BUCKINGHAMSHIRE
CHILD DEATH OVERVIEW PANEL
(CDOP)

ELEVENTH ANNUAL REPORT
APRIL 2018 – MARCH 2019

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Introduction and background:

This report is the eleventh annual report by Buckinghamshire CDOP and it focuses on the work of the panel during 2018-19 and reports on the activity and the findings from the analysis of data collected locally. This report consists of the following sections:

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A. 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.

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.

A1. CHANGES TO THE CHILD DEATH REVIEW PROCESS - OCT 2018

The Child Death Review Statutory and Operational Guidance for England was published in October 2018. The guidance is issued under section 16Q of the Children Act 2004 and it builds on the high-level principles for child death review set out in Chapter 5 of Working Together.

The new guidance clarifies processes and sets out high-level principles for how professionals across all agencies involved in the child death review process should work together. This is for two main reasons:

- ✓ Firstly, and most importantly, to improve the experience of bereaved families, as well as professionals involved in caring for children, in the devastating and bewildering period after the death of a child.

- ✓ Secondly, to ensure that information from the child death review process is systematically captured in every case, to enable learning to prevent future deaths.

The Children Act 2004 requires Child Death Review (CDR) partners to make arrangements to carry out child death reviews. These arrangements should result in the establishment of a Child Death Overview Panel (CDOP), or equivalent, to review the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children. The review should then be carried out by a Child Death Overview Panel (CDOP), on behalf of CDR partners, and should be conducted in accordance with this guidance and that contained in Working Together.

The new guidance specifies that:

- CDR partner footprints should be locally agreed; they should be aligned to existing networks of NHS care and other children's services, and should take account of agency and organisational boundaries. They should cover a child population such that they typically review at least 60 child deaths each year.

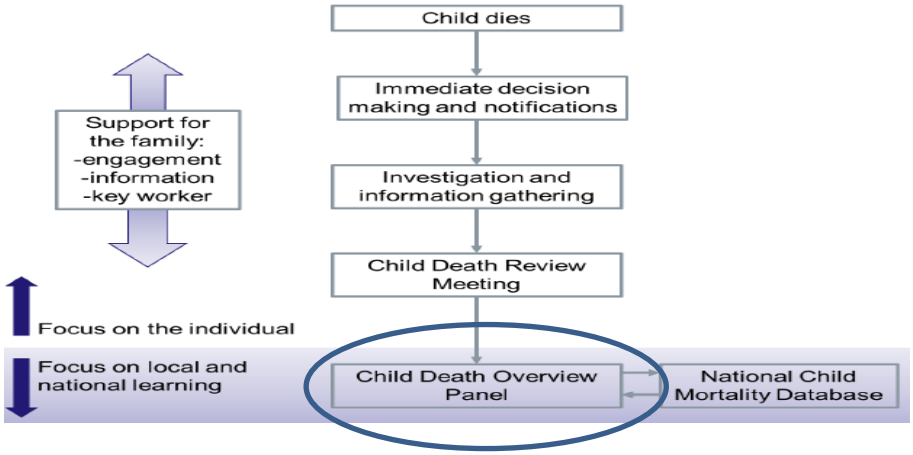
- Reviewing at least 60 deaths each year will better enable thematic learning in order to identify potential safeguarding or local health issues that could be modified in order to protect children from harm and, ultimately, save lives.

A.3 Child Death Overview Panel (CDOP) responsibilities:

The functions of CDOP include:

- to collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members;
- to analyse the information obtained, including the report from the Child Death Review Meetings (CDRM), in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;
- to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children;
- to notify the Child Safeguarding Practice Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected;
- to notify the Medical Examiner and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death (any correction to the child's cause of death would only be made following an application for a formal correction).
- to provide specified data to NHS Digital and then, once established, to the National Child Mortality Database;
- to produce an annual report for CDR partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process; and
- to contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

The flow chart below sets out the main stages of the child death review process



B. KEY FINDINGS

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

- In 2018-19 the panel reviewed 24 cases in total. Of the 24 cases, 5 cases were from the previous year. Of the 24 cases reviewed, 75% (18 cases) were completed in less than 6 months compared with the national average of 30% (2018-19). This shows continued improvement on previous years; 57% in 2017-18, 29% in 2016-17, 19% in 2015-16 and 8% in 2014-15.

- 21% (5 cases) were completed in 6-12 months compared with 43% nationally (2018-19). This is a significant improvement from 39% in 2017-18 and 45% in 2016-17. Only 1 case (4%) took longer than a year to review which is significantly better than the national average of 26% in 2018-19. This means 96% (23 cases) were completed within 12 months of the notification which is significantly better than the national average of 72.5% (2018-19).

- 11 cases (46%) were 0-27 days old at the time of death compared with 42% nationally (2018-19). A further 3 cases (13%) were aged between 28 and 364 days which is lower than the national average of 19% in 2018-19 (the differences are not statistically significant).

- Overall, 14 cases (58%) were in children aged 0-1 year old which is similar to the national average of 62% (2018-19).

