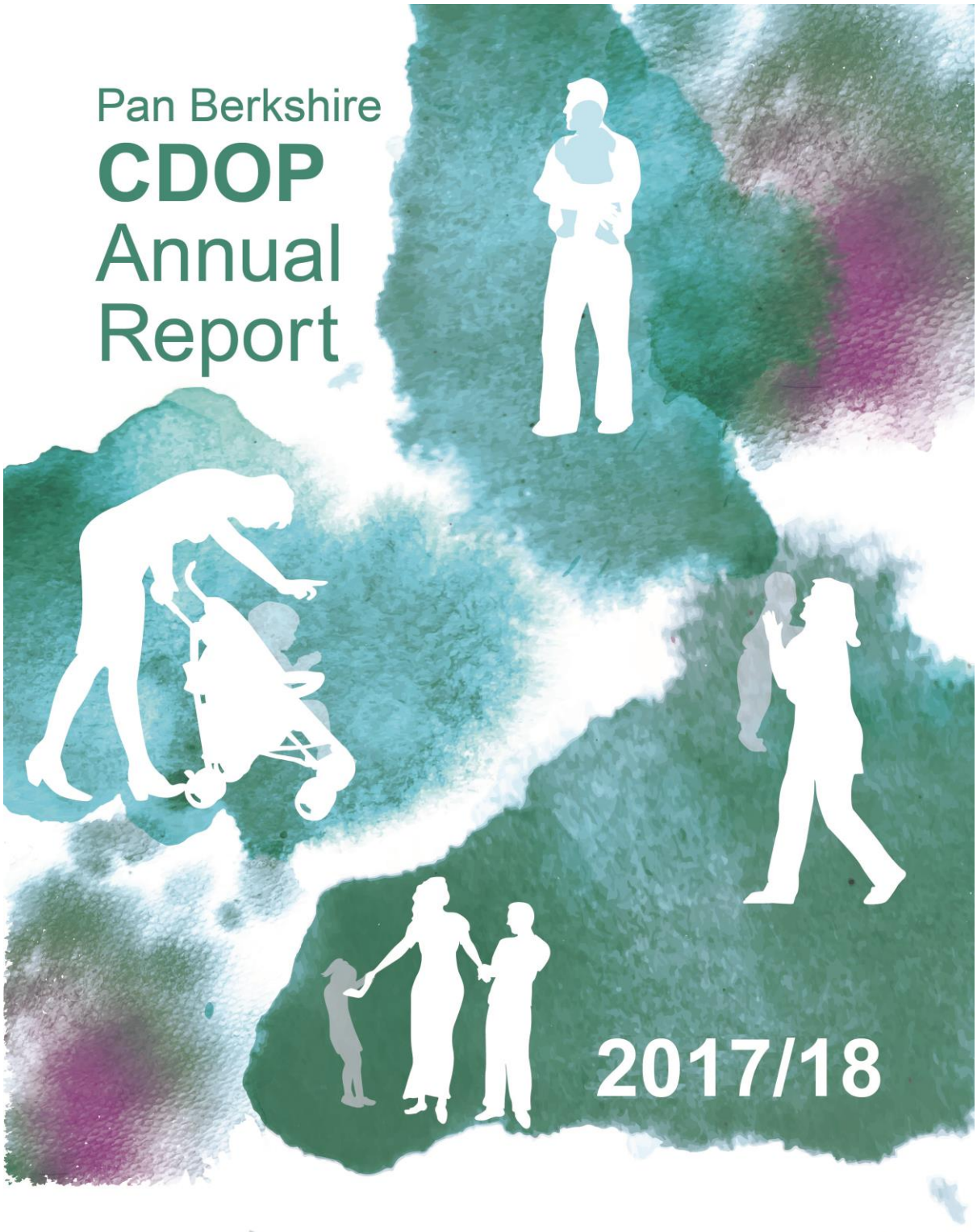
Pan Berkshire
CDOP
Annual Report



2017/18

Bracknell Forest Local Safeguarding Children Board

Windsor and Maidenhead Local Safeguarding Children Board

Slough Local Safeguarding Children Board

Reading Local Safeguarding Children Board

West Berkshire LSCB

Wokingham Board safeguarding children

In 2008, Child Death Overview Panels (CDOPs) were statutorily established in England under the aegis of Local Safeguarding Children Boards (LSCBs) with the responsibility of reviewing the deaths of all children (0 to <18 years) in their resident population.

In Berkshire the CDOP is a subgroup of the six Unitary Authority Local Safeguarding Children Boards. It is made up of representatives from across the county from a range of organisations, including health, social care and police. The CDOP also has representation from those with experience of supporting families bereaved through a child's death. This is because experience and evidence tells us that what happens when a child is dying, or has died, can affect how families grieve and face life with this sorrow always present.

Families will often want to know: Why did my child die? Was this death preventable? What lessons can be learnt? In some circumstances, the wider public may have similar questions. The Pan Berkshire CDOP has a professional interest in seeking answers to these questions with the intention of trying to prevent future child deaths. In undertaking this work it also reflects on how better to understand and support bereaved families.

