MK TOGETHER
Safeguarding Partnership

CHILD DEATH BOARD
ANNUAL REPORT 1 April 2023 – 31 March 2024

Executive Summary

The Milton Keynes Child Death Board is responsible for the statutory duty of the MK Together Safeguarding Partnership (MKTSP) in terms of receiving notifications of child deaths and ensuring there is a final independent, multi-agency scrutiny by senior professionals with no named responsibility for the child's care during life. The Child Death Board reviews the circumstances of each child's death in order to learn lessons, identify themes and share any findings for the prevention of future deaths.

During the 1 April 2023 - 31 March 2024 reporting period the deaths of 15 Milton Keynes children were reported to the Child Death Board.

The Milton Keynes Child Death Board met four times during the year and fully completed the reviews of 17 child deaths.

All information provided by agencies and reported to the Milton Keynes Child Death Board was recorded on the National Child Mortality Database.

Modifiable factors were identified in one of the child deaths reviewed.

None of the child deaths reviewed by the Milton Keynes Child Death Board were referred to the MKTSP Review Board for CSPR consideration.

Agencies continue to promote healthy lifestyles and give consistent safe-sleeping advice to parents.

Promoting non-smoking is a priority for agencies, including for Milton Keynes Public Health colleagues.

The Milton Keynes Child Death Board currently lacks the contribution of a Milton Keynes Designated Doctor for Child Deaths. The contribution from a locally based designated doctor has been invaluable over the years the previous individual was in that post.

During the reporting period the Luton Designated Doctor for Child Deaths attended CDB meetings and contributed to the review of Milton Keynes child deaths, which was extremely helpful.

The MK Child Death Board continues to highlight to the MKTSP the need for a locally based Milton Keynes Designated Doctor for Child Deaths.

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Background and Context

In April 2008 Local Safeguarding Children Boards (LSCBs) were given statutory responsibility to review deaths of all children (up to the age of 18 years) who had resided in their area with the final analysis of all child deaths being undertaken by Child Death Overview Panels (CDOPs). In the revised *Working Together 2018* statutory guidance LSCBs were replaced with Safeguarding Children Partnerships (SCPs) and Child Death Review Partners were identified as Local Authorities and Clinical Commissioning Groups (CCGs); later CCGs were replaced by ICBs – Integrated Care Boards. Child Death Review partners have responsibility for ensuring child death review processes are in place. Under the Milton Keynes Safeguarding Partnership arrangements, the Milton Keynes Child Death Board has responsibility for the final analysis stage of the child death review process and for producing an annual report.

This is the sixteenth annual report produced by the Safeguarding Partnership. The report covers the reporting period 1 April 2023 – 31 March 2024 and summarises the following data reported to NCMD:

i. Child death notifications **reported** during the period (15)
ii. Child deaths **reviewed** by the Milton Keynes Child Death Board (17)

The MK Child Death Board considers consolidated agency information and contributory factors and aims to identify learning arising from the child death review process that may prevent future deaths. Where appropriate and the Child Death Board considers there are actions that may either promote the future health, safety, and wellbeing of children in Milton Keynes, or prevent future child deaths, the Child Death Board makes appropriate recommendations to relevant agencies.

The Child Death Report is submitted to the MK Together Safeguarding Partnership (MKTSP) and to the Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) Quality Committee.

The Milton Keynes Child Death Board submits specified data to the National Child Mortality Database (NCMD), in line with statutory guidance.

Child Death Board Meetings

The Milton Keynes Child Death Board met four times during the reporting period to review the deaths of 17 children. Meetings were well attended by members.

Milton Keynes Child Death Board Membership:

- Public Health (Including Director of Public Health - Chair)
- Designated Doctor for Child Deaths - Luton
- Milton Keynes Children's Services
- Milton Keynes Hospital Midwifery (including Bereavement Midwife)
- Milton Keynes Hospital Safeguarding representative
- Milton Keynes Coroner's Office
- Thames Valley Police
- BLMK ICB Designated Nurses - Milton Keynes and Bedford
- MK Together Safeguarding Partnerships Officer & Child Death Review Co-ordinator

In the coming year the MK Child Death Board will endeavour to include wider agency involvement in the Child Death Board, including from senior managers at Central & North West London NHS Foundation Trust - the agency responsible for delivering community and mental health services.

