Wakefield, Kirklees, & Calderdale

Annual Child Death Overview Panel Report 2021-2022

Kirklees Safeguarding Children Partnership

Calderdale Safeguarding Children Partnership

Wakefield Safeguarding Children Partnership

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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, 2018). This process is undertaken locally for all children who are normally resident in Kirklees, Calderdale and Wakefield (KCW).

Every death of a child is a tragedy and we must therefore learn from the circumstances and factors present in each death so we can:

- Identify any changes that we can make or actions we can take that might help to prevent similar deaths in the future.
- Share this learning with colleagues regionally and nationally so that the findings will have a wider impact.
- Analyse trends and targeted interventions delivered in response to these. For example, introducing the requirement to view where a baby sleeps as part of routine enquiry by Health Visiting and Midwifery services, if there have been a spate of deaths where unsafe sleeping practices have been a factor. It could also include launching a targeted water safety campaign aimed at children and young people if there have been deaths due to drowning.

The deaths reviewed by the CDOP are not about allocating blame, it is instead about learning and putting actions in place to prevent future deaths.

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 in order 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 2021/2022, the Kirklees, Calderdale and Wakefield CDOP's reviewed a total of 101 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

Kirklees, Calderdale and Wakefield share arrangements for reviewing the deaths of all children in these areas. During 2021/22 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. Use of this system has enabled CDOP Coordinators to manage the cases in a much more effective and efficient manner, allowing for quicker and easier chase up of any outstanding information. Services can also quickly report back at the click of a button if the child and family is not know to them, so we can quickly build up a picture of which services were involved with the child's care.

Panel Meetings

During the COVID19 Pandemic CDOP meetings were held virtually. 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. The virtual arrangements continue to date, however this has not been of any detriment to the quality of the CDOP meetings held, which are well attended by a wide range of multi-agency professionals. 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 joint Chairs of the CDOP meetings are Julia Caldwell, Safeguarding Children Partnership Manager (Co-Chair - Calderdale) Ben Leaman, Consultant in Public Health (Co-Chair – Calderdale) ,
Emily Parry-Harries, Consultant in Public Health (Chair - Kirklees) and Melanie Robinson, Service Manager, Children's Public Health (Chair - Wakefield).

What have we achieved

Reflecting on the discussions had by the CDOP over the last 12 months, four specific areas were agreed as priorities for the Panel for 2021/22, and the following progress made.

1) **Increase professional's awareness and understanding of their roles and responsibilities within child death processes and the eCDOP system to assist meeting Working Together to Safeguard Children 2018 timescales.**

- In Kirklees, a briefing has been shared via the Primary Care bulletin to increase awareness on CDOP processes and engagement. Work on a specific practice basis has been undertaken where any delays have been noted on receiving the required information. Kirklees CCG (now KHCP) have also included some information on their intranet.

- Calderdale CCG (now known as Calderdale Care Partnership) has shared a briefing with GPs to increase their awareness on CDOP processes and boost their engagement.

- Mid Yorkshire Hospital Trust (MHYT) have commissioned a full time Child Death Lead Nurse covering the Wakefield and North Kirklees footprint as a 50/50 split between both areas. This appointment helps to ensure both Kirklees and Wakefield are compliant with CDOP/child death guidance particularly around child death review processes. The Child Death Lead Nurse also acts as a key worker for the bereaved family and provides support, not only as they come to terms with the death of their child, but as they navigate their way through child death review processes such as the post-mortem and Coroner's Inquests.

- All 3 authorities now use eCDOP to notify and report. By using a unified method, it assists agencies that cross borders e.g., Police, to have the one system to provide information. By using this system, it has now streamlined the child death review process. CDOP Co-ordinators in Kirklees, Calderdale and Wakefield act as point of contact for professionals and are on hand to answer any questions and queries, particular in relation to the use of the eCDOP system and completion of Reporting Forms.

- In Wakefield it was identified that GPs were not receiving Reporting Forms following the move to eCDOP, this has now been rectified.

2) **To work towards reducing smoking prevention in the population as a whole and recognising the impact on women in pregnancy.**

- Work has been undertaken by professionals with parents to identify the risks or smoking during pregnancy and the effects it can have on babies and young children.

- Work at Place is now captured in the CDOP modifiable factors document, highlighting the current provision, gaps and future work plans. This document provides assurance to CDOP that work is ongoing to prioritise reducing smoking rates across Kirklees, Calderdale and Wakefield.

3) **Consanguineous Marriages: To provide information that needs to be understood by families in order that they can then make informed choices.**

- Kirklees are working at national level to progress a standardised definition of consanguinity. This will influence the CDOP guidance for the recording on consanguinity to ensure it is correct and consistent.

- Kirklees are due to receive national funding to support this agenda locally, with a focus to reach the Pakistani community. There are four components to the work:
  1) An Equity Midwife
  2) A Genomic Associate based in the Genetics Service in Leeds
  3) Genomic literacy works with the community

- Calderdale are interested in taking a West Yorkshire approach to working with the ICB at scale to progress work about consanguinity.

