# Child Death Overview Panel (CDOP) Annual Report

## April 2024 - March 2025

**North & South of Tyne**

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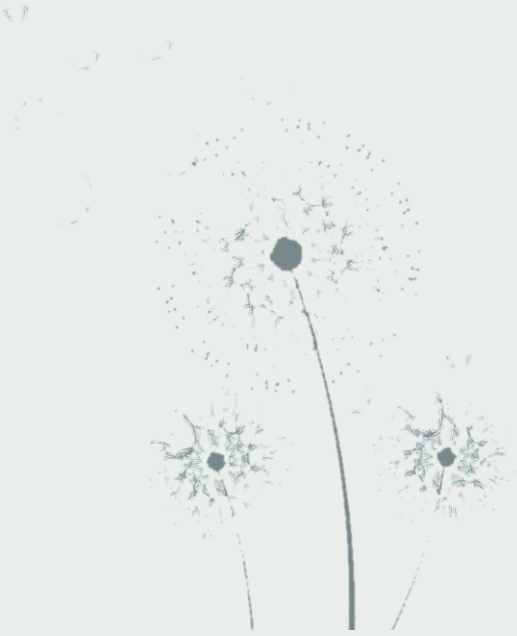


# Foreword

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

Welcome to the fifth 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 five years. Meeting virtually is well-established and this has also 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 eight times within the timeframe of this annual report (April 2024 - March 2025) with very good multi-agency attendance. We have continued to welcome observers to the panel from constituent agencies 10 observers this year from nursing, medicine, and safeguarding. We reviewed 89 cases this year, slightly fewer than last year. A full data set is contained within the report.

Thanks must go to Jill Rennie who has provided secretarial support and Wendy Mitchell (Public Health Principal) who provided a Public Health overview, to enable the smooth production of 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 2023[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 plus 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 2023 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://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[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 2024/2025, 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 2024/2025 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 2024/2025, the North and South of Tyne CDOP had two neonatal-themed panels. Panel members were very positive around the depth of learning which took place whilst focusing on one category of child death.

# 3 Membership of the Child Death Overview Panel

| Named Representative | Agency/Title |
|---|---|
| Sheila Moore | Independent Chair |
| Jill Rennie<br>Tracey Hadaway | North of Tyne CDOP Coordinator<br>South of Tyne CDR 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 |
| Rachael Upton | Designated Nurse Safeguarding Children, Newcastle and Gateshead |
| Alison Johnson | Designated Nurse Safeguarding Children, North Tyneside/Northumberland |
| Louisa Turner | Head of Midwifery Northumbria/Head of Midwifery Gateshead |
| Alex Hume/Phillip Cleugh | Northumbria Police |
| Saira Park | Business Manager SCP |
| Tom Hall/Wendy Mitchell | Director of Public Health (DPH) South Tyneside Council/Public Health Principal, Sunderland City Council |
| Aarti Ullal | Consultant Obstetrician (Themed Panel Member) |

# 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.

## Eyes on the Baby

Eyes on the Baby[5] is a multi-agency SUDI prevention training and implementation programme, developed as a pilot in 2022/23 in County Durham and further refined when implemented in Northumberland in 2023/24. It has also been adopted by the Nort-East Ambulance Service.

Eyes on the Baby leverages a multi-agency workforce to nudge, signpost, and support priority families to implement safer sleep practices. Relevant staff groups are identified, upskilled to help families implement safer sleep practices, and embed SUDI prevention in their everyday work.

Training is available in the following three strands:

Strand 1: For workforce members who access homes, who speak to new families, or who provide support in a crisis.
Strand 2: For workforce members who provide support to vulnerable families.
Strand 3: For healthcare professionals who are involved in the routine or emergency care of pregnant and post-partum women and babies.

A full North East approach is currently being explored with a regional session taking place in May 2025 aimed at strategic leads who have a role around SUDI prevention. Participants will learn more about Eyes on the Baby and be equipped with the tools they need to take this work forward in local systems.

## Smoking in Pregnancy

The percentage of mothers smoking at time of delivery continues to decline, nationally there has been a 46% decrease from 13.6% in 2010/11 to 7.4% for 2023/24. Regionally the decrease is 48% from 21.8% in 2010/11 to 10.2% for 2023/24.

