Calderdale, Kirklees & Wakefield Annual Child Death Overview Panel Report 2023-2024

Calderdale Safeguarding Children Partnership

Kirklees Safeguarding Children Partnership

Wakefield Safeguarding Children Partnership

Contents

Introduction

From 1st April 2008, all deaths of children (up to the age of 18 years, excluding still births and planned terminations) are reviewed by a Panel of professionals from a range of organisations and expertise. This review is part of a national process called the Child Death Overview Panel (CDOP) which is outlined in national guidance (Working Together to Safeguard Children, 2023). This process is undertaken locally for all children who are normally resident in Calderdale, Kirklees, and Wakefield.

Statutory requirements

When a child dies, in any circumstances, it is important for parents and families to understand what has happened and whether there are any lessons to be learnt. The responsibility for ensuring child death reviews are carried out is held by 'child death review partners', who, in relation to a local authority area in England, are defined as the local authority for that area and any ICBs operating in the local authority area.

Child death review partners must make arrangements to review all deaths of children normally resident in the local area and, as indicated, of any non-resident children who have died in their area. This should be done via a Child Death Overview Panel (CDOP). Child death review partners for two or more local authority areas may combine and agree that their areas be treated as a single area for the purpose of undertaking child death reviews. Child death review partners must make arrangements for the analysis of information from all deaths reviewed by the National Child Mortality Database (NCMD).

The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area, or to public health and safety, and to consider whether action should be taken in relation to any matters identified.

CDOP Process

Unexpected deaths

An unexpected death is defined as the death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility, for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death.

When an unexpected child death occurs there are specific actions that must be taken by professionals. A Joint Agency Response (JAR) meeting will take place within 72 hours of the death. This meeting will be coordinated by the appropriate Child Death Review partner i.e. Police or Consultant Paediatrician. The purpose of the JAR (sometimes referred to as a rapid response) meeting is to enable the sharing of information, multi-agency discussion and planning to safeguard other individuals if identified.

Expected deaths

An expected death is defined as the death of an infant or child which was anticipated following on from a period of illness that has been identified as terminal, and where no active intervention to prolong life is ongoing.

The process for expected deaths differs slightly as they do not normally require a JAR. When a notification is received by CDOP, each agency that knew the child prior to their death receives a Reporting Form (or Form B). 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 a 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 to establish who died and how, when and where the death occurred.

Child Death Review Meetings

All expected and unexpected child deaths are required to have a Child Death Review (CDR) meeting. This is a multi-agency meeting where all matters relating to an individual child are discussed by professionals directly involved in the care of the child during their life. A CDR meeting can take many forms such as a Local Case Discussion, Perinatal Mortality Meeting, an NHS Serious Incident Investigation or a Hospital Morbidity and Mortality meeting and typically, this meeting happens three months or more following the death of a child.

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 (CDOP) for discussion and review. All the strategic leads from across the organisations (Public Health, Health, Social Care and Police) are represented at the meeting, along with the CDOP Coordinator and the Designated Doctor for Child Deaths. The purpose of the CDOP 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 Calderdale, Kirklees and Wakefield CDOP's reviewed a total of **84** cases. There are many reasons why it can take more than 6 months for a child death to be reviewed by the CDOP; one reason may be that information from agencies is still outstanding so the case cannot be progressed. In addition, if there is an on-going investigation (for example a Police investigation, Child Safeguarding Practice Reviews and Inquests) then discussions may be deferred pending the result of the inquiries. It must be noted that a child's death cannot be discussed at CDOP until all information is received.

Membership and Panel Meetings

Panel Arrangements

Calderdale, Kirklees and Wakefield share arrangements for reviewing the deaths of all children in these areas. During 2023/24 the pan CDOP has continued to use the eCDOP system for all child death notifications and to send out the subsequent Reporting Forms to the services who were involved with the child and family. Services can quickly report back at the click of a button if the child and family is not known to them, so we can quickly build up a picture of which services were involved with the child's care.

Panel Meetings

CDOP meetings continue to be held virtually. They are well attended by a wide range of multi-agency professionals. This ensured that any learning and actions to come from a child's death could be identified and shared without delay, helping to prevent future deaths. CDOP Coordinators ensure that the documentation to be discussed at the CDOP meeting is circulated in advance, so members have time to review it and come ready to give their input and feedback.

Panel Membership

The Panel meetings are held every two months and have had consistent organisational commitment since they were established in 2008. The Chair of the CDOP meetings is Emily Parry-Harries, Consultant in Public Health, Kirklees supported by Julia Caldwell, Calderdale Safeguarding Partnerships Manager and Melanie Robinson, Service Manager, Children's Public Health, Wakefield.

Reflecting back on our identified priorities

- Priority 1: To continue to provide safe sleeping training for professionals so that information can be shared with families.
- Priority 2: Continued focus on reducing population level smoking rates across Kirklees/Calderdale and Wakefield with a particular focus on reducing smoking in pregnancy.
- Priority 3: Continue to build upon and strengthen existing child death review processes.
- Priority 4: Continuing to develop the partnership arrangements across the shared panels.

What we have achieved:
Priority 1- To continue to provide safe sleeping training for professionals so that information can be shared with families.

Over the past few years CDOP have reviewed cases which have involved unsafe sleeping practices, and a lot of work has been undertaken in the Wakefield district to address this, which includes:

- Lullaby Trust commissioned training on sudden infant death and unsafe sleep
- Wakefield Safer Sleep Standard, providing clear guidance on what is required in terms of ensuring parents and carers are provided with effective safe sleep advice
- Safeguarding Babies and Childrens Masterclass
- Guidance on viewing where a baby sleeps during health visiting and community midwifery home visits is now embedded as standard practice.
- Specific page on safeguarding babies and infants on the WSCP website, providing a 'one stop shop' on all key information and resources on safe sleep
- This has coincided with there being no sudden deaths concerning unsafe sleep since 2022
- In addition to all of the above 2023 saw Every Sleep a Safe Sleep Multi Agency Risk Minimisation Training offered to a wide range of partners. This enabled a number of our services to attend and then share across their own workforce. One particular highlight was West Yorkshire Police Force who adapted the training and presentation to suit their frontline officers and to date 1087 staff have undergone the training with positive feedback about the user-friendly risk minimisation tool which enabled officers to successfully identify risks in some vulnerable families.
- In 2023/24 CDOP reviewed a number of cases where the use of Unsafe Sleeping Equipment, such as Dok-A-Tots had been a feature. At the recommendation of CDOP a letter was sent to organisations in the Wakefield district, who provide sleeping equipment to families, such as Baby Banks, providing guidance that second hand equipment should clearly meet the requirements of British Safety Standards, and any items/equipment missing instructions should have them downloaded from the manufacturer’s website’s and provided to parents/carers to highlight appropriate use.

What we have achieved:

Priority 2 - Continued focus on reducing population level smoking rates across Kirklees/Calderdale and Wakefield with a particular focus on reducing smoking in pregnancy.

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.

