Gateshead
local safeguarding
children board

een classified as:

South Tyneside Safeguarding
Children Board

South of Tyne
Child Death Overview Panel
2017-2018
Annual report

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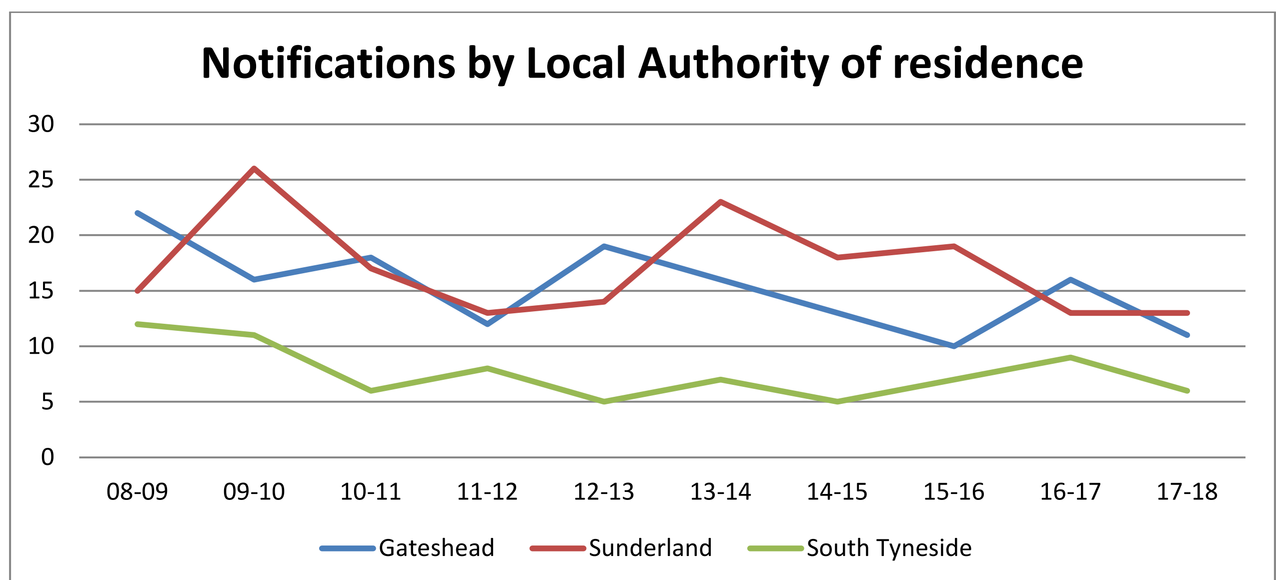
1. Introduction

The South of Tyne Child Death Overview Panel (CDOP) has undertaken its role to review the death of every child aged under 18 resident in Sunderland, Gateshead and South Tyneside on behalf of the Local Safeguarding Children Boards since April 2008. Its functions are laid out in Working Together to Safeguard Children 2015. The CDOP works to a national methodology which enables it to clarify the cause and circumstances of each child death, and hence identify whether there were modifiable factors which may have contributed to the death to ensure other siblings and the wider public are protected from similar circumstances. The process also monitors the availability of resources to support bereaved parents.

2. Number of Deaths

The South of Tyne CDOP was notified of the death of 30 children during 2017-18, this is a decrease of approximately 20% on the previous year. It should be noted however that 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. In 2017-18 there were 11 deaths in Gateshead, 13 in Sunderland and 6 in South Tyneside. These comprised of 9 expected deaths of children with known life limiting medical conditions, 14 neonatal deaths and 7 deaths that were unexpected.



