Every child death is a tragedy.

4LSCB CHILD DEATH OVERVIEW PANEL: Annual Report 2015/16

4LSCB - HAMPSHIRE, ISLE OF WIGHT, SOUTHAMPTON AND PORTSMOUTH

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4LSCB CHILD DEATH OVERVIEW PANEL Annual Report 2015/16

Foreword

Every child death is a tragedy that affects families and communities. The 2015/16 4LSCB Child Death Overview Panel (CDOP) Annual Report looks at the child deaths reviewed that year across the 4LSCB area. This incorporates Hampshire, the Isle of Wight, Portsmouth and Southampton.

The process for reviewing child deaths has continued to develop over the last year and the Panel has seen a number of changes. This includes the decision part way through the year for each of the individual Local Safeguarding Children Boards (LSCBs) that used to work under the 4LSCB umbrella partnership to take responsibility for reviewing child deaths within their respective LSCB Local Authority area. The annual report describes the experiences gained during the transitional year of the new structural arrangements.

It is envisaged that the work of the Panels, as demonstrated in this report, will help improve outcomes for children and young people across Hampshire, Isle of Wight, Portsmouth and Southampton by identifying learning points to feedback to the LSCB and wider system. This report provides information for the four individual LSCBs to use when publishing their Annual Reports - a powerful resource for driving public health action to promote child safety and well-being.

The 4LSCBs continue to work together in reviewing child deaths by holding a twice yearly workshop to share learning and identify any challenges and joint pieces of work across the 4LSCB area. During April 2016 CDOP Chairs along with Board Managers from the 4LSCBs were invited to attend a workshop to discuss the 2015/16 annual report and identify emerging themes and priorities across the 4LSCB partnership for 2016/17. It was agreed that suicide and self-harm would be priorities across the 4LSCB area. Hampshire and the Isle of Wight also wanted to include neonatal deaths as a priority. A further workshop will be planned for October 2016.

Core Functions of the Child Death Overview Panel

Every child death is a tragedy. The most important reason for reviewing child deaths is to understand why children die, learn lessons and take steps wherever possible to protect other children and prevent future deaths.

LSCBs have had a statutory duty to review deaths of all children from birth (excluding planned terminations carried out within the law and still born babies) up to 18 years old, who are normally resident within their area. This is known as the Child Death Review Process. Under *Working Together*[1]*,* the primary purpose of the 4LSCB CDOP (and latterly individual CDOPs) is to review individual deaths to identify modifiable causes that will inform strategic planning on how "best to safeguard and promote the welfare of the children". Reviewing deaths involves collating information on the cause, location and other circumstances of the death.

It is not an investigation into why a child has died and is not a serious case review (SCR), although a SCR may be undertaken outside the panel in respect of a death where abuse or neglect is considered to be a factor. The focus is about making recommendations at a population-level to improve and protect the health of children based on emerging themes and trends arising from child death reviews.

Since 1 April 2010, LSCBs have been required to determine whether there were modifiable factors in the death of a child when reviewing the death. Factors are judged to be modifiable if nationally or locally achievable interventions could be used to reduce the risks of future child deaths.

The CDOPs should receive notifications of the deaths of all children from birth to 18 years in each LSCB area from a number of sources including Healthcare Providers (primary care, emergency departments, and paediatricians), the Registrar of Births, Deaths and Marriages, the Coroner and the Police.

CDOP reviews all deaths that are notified to the panel, drawing on comprehensive information from all agencies on the circumstances of each child's death. Particular consideration is given to the review of sudden unexpected deaths in infancy (SUDI) and childhood; accidental deaths; deaths related to maltreatment; suicides and any deaths from natural causes where there are potential lessons to be learnt about prevention.

Through these reviews the Panels identify:

- Any lessons to be learnt or overall patterns and trends, including any system or process issues within any agency or voluntary sector and any public health issues;
- Any case giving rise to the need for a referral to the Serious Case Review (SCR) Committee; serious case reviews are inquiries into child deaths or cases where children have experienced serious harm, where abuse or neglect is known or suspected and there are concerns about how organisations or professionals worked together to safeguard the child
- Any matters of concern affecting the safety and welfare of children in the area;
- Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area.

The Panels also monitor professional and organisational responses and learning from child deaths, and identify good practice as well as any gaps or deficiencies in the process, for example, reference to bereavement support following the unexpected death of a child. Through systematic review, detailed discussion and scrutiny of the information available to them, the Panels develop recommendations to the four LSCBs. Collation of work of the Panels contributes to overall recommendations to the four LSCBs on areas of learning and changes that may need to be made to training, policy and practice to prevent future child deaths.

Governance arrangements

Central Government responsibility and oversight for safeguarding children is located in the Department for Education (DfE) and locally within each respective LSCB. During early 2015 the Independent Chairs of each LSCB agreed that the 4LSCB CDOP would disband, with each LSCB taking on responsibility for reviewing deaths in its Local Authority area. A range of reasons triggered this change and a memorandum of understanding was developed to support the transition and the new CDOP configuration. This took place in November 2015.

The membership of all the Panels is arranged to ensure that there is the required level of expertise and experience and that each agency is appropriately represented. This arrangement ensures any patterns or trends can be identified. The LSCBs quality-assure the safeguarding children activities of member agencies, such that outcomes for children improve.

The CDOPs and their Chairs are accountable to the Independent Chairs of each of the LSCBs.

An updated Memorandum of Understanding[2] (MOU) is in place between the four LSCBs in Hampshire, Southampton, Portsmouth and the Isle of Wight. It sets out where and how each LSCB and CDOP will work together under the new arrangements, effective from 1 November 2015.

<u>CDOP Chairs</u>

Hampshire – Sallie Bacon, Director of Public Health (Interim), Hampshire County Council

Portsmouth - Kate Lees, Consultant in Public Health, Portsmouth City Council

Southampton - Fiona Bateman, Independent Chair, Southampton Local Safeguarding Children Board

Isle of Wight - Rida Elkheir, Director of Public Health, Isle of Wight Council

Context

Child deaths have fallen to very low levels over the past century and are thus a rare occurrence in the UK, but even one death is a death too many. Whilst the overall numbers of children dying are small, they represent the tip of the iceberg below which are many more children suffering from maltreatment[3], and we need to examine the modifiable factors that might reduce child deaths still further.

On a year to year basis deaths at an individual CDOP level fluctuate randomly due to small numbers and the inevitable variability of natural events, making it difficult to make valid interpretations of trends. Data collated at a 4LSCB CDOP level (child population aged 0-17 years - 400,155) gives some indication of the themes, trends and variances in services that are likely to contribute to child deaths and these are described in this report. If the population were scaled up even further, the data would allow more meaningful analysis and sufficient anonymisation to prevent identification of individual children. The *Wood Report*[4] recommends introducing a national-regional model for CDOPs and a national database of child death reviews. This would assist the collection of local information and a national analysis of child deaths to inform regional CDOPs. Currently all LSCBs are required to submit an annual return to the DfE for the annual Statistical First Release (SFR) that provides an overview of child deaths that were reviewed during the year.

Scope

This annual report for 2015/16 contains information from the 4LSCB CDOP (1 April 2015 - 31 October 2015) and the individual CDOPs (1 November 2015 - 31 March 2016). It includes a descriptive analysis in the context of CDOP and considers policy drivers and topical themes. This is the first 4LSCB annual report since disbanding the 4LSCB CDOP and in keeping with the 4LSCB memorandum of understanding the report focuses on an overall 4LSCB analysis followed by individual LSCB analysis. It then presents an aggregated summary of lessons learned and resulting recommendations.

Limitations

There are several limitations to this report that must be borne in mind when reading it. There are difficulties in sharing child death information between agencies, differences in classification of deaths between CDOPs and death certification which means that there are gaps in our knowledge and we are not sufficiently extracting learning from the data and intelligence we have available. The analysis of child deaths can be delayed, incomplete and inconsistent due to poor quality of some forms. Meaningful information to ensure that the report serves its purpose is also dependent on consistent and timely data submissions by individual CDOPs which is currently proving difficult and needs addressing.

