North of Tyne

Child Death Overview Panel

Annual Report

April 2017 - March 2018

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 2017 - March 2018) and has enjoyed very good multi-agency attendance. It has been the third 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.

We have continued to welcome observers from the constituent agencies and there have been 9 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 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 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 July 2018 and was reviewed by Public health colleagues. The national data has not been available from the DfE due to the imminent changes to the governance of CDOPs nationally, so the usual comparisons we undertake are missing from this draft. This will be rectified as soon as possible.

Thanks must go, once again, to North Tyneside CCG for providing a venue and hospitality for our panel meetings and Racheal 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 2017/18, 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.

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 Serious Case Review (SCR) 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 SCR might be met in certain cases, whether or not it has already been considered by the LSCB, and to make recommendations appropriately.

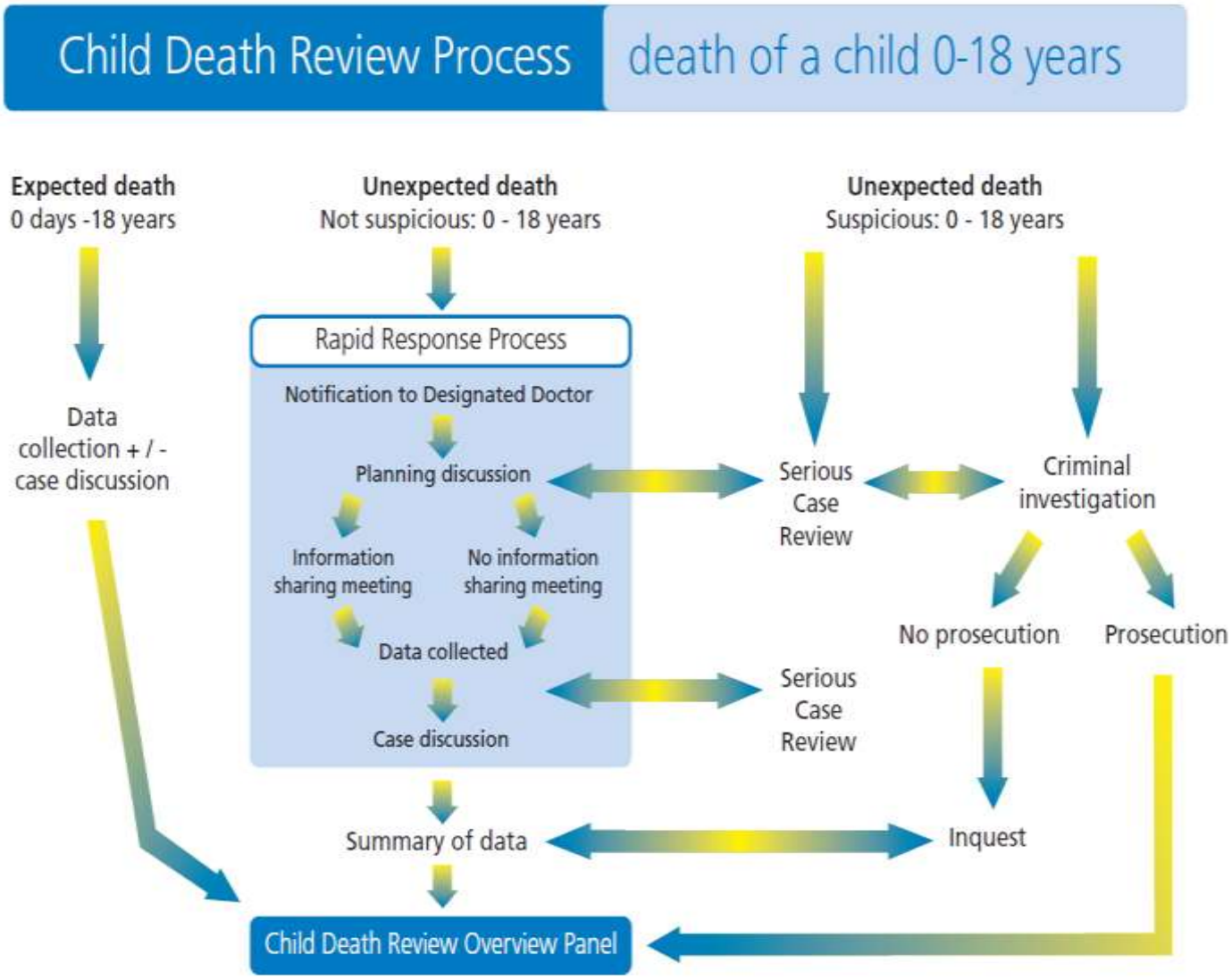


Fig. 1 - The Death Review Process

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 LSCB
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
Shelley Hudson	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