	08-09	09-10	10-11	11-12	12-13	13-14	14-15	15-16	16-17	17-18
Gateshead	22	16	18	12	19	16	13	10	16	11
Sunderland	15	26	17	13	14	23	18	19	13	13
South Tyneside	12	11	6	8	5	7	5	7	9	6
Total	**49**	**53**	**41**	**33**	**38**	**46**	**36**	**36**	**38**	**30**

3. Number of Completed Reviews

In 2017-18 the SoT CDOP completed the reviews of 11 (36%) of the 30 deaths notified but it is noted that this decrease is largely due to the issues identified in the footnote below. The SoT CDOP also closed 10 cases from the 2016/17 notifications during this period.

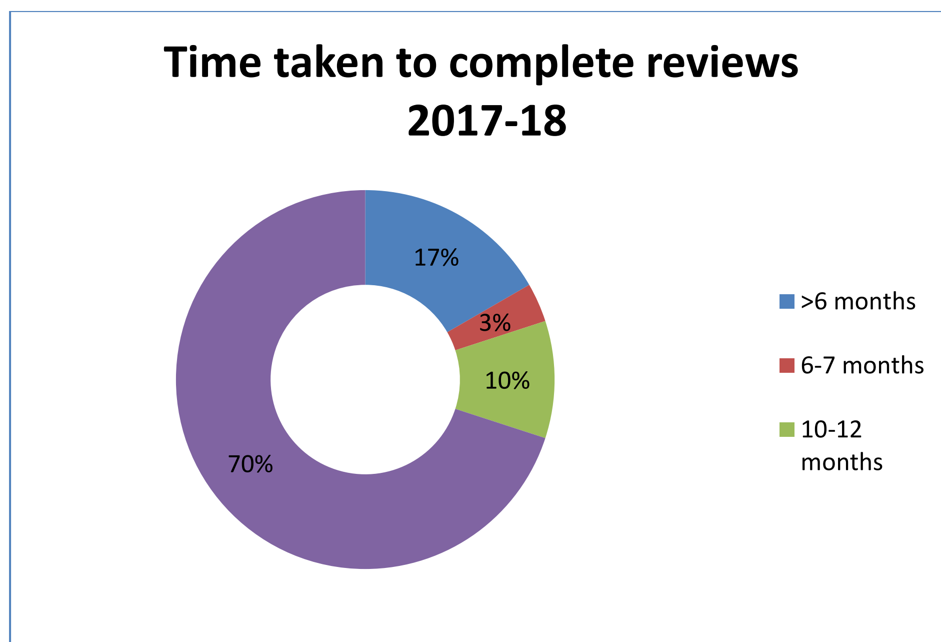
There were 4 CDOP meetings held in 2017-18 with an average of 3 completed reviews per meeting.

4. Duration of Reviews

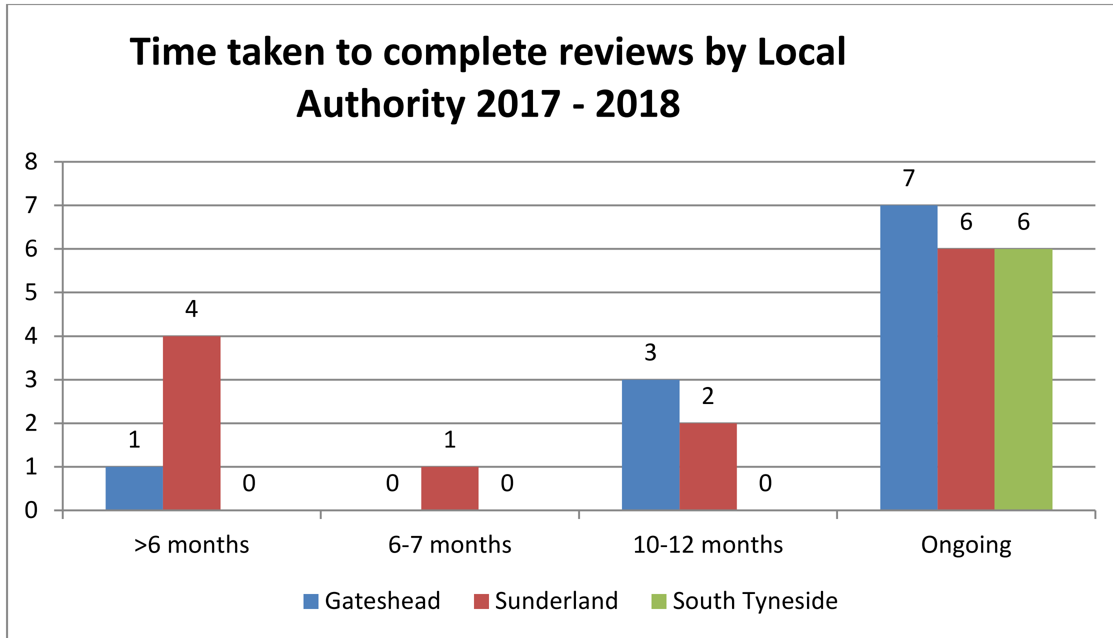
60% of completed reviews in 2017-18 have been concluded within 12 months of the death.

