HIPS CDOP Annual Report 2021/2022

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1. Foreword

This is the third 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, in a way that will support the prevention of future deaths.

It has been my privilege to be the Chair for over two years now. I would like to thank the Panel members for their contribution and engagement during this time. For two years, despite the meetings being held virtually, the Panel has worked together effectively to ensure that all members are able to contribute to the analysis and decisions for actions. Some of the Panel members are now handing over to colleagues in the spirit of individuals representing their professional discipline across HIPS, rather than solely their local authority area.

The HIPS CDOP process works effectively and the performance in relation to notifications and submission of data to the National Child Mortality Database (NCMD) is recognized as being well managed. This is down to the immense commitment of a small team. I thank them for supporting the CDOP to deliver its function. This enables the Panel to focus on the learning to prevent future child deaths and the needs of the families.

For 2021/2022 I set out four areas I wanted to focus on. For some of the areas there has been good progression, however there is still more work to do:

1. **To ensure that parents and families are receiving the right bereavement support, at the right time for their grief journey.**
   The Panels have continued to view the good support for families where their child has been on an end-of-life pathway. However, the support is not always as clear for those families for whom a child has died suddenly, and unexpectedly. Although there has been some good evidence of support by schools, health, and social care, this needs to be more consistent, especially in terms of the need for every family to have access to a key worker to signpost them to the bereavement support.

2. **Build on the Neonatal Themed Panels from the previous year and ensure that the CDOP is fully understanding any reasons for the deaths in the 0-27 days age group.**
   The Neonatal Themed Panels have become embedded within the work of the Panel, and this has enabled the wider themes to be explored and disseminated across the HIPS area.

3. **Extend the use of themed panels for unexpected causes of death.**
   Themed panels for unexpected deaths rely on the information and complex investigations that are needed in such circumstances. Therefore, it is necessary to wait until there are sufficient numbers of cases to hold a themed panel. How we have managed this is to hold themed elements within a more general panel if there are two or three deaths due to similar circumstances. The learning from these is included in briefings and used when there are full themed panels. This ensures that the learning from the death of any one child is not lost and that there is a legacy for all the children who have died.

4. **Ask the CDOP and local child death review teams to be attentive to the gender and ethnicity of the children.**
   The information from local reviews has significantly improved to include gender and ethnicity. This is being used to undertake deeper scrutiny to identify any themes for the gender or a particular ethnic background of a child. The learning will be included in briefings for dissemination across the HIPS systems.

For 2022/2023, I want the CDOP to focus on:

- Continuing the work to ensure that parents and families are receiving the right bereavement support, at the right time for their grief journey, and to confirm that all families have equitable access to key worker support at a local level.
- Develop the use of the briefings for wider dissemination of learning about the themes and trends across 2019-2023.
- With the formalization of the Integrated Care System, the CDOP will ensure that the learning from the death reviews is shared to enable the experience of children and families to inform the work of the Integrated Care Board.
- Additionally, I have escalated to the Child Death Partners, the need to undertake a review of the CDOP arrangements that have been in place for over two years.

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 themes, learning and recommendations from the CDOP Annual Report 2020/2021;**
- **Child death notifications for the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) local authority areas between 1 April 2021 and 31 March 2022;**
- **An overview of the Child Death Reviews completed during 2021/2022; and**
- **A focus on the learning arising from the completed reviews.**

In summary, the key themes were seen in child death reviews and where recommendations for learning for the multi-agency partnerships working with children and families are:

- **Promotion of health in families**
- **Social environmental impact on the safety of young children**
- **Service provision**
- **Physical environment impacting on family health**

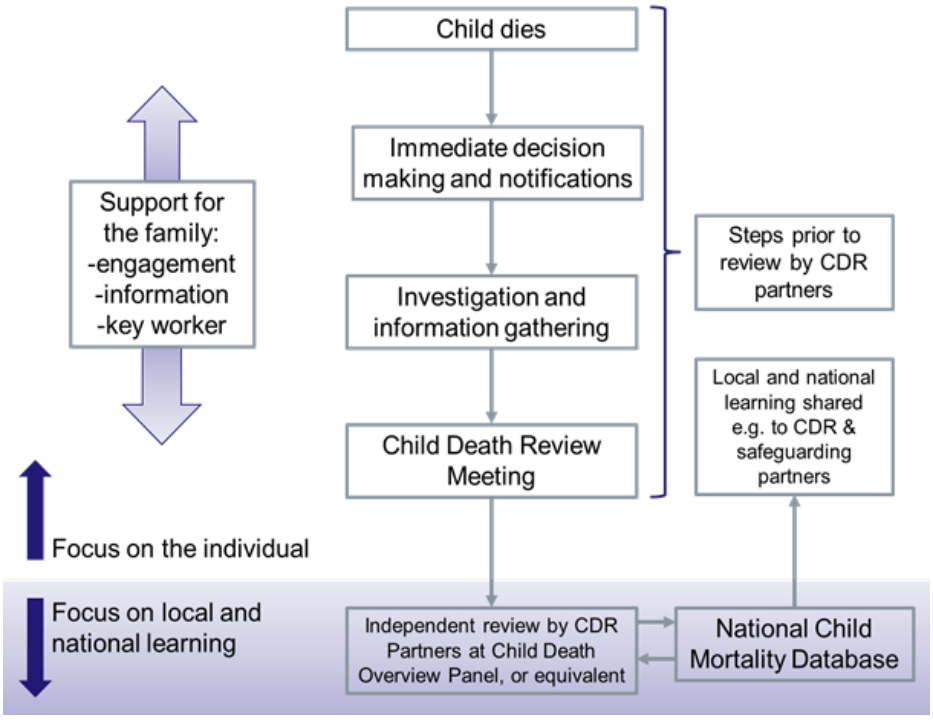
The HIPS services and multi-agency partnerships are asked to:

- **Consider the themes and to provide a response to the CDOP as to what actions will be taken on specific areas of learning**
- **Provide information to the CDOP on any practice changes 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 Themes 2020/2021

In 2020/2021, the CDOP and local reviews identified the themes and learning which focused on the following areas in the 2020/2021 annual report:

- Maternal Health and Wellbeing, and 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

Further narrative on the CDOP learning from 2020/2021 is available in Appendix 2.

Progress against these themes is provided below:

Maternal Health and Wellbeing, and Professional Responses

The annual report highlighted maternal health during pregnancy, impacting on mother and baby after birth. This includes health-related behaviours such as smoking and substance use, and risk factors such as poor mental health, maternal obesity at the onset of pregnancy, and domestic violence. The Local Maternity System continues to deliver *NHS Long Term Plan* commitments to improve maternity outcomes, especially among women with complex health needs that may affect their pregnancy, their wellbeing 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 the 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.

Public Health commissions public health nursing services to lead delivery of the Healthy Child Programme. In the early life stages, this focuses on a universal programme of prevention and support, along with targeted early intervention and additional support for those who may benefit. The Healthy Child Programme provides 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 and Solent NHS Trust.

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*. Plans are in development across the area to develop Family Hubs models which will aim to provide a one-stop support service for families, including links with maternity for support during pregnancy.

At a place and/or Local Authority level, maternal health is addressed through different mechanisms:

- In Southampton:
    - The Southampton CYP Strategy 2022–2027 and Prevention and Early Intervention Plan include commitments to maternal health and support during pregnancy, including maternal mental health, smoking.
    - The draft Tobacco, Alcohol and Drugs Strategy 2023-2028 (currently out for consultation) commits to support for stop smoking in maternity services, and as possible, pilot an e-cigarette scheme and consider incentives pilot for pregnant people.

Work is also underway to enable the Family Nurse Partnership (FNP) to deliver Nicotine Replacement Therapy to pregnant people, partners, and wider family.
    - The Public Health team commission a weight management in pregnancy service (Slimming World) that maternity services can refer into. Public Health and maternity services have worked together to increase uptake of this service, but referrals have remained low so are now committed to exploring alternative options for supporting weight management in pregnancy and postnatally (to support healthy weight for subsequent pregnancies as well as healthy weights within the family as a whole).
    - Continued implementation of the Saving Babies Lives Care Bundle (2019).
    - Continued audit and implementation of the recommendations from the Ockenden report (2022).
- Portsmouth's multi-agency strategy for improving long-term physical health outcomes for children, Children's Public Health Strategy (2021 - 2023) was developed as part of the work of the Portsmouth Children's Trust. It includes the following priorities in relation to maternal health and wellbeing:
    - Perinatal mental health and infant SEMH; focusing on improving early identification of vulnerabilities for women and their families, identifying, and supporting women and their partners when they deal with mental health issues and seeking to build strong attachment and resilience.
    - Reduction of smoking including increasing uptake of support from pregnant women and partners and decreasing the number of mothers smoking at birth.
    - Healthy weight of pregnant women, increasing the uptake of women seeking support to maintain a healthy weight gain in pregnancy.
- In Hampshire:
    - The Children and Young People's Plan 2022-2025 includes a commitment to reduced maternal smoking rates.
    - There is a review of the first 1,001 days, in recognition of that the time from pregnancy to when a child is two are the most crucial in a child's life, when the building blocks for lifelong emotional and physical health are laid down. This includes maternal health during this time.
- The Isle of Wight:
    - The Children, Young People and Families Plan for the Children's Trust has been paused in its development to ensure the right focus for the future, during a period of change in Children's Services and the NHS. In the initial development phase, it was agreed that the 'Isle be healthy' chapter would focus on improving the mental health of children and parents, reduce obesity, support breastfeeding, reduce smoking in pregnancy, and engage more with families to understand their views. It is expected that this plan will be completed in 2023.
    - The Public Health team and maternity services have been working together to reduce smoking in pregnancy, aiming to increase uptake of and improve access to smoking cessation services for pregnant women, recognising them as a priority group.
    - There is a review of the first 1,001 days, in recognition of that the time from pregnancy to when a child is two are the most crucial in a child's life, when the building blocks for lifelong emotional and physical health are laid down. This includes maternal health during this time.
    - The Isle of Wight has been identified as an area to lead the way in the development of Family Hubs and work has begun to develop plans which will focus on parenting, infant feeding, and mental health of parents in the first 1001 days. There will be lots of engagement with families to develop the plans.
    - All these plans and areas of work are purposefully interlinked.

The *Wessex Healthier Together programme* continues to provide information resources to parents and health professionals, aiming to help to them manage and prevent ill-health in children and young people.

There are also resources available such as Connect to Support Hampshire to facilitate self-help, 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.

Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) safeguarding children procedures manual

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 Public Health England 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 2023/2024.

There continues to be a centralised labour line across HIPS for advice for those in labour. A maternity antenatal triage line is due to launch in November 2022 to help support families.

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 has been transformation of communication strategies across HIPS which need to be further developed and evaluated going forward.

There has been more emphasis on maternal evidence networks and national funding has been made available.

Professional Support for Parents and Families

Some of the child deaths reviewed by the CDOP in 2020/2021 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.

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.

Childhood Trauma and Exploitation

Local Safeguarding Children Partnerships continue to highlight learning from case reviews including the need to consider early help support for children and young people, the importance of a whole family, strengths-based approach, ensuring a holistic view is taken of the child/family to try and fully understand what is going on rather than just the presenting issue, and the importance of full consideration of a child/family's history.

Practitioners must see the child in the context of them and their family's history, not just what is seen in front of them.

Local Safeguarding Children Partnerships have ensured pathways of support are available for parents of children at risk of harm due to exploitation and has considered whether engagement with parents and carers is sufficiently reflected in the HIPS Exploitation Strategy 2020-2023 and its workstreams.

Further information on local HIPS safeguarding strategies and procedures is available here.

Impact of Childhood Transitions, Emotional Wellbeing and Risky Behaviour

The RSE curriculum is statutory and features all elements of bullying, sexuality issues, suicide prevention and safe relationships; therefore, it is a requirement of schools to address them within curricular provision. Hampshire and Isle of Wight schools have been invited to free of charge briefings on RSE requirements/content and have access to an extensive range of RSE training, both universally available to all and bespoke to specific training requirements. All Hampshire and Isle of Wight schools have access to the Prejudicial Language and Behaviour Toolkit, and it is well used. The annual Personal Development Learning conference featured all these elements and had a particular focus this year on the lived experiences of children and young people; it was again open to all schools. A good practice document has been circulated capturing approaches to positive culture setting following work with 8 secondary schools. There has also been a project involving 22 schools across Hampshire and Isle of Wight focusing on different aspects of positive, healthy relationships, the learning from which is due to be shared in the autumn. Much of this work has been undertaken in collaboration across partners such as Public Health and Police, with Education taking the lead.

Additionally, the advice given to schools following previous serious case review learning and so forth encourages schools to consider how they support all the areas below through their PHSE curriculum in Southampton and Portsmouth. Cross phase advisors in Southampton have been working with local Education Psychology and the Violence Reduction Unit looking at Violence against women and girls (VAWG) and safe relationships through training days, cross school policy working and Educational Psychology action research considering young people's understanding of peer relationships. Additionally, professionals are working with the Online Trolls initiative and all schools need to complete a report/self-evaluation tool sent to the cross advisors detailing how they are supporting children and young people in relation to bullying, sexuality issues, suicide prevention and safe relationships. Following this, the advisors can follow up on any support that is needed in developing policies and curriculums.

Furthermore information is also available with the Portsmouth PSHE framework, and other supporting information is available here.

The place and/or Local Authority level initiatives listed above, namely the Hampshire Children and Young People's Plan, Isle of Wight Children and Young People's Plan, Portsmouth Children's Public Health Strategy and Southampton CYP Strategy, and Tobacco, Alcohol and Drugs Strategy highlight place based partnerships' priorities and commitment to action to protect and enhance children and young people's mental and emotional wellbeing and reduce risky behaviours, including risky behaviours related to alcohol and other substance use. All areas work together to share good practice towards the

development and implementation of local suicide prevention plans. A multi-agency partnership is developing and implementing a real-time surveillance system for suspected suicides, enabling both better prevention and postvention support; and facilitating more timely and better identification of arising issues or clusters of potential concern.

5. HIPS CDOP Notifications 2021/2022

The annual report refers to the overall number of child death notifications in 2021/2022, 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 learned, and actions taken, and these outstanding child death reviews will be reported on in the following year.

The HIPS CDOP received 89 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 2021/2022.

The 89 registered child deaths for each area within HIPS are as follows:

- 60 for Hampshire
- ≤5 for the Isle of Wight
- 10 for Portsmouth
- 16 for Southampton

Please note that the number of children living in Hampshire is much larger than other areas, therefore numbers cannot be directly compared between authorities.

More cases were notified in 2021/2022 (89) compared to 2020/2021 (79). 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, 2015/2016-2021/2022

Child Deaths by Local Authority Area					
Year	**Hampshire**	**Isle of Wight**	**Portsmouth**	**Southampton**	**Totals**
2021/2022	60	≤5	10	16	**89**
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

The monthly variation in cases is presented in table 2 in a month-by-month comparison for 2019-2022.

Table 2: All child death notifications from 1 April 2019 for the HIPS CDOP

All death notifications from 01/04/19 by month and year

Month of death	2019-20	2020-21	2021-22
Apr	6	8	5
May	8	4	7
Jun	8	5	11
Jul	3	6	5
Aug	8	11	5
Sep	7	5	7
Oct	13	8	7
Nov	7	7	11
Dec	8	9	10
Jan	13	7	8
Feb	5	3	8
Mar	19	6	5
Total	**105**	**79**	**89**

Table 2 shows the monthly number of child death notifications for 2021/2022. It shows that notifications of child deaths are not completely straightforward and vary by month, with the highest number of notifications (28) in quarter 3 of 2021/2022 and the single highest numbers of notifications in June and November 2021 (11).

The number of notifications by age of child across the HIPS area is presented in figure 2 and shows that over half (55%) of the children who died are under the age of one (49). This remains consistent with 2020/2021 notifications.

Figure 2: Number of child death notifications by age of child 2021/2022, HIPS CDOP

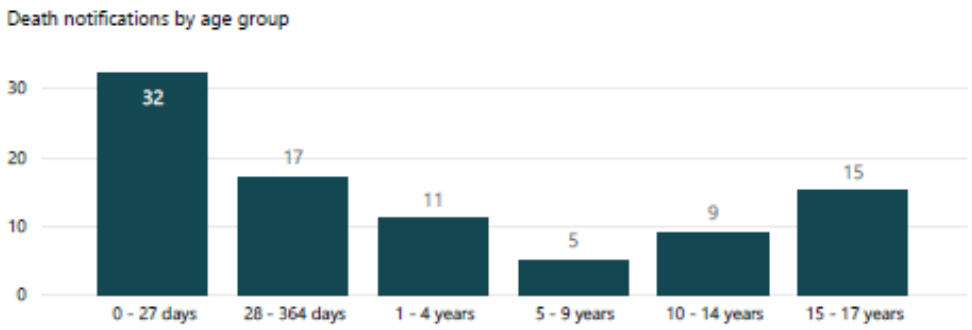


Figure 3 shows comparative percentages of child death notifications by age group for the HIPS CDOP against the national average. The proportion of deaths in the 0–27 days age group is less than the national average, which has a knock-on effect on the proportion of deaths in the other age groups. There is a higher number of deaths in the 15–17-year-old age group, than the national average. This has been considered in a 3-year thematic review (Appendix 3).

Figure 3: Percentage of child death notifications by age group 2021/2022, HIPS CDOP and National

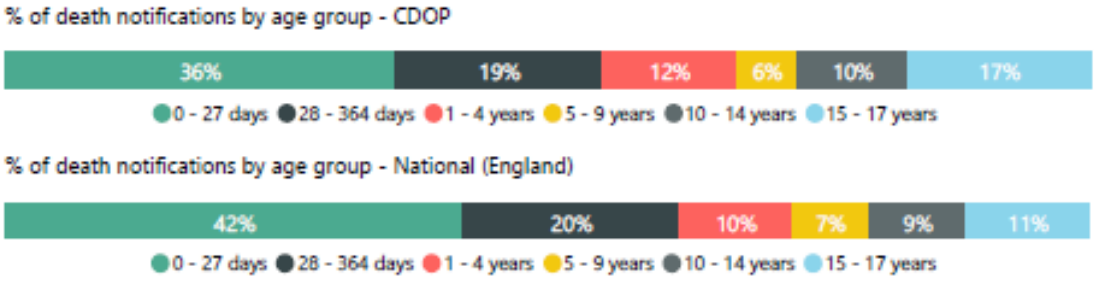


Table 3 shows the numbers of child death notifications by age group and year between 2019-2022. It shows that the proportion of deaths by age over time are similar to the national average.

Table 3: Child death notifications by age group and year 2019-2022, HIPS CDOP

Age	2019-20	2020-21	2021-22	3-year total	% Notifications by age group
0-27 days	48	42	32	122	45%
28-364 days	13	13	17	43	16%
1-4 years	13	6	11	30	11%
5-9 years	11	4	5	20	7%
10-14 years	7	5	9	21	8%
15-17 years	13	9	15	37	14%

Most child deaths occurred in hospital environments (63) and home and other family residences (20). 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.

Boys' deaths accounted for just under two thirds (65%) of the notifications and ethnicity of the child was recorded in all 89 cases notified. Deaths of children from a White background at 78%, 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%. Within the 78% of White background children, 90% were White British, 7% White European and 3% Other White ethnicity.

By contrast, 21% 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%. This suggests that death notifications in children reported from a non-White ethnicity are over-represented. Further analysis is being undertaken with the support of Public Health.

On notification, a case is initially categorised using the following schema (pending further information), definitions of these can be found in Appendix 4:

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 2021/2022, 40% of the HIPS child deaths, notified, triggered a JAR (36) with 28 cases for a male child and 8 cases for a female child. 31 of these cases currently remain under investigation.

With regards to multi-agency involvement, out of the 89 child deaths across HIPS for 2021/2022:

- 9 of the children were classed as a Child in Need, the subject of a Child Protection Plan or a Looked After Child arrangement
- 5 were being supported for health reasons (but not on a Child in Need plan) or known previously for support for health reasons
- 6 families were known to Children's Services previously but did not have an open case
- 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 identification of a key worker for the family. The role of the key worker is to be the point of contact for the family 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 2021/2022: 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.

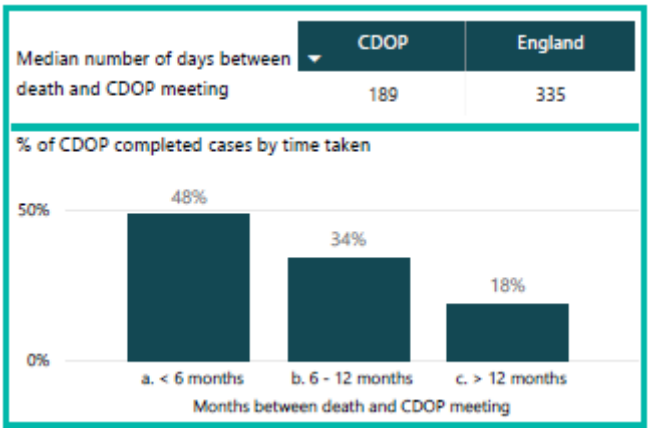
A total of 71 reviews have been completed from 1 April 2021 to 31 March 2022. These relate to deaths from 2020-2021 as well as some from 2018-2020 which were delayed due to other investigations. The aim is for the strategic CDOP to review deaths with 6-12 months from notification. Local reviews are undertaken immediately following a death and will vary in the time taken to complete depending on the complexity of the circumstances surrounding the death, and therefore, can have an impact on the timeliness of the CDOP review.

During 2021/2022, there were 13 CDOP meetings held, including 5 Neonatal Themed Panels.

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 189 days, compared to the national average of 335 days (Figure 5). Figure 5 also shows the percentage of completed cases by time taken with 82% within 12 months.

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 or Coroner cases where the legal proceedings need to be concluded prior to the CDRM/CDOP review.

Figure 5: Time between the death of a child and child death review completion 2021/2022, HIPS CDOP and Nationally and percentage of completed cases by time taken



8. HIPS CDOP Reviews 2021/2022: Findings

8.1 Category of death

Table 4 shows the categorisation of the 71 child deaths reviewed as set out and defined by the NCMD (Appendix 4). Some categories have been amalgamated to enable reporting of small numbers. The table shows that 41% of the child deaths reviewed were due to a perinatal/neonatal event which was the most common contributory factor. This is consistent with 40% in 2019/2020 and 38% in 2020/2021 reviews. At 27%, chromosomal, genetic, and congenital anomalies was the second most common contributory factor of the child deaths reviewed as it was in 2021 (19%).

Just over half of all child deaths reviewed were of children who died under 28 days old (52%) and this is consistent with previous years.

Table 4: Completed CDOP reviews by categories of death, 2021/2022, HIPS CDOP

Categories of death	No.	%
Perinatal/ neonatal event	30	41%
Chromosomal, genetic, and congenital anomalies	19	27%
Malignancy, acute medical or surgical condition (including infection) and chronic medical conditions	9	13%
Trauma, deliberately inflicted injury and self-injury, abuse, or neglect, including suicide and trauma	8	11%
Sudden unexpected, unexplained death	5	7%

8.2 Modifiable factors

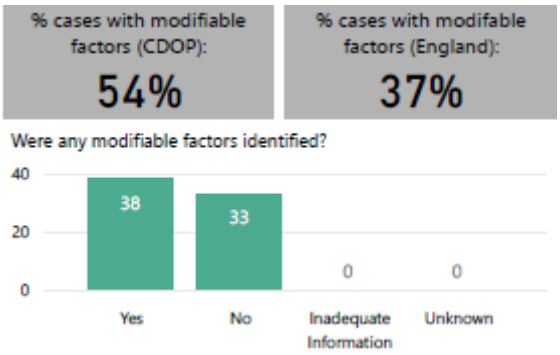
A key aspect of the analysis the CDOP undertakes is to consider whether there were any modifiable factors that may have contributed to the child's death. Factors may be judged modifiable if actions at a national or local level could be taken to reduce the risks of future child deaths and are discussed in the CDRMs and recorded on the analysis form (Appendix 5).

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 71 cases reviewed in 2021/2022, 54% of the cases had modifiable factors identified by the HIPS CDOP, higher than the national average (Figure 7). This does not however cover all child death notifications in the same period so may not be wholly representative. Modifiable factors were identified in 38 cases out of the 71 cases reviewed.

This is an increase on case reviews with modifiable factors identified from 2019-2021 and may reflect that there were reviews of more of the most complex cases during the year.

Figure 6: Percentage of cases reviewed with modifiable factors, HIPS CDOP and Nationally, and number of cases reviewed with or without modifiable factors identified, 2021/2022



8.2.1 Modifiable factors in relation to category of death

Modifiable factors were identified in just over half (54%) of all deaths reviewed. They were present in all cases where the category of death was trauma and other external factors, suicide or deliberate self-inflicted harm, sudden unexpected, unexplained death, infection, and deliberately inflicted injury, abuse, or neglect. Modifiable factors were identified in half (50%) of perinatal/neonatal events, chronic medical conditions and acute medical or surgical conditions and in just over a third (37%) of deaths categorised as chromosomal, genetic and congenital anomalies.

This emphasises the need for targeted work by the wider system to focus on the modifiable factors, including reducing the risk factors for and enhancing protective factors against trauma and suicide, and consideration of health literacy, and the effectiveness of health messaging in preparation for pregnancy, during pregnancy and postnatally. It should be noted that the impact of the increase in viable births at an earlier gestation on the vulnerability of the infant due to organ immaturity.

8.2.2 Modifiable factors in relation to age

Modifiable factors were identified across all age groups. The 28–364-days age group was most likely to identify modifiable factors (90% of the cases reviewed). 70% of those in the 15-17-year-old age groups had modifiable factors identified.

8.2.3 Modifiable factors in relation to ethnicity

Due to small numbers, it is not possible to draw any conclusions about modifiable factors by ethnicity. The CDOP is mindful of the need to continue to monitor closely to identify any prominent themes in relation to specific ethnicities.

8.2.4 Key themes emerging from the reviews completed are:

The main themes of the reviews which professionals reported may have made a difference to the outcome focus on the following key areas:

- **Promotion and enabling of health in families**
- **Social environmental impact on the safety of young children**
- **Service provision across agencies working with children**
- **Physical environment impacting on family health, e.g., housing**

9. Themes and Learning from 2021/2022

The HIPS CDOP continues to support the recommendations made in the 2020/2021 HIPS CDOP Annual Report and builds on the themes and learning identified in the 2021/2022 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 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.

Table 7 shows the learning from the themes emerging from the work of the CDOP. 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.

It is expected that there will be feedback from the ICB Quality Board, Executive Directors of Public Health Group, and HIPS Safeguarding Executive to the CDOP on the following areas of learning.

Table 7: Themes and Learning 2021/2022

Theme	Learning
Promotion and enabling of health in families	A recurring theme across CDOP discussions has been in relation to how professionals talk to parents and find the right way of signposting parents to counselling, for example, when declined antenatally or when parents have not been prepared for a poor outcome. Professionals should consider whether the parents have fully comprehended the risks and the outcome for their baby and provide person-centred care that addresses the child, parent and family needs including their personal, cultural, and religious beliefs, attitudes, and values. The CDOP recommends that there should be more awareness of the Wessex Healthier Together website/app for parents and how population profiles can be monitored to identify localities where there could be more intensive preventative work: https://what0-18.nhs.uk/. The NCMD report stated that the main modifiable factor for neonatal deaths was noted to be in the social environment: smoking by a parent or carer, raised maternal BMI during pregnancy, substance and/or alcohol misuse by a parent or carer, domestic violence, challenges with access to services and un-booked pregnancies.[1] The HIPS CDOP has found that parental smoking, raised maternal BMI and some incidences of domestic abuse have been identified in some cases reviewed. Therefore, it is vital that the health promotion for parents from preconception to postnatally continues to develop to meet the needs of the population to reduce the number of child deaths where there are social environmental factors. The forthcoming ICB CYP strategy includes a focus on the first 1,001 days, recognising the importance of maternal and family health as critical in a child's future physical and mental well-being.
Social environmental impact on the	The impact of the social environment on the safety of young children has been stark in some reviews.

[1] NCMD Second Annual Report

safety of young children	This links to the promotion of health in families is significant but it is so important to ensure that professionals ensure parents and carers have heard and understood the messages given so any risks are managed, for example, when they smoke or do not practice safe sleeping routines. Professionals provide information to inform decision making but it is also important to ensure professionals are reassured parents and families understand the messaging. Services need to ensure that their professionals have the knowledge and skills to be able to assess the potential harm to a child when they are aware of social issues, and to be able take action to reduce the risk of harm.
Service provision	Within service provision there was good practice in situations where it was known that a child would die. In these cases, professionals worked together with the families to ensure a good death and support following the event. There was also an improvement in the integrated work between local maternity units and tertiary settings for neonatal deaths. This work might not have prevented the deaths but demonstrated continuity of care for the families coping with the death of a new-born infant. However, in there were concerns in how service work to prevent child deaths. For example: • Insufficient evidence of professional challenge when witnessing an infant in an inappropriate sleep position • Lack of confirmation that parents have heard, and fully understood, child safety messages • Parental behaviours, for example, smoking or substance misuse, not being seen as significant risk for infant • Parental vulnerabilities not assessed in terms of their capacity to make safe choices for their infant, for example, parental mental health and/or learning disability • Getting the communication right so expectations of parents and their understanding are clear, messages are delivered appropriately, and ensuring interpreter services are used when necessary and ensuring cultural competence • Ensuring early and robust planning, investigations, and risk assessments are made and professionals continue to share information across services
Physical environment impacting on family health	The impact of the physical environment on the health and wellbeing of a family has been a theme from some of the reviews of deaths of children with complex needs or those who have died unexpectedly at a very young age. The key issues relate to overcrowding or cluttered environments. This raises the question of how professionals assess the home environments when visiting families, and the appropriateness of local authority funded housing. Within the reviews of deaths related to unsafe sleeping practices, the CDOP was concerned that it was common for a Moses basket not to be used or that there was extensive use of pillows, or items that could cause suffocation, within the cot or Moses basket.

This demonstrates the need for any professional visiting a home to assess the appropriateness of the sleeping arrangements through asking to see the room or through a conversation with the parents or carers that is fully recorded in the case notes. This includes risk factors such as housing and overcrowding to fully understand the reasons families are making the choices they do.

Professionals need to ensure appropriate signposting is made and ensure services who families are referred to are aware of any risk factors and/or vulnerabilities of families. It is important for services to understand the family context.

10. Promoting Good Practice

The child death review process identifies factors intrinsic to the child, social environment, 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 2021/2022 in what has continued to be another challenging year.

The importance of working together of all professionals is vital, particularly the engagement of primary care in the Child Death Review process.

With the HIPS area, we acknowledge the efforts our multi-agency colleagues, and some highlights include:

- Continued development of the Joint Agency Response process and collaboration across the CDR and CDOP reviews
- Continued development of Child Death Review frameworks within local Trusts
- JAR professional restorative and reflection sessions and chair training
- Working with parents and consideration of parental choice in decision making
- Early identification of care issues and advanced testing used in perinatal and neonatal cases
- Themed Panels with briefing and learnings shared across HIPS and engagement by professionals including professional bodies such as the Healthcare Safety Investigation Branch, and joining together of multi-agency and out of area colleagues at Panel meetings
- The production of a bi-annual CDOP report to enable a timelier sharing of child death review data and key findings
- Continuing joined up discussions on bereavement support
- A local Trust and the CDOP Team involvement in the phase 1 roll out of the MBRRACE/PMRT/NCMD/CDOP integration project
- Chair and CDOP Manager representation at the Association of Child Death Review Professionals
- CDOP representation at the National Network for CDOPs

Asher

Asher was a 15-year-old who had a life limiting malignancy and she had an advanced care plan which had been agreed with a multi-disciplinary team and Asher's parents. Asher had received treatment at several specialist hospitals but sadly there were no curable options. Asher was well supported in the months leading up to her passing by community professionals and every effort was made to ensure she was comfortable, and her symptoms were managed. The end-of-life care was as per Asher and her family's wishes and professionals made arrangements for a private family space, for time and memory making together.

