2024 - 2025

CALDERDALE, KIRKLEES AND WAKEFIELD CDOP ANNUAL REPORT

Wakefield Safeguarding Children Partnership

Calderdale Safeguarding Children Partnership

Kirklees Safeguarding Children Partnership

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1) INTRODUCTION, STATUTORY REQUIREMENTS AND AIMS OF CDOP:

One of the most devastating things for a family to experience is the death of a child and it is recognised that this will have a profound and long-lasting impact on everyone involved in that child's life. All deaths of children up to the age of 18 years, excluding stillbirths and planned terminations, is subject to the Child Death Review (CDR) process

The Child Death Review process is undertaken in accordance with national and statutory guidance set out in **Working Together to Safeguard Children 2023** and **The Child Death Review Statutory and Operational Guidance 2018.**

The Child Death Review process consists of two panels who have different roles, which are:

a) Child Death Review Meeting (CDRM) Panel
This is the stage of the review process that precedes the multi-agency Child Death Overview Panel (CDOP). This meeting should be a multi-professional meeting where all matters relating to an individual child's death are discussed. CDRM should be attended by professionals who were directly involved in the care of the child during his or her life, and any professionals involved in the investigation into his or her death. The CDR panel will identify if any of the contributory factors evident were modifiable. Modifiable factors are defined as factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

b) Child Death Overview Panel (CDOP)
This is a multi-agency panel set up by CDR partners to review the deaths of all children normally resident in their area, and, if appropriate and agreed between CDR partners, the deaths in their area of non-resident children, in order to learn lessons and share any findings for the prevention of future deaths. The CDOP should be informed by a standardised report from the CDR meeting, and ensures independent, multi-agency scrutiny by senior professionals with no named responsibility for the child's care during life. In practice, CDOPs will conduct the independent multi-agency scrutiny on behalf of the local CDR partners responsible for ensuring that the review of deaths of all children normally resident in that area takes place.

The purpose of the Child Death Review process is to understand why a child has died, identify any modifiable factors that may have contributed to the death, and to prevent future child deaths by learning from these circumstances. This process intends to:

- Document, analyse and review information in relation to each child that dies to confirm the cause of death, determine any contributing factors and identify learning arising from the process that may prevent future deaths.

- To make recommendations to all relevant organisations where actions have been identified which may prevent future deaths or promote the health, safety and wellbeing of children.

- To contribute to local, regional and national initiatives to improve learning from child deaths.

The collation and sharing of all learning from the Child Death Reviews and the CDOP is managed by the National Child Mortality Database (NCMD), which has been operational since 1st April 2019. The NCMD gathers information from all the local reviews of children who die across England with the aim to identify common risk factors or themes which could be addresses to reduce child mortality.

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 Integrated Care Boards (ICBs) operating in the local authority area. 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).**

Calderdale, Kirklees and Wakefield Safeguarding Children Partnerships, work together to coordinate the review of child deaths and share learning to help safeguard children across these districts. This is referred to as the Pan-CDOP.

This report focuses on the outcomes/findings from the child deaths that were reviewed by the Pan-CDOP during CDOP meetings held from 1st April 2024 – 31st March 2025.

2) MEMBERSHIP AND PANEL MEETINGS

- Panel Arrangements

Calderdale, Kirklees and Wakefield share arrangements for reviewing the deaths of all children in these areas. During 2024/25 the pan CDOP has continued to use the eCDOP system for all child death notifications and to send out the subsequent Reporting Form (Form B) to the services who were involved with the child and family. Services can rapidly 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 are well attended by a wide range of multi-agency professionals. The meetings allow for any learning and actions to come from a child's death to be identified quickly and shared without delay, helping to prevent future deaths.

- Panel Membership

The Panel meetings are held every quarter and have had consistent organisational commitment since they were established in 2008. The Chair of the CDOP meetings is currently the Service Manager for Children's Public Health in Wakefield supported by the Consultant in Public Health for Kirklees and the Calderdale Safeguarding Partnerships Manager. The meetings are structured so that Wakefield and North Kirklees hold a joint meeting together, as do Calderdale with Kirklees.

3) 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 led to the death.

- Joint Agency Response (JAR) Meeting

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.

Supporting and engaging with a family who have lost a child is of the uttermost importance throughout the Child Death Review Process, as it can be a very complex and emotional process. During the JAR meeting it will be identified who will act as the “Key Worker” for the family, who will then support and guide the family through the Child Death Review Process. For the Pan-CDOP, the key worker is usually the Child Death Lead Nurse at Mid Yorkshire Teaching Trust (MYTT) Hospital, and the Child Death Key Worker Nurse at Calderdale and Huddersfield NHS Foundation Trust (CHFT).

- 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 meeting. When a notification is received by CDOP, each agency that knew the child prior to their death receives a Reporting Form (Form B). This form captures all the relevant information about the child and family to inform the CDOP process when considering modifiable factors.

- 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 (CDR)

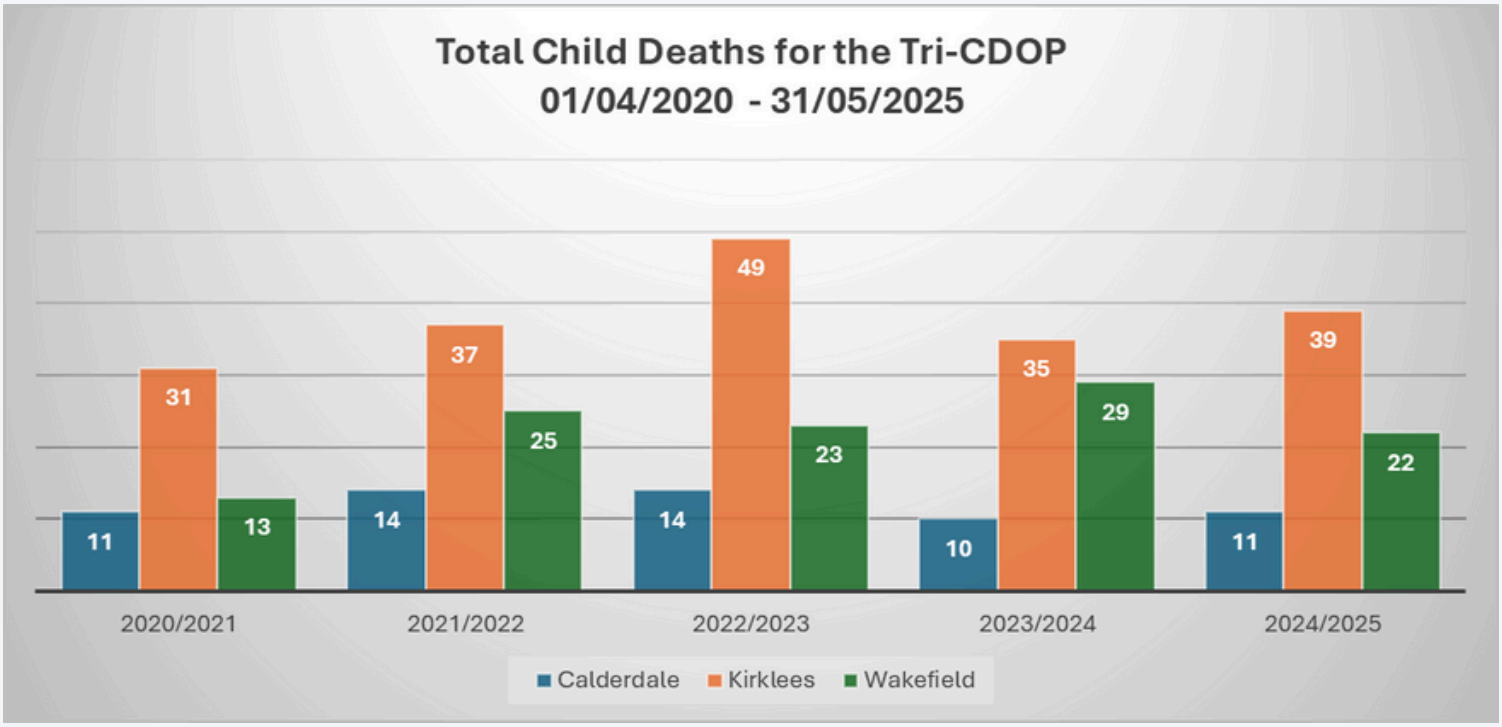
All expected and unexpected child deaths are required to have a **Child Death Review (CDR) meeting**. This is a multi-agency meeting where all matters relating to an individual child are discussed by professionals directly involved in the care of the child during their life. A CDR meeting can take many 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. The draft analysis form (Form C) is completed within this meeting, which is then presented to and either amended or affirmed when the child's death is reviewed by the CDOP.

