Kirklees CDOP Annual Report

2022/2023

Kirklees Safeguarding Children Partnership

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 2022/2023, the Panel reviewed a total of 32 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

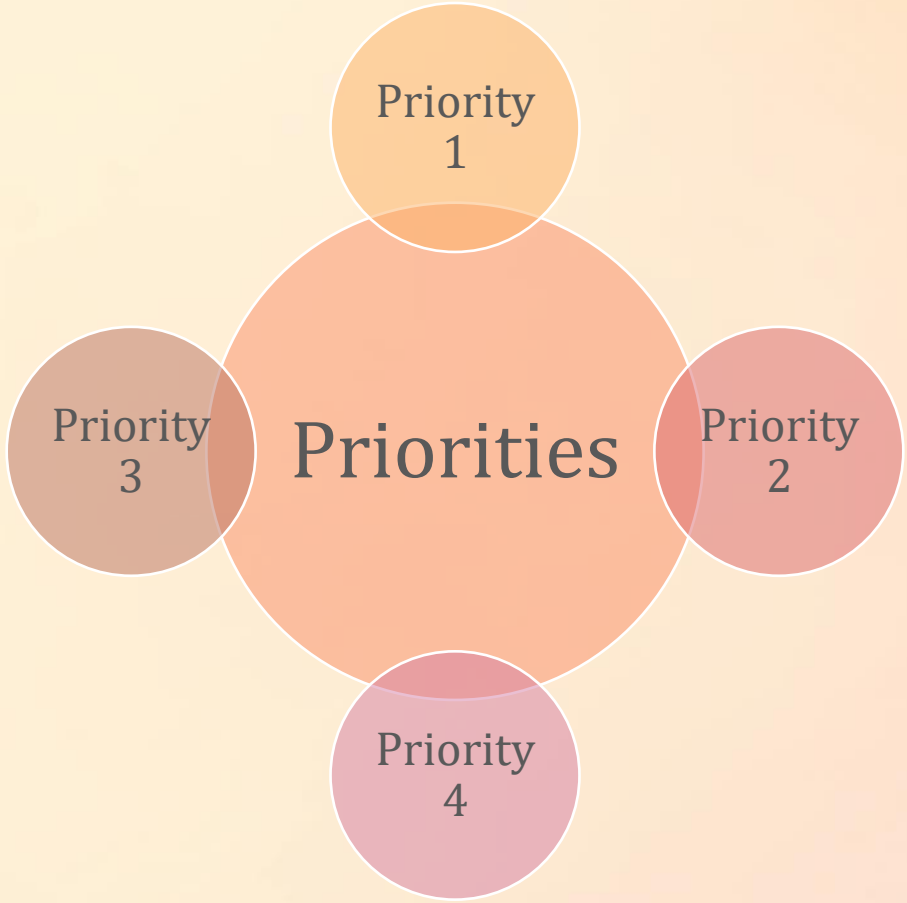
Following the COVID19 pandemic, meetings have continued to take place virtually. Within Kirklees we have held 10 panel meetings in this manner during 2022/2023.

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).

Priorities for 2023/2024

- 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 with a particular focus on reducing smoking in pregnancy
- Priority 3: Continue the roll out culturally competent genetics services for consanguineous couples, and the evaluation of the first phase of the Healthy Families element of the culturally competent genetics work (Strand 1)
- Priority 4: Continue to build upon and strengthen existing child death review processes and to continue to develop the partnership arrangements across the shared panels



What we have achieved

1) 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

2) Safe Sleep: Multi-Agency training has now been implemented. This will continue to be offered through our training providers.

3) Smoking in Pregnancy: Kirklees offers stop smoking services across the Local Authority. Auntie Pam`s offers a 1:1 service by local women who are trained as peer volunteers.

4) 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.

5) 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

6) 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.

7) Kirklees have commissioned TSL to deliver outcomes of the NHSE funding for CRM.

Close Relative Marriages

In 2022 NHS England made a commitment to roll out culturally competent genetics services for consanguineous couples in 8 high need areas - with the focus of the first phase of the work being on the Pakistani community. Kirklees was identified as one of these areas.

One element of the work is to raise genetic literacy at a community level. A Community Champion model project has been commissioned via Third Sector Leaders Kirklees, which is known locally as Healthy Families: Improving Outcomes for the Next Generation.

The project is framed around improving maternal and infant outcomes and reducing maternal inequalities, with a specific focus on preconception and early antenatal education – genetics are included as one issue to consider.

From January to March 2023 the Champions had 864 conversations about improving preconception health

210 individuals (88% female and 12% males), 80% of who had 1 child or more

654 people as part of 47 group session, 95% of which had 1 child or more

51% of the individual conversations included genetics as part of them

20 of the group conversations included genetics as part of them

From April 2023 onwards the Champions have worked to develop a regular programme of preconception, early antenatal education and ESOL workshops, and have also supported the Book Early campaign.

