**A dirt road lined with trees

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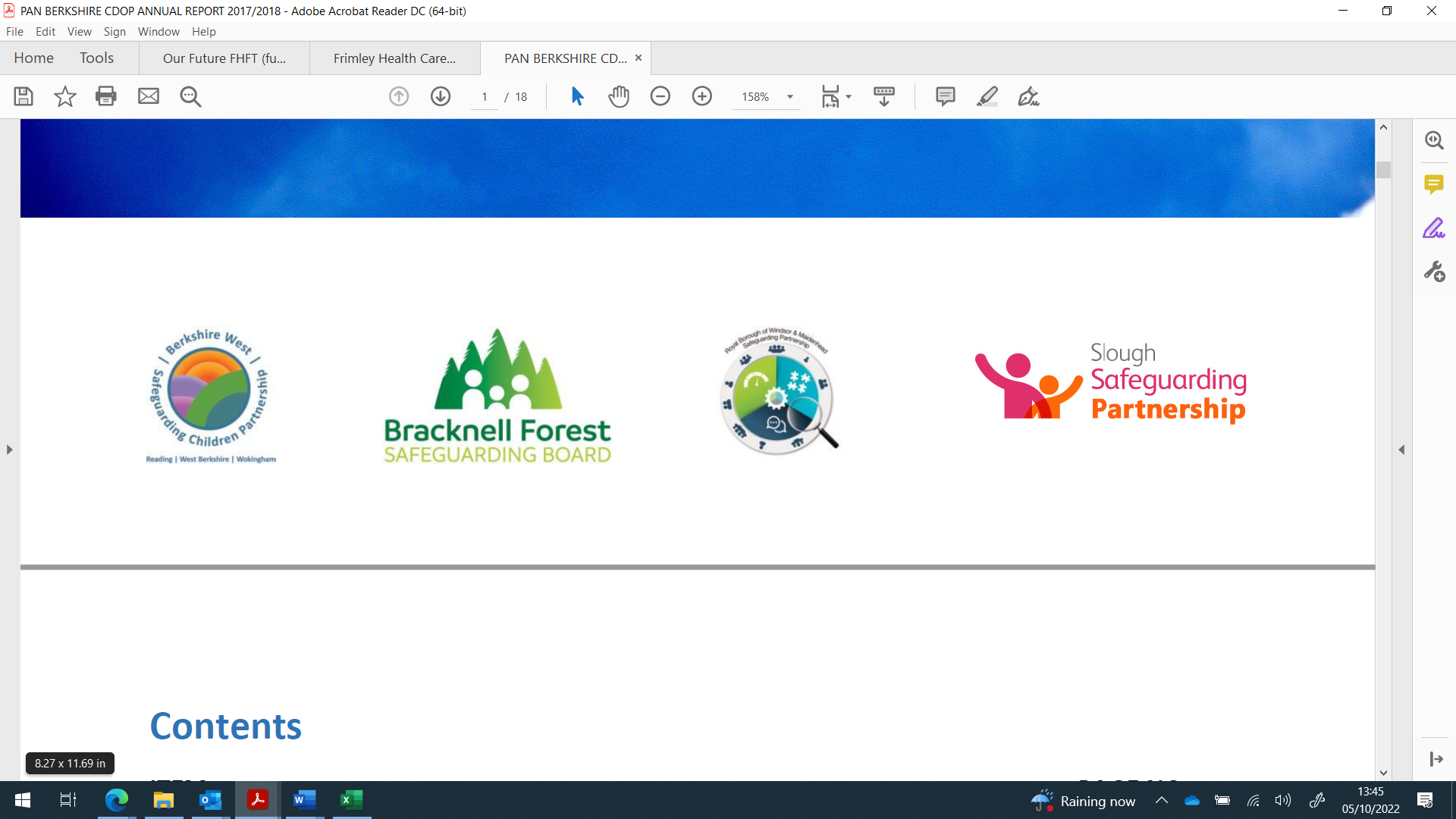
Pan Berkshire

Child Death Overview Panel

Annual Report

2021/22

1st April – 31st March



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**Chair Foreword**

Every death of a child is a tragedy for all those involved. Learning from these events is important in helping prevent deaths of children and young people wherever and whenever it is possible.