Child deaths may result from previously recognised or unrecognised medical conditions or as a result of unintentional incidents or (rarely) deliberate acts. A significant proportion of sudden unexpected deaths in infancy (SUDI) remain unexplained. Understanding that the death of an infant or child, whatever its cause is a tragedy for the family and for all involved, the Pan Berkshire CDOP strives to make enquiries that keep an appropriate balance between forensic, medical and social care requirements and supporting the family at a difficult time.

The purpose of the CDOP, (as required by the Local Safeguarding Children Boards Regulations 2006) is to collect and analyse information about each child death in order to:

- Identify any changes that we can make or actions we can take that might help to prevent similar deaths in the future.
- Share learning with colleagues regionally and nationally so the findings will have wider impact.

This process is undertaken locally for all children who are normally resident in Berkshire and is started for any non-resident child that dies unexpectedly.

The aggregated findings from all child deaths should inform local strategic planning, including the local Joint Strategic Needs Assessment (JSNA), on how to best safeguard and promote the welfare of children in the area.

Every CDOP should prepare an annual report of relevant information for the LSCB. This information should in turn inform the LSCB Annual Report. This is the 2017/18 report of the Pan Berkshire CDOP panel. The report reflects the continued commitment of its members to ensuring that we review with rigour and care each individual tragedy and support the system in identifying key learning and opportunities to develop our responses.

Tessa Lindfield (Strategic Director of Public Health for Berkshire) Chair of Pan Berkshire Child Death Overview Panel
Report written by Lorna Tunstall CDOP Coordinator

Berkshire CDOP Process

Working Together to Safeguard Children 2018 sets out a CDOP process for all child deaths and a Sudden Unexpected Death in Childhood (SUDIC) process for when a child dies unexpectedly. The two are separate processes, but closely linked. All child deaths are to be notified to the Designated Person within the LSCB. The Designated Person is the CDOP Coordinator. Following notification the CDOP Coordinator manages the information gathering and collation with all professionals who have been involved with the child or family prior the child's death. The SUDIC process involves early notification of the unexpected death of a child, a prompt process of investigation led by the Designated Paediatrician or Designated Healthcare Professional involving discussion with a range of partners, a visit to the place of death, and a meeting between professionals involved with the child in order to gather information, learn lessons and ensure the family and others are supported. A report into the circumstances of the child's death is produced, which is shared with the Coroner, and with the CDOP.

The CDOP panel meets quarterly and during this meeting reviews the death of every Berkshire resident child aged under 18 years and is required to complete a national proforma regarding its findings in respect each child's death. The proforma includes factors relating to:

- **the child and family, and service provision;**
- **categorisation of the cause of death;**
- **a judgment regarding whether there were modifiable factors;**
- **learning points and recommendations;**
- **immediate follow up actions for work with the family;**
- **whether to refer the case to the LSCB Chair for consideration of a Serious Case Review.**

Membership of the Pan Berkshire CDOP includes:

- Strategic Director of Public Health - CDOP Chair
- CDOP Coordinator
- Designated Paediatrician/Designated Health Professional – East and West Berkshire
- Police Representative – East and West Berkshire
- Ambulance Service Representative
- Local Safeguarding Children Board Business Managers – where case relevant
- Children's Social Care Representative
- Bereavement Organisation Representative
- CCG Representative – East and West
- Berkshire Healthcare NHS Foundation Trust (BHFT) Representative
- Head of Midwifery – East and West Berkshire
- Paediatrician with a special interest in neonatology – East and West Berkshire
- Safeguarding Named Nurse, Frimley Health NHS Foundation Trust
- Hospice Representative
- CCN Representative
- Health Visitor/School Nurse Representative

Other professionals are invited to attend for specific cases or for professional development. The work of CDOPs is aggregated nationally in a statistical release by the Department of Education *www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2017* For this report we have referred to the 2016/2017 review as we do not have national data for 2017/2018.

Our Activity

This section summarises all deaths notified to the Berkshire CDOP between April 1st 2011 and 31st March 2018. It includes all children who have died in the area and children residing in the area but who have died elsewhere. This data is drawn from the database of Notifications to CDOP (Form A from the National Data Set).

The total number of deaths which occurred during April 2017 and March 2018 was 57. As expected because of the low numbers involved, the year on year numbers fluctuate somewhat, with no clear trend observed over recent years.

