South of Tyne
Child Death Overview Panel

2015-2016
Annual report

Sunderland Safeguarding Children Board

South Tyneside Safeguarding Children Board

Gateshead local safeguarding children board

Contents

Index of Figures

1. Foreword

Welcome to the 8th Annual Report of the South of Tyne Child Death Overview Panel. I have been appointed as chair of this panel which covers Sunderland, South Tyneside and Gateshead council areas in April 2016. I am pleased to present the annual report of the panel for 2015/16. The report outlines the overview process, reports on work undertaken during the year, presents the data on child deaths, and outlines recommendations for future action.

It is always an occasion of great sadness when a child dies. Sometimes, however, it is possible to learn lessons which can reduce the likelihood of deaths of children in similar circumstances in future.

Working Together established child death review and child death overview panels with to ensure that this process happens in a systematic and consistent fashion across the country. The role of the Child Death Overview Panel is to consider any trends or patterns of child deaths which our Safeguarding Boards need to consider and address through the work of the partner agencies.

The lessons learnt and related recommendations can be found in the executive summary, and the business plan for the ongoing work of the panel is at section 7 of the report.

I commend this report to you and if it raises further questions please do not hesitate to contact our office (0191 4333547) for additional information.

Amanda Healy
Director of Public Health for South Tyneside
Chair,
South Of Tyne Child Death Overview Panel

2. Executive Summary

This is the eighth annual report of the South of Tyne Child Death Overview Panel. The panel is responsible for reviewing the deaths of all children in Gateshead, South Tyneside and Sunderland between birth and 18 years of age.

The processes to be followed when a child dies are outlined within Working Together to Safeguard Children 2015: Chapter 5 Child Death Review Processes https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf.

Data related to Child Death Notifications

There were 331 child deaths notified to the South of Tyne (SoT) Child Death Overview Panel (CDOP) between 1 April 2008 and 31 March 2016. Over the eight year period, in 27% of cases the "final event leading to death" happened in Neonatal Units, 17% in Paediatric Intensive Care Units (PICU) or adult Intensive Care Units (ICUs) and 33% in the home. Between 2008 and 2016, 62% of deaths occurred during the first year of life, 10% of deaths were of children aged 1-4 years, and rates then decrease in mid-childhood before peaking again in adolescence, with 13% of deaths occurring between the ages of 15-17.

Data from cases reviewed by the Child Death Overview Panel

The SoT CDOP completed the detailed review of 89% of cases between 1 April 2008 and 31 March 2016. 11% of cases are currently ongoing. There is an inevitable time-lag between notification of the child's death to discussion at CDOP but 100% of the cases requiring review from 2012-13 have now been reviewed and 89% from 2013-14. CDOP identified 'modifiable factors' in 17% of completed cases. Modifiable factors are defined as 'one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths'. The highest percentage of cases within a category of death with modifiable factors present was the Sudden Unexpected Deaths in Infancy (SUDI) with 59% of these deaths having modifiable factors present.

Focus on Deaths of Children under 1 years old

CDOP have undertaken an analysis of the 56 review of deaths of children under 1 year old completed within 20013-2016. 61% of these deaths were of children born prematurely (before 37 weeks gestation) and CDOP identified modifiable factors as being present in 21% of the reviews completed. Among the issues identified by the reviews were parental smoking (21% of cases), high/very high maternal BMI (9%) and consanguinity (5%). Issues around the availability of local specialist neonatal beds were also highlighted in 9% of cases.

Actions undertaken from reviews

- Concerns around the availability of neonatal beds raised with the regional neonatal network
- The need to include obstetric/maternal information in internal mortality review raised with regional neonatal units
- Partner agencies reminded of the importance of attending pre-birth strategy meetings/Child Protection Conferences
- Discussions held with council licencing department around the process for licencing taxi drivers, particularly in relation to the nature of historic convictions which may have been disclosed.
- Dangers of blind cords included in birth information packs
- Regional Units reminded that there should always be a planning meeting before the discharge of vulnerable infants. For very vulnerable families these should be carefully planned with prior notification of all community services known to be involved in caring for and supporting the family
- National alert issued via Public Health England re the risk of infection from heated home birthing pools
- NEAS asked to review policies and practice around the use of adrenaline on initial response
- NEAS requested to make paramedic crews available to attend Rapid Response/Case discussion meetings where ever possible
- NEAS to use nationally agreed timelines when preparing reports for the CDR process
- SoT CDOP have reviewed their procedures around how parents are included in the process

3. The Child Death Review Process

Since 1 April 2008, Local Safeguarding Children Boards (LSCBs) in England have had a statutory responsibility for child death review processes. The relevant legislation is enshrined within the Children Act 2004, and applies to all young people under the age of 18 years. The processes to be followed when a child dies are outlined within Working Together to Safeguard Children 2015: Chapter 5 Child Death Review Processes. The process focuses on identifying 'modifiable factors' in the child's death. The overall purpose of the child death review process is to understand how and why children die, to put in place interventions to protect other children and to prevent future deaths. It is intended that these processes will:

- Document and accurately establish causation of death in each individual child
- Identify patterns of death in a community so that preventable factors can be recognised and reduced
- Contribute to improved multi-professional collection of medical, social and forensic evidence in the small proportion of deaths where there has been maltreatment or neglect
- Ensure appropriate family and bereavement support is in place
- Identify learning points for service provision, which relate to care of the child

Working Together (2015) outlines two interrelated processes…a **'Rapid Response'** where a group of professionals come together for the purpose of evaluating the cause of death in an individual child, where the death of that child is unexpected, and a **'Child Death Overview Panel'** that comes together to undertake an overview of all child deaths under the age of 18 years in a defined geographical area. These processes have been outlined in detail in previous annual reports.

