4LSCB CDOP Annual Report Summary 2018/19

The death of a child is a profound, difficult, and painful experience. By highlighting learning opportunities through child death reviews undertaken by the 4Local Safeguarding Children Board (4LSCB) Child Death Overview Panels (CDOPs) across Hampshire, the Cities and the Isle of Wight, we can improve opportunities to prevent future deaths. This report covers child death reviews conducted in the 4LSCB area during 2018/19.

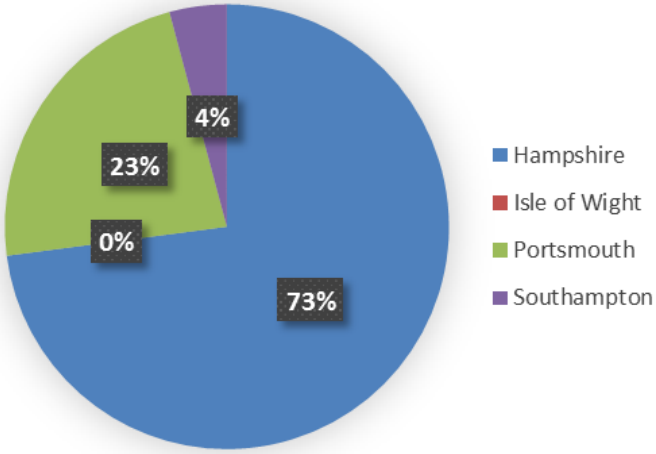
Key findings

In the 4LSCB area during 2018/19, there were:

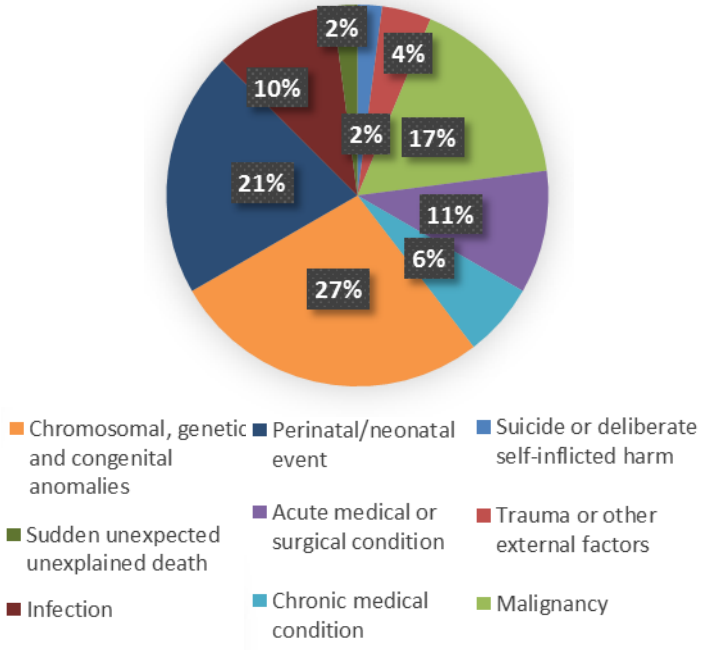
- 403,749 under 18s (0-17 year olds) estimated to be resident
- 75 child deaths registered during the year 2018/19
- 48 (64%) child death reviews completed of the deaths registered in 2018/19
- 27 (36%) ongoing CDOP reviews for deaths that occurred in 2018/19

Characteristics of child death reviews:

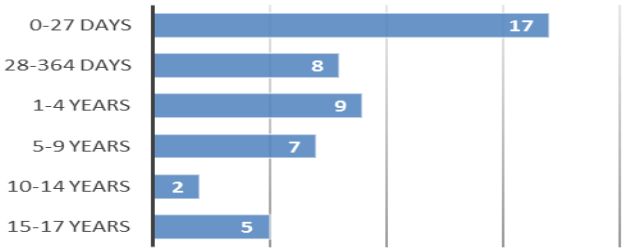
- As shown in the adjacent pie chart, Hampshire CDOP (supporting the most populous LSCB area) completed the most child death reviews, accounting for 35 (73%) of the 48 4LSCB child death reviews in 2018/19. The small numbers of child death reviews completed in the Isle of Wight, Southampton and Portsmouth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



- Category 7 (Chromosomal, genetic and congenital anomalies) accounted for 27% of child death reviews and was therefore the most frequently cited category of death.



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



- Approximately 73% of deaths were expected and 27% were unexpected.

- 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.

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

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Update on the 2017/18 CDOP report recommendations:

Recommendation	*Update*
Safe Sleeping	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. Southampton LSCB 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.
Bereavement Support	Southampton CDOP identified a need to review the commissioning of bereavement support and also the new Key Worker role in the updated child death guidance. Hampshire CDOP provided a response to the *2019/24 Hampshire Health and Wellbeing strategy* consultation to recognise access to bereavement support and services as a key priority area for improvement.
Maternal Smoking and Obesity	Work is being undertaken across the health system towards the NHS Long Term Plan commitments. Amendments previously made to the Hampshire and Portsmouth CDOP forms continues to include mothers BMI and use of e-cigarettes in addition to smoking in pregnancy or in the household.
CDOP process	<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.

Recommendations for 2019/20:

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.
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.
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.