Our Child Death Overview Panel (CDOP) is made up of professionals from different organisations across Berkshire and is part of a national programme to examine all deaths in children. Our job is to look at the circumstances around the child and determine what can be learned, to prevent further deaths and better support families and communities affected by the death of a child. There is a broad network of committed and inspirational professionals across Berkshire who contribute to this work, and it is a pleasure to work alongside them. Their work is often unseen but crucial in improving services and support for children, their families, and communities.

During 2021/22 we have developed our ways of working to accommodate the challenges presented by the pandemic and post pandemic and put in place processes to improve our focus and effectiveness.  eCDOP is fully embedded as the web-based tool for child death review management and information from our case reviews on eCDOP are fed into the National Child Mortality Database (NCMD). This is important as it enables the early identification of any patterns there may be locally and nationally, so enhancing our learning and improving opportunities for intervention and prevention. We have also continued to streamline our panels to support better discussion and analysis and are working through an executive group to drive further improvements and coordination.

The report outlines the numbers and patterns of child deaths across Berkshire.  It also reports on our performance in reviewing the deaths and sharing learning. Our numbers are small and therefore we see some fluctuation, but the overall trend is downward, and our reviews are completed in a timely manner.

**Stuart Lines FFPH**

Joint Director of Public Health for Berkshire East & Frimley

*Slough Borough Council | Royal Borough of Windsor & Maidenhead | Bracknell Forest Council | Frimley ICS*

Chair of Pan-Berkshire Child Death Overview Panel (CDOP)

*Public Health Hub Berkshire East*

# **Introduction**

**The Aims of the Report**

The aim of this report is to summarise the work of the Pan Berkshire Child Death Overview Panel (CDOP) during the period of 1st April 2021 – 31st March 2022. The purpose is to:

* Summarise local patterns and trends in child deaths
* Identify any lessons learnt and actions taken
* Summarise the effectiveness of the child death review process

This analysis is based on the child deaths that have been reported and reviewed by the panel. This report is primarily produced for Child Death Review (CDR) partners in accordance with the Statutory and Operational Guidance.

Fortunately, the number of cases of child deaths is small and therefore some of the data cannot be shared to ensure compliance with data protection legislation; specifically, statistics representing fewer than five cases will not be published. As a result, it is not possible to draw significant conclusions from the data available from one singular year. Three-yearly data has been collated regionally and nationally to overcome this.

**Introduction**

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

# **Introduction**

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.

In 2008, Child Death Overview Panels were statutorily established in England as set out in Chapter 7 of ‘Working Together to Safeguard Children 2008’ with the responsibility of reviewing all deaths of children up to 18 years in their resident population. This excludes stillbirths, late foetal loss, and legal terminations of pregnancy.

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.

A National Child Mortality Database (NCMD) was set up in April 2019 to enable more detailed strategic analysis and interpretation of the data arising from the complete Child Death Review process across England. CDOPs are required to submit copies of their data collected and analysis via eCDOP to the NCMD who will ensure that learning from the reviews of child deaths is widely shared, locally and nationally with the aim of saving lives. With the establishment of the NCMD, the quality of local CDOP data collection has seen improvements compared to previous years. Consistent and enhanced local data has allowed the NCMD to conduct national analysis and produce a variety of reports and findings: <https://www.ncmd.info>.

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.

# **Introduction**

The key functions of CDOP are the following:

* To collect and collate information about each child death, seeking relevant information from professionals.
* To analyse the information obtained, including the report from the Child Death Review Meeting (CDRM), in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths.
* To make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety, and wellbeing of children.
* To notify the Child Safeguarding Practice Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected.
* To produce an annual report for CDR partners on local patterns and trends in child deaths, any lessons learnt, and actions taken, and the effectiveness of the wider child death review process; and
* To contribute to local, regional, and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection reviews is to understand how and why children die, put into place interventions to protect other children, and prevent future deaths.

