

Child Death Overview Panel

10th Annual Report

1st April 2017 – 31st March 2018

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**Welcome**

Welcome to the tenth annual report of the West Sussex Child Death Overview Panel

(CDOP).

Included in this report is information about the 48 child deaths that occurred during 2017-2018 and about the 33 child deaths that were reviewed by the CDOP between April 2017 and March 2018. There is an overview of issues arising from the review of child deaths by the Panel, information on the response to unexpected child deaths and an outline of actions taken to reduce future child deaths. The publication of National CDOP data has been delayed, so comparisons within the report have been made against the national data from 2016-2017. Future priorities are outlined in the report that will inform the on-going work of the CDOP and the West Sussex Safeguarding Children Board (WSSCB) in 2018-2019.

Over half of the deaths that were reviewed by CDOP were of babies aged under the age of 1 year. Modifiable factors that may have contributed to child deaths were identified for ten of the deaths reviewed. This was the same number as in 2016-2017 but there was no single, common modifiable factor identified in 2017-2018.

There were no child deaths identified at the Panel reviews where safe sleeping and co-sleeping were reported as modifiable factors. This is a 100% reduction in the number of deaths where this was identified as a modifiable factor over the last 4 years. CDOP continues to work closely with local charities, frontline staff and the LSCB to continually communicate the risks and to promote good practice associated with safer sleep.

Planning for collaboration with East Sussex and Brighton and Hove CDOPs is starting, following the recent national review of Child Death Review processes. This joint work will build on current collaboration, such as at Kent, Surrey and Sussex CDOP shared learning events and on Pan Sussex Suicide Prevention work.

As it is my last year as Chair of CDOP, I should like to thank all the current and past members of CDOP and Local Safeguarding Children Board partners for their commitment and support to the Panel, for their sharing of the learning from CDOP and for their actions aimed at reducing the risks of future child deaths in West Sussex.

Dr Ann Corkery

Chair of West Sussex CDOP

**Executive Summary**

**Child Death Notifications**

Between 1st April 2017 and 31st March 2018 there were 48 deaths of children aged under 18 years notified to the West Sussex Child Death Overview Panel (CDOP). After a 39% reduction in the number of deaths in 2016-2017 with 28 child deaths reported in 2017-2018 there was a 71% increase with a similar number of deaths being reported as were in 2015-2016 when there were 46 deaths reported. Of the 48 deaths notified to the CDOP in 2017-2018:

* There were 29 male deaths and 18 female deaths and 1 classed as “indeterminate”
* There were 20 neonates (infants who die before reaching 28 days of age).
* A further 8 were aged between a month and a year of age.
* There were 30 deaths classified as expected and 18 (38%) classified as unexpected (deaths that were not anticipated as a significant possibility 24 hours before death or where there was an unexpected collapse leading to or precipitating the events that led to the death). In 2016-2017 43% of child deaths were unexpected.

The number of deaths of children normally resident in West Sussex reported to CDOP in 2017-2018 was 48. After a large reduction in the number of deaths in 2016-2017, the number of child deaths in 2017-2018 was much closer to the average number of child deaths recorded over the last 10 years, which was 44 deaths per year.

**Child Death Reviews**

During 2017-2018 West Sussex CDOP met 6 times and reviewed the deaths of 33 children. There were no reviews carried out by other CDOPs following the deaths of West Sussex children. Of the child death reviews that were completed 82% were completed within 7 months, a significant improvement from 2016-2017’s figure of 47%.

14 of the child deaths reviewed during 2017-2018 were of infants who died before reaching 28 days of age (neonatal deaths) and a further 3 deaths reviewed were those of older babies aged under 1 year. As expected, there continue to be more deaths reviewed of babies and young children under a year of age, than of older children, with babies under a year accounting for 52% (64% in 2016-2017) of the child deaths reviewed during 2017-2018 in West Sussex.

Modifiable factors, factors which by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths, were identified during the reviews of 10 deaths this year. Of these, 5 deaths where modifiable factors were identified were of babies aged under a year of age.

