CIPFA peers, but similar to the England average as shown in figure 5 below.

Figure 5: Low birth weight for all births among Buckinghamshire’s CIPFA peers, 2015



Source: Office for National Statistics, Vital Statistics Table VS2.

C. CHILD DEATH REVIEW PANEL ACTIVITY 2016-17

Clearing the inherited backlog and reducing the review time were the top priorities for the panel in 2016-17. The panel made good progress in achieving both priorities as described in section C4.

C.1. CDOP Membership

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

Core members of CDOP in 2016-17 include:

- A Public Health Consultant (Chair)
- A Consultant Paediatrician / Designated Doctor, Bucks Healthcare NHS Trust
- A named Nurse for Child Protection, Bucks Healthcare NHS Trust
- A Midwife, Bucks Healthcare NHS 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 1.4.2016 - 31.3.2017

Between 1st April 2016 and 31st March 2017, CDOP was notified of 29 deaths of children aged 0-17 in Buckinghamshire.

Table 2 below shows the number of notifications received by the panel since 2012-13. On average CDOP receives 39 notifications and reviews 45 cases per year. While the number of deaths has fluctuated year on year, in 2016-17, CDOP received a lower number of notifications of death in children in Buckinghamshire compared with 2015-16.

Table 2: Number of child death notifications to CDOP and number of reviews per year, April 2012- Mar 2017

	Yr 5 12/13	Yr 6 13/14	Yr 7 14/15	Yr 8 15/16	Yr 9 16/17
No. of Notifications	54	42	27	43	29
No. of Reviews	39	38	39	49	58

C.3. Number of CDOP Review Meetings 1.4.2016 - 31.3.2017

The Multi-agency Child Death Overview Panel met six times a year during 2016-17 and completed a total of 58 reviews. The table below summarises the attendance of each agency at Panel meetings for the period 1.4.2016 to 31.3.2017.

Table 3: Number of CDOP meetings in 2016-17 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	No	Yes	No	Yes	No	Yes
Police	Yes	Yes	Yes	Yes	Yes	Yes
Coroner's Representative	No	Yes	No	Yes	No	No
Midwifery	Yes	No	No	Yes	Yes	Yes

C.4. Number of reviews and review time

In 2016-17 the panel reviewed 58 cases in total. Of the 58 cases, 69% (40 cases) were old cases from previous years.

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 4 below shows the year in which death occurred for the 58 cases that were reviewed in 2016-17.

Table 4: Year in which death occurred

Deaths occurred in:				Total
Yr 5 12/13	Yr 7 14/15	Yr 8 15/16	Yr 9 16/17	
1	10	29	18	58

Table 5 and figure 6 below show the total number of reviews and review time in Buckinghamshire since 2012-13. The data shows a major improvement in review time in 2016-17 compared with previous years.

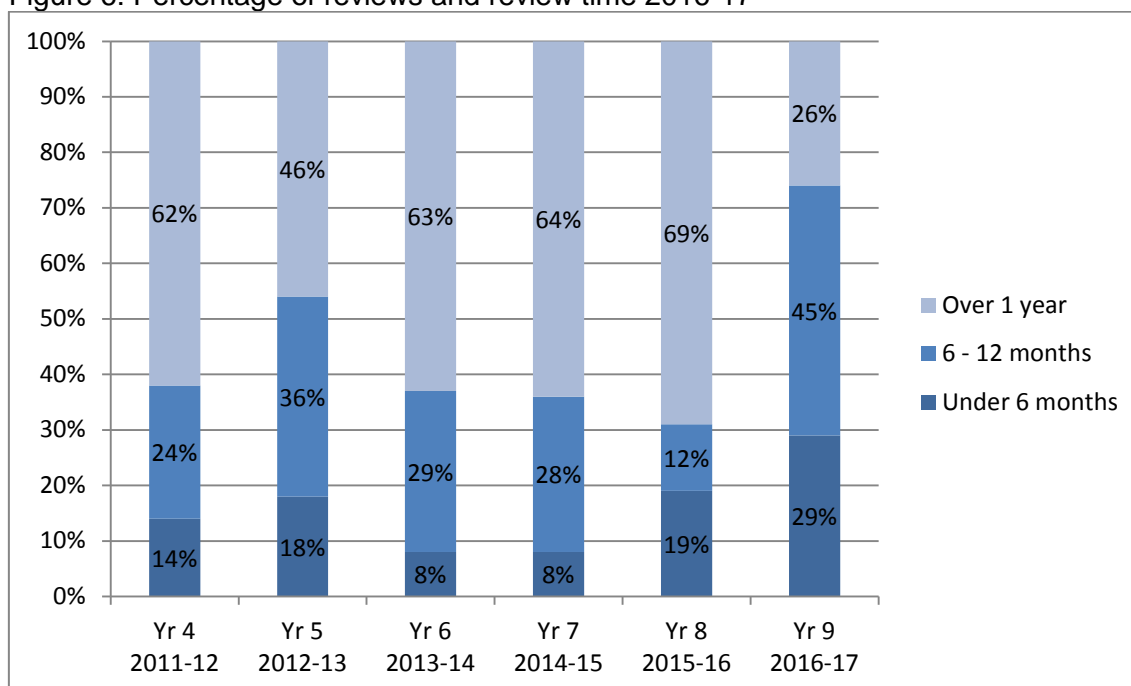
- Of the 58 child deaths reviewed in the year ending 31 March 2017, 29% (17 cases) were completed in less than 6 months which is an improvement from 19% in 2015-16 and 8% in 2014-15.
- 74% (43 cases) were completed within 12 months of the notification compared with 30% in previous year. This is above the national average of 70% in 2015-16.

