Kirklees Child Death Overview Annual Report

2023 - 2024

Contents

Background

Child Death Overview Panels (CDOP) were established in April 2008 as a new statutory requirement as set out in Chapter 7 of 'Working Together to Safeguard Children 2018. Their primary function is to understand how and why children die, put into place interventions to protect other children, and prevent future deaths.

This guidance was updated in Working Together to Safeguard Children (2018) and Child Death Review Statutory and Operational Guidance (2018). This report has been written in accordance with both of these guidance's. The CDOP has specific functions laid down in statutory guidance, including:

Reviewing the available information on all deaths of children up to 18 years who would have ordinarily been resident in Kirklees (including deaths of infants aged less than 28 days) to determine whether there have been any gaps in the care being provided.

Collecting, collating and reporting on an agreed national data set for each child who has died.

Meeting regularly to review and evaluate the routinely collected data on the deaths of all children, and thereby identifying lessons to be learnt or issues of concern.

Monitoring the response of professionals to an unexpected death of a child

Referring to the Chairs of the local Safeguarding Children Partnership within the reporting area any deaths where the panel considers there may be grounds to consider a serious case review.

Monitoring the support services offered to bereaved families.

Identifying any public health issues and considering, with the Director of Public Health, how best to address these and their implications for the provision of both services and training

The principles

The principles underlying the overview of all child deaths are:

- Every child's death is a tragedy
- Learning lessons
- Joint agency working
- Positive action to safeguard and promote the welfare of children

CDOP Process

Unexpected deaths

When an unexpected child death occurs there are specific actions that must be taken by professionals. Within this process the lead agency i.e. Police or Consultant Paediatrician will ensure a 'rapid response' teleconference will take place within 48 hours of the child's death. The aim of the rapid response teleconference is to have an initial multi-agency information sharing and planning discussion to inform initial decision making.

Expected deaths

The process for expected deaths differs slightly. When a notification is received by CDOP each agency that knew the child prior to their death receives an 'Agency Report Form' known locally and nationally as a Reporting Form. This form captures all the relevant information about the child and family to inform the CDOP process when considering modifiable factors. This process does not have an initial multi agency discussion.

Inquests held

It is the Coroner's responsibility to determine the cause of death where this is not known. If it is not possible to find out the cause of death from the post mortem examination, or the death is found to be unnatural, the Coroner holds an inquest which is a public court hearing held by the Coroner in order to establish who died and how, when and where the death occurred.

CDOP Panel

Once all of the previous stages have been completed and when the cause of the child's death has been determined for both expected and unexpected child deaths, this information is taken to the Child Death Overview Panel for discussion and review. This process is expected to take place within a 6 month period. All the strategic leads from across the organisations (Public Health, Health, Social Care and Police) are represented at the meeting, along with the Partnership Business Managers, CDOP Coordinator and the Designated Doctor for Child Deaths. The purpose of the Panel is to consider any learning or factors that could prevent future deaths of children. The information taken to Panel is anonymised.

During 2023/2024, the Panel reviewed a total of 46 cases. There are many reasons why it can take more than 6 months for cases to be reviewed by the Panel; one reason may be that the CDOP Coordinator is awaiting information from agencies. In addition, if there is an on-going investigation (for example a police investigation, inquest or Child Safeguarding Practice Review) then discussions may be deferred pending the result of those enquiries. It must be noted that a child's death cannot be discussed at Panel until all information has been received.

Membership and Panel Meetings

Panel arrangements

During this year CDOP has continued to use the eCDOP system, this has ensured that we have been able to manage the cases in a more effective and efficient manner.

Kirklees, Calderdale and Wakefield share arrangements for reviewing the deaths of all children in the area. This decision was made as there is a shared health footprint across Kirklees. With this partnership we have brought together the three Authorities into eCDOP, this had provided an opportunity for shared learning and a consistency in practice.

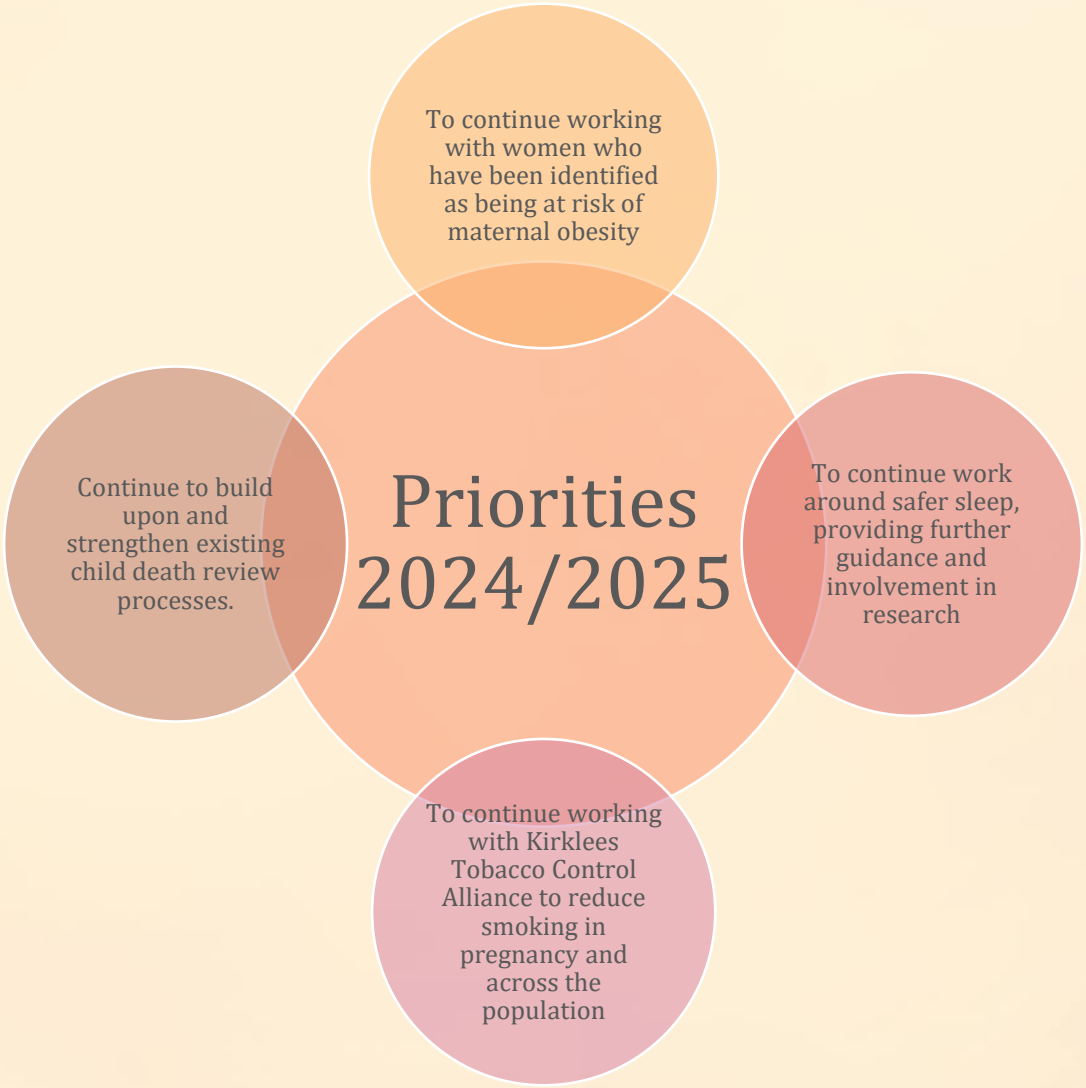
Panel Meetings

Following the COVID19 pandemic, meetings have continued to take place virtually. Within Kirklees we have held 8 panel meetings in this manner during 2023/2024.

Panel membership

The Panel meetings are held monthly, with Kirklees alternating between Calderdale and Wakefield to cover the hospital trusts footprints (Calderdale and Huddersfield Foundation Trust and Mid Yorkshire Health Trust) and have had consistent organisational commitment since they were established in 2008. The chair for each acute trust based board rotates between senior public health and child protection staff.

Priorities for 2024/2025



What we have achieved

Guidance for professionals on Consanguinity: We have been part of a national group to create guidance on consanguinity and to help identify whether there are modifiable and contributory factors. we have fully implemented the Consanguinity guidance at CDOP and have used this to inform cases

Safer Sleep: Multi-Agency training has been implemented and 'train the trainer' programme has been completed, now supported by KSCP and made available to a broad range of professionals across West Yorkshire. This will continue to be offered through our training providers. A major funding bid has been submitted to the NIHR that, if successful, will broaden the impact of the programme and connect it to a national footprint.

Smoking in Pregnancy: Kirklees offers stop-smoking services across the Local Authority. This is support is available via Auntie Pam's, the Wellness Service and CHFT and Mid Yorkshire Trust Hospitals (via the Long -Term Plan – Smokefree pregnancy). Women are offered behavioural support, nicotine replacement therapies and vapes.

Data reporting: In Kirklees we have continued to complete a quarterly report along with analysis to monitor themes and trends arising to discuss in the CDOP Panels.

Modifiable factors: Kirklees Public Health has continued to take the lead during the year to create a spreadsheet which has identified the leading modifiable factors of the cases reviewed. By using this it has been possible to identify gaps in service along with proposed future work and work already ongoing with families

Improvement in caseload: In Kirklees we have worked hard to reduce the backlog of older cases that we held. We continue to be robust in gathering information to reduce the figures further.

Kirklees Council commissioned Third Sector Leaders Kirklees who worked with 4 community organisations to deliver the community genetic literacy element of the NHS England funded work around culturally competent genetics. This work focused on raising awareness of preconception health, early antenatal education and genetic awareness within the Pakistani community. In 2024/25 the focus of this work is shifting away from community genetic literacy to have a focus on neonatal support for families with affected babies. (evaluation report available)

Culturally competent genetics - "Healthy Families" Improving genetic literacy through community conversations and activities linked to preconception and early antenatal advice

Contact type	Numbers
One to one conversations	1002
Group visits	59
Additional contacts as a result of group visits	262
Workshops	46
Workshop participants	348

Workshop type	Participant Numbers
Early antenatal	68
Preconception	192
ESOL	88

1:1 Conversations:

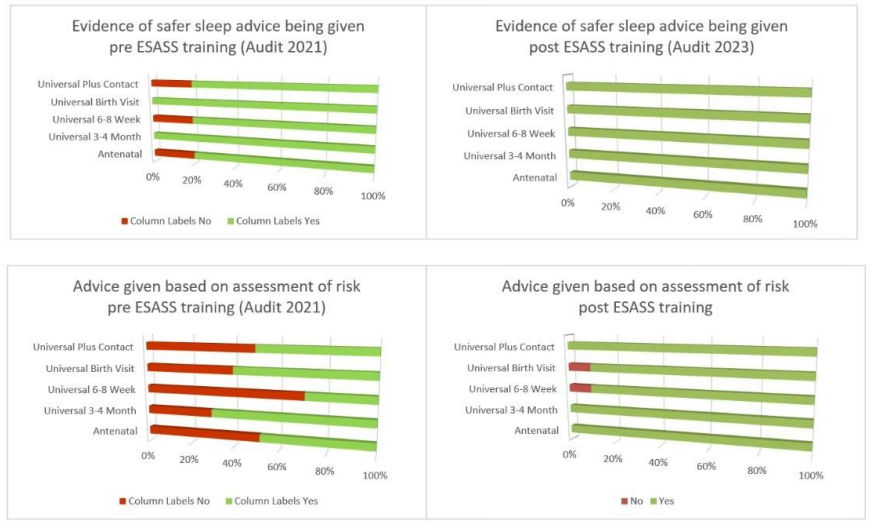
- Ages 18 to 80 plus! Males and females
- 12 different ethnic backgrounds
- 743 people who had between 1 to 5 children
- 157 people with existing recessive genetic conditions

As a result of having conversations:

- 597 people said they had an improved understanding of genetics
- 716 had a better awareness around the importance of prenatal and antenatal health
- 704 people were signposted for further support or activity
- 546 were signposted to their GP/Midwife or healthcare provider
- 173 received information on the importance of booking early midwife appointments

Safer Sleep: “Every Sleep A Safe Sleep”

- Health Visiting audit shows ESASS has enhanced both safer sleeping advice given and assessed risk advice.



- Health Visiting audit shows ESASS has increased both professional curiosity and evidence of meaningful conversation.

In 2024:

- Training module and linked seminar on ESASS rolled out on MyLearning at Kirklees Council to target all professionals in Adults and Children's Social Care (marked 'essential training'), Early Support and Homes and Neighbourhoods. This responds to recommendation in ESASS audit, April ‘24. Training continues and can be bespoke to teams.
- Embedded in W Yorks Police (c. 1100 trained).
- Audit report available by request.
- Safeguarding platforms in Calderdale and Kirklees being utilised to facilitate training.

Next Steps:

- Major NIHR funding bid for research project to share learning and create national resource for safer sleep under consideration.
- Increasing reach in nursing/midwifery/social care/medical courses in higher education.
- ESASS Webinar refresh and evaluation of risk minimisation tool underway. Discussions on differentiating training to need/professional context.

Maternal Obesity

Work is underway to adopt a compassionate approach to supporting pregnant women living with obesity across the Calderdale, Kirklees and Wakefield footprint.

This work is in its early stages however a Calderdale, Kirklees and Wakefield working group has been established.

Colleagues have been working with Doncaster colleagues to understand best practice on a compassionate approach to weight.

There's been an agreed partnership approach to review the current pathway/offer for women and a patient and professional insight survey has been completed into experiences – which has provided some useful insight.

Next steps

To develop resource for practitioners supporting implementation of a compassionate approach, supporting conversations for women living with obesity in pregnancy.

To develop evidence-based resources for practitioners supporting conversations & signposting to support services outside of maternity.

Reducing Smoking in Pregnancy

Smoking in pregnancy continues to remain a priority within the Kirklees Tobacco Control Plan.

In Kirklees smoking cessation support is provided via Auntie Pam's and The Wellness Service. Maternity Services at Calderdale and Huddersfield NHS Trust (CHFT) The Mid- Yorkshire Trust have been delivering the NHS Long Term Plan - Smokefree pregnancy to support pregnant women and their partners, with an in-house smokefree pregnancy pathway including focused sessions and treatments.

Activities and interventions to reduced smoking rates among pregnant smokers.

- Work with the Trust Maternity Services and its workforce to ensure women are offered all options to quit, including vapes and referral into community stop smoking services.

- Promote the community stop smoking service which offers access to vaping devices as per national guidance within Trust Maternity Service and key community touchpoint services.

- Continue to provide training and development to support smoking cessation advisor to effectively engage with pregnant smokers.

- Continue to develop activities and interventions led by the Kirklees Tobacco Control Alliance and work collaboratively to the Kirklees local Tobacco Control Plan to:
    - Supporting Smokers to Stop,
    - Stopping People Starting, and,
    - Smokefree Kirklees place.

Smoking at the time of delivery (SATOD) is recorded annually and published via the public health profiles produced by the Office of Health Inequalities and Disparities.

Recent trend: ⬇ Decreasing & getting better

Period		Kirklees Count	Value	95% Lower CI	95% Upper CI	Yorkshire and the Humber	England
2010/11	🟡	749	14.0%	13.1%	14.9%	16.9%	13.6%
2011/12	🟡	715	13.3%	12.5%	14.3%	16.7%	13.3%
2012/13	🟡	671	13.1%	12.2%	14.0%	16.6%	12.8%
2013/14	🔴	693	13.8%	12.9%	14.8%	16.3%	12.2%
2014/15	🟡	636	12.3%	11.5%	13.3%	15.7%	11.7%
2015/16	🟡	554	11.1%	10.3%	12.0%	14.6%	11.0%
2016/17	🔴	601	12.4%	11.5%	13.4%	14.4%	10.7%
2017/18	🔴	595	12.6%	11.7%	13.6%	14.2%	10.8%
2018/19	🔴	579	12.7%	11.7%	13.7%	14.4%*	10.6%
2019/20	🔴	537	12.1%	11.2%	13.1%	14.0%*	10.4%
2020/21	🔴	488	11.4%	10.5%	12.4%	13.1%	9.6%
2021/22	🔴	460	10.4%	9.6%	11.4%	12.0%	9.1%
2022/23	🟡	377	9.4%	8.5%	10.3%	11.6%	8.8%

Source: Calculated by the Office for Health Improvement and Disparities from the NHS England r eturn on Smoking Status At Time of delivery (SATOD)

Continue to build upon and strengthen existing child death review processes.

There has been a good level of completion of fields on notifications with 100% across all fields apart from Gestational Age (Under 1`s) which stands at 95%.

Median number of days between death and CDOP meeting is 414, this is an increase from the previous year of which stood at 289 days. This is due to other parallel proceedings in a few cases. The average in England has also increased from 335 to 411 days.

There has been a continued programme of training for professionals in the completion of notifications and reporting forms to improve the quality of information being provided.

There is continued support from the National Child Mortality Database (NCMD) in the completion of analysis forms to ensure accuracy of information which forms the basis of future thematic reports.

NCMD have also provided numerous guidance documents throughout the year.

The Local Picture – A snapshot of Kirklees

35 Death notifications received during the year

5 Joint Agency Response meetings have taken place.

24 deaths were of female children

22 deaths were of male children

13 Children lived within the Calderdale and Huddersfield Foundation Trust area

22 Children lived within the Mid Yorkshire Health Trust area

The majority of children were from Asian or British Asian- Pakistani and White British ethnicity

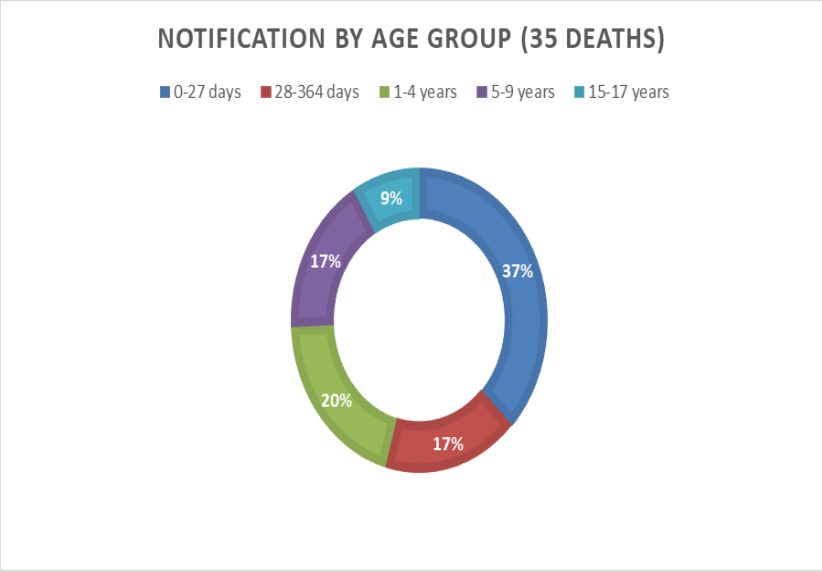
Neonatal and Perinatal continue to be the highest cause of death representing 37% of all deaths, this is comparative to National figures (42%)

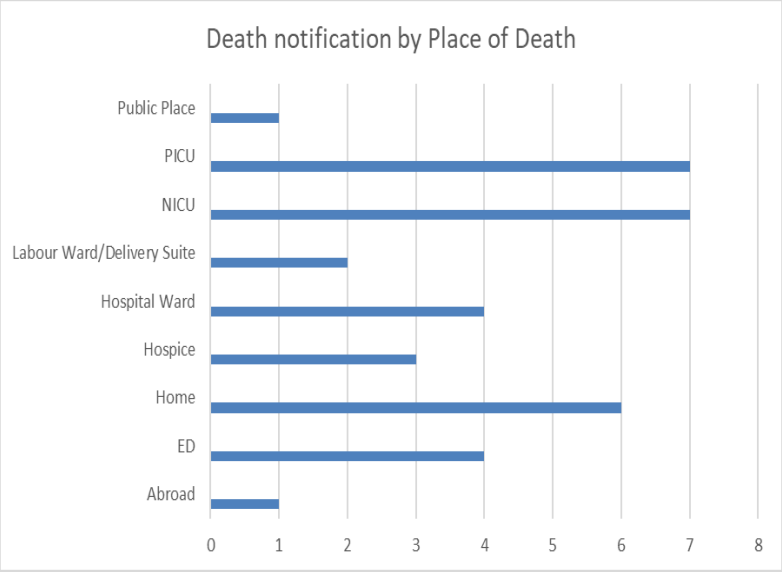
These are small numbers and we should be mindful that it may look like significant shifts when information is provided in graph form.

