Pan Berkshire CDOP **Annual Report**

1 April 2024-31 March 2025

NHS Frimley

Berkshire West Safeguarding Children Partnership
Reading | West Berkshire | Wokingham

Bracknell Forest Safeguarding Board

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Royal Borough of Windsor & Maidenhead Safeguarding Partnership

Slough Safeguarding Partnership

Contents

Foreword

One of the most devastating things for a family to experience is the death of a child and it is recognised that this will have a profound and long-lasting impact on everyone involved in that child's life and beyond into the community. The Pan Berkshire Child Death Overview Panel (CDOP) has the responsibility for reviewing the deaths of all live-born children, up to but not including their 18th birthday, resident in Berkshire (excluding stillbirths and legal terminations). The CDOP team currently sits in Bracknell Forest Council but covers the whole county. The CDOP has approximately, just under 60 child deaths a year and in 2024/2025 Berkshire had 56 deaths, slightly less on the year before (58). I was particularly pleased to see that Slough deaths, which had risen over the previous 2 years had dropped this year.

As chair of the Child Death Overview Panel, I would like to take this opportunity to focus on the professionals who make up the panel. The expertise provided by panel members and staff, facilitates open discussion and detailed analysis. It is only through their continued commitment in coming together with professional curiosity, resilience, care, diligence and respect for our children and their families, that we can raise awareness of issues which can be mitigated and contribute to keeping children safe and as well as possible, both locally in Berkshire and nationally.

I joined the Child Death Overview Panel as their first Independent Chair in November 2024. The decision to have the panel led by an Independent Chair was felt to bring it more into line with the national guidance - 'The CDOP should be chaired by someone independent of the key providers' (NHS, social services, and police) in the area (Child Death Review Statutory and Operational Guidance (England) 2018). I thank my predecessor, Tessa Lindfield who was Chair during the first 6 months of this review period and Lorna Tunstall the CDOP Coordinator for her support both to me and the whole panel throughout the year. During this year, we have reviewed processes by means of a survey, to look at any potential improvements and, have looked to engage further with other groups to improve knowledge of the child death review processes. We feed back all the data we gather through the year to the National Crime Mortality Database to assist locally and nationally with the prevention of child deaths.

We remain committed to learning and improving.

Debra Clothier MSc
Independent Chair

Acknowledgements

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

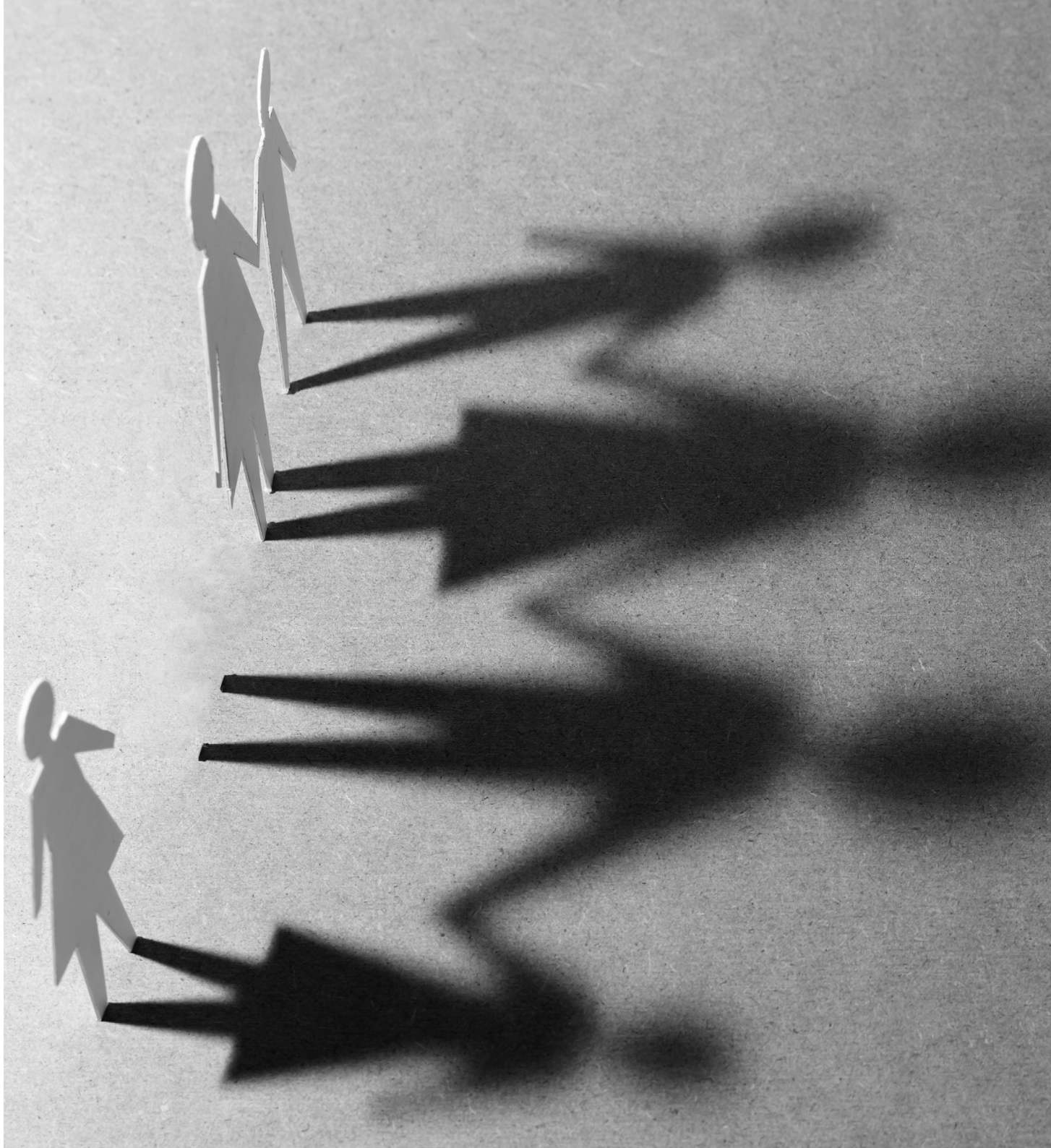
- Lorna Tunstall, Pan Berkshire CDOP Coordinator
- Sarah Rayfield, Public Health Consultant, Slough Borough Council
- Nkemjika Ugwa, Public Health Intelligence Analyst, Slough Borough Council

The purpose of this report

CDOP publishes a report each year. The purpose is to describe the nature of child deaths locally, drawing out any patterns or anomalies. Also, to summarise the learning identified by the process and the actions resulting from that learning, and finally to recommend improvements for CDOP to take forward.

The analysis is based on the child deaths that were reported and reviewed by the panel between 1st April 2024 and 31st March 2025. Fortunately, the number of child deaths is small and therefore some of the data cannot be shared to ensure compliance with data protection guidance; specifically, statistics representing fewer than five cases are not published. As a result, it is not possible to draw significant conclusions from a single year's data. For comparison, child death data is collated over several years to show trends across time.

This report is primarily produced for Child Death Review (CDR) partners in accordance with the Statutory and Operational Guidance.



Introduction

Families will often want to know: Why did my child die? Was this death preventable? What lessons can be learnt to avoid future deaths? 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 because of unintentional incidents or (rarely) deliberate acts. A significant proportion of sudden unexpected deaths in infancy (SUDI) remain unexplained. Understanding that the death of an infant or child, whatever its cause, is a tragedy for the family and for all involved, the Pan Berkshire CDOP strives to make enquiries that keep an appropriate balance between forensic, medical, and social care requirements and supporting the family at a difficult time.

Since 1st April 2008, there has been a legal requirement across England that Child Death Overview Panels conduct a review for all child deaths (including live-born babies of any gestation) up to the age of 18 years. Under the Children Act 2004, as amended in the Children and Social Work Act 2017, it is the statutory responsibility of the Child Death Review Partners to make arrangements to review all deaths of children normally resident in the local area and, if they consider it appropriate, for those not normally resident in the area. These reviews should be carried out through a Child Death Overview Panel. The process from the moment of a child's death, to the completion of the review by the Child Death Overview Panel, is set out in the Child Death Review Statutory and Operation Guidance (England).

Reviews are not indicated for:

- stillbirths (a baby born without signs of life after 24 weeks gestation)
- late foetal loss (where a pregnancy ends without signs of life before 24 weeks gestation)
- terminations of pregnancy (of any gestation) carried out within the law, even if signs of life were present.

Neonatal deaths should be reviewed at a themed neonatal panel for infants of any gestation with signs of life as determined medically using the MBRRACE-UK guidelines.

The Child Death Review (CDR) partners for Berkshire are the local authorities and Integrated Care Boards (ICBs) for the area, namely:

- Bracknell Forest Council
- Reading Borough Council
- Royal Borough of Windsor & Maidenhead
- Slough Borough Council
- West Berkshire Council
- Wokingham Borough Council
- BOB (Berkshire West, Oxfordshire and Buckinghamshire) ICB
- Frimley ICB

During 2024–25, the 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 has a broad membership with county wide representation from local authorities, the NHS, the police, and the voluntary sector. Importantly our CDOP includes those with experience of supporting families of children and young people with life limiting conditions and those bereaved through a child's death. There is flexibility to bring others into the panel process who can provide further information to assist the review. As a collective the panel seeks to learn what happened and how it happened in the time leading up to and surrounding the death, understanding that what happens when a child is dying, or has died, affects how families grieve and their future wellbeing.

Key functions of CDOP

- To collect, collate and analyse the information obtained about each child death to confirm or clarify the cause of death, to determine any contributory factors, to determine whether the death was modifiable, 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 produce an annual report for Child Death Review 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
- 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.

Pan Berkshire CDOP Membership

- Independent Chair (Since November 2024*)
- CDOP Coordinator
- CDOP Administrator
- NHS Designated Doctors for Child Death
- Designated Nurses for Safeguarding, (Deputy Chairs Main Panel)
- Thames Valley Police, Child Abuse Investigation Unit (CAIU) (not for neonatal cases unless appropriate)
- Head of Operations SCAS for Oxfordshire and Berkshire West (not for neonatal cases unless appropriate)
- Children's Social Care Representatives
- Clinical Director Children, Young People and Families, BHFT
- Safeguarding Partners Representatives
- Public Health
- Hospice care representatives: Alexander Devine, Helen & Douglas House and any other as appropriate
- Community Children's Nurses (CCN)
- Health Visitor BHFT
- Daisy's Dream Bereavement Charity

*The Pan Berkshire CDOP was Chaired by the Director of Public Health & Public Protection (Slough Borough Council) until October 2024.

The neonatal panel has a specialist membership including a Neonatologist, Midwife and Obstetrician.

The Pan Berkshire Child Death Review Process

Building on Working Together to Safeguard Children, the Child death review guidance sets out a process for all child deaths alongside a separate but closely linked Sudden Unexpected Death in Childhood (SUDIC) process for when a child dies unexpectedly. All child deaths are notified via the eCDOP platform.

Following notification, the CDOP team gathers information from professionals who have been involved with the child or family prior to the child's death. A prompt process of investigation led by the Designated Paediatrician or Designated Healthcare Professional involves discussions with Child Death Review partners[1]; a visit to the place of death, and a meeting between the professionals involved with the child, to gather information, identify learning and ensure the family and others are supported. A report summarising findings is shared with the Coroner and the CDOP.

