Gateshead local safeguarding children board

Sunderland Safeguarding Children Board

South Tyneside Safeguarding Children Board

South of Tyne
Child Death Overview Panel
2018-2019
Annual report

Contents

1. Introduction

The Child Death Review process covers children (a child is defined as a person under 18 years of age) and a child death review must be carried out for all children regardless of the cause of death. This includes the death of any live-born baby where a death certificate has been issued. For avoidance of doubt it does not include still births, late foetal loss, or terminations of pregnancy carried out within the law. For clarification see:

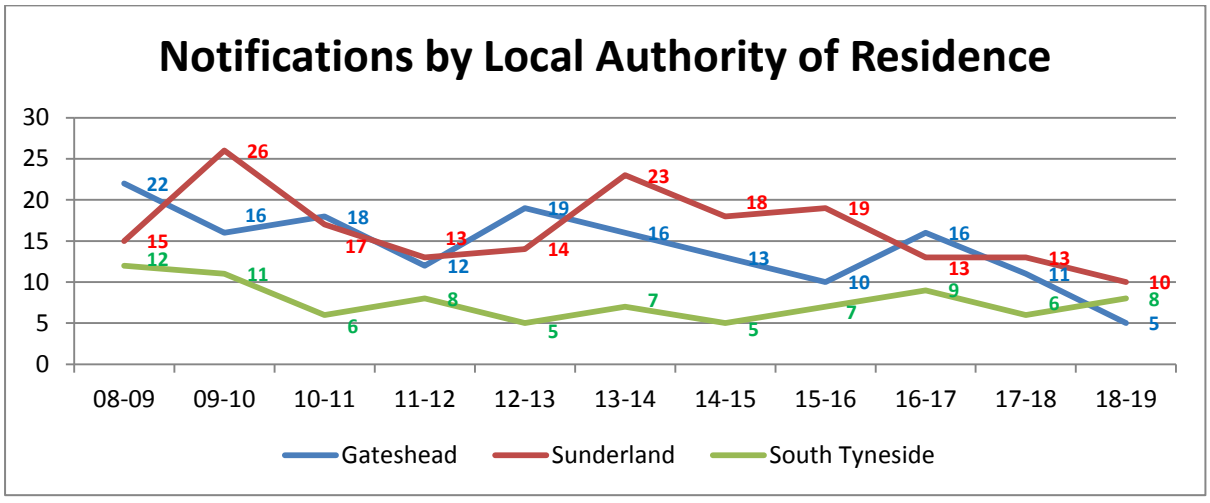
Working Together to Safeguard Children 2018
Child Death Review Statutory and Operational Guidance (England) October 2018

The South of Tyne Child Death Overview Panel (SoT 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.

The panel is made up of multi-agency professionals with an emphasis on strong partnership learning (see appendix 1 for panel membership). Reviewing the circumstances surrounding the sad death of a child ensures that learning can be shared with colleagues in a timely manner, identifying changes that can be made/ actions that can be taken to prevent similar deaths in the future.

2. Number of Deaths Notified 2018-19

The SoT CDOP was notified of the death of 23 children during 2018-19, 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 2018-19 there were 5 deaths in Gateshead, 10 in Sunderland and 8 in South Tyneside. These comprised of 5 expected deaths of children with known life limiting medical conditions, 11 neonatal deaths and 7 deaths of children beyond the neonatal period that were unexpected.

