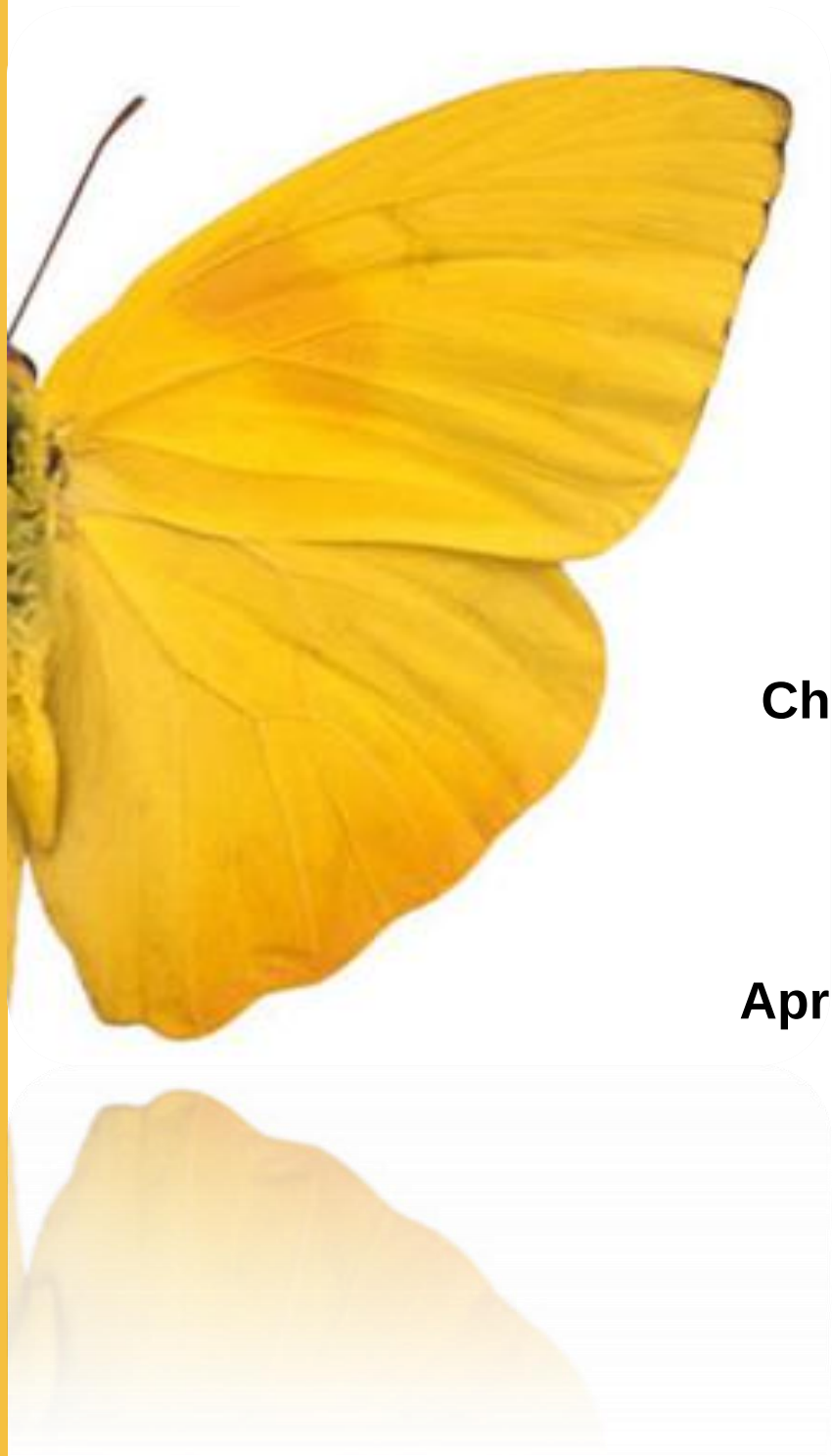


North of Tyne

Child Death Overview Panel

Annual Report

April 2014 - March 2015

Contents

Introduction

Child Death Overview Panel Independent Chairperson (North of Tyne)

Child Death Overview Panels (CDOPs) have been in place since April 2008. Their role, outlined in Working Together 2015 is to review all deaths of children up to the age of 18 years, excluding stillbirths and planned terminations. CDOPs are made up of people with professional expertise from a range of organisations.

North of Tyne CDOP undertakes the review process locally for all children normally resident in Northumberland, North Tyneside and Newcastle.

Every death of a child is a tragedy and the panel's task is to learn from the circumstances of every death to:

- Identify any changes which can be made that might help prevent further deaths
- Share the learning regionally and nationally, with other CDOPs and agencies involved in the process.
- Identify trends and target interventions to prevent further deaths

The review process is not about allocating blame but is about learning lessons to prevent deaths in the future.

Behind every child's death there is a grieving family and I am always impressed by the sensitivity with which the panel members approach each case discussion. It is crucial that we keep the family and children at the centre of what we do.

Membership and Panel Meetings

The North of Tyne panel has met 8 times in the timeframe of this report (April 2014 - March 2015) and generally has enjoyed good multi-agency attendance and commitment. It is important to acknowledge the work and commitment from frontline staff and managers of all the organisations who are involved in the Child Death process and without whom we could not undertake our task.

The panel welcome observers to the panel from any of the organisations which are represented and we had nine observers from nursing and medicine during the year.

They all found the experience very interesting and it helped them to understand the process in its entirety.

We have also welcomed new members to the panel which has expanded and enriched the discussions.

In November, Edwina Harrison, chair of the panel for several years, resigned her post. Thanks must go to Edwina who began chairing when the panel was in its infancy, she has steered it through that early developmental stage and it is Edwina's

supportive challenge to member organisations which has assisted the panel to its current mature state.

The panel membership is listed in Appendix 2.

Accountability and Reporting arrangements

As well as the Annual report the CDOP produces quarterly reports which are received by the 3 LSCBs and CCGs. The relevant representatives are responsible for presenting these quarter reports to their respective organisations.

The reports contain information on the performance of the process e.g. how many cases have been reviewed, how many parents were informed of the process, the reasons why the review of a case may be delayed and any modifiable factors identified. This information allows for LSCBs as well as commissioners in the NHS to be alerted to any particular issue on child safety or concern and also to challenge any areas of the process.

The Panel was aware during the development of this annual report that we had to be aware of the possibility that people may be able to identify individual cases. This report broadens individual case factors to prevent breach of confidentiality.

Whilst the panel has enjoyed full attendance from organisations the Q4 report highlighted for the LSCBs an issue with Police attendance. The LSCBs acted on behalf of the CDOP to rectify this problem.

The CDOP Coordinator regularly distributes information from other CDOPs to panel members for distribution to all agencies on lessons learnt from other reviews e.g. Advice on encountering Dangerous Dogs.

Thanks go to North Tyneside CCG for undertaking the data analysis on behalf of the CDOP and providing a venue and hospitality for panel meetings.

Sheila Moore, MA, RGN, DN, HV
Independent Chair

Executive Summary

The NoT CDOP met 8 times between April 2104 and March 2015 to review 52 cases. The numbers of child deaths are thankfully small and analysis of the data showed the following:

- Of the 52 cases 20 were neonatal, 13 were expected and 19 were unexpected
- The numbers of reviews undertaken has increased from 45 in 13/14, 43 in 12/13 and 33 in 11/12. This compares with the national trend which is showing a year on year decrease.
- North Tyneside has seen their cases increase from 8 in 2013/14 to 13 in 2014/15.
- Northumberland's cases have remained static at 15.
- Newcastle's cases have dropped from 25 to 24.
- The panel has reviewed 38.46% of cases within the 6 month indicative timescale, an increase from 2013/14.
- The largest number of reviews are neonates (38.64%) and 63.46% were in the age-group 0-364 days. There have been no road traffic deaths or apparent homicides. There was one substance misuse death, one suicide and one drowning in 2014/2015
- 29% of the reviewed cases had modifiable factors identified in 2014/15
- In 3 cases unsafe sleeping arrangements were identified as a modifiable factor.
- Over the last 4 years the rate of cases with modifiable factors is 22% (170 cases), equal to the North East and England figure.

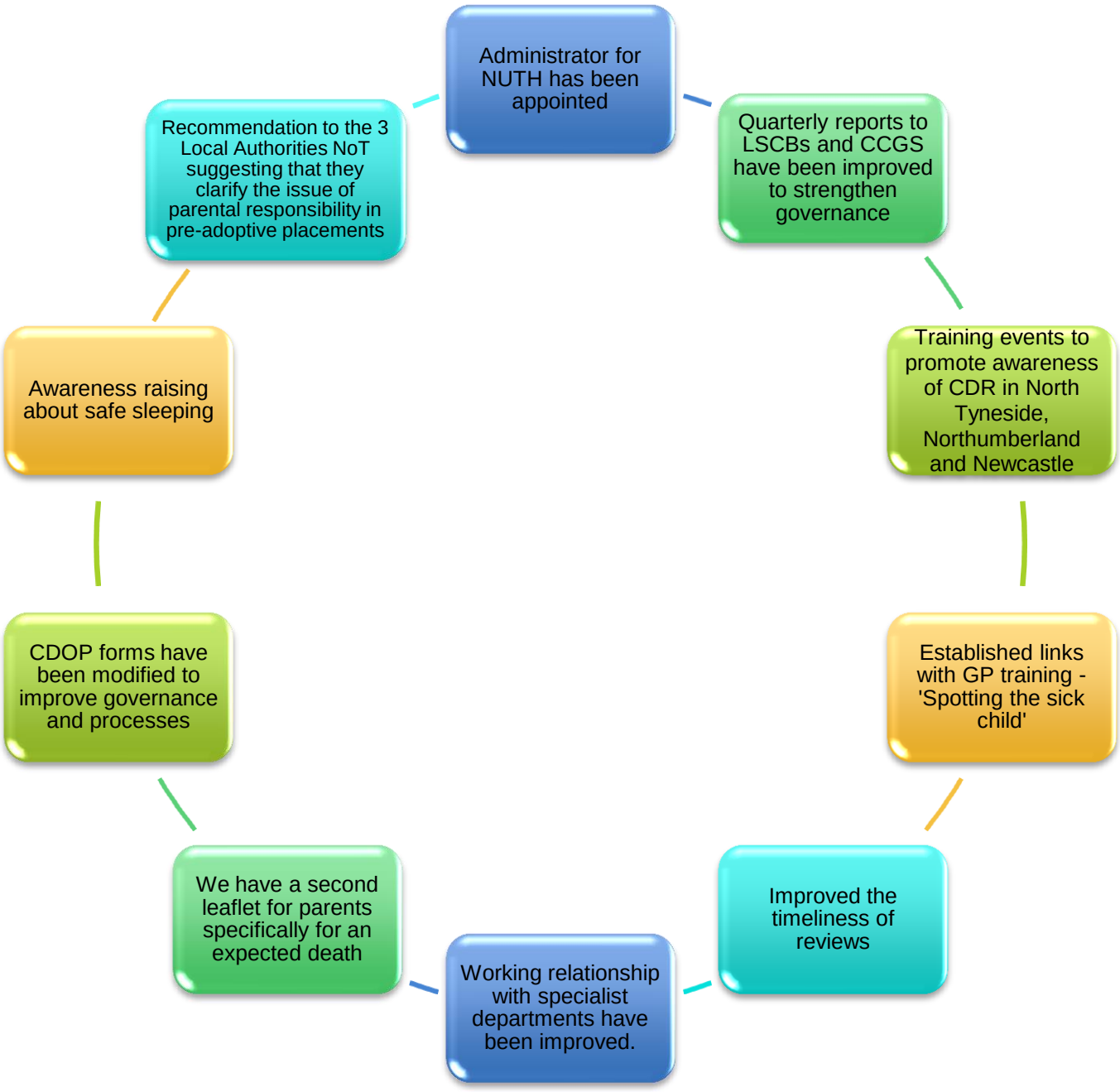
The modifiable factors identified by the panel were:

- Importance of the whooping cough immunisation being given during pregnancy. This should include the flu immunisation.
- Capacity issues in service delivery
- Smoking and maternal obesity during pregnancy
- Drowning - Risk of uncovered garden ponds
- Raising awareness of inherited disease when parents are related (Consanguinity)
- Asthma - poor attendance re routine follow ups with GP/hospital.
- Delayed recognition of treatment side effect
- Safe Sleeping
  - Alcohol
  - Drugs
  - Bed/settee sharing
  - Smoking
  - Side Sleeping

Recommendations

- The Panel recommend that the 3 LSCBs endorse the CDOP Annual report.
- The panel would also like to recommend that, in conjunction with Public Health colleagues, the awareness-raising work which commenced in 2013 continues to be supported so that safe sleeping advice (including avoiding smoking, alcohol and drug use) is part of the advice given by all professionals to every family.