	2013/14	2014/15	2015/16	2016/17	2017/18	5 year average
Northumberland	12	15	19	12	13	16
North Tyneside	8	13	4	12	9	9
Newcastle	25	24	13	13	16	16
Out of Area	0	0	0	0	0	0
North of Tyne Total	45	52	36	37	38	41

The average number of child deaths that have been reviewed across the North of Tyne over the past 5 years is 41.

In 2017/2018 there were a total of 38 child death reviews across Northumberland, North Tyneside and Newcastle (North of Tyne). Since the annual report in 2013/2014 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	
	2013/14	2014/15	2015/16	2016/17	2017/18	North of Tyne	England
0-27 days	21	20	11	14	18	41%	N/A
28 days- 364 days	12	13	8	4	8	22%	N/A
1 year-4 years	8	9	6	5	4	15%	N/A
5-9 years	1	3	2	1	1	4%	N/A
10-14 years	2	4	6	6	2	10%	N/A
15-17 years	1	3	3	7	4	4%	N/A

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 38 deaths notified in 2017/18, the vast majority 29 (= 76%) occurred in hospital followed by 9 (=24%) in the home.

Gender

Table 3 – Gender of child

	2013/14	2014/15	2015/16	2016/17	2017/18	5-year average
Male	27	30	20	19	19	53%
Female	18	22	16	18	19	43%

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

Fig. 2 - Pattern of deaths by gender North of Tyne 2013-2018

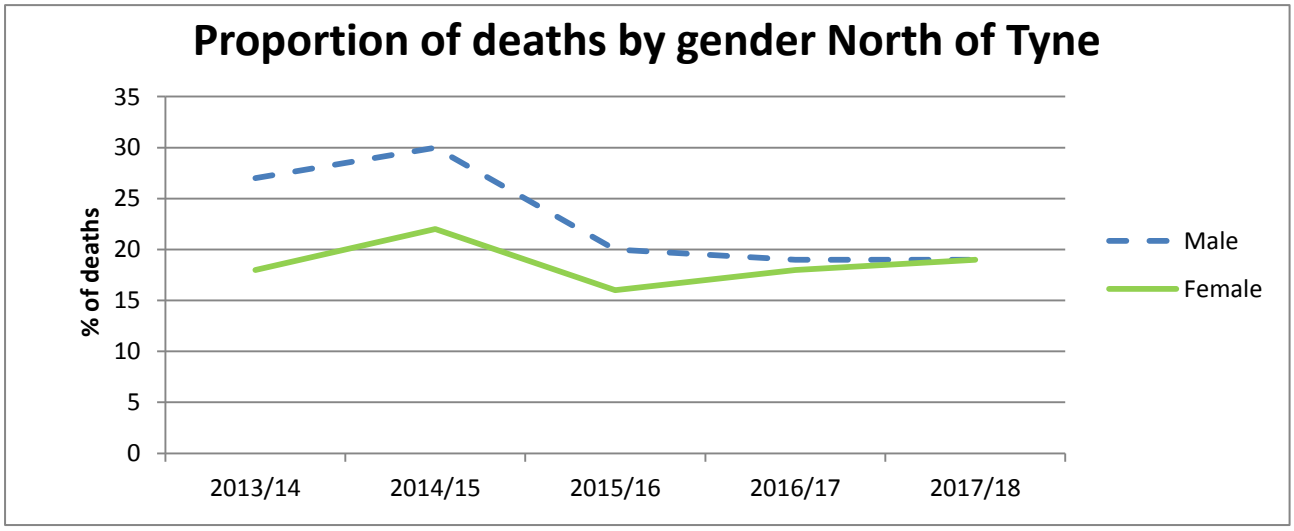


Table 4 - Number and % of deaths by ethnicity

Ethnicity (Broad)	13/14	14/15	15/16	16/17	17/18	Total (5yr)	% of deaths	% of population
White	35	43	30	32	34	174	83%	
Mixed	0	1	0	0	0	1	1%	
Asian	9	4	4	5	2	24	12%	
Black	2	3	1	0	2	8	4%	
Other	0	1	1	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 has been noted in previous CDOP annual reports and also fits with the national picture. NB this interpretation is from the 2016/2017 annual report. We have no current analysis of the 2017/2018 data.

