Child Death Overview Panel

Wiltshire & Swindon

Annual Report
2023-2024

Swindon Borough Council

Wiltshire Council

Contents

Acknowledgements

We would like to acknowledge the hard work of all the professionals involved in every step of the Child Death Review process and those representatives that sit on the Wiltshire and Swindon CDOP who have made the content of this year's annual report possible.

This report has been compiled by Wiltshire Council's Public Health Consultant – Hayley Morgan, with a particular note of thanks to Sarah Lakin, Public Health Analyst, Wiltshire who has provided the analytical support and background demographics.




Chair's reflections and Executive Summary

Chair's reflections

Wiltshire and Swindon Child Death Overview Panel (CDOP) is a multi-professional forum covering both Wiltshire and Swindon Local Authority areas. Representation is made up from a range of organisations, including health, social care and the police.

Whilst every child death is a rare event, each one has a devastating and lasting impact on family, friends, community and those professionals involved.

As you read this year's report, I ask for you to consider the data and the learning identified, which may help prevent further deaths, as well as ensure children and young people receive excellent care and families are supported.

Please can I also take the opportunity to acknowledge the hard work and commitment of the Panel members, and the support of Dr Fiona Finlay, Designated Doctor for Children's Deaths, and the team at the Child Death Enquiry Office who are all committed to ensuring we continuously look for ways to make things safer for children and families across Wiltshire and Swindon.

In my first year as Chair of the Panel, it has been reassuring to see the dedication and sensitivity shown to each case discussed by the Panel. It has been a privilege to be part of this process, which has improving outcomes for our children and young people at the heart.

Hayley Morgan, Consultant in Public Health, Wiltshire
Chair of Wiltshire and Swindon CDOP

Executive summary:

This report represents the **15th annual report of the Wiltshire and Swindon Child Death Overview Panel** and the data ranging from **April 2019 to March 2024**. It provides an opportunity to review the data insights around child death to identify any emerging trends, as well as ensure the Panel is working effectively.

Summary statistics:

- Wiltshire and Swindon CDOP reviewed **163 cases between the 1st April 2019 and the 31st March 2024** (102 Wiltshire and 61 Swindon).
- CDOP reviewed a total of **28 cases** (15 from Wiltshire and 13 from Swindon) in 2023/24. There continues to be a reduction in the number of cases reviewed (not in the number of actual deaths) in the previous two years. These delays are primarily due to coronial and legal processes and police investigations.
- The most common **cause of death** for children across Wiltshire and Swindon is a **perinatal or neonatal event**, followed by a chromosomal categorisation of death.
- Across both England and the South West, the percentage of reviewed cases with modifiable factors was 39% for the most recent year of data (2022/23). Both Swindon and Wiltshire had a lower percentage of reviewed cases with modifiable factors at 23% and 32.4% respectively.
- For both Swindon and Wiltshire, the **percentage of notified deaths for males is higher than females**, at 60% and 53.8% respectively. This is similar to the proportion seen nationally, where 58.5% of child death notifications were male (2022/23).
- **Paediatrics and specialist services** (including obstetrics, neonatology, cardiology and oncology) were the **family follow up** outcome most taken up, with 46.4% Wiltshire cases reviewed using this service, and 57.1% Swindon cases reviewed.
- Swindon and Wiltshire have a lower percentage of child death notifications for the most deprived quintile, IMD Quintile 1, at 14.4%, compared to the South West which recorded 16.6%.

Key learning and actions

Learning identified will often be specific to individual organisations, CDOP seeks assurance that learning has been considered and necessary improvements implemented. Wiltshire and Swindon CDOP review and monitor action compliance regularly. Across 2023-24, additional activities have been undertaken to continue to embed learning and enable development of thematic areas following discussions at CDOP.

Wiltshire Self-Harm Summit – A Call for Action

Wiltshire Public Health hosted its first Self-Harm summit in Wiltshire in November 2023, to bring together 60+ partners working across this agenda. Discussions were supported by invaluable contributions from a group of young people from the Children and Adolescent Mental Health Service (CAMHS) Participation group, who shared their personal experiences of self-harm with professionals.

Wiltshire published its first **Self-harm Insight** report in 2024.

Self-Harm Insight Report - Wiltshire Intelligence

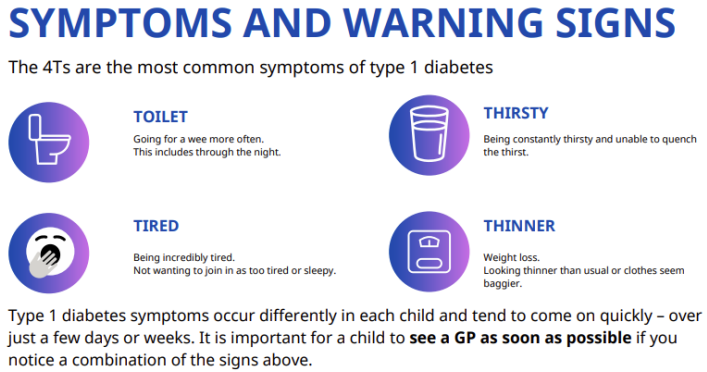
Development of the Critical Incident Guidance for 'Educational settings'

Throughout 2023-24, Wiltshire undertook the development of the Critical Incident Guidance for Wiltshire Schools. Work was driven through the Wiltshire Suicide Reduction group following the death by suicide of a young person.

Guidance has been refreshed as part of a collaborative piece of work, involving officers from across the Council and external partners and incorporates suicide specific advice and guidance. It has been co-produced, ensuring actions and agencies roles and responsibilities are clear when faced with a critical incident.

Recognising the signs and symptoms of Diabetes in children and young people

Following discussions at CDOP, work was undertaken to develop some communications to raise awareness of the signs and symptoms of Diabetes in children and young people



Evidence review into Cannabis Use and Parental Responsibility

An increasing number of cases reviewed at CDOP where the use of cannabis by the parents/carers has been identified.

Work was undertaken to review the evidence-base exploring problematic cannabis use and its associations on parenting, to understand the impacts.

Findings:

Professionals have less of an understanding and tend to 'normalise' the impact of significant cannabis use compared to other substances; and find it hard to assess the risks posed, due to the use now being so widespread

The full review can be accessed through the Wiltshire Intelligence site – click here

Key learning and actions

CDOP Newsletter

To ensure local learning is shared, the Wiltshire and Swindon CDOP have continued to produce its newsletter, which is disseminated to a wide audience.

The newsletter is for professionals working with parents and their children, to highlight the learning, guidance, and useful resources to support safe, healthy families. Themes included:

Enhancing Road Safety; Advice and signposting for professional's and parents

Following a case involving a young cyclist transitioning from a quiet road to a busier road, a reminder of general road safety advice was initiated. Walking, Scooting and Cycling are enjoyable activities that help to reduce obesity, which impacts around one third of children. Sadly, road traffic collisions contribute to around 35% of all childhood deaths. Therefore, ensuring road safety for children and families is essential, especially as young people become more independent on the road. [link to article]

Diabetes: what to look out for in Children

While we all know to check the **ABCs** (Airways, Breathing and Circulation) when treating or providing care for a child, it is easy to overlook glucose when a patient is sick. Measuring the child's level of consciousness and alertness and adding **Don't Ever Forget Glucose** (DFEGs) to the ABCs could help diagnose a child with diabetes, prevent long term harm or even save a child's life, especially in children with profound learning disabilities. [link to article]

Maintaining Safe Temperatures for Infants in Hot Weather

Responding to a case relating to overheating and the increasing likelihood of heatwaves, the Child Death Overview Panel (CDOP) have discussed safe temperature recommendations for infants. It is crucial that parents receive accurate information and understand how to regulate their infants' body heat. [link to article]

The Lullaby Trust have created a video: https://youtu.be/y_u13PSlavY

Effective communication for children and young people

Miscommunication had emerged as a theme in a number of cases reviewed by CDOP, as a critical factor leading to adverse outcomes for children and their families. As professionals working across healthcare, social work, and public health, we recognise the significance of effective communication in safeguarding the well-being of our young patients. Especially where there are barriers to communication due to developmental differences in understanding and learning difficulties. [link to article]

BSW Vulnerability and Protective Factors in Pregnancy and Early Parenthood

CDOP reviewed a case where there may have been opportunities for vulnerabilities and protective factors in pregnancy and early parenthood to be identified and supported. If these are not identified in a timely and appropriate way, then maternal mental health and child attachment can be significantly affected. [link to article]

Introduction

Child death remains a rare event in our society; however, each death represents a tragedy for the family, community and professionals involved. The purpose of the Child Death Review (CDR) process 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 of services and other relevant organisations. For example, in the case of children with life-limiting conditions the CDR process can 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 (CDOP) on behalf of the Child Death Review Partners (CDR Partners) in Wiltshire and Swindon respectively.

The CDR partners are Local Authorities and Integrated Care Boards and are joined on the Panel by partners from across health, social care and the Police. Invitations are extended to other agencies where there is relevance to ensure the discussions are extensive and considered as possible.

This CDOP continues to review the deaths of all children resident in Wiltshire and Swindon. Some of these deaths may occur outside of the region and these will also be reviewed by this panel. The panel may choose to review the deaths of non-resident children who die in the Swindon or Wiltshire area if appropriate e.g. in the case of a road traffic collision.