1. What We Have Done

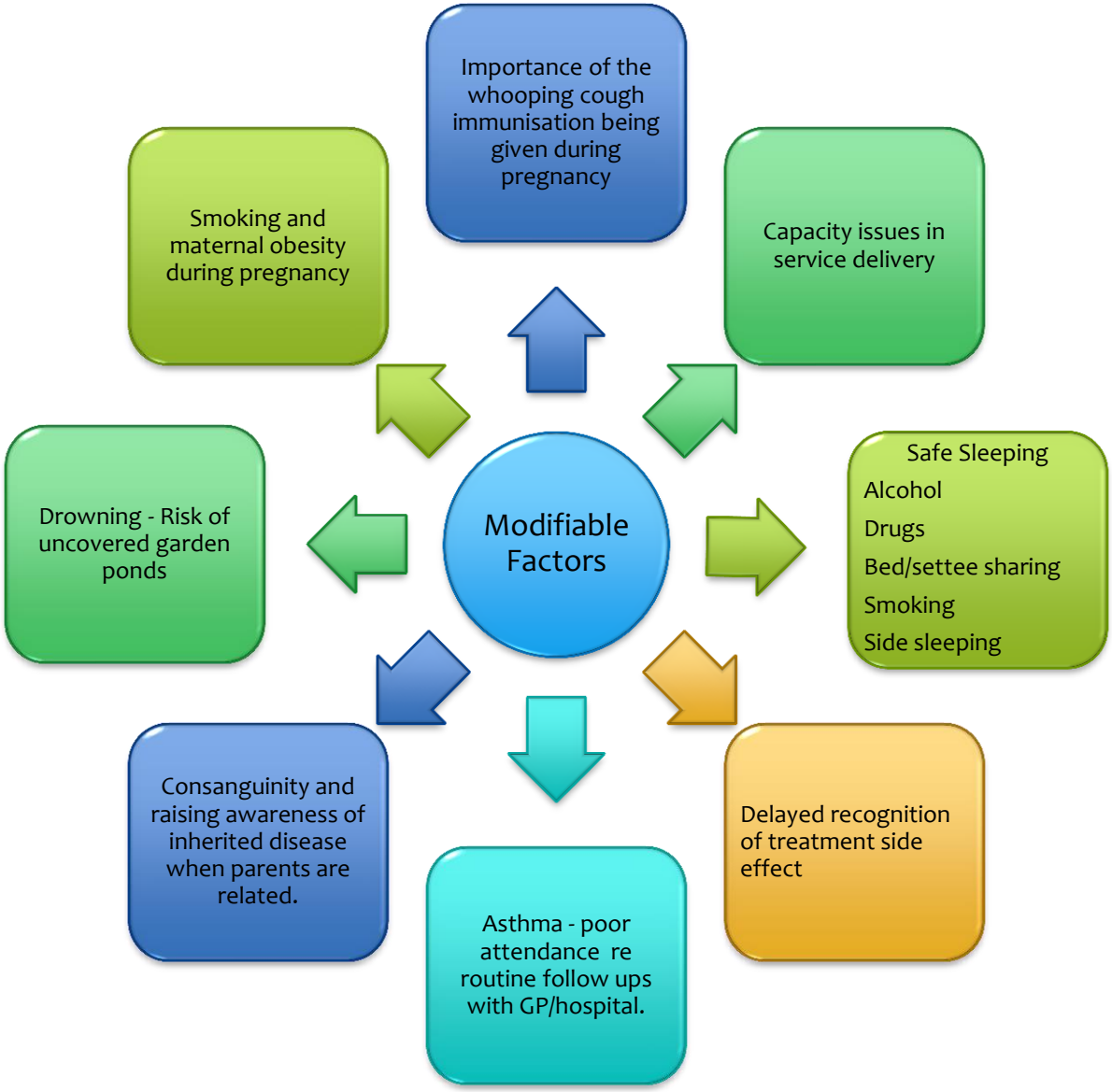


2. Modifiable Factors

Modifiable factors identified - The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths

Out of the 52 cases reviewed 15 were found to have modifiable factors.

These included:



3. Case Studies

The following cases show the small but often significant changes which the CDOP can recommend as the result of the in depth review of a case. We have generalised the facts to ensure the family's confidentiality.

Case 1

After the death of a child – family move to a different area

Discussion

- How can we ensure there are appropriate methods of transferring information to the next family GP/Health visitor re sharing concerns/information around a child death which has occurred in a family to ensure continuity of care.
- How can we improve the transfer of important information when families move?

Action

- Request that the family's GP puts the form C (form which is sent to the panel with all of the information) into every mother's notes to enable information to be shared for the benefit of the mother and healthcare professionals.
- Store form C in the health visitors' family record.

Case 2

Case of a child who was known to have poorly controlled asthma

Discussion

- The panel reviewed the death of a teenager who was known to have long term asthma. It was highlighted that there was poor attendance with general follow up with GP/hospital appointments and parents were unaware that asthma can kill.

Action

- The panel felt there was a need for clear pathways for asthma care to include management of non-attenders and triggers for onward referral. This has resulted in the development of an asthma pathway between hospitals and GPs. The hospital involved to review their current 'Did Not Attend' policy.
- Raising awareness of asthma care with GPs.

Case 3 Documentation of Observations

Discussion

- A previously healthy child who visited the GP after a short history of being unwell. The child was examined and observations taken. This was uneventful and was therefore sent home with parents with advice to contact GP/hospital if the child deteriorated. The child was later admitted to hospital with severe respiratory problems and died from a viral infection. It was established that the child's observations were not recorded in the GP record.

Action

- The learning has been included in work being done by Safeguarding GP - 'Spotting the Sick Child'.

Case 4 Safe Sleeping

Discussion

- This case highlights an unexpected death where the contributory factors to unsafe sleeping were present. A previously healthy baby where both parents smoked and alcohol had been consumed. Baby was fed and parent fell asleep in bed with baby. Parents awoke to find baby unresponsive.

Action

- Continued work around promoting safe-sleeping
- Safe sleeping is now part of training for early years staff and teachers

General Discussion Point

- There were three deaths in 2014/15 where unsafe sleeping was identified as a modifiable factor. In the last four years we have reviewed 8 such deaths:

    - 2011/2012 – 0
    - 2012/2013 – 3
    - 2013/2014 – 2
    - 2014/2015 - 3

4. Impact

Safe Sleeping

- Multi-agency awareness raising sessions around promoting safe sleeping.
- Safe sleeping was part of training for early years staff and teachers
- Safe sleeping is discussed as part of the protection plan at unborn child protection conferences.
- An aide-memoire for staff about the importance of offering parents and family members advice on safe sleeping.

Early Years staff at an awareness-raising session on safe sleeping found the information about the local picture very useful and helped them to address the issue with parents and grandparents.

Promoting Child Death Review Process

- The CDR Leaflet has been redesigned to improve information to bereaved parents. Liaising with specialist departments around developing a separate leaflet to accommodate their patients resulted in willingness from them to engage more with the CDR. process.

"Love the picture on the front!! We feel the language used to discuss the CDOP is still aimed at unexpected deaths- It may be that it's more appropriate for us to have a leaflet which purely explains the CDOP process and not the rapid response, I am happy to be involved in any ongoing work"

POONS NURSE

- It was established at Rapid Response Meetings that it would be useful to have the paramedics who were involved at a death to attend. This was difficult to arrange due to the timing of meetings however this has been achieved in some cases and feedback has shown that it was felt to useful and improves information sharing.

> *"Thank you for attending the rapid response meeting yesterday at short notice. I do appreciate that this can be a daunting/emotional meeting for the professionals involved. I have for some time now tried to ensure staff are released to attend which was not considered as a priority due to the nature of our emergency role/shift I understand that you found this meeting to be beneficial in understanding the background for the family and the child's life limiting health condition. In turn this will assist you with closure by knowing your interventions were appropriate and the family will be supported through this tragic time".*
>
> *NEAS*

- Appointment of the CDR Admin for NUTH in September 2014 has had a positive impact on the process within the trust. Examples of this are quicker notifications of death; cases are presented at the panel in a more timely manner, development of a quarterly dashboard and working alongside specialist teams to provide admin support to relieve work pressures within that team.

> *"As Independent Chair I have noticed that reviews are being completed in a more timely way and working in conjunction with the CDOP Coordinator, the management of the whole process is more streamlined and compliant with Working Together 2013"*

5. Priorities for 2015-16

1. Maintain the progress made in engaging specialist areas in the process.
2. Ensure that cases are reviewed within the 6 month indicative timescale unless there are special circumstances.
3. Review the current performance indicators for the panel.
4. Review the process to improve parental engagement in the process
5. Revising our terms of reference and procedures re Working Together 2015

Key Points from the 2014/15

Data Analysis

Each year the CDOP has to submit a data return to the DfE which is then analysed nationally. The CDOP also undertakes local data analysis and below are some of the key points:

- 52 review were undertaken, an increase year on year from 45 in 2013/14, 43 in 2012/13 and 30 in 2011/12. This compares with the national picture which has shown a decrease year on year.
- Cases under category “Perinatal/Neonatal event and “Chromosomal, genetic and congenital anomalies together accounted for 53.85% of the reviews in 2014/15.
- Of the 52 cases 20 were neonatal, 13 were expected and 19 were unexpected
- North Tyneside has seen their cases increase from 8 in 2013/14 to 13 in 2014/15.
- Northumberland’s cases have remained static at 15.
- Newcastle’s cases have dropped from 25 to 24.
- The panel has reviewed 38.46% of cases within the 6 month indicative timescale, an increase from 2013/14.
- The largest number of reviews are neonates (38.64%) and 63.46% were in the age group 0-364 days. There have been no road traffic deaths, apparent homicide or substance misuse deaths in 2014/15. There has been one suicide and one drowning.
- 29% of the reviewed cases in 2014/15 had modifiable factors identified.
- In 3 cases unsafe sleeping arrangements were identified as a modifiable factor.
- Over the last 4 years the rate of cases with modifiable factors is 22% (170 cases), equal to the North East and England figure.

The full analysis is contained in Appendix 1 at the back of the report.

Appendix 1

Data Analysis 2014/15

The panel met 8 times between 1 April 2014 and 31 March 2015 to review a total of 52 cases.

Number of cases reviewed at each panel meeting within 2014/15

April	June	Aug	Sept	Oct	Dec	Jan	March	Total
5	9	7	3	8	7	7	6	52

1 Child Death Review Data (National and North of Tyne)

1.1 The following data is reported from the Department for Education (DfE) LSCB statistical return. The return requires all Local Safeguarding Children Boards (LSCBs) in England to submit data concerning the numbers of reviews that have been completed on child deaths by Child Death Overview Panels (CDOPs) in their area on behalf of their LSCBs during the year.

1.2 The return includes data on cases where there were both modifiable factors identified and where there were no modifiable factors identified. The definitions of these factors are as follows:

- **Modifiable factors identified**: *A modifiable death is defined where there are factors which may have contributed to the death. These factors are defined as those which by means of nationally and locally achieved intervention could be modified to reduce the risk of future deaths*
- **No modifiable factors identified:** *This is recorded when the panel have not identified any potentially modifiable factors in relation to the death*

2 National Context 2014-2015

- 3,515 reviews completed by Child Death Overview Panels in the year ending 31 March 2015 – a year on year decrease from 4,061 in the year ending 31 March 2011
- 24% is the percentage of chid death reviews (827 reviews) identified as having modifiable factors, a moderate increase from 20% in the year ending 31 March 2011
- 67% is the percentage of death reviews of children under one year old in the year ending 31 March 2014. This percentage is consistent with the previous three years.