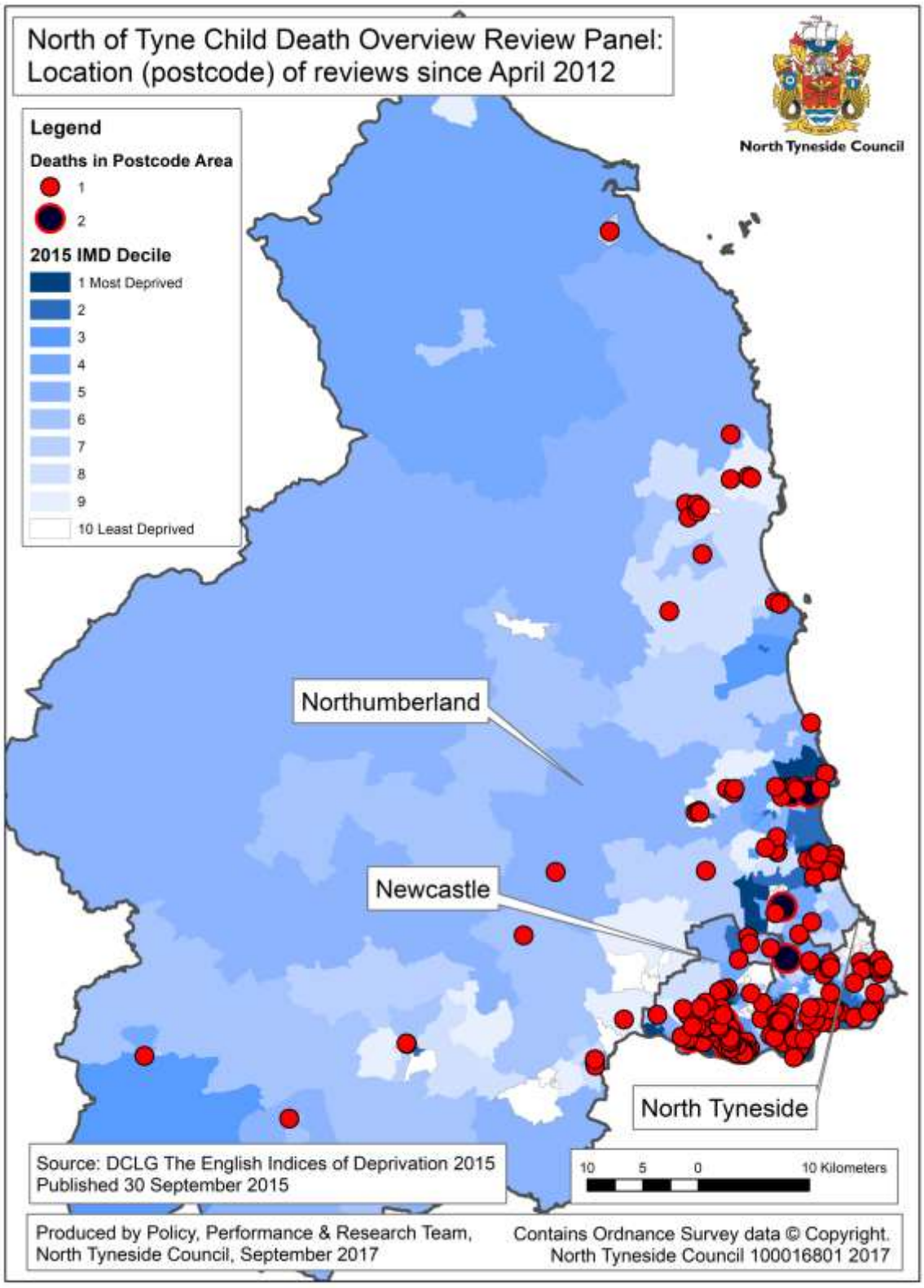
The CDOP commissioned a report on consanguinity which was received in June 2017 and a recommendation was made to the three boards.