The CDOP meets quarterly to review the death of every Berkshire resident child to identify themes, trends and learning. CDOP finalises the "Analysis Form" (previously known as a Form C) initially compiled during a Child Death Review meeting ideally held 3-6 months after the death. The information gathered includes:

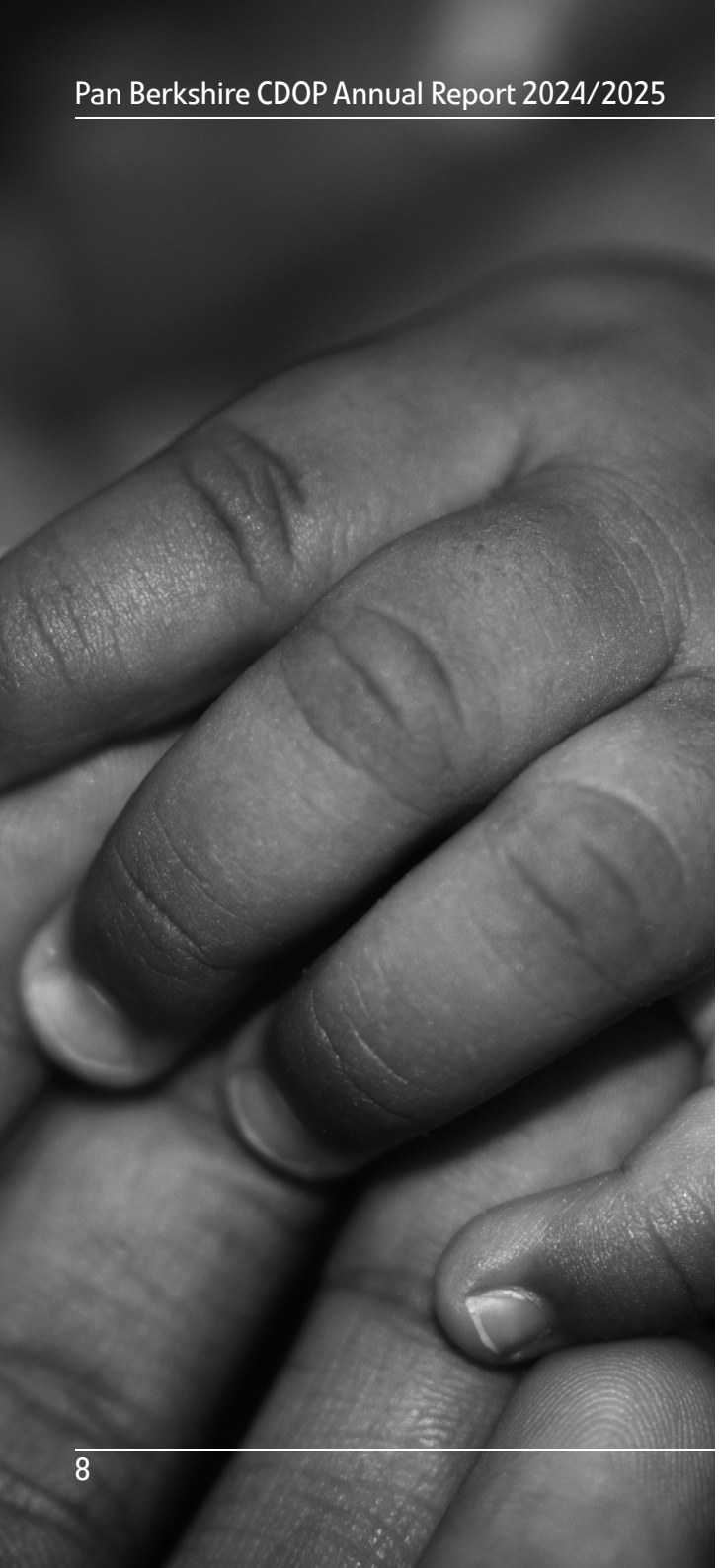
- the child and family, and service provision.
- identification of the key worker.
- categorisation of the cause of death.
- a judgment regarding whether there were modifiable factors.
- learning points and recommendations.
- immediate follow up actions for work with the family.
- whether to refer the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

Working Together to Safeguard Children 2023 and CDOP changes:

The update of Working Together to Safeguard Children in 2023 included minor changes regarding the processes around child death. The Pan Berkshire CDOP is already compliant with the changes:

- Replaces reference 'Child Death Overview Panel (CDOP) framework' with Child Death Review Statutory and Operational Guidance (2018)
- Modified language around the child death review process where the death of a child occurs in an area outside where the child usual resides.
- Reflected new guidance of coroner's duty to include post-mortem reports with relevant child death review.
- Reflects change of name by removing independent review by child death review partners and replacing with child death overview panel.
- Modifies the language around the responsibility of professionals where relevant, to inform relevant safeguarding partners and the Child Safeguarding Practice Review Panel.

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



National Child Mortality Database (NCMD)

The NCMD was set up in April 2019 to enable 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 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 analyses, which are available on the NCMD website.

Learning Disabilities Mortality Review (LeDeR) Programme

The LeDeR Programme reviews deaths to identify areas of learning, opportunities to improve, and examples of excellent practice.

From 1st July 2023, LeDeR policy relating to the deaths of children and young people under the age of 18 changed and the CDOP team is no longer required to notify the deaths of children with a learning disability to LeDeR. Instead, the deaths of children with a learning disability and autistic children will be reviewed by the national mandated processes that look at the deaths of all children via NCMD.

In July 2024, NCMD published a thematic review on Learning from Deaths: Children with a learning disability and autistic children aged 4-17 years. Along with a number of system wide recommendations, this also included the next step to further developing the CDR collection forms including adding a new question on neurodevelopmental conditions. This aims to provide more granular and comprehensive data to support deeper understanding of deaths of children with a learning disability and autistic children.

Pan Berkshire CDOP will continue to note which cases will be referred to LeDeR via NCMD by sharing the Analysis Form with the local LeDeR teams in Berkshire East and Berkshire West to ensure information is appropriately shared and captured for this cohort. Templates for collecting data have been adapted to include whether a child has a learning disability, an annual health check and hospital passport.

Children and Young People in Berkshire

Over 10,000 babies are born each year to **Berkshire residents** (Office for National Statistics 2024).

The 2021 Census indicated that nearly 23% of the Berkshire population are children and young people aged under 18 years (218,034 in 2021).

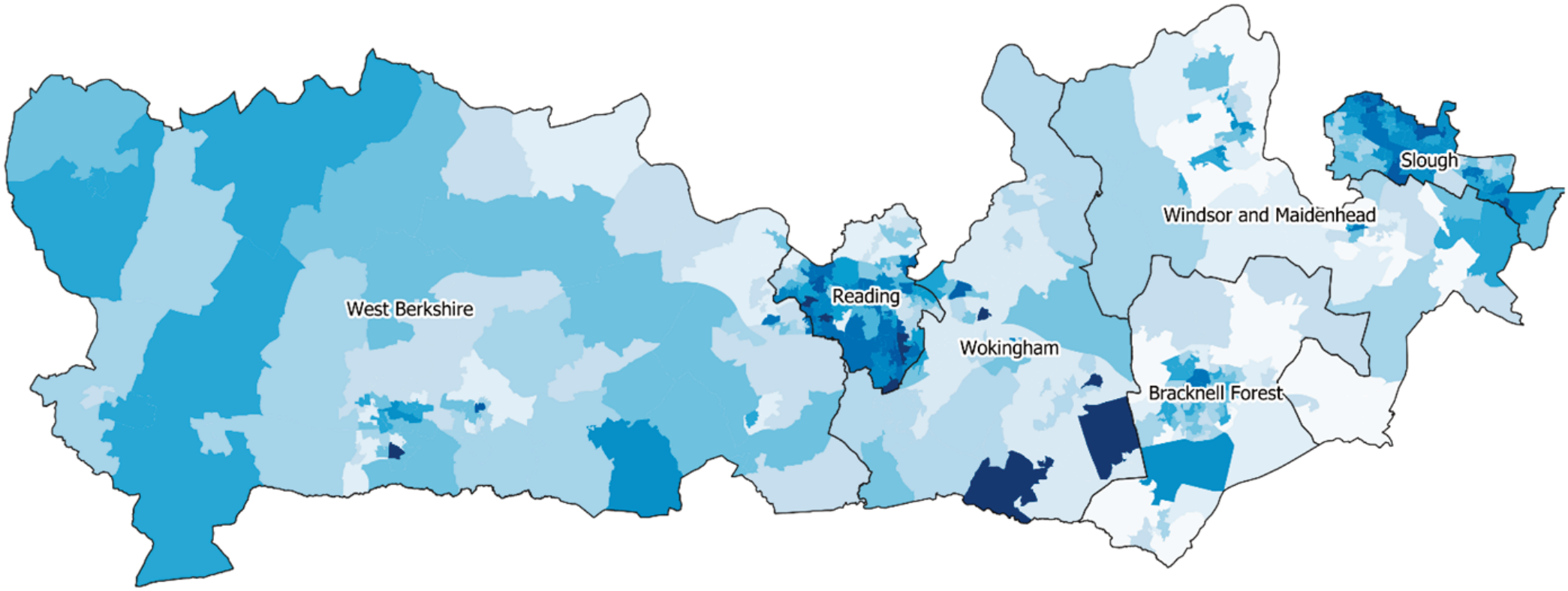
24% of the population of Berkshire East (Bracknell Forest, Windsor and Maidenhead and Slough) are aged under 18. The proportion of younger residents in Slough's population is nearly 28%, higher than Bracknell Forest and Windsor and Maidenhead who both have approximately 22% of their population aged under 18.

22% of the population of Berkshire West (Reading, West Berkshire and Wokingham) are aged under 18. The proportion of younger residents in Wokingham's population is over 23%, slightly higher than Reading and West Berkshire who have 21% and 22% of their population aged under 18, respectively.

Deprivation

Berkshire is a largely affluent county with significant pockets of deprivation and a mix of urban and rural communities. The map in Figure 1 illustrates these pockets of deprivation across the six local authorities in Berkshire. The darker the colouring, the higher the level of deprivation. Deprivation is not restricted to the town centres and spans into more rural areas.