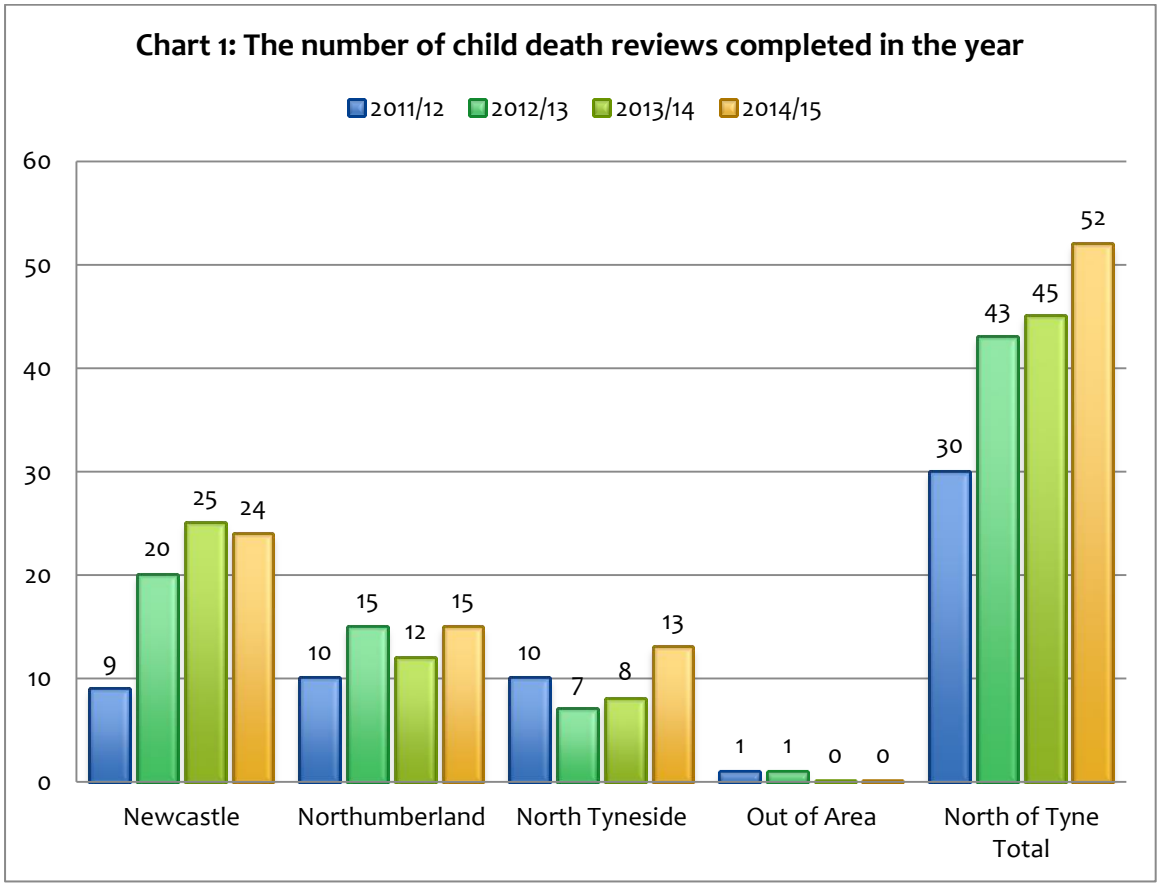
- 53% is the percentage of child death review for boys (1,931) compared to 47% for girls (1,512). The majority of reviews have been for boys deaths for in each of the last five years.

- 23.74% is the percentage of serious case reviews related to a child death where modifiable factors were found.

3 Cases reviewed by North of Tyne CDOP 2014/2015

3.1 **Chart 1** provides numbers of child death reviews completed in the last 4 years for each of the 3 authorities individually who make up the North of Tyne CDOP and combined for the North of Tyne CDOP area as a whole. In 2014/15 a total of 52 reviews were completed, an increase from 45 in 2013/14 & an increase from 30 in 2011/12.

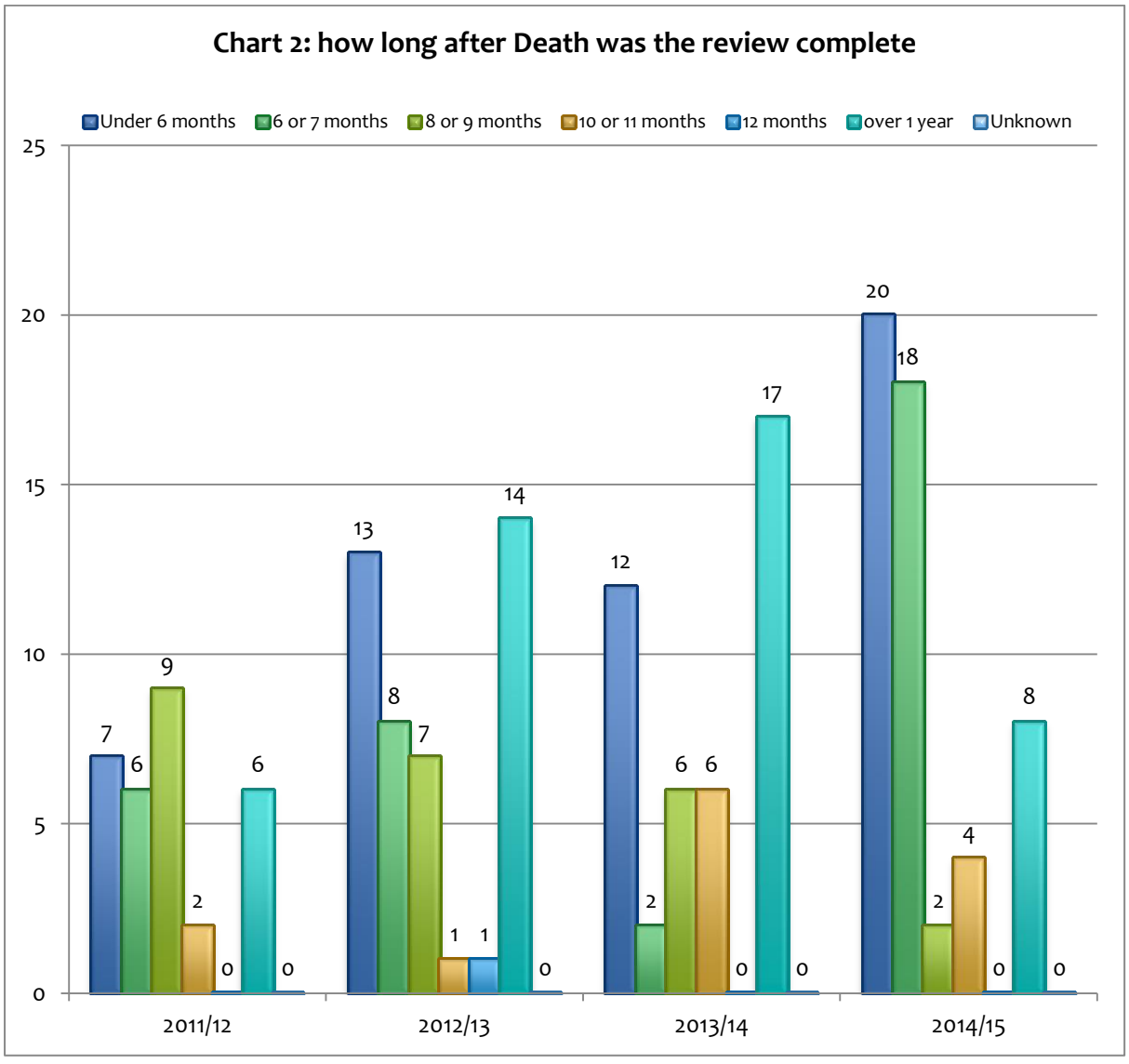
3.1.1 North Tyneside has seen their cases increase between 2013/14 and 2014/15, from 8 to 13. Newcastle's cases have dropped from 25 to 24, Northumberland have remained static at 15.



3.2 The DfE request as part of the LSCB1 return that CDOPs report the length of time taken to complete the review from the date of the child's death. They state however in their guidance notes that they recognise reviewing child deaths is an extremely complex task and it may take a number of months to gather all the relevant information to be able to fully review the death.

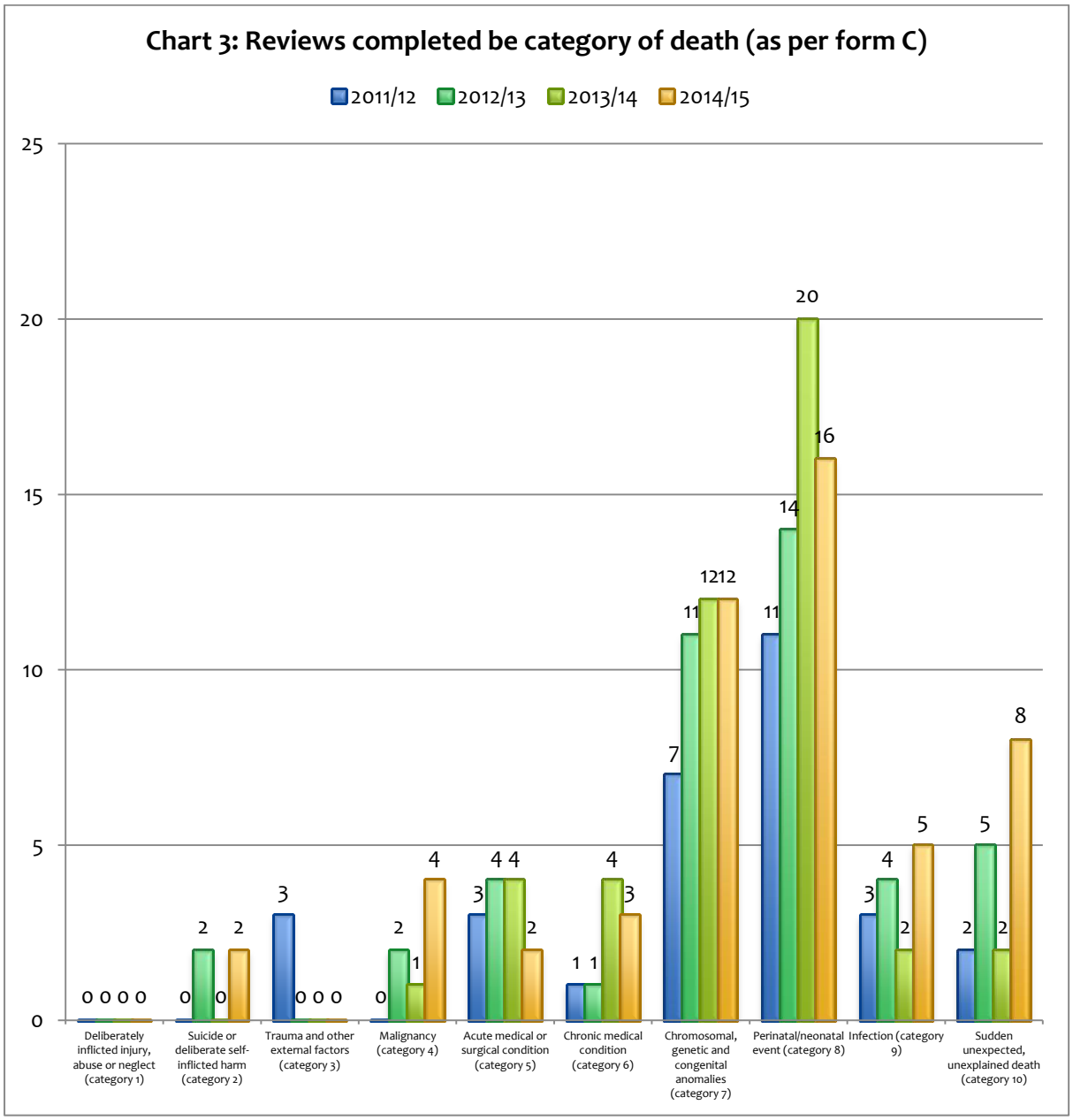
Therefore they state while the data is used to make an assessment of the average length of time between a child's death and the completion of reviews the data is not to be used as a performance measure.

3.3 **Chart 2** shows in the 2014/15 the largest single proportion of cases, 20 (38.46%) were completed in under 6 months, this is an increase from the previous year of 2013/14 when 12 cases took over a year to complete. In 2011/12, 7 cases where completed in under 6 months. The second largest proportion of cases in 2014/15 18 (34.62%) were competed between 6 & 7 months, this is a large increase from the previous year when 2 were completed in this time frame



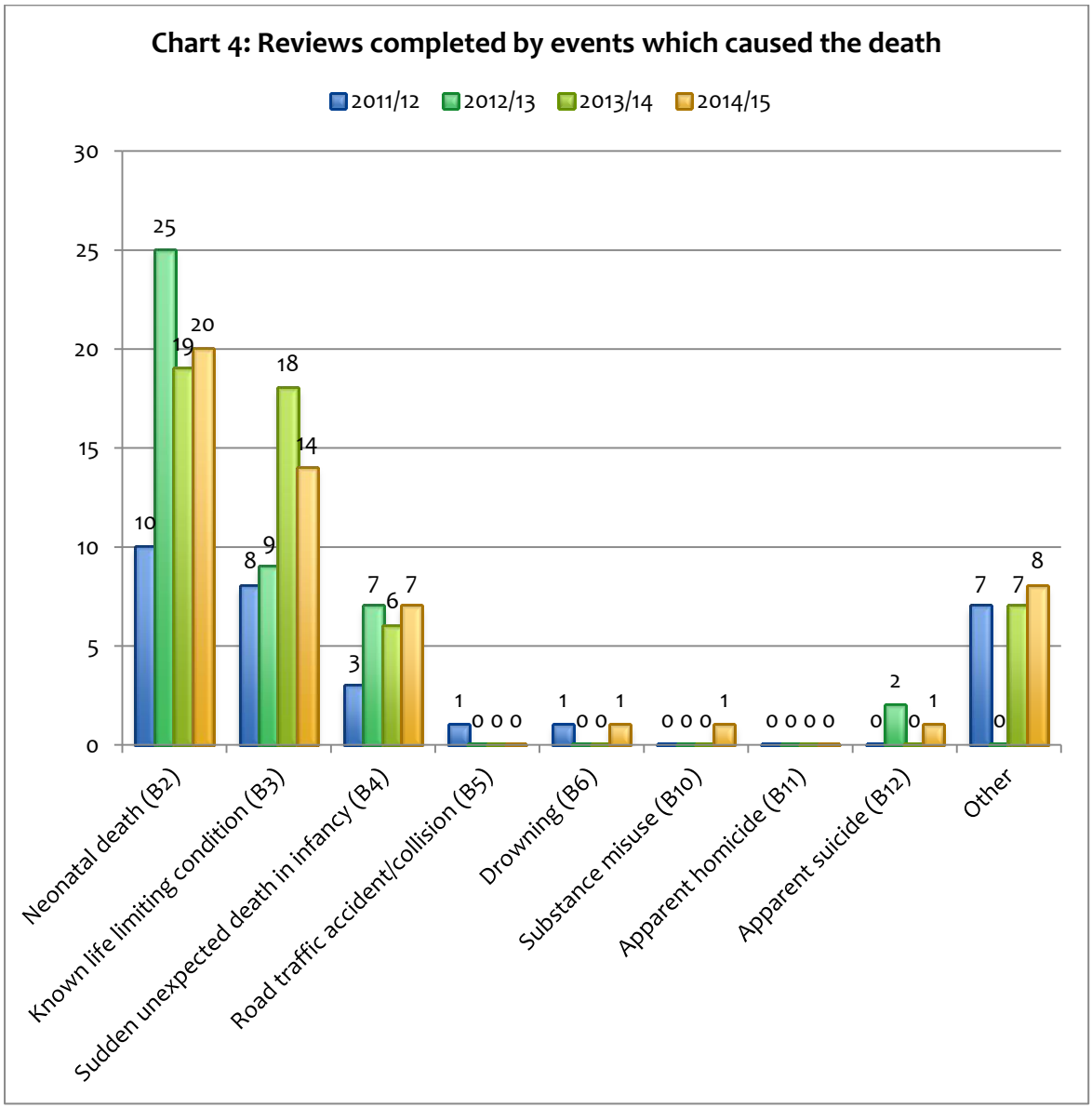
3.4 **Chart 3** shows the category of death as recorded on the Form C for the reviews completed in the 4 year period. In the last 4 years the single largest number of reviews had a category of death recorded as '*Perinatal/Neonatal event'*, cases with this cause accounting for 30.77% of reviews completed in the year, a reduction from 44% in 2013/14, 33% in 2012/13 and 36% in 2011/12.

