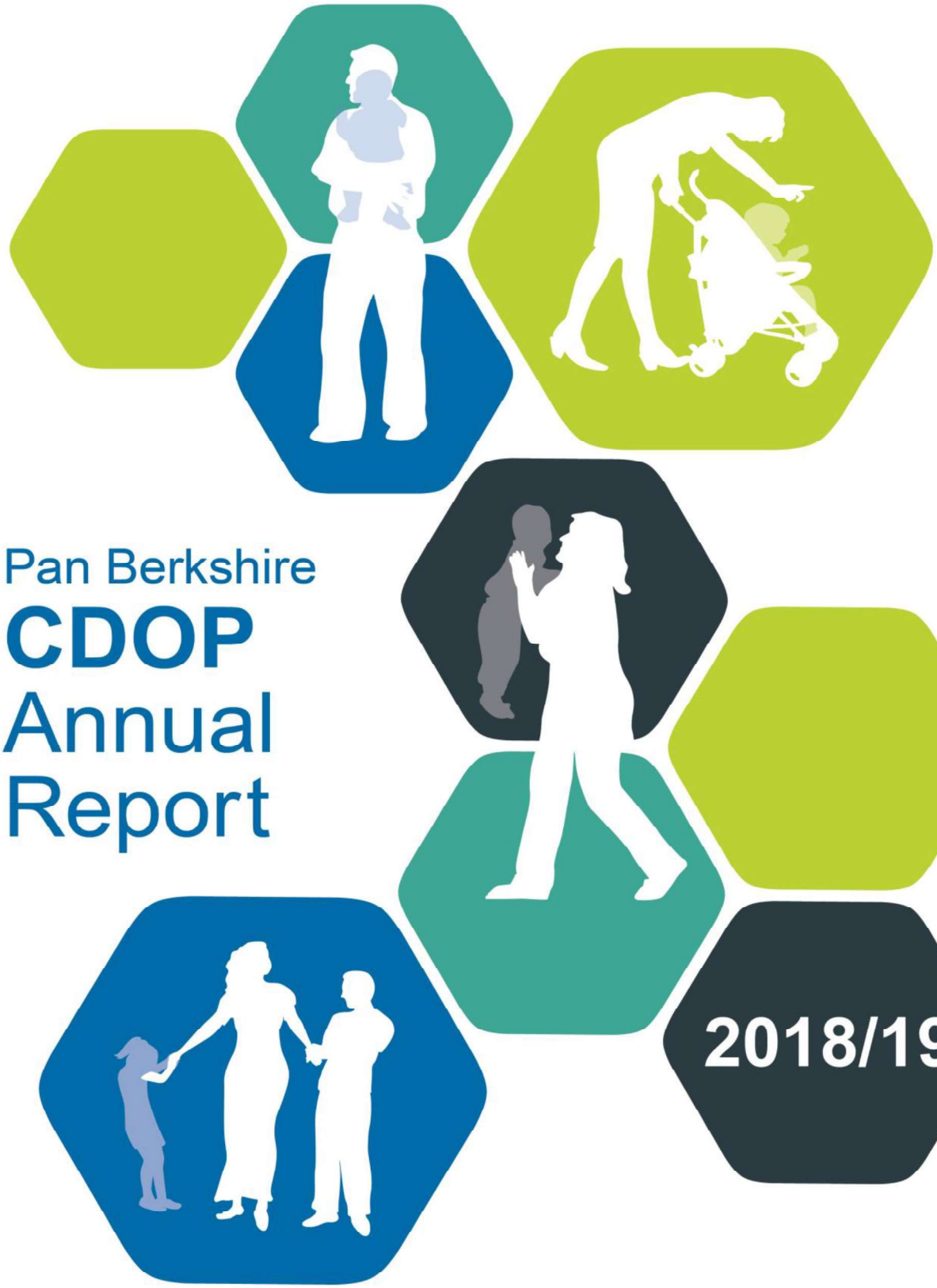

Pan Berkshire CDOP Annual Report

2018/19

Berkshire West Safeguarding Children Partnership
Reading | West Berkshire | Wokingham

Bracknell Forest Local Safeguarding Children Board

Windsor and Maidenhead Local Safeguarding Children Board

Slough Local Safeguarding Children Board

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FOREWORD

Every child death represents a tragedy, a life changing event for families and communities. Aiming to prevent deaths where we can and improve care and support for children, their families and communities, every child death is reviewed in detail, to draw out any learning and to apply those lessons for the future.

In Berkshire we run a joint Child Death Overview Panel, (CDOP) which looks at the causes of death and the services provided for all the Berkshire children that die. Our panel works across the six local authorities in the county, Bracknell Forest Council, Reading Borough Council, The Royal Borough of Windsor & Maidenhead, Slough Borough Council, West Berkshire Council and Wokingham Borough Council. CDOP members come from services that surround children, keeping them safe and well and caring for them and their families when they need it.

Each year we produce an annual report for our host Safeguarding Partnerships, highlighting our work, the learning we have identified for the system and our promotion of knowledge and skills in this arena.

This is the 2018/19 report of the Pan Berkshire CDOP panel. This was a year of change for the panel, with new guidance on investigating and responding to child deaths. The report reflects our continued commitment to review each death with respect, rigour and care to support our system to further learn and develop.

Tessa Lindfield

Strategic Director of Public Health for Berkshire

Chair of Pan Berkshire Child Death Overview Panel

Report written by Lorna Tunstall CDOP Coordinator

Introduction

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 October 2018 new guidance from Government titled 'Child Death Review (CDR) Statutory and Operational Guidance' https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england set out the key features of a good review process when a child dies, combining both statutory requirements and best practice. The Pan Berkshire CDOP assessed current processes against the new Guidance and put a plan in place to embed the necessary changes. Our formal response to the new Guidance was published on the CDOP website: New CDOP Arrangements – June 2019

During 2018/19 in Berkshire the CDOP was a subgroup of the Berkshire West Safeguarding Partnership (Reading, West Berkshire and Wokingham in collaboration) and the individual Safeguarding Partnerships (or Boards) of Bracknell Forest, Slough and Windsor & Maidenhead. It was made up of representatives from across the county from a range of organisations, including health, social care and police. The CDOP also had representation from those with experience of supporting families of children and young people with life limiting conditions and those 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 their future wellbeing.