There was particularly commendable involvement from the family GP who attended some of the Paediatric Palliative Oncology MDT meetings and professionals felt the GPs involvement was valuable. Care was delivered throughout the COVID-19 pandemic and although masks had to be used in healthcare settings, professionals did everything possible to communicate effectively with the child and family to ensure understanding and support was in place.

The HIPS CDOP acknowledged the outstanding level of care provided and how professionals came together with the family to ensure comfortable and well-managed end-of-life support. The family continue to receive appropriate bereavement support.

Mohammed

Mohammed was a 9-year-old who had complex health concerns due to a gene mutation diagnosed earlier in life. Throughout Mohammed's life clinicians extensively supported the family to understand their child's condition and they administered the best treatment options available. The professionals supported the parental decision making, heard their views and answered their questions. Full counselling was provided to the family along with genetic testing offered, giving wrap around care, and also to inform the family's future decision making if they wished to extend their family.

When Mohammed's condition began to deteriorate, the palliative care and community nursing teams facilitated a family trip so the family could share time away from a medical environment and make more memories.

Following Mohammed's end-of-life care and support, the bereavement team worked collaboratively with professionals and the family to make sure the best possible support was offered, and the family have been grateful for all the care received and appreciated the information shared by professionals when explaining the complexity of Mohammed's condition.

The HIPS CDOP highlights the continuity of compassionate care throughout this child's life and commends the community specialists involved in enabling this family to be able to spend some treasured time together.

Lily

Lily was born prematurely with an antenatally diagnosed chromosomal anomaly and sadly passed away at two days old. Parents were counselled with regards to the poor outcome of their baby but choose to continue with their pregnancy. The baby and Mother were closely monitored and regularly scanning to ensure enhanced care. Significant preparation was made, and an advanced care plan agreed, and although Lily arrived earlier than expected, Maternity, Obstetric and Neonatal professionals worked closely to continue to support parental choices and care in the best interests of Lily and her family. Lily and her mother received one to one care and were moved to a dedicated room where family were able to join them for uninterrupted time together. Professionals arranged for a blessing in the hospital as per the family's wishes.

Lily's parents had met the Bereavement Midwife prior to delivery as well as the Consultant Midwife to ensure they were fully supported. The advanced care plan took into consideration personal and religious beliefs of the family. The parents continue to be supported by the Bereavement Midwife and the GP is available for additional support. Counselling has been offered and the parents have good support from their family and friends. The family has additionally been signposting to charity organisations to ensure they have options that suit them when they are ready.

Should the family wish to plan for a future pregnancy, parents will be seen in a specialist clinic and an individualised plan of care will be agreed.

The HIPS CDOP recognises the evidence of joined up and pro-active care for this child and family and is reassured by the positive feedback received from Lily's parents who felt they received an excellent level of care.

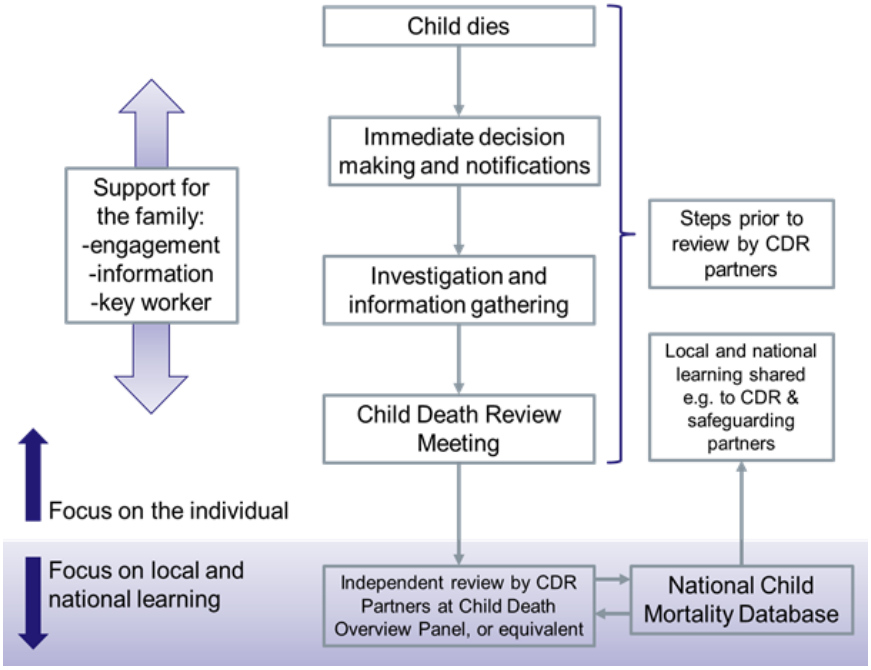
N.B. Please note pseudonyms are used in these vignettes which illustrate good practice in circumstances where a child has sadly passed away.

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
- Publicize 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 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) (ICB from July 1st 2022) 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 continues to be 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 colleagues across the system.

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 or malignancy (see Appendix 4). 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 Learning from 2020/2021:

Theme	Learning
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.
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 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.
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.
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.
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.

Appendix 3

2019-2022 Thematic Review of Deaths of 15–17-year-old children across HIPS

Context

The HIPS CDOP has noted an increase in the number of deaths of children aged 15-17 years old since 2020, which does not reflect the national average for this age group (2021/2022 national average 11%, HIPS 17%). In 2020/2021, a themed panel was held to review deaths due to suicide which identified some themes relating to:

- More males
- Known to services/complex histories
- Bullying and isolation
- Risks of transition periods during childhood
- Online safety - suicide games

However, the CDOP recognised that not all deaths for this age group were due to suicide. Therefore, a thematic review of the data covering the three-year period since the HIPS CDOP has been in place was undertaken. The data has been divided into two general categories of deaths: life limiting conditions/expected deaths, suicide/trauma/accidents.

Data

	Percentage by category	% Male	% Female	% White British	% Non White British
Total number of deaths 15-17 years old is 26		**81%**	**19%**	**81%**	**19%**
Life limiting or specific medical circumstances	**23%**	**67%**	**33%**	**83%**	**17%**
Suicide/trauma/accidents	**77%**	**85%**	**15%**	**80%**	**20%**

Categories: Expected

Life limiting/medical conditions
The thematic review concluded that the CDOP has identified good practice in the support for families. However, there was evidence of some difficulties in working together, follow up of children not brought to appointments, limited knowledge of parents of children with complex needs, and obesity. This might reflect the difficulties for families trying to care for older children with complex needs and raises questions about the transition into adult period for older children with complex needs.

Categories: Unexpected

The risk factors identified by the National Child Mortality Database in relation to suicide were used by Surrey Child Death Review Partners to undertake a suicide thematic review. The risk factors have been used to explore the wider unexpected deaths within HIPS of this age group. The most common factors have been included in the table below. This table highlights in red the factors of particular concern for Hampshire, Isle of Wight, Portsmouth, and Southampton.

Deaths due to suicide/trauma/accident				
National risk factor	**National (suicide) 2020/2021 %[2]**	**Surrey 2015-2021/2022 (suicide) %[3]**	**HIPS suicide %**	**HIPS trauma/accident %**
Household functioning	**69**	**82**	**30**	**10**
Loss of key relationships	**62**	**41**	**30**	**10**
Mental Health needs of child	**55**	**88**	**80**	**20**
Risk taking behaviour	**49**	**88**	**40**	**40**
Relationship conflict	**45**	**71**	**60**	**10**
Problems at school	**30**	**71**	**80**	**20**
Bullying	**21**	**24**	**50**	**0**
Drug/alcohol misuse by child	**20**	**29**	**20**	**50**
Social media /internet use	**18**	**24**	**60**	**10**
Neurodevelopmental condition	**16**	**41**	**50**	**30**
Sexual orientation /identity	**9**	**12**	**40**	**0**
Additional factors (HIPS)				
Suicide pact			**20**	
Potential organisational negligence (not health or social care)				**40**

Discussion Points

The impact of mental health needs on the risk of suicide in the 15–17-year-old age group is significantly higher in HIPS in comparison to the national average, although similar to that seen within Surrey. Therefore, it would be of benefit to measure the impact of the work of the CAMHS Closer to Home programme commenced in 2022.

The key risks for those dying through trauma or accident are:

- The use of drugs or alcohol. This represents the risk taking that would not be unusual for adolescents. However, this emphasises the need for continued education of children and their parents on how to keep safe
- Safety of sites managed by organisations. This indicates the need for security measures to prevent children from accessing dangerous places

Key risk factors for suicide demonstrate a need for agencies to focus on how to support children through:

- Relationship conflict
- Problems at school
- Bullying

[2] NCMD (2021) Suicide in Children and Young People

[3] SSCP/Surrey Child Death Review Partnership (2022) Thematic Review of Adolescent Suicides 18-month Report

- Social media
- Sexual orientation/identity

In addition, a theme cross cutting suicide and other traumatic deaths seems to be for children diagnosed with a neurodevelopmental condition. This suggests that children with such conditions need to be supported to a greater extent to manage the risks of harm during their teenage years.

Conclusion

This review is intended to support partnerships and professional groups across HIPS to consider the learning from death reviews when addressing the needs of individual adolescents, as well as for informing transformation of services. The findings will be helpful to ensure that health inequalities are given the scrutiny needed to reduce the risk of child deaths across the region.

Nicola Brownjohn, Independent Chair HIPS CDOP
Julie Hulls, Senior Designated Nurse for Safeguarding Children, NHS Hampshire and Isle of Wight ICB.

Appendix 4

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. Please choose from the sub-categories below: 2 (i) Suicide (where the panel feels the intention of the child was to take their own life) 2 (ii) Self-inflicted harm leading to death (where it is unclear if the child's intention was to take their own life) 2 (iii) Death as the result of substance misuse (excluding deaths as a result of a deliberate overdose)
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 5

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 collisions).	**Relevance (0-2)**	**Is this factor deemed to be modifiable?**	**CDOP affirmation (0-2)**	**Is this factor deemed by CDOP to be modifiable?**

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 6

Acronyms

AICU	Adult Intensive Care Unit
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
ED	Emergency Department
HIPS	Hampshire, Isle of Wight, Portsmouth and Southampton
IVF	In Vitro Fertilisation
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