Learning from Child Death Reviews

The Hampshire, Isle of Wight, Portsmouth & Southampton 4LSCB
CHILD DEATH OVERVIEW PANEL (CDOP): Annual Report 2018/19

1. Foreword

The Local Safeguarding Children Boards (LSCBs) of Hampshire, the Isle of Wight, Portsmouth and Southampton (collectively known as the *4LSCB area; see Figure 1*) would like to extend condolences to all families, carers and communities affected by the pain of a child death. It would like to thank professionals within the 4LSCB areas that work and support families during this difficult time.

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

Child deaths are tragic, and thankfully rare, and it's important that we take the opportunity to learn from these devastating events. Comprehensive reviews of child deaths (undertaken by LSCBs) serve a valuable public health function: by investigating what happened and why, and identifying common themes where possible, we can help improve the quality of health and social care, which informs inter-agency child-safeguarding work and promotes child welfare, ultimately to prevent future deaths.

This report covers all registered and reviewed child deaths in the 4LSCB area during 2018/19. The Hampshire LSCB leads on collation of the 4LSCB CDOP Annual Report, with all LSCBs providing their data and information in an agreed format. Subsequent to the child death reviews conducted in 2018/19, the LSCBs have identified areas requiring targeted action and have developed recommendations to help prevent future tragedies.

2. Executive Summary

The death of a child is a profound, difficult, and painful experience. By highlighting lessons learned through child death reviews, we can provide opportunities to prevent future deaths. This report covers child death reviews conducted in the 4LSCB area during 2018/19.

Globally, children under one year of age (i.e. infants) face the highest risk of death, with babies aged between 0 and 27 days (i.e. neonates) being especially vulnerable. The Infant Mortality Rate (IMR) in the UK has risen for the third consecutive year, to 3.9 deaths per 1,000 live births in 2017 – a statistically significant increase relative to 2014. Continuation of this trend will lead to the UK IMR being 140% higher than that of other comparably wealthy countries by 2030.

The IMR for the 4LSCB area has typically been lower than the national average since 2001. However, in line with the national picture, a general upward trend in IMR in the LSCB area has been observed since 2013 – particularly in Southampton, where IMR increased to 4.7 deaths per 1000 live births for the latest 2015-17 three-year period, overtaking the national average. This is likely to reflect the higher levels of deprivation in Southampton compared to England overall (2015 IMD deprivation scores being 26.9 and 21.8, respectively). However, these figures need to be interpreted with caution because the IMR is a crude rate that is not adjusted for factors such as sex, ethnicity and socio-economic status, and is based on small numbers of child deaths, which means the rates are subject to large annual variation.

The association between deprivation and poor health outcomes is well established. In 2017, IMR was highest in the most deprived areas of England, at 5.2 deaths per 1000 live births, and lowest in the least deprived areas, at 2.7 deaths per 1000 live births. Worryingly, the gap between most and least deprived deciles has only narrowed slightly since 2010. Local deprivation patterns are an important consideration when formulating LSCB plans to prevent future child deaths; initiatives should be proportionate to need, targeting the most vulnerable groups as a priority.

2.1 Key findings

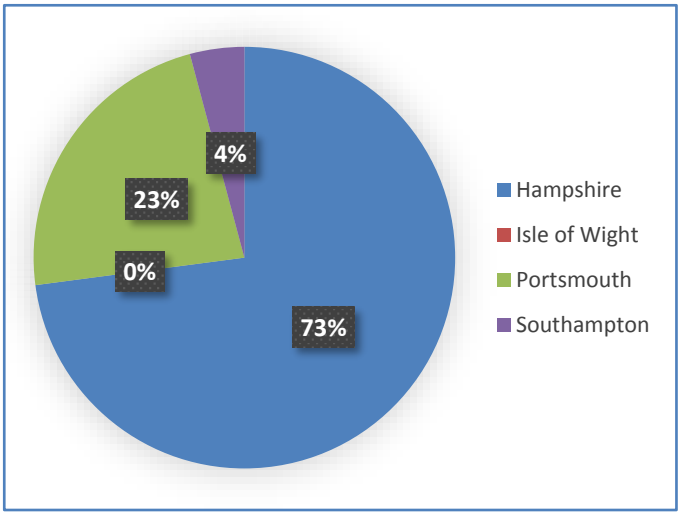
In the 4LSCB area during 2018/19:

- 403,749 under 18s (0-17 year olds) were estimated to be resident;
- 75 child deaths were registered;
- 48 of the 75 deaths registered (64%) were reviewed; and
- 27 of the 75 deaths registered (36%) are awaiting review.

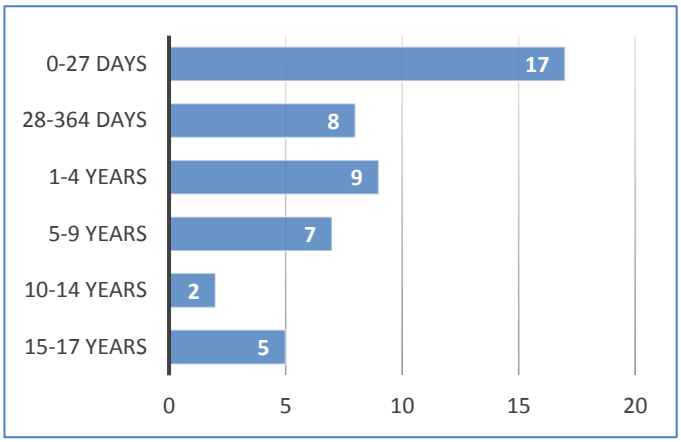
Due to the proportion of outstanding/ongoing death reviews (36%), the report findings may not be representative of all child deaths registered in the 4LSCB area in 2018/19.

2.2 Characteristics of Child Death Reviews

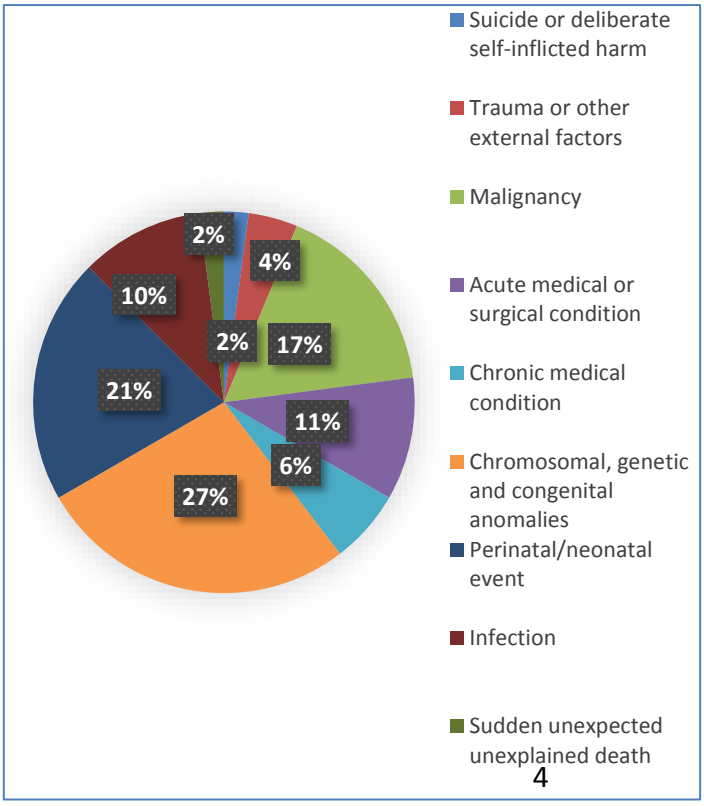
- As shown in the adjacent pie chart, Hampshire CDOP (supporting the most populous LSCB area) completed the most child death reviews, accounting for 35 (73%) of the 48 4LSCB child death reviews in 2018/19. The small numbers of child death reviews completed in the Isle of Wight, Southampton and Portsmouth mean that local themes could not be drawn out; hence any themes described herein relate to the 4LCSB area overall.



- Approximately half (52%) of completed child death reviews were for children who died in the first year of life.



- Category 7 (Chromosomal, genetic and congenital anomalies) accounted for 27% of child death reviews and was therefore the most frequently cited category of death.
- Only 11 out of 48 (23%) child deaths reviewed were noted as having one or more *modifiable factors*[*] that may have contributed to the death of the child. 27 modifiable factors were identified in 2018/19.
- Approximately 73% of deaths were expected and 27% were unexpected.



[*]Factors which may have contributed to the child's death, which could potentially be modified to reduce the risk of future deaths.

2.3 Update on 2017/18 CDOP report recommendations

Progress against the recommendations from the 2017/18 CDOP annual report has been challenging for all the areas. The previous report formulated recommendations on ‘safe sleeping’, ‘language barriers’, ‘bereavement support’, ‘maternal smoking and obesity’ and issues with ‘CDOP processes’.

Progress on ‘safe sleeping’, ‘language barriers’, ‘bereavement support’, ‘maternal smoking and obesity has been variable, with improvement in some actions but falling short in others, thus needing re-endorsement. Some of the CDOPs have made concerted and effective improvements against the recommendation on issues with ‘CDOP processes’.

2.4 Recommendations for 2018/19

Relevant recommendations for 2018/19 on action required to help improve the health, care and safety of children living in the 4LSCB areas have been drawn out from themes identified in 2018/19 CDOP annual report. Most of these themes and corresponding recommendations on ‘smoking’, ‘maternal health’ and ‘safe sleeping’ are re-endorsements of previous recommendations.

3. The 4LSCB CDOP Annual Report 2018/19 - Purpose, Scope and Limitations

3.1 Purpose

The aim of this annual report is to collate, analyse and present data provided by the 4LSCB CDOPs on child deaths registered and reviewed between 01 April 2018 and 31 March 2019.

