

Buckinghamshire



**Safeguarding
Children Board**

**BUCKINGHAMSHIRE CHILD DEATH OVERVIEW
PANEL (CDOP)**

**SEVENTH ANNUAL REPORT
APRIL 2014 – MARCH 2015**

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CHILD DEATH REVIEW PROCESS

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

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

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

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

1. Rapid Response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death. Unexpected death in childhood is defined as 'the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to, or precipitating the events that led to the death'
2. An overview of all deaths up to the age of 18 years (excluding both those babies that are stillborn and planned terminations of pregnancy carried out within the law) which happens at a later stage as part of a multidisciplinary panel discussion (CDOP). CDOP is a confidential review in which professionals from the services involved discuss cases and the circumstances leading to the death.

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

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

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

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

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 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.

In 2014/15 and in the previous six years CDOP meetings were chaired by an independent Chair appointed by the Buckinghamshire LSCB. This role, however was transferred to the Public Health Team in April 2015, and with it the responsibility of writing this annual report.

This report is the seventh annual report by the CDOP and it focuses on the work of the panel during 2014/15 and reports on the activity and the findings from the analysis of data collected locally and of the annual return to the national government. This report consists of the following six sections:

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A. EXECUTIVE SUMMARY

- Children and young people under the age of 18 years make up 23% (118,338) of the population of Buckinghamshire (2014).
- 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.
- Child mortality rates in Buckinghamshire are similar to the England average; however there is a large disparity between the most and least deprived populations in Buckinghamshire. The evidence suggests that adverse birth outcomes for infants are closely linked to measures of social disadvantage. In Buckinghamshire, the incidence of LBW, congenital anomalies and infant deaths are higher in socially deprived communities.¹
- In 2014/15 CDOP was notified of 27 deaths of children aged 0-17 in Buckinghamshire and reviewed a total of 39 cases.

Of the 39 cases reviewed:

- 14 cases (36%) were reviewed within 12 months of the notification compared with 70% nationally. 25 cases (64%) took longer than a year to review compared with 30% nationally.
- 24 deaths (62%) were in children aged 0-1 year old compared with 64% nationally. 5 deaths (13%) were in 1-5 year olds which is similar to the national average. 10 deaths (26%) were in 5-17 year olds compared with 23% nationally.
- 23 deaths (59%) were in males and 15 deaths (38%) were in females. Nationally, boys' deaths have consistently accounted for over half of deaths reviewed since the year ending 31 March 2011.
- 18 deaths (46%) were in children of white ethnic background compared with 63% nationally. 9 deaths (23%) were in children of Asian Pakistani background. Evidence suggests that child mortality is more strongly linked to measures of social disadvantage than to ethnicity.

¹ A retrospective analysis of adverse birth outcomes in Buckinghamshire, Sep 2013 .Public Health Team, Buckinghamshire County Council

- Chromosomal/ congenital abnormalities are the top category of death in Buckinghamshire (36% compared with 25% nationally) followed by perinatal /neonatal deaths² (28% compared with 33% nationally).
- In 16 cases (41%) the cause of deaths was determined as 'known life limiting conditions' compared with 28% nationally. 15 cases (38%) were classified as neonatal deaths compared with 39% nationally.
- In 23 cases (59%) Acute Hospitals were the place of death followed by 9 cases (26%) in the normal residence of the child and 6 cases (15%) in hospices. Nationally, 67% of the deaths reviewed occurred in an acute hospital, 22% in the normal residence of the child and 4% in hospices.
- Modifiable factors were identified in 3 cases (8%) compared with 20% of cases in the South East and 24% nationally (2015). Nationally the number and percentage of reviews which were assessed as having modifiable factors has increased from 20% in 2011 to 24% in 2015. (Issues identified and lessons learnt are presented in section E5). Analysis of historic data by Public Health Team in 2013 has shown a downward trend in "unexpected" deaths of children in Buckinghamshire³.

² Death under 28 days of age

³ A retrospective analysis of adverse birth outcomes in Buckinghamshire, Sep 2013 .Public Health Team, Buckinghamshire County Council.

B. BACKGROUND

Table 1: Population of children aged 0-17 in Buckinghamshire 2010-14

Age	2010	2011	2012	2013	2014
0-27 days	6,033	6,299	6,261	6,056	6,234
28-364 days					
1-4 years	25,233	25,619	26,434	26,737	26,681
5-9 years	30,788	31,030	31,924	33,057	33,550
10-14 years	32,820	32,510	32,271	32,085	31,959
15-17 years	19,969	20,047	19,988	19,948	19,915
Total	114,843	115,505	116,878	117,883	118,338

The health and wellbeing of children in Buckinghamshire is generally better than the England average. Infant and child⁴ mortality rates are similar to the England average. The table below shows how children's health and wellbeing in this area compares with the rest of England. The local results for each indicator are shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown within the table.

