HIPS CDOP Annual Report 2020/2021

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1. Foreword

This is the second annual report for the joint Child Death Overview Panel (CDOP) across Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS).

The HIPS CDOP complies with the Children Act 2004 (Section 16M-P) and the statutory guidance, Working Together to Safeguard Children 2018 that supports the legislation. The structure of the CDOP procedure was amended within the statutory guidance in 2018.

As Independent Chair of the CDOP, my role is to be accountable for the performance of the CDOP system across HIPS and to ensure that information is shared appropriately with the Child Death Partners and HIPS Safeguarding Executive, in a way that will support the prevention of future deaths.

It has been my privilege to be the Chair during this time and I would like to thank the Panel members for their contribution and engagement, and the CDOP Team for their immense work in this sensitive and challenging area of work.

I am pleased to see the improvements made over the year in the scrutiny of local child death reviews into individual cases and the identification of local learning. This work has aided the CDOP to develop themed panels that can strengthen the opportunities to determine areas for development and change. An example of this has been in relation to neonatal deaths. There has been good evidence of the perinatal mortality reviews undertaken, as well as the work of the Healthcare Safety Investigation Branch (HSIB) which the CDOP has been able to use in association with learning from deaths not investigated by HSIB. This means that there is continual learning and critical thinking about how to prevent future child deaths.

For 2021/2022 I am keen to continue the work achieved but have four areas of particular interest. Firstly, my aim is to ensure that parents and families are receiving the right bereavement support, at the right time for their grief journey; secondly, I want to build on the themed neonatal panels from this year and ensure that the CDOP is fully understanding any reasons for the deaths in the 0-27 days of age; thirdly, I will be working on the extension of themed panels for unexpected causes of death; fourthly, I will be asking the CDOP and local child death review teams to be attentive to the gender and ethnicity of the children.

Nicola Brownjohn

Independent Chair for the HIPS CDOP

2. Executive Summary

Child deaths are tragic, and thankfully uncommon, and it is important that we take the opportunity to learn from these devastating events. Comprehensive reviews of child deaths undertaken by the Child Death Overview Panel (CDOP) serve an invaluable public health function. They investigate what happened and why and identify common trends or themes to help inform and improve the quality of health and social care. This in turn links to multi-agency child safeguarding and promotes child welfare, ultimately with the aim of preventing future child deaths.

Since October 2019, there has been a strategic CDOP covering all of Hampshire, Isle of Wight, Portsmouth and Southampton, the HIPS CDOP. This is an equal partnership for the mutual benefit of all children and young people involved and provides an oversight and assurance of the whole Child Death Review (CDR) processes in accordance with the National Child Death Review Statutory and Operational Guidance 2018 and local CDR policies. It is important to recognise this is a statutory process and must demonstrate how local services and multi-agency partnerships have contributed to the review of deaths, in an open and transparent way, and recognised the need to take the learning forward to constantly improve the systems for children.

This report is divided into four core areas: a summary of feedback from the agencies leading on the recommendations from the 2019/2020 report; child death notifications for the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) local authority areas between 1 April 2020 and 31 March 2021; an overview of the child death reviews completed during 2020/2021; and a focus on the learning arising from the completed reviews and recommendations for changes in practice.

The key areas of note are:

The process is working, and this is demonstrated by the short time taken to review those deaths which are not subject to parallel investigations. This compares well to the national average.

Modifiable factors are most likely identified in the deaths of those aged between 28-364 days and 15-17 years. The factors have been aligned into six themes and used to make recommendations for learning for the multi-agency partnerships working with children and families:

- **Maternal Health and Wellbeing**
- **Professional Responses**
- **Professional Support for Parents and Families**
- **Parenting Responsibilities, Capacity and Supervision**
- **Childhood Trauma and Exploitation**
- **Impact of Childhood Transitions, Emotional Wellbeing and Risky Behaviour**

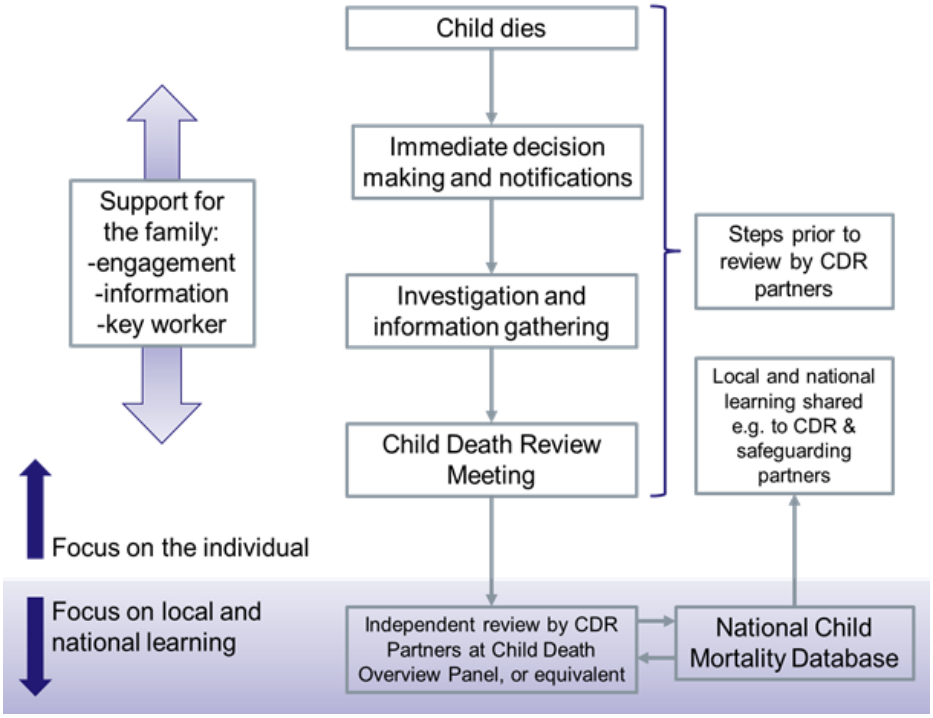
The HIPS services and multi-agency partnerships are asked to:

- **Consider the themes and recommendations**
- **Demonstrate how they have made changes to their work to help to prevent future child deaths**

3. Function of the HIPS Child Death Overview Panel

The HIPS CDOP has the single statutory duty to report every child death under the age of 18 to the National Child Mortality Database (NCMD) immediately after death and regardless of cause, and has the purpose of strategically reviewing all cases according to the Child Death Review (CDR) process. A CDR must be carried out for all children regardless of the cause of death. This includes the death of any live-born baby where a death certificate has been issued. The CDR runs from the moment of a child's death to the completion of the review by the CDOP as show in Figure 1.

Figure 1: The main stages of the child death review process



Source: Child Death Review Statutory and Operational Guidance 2018

The review concludes with considering actions and learning points raised at the local CDRM, wider affirmation by the CDOP, along with highlighting ongoing support needs and follow up plans for the family and professionals including bereavement support.

Further information on the purpose of the CDOP processes and the HIPS CDOP is available in Appendix 1.

4. Progress following the CDOP Recommendations 2019/2020

In 2019/2020, the CDOP and local reviews identified the themes, relevant modifiable factors and recommendations from the 2019/2020 annual report focused on:

- Impact of maternal health and wellbeing on the outcomes for babies
- Parenting capacity and capability
- Effectiveness of services
- Smoking
- Child Safety

Further narrative on the CDOP recommendations from 2019/2020 is available in Appendix 2.

Progress against these themes and recommendations is provided below:

Impact of maternal health and wellbeing on the outcomes for babies

The annual report highlighted concerns about unhealthy lifestyles during pregnancy, impacting on mother and baby after birth. The SHIP LMS delivers *Better Births* recommendations and *NHS Long Term Plan* commitments to improve maternity outcomes, especially among women with complex health needs that may affect their pregnancy, their well-being and that of their baby. It is uniquely placed to address challenges in care that are difficult for organisations to address in isolation across the HIPS CDOP area. This is enabled through the *SHIP LMS Maternity Specification, 2020/21* which addresses unhealthy public health behaviours that relate to young parents, first time parents and vulnerable women who are more likely to experience adverse maternal outcomes and less likely to access health and maternity services at an early stage in their pregnancy. The specification outlines the need for screening of risk factors relating to smoking, substance misuse, alcohol use, exposure to domestic abuse and/or perinatal mental health issues with specialist midwifery support to provide outreach and referral to relevant services as appropriate. The *NHS Long Term Plan* provides additional detail to enhance the delivery of several existing workstreams within the LMS: Safety, Neonates, Continuity of Carer, Perinatal Mental Health, Prevention and Postnatal Care.