4) JOINT DATA ANALYSIS 2024 – 2025

Between 1st April 2024 to 31st March 2025, the Calderdale, Kirklees and Wakefield CDOP's reviewed a total of 38 child deaths. 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 Review or an Inquest) 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 the Child Death Review meeting has been held and the necessary forms completed.

- Total deaths for the Tri-CDOP Areas 01/04/2020 – 31/03/2025 (**not cases reviewed**)

Table 1



Since 1st April 2020 a total of 363 children have died in the Tri-CDOP areas, 72 of these deaths happened from 1st April 2024 to 31st March 2025. This is the lowest number of child deaths in the reporting year since 2020/2021.

- Modifiable factors

Modifiable factors are defined as “those, where if actions could be taken through national or local interventions, the risk of future child deaths could be reduced”. When the Panel reviews the death of a child they identify and agree if there are any modifiable factors that may have prevented the death and what actions are required as a result. All actions are monitored via the CDOP action log. Public Health have also created the Calderdale, Kirklees, and Wakefield Modifiable Factors Document. The purpose of this document is to identify the top modifiable factors for each Place and to demonstrate the key Public Health initiatives/programmes of work that have a significant relevance to some of the modifiable factors identified in the CDOP meetings. The document is reviewed periodically, and updates are fed into CDOP meetings on a regular basis.

Of the 38 child deaths that were reviewed in 2024/2025 the CDOP identified 16 instances where modifiable factors were present. This equates to 41% of the child deaths that were reviewed by the Pan-CDOP areas. By comparison in 2024/2025 the percentage of child deaths with a modifiable factor in England was 43%. Therefore, the Pan-CDOP areas findings are similar to the national picture. For all three areas parental smoking was the predominant modifiable factor.

- Categories of death

The table below shows the combined categories of death for cases reviewed in Calderdale, Kirklees and Wakefield from 1st April 2020 to 31st March 2025

Table 2

Category of death	2020/ 2021	2021/ 2022	2022/ 2023	2023/ 2024	2024/ 2025	Total
Deliberately inflicted injury abuse or neglect: Includes numerous physical injuries, which may be related to homicide as well as deaths from war, terrorism or other mass violence. It also includes severe neglect leading to death.	0	0	0	3	1	**4**
Suicide or deliberate self-inflicted harm: This includes any act intentionally to cause one's own death. It will usually apply to adolescents rather than young children.	0	3	1	3	0	**7**
Trauma or other external factors: Unintentional physical injuries caused by external factors. It does not include any deliberate inflicted injury, abuse or neglect.	4	9	3	4	4	**24**
Malignancy: This includes cancer and cancer like conditions such as solid tumours, leukaemia's and lymphomas and other malignant proliferative conditions, even if the final event leading to death was infection, haemorrhage etc	5	7	7	4	2	**25**
Acute medical or surgical condition: A brief sudden onset of illness which resulted in the death of a child	3	7	3	2	5	**20**
Chronic medical condition: A medical condition which has lasted a long time or was recurrent and resulted in the death of a child.	1	6	5	6	2	**20**
Chromosomal, genetic and congenital condition: Medical conditions resulting from anomalies in genes or chromosomes as well as a defect that is present at birth	15	25	21	18	9	**88**
Perinatal/neonatal event: The death of a child as a result of extreme prematurity, adverse outcomes of the birthing process, intrauterine procedure or within the first 4 weeks of life.	7	22	15	19	9	**72**
Infection: This can be any primary infection (i.e. not a complication of one of the above categories), arising after the first post-natal week, or after discharge of a preterm baby.	2	3	4	10	5	**24**
Sudden unexpected or unexplained death: This is where pathological diagnosis is either Sudden Infant Death Syndrome (SIDS) or unascertained, at any age	9	19	6	15	1	**50**
Total number of child deaths reviewed by CDOP	**46**	**101**	**65**	**84**	**38**	**334**

334 child deaths have been reviewed by the Pan CDOP since April 2020 up to March 2025. The majority of child deaths that were reviewed in 2024/25 were due to chromosomal, genetic and congenital conditions and perinatal/ neonatal events which is a consistent finding since April 2020.