Wiltshire and Swindon Child Death Overview Panel (CDOP) has been established since April 2008 and is chaired by a Consultant in Public Health, Wiltshire.

A full list of panel representatives is available in appendix A.

Production of this report

Each CDOP is required to produce an annual report outlining the work of the panel and relevant learning from the cases reviewed to inform the priorities of the CDR Partners.

This 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 the eCDOP case management tool. Information collected from statutory forms, Child Death Review Meetings and CDOP reviews is populated onto eCDOP as the case progresses through the child death review process. The eventual CDOP multi-agency dataset is extremely comprehensive.

The annual report includes five years of aggregate 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.

The time-period for this data insight analysis will cover a 5 year range from

April 1st 2019 to March 31st 2024

The National Child Mortality Data (NCMD) will cover up to and including March 2023.

Background of the Child Death Review process

Background

Since April 2008, Local Safeguarding Boards in England having a statutory responsibility for child death review processes; continuing under the alternative local safeguarding arrangements introduced in 2019.

The current framework for when a child dies, follows **Working Together to Safeguarding Children 2023: Chapter 6 Child Death Review Processes**

N.B Cases reviewed as part of CDOP 2023-24 would have followed Working Together 2018: Chapter 5

Child Death Review: statutory and operational guidance (SOG) published in 2018, applies to all deaths reviewed in this annual report.

The overall purpose of the child review process is to understand **'how'** and **'why'** children die.

Processes focus on identifying **modifiable factors** in the child's death; considering any actions or interventions that seek to protect other children and to prevent future deaths.

Working Together (2023) and the CDR Statutory Guidance (2018) outline two inter-related processes:

'Joint Agency Response' (JAR) where a group of professionals came together for the purpose of evaluating the cause of death in an individual child, ***'where the death of that child was not anticipated, and the cause is not fully understood.'***

JAR process will be triggered much earlier, where the death of a child meets the above criteria and ensures a prompt process of investigation commences. This process will happen *prior* to CDOP happening.

'Child Death Overview Panel' (CDOP) comes together to undertake an overview of all child deaths under the age of 18 years in a defined geographical area.

CDOP ensures every child's death is comprehensively reviewed and opportunities for lessons learned to be identified, so action can be taken to prevent future deaths where possible.

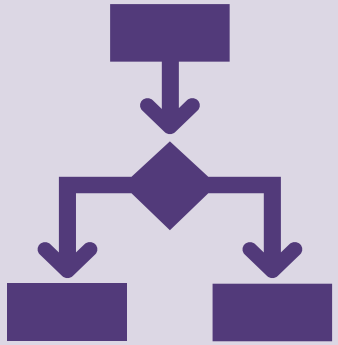
Child Death Review process

A child's death is reviewed by CDOP, following the collation of a range of information:

- Notification form
- Reporting form
- Supplementary reporting form
- Analysis form

Case discussed at child death review meeting (CDRM) by those professionals involved in the child's life.
Information is collated and anonymised by the Child Death Enquiries Office, University of Bristol for presentation at the CDOP

CDOP review each case, identifying modifiable factors and opportunities for learning.



CDOP can make recommendations to prevent similar future deaths, as well as service improvement or changes in practice which could lead to improve experiences for children & young people at the end of life or during their treatment.

Data summary

Deaths notified to Wiltshire and Swindon CDOP

Number of deaths notified to Wiltshire and Swindon CDOP in 2023/24:

Swindon	Wiltshire
18	20

Across a five-year period, 2019/20 – 2023/24

The largest proportion of notified deaths occurred during the **neonatal period** (0-27 days) for both Swindon and Wiltshire.

For both Swindon and Wiltshire, a large proportion of child deaths **occurred in a hospital**, at 63.1% and 70.8%, respectively.

For Wiltshire, 75.5% of the notifications to CDOP were for children of White British **ethnicity.**

While only 63.1% of notifications in Swindon were for children of White British ethnicity

15.4% were Asian/Asian British and 9.2% were Black African/Black Caribbean/Black British

Cases reviewed by Wiltshire and Swindon CDOP

Number of cases reviewed by Wiltshire and Swindon CDOP in 2023/24:

Swindon	Wiltshire
13	15

Across a five-year period, 2019/20 – 2023/24

Most cases reviewed were categorised as perinatal/neonatal or chromosomal deaths.

Looking at factors in the social environment, 32.5% of cases reviewed across Swindon and Wiltshire combined mentioned smoking by a parent or carer, and 27.6% mentioned a mental health condition in a parent or carer.

Mode of death: 50.8% and 40.2% of cases reviewed by CDOP were due to withdrawal of treatment for Swindon and Wiltshire, respectively.

Cases reviewed with modifiable factors

Swindon: 23.0%
Wiltshire: 32.4%

Family bereavement follow up was offered but declined in 8.6% (Swindon) and 8.2% (Wiltshire) of all cases reviewed by CDOP.

Swindon Borough Council
Wiltshire Council

Notified deaths

Number of deaths notified to CDOP by year from 2019/20 to 2023/24, crude rates (per 100,000 population)							
		2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24**	Totals
Swindon	**Number of deaths** (0 – 17 years old)	14	13	6	14	18	**65**
	Crude rate of deaths (0 – 17 years old, per 100,000 population)	27.44	25.34	11.67	26.82	33.97	
	Number of deaths (1 – 17 years old)	2	8	2	4	9	**25**
	Crude rate of deaths (1 – 17 years old, per 100,000 population)	4.13	16.41	4.09	8.05	17.81	
Wiltshire	**Number of deaths** (0 – 17 years old)	23	26	21	16	20	**106**
	Crude rate of deaths (0 – 17 years old, per 100,000 population)	22.25	25.23	20.37	15.53	19.35	
	Number of deaths (1 – 17 years old)	12	8	4	10	6	**40**
	Crude rate of deaths (1 – 17 years old, per 100,000 population)	12.17	8.14	4.06	10.16	6.07	

Table 1: Number of deaths notified to CDOP by year from 2019/20 – 2023/24 for Wiltshire and Swindon, crude rates (per 100,000) using ONS mid-year population estimates

Rates for 0-17 years old: The most recently available rates for **South West** (2022/23) show a rate of **24.2** deaths per 100,000 population, which is lower than the rate for Swindon for that time period, but higher than the rate for Wiltshire.

The national figure for this same time period is 31.8 per 100,000.

Rates for 1-17 years old: The most recently available rates for **South West** (2022/23) show a rate of **11.5** deaths per 100,000 population, which is higher than the rate for both Swindon and Wiltshire for that time.

The national figure for this same time period is 13.6 per 100,000.

Note: When interpreting the year-on-year data, variation between years is expected with rare events such as child deaths. These small numbers can create the appearance of a big difference when looking at totals and rates.

Notified deaths

Number of deaths notified to CDOP by year from 2019/20 to 2023/24, crude rates (per 1,000 live births)							
		2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24**	Totals
Swindon	**Number of deaths** (0 – 365 days old)	12	5	4	10	9	40
	Crude rate of deaths (0 – 365 days old, per 1,000 live births)	4.6	2.0	1.6	4.2	3.8	
Wiltshire	**Number of deaths** (0 – 365 days old)	11	18	17	6	14	66
	Crude rate of deaths (0 – 365 days old, per 1,000 live births)	2.3	4.0	3.7	1.3	3.1	

Table 2: Number of deaths notified to CDOP by year from 2019/20 – 2023/24 for Wiltshire and Swindon, crude rates (per 1,000 live births) using ONS live birth tables

For deaths for children under 1 year of age, in line with the methods used by the National Child Mortality Database, rates are calculated using ONS data for live births, and the rate is represented per 1,000 live births.

The estimated rate of infant (defined as a child under 1 year of age) deaths across the **South West** for the most recent year of data available (**2022/23**) is **2.9 per 1,000 live births**. This is higher than the rate for Wiltshire for the same period of 1.3, yet lower than the rate for Swindon of 4.2.

Nationally, the estimated infant death rate for 2022/23 was 3.8 per 1,000 live births.