- 26% (15 cases) took longer than a year to review compared with 69% in previous year. This is well below the national average of 30% in 2015-16.

Table 5: Total number of reviews and review time 2016-17

Duration	Yr 5 12/13	Yr 6 13/14	Yr 7 14/15	Yr 8 15/16	Yr 9 16/17	National Benchmark 2015/16
< 6 months	7 (18%)	3 (8%)	3 (8%)	9 (19%)	17 (29%)	29%
6-7 months	5	3	5	1	9	41%
8-9 months	7	4	4	4	6	
10-11 months	2	4	1	1	9	
12 months	0	0	1	0	2	
Over 1 year	18 (46%)	24 (63%)	25 (64%)	34 (69%)	15 (26%)	30%
Total	39	38	39	49	58	

Figure 6: Percentage of reviews and review time 2016-17

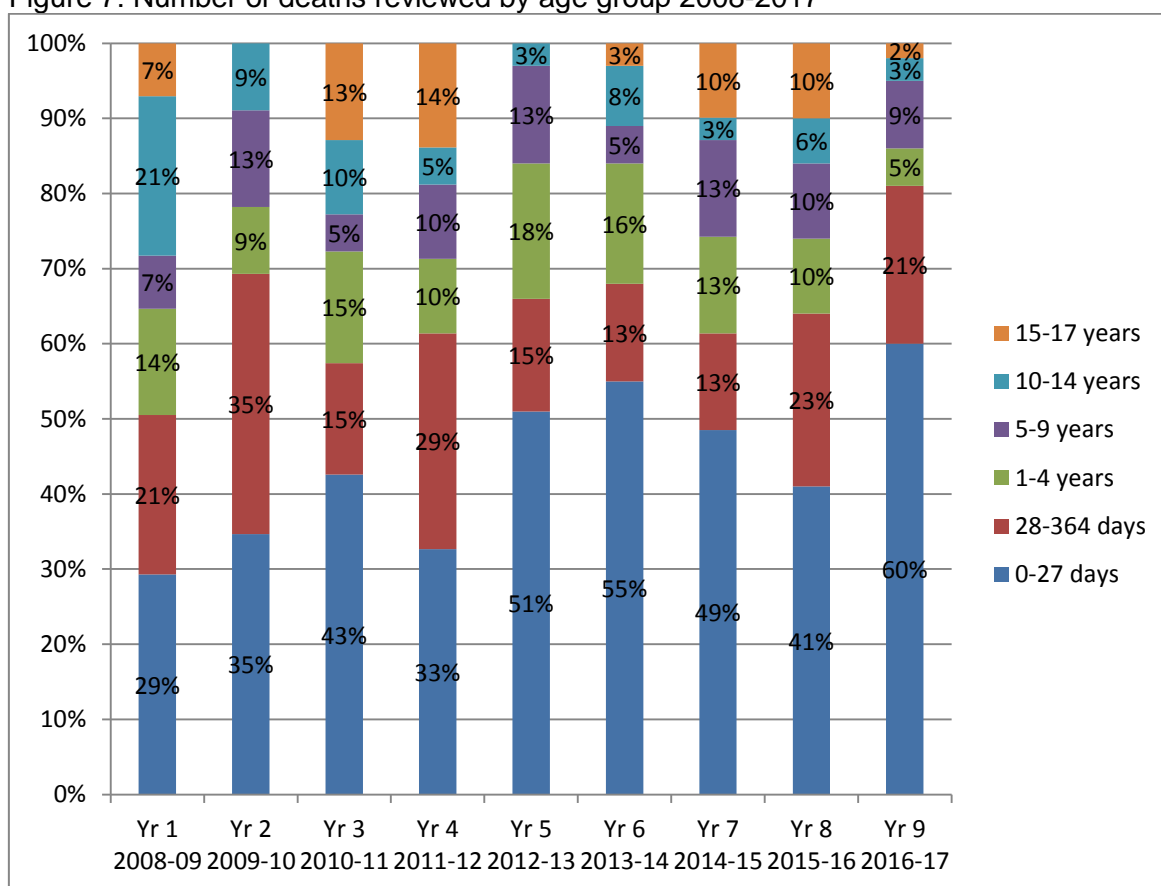


D. ANALYSIS OF CHILD DEATH REVIEWS & FINDINGS

D.1. Number of deaths reviewed by age group

- Of the 58 cases reviewed, 35 cases (60%) were 0-27 days old at the time of death compared with 43% nationally (2015-16). A further 12 cases (21%) were aged between 28 and 364 days which is similar to the national average for that age group (2015-16).
- Overall, 81% (47 cases) were in children aged 0-1 year old which is higher than the national average of 64% (2015-16).
- 5% of cases were in 1-5 year olds which is lower than the national average of 10% for these age groups (2015-16). 8 cases (14%) were in 5-17 year olds compared with 23% nationally.