3.4.1 Cases with a cause of death of *'Chromosomal, genetic and congenital anomalies',* were the second highest cause of death accounting for 23.08% of cases in 2014/15. These two causes alone accounted for 53.85% of all cases reviewed in 2014/15. As in 2011/12, 2012/13 & 2013/14 there were no cases with a cause of death of *'deliberately inflicted injury, abuse or neglect'* in 2014/15 either.

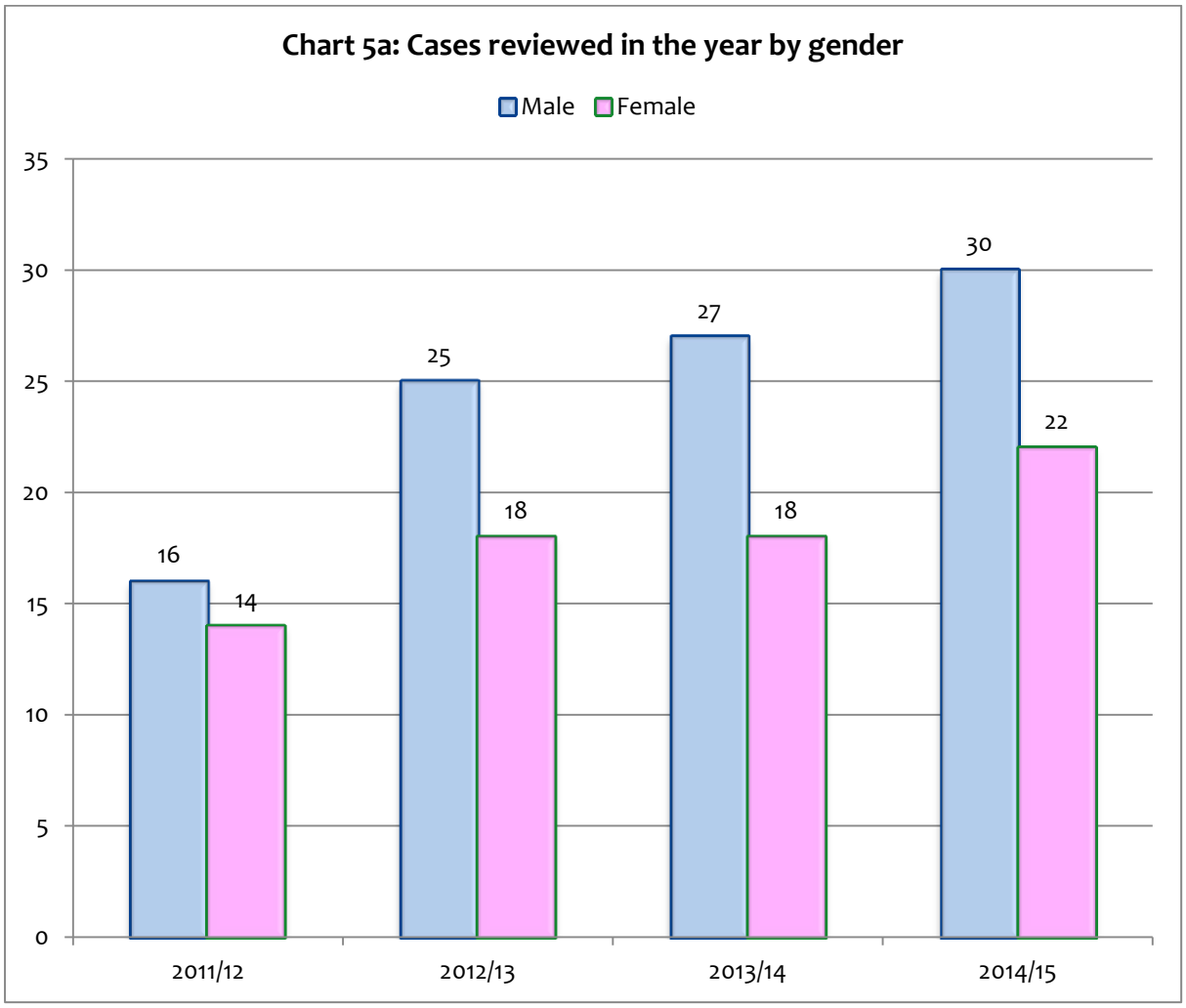


3.5 **Chart 4** shows the events which led to the death in the reviews completed in the period. In each of the 4 years *'Neonatal death'* has consistently accounted for the largest single event for cases reviewed by the CDOP. In 2014/15, 20 of the 52 cases (38.46%) reviewed by the CDOP listed this type of event leading to the cause of death. This remains in line with 2013/14 with 19 of the 45 cases being *'Neonatal death'*.

3.5.1 In 2014/15 the number of cases with *'Known life limiting condition'* listed as the event that caused the child's death dropped from the previous year from 18 to 14. Since 2011/12 there have been no cases which had *'apparent homicide'* listed as the event that caused the death. There have been no 'road traffic accident/collisions' since 2011/12. In the event of death by 'drowning' since 2011/12 there was one case 2014/15. There were no substance misuse deaths for the previous 3 years until 2014/15 where one occurred. Throughout the four year period there were 2 deaths by '*apparent suicid*e' one in 2012/13 and one in 2014/15

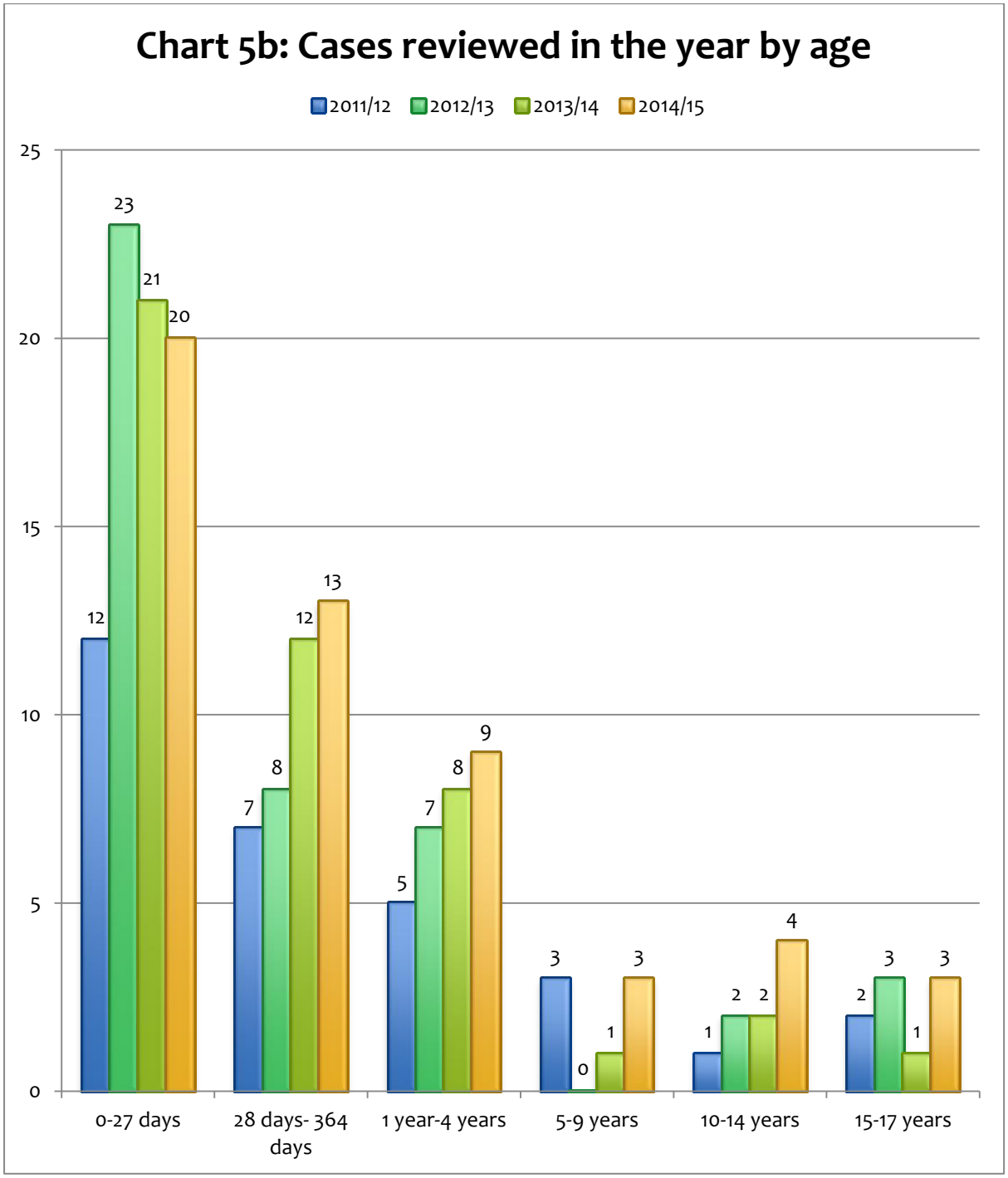


3.6 **Gender - Chart 5a** shows that in each of the individual years males accounted for the larger proportion of cases reviewed by the CDOP. In 2014/15, 57.69% of reviews (30) were for males, with 42.31% (22) for females. This compares with 58% male and 42% female in 2012/13. In 2011/12 53% were male and 47% were female.