In addition to the ‘saving babies’ lives care bundle’ pathway[6] an evidence-based national smoke-free incentive scheme was announced in 2023 and builds on the treatment for tobacco dependence already being delivered. The Office for Health Improvements and Disparities has extended funding for 2025/26 meaning more pregnant women who smoke can take advantage of the scheme from 1 April 2025, building on local community pathways.

National funding has also been provided to support Local Authority led stop smoking services and has been utilised in some areas to enhance smoking in pregnancy

[5] Eyes on the Baby – SUDI Prevention for the North East

[6] https://www.england.nhs.uk/mat-transformation/saving-babies/

pathways.  For example: dedicated co-ordinators within Family hubs, ensuring practitioners are competent in the delivery of a community stop smoking pathway and targeting more at risk populations.

The All Parliamentary Group on Smoking and Health[7] calls for current investment to be maintained within the next spending review to ensure progress continues and every baby has a smoke free start in life.

# 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**

| | 2023/24 | 2024/25 |
|---|---|---|
| Northumberland | 13 (14%) | 13 (17%) |
| North Tyneside | 14 (15%) | 10 (13%) |
| Newcastle | 24 (26%) | 20 (26%) |
| Gateshead | 11 (12%) | 9 (12%) |
| South Tyneside | 13 (14%) | 8 (10%) |
| Sunderland | 17 (18%) | 17 (22%) |
| Out of Area | 0 | 0 |
| North and South of Tyne Total | 92 | 77 |

There were 77 deaths notified to the CDOP in 2024/2025, compared with 92 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, prior to the CDOP meeting, can take several months, particularly if there are police or coronial processes to be concluded.

[7] https://ash.org.uk/uploads/APPG-on-Smoking-and-Health-Report-2025-Web-Version.pdf

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

| | 2023/24 | 2024/25 |
|---|---|---|
| 0-27 days | 38 (41%) | 35 (45%) |
| 28 days- 364 days | 11 (12%) | 8 (10%) |
| 1 year-4 years | 14 (15%) | 9 (12%) |
| 5-9 years | 2 (2%) | 8 (10%) |
| 10-14 years | 14 (15%) | 6 (8%) |
| 15-17 years | 13 (14%) | 11 (14%) |
| North and South of Tyne Total | 92 | 77 |

**Table 5.3 - Place of Death identified at notification**

| | 2023/24 | 2024/25 |
|---|---|---|
| Hospital | 66 (72%) | 65 (84%) |
| Home | 19 (21%) | 9 (12%) |
| Hospice | 0 | 0 |
| Public Area | 1 (1%) | 2 (3%) |
| Abroad | 2 (2%) | 0 |
| Other Residence | 4 (4%) | 1 (1%) |
| North and South of Tyne Total | 92 | 77 |

In 2024/2025 65 of the deaths occurred in a hospital setting, with 9 occurring at home.

### Table 5.4 – Sex of child at time of notification

| | 2023/24 | 2024/25 |
|---|---|---|
| Male | 53 (58%) | 44 (57%) |
| Female | 39 (42%) | 32 (42%) |
| Indeterminate | 0 | 1 (1%) |
| North and South of Tyne Total | 92 | 77 |

### Table 5.5 - Number of death notifications by ethnicity

| Ethnicity (Broad) | 2023/24 | 2024/25 |
|---|---|---|
| White | 70 (76%) | 54 (70%) |
| Mixed | 4 (4%) | 5 (6%) |
| Asian | 8 (9%) | 6 (8%) |
| Black | 7 (8%) | 9 (12%) |
| Other | 2 (2%) | 3 (4%) |
| Unknown | 1 (1%) | 0 |
| North and South of Tyne Total | 92 | 77 |

## Deaths which have been reviewed and cases closed

The North and South of Tyne CDOP panel reviewed and closed 89 cases in 2024/25, compared with 90 cases in the year prior.