**Membership**

The CDOP is made up of senior representatives from a range of organisations; including local authorities (Public Health, Children’s Social Care); NHS (2 local designated doctors for child deaths: one for Berkshire West and Berkshire East, safeguarding, primary care, nursing and/or midwifery); safeguarding partners, ambulance services and police. Outside of the core memberships, the CDOP also considers representation from additional professionals on a case-by-case basis, for example: the coroner’s office, education, council services, health and wellbeing board, hospices, or relevant experts.

# **The 2021/22 CDOP Process**

**How was the 2021/22 Pan Berkshire CDOP Annual report prepared?**

Resources used:

* Data collected from eCDOP 2021/22
* Minutes of CDOP panel meetings and Neonatal panel meetings in 2021/22
* The England CDR Statutory and Operational Guidance
* National Census Data 2011
* Child death review data release 2020/2021

Data Management Decisions:

* Due to small numbers and the need to keep with data protection legislation, much of the data has been presented as 3-year averages.
* Frequencies smaller than 5 will be presented as <5 in keeping with data protection legislation.
* Where comparisons with national data are made, we used 2018/21 as the most recent reporting period as NCMD data for 2021/22 has not yet been published at the time of this report’s release.
* 2019/22 period was used for the categories of death as digital data for the year 2018/19 was incomplete via eCDOP due to the transfer from physical to digital data storage that year, and it had not been collated previously.

**How did the Pan Berkshire CDOP operate in 2021/22?**

During 2021/22 the Pan Berkshire CDOP was a subgroup of the Berkshire West Safeguarding Partnership (Reading, West Berkshire, and Wokingham in collaboration) and the individual Safeguarding Partnerships of Bracknell Forest, Slough and Windsor & Maidenhead. The panel’s geographical coverage includes all children who died in the area and children residing in the area but who died elsewhere. The CDOP met as a review panel four times in 2021/22, with two separate themed neonatal panel meetings held. Joint Agency Response has been conducted for all sudden and unexpected deaths.

# **The 2021/22 CDOP Process**

**Prioritisation for panel meetings was made for cases with the earliest date of death. Reviews for individual cases may be delayed due to post-mortems, coroner’s inquests, serious incident / police investigations, and cases requiring review by the Court.**

**Training**

* A training need was identified for the relaunched joint home visiting service. As a result, a half day course was codesigned and delivered online for BHFT Rapid Response nursing team who provide joint home visits with TVP.
* RBFT Training - Saving Young Lives Child Death – Overview and Learning sessions provided at all face-to-face full level 3 child safeguarding days to raise the profile of the child death review process.
* A Pan Berkshire key worker audit was completed to find out how the key worker role is working in our community and identify any gaps in the service. A local thematic review was carried out on the role of the key worker.  It was agreed that a priority would be to develop a training course bespoke to key workers in the Pan-Berkshire area. A workshop was arranged for September 2022 but was postponed until January 2023.

**Staffing**

* Succession planning – Dr K, Consultant Paediatrician shadowing Designated Professional, from April 2021 and took over the responsibilities of the Designated Doctor on 31/12/21 for Berkshire West
* Appointment of Pan Berkshire CDOP Administrator in January 2022 to work alongside the CDOP Coordinator

# **The 2021/22 CDOP Process**

**Compliance**

Berkshire East and Berkshire West was compliant with Child Death Review Statutory and Operational Guidance 2018:

* Child Death Review meetings – established
* Berkshire wide thematic CDOP working group safe sleeping established 2021/22
* JAR process for all unexpected child deaths in 2021/22 triggered
* When a child dies: A guide for parents and carers available
* Appropriate key workers appointed for all child deaths

**Challenges**

The CDOP have been working hard on reducing the backlog of cases to be reviewed at panel. Some cases remain open due to a continued delay in the coronial process including post-mortems being carried out and inquests not held due to the impact of Covid 19. Information gathering has been hampered at times by safeguarding and clinical teams’ capacity pressures.

