Buckinghamshire BSCB Safeguarding Children Board

BUCKINGHAMSHIRE CHILD DEATH OVERVIEW PANEL (CDOP)

TENTH ANNUAL REPORT
APRIL 2017 – MARCH 2018

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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 2** 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 tenth annual report by the CDOP and it focuses on the work of the panel during 2017-18 and reports on the activity and the findings from the analysis of data collected locally. This report consists of the following six sections:

A. EXECUTIVE SUMMARY

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

- In 2017-18 CDOP was notified of 26 deaths of children aged 0-17 in Buckinghamshire and reviewed a total of 28 cases.

Review time:

- Of the 28 cases reviewed in the year ending 31 March 2018, 57% (16 cases) were completed in less than 6 months compared with the national average of 32% (2016-17). This is a significant improvement from 29% in 2016-17, 19% in 2015-16 and 8% in 2014-15.

- 39% (11 cases) were completed in 6-12 months compared with 44% nationally. This is a significant improvement from 45% in 2016-17.

- Only 1 case (4%) took longer than a year to review, a significant improvement from 26% in previous year and significantly better than the national average of 24% in 2016-17. This means 96% (27 cases) were completed within 12 months of the notification which is a significant improvement from 74% in the previous year and significantly better than the national average of 76% in 2016-17.

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

- Of the 28 cases reviewed, 8 cases (29%) were 0-27 days old at the time of death compared with 43% nationally (2016-17). A further 11 cases (39%) were aged between 28 and 364 days which is higher than the national average of 21% in 2016-17 (the differences are not statistically significant).

- Overall, 68% (19 cases) were in children aged 0-1 year old which is similar to the national average of 64% (2016-17).

- 11% of cases were in 1-5 year olds which is the same as the national average for these age groups (2016-17). 6 cases (21%) were in 5-17 year olds compared with 24% nationally.

- 14 cases (50%) were male and 14 cases (50%) were female, compared with the national average of 56% and 44% respectively (2016-17).

Nationally, boys' deaths have consistently accounted for over half of deaths reviewed since the year ending 31 March 2011 (2016-17).

- Information on ethnicity was known for all the cases which is a major improvement from previous years. In 2014-15 and 2015-16, the information on ethnicity was unknown or not stated in 32% and 17% of the cases respectively. Nationally in 7% of the cases ethnicity was either unknown or not stated (2016-17).

- 15 deaths (54%) were in children of White (Any White) ethnic background combined. 8 deaths (29%) were in children of any Asian/mixed Asian background combined. A small proportion of deaths were in children of any black and mixed black background.

- Three children were subject to child protection plans or statutory orders either previously or at the time of death 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 (12 cases, 43%), followed by chromosomal/congenital abnormalities (7 cases, 25%). This compared with the national average of 34% and 25% respectively (2016-17). Child mortality rates including perinatal mortality and patterns of death in Buckinghamshire are consistent with the national picture and with research evidence. All child mortality rates show that Buckinghamshire does not differ significantly from the national average[1].

Events that caused the death as determined by CDOP:

- In 14 cases (50%) the cause of deaths was determined as neonatal deaths compared with 39% nationally (2016-17). In 8 cases (29%) the cause of death was determined as 'known life-limiting conditions' compared with 27% nationally (2016-17).

- In 14 cases (50%) Acute Hospitals were the place of death followed by 9 cases (32%) in the normal residence of the child. Nationally, 69% of the deaths reviewed occurred in an acute hospital and 20% in the normal residence of the child.

- Modifiable factors were identified in 2 (7%) cases compared with 16% of the cases in 2016-17 and 26% of cases nationally (2016-17). (Issues

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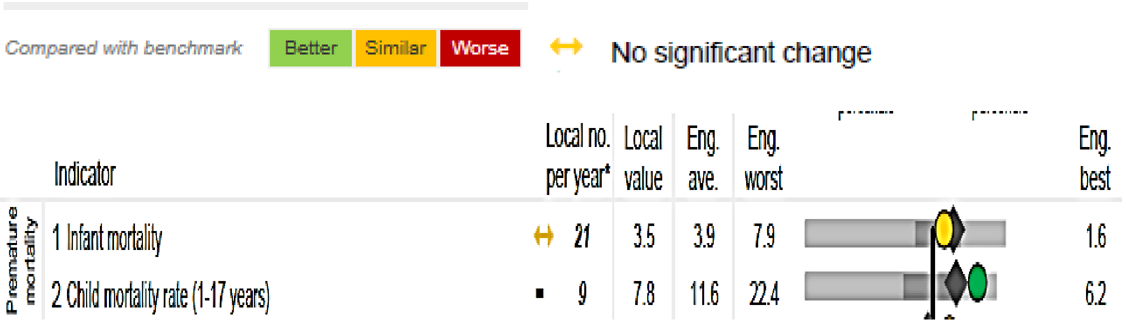
[1] A review of child mortality in Buckinghamshire, Public Health Team, 2017.

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 26% in 2017.

B. BACKGROUND

The health and wellbeing of children in Buckinghamshire is generally better than the England average. As shown by table 1, infant mortality rate is similar to the England average and child mortality rate is better than the England average.

Table 1: Infant and Child Mortality Rates in Buckinghamshire 2014-16 (PHE, Child Health Profile 2018)



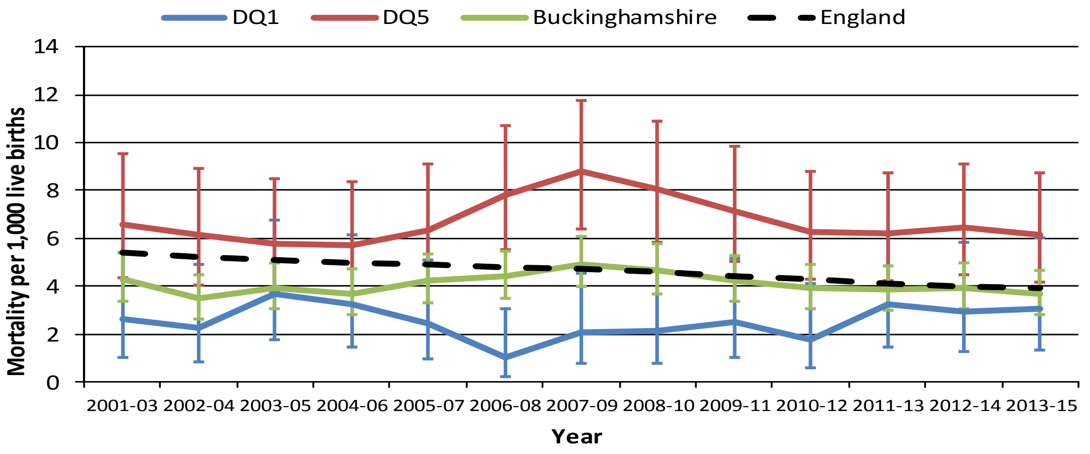
Compared with benchmark 🟩 Better 🟨 Similar 🟥 Worse ↔ No significant change

	Indicator		Local no. per year*	Local value	Eng. ave.	Eng. worst		Eng. best
Premature mortality	1 Infant mortality	↔	21	3.5	3.9	7.9	●	1.6
	2 Child mortality rate (1-17 years)	▪	9	7.8	11.6	22.4	●	6.2

1 Mortality rate per 1,000 live births (aged under 1 year), 2014-2016
2 Directly standardised rate per 100,000 children aged 1-17 years, 2014-2016

Figure 1 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.

Figure 1: 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.

C. CHILD DEATH REVIEW PANEL ACTIVITY 2017-18

C.1. CDOP Membership

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

Core members of CDOP in 2017-18 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 1.4.2017 - 31.3.2018

Between 1st April 2017 and 31st March 2018, CDOP was notified of 26 deaths of children aged 0-17 in Buckinghamshire. While the number of deaths has fluctuated year on year, in 2017-18, CDOP received the lowest number of notifications of death in children in Buckinghamshire since 2008 when CDOP was established.
Table 2 below shows the number of notifications received by the panel since 2013-14.

Table 2: Number of child death notifications to CDOP and number of reviews per year, April 2013- Mar 2018

	Yr 6 13/14	Yr 7 14/15	Yr 8 15/16	Yr 9 16/17	Yr 10 17/18
No. of Notifications	42	27	43	29	26

C.3. Number of CDOP Review Meetings 1.4.2017 - 31.3.2018

The Multi-agency Child Death Overview Panel met six times a year during 2017-18 and completed a total of 28 reviews. The table below summarises the attendance of each agency at Panel meetings for the period 1.4.2017 to 31.3.2018.