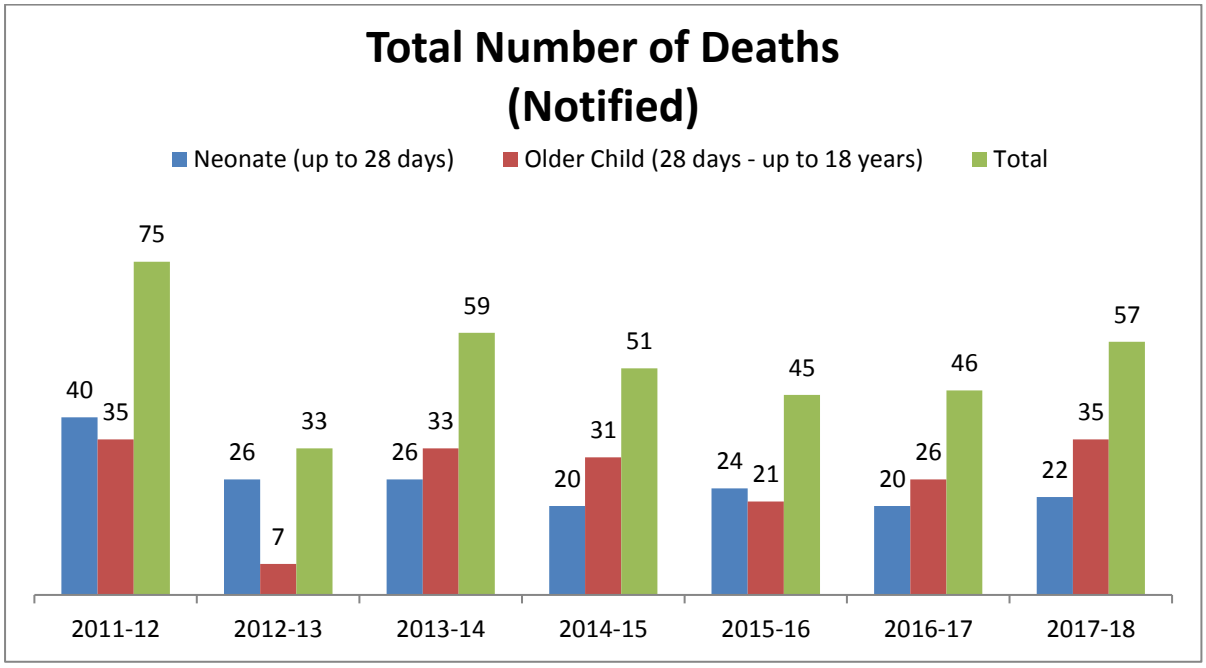


Figure 1: Number of deaths (neonates and older children) notified by year

During 2017-18 there were 52 cases reviewed by the panel. The number of notifications and reviews differ as the cases reviewed include deaths notified in previous years but not reviewed until the current year. This anomaly occurs because of the time taken to review the circumstances of each death following notification which can be significant in the event of an inquest or criminal proceedings.

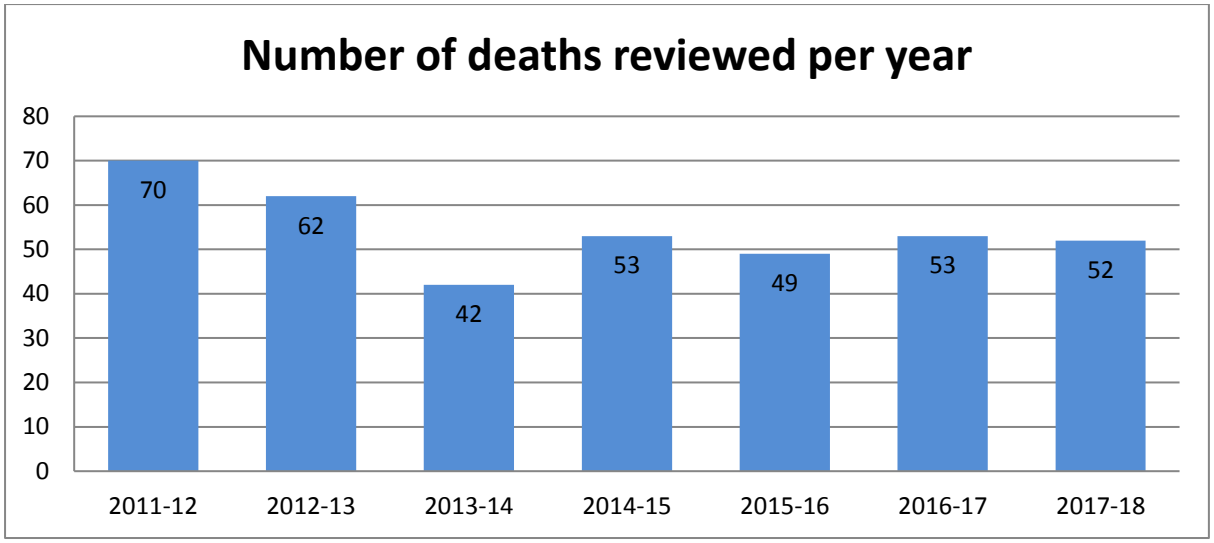


Figure 2 – Number of deaths reviewed, by year.

In 2017/18 of the 57 deaths that occurred, 34 deaths were reviewed within the year with 23 outstanding at April 2018.

Of the 52 cases that we reviewed during 2017/18:

- 30 (57%) were reviewed within 0-6 months of child death
- 16 (30%) were reviewed within 6-12 months of child death
- 7 (13%) were reviewed 12+ months of child death

England & Wales data from 2016/2017 reported 76% of cases were reviewed within 12 months (currently we do not have the data from the Department of Health for 2017/2018): locally this year we achieved closure on 87% of cases within 12 months.

In cases where modifiable factors were identified (see later for definition) we would expect the process to be longer, indeed this is seen nationally. However locally we managed to achieve a quicker turnaround as the majority of cases were reviewed within the first six months.