Delivery of the Healthy Child Programme for the early life stages focuses on a universal preventative service, providing families with a programme of screening, immunisation, infant feeding, health and development reviews and advice around health, wellbeing and parenting. In the HIPS area the programme is provided by Southern Health NHS Foundation Trust, Solent NHS Trust and IOW NHS Trust. In addition, the HIOW Children's STP programme prioritises its ambition to give children in the HIPS area the best start in life, as detailed in the *2019-2024 HIOW STP Maternity Strategic Delivery Plan*. The *Wessex Healthier Together programme* continues to provide information resources to parents and health professionals, thus improving the health of children and young people.

There are also resources available such as Connect to Support Hampshire to help you look after yourself, Get it on for sexual health, Weight Watches for health solutions, NHS Health Check and the Hampshire Domestic Abuse Service.

Additionally, the HIPS safeguarding children procedures manual provides specific information on substance misuse in households and also covers substance misuse in pregnancy.

In 2019/2020, there were cases were private IVF treatment and maternal age were presenting factors. The NHS has strict criteria on IVF conception in regards to maternal age and BMI; however the private sector does not have the same restrictions. These are out of scope of this report but communication on risks continues to be communicated nationally.

In terms of vulnerable women locally, they are cared for by Case Loading Teams and so have advocates to guide them through their Antenatal, Labour and Postnatal care. The national drivers for case loading are now focusing on vulnerable communities and so locally there should be a more focused allocation of case loading to these groups of women during 2021/2022.

It is important to note the entire antenatal and postnatal pathways have been changed during the COVID-19 pandemic, but they have now all returned to the NICE guidance standards of care.

Addressing teenage pregnancy continues to be a priority in Hampshire. Pregnant teenagers and their partners depending on age and identified needs will either be eligible for the Family Nurse Programme or an enhanced Health Visiting Service. Specific support needs maybe identified through their GP, Maternity or Health Visiting and services work together to meet these needs including signposting and referral to other services as appropriate.

Parenting capacity and capability

The Isle of Wight LSCP has been delivering learning workshops where discussions around how professionals follow up on children not brought to appointments have been held to find out the reasons for non-attendance and to support appointment attendance as well as alerting other agencies to potential issues and risks for the child and escalating if they feel there are safeguarding risks.

The LSCP has highlighted the need to follow up on signposting to other services with vulnerable or chaotic families to ensure that the family have made contact with recommended services and to support them if needs be to access services, rather than simply assuming the family have acted upon the signposting information.

The Every Sleep Counts campaign has been combined with ICON (this is the programme aimed at helping parents with young babies cope with infant crying) and a strategic group is now in place led by the Hampshire LSCP supported by Public Health and involving multi-agency professionals across HIPS.

The three areas of focus are:

- Embedding programmes in practice
- Monitoring national and local research and evidence coming through to learn from
- Evaluating impact

The LSCPs across HIPS are continuing to deliver training for professionals across the region on safeguarding infants and safeguarding adolescents.

Effectiveness of services

The recommendation with regards to delays in screening was also reviewed locally and action has been taken.

Local Midwifery Services now have new laptops with better connectivity to be able to accurately record in a timely manner and share maternity booking information and screening results. The local system also has been adapted to enable users to note screening results have been viewed and the necessary actions have been taken.

This has been shared with Midwifery staff and steps taken to prevent future delays in practice,

Smoking

Maternal smoking remains a joint priority for the SHIP LMS and Local Authority Public Health Team. Across the SHIP LMS, all NHS Trusts have a partnership Smokefree Pregnancy Steering Groups, actively working to streamline pathways for pregnant women and their partners to meet NICE Recommendations (PH26 & PH48) for smoking in pregnancy.

All trusts are undertaking the PHE CLeaR Self-Assessment on Smoking in Pregnancy, to support the development of local action plans and the implementation of the NHS Long term Plan, with the ambition of delivering with a new smoke-free pregnancy pathway, including focused sessions and treatments by 2023/24.

Work continues to focus on the use of digital systems to enhance referral processes for pregnant women, improving communication with women and more accessible training options for midwives.

The existing *Hampshire Smoking in Pregnancy Strategy 2017-20* is due for refresh and consideration is being given to a partnership strategy across SHIP and the LMS. These will continue to translate into practice the recommendations of *Saving Babies' Lives Care Bundle*, the *Smoking in Pregnancy Challenge Group*.

All HIPS Local Authority Public Health-led strategies for Tobacco Control are due to be refreshed following the imminent release of the New National Tobacco Control Plan for England in July 2021

Child Safety

The CDOP Team worked with the Hampshire Safeguarding Children Partnership to deliver an e-learning module for professionals across HIPS to increase their awareness of the importance of keeping children safe from harm of button batteries in and around the home. The CDOP also worked with the Child Accident Prevention Trust (CAPT) to ensure consistency of messages locally and nationally.

CAPT continues to communicate messages on button batteries and the safety of children: https://www.capt.org.uk/button-battery-safety and https://www.capt.org.uk/Pages/Category/safety-advice-injury-types

The Local Safeguarding Children Partnerships and Health colleagues across HIPS continue to support child safety in the home and in public places and they have supported Child Safety Week, 7-13 June 2021 run by CAPT.

5. HIPS CDOP Notifications 2020/2021

The annual report refers to the overall number of child death notifications in 2020/2021, and findings focus on those cases reviewed. It recognises that the unreviewed cases means that the report may be unrepresentative of local patterns and trends in child deaths, lessons learnt and actions taken, and that these outstanding child death reviews will be reported on in the following year.

The HIPS CDOP received 79 child death notifications relating to 688,431 children aged under 18 years resident in the HIPS area (mid-2019 estimates, Office for National Statistics) in 2020/2021.

The 79 registered child deaths for each area within HIPS are as follows:

- 49 for Hampshire
- 7 for the Isle of Wight
- 8 for Portsmouth
- 15 for Southampton

A smaller number of cases were notified in 2020/2021 (79) compared to 2019/2020 (105). However the numbers of child deaths for the years previous do fluctuate with no discernible clear trends for the variations. The annual number of cases by local authority area within HIPS is as presented in table 1.

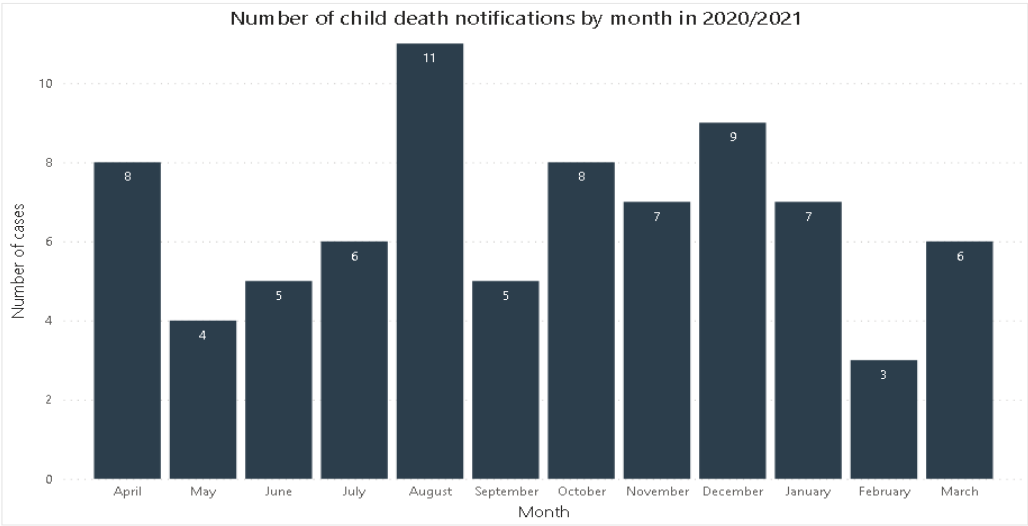
Table 1: Annual number of cases notified by HIPS local authority, 2015/2016-2020/2021

Child Deaths by Local Authority Area					
Year	**Hampshire**	**Isle of Wight**	**Portsmouth**	**Southampton**	**Totals**
2020/2021	49	7	8	15	**79**
2019/2020	69	≤5	11	21	**105**
2018/2019	50	≤5	14	9	**75**
2017/2018	92	≤5	10	14	**120**
2016/2017	61	6	11	23	**101**
2015/2016	76	8	9	24	**117**

For reasons of confidentiality, figures ≤ 5 have been suppressed

Figure 2 shows the monthly number of child death notifications. It shows that notifications of child deaths are not completely straightforward and vary by month, with the highest number of notifications (24) in quarter 3 of 2020/2021 and the single highest number of notifications in August 2020.