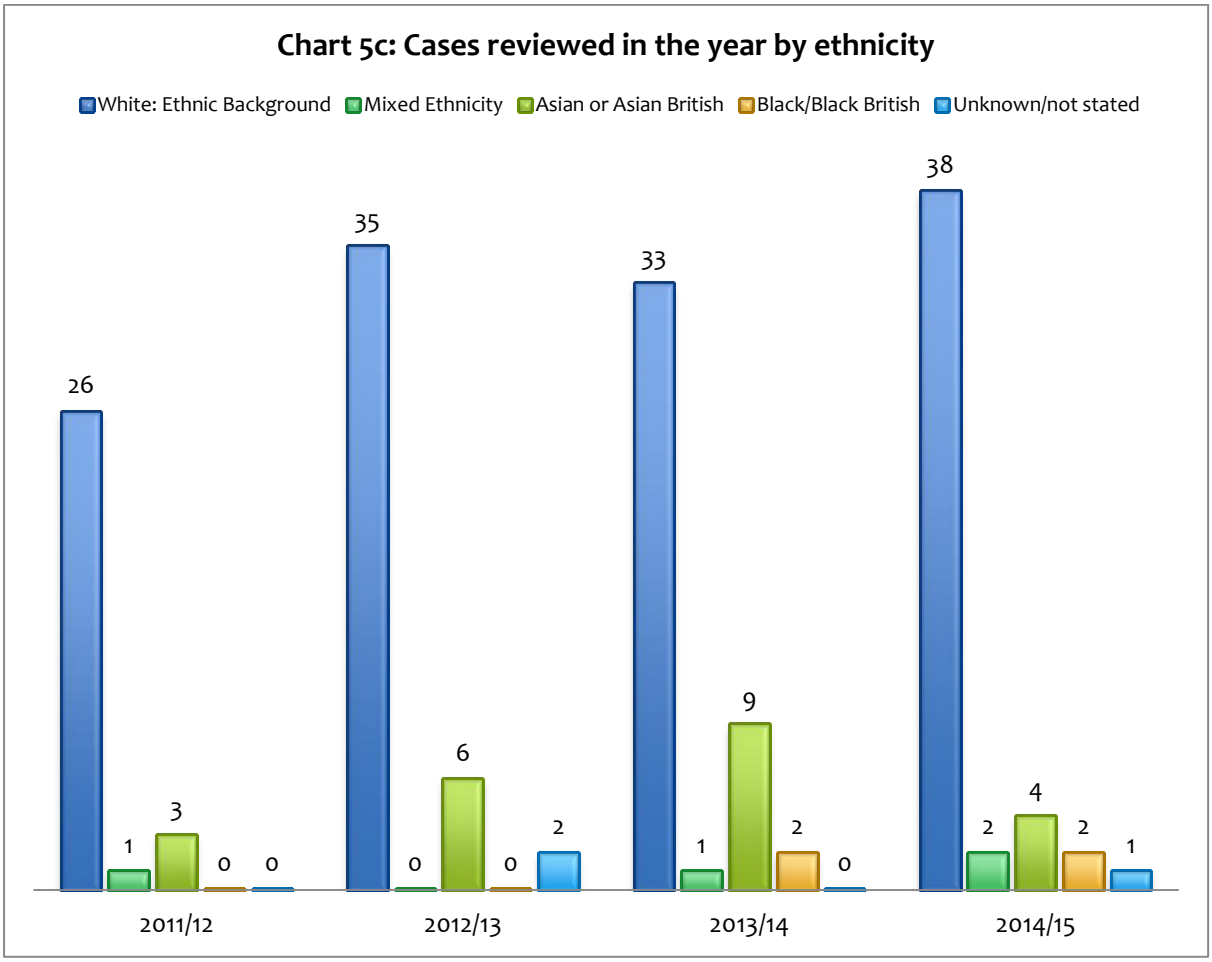


3.7 **Age - Chart 5b** shows the age of children who were the subject of reviews. In all the 5 years children aged 0-27days accounted for the largest number of reviews with 20 in 2014/15, 21 in 2013/14, 23 in 2012/13, and 12 in 2011/12.

3.7.1 The 20 reviews in 2014/15 were 38.46% of the overall cases reviewed. The second largest age group was 28-364 days with 13 reviews and this accounted for 25%. These 2 age categories combined accounted for 63.46% of children reviewed.



3.8 **Ethnicity - Chart 5c** shows the ethnicity of children who were the subject of reviews. In all the 4 years children from a white ethnic background made up the majority of the cases reviewed by the CDOP. The proportions of ethnicity were 80.85% in 2014/15, 73% in 2013/14, 81% in 2012/13, and 87% in 2011/12. Cases from an Asian or Asian British background are the next largest ethnicity with the proportion steadily increasing over the previous 3 years from 10% in 2011/12, 14% in 2012/13, 20% in 2013/14. However in 2014/15 there was decrease to 8.51%



3.9 Table 2 provides numbers of child death reviews completed in the last 4 years for each of the 3 authorities individually who make up the North of Tyne CDOP and combined for the North of Tyne CDOP area as a whole, the table breaks the figures down into those reviews where there were modifiable factors identified in the case and those where there were no modifiable factors identified. Figures for the North East region and England are also provided for comparative purposes also.

3.9.1 Table 2 shows across the 4 year period as a whole, of the 170 reviews completed by the North of Tyne CDOP 22% (37) modifiable factors were identified in the review. This is equal to both the North East total and England total for the same period, where the figures match at 22%.

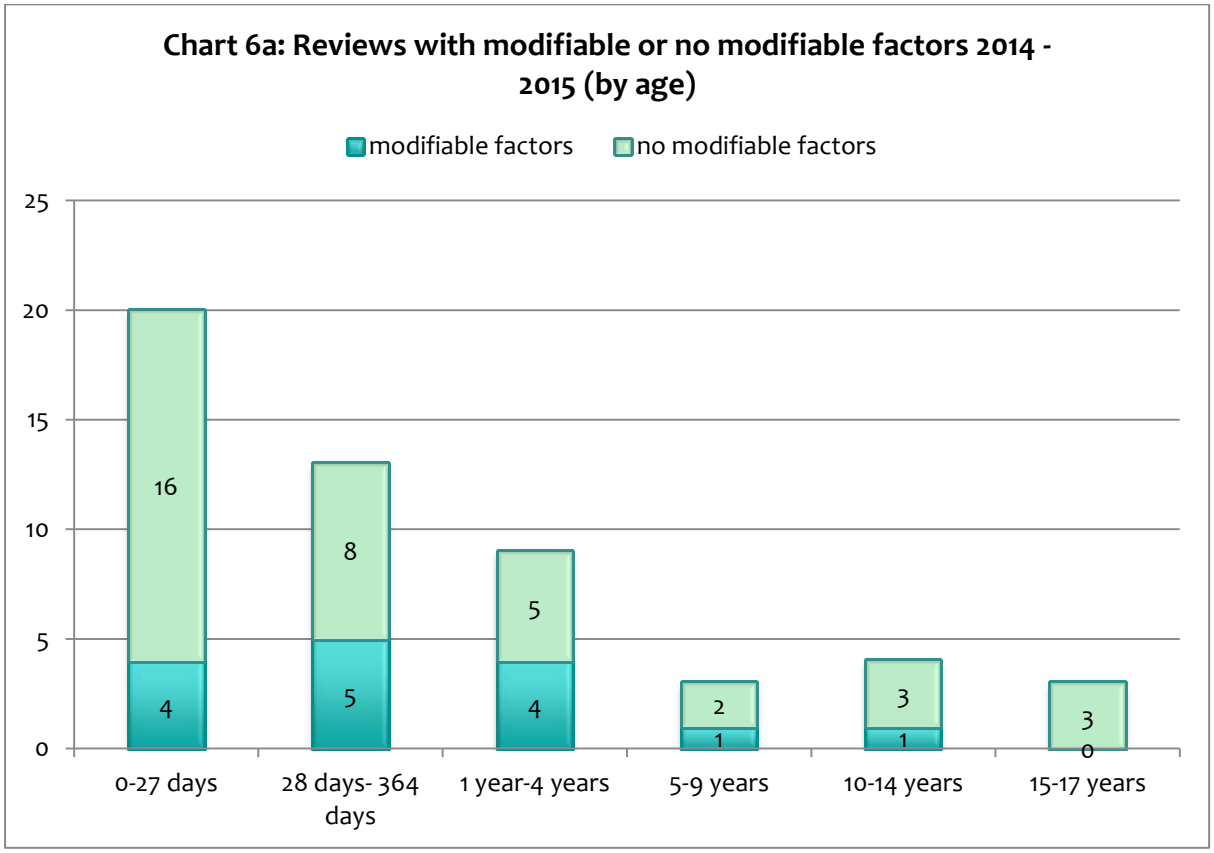
Table 2

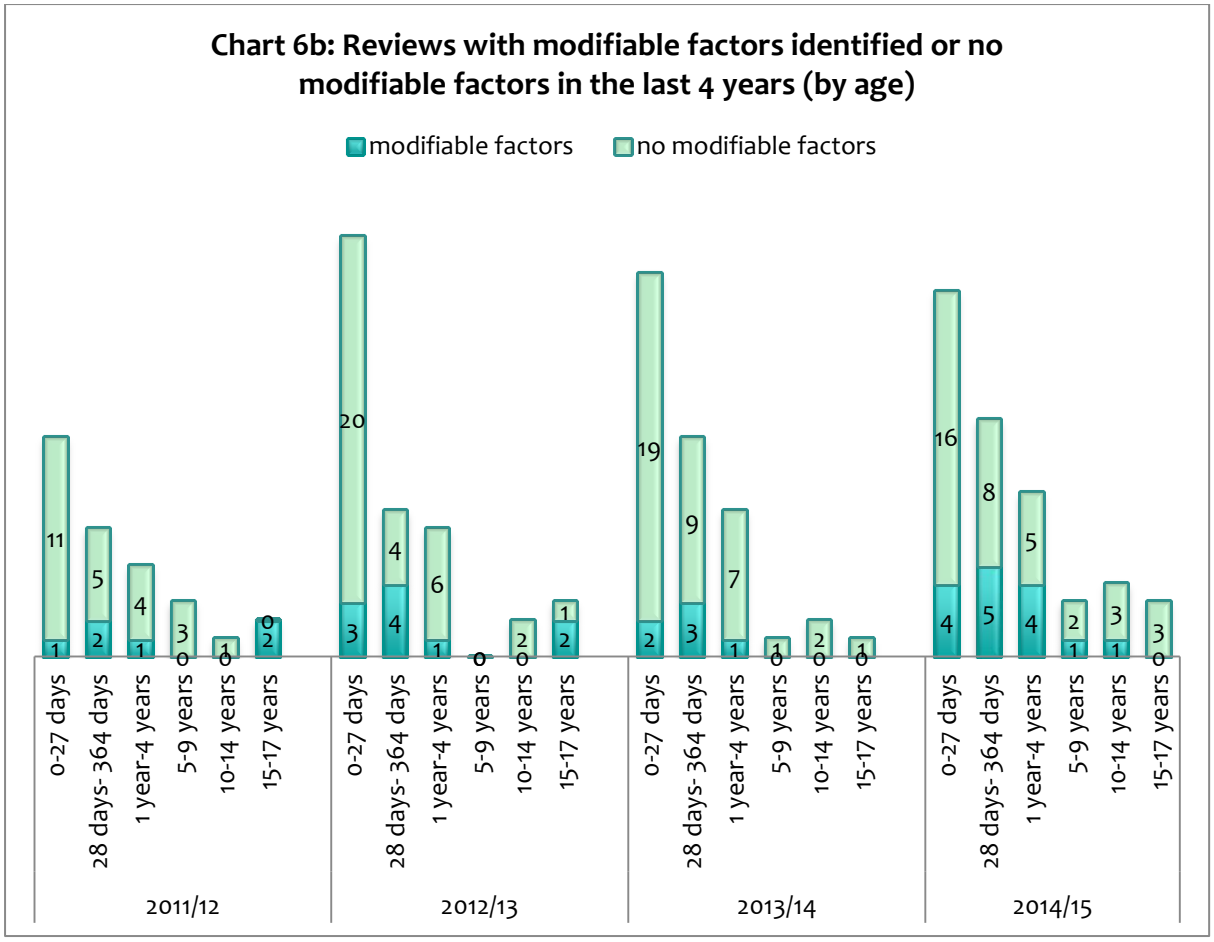
	Year Ending 31 March 2012			Year Ending 31st March 2013			Year Ending 31st March 2014			Year Ending 31st March 2015			4 Year Total		
	No Modifiable factors identified	Modifiable factors identified (number and % of reviews)		No Modifiable factors identified	Modifiable factors identified (number and % of reviews)		No Modifiable factors identified	Modifiable factors identified (number and % of reviews)		No Modifiable factors identified	Modifiable factors identified (number and % of reviews)		No Modifiable factors identified (number of reviews)	Modifiable factors identified (number and % of reviews)	
Newcastle	8	1	11%	18	2	10%	20	5	20%	13	11	42%	59	19	24%
Northumberland	8	2	20%	9	6	40%	11	1	8%	13	2	13%	41	11	21%
North Tyneside	7	3	30%	5	2	29%	8	0	0%	11	2	15%	31	7	18%
Out of Area	1	0	0%	1	0	0%	0	0	0%	0	0	0%	2	0	0%
North of Tyne CDOP Total	24	6	20%	33	10	23%	39	6	13%	37	15	29%	133	37	22%
North East Total	110	25	19%	117	29	20%	123	35	22%	113	44	28%	463	133	22%
England Total	3180	784	20%	3029	806	21%	2795	823	23%	2688	827	24%	11692	3240	22%

Source: North East & England - https://www.gov.uk/government/statistics/child-death-reviews-year-ending-march-2014

3.9.2 Across the 3 individual authorities in the North of Tyne CDOP, the percentage of cases with modifiable factors varied. In total over the 4 year period, 24% of cases in Newcastle were identified as having modifiable factors compared with 18% in North Tyneside and 21% of cases in Northumberland. In 1 out of the 4 years Northumberland had the highest percentage of cases with modifiable factors of any of the 3 authorities (40% in 2012/13), with North Tyneside having the highest proportion in 2011/12 (30%) and Newcastle in 2014/15 (42%).

3.10 Age - Charts 6a and 6b provide data on reviews where modifiable or no modifiable factors were identified broken down by the child's age. Chart 6a provides total numbers over 2014/15 period, while 6b breaks the data down for each of the individual years. Those aged 15-17 years and 28-364 days account for the largest number of cases with modifiable factors.



