1. Executive Summary

1.1 **The Child Death Overview Panel (CDOP)** is the inter-agency forum that meets bi-monthly to review the deaths of all children normally resident in East Sussex and Brighton & Hove. It is a sub-group of the two Local Safeguarding Children Boards (LSCBs) for Brighton & Hove and East Sussex and is therefore separately accountable to the two LSCB Chairs, Reg Hooke, Chair of East Sussex LSCB and Graham Bartlett, Chair of Brighton & Hove LSCB.

1.2 During 2014-2015 there were a total of 42 deaths of children who were resident in East Sussex (26) and Brighton & Hove (16) notified to the CDOP. The CDOP has reviewed a total of 47 (31 East Sussex & 16 Brighton & Hove) deaths during 2014/15.

1.3 If during the process of reviewing a child death, the CDOP identifies: an issue that could require a Serious Case Review (SCR); a matter of concern affecting the safety and welfare of children in the area; or any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area, a specific recommendation is made to the relevant LSCB.

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

For Brighton & Hove LSCB:

- That the LSCB to seek re-assurance from Brighton & Sussex University Hospital Trust that their services are operating in accordance with NICE guidance[1] on Feverish Illness in Children (2013) and how this is being monitored. LSCB to request the Clinical Commissioning Group and NHS England Area Team to provide a reminder to all health professionals of the importance of listening to parents when they report that their children are acutely unwell and that they encourage parents to bring the child back for further assessment if the child's health does not improve or deteriorates.
- That the LSCB should request regular updates from the Clinical Commissioning Group on the implementation of the Action Plan relating to communication difficulties between community services, local hospital and tertiary centre until all the recommendations are achieved.

[1] Feverish illness in children: Assessment and initial management in children younger than 5 years (https://www.nice.org.uk/guidance/cg160)

For East Sussex LSCB:

- That the Chair of the LSCB seeks assurance that a potential child protection matter was appropriately investigated, regarding a terminally ill child.

1.5 There were additional recommendations made regarding particular agencies in both LSCBs, which related to issues specific to particular case histories, which do not have general relevance so have not been included in this report.

2. Organisation of the Child Death Overview Panel.

2.1 The East Sussex and Brighton & Hove CDOP is independently chaired by Fiona Johnson[2]. The Panel comprises of representatives from key partner agencies who together have expertise in a wide range of services regarding children's health and wellbeing. Membership is listed below:

<table>
<tr><td colspan="2">Core Membership:

Fiona Johnson –Chair
Laura Scott – CDOP Coordinator
Connor Walsh- South East Coast Ambulance Service NHS Foundation Trust
Edmund Hick – Sussex Police</td></tr>
<tr><td>East Sussex:
Annie Swann - Specialist Nurse for Child Deaths
Debbie Barnes – Designated Nurse
Dr Tracey Ward - Designated Paediatrician
Douglas Sinclair – Head of Safeguarding
Joanne Bernhaut – Public Health
Jenny Crowe – Midwifery
Dr Graham Whincup – Neonatologist
Mini Nair - Obstetrician</td><td>Brighton & Hove:
Ali Jenkins - Specialist Nurse for Child Deaths
June Hopkins – Designated Nurse
Dr Anne Livesey - Designated Paediatrician
Deb Austin – Head of Safeguarding
Lydie Lawrence - Public Health
Fiona Rose – Named Midwife
Dr Cassie Lawn – Neonatologist
Heather Brown - Obstetrician</td></tr>
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2.2 The administrative work of East Sussex Brighton & Hove CDOP is organised by the CDOP Coordinator, with support from the CDOP Chair and other panel members.

3. National Developments, Challenges and Achievements

3.1 Following consultation the government has updated and replaced the current statutory guidance Working Together to Safeguard Children revised and published in 2013. The revisions include changes to:

[2] Fiona Johnson is not involved in directly providing services to children and families in East Sussex or Brighton & Hove

1. the referral of allegations against those who work with children;
2. notifiable incidents involving the care of a child; and
3. the definition of serious harm for the purposes of serious case reviews.

There were some minor changes to the definition of a modifiable death for the purpose of national data collection however as yet, these have not significantly impacted upon the processes of the CDOP.

3.2 In 2013 the Government commissioned research which reported that 'There was a clear and vociferous call from CDOP staff and chairs for a proper national system of collecting, analysing and reporting CDOP data which would enable appropriate alerts and alarms to be issued and which would provide a focus for national information sharing and learning.[3]' To date the Government has not responded to this report. Further research has however been commissioned by the Health Care Quality Improvement Partnership on behalf of NHS England and the Scottish Government. The purpose of this research is 'To investigate whether and how it would be possible to develop a 'national' database to collect information from child death reviews from all CDOPs'. This research will relate to England and Scotland. The Chair of the Brighton & Hove and East Sussex CDOP has contributed to this project which will be report in June 2016.

4. Local Developments, Challenges and Achievements

4.1 This year has been challenging for the CDOP as the CDOP co-ordinator was absent due to sickness for a significant period and then left. The organisation and administration of the CDOP during 2014-2015 was therefore covered by temporary staff. A new permanent CDOP coordinator has now been appointed and significant work is underway to review and streamline CDOP review systems.

4.2 One effect of these changes was that a number of CDOP meetings were cancelled in 2013/14 which led to some delays in reviews being completed. This particularly impacted on East Sussex neonatal death reviews and was compounded by the short term absence, due to sickness, of the neonatologist. This resulted in a backlog of cases awaiting review, however, due to significant efforts by the East Sussex Neonatal Panel members, this has been addressed and next year review time frames should improve.

5. Work of the Panel

5.1 The CDOP has held 8 meetings in the past year (including 2 Brighton & Hove neonatal panels and 2 East Sussex neonatal panels).The main work of the panel is to review the deaths of all children who die across East Sussex and Brighton & Hove, on behalf of the two Local Safeguarding Children Boards (LSCBs).

[3] Jennifer J Kurinczuk & Marian Knight National Perinatal Epidemiology Unit University of Oxford Child death reviews: improving the use of evidence Research Brief DfE October 2013

5.2 Between April 2014 and March 2015 the CDOP was notified of 42 deaths of children who were resident in East Sussex (26) and Brighton & Hove (16) which is a decrease in numbers of deaths since last year.

5.3 The CDOP has reviewed a total of 47 deaths (31 East Sussex and 16 Brighton & Hove) during 2014/15. There will always be a delay between the date of a child's death and the CDOP review being held. Of the 16 Brighton & Hove reviews completed in 2014/15, ten were completed within six months. In East Sussex seven out of 31 reviews were completed within six months. This lower rate in performance can be partly explained by the long term sickness of some key CDOP panel members over the course of the year.

5.4 The purpose of the review is to determine whether the death was deemed preventable, that is one in which there are identified modifiable factors which may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be prevented. If this is this case the panel must decide what, if any, actions could be taken to prevent such deaths in future.

5.5 Of the 287 deaths reviewed between 2008 and 2015, 56 (one in five) have been identified as having factors which may have contributed to the death and could be modified to reduce the risk of future deaths (36 East Sussex and 20 Brighton & Hove). Of these 56 deaths reviewed during these years, where modifiable factors were identified, 34 related to babies (23 East Sussex and 11 Brighton & Hove). Modifiable factors included inappropriate sleeping arrangements for babies and high risk pregnancies where there were problems with the obstetric and midwifery care. During the past year there were 10 deaths reviewed that identified modifiable factors and five of them were Sudden Unexplained Deaths in Infancy (four in East Sussex) and all of these babies had inappropriate sleeping arrangements at the time of their deaths.