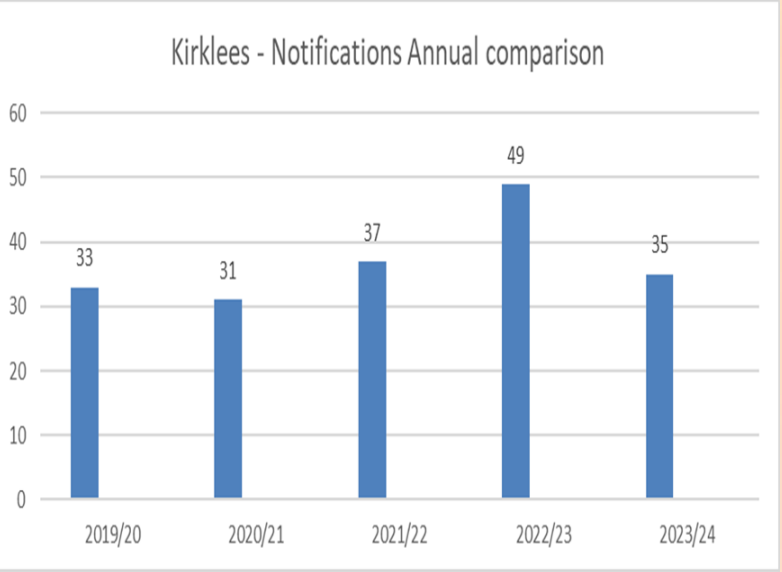
There are 54 ongoing cases

Note: We are unable to make National comparisons as the NCMD annual data for 2023/24 is not yet available. It is difficult to make regional comparisons due to the differing demographics in the population, such as ethnicity.

The Local Picture - Kirklees
Death Notifications during this year



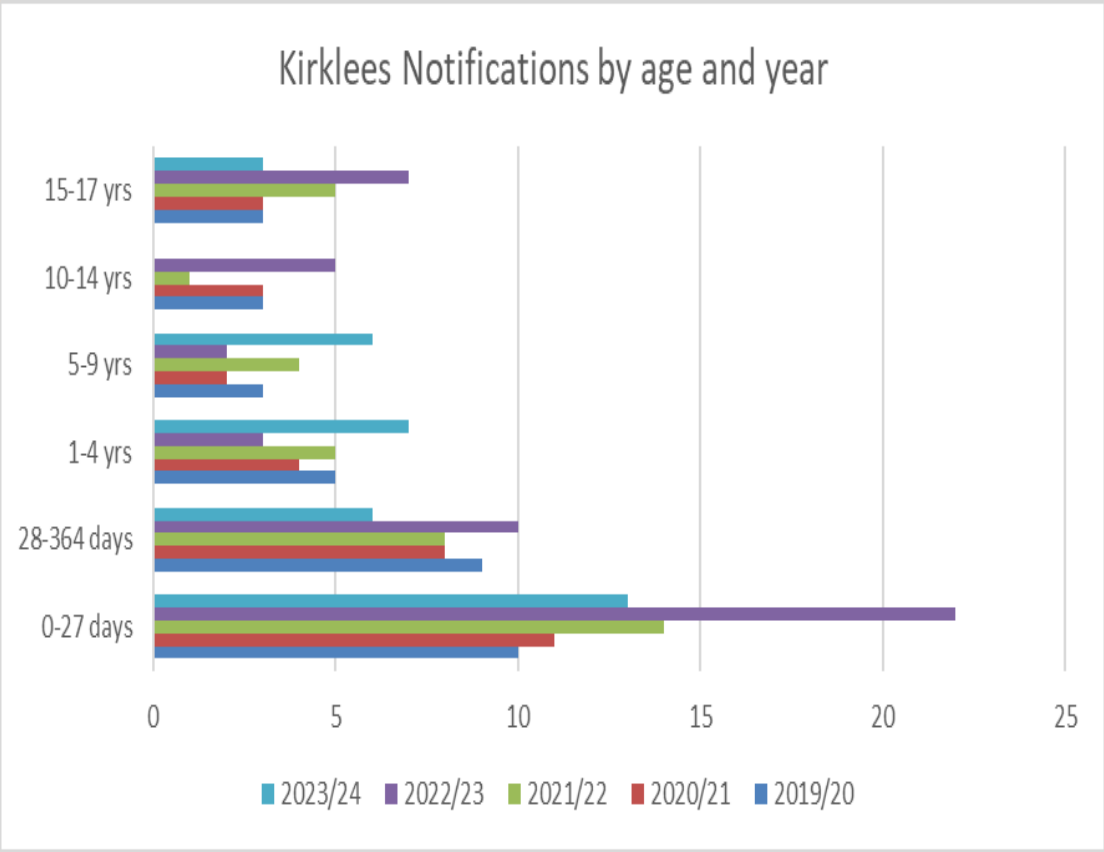




Total Population: 437,593

Child Population: 10,186 (2.3%)

