Kirklees CDOP Annual Report

2021/2022

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 2008. 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 (including deaths of infants aged less than 28 days) to determine whether the death was preventable.
- 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 Boards (LSCB) (changed to 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 2021/2022, the Panel reviewed a total of 53 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. Due to this partnership with Calderdale and Wakefield we have brought together both areas into eCDOP, thus ensuring seamless meetings in the future.

Panel Meetings

With the ongoing COVID19 pandemic, arrangements have been put into place to ensure that meetings were still able to be held, and these were arranged virtually. Within Kirklees we have held 10 panel meetings in this manner.

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 joint Chairs of the CDOP meetings are Ben Leaman, Consultant in Public Health (Calderdale), Emily Parry-Harries, Consultant in Public Health (Kirklees) and Clare Offer, Consultant in Public Health (Wakefield).

What we have achieved

1)Every Sleep a Safe Sleep: Work has been undertaken over the last year to produce a training and information package for professionals to assist in reaching families where there is a risk of unsafe sleeping. A Training package along with a risk minimisation tool has been rolled out across West Yorkshire.

2) Improvement in caseload: In Kirklees we have worked hard to reduce the backlog of cases that we held. We achieved this through rigorous information gathering to prepare cases and also by holding a Kirklees CDOP panel. We continue to be robust in gathering information to reduce the figures further.

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

4) Training: In Kirklees we have provided Practice Guidance Presentations on Safe Sleeping and ICON, briefings have been prepared on Sudden Infant Death Syndrome and ICON. These have been shared on the CDOP newsletter and are also available on the KSCP website.

5) CDR process: The CDR process has now been embedded within Calderdale and Huddersfield Foundation Trust and Mid Yorkshire Health Trust. This has ensured a timely return of analysis forms in preparation for CDOP panel meetings.

6) Modifiable factors: Kirklees Public Health has taken 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

Priorities for 2022/2023

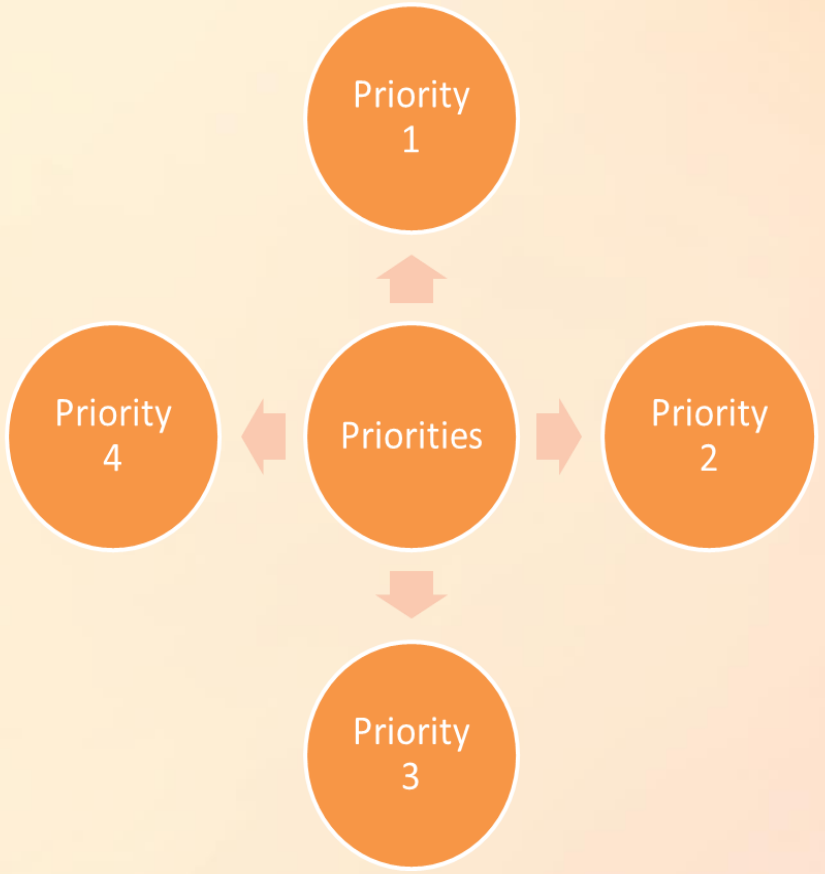
The following have been identified as priorities for the Panel for the year ahead:

Priority 1: KCW roll out of the safe sleep training for the workforce, which will be evaluated throughout the year to measure effectiveness. Launch of a public facing safe sleep campaign across KCW.