Safe Sleep “Every Sleep A Safe Sleep”

The Every Sleep a Safe Sleep multiagency risk minimisation guidance package continues to grow in reach and has been rolled out as a ‘Train the Trainer’ session most recently in May 2023. A further training opportunity is upcoming on 28 September 2023, building on the success of the May event. As the second part of the training is delivered virtually, it can be accessed across a wide geography, and the online resources that form the first part can be accessed freely by any interested or referred organisation or individual.

All West Yorkshire regions are now covered by a nominated strategic lead. Training leads continue to reach out to trainers to evaluate place coverage and assess and monitor training frequency. Leads can capture interest and bespoke training can be provided, beyond the regular bi-annually provided ‘train the trainer’ events, if there is sufficient demand.

There are now around 100 ESaSS trainers across the health and care sectors, frontline and emergency services, educational settings and housing and benefits organisations. Conversations are ongoing regarding embedding ESaSS training in educational and primary care networks to enhance early awareness. Some national recognition is emerging on ESaSS, linking in to the Durham Sleep project led by Prof Helen Ball, for instance. Information on the programme and training opportunity communications are distributed through the Families Together network in Kirklees, the Improving Population Health Programme updates, WYHCP bulletins, and local place-based comms networks.

There are ongoing conversations with the Local Maternity and Neonatal System regarding embedding the programme in the Integrated Care Board system rather than in 'place' as previously suggested by West Yorkshire Health and Care Partnership – this may clarify and assure the future funding and 'hosting' position. The training leads are addressing the need for evaluation/data analysis capacity (e.g. analysis of courses delivered vs. modifiable risk outcome measure (Sudden Unexplained Deaths in Infants) reduced)). Seeking a kitemark from Lullaby Trust is another mechanism by which the training leads are seeking quality assurance and to broaden uptake. The online module of the training package is due to be refreshed to further enhance the quality of the programme.”

Reducing Smoking in Pregnancy

Smoking in pregnancy continues to remain a priority within the Kirklees Tobacco Control Plan. In Kirklees, Public Health has a dedicated service, Auntie Pam's, to support women of childbearing age, which includes smoking cessation support at pre-conception, pregnancy, and perinatal stages. 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. The rates of smoking at time of delivery have been reducing year and year from 14% in 2010/11 to 10.4% in 2021/22 (Local Tobacco Control Profiles - Data - OHID (phe.org.uk))

The NHS Long Term plan sets out the commitments to help deliver the wider prevention agenda and which include an adapted model to support pregnant women and their partners, with a new in-house smokefree pregnancy pathway including focused sessions and treatments. This has been implemented at place. In Kirklees, the Smokefree pregnancy model under the NHS Long Term plan has been rolled out via Calderdale and Huddersfield NHS Trust (CHFT), from October 2022 and The Mid- Yorkshire Trust form July 2023.

Activities and interventions to reduced smoking rates among pregnant smokers.

Continue to liaise with Trust Maternity Services and its workforce to ensure women are offered all options to quit, including access to 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.

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 94%.

Further work is required to improve the information in the reviews in relation to Ethnicity (97%)and the mode of death (88%).

Median number of days between death and CDOP meeting is 289, this is a decrease from the previous year of which stood at 479 days. The average in England is 335 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 guidance documents on:

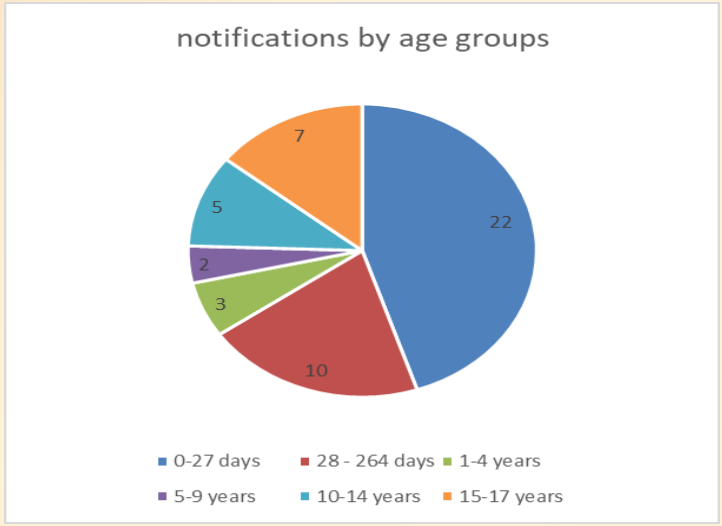
- ✓ Contributory factors and database changes - October 2022
- ✓ Guidance on recording consanguinity – January 2023
- ✓ Advice for GPs following the death of a child – August 2022