Figure 2: Monthly number of child death notifications in 2020/2021, HIPS CDOP



The number of notifications by age of child across the HIPS area is presented in figure 3 and shows that children who died under the age of one (55) accounted for the highest number of notifications.

Figure 3: Number of child death notifications by age of child, HIPS CDOP

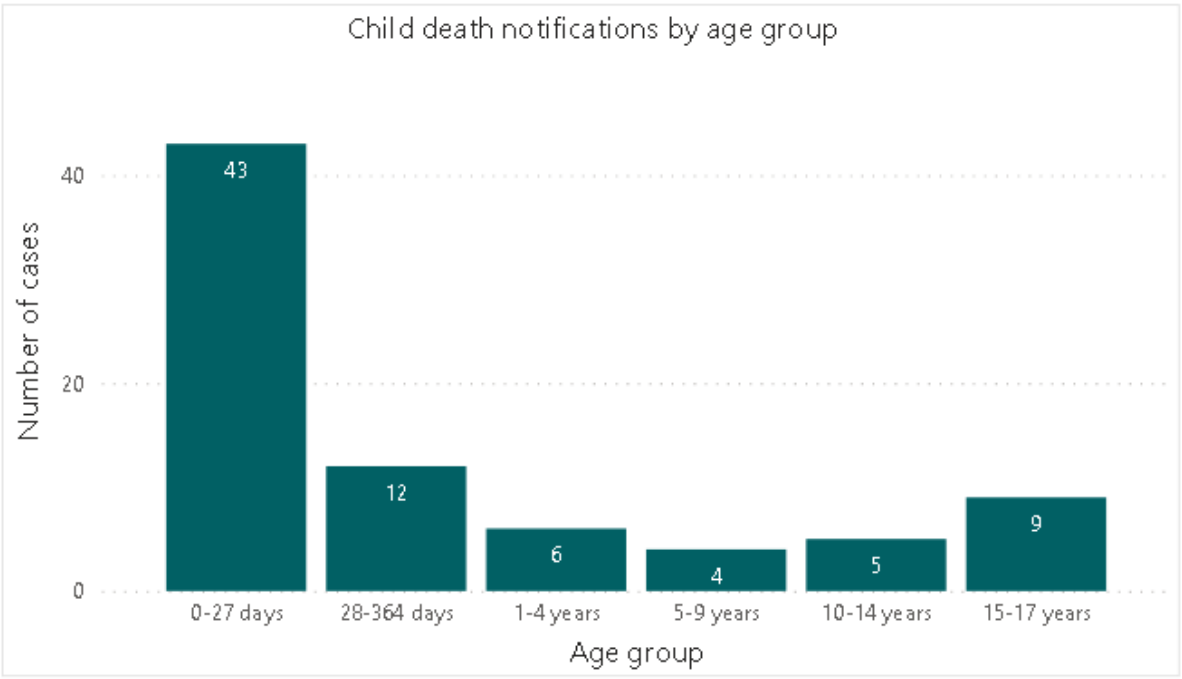
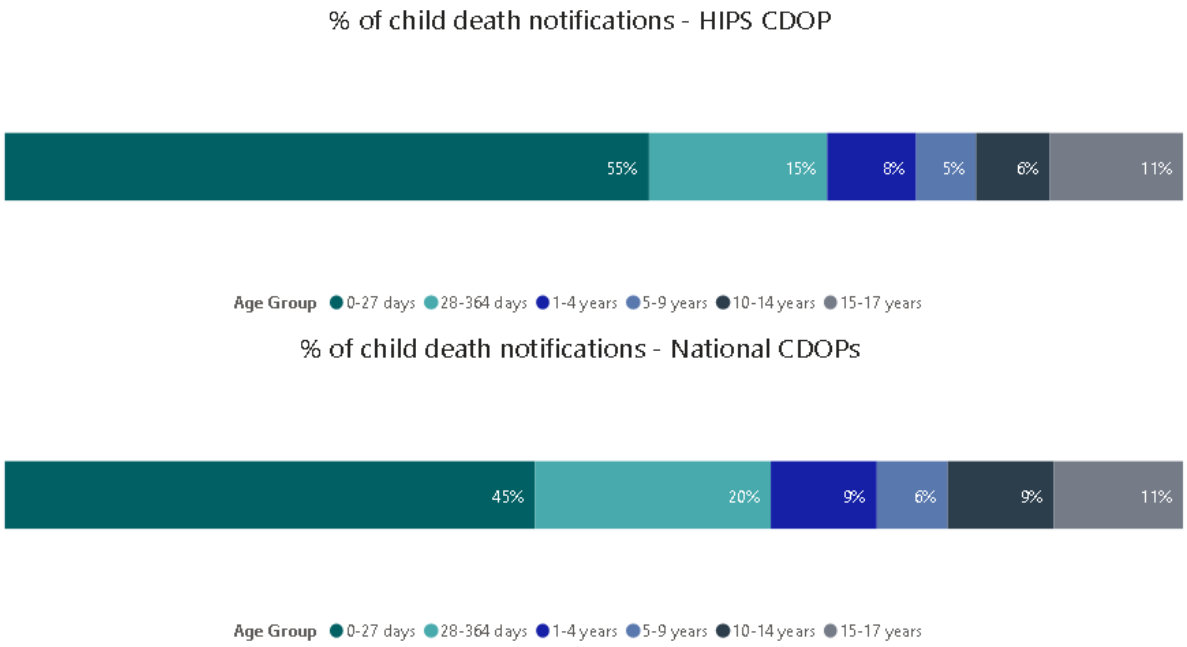


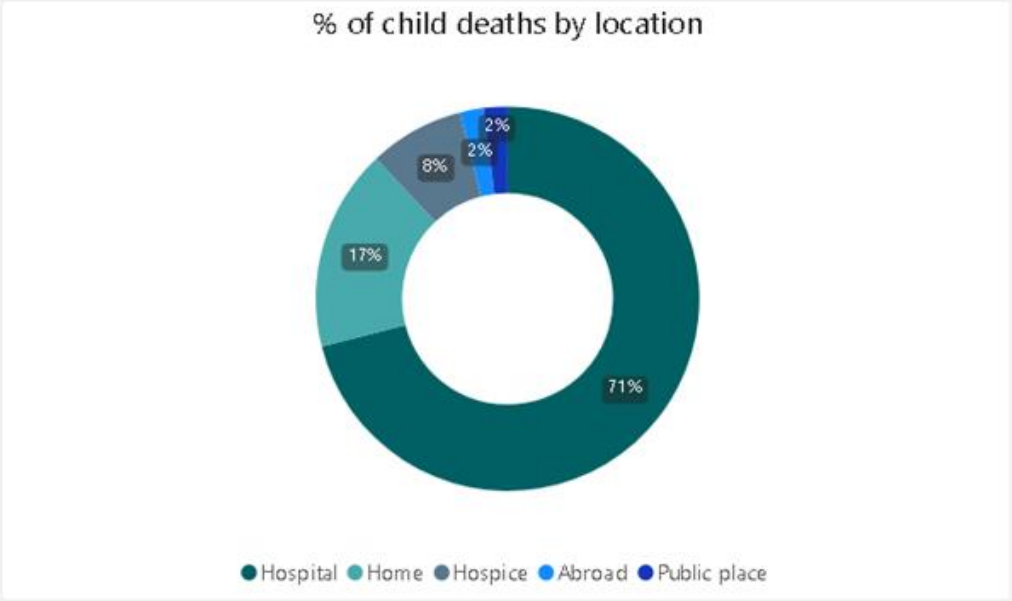
Figure 4 shows comparative percentages of child death notifications by age group for the HIPS CDOP against the national average. Overall, figures for the HIPS CDOP are broadly in line with national figures, with higher numbers in the 0-27 days age range and national notifications for children aged between 28 and 364 days were higher than those for the HIPS CDOP.