Table 3: Number of CDOP meetings in 2017-18 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	No	Yes	No
Social Care Representative	Yes	Yes	Yes	No	Yes	No
Designated Doctor/BHT	Yes	Yes	Yes	Yes	Yes	Yes
Community Public Health Nurse, BHT	No	Yes	Yes	Yes	Yes	Yes
Designated Nurse, Safeguarding Children/CCG	Yes	Yes	Yes	Yes	Yes	No
Police	Yes	Yes	Yes	No	Yes	Yes
Coroner’s Representative	Yes	No	No	Yes	No	No
Midwifery	Yes	Yes	Yes	Yes	Yes	Yes
Ambulance Service	No	No	No	Yes	No	No

C.4. Number of reviews and review time

In 2017-18 the panel reviewed 28 cases in total. Of the 28 cases, 36% (10 cases) were from the previous year.
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 28 cases that were reviewed in 2017-18.

Table 4: Year in which death occurred

Deaths occurred in:		**Total**
Year 9 (2016/17	**Year 10 (2017/18)**	
10	18	28

Table 5 and figure 2 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 2017-18 compared with previous years.

- Of the 28 cases reviewed in the year ending 31 March 2018, 57% (16 cases) were completed in less than 6 months compared with the national average of 32% (2016-17). This is a significant improvement from 29% in 2016-17, 19% in 2015-16 and 8% in 2014-15.

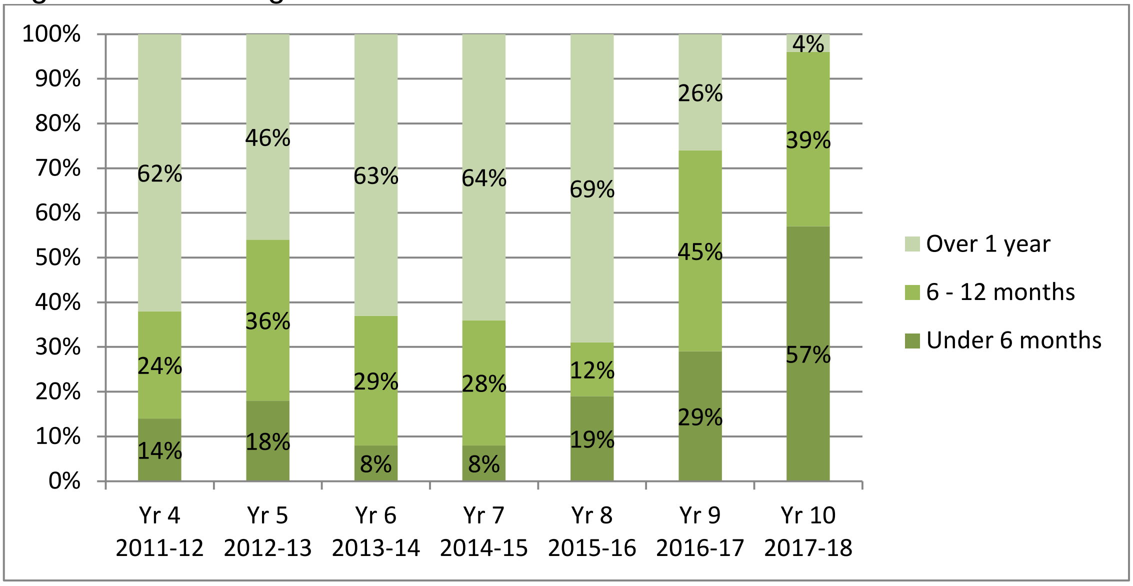
- 39% (11 cases) were completed in 6-12 months compared with 44% nationally. This is a significant improvement from 45% in 2016-17.

- Only 1 case (4%) took longer than a year to review, a significant improvement from 26% in previous year and significantly better than the national average of 24% in 2016-17. This means 96% (27 cases) were completed within 12 months of the notification which is a significant improvement from 74% in the previous year and significantly better than the national average of 76% in 2016-17.

Table 5: Total number of reviews and review time 2012-18

Duration	**Yr 5** **12/13**	**Yr 6** **13/14**	**Yr 7** **14/15**	**Yr 8** **15/16**	**Yr 9** **16/17**	**Yr 10** **17/18**	***National Benchmark 2016/17***
< 6 months	7 (18%)	3 (8%)	3 (8%)	9 (19%)	17 (29%)	**16** **(57%)**	*32%*
6-7 months	5	3	5	1	9	**4**	*44%*
8-9 months	7	4	4	4	6	**5**	
10-11 months	2	4	1	1	9	**1**	
12 months	0	0	1	0	2	**1**	
Over 1 year	18 (46%)	24 (63%)	25 (64%)	34 (69%)	15 (26%)	**1** **(4%)**	*24%*
Total	**39**	**38**	**39**	**49**	**58**	**28**	

Figure 2: Percentage of reviews and review time 2011-18

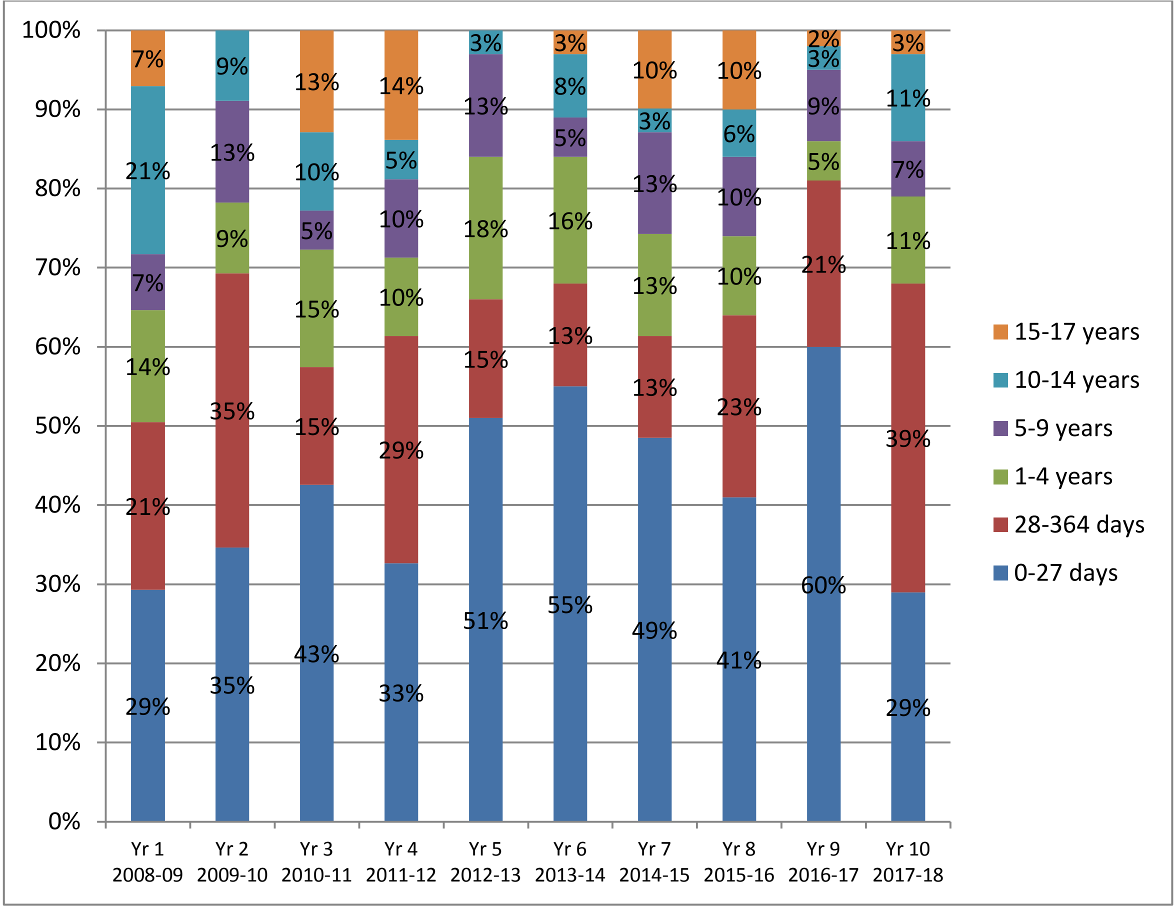


D. ANALYSIS OF CHILD DEATH REVIEWS & FINDINGS

D.1. Number of deaths reviewed by age group

- Of the 28 cases reviewed, 8 cases (29%) were 0-27 days old at the time of death compared with 43% nationally (2016-17). A further 11 cases (39%) were aged between 28 and 364 days which is higher than the national average of 21% in 2016-17.
- Overall, 68% (19 cases) were in children aged 0-1 year old which is similar to the national average of 64% (2016-17).
- 11% of cases were in 1-5 year olds which is the same as the national average for these age groups (2016-17). 6 cases (21%) were in 5-17 year olds compared with 24% nationally.