In Wakefield the risks of smoking are discussed with all women by the midwife at the very first appointment and a referral made to the Stop Smoking service. This is an opt out service and pregnant women are referred for support as early as possible. Tobacco Dependence Advisors are coming in to post who will work across the Pontefract, Wakefield, and Dewsbury areas. Hard hitting leaflets highlighting the dangers of smoking in pregnancy and the impact of the unborn child have been created. If the pregnant woman is still smoking at 20 weeks gestation the Tobacco Dependence Advisors will use these leaflets as part of a discussion with them when all other efforts to engage them in a quit attempt has failed. Extra scans for women smoking (32, 36 and 40 weeks) have also been introduced in October 2020 as part of the Saving Babies Lives Care Bundle.

Wakefield Public Health and other councils are also currently working with OHID (Office for Health Improvements & Disparities (OHID formerly PHE) to develop resources around smoke free social housing.

What we have achieved:
Priority 3 - Continue to build upon and strengthen existing child death review processes.

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.

In Wakefield Child Death Review meetings, facilitated by Mid Yorkshire NHS Teaching Trust (MYTT) with relevant partners present, are routinely being held for all unexpected child deaths, once postmortem investigations have been completed. This information then feeds into CDOP. MYTT have also now commenced a process for holding child death review meetings for expected deaths. CDOP Co-ordinator will attend these meetings where possible, which should allow for the timely completion of form B ‘s from consultations for expected deaths.

Wakefield CDOP Co-ordinators have commenced sending letters to parents on behalf of CDOP Chairs, explaining what CDOP meetings are and why they have to be held. The letter details how parents can be involved in the CDOP process should they have any information or feedback they want the Panel to be aware of. This process is going well with contact made by one parent to date in Wakefield.

From Autumn 2024, the CDOP panels will trial reviewing child death cases using the electronic eCDOP system rather than using the traditional paperwork format. The eCDOP system is a secure cloud base tool, and once an account is created for a Panel member, they will be able to log into the system and review all the paperwork relevant to that case. The anticipated benefits of this is that:

- All the information regarding the child’s death is stored in one place and is easily accessible, which in theory should reduce the amount of time it takes the co-ordinator to prepare a case for Panel review.
- It will align all the paperwork used in the Kirklees and Wakefield areas, which to date has slightly differed, which can cause confusion for Panel members when trying to find the information they need, thus extending the time it takes to review a child death case during the Panel meeting.
- The risk of paperwork being sent to the wrong recipient is significantly reduced. Whilst stringent security measures are always taken when sharing documentation with Panel members, eCDOP requires each Panel member to log in to the system using their own personal username/password before they can view the documentation.

This new process is only at the trial stage and further information about its success will be reported in the 2024/25 CDOP Annual Report.

What we have achieved:
Priority 4 - Continuing to develop the partnership arrangements across the shared panels.

Kirklees and Wakefield Public Health have continued to work together 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. Wakefield have further extended their spreadsheet to include newly emerging factors and have identified services available across the district to support the highlighted modifiable factor, this enables the CDOP Partnership Manager to share with partners.

The tri-cdop arrangements in place between Calderdale, Kirklees and Wakefield have enabled CDOP to review deaths and identify modifiable factors and required actions consistently. When cases are reviewed, and emerging trends are identified these are added to the modifiable factors spreadsheet and consideration is given to what services are already in place to address these and what extra support is needed that isn't already available.

Additional CDOP Achievements/Activities

Since 2019 there has been three deaths in the Wakefield district suspected to have been due to drowning in open water. The work of CDOP led to the creation of a dedicated WSCP Water Safety Page water safety information, resources and messaging being regularly promoted via the WSCP e-bulletin, CDOP newsletter, and social media, Yorkshire Water live assemblies to schools. This work overlapped and culminated into a Be Water Wise campaign as part of the Wakefield District water safety group who produced a series of films, including one which was based on the incidents of drowning concerning children. Since the Be Water Wise campaign launched, the film series has been viewed over 6,000 times and has been incorporated into school's water safety delivery, along being viewed at the district's Build Our Futures, youth summit. The WSCP Water Safety page, for the yearly reporting period has had 1,154 views by 645 people which is the highest viewed single topic page on the WSCP website for the year.

The NCMD have been invited WSCP to deliver a presentation to colleagues nationally outlining all the work that has been undertaken in the Wakefield district to promote water safety. WSCP have accepted this invitation and has prepared the presentation and is currently awaiting confirmation of the date this event will take place. Further feedback to follow.

The tri-cdop have reviewed several cases where there was use of unsafe sleeping equipment and have notified the Coroner's Office and the National Child Mortality Database (NCMD). This has led to the NCMD incorporating this into a national training, safety and engagement programme, coproducing a video with the Lullaby Trust and Royal College of Midwifery to be used in training with midwives to further support conversations with families about creating a safer sleep environment.

WSCP have published a bereavement support page on the WSCP website; to provide a single point of access for bereaved parents and carers to help ensure they can access any support they wish. This page in shared with parents and carers as routine practice by those who provide immediate support in the aftermath of a child death.

In Wakefield links have been made with the Health Improvement Specialist Team and the British Cycling Association to look at what safety advice and resources are provided to young cyclists, to help them learn to cycle safely.

Calderdale Data

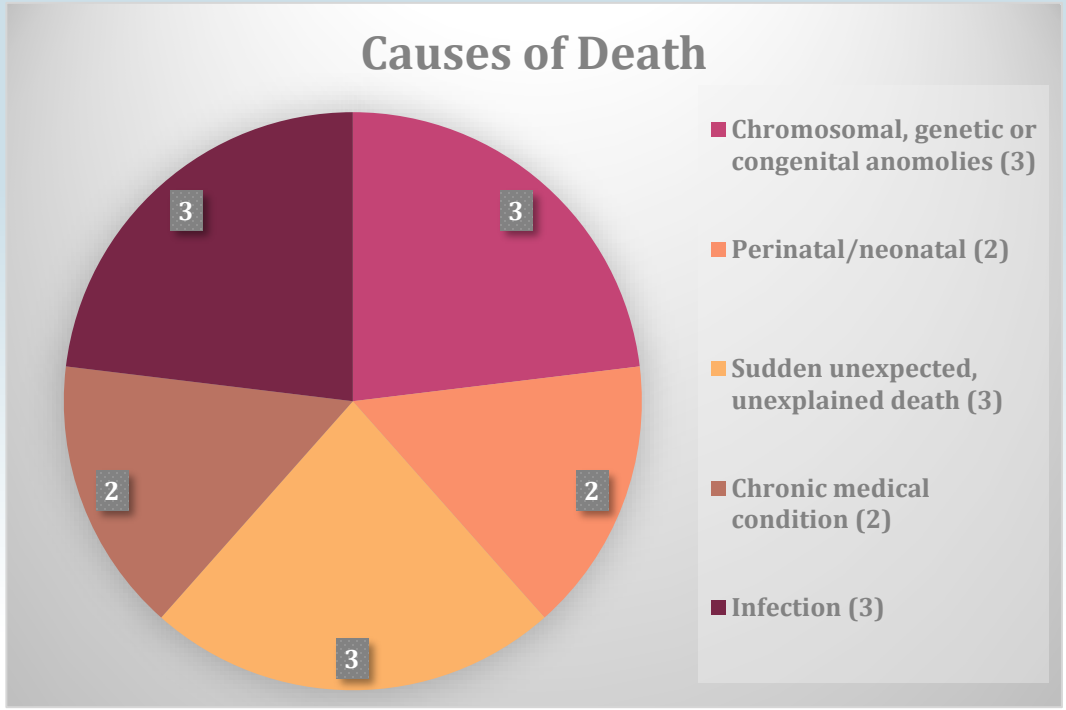
During 2023/2024 there have been 10 deaths reported, which is lower than the past 4 years. During the year, 13 cases have been reviewed and completed, with a further 11 cases to be reviewed.