**Acknowledgements**

Thank you to the team who wrote and produced this report, in particular:

Kin Lam, Foundation Year 2 Doctor

Lorna Tunstall, Pan Berkshire CDOP Coordinator

Anne Miller, Pan Berkshire CDOP Administrator

Rebecca Willans, Public Health Consultant Berkshire East

# **Our Activity in 2021/22**

51

Deaths reviewed in 2021/22

57

Death notifications in 2021/22

Figure 1 summarises the cases reviewed in the 2021/22 CDOP by year of death. Out of the 51 deaths reviewed in 2021/22, 67% were of children who died during the year 2020/21, and 10% were of deaths in 2021/22. **Hence, the majority of data on reviewed deaths in this report reflect deaths which occurred in previous years.**

# **Our Activity in 2021/22**

As shown in Figure 2, following the dip in the number of cases reviewed over 2019/20 and 2020/21, the CDOP panel were able to review similar numbers of cases to pre-pandemic levels in 2021/22. The number of reviewed deaths across the last three years have been very similar between the Berkshire East and Berkshire West local authority areas (Figure 3). There was a comparable number of deaths notified to Berkshire CDOP between 2019/20 and 2021/22. The general trend in death notifications shows a small fluctuation which is expected from the small numbers, and the lack of major variations is reassuring.

Additionally, the median number of days between death and review by CDOP is 404 days. This compares with the national average (335) and the 2020/21 local performance (364). This is most likely due to the accumulation of workload secondary to the pandemic.

# More male children’s deaths have been reviewed compared to females during 2021/22 CDOP (Figure 4). This is in line with the national picture for child deaths where <18 males have a higher mortality rate than females. The trend is fairly consistent for Berkshire, likely reflecting a higher number of deaths notified to the panel for review among males.

# **Our Activity in 2021/22**

Figure 5 shows the number of cases reviewed by age of death in 2021/22. Children who died under 1 year of age made up over half of the total reviewed deaths in 2021/22 (57%); of these deaths, just over half were of neonates (0-27 days of age). This was followed by the 1- to 4-year-olds (17%) and the 5- to 9- year-olds bracket (12%), with just under 14% of total cases reviewed being of children aged 10 to 17.

In terms of ethnicity, the largest proportion of deaths reviewed in 2021/22 were of white children (41%) (which includes white British and white other), followed by those of Asian/Asian British ethnicity (31%). It is worth noting that this data does not take into account the ethnicity makeup of the local area as the number of deaths is so small by ethnic group. It would not be statistically appropriate to generate this information as age adjusted rates annually therefore, we have explored this in the next section of the report as three-year averages instead and compared to national statistics.

**Comparison of Berkshire child deaths with child deaths nationally**

**This section of the report presents three-year averages for 2018-2021 for most of the statistics (other than categories of death data, which is shown for 2019-2022) to aid comparison of child deaths in Berkshire with national data. This is because the small number of local deaths mean data fluctuates annually; this approach attempts to rectify that and enable a more accurate comparison.**

**Gender**

Between 2018-2021 there has been a higher proportion of male deaths reviewed compared to female deaths in Berkshire, consistent with the national picture (Figure 6).

**Age**

In line with recent local data and national picture (Figure 7), neonates (0-27 days) remained the age group with the most cases reviewed, followed by 28-364 days and 1-4 years. Figure 8 showed the local trend of age ranges of child deaths, which has been fairly consistent bar increased neonatal deaths reviewed in 2015/18. Zero neonatal deaths were reviewed by the Berkshire CDOP in 2019/20, as a consequence of the pandemic. This lowered the average proportion of neonatal deaths reviewed in the reporting period 2018/2019 – 2020/21. Neonatal panels were held throughout 2021/22 with an aim to review the backlog of neonatal deaths.

# **Comparison of Berkshire child deaths with child deaths nationally**

# 

**Comparison of Berkshire child deaths with child deaths nationally**

**Ethnicity**

There is a general trend that there were more cases reviewed per population size for the death of children of ethnic minorities (excluding white minorities) compared to their white counterparts in both Berkshire CDOP and NCMD data (Figure 9). This is especially prominent in Asian/Asian British. Note that this was calculated from Census 2011 population data as data from Census 2021 was not available at the time of this report’s release, hence it may not reflect the current ethnicity compositions.