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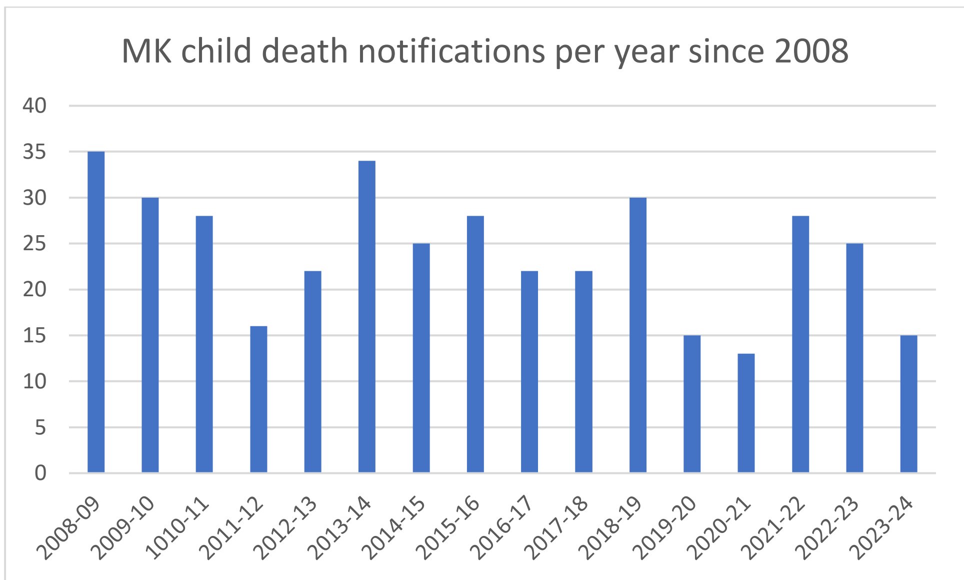
Section 1:
Child Deaths Reported Between 1 April 2023 and 31 March 2024

15 child death notifications were received by the Milton Keynes Child Death Board. This is a decrease from the child deaths recorded the previous year.

Figure 1: Child deaths reported per year from 2008 - 2009 to 2023 - 2024



Please note, percentages may add to over 100% or not quite 100% due to percentages in the following tables being rounded up or down.

<u>Age of the children at the time of death</u>

Age at death	Number/%*
0 – 28 days	7 (47%)
29 – 364 days	1 (7%)
1 – 4 years	1 (7%)
5 – 9 years	3 (20%)
10 – 14 years	2 (13%)
15 – 17 years	1 (7%)

<u>Gender</u>

Of the 15 child deaths reported in 2023 – 2024, 5 (33%) were female and 10 (66%) were male.

Ethnicity of the MK children whose deaths were reported

Ethnicity	number of deaths recorded
Asian or Asian British	5
White/White British	4
Not known	2
Black or Black British	1
White & Black Caribbean	1
White, Any Other Background	1
Other Ethnic Group	1
Total	**15**

Place of Death of the 15 Milton Keynes Children who died during the reporting period

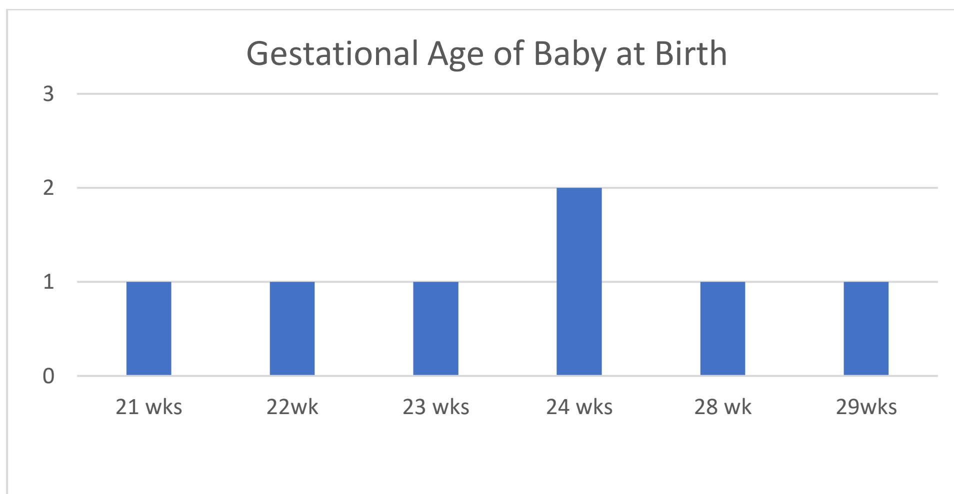
The place of death recorded for the majority of children who died in this year was at hospital (73%)