Figure 1: Berkshire Index of Multiple Deprivation 2019 at a Lower Super Output Area



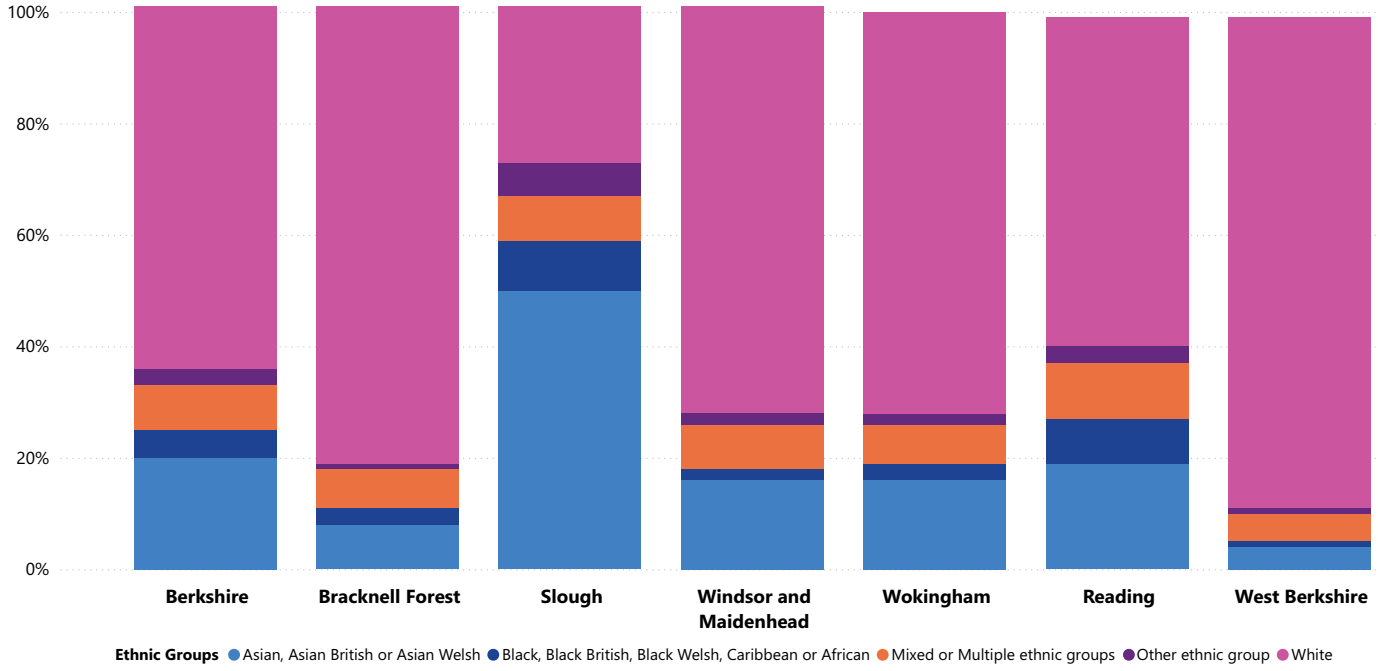
Source: Ministry of Housing, Communities & Local Government (2019); English indices of deprivation 2019
NB. Updated data is due to be published in late 2025.

Ethnicity

The 2021 census showed that 65% of Berkshire's residents aged 0 to 24 identified as a white ethnic group (Office for National Statistics 2023). The ethnicity of the population varies considerably between local authorities with Slough and Reading being more diverse than other areas.

Figure 2 provides a breakdown of ethnic groups for the 0 to 24 age group for each Berkshire local authority. Data has been presented for the 0 to 24 age group, as this is the most appropriate available age-band for this analysis.

Figure 2: Proportion of Berkshire local authority population aged 0 to 24 by ethnic group



Source: Office of the National Statistics (2025); Ethnic Group by sex and age

Child Deaths and Reviews in Berkshire

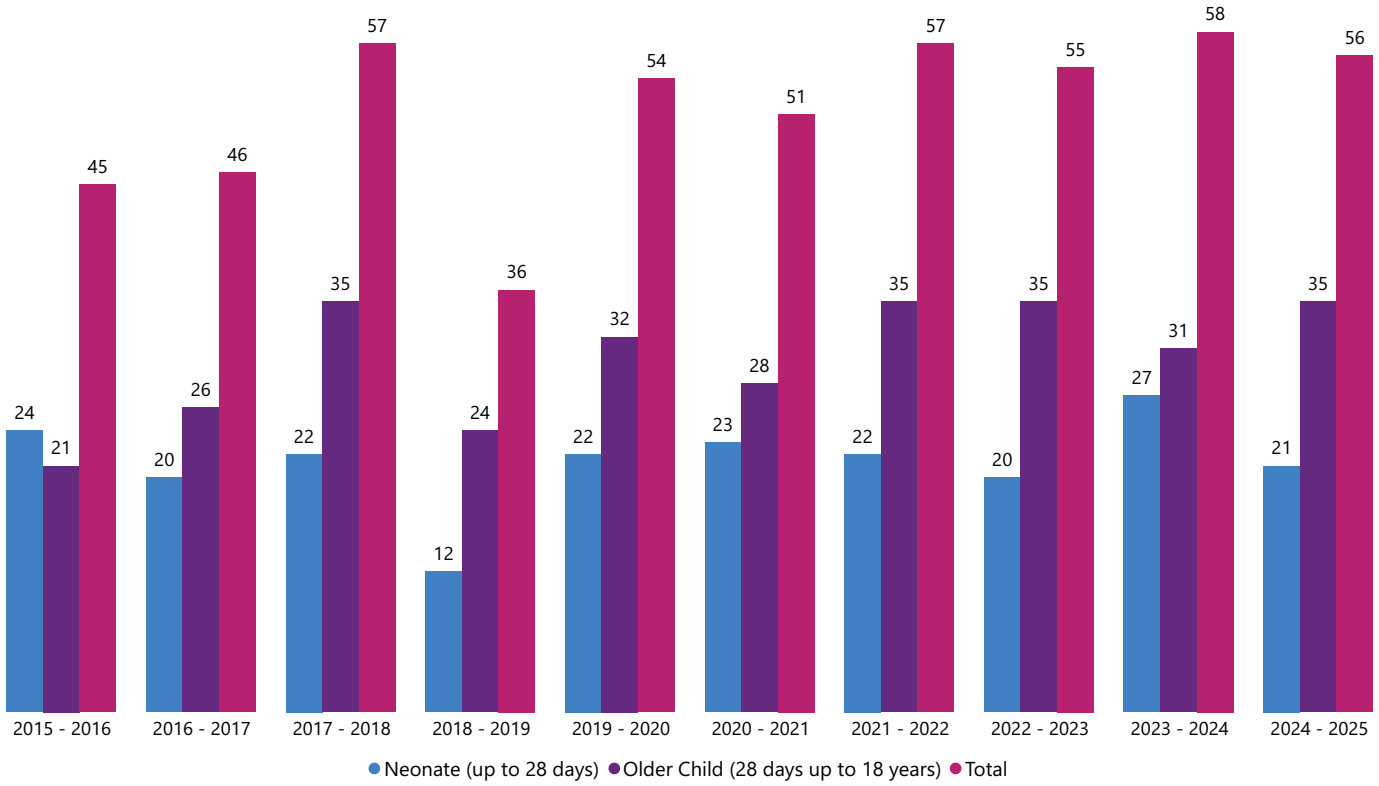
Overall Notifications

This section summarises data from deaths reviewed by Pan Berkshire CDOP between 1st April 2024 and 31st March 2025 and also notifications of deaths that have occurred during that time. It includes both children who have died in Berkshire and children residing in the area who have died elsewhere. This data is drawn from the database of notifications to eCDOP (Form A from NCMD). Numbers lower than 5 are suppressed to prevent the identification of individuals. As low numbers are involved, year-on-year fluctuation is expected.

Nationally there were 3,577 child deaths in England in the year ending 31st March 2024, at a rate of 29.8 deaths per 100,000 children. This is higher than the South East rate of 24.2 per 100,000. The number of deaths nationally decreased by 4% on the previous year, but remained higher than 2019-2022 (NCMD 2024).

In Berkshire, there were 56 child deaths (0-17 years) reported between April 2024 and March 2025, similar to previous years. The number and distribution of deaths across age groups have been broadly stable over recent years (Figure 3). Neonatal deaths consistently make up a significant proportion of total child deaths. Further detail on patterns within Berkshire are provided later in the report.

Figure 3: Number of deaths for people aged under 18 years in Berkshire by year of notification



Source: Pan Berkshire Child Death Review databases (restricted)

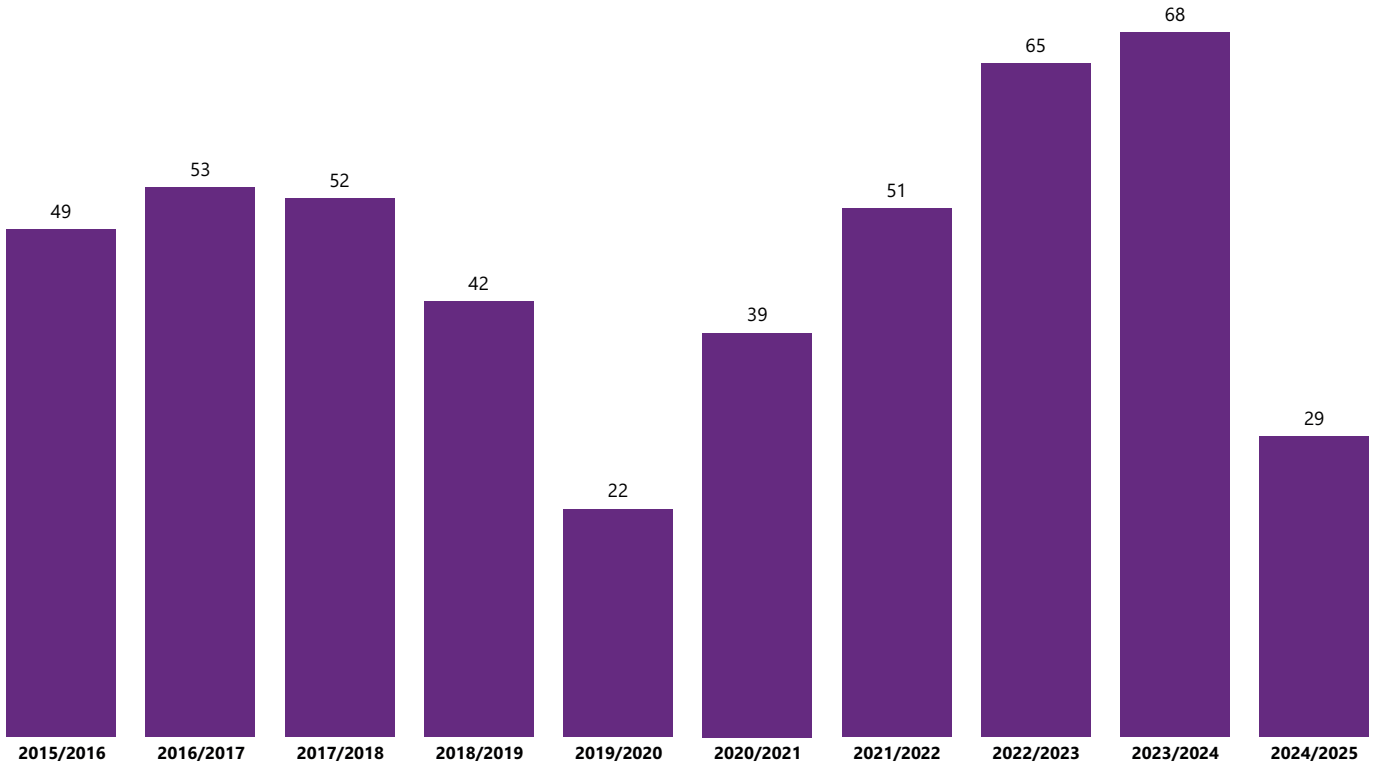
Completed Reviews

During 2024/25, 29 cases were reviewed by the Pan Berkshire CDOP. This is a decrease on the previous year (figure 4) primarily because the CDOP neonatal panel met later than usual in April 2025, reviewing 30 deaths. Due to this timing, the data on these deaths are not included in this report but will be included in the report for 2025/26. However, the learning from the neonatal review is summarised later in the report.

The number of notifications and reviews differ for each year (Figure 4) due to the time taken to the review the circumstances of each death following notification. This can be significant in the event of an inquest or criminal proceedings. The highest number of deaths reviewed was 68 (2023/24), with the lowest number being 22 (2019/20).