Aggregated findings on child deaths determine recommendations/actions on how best to safeguard and promote the health and welfare of children across Hampshire and the Isle of Wight. These findings will later inform local strategic planning, including the local Joint Strategic Needs Assessments.

3.2 Scope

The report begins by considering national child mortality trends and guidance from relevant professional bodies. A descriptive analysis of 4LSCB child death reviews which is the core purpose of the report is then presented, including a review of modifiable factors and identification of key themes. Reporting is on an aggregated level, with small-number suppression (where possible) to ensure that individual children and their families are not identifiable from the information published. Individual LSCB analyses are provided in the next section. An overview of current and future statutory arrangements concerning the child death review process follows and the report concludes with emerging themes and recommendations for 2018/19, as well as an update on progress against recommendations from the 2017/18 CDOP Annual Report.

3.3 Limitations

There has been considerable improvement with respect to the quality of information submitted to CDOPs. However, in some cases, the information received is incomplete and inconsistent, potentially due to inter-agency difficulties and delays in sharing child death information, inconsistencies in death classification between CDOPs, and variations in death certification. Consequently, gaps in our knowledge remain, leading to incomplete learning.

Secondly, there will always be a discrepancy between the number of children *dying* in a year, the number of deaths *registered* in that year (‘Registered Deaths’) and the number of child deaths *reviewed* in the same year. The review of a child’s death by the CDOP occurs at the very end of the process; hence, review backlogs can arise due to delays in registering deaths (for example, due to specialist post mortem, forensic toxicology, police investigation, and the time it takes to obtain the necessary information from all agencies involved) and post-registration, for example, if the death is the subject of a criminal investigation, serious case review (SCR) or if there is a safeguarding element. Death registration delays mean that some deaths may have occurred months or even years earlier but were only *registered* in 2018/19.

Thirdly, as the annual number of child deaths for the 4LSCB area is (fortunately) small, this gives rise to random (chance) variation in the annual numbers of deaths, making it difficult to identify statistically significant trends, or make valid comparisons with datasets from previous years.

It should finally be noted that the information in this report is (unavoidably) weighted towards Hampshire, as at 70%, it has a significantly larger child population than the Isle of Wight, Portsmouth and Southampton and consequently undertook the largest number of child death reviews within the 4LSCB area in 2018/19. The small numbers of child death reviews in the Isle of Wight, Portsmouth and Southampton CDOPs mean that meaningful local themes could not be drawn out. Thus, any themes identified in the report are largely based on Hampshire data, but are presented as collective themes for the 4LSCB region.

4. National Trends in Child Mortality and Professional Body Guidance

In June 2019, the Office for National Statistics (ONS) published their annual statistical bulletin on *Child Mortality in England and Wales: 2017*[1] which discusses stillbirths, infant and childhood deaths, and associated risk factors.

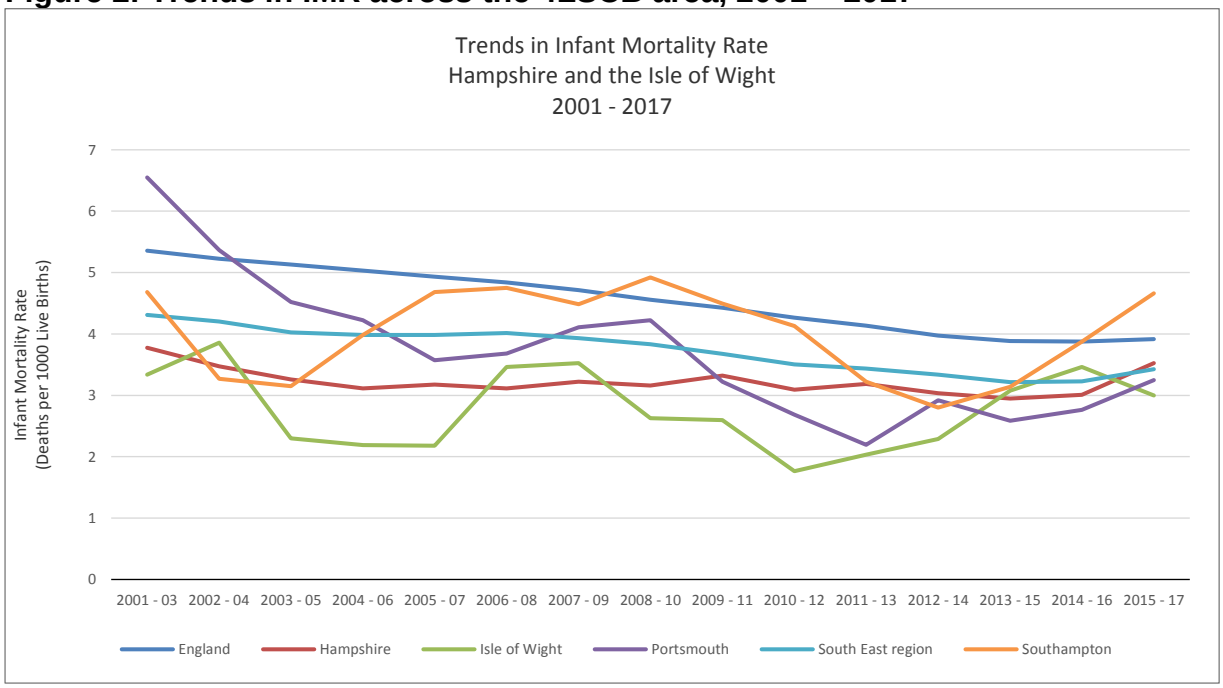
In line with 2016 trends, neoplasms (i.e. cancers) remain the most common cause of death for children aged between 1 and 15 years, accounting for 26.4% of deaths in girls and 24.3% of deaths in boys in 2017.

Despite fewer absolute numbers of infant deaths in England and Wales in 2017 compared with 2016, 2.5% fewer live births in 2017 have resulted in an overall *increase* in the IMR, from 3.8 deaths per 1,000 live births in 2016 to 3.9 deaths per 1,000 live births in 2017. Although the change from 2016 to 2017 does not constitute a statistically significant increase, the 2017 figures *are* statistically significant relative to 2014 when IMR was 3.6 deaths per 1,000 live births.

In their 2019 *Prevention Vision for Child Health*[2] (written in response to the Government's proposed Green Paper on prevention) the Royal College of Paediatric and Child Health (RCPCH) has noted that this is the third consecutive year of IMR increases, and that if the current trend were to continue as is, by 2030 the UK IMR would be 140% higher than that in comparably wealthy countries.

Trends in IMR across the 4LSCB area between 2001 – 2017 compared with IMR for England over the same period, are presented at Figure 2 below. These are Public Health England (PHE) data and use three-year rolling-average data points to take account of the small numbers involved.

Figure 2: Trends in IMR across the 4LSCB area, 2001 – 2017

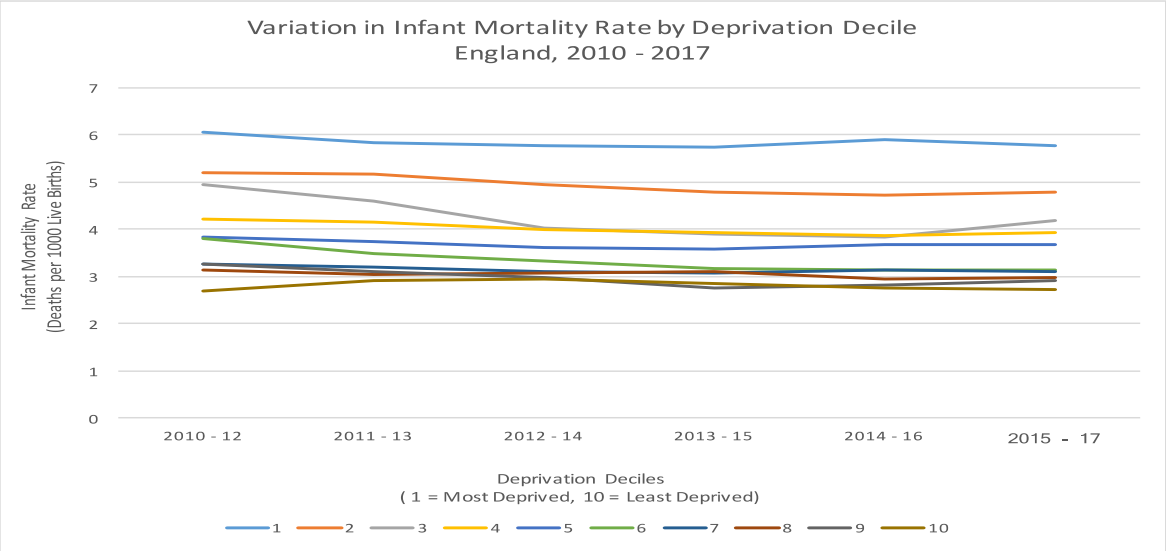


Source: PHE

A general upward trend in IMR can be seen both across the 4LSCB area and nationally since 2013-2015, except for the Isle of Wight, which has seen a decrease from 3.5 (2014-16) to 3.0 deaths per 1000 live births (2015-17). Over 2001-2017, IMR has been (on average) lower than the national average for all 4LSCB areas in general. However, in the case of Southampton, it has fluctuated, with rates sometimes higher than the national average and at times significantly lower. The latest Southampton data suggest a steep increase from 2.8 (2012-14) to 4.7 deaths per 1,000 live births (2015-17), overtaking the national average of 3.9 deaths per 1,000 live births (2015-17). However, there is a high level of uncertainty in IMR trends due to the effect of small numbers of child deaths and so the data need to be interpreted carefully. A reconciliation exercise between Local Authorities' Public Health Mortality (PHM) dataset, accessed from NHS Digital's Primary Care Mortality Database (PCMD)[a] and PHE data may help ascertain if the upward trend in IMR is a true increase or is due differences in coding practices.