In the South of Tyne sub region three neighbouring Local Safeguarding Children Boards (LSCBs) (Sunderland, South Tyneside and Gateshead) have come together to form a single South of Tyne (SoT) Child Death Overview Panel. Each locality has established a Local Child Death Review Group which report directly into the CDOP. The membership of the Panel is arranged to ensure that there is the necessary level of expertise and experience, and that each LSCB is appropriately represented. During 2015-16, the SoT CDOP was chaired by the Director of Public Health for Gateshead. The panel will be chaired by the Director of Public Health for South Tyneside in 2016-17

The Child Death Review Co-ordinator administers all functions of the SoT CDOP. The SoT CDOP reviews information on every child who has died whose post code of residence is within its geographical boundary. Some of these deaths may occur outside the South of Tyne. A child's case is reviewed by the CDOP after it has been discussed at a local Child Death Review Sub Group meeting. Standard information on each child is collected on national Forms A and B during the Child Death Review process. Form A is a basic notification form that has essential identifying information on the child and key professionals. Form Bs are completed by all agencies involved in the care of a child, and capture basic clinical and social data on the child and background information relating to the family. Additional Forms B2 –B12 capture specific data relating to the type of death (sudden infant death, life-limiting condition etc.). Form B13 has information relating to post mortem findings.

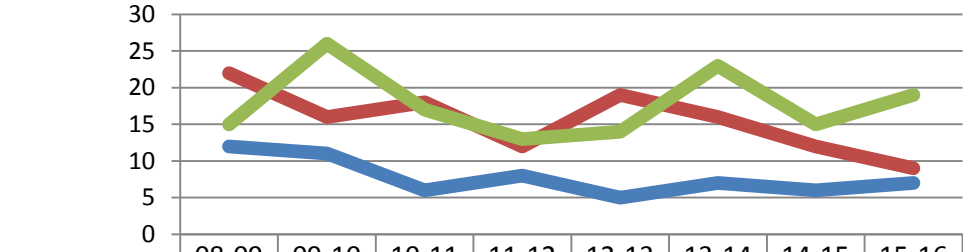
Form C is completed at the local Child Death Review meeting and aims to identify modifiable factors relating to the child's death, as well as highlight learning arising from each case. All patient information is anonymised. A detailed compilation of all data on Forms B & C on each child is presented to the CDOP as an anonymised case record. At CDOP meetings each case is reviewed and the panel deliberates on the decisions reached at the local Child Death Review meeting. The panel will agree any additions or amendments on a final Form C for each child. The CDOP Chair records recurring themes relating to modifiable factors.

4. Summary SoT CDOP Data

This section of the annual report summarises all deaths notified to the SoT CDOP, between 1 April 2008 and 31 March 2016, of children who resided in the SoT area, whether the child died in SoT or elsewhere. The data is drawn from the Notification database. Data is presented over the eight years of the Child Death Review process to help avoid the year on year variations that we expect when considering rare events one year at a time.

Analysis of notifications by year

Figure 1 Notifications by region of residence

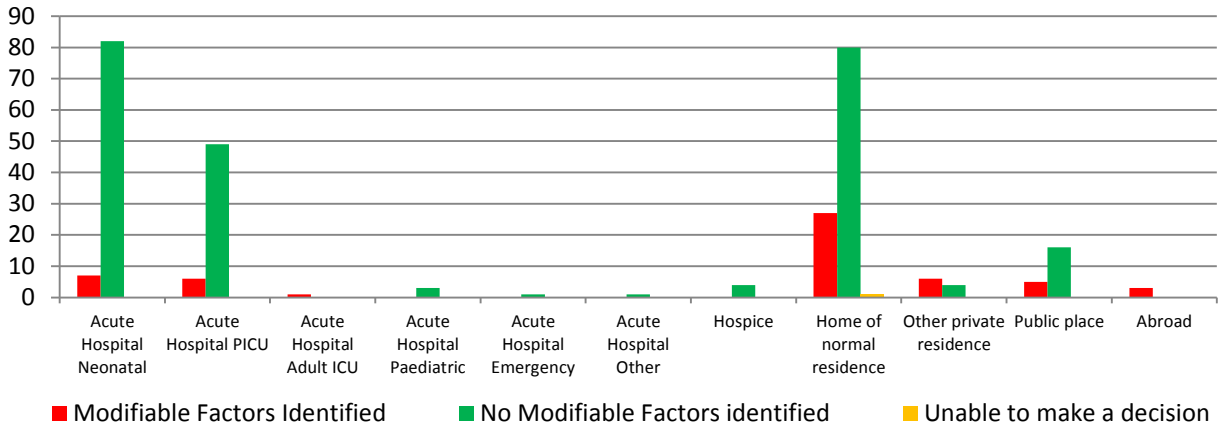


	08-09	09-10	10-11	11-12	12-13	13-14	14-15	15-16
South Tyneside	12	11	6	8	5	7	6	7
Gateshead	22	16	18	12	19	16	12	9
Sunderland	15	26	17	13	14	23	15	19

