North of Tyne

Child Death Overview Panel

Annual Report

April 2018 - March 2019

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.

The strength of the multi-agency panel lies in its ability to scrutinise the circumstances surrounding each child's death and to provide challenge to the agencies where members feel that the learning from the review could be further enhanced and more rigorous. E.g. the panel where appropriate send form Cs back to the agencies for further analysis. The panel feel that since its inception in 2008 that level of scrutiny, challenge and rigour has strengthened year on year.

Membership and Panel Meetings

The North of Tyne panel met 5 times within the timeframe of this annual report (April 2018 - March 2019) and has enjoyed very good multi-agency attendance. It has been the fourth year of my chairmanship and I continue to be impressed with the commitment and level of challenge by panel members. As well as thanking the panel members it is also important to acknowledge the work and commitment from frontline staff and their managers in all agencies involved in the child death review process, without which we could not fulfil our task. There have been some personnel changes in the panel membership within the year, notably the designated Doctor for Newcastle who retired. The changes are reflected in the membership list on page 7.

We have continued to welcome observers from the constituent agencies and there have been 7 such observers this year, from nursing and medicine.

Accountability and Reporting Arrangements

As well as the Annual report the CDOP produces quarterly reports which are received by the 3 SCBs 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 SCBs 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 coordinator creates an action log after each panel meeting which allows the panel to monitor the implementation of actions and recommendations which arise from the reviews. This is to ensure constant service improvement. The panel are planning to request further assurance from service providers that recommendations made at service level have been implemented. This will be an annual assurance report from the relevant service providers that there is a robust monitoring system for the implementation for recommendations.

During the development of this annual report we had to ensure that children and families could not be identified. This report broadens individual case factors to prevent breaches of confidentiality.

Timing

The report was drafted in August 2019 and was reviewed by Public health colleagues. The national data has not been available from the DfE due to the changes to the governance of CDOPs nationally, so there are no comparisons with the national data.

Thanks must go, once again, to North Tyneside CCG for providing a venue and hospitality for our panel meetings and Rachel Nicholson from North Tyneside Public Health department for her contribution to the report.

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

THE PROCESS OF THE CHILD DEATH OVERVIEW PANEL ACROSS NORTH OF TYNE

Northumberland, North Tyneside and Newcastle work together via the North of Tyne Child Death Overview Panel (CDOP) to review the death of every child who normally resides in each of these areas, regardless of where the death occurs. This document reports on all the children whose deaths were reviewed in 2018/19, regardless of the year in which the child died.

When a child dies, an appropriate clinician will assess the death as expected or unexpected. (These terms are defined and the process outlined in *Working Together to Safeguard Children* 2015 Chapter 5),

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.