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 seeks answers to these questions to prevent future child deaths and improve care and support to children and their 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 Assessments (JSNA)s, on how to best safeguard and promote the welfare of children in the area.

The Pan 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 are closely linked. All child deaths are to be notified to the Designated Person who is the CDOP Coordinator within the Safeguarding Partnership. Following notification, the CDOP Coordinator manages the information gathering and collation with all professionals who have been involved with the child or family prior to 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 involves discussion with a range of Child Death Review partners[1]; 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* (see below) meets quarterly and during this meeting reviews the death of every Berkshire resident child aged under 18 years in order to identify any themes, trends and learning. Under the new guidance the CDOP is required to finalise the "Analysis Form" (previously known as a Form C) completed by the Child Death Review meeting generally held 3 – 6 months after the death of the child in regard to its findings in relation to each child's death. The proforma collates information on;

- **the child and family, and service provision;**
- **identification of the key worker;**
- **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 Safeguarding Partnership 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

[1] Child death review partners" ("CDR partners") are defined in section 16Q of the Children Act 2004 and means, in relation to a local authority area in England, the local authority and any CCG for an area any part of which falls within the local authority area. CDR partners for two or more local authority areas in England may agree that their areas should be treated as a single area.

- 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 Health https://digital.nhs.uk/data-and-information/publications/statistical/child-death-reviews/2019 and we have referred to this review for comparison.

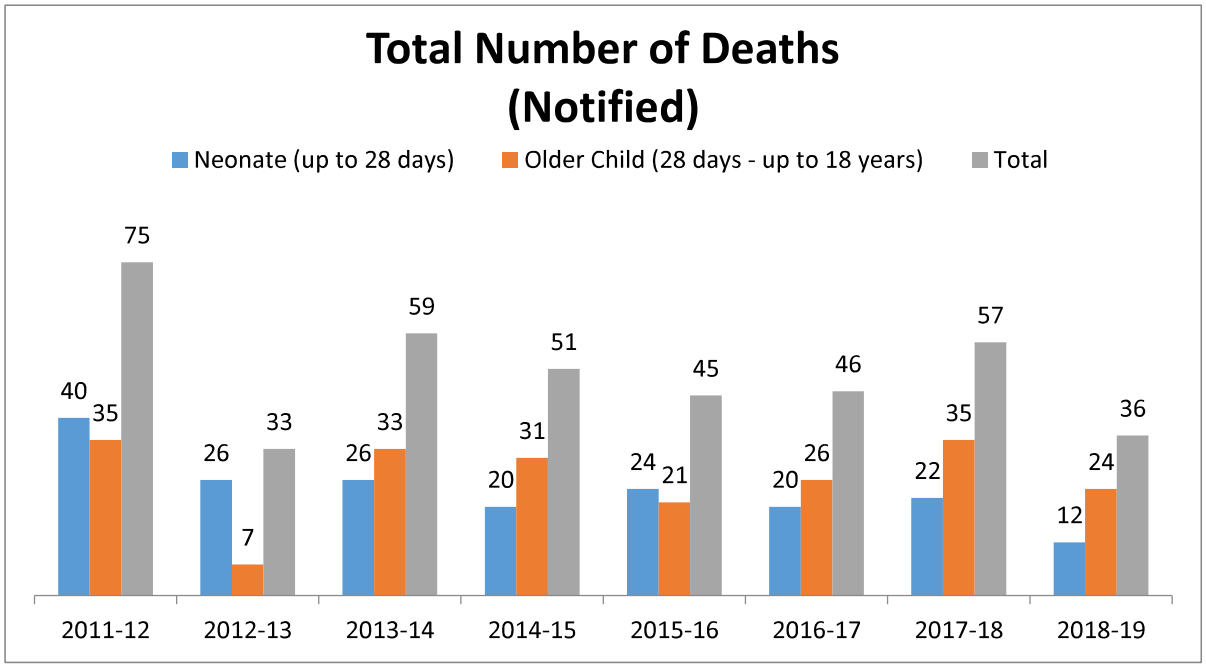
Our Activity

This section summarises data from all deaths notified to the Berkshire CDOP between 1st April 2018 and 31st March 2019. 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).

Throughout this report where numbers are <5 the data has been suppressed to prevent the identification of individuals.

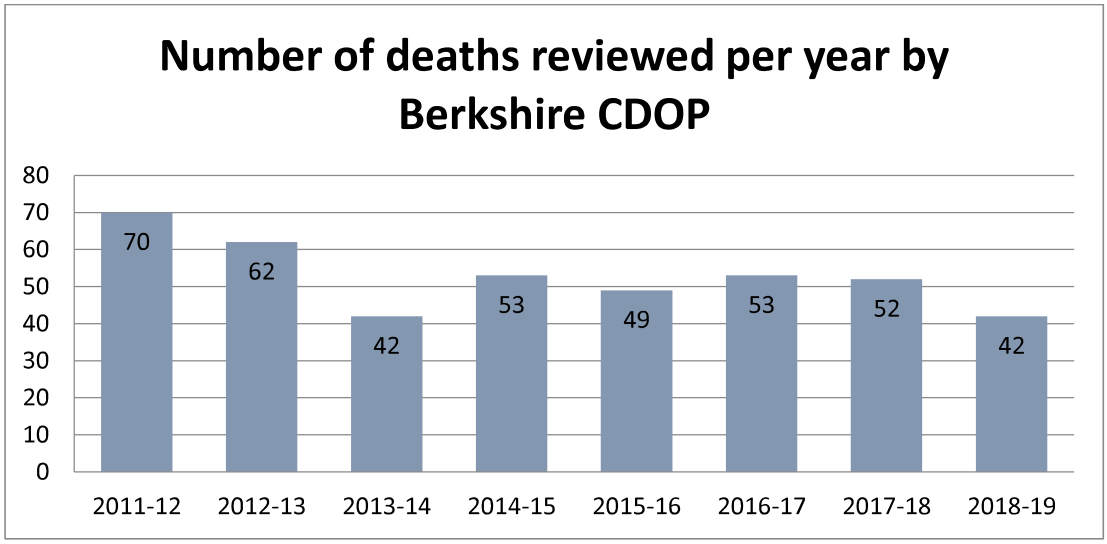
The total number of deaths which occurred during April 2018 and March 2019 was 36. The number of neonatal deaths was the lowest since 2011. However, for the older child (28 days – up to 18 years) numbers remained static. Because of the low numbers involved, we would expect the year on year numbers to fluctuate somewhat and the changes do not form a clear trend over recent years.