Figure 3: Number of deaths reviewed by age group 2008-2018



D.2. Number of deaths reviewed by gender:

- 14 cases (50%) were male and 14 cases (50%) were female, compared with the national average of 56% and 44% respectively (2016-17). Nationally, boys’ deaths have consistently accounted for over half of deaths reviewed since the year ending 31 March 2011 (2016-17).

Table 6: Number of deaths reviewed by gender 2008-2018

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	Yr 10 17/18
Male	9 (64%)	12 (52%)	20 (50%)	16 (76%)	17 (44%)	21 (55%)	23 (59%)	29 (59%)	28 (48%)	14 (50%)
Female	4 (29%)	11 (48%)	20 (50%)	5 (24%)	21 (54%)	16 (42%)	15 (38%)	18 (37%)	30 (52%)	14 (50%)
Not stated /undetermined	1	-	-	-	1	1	1	2	-	-
Total	**14**	**23**	**40**	**21**	**39**	**38**	**39**	**49**	**58**	**28**

D.3. Number of deaths by ethnicity

- Information on ethnicity was known for all the cases. This is a major improvement from previous years as in 2014-15 and 2015-16 the information on ethnicity was unknown or not stated in 32% and 17% of the cases respectively. Nationally in 7% of the cases ethnicity was either unknown or not stated in 2016-17.

- Of the 28 cases reviewed in 2017-18, 15 deaths (54%) were in children of White (Any White) ethnic background combined. 8 deaths (29%) were in children of any Asian/mixed Asian background combined. A small proportion of deaths were in children of any black and mixed black background.

A detailed analysis of child mortality data by the Public Health Team in 2017 showed that child mortality rates and patterns of death among the ethnic minority groups in Buckinghamshire are consistent with the national picture and with research evidence.

It is important to note that in Buckinghamshire 13.6% of population are from BME communities compared with 14.6% nationally (2011 Census). However, Buckinghamshire has a higher proportion of Asian residents (8.6%) compared with the national average (7.8%). The general fertility rate is much higher among the BME and Asian population. Low birth weight and infant mortality rates are much higher among the BME and particularly among the Asian population. Buckinghamshire also has a much higher proportion of school-age children from BME groups (32.8%) compared with the national average of 29.2%. Similarly, the proportion of school children with an Asian background is much higher at 16.7% compared with 10.2% nationally. More importantly, the proportion of pupils with a Pakistani background is twice as high as the England average at 9.3% compared with 4.2%. There is strong evidence that child death rates are much higher among children of BME population particularly among those of Asian Pakistani and Black ethnic groups[2].

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[2] Childhood mortality in England and Wales: 2015. Stillbirths, infant and childhood deaths occurring annually in England and Wales, and associated risk factors

D.4. Child deaths where the child was an asylum seeker 2017-18

Of the 28 deaths reviewed, no case was identified as an asylum seeker. 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.

D.5. Child death reviews where the child was subject to a Child Protection Plan or any statutory orders 2017-18

Three children were subject to child protection plans or statutory orders either previously or at the time of death.

D.6. Category of deaths as determined by CDOP 2017-18

The Panel is required to classify the deaths into 10 categories and record 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 annual report shows that perinatal/neonatal deaths[3] were the top category of death in Buckinghamshire (12 cases, 43%), followed by chromosomal/congenital abnormalities (7 cases, 25%). This compared with the national average of 34% and 25% respectively (2016-17). Further analysis of morality data using the ONS mortality data showed that perinatal, neonatal and infant mortality rates do not differ significantly from the national rates (Table 7, 8 and 9 below). In addition a detailed analysis of data on infant mortality in Buckinghamshire in early 2017 also concluded that child mortality rates and patterns of death in Buckinghamshire are consistent with the national picture and with research evidence. The detailed analysis also confirmed that locally, infant mortality rates are higher amongst the Asian children, however; this trend is also seen throughout the whole country. A similar picture is seen with

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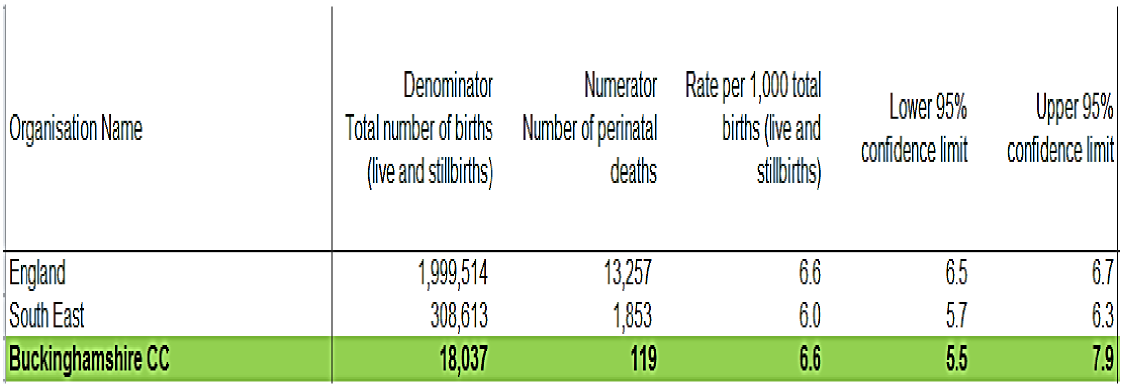
[3] Perinatal mortality rate: the number of stillbirths and deaths in the first six postnatal days per 1,000 total births .
Neonatal mortality rate: the number of infants dying in the first 27 postnatal days per 1,000 live births
Post-neonatal mortality rate: the number of infants dying at 28 days and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

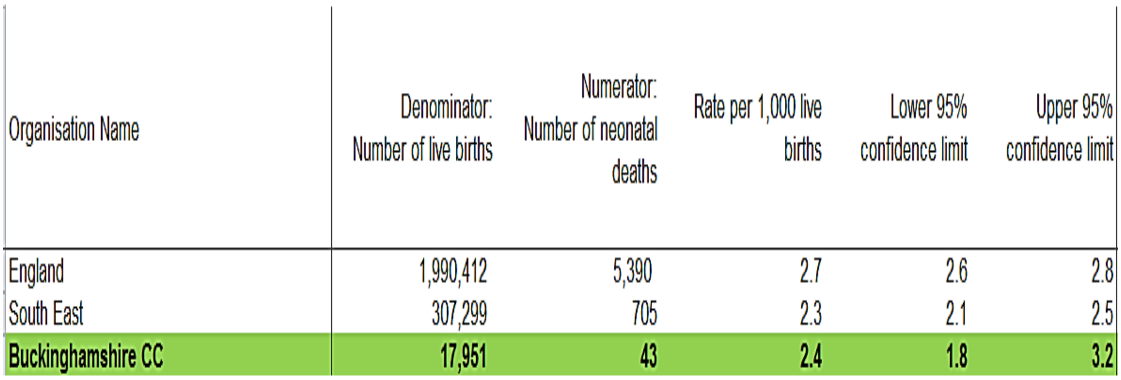
regard to stillbirths, prematurity and congenital abnormalities.

