



**WEST OF ENGLAND
CHILD DEATH OVERVIEW PANEL**

April 2015 – March 2016

ANNUAL REPORT

Dr Mary Gainsborough
Consultant Community Paediatrician
Designated Doctor for Child Deaths
University Hospitals Bristol NHS Foundation Trust

Vicky Sleep
Child Death Review Process Manager
University of Bristol

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1. Acknowledgement

The compilation of this report has only been made possible with the help of the following individuals: Jon Roberts (Consultant in Public Health, North Somerset Council) for providing data on crude death rates (2010-2014) for Section 6.1 and Vicky Slep for co-authorship of the report.

Mary Gainsborough

2. Foreword

As the outgoing Chair of the West of England Child Death Overview Panel (CDOP), I am pleased to introduce the eighth Annual Report of the Panel. This report highlights the main themes and findings from 2015/16.

The Panel has built on the already strong and effective collaborative arrangements for reviewing child deaths within the Local Safeguarding Children Board areas (Bath & North East Somerset, Bristol, North Somerset and South Gloucestershire). This Annual Report offers an important source of intelligence and information that local agencies should take account of to improve the quality of services and shape the future safety and wellbeing of children and young people.

The Panel has been proactive in pursuing modifiable factors. This has included advice to Local Safeguarding Children Boards on the specific actions and learning points arising from the reviews.

The following key themes have been noted by the Board over the course of the past year:-

- Lack of bereavement support for families, particularly when they lose a child unexpectedly
- Distress caused by delay in receipt of the final post-mortem report
- Difficulty in obtaining information about fathers' of children who have died

The West of England CDOP continues to be an excellent example of effective partnership working across local authority, NHS, police and the voluntary sector. This is due to the dedication and commitment of colleagues and I would like to thank all who have contributed to the detailed work of the panel and the Local Safeguarding Children Boards for their continued support.

In particular I would like to thank Vicky Slep and her team in the Child Death Enquiry Office for their efficient and proactive administration of the Child Death Review process and Dr Mary Gainsborough for her role as Designated Doctor.

The West of England Child Death Overview Panel will continue to work towards identifying and addressing issues of preventable deaths for children and young people across the West of England in the year ahead.



Natalie Field
Chair of the West of England Child Death Overview Panel (April 2015 to March 2016)
Interim Director of Public Health, North Somerset Council

3. Executive Summary

1. The processes to be followed when a child dies are currently outlined within Working Together to Safeguard Children 2015: Chapter 5 Child Death Review Processes¹.
2. Crude death rates for the individual authorities across the West of England range from 1.97 to 3.59 per 10,000 children aged under 18. There is some variation between authorities with Bristol having the highest rate. This is likely to be due to multi-factorial reasons.

Data related to Child Death Notifications:

3. 589 child deaths were notified to the West of England Child Death Enquiries Office between 1st April 2011 and 31st March 2016.
4. Between 2011 and 2016, (39/109) 36% of children were not residents of Bristol, North Somerset, South Gloucestershire or Bath and North East Somerset (BANES). The great majority of these children were receiving specialist medical care in Bristol Children's Hospital or St Michaels Hospital (NICU). This figure is lower than previously as from January 2015 the West of England CDOP stopped reviewing and collecting data on the deaths of Welsh children within hospitals in the West of England area.
5. Over the 5 year period, 32.8% died in NICUs, 27% died in PICU or adult ICUs, 8.3% in Emergency Departments, 12.6% in other hospital wards/theatres/central delivery suites, 10% in the parental home or in a relative's home, 5.5% in hospices and 2% in other locations.
6. Between 2011 and 2016, 70% of deaths occurred during the first year of life, 12% of deaths were of children ages 1-4, and rates then decrease in mid-childhood but are higher in ages 15-17 with 6% of deaths. The number of deaths in the 7-27days age bracket dropped over the 5 year period by almost a half, and deaths in 1-4 year olds also dropped notably.
7. 75% of deaths notified in the last 5 years were children expected to die and 25% of deaths in children aged 0-17 years were unexpected; 30% remaining unexplained after a full investigation and the local case review meeting. 34% of deaths due to perinatal complications (mostly extreme prematurity), and 28% children with chromosomal, genetic or congenital conditions. Acquired natural causes account for 21% and external causes, encompassing deliberate injury, suicide and trauma, accounted for 9%.
8. Between 2011 and 2016, 45% of children had a post-mortem examination and of these 71% had a Coroner's post mortem and the rest had a hospital post mortem.

Data from cases reviewed by the Child Death Overview Panel:

9. The West of England CDOP reviewed 348 cases in detail between 1st April 2011 and 31st March 2016. There is an inevitable time-lag between notification of the child's death to discussion at CDOP but 100% of the cases requiring review from 2011/12, 2012/13 and 2013/14 have now been reviewed.
10. The most common mode of death is following the active withholding, withdrawal or limitation of life-sustaining treatment, which occurred in 43.1% of cases.
11. 9% of children reviewed had a motor impairment and 6% of children reviewed had a learning disability which was recorded as contributory
12. In 98.3% of cases, factors intrinsic to the child (i.e. the underlying medical or surgical problem) provided a complete and sufficient explanation for the death. In 1% factors in

¹ HM Government Department for Education (June 2013)

service provision provided a complete and sufficient explanation for the death, and in one case issues with parenting capacity provided a complete explanation.

13. Factors that may have contributed to the vulnerability, ill-health or death were identified in the family in 30.5%, related to parenting capacity in 12.6% and in service provision in 26.1%. Parenting capacity issues include poor parenting/supervision and/or child abuse/neglect and poor engagement with services. Parental smoking was classed as contributory in 9.5% of deaths, emotional, behavioural or mental health issues in 4.8% alcohol or substance abuse in 5.2%, housing issues in 3.2% and domestic violence in 4.3%. It should be highlighted that positive parenting was noted in many cases.
14. CDOP identified 'modifiable factors' in 33%. 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'. Current national data shows this is higher than the national average and the average from the South West. This may be due to the open scrutiny with which this panel seeks opportunities to learn from every case reviewed and the fact that factors considered to be modifiable may not be considered modifiable by other panels
15. Family bereavement follow-up was documented in over 85.6% of cases, with paediatrics/specialists services providing this in 48.9%, primary care in 21.6% and hospice/community nursing in 14.7%. In 6.1% the offer of follow-up had been declined or was yet to be taken up, and no information was available in 7.2% including whether families had accessed national or local non-statutory bereavement support, information about which is routinely provided through the child death review process.

Focus on Suicides

16. In 2015 CDOP reviewed the deaths of a small number (<15) of children in this category. In 84% the method of death was hanging / strangulation injury. 31% in this group were previously known to mental health services and 54% had previously engaged in deliberate self harm. The most common factors identified in this group were family discord in 46%, relationship problems in 38% and problems at school in 23%. CDOP identified a number of areas for learning and recommendations including prevalence of the 'Choking Game', use of bunk beds, and peers rather than professionals being aware of the child's true feelings and intentions.

Service improvement issues:

17. Some service improvement actions were taken as a direct result of discussion at the local child death review meeting and in some cases good practice was commended.
18. Important issues highlighted by CDOP were disseminated through the constituent agencies and the chairs of the Local Safeguarding Children Boards.
19. Issues noted at CDOP led to specific actions in some cases:
 - Importance of providing opportunities to parents to voice their questions through the Child Death Review process
 - The importance of safely joining vehicles e.g. attaching trailers to cars. What is this?
 - Ensuring Head Start guidance is available in GP surgeries
 - The question of whether adult palliative care services could help children whose families wish them to stay at home, including the provision of community nursing for children at End of Life
 - Importance of the role of implanted devices being considered at Coroners post mortem

20. Certain themes have emerged from reviewing children's deaths in the West of England this year:

- Children who survive longer than expected raising specific challenges for families and palliative care agencies
- Communication challenges with non-English speaking families, especially about complex medical information
- Delays in post-mortem reporting due to national shortage of paediatric pathologists
- Involvement of young people in decision making about their care
- Transition to adult health care and the challenges in achieving this

4. The Child Death Review Process

Since April 1st 2008, Local Safeguarding Children Boards (LSCBs) in England have had a statutory responsibility for child death review processes. The relevant legislation is enshrined within the Children Act 2004, and applies to all young people under the age of 18 years. The processes to be followed when a child dies are currently outlined within Working Together to Safeguard Children 2015: Chapter 5 Child Death Review Processes². The process focuses on identifying 'modifiable factors' in the child's death.

The overall purpose of the child death review process is to understand how and why children die, to put in place interventions to protect other children and to prevent future deaths. It is intended that these processes will:

- Document and accurately establish causation of death in each individual child
- Identify patterns of death in a community so that preventable factors can be recognised and reduced
- Contribute to improved multi-professional collection of medical, social and forensic evidence in the small proportion of deaths where there has been maltreatment or neglect
- Ensure appropriate family and bereavement support is in place
- Identify learning points for service provision, which relate to care of the child

Working Together (2015) outlines two inter-related processes...a '**Rapid Response**' where a group of professionals come together for the purpose of evaluating the cause of death in an individual child, where the death of that child is *unexpected*, and a '**Child Death Overview Panel**' (CDOP) that comes together to undertake an overview of *all* child deaths under the age of 18 years in a defined geographical area. These processes have been outlined in detail in previous annual reports.