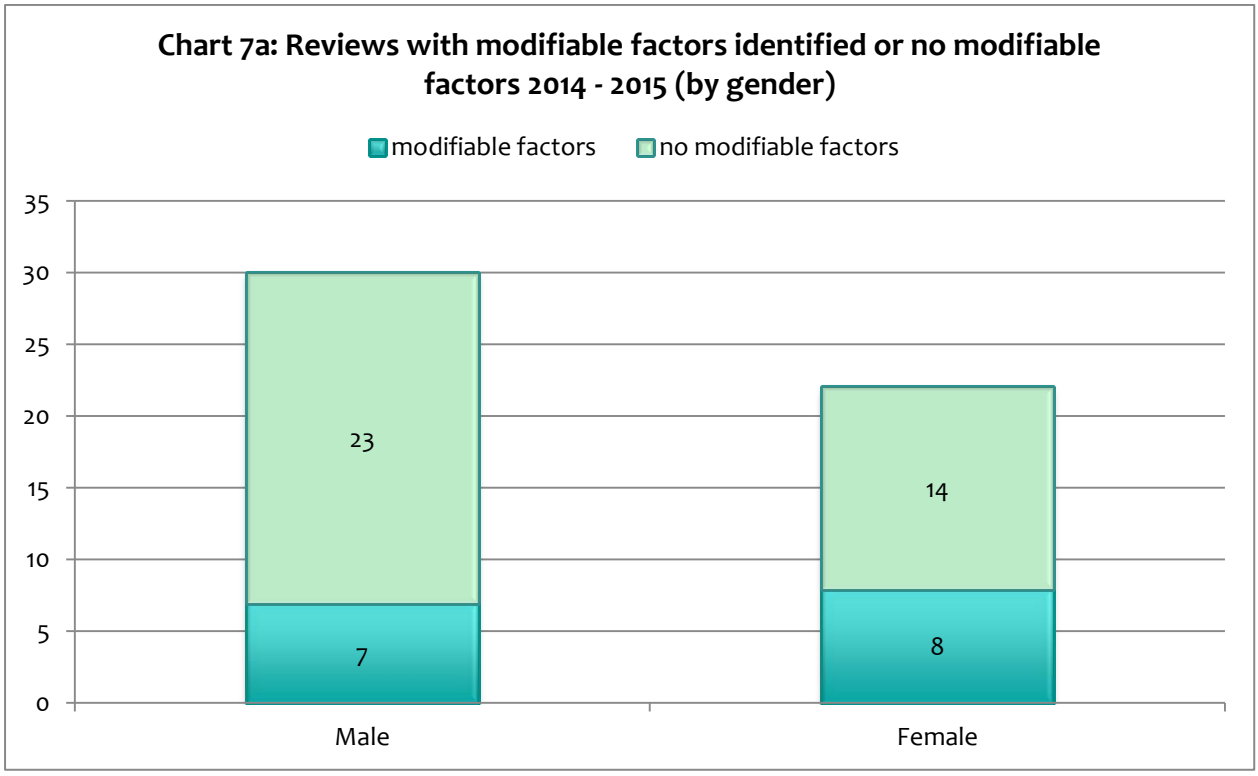


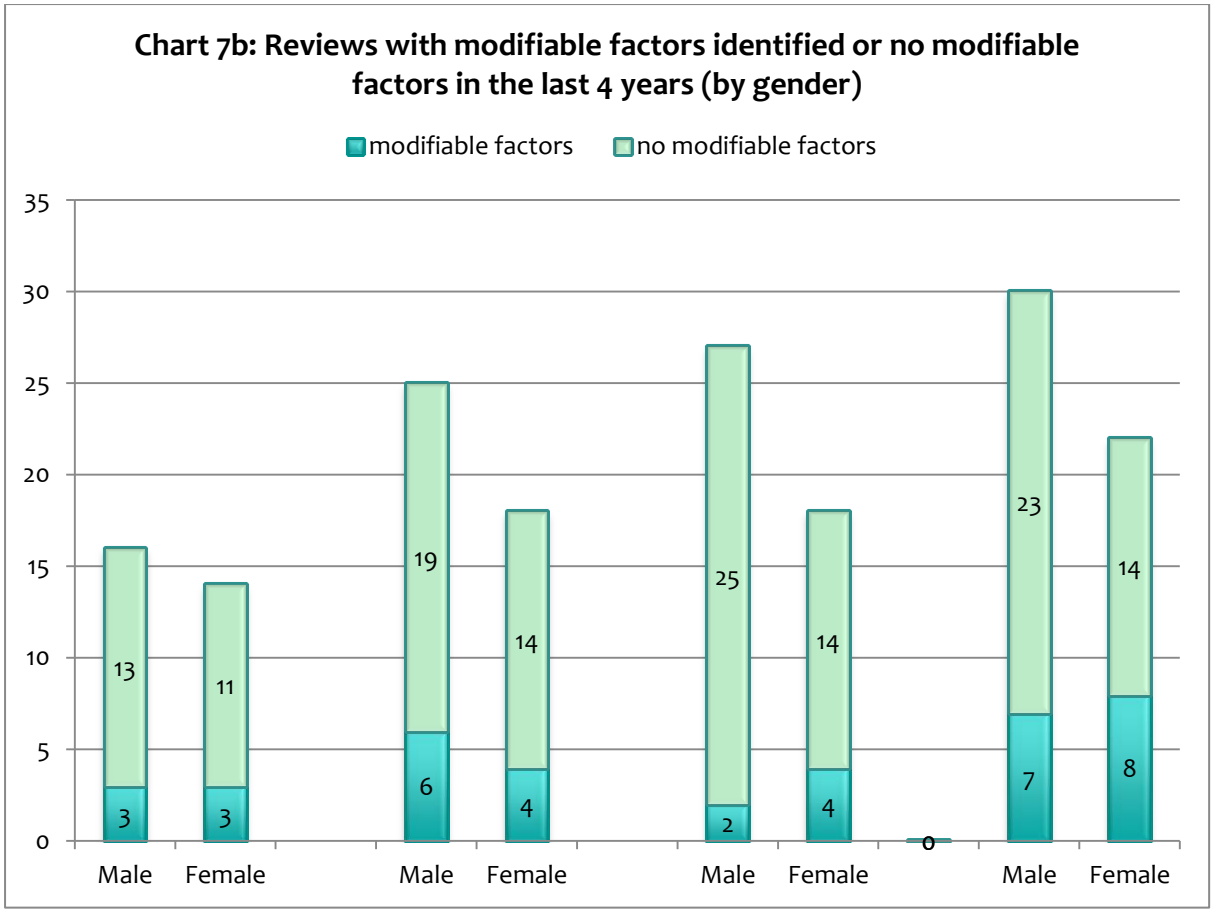
3.10.1The charts show across the 4 year period as a whole the age group which had the largest proportion of cases with modifiable factors identified was those aged 28 days – 364 days, 35% of cases (14 out of 40) in this age group had modifiable factors identified.

3.10.2 Following those aged 0-27 days accounted for the next largest proportion of cases with modifiable factors of 13.16% (10 out of 76).

3.10.3 While cases of children aged 0-27 days accounted for the largest number of cases considered overall, there were 10 cases in this age group where modifiable factors were identified. Across the 4 year period as whole only 13.16% of cases (10 out of 76) in this age group identified modifiable factors, the proportions in the individual years were similarly low. In addition in 24.14% (7 of the 29 cases) of children aged 1-4 years, modifiable factors were identified, this means this is proportionally higher but with fewer cases.

3.11 **Gender - Charts 7a and 7b** provide data on reviews where modifiable or no modifiable factors were identified broken down by the child's gender. Chart 7a provides total numbers over the 2014/15 period, while 7b breaks the data down for each of the individual years. Over the 4 year period males had 18 reviews with modifiable factors identified and females 19.