**Comparison of Berkshire child deaths with child deaths nationally**

**Categories of Death**

**Table 1: categories of death among <18s in Berkshire compared to national data (three-year average %)**

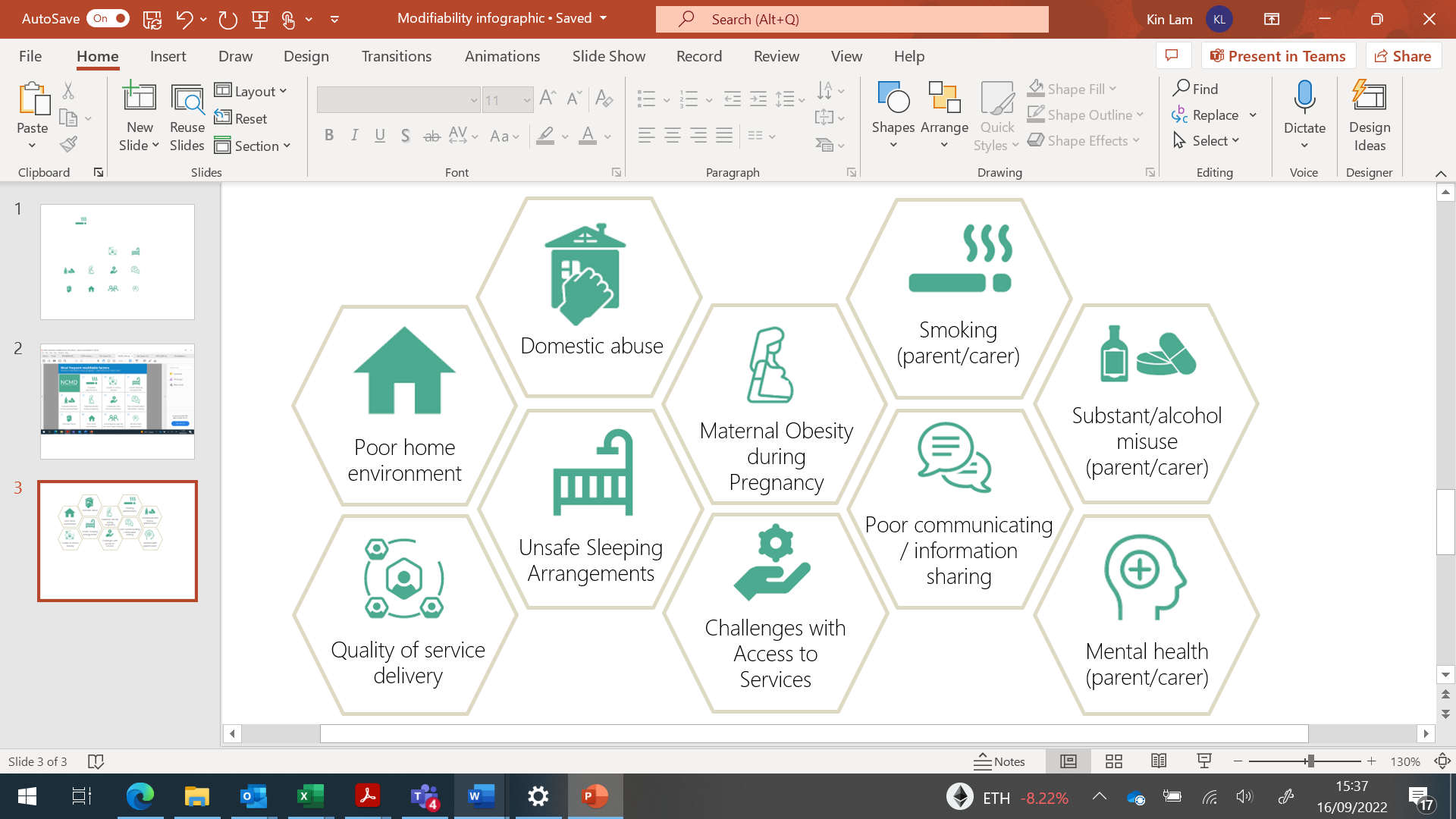
*\* Greyed out where the numerical frequency was less than five*

