NHS
Hampshire and Isle of Wight

Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel

Annual Report

1st April 2023 – 31st March 2024

NHS Hampshire and Isle of Wight Integrated Care Board

Contents

1.0 Overview

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

Since October 2019, there has been a strategic Child Death Overview Panel covering all of Hampshire, Isle of Wight, Portsmouth and Southampton. This is an equal partnership for the mutual benefit of all children and young people involved and provides an oversight and assurance of the entire Child Death Review process in accordance with legislation and local Child Death Review policies.

The Children Act 2004 requires Child Death Partners, to ensure arrangements are in place to carry out child death reviews, including the establishment of a Child Death Overview Panel. The reviews are conducted in accordance with Working Together 2023 alongside the Statutory and Operational Guidance.

The Hampshire, Isle of Wight, Portsmouth, and Southampton Child Death Overview Panel process works effectively and the performance in relation to notifications and submission of data to the National Child Mortality Database (NCMD) is recognised as being well managed. This is down to the immense commitment of the team.

2.0 Achievement and Challenges in 2023/2024

NHS Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel Team can provide assurance on the progression of priority work areas over the reporting year of 2023/2024, and these have been:

- Following a review of the Child Death Overview Panel arrangements by Public Health, the Child Death Overview Panel moved across on the 1st of October 2023 to NHS Hampshire and Isle of Wight. Following the move, the Child Death Overview Panel was held by the Safeguarding Deputy and Senior Designated Nurse for Safeguarding Children (Hampshire place), where work began to understand and review current processes, governance and structure whilst managing the day-to-day operational management. This continued while new members of the team were able to fully undertake their roles
- A new team were recruited at the start of 2024, with a Manager and Co-ordinator now in post working closely with the Designated Doctor for child deaths. As a result, this is the first annual report provided by NHS Hampshire and Isle of Wight for the Hampshire, Isle of Wight, Portsmouth, and Southampton Child Death Overview Panel
- A well-established and robust system for notifying the death of a child. Any agency can complete and submit a child death notification via the eCDOP Portal

- A Memorandum of Understanding with clear finance contributions as a partnership approach was developed and agreed at the safeguarding children Hampshire, Isle of Wight, Portsmouth, Southampton (HIPS) executive group in September 2023, with yearly updates regarding funding to be taken to the executives for yearly sign off
- Themed Panels with briefing and learnings shared across Hampshire, Isle of Wight, Portsmouth and Southampton (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
- A multi-agency learning from child deaths training event took place in July 2023 and was well attended with good feedback from the event
- Continued development of the Joint Agency Response (JAR) process and collaboration across the Child Death Review (CDR) and Child Death Overview Panel reviews
- Continued development of Child Death Review frameworks within local Trusts
- Joint Agency Response professional restorative and reflective supervision sessions
- Continuing joined up discussions on bereavement support
- Child Death Overview Panel representation at the National Network for Child Death Overview Panel's
- Challenge continues across the system in this reporting year regarding the Key Worker role and identification of a Key Worker to support the families when there is an unexpected child death, and a Joint Agency Response is convened. 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

Child Death Review partners who are the Local Authorities and Integrated Care Boards (now known as NHS Hampshire and Isle of Wight Integrated Care Board) for Hampshire, Isle of Wight, Portsmouth and Southampton hold the legal responsibility for reviewing child deaths as set out in the Children Act 2004, as amended by the Children and Social Work Act 2017.

The purpose for reviewing the deaths is grounded in respect for the rights of children and their families with the intention to ascertain why children die and put in place interventions to protect other children and prevent future deaths from occurring.

On behalf of the Child Death Review Partners, the Child Death Overview Panel will conduct the statutory review and provide the final independent multi agency scrutiny for the deaths of all children who are normally resident in Hampshire, Isle of Wight, Portsmouth and Southampton. The review will occur once all other child death processes i.e. coronial inquest or Child Safeguarding Practice Review (CSPR) have been completed. The statutory task of the multi-agency panel lies in its ability to scrutinise the circumstances surrounding each child's death and where appropriate, to provide challenge to the agencies involved to further enhance the learning, as well

as make recommendations to the appropriate agencies to improve service delivery and patient experience.

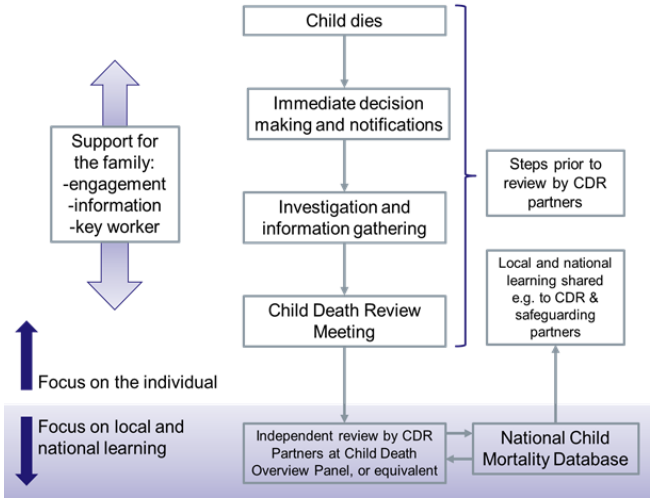
3.0 Functions of Child Death Overview Panel

Child Death Overview Panel covers all the of the four local authority areas which make up Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel. The population of each local authority differs considerably with a much larger population within Hampshire (see Appendix 1 for population numbers). Numbers of child deaths cannot therefore be directly compared between authorities.

The Hampshire and Isle of Wight, Portsmouth and Southampton Child Death Overview Panel, 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 process.

A Child Death Review 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 Child Death Review (CDR) runs from the moment of a child's death to the completion of the review by the Child Death Overview Panel (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)



4.0 Child Death Overview Panel Notifications 2023/2024

The Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel received 97 child death notifications during 2023/2024 relating to 395,537 children aged under 18 years resident in the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) area (Office for National Statistics 2021 Census).

The registered child deaths for 2023/2024 in each area Hampshire, Isle of Wight, Portsmouth and Southampton are as follows:

• 58 in Hampshire

• <5 on the Isle of Wight

• 13 in Portsmouth

• 22 in Southampton

There has been no significant change in the number of child deaths recorded since 2015, with the average number being 98.7. Cases notified in 2023/2024 (97) remained stable and this is evident to previous years notifications; 2022/2023 (98), 2021/2022 (89), 2020/2021 (79). The numbers of child deaths for the years previous do fluctuate with no discernible clear trends for the variations.

There is a well-established and robust system for notifying the death of a child. Any agency can complete and submit a child death notification via the eCDOP Portal. This is in line with the statutory requirements to notify all child deaths 0-18 years of age immediately after the death of the child. Multi-agency data regarding the child death is then transferred to National Child Mortality Database, reducing duplication.