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



During 2018-19 there were 42 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 per year by Berkshire CDOP



In 2018/19, of the 36 deaths that occurred, 20 deaths were reviewed within the year with 16 outstanding at April 2019.

Of the 42 cases that we reviewed during 2018/19:

- 19 (45%) were reviewed within 0-6 months of child death
- 15 (36%) were reviewed within 6-12 months of child death
- 8 (19%) were reviewed 12+ months of child death

England & Wales data from 2018/2019 reported 69% of cases were reviewed within 12 months. Locally this year we achieved closure on 81% of cases within 12 months.

In cases where modifiable factors[2] were identified we would expect the process to be longer, indeed this is seen nationally. However, locally the majority of cases were reviewed within the first six months.

- Reviewed deaths with modifiable factors: 7
- 6 (71%) were reviewed within 0-6 months of child death
- 1 (29%) were reviewed within 6-12 months of child death
- 0 were reviewed 12+ months of child death

We reported in last year's Annual Report 2017/2018 there was one outstanding case not yet reviewed as at end March 2018. This is an overseas death that has involved lengthy criminal proceedings. All civil and criminal proceedings are now complete and an inquest has been held. This case is due to be reviewed at panel in October 2019.

[2]Modifiable factors are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Our Children

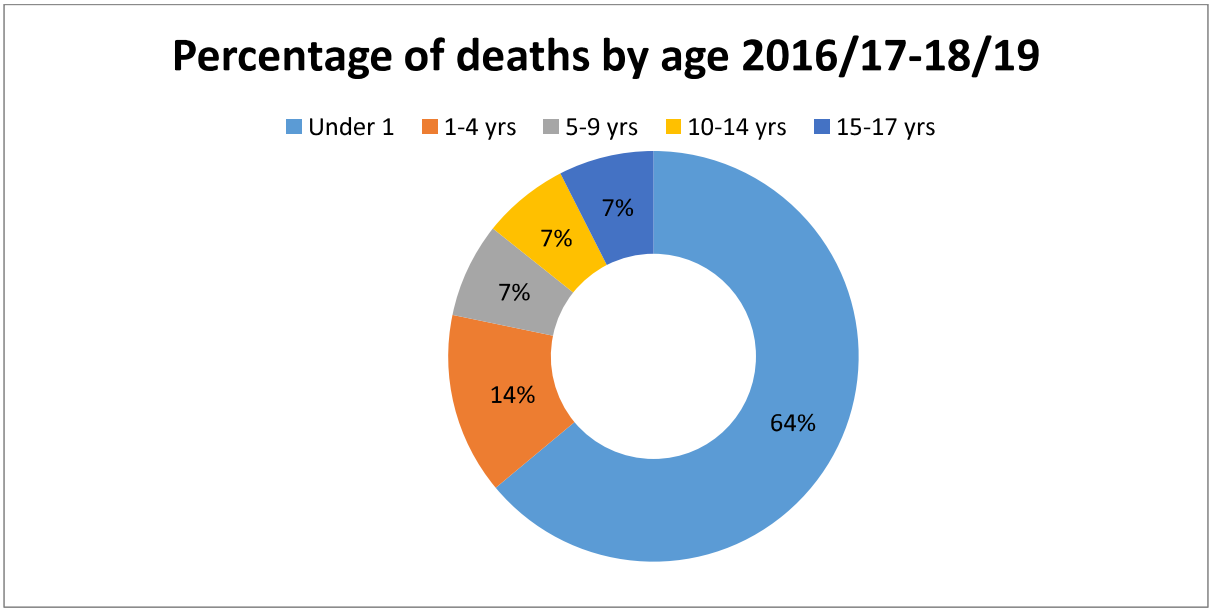
Age

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

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

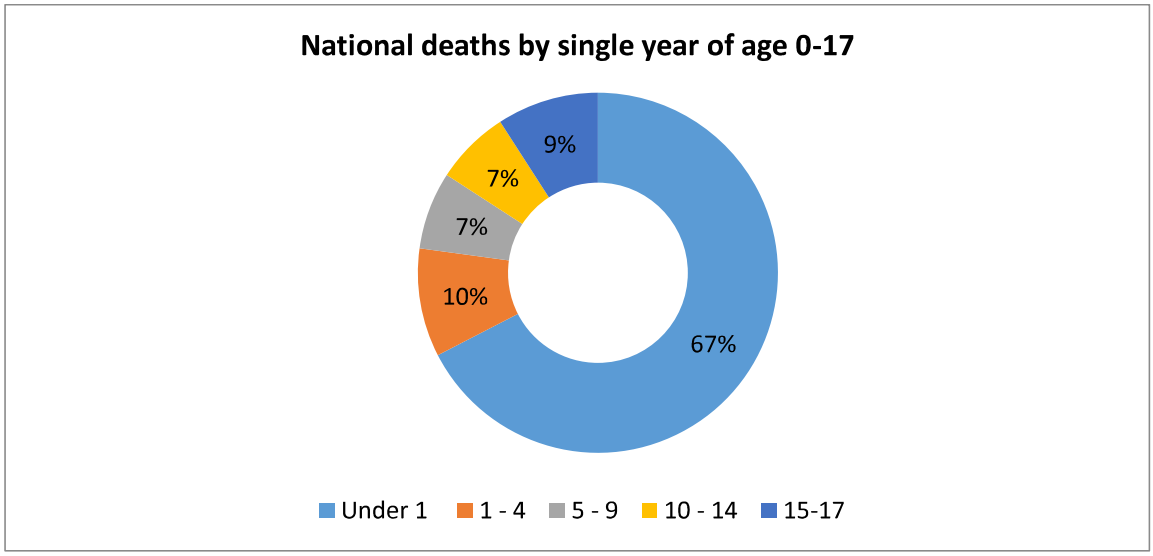
Locally, over the past six years the pattern of age at time of death has fluctuated slightly. This is to be expected because of the low numbers involved. Over the past 3 years, as can be seen from figure 3, the proportion of deaths in the neonatal period (under 28 days) and older children has changed, with neonatal now accounting for a higher proportion which is back in line with the national picture[3]. In 2018-19 58% of actual deaths in year were in children under 1 year (and of reviewed deaths 57% were under 1 year). This is broadly consistent with the national figure (61%).

Figure 3: Age at time of death 2016/17-18/19



[3] 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

Figure 4: National deaths by single year of age 0-17



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

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 third time in February 2019 to review all neonatal deaths in the period 01/01/2018 – 31/12/2018 and share the learning from this meeting. 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 all of the care for our cases had been as inpatients on the neonatal units.

The Neonatal panel consisted of the following CDOP members:

Consultant Paediatrician FHFT (Frimley Health Foundation Trust) and Chair of the CDOP Neonatal panel

Head of Midwifery FHFT

Consultant Paediatrician RBHFT (Royal Berkshire NHS Foundation Trust)

Maternity Clinical Risk Manager - RBHFT

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

Pan Berkshire CDOP Co-ordinator

Of the 16 deaths reviewed by the panel 12 cases were found to be caused by perinatal factors (Category 8) including smoking in pregnancy and chromosomal/genetic factors (Category 7).

This review identified the following learning points:

Excellent care

- All cases had received an internal review and there were examples of excellent practice including care delivery by senior clinicians from the outset.
