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Wiltshire and Swindon

Child Death Overview Panel

Fifth Annual Report

2013-2014

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Introduction

We are fortunate that a child death is a rare event in our society, however, each death represents a tragedy for the family and the purpose of the Child Death Review process (CDR) is to identify potentially modifiable factors which may prevent future deaths from occurring. The CDR process is also able to identify local and regional trends to inform the work of Commissioners, Providers and other relevant organisations. For example in the case of children with life-limiting conditions the CDR process is able to consider whether these children were in receipt of appropriate care during their life and had access to appropriate support services at the end of life . Where the CDR process identifies learning this is fed back to the relevant agencies by the Child Death Overview Panel on behalf of the Local Safeguarding Children Boards (LSCBs) in Swindon and Wiltshire respectively.

At the beginning of the CDR process in 2008 the Swindon and Wiltshire LSCBs came together to form a single Child Death Overview Panel (CDOP). This CDOP continues to review the deaths of all children resident in those areas. Some of these deaths may occur outside of the region and these will also be reviewed by this panel.

Background to the Child Death Review Process

Chapter 5 of "Working Together to Safeguard Children" (2013) provides the framework for processes to review all child deaths. Under statutory national guidance LSCBs are required to establish a procedure to respond rapidly in the event of an unexpected death of any child under 18 years of age. In Swindon a joint police and health rota is staffed during office hours (Monday to Friday 9am to 5pm). Outside of these hours the rapid response is undertaken by police alone. In Wiltshire a joint police and health rota is staffed 24 hours a day seven days a week. LSCBs are also required to ensure there is a Child Death Overview Panel (CDOP) process. The two are separate processes, but are closely linked. The Rapid Response process ensures early notification of the unexpected death of a child and a prompt process of investigation. The CDOP process ensures that every child's death is comprehensively reviewed and lessons learnt so that action can be taken to prevent future deaths where possible.

The Child Death Review Process

A child's death is reviewed by CDOP after a range of standard information has been collected using statutory forms and the case has been discussed by professionals involved in the child's life at a local case review (LCR) meeting. Following the LCR meeting a detailed compilation of data from the statutory forms (Form B's) and outcomes of the LCR meeting (Form C) is produced and anonymised by the Child Death Enquiries Office at the University of Bristol for presentation to CDOP. CDOP reviews each case with the aim of identifying modifiable factors and highlights learning arising from each case. The CDOP panel is primarily concerned with prevention. It aims to identify those factors in the course of a child's life, and leading to the child's death, which might have led to the child's death or increased their vulnerability, and which might have been amenable to modification. It also makes recommendations which may prevent similar deaths occurring in the future. However it may also make recommendations related to service improvement, where changes in practice could lead to improved experiences for children and young people at the end of life or during the course of their treatment.

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Production of this report

The CDOP is required to produce an annual report each year outlining the work of the panel and relevant learning from the cases reviewed to inform the priorities of the LSCBs. The annual report is produced using data collected by the University of Bristol through the Child Death Enquiries Office. Information collected at the point of notification of death is entered onto a **Notification Database**. Information collected from statutory forms, local case review meetings and CDOP reviews is entered onto a separate **CDOP Database**. The eventual CDOP multi-agency dataset is extremely comprehensive. This year the annual report includes a four year rolling average of data to help reduce year on year variations associated with rare events such as a child death. This allows better identification of longer term trends or key themes which may not have been as apparent within a single year of data.

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Notifications of child deaths

Summary Data (four year average from 2010 – 2014)

This section summarises all the deaths notified to the Child Death Enquiries Office between 1st April 2010 and 31st March 2014, of children resident in the Swindon and Wiltshire areas. These data are drawn from the notification database.

Analysis of notifications by year (2010-2014)

During the period 2010-2014, 201 child deaths were notified. Year on year variation in notifications is to be expected and with rare events such as a child death, small variations can appear to represent a big difference. However because the number of notifications for one area of residence are so small the most likely explanation for any patterns is random year-on year variation. The variation in numbers of deaths between Swindon and Wiltshire are due to the different underlying population sizes.

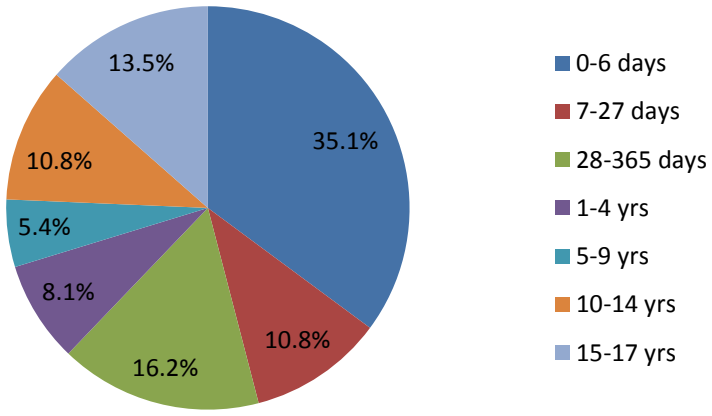
Numbers of deaths notified by year 2010/11 to 2013/14 in Wiltshire and Swindon

	Number of child deaths notified				
	2010-2011	2011-2012	2012-2013	2013-2014	Totals
Wiltshire	41	36	36	33	146
Swindon	11	21	7	16	55

Age at death

Using averaged four year data for Wiltshire children, the greatest proportion of notifications (45.9%) were received for babies dying in the neonatal period (under one month of age). This figure increases to 62.1% when all deaths under one year are included. .

Wiltshire notifications by age group (four year average) 2010-2014



When looking at the deaths of children resident in Swindon between 1st April 2010 and 31st March 2014, 38.5% of children died in the neonatal period and 61.6% died in the first year of life.