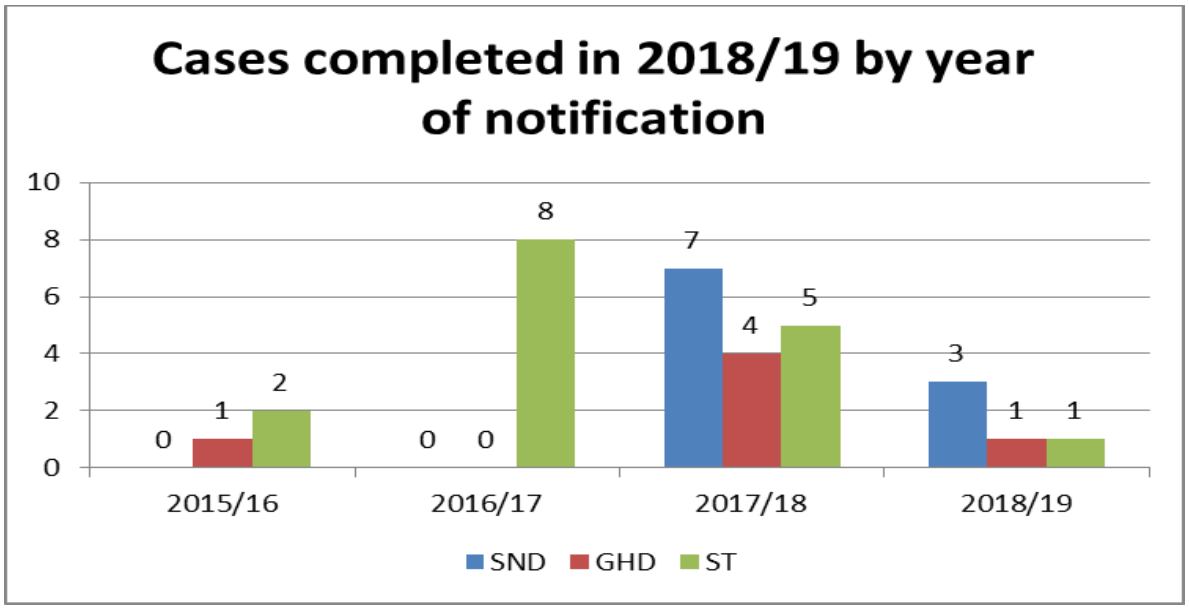


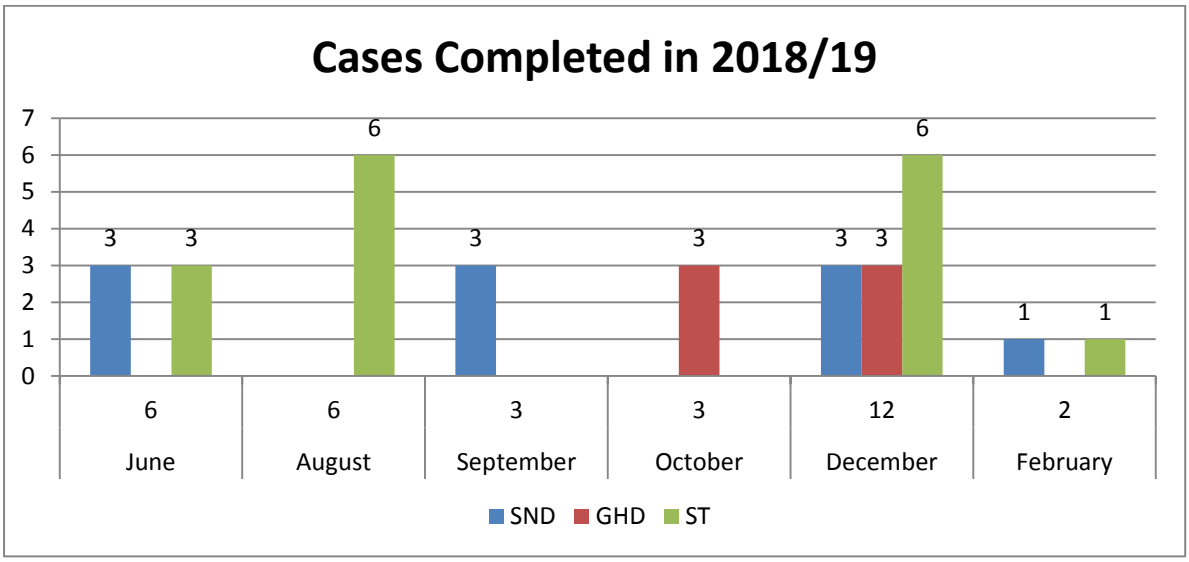
3. Number of Completed Reviews

In 2018-19 the SoT CDOP completed the reviews of 5 of the 23 deaths notified (21%). It should be noted however that of the 18 outstanding cases the delays were due to the following reasons:

6 – Delay in receiving hospital information
4 – Coroners/Police Investigations
3 – Local discussions concluded, due to be heard at next CDOP meeting
4 – Death occurring in the last 3 months, local discussions were in progress
1 – Closed in the first meeting of 2019/20

There were 6 CDOP meetings held in 2018-19 with an average of 5 completed reviews per meeting, 3 for deaths notified in 2015/16, 8 for deaths notified in 2016/17, 16 for deaths notified in 2017/18 and 5 for deaths notified in 2018/19.

