

HIPS CDOP

Annual Report

2019/2020

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Foreword

This is the first annual report for the joint Child Death Overview Panel (CDOP) across Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS), which came together in October 2019. The report also brings together the information gathered from the four separate CDOPs between April 2019 and November 2019.

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.

The statutory guidance requires local areas to establish joint arrangements with their neighbours to enable child deaths to be reviewed across a larger footprint to strengthen the learning to proactively prevent future deaths. Underpinning this strategic work, focused investigations, in consultation with the family, are required to be undertaken by local child death review teams which are then assessed by the CDOP and submitted to the National Child Mortality Database to inform the national picture and push forward the work to reduce child deaths.

A vital element that is given greater attention in the 2018 model is that of support for families from a key worker and includes bereavement support. This ensures that families are listened to and helped to move forward through their grief.

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 at the start of these new arrangements 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 look forward to continuing to work to strengthen the arrangements during 2020/2021.

Nicola Brownjohn

Independent Chair for the HIPS CDOP

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.

The CDOPs were historically managed under the four Local Children's Safeguarding Partnerships (LCSPs) and they now work together under one 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.

This report covers child deaths in the HIPS local authority areas during 2019/2020. The HIPS CDOP is supported by information shared from partners across the HIPS area, and in some cases from out of area partners. Subsequent to the child death reviews conducted in 2019/2020, the HIPS LSCPs identified learning from the reviews and have developed recommendations to help prevent future tragedies.

The aim of this annual report is to collate, analyse and present data provided by the HIPS CDOP on child deaths between 1 April 2019 and 31 March 2020.

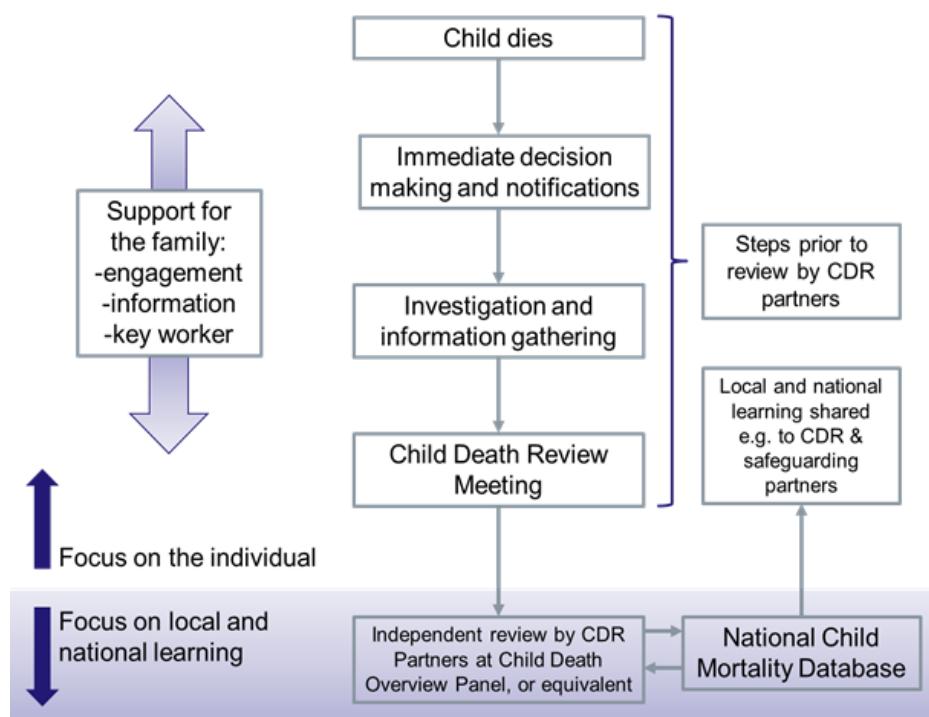
Purpose of the Child Death Overview Panel

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. It runs from the moment of a child's death to the completion of the review by the CDOP as shown in Figure 1.

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, as set out in the [Child Death Review Statutory and Operational Guidance 2018](#) and in accordance with [Working Together to Safeguard Children 2018](#).

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



Source: *Child Death Review Statutory and Operational Guidance 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.

The HIPS CDOP Process

Following the explained changes in the national guidance, CDR partners representing all Local Authorities and Clinical Commissioning Groups (CCGs) across Hampshire, Isle of Wight, Portsmouth and Southampton, came together to agree a combined HIPS CDOP, covering all children resident in the HIPS area.

The HIPS CDOP was therefore established in October 2019 with 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 actions, learnings and recommendations from the CDOP .

Collectively reviewing 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. This reflects the wider *Working Together* principles for safeguarding children and can mean a more aligned process for the CDR partners, for example joint campaigns.

The Designated Doctor for Child Deaths is imperative in the operation of the CDOP and for HIPS this position has experienced a change in January 2020. With this in mind, the HIPS CDOP would like to acknowledge the invaluable contribution made by the previous Designated Doctor, Dr Sheila Peters and highlight the vital support and commitment shown by the new Designated Doctor, Dr Mark Alderton.

Furthermore, the membership of the HIPS CDOP has been determined to ensure 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
- Health/Midwifery Professional
- Consultant Neonatologist/Obstetrician/Paediatrician
- Children's Social Care
- 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 has been excellent and they not only bring a wealth of knowledge and experience to the reviews but an objective, comprehensive and meaningful review where the child really does matter in every single case. The HIPS area experiences a significant number of perinatal/neonatal child deaths and, the contribution and insight our Neonatology member and local Consultant Neonatologist, is key and of utmost importance 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, the Regional Medical Examiner, Bereavement Services, the Coroner's Office, Housing, Council Services, Health and Wellbeing Board, Ambulance Services and Hospices.

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 1). 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](#).

HIPS CDOP Reviews 2019/2020

The annual report refers to the overall number of child death notifications in 2019/2020, 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 separately as an addendum to next year's annual report.

The HIPS CDOP received 105 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 2019/2020.

The 105 registered child deaths for each area within HIPS are as follows:

- 69 for Hampshire
- Potentially disclosive as count fewer than 5 for the Isle of Wight
- 10 for Portsmouth
- 22 for Southampton

A greater number of cases were notified in 2019/2020 (105) compared to 2018/2019 (75). However the numbers of child deaths for the three years preceding 2018/2019 were significantly higher and there are no discernible clear trends for the fluctuations. The annual number of cases by local authority area within HIPS are as presented in table 1.

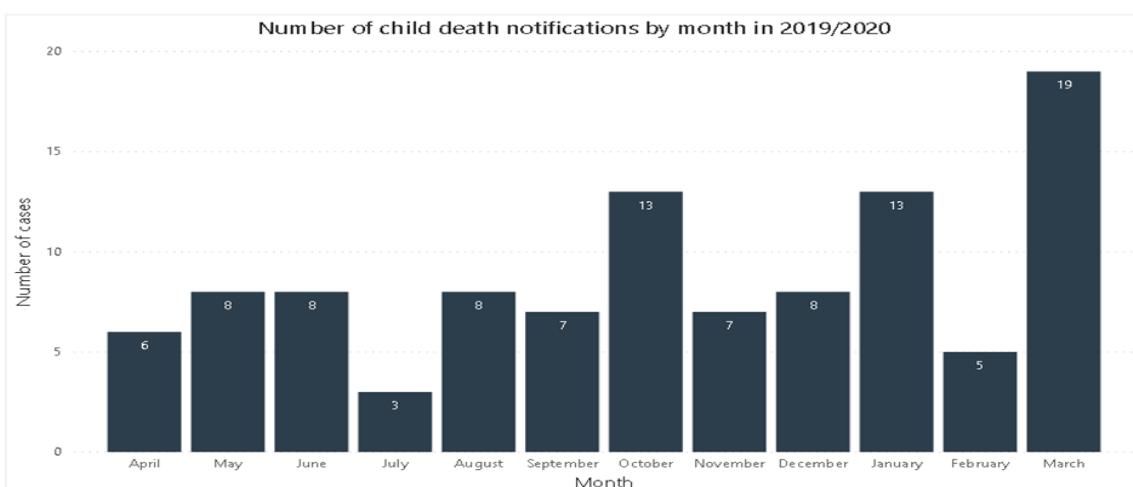
Table 1: Annual number of cases notified by HIPS local authority, 2016/2017-2019/2020

Child Deaths by Local Authority Area					
Year	Hampshire	Isle of Wight	Portsmouth	Southampton	Totals
2019/2020	69	≤5	10	22	105
2018/2019	50	≤5	14	9	75
2017/2018	92	≤5	10	14	120
2016/2017	61	6	11	23	101

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 (37) in quarter 4 of 2019/2020.

Figure 2: Monthly number of child death notifications in 2019/2020, 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 (61) accounted for the highest number of notifications.

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

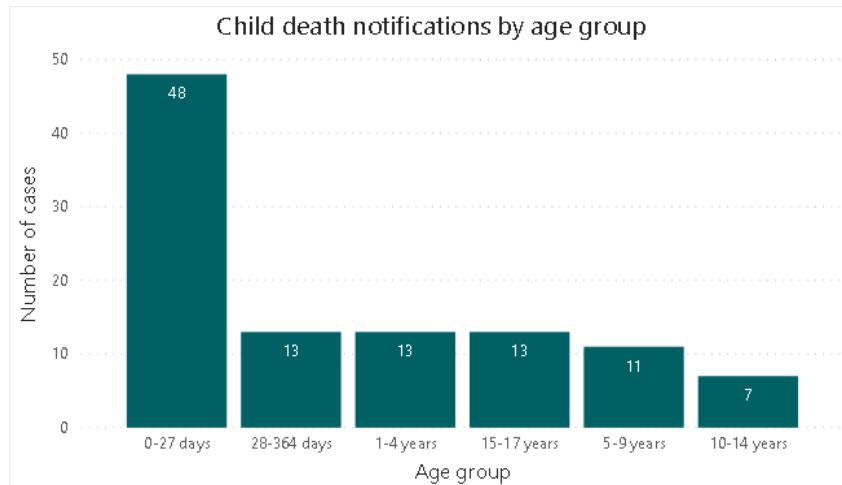
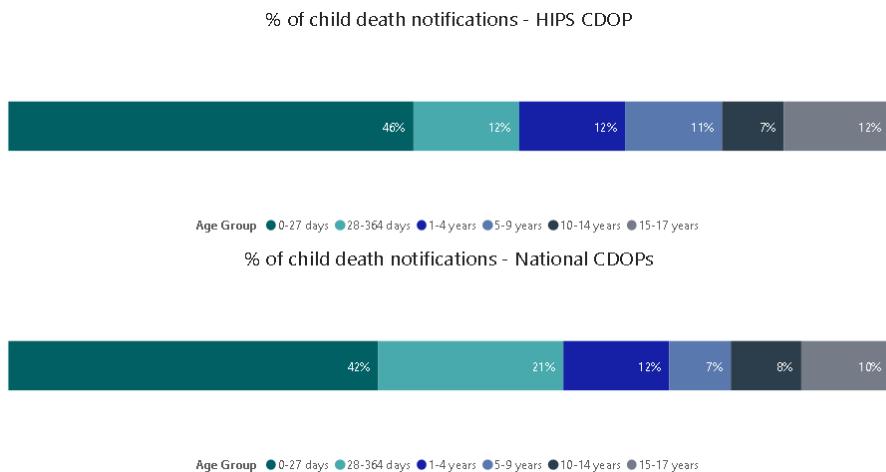


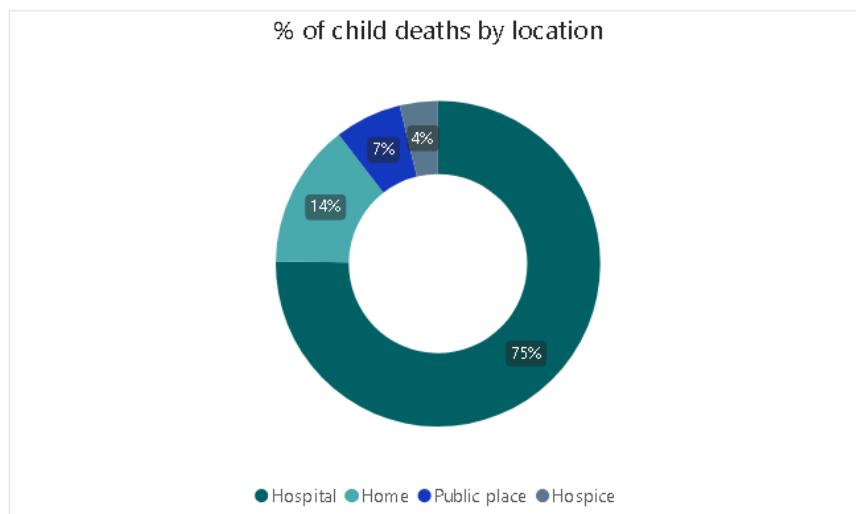
Figure 4 shows comparative percentages of child death notifications by age group for the HIPS CDOP against the national average. Overall, figures for the HIPS CDOP are broadly in line with national figures, but national notifications for children aged between 28 and 364 days were almost twice as high as those for the HIPS CDOP.

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



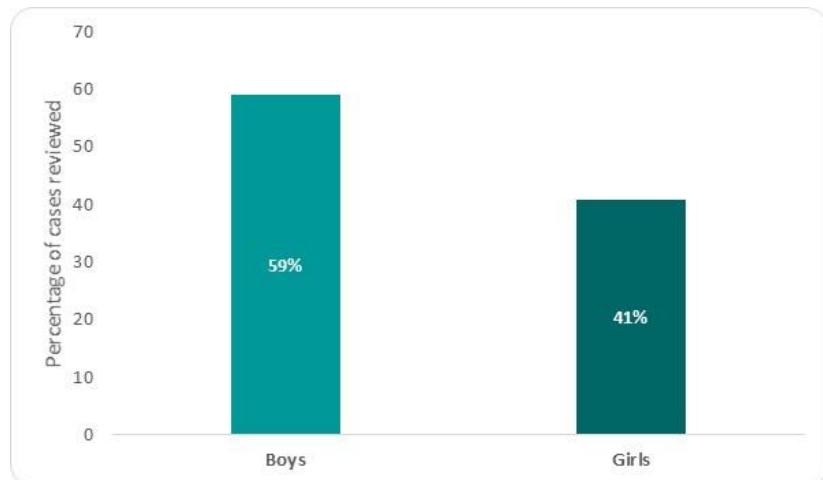
For information on the location of death, figure 5 shows that the majority of child deaths occurred in hospital (75%) and hospice (14%) environments. This is consistent with the large proportion of cases where the event which caused the child death was a health problem, a known life limiting condition or a neonatal death.

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



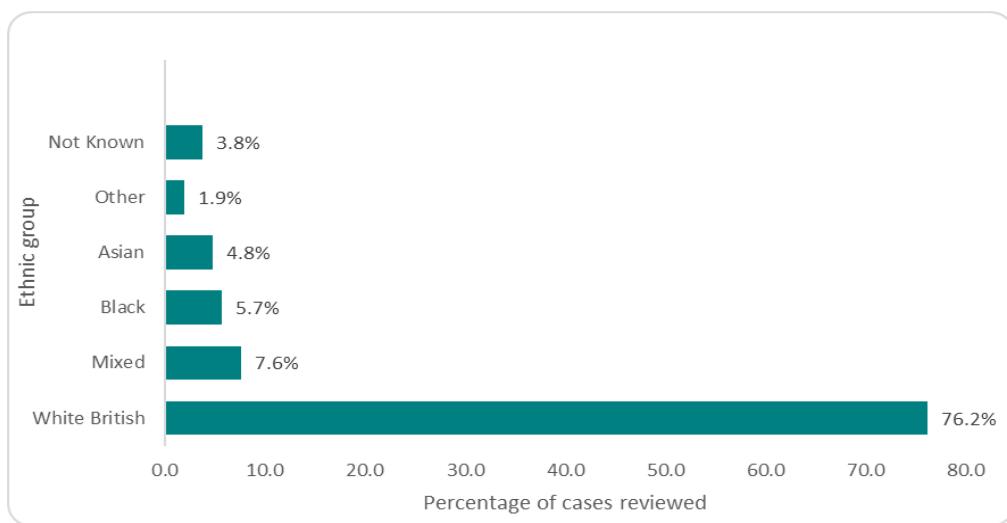
Boys' deaths accounted for just under two thirds (59%) of deaths reviewed (figure 6).

Figure 6: Child death notifications by gender, HIPS CDOP



Ethnicity of the child was recorded in all 105 cases notified (figure 7), suggesting better documentation of information by agencies. Deaths of children from a White background at 76.2%, accounted for most notifications. However, this is lower than the proportion of all children from a White background, which for the HIPS CDOP is 89%. By contrast, 20% 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 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. Furthermore, there have sadly been numerous twin deaths which have had an impact on the proportions within the Mixed and Black ethnic groups. The HIPS CDOP does nonetheless acknowledge there are inequalities across the HIPS area.

