4LSCB CDOP Annual Report Summary 2016/17

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 their area. There are four CDOPs across the 4LSCB area; Hampshire, Isle of Wight, Portsmouth and Southampton.

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.

Progress on the priority areas for 2016/17

Maternal smoking in pregnancy and/or household smoking: Supporting efforts to reduce smoking rates in the population and influence women to engage with services

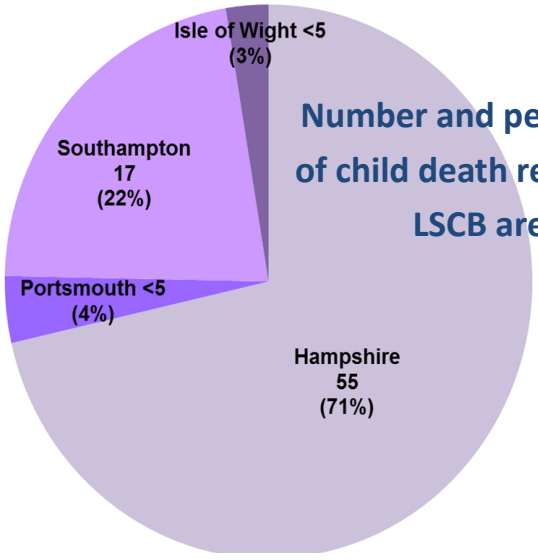
Emotional, behavioural and/or mental health condition in the parent/carer: Promoting ongoing wider partnership working with multiple agencies including Health and Social Care

'Deaths by suicide' : Contributing information to suicide audits; thematic review regarding online safety linking to self-harm and suicide

Child deaths from epilepsy and deaths due to other long term conditions (LTC): Joined up working, highlighting greater risks of a child with a LTC living in chaotic households

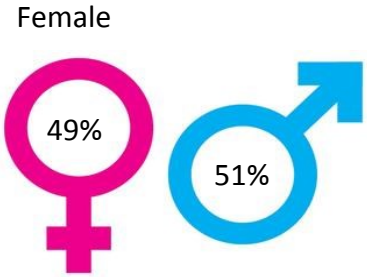
In the 4LSCB during 2016/17

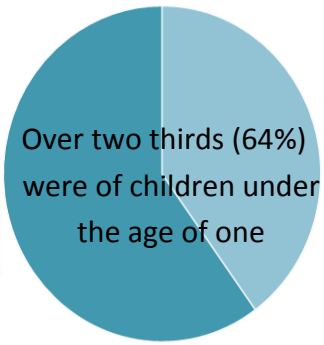
401,892	101	76	24
under 18s (0-17 year olds)	Child deaths	child death reviews completed	Ongoing reviews



Number and percentage of child death reviews by LSCB area

Of reviews completed





2016/17

N.B. The reported figures provide an overview of CDOP arrangements across Hampshire, Isle of Wight, Portsmouth and Southampton and are supported by qualitative analysis and assessment

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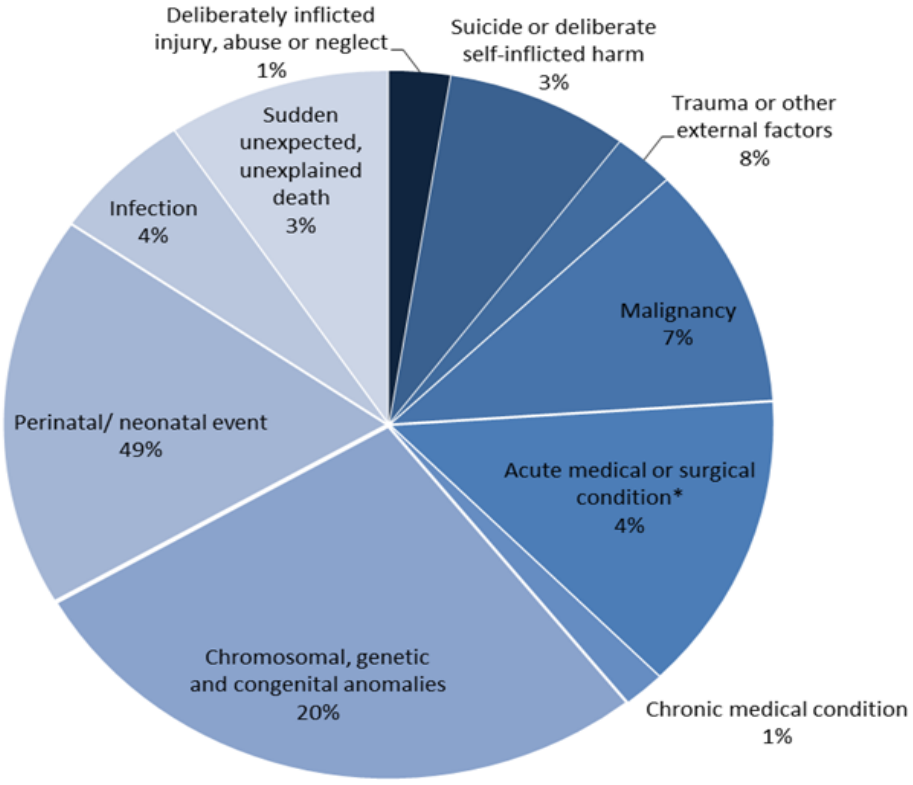
Categorisation of child deaths reviewed in 2016/17



Modifiable Factors

Of the 76 deaths reviewed across the 4LSCB area, 25 were noted as having one or more modifiable factors that may have contributed to the death of the child.

Priority Areas for action in 2017/18

Maternal factors; tackling smoking in pregnancy and/ or household smoking, and maternal obesity	Further delvelop the CDOP database to enable innovative and insightful analysis	Implementation of the new "Working Together to Safeguard Children" arrangements
Child safety	Continue to focus on improving multi-agency working in regards to addressing difficulties in sharing child death information	Clinical practice
Public health interventions	Improve the notification of child deaths and quality of the CDOP process	Social inequalities

To view the full report and find out more about the CDOP process, please go to www.iowscb.org.uk; www.hampshiresafeguardingchildrenboard.org.uk; www.southamptonlscb.co.uk; www.portsmouthscb.org.uk