A broader range of modifiable factors were recorded in 2017-2018 with no recurring factors being identified for specific scrutiny and action. There were no deaths reviewed in 2017-2018 where safer sleeping was identified as a modifiable factor, showing a 100% reduction in this as a modifiable factor over the last 4 years.[[1]](#footnote-1)

**Data Analysis: Child Death Notifications in 2017-2018**

Population estimates as reported in the Office of National Statistics (ONS) mid-year population estimates for 2016, estimate that West Sussex had a total population of 843,765 (836,256 in 2016 and 828,398 in 2014) of which 171,761 were aged 0-17 years inclusive. This is a 4.6% increase in the number of children (7625 children) between the 2011 census and the mid-year estimate in 2016.

District and borough population estimates vary from 12,825 children aged 0-17 in Adur District (7.5% of the county total) to 32,206 children aged 0-17 in Mid Sussex district (19% of the county total).

There are estimated to be 5909 more males than females in the 0-17 age group, with 0-17 males making up 10.5% of the total population of West Sussex (51.7% of 0-17 year olds), while 0-17 females make up 9.8% of the total population (48.3% of those aged 0-17 years). The rate of male child deaths in 2017-2018 was higher than that of female child deaths with 62% of the reported deaths being deaths of male babies or children compared to 38% female.

Over the past 10 years there has been an average of 44 child deaths in West Sussex notified per year. Between 1st April 2017 and 31st March 2018 a total of 48 deaths were notified of children normally resident in West Sussex. This was a 71% increase compared with 2016-2017 and higher than the yearly average of 44 deaths per year but followed a year where there had been a significant reduction in child deaths.

Table 1 below shows the number of child deaths between April 2008 and March 2018. A comparison of the average number of child deaths in the first 5 years (48) and the last 5 years (41), suggests that there has been a reducing trend in the number of deaths over time, although there is considerable year to year variation.

**Table 1: Child deaths data 2008-2018 for West Sussex**

|  |  |
| --- | --- |
| **Year** | **Number of Deaths** |
| 2008-09 | 62 |
| 2009-10 | 40 |
| 2010-11 | 47 |
| 2011-12 | 52 |
| 2012-13 | 38 |
| 2013-14 | 37 |
| 2014-15 | 44 |
| 2015-16 | 46 |
| 2016-17 | 28 |
| 2017-18 | 48 |

**Chart 1: Ages of children that have died by year: 2013 - 2018**

Considering the ages of the children who died in West Sussex between April 2013

and March 2018 (see chart 1 above) it is apparent that the greatest number of child deaths occur in the first 4 weeks of life.

Chart 1 illustrates how two-thirds (63%) of all child deaths in West Sussex over the last 5 years have been of infants under 1 year of age (68% in 2016-2017). There has been a decrease in 2017-2018 in the percentage of child deaths that are of children under 12 months, accounting for 58% of all child deaths, as compared to 68% in 2016-2017 although the number of deaths of babies aged under a year increased from 19 in 2016-2017 to 28 in 2017-2018.

**Table 2: 1Age of children whose death was reported in 2017-2018**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **0-27 days** | **28-364 days** | **1-4 yrs.** | **5-9 yrs.** | **10-14 yrs.** | **15-17 yrs.** |
| 20 | 8 | 6 | 6 | X | X |

*1 Note that some numbers have been replaced with an X to protect confidentiality as some figures are below 6*

Appendix 1 contains ONS data for 2016 (the latest data available in June 2018) for comparison of child death data at national, regional and at the West Sussex local authority area level. When making comparisons it should be borne in mind that the local numbers of deaths are very small and will vary year to year, making it difficult to compare 2017-2018 figures to national data from 2016. It can be seen also that nationally child deaths under a year of age account for a large proportion of child deaths.

**Data Analysis: Child Death Overview Panel Findings in 2017-2018**

During 2017 – 2018 the CDOP met 6 times and completed the review of **33** child deaths. All of these were children normally resident within West Sussex. Of the cases reviewed **21** related to deaths occurring between 1st April 2017 and 31st March 2018, **11** were deaths that had occurred during the year 2016 -2017 and one case related to a death that occurred in the year 2015-2016. This last case had been delayed due to the death happening abroad and local investigations taking place.