In compiling this report we have identified a discrepancy in the number of children dying (registered deaths) each year and the number of child deaths being reviewed in that year. This is because of the lag time between a death and that death being reviewed by the panel. The delay in reviewing a death can be due to several factors including the time required for final reporting of a specialist post mortem, Police investigation, the need for a SCR and the time it takes to obtain complete information from all involved agencies. Previous understaffing of the administrative function for the panel led to a backlog of cases from previous years at the start of 2015/16. This has been reduced dramatically in year following a more sustained level of administrative and managerial support enabling a review and improvement of reporting and data collection processes.

Purpose

The purpose of the report is to identify key themes, patterns or trends from local data. The aggregated findings from all child deaths inform recommendations and actions on how to best safeguard and promote the health and welfare of children.

These findings should drive local strategic planning and inform the 2016/17 CDOP work plans and may highlight areas for a deep dive as part of the local Joint Strategic Needs Assessment.

Policy drivers

Child deaths have been the subject of several national, regional, local and Royal College policies, guidance, regulation and audits. Findings from the first Confidential Enquiry for Maternal & Child Health (CEMACH, now replaced by MBRRACE-UK [Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK]) study in 2006 *Why children die: death in infants, children and young people in the UK*[5] have informed much of the work on child death review processes.

In 2014 the Royal College of Paediatrics and Child Health's (RCPCH) *Why Children Die campaign* aimed to identify ways to reduce preventable child mortality across the UK[6]. Earlier in 2013 the RCPCH and University College London presented an overview of child deaths in the four UK countries[7], as part of the Child Health Clinical Outcome Review Programme working with the Healthcare Quality Improvement Partnership (HQIP).

Recognising the importance of further reducing child mortality, the Lancet in 2014 published a series of three papers[8] discussing variation in child death in high-income countries in the context of evolving child death review processes.

The DfE has published several guidance documents, including *Working Together to Safeguard Children, 2010*, updated in *2013* and refreshed more recently in *2015*[9], with the aim of unifying operational aspects of CDOPs. In 2013 the DfE brought out *Child death reviews: improving the use of evidence*[10], on how to make better national use of the information collected through the child death review processes. A series of data collection templates for use by CDOPs are provided by the DfE- *Child death data collection: guide to submitting data*[11]. Using these data submissions by CDOPs, the DfE publishes annual child death statistical releases[12] of aggregated national data. More recently in May 2016 the *Wood Report* set out a new framework for improving the role and functions of LSCBs, including how child deaths are reviewed.

Theme based policy includes the *2014 National Review of Asthma Deaths*[13], where 36 out of the 900 deaths occurred in children and young people under 20 years of age. The RCPCH campaign included a focus on - *Reducing deaths from injuries and poisoning, Promoting mental health and reducing risk-taking behaviours* and *Reducing healthcare amenable deaths* including suboptimal diabetes care. *Coordinating Epilepsy Care: a UK-wide review of healthcare in cases of mortality and prolonged seizures in children and young people with epilepsies*[14], was also part of the RCPCH Child Health Clinical Outcome Review Programme.

Local work in regards to safeguarding children in the 4LSCB has been informed by these policy drivers.

Overall Summary Data on child death reviews in Hampshire, Isle of Wight, Portsmouth and Southampton 2015/16

This section contains information on child death reviews that were completed in the year 1 April 2015 to 31 March 2016. Collaborative working of the 4LSCB partnership enables access to a larger dataset for analysis and the identification of emerging themes. Out of area deaths occurring in the 4LSCB area are no longer included in this report as they are referred immediately to the area in which the child normally resided. It is important to note that this data relates to the number of child death reviews that have taken place rather than the number of child deaths that have occurred during the year 2015-16. The number of reviews relating to deaths that occurred in the preceding years was 85 - Hampshire (56), Isle of Wight (6), Portsmouth (11) and Southampton (12).

Number of child deaths reviewed in 2015/16

Table 1 and figure 1 present information on child deaths that the CDOPs have reviewed on behalf of the 4LSCB partnership in 2015/16. A total of 117 child death reviews were completed in the year ending 31 March 2016 – an increase from 85 in 2015. The Hampshire LSCB being the most populous area accounted for the highest absolute number of child death reviews. Of the 117 child death reviews, the Hampshire LSCB accounted for the highest proportion at 65% and the Isle of Wight LSCB the least at 7%.

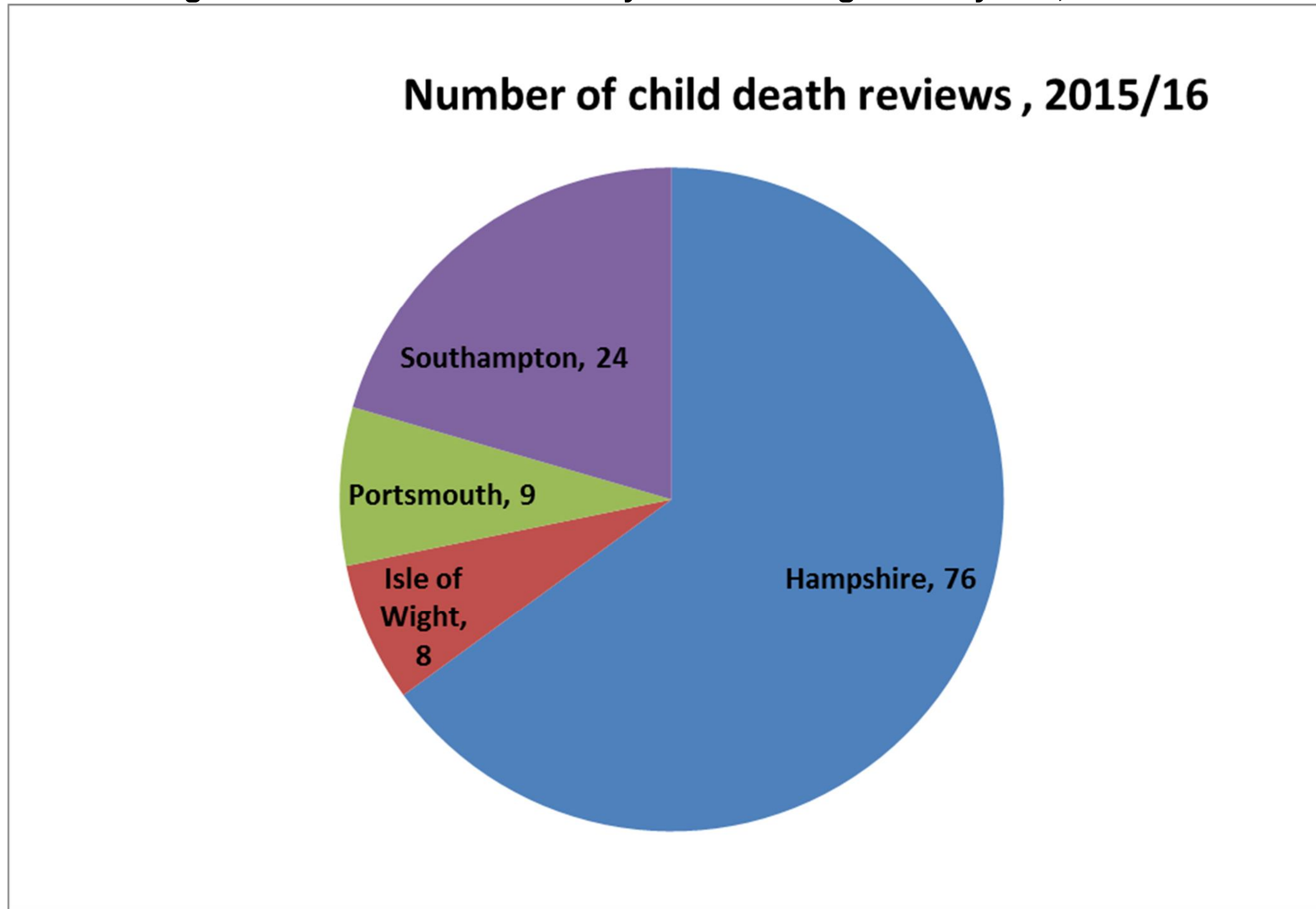
Table 1: Child death reviews completed by CDOPs on behalf of the 4 LSCBs, 2015/16

LSCB area of residence	Population aged 0-17*	Number of child death reviews	Percentage of total child death reviews**
Hampshire	281,923	76	65%
Isle of Wight	25,314	8	7%
Portsmouth	43,766	9	8%
Southampton	49,152	24	21%
Total	400,155	117	100%

Source: 4LSCB; *ONS 2015 Mid-year population estimates; **Figures may not add up due to rounding

Figure 1 shows the number of child death reviews across the 4LSCB area and reflects the volume across different LSCB population sizes.