The RCPCH have also noted that children and young people in the UK presently have amongst the worst health outcomes and inequalities in the developed world. Consequently, one of the RCPCH's overarching priorities for prevention is tackling inequalities, focusing on the most vulnerable, as children who live in deprived households are more likely to have poorer health outcomes. Indeed, in the (aforementioned) 2017 ONS annual statistical bulletin on child mortality, IMR was highest in the most deprived areas of England at 5.2 deaths per 1,000 live births, and lowest in the least deprived areas, at 2.7 deaths per 1,000 live births. Trends in IMR by deprivation decile for England, from 2010 to 2017 (where data points are based on 3-year rolling averages), are presented in Figure 3 below. (Note that for 2015-17, the gap between most and least deprived deciles has only narrowed slightly since 2010-12).

Figure 3: Trends in IMR by deprivation decile for England, 2010 - 2017



Source: PHE

[a] The PCMD is now managed by NHS Digital and is updated monthly using a file of death records from the Office for National Statistics

This concurs with the findings of Best *et al.*[3] who reviewed all single births in England, Scotland, Wales and the UK Crown dependencies between 1 January 2014 and 31 December 2015 and found that women from the most deprived areas were 1.67 times more likely to experience a neonatal death than those from the least deprived areas i.e. there were 231 additional neonatal deaths associated with deprivation. They also found that congenital anomalies accounted for most (59%) of the deprivation gap in neonatal deaths and recommended that public health interventions focus on addressing the socioeconomic determinants of congenital anomalies.

The socioeconomic gradient in infant mortality may be due to the link between increasing levels of deprivation and poorer maternal health. The RCPCH note that maternal health is imperative to the health outcomes of children, particularly in the early years, and that women should be supported from pre-conception through to the post-natal period. Indeed, the 2019 Health and Social Care Committee report entitled *The First 1000 Days of Life*[4], recommends investing further in the *Healthy Child Programme*, so that the programme begins prior to conception, extends home visits to beyond 2.5 years, and ensures that children/families receive continuity of care.

Regarding poor maternal health, the RCPCH's *Prevention Vision for Child Health* refers to obesity and gestational diabetes as being associated with an increased risk of infant death. Also, substance abuse (i.e. taking drugs and drinking alcohol), poor nutrition and smoking before and during pregnancy are associated with adverse outcomes for infants. Smoking is associated with low birthweight – one of the known risk factors for infant mortality. In 2017, the ONS reports that IMR was highest amongst low birthweight babies at 34.7 deaths per 1,000 live births, an increase of 5.8% from 2016.

According to the ONS and numerous other studies, mothers from routine[b] and manual occupations are less likely to breastfeed and more likely to smoke during pregnancy. In the UK, the smoking rate during pregnancy is higher than that in most other European countries; PHE statistics suggest that 10.8% of women smoked at time of delivery in 2017/18 in England. The DHSC *Prevention Vision*[5], published in 2018, recognises that quitting smoking before or during pregnancy is the 'biggest single factor that will reduce infant mortality' and suggests making smoking cessation a major priority. The RCPCH's *Prevention Vision for Child Health* goes further and recommends tailored smoking cessation programmes during pregnancy, with targeted support in areas of greatest deprivation.

[b] Routine occupations as defined by the National Statistics Socio-economic Classification (NS-SEC) terminology are: sales and service/production/ technical/operative/agricultural occupations

5. Descriptive Analysis of 4LSCB Child Death Reviews in 2018/19

5.1 Introduction

This section summarises and presents a descriptive analysis of all registered and reviewed child deaths occurring in Hampshire, the Isle of Wight, Portsmouth and Southampton during 2018/19. Collating data at the 4LSCB-CDOP-level facilitates identification of child death themes, to help prevent future tragedies.

For a contemporaneous analysis of child deaths, the report focuses on child death *reviews* completed during 2018/19, relating to children aged 0 to 17 years who were resident in the 4LSCB area and whose deaths were *registered* during 2018/19. Note that the 4LSCB child population (i.e. aged 0-17 years) during 2018/19 was 403,749 (see Table 1 below for breakdown by LSCB area).

5.2 Numbers of Child Deaths Reviewed in 2018/19

Table 1 presents child death reviews completed by the 4LSCB CDOPs in 2018/19. In 2018/19 there were 75 registered child deaths, and the total number of registered deaths *reviewed* by CDOPs was 48 (i.e. 64%), comprising: Hampshire (35), Isle of Wight (0), Portsmouth (11) and Southampton (<5). Thus, there are 27 (36%) ongoing/outstanding CDOP reviews for deaths registered between 01 April 2018 to 31 March 2019: Hampshire (15), Isle of Wight (<5), Portsmouth (<5) and Southampton (7).

In line with 2017/18, most child death reviews in 2018/19 were completed by Hampshire CDOP (73%), whilst Isle of Wight CDOP completed the fewest (once again reflecting the respective LSCB population sizes – Hampshire being the most populous, the Isle of Wight the least).

Table 1: Child Death Reviews Completed by 4LSCB CDOPs, 2018/19

LSCB area of residence	Population aged 0-17*	Number of child death reviews**	Percentage of total child death reviews	Number of registered child deaths
Hampshire	284,002	35	73%	50
Isle of Wight	24,869	≤5	0%	≤5
Portsmouth	44,046	11	23%	14
Southampton	50,832	≤5	4%	9
Total	403,749	48	100%	75

ONS 2018 mid-year population estimates; **4LSCB CDOP data.

5.3 Annual Numbers of Child Deaths Reviewed, 2008 - 2019

Over the past decade, there have been fluctuations in the numbers of child death reviews completed annually (see Table 2 below). A total of 987 child death reviews have been completed since establishment of the 4LSCB CDOPs in 2008/09. Although variations in the (small) numbers of child deaths occurring annually are likely to be due to statistical chance (i.e. random error), annual fluctuations in numbers of child death *reviews* completed are more likely the result of non-random error associated with the

child death review process, such as delays around receipt of necessary information/documentation and timing/attendance of panel meetings.

Although more deaths were reviewed (deaths from a previous year but only reviewed in 2018/19), in keeping with the report requirement for the death to have been registered and reviewed in the same year it appears that fewer child death reviews were completed in 2018/19 (48) than in 2017/18 (62). However, there were lower numbers of registered deaths in 2018/19 (75) compared with 120 in 2017/18, so we had less deaths to review. Whilst the number of child death reviews completed in 2018/19 is low compared to 2016/17, (when the report format changed to contemporaneous reporting on in year 'reviewed and registered' deaths), they are not comparable to report figures over previous years which were based on reviews for cases some of which were 2-3 years old. Presently, 27 child death reviews (for deaths occurring in 2018/19) are ongoing and may be presented separately as an addendum report.

Table 2: Yearly number of child death reviews by 4LSCB area, 2008/09 - 2018/19

LSCB area of residence	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17*	2017/18	2018/19
Hampshire	66	66	67	70	62	64	56	76	55	51	35
Isle of Wight	10	7	≤5	≤5	≤5	7	6	8	≤5	≤5	0
Portsmouth	10	13	15	≤5	13	6	11	9	≤5	≤5	11
Southampton	22	20	25	16	14	12	12	24	23	≤5	≤5
Total reviewed	**108**	**106**	**109**	**92**	**94**	**89**	**85**	**117**	**77**	**62**	**48**

For reasons of confidentiality, some figures ≤ 5 have been suppressed.
****Not comparable with previous years due to change in report format.***

Although unlikely to be representative of all child deaths occurring in the year (as only 64% of deaths registered in 2018/19 were reviewed), descriptive analyses of completed child death reviews are presented below to enable identification of pan-Hampshire child mortality themes.

5.4 Characteristics of child death reviews

Gender

Three-fifths (60%) of the 48 deaths reviewed related to boys (29), whilst 38% (18) were attributable to girls, and 2% (1) were unknown/not stated. Modifiable factors were identified in 11 (23%) deaths, a with a higher proportion relating to boys.

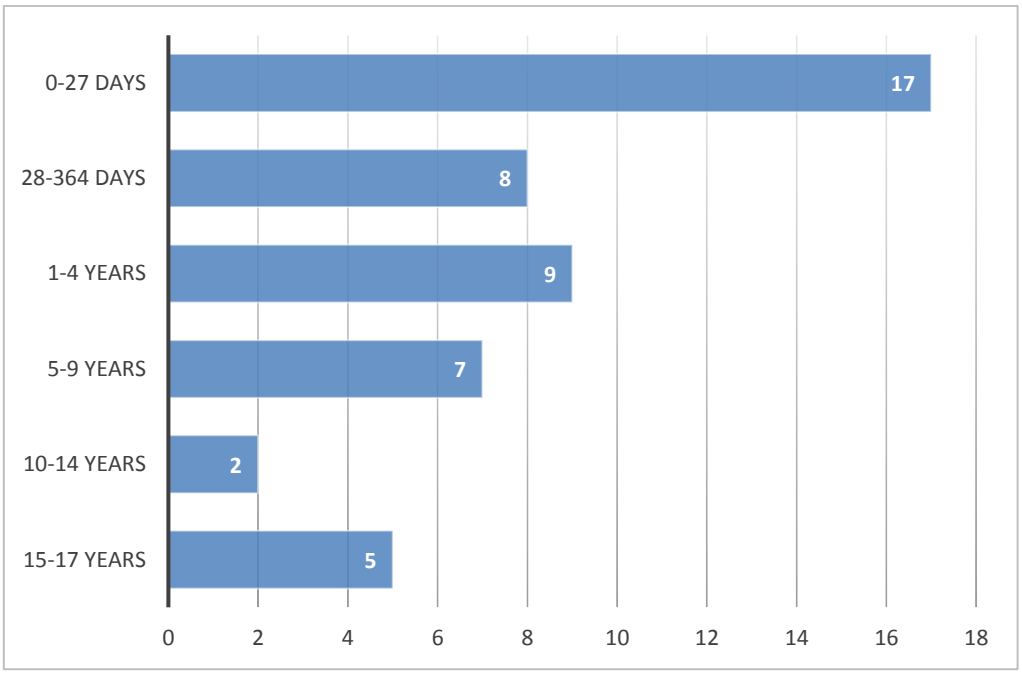
Age

As shown in Figure 4, in 2018/19 there was a general decline in the numbers of reviews completed with increasing age of child. Indeed, just over half (25 of 48, 52%) of completed reviews related to children who died in the first year of life, 17 (35% of total reviews) of whom were neonates (i.e. babies aged 0-27 days), the remaining 8

(17% of total reviews) being children aged 28-364 days at time of death. Although potentially coincidental, this trend correlates with global child mortality data[6] which shows a decreasing death rate with increasing age of child, from 18 deaths per 1000 live births during the neonatal period (when children are at their most vulnerable and face the highest risk of death), to 12 deaths per 1000 live births after the first month of life but before the age of one.