Notified deaths: Age

Number of deaths by age Five-year period, 2019/20 – 2023/24		
Age at death	**Swindon**	**Wiltshire**
0 – 27 days	30	46
28 – 365 days	10	20
1 – 4 years	8	12
5 – 9 years	*	6
10 – 14 years	8	11
15 – 17 years	8	11

Table 3: Number of deaths notified to CDOP by age for 5-year period, 2019/20 – 2023/24

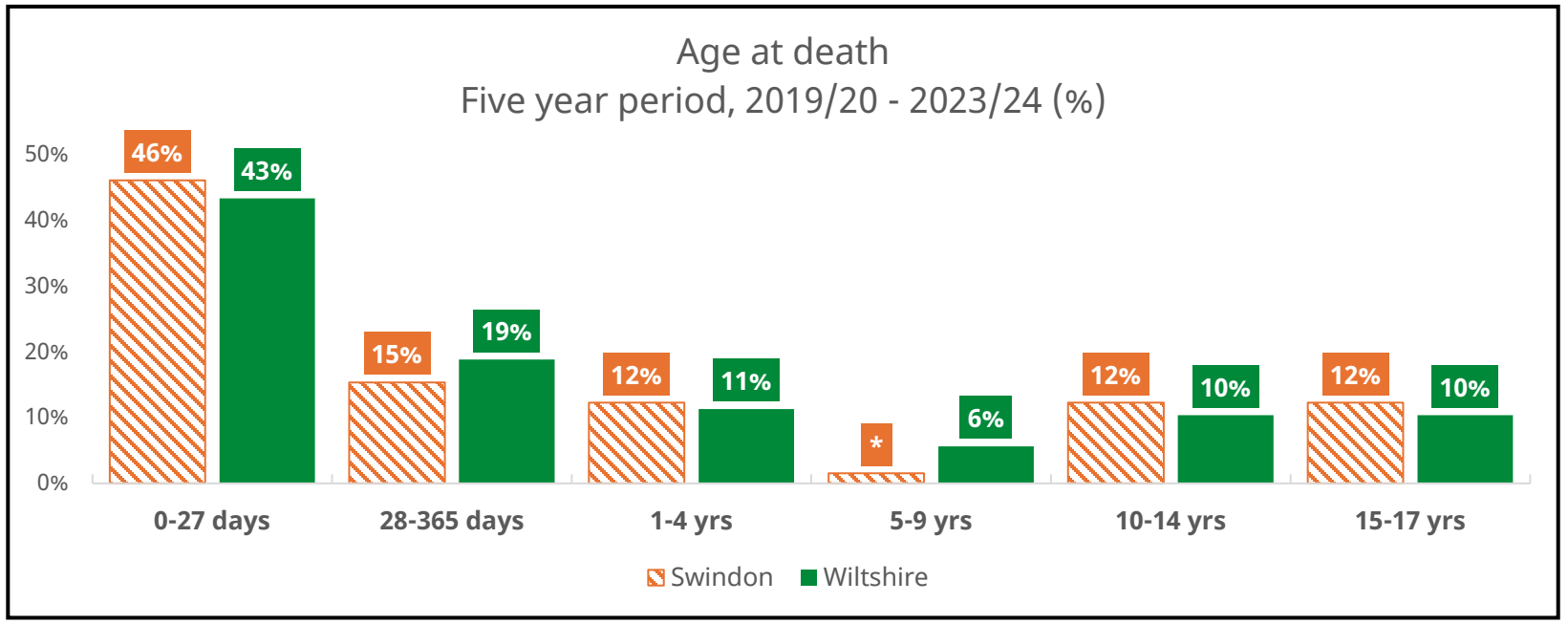


Chart 1: Percentage of deaths notified to CDOP by age for 5-year period from 2019/20 – 2023/24

Please note: Due to the small numbers of notified deaths year on year, and the variation that this produces, most of the data within this report will be presented as a total across the most recent five-year period (2019/20 2023/24).

Numbers of 5 or less have been suppressed from the data presentations, and replaced with an asterisk (*).

For both Swindon and Wiltshire, the largest proportion of deaths occurred during the neonatal period (0-27 days), at 46% and 43%, respectively.

This is similar to the proportion seen nationally of 41% for the most recent year of data available (2022/23).

Combining the totals from 0-27 days and 28-365 days shows that nearly **two thirds** of deaths occur **before the age of one** in both Swindon (62%) and Wiltshire (62%).

Notified deaths: Gender

Number of deaths by gender Five-year period, 2019/20 – 2023/24		
Gender	**Swindon**	**Wiltshire**
Male	30	46
Female	10	20

Table 4: Number of deaths notified to CDOP by gender for 5-year period from 2019/20 – 2023/24

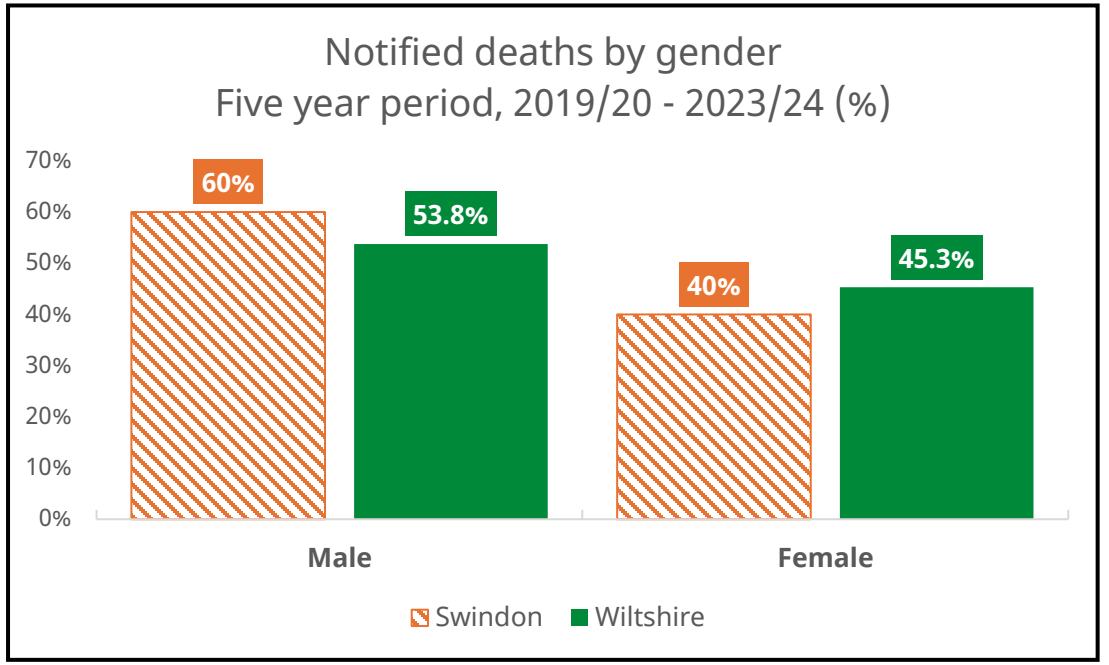


Chart 2: Percentage of deaths notified to CDOP by gender for 5-year period from 2019/20 – 2023/24

For both Swindon and Wiltshire, the percentage of notified deaths for males is higher than females, at 60% and 53.8% respectively.

This is similar to the proportion seen nationally, where 58.5% of child death notifications were male for the most recent year of data available (2022/23).

Notified deaths: Location

Number of deaths by location Five-year period, 2019/20 – 2023/24		
Location of death	**Swindon**	**Wiltshire**
Great Western Hospital	12	9
Salisbury District Hospital	0	14
Royal United Hospital	*	9
St Michael's Hospital	6	7
Bristol Children's Hospital	8	13
Other Hospital	14	13
Home / Private Residence	13	22
Hospice	*	6
Other/Public Place	8	*
Princess Anne Hospital	0	6
Southampton General	0	*

Table 5: Number of deaths notified to CDOP by location of death for 5-year period from 2019/20 – 2023/24

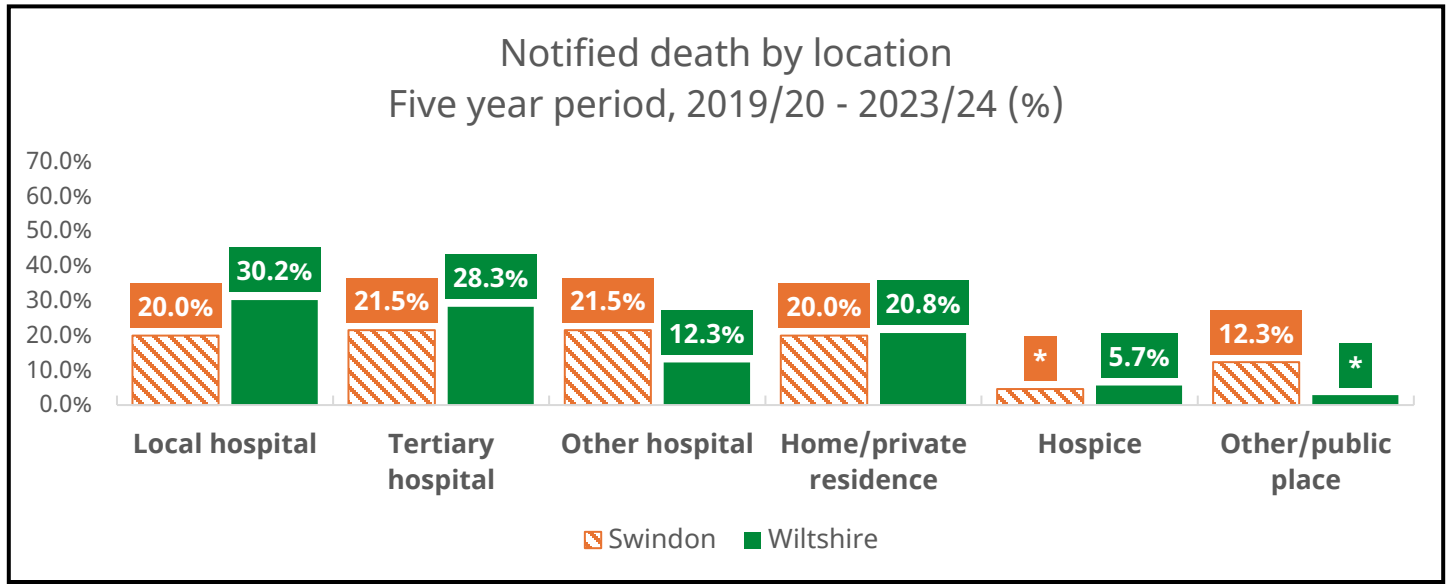


Chart 3: Percentage of deaths notified to CDOP by location of death for 5-year period from 2019/20 – 2023/24

For both Swindon and Wiltshire, a large proportion of child deaths occurred in a hospital, at 63.1% and 70.8% respectively. The split between local and tertiary hospitals (please see next page for definitions) is relatively equal across both areas. There is a greater number of hospital locations for those from Wiltshire, likely due to the large geographical area that the county covers, and the number of other counties it borders.