During the period 2008-2016, the deaths of 331 children were notified to the CDOP. Year on year variation in notifications is to be expected in relatively rare events such as child deaths, small variations each year can appear to represent a big difference. The deaths notified over the eight year period are reported by area of residence and by year in Figure 1. During the last eight years, postcode of residence has been used consistently and there have been no significant changes in local authority boundaries. Additionally, analysis of category of death shows that there is no single category of death that appears to account for the patterns seen over the eight year period. It is therefore most unlikely that these variations in notifications within LSCBs areas reflect any particular underlying cause and as such they should not be over-interpreted.

Location of death

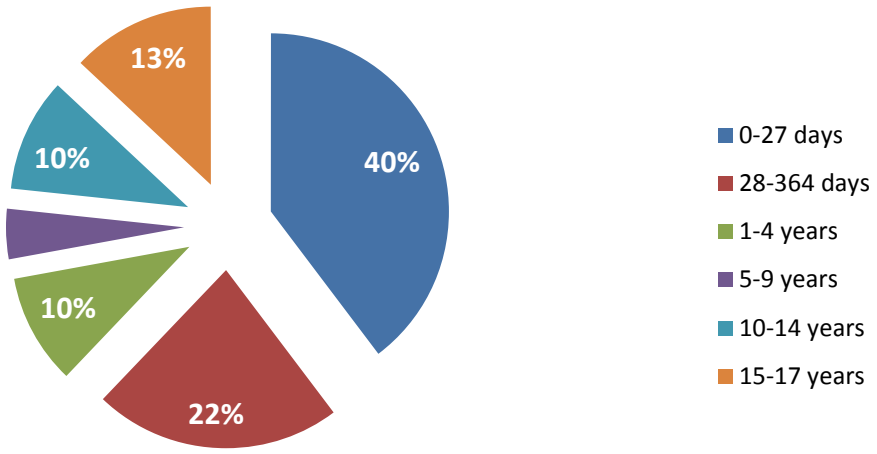
Figure 2 Place of final event leading to death



Places of final event leading to the child deaths seen locally reflects those identified in regional and national findings with the largest proportion of deaths being associated with premature birth and the deaths occurring within the first 28 days of life in Neonatal Units.

Age at Death

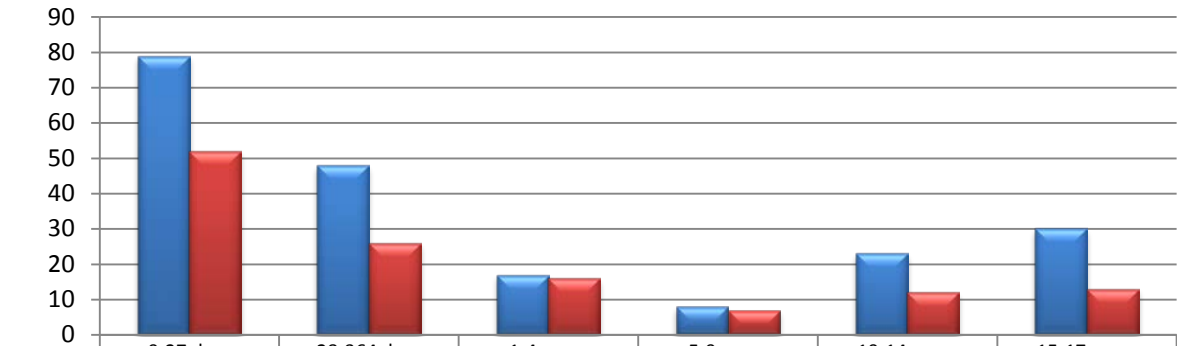
Figure 3 Notifications received by age group 2008-16



Most notifications (40%) were received for babies dying in the neonatal period (0-28 days). Figure 3 shows that the first year of life has the highest risk, with 62% of deaths occurring during this period. Rates then decrease in mid-childhood before peeking again at ages 15-17 with 13% of deaths. It is worth noting that the age bands used do not cover equal periods of childhood e.g. 10-14 years covers a five year period and 15-17 years covers a three year period.

Gender

Figure 4 Notifications received by gender/age group 2008-16



	0-27 days	28-364 days	1-4 years	5-9 years	10-14 years	15-17 years
Male	79	48	17	8	23	30
Female	52	26	16	7	12	13

There have been more notifications of deaths in boys (62%) than girls (38%). This mirrors national data from the child death review process, with 57% of deaths reviewed occurring in

boys nationally in 2014-15. The national data shows that boys are more likely to die at all ages and from all causes.