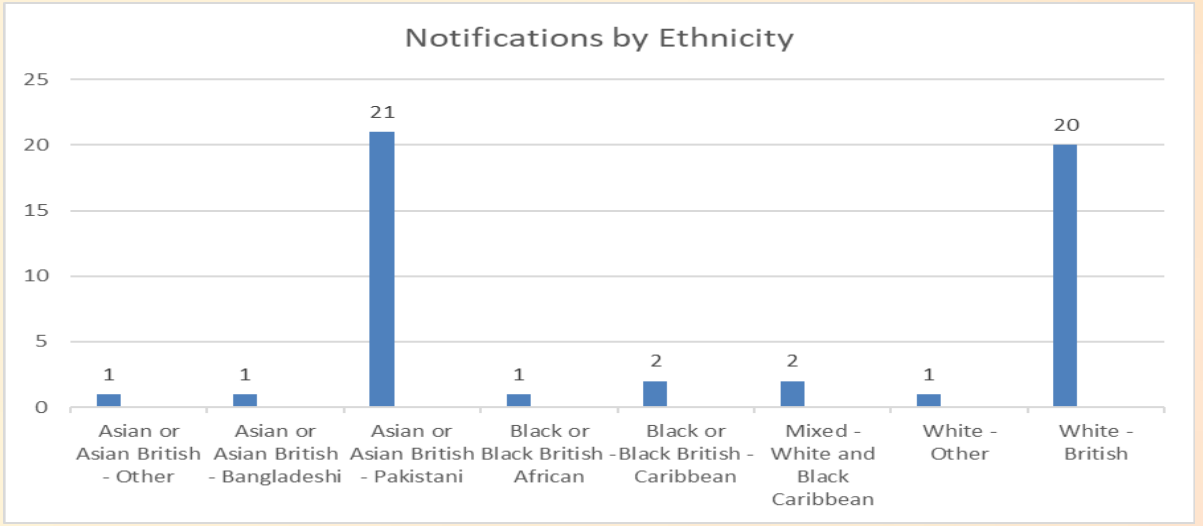
The Local Picture - Kirklees

- 49 Death notifications received during the year
- 12 Joint Agency Response meetings have taken place.
- 28 deaths were of female children
- 21 deaths were of male children
- 26 Children lived within the Calderdale and Huddersfield Foundation Trust area
- 23 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 45% of all deaths, this is comparative to National figures (41%)
- 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 66 ongoing cases

- Note: We are unable to make National comparisons as the NCMD annual data for 2022/23 is not yet available. It is difficult to make regional comparisons due to the differing demographics in the population, such as ethnicity.

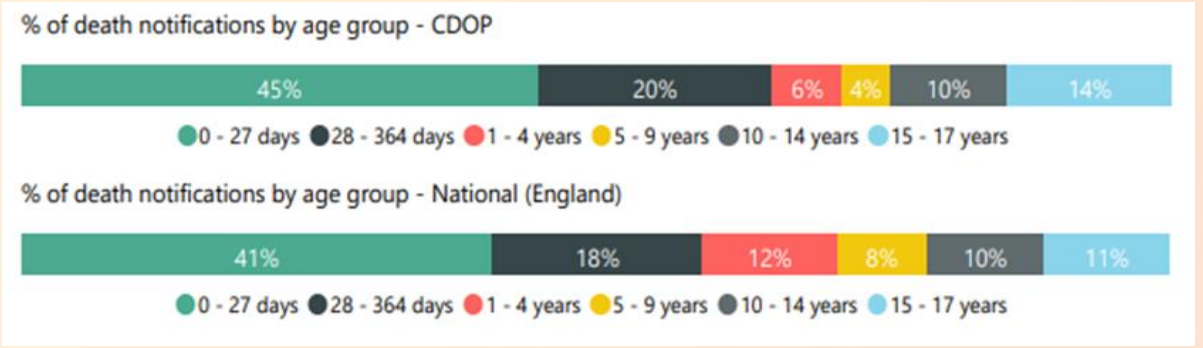
The Local Picture - Kirklees
Death Notifications during this year



