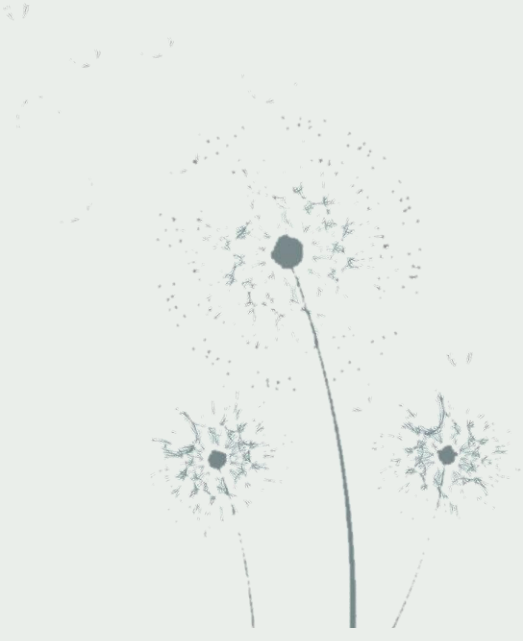
Child Death Overview Panel (CDOP) Annual Report

April 2022 - March 2023

North & South of Tyne

Contents



Foreword

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

Welcome to the third annual report of the North and South of Tyne Child Death Overview Panel (CDOP). This report summarises the panel's activity which aims to drive improvements in children and young people's health across Gateshead, Newcastle, Northumberland, North Tyneside, South Tyneside, and Sunderland.

The child death process requires agencies to undertake a review process prior to the panel review. Thanks must go to all frontline staff and 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 is to scrutinise the circumstances surrounding each child's death and where appropriate, to provide challenge to the agencies involved to enhance learning, as well as to make recommendations to appropriate agencies to improve service delivery and patient experience.

The merged panel has been functioning for three years. Meeting virtually is well established and this has facilitated a wider diversity of professionals' attendance at Joint Agency Response meetings (JARs) and Child Death Review Meetings (CDRMs) leading to improved information sharing and learning.

The North and South of Tyne panel met 10 times within the timeframe of this annual report (April 2022 - March 2023) with very good multi-agency attendance. We have continued to welcome observers to the panel from constituent agencies 14 observers this year from nursing, medicine, and safeguarding.

Thanks must go to Jill Rennie who has provided secretarial support to enable the smooth production of this report. Thanks also to the various panel members who provided information for section 4.

I would like to extend a huge thanks to Miranda Trevor, Academic Fellow in Public Health in South Tyneside for her extensive help and support in the development of this report. Her expertise in data analysis and editing skill has been invaluable. Further thanks go to Local Knowledge and Information Service (LKIS) North East and Yorkshire for support in the analysis of Primary Care Mortality Database data used through this report.

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

1 Introduction

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 reviewed by CDOP to comply with the statutory requirement set out in Working Together 2018[1]. In the event of a birth which 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.

The Children Act 2004[2] requires Child Death Review (CDR) Partners, (6 Local Authorities from 1 ICB 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[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 arrange for review of a death of a child not normally resident there. This process is pragmatic with consideration given to where the most learning can take place.

In April 2019 the National Child Mortality Database[4] (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.

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,
- 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 is analysed nationally and regular reports are produced 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.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

[2] https://www.legislation.gov.uk/ukpga/2004/31/enacted

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf

[4] https://www.ncmd.info/

2 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 & South of Tyne CDOP to review the death of every child who normally resides in these areas, regardless of where the death occurs. This document reports on all the children whose deaths were reviewed by the panel in 2022/2023, 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, collated and presented to the CDOP.

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 CDRM follows once all the information is available and is then collated and presented to the Child Death Overview Panel. The CDOP will classify the cause of death and identify contributory factors and modifiable factors (those which can be changed through national or local interventions). The panel will make recommendations to prevent future similar deaths or improve the safety and welfare of children in the local area and further afield.

Child Safeguarding Practice Reviews (CSPRs) investigate cases where abuse or neglect is known or suspected and the child has died or been seriously harmed. These are locally undertaken by Local Safeguarding Children Partnerships (LCSP) or nationally to fulfil the requirements outlined in the legislation and Working Together. 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 CSPR are met, even if it has already been considered by the Safeguarding Child Partnership (SCP) and to make recommendations appropriately. Learning Reviews can also be undertaken. In 2022/2023 there were two 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 2022/2023, the North and South of Tyne CDOP had two neonatal-themed panels and one cardiology-themed panel. Panel members were very positive around the depth of learning which took place whilst focusing on one category of child death.

If the CDOP is notified of the death of a child with an identified learning disability or with high likelihood of a diagnosis this information is shared with the Learning Disabilities Mortality Review (LeDeR)[5] Programme via online referral. Further liaison takes place to share core data and ensure the CDOP supports the LeDeR Programme.

[5] https://leder.nhs.uk/

3 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
Patricia Grant	Deputy Designated Nurse Safeguarding Children, North Tyneside
Jenna Wall/Lesley Heelbeck	Head of Midwifery Northumbria/Head of Midwifery Gateshead
Louise Cass-Williams/Shelley Hudson	Northumbria Police
David Garner	Practice Manager ISIT (Social care)
Mark Quinn	Children's Services Manager
Tom Hall	Director of Public Health (DPH) South Tyneside Council

Dr Therese Hannon	Consultant Obstetrician (Themed Panel Member)
Dr Abbas Khushnood	Consultant Cardiologist (Themed Panel Member)
Tracey Hadaway	South of Tyne CDR Coordinator

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

The CDOP is not commissioned to deliver public health interventions but learning from the CDOP is shared with partners and integrated into programmes to support the health and wellbeing of children in the region.