- Examples of good antenatal discussions and counselling.
- Examples of good communication between care providers.
- Early consideration of culture specimens from placenta and bronchoalveolar lavage to aid with further management.
- Continued focus on thermoregulation despite prolonged resuscitation.
- Examples of bereavement support and counselling from local and specialist teams.

Learning from CDOP review of Neonatal Cases (2018)

Communication

- Importance of good communication at the time of handover of care for a woman in labour and of monitoring foetal wellbeing during labour.

- Importance of communication between Senior Obstetric and Neonatal Teams particularly in cases of preterm gestation.
- Importance of confidence to act if a response does not sound right - to escalate for a Consultant to Consultant discussion.
- To keep parents informed if a review of the care is to take place and ensure their perspective and questions are addressed in the review.
- To consider checking parental expectations when patients are moved between care providers.

Recording

- Always check that the cause of death is accurately recorded in the notes and that it is the same wording as that on the Death Certificate.
- Remember to complete all necessary documentation correctly to avoid delays in cremation because of incorrect paperwork.
- If there is a death checklist in place – ensure that this is fully completed.

Clinical

- The transport team have a role to support the local neonatal unit in stabilising a baby on site in addition to transporting the child.
- Remember to consider alternative diagnoses – for example a baby with Hydrops and Pleural Effusions can also have Respiratory Distress Syndrome and may need surfactant.
- Consider collecting samples for genetic analysis particularly if the diagnosis is unclear.
- Consider early escalation to a Consultant regardless of time of day or night.
- Community midwives should ensure that guidance is followed for risk assessment of women to facilitate allocation of the correct care pathway.

Application of Learning - Changes in Practice

- There has been a guideline change at Frimley Health to offer a single growth scan at approximately 32 weeks gestation if the PAPP-A level is low at screening.
- Royal Berkshire Hospital (RBH) is looking at the provision of a second Consultant on call from home for Obstetrics.
- Wexham Park Hospital (WPH) has checked that adequate gas supply is available for resuscitaires.
- RBH are developing a guideline for the in-utero transfer of women in preterm labour – this is likely to be used across the Network.
- RBH are conducting an external review of Neonatal Deaths as part of their ongoing quality improvement programme.
- RBH are updating their guidance on re-evaluation of risk assessment at the onset of labour.
- A themed panel for Neonatal Cases is under consideration in partnership with Oxfordshire and Buckinghamshire CDOPs. It could be particularly useful to involve a Neonatologist from Oxford as a number of babies are transferred there prior to death.
- Currently the review team receives a copy of the Badgernet Discharge Summary which is not considered sufficient to conduct a review. It was agreed that all units must submit a copy of the Network Mortality Governance Review Form, a copy of learning from the RCA (Root Cause Analysis)/SI (Serious Investigation) if carried out and a copy of recommendations from the PMRT (Perinatal Mortality Review Tool) and HSIB (Healthcare Safety Investigation Branch) investigations. The HSIB is a national body which looks at patient safety incidents.