- Age of Children

Table 3

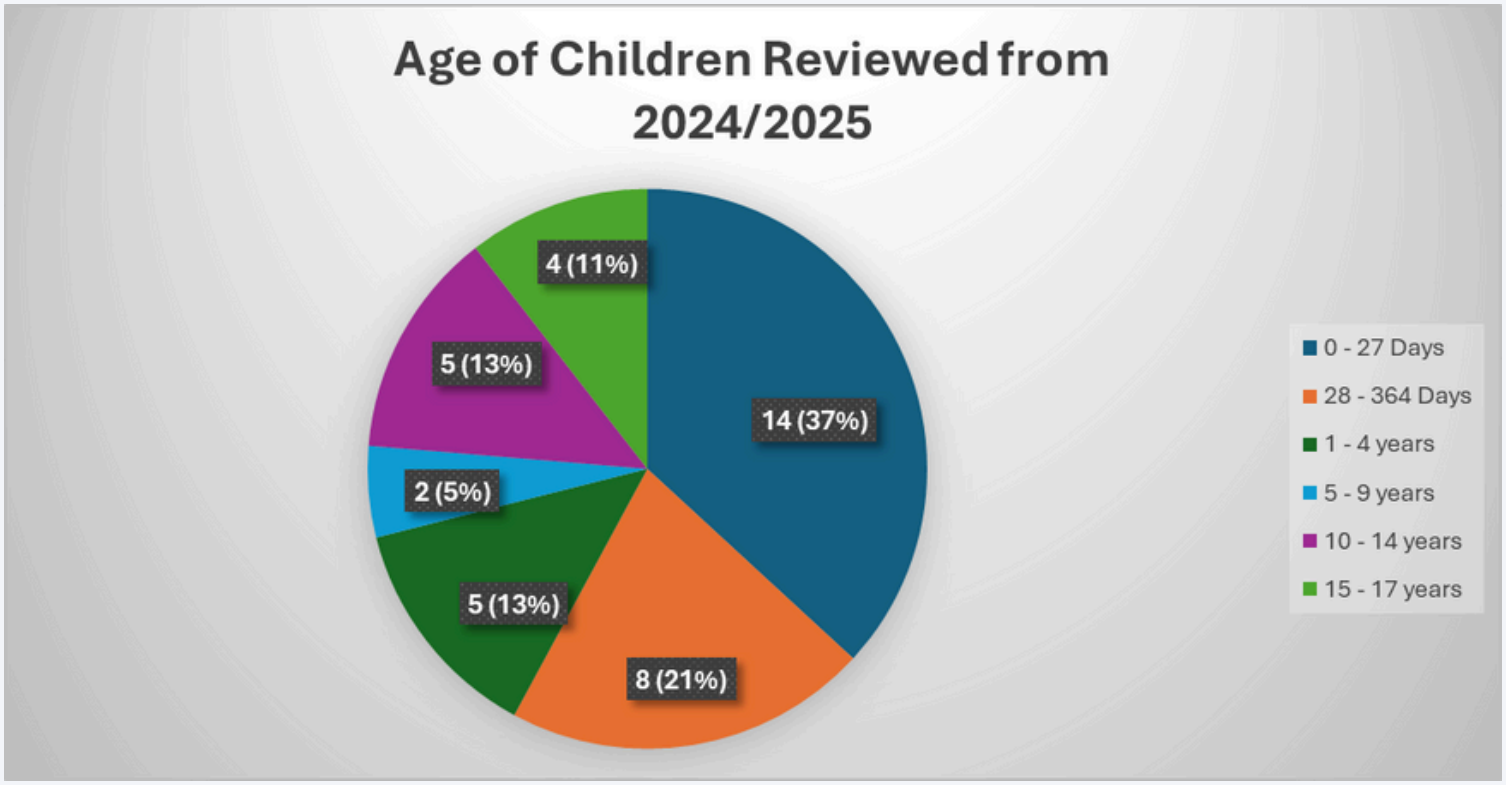
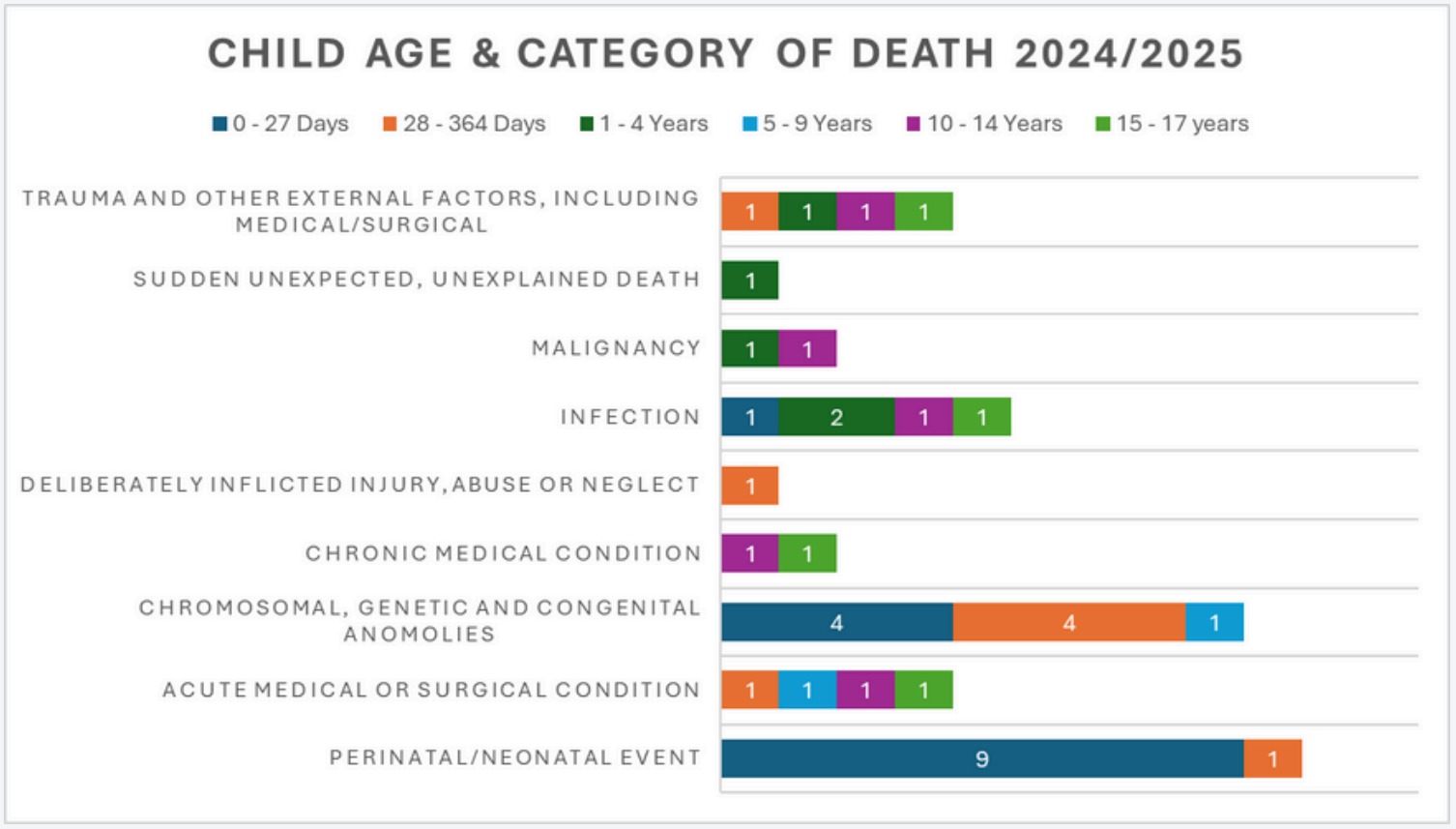


Table 4



A child is most at risk of death within the first year of life, and particularly within the first 27 days as the data above for the Pan-CDOP areas shows.

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.

58% of the children who were reviewed by the Pan-CDOP in 2024/25 died within the first year of their life. The lowest age group of children who have died are 5 – 9 years, which is a change from 2023/24 when children aged 1 – 4 years was the lowest category.

Of all the children who have died, 37 % died within 27 days of birth and the main category of death for this age group is chromosomal, genetic and congenital anomalies, a perinatal/neonatal event.

These findings are consistent with previous years, with the only variation being with the lowest age category of children who have died, please see the table below:

Table 5

Reporting Year	% of children reviewed who were aged under 1year	% of children reviewed who died within the first 27 days of life	Primary category of deaths for children who died in the first 27 days of life	Lowest age category that year
2020/2021	63%	35%	Chromosomal, genetic and congenital anomalies, a perinatal/neonatal event of SUDIC	15 – 17 years
2021/2022	57%	27%	Chromosomal, genetic and congenital anomalies, a perinatal/neonatal event of SUDIC	5 – 9 years
2022/2023	55%	37%	Chromosomal, genetic and congenital anomalies, a perinatal/neonatal event of SUDIC	15 – 17 years
2023/2024	64%	38%	Chromosomal, genetic and congenital anomalies, a perinatal/neonatal event	1 – 4 years