Figure 1: Child death reviews by LSCB area aged 0-17 years, 2015/16



Source: 4LSCB

Yearly number of child deaths reviewed

The absolute number of child death reviews has fluctuated annually across the 4LSCB since 2008/09 (see table 2 and figures 2 and 3). A total of 800 child death reviews have been completed since the introduction of data collection in 2008/09. Latest data show that the overall number of child death reviews increased between the years ending 31 March 2015 and 31 March 2016. The latest national statistical first release shows that nationally the numbers of child death reviews have also shown a rise in the most recent year after decreasing steadily over previous years' data.

It is likely that some of the local increase in the number of child death reviews in 2015/16 (in Hampshire and Southampton only) is due to the CDOPs ensuring that outstanding reviews from the previous year were undertaken and improved processes, rather than an increase in child deaths. However, other factors must be considered. We do not know if there has been a true increase in child mortality in the 4LSCB area because we do not have access to individual mortality figures although statistics suggest that there has been a slight increase in the population of 0-17 year olds in the 4LSCB area (1,211 children). Changes in the numbers of child death reviews maybe due to chance, especially in the Unitary Authorities where numbers are small.

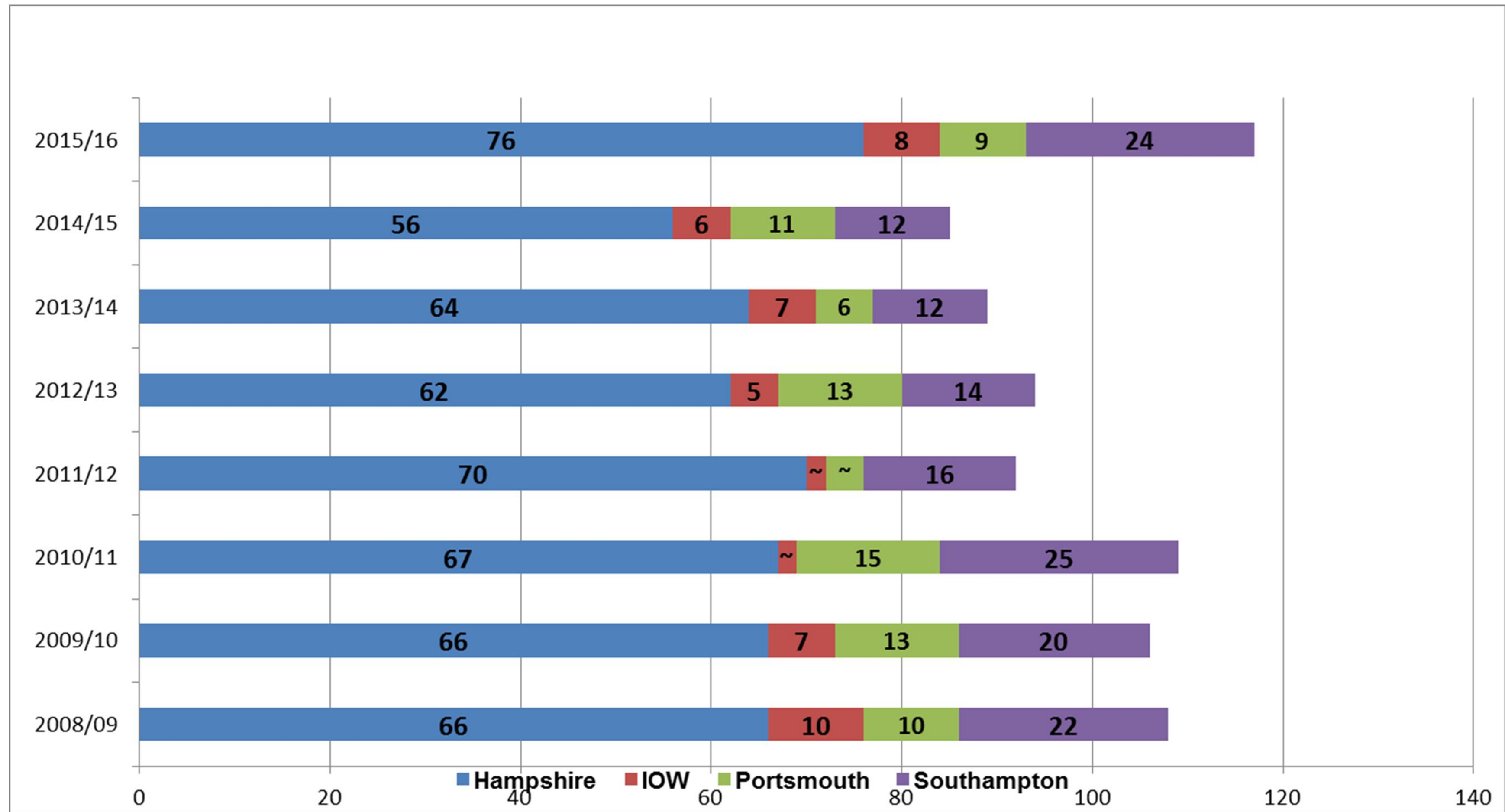
Table 2: Yearly number of child deaths reviewed by LSCB area of residence, 2008/09 - 2015/16