4) To create a sub-group to look at: Smoking cessation; Alignment of Processes & Procedures; Themes and trends and Data

- Smoking is prioritised across all three Places.
- CDOP modifiable factors report captures data on smoking.
- Kirklees Smoking Status at Time of Delivery (SATOD) rates have decreased over time – 12.7% (2018/19), 12.1 % (2019/20) and 11.4 % (2020/21)
- Wakefield SATOD rates are- 16.4% (2018/19), 15.7% (2019/20) and 14.6% (2020/21). Although Wakefield is an outliner compared to our neighbour and the national average, Wakefield rates are falling much faster than the national average.
- A quarterly report is produced by colleagues in Kirklees, which highlights child death cases received and reviewed, modifiable factors and it provides narrative and analysis around this data. This report is shared with the Kirklees Executive group and supports the outline of local themes and trends and what is being progressed in relation to the modifiable factors.
- A Child Death Working Group has been initiated in Wakefield with key partners in attendance and currently meeting approximately bi-monthly. The remit of this group is to look at child death processes and pathways and try to improve or streamline where possible.
- Midwifery in Calderdale started doing electronic referrals to Yorkshire Smokefree in April 2020 during the pandemic and have increased referrals during that time by approximately 60%.

- Increased referrals to Stop Smoking Services in Calderdale and Yorkshire Smokefree, 231 (2020/21) 343 (2021/22).

Additional Achievements across Kirklees, Calderdale and Wakefield in 2021/22:

- "The Every Sleep a Safe Sleep" multi-agency risk minimisation guidance has been launched and piloted by the Local Maternity System (LMS). The "Every Sleep a Safe Sleep" guidance incorporates both training and resources, the aim of which is to help reduce the risk of the sudden and unexpected death of an infant. The resources are designed for colleagues who work with pregnant women and families where there are babies aged up to 12 months.

- Colleagues in Calderdale led on "The Every Sleep a Safe Sleep" work along with the LMS. The risk minimisation tool, and associated guidance, was co-designed by Janet Smethurst from Calderdale, and this has been shortlisted for a Nursing Times Award. Janet will be attending a meeting in London to present details of the work to the judges, before the outcome is revealed at the Nursing Times Award Ceremony to be held on the 26th October. 2022

- Wakefield Safeguarding Children Partnership launched their safeguarding children monthly e-bulletin which has almost 1000 subscribers. The e-bulletin regularly contains information and guidance aimed at both parents/carers and professionals in relation to the modifiable factors that have been identified when child death cases are reviewed. For example, safer sleep information, water safety resources, drug and alcohol support services available within the Wakefield district. This allows for any learning from child death's that has been put into tangible action to quickly be shared with a large audience.

Modifiable Factors Across Kirklees, Calderdale & Wakefield

Background:

- Of the 101 cases the Panel reviewed in 2021/22, there were 51 cases where modifiable factors were present. This represents an average of 50%. The average nationally for 2021-22 is 37% (NCMD Annual Report 2021-22).
- Modifiable factors were identified and discussed in Panel meetings, with an overarching monitoring and analysis log being developed and introduced to provide assurance to the CDOP that work is in progress to address the identified modifiable factors.
- It was agreed that Public Health colleagues across the Places would produce a report to share with CDOP colleagues for review twice yearly. This has also been shared wider across Wakefield.
- The purpose of the KCW modifiable factors log is to identify the key modifiable factors for each Place and to demonstrate what services/interventions are available, identification of gaps in service/interventions and to support actions and activities for future planned work.

The log includes information on the following:

- ❖ Work currently being delivered at Place for the identified modifiable factor.
- ❖ Gaps identified in service provision.
- ❖ Future work planned.
- ❖ Local data (where relevant).

The log is evolving to include:

- ❖ The emerging modifiable factors that are being identified by the Panel throughout the year.
- ❖ The top modifiable factors for 2021/22 for KCW.

Priorities for 2022/2023

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

Priority 1: KCW exploration of potential roll out of the safe sleep training for the workforce. 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.