- **Ethnicity of children**

Table 6

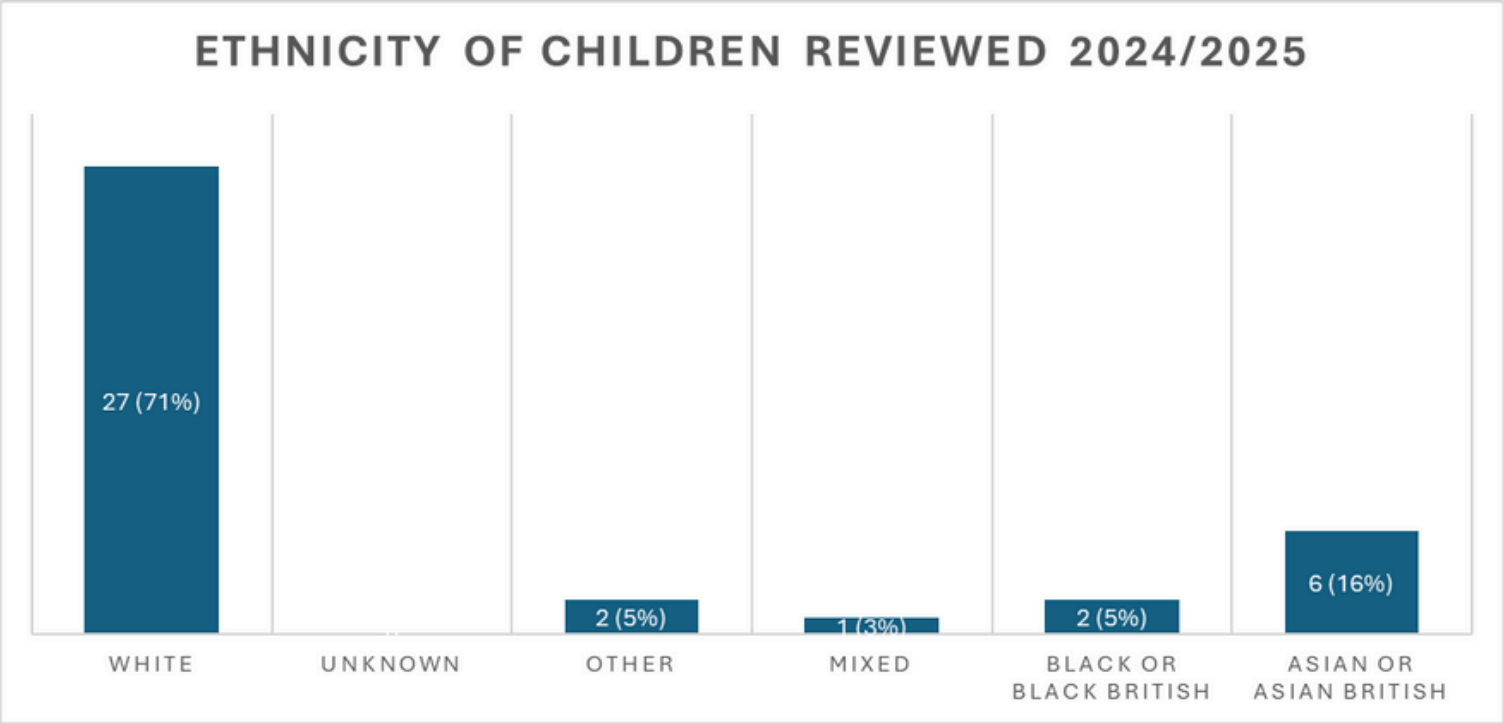


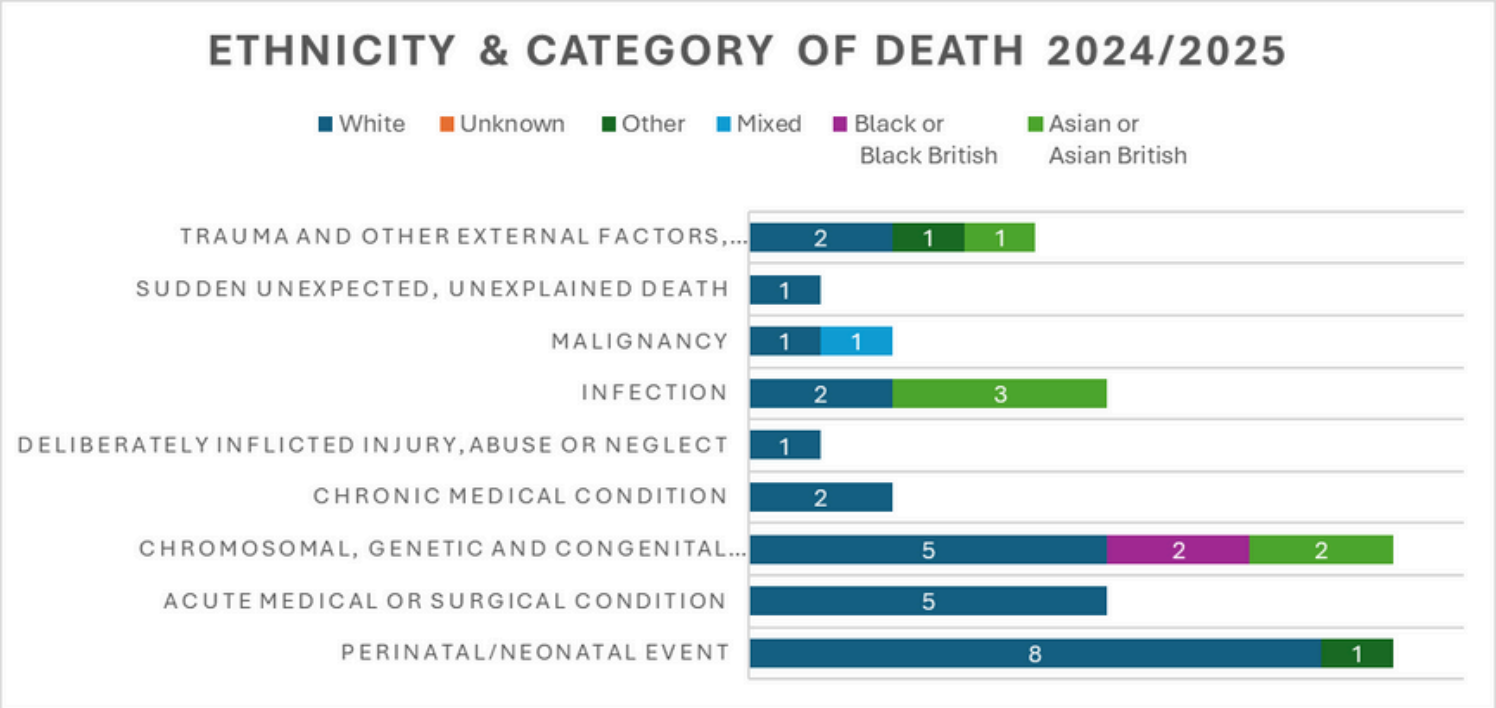
Table 7

Reporting Year	% of children reviewed who were classified as White ethnicity	Primary category of deaths for all children who were reviewed
2020/2021	40%	Chromosomal, genetic and congenital anomalies
2021/2022	36%	Chromosomal, genetic and congenital anomalies
2022/2023	36%	Chromosomal, genetic and congenital anomalies
2023/2024	57%	Chromosomal, genetic and congenital anomalies, a perinatal/neonatal event

Across the Pan-CDOP when looking at the ethnicity of the child deaths along with category of deaths, the largest categories of death was perinatal/neonatal event and chromosomal, genetic and congenital anomalies. Of the children that were reviewed during the 2024/25 reporting year 27 (71%) were classified as White with the remainder either classified as Other 2 (5%), Mixed 1 (3%), Black or Black British 2 (5%) or Asian or Asian British 6(16%) ethnicity.

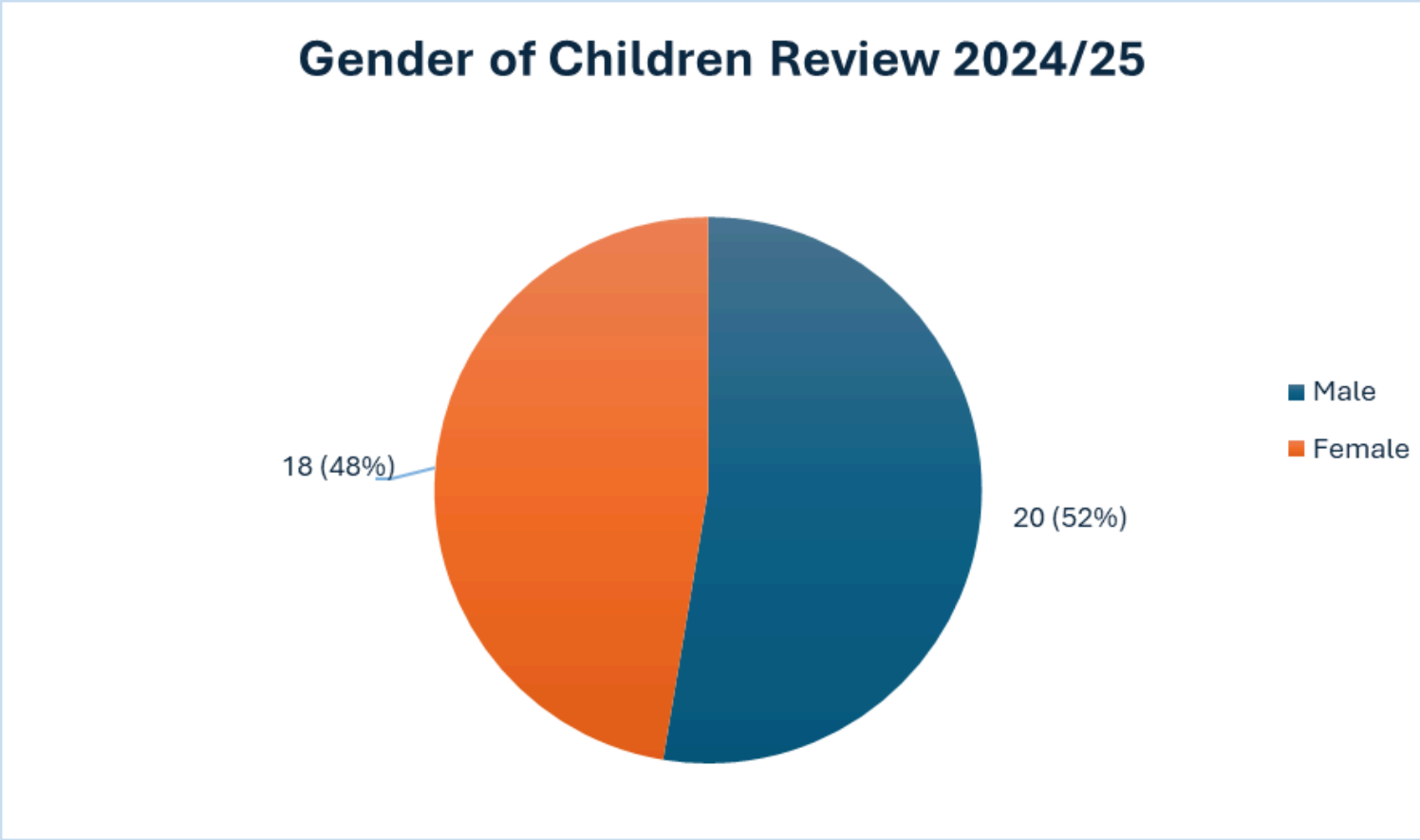
These findings are slightly different to what has been evident in previous years when the percentage of children who were reviewed were not predominately of White ethnicity, except in the 2023/24 reporting year. However, the primary category of death across all ethnicities remains largely unchanged. Please see the table below:

Table 8



- **Gender of children**

Table 9



The gender split between the children who have been reviewed in 2024/25 is an almost equal split at 52% males and 48% females. The table below shows the gender split between the children who have died from 2020/21. Whilst there has been two reporting years where there had been predominately more males than female children that have died, the gender split tends to be fairly even.