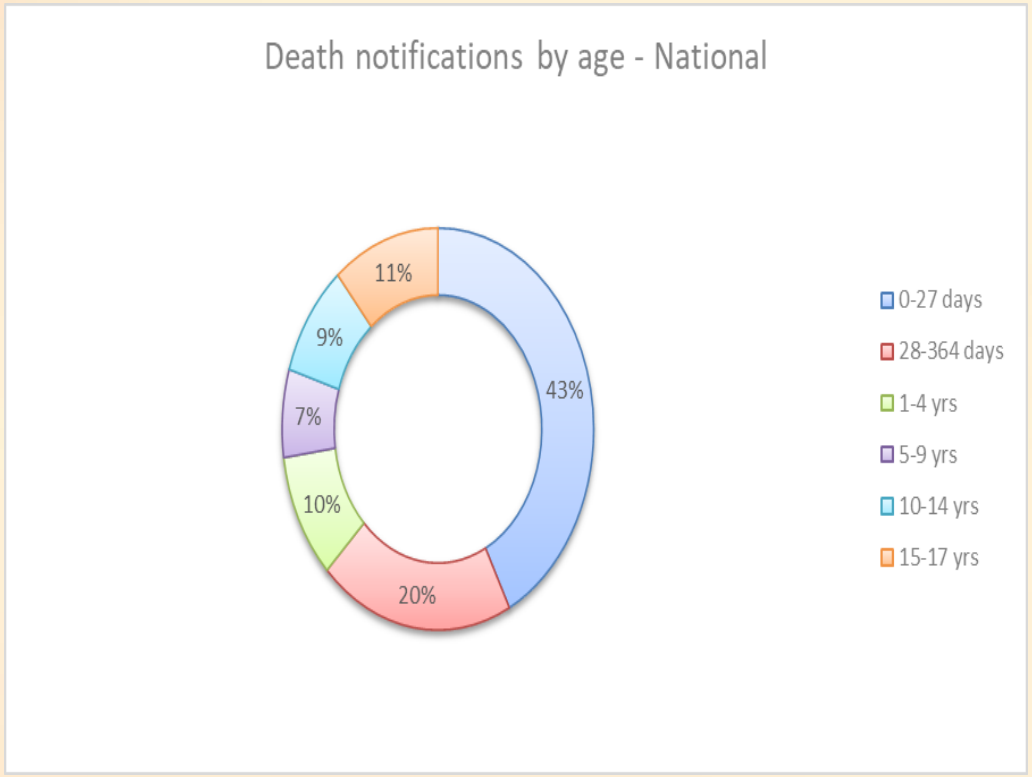
Priority 2: Continued focus on reducing population level smoking rates across KCW, with a particular focus on reducing smoking in pregnancy.

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

Priority 4: Modifiable Factors decision making across KCW to be reviewed to ensure consistency.