43% of all child deaths reviewed were of infants who died before reaching 28 days of age, excluding any stillbirths or any live births resulting from a planned termination of pregnancy. See Chart 2.

**Chart 2: Child Deaths Reviewed 2017-2018 by Age Group**

Table 3 shows that of the deaths reviewed by the CDOP and the categorisation of the deaths, 30% of the deaths were considered to have modifiable factors, compared to 27% nationally.

Of the deaths reviewed, as found in previous years, the largest number were classified as due to **perinatal/neonatal events (**13 cases (38%)). This refers to a cause of death ultimately related to perinatal events, irrespective of the child’s age at death. This is a increase on 2016-2017’s figure of 30% . The national figure in 2016-2017 for child deaths classified as due to perinatal/neonatal events was 34% (32% in 2015-2016).

The number of child deaths in “Category 4: Malignancy” has risen in 2017-2018 to the second largest category of deaths with 21% of all cases being classified in this category. The number of deaths categorised as Sudden Unexplained Death of an Infant (SUDI) has reduced to zero for the first time in the last 5 years.

There were no deaths reviewed that were categorised as “suicide” in 2017-2018, the first time in the last 4 years. The Panel are aware however that there are a growing number of deaths in young people from Suicide being reported nationally and Panel members were actively involved in the West Sussex Suicide Prevention Group and a new Pan Sussex Suicide Prevention Group. They have been proactive in encouraging the joint working of the 3 existing groups across East Sussex, West Sussex and Brighton and Hove.

**Table 3: Categories of child deaths reviewed in 2017-2018: WSSCB CDOP and National CDOP Data from 2016-17**

| **Categories** | **WSSCB CDOP Total**  **number of children6** | **WSSCB CDOP % of Cases identified with modifiable**  **factors6** | ***National CDOP Total number of children6*** | ***National CDOP Data 2016-17***  ***% with modifiable factors*** |
| --- | --- | --- | --- | --- |
| 1. Deliberately inflicted injury, abuse or neglect | X | 0 | 47 | 64% |
| 2**.** Suicide or deliberate self-inflicted harm | 0 | 0 | 101 | 46% |
| 3. Trauma and other external factors | X | 75% | 210 | 60% |
| 4. Malignancy | 7 | 0 | 263 | 3% |
| 5. Acute medical or surgical condition | X | 100% | 202 | 26% |
| 6. Chronic medical condition | X | 0 | 176 | 15% |
| 7. Chromosomal, genetic and congenital anomalies | X | 0 | 884 | 10% |
| 8. Perinatal/neonatal event | 13 | 38% | 1194 | 28% |
| 9. Infection | 0 | 0 | 212 | 35% |
| 10. Sudden unexpected, unexplained death | 0 | 0 | 260 | 71% |
| 11. Unknown category | 0 | 0 | 6 | 67% |
| **Total No of cases** | **33** | **30%** | **3555** | **27%** |

Of the 33 child deaths reviewed by the Panel in 2017-2018 10 deaths (30%) were classed as having modifiable factors, a slightly higher percentage of cases compared with 2016-2017 (28%) and the previous year (25%). These factors are defined as those which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths. 17 (51%) of the cases identified with modifiable factors related to children under the age of 1 year, a fall of 13% on 2016-2017’s figure (64%) and the second year in a row that this percentage has fallen.

There were no specific, recurring modifiable factors in 2017-2018. Some factors identified during reviews included; Obesity of Mother, Obesity of Child, Consanguinity, Smoking by Mother during Pregnancy, Smoking by both parents and delays in medical intervention.

**Chart 3: Categories that explain a child’s death: 5 Year Comparison**

Of the 33 deaths reviewed, 13 were male and 19 were female. There was one child where the gender was indeterminate. The ethnicity of all the cases reviewed in 2017-2018 is shown in Chart 4 below. 88% of the child deaths reviewed in 2016-2017 were of children in the ethnic group “White British/White other” which is the largest ethnic group in West Sussex accounting for 95% of the population in 2016 (West Sussex Life 2017-2019).

