CHILD DEATH OVERVIEW PANEL

East Sussex and Brighton & Hove
Fourth Annual Report 01-04-12 to 31-03-13

1. **The Child Death Overview Panel (CDOP)** is the inter-agency forum that meets regularly to review the deaths of all children normally resident in East Sussex and Brighton & Hove. It is a sub-group of the two Local Safeguarding Children Boards (LSCBs) for Brighton & Hove and East Sussex and is therefore accountable to the two LSCB Chairs, Cathie Pattison, Chair of East Sussex LSCB and Graham Bartlett, Chair of Brighton & Hove LSCB. If during the process of reviewing a child death, the CDOP identifies:
    - an issue that could require a Serious Case Review (SCR);
    - a matter of concern affecting the safety and welfare of children in the area; or
    - any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area;

    a specific recommendation is made to the relevant LSCB(s).

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

    These included recommending to the East Sussex LSCB that: -

    - The LSCB should discuss with a local school how to strengthen policies and procedures around supervising children around the pool and that appropriate safeguards are put in place when non swimmers are in the pool.

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

    - The LSCB should request that Brighton and Sussex University Hospital Trust explore the possibility of increasing the provision for specialist neonatal counselling, because the current service is part time and limited.
    - The LSCB should request that public health with relevant agencies consider how to promote understanding of the risks that can be associated with birth, particularly if women go against professional advice based on NICE guidelines.
    - The LSCB should raise with a London Hospital the concerns expressed by some parents about how families are supported in receiving and responding to news about their children having a terminal condition.

There were additional recommendations made to member agencies of both LSCBs which related to issues specific to particular case histories and not necessarily having general relevance.

2. Organisation of the Child Death Overview Panel

Fiona Johnson is the Independent Chair of East Sussex and Brighton & Hove CDOP. The panel members comprise representatives from key partner agencies who together have expertise in a wide range of issues pertinent to children's well-being and are listed below.

Core Membership:

Fiona Johnson –Chair
Carolyn Minto – CDOP Coordinator
Jane Mitchell- South East Coast Ambulance NHS Service Foundation Trust
Edmund Hick – Sussex Police

East Sussex

Annie Swann – Specialist Nurse for Child Deaths
Douglas Sinclair – Head of Safeguarding
Dr Tracey Ward - Community Paediatrician
Sarah-Jane Pateman - Education Welfare
Debbie Barnes - - Designated Nurse
Dr Dulcie McBride/ Sharon Paine – Public Health
Debra Young – Head of Midwifery
Dr Graham Whincup – Neonatologist

Brighton & Hove

Ali Jenkins- Specialist Nurse for Child Death
Jane Doherty – Head of Safeguarding
Dr Anne Livesey - Community Paediatrician
Lisa Harvey – Designated Nurse
Lydie Lawrence - Public Health
Fiona Rose – Named Midwife
Dr Cassie Lawn – Neonatologist

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

3. National Developments, Challenges and Achievements

Working Together 2013 was published in March 2013 which reaffirmed the role and function of the Child Death Overview Panel. The CDOP however needs to be considered in the context of a new requirement on LSCBs to develop a Learning and Improvement Framework which covers a range of reviews and audits of which the CDOP is a part. CDOPs are still required to report annually to the DfE on the functioning of the Panel and this year the data return required even greater detail about the outcome of case discussions. A national research project on how public health data from CDOPs can be collected and analysed was undertaken during 2013. East Sussex and Brighton & Hove CDOP contributed to the research however it has not yet been published. The local funding for CDOP has been maintained and the cost of the CDOP process within East Sussex and Brighton & Hove continues to be less than the funding provided by Government.

4. Local Developments, Challenges and Achievements

There were some questions about the full implementation of the multi-agency response following the unexpected death of a child and therefore an audit of the rapid response process across Sussex was undertaken during Spring 2013. Findings from this audit will be presented to the CDOP later in 2013. Working Together 2013

allows greater flexibility about the frequency and timing of early and late case discussions and the potential for greater flexibility regarding use of the rapid response process where there are unexpected deaths of children with life limiting conditions. It is intended that the local procedures will be reviewed during 2013 in response to the findings from the audit and the changes in Working Together 2013.