Regionally across the South West, a hospital is the most frequently reported place of death, with 63% of deaths occurring in a hospital. This is the same for notifications across England, with 75% of deaths occurring in a hospital.

Notified deaths: Location [defined]

Local and tertiary hospitals can be differentiated by the level of care that they provide. Certain hospitals with specialist units such as NICU or PICU would be considered **'tertiary hospitals'**.

The hospitals listed on the previous page have been categorised as the following:

Local
- Great Western Hospital
- Salisbury District Hospital
- Royal United Hospital

Tertiary
- St Michael's Hospital
- Bristol Children's Hospital
- Princess Anne Hospital
- Southampton General

Other hospital has been retained as its own category.

Notified deaths: Deprivation

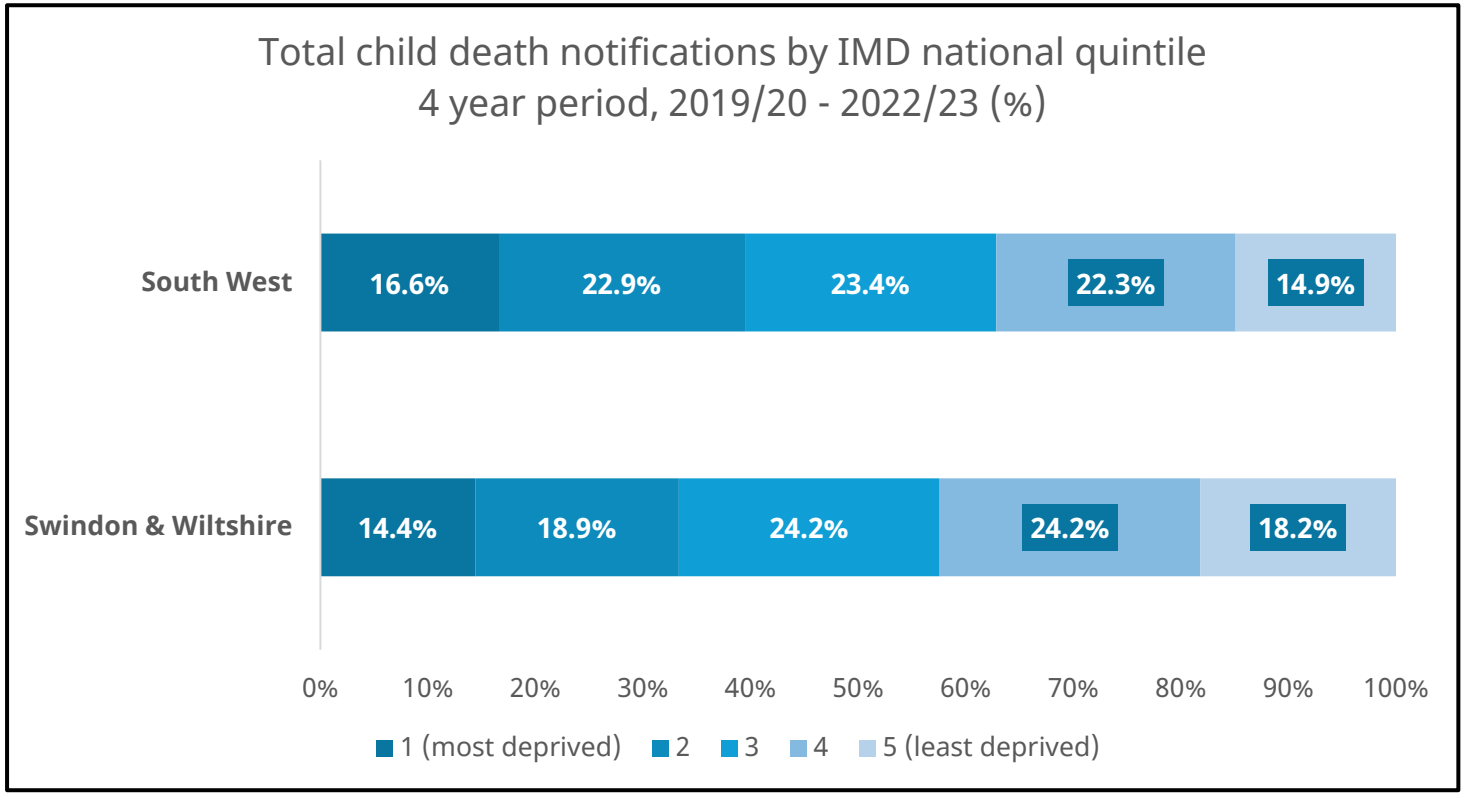


Chart 4: Percentage of deaths notified to CDOP by IMD deprivation quintile for 4-year period from 2019/20 – 2022/23

IMD National Quintile for child death notifications is based on the child's postcode of residence.

In 2022/23, nationally, the estimated child death rate is more than double for those living in the most deprived areas (IMD Quintile 1) at 48.1 per 100,000, compared with 18.7 per 100,000 for the least deprived areas (IMD Quintile 5). Looking at the number of child death notifications across England for this same period, 36% were for children living in IMD Quintile 1.

Across the South West, 16.6% of child death notifications are seen for the most deprived quintile, IMD Quintile 1. In comparison to Swindon and Wiltshire this is lower, at 14.4%.

Overall, Swindon and Wiltshire have a higher percentage of notifications for the less deprived areas, at 42.4% for IMD quintiles 4 and 5, compared to 37.2% in the South West region.

Notified deaths: Ethnicity

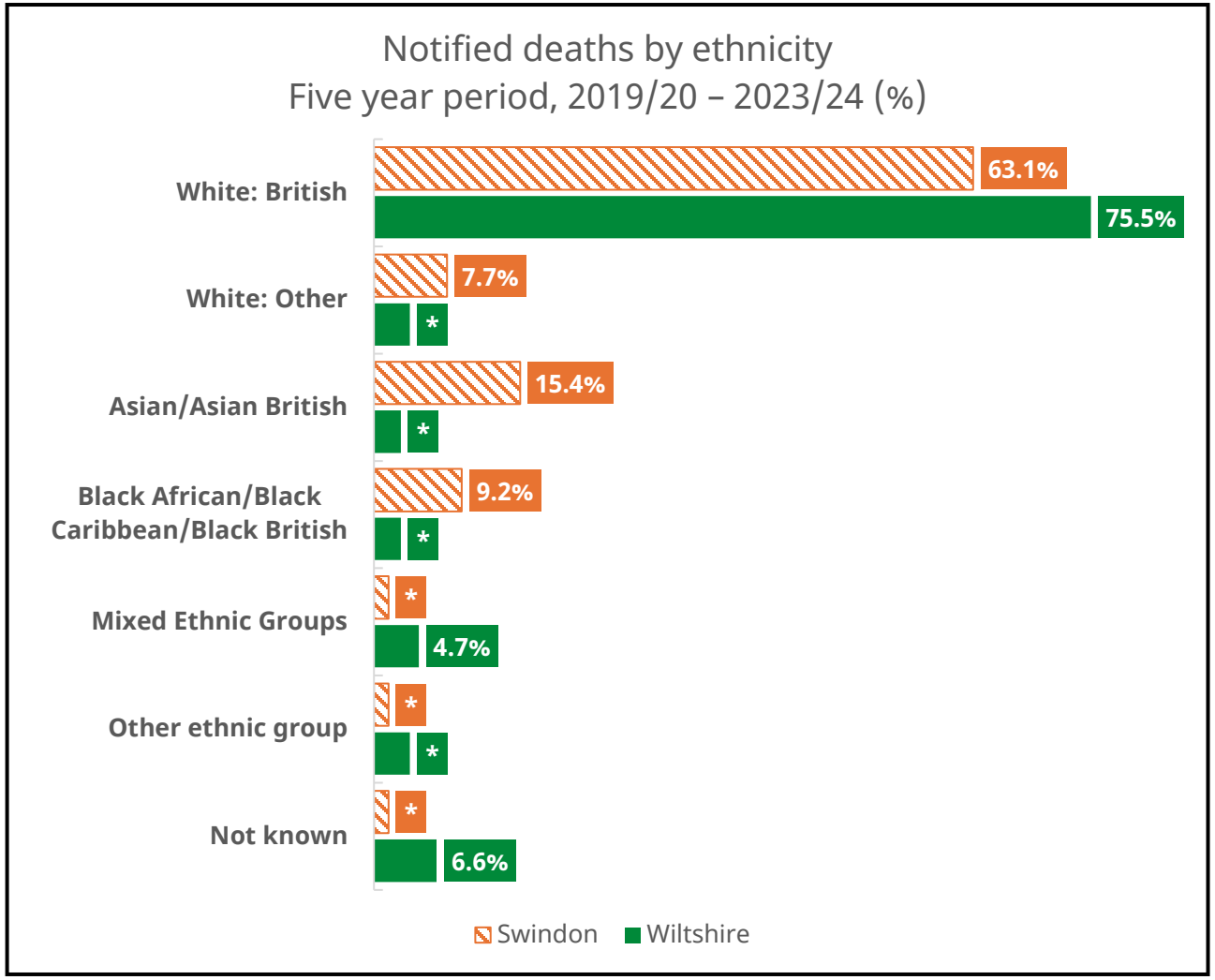


Chart 5: Percentage of deaths notified to CDOP by ethnicity for 5-year period from 2019/20 – 2023/24

Number of deaths by ethnicity
Five-year period, 2019/20 – 2023/24

Location of death	Swindon	Wiltshire
White: British	41	80
White: Other	5	*
Asian/Asian British	10	*
Black African/Black Caribbean/Black British	6	*
Mixed Ethnic Groups	*	5
Other ethnic group	*	*
Not known	*	7

Table 6: Number of deaths notified to CDOP by ethnicity for 5-year period from 2019/20 – 2023/24

For Wiltshire, 75.5% of the notifications to CDOP were for children of White British ethnicity.

