Hull Child Death Overview Panel

Annual Report 2024/25

Hull City Council

NHS
Humber and North Yorkshire
Integrated Care Board (ICB)

Hull Health and Care Partnership
Creating a healthier Hull

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1. CHAIR'S FOREWORD

The Child Death Overview Panel operates to ensure that every child death in Hull is comprehensively reviewed and that we highlight to the system where we can act to try to prevent the deaths of babies and children and to improve support services for families. Our role as a panel is to ensure all steps have been taken and the learning shared. We are sensitive to the weight of the task and operate to ensure each child is reviewed with compassion and care.

This report summarises the insights of the panel and identifies some clear recommendations for agencies and partners.

As a CDOP, we remain deeply grateful to the members of our partner organisations who, time after time, go out of their way to make the lives of children and their families their absolute priority. Despite often challenging circumstances, they consistently work above and beyond to ensure that every child receives the care, support, and experiences they deserve.

I also wish to formally acknowledge the members of the Child Death Review Team, the Child Death Review Partners, and the Child Death Overview Panel (CDOP). Their dedication, professionalism, and sustained efforts in reviewing the deaths of all Hull children are vital to improving learning, strengthening safeguarding practice, and honouring every child and family involved.

As we move forward, we encourage all partners and stakeholders to continue engaging fully with the child death review process, to act on identified learning, and to collaborate proactively to prevent future deaths and improve outcomes for all children in Hull. Our collective commitment remains essential to driving meaningful change.

Our deepest condolences are always with those families who are bereaved.

Acknowledgements
I would like to acknowledge the contributions of key individuals in supporting the production of this report: Mandy Porter, Helen Christmas, Laura Pickering, Dr Mary Barraclough, Dr Chris Wood and Cathy Eccersley.

Ali Patey, Director of Public Health, Hull City Council
CDOP Chair

2. INTRODUCTION & CHILD DEATH REVIEW PROCESS

The child death review process exists to understand why children die and to learn lessons that can help prevent future deaths. It also aims to improve services for families and carers and protect other children wherever possible.

Child Death Overview Panels (CDOPs) have been a statutory requirement since April 2008. CDOP reviews the deaths of all children under 18 who live in Hull, and occasionally those from outside the area if there is significant learning for local agencies and professionals. This includes any baby or child for whom a death certificate has been issued, regardless of gestational age. Reviews do not cover stillbirths, late fetal loss, or lawful, planned terminations.

The statutory partners involved in child death reviews in England are the local authorities and integrated care boards (ICBs). These partners are responsible for setting up arrangements to review all deaths of children normally resident in their local area and, if appropriate, for any non-resident child who has died in their area. The Child Death Overview Panel (CDOP) conducts the reviews on behalf of these partners. The Child Death Review Statutory and Operational Guidance (2018) explains how professionals and organisations should work together using national standards. This guidance builds on Working Together to Safeguard Children (updated in 2023). The process aims to:

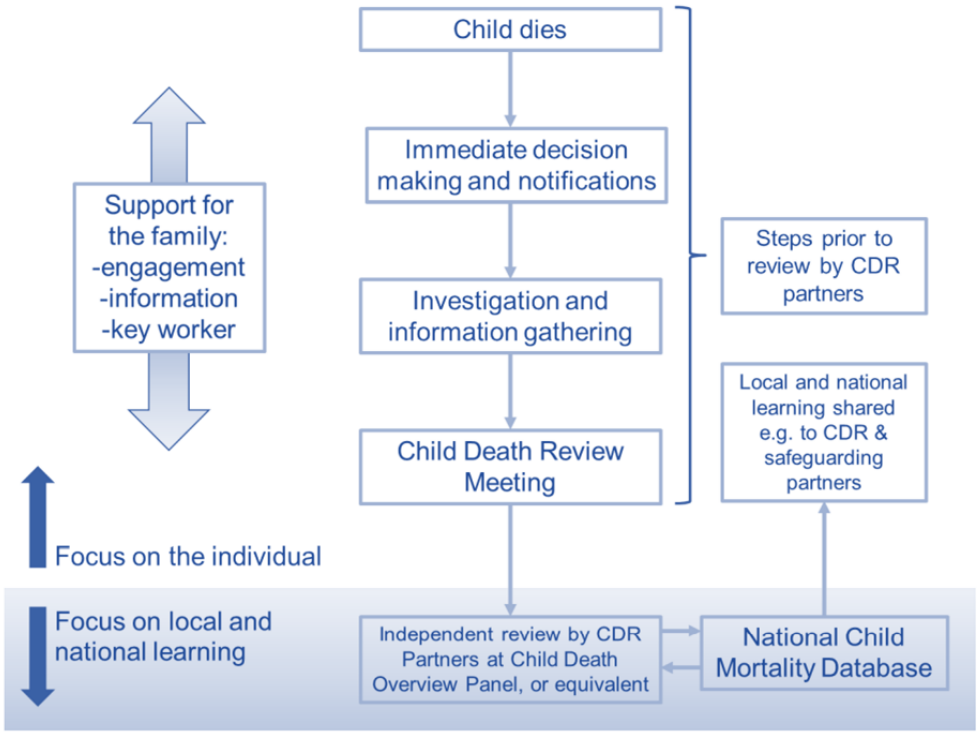
- Collect and review information about each child's death to confirm the cause, identify any contributing factors, and learn lessons that may prevent future deaths.
- Make recommendations to organisations where actions could improve safety and wellbeing for children.
- Produce an annual report showing local patterns and trends, lessons learned, and actions taken.
- Share learning locally, regionally, and nationally to help prevent future child deaths.

In Hull, our statutory partners are the Humber and North Yorkshire Integrated Care Board and Hull City Council. They work together through a Child Death Review Executive Group, which provides strategic oversight and ensures compliance with national guidance. Members include senior leaders from health, safeguarding and public health, as well as the Child Death Review Co-ordinator.

Since January 2021, Hull has used an online system called eCDOP to record notifications, casework, and reports. This system automatically transfers data to the National Child Mortality Database (NCMD).

Figure 1 illustrates the full process of a child death review.

Figure 1: Full process of a child death review



Processes ensure appropriate links are made with other statutory review processes, for example:

- [1]Perinatal Mortality Review Tool (for infants under 28 days or older who died on Neonatal Intensive Care (NICU)
- [2]Patient Safety Incident Response Framework (PSIRF)
- [3]Post Mortem examination
- [4]Inquest
- [5]Coroner's Regulation 28 report to prevent future deaths
- Police criminal investigation
- Road Traffic Collision investigation

[1] The PMRT is a web-based tool that is designed to support a standardised review of care of perinatal deaths in neonatal units from 22+0 weeks gestation to 28 days after birth. It is also available to support the review of post-neonatal deaths where the baby dies in a neonatal unit after 28 days but has never left hospital following birth. The PMRT is integrated with the national collection of perinatal mortality surveillance data.

[2] The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

[3] A -post mortem is detailed physical examination of the child after he or she has died.

[4] An Inquest is an investigation into a death which appears to be due to unknown, violent or unnatural causes. Purpose is to answer 4 questions: who the deceased was, and where, when and how they died. It is different to other courts because there are no formal allegations or accusations and no power to blame anyone directly for the death. At the end of the Inquest, the Coroner will give his/her conclusion and this will appear on the final death certificate. The death can then be officially registered.

[5] If any information is revealed as part of the Coroner's investigation or during the course of the evidence heard at the inquest, which gives rise to "a concern that circumstances creating a risk of other deaths will occur, or will continue to exist in the future;" and if the Coroner is of the opinion that action needs to be taken, under Paragraph 7 of Schedule 5 of the Coroner and Justice Act 2009, the Coroner has a duty to issue a report to a person, organisation, local authority or government department or agency. The Coroner's Regulation 28 Report will set out the concerns and request that action should be taken. All Regulation 28 Reports and the responses are sent to the Chief Coroner and in most cases these will be published on the judiciary.gov.uk website.