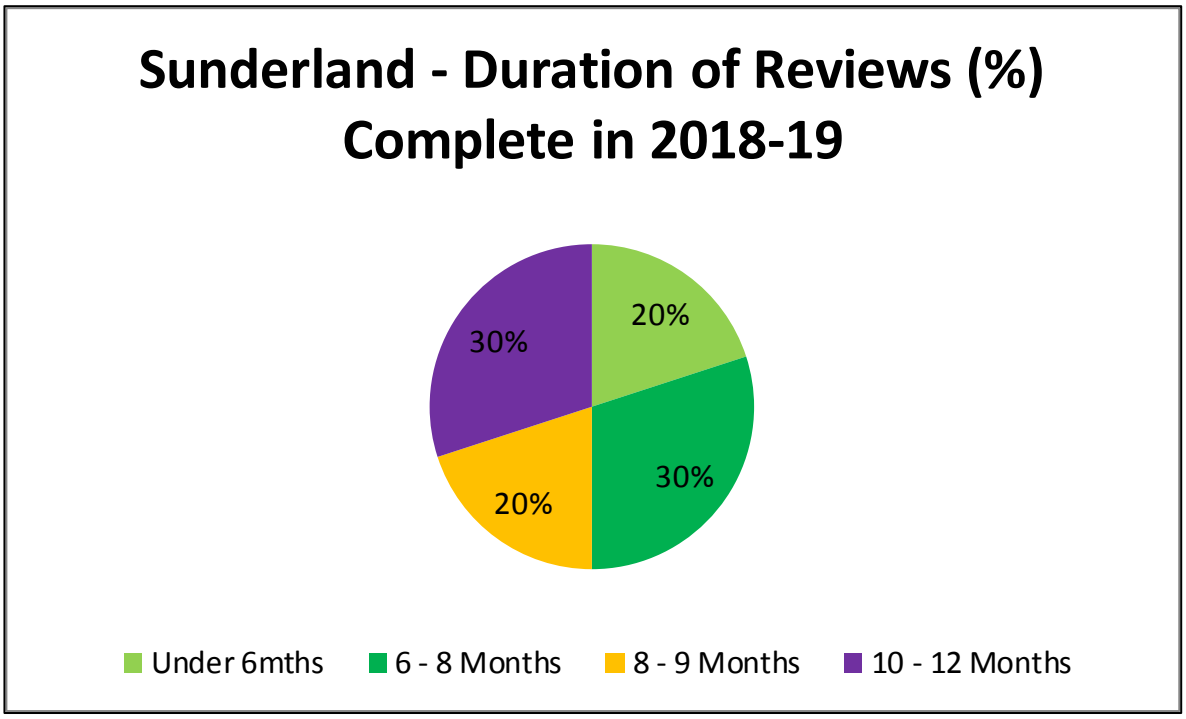


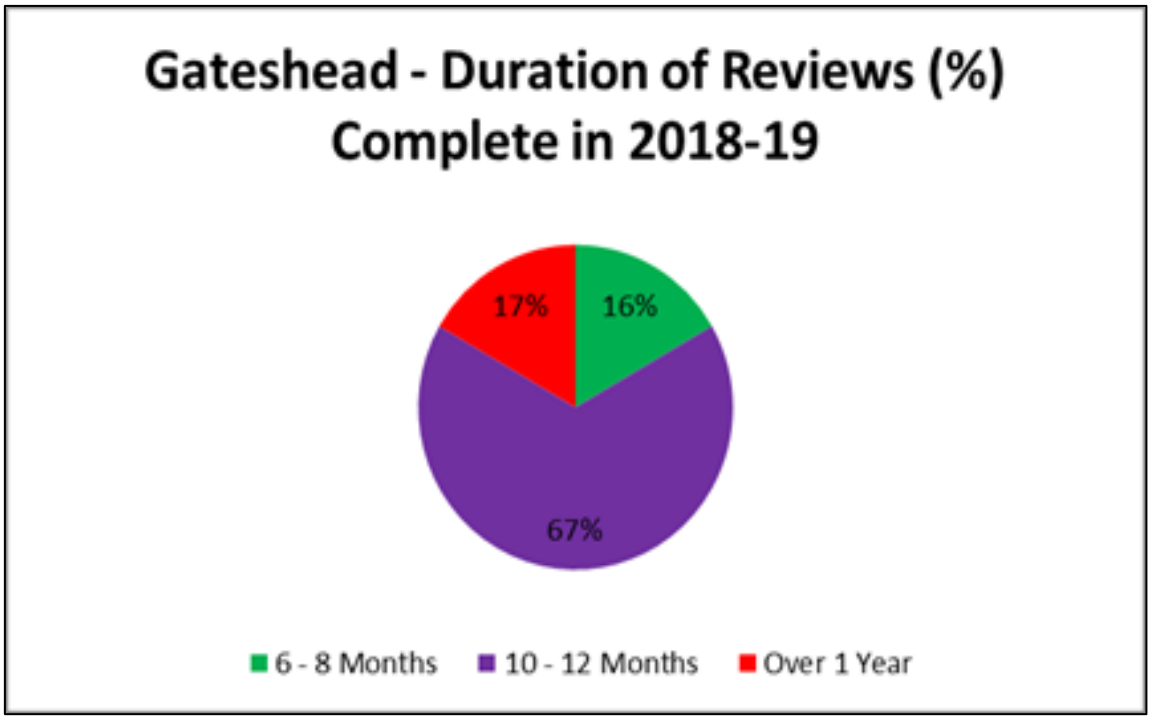


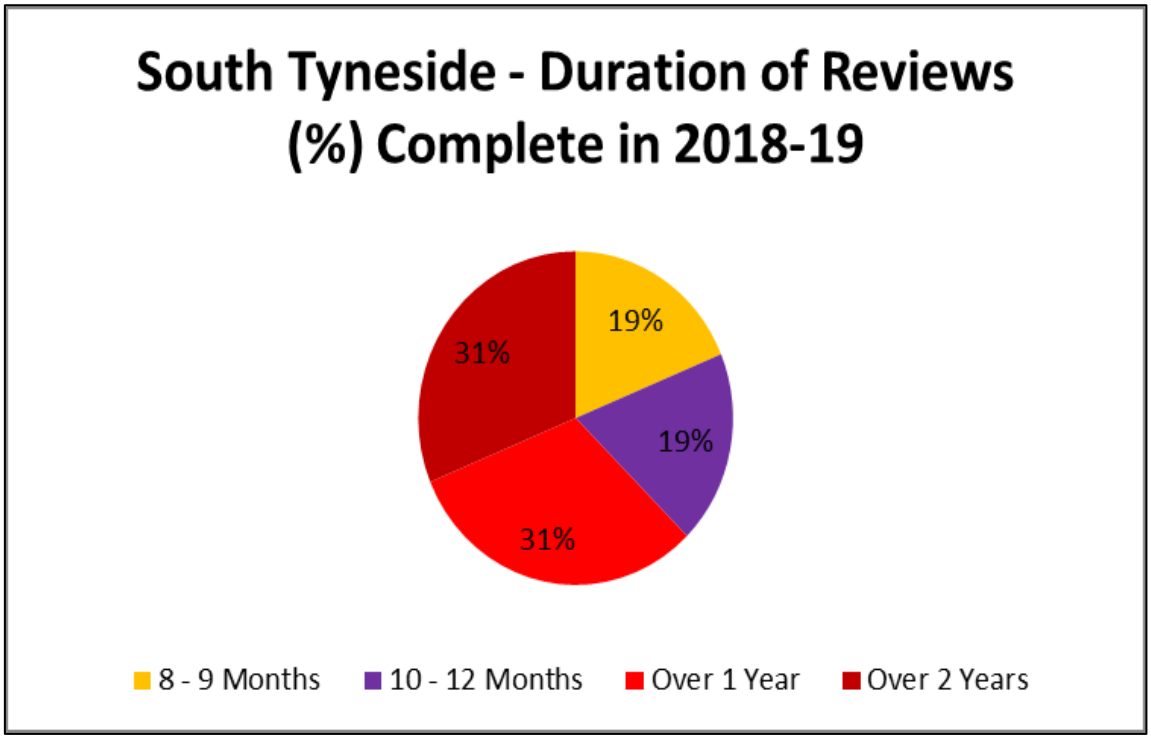
It was noted that a substantial number of cases completed in 2018/19 from previous years were outstanding South Tyneside cases caused by the lack of a Child Death Review Coordinator and Designated Doctor. The panel acknowledged the considerable amount of time and work carried out by Designated Doctor for South Tyneside in order to progress these cases in 2018/19.[i]