Figure 4: Percentage of child death notifications by age group, HIPS CDOP and National



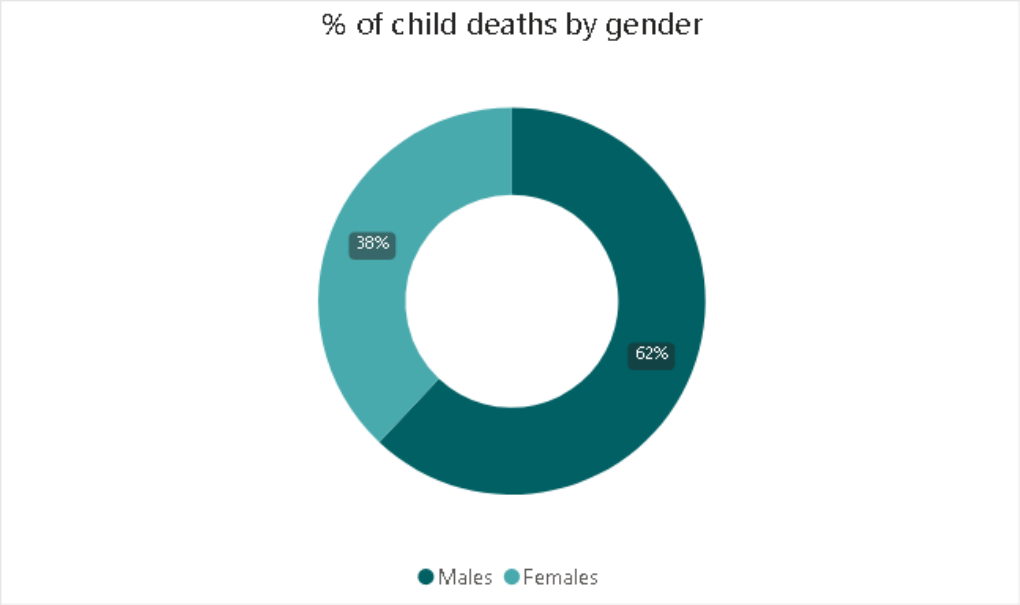
For information on the location of death, figure 5 shows that the majority of child deaths occurred in hospital (71%) and hospice (17%) environments. This is consistent with the large proportion of cases where the event which caused the child death was a health problem, a known life limiting condition or a neonatal death.

Figure 5: Child death notifications by location of child death, HIPS CDOP



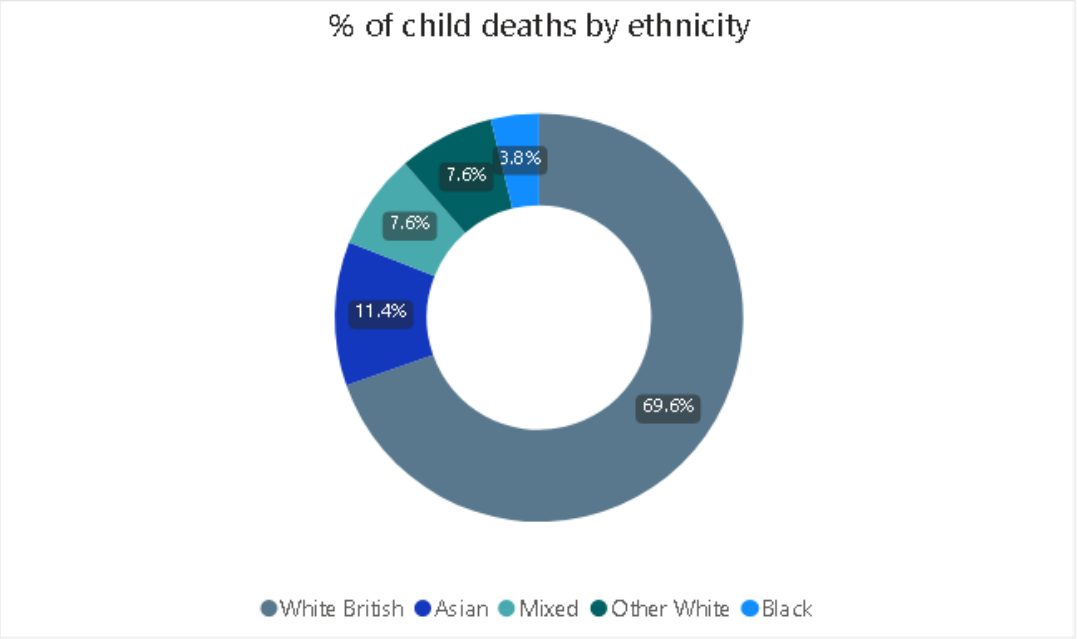
Boys' deaths accounted for just under two thirds (62%) of deaths reviewed (figure 6).

Figure 6: Child death notifications by gender, HIPS CDOP



Ethnicity of the child was recorded in all 79 cases notified (figure 7), suggesting better documentation of information by agencies. Deaths of children from a White background at 77%, accounted for most notifications. However, this is lower than the proportion of all children from a White background, which for the HIPS region is 89%. By contrast, 23% of the death notifications were for children from a non-White background, which is higher than the proportion of non-White children in the population, at 11%. These numbers are small relative to the population and need to be interpreted cautiously as the numbers will be not be wholly representative of the total non-White ethnic population. There were no apparent identifiable causal factors and deaths were spread relatively consistently across all ethnic groups. The HIPS CDOP does nonetheless acknowledge there are known inequalities across the HIPS area.

Figure 7: Child death notifications by ethnic group, HIPS CDOP



On notification, a case is initially categorised using the following schema (pending further information), definitions of these can be found in Appendix 3:

1. Deliberately inflicted injury, abuse or neglect
2. Suicide or deliberate self-inflicted harm
3. Trauma and other external factors, including medical/surgical complications/error
4. Malignancy
5. Acute medical or surgical condition
6. Chronic medical condition
7. Chromosomal, genetic and congenital anomalies
8. Perinatal/neonatal event
9. Infection
10. Sudden unexpected, unexplained death

6. Immediate Response to Child Deaths: Local Child Death Reviews and Joint Agency Response

Consideration of a Joint Agency Response (JAR) should occur each time a child dies and a joint decision should be taken as to whether it is required. The new guidance no longer distinguishes deaths in terms of unexpected or expected. A Joint Agency Response should be triggered if a child's death:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (including SUDI/C);
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural; or
- in the case of a stillbirth where no healthcare professional was in attendance.

For 2020/2021, 32% of the HIPS child deaths, notified, triggered a JAR (20) with 16 cases for a male child and 4 cases for a female child. 15 of these cases currently remain under investigation.

With regards to multi-agency involvement, out of the 79 child deaths across HIPS for 2020/2021:

- 5 of the children were classed as a Child in Need (3 for health reasons)
- 3 children were subject of a Child Protection Plan or a Looked After Child arrangement
- 4 were being supported for health reasons (but not on a Child in Need plan) or open to a Children's Services Assessment
- 4 children were known previously for support for health reasons
- There were no asylum-seeking children

The JAR and local child death review enable those practitioners involved with the child and family to report and reflect on the events surrounding the child's death. At this stage there is confirmation of the identity of a key worker for the family. The role of the key worker is to take the lead in supporting the family to gain answers to any questions they have relating to their child's death. Additionally, the key worker is able to signpost the family to bereavement services which the family might need some months, or years, after the death. Therefore, it is expected that the key worker retains a link with the family indefinitely to allow for advice to be sought when needed.

7. HIPS CDOP Reviews 2020/2021: Process

Once a local review has been completed, the case analysis is submitted to the statutory HIPS CDOP. This ensures that there is oversight of the local investigation and consideration of the wider themes emerging from the collation of the death reviews across the region.

Despite the challenges of the COVID-19 pandemic and related response over the past year, the HIPS CDOP has continued to meet virtually each month and a significant number of robust reviews have still taken place.

A total of 86 reviews have been completed from 1 April 2020 to 31 March 2021. 59% of the cases (51) were from the outstanding cases which were being investigated from deaths that had occurred in 2019/2020 and one case that had occurred in 2018/2019 and the investigations had been completed. 41% of the cases (35) were from deaths that had occurred and reviewed within year. These 35 cases (44%) are of the 2020/2021 child deaths that occurred in 2020/2021.

Of the remaining 54% (44) of the 2020/2021 (79) child death notifications these will be reviewed in 2021/2022 or remain open due to ongoing investigations.

During 2020/2021, there were 11 CDOP meetings held, including two themed panels: a Neonatal Themed Panel and a Suicide Themed Panel.

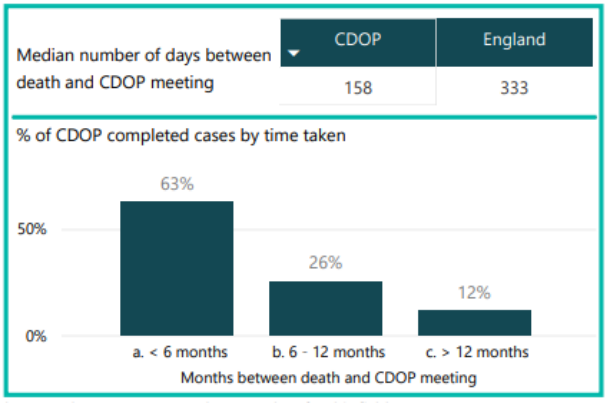
This demonstrates the number of cases outstanding from previous CDOP arrangements and the high number of deaths in previous years.