On par with recent years and national data, the highest percentages of deaths in 2019/22 were in the categories of perinatal/neonatal events and chromosomal, genetic, or congenital anomaly. The former of which is in line with neonatal deaths dominating in deaths by age group. A portion of child deaths remain unexplained.

|  |  |  |
| --- | --- | --- |
| **Categories of Death** | **Local % (2019/22)** | **National % (2018/21)** |
| Acute medical or surgical condition | 8.5 | 6.0 |
| Chromosomal, genetic, or congenital anomaly | 27.1 | 24.5 |
| Chronic medical condition. | 7.0 | 4.8 |
| Deliberately inflicted injury, abuse, or neglect | \* | 2.0 |
| Infection | 6.2 | 5.7 |
| Malignancy | 4.7 | 8.3 |
| Perinatal/neonatal event | 25.6 | 32.6 |
| Sudden unexpected, unexplained death | 7.0 | 7.6 |
| Suicide or deliberate self-inflicted harm | \* | 3.6 |
| Trauma and other external factors | 7.8 | 4.9 |

# 

# **Modifiable factors**



**Figure 10: Infographic of most frequently cited modifiable factors 2019**

Modifiable factors are defined as factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths. Figure 10 shows the most frequent examples, according to NCMD 2019/20.

37%

of cases reviewed in 2021/22 with modifiable factors (England)

20%

of cases reviewed in 2021/22 with modifiable factors (Berkshire)

# **Modifiable factors**

20% of cases reviewed by the CDOP this year presented with modifiable factors. This is lower than both the national average (37%) and last year’s local data (33%).

It is recognised nationally that there are inconsistencies in data recording and interpretation of modifiable factors. However, there is ongoing work that will be completed to enable more reliable analysis and coding.

All deaths caused by deliberately inflicted injury, abuse or neglect are found to be modifiable. The next category of death with the highest proportion of modifiability remains sudden unexpected, unexplained deaths (67%).

# 

# **Key Themes and Priorities**

**Neonatal Learning**

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.

A neonatal death is a baby born who lives even briefly but dies within 28 days of being born. There were two neonatal panels held during 2021/22: one was for infants who had died at John Radcliffe Hospital, Oxford from across the county and one was held for the Berkshire West geography (Reading, West Berkshire and Wokingham local authority areas) to review the neonatal deaths of babies whose parents were resident in Berkshire West and died in the Royal Berkshire Hospital.

Clinical learning of these highly complex cases has been shared in detail with clinical staff. The panel noted the following points whilst carrying out their review:

Early recognition and appropriate treatment, an antenatal Advanced Care Plan (ACP) which included siblings, involvement of tertiary centre as well as local hospital and hospice service. Excellent bereavement support for this family.

Paediatrics to be included in Practical Obstetric Multi-Professional Training (PROMPT) training which includes scenarios on leading resuscitation and decisions to stop.

If any pregnant woman presents/makes contact even if unbooked they should be invited in.

# **Key Themes and Priorities**

In one case staff in the neonatal unit required personal protective equipment (PPE) as High-flow nasal cannula (HFNC), an aerosol generating procedure was being delivered. PPE was a physical barrier to observation and may have slowed down escalation, this was not a contributing factor to the death. Within the TVP and Wessex neonatal network, RBFT was the only hospital using PPE during COVID at that time in 2020. This is no longer the case. Practice changed in April 2021.

Key Workers were identified early on and involved throughout when needed.

One case of an Unexpected Neonatal Death had previously been presented to the Pan Berkshire CDOP and closed. For learning written information was shared with FHFT colleagues.

Three Unexpected Neonatal Deaths could not be reviewed as the outcome of Home Office (forensic) Post-mortems (HOPM) were not available. It was agreed that: Two of these cases should be presented to the Pan Berkshire CDOP and one case reviewed by the Berkshire West Neonatal Panel in 2022.

***Priority for 2022/24 identified***

A revamp of the format of the three neonatal panels is underway during the latter half of 2022. The CDOP will be working with partner agencies to issue revised terms of reference with a relaunch in 2023.