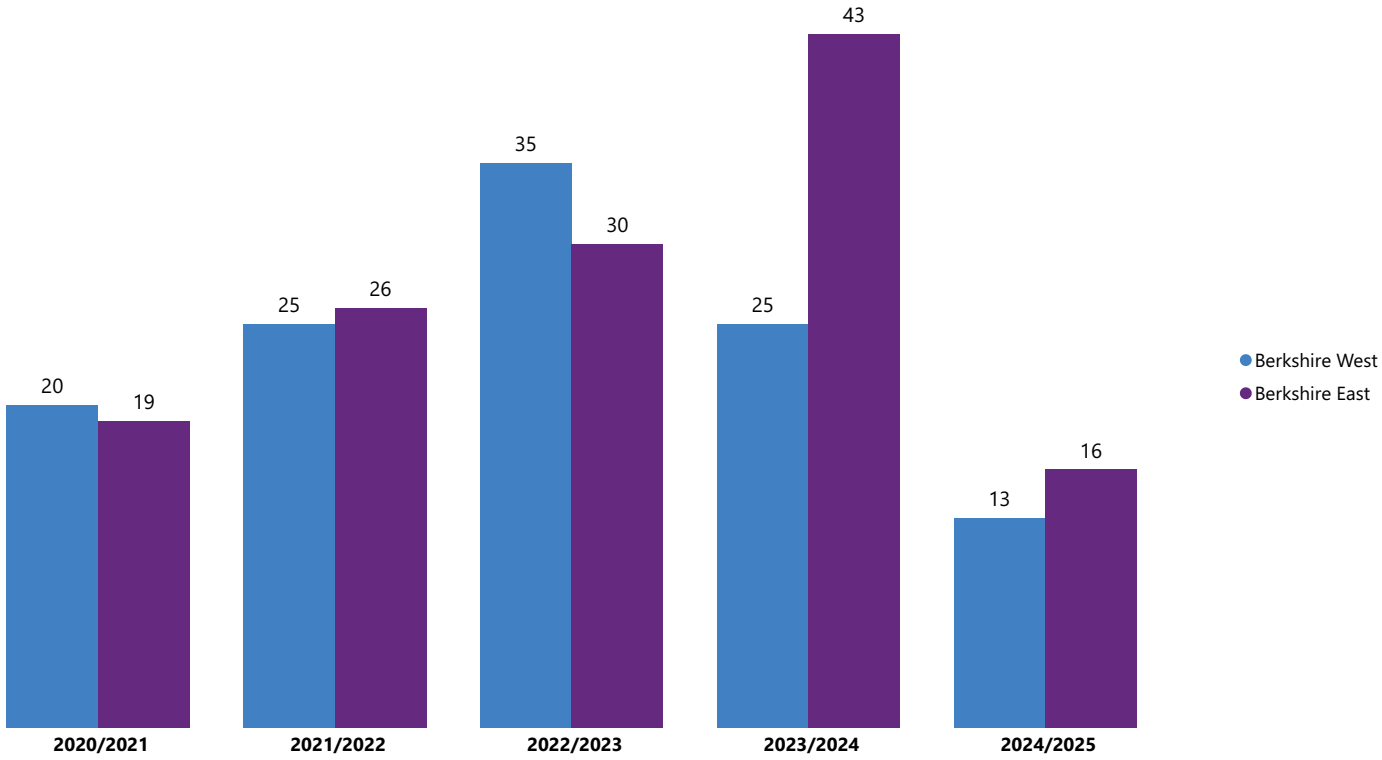
Figure 5 shows the number of child deaths reviewed annually across Berkshire, broken down by East and West geographies. The highest number in Berkshire West was in 2022/23 whereas East Berkshire had the highest number of deaths reviewed in 2023/24, the highest single total across both regions. Numbers of deaths reviewed declined significantly in 2024/25, primarily due to the timing of the neonatal panel as outlined above.

Figure 4: Number of deaths reviewed per year by the Pan Berkshire CDOP



Source: Pan Berkshire Child Death Review databases (restricted)

Figure 5: Number of deaths reviewed per year by Berkshire East and Berkshire West geographies



Source: Pan Berkshire Child Death Review databases (restricted)

For those CDOP reviews completed in 2024/25, most deaths were from Slough, followed by Wokingham (table 1).

Berkshire CDOP aims to complete reviews in a timely fashion to enable identification of themes and patterns and prompt implementation of any learning. Most of the deaths reviewed in 2024/25, were from 2023/24 (table 2). Figure 6 indicates the time between the death and the CDOP review. The median number of days between death and review by CDOP is 272 days. This is compared to the national average of 411 days and an improvement on the 2023/24 performance in Berkshire of 352 days. It is worth noting that if a death occurs, there is a process by which CDOP can 'alert' the NCMD, so swift action can be taken if appropriate prior the formal review taking place.

Table 1: Completed CDOP reviews by local authority of residence (2024/25)

Local Authority area	Cases
Bracknell Forest	<5
Reading	<5
Slough	9
West Berkshire	<5
Windsor & Maidenhead	<5
Wokingham	6
Total	29

Source: Pan Berkshire Child Death Review databases (restricted)

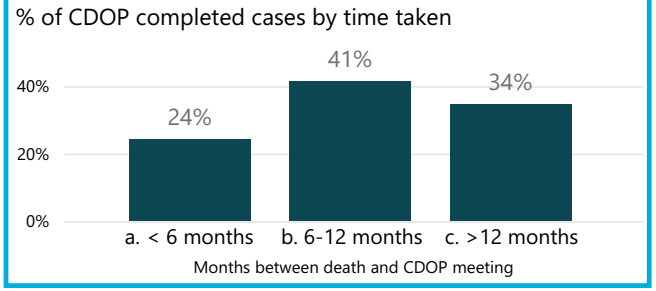
Table 2: Completed CDOP reviews in 2024/25, by year of death

Year of death	Cases
2020-21	<5
2022-23	<5
2023-24	20
2024-25	5
Total	29

Source: Pan Berkshire Child Death Review databases (restricted)

Figure 6: Interval between date of death and CDOP meeting

Median number of days between death and CDOP meeting	CDOP	England
	272	411



Source: NCMD Monitoring Report Pan Berks CDOP 31/03/2025

Place of residence

The number of reviews completed for each local authority reflects the geographical variations in the numbers of deaths. Slough has the highest number of cases outstanding across Berkshire to be reviewed (33% of ongoing cases) but are also the Berkshire local authority with the highest number of deaths, accounting for 31% of the CDOP cases reviewed in 2024/25. Table 3 outlines the pattern of death notifications by local authority area and year. Notifications of child deaths in Slough reached a peak of 27 in 2022/23 and have reduced to 17 in the most recent year. This is still the highest across Berkshire, with Reading having the second highest number at 12 deaths in 2024/25.

There are variations in the numbers and rates of child deaths between local authorities across Berkshire. Numbers are small across the local authorities, so three-year periods have been used to calculate the mortality rates per local authority (Table 4). Mortality rates are the highest in Slough, across all ages.

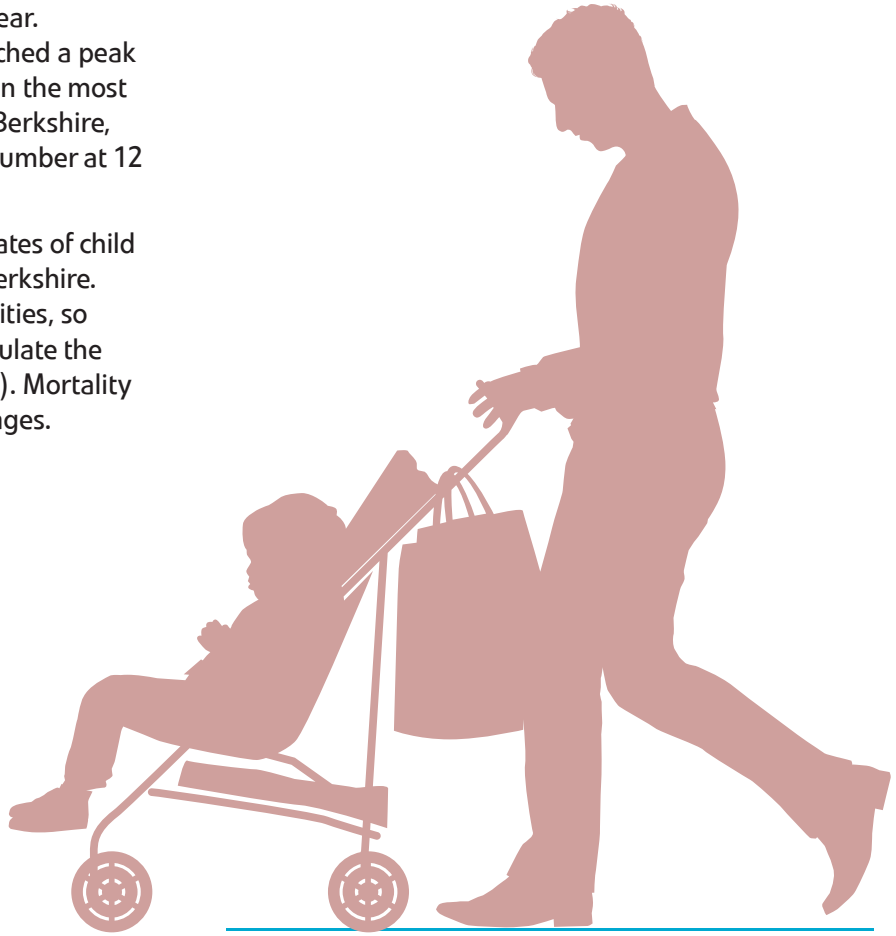


Table 3: Death notifications by local authority area and year of death

Local Authority area	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Bracknell Forest	<5	<5	9	<5	5	8
Reading	14	20	10	7	8	12
Slough	17	12	14	27	25	17
West Berkshire	7	7	12	11	5	6
Windsor & Maidenhead	9	5	7	5	6	5
Wokingham	<5	8	5	<5	9	8
Total	55	54	57	55	58	56

Source: NCMD Monitoring Report Pan Berks CDOP 15/05/2025

Table 4: Rates of infant and child mortality in Berkshire local authorities in 2022-23 to 2024-25

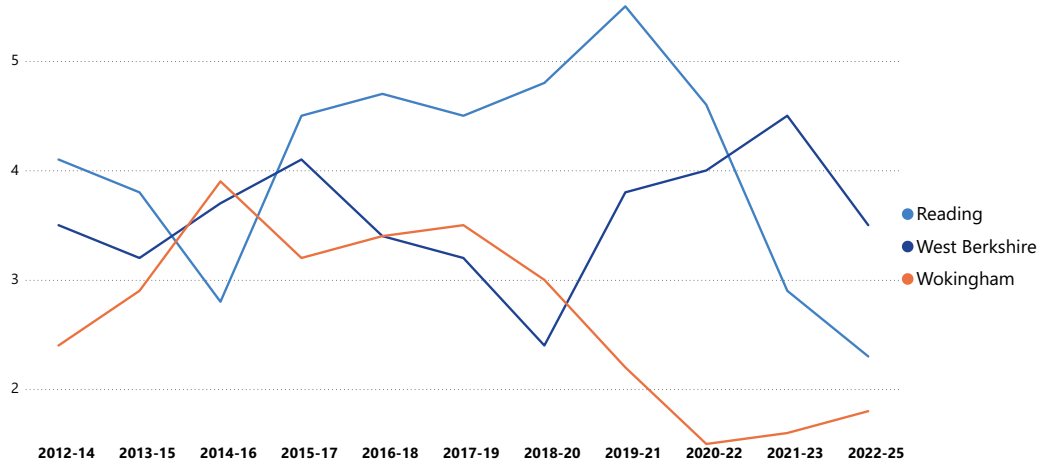
Local Authority area	Neonatal mortality rate per 1,000 live births (deaths under 28 days)	Post-neonatal mortality rate per 1,000 live births (deaths from 28 days to 1 year)	Infant mortality rate per 1,000 live births (deaths under 1 year)	Child mortality rate per 100,000 population (deaths aged 1 to 17 years)
Bracknell Forest	2	0.5	2.5	10.2
Reading	1.3	1	2.1	12.9
Slough	4.6	2.2	6.8	15.3
West Berkshire	2	1.6	3.5	5.6
Windsor & Maidenhead	1	0.7	1.5	8.6
Wokingham	1.4	0.4	1.8	9.0
Total	2.2	1.2	3.4	10.4

Source: Pan Berkshire Child Death Review databases (restricted)

Figures 7 and 8 show the infant mortality rates in Berkshire local authorities since 2012-14. Over this time there has been a steady decline in infant mortality rates across Berkshire West, although rates increased in Reading (from 2014/16 to 2019/21) and West Berkshire (2018/20 to 2021/23), before declining again more recently.