69% of reviews concluded in 2018-19 were signed off within 12 months of the death. The reviews from previous years that remain outstanding are those that are delayed by Coronial/Police investigations however it must me noted that these delays have not impacted on identifying and disseminating learning.

Length of Review	SND	GHD	ST
Under 6mths	2 (20%)	0 (0%)	0 (0%)
6 - 8 Months	3 (30%)	1 (17%)	0 (0%)
8 - 9 Months	2 (20%)	0 (0%)	3 (19%)
10 - 12 Months	3 (30%)	4 (66%)	3 (19%)
Over 1 Year	0 (0%)	1 (17%)	5 (31%)
Over 2 Years	0 (0%)	0 (0%)	5 (31%)

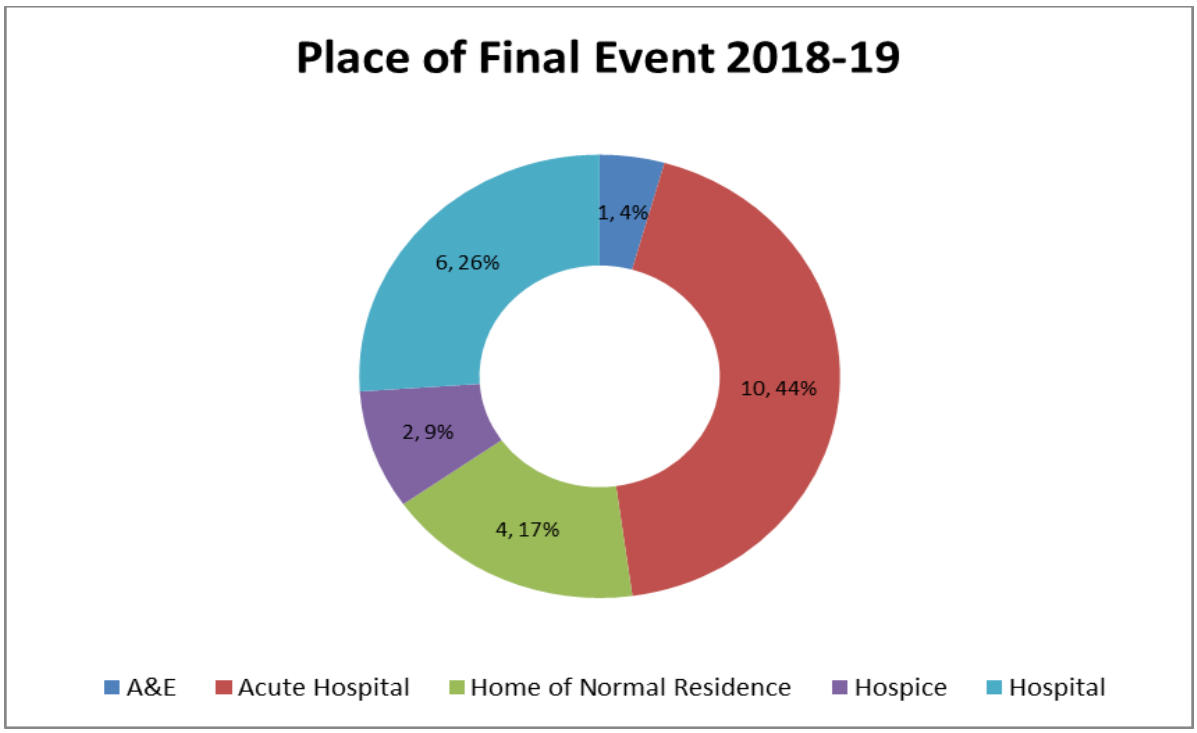



Gateshead - Duration of Reviews (%) Complete in 2018-19
17%
16%
67%
6 - 8 Months
10 - 12 Months
Over 1 Year


South Tyneside - Duration of Reviews (%) Complete in 2018-19
19%
31%
19%
31%
8 - 9 Months
10 - 12 Months
Over 1 Year
Over 2 Years

4. Circumstances of Deaths 2018-19

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.