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

Source: 4LSCB

For reasons of confidentiality figures below 5 are suppressed

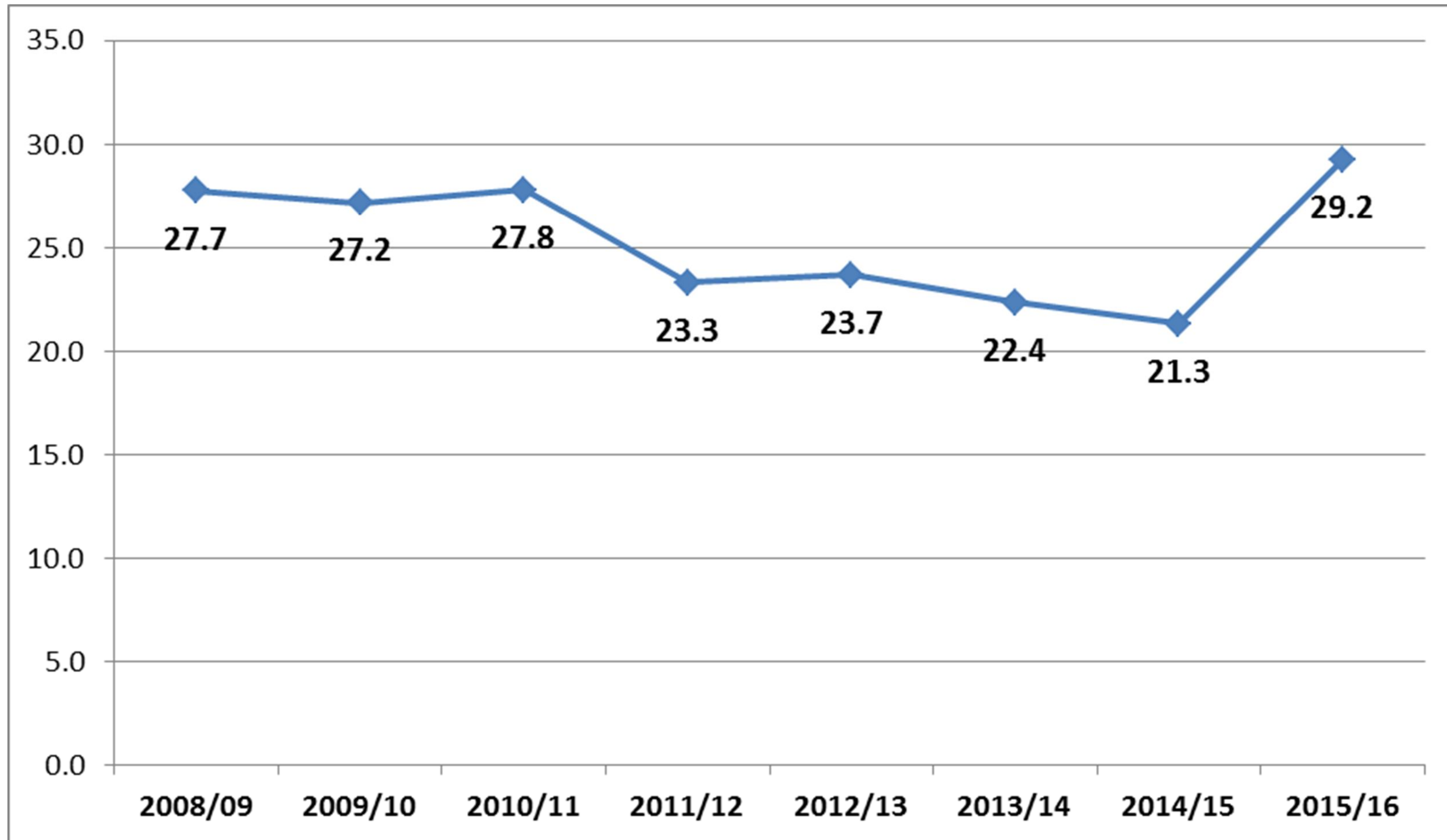
Figure 2: Number of child death reviews by LSCB area of residence, 2008/09 - 2015/16



Source: 4LSCB

~For reasons of confidentiality figures below 5 are suppressed

Figure 3: Yearly crude rate* of child deaths reviewed 4LSCB, 2008/09 - 2015/16



Source: 4LSCB; *Crude rate of child death reviews per 100,000 LSCB population aged 0-17 calculated using ONS mid-year population estimates

Characteristics of child death reviews

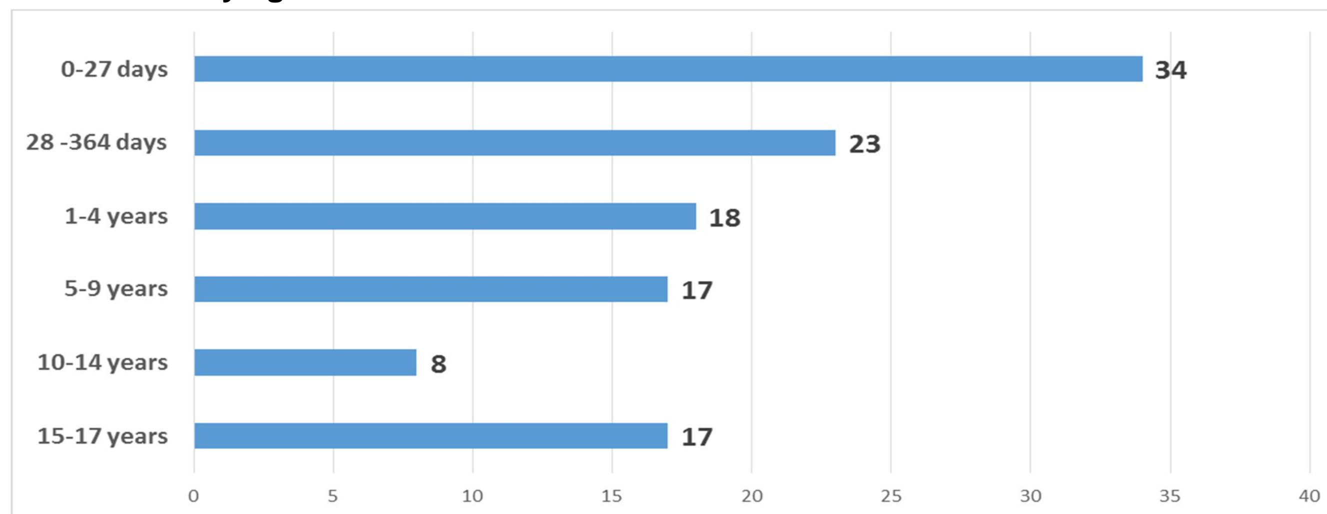
Gender

Boys' deaths accounted for over half (54%, 63) of the 117 deaths reviewed with 54 deaths in girls. Across England boys' deaths accounted for a slightly higher proportion at 58%.

Age

The findings shown in the chart below (figure 4), mirror those nationally with the majority of child deaths reviewed occurring in the neonatal period and declining with increasing age until there is a gradual increase in the late teenage years. The relatively high deaths in the teenage years raised concerns regarding suicide numbers and a Consultant in Public Health provided specialist input to the discussion on the Suicide and Self-Harm pathway in Hampshire. Just under half of reviews (49%, 57) completed were of children who died under the age of one; with 29% for children aged 0-27 days; and a further 20% for children aged between 28 and 364 days at the time of death.

Figure 4: Child death reviews by age band



Source: 4LSCB

Neonatal deaths with/ without modifiable factors

Of the 117 deaths reviewed across the 4LSCB area, 34 were neonatal deaths (babies who died within 28 days of birth). Modifiable factors were identified in fewer than five of these deaths. The factors identified were maternal smoking in pregnancy and/or

household smoking and emotional/ behavioural/ mental health condition in the parent/ carer. Some of the modifiable factors relating to the mother's pregnancy that are also known to contribute to neonatal deaths and none of which were identified in our reviews include:

- poor access to appropriate antenatal care
- maternal obesity
- maternal co-morbidities
- multiple births
- influenza in pregnancy
- consanguinity
- extremes of maternal age of childbearing
- adverse family environment such as deprivation and homelessness
- pregnant women/vulnerable families with complex social factors - women who misuse substances (alcohol and/or drugs), are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English and women who experience domestic abuse

Ethnicity, asylum seeking status, child protection, statutory order status and areas of higher deprivation

Reviews of deaths indicated a paucity of information on ethnicity, area deprivation, asylum seeking status, whether children were on a child protection plan or subject to any statutory orders. Whilst some of the forms may not contain this information, the children's social care representative on the panel would always provide the panel with information on any social care involvement with the child and family, including any child protection procedures such as whether the child was on a child protection plan. 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*[15], thus emphasising the need to examine this data across the 4LSCB population.

Categorisation of deaths

Table 3 below shows the CDOP categorisation of all the 116 deaths that were reviewed in 2015/16. 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 (as determined in the statutory guidance).