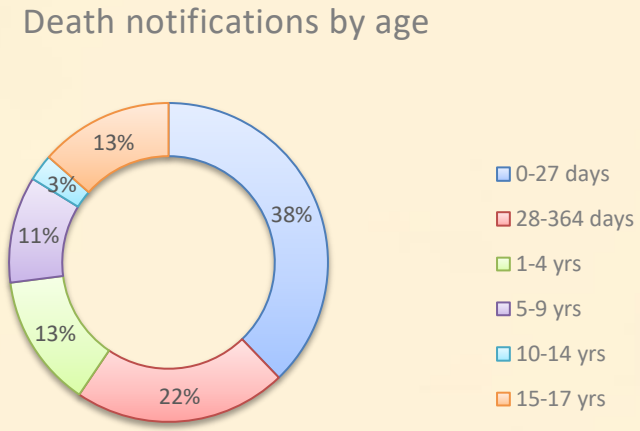
The National Picture

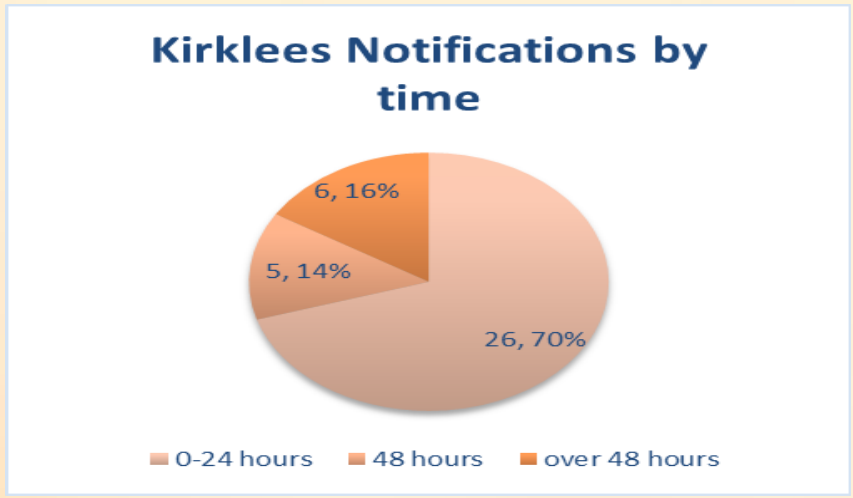


37% of cases with modifiable factors

Median number of days between death and CDOP meeting
335

The Local Picture - Kirklees Death Notifications during this year

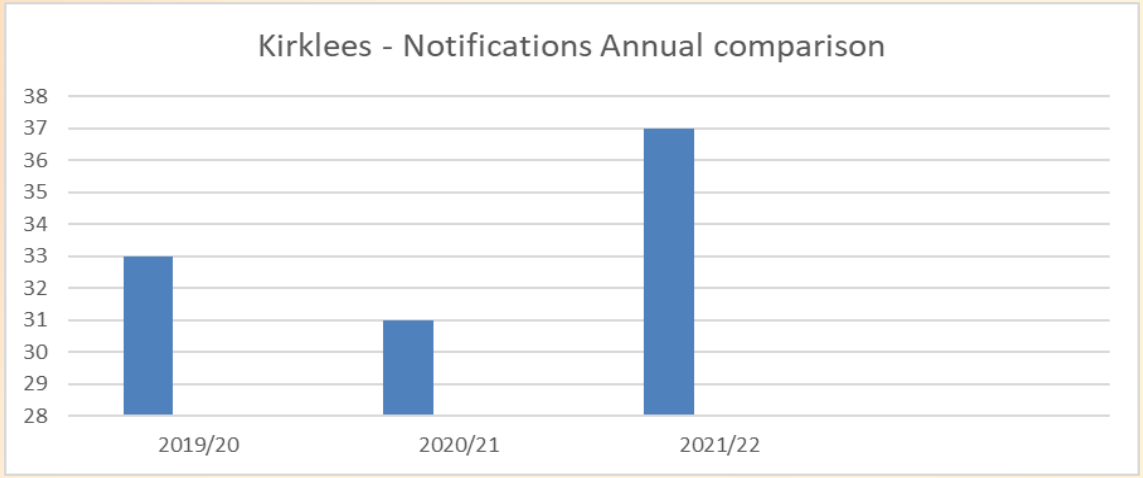