Many of the cases reported in the last financial year (01/04/2023–31/03/2024) have not yet been reviewed at the Child Death Overview Panel due to processes not yet fully completed, i.e. awaiting coroner's conclusion reports, legal safeguarding issues still in process etc. This report 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.

It is recognised that postmortem results and inquests can take a considerable amount of time, and most cases cannot be progressed to panel until these have been concluded and the results received.

4.1 Child Mortality Rate

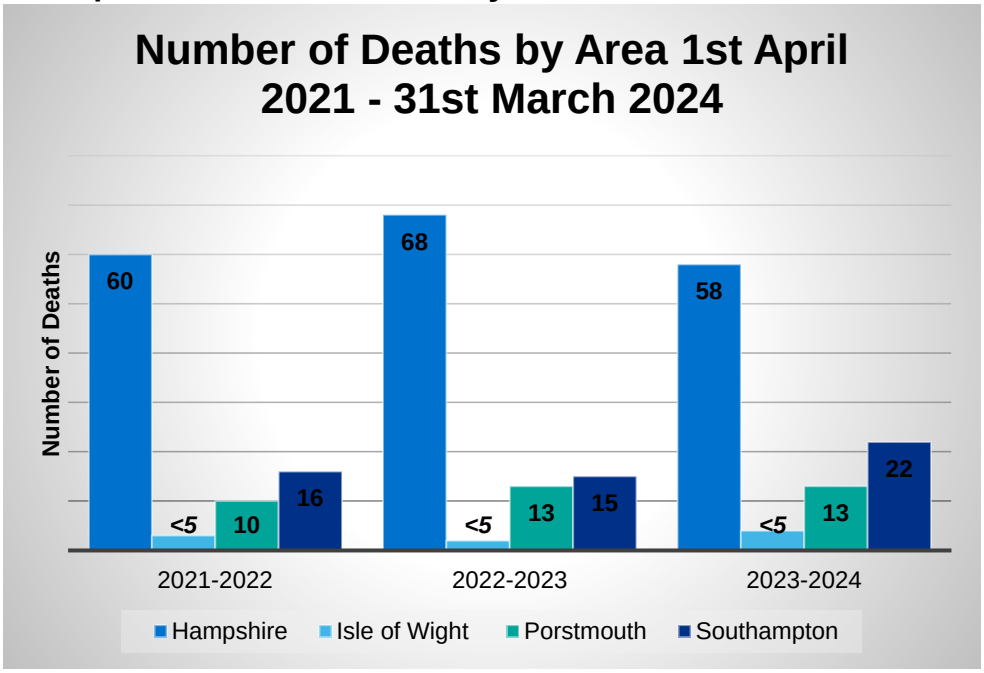
National Child Mortality Database data 2022/2023 indicated that there were 3,743 child (0 – 18 years) deaths in England in the year ending 31 March 2023, an estimated rate of 31.8 deaths per 100,000 children. The number of deaths increased by 8% on the previous year and was the highest number of deaths in a year since National Child Mortality Database (NCMD) started data collection in 2019. Infant (children under 1 year) deaths increased by 4% on the previous year and deaths of children aged between 1 and 18 years increased by 16%.

Nationally, for children aged between 1 and 18 years, the highest death rate continued to be for children aged between 15-18 years (21.3 per 100,000 population), followed by 1–4-year-olds (17.6 per 100,000 population). Death rates for all age groups increased in comparison to the previous year, (NCMD 2023). In the Southeast area it was reported as 9.4% per 100,000 (Fingertips Office for National Statistics data 2021).

In Hampshire, Isle of Wight, Portsmouth and Southampton area, Hampshire has 8.0 per 100,000, Isle of Wight figures not available in national data, Portsmouth has 9.4 per 100,000 and Southampton has 10.4 per 100,000 children. Southampton is inline the national data with lower than national statistics for the other areas within the footprint.

Hampshire Isle of Wight, Portsmouth and Southampton sits within the Southeast region where the infant mortality rate is 3.3 per 1000 – slightly lower than across England. The Southampton infant mortality rate of 3.9 per 1000 births is in keeping with the national average, whilst all the other local authorities are below this. The Isle of Wight data noticeably lower at 2.7 per 1000, please see 4.1 regarding deprivation data.

Graph 1 - Number of deaths by area 01/04/2021 – 31/03/2024



For reasons of confidentiality, figures <5 have been suppressed.

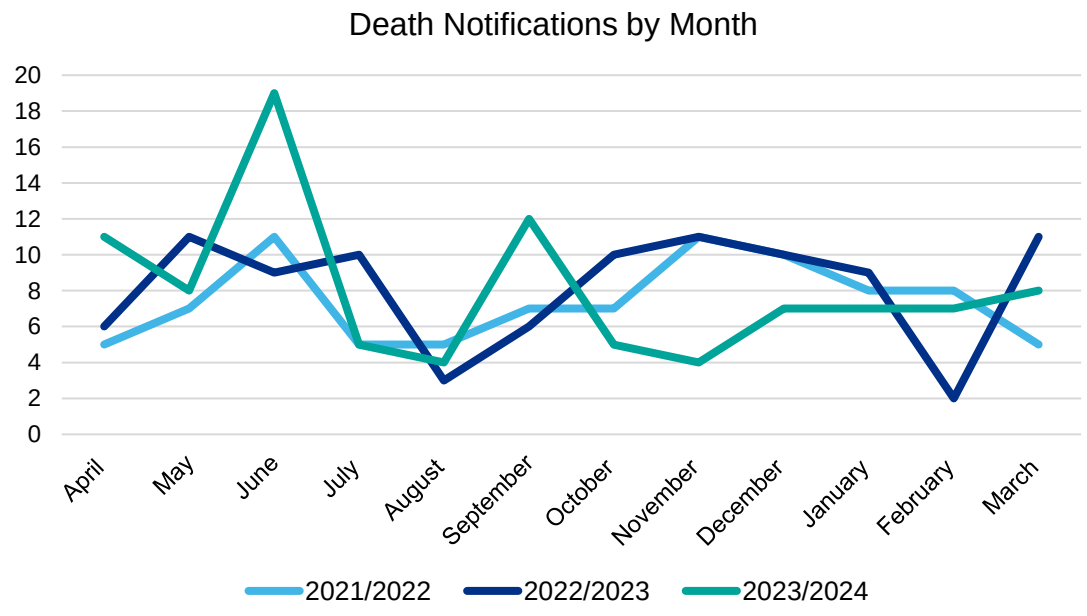
The above graph demonstrates that 66% of child deaths occurring across the patch between 2021-2024 are Hampshire residents. This is what would be expected as 71.6% of the under 18 population reside in Hampshire, with Isle of Wight (5.98%), Portsmouth, (12.5%) and Southampton, (14%). Numbers of child deaths can therefore not be directly compared between Local Authorities.