Place of death of children who died

Hospital	11
Home	2
Hospice	2
Total	**15**

Gestation of the babies who died at less than 28 days old

Of the 7 babies who died before 28 days of age the gestation is recorded:



Gestation of the baby who died between 28 and 364 days old

One baby who died between the ages of 28 and 364 days had been born at 38 weeks gestation.

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Public Health Data

Trends in infant deaths (0-364 days) from national data

The rate per 1,000 of infant deaths in Milton Keynes is similar to areas with a comparable level of deprivation and to the England average. Since 2001-2003 the infant mortality rate in MK has dropped considerably and is now in line with areas with a comparable level of deprivation on this measure.

Infant deaths, 2020-22: rate and count, benchmarked against deprivation decile

Better 95% | Similar | Worse 95% | Not compared

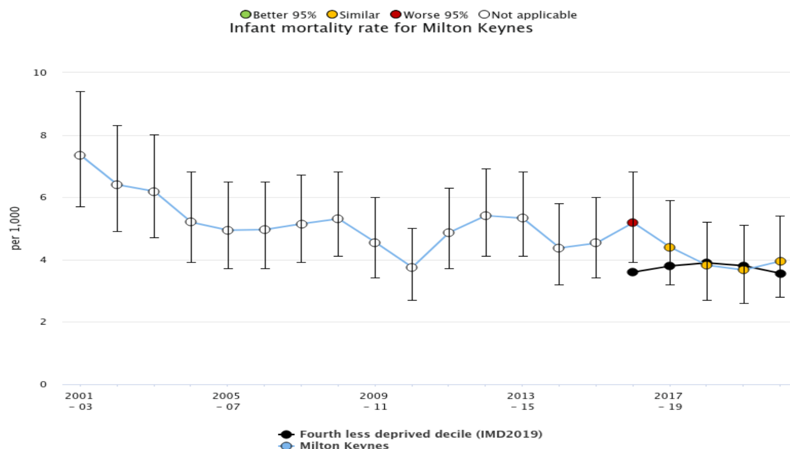
Recent trends: – Could not be calculated | No significant change | Increasing & getting worse | Increasing & getting better | Decreasing & getting worse | Decreasing & getting better

Infant mortality rate 2020 - 22 — Crude rate - per 1,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	6,918	3.9	3.8	4.0
Fourth less deprived decile (IMD2019)	–	793	3.6	3.3	3.8
Bedford	–	29	4.6	3.1	6.7
Nottinghamshire	–	106	4.6	3.7	5.5
Reading	–	28	4.5	3.0	6.5
Worcestershire	–	69	4.3	3.3	5.4
Hillingdon	–	51	4.2	3.1	5.6
Herefordshire	–	19	4.1*	2.5	6.4
Warrington	–	23	4.0	2.5	6.0
Milton Keynes	–	38	3.9	2.8	5.4
Kent	–	163	3.3	2.8	3.9
Derbyshire	–	70	3.2	2.5	4.1
Suffolk	–	66	3.2	2.5	4.1
Cheshire West and Chester	–	29	3.0	2.0	4.3
Somerset UA	–	42	2.8	2.0	3.8
Bournemouth, Christchurch and Poole	–	28	2.6	1.8	3.8
Westmorland and Furness	–	13	2.5*	1.4	4.3
Swindon	–	19	2.5*	1.5	4.0

(Source: Child and Maternal Health - Data - OHID (phe.org.uk) Indicator Id: 92196 accessed 29 July 2024)

Trend in Milton Keynes infant mortality rate from 2001-03 to 2020-22, benchmarked against deprivation decile