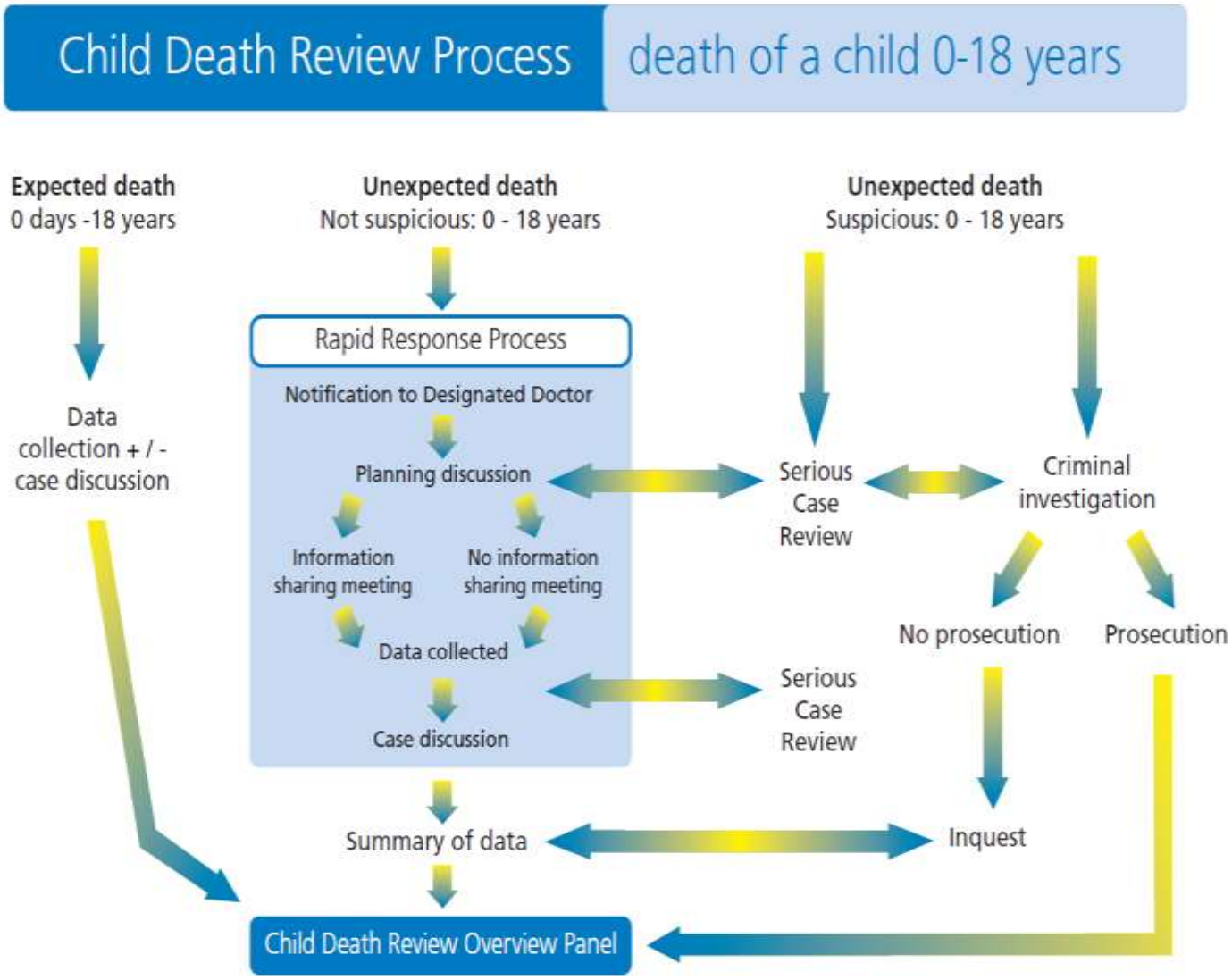
Where a death is unexpected a series of rigorous investigations take place, including a post-mortem. In such cases a multi-agency meeting (known as a Local Case discussion Meeting) is held to establish, as far as possible, the cause of death and plan future support for the family. This process usually takes 3-4 months. All available information is then collated and presented to the Child Death Overview Panel

The Child Death Overview Panel (CDOP) will in each case classify the cause of death, identify contributory factors, reach a decision about whether the death was modifiable, identify any modifiable factors (those which can be changed through national or local interventions) and make recommendations to prevent future similar deaths.

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.

Safeguarding Children Boards (SCBs) 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 SCB should always consider whether to undertake a Case Review (CR) into the involvement of organisations and professionals in the lives of the child and family. The CDOP has to consider whether the criteria for a CR might be met in certain cases, whether or not it has already been considered by the SCB, and to make recommendations appropriately.

Fig. 1 - The Death Review Process



MEMBERSHIP OF THE CHILD DEATH OVERVIEW PANEL

Named Representative	Agency/Title
Sheila Moore	Independent Chair
Jill Rennie	North of Tyne CDOP Coordinator
Sue Kirkley	Newcastle Safeguarding Children Board Coordinator
Robin Harper Coulson	Business Manager Northumberland SCB
Sue Burns	Business Manager North Tyneside SCB
Dr Karen Rollison until Dec 18 Dr Anna Thorley from Dec 2018	Designated Doctor Child Deaths Newcastle
Dr Stephen Bruce	Designated Doctor Child Deaths Northumberland & North Tyneside
Karen Arkle	Named Professional Safeguarding North East Ambulance Service
Shelley Hudson until Jan 2019 Eric Myers from Jan 2019	Detective Chief Inspector, Safeguarding Department Northumbria Police
Susan Simpson	Named Midwife Safeguarding Children Newcastle upon Tyne Hospitals
Jan Hemingway	Designated Nurse Child Protection, North Tyneside
Margaret Tench	Designated Nurse Child Protection, Northumberland
Judith Corrigan	Designated Nurse, Child Protection, Newcastle
Wendy Burke	DPH North Tyneside Council
Richard Hearn	Consultant Neonatologist
Lynn Tilley	Acting Head of Midwifery