### Table 5.6 – Total number of deaths reviewed and closed

| | 2023/24 | 2024/25 |
|---|---|---|
| Northumberland | 13 (14%) | 16 (18%) |
| North Tyneside | 10 (11%) | 13 (15%) |
| Newcastle | 23 (26%) | 23 (26%) |

| | | |
|---|---|---|
| Gateshead | 13 (14%) | 8 (9%) |
| South Tyneside | 12 (13%) | 13 (15%) |
| Sunderland | 19 (21%) | 16 (18%) |
| Out of Area | 0 | 0 |
| North and South of Tyne Total | 90 | 89 |

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

| | 2022/23 | 2023/24 |
|---|---|---|
| 0-27 days | 31 (34%) | 28 (31%) |
| 28 days- 364 days | 17 (19%) | 11 (12%) |
| 1 year-4 years | 12 (13%) | 14 (16%) |
| 5-9 years | 7 (8%) | 7 (8%) |
| 10-14 years | 12 (13%) | 17 (19%) |
| 15-17 years | 11 (12%) | 12 (13%) |
| North and South of Tyne Total | 90 | 89 |

The majority of cases reviewed by the CDOP were in children <1 year old with 28 cases (31%) in the 0-27 days category and 11 cases (12%) in the 28-264 days category. This is a consistent pattern year on year.

**Table 5.8 - Place of Death of cases reviewed and closed**

| | 2023/24 | 2024/25 |
|---|---|---|
| Hospital | 73 (81%) | 63 (71%) |
| Home | 11 (12%) | 18 (20%) |
| Hospice | 0 | 0 |
| Public Area | 3 (3%) | 4 (4%) |

| | | |
|---|---|---|
| Abroad | 2 (2%) | 0 |
| Other Residence | 1 (1%) | 4 (4%) |
| North and South of Tyne Total | 90 | 89 |

In the majority of cases 63 (71%) reviewed by the CDOP the death occurred in hospital which is consistent with the pattern of the previous years.

**Table 5.9 – Sex of child of cases reviewed and closed**

| | 2023/24 | 2024/25 |
|---|---|---|
| Male | 49 (54%) | 51 (57%) |
| Female | 39 (43%) | 38 (43%) |
| Indeterminate | <5 | 0 |
| North and South of Tyne Total | 90 | 89 |

Just over half 51 (57%) of cases reviewed by the CDOP in 2024/25 were male children.

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

| Ethnicity (Broad) | 2023/24 | 2024/25 |
|---|---|---|
| White | 63 (70%) | 66 (74%) |
| Mixed | 4 (4%) | 4 (4%) |
| Asian | 8 (9%) | 7 (8%) |
| Black | 9 (10%) | 7 (8%) |
| Other | 5 (6%) | 5 (6%) |
| Unknown | 1 (1%) | 0 |
| North and South of Tyne Total | 90 | 89 |

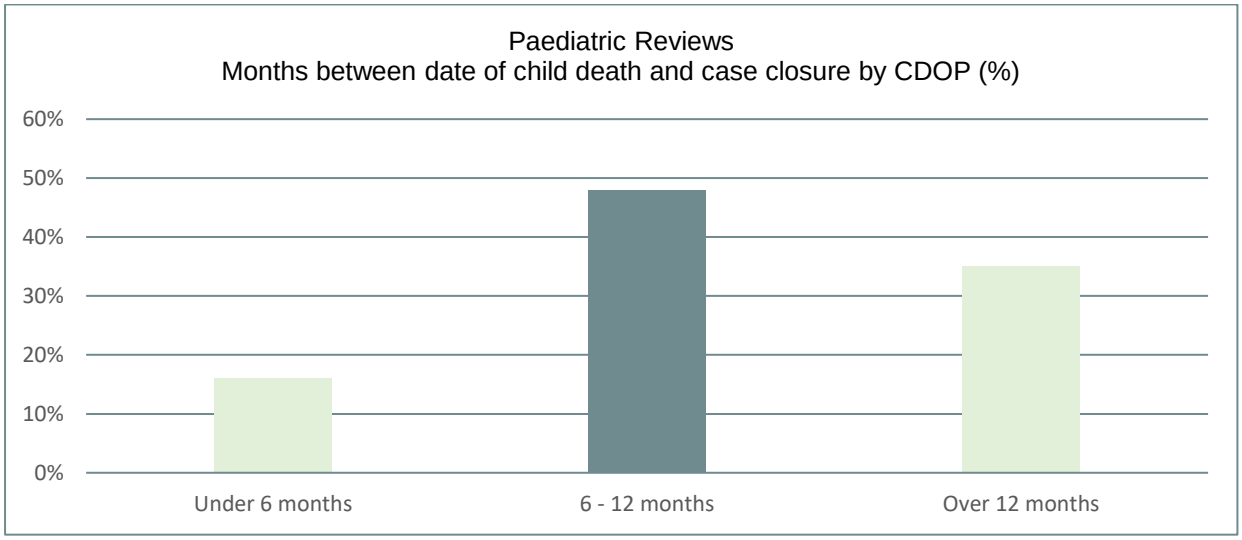
The majority 66 (74%) of cases reviewed and closed by the CDOP in 2024/25 were relating to white children. This is consistent with the distribution seen in the previous years.