Ethnicity

Figure 5 *Notifications by ethnic group, 2008-2016*

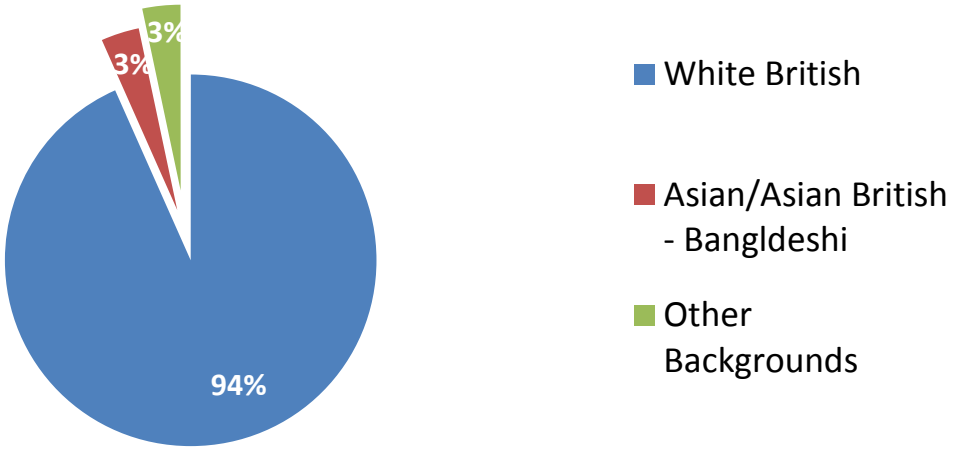
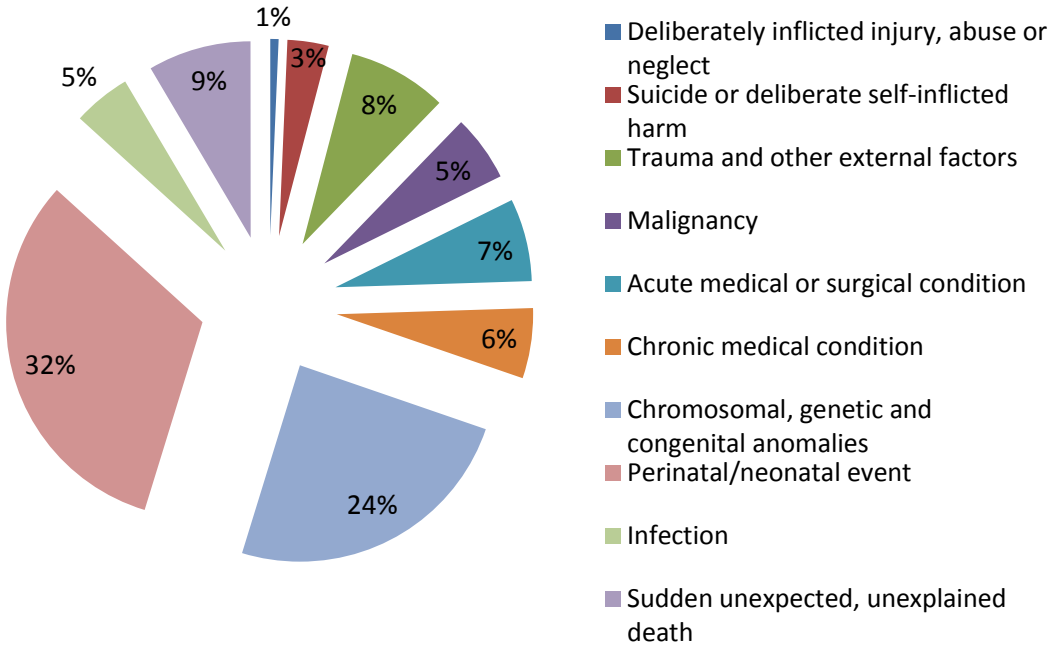


Figure 5 shows that 94% of notifications received by the SoT CDOP in 2008-16 were for children of White, British origin. The number of notifications for children whose ethnicity was recorded as Asian or Asian, British – Bangladeshi was 3%, with the remaining deaths being White Other, Black African, Arab or Other Asian backgrounds which broadly reflects the ethnicity of the local population.

Category of Death

Figure 6 Category of death for cases reviewed by CDOP, 2008-2016

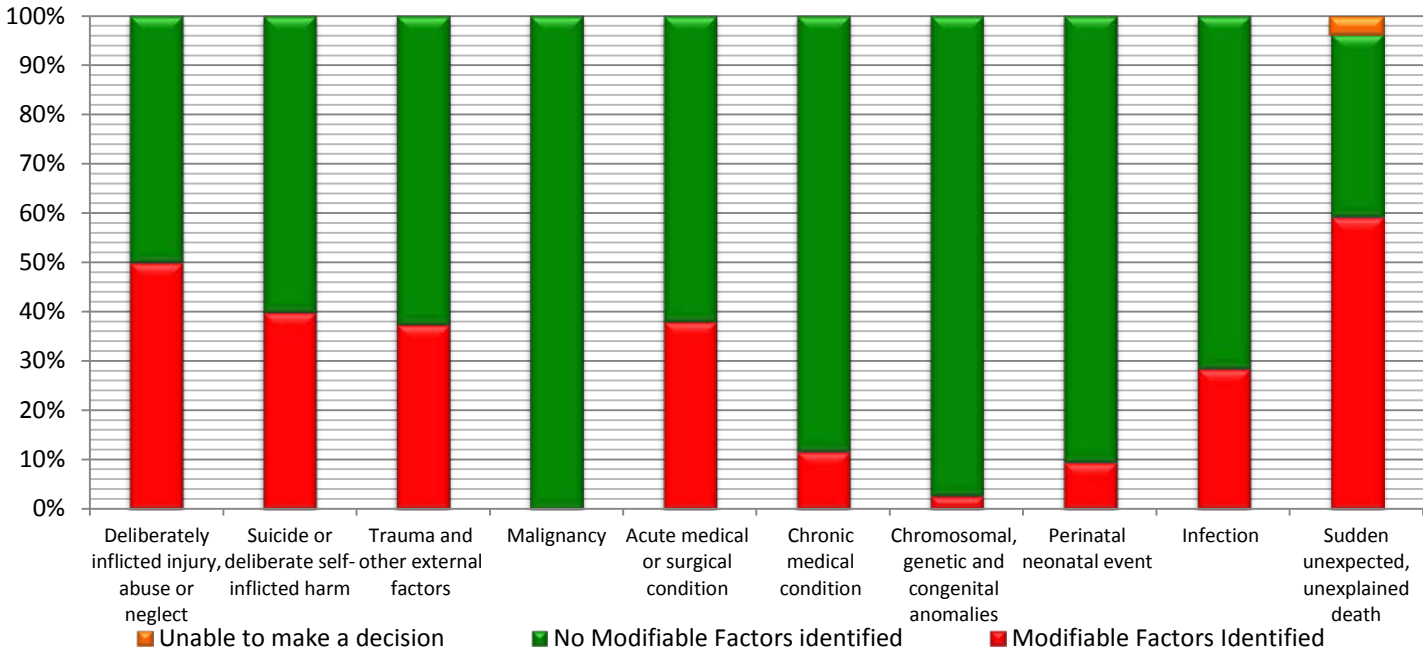


The Child Death Overview Panel is required to categorise each child death using a standard list of categories shown in Figure 6. During the eight-year period, 32% of deaths were categorised as perinatal/neonatal events. The second most common cause was

chromosomal, genetic or congenital abnormalities, with 24% of the deaths fitting into this category. Sudden unexpected, unexplained deaths (9%), trauma (8%), acute medical or surgical conditions (7%), chronic medical conditions (6%) comprise the next most common causes with malignancy (5%), infection (5%), deliberate harm by others (1%) or self (3%) being less common.

Since 2010 deaths have been classified as "Modifiable Factors Present" or "No Modifiable Factors Present" rather than "Preventable", "Potentially Preventable" and "No Preventable", as they were previously coded. Therefore the "Modifiable Factors Identified" category now includes cases that were classified as "Potential Preventable" and "Preventable" as the description within *Working Together to Safeguard Children* (2010) defines this as "The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths".

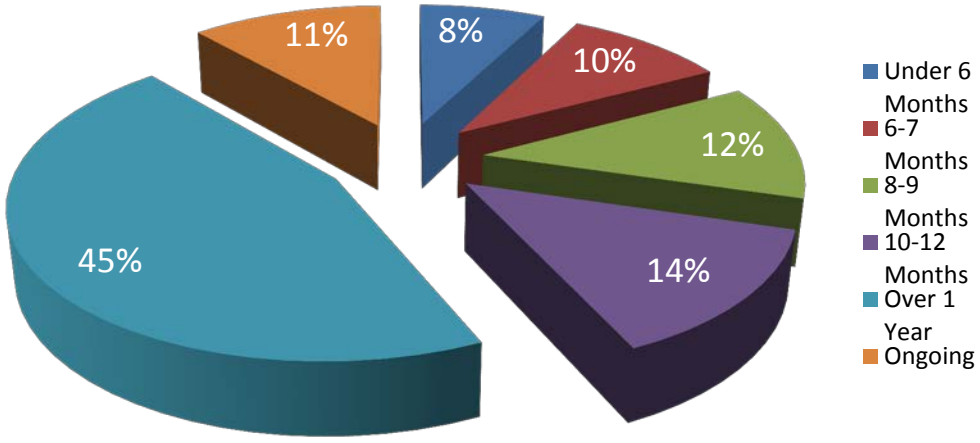
Figure 7 Percentage of Modifiable identified in completed reviews by category of death, 2008-2016



CDOP identified 'modifiable factors' in 17% of all completed cases. Modifiable factors are defined as 'one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths'.

The highest percentage of cases with modifiable factors present was within the Sudden Unexpected Deaths category with 59% of deaths having modifiable factors present. Deliberately inflicted injury, abuse or neglect is next highest at 50%, but there have been less than 5 deaths in this category during 2008-16.

