CHILD DEATH OVERVIEW PANEL

East Sussex and Brighton & Hove

Eighth Annual Report

April 2015 to March 2016

1. Executive Summary

1.1 **The Child Death Overview Panel (CDOP)** is the inter-agency forum that meets bi-monthly to review the deaths of all children normally resident in East Sussex and Brighton & Hove. It is a sub-group of the two Local Safeguarding Children Boards (LSCBs) for Brighton & Hove and East Sussex and is therefore separately accountable to the two LSCB Chairs, Reg Hooke, Chair of East Sussex LSCB and Graham Bartlett, Chair of Brighton & Hove LSCB.

1.2 The purpose of the review is to determine whether the death was deemed preventable, that is one in which there are identified modifiable factors which may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced. If this is this case the Panel must decide what, if any, actions could be taken to prevent such deaths in future.

1.3 If during the process of reviewing a child death, the CDOP identifies: an issue that could require a serious case review (SCR); a matter of concern affecting the safety and welfare of children in the area; or any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area, a specific recommendation is made to the relevant LSCB.

1.4 There were no recommendations made to the LSCBs regarding the need for a serious case review. The following recommendations were made regarding matters of concern about the safety and welfare of children, and wider public health concerns:

The CDOP recommended to the East Sussex LSCB that: -

- That the chair of the LSCB raise with the chair of a neighbouring LSCB the CDOP concerns regarding the non-compliance with national CDOP procedures by the coroner and other agencies following the unexpected death of a child.

- The board seeks assurance from all health agencies where they have professionals that have contact with children who are eligible for annual flu vaccinations that they are promoting take up of this vaccination with families.

Recommendations made to the Brighton & Hove LSCB were that: -

- The LSCB asks agencies to review the guidance that is given to parents and young people about ensuring personal safety if taking drugs or alcohol. In particular, whether the risks of physical harm are identified and whether advice is given about ensuring that a friend who has not taken drugs is present and can provide support. This review to include looking at the guidance on "talk to Frank".

- The LSCB should ask BSUHT and the CCG (NHS England) to consider how to share the learning from this case about how to improve communication between agencies around end of life care planning for children with life limiting conditions where there is a Do Not Attempt Resuscitation (DNAR) agreement in place.

2. Organisation of the Child Death Overview Panel.

2.1 The East Sussex and Brighton & Hove CDOP is independently chaired by Fiona Johnson[1]. The Panel comprises of representatives from key partner agencies who together have expertise in a wide range of services regarding children's health and wellbeing. Membership is listed below:

Core Membership: Fiona Johnson –Chair Laura Scott – CDOP Coordinator Conor Walsh- South East Coast Ambulance Service NHS Foundation Trust Edmund Hick – Sussex Police	
East Sussex: Annie Swann - Specialist Nurse for Child Deaths Debbie Barnes – Designated Nurse Dr Tracey Ward - Designated Paediatrician Douglas Sinclair – Head of Safeguarding Victoria Spencer-Hughes – Public Health Jenny Crowe – Midwifery Dr Graham Whincup – Neonatologist Mini Nair – Obstetrician Dr Sarah Thomson, Named GP	**Brighton & Hove:** Ali Jenkins - Specialist Nurse for Child Deaths June Hopkins – Designated Nurse Dr Anne Livesey - Designated Paediatrician Deb Austin – Head of Safeguarding Lydie Lawrence - Public Health Fiona Rose – Named Midwife Dr Cassie Lawn – Neonatologist Heather Brown - Obstetrician

2.2 The administrative work of East Sussex Brighton & Hove CDOP is organised by the CDOP Coordinator, with support from the CDOP Chair and other panel members.

[1] Fiona Johnson is not involved in directly providing services to children and families in East Sussex or Brighton & Hove

3. National Developments, Challenges and Achievements

3.1 The Prime Minister announced on 14 December 2015 that ministers had asked former ADCS President, Alan Wood CBE, to undertake a fundamental review of the Role and Functions of Local Safeguarding Children Boards (LSCBs) within the context of local strategic multi-agency working. This included consideration of the child death review process, and how the intended centralisation of serious case reviews would work effectively at local level.

3.2 The DfE published the Wood Review of the Role and Functions of Local Safeguarding Children Boards, together with the government's response on the 26 May 2016. The recommendations include proposals to reform the statutory framework that underpins the model of Local Safeguarding Children Boards (LSCBs), Serious Case Reviews (SCRs) and Child Death Overview Panels (CDOPs). The review argues for a fundamental change, bringing to an end the existing system of serious case reviews, and replacing it with a new national learning framework for inquiries into child deaths and cases where children have experienced serious harm. The review found that the gathering and analysis of data on child deaths is incomplete and inconsistent, leading to a gap in knowledge. It suggests that child deaths need to be reviewed over a population size that gives a sufficient number of deaths to be analysed for patterns, themes and trends of death. It suggests greater regionalisation with consideration being given to establishing a national-regional model for CDOPs. The review argues that child death reviews should continue to be hosted within local multi-agency arrangements but that CDOPS should be hosted within the NHS, and that ownership of the arrangements for supporting them should move from the Department for Education to the Department of Health.