- 4 cases (17%) were in 1-4 year olds compared with 11% nationally (2018-19). 6 cases (25%) were in 5-17 year olds compared with 26% nationally (2018/19).

- 15 cases (62.5%) were male and 9 cases (37.5%) were female, compared with the national average of 56% and 42% respectively (nationally in 2% of the cases the gender was unknown/not stated). Nationally, boys' deaths have consistently accounted for over half of deaths reviewed since the year ending 31 March 2011.

- 15 deaths (62.5%) were in children of White (Any White) ethnic background combined. 5 deaths (21%) were in children of any Asian/mixed Asian background combined and 4 deaths (17%) were in children of any black and mixed black background. Nationally 57% of deaths were in children of White background, 15% in Asian, 7% in Black and 7% in mixed

and other ethnic groups. In 12% of the cases ethnicity was unknown or not stated.

- Perinatal/neonatal deaths were the top category of death in Buckinghamshire (8 cases, 33%), followed by chromosomal/congenital abnormalities (7 cases, 29%). This compared with the national average of 33% and 24% respectively (2018-19). 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].

- Modifiable factors were identified in 7 case (29%) compared with 30% of cases nationally (2018-19), important lessons were learned and areas for improvement in local services were identified (see section F for more detail).

C. BACKGROUND

Overall, the health and wellbeing of children in Buckinghamshire is generally better than the England average. The infant mortality rate is similar to England with an average of 25 infants dying before age 1 each year. Recently there have been 10 child deaths (1-17 year olds) each year on average (Table 1).

Local data suggests that, while the number of deaths is small and fluctuates year on year, there is 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. However due to small numbers the differences are not statistically significant.

Table 1: Infant and Child Mortality Rates in Buckinghamshire 2015-17 (PHE, Child Health Profile 2019)

Compared with benchmark | Better | Similar | Worse | ↔ No significant change

	Indicator	Local no. per year*	Local value	Eng. ave.	Eng. worst
Premature mortality	1 Infant mortality	↔ 25	4.1	3.9	8.1
	2 Child mortality rate (1-17 years)	▪ 10	8.3	11.2	24.3

1 Mortality rate per 1,000 live births (aged under 1 year), 2015-2017
2 Directly standardised rate per 100,000 children aged 1-17 years, 2015-2017

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

D. CHILD DEATH REVIEW PANEL ACTIVITY 2018-19

D.1. CDOP Membership

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

Core members of CDOP in 2018-19 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

D.2. Number of child death notifications to CDOP 1/04/2018 – 31/03/2019

Between 1st April 2018 and 31st March 2019, CDOP was notified of 37 deaths of children aged 0-17 in Buckinghamshire. The number of deaths varies from year to year as is shown in table 2 below.

It is important to note that not all child deaths which occur each year will have their panel review completed by 31 March because it may take a number of months to gather sufficient information to fully review a child's death. This means that deaths that are notified in the last quarter of the year may not have their reviews completed in the same year and are therefore carried over to the next financial year.

Table 2: Number of child death notifications to CDOP and number of reviews per year, April 2013- Mar 2019

	Yr 6 13/14	Yr 7 14/15	Yr 8 15/16	Yr 9 16/17	Yr 10 17/18	Yr 11 18/19
No. of Notifications	42	27	43	29	26	37
No. of Reviews	38	39	49	58	28	24

D.3. Number of CDOP Review Meetings 01/04/2018 – 31/03/2019

The Multi-agency Child Death Overview Panel met six times during 2018-19 and completed a total of 24 reviews. Table 3 below summarises the attendance of each agency at Panel meetings for the period 01/04/2018 to 31/03/2019.

Table 3: Number of CDOP meetings in 2018-19 and attendances by each agency

Agency	May	Jul	Sep	Nov	Jan	Mar
Public Health	Yes (Chair)	Yes (Chair)	Yes (Chair)	Yes (Chair)	No	No
Education Representative	Yes	Yes	No	Yes	No	No
Social Care Representative	Yes	No	No	No	Yes	Yes
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 (Chair)	Yes (Chair)
Police	Yes	Yes	No	Yes	Yes	Yes
Coroner's Representative	No	No	No	No	No	No
Midwifery	Yes	Yes	Yes	Yes	Yes	Yes
Ambulance Service	No	Yes	No	No	Yes	No

Due to department staffing levels on the day the panel usually meets, it has not been possible for the Coroner's Representative to attend any panel meetings this year. They have, however, collaborated with the CDOP Coordinator to ensure sharing of relevant information and input into panel discussions.

D.4. Number of reviews and review time

In 2018-19 the panel reviewed 24 cases in total. Of the 24 cases, 5 cases (21%) were from 2017-18.

Table 4 below shows the total number of reviews and review time in Buckinghamshire for the last 4 years. The data shows a major improvement in review time in 2018-19 compared with previous years.