- Learning Disabilities Mortality Review (LeDeR) - to avoid duplication, as of 1st July 2023, there is no longer any requirement for deaths of children with a learning disability to also be notified to LeDeR; these deaths will be reviewed by the national mandated processes that look at the deaths of all children, with additional shared learning arrangements between the National Child Mortality Database and the LeDeR programmes.
- [6]Child Safeguarding Practice Review (CSPR) undertaken by Local Safeguarding Children Partnerships when a child dies (including death by suspected suicide) or is seriously harmed, and abuse or neglect is known or suspected
- [7]National Guidance on Learning from Deaths - A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care
- The Medical Examiner (ME) process (from Sept 2024) applies to all non-coronial deaths before registration and focuses on accurate death certification and immediate family concerns before a death is registered. MEs in the UK are senior doctors employed by NHS trusts who provide independent scrutiny of causes of death.

Each review carried out by the CDOP is based on information gathered from the initial notification of the child's death and from meetings with professionals involved in the child's care. Where appropriate, the family's views and experiences are also included. This helps ensure the review is as complete and accurate as possible.

CDOP is the final stage of the child death review process. Its role is to bring together all the learning from individual cases and identify patterns or themes. This learning is used to make recommendations that can help prevent future child deaths and improve services for children and families.

[6] The prime purpose of a CSPR is for agencies and individuals to learn lessons to improve the way in which they work, both individually and collectively, to safeguard and promote the welfare of children.

[7] Guidance to help standardise and improve the way acute, mental health and community trusts identify, report, review, investigate and learn from deaths, and engage with bereaved families and carers.

3. NATIONAL CHILD MORTALITY DATABASE (NCMD)

The National Child Mortality Database is funded by the NHS. It collects information about every child who dies in England under the age of 18. The purpose is to understand why children die and to learn lessons that can help prevent future deaths. By looking at patterns and risks, NCMD supports changes to care and policies that aim to keep children safe.

All reports and data sent to NCMD are on national forms and are anonymous; no names or personal details are included. The information is only used to learn and improve care, not to identify individual children and families.

NCMD also looks at whether some families face extra risks because of things like ethnicity, poverty, disabilities or where they live. These data can help with health needs assessment and planning of resource allocation to try to ensure the support goes to the families who need it most.

To share what is learned, NCMD publishes reports, safety notices, and toolkits to help professionals improve care and communication with families. It also sends newsletters with updates on national learning, policy changes, safety alerts, and new resources. These updates help everyone involved in child death reviews work together to improve outcomes.

NCMD also runs webinars for professionals involved in child death reviews. These sessions share updates, new research, and resources to support best practice and improve care for children and families.

This year, Hull Child Death Review partners have learned from a range of NCMD thematic reports, webinars and guidance documents with the further details presented in **APPENDIX 2**.

4. CHILD DEATH OVERVIEW PANEL (CDOP)

The Child Death Overview Panel is a multi-agency panel with differing areas of professional expertise; comprising senior professionals from a range of agencies who can provide independent scrutiny and learning. Core membership of Hull's CDOP during the year can be found on **page 9**. Panels meet throughout the year to review child deaths. Panels are not given the names of the children who died, or the professionals involved in their care. The main purpose is to learn any lessons that may prevent similar deaths in the future.

CDOPs do not produce reports on individual child deaths, which is why parents are not invited to review meetings. However, their findings and learning are described in an annual report that is a public document.

The CDOP review ensures independent scrutiny by senior professionals with no named responsibility for the child's care during life. This is an anonymised, secondary review of each death in order to:

- confirm or clarify the cause of death,
- determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths,
- make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children.

