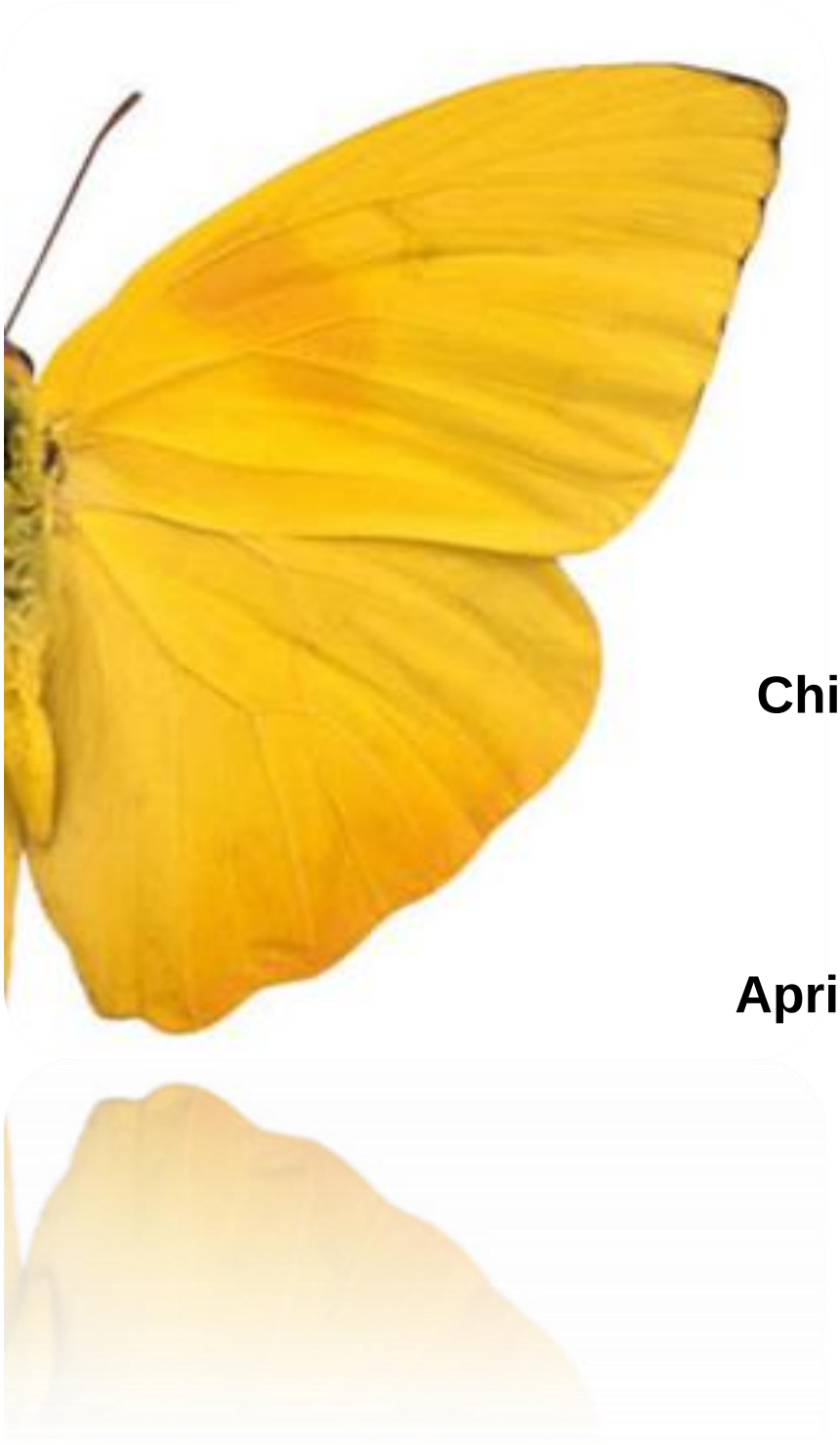


North of Tyne

Child Death Overview Panel

Annual Report

April 2015 - March 2016

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 6 times within the timeframe of this annual report (April 2015 - March 2016) and has enjoyed very good multi-agency attendance. It has been the first full year of my chairmanship and I have been 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 whom we could not fulfil our task.