Table 2: Infant and Child Mortality Rates in Buckinghamshire 2011-13 (PHE, Child Health Profile 2015)

		Local no.	Local value	Eng. ave.	Eng. Worst	25th percentile	England average	75th percentile	Eng. Best
Premature mortality	1 Infant mortality	24	3.9	4.1	7.5				1.7
	2 Child mortality rate (1-17 years)	13	11.9	11.9	22.8				3.0

1 Mortality rate per 1,000 live births (age under 1 year), 2011-2013

2 Directly standardised rate per 100,000 children age 1-17 years, 2011-2013

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

Age	2010	2011	2012	2013	2014	Total 2010-14
0-27 days	16	11	20	13	7	67 (37%)
28-364 days	9	9	7	10	11	46 (26%)
1-4 years	7	11	7	10	8	67 (37%)
5-9 years	6					
10-14 years	7					
15-17 years	7					
Total	45	31	45	33	26	180

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

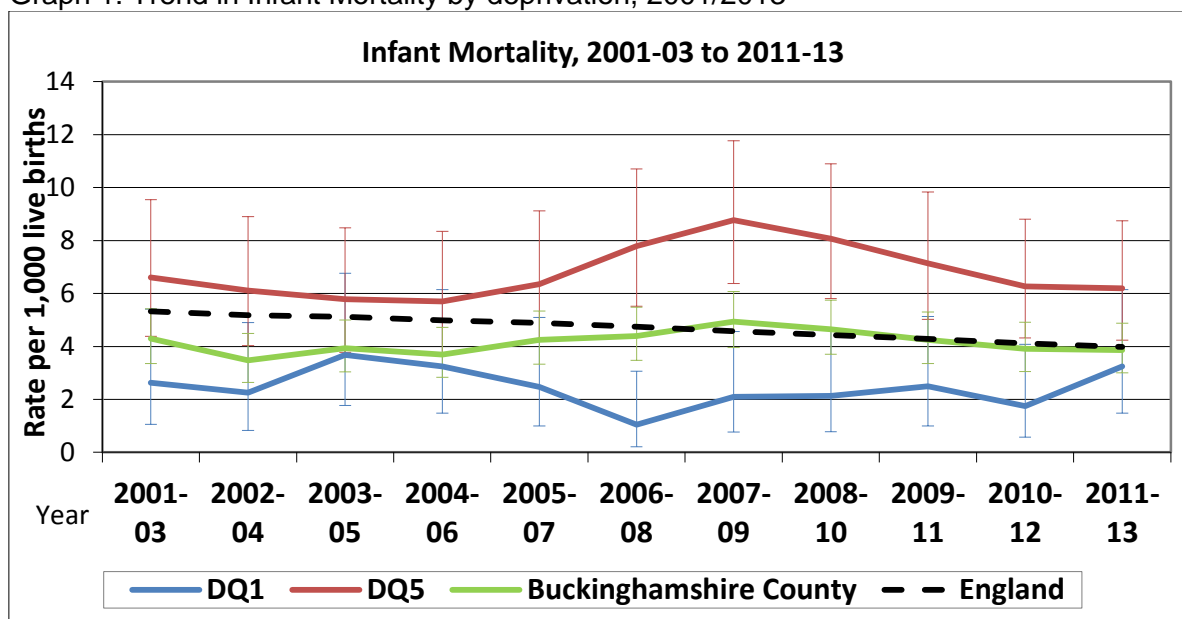
⁴ Infant : aged under 1 year , child: Age 1-17 year

Table 4: Trend in Infant Mortality Rates⁵ in Buckinghamshire 2010-14

Crude infant mortality rate per 1000 population (0-1 y)					
Year	2010	2011	2012	2013	2014
0-1 year	4.1	3.2	4.3	3.8	2.9
Crude child mortality rate per 10,000 population (<18 y)					
Year	2010	2011	2012	2013	2014
<18s (Total)	3.92	2.68	3.85	2.80	2.20

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

Graph 1: Trend in Infant Mortality by deprivation, 2001/2013



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

There is a wide gap in Infant Mortality between the 5th most deprived population (Deprivation Quintile 5 (DQ5)) (6.2/1,000 live birth) and the least deprived population (Deprivation Quintiles 1(DQ1)) (3.2/1000 live birth) in Buckinghamshire (2011-13), however due to small numbers the differences are not statistically significant (2009-13).

Table 5: Pre-term⁶ birth in Buckinghamshire 2013

	No of Preterm births	Total No of births	% Pre- term births
<i>Aylesbury Vale Clinical Commissioning Group (AVCCG)</i>	129	1,828	7.1
<i>Chiltern Clinical Commissioning Group (CCCG)</i>	136	2,359	5.8
Buckinghamshire County Council	265	4,187	6.3

Source: Maternity Profiles 2015, Buckinghamshire Public Health

The differences in proportion of preterm births between the two CCGs and the Buckinghamshire average are not statistically significant.

⁵ Infant mortality rate: the number of infants dying before their first birthday per 1,000 live births

⁶ Preterm birth is defined as babies born alive before 37 weeks of pregnancy are completed.