The 24 deaths of Asian children in the 5 year period were in the following categories

Acute medical or surgical condition	1
Chronic medical condition	2
Chromosomal, genetic and congenital anomalies	13
Perinatal/neonatal event	6
Sudden unexpected, unexplained death	1
Malignancy	1

Deprivation

Fig. 3 - Child Deaths by geography and deprivation level, 2012-2017, South, Northumberland, North Tyneside and Newcastle



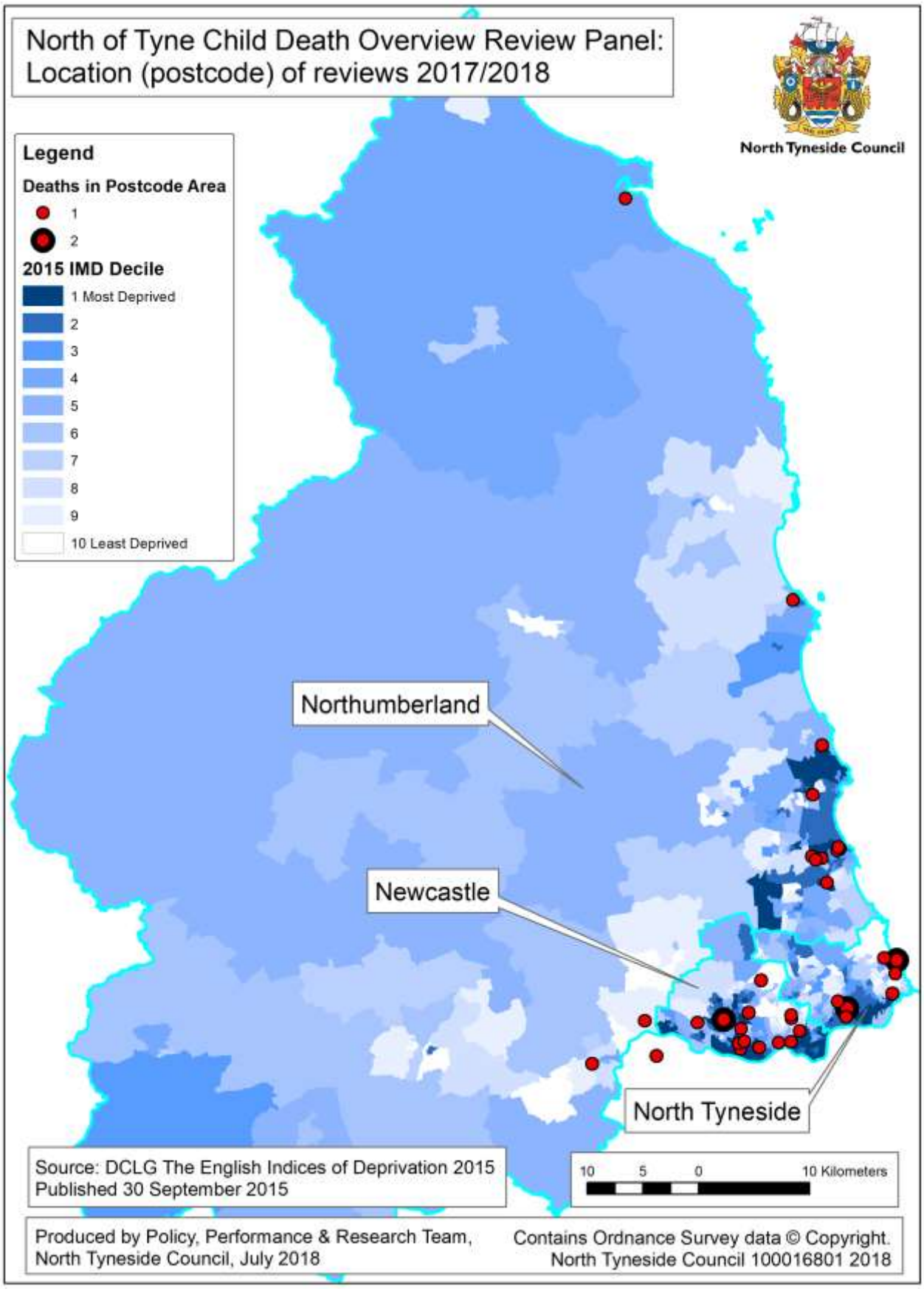

North of Tyne Child Death Overview Review Panel:
Location (postcode) of reviews 2017/2018
North Tyneside Council
Legend
Deaths in Postcode Area
1
2
2015 IMD Decile
1 Most Deprived
2
3
4
5
6
7
8
9
10 Least Deprived
Northumberland
Newcastle
North Tyneside
Source: DCLG The English Indices of Deprivation 2015
Published 30 September 2015
10 5 0 10 Kilometers
Produced by Policy, Performance & Research Team,
North Tyneside Council, July 2018
Contains Ordnance Survey data © Copyright.
North Tyneside Council 100016801 2018

Table 5 - North of Tyne child deaths reported to panel by deprivation decile, 2012-2017

Decile	Deaths
1 - Most deprived	44
2	22
3	20
4	29
5	25
6	14
7	11
8	11
9	13
10 - Least deprived	6

The above table does not include 2017/2018 data. Therefore a separate map for this year is included in this report (see above)

N.B. these data do not include out of area deaths or those where a deprivation score was unavailable.