- 96% of Sunderland deaths were concluded within 1 year (11 out of 13)
- 75% of Gateshead deaths were concluded within 1 year (12 out of 16)
- 0% of South Tyneside deaths reported in 2017-18 have been concluded[1]

Area	2016 - 17	2017 - 18
Gateshead	75%	75%
South Tyneside	0%	0%
Sunderland	85%	96%

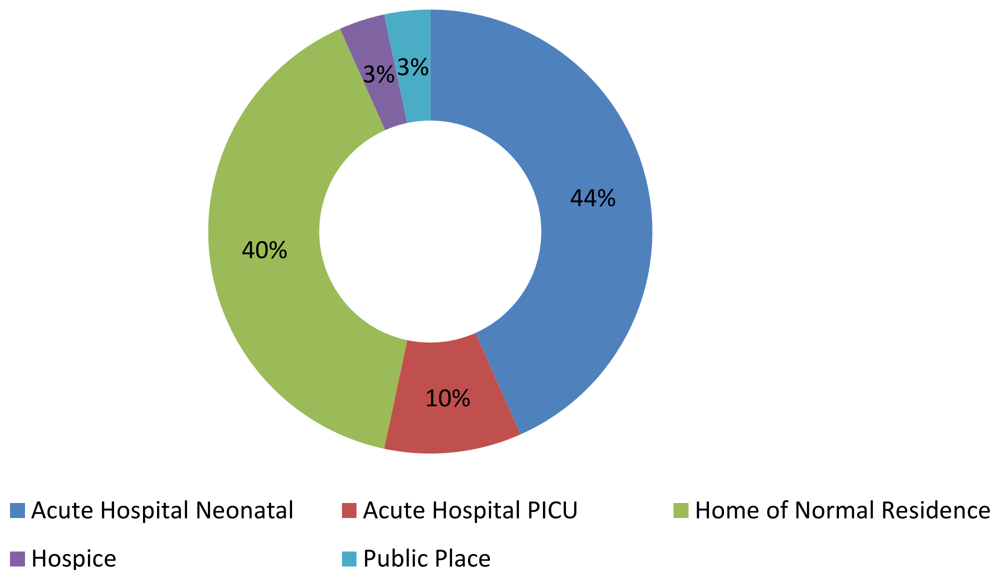


[1] During 2017/18 all of the child deaths were reviewed in a timely manner at the local panel however there were considerable difficulties in ensuring the reviews were then taken to CDOP; this was due to a combination of factors such as lengthy delays in the coronial process, police investigations, lack of a Child Death Review Coordinator and no cover arrangements for the Designated Doctor while away from work for several months. The SoT CDOP will focus on expediting the review of South Tyneside deaths in early 2018/19



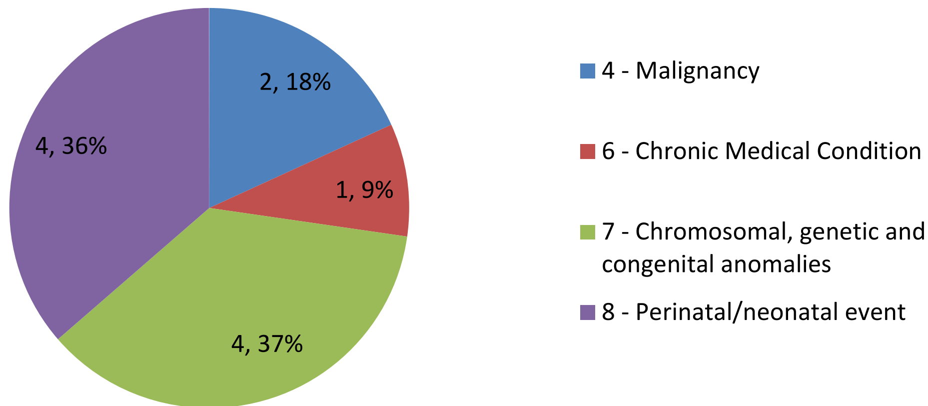
5. Circumstances of Deaths 2017/18

The largest proportions of deaths continue to be those associated with premature birth and deaths occurring within the first 28 days of life in a hospital setting and those occurring within the home.



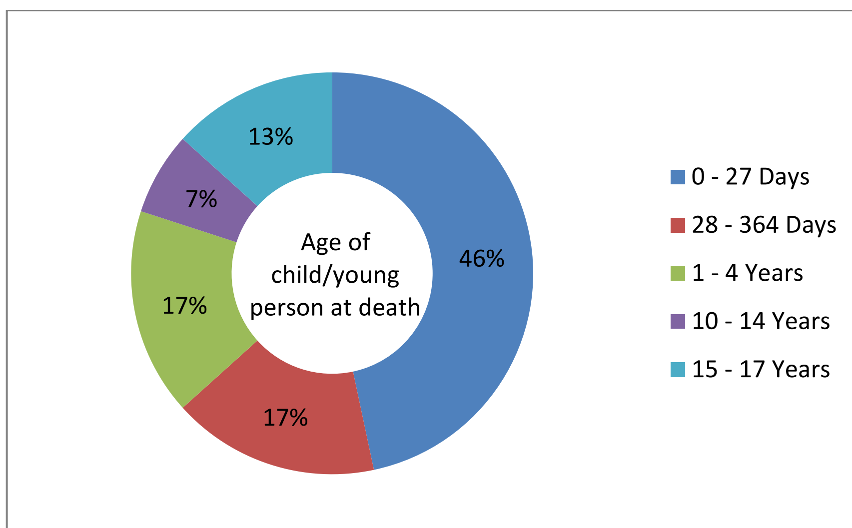
The Child Death Overview Panel is required to categorise each child death using a national standard list of categories. During 2017-18 there was an equal split (37%) of those deaths categorised as perinatal/neonatal events and chromosomal/genetic/ congenital anomalies.

Cause of death (completed reviews) 2017/18



6. Characteristics 2017/18

Most notifications (46%) were received for babies dying in the neonatal period (0 - 28 days). The first year of life has the highest risk, with 63% of deaths occurring during this period. Rates then decrease in mid-childhood before peeking again at ages 15-17 with 17%. 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. There have been more notifications of deaths in boys (19) than girls (11). National data is not available for the period 2017/18 however historically the national data shows that boys are more likely to die at all ages and from all causes.



97% of notifications received by the SoT CDOP in 2017/18 (91% in 2016/17) were for children of White, British origin with the remaining 3% being Arabic.

Due to small numbers, information in this section should be treated with caution.

7. Serious Case Reviews

Only one SCR was commissioned (still ongoing) from the 30 reported deaths this year.