- Reviewed deaths with modifiable factors: 10
- 6 (60%) were reviewed within 0-6 months of child death
- 1 (10%) were reviewed within 6-12 months of child death
- 3 (30%) were reviewed 12+ months of child death

We reported in last year's Annual Report 2016/2017 that there were three outstanding cases not yet reviewed. Two have now been reviewed and one is outstanding as at end March 2018. This is an overseas death that had involved lengthy criminal proceedings. All civil and criminal proceedings are now complete and we await an inquest date. Cases are not normally reviewed by CDOP until after the inquest has been held.

Our Children

Age

Across England & Wales, most children's' deaths occur in children aged under 1.

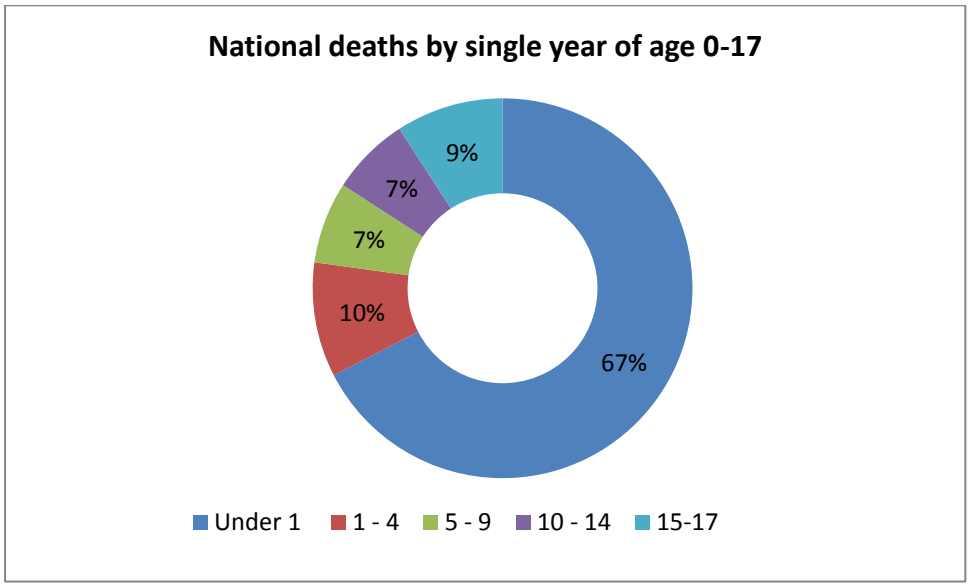


Figure 3: National deaths by single year of age

Source: *ONS: Deaths by single year of age, England and Wales 2017*

England & Wales data identifies that the next highest age group for mortality was for children aged 1-4 years. This is similarly reflected in the Berkshire data.

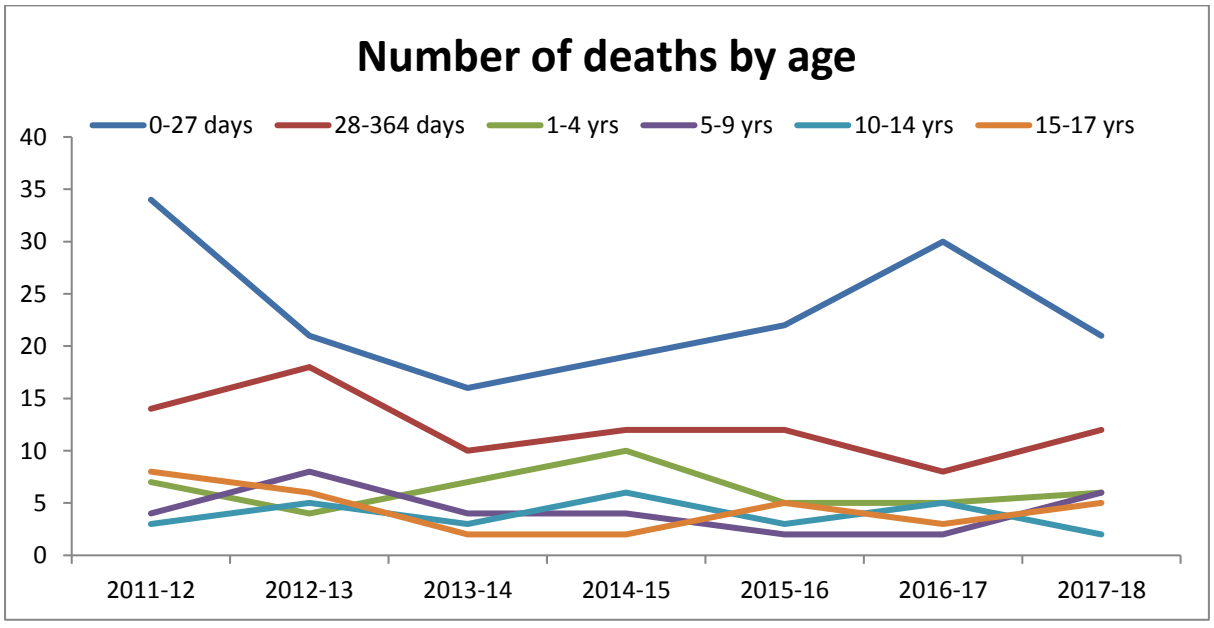


Figure 4: Age at time of death 2011 – 2018

Locally over the past six years the pattern of age at time of death has fluctuated slightly. In the past year, as can be seen from figure 4, the proportion of deaths in the neonatal period (under 28 days) and older children has changed, with neonatal now accounting for a higher proportion which is back in line with the national picture[1]. In 2017-18 57% of actual deaths in year were in children under 1 year (and of reviewed deaths 60% were under 1 year). This is broadly consistent with the national figure (66%).