Seven of the 11 deaths attributable to modifiable factors (64%) occurred in children who died under one year of age.

Figure 4: Child Death Reviews by Age Group, 2018/19



Source: 4LSCB

Neonatal deaths with modifiable factors

There were 17 neonatal deaths (babies who died within 28 days of birth) amongst the 48 deaths reviewed across the 4LSCB area. Modifiable factors were identified in less than five of these deaths.

Ethnicity

Reviews of deaths of children from a White background accounted for 71% of the reviews where the child's ethnicity was recorded. The higher proportion is similar to the 4LSCB child population as a whole where most children (89%) are from a White background.

Asylum seeking status

There were no *known* asylum-seeking children amongst the 48 child deaths reviewed across the 4LSCB area in 2018/19.

Child protection

Of the 48 child deaths reviewed in 2018/19, only one child was subject to a child protection plan at the time of their death, and there were no serious case reviews (SCRs).

Statutory order status

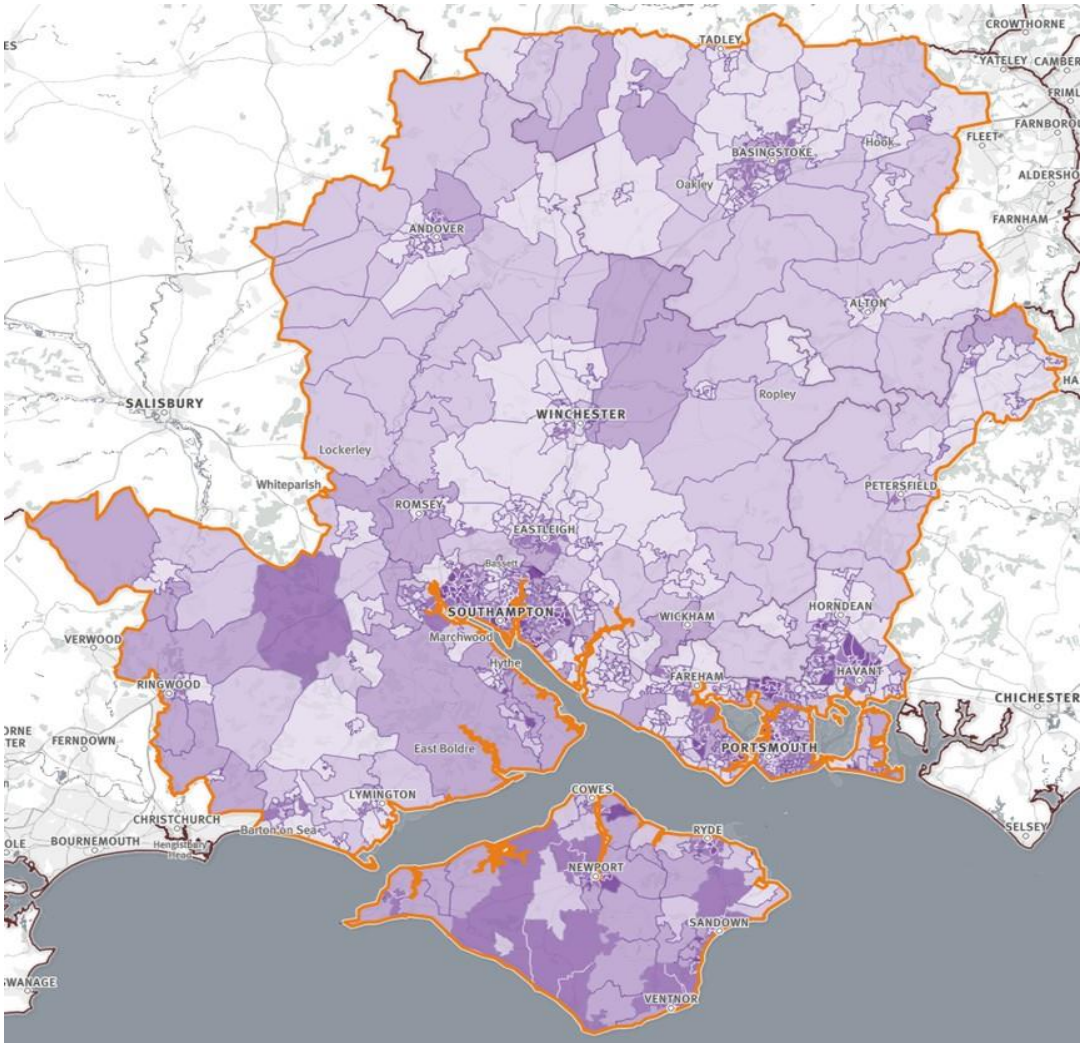
None of the 48 children, whose deaths were reviewed in 2018/19, were subject to a statutory order at the time of their death.

Deprivation

Similar to 2017/18, there has again been a paucity of information on socioeconomic deprivation in the 2018/19 child death review process data. However, as highlighted by Sir Michael Marmot in *Fair Society, Healthy Lives*[7]and discussed extensively in Section 5 of the present report: *National Trends in Child Mortality and Professional Body Guidance,* deprivation is known to be associated with poorer health outcomes and higher numbers of child deaths (with the highest numbers occurring amongst the most vulnerable groups). Deprivation within the 4LSCB area is presented at Figure 5, mapped according to *Child Poverty – Index of Deprivation 2015*. Interestingly, Hampshire – which has had a consistently higher IMR than Portsmouth since 2009 (see Figure 3) has lower overall levels of child poverty compared to Portsmouth, according to the index below. However, this is likely to be due to the wide variation in IMR due to the small numbers of events.

As the work on ACEs (Adverse Childhood Experiences) progresses across the 4LSCB area, we need to start to look at the impact of ACEs/adversity, which is not always linked to deprivation.

Figure 5: Deprivation in the 4LSCB area



Source: PHE SHAPE

5.5 Categorisation of deaths

Table 4 presents the CDOP categorisation of all 48 deaths that were reviewed in 2018/19. A nationally standardised approach to death categorisation has been taken; where more than one category is deemed relevant to a death, that death is categorised using the highest category number, where 1 is high and 10 is low.

Table 3: Categorisation of child death reviews 2018/19

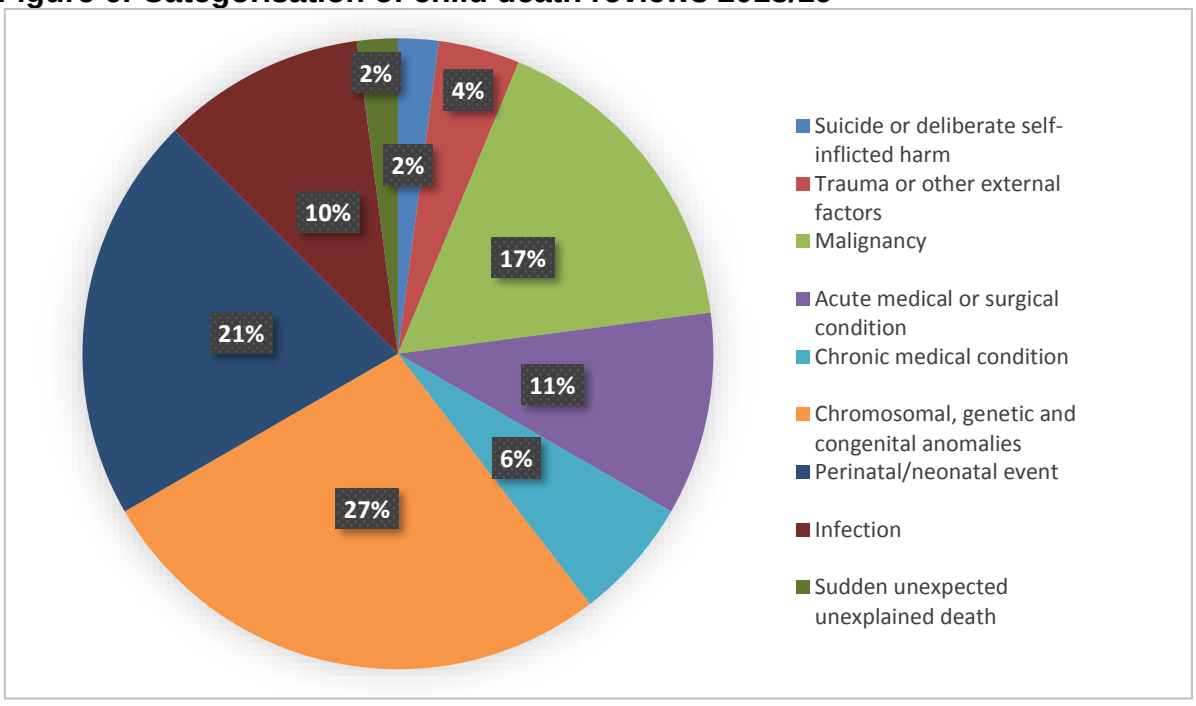
	Category	Cases Reviewed	Modifiable factors
1	Deliberately inflicted injury, abuse or neglect	0	0
2	Suicide or deliberate self-inflicted harm	≤5	1
3	Trauma or other external factors	≤5	1
4	Malignancy	8	0
5	Acute medical or surgical condition	≤5	2
6	Chronic medical condition	≤5	0
7	Chromosomal, genetic and congenital anomalies	13	0
8	Perinatal/neonatal events	10	3
9	Infection	≤5	4
10	Sudden unexpected, unexplained death	≤5	0
	Unknown	0	0
	Total	48	11

Source: 4LSCB.