Figure 8 Time taken to complete reviews



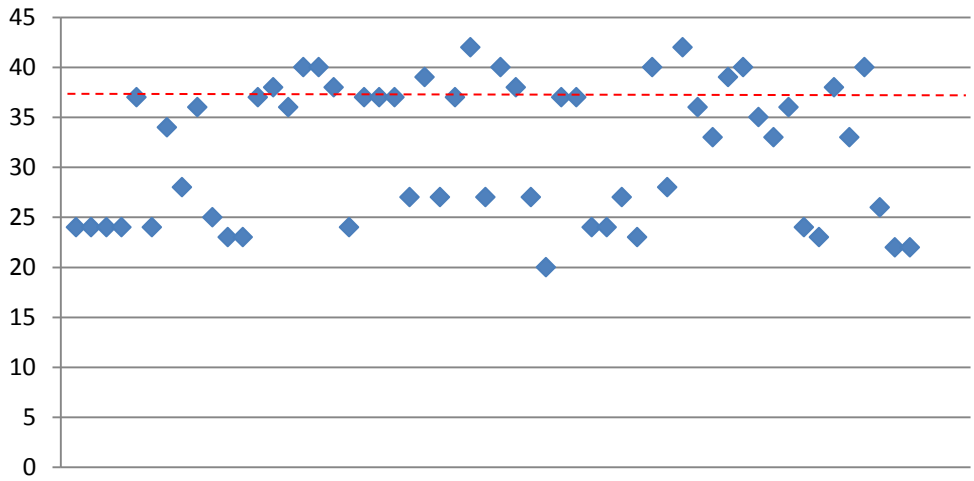
Currently 44% of all deaths have been reviewed with 12 months, with 11 % of reviews being ongoing. The majority of the cases taking over 12 months to review have been subject to parallel processes (inquests, legal proceedings, Serious Case Reviews, internal agency reviews) which have delayed their discussion at CDOP.

5. Deaths in Children under 1 year old 2013 - 2016

As part of CDOP's overview function they continually monitor factors associated with child deaths to identify any emerging themes. As the majority of deaths reviewed by SoT CDOP are in children under 1 year of age (62%) CDOP have undertaken a detailed analysis of all reviews completed in the last 3 years for children within this age band.

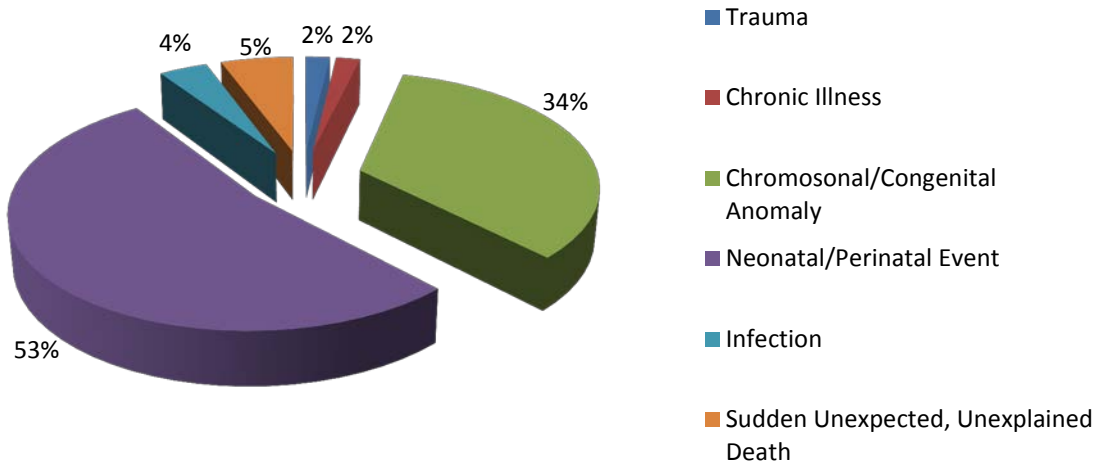
From 2013-2016 CDOP completed the review of 56 deaths of children under 1 year old. As with all child deaths within SoT there are more deaths of males (62%) than females (38%) and this reflects national and local data. 61% of the deaths were of children who were born prematurely (before 37 weeks gestation) and 4% were children born at 42 weeks gestation .

Fig 9 Completed Review of Children under 1 year old by week's gestation at birth



53% of deaths were due to neonatal/perinatal events which reflect the number of premature births. Chromosomal/congenital anomalies are the next largest category of deaths at 34% which corresponds with 35% of the deaths being of children with known life limiting conditions. Sudden Unexpected, Unexplained Deaths have previously been a focus of the SoT annual report and in 2011-2012 accounted for 10% of all deaths (0-17 years) reported to the CDOP. However for 2013-2016 these deaths only accounted for 5% of the reviews completed by CDOP.

Fig 10 Completed Reviews of Children under 1 2013-2016 by Category of Death



There are a number of factors that are known to increase the risk of infant mortality/SIDS deaths and these are monitored as part of the review process. The highest within this time period was parental smoking which was recorded in 21% of the deaths, but this figure is likely to be higher as paternal information is not always available to the CDOP. Other known risk factors identified as being present were unsuitable sleep environment (bed sharing/sleeping on sofa etc.) 4%, High/Very High Maternal BMI 9%, other maternal health issues 16%, Consanguinity (parents first cousins) 5% and social issues (housing, known to multiple services, domestic violence etc.) 15%. In 9% of cases it was noted that there had been issues around the availability of bed at the local specialist neonatal units. Overall CDOP identified that modifiable factors were identified in 21% of the reviews completed.