**Chart 4: Child Deaths: Ethnicity 2017-2018**

None of the children who had their deaths reviewed by the CDOP in 2017-2018 were asylum seekers, none were or had been subject to a statutory order and none had previously been on a child protection plan.

Chart 5 below shows the location of the child at the time of the event or condition which led to their death and compares 2017-2018 data with that of the previous 4 years. The “Home of Normal Residence” remains one of the most common locations of child deaths and over the last 5 years more children have died at home than in any other single location. In 2016-2018 most child deaths occurred within Acute: Neonatal Units (39%) followed by home of normal residence (27%).

**Chart 5: Location of the child at time of event or condition which led to their death**

There has been a slight drop in the number of child deaths reviewed in 2017-2018 down to 33. At the end of 2017-2018 there were 30 cases waiting to be reviewed which was an increase when compared to the last 2 years (2015/16 - 23 cases, 2016/17 -15 cases). This is due, in part, to the increased number of child deaths during the year and was contributed to by 7 cases that have been delayed due to Serious Case Reviews being undertaken or delayed awaiting inquests.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **2013-14** | **2014-15** | **2015-16** | **2016-17** | **2017-18** |
| **No of Cases Reviewed** | 51 | 33 | 51 | 36 | 33 |

The timeliness of reviews being undertaken has improved significantly in 2017-2018. In 2017-2018 82% of cases reviewed were completed in 7 months (47% in 2016-2017) from the date of death (compared to the 2016/17 National figure of 48%). This shows a 74% improvement on 2016-2017’s figures.[[2]](#footnote-2)

**Chart 8: Time taken to review cases 2017-2018: Comparison with national average for 2016-2017**

**Review of the location of death for West Sussex Children**

In preparation for the awaited changes to the way in which child deaths are reviewed nationally and the publication of the new guidance which is due in the Summer of 2018, a review was undertaken to find out where our children have died over the last 3 years. There were114 deaths of West Sussex Children in the 3 year period reviewed and the results showed that:

* 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
* 16% of West Sussex Children died at HOME (compared to just 8% for East Sussex and Brighton & Hove Children)

**Rapid Response to unexpected child deaths during 2017-2018**

An **expected** death is categorised as the natural and inevitable end to an irreversible terminal illness, so death is recognised as the inevitable outcome. The decision that a death is expected should be clearly recorded in clinical records. An **unexpected death** is one where the death of the child was not anticipated as a significant possibility 24 hours before or where there was a similarly unexpected collapse or incident leading to or precipitating the event which led to the death. (*Working Together to Safeguard Children 2015.)*

The Rapid Response protocol is currently only relevant to those deaths that are unexpected. Of the 48 children whose deaths were recorded between 1st April 2017 and 31st March 2018, 19 were recorded as unexpected and the rapid response protocol was activated for 16 of these cases. Audits of the Rapid Response process have shown that the timeliness of the response when a child dies unexpectedly and the overall ethos of multi-agency working are good.

There have been 2 audits completed on the rapid response procedures during 2017-2018 to identify opportunities to improve the process. In the first half of the year the audit reported that Joint Home Visits were not always being undertaken by Police and Health representatives together, which is a requirement of the Pan Sussex SUDI protocols and is recognised good practice. The Police representative on the Panel committed to promote good practice and compliance with the protocols within the Police safeguarding teams and the second audit of the year showed that there had been an improvement. The panel will continue to monitor this in the future.

The timeliness and quality of record keeping was another area for improvement that was identified and this is being addressed by the introduction of meeting minutes and agenda templates to be used for all early and late case discussions. The take up and use of these templates is an ongoing issue and remains a focus for improvement over the coming year. Training is one way in which the correct protocols can be promoted and reinforced with both new and existing members of the rapid response team, however there has been no multiagency rapid response training delivered during 2017-2018 due to the retirement of one of the key trainers. The provision of multi-agency training in rapid response protocols remains a key priority for the coming year.