C. CHILD DEATH REVIEW PANEL ACTIVITY 2014-15

In 2014/15 and in the previous six years CDOP meetings were chaired by an independent Chair appointed by the Buckinghamshire LSCB. This role, however was transferred to the Public Health Team in April 2015.

C.1. CDOP Membership

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

Core members of CDOP in 2014/15 include:

- An independent Chair
- A consultant Paediatrician / Designated Doctor, Bucks Hospital Trust
- A named Nurse for Child protection, Bucks Hospital Trust
- A midwife, Bucks Hospital Trust
- An education representative
- A representative from Children's Social Care
- A representative from Thames Valley Police Child Abuse Investigation Unit
- A Public Health Consultant
- The CDOP Business Manager/Administrator

C.2. Number of child death notifications to CDOP 1.4.2014 - 31.3.2015

Between 1st April 2014 and 31st March 2015 CDOP was notified of 27 deaths of children aged 0-17 in Buckinghamshire.

Table 6 below shows historic data on the number of notifications received by the panel since 2008. On average CDOP receives 41 notifications and reviews 30 cases per year. While the number of deaths has fluctuated year on year, in 2014-15, CDOP has received the lowest number of notifications of death in children in Buckinghamshire since 2008.

Table 6: Number of child death notifications to CDOP and number of reviews per year, April 2008- Mar 2015

	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	Total
No. of Notifications	35	53	47	32	54	42	27	290
No. of Reviews	14	23	40	21	39	38	39	214

C.3. Number of CDOP Review Meetings 1.4.2014 - 31.3.2015

The Multi agency Child Death Overview Panel met six times a year during 2014/15 and completed a total of 39 reviews. The table below summarises the attendance of each agency at Panel meetings for the period 1.4.2014 to 31.3.2015.

Table 7: Number of CDOP meetings in 2014/15 and attendances by each agency

Agency	Apr	Jun	Oct	Dec	Feb	Mar
Independent Chair	Yes	No	Yes	No	No	No
Education Representative	Yes	Yes	Yes	Yes	No	No
Social Care Representative	Yes	No	No	No	Yes	Yes
Designated Doctor/BHT	Yes	Yes	Yes	Yes	Yes	Yes
Named Nurse for Child Protection/BHT	No	No	No	No	Yes	No
Police	No	No	No	Yes	Yes	Yes
Public Health	No	Yes	Yes	Yes	Yes	Yes
Midwifery	No	Yes	No	Yes	No	No

C.4. Number of reviews and review time

Not all child deaths which occur each year will have their child death review completed by 31 March. This is mainly because it may take a number of months to gather sufficient information to fully review a child's death. Table 8 below shows the year in which death occurred for the 39 cases that were reviewed in 2014/15.

Table 8: Year in which death occurred

Deaths occurred in					Total
10/11	11/12	12/13	13/14	14/15	
1	3	14	19	2	39

Table 9 and graph 2 below show the total number of reviews and review time in Buckinghamshire since 2008/09. Of the 39 child deaths reviewed in the year ending 31 March 2015, 36% (14 cases) were completed within 12 months of the notification compared with 70% nationally and 64% (25 cases) took longer than a year compared with 30% nationally.

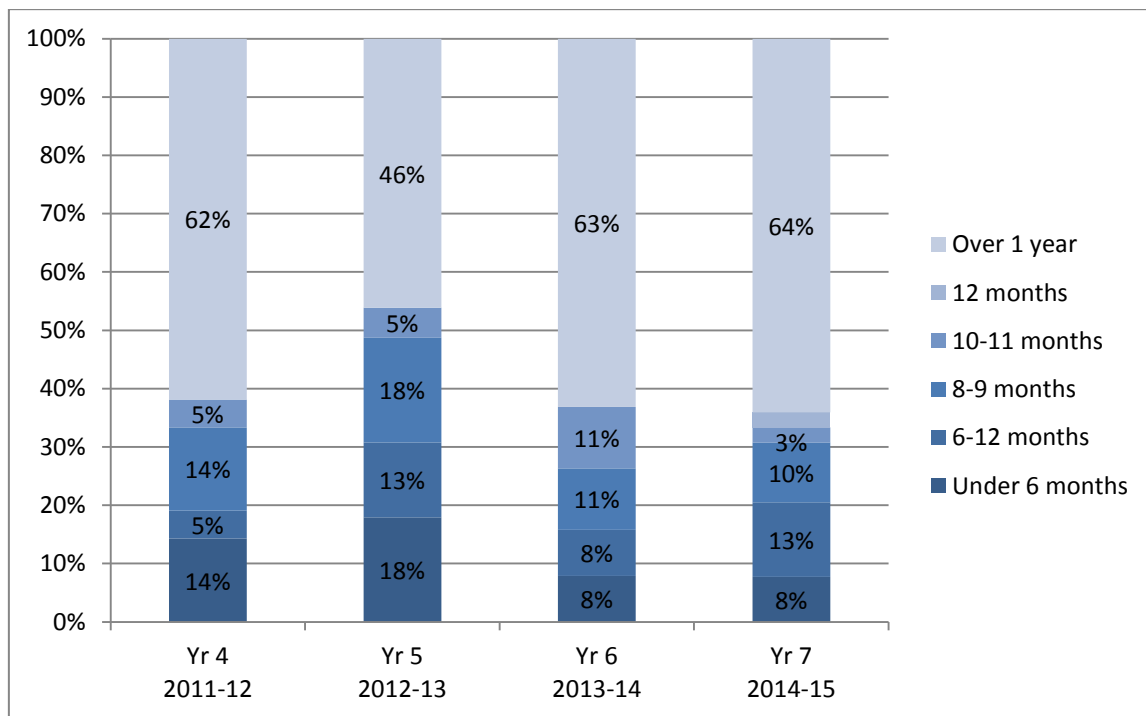
The data suggests that the number of reviews completed within 6 months has gradually declined and the majority of the reviews took more than 12 months to complete. The delays in completing the reviews detailed above were in some cases due to the complexity of the case particularly when a police or criminal investigation is required, however, on occasions unnecessary delay has been caused due to late access to coroners' reports by the CDOP panel.