Cases Completed with cause of death:

Of the cases reviewed 5 (38%) had modifiable factors,

and these have been identified as:

- Smoking
- Alcohol consumed prior to co-sleeping
- Unsafe sleeping arrangements
- Premature baby not born in an obstetric centre with neonatal unit providing appropriate level of care



(***each case can have more than one modifiable factor identified***)

Kirklees Data

During 2023/2024 there have been **35** deaths reported. During the year **46** cases have been reviewed and completed. There are a further **54** cases to be reviewed.

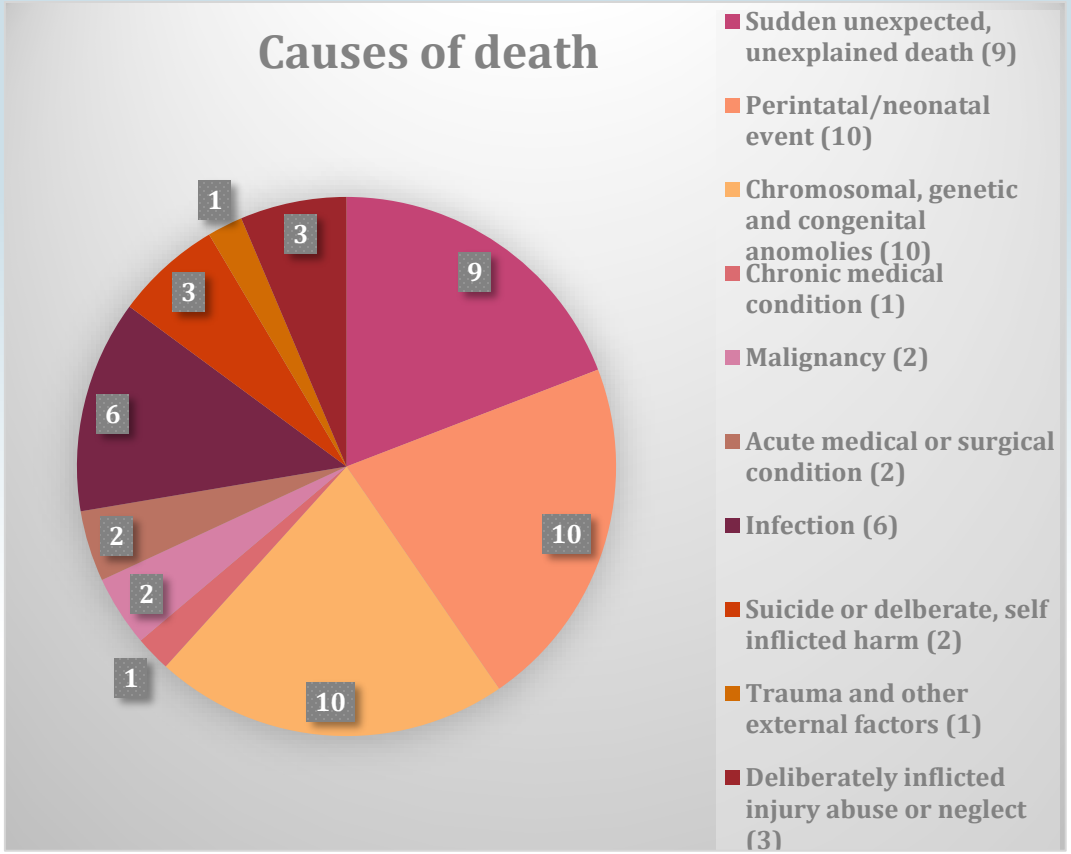
Cases completed with cause of Death:

Of the cases reviewed 14 (30%) had modifiable factors, the

top 5 of which were:

- Smoking
- Unsafe sleeping arrangements
- Domestic Abuse
- Consanguinity
- An emerging modifiable factor – Maternal obesity during pregnancy

(***each case can have more than one modifiable factor identified***)



Wakefield Data

During 2023/2024 there have been 29 deaths reported. During the year 25 cases have been reviewed and completed, with a further 45 cases to be reviewed.

Cases Completed with cause of death:

Of the cases reviewed, 13 (52%) had modifiable factors and these have been identified as including:

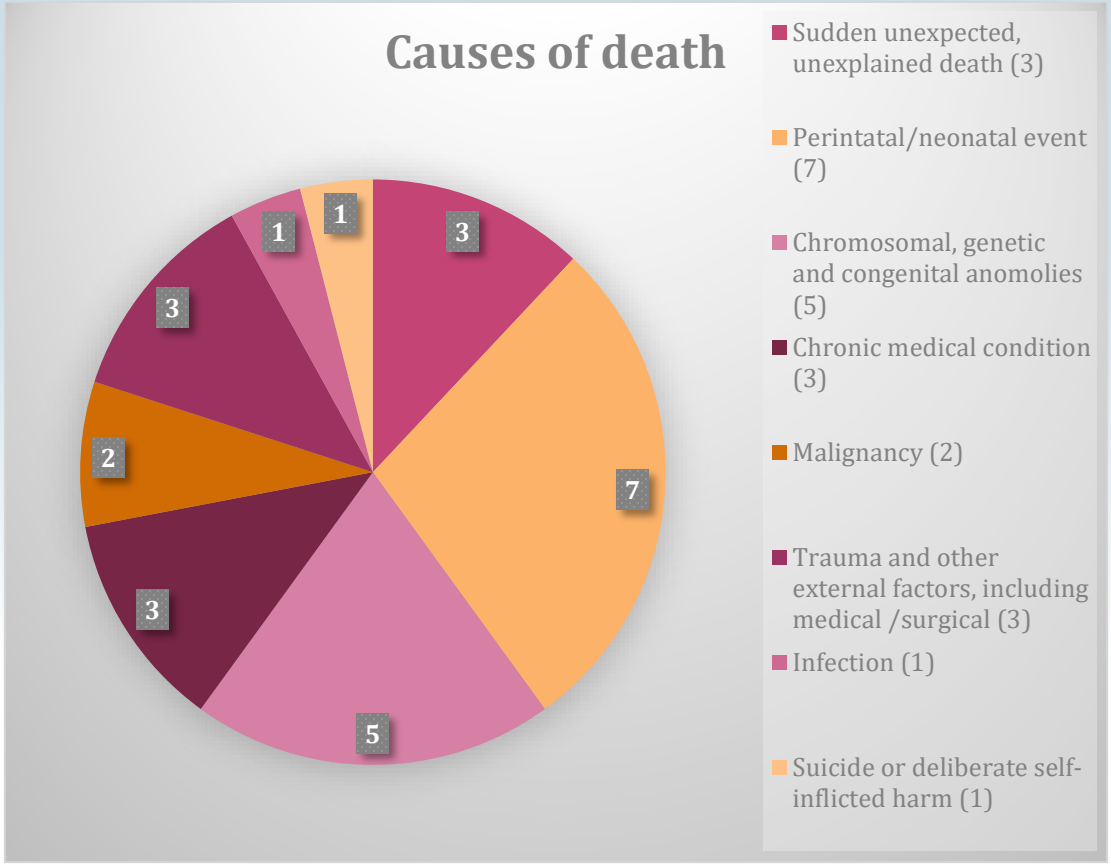
<u>Factors identified which may have contributed to ill-health or a death</u>