While only 63.1% of notifications in Swindon were for children of White British ethnicity; 15.4% were Asian/Asian British and 9.2% were Black African/Black Caribbean/Black British.

Percentage of deaths by ethnicity with comparison to 2021 census 0 – 17 population by ethnicity
Five-year period, 2019/20 – 2023/24 for percentage of deaths

Location of death	Swindon: 2021 Census 0-17 population	Swindon	Wiltshire: 2021 Census 0-17 population	Wiltshire
White: British	69.2%	63.1%	87.5%	75.5%
White: Other	5.6%	7.7%	3.3%	*
Asian/Asian British	14.1%	15.4%	2.6%	*
Black African/Black Caribbean/Black British	3.5%	9.2%	1.7%	*
Mixed Ethnic Groups	6.2%	*	4.2%	4.7%
Other ethnic group	1.4%	*	0.8%	*
Not known	-	*	-	6.6%

Table 7: Percentage of deaths ethnicity notified to CDOP by ethnicity for 5-year period from 2019/20 – 2023/24 with comparison to 2021 census 0-17 population by ethnicity

Comparing deaths by ethnicity with the 2021 census population by ethnicity, the percentage of deaths for those of White: British ethnicity in Swindon is similar to the overall White: British population, while the percentage of deaths seen among the Black African/Caribbean/British is higher than the known population of this ethnicity. The percentage of deaths in the White: British population for Wiltshire is lower than the census population for this ethnicity, however it is worth noting the relatively high percentage of deaths where the ethnicity was reported as "Not known" for Wiltshire, which could account for this difference.

Total number of cases reviewed by CDOP 2019/20 – 2023/24		
Year	**Swindon**	**Wiltshire**
2019/20	10	16
2020/21	6	20
2021/22	22	25
2022/23	10	26
2023/24	13	15
Total	**61**	**102**

Table 8: Number of cases reviewed by CDOP from 2019/20 – 2023/24

Postmortem, Police investigation or Safeguarding review

For Swindon cases across the period of 2019/20 to 2023/24, 18 received a postmortem, 3 had a police investigation and 4 were subject to a safeguarding review.

Looking at the cases across Wiltshire for this period, 33 had a postmortem, 1 received a police investigation and 4 were subject to a safeguarding review.

Child Death Overview Panel reviewed cases

There is an inevitable time lag between the notification of a child's death and the discussion at CDOP. There are various factors contributing to this, including return of statutory paperwork by professionals, receipt of the final post-mortem report and receipt of the report from the Child Death Review Meeting.

Wiltshire and Swindon CDOP decided in 2009 to wait for the inquest verdict in child deaths that involve the Coroner before reviewing the case. In these cases, there may be a delay of over a year before a case might be brought for review by CDOP. Additionally, the undertaking of a criminal investigation can also affect when a case is discussed at panel. Whilst this impacts on timeliness it is the opinion of the CDOP that the quality of the review of the cases is better with this information.

The notification data and review data totals will therefore differ year on year.

Wiltshire and Swindon CDOP reviewed 163 cases between the 1st April 2019 and the 31st March 2024 (102 Wiltshire and 61 Swindon).

During 2023/24 period Wiltshire and Swindon CDOP reviewed a total of 28 cases (15 Wiltshire and 13 Swindon).

There continues to be a reduction in the number of cases reviewed in the previous two years.

Reviewed cases: Length of time to review

Number of cases reviewed by length of time taken to complete Five-year period, 2019/20 – 2023/24

Length of time	Swindon	Wiltshire
Under 6 months	*	0
6 to 12 months	5	10
13 to 18 months	25	32
Over 18 months	30	60

Table 9: Number of cases reviewed by length of time taken to complete, for 5-year period from 2019/20 – 2023/24

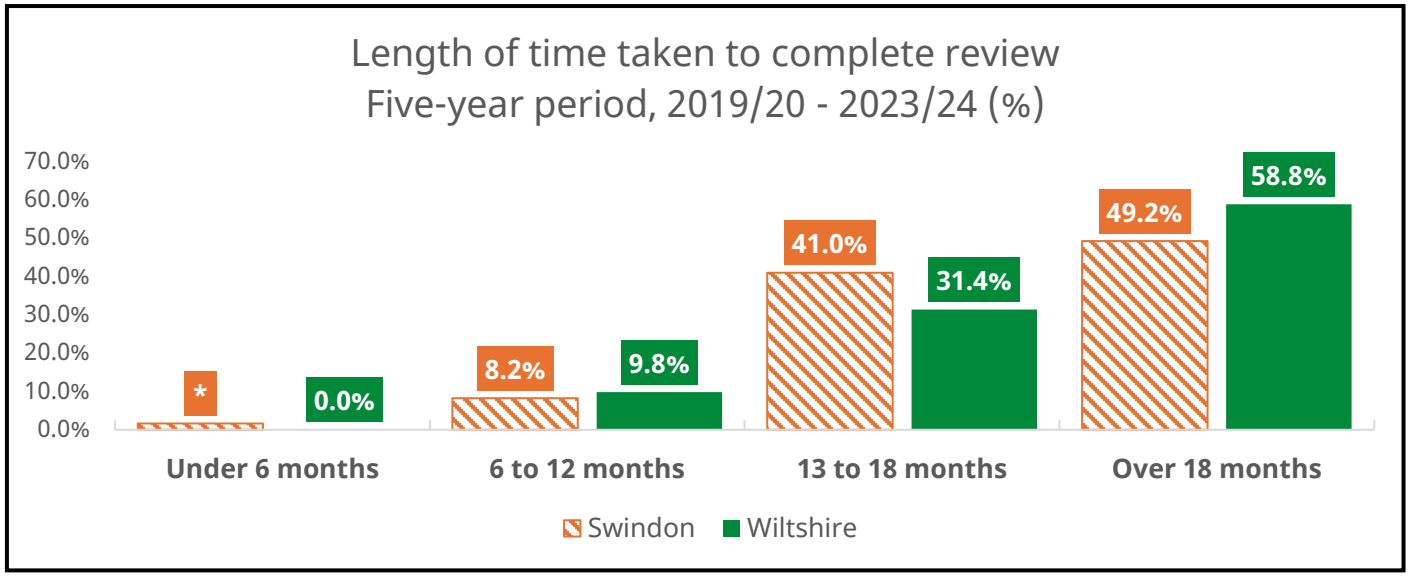


Chart 6: Percentage of cases reviewed by length of time taken to complete, for 5-year period from 2019/20 – 2023/24

For both Swindon and Wiltshire, for the five-year period of 2019/20 to 2023/24, 90% of reviews took longer than 12 months to complete. 58.8% and 49.2% of reviews for Wiltshire and Swindon respectively took over 18 months to complete.

Across England, for the most recent year of data available (2022/23), 55% of reviews took more than 12 months to complete. Nationally, 35.2% of reviews took 6-12 months to complete, and 9.9% took under 6 months.

The principal reasons for why cases are being delayed in being bought to CDOP for discussion are due to coronial and legal processes and police investigations.

There are currently 26 cases outstanding where the child has passed away over 12mths ago in Wiltshire and Swindon.