Neonatal Deaths – Special Review Panel

In response to the balance of neonatal deaths among the overall numbers of child deaths reviewed, the Berkshire CDOP established a specialist panel in 2016/2017 to better enable the CDOP to consolidate the possible learning. The panel met for the second time in March 2018 to review all neonatal deaths in the period 01/01/2017 – 31/12/2017. Not all the cases reviewed strictly met the criteria for Neonatal Death (a death in a child under 28 days old) but the process for reviewing neonatal deaths was felt to be appropriate as the cases had never left the neonatal unit.
The panel consisted of the following CDOP members:

Consultant Paediatrician FHFT and Chair of the CDOP Neonatal panel

Head of Midwifery FHFT

Consultant Paediatrician RBHFT

Director of Midwifery RBHFT

Consultant Community Paediatrician and Designated Doctor for Child Death (East Berkshire)

Named Midwife for Child Protection RBHFT (observing)

Pan Berkshire CDOP Co-ordinator

Of the 23 deaths reviewed by the panel 15 cases were found to be caused by perinatal factors; 5 were caused by chromosomal/genetic factors; 2 were caused by infection (both term infants); and 1 (a term infant) was a sudden, unexpected, unexplained death (SUDI).

None of the deaths caused by perinatal factors occurred at term; 10 occurred at a gestational age of pre-30 weeks and 5 of the deaths occurred between 30 weeks and 39 weeks. In contrast 3 of the deaths caused by chromosomal/genetic factors occurred at or after term.

This review identified the following learning points:

- Based on national and local guidelines the reviewers only included babies born above 23 completed weeks of gestation. There were no cases where Intensive Care had been offered at 22 weeks gestation so 23 weeks was felt to be an appropriate cut off for inclusion.
- It was noted that while information was available about local multidisciplinary reviews and learning from the centres where the reviewers were based, there was no such information available from other centres.
- The Local Maternity Systems (BOB and FH) have set up a governance group where it is thought that learning from these cases which is largely around local processes and human factors can be shared.

[1] The latest national data for the period 2014-16 states there are 2.74 per 1,000 deaths for neonatal mortality and 1.14 per 1,000 deaths for post-neonatal mortality. Source: PHE Child health mortality profile. https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-mortality

- The Reviewers recognised good practice in that a number of cases had undergone detailed reviews in the form of either Serious Incident (SI) or Root Cause Analysis (RCA) investigations.

Expected and Unexpected Deaths

An unexpected death is defined as 'the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.'

In the past year, 15 cases where there were unexpected deaths were reviewed. All have documented rapid response reviews[2]. During the last seven years the proportion of unexpected deaths continues to fall although this year there was a small increase. Over 82% of all deaths occur within the hospital setting.

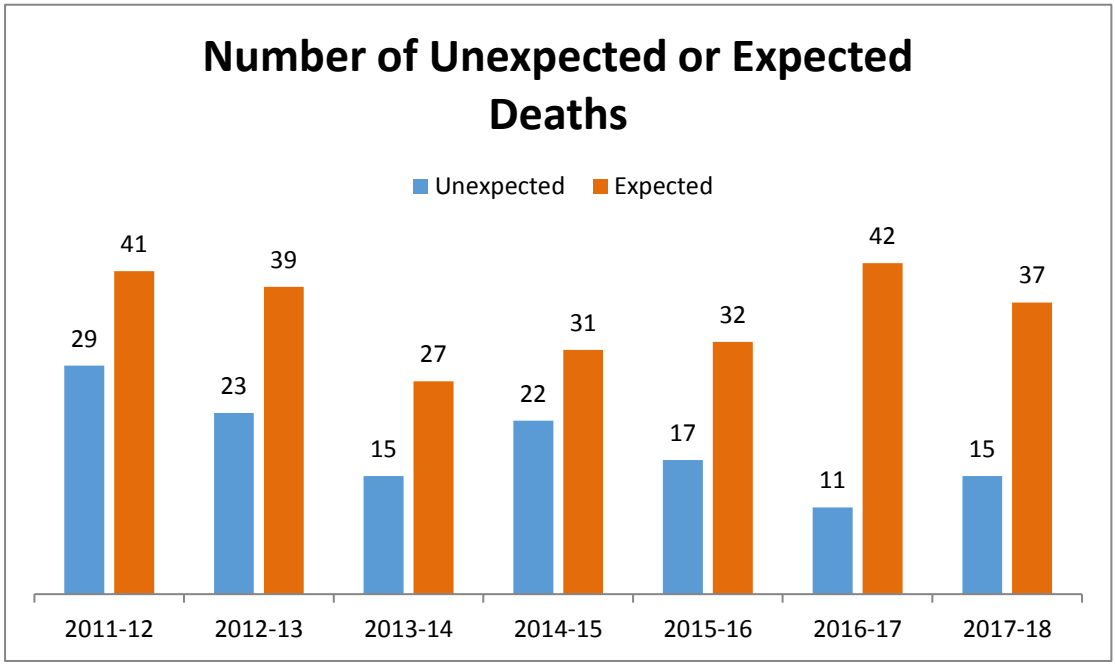


Figure 5: Number of Unexpected or Expected Deaths, by Year.