8. Modifiable Factors

Since 2010 deaths have been classified as "Modifiable Factors Present" or "No Modifiable Factors Present". *Working Together to Safeguard Children* (2010) defines modifiable factors 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". Due to the small number of deaths reviewed each year there will be some variation at a local level but the percentage of SoT cases with modifiable factors identified reflects those identified at a regional and national level.

Modifiable %	2014-2015	2015-2016	2016-2017	2017-18
SoT	24%	17%	26%	7%
North East	28%	18%	25%	Information Not Available
England	24%	24%	27%	Information not available

Percentage of Completed Reviews with Modifiable factors Identified

Sudden Unexpected, Unexplained Deaths continue to have the highest percentage of identified modifiable factors identified 74%, with recurring themes of co-sleeping, unsafe sleep environments (sleeping on sofa etc.) and parental consumption of alcohol. These have been subject to previous CDOP interventions, such as the "Give me room to breathe" campaign, and the promotion of safe sleep information with parents/carers and continue to be a high priority for the CDOP partners.

Infection classification has seen an increase in modifiable factors identified to 60% with the modifiable factors identified relating to the early recognition of symptoms, the need for seeking timely medical intervention and prompt commencement of medication.

9. National/Regional Information

The national aggregated information is usually made available by the DfE in July however due to the change in Governmental Departments overseeing the Child Death Review process (i.e. change from Department of Education to Department of Health) the 2017/18 information was not available at the time of writing this report. The SoT CDOP will review the national/regional data and compare local information when it is made available.

10. Summary and Recommendations to Statutory Partners

The business plan for the SoT CDOP was completed and reported in the annual report 2017/2018. Appendix one outlines the key priorities of this panel for 2018-2020 and progress will be monitored against this business plan at every CDOP.

Whilst Sunderland has improved its review of local deaths from 85% to 95% over 2017/18 and Gateshead maintained its position at 76% the impact of having no Designated Paediatrician in South Tyneside for Child Death was compounded by the absence of the SoT Child Death Review Co-ordinator and resulted in no reviews being completed. This demonstrates the importance of building resilience into the process and ensuring there is sufficient administrative support. The Designated Paediatrician for South Tyneside has now returned and interim arrangements for administrative support were put in place from April 2018.

The business plan anticipates the statutory changes expected in Working Together 2018 resulting from the Children and Social Work Act 2017; however, specific assurance will be sought from the statutory partners that staffing provision to cover the key roles is appropriate and supported by dedicated administrative resources. In addition there must be consideration to how key roles can be covered during periods of extended absence.

Appendix 1: South of Tyne Child Death Overview Panel Business Plan 2018 – 2020

Objective/Priority		Action(s)	Responsible Person(s)	Timescale	Progress/Outcomes	RAG Rating
1.0	**To ensure the Child Death Review Process across SoT fulfils its statutory functions in line with Working Together 2018**	To agree local processes and governance arrangements between the key statutory CDR partners in: • Gateshead • South Tyneside • Sunderland	• 3 LSCB Business Managers • Chair CDOP • Chief Officers CCGs • Chief Executives LAs	31/03/2020		Amber
		To determine whether any local area leads on the CDR process on behalf of neighbouring authorities SoT	• Chair CDOP • Chief Officers CCGs • Chief Executives LAs	31/03/2020		Amber
		To agree the footprint of CDOP across Northumbria Force area.	• Chair CDOP • Chief Officers CCGs • Chief Executives LAs	31/03/2020		Amber
		To agree an annual budget for CDR processes aligned to the agreed footprint and maintain oversight of this budget	• Chief Officers CCGs • Chief Executives LAs	31/03/2020		Amber
		To agree a process for undertaking thematic learning events on a regional basis	• 3 LSCB Business Managers	31/03/2020		Amber
		To ensure final agreed CDR arrangements are disseminated and regular reports are provided to the relevant strategic partnership	• Chair CDOP • 3 LSCB Business Managers	31/03/2020		Amber
		Ensure dedicated administrative support is available to support the	• Chair CDOP • 3 LSCB Business	31/03/2020		Amber