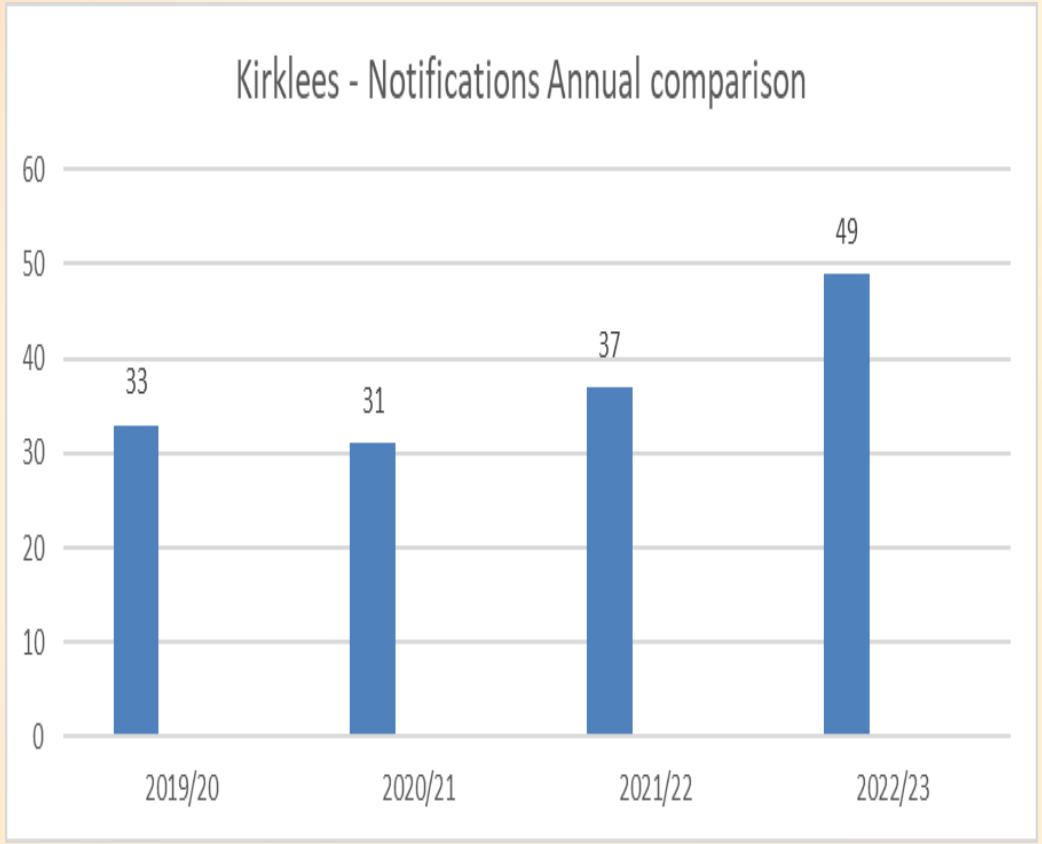


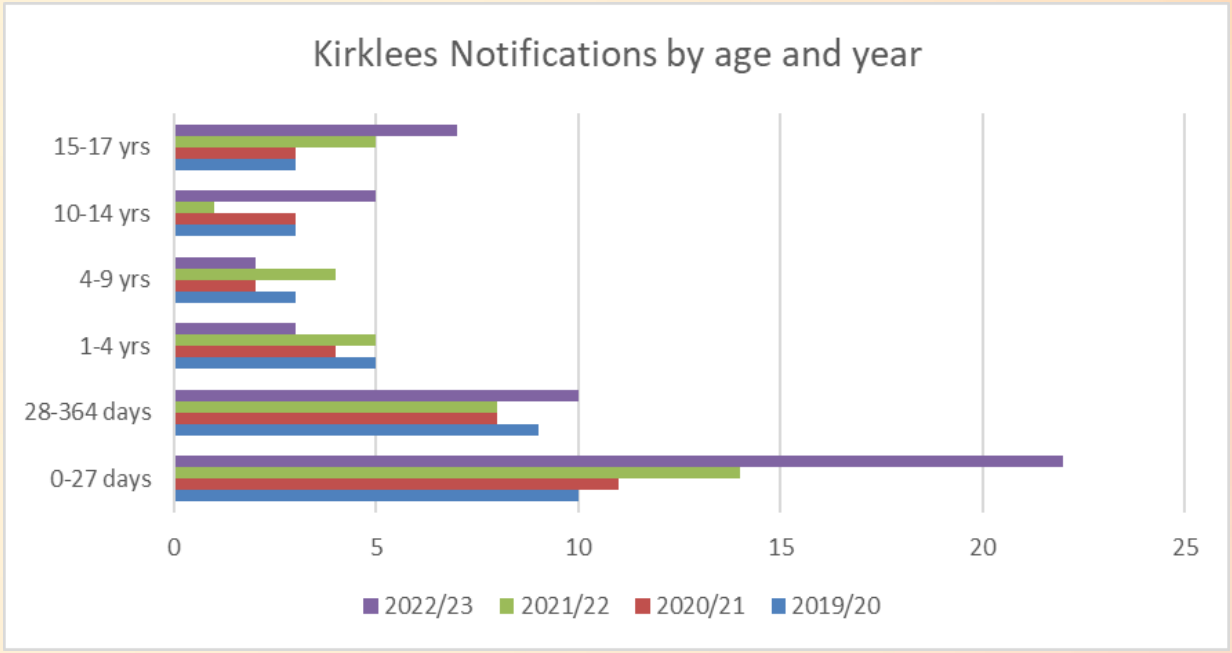
Kirklees population 433,300

23% of the population are children

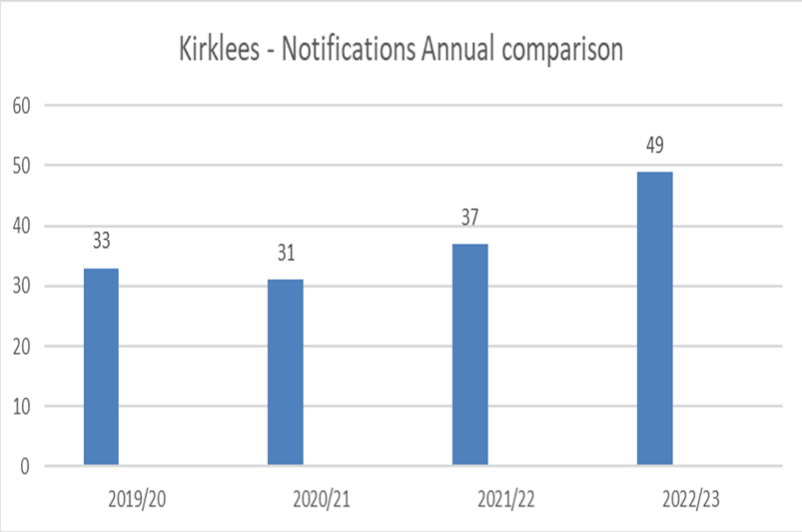


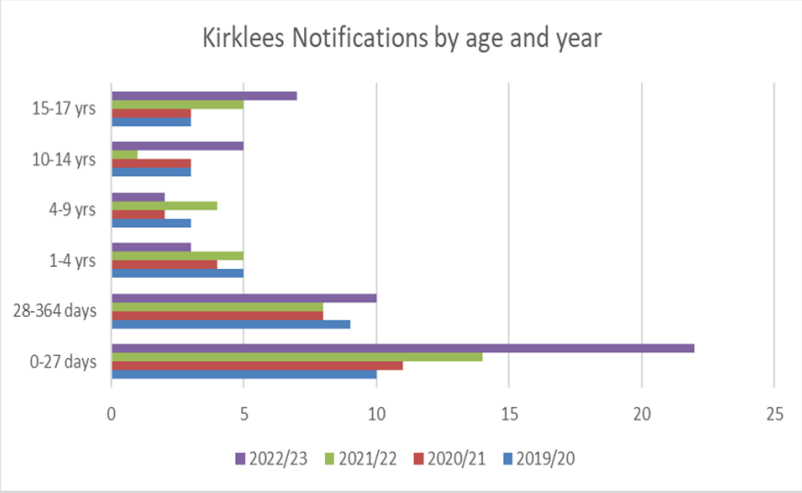
The Local Picture – Annual comparison





The Local Picture – Annual comparison





Neo-natal and peri-natal deaths remain the highest over the four years. An increase 7% on the previous year. Based on latest information from NCMD in 2021/22 there had been a national increase of 12.8% on child deaths.

