North of Tyne

Child Death Overview Panel

Annual Report

April 2019 - March 2020

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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 2018 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. 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 2019 - March 2020) and has enjoyed very good multi-agency attendance. It has been the fifth 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 5 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.

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 protect confidentiality.

This year two new data collection processes were introduced. Healthcare Quality Improvement Partnership, HQIP were commissioned by NHS England to develop the National Child Mortality Database, NCMD. Information inputted via ecdop is transferred to the NCMD.

During 2019, on the back of the new statutory guidance, the panel has been working with colleagues south of Tyne to facilitate a merger of the two CDOPs.

Workshops and process mapping has been undertaken and a smaller task and finish group has undertaken a re-write of Terms of Reference, policies and procedures and a review of administrative capacity and requirements.

The first merged panel is planned for late April 2020.

I am privileged to continue in the chairing role through this transition and for the foreseeable future.

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 2019/20, 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* 2018 Chapter 5),

Where a death is 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 requires a series of rigorous investigations, including a post-mortem, a multi-agency meeting (known as a 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 follows once all of the information is available and then all available information is 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, 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

Safeguarding Children Partnerships (SCPs) 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 SCP should always consider whether to undertake a Safeguarding Practice Review (SPR) 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 SPR might be met in certain cases, whether or not it has already been considered by the SCB, and to make recommendations appropriately.

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 Anna Thorley	Designated Doctor Child Deaths Newcastle
Dr Stephen Bruce	Designated Doctor Child Deaths Northumberland & North Tyneside
Karen Arkle left Jan 2019 Nichola Howard Feb 2019	Named Professional Safeguarding North East Ambulance Service
Eric Myers	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
Trina Holcroft	Designated Nurse, Child Protection, Newcastle
Wendy Burke	DPH North Tyneside Council
Richard Hearn	Consultant Neonatologist
Lynn Tilley	Acting Head of Midwifery, Northumbria Healthcare Foundation Trust

CHILD DEATH DATA

Table 1 – Total number of child deaths reviewed

	2015/16	2016/17	2017/18	2018/19	2019/20	5 year average
Northumberland	19	12	13	11	9	13
North Tyneside	4	12	9	12	11	10
Newcastle	13	13	16	16	25	17
Out of Area	0	0	0	0	0	0
North of Tyne Total	36	37	38	39	45	40

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

The total number of deaths reviewed from 2015/16 – 2019/20 is 195. The average number of child deaths that have been reviewed across the North of Tyne over the past 5 years is 39.

In 2019/20 there were a total of 45 child death reviews across Northumberland, North Tyneside and Newcastle (North of Tyne). Since the annual report in 2015/16 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
	2015/16	2016/17	2017/18	2018/19	2019/20	North of Tyne
0-27 days	11	14	18	16	15	38%
28 days- 364 days	8	4	8	7	11	19%
1 year-4 years	6	5	4	4	9	14%
5-9 years	2	1	1	6	4	7%
10-14 years	6	6	2	3	3	10%

15-17 years	3	7	5	3	3	11%

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 45 deaths reviewed in 2019/20, the vast majority (37 = 82 %) occurred in hospital followed by (7 =16%) in the home or outside area.

Gender

Table 3 – Gender of child

	2015/16	2016/17	2017/18	2018/19	2019/20	5-year average
Male	20	19	19	21	27	54%
Female	16	18	19	18	18	46%

Fig. 2 - Pattern of deaths by gender North of Tyne 2015 -2020

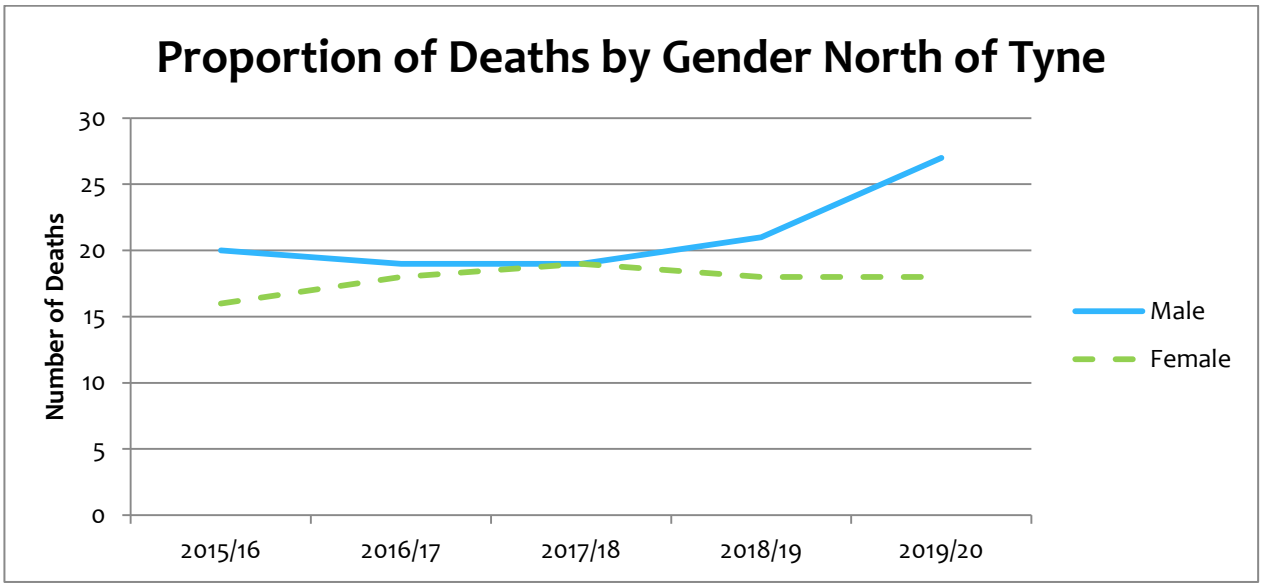

Table 4 - Number and % of deaths by ethnicity

Ethnicity (Broad)	15/16	16/17	17/18	18/19	19/20	Total (5yr)	% of deaths
White	30	32	34	31	31	158	81%
Mixed	0	0	0	0	1	1	0.5%
Asian	4	5	2	7	11	29	15%
Black	1	0	2	1	2	6	3%
Other	1	0	0	0	0	1	0.5%
Unknown	0	0	0	0	0	0	0%

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. These figures are looked at with some caution as recordings of ethnicity can be unreliable.