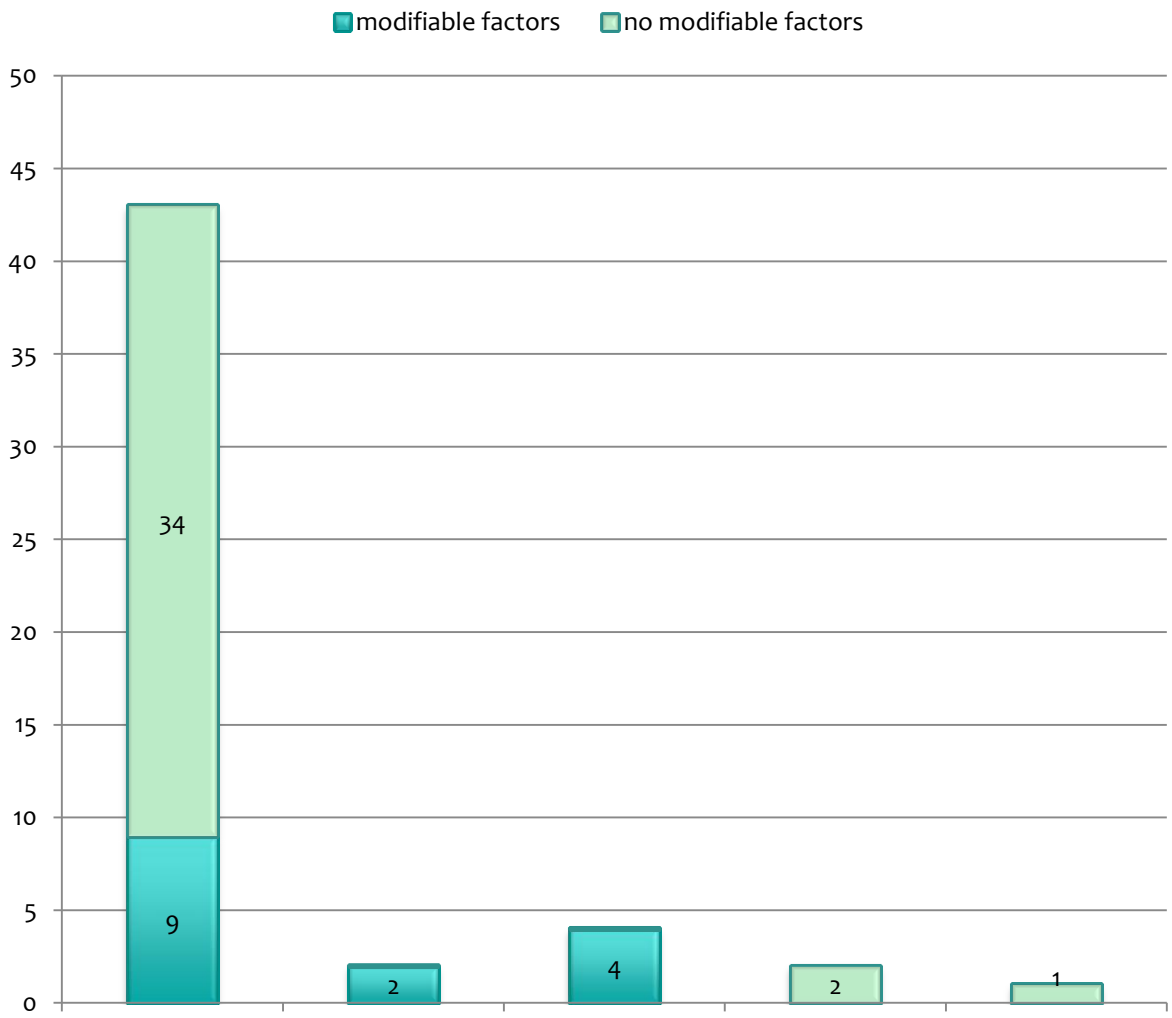


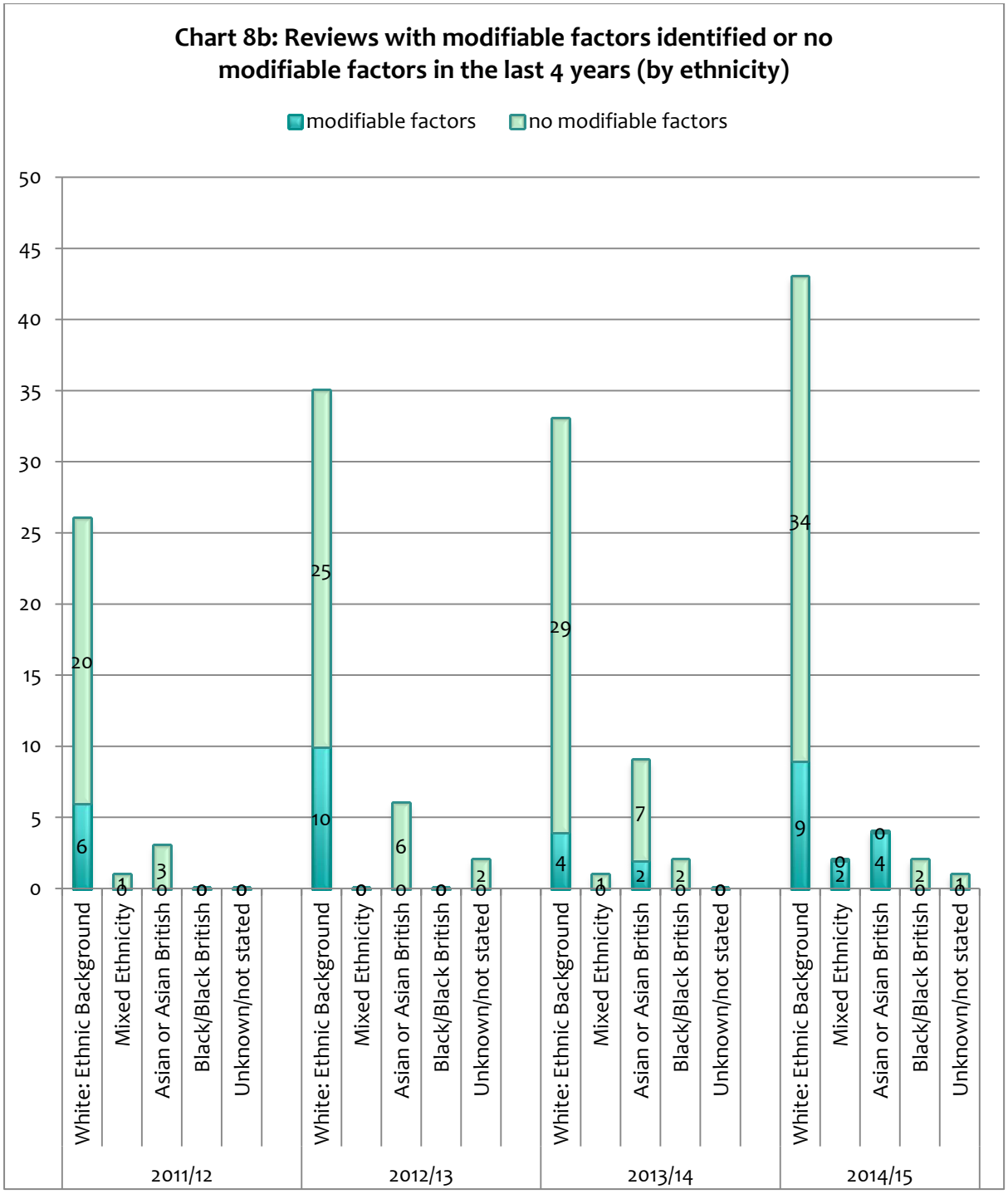


3.11.1 The national data suggests that the deaths of males were slightly more likely to have modifiable factors involved, although there was no actual statistically significant difference between the genders. Across the 4 year period as a whole, in the North of Tyne CDOP it was in fact females who were slightly more like to have modifiable factors identified, however only just. In 26.39% (19 out of 72) of cases for females modifiable factors were identified, compared to 18.37% (18 out of 98) of males.

3.12 **Ethnicity - Charts 8a and 8b** provide data on reviews where modifiable or no modifiable factors were identified broken down by the child's ethnicity. Chart 8a provides total numbers over the 2014/15 period, while 8b breaks the data down for each of the individual years. Until 2013/14 modifiable factors had only been identified in cases from a White Ethnic background.

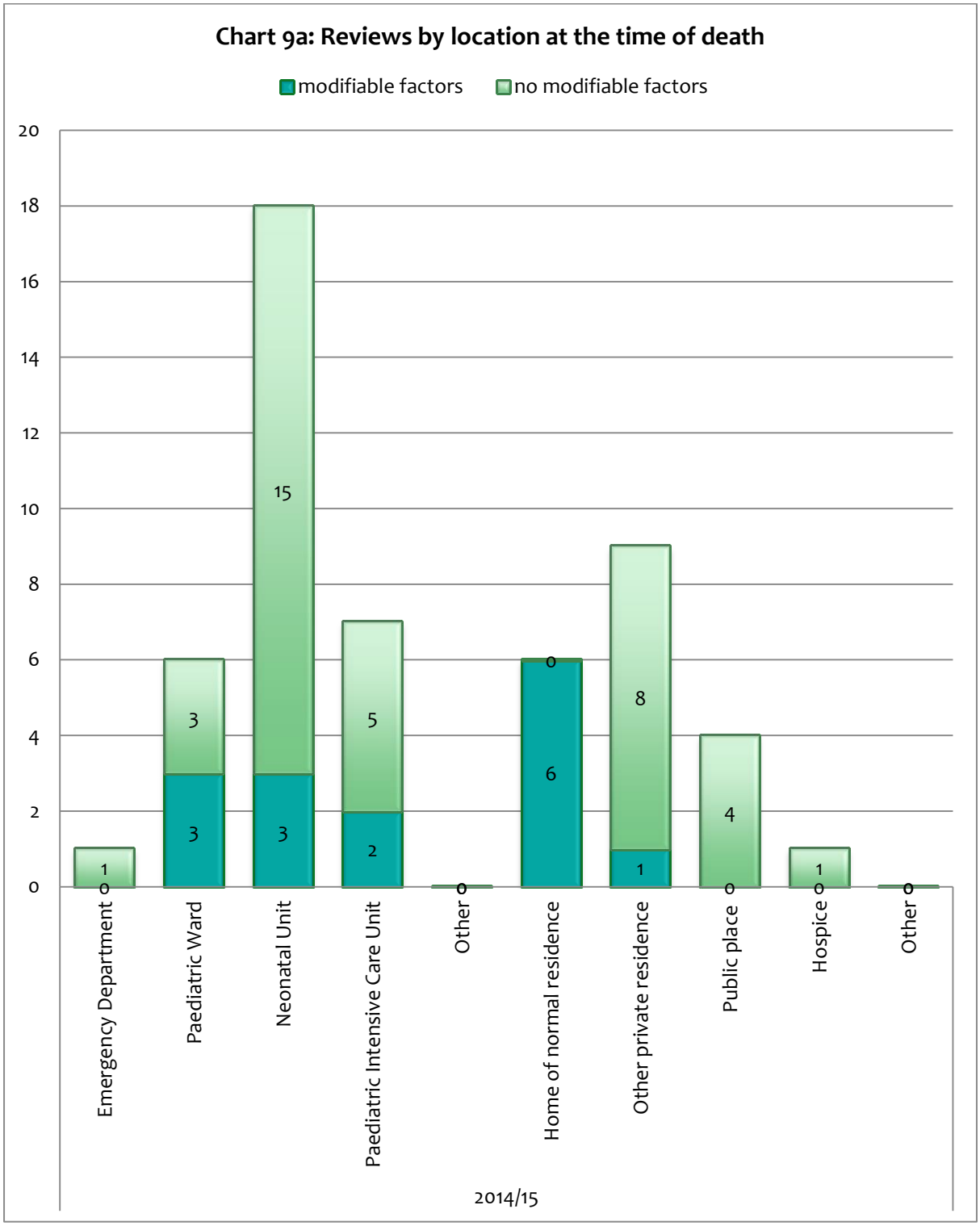
Chart 8a: Reviews with modifiable factors identified or no modifiable factors 2014 - 2015 (by ethnicity)

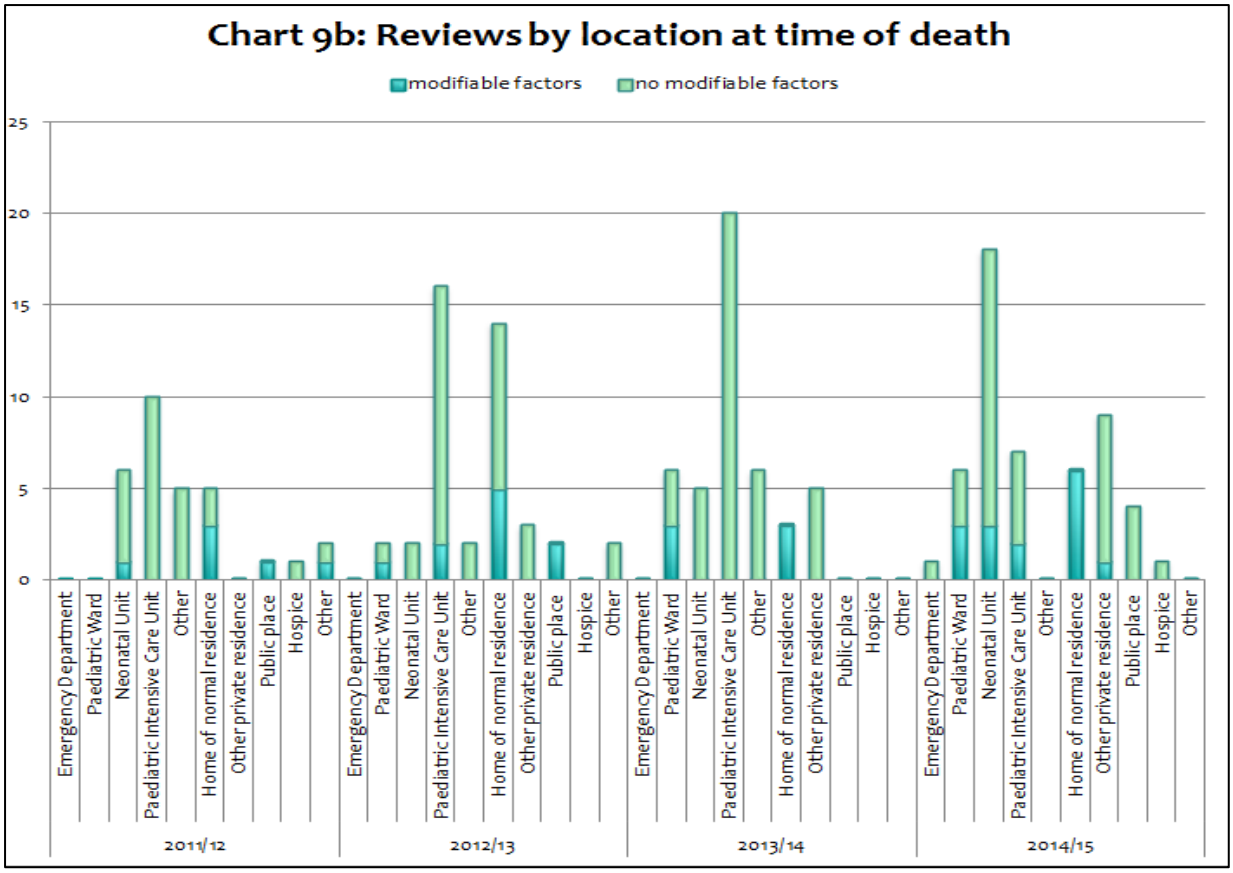




3.12.1 Out of the 41 cases of children from a combined minority background reviewed across the 5 year period 25% (8 out of 32) were identified with modifiable factors involved compared with 21.17% (29 out of 137) from a white ethnic background.

3.13 **Location - Charts 9a and 9b** provide data on reviews where modifiable or no modifiable factors were identified broken down by the location of the child at the time of death. Chart 9a provides total numbers over the 2014/15 period, while 9b breaks the data down for each of the individual years. Deaths in an acute hospital setting, while accounting for the largest proportions of deaths have the lowest proportions of cases with modifiable factors identified.