It is recognised that a small proportion of deaths occurring each year within Hampshire, Isle of Wight, Portsmouth and Southampton are of children who reside in other areas across the UK. University Hospitals Southampton is a tertiary referral unit for neonates and children and houses specialist services including paediatric intensive care, cardiology, oncology and neurology. Most deaths that occur of out of area are children who are under the care of University Hospitals Southampton. These out of area cases are then notified to their own area Child Death Overview Panels, and a discussion takes place as to where the child death review should take place.

During the reporting year 2023/2024 there were 16 child deaths for out of area children. These included children who sadly died at acute Hospitals Trusts and in Hospice environments within the Hampshire, Isle of Wight, Portsmouth and Southampton footprint. These deaths are in addition to the 97 deaths which are referred to within this report as they will be reviewed within their own area child death overview panels.

When reviewing the number of deaths during 2023/2024 it was recognised that there was a significant increase in child deaths during the month of June 2023. Data from the last 3 financial years has therefore been further considered to identify if there are any themes or trends at specific times of the year. The last 3 years data is presented in graph 2 below:

Graph 2 - HIPS Death Notifications by Month 1st April 2021 – 31st March 2024



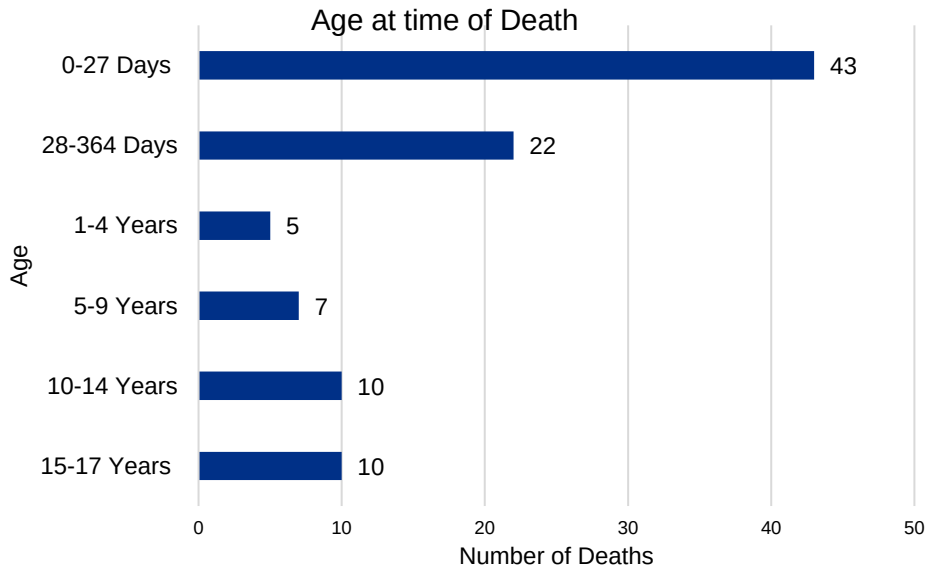
Having reviewed the cases by month, no significant themes or trends have been identified and the Child Death Overview Panel (CDOP) team are confident that there are no significant similarities between deaths which would account for the increase in June.

4.2 Age at time of Death 2023/2024

Most childhood deaths occur during the first year of life, particularly the first month of life largely due to perinatal causes, some of which can be prevented through lifestyle factors before and during pregnancy as per RCPCH Infant mortality.

Of the deaths notified in this reporting year, the breakdown of ages is detailed in Graph 3 below:

Graph 3 Age at Time of Death



The figures above reflect that during the reporting year 2023/2024, 68% of deaths within the Hampshire, Isle of Wight, Portsmouth, and Southampton area occurred within the first year of life, which is comparable to national statistics.

4.3 Gender

During the reporting year 2023/2024, 46% of the child deaths were female and 52% were male. 2% of the infant deaths were classed as Indeterminate as detailed in Appendix 2.

The gender distribution of deaths across Hampshire, Isle of Wight, Portsmouth and Southampton follows the national trend where a higher number of deaths are seen amongst males.

4.4 Number of Deaths by Ethnicity

Nationally, the child death rate in the year ending 31 March 2023 across England was highest for children of Black or Black British ethnicity (56.6 per 100,000 population) and Asian or Asian British ethnicity (50.8 per 100,000 population). The child death rate for this period across England for children of White ethnicity was 25.3 per 100,000 for children of White ethnicity (National Child Mortality Database 2022/2023 report). Nationally, the rates for both ethnic groups continued to increase in comparison to previous years, whilst the death rate for children of White ethnicity decreased from the previous year and remained lower than all other ethnic groups, (National Child Mortality Database 2022/2023 report).

In Hampshire, Isle of Wight, Portsmouth and Southampton area during the reporting year 2023-2024, the highest number of deaths by ethnicity were White British, this amounted to 74% of the overall child deaths. 5% were recorded as White (any other White background). This is in keeping with the demographic population of the area but is not reflective of the national data. It could account in this area for a higher than proportion of deaths by ethnicity being white background due to in Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS), 81% of the overall population are White British.

4.5 Deprivation across Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS)

The Child Mortality and Social Deprivation report (2021) highlighted a clear association between the risk of death and level of deprivation. There is a relative 10% increase in the risk of death between each decile of increasing deprivation. Over a fifth of child deaths within England may have been avoided if those children living in deprived areas had the same risk as those living in the least deprived areas.

The death rate of infants who were resident in the most deprived neighbourhoods of England was 5.9 per 1,000 infant population, more than twice that of infants' resident in the least deprived neighbourhoods (2.2 per 1,000 infant population). Like all child deaths, inequalities in infant deaths widened, with the infant death rate for the most deprived having increased, despite the rate for the least deprived having decreased from the previous year. At a national level, it is estimated that 1 in 5 child deaths in England might be avoided if every child had same level of deprivation as least deprived communities.

Deprivation is made up of many factors. In England deprivation is calculated using the Index of Multiple Deprivation, a composite measure of the following factors:

- Living Environment
- Employment
- Crime
- Education
- Health
- Income
- Barriers to housing

The Index of Multiple Deprivation (IMD) datasets are small area measures of relative deprivation across each of the constituent nations of the United Kingdom.

The average deprivation score in England is 21.7, with the highest being 45. The Deprivation scores across Hampshire, Isle of Wight, Portsmouth and Southampton are as follows; Hampshire 12.7%, Isle of Wight 23.3%, Portsmouth 26.9%, Southampton 26.9% (Fingertips Deprivation Score IMD 2019).