- Of the 24 cases reviewed in the year ending 31 March 2019, 75% (18 cases) were completed in less than 6 months compared with the national average of 30% (2018-19). This shows continued improvement on previous years; 57% in 2017-18, 29% in 2016-17, 19% in 2015-16 and 8% in 2014-15.

- 21% (5 cases) were completed in 6-12 months compared with 43% nationally (2018-19). This is a significant improvement from 39% in 2017-18 and 45% in 2016-17.

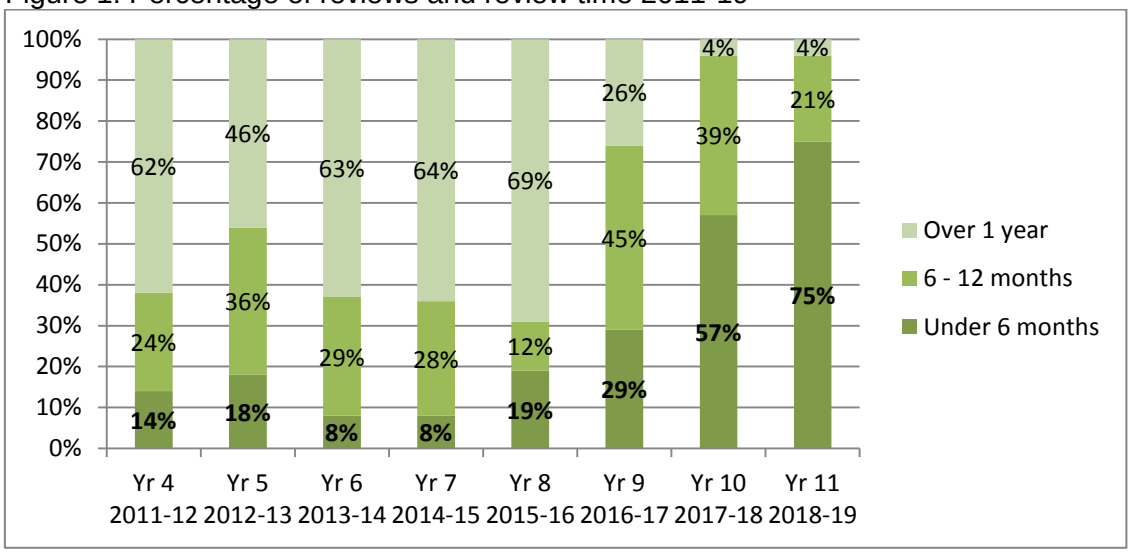
- Only 1 case (4%) took longer than a year to review (the national average was 26% in 2018-19). This means 96% (23 cases) were completed within 12 months of the notification which is significantly better than the national average of 72.5% in 2016-17. This information is summarised in Table 4 below.

Table 4: Total number of reviews and review time 2015-19

Duration	Yr 8 15/16	Yr 9 16/17	Yr 10 17/18	Yr 11 18/19	*National Benchmark 2018/19*
< 6 months	9 (19%)	17 (29%)	16 (57%)	**18 (75%)**	*30%*
6-7 months	1	9	4	**2**	*43%*
8-9 months	4	6	5	**2**	
10-11 months	1	9	1	**0**	
12 months	0	2	1	**1**	
Over 1 year	34 (69%)	15 (26%)	1 (4%)	**1 (4%)**	*26%*
Total	**49**	**58**	**28**	**24**	

Figure 1 below shows the total number of reviews and review time in Buckinghamshire in the last 8 years since 2011. The data shows a major improvement in review time in 2018-19 compared with previous years.