Summary

Overall the findings show that the pattern of child deaths seen locally reflects those identified in regional and national findings; the largest proportion of deaths are associated with premature birth and males account for the majority of all deaths. The majority of modifiable factors identified by CDOP are in relation to known risk factors for Sudden Infant Death Syndrome, as identified in previous years, and are subject to ongoing work by CDOP and local health agencies.

6. Actions undertaken/Learning shared following reviews

- Concerns around the availability of neonatal beds raised with the regional neonatal network
- The need to include obstetric/maternal information in internal mortality review raised with regional neonatal units
- Partner agencies reminded of the importance of attending pre-birth strategy meetings/Child Protection Conferences
- Discussions held with council licencing department around the process for licencing taxi drivers, particularly in relation to the nature of historic convictions which may have been disclosed.
- Dangers of blind cords included in birth information packs
- Regional Units reminded that there should always be a planning meeting before the discharge of vulnerable infants. For very vulnerable families these should be carefully planned with prior notification of all community services known to be involved in caring for and supporting the family
- National alert issued via Public Health England re the risk of infection from heated home birthing pools
- NEAS asked to review policies and practice around the use of adrenaline on initial response
- NEAS requested to make paramedic crews available to attend Rapid Response/Case discussion meetings where ever possible
- NEAS to use nationally agreed timelines when preparing reports for the CDR process
- SoT CDOP have reviewed their procedures around how parents are included in the process

7. BUSINESS PLAN

South of Tyne (SoT) Child Death Overview Panel (CDOP) 2015 – 2017

Objective/Priority		Action(s)	Responsible Person	Timescale	Progress/Outcomes	RAG Rating
1.0	**To ensure the Child Death Process across SoT fulfils its statutory functions in line with Working Together 2015**	Ensure dedicated administrative support is available to support the work of the CDOP and that this role is clearly outlined in a job description with a clear accountability framework with links to the 3 Local Safeguarding Children Boards (LSCBs)	3 LSCB Business Managers Chair CDOP	November 2016 (for 2017-18 arrangements)	CDR Coordinator in place till March 2017. Will need to be reviewed once timescales are available for changes recommended in Wood Report	Amber
		Ensure the CDOP provides regular reports on activity to each LSCB.	Child Death Review Co-ordinator Chair CDOP	July 2016	Annual Report to be ready for sharing with 3 LSCBs and CCGs by July of each year. July 2016 CDOP cancelled so report not agreed till September 2016 LCDRP's have an agreed reporting arrangements to their LSCB	Red

Objective/Priority		Action(s)	Responsible Person	Timescale	Progress/Outcomes	RAG Rating
		Ensure the CDOP receives regular budget updates	Gateshead Council Corporate Finance Gateshead LSCB Business Manager Chair CDOP	Ongoing Action	Bi annual reports	Amber
		To maintain effective communication and good working relationships with the Coronial System across SoT	Child Death Review Co-ordinator Chair CDOP Des Drs CDR	Ongoing Action	Annual meeting to take place with Coroners to maintain relationships. Coroners will need to be involved in discussions once timescales are available for changes recommended in Wood Report. LSCBs and Coroners to liaise/share information to assist enquiries in cases subject to SCR.	Amber
		SoT CDOP Terms of Reference, including chairing arrangements, to be updated and agreed by CDOP Members	Chair CDOP LSCB Business Managers	November 2016	ToR to be updated to reflect the Wood report outcomes	Amber

Objective/Priority		Action(s)	Responsible Person	Timescale	Progress/Outcomes	RAG Rating
2.0	**To collect and collate data on all child deaths in SoT and to evaluate the data on these deaths to identify lessons to be learnt or any issues of concern and ensure learning is disseminated to the public and professionals**	To ensure the notification procedures following child death are timely and ensure relevant personnel are informed	Child Death Review Co-ordinator	Ongoing Action	Notification procedures to be monitored across all 3 localities	Amber
		Monitor out of area deaths to ensure reports/information are provided within timescales	Child Death Review Co-ordinator Chair CDOP	Ongoing Action		Amber
		Raise any issues of non-compliance by health providers in the statutory process with commissioners in the CCGs and Area Teams (NHS England)	Chair CDOP Designated Professionals	Ongoing Action	Included in the ST and Sunderland Commissioning Action Plan which is shared at the Strategic Safeguarding Committee Designated Professionals have links to NHS England Quality Surveillance Group via network and Directors of Nursing & Medical Directors Training continues for all involved in the Child Death Review Process	Amber

Objective/Priority		Action(s)	Responsible Person	Timescale	Progress/Outcomes	RAG Rating
		Information is collated and reviewed by CDOP to identify lessons to be learned or any issues of concern:	CDOP/Local CDRG	Ongoing Action	Cases reviewed at local child death groups Updates provided to LSCBs Links well established with local Case Review Sub-committees Learning from serious case reviews where a child has died is shared with LCDRP when report published and then shared at CDOP. Verbal updates on SCRs given at every LCDRP. Learning is also shared with regional LSCB Business Managers	Amber
		Give Me Room to Breathe campaign review actions to be implemented	Child Death Review Co-ordinator CDOP Chair	September 2016	Task and finish group to be identified, along with an appropriate lead within Public Health	Amber