Statutory guidance recommends that CDOP reviews take place around six weeks after a Child Death Review Meeting or following an Inquest. While this timeframe supports prompt learning, it can be challenging to achieve in practice. Hull CDOP meets approximately monthly, for a couple of hours, regularly throughout the year. Whilst aiming to balance the need for timely lessons, members are committed to ensuring every review is given the time needed in CDOP for a thorough and compassionate review for each child. Factors such as the preparation required and the number of cases that can be meaningfully discussed in one meeting will often influence whether the suggested timescale can be met.

During 2024/25, Hull CDOP met ten times and eight of these meetings reviewed 16 child deaths, with the year of death presented in **Table 1**.

Table 1: Year of death for child deaths reviewed during 2024/25

Year of death	2020/21	2021/22	2022/23	2023/24	2024/25
Number of deaths reviewed in 2024/25	1	2	2	7	4

At the year-end, Hull CDOP had reviewed 93% (n=354) of child death notifications received since the process commenced, on 1st April 2008.

15 multi-agency child death review meetings and three agency documentary reviews took place during the year. Going into 2025/26 there were 27 child deaths pending final review by CDOP, at various stages of the process:

- 10 deaths were undergoing parallel processes (such as perinatal mortality reviews, coronial inquries or patient safety reviews) and pending conclusion of enquiries and investigations.
- 13 deaths were waiting for child death review meetings to take place (including three from an out of area CDOP); five deaths were within the recommended three-month timeframe and eight were outside of this timeframe.
- 4 child death review meetings were completed and pending CDOP review.

The Child Death Review Executive Group has continued to maintain oversight of the scheduling of Child Death Review Meetings during 2024/25. In acknowledging the challenges, the group has continued to support a revised approach to use virtual meetings and the option to `cluster` similar cases whereby the medical and clinical teams and some designated professionals are the same. This approach has the benefit of richer learning from theme-like meetings and will continue into 2025/26.

5. MEMBERSHIPS AND PANEL MEETINGS

The membership at 31/3/25 can be seen below:

Public Health Consultant	Hull City Council (Chair)
Consultant Paediatrician for Deaths in Childhood	Humber and North Yorkshire ICB, hosted by Humber Health Partnership NHS Trust
Designated Nurse, Safeguarding Children and Young People	Humber and North Yorkshire ICB, Hull Place (Vice chair)
Designated Doctor, Safeguarding Children and Young People	Humber and North Yorkshire ICB, hosted by Humber Health Partnership NHS Trust
Named GP, Safeguarding Children and Young People	Humber and North Yorkshire ICB, Hull Place
Safety & Quality Lead	Humber and North Yorkshire Local Maternity & Neonatal System
Detective Chief Inspector, Safeguarding Governance Unit	Humberside Police
Head of Service (EHASH/Assessment/VEMT/EDT)	Hull Children, Young People & Families Services, Hull City Council
Assistant Coroner	East Riding and Hull Coroner's Service
Bereavement Midwife	Humber Health Partnership NHS Trust
Child Death Review Co-ordinator	Hull City Council

6. HULL CHILD DEATH OVERVIEW PANEL DATA ANALYSIS

This section of the report outlines Hull child deaths that were notified/occurred between 1st April 2024 and 31st March 2025 and those reviewed by our local Panel in the same period. Not all child deaths which occurred in the year they were notified will have their child death review completed in the same year; this is because it may take several months to gather sufficient information to fully review a child's death and some cases are subject to parallel processes which need to conclude prior to a review at CDOP, such as post mortem examinations, health reviews, Inquests and Child Safeguarding Practice Reviews.