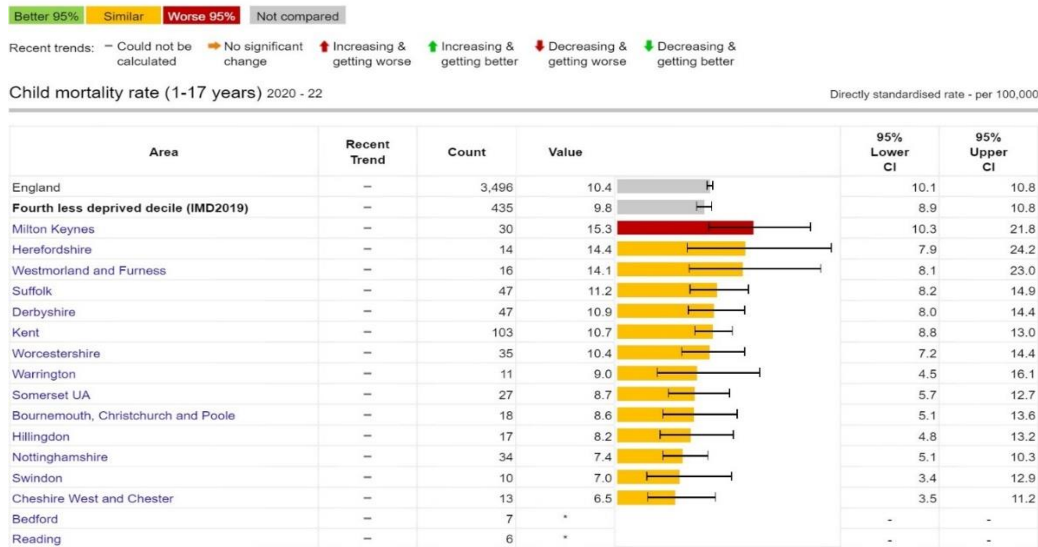


(Source: Child and Maternal Health - Data - OHID (phe.org.uk) Indicator Id: 92196 accessed 29 July 2024)

Trends in child deaths (age 1-17) in MK from national data

The rate per 1,000 of child deaths in Milton Keynes was statistically significantly higher than average for areas with a comparable level of deprivation in 2020-22. Since 2010-2012, the child mortality rate in MK has remained broadly stable in line with national trends. An increase is evident in the latest data for 2020-2022, however this is not statistically significant. We will need to monitor the trend over time to see whether this potential increase is sustained.

Child deaths, 2020-22: rate and count, benchmarked against deprivation decile



Better 95% | Similar | Worse 95% | Not compared

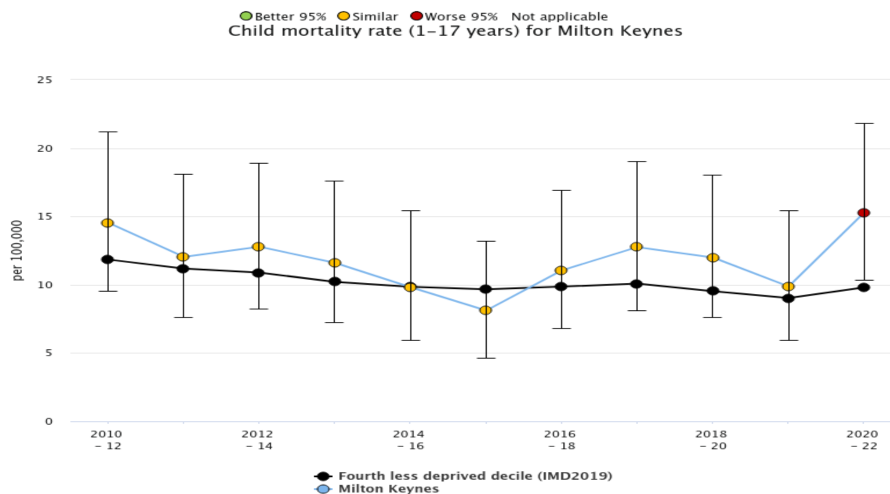
Recent trends: – Could not be calculated | No significant change | Increasing & getting worse | Increasing & getting better | Decreasing & getting worse | Decreasing & getting better