Figure 7: Number of deaths reviewed by age group 2008-2017



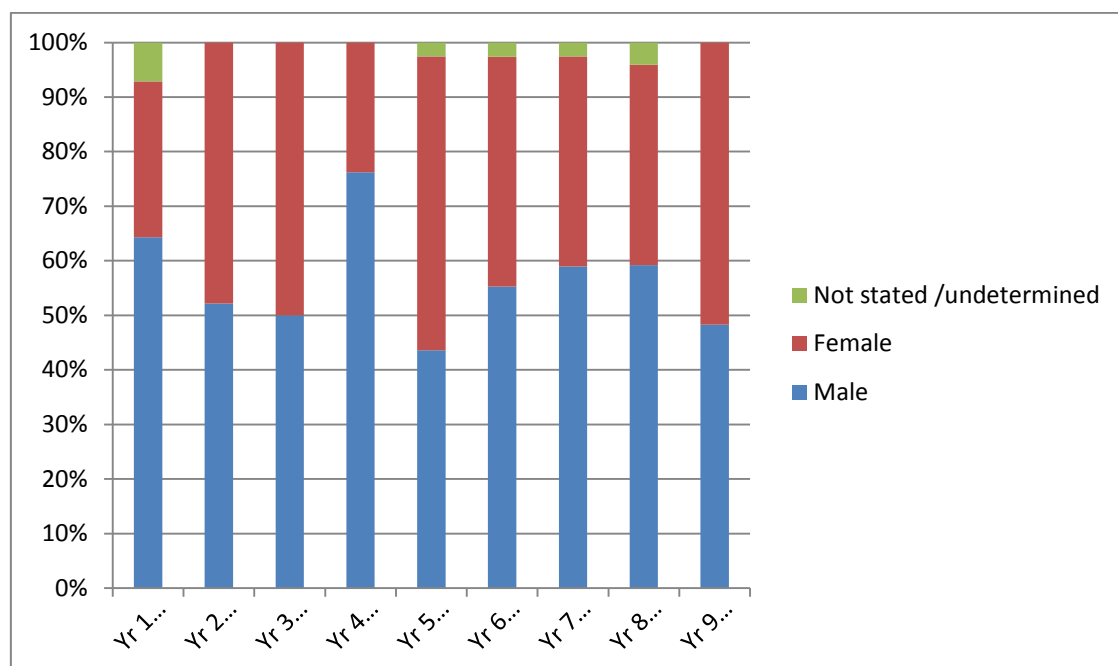
D.2. Number of deaths reviewed by gender:

Of the 58 cases reviewed in 2016-17, 28 cases (48%) were male and 30 cases (52%) were female (table 6 & figure 8), compared with the national average of 57% and 42% respectively (2015-16). Nationally, boys' deaths have consistently accounted for over half of deaths reviewed since the year ending 31 March 2011.

Table 6: Number of deaths reviewed by gender 2008-2017

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	Yr 9 16/17
Male	9 (64%)	12 (52%)	20 (50%)	16 (76%)	17 (44%)	21 (55%)	23 (59%)	29 (59%)	28 (48%)
Female	4 (29%)	11 (48%)	20 (50%)	5 (24%)	21 (54%)	16 (42%)	15 (38%)	18 (37%)	30 (52%)
Not stated /undetermined	1	-	-	-	1	1	1	2	-
Total	14	23	40	21	39	38	39	49	58

Figure 8: Number of deaths reviewed by gender 2008-2017



D.3. Number of deaths by ethnicity

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 reliable statistical analysis problematic. It is therefore not possible to benchmark these figures against the national average.

- Of the 58 cases reviewed, in 10 cases (17%) information on ethnicity was either unknown or not stated compared with 10% nationally (2015-16). This is an improvement from 32% of cases with unknown/not stated ethnicity in previous year.
- 20 deaths (33%) were in children of White (Any White) ethnic background compared. 22 deaths (38%) were in children of any Asian/mixed Asian background compared. A small proportion of deaths were in children of any black and mixed black background.

Table 7: Number of deaths reviewed by ethnicity 2009-2017

Ethnicity	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9
	10/11	11/12	12/13	13/14	14/15	15/16	16/17
White: English/Welsh/ Scottish/Northern Irish/British	18 (45%)	13 (62%)	16 (41%)	16 (42%)	18 (46%)	13 (26%)	15 (26%)
White: Gypsy or Irish Traveller	0	x	0	0	0	0	0
White: Any Other White background	x	0	x	x	x	6 (12%)	5 (7%)
Mixed/multiple ethnic groups: White & Black Caribbean	0	0	x	0	0	x	x
Mixed/multiple ethnic groups: White & Black African	0	0	0	x	0	0	x
Mixed/multiple ethnic groups: White & Asian	x	0	0	0	0	0	x
Mixed/multiple ethnic groups: Any other mixed/multiple ethnic background	x	0	x	0	0	x	0
Asian or Asian British: Indian	0	0	x	x	x	x	x
Asian or Asian British: Pakistani	10 (25%)	0 (0%)	11 (28%)	11 (29%)	9 (23%)	x	15 (26%)
Asian or Asian British: Bangladeshi	0	0	0	0	0	0	x
Asian or Asian British: Any other Asian background	x	x	0	0	x	x	x
Black/Black British: Caribbean	0	0	0	0	0	x	0
Black/Black British: African	x	x	0	0	0	0	x
Any other Black/Black British/ African/Caribbean background	0	0	0	0	0	x	x
Other: Any other	0	0	0	0	0	0	x
Unknown/not stated	6 (15%)	3 (14%)	4 (10%)	7 (18%)	6 (15%)	16 (32%)	10 (17%)
TOTAL	40	21	39	38	39	49	58

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

D.4. Child deaths where the child was an asylum seeker 2016-17

Of the 58 deaths reviewed, while no case was identified as an asylum seeker, 18 cases 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 2016-17

Of the 58 deaths reviewed, one child was subject to a child protection plan or statutory order at the time of death.

D.6. Category of deaths as determined by CDOP 2016-17

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.

The data shows that perinatal/neonatal deaths¹ were the top category of death in Buckinghamshire (27 cases, 47%) in 2016-17 compared with 32% nationally (2015-16), followed by chromosomal/congenital abnormalities (16 cases, 28%) compared with 26% nationally (2015-16).

Table 8 below shows the category of deaths as determined by CDOP. Figure 9 below shows the trend in the category of deaths since 2008.