Table 7: Perinatal (<7 days old) mortality crude rate per 1,000 births (live and stillbirths), 3-year pooled data 2013-2015 - ONS



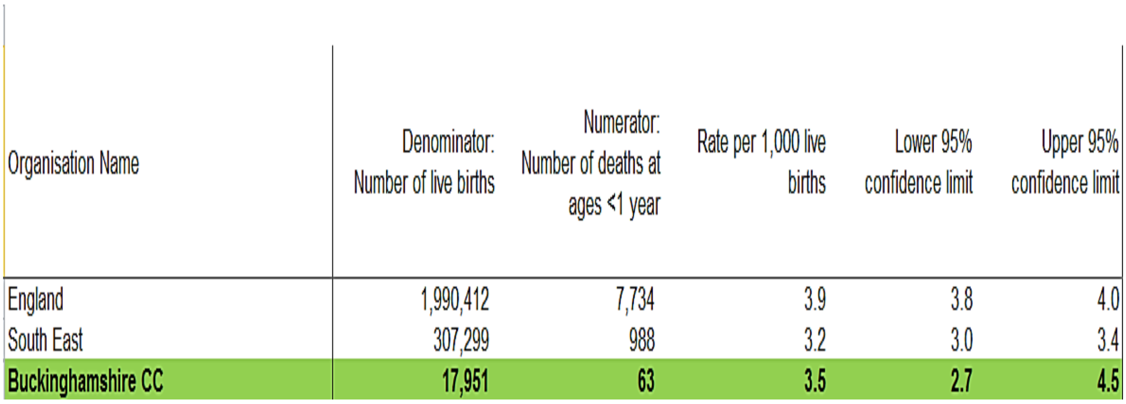
Organisation Name	Denominator Total number of births (live and stillbirths)	Numerator Number of perinatal deaths	Rate per 1,000 total births (live and stillbirths)	Lower 95% confidence limit	Upper 95% confidence limit
England	1,999,514	13,257	6.6	6.5	6.7
South East	308,613	1,853	6.0	5.7	6.3
Buckinghamshire CC	**18,037**	**119**	**6.6**	**5.5**	**7.9**

Table 8: Neonatal (<28 days) mortality crude rate per 1,000 live births, 3-year pooled data 2013-2015



Organisation Name	Denominator: Number of live births	Numerator: Number of neonatal deaths	Rate per 1,000 live births	Lower 95% confidence limit	Upper 95% confidence limit
England	1,990,412	5,390	2.7	2.6	2.8
South East	307,299	705	2.3	2.1	2.5
Buckinghamshire CC	**17,951**	**43**	**2.4**	**1.8**	**3.2**

Table 9: Infant (<1 year old) mortality crude rate per 1,000 live births, 3-year pooled data 2013-2015

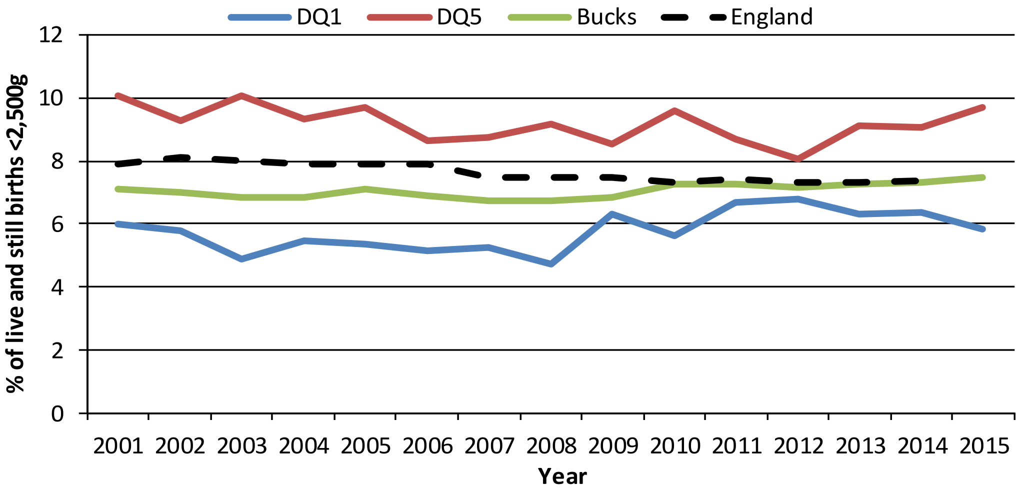


Organisation Name	Denominator: Number of live births	Numerator: Number of deaths at ages <1 year	Rate per 1,000 live births	Lower 95% confidence limit	Upper 95% confidence limit
England	1,990,412	7,734	3.9	3.8	4.0
South East	307,299	988	3.2	3.0	3.4
Buckinghamshire CC	**17,951**	**63**	**3.5**	**2.7**	**4.5**

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 2016, 157 babies (2.8%) of live-born babies, born at term to mothers living in Buckinghamshire were born at a low birth weight (less than 2,500 grams). 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 2015The proportion of babies born prematurely is similar to the national average and 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 (Figure not included in the report).

Many factors contribute to poor outcomes for babies. For example maternal weight, smoking, alcohol/substance misuse, folic acid intake, immunisations, long-term physical and mental health conditions, previous pregnancy complications, maternal age, consanguineous relationships and domestic violence all influence these outcomes. It is therefore important to promote preconception health which relates to the health behaviours, risk factors and wider determinants for women and men of reproductive age which impact on maternal, infant and child outcomes. Analysis of infant mortality at national level highlights the relationship of inequalities and wider determinants to poor outcomes. These relationships are complex; for example some minority ethnic groups are at greater risk as they are more likely to experience deprivation[4].

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[4] Public Health England. Health equity in England. 2017

Table 10 and figure 5 below show the category of deaths as determined by local and national CDOP reviews.

Table 10: Category of deaths as determined by CDOP 2017-18

Category of death	Total
Category 1: Deliberately inflicted injury, abuse or neglect	0
Category 2: Suicide or deliberate self-inflicted harm	0
Category 3: Trauma and other external factors	2 (7%)
Category 4: Malignancy	3 (11%)
Category 5: Acute medical or surgical condition	0
Category 6: Chronic medical condition	0
Category 7: Chromosomal, genetic and congenital anomalies	7 (25%)
Category 8: Perinatal/neonatal event	12 (43%)
Category 9: Infection	2 (7%)
Category 10: Sudden unexpected, unexplained death	2 (7%)
Total	**28**

Figure 5 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. Figure 7 below shows the trend in the category of deaths since 2008.

Figure 5: Number of deaths reviewed in each category, England 2016-17

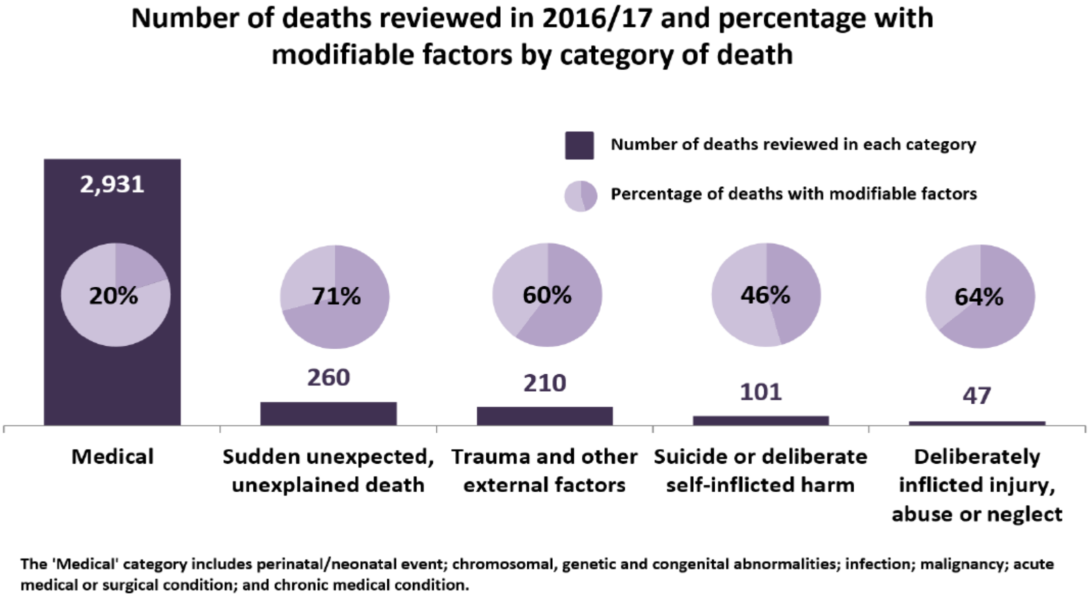
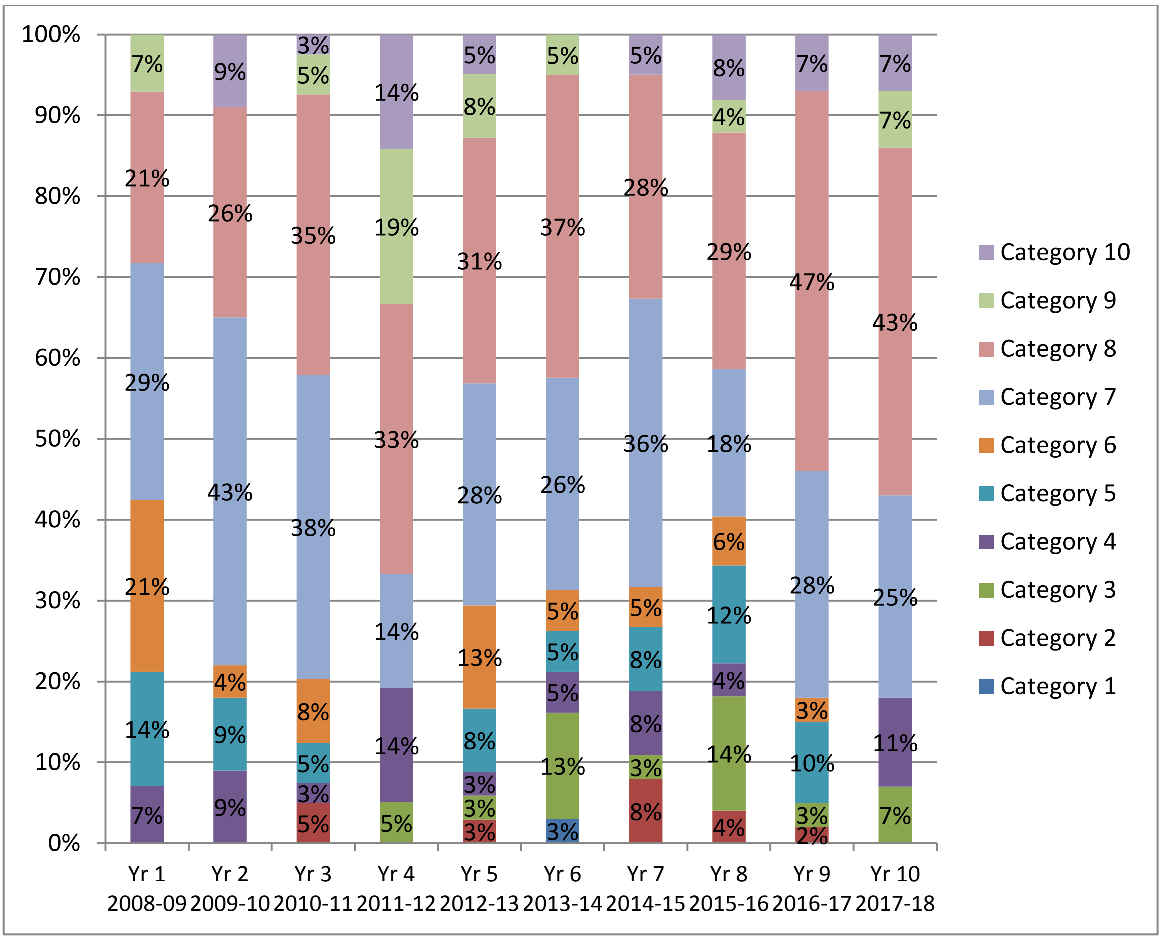