In the area of the former county of Avon, four neighbouring LSCBs (Bristol, North Somerset, South Gloucestershire and Bath and North East Somerset) have come together to form a single West of England (WoE) CDOP. The membership of the Panel (Appendix B) is arranged to ensure that there is the necessary level of expertise and experience, and that each LSCB is appropriately represented. During 2015/16, the WoE CDOP Chair has rotated from BANES to North Somerset LSCB. The Terms of Reference, Governance Arrangements, and Membership are summarised in documents available at www.bristol.gov.uk. The Child Death Enquiries Office at the University of Bristol administers all functions of the WoE CDOP.

The WoE CDOP reviews information on every child who has died whose post code of residence is within its geographical boundary. Some of these deaths may occur outside the West of England. The WoE CDOP additionally reviews the deaths of some non-resident children who may be under the care of a specialist paediatric medical or surgical team in Bristol.

A child's case is reviewed at the CDOP after it has been discussed at a local child death review meeting. Standard information on each child is collected on national Forms A and B during the child death review process. Form A is a basic notification form that has essential identifying information on the child and key professionals. Form Bs are completed by all agencies involved in the care of a child, and capture clinical and social data on the child and background information relating to the family. Additional Forms B2 –B12 capture specific data relating to the type of death (sudden infant death, life-limiting condition etc). Form B13 has information relating to post

² HM Government Department for Education (June 2013)

mortem findings. Form C is completed at the local Child Death Review meeting and aims to identify modifiable factors relating to the child's death, as well as highlight learning that arises from each case. All patient information is made anonymous. A detailed compilation of all data on Forms B & C on each child is presented to the CDOP as an anonymous case record. At CDOP meetings each case is reviewed and the Panel deliberates on the decisions reached at the local Child Death Review meeting. The panel will agree any additions or amendments on a final Form C for each child. The CDOP Chair records recurring themes relating to modifiable factors.

5. Production of annual report (processing and verification of data)

This is the eighth Annual Report of the West of England CDOP. It was approved by the Panel on 1st July 2016 and will be presented to each of the four constituent LSCBs and will be a public document. Previous year's Annual Reports can be found online.

The report is produced using data collected by the Child Death Enquiries office. They enter Form A information on all children who die in the West of England region onto a **Notification database**. Information collected from Form Bs and both the local child death review and CDOP Form C (including a case summary) is entered into a separate **CDOP database**. The eventual CDOP multiagency dataset on each child is extremely comprehensive. The dataset is verified through the following means:

- Weekly inquest returns from the Coroner's Office
- Information downloads from the I.T. departments at University Hospitals Bristol NHS Foundation Trust, and North Bristol NHS Trust
- Print outs from the Child Health System
- Office for National Statistics downloads from the General Registrar's Office*
- Post mortem reports
- Reports from BADGER
- Monthly reports from UH Bristol Trust Data Analysts

***The returns from the GRO do not capture coroners' cases that have not yet proceeded to Inquest. Thus data presented through the child death review process is more complete and up to date than national statistics.**

Note: The UK Office for National Statistics advises that care should be taken with regard to publishing small numbers of events in person-related statistics. This is due to the need to preserve confidentiality as there may be a risk that individuals could be identified.

6. Summary Data (five year dataset from 2011 – 2016)

This section summarises all deaths notified to the Child Death Enquiry Office, between April 1st 2011 and March 31st 2016, of children who have died in the West of England area or of a child residing in the West of England area who has died elsewhere. These data are drawn from the Notification database. This allows us to present information as a rolling total across the last five years. Data presented this way helps to "smooth out" the year on year variations that we expect if we are looking at rare events one year at a time.

6.1 Crude Death Rates

Table 1 shows the crude death rate per 10,000 children aged 0-17 years for the period 2011-16.

Crude death rates by area, 2010/11 -2014/15, five year average

	Crude Rate per 10,000	Lower Limit	Upper Limit
BANES	1.97	1.38	2.73
Bristol	3.59	3.07	4.17
North Somerset	2.65	2.02	3.42
South Gloucestershire	2.08	1.60	2.67
West of England	2.78	2.49	3.10

Notes: (1) 95% confidence intervals estimated using Byar's approximation

(<http://apho.org.uk/resource/view.aspx?RID=48457>)

(2) Due to non-release of 2015 mid-year population estimates, 2014 populations have been used as a proxy for 2015 figures.

The crude death rates and corresponding confidence intervals overlap for BANES, North Somerset and South Gloucestershire indicating there is unlikely to be a significant difference between these areas. The rate and confidence interval for Bristol is higher than BANES and South Gloucestershire, but similar to North Somerset. The reasons behind the higher crude death rate in Bristol compared to some of the other localities is likely to be multi-factorial.

6.2 Analysis of notifications by year, 2011-2016

During the period 2011-2016, 581 child deaths were notified. Year on year variation in notifications is to be expected, and is demonstrated in Table 2. With relatively rare events such as child deaths, small variations each year can appear to represent a big difference.

The deaths notified over the 5 year period are reported by area of residence and by year in Table 2.

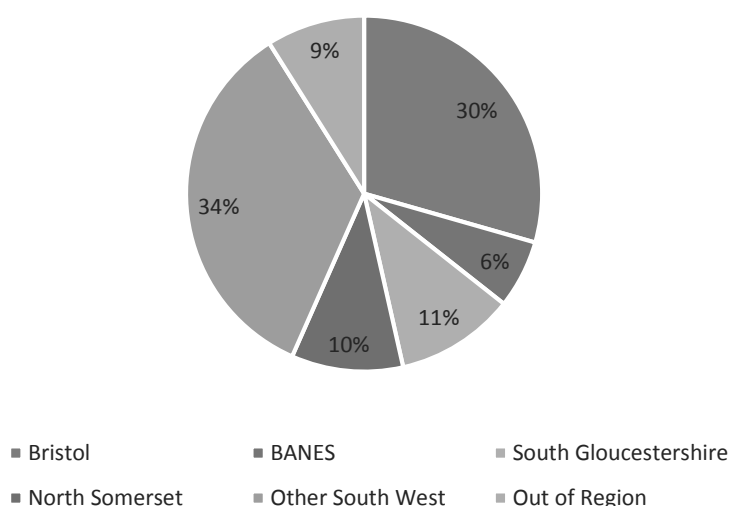
Table 2: Notifications by region of residence, 2011-2016

Region	2011/12 Deaths	2012/13 Deaths	2013/14 Deaths	2014/15 Deaths	2015/16 Deaths
BANES	8	6	6	8	8
Bristol	30	43	30	31	35
North Somerset	15	10	13	6	14
South Gloucestershire	11	15	12	12	13
Other South West	48	43	37	37	36
Out of Region	14	12	14	9	3
Total	126	129	112	103	109

Table 2 indicates that a large proportion of notifications each year come from areas outside the West of England region (BANES, Bristol, North Somerset and South Gloucestershire), either within the South West region ('Other South West') this includes Wiltshire, Gloucestershire, Somerset, Swindon, Devon, and Cornwall, or outside the South West region ('Out of Region') this includes South Wales and children visiting the area from other parts of the UK. This is because Bristol contains tertiary referral units for neonates and children and specialist services including cardiology, oncology and neurology.

The numbers of notifications for any one area of residence are so small that the most likely explanation for any pattern is random year-on-year variation. However CDOP should always try and exclude contributory factors such as differences in coding practice or an increase in a particular category of death. During the last 5 years, postcode of residence has been used consistently and there have been no significant changes in local authority boundaries. Additionally, analysis of category of death shows that there is no single category of death that appears to account for the patterns seen over the five-year period. It is therefore most unlikely that these variations in notifications within LSCBs reflect any particular underlying cause and as such they should not be over-interpreted.