Gender

Over the last seven years there have been more notifications of male deaths than female deaths. In 2017/2018: 55% were males and 46% females. However, caution should be taken in interpreting any trend due to the small numbers. The percentage of child deaths for males over the past 5 years is consistent with national data published by the Department of Education in its Statistical Release of Child Death Reviews. In 2016/2017 56% were males and 44% were females.

[2] Rapid Response Protocol here: http://www.westberkslscb.org.uk/professionals-volunteers/cdop/

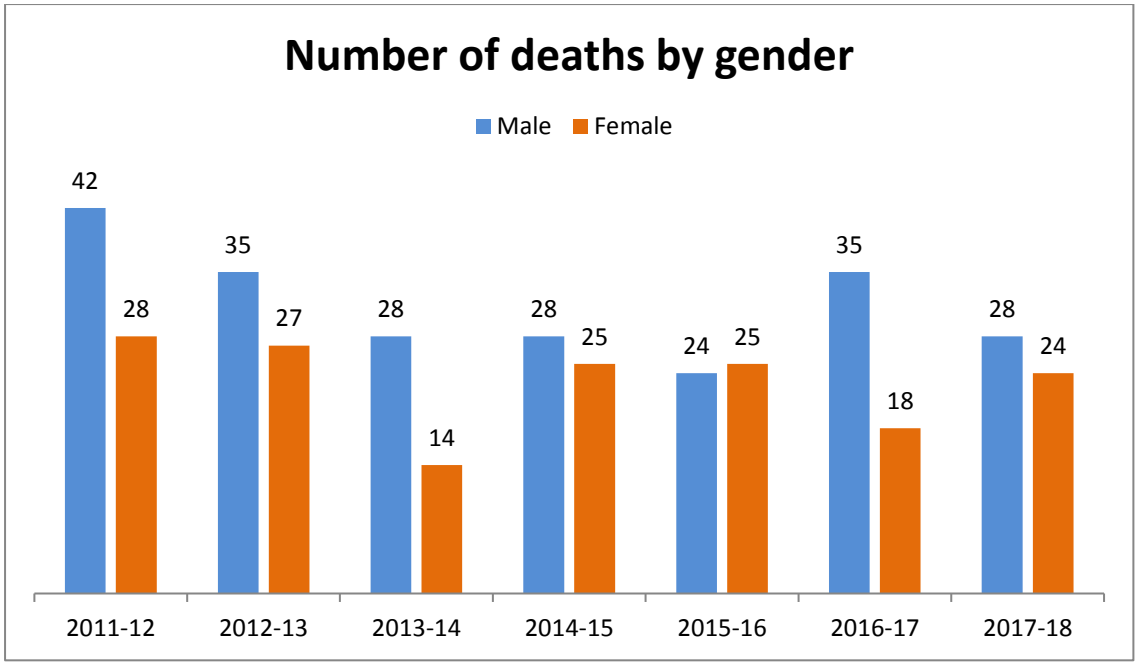


Figure 6: Deaths by gender, per year.

Ethnicity

Over the past seven years the largest numbers of child deaths have occurred in the white British population, with the next largest number occurring in the Asian/Asian British population. However, children who are of ethnicity other than White British appear to be over-represented among child deaths compared with their prevalence in the general population as measured in the 2011 census, which found Berkshire's general population to be 80.04% white.

