Learning from Child Death Reviews

The Hampshire, Isle of Wight, Portsmouth & Southampton 4LSCB
CHILD DEATH OVERVIEW PANEL (CDOP): Annual Report 2017/18

Foreword

The four Local Safeguarding Children Boards (4LSCBs) in Hampshire, the Isle of Wight, Portsmouth and Southampton would like to extend condolences to all the families, carers and communities who have been affected by the pain of a child death.

Child deaths are tragic and thankfully rare, and we need to take the opportunity to learn from these tragic events. Comprehensive reviews of child deaths undertaken by the LSCBs serve a valuable public health function in providing information on child deaths that promotes action to reduce the risk of future child deaths and supports inter-agency working to safeguard children and promote their welfare.

This report covers child death reviews conducted in the 4LSCB area during 2017/18. The Hampshire LSCB leads on the collation of the 4LSCB CDOP Annual Report with all LSCBs providing their data and information in an agreed template. Over the past year the LSCBs have worked to identify areas where focused action is needed through the child death review process and developed recommendations about what can be done to help prevent future deaths. The combined report provides information for the four individual LSCBs to use to inform their own work plans. Progress against previous recommendations is also updated within the report.

Figure 1: The 4LSCB area - Hampshire, the Isle of Wight, Portsmouth and Southampton

Source: Public Health England (PHE) Local Health

Executive Summary

The death of a child is a profound, difficult, and painful experience. By highlighting learning opportunities through child death reviews undertaken by the 4Local Safeguarding Children Board (4LSCB) Child Death Overview Panels (CDOPs) across Hampshire, the Cities and the Isle of Wight, we can improve opportunities to prevent future deaths. This report covers child death reviews conducted in the 4LSCB area during 2017/18.

Key findings

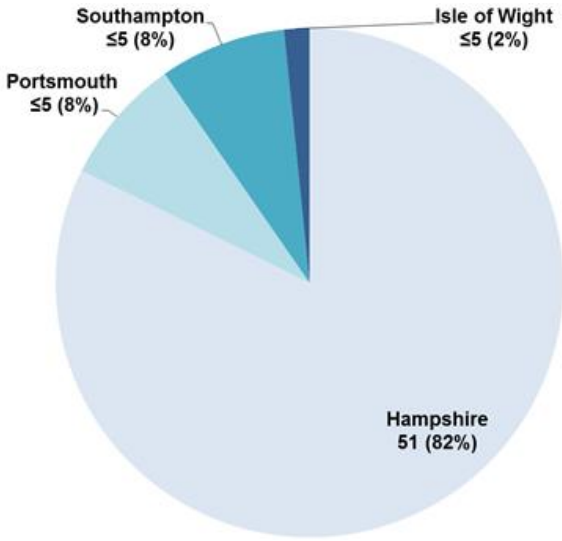
In the 4LSCB area during 2017/18, there were:

- 402,866 under 18s (0-17 year olds) estimated to be resident
- 120 child deaths registered during the year 2017/18
- 62 (52%) child death reviews completed of the deaths registered in 2017/18
- 58 (48%) ongoing CDOP reviews for deaths that occurred in 2017/18

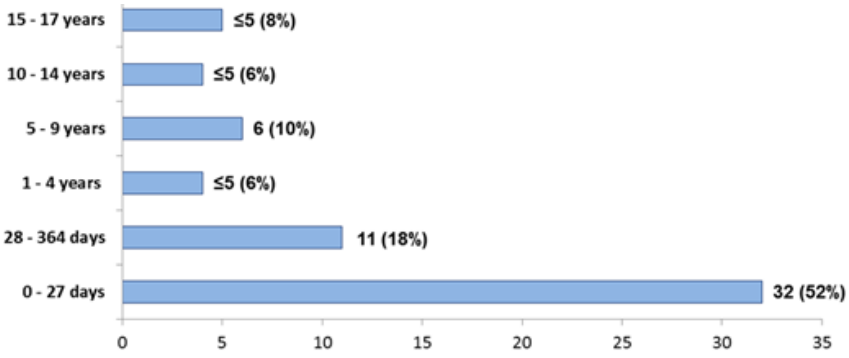
The high proportion of unreviewed deaths is due to delays in death registration and means that the report findings may be unrepresentative of the total child deaths registered during the year 2017/18.

Characteristics of child death reviews:

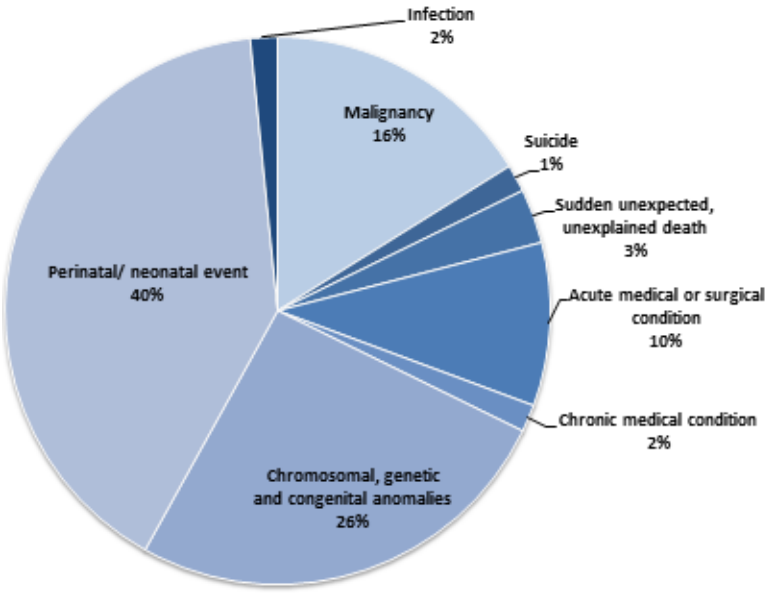
- The number and percentage of child death reviews by LSCB area is shown in the pie chart. Hampshire CDOP, supporting the most populous LSCB area, completed the most child death reviews, and accounted for 82% of the 62 child death reviews. The small numbers of child death reviews in the Isle of Wight and Cities mean that local themes could not be drawn out and thus the themes described relate to the 4LCSB area.



- Almost 70% of the child death reviews were for children in the first year of life and the number of reviews declined with increasing age as shown in the bar chart.



- Perinatal/neonatal events accounted for 40% of reviews and were the most common category of death. However, the low numbers of deaths reviewed made it difficult to identify overall trends.



- Very few modifiable factors were identified with just 15% (9 deaths) noted as having one or more modifiable factors that may have contributed to the death of the child. This is lower than last year (31%, 13 deaths of the 77 reviewed) and lower than we would expect.
- Approximately 81% of deaths were expected and 19% were unexpected deaths.

Update on the 2016/17 CDOP report recommendations:

Recommendation	***Update***
1. Maternal smoking in pregnancy and/or household smoking	*All local authorities have prioritised work to address maternal smoking and this is also upscaled through NHS Sustainability & Transformation Partnership (STP) work. Hampshire has prioritised maternal smoking through the Hampshire Smoking in Pregnancy Strategy 2017-20. Good progress has been made engaging with obstetricians. But challenges relate to influencing women to engage with the services. In Southampton and Portsmouth this is through the action plans informed by the PHE-recommended CLeaR tool.*
2. Youth suicide	*Several initiatives were progressed such as adapting the Hampshire Self Harm Pathway and using the postvention protocol, conducting the annual suicide audit and updating local suicide prevention plans.*
3. Promoting public health interventions	*The 4LSCB local authorities continue to work to address substance/alcohol misuse, smoking, domestic abuse and maternal obesity issues through ongoing public health strategy implementation and also supporting the delivery of screening and immunisation programmes.*
4. Accidents	*Collaborative working to deliver several child safety initiatives has evolved. The Hampshire Road Safety Partnership delivered several national and local road safety campaigns and activities, Southern Health Foundation Trust worked with the Child Accident Prevention Trust (CAPT) to produce a video promoting awareness about child safety on button batteries.*

Recommendations for 2018/19:

1.	Minimise deaths due to unsafe sleeping by ensuring it continues to be a high priority by working to promote safe sleeping messages and practices.
2.	Reduce the negative impact of language/communication barriers on children's health and social care by raising these issues with local care health, education and social provider agencies.
3.	Work to improve bereavement support for parents, families and communities.
4.	Continue to engage system leadership to encourage women of reproductive age to adopt healthy lifestyles, stop smoking and achieve healthy body weights before conception.
5.	Prioritise reducing the backlog and delay in child death reviews to improve opportunities to more swiftly prevent future deaths.

The Child Death Overview Panel (CDOP)

The Child Death Overview Panel (CDOP) is a sub-group of the LSCB and is responsible for reviewing all deaths of children from birth up to 18 years of age who reside in its area. CDOPs were statutorily established in April 2008 under the *Children Act (2004*). There are currently four CDOPs across the 4LSCB area – the Hampshire, Isle of Wight, Portsmouth and Southampton CDOPs.