Figure 6: Trend in category of deaths as determined by CDOP 2008-18



Category	Yr 1 2008-09	Yr 2 2009-10	Yr 3 2010-11	Yr 4 2011-12	Yr 5 2012-13	Yr 6 2013-14	Yr 7 2014-15	Yr 8 2015-16	Yr 9 2016-17	Yr 10 2017-18
Category 10		9%	3%	14%	5%		5%	8%	7%	7%
Category 9	7%		5%	19%	8%	5%		4%		7%
Category 8	21%	26%	35%	33%	31%	37%	28%	29%	47%	43%
Category 7	29%	43%	38%	14%	28%	26%	36%	18%	28%	25%
Category 6	21%	4%	8%		13%	5%	5%	6%	3%	
Category 5	14%	9%	5%		8%	5%	8%	12%	10%	
Category 4	7%	9%	3%	14%	3%	5%	8%	4%		11%
Category 3				5%	3%	13%	3%	14%	3%	7%
Category 2			5%		3%		8%	4%	2%	
Category 1						3%				

D.7. Place of death

In 14 cases (50%) Acute Hospitals were the place of death followed by 9 cases (32%) in the normal residence of the child. Nationally, 69% of the deaths reviewed occurred in an acute hospital and 20% in the normal residence of the child. Of the other deaths reviewed, 3 (10.5%) were in a hospice, 1 (3.5%) abroad and 1 (3.5%) in a public place.

D.8. Events that caused the death as determined by CDOP

Of the 28 cases reviewed, 14 cases (50%) were classified as neonatal deaths compared with 39% nationally (2016-17). In 8 cases (29%) the cause of death was determined as ‘known life-limiting conditions' compared with 27% nationally (2016-17). In 2 cases (7%) modifiable factors were identified (see section D9 for more detail).

Table 11: Events that caused the death as determined by CDOP 2017-18

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 (2016-17)**
Neonatal death	0	14	0	14 (50%)	*39%*
Known life limiting condition	0	8	0	8 (29%)	*27%*
Sudden unexpected death in infancy	1	1	0	2 (7%)	*9%*
Road traffic accident/ collision	1	0	0	1 (3.5%)	*3%*
Drowning	0	0	0	0	*1%*
Fire and burns	0	0	0	0	*0.2%*
Poisoning	0	0	0	0	*0.3%*
Other non-intentional injury/accident/ trauma	0	1	0	1 (3.5%)	*2.4%*
Substance misuse	0	0	0	0	*0.2%*
Apparent homicide	0	0	0	0	*1%*
Apparent suicide	0	0	0	0	*3%*
Other	0	2	0	2 (7%)	*15%*

D.9. Modifiability/Preventability

Modifiable factors were identified in 2 (7%) cases compared with 16% of the cases in 2016-17 and 26% of cases nationally (2016-17). (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 26% in 2017.

Of the 2 cases with modifiable factors:

1. One case related to the child of a teenage mother who had been known to Social Care herself as a child and had been involved with a number of services across three Counties since the birth of her son. It was noted that engagement with these services had been difficult at times and her accommodation was not suitable for a young child. A thematic review had

been carried out by Milton Keynes Safeguarding Board in order to identify learning opportunities.

2. One case related to a young boy that was knocked down by a vehicle on his drive. There were concerns around parental supervision of young children in the vicinity of moving vehicles particularly as a number of other CDOPs in the region had had similar cases. These cases have been referred to the Royal Society for the Prevention of Accidents (RosPA) to see if an awareness campaign could be run.

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 28 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 have been 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. In the cases reviewed in this year CDOP did not identify any local actions which would have a direct impact on helping to prevent further deaths. Of the two cases with modifiable factors one was related to Milton Keynes Safeguarding Board and one was related to the Royal Society for the Prevention of Accidents (RoSPA). CDOP referred both cases to the relevant agencies.

1. An action was taken to combine the new mandatory learning disabilities mortality review process with the CDOP review process. The Learning Disabilities Mortality Review (LeDeR) Programme went live during 2017-18 in Buckinghamshire and there is some overlap with CDOP as it includes children aged 4 and over who have a Learning Disability. The combined process is more efficient and has reduced the number of times professionals are contacted for information on the same child for different reviews. Data is now collected for both reviews by the CDOP Coordinator who liaises with the LeDeR reviewer to ensure that there is sufficient information to perform both reviews by the CDOP panel.

2. CDOP procedures have been amended to improve CDOP link with mental health professionals especially where there is a history of mental health issues in the family. As a result, when relevant, notifications are sent to Oxford Health so that key information is obtained and mental health professionals are invited to panel meetings when necessary.

3. An action was taken to improve the quality of data received by CDOP from GPs on neonate cases. As maternity services have more accurate information on antenatal care, the new process involves sending an amended Form B2 to the maternity department at SMH and an email sent to GPs for specific questions to be answered if further information was required.

4. Some changes have been made around the Rapid Response (RR) process after some feedback and reflective learning sessions to ensure that new member of staff are fully briefed about the purpose of the RR meetings and where to access support following distressing meetings.

5. A case study was developed covering child death abroad in order to raise awareness about local procedures. This was following an incident where a death of a young child abroad was reported by the family to their GP but this information was not passed on by the surgery to relevant professionals.

6. The panel have participated in a national study into the CDOP classification on infant related sleep deaths and are awaiting any learning arising from this study.

F. PROGRESS AND ACHIEVEMENTS IN 2017-18

- Significant improvements have been achieved in review times with 57% of the cases being reviewed within 6 months compared with 29% in 2016-17, and 96% reviewed within 12 months compared with 74% last year. These figures are significantly better than the national average for review times.
- A detailed analysis of child mortality in Buckinghamshire was undertaken by the Panel, focusing on ethnicity, prematurity and congenital abnormalities in order to help identify opportunities for improving health and reducing mortality among children in Buckinghamshire.
- 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 comment on the revised guidelines for child death reviews.
- Links have been established with those responsible for LeDeR reviews in Bucks to avoid duplication of information gathering for deaths of children under the age of 18 who require a LeDeR review.
- All cases carried forward at the beginning of the year were uploaded to eCDOP and all new cases this year have been processed through eCDOP. Once details are available eCDOP will be used to produce the annual data return
- Significant improvements have been achieved in CDOP internal processes as mentioned in section E above.