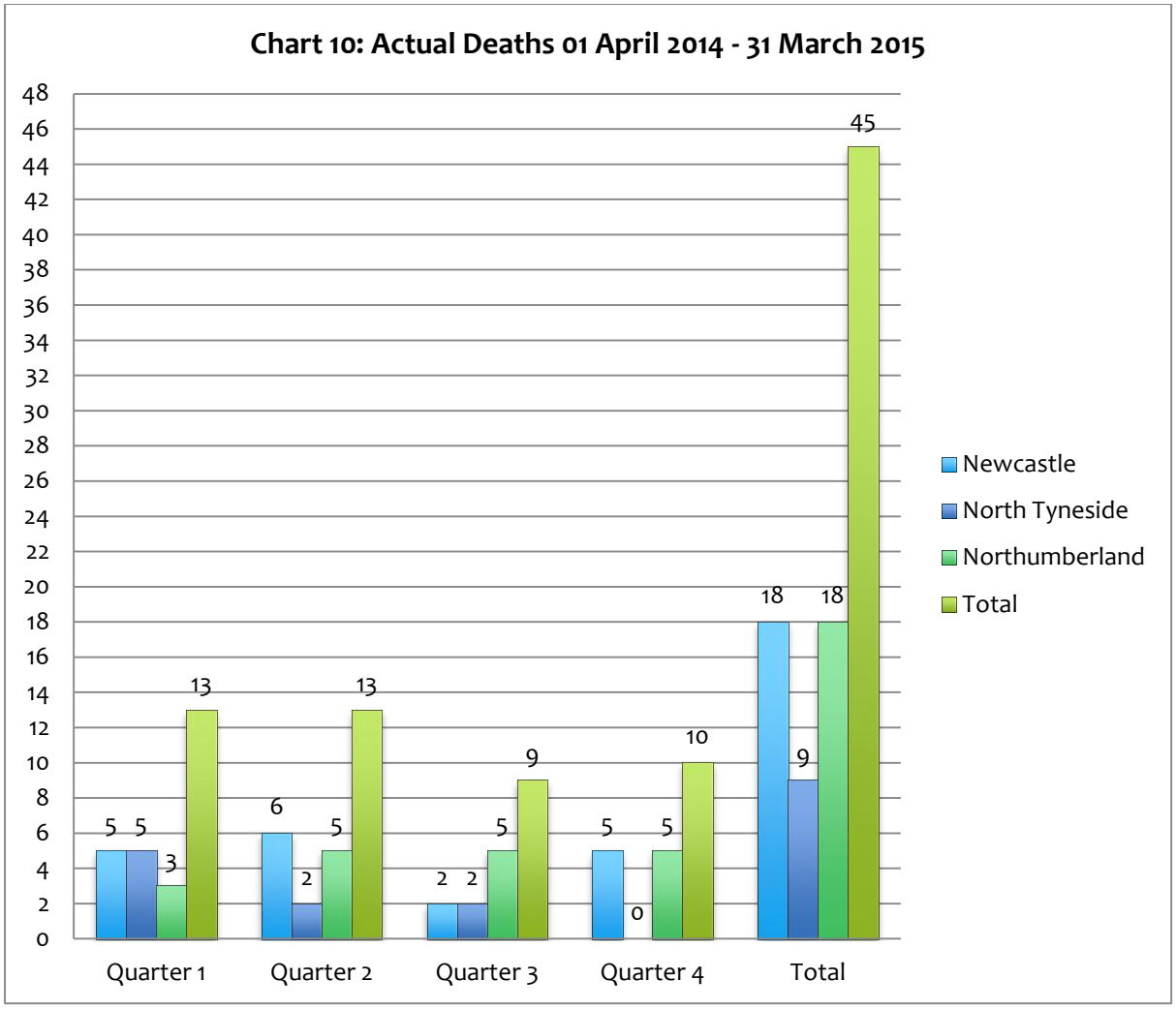


3.13.1 Across the year period as a whole, and in each of the 4 individual years the largest number of deaths were recorded within an Acute Hospital setting, specifically in the *'Paediatric Intensive Care Unit'.* Across the 4 years in total around a third, 31.18% of cases reviewed (53 out of 170) identified *'Paediatric Intensive Care Unit'* as the location of death. In each of the individual years the percentage of cases at this location have fluctuated quite a bit, ranging from 11.54% in 2014/15, 44.44% in 2013/14, 37.21% in 2012/13, 33.33% in 2011/12.

3.13.2 Of those locations within a Non-acute hospital setting, *'Home of normal residence'* accounted for the largest proportion of cases, 16.47% (28 out of 170) in total across the 4 years, with individual years figures ranging from 10% in 2011/12 to 19% in 2012/13. 7% (7 out of 170) of cases across the 4 years had the location identified as *'Public place'*, however in each of the individual 4 years the actual number and proportion of cases from this location has reduced year on year from 3 (10%) in 2011/12, 2 (5%) in 2012/13 to 0 (0%) in 2013/14 and finally 0.9% in 2014/15.

3.13.3 While *'Paediatric Intensive Care Unit'* accounts for the largest proportion of cases overall, it has a low proportion of cases with modifiable factors identified, only 7.55% of cases (4 out 53) from the location had modifiable factors identified across the 4 year period as a whole. The 2 locations with the highest proportion of modifiable factors identified were both in the non-acute hospital group. These were *'Public place'* with 42.86% (3 out of 7) and *'Home*

of normal residence' with 60.71% (17 out of 28) of cases with modifiable factors identified.



3.14 Chart 10 provides data on the actual numbers of deaths in each of the 3 LAs in the North of Tyne CDOP area, in the last year. The charts shows a total of 45 deaths were recorded, with Newcastle and Northumberland having a total of 18 each and North Tyneside, having a total of 9 deaths over the last 12 months.

Appendix 2

1 The Process Following the Death of a Child

All deaths that occur are classified as expected or unexpected. (These terms are defined in *Working Together to Safeguard Children* 2013 Chapter 5) which also includes indicative timescales.

1.1 Expected Death

1.1.1 Where a death is expected, for example from a life-limiting or life-threatening illness, the death will be registered in the usual way and the family is offered support. Information is gathered from professionals involved which is then collated and presented to the Child Death Overview Panel.

1.2 Unexpected Death

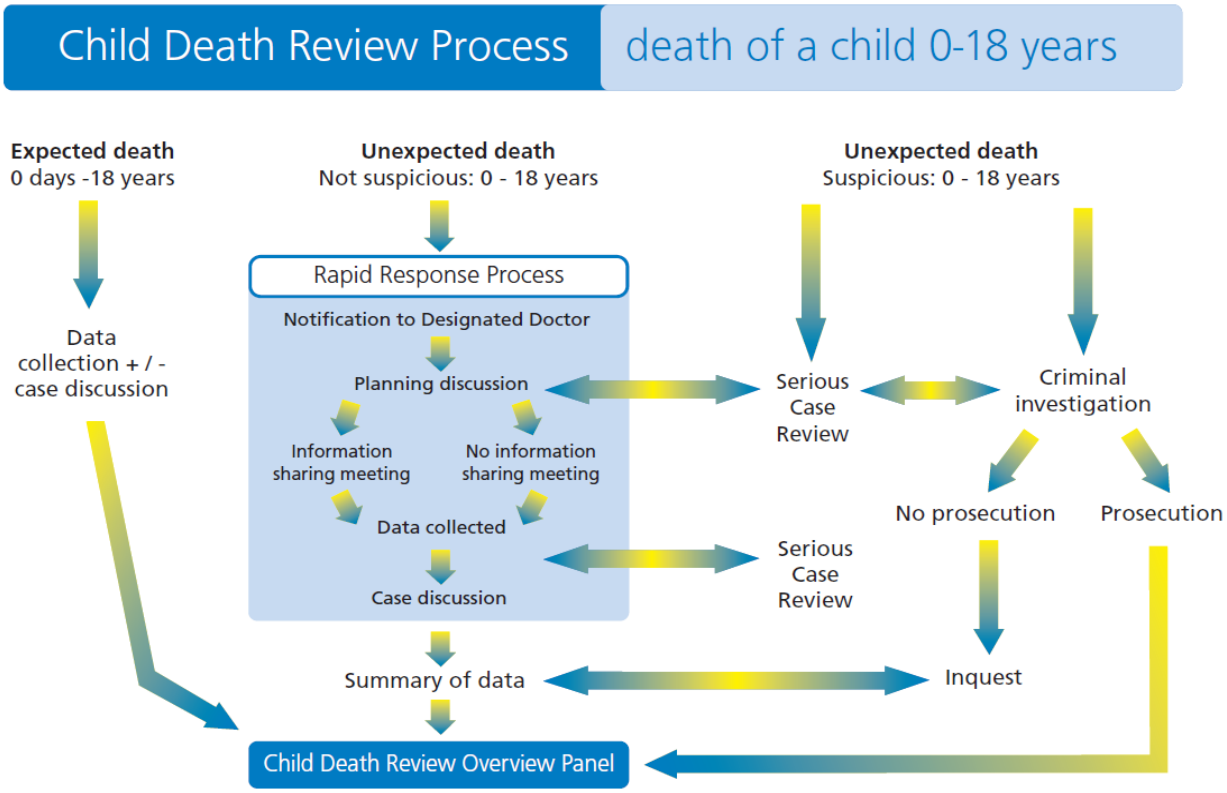
1.2.1 An unexpected death is 'the death of a child which was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death'

1.2.2 Where a death is unexpected a Rapid Response is formed from those professionals who knew the child or their family, or were involved in the child's death. Information held is shared either by telephone discussion or in a face to face meeting. In some circumstances, a home visit is undertaken, either by the police or a paediatrician, or jointly; the information gathered from the professionals helps to inform the questions asked during the home visit. Once the final post mortem results are known, approximately 3-4 months after the death (investigations can be complex and results of tests may take time), a multi-agency meeting is held involving all the professionals involved with the family. This meeting is to establish, as far as possible, the cause of death and plan future support for the family. The minutes of this meeting are forwarded to the Coroner and an inquest will usually be held on all unexpected deaths. All available information is then collated and presented to the Child Death Overview Panel on the Form B (appendix 1)

1.2.3 When a child dies (including death by suspected suicide) and abuse or neglect is known or suspected to be a factor in the death, the LSCB should always consider whether to undertake a SCR into the involvement of organisations and professionals in the lives of the child and family. (WT Ch 4)

1.2.4 Processes and Procedures are now in place to receive notifications of child death and the collection of data from agencies and professionals involved in the death of a child. Information is obtained and provided in a timely manner in order to undertake an effective and thorough review into the death of a child.

1.2.5 The following diagram shows the process following the death of a child as described above leading to the review of the death at the Child Death Overview Panel. A local agreed definition of expected and unexpected can be found in the Terms of Reference appendix.



1.3 The Child Death Overview Panel

1.3.1 The Child Death Overview Panel (CDOP) reviews all deaths of children 0-18 years old, classifying the cause of death, identifying contributory factors, reaching a decision about whether the death was modifiable, identifying any modifiable factors (those which can be changed through national or local interventions) and making recommendations to prevent future similar deaths.

1.3.2 In reviewing the death of each child, the CDOP should consider modifiable factors in the family and environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level. This is achieved using information collated from Rapid Response and Local Case Discussion meetings.

1.3.3 This information is contained in the 'Form C', which is used nationally. The process of completing the Form C begins at the local case discussion, and is finalised when all information is available, at the CDOP. The four aspects below are outlined on the Form C for consideration in the review process and ultimately determine the "preventability" of the death as follows:

- Factors intrinsic to the child
- Family and environment
- Parenting capacity
- Service provision

1.3.5 The CDOP is expected to make recommendations about interventions that could help to prevent future child deaths, or improve the safety and welfare of children in the local area or further afield.

1.3.6 The Panel can also take an overview of multiple deaths (e.g.: road traffic collisions) and may identify common themes or trends which could lead to recommendations. Any recommendations made are passed to the appropriate agency and/or Local Safeguarding Children Board and progress on their implementation is monitored.

1.3.7 Each CDOP will formally report back to their LSCB annually

1.4 Serious Case Reviews and the CDOP Process

1.4.1 Local Safeguarding Children Boards (LSCBs) are required to undertake reviews of serious cases. When a child dies (including death by suspected suicide) **and** abuse or neglect is known or suspected to be a factor in the death, the LSCB should always consider whether to undertake a SCR into the involvement of organisations and professionals in the lives of the child and family.

1.4.2 There are a range of other related review processes which the CDOP may be required to feed into e.g. Drug Death review, Domestic Homicide review.

1.4.3 One role of the North of Tyne CDOP is to consider whether the criteria for Serious Case Review might be met in certain cases, whether or not it has already been considered by the LSCB. The Chair of North of Tyne CDOP should ensure that the recommendation(s) are communicated to the appropriate Safeguarding Children Board Manager.

2. Panel Membership and Meetings

2.1 The North of Tyne Child Death Overview Panel Members

2.1.1 The Child Death Overview Panel consists of senior managers in those organisations which regularly have contact and care of children. A Child Death Overview Panel Co-ordinator is employed to coordinate the Child Death Overview Panel arrangements as well as the rapid response and local case discussions (JD reviewed in 2013)

North of Tyne Child Death Overview Panel Members (April 2014/15)

Named Representative	Agency/Title
Edwina Harrison (Chair) Until November 2014	Independent Chair
Sheila Moore (Chair) from November 2014 - present	Designated Nurse Child Protection , North Tyneside/Independent Chair from April 2015
Jill Rennie	North of Tyne CDOP Coordinator (From May 2014)
Sue Kirkley	Newcastle Safeguarding Children Board Coordinator
Steve Day	Northumberland Safeguarding Standards Manager
Sue Burns	Business Manager, North Tyneside LSCB
Dr Karen Rollison	Designated Doctor Child Deaths, Newcastle
Dr Stephen Bruce	Designated Doctor Child Deaths, Northumberland & North Tyneside
Lesley Thirlwell	Named Professional Safeguarding, North East Ambulance Service
John Douglas	Detective Chief Inspector, Public Protection Unit, Northumbria Police
Caroline Ruddick	Lead Midwife Safeguarding Children (RVI)

Jan Hemingway	Acting Designated Nurse, Northumberland (from Nov 2013)
Linda Lincoln – left February 2015	Designated Nurse Child Protection, Northumberland
Margaret Tench	Designated Nurse, Child Protection, Newcastle
Marietta Evans	DPH North Tyneside Council

2.1.2 Each panel meeting has been quorate as stated in the Terms of Reference.

2.1.3 In addition a number of co-opted members can be invited to attend panel meetings for case discussions where their particular knowledge and expertise is required to effectively review the death. This would include statutory agencies and the voluntary/community sector. We encourage professional observers shadowing after prior agreement with the chair person.

3 Coroner

3.1 The Coroner's Office is provided with the case minutes of relevant local case and discussions that are subject to an inquest.

Glossary of terms	
NoT	**North of Tyne**
NHCT	**Northumbria Healthcare Trust**
NUTH	**Newcastle upon Tyne Hospitals**
CDR	**Child Death Review**
LSCB	**Local Safeguarding Children Board**