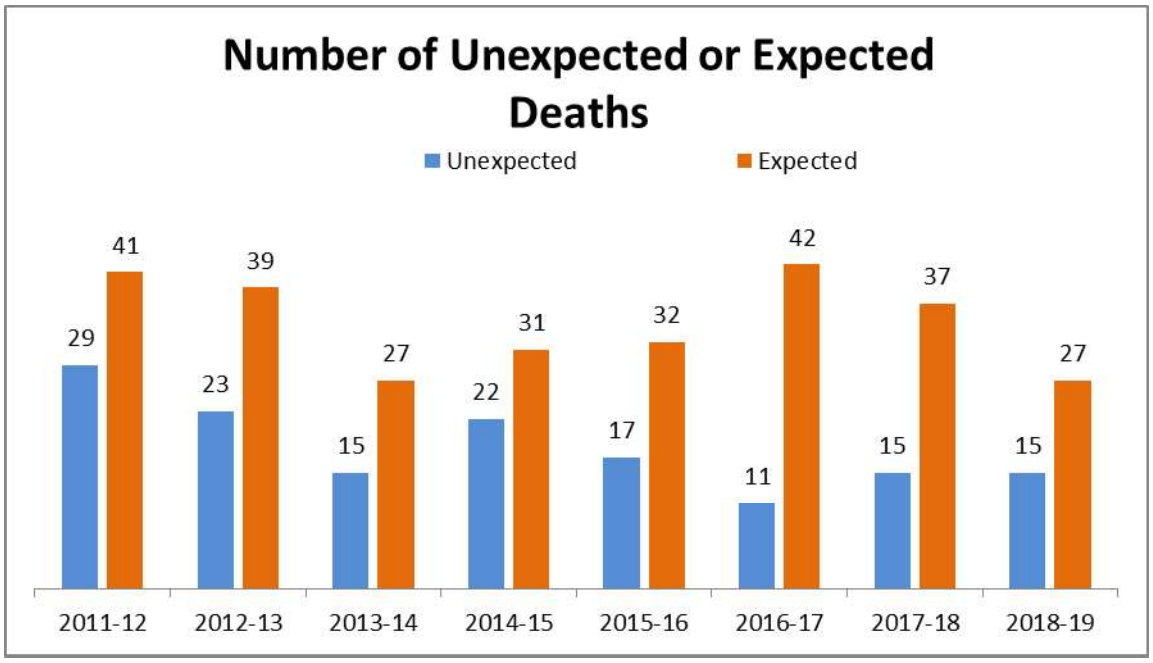
- A Network wide Organ Donation Policy for Neonatal Deaths has been suggested.

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.'

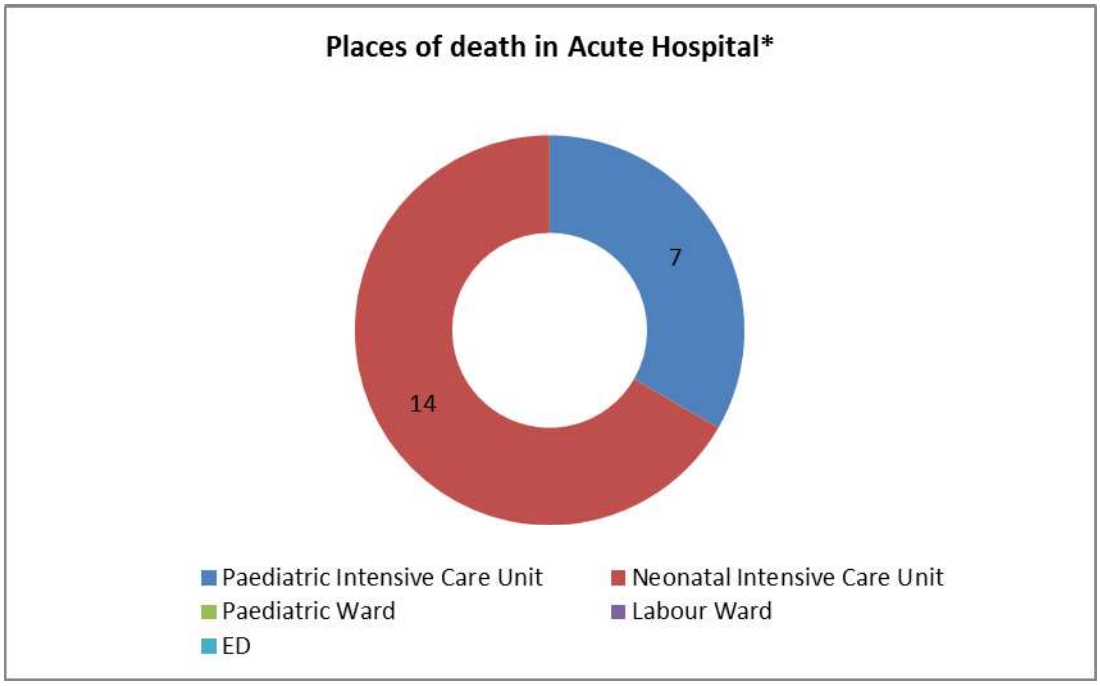
Looking at all the deaths in 0-18 years in 2018/2019 15 unexpected deaths were reviewed. 8 have documented rapid response reviews[4]. The remaining 7 cases were unexpected but explained and didn't meet the criteria for a Rapid Response Meeting (now known as a Joint Agency Response or JAR). During the last seven years the proportion of unexpected deaths continues to fall although this year the numbers remained the same. 76% of all deaths occur within the hospital setting. Figure 6 overleaf is a breakdown of location of death within a hospital setting.