Newcastle and Gateshead

The North and South of Tyne CDOP continues to see infants who have sadly died of SIDS where modifiable risk factors were present. In the light of these persistent cases and publication of a national review of deaths in infancy in families where the children are considered at risk of significant harm called, 'Out of Routine,' a multi-agency working group was established by the Safeguarding Partnership in Newcastle and Gateshead. [6]

This approach encouraged practitioners from a wide range of agencies working with families with an unborn baby or infant including Local Authorities, police, housing, drug and alcohol services, fire service, public health, 0-19 services, maternity, early help, foster carers, and IROs etc. to support, promote, and embed guidance on minimising SIDS risk into their own organisation. The focus of the approach is to raise awareness of modifiable risk factors for infant sleeping and tailors the advice to families according to their individual needs.

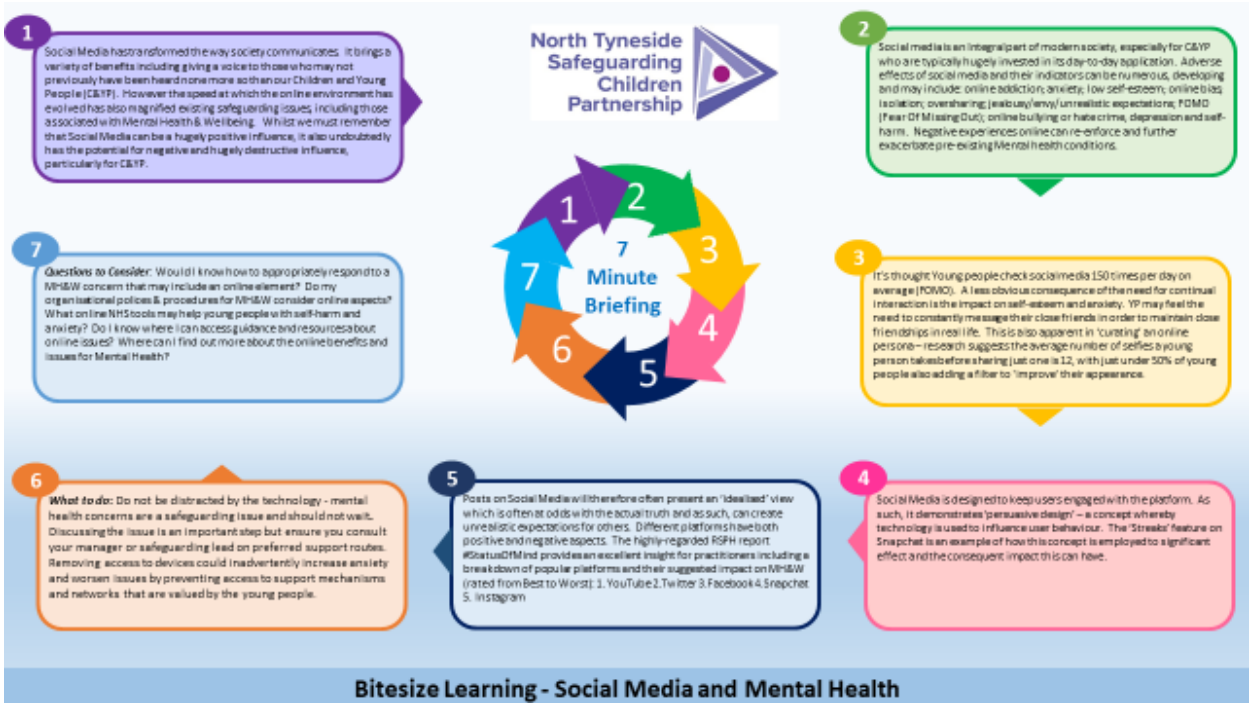
North Tyneside

Social Media has the potential to provide significant support by understanding the experiences of others, sharing problems with friends and peers, and as a platform for positive self-expression, however, there are potential harms to social media on young people's mental health. These can include online addiction, anxiety, jealousy, depression and/or self-harm. The North and South of Tyne CDOP continues to see deaths associated with deliberate self-harm.

In the light of these concerns and reviews on the effects of social media on young people's health North Tyneside has developed a 7-minute briefing to be shared across

[6] Minimising the Risks of Sudden Infant Death Syndrome (SIDS) - Newcastle Safeguarding

the partnership. Furthermore, a session for professionals about social media and the impact on adolescents' mental health is in development. Young people are supporting and shaping the content of these projects with the support of the youth council.



Midwifery Services

Whilst reviewing the 2021/2022 CDOP Annual report, the Local Maternity and Neonatal System (LMNS) of the North East and North Cumbria ICS felt that the modifiable factors associated with infant deaths, particularly around safe sleeping practices, required an ICS approach.

A LMNS project lead was allocated to scope an ICS approach to safe sleeping, which incorporates the findings of the 'Eyes on the Baby' pilot evaluation and identifies opportunities for system working, including working alongside the Office for Health Improvements and Disparities. Work is ongoing to finalise the system approach.

In the interim, Northumbria Healthcare NHS Foundation Trust (NHCFT) has funded a further pilot of the 'Eyes on the Baby' training in Northumberland and are also providing room thermometers and baby sleeping bags to vulnerable families.