We aim to reduce the proportion of reviews that take more than 1 year to complete from 64% to less than 50% by next year.

Table 9: Total number of reviews and review time 2014-15

Duration	Yr 1 08/09	Yr 2 09/10	Yr 3 10/11	Yr 4 11/12	Yr 5 12/13	Yr 6 13/14	Yr 7 14/15	National Benchmark 2014/15
< 6 months	11 (79%)	11 (48%)	17 (43%)	3 (14%)	7 (18%)	3 (8%)	3 (8%)	32%
6-7 months	0	8	4	1	5	3	5 (13%)	38%
8-9 months	3	3	3	3	7	4	4 (10%)	
10-11 months	0	0	6	1	2	4	1 (3%)	
12 months	0	0	1	0	0	0	1 (3%)	
Over 1 year	0 (0%)	1 (4%)	9 (22%)	13 (61%)	18 (46%)	24 (63%)	25 (64%)	30%
Total	14	23	40	21	39	38	39	

Graph 2: Percentage of reviews and review time 2014-15

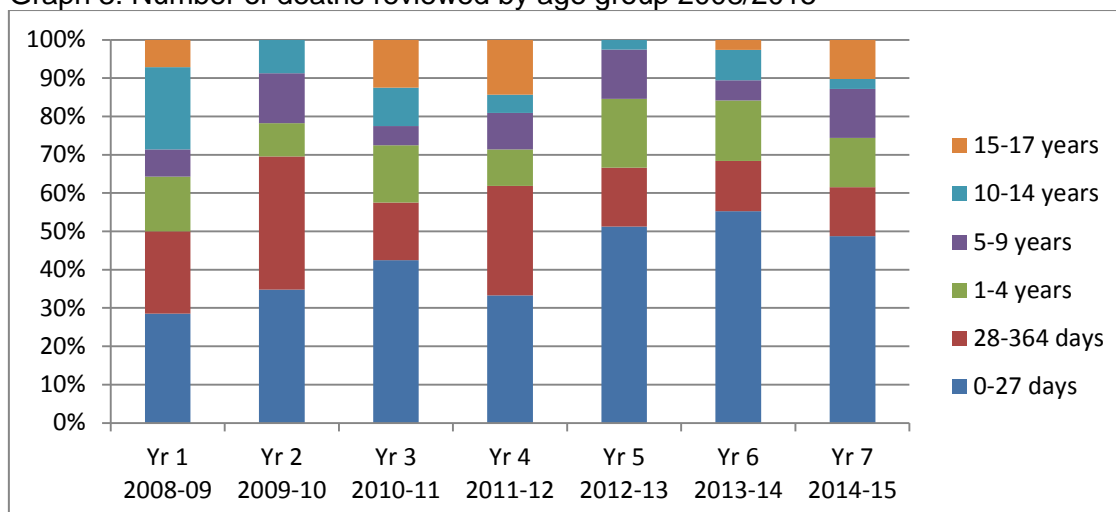


D. ANALYSIS OF CHILD DEATH REVIEWS & FINDINGS

D.1. Number of deaths reviewed by age group

Of the 39 cases reviewed, 24 cases (62%) were in children aged 0-1year old compared with 64% nationally. 5 cases (13%) were in 1-5 year olds which is similar to the national average. 10 cases (26%) were in 5-17 year olds compared with 23% nationally.