¹Perinatal 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

Table 8: Category of deaths as determined by CDOP 2016-17

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)	0	1 (2%)	0	1 (2%)
Trauma and other external factors (category 3)	0	2 (3%)	0	2 (3%)
Malignancy (category 4)	0	0	0	0
Acute medical or surgical condition (category 5)	1 (2%)	5 (9%)	0	6 (10%)
Chronic medical condition (category 6)	1 (2%)	1 (2%)	0	2 (3%)
Chromosomal, genetic and congenital anomalies (category 7)	1 (2%)	15 (26%)	0	16 (28%)
Perinatal/neonatal event (category 8)	6 (10%)	21 (36%)	0	27 (47%)
Infection (category 9)	0	0	0	0
Sudden unexpected, unexplained death (category 10)	0	3 (5%)	1 (2%)	4 (7%)
Total	9 (16%)	48	1 (2%)	58

Figure 9: Trend in category of deaths as determined by CDOP 2016-17

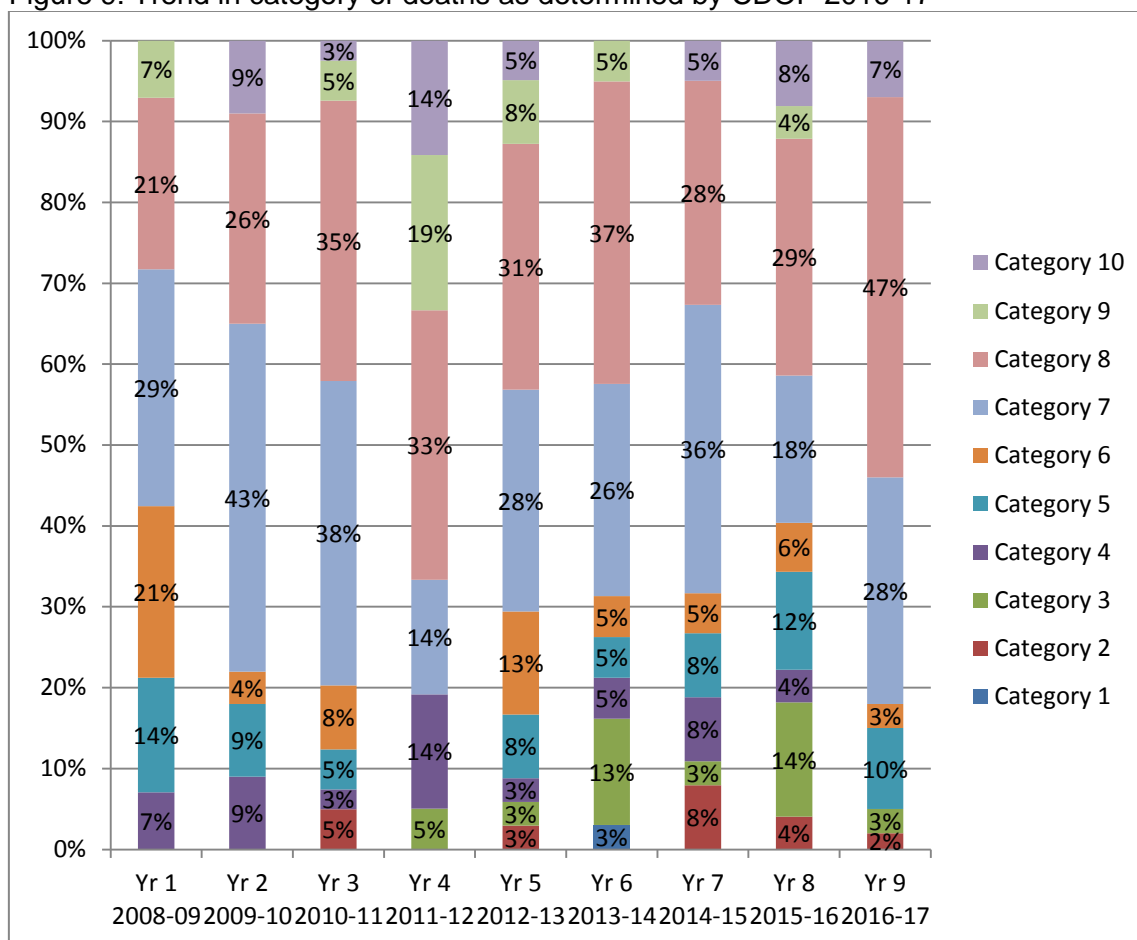
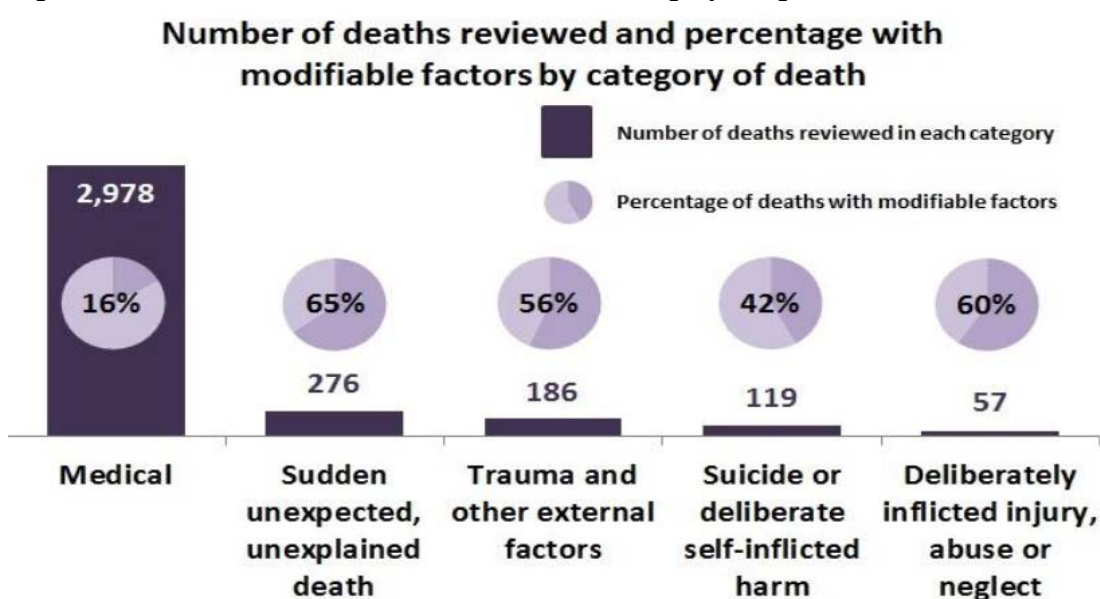