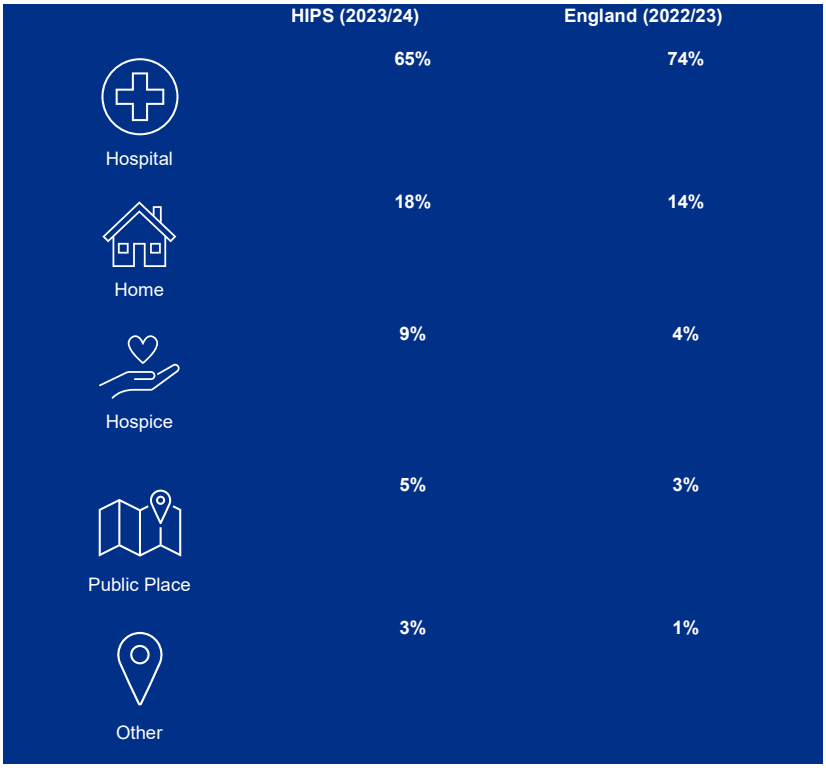
As Hampshire is a borough with a large population size, although it has a lower-than-average deprivation score there are areas in Hampshire as an individual borough which are high in deprivation. These include Rushmoor, Havant, Gosport and Eastleigh with pockets also in the New Forest, (Hampshire JSNA 2021). Looking at the child deaths in Hampshire, there does not currently appear to be a correlation as Basingstoke had a larger proportion of child deaths, but this would be understandable when you look at the borough population size as it is the largest town in Hampshire. There is no clear association between deprivation across boroughs in Hampshire, although comparison is difficult due to the small numbers.

4.6 Place of Death 2023/2024

Most of the deaths occurred in hospital (65%) or at home (18%) as detailed in Table 1 below. These figures reflect that locally and nationally most child deaths occur within a hospital, home or Hospice environment. No concerning themes have been identified during this period. This will continue to be closely monitored by the Child Death Overview Panel team.

The image below reflects the place of death for the reporting year 2023/2024 along with the national percentage for 2022/2023 as a comparison.

Table 1 - Place of Death



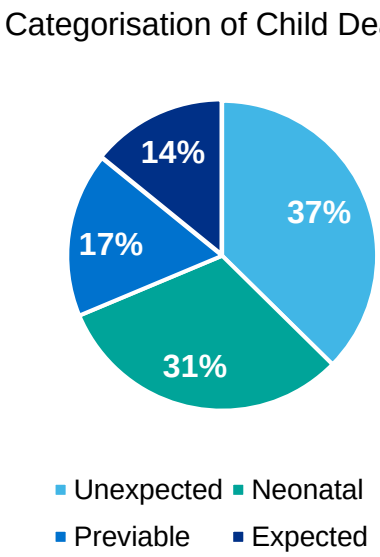
With national concern following the Lucy Letby investigation, Hampshire, Isle of Wight, Portsmouth & Southampton Child Death Overview Panel have reviewed how data pertaining to place of death is captured. Previously information regarding which Hospital a death occurred was recorded, however this has now changed and specific locations within each Hospital are also identified.

Hampshire, Isle of Wight, Portsmouth, and Southampton Child Death Overview Panel can provide assurance that this new robust recording system will aid in early identification of any themes or concerns with specific areas within provider services. This will be revisited when the Thirlwall inquiry is published, and any additional recommendations and learning will be actioned.

5.0 Causes/Categorisation of Child Deaths and Modifiable Factors

The majority of the 97 child deaths that occurred during the reporting year have not yet been heard at panel. When notifications are received, they are initially classified as either expected, unexpected, neonatal or previable to ensure the correct response is initiated. The 97 child deaths were classified as follows in graph 5 below:

Graph 5 - Categorisation of Child Deaths



5.1 Unexpected child deaths

A Joint Agency Response is a coordinated multi-agency response for investigating and reviewing all sudden and unexpected child deaths. This should be triggered if a death, or a collapse that will likely lead to death is due to external causes, is sudden with no apparent cause, occurs within custody, there are suspicions that the death may not be natural, or is a stillbirth with no healthcare professional in attendance.

During 2023/2024, a Joint Agency Response was planned in a third (36/97) of deaths. 61 cases did not fall within the Joint Agency Response criteria for unexpected deaths. The number of unexpected child deaths has remained relatively the same over the past 3 years.

5.2 Cause of Death 2023/2024

The initial cause of death is recorded on the Notification form when it is submitted to the electronic system. This will frequently be amended at panel when all outstanding information is collated and reviewed.

The cause of death for the reporting year has been recorded as detailed in Table 2 below:

Table 2 - Cause of Death

Cause of Death	Number of Deaths
Medically explained cause of death (at any age)	**30**
Unknown at present – (i.e. Sudden unexpected death in infants/Sudden unexplained death in childhood	**12**
Neonatal/Perinatal (including extreme prematurity, prematurity and pre-viable)	**45**
Suicide/ Death by misadventure	**<5**
Trauma	**6**

For reasons of confidentiality, figures <5 have been suppressed

National Child Mortality Data 2022/2023 found that nationally the most common primary category (i.e., the likely cause) of death for reviews in 2022/2023 was Perinatal/Neonatal event, which was recorded for 34% of all child death reviews, followed by Chromosomal, genetic and Congenital Anomalies (24%), Malignancy (9%) and Sudden Unexpected and Unexplained Death (7%). These patterns were like previous years. In the Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel we hold specialist neonatal Child Death Overview Panel (CDOP), with consultant neonatologists and specialist midwives present enabling clinical experts to contribute to reviews. This ensures both clinical expertise and a high degree of scrutiny with independent experts.

Nationally, when the child deaths have been categorised in age groups, the most common primary category of death was Perinatal/Neonatal event for children aged under 1, Malignancy for children aged between 1 and 9 years, and Suicide or

deliberate self-inflicted harm for children aged between 10 and 18 years. This is reflective of our data with the Hampshire, Isle of Wight, Portsmouth and Southampton area.

The Child Death Overview Panels are themed, under Neonatal, Joint Agency Response, Life Limiting/Medical and Suicide. In addition to these a pre-viable meeting is held monthly for those born with signs of life between 18- and 22-weeks' gestation who sadly die.