Core Functions of the CDOP

One of the most important reasons for a CDOP to review child deaths is to identify any themes so that steps can be taken wherever possible to protect other children and prevent future deaths. There is an established process for reviewing child deaths within the individual LSCB areas.

Governance arrangements

Central Government responsibility and oversight for safeguarding children is located in the Department for Education (DfE) and locally within each respective LSCB. Statutory arrangements and governance structures will change following recommendations from the *Wood Report*[1] enacted through the *Children and Social Work Bill 2017*[2] and new *Working Together* 2018 guidance. This includes the establishment of a national-regional model for CDOPs, introducing a national child mortality database and ownership of the arrangements for supporting CDOPs, moving from the DfE to the Department of Health (DH). The expectation is that local plans will be agreed and published no later than June 2019, with an additional three months for implementation. Areas may propose and have agreed new arrangements ahead of this during a period of transition.

Within the current arrangements the CDOPs and their Chairs are accountable to the Independent Chairs of each of the LSCBs.

During April 2018, CDOP Chairs along with Board Managers from the 4LSCBs confirmed renewal of the existing memorandum of understanding (MOU) that covers production of a joint 4LSCB CDOP Annual Report by the Hampshire LSCB CDOP.

Panel membership

Panel membership is designed to ensure that there is an appropriate level of expertise and experience as well as correct agency representation. All 4 panels have seen changes in membership over the past year and whilst this is inevitable there is a need to ensure consistency in the quality assurance of the CDOPs.

<u>CDOP Chairs</u>

Hampshire – Dr Sallie Bacon, Director of Public Health, Hampshire County Council
Portsmouth - Tina Scarborough, Deputy Director of Quality and Safeguarding, NHS Portsmouth CCG
Southampton - Debbie Chase, Consultant Public Health, Southampton City Council
Isle of Wight – Dr Emma Blake, Paediatric Consultant, Isle of Wight NHS Trust

Purpose

The intention of the report is to provide an analysis of the child death reviews in order to identify areas for action. It will inform part of the 2018/19 priorities for the 4LSCB although these are already set. The report may highlight areas for a deep dive as part of local Joint Strategic Needs Assessments.

Scope

This annual report contains information on reviews of child deaths from the 4LSCB CDOPs that occurred between 2017/18. A descriptive analysis of child death reviews is presented, including a review of modifiable/non-modifiable factors and correlations. Information on pre-24 gestational week and neonatal deaths, safe sleeping, abusive head trauma, language barriers including communication issues and life limiting conditions, are also highlighted as these were areas of focus drawn from CDOPs across the 4LSCB area. Reporting is on an aggregated level with small number suppression to ensure that individual children and their families are not identifiable from the information published. An overall 4LSCB analysis followed by individual LSCB analyses is provided. The report concludes with an aggregated summary of lessons learned and resulting recommended priorities for 2018/19. Reflections on current national drivers/reports are provided in the appendix. A detailed update on the recommendations from the 2016/17 CDOP Annual Report is also appended.

Limitations

Considerable improvements have been made during the year in the quality of information submitted to CDOPs. However, there are still limitations to our analysis. In some cases, we have incomplete and inconsistent information. This is due to a variety of reasons: there may be difficulties and delays in sharing child death information between agencies, differences in classification of deaths between CDOPs and variation in death certification. This means that there remain gaps in our knowledge leading to incomplete learning. There are some data quality concerns - the poor quality of some forms with a paucity of information about ‘fathers’ in regard to their health and social factors, maternal smoking status, Maternal BMI and local area deprivation, means that the analysis of child deaths can be delayed, incomplete and inconsistent. Delays in reviewing a death can be due to several factors, including the time required for final reporting of a specialist post mortem, Police investigation and the time it takes to obtain complete information from all involved agencies.

There will always be a discrepancy in the number of children dying (registered deaths) and number being reviewed (CDR) in year i.e. if a child dies in one financial year their case may not be reviewed in the same year. This is because of there will always be some time between a death and that death being reviewed, and thus figures on registered child deaths and child death reviews are not comparable. Also, death-year and death-registration-year may differ, so whilst the dataset largely includes deaths that occurred within this time period, registration-delay means that

some deaths occurred months or even years earlier but were only registered during this time period.

Fortunately the number of child deaths is relatively small which means that there is random variation in the number of deaths due to the inevitable variability of natural events. This can make it difficult to make valid comparisons and interpretations of trends between years.

In addition, the information in the report is unavoidably heavily weighted towards Hampshire, as it has a significantly larger child population than the Isle of Wight, Portsmouth or Southampton and so has the largest number of child death reviews within the 4LSCB population. The small numbers of child death reviews in the Isle of Wight, Portsmouth and Southampton CDOPs mean that local themes could not be drawn out and so these are collective themes across Hampshire, the Cities and the Isle of Wight.

Child death reviews

This section presents an overall summary of child deaths and reviews in Hampshire, the Isle of Wight, Portsmouth and Southampton during 2017/18. Collating data at a 4LSCB CDOP level (child population aged 0-17 years - 402,866) allows us to identify themes and trends associated with child deaths that may help us prevent future child deaths. Currently all LSCBs are required to submit an annual return to the DfE for the annual Statistical First Release (SFR). Whilst the analysis provides a useful overview of child death reviews it does not allow learning to be identified, nor actions to prevent future child deaths and the evaluation of such actions because it is a descriptive summary.

This section contains information on child death reviews completed during 2017/18 within the 4LSCB area. The CDOPs would also have reviewed deaths that occurred prior to 2017/18, but the data within this report only relate to registered deaths of children aged 0 to 17 who were resident in the 4LSCB area and died during the year 2017/18 to allow for a more contemporaneous review of child deaths[1]. Thus in 2017/18 there were 120 registered child deaths, but the total number reviewed by CDOPs was 62 - Hampshire (51), Isle of Wight (≤5), Portsmouth (≤5) and Southampton (≤5). There are 58 ongoing CDOP reviews for deaths that occurred between 01 April 2017 to 31 March 2018 - Hampshire (41), Isle of Wight (≤5), Portsmouth (≤5) and Southampton (9). This indicates that just over half (52%) of the registered child deaths were reviewed in year, with Hampshire reviewing 55% of the deaths registered in 2017/18. We are mindful of the inevitable lengthy backlogs due to delayed registration of deaths occurring prior to 2017/18 and are actively working to identify opportunities to review these deaths more swiftly. Various factors contribute to this time-lag, such as deaths due to external causes subject to a coroner's inquest verdict and an increase in the number of child deaths requiring a specialist post mortem with forensic toxicology testing which itself is a lengthy process.

Number of child deaths reviewed in 2017/18

Table 1 presents information on child deaths that the CDOPs have reviewed on behalf of the 4LSCB partnership in 2017/18. The Hampshire CDOP completed the largest number of child death reviews accounting for 82% of the 62 child death reviews, with the Isle of Wight CDOP completing the lowest. This is a reflection of the size of the LSCB populations, with Hampshire being the most populous LSCB and the Isle of Wight the least populous.

[1] However, not all these child deaths will have their child death review completed by 31 March 2018 due to the time needed to gather sufficient information to fully review a child's death.

Table 1: Child death reviews completed by the 4 LSCBs' CDOPs, 2017/18

LSCB area of residence	Population aged 0-17*	Number of child death reviews	Percentage of total child death reviews**	Number of child deaths
Hampshire	283,314	51	82%	92
Isle of Wight	25,055	≤5	8%	≤5
Portsmouth	44,192	≤5	8%	10
Southampton	50,305	≤5	≤5%	14
Total	402,866	62		120

Source: 4LSCB; *ONS 2017 Mid-year population estimates; **Figures may not add up due to rounding

Yearly number of child deaths reviewed

Over the past decade, there have been fluctuations in the absolute number of child death reviews every year (see table 2). A total of 938 child death reviews have been completed since the establishment of the 4LSCB CDOP in 2008/09. Changes in the numbers of child death reviews maybe due to statistical chance, especially in the Unitary Authorities where numbers of child deaths are small. Delays in the registration of deaths due to the fact of death being coupled with the registration of cause of death also impacts on annual figures of death reviews. Importantly, child mortality rates are not completely straightforward and can also vary by region and fluctuate over time.

Figures for 2017/18, presenting data only on child deaths that occurred in 2017/18, show fewer reviews reflected in the analysis than was the case in 2016/17. This is despite a greater number of deaths – 120 in 2017/18 as opposed to 101 in 2016/17. The apparent decrease in reviews does not reflect a lower mortality rate, rather that we did not get round to reviewing all the child deaths in the year they died. We need to review all these deaths and will report on the outstanding 58 child death reviews from 2017/18 separately as an addendum to next year's report.

Whilst the number of reviews in any year does not reflect the number of deaths in that year, they do provide trends in child death review statistics.