Figure 10 below shows the national figures on the number of reviews for each category of death together with the proportion of that category which had modifiable factors.

Figure10: Number of deaths reviewed in each category, England 2015-16



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

Of the 58 cases reviewed, 34 cases (59%) were classified as neonatal deaths compared with 41% nationally (2015-16). In 7 cases (12%) the cause of death was determined as 'known life-limiting conditions' compared with 27% nationally (2015-16). In 9 cases (16%) modifiable factors were identified (see section D9 for more detail).

Table 9: Events that caused the death as determined by CDOP 2016-17

Category of death	No of deaths with modifiable factors	No of deaths with no modifiable factors	Number of child deaths where there was insufficient information to assess if there were modifiable factors	Total	National benchmark (2015-16)
Neonatal death	6	28	0	34 (59%)	41%
Known life limiting condition	0	7	0	7 (12%)	27%
Sudden unexpected death in infancy	0	3	0	3 (5%)	10%
Road traffic accident/collision	0	1	0	1 (2%)	2%
Drowning	0	0	0	0	0.7%
Fire and burns	0	0	0	0	x
Poisoning	0	0	0	0	x
Other non-intentional injury/accident/trauma	0	0	0	0	x
Substance misuse	0	0	0	0	2.4%
Apparent homicide	0	0	0	0	0.8%
Apparent suicide	0	1	0	1 (2%)	3%
Other	3	8	1	12 (21%)	12%

D.8. Place of death

In 42 cases (72%), acute hospitals were the place of death followed by 10 cases (17%) in the normal residence of the child. Nationally, 67% of the deaths reviewed occurred in an acute hospital and 22% in the normal residence of the child. Of the other deaths reviewed, 2 (3%) were in a hospice, 2 (3%) abroad, 1 (2%) in a public place and 1 (2%) in an ambulance.

D.9. Modifiability/Preventability

In Buckinghamshire, modifiable factors were identified in 9 cases (16%) compared with 17% in the South East and 24% nationally (2015-16). 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 9 cases with modifiable factors:

1. One case related to a 29 week premature baby who died because of extreme prematurity, respiratory distress syndrome, sepsis and pulmonary haemorrhage. The review identified suboptimal management of this child's metabolic acidosis; however, the panel agreed that it was unlikely that this would have made a difference to the outcome for this baby.
2. One case related to a baby born at 41 weeks gestation. It was felt that due to reduced foetal movements the mother should have been asked to attend hospital earlier.
3. One case related to baby born at 37 weeks by emergency C-section due to major placenta praevia (an obstetric complication) and loss of foetal heart beats. The baby was born in very poor condition with no heart beats and no spontaneous breathing. The modifiable factor was around the management of prolonged labour.
4. A baby was born at 32 weeks making no respiratory effort. The review identified issues around baby's monitoring during the 2nd stage of labour, although it was felt that this was unlikely to have changed the outcome for this child.
5. One case was related to a 6 day old baby who had been born at 41 weeks in good condition but died of respiratory infection. Parents did not speak very good English. The modifiable factors identified included better recognition of signs of infection in babies.
6. A baby was born at 39 weeks by C-section with evidence of an abnormal foetal heartbeat prior to C-section. It was felt that there was a delay in acting on the abnormal heartbeat and that labour could have been induced earlier.
7. Another case was of a 5 month old baby presented to MIU and later reviewed in A&E. He was thought to have early bronchiolitis and was sent home with an advice leaflet with instructions to return if he deteriorated. He presented to Wycombe Hospital the following day with reduced feeding. It was felt that if the infant had been admitted when he first presented to A&E, treatment could have been started earlier and may have made a difference. It was acknowledged that it is not possible to admit every child

that presents with bronchiolitis and it is extremely difficult to identify which children will improve and which run the risk of deterioration.

8. One case was of a baby born at 32 weeks with multiple congenital abnormalities included a combination of cardiac, renal, ophthalmic and ano-rectal malformation. Over a 6 month period she was readmitted 5 times with increasing respiratory problems and oxygen requirement. It was felt that there should have been more involvement with the cardiology team.
9. In one case a woman with a previous history of undiagnosed breech deliveries went into labour at 39 weeks and the baby was born breech with no heartbeat or respiratory effort. Although this was a low risk and uneventful pregnancy, given her ante-natal history, the panel felt that, despite it not being a normal procedure, it would have been best practice for this mother to have been given an extra scan.

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 58 cases reviewed, there was one where the panel felt that a serious case review should be undertaken. This was considered by the Serious Case Review sub group who decided not to undertake a review, a decision that was backed up by the National Panel. Nationally, serious case reviews take place in 2% of deaths reviewed by CDOP.

More detailed information on serious case reviews undertaken by BSCB including the full reports and lessons learnt can be found on <http://www.bucks-lscb.org.uk/serious-case-review/>.