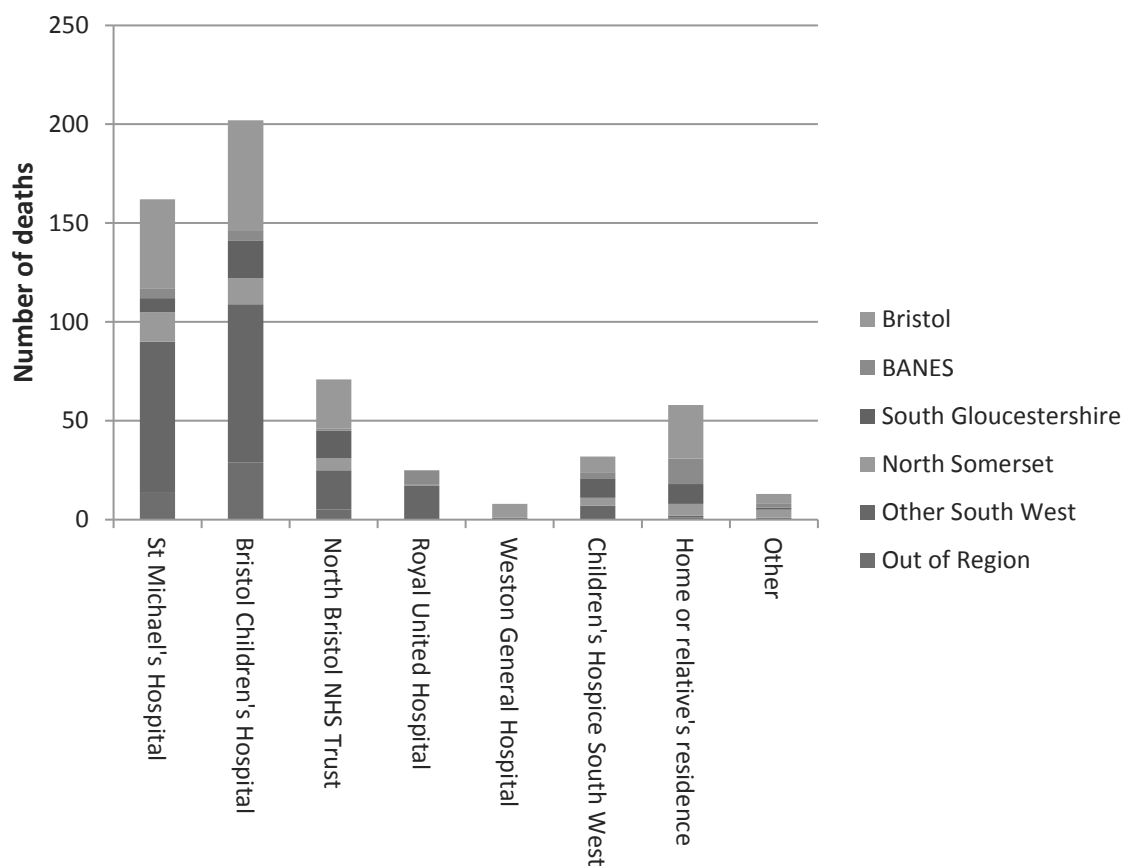
Figure 1: Notifications by area of residence, 2011-2016



6.3 Location of death

This data records where the child actually died. Over the five-year period (202/581) 35% of all child deaths occurred at the Bristol Children's Hospital, (162/581) 28% at St. Michael's Hospital, (71/581) 12% at hospitals within North Bristol NHS Trust (Southmead and formerly Frenchay Hospitals) (32/581) 5.5% died in a hospice, and (58/581) 10% died at home or at a relative's residence. Of the children who died at home or at a relative's residence, 73% (43/59) were unexpected deaths and 27% (16/59) were expected deaths (See section 6.9 for further information on expected vs unexpected deaths). (43/581) 7.4% died in other hospitals and (12/581) 2% died in other locations. This includes deaths abroad and deaths in public places e.g. road traffic collisions. Bristol contains tertiary referral units for patients with obstetric, neonatal and childhood illness. A large proportion of the deaths at the Bristol Children's Hospital, St Michael's Hospital and Southmead Hospital are in children who are resident outside of the West of England area, or outside the South West region, illustrating their importance as receiving hospitals for the sickest children who need access to specialist services (Figure 2).

Figure 2: Place of death categorised by area of residence, 2011-2016



The precise location of death for children dying within hospitals in the West of England region in 2011-2016, is shown below in Table 3.

Table 3: Number of children dying in different locations within West of England hospitals

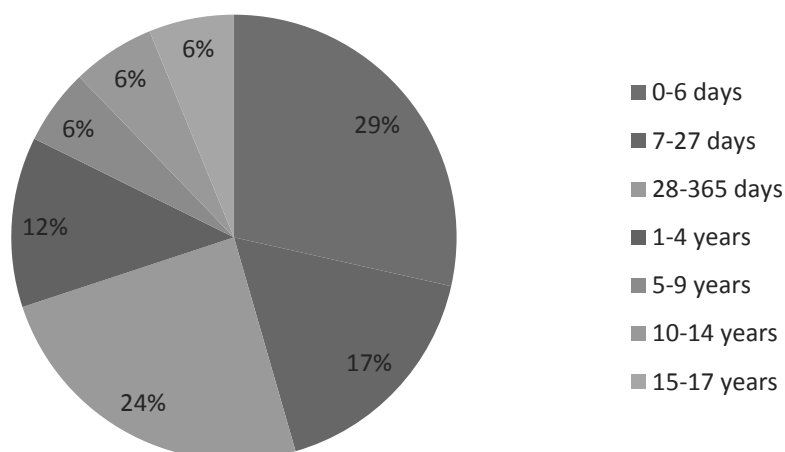
Hospital	Paediatric/Neonatal Intensive Care Units (PICU/NICU)	Emergency Department	Children's Wards/Theatres/Central Delivery Suite	Adult ICU
Bristol Children's Hospital, University Hospitals Bristol	149 (PICU)	30	23	n/a
Royal United Hospital, Bath	8 (NICU)	5	12	0
St Michael's Hospital, University Hospitals Bristol	148 (NICU)	n/a	14	n/a

North Bristol NHS Trust Hospitals	43 (NICU)	3	21	4
Weston General Hospital	n/a	7	1	0
Other Hospitals	4	3	2	1

6.4 Age at Death

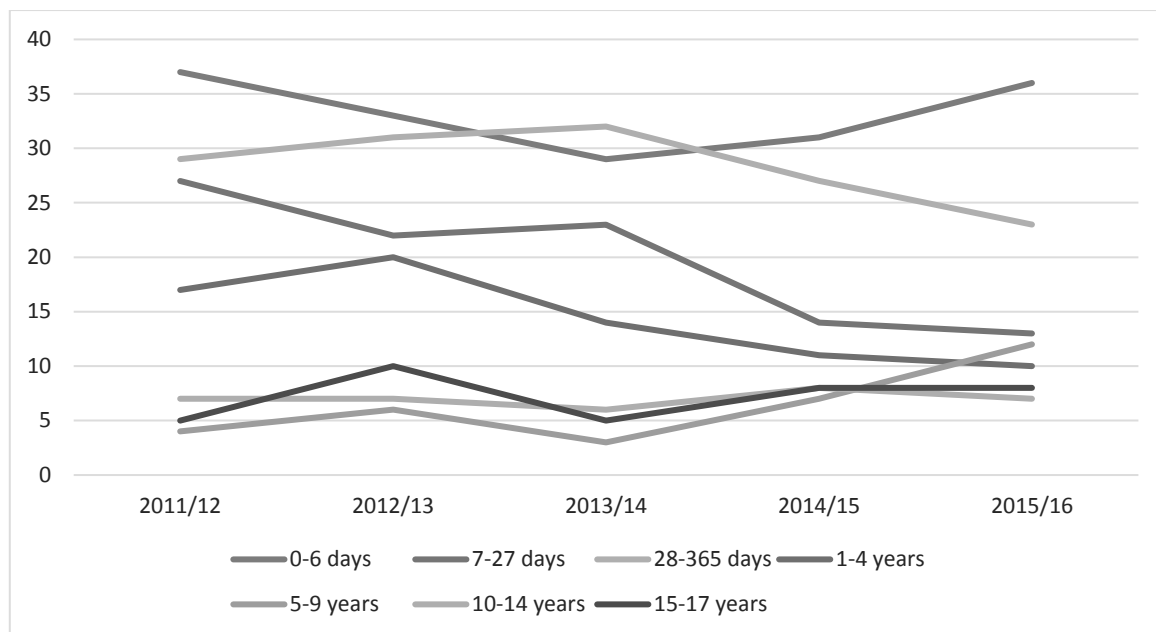
Using 5 year data, the greatest proportion of notifications (29%) were received for babies dying in the early neonatal period (less than seven days of life) (Figure 3). Considering the neonatal period as a whole (0-28 days) 46% of deaths occurred during this time. The first year of life is routinely categorised into three groups; deaths in the first week of life (early neonatal deaths), deaths between one week and one month of life (late neonatal deaths) and deaths between one month and one year of life. The term 'infant death' refers to the death of any live born infant up to the age of one year. Figure 3 shows that the first year of life is the most risky period of childhood, with 70% of deaths occurring during this period. It is worth noting that the age bands used below do not cover equal periods of childhood e.g. 10-14 years covers a five year period and 15-17 years covers a three year period.

Figure 3: Notifications by age group, 2011-2016



We can also look at the trends in deaths by age group over the five year period in the line graph in Figure 4 below. This shows that the number of deaths in the 7-27 day age group has decreased over the five year period by almost half. A similar trend can be seen in the deaths of 1-4 year olds, where after a peak in 2012/13 there has been a steady decline in numbers.

Figure 4: Line Graph to show the trends in notifications by age over the 5 year period:



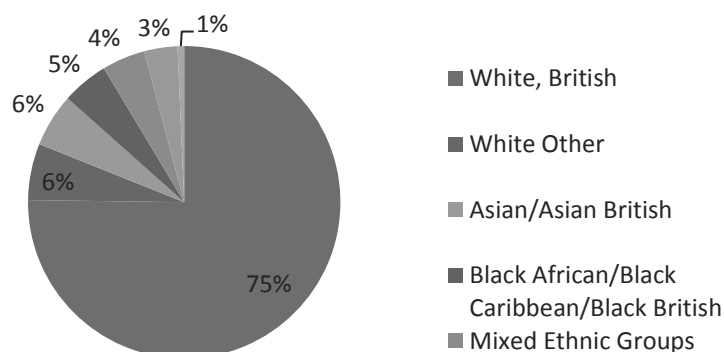
6.5 Gender

There have been more notifications of deaths in boys (55%) than girls (45%). This mirrors national data from the child death review process, with 57% of deaths reviewed occurring in boys nationally³. The data shows that boys are more likely to die from all causes.