The acute hospital trust have stated “We were well sighted on the rise in neonatal deaths as it was occurring during the 22/23 year, as a result we completed a deep dive to review each case during the 2022 year. This has been shared at maternity forum and the perinatal quality surveillance meetings.

Of the cases audited for 2022:

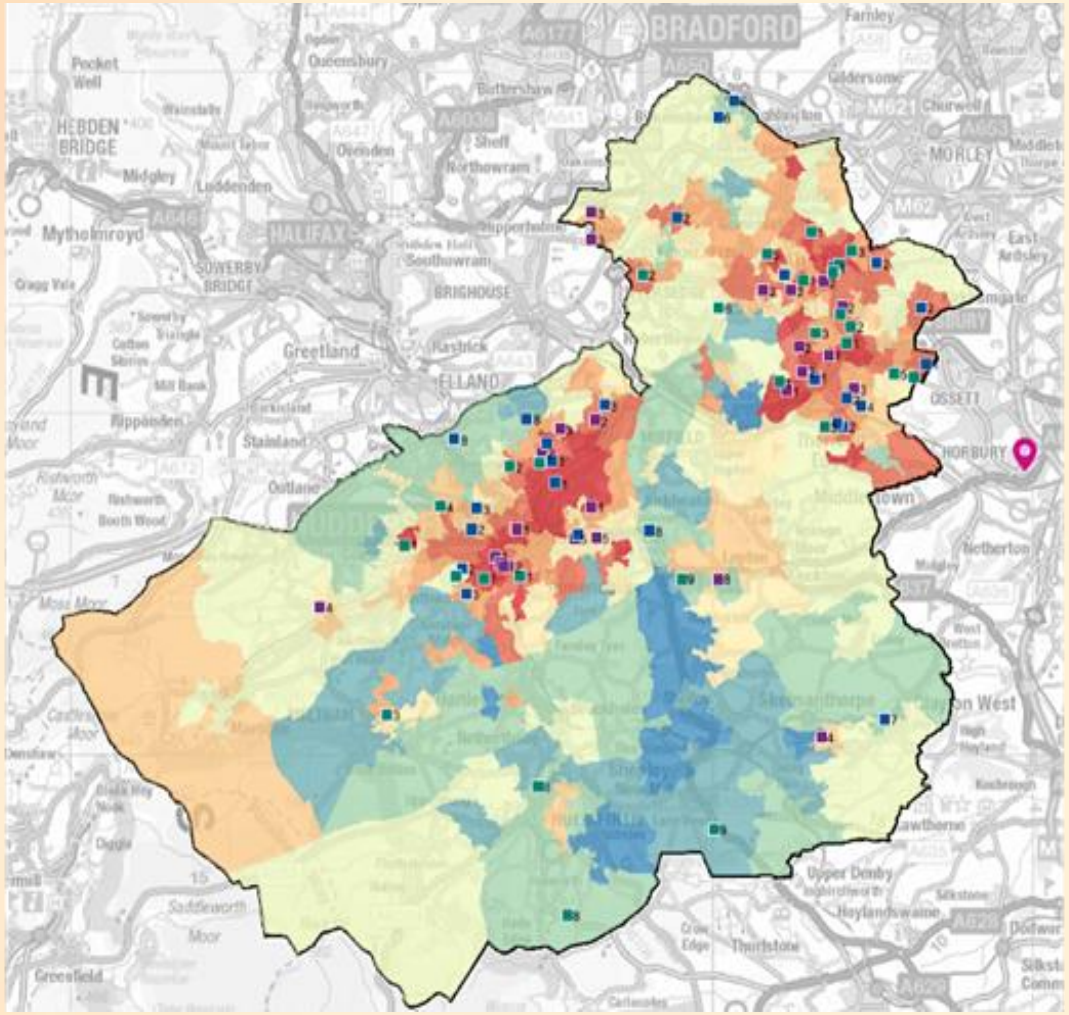
- 6 were under 24/40
- 5 had known congenital abnormalities
- 3 cases were not booked at CHFT