3.3 The Government response to the Wood Review indicates that it intends to replace the current system of SCRs and miscellaneous local reviews with a system of national and local reviews in order to:

- bring greater consistency to public reviews of child protection failures;
- improve the speed and quality of reviews including accrediting authors;
- make sure that reviews which are commissioned are proportionate to the circumstances of the case they are investigating;
- capture and disseminate lessons more effectively;
- make sure lessons inform practice.

3.4 With regards to Child Death Reviews the Government says that evidence suggests that over 80% of child deaths have medical or public health causation and that only 4% of child deaths relate to safeguarding. Therefore, it intends to transfer national oversight of CDOPs from the Department for

Education to the Department of Health, whilst ensuring that the focus on distilling and embedding learning is maintained within the necessary child protection agencies.

4. Local Developments, Challenges and Achievements

4.1 The CDOP set itself a number of challenges with regards to improving its functioning. These included improving data collection regarding ethnicity for the CDOP process and developing the CDOP database to ensure that data could be extracted easily to inform the annual report and other learning. Both of these have been put in motion and recording of ethnicity in the last annual DfE data return was significantly improved. The data base has been adapted and it will make it easier in the future to provide more detailed data reports.

4.2 Another goal was to strengthen the functioning of the East Sussex neonatal panel by developing closer joint working between East Sussex and Brighton & Hove neonatal panels. Progress on this has been slow however the need for succession planning to enable a smooth transition when the current neonatologist retires has been raised.

4.3 Collating learning on deaths resulting from self-harm and suicide across Brighton & Hove and East Sussex to inform future preventative work. This is being taken forward by Public Health via the existing Suicide Prevention Group(s) for each LSCB.

4.4 A positive development during the year has been the strengthened engagement with Public Health in East Sussex who have assisted greatly in improving the content of the CDOP annual report.

4.5 Since the CDOP panel started in 2007 smoking and unsuitable sleeping arrangements have regularly featured as modifiable factors in deaths. Following this issue being discussed at the LSCB in the previous year the following actions have been taken by East Sussex Heath Trust: -

- Two Safe Sleep training sessions have been delivered by the Lullaby Trust. These were well attended by Health and Children's Services colleagues.
- Champions/link professionals have been identified and established across the Trust. Midwifery and Health Visiting teams have adopted the use of Lullaby Safe Sleep resources
- Electronic records systems now include specific records regarding Safe Sleep advice that require completion and serve to prompt all colleagues delivering care

5. Work of the Panel

5.1 The CDOP has held 11 meetings in the past year (including 2 Brighton & Hove neonatal panels and 3 East Sussex neonatal panels). The main work of the panel is to review the deaths of all children who die across East Sussex and Brighton & Hove, on behalf of the two Local Safeguarding Children Boards (LSCBs).

5.2 Between April 2015 and March 2016 the CDOP was notified of 48 deaths of children who were resident in East Sussex (33) and Brighton & Hove (15) which is an increase in numbers of deaths since last year.

5.3 The CDOP has reviewed a total of 43 deaths (26 East Sussex and 17 Brighton & Hove) during 2015/16. There will always be a delay between the date of a child's death and the CDOP review being held. Of the 17 Brighton & Hove reviews completed in 2015/16 9 (53%) were completed within six months. In East Sussex 7 (27%) out of 26 reviews were completed within six months. One explanation for fewer reviews being completed within six months in East Sussex may be that there have been a number of reviews that required a serious case review (SCR) which always delays the CDOP review as it cannot be completed until the SCR report has been presented to the LSCB.

APPENDIX A – CHANGING DEFINITIONS OF PREVENTABLE CHILD DEATHS

Between April 2008 and March 2009 the following classification was used: -

Classification of death as preventable or otherwise: -

Preventable	Identifiable failures in the child's direct care by any agency, including parents; latent, organisational, systemic or other indirect failure(s) within one or more agency
Potentially preventable	Potentially modifiable factors extrinsic to the child
Not preventable	Death caused by intrinsic or extrinsic factors, with no identified modifiable factors
	Inadequate information upon which to make a judgement. *NB this category should be used very rarely indeed.*

Between April 2009 and March 2010 the following classification was used

Classification of death as preventable or otherwise: -

Preventable	Modifiable factors where if a particular action had been taken the death could have been prevented
Potentially preventable	Potentially modifiable factors extrinsic to the child
Not preventable	Death caused by intrinsic or extrinsic factors, with no identified modifiable factors
	Inadequate information upon which to make a judgement. *NB this category should be used very rarely indeed.*

From April 2010 the following classification has been used: -

Modifiable factors identified	The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths
No Modifiable factors identified	The panel have not identified any potentially modifiable factors in relation to this death
	Inadequate information upon which to make a judgement. *NB this category should be used very rarely indeed.*

From March 2015, preventable child deaths have been identified as:
Preventable child deaths as those in which modifiable factors may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced.