PSCB
Portsmouth
Safeguarding
Children Board
Protecting Portsmouth's Children

December 2017

Child Death Overview Panel

Bulletin

Low Infant Mortality Rates in Portsmouth

The Child Death Overview Panel (CDOP) for Portsmouth has the statutory duty to look for patterns and trends in child deaths, lessons learnt and any actions taken. We are working with partners to reduce modifiable factors to prevent deaths from prematurity, including maternal smoking and obesity, to reduce deaths from sepsis and accidents and to improve management of long term conditions.

Although there is a lot of work to be done, it is important to remember that, in Portsmouth, the infant (aged 0 to 1 year) mortality rate remains consistently lower than the England average with recent figures for Portsmouth at 2.8 per 1,000 live births, (England average 3.9 per 1,000) with no deaths due to sudden infant death syndrome (SIDS). The child (aged 1 to 17 years) mortality rate is also lower than the rest of England at 6.6 per 100,000, compared with 11.9 per 100,000. This is despite the proportion of children under 16 living in low income families being 24.0%, which is higher than the England average of 20.1%.

It's not clear why our infant and child mortality rates are lower than expected, but its seems that the hard work done by the local authority and public health, health visitor and school nursing teams, primary care, maternity and neonatal services and paediatrics must have a role to play, and that we can be proud of the work we are doing. If we could get smoking rates in pregnancy down, the morbidity and mortality rates might be expected to reduce still further, and this remains a priority as we head into the coming year. See NICE guidance 'Quitting smoking in pregnancy and following childbirth' https://www.nice.org.uk/guidance/ph26.

Form B Audit Outcomes

During the summer an audit was undertaken to establish the quality of returned information included in the standard Form B completed by all agencies involved with a child and family, both previously and around the time of the child's death.

Agencies are not expected to complete all of the form, rather they are asked to complete only those sections on which they hold information. This is a statutory requirement. It is useful for agencies to complete the N/A tick box in this scenario though just to confirm they have considered the question.

Four cases were audited and in general the forms reviewed contained a better than expected return rate. It was noted that some agencies have a tendency to attach documentation rather than input directly into the form. It would be preferable if all information is returned via one medium. Obviously not all agencies had input to each case and this was noted at the time of the audit.

The panel would like to thank all agencies involved in this sensitive process for their co-operation; having as much information as possible really helps to inform the discussion when each death is reviewed.

Web: www.portsmouthscb.org.uk
Email: CDOP@portsmouthcc.gcsx.gov.uk
Tel: 02392 841540

Solent NHS Trust Exploring Loss Workshop

Solent NHS is running workshops that provide an opportunity for Child Practitioners to understand the impact of loss when experienced by children and young people and their families.

Date	Time	Location
26 January 2018	09.30 - 15.00	The View, Meeting Room 2, Floor 5
22 February 2018		The View, Meeting Room 2, Floor 5
06 March 2018		The View, Meeting Room 2, Floor 5
21 March 2018		Ground Floor Meeting Room 5

The training is a relaxed day, offering participants the chance to explore:

- Models of grief
- Social and cultural influences
- Ages and stages
- Language
- Attachment
- Resilience
- Taking care

The workshop will be run by Sarah Tollast, Children's Community Nurse Therapist. To book your place, please email Joe Sippits joe.sippits@solent.nhs.uk

CDOP Annual Report

The 4LSCB CDOP Annual Report has now been published and can be viewed on the PSCB website here

The report provides a reflection on current national drivers/reports. A descriptive analysis of child death reviews is also presented, including a review of trends in modifiable/non-modifiable factors and correlations for Hampshire as a whole as well as the local area.

The report concludes with an aggregated summary of lessons learned and resulting recommendations on priorities for 2017/18.

The Child Death Review Process

You may be closely involved with a family following the death of a child. A leaflet has been produced outlining the Child Death Review Process that can help you answer some of the questions the family may have.

The leaflet also contains information on bereavement support that is available. Please follow the link here to view the information on the PSCB website.

Proposed New Child Death Review Process

The consultation on the revisions to the statutory safeguarding guidance *Working Together to Safeguard Children* also includes the proposed new child death review practice guidance. The consultation closes on Sunday 31st December and further information can be found here.