Parents have contributed to the CDOP process by providing feedback on services received. This has continued throughout 2013 and parents have contributed to most reviews about children who die beyond the neonatal period.

The CDOP continues to work closely with the Coronial Service providing coroners with information and receiving information from them. Previously there were concerns about delays in holding inquests within reasonable time-scales in East Sussex however following discussions these have improved.

5. **The CDOP has held 11 meetings in the past year (including 2 Brighton & Hove neonatal panels and 3 East Sussex neonatal panels).**
The main work of the panel is reviewing the deaths of all children who are resident in East Sussex and Brighton & Hove, on behalf of the two Local Safeguarding Children Boards (LSCBs). Between April 2011 and March 2012 the CDOP was notified of 45 deaths of children who were resident in East Sussex (26) and Brighton & Hove (19) which is a reduction in numbers of deaths since last year. The CDOP has reviewed a total of 45 (28 East Sussex & 17 B&H) deaths during 2012/13. There will always be a delay between the date of a child's death and the CDOP review being held; of the 17 Brighton & Hove reviews completed in 2012/13 12 were completed within six months. In East Sussex 17 out of 28 reviews were completed within six months. This is slightly longer time periods than last year which may be explained by two neonatal panels having to be cancelled in January 2013 because of sickness.

The purpose of the review is to determine whether the death was deemed preventable, that is a death in which modifiable factors may have contributed to the death. If this is this case the panel must decide what, if any, actions could be taken to prevent such deaths in future. Of the 198 deaths reviewed between 2008 and 2013 twenty have been identified as having factors which may have contributed to the death and could be modified to reduce the risk of future deaths. Modifiable factors identified through reviews included factors associated with sudden unexplained death in infancy such as parental abuse of alcohol, smoking and the baby not sleeping in appropriate environments. Other issues included the need for services that are able to engage vulnerable adolescents as well as the risks associated with adolescents using mobile phones and other electronic devices whilst crossing roads.

6. **Child Death data**
Total population: In East Sussex, 21% of the population are aged under 18 years (111,000 out of 527,000) and in Brighton 20% of the population are aged under 18 years (55,000 out of 273,000). This compares to 23% for the South East region and for England. (Source: Census 2011)

Table 1 All deaths notified to CDOP from 1st April 2008 to 31st March 2013

	1/4/08-31/3/09	1/4/09-31/3/10	1/4/10-31/3/11	1/4/11-31/3/12	1/4/12-31/3/13	Total
East Sussex	38	37	26	34	26	169
Brighton & Hove	16	20	11	21	19	87

Deaths notified to CDOP in both East Sussex and Brighton & Hove decreased during the last year. There had been an increase in deaths in the previous year however it seemed likely that this was cyclical and so the decrease is not unexpected. Data will need to be monitored for a much longer period before trends can be identified.