E. ACTIONS TAKEN & LESSONS LEARNED

This section summarises some of the actions that are taken following CDOP reviews or internal reviews by the Trust. Information on individual cases from which the actions have been derived is not presented here as this is beyond the scope of this report.

1. An internal review by the Trust identified poor documentation and recording as an issue and as a result appropriate measures were taken to improve recording and documentation.
2. In one case there was some uncertainty about the positioning of the tube in the oesophagus. As a result relevant training was given to staff.
3. In one case the accuracy of a telephone conversation between a patient and maternity staff was an issue and as a result of this all calls to the labour ward are now being recorded.
4. Following a couple of deaths due to Bronchiolitis, improvements have been made to the Bronchiolitis pathway and PEWS chart. The new bronchiolitis pathway now includes an additional section on the use of high flow oxygen therapy, when and when not to use. This means that there is now clear guidance on the management of severe bronchiolitis. The new chart and pathway have been successfully used over this last winter. Alongside this a new High Dependency pathway has also been developed involving increased monitoring.
5. Changes have been introduced to existing procedures with regard to undiagnosed breech presentation. Learning from one case has led to a decision that, in future, additional scans will be offered to those with a previous undiagnosed breech presentation.
6. Following a number of neonatal deaths our local hospital trust invited the Royal College of Obstetricians and Gynaecologists to carry out an independent review and the findings of this have been openly shared with CDOP enabling the panel to monitor these themes in the future.

F. PROGRESS AND ACHIEVEMENTS IN 2016-17

- The inherited backlog has been cleared and the review time has improved considerably. Our review time is now better than the national average.
- Close links between CDOP and the Buckinghamshire Healthcare Trust' Mortality Review Group have been established. The CDOP chair attends the hospital mortality review group and data on child mortality is being shared with the group as appropriate.
- eCDOP is up and running and plans are in place to train primary care clinicians in the new reporting process.
- A close link with the Acute Trust's Clinical Governance Team has been established
- Strong links with National and Regional Network of CDOP's have been maintained and members of the panel participated in the national stakeholder events held to review and standardise the processes and collection of data for child mortality reviews.

G. RECOMMENDATIONS

Recommendations for CDOP

1. CDOP to further improve the review time and aim to reduce the proportion of reviews that take more than 1 year by 50%.
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 to ensure that the recommendations of the Buckinghamshire neonatal mortality review by the Royal College of Obstetrics and Gynaecology are fully implemented, monitored and audited by Buckinghamshire Healthcare Trust.
4. 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. Ensure commissioners and providers improve and enhance data collection and reporting on important risk factors such as ethnicity, consanguinity, obesity, smoking and alcohol and substance misuse in children and maternity records in all health and social care settings.
3. Ensuring there is a clear and agreed process in place for referring and sign-posting at-risk women particularly those from areas of social deprivation including ethnic minorities to relevant services such as genetic screening and counselling, the Skilled for Health classes for BME population, healthy lifestyle services and services that aim to prevent pre-term birth such as the local prematurity clinics.
4. Ensure effective actions are taken by relevant partner agencies to reduce sudden unexpected death in infancy (SUDI), including promoting safer sleeping practice for babies, reduce parental smoking, encouraging and supporting breastfeeding and through clear communication of risk factors.
5. Ensure close links between LSCB and Children and Young Peoples 'Emotional Well-Being Group' and the Suicide Prevention Group in order to ensure the full implementation of the Buckinghamshire Suicide Prevention Partnership Action Plan for children and young people.
6. The LSCB to promote actions to reduce child death as described in Appendix 1 of this report.
7. The LSCB should adopt these recommendations and request a progress report on them from commissioners by March 2018.











Appendix 1: Actions to reduce Child Death²

Actions to reduce child death - overview

Risk factors for child deaths include:	Actions to reduce child deaths	Useful resources
 Factors intrinsic to the child <ul style="list-style-type: none"> • Prematurity • Chronic illness 	 Reduce health inequalities	 Useful resources <ul style="list-style-type: none"> ✓ Fraser J, Sidebotham P, Covington T et al The Lancet 2014;384:894-902 Learning from child death review in the USA, England, Australia and New Zealand
 Factors around parental care <ul style="list-style-type: none"> • Basic care of child • Responding to health needs • Parental smoking 	 Provide safe environments for children and young people inside and outside their homes	<ul style="list-style-type: none"> ✓ Sidebotham P, Fraser J, Fleming P et al The Lancet 2014;384: 904-914 Patterns of child death in England and Wales
 Environmental factors <ul style="list-style-type: none"> • Parental age • Social class • Housing 	 Optimise maternal physical and mental health before, during and after pregnancy	<ul style="list-style-type: none"> ✓ Sidebotham P, Fraser J, Covington T et al The Lancet 2014: 384;915-927 Understanding why children die in high income countries ✓ Wolfe I, Marcfarlane A, Donkin A et al on behalf of RCPCH, NCB, BACPH (2014) Why children die: death in infants, children and young people in the UK
 Service need and provision <ul style="list-style-type: none"> • Unmet medical needs • Inadequate health care • Lack of support services 	 Increase uptake of child immunisations	<ul style="list-style-type: none"> ✓ Local authority child health profiles: atlas.chimat.org.uk/IAS/dataviews/childhealthprofile
	 Better training of healthcare staff to improve the recognition of serious illnesses	 References
	 Communication with families to spot the signs of illness or failing health	<ul style="list-style-type: none"> • Department for Children, Schools and Families (2007) Patterns and causes of child deaths: Information sheet • Department of Health (2007) Review of the Health Inequalities PSA Target • Korkodilos M, Cole M (2016) The health and wellbeing of children and young people in Barking & Dagenham, Havering and Redbridge