**Table 5.11 - Number of reviews at each meeting 2024/25**

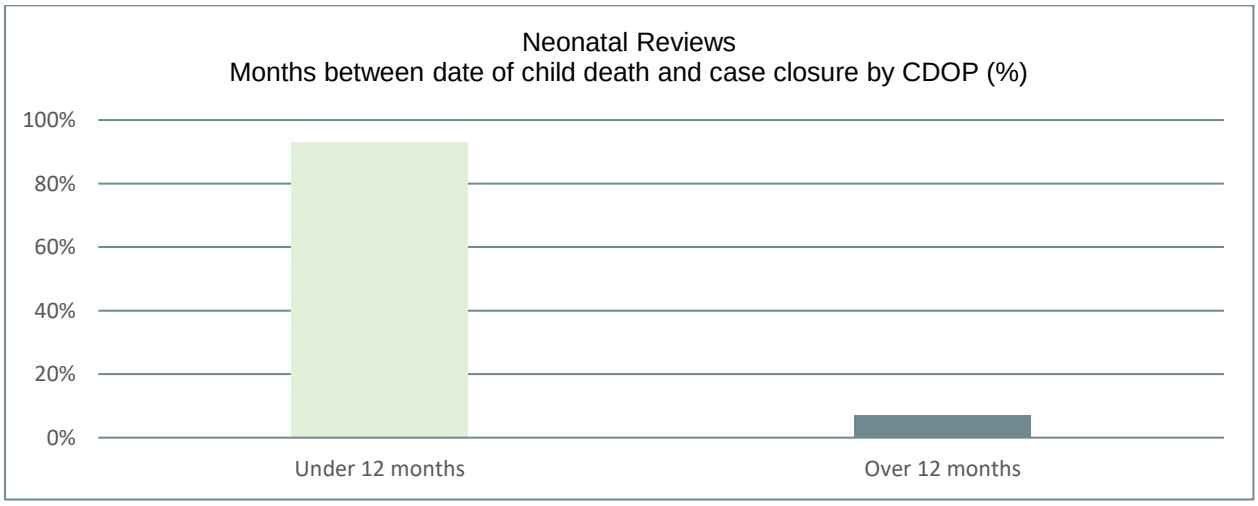
The North and South of Tyne CDOP met eight times between April 2024 and March 2025 and reviewed between 6 and 15 cases at each meeting. Two themed panels were conducted in line with recommendations of the child death review process.

| April | June | July Themed | Sept | October | Dec | January Themed | March | Total |
|---|---|---|---|---|---|---|---|---|
| 11 | 14 | 10 | 11 | 10 | 6 | 15 | 12 | 89 |

**Table 5.12 - Duration of Reviews 2024/25**




Paediatric deaths are those which occur from one month of age up to 17 years 364 days. Of the 89 reviews closed in 2024/25, 64 were of paediatric deaths (one month to 17 years). Of these 64 cases, 13 (20%) of the reviews were finalised within 6 months of the child's death, 31 (48%) were completed between 6-12 months, and 19 (30%) 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 reviews closed in 2024/25, 25 were neonatal deaths (deaths at less than 1 month of age). These cases were reviewed in 2 neonatal-themed panels. Of the 25 reviewed and closed neonatal deaths, 18 (72%) were reviewed within 12-month timescale and 6 (24%) 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:

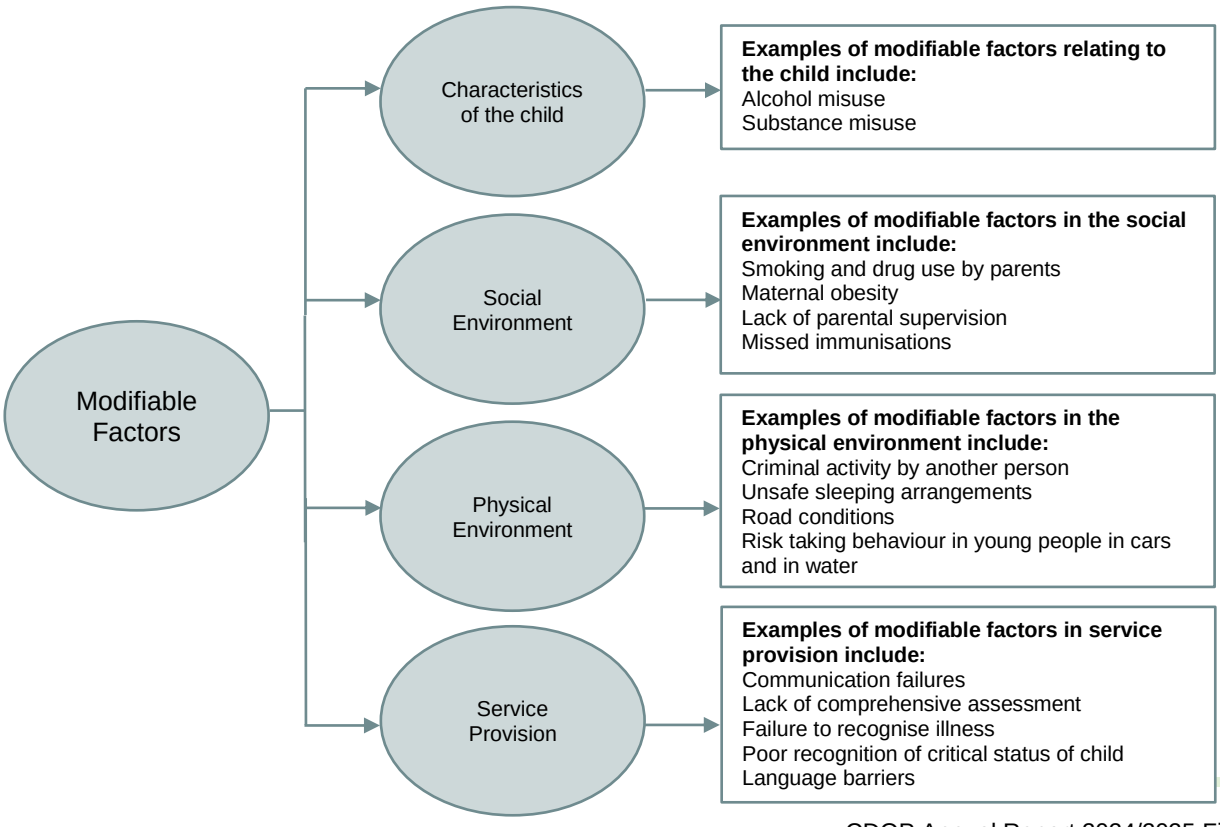
Domain A: Factors intrinsic to the child.
Domain B: Factors in social environment including family and parenting capacity.
Domain C: Factors in the physical environment.
Domain D: Factors in service provision.

Of the 89 cases reviewed in 2024/25, modifiable factors were identified in 34 cases (38%). The England data showed 43% of cases with modifiable factors

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

| Area | 2023/24 - 2024/25 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Total number of cases | | No modifiable factors | | Modifiable factors | | % with modifiable factors | |
| | 23/24 | **24/25** | 23/24 | **24/25** | 23/24 | **24/25** | 23/24 | **24/25** |
| Newcastle | 23 | **23** | 13 | **13** | 10 | **10** | 43% | **43%** |
| Northumberland | 13 | **16** | 7 | **9** | 6 | **7** | 46% | **44%** |
| North Tyneside | 10 | **13** | 9 | **10** | 1 | **3** | 10% | **23%** |
| Gateshead | 13 | **8** | 4 | **4** | 9 | **4** | 69% | **50%** |
| South Tyneside | 12 | **13** | 9 | **7** | 3 | **7** | 25% | **54%** |
| Sunderland | 19 | **16** | 12 | **12** | 7 | **3** | 37% | **23%** |
| Out of Area | 0 | **0** | 0 | **0** | 0 | **0** | 0% | **0%** |
| North & South of Tyne | 90 | **89** | 54 | **55** | 36 | **34** | 40% | **38%** |

## 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[8] 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.

People with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African–Caribbean background are prone to central adiposity and their cardiometabolic risk occurs at lower BMI, so use lower BMI thresholds as a practical measure of overweight and obesity[9]:

Overweight: BMI 23 to 27.4
Obesity: BMI 27.5 or above.