	Objective/Priority	Action(s)	Responsible Person(s)	Timescale	Progress/Outcomes	RAG Rating
		work of the CDOP and that this role is clearly outlined in a job description with a clear accountability framework	Managers			
		To seek assurance from the CCGs that the agreed working arrangements have sufficient Designated Paediatrician capacity with dedicated administrative support. The Designated role must be supported by agreed processes for ensuring support during any extended period of absence	• CCG Directors of Nursing	31/03/2019		Amber
		To maintain effective communication and good working relationships with the Coronial System across SoT	• Chair CDOP • Designated Doctors LCDRG	Ongoing		Amber
		SoT CDOP Terms of Reference, including chairing arrangements, to be updated and agreed by CDOP members and reviewed annually	• CDOP Members	31/03/2019		Amber
2.0	**To collect and collate data on all child deaths in SoT and to evaluate the data on these deaths to identify**	Ensure the notification procedures following child death are timely and ensure relevant personnel are informed	• Child Death Review Co-ordinator	Ongoing		Amber

Objective/Priority	Action(s)	Responsible Person(s)	Timescale	Progress/Outcomes	RAG Rating
lessons to be learnt or any issues of concern and ensure learning is disseminated to the public and professionals	Monitor out of area deaths to ensure reports/information are provided within timescales	• Child Death Review Co-ordinator • Chair CDOP • LCDRG Chairs	Ongoing		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		Amber
	Information is collated and reviewed by CDOP to identify lessons to be learned or any issues of concern and to consider convening a thematic learning event	• Chair CDOP • Local CDRG Chairs	Ongoing		Amber
	Establish a performance and quality framework within each local child death group to inform CDOP & give consideration to this being aligned to final agreed arrangements following implementation of recommendation 1	• 3 LSCB Business Managers	31/03/2019		Amber
	Public Health issues are raised with the DPHs across the CDOP footprint and the LSCBs engage in supporting with appropriate local/ regional campaigns.	• Chair CDOP	Ongoing		Amber

Objective/Priority		Action(s)	Responsible Person(s)	Timescale	Progress/Outcomes	RAG Rating
		To ensure high quality data is submitted for national return requirements	• 3 LSCB Business Managers	31/03/2019		Amber
		Share learning regionally and nationally via the child death networks and other groups, e.g. local child accident prevention groups	• Designated Doctors • Chair CDOP	Ongoing		Amber
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 review the local leaflet issued to parents to ensure this is compliant with the leaflet recommended within WT 2018	• Designated Doctors • Coroner's Officers	31/12/2018		Amber
		To ensure families are provided with the SoT leaflet on the Child Death Review Process	• Designated Doctors • Coroner's Officers	Immediate		Amber
		Designated Paediatrician to inform local case discussion/rapid response of parental views or queries	• Designated Doctors	Immediate		Amber
		Family support protocol to be reviewed and agreed within each locality	• 3 LSCB Business Managers • Designated Professionals or specialist professionals	31/03/2018		Amber
		To ensure there is adequate provision of Care of Next Infant Programme across the identified footprint	• Chair CDOP • Local Commissioners	31/03/2020		Amber

	Objective/Priority	Action(s)	Responsible Person(s)	Timescale	Progress/Outcomes	RAG Rating
		Review service provision for bereaved families and ensure any gap in provision is highlighted to the Commissioners	• CDOP Members • Chair CDOP	31/03/2020		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		Amber
		To ensure policies and procedures across SoT are reviewed and updated in response to updated guidance or new legislation is this not included in the review of TOR	• Chair CDOP	Ongoing		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	31/03/2020		Amber
6.0	**To publish a CDOP Annual Report**	To ensure an annual report is developed, agreed and shared with the relevant partnerships prior to publication	• Chair CDOP	2018/19 by 30/04/2019 2019/20 by 30/04/2020		Amber

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

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