12

Actions to reduce child death - reducing infant mortality

Risk factors for infant mortality include:	Actions to reduce infant mortality	Useful resources
 <p>In 2014, the infant mortality rate (IMR) was 28x higher for low birth weight babies than for babies of normal birth weight</p>	 Co-ordination and leadership Vital for an effective cross-agency approach	 Useful resources <ul style="list-style-type: none"> ✓ University of Oxford, National Perinatal Epidemiology Unit (2015) Inequalities in Infant Mortality Work Programme
 <p>The IMR for babies born to teenage mothers is 44% higher than mothers aged 20-39</p>	 Commissioning Integrated commissioning to ensure a whole systems approach	<ul style="list-style-type: none"> ✓ Royal College of Paediatrics and Child Health and National Children's Bureau (2014) Why children die: death in infants, children and young people in the UK Part B
 <p>In 2014, the IMR was 2.5x higher in babies in families in the routine and manual group compared with those in higher managerial and professional groups</p>	 Communication Understand the preferences and needs of the local population	<ul style="list-style-type: none"> ✓ National Institute for Health and Care Excellence (2014) clinical guideline 37 Postnatal care ✓ National Institute for Health and Care Excellence (2014) NICE guideline PH26 Quitting smoking in pregnancy and following childbirth
 <p>In 2014, the IMR of babies of mothers born in Pakistan was 2.1x higher than babies of mothers born inside the UK</p>	 Care pathway development Vital to support sustained improvements in service delivery and quality	 References
		<ul style="list-style-type: none"> • ONS (2016) Statistical Bulletin. Childhood mortality in England and Wales: 2014 • PHE London (2015) Reducing infant mortality in London: an evidence-based resource

13

² Reducing Child Mortality in the South East. Public Health England, December 2016.

Actions to reduce child death - improving communication

Good communication with families and between professionals is an **essential** component of high-quality care

Factors contributing to poor communication include:



Individual ability

Human factors that influence the effectiveness of communication include skills and ability, attitude, stress, distractions



Team behaviours

Role confusion and professional conflict



Organisational

- Working arrangements creating barriers to effective communication
- A lack of staff and inadequate resources

Actions to improve communication



Families

Clear information given to families in a manner they can understand

A clearly documented information 'passport' for children with long-term conditions



Organisational

Make effective communication an organisational priority



Tools

These include:

- The 'SBAR' (Situation, Background, Assessment, Recommendation) tool
- Clinical handover routines
- Safety briefings



Useful resources

- ✓ [patientsafety.health.org.uk/resources?f\[0\]=field_tags:58&f\[1\]=field_area_of_care:22](https://patientsafety.health.org.uk/resources?f[0]=field_tags:58&f[1]=field_area_of_care:22)
- ✓ www.institute.nhs.uk/safer_care/safer_care/Situation_Background_Assessment_Recommendation.html



References

- Child Health Reviews UK (2013) Co-ordinating Epilepsy Care: a UK-wide review of healthcare in cases of mortality and prolonged seizures in children and young people with epilepsies
- National Children's Bureau (2008): a shared responsibility safeguarding arrangements between hospitals and children's social services
- Lim I (2014): effective communication among healthcare workers to improve patient safety and quality
- RCOG (2010): improving patient handover

14

Actions to reduce child death - reducing SUDI

Risk factors for SUDI* include:



Low birth weight

5x higher risk



Smoking

5x higher risk



Deprivation

3.5x higher risk



Bed sharing

2.7x higher risk



Mothers <20 years

2.5x higher risk



Ensure safer sleeping practice for babies



Reduce parental smoking



Encourage and support mothers to breastfeed



Change knowledge and behaviour through clear communication of risk factors



Useful resources

- ✓ www.bestbeginnings.org.uk/babybuddy
- ✓ www.gov.uk/government/uploads/system/uploads/attachment_data/file/431396/London_sudden_deaths_in_infancy_update_factsheet.pdf
- ✓ www.lullabytrust.org.uk
- ✓ National Institute for Health and Care Excellence (2014) NICE guideline PH26 Quitting smoking in pregnancy and following childbirth
- ✓ Public Health England London (2014) The health and wellbeing of children and young people in London: an evidence-based resource



References

- PHE London (2015) Reducing infant mortality in London: an evidence-based resource

*SUDI: Sudden Unexpected Death in Infancy

16

Actions to reduce child death - reducing suicides



149 children aged 10-19 years in England committed suicide in 2014, almost **three** children every week

Risk factors include:



Biological

- Family factors eg mental illness or history of suicide
- Physical illness and long-term conditions



Psychological

- Alcohol or drug abuse
- Bereavement and experience of suicide
- Mental ill health, self-harm and suicidal ideas
- Social isolation or withdrawal



Environmental

- Abuse and neglect
- Bullying
- Suicide-related internet use
- Academic pressures related to exams

Actions to reduce suicide



Tailor approaches to improvements in mental health



Reduce access to the means of suicide



Support the media in delivering sensitive approaches to suicide



Support research, data collection and monitoring



Provide better information and support to those bereaved or affected by suicide



Useful resources

- ✓ www.gov.uk/government/collections/suicide-prevention-resources-and-guidance
- ✓ www.supportaftersuicide.org.uk/
- ✓ www.samaritans.org/about-us/our-organisation/national-suicide-prevention-alliance-nsps
- ✓ www.beatbullying.org/dox/resources/resources.html
- ✓ www.stonewall.org.uk/at_school/education_for_all/default.asp