Table 10

Reporting Year	% of children reviewed who were male	% of children reviewed who were female
2020/2021	63%	37%
2021/2022	53%	47%
2022/2023	62%	38%
2023/2024	53%	47%
2024/2025	52%	48%

- **Indices of Multiple Deprivation (IMD)**

By linking each child's address to the **UK government's ten deciles of deprivation** (calculated using seven indicators of income, employment, education, health, crime, access to housing and services, and living environment), it is possible to determine whether child mortality increases as deprivation increased.

In 2024 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 (NCMD Child Death Review Date Release: Year ending 31 March 2024).

The table below shows the combined number of deaths for each deprivation indices in Calderdale, Kirklees and Wakefield from 1st April 2020 to 31st March 2022. It shows that for the Pan-CDOP child mortality rates are significantly higher consistently in the more deprived areas, which reflects the national picture in 2024.

The data clearly shows a consistent and significant inequality in child mortality across Calderdale, Kirklees and Wakefield between the least and the most deprived communities. This reinforces the need for targeted, place-based interventions and a continued focus on addressing the wider determinants of health, particularly in communities experiencing the highest levels of deprivation.

Table 11

Indices of Multiple Deprivation (IMD)	2020/ 2021	2021/ 2022	2022/ 2023	2023/ 2024	2024/ 2025	Total
IMD 1 Most deprived 10%	12	18	15	15	14	**74**
IMD 2 10% to 20%	11	27	31	22	18	**109**
IMD 3 20% to 30%	8	12	13	6	11	**50**
IMD 4 30% to 40%	3	8	14	7	9	**41**
IMD 5 40% to 50%	7	3	5	8	5	**28**
IMD 6 50% to 60%	2	2	2	5	1	**12**
IMD 7 60% to 70%	3	1	0	6	5	**15**
IMD 8 70% to 80%	6	5	4	3	5	**23**
IMD 9 80% to 90%	2	0	1	1	4	**8**
IMD 10 10% Least deprived	1	0	1	1	0	**3**
Total number of child deaths	**55**	**76**	**86**	**74**	**72**	**363**

5) INDIVIDUAL AREA DATA ANALYSIS

- **Calderdale Data:**

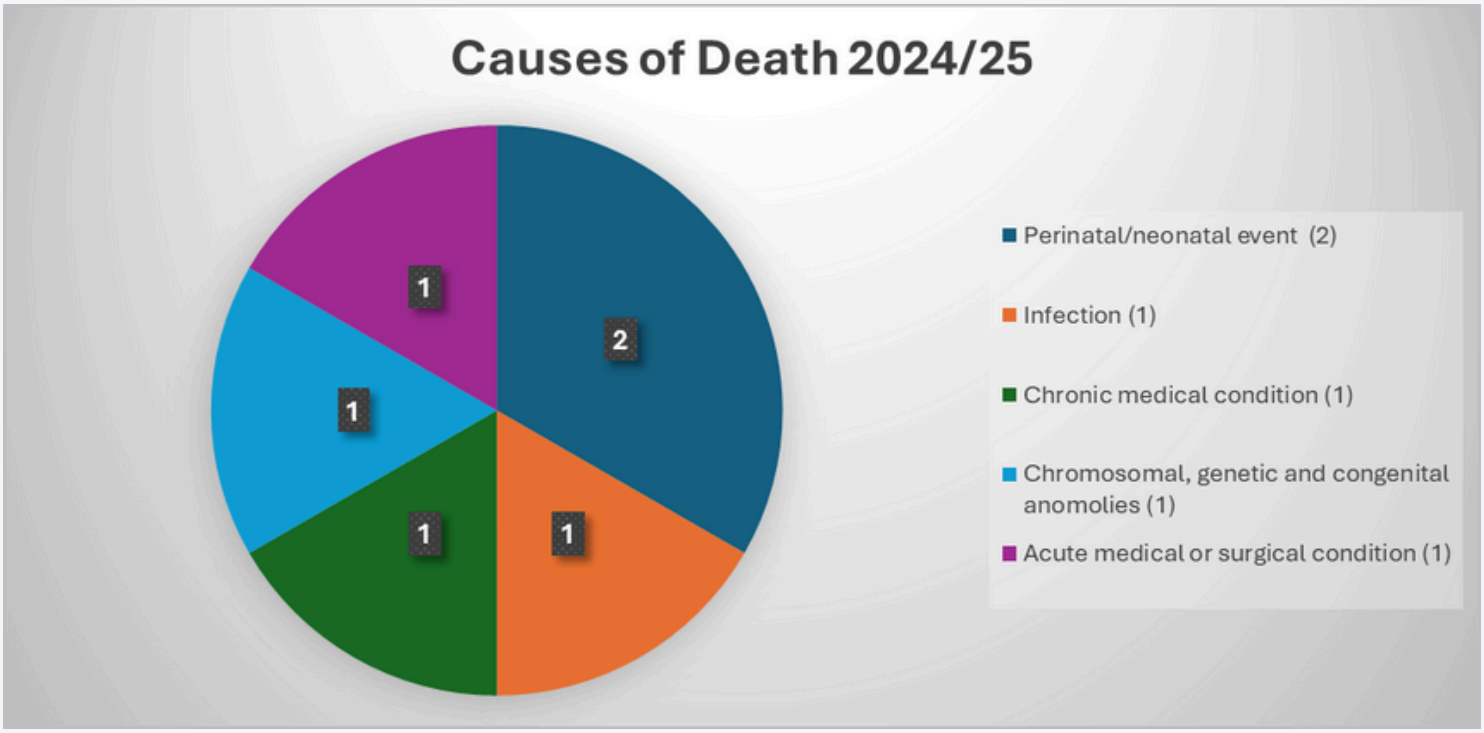
During 2024/2025 there have been 11 deaths reported, which is slightly higher than 2023/24. During the year, 6 child deaths have been reviewed and completed, with a further 16 cases to be reviewed.

- Cases completed with cause of death:

Of the cases reviewed 3 (50%) had modifiable factors, and these have been identified as:

- Parental smoking (3)

Table 12



- **Kirklees Data:**

During 2024/2025 there have been 39 deaths reported, which is slightly higher than 2023/24. During the year, 18 child deaths have been reviewed and completed, with a further 76 cases to be reviewed.