- Unsafe sleeping practices (3)
- Parental Smoking (5)
- Non-swimmer (2)
- No visible safety signage/life saving devices at waterside (2)
- Parental substance use (3)
- Child Substance Misuse (1)
- Parental alcohol use (1)
- A lack of clinical awareness of the risk of pre-term labour in MCDA twin pregnancies, delayed the identification of pre-term labour. (2)

<u>Factors identified but has not contributed to a death</u>

- Parental Smoking (2)
- Domestic Abuse (2)

Each case can have more than one modifiable factor identified



Categories of Death for Pan CDOP - Cases Reviewed In Year 2023/24

Joint Data and Analysis

Modifiable Factors

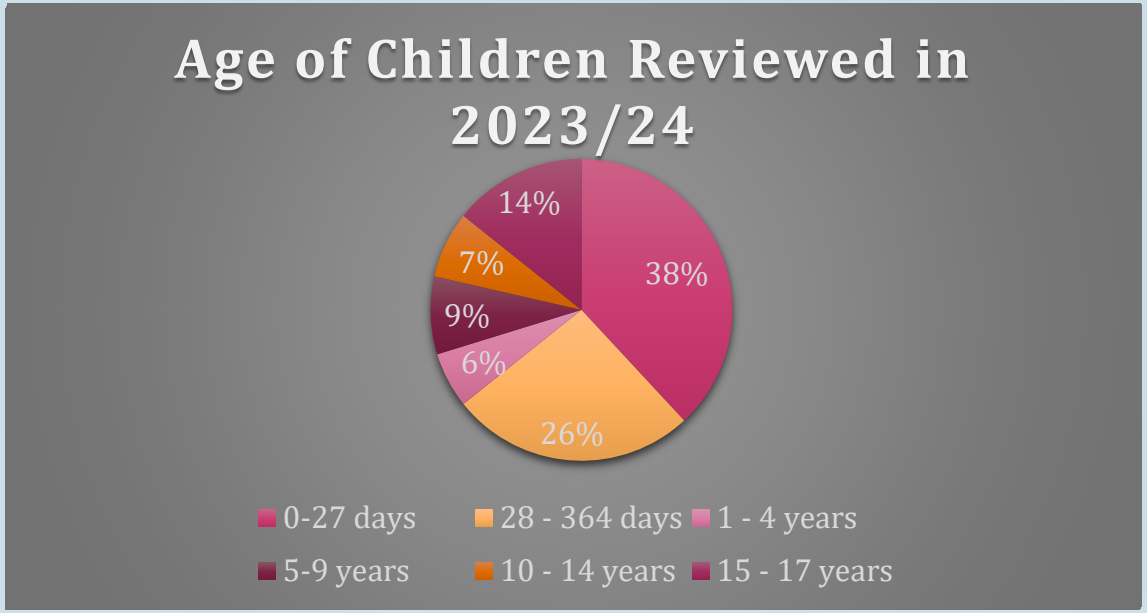
Modifiable factors are defined as ‘if actions could be taken through national or local interventions, the risk of future child deaths could be reduced’

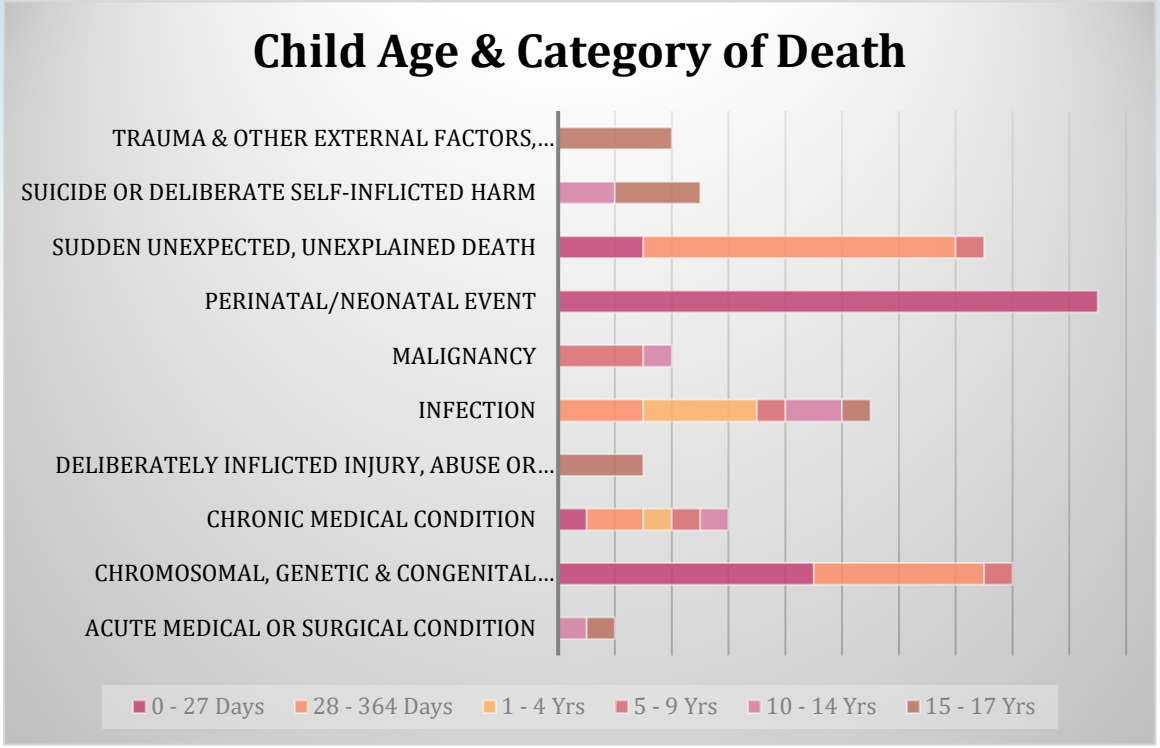
When the Panel has reviewed the death of a child they will then identify and agree any modifiable factors that may have prevented the death. Out of the 84 child deaths reviewed by the Panels during 2023/2024, there were 32 cases where modifiable factors were identified. This represents an average of 38%, (20% decrease from 2022/2023). The average for England was 43% for the same period.

The explanation for the decrease could be attributed to the publication of the NCMD guidance on Consanguinity which has been in use in CKW from April 2023 and means the decisions on whether consanguinity is modifiable is in line with national standards.