New Bereavement Service

Nurses in NHCFT are proud to be developing a new bereavement service where each family will receive a named keyworker after the death of their child. This keyworker will be a single point of contact for the family, avoiding the need for the family to contact multiple professionals with questions, they will also make families aware of the process following a child death, and act as an advocate for families at professionals' meetings. The role of the keyworker may also involve signposting families to bereavement support, assist with obtaining funding for the funeral, or assist with religious/cultural beliefs for example by arranging for a blessing from the Chaplaincy.

In setting up this service the nurses have worked hard to make good links with other professionals such as Northumbria Police, CDOP, Chaplaincy, Coroner's office, and Charities to ensure effective communication, and made presentations about our service to the police and CDOP. The service has received a huge amount of support from charities such as 4Louis, Teardrop, Pyjama Fairies, Aching Arms, and Cherished Gowns. As well as the bereavement midwives within the trust, 4Louis have helped fund and design a family room where these families can spend their last precious moments with their child after death and a cold blanket to help facilitate this. They have provided baby grows for little ones to wear until after PM, as their clothing is often taken by the police, and Teardrop have arranged for the use of a cold cot if required.

The bereavement service will be offered to the family of any child between the age of 0-17 years who has died within paediatric or adult ED or critical care, with the Children's Community Nurses providing support for families where the child has died in the community. If a family wishes not to use the service, the keyworker will only contact the family with details of any professionals' meetings or investigation updates.

Moving forward the service plans to deliver regular training to nursing and medical staff on the SUDI/SUDC process to reduce the anxiety staff feel at the time of a child death and ensure a smooth process for families, strengthen the professional relationships and expand the service to cover all child deaths within the trust.

Drowning

The CDOP has reviewed two drowning deaths in recent years. This data is included in the recent themed report produced by NCMD, Deaths of Children and Young People due to traumatic incidents.[7] There is some important learning for agencies across the UK:

- The number of drownings, specifically inland drownings, and drownings in the bath, have increased across the 3 years.
- The most common place of drowning for 15 -17 years was inland water.
- Nearly half of the deaths over the 3-year period of this report 2019 - 2022 were between June and August.
- There were three times as many drownings in boys than girls.
- For children aged between 10 -17 years, 83% (n=19/23) were unsupervised by an adult, including 13 (57%) who were accompanied by another young person at the time of death. This raised concerns about the possible effect of peer pressure and worry about social exclusion and the potential impact this may have on risk-taking for children and young people around the water.
- Learning reported from CDOP reviews included the importance of supervision of children and young people, the need to ensure appropriate warning signs and lifesaving equipment, and the importance of water safety; both in the home and in public places.

The recommendation made to address this is:

[7] www.ncmd.info/wp-content/uploads/2023/07/NCMD-Trauma-Thematic-Report.pdf

"Consider an urgent focused agenda to address current inequalities and provide children unable to access statutory or private swimming and water safety tuition with access to class-based water safety education". Action by: Department for Levelling Up, Housing and Communities, Department for Education and charities and not-for-profit agencies[8]

Following a number of deaths due to bath drowning in young children in the North East, Great North Children's Hospital have created a Bath Safety Advice Page which can be accessed on Healthier Together North East and North Cumbria[9]. This has also been distributed to the Matron for midwifery services within the RVI to include in their bathing education on the post-natal ward pre discharge and also shared with the 0-19 service for Newcastle for the health visiting service to promote bath safety.

5 Child Death Data

Deaths Notified to North & South of Tyne CDOP

There is a well-established and robust system for notifying the CDOP of the death of a child; all relevant agencies have access to the electronic eCDOP in line with the statutory requirements to notify all child deaths 0-17 years of age immediately after the death of the child. Multi-agency data is then transferred to NCMD, reducing duplication.

Table 5.1 – Total number of notifications of deaths

	2021/22	2022/23
Northumberland	19 (21%)	14 (13%)
North Tyneside	7 (8%)	11 (10%)
Newcastle	19 (21%)	32 (30%)
Gateshead	13 (14%)	13 (12%)
South Tyneside	12 (13%)	14 (13%)
Sunderland	12 (13%)	17 (16%)
Out of Area	9 (10%)	5 (5%)
North and South of Tyne Total	91	106

There were 106 deaths notified to the CDOP in 2022/2023, compared with 91 the previous year. The number of cases notified to the CDOP differs from the number of cases which the panel reviews during a given year as the child death review process,

[8] https://www.gov.uk/government/organisations/department-for-levelling-up-housing-and-communities

[9] https://www.nenc-healthiertogether.nhs.uk/

prior to the CDOP meeting, can take several months, particularly if there are police or coronial processes to be concluded.

Table 5.2 – Age of child at time of notification of death

	2021/22	2022/23
0-27 days	33 (36%)	33 (31%)
28 days- 364 days	22 (24%)	20 (19%)
1 year-4 years	15 (16%)	17 (16%)
5-9 years	6 (7%)	7 (7%)
10-14 years	7 (8%)	17 (16%)
15-17 years	8 (9%)	12 (11%)
North and South of Tyne Total	91	106

Table 5.3 - Place of Death identified at notification

	2021/22	2022/23
Hospital	71 (78%)	83 (78%)
Home	18 (20%)	15 (14%)
Hospice	2 (2%)	0
Public Area	0	6 (6%)
Abroad	0	2 (2%)
North and South of Tyne Total	91	106

In 2022/2023 83 (78%) of the deaths occurred in a hospital setting, with 15 (14%) occurring at home.