Table 3: Categorisation of child death reviews 2015/16

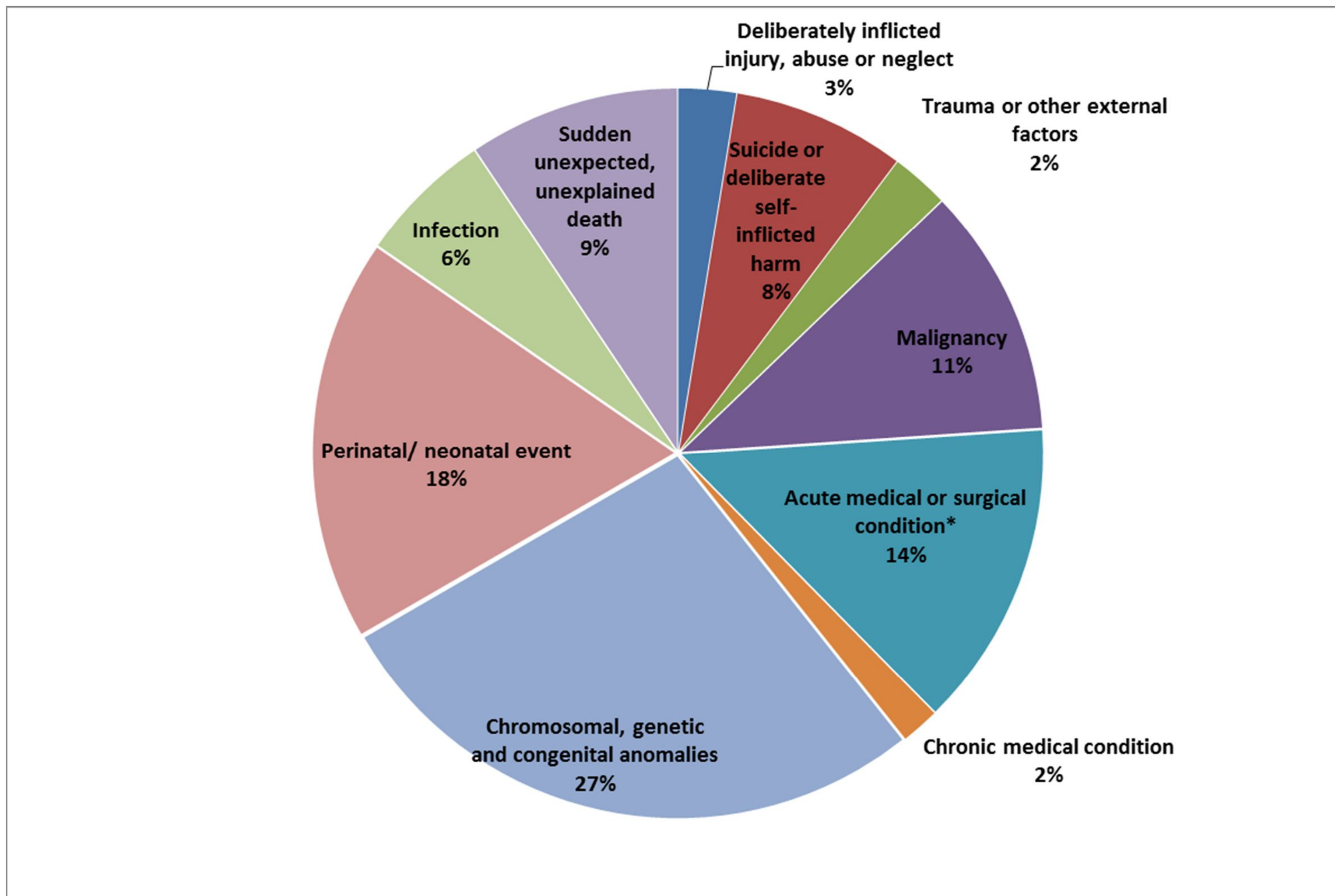
	Category	Cases	Modifiable factors
1	Deliberately inflicted injury, abuse or neglect	<5	<5
2	Suicide or deliberate self-inflicted harm	9	<5
3	Trauma or other external factors	<5	<5
4	Malignancy	13	0
5	Acute medical or surgical condition[1]	16	<5
6	Chronic medical condition	<5	0
7	Chromosomal, genetic and congenital anomalies	32	<5
8	Perinatal/ neonatal event	21	0
9	Infection	7	0
10	Sudden unexpected, unexplained death	11	<5
	Total	117	12

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

Chromosomal, genetic and congenital anomalies were the most common contributory factor (27%) of the child deaths reviewed and similar to the national proportion (26%). However, perinatal/ neonatal events at 32% were the most common category contributory factor across England compared to a figure of 18% locally (see figure 5). Often this is due to extreme prematurity causing complex medical needs that weren't expected prior to the birth. Among the 16 medical/surgical deaths in children there were a number of deaths where epilepsy was a contributory factor. There have been a total of nine 'deaths by suicide' between in 2015/16. The 4LSCB CDOP was notified of less than five cases of suicide in 2014/15. Due to the low numbers it is difficult to identify trends although there does seem to be, from local and national data, an increase in 'death by suicide' cases.

Figure 5: Categorisation of child death reviews 2015/16

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



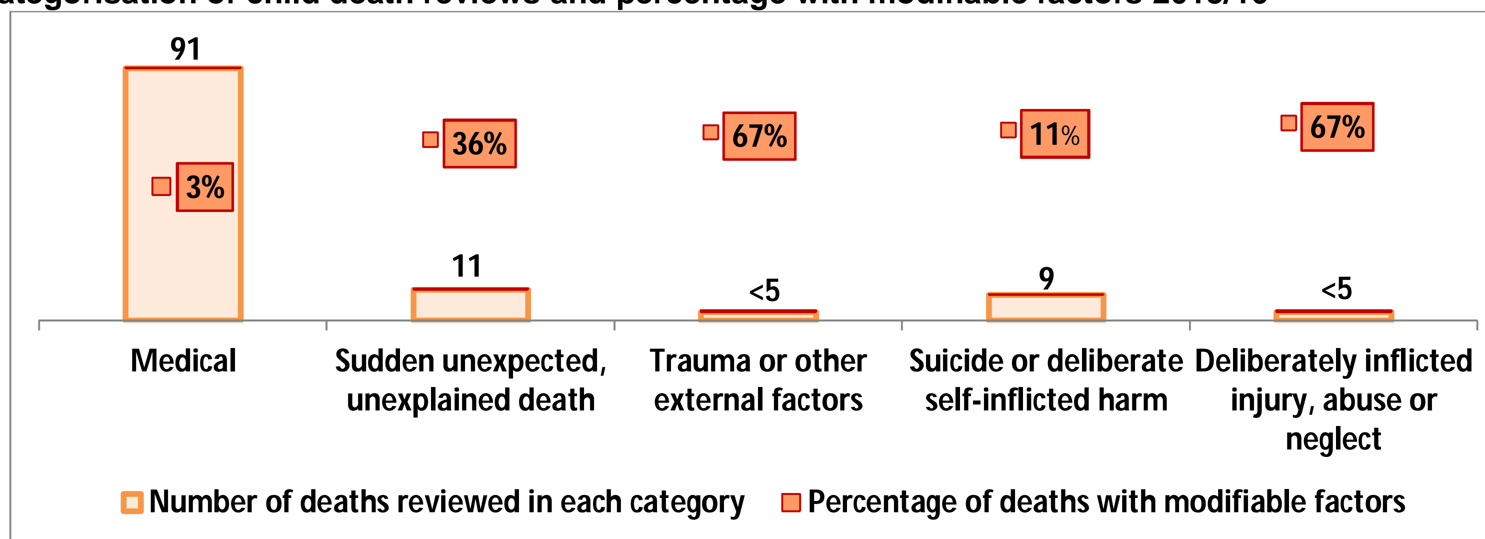
The "Medical" category includes perinatal/neonatal event; chromosomal, genetic and congenital abnormalities; infection; malignancy; acute medical or surgical condition; and chronic medical condition

Source: 4LSCB

Modifiable factors

From the 117 cases reviewed across the 4LSCB area, in only 12 cases (10%) were modifiable factors identified. These included alcohol/ substance misuse, smoking in the household, emotional/ behavioural/ mental health conditions in the parent/ carer, domestic abuse, poor parenting/ supervision, child abuse/ neglect and poorly managed long term health conditions. Figure 6 shows the numbers of reviews by category of death together with the proportion of that category which had modifiable factors. Over three quarters of the 117 deaths reviewed (78%, 91) can be classified as being in the medical[2] category. Although slightly lower this is similar to the national proportion of 81% of deaths reviewed with a medical factor. Whilst death reviews with a medical label accounted for the largest category, they had the lowest percentage of modifiable factors. Trauma and deliberately inflicted injury, being categories most likely to be modifiable, are areas that warrant further exploring and need to be prioritised for action. The distribution of category of death and proportion of modifiable factors across the 4LSCB is consistent with that observed nationally.