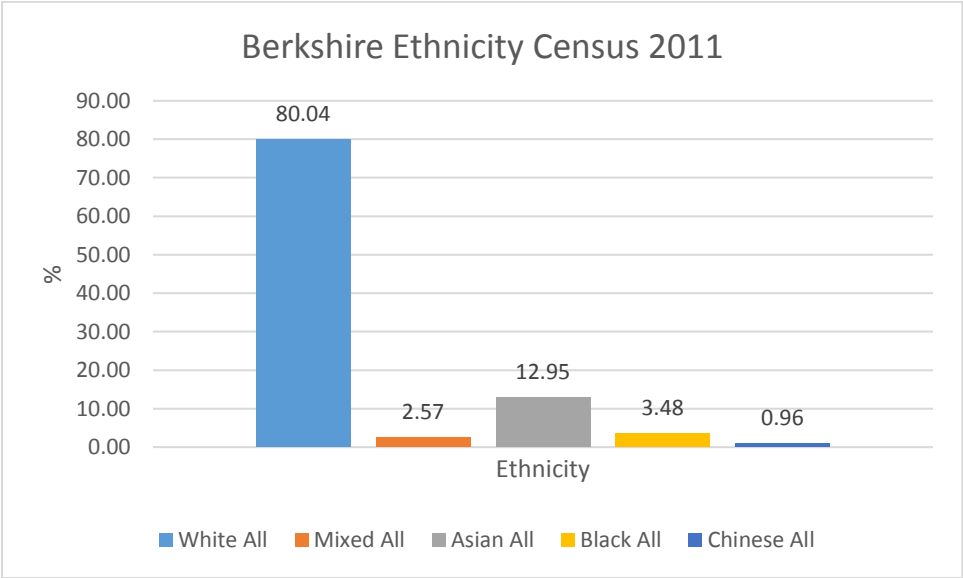


Figure 7: Census ethnicity data for Berkshire

Some of the chromosomal / genetic causes of death are known to be linked to consanguinity, which is more common within certain ethnic groups than in others. The CDOP is working sensitively with local communities to share information about the risks of consanguinity and the increased risk of chromosomal abnormalities so that parents and communities can be better informed.

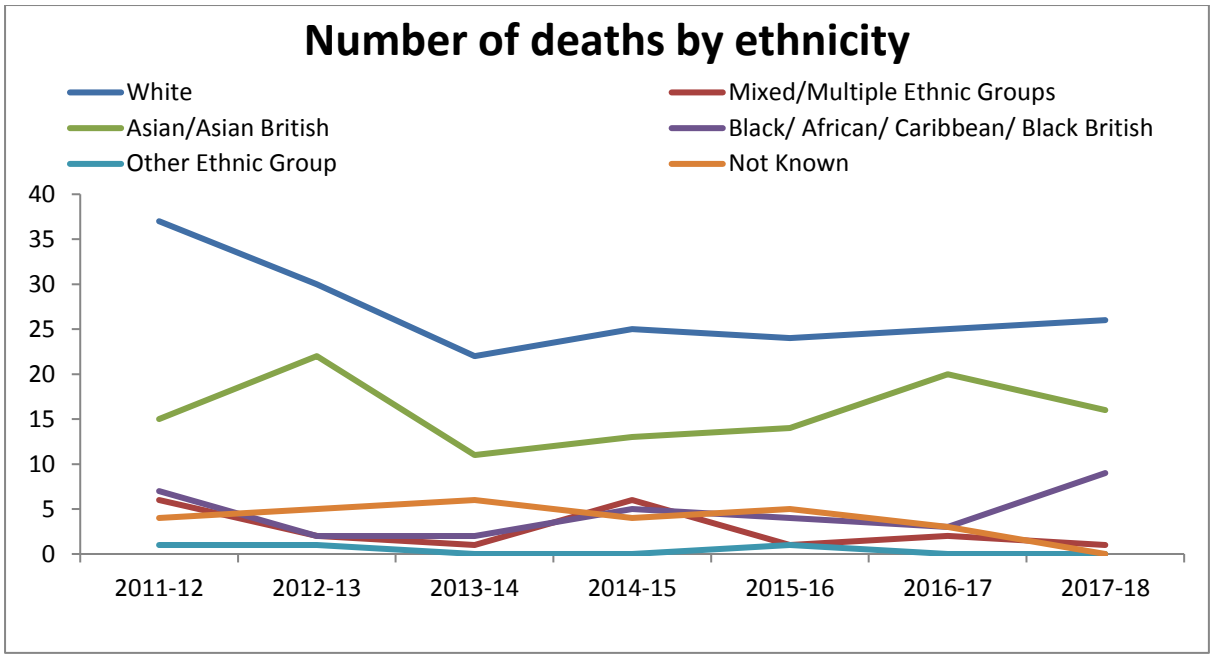


Figure 8: Deaths by ethnicity, per year.

Modifiable Factors

Modifiable factors are defined as 'those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced'.

Nationally the proportion of deaths which were assessed as having modifiable factors has remained unchanged at 27 per cent in 2016/2017. Locally in 2017/2018 of the cases reviewed 18% were considered to have modifiable factors including:

- Consanguinity
- Not following safe sleeping advice
- Management of health conditions
- Prop feeding
- Vaccination
- Parenting issues

Some modifiable factors were relevant to more than one child death.

Categorisation of cases

During the CDOP meeting the panel members categorise a child's death according to nationally defined categories which are determined by the Department of Education. The numbers in each category are collated for learning within the CDOP. This process is subject to the scrutiny of the LSCBs and Independent Chairs.

Summary of CDOP key findings during 2017-18

Specific areas for learning have been identified by the panel and included:

- Antibiotics for ear infections in children with cochlear implants.
- Vaccination of 'at risk' groups with the PCV13 and PPV23 vaccines.
- Catch up pneumococcal vaccination for at risk groups who were too old to have been included in 2010 programme and new migrant children.
- The need to be aware that migrant families may not know about the services offered to children and young people with complex disabilities.
- The need to promote tuberculosis testing in families from countries where the disease is endemic.
- The need for ongoing promotion of Safer Sleep information including the risks of co-sleeping to families and for consideration of extending training to all professionals who have contact with families.
- Learning in relation to domestic abuse and chronic neglect, 'the voice of the child' and the challenge for all agencies in relation to a patterns of behaviours that intimidate where there is partial or disguised compliance.
- The need to continue to highlight to the public the risks of using a mobile phone whilst driving.
- The need for ongoing vigilance to identify patterns of deaths in groups of children.