Table 5.4 – Gender of child at time of notification

	2021/22	2022/23
Male	61 (67%)	57 (54%)
Female	29 (32%)	47 (44%)
Indeterminate	<5	<5
North and South of Tyne Total	91	106

Table 5.5 - Number of death notifications by ethnicity

Ethnicity (Broad)	2021/22	2022/23
White	73 (80%)	73 (69%)
Mixed	2 (2%)	5 (5%)
Asian	11 (12%)	12 (11%)
Black	2 (2%)	9 (8%)
Other	3 (3%)	7 (7%)
Unknown	0	0
North and South of Tyne Total	91	106

Deaths which have been reviewed and cases closed

The North and South of Tyne CDOP panel reviewed and closed 103 cases in 2022/23, compared with 73 cases in the year prior.

Table 5.6 – Total number of deaths reviewed and closed

	2021/22	2022/23
Northumberland	10 (14%)	20 (19%)
North Tyneside	10 (14%)	6 (6%)
Newcastle	17 (23%)	28 (27%)

Gateshead	9 (12%)	16 (16%)
South Tyneside	8 (11%)	11 (11%)
Sunderland	17 (23%)	15 (15%)
Out of Area	2 (3%)	7 (7%)
North and South of Tyne Total	73	103

The panel reviewed seven cases from out of the area, i.e. children who were resident in another local authority area or country. One of the acute hospitals in our footprint is a tertiary facility providing specialist services and cares for children from a wide catchment area. These cases were brought to panel as the clinicians involved felt there was learning for the system.

Table 5.7 – Age of child at time of death in cases reviewed and closed

	2021/22	2022/23
0-27 days	26 (36%)	40 (39%)
28 days- 364 days	14 (19%)	24 (23%)
1 year-4 years	12 (16%)	13 (13%)
5-9 years	4 (5%)	7 (7%)
10-14 years	6 (8%)	10 (10%)
15-17 years	11 (15%)	9 (9%)
North and South of Tyne Total	73	103

The majority of the cases reviewed by the CDOP were in children <1 year old with 40 cases (39%) in the 0-27 days category and 24 cases (23%) in the 28-264 days category.

Table 5.8 - Place of Death of cases reviewed and closed

	2021/22	2022/23
Hospital	49 (67%)	81 (79%)
Home	19 (26%)	19 (18%)

Hospice	1 (1%)	1 (1%)
Public Area	4 (5%)	2 (2%)
Private Care Home	0	0
North and South of Tyne Total	73	103

In the majority of cases (79%) reviewed by the CDOP the death occurred in hospital which is consistent with the pattern of the previous year.

Table 5.9 – Gender of child of cases reviewed and closed

	2021/22	2022/23
Male	37 (51%)	66 (64%)
Female	36 (49%)	37 (36%)
North and South of Tyne Total	73	103

The majority (64%) of cases reviewed by the CDOP in 2022/23 were male children.

Table 5.10 - Number of deaths by ethnicity of cases reviewed and closed

Ethnicity (Broad)	2021/22	2022/23
White	59 (81%)	84 (82%)
Mixed	1 (1%)	3 (3%)
Asian	6 (8%)	12 (12%)
Black	3 (4%)	2 (2%)
Other	2 (3%)	2 (2%)
Unknown	2 (3%)	0
North and South of Tyne Total	73	103

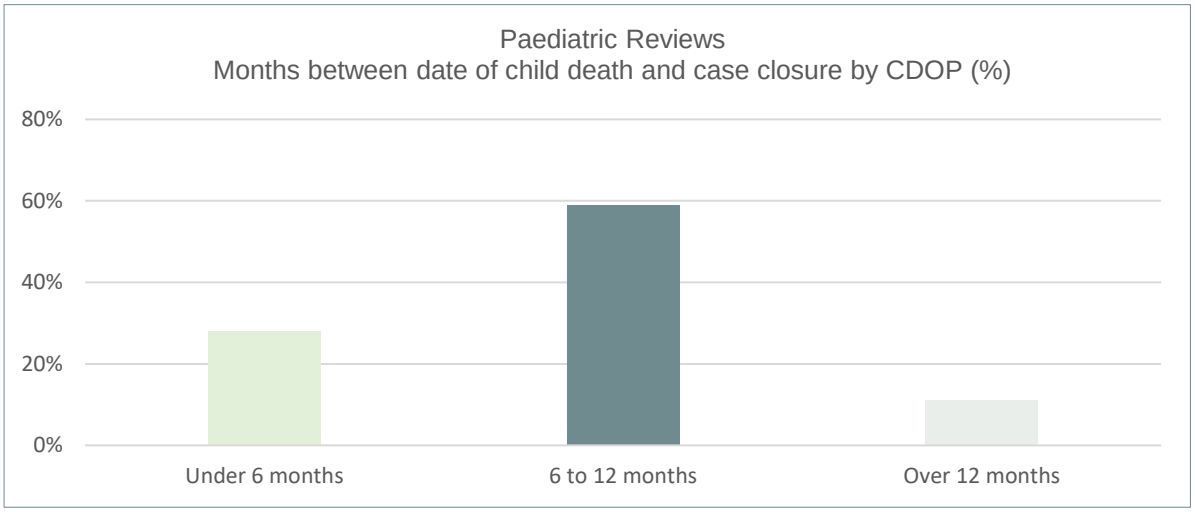
The majority (82%) of cases reviewed and closed by the CDOP in 2022/23 were relating to white children. This is consistent with the distribution seen in the previous year.