Figure 1: Percentage of reviews and review time 2011-19



E. ANALYSIS OF CHILD DEATH REVIEWS & FINDINGS

E.1. Number of deaths reviewed by age group

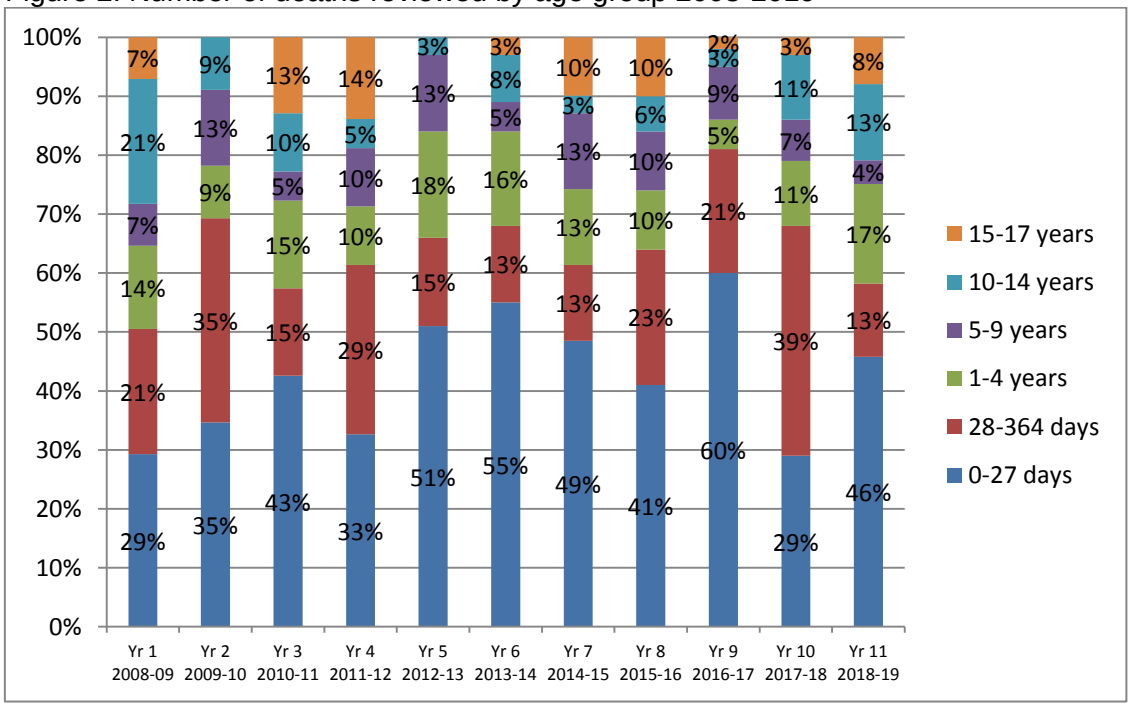
- Of the 24 cases reviewed, 11 cases (46%) were 0-27 days old at the time of death compared with 42% nationally (2018-19). A further 3 cases (13%) were aged between 28 and 364 days which is lower than the national average of 19% in 2018-19 (the differences are not statistically significant).

- Overall, 14 cases (58%) were in children aged 0-1 year old which is similar to the national average of 62% (2018-19).

- 4 cases (17%) were in 1-4 year olds compared with 11% nationally (2018-19). 6 cases (25%) were in 5-17 year olds compared with 26% nationally (2018/19).

Trends in the ages of deaths reviewed by CDOP in Buckinghamshire are set out in Figure 2 below.

Figure 2: Number of deaths reviewed by age group 2008-2019



E.2. Number of deaths reviewed by gender:

- 15 cases (62.5%) were male and 9 cases (37.5%) were female, compared with the national average of 56% and 42% respectively (nationally in 2% of the cases the gender was unknown/not stated (2018/19)). Nationally, boys' deaths have consistently accounted for over half of deaths reviewed since the year ending 31 March 2011.

E.3. Number of deaths by ethnicity

Information on ethnicity was known for all the cases. Of the 24 cases reviewed in 2018-19, 15 deaths (62.5%) were in children of White (Any White) ethnic background combined. 9 deaths were in children of any mixed multiple ethnic backgrounds including (any Asian and any Black combined).

Nationally 57% of reviews were in children of White background, 15% in Asian, 7% in Black and 7% in mixed and other ethnic groups combined. In 12% of the cases ethnicity was unknown or not stated (2018/19).

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.

E.4. Child deaths where the child was an asylum seeker 2018-19

Of the 24 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.

E.5. Child death reviews where the child was subject to a Child Protection Plan or any statutory orders 2018-19

None of the children reviewed this year were subject to child protection plans or statutory orders either previously or at the time of death.

E.6. Category of deaths as determined by CDOP 2018-19

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. The criteria now used nationally are:

- 'Modifiable factors identified' – where the Panel has 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 has 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.

With regards to the category of death, our data shows that perinatal/neonatal

deaths[2] were the top category of death in Buckinghamshire (8 cases, 33%), followed by chromosomal/congenital abnormalities (7 cases, 29%). This compared with the national average of 33% and 24% respectively (2018-19). 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[3]. Table 5 below shows the category of deaths as determined by CDOP reviews.