Chart 1 All deaths notified to CDOP from 1st April 2008 to 31st March 2013

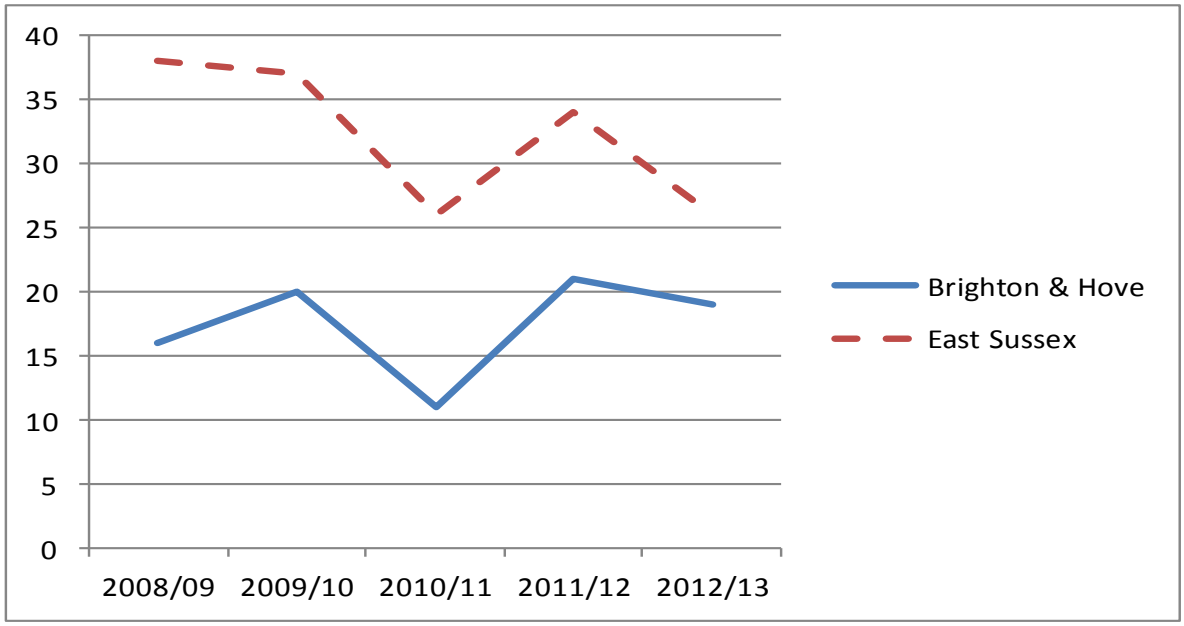
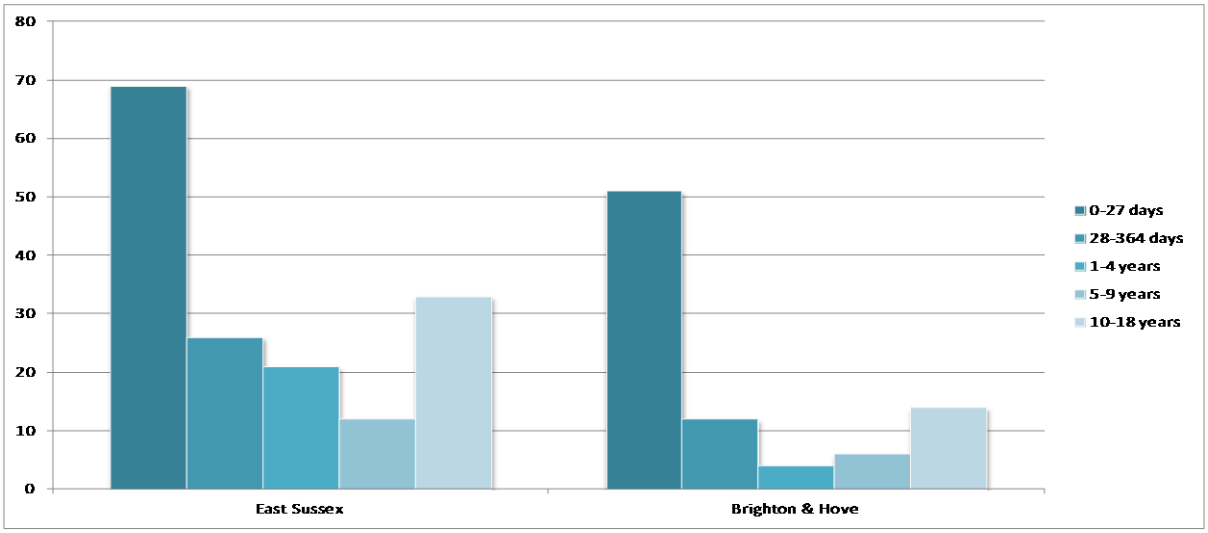


Chart 2 Age at death of all children notified to CDOP 2008 – 2013



The age distribution of deaths in children follows an expected pattern linked to national trends with most deaths being seen in children in the first month of life closely followed by deaths in the first year of life with an increase in deaths during adolescence. Previously adolescent deaths in East Sussex were mainly road traffic accidents however in the past two years deaths in this age have been more closely linked with suicide and self-harm. In East Sussex there are more deaths in the age range 1-4 than 5-9 which follows the national pattern whereas in Brighton & Hove there are slightly more deaths in the age range 5-9 than 1-4 however numbers are very low.