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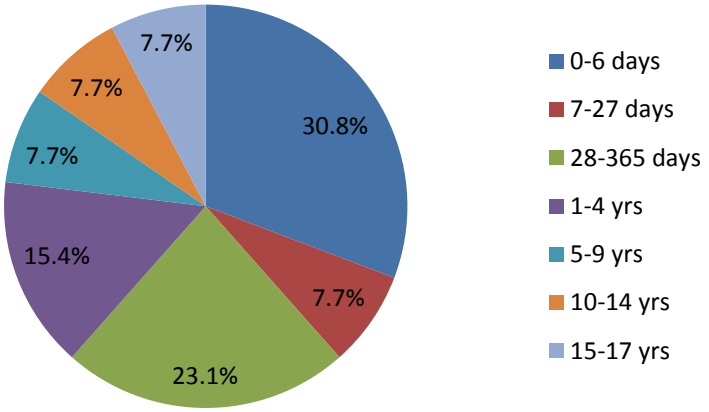
Swindon notifications by age group (four year average) 2010-2014



Location of death

This data records where the child actually died. Many children resident in Swindon and Wiltshire may be transferred to tertiary hospitals in other regions for treatment. A number of these children go on to die in those locations as can be seen in the table below. The figures in this section represent the total number of deaths at each hospital during the four year period.

Children resident in Wiltshire are treated in a greater number of hospitals than children resident in Swindon. This reflects the wide geographical area covered by Wiltshire and the number of counties in which Wiltshire residents receive healthcare services including Hampshire, Bristol, Swindon and Bath. This can present particular issues for Wiltshire for the timely and complete collation of information for the review of children's deaths due to the wide range of organisations that must be engaged.

Wiltshire and Swindon Notifications by Place of Death 2010-2014

Place of death	Number of deaths	
	Wiltshire	Swindon
Great Western Hospital	11	25
Salisbury District Hospital	20	0
Royal United Hospital	13	0
St Michael's Hospital	12	8
Bristol Children's Hospital	11	<5
Princess Anne Hospital	16	0
Southampton General	7	0
Home	28	7
Hospice	9	6
Other	19	<5
Total	146	55

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The most common location of death for Wiltshire children is in hospital, where 90 children died (61.6%). In total 28 (19%) children in Wiltshire died at home in the 4 year period, which can include both expected deaths where a child has received palliative care support at home and unexpected deaths that happened within the home setting.

The most common location of death for Swindon children was also hospital with the majority of these occurring at the Great Western Hospital (45% of places of death). Thirteen percent of children died at home.

Gender

There have been more notifications of deaths in boys than in girls in both Swindon and Wiltshire as can be seen in the table below. In total 62% of deaths in Wiltshire and 53% of deaths in Swindon were male. This is in line with national trends for childhood deaths which also show slightly higher proportions of deaths registered in England were for male children[1].

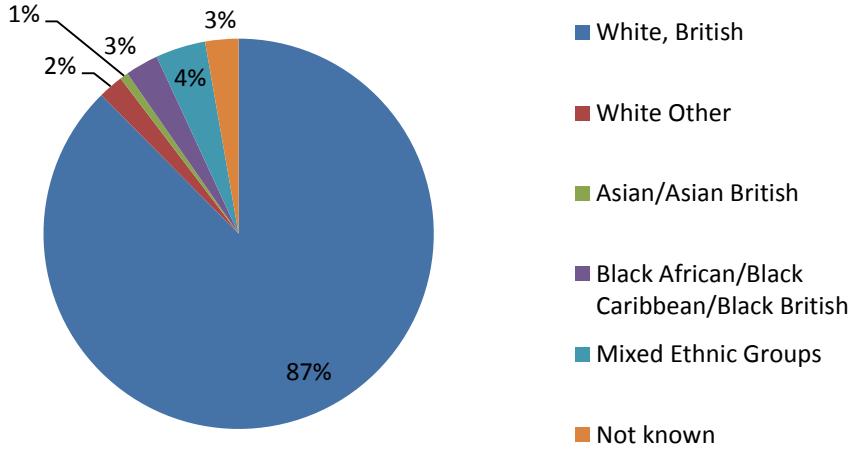
Numbers of deaths notified between 1st April 2010 and 31st March 2014 by gender

	Male	Female	Indeterminate
Wiltshire	91	54	<5
Swindon	29	26	0

Ethnicity

The data presented here shows that the majority of deaths for Swindon and Wiltshire are children of White, British ethnic origin. In Wiltshire 87% of deaths were among children from White British backgrounds, this is roughly in line with the proportion of the Wiltshire population, aged under 19 years from White British backgrounds (92%).

Wiltshire notifications by ethnic group (2010-2014)



[1] Department for Education, Statistical Release - Child Death Reviews: Year ending March 2013

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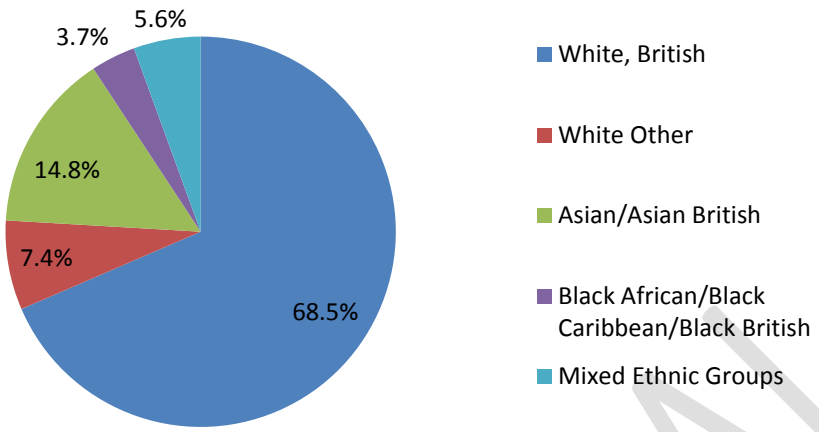
Swindon notifications by ethnic group (2010-2014)



In Swindon 68.5% of deaths were among children of White British backgrounds, notably lower than the proportion of White British children aged 0-19 in the population as a whole (82.1%).

The table below presents a breakdown of children's ethnicity for the Swindon population aged 0-19 compared with the proportion of deaths recorded in each ethnic group. It should be noted that although this presents a combination of data from 2010-2014 the number of deaths is still small at 55 in total.