On average, the time lag between the death of a child and the completion of the child death review by the HIPS CDOP has been 158 days, compared to the national average of 333 days (Figure 8). Figure 8 also shows the percentage of completed cases by time taken with 63% of cases reviewed under 6 months and 12% of reviews took longer than 12 months to be completed.

This demonstrates the importance placed on having an efficient CDR process and some excellent ways of working across the multi-agency professionals across the HIPS area to really bring the reviews together. Effectively reviewing each case means the actions, learning and recommendations can be communicated and put into practice in a timely manner to really try to reduce the harm to our children.

Those cases taking longer to review have been due to outstanding Police cases where the legal proceedings need to be concluded prior to the CDRM/CDOP review.

Figure 8: Time between the death of a child and child death review completion, HIPS CDOP and Nationally and percentage of completed cases by time taken, HIPS CDOP



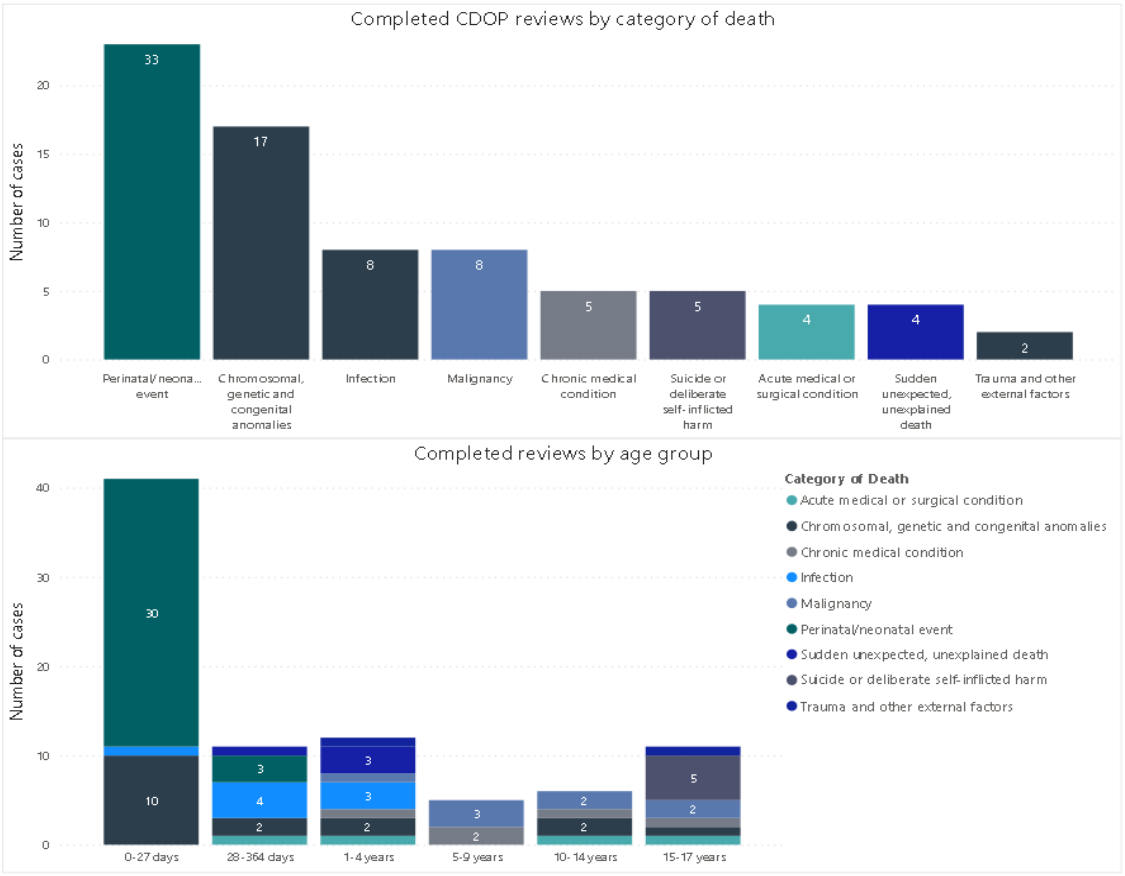
8. HIPS CDOP Reviews 2020/2021: Findings

8.1 Category of death

Figure 9 shows the categorisation of the 86 child deaths reviewed as set out and defined by the NCMD (Appendix 3). 38% of the child death reviewed were due to a perinatal/neonatal event and were the most common contributory factor. This is consistent with 40% in 2019/2020 reviews. At 19%, chromosomal, genetic and congenital anomalies was the second most common contributory factor of the child deaths reviewed.

This also shows the age group for each category of the 86 reviewed child deaths and almost half of all child deaths are of children who died under 28 days old (48%).

Figure 9: Completed CDOP reviews by category of death and age group, HIPS CDOP



8.2 Modifiable factors

A key aspect of the analysis the CDOP undertakes is to consider whether there were any modifiable factors that may have contributed to the child's death. Factors may be judged modifiable if actions at a national or local level could be taken to reduce the risks of future child deaths (Appendix 4).

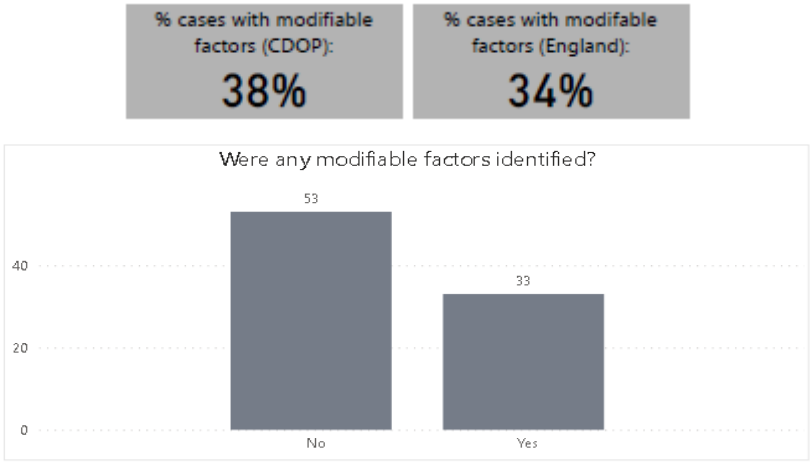
Please note the removal or reduction of these factors would not necessarily have prevented the child death under review or altered the outcome. The modifiable factors are areas which the CDOP considers could have had an impact, but this is neither definitive nor resolute.

From the 86 cases reviewed in 2020/2021, 38% of the cases had modifiable factors identified by the HIPS CDOP, higher than the national average (Figure 10). This does not however cover all child

death notifications in the same period so may not be wholly representative. Modifiable factors were identified in 33 cases out of the 86 cases reviewed.

This is an increase on case reviews with modifiable factors identified from 2019/2020 and may reflect the complex nature of some of the cases reviewed during the year.

Figure 10: Percentage of cases reviewed with modifiable factors, HIPS CDOP and Nationally, and number of cases reviewed with or without modifiable factors identified



8.2.1 Modifiable factors in relation to category of death

Table 2 shows modifiable factors were identified in all cases where the category of death was infection, suicide or deliberate self-inflicted harm and trauma and other external factors. This is 45% of all reviews where a modifiable factor was identified. A third of cases where the category of death was due to a perinatal/neonatal event had modifiable factors identified in the review (11).

Table 2: Percentage of cases reviewed where modifiable factors were identified by category of death, HIPS CDOP

% of cases where modifiable factors were identified by category of death

Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Acute medical or surgical condition	4	1	25%
Chromosomal, genetic and congenital anomalies	17	3	18%
Chronic medical condition	5	0	0%
Deliberately inflicted injury, abuse or neglect	0	0	0%
Infection	8	8	100%
Malignancy	8	2	25%
Perinatal/neonatal event	33	11	33%
Sudden unexpected, unexplained death	4	1	25%
Suicide or deliberate self-inflicted harm	5	5	100%
Trauma and other external factors, including medical/surgical complications/error	2	2	100%
Total	**86**	**33**	**38%**

8.2.2 Modifiable factors in relation to age

Table 3 shows modifiable factors were identified in 4 out of the 6 age groups with age groups 28-364 days and 15-17 years having modifiable factors identified in over 50% of the cases reviewed. The 0-27 days age group has had the most reviews (41) with 34% of cases having modifiable factors identified.

Table 3: Percentage of cases reviewed where modifiable factors were identified by age group, HIPS CDOP

% of cases where modifiable factors were identified by age group

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	41	14	34%
28 - 364 days	11	6	55%
1 - 4 years	12	5	42%
5 - 9 years	5	0	0%
10 - 14 years	6	0	0%
15 - 17 years	11	8	73%
Total	**86**	**33**	**38%**

8.2.3 Modifiable factors in relation to ethnicity

Table 4 shows modifiable factors were identified were for children in three ethnic groups, Asian/Asian British, Mixed and White ethnic groups. The White ethnic group accounts for 76% of cases reviewed with modifiable factors identified.