# **Key Themes and Priorities**

**Consanguinity**

The Berkshire CDOP panel has decided that consanguinity is no longer a modifiable factor, as modifiability lies in contributing factors such as provision of genetic counselling and education instead. However, it continues to be a factor which, if present, increases the likelihood of birth defects and genetic conditions which may shorten a child’s lifespan. Consanguinity in this report refers to its biological sense - children born from parents who are close blood relatives. This report identified five cases reviewed by Pan Berkshire CDOP in 2021/22 which were of death of a child born from consanguineous parents. In such cases, parents and siblings are offered genetic counselling to mitigate potential harm on the family by identifying abnormalities or risk factors early on for future pregnancies. Consanguineous unions are often associated with religious and cultural practices; hence inclusive and culturally competent practice needs to be applied when working to inform families of potential risks and providing accessible and timely genetic counselling.

***Priority for 2022/24 identified***

The Slough Genetics Literacy Task & Finish Group was newly created during 2021/22 and is governed by the Joint Director of Public Health for Berkshire East & Frimley ICS. The overarching aim of the group is to develop a sustainable local genetic literacy programme which aims to: raise awareness of genetic risk and improve access to NHS services to support informed reproductive decision-making, improve the experience of people accessing local genetics services, and improve the understanding and cultural competence of statutory and voluntary community sector services supporting communities affected by inherited conditions. We are planning to have midwives included in the national training and submit a future bid to establish a multi-stakeholder bid.

# **Key Themes and Priorities**

**Water Safety**

Following cases reviewed by the CDOP in 2022/23, there have been concerns surrounding water safety in Berkshire, especially as it is home to a number of significant water courses. Many of these bodies of water extends into accessible urban areas – leading to an increased risk of accidental drowning.

***Priority for 2022/24 identified***

In April 2021 a Water Safety Partnership was established to improve safety around the district’s canals and rivers. Thames Valley Police, the Canal & River Trust, the Royal Berkshire Fire and Rescue Service, South Central Ambulance Service and colleagues from the NHS were involved. The aim of the partnership was for the different agencies to work closely together to improve the safety of the waterway through the area for residents and visitors using the canals and rivers, as well as gathering data and sharing best practice and resources related to the topic. It looks at addressing the broad issues of water safety and river usage, working to raise awareness of the risks of waterways among communities most at risk and engaging with the public, private and voluntary sectors with responsibility for waterways. An initial meeting was held in April 2021 and plans included working with parents, schools, and pre-schools on water safety education, as well as raising awareness of the need for care when being near water and physical safety improvements such as throw lines and fencing.

Due to the high number of drownings in our region during 2021/2022 the CDOP will be working closely with the Water Safety Partnership to devise a Pan Berkshire water safety campaign (with shared resources) due to be launched in April 2023.

# **Key Themes and Priorities**

**Learning Disabilities Mortality Review (LeDeR) Programme**

The LeDeR Programme reviews deaths to identify areas of learning, opportunities to improve, and examples of excellent practice. Deaths of children aged 4-17 (inclusive) are reviewed through the Child Death Review process. Pan Berkshire CDOP notifies the Local Area Contact for the LeDeR programme, who supports this process and routinely contributes their expertise to the final CDOP review. Of the 57 child deaths notified in 2021/2022 there were 6 children who were known to have a learning disability (aged 4+). This compares to <5 in 2020/2021 and 7 in 2019/2020.

**COVID-19**

Reassuringly, amongst the children (less than five) testing positive for COVID at the time of death, the panel did not identify any cases where COVID was a direct cause of death. However, the pandemic has certainly had an impact in delayed access to appropriate healthcare and increased difficulties managing complexity of certain cases. The CDOP process has also been hindered as a result of COVID as demonstrated by the reduced number of cases reviewed in the past two years, but this has since returned to pre-pandemic levels. No patterns emerged from the CDOP panels that could direct action around specific services / organisations / care pathways to mitigate the impact of poor healthcare access or identify work among populations affected by complex cases.

It is recognised that it is possible that the impact of the pandemic may be seen in the years to come, and this will be closely monitored by CDOP.