CDOP Panel

In 2019 /2020 the panel met 6 times. Below is a table showing the number of cases reviewed at each meeting.

Table 5 - Number of reviews at each meeting, 2019/20

May	July	Sept	Nov	Jan	March	Total
9	11	4	7	8	6	45

Timeliness and Frequency of CDOP Meetings

Working Together 2018 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 analysis forms, 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 analysis forms 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 19/20.

In 2019 the CDOP received a challenge from NTCCG on the validity of the data we were providing around timeliness. This led to a consultation with CCG staff who have worked with panel members to develop improved data collection and analysis. This will lead to reformed performance reports in the future.

There will always be cases which are unavoidably delayed by other processes, e.g. coronial investigations and case reviews by Safeguarding Partnerships and the new KPI report will assist the panel with more robust evidence of the reasons for the delays.

Table 6 - Timeliness of reviews

Year	Number of cases Reviewed at panel	% of cases reviewed within timescale
2015/2016	36	56%
2016/2017	37	62%
2017/2018	38	55%
2018/2019	39	28%
2019/2020	45	51%

Modifiable Factors

Table 7 - Shows the recent trend in the proportion of deaths where modifiable factors were identified.

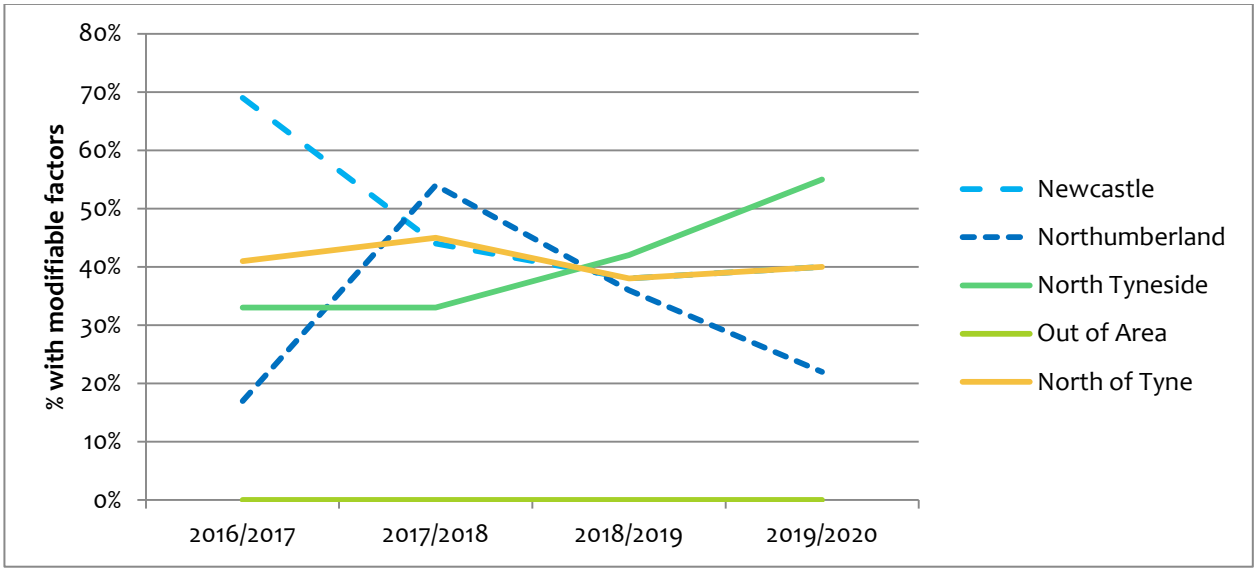

Table 8 - Numbers and % of child deaths where modifiable factors were identified

Area	2016/17			2017/2018			2018/2019			2019/2020			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	4	9	69%	9	7	44%	10	6	38%	15	10	40%	38	32	46%
Northumberland	10	2	17%	6	7	54%	7	4	36%	7	2	22%	30	15	33%
North Tyneside	8	4	33%	6	3	33%	7	5	42%	5	6	55%	26	18	41%
Out of Area	0	0	0%	0	0	0%	0	0	0%	0	0	0%	0	0	0%
North of Tyne	22	15	41%	21	17	45%	24	15	38%	27	18	40%	94	65	41%

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, 46% of cases in Newcastle were identified as having modifiable factors compared with 41% 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 45 cases reviewed in 2019 /2020 modifiable factors were identified in 18 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 18 cases where modifiable factors were identified:

- Consanguinity
- Unsafe sleeping
- Maternal smoking
- Maternal obesity
- Monitoring temperature of unborn babies
- Late access to ante-natal care
- Difficulty accessing medical care abroad
- Maternal type 2 diabetes
- Social situation of families
- Exposure to hospital-acquired infection.

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)

		2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	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.	1	1	0	0	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.	0	3	1	1	2	4%
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	3	0	4	1	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.	2	5	3	7	6	12%
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	0	2	3	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	1	2	2	6%
7	**Chromosomal, genetic and congenital anomalies** - Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.	9	5	9	11	12	24%

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).	11	13	16	8	11	30%
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	3	1	0	5	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).	1	2	5	3	2	7%