We have continued to welcome observers from the constituent agencies and there have been 4 such observers this year, from nursing and medicine.

Two new members have joined the panel, a neonatologist and a senior midwifery manager, which has enhanced our discussions, challenge and learning. Panel membership is listed on pages 7&8.

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.

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.

Inspection

Northumberland Children's Social Care services were inspected by Ofsted in February 2016 which includes an interview of the CDOP Chair. I am pleased to report that the Inspectors concluded…."the CDOP is well-regarded and……..is efficient. Child death reviews considered by CDOP have led to focused work on safe sleeping and this issue is now considered at all ICPCs concerning unborn and new born babies".

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

Thanks must go to Paul Madill Consultant in Public Health who interpreted and presented the data and Mark Rice data analyst NTCCG who analysed the data in this report and also thanks to Bev Harris and Neil Tait from North Tyneside Council for the maps and deprivation data.

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

EXECUTIVE SUMMARY

We are pleased to report that the timeliness of reviews of child deaths continues to improve in the North of Tyne area.

This year, we have looked at data trends and compared aggregated data between North of Tyne, England and, where possible, the North East. Some key findings are:

Child deaths tend to cluster in certain age bands, and when we looked at this we found that the pattern was similar to that for England. This was also true of the pattern of deaths by gender and by place of death.

We found some surprising patterns in deaths by ethnicity in the North of Tyne area, and we will be doing some work to consider the implications of these patterns

For the first time, we have included a map to show deaths by geography. This helps us to target messages in relation to lessons learned from child death reviews.

We also found an association between high levels of deprivation and high rates of child deaths. This was particularly striking when we compared decile 1 (high deprivation) with decile 10 (low deprivation). Although they have the same population (12% v. 13%), decile 1 accounted for 21% of all deaths, compared with decile 10 (4%)

No patterns of note were found in either trends or national comparisons of the categories of deaths or the percentage where modifiable factors were identified. In all, ten deaths were identified as having modifiable risk factors, and the lessons learnt from these - outlined on page 16 below – will be widely disseminated to try to reduce risks in the future.

Priority actions as a result of this review include:

- An in-depth look at the data on death by disability
- The development of performance dashboards for the 3 LSCBs to commence April 2017
- To continue to monitor the timeliness of reviews against a target: 60% of form Cs should be logged with the coordinator within six months of the death. * (see page 14 for an explanation)
- To ensure that local needs assessments and health strategies are informed by the variation in child death rates by deprivation decile.
- An in-depth review of child deaths in the Asian community, including approaching other areas where similar patterns may exist
- To exchange information and intelligence with the South of Tyne CDOP area in order to maximise learning and improve outcomes

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 2015/16, 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.