Objective/Priority		Action(s)	Responsible Person	Timescale	Progress/Outcomes	RAG Rating
		Share learning regionally and nationally via the child death networks and other groups, e.g. local child accident prevention groups	Child Death Review Co-ordinator Designated Doctors CDOP Chair	Ongoing Action	Representative from Sunderland CAPG is a member of the LCDRP South Tyneside in process of setting up a CAPG CDR Coordinator attends CAPG meetings	Green
3.0	**To ensure bereaved families receive support and continued care appropriate to their needs and that their views are represented within the Child Death Review Process**	To ensure families are provided with the SoT leaflet on the Child Death Review Process	Designated Doctors Coroner's Officers	Ongoing Action	All form Cs to include if information has been shared with the family	Green
		Designated Paediatrician to inform local case discussion/rapid response of parental views or queries	Designated Doctors	Ongoing Action		Amber
		Family support protocol to be reviewed and agreed within each locality, and endorsed by each LSCB and implemented across the partnership	LSCB Business Managers Designated Professionals or specialist professionals	April 2016		Amber

Objective/Priority		Action(s)	Responsible Person	Timescale	Progress/Outcomes	RAG Rating
		Review service provision for bereaved families and ensure any gap in provision is highlighted to the Clinical Commissioning Groups (CCGs)	CDOP Members or specialist nurses Chair CDOP	Ongoing Action	Families will be able to access local support services following a bereavement Bereavement services available for adults and children	Amber
4.0	**To identify and advocate for needed changes in legislation, policy and practice to promote child health and safety and to prevent child deaths**	To influence statutory guidance, policy and practice by responding to consultations and influencing local and national developments from learning across SoT	Chair CDOP	Ongoing Action	Any publications to child death shared LSCBs and CDOP to respond to the outcome of the Wood Report	Amber
		To ensure policies and procedures across SoT are reviewed and updated in response to updated guidance or new legislation is this not inc in the review of TOR	Chair CDOP Child Death Review Co-ordinator	November 2016	Policies and Procedures to be reviewed in relation to the outcome of the Wood Report once timescales are known.	Amber
5.0	**To ensure recommendations from Inspections are responded to in a timely effective manner**	Review arrangements in line with any recommendations from statutory inspections	Chair CDOP	Ongoing	Recommendation from SSCB inspection in May 2016 addressed	Amber

8. CDOP Membership

Chair – Public Health representative, to be rotated annually between the 3 local authority areas

LSCB Business Managers for Gateshead, Sunderland and South Tyneside

Designated Dr for Child Deaths for Gateshead, Sunderland and South Tyneside

Designated Nurse Safeguarding/CCG Head of Safeguarding for Gateshead, Sunderland and South Tyneside

Local Authority Children's Services Representative for Gateshead, Sunderland and South Tyneside

Police Protecting Vulnerable People Unit Representative

North East Ambulance Service Representative

Specialist Heath Practitioners for Children and Young People with Additional Support Needs Representative

Legal advisor, to be rotated annually between the 3 local authority areas in line with Chair

SoT Child Death Review Co-ordinator

Chair of the Gateshead, Sunderland and South Tyneside local Child Death review Groups (if not included in the above members)

Other Ad hoc members can be invited to discuss particular cases/patterns of cases as required such as Fire Service, RNLI, representative from out of area hospitals etc.

9. What support is available for families when a child dies?

When a child dies, the loss is unimaginable to those who have not been through it. There are specialised support groups who may be able to help such as those listed below:

The Lullaby Trust

Tel: 0808 802 6868

Website: www.lullabytrust.org.uk

Helpline is answered personally by specially trained advisors from 10am to 6pm Monday to Friday, from 6pm to 10pm weekends and bank holidays by trained befrienders who are themselves bereaved parents. The information you give will be kept confidential

The Child Bereavement Trust

Tel: 0845 357 1000

Website: www.childbereavement.org.uk

Offers confidential telephone support and online forums, along with training for professionals working with grieving families and children.

The Child Death Helpline

Tel: 0800 282 986

Website: www.childdeathhelpline.org.uk

Offers telephone support on every weekday evening from 7pm to 10pm, every weekday from 10am to 1pm and on Wednesday afternoons from 1pm to 4pm

Cruse Bereavement Care

Tel: 0870 167 1677 (adult helpline); 0808 808 1677 (young people's helpline)

Website: www.crusebereavementcare.org.uk

A national voluntary organisation that offers a free, confidential bereavement counselling service to people of all ages.

Samaritans

Tel: 0345 909 090

Website: www.samaritans.org.uk

The Compassionate Friends

Tel: 0117 953 9639

Website: www.tcf.org.uk

A national organisation offering support and friendship to bereaved parents and families.

The principles underlying the overview of all child deaths:

- Every child's death is a tragedy
- Learning lessons
- Joint agency working
- Positive action to safeguard and promote the welfare of children

South of Tyne

Child Death Overview Panel,

LSCB Business Unit,

1st Floor,

Civic Centre,

Regent Terrace

Gateshead,

NE8 1HH

Tel: 0191 433 3547 Fax: 0191 4333950

email: CDOP@Gateshead.GCSX.Gov.UK

Sunderland Safeguarding Children Board

South Tyneside Safeguarding Children Board

Gateshead local safeguarding children board