Graph 3: Number of deaths reviewed by age group 2008/2015



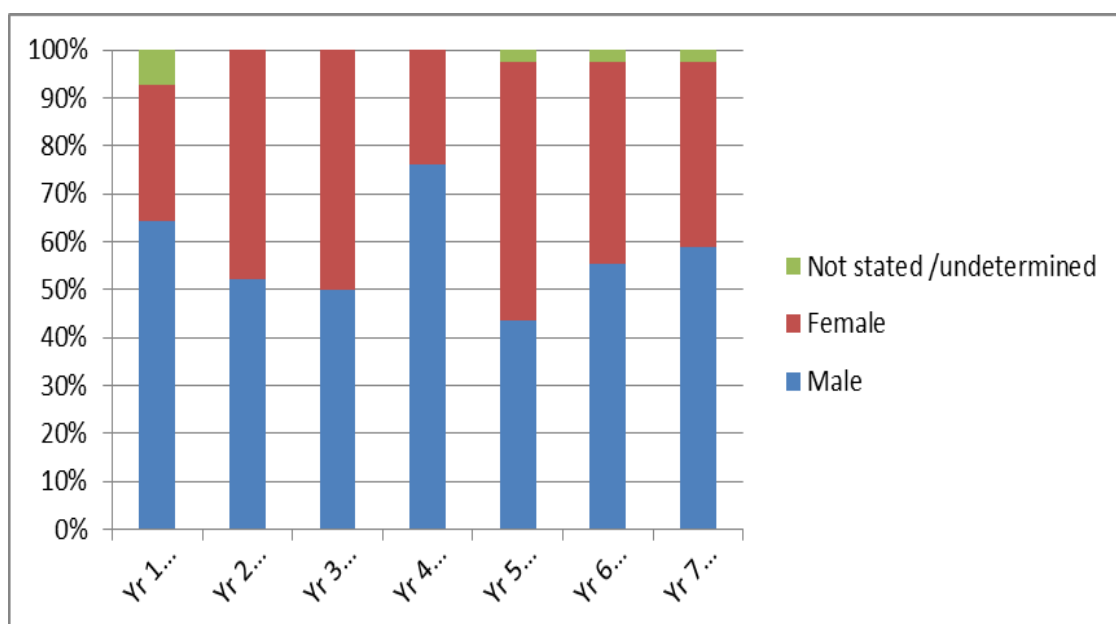
D.2. Number of deaths reviewed by gender:

Of the 39 cases reviewed in 2014/15, 23 cases (59%) were male and 15 cases (38%) were female (table 10 & graph 4) . One case did not include information on gender. Nationally, boys' deaths have consistently accounted for over half of deaths reviewed since the year ending 31 March 2011.

Table 10: Number of deaths reviewed by gender 2008/2015

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

Graph 4: Number of deaths reviewed by gender 2008/2015



D.3. Number of deaths by ethnicity

Of the 39 cases reviewed, 18 deaths (46%) were in children of white ethnic background and 9 deaths (23%) of deaths were in children of Asian Pakistani background. A much smaller proportion of deaths were in other ethnic minorities. In 6 cases (15%) information on ethnicity was either unknown or not stated. Nationally, reviews of deaths of children from a White background accounted for the around three out of five of reviews completed in the four previous reporting years (63% in the year ending 31 March 2014). Table 11 below shows the ethnicity of cases reviewed since 2009.

Table 11: Number of deaths reviewed by ethnicity

Ethnicity	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Total 09/15
	09/10	10/11	11/12	12/13	13/14	14/15	
White: English/Welsh/Scottish/ Northern Irish/British	5 (22%)	18 (45%)	13 (62%)	16 (41%)	16 (42%)	18 (46%)	68 (34%)
White: Gypsy or Irish Traveller	x	x	x	x	x	x	x
White: Any Other White background	x	x	x	x	x	x	11
Mixed/multiple ethnic groups: White & Black Caribbean	x	x	x	x	x	x	x
Mixed/multiple ethnic groups: White & Black African	x	x	x	x	x	x	x
Mixed/multiple ethnic groups: White & Asian	x	x	x	x	x	x	x

Mixed/multiple ethnic groups	x	x	x	x	x	x	x
Asian or Asian British: Indian	x	x	x	x	x	x	5
Asian or Asian British: Pakistani	x	10 (25%)	0 (0%)	11 (28%)	11 (29%)	9 (23%)	45 (23%)
Asian or Asian British: Any other Asian background	x	x	x	x	x	x	6
Black/Black British: African	x	x	x	x	x	x	x
Other: Any other	x	x	x	x	x	x	x
Unknown/not stated	9 (39%)	6 (15%)	3 (14%)	4 (10%)	7 (18%)	6 (15%)	35 (18%)
TOTAL	23	40	21	39	38	39	200

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

The data shows that deaths among children of Asian/ Pakistani background make up a relatively large proportion of overall deaths. While the Asian population is disproportionately affected given the small size of the Pakistani population of Buckinghamshire as a whole (4.2% of total population of Buckinghamshire (2011 Census)) and the small proportion of births in this group (8.2% of total births in Buckinghamshire (2013/14)⁷, local and national evidence suggests that adverse birth outcomes such as low birth weight, congenital abnormality and death have a much stronger link to measures of social disadvantage than ethnicity. In Buckinghamshire, the incidence of LBW, congenital anomalies and infant deaths are higher in socially deprived communities.