For reasons of confidentiality figures ≤ 5 are suppressed.

Category 7 (Chromosomal, genetic and congenital anomalies) was the most frequently cited category, accounting for 27% of child death reviews (see Figure 6). Category 8 (Perinatal/neonatal events) was the next most frequently cited category, followed by Category 4 (Malignancy), accounting for 21% and 17% of child deaths reviewed in 2018/19, respectively.

Figure 6: Categorisation of child death reviews 2018/19



Category 2 (Suicide or deliberate self-inflicted harm) accounted for fewer than five child deaths. Note that suicide data is reviewed in the annual (Local Authority led) suicide audit, producing an in-depth analysis of all deaths from suicide (including reviews from coroners' report) to inform suicide prevention plans.

5.6 Modifiable factors

As part of the child death review process, CDOP members consider whether there were any ‘modifiable factors’ i.e. factors which may have contributed to the child's death, which could potentially be modified by means of nationally or locally achievable interventions, to reduce the risk of future deaths. Note, however, that removal or reduction of these factors would not necessarily have prevented the death under review.

Various types of socially modifiable factors were identified and are listed in Figure 7, with how often each modifiable factor was cited given by the number in parentheses. The most frequently cited modifiable factor was *Smoking in Pregnancy* (10 citations), followed by *Smoking in Household* (6 citations), *Substance Misuse* (4 citations), *Care of Baby* (4 citations) and *Co-Sleeping* (4 citations). The other modifiable factors were each cited two or fewer times. Whilst this was a wide range of modifiable factors, very few cases tend to have modifiable factors. So, of the 48 deaths reviewed in 2018/19 across the 4LSCB area, only 11 (23%) were associated with one or more modifiable factors that may have contributed to the death of the child. The low number and percentage of reviews assessed as having modifiable factors may be due to the smaller number of child deaths reviewed this year.

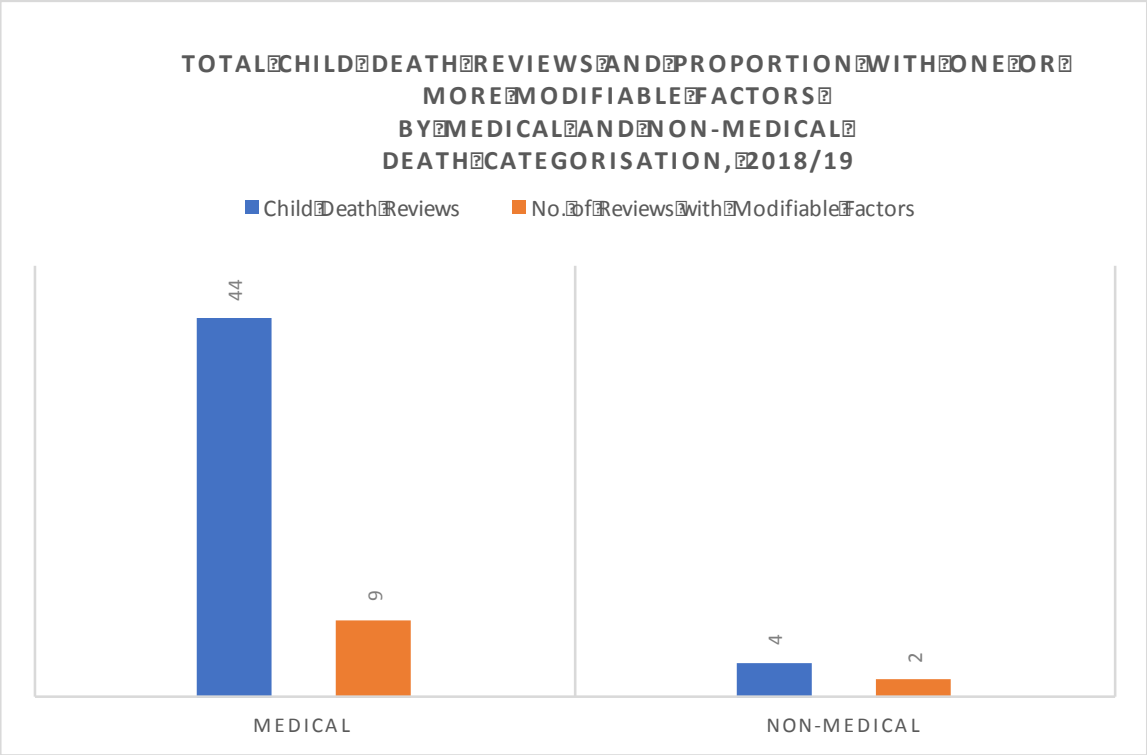
Figure 7: Modifiable Factors Identified in Child Deaths Reviewed 2018/19

- Smoking in pregnancy (10); Smoking in household (6)
- Care of baby (4)
- Substance misuse (4)
- Co-sleeping (4)
- Domestic abuse (2)
- Housing (2)
- Seatbelt (2)
- Alcohol misuse (2)
- Awareness of Sepsis pathway (2)
- Impact of Mother's Health on unborn baby not adequately considered (1)
- Seeking medical advice for illness – calling NHS111; contacting GP/going to hospital (1)
- Wearing a helmet (1)
- Access to services (1)
- Awareness of sexually transmitted infections (STIs) (1)
- Road Safety (1)
- Earlier Identification of Labour (1)
- Disorganised Parenting (1)
- Cultural Support (1)
- Greater social support (1)
- Complying with Prelabour Rupture of Membranes (PROM) guidance (1)
- Recognising a deteriorating baby (1)
- Management of Self-Harm (1)
- Presentation/Anti-Social Behaviour (1)
- Relationships with Friends and Family (1)
- Obesity (1)
- Flu jabs for children with disabilities (1)

44 of the 48 deaths reviewed in 2018/19 (92%) may be classified as 'Medical', comprising death categories 4-9 (i.e. Malignancy; Acute medical or surgical condition; Chronic medical condition; Chromosomal, genetic and congenital anomalies; Perinatal/neonatal event; and Infection). The remaining four reviews (8%) may be classified as 'Non-Medical', comprising death categories 1-3 and 10 (i.e. Deliberately inflicted injury, abuse or neglect; Suicide or deliberate self-harm; Trauma or other external factors; and Sudden unexpected, unexplained death).

Figure 8 shows the numbers of reviews by broad category of death (Medical or Non-medical), together with the number of reviews in each category with one or more modifiable factors. Nine out of 44 (20%) child death reviews in the 'Medical' category had one or more modifiable factors, whilst two out of the four (50%) 'Non-medical' child death reviews had one or more modifiable factors.

Figure 8



Source: 4LSCB

5.7 Expected and unexpected deaths

Unexpected deaths

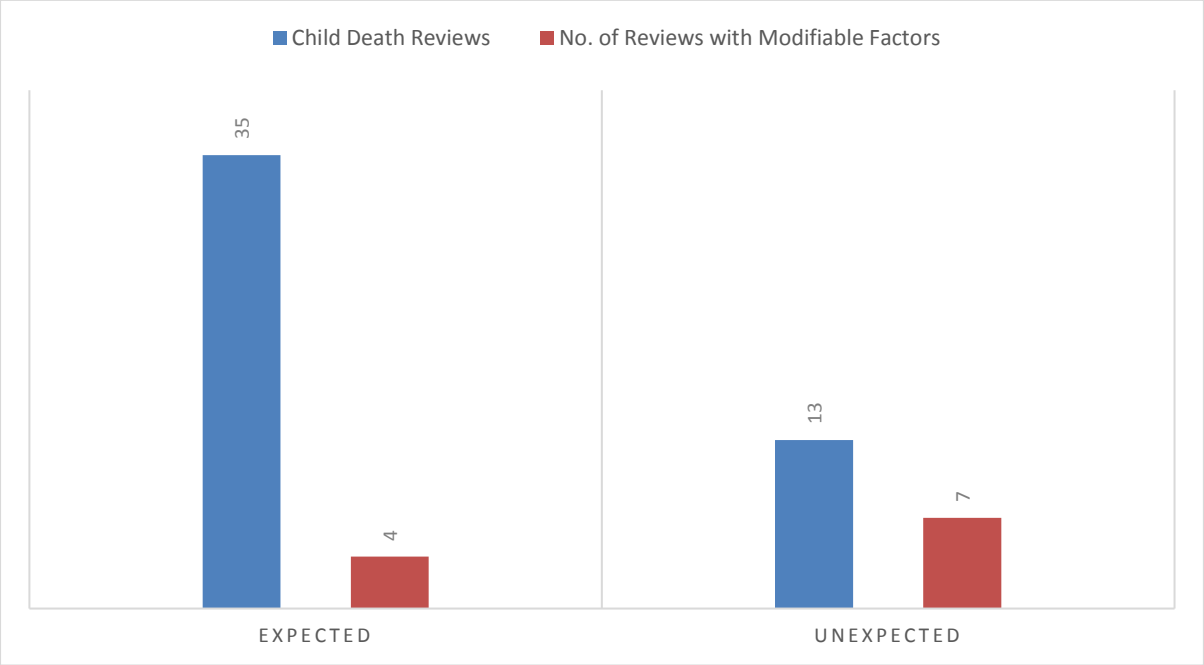
An '*unexpected'* death has been defined in *Working Together to Safeguard Children 2015*[8] as '*the death of an infant or child that was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which led 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[9] 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 process does not take place.