6.6 Ethnicity

Figure 5 shows that 75% of notifications received by the Child Death Enquiries office between 2011 and 2016 were for children of White, British origin. 6% of notifications were for children of White, Other origin. This includes children of European ethnicity. The number of notifications for children whose ethnicity was recorded as Asian or Asian British was 6% and the number of notifications for children whose ethnicity was recorded as Black or Black British was 5%.

Figure 5: Notifications by ethnic group, 2011-2016

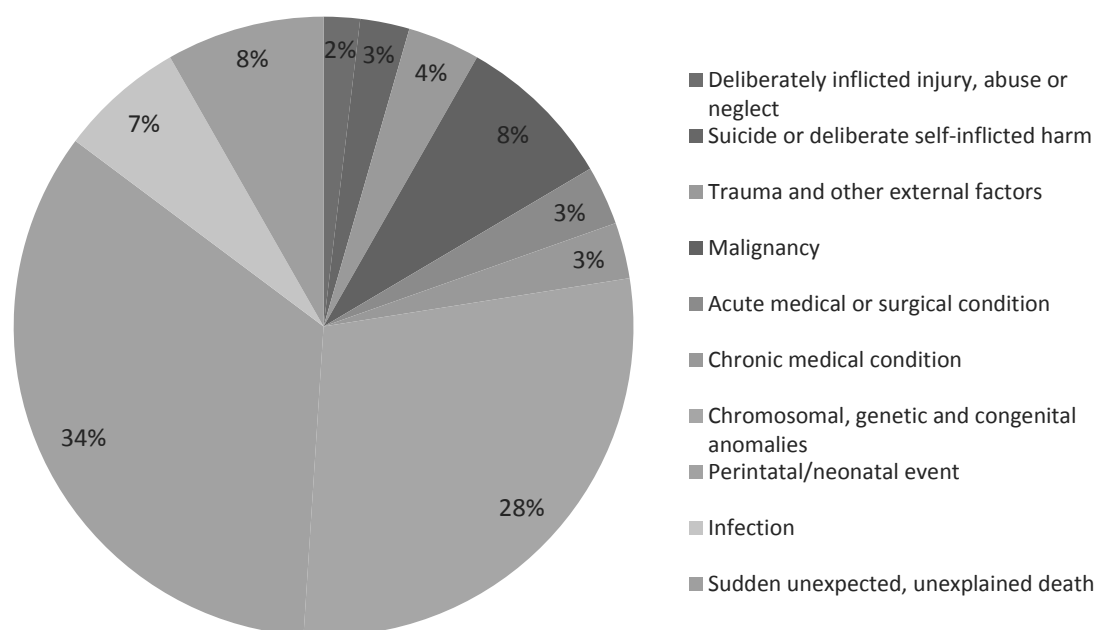


³ Department for Education *Child Death Reviews: Year Ending 31 March 2013*, Department for Education, SFR 26/2013, 18th July 2012

6.7 Category of Death

The CDOP is required to categorise each child death using a standard list of categories shown in Figure 6. During the five-year period, 34% of deaths were categorised as perinatal/neonatal events. The second most common cause was chromosomal, genetic or congenital abnormalities, with 28% of the deaths fitting into this category. Malignancy (8%), sudden unexpected, unexplained deaths (8%), infection (7%) and trauma (4%) comprise the next most common causes. Chronic medical conditions (3%), acute medical or surgical conditions (3%) suicide or self-inflicted injury (3%) and deliberate harm by others (2%) are less common. Figure 6 shows the breakdown of childhood deaths for each category.

Figure 6: Notifications by category of death over the 5 year period, 2011-2016

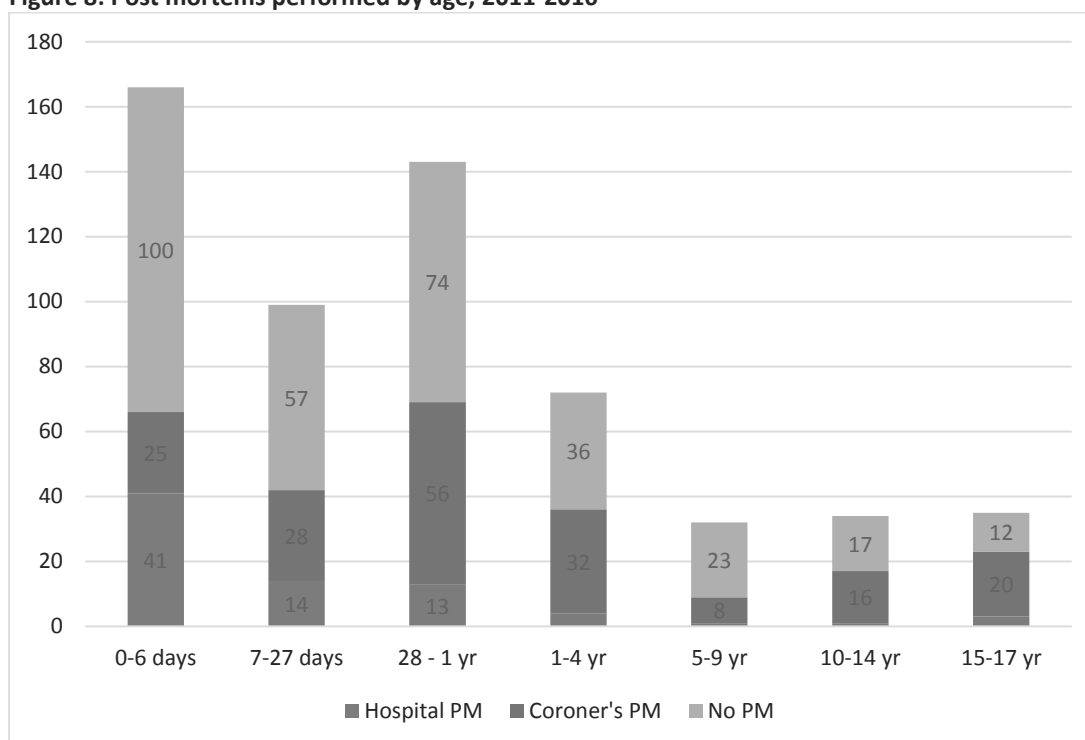


The same data can be grouped into categories as seen in Figure 7 where it is seen that perinatal/neonatal remains the largest category for <1 month olds, followed by chromosomal, genetic and congenital causes. 'Acquired natural causes' groups together malignancy, acute medical or surgical conditions and infection. 'External causes' groups deliberately inflicted injury, suicide, trauma and other external factors. It can be seen that in early childhood, 1-4 years, acquired natural causes and chromosomal, genetic and congenital conditions predominate, but by later teenage years, ages 15-17, external causes are almost as frequent as acquired natural causes as cause of death.

6.8 Post mortem examinations

Post mortem examinations make an important contribution to explaining how a child dies and may be ordered by the Coroner or offered by the attending clinician when the circumstances surrounding the death remain unclear. Over the last five years detailed data was collected relating to the post mortem process. A Coroner's post mortem occurred in 185/581 deaths (32%) and a hospital post mortem occurred in 78/581 deaths (13%). 319/581 (55%) cases did not have a post mortem. There were no hospital post mortems carried out in children in the 5-9 year age group. Figure 8 below shows post mortems performed by age group.

Figure 8: Post mortems performed by age, 2011-2016



6.9 Unexpected and Expected deaths

An unexpected death is defined as the death of an infant or child, which was not anticipated as a significant possibility 24 hours before the death or, where there was a similarly unexpected collapse or incident leading to or precipitating the events that led to the death. They are defined in the Notification database as deaths that were unexpected and triggered a rapid response.

145/581 (25%) of deaths in children aged 0-17 years were unexpected. 34% of those unexpected deaths remained unexpected and unexplained after a full investigation and the local child death review meeting. The main categories of these unexpected deaths can be broken down as follows:

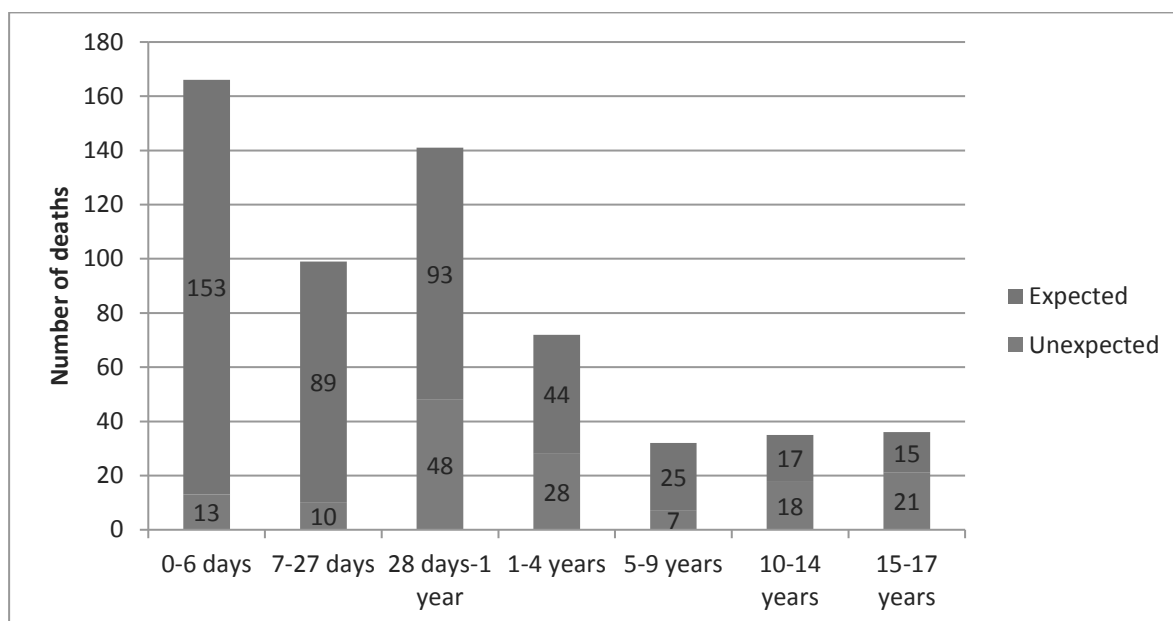
Table 4: Causes of unexpected deaths of children 2011-2016