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



Despite the changes in the HIPS CDOP arrangements over the past year, a significant number of robust reviews have still taken place and out of the 105 child death notifications:

- 56 of the registered child deaths (53%) were reviewed; and
- 49 of the registered child deaths (47%) were awaiting review

Of the 56 reviewed deaths, 44 (79%) were completed by 31 December 2019 since commencement of the interim arrangements in September 2019, and an additional 12 by 31 March 2020. This compares favourably to the 48 reviews completed in 2018/2019. The 56 reviews were analysed at 14 CDOP meetings.

At 49, just under half (47%) of the 105 child death notifications for 2019/2020 were unreviewed. Some of the reasons for the unreviewed cases by 31 March 2020 were due to ongoing investigations, outstanding post-mortems and open inquests. However, of the 49 unreviewed child deaths, a large number 37 (76%), occurred in January, February and March 2020 when timeliness of reviews was difficult to achieve being so very close to the end of annual data return period.

The annual report refers to the overall child death notifications (105 cases) and findings focus on those reviewed (56 cases). It recognises that the unreviewed cases may be unrepresentative of the total child death notifications. The outstanding 49 child death reviews from 2019/2020 will be reported on separately as an addendum to next year's annual report.

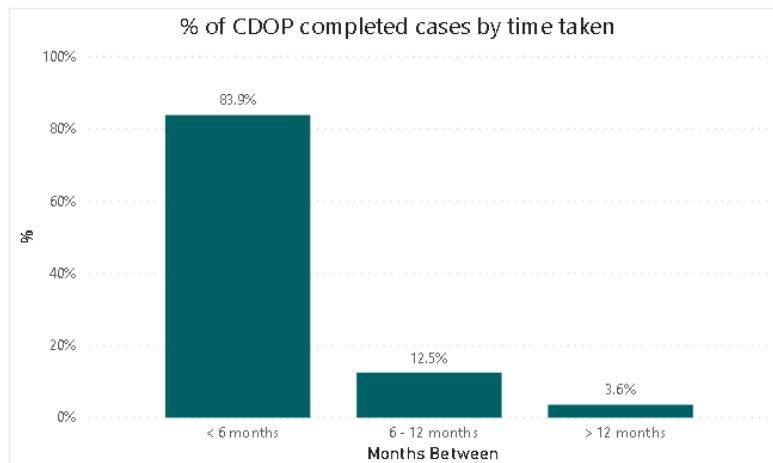
On average, the time lag between the death of a child and the completion of the child death review by the HIPS CDOP was 107 days, compared to the national average of 274 days (Table 2). This demonstrates the importance placed on having an efficient CDR process and some excellent ways of working across 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.

Table 2: Time between the death of a child and child death review completion

	HIPS CDOP	National CDOPs
Average number of days	107	274

Figure 8 shows the timeliness of completing child death reviews by the HIPS CDOP and shows that, at 84%, most reviews were finalised within 6 months of the child's death. Less than 5% of reviews took longer than a year to be completed.