Table 5.11 - Number of reviews at each meeting 2022/23

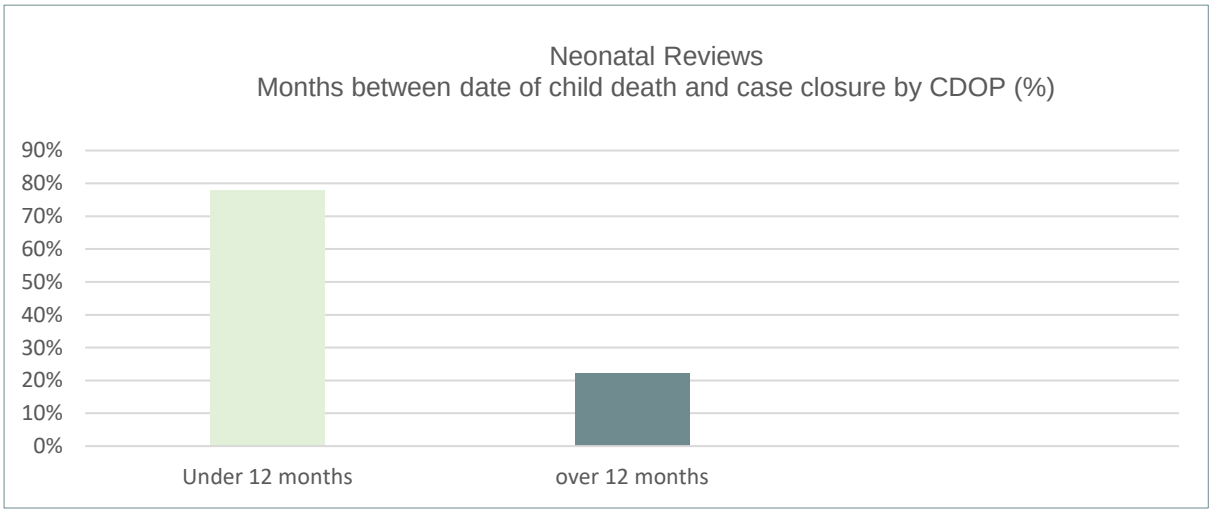
The North and South of Tyne CDOP met 10 times between April 2022 and March 2023 and reviewed between 3 and 14 cases at each meeting. Four themed panels were conducted in line with recommendations of the child death review process.

April	May Themed	July	Aug	Oct	Nov	Dec Themed	Jan Themed	Mar	Mar Themed	Total
11	12	13	10	3	9	5	14	12	14	103

Table 5.12 - Duration of Reviews 2022/23



Paediatric deaths are those which occur from one month of age up to 17 years 364 days. Of the 103 reviews closed in 2022/23, 57 were of paediatric deaths (one month to 17 years). Of these 57 cases, 16 (28%) of reviews were finalised within 6 months of the child's death, 35 (59%) were completed between 6-12 months, and 6 (11%) took over a year.



Neonatal deaths are those which occur between birth and one month of age and have not left in-patient hospital care.

Of the 103 reviews closed in 2022/23, 46 were neonatal deaths (deaths at less than 1 month of age). These cases were reviewed in 3 neonatal-themed panels and five cases were reviewed in the cardiology-themed panel. Of the 46 reviewed and closed neonatal deaths, 36 (78%) were reviewed within 12-month timescale and 10 (22%) took over a year to be closed by the CDOP.

There are several factors that may contribute to a longer length of time between the death of a child and the final CDOP review including delay in the return of reporting forms, awaiting completion of necessary investigations including post-mortem reports or a criminal investigation, or the undertaking of a Child Safeguarding Practice review or Coroner's inquest. All other investigations and reports must be completed prior to review and case closure by the CDOP.

6 Modifiable Factors

The review process is required to identify modifiable factors in the cases so agencies can learn lessons, improve practice, and ultimately prevent further deaths. 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".

While identified modifiable factors by the CDOP provide significant learning to improve practice and prevent future harm, there are opportunities through the entirety of the child death process (including Joint Agency Response Meetings, Morbidity and Mortality and Child Death Review Meetings) to identify learning and opportunities for smaller, micro-changes to practice, e.g., a need for workplace training or amendments to internal policies and procedures.

There is a degree of subjectivity in identifying modifiable risk factors which is decided on a case-by-case basis. Information on factors contributing to the child's death is reliant on the thorough completion of national CDOP reporting forms by clinicians. Completion of the CDOP reporting form is done after the CDRM where all the relevant professionals who know the family share knowledge of the child's life and the circumstances of the death. Four domains are used to categorise the identified risk factors with a corresponding level of relevance (0-2):

0 - Information not available
1 - No factors identified, or factors identified but are unlikely to have contributed to the death
2 - Factors identified that may have contributed to vulnerability, ill health or death

This information should inform the learning of lessons at a local level:

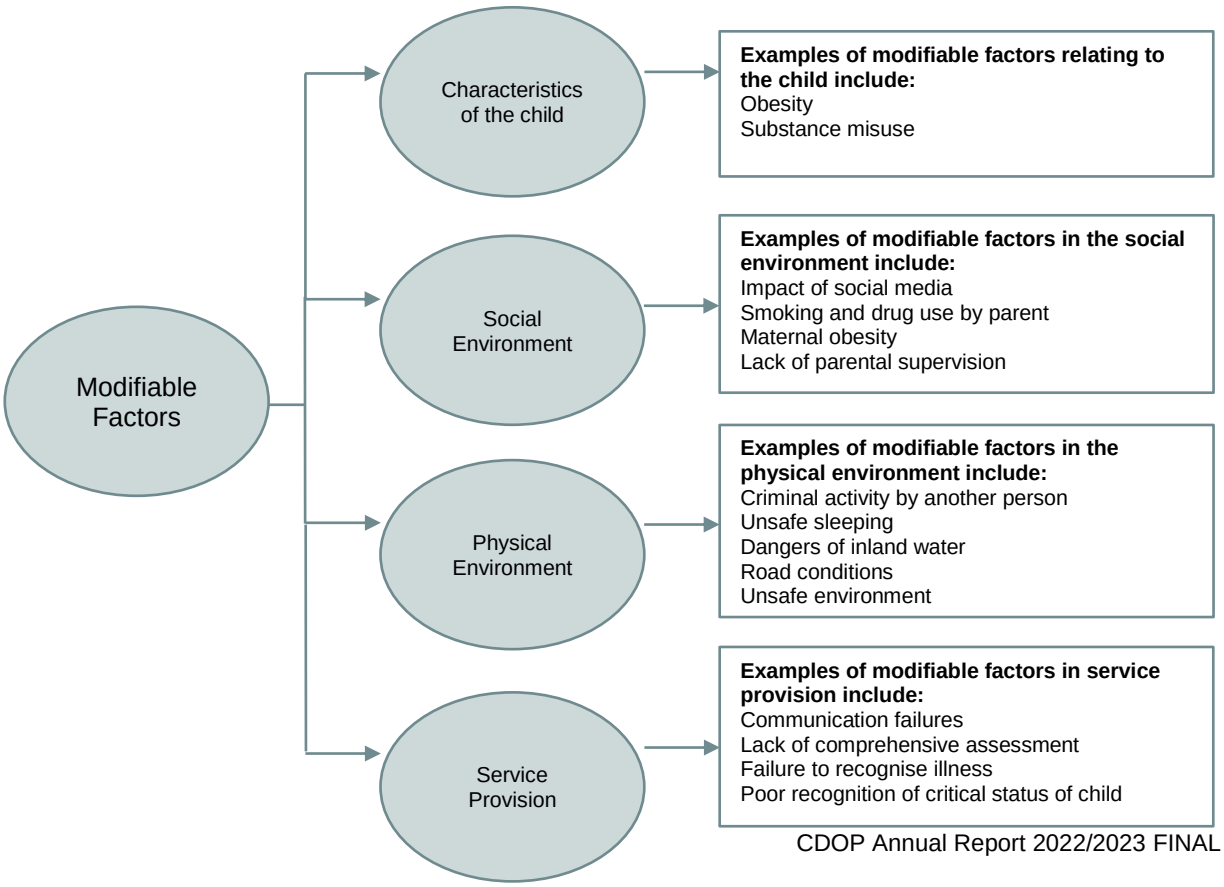
Domain A: Factors intrinsic to the child.
Domain B: Factors in social environment including family and parenting capacity.
Domain C: Factors in the physical environment.
Domain D: Factors in service provision.

Of the 103 cases reviewed in 2022/23, modifiable factors were identified in 43 (42%).

Table 6.1 - Numbers and % of child deaths with identified modifiable factors

Area	2021/22 - 2022/23							
	Total number of cases		No modifiable factors		Modifiable factors		% with modifiable factors	
	21/22	**22/23**	21/22	**22/23**	21/22	**22/23**	21/22	**22/23**
Newcastle	17	**28**	12	**19**	5	**9**	29%	**32%**
Northumberland	10	**20**	4	**11**	6	**9**	60%	**45%**
North Tyneside	10	**6**	9	**2**	1	**4**	10%	**67%**
Gateshead	9	**16**	5	**11**	4	**5**	44%	**31%**
South Tyneside	8	**11**	3	**5**	5	**6**	63%	**55%**
Sunderland	17	**15**	10	**9**	7	**6**	41%	**40%**
Out of Area	2	**7**	2	**3**	0	**4**	0%	**57%**
North & South of Tyne	73	**103**	45	**60**	28	**43**	38%	**42%**

6.2 Examples of modifiable factors identified by CDOPs



6.3 Maternal Obesity in Pregnancy

A modifiable and relevant factor highlighted by the North and South of Tyne CDOP is the mother's body mass index (BMI) during pregnancy. For most adults, an ideal BMI is in the 18.5 to 24.9 range (healthy weight range). The NHS defines the BMI[10] categories as:

Below 18.5 - underweight,
Between 18.5 and 24.9 - healthy weight range,
Between 25 and 29.9 - overweight range,
Between 30 and 39.9 - obese weight range,
40 and over - severely obese weight range.

Being overweight or obese increases the risk of complications for pregnant women and her baby[11] including gestational diabetes, pre-eclampsia, high blood pressure, shoulder dystocia, premature delivery and risk of stillbirth and birth defects. The higher a woman's BMI, the higher the chance of these complications.

6.4 Smoking

Smoking continues to have a negative impact on the general health of children and remains a key modifiable factor for child deaths in the North East. Depending on the nature of the death, the CDOP collates information regarding the smoking status including maternal smoking in pregnancy and parental and household members during the child's life.