NOTIFICATIONS AND MORTALITY RATES

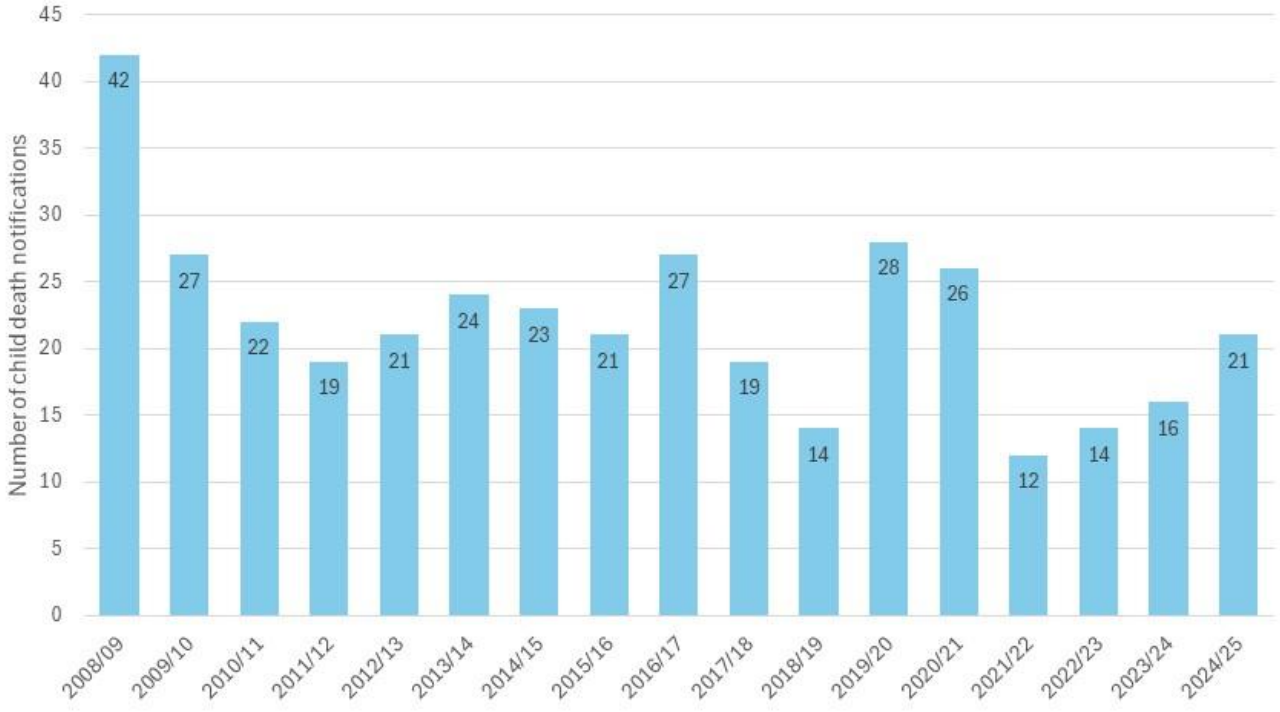
The deaths of 21 children from Hull were notified in 2024/25. This is five more than the number of children in the previous year; there has been a slight increase year on year since 2021/22 (see **Figure 2**). We do expect to see variation in numbers year on year.

The latest five-year average is 18 child deaths per year in Hull (2020/21 – 2024/25), compared with 19 in the previous five-year period (2019/20 – 2023/24).

The Child Death Review Statutory Guidance requires child deaths to be categorised as either 'expected' or 'unexpected'. Seven deaths were unexplained and/or unexpected so met the criteria for a multi-agency professionals' Joint Agency Response meeting. Two additional multi-agency professional meetings were held for children who had complex needs and were receiving extensive multi-agency support.

Four of the 21 deaths were reviewed and completed by CDOP during the year, while the remaining cases will be scheduled for review in 2025/26 and beyond.

Figure 2: Number of child death notifications in Hull from 2008/09 to 2024/25



In 2024/25, the rate of child deaths per 100,000 population was 33.7, compared with a rate of 26.6 in the previous year. Information for 2024/25 is published for England in autumn 2025, so was not available at the time of preparing this report, so comparisons have been made with England data for 2023/24.

For 2023/24, the mortality rate for England was 29.7 deaths per 100,000 population and, whilst the mortality rate is higher in Hull, it is not statistically significantly different from England. The child death rate varied across regions in England, with the rate ranging from 24.2 to 40.7 per 100,000 population of 0-17-year-olds.