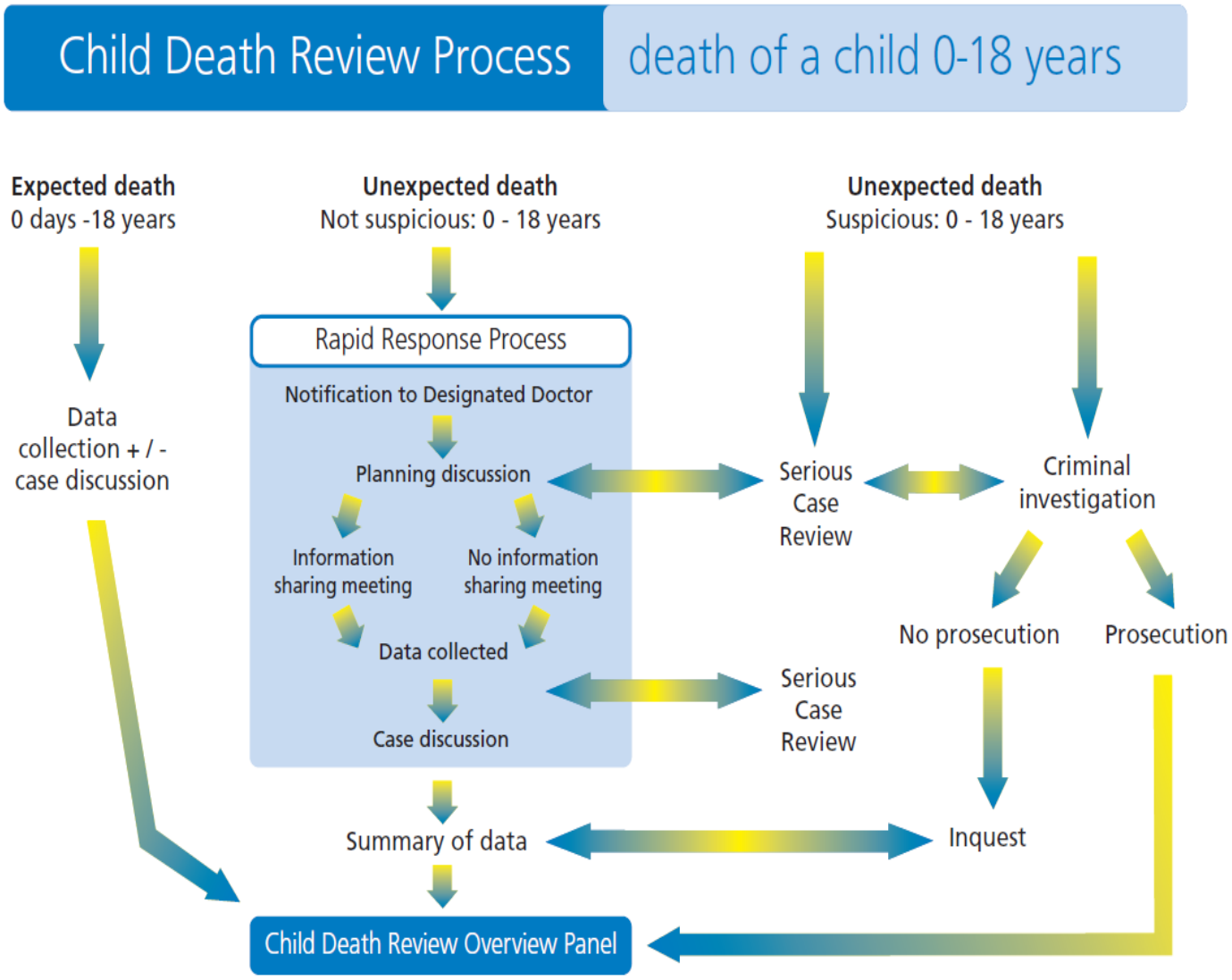
Where a death is unexpected a series of rigorous investigations take place, including a post-mortem. In such cases a multi-agency meeting (known as a Local Case discussion Meeting) is held to establish, as far as possible, the cause of death and plan future support for the family. This process usually 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 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 Serious Case Review 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(from Sep 2015 – previously Steve Day)	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 (previously John Douglas)	Detective Chief Inspector, Safeguarding Department Northumbria Police
Caroline Ruddick	Lead Midwife Safeguarding Children (RVI)
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 (from Sept 2015)	Consultant Neonatologist
Janice McNichol (from Sept 2015)	Lead Midwife Safeguarding Children Northumbria

CHILD DEATH DATA

Table 1 – Total number of child deaths reviewed

	2011/12	2012/13	2013/14	2014/15	2015/16	5 year average
Northumberland	10	15	12	15	19	14
North Tyneside	10	7	8	13	4	8
Newcastle	9	20	25	24	13	18
Out of Area	1	1	0	0	0	0
North of Tyne Total	30	43	45	52	36	41

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

In 2015/2016 there were a total of 36 child death reviews across Northumberland, North Tyneside and Newcastle (North of Tyne). Since the annual report in 2011/2012 the number of child deaths have increased year on year except in 2015/2016, this is detailed in table above. The national trend shows a decrease year on year until 2015/16, when there was a rise from 3515 to 3665. Overall this represents a national decrease of about 10%, but a local increase of just over 20%. Given the low numbers involved, this may not be a significant difference, but this is worth monitoring in case this changes

Table 2 – Age of child at time of death

						5 year proportion	
	2011/12	2012/13	2013/14	2014/15	2015/16	North of Tyne	England
0-27 days	12	23	21	20	11	42%	44%
28 days- 364 days	7	8	12	13	8	23%	22%
1 year-4 years	5	7	8	9	6	17%	12%
5-9 years	3	0	1	3	2	4%	7%
10-14 years	1	2	2	4	6	7%	7%
15-17 years	2	3	1	3	3	6%	9%

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.