CHILD DEATH DATA

Table 1 – Total number of child deaths reviewed

	2014/15	2015/16	2016/17	2017/18	2018/19	5 year average
Northumberland	15	19	12	13	11	14
North Tyneside	13	4	12	9	12	10
Newcastle	24	13	13	16	16	16
Out of Area	0	0	0	0	0	0
North of Tyne Total	52	36	37	38	39	40

The total number of deaths reviewed from 2014/15 – 2018/19 is 202. The average number of child deaths that have been reviewed across the North of Tyne over the past 5 years is 40.

In 2018/2019 there were a total of 39 child death reviews across Northumberland, North Tyneside and Newcastle (North of Tyne). Since the annual report in 2014/2015 the number of child deaths is detailed in table above. Numbers fluctuate and it is difficult to ascertain any trend in the overall number of deaths over the years in which the Panel has operated. It is thankfully rare for children to die in this country therefore the number of child deaths in any particular year within a local area is small in number. This means that generalisations are rarely appropriate and for lessons to be learnt from the deaths reviewed, data needs to be collected and reported on nationally over a longer period of time.

Table 2 – Age of child at time of death

						5 year proportion
	2014/15	2015/16	2016/17	2017/18	2018/19	North of Tyne
0-27 days	20	11	14	18	16	39%
28 days- 364 days	13	8	4	8	7	20%
1 year-4 years	9	6	5	4	4	14%
5-9 years	3	2	1	1	6	6%
10-14 years	4	6	6	2	3	10%
15-17 years	3	3	7	5	3	10%

N.B. percentages may not add up to 100 due to rounding

A child is most at risk of death within the first year of life, and particularly within the first 27 days of life.

Place of Death

Of the 39 deaths notified in 2018/19, the vast majority 25 (= 64%) occurred in hospital followed by 14 (=36%) in the home or outside area.

Gender

Table 3 – Gender of child

	2014/15	2015/16	2016/17	2017/18	2018/19	5-year average
Male	30	20	19	19	21	54%
Female	22	16	18	19	18	42%

The pattern of child deaths according to gender is similar to the national picture