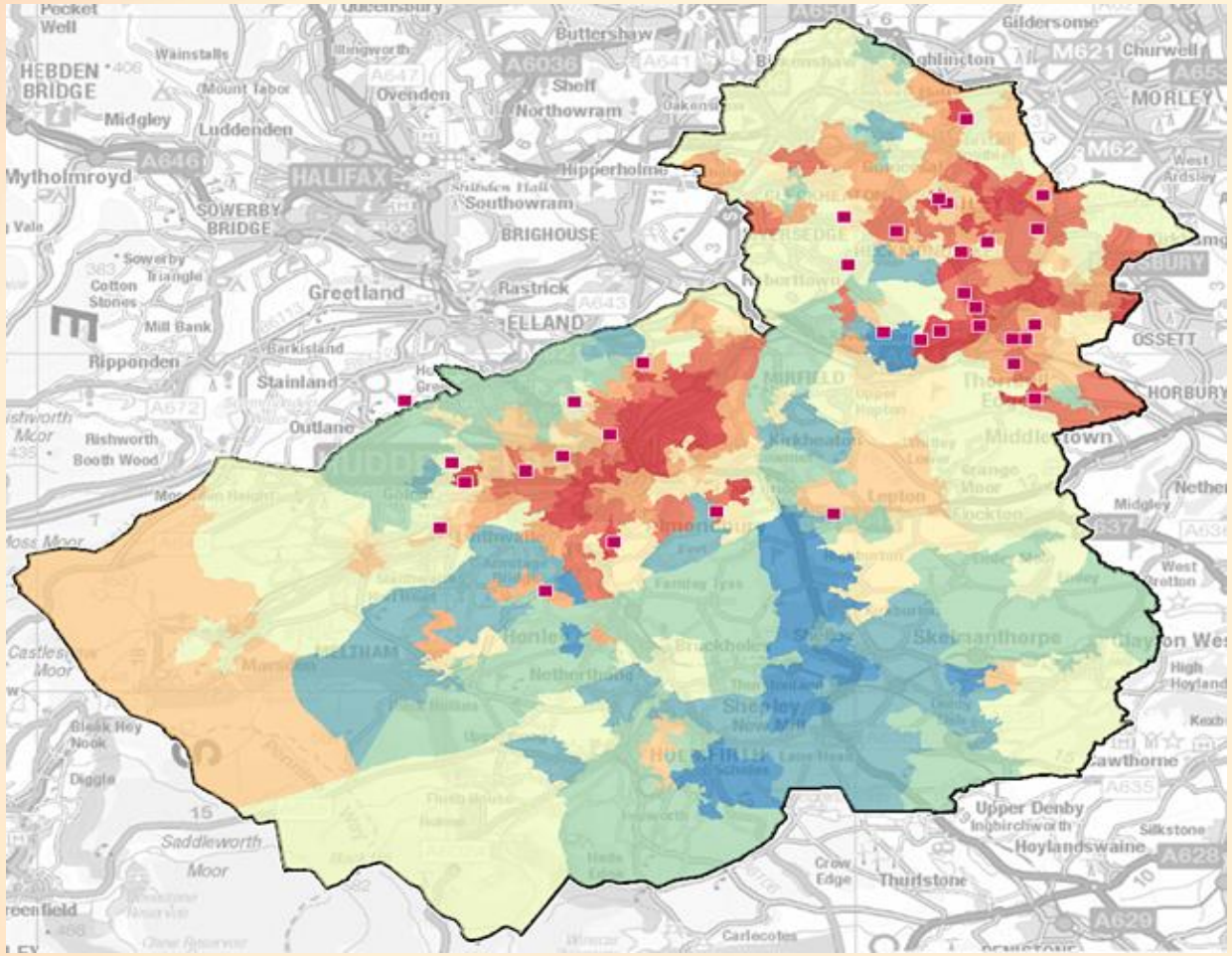
The Local Picture – Annual comparison

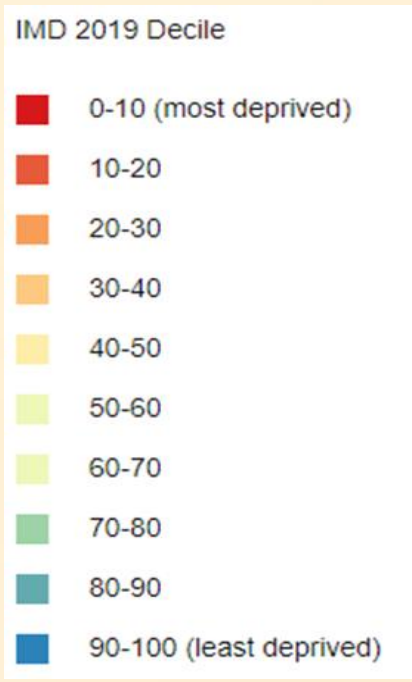


Neonatal and Perinatal deaths continue to the largest category for child deaths.