Given the small numbers in each age group, it is hard to discern trends in these data. However, 3 year rolling averages suggest that this pattern remains fairly stable with about 47% of child deaths being in the 0-28 day range and about 23% between 4 weeks and one year of age. This is consistent with the national picture.

The age group with the second highest mortality nationally is when a child reaches the years of 15 - 17. The rolling 3-year average has remained steady at 5% of all childhood deaths taking place in this age group. This is lower than the national proportion for this age group, which is 9%

Place of Death

Of the 36 deaths notified in 2015/16, the vast majority (30= 83%) occurred in hospital followed by 5 (=14%) in the home. This compares to national figures of 68% and, 22% respectively.

Gender

Table 3 – Gender of child

	2011/12	2012/13	2013/14	2014/15	2015/16	5-year average
Male	16	25	27	30	20	24
Female	14	18	18	22	16	18

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

Fig. 2 - Pattern of deaths by gender, North of Tyne v. England, 2012-2016

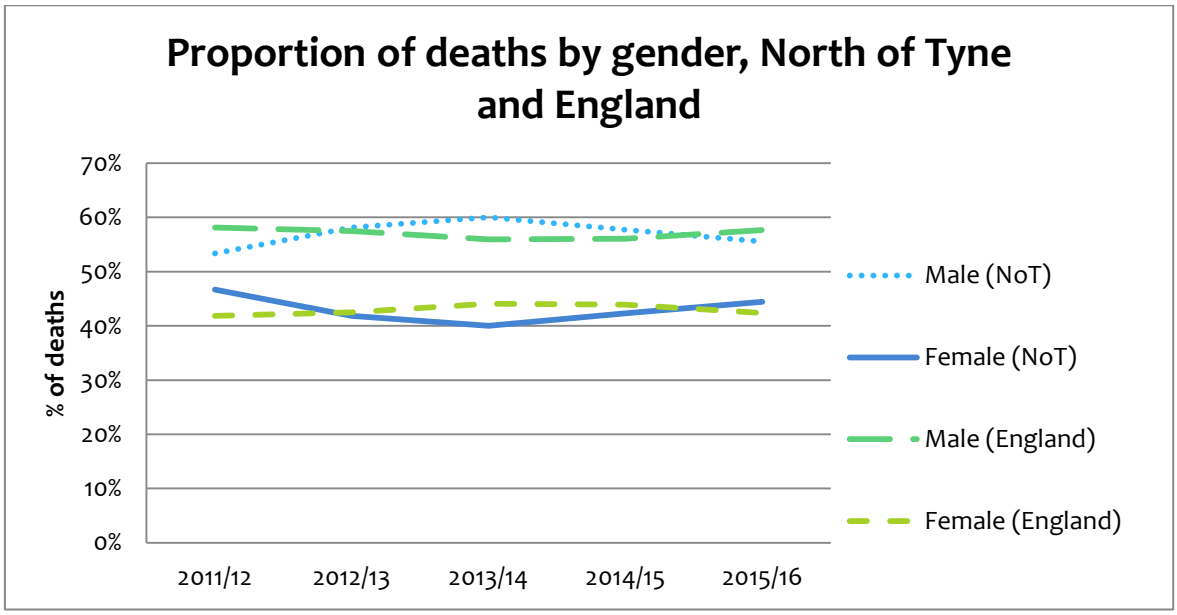


Table 4 - Number and % of deaths by ethnicity

Ethnicity (Broad)	11/12	12/13	13/14	14/15	15/16	Total (5yr)	% of deaths	% of population
White	26	35	34	43	30	168	82%	93%
Mixed	1	0	0	1	0	2	1%	1%
Asian	3	6	9	4	4	26	13%	4%
Black	0	0	2	3	1	6	3%	1%
Other	0	0	0	0	1	1	0%	1%
Unknown	0	2	0	1	0	3	1%	0%

Although the numbers are small, there appears to be a big over-representation in Asian children in these death statistics in comparison to their numbers in the population.