Kirklees Data

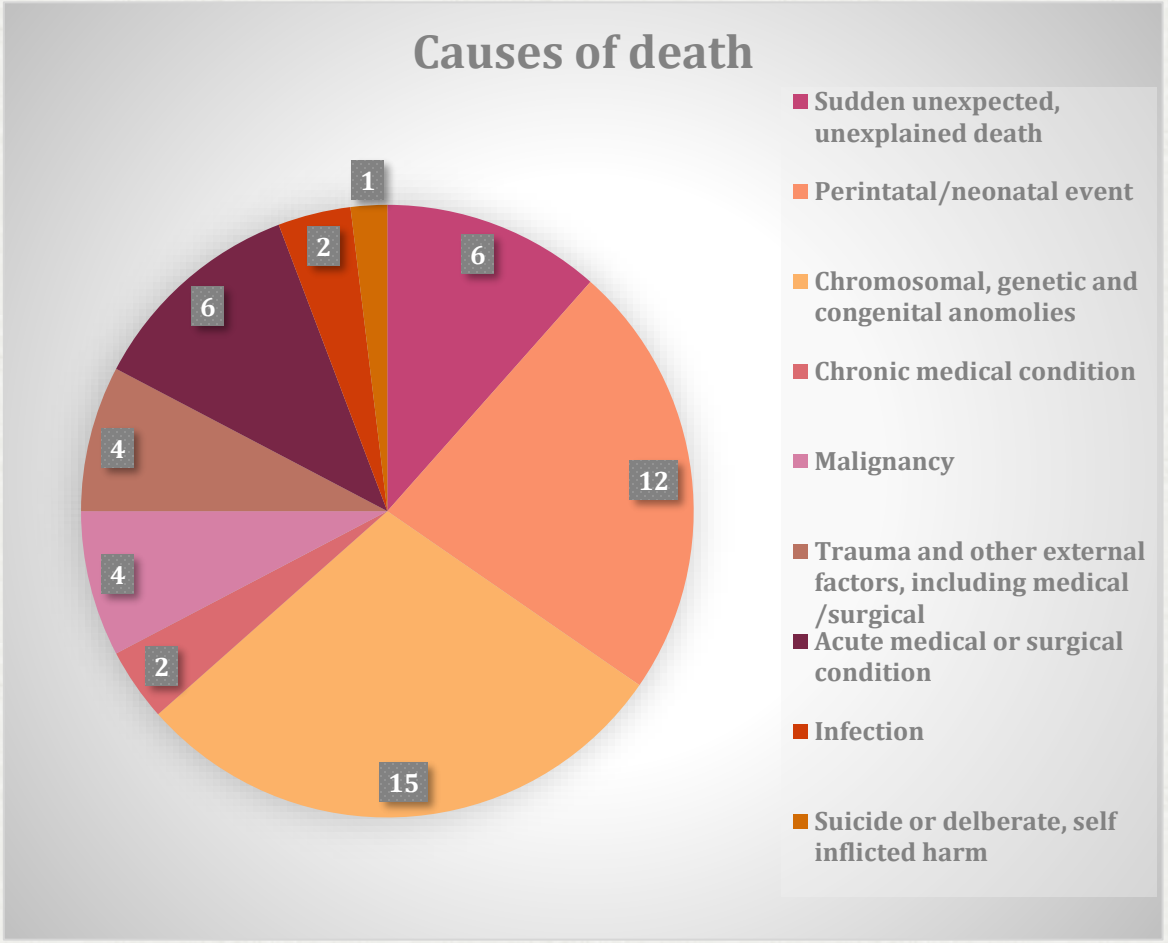
During 2021/2022 there have been 37 deaths reported in Kirklees. During the year 52 cases have been reviewed and completed. There are a further 49 cases to be reviewed.

Cases completed with cause of Death:

Of the cases reviewed 28 (54%) had modifiable factors, the top 5 of which were (in order)

- Smoking (14)
- Unsafe sleeping (5)
- Consanguinity (5)
- Maternal obesity (4)
- Domestic violence (4)

Other modifiable factors noted by Kirklees but not recognised as a theme were alcohol, substance misuse, deprivation, no recourse to public funds, parental mental health, dangerous driving, and health service provision concerns e.g. recognition of sepsis.



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

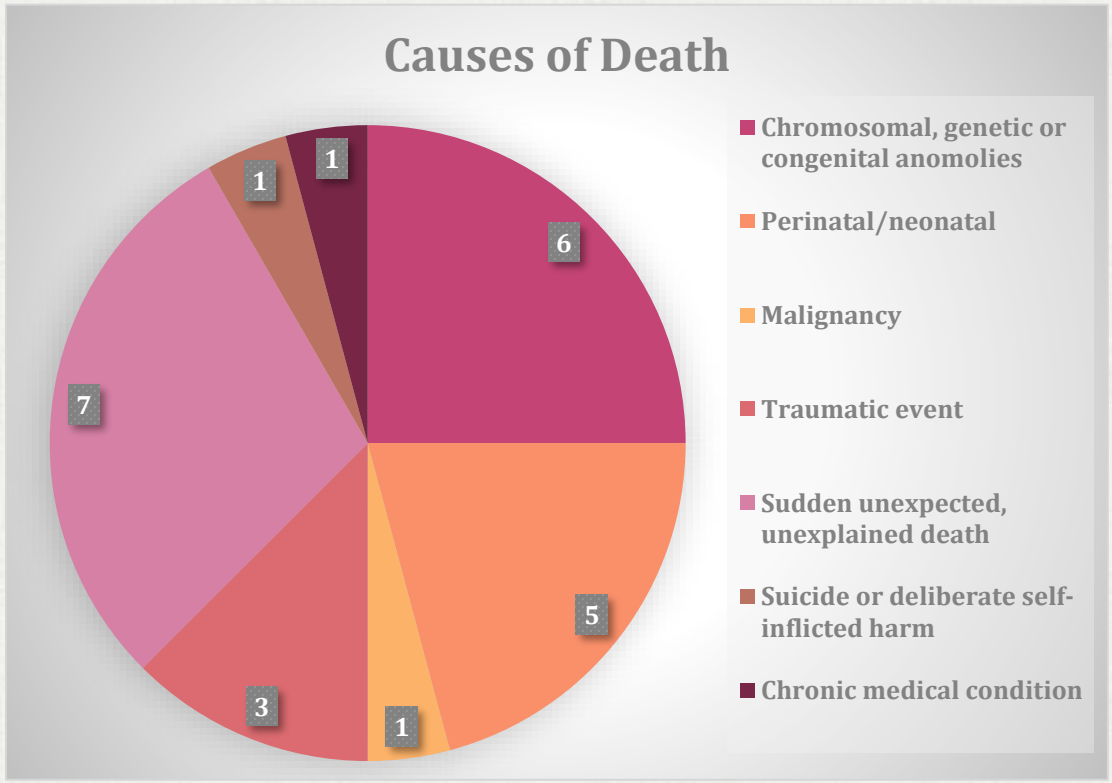
Calderdale Data

During 2021/2022 there have been 14 deaths recorded, which is in line with previous years. During the year 24 cases have been reviewed and completed, with a further 16 cases to be reviewed.