Table 4: Percentage of cases reviewed where modifiable factors were identified by ethnic group, HIPS CDOP

% of cases where modifiable factors were identified by ethnic group

Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Asian or Asian British	6	5	83%
Black or Black British	4	0	0%
Mixed	7	3	43%
Other	2	0	0%
Unknown	0	0	0%
White	67	25	37%
Total	**86**	**33**	**38%**

8.2.4 Key themes emerging from the collation of modifiable factors

The main themes focus on the following key areas:

- **Maternal Health and Wellbeing (during pregnancy)**
- **Professional Responses (during crisis periods for a child or in preventing contributing factors)**
- **Professional Support for Parents and Families**
- **Parenting Responsibilities, Capacity and Supervision**
- **Childhood Trauma and Exploitation**
- **Impact of Childhood Transitions, Emotional Wellbeing and Risky Behaviour**

9. Themes and Recommendations from 2020/2021

The HIPS CDOP continues to support the recommendations made in the 2019/2020 HIPS CDOP Annual Report and builds on modifiable factors identified in the 2020/2021 reviews. It is recognised that much work has and continues to be done across the HIPS area to encourage healthy and safe environments for children and families.

Nevertheless, it is imperative that information, advice and support is made available to potential and current mothers, parents, carers and families, but it is equally important for them to be able to engage with and apply the advice available, and that multi-agency systems enable guidance to be followed so that they are supported to actively do what they can to keep all children safe and away from harm.

The detail of the modifiable factors for each child death review reported to the NCMD can be viewed in Appendix 5 for professionals and agencies to consider.

Table 5 shows the learning from the themes emerging from the work of the CDOP on modifiable factors. From this learning, recommendations have been formulated for key agencies or partnerships in relation to some aspects of the learning that have a significant impact for the HIPS region, rather than a single organisation.

Table 5: Themes, Learning and Recommendations

Theme	Learning	Recommendation	Lead Agency
Maternal Health and Wellbeing	The health and wellbeing of mothers continues to be a significant factor in neonatal deaths. This has included high BMI, smoking, mental health issues, maternal age and gynaecological problems. This highlights the need for good antenatal screening and discussion with parents about any risk factors as well as raising awareness of health promotion prior to pregnancy.	• For Public Health to review the effectiveness of the measures in place to promote health for children and young adults. • For Maternity Services to measure the impact of the work done to advise mothers regarding their own health and the implications on the health of their baby. • For Primary Care to raise awareness with their patients of impact of healthy lifestyles for women before they consider pregnancy	Public Health Maternity Network Primary Care Networks, CCGs
Professional Responses	The CDOP found the quality of communication with parents, for example, during labour of when a child shows signs of deteriorating health, can make the difference in how advice and support is interpreted. Additionally, there was evidence of some gaps in the communication between	• For Maternity Services to review the effectiveness of the pathway for women in labour, including the response when a woman seeks advice, the transfer of women to tertiary centres and the level of observations women receive during labour	Maternity Network

	services which suggests that there needs to be more consistent and co-ordinated care.		
Professional Support for Parents and Families	Some of the child deaths reviewed by the CDOP demonstrated insufficient education of parents to support them in recognizing when to seek help for their child or to enable them to make informed decisions about their child's care.	• For the CCGs to consider how health services provide information and education for parents who have children with complex needs • For the CCGs to review the access to mental health services for children and those not brought for appointments	CCGs CCGs
Parenting Responsibilities, Capacity and Supervision	When child deaths occur within families where there have been complex issues or difficulties in maintaining oversight of the child, this has indicated the need for professionals working with families to identify early indicators of risk and to assess the capacity of the parents to keep their child safe.	• For Children's Services to examine how parenting capacity assessments are used in child protection	Safeguarding Children Executive
Childhood Trauma and Exploitation	In child deaths caused by trauma there were patterns of how the children had difficulties either through being isolated, excluded or having a lack of support networks.	• LSCPs are asked to consider the learning regarding children who are isolated or at risk of exploitation • LSCPs are asked to scrutinise the impact of school exclusions for children with complex needs	LSCPs, Safeguarding Children Executive
Impact of Childhood Transitions, Emotional Wellbeing and Risky Behaviour	The CDOP found there were adolescents who were risk taking or making poor decisions unseen, or not recognised, by the adults and peers involved in their lives. This emphasises the need for continued awareness raising about the risks to adolescents who spend a lot of time online.	• For education to ensure that their RSE curriculum and policies include how to address bullying, sexuality issues, suicide prevention and safe relationships • For Public Health to ensure that there is awareness raising, across professional networks, about online safety and the links to suicide risks in adolescents	Local Authorities Education Public Health

10. Promoting Good Practice

The child death review process identifies factors intrinsic to the child, the social environment, the physical environment and service provision during a child's journey with the aim of learning from the very sad and tragic events. What is also highlighted locally and nationally, are the good practices of professionals involved in a child's journey and the positive aspects of care and support received. The HIPS CDOP has acknowledged many positive examples of care, support and service delivery in the child death review process during 2020/2021 in what has been an incredibly challenging year and continues to work with our lead Child Death Review Partners to improve and support ways of working

With the HIPS area, we acknowledge the efforts our multi-agency colleagues have and are devoting to this vital area of work, some of which include:

- Development of the Joint Agency Response process and collaboration across the CDR and CDOP reviews
- Development of Child Death Review frameworks within local Trusts
- Best practice of the Paediatric Palliative Care pathway
- Themed Panels with briefing and learnings shared across HIPS and engagement by professionals
- Let's Talk sessions held in the Summer and Autumn of 2020 by the HIPS CDOP Team for professionals across HIPS to come together virtually to discuss child death
- The introduction of a bi-annual CDOP report to enable a more timely sharing of child death review data and key findings
- Continuing joined up discussions on bereavement support
- Importance of family choice and options given to parents and families at end of life

Sasha

Sasha had a brain tumour and she had an advanced care plan in place. Sasha's condition sadly deteriorated and she had end of life care with the Palliative Care pathway with support from multi-agency professionals. There was excellent support and cross working between the Hospital Oncology Team, Palliative Care Consultants, Paediatric Oncology Outreach Nurses, Children's Community Nurses, GP and the Hospice.

Virtual multi-disciplinary meetings were necessary due to the COVID-19 pandemic and they encouraged more inclusion at meetings and this was extremely valuable. Services were able respond in a timely way to meet the needs of the family.

The family continue to be supported by the Hospice and are having psychosocial support as part of their bereavement journey.

The HIPS CDOP has shared the positive aspects of service delivery of effective working relationships and excellent care for a family under difficult circumstances and with their wishes being met.

Bethany

Bethany was born with an antenatally diagnosed congenital anomaly and sadly passed away shortly after birth. Parents were counselled with regards to the poor outcome but wished to continue with their pregnancy. Much preparation was made around the birth for sensitive care and support and Parents were well supported with an extensive management and care plan. Midwifery also enabled an outside space to be opened up for the wider family to have time with Bethany. Parents reported being looked after very well and had no concerns regarding their care.

The HIPS CDOP has acknowledged the appropriate pathway management under Obstetric and Fetal Medicine led care and how Parents were well supported in their decision making.

It has also noted the good bereavement support offered by the Consultant and Midwifery Team along with signposting for national and local support groups given.

Stefan

Stefan was a teenager with a rare cancer that affected the tissue around the bones and had undergone intensive chemotherapy and radiotherapy. Despite a period of remission, the cancer returned and no further oncological treatment was effective.

An advanced care plan was established after much multi-disciplinary discussion and the family's wishes as to end of life care were agreed so they could care for Stefan at home. The family received around the clock service by the Community Children's Nursing Team, Clinical Nurse Specialists and the local Hospice.

Stefan had access to psychological support and excellent provision throughout treatment from diagnosis to death by the local Paediatric Oncology Team.

The HIPS CDOP acknowledged the excellent Community Children's Nursing Team and Palliative Clinical Nursing Specialists in this case. They were incredibly helpful, hard-working and collaborative in providing support and compassionate care to the family in their own home.