Thirty-five of the 48 child deaths (73%) reviewed in 2018/19 were expected, whilst 13 (27%) were unexpected. Further analysis indicates that modifiable factors were identified in 4 (11%) of the 35 expected deaths, and in 7 (54%) of the 13 unexpected deaths (see Figure 9).

Figure 9



Source: 4LSCB

6. Individual CDOP summaries

6.1 Hampshire

6.1.1 *Analysis of death reviews*

During 2018/19, a total of 35 child death reviews were undertaken in Hampshire out of the 50 deaths that the CDOP were notified of in the year, indicating that we have 15 ongoing CDOP reviews. This is due to many outstanding post-mortem reports, and deaths being notified close to the cut-off date of 31 March 2019. Quality assurance was undertaken to assess completeness of the data on child death notifications submitted to the CDOP in 2018/19. Additionally, the four main hospitals serving the Hampshire population were asked to provide a list of all neonatal deaths within 2018/19. This exercise identified an additional 9 child deaths which will be reviewed in 2019/20.

Checks on the number of child deaths were compared against death records held in the Hampshire extract of the Primary Care Mortality Database (PCMD). Whilst the PCMD is a robust data source, it should be noted that the data extract is not complete for 2018/19 and represents a snapshot of deaths up to January 2019. In addition, data from NHS Digital are now based on a bespoke extract, containing only recorded underlying cause of death, resulting in some extremely premature deaths not being included that may have been included in previous years. The PCMD dataset indicates that a total of 44 deaths were registered between 01 April 2018 and 31 January 2019. A greater number of deaths is expected up to March 2019, which would not match the 50 deaths notified to the CDOP, suggesting a likely under-ascertainment of child deaths, which may improve with the new child death review arrangements.

There were very few cases with modifiable factors identified. Of the 35 deaths reviewed by Hampshire CDOP, only 9 (26%) were identified as having one or more modifiable factors. This year there was an approximately equal representation of boys (51%) and girls (49%) amongst child death reviews. Forty-three per cent of reviews completed were for children who died under the age of one (60% of whom were neonates). 77% of reviews related to children of White ethnicity, with some from Mixed, Asian and unknown ethnic backgrounds. None of the children were known to come from an asylum-seeking background, nor were they known to be subject to Statutory Orders or Child Protection Plans at the time of their deaths. In comparison to 2017/18, we have reviewed fewer deaths due to suicide amongst older adolescents. In response to the identification of abusive head trauma as a key theme in 2016/17, the ICON programme of work –developed to tackle the problem– continued to grow in 2018/19 and was submitted for national awards (HSJ and Parliamentary Awards).

6.1.2 *Learning, issues and actions arising from these reviews*

Improvements have been made 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.

- Smoking continues to be the most identified modifiable factor and was particularly prevalent in preterm baby deaths. Significant work is being undertaken across the health system with escalation to the Hampshire and the Isle of Wight Sustainable Transformation Partnership (STP) and Local Maternity System (LMS), as well as working towards the *NHS Long Term Plan*[b] commitments.

- Liaison with the Learning Disabilities Mortality Review (LeDeR) programme reviewer to gain expertise about deaths of children with learning disabilities is ongoing. The CDOP and Board sub-groups 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.

- 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). However, deaths where safe sleep has been a presenting factor have been reported by the coroner as unascertained as they have not used SIDS or SUDI as the cause of death. These issues have been highlighted to the Hampshire Safeguarding Children Partnership (HSCP) 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. A working group has been established to oversee the Safe Sleep Programme. This is expected to launch in 2019/20. Once embedded in practice the programme will be audited.

- Following the recognition of bereavement support for parents through the reviews this was fed into the Hampshire Health and Wellbeing Strategy for action. As a result, improving access to bereavement support and services locally has been agreed as a Strategy priority.

6.1.3 *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 third year of running. During 2018/19, the panel reviewed a smaller number (14 cases) of pre-24-week gestational week neonatal deaths in one meeting. Extreme prematurity was associated with all these deaths. Some of the common modifiable

[b] NHS Long Term Plan available at: https://www.england.nhs.uk/long-term-plan/

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. Accessing information from the Perinatal Mortality Surveillance Reporting system via the MBRRACE-UK remains challenging.

6.1.4 *The CDOP process*

The Hampshire CDOP continues to prioritise improving quality and completeness of the information received from agencies. 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 and those that die at home. 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.

6.1.5 *Membership update*

The neonatologist input into CDOP has been hugely beneficial, providing greater insight into this area of specialism. Hampshire's CDOP continues to be supported by both the Learning Reviews and Stakeholder Engagement Co-ordinator and Administrator.

6.1.6 *Backlog of cases*

The backlog of cases brought forward to 2018/19 was reviewed within the first six months and an addendum report produced.

6.2 Isle of Wight

There were less than five deaths in 2018/19, none of which were reviewed in the year. They have subsequently been rolled over to 2019/20. It has taken a long time to get the medical documentation needed in time for the CDOP meetings.

6.3 Portsmouth

The Portsmouth CDOP received 14 child death notifications during this reporting period, of which 11 were reviewed. Only one of the 14 deaths were unexpected. Reviews of the remaining three cases were delayed due to serious case reviews and single agency reviews being finalised. These deaths will be reviewed when all relevant information is available. A total of 16 cases were reviewed by the panel over the

2018/19 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. Most of the cases involved children from a White British background and the rest of the 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 and fewer than five cases were subject to a child protection plan. None of the deaths included child asylum seekers. Fewer than five of the children whose deaths were reviewed were within the 10% most deprived areas of England. All child deaths occurred in an acute hospital/hospice setting or the child's home and the reviews were completed in under six months since the child's death.

Some of the outcomes of deaths reviewed this year will feed into the development of the new child death process, especially regarding the rapid response to unexpected deaths in childhood, to ensure robust information gathering and support for both families and professionals. Cases involving particularly traumatic events were also reviewed and it was agreed that immediate debriefing involving staff directly involved was best practice and was being undertaken robustly within maternity services. It was identified that more consideration was required when a tragic and traumatic event occurred in cases with wider multi-agency involvement, especially when the threshold for responding under the rapid response unexpected death processes is not met. It was identified in one case that a multi-agency meeting would have been beneficial to ensure adequate support for the wider workforce and to enable improved support for families and staff involved.

Screening for domestic abuse within the local acute hospital setting was discussed by the CDOP panel this year and there was a recommendation for the local hospital to consider this and update their procedures accordingly. Feedback to the panel has been requested.

This year fewer than five cases were referred to the LeDeR programme, which supports local areas in England to review the deaths of people with learning disabilities. Some of these cases were also referred to the Portsmouth Case Review Committee for further scrutiny to ensure that any local learning is cascaded appropriately.

The panel also reviewed safe sleeping and co-sleeping messages given to parents of new-born babies, especially regarding parental consumption of alcohol, to ensure that these are robust and consistent. Messages given by professionals across the city do seem to be effective. The panel was also reassured that messages are being promoted by Public Health Portsmouth and printed within local publications for circulation across the city.

Public Health Portsmouth presented the panel with an overview of air pollution in the city at the March meeting. Like many cities across the country, Portsmouth is facing a

serious problem with air quality and the Local Authority has issued guidance to the population on ways to help improve this.

The Portsmouth CDOP has considered the new *Working Together to Safeguard Children 2018* guidelines around the revised Child Death Review process and will be supporting colleagues during this transition period, ensuring that any cases handed over to the 'Hampshire and the Isle of Wight' Child Death Review Partners are as complete as possible.

Staffing issues: 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 four times over this financial year and reviewed 16 cases.

6.4 Southampton

A learning requirement was identified from the cases reviewed, and this was to ensure bereavement support was offered to parents. This has subsequently been checked and confirmed with Obstetrics*.*

7. Conclusion and Recommendations

In 2018/19, the 4LSCB CDOPs reviewed 48 child deaths. Only 11 (23%) of these reviews were associated with one or more modifiable factors that may have contributed to the death of the child. A wide range of modifiable factors were identified, the top five most frequently cited being: *Smoking in Pregnancy*, *Smoking in Household*, *Substance Misuse*, *Care of Baby* and *Co-Sleeping*. Given the small number of cases reviewed with one or more modifiable factors, it has not been possible to elucidate any statistically significant regional trends. However, in light of the most frequently cited modifiable factors, together with the professional body guidance discussed in Section 4 and previous recommendations made in the 2017/18 report, a number of themes have emerged. These themes, and corresponding recommendations, are presented in the table below.