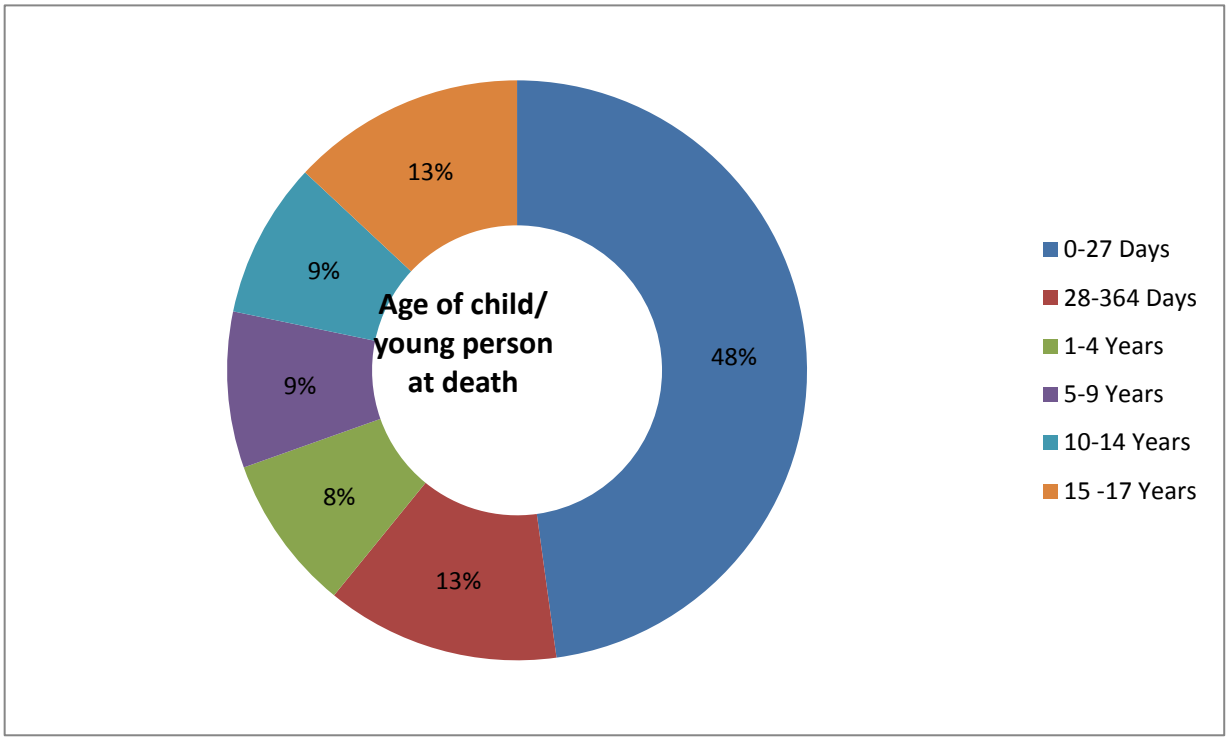


The Child Death Overview Panel is required to categorise each child death using a national standard list of categories. Of the reviews completed in 2018/19 the categories are:

Category		15/16	16/17	17/18	18/19
1.	Deliberately Inflicted Injury, Abuse or Neglect	1			
2.	Suicide or Deliberate Self-Inflicted Harm		1		
3.	Trauma and Other External Factors			1	1
4.	Malignancy			4	1
5.	Acute Medical or Surgical Condition				
6.	Chronic Medical Condition				
7.	Chromosomal, Genetic and Congenital Anomalies	1	2	4	1
8.	Perinatal/Neonatal Event	1	4	3	1
9.	Infection			1	1
10.	Sudden Unexpected, Unexplained Death		1	3	
		3	**8**	**16**	**5**

5. Characteristics 2018-19

Most notifications (48%) were received for babies dying in the neonatal period (0 - 28 days). 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 has been an equal split of male/female notifications (11 of each) with one unknown gender.