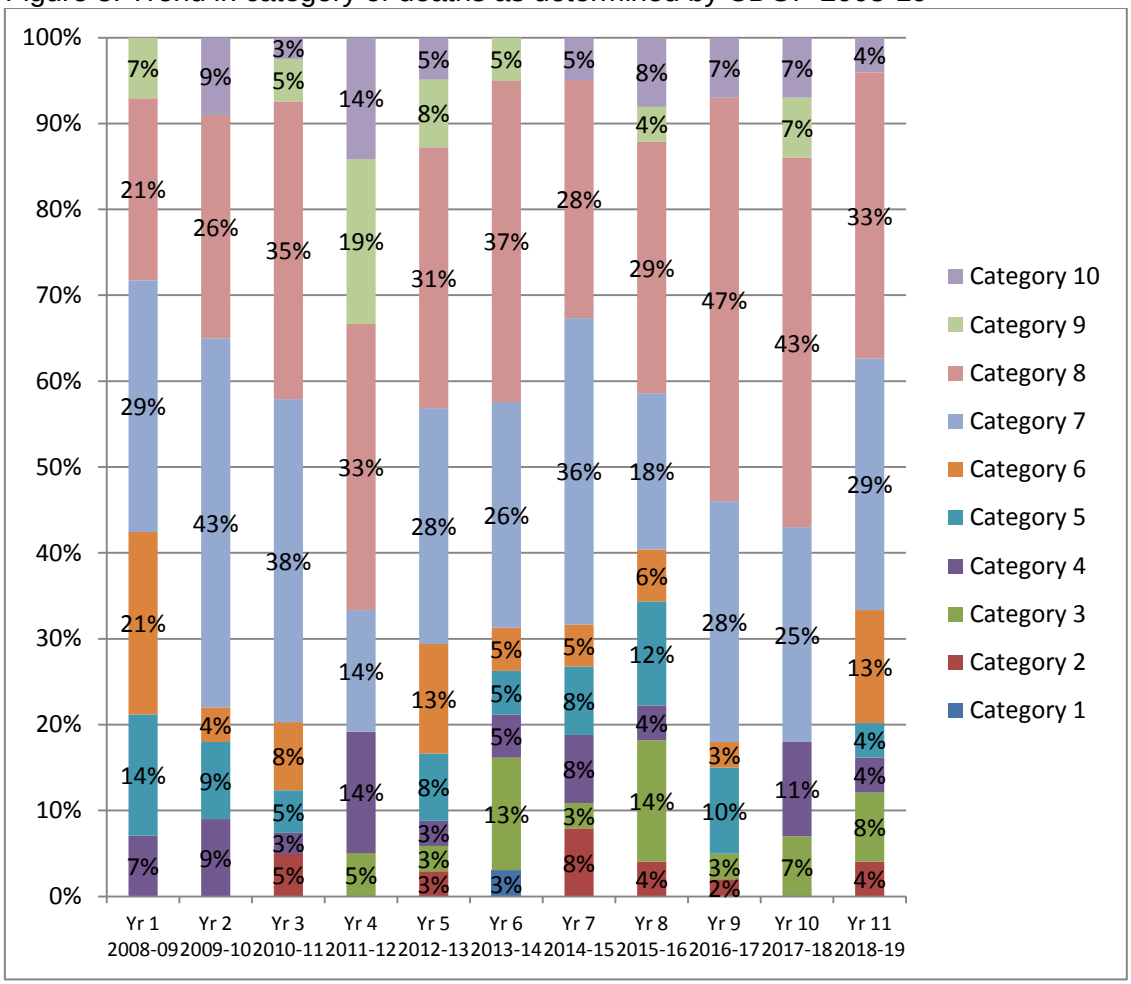
Table 5: Category of deaths as determined by CDOP 2018-19

Category of death	Total	National Benchmarking (2018/19)
Category 1: Deliberately inflicted injury, abuse or neglect	0	2%
Category 2: Suicide or deliberate self-inflicted harm	1 (4%)	3%
Category 3: Trauma and other external factors	2 (8%)	6%
Category 4: Malignancy	1 (4%)	9%
Category 5: Acute medical or surgical condition	1 (4%)	6%
Category 6: Chronic medical condition	3 (13%)	4%
Category 7: Chromosomal, genetic and congenital anomalies	7 (29%)	24%
Category 8: Perinatal/neonatal event	8 (33%)	33%
Category 9: Infection	0	5%
Category 10: Sudden unexpected, unexplained death	1 (4%)	7%
Total	**24**	**3,215**

Figure 3 below shows the trend in category of deaths as determined by CDOP between 2008 and 2019.

[2]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
[3] A review of child mortality in Buckinghamshire, Public Health Team, 2017.

Figure 3: Trend in category of deaths as determined by CDOP 2008-19



A detailed analysis of perinatal and neonatal mortality and deaths due to congenital abnormalities in Buckinghamshire was undertaken in 2017 which showed that child mortality rates and patterns of death in Buckinghamshire are consistent with the national picture and with research evidence.

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 of health for women and men of reproductive age which impact on maternal, infant and child outcomes. Analyses of infant mortality at national level highlight 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]. Many of these factors can result in prematurity and low birth weight.

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

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. The proportion of babies born prematurely in Buckinghamshire is similar to the national average and has not changed significantly over the last four years.

E.7. Place of death

In 15 cases (63%) Acute Hospitals were the place of death followed by 6 cases (25%) in the normal residence of the child. Nationally, 68% of the deaths reviewed occurred in an acute hospital and 19% in the normal residence of the child (2018/19). Of the other deaths reviewed, 1 (4%) was in a hospice, 1 (4%) abroad and 1 (4%) in a GP surgery.

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

Of the 24 cases reviewed, 11 cases (46%) were classified as neonatal events compared with 39% nationally (2018-19). In 7 cases (29%) the cause of death was determined as 'known life-limiting conditions' compared with 26% nationally (2018-19). In 7 cases (29%) modifiable factors were identified (see section E9 for more detail).

E.9. Modifiable factors

Modifiable factors were identified in 7 cases (29%) compared with 30% of cases nationally (2018-19). In one case the modifiable factor was related to a young child who was knocked down by a vehicle near his home. In four cases consanguinity was identified as modifiable factor and in two cases passive smoking was identified as a modifiable factor.