Fig. 2 - **Pattern of deaths by gender North of Tyne 2014-2019**

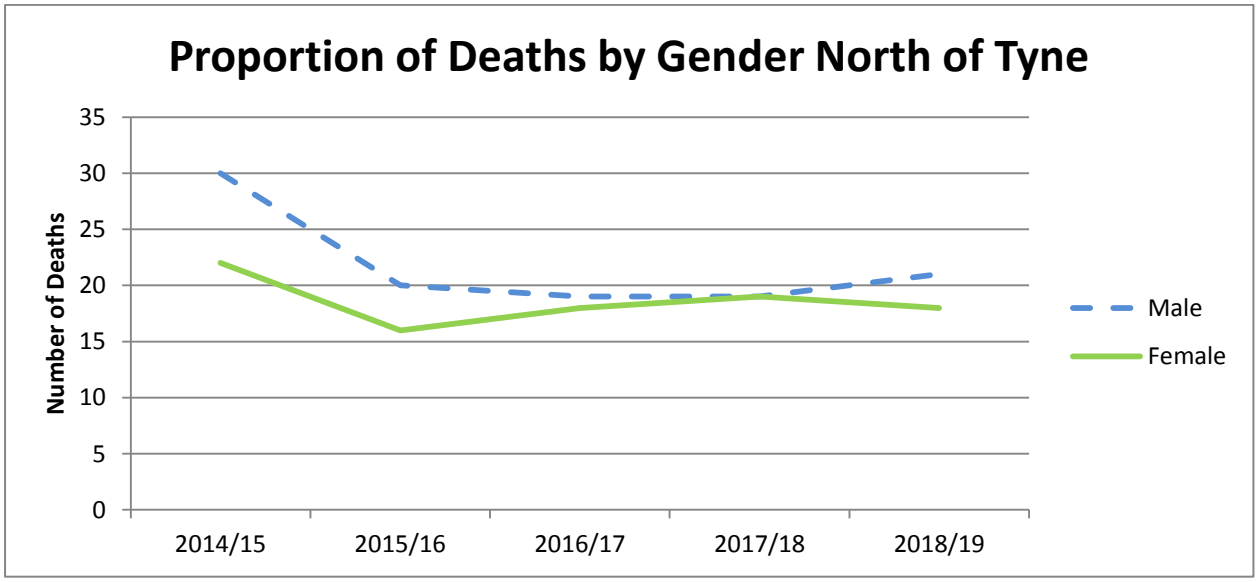


Table 4 - Number and % of deaths by ethnicity

Ethnicity (Broad)	14/15	15/16	16/17	17/18	18/19	Total (5yr)	% of deaths
White	43	30	32	34	31	170	84%
Mixed	1	0	0	0	0	1	1%
Asian	4	4	5	2	7	22	11%
Black	3	1	0	2	1	7	4%
Other	1	1	0	0	0	2	1%
Unknown	0	0	0	0	0	0	1%

Although the numbers are small, there appears to be an over-representation in Asian children in these death statistics in comparison to their numbers in the population. This pattern is noted in previous CDOP annual reports and also fits with the national picture. NB this interpretation is from the 2016/2017 annual report.

The 22 deaths of Asian children in the 5 year period were in the following categories

Acute medical or surgical condition	1
Chronic medical condition	1
Chromosomal, genetic and congenital anomalies	9
Perinatal/neonatal event	6
Sudden unexpected, unexplained death	1
Malignancy	3
Suicide or deliberate self-inflicted harm	1

Deprivation

Fig. 3 - Child Deaths by geography and deprivation level, 2011-2019, South, Northumberland, North Tyneside and Newcastle