21 of the 23 (92%) received by the SoT CDOP in 2018-19 (97% in 2017-18) were for children of White, British origin (the other 2 were Lithuanian and British Indian).

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

6. Serious Case Reviews

LSCBs are required to undertake reviews of serious cases (Serious Case Reviews) in specified circumstances and advising the authority and their Board partners on lessons to be learned. A serious case is one where:

(a) abuse or neglect of a child is known or suspected; and
(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

There were no Serious Case Reviews commissioned for child deaths notified in the 2018-19 period.

The Children and Social Work Act 2017 removes the statutory basis of LSCBs and requires the statutory safeguarding partners (Local Authorities, Police and CCGs) to agree their multi-agency safeguarding arrangements (MASA) and publish these by June 2019. Such arrangements must comply with the requirements outlined in the legislation and Working Together 2018 to undertake Child Safeguarding Practice Reviews which can be locally or nationally led; overseen by a national panel. This CDOP must be cognisant of the implementation of the MASAs across the South of Tyne and their emerging learning and improvement frameworks.

7. Modifiable Factors

Working Together to Safeguard Children (2018) defines modifiable factors as "factors which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future 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.

Although the cases notified and completed in 2018/19 have no cases where modifiable factors have been identified there have been some cases closed in this period that were notified in the previous period which have identified some modifiable factors:

- Co-sleeping
- Parental consumption of alcohol and other substances
- Parental smoking
- Concealed Pregnancies
- Driving issues (whilst under the influence; using mobile telephones; not wearing seat belts)

In some cases there were no modifiable factors identified but learning included:

- Consistency of policies and procedures around Looked After Children (LAC) admitted to hospital/funeral arrangements/joint pathways into hospice care
- Recording of risk assessment for pre-eclampsia
- Transfer of babies at an early point where blood transfusion may be necessary
- Drugs altering the state of mind of a young person considering suicide

8. 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 2018-19 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.

9. Involvement of the Family

The Designated Doctors ensure that parents/families are kept informed at all stages of the Child Death Review process after death, and parents have the opportunity to ask questions and raise issues that can be considered at the case discussion.

10. Summary and Recommendations to Statutory Partners

South of Tyne Business Plan

Appendix two outlines the key priorities of this panel for 2018-2020 and progress will be monitored against this business plan at every CDOP. 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.

11. Next Steps

National Child Mortality Database (NCMD)

From April 2019 The National Child Mortality Database (NCMD) will collect information about all children in England who die before their 18th birthday. The Healthcare Quality Improvement Partnership (HQIP) is commissioning this programme of work on behalf of NHS England. The NCMD will drive improvement in the quality of health and social care for children in England to help reduce potentially avoidable deaths. It will collect a minimum dataset from the Child Death Overview Panel (CDOP) reviews of all child deaths in England. The collection, analysis and public reporting of information from all child deaths across England will facilitate learning to reduce preventable child mortality.

New Statutory Guidance

The Child Death Review Statutory and Operational Guidance (England) October 2018 recommends that CDOPs should cover a child population to review at least 60 child deaths each year. This will better enable thematic learning in order to identify potential safeguarding or local health issues that could be modified in order to protect children from harm and ultimately save lives. The South of Tyne and North of Tyne CDOPs have discussed merging in order to satisfy this requirement, but no agreement has been reached at the time of writing this report. Recommendations from discussions included:

- By the end of 2019 SoT and NoT CDOPs should be merged into one. After a further year and depending upon work done further south in the region a larger footprint could be considered

- Development of themed panels for Neonatal deaths should be considered. These are largest category of deaths and require particular expertise, often including obstetrics as well as neonatologists, to truly analyse and consider if there were any modifiable factors
- The acquisition of eCDOP will support all processes and it was felt that this should be agreed asap – although some discussion regarding funding is required
- The role of the Designated Doctor was discussed and it was felt that it would not be reasonable to expect 6 Designated Doctors to attend all meeting. Consideration could be given to a medical 'keyworker'
- A mechanism should be embedded in the processes for modifiable factors and local earning to be implemented/disseminated in as timely a manner as possible
- There will be a greater need for a strong co-ordinator/manager of the larger CDOP – this should be a full-time post but one that could sit within any of the Local Authorities
- It is important that there is challenge within CDOP and agreement on the quoracy of meetings and ensuring consistent attendance from non-medical members will be vital