Cases Completed with cause of death:

Of the cases reviewed 12 (50%) had modifiable factors, and these have been identified as:

- Unsafe sleeping (5)
- Smoking (8)
- Consanguinity (1)
- Alcohol Use (1)
- Service Provision (1)



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

Wakefield Data

During 2021/2022 there have been 25 deaths recorded. During the year, 25 cases have also been reviewed and completed. The cases reviewed where the data below is drawn from are from deaths which took place between 2017 – early 2021. As of March 31st 2022, Wakefield had 34 cases to be reviewed.

Cases Completed with cause of death:

Of the cases reviewed 11 (44%) had modifiable factors, and these have been identified as including:

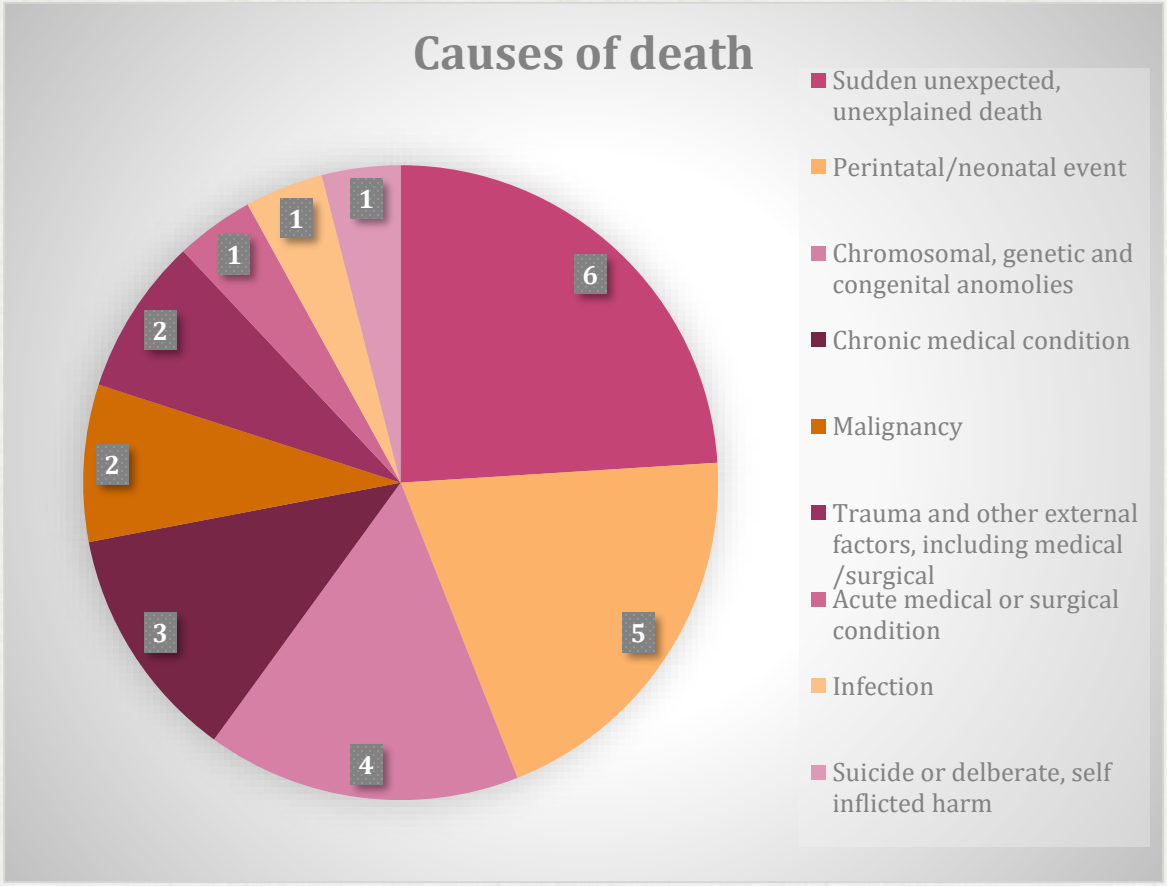
Factors identified which may have contributed to ill-health or a death

- Smoking (7)
- Unsafe sleeping (5)
- Parental alcohol use (4)
- Parental substance use (3)
- Poor engagement with antenatal services (1)