Of the 32 child deaths reviewed where modifiable factors were identified, the predominant factors recorded were:

- Smoking
- Alcohol consumed prior to co-sleeping
- Consanguinity
- Substance Misuse
- Domestic Abuse
- Unsafe sleeping Arrangements
- An emerging modifiable factor – Maternal obesity during pregnancy





Joint Data and Analysis

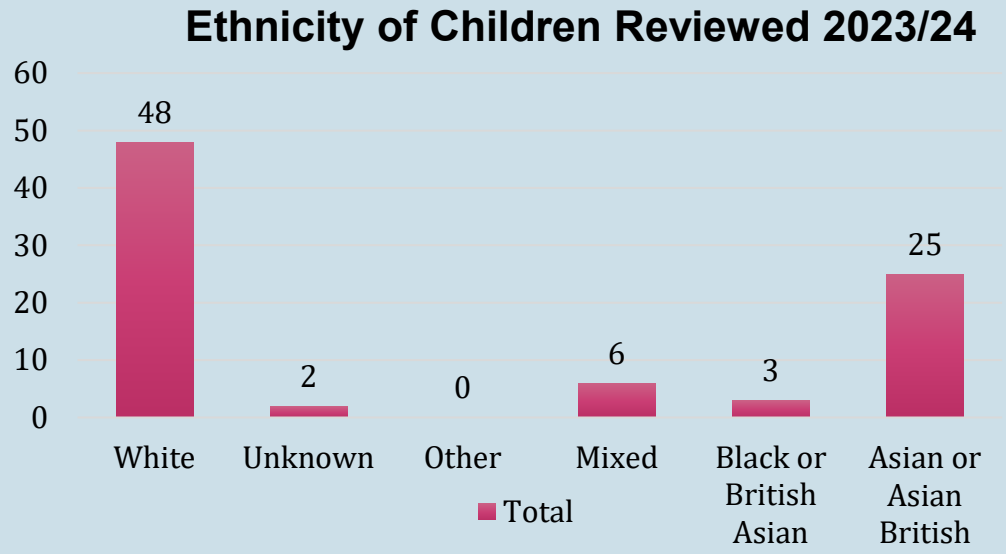
Age of children:

A child is most at risk of death within the first year of life, and particularly within the first 27 days of life.

There are many reasons for the causes of death during the first 27 days of life, but there are also children who die where the cause is unknown. These cases are referred to the Coroner, to determine through the Coronial process the child's cause of death.

64% of the children who died in the pan CDOP, died within their 1st year of life. The lowest age group of children who have died are 1–4-year-olds which is a change from 2022/23 when 15–17-year-olds was the lowest category.

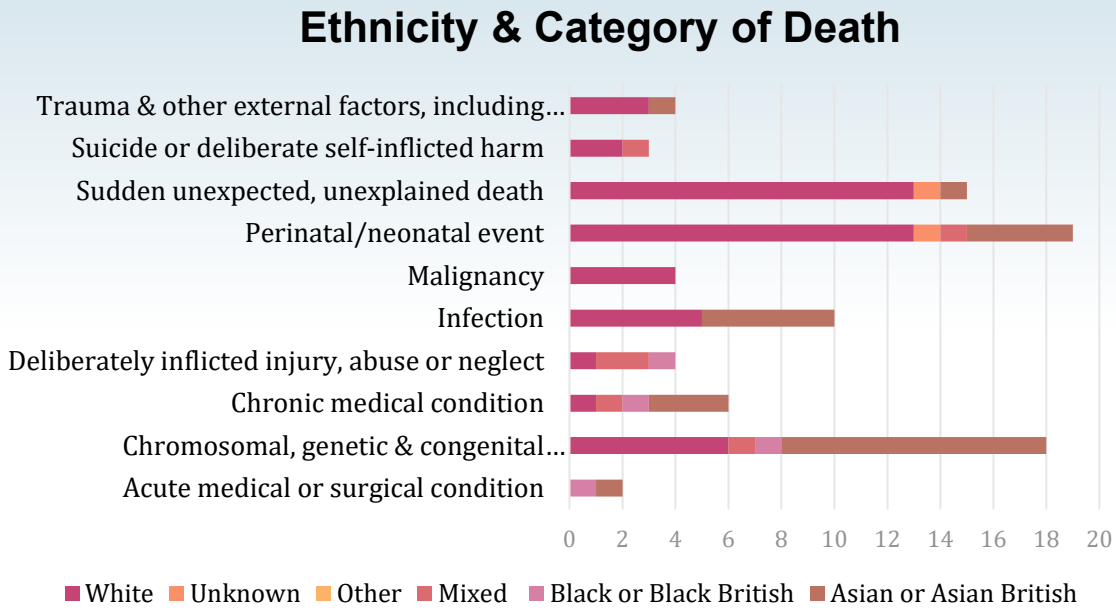
Of all the children who have died, 38% died within 27 days of birth and the main categories of death for this age group being perinatal/neonatal event and chromosomal, genetic and congenital anomalies.