The 26 deaths of Asian children in the 5 year period were in the following categories

Acute medical or surgical condition	3
Chronic medical condition	2
Chromosomal, genetic and congenital anomalies	16
Perinatal/neonatal event	4
Sudden unexpected, unexplained death	1

The relatively high proportion of deaths relating to chromosomal abnormality in this population (65% v. 25% for the overall population) may be related to cousin marriages (consanguinity). Consequently one of our actions going forward will be to consult with other areas who may have particular knowledge and experience of this issue, such as Bradford.

Deprivation

Fig. 3 - Child Deaths by geography and deprivation level, 2011-2015, South, Northumberland, North Tyneside and Newcastle

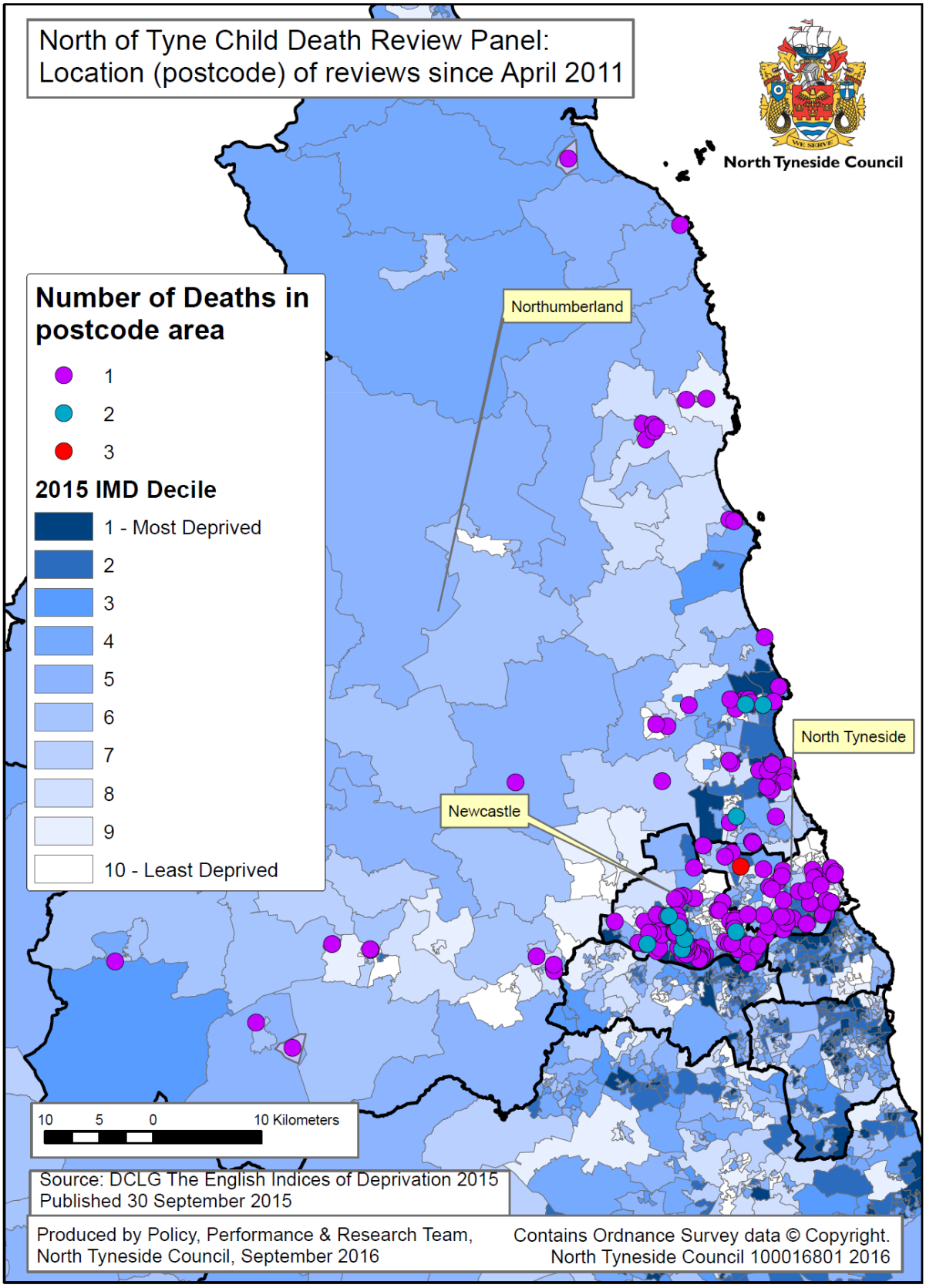


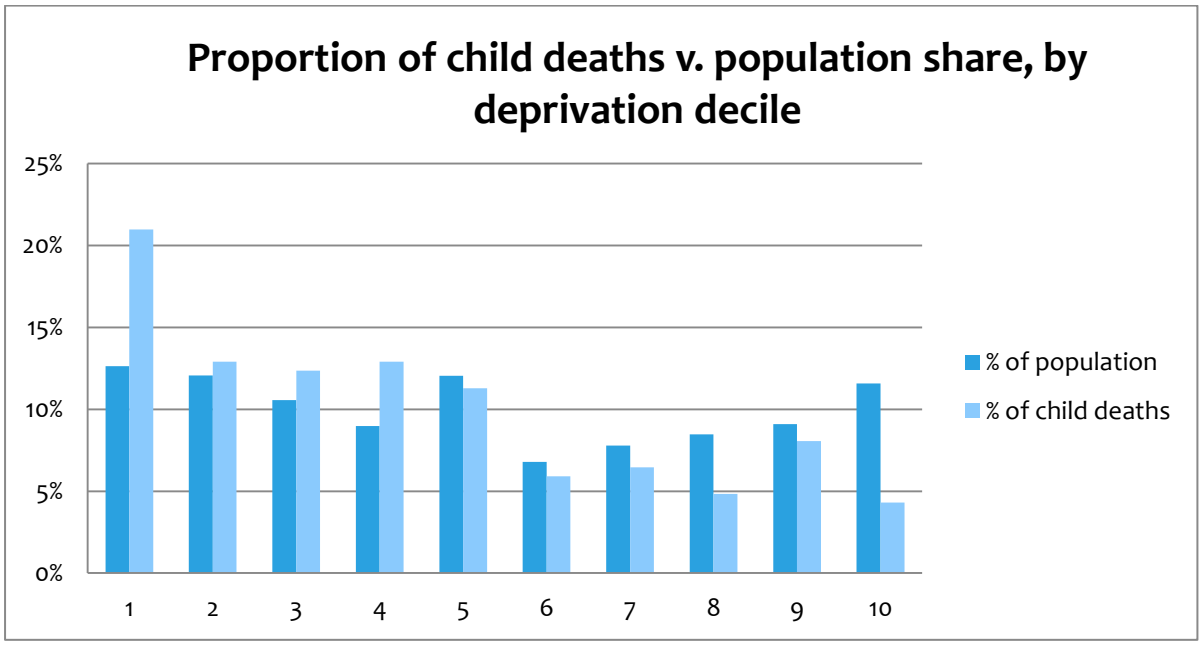
Table 5 - North of Tyne child deaths reported to panel by deprivation decile, 2011-2015

Decile	Deaths
1 – Most deprived	39
2	24
3	23
4	24
5	21
6	11
7	12
8	9
9	15
10 – Least deprived	8

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.

Fig. 4 - Proportion of deaths by deprivation decile in North of Tyne, 2011-2016



It is particularly striking that decile 1 accounts for 21% of child deaths as compared to only 4% for decile 10, given they have a similar population share (13% v. 12%)

Timeliness of Reviews in the Last 4 Years

The indicative timescale referred to in Working Together 2015 is that cases should be reviewed by the CDOP within six months. The figures for the last four years are outlined below.

Table 6 - Timeliness of reviews

Year	Number of cases Reviewed at panel	% of cases reviewed within timescale
2011/2012	30	30%
2012/2013	43	30%
2013/2014	45	24%
2014/2015	52	40%
2015/2016	36	56%

The figures above show that there has been a significant improvement in the indicative target of reviewing cases within six months of the death apart from in 2013/2014. 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.

