NHS
Northumberland
Clinical Commissioning Group

Child Death Overview Panel (CDOP) Annual Report April 2020- March 2021

This is the first annual report of the North and South of Tyne Child Death Overview Panel (CDOP), this contains a summary of the activity carried out by the panel, activity which seek to drive improvements in children and young people's health across the 6 areas represented. These areas are Gateshead, Newcastle, Northumberland, North Tyneside, South Tyneside and Sunderland, (5 CCGs and 6 Local Authorities in this footprint). The Statutory task of the CDOP multiagency panel lies in its ability to scrutinise the circumstances surround each child's death and where appropriate to provide challenge to agencies involved to enhance the learning as well as recommendations to the appropriate agencies to improve services delivery and patient experience.

North and South of Tyne Child Death Overview Panel (CDOP) review the death of every child who normally resides in each of these areas, regardless of where the death occurs. This document reports on all the children whose deaths were reviewed in 2020/21, regardless of the year in which the child died. The CDOP will in each case classify the cause of death, identify contributory factors, identify any modifiable factors (those which can be changed through national or local interventions) and make recommendations to prevent future similar deaths, or improve the safety and welfare of children in the local area and further afield.

The report acknowledges this has been a challenging year due to COVID 19 as well as being a reconstituted panel, the combining of North and South of Tyne CDOP. The meetings held virtually and the eCDOP facility allowed all the cases to be viewed in new format and electronically. The panel met 8 times within the timeframe of this report.

The total number of child deaths reviewed by the panel was 82 of which 20 were child deaths in Northumberland, and of these 20 deaths 9 had modifiable factors. These included maternal smoking, parental drug misuse, high maternal BMI, a child who did not receive flu vaccine and late pregnancy booking including drug misuse and alcohol misuse. The ages of the child deaths are not broken down in the report for each

geographical area however the highest category of child death 45% (37) is within the first 27 days of life.

The report also includes examples of actions taken to reduce child deaths across the CDOP footprint includes an example in Northumberland following a death of young person after ingesting MDMA which highlighted lack of first aid knowledge amongst young people, the substance misuse team worked with public health to deliver session in schools across the county on recognising signs of substance misuse and first aid. Examples from other areas are included in the report which include safe sleep, ICON which is an evidence-based programme to reduce abusive head trauma in infancy and the introduction of a question on food allergies incorporated into existing asthma review templates following the death of a child from anaphylaxis. with additional work to raise awareness of this in primary

All the panel members are tasked with taking the learning from these cases and sharing it widely within their organisations in order that staff in all the constituent agencies are aware of the risk factors when supporting and advising parents and carers. The learning is also included in the training package which is delivered to staff groups

Alison Johnson
Interim Designated Nurse Safeguarding Children