Ethnicity of cases reviewed for Swindon, 2010-14 compared to the ethnicity of the 0-19 Swindon population

Ethnicity	% of Swindon population aged 0-19	% of deaths notified 2010-2014, Swindon
White British	82.1%	68.5%
White other	3.5%	7.4%
Asian/ Asian British	7.8%	14.8%
Black/ Black British	1.7%	3.7%
Mixed	4.4%	5.6%

Source: Swindon PH, Census 2011

Unexpected and Expected Deaths

An unexpected death is defined as the death of a child which was not anticipated as a significant possibility 24 hours before the death or, where there was a similarly unexpected collapse or incident leading to or precipitating the events that led to the death. During the 4 year period 54 deaths (27%) in children in Wiltshire and Swindon were unexpected. The remaining 147 (107 in Wiltshire and 40 in Swindon) were expected deaths of children with known illnesses or life-limiting conditions.

The following tables present data on unexpected deaths for 2013/14 and a breakdown of the last 4 years data on unexpected deaths by age group. For Wiltshire this shows that the highest numbers of unexpected deaths occur in the under 1 and the 15-17 year age groups.

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Numbers of unexpected deaths, even when pooled over 4 years are too small to present in detail for Swindon.

Unexpected and Expected Deaths Notified for Wiltshire and Swindon Children 2013/14

	Wiltshire	Swindon
Expected	27	9
Unexpected	6	7

Unexpected and Expected Deaths of Wiltshire Children by Age (2010-2014)

Age	Unexpected deaths	Expected deaths
0-6 days	<5	52
7-27 days	<5	14
28 days – 1 year	12	13
1 – 4 years	5	8
5 – 9 years	<5	5
10 – 14 years	6	14
15 -17 years	13	5
Total	39	107

Unexpected and Expected Deaths of Swindon Children by Age (2010-2014)

Age	Unexpected deaths	Expected deaths
0-6 days	<5	13
7-27 days	<5	<5
28 days – 1 year	<5	6
1 – 4 years	<5	5
5 – 9 years	<5	<5
10 – 14 years	<5	<5
15 -17 years	<5	<5
Total	15	40

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Child Death Overview Panel Review Data

These data are drawn from the CDOP database. They summarise the panel's review decisions for 2010-2014 and its actions for 2013-2014. There is an inevitable time lag between the notification of a child's death and the discussion at CDOP. There are various factors that contribute to this including return of statutory paperwork by professionals, receipt of the final post mortem report and receipt of the report from the local case review meeting. The Swindon and Wiltshire CDOP took the decision in 2009 to wait for the inquest verdict in child deaths that involve the Coroner. In these cases there may be a delay of over a year before a case might be brought for review by CDOP. The undertaking of a criminal investigation or a Serious Case Review can also affect when a case is discussed at panel.

For these reasons the population of children described in the notifications section (drawn from the Notification Database) may partially overlap but is distinct from the population of children described in this section (drawn from the CDOP Database).

The Swindon and Wiltshire CDOP has reviewed 189 cases between 1st April 2010 and 31st March 2014. 137 were children resident in Wiltshire and 52 were children resident in Swindon.

During the 2013/14 financial year the Wiltshire and Swindon CDOP panel reviewed a total of 64 cases, 50 of which were Wiltshire resident children and 14 of which were Swindon resident children. This compares with a total of 36 cases reviewed in 2012/13 (23 Wiltshire and 13 Swindon).

Number of child deaths reviewed by CDOP, 2010/11 – 2013/14

	2010-2011	2011-2012	2012-2013	2013-2014	Totals
Wiltshire	21	42	24	50	137
Swindon	10	15	13	14	52

Length of time from death to review

It can take a number of months for a child's death to come to be reviewed by CDOP. The third CDOP annual report made a recommendation that CDOP would aim to review every child's death within 1 year.

The following two pie charts show the length of time from date of death to the child being reviewed by CDOP for children resident in Swindon and Wiltshire. These data show that in the period between 1st April 2013 and 31st March 2014 the deaths of 63% of Wiltshire children were reviewed within a year, a notable improvement on the preceding year when 33% of Wiltshire children's deaths were reviewed within a year. For Swindon the proportion of cases reviewed within 12 months was lower than in the previous year at 14% compared to 39%. However an analysis of the Swindon cases reviews in 2013/14 indicates that of the 7 children whose deaths were notified in the 2012/13 year, 6 were reviewed by CDOP in 2013/14. A further 6 of the cases reviewed from Swindon were cases that had been delayed since 2011/12, suggesting some of reason for this apparent drop off in timeliness has been driven by clearing a backlog of older cases in Swindon.

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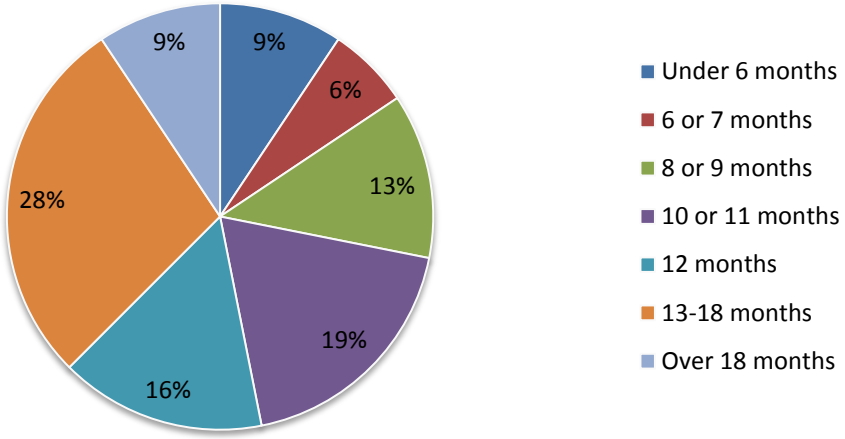
Percentage of cases reviewed within 12 months of a child's deaths 2011/12 -2013/14