Figure 6: Categorisation of child death reviews and percentage with modifiable factors 2015/16



Source: 4LSCB

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

Expected and unexpected deaths

Working Together 2015 defines an unexpected death as 'the death of an infant or child which 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 continues to emphasise the focus on responding rapidly when a child dies unexpectedly. There are established locally agreed 'rapid response' procedures for responding to unexpected deaths of children. *Together for Short Lives, 2012*[16] 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 occur.

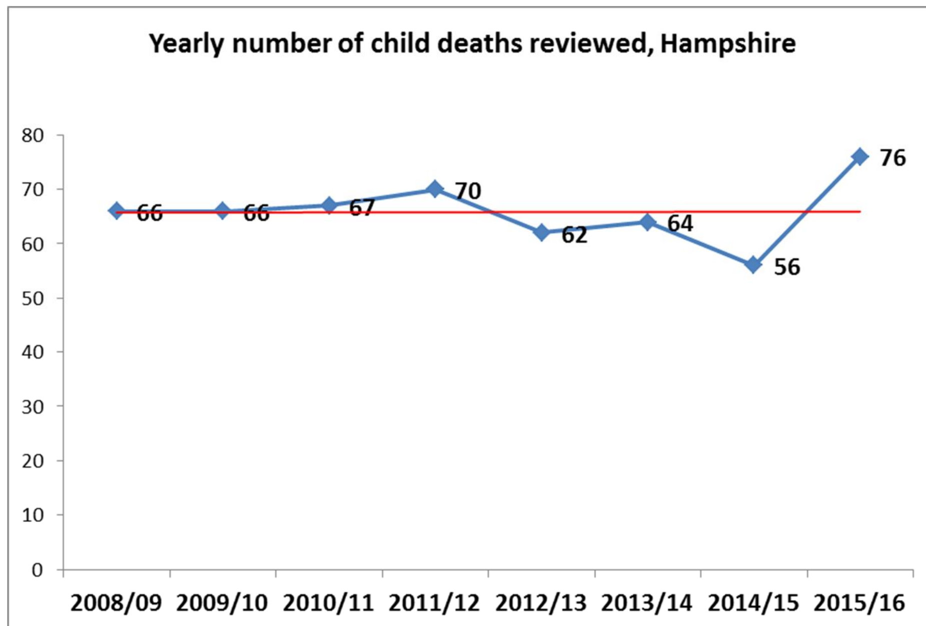
Approximately 63% of the child deaths reviewed in 2015/16 were expected and 37% were unexpected deaths. However we do not have any further analysis and do not know whether there is a difference in modifiable factors between the two groups of expected and unexpected deaths. This is something we will be addressing next year and recommending that panels build a consistent approach to assessing and understanding 'modifiable factors' when reviewing child deaths.

Individual CDOP summaries

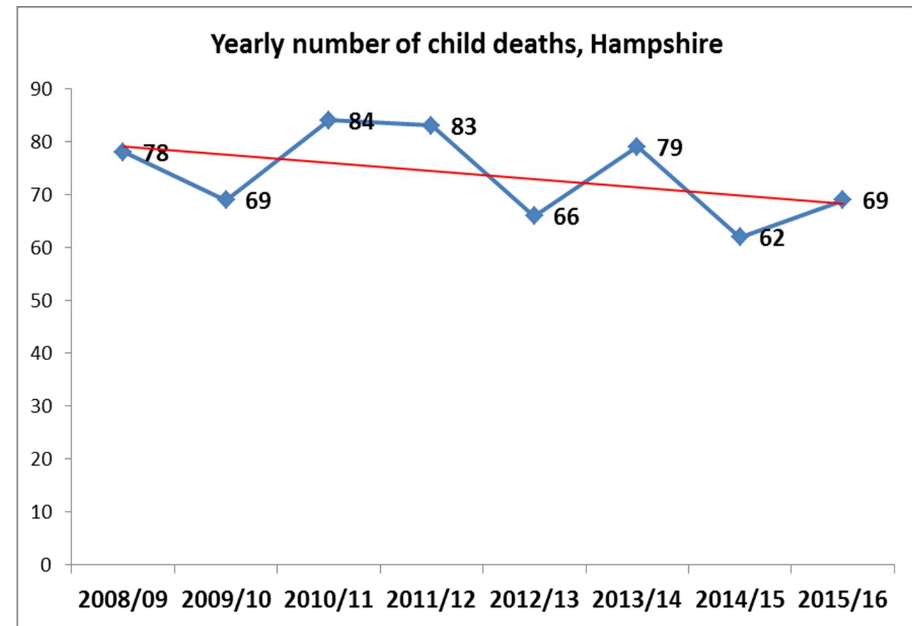
1. Hampshire

Analysis of the death reviews - There were 76 child death reviews completed in Hampshire in 2015/16. An attempt at correlating the trend in the number of child death reviews in Hampshire with the number of registered child deaths was made (see figure 7). Whilst there is a clear discrepancy between the number of children dying and the number being reviewed, the trend (red trend line) in reviews and deaths is similar. There is a need to ensure that all registered child deaths are reviewed in a timely manner.

Figure 7: Correlation between child death reviews and registered child deaths 2008/09 -2015/16



Source: Hampshire LSCB



Source: ONS Public Health Mortality Database

Since becoming four individual CDOPs, the Hampshire CDOP has made improving the quality and completeness of the information received from agencies a priority. Co-ordination roles have been established since November 2015 in all organisations to support frontline practitioners in completing the forms required by CDOP to undertake a comprehensive review and the co-ordinators quality assure information prior to submission. This has had a really positive impact on the review of cases and is expected to continue to improve further during 2016/17. However, there remain some gaps - the panel receives little information about fathers in regards to their health and social factors, with many CDOP forms coming through categorised as 'not known' in these areas. In a fifth of cases it was 'not known' if the child was an asylum seeker, around 16% of cases where it was 'not known' if a child was on a current or previous child protection plan and another one in five cases (20%) where it was 'not known' if there was a current or previous statutory order. Local area deprivation is rarely captured.

Notifications of expected deaths when the child is born with a life limiting condition (Form As) can be patchy as they are not routinely sent in a timely manner to the CDOP for review. Quite often expected deaths are notified by one particular NHS Trust or in some instances by the Registrar of Births, Deaths and Marriage. To address the issue of poor quality and non-completion of CDOP forms that are so vital to delivering a comprehensive review of child deaths, we are planning to tailor the CDOP forms for agencies to complete will assist in the quality of information being provided as the forms will have more relevance to the completing agency. In contrast the process for undertaking a rapid response when a child dies unexpectedly looks in greater detail at these deaths and generates better quality data.

A short pre-CDOP meeting is held with the Designated Doctor and Hampshire Safeguarding Children Board (HSCB) business unit to review the information received from agencies and identify any gaps to ensure that the panel has comprehensive information on all cases thus enabling a better quality review of child deaths. In this way the Designated Doctor is also prepared for their role within the CDOP meeting in regards to specific cases and any background work that might be needed.

As shown in the graph in figure 4 (page 14) the majority of child deaths are in babies in the neonatal period. During 2015/16 Hampshire's CDOP identified a neonatologist to attend panel meetings two or three times a year when the majority of neonatal deaths will be reviewed so that the panel has additional specialist input and support to the discussion of these cases. Specialist input was also provided to inform the debate on 'deaths by suicide' from a Public Health Consultant. An audit undertaken in Hampshire was described and information on factors associated with these deaths was shared.