**2021/22 Achievements**

A strategic plan to safeguard adolescent welfare and risk reduction was developed at Reading and Leeds festivals due to child deaths in previous years. A Berkshire West Schools’ survey and workshops took place with five schools and 256 students participating in the live session introducing contents of substance abuse and consent in relation to sexual activity as well as good preparation and hydration. This student’s evaluation of the material will be analysed and report to be shared in preparation for the next festival. Additional work included:

* A Safeguarding and Welfare sub-group reviewed and updated the 2019 safeguarding arrangements for the festival and was shared widely to those involved in the process including a multiagency ‘Senior managers on call’ information sheet.
* A Reading/Leeds public health group that has included representation from Change, Grown, Live (CGL), Reading’s substance abuse service, and Thames Valley Police Chief Inspector, Violence Reduction Unit (VRU), Drugs, Exploitation & Harm Reduction Lead reviewed the safety and risk reduction services and messages to festival goers.
* Welfare services and personal safety messaging sent to all Festival goers were published on the Reading Festival website <https://www.readingfestival.com/information-category/personal-safety>

**2021/22 Achievements**

All bereaved families should have a named key worker as a single point of contact who can provide information on the child death review process and signpost families to sources of support. A survey identified gaps amongst key workers regarding training and knowledge of the child death process. Training outside the role was suggested as the preferred option and a Pan Berkshire training day for key workers was developed and booked for September 2022.

Medical examiners are senior doctors who provide independent scrutiny of the causes of deaths, and, from April 2023, this role will extend for all deaths not taken for coronial investigation. By establishing processes for medical examiners to provide scrutiny after the death of a child, we will ensure that bereaved parents benefit from scrutiny in the same way as other bereaved people.

In response to sadly several baby and infant deaths where alcohol had been consumed by the responsible adult and is considered to be a contributory factor, a Safe Sleep campaign has been launched by NHS Frimley and Frimley Healthier Together. This campaign consists of important messages and infographics being distributed via major social media platforms, as well as two short films designed to raise awareness of drinking alcohol, whether at home or in other settings, when caring for children. [Who's in charge? Safe Sleeping: Frimley Healthier Together (frimley-healthiertogether.nhs.uk)](https://frimley-healthiertogether.nhs.uk/parentscarers/whos-charge-safe-sleeping)

**2021/22 Achievements**

As children become older and move towards adolescence, they are more likely to face risks and challenges outside of their home in wider extra-familial contexts such as peer groups, schools, neighbourhoods and in the wider community where they live their lives. In order to tackle this the Reading Adolescent Risk Strategy Group developed the ‘One Reading Extra Familial Harm’ Strategy. Extra-familial harm may include child sexual exploitation, criminal exploitation, missing children, gang affiliation, county lines and serious youth violence. The strategy is focused on prevention and response to extra familial risk and harm in its range of contexts including online and in social media.

A ‘Practical guide for dealing with sudden or traumatic death

of a child or young person’ was produced for educational settings and early years providers in the Berkshire area. It outlines processes following a child’s death as well as actions to be considered. It also includes useful contacts and resources.

**List of Acronyms**

|  |  |
| --- | --- |
| **Acronym** | **Full term** |
| BHFT | Berkshire Healthcare NHS Foundation Trust |
| CCG | Clinical Commissioning Group |
| CDOP | Child Death Overview Panel |
| CDR | Child Death Review |
| CDRM | Child Death Review Meeting |
| CSPR | Child Safeguarding Practice Review |
| GDPR | General Data Protection Regulation |
| FHFT | Frimley Health Foundation Trust |
| ICB | Integrated Care Board |
| JAR | Joint Agency Response |
| LeDeR | Learning Disabilities Mortality Review Programme |
| NCMD | National Child Mortality Database |
| NHS | National Health Service |
| ONS | Office for National Statistics |
| PMRT | Perinatal Mortality Review Tool |
| RBHFT | Royal Berkshire NHS Foundation Trust |
| SIDS | Sudden Infant Death Syndrome |
| TVP | Thames Valley Police |