Smoking during pregnancy has well known detrimental effects for the growth and development of the unborn baby as well as the health of the mother. Smoking during pregnancy can cause serious complications including an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy (SUDI). Maternal smoking in pregnancy and/or parental household smoking was the most common occurring modifiable factor which the CDOP deemed a significant relevant factor in relation to the cause of death. A smoke-free home is the best way of protecting babies and children.

6.5 Modifiable Factors Associated with Sudden & Unexpected Death in Infancy/Childhood (SUDI/SUDC)

Unexpected and unexplained deaths where the pathological cause of death was recorded as either 'sudden infant death syndrome (SIDS)' or 'unascertained', continue to be associated with multiple modifiable factors relating to unsafe sleeping arrangements. Unsafe sleeping arrangements such as co-sleeping, are particularly dangerous if the parent/carer has consumed alcohol or ingested substances, which may limit their awareness. Other known risk factors for co-sleeping include co-sleeping with babies born prematurely or those with a low birth weight. Other factors associated with SUDI include; overheating, covering baby's face or head while sleeping, loose bedding and falling asleep with baby on a sofa or in an armchair.

[10] https://www.nhs.uk/conditions/obesity/

[11] https://www.nhs.uk/conditions/pregnancy-and-baby/overweight-pregnant/

In deaths categorised as sudden unexpected or unexplained, the CDOP highlighted several modifiable factors identified including:

- Parental smoking and/or other household smokers,
- Unsafe sleeping arrangements such as co-sleeping where the carer has used alcohol or drugs.

6.6 Deprivation

Deprivation is a key factor that is associated with poorer outcomes for child health and wellbeing. The English Indices of Deprivation 2019 (IoD2019)[12] are used to assess Lower-layer Super Output Areas (LSOAs) of England in terms of seven domains of deprivation. These seven domains create an aggregate relative measure of deprivation. The IoD2019 can be used to compare local authorities in terms of their overall deprivation.

The seven domains used to create the Indices of Multiple Deprivation (IMD2019) are:

- Income: The proportion of the population experiencing deprivation relating to low income
- Employment: The proportion of the working age population in and area involuntarily excluded from the labour market
- Education: Measure of the lack of attainment and skills in the local population
- Health: The risk of premature death and the impairment of the quality of life through poor physical or mental health
- Crime: The risk of personal and material victimisation
- Barriers to Housing and Services: The physical and financial accessibility of housing and local service
- Living environment: The quality of both the 'indoor' and 'outdoor' local environment[13]

By creating a weighted average of the combined ranks for the LSOAs in larger areas an IMD ranking can be derived. In this way, local authorities can be ranked in terms of their deprivation; a rank of 1 is the most deprived and 317 is the least deprived.

Table 1 - IMD2019 Rank for Local Authorities in the North and South of Tyne

Local Authority	IMD2019 Rank
Northumbria	131
North Tyneside	128
Newcastle	150
South Tyneside	26
Sunderland	33
Gateshead	54

[12] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/833959/IoD2019_Infographic.pdf

[13] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/833959/IoD2019_Infographic.pdf

All local authorities in the North and South of Tyne are in the top 50% most deprived in England and half are in the top 20% most deprived local authorities. Nationally, deprivation is associated with a wide range of acute and long-term illness as well as child mortality. Children living in poverty are significantly more likely to require admission to hospital[14] and be diagnosed with a long-term illness[15]. Deprivation is also associated with the risk of death in childhood; a report from the NCMD shows that over a fifth of child deaths could have been avoided if those children in the most deprived area had the same risk of death of those in the least deprived areas, this suggests that more than 700 child deaths per year could be avoided[16].

In the 6 Local Authorities included in the North and South of Tyne CDOP sees variability in child mortality rates across areas of different deprivation. Based on data from the Office for National Statistics (ONS) National Statistics Postcode Lookup based deaths and births data from 2017 to 2021 (the most recent data available)[17] show that a higher proportion of the child deaths in the region occur in those living in the most deprived areas than the less deprived areas which is consistent with the national picture.

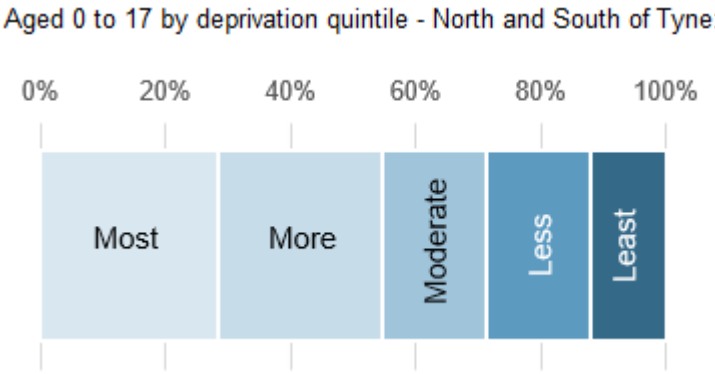
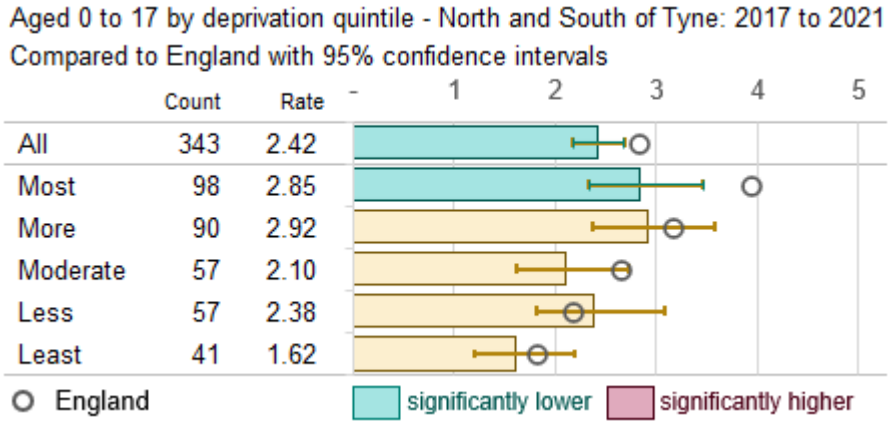