Cause of death	% of total unexpected deaths
Sudden unexpected, unexplained death (including SIDS)	34
Trauma and other external factors (including road traffic accidents, drowning, deliberately inflicted harm and suicide)	32
Other (including chronic and acute medical conditions)	16.5
Chromosomal, genetic and congenital anomalies	10
Infection	7.5

It is worth noting that children with chromosomal, genetic and congenital anomalies often die in an unexpected fashion many years after their birth.

Over the five year period there were 436 expected deaths notified to the Child Death Enquiries Office. Of these deaths 335/436 (77%) were children under 1 year of age. The vast majority of expected deaths in children aged 0-17 years were categorised as due to perinatal/neonatal events (43%) or chromosomal, genetic or congenital anomalies (34%). 10% were due to malignancy.

Figure 9: Expected versus unexpected deaths by age group, 2011-2016



7. Child Death Overview Panel Review Data

These data are drawn from the CDOP database (see Section 5). They summarise the Panel's review decisions for 2011-2016 and its actions for 2015-16. As explained previously, not all notifications received by the West of England Child Death Enquiry Office will be reviewed by the West of England CDOP. They will be reviewed by their local CDOP if it is deemed more appropriate.

There is an inevitable time-lag (4-12 months) between notification of a child's death and discussion at CDOP. There are various factors that contribute to this: the return of Form Bs from professionals, the completion of the final post mortem report by the pathologist and receipt of the final report from the local child death review meeting. On occasion when the outcome of a Coroner's inquest is awaited, there may be a delay of over a year before a case might be brought before CDOP. The undertaking of a criminal investigation or a Serious Case Review will also affect when a case is discussed at Panel.

For these reasons the population of children described in Section 6 Summary Data (drawn from the Notification database) may partially overlap but is distinct from the population of children described in this section (drawn from the CDOP database). This is illustrated in Table 5.

Table 5: The number of cases reviewed each year by year of death

	2011/12	2012/13	2013/14	2014/15	2015/16

Total number of notifications	126		128		112		106		109	
Number of cases to be reviewed by WOE CDOP	78		82		66		60		72	
Years of Review	Number reviewed	% reviewed	Number reviewed	% reviewed	Number reviewed	% reviewed	Number reviewed	% reviewed	Number reviewed	% reviewed
2011/12	8	10								
2012/13	55	71	15	18						
2013/14	14	18	45	55	5	8				
2014/15	1	1	20	25	46	70	5	8		
2015/16	0	0	2	2	15	22	42	70	12	17
Total	78	100	82	100	66	100	47	78	12	17

*this includes all children resident within the West of England area at the time of their death and selected specialist cases more appropriately discussed by the West of England CDOP e.g. those involving cardiac surgery

All cases of children who died prior to 1st April 2014 have been reviewed by CDOP.

Sections 7.1 to 7.5 describe data relating to the 348 children reviewed by the West of England CDOP between 1st April 2011 and 31st March 2016. The data is drawn from the CDOP database into which all information from Form B, C, the local child death review meeting and final CDOP review is entered.

7.1 Other co-morbidities

CDOP reviews information on co-morbidities in children who die. These are underlying conditions which, while not considered to be the direct cause of death, are thought to have contributed to vulnerability in the child. In some cases, the children reviewed in this section may have more than one co-morbidity. Of the 348 children reviewed, 246/348 (71%) had no co-morbidities at all and 102/348 (29%) had at least one co-morbidity. 43/102 (42%) of children had a single co-morbidity and 59/102 (58%) had two or more co-morbidities.

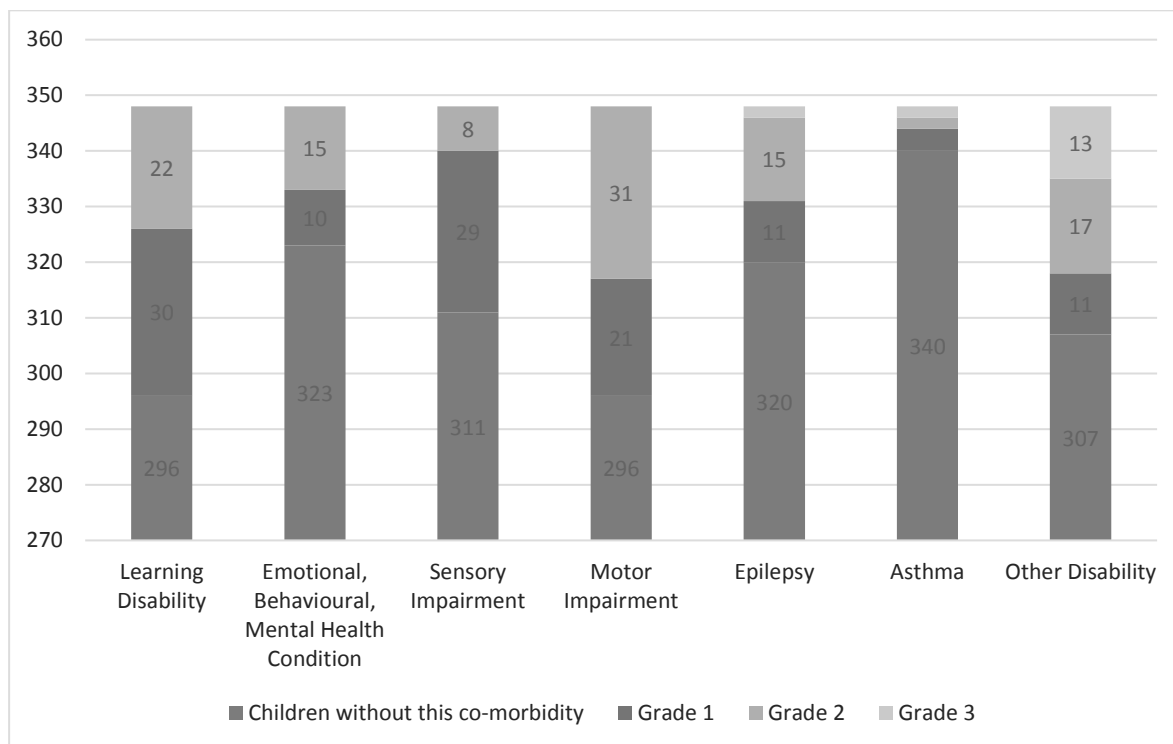
The CDOP grading system grades factors identified with a 1 if they are notable but not felt to have contributed to the ill-health or vulnerability of the child, with a 2 if they may have contributed to the ill-health, vulnerability or death of the child and with a 3 if they are felt to provide a complete and sufficient explanation of the death of the child. Figure 10 details the figures for children who have at least one co-morbidity graded as a 2 or higher when reviewed by CDOP.

Looking at factors graded as 2 or higher (the green and yellow sections in the chart below), we can see that children with a motor impairment 31/348 (9%) and children with a diagnosed learning disability 22/348 (6%) represent the most common co-morbidities thought to contribute to vulnerability.

In 37/348 (10%) of cases reviewed the child suffered from a sensory impairment. In 25/348 (7%) of cases reviewed, the child suffered from an emotional, behavioural or mental health condition such as ADHD. Epilepsy was present in 26/348 (7.5%).

41/348 (12%) of children reviewed had another disability. An example of a co-morbidity included under “other” would be an underlying genetic or congenital condition which is not known to be life-limiting but may impact on the child’s ongoing healthcare needs or irreversible but non-progressive conditions causing severe disability such as cerebral palsy. Of those 41 children the disability was felt to be significant in 30/41 (73%) of cases.