**Progress made against 2017-2018 Priorities**

**For LSCB partners to highlight the hazards to a child’s health and wellbeing caused by smoking, to all mothers and mothers to be.**

Good progress has been made in 2017-2018 in highlighting the risks to mothers of smoking during pregnancy and via the smoking cessation service which operates at more local and accessible points of contact within GP surgeries and pharmacies. There has been a reduction in 2017-2018 in the number of cases where smoking during pregnancy or smoking by a parent has been identified as a modifiable factor.

**To take action to reduce other modifiable factors that are identified as a result of on-going child death reviews, locally and nationally, to reduce the risk of harm to children in the future.**

There have been no recurring modifiable factors recorded during the reviews in 2017-2018 and therefore no trends identified for action.

**To continue to improve awareness, understanding and application of Rapid Response protocol across the different agencies.**

There have been delays in the delivery of multi-agency rapid response training in 2017-2018 due to the departure and non-replacement of key trainers from the Police Service. This has meant that some new members of staff participating in the rapid response process have not been recently trained. This has resulted in additional work for more experienced members of the rapid response teams, such as the Specialist Nurse Rapid Response, who have guided and steered their colleagues proactively to ensure that the protocols continue to be met. This has been picked up as an issue within the Rapid Response Audit Reports and remains a high priority for the panel in the coming year.

**To review and implement the new Working Together guidance when it is published by NHS England.**

The panel has been actively involved in the consultation process for shaping the new national guidance for Child Death Reviews over the last 12 months and is currently awaiting the publication of the new guidance. West Sussex has agreed to participate in a Pan Sussex Transition Planning Group which is being led by the CCGs and Local Authorities across the region. This group will work together to plan and implement the new Child Death review guidance across Sussex.

**To review the way in which the deaths of children with life limiting conditions are managed, when a child dies unexpectedly.**

There has been no progress possible on this during the year as no deaths have fallen within scope. The new LeDeR (Learning Disability Mortality Review) programme was introduced in 2017-2018 and West Sussex CDOP has engaged fully with their local LeDeR representative who is now actively participating in the CDOP reviews of the deaths of children with Learning Disabilities.

**To support the LSCBs 3 strategic priorities for 2017-2018 by ensuring that child deaths are suitably scrutinised in relation to; Neglect, Child Sexual Abuse (CSA) and children Missing and Emotional Wellbeing and Mental Health**

There have been no cases reviewed by the panel in 2017-2018 where CSA, Missing Children, Neglect or Mental Health were identified as an issue. The panel did discuss factors related to Neglect and considered ways in which their review of the recording of relevant data and information may be strengthened. The use of the Form C was felt to be an adequate mechanism at present to ensure that factors related to neglect were being sufficiently considered and recorded.

**To share information and learning with other CDOPs and take proactive and preventative actions in order to minimise the risk of harm to children in West Sussex.**

Members of the panel have participated in a range of information sharing activities in 2017-2018 including the; South East Sharing Good Practice Event (Nov 2017); Annual CDOP Conference (May 2018); SUDI Survey (Dr Joanna Garstang – Warwick Medical School). The panel has also carried out regular reviews of Regulation 28 reports that are published nationally and have, where appropriate, taken actions to ensure that local procedures are suitably robust to reduce the risk of similar issues arising here in West Sussex.

**Supporting Bereaved Families**

The Specialist Nurse continues to manage a caseload of bereaved families across West Sussex, mainly those who have had children who have died unexpectedly, supporting them through the child death review and bereavement process. With an increased number of unexpected deaths since January 2018 this has resulted in a higher number of bereavement visits and clients on the caseload. There has been a rise in clients who have needed support prior to inquest following a neonatal death. Some of the clients have required a greater intensity of support due to lack of their own support network. The spread of deaths across the county resulted in much travelling across county. The specialist nurse has established a strong working relationship with Chestnut Tree Hospice and when appropriate families have been signposted to the hospice bereavement team.