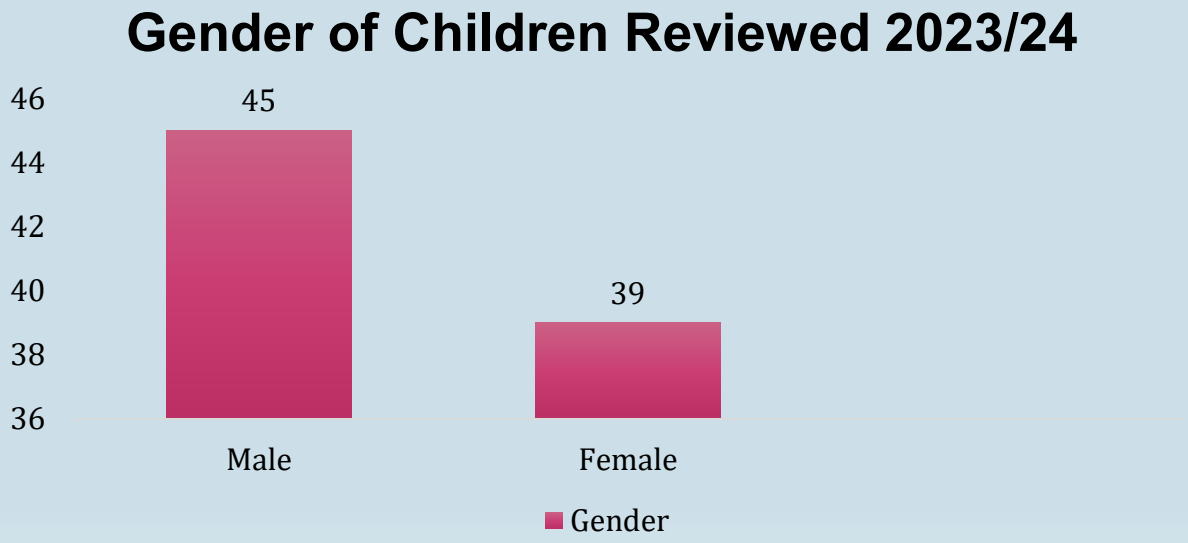
Joint Data and Analysis

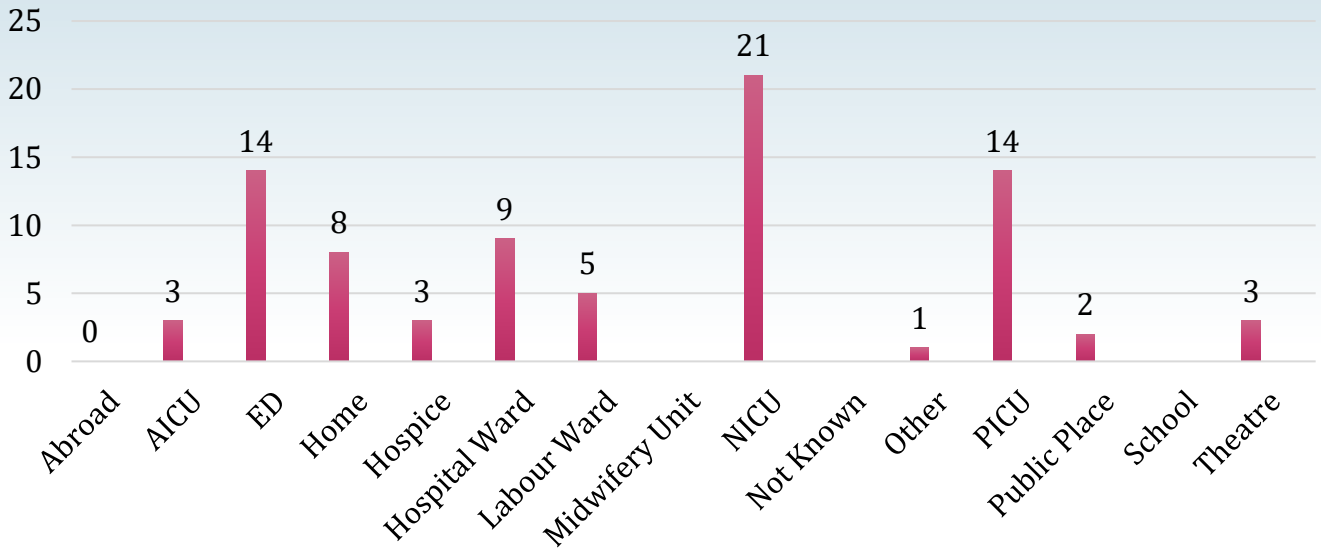
Ethnicity:

Across the pan CDOP when looking at the ethnicity of the child deaths along with the category of deaths, the largest categories of death was Perinatal/neonatal event and chromosomal, genetic and congenital anomalies. This year saw over half of the child deaths being of white ethnicity.



This is consistent with the 2022/23 data which saw chromosomal, genetic and congenital anomalies as the main category of death, however, perinatal/neonatal has slightly overtaken this figure this year.





Joint Data and Analysis

Gender:

This year the gender split between the children who have died is more equal at 53% males and 47% females compared to 2022/23 when there was a larger (62% males compared to 38% females).

Location of death:

Of the 84 cases reviewed, 85% of the deaths occurred in a medical setting. This is higher than 2022/23 which was 78%.

Indices of Deprivation

Nationally

The child death rate for children resident in the most deprived neighbourhoods of England was 42.9 per 100,000 population, more than twice that of children resident in the least deprived neighbourhoods (17.2 per 100,000 population). The child death rates decreased from the previous year for both quintiles, although the difference in rates between these areas is still higher than any year recorded before 2023.

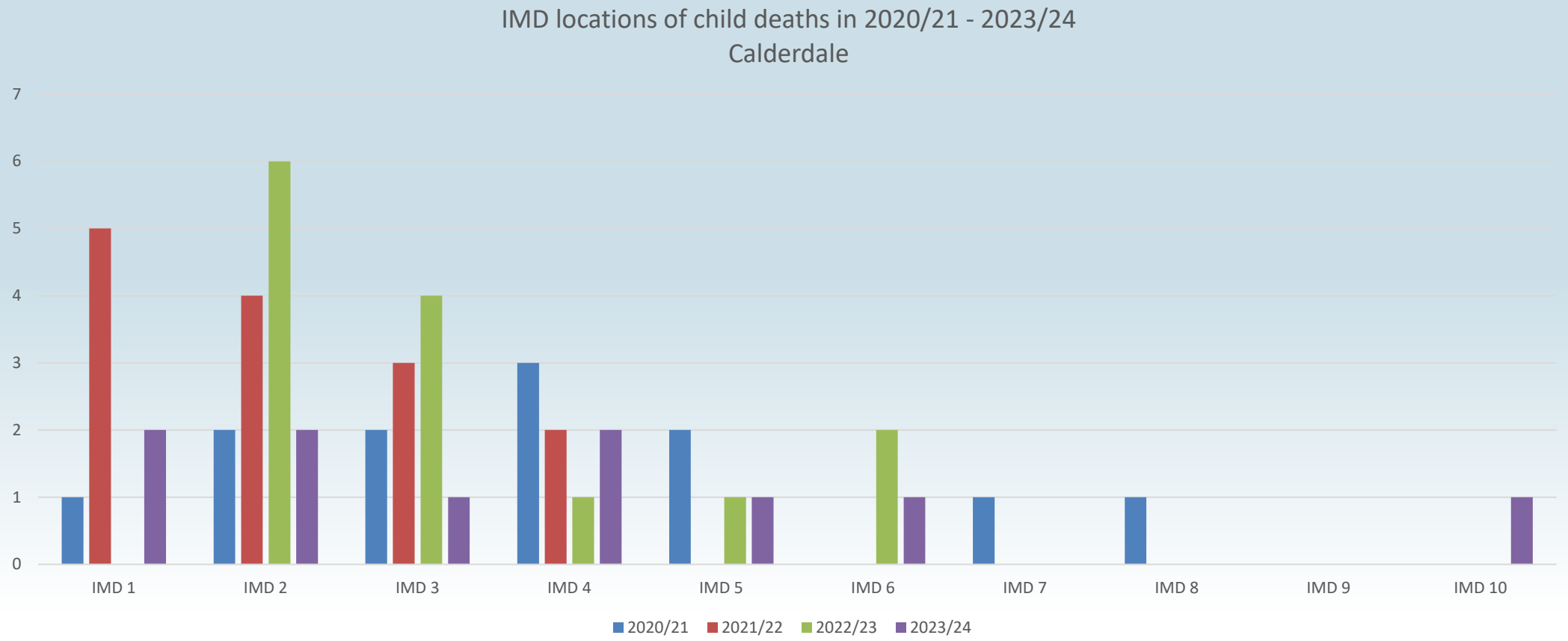
Over the five-year period, death rates for children of black and Asian ethnicity remained higher than for children of white British ethnicity across all five deprivation quintiles.