Table 2: Yearly number of child death reviews by LSCB area, 2008/09 - 2017/18

LSCB area of residence	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17*	2017/18
Hampshire	66	66	67	70	62	64	56	76	55	51
Isle of Wight	10	7	≤5	≤5	≤5	7	6	8	≤5	≤5
Portsmouth	10	13	15	≤5	13	6	11	9	≤5	≤5
Southampton	22	20	25	16	14	12	12	24	23	≤5
Total reviewed	108	106	109	92	94	89	85	117	77	62

Source: 4LSCB

For reasons of confidentiality figures ≤ 5 are suppressed; *Not comparable with previous years

Characteristics of child death reviews

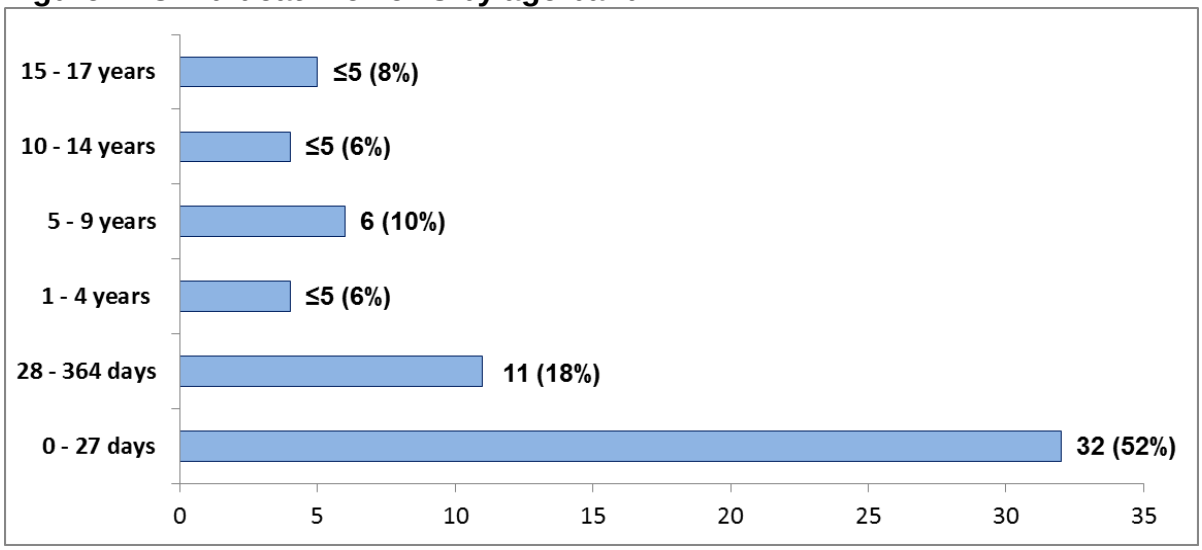
Gender

Two thirds of the 62 deaths reviewed were among boys (60%, 37) with 25 deaths in girls. Within the 9 deaths where we identified modifiable factors, they were more likely to be identified in reviews of boys' deaths (67%) than in girls' deaths (33%). However, this distribution is unlikely to be representative of the total number of deaths registered in 2017/18 as only 52% were reviewed.

Age

After the first year of life, children are most likely to die during adolescence. Almost 70% of the reviews completed by the 4LSCB CDOPs were of children who died under the age of one; with 52% for children aged 0-27 days; and a further 18% for children aged between 28 and 364 days at the time of death. These findings are shown in the chart below (figure 2) and show most child deaths reviewed occurring in the first year of life and declining with increasing age. Due to the proportion of unreviewed deaths we do not yet have a true picture of the age distribution of deaths. Once we have completed the outstanding reviews we will be able to determine the actual extent of adolescent deaths. Child death reviews among the neonatal age group had the highest proportion of modifiable factors.

Figure 2: Child death reviews by age band



Source: 4LSCB

Neonatal deaths with modifiable factors

There were 32 neonatal deaths (babies who died within 28 days of birth) out of the 62 deaths reviewed across the 4LSCB area. Prematurity is a principle cause of death among these deaths. Modifiable factors were identified in 22% (7 child death reviews) of these deaths. The range of modifiable factors identified was wide and included maternal smoking and/or household smoking, maternal obesity, maternal infections such as genital herpes, maternal mental ill health and pregnant women/vulnerable families with complex social factors/with chaotic lifestyles.

Ethnicity

Out of a total of 62 reviews completed, ethnicity of the child was recorded in 70 (95%) of the reviews. Reviews of deaths of children from a White background accounted for 81% of the reviews where the child's ethnicity was recorded. This reflects the 4LSCB child population as a whole, where 89% of children are from a White background and 11% are non-White.

Asylum seeking status

The DfE collects information on reviews of deaths of asylum seeking children but there were no children in this group from the reviews undertaken in the 4LSCB area.

Child protection

Across the 4LSCB area negligible numbers of children whose death was reviewed during the year were the subject of a child protection plan at the time of their death, with the caveat that the large proportion of unreviewed deaths, may limit this finding. However, this should reflect the agreement that SCRs should not delay CDOP reviews. But, if there are other parallel proceedings or inquests then that will delay both reviews.

Statutory order status

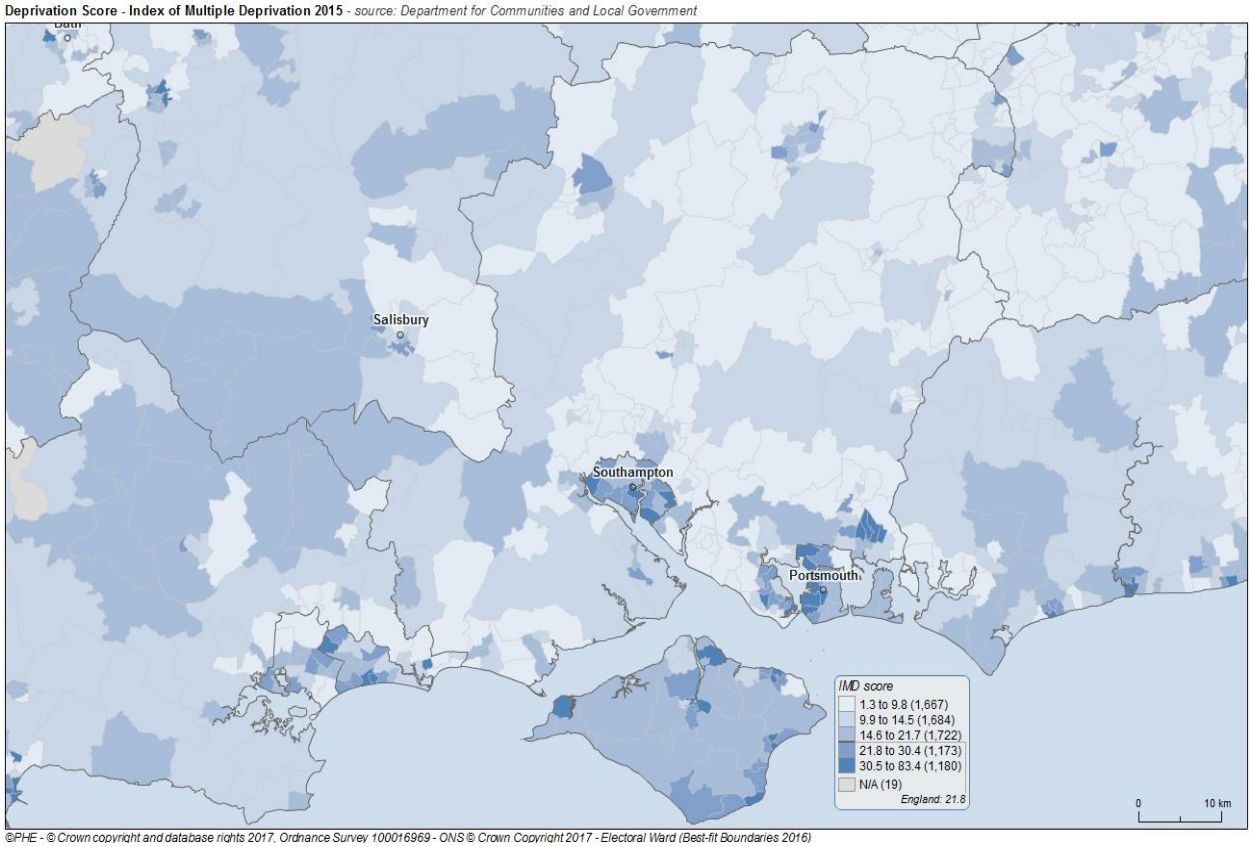
None of the children whose deaths were reviewed were subject to a statutory order[2] at the time of their death, although this may not reflect the unreviewed deaths.

Deprivation

Reviews of deaths indicated a paucity of information on whether children/families lived in areas of socio- economic deprivation. Some of the paucity of information may be due to small numbers, but higher levels of child deaths are known to occur among vulnerable groups as highlighted by Sir Michael Marmot in *Fair Society, Healthy Lives*[3,] thus emphasising the need to examine this data across the 4LSCB population. Figure 3 suggests that overall the 4LSCB area has lower levels of deprivation compared to national levels. However, this masks localised social deprivation that exists within all the four local authorities which is where we would expect to see the greatest health inequalities, the poorest health outcomes and higher numbers of child deaths.