CDOP Panel

In 2015/2016 the panel met 6 times. Below is a table showing the number of cases reviewed at each meeting.

Table 7 - Number of reviews at each meeting, 2015/16

May	July	Sept	Nov	Jan	March	Total
8	7	7	2	6	6	36

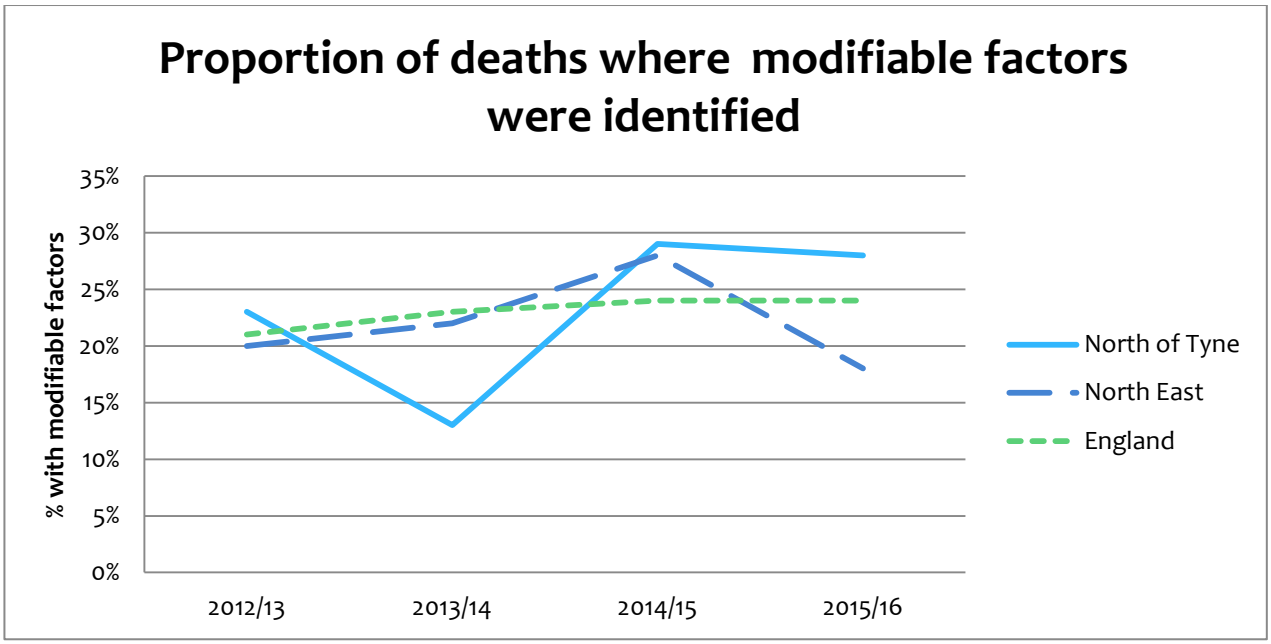
Timeliness and Frequency of CDOP Meetings

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.

Modifiable Factors

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



The proportion for North of Tyne and the region fluctuate around the national figure year on year. This is to be expected given the very small numbers involved. When we looked at aggregate figures over the last 4 years, there was very little difference: 23% for North of Tyne, 22% for the region and 23% for England. The detailed numbers are presented in the table below.

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

Area	2012/13			2013/14			2014/15			2015/16			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	18	2	10%	20	5	20%	13	11	46%	9	4	31%	60	22	27%
Northumberland	9	6	40%	11	1	8%	13	2	13%	14	5	26%	47	14	23%
North Tyneside	5	2	29%	8	0	0%	11	2	15%	3	1	25%	27	5	16%
Out of Area	1	0	0%	0	0	0%	0	0	0%	0	0	0%	1	0	0%
North of Tyne	33	10	23%	39	6	13%	37	15	29%	26	10	28%	135	41	23%
North East	117	29	20%	123	35	22%	113	44	28%	124	27	18%	477	135	22%
England Total	3029	806	21%	2795	823	23%	2688	827	24%	2802	863	24%	11314	3319	23%

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, 25% of cases in Newcastle were identified as having modifiable factors compared with 15% in North Tyneside and 22% 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 36 cases reviewed in 2015/16 modifiable factors were identified in 10 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. on-the-job training.