Figure 7: Timeliness of completing child death reviews by the HIPS CDOP

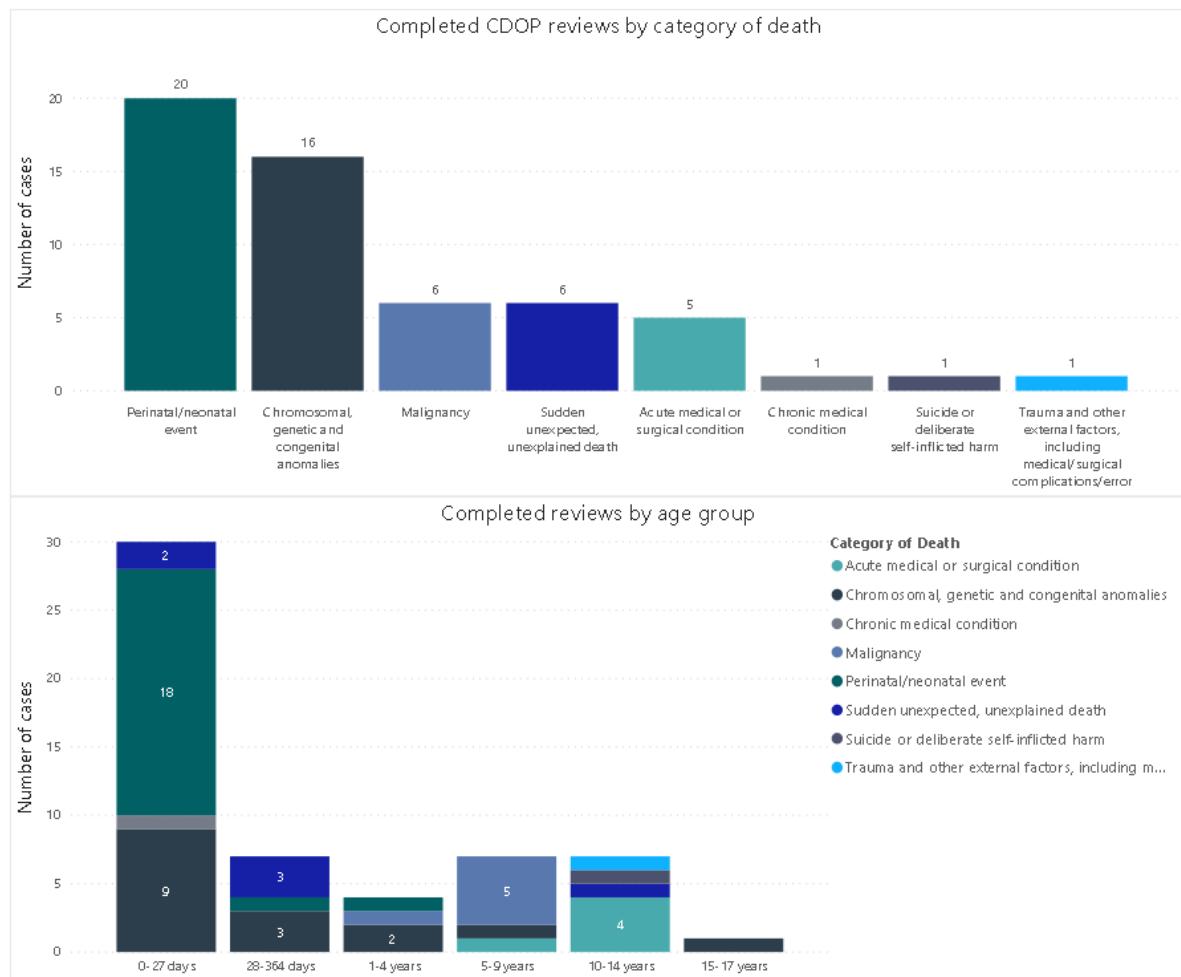


With regards to multi-agency involvement, out of the 105 child deaths across HIPS:

- 10 of the children were classed as a Child in Need
- 6 were on a Child Protection Plan
- 3 of the cases went on to have a Rapid Review, 2 a Local Learning Review and 2 a full Child Safeguarding Practice Review ([Working Together to Safeguard Children 2018](#))
- None of the 56 children reviewed were subject to a Statutory Order Status at the time of their death, although this may not reflect the 49 unreviewed deaths
- There were no reviews of deaths of asylum-seeking children

Figure 10 shows the categorisation of the 56 child deaths as set out and defined by the NCMD (Appendix 1) and the age groups for each category. Around a third of all child death reviews (64%) were due to a perinatal/neonatal event and were the most common contributory factor. At 16%, chromosomal, genetic and congenital anomalies were the second most common contributory factor of the child deaths reviewed. 66% of the reviews completed by the HIPS CDOP were of children who died under the age of one.

Figure 8: Categorisation of child death reviews and categorisation by age group



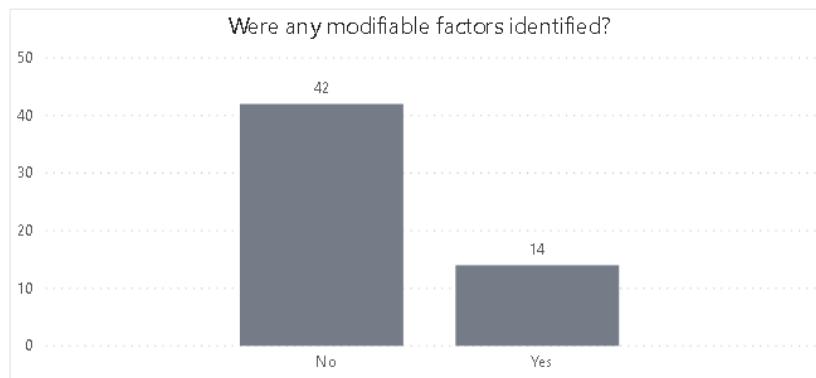
As part of the child death review process, the CDOP considers whether there were any modifiable factors that may have contributed to the child's death. Factors may be judged modifiable if actions (at a national or local level) could be taken to reduce the risks of future child deaths. (Appendix 2). Please note, however, 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 feels may or could have had an impact, but this is neither definitive nor resolute.