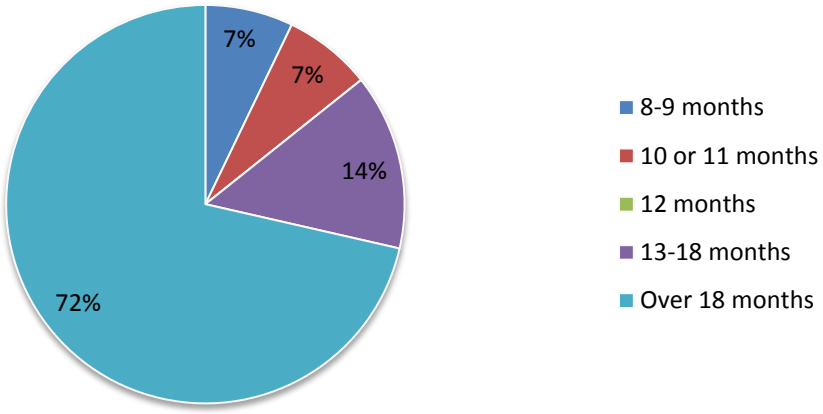
	2011/12	2012/13	2013/14
Wiltshire	51%	33%	63%
Swindon	20%	39%	14%

In 2013/14, 9% of cases reviewed by CDOP for Wiltshire had taken 18 months or longer to come to panel while 72% of cases reviewed for Swindon had taken 18 months or longer to be reviewed.

Length of time from death to review for Wiltshire children, 2013-14



Length of time from death to review for Swindon children, 2013-14



Categorisation of death for cases reviewed by CDOP

As part of part of the Child Death Review process each death reviewed by the panel is categorised by the most likely cause of death based on a set of pre-defined categories (Appendix A).

The categorisation of deaths for cases reviewed by the panel in 2013/14 is shown below

Categorisation of death for Wiltshire and Swindon Children of cases reviewed by CDOP 2013/14

Categorisation of death	Number of deaths reviewed 13/14
Deliberately Inflicted Abuse or Injury	0
Suicide or deliberate self-inflicted harm	<5
Trauma or other external factors	<5
Malignancy	8
Acute medical or surgical condition	5
Chronic medical condition	0
Chromosomal, genetic and congenital anomalies	16
Perinatal /neonatal event	28
Infection	0
Sudden unexpected unexplained death	<5

The categorisation of death of cases reviewed by CDOP between 1st April 2010 and 31st March 2014 is shown in the following pie charts. This shows that in both Wiltshire and Swindon the main cause of death for cases reviewed by CDOP was perinatal/neonatal event (36.2% in Wiltshire and 42.3% in Swindon). The second most common categorisation of death for both areas was those children who died of chromosomal, genetic or congenital anomalies (23% in Wiltshire and 25% in Swindon). This is in line with the national picture where in 2012/13 36% of cases reviewed were classed as perinatal or neonatal events and 23% of cases were categorised as chromosomal, genetic and congenital anomalies.

In the remaining categories 22.5% of Wiltshire children and 25% of Swindon children died of acquired natural causes, which includes cancers, acute and chronic medical conditions and infections. In 2012/13, 24% of cases reviewed nationally were categorised as acquired natural causes.

13.8% of Wiltshire children and 3.8% of Swindon children died of external causes, which includes trauma from external factors, self inflicted harm and suicide. In 2012/13, 10% of cases reviewed nationally were categorised as acquired natural infections.

Only 4.3% of the deaths of Wiltshire children and 3.8% of the deaths of Swindon children were categorised as sudden unexpected and unexplained following full investigation.

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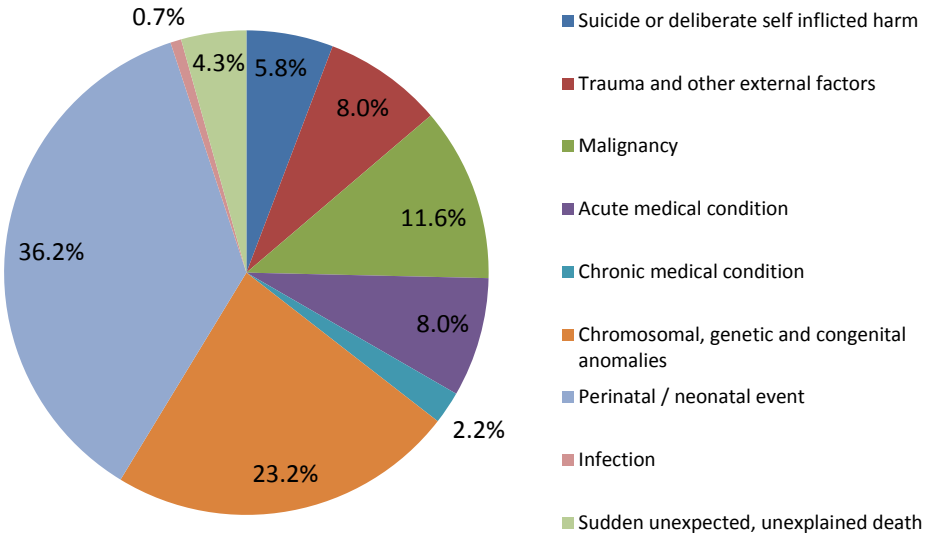
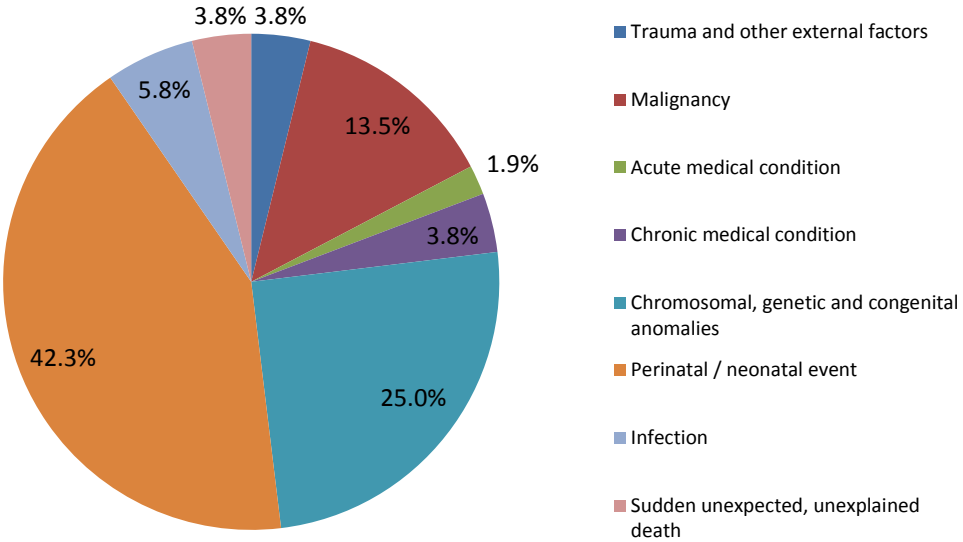
Categorisation of death for Wiltshire children of cases reviewed by CDOP (2010-2014)



