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: -

The LSCB should ask all member agencies to review the information they provide to parents about feeding young children to ensure that it includes reference to the need for supervision of young children whilst eating and highlights the risk of choking from certain foods.

The CDOP is concerned regarding the problems with coronial process namely that the parents had not been informed of the date of the post mortem and that almost a year after the death the GP had still not received a copy of the post mortem or the cause of death. The CDOP recommends that the chair of the LSCB raise these concerns with the coroner in Southwark.

There were no recommendations to the Brighton & Hove LSCB

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 Maggie Pugh– 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:** Sam Tyler - Specialist Nurse for Child Deaths Jo Tomlinson – Designated Nurse Jamie Carter - Designated Paediatrician Deb Austin – Head of Safeguarding Kerry Clarke - Public Health Fiona Rose – Named Midwife Dr Cassie Lawn – Neonatologist Heather Brown - Obstetrician Mary Flynn, Named GP

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.

3. National Developments, Challenges and Achievements

3.1 In May 2016 the Government published its response to the Wood review saying that as 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. To date this has not occurred although Department of Health convened consultation conferences in Spring 2017.

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

3.2 Another national development was further research regarding a national CDOP database, this 18-month feasibility study was funded by NHS England, commissioned by the Healthcare Quality Improvement Partnership (HQIP). This involved consultation with a range of professionals involved in CDOP work as well as with bereaved parents. The outcome of the research was that there was overwhelming support from everyone for the development of a national database. It was noteworthy that bereaved parents not only considered that such a database was a positive development but several of the parents interviewed objected to the fact that such a database did not already exist. The recommendations of this research have been submitted to NHS England who released the following statement: *"A Child Death Review Database is planned to be commissioned and further details of the procurement process will be available on the HQIP website early in the New Year.* This was updated on 10 May 2017 when a further statement was released that said HQIP had been requested to commission a National Child Mortality Database on behalf of NHS England. This contract opportunity has been withdrawn at this time.

4. Local Developments, Challenges and Achievements

4.1 Locally the Brighton and Hove component of the CDOP has been subject to significant change with changes in the representation on CDOP by the Designated Doctor, CDOP Nurse, Designated Nurse and Public Health. There was good handover by those professionals and this panel has been further strengthened by the named GP becoming a member.

4.2 There has also been a change in the CDOP co-ordinator and the CDOP had a vacancy in this role for three months which did present a challenge to the smooth functioning of the panel resulting in the cancellation of two panel meetings which influenced performance data for East Sussex. The CDOP co-ordinator function is currently being fulfilled by the CDOP co-ordinator for West Sussex CDOP which is very positive as it enables closer working with a neighbouring CDOP and promotes consistent working and shared learning across the geographical area.

4.3 There has been a focus across the area on deaths from suicide as all three LSCBs have experienced a number of such deaths, some of which have required serious case reviews. There has been co-ordination of findings across Brighton & Hove and East Sussex and it is hoped that this will extend to West Sussex in the near future.

4.4 An area of development work agreed in 2016 for the panel was suicide prevention as there had been a number of such deaths across both LSCBs. Work in Brighton & Hove has included:

- 'Talking about suicide' a young people's guide,
- suicide prevention training across a whole school system,
- protective behaviours work supporting transitions to Year 7 in secondary school,
- parent workshops aimed at parents whose children or young people have been involved in self-harm,
- art activities for young people.

5. Work of the Panel

5.1 The CDOP has held 9 meetings in the past year (including 2 Brighton & Hove neonatal panels and 2 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 in order to identify modifiable factors and establish learning about professional practice on behalf of the two Local Safeguarding Children Boards (LSCBs).

5.2 Between April 2016 and March 2017, the CDOP was notified of 32 deaths of children who were resident in East Sussex (21) and Brighton & Hove (11) which is a decrease in the number of deaths since last year.