Reviewed cases: Modifiable factors

Modifiable factors identified in cases reviewed by CDOP
Five-year period, 2019/20 – 2023/24

Modifiable factors	Swindon	Wiltshire
No modifiable factors	46	68
Modifiable factors	14	33
Inadequate Information	1	1

Table 10: Number of cases reviewed by modifiable factors identified, for 5-year period from 2019/20 – 2023/24

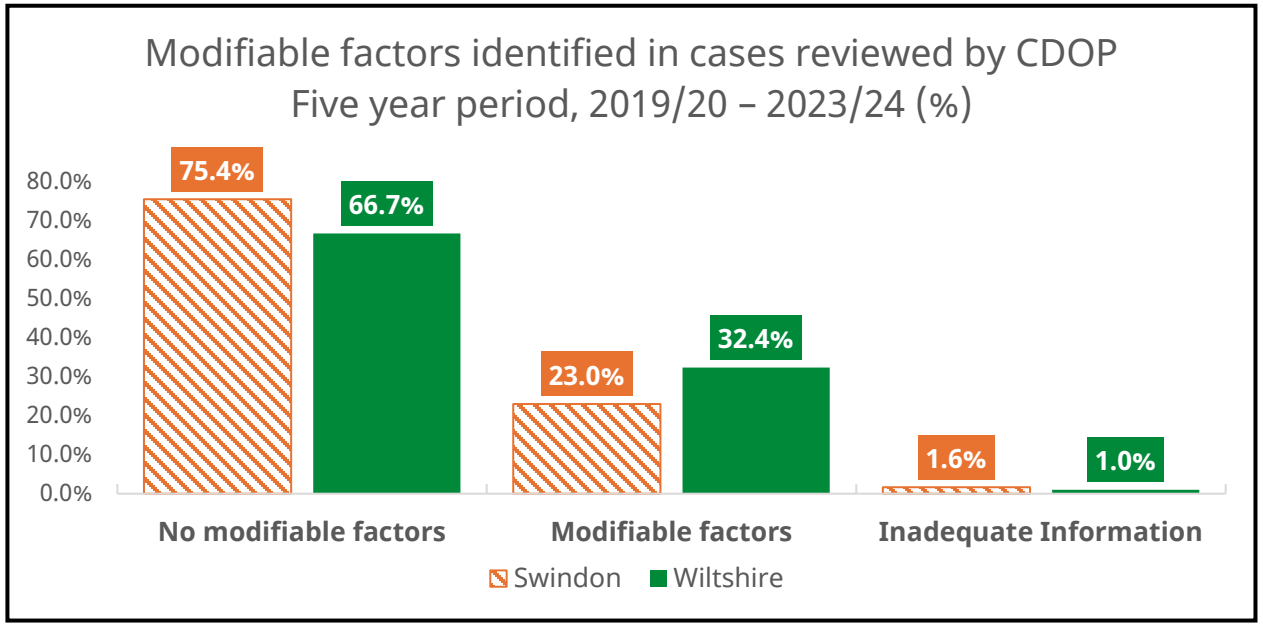


Chart 7: Percentage of cases reviewed by modifiable factors identified, for 5-year period from 2019/20 – 2023/24

Across both England and the South West, the percentage of reviewed cases with modifiable factors was 39% for the most recent year of data (2022/23). Both Swindon and Wiltshire had a lower percentage of reviewed cases with modifiable factors at 23% and 32.4% respectively.

A role 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 parent, 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 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.

In addition, CDOP would regard a death as having modifiable factors if practice had changed due to learning arising from that child's death, even when the outcome for that child might not have changed. This allows for a precautionary approach with the aim of using learning identified to limit future deaths.

Reviewed cases: Categorisation of cases reviewed

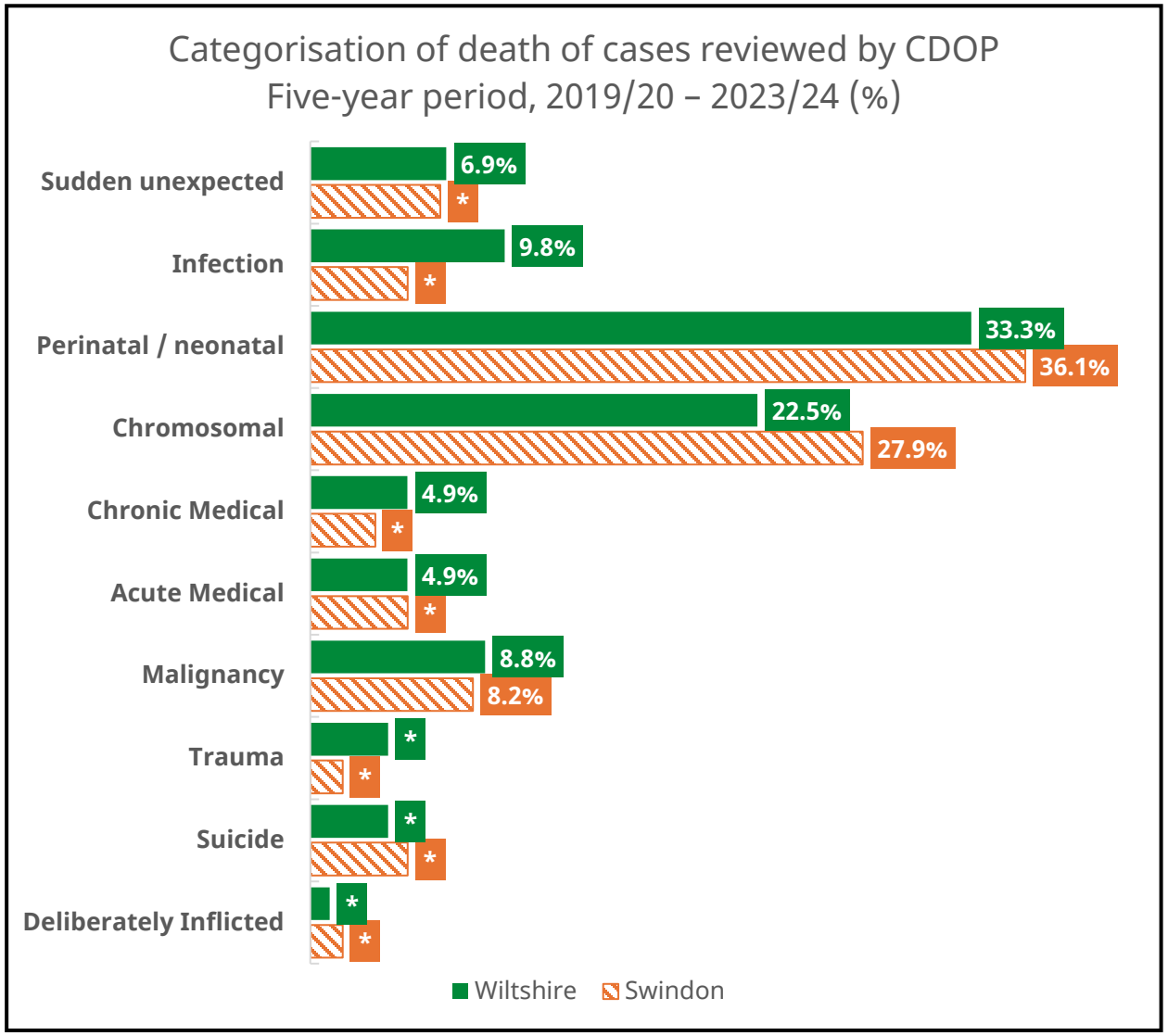


Chart 8: Percentage of cases reviewed by categorisation of death, for 5-year period from 2019/20 – 2023/24

Categorisation of death of cases reviewed by CDOP Five-year period, 2019/20 – 2023/24

Categorisation	Swindon	Wiltshire
Deliberately Inflicted	*	*
Suicide	*	*
Trauma	*	*
Malignancy	5	9
Acute Medical	*	5
Chronic Medical	*	5
Chromosomal	17	23
Perinatal / neonatal	22	34
Infection	*	10
Sudden unexpected	*	7

Table 11: Number of cases reviewed by categorisation of death, for 5-year period from 2019/20 – 2023/24

Categorisation of cases reviewed

As 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 CDOP categories as represented in chart 8.

Locally, as shown in chart 8, cases were most frequently categorised as perinatal and neonatal deaths (defined as the death of a live born baby of 22 or more completed week or within 28 days of birth) at 33.1% for Wiltshire and 36.1% for Swindon. This is followed by chromosomal deaths, at 22.5% (Wiltshire) and 27.9% (Swindon).

Trauma and deliberately inflicted were amongst the least used categorisations across Swindon and Wiltshire.

These local findings reflect those seen nationally, where 34.4% of deaths were categorised as perinatal/neonatal events in 2022/23, and 23.5% as chromosomal.