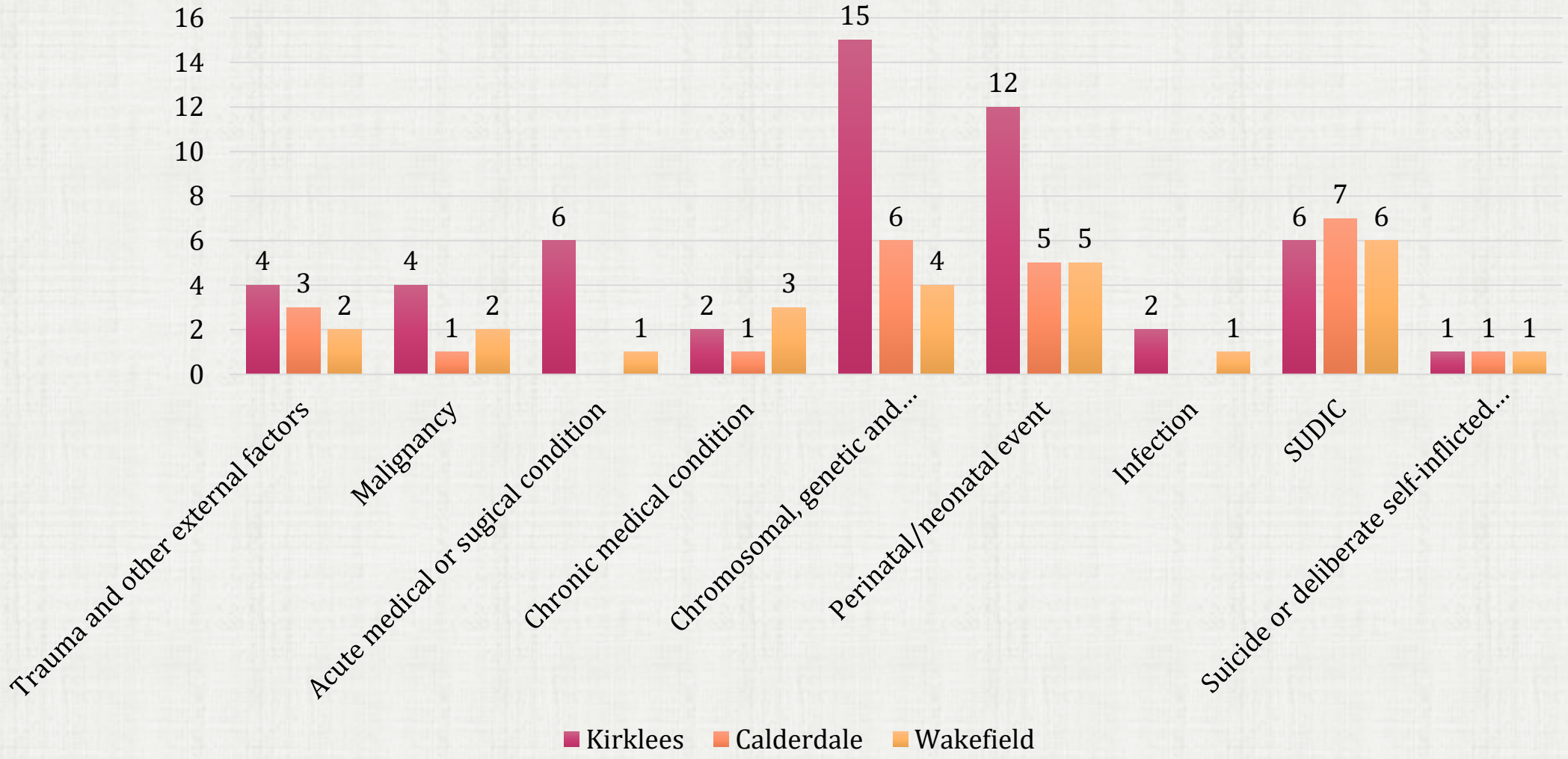
Factors identified but has not contributed to a death

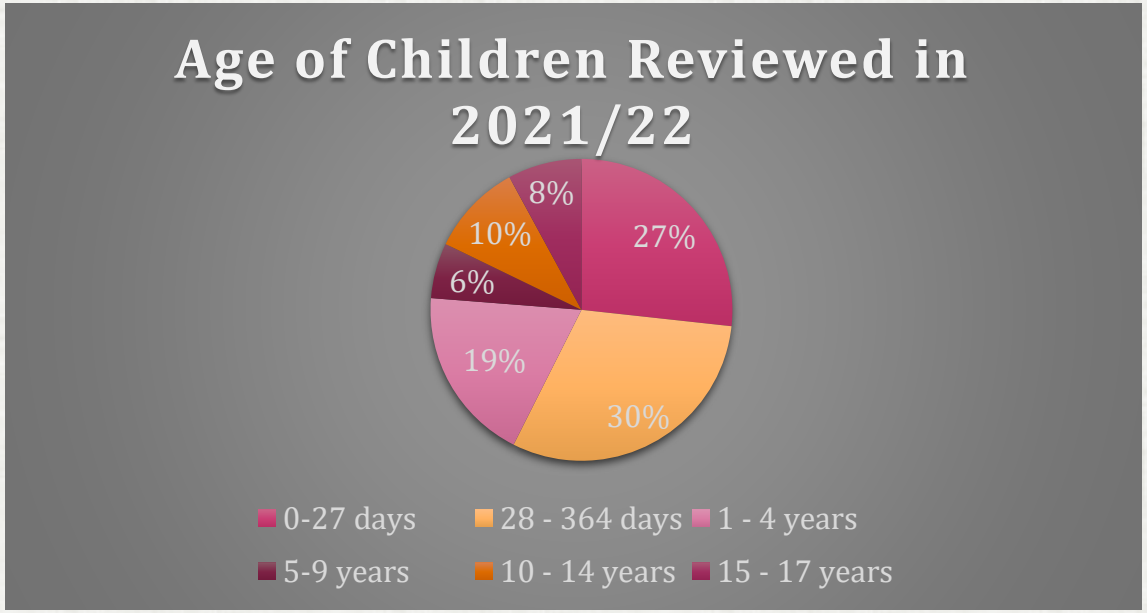
- Domestic abuse (4)
- Parental substance use (4)
- Neglect (3)
- Parental alcohol use (3)
- Parental mental ill-health (1)
- Outbreak of infection on neonatal unit (1)