5.3 The CDOP has reviewed a total of 35 deaths (22 East Sussex and 13 Brighton & Hove) during 2016/17 which is fewer than were reviewed last year. There will always be a delay between the date of a child's death and the CDOP review being held. Of the 11 Brighton & Hove reviews completed in 2016/17 6 (56%) were completed within six months. In East Sussex 4 (19%) out of 22 reviews were completed within six months. East Sussex do have almost twice the number of deaths which may be one explanation for the longer time taken to complete reviews. Performance was also significantly affected by the absence of a CDOP co-ordinator for three months leading to the cancellation of two East Sussex CDOP panel meetings.

6. Child Death data

6.1 In East Sussex 19% of the population were aged under 18 years and in Brighton & Hove 18% of the population were aged under 18 years. Child poverty is significantly lower compared to England however within East Sussex the boroughs of Eastbourne and Hastings have significantly higher child poverty compared to the national average.

6.2 For indicators around pregnancy and infancy Brighton and Hove is significantly better or similar to the national average. East Sussex is significantly better or similar to the national average for most indicators except mothers smoking at the time of delivery which is significantly higher at a county level and in Eastbourne and Hastings. Eastbourne and Hastings Boroughs have significantly higher proportions of children in poverty and in Hastings although breastfeeding initiation is significantly better compared to nationally, breastfeeding at 6-8 weeks after birth is significantly worse. This may be a contributory factor to the higher rates of sudden infant death in East Sussex.

Table 1: Population, births and infancy data for East Sussex and Brighton and Hove

	England	Brighton & Hove	East Sussex	Eastbourne	Hastings	Lewes	Rother	Wealden
Population aged under 18 years, 2015	11,677,856	51,249	105,873	19,924	19,239	19,756	16,171	30,783
Live births, 2015	664,399	2,952	5,046	1,070	1,099	877	677	1,323
Still births, 2015 (* n<5)	2,952	14	18	6	*	*	*	*
Maternities to mothers under 20 years, 2015	22,397	93	198	48	59	25	27	39
Children in poverty (under 16s) (%), 2014	20	18	19	21	29	16	19	11
Smoking status at time of delivery (%), 2016/17	11	5	12	13	18	7	13	9
Low birth weight of term babies (%), 2015	3	3	3	4	3	2	3	2
Breastfeeding initiation (% of all maternities), 2016/17 (Eng and B&H Q1-Q3 only)	73	88	80	81	76	82	75	83
Breastfeeding 6-8 weeks after birth (% of all eligible infants), 2016/17 (Eng and B&H Q1-Q3 only)	44	66	47	46	38	50	42	55
Infant mortality (per 1,000 live births), 2013-15	4	4	3	4	5	2	4	2
Child mortality 1-17 years (age-standardised rate per 100,000), 2013-15	12	10	14					
Significantly better compared to England								
No significant difference to England								
Significantly worse compared to England								

Deaths notified to CDOP (9 years pooled data)

6.3 Over the 9-year period April 2008 – March 2017 CDOP were notified of 419 deaths. On average, 31 deaths per year are notified to CDOP for East Sussex and 16 per year for Brighton and Hove. 59% of deaths were for males.

Table 2: Deaths notified to CDOP by year of death, 2008/09 to 2016/17

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	Total
East Sussex	37	37	26	33	26	36	26	33	21	275
Brighton & Hove	16	20	11	21	18	16	16	15	11	144

Age at death (9 years pooled data)

6.4 The age profiles of the deaths notified to CDOP are shown in figure 1. During the 9-year period around 3 in 5 deaths (56%) notified for Brighton and Hove were for babies aged under 28 days compared to 2 in 5 (41%) for East Sussex, which is more similar to England (46%). East Sussex has the highest proportion of deaths that were for 15-17 year-olds (13% vs 9% for B&H and 11% for England).