[2] Subject to any pre-court disposals, Referral Orders, Youth Rehabilitation Orders, and Detention and Training Orders

Figure 3: Deprivation in the 4LSCB area



Source: Public Health England (PHE) Local Health

Categorisation of deaths

Table 3 below shows the CDOP categorisation of all 62 deaths that were reviewed in 2017/18. A nationally standardised approach is taken when more than one category is relevant to a death it is categorised using the highest value, where one is high and 10 is low.

Table 3: Categorisation of child death reviews 2017/18

	Category	Cases	Modifiable factors
1	Deliberately inflicted injury, abuse or neglect	0	
2	Suicide or deliberate self-inflicted harm	≤5	
3	Trauma or other external factors	0	
4	Malignancy	10	
5	Acute medical or surgical condition[3]	6	
6	Chronic medical condition	≤5	
7	Chromosomal, genetic and congenital anomalies	16	
8	Perinatal/ neonatal event	25	8
9	Infection	≤5	≤5
10	Sudden unexpected, unexplained death	≤5	
	Unknown		
	Total	62	9

[3] The "Medical" category includes perinatal/neonatal event; chromosomal, genetic and congenital abnormalities; infection; malignancy; acute medical or surgical condition; and chronic medical condition

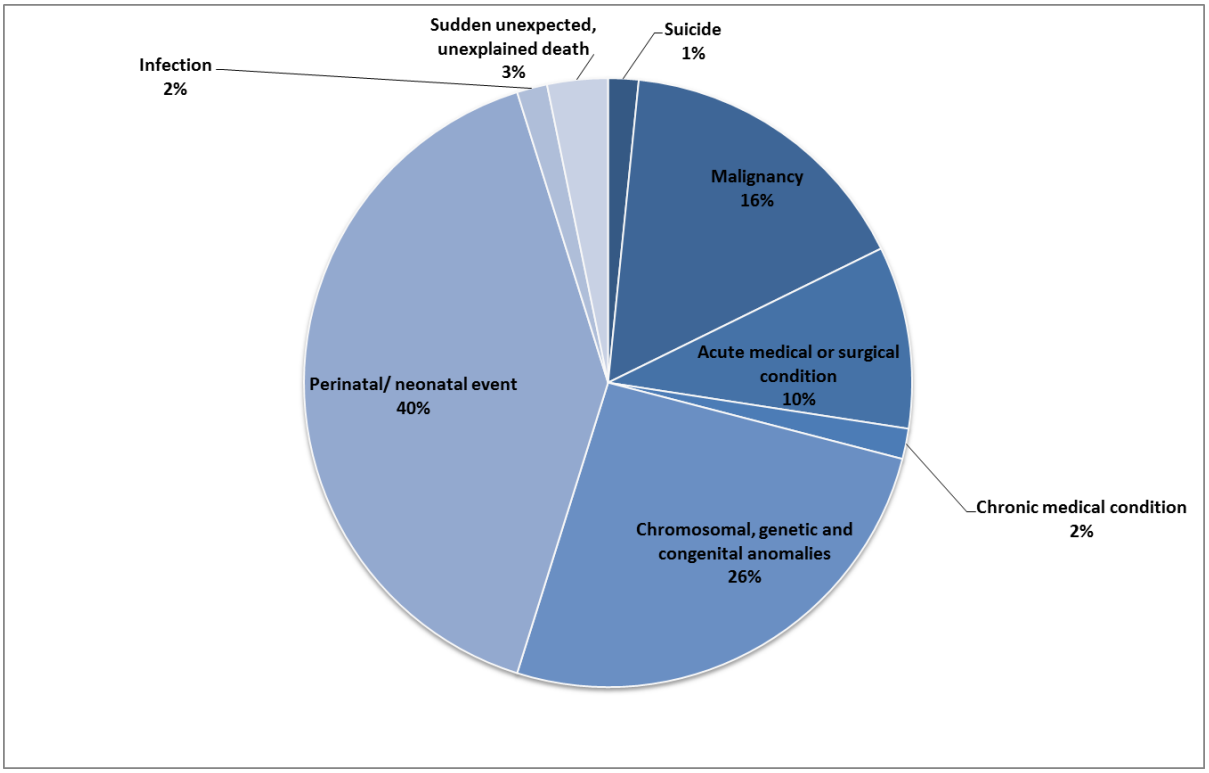
Source: 4LSCB; ~For reasons of confidentiality figures ≤ 5 are suppressed

Perinatal/neonatal events at 40% were the most common contributory factor (see figure 4). The great majority of neonatal deaths are due to perinatal causes, particularly preterm birth, and are strongly related to maternal health, as well as congenital malformations. It is important to highlight that apart from medical factors, there are a wide range of factors that may have contributed to some of the premature deaths. Domestic violence, antenatal care not being taken up, nutrition, smoking, alcohol and/or drug misuse in pregnancy and deprivation are all identified significant factors. At 26%, chromosomal, genetic and congenital anomalies were the second most common contributory factor of the child deaths reviewed.

Cancer was the third most common contributory factor among child deaths reviewed in 2017/18. Death by suicide accounted for fewer than five child deaths and these data are linked with the annual suicide audit which produces an in-depth analysis of all deaths from suicide including reviews from coroners' reports to inform suicide prevention plans.

Due to the number of deaths reviewed and the wide variety of contributory factors it is difficult to identify trends.

Figure 4: Categorisation of child death reviews 2017/18



**** The "Medical" category includes perinatal/neonatal event; chromosomal, genetic and congenital abnormalities; infection; malignancy; acute medical or surgical condition; and chronic medical condition***

Source: 4LSCB

Modifiable factors

In reviewing deaths, CDOP members consider whether there were any contributory factors known to be associated with increased risk which could be modified to reduce the risk of future deaths. This does not mean that removing these factors would have prevented the death.

There were very few modifiable factors identified in the child deaths reviewed. Of the 62 deaths reviewed across the 4LSCB area, 9 (15%) were noted as having one or more modifiable factors that may have contributed to the death of the child. The modifiable factors identified in these deaths are listed below:

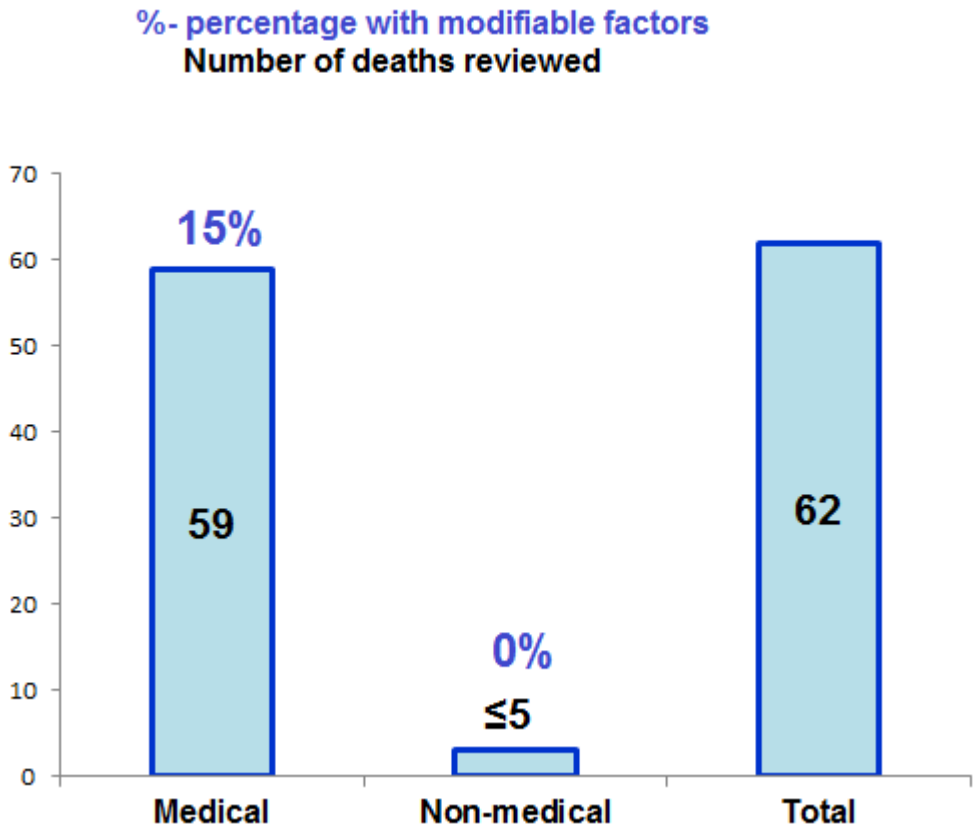
Figure 5: List of modifiable factors identified in child deaths reviewed

- driving under the influence of alcohol
- domestic abuse
- alcohol/substance misuse
- maternal smoking as well as smoking in the household
- maternal obesity
- maternal genital infections,- (herpes simplex in particular)
- screening of potential surrogates i.e. when a woman carries a child for someone who is unable to conceive or carry a child for themselves
- chaotic parenting
- parental mental health concerns
- seatbelt and road safety issues, young drivers and road safety
- sub-optimally managed long term health conditions
- having robust processes for clinical recognition of an unwell baby
- getting school nurses involved with home educated children, specifically those with chronic illnesses
- co-sleeping
- abusive head trauma and
- adverse childhood experiences (ACEs)

Essentially this list reflects a snapshot of modifiable factors identified and cannot be interpreted as indicating emerging themes or trends. Figure 6 shows the numbers of reviews by category of death together with the proportion of that category which had modifiable factors. The majority of the 62 deaths reviewed (95%, 59) can be classified as being in the medical[4] category. Whilst death reviews with a medical label accounted for the largest category, they had a low percentage of modifiable factors at just 15%. There were relatively very few non-medical deaths and none of them had modifiable factors.