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

D.4. Child deaths where the child was an asylum seeker 2014-15

Of the 39 deaths reviewed, while no case was identified as an asylum seeker, one case did not have a known status. Nationally, due to low numbers of deaths in children recorded as asylum seekers (around 10 deaths each year), this information has been removed from the national reports. There are no indications that the proportion of deaths of asylum seekers with modifiable factors is different from that of other children.

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

⁷ Secondary Uses Service (SUS) which is the single, comprehensive repository for healthcare data in England.

Of the 39 deaths reviewed, one child was subject to a child protection plan at the time of death and one child was subject to a child protection plan previously. No child was subject to any statutory order.

D.6. Category of deaths as determined by CDOP 2014-15

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

- ‘Modifiable factors identified’ – where the Panel have identified one or more factors in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.
- ‘No modifiable factors identified’ – where the panel have not identified any potentially modifiable factor in relation to the child’s death
- ‘Inadequate information to make a judgement’ – this category should be used very rarely indeed.

Chromosomal/ congenital abnormalities are the top category of death in Buckinghamshire (36% compared with 25% nationally) followed by perinatal /neonatal deaths⁸ (28% compared with 33% nationally).

Table 13 below shows category of deaths as determined by CDOP. Graph 5 below shows trend in category of deaths since 2008.

Table 13: Category of deaths as determined by CDOP 2014-15

Category of death	Number of child deaths with modifiable factors recorded under this category of deaths	Number of child deaths with no modifiable factors recorded under this category of deaths	Number of child deaths where there was insufficient information to assess if there were modifiable factors
Deliberately inflicted injury, abuse or neglect (category 1)	0	0	0
Suicide or deliberate self-inflicted harm (category 2)	1	2	0

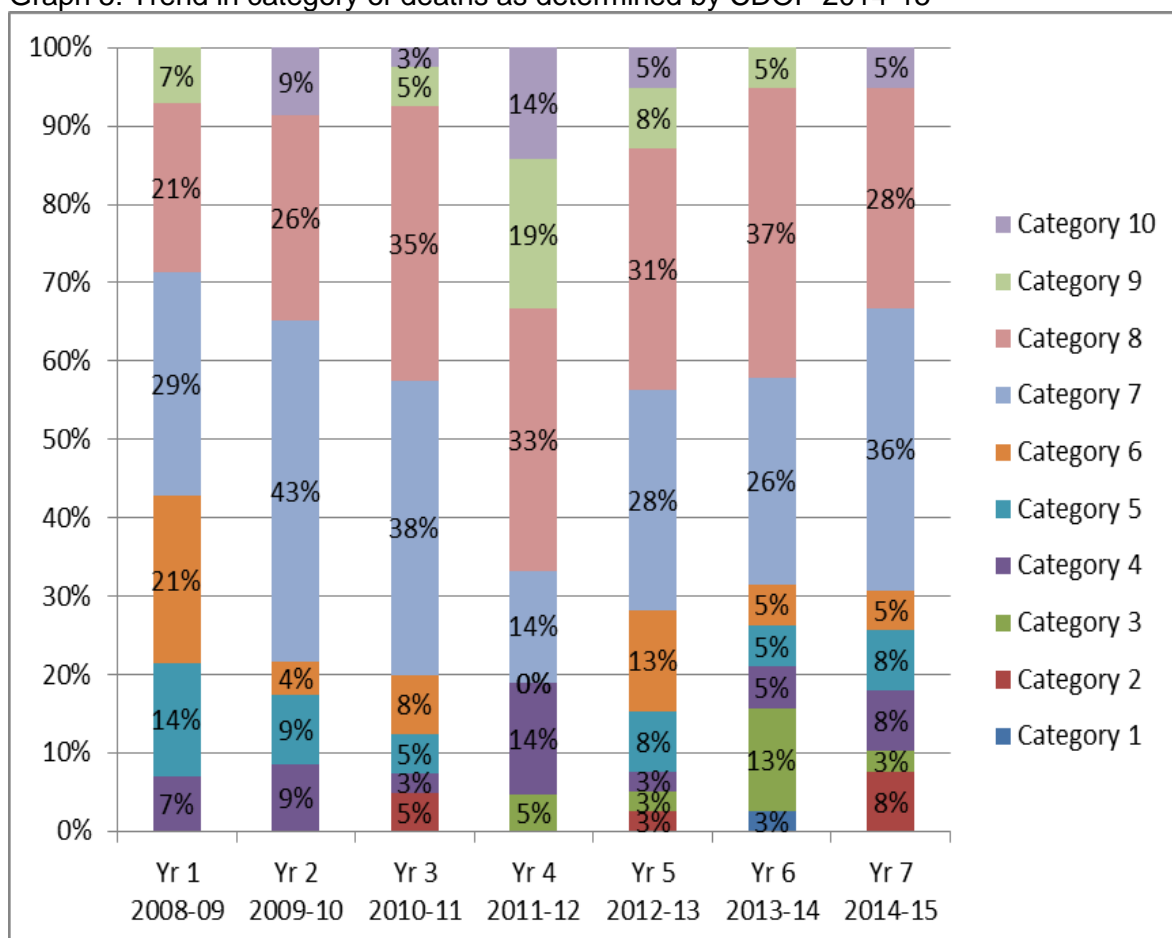
⁸Perinatal mortality rate: the number of stillbirths and deaths in the first six postnatal days per 1,000 total births