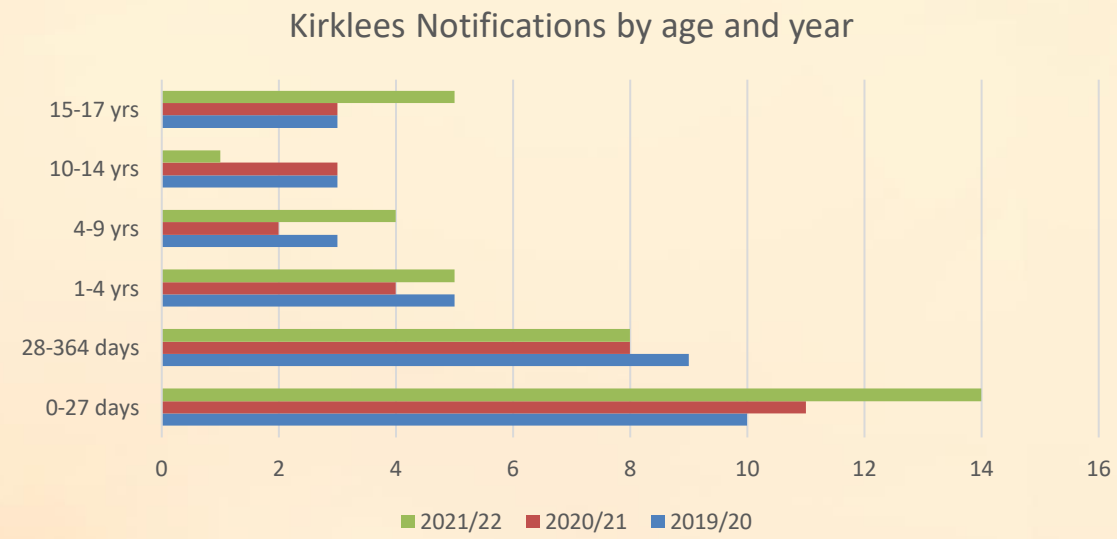


During this year there has been a total of 37 child deaths

- 15 deaths were of female children
- 22 deaths were of male children
- 12 cases held JAR meetings
- 70.2% of cases were notified within 24 hours
- 6 cases were notified over 48 hours, with 1 case being notified after 15 days.