The mortality rate in Hull has increased over the last three years from its low of 20.3 deaths per 100,000 population in 2021/22. However, the numbers are small and there is considerable year-on-year variability, and there is no statistically significant difference or trend over the last four years in Hull.

Ages

During 2024/25, the age group proportion in child deaths notified are given in **Table 2**.

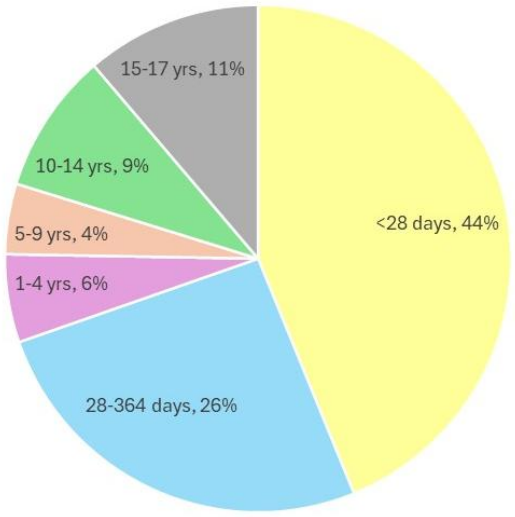
Table 2: Ages of child deaths notified during 2024/25

Age of child	Percentage
Infants under the age of 28 days	57%
28-364 days	14%
1-4 years	10%
5-9 years	5%
10-14 years	10%
15-17 years	5%

Whilst there was an increase in the proportion of infants under 28 days old and a significant decrease in infants aged 1 month-1 year, compared to the 38% for each of these age groups in the previous year, the differences were not statistically significant. The other age groups were of a similar proportion.

Figure 3 shows the distribution of age at death over the past five years, showing that the highest risk occurs during the first year of life. In England, deaths of babies under 1 year of age accounted for 61% of all child deaths in 2023/24.

Figure 3: Ages of the 89 child death notifications in Hull from 2020/21 to 2024/25



Categories of death

There are five categories for cause of death that can be used at the time of death, and these are further refined at CDOP into one of 10 categories defined in the statutory guidance.

The proportion of our child deaths within these broad categories fluctuates slightly year on year, but the proportional trend for 2024/25 is similar to the type of deaths notified over a five-year period as illustrated in **Figure 4**.

Figure 4: Initial categories of death among child death notifications in Hull during years 2020/21 to 2024/25