To ensure effective local learning, an overview of the role of the Coroner's office and how families are supported through the inquest process was presented at a panel meeting. An opportunity to attend an inquest was also extended to members.

Presentations have been made to various agencies including Primary and Special School heads and named professionals within health to explain the role of CDOP and raise awareness of the importance of providing complete, accurate and timely information through completion of the CDOP forms. A programme of presentations is planned for 2016/17.

In future, use of a local CDOP data base will help track and monitor emerging themes. This database was designed by Hampshire County Council specifically to meet the individual needs of CDOP.

Over the next year the CDOP plans to focus on suicide and neonatal deaths.

Staffing issues - Until November 2015 CDOP was staffed with only an administrator. Since the separation of the 4LSCB CDOP Hampshire's CDOP has been supported by both an administrator and Learning Reviews and Stakeholder Engagement co-ordinator.

Backlog of cases - At the start of 2015/16 a significant number of cases were outstanding from previous years. These have been reduced dramatically in year and it is expected that all outstanding cases will have been reviewed by Autumn 2016.

Number of times CDOP has met to review cases – The 4LSCB partnership met twice between 1 April 2015 - 31 October 2015. From 1 November 2015 – 31 March 2016, the Hampshire CDOP met three times.

2. Isle of Wight

Eight child death reviews were completed across the Isle of Wight (IOW) in 2015/16 and there were less than five registered deaths.

The Isle of Wight Safeguarding Children Board (IOWSCB) took responsibility for CDOP in November 2015 following a review of the 4LSCB arrangements. This was as a consequence of the LSCB review undertaken by Ofsted as part of the single inspection framework published in November 2014.

All cases discussed at panel had been expected deaths due to medical issues or prematurity and no modifiable factors were identified. There was a greater preponderance among girls. There were no deaths reviewed in which a Statutory Order had been in place at the time of the child's death, where the child was an asylum seeker or subject to a child protection plan. Most of the child death reviews were categorised as perinatal/ neonatal events. The case not yet reviewed has been subject to a serious case review and the inquest is awaited before completing the CDOP process.

The CDOP has had discussions about preterm baby deaths and agreed with the Head of Midwifery who is a CDOP member to trial a maternity information form to look at lifestyle choices and other environmental factors during pregnancy such as smoking or domestic abuse in more detail. This would identify any possible modifiable factors during pregnancy that could be the focus for Public Health or Midwifery health promotion work to improve health and social care provision.

Joint areas of work have been agreed across the 4LSCB areas around self-harming and suicide. Although there have been no suicides on the IOW, there is a concern about the growing number of self-harming incidents being reported at the emergency department.

A booklet has been produced for parents and families on CDOP processes which it is hoped will provide necessary information and enable them to ask questions about the process if they need to.

Staffing issues - No staffing issues have been identified. The team were well prepared through discussions and planning at the serious case review group and had a good information and systems handover with Hampshire staff. There has needed to be a culture shift for some staff in partner agencies being responsible for completing Form Bs but this has now resolved itself.

The business unit senior administrator responsible for the administration of CDOP has set up robust systems and records and ensures that all cases are processed in a timely way. The business co-ordinator and senior administrator meet with the Designated Doctor for a short meeting before each CDOP to review the cases for discussion. This enables them to pre-populate parts of Form C and seek clarification where needed. In this way the Designated Doctor is also prepared for their role within the CDOP meeting with regards to specific cases and any background work that might be needed.

Backlog of cases - There was a small back log of cases at the point of transfer in November 2015. These were due largely to the information from mainland hospitals needing to be chased before it was forthcoming.

Attendance issues – There is good attendance from a range of professionals on the IOW CDOP including representation from the Coroner's office and the Ambulance Service. There have been some issues regarding the chairing of the CDOP. The first meeting in November 2015 was chaired by the Area Director and the second one by the Police.

Number of times CDOP has met to review cases - The IOW CDOP has met twice between November 2015 and March 2016. At the November 2015 meeting, two cases were discussed as well as finalising the terms of reference for this newly formed group, and discussing forthcoming training for new members.

3. Portsmouth

Portsmouth Safeguarding Children Board (PSCB) took responsibility for CDOP in October 2015 following a review of the 4LSCB arrangements.

Tragically there were nine child death reviews completed in Portsmouth in 2015/16 and 10 registered child deaths. PSCB extends their sincere condolences to the families of all these children. Girls' deaths accounted for a greater preponderance. There were no deaths reviewed in which a Statutory Order had been in place at the time of the child's death or where the child was an asylum seeker. Children were subject to a child protection plan in less than five cases. During the period of review six deaths were unexpected.

Compared to other LSCB areas, the number of child deaths in Portsmouth in 2015/16 are small. Therefore no themes or trends were identified connected to the deaths that the Portsmouth CDOP has reviewed. Seven of the reviews completed were of children who died under the age of five. Five deaths were in the first 2 quarters of the year and six in the final quarter. Of the cases reviewed by the Portsmouth panel none had any modifiable factors.

Staffing issues - This has been a steep learning curve for the whole panel but the process is becoming more familiar and the panel is reflecting on the way each case is reviewed to enable this to be done more efficiently whilst maintaining the sensitivity required.

Backlog of cases - 8 cases were handed over to Portsmouth CDOP in October 2015, of which 4 still required a review. As of 31st March 2016 there were nine cases to be reviewed. Since then the panel has met twice and the backlog has reduced to five. One of these includes an ongoing serious case review.

Attendance issues - There is good attendance from a range of professionals on the Portsmouth CDOP.

Number of times CDOP has met to review cases - The Portsmouth panel met twice during the reporting year, in October and March. The first meeting agreed the terms of reference for this newly formed group and formed a training exercise. 1 case was were reviewed in January.

4. Southampton

As the title of this report suggests, every child is a tragedy. The Southampton LSCB sends condolences to every family affected. During 2015/16 tragically there were 16 reported deaths of children normally resident in Southampton. In each of these cases the Southampton LSCB were notified of the case as detailed in statutory guidance, *Working Together 2015*. The cases were then referred to CDOP for review as appropriate.

It has been reported earlier in this document that 24 child death cases from Southampton were reviewed during the period covered by this report. As also explained, the reviews of cases during this year were split between a 4LSCB CDOP arrangement and the new Southampton only arrangement that was created in November 2015. Of the 24 reviews, 15 related to children that had tragically died during previous years and reporting periods. Nine reviews related to children that had died during 2015/16. There was a need to obtain further information to inform the CDOP review for a number of cases during this year and as such findings from these cases will be reported with the 2016/17 annual report. The Southampton LSCB experienced the issue of out of area death notifications and worked collaboratively across more than one LSCB area.

A summary of the findings in the 24 cases child death cases reviewed is as follows:

- Fifteen of the cases were expected deaths, nine were unexpected.
- Thirteen of the children were male and eleven were female.
- Six of the children died within 27 days of birth and a further seven children died in their first year of life. Less than five children were aged between one and four years old, between five and nine years and between fifteen to seventeen years old, each at the time of their deaths.
- In terms of child protection, less than five cases had statutory orders made. In a higher numbers of cases this is recorded as unknown. The immigration status of the child was also unknown in many cases, with eleven cases where the child was not an asylum seeker. Under the revised Southampton managed arrangements this information is always sought and recorded prior to the case being reviewed.

There were no modifiable factors found within the majority of cases reviewed during this financial year. However, an identified modifiable factor was ‘management of frequent attendance in a certain period of time’.

Chromosomal, genetic and congenital anomalies were the most frequently identified category with perinatal/neonatal death the second most identified. Sudden, unexpected and unexplained death was the third most frequent category identified. Other categories recorded in lower numbers included malignancy and acute medical or surgical conditions, chronic medical conditions, suicide or deliberate self harm and deliberately inflicted injury, abuse or neglect were also recorded as categories of death.