Theme	Relevant Modifiable Factors	Theme Description	Recommendations
Smoking	*Smoking in Pregnancy; Smoking in Household.*	• Smoking in pregnancy is associated with adverse outcomes for infants such as low birthweight - a known risk factor for infant mortality. • Mothers from lower socioeconomic groups are more likely to smoke during pregnancy.	Focus on quitting smoking before or during pregnancy through tailored smoking cessation programmes for pregnant women, with targeted support in areas of greatest deprivation. Greater concerted local action required to help reduce smoking in pregnancy to 6% or less by 2022 as per the *Government's Tobacco Control Plan*[10].
Maternal Health	*Substance Misuse*	• Maternal health is imperative to the health outcomes of children, particularly in the early years. • Substance abuse (i.e. taking drugs and drinking alcohol), poor nutrition and obesity during pregnancy are associated with adverse outcomes for infants.	Nationally, women should be supported from pre-conception through to the post-natal period, for example, by investing further in the *Healthy Child Programme*, so that the programme begins prior to conception, extends home visits to beyond 2.5 years, and ensures that children/families receive continuity of care. Locally, 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.
Co-sleeping	*Care of Baby; Co-Sleeping*		Continue to promote safe sleeping messages and support the Lullaby Trust annual awareness campaign. Ensure that all staff are fully aware of current policies and guidance and effectively communicate the risks of unsafe sleeping to parents and families.

8. Update on Priorities from the 2017/18 CDOP annual report

Progress against the recommendations from the 2017/18 CDOP annual report has been challenging for all the areas. An update is provided below.

Recommendation	*Update*
1. Safe Sleeping – *'Minimise the risk of future deaths due to unsafe sleeping by ensuring that work to promote safe sleeping messages and practices continues to be a high priority'*	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. A Hampshire and Isle of Wight Safe Sleep group has been established to raise awareness of consistent safe sleep messages and is due to launch in 2019/20. Once embedded in practice the programme will be audited. Southampton LSCB has also commissioned a 'co-sleeping thematic review' due to two SCR cases where there were issues around safe sleeping, and CDOP cases where safe sleep was identified as a modifiable factor. Further information is provided in the Learning and Improvement Plan on the LSCB website.
2. Language barriers – *'Reduce the negative impact of language and communication barriers on children's health and social care by raising these issues within health, education and social agencies'*	There has been no notable progress to date.
3. Bereavement Support – *'Work to improve bereavement support for parents, families and communities'*	Southampton CDOP discussed sending copies of the Lullaby Trust leaflet which explains the CDOP process, to all affected parents. However, there is a need to review the commissioning of bereavement support and also the new Key Worker role in the updated child death guidance. The Hampshire CDOP provided a response to the *2019/24 Hampshire Health and Wellbeing strategy*[11] consultation to recognise access to bereavement support and services as a key priority area for improvement.

4. *Maternal Smoking and Obesity –* *'Continue to engage system leadership to encourage women of reproductive age to adopt healthy lifestyles, stop smoking and achieve healthy body weights before conception'*	• Hampshire CDOP received a repost on all child deaths where smoking was a modifiable factor over the past three years. This was followed by a presentation from Hampshire Public Health on the work that is currently being undertaken on tackling smoking . • Significant work is being undertaken across the health system with escalation to the HIOW STP and LMS as working towards the NHS Long Term Plan commitments. • Amendments previously made to the Hampshire CDOP forms continues to include mothers BMI and use of e-cigarettes in addition to smoking in pregnancy or in the household. Portsmouth CDOP have amended their Form B to capture information on smoking status during pregnancy and mother's BMI at 12-weeks gestation. This additional information has helped inform case review discussions. Moving forward, including information on smoking status and maternal BMI in the new CDOP forms in order to improve the quality of reviews, needs consideration.
5. *CDOP process –* • ***'****Improve the quality of reviews with continued focus on timely and full completion of the forms'* • *'Prioritise reducing the backlog and delay in child death reviews to improve opportunities to more swiftly prevent future deaths'.*	<u>Quality of form completion</u> – Last year, Portsmouth CDOP identified inconsistencies in the quality of forms received from agencies. The panel is pleased to report that quality has greatly improved this year and the local hospital safeguarding team are reviewing their processes to help expedite information gathering on behalf of the CDOP. Hampshire has seen an improvement in the quality of information submitted to CDOP following significant amendments made to the Form B during the previous year. Work has been undertaken within provider services to explain the purpose and importance of the CDOP process. <u>Backlog in child deaths reviews</u> – A recent review of Southampton CDOP cases shows a minimal backlog. Cases not yet signed-off are subject to parallel processes or SCR. During 2018/19 Hampshire was able to reduce the backlog from the previous year by reviewing how the cases were managed within panel meetings. Form C's are now pre-populated and presented to the panel for categorisation of death, identification of modifiable factors and approval of contributory factors. At the end of 2018/19 the only cases outstanding were due to outstanding postmortems and deaths being notified very close to the 31 March cut off.

9. Child Death Review Arrangements

9.1 Current Child Death Review Arrangements

The death of a child is a tragic and devastating loss that profoundly affects all involved. When a child dies, under any circumstances, it is important for parents and families to understand what has happened and why. The objective of the child death review process is not to allocate blame, but rather to learn lessons which may help to prevent future child deaths. Enquiries should be grounded in respect of the rights of children and their families and should seek to achieve an appropriate balance between forensic/medical requirements and supporting the family at a difficult time.

9.1.1 *LSCBs and CDOPs*

Local Authorities were statutorily required to establish Local Safeguarding Children Boards (LSCBs) in April 2008 under the *Children Act (2004)*.

The Child Death Overview Panel (CDOP) is a sub-group of the LSCB, responsible for reviewing all deaths of children (0-17 years of age) normally resident in the LSCB area.

The Hampshire, Isle of Wight, Portsmouth and Southampton CDOPs are collectively referred to in this report as the '4LSCB CDOP'.

9.1.2 *Membership*

CDOP membership has a fixed core, drawn from organisations represented on the LSCB, and is designed to ensure that there is an appropriate level of expertise and experience, including professionals from public health and child health.

Each CDOP should be chaired by an independent representative of the LSCB i.e. an individual not directly involved in providing services to children and families in the area. The 4LSCB CDOP chairs are as follows:

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, Designated Doctor, Isle of Wight Clinical Commissioning Group.

9.1.3 *Governance*

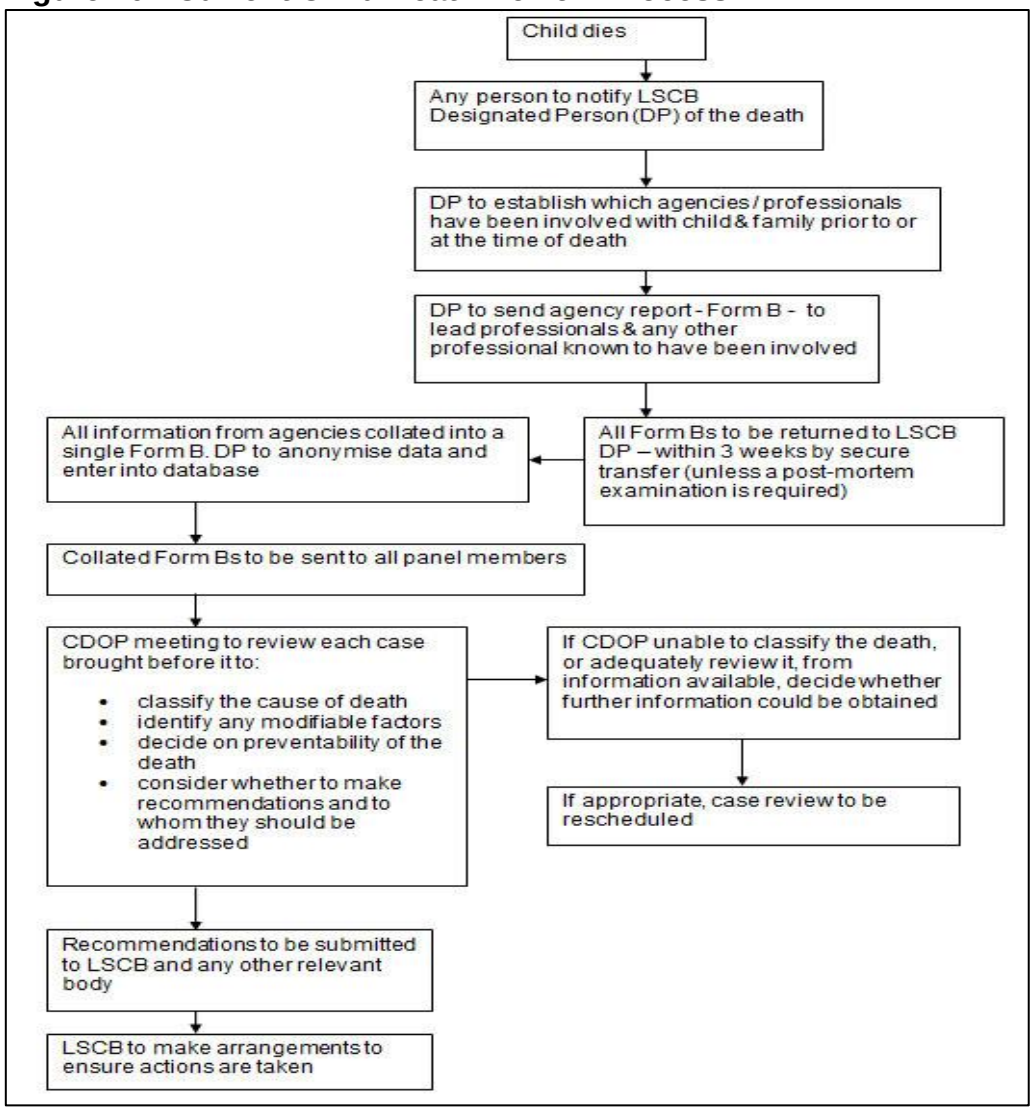
Central Government responsibility for safeguarding children is currently located within the Department for Education (DfE) and locally within each respective LSCB. As part of the current arrangements, the CDOPs and their Chairs are accountable to the Independent Chairs of each of the LSCBs.

