Child Death Overview Panel (CDOP) Annual Report

April 2020 - March 2021

North & South of Tyne

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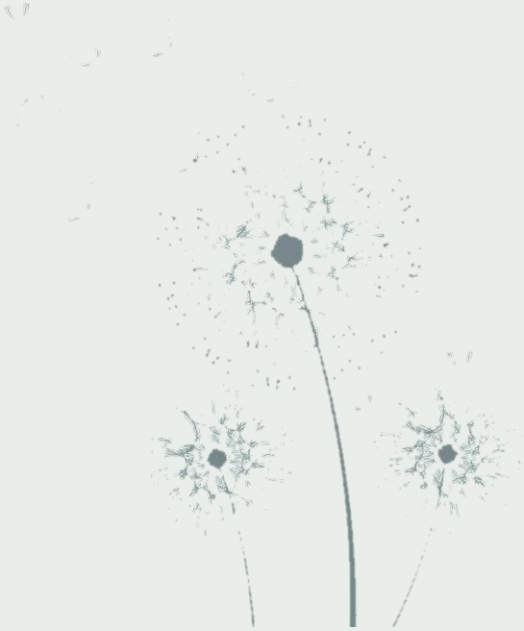


Foreword

Child Death Overview Panel Independent Chairperson (North & South of Tyne)

Welcome to the first annual report of the North and South of Tyne Child Death Overview Panel (N&S Tyne CDOP), which contains a summary of the activity carried out by the panel, activity which seeks to drive improvements in children and young people's health across the 6 areas represented: Gateshead, Newcastle, Northumberland, North Tyneside, South Tyneside and Sunderland.

As the chair I would like to extend thanks to the multi-agency Task and Finish group, whose work helped to steer the two former CDOPs to a merger in April 2020.

The Child Death process requires agencies to undertake a review process prior to the panel review. Thanks must go to all those frontline staff and their managers involved in this process, without whom we could not fulfil our task. Frontline staff are the ‘human face’ of the child death review process, supporting families at the most difficult time of their lives.

The statutory task of the multi-agency panel lies in its ability to scrutinise the circumstances surrounding each child's death and where appropriate, to provide challenge to the agencies involved to further enhance the learning, as well as make recommendations to the appropriate agencies to improve service delivery and patient experience.

It has been a challenging year, for as well as being a reconstituted panel, the Covid-19 restrictions have meant that all the panel meetings have been held virtually, plus we have embraced the facility in eCDOP which allows us to view cases in a new format and electronically. I would like to thank panel members for their forbearance as we navigated our way through these challenges.

We have also been cognisant of the impact of Covid-19 on the delivery of services, particularly in the health sector. We have encouraged frontline services to adhere to the requirement via eCDOP and the National Child Mortality Database (NCMD) to ensure timely (i.e. within 48 hours) notification of children's deaths in order that urgent action could be taken where necessary across the UK.

The North and South of Tyne panel met 8 times within the timeframe of this annual report (April 2020 - March 2021) and has enjoyed very good multi-agency attendance. We have continued to welcome observers to the panel from the constituent agencies and there have been 7 such observers this year from nursing, medicine and safeguarding.

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

Introduction

1.1 The death of a child is a devastating loss which profoundly affects all those involved. Since April 2008 all deaths of children up to the age of 18 years, excluding stillbirths and planned terminations are to be reviewed by CDOP to comply with the statutory requirement set out in Working Together 2018. In the event that a birth is not attended by a healthcare professional, child death partners may carry out initial enquiries to determine whether the baby was born alive. If the baby was born alive then the death must be reviewed.

1.2 The Children Act 2004 requires Child Death Review Partners, (5 CCGs and 6 Local Authorities in our footprint) to ensure arrangements are in place to carry out child death reviews, including the establishment of a CDOP. The reviews are conducted in accordance with Working Together 2018 alongside the Statutory and Operational Guidance (England) 2018.

1.3 The North and South of Tyne CDOP panel is multi-agency and the process is carried out for all children resident in the 6 Local Authority areas listed in the foreword. Legislation allows for CDR partners to make arrangements for a review of a death of a child not normally resident there. This process needs to be pragmatic with consideration given to where the most learning can take place.

1.4 In April 2019 the National Child Mortality Database (NCMD) became operational and is populated directly with the relevant data from eCDOP, a cloud-based information management system commissioned by the CDR partners for use across our footprint.