E-CDOP System

A webinar was held in conjunction with North Tyneside to consider the benefits of signing up to the E-CDOP System. E-CDOP was developed in 2015 to realise effectiveness of data collection for the purposes of child death reviews and consideration has been given to purchasing the system but this has been put on hold until the merger of the South of Tyne/North of Tyne CDOPs has been agreed.

Premature Babies

Serious consideration was given to the need to review the deaths of babies born before 22 weeks gestation in CDOP meetings during 2018/19. Guidance states that babies born before 22 weeks gestation can be discussed at the discretion of the CDOP but generally learning will picked up through other forums, for example MBRRACE. It was agreed that when a baby had been notified as a live birth then a review should be undertaken but that Designated Doctors should identify within their organisations the importance of live births being correctly identified.

Appendix 1: South of Tyne Child Death Overview Panel Membership

Name	Organisation	Designation
Gillian Gibson (Chair)	Sunderland City Council	Director of Public Health
Deanna Lagun (Vice Chair)	Sunderland Clinical Commissioning Group	Head of Safeguarding
Aelfwynn Sampson	Northumbria Police	Detective Chief Inspector
Anne Fearon	South Tyneside NHS Foundation Trust	Specialist Health Visitor
Carl Harvey	Sunderland NHS Foundation Trust	Designated Doctor (Sunderland)
Carmen Howey	Gateshead NHS Foundation Trust	Designated Doctor (Gateshead)
Carol Drummond	South Tyneside Clinical Commissioning Group	Head of Safeguarding
Diane Watson	South Tyneside NHS Foundation Trust	Specialist Health Visitor for Children with Additional Needs
Gerald Tompkins	Gateshead Council	Public Health Consultant
Hilary Bagley	South Tyneside Council, Children's Standards Unit	Safeguarding Manager
Jackie Nolan	South Tyneside Safeguarding Boards (Children and Adults)	Business Manager
Karen Arkle	North East Ambulance Service	Named Lead Professional for Safeguarding Children
Laura Jones	Sunderland City Council	Children's Disability Team Manager
Lynn Wilson	Gateshead Council and Newcastle Clinical Commissioning Group	Director of Joint Commissioning, Performance and Quality
Lynne Thomas	Sunderland Safeguarding Children Board	Strategic Business Manager
Saira Park	Gateshead Safeguarding Children Board	Business Manager
Sunil Gupta	South Tyneside NHS Foundation Trust	Designated Doctor (South Tyneside)
Trina Holcroft	Newcastle-Gateshead Clinical Commissioning Group	Designated Nurse Safeguarding Children

Appendix 2: 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 legislation and guidance**	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 and consider wider footprint in line with Integrated Care System.	• 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

Objective/Priority		Action(s)	Responsible Person(s)	Timescale	Progress/Outcomes	RAG Rating
		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	• Chair CDOP • 3 LSCB Business Managers	31/03/2020		Amber
		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	31/03/2019		Amber
		SoT CDOP Terms of Reference, including chairing arrangements, to be updated and agreed by CDOP Members	• 3 LSCB Business Managers	31/03/2019		Amber
2.0	**To collect and collate data on all child deaths in SoT and to evaluate the data on these**	To 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
	deaths to identify 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	31/03/2019		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	31/03/2019		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 any local/regional	• Chair CDOP	31/03/2019		Amber

Objective/Priority		Action(s)	Responsible Person(s)	Timescale	Progress/Outcomes	RAG Rating
		campaigns.				
		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	31/03/2019		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

Objective/Priority		Action(s)	Responsible Person(s)	Timescale	Progress/Outcomes	RAG Rating
		To ensure there is adequate provision of Care of Next Infant Programme across the identified footprint	• Chair CDOP • Local Commissioners	31/03/2020		Amber
		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	31/03/2020		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	31/03/2020		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	31/03/2020		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

South of Tyne Child Death Overview Panel,

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