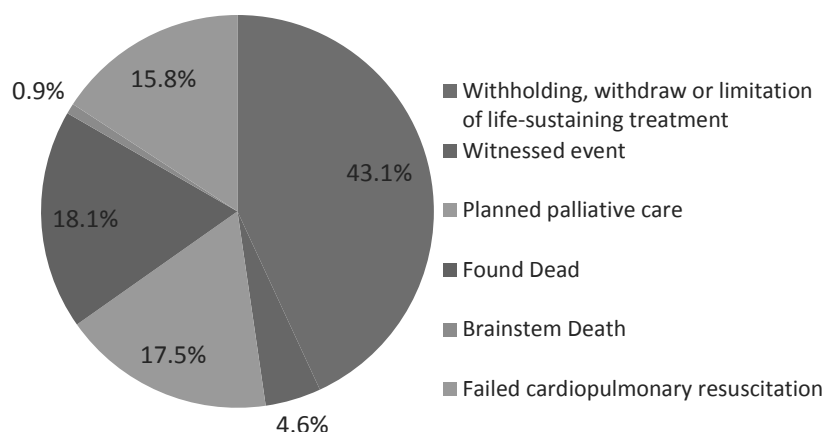
Figure 10: Co-morbidities in children reviewed by CDOP between 1st April 2011 and 31st March 2016



7.2 Mode of death

The most common manner in which children died was following active withdrawal of life sustaining treatment most commonly in an intensive care situation (this decision is always made following careful consideration with the parents and carers). This occurred in almost half of the deaths reviewed by CDOP. In 18.1% of cases the child was found dead and in 17.5% of cases the child died following planned palliative care. In 15.8% of cases the child died following failed cardio-pulmonary resuscitation and in 4.6% of cases the child’s death was a witnessed event. This includes road traffic collisions and other deaths by external causes.

Figure 11: Mode of death of cases reviewed by CDOP between 1st April 2011 and 31st March 2016

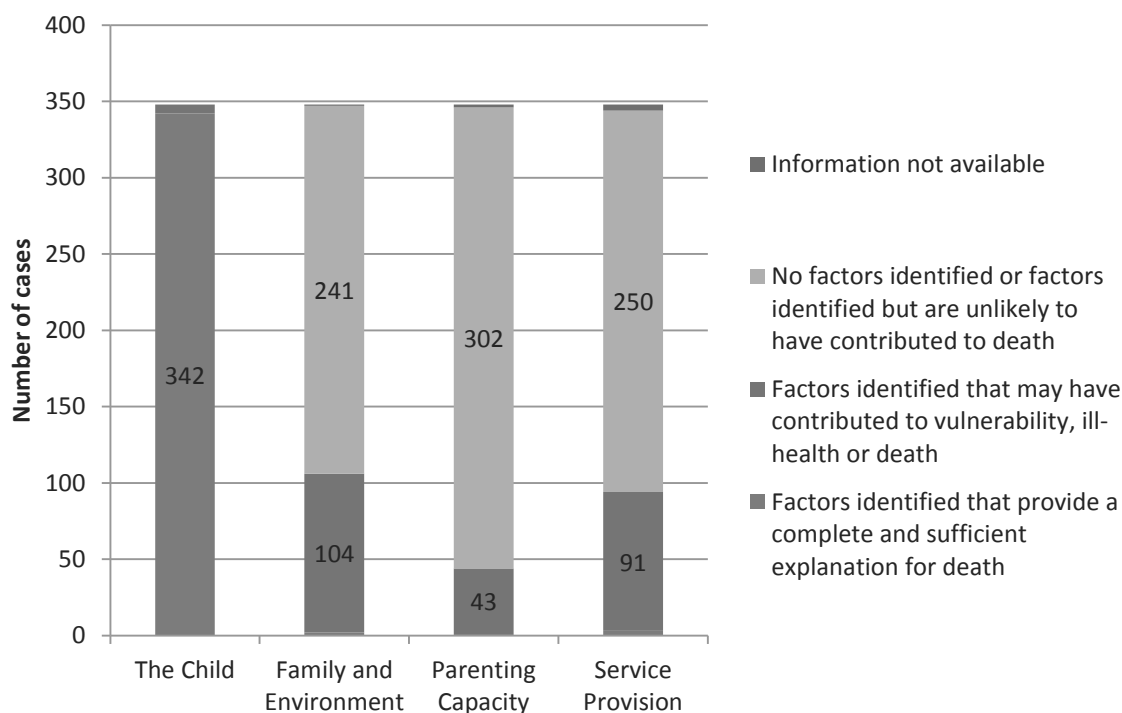


7.3 Summary factors identified as contributing to death

Form C of the national dataset requires the local child death review meeting to identify and 'grade' factors that have contributed to the child's death. The CDOP may amend this grading after full deliberation of the facts, to maintain consistency across cases, and this occurred in 83% of the 348 cases reviewed in the five year period.

Figure 12 shows that in 98.3% of cases reviewed between 1st April 2011 and 31st March 2016, factors intrinsic to the child (i.e. the underlying medical or surgical problem) provided a complete explanation for the death. In 30.5% of cases, factors in the family and environment were identified that may have contributed to the vulnerability, ill health or death of the child, for example domestic violence or drug using parents. In 12.6% of cases factors in the parenting capacity were identified that may have contributed to the vulnerability, ill health or death of the child, for example poor parental supervision and in one case parenting capacity was thought to have provided a complete explanation for the death. In 26.1% of cases factors related to service delivery in an agency were identified that may have contributed to the vulnerability, ill health or death of the child. CDOP examines service delivery by all agencies e.g. social care, health education and in all LSCB areas. Examples of service delivery issues highlighted in the 2015-16 review year are lack of referral to Children & Young People's services following disclosure of domestic violence, difficulty accessing medical information from private services and in one case a sub-optimal post-mortem report.

Figure 12: Contributory factors identified by CDOP in cases reviewed between 1st April 2011 and 31st March 2016



7.3.1 Additional factors in the family and environment

Social factors relating to mental health issues, drug abuse and other factors are routinely collected on the Form B dataset, summarised on the Form C dataset at the local child death review meeting, and carefully reviewed at Panel. These are shown in Table 5. Of the 348 cases reviewed by CDOP between 1st April 2011 and 31st March 2016, parental smoking was noted to have contributed to the ill-health, vulnerability or death of the child in 9.5% of cases. Emotional, behavioural or mental health issues in a parent or carer were thought to have contributed to the ill-health, vulnerability or death of the child in 4.8% of cases. Mental health issues include maternal or paternal depression, previous self-harm and previous suicide attempts. Alcohol and/or substance misuse by a parent or carer was thought to have contributed to the ill-health, vulnerability or death of the child in 5.2% of cases. Housing issues were felt to be a significant factor in 3.2% of the deaths reviewed. These issues were usually overcrowding and/or a chaotic or extremely unclean environment. Domestic violence was present in 17.5% of cases reviewed, however it was thought to have contributed to ill-health, vulnerability or death in 3.2% of cases reviewed.

Table 6: Factors in the family and environment recorded in cases reviewed by CDOP between 1st April 2011 and 31st March 2016

	Grade 1	Grade 2	Grade 3	Factor not present	Not known if factor present	% of cases where factor considered to be significant
Smoking by a parent or carer / Smoking by Mum during pregnancy	86	33	0	204	25	9.5
Alcohol or Substance Misuse by a parent or carer	26	18	0	276	28	5.2

Emotional, Behavioural or Mental Health condition in a parent or carer	87	17	0	224	20	4.8
Domestic violence	46	15	0	283	4	4.3
Housing	27	11	0	310	0	3.2

NB: The CDOP grading system grades factors identified with a 1 if they are notable but not felt to have contributed to the ill-health or vulnerability of the child, with a 2 if they may have contributed to the ill-health, vulnerability or death of the child and with a 3 if they are felt to provide a complete and sufficient explanation of the death of the child.

7.3.2 Additional factors in Parenting Capacity

Notable factors relating to parenting capacity are identified through the Form B and Form C data sets, and carefully reviewed at panel. These are shown in Table 7.

Table 7: Factors in parenting capacity recorded in cases reviewed by CDOP between 1st April 2011 and 31st March 2016

	Grade 1	Grade 2	Grade 3	Factor not present	% of cases where factor considered to be significant
Poor parenting / Supervision	9	20	0	319	5.7
Child abuse / neglect	5	12	3	328	4.3

Of the 348 cases reviewed between 1st April 2011 and 31st March 2016, CDOP concluded that poor parenting/supervision was a factor that had contributed to the ill-health, vulnerability or death of the child in 5.7% of cases. In 4.3% child abuse or neglect was judged to have contributed to the ill-health, vulnerability or death of the child. CDOP also noted examples of positive parenting during review of cases.

7.4 Preventability – Modifiable Factors

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’. 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. The West of England CDOP has also regarded bed-sharing with parents known to be smokers to be a modifiable factor in cases of Sudden Infant Death Syndrome (SIDS).

In 230 of the 348 cases reviewed by the West of England CDOP in the five year period (66%) no modifiable factors were identified. In 114/350 (33%) cases modifiable factors were identified. In 4/348 (1%) of cases there was not enough information available to determine if modifiable factors were present. An example of a case in which CDOP may not be able to determine modifiable factors would be the death of a child abroad. In these cases it can be difficult to obtain sufficiently detailed information from agencies in the country of death to make a decision.