1.5 The purpose of the panel is to:

- Ascertain why a child has died by a thorough but proportionate review of the facts and circumstances surrounding the death
- Determine the contributory and modifiable factors
- To make recommendations to all relevant organisations where actions have been identified which may prevent further deaths or promote the health, safety and well-being of children
- Provide detailed data to NCMD which they analyse nationally and produce regular reports e.g. on the impact of deprivation on child deaths.
- Produce an annual report highlighting local trends and patterns and any actions taken by the panel
- Contribute to the wider learning locally, regionally and nationally.

The CDOP is not commissioned to undertake public health campaigns or deliver interventions arising from the learning from reviews, rather it relies on its' partners in the Health and Well-being Boards and the Safeguarding Children Partnerships to incorporate the lessons learned into policy and develop appropriate interventions.

The Process of the Child Death Overview Panel across North & South of Tyne

Northumberland, North Tyneside, Newcastle, Gateshead, South Tyneside and Sunderland work together via the North and South 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 2020/21, regardless of the year in which the child died.

When a child dies, an appropriate clinician will, in liaison with other professionals make immediate decisions on whether a Medical Certificate of Cause of Death (MCCD) can be issued or whether a referral is required to the coroner.

Where a death is, for example, from a life-limiting 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 requires a series of rigorous investigations, including a post-mortem, a multi-agency meeting, known as a Joint Agency Response (JAR) is held to establish, as far as possible, the cause of death and plan future support for the family. A Child Death Review meeting (CDRM) follows once all the information is available and is then collated and presented to the Child Death Overview Panel.

The CDOP will in each case classify the cause of death, identify contributory factors, identify any modifiable factors (those which can be changed through national or local interventions) and make recommendations to prevent future similar deaths, or improve the safety and welfare of children in the local area and further afield.

The Children and Social Work Act 2017 ended the requirement for serious case reviews when the LSCB converted into the new multi-agency safeguarding arrangement. Following the ending of the LSCB the new Multi-Agency Safeguarding Arrangements must comply with the requirements outlined in the legislation and Working Together 2018 to undertake, Child Safeguarding Practice Reviews (CSPRs) which can be locally or nationally led and overseen by a national panel. The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children.

The CDOP need to consider whether the criteria for a local or national SPR might be met in certain cases, even if it has already been considered by the SCP, and to make recommendations appropriately.

Learning Reviews can also be undertaken. In 2020/2021 there were no cases subject to a SCPR and one case subject to a learning review.

The Child Death Review process recommends that panels undertake themed panels, in January 2021 the panel held its first neonatal themed panel with added expertise from obstetric services. Panel members were very positive about the range of learning which occurred whist focussing on one category of child death. There are plans to undertake two neonatal themed panels in 2021/22.

Membership of the Child Death Overview Panel

Named Representative	Agency/Title
Sheila Moore	Independent Chair
Jill Rennie	North of Tyne CDOP Coordinator
Dr Richard Hearn	Consultant Neonatologist NUTH
Dr Anna Thorley	Designated Doctor Child Deaths Newcastle
Dr Stephen Bruce	Designated Doctor Child Deaths Northumberland & North Tyneside
Dr Maryam Rehan	Designated Doctor Child Deaths Gateshead
Dr Sunil Gupta	Designated Doctor Child Deaths South Tyneside
Dr Carl Harvey	Designated Doctor Child Deaths Sunderland
Nichola Howard	Named Professional Safeguarding North East Ambulance Service
Trina Holcroft	Designated Nurse Safeguarding Children, Newcastle and Gateshead
Jan Hemingway	Designated Nurse Safeguarding Children, North Tyneside
Jenna Wall/Lesley Heelbeck	Head of Midwifery Northumbria/Head of Midwifery Gateshead
Louise Cass-Williams	Northumbria Police
David Garner	Practice Manager ISIT (Social care)
Dawn Hodgson	Children's Services Manager
Wendy Burke	Director of Public Health (DPH) North Tyneside Council

Tom Hall	Director of Public Health (DPH) South Tyneside Council
Dr Therese Hannon	Consultant Obstetrician (Themed Panel Member)
Tracey Hadaway	South of Tyne CDOP Coordinator

Examples of actions taken to reduce child deaths across the CDOP footprint.