In 3 of the cases unsafe sleeping arrangements were identifiable as modifiable, which was disappointing given the work undertaken by all agencies North of Tyne to promote safe sleeping (see last 4 CDOP Annual reports). It is worth noting, however that in two of the cases the babies died in 2013 and immediate action was taken by agencies to reinforce the safe sleeping messages. The cases are featured in this Annual report, delayed, due to other reviews which took precedence i.e. Serious Case Review.

It maybe that we will only be able to fully assess the impact of the public health messages about safe sleeping in subsequent years. It is certainly something on which the CDOP will keep a watching brief.

In the other 7 cases, the factors identified were:

- Consanguinity – First cousin marriages
- The need for the influenza vaccination for eligible children.
- Importance of early booking in pregnancy and good ante-natal care
- The risk to the unborn baby of exposure to cigarette smoke *
- The importance of early recognition of meningitis: a range of awareness-raising was undertaken with the agencies involved and the case details were shared with the group looking at sepsis.
- The importance of effective communication between the various health agencies: this case generated a great deal of discussion in the agencies involved in the child's care with aware-raising of the issues and a review of protocols. The case details were also shared with a group looking at sepsis.

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

1. Maternal smoking during pregnancy
2. Co-sleeping – smoking was also one of the factors
3. Co-sleeping – smoking was also one of the factors

It is recognised that smoking is a difficult issue to tackle but strategies are currently in place throughout primary care i.e. midwives repeating the question about maternal smoking at each visit. Mothers and fathers who do smoke are offered support to stop.

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)

		2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	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	0	0	1	1%	2%
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	2	0	2%	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).	3	0	0	1	0	2%	5%
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.	0	2	1	4	2	4%	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	4	4	2	3	8%	6%
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.	1	1	4	2	4	6%	5%
7	**Chromosomal, genetic and congenital anomalies** - Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.	7	11	12	13	9	25 %	26 %

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).	12	14	19	16	11	35 %	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.	1	4	3	5	5	9%	6%
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).	2	5	3	7	1	9%	8%

The proportion of deaths in each category in North of Tyne is comparable to the national picture

THINGS WE HAVE DONE

- The CDOP is part of the national network and as such can share learning from other CDOPs. The co-ordinator distributes this information to panel members for them to share within their respective agencies.

- The CDOP has shared anonymised information, with the permission of the family, with Derby CDOP who is planning to approach firms who manufacture nappy sacks to improve the safety of them. There have been several accidental deaths from nappy sacks nationally.

- One of our Designated Doctors presented to the panel recent research on why children die which looks at the negative impact of poverty on children's health and well-being. This is particularly relevant given the analysis on page 12.

- The panel contributed to the national review of LSCBs, which included CDOPs.

- Contributed to the Ofsted inspection of Northumberland's Children's services.

- Presented awareness-raising sessions to staff groups in the two main trusts; Newcastle and Northumbria. This includes highlighting the lessons learned from reviews.

- A new panel member provided a challenge to the panel on the robustness of the parental contribution to the process.

PRIORITIES FOR 2016/2017

1. Disabled children - We have never analysed this data in depth in previous annual reports but feel that although this might be difficult to categorise due to the spectrum of disability it would be beneficial to consider including this in our next annual report.

2. To develop performance dashboards for the 3 LSCBs to commence April 2017

3. To continue to monitor the timeliness of reviews against a target: 60% of form Cs should be logged with the coordinator within six months of the death.

4. To ensure that local needs assessments and health strategies are informed by the variation in child death rates by deprivation decile.

5. To investigate further the pattern of child deaths in the Asian community and to consult with other areas where high rates of consanguinity may contribute to increased child mortality.

6. To exchange information and intelligence with the South of Tyne CDOP area in order to maximise learning and improve outcomes.

7. To request an annual assurance report from relevant service providers that there is a robust monitoring system for the implementation for recommendations.