Table 6: Category of deaths as determined by CDOP 2018-19

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 (4%)	0	**1 (4%)**
Trauma and other external factors (category 3)	1 (4%)	1 (4%)	0	**2 (8%)**

Malignancy (category 4)	0	1 (4%)	0	**1 (4%)**
Acute medical or surgical condition (category 5)	0	1 (4%)	0	**1 (4%)**
Chronic medical condition (category 6)	0	3 (13%)	0	**3 (13%)**
Chromosomal, genetic and congenital anomalies (category 7)	4 (16%)	3 (13%)	0	**7 (29%)**
Perinatal/neonatal event (category 8)	1 (4%)	7 (29%)	0	**8 (33%)**
Infection (category 9)	0	0	0	**0**
Sudden unexpected, unexplained death (category 10)	1 (4%)	0	0	**1 (4%)**
Total	**7 (29%)**	**17 (71%)**	**0**	**24**

E.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 24 cases reviewed, there was one case where the panel felt that the opinion of the Serious Case Review sub-group should be sought regarding whether a SCR was needed. The Serious Case Review sub-group concluded that the case did not meet the threshold for a review. 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/.

F. 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 not CDOP's remit in presenting this summary report. In the cases reviewed in this year CDOP did not identify any specific local actions which would have a direct impact on helping to prevent further deaths. This outcome can be expected from time to time. The panel was satisfied that all reviews were thorough and that no specific actions were missed. Some of the actions reported below are related to improving child death review processes in order to ensure they are efficient and compliant with the new national guidance.

1. In one case a Joint Agency Response (JAR) meeting had not been held following an unexpected death at a hospital in a neighbouring authority. The child was resident in Buckinghamshire but had complex medical needs and had received medical care from the hospital in the authority. In accordance with their local procedures, a JAR meeting was not held as it was felt that there were no safeguarding concerns. Given the child's complex medical needs, whilst the death was not expected, the child was very vulnerable and death was always a possibility. The panel felt that some information was missing from the review which could have been captured as part of the JAR process and that in future where a child dies in another area there should be a clearer discussion with the lead consultant involved about the need for a JAR meeting and the best place to host this. Sufficient information was obtained to enable the panel to carry out a review but collection of this information was more difficult than if a JAR meeting had been held.

2. Capacity issues at two local hospitals were identified in two of the cases reviewed. In both cases it was felt that these would not have affected the final outcome, but it did affect the care that the patient and their families received at a very distressing time. One hospital is outside our area but a concern has been raised with the relevant CCG, and with the Medical Director of the hospital concerned in Buckinghamshire. The panel are awaiting feedback from this and will continue to monitor this as an action for the coming year.

3. On two occasions pregnant women had contacted the local maternity unit as they had concerns and it was felt that the advice given over the phone could have been better. In both cases it was felt that the women should have been invited to attend the unit for review although it was noted that it was unlikely to have made a difference to the outcome in either of the

cases. Procedures have been reviewed at the unit to make sure pregnant women are given the most appropriate advice in future.

4. In one case it was felt that there was a missed opportunity to offer a family some early help. This case has been summarised and taken back to Children's Social Care and the Early Help teams for them to review and derive learning from it.

5. Good progress has been made in implementing the new national guidance on child death review. Under the new guidance child death review partner footprints should be locally agreed; they should be aligned to existing networks of NHS care and other children's services, and should take account of agency and organisational boundaries. They should cover a child population such that they typically review at least 60 child deaths each year. Buckinghamshire reviews on average 37 deaths per year so falls short of this target. With this in mind a formal arrangement has been established with Oxfordshire so that themed reviews can be carried out across a broader caseload. Discussions have also taken place with Berkshire with regard to inclusion in these themed reviews as this would tie in with the Buckinghamshire, Oxfordshire and Berkshire West (BOB), Sustainability and Transformation Partnership (STP).

6. The new guidance requires a keyworker to be appointed for each family suffering bereavement. Progress has been made in conjunction with Oxfordshire to identify individuals or roles that could meet this requirement.

G. PROGRESS AND ACHIEVEMENTS IN 2018-19

- Further improvements have been achieved in review times with 75% of the cases being reviewed within 6 months compared with 57% in 2017-18 and 29% in 2016-17, and 96% reviewed within 12 months which is the same as last year. These figures are significantly better than the national average for review times.

- Strong links with National and Regional Network of CDOP's have been maintained and closer links forged with neighbouring CDOP's in Oxfordshire and Berkshire.

- All cases this year have been processed through eCDOP and all open cases were automatically shared with the new National Child Mortality Database when it went live on 1st April 2019.

- Although some teething problems have been encountered with professionals completing CDOP's forms online through eCDOP, the information provided has been much richer and has led to far more robust and informed reviews.

- It is important to note that the number of cases awaiting CDOP review has increased significantly this year which will have a knock on effect on next year's performance. This is mainly attributed to a larger number of cases that are currently awaiting Serious Case Reviews, coronial inquests or police prosecution. In addition, receiving information from Primary Care professionals (e.g GPs) is always a challenge which can introduce further delay in the process. All panel members have agreed to assist the CDOP Coordinator in improving contact with these professionals to expedite the information gathering process for more timely reviews.