G. RECOMMENDATIONS

G1: Recommendations for frontline staff [5]

1. **Access to universal services**: All professionals in contact with pregnant women and families with young children should encourage parents to access universal parenting advice via the red book, national start4life website, Baby Buddy app and the Buckinghamshire Family Information Service.

2. **Assessing risk factors:** Healthcare professionals in contact with pregnant women or new mothers should assess all the factors that could impact on the mother's, baby's and family's health and offer advice, support and referral to appropriate services. This includes lifestyle factors such as smoking, alcohol consumption, drug use, weight and healthy eating as well as mental health, exposure to domestic violence and other social factors.

G2: Recommendations for commissioners[6]'

1. **Supporting health improvement**: Supporting health improvement for individuals across their reproductive life-course, aligning local services to provide universal support for everyone, as well as targeted support where it is most needed.

2. **Embedding preconception care into care pathways:** Preconception care, combining planning and fitness for pregnancy, needs to be visible in all relevant health and social care pathways.

3. **Enhancing the quality of data:** Commissioners and providers of maternity, early years, mental health and substance misuse services should enhance the data collected on the physical and mental health of mothers and babies, the prevalence of risk factors and referral to and outcomes of services

4. **Developing preconception indicators:** To prioritise preconception health, population health measures need to include preconception indicators and outcomes. Improving the quality and completeness of

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[5]: Director of Public Health Annual Report 2016- From the very beginning - pregnancy and beyond
https://www.westsussexconnecttosupport.org/s4s/api/FileManagement/GetFileContent?id=/98/

[6].https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729018/Making_the_case_for_preconception_care.pdf

information gathered at booking in the maternity services dataset, will allow for indicators to be developed and published.

5. **Addressing wider determinants:** To improve the circumstances in which women enter pregnancy, the impact of housing, education, income, work and relationships needs to be recognised.

G3: Recommendations for CDOP

1. CDOP to maintain the improved review times and should aim to further reduce the proportion of reviews that take more than 6 months.

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 to continue the surveillance of child mortality and periodically analyse child death data over a number of years to get an accurate picture of deaths in children in Buckinghamshire.

5. CDOP to strengthen its relationship with neighbouring CDOPs in order to improve data sharing across the system.

6. Build on the links established with Oxford Health CDOP to ensure that mental health professionals are involved in the CDOP review process.

7. Participate in a peer review carried out by another CDOP and ensure that any recommendations are built into the new Child Death Review process following release of the new guidelines.

G4: 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. Championing improvement in 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.

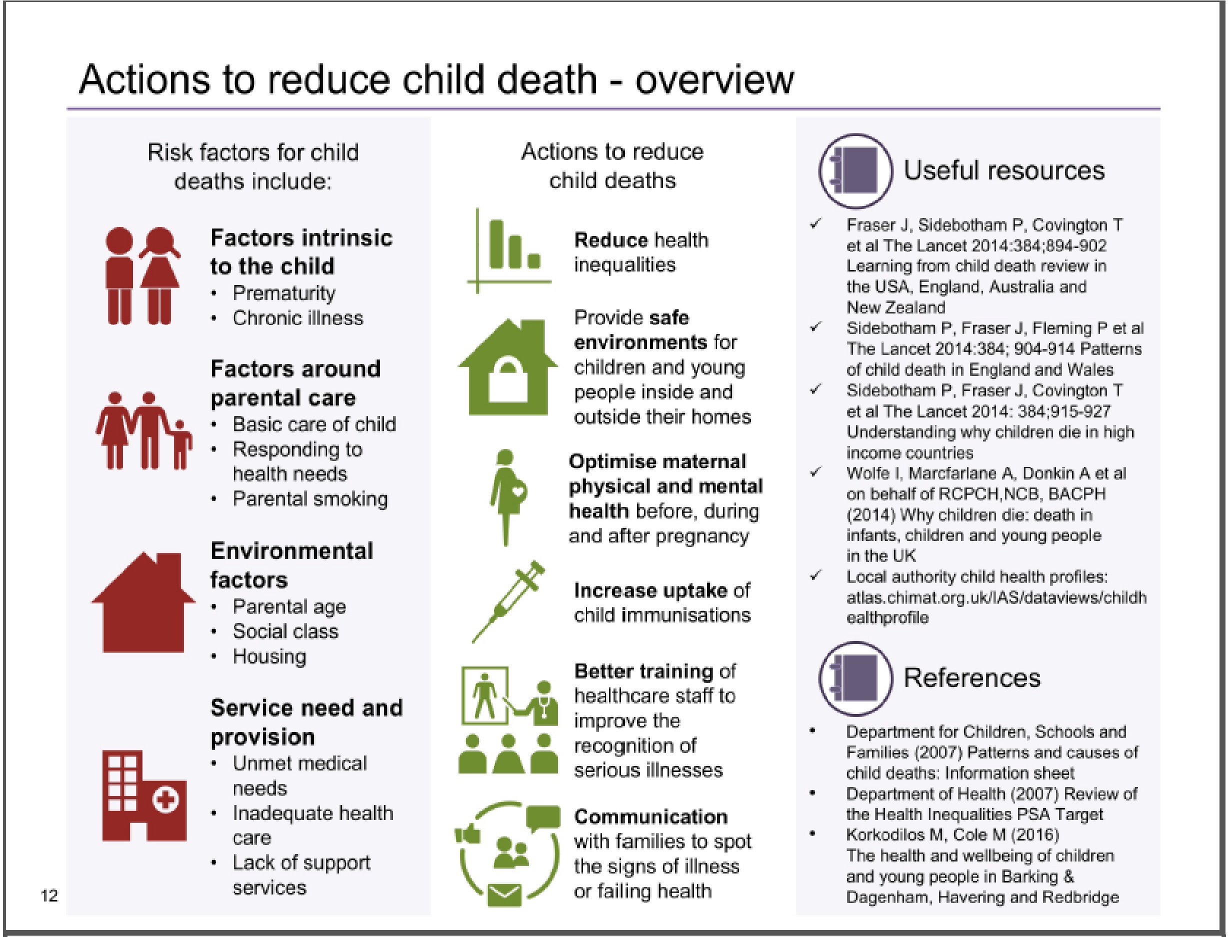
3. Ensure that commissioners and providers have clear and agreed processes in place for referring and sign-posting at-risk women and

children particularly those from areas of social deprivation including ethnic minorities to relevant services.

4. Ensure strong links between LSCB subgroups are established in order to ensure a coherent approach to reducing preventable death among children in Buckinghamshire.

5. The LSCB to ensure that actions to reduce child death as described above (Recommendations for commissioners) and in **Appendix 1** of this report are implemented by the relevant agencies.

Appendix 1: Actions to reduce Child Death[7]



Actions to reduce child death - overview

Risk factors for child deaths include:

Factors intrinsic to the child
- Prematurity
- Chronic illness

Factors around parental care
- Basic care of child
- Responding to health needs
- Parental smoking

Environmental factors
- Parental age
- Social class
- Housing

Service need and provision
- Unmet medical needs
- Inadequate health care
- Lack of support services

Actions to reduce child deaths

Reduce health inequalities

Provide **safe environments** for children and young people inside and outside their homes

Optimise maternal physical and mental health before, during and after pregnancy

Increase uptake of child immunisations

Better training of healthcare staff to improve the recognition of serious illnesses