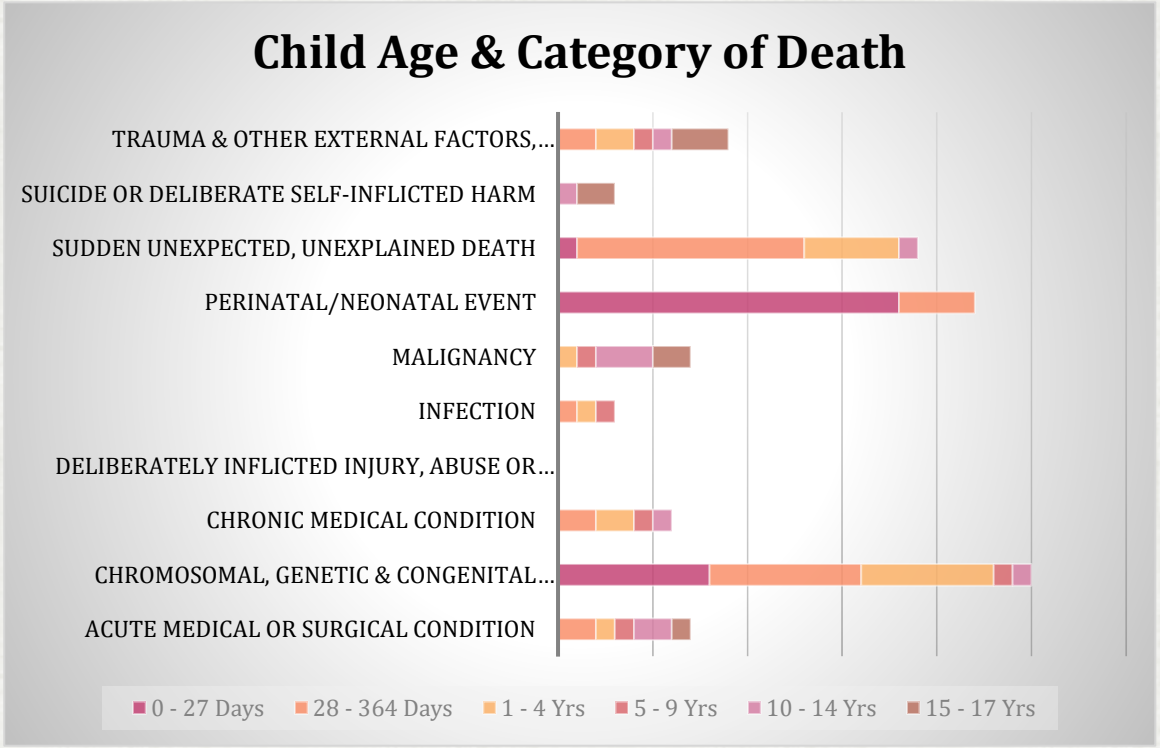
(***each case can have more than one modifiable factor identified***)



Categories of Death for Pan CDOP - Cases Reviewed In Year 2021/22







Joint Data and Analysis

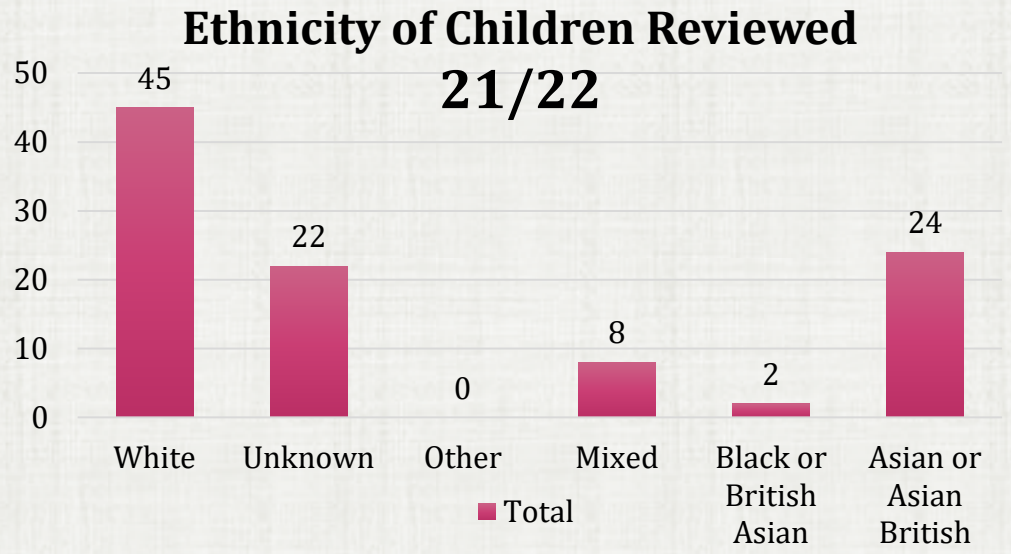
Age of children:

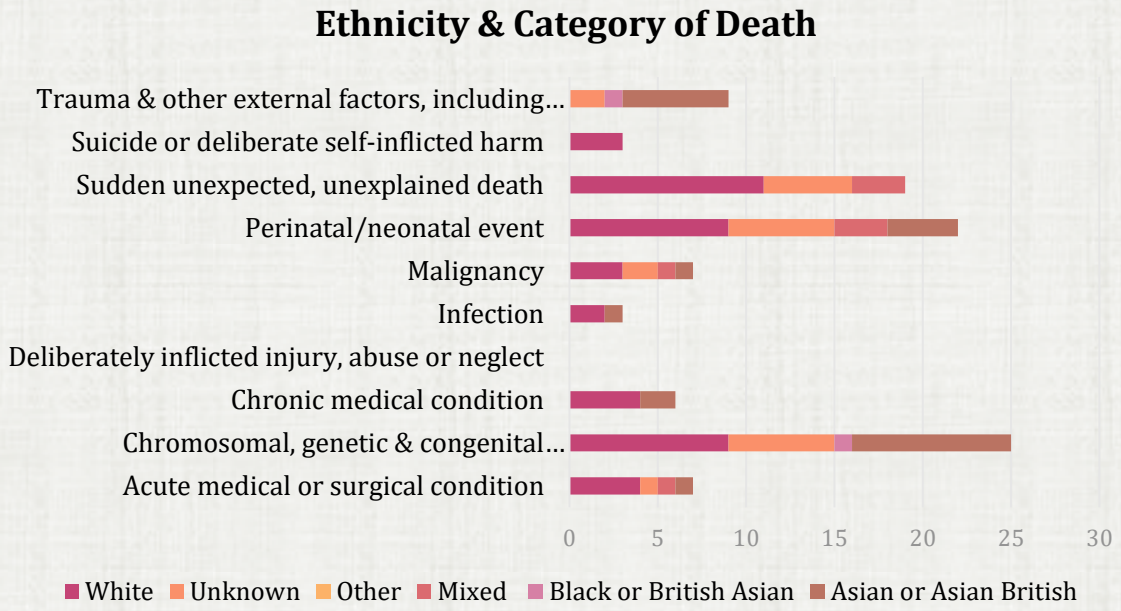
A child is most at risk of death within the first year of life, and particularly within the first 27 days of life.

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.

57% of children in the pan CDOP died within their 1st year of life. The lowest age group of children who have died are 5 –9 year olds which is a change from 2020/21 when 15 – 18 year olds was the lowest category.