[4] The "Medical" category includes perinatal/neonatal event; chromosomal, genetic and congenital abnormalities; infection; malignancy; acute medical or surgical condition; and chronic medical condition

Figure 6: Categorisation of child death reviews and percentage with modifiable factors, 2017/18



Source: 4LSCB

Expected and unexpected deaths

Unexpected deaths

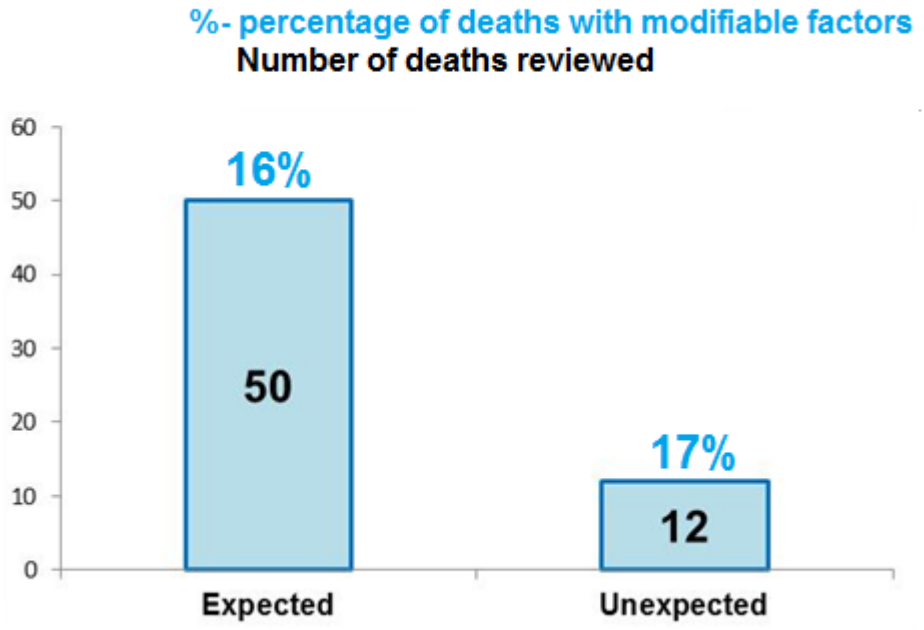
An unexpected death has been defined in *Working Together 2015* as 'the death of an infant or child that was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death'. The guidance emphasises the need to respond rapidly when a child dies unexpectedly. Services within the 4LSCBs have well established locally agreed 'Rapid Response' procedures for responding to unexpected deaths of children.

Expected deaths

Together for Short Lives, 2012[4] defines an expected death as 'the natural and inevitable end to an irreversible terminal illness. Death is recognised as an expected outcome'. Where death is expected, the rapid response does not take place.

Approximately 81% (50 deaths) of the 62 child deaths reviewed in 2017/8 were expected and 19% (12 deaths) were unexpected deaths. Further analysis indicates that modifiable factors were identified in 16% of the 50 expected deaths. Within the 12 unexpected deaths 17% had modifiable factors (see figure 7).

Figure 7: Expected and Unexpected deaths and percentage with modifiable factors, 2017/18



Source: 4LSCB

Individual CDOP summaries

1. Hampshire

Analysis of the death reviews – During 2017/18 a total of 51 child death reviews were undertaken in Hampshire out of the 92 deaths that the CDOP were notified of 2017/18 indicating that we have a significant number of outstanding reviews. There are still 41 ongoing CDOP reviews on deaths some of which occurred in the preceding financial years. This has made it difficult at the time of writing this report to identify themes or trends from the deaths reviewed this year.

Quality assurance was undertaken to assess completeness of the data on child death notifications to CDOP in 2017/18. Checks on the number of child deaths were compared with ONS-based statistics in the Hampshire Public Health Mortality File[5] (PHMF). Whilst the PHMF is a robust data source, it should be noted that this is not a complete 2017/18 dataset as there is a lag in the mortality file data extracts supplied directly by ONS with final validated annual data only published in August each year. The PHMF data indicate that there was a total of **86** deaths registered between 01 April 2017 and 19 March 2018 which is lower than the **92** deaths of which the CDOP was notified. This discrepancy may be due to the under-ascertainment of pregnancy loss before 24 weeks gestation following the lack of provision to allow registration of these deaths, death registration delays, due in particular to deaths from external causes.

There were very few modifiable factors identified. Of the 51 deaths reviewed by the Hampshire CDOP, 7 (14%) were identified as having modifiable factors referred to earlier. This year there was a greater preponderance of child death reviews among boys (63%) compared to girls (37%). Over two thirds (67%) of reviews completed were of children who died under the age of one; with 53% for neonates; and a further 14% for children aged between 28 and 364 days at the time of death. The majority were of White ethnicity (86%) with some mixed, Asian and Black ethnic backgrounds. None of the Hampshire reviews identified children as being subject to Statutory Orders or subject to child protection plans at the time of the child's death. The child death reviews suggested that none of the children had an asylum-seeking background.

We have reviewed fewer deaths due to suicide among older adolescents has fallen.

Whilst abusive head trauma continued to be a significant factor, not all cases result in death and so the full extent of this issue will not be shown in this report. In response to the identification of this theme in 2016/17 a programme of work to tackle the problem has been developed. The Hampshire Safeguarding Children Board (HSCB) collaborating with national experts and parents has developed ICON[6], a

[5] The Primary Care Mortality Database (PCMD) holds data on deaths supplied directly by ONS and is managed by NHS Digital. The Public Health Mortality File (PHMF) is an extract derived from the PCMD and for use by Public Health analysts in Local Authorities.

[6] ICON stands for: 'I' Infant crying is normal, 'C' Comfort methods can sometimes soothe the baby, 'O' It's OK to walk away if you have checked the baby is safe and the crying is getting to you, 'N' Never ever shake or hurt a baby

programme of intervention aimed at educating parents about how to cope with a crying baby and handle a baby safely which will be launched in September 2018.

Learning, issues and actions arising from these reviews:.

Challenges are being faced around effective dissemination of the messages CDOP identify. The CDOP has reviewed mechanisms to inform actions about the engagement and leadership of the local NHS to prevent future deaths. For example, being clearer in the quarterly reports that go to the Board and then the health subgroup about what the learning area is, what the action is and who has been charged with it.

The panel identified several issues that need to be considered by the health subgroup of the Board:

- Acute management of older adolescent children in hospitals, specifically encounters between acute paediatric involvement and adult ICU involvement. The panel noted cases where the hospital management of older adolescents needed improvements in early paediatric involvement. Health professionals tend to see adolescents as adults and fail to ensure a shared approach to their healthcare between paediatric and adult teams. The health subgroup needs to review arrangements for close co-ordination between acute paediatric and adult services within the local NHS to deliver good care and more joined-up services.
- We identified surrogate health, including mental health needs, and the lack of surrogacy laws and guidelines, during a panel meeting. Since then national guidance[5,6] has been published and healthcare professionals, commissioning parents and hospital's risk management and legal teams need to be informed and prepared in managing surrogate pregnancies. The health subgroup should take a key role in promoting good professional practice on surrogate health within organisations by working with designated professionals in the local NHS.
- A key finding of the panel was the lack of appropriate support for parents following deaths of older adolescent children. Contending with unexpected support meant for the loss of a younger child was an insensitive experience. A desk review suggests that relatively little attention has been paid to this issue, with agencies often tending to treat children and young people as a homogeneous group. We are not aware of any guidelines or best practice following deaths of older children and need to consider this as a system. More work is needed by the health subgroup to map out what local bereavement support there is following the death of an adolescent and ensuring that professionals who liaise with families in the aftermath of a child death know where to signpost to their support.
- Difficulties children with communication and/or speech problems face. We identified some cases where parents had not adequately understood advice when managing children with communication problems. Health professionals need to be mindful of this and ensure that there is a better understanding of their

needs. This has been raised with the health subgroup and service improvement discussions have been held on the possible use of a specialist resource to enable better understanding of their needs. Specific actions need to be raised with the local NHS to ensure delivery of good care for children/parents affected.

- Mothers who disengage with the midwifery service. The impact of disengaging with health services is important. Health professionals need to better understand the risks and the health subgroup needs to ensure that all agencies enhance their engagement with mothers who fail to engage with health services. The midwife on the CDOP is reviewing processes and levels of midwifery engagement, including tenacity and proactiveness around challenging non-engagement and will take this forward with colleagues. .