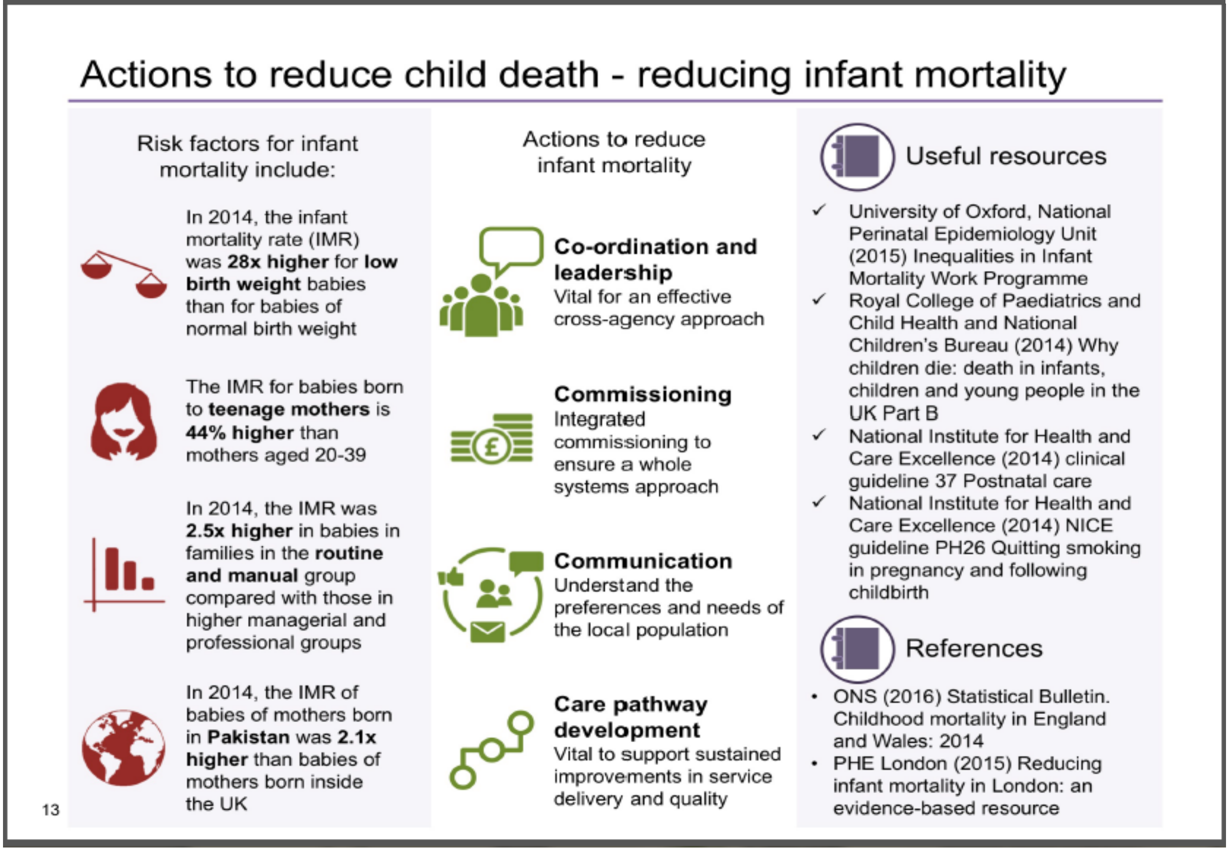
Communication with families to spot the signs of illness or failing health

Useful resources

- ✓ 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
- ✓ Sidebotham P, Fraser J, Fleming P et al The Lancet 2014:384; 904-914 Patterns of child death in England and Wales
- ✓ 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
- ✓ Local authority child health profiles: atlas.chimat.org.uk/IAS/dataviews/childhealthprofile

References

- 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



Actions to reduce child death - reducing infant mortality

Risk factors for infant mortality include:

In 2014, the infant mortality rate (IMR) was **28x higher** for **low birth weight** babies than for babies of normal birth weight

The IMR for babies born to **teenage mothers** is **44% higher** than mothers aged 20-39

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

In 2014, the IMR of babies of mothers born in **Pakistan** was **2.1x higher** than babies of mothers born inside the UK

Actions to reduce infant mortality

Co-ordination and leadership
Vital for an effective cross-agency approach

Commissioning
Integrated commissioning to ensure a whole systems approach

Communication
Understand the preferences and needs of the local population

Care pathway development
Vital to support sustained improvements in service delivery and quality

Useful resources

- ✓ University of Oxford, National Perinatal Epidemiology Unit (2015) Inequalities in Infant Mortality Work Programme
- ✓ 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
- ✓ 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

References

- ONS (2016) Statistical Bulletin. Childhood mortality in England and Wales: 2014
- PHE London (2015) Reducing infant mortality in London: an evidence-based resource

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[7] 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
- ✓ 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

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

Actions to reduce SUDI

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/baby buddy
- ✓ 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

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-nspa
✓ 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

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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.rospa.com/

References

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

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

School

Improve safety for children travelling to and from school
Including developing school travel plans, education and engineering measures to physically change the road environment

20

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

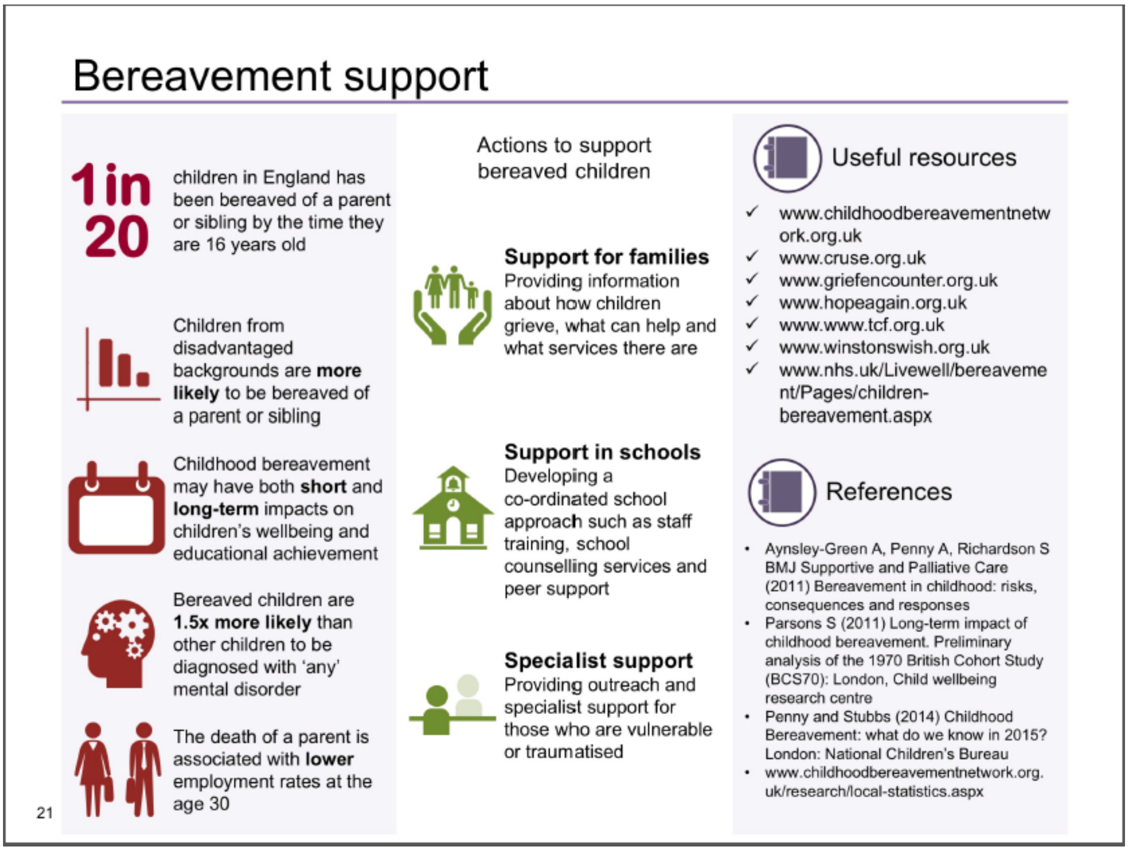
- Educating and challenging young people about healthy relationships, abuse and consent
- Earlier identification and intervention to prevent abuse
- Improving access to parenting programmes which specifically address domestic abuse
- Moving to an integrated model of family support
- Strengthening the 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