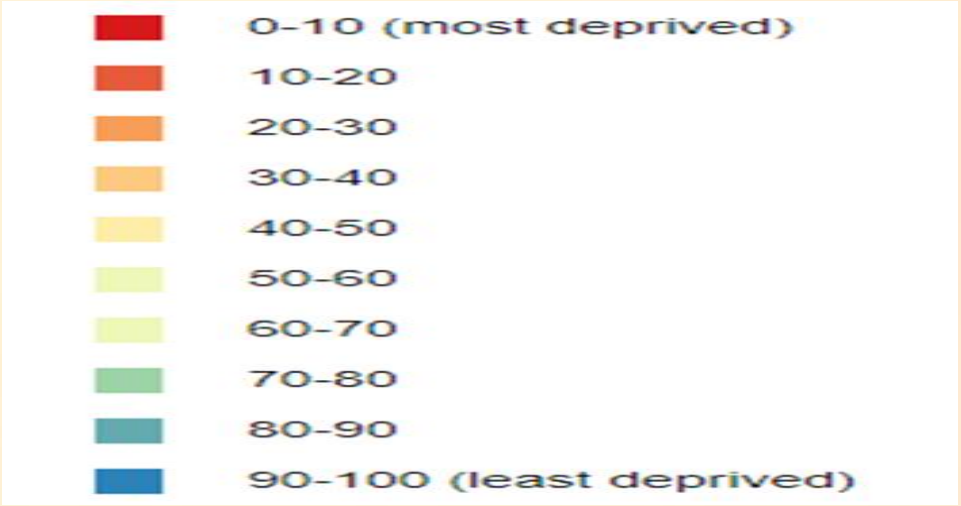
The 3 cases not booked at CHFT delivered with us but had received no previous antenatal care with us:

- 1 was an inutero transfer and delivered after transfer
- 1 was totally unbooked and had no AN care anywhere
- 1 was booked at another provider but was ‘sofa surfing’ and in the area when needed admission in labour

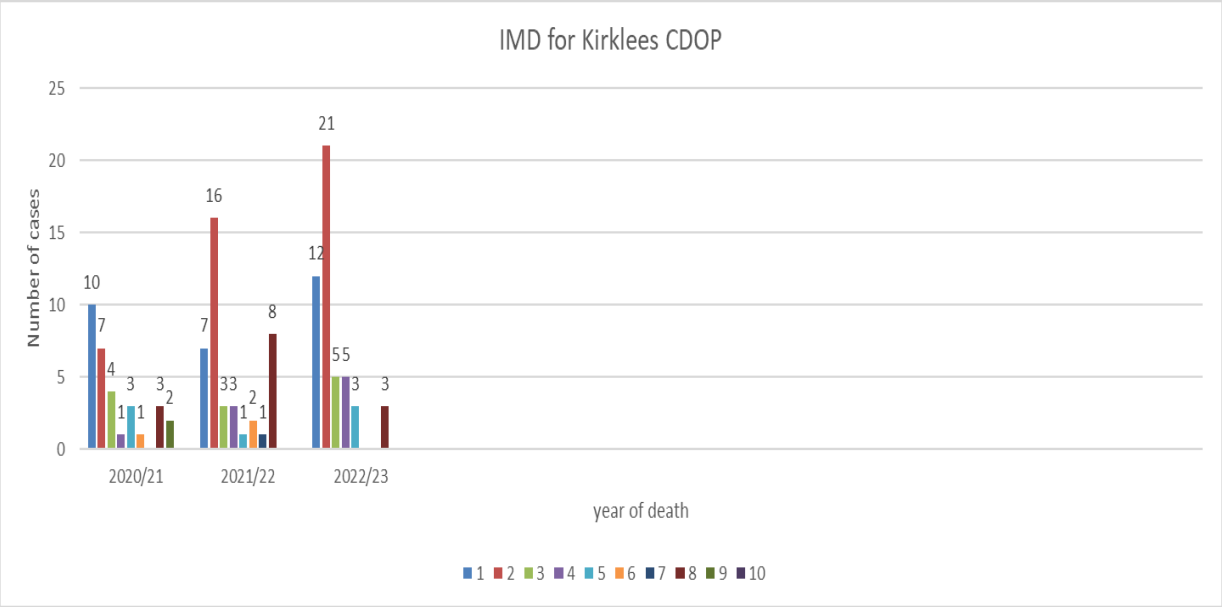
We continue to review all neonatal deaths and audit continues. “