From the 1st April 2023 – 31st March 2024, 78 cases have been reviewed at the Child Death Overview Panel. The panel aim to review and close 6 to 8 cases per meeting. Those cases where the panel request additional information or there are uncertainties around specific aspects of the case, remain open, are added to the action tracker and reviewed at the next panel meeting.

6.0 Key Learning and Recommendations from Child Deaths

During 2023/2024, Hampshire, Isle of Wight, Portsmouth and Southampton, Child Death Overview Panels were held monthly, focusing on a variety of types of deaths. These were further categorised under themed panels where there were commonalities in the types of death. i.e. neonatal etc. The statutory guidance suggests that themed panels can enable appropriate professional experts to be present to inform discussions and easier identification of themes and modifiable factors which are explained further in section 6.1 below of the report. The Child Death Overview Panel can provide assurance that we are operating within and meeting the statutory guidance.

6.1 Modifiable Factors/Themes

One of the key functions of the Child Death Overview Panels is to decide whether a child death is modifiable. Deliberation over cases has demonstrated to the Panel that whilst in some cases it is relatively clear whether the death was modifiable or not, in many cases the decision has previously not been as clear. The National Child Mortality Database has now provided clearer national guidance to enable panels to be more consistent with the identification of modifiable factors and plans to include further detail on the specific factors reported in future data releases. This will support panel members in making more robust decisions regarding modifiable factors.

The Panel works to the national definition as shown below, but beyond this there are no other nationally directed tests or approaches that would support the reaching of a decision.

The national definition is as follows: "*A death should be categorized as modifiable if: The panel have identified factors that could be changed to reduce the risk of future deaths by means of locally or nationally achievable interventions". (NCMD 2023).*

Determining modifiability is not about determining whether the death of the case being reviewed was preventable but whether there was a reasonable probability that if the factor in question was modified, by achievable methods, the risk of future child deaths would be reduced.

Modifiable factors are discussed within the local child death review meetings prior to panel, and it is expected that these will be identified and actioned immediately. The Panel has the benefit of having the oversight of all child deaths across Hampshire, Isle of Wight, Portsmouth and Southampton.

During the process of reviewing a child death at panel if any matters of concern are identified which may affect the safety and welfare of children in the area, or a wider public health or safety concern arising from a particular death or from a pattern of deaths within the area, immediate action is taken and recommendations are made, despite identifying whether it was modifiable or not.

Following review of the cases heard at the Child Death Overview Panel 34 modifiable factors were identified which equated to 44% of the reviewed cases. As table 3 below reflects, this is in line with the National picture.

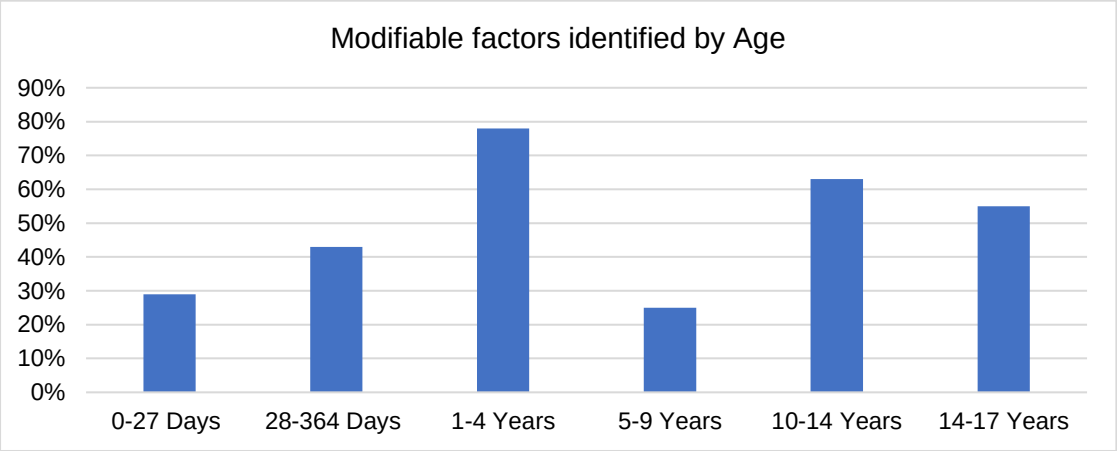
Table 3 - Modifiable Factors

Percentage of modifiable factors within Hampshire and Isle of Wight, Portsmouth and Southampton	Percentage of modifiable factors within England
44%	**43%**

It is recognised that the percentage of deaths each year that have modifiable factors may change as more reviews are completed. It is recognised nationally that there have been inconsistencies in data recording and interpretation of modifiable factors over the past few years.

Of those cases reviewed during 2023/2024 the highest percentage of modifiable factors were identified in the 1-4 years age group. The least modifiable factors were identified in the 5-9 years age group. This is reflected in graph 6 below:

Graph 6 - Modifiable factors by Age



Modifiable factors have been reviewed by category of death. All deaths categorised as trauma, suicide, deliberate inflicted injury, abuse or neglect, and chronic medical condition identified modifiable factors.

At a national level the most frequent modifiable factor identified was smoking by a parent or carer. The next most frequently identified factors were associated with quality-of-service delivery and unsafe sleeping arrangements. Challenges with access to services and poor communication both also feature in the most frequently identified modifiable factors.

This reflects the picture in Hampshire, Isle of Wight, Portsmouth and Southampton, which identified that in 75% of the sudden unexpected, unexplained deaths, the modifiable factors were high maternal body mass index, smoking in pregnancy, co-sleeping (unsafe sleep arrangements), delayed diagnosis (quality of service delivery), domestic abuse, housing issues. (see Appendix 3 for Modifiable Factors identified by category of death)

6.2 Domestic Abuse

Statistics show that 1 in 4 women will suffer domestic abuse in their lifetime and we know 40-60% of women suffering with domestic abuse state they were abused during pregnancy and over a third of women state it escalated or started during a pregnancy. (Best beginnings, 2022). NICE (2016) recommends that mental health services, reproductive care, midwifery, sexual health, alcohol or drug misuse and children's and vulnerable adults' services routinely enquire about domestic abuse with every patient/service user. In this reporting year, the Child Death Overview Panel have noted several child deaths, where domestic abuse was a modifiable factor.

Neonatal deaths across the Hampshire, Isle of Wight, Portsmouth and Southampton area were reviewed between April and October 2023. For 2023, the Child Death Overview Panel has been able to note that there is a Perinatal Mortality Review Tools for monitoring the use of routine enquiry during the antenatal period. The Child Death Overview Panel were pleased to be informed that domestic abuse routine enquiry is an area of focus for the Local Maternity System (LMS) and is also a focus for the system wide health Domestic Abuse Portfolio Group which is led by the Senior Designated Nurse for Safeguarding Children, NHS Hampshire and Isle of Wight (Hampshire based), and has representation from each of the health providers across the footprint. Routine enquiry is an identified theme in the workplan for this group and will be explored in the Domestic Abuse Portfolio Group and developed in 2024/2025.