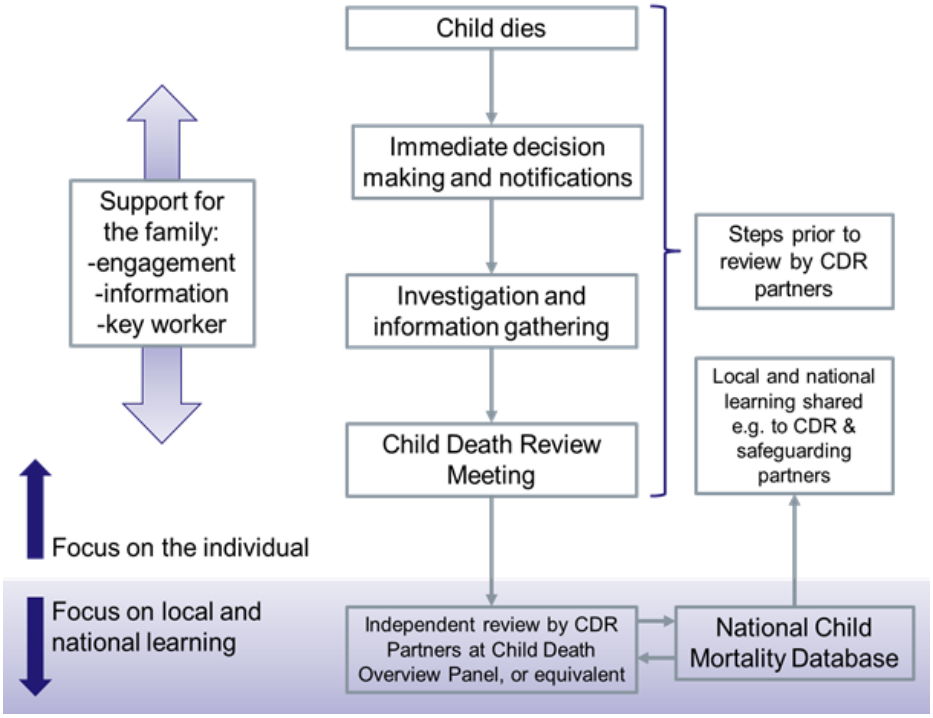
A Social Support Charity has been involved with the family for several years offering emotional and social support and there is also ongoing bereavement support in place for the family through the hospital and hospice professionals and the GP.

Appendix 1

Purpose of the Child Death Overview Panel

The Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Child Death Overview Panel (CDOP) has the single statutory duty to report every child death to the National Child Mortality Database (NCMD) immediately after death.

The Child Death Review (CDR) is the process then followed when responding to, investigating, and reviewing the death of any child under the age of 18, as defined in the Children Act 2004 from any cause. A CDR must be carried out for all children regardless of the cause of death. This includes the death of any live-born baby where a death certificate has been issued. The CDR runs from the moment of a child's death to the completion of the review by the CDOP as show below:



Source: Child Death Review Statutory and Operational Guidance 2018

The process is designed to capture the expertise and thoughts of all individuals who have interacted with the case in order to share information and identify opportunities to save the lives of children going forward, as set out in the Child Death Review Statutory and Operational Guidance 2018 and in accordance with Working Together to Safeguard Children 2018.

The stage of the review process that precedes the independent multi-agency CDOP is the local Child Death Review Meeting (CDRM) either led by the place of death, for example a Perinatal Mortality Review Team (PMRT) group meeting if a child dies in a Neonatal Unit, or following the Joint Agency Response (JAR) process in the case of unusual situations, as set out in *Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation (2016)*. This meeting should be a multi-professional meeting where all matters relating to an individual child's death are discussed. The CDRM should be attended by all professionals who were directly involved in the care of the child during their life, any professionals involved in the investigation into their death and any agencies who are working with the family. The key worker will continue to support the family throughout the bereavement.

The nature of all meetings will vary according to the circumstances of the child's death and the information discussed and output of every CDRM is shared with the CDOP so that local actions and learning can be strategically reviewed.

To explain the wider context of the CDR process, the statutory requirements in the Working Together to Safeguard Children 2018 guidance outlines the following requirements:

- To make arrangements to review the deaths of children normally resident in the local area (including if they die overseas)
- To make arrangements for the analysis of information from all deaths reviewed (NCMD submission)
- At such times as are considered appropriate, prepare and publish reports on what has been done as a result of the child death review arrangements in the area, and how effective the arrangements have been in practice (Learning reviews, CDOP Annual Report)
- To consider the core representation of the CDOP
- To appoint a Designated Doctor
- Publicise information on the arrangements for child death reviews in the area
- CDR partners should agree locally how the CDR process will be funded

Additionally, the Child Death Review Statutory and Operational Guidance 2018 sets out the following:

- CCGs and Local Authorities should ensure all of their staff who are involved in the CDR process read and follow the operational guidance
- Families should be given a single, named point of contact, the "key worker", for information on the processes following their child's death, and who can signpost them to sources of support
- Report deaths of children with learning disabilities or suspected learning disabilities to the Learning Disabilities Mortality Review Programme (LeDeR)
- A JAR should be considered if certain criteria, as set out in the guidance, are met.
- Conduct a CDRM for every child as led by the place of death:
    - Hospitals
    - Neonatal deaths (including use of PMRT)
    - Community deaths
    - JARs
- Produce an annual report on local patterns and trends in child deaths, any lessons learnt, actions taken and effectiveness of the wider CDR process

Taking into consideration all of the above guidance, the HIPS CDOP process is explained further.

HIPS CDOP

The HIPS CDOP is a collaboration of CDR partners representing all Local Authorities and Clinical Commissioning Groups (CCGs) across Hampshire, Isle of Wight, Portsmouth and Southampton covering all children resident in the HIPS area.

The HIPS CDOP has the purpose of reviewing and identifying any matters related to child deaths and relevant to the health, safety and welfare of children in order to establish learnings, actions and recommendations from the CDOP.

Maintaining the collaborative reviewing of child deaths under the HIPS CDOP arrangement means a more effective and efficient process but also one which looks *more* strategically at the analysis and provides more quantitative and qualitative data across the whole region. This reflects the wider *Working Together* principles for safeguarding children and can mean a more aligned process for the CDR partners with joint work streams and campaigns.

The Designated Doctor for Child Deaths remains vital in the operation of the CDOP and the HIPS CDOP would like to acknowledge and thank Dr Mark Alderton in this regard.

Furthermore, the membership of the HIPS CDOP has been successful in ensuring professional representation across the HIPS area. The group will be quorate if the Designated Doctor for Child Deaths (CCG) and the Local Authority are represented, plus representation of four of the following professionals at each CDOP meeting:

- Public Health
- Police
- Designated Nurse for Safeguarding Children
- Consultant Neonatologist
- Consultant Obstetrician
- Consultant Midwife
- Children's Services
- Children's Education
- Lay Representation

The Panel members are all senior professionals who bring significant expertise from a wide range of perspectives and settings. The expertise, engagement, leadership and commitment of the core HIPS CDOP members have been outstanding and they not only bring a wealth of knowledge and experience to the reviews but an objective, comprehensive and meaningful child-centred review. The HIPS area experiences a significant number of perinatal/neonatal child deaths and, the contribution and insight our Neonatology member and local Consultant Neonatologist, remains significant and paramount to the HIPS CDOP.

In addition to the core membership, relevant experts from health and other agencies are invited as necessary to inform discussions, for example, Palliative Care Services, Hospices, Bereavement Services, Health Visiting, Safeguarding Service Providers and the Coroner's Office.

The HIPS CDOP meetings are held monthly to review child death cases where the full reporting forms, CDRM information and any external investigations are completed, for example inquests or Police investigations. There is an extensive amount of work that goes into the collation of the information for the CDOP reviews and the cases are anonymised.

Each review discusses what has happened in the child's journey, the policy and practice involved with each case and ultimately what could have been done differently to reduce child deaths. Positive experiences in service provision are also noted along with the encouragement of best practice from what is a devastating event.

The review includes factors intrinsic to the child, family, social environment, physical environment and service provision that may have contributed to the child's death. It considers any modifiable factors which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future child deaths and it categorises the death according to the 10 NCMD definitions, such as a neonatal event, trauma or malignancy (see Appendix 3). The review concludes with considering actions and learning points raised at the local CDRM, wider affirmation by the CDOP, along with highlighting ongoing support needs and follow up plans for the family and professionals.

Once cases have been reviewed at the CDOP, the analysis is shared with the NCMD. This is so the local information can be collated on a national basis and contributes to the learning across the country to prevent future child deaths.

The HIPS CDOP also shares the review information with the LeDeR links across the HIPS area to continue to reinforce the working together across the CDR partners.

More information on the HIPS CDR process is available here.