Categorisation of death for Swindon children of cases reviewed by CDOP (2010-2014)

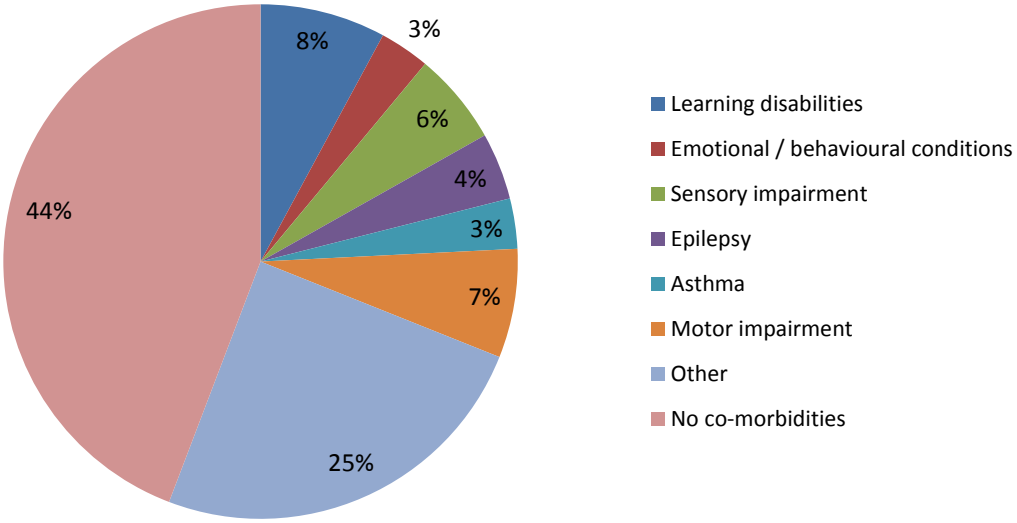


Co-morbidities

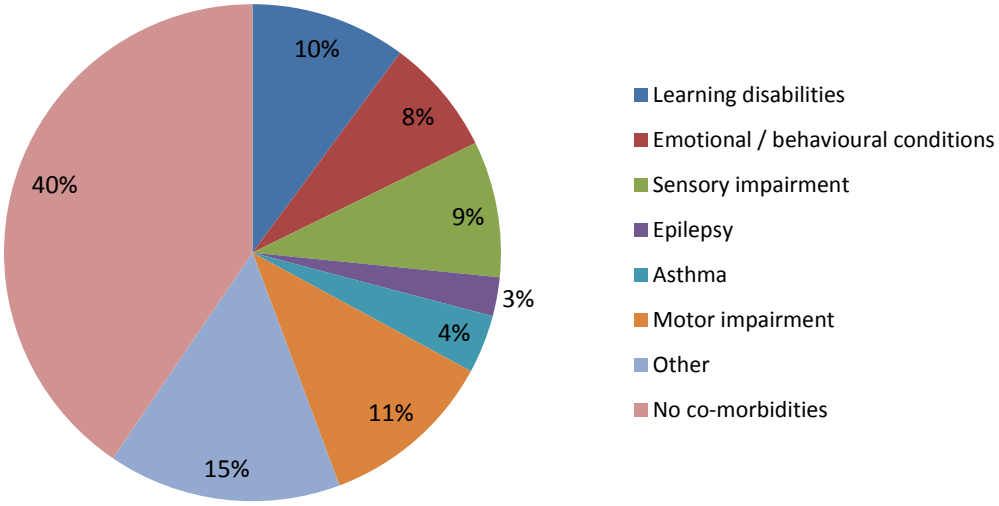
As well as categorising the cause of death CDOP considers information on co-morbidities in children who die. These are underlying conditions which, while not considered to be the direct cause of death, are thought to have potentially contributed to vulnerability in the child, for example by making treatment more complex or contributing additional challenges to a child living a full and active life. It should be noted however that the existence of a co-morbidity does not necessarily have an impact on the circumstances that led to a child's

death. The following pie charts show that 8% of Wiltshire children reviewed and 10% of Swindon children reviewed had a diagnosed learning disability. For children resident in Wiltshire this was the most common co-morbidity followed by motor impairment (7%). For children resident in Swindon, the most common co-morbidity was motor impairment (11%) followed by learning disability and then sensory impairment (9%). The "other" category on these pie charts includes children suffering from a range of other chronic illness or other disability.