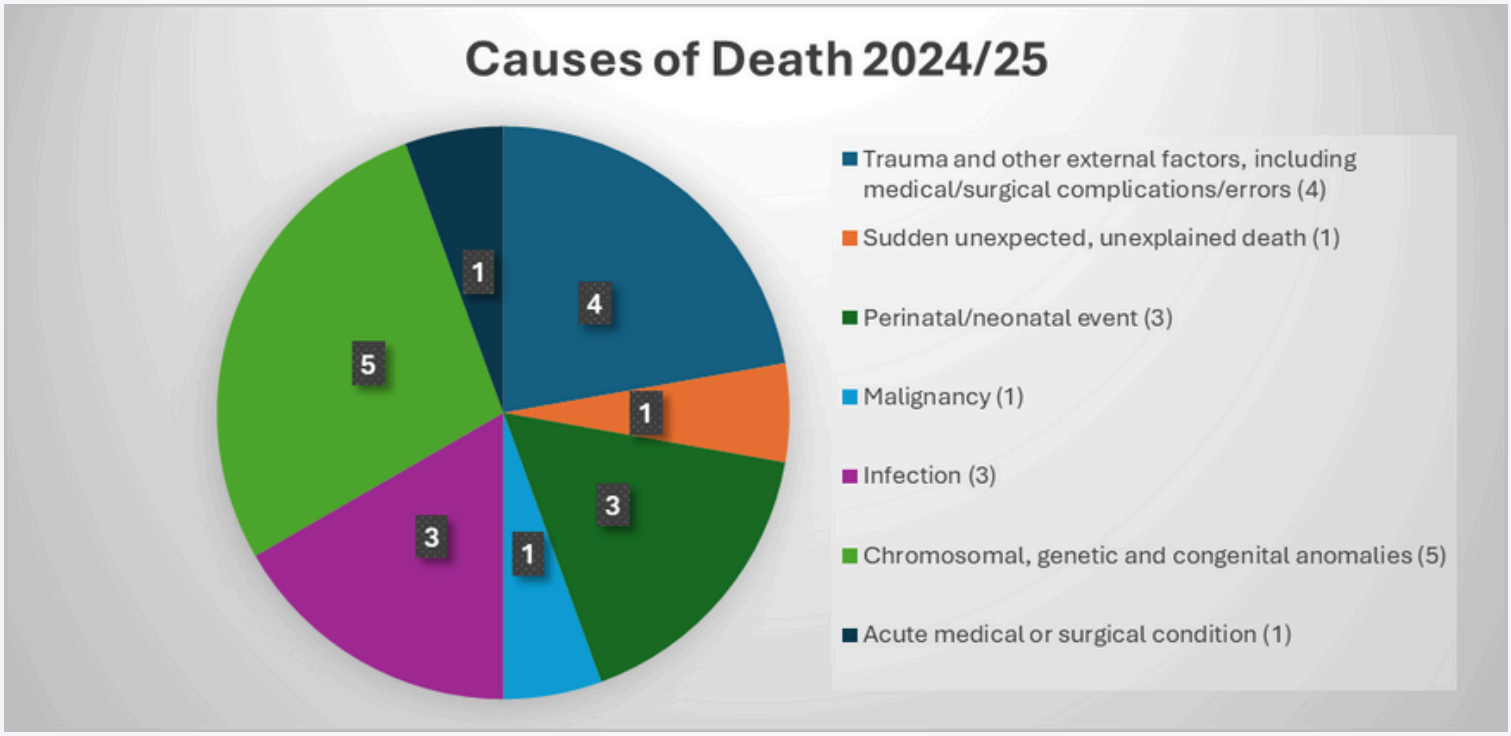
- Completed cases with cause of death

Of the cases reviewed 6 (33%) had modifiable factors, and these have been identified as:

- Smoking in household (2)
- Smoking in pregnancy (2)
- Child not wearing protective equipment (helmet) (1)
- Alcohol abuse (1)
- Delays in treatment (1)

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

Table 13



- **Wakefield Data:**

During the 2024/2025 there have been 22 deaths reported. During the year 14 cases have been reviewed and completed, with a further 53 cases to be reviewed.

- Completed cases with cause of death

Of the cases reviewed 7 (50%) had modifiable factors, and these have been identified as:

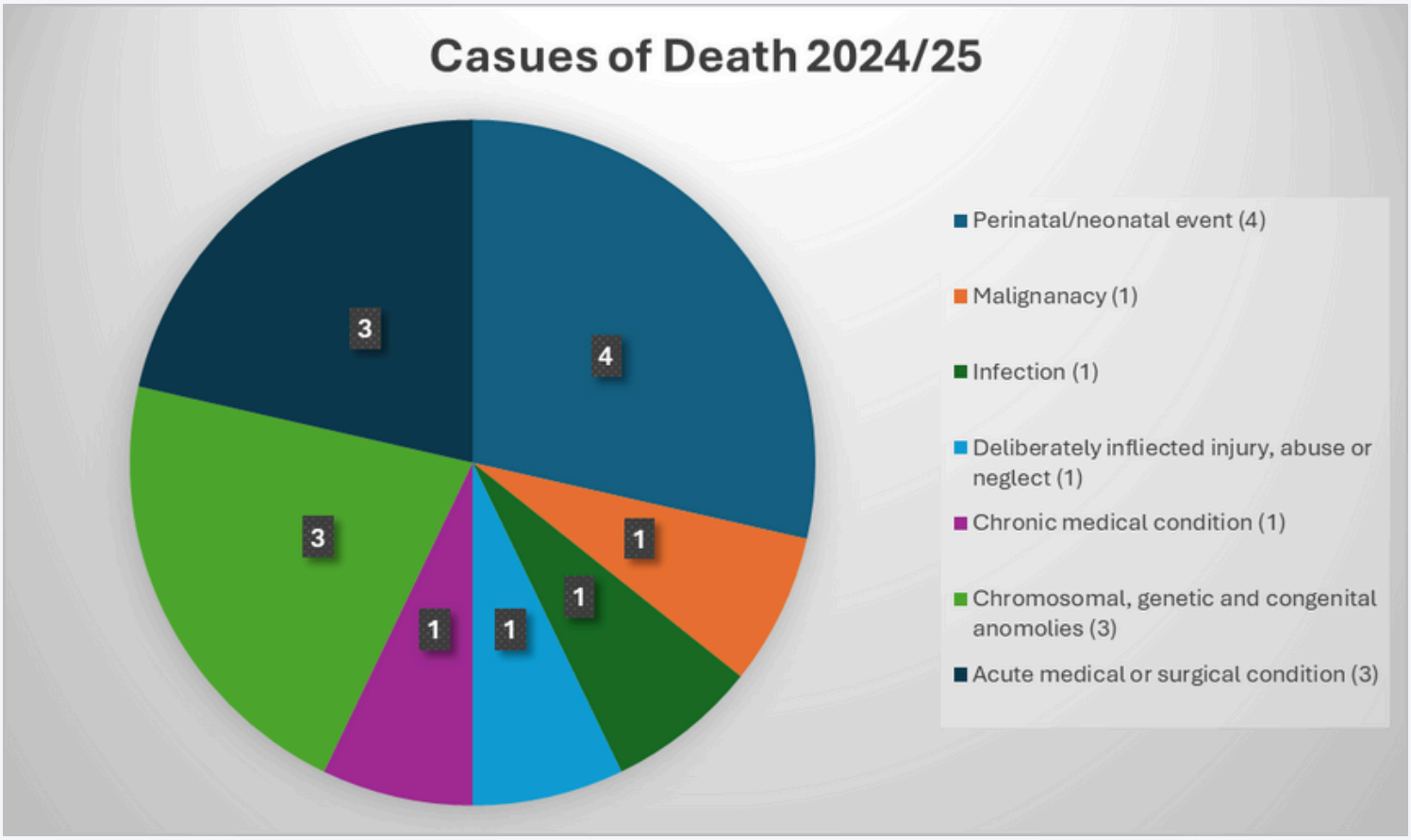
Factors identified which may have contributed to ill-health or a death

- Intravenous antibiotics not commenced when first advised (1)
- Non accidental head injury (1)
- Unidentified non recent injury (1)
- Failure to attend antenatal appointments (1)

Factors identified but have not contributed to a death

- Parental smoking (4)
- Parental drinking (1)
- Non recent domestic abuse (5)
- Non recent substance abuse (4)
- Non recent alcohol use (1)
- Housing needs (1)
- Vaping (1)
- Obesity (1)

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



6) CONCLUSIONS FROM THE DATA ANALYSIS

The total number of child death's reviewed by the Pan-CDOP during 2024/25 was 38. This is a reduction from previous years of 84 in 2023/24 and 65 in 2022/23. Typically, 4 CDOP meetings are held between Kirklees/Wakefield and Calderdale/Kirklees every financial year (one per quarter). However, during 2024/25 from a Wakefield/Kirklees perspective there was only 3 meetings held in the reporting year compared to 5 in 2023/24. This was due to the availability of key CDOP representatives, resulting in meeting that would have normally been held in 2024/25 falling just outside the reporting period. In Kirklees/Calderdale one meeting also had to be cancelled due to unforeseen circumstances. Therefore, the number of cases reviewed by the Pan-CDOP is lower than previous years due to having slightly less Panel meetings in the reporting period. There are no concerns for any area of adherence to statutory functions, some delays in respect of CDOP processes experienced in previous years have been addressed, and it will always be the case that some child deaths will be possible to review quicker than others due to other investigations that are taking place.