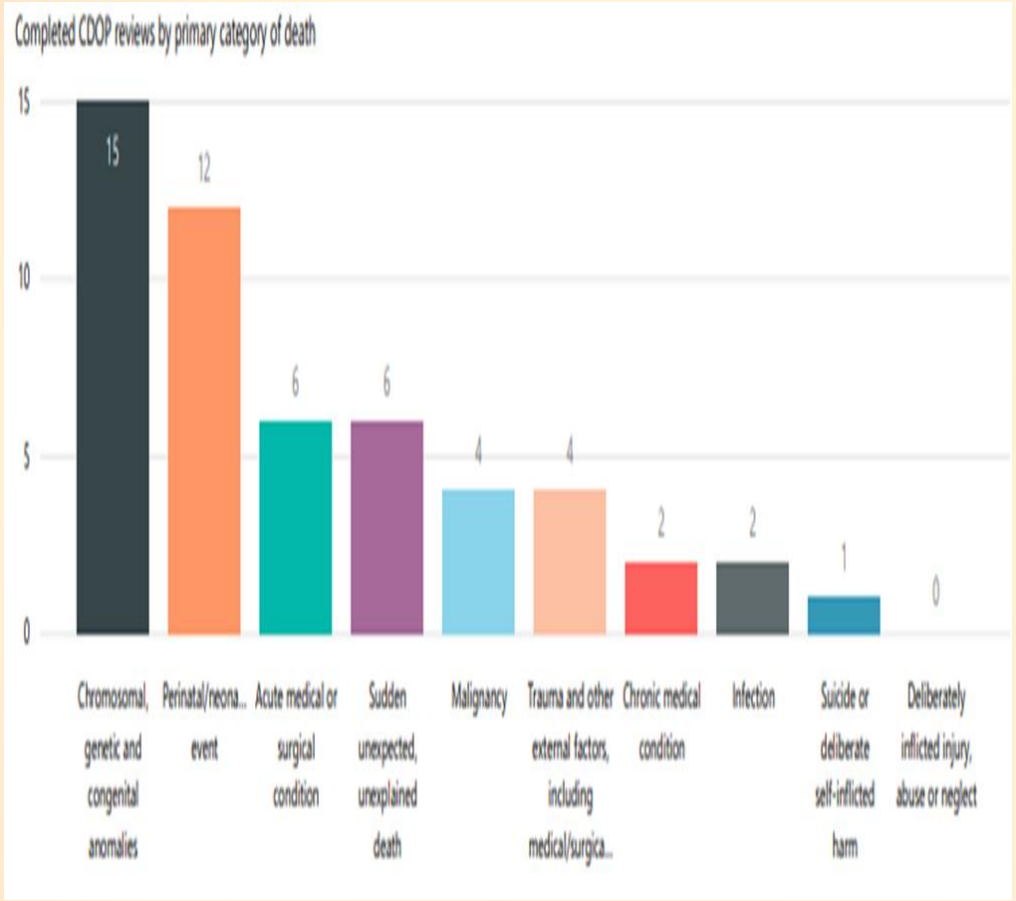
The Local Picture – Annual Comparison





- The number of deaths has remained comparatively steady over the three years
- Neo-natal and peri-natal deaths remain the highest over the three years
- January and March and July have remained the highest months when deaths occur

Kirklees completed reviews by primary category of death

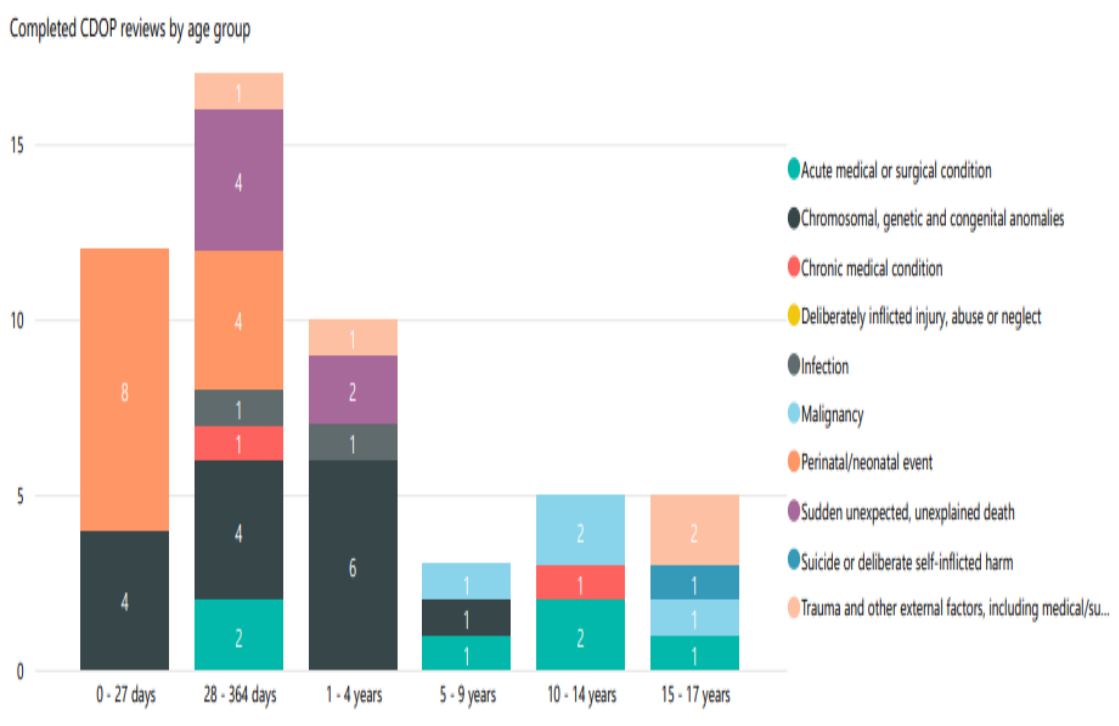


The most prevalent categorisation of death is split between perinatal/neonatal event and chromosomal, genetic, or congenital anomaly. These categories have remained at a consistent level throughout the year.