Co-morbidities in Wiltshire Children in cases reviewed by CDOP (2010-2014)



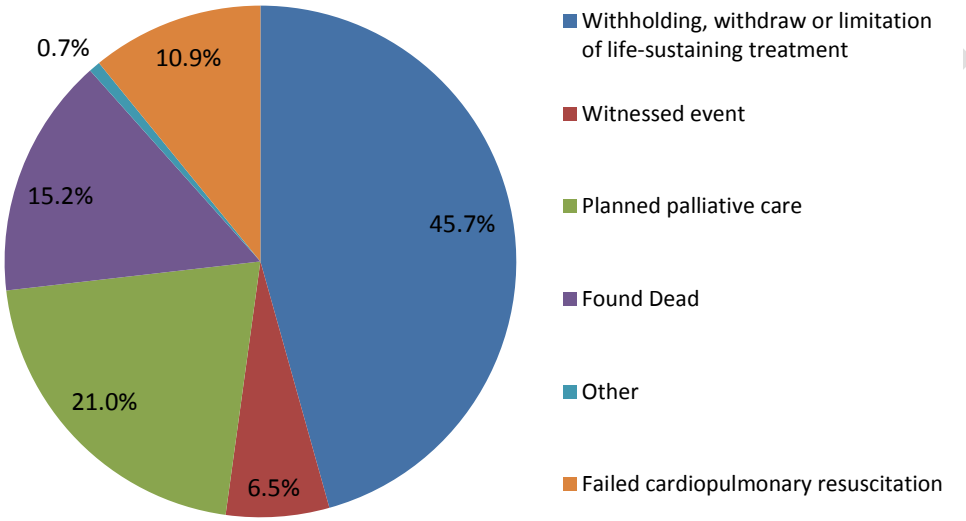
Co-morbidities in Swindon Children in cases reviewed by CDOP (2010-2014)



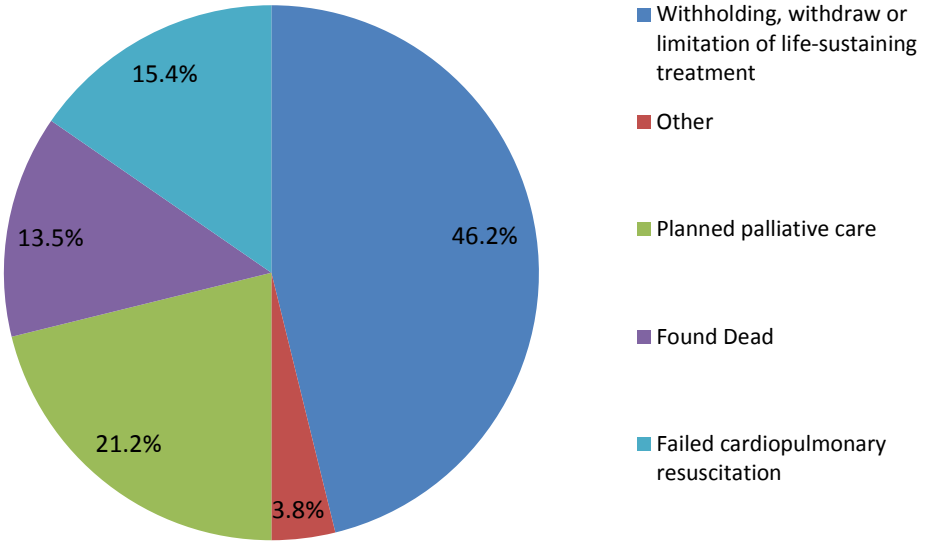
Mode of death of cases reviewed by CDOP

As can be seen from the pie charts below, the most common manner of death for both Wiltshire and Swindon children is withholding, withdrawing or limitation of life-sustaining treatment. This decision is always made following careful consideration with the childs parents and carers. This is followed by planned palliative care (21% in both Swindon and Wiltshire). In Wiltshire, 15% of children were found dead compared with 13.5% of children in Swindon.

Mode of Death for Wiltshire Children (2010-2014)



Mode of Death for Swindon Children (2010-2014)



The table below presents the mode of death data for cases reviewed by the panel in 2013/4.

Mode of death for cases reviewed 2013/14

	Withdraw of treatment	Witnessed event	Planned palliative care	Found Dead	Brainstem death	Failed resuscitation
Wiltshire	28	<5	7	8	0	<5
Swindon	6	0	6	<5	0	<5

Factors identified as having contributed to death

Form C of the national dataset requires that the professionals present at the local case review meeting identify and "grade" factors that have contributed to the child's death. CDOP may amend this grading after full deliberation of the facts. This occurred in 71% of Swindon child deaths reviewed and 88% of Wiltshire child deaths reviewed over the four year period. In 96% of deaths reviewed for both areas factors in the child (i.e. the underlying medical or surgical condition) provided a complete and sufficient explanation of the death.

Contributory factors identified for Wiltshire children by CDOP (2010-2014)

	The Child	Family & Environment	Parenting Capacity	Service Provision
Information not available	0	0	<5	<5
No factors identified or factors identified but are unlikely to have contributed to death	0	111	122	114
Factors identified that may have contributed to vulnerability, ill-health or death	5	26	14	20
Factors identified that provide a complete and sufficient explanation for death	131	0	<5	<5

Contributory factors identified for Swindon children by CDOP (2010-2014)

	The Child	Family & Environment	Parenting Capacity	Service Provision
Information not available	<5	0	<5	<5
No factors identified or factors identified but are unlikely to have contributed to death	<5	43	45	44
Factors identified that may have contributed to vulnerability, ill-health or death	<5	9	6	7
Factors identified that provide a complete and sufficient explanation for death	50	0	<5	<5

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In 18% of Wiltshire children and 17% of Swindon children factors in the family and environment were identified that may have contributed to vulnerability, ill health or the death of the child, and in 10% of Wiltshire children and 11% of Swindon children factors in the parenting capacity were identified that may have contributed to the vulnerability, ill-health or death of the child. 14.5% of Wiltshire children and 13.5% of Swindon children factors related to service delivery were identified that may have contributed to the vulnerability, ill-health or death of the child. These included poor communication between agencies and delay in transfer of the child or access to appropriate treatment.

Additional social factors in the family and environment

The presence or absence of social factors in the family and environment such as mental health issues and drug abuse are routinely collected on the Form B dataset from professionals who have contact with the families. These are summarised on the Form C dataset at the local child death review meeting and carefully reviewed by CDOP. They are shown for Swindon and Wiltshire in the tables below. Please note that these factors are not necessarily considered to be modifiable in every case and may not have been directly contributory to the child's death, rather this data reflects the presence or absence of a social factor within the family or environment. Hence the numbers and percentages in the tables do not equal the number of cases reviewed.