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

Trauma and other external factors (category 3)	0	1	0
Malignancy (category 4)	0	3	0
Acute medical or surgical condition (category 5)	0	3	0
Chronic medical condition (category 6)	1	1	0
Chromosomal, genetic and congenital anomalies (category 7)	0	14 (36%)	0
Perinatal/neonatal event (category 8)	1	10 (28%)	0
Infection (category 9)	0	0	0
Sudden unexpected, unexplained death (category 10)	0	2	0
Total	3 (8%)	36	0

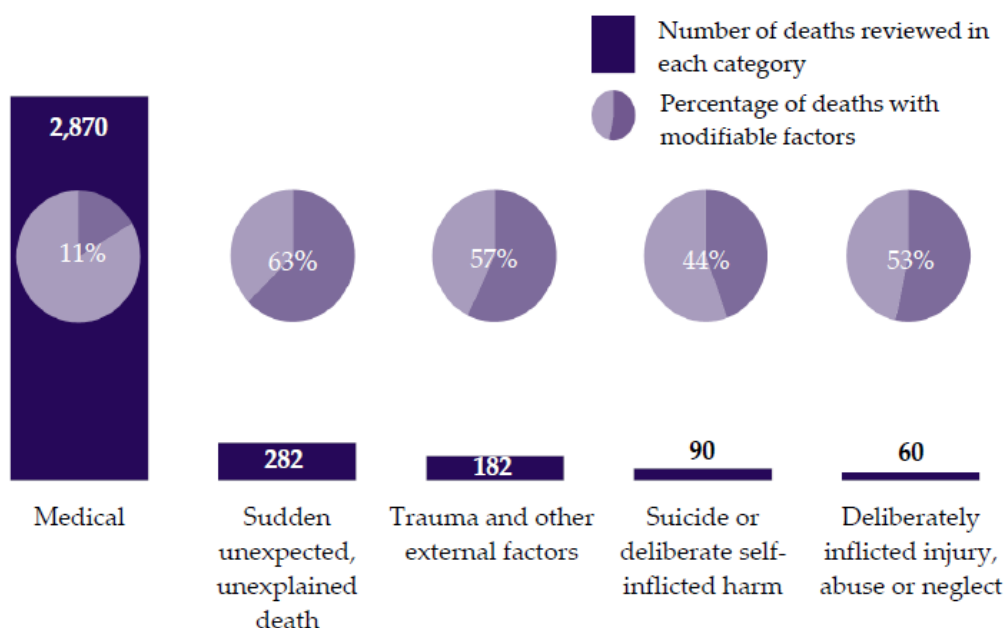
Graph 5: Trend in category of deaths as determined by CDOP 2014-15



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

modifiable factors.

Graph 6: Number of deaths reviewed in each category, England 2014-15



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

Of the 39 cases reviewed, in 16 cases (41%) the cause of deaths was determined as 'known life limiting conditions' compared with 28% nationally. 15 cases (38%) were classified as neonatal deaths compared with 39% nationally.

Table 15: Events that caused the death as determined by CDOP 2014-15

Category of death	No of deaths with modifiable factors recorded under this category of deaths	No of deaths with no modifiable factors recorded under this category of deaths	Total	National benchmark
Neonatal death	1	14	15 (38%)	39%
Known life limiting condition	0	16	16 (41%)	28%
Sudden unexpected death in infancy	0	2	2 (5%)	9%
Road traffic accident/collision	0	0	0	2%
Drowning	0	0	0	0.8%
Fire and burns	0	0	0	x
Poisoning	0	0	0	x

Other non-intentional injury/accident/trauma	0	1	1 (3%)	2.5%
Substance misuse	0	0	0	0.3%
Apparent homicide	0	0	0	1.3%
Apparent suicide	1	2	3 (8%)	2.2%
Other	1	1	2 (5%)	14%

D.8. Place of death

In 23 cases (59%) Acute Hospitals were the place of death followed by 10 cases (23%) in the normal residence of the child and 6 cases (15%) in hospices. Nationally, 67% of the deaths reviewed occurred in an acute hospital, 22% in the normal residence of the child and 4% in hospices. Table 17 below shows place of death for the 39 cases reviewed in 2014/15.