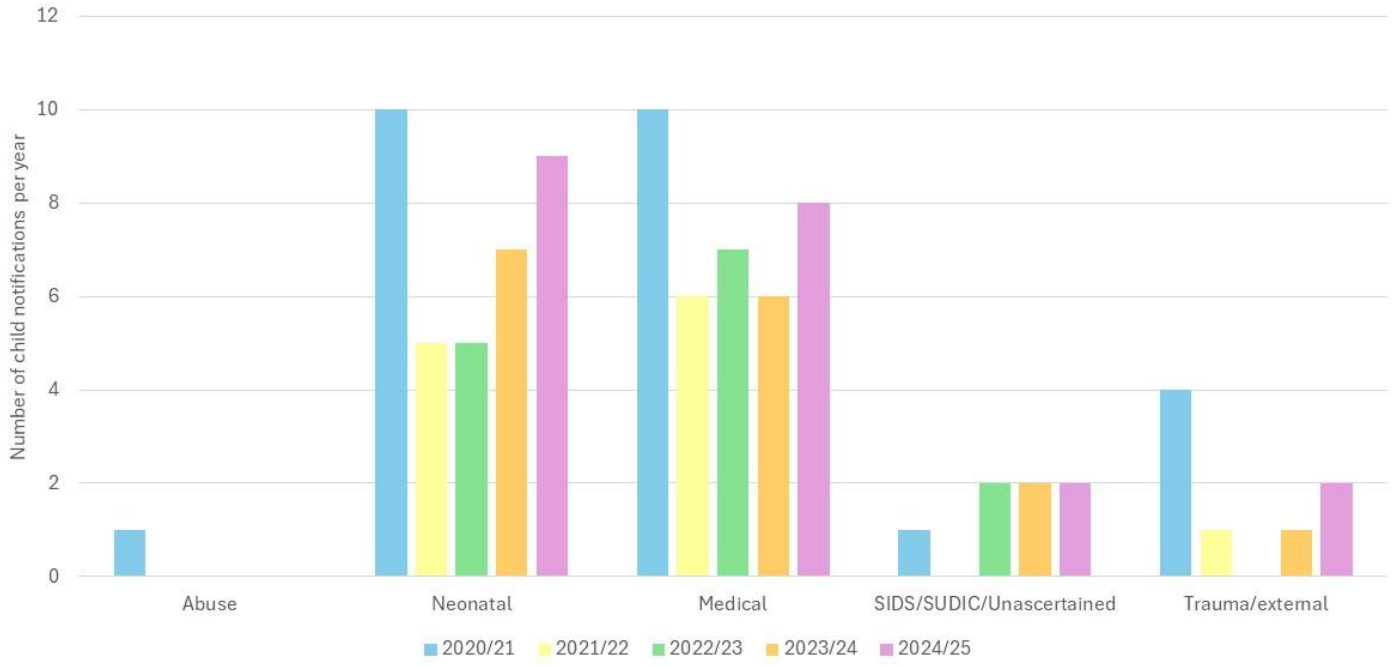
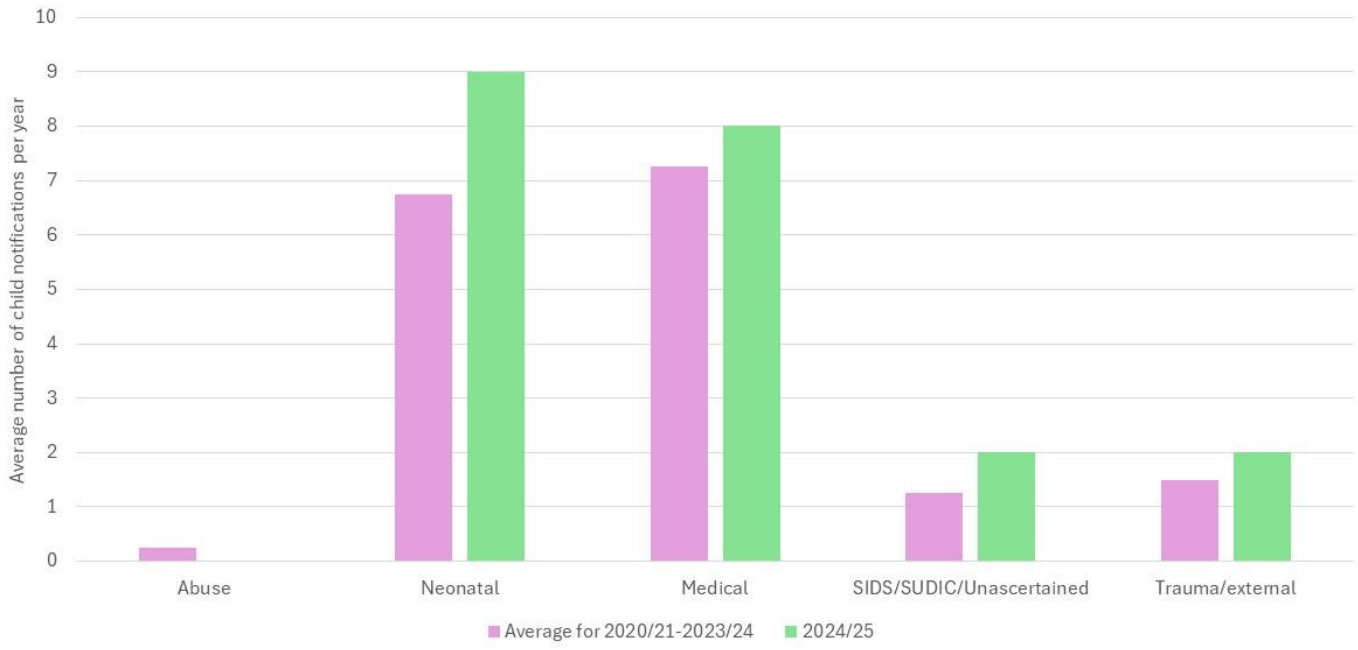