- Significant improvements have been achieved in CDOP internal processes as mentioned in section E above.

H. RECOMMENDATIONS

H1: Recommendations for CDOP

1. CDOP to analyse child death data every 3 years using the data from the 2018 review as a baseline (3 year provides sufficient numbers of deaths for meaningful analysis).

2. CDOP should ensure that at least 60% of the cases are reviewed within 6 months of notification to CDOP and 75% of the cases should be reviewed within 12 months.

3. CDOP should participate in a peer review in 2021 carried out by another CDOP as before.

4. CDOP should fully implement the new arrangements for the child death review process as specified by the new national guidance by March 2021.

H2: Recommendations for Buckinghamshire LSCB and partners:

Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are: (a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and (b) to ensure the effectiveness of what is done by each such person or body for those purposes.

1. Each LSCB partner should ensure that front line staff in their respected organisations, when in contact with pregnant women or new mothers, improve the assessment of all the known factors that could impact on the mother's, baby's and family's health and improve the offer of advice, support and referral to appropriate services. This includes improving the assessment and management of lifestyle factors such as smoking, alcohol consumption, drug use, weight and healthy eating as well as mental health issues and the detection of exposure to domestic violence. In order to deliver the above recommendation, LSCB members should consider taking the following specific actions:

    1.1 LSCB partners mandate the "Making Every Contact Count" training programme for all their employees by March 2021. This is in line with the system-wide commitment to the Bucks' Shared Approach to Prevention".

    1.2 The integrated commissioning teams ensure that "Making Every Contact Count" and brief advice on healthy life styles are included in the service specifications for all relevant contracted and commissioned services at the point of renewal or when issuing new

contracts. Commissioners should aim to achieve 100% coverage by 2022.

1.3 At least 50% of front-line staff in children and adults' social care services to have attended the Making Every Contact Count training programme by March 2021 and 80% by March 2022.

1.4 LSCB member organisations to develop and present their action plans for delivering the above recommendations to LSCB Board by March 2021.

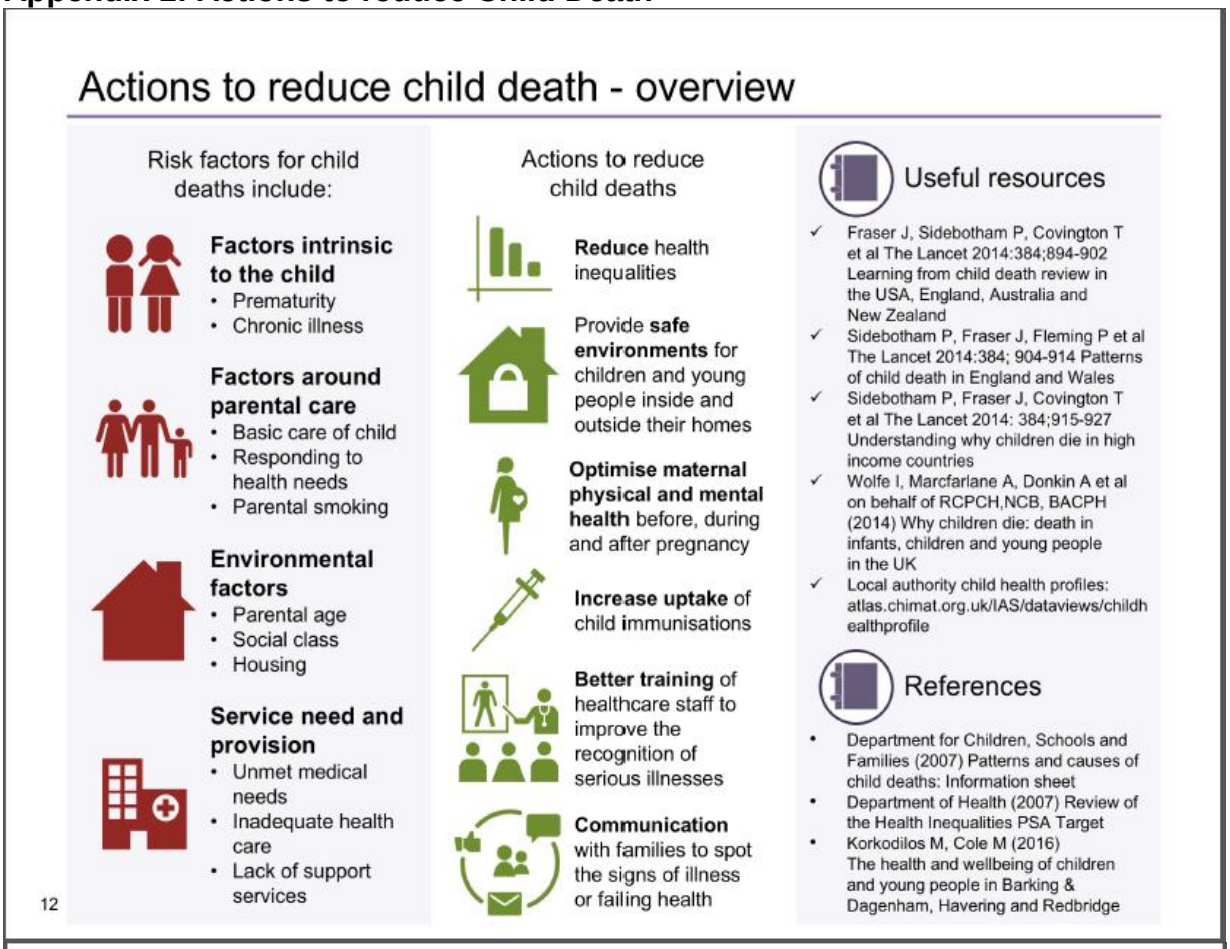
2. The LSCB partners should champion improvement in data collection and reporting on important risk factors such as ethnicity, consanguinity, obesity, smoking and alcohol and substance misuse in children's records and maternity records in all health and social care settings. LSCB members should take the following specific actions:

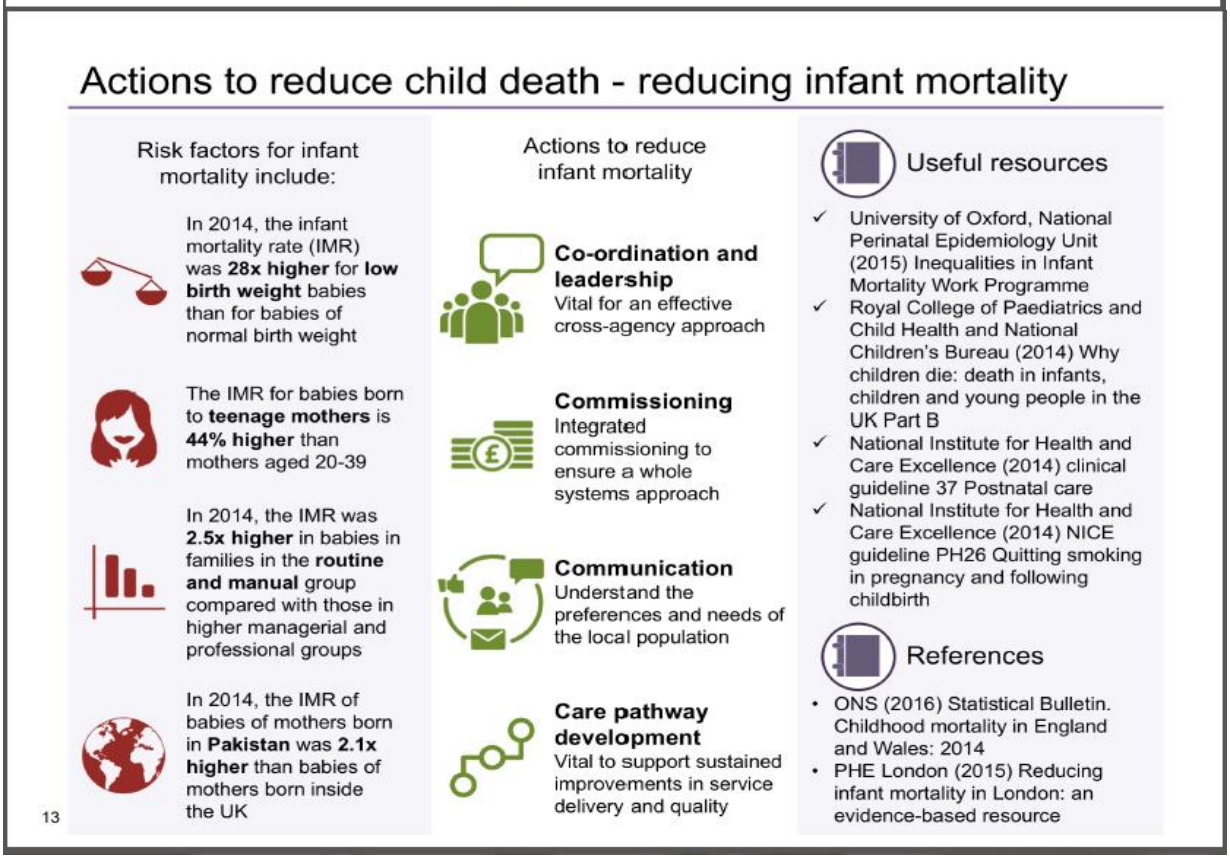
   2.1 LSCB partners to develop a strategy for improving data quality and present their strategy to the Board by March 2021.

3. LSCB to request a progress report from the commissioners on the recommendations of CDOP 2016-17 annual report particularly around the implementation of the pre-conception pathway by March 2020.

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

Appendix 1: Actions to reduce Child Death[5]





[5] 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

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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/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

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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

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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.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

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