South Tyneside

South Tyneside Safeguarding Children and Adult Partnership ran a number of multi-agency briefing sessions to support Safer Sleep Week 2021. This included the promotion and awareness raising of the safer sleep message and the support services available to parents and professionals in South Tyneside.

Three sessions were held with the invaluable support of a range of professional speakers from the following agencies:

- Lullaby Trust,
- South Tyneside and Sunderland NHS Foundation Trust, Health Visiting, Midwifery and Chaplaincy services
- South Tyneside Clinical Commissioning Group, Named Nurse primary care and Designated Nurse

The sessions were positively received by the audiences.

- An example of timely dissemination of learning from reviews is the inclusion of lessons learned from the death of a child with asthma. The learning was included in the public health messages on World Asthma Day on 4th May 2021. This event falls out of the timescale of this report but it's important that it is acknowledged.

North Tyneside

UNICEF AWARD

The NTC 0-19 service has been awarded the UNICEF Baby Friendly Initiative (BFI) Achieving Sustainability award. This is the highest level of award given to services that meet a holistic, child rights-based set of standards which provide parents with the best possible care to build close and loving relationships with their baby and feed them in ways to support optimal health and development.

Gateshead

- The deaths where children had not received their flu vaccine and the processes around consent and follow up was raised by the Consultant in public health in Gateshead with NHSE, who are now reviewing the consent process and exploring ways to improve planning of the flu programme at a local level.

- Advice is given to all new parents on: thermoregulation, safe sleeping, car safety, advice on bottle and breast feeding, when to seek advice when there

are concerns about the babies and all parents of preterm babies are signposted to the 'BLISS' website.

Sunderland

ICON is an evidence-based programme which has been supported by NHSE (National Health Service England) to reduce abusive head trauma in infancy (ABH) which is100% preventable. ICON aims to provide advice consisting of a series of brief ‘touchpoint’ interventions that reinforce the simple message making up the ICON acronym.

I – Infant crying is normal
C – Comforting methods can help
O – It’s OK to walk away
N – Never, ever shake a baby

Training to deliver the ICON message has been provided across the 5 touchpoints to Midwives, Health Visitors and GPs across Sunderland. Resources provided included leaflets, stickers, posters, and banners all embedded with the QR code to provide direct access to the ICON website. Training has also been provided to the Family Nurse Partnership, Practice Nurses, Social Prescribers and some GP practices have accessed individual sessions as well.

Partner agencies have also been provided with bespoke sessions and included Together for Children; Pre-Birth Team and Early Help, Perinatal Mental Health Team for Cumbria, Northumbria and Tyne and Wear Mental Health Services. Further training is planned for Adoption and Fostering Teams and Best Start in Life.

This has now been rolled out across all six areas represented at the panel.

Northumberland

Following the death of a young person after ingesting MDMA which highlighted a lack of first aid knowledge amongst young people, the substance misuse team worked with public health to deliver sessions in schools across the county on recognising signs of substance misuse and first aid.

Newcastle

There was learning from a review of a child who had died of asthma which identified there is limited awareness in general population and among healthcare professionals of the risk of Anaphylaxis in individuals with food allergies and moderately severe asthma. This was shared at a Designated Professionals and Named GP meeting where ideas were shared as to how awareness of this issue could be improved. A question on food allergies is being incorporated into existing asthma review templates with additional work to raise awareness of this in primary care.

A system-wide intervention

The local ICS/Maternity Systems Prevention Team has worked with providers to develop a consistent offer to shift from individual organisations delivering components of maternity care to a whole-system approach, in partnership with families.

Headline findings are:

- Measurable impact on tobacco use in pregnancy through providing a consistent approach and changing the narrative around dependency
- A pathway, screening tool and training package on alcohol use in pregnancy
- Enhanced breastfeeding support through a regional multi agency strategy and pathway which is underpinned by UNICEF accreditation planning
- Pathway development and training to assist in identification of need of perinatal mental health support
- Development of an immunisation delivery model delivered and led by maternity in the acute settings

Some of the initiatives have been impacted by Covid-19 restrictions but as soon as the situation changes the programmes will be rolled out in full.

NHS England webinars

In the last year NHS England has held two webinars with the aim of disseminating good practice and learning from reviews. The webinar in October 2020 focussed on young babies and infants and Richard Hearn, our panel neonatologist's presentation posed the question: 'How well do people understand the contributory factors?'