Reviewed cases: Mode of death of cases reviewed

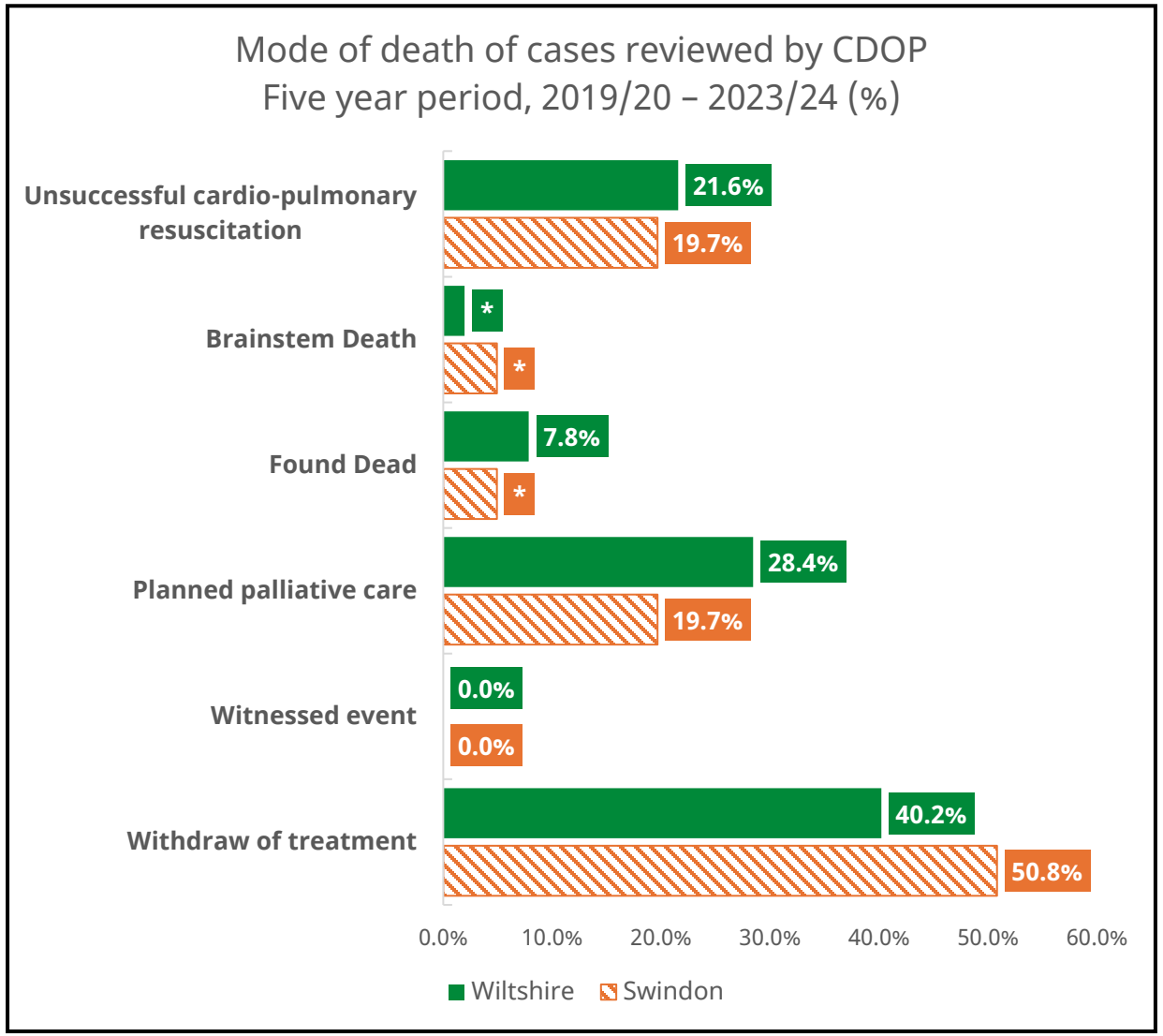


Chart 9: Percentage of cases reviewed by mode of death, for 5-year period from 2019/20 – 2023/24

Mode of death of cases reviewed by CDOP
Five-year period, 2019/20 – 2023/24

Mode of death	Swindon	Wiltshire
Unsuccessful cardio-pulmonary resuscitation	12	22
Brainstem Death	*	*
Found Dead	*	8
Planned palliative care	12	29
Witnessed event	*	*
Withdraw of treatment	31	41

Table 12: Number of cases reviewed by mode of death, for 5-year period from 2019/20 – 2023/24

Withdrawal of treatment was the most common mode of death of cases reviewed for Swindon and Wiltshire, with 40.2% (Swindon) and 50.8% (Wiltshire) of cases classified as this.

Such decisions are always made following careful consideration with the child's parents and carers.

Reviewed cases: Factors in the social environment

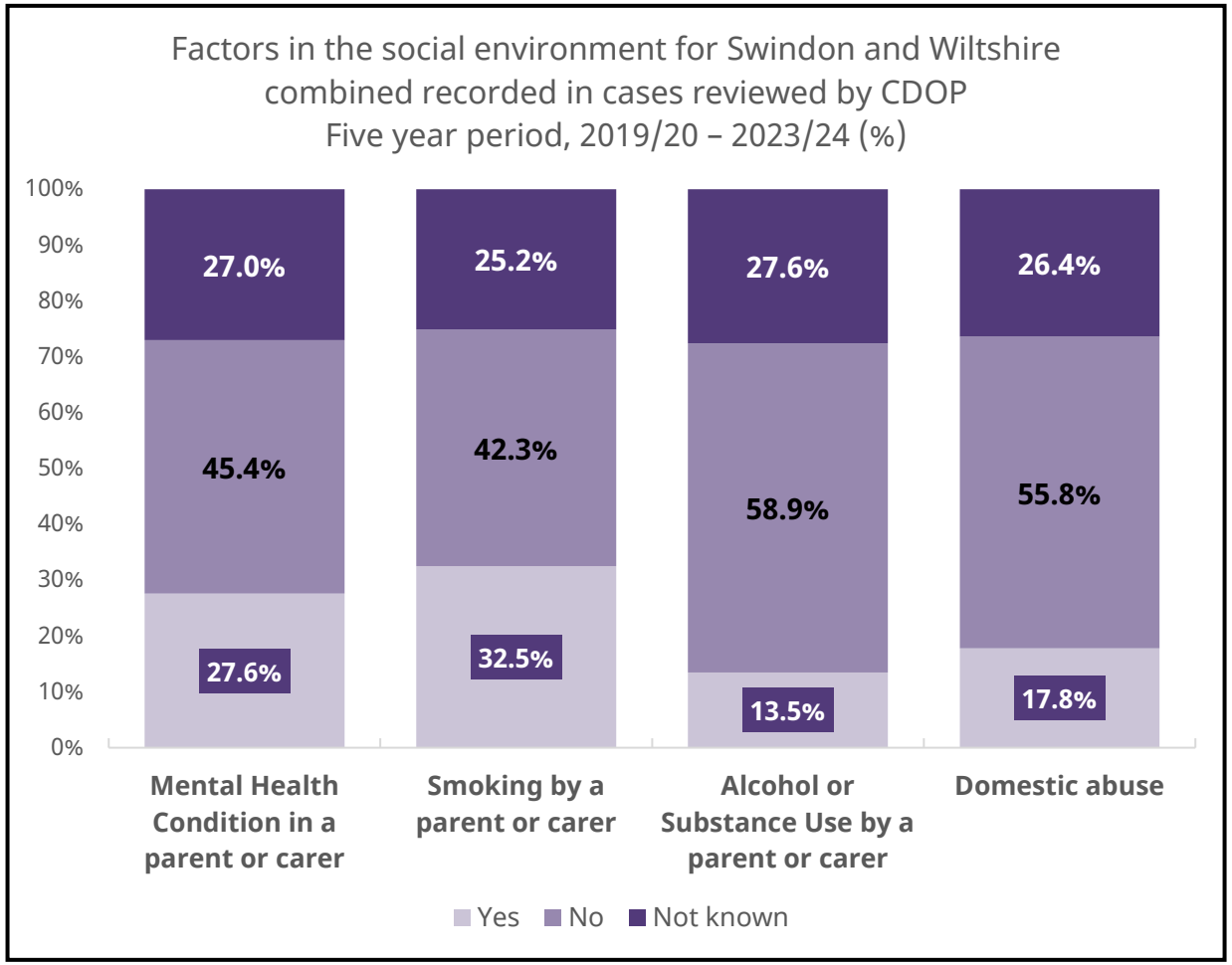


Chart 10: Percentage of cases reviewed by recorded factors in the social environment, for 5-year period from 2019/20 – 2023/24

The presence or absence of social factors in the family and environment such as mental health issues, smoking, domestic abuse and drug abuse are routinely collected on the Reporting Form dataset from professionals who have contact with the families.

These are summarised on the Analysis Form dataset at the Child Death Review Meeting and carefully reviewed by CDOP. These factors have been shown for Swindon and Wiltshire in chart 10.

It is important to note that these factors may not have been directly contributory to the child's death; rather this information reflects the presence or absence of a factor within the social environment.

Smoking by a parent or carer was the most frequently recorded factor in the social environment for Swindon and Wiltshire, which was then followed by mental health condition in a parent or carer.

Reviewed cases: Family follow up

Number of cases reviewed by family follow up outcome Five-year period, 2019/20 – 2023/24		
Length of time	**Swindon**	**Wiltshire**
Primary care	7	12
Paediatrics/Specialist Services	40	51
Hospice/Community Nursing	*	5
Offered but declined	6	9
No information available	5	6
Other/Not known	8	27

Table 13: Number of cases reviewed by family follow up outcome, for 5-year period from 2019/20 – 2023/24

Active engagement with bereaved parents underpins the entire child death review process. Parental input into the child death review meeting should occur as a matter of course. Parents are invited to submit questions to the local child death review meeting, and feedback by the lead health professional on all aspects of this meeting is then given at a follow-up appointment with the family. Families may access follow-up from more than one professional agency.

Paediatrics and specialist services (including obstetrics, neonatology, cardiology and oncology) were the family follow up outcome that was most commonly taken up, with 46.4% of cases reviewed in Wiltshire using this service, and 57.1% of cases reviewed in Swindon.

Data for family follow up outcome can be provided by several agencies, and so may differ from the total cases reviewed by CDOP seen elsewhere in the report.