It has been noted that the high number of SUDIC categorisation was attributed to an ongoing backlog of cases, and these related deaths were from 2019 and 2020.

Kirklees – A local picture

Age Groups for cases reviewed



Modifiable Factors

% of cases where modifiable factors were identified by age group

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	12	9	75%
28 - 364 days	17	11	65%
1 - 4 years	10	5	50%
5 - 9 years	3	2	67%
10 - 14 years	5	0	0%
15 - 17 years	5	1	20%
Total	**52**	**28**	**54%**

54% of cases with modifiable factors

Top Factors Identified

Smoking
Unsafe Sleeping
Consanguinity
Maternal Obesity
Domestic Violence

% of cases where modifiable factors were identified by ethnic group

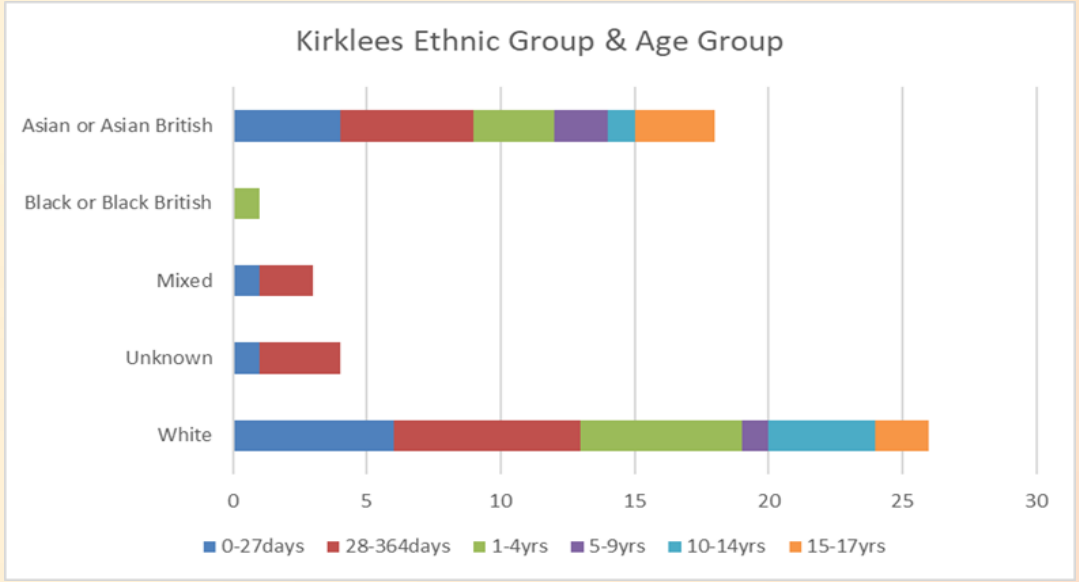
Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
White	26	15	58%
Unknown	4	2	50%
Other	0	0	0%
Mixed	3	3	100%
Black or Black British	1	0	0%
Asian or Asian British	18	8	44%
Total	**52**	**28**	**54%**

Kirklees - Completed Reviews

Ethnic group and Age group

We continue to see that the largest groups of child deaths are within 0 -27 days and 28 – 364 days. This is consistent with previous years.

The highest collective number of cases within Asian or Asian British – Pakistani is now chromosomal, genetic, or congenital anomaly, consisting of six cases.