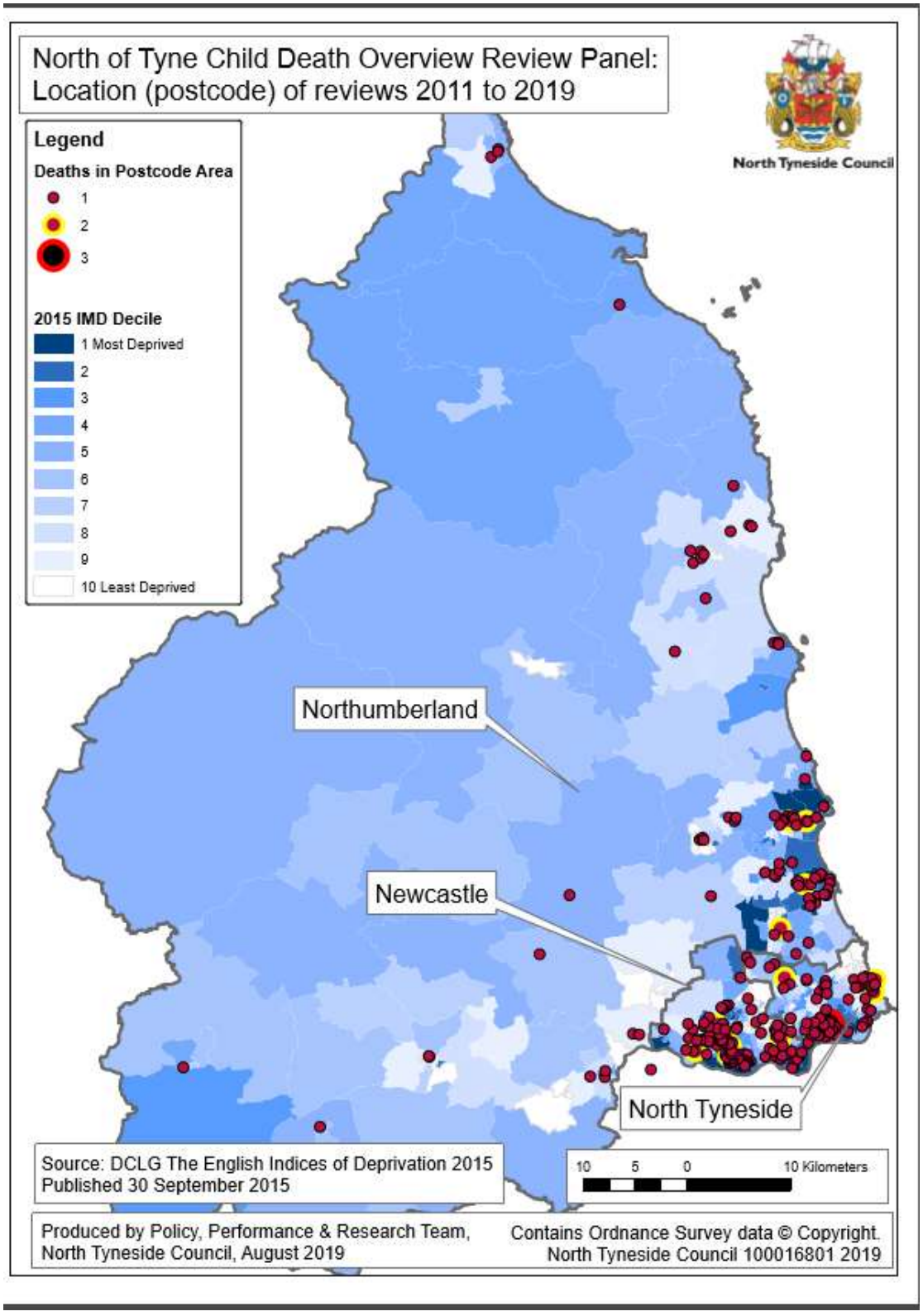


Fig 3b: Child Deaths by geography and deprivation level, 2018-2019, South, Northumberland, North Tyneside and Newcastle