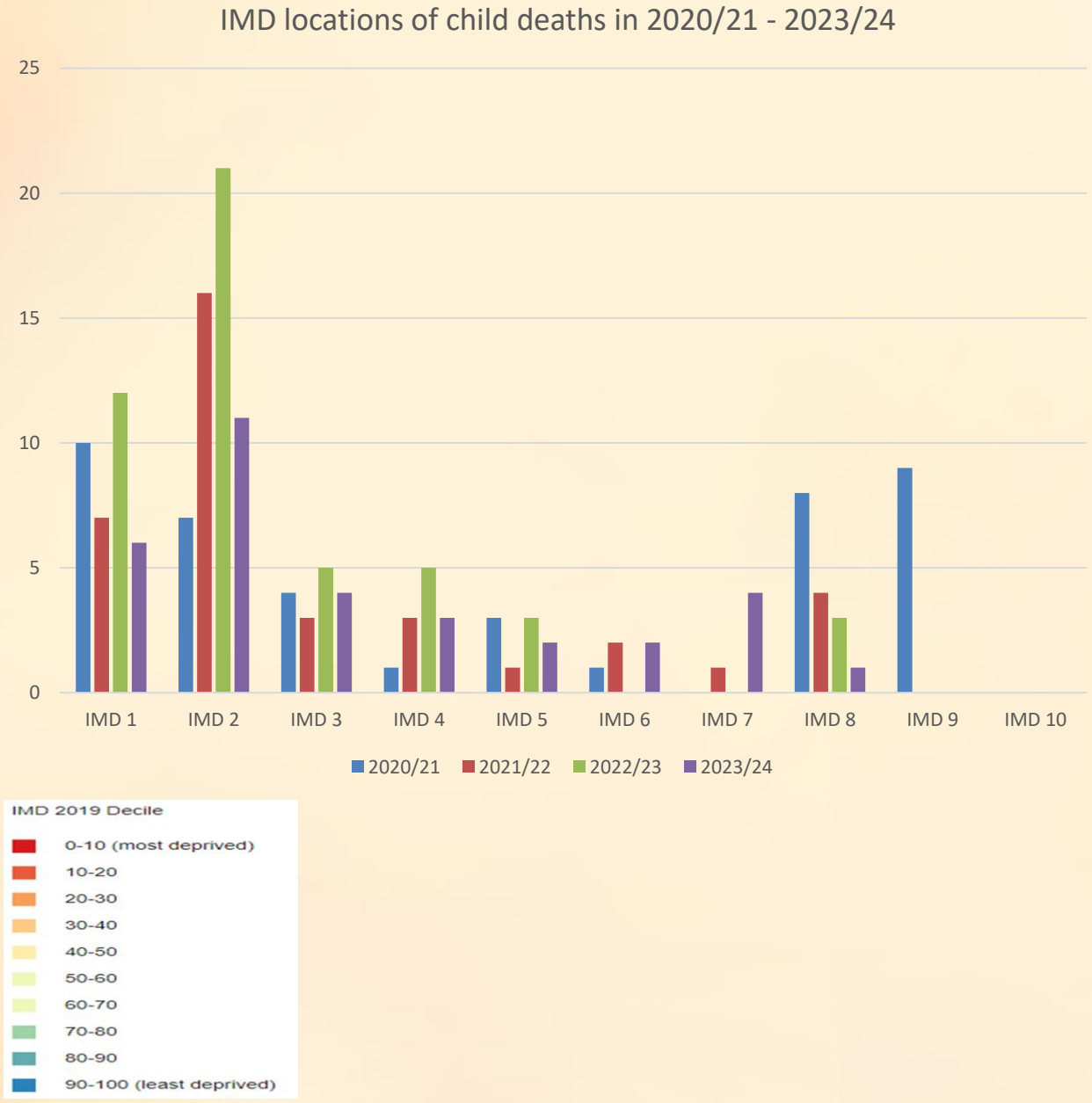
Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn.

Indices of Multiple Deprivation 2023/24 Kirklees Picture





The Index of Multiple Deprivation (IMD) combines information from seven domains to produce an overall relative measure of deprivation for small areas in England. The domains are: Income; Employment; Education; Skills and Training; Health and Disability; Crime; Barriers to Housing Services; Living Environment.



Of the 35 children who died in 2023/24 19 lived in the 2 most deprived areas, this represents 54% of deaths.

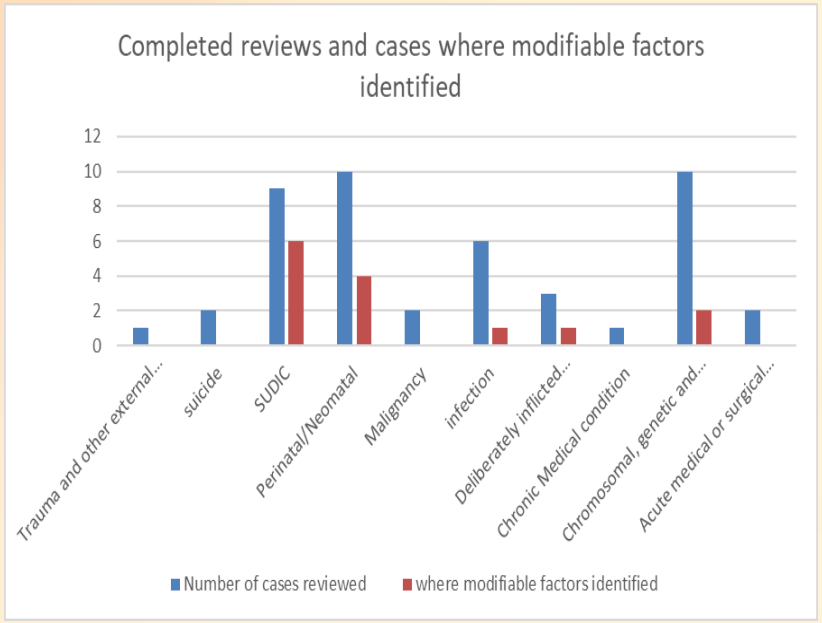
In 2022/23 67% of deaths were in the 2 most deprived areas

In 2021/22 46% of deaths were in the 2 most deprived areas.