Table 17: Place of death 2014-15

Place of the event which led to the child's death		Modifiable factors identified	No Modifiable factors identified
Acute hospital	Emergency Department	0	0
	Paediatric Ward	0	4
	Neonatal Unit	1	5
	Paediatric Intensive Care Unit	0	3
	Other (including delivery suites, labour wards, transplant units, etc)	0	9
	Unknown	0	1
Home of normal residence		2	8
Other private residence		0	0
Public place		0	0
Hospice		0	6
Abroad		0	0

D.9. Modifiability/Preventability

In Buckinghamshire, modifiable factors were identified in 3 (8%) cases that were reviewed in 2014/15 (8% in 2013/14 and 5% in 2011/12). National benchmarking data shows that modifiable factors were identified in 20% of the reviews in the South East, and in 24% of reviews nationally (2014/15). Nationally the number and percentage of reviews which were assessed as having modifiable factors has increased from 20% in 2011 to 24% in 2015.

Of the three cases with modifiable factors, one was related to an apparent suicide for which a serious case review took place (see section D10 below). The second case with a modifiable factor was related to a 17 year old child who required urgent admission to hospital for investigation and management by specialist clinicians. A breakdown in communication between the GP in primary care and the pathology laboratory in Secondary Care resulted in a lost opportunity to provide effective medical treatment.

The third case with a modifiable factor was a neonatal death. The modifiable factor was a lack of proper monitoring of the unborn baby in a mother with some risk factors in the pregnancy. The baby was born in a poor physical state by emergency caesarean section and did not show any improvement with intensive care management. The baby was transitioned to end of life care on day 6 and died peacefully.

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 of 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 39 cases reviewed, serious case reviews took place in 2 cases (5%), compared with 2% nationally. One of the cases was related to the death of a young person who died at the age of 17 years in 2012 after hanging himself.

The second case was related to a young girl who in July 2012 took her own life. More detailed information on these cases including the full reports and lessons learnt can be found on <http://www.bucks-lscb.org.uk/serious-case-review/>.

E. ISSUES IDENTIFIED AND ACTIONS TAKEN AS A RESULT OF THE REVIEWS BY CDOP

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

- The quality of handover in maternity service has been improved.
- Procedures for the monitoring of twin pregnancies have been amended.
- Police procedures have been clarified so that 17-18 years old fatalities are now taken to A&E instead of to mortuaries to improve the rapid response process.
- The use of language interpreters in maternity services has been promoted.
- Recommendations have been made that advice regarding the risk of smoking and overcrowding to new born babies should be communicated to parents.
- Some CDOP meetings are now dedicated 'neonatal' meetings with attendance from a representative from obstetrics/maternity as it was felt that the panel would benefit from additional expertise from specialists in obstetrics/maternity care.
- As the majority of deaths reviewed fell into category 7 (Chromosomal/genetic and congenital anomalies), the panel felt that access to genetic counselling was important and the Designated Doctor for CDOP is working with other consultants to ensure that families are given adequate advice and support in this area.
- Regular communication has taken place between CDOP members and relevant bodies in order to improve data recording and data submission to the panel as lack of documentation and the quality of the information received by the panel continues to be an issue.
- The Buckinghamshire CDOP procedures indicate that there should be representation from the coroner on the panel as this would make the review process more efficient. Coroner representation was not possible and timely access to coroners' reports was an issue in 2014/15, however, this issue has been resolved now.
- Some examples of good practice from neighbouring CDOPs have been shared with relevant agencies and health professionals, e.g. Information regarding the dangers of suffocation by nappy sacks has been disseminated to relevant partners.

F. RECOMMENDATIONS

Recommendations for CDOP

1. CDOP should improve the review time and aim to reduce the proportion of reviews that take more than 1 year from 64% to less than 50% by next year.
2. CDOP should work with Primary and Secondary Care and other partners to improve quality of data reported to CDOP. To be able to carry out meaningful analysis data needs to be of high quality and needs to be 100% complete. There are far too many missing items that make meaningful analysis impossible.
3. CDOP should use this improved data to monitor epidemiological trends annually. Completed data amassed over a number of years would enable more accurate statistical analysis.

Recommendations for Buckinghamshire LSCB:

1. Ensure CCGs and NHS England improve early access to antenatal and maternity services for pregnant women particularly those from areas of social deprivation including ethnic minorities.
2. Ensure commissioners improve the identification and clinical management of high risk pregnancies. Ensuring there is a clear and agreed process in place for referring and sign-posting at-risk women to relevant services such as genetic screening and counselling, healthy lifestyle services and services that aim to prevent pre-term birth.
3. Ensure commissioners improve and enhance data collection on risk factors for child death in primary and secondary care settings through improved and robust contract and performance monitoring processes.
4. Ensure commissioners target health promotion and service improvements at the most hard-pressed families in the most deprived geographical areas in order to reduce the gap in infant mortality between the most and the least affluent populations in Buckinghamshire.
5. Ensure close monitoring and surveillance of infant mortality continues and remains a top priority for all organisations in Buckinghamshire including the LSCB.
6. The LSCB should adopt these recommendations and request a progress report on them from commissioners by December 2016.

Appendix 1: Child death review process in Buckinghamshire