6.3 Quality of Service Delivery

At a national level, a frequently identified factor is associated with quality-of-service delivery, challenges with access to services and poor communication also feature in the most frequently identified modifiable factors.

The Child Death Overview Panel found that there can be missed opportunities for health visitors to be informed when there have been decisions for newborn infants to receive palliative care. This highlights the importance of health visitors being updated to enable them to offer effective support to parents.

The Child Death Overview Panel has also noted that in some units there is insufficient provision of a soundproof room for parents to be supported. This has been reported through feedback from parents about the impact of hearing live infants when their baby has died. This has now been addressed and it has also been noted that there is good practice in units where there are bereavement suites.

All modifiable factors around service delivery are discussed at the Child Death Overview Panel and each provider has a representative to take any actions back to their service to ensure quality improvement.

The Child Death Overview Panel noted the immense learning that had taken place by the local system in relation to the Congenital Cardiac Pathway. This means that there is a clearer expectation that arrangements will be made for an infant to be cared for in a regional tertiary unit for cardiac care.

There was good practice noted in the care and support for a newborn infant who became unwell rapidly after birth. This included rapid responses from the neonatal team, clinical discussions, and reviews. This good practice was within a context of the parents being fully included in the decision-making process and supported throughout.

6.4 Smoking in Pregnancy

In maternity services there is a guideline for practitioners to use with regards to identifying smoking in pregnancy. Carbon monoxide monitoring is completed at every antenatal contact. All pregnant people who are identified as smokers and those with Carbon monoxide reading of 4 and above are referred to the appropriate smoking cessation service.

The Health Visiting team discuss the potential effects of smoking and passive smoking at each universal mandated contact. Universal contacts are offered to all children and families as part of the Healthy Child Programme.

The Health Visitors share information verbally at these contacts and signpost to resources as appropriate.

NHS Trusts safeguarding teams strategies encompasses a whole family approach, and as such considers parental factors, requiring the involved professionals being able to recognise how the child's wellbeing and development are affected by their caring role. This further embeds the health promotion messages.

6.5 Unsafe Sleeping

The National Child Mortality Database Thematic Report on Sudden and Unexpected Deaths in Infancy and Childhood details how within their analysis of infant deaths (under one year old), 87% of cases identified modifiable factors that may have prevented these deaths. Causes of these deaths are detailed in Table 2 page 13.

National Modifiable Factors mirror the key themes identified in local reviews including unsafe sleeping arrangements, smoking within household and during pregnancy, and alcohol and substance misuse by a parent or carer. It is important that families and all those caring for infants understand the risk of Sudden Infant Deaths and mitigating actions are taken, particularly when normal routines are disrupted, which may affect the ability to follow recommended safer sleeping advice.

Safe sleep advice is discussed at each midwifery and health visiting contact with the underlying message – every sleep matters. Families are advised that the advice is followed until a child is 12 months of age (adjusted for premature babies). Families are signposted to appropriate resources including the Lullaby Trust to further embed this message. The Lullaby Trust - Safer sleep for babies, Support for families

It is recognised that some parents choose to co-sleep. In these instances, individual circumstances are discussed, and families are signposted to the lullaby trust co-sleeping with your baby leaflet. Co-sleeping with your baby: advice from The Lullaby Trust - The Lullaby Trust

The Healthier Together App and Website is another useful tool parents are signposted to, where they can find advice and resources regarding safe sleep amongst many other topics and health promotion materials. The Healthier Together website is also used by Professionals across the Hampshire, Isle of Wight, Portsmouth and Southampton footprint meaning families will receive high quality care irrespective of which area they live in or which health care provider they are

accessing. Reducing unnecessary variation between professionals improves the overall quality of care and reduces the anxiety that inconsistent advice can generate. Safe sleeping :: Healthier Together

Professionals need to assess the risks for the infant when providing safe sleep messages – either due to factors intrinsic to the infant such as premature birth, or factors affected by the environment or family.

Safe Sleep (including smoking and alcohol use) and ICON are encompassed in the Generic Level 3 safeguarding children training which is offered to those staff who are identified as requiring this level of training.

6.6 High Maternal Body Mass Index

In maternity services, the National Institute for Health and Care Excellence (NICE) guidelines are followed for the care of pregnant people with a raised Body Mass Index (BMI). Body Mass Index is first calculated at the antenatal booking appointment and the appropriate pathways and processes are followed as in accordance with the guidance. This may include referral for consultant-led antenatal care.

Most women with a raised Body Mass Index have a straightforward pregnancy and have healthy babies, however evidence does show that having a raised Body Mass Index does increase the risk of complications, with an increase in the risk of miscarriage, premature birth and still birth. The higher the Body Mass Index, the greater the risks are for mother and baby. A raised Body Mass Index is also linked to increased risk of obesity and diabetes in later life. Being overweight in pregnancy and after birth | RCOG

The Health Visiting Team discuss health and wellbeing at each of their universal contacts and signpost to appropriate services available within their locality and service specification. This may include specific tailored interventions which may differ across the Hampshire, Isle of Wight, Portsmouth and Southampton footprint.

6.7 Work around Suicide Prevention

Work has been undertaken with the Hampshire, Isle of Wight, Portsmouth, and Southampton Public Health Real Time Surveillance team (RTS) with cases where suicide has been identified as the determining factor. The Senior Designated Nurse for Safeguarding Children (Hampshire) also attends the monthly Public Health Real Time Surveillance (RTS) meeting to ensure that the voice of the child forms part of the conversations where themes, trends and actions are identified and developed. The Real Time Surveillance (RTS) Chair is now invited to the suicide themed Child Death Overview Panel's, this enables reciprocal sharing of expertise. The Child Death Overview Panel team are also working with the charity Amparo, who offer families support following suicide. Amparo and a member of the Public Health team are now included in the Joint Agency Response meetings where suicide is a factor. This helps to ensure support is provided from a contextual safeguarding perspective to include schools, peer groups and communities. A bespoke suicide panel was held in September 2024 and details will be included in the quarter 2 report.

Across Hampshire, Isle of Wight, Portsmouth and Southampton there were several deaths by suicide between 2019 and 2020. There has been a steady fall in the number of suicide cases heard at panel since then and work continues regarding suicide prevention across the Hampshire, Isle of Wight, Portsmouth and Southampton area, working with Public Health who lead on this work.

By reviewing the deaths at a themed panel, where suicide is indicated, it is possible for specialist professionals to attend thereby enabling the wider discussions regarding suicide prevention work in the region. The Panel focus on each of the domains of the child death analysis form to consider the shared themes identified within the individual cases. This also allows the Panel to consider the research relating to suicide in children and the learning for Hampshire, Isle of Wight, Portsmouth and Southampton services.