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



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

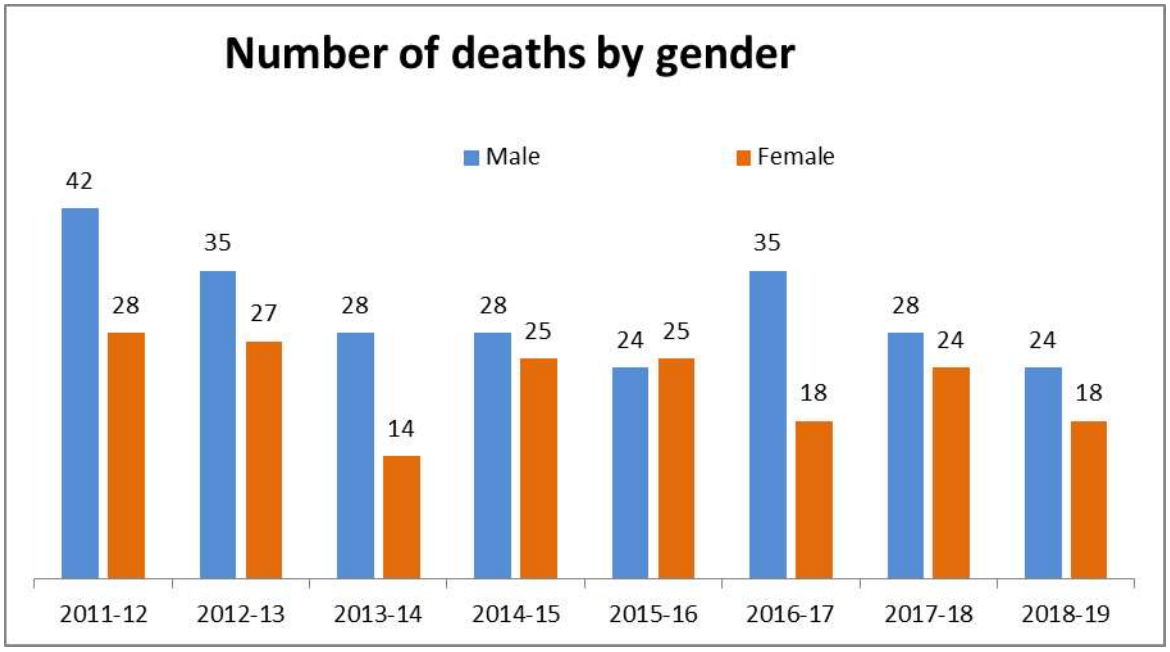
Figure 6: Places of death in Acute Hospital
***Numbers are suppressed in some categories because there are <5.**



Gender

Figure 7 shows the pattern of deaths for males and females. Over the last seven years there have been more notifications of male deaths than female deaths. In 2018/2019: 57% were males and 42% females. This pattern is reflected in the national data: of the 3,215 child deaths reviewed between 1st April 2018 and 31st March 2019, 56% were for male children and 42% female children. There were 2% cases where the gender was not known.

Figure 7: Deaths by gender, per year

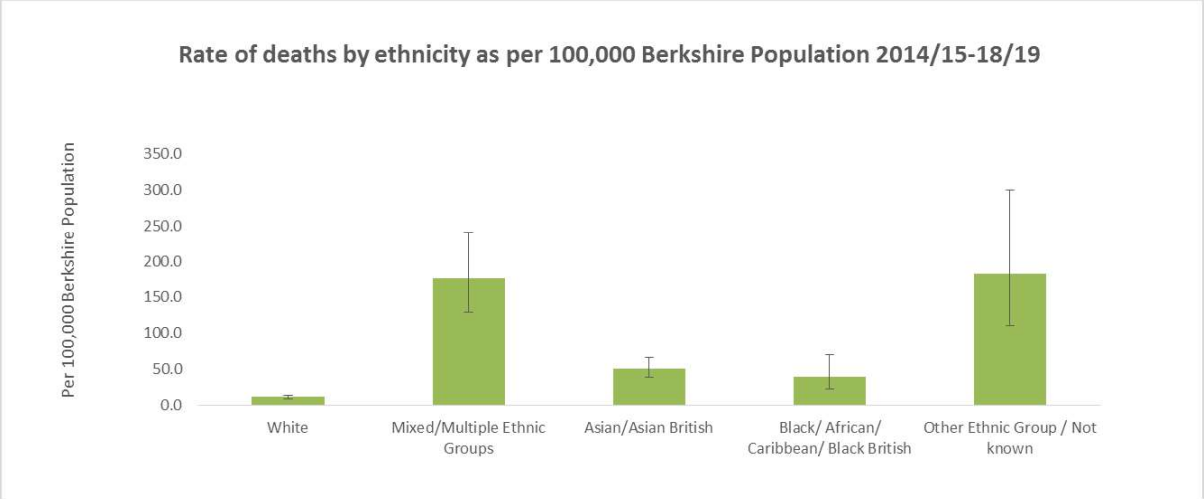


Ethnicity

The 2011 census, found Berkshire's general population to be 80.04% white with some Boroughs having more ethnic diversity than others, particularly Slough and Reading.

Figure 8 shows rates per 100,000 of the Berkshire population to compare ethnic groups. The white population group has lower rates than other ethnic groupings.

Figure 8: Deaths by ethnicity in Berkshire, 2014/15 – 2018/19



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 risen to 30% in 2018/2019. Locally in 2018/2019 of all cases reviewed 16% were considered to have modifiable factors including:

- Consanguinity
- Smoking in pregnancy
- Co-sleeping
- Risky behaviour
- The giving of timely pneumococcal vaccines

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 Health. The numbers in each category are collated for learning within the CDOP. This process is subject to the scrutiny of the Safeguarding Partnerships/LSCBs and Independent Chairs.

Summary of CDOP key findings during 2018-19

See Pages 10/11 for learning from the annual neonatal review

Specific areas for learning have been identified by the panel around:

- 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 the 2010 programme and new migrant children with incomplete UK vaccination coverage.
- 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, in particular listening to 'the voice of the child' and recognising patterns of behaviours that intimidate where there is partial or disguised compliance.
- The need to highlight the risks of using a mobile phone whilst driving.
- Continued close collaboration with Festival Republic, Thames Valley Police and other partners to learn from ED, safeguarding and other data gathered during Reading Festival.
- Ongoing vigilance to identify potential patterns of child deaths.
- Ongoing training around unexpected child death and the purpose of CDOP.
- The need to continue to work sensitively with local communities around consanguinity risks.

Reflections on the work of CDOP

The Panel - Changes

During the past year the panel has continued to maintain good operational performance against national standards whilst making arrangements for sweeping changes to Child Death Review. The CDOP is well attended by relevant partners. Discussions are thorough and considered of high quality.