From the 56 cases reviewed, 25% of the cases had modifiable factors identified by the HIPS CDOP, lower than the national average (Figure 11). The large proportion of unreviewed deaths may have resulted in fewer modifiable factors being identified. The number of child death reviews with modifiable factors is also presented in figure 12.

Figure 9: Percentage of child death reviews with modifiable factors

HIPS CDOP	National CDOPs
25%	30%

Figure 10: Number of child death reviews with modifiable factors



The modifiable factors identified in the 2019/2020 CDOP reviews focus not only on safe physical and emotional environments for children, but also on maternal health and wellbeing, as well as support and information available to mothers, parents and families. Changing any of these variables may or may not have altered the outcome but the professionals involved in the review process, identified them as potential areas of impact.

Of the modifiable factors identified from the CDOP reviews, 71% were among children under the age of one and 29% among children aged 10-14 years. Child death reviews identified the neonatal age group as having the highest proportion of modifiable factors. Among sudden unexpected/unexplained or suicide/deliberate self-inflicted child deaths, modifiable factors were identified in 25% of the cases reviewed.

The range of modifiable factors identified in 2019/2020 CDOP reviews are consistent with those from the previous CDOPs and much work has and is being done across the HIPS area to encourage healthy and safe environments for children and families.

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 multiagency 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.

Trying to reduce child deaths is a joint approach with those wanting, having or had children and those professionals involved with a child's journey. A child death has lasting consequences and something which no-one wishes to experience.

Progress following the CDOP Recommendations 2018/2019

In 2018/2019, the Hampshire, Isle of Wight, Portsmouth and Southampton 4 Local Safeguarding Children Partnerships (LSCP) CDOPs reviewed 48 child deaths with 11 (23%) of these reviews associated with one or more modifiable factors that may have contributed to the death of the child. A wide range of modifiable factors were identified, the top five most frequently cited being: Smoking in Pregnancy, Smoking in Household, Substance Misuse, Care of Baby and Co-Sleeping, presented in Figure 13.

The subsequent themes, relevant modifiable factors and recommendations from the 2018/2019 annual report focused on:

- Smoking
- Maternal health
- Co-sleeping

Figure 11: Themes and recommendations, CDOP 2018/2019

Theme	Relevant Modifiable Factors	Recommendations
Smoking	<i>Smoking in Pregnancy; Smoking in Household.</i>	Focus on quitting smoking before or during pregnancy through tailored smoking cessation programmes for pregnant women, with targeted support in areas of greatest deprivation. Greater concerted local action required to help reduce smoking in pregnancy to 6% or less by 2022 as per the <i>Government's Tobacco Control Plan</i> .
Maternal Health	<i>Substance Misuse</i>	Nationally, women should be supported from pre-conception through to the post-natal period, for example, by investing further in the <i>Healthy Child Programme</i> , so that the programme begins prior to conception, extends home visits to beyond 2.5 years, and ensures that children/families receive continuity of care. Locally, continue to engage clinical, social and public health leadership to encourage women of reproductive age to adopt a healthy lifestyle, stop smoking, and achieve a normal body weight before conception.
Co-sleeping	<i>Care of Baby; Co-Sleeping</i>	Continue to promote safe sleeping messages and support the Lullaby Trust annual awareness campaign. Ensure that all staff are fully aware of current policies and guidance and effectively communicate the risks of unsafe sleeping to parents and families.

Progress against these themes and recommendations is provided below:

Smoking

Tackling smoking in pregnancy and in households was prioritised because child death reviews identified smoking as the single biggest and most cited modifiable risk factor. Both the Hampshire and the Isle of Wight (HIOW) Sustainability and Transformation Partnership (STP) and the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Local Maternity System (LMS) continue to drive significant work to reduce smoking rates across the health system. The HIOW STP Strategic Delivery Plan 2019-2024 makes a strong commitment to tackle smoking by improving identification, offering

help and support to quit and increasing smoke-free settings, in line with the [NHS Long Term Plan](#) ambitions.