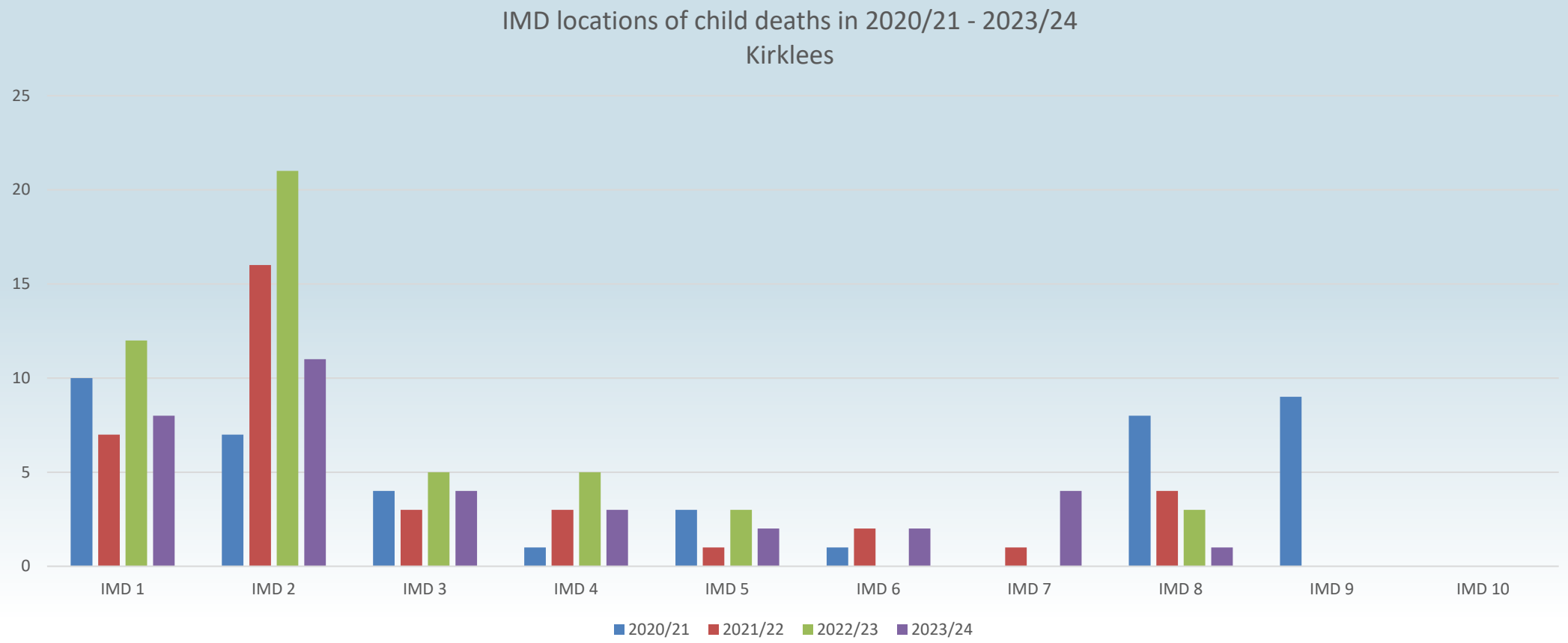
Locally

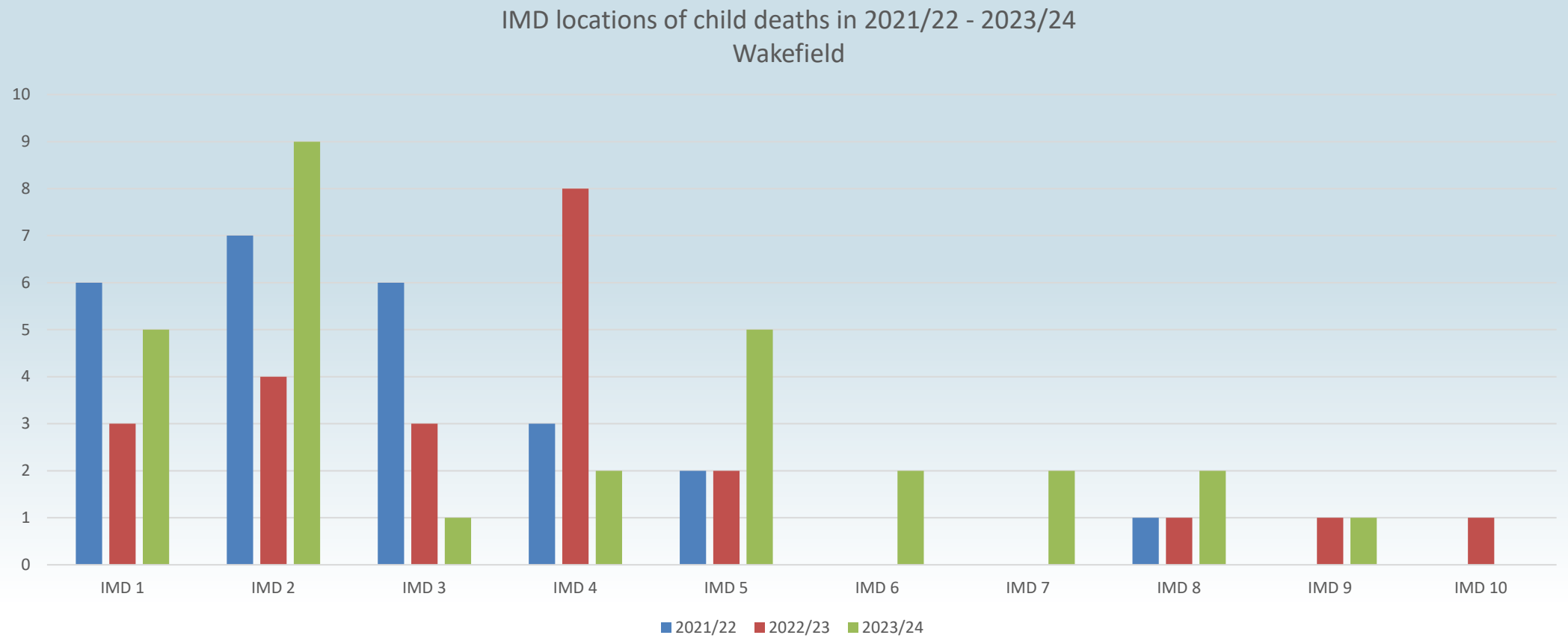
Calderdale: Of the 10 children who died in 2023/24, 4 had been resident in the 2 most deprived areas of Calderdale which are urban (40%). 50% of those children were male and 50% were female and 50% were of Asian/Asian British Pakistani ethnicity and the other 50% were White British.

Kirklees: Of the 35 children who died in 2023/2024, 19 had been resident in the 2 most deprived areas in Kirklees which are urban (50%). 58% were female and 42% were male. 53% of children were White British, 42% were of Asian/Asian British Pakistani ethnicity 5% were other ethnicity.

Wakefield: Of the 29 children who died in 2023/24, 14 had been resident in the 2 most deprived areas of Wakefield which are urban (48%). 64% we male and 36% were female. 78% of children were of White ethnicity.