The second webinar in March 2021 presentations included learning around consanguinity plus insights on current research around safe sleeping.

We welcome the support from NHS England and look forward to further webinars in the future.

NCMD webinars

There have been several webinars from NCMD which are available to all professionals on their website. They have been widely attended with one focussing on the recent report on the link between deprivation and child deaths.

Training package

Two panel members collaborated to produce an updated training package which is available to local agencies to deliver to multi-agency groups of staff.

Impact of CDR process nationally

The 58 CDOPs contribute data nationally which is then used to develop themed reports and inform professionals and policy makers, highlights from this work includes:

- Continued sharing of real-time child death data with NHS England to support and inform the national response to COVID-19 pandemic.

- NCMD webinar featuring Professor Simon Kenny, NHS England, held to demonstrate impact of CDR data, Jan 2021.

- Safety notices shared on postnatal care/bed-sharing, baby slings and open windows

- 33% increase in sector-specific representation on Public Involvement group, with charities representing suicide, poverty, cancer, neonates, SUDI, infection, trauma and chromosomal, genetic and congenital anomalies now represented. Expansion of group membership by 39% following introductory event in Feb 2021

Child Death Data

Table 1 – Total number of child deaths reviewed

	2020/21	Percentage
Northumberland	20	24%
North Tyneside	5	6%
Newcastle	23	28%
Gateshead	16	20%
South Tyneside	4	5%
Sunderland	14	17%
Out of Area	0	0%
North and South of Tyne Total	82	100%

In 2020/21 there were a total of 82 child death reviews across Northumberland, North Tyneside, Newcastle, Gateshead, South Tyneside and Sunderland (North and South of Tyne).

Table 2 – Age of child at time of death

	2020/2021	Percentage
0-27 days	37	45%
28 days- 364 days	13	16%
1 year-4 years	10	12%
5-9 years	7	8%
10-14 years	7	8%
15-17 years	8	10%

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

Table 3 - Place of Death

	2020/2021	Percentage
Hospital	66	80%
Home	9	11%
Hospice	3	4%
Public Area	3	4%
Private Care Home	1	1%

Table 4 – Gender of child

	2020/2021	Percentage
Male	46	56%
Female	36	44%

Table 5 - Number and % of deaths by ethnicity

Ethnicity (Broad)	2020/2021	Percentage
White	71	87%
Mixed	2	2%
Asian	8	10%
Black	1	1%
Other	0	0%
Unknown	0	0%