The Specialist Nurse has also been involved in the following networks during 2017-2018:

* **West Sussex Child Bereavement Forum**

This forum has continued to meet 6 monthly during the year, as a vehicle for sharing good practice and providing updates on the latest service provision. There continues to be gaps in NHS counsellor provision in the Worthing Children Community Nursing Team and the North team. There is no NHS provision for couples counselling in West Sussex following the death of a child.

The Forum, in conjunction with Horsham and Mid Sussex and Crawley Clinical Commissioning Groups, organised a public event to raise the profile of Dying Matters week in May 2017. The emphasis was on promoting talking about death to children.

* **CONI (Care of Next Infant)**

Parents who have suffered a sudden and unexpected death of a baby will often feel worried and need additional guidance and support when they have another baby. CONI is a national health-visitor led service for bereaved parents that offers support to families before and after the birth of their next new baby. The Specialist Nurse is the lead for the CONI programme in West Sussex. She takes the referrals and allocates families to the CONI coordinators across the county. The CONI coordinators have helped to promote the safer sleep messages during “Safer Sleep week” in March 2018.

There have been 2 CONI coordinators who have stepped down from their roles which have not been filled. However the number of referrals has reduced. There have been 4 families receiving support through the CONI programme.

**Information sharing to improve practices**

West Sussex CDOP continues to be proactive in networking with other CDOPs both at a regional and national level. In May 2017 the role of the West Sussex CDOP Officer was combined with the equivalent roles in East Sussex and Brighton and Hove to provide a single Pan Sussex CDOP role, covering the coordination of all CDOP Panels across Sussex. This has facilitated the sharing of information across the 3 Counties and helped to build greater consistency of approach.

The Pan Sussex CDOP Officer has also taken on the role of South East Representative within the National CDOP Network Executive Team, contributing to the national consultation on the future of Child Death Reviews and helping to shape and deliver the Annual National CDOP Conference that was held in May 2018.

**Training and Development**

* Safer Sleep: This topic has now been added to the WSSCB Learning and Development programme, in recognition of the fact that the continual delivery of the safer sleeping messages is crucial in the prevention of future child deaths. Two training sessions, given by the Specialist Nurse Rapid Response and the South East Regional Coordinator from the Lullaby Trust, took place with 40 attendees. Since the campaign in Nov 2014 the number of babies dying through sudden infant death syndrome remains low and no cases were recorded at CDOP reviews during 2017-2018. . It is recognised however that there is no place for complacency. Work continues to raise awareness of reducing the risks for sudden infant death in safer sleep week and working with Child Health Improvement specialists and the LSCB in sending out regular information via bulletins and on the WSSCB website.
* There was no multi-agency Advanced Rapid Response Training run during 2017-2018 due to the retirement of the previous trainer and the need for a replacement to be identified. This is a key priority for 2018-2019.
* The Annual National CDOP Networking event was held in Birmingham in May 2018 and was attended by 2 CDOP members, the Specialist Nurse and the Pan Sussex CDOP Officer. Key points of learning were brought back and shared with the Panel via a briefing paper prepared by the CDOP Officer.

**Evidence of Impact**

* For the first time in 2017-2018, within the last 4 years, there have been no SUDIs (Sudden Unidentified Death in Infancy) due to safer sleep recorded. The Panel, the LSCB and its representatives working within Health continue to promote the safer sleep messages and to train frontline staff. (100% reduction over 4 years).
* Timeliness of child death reviews has improved significantly in 2017-2018 (82% of cases reviewed within 7 months compared to 47% in 2016-2017). National figure is 48%.