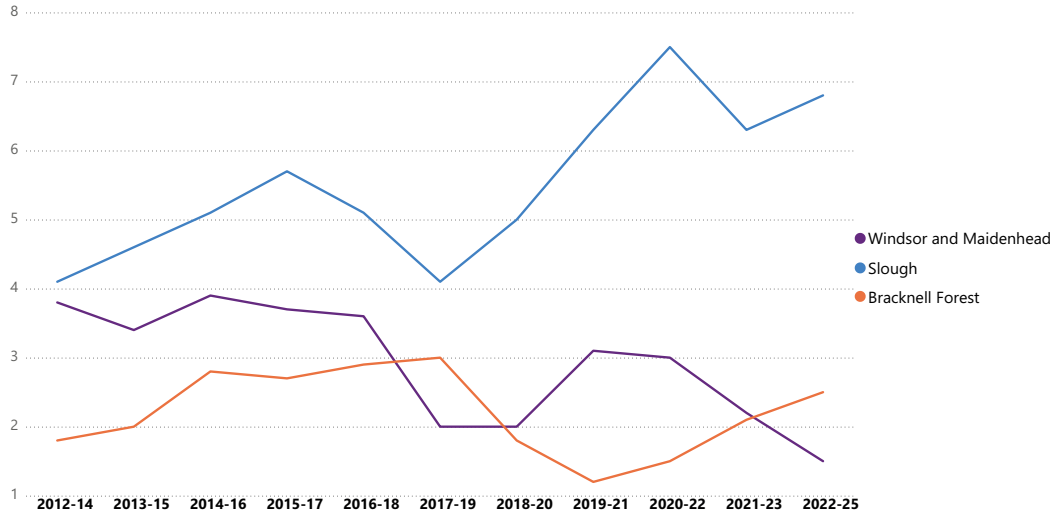
In Berkshire East, infant mortality rates have shown a gradual declining trend in Bracknell Forest and Royal Borough of Windsor and Maidenhead. However, infant mortality rates in Slough increased between 2017/19 and 2020/22.

Figure 7: Infant mortality rates per 1,00 live births for Berkshire East local authorities (3-year pooled figures)



Source: Pan Berkshire Child Death Review databases (restricted)

Figure 8: Infant mortality rates per 1,00 live births for Berkshire East local authorities (3-year pooled figures)



Source: Pan Berkshire Child Death Review databases (restricted)

Age of death

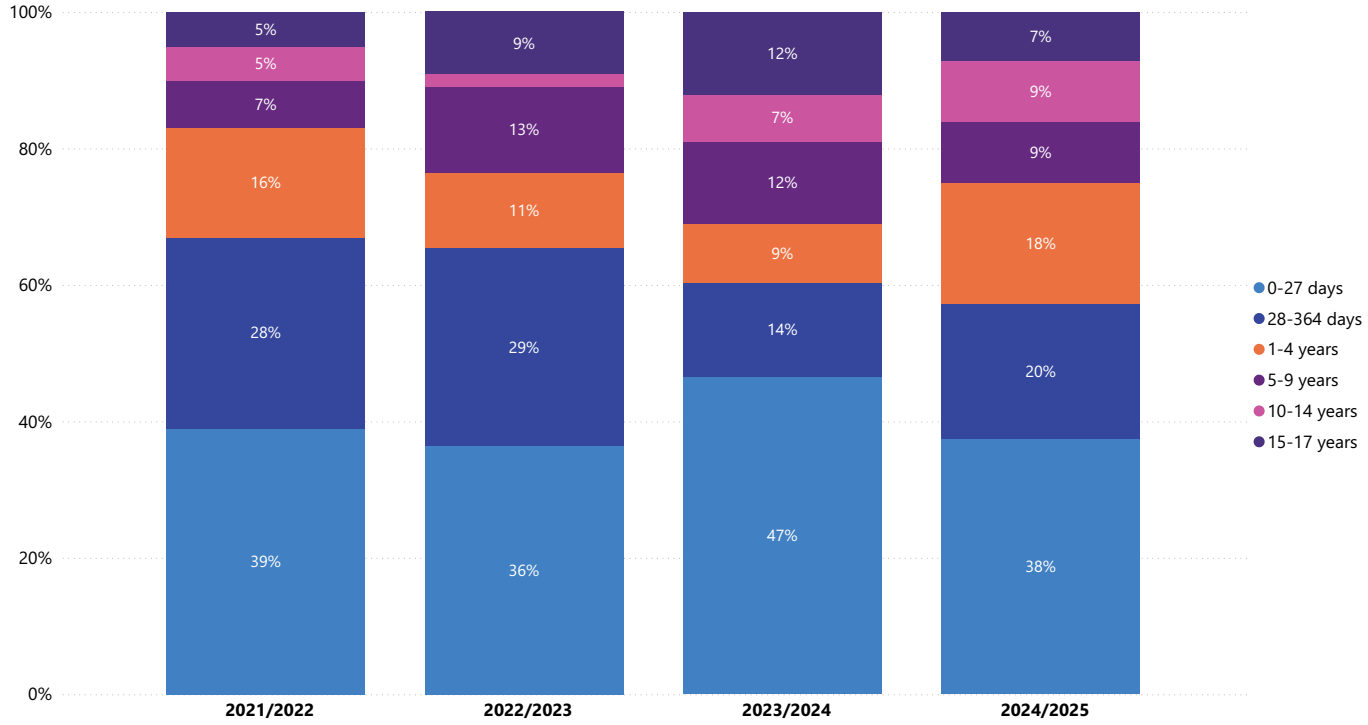
Across England & Wales, most child deaths occur in children aged under 1 followed by children aged 1-4 years. In 2023/24, there were 3,577 child (0-17 years) deaths in England. Infant (children under 1 year) deaths decreased by 2% on the previous year and deaths of children aged between 1 and 17 years increased by 8% (NCMD 2024). Although the number of infant deaths decreased, there was an increase in the estimate infant death rate - from 3.8 to 3.9 per 1,000 live births.

In Berkshire, most deaths occur in children aged under 1 year, although this can vary on a year-to-year basis due to small numbers.

Figure 9 shows that the highest proportion of deaths from 2021/22 to 2024/25 were consistently in the neonatal period (aged under 28 days), followed by the perinatal period (aged 28 days to 1 year). Although the proportion of deaths amongst those aged 1-2 years, rose from 9% (2023/24) to 18% (2024/25).

In 2023/24, 42% of all child deaths in England were neonatal deaths (deaths of babies under 28 days of age) (NCMD 2024). In Berkshire, neonatal deaths accounted for 47% of deaths in 2023/24 and 38% of deaths in 2024/25.

Figure 9: Proportion of deaths by age-group in Berkshire over time



Source: Pan Berkshire Child Death Review databases (restricted)

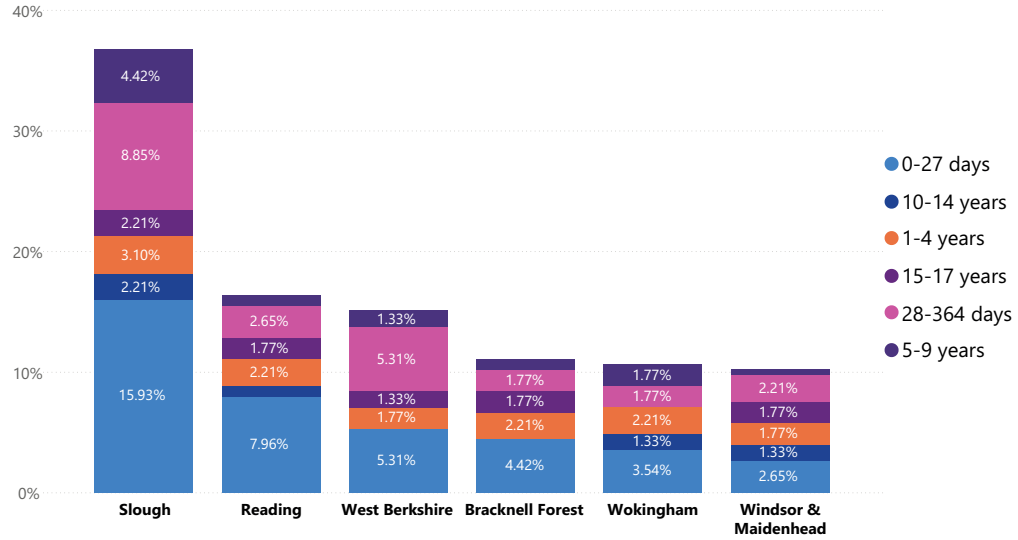
Age at death by local authority

Due to small numbers, data for age at time of death by local authority uses data between 2021/22 and 2024/25. Consistently across all six local authorities in Berkshire, the highest proportion of deaths are within the neonatal age group. Slough has the highest numbers of deaths in both the neonatal and perinatal period.

Gender

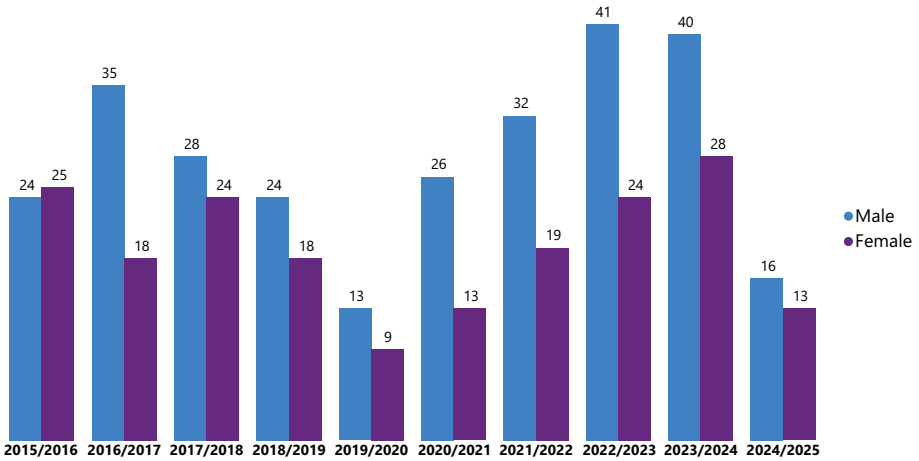
Over the last five years there have been more male deaths than female deaths in Berkshire, which is in line with the national picture. In 2024/25, 55% of child deaths reviewed in Berkshire were male and 45% female. Figure 11 outlines the breakdown of deaths by gender since 2015/16. The biggest difference was seen in 2016/17 and 2020/21, when the proportion of males was 66% and 67% respectively. The only year with more female deaths was 2015/16, where 49% of deaths reviewed were male. This is consistent with the national trend, where male child deaths were generally higher than female deaths across most local authorities.

