**West Sussex Child Death Overview Panel**

**What are we committed to?**

All children in England that die aged under 18 years will have their death reviewed by a multi-agency team of professionals from Health, emergency services, Local Authority Children’s Services, Education, Coronial Services and Public Health. This has been a statutory requirement since 2008. The West Sussex Child Death Overview Panel (CDOP) is committed to:

* Identifying what we can learn from each child death and what actions we can take to help prevent future deaths
* Sharing our learning with professionals and colleagues both locally and nationally and learning lessons from the experiences of other CDOPs and professional bodies
* Getting messages out to the wider public audience when risks and modifiable factors are identified and the general public need to be made aware.

**Modifiable Factors**

These are the factors that are identified during the child death reviews, factors which may have contributed in some way to the deaths but which, with appropriate local or national actions, could be modified in a way that would help to prevent future child deaths. The West Sussex CDOP works hard to reduce modifiable factors it has identified during the review of child deaths such as; smoking by the mother during pregnancy, keeping children safe in the water, choking hazards and ensuring that babies are sleeping in a safe environment.

**What have we learnt in 2017-2018?**

There have been 48 child deaths reported in 2017 – 2018. These have shown us that:

* There were more male deaths (62%) than female deaths (38%)
* The greatest number of child deaths occur within the first 4 weeks of life (42% )
* 38% of the child deaths were classified as “unexpected”

There have been 33 deaths of West Sussex children reviewed by the West Sussex CDOP in 2017-2018 and we have learnt that:

* 30% of those deaths had modifiable factors identified (national figure for 2016-2017 was 27%)
* The largest numbers of child deaths were related to perinatal/neonatal events (38%)
* 21% of child deaths were categorised as “ Malignancy” (Cancer related illnesses)
* There have been no suicide related deaths reviewed in 2017-2018 but the Panel recognises that these deaths are increasing in number nationally and therefore the prevention of suicide in young people will remain a key priority for its future work.

**What have we achieved in 2017-2018?**

* Stronger links and information sharing has been achieved across Sussex to improve practices. All Sussex CDOPs are now managed by a single Pan Sussex CDOP Officer and a new Pan Sussex Suicide Prevention Group was started.
* A lot of information needs to be collected from a wide range of agencies before a child death is brought to panel for review. This has been done in a much more timely way in 2017-2018 with 82% of child deaths being reviewed within 7 months (48% nationally).
* The active promotion of safer sleep messages by the Panel and its partners and via LSCB training programmes has resulted in a 100% reduction in modifiable factors relating to sleeping practice being identified during child death reviews over the last 4 years, with it not being identified in any reviews in 2017-2018.
* Support for bereaved families continues to be a strength despite ongoing resourcing issues. This is made possible by an active West Sussex Bereavement Forum, the CONI (Care of Next Infant) programme and a dedicated and trained Bereavement Counsellor who is a central figure within our Rapid Response Team.

**What do we want to achieve in 2018-2019?**

The way in which child death reviews are conducted is changing and we are currently waiting for the new “Child Death Reviews Statutory Guidance” to be published by the Government. The location of a child death will, in future, determine where the death is reviewed and by whom and so in 2017-2018, as part of our transition planning, West Sussex conducted a review of the location of child deaths over the previous 3 years. The results showed us that in that period:

* 34% of West Sussex Children died within a Sussex based Hospital
* 36% of West Sussex Children died within a hospital outside of Sussex
* 30% of West Sussex children died outside of a hospital based environment

During 2018-2019 we will be developing and implementing our transition plans to ensure that child death reviews in West Sussex continue to be robust, timely, meaningful and able to meet the new statutory requirements.

The Panel and its partners will continue to actively promote the risks that are identified during our child death reviews and search for ways in which these can be minimised in order to prevent the future deaths of children here in West Sussex.