Reflections on the work of CDOP

During the past year the panel has continued to maintain good operational performance against national standards. The CDOP is well attended by relevant partners. Discussions are thorough and considered of high quality. Improvements have been made to documentation to facilitate categorisation of deaths, identification of modifiable factors and recording of recommendations, which are circulated via a regular CDOP Newsletter and to LSCBs for their attention and action.

Following a training needs analysis Pan Berkshire CDOP agreed to organise a child safeguarding training event to promote knowledge and understanding of the CDOP processes within Berkshire. This is now an annual event and a second multi-agency training day entitled "Saving Children's Lives" was held on 7 March 2018 in Reading with 90+ people attending. The keynote speaker was Professor Peter Fleming, Professor of Infant Health and Developmental Physiology at Bristol Medical School. His talk was entitled "Unexpected and unexplained deaths of infants and young children: what do we know and what we can do to prevent them". Other notable speakers included the Police; SCAS; Children's Social Care, Health and Education.

This was followed by break out groups with practical sessions reviewing real cases. The training came to a close with a Q and A panel session which was new for this year. Our event counted as a full day CPD training course and Level 3 Child Protection training. The event received very positive evaluation by delegates including feedback about future training needs and themes. Details of the day can be found on the CDOP website link http://www.westberkslscb.org.uk/professionals-volunteers/cdop/

The panel approved the purchase of eCDOP: an online recording, casework and reporting system for child deaths. eCDOP has already been adopted by more than 55 CDOPs nationally including our closest neighbours Oxfordshire and Buckinghamshire.

eCDOP will link into both the Department of Health national dataset (submitted annually) and the National Child Mortality Database (NCMD) currently being developed by the University of Bristol. The NCMD will collect a minimum dataset from the Child Death Overview Panel reviews of all child deaths in England. The collection, analysis and public reporting of information from all child deaths across England will facilitate learning to reduce preventable child mortality.

The panel shared learning via the CDOP newsletter on safety around water, hot weather and falls, and self-harm websites.

Themed reviews were carried out on:

- Working with schools following a death
- Reading Festival 2017 and preparing for 2018
- Home educated children

A review of knife crime was commissioned during 2017/2018. The panel expect to report back on findings during 2018/2019.

In the absence of a substantive Director of Public Health for Berkshire, the panel has been expertly chaired by Rachael Wardell, Liz Stead and Darrell Gale during 2017/2018. The new SDPH will take over the chair from October 2018.

Priorities for 2018/19

Background

The Children and Social Work Act 2017 and the Wood Review were published during 2016/2017. These documents amend the overarching 'Working Together to Safeguard Children' guidance and in turn require the Pan Berkshire LSCBs to review, reflect and create a new structure to ensure they underpin its formal requirements. During the course of this report the CDOP followed the guidance of Working Together to Safeguard Children 2015.

Working Together to Safeguard Children guidance was published this year (August 2018). Significant changes have been made to arrangements for Serious Case Reviews and Child Death Overview Panels. These require the Boards to amend their processes to reflect these changes and will include the transfer of responsibility for CDOP from the Department of Education to the Department of Health.

This review is currently being undertaken by the 6 LSCBs who will report back to the CDOP panel.

It should be noted that the main document relating to changes to the CDOP process (Transition) has yet to be published. This is the Child Death Review Statutory Guidance and is intended to sit alongside the main Working Together 2018 documents. It is understood that the Department of Health is intending to publish our guidance during the latter half of 2018.

The 3rd annual multi-agency CDOP training day will take place in March/April 2019 with the focus on the older child/young person; particularly those engaging in risky behaviour. Planning for this event will begin in the autumn.

The CDOP will continue to build on our successful work to date in supporting a reduction in mortality from SUDI and accidents. We will look to reduce risk factors for preterm and low birth weight deaths and to continue our work with families and communities to reduce the risk of congenital / genetic abnormality.

The panel is taking part in the LeDeR (Learning Disability Mortality Review) based at the University of Bristol. Deaths of children from 1st September 2017 (4 years and over) with learning disabilities will be notified to LeDeR and learning shared.

For 2018/2019 we will be carrying out thematic reviews on the following:

As children with life limiting conditions and deteriorating neurological conditions continues to be the largest group we review other than neonatal a 2 year audit of deaths in neurodisability across Berkshire will be carried out by a local Community Paediatrician.

Safe sleeping: issues have been noted by the panel where safe sleep recommendations have not been followed. As there is evidence based prevention practice in this area, this was felt to be a useful area for further action. A local and regional campaign is to take place in 2018, predominantly aimed at parents and families including a focus on raising fathers' awareness about the dangers of co-sleeping, including shared beds, and dangerous sleeping situations such as sofa sleeping.

Berkshire West (BW) CCG will lead a review of the Rapid Response joint home visit service model against the current profile of unexpected deaths in Berkshire.

Lorna Tunstall

Pan Berkshire CDOP Coordinator

September 2018