7.0 Good Practice

Below are some examples of good practice that are happening across the Hampshire, Isle of Wight, Portsmouth and Southampton area and is helping in promoting good practice around preventing child deaths.

7.1 ICON

ICON is a program embraced by health and social care organisations across the UK, providing essential information about infant crying, including coping strategies, parental support, and stress reduction. ICON focuses on sharing ideas and best practices.

ICON means:

I - Infant crying is normal
C - Comforting methods can help
O - It's ok to walk away
N - Never, ever shake a baby

ICON raising awareness weeks are firmly embedded. Hampshire Isle of Wight, Portsmouth and Southampton continue to support the ICON programme. This has been promoted and embedded across Hampshire, Isle of Wight, Portsmouth and Southampton services. Training is available through the safeguarding partnerships, alongside midwifery services across our maternity departments. Teams are encouraged to discuss in supervision sessions to keep this relevant. Health visitor, midwives and GPs are key to delivering this message. Health teams have also utilised this across social care, early years and voluntary services. Hampshire and Isle of Wight Integrated Care Board continue to support the National ICON Network.

7.2 Multi-agency 'Learning from Child Death's' learning event

To upskill our front-line practitioners on research and best practice around learning from child deaths, on 26th June 2023, the Designated Nurse for Safeguarding Children, with the learning from child death portfolio group leads, developed and held the first multi-agency learning event across the Hampshire, Isle of Wight, Portsmouth and Southampton footprint. Over 50 professionals were in attendance from Police, Primary Care, acute and community trusts and Childrens Services. Various speakers attended and the event had positive feedback with attendees requesting that the event is completed annually by the portfolio group. A further event was planned and delivered in June 2024 and various speakers attended which included a powerful presentation by a bereaved mother who talked about her own experience.

7.3 Key Worker

Work has continued over the year to help address the issue regarding Key Worker role which continues to be a gap across the footprint for unexpected child deaths and was a priority in last year's annual report.

Over the reporting year, Southern Health NHS Foundation Trust (SHFT) health provider have provided training to the Trust Family Liaison Officers about the Joint Agency Response process. The main aim of the Family Liaison Officers role is to support families and loved ones through the difficult process of an investigation into a serious incident or a serious complaint. Sometimes that means supporting a family through the entire process, from incident to inquest. Sometimes it means signposting to specific services such as bereavement counselling or just being available for them.

The Family Liaison Officers have agreed to take on the key worker role when appropriate to support those families. It was raised as a concern due to families getting different levels of support through the Joint Agency Response process.

7.4 Restorative Supervision

Restorative Supervision for Joint Agency Response safeguarding leads has continued over the reporting year and the Terms of Reference for this was approved by the Child Death Overview Panel. The sessions are facilitated by the Designated Doctor for Child Deaths, (NHS Hampshire and Isle of Wight).

The session does not replace practitioners normal safeguarding supervision arrangements within their own organisations, but it is an additional session to help to ensure that healthcare professionals are clear about their roles and responsibilities in relation to Joint Agency Response and identify any issues they are encountering to help be solution focused through a nurturing/ supportive approach. It also serves to help in an individual's professional development and identify any themes and trends emerging which are then discussed in the 'Learning from Child Deaths' Portfolio group to help embed learnings across the footprint.

7.5 Learning from Child Deaths Portfolio Group

Learning from Child Deaths Portfolio Group is led by the Senior Designated Nurse for Safeguarding Children, NHS Hampshire and Isle of Wight (Hampshire safeguarding team), and has continued over the reporting year. There is

representation from each of the health providers and Hampshire Police Constabulary. The aim of the group is to discuss any themes or trends emerging around child deaths and to work in a systematic and coordinated approach regarding quality improvement methods which helps to strengthen processes, pathways and governance. It also helps identify best practice which can then be utilised across the footprint. The group over the year developed the multi-agency training event and ensured that training delivered, and paperwork used for child deaths across the footprint is consistent. The group will continue to support with the delivery of priorities for 2024/2025.

8.0 Priorities

Last year's priorities 2022 - 2023

Below are the priorities from last year Child Death Overview Panel (CDOP) 2022/2023 report, with update in italics:

- There are urgent changes made to the provision of the key worker role to ensure that every bereaved family is offered the support to navigate the system following a child's death. ***This has been further explained in Section 7.3 regarding progress.***

- There is urgent work needed to gather feedback from bereaved families on their experience following a child's death. ***A pilot study that was overseen by the Designated Doctor for Child Deaths has been concluded and the results were presented in the regional learning event. This was conducted in a single centre and will now be considered for use across the region.***

- The good practice in supporting children and their families through palliative care is acknowledged and used to inform the commissioning of services to strengthen the out of hours provision for palliative care. ***This continues***.

- Use the learning in relation to 15–17-year-olds, neonatal care and under 1 year old unsafe sleep to be used to review the service provision for these cohorts. ***These have been explained in the annual report regarding progress with themed panels held.***

- To review Child Death Overview Panel (CDOP) arrangements. ***As explained in section 2 of the report.***

8.1 Priorities for 2024/2025

- Suicide (awareness and prevention) - to support the work of national and local agencies in tackling deaths of young people where suicide and self-harm has been identified

- Out of routine and dangerous sleeping arrangements – to highlight the increased risk to infants when unsafe sleeping practices are undertaken Themed panel to be convened in this reporting year around safe sleep
- Smoking – the impacts of and cessation support - to continue to highlight the dangers of smoking on infants, children and unborn babies
- Key Worker role – to further strengthen this so every family is offered a Key Worker during this difficult time. Currently there is a plan to discuss with local hospice for this provision in unexpected deaths
- To continue to develop and deliver the yearly Learning from Child Death Multi-agency event for the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) professionals
- Audit of the form A's and form B's that are submitted by multiagency partners to eCDOP to help improve standards and highlight where improvements can be made
- Audit of the Joint Agency Response that have taken place between April 2023/2024 to be developed and undertaken. This will help to highlight any key learnings which will help to strengthen the Joint Agency Response Data
- To continue with the monthly themed panels
- Future discussions for Child Death Overview Panel for 2024/2025 regarding independent chair and recruitment to the role
- Linking with the Southeast Child Death Overview Panel Regional Network to share learning and aim towards a more standardised process and reporting for Child Death Overview Panels across the region incorporating national good practice
- To improve communications with the coroners and increase their understanding of the role of the Child Death Overview Panel. Clear and robust pathways regarding Post-Mortems are required
- Develop the use of the briefings for wider dissemination of learning about the themes and trends