**Future Priorities**

The priorities for 2018-2019 will be focussed around the following:

* To ensure that West Sussex CDOP is structured and operates in a way that meets the new guidance for conducting Child Death Reviews.
* Providing a multi-agency training programme for all staff involved in the new Joint Agency Reviews (known previously as Rapid Response)of unexpected child deaths

**Overview of the Work of a Child Death Overview Panel**

|  |  |
| --- | --- |
| **Background to the CDOP**  Working Together to Safeguard Children (2015) sets out the protocol to be followed when a child dies in a Local Safeguarding Children Board (LSCB) area. The death of a child, whether expected or unexpected, represents a tragedy for families, friends and communities. By learning lessons from the systematic review of child deaths in our area, the agencies operating within West Sussex seek to prevent future child deaths and to make a wider contribution to the wellbeing of children and young people.  The CDOP collects data concerning all deaths of children that are normally resident within West Sussex and analyses it with a view to identifying:   * Any case that may give rise to the need for a Serious Case Review; * Any issues that may affect the safety and welfare of children in the West Sussex LSCB area; * Any wider public health or safety concerns arising from a particular death or patterns of deaths.   **Our Purpose**  The overall purpose of the child death review protocol is to understand why some children die and, wherever possible, put in place interventions to prevent future deaths and to protect other children. It is intended that this protocol will:   * classify the cause of death for individual children; * make a decision as to the preventability of the death; * identify any modifiable factors, consider any recommendations that may be made about actions which could be taken to prevent such deaths in the future at a local, regional and national level; and * monitor the support offered to families of children who have died. | **Expected/Unexpected Child Deaths**  Working Together identifies two inter-related processes for reviewing child deaths. These are:  **Rapid Response to the unexpected death of a child** which is carried out by a group of professionals who come together as soon as possible after a child has died for the purpose of enquiring into and evaluating each unexpected death; and  **Review of all child deaths** for children up to the age of 18 years when the child who has died would normally be resident in the West Sussex Safeguarding Children Board (WSSCB) area. This review is undertaken by a designated multi-agency Panel. It is a paper exercise, based on information that has been made available from those who were involved in the care of the child, both before and immediately after the death, and other sources as appropriate.  **Definitions**  A **child** is defined as being less than 18 years of age.  An **unexpected death** is defined as the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death.  **Modifiable Factors** are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths. The CDOP considers modifiable factors in relation to the family and environment, parenting capacity or service provision, and considers what action could be taken locally and what action could be taken at a regional or national level.  **Rapid Response**  A protocol followed by a multi-agency team when a child dies unexpectedly. |

**The Child Death Overview Panel in West Sussex 2017-2018**

|  |  |
| --- | --- |
| **Role** | **Name** |
| Consultant in Public Health - Chair | Dr Ann Corkery |
| WSSCB - CDOP Officer | Maggie Pugh |
| Designated Doctor (CDOP) | Dr Ann Wallace |
| Designated Nurse - Safeguarding Children | Sarah Smith and Rachel Redwood |
| Specialist Nurse, Rapid Response | Annette Lawrance-Owen |
| Child Protection Manager, Sussex Police | Pip Taylor |
| Safeguarding Support Officer, South East Coast Ambulance Service | Terence Gibson |
| Children’s Safeguarding in Education Manager | Jez Prior |
| Service Manager, Children’s Social Care | Caroline Lees |
| Named GP | Hannah Davies |
| IPEH Services Manager | Mark Frankland |
| Representative from HM Coroner’s Office | Jemma Gaule |

**The Annual Report**

Working Together requires every CDOP to prepare an annual report for the LSCB. This report in turn informs the LSCB annual report which should serve as a powerful resource to promote child health, safety and wellbeing. This annual report is a public document, but when published it will not contain any personal information that could identify an individual child or their family.

In order to protect individual data where there are fewer than 6 cases the numbers from 1 to 5 inclusive have been suppressed and are shown as crosses (x). Where any number is shown as zero (0), the original figure was zero. Percentages are shown rounded to whole numbers but where the numerator was 5 or less or the denominator was 10 or less, they have been suppressed and replaced by a cross.

**Communication**

The WSSCB CDOP Officer acts as the Single Point of Contact in West Sussex for notifications of child deaths and as the CDOP Coordinator. The CDOP Officer disseminates the notification of a child’s death to agencies across West Sussex and requests and collates information from those agencies that have been involved with the child prior to and after their death.