9.1.4 *CDOP Functions*

CDOP responsibilities include:

- Reviewing all child deaths (excluding stillborn babies and legal planned terminations of pregnancy) according to the process set out in Figure 10 below;
    - Discussing each child's case and classifying the cause of death, seeking further information from professionals and family members if necessary;
    - Determining whether the death was 'preventable', i.e. ascertaining if there were any modifiable factors which may have contributed to the death;
    - Making recommendations to the LSCB or other relevant bodies, so that timely action can be taken to prevent future such deaths where possible; and
    - Identifying patterns or trends in local data and reporting these to the LSCB by means of an annual report.

Figure 10: Current Child Death Review Process



9.2 Revised Child Death Review Arrangements

Child death review statutory requirements and governance structures have been updated, enacted through the *Children Act 2004* (as amended by the *Children and Social Work Act 2017)* and described in the new Working Together to Safeguard Children guidance[12,13,14,15] issued by the DfE in July 2018. These updates have been made based on recommendations in the 2016 Wood Report[16] and include:

- Establishment of a national-regional model for CDOPs, so that sufficient numbers of child deaths may be analysed to identify statistically significant patterns, themes and trends; and
- Creation of a national database to facilitate local data collection and national analysis of child deaths.

Wood[4] also proposed transfer of ownership of CDOP support arrangements from the DfE to the Department of Health and Social Care (DHSC).

9.2.1 *Timeframe for Implementation*

As specified in *Working Together: Transitional Guidance*, the transition from LSCB to safeguarding partner and child death review partner was due to commence on 29 June 2018, with agreement and publication of updated local plans by 29 June 2019 and implementation of new plans within 3 months i.e. by 29 September 2019. Each LSCB, now Local Safeguarding Children Partnerships (LSCP) then has a further four months (i.e. until 29 January 2020) to complete any outstanding child death reviews; thereafter, any incomplete reviews should be passed to the new child death review partners.

9.2.2 *Revised Purpose of Child Death Reviews*

The purpose of a child death review is to identify any matters (related to the death) that are potentially relevant to the welfare of children in Hampshire and the Isle of Wight, or to public health and safety, and to consider whether any action should be taken in respect of these matters.

9.2.3 *CDRPs and CDOPs*

Going forward, the responsibility for ensuring that child death reviews are carried out will be held by *Child Death Review Partners* (CDRPs) who, in relation to a local authority area in England, are defined as 'the local authority/authorities for that area and any clinical commissioning groups (CCGs) operating in the local authority area'.

Reviews should be carried out by the CDRP at a Child Death Overview Panel (CDOP), conducted in accordance with the *Child Death Review Statutory and Operational Guidance 2018* and *Working Together to Safeguard Children 2018*.

The CDRPs relevant to the present report are: Hampshire County Council; Isle of Wight Council; Portsmouth City Council; Southampton City Council; the Hampshire

and Isle of Wight Partnership of CCGs; West Hampshire CCG; Portsmouth City CCG; and Southampton City CCG.

For the purposes of undertaking child death reviews, from 30 September 2019 the CDRPs from Hampshire, Southampton, Portsmouth and the Isle of Wight will be treated as a single area: *Hampshire and the Isle of Wight (HIOW)*.

9.2.4 *Geographical Area Covered by HIOW*

The HIOW CDOP will review the deaths of all children up to the age of 18 (i.e. 0-17 years of age), excluding stillborn babies and planned terminations of pregnancy carried out within the law, normally resident in the Local Authority areas of Hampshire, the Isle of Wight, Portsmouth and Southampton. If deemed appropriate, the CDOP may also review the death of a non-resident child who has died in the area.

As recommended by *Working Together to Safeguard Children 2018* guidance, the HIOW CDOP will typically review at least 60 deaths per year. This will better enable thematic learning to protect children from harm and ultimately save lives.

9.2.5 *Membership*

As per the *Child Death Review Operational Guidance*, the CDOP should be chaired by someone independent of the key providers in the area (i.e. NHS, social services, and police). The CDRPs will commission an Independent Chair, with relevant knowledge and expertise of the child death review process, to provide independent scrutiny and challenge to the panel.

Core Panel Membership will be as follows: Public health; a Designated Doctor for child deaths (and a hospital clinician if the Designated Doctor is a community doctor or vice versa); Children's Social Care and Safeguarding; Police; Education; Safeguarding (Designated Doctor or Nurse); Health professional; and Lay representation.

In addition to the core membership, relevant experts from health and other agencies will be invited as necessary to inform discussions. Once the panel is established, membership from other sectors will be considered, for example: The Housing Association; Council Services; Health & Wellbeing Boards; Ambulance Services; and Hospices.

The work of the CDOP will be led and coordinated by the CDOP Manager and CDOP Administrator. The team will work closely with the CDRPs, Independent Chair and partner agencies, to ensure that the CDOP operates effectively and fulfils its statutory requirements.

9.2.6 *Governance and Accountability*

The CDRP is accountable to the overarching Hampshire, Isle of Wight, Portsmouth & Southampton (HIPS) Safeguarding Children Partnership (SCP) Executive Group.

The CDRPs will prepare and publish an annual report (to be shared with the CCG Governing Bodies and four LSCPs) that will highlight local patterns and trends in child deaths, lessons learnt, actions taken and how effective arrangements have been in practice.

The Local Authority Public Health representative and Designated Doctor for child deaths should liaise with decision makers in partner organisations to share key learning and take forward any actions arising from recommendations made at CDOP.

9.2.7 *CRDP-CDOP Responsibilities*

The responsibilities of CDOPs associated with CDRPs (rather than LSCPs) include:

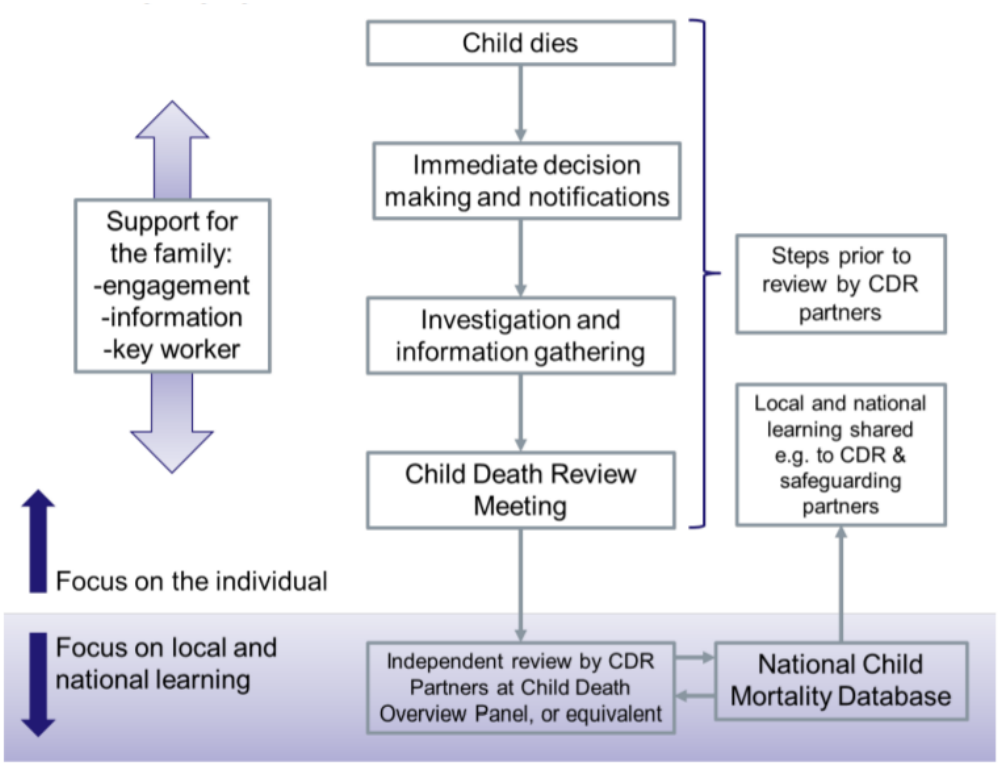
- Analysing the information obtained, including the Child Death Review Meeting (CDRM) report, to confirm or clarify the cause of death, to determine any contributory or modifiable factors, and to identify learning arising from the child death review process that may prevent future child deaths;
- Making recommendations to the HIPSSCP (where actions have been identified) which may prevent future child deaths and/or promote the health, safety and wellbeing of children;
- Notifying the Child Safeguarding Practice Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected;
- Notifying the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction; and
- Reviewing cases within six to eight weeks of receipt of the CDRM report or the result of the coroner's inquest, apart from cases requiring a Child Safeguarding Practice Review (formerly Serious Case Reviews [SCR]), or those due to be discussed at a themed panel meeting (see below).

It may be more appropriate to review certain child deaths at a themed meeting. This is where the deaths resulting from a particular cause are collectively reviewed, for example, neonatal deaths or suicides. The frequency of themed panel meetings should be dictated by the number of deaths in each category; however, the meeting should occur within 12 months of the child's death.

9.2.8 *Child death review process*

The HIOW CDOP will adhere to the statutory guidance *Child Death Review Statutory and Operational Guidance 2018*, following the child death review process presented in Figure 11 below.

Figure 11: The revised child death review process, to take effect from 30 September 2019



Source: DHSC and DfE Child Death Review Statutory and Operational Guidance

CDOPs should record the outcome of CDRM discussions on a final Analysis Form and submit this to NHS Digital.

Once operational, CDOPs should submit copies of all completed forms associated with the child death review process (including but not limited to the Notification Form, Reporting Form, Supplementary Reporting Forms and the Analysis Form) to the National Child Mortality Database.

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