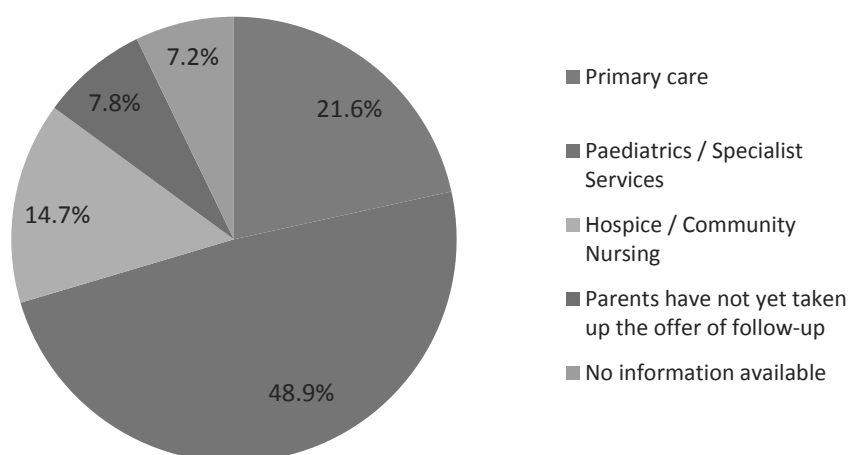
Data from the Department for Education for the period 1st April 2014 to 31st March 2015 shows that nationally 24% of child deaths were found to have modifiable factors. However historically

panels in the South West have identified the highest proportion of modifiable factors in the child death reviews they completed (29%)⁴. This may be due to the open scrutiny with which this panel seeks opportunities to learn from every case reviewed and the fact that factors considered to be modifiable may not be considered modifiable by other panels.

7.5 Family follow up

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. Figure 13 shows the agency offering follow up to the families of children whose cases were reviewed by CDOP between 1st April 2011 and 31st March 2016. 48.9% of families received follow-up from paediatrics or specialist services. This includes obstetrics, neonatology, cardiology and oncology. 21.6% of families received follow up from primary care (GP or health visitor) and 14.7% of families received follow up from a hospice or community nursing organisation such as CLIC Sargent, the Lifetime Service or Jessie May. 7.8% of families were offered follow up but had not yet taken it up. In 7.2% of cases reviewed by CDOP the follow-up status of the family was unknown. In most cases this was because the family had moved out of the area following the death of the child. Families are routinely given national and local information on charities offering bereavement support.

Figure 13: Agency providing follow up to families in cases reviewed by CDOP between 1st April 2011 and 31st March 2016



8. Focus on Suicides and Deliberate Self-Inflicted Harm

This year's annual report focus is on suicide and deliberate self-inflicted harm. This includes children who are known to have chosen to take their own lives and children that died following risk-taking behaviour, whose intention remained unclear following a full investigation and Coroner's inquest. An example of a child in the second group would be a child that died following use of drugs. CDOP recognised in reviewing these deaths, that the current statutory classification

⁴ Department for Education *Child Death Reviews: Year Ending 31 March 2013*, Department for Education, SFR 26/2013, 18th July 2013

system does not allow for easy classification of deaths where it is not known if the child intended to take their own life.

Due to the small numbers of deaths within this category this section will not give specific numbers in order to maintain confidentiality of personal information.

In the period between 1st April 2011 and 31st March 2016 CDOP reviewed the deaths of a small number (< 15) of children who were felt to fall into this category. In 84% of cases the method of death was hanging/strangulation.

CDOP routinely collects information on supplementary Form B12 which asks specific questions relating to suspected suicide. This includes whether the child was known to mental health services prior to death and whether the child was known to have engaged in any deliberate self-harm. 31% of children reviewed by CDOP in this group were previously known to mental health services and 54% had previously engaged in deliberate self-harm.

The Form B12 also asks professionals to identify any specific factors which are thought to have contributed to the child's decision to take their own life e.g. bullying, domestic violence or bereavement. The most common factors identified were family discord (present in 46% of deaths reviewed) followed by relationship problems (present in 38% of deaths reviewed) and problems at school (present in 23% of deaths reviewed).

In May 2015 CDOP held a suicide themed panel meeting. Review of deaths using the themed approach can often help to highlight patterns or common features in a group of deaths which can help to identify learning and recommendations as follows:

- Bunk beds are often used as the point of suspension in child suicides across the country. There are challenges around the design of bunk beds that make them suitable for this purpose.
- The prevalence of "The Choking Game" was noted within children of secondary school age and the availability of videos relating to this on social media sites. Panel members and their colleagues are in the process of submitting a paper related to this to Archives of Disease in Childhood for publication. There was discussion about possible ways of addressing this including at a national level putting a plot into a popular television programme. CDOP was made aware of a paper on this topic contributed to by a former WOE CDOP panel member⁵.
- Press intrusion following death causing distress to family members.
- Often the child's friends are more aware of their true feelings/intentions than family or professionals. This highlighted the importance of the peer to peer approach which has been used successfully in regard to the issue of bullying. CDOP has recommended that this approach be considered further in the Emotional Health and Well-being Strategy within each of the CCG areas, in particular considering how and what peers should do if they have concerns about a friend.
- The removal of the statutory nature of the PHSE programme, with the effect that some schools are struggling to find the time to keep this in the curriculum now it is voluntary. CDOP felt strongly that PHSE is a valuable avenue to engage with young people on the issues raised by this review

⁵ "Prevalence and associated harm of engagement in self-asphyxial behaviours ('choking game') in young people: a systematic review" Busse, H ; Harrop, T ; Gunnell, D ; Kipping, R - Archives Of Disease In Childhood, 2015 Dec, Vol.100(12), pp.1106-1114

- CDOP felt that this group of deaths in particular would benefit from more detailed regional or national level data collation to see if the issues above are reflected in the data collected by other CDOPs.

CDOP took the following actions in relation to the learning that was identified in the themed CDOP meeting:

- A letter was sent to the Head of Medicines Management at the Bristol Clinical Commissioning Group (CCG) asking for details of the local prescribing policy for young people and raising the issue of returning/destroying unused medication. CDOP made a recommendation that they discuss these issues with their suicide prevention leads. A comprehensive response was received from the Head of Medicines Management confirming that CCG staff have undertaken a significant amount of work over the last 12 months to raise awareness of the volume of prescribed medication in Bristol that is not taken by those for whom it is prescribed. This included engaging with local healthcare professionals, patients and carers in a variety of settings. The aim has been to raise awareness of the problem so that all stakeholders can reflect on the way they currently prescribe, request and use medication and modify their behaviours and medication related policies as appropriate. A number of further actions were detailed in the response which have not been published here in order to maintain confidentiality.
- The CDOP Manager spoke to the Royal Society for the Prevention of Accidents (ROSPA) to discuss if it would be possible to review the design of bunk beds to remove the slats which can be used as a point of suspension in deaths resulting from hanging. ROSPA explained that there are a number of standards in place relating to the construction of bunk beds, which are designed to keep children from falling out of the bed and therefore it may be a challenge to get this changed unless CDOP could offer an evidence base for how often bunk beds have been used as a point of suspension. However, ROSPA currently offers advice to families on safety in the home, including in children's bedrooms. CDOP felt this was an example of where a national child death database could be useful in providing such an evidence base to enable informed decision-making in relation to actions around this issue
- A letter was sent to the Secretary of State for Education regarding the removal of the statutory nature of the PSHE programme, asking him to consider reinstating it as a statutory requirement. This arose because CDOP felt that PSHE is a valuable avenue to engage with young people on two specific issues raised in the themed review, which were the risks from self-induced asphyxia, also known as "The Choking Game" and young people's awareness of what to do if they are concerned about a friend's possible intention to take their own life, particularly when family or professionals may not be aware of this intention. A response was received from Edward Timpson MP, the Minister of State for Children & Families, stating that the government believes that teachers are best placed to understand the needs of their pupils and do not need additional central prescription and that it is for schools to tailor their local PSHE programme to reflect the needs of their pupils and this freedom is reflected in curriculum reform. However he also advised that there is recognition that PSHE is not yet good enough in schools and measures had been announced to improve the quality of PSHE following the publication of the Education Select Committee report "Life Lessons: PSHE and SRE in Schools" in July 2015. Following this response CDOP then wrote to the Chair of the Education Select Committee, Neil Carmichael MP highlighting both Mr Timpson's response and that the Life Lessons report supported CDOP's contention that the statutory nature of PSHE should be re-introduced. In this letter CDOP added its support to the Committee's recommendation and confirmed that they were also supporting local initiatives to introduce peer to peer support and would welcome suggestions from the Committee about ways to take this issue forward. A

response was received confirming that the Government response to Life Lessons stated that Ministers would consider in full the arguments put forward by the Select Committee before reporting back later in the year. The response confirmed that the Committee intended to pursue this issue and press the Government for a fuller response to the key issue of statutory status for the subject.

- A letter was sent to the 4 Local Safeguarding Children Board Chairs and the Emotional Health and Well-being Leads in all 4 Clinical Commissioning Group areas to advise them of the themes, learning and actions that were identified through this meeting

9. Child Death Overview Panel Activity

9.1 Actions arising from CDR/CDOP review of individual cases (*details are not presented to maintain confidentiality of personal information*)

Effective governance procedures within organisations should ensure that significant factors are identified and managed through the local child death review process. The CDOP reviewed many cases where good practice had been identified.

In order to ensure that issues identified at CDOP were rapidly disseminated through their constituent agencies, the Chairs of each LSCB within the West of England area have CDOP matters as a standing agenda item at their Board meetings.

In certain cases, the CDOP sought assurance that a particular action arising from a child's death had been addressed. Table 8 summarises cases where issues were identified and followed up by the CDOP through the Chair or through individual agency leads. This table reflects a selection of CDOP actions for this year.