Indices of Multiple Deprivation 2020/21 – 2022/23
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.



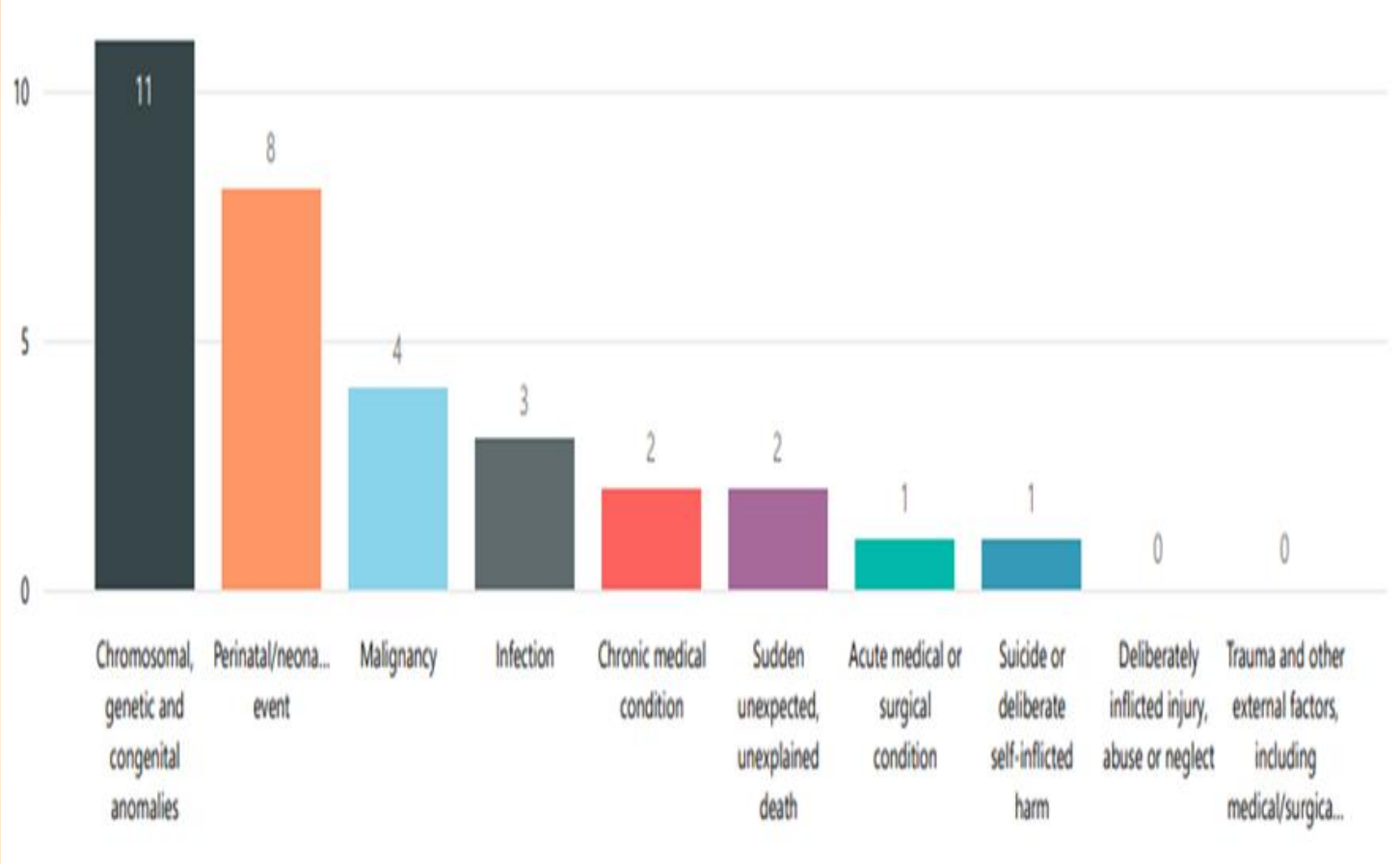
Of the 31 children who died in 2020/2021, 17 had been resident in the 2 most deprived areas in Kirklees. Of the 17 children whose cases have been reviewed 13 were in the age ranges of birth – 364 days and 3 of these cases involved parental smoking.