Factors in the family and environment recorded in cases reviewed by CDOP of children resident in Wiltshire

Family or environmental factors	Total over 4 years	% of cases reviewed over the 4 years
Parental mental health issue	28	20%
Parental physical health issue or disability	43	31%
Parental drug or alcohol abuse	10	7%
Parental smoking	42	31%
Parental police record	14	10%
History of domestic violence or child protection issues	11	8%

Factors in the family and environment recorded in cases reviewed by CDOP of children resident in Swindon

Family or environmental factors	Total over 4 years	% of cases reviewed over the 4 years
Parental mental health issue	8	15%
Parental physical health issue or disability	17	33%
Parental drug or alcohol abuse	5	10%
Parental smoking	17	33%
Parental police record	8	15%
History of domestic violence or child protection issues	8	15%

Modifiable Factors – Reducing the Risk of Future Deaths

The focus of the Child Death Review process is to assess modifiable factors in each child's death. Modifiable factors are defined as "one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths". Panels can identify modifiable factors in the child's direct care by any agency, including parents, latent, organisational, systemic or other indirect failure(s) within one or more agency. Therefore a death identified as having modifiable factors may not necessarily be due to a failure of the Local Authority or other agencies to safeguard the child's welfare. An example of a modifiable factor might be a death resulting from a vaccine preventable infection where the vaccine had not been given to the child.

For cases reviewed of children resident in Wiltshire modifiable factors were identified in 25% of cases over the four year period. For cases reviewed of children resident in Swindon, modifiable factors were identified in 23% of cases. In the majority of cases for both Swindon children (40/52) and Wiltshire children (100/137), no modifiable factors were identified. In the case of two Wiltshire children there was inadequate information on which to make a judgment.

In 2013/14 20% of cases reviewed in Wiltshire and 14% of cases reviewed for Swindon identified modifiable factors associated with a child's death.

Percentage of cases where sufficient information was available and modifiable factors were identified, by year of review

	2010/11	2011/12	2012/13	2013/14
Wiltshire	32%	20%	39%	20%
Swindon	30%	33%	15%	14%
England	20%	20%	21%	-

Family Follow Up

Active engagement with bereaved parents underpins the entire child death review process. The pie charts below show the agencies offering support to families following the death of their child. These data relate to the child deaths reviewed by CDOP during the four year period. These pie charts show that for the families of both Swindon and Wiltshire children the majority of follow-up is provided by paediatrics or other specialist services including cardiology, oncology, obstetrics and neonatology. In Wiltshire 23% of families have received follow-up from their GP surgery or other primary care provider (e.g. health visitor) compared with 6% in Swindon. The same percentage of families in Swindon and Wiltshire declined the offer of follow up (6% each).

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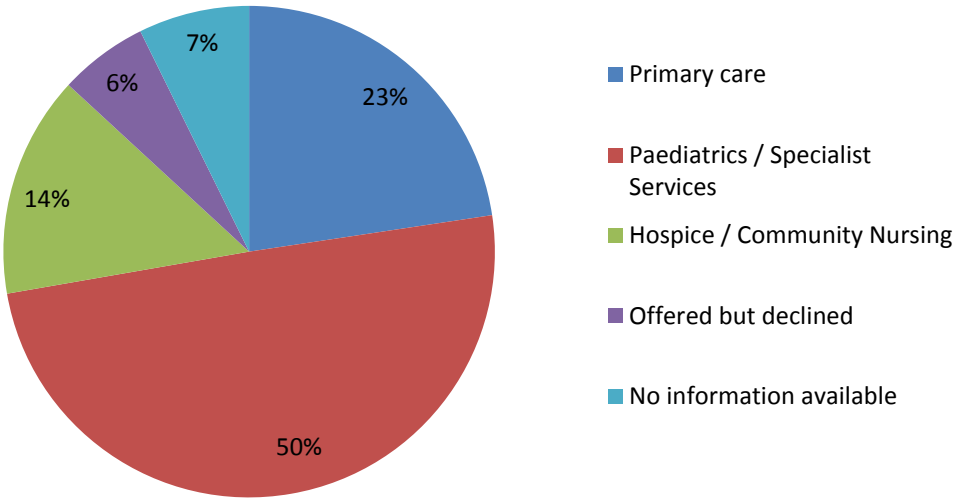
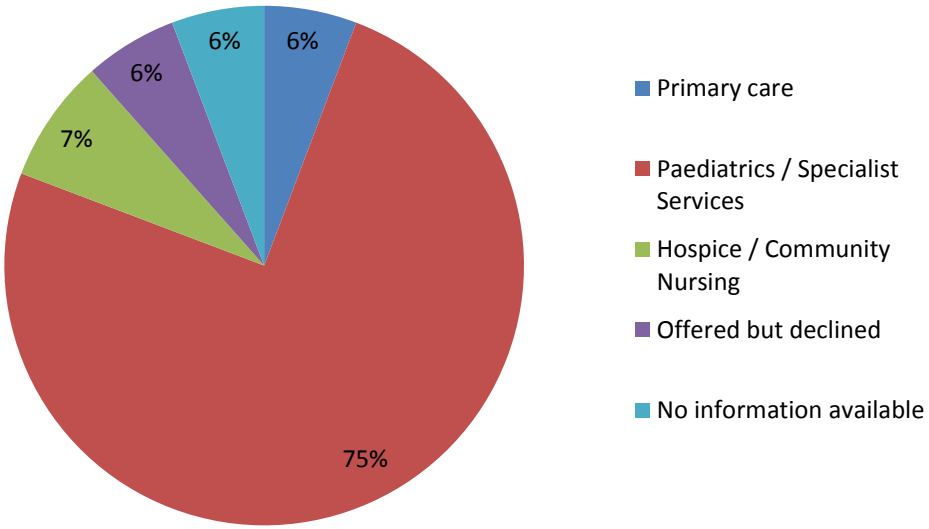
Agency providing follow-up to families of Wiltshire Children (2010-2014)



Agency providing follow-up to families of Swindon Children (2010-2014)



Lessons Learnt, Actions Taken and Recommendations as a Result of the Wiltshire and Swindon CDOP in 2013/14

Lessons Learnt

- The majority of child deaths are expected deaths accounting for 73% of child deaths in the past 4 years.
- The majority (46%) of child deaths occur in the perinatal or neonatal period and 62% occur within the first year of life.
- The most common causes of death in Wiltshire were perinatal or neonatal event (36.2%) followed by chromosomal, genetic or congenital anomalies (23%). This is in line with the national picture.
- Deaths from external causes, which includes trauma from external factors or self inflicted harm and suicide are rare but still accounted for 13.8% of deaths reviewed in the last 4 years (equivalent to 20 child deaths).
- In the majority of deaths reviewed no modifiable factors are identified. However modifiable factors were identified in 20% of Wiltshire cases reviewed by the panel in 2013/14. This is in line with the national picture.