Child mortality rate (1-17 years) 2020 - 22 — Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	3,496	10.4	10.1	10.8
Fourth less deprived decile (IMD2019)	–	435	9.8	8.9	10.8
Milton Keynes	–	30	15.3	10.3	21.8
Herefordshire	–	14	14.4	7.9	24.2
Westmorland and Furness	–	16	14.1	8.1	23.0
Suffolk	–	47	11.2	8.2	14.9
Derbyshire	–	47	10.9	8.0	14.4
Kent	–	103	10.7	8.8	13.0
Worcestershire	–	35	10.4	7.2	14.4
Warrington	–	11	9.0	4.5	16.1
Somerset UA	–	27	8.7	5.7	12.7
Bournemouth, Christchurch and Poole	–	18	8.6	5.1	13.6
Hillingdon	–	17	8.2	4.8	13.2
Nottinghamshire	–	34	7.4	5.1	10.3
Swindon	–	10	7.0	3.4	12.9
Cheshire West and Chester	–	13	6.5	3.5	11.2
Bedford	–	7	*	-	-
Reading	–	6	*	-	-

(Source: Child and Maternal Health - Data - OHID (phe.org.uk) Indicator Id: 90801 accessed 29 July 2024)

Trend in Milton Keynes child mortality rate from 2010-2012 to 2020-22, benchmarked against deprivation decile



(Source: Child and Maternal Health - Data - OHID (phe.org.uk) Indicator Id: 90801 accessed 29 July 2024)

Section 2:
Child Deaths Reviewed During the Reporting Period

The child death review is the final process of review and takes place only after all other reviews or investigations have been completed. It can therefore take some time before a child's death is scheduled for final review by the MK Child Death Board.

The deaths of 17 Milton Keynes children were reviewed by the MKCDB during the reporting period.

The child death review process includes consideration of whether a review has identified one or more factors across any domain which may have contributed to the death of the child. The reviews also consider whether there are any 'modifiable factors' - any factors that might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future child deaths.

Prior to the final analysis by the Child Death Board each child death is reviewed at a Child Death Review Meeting. These meetings are attended by those professionals who had contact/involvement with the child and family during their life or were involved in investigation of their death. At the Child Death Review Meeting, having considered the agency information, professionals complete the draft analysis and submit to the MK Child Death Board.

Modifiable factors identified during reviews

Of the 17 deaths reviewed during the reporting period, the CDB recorded 'modifiable factors' in just one of the deaths.

Primary category of death recorded by MK Child Death Board for the child deaths reviewed

The MK Child Death Board is required to identify the primary category of death during the final review of each child's death. The table below provides a summary of the categories of death agreed by the MK Child Death Board.

Category	Number
Trauma	0
Acute medical or surgical condition	2 (12%)
Chromosomal, genetic and congenital anomalies	9 (53%)
Chronic medical condition	0
Deliberately inflicted injury, abuse or neglect	2 (12%)
Malignancy	1 (6%)
Perinatal/neonatal	0
Sudden Unexpected Death in Childhood	0
Suicide or deliberate self-inflicted harm	1 (6%)

Age at death

Of the 17 deaths reviewed, two children (12%) died at less than 28 days old; two children (12%) were between 28 days and one year at the time of death, two children (12%) were in the 1 – 4 years age range, five (29%) were in the 5 – 9-year age range, three (18%) were in the 10 – 14 age range and three (18%) were aged between 15 and 17 years at the time of death.

Completed Reviews by Age Group and Category of Death Recorded

Less than 28 days:
Two of the children whose deaths were reviewed during the period had died at less than 28 days of age. In both the child deaths the category of death was recorded as 'Chromosomal, genetic and congenital anomalies'.

28 – 364 days:
Two of the children had died between the ages of 28 and 364. In both the child deaths the category of death was recorded as 'Chromosomal, genetic and congenital anomalies'.

1 – 4 years:
Two children had been between 1 and 4 years of age when they died. One of the deaths was recorded under the category of 'In both the child deaths the category of death was recorded as 'Chromosomal, genetic and congenital anomalies' and one was recorded under the category of 'Malignancy'.

5 – 9 years:
Five child deaths reviewed were in this age range. Three of the child deaths were recorded as In both the child deaths the category of death was recorded as 'Chromosomal, genetic and congenital anomalies', one was recorded as 'Acute medical or surgical condition' and one was recorded as 'Infection'.

10 – 14 years:
Three child deaths reviewed were of children in this age range. One child's death was recorded as In both the child deaths the category of death was recorded as 'Chromosomal, genetic and congenital anomalies', one was recorded as 'Acute medical or surgical condition' and one was recorded as 'suicide or deliberate self-inflicted harm'.