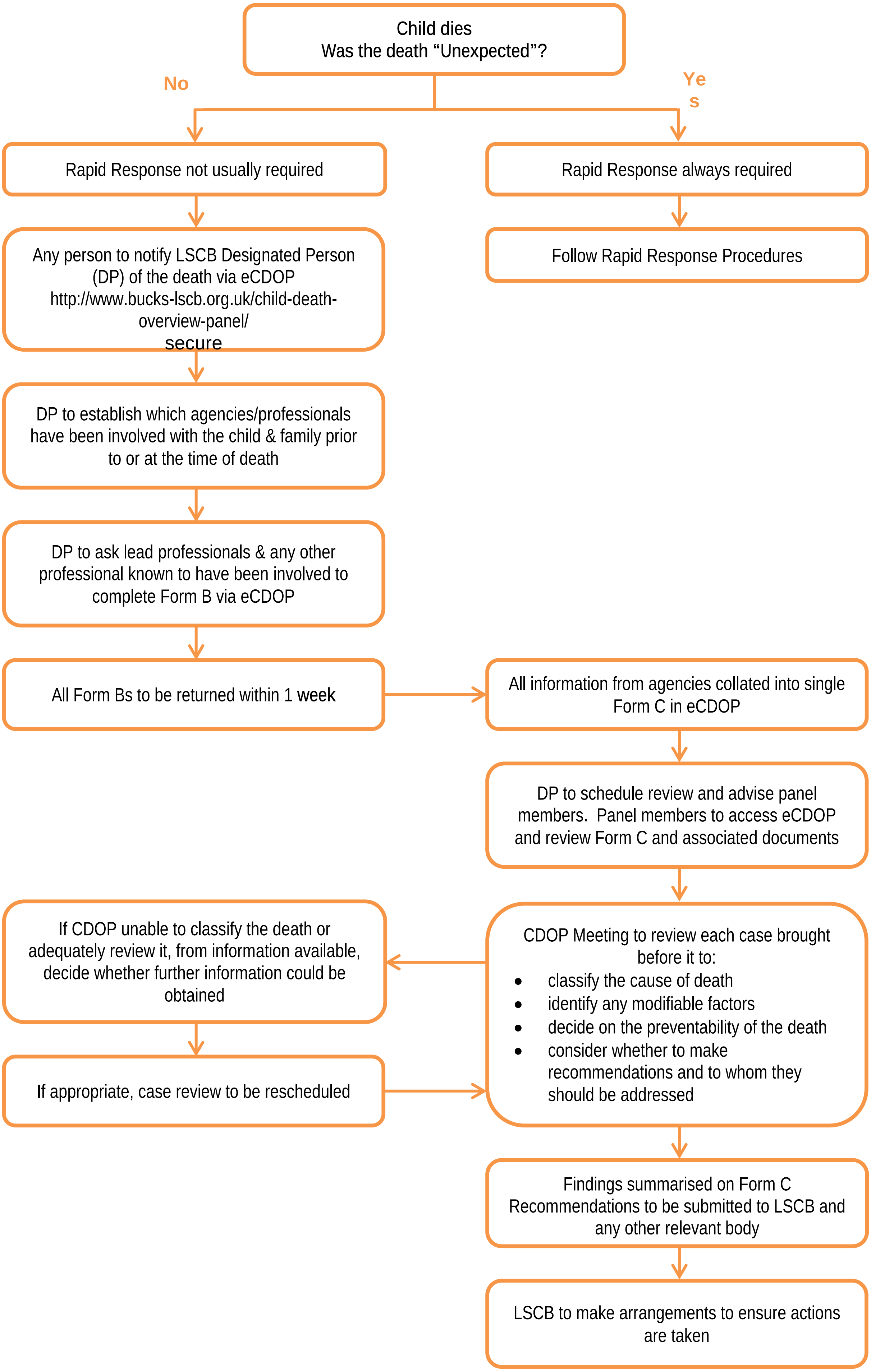
Useful resources

- ✓ www.childhoodbereavementnetwork.org.uk
- ✓ www.cruse.org.uk
- ✓ www.griefencounter.org.uk
- ✓ www.hopeagain.org.uk
- ✓ www.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



Child dies
Was the death "Unexpected"?

Rapid Response not usually required

Any person to notify LSCB Designated Person (DP) of the death via eCDOP http://www.bucks-lscb.org.uk/child-death-overview-panel/ secure

DP to establish which agencies/professionals have been involved with the child & family prior to or at the time of death

DP to ask lead professionals & any other professional known to have been involved to complete Form B via eCDOP

All Form Bs to be returned within 1 week

Rapid Response always required

Follow Rapid Response Procedures

All information from agencies collated into single Form C in eCDOP

DP to schedule review and advise panel members. Panel members to access eCDOP and review Form C and associated documents

CDOP Meeting to review each case brought before it to:

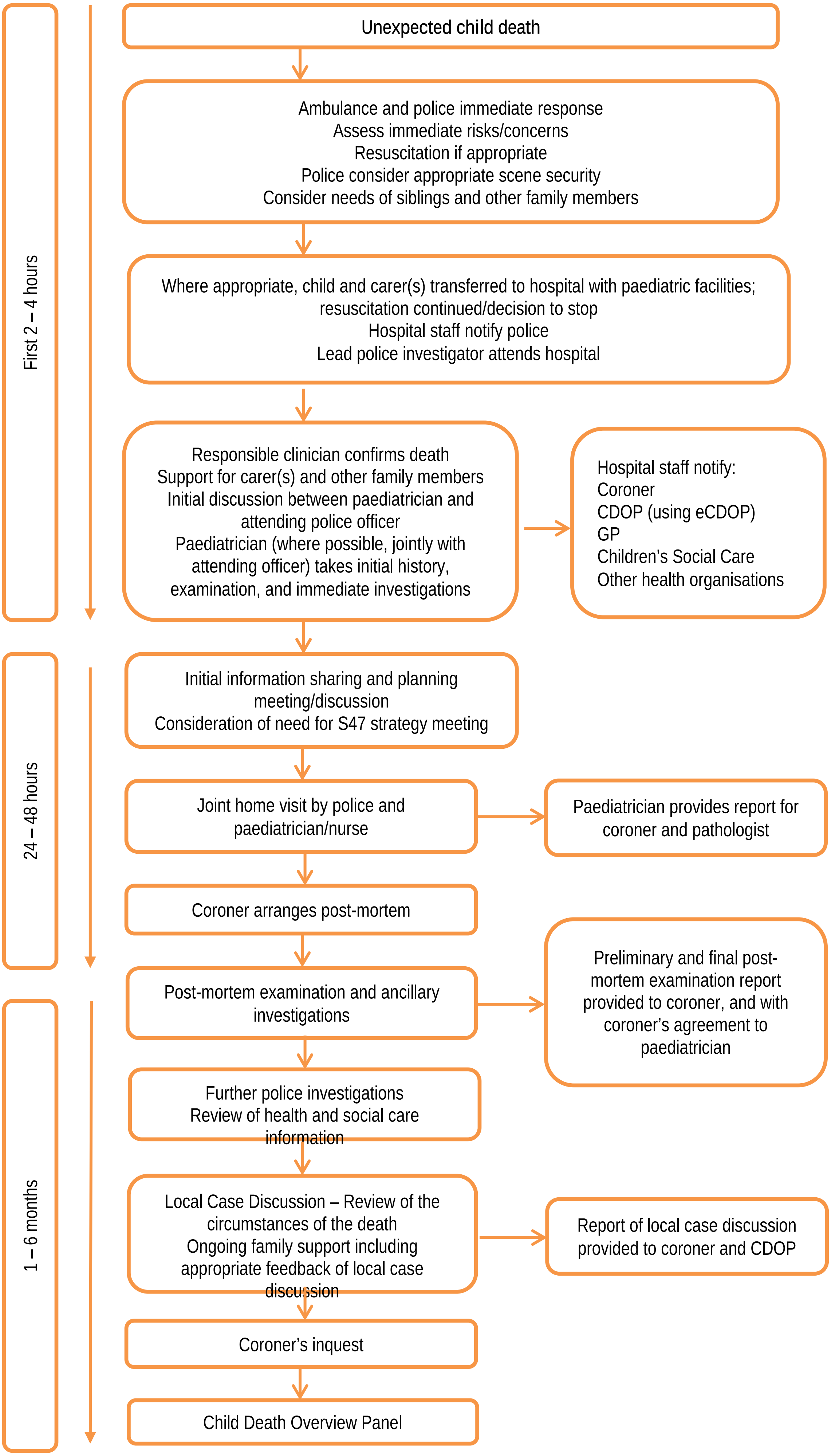
- classify the cause of death
- identify any modifiable factors
- decide on the preventability of the death
- consider whether to make recommendations and to whom they should be addressed

If CDOP unable to classify the death or adequately review it, from information available, decide whether further information could be obtained

If appropriate, case review to be rescheduled

Findings summarised on Form C
Recommendations to be submitted to LSCB and any other relevant body

LSCB to make arrangements to ensure actions are taken


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 eCDOP)
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 information
Local Case Discussion – Review of the circumstances of the death
Ongoing family support including appropriate feedback of local case discussion
Report of local case discussion provided to coroner and CDOP
Coroner's inquest
Child Death Overview Panel