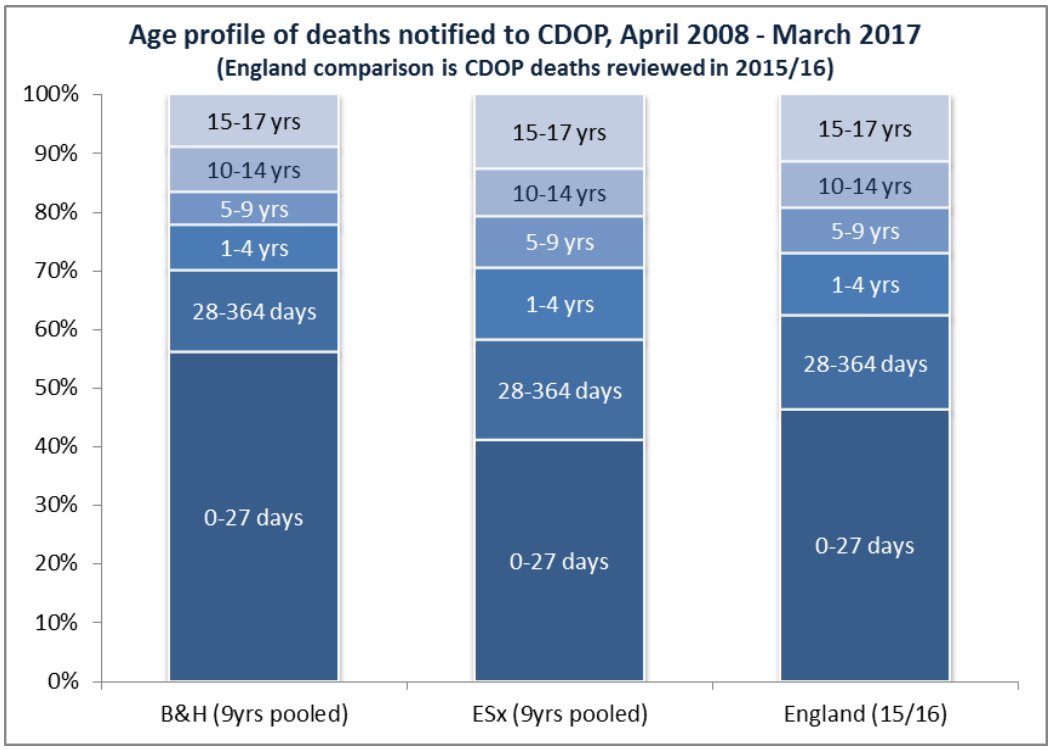

Figure 1: Age profile of deaths notified to CDOP, 2008/09 to 2016/17

6.5 Across all age groups there are no significant differences in the rates of deaths between the two areas or compared to nationally (figures 2 and 3).