Key issues that need multi-agency actions by the Board sub-groups:

- Liaise with the Learning Disabilities Mortality Review (LeDeR) programme reviewer to gain expertise about deaths of children with learning disabilities. The CDOP and Board sub-groups need to continue to work with the LeDeR programme and ensure that processes are better coordinated such as ensuring that deaths get referred to the LeDeR programme reviewer. The CDOP and Board/sub-groups need to collaborate with the NHS England Wessex Steering Group/ Hampshire Reviewer Support Group to ensure that information exchange is enabled and that there are robust processes for learning and oversight of recommendations.
- Risks of co-sleeping, safe sleeping practices. Co-sleeping and compliance with safe sleeping practices continue to come to light through case reviews following sudden infant death syndrome (SIDS) and other sudden unexpected deaths in infancy (SUDI). These issues have been highlighted to the HSCB and were recommended as an area of focus for 2018/19. The need for improvement in agencies' delivery, recording and coordination of advice about safe sleeping practices and improved public and professional awareness about safe sleeping continues to be an ongoing issue. The CDOP needs to consider re-promotion of safe sleeping messages. Whilst this work has already started with the e-learning initiative, it could be delivered through another campaign. The Health subgroup may want to consider regular auditing the consistency in messaging and delivery and recording of safe sleeping advice by Health Visiting, to check effectiveness of processes.
- Bereavement support concerns. Bereavement support and the issue of post-birth communications as well as availability of resources to schools and colleges to assist them in dealing with the death of a child have been discussed at the CDOP. Whilst a leaflet is available on the HSCB website for both Early Years Providers and Schools providing information on how and where they can access support following the death of a child,, it is not clear how well this support is offered to families and educational communities. The Board sub-groups need to promote and ensure bereavement support and services locally. It should seek

evidence that there are bereavement pathways and that they direct families/educational communities early in the bereavement process to appropriate national/local charities offering bereavement support services and resources. We know that for expected child deaths care pathways include bereavement support, often provided by a hospice, for example Naomi House and that hospitals do have some in-house bereavement support although this may vary. As part of the Rapid Response process for unexpected deaths a conversation takes place between professionals as to who will be providing what supports to the family, with the GP often signposting the family to bereavement charities.

Pre-24 gestational week neonatal deaths

Most child deaths are in babies in the neonatal period, of which pre-24 gestation week neonates form a significant proportion. The 'pre-24 week panel' is in its second year of running. During 2017/18, the panel reviewed 18 pre-24 week gestational week neonatal deaths in one dedicated meeting.

Extreme prematurity, ventriculomegaly (enlargement of the ventricles of the brain) and oligohydramnios [too little fluid (amniotic) that surrounds the unborn baby] were some of the most common causes of death in these neonatal deaths. Multiple births especially following assisted fertility treatments such as in vitro fertilisation (IVF), maternal complications [antepartum haemorrhage (genital bleeding prior to the birth of the baby), cervical incompetence (inability of the cervix to retain a pregnancy), joint hypermobility syndrome (loose or unstable joints), were risk factors associated with some of these deaths. Some of the common modifiable factors identified in these reviews were maternal smoking, maternal obesity, mental health issues and complex social factors. It was noted that the information in the forms was heavily weighted on medical factors with a paucity of information about social factors, hampering a complete review of these cases. The information needs to be proportionate and the panel discussed further work to investigate accessing information from the Perinatal Mortality Surveillance Reporting system via the MBRRACE-UK.

The CDOP process

The Hampshire CDOP has prioritised improving quality and completeness of the information received from agencies. This has had a positive impact on the review of cases and is expected to continue to improve further during 2017/18. Notifications of death have been made in a timelier manner however there remains challenges with the notification of deaths of babies born pre-24 week gestation.

The completion of CDOP forms by practitioners continues to be an area of ongoing work as issues have been identified with obtaining requested information. We need

the board members to continue to raise this with health colleagues. The amended specific agency 'Form B' is being reviewed.

We continue to see the growing use of the access CDOP database developed in house. The database has made data collection much easier and data can be extracted to look at trends and themes. Additional data points such as the age of Mother, Father and any Siblings were added to the database.

Membership update – There have been a few changes in the neonatologist input of the pre-24 week meetings, midwifery representation and appointment of a CDOP vice chair. Hampshire's CDOP continues to be supported by both the Learning Reviews and Stakeholder Engagement Co-ordinator and Administrator.

Backlog of cases – 2017/2018 saw an overall increase in the number of unexpected child deaths. In most of these cases a post mortem was required and in some an inquest was scheduled. Due to the timescales for these processes being undertaken it was not possible to review all cases within the year. Deaths that occurred during quarter four of 2017/18 are also included in the backlog of cases due to the time it takes between notification of death and receiving all the Form Bs to collate information for the panel meeting. The time frame within which the deaths were reviewed is tabulated below and shows that most child deaths were reviewed within six months.

Time taken to review cases	Percentage of cases reviewed in timescale
0-3 months	39%
3-6 months	29%
6-9 months	21%
9-12 months	10%

Number of times CDOP has met to review cases – The Hampshire CDOP met six times over the year to review the 51 child deaths. There was a pre-24 week meeting to review the 18 pre-24 week viable cases in Hampshire.

2. Isle of Wight

Analysis of the death reviews - Fewer than five child deaths were reviewed by the Isle of Wight CDOP in 2017/18. Some of the unreviewed cases were due to awaiting inquest outcomes prior to completing the CDOP process, death occurring at the end of the year and seeking further detail in the information from an agency in order to complete the panel review of the case.

There were no modifiable factors identified, but there were two systems based actions:

- Review communications systems to ensure that schools and Isle of Wight Council (IWC) Personnel are notified as soon as possible after the death of a school aged child and can make appropriate arrangements to support all in the

community. This has been reviewed and effective systems put in place to ensure swift information sharing in the event of a child death.

- Remind agencies that if they tick yes on the form B, they must then provide detail in their explanation to assist the panel. Information on Form B's is checked and returned to agencies for further explanation if needed prior to panel meetings.

Fewer than five cases were neonatal deaths, among which SIRI reports were awaited. Also, for some a re-review and further discussion will occur where death was at a mainland hospital and contingent on completion of a SIRI report by the Trust.

Learning, issues and actions arising from these reviews:

- Pause service needed to coordinate support for women with repeated pregnancies and their children are taken into care.
- Concerns about alcohol in the family and the need for early information sharing so that cessation /support work can begin.
- Need to improve access to effective smoking cessation advice via midwives (specialist midwife role no longer in place)
- Length of time between child death and inquest was unusually long in onecase (3 years) and this needs discussing with Coroners since it is distressing for the family and difficult to complete a CDOP review effectively. The most recent child death in 2017 has not yet been to inquest since the Coroner was awaiting a review report.
- One case had a range of localised and specific SIRI findings that are being monitored and reviewed via CDOP group. NHS Trust presented update information on the recommendations for their SIRI report and the CDOP panel were satisfied that appropriate action had been taken to improve practice.

Membership update - . The Director for Public health on the IOW was chair of the CDOP. He was seconded into another role and has subsequently left. It was not possible to secure another Public health chair and so a new chair was elected who is the designated Dr on the IOW. Membership of the group continues to include Public Health but we are currently awaiting the arrival of a Public Health consultant onto the IOW membership.

Backlog of cases - The cases being reviewed included ongoing reviews for child deaths that occurred in 2014 where we were awaiting Coroner inquest outcomes before cases came to panel..

Number of times CDOP has met to review cases - The IOW CDOP met four times in 2017/18.

3. Portsmouth

Analysis of the death reviews - The Portsmouth CDOP received 10 child death notifications during this reporting period of which fewer than five were reviewed. The reviews of the remaining cases were delayed due to post mortem results and single agency reviews being finalised and these deaths will be reviewed when all relevant information is available. A total of 13 cases were reviewed by the panel over the last financial year but some of these deaths occurred in the preceding financial year. No themes or trends were identified from the deaths reviewed this year.

All cases (both expected and unexpected) discussed at panel were due to medical causes, perinatal/neonatal events or known life limiting conditions. Boys' deaths accounted for a greater preponderance and all cases involved children from mixed ethnicity. None of the deaths reviewed had a Statutory Order in place at the time of the child's death or were subject to a child protection plan. None of the deaths included child asylum seekers and none of the children whose deaths were reviewed were within the 10% most deprived areas of England. All of the child deaths occurred in an acute hospital setting and the reviews were completed in less than six months since the child's death.

Learning, issues and actions arising from these reviews:

- Last year the panel identified a requirement to provide refresher training on the Rapid Response process within Portsmouth. This was investigated by the panel and Hampshire Constabulary has recently trained emergency department staff at Queen Alexandra Hospital on the process. The aim is to roll this out further to partner agencies later in the year.
- The panel previously identified the inconsistent quality of the returned 'Form B' from agencies. To ascertain the picture an audit took place during summer 2017 and the findings showed the forms audited contained a better than expected return rate. It was noted that some agencies have a tendency to attach documentation rather than input directly into the form. It would be preferable if all information is returned via one medium and this is being addressed accordingly by the panel.
- Bereavement training for professionals supporting a family or sibling affected by the death of a child was considered by the Portsmouth CDOP to gain assurance that this was consistent and appropriate. Each panel member investigated the support provided to staff within their own agencies and the returned information was reviewed by the panel and it was deemed robust. Solent NHS also ran workshops for child practitioners to understand the impact of loss when experienced by children and young people and their families.
- It was identified this year that it would be useful to capture the mother's BMI at 12 weeks gestation and to understand if there was any smoking in pregnancy.
- The Portsmouth Form B is to be amended to enable this information to be captured for future cases to help inform discussion at case reviews.