IMD locations of child deaths in 2020/21 - 2023/24
Calderdale
7
6
5
4
3
2
1
0
IMD 1
IMD 2
IMD 3
IMD 4
IMD 5
IMD 6
IMD 7
IMD 8
IMD 9
IMD 10
2020/21
2021/22
2022/23
2023/24


IMD locations of child deaths in 2020/21 - 2023/24
Kirklees
25
20
15
10
5
0
IMD 1
IMD 2
IMD 3
IMD 4
IMD 5
IMD 6
IMD 7
IMD 8
IMD 9
IMD 10
2020/21
2021/22
2022/23
2023/24


IMD locations of child deaths in 2021/22 - 2023/24
Wakefield
10
9
8
7
6
5
4
3
2
1
0
IMD 1
IMD 2
IMD 3
IMD 4
IMD 5
IMD 6
IMD 7
IMD 8
IMD 9
IMD 10
2021/22
2022/23
2023/24

Conclusion

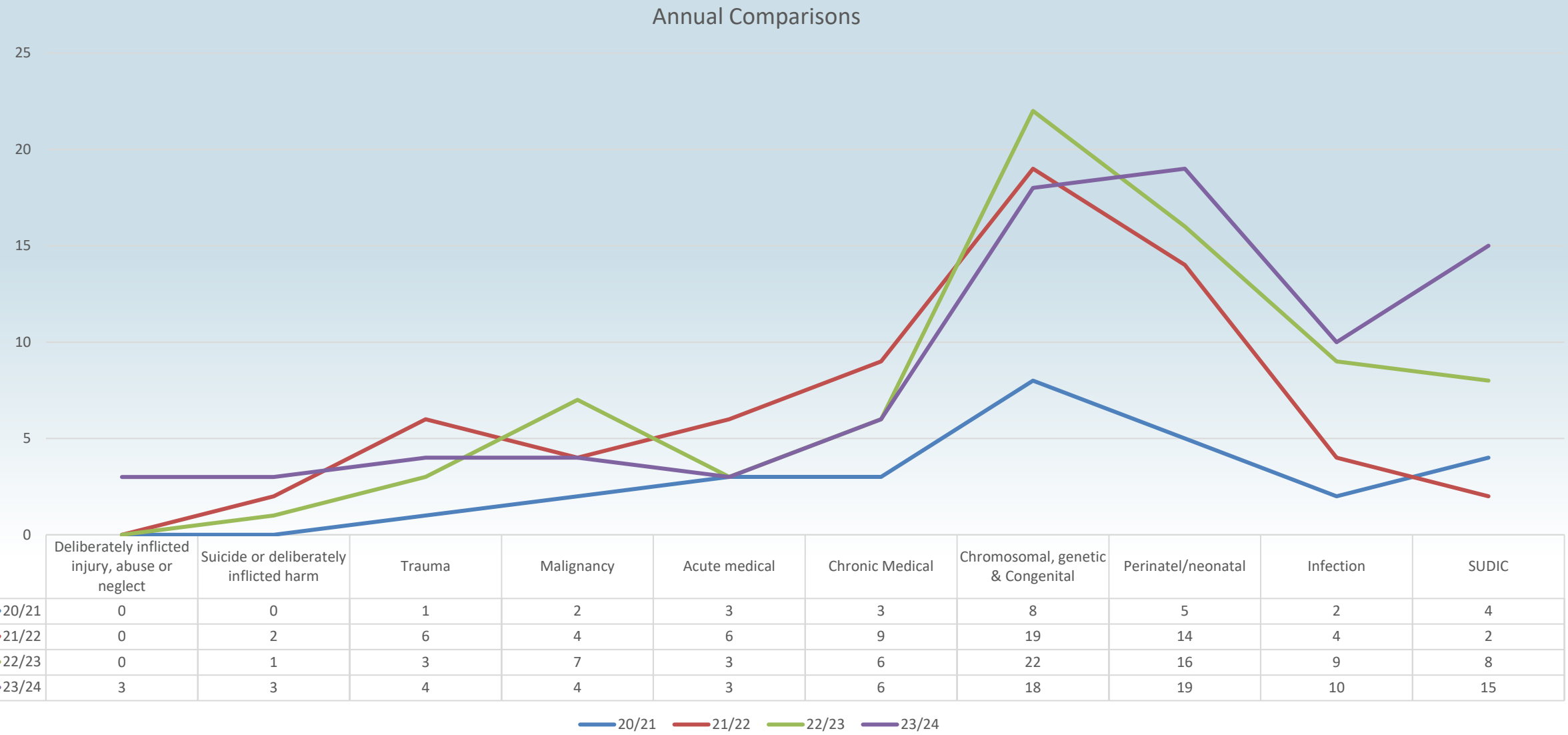
The number of cases reviewed in 2023/24 (84) has increased from the previous year 2022/23 (65). The number of deaths in Calderdale in 2023-2024 has reduced from 14 to 10.

The majority of children who were reviewed in this year, die before the age of 1 (64%). 28% were aged 28 – 364 days, 37% aged 0 – 27 days. The main category of death for this age group continues to be perinatal/neonatal event or chromosomal, genetic and congenital anomalies.

Of the 84 deaths reviewed, 45 were male and 39 were female This is consistent with the findings from 2022/23, where there were also more male than female deaths.

Inequalities and the links to child deaths will continue to be a focus across CKW. Inequalities are a golden thread in everything the Panel does, monitoring this will allow targeted work to be undertaken where inequality can be a contributory factor to the death e.g. poverty and safer sleep.

The main categories CDOP has recorded child deaths against in 2023/24 remained the same as 2022/23 and 2021/22.



	Deliberately inflicted injury, abuse or neglect	Suicide or deliberately inflicted harm	Trauma	Malignancy	Acute medical	Chronic Medical	Chromosomal, genetic & Congenital	Perinatel/neonatal	Infection	SUDIC
20/21	0	0	1	2	3	3	8	5	2	4
21/22	0	2	6	4	6	9	19	14	4	2
22/23	0	1	3	7	3	6	22	16	9	8
23/24	3	3	4	4	3	6	18	19	10	15

- There has been a decrease in the percentage of deaths in 2023/24 in comparison to 2022/23 where modifiable factors were present (38% v 58%). Part of this decrease could be attributed to the fact we are now referencing the flowchart in relation to consanguious parents which has resulted in less cases being considered modifiable.

- Calderdale have reviewed 13 cases compared to 16 in 2022/23. Kirklees reviewed 46 cases compared to 32 in 2022/23 compared to and Wakefield reviewed 25 cases in comparison to 17 cases in 2022/23.

- Inequalities and the links to child deaths will continue to be a focus across CKW. Inequalities are a golden thread in everything the Panel does, monitoring this will allow targeted work to be undertaken where inequality can be a contributory factor to the death e.g. poverty and safer sleep.

- According to the last published national data, perinatal/neonatal event continues to be the highest category used by CDOPs nationally https://www.ncmd.info/publications/child-death-data-2023/

Priorities for 2024/2025

The following have been identified as priorities for the Panel for the year ahead:

Priority 1: To continue work around safer sleep, providing further guidance and involvement in research

Priority 2: To continue working with women who have been identified as being at risk of maternal obesity

Priority 3: Continue to build upon and strengthen existing child death review processes.

Priority 4: To continue working with Yorkshire Smokefree in Calderdale, Kirklees Tobacco Control Alliance and Wakefield Stop Smoking Service to reduce smoking in pregnancy and across the population

The panels will continue to highlight and provide analysis on social and health inequalities, recognised nationally as higher mortality risks.