9.0 Conclusion

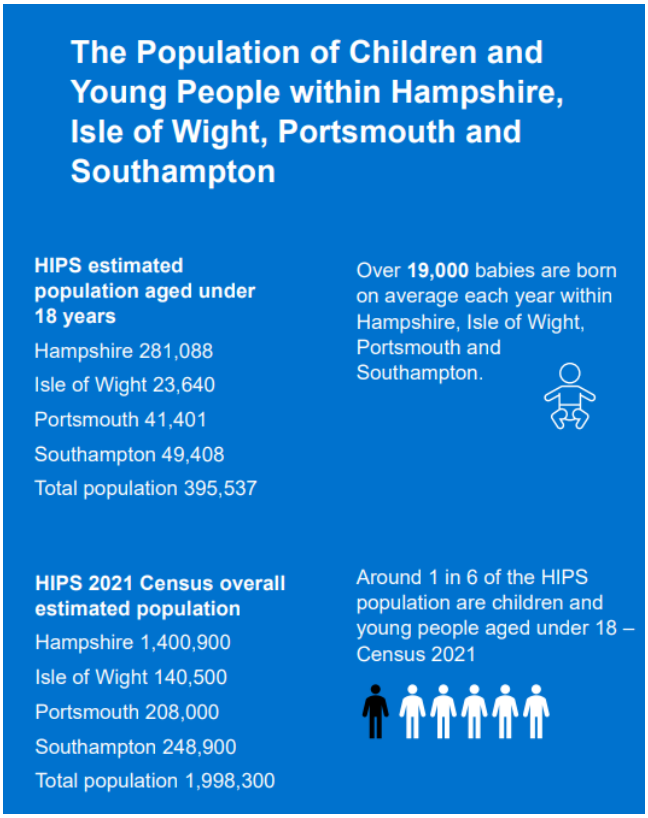
In overall conclusion, the annual report has demonstrated the team's commitment regarding quality improvement and strengthening the pathways and processes to help with the Child Death Overview Panel robustness of its functions. It also highlights the assurances that statutory roles are being fulfilled and that the team are meeting requirements for child deaths with plans in place around the independent chair role.

A collaborative approach in relation to child deaths will continue across the Hampshire, Isle of Wight, Portsmouth and Southampton footprint and Panel members will continue to be tasked with taking the learning from the reviews and sharing it widely within their organisations and networks so staff in all the constituent agencies are aware of modifiable factors when supporting and advising parents and carers.

Appendix 1

The Hampshire, Isle of Wight, Portsmouth and Southampton footprint

This area of the report explores the demographics of the four local authority areas which make up Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel. The population of each local authority differs considerably with a much larger population within Hampshire. Numbers of child deaths cannot therefore be directly compared between authorities.



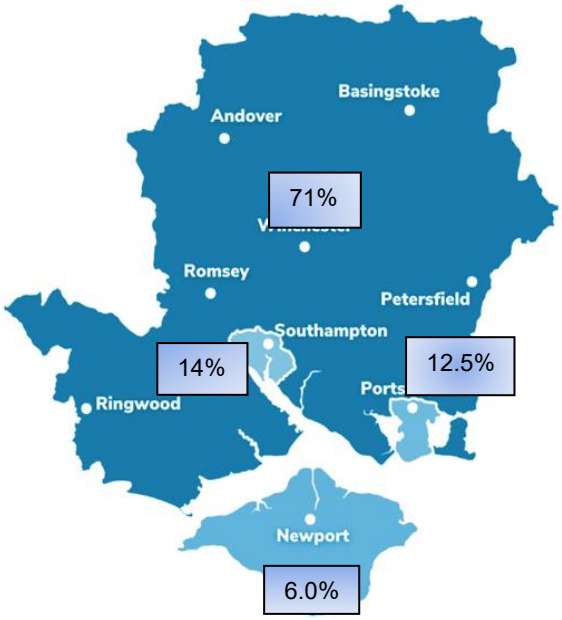
The map below shows the distribution of the under 18 populaton across all 4 local authorities.

71% of the under 18 population live in Hampshire

14% of the under 18 population live in live in Southampton

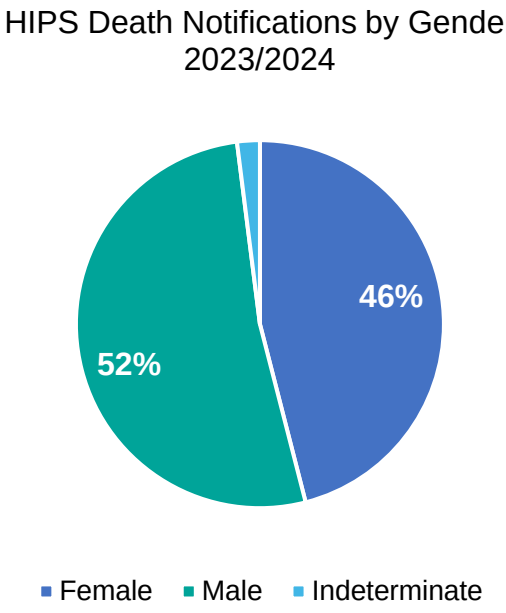
12.5% of the under 18 population live in live in Portsmouth

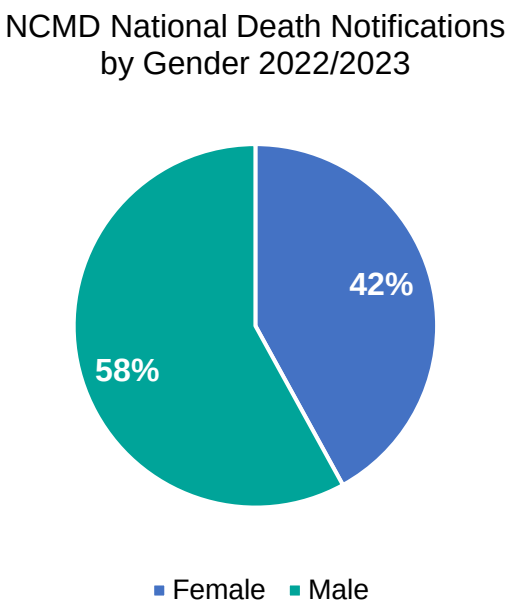
6.0% of the under 18 population live in live on Isle of Wight



Appendix 2

Graph 4 - Death Notifications by Gender





Appendix 3

Table - 4 Modifiable Factors identified by category of death

Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Trauma and other external factors, including medical/surgical complications/error	6	6	100%
Suicide or deliberate self-inflicted harm	<5	<5	100%
Deliberately inflicted injury, abuse or neglect	<5	<5	100%
Chronic medical condition	<5	<5	100%
Sudden unexpected	<5	<5	75%
Infection	7	<5	43%
Perinatal / Neonatal event	20	<5	40%
Malignancy	10	<5	30%
Chromosomal, genetic and congenital anomalies	22	6	27%
Acute medical or surgical condition	5	<5	20%
Total	**78**	**34**	**44%**

Appendix 4

References

Amparo support following suicide - Get help now. Free and confidential, for as long as you need it.

Best beginnings for every parent, for every child
https://www.bestbeginnings.org.uk/safer-beginnings

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