Table 8: Actions arising and outcomes

Case Description	Issue	CDOP Action	Response/evidence	Recommended National Learning
Suicide	CDOP recognised the importance of providing opportunities to parents to voice their questions / concerns when their child died	Write to the professional who helped the family to compile and send in their questions in this case to thank her	Share good practice through peer review encouraging this approach as part of child death review process in other deaths	N/A
Road Traffic Collision	Raise awareness of the importance of safely coupling vehicles and the potential dangers	Contact family to find out if they want this learning to be shared	Family confirmed they were happy to have the learning from their child's death shared and this was passed onto	Importance of following the appropriate procedures when coupling vehicles to ensure they are

			the West of England Road Safety Partnership to identify a mechanism for raising awareness of this issue and for dissemination of the learning.	secured appropriately.
Malignancy	Unclear if Head Start guidance is used by professionals in primary care to help identify the symptoms of brain tumours in children	Investigate through the General Practitioner (GP) Representative on CDOP	This guidance has been disseminated through GPs with a Special Interest (GPSIs) and is currently in use in this area	Importance of early consideration of brain tumour as a possible diagnosis in children presenting with symptoms identified in the Head Start guidance.
Malignancy	Difficulty in finding specialist nurses to care for children at short notice, even when funding is available	Write to Adult Commissioning Services in the 4 CCGs to ask them to explore how relevant adult services could support children and families.	Letter sent April 2016	Possibility of linking adult palliative care services with the needs of young people and their families to ensure that homecare is an achievable option in their end of life planning.
Sudden death of a child with complex health needs	Final post-mortem report did not appear to consider the potential role of an implanted device in relation to the death.	Write to the Coroner that heard the case highlighting this issue.	Following further investigation it was determined that some investigations had been carried out, however it did not appear malfunction of the ITB pump had been considered as a possible cause of death.	Consideration of nationally achievable means to ensure any death which could be contributed to by this type of implanted device is investigated appropriately and promptly. CDOP has written the Chief Coroner about this.
Life-limiting condition	CDOP recognised excellent practice in a number of cases this year including this one	Write to the Coroner's Office, Hospice and the Ambulance Service commending them on their good practice, considering parents experience	N/A	N/A

		following the child's death		
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9.2 Themes emerging from aggregate review of cases at CDOP during the year April 2015 – March 2016

Lack of bereavement support for families

This year CDOP has recorded some dissatisfaction with bereavement provision for some families. A number of cases in past meetings have reflected this and while this issue is not directly related to identifying modifiable factors in relation to the death the panel felt it is important to try to address. One forward step is that CDOP has flagged this issue to the local children's hospital trust who now have a bereavement team in place. CDOP have also helped to raise awareness of bereavement support for specific cultural groups.

Delay in receipt of final Post Mortem Reports

Unfortunately the effects of the national shortage of paediatric pathologists continues to impact families after their child's death. CDOP reviewed a number of cases this year where the delay in the final post-mortem report being available to families caused significant distress. This year CDOP wrote to the Royal College of Pathologists who confirmed that the College is aware of this issue and has reported that paediatric pathology remains a shortage speciality to Health Education England. They reflected that there are an adequate numbers of training posts at present, but there are difficulties in attracting high quality trainees to the speciality and events were run by the College last summer to ensure that paediatric pathology is represented to trainee doctors at an early stage. The Designated Doctor for Children's Deaths has also dealt with some media contact in relation to this issue.

Difficulty in obtaining information on fathers of children who have died

As part of the child death review process, information on the child's family and background circumstances is routinely reviewed. However CDOP recognised that it is often difficult to collect adequate information on the fathers of children who have died as this information is often not held on agency records. CDOP is aware that this is also an issue for other CDOPs and may be a national issue. CDOP has been able to remind clinicians involved in the child death review process about this issue, for example, where there has been a rapid response in relation to an unexpected child death professionals have been reminded to ensure that wherever possible information on the GP surgery that the father is registered with is collected.

Medical learning from case reviews:

This year CDOP has highlighted important medical learning from a number of cases, in particular in relation to presenting features of infection and childhood malignancies. Discussions have taken place about how best to disseminate this learning to relevant agencies. CDOP has received anecdotal evidence that many parents wish to contribute to future learning in this way.

10. Future priorities and challenges

How to maximise the learning from CDOP remains a key challenge in 2016. The anonymous and confidential nature of case reviews should not stand in the way of work aiming to prevent future child deaths. Sharing data needs to happen to enhance audit and research, as well as to contribute to mandatory processes. With sparse national guidance about this, West of England CDOP will continue to debate with the University of Bristol (who are responsible for delivery of the CDR process in this area), LSCBs and partner agencies.

Slow progress continues towards a national CDOP database, with the scoping exercise commissioned by the Health Quality Improvement Partnership (HQIP) about to be completed, and WoE CDOP will offer their involvement in the next steps of setting up a database. In the meantime we have found much learning to be available on a regional basis. Further themed meetings will be convened, as modelled recently for neonates and for suicides.

Any service provision issues will be fed back to the Clinical Commissioning Groups and individual agencies even more promptly.

Bereavement support has taken a leap forward with the establishment of a Bristol Children's Hospital team. CDOP continues to advocate for the needs of families, especially those who have lost a child unexpectedly and do not have support available through existing agencies. The establishment of a Care of the Next Infant programme will remain a priority.

Lay representation on CDOP is being reviewed, to ensure appropriate guidance in both choosing individuals and their supporting organisation.

Support for professionals should also be available in this most challenging area, and the CDR budget will continue to directly provide a small psychology service to frontline staff in rapid responses to unexpected deaths.

West of England CDOP aims to continue to highlight and compliment good practice and there is fortunately much to praise. We have also contributed to the National Review into the Local Safeguarding Children Boards Role and Function conducted by Alan Wood MP, in particular suggesting the potential benefits of moving to a regional model of CDOPs. The report from Alan Wood's review has been published and makes the following recommendations in relation to Child Death Overview Panels

- Child deaths need to be reviewed over a population size that gives sufficient number of deaths to be analysed for patterns, themes and trends of death
- We need to encourage regionalisation and consideration should be given to establishing a national-regional model for CDOPs.
- The introduction of a national database has to be a priority for implementation. This would assist the collection of local information and a national analysis of child deaths to inform regional CDOPs
- Ownership of the arrangements for supporting CDOPs should move to the Department of Health.

Appendix A - CDOP membership April 2015 to March 2016

	Core member	LSCB/Organisation
Nominated Chair	Natalie Field	North Somerset
Consultant in Public Health	Jon Roberts	North Somerset
Designated Doctor for Child Deaths	Mary Gainsborough	North Bristol NHS Trust
Coroner's Officer	Debra Neil	Bristol
Children's social care (until 01.09.15)	Catherine Boyce	South Gloucestershire
Children's social care (from 01.09.14)	Sally Churchyard	BANES
Designated nurse for safeguarding children (until 01.09.14)	Sue Masters	North Somerset
Designated nurse for safeguarding children (from 01.09.14)	Jackie Mathers	Bristol
Midwifery	Julie Northrop	UHB NHS Trust
Obstetrics	Mark Denbow / Tim Overton	UHB NHS Trust
Neonatology	Paul Mannix	North Bristol NHS Trust
General Practice	Patrick Nearney / Sarah Woodward	Bristol
Police	Ed Yaxley	Avon & Somerset Constabulary
Bereavement Services	Claire Storey	International Stillbirth Alliance
Paediatric Palliative Care	Francis Edwards / Charlotte Mellor	UHB NHS Trust
Acute Paediatrician	Margrid Schindler / Nick Sargant	UHB NHS Trust
Community Paediatrician	Fiona Finlay	BANES
Ambulance Service	Simon Hester	South Western Ambulance Service NHS Foundation Trust
Chief Executive of Survive	Sarah Telford	South Gloucestershire

Appendix B – UHB Financial Summary 2015/16

MPR = Multi-professional Review

BRCH – Bristol Royal Hospital for Children

RRT = Rapid Response team

PNM – Perinatal Mortality Meeting St Michael's Hospital

Child Death Review Costs for 2015/16			
Description of Cost		Payment Due	£ Cost to UHB
Designated Doctor	MPR	1.5 Additional PA's	£16,500
Paediatric Lead – Bristol Children's Hospital	BRCH	1 Additional PA	£11,527
Neonatology Lead - St Michael's	MPR	1 Additional PA	£10,794
Neonatology Lead - Southmead	MPR	0.5 Additional PA	£6,078
Community Paediatricians	RRT	320 hours Total	£18,560
GP and ED Consultant Costs	MPR	Attendance at some panels	£5,007
UOB Senior Manager	MPR	21 hours per week	£30,991
UOB Secretarial Support	MPR/PNM	3 days per week	£21,640
Additional admin support to CDE Office	MPR	3 months	£19,600
UOB Secretarial Support	PNM	2 days per week	£10,533
UOB Secretarial Support – NBT Community Paediatricians	RRT		£2,500
NBT Psychology support	RRT		£5,000
Sub-total			£158,730
Local authority funding UOB office			
• Manager	MPR		£5238
• Administrative support	MPR/RRT		£20,954
Total Costs			£184,922