In January 2019 the panel decided to restructure the CDOP into two meetings – described below:

- A small multi-agency CDOP Executive Group led by Child Death Review Partners has been formed to drive the CDOP programme across Berkshire. This group meets separately from the main panel meeting where cases are discussed.

- The CDOP panel meetings are structured in a manner to focus the discussion on learning - key people are present but the group is not too unwieldy.

- The panel agreed to attend for cases where they considered their input would be beneficial to the process and liaise with partners to cross-cover where this was appropriate and attend virtually where this was more time efficient.

Appointments

Tessa Lindfield, Strategic Director of Public Health, Public Health Services for Berkshire, became the Chair of CDOP in July 2018 and Liz Stead, Head of Safeguarding Children, Berkshire West CCG, was confirmed as Deputy Chair.

Improvements

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 Safeguarding Partnerships/LSCBs for their attention and action.

Campaigns

Lift the Baby

Issues were noted by the CDOP where safe sleep recommendations had not been followed. As there is evidence based prevention practice in this area, it was felt to be a useful area for further action.

As a result players from London Irish Rugby Club have teamed up with health chiefs to launch a major video campaign aimed at cutting baby deaths. The video is the result of a year long piece of work pioneered by Berkshire West CCG, East Berkshire CCG and a range of health partners.

Launched in London on Tuesday 25 June 2019 the video is called Lift the Baby and is aimed at promoting safer sleeping in younger babies. A special website has been developed in partnership with the Lullaby Trust and features a link to the video along with a range of safe sleeping advice.

We were delighted that the "Lift the Baby Campaign " won silver in the UK Public Sector Communications Excellence Awards held in Manchester earlier this month. It was in competition with more than 80 other publicity campaigns including ones from the Metropolitan Police and Department for Work and Pensions. Further details about the award can be found on the link below.

https://liftthebaby.org.uk/baby-safety-film-takes-top-award/

www.liftthebaby.org.uk

Reading Festival

A Reading multiagency partnership group worked with Festival Republic, to develop a robust action plan in response to concerns at Reading Festival. That plan was circulated to CDOP and the LSCB in the months leading up to 22nd-27th August 2018 and tested at table top exercises.

Drowning

Following two deaths by drowning in Slough's Jubilee River in summer 2018 including a Slough teenager, the Community Safety Team at Slough Borough Council undertook to work with agencies to look at what could be done to minimise further deaths. Working with the Environment Agency, who have lead responsibility for the river, as well as Thames Valley Police, Berkshire Fire and Rescue Service and The Riverside Centre, the following actions have been taken:

- Fencing has been replaced to make it more difficult to access the river and new signage about the dangers of the river and weir has been put on site.

- The TVP schools liaison officer has been talking to young people about water safety as part of her personal safety sessions.

A leaflet has been produced about the dangers of the river; this has been shared via the CDOP newsletter, social media and services that work with school children and young people across Slough. A local family who lost a child to drowning agreed to engage with local press to support this prevention messaging. The same information has been sent out on The Link, which all Slough schools can access, along with information for contacting the fire service about road and water safety sessions: https://thelink.slough.gov.uk/news/stay-out-jubilee-river-hot-weather

Training

In response to requests for better understanding of the processes around unexpected child death and the purpose of CDOP the following training was provided by the Designated Professional Child Death, Berkshire West:

- 2 hour 'Learning from Child Death' and CDOP, Addington School – 17th May 2018 – 12 people attended.
- 2 hour 'Learning from Child Death' and CDOP, Brookfield School – 5th July 2018 – 10 people attended.
- 2 hour LSCB 'Learning from Child Death' and Safeguarding – 1st October 2018 – 40 people attended 1 hour 'Responding to and Learning from Unexpected Child Death', Regional Paediatric Registrars Training Days – 18th October 2018 and 20th May 2019 – 40 + trainee paediatricians attended.

This was in addition to sessions, provided twice a year as part of the RBFT level 3 safeguarding training.

CDOP Conference

Pan Berkshire CDOP held its third multi-agency training day entitled "Saving Children's Lives" on 24th April 2019 at Reading University with 80+ people attending. The aim of the day was to promote knowledge and understanding of the CDOP processes within Berkshire.

This year's presenters focussed on the older child and young person; those living with complex health needs; neuro developmental disorders and acquired brain injury who may be vulnerable to exploitation and violence. Their aims were to get the messages out on the learning from child death review, serious case reviews and near misses.

The keynote speakers were Detective Chief Inspector Christina Berenger, *PVP (Protecting Vulnerable People) Berkshire, Thames Valley Police* - Every Child Matters
Dr Sarah Hughes, *Paediatric Consultant in Neurodisability, Dingley Child Development Centre and the Royal Berkshire Hospital, Reading* - Being and Dying: Experiences of Death in Disabled Children
Superintendent Stan Gilmour, *Local Police Area Commander, Reading* – 'Understanding Trauma' risks, rights, resilience and relationships

Successful CDOP campaigns were shared with delegates around safe sleeping; improving the health, wellbeing and safety of young people at Reading Festival and raising awareness of Pneumococcal death and its prevention in 'at risk' groups.

This was followed by break out groups with practical sessions reviewing cases. Delegates were able to peruse a marketplace of exhibition stands which was a new feature for this year. Our event counted as a full day CPD training course and Level 3 Child Protection training. The event received very positive feedback by delegates including feedback about future training needs and themes. A full evaluation is attached. Conference evaluation

Details of the day can be found on the CDOP website link
http://www.westberkslscb.org.uk/professionals-volunteers/cdop/

eCDOP

The purchase of eCDOP (an online recording, casework and reporting system for child deaths) went ahead towards the end of 2018 and the system went live on 1st April 2019. A roll out of training with partners is well underway. Sessions with Police CAIUs (Child Abuse Investigation Units) East and West; the Paediatric Consultants at Wexham Park Hospital and staff at the Coroner's Office have already been completed. Training for Royal Berkshire Hospital staff and GPs is planned for October 2019.

eCDOP has now been adopted by over 100 CDOPs nationally and has been well received within the CDOP network enabling the sharing and managing of information regarding child death to be made totally securely.

eCDOP links into both the Department of Health national dataset (submitted annually) and the National Child Mortality Database (NCMD) developed by the University of Bristol which went live on 1st April 2019. 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.