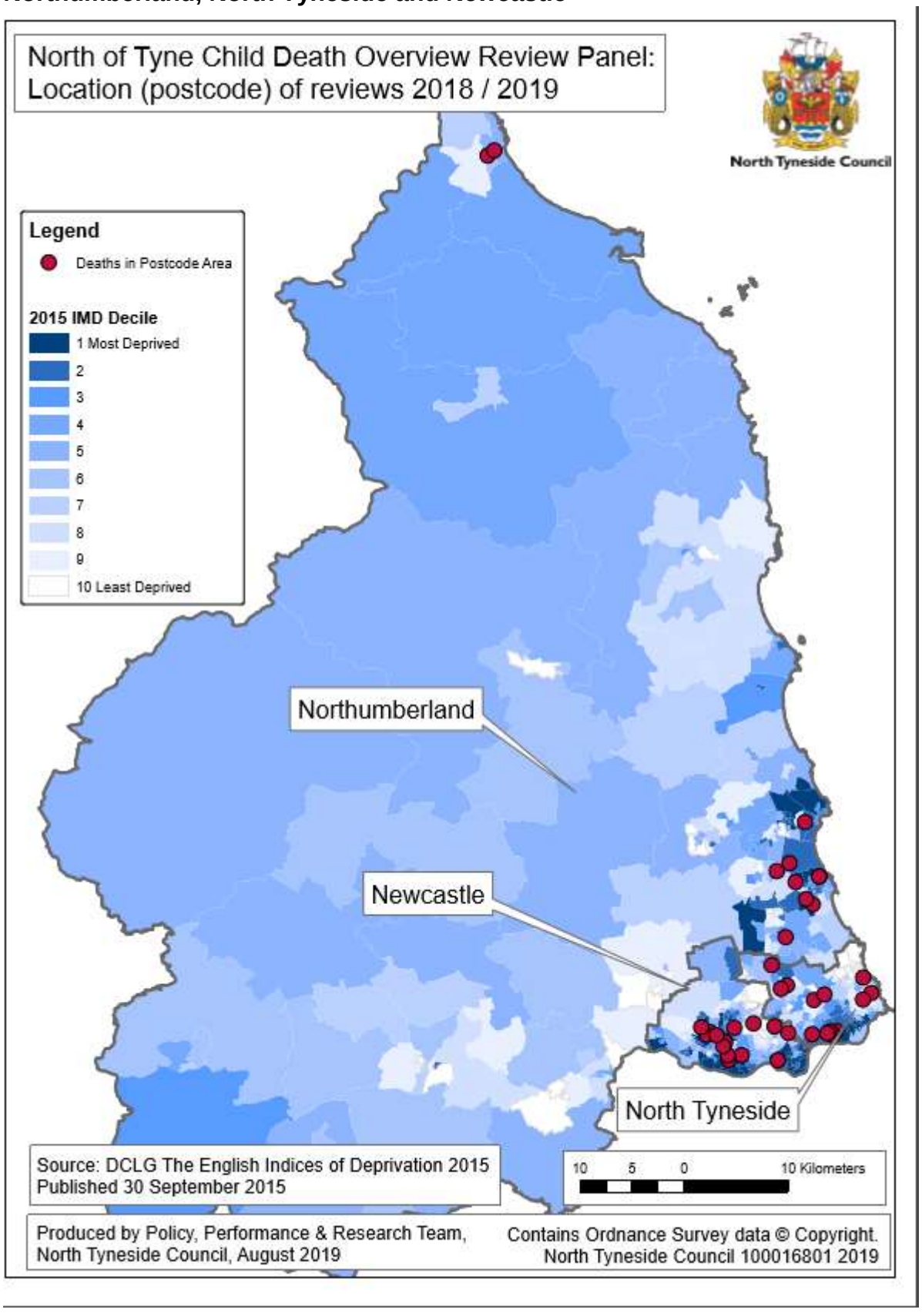


Table 5 - North of Tyne child deaths reported to panel by deprivation decile, 2011-2019

Decile	Deaths
1 - Most deprived	60
2	37
3	34
4	34
5	24
6	16
7	16
8	15
9	22
10 - Least deprived	13

The largest numbers of deaths are occurring in the areas of highest deprivation. This relationship holds up when we compare the proportion of deaths with the proportion of population for each decile. N.B. decile 1 has the highest deprivation score, decile 10 the lowest. This reflects the national picture.

CDOP Panel

In 2018/2019 the panel met 5 times. Below is a table showing the number of cases reviewed at each meeting.

Table 6 - Number of reviews at each meeting, 2018/19

May	July	Sept	Jan	March	Total
5	4	7	15	8	39

Timeliness and Frequency of CDOP Meetings

Working Together 2015 suggests that all cases should be reviewed by the panel within 6 months of the death, however nationally not every CDOP uses this indicative target. North of Tyne panel decided that they would use it as a performance indicator to assure SCBs and CCGs that the child death review process was effective.

The CDOP meets every second month and this can lead to form Cs, the forms which the panel use to scrutinise each child's death, being available for review but having to be delayed because of how frequently the panel meet; e.g. if a child dies on the twelfth of the month, the review date for completion of the paperwork is also on the twelfth of the month, 6 months ahead. This means that there will always be cases which are reviewed late by the panel due to the panel dates; however this does not mean that the process preceding the panel review has been delayed. The panel have therefore chosen a performance target of 60% of form Cs to be logged with the coordinator and available for review by the panel within 6 months of the death. The panel have not achieved this target in 18/19.

The panel are apprised throughout the year of the timeliness of the reviews via the quarter reports, including detail on the reason for the delay. There will always be cases which are unavoidably delayed by other processes, e.g. coronial investigations and case reviews by Safeguarding Boards.

We were aware in Q2 and Q3 of the problems around the delays in PM reports, this was subsequently resolved by direct conversations with the Pathology department where planned expansion in staffing levels has improved the situation.

Neonatal cases have also been delayed. There are multiple contributory factors here including the aforementioned coronial investigations and post-mortem delays. The main factor is however is that the neonatal team are working to capacity in terms of their ability to complete reviews. The neonatal period is the time when children are most likely to die due to the lethality of many of the pathological presentations in this period. This has been recognised and though the national introduction of new parallel processes has made the review process more complex. Locally, it has been taken as an opportunity to improve the overall process with introduction of independent, external oversight and more regional representation at mortality meetings. This has reportedly improved the scrutiny of cases. The neonatal team are committed to improving the timeliness of their internal review process. However there is a view that it is ultimately better to delay a review in order that all the relevant information is available to ensure high quality than to complete reviews on time but without essential information.