- The Portsmouth CDOP felt it was important to highlight to the workforce that in the City the infant (aged 0 to 1 year) mortality rate remains consistently lower than the England average with recent figures for Portsmouth at 2.8 per 1,000 live births, (England average 3.9 per 1,000) with no deaths due to sudden infant death syndrome (SIDS). The child (aged 1 to 17 years) mortality rate is also lower than the rest of England at 6.6 per 100,000, compared with 11.9 per 100,000. This is despite the proportion of children under 16 living in low income families being 24.0%, which is higher than the England average of 20.1%. It's not clear why the infant and child mortality rates are lower in Portsmouth, but its seems that the hard work done by the local authority and public health, health visitor and school nursing teams, primary care, maternity and neonatal services and paediatrics must have a role to play in this.
- The Portsmouth CDOP reviewed local safe sleeping messages and colleagues within Public Health confirmed messages are regularly disseminated via various methods including articles within regular publications that are sent directly to homes and schools within the city. Whilst Portsmouth has not had any deaths related to sleeping practices we recognise that our population is at increased risk due to the levels of deprivation in the city and will be supporting the work carried out across the 4CDOP area.

Membership update - The Portsmouth CDOP is consistently well attended by representatives from across all agencies in the city.

Number of times CDOP has met to review cases - The Panel met three times over this financial year and reviewed 13 cases.

4. Southampton

Analysis of the death reviews – During 2017/18, Southampton CDOP reviewed fewer than five of the 14 notified deaths. The outstanding cases are scheduled for review in 2018/19.

The CDOP process requires the panel to categorise the deaths and report these back to the DfE annually. It is worth noting that the category agreed does not necessarily reflect the registered cause of death. Tragically 20% of the deaths took place during the pre-viable stage and 40% of the deaths were neonatal. Twenty per cent of the deaths were due to a known life limiting condition and 20% were a sudden unexpected death in infancy. Eighty per cent of the cases were expected. In reviewing deaths, CDOP members consider whether there were any contributory factors known to be associated with increased risk which could be modified to reduce the risk of future deaths. This does not mean that removing these factors would have prevented the death. Forty per cent of the deaths reviewed had modifiable factors leaving 60% that did not.

Forty per cent of the children that Southampton reviewed were male and 60% were female. None of the children whose death was reviewed were ever subject to a Child Protection plan nor were there any Statutory Orders in place. None of the children were known to be asylum seekers.

Learning, issues and actions arising from the reviews:

- Southampton CDOP has not noticed any trends across the cases that have been reviewed.
- The majority of deaths were neonatal and expected.
- The issue of language barriers within services offered to new parents arose from cases reviewed. This was also highlighted last year and been raised with local care providers.
- Appropriate bereavement support across various cultures has also been identified as an emerging learning point when supporting families.

Southampton CDOP is aware of pending national changes with regard to the way in which it operates and is preparing for alternative methods of reviewing child deaths in the local area. This may be through linking with other health agencies or with other geographical areas.

Membership update – This year Southampton CDOP welcomed a new interim chair from Public Health. This has been useful when identifying learning across Public Health and CDOP. The meetings are always well attended and the group benefits from the expertise of a neonatal consultant and the Designated Doctor for child deaths, in addition to Safeguarding leads from various Services in the City.

Number of times CDOP has met to review cases – The CDOP group met x times throughout the year. Emma to add figure

Conclusion and recommendations

This report on child death reviews across the 4LSCBs has identified several learning points. The large proportion of unreviewed deaths may have resulted in very few modifiable factors being identified. However, several issues have been identified and these include: unsafe sleeping practices, abusive head trauma, sub-optimal management of children with chronic medical conditions, the conundrum around the acute management of older children in adult hospitals, addressing language barriers as well as communication issues, effective dissemination of CDOP messages to agencies who need to act on them and appropriate bereavement support.

Some of these issues are highlighted as lessons with actions either directed to the Board or to agencies. They are grouped into those identified through the reviews and those related to the CDOP process:

Lessons from the analysis of the 2017/18 child death reviews

1. Unsafe sleeping

Challenge: Over the year the 4CDOP area has seen several deaths related to sleeping practices. In most cases it has occurred along-side co-sleeping in bed with risk factors such as smoking, alcohol or drug use or sometimes sleeping on a sofa.

Recommendation: Minimise the chances of similar deaths in the future by ensuring that safe sleeping continues to be a high priority.

Actions: Promoting safe sleeping messages and supporting the Lullaby Trust annual awareness campaign are some of the actions being undertaken by agencies within the panels. The 4CDOP would like health agencies through the health subgroups of the respective Boards to ensure that all staff are fully aware of current policies and guidance and routinely communicate the risks of unsafe sleeping effectively with parents and families.

2. Language barriers including communication issues

Challenge: The issue of unaddressed language barriers including communication issues within services arose from cases reviewed. Language barriers pose significant challenges to providing safe and effective health and social care.

Recommendation: Reduce the negative impact of language and communication barriers on children's health and social care.

Actions: This was also highlighted last year and been raised with local care providers. The 4LSCB needs to ensure that language barriers including communication issues are raised within health, education and social agencies and that strategies are developed to promote appropriate action.

3. Bereavement support

Challenge: Communicating effectively with bereaved parents, including availability of appropriate literature/resources and bereavement support for dealing with the death of a child were identified as issues across the 4CDOP area.

Recommendation: Further work is needed to explore the opportunities to improve bereavement support for parents, families and communities.

Actions: Several aspects of bereavement care provision were identified by the CDOPs. This ranged from the need for sensitivity around post-birth communications to appropriate processes following deaths of older adolescent children and actions to schools and colleges to assist them in dealing with the death of a child. Bereavement training and workshops for professionals were also considered and reviewed within panel agencies. Appropriate bereavement support across various cultures was identified as an emerging learning point when supporting families. These findings need to be addressed by the LSCBs in the four areas to inform future business planning for the respective Boards.

4. Maternal smoking and obesity

Challenge: Maternal smoking remains the most significant modifiable factor and an ongoing priority for the 4LSCB, with maternal obesity also being a major health concern.

Recommendation: Women within the child bearing age should be informed of the importance of having a healthy lifestyle both before getting pregnant and during pregnancy.

Action: Continue to engage clinical, social and public health leadership to encourage women of reproductive age to adopt a healthy lifestyle, stop smoking, and achieve a normal body weight before conception. Efforts to reduce smoking rates in the population continue. The panels agreed to support this work within their agencies, in particular getting the message out and influencing women to engage with services. Smoking in pregnancy is an ongoing priority and the respective boards need to continue focussing action within their own agencies.

<u>Lessons regarding the CDOP process and working of the panels</u>

- Prioritise implementing the new "*Working Together to Safeguard Children"* arrangements, including transition plans to be published no later than June 2019.
- Facilitate training needs for professionals with the new arrangements.
- Build on the work to date and use the new arrangements as an opportunity to improve the quality of reviews with continued focus on timely and full completion of the forms.
- Promote learning and dissemination of good practice through continuous professional development including refresher and multi-agency training.
- Prioritise reducing the backlog and delay in child death reviews to improve opportunities to more swiftly prevent future deaths
- Explore multiple sources of notification of child deaths and data collection to ensure a comprehensive and accurate data set. This includes investigating the option of accessing information from the Perinatal Mortality Surveillance Reporting system via the MBRRACE-UK which is more efficient and robust.

These findings will be reported to the LSCBs in the four areas to inform future business planning for the respective Boards. Coordination of joint areas for action and future learning will be taken forward by representatives of the four areas in regular learning meetings. The report recommends that these findings inform the development of CDOP priorities for 2018/19.

Summary update on priorities from the 2016/17 CDOP annual report

Progress on the recommendations from the 2016/17 CDOP annual report is summarised below and further detailed in the Appendix attached to this report.

1. Maternal smoking in pregnancy and/or household smoking remains an ongoing area of focus across the 4LSCB area. Strategies and action plans have been developed and CDOP members are supporting this work within their agencies. Challenges include how the CDOP Board can promote public health messages and influence women to engage with the services. Clinical leadership via the Hampshire & Isle of Wight Sustainability & Transformation Partnership (HIOW STP) Clinical Executive Group (CEG) is another approach being sought to upscale the response to smoking in pregnancy. All local authorities within the CDOPs have prioritised working to address maternal smoking. Hampshire has prioritised maternal smoking as part of delivery of the *Hampshire Smoking in Pregnancy Strategy 2017-20*. In Southampton this is through the action plan informed by the multi-agency self-assessment using the PHE-recommended CLeaR tool. The behaviour change service works with maternity services to offer free, confidential stop smoking support to pregnant women. Portsmouth also uses the PHE-recommended CLeaR tool multi-agency self-assessment and action plan. It has a *Smoking in Pregnancy Joint Steering Group,* a specialist smoking in pregnancy behaviour change service within the wellbeing service and an electronic referral system from maternity services to the specialist services. Whilst the Isle of Wight currently supports women in pregnancy to stop smoking within the midwifery service, this is under review. From the LSCB's point of view the concern is about having a holistic approach to families with complex needs which would include tobacco use.