Of the children who have died 57% did so before reaching the age of 1, 37% were aged 0-27 days and 21% were aged 28-364 days. This is a consistent finding to the 2023/24 reporting year when 37% of the children who had died were aged 0 – 27 days and 28% were aged 28-364 days. The main category of death for this age group is chromosomal, genetic and congenital anomalies, a perinatal/neonatal event, which is a consistent finding going back to the 2020/21 reporting year, see Table 5).

Of the 38 deaths reviewed 20 (52%) were male and 18 (48%) were females. This is a consistent finding with 2023/24 when there were also more males than females and is a trend that has been evidenced since the 2020/2021 reporting year, see Table 9.

Inequalities and the links to child deaths will continue to be a focus across Kirklees, Calderdale and Wakefield. 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 2024/25 remained the 2 same categories as 2023/24 but saw some percentile variances. Chromosomal, genetic and congenital anomalies rose by 3% (24% in 2024/25 v 21% in 2023/24) and perinatal/neonatal events increased very slightly by 1% (24% in 2024/25 v 23% in 2023/24). With the exception of the 2020/21 reporting year, where sudden unexpected or unexplained deaths was the second highest category, the main categories of death have remained consistent at Chromosomal, genetic and congenital anomalies and perinatal/neonatal events (see Table 5).

According to the latest published national data, perinatal/neonatal events was the most common primary category of death used by CDOP nationally for reviews in 2023-24, which was recorded for 31% of all child death reviews, followed by Chromosomal, genetic and congenital anomalies (24%), Sudden unexpected and unexplained death (8%), Acute medical or surgical condition (8%) and Malignancy (8%) (Figure 16). These patterns were similar to previous years. **Child death data release 2024 | National Child Mortality Database**

There has been a slight increase in the percentage of deaths in 2024/25 in comparison to 2023/24 where modifiable factors were present (41% v 38%). The predominant modifiable factor identified in all three areas was parental smoking. This a change from previous years where consanguinity always featured in the primary modifiable factors recorded. This change could be attributed to the publication of the NCMD guidance on Consanguinity which has been in use in Calderdale, Kirklees and Wakefield from April 2023 and means the decisions on whether consanguinity is modifiable is in line with national standards.

Calderdale have reviewed 6 cases in 2024/25 compared to 16 in 2023/24. Kirklees reviewed 18 cases in 2024/25 compared to 46 in 2023/24 and Wakefield reviewed 14 cases in 2024/25 in comparison to 25 cases in 2023/24.

7) REFLECTING BACK ON OUR IDENTIFIED PRIORITIES - WHAT WE HAVE ACHIEVED

The following priory areas were agreed for the Pan CDOP to progress in 2024-26

- 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

- **What have we achieved**

Priority 1	What we have achieved across the Pan CDOP Areas
To continue work around safer sleep, providing further guidance and involvement in research	**Every Sleep a Safer Sleep Training:** · Throughout 2024, ESaSS training sessions were delivered across Calderdale, Kirklees, Wakefield Leeds and Harrogate. The ESaSS training has improved professionals' knowledge of both normal infant sleep and what constitutes a safe sleep environment in the home, and in EYFS settings across our localities. It has increased professional confidence to identify and discuss risks to ensure families receive individualised safer sleep information. Discussions are taking place to support parents with safe bedsharing in the absence of risk. Emphasis is placed on never falling asleep on a sofa with a baby, and safety planning for out of routine situations such as being made homeless, alcohol use and drug taking. · The ESaSS training is delivered to each cohort of the BSc Midwifery students at Huddersfield University. As the uptake of the training for midwives in CHFT has been a challenge, it is hoped that by delivering the training to midwifery students they will be able to bridge this gap somewhat. · Funding has been secured from the ICB to re-record the ESaSS webinar, and it is housed on the West Yorkshire Health & Care Partnership (WYHCP) website. The webinar is now up to date with new evidence and reports and professionals have been invited to renew their knowledge by watching the training video. · A representative from Calderdale attended the Association of the Directors of Public Health Yorkshire and the Humber Sector-led Improvement Conference in November 2024. The representative delivered a breakout session to delegates showcasing the ESaSS programme of work around SUDI prevention, and they shared best practice across Yorkshire and the Humber about how to develop a multi-agency training programme.
	The West Yorkshire Safer Sleep Procedural Guidance · The West Yorkshire Safer Sleep Procedural Guidance document has been published **1.4.35 West Yorkshire Safer Sleep Protocol Guidance: for professionals working with families where there is a child aged up to 12 months**. This procedural guidance is now available across West Yorkshire for all professionals working with families where there is a child aged up to 12 months to reduce deaths from SUDI.

Priority 1	What we have achieved across the Pan CDOP Areas
To continue work around safer sleep, providing further guidance and involvement in research	**<u>Care of Next Infant (CONI) guidelines:</u>** · CONI guidelines for Calderdale and Kirklees Health Visiting teams have been reviewed and updated to meet the guidelines set by The Lullaby Trust and are awaiting ratification by the Quality Team in Locala. **<u>Safer Sleep Campaign:</u>** · During Safeguarding Week 2024 colleagues in Calderdale ran a Safer Sleep campaign utilising materials from Birmingham's 'Who's in Charge' campaign and The Lullaby Trust how baby's sleep. · During Safeguarding Week 2024 Locala and partners (including a Community Champion from Fresh Futures) delivered a communications campaign in the Kirklees and Calderdale communities to promote safer sleep practices for babies and young children. A clinical van was set up with equipment and a cot showcasing what a safe sleeping space should look. The team talked to families, parents and carers about safer sleep, and shared resources from Lullaby Trust, Who's in Charge, UNICEF and Baby Sleep Info Source (BASIS). For more information visit **https://bit.ly/3EK8F75**. The campaign has also been shared on several social media sites. · In Kirklees and the surrounding areas Fresh Futures have increased their preventative work around Safer Sleep as part of their Safety in the Home visits. Partnering with Kid Rapt child safety company, Fresh Futures fitting staff have been distributing bedroom thermometers to vulnerable families to increase awareness of the home environment impact on infant safety

Next steps for this priority area in 2025/26

- Further ESaSS training sessions will be delivered throughout 2025. Colleagues in Calderdale plan to do a parent/carer version of the ESaSS training to be delivered through antenatal classes online.
- Public Health colleagues in Calderdale have developed a bespoke Early Years Training Package and are due to deliver this on the 30th April 2025. Following this Wakefield Public Health Children's Team are funding the 2-hour Early Years ESaSS package to be filmed so all Early Years settings/Nurseries/Childminders can have access to the training package and will be included in any Induction Packs.

- Fresh Futures will have additional resources to distribute travel cots to those in need, thus reducing the risk to infants in temporary sleep settings.
- There will be further campaign activity across the Pan-CDOP areas to promote Safer Sleep via different formats such as posters/external materials, via safeguarding children partnership websites and social media campaigns.
- Calderdale have secured funding for all Locala nursery nurses to undertake the BASIS 'Normal Infant Sleep' course at Durham University; this will be achieved by December 2025 and is in addition to the 'Sleep, Baby and You' intervention course.
- Following discussions with Wakefield Trinity and Castleford Tigers rugby teams, there are plans being made in Wakefield to display the 'Lift the Baby' (safer sleep video) at half time on match days on the pitch screens, to promote safer sleep messaging to a wider public audience, including males.

Priority 2	What we have achieved across the Pan CDOP Areas
To continue working with women who have been identified as being at risk of maternal obesity	**<u>Diabetes Workstream:</u>** · A gestational diabetes information sheet has been developed, which is available in multiple languages. · There has been collaboration with primary care teams to promote a pre-conception pathway for women with existing diabetes planning a pregnancy, providing access to the preconception team at CHFT for tailored support. · Colleagues in Kirklees and Calderdale have partnered with Reed Wellbeing to engage women during the antenatal period for the National Diabetes Prevention Programme (NDPP), ensuring referrals are in place before birth. A Reed Wellbeing coach attends CHFT antenatal diabetes clinics monthly to promote the NDPP to expectant mothers. This has resulted in increased engagement with the NDPP during the antenatal period.