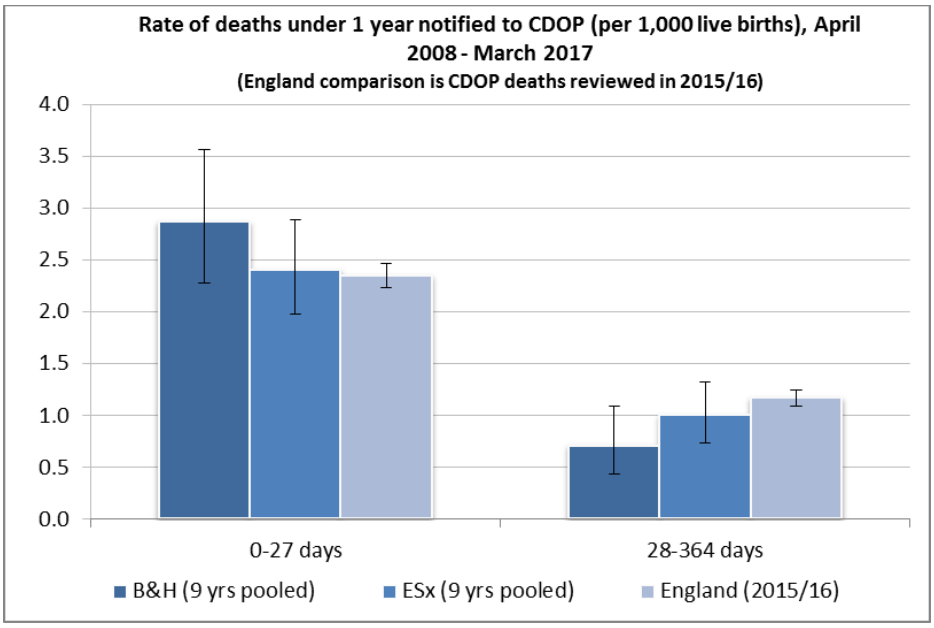

Figure 2: Rate of deaths under 1 year notified to CDOP, 2008/09 to 2016/17

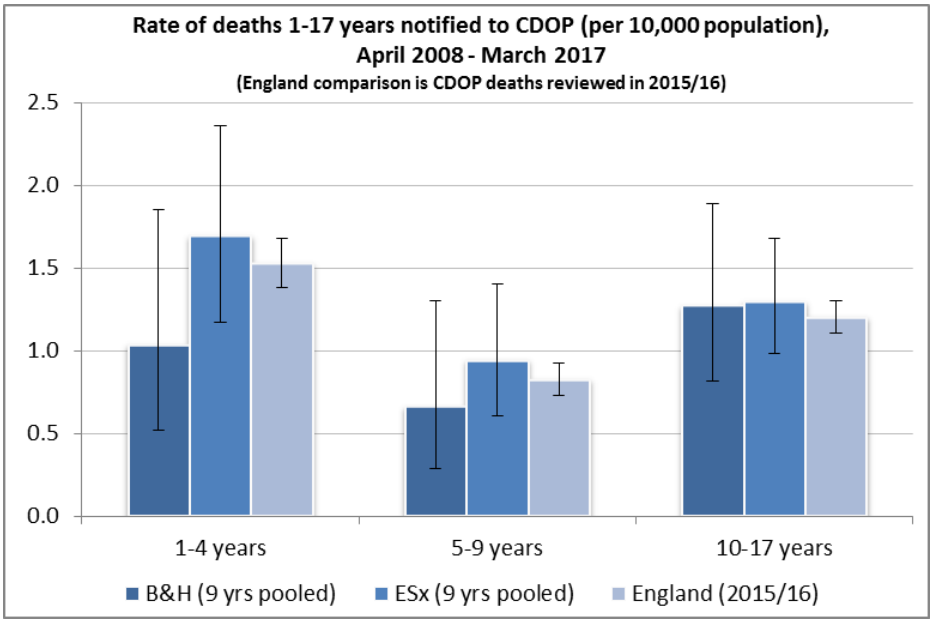

Figure 3: Rate of deaths 1-17 years notified to CDOP, 2008/09 to 2016/17

Deprivation (9 years pooled data)

6.6 Figures 4 and 5 shows the rate of deaths by national income deprivation affecting children index (IDACI) quintile. Quintile 1 is the most deprived and means that

those areas are in the most 20% deprived areas in England based on IDACI. Quintile 5 means those areas are in the 20% least deprived areas in England.

Figure 4 shows that within East Sussex the rate of deaths in under 1s is significantly higher in the most deprived quintile compared to the least deprived. There are no other significant differences between areas in East Sussex. In Brighton and Hove the under 1 year death rate is significantly higher in the most deprived quintile compared to the 2nd least deprived (quintile 4). For Brighton and Hove the rate of deaths in babies under 1 year from the least deprived quintile is higher compared to quintiles 2-4 but it is not significantly different.