LeDeR

The panel notified 7 cases to the LeDeR (Learning Disability Mortality Review) based at the University of Bristol. Cases will be reviewed locally within the LeDeR network and information shared with the CDOP when relevant.

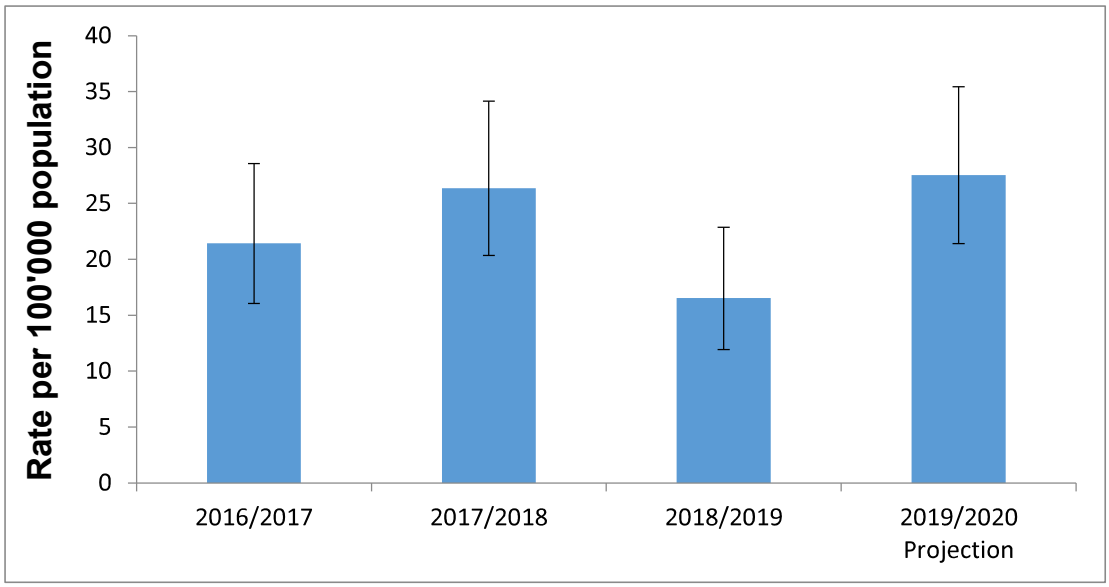
Data Analysis

The number of child deaths in Berkshire, from 1st April – 31st August 2019, was 25. This figure was higher than expected and prompted a review of the data.

Data for the number of child deaths in Berkshire was gathered for the financial years 2016/17, 2017/18, 2018/19. An annual rate of child deaths per 100,000 population, was modelled and compared with recent years to assess if this was a meaningful trend.

Confidence Intervals and the results were graphed as in Figure 9. There is no statistically significant increase in the rate of child deaths in Berkshire over the last 3 years or the projected rate of child deaths for 2019/2020.

Figure 9: Graph showing the number of child deaths per 100,000 population in Berkshire between 2016/2017 and 2018/2019



Sources: 1. Child death data gathered from Child Death Overview Panel Berkshire
2. Population estimates gathered from nomis - 'Population estimates - local authority based by single year of age'

Pan Berkshire - End of Life Pathway

Berkshire West (BW) CCG has shared with the CDOP Executive Group the proposed End of Life Pathway offer for Berkshire, seeking approval to enable the pathway to be further agreed by the wider health partnership or the Integrated Care System(s). Approval was given by the CDOP. This report is the first step towards assuring the CCG and health partners that the right pathway and service offer is in place for children and young people in their end of life journey.

Themed Reviews

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

A review of knife crime was commissioned during 2017/2018 which will now feed into the regional work on preventing violence.

Priorities for 2019/20

- New local multi-agency safeguarding arrangements are planned (as of June 2019) in line with Working Together 2018 but partners in each of the Berkshire areas have committed to continuing to work as a Pan Berkshire arrangement for certain statutory responsibilities such as CDOP. Safeguarding concerns will continue to be considered as part of the new CDOP arrangements and any significant safeguarding issues identified will be formally reported to the statutory safeguarding partners of the area concerned.

- The CDOP will carry out a review of the implementation of the new arrangements for Child Death Review later this year to see how the new processes and procedures are bedding in.

- A review of the training offer from CDOP for 2020 will be carried out as it is felt a new format of small in-situ workshops aimed at reaching groups who are not normally able to attend the training day e.g. GPs could work really well.

- The CDOP will build on our work to reduce 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 CDOP website will be moving from its current host Phew when the contract ends in 2020. We are looking to relocate to the Berkshire West CCG/Berkshire East CCG websites.

- With the changes to Child Death Review implemented we will be updating all our documentation including the CDOP Induction Pack and Terms of Reference.

For 2019/2020 we will be carrying out thematic reviews on the following:

- Clarification of the arrangements within Berkshire for the transportation of children's bodies after death.

- Using data provided by SCAS (South Central Ambulance Service) the CDOP will carry out a review of drownings and near drownings over 5 years within Berkshire.

- Looked After Children.

- Domestic Abuse.

A 10 year audit of deaths in neurodisability across Berkshire expects to publish by end of Q1 2020.

Lorna Tunstall

Pan Berkshire CDOP Coordinator, November 2019

Berkshire West Safeguarding Children Partnership
Reading | West Berkshire | Wokingham

Bracknell Forest Local Safeguarding Children Board

Windsor and Maidenhead Local Safeguarding Children Board

Slough Local Safeguarding Children Board