Being overweight or obese increases the risk of complications for pregnant women and her baby[10] 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). Stopping smoking at any point during pregnancy will help reduce these risks as described. 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.

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

[9] https://www.nice.org.uk/guidance/ng246/chapter/Identifying-and-assessing-overweight-obesity-and-central-adiposity

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

## 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.

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)[11] 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[12]

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

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

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 |
|---|---|
| Northumberland | 131 |
| North Tyneside | 128 |
| Newcastle | 150 |
| South Tyneside | 26 |
| Sunderland | 33 |
| Gateshead | 54 |

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[13] and be diagnosed with a long-term illness[14]. 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[15].

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)[16] 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.

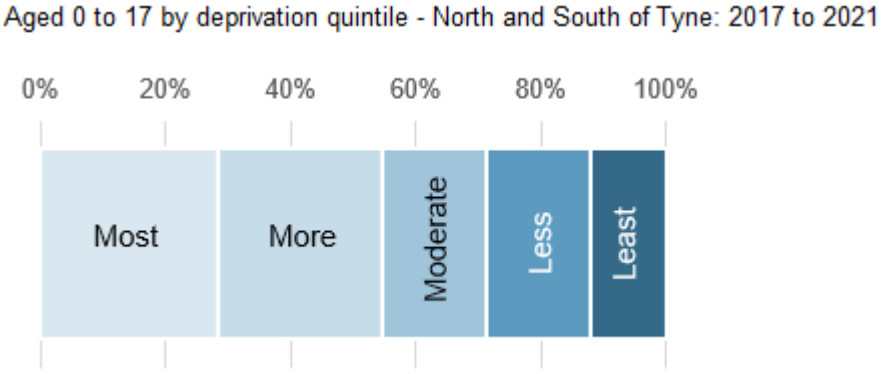



*Figure 1 - Proportion of mortalities by deprivation quintile*

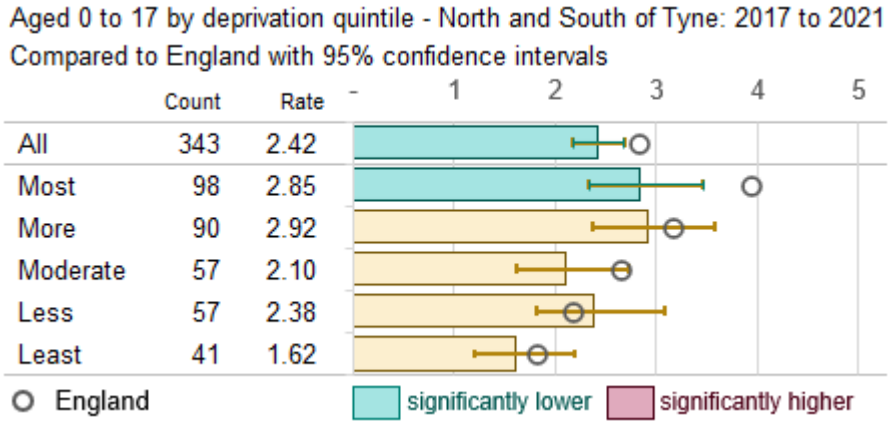
[13] Kyle RG, Kukanova M, Campbell M, Wolfe I, Powell P, Callery P. Childhood disadvantage and emergency admission rates for common presentations in London: an exploratory analysis. Archives of Disease in Childhood 2011; 96: 221–6

[14] 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

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

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

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.




# 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 | | 2023/2024 | 2024/2025 |
|---|---|---|---|
| 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. | 3 | 3 |
| 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. | 2 | 8 |
| 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 | 4 | 10 |

| | | | |
|---|---|---|---|
| | factors. **Excludes** Deliberately inflected injury, abuse or neglect. (Category 1). | | |
| 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. | 6 | 11 |
| 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. | 3 | 6 |
| 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. **Includes** cerebral palsy with clear post-perinatal cause. | 9 | 3 |
| 7 | **Chromosomal, genetic and congenital anomalies** - Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac. | 24 | 18 |
| 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). | 22 | 21 |
| 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. | 5 | 3 |
| 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). | 12 | 6 |

## Dissemination of the learning from reviews

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.