References

- Butterworth S, Suicide and self-harm in young people: risk factors and interventions
- Department of Health (2012) Preventing suicide in England: a cross-government outcomes strategy to save lives
- National Confidential Inquiry into Suicides and Homicides by People with Mental Illness (2016) Suicide by children and young people in England

17

Actions to reduce child death - home safety

Unintentional injuries in and around the home are a **leading** cause of **preventable** death and a **major** cause of ill health and disability



Every year over **62** children under 14 die as a result of an accident in the home



Over **76,000** children under the age of 14 are admitted for treatment



Each year about **two million** children under the age of 15 are taken to A&E after being injured in or around the home



Risk factors for unintentional injuries include age < 5 years, boys and deprivation



£15.5-87 million
Estimated annual hospital costs of severe, unintentional injuries to children

Actions to improve home safety



Environment

Improvement in planning and design results in safer homes and leisure areas



Education

Increasing the awareness of the risk of accidents in a variety of settings and providing information on ways of minimising these risks



Empowerment

Accident prevention initiatives, which have been influenced by the community, are more likely to reflect local need and therefore encourage greater commitment



Enforcement

Child safety legislation. Local councils assess hazards to privately rented homes



Useful resources

- ✓ www.chimat.org.uk/earlyyears/injuries
- ✓ www.gov.uk/government/publications/reducing-unintentional-injuries-among-children-and-young-people
- ✓ www.capt.org.uk/
- ✓ www.rospe.com/



References

- Department of Health (2012) Our children deserve better: prevention pays
- www.rospe.com/home-safety/advice/general/facts-and-figures/
- www.rospe.com/home-safety/advice/child-safety/accidents-to-children/#who

18

Actions to reduce child death - reducing road traffic injuries (RTIs)

7 children are killed or seriously injured on Britain's roads every day

15 people are seriously injured for every 1 person aged < 25 years who dies in a RTI

16 deaths or serious injuries to children under 16 years **each week** occur between 8am to 9am and 3pm to 7pm

547 million pounds is the estimated annual cost of child road deaths and injuries

936 fewer serious or fatal injuries to child pedestrians and child cyclists annually would occur if all children had a risk of injury as low as children in the least deprived areas

Actions to reduce RTIs



Improve safety for children travelling to and from school

Including developing school travel plans, education and engineering measures to physically change the road environment



Introduce 20mph limits in priority areas as part of a safe system approach to road safety
Supported by providing publicity, information and community engagement



Co-ordinate action to prevent traffic injury

Within local authorities to encourage active travel and create liveable streets



Useful resources

- ✓ www.capt.org.uk/resources/road-safety



References

- www.makingthelink.net/tools/costs-child-accidents/costs-road-accidents
- PHE (2014) Reducing unintentional injuries on the roads among children and young people under 25 years

Actions to reduce child death - reducing domestic abuse



About **one in five** children aged 11-17 years has been exposed to domestic abuse



About **130,000** children live in households with **high-risk** domestic abuse



62% of children exposed to domestic abuse are directly harmed



80% of children exposed to domestic abuse are known to at least one public agency



Children suffer multiple **physical** and **mental health** consequences because of living with domestic violence

Actions to reduce domestic abuse



Educating and challenging young people about healthy relationships, abuse and consent



Earlier identification and intervention to prevent abuse



Improving access to parenting programmes which specifically address domestic abuse



Moving to an integrated model of family support



Strengthening the role of health services and providing effective help through specialist children's services



Changing perpetrators' behaviours to prevent abuse and reduce offending



Building the evidence base in what works in early intervention and tackling perpetrators



Useful resources

- ✓ www.caada.org.uk
- ✓ www.nspcc.org.uk
- ✓ www.ncdv.org.uk
- ✓ www.gov.uk/government/uploads/system/uploads/attachment_data/file/337615/evidence-review-interventions-F.pdf



References

- CAADA (2014) In plain sight: effective help for children exposed to domestic abuse
- Home Office (2016) Ending violence against women and girls Strategy 2016-2020
- Radford L et al (2011): child abuse and neglect in the UK today
- Safe Lives (2015) Getting it right the first time

Bereavement support

1 in 20

children in England has been bereaved of a parent or sibling by the time they are 16 years old



Children from disadvantaged backgrounds are **more likely** to be bereaved of a parent or sibling



Childhood bereavement may have both **short** and **long-term** impacts on children's wellbeing and educational achievement



Bereaved children are **1.5x more likely** than other children to be diagnosed with 'any' mental disorder



The death of a parent is associated with **lower** employment rates at the age 30

Actions to support bereaved children



Support for families

Providing information about how children grieve, what can help and what services there are



Support in schools

Developing a co-ordinated school approach such as staff training, school counselling services and peer support



Specialist support

Providing outreach and specialist support for those who are vulnerable or traumatised



Useful resources

- ✓ www.childhoodbereavementnetwork.org.uk
- ✓ www.cruse.org.uk
- ✓ www.griefencounter.org.uk
- ✓ www.hopeagain.org.uk
- ✓ www.tcf.org.uk
- ✓ www.winstonswish.org.uk
- ✓ www.nhs.uk/Livewell/bereavement/Pages/children-bereavement.aspx



References

- Aynsley-Green A, Penny A, Richardson S BMJ Supportive and Palliative Care (2011) Bereavement in childhood: risks, consequences and responses
- Parsons S (2011) Long-term impact of childhood bereavement. Preliminary analysis of the 1970 British Cohort Study (BCS70): London, Child wellbeing research centre
- Penny and Stubbs (2014) Childhood Bereavement: what do we know in 2015? London: National Children's Bureau
- www.childhoodbereavementnetwork.org.uk/research/local-statistics.aspx

Appendix 2: Child death review process in Buckinghamshire