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 2017/2018 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, 2017/18

July	Sept	Nov	Jan	March	Total
14	7	2	11	4	38

Timeliness and Frequency of CDOP Meetings

Working Together 2015 suggests that all cases should be reviewed by the panel within six 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 LSCBs 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 12th of the month, the review date for completion of the paperwork is also on the 12th of the month, six 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 six months of the death. The panel have not achieved this target in 17/18 (needs further explanation)

Timeliness of Reviews in the Last 5 Years

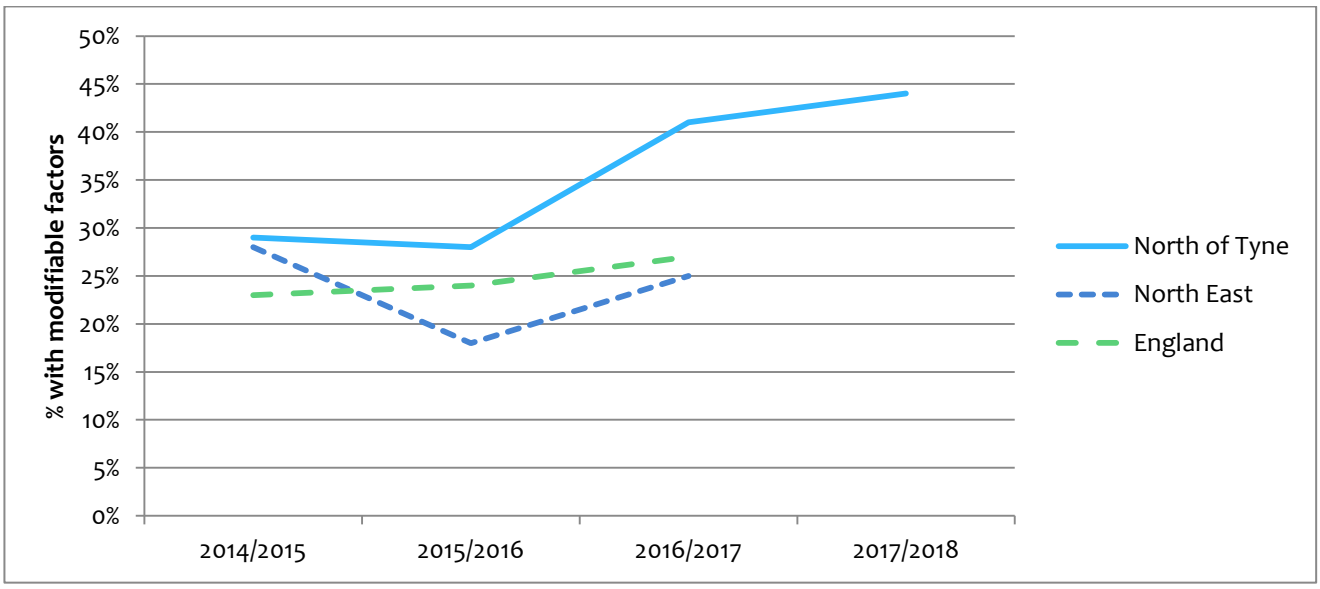
Although the timeliness of cases is important, it is recognised that other factors, e.g. serious case reviews, learning reviews and post mortem reports can have an impact on when a case is brought to panel.

