4LSCB CDOP Annual Report Summary 2017/18

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

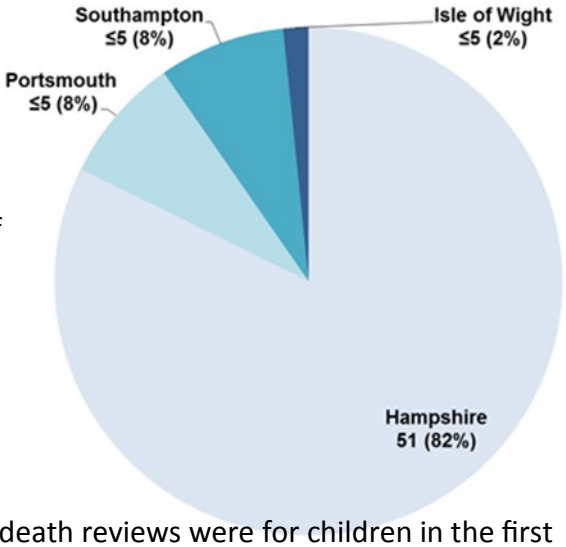
Key findings

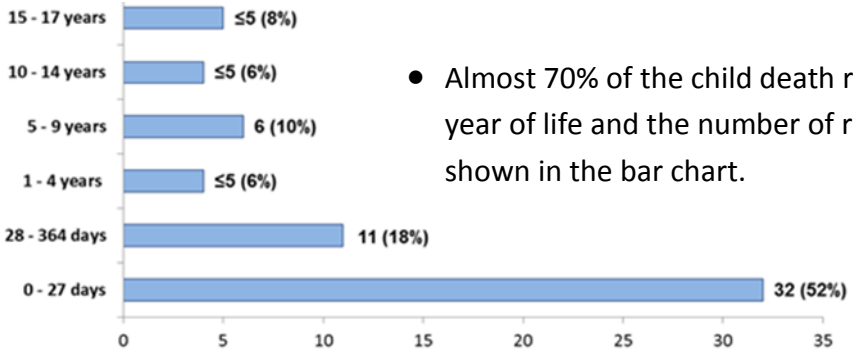
In the 4LSCB area during 2017/18, there were:

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

Characteristics of child death reviews:

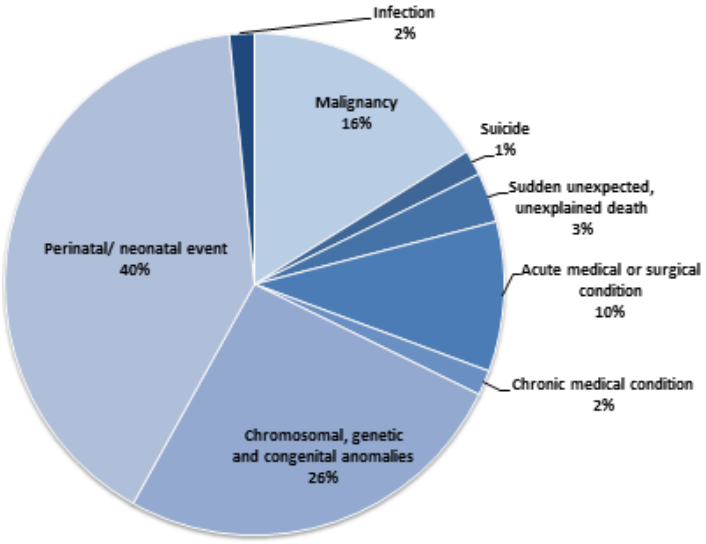
- The number and percentage of child death reviews by LSCB area is shown in the pie chart. Hampshire CDOP, supporting the most populous LSCB area, completed the most child death reviews, and accounted for 82% of the 62 child death reviews. The small numbers of child death reviews in the Isle of Wight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





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

- Approximately 81% of deaths were expected and 19% were unexpected deaths.



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

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

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Update on the 2016/17 CDOP report recommendations:

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

Recommendations for 2018/19:

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