Actions Taken

- The CDOP panel has identified risky behaviours, such as alcohol and substance misuse including prescription drug misuse, as a theme in a number of deaths reviewed. CDOP has followed up with the Healthy Schools service and Substance Misuse Commissioners to ensure programmes are in place to support young people to make informed choices and that services are aware of and considering the impact of changing patterns of risky behaviours such as the use of legal highs.
- The CDOP panel has continued to ensure work on raising awareness among families of safe sleeping environments takes place. This year the panel has sought assurance from local Health Visiting services that tailored support is available to support families caring for subsequent children where they have experienced a Sudden Unexpected Infant Death (SUDI) in the past. Sudden infant death remains an issue that requires continued focus, as although incidences are dropping it presents an ongoing inequalities issue.
- The CDOP panel has requested that the South West Neonatal Network carry out an audit of the presence of senior medical staff at the delivery of premature neonates to ensure appropriate staff are present at premature births to ensure the best possible outcomes for these children.
- The CDOP panel has also identified a number of examples of good practice over the past 12 months including a support resource for the parents of premature babies developed by a charitable organisation. The panel is due to review the content of this resource and will consider recommending use of the resource across hospitals within the SW neonatal network.
- The panel identified that there was a backlog of deaths of Swindon children and therefore there were long delays in these cases coming to be reviewed by panel. On investigation, this was found to be due to the Form C not being provided to the Child

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Death Enquiries Office in a timely manner. Further investigation highlighted the lack of time provided in the work plan of the Designated Doctor for Child Death in Swindon and the lack of administrative support for this role. An interim system has been put into place to help support the Designated Doctor to provide this information, however this remains an ongoing issue which will need to be addressed in the forthcoming year in order to avoid a further backlog of cases.

- The WSCB Chair attended the 5th December 2013 CDOP Panel meeting to learn more about the work of CDOP and to take the opportunity to discuss opportunities for problem solving in terms of the current CDOP workload that were raised in the last annual report. As a result a review of the CDOP processes and membership has been carried out with input from both Wiltshire and Swindon's LSCB's and improvements made. The panel has reviewed significantly more cases in the last 12 months than in previous years, however maintaining the pace of improvement remains a challenge and more work is needed to embed efficient processes, particularly with regard to timely return of paperwork from Local Case Reviews.
- The WSCB has clarified arrangements for data sharing in relation to CDOP paperwork to ensure that requests to access CDOP records are managed consistently and in line with national guidance.

Recommendations

- Provision of paediatric palliative care has been identified through the Executive Panel and CDOP as an area that is frequently reported as being reliant on good will from frontline staff. This is also known to be a regional issue although progress has been made in the West of England region with spot purchase of services now possible through commissioners in the child's area of residence. CDOP recommends that commissioners in Wiltshire and Swindon examine best practice in neighbouring counties in relation to this issue.
- The CDOP annual report has identified a potential disproportionate representation of children from Black and Minority Ethnic Groups among the child deaths reviewed for Swindon. It should be noted that this is based on small numbers of incidents, making it hard to analyse the significance of this finding based on the CDOP dataset alone. However it warrants further investigation to understand any possible trends and inequalities and the Swindon Council Public Health team are carrying out a review of cases to ensure any possible issues are understood ensuring appropriate preventative activity is undertaken if required.
- Ensuring timely review of cases remains and challenge the current model of meeting delivery should be kept under review over next 12 months to ensure all members are happy that it is meeting the expectations of the respective LSCBs for Wiltshire and Swindon. The LSCBs are asked to support commissioners to identify routes for improving the timeliness of the return of statutory paperwork from professionals as part of the Child Death Review Process. Providers with responsibilities for returning statutory paperwork (Form B's and Form C's) are also asked to assure themselves of the capacity within their services to provide the required returns in a timely manner.

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APPENDIX A - CATEGORISATION OF DEATH

The CDOP should categorise the likely cause of death using the following schema. This classification is hierarchical; where more than one category could reasonably be applied, the highest up the list should be marked.

Cat	Name and description of category	LCR evaluation	CDOP evaluation
1	**Deliberately inflicted injury, abuse or neglect** *This includes suffocation, shaking injury, knifing, shooting, poisoning and other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death*	☐	☐
2	**Suicide or deliberate self-inflicted harm** *This includes hanging, shooting, self-poisoning with Paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children*	☐	☐
3	**Trauma and other external factors** *This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis and other extrinsic factors. Excludes deliberately inflicted injury (category 1)*	☐	☐
4	**Malignancy** *Solid tumours, leukaemias and lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc*	☐	☐
5	**Acute medical or surgical condition** *For example: Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy*	☐	☐
6	**Chronic medical condition** *For example: Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Includes cerebral palsy with clear post-perinatal cause*	☐	☐
7	**Chromosomal, genetic and congenital anomalies** *Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis and other congenital anomalies including cardiac*	☐	☐
8	**Perinatal / neonatal event** *Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral palsy without evidence of cause, and includes congenital or early-onset bacterial infection (onset in first postnatal week)*	☐	☐
9	**Infection** *Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a pre-term baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc*	☐	☐
10	**Sudden unexpected, unexplained death** *Where the pathological diagnosis is either "SIDS" or "unascertained", at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5).*	☐	☐

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