Further actions taken as a result of CDOP reviews:

Less than five of these cases were referred to Southampton LSCB for consideration of serious case review with one of these agreed as meeting the criteria – this resulted in a serious case review and subsequent learning being identified by the LSCB. The LSCB decided to instigate and deliver a thematic review in 2016 in relation to self harm and suicide following on from issues identified among the referrals.

Southampton's CDOP were also advised that the Princess Anne Neonatal service has developed an outreach service to ensure, in line with recent National and local Commissioning drivers, they encourage early discharge from the neonatal unit into community care. However, a small cluster of deaths in babies shortly after discharge, prompted questions regarding the safety of the current practices. A review of the cases indicated that care and decision making was in line with accepted national and international practice. As a failsafe, however, the neonatal service has decided not to discharge babies before 34 weeks corrected gestation and to ensure that babies clearly demonstrate a period of physiological stability prior to discharge. In addition for babies with on-going complex needs the service has established a protocol of active referral to a named general paediatrician prior to discharge to enhance continuity of care if an admission to the paediatric wards becomes necessary. Going forward the CDOP panel plan to monitor neonatal deaths to ensure no further actions are indicated and whether there is any learning that would have national importance.

Staffing and attendance issues - During the period of 1st November 2015 – 31st March 2016, the CDOP group met four times. The Panel was well staffed, with good attendance from all relevant professionals including experts in neonatal care, the area's designated doctor and nurse and relevant safeguarding or service leads. Training was also provided to the group to ensure that they fully understood the CDOP processes. The group has also identified training needs for those completing information for the process and offered support and advice to ensure that the relevant information is available.

In 2016-17 CDOP anticipate meeting on a quarterly basis, though retaining flexibility to increase frequency if necessary. Mindful of the Government's review into the work of CDOP, the group also intend to work ever more closely with CDOP panel's across the Hampshire and Isle of Wight area, comparing data and raising issues of mutual interest or concern so that we are better able to identify earlier any modifiable factors within such tragic events to prevent future deaths.

In addition, the Chair of CDOP in Southampton is working with the cross Hampshire working party to assist in developing a sustainable solution for the monitoring of mortality within the area. This work should bring improvements by identifying any modifiable factors across care, support and treatment that could improve outcomes for the wider community.

Conclusion and recommendations

Several issues have emerged from the review of child deaths by the CDOPs that if addressed would help safeguard children and reduce child deaths across the 4LSCB area. Many of the identified themes below come from learning identified within the Hampshire LSCB. This is because the low numbers of child deaths across the Unitary Authorities can make it challenging to identify themes from the child deaths reviewed. The *Wood Report* also highlighted the issue of small population sizes limiting the ability to draw valid inferences from the data on child deaths being reviewed. In view of this, the implications of continuing individual CDOPs within the current configuration need to be considered, against the option of a flexible 4LSCB arrangement.

CDOPs have a role to identify factors in child deaths for action within the system by the representative membership agencies within the 4LSCB partnership and the HSCB.

The findings of this report in regards to CDOP issues identified in 2015/16 are grouped into lessons learnt from the reviews and those regarding the CDOP process:

<u>Lessons from the analysis of child death reviews</u>

Over the year the following themes were identified in the death reviews and so work is needed to identify how we can intervene to reduce the number of deaths in these categories:

- Neonatal deaths
- Co-sleeping and SUDI, especially where the parent has consumed alcohol or drugs
- Self-harming, teen suicide and implementation of the *Suicide Prevention Plan*
- Sudden unexpected death in epilepsy (SUDEP)
- Addressing modifiable factors in ‘trauma’ and ‘deliberately inflicted injury’ categories of death

Lessons regarding the CDOP process

- It is clear that the quality of reviews needs to improve with much more focus on completing the forms (in particular father's details, ethnicity, asylum seeking status, whether children were on a child protection plan or subject to any statutory orders, deprivation status). This has been raised in previous CDOP reports and whilst we have made some good progress in improving our data reporting processes, issues regarding data completeness, timeliness and quality remain.
- Support parents and families by developing literature on CDOP processes.
- Ensure representation of specialist staff at CDOPs for a more comprehensive review of child deaths.
- Improve learning and dissemination of good practice through continuous professional development including refresher and multi-agency training.

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 2016/17 outlined below:

4LSCB CDOP priority areas for action for 2016/17:
Priorities are grouped into themes relating to the reviews of the child deaths and themes to improve the working of the panels:

Themes related to child deaths

- From the modifiable factors identified, maternal smoking in pregnancy and/or household smoking featured in a number of child death reviews and it is probable that some of these deaths could have been prevented if there were lower smoking rates in the population. Efforts to reduce smoking rates must continue to prevent future child deaths.
- Emotional/ behavioural/ mental health condition in the parent/ carer was another modifiable factor identified and interventions to promote the mental health and wellbeing of families and good parenting is likely to have persistent later life effects. This is not only about health service provision, but also the wider socio-cultural context. It is not only about ensuring every pregnant woman is provided with good pre-conceptual and antenatal care, but also about the role of father's in ensuring the best start to a child's lifelong aspects of health and well-being, foundations that start in the womb.

- ‘Deaths by suicide’ have highlighted the need for joined up working on suicide and self-harm across the 4LSCB area. The CDOPs need to continue to contribute all suitable information to suicide audits to help understand the local picture about those most at risk, the context to suicides and thus target suicide prevention strategies appropriately.
- Child deaths from epilepsy were identified as an area of concern in Hampshire and the CDOP will be bringing this finding to the attention of NHS commissioners. Commissioners need to review local epilepsy clinical network service provision - *The Children’s Hospitals Network* [17](CHN) across the Thames Valley and Wessex region, so that access to specialist paediatric epilepsy nursing, care planning, self-management and transition programs, ensures optimal management and prevents child deaths due to epilepsy. Additionally, joined up working with community services including GPs and the School Nursing Service are integral to supporting children with epilepsy. This would also be applicable to other long term conditions such as diabetes and asthma. The CDOP needs to monitor the situation on child deaths from epilepsy and ensure that it receives an update on progress from NHS Commissioners.

<u>Themes around improving the working of the panels</u>

- Work over the year has identified the need to improve the quality of the CDOP process. There is a requirement to strengthen and consolidate data reporting processes by ensuring all agencies have systems in place to achieve complete data, timely return of CDOP forms and quality information to improve child death reviews. Introducing a process for completing a case summary prior to the panel would allow more time for case discussion. Panels need to build a consistent approach to assessing and understanding ‘modifiable factors’ when reviewing expected and unexpected child deaths. Importantly the interface with individual CDOPs needs to improve to ensure timely and consistent data submission when compiling the CDOP Annual Report.
- The challenges around identifying themes from child death reviews in the Unitary Authorities highlights the need for a generic approach to sharing learning across the 4LSCB CDOP panels. This includes encouraging innovative and efficient practice in reviewing child deaths that needs to be disseminated across agencies. Practice can be quality assured through joint audits of case files.
- It is clear from the child deaths reviewed during this transition year that in order to ensure robust and consistent data, effective collaboration between individual CDOP panels needs to be strengthened. This would also ensure maintaining the confidentiality of information.

- Utilising local databases to capture information regarding all child deaths referred to Panel will support the CDOP Annual Report, allow monitoring of emerging themes and facilitate information requests from the DfE (currently this is done manually and severely limits meaningful data analysis).
- The identification of emerging themes needing specialist expertise highlights the need for more specialist input to CDOPs, for example from a Neonatologist, Coroner, Public Health expertise on suicide prevention and self-harm.
- There is a need to improve multi-agency working in regards to addressing difficulties in sharing child death information each bringing to bear the intelligence and information they hold, for example, that a death has occurred and the factors around the death.
- Prioritise implementing the findings of the *Wood Report* on good practice for CDOPs.

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