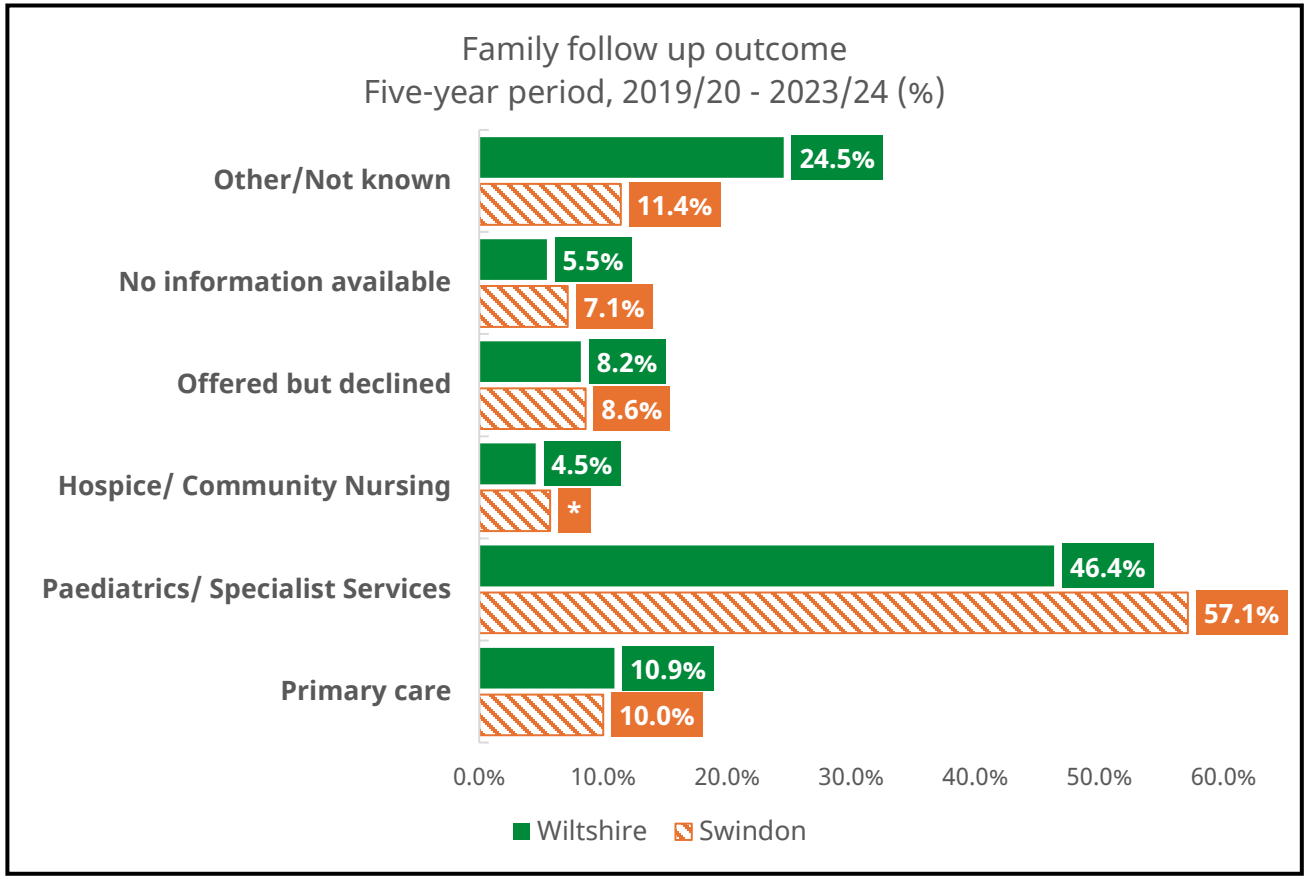


Chart 11: Percentage of cases reviewed by family follow up outcome, for 5-year period from 2019/20 – 2023/24

Going forward

Wiltshire and Swindon CDOP have agreed to make some changes to the geographic coverage the CDOP incorporates.

As from April 2024, the CDOP arrangements will align with the Integrated Care Board's (ICB) footprint to include the areas of:

- **BaNES** (Bath and North East Somerset),
- **Swindon** and;
- **Wiltshire**

The BaNES, Swindon and Wiltshire (BSW) CDOP will include the review of BaNES child deaths, who were formally reviewed under the West of England CDOP arrangements.




Data sources and references

Section title	Reference title	Data source	Date	Link
Summary	Deaths notified to Wiltshire and Swindon (all indicators)	Wiltshire and Swindon Child Death Overview Panel	2019/20 - 2023/24	
Summary	Cases reviewed by Wiltshire and Swindon CDOP (all indicators)	Wiltshire and Swindon Child Death Overview Panel	2019/20 - 2023/24	
Notified deaths	Number of notified deaths for Swindon and Wiltshire	Wiltshire and Swindon Child Death Overview Panel	2019/20 - 2023/24	
Notified deaths	Crude rate of deaths (per 100,000 population)	ONS mid-year estimates: Mid-2011 to mid-2022 detailed time series edition	2019-2022	Estimates of the population for England and Wales - Office for National Statistics (ons.gov.uk)
Notified deaths	Crude rate of deaths (per 100,000 population)	ONS mid-year estimates: Mid-2023: 2023 local authority boundaries edition of this dataset edition	2023	Estimates of the population for England and Wales - Office for National Statistics (ons.gov.uk)
Notified deaths	Rates for 0-17 years old: Regional and national figures	National Child Mortality Database, Child death review data release, 2023	2022/23	Child death data release 2023 | National Child Mortality Database (ncmd.info)

Data sources and references

Section title	Reference title	Data source	Date	Link
Notified deaths	Rates for 1-17 years old: Regional and national figures	National Child Mortality Database, Child death review data release, 2023	2023	Child death data release 2023 | National Child Mortality Database (ncmd.info)
Notified deaths	Crude rate of deaths (per 1,000 live births)	Births in England and Wales: summary tables, 2022 edition	2022	Births in England and Wales: summary tables - Office for National Statistics (ons.gov.uk)
Notified deaths: Age	Number of deaths by age for Swindon and Wiltshire	Wiltshire and Swindon Child Death Overview Panel	2019/20 - 2023/24	
Notified deaths: Age	National figures for deaths by age	National Child Mortality Database, Child death review data release, 2023	2022/23	Child death data release 2023 | National Child Mortality Database (ncmd.info)
Notified deaths: Gender	Number of deaths by gender for Swindon and Wiltshire	Wiltshire and Swindon Child Death Overview Panel	2019/20 - 2023/24	
Notified deaths: Gender	National figures for deaths by gender	National Child Mortality Database, Child death review data release, 2023	2022/23	Child death data release 2023 | National Child Mortality Database (ncmd.info)

Data sources and references

Section title	Reference title	Data source	Date	Link
Notified deaths: Location	Number of deaths by location for Swindon and Wiltshire	Wiltshire and Swindon Child Death Overview Panel	2019/20 - 2023/24	
Notified deaths: Location	Regional and national figures for deaths by location	National Child Mortality Database, Child death review data release, 2023	2022/23	Child death data release 2023 | National Child Mortality Database (ncmd.info)
Notified deaths: Deprivation	Child death notifications by IMD national quintile for Swindon and Wiltshire	South West NCD Regional Report	2019/20 - 2022/23	
Notified deaths: Deprivation	Regional and national figures for deaths by deprivation	National Child Mortality Database, Child death review data release, 2023	2022/23	Child death data release 2023 | National Child Mortality Database (ncmd.info)
Notified deaths: Ethnicity	Number of deaths by ethnicity for Swindon and Wiltshire	Wiltshire and Swindon Child Death Overview Panel	2019/20 - 2023/24	
Notified deaths: Ethnicity	2021 Population for Swindon and Wiltshire for 0 – 17 years by ethnicity	Census 2021	2021	Detailed ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

Data sources and references

Section title	Reference title	Data source	Date	Link
Reviewed cases	Number of cases reviewed by Swindon and Wiltshire CDOP	Wiltshire and Swindon Child Death Overview Panel	2019/20 - 2023/24	
Reviewed cases	Reviewed cases receiving a postmortem, police investigation or safeguarding review	Wiltshire and Swindon Child Death Overview Panel	2019/20 - 2023/24	
Reviewed cases: Length of time to review	Number of cases reviewed by length of time taken to complete review	Wiltshire and Swindon Child Death Overview Panel	2019/20 - 2023/24	
Reviewed cases: Length of time to review	National figured for reviews by length of time taken to complete	National Child Mortality Database, Child death review data release, 2023	2022/23	Child death data release 2023 | National Child Mortality Database (ncmd.info)
Reviewed cases: Modifiable factors	Number of cases reviewed by CDOP presence of modifiable factors	Wiltshire and Swindon Child Death Overview Panel	2019/20 - 2023/24	
Reviewed cases: Modifiable factors	National figured for reviews by presence of modifiable factors	National Child Mortality Database, Child death review data release, 2023	2022/23	Child death data release 2023 | National Child Mortality Database (ncmd.info)

Data sources and references

Section title	Reference title	Data source	Date	Link
Reviewed cases: Categorisation of cases reviewed	Number of cases reviewed by categorisation of death	Wiltshire and Swindon Child Death Overview Panel	2019/20 - 2023/24	
Reviewed cases: Categorisation of cases reviewed	National figured for reviews by categorisation of death	National Child Mortality Database, Child death review data release, 2023	2022/23	Child death data release 2023 | National Child Mortality Database (ncmd.info)
Reviewed cases: Mode of death of cases reviewed	Number of cases reviewed by mode of death	Wiltshire and Swindon Child Death Overview Panel	2019/20 - 2023/24	
Reviewed cases: Factors in the social environment	Total cases reviewed for Swindon and Wiltshire by the factors in the social environment	Wiltshire and Swindon Child Death Overview Panel	2019/20 - 2023/24	
Reviewed cases: Family follow up	Number of cases reviewed by family follow up outcome	Wiltshire and Swindon Child Death Overview Panel	2019/20 - 2023/24	