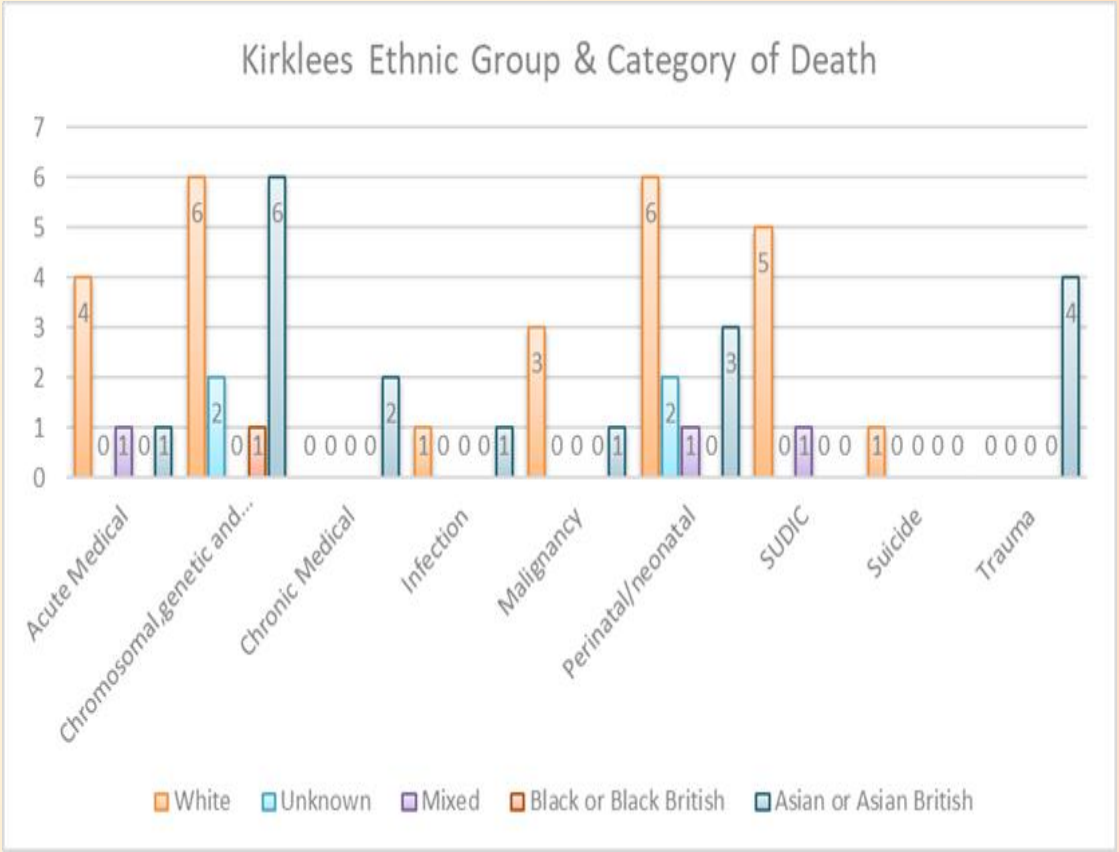


Kirklees - Completed Reviews

Ethnic group and Category of death

Half of the children who have died are from a white background with a reduction of Asian children of 17% compared to the last year.

The highest collective number of cases within White British is spread between SUDIC, chromosomal, genetic, or congenital anomaly, and perinatal/neonatal category, all consisting of five cases each. The highest collective number of cases within Asian or Asian British – Pakistani is now chromosomal, genetic, or congenital anomaly, consisting of six cases.



Kirklees - Data completeness on notifications and completed reviews

Notifications

There has been a good level of completion of fields on notifications with 100% across all fields apart from Joint Agency Response which stands at 95%.

Completed Reviews

Further work is required to improve the information in the reviews in relation to JAR`s (67%), whether cases have been subject to SPR`s(75%) and the mode of death (79%).

Median number of days between death and CDOP meeting 479

Conclusion

The majority of children who have died in Kirklees do so before the age of nine.

The most prevalent categorisation of death is split between perinatal/neonatal event (12) and chromosomal, genetic, or congenital anomaly (15).

There were 37 notifications during the 2021/2022 year

The median number of days between death and CDOP meetings has reduced from 625 last year to 479 this year, and we are continuing to improve this figure.