Appendix 2

Themes and Recommendations, CDOP 2019/2020:

Theme	Modifiable Factor	Recommendation	Lead Agency
Impact of maternal health and wellbeing on the outcomes for babies	**Maternal wellbeing** • BMI • Age • IVF risks within private sector **Assessment of need** • Discharge planning • Support for vulnerable women • Substance misuse • Teenage pregnancy • Impact of Child sexual exploitation (CSE) on mental and physical health of young women	Maternity and Community Services should reflect on how antenatal and postnatal care can be strengthened considering the learning from deaths.	Maternity and Community Services
Parenting capacity and capability	• Child not brought for appointments • Disorganized parenting • Domestic abuse • Access to support information	The LSCPs should consider how to include parenting capacity and capability within the scrutiny of the effectiveness of the services, to ensure safeguarding children across HIPS.	LSCPs
Effectiveness of services	• Delays in screening results	The CCGs/NHSEI should ensure that there are clear monitoring arrangements for the timeliness of screening results and how patients are informed about delays.	CCG/NHSEI (SE)
Smoking	• Maternal smoking • Parental smoking • Household smoking	NHS Long Term Plan, HIOW SDP and SHIP LMS monitoring to continue.	Health, Public Health and System wide
Child Safety	• Child has access to button batteries	The LCSPs should continue to support parents and families with information on possible objects of harm within the household. Re-launch joint campaign with Southern Health NHS Foundation Trust and Child Accident Prevention Trust (CAPT) to raise awareness of the dangers of button batteries.	LSCPs, Health and CAPT

Appendix 3

NCMD Categories

Category	Name & description of category
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.
3	**Trauma and other external factors, including medical/surgical complications/error** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death. **Excludes** Deliberately inflected injury, abuse or neglect. (category 1).
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week). 8 (i) Immaturity/Prematurity related 8 (ii) Perinatal Asphyxia (HIE and/or multi-organ failure) 8 (iii) Perinatally acquired infection 8 (iv) Other (please specify)
9	**Infection** Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.

10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either ‘SIDS’ or ‘unascertained’, at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).

Appendix 4

Child Death Review Analysis Form Extract

The review meeting should analyse any relevant factors that may have contributed to the child's death. In doing so you might take into account those issues that have been highlighted in the Reporting Form. For each of the four domains below, list the factor, and determine the level of influence (0-2):

0 - Information not available

1 - No factors identified, or factors identified but are unlikely to have contributed to the death

2 - Factors identified that may have contributed to vulnerability, ill health or death

This information should inform the learning of lessons at a local level.

Domain A: **Factors intrinsic to the child.** Please list factors in the child (and in neonatal deaths, in the pregnancy). Consider factors relating to the child's age, gender and ethnicity; any pre-existing medical conditions, developmental or behavioural issues or disability, and for neonatal deaths, the mother's health and wellbeing.	**Relevance (0-2)**	**Is this factor deemed to be modifiable?**	**CDOP affirmation (0-2)**	**Is this factor deemed by CDOP to be modifiable?**

Domain B: **Factors in social environment including family and parenting capacity.** Please list factors in family structure and functioning and any wider family health issues; provision of basic care (safety, emotional warmth; stimulation; guidance and boundaries; stability); engagement with health services (including antenatal care where relevant); employment and income; social integration and support; nursery/preschool or school environment.	**Relevance (0-2)**	**Is this factor deemed to be modifiable?**	**CDOP affirmation (0-2)**	**Is this factor deemed by CDOP to be modifiable?**
Please also describe positive aspects of social environment and give detail to examples of excellent care				

Domain C: **Factors in the physical environment.** Please list issues relating to the physical environment the child was in at the time of the event leading to death, and for neonatal deaths, the mother's environment during pregnancy. Include poor quality housing; overcrowding; environmental conditions; home or neighbourhood safety; as well as known hazards contributing to common childhood injuries (e.g. burns, falls, road traffic	**Relevance (0-2)**	**Is this factor deemed to be modifiable?**	**CDOP affirmation (0-2)**	**Is this factor deemed by CDOP to be modifiable?**

collisions).				

Domain D: **Factors in service provision.** Please list any issues in relation to service provision or uptake. Include any issues relating to identification of illness, assessment, investigations and diagnosis; treatment or healthcare management; communication or teamwork within or between agencies; and organisational or systemic issues. Consider underlying staff factors, task factors, equipment, and work environment, education and training, and team factors.	**Relevance (0-2)**	**Is this factor deemed to be modifiable?**	**CDOP affirmation (0-2)**	**Is this factor deemed by CDOP to be modifiable?**
Please also describe positive aspects of service delivery and give detail to examples of excellent care				

Consider whether the Review has identified one or more factors across any domain which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future child deaths	**CDR Review**	**CDOP affirmation**
Modifiable factors identified – please list these below	☐	☐
No modifiable factors identified	☐	☐
Inadequate information upon which to make a judgement. *NB this category should be used very rarely indeed.*	☐	☐
List of modifiable factors identified:		

Appendix 5

Modifiable factors identified in 2020/2021 child death reviews:

Theme	Modifiable Factor
Maternal Health and Wellbeing Risk Factors	• High maternal BMI impacting on antenatal screening, detection of anomalies and on poor outcomes for babies • Maternal smoking • Maternal mental health • Maternal age • Existing maternal health conditions • Maternal decision making
Professional Responses	• Consideration to be given to offering an induction earlier, if/when required • Safety netting and observations • Consideration of a holistic view to treatment and communication – evolving symptoms, previous health issues, history of the family and ongoing review of siblings • Triage of children from 111 to 999 at first call • GP and 111 were the first to be contacted, however the incident should have been triaged straight to the hospital (Maternity 24/7 helpline) • Importance of treatment within the first hour of birth and/or illness • Lack of telephone call escalation of a child with complex medical history and recent discharge • The time taken at the home address was delayed with the child not being stabilised • If the child was delivered / transferred straight to a Tertiary Hospital this may have had a different outcome, potential impact of an earlier transfer and/or not moving the child • Counselling of parents to ensure understanding of all risks involved with decisions made • Lack of saturation monitor provision. Even though it was not standard practice at the local acute trust, there was no community health team follow up to do spot checks • Retrieval Team should have been contacted sooner (a collaboration between two PICUs) • Continuous access to medical treatment throughout journey may have changed the outcome for the child. If the child had not have gone abroad, this may have made a difference as it was in the middle of a global pandemic. Questions were asked but nothing in writing, no-one said the family should not travel and professionals knew they were going abroad • Consideration of prescribing antibiotics earlier, may have preventing the worsening of the condition/could of prevented death • Multiple appointment cancellations and lost to follow up • Lack of interaction between health agencies • Risk assessment(s) for children with mental health and emotional behavioural issues
Professional Support for Parents and	• Fetal heart rate monitoring information given to Parents • Counselled and began a termination and then changed mind which subsequently may have led to the premature labour

Families	• Lack of education of a family with a child with complex health needs (although recognised changes have taken place since this time) • Parental lack of education regarding Epilepsy (and may have acted differently with the full episode) • Access to mental health services and use of thresholds for services
Parenting Responsibilities, Capacity and Supervision	• Parental smoking with co-sleeping • Child ingestion of unsafe substance/object(s) • Parenting capacity, the parents IQ had not been tested to assure they understood and retained information regarding parenting and advice • Obesity in children – Raised BMI. Recognition and support required • Children not brought for CAMHS appointments
Childhood Trauma and Exploitation	• Consideration of the impact of previous trauma and multiple health issues, especially in Looked After Children • Child exploitation • Young Carer responsibilities (how supported and how impacts on mental health) • Risks of transition periods during childhood • Long term bullying, via social media and physically • Isolation and difficulties in forming relationships • Neglect and insufficient support for a child living independently • Professional network understanding of impact of exclusions and changes of school for complex children
Impact of Childhood Transitions, Emotional Wellbeing and Risky Behaviour	• Child decision making - the child was knew he was and was seen to be too tired to drive but he made the decision to drive • Long term impact of mental health issues and previous suicide attempts on child's ability to cope with life changes and their capacity to manage the transition phase of adolescence • Online safety - suicide games • Peer knowledge of suicide • Capability of schools/colleges to address bullying, sexuality issues, suicide prevention and relationships

Appendix 6

Acronyms

BMI	Body Mass Index
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CDR	Child Death Review
CDRM	Child Death Review Meeting
DD	Designated Doctor
HIPS	Hampshire, Isle of Wight, Portsmouth and Southampton
IVF	In Vitro Fertilisation (to help with fertility issues)
JAR	Joint Agency Response
LeDeR	Learning Disabilities Mortality Review
LSCP	Local Safeguarding Children Partnership
NCMD	National Child Mortality Database
NICU	Neonatal Intensive Care Unit
PICU	Paediatric Intensive Care Unit
PMRT	Perinatal Mortality Review Tool