15 – 17 years:
Three child deaths reviewed were of children in this age range. Two of the child deaths were recorded as 'deliberately inflicted injury, abuse or neglect, and one was recorded as 'trauma or other external factor'.

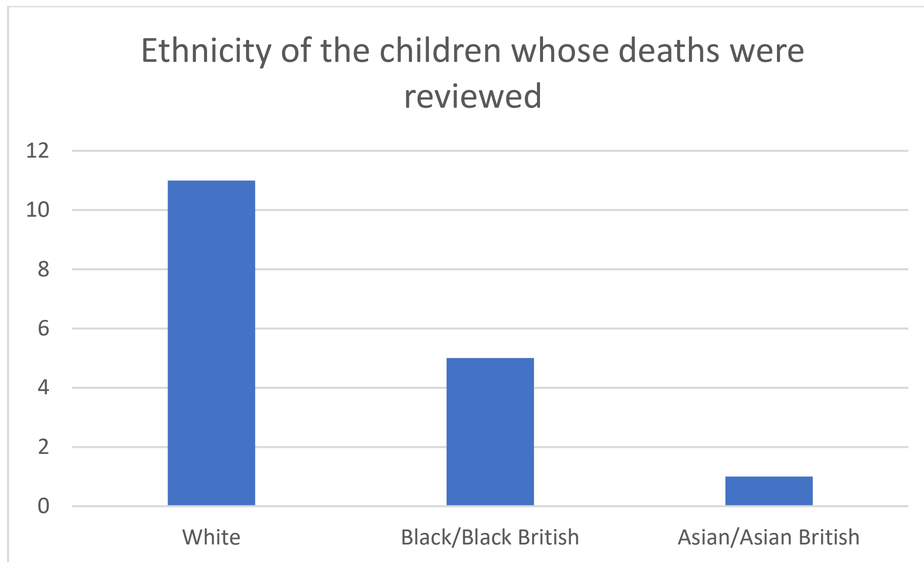
Gender

Six (35%) of the children whose deaths were reviewed were female, and eleven (65%) were male.

Ethnicity of children whose deaths were reviewed during the reporting period

Ethnicity was recorded for all the child deaths reviewed.

- 11 children whose deaths were reviewed were of White British origin.
- Five children whose deaths were reviewed were of Black/Black British origin.
- One child whose deaths was reviewed was of Asian/Asian British origin.



Child Safeguarding Practice Reviews

One of the MK child deaths reviewed during the reporting period had been the subject of Child Safeguarding Practice Reviews (CSPR). The MK Child Death Board completed the final analysis following completion of the inquest into the death and the MK CSPR. Local agencies contributed to the CSPRs and learning from the CSPR process fed into the final analysis by the Child Death Board.

Bereavement Support for Families

When a child dies families are supported by professionals and signposted to relevant sources of support, including Child Bereavement UK.

Families of babies who die at Milton Keynes Hospital are offered support by the MKUHFT Bereavement Midwife, support that is very much appreciated by families.

In other situations bereavement support is offered by the professional who is considered to have the best relationship with the family.

Key Findings During MKCDB Review of Child Deaths

- The MK Child Death Board identified modifiable factors in one of the child death reviews completed during this reporting period, which was the death that was the subject of a CSPR.
- Two child deaths were deferred to enable additional information to be gathered.

MKCDB Priority Areas for Action

The MK Child Death Board will continue to operate as a local Milton Keynes Board whilst exploring opportunities for sharing learning about child deaths across the Bedford, Luton and Milton Keynes ICB area and nationally.

MK Child Death Board will explore expanding membership to include strategic managers from community health services (CNWL).

MK Child Death Board will continue to highlight the need for a local Milton Keynes Designated Doctor for Child Deaths to contribute to discussions and the local child death review process.

MK Child Death Board will continue to have oversight and lead the review of the BLMK Joint Agency Response to an unexpected child death and explore opportunities for learning and making improvements to the process where the need is identified.

The Child Death Board will continue to work to ensure the most appropriate support is offered to bereaved families, highlighting where this support is lacking.

The MK Child Death Board will utilise the guidance produced by the National Child Mortality Database (NCMD) project on contributing factors to assist in the final analysis of child deaths.