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



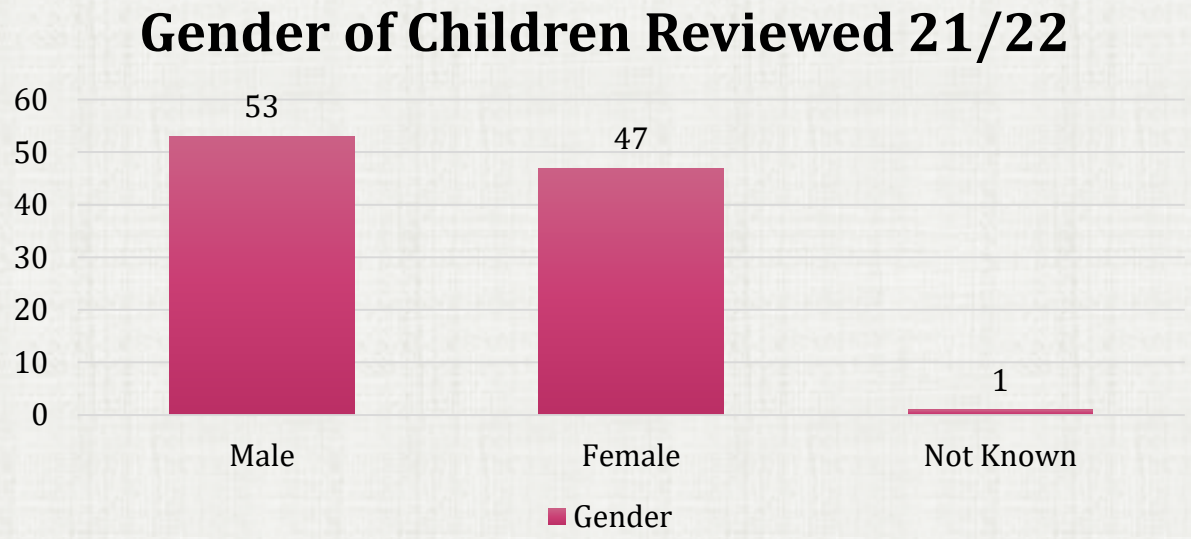


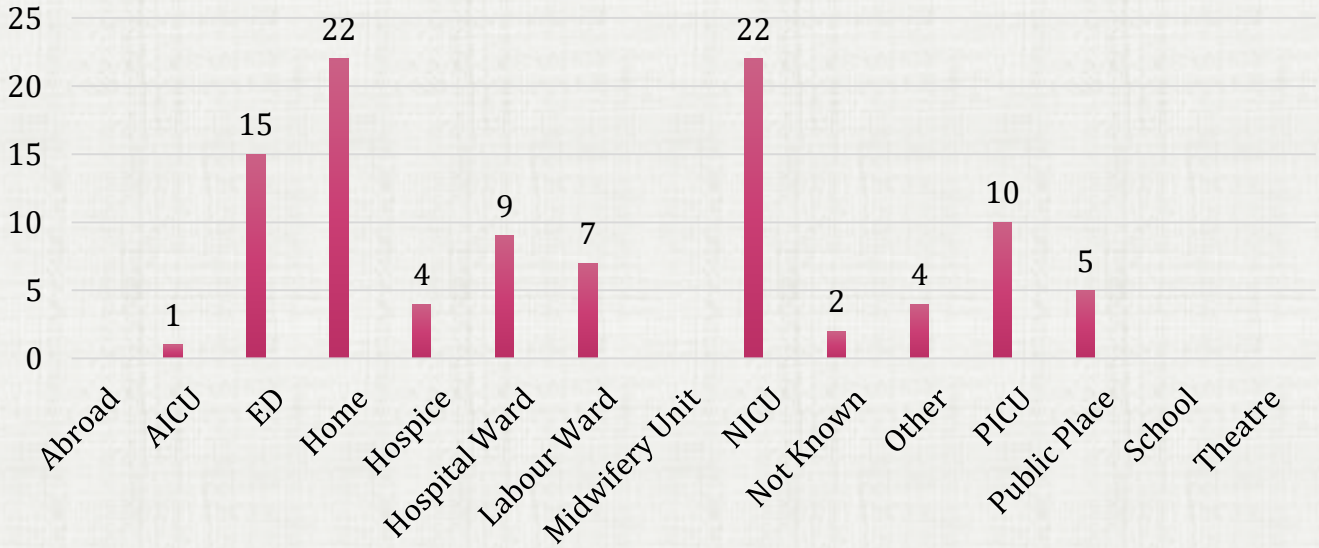
Joint Data and Analysis

Ethnicity:

Across the pan CDOP when looking at the ethnicity of the child deaths along with the category of deaths, the largest category of death was chromosomal, genetic and congenital anomalies. There is a 36% split between White children and Asian/British Asian children with the remainder either unknown or of Black or Black Asian ethnicity.

This is consistent with the 2020/21 data which saw chromosomal, genetic and congenital anomalies as the main category of death split 40% between White children and Asian/British Asian children and the remainder were unknown or mixed. Therefore there hasn't been a significant change.





Joint Data and Analysis

Gender:

This year the gender split between the children who have died is closer at 53% males and 47% females compared to 2020/21 when there was a lot more males (63% males compared to 37% females).

Location of death:

An equal amount of deaths occurred in both the child's own home and NICU. This is comparable to 2020/21 data where the largest number of deaths occurred in NICU, and one in five children died at home.

Joint Data and Analysis

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 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 101 child deaths reviewed by the Panels during 2021/2022, there were 51 cases where modifiable factors were identified. This represents an average of 50%, (9% increase from 20/21 – 41.3%) whereas the average for England is 37% (NCMD Annual Report, 21-22)

Of the 51 child deaths reviewed where modifiable factors were identified, the predominant factors recorded were:

- Unsafe sleeping arrangements
- Smoking
- Substance/alcohol Abuse
- Consanguinity

Conclusion

- Due to system developments undertaken across 2021/22 in respect of CDOP processes to address some of the delays in previously reviewing deaths, CDOP in 2021/22 reviewed 101 deaths. This is a significant increase (~119%) in comparison to the 2020/21 figure of 46 reviews.

- The majority of children who die do so before the age of 1 (57%). 30% were aged 28 – 364 days, 27% aged 0 – 27 days.

- Of the 101 deaths reviewed, 57 were male and 43 were female and 1 not known. This is consistent with the findings from 2020/21, where there were also more male than female deaths.

- The main categories CDOP has recorded child deaths against in 2021/22 remained the 3 same categories to 2020/21 but saw some percentile variances. Chromosomal, genetic and congenital anomalies reduced by 7% (25% in 21/22 v 32% in 20/21); SUDIC reduced slightly (19% in 21/22 v 20% in 20/21); and perinatal/neonatal event increased by 7 % (22 in 21/22 v 15% in 20/21).

- Perinatal/neonatal event continues to be the highest category used by CDOPs nationally (NCMD Annual Report, 2021-22).

- There has been an increase in the percentage (9%) of deaths in 2021/22 in comparison to 2020/21 where modifiable factors were present (50% v 41.3%). Part of this increase can be attributed to the system developments districts have undertaken in relation to CDOP processes which has resulted in deaths being reviewed more effectively and in greater volume. Wakefield reviewed 25 deaths in 2021/22 in comparison to 7 deaths in 2020/21. Kirklees reviewed 52 in 2021/22 compared to 29 in 2020/21. Calderdale reviewed 24 deaths in 2021/22 compared to 10 in 2020/21.

- Inequalities and the links to child deaths will continue to be a focus across KCW. 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.