The chair of the panel is in agreement with this approach, whilst maintaining a watching brief on the timeliness and reporting the issues to CCGs and SCBs via quarter reports. The panel chair could also escalate the issue to provider trusts via the escalation policy contained in the Terms of Reference.

Table 7 - Timeliness of reviews

Year	Number of cases Reviewed at panel	% of cases reviewed within timescale
2014/2015	52	40%
2015/2016	36	56%
2016/2017	37	62%
2017/2018	38	55%
2018/2019	39	28%

Modifiable Factors

Fig 5 - Shows the recent trend in the proportion of deaths where modifiable factors were identified.

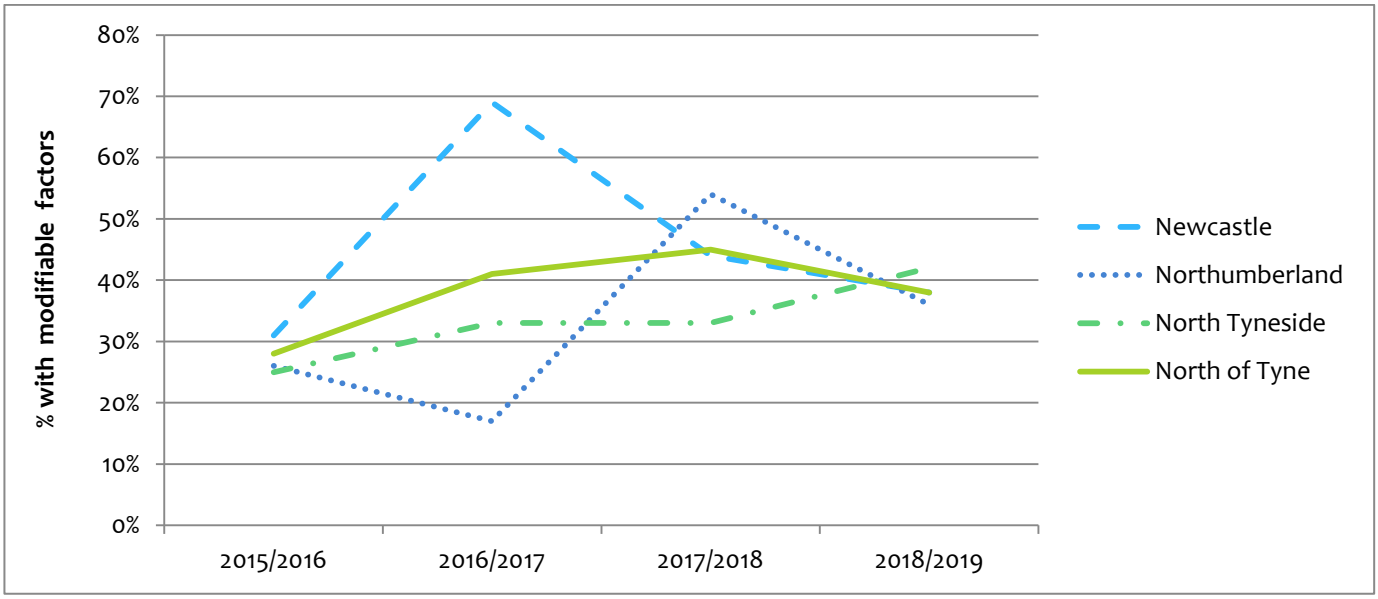


Table 8 - Numbers and % of child deaths where modifiable factors were identified

Area	2015/16			2016/17			2017/2018			2018/2019			4 year Aggregate figures		
	No modifiable factors	Modifiable factors	% with modifiable factors	No modifiable factors	Modifiable factors	% with modifiable factors	No modifiable factors	Modifiable factors	% with modifiable factors	No modifiable factors	Modifiable factors	% with modifiable factors	No modifiable factors	Modifiable factors	% with modifiable factors
Newcastle	9	4	31%	4	9	69%	9	7	44%	10	6	38%	32	26	45%
Northumberland	14	5	26%	10	2	17%	6	7	54%	7	4	36%	37	18	33%
North Tyneside	3	1	25%	8	4	33%	6	3	33%	7	5	42%	24	13	35%
Out of Area	0	0	0%	0	0	0%	0	0	0%	0	0	0%	0	0	0%
North of Tyne	26	10	28%	22	15	41%	21	17	45%	24	15	38%	93	57	38%

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, 45% of cases in Newcastle were identified as having modifiable factors compared with 35% in North Tyneside and 33% of cases in Northumberland.