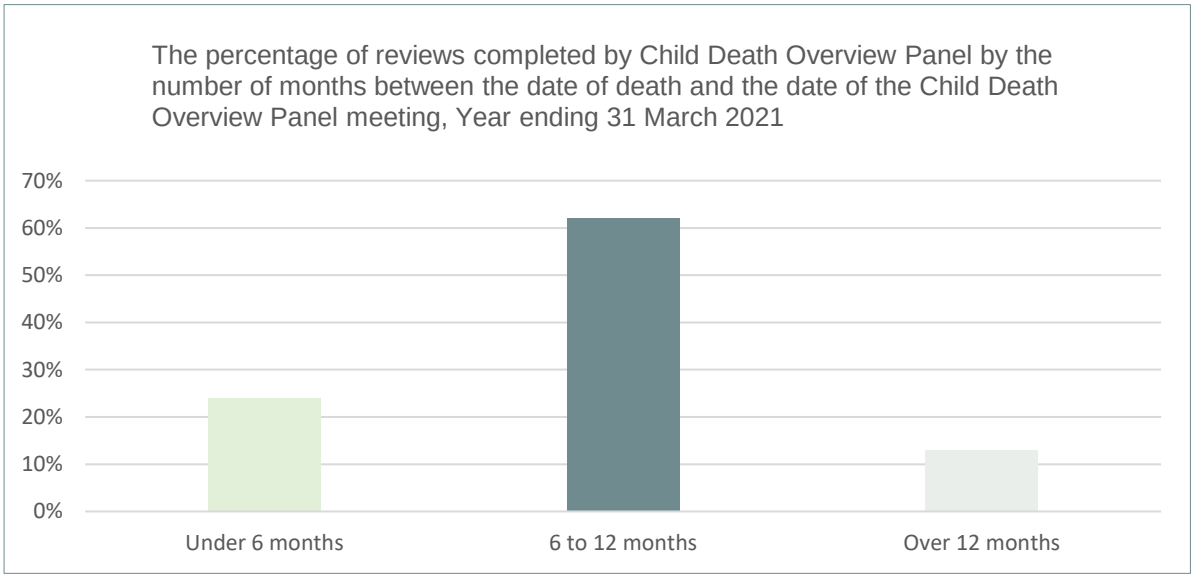
CDOP Panel

In 2020/2021 the panel met 8 times. Below is a table showing the number of cases reviewed at each meeting. April panel was the first merged panel which was held to review and agree the terms of reference.

Table 6 - Number of reviews at each meeting, 2020/21

April	May	June	Aug	Oct	Dec	Jan	Feb	Total
0	11	13	14	12	8	15	9	82

Table 7 - Duration of Reviews 2020/21



In this year 24% of reviews were finalised within 6 months of the child's death, while 62% were completed between 6-12 months and 13% took over a year.

The national data highlighted that 17% of reviews took less than six months to complete, 39% of reviews took between six and twelve months to complete and 44% took over twelve months to complete.

There are a number of factors that may contribute to a longer length of time between the death of a child and the final CDOP review. Examples are: the return of reporting forms, the receipt of the final post mortem report, undertaking a criminal investigation or a Child Safeguarding Practice Review and receipt of the final report from the local child death review meeting. In addition, on occasion when the outcome of a Coroner's inquest is awaited, there may be a longer delay before the panel can finalise the review process.

We are not achieving our targets due to late PM reports, which has been a recurring issue. The providers of the pathology service are aware of the problems which will continue to create delays. There is a national shortage of paediatric pathologists and we are currently recording the delay on an individual case-by-case basis with NCMD in order that they can monitor this nationally. It has also been flagged with commissioners.

In 2019 the CDOP received a challenge from North Tyneside Clinical Commissioning Group (NTCCG) on the validity of the data we were providing around duration of reviews. This led to a consultation with CCG staff who have worked with panel members to develop relevant data collection and analysis. This has led to improved performance reports which will be scrutinised at each panel meeting in order that we maintain a focus on and a challenge to the process.

Modifiable Factors

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

Area	2020/2021			
	Total number of cases	No modifiable factors	Modifiable factors	% with modifiable factors
Newcastle	23	18	5	22%
Northumberland	20	11	9	45%
North Tyneside	5	5	0	0%
Gateshead	16	10	6	37%
South Tyneside	4	2	2	50%
Sunderland	14	9	5	36%
Out of Area	0	0	0	0%
North & South of Tyne	82	55	27	33%

The review process is required to identify deaths where modifiable factors occur, in order that agencies learn lessons, improve practice and ultimately prevent further deaths.

Of the 82 cases reviewed in 2020 /2021, modifiable factors were identified in 27 cases, and in four cases, several factors were deemed modifiable.

NCMD national data shows the North East rate was 31% and the national rate was 34%.

A modifiable factor is defined 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”.