Figure 1 - Proportion of mortalities by deprivation quintile

Age-group specific mortality rates are broadly similar to those for England overall, however, the mortality rate for those from the most deprived areas is significantly lower than the rate in the most deprived regions in England overall.



[14] Kyle RG, Kukanova M, Campbell M, Wolfe I, Powell P, Callery P. Childhood disadvantage and emergency admission rates for common presentations in London: an exploratory analysis. Archives of Disease in Childhood 2011; 96: 221–6

[15] Spencer NJ, Blackburn CM, Read JM. Disabling chronic conditions in childhood and socioeconomic disadvantage: a systematic review and meta-analyses of observational studies. BMJ Open 2015; 5: e007062

[16] https://www.ncmd.info/publications/child-mortality-social-deprivation/

[17] ONS (Office for National Statistics) NSPL (National Statistics Postcode Lookup) based deaths and births data

7 Categories of Child Deaths

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

Table 7 .1 - Category of child deaths

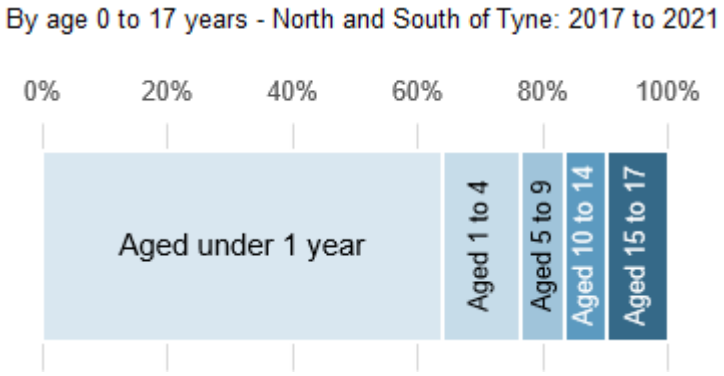
Category		2021/2022	2022/2023
1	**Deliberately inflicted injury, abuse or neglect -** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	1	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.	7	2
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).	5	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.	9	7
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.	6	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.	1	7

	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	30
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).	17	31
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.	2	4
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).	7	11

8 Recommendations and Learning from CDOP 2022/23

Recommendation re SUDI prevention

Drawing on data from ONS data, we can identify trends and patterns. For the period from 2017 to 2021 the child mortality rate for the North and South of Tyne was 2.42 per 10,000 population, but child mortality rates vary significantly by age group with the under-1 age group being the largest with more than 60% of child deaths occurring in this age group. This is consistent with national trends.



In 2022/23 the second commonest category of child deaths, excluding perinatal and neonatal events, was category 10: “Sudden unexpected, unexplained death.” The 3-year average for our CDOP footprint is 7 cases of SUDI per year, which represents significant suffering for families in our region. Risk factors for SUDI are well-known and were often seen in reviews at CDOP. A 2020 report by the Child Safeguarding Practice Review Panel, 'Out of Routine: A review of SUDI in families where the children are considered at risk of significant harm' concluded[18]:

> *"As stated in the foreword to this report, the sudden and unexpected death of an infant is one of the most devastating tragedies that could happen to any family. The fact that over 300 infants die this way each year in the UK, many in circumstances that could be prevented, is a cause for great concern. As this review has shown, although the advice around safer sleeping is well established and evidence-based, many families living in challenging circumstances are not managing to follow this advice. Through the literature review and field work, we have identified approaches with the potential to reduce the risks of SUDI. While there is still much to learn and further research to be done, we believe the proposed prevent and protect practice model offers a framework for local safeguarding partners to develop their services and support their front-line practitioners. We hope that, acting on the learning from this review, individual practitioners from all agencies will be able to work more effectively with parents and families, particularly those whose children are at risk of significant harm. Embedding safer sleeping advice in wider multi-agency initiatives recognises that this is not just about preventing sudden unexpected deaths, but part of a broader approach to promoting infant safety, health and well-being".*

[18] July 2020 The Child Safeguarding Practice Review Panel – Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm.

Some of the areas in the CDOP footprint have developed unilateral approaches to SUDI prevention and these are welcomed.

However, the panel would like to recommend a collaborative approach between the child death review partners in all six areas to explore existing local and national SUDI prevention programmes and agree a regional strategy to tackle this problem.

Dissemination of the learning from reviews

The panel chair is a member of the Quality and Safety group within the ICB and has links with the 6 children's partnerships as well as the regional maternity group. This report will be shared with all these groups.

Panel members are tasked with taking the learning from the reviews and sharing it widely within their organisations and networks so staff in all the constituent agencies are aware of modifiable factors when supporting and advising parents and carers.