Of the 37 children who died in 2021/2022, 23 had been resident in the 2 most deprived areas in Kirklees. Of the 37 children whose cases have been reviewed 16 were in the age range of birth – 364 days, one involved parental smoking and two involved consanguinity.

Of the 49 children who died in 2022/2023, 33 had been resident in the 2 most deprived areas in Kirklees.

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.

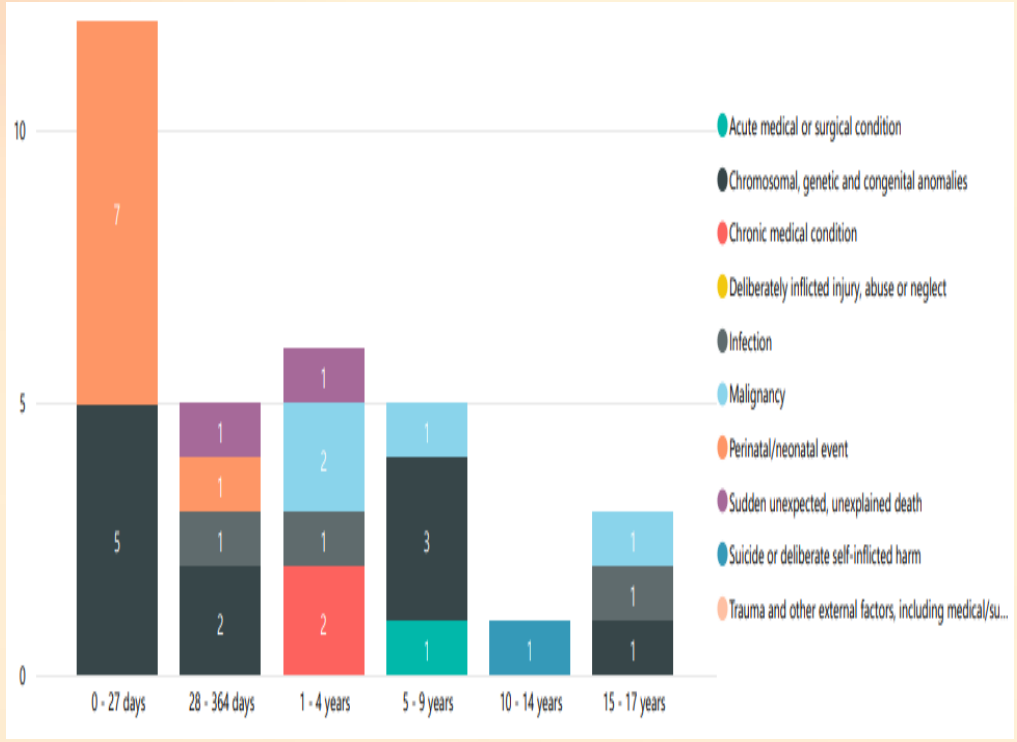
Kirklees completed reviews by primary category of death



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.

Kirklees – A local picture

Age groups and Categories for cases reviewed



Modifiable factors

41% of cases included modifiable factors

Percentage of cases with modifiable factors (England) 39%

Top modifiable Factors Identified

Unsafe sleeping arrangements

Smoking

Drug & Alcohol Abuse

Consanguinity

Kirklees - Data completeness on notifications and completed reviews

Notifications

We have continued to have a good level of completion of fields on notifications with 97% - 100% across all fields.

Completed reviews

- We have worked hard during the year to review our older cases and this has now been reflected in the median number of days between death and CDOP meeting.

  Kirklees – 289: National (England) – 335

- 59% of cases are discussed and completed within 6-12 months
- 31% of cases took over 12 months, this was due to parallel proceedings.
- 9% of cases took less than 6 months to complete

Conclusion

The majority of children who have died in Kirklees do so before the age of one (65%).

The most prevalent categorisation of death is split between perinatal/neonatal event (8) and chromosomal, genetic, or congenital anomaly (11).

There were 49 notifications during the 2022/2023 year

Kirklees reviewed 32 cases during the year.

The median number of days between death and CDOP meetings has reduced from 479 last year to 289 this year, and we are continuing to improve this figure.

Of the cases reviewed 53% were male children and 47% were female children

18 cases reviewed were from deaths occurring in 2021/22, 6 deaths were from 2022/23 and the remaining 8 were from earlier years.

We are continuing our work to help reduce deaths of children by focussing on our priorities and reaching out to the communities we serve.

Over the period 20/21 – 22/23 59% of child deaths occurred in the two most deprived areas of Kirklees.