In 2020/21 61% of deaths were in the 2 most deprived areas.

Work is continuing with families within our more deprived areas to assist in ensuring that they have healthy babies and to help reduce the number of deaths.

Kirklees completed reviews by primary category of death and modifiable Factors

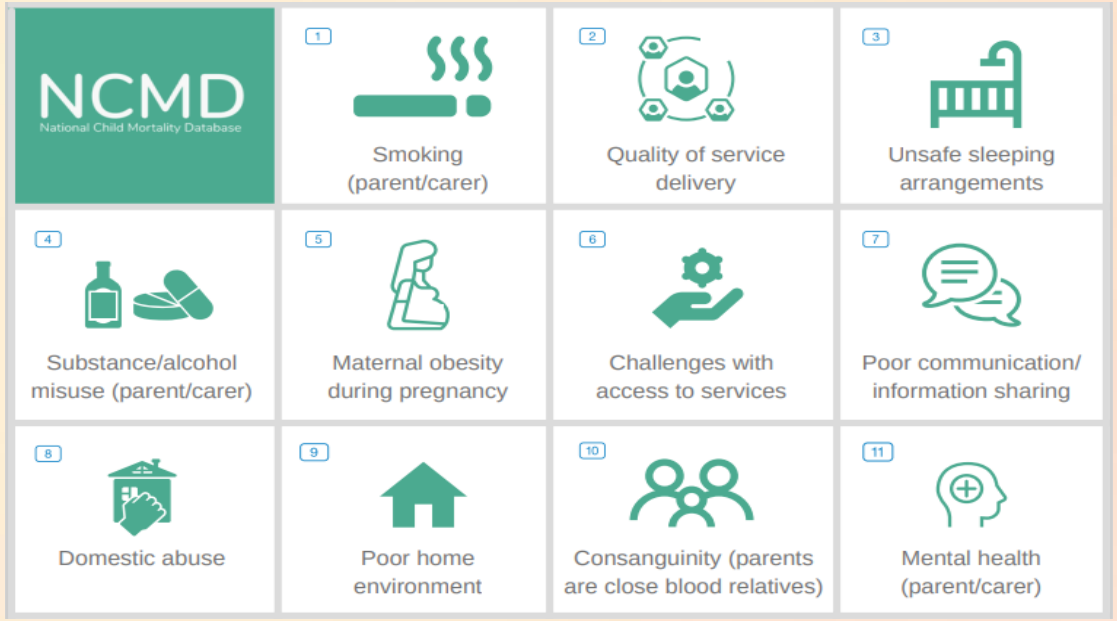


This information covers 10 cases, therefore a case may have more than one modifiable factor.

What are modifiable Factors?

A modifiable factor is defined as any factor which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

The most frequent modifiable factors



Kirklees
30% of cases included modifiable factors

England
43% of cases included modifiable factors

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	19	8	42%
28 - 364 days	10	5	50%
1 - 4 years	2	0	0%
5 - 9 years	3	0	0%
10 - 14 years	4	0	0%
15 - 17 years	8	1	13%
Total	**46**	**14**	**30%**

Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
White	20	11	55%
Unknown	0	0	0%
Other	0	0	0%
Mixed	4	1	25%
Black or Black British	2	0	0%
Asian or Asian British	20	2	10%
Total	**46**	**14**	**30%**

Kirklees - Data completeness on notifications and completed reviews

Notifications

We have continued to have a good level of completion of fields on notifications with 98% - 100% across all fields.

Completed reviews

We have worked hard during the year to review our older cases, we have managed to review some but due to other ongoing proceedings we still a number of older cases outstanding. This has therefore been reflected in the data.

Kirklees – 414: National (England) – 411

26% of cases are discussed and completed within 6-12 months

70% of cases took over 12 months, this was due to parallel proceedings.

4% of cases took less than 6 months to complete

Supporting bereaved families

The death of a child brings about immense grief and is a deeply painful experience. As part of the child death review process, all bereaved families should be provided with a named keyworker who will listen, provide compassionate care, and will signpost the family to additional support when it is appropriate for them. The processes that follow the death of a child can be complex, particularly when multiple investigations are required and occur simultaneously. The child death keyworker provides information and support for families to better understand and navigate these processes. In all our cases the keyworker was a child death review (CDR) nurse working from within Mid Yorkshire and Calderdale & Huddersfield Foundation Trust.

Every one of the 35 families in Kirklees whose child died during 2023/2024 had a named child death keyworker.

Conclusion

- Good work has been undertaken locally and nationally in respect of Safer sleep, Consanguinity and Smoking Cessation.
- There were 35 notifications in 2023/2024, this was a reduction of 14 child deaths from the previous year.
- Neonatal deaths at 37% continue to be the highest group of child deaths
- Over the period 20/21 – 23/24 57% of child deaths occurred in the two most deprived areas of Kirklees.
- 30% of cases within Kirklees had modifiable factors compared to a national figure of 43%. The majority of cases had modifiable factors in deaths up to the age of one.