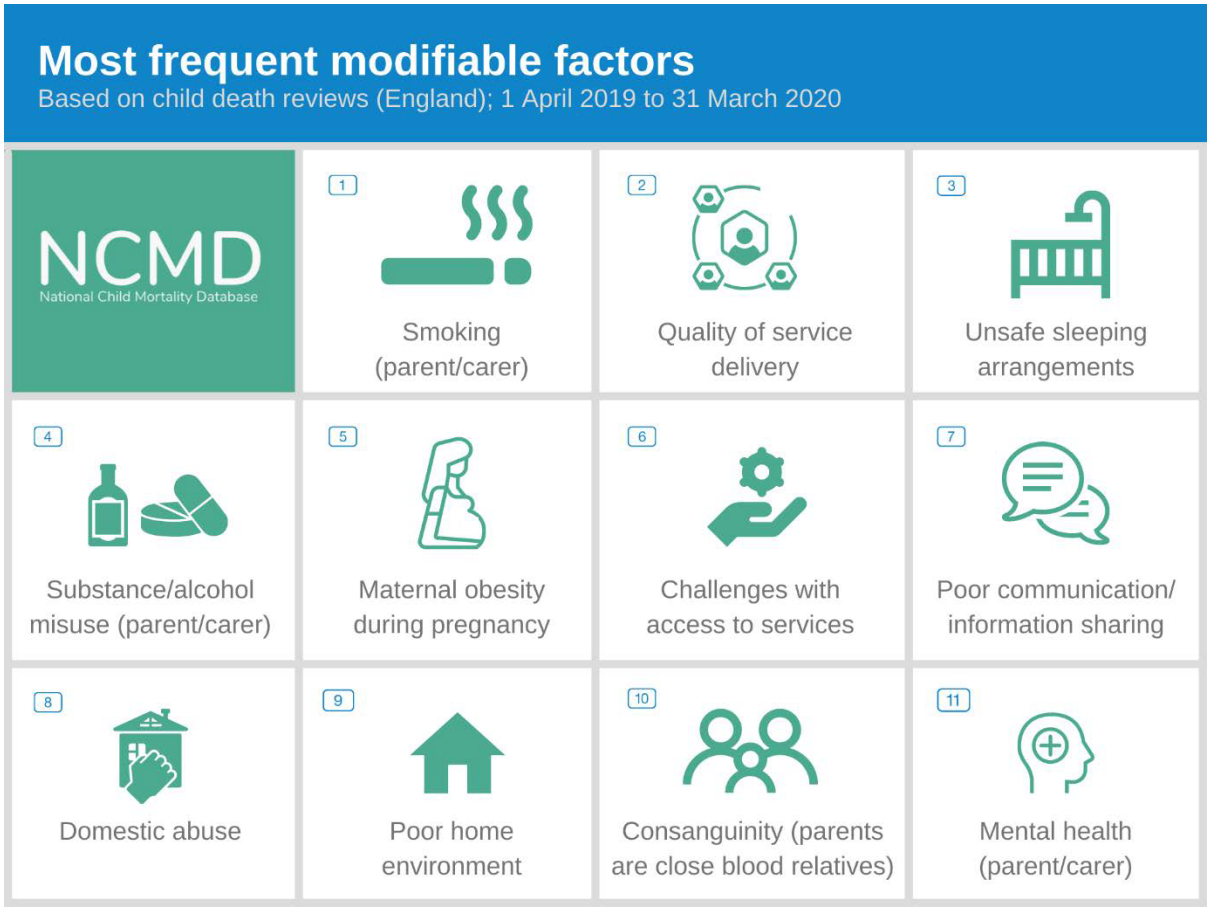
It is worth noting that the child death process also creates an opportunity at the meetings held before the panel review (Joint Agency Response Meetings, Morbidity and Mortality and Child Death Review Meetings) for services to identify other smaller, micro changes to practice, e.g. a need for workplace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

There were 27 cases where modifiable factors were identified and these are summarised below:

- **Parental smoking**
- **Consanguinity**
- **Missed immunisations**
- **Clinical incidents**
- **Maternal obesity during pregnancy**
- **Risk factors associated with asthma**
- **Substance misuse by parent/carer**
- **Late ante-natal booking and subsequent limited ante-natal care**
- **Unsafe sleeping arrangements**

Below is recent data from NCMD highlighting the top 11 modifiable factors identified in 2019/2020. Many of these are reflected in our findings in this report.

Panel members are tasked with taking the learning from these cases and sharing it widely within their organisations in order that staff in all the constituent agencies are aware of the risk factors when supporting and advising parents and carers. The learning is also included in the training package which is delivered to staff groups.


Most frequent modifiable factors
Based on child death reviews (England); 1 April 2019 to 31 March 2020
NCMD
National Child Mortality Database
1
Smoking (parent/carer)
2
Quality of service delivery
3
Unsafe sleeping arrangements
4
Substance/alcohol misuse (parent/carer)
5
Maternal obesity during pregnancy
6
Challenges with access to services
7
Poor communication/ information sharing
8
Domestic abuse
9
Poor home environment
10
Consanguinity (parents are close blood relatives)
11
Mental health (parent/carer)

Categories of Child Deaths

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

Table 9 - Category of child deaths

Category		2020/2021	%
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.	2	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.	4	5%
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).	2	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.	7	8%
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.	3	4%
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.	5	6%

	Includes cerebral palsy with clear post-perinatal cause.		
7	**Chromosomal, genetic and congenital anomalies** - Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.	18	22%
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).	32	39%
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	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).	4	5%