Each year, the panel takes a close look at deaths where modifiable factors occur, in order to learn lessons for the future.

Of the 39 cases reviewed in 2018/2019 modifiable factors were identified in 15 cases.

A modifiable factor is identified as something which: "may have contributed to the death of the child and which, by means of locally and nationally achievable interventions, could be modified to reduce the risk of future child deaths".

It is worth noting that the child death process also creates an opportunity at the meetings held before the panel review (Rapid Response, Morbidity and Mortality and Local Case Discussions) for services to identify other smaller, micro changes to practice, e.g. a need for workplace training or amendments to internal policies and procedures.

There were 15 cases where modifiable factors were identified:

- 2 cases of accidental drowning, one with a risk factor of being abroad and the other with a risk factor of lack of supervision whilst bathing.

- There were 6 cases of unsafe sleeping arrangements accompanied by known risk factors e.g. parental smoking, drug and alcohol use and overheating. In one case domestic violence was also noted.

- One suicide where timely access to a local inpatient mental health facility was a factor.

- 3 cases where service provision was a factor: the first identified a missed hospital appointment, the second identified inadequate use of the Paediatric Early Warning System (PEWS) charts. The third case highlighted communication issues between primary and secondary care and between health, social care and education.

- 3 neonatal cases identified recognised risk factors in pregnancy: one of maternal cannabis use, and 2 of high maternal BMI.

Panel members are tasked with taking the learning from these cases and sharing it widely within their organisations in order that health and social care staff are aware of the risk factors when supporting and advising parents and carers.

Categories of Child Deaths

The categories below are determined by the DfE and every CDOP nationally follows them.

Table 9 - Category of child deaths (includes all North of Tyne)

		2014/2015	2015/2016	2016/2017	2017/2018	2018/2019	Proportion
1	**Deliberately inflicted injury, abuse or neglect -** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	0	1	1	0	0	0%
2	**Suicide or deliberate self-inflicted harm** - This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.	2	0	3	1	1	3%
3	**Trauma and other external factors** - This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury, abuse or neglect. (Category 1).	1	0	3	0	4	4%
4	**Malignancy -** Solid tumours, leukaemia & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	4	2	5	3	7	10%
5	**Acute medical or surgical condition** - For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.	2	3	0	2	3	5%
6	**Chronic medical condition** - For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.	2	4	2	1	2	5%
7	**Chromosomal, genetic and congenital anomalies** - Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.	13	9	5	9	11	23%

8	**Perinatal/neonatal event** - Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intra-partum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).	16	11	13	16	8	32%
9	**Infection** - Any primary infection (i.e., not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.	5	5	3	1	0	7%
10	**Sudden unexpected, unexplained death -** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	7	1	2	5	3	9%

Supplementary work undertaken by the panel in 2018/19.

- The panel completed a questionnaire for the National Network of CDOPs – we were given 4 case studies and asked to categorise the cause of death which prompted a thorough discussion. We await the results of the study.

- We amended the Terms of Reference as a result of a query for access to CDOP information from parents.

- We now have a process for sharing information with the LeDeR review (cases where children had an identifiable learning disability).

- New Guidance for the Child Death process came into place in October 2018 alongside the revised Working Together (July 2018)

- Collaboration began early in 2019, between our panel and South of Tyne panel to look at the new guidance and produce an options paper for the safeguarding partners to consider in due course. This has included producing a process map of the respective processes as well as joint collaborative workshops to develop the options.

- There has been agreement that the panel will transition to using eCDOP, a secure, cloud-based, case management system which will reduce the administrative time across the system, including production of reports and data collection.

- New CDOP forms are being introduced across the patch with a view to be used from April 2019

- The National Mortality Database was operational from April 2019