In West Sussex we have a specifically designed leaflet that explains the CDOP protocol for parents whose baby dies before the age of 28 days (neonatal) and this is given to them by a health professional who already knows the family. Parents of a child whose death was expected are given the national leaflet explaining the child death protocol to them by a health professional they know and they are offered a home visit from the Specialist Nurse Rapid Response. The parents of children who die unexpectedly are visited by the Specialist Nurse Rapid Response who provides them with the leaflet, explains the purpose of the CDOP and offers them an opportunity to provide feedback of their experience to the Panel.

West Sussex CDOP has been actively involved within the wider national CDOP Network this year with regular participation in the combined South East/South West CDOP Network. This provides a valuable forum for sharing information and ideas, seeking advice and providing support to each other when the need arises.

**Confidentiality**

As stated in Working Together 2015, parents should be informed that for all cases information gathered will be stored securely and only anonymised data will be collated at a regional or national level. Parents should also be made aware that the

CDOP will make recommendations and report on the lessons learned to the WSSCB.

All cases are anonymised at the Panel meeting and all Panel members, any deputies they send and any observers at the meeting must sign a confidentiality statement prior to attending their first meeting. The deliberations of the CDOP are confidential, and are exempt from Freedom of Information requests.

The conclusions reached by the Panel on individual cases are not published but they are communicated to relevant professionals.

**Appendix 1: Data from Office of National Statistics – live births by area of usual residence‚ 2016 death registrations, United Kingdom and constituent countries *(data published by ONS )***

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Area of usual residence** | **Population**  **(thousands)** | **Deaths (numbers)** | | | | | | **Per 1,000 live births** | | |
| **All Ages** | | | **Infant (under**  **1 year)** | **Neonatal (under 4 weeks)** | **Perinatal (stillbirths and deaths under**  **1 week)** | **Infant mortality rate** | **Neonatal mortality rate** | **Perinatal**  **mortality rate (per**  **1,000 live births and stillbirths)** |
| **Persons** | **Male** | **Female** |
| United  Kingdom | **65,648.1** | **597,206** | **293,001** | **304,205** | **3,004** | **2,136** | **5,125** | **3.9** | **2.8** | **6.6** |
|  |  |  |  |  |  |  |  |  |  |  |
| England | **58381.2** | **525,048** | **257,811** | **267,237** | **2,711** | **1,929** | **4,648** | **3.9** | **2.8** | **6.6** |
|  |  |  |  |  |  |  |  |  |  |  |
| **South East** | **9,026.3** | **80,429** | **38,818** | **41,611** | **351** | **272** | **645** | **3.4** | **2.7** | **6.3** |
|  |  |  |  |  |  |  |  |  |  |  |
| **West Sussex** | **843.8** | **9034** | **4265** | **4769** | **19** | **11** | **44** | **2.2** | **1.3** | **5.0** |
| Adur | **63.5** | **666** | **305** | **361** | **0** | **0** | **3** |  |  | **4.5** |
| Arun | **157** | **2219** | **1048** | **1171** | **7** | **3** | **8** | **4.5** | **1.9** | **5.1** |
| Chichester | **118.2** | **1415** | **703** | **712** | **0** | **0** | **5** |  |  | **5.2** |
| Crawley | **111.4** | **759** | **346** | **413** | **3** | **3** | **7** | **1.9** | **1.9** | **4.4** |
| Horsham | **138** | **1262** | **581** | **681** | **1** | **1** | **8** |  |  | **6.0** |
| Mid Sussex | **147.1** | **1343** | **653** | **690** | **5** | **1** | **3** | **3.1** |  | **1.9** |
| Worthing | **108.6** | **1370** | **629** | **741** | **3** | **3** | **10** | **2.7** | **2.7** | **9.0** |

1. At the time of writing this report the panel are aware that safer sleeping may be a factor that will occur in future cases that will be reviewed during 2018-2019. [↑](#footnote-ref-1)
2. There has been an increase in the number of Serious Case Reviews and Inquests during 2017-2018 which has delayed the review of a number of cases. These cases are likely to be reviewed by the panel in 2018-2019 which will affect the turnaround times in the next annual report. [↑](#footnote-ref-2)