Priority 2	What we have achieved across the Pan CDOP Areas
To continue working with women who have been identified as being at risk of maternal obesity	**Maternal Obesity Workstream:** · Healthy Pregnancy Clinics have been offered to women with a BMI of 35 or over, led by a Public Health Midwife, covering care packages, lifestyle, nutrition, smoking, exercise, and vitamins. · Referrals can be made to Wakefield Council's Health & Wellbeing Service whilst planning a pregnancy if BMI is above 30 and also whilst pregnant. · There has been the development of a compassionate approach to obesity in maternity through a multi-agency Calderdale, Kirklees and Wakefield working group, with plans for rollout and implementation. See**https://www.wakefieldscp.org.uk/resource-download/a-compassionate-approach** for more information. This work is now embedded within the maternity services. · Across the Pan-CDOP areas the Healthy Start Scheme has been initiated. Calderdale, Kirklees and Wakefield midwifery, Health Visiting and Family Hubs promote the NHS Healthy Start Scheme which entitles eligible families accessing certain benefits to vitamins throughout pregnancy and early childhood as well as financial help to buy healthy food and milk. The Healthy Start Scheme is available for women from 10 weeks pregnant and to babies and children if aged under 4 years old. Calderdale has a working group that leads on maintaining the promotion of Healthy Start. The Health Visiting team and Public Health deliver bitesize training sessions to practitioners and professionals so they can promote the scheme to families and support online sign up for those eligible. · An Aspire team member from Wakefield attended a webinar by British Nutrition Foundation, discussing, and sharing information about healthy beginnings, weight matters (based on preconception/pregnant women and maternity leave). Awareness was raised of the issues to the broader staff team.
	Moving Mums Walking Group Initiative: · This walking group is an initiative developed by the CHFT maternity team and Active Calderdale and supports both antenatal and postnatal mothers. Active Calderdale supports implementation within Kirklees, working closely with established groups like Parents Sanctuary.

Next steps for this priority area in 2025/26

- Within the Calderdale and Kirklees footprints there will be a review of current maternal obesity guidance to bring it in line with the new NICE guidance 2025.
- The Compassionate Approach to Communication Toolkit will be rolled out across all maternity staff.
- Post-natal care planning for women with a BMI of 40+ will be implemented including weight loss plans and referrals to local services.
- Universal health pregnancy antenatal classes will be offered which will cover nutrition, activity and weight gain.
- There are plans to further develop and promote the Moving Mums initiative within Kirklees
- Active Calderdale is working in specific areas to promote activity and movement for all ages with family friendly activities.
- There will be an increased focus on Preconception Care to ensure women are entering pregnancy at a safe weight before becoming pregnant.
- Discussions will be undertaken with the Local Maternity and Neonatal System (LMNS) to identify preconception as a priority, targeting health care professionals to deliver consistent advice and support before pregnancy making this ‘Everyone’s Business’.
- Links to be made with the UK Preconception Network to learn good practice from elsewhere and once launched explore the Preconception Care Toolkit.

Priority 3	What we have achieved across the Pan CDOP Areas
Continue to build upon and strengthen existing child death processes	**<u>Sharing documentation ahead of CDOP meetings:</u>** · Following a successful trial in late 2024, the Pan-CDOP now have a consistent approach when sharing case documentation with CDOP members ahead of meetings. Previously papers were emailed to Panel members ahead of the meetings, however, the eCDOP system, which is cloud based and secure is now used to upload and circulate all documentation in relation to a child's death. All Panel members have access to this and can easily review all the documentation ahead of the meeting. The Analysis Form C can be completed and affirmed live time during the CDOP meeting, and updates can be immediately added to the eCDOP system as the child's death is discussed. Feedback received from the Panel about this new process has been positive. By using eCDOP for this process, the risk of sending paperwork to the wrong recipient is significantly reduced. ECDOP requires each Panel member to log in to the system using their personal username/password before they can view the documentation.
	<u>Notification of Neonatal Deaths to CDOP:</u> · There have been changes in relation to neonatal deaths and how these are notified to CDOP. This has seen the integration of the process of notifications of neonatal deaths (babies born alive who die within 28 days) to MBRRACE-UK and CDOP to make this a single activity. Now the system (Cascade) has been released a single notification is forwarded to local CDOPs and the National Child Mortality Database (NCMD). This helps prevents notifications from being missed and saves CDOP Co-ordinators time in having to chase them up.

Next steps for this priority area in 2025/26

- There will be focus on use of language during CDOP meetings, and the impact on Panel members health and wellbeing and how this might be supported moving forward. In 2024 documentation was produced and circulated to all Panel members, which outlined CDOP member roles and responsibilities. Going forward this documentation will be shared with any new members joining the CDOP, so they are aware from the outset of what to expect during the meetings.
- Assist CHFT and MYTT in strengthening the Child Death Review process particularly for expected deaths. This will help with the completion of Form B 's from consultants for expected deaths, which can still sometimes be difficult to obtain in a timely manner.

Priority 4	What we have achieved across the Pan CDOP Areas
To continue working with Yorkshire Smokefree in Calderdale, Kirklees Tabacco Control Alliance and Wakefield Stop Smoking Service to reduce smoking in pregnancy across the population	**Smoking in Pregnancy:** · MYTT and CHFT have in-house Smokefree Pregnancy Services which supports pregnant women to quit smoking within maternity services. Nicotine Replacement Therapy (NRT) and support to quit is offered from the booking appointment. The 12 weeks programme of behavioural support and NRT can be delivered either remotely or in face-to-face during clinic. · Significant others are signposted to the Wellness Service at MYTT. The Wellness Service contact details are shared in the smokefree home bags, leaflet, diary inserts for midwives and website to ensure that everyone knows how to contact wellness. Please see posters and guidance below that are shared: **CO Screening Flowchart** **Smokefree Home** · 2024 saw a reduction in smoking at time of delivery (SATOD) scores across the Pan-CDOP areas. Within maternity, reducing smoking in pregnancy is a priority, as it is one of those elements of care which can reduce the number of still births. · In line with the Long-Term Plan, NICE guidance and SBLCBv3, MYTT has a Lead Midwife for the service, every member of staff has annual training, CO screening is standard for pregnant women at each antenatal appointment, referral to the Smokefree Pregnancy Service at the first booking appointment is standard and women are supported by a team of dedicated, well trained Tobacco Dependence Advisors (TDA). The TDA team offer one to one behavioural support plus NRT, vapes as a quit aid, Swap to Stop vapes for significant others and the national incentive scheme for those who are eligible. · Pregnancy Financial Incentive Scheme has commenced, up to £400 in vouchers are available for women who quit during pregnancy. · Remote single use carbon monoxide monitors have been for use with pregnant women who live in rural areas or who otherwise may struggle to attend face to face clinics regularly. · Health visitors ask parents about their smoking status and promote Yorkshire Smokefree Calderdale.

Next steps for this priority area in 2025/26

- CHFT will continue to audit compliance with Saving Babies Lives and Action Plan in place
- Kirklees Public Health are to identify capacity to review data with both trusts (MYTT and CHFT) and explore how to increase engagement and access support in community services (the Wellness Service) where engagement in maternity services has been ineffective.
- There will be a continuation of the Swap to Stop scheme, and it will be explored whether there is the potential for extending access to free vapes to other friends/family of pregnant women to increase the likelihood of the pregnant woman successfully quitting.
- Conversations will take place with Public Health officers to explore opportunities for using Local Stop Smoking Services and Support grant funding from the Department of Health and Social Care (DHSC) to enhance the local support offer and/or encourage more pregnant women to stop smoking
- Smoking is identified as one of the biggest risk factors in pregnancy. The LMNS and the ICB are looking to see if they can do some work on preconception messaging, stopping smoking would be a key topic area of this.

8) PRIORITIES FOR 2026 ONWARDS

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

Priority 1 - 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

Priority 2 - Work to ensure that CDOP members are supported effectively in respect of emotional wellbeing and reducing the risk of vicarious trauma.

Priority 3 - Continued focus on every sleep a safer sleep, given the majority of deaths for the Pan-CDOP occur under 1 year old.

Priority 4 - Continue to build upon and strengthen existing child death processes, ensuring national guidance is applied consistently when deciding what is/isn't a modifiable factor.

Priority 5 - Strengthen approaches to reducing maternal obesity through pre-conception and early pregnancy support to help reduce complications and improve outcomes for both mothers and babies.

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