2. Youth suicide – Several initiatives have been undertaken to address youth suicide including ratification and sign-off of the Hampshire *Self Harm Pathway* and the Hampshire CAMHS – SAFE (Suicide Awareness For Everyone) Campaign. Work is underway to adapt the Self Harm Pathway to apply across the 4LSCB area. Local suicide prevention plans for each local authority area include actions relating to young people.

3. Promoting public health interventions – Ongoing implementation of public health strategies, lifestyle advice and screening and immunisation programmes are some of the approaches being undertaken to address substance misuse, levels of smoking, domestic abuse, alcohol misuse and maternal obesity that are linked to adverse health outcomes and child deaths.

Appendix

Policy drivers

The subject of child deaths has been a feature of several reports and guidance documents over the past year. The following documents were key drivers that have influenced work within the 4LSCB CDOPs and are reflected in this year's annual report.

One of the key drivers in 2018 has been the publication of the new '*Working Together to Safeguard Children (2018)*[7]*'* statutory DfE guidance which replaces the *Working Together (*2015) guidance. An important change is the replacement of the LSCB requirement for child death reviews through CDOPs with "Child Death Review Partners" (consisting of local authorities and local clinical commissioning groups) arrangements for reviewing child deaths.

The updated MBRRACE-UK [Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK]) *Perinatal Mortality Surveillance Report for Births in 2016*[8]*,* informs further work on neonatal deaths and highlights the fact that with improvements to the care provided to mothers and their babies, a continuing reduction mortality rates is possible.

In February 2018, a Parliamentary Office of Science and Technology (POST) note[9]*,* reviewed the impact of parental alcohol misuse (PAM) on children and reported that 37% of child deaths and serious injuries through neglect were linked to parental drinking.

The RCPCH *State of Child Health Report 2017*[19] presents updated information on the gains in child mortality, for example the excellent low UK injury mortality but also comments on the slowing of the decline in child mortality.

A new study published in the Lancet[10] reported that English under 5's are one and half times more likely to die than those living in Sweden. The study compared child mortality rates of more than 3.9 million English births and 1 million Swedish births and attributes the difference due to children in England typically weighing less at birth, being born earlier, and having more birth anomalies (such as congenital heart defects) than in Sweden.

In March 2018 the ONS published the annual statistical bulletin on *Child mortality in England and Wales: 2016*[11] of stillbirths, infant and childhood deaths, and associated risk factors. Cancers remain the most common cause of death for children aged 1 to 15 years, accounting for 20.6% of deaths in 2016.

Detailed update on priorities from the 2016/17 CDOP annual report

Progress has been made on the Hampshire recommendations from the 2016/17 CDOP annual report outlined below:

Lessons from the analysis of child death reviews

1. Neonatal deaths

Challenge: Recognising and addressing the wide range of factors that play a role in these deaths - maternal smoking remains the most significant modifiable factor, maternal obesity is identified as an emerging factor

Action: Approach developed for reviewing deaths of pre-24 week babies. Strategies and action plans have been developed and CDOP members are supporting this work within their agencies. Challenges include how the Board can get the message out and influence women to engage with the services. Clinical leadership via the Hampshire & Isle of Wight Sustainability & Transformation Partnership (HIOW STP) Clinical Executive Group (CEG) is another approach being sought to upscale the response to smoking in pregnancy.

2. Accidents

Challenge: In-car safety and wearing of seatbelts, young drivers and road safety and the dangers of button batteries were identified as significant concerns

Action: Focused action on road safety campaigns has been undertaken. During Child Safety Week health visiting teams promoted awareness about child safety and accident prevention. Health Visitors from Southern Health NHS Foundation Trust, in partnership with The Child Accident Prevention Trust (CAPT) focused on raising awareness of the dangers associated with button batteries. They worked with the family of a child who tragically died following consumption of a button battery and CAPT, by developing a video to raise national awareness.

- **Social inequalities**

Challenge: Improve the analysis of child deaths in areas of socio- economic deprivation.

Action: Whilst this is ongoing within multiagency working, analysis of child deaths in areas of socio- economic deprivation has not been responded to as yet and remains an outstanding action. This is mainly due to because of challenges with the data.

- **Public health interventions**

Challenge: Promote the importance of interventions such as flu vaccination, lifestyle advice.

Action: Ongoing implementation of public health strategies, lifestyle advice and screening and immunisation programmes are some of the approaches being undertaken to address substance misuse, levels of smoking, domestic abuse, alcohol misuse and maternal obesity.

Lessons regarding the CDOP process

- **Inaccuracies in child death data notifications**

Challenge: Inaccuracies in the number of Hampshire child deaths held by the DfE and the Hampshire CDOP has identified the need to improve the notification of child deaths and quality of the CDOP process.

Action: Continue to persevere in identifying ways to improve child death notifications. Reconciliation of local child death data with that held on the Public Health Mortality File has improved understanding of actual numbers.

- **Working Together to Safeguard Children" arrangements**

Challenge: Prioritise implementing the new "*Working Together to Safeguard Children 2018"* arrangements.

Action: Attendance at conferences and networking has helped improved understanding of the new arrangements in order to have a proactive and preparatory approach for the new arrangements. Following launch of the guidance in July 2018, the contents are being reviewed within the Partnership Support Team and subgroups where appropriate for compliance by June 2019.

- **CDOP database**

Challenge: Further development of CDOP database to enable innovative and insightful analysis

Actions: The CDOP database is fully functional and compiles learning from all child death reviews. It is likely that it will be compatible with the National Child Mortality Database once operational.

- **Improving multi-agency working in regard to addressing difficulties in sharing child death information**

Challenge: Continue to focus on improving multi-agency working in regard to addressing difficulties around awareness in sharing child death information, by promoting and sharing good practice across the 4LSCB, including working with local MASHs to develop effective solutions.

Actions: This is ongoing work. Work is being undertaken with safeguarding leads across partner agencies to embed the CDOP processes in practice. Significant improvement has been made in notifications of deaths to CDOP, with a timelier response and better quality information. There has been a focus on notification of babies born pre-24 week gestation as this remains an area of challenge for CDOP notifications and work is being undertaken directly with the hospitals to address this.

References

[1] Wood Report - Review of the role and functions of Local Safeguarding Children Boards. 2016 Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526329/Alan_Wood_review.pdf (accessed August 2017)

[2] Children and Social Work Bill 2017. Available at: http://services.parliament.uk/bills/2016-17/childrenandsocialwork.html (accessed September 2017)

[3] Marmot MG, Allen J, Goldblatt P, et al. Fair society, healthy lives: the Marmot review. Strategic Review of Health Inequalities in England Post 2010. 2010. Available at: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review (accessed September 2017)

[4] Together for Short lives. The verification of expected death in childhood- Guidance for children's palliative care services, 2012. Available at: http://www.togetherforshortlives.org.uk/assets/0000/1856/FINAL_TfSL_Verification_of_Expected_Death_in_Childhood_Report.pdf (accessed September 2016)

[5] Department of Health & Social Care. Care in Surrogacy - Guidance for the care of surrogates and intended parents in surrogate births in England and Wales. February 2018. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/684259/surrogacy-guidance-for-healthcare-professionals.pdf (accessed July 2018)

[6] Department of Health & Social Care. The Surrogacy Pathway - Surrogacy and the legal process for intended parents and surrogates in England and Wales. February 2018. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/684275/surrogacy-guidance-for-intended-parents-and-surrogates.pdf (accessed July 2018)

[7] Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children. July 2018. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722305/Working_Together_to_Safeguard_Children_-_Guide.pdf (accessed July 2018)

[8] Draper ES, Gallimore ID, Kurinczuk JJ, Smith PW, Boby T, Smith LK, Manktelow BN, on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2016. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester. 2018. Available at: https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Perinatal%20Surveillance%20Full%20Report%20for%202016%20-%20June%202018.pdf (accessed July 2018)

[9]Parliamentary Office of Science and Technology (POST), Parental Alcohol Misuse and Children, Post Note 570, February 2018. Available at: http://researchbriefings.files.parliament.uk/documents/POST-PN-0570/POST-PN-0570.pdf (accessed July 2018)

[10] Zylbersztejn A, Gilbert R and Hjern A et al. Child mortality in England compared with Sweden: a birth cohort study. Lancet 2018; 391: 2008–18. Available at: https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)30670-6.pdf (accessed July 2018)

[11] Office for National Statistics (ONS). Statistical Bulletin. Child mortality in England and Wales: 2016. Stillbirths, infant and childhood deaths occurring annually in England and Wales, and associated risk factors. March 2018. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2016 (Accessed July 2018)