Table 7 - Timeliness of reviews

Year	Number of cases Reviewed at panel	% of cases reviewed within timescale
2013/2014	45	24%
2014/2015	52	40%
2015/2016	36	56%
2016/2017	37	62%
2017/2018	38	55%

Modifiable Factors

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



National data not available for 2017/2018

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

Area	2014/15			2015/16			2016/2017			2017/2018			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	13	11	46%	9	4	31%	4	9	69%	9	7	44%	30	31	51%
Northumberland	13	2	13%	14	5	26%	10	2	17%	6	7	54%	43	16	10%
North Tyneside	11	2	15%	3	1	25%	8	4	33%	6	3	33%	28	10	26%
Out of Area	0	0	0%	0	0	0%	0	0	0%	0	0	0	0	0	0%
North of Tyne	37	15	29%	26	10	28%	22	15	41%	21	17	45%	106	57	35%
North East	113	44	28%	124	27	18%	118	39	25%	*	*	*	*	*	*
England Total	2688	827	24%	2802	863	24%	2601	974	27%	*	*	*	*	*	*

* National data not available

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, 51% of cases in Newcastle were identified as having modifiable factors compared with 26% in North Tyneside and 10% 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 38 cases reviewed in 2017/2018 modifiable factors were identified in 17 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.

In the 17 cases, the factors identified were:

- Consanguinity - First cousin marriages
- Poorly managed asthma treatment with a delay in ambulance reaching patient due to location of patient being withheld
- Co-sleeping and alcohol
- Three cases of maternal obesity as a risk factor for prematurity
- One case of smoking in pregnancy associated with prematurity
- Two cases of maternal smoking
- Poor engagement with healthcare services and maternal smoking

- Smoking in pregnancy. This case has also been recorded as potentially modifiable as it is possible a different mode of delivery would have avoided the shoulder dystocia and subsequent hypoxic insult to the infant.
- Smoking/Domestic Violence/Neglect/Unhygienic home environment
- Co-sleeping with alcohol and smoking.
- Opiate withdrawal and maternal smoking
- Co sleeping with alcohol and illegal drugs found in mothers system
- Sudden unexpected death in epilepsy. Lack of sleep may have contributed to a greater likelihood of a seizure.
- Lack of antenatal care sought by mother.

The panel looked at all cases where a modifiable factor was identified and it was noted that in eight cases smoking was a contributory factor:

1. Two cases of smoking in pregnancy associated with prematurity
2. Smoking in pregnancy. This case has also been recorded as potentially modifiable as it is possible a different mode of delivery would have avoided the shoulder dystocia and subsequent hypoxic insult to the infant.
3. Two cases of maternal smoking
4. Smoking/Domestic Violence/Neglect/Unhygienic home environment
5. Co-sleeping with alcohol and smoking
6. Co-sleeping with alcohol and illegal drugs found in mother's system

Panel members are tasked with taking the learning from these cases and sharing them widely within their organisations

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)

		2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	Proportion	Prop', Eng
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	0	1	1	0	1%	*
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.	0	2	0	3	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).	0	1	0	3	0	2%	*
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.	1	4	2	5	3	7%	*
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.	4	2	3	0	2	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.	4	2	4	2	1	6%	*
7	**Chromosomal, genetic and congenital anomalies** - Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.	12	13	9	5	9	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).	19	16	11	13	16	36%	*
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.	3	5	5	3	1	8%	*
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).	3	7	1	2	5	9%	*

* National data not available yet

WHAT WE HAVE ACHIEVED

- The CDOP commissioned a report on consanguinity (cousin marriage) this was written by Rachel Nicholson, a member of the PH team at North Tyneside local authority and assisted by Jill Rennie, the CDOP coordinator; it was received by the panel in June 2017. The report recommended that each board "consider what more could be done to tackle the issue of consanguinity and in particular how they could work sensitively and appropriately with local BME communities". It was then presented to the 3 LSCBs for their consideration.

- The CDOP commissioned an audit of cases of suicide; this was written by Rachel Nicholson with the assistance of Jill Rennie and two panel members, Margaret Tench and Sue Kirkley. It was received by the panel in June 2107. The report recommended "each board could consider what more could be done to reduce suicide in young people and the role that partnerships can play, in particular local suicide prevention partnership groups and young people mental health partnerships". It was presented to the 3 LSCBs in for their consideration.

- The chair of the panel was interviewed for the Newcastle Ofsted inspection in May 2017. The report commented that the CDOP had a "learning approach to improving its function and effectiveness. Information and data is used effectively to identify and act on areas for learning and development".

- The panel contributed to the consultation on WT and submitted its views online on the proposed changes to the Child Death process.

- The format of the quarter reports was amended and was well received by the boards

- In January 2018 David Galloway a doctor at the neonatal department at Newcastle hospitals presented an audit of RVI Neonatology cases.

- As members of the national CDOP network we contributed to a research project on SIDS from Warwick University. The study will help to demonstrate current English practice in classification of deaths and help produce guidance to standardise procedures.