6. Child Death data

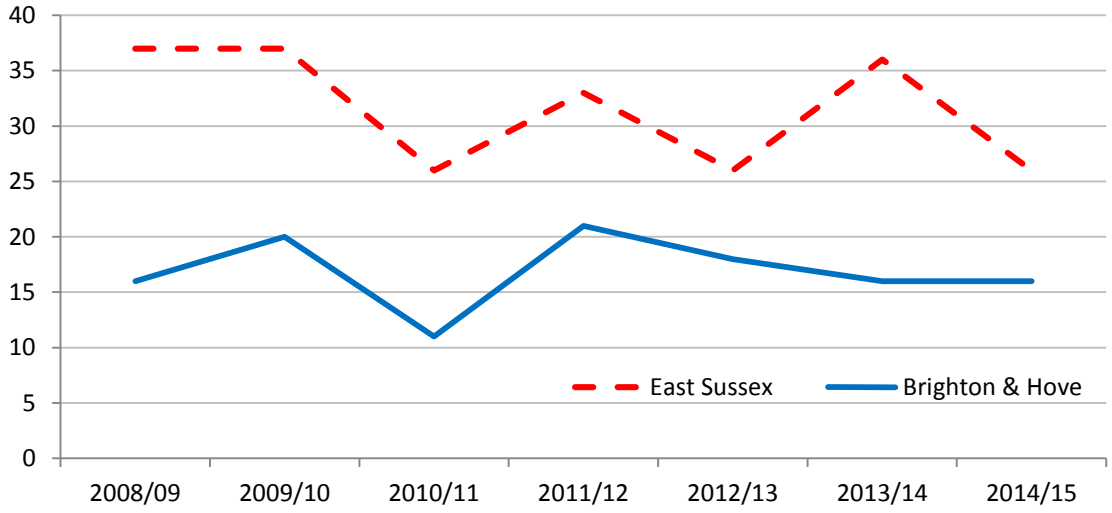
6.1 In East Sussex 20% of the population are aged under 18 years (105,392 out of 539,766) and in Brighton & Hove 18% of the population are aged under 18 years (50,951 out of 281,076). This compares to 21% for the South East region and for England. (Source: Office for National Statistics Mid-Year Estimates 2014).

6.2 Deaths notified to CDOP in East Sussex decreased last year whilst Brighton & Hove had a similar number of deaths. In East Sussex the median figure over the seven years is 33 and the mean is 32.5 whilst in Brighton & Hove the mean is 16 and median is 17.

Table 1: All deaths notified to CDOP from 1st April 2008 to 31st March 2015

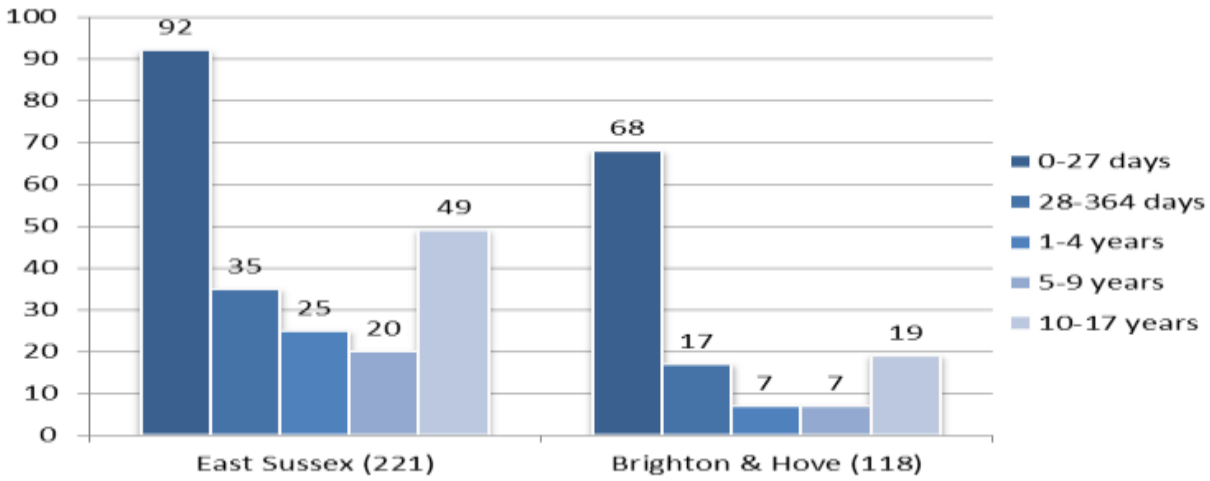
	1/4/08-31/3/09	1/4/09-31/3/10	1/4/10-31/3/11	1/4/11-31/3/12	1/4/12-31/3/13	1/4/13-31/3/14	1/4/14-31/3/15	Total
East Sussex	37	37	26	33	26	36	26	221
Brighton & Hove	16	20	11	21	18	16	16	118

Chart 1: All deaths notified to CDOP from 1st April 2008 to 31st March 2015



6.3 The age distribution in deaths in children follows an expected pattern linked to national trends with most deaths being seen in children in the first month of life followed by deaths in the first year of life, with a slight[4] increase in deaths during adolescence.

6.4 *Chart 2: Age at death of all children notified to CDOP April 2008 – March 2015*



[4] This may in part be due to the fact that this is a larger age group 1-4 and 5-9 both span 5 years where as 10-17 is an age group spanning 8 years – these age bands are determined by the DfE