Maternal smoking is a joint priority for the SHIP LMS and Local Authority Public Health. A midwife-led smoking cessation service in University Hospital Southampton using a smoking cessation model has been piloted targeting women who continue to smoke later in pregnancy through the joint *Prevention* workstream. In addition, some of the key national policy developments translated locally that set the vision to support pregnant women to quit include the [Saving Babies' Lives Care Bundle](#), the [Smoking in Pregnancy Challenge Group](#) and the [NHS Long Term Plan](#) commitments to implement “a new HIOU smoke-free maternity pathway for expectant mothers and their partners” by 2023/2024.

HIPS Local Authority Public Health-led strategies, briefings and plans have been developed to reduce smoking prevalence in line with the national plan - [Towards a Smokefree Generation - A Tobacco Control Plan for England](#) and include: [Tobacco Control in Portsmouth 2019–2022](#), [Hampshire Tobacco Control Strategy 2018 to 2021- Towards a healthier Hampshire](#), [Hampshire Smoking in Pregnancy Strategy 2017-20](#), [Southampton Strategic Assessment \(JSNA\)](#), [Smoking, June 2018](#) and [Isle of Wight Council Public Health Strategy 2020-2025](#). Implications of the Government's Prevention Green Paper consultation [Advancing our health: prevention in the 2020s](#) which sets the vision for achieving a smokefree generation – where less than 5% of the population smokes – by 2030, are key.

LMS Smokefree Pregnancy Pathway

smoking in pregnancy
challenge group

Maternal health: substance misuse

The annual report highlighted concerns about maternal substance misuse, 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 health visitors (qualified nurses and/or midwives with additional training in child and family health). In addition, the HIOU 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 HIOU 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.

The [HIPS safeguarding children procedures manual](#) provides specific information on substance misuse in households and also covers substance misuse in pregnancy.

Co-sleeping

Following findings from a range of serious case and child death reviews the Hampshire and Isle of Wight Safeguarding Children Partnerships commissioned a HIPS campaign to promote safe sleeping - 'Every Sleep Counts'. As part of the campaign the Partnerships jointly developed and launched a [Hampshire and Isle of Wight Every Sleep Counts Toolkit](#).

The HIPS partners have agreed to ensure that all safe sleep messages are delivered to parents consistently across the areas and have continued to work with [The Lullaby Trust's Safer Sleeping awareness campaigns](#).



- Every Sleep Counts is a programme of prevention aimed at parents and carers
- It supports professionals to deliver consistent key safe sleep messages at numerous touch points during pregnancy and after birth
- It brings together information on multiple risk factors associated with safe sleep

Findings and Recommendations from 2019/2020

The HIPS CDOP continues to support the recommendations made in the 2018/2019 CDOP annual report and builds on modifiable factors identified in the 2019/2020 reviews.

Modifiable factors were identified in 14 child death reviews out of the 56 cases reviewed (25%) with no modifiable factors identified in 42 of the reviews. The 14 reviews did identify one or more factors across any domain which may have contributed to the death of the child (Appendix 2). These modifiable factors have been grouped into themes and are used as recommendations for areas of learning among agencies and professionals involved in children's lives across HIPS.

Theme	Modifiable Factor	Recommendation	Lead Agency
Impact of maternal health and wellbeing on the outcomes for babies	Maternal wellbeing <ul style="list-style-type: none"> BMI Age IVF risks within private sector Assessment of need <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Child has access to button batteries 	The LSCPs 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 1

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 inflicted 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).
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 2

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)	CDOP affirmation (0-2)

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)	CDOP affirmation (0-2)
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 collisions).	Relevance (0-2)	CDOP affirmation (0-2)

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)	CDOP affirmation (0-2)
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	<input type="checkbox"/>	<input type="checkbox"/>
No modifiable factors identified	<input type="checkbox"/>	<input type="checkbox"/>
Inadequate information upon which to make a judgement. <i>NB this category should be used very rarely indeed.</i>	<input type="checkbox"/>	<input type="checkbox"/>
List of modifiable factors identified:		

Appendix 3

Acronyms

BMI	Body Mass Index
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
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