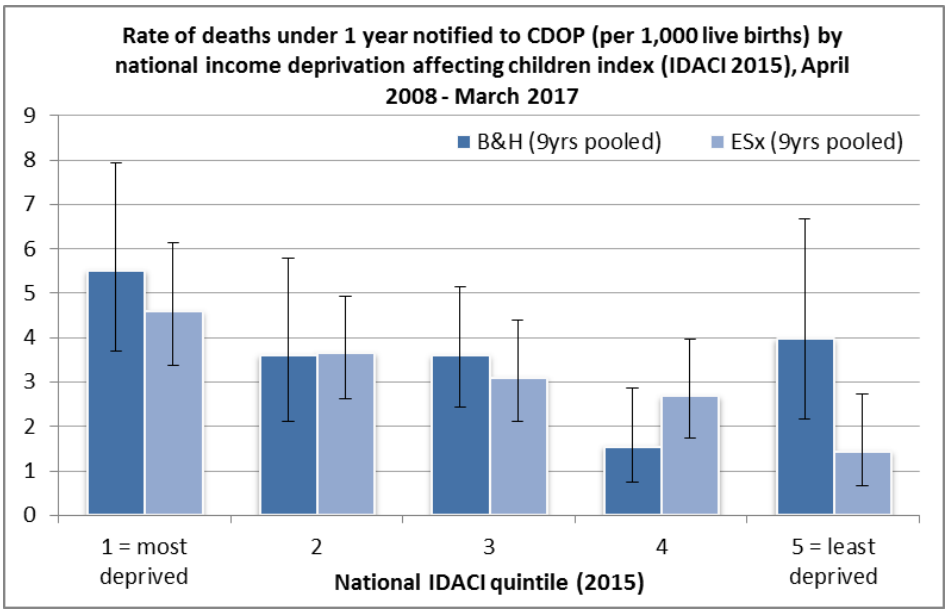

Figure 4: Rate of deaths under 1 year notified to CDOP by income deprivation affecting children, 2008/09 to 2016/17

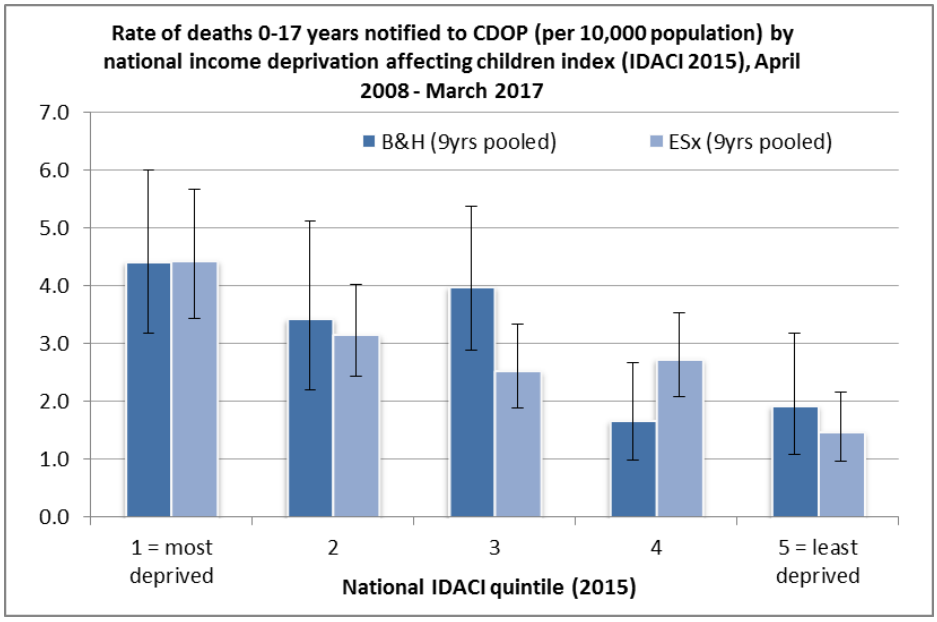

Figure 5: Rate of deaths 0-17 years notified to CDOP by income deprivation affecting children, 2008/09 to 2016/17