Figure 10: Age of death by local authority



Source: Pan Berkshire Child Death Review databases (restricted)

Figure 11: Number of reviewed deaths by gender 2024-25 in Berkshire



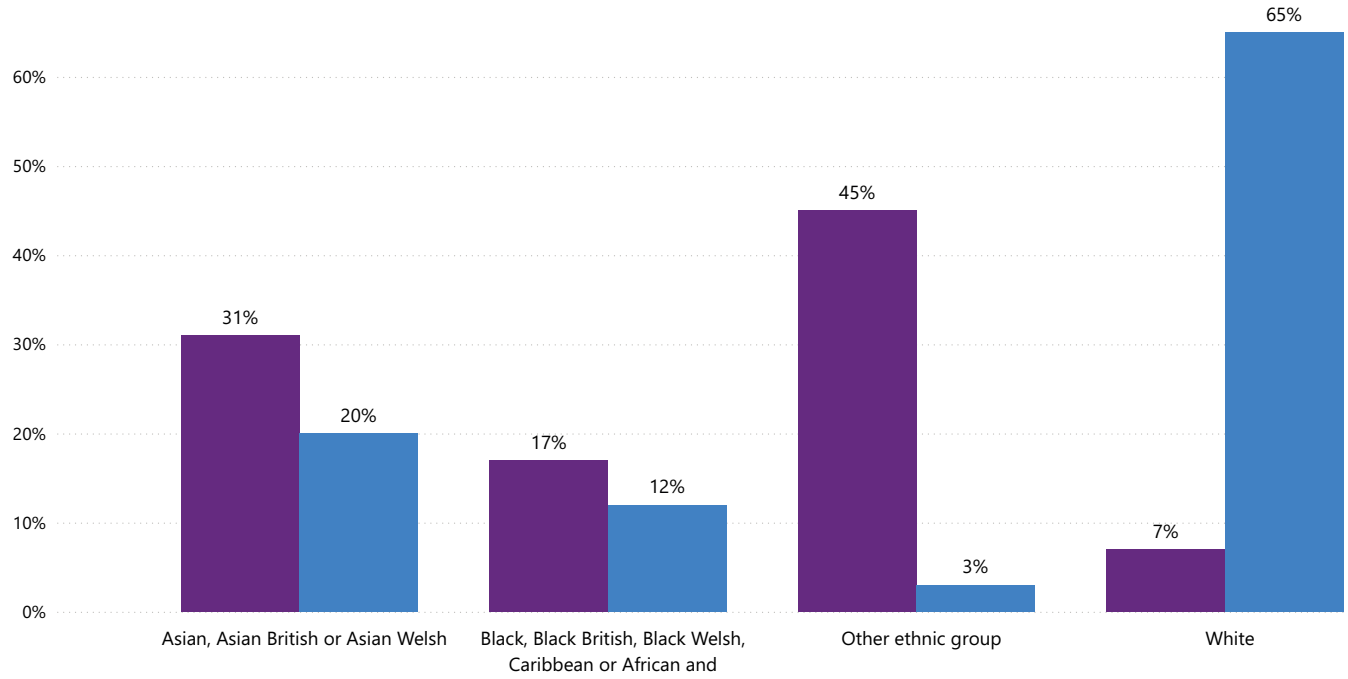
Source: Pan Berkshire Child Death Review databases (restricted)

Ethnicity

Nationally, higher rates of child deaths are seen in Asian and Black ethnic groups and this pattern is also seen across the South East region (NCMD 2024). Figure 12 shows Berkshire children from an Asian or Asian British ethnic group were over-represented in the proportion of child deaths in 2024/25. Children from white ethnic backgrounds were under-represented in the proportion of deaths.

As previously shown in this report (Figure 2 and Table 1), Slough's population is more diverse than other areas of Berkshire, with half of the younger population identifying as Asian or Asian British. In all other Berkshire local authorities, young people from a white ethnic group make-up the majority of the 0 to 24 population.

Figure 12: Proportion of child deaths in 2024/25 (aged under 18 years) by ethnicity, compared to Berkshire's population profile for people aged under 24



**Black/Black British and other ethnic groups have been combined in this graph, as the number of children who died from these ethnic groups was too small to analyse*

Source: Child deaths by ethnicity - Pan Berkshire Child Death Review databases (restricted); Population profile - Office for National Statistics (2025);); Ethnic Group by sex and age

Deprivation

Figures 13 & 14 shows the proportion of infant and child deaths in the South East and in Berkshire by deprivation decile (NCMD 2024; Regional Report - South East). This indicates that there is an over-representation of deaths in both infants and children, in more deprived areas, when compared to the deprivation profiles of Berkshire and the South East. This has been a consistent pattern seen in recent years.

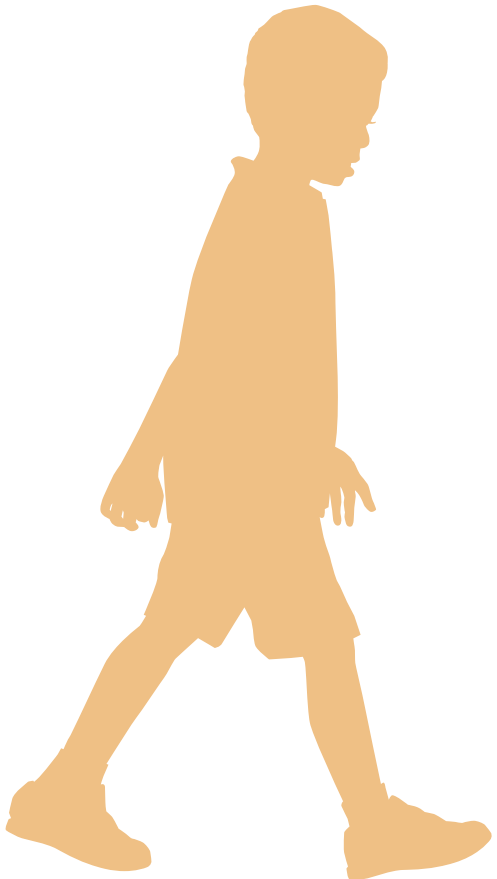
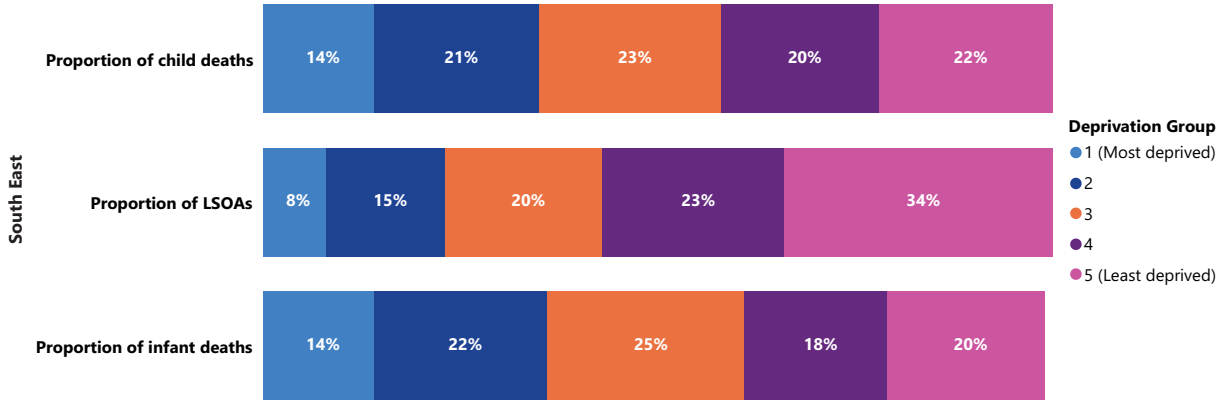
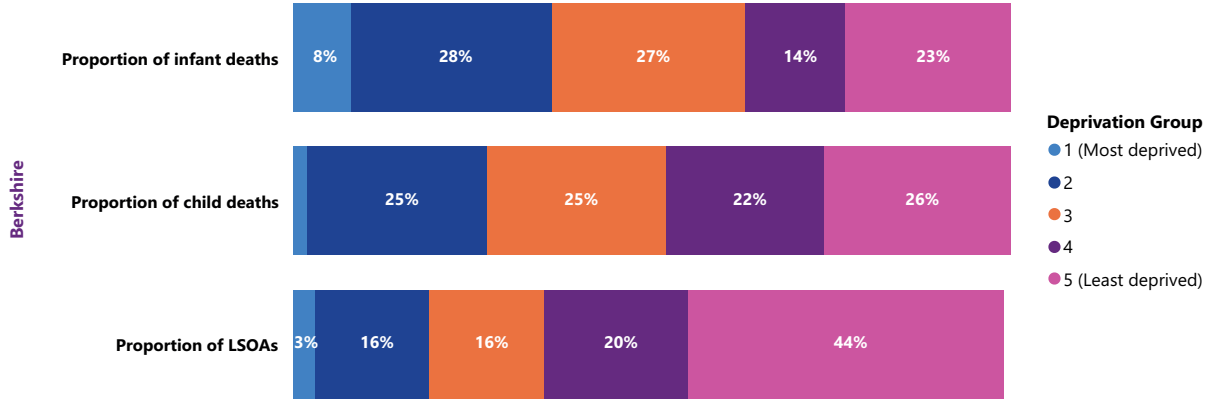


Figure 13: Proportion of deaths in the South East by IMD quintile (2019-20 to 2023-24), compared to proportion of Lower Super Output Areas (LSOAs) by IMD quintile



Source: National Child Mortality Database (2024); Regional Report: South East Data up to 31st March 2024 and Ministry of Housing, Communities & Local Government (2019); English indices of deprivation 2019

Figure 14: Proportion of deaths in Berkshire by IMD quintile (2019-20 to 2023-24), compared to proportion of Lower Super Output Areas (LSOAs) by IMD quintile



Source: National Child Mortality Database (2024); Regional Report: South East Data up to 31st March 2024 and Ministry of Housing, Communities & Local Government (2019); English indices of deprivation 2019

Patterns: Modifiable Factors

The Child Death Review process determines whether there were any modifiable factors which may have contributed to the death. These are defined as factors which, by means of nationally or locally achievable interventions, actions could be taken to reduce the risk of future child deaths. Each year, the panel takes a close look at deaths where modifiable factors occur, in order to learn and implement change.

In 2024/25, the Pan Berkshire CDOP reviews identified 10 deaths (34%) deemed to have modifiable factors. This is closer to the national average than previously seen. Nationally the overall proportion of deaths assessed as having modifiable factors was 43% in 2024/2025, ranging from 34% in the South East to 57% in the West Midlands (NCMD 2024).

In Berkshire, the following modifiable factors were noted, in 2024/25 some of which were relevant to more than one child death:

- Suboptimal communication and information sharing
- Diagnostic delays
  - Identification of jaundice after birth
  - Missed antenatal diagnosis
  - Incorrect advice given to parents which delayed presentation
  - Newborn physical examination not identifying ambiguous genitalia and dysmorphic features
- Unsafe sleeping practices
- Alcohol, drug use or smoking by parent
- Difficulty accessing medical supplies and medication (where transportation required)
- Lack of supervision of the child
- No warning signs on the river or water rescue equipment

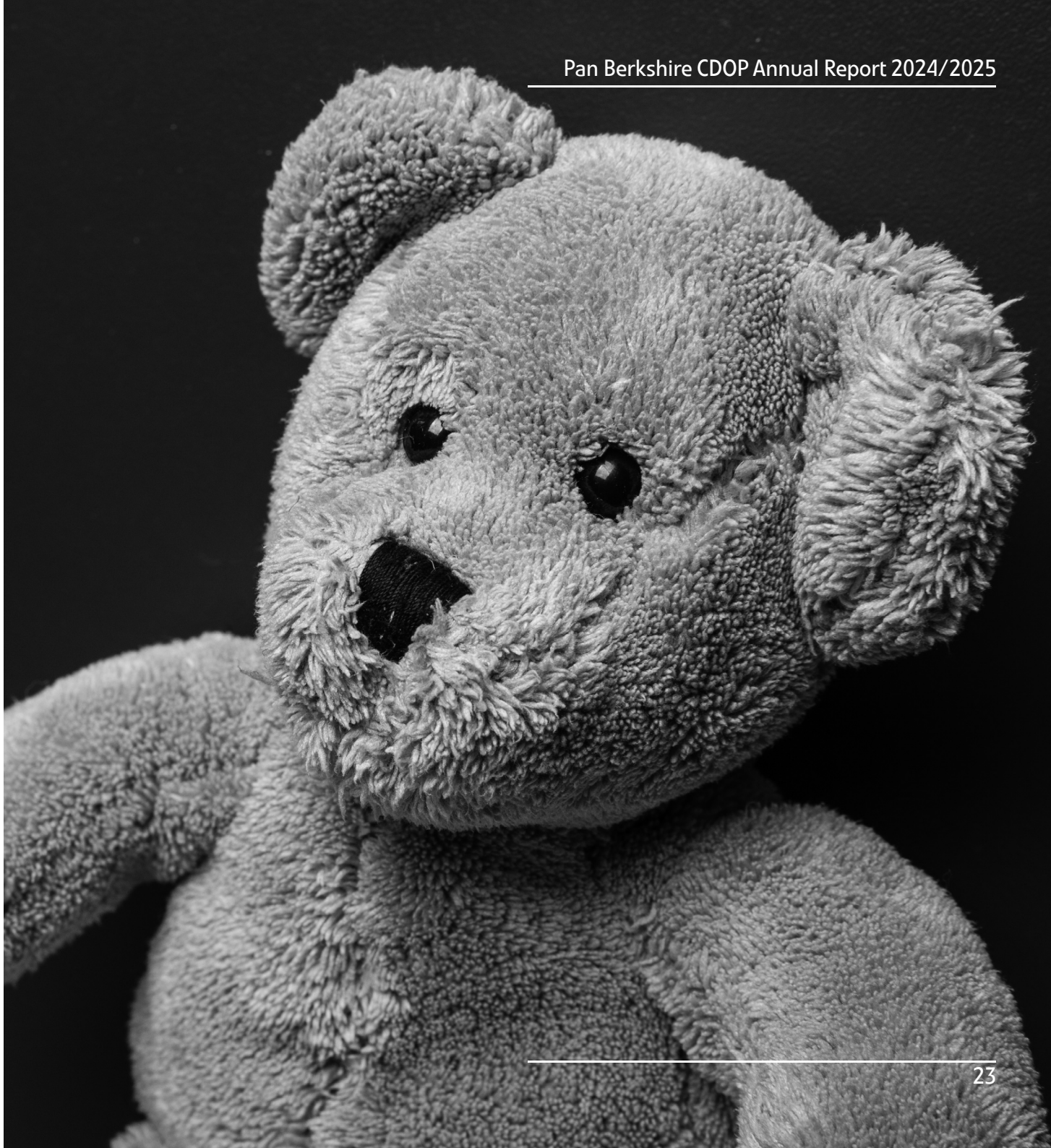
Panel members are tasked with taking the learning from these cases and sharing it widely within their organisations to improve knowledge and change practice.

Nationally, the most common modifiable factors identified by CDOPs in 2023/24 were as follows (NCMD 2024)

Categorisation of cases

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

Of the 29 deaths reviewed in 2024-25 across Berkshire, 24% were classed as Category 5 "Acute medical or surgical condition", followed by 21% of all deaths reviewed being Category 6 "Chronic medical condition".



Reviewing Neonatal Deaths

In line with best practice, Pan Berkshire CDOP established a specialist panel in 2016/17 to consolidate learning from deaths in the first 28 days of life.

During the past year, the neonatal panel met once in person with cases reviewed by location of death: Royal Berkshire Hospital, Reading; John Radcliffe Hospital, Oxford and, Wexham Park Hospital, Frimley plus out of area of all cases. As this panel met in April 2025, the numbers are not included in the data in this report, however a summary of learning points is included below. In total, 30 neonatal deaths were reviewed, and all had had a Perinatal Mortality Review Team Meeting. In addition, 4 non-viable cases had a light touch review.

In Berkshire, cases whose entire care had been delivered in patient neonatal units are included, even if death occurs after 28 days. Inclusion of these cases in a focussed panel is felt to be the most appropriate way to identify learning.

Summary of Cases Reviewed

The panel reviewed those neonates who died at under 28 days of age (excluding babies who are very unlikely to survive). Both the primary cause of death and the contributing factors are outlined in Table 5 & 6.

Examples of good practice was highlighted during the neonatal panel, including:

- There has been an increased offer of genetic screening
- Examples of good counselling and planning of comfort care, including the use of the tertiary team to help plan this were highlighted and recognised
- Good MDT working was acknowledged in some cases, including the development of the preterm lead
- There was a good example of consideration of the family needs, including keeping the family together and meeting all their care and emotional needs
- The offer of a virtual appointment post-event at the family's request was granted
- Simulation training has taken place
- Further training is planned for sonographers to support the detection of Ventricular Septal Defects (VSDs)
- The Royal Berkshire Hospital has carried out a study regarding the antenatal and post-natal experiences of black mothers. The final report is awaited but will be shared through the Pan Berkshire CDOP when available.

Table 5: Primary causes of neonatal deaths

Primary Cause	Number
Extreme Prematurity	7
Congenital/Genetic	7
Perinatal	5
Infection	<5
Pulmonary/cardiac	<5
Medical	<5

Source: Pan Berkshire Child Death Review databases (restricted)

Table 6: Contributing factors to neonatal deaths

Contributing factors	Number
Chorioamnionitis	11
Multiple births	7
Consanguinity	<5
Group B streptococcus	<5
Herpes Simplex Virus (HSV) infection in a newborn baby	<5
IVF	<5
Maternal sepsis	<5
Maternal mental health	<5
Children's social care	<5
Domestic Abuse	<5
Substance misuse	<5
Antenatal screening	<5

Source: Pan Berkshire Child Death Review databases (restricted)

The learning points identified from the cases reviewed at the neonatal panel are summarised below.

Theme	Learning identified
Communication with parents	Healthcare staff should be responsive to parental concerns, acknowledging parental vulnerability and the possibility of unconscious bias There should be robust counselling before the decision is taken to transfer to Tertiary care. This should include a recognition and understanding of the parent's communication needs, in particular when parents may have their own medical conditions. The use of translators and interpreters when needed is essential. A Standard Operating Procedure (SOP) for Interpreting Services in Maternity has been developed and there is ongoing work with the Local Maternity and Neonatal System (LMNS), National Maternity Voices and the Trust lead for Quality and Diversity manager and Maternity on improving the provision of the interpreting service to ensure that all women are offered an interpreter at every appointment.
Preventative measures	Pre-screening on cervical length would potentially be beneficial in some cases. This is now a new service being offered in pre-term clinic. There is a need for robust antenatal screening and referral onwards as required.
Medical management	Trauma informed practices should be included in maternity care as standard. Anti-viral treatment should be commenced at initial presentation (as appropriate). All team members should be fully aware of the location of emergency blood and how to access it when needed.
Other	It was emphasised that a doctor needs to see the baby alive (within 14 days prior to death) to be able to complete the death certificate. If no doctor who cared for the patient can be found, then the death certificate must be referred to the coroner. Environmental concerns were noted regarding cleanliness of clinical rooms in one case. It was suggested that teams to be mindful of cleanliness and hygiene of rooms to improve the experience for parents in such circumstances.

Reflections on the work of the Pan Berkshire CDOP

CDOP Panel

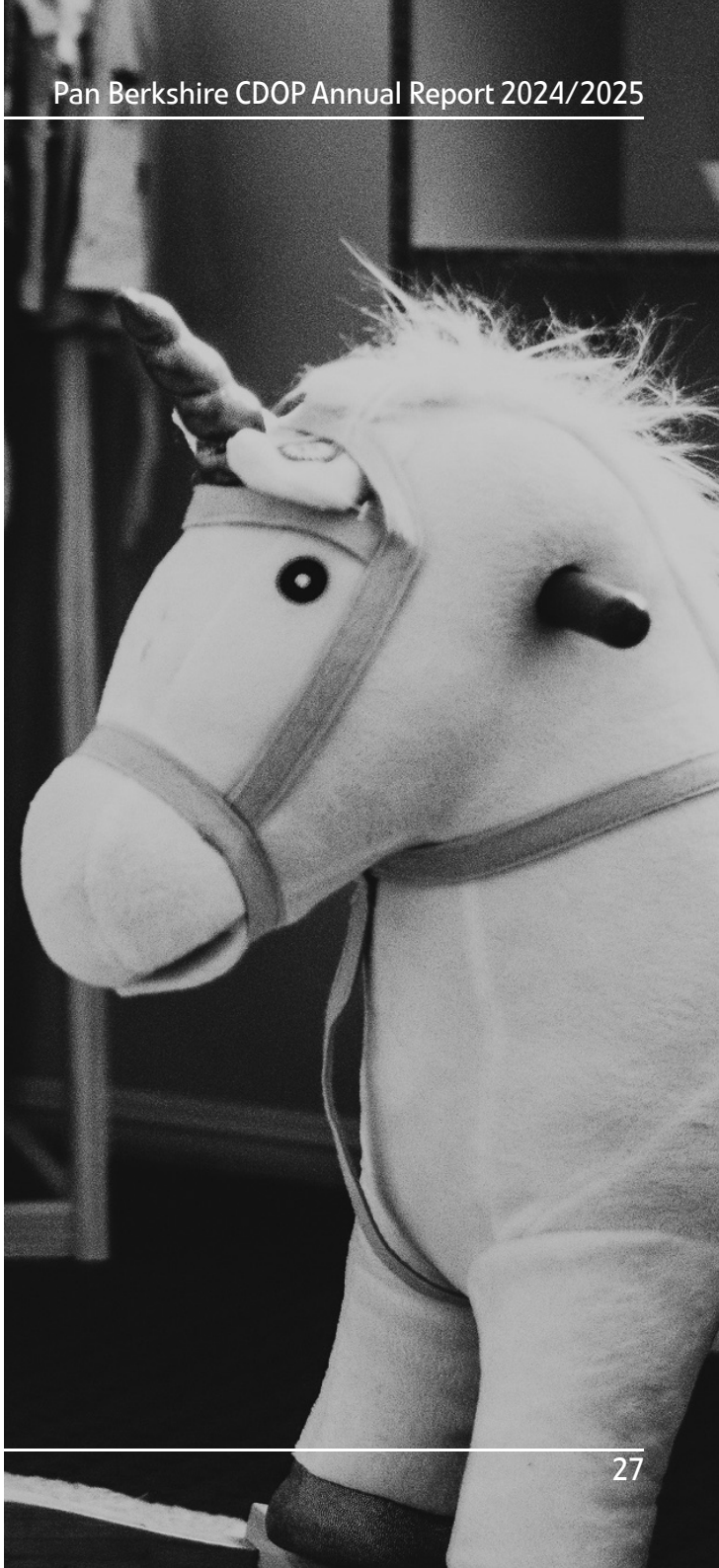
During the past year the panel has maintained good operational performance against national standards and worked hard to review each child death in a timely manner. In 2024/25 the CDOP Panel met four times including once in person and reviewed on average 7-8 cases per meeting. All meetings are well attended by relevant partners. Panel members are experts in their field and encouraged to offer constructive challenge. Discussions are detailed and thorough and considered to be high quality. There were previous challenges in the consistency of chairing the CDOP, however this has been addressed by the recruitment of an Independent CDOP chair who started in November 2024.

The CDOP Exec exists to facilitate the delivery of the CDR programme across Berkshire, and this met twice in 2024/25, with one meeting cancelled due to staff pressures within the NHS and other agencies.

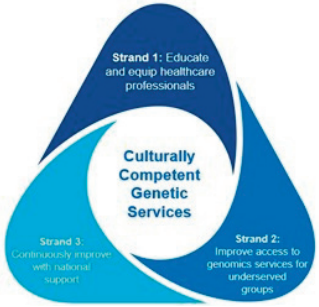
Achievements in 2024-2025

CDOP	The CDOP successfully recruited an Independent Chair, starting in November 2024. This will ensure stability and consistency as well as an impartial critical perspective to support the panel's work over the next few years.
	A Memorandum of Understanding was developed between the six local authorities in Berkshire, to develop robust and sustainable support for CDOP. The MOU was signed off in 2024/25 valid for three years.
	As part of a deep dive into the efficiency of the CDOP in Berkshire, a survey of panel members was undertaken by the CDOP Coordinator. The findings were shared and as a result, time for case presentation has been reduced with less emphasis on medical descriptions. This allows more time to focus on themes and learning, and for all panel members the opportunity to contribute their expertise. eCDOP training was also requested through the audit and this has been offered to panel members.
	The CDOP Coordinator provided training to Berkshire East GPs to raise awareness of CDOP and Child Death Review. Training was also provided to all six local authority MASH teams.

Child death process	Embedding the medical examiner model for under 18 years throughout Berkshire: following the Death certification reforms and introduction of the Medical Examiner for all community deaths, children are being routinely being discussed, supporting issuing of certificate in a timely manner, and we have noted good practice. The ICB CDOP Lead and Quality Lead are linking work regarding Child Death and the Medical Examiner reviews to note good practice and identify any concerns.
	A second key worker training day was held in June 2024, including presentations on the child death review and scenario training. The Child Death Review Toolkit was shared with keyworkers through this training, to support them in their role supporting families.
	Thames Valley Police worked with a local Consultant Paediatrician to produce a protocol for management of an expected child death. This has been cascaded to all agencies.
	Frequently Asked Questions and feedback about common difficulties completing forms have been collated, enabling the review and improvement of processes and guidance for professionals.
	The CDOP coordinator met with all six local authority Designated Safeguarding Lead teams within education to reinforce their duty to refer if they are made aware of the death of a pupil and/or sibling. This was followed up with a letter of reminder to all schools regarding the process required if a child dies overseas.
	The CDOP Coordinator worked with maternity teams to develop a local protocol on the review process for non-viable infants. As a result, the CDOP team has been receiving more timely notifications via eCDOP.
	Funding was identified to create a Child mortality/bereavement nurse (for 5 - <18 year olds) in Berkshire West. This role has improved support for families, increased the quality of referral and provided support to the designated doctor and child death process.



Safe Sleeping	A "Safe Sleep" bite size multi-agency training campaign was created and delivered across the network. Over the past year, the training has been delivered to a wider cohort, including police officers, local schools, social workers, foster carers, paramedics and primary care colleagues.
	A safe sleeping campaign has been rolled out in Maternity at the Royal Berkshire Hospital, Reading including: • Sharing of information on safe sleeping and the right equipment at Easy English, NCT classes and events with charity groups, including the distribution of thermometer cards • Postnatal education leaflets and a multi-language visual display on the postnatal ward • Infant feeding sessions include a focus on safe sleeping • Videos on safe sleeping and posters from the Lullaby Trust are displayed on maternity wards and in parents' rooms on paediatric wards. • Information on safe sleeping has been shared through the ICB for GP Bulletin Boards. The use of routine assessments • At the 20 week scan, a QR code displayed on TV screens links to the Lullaby Trust leaflet in the most common 5 languages. • Questions on safe sleep and the right equipment are now part of the 25/40 appointment. • Exploring the possibility of introducing antenatal visits identifying women who need support with equipment, using maternity assistants. • Updating the postnatal assessment to include asking about safe sleeping.

Close relative Parents Project	**Culturally Competent Genetic Services project for close relative parents** Slough is in the third year of funding to support the delivery of the NHSE Culturally Competent Genetic Services project which aims to provide education and access to genetic screening and support for parents when planning a family. Slough is one of ten identified High Need Areas (HNAs) involved in the pilot project and has received funding through Frimley ICS to support its implementation. The NHS England (NHSE) national strategy on genetic risk and close relative parents is comprised of three strands: **Strand 1:** Education and equip healthcare professionals **Strand 2:** Improve access to genomics services for underserved groups **Strand 3:** Continuously improve with national support  The funding allocation for Frimley ICS - Slough HNA 2024/25 covers the following: 1. Genetic literacy (project support for Strand 2) 2. Close Relative Marriage (CRM) neonatal nurse 3. Close Relative Marriage (CRM) Midwife The Close Relative Marriage Midwife is based between Wexham Park Hospital and the Slough maternity hubs to champion the service. They support midwives to engage in sensitive conversations with families in a culturally competent manner, enabling improved completeness, quality and accuracy of booking data, which flows into the Maternity Service Data Set (MSDS). An additional CRM Neonatal Nurse post was funded for 24/25, supporting the neonatal outreach team to improve access to genetic services for families to enable informed reproductive decision-making. They work with families that are admitted to NICU with a probable or likely genetic aetiology linked to close relative marriage and conditions likely to be inherited in an autosomal manner, initiating conversations with family in a sensitive, culturally appropriate manner. This role links closely with the CRM Midwife role championing the wider service.

Thematic Reviews	A Joint Themed Review was held with CDOP colleagues from Berkshire, Oxfordshire and Buckinghamshire. This event was hosted by Buckinghamshire on "Non-Cancer Child Deaths in the Hospice Setting" and included representatives from a variety of hospices across the patch. This identified learning including noting challenges with medication accessibility and management, highlighting the differences between the key worker role and bereavement support and ensuring that there is collaboration with community paediatrics for non-cancer hospice and community deaths to ensure effective communication.
	A deep dive review into deaths in Slough was undertaken in 2024/25. Enhanced interrogation of local data in Slough and a comparison with areas similar demographically did not reveal clusters or patterns of death beyond that identified previously. However, regular review of local data was recommended.
Water Safety	Following a series of drownings of Berkshire children and young people at home and overseas during 2022/23, a campaign was launched to promote water safety in collaboration with the Water Safety Partnership. There were no drownings reported in 2024/25. The CDOP will continue to advocate improved water safety messaging during 2025/26.

Challenges

- Ongoing complexities have been highlighted in gathering information and planning support when a child dies abroad and not a UK national.
- The complexity of cases reviewed by CDOP continues to increase, requiring an increased time for review and discussion.
- Information gathering has been hampered by the pressure on the capacity of clinical teams. It has also been noted that there still is a lack of awareness of CDOP, child death review and its statutory duties which is challenging for the CDOP team.
- The role of key worker is now established, however, the appointment of key workers with the requisite knowledge and capacity to dedicate to the role continues to prove challenging. In line with the National Guidance, it is important that families are supported to engage at all stages in the review of their child's death, including the review process, contributing to investigations and being informed of the outcomes from post-mortems or other investigations. The CDOP Panel have agreed that key worker representatives can attend case review meetings as part of their peer review and to be able to feedback to families.
- The number of child deaths remains static despite many interventions and an increase in the numbers with modifiable factors. The challenge remains in choosing local actions that have potential to reduce numbers whilst supporting national actions.
- There was a period of transition for the Berkshire CDOP team during 2024/25 as they moved into Bracknell Forest Council. This included a period of limited capacity to support epidemiological analysis. However, this is now provided by public health through the MOU.

Priorities for 2025-2026

- To continue to support the Culturally Competent Genetic Services programme within Slough.
- To emphasise messages on water safety, linking with the Water Safety Partnership and wider stakeholders.
- To continue to raise the profile of CDOP and improve the Child Death Review Process by:
  - delivering multiagency training across the system.
  - ensuring learning from child death is shared widely and is regularly reviewed for progress, including dissemination of events provided by NCMD and other agencies.
  - auditing the effectiveness of dissemination of learning and impact on service provision.
  - escalating issues where agencies are not providing timely information.
  - discussing at the CDOP Exec the potential risks to CDOP in the future.
  - to continue to develop the working relationship with the senior coroner and team, through a multi-agency training and networking session including Child Death Review partners.
- To continue to strengthen the key worker role across Pan Berkshire with further training.
- East Berkshire may wish to explore options to fund and recruit a Child mortality/bereavement nurse (for 5 - <18 year olds) to support the child death review process, whilst recognising the strain on current resources.
- To await the recommendations from the Thirlwell Enquiry, anticipated in early 2026. A local response will be considered through the CDOP Exec meeting.

Appendix 1: Glossary

Acronym	Explanation
ACDRP	Association of Child Death Review Professionals
AMU	Acute Medical Unit
BHFT	Berkshire Healthcare NHS Foundation Trust
BOB	Berkshire West, Oxfordshire and Buckinghamshire
CAIU	Child Abuse Investigation Unit
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
HSIB	Healthcare Safety Investigation Branch
ICB	Integrated Care Board

Acronym	Explanation
JAR	Joint Agency Response
LeDeR	Learning Disabilities Mortality Review Programme
MDT	Multi-Disciplinary Team
NCMD	National Child Mortality Database
NCT	National Childbirth Trust
NICU	Neonatal Intensive Care Unit
NIPE	Newborn and Infant Physical Examination
ONS	Office for National Statistics
PMRT	Perinatal Mortality Review Tool
RBHFT	Royal Berkshire NHS Foundation Trust
SIDS	Sudden Infant Death Syndrome
SUDIC	Sudden Unexpected Death in Childhood

Appendix 2: Categories of Death

Category		Tick box below	CDOP affirmation
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. **Please choose from the sub-categories below:**		
2(i)	**Suicide (where the panel feels the intention of the child was to take their own life)**	☐	☐
2(ii)	**Self-inflicted harm leading to death (where it is unclear if the child's intention was to take their own life)**	☐	☐
2(iii)	**Death as the result of substance misuse (excluding deaths as a result of a deliberate overdose)**	☐	☐
3	**Trauma and other external factors, including medical/surgical complications/error** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis and other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death. **Excludes** Deliberately inflicted injury, abuse or neglect (category 1).	☐	☐
4	**Malignancy** Solid tumours, leukaemias & 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.	☐	☐

Category		Tick box below	CDOP affirmation
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, necrotising enterocolitis, 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 the first postnatal week). **Please choose from the sub-categories below:**		
8(i)	**Immaturity/Prematurity related**	☐	☐
8(ii)	**Perinatal Asphyxia (HIE and/or multi-organ failure)**	☐	☐
8(iii)	**Perinatally acquired infection**	☐	☐
8(iv)	**Other (please specify)**	☐	☐
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 preterm 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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