Figure 5 Initial categories of death among child death notifications in Hull for 2024/25 compared to average during 2020/21-2023/24



Expected and Unexpected child deaths

The Child Death Review Statutory Guidance requires child deaths to be categorised as either 'expected' or 'unexpected.

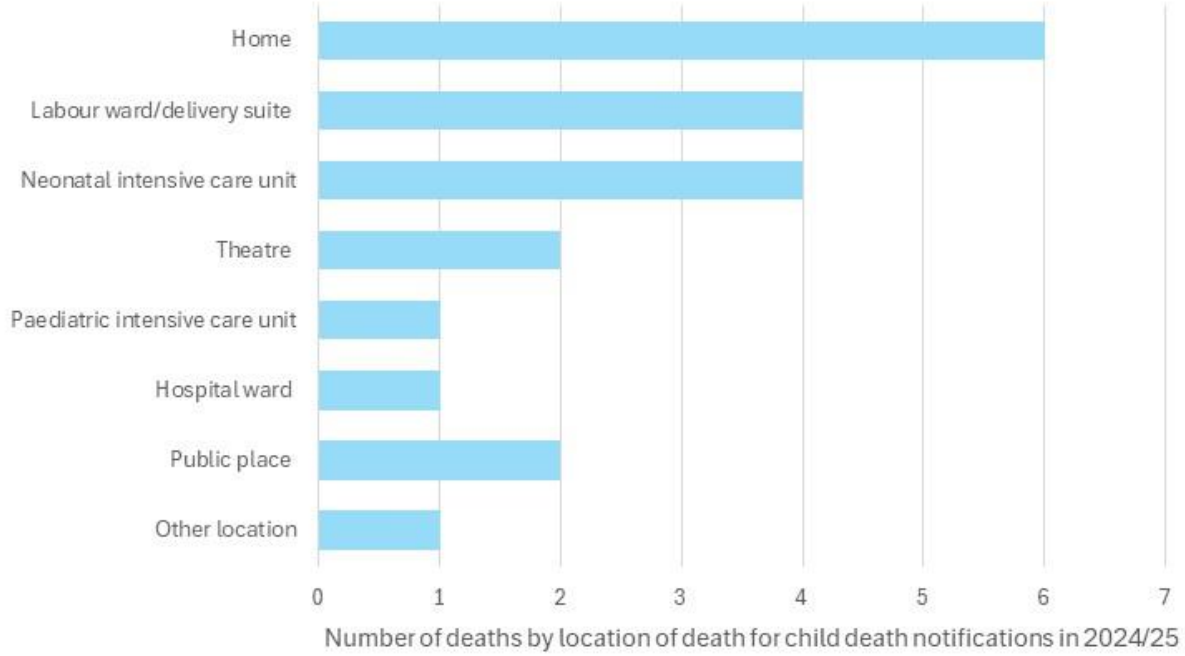
- A child death is an "expected" death where the death of an infant or child was anticipated due to a life limiting condition, including some deaths relating to prematurity and birth complications.
- A child death is an "unexpected" death where the death of an infant or child was not anticipated as a significant possibility, for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which led to the death; these could be due to external causes or complications of a medical illness or intervention.

Seven of the 21 child death notifications in 2024/25 were classified as unexpected and initiated the Joint Agency Response process. Over the past five years, 33% of the 89 Hull child deaths were regarded as unexpected.

Location of death

Of the 21 deaths notified to Hull CDOP in 2024/25, 12 (57%) occurred in hospital, six children died at home and three died in public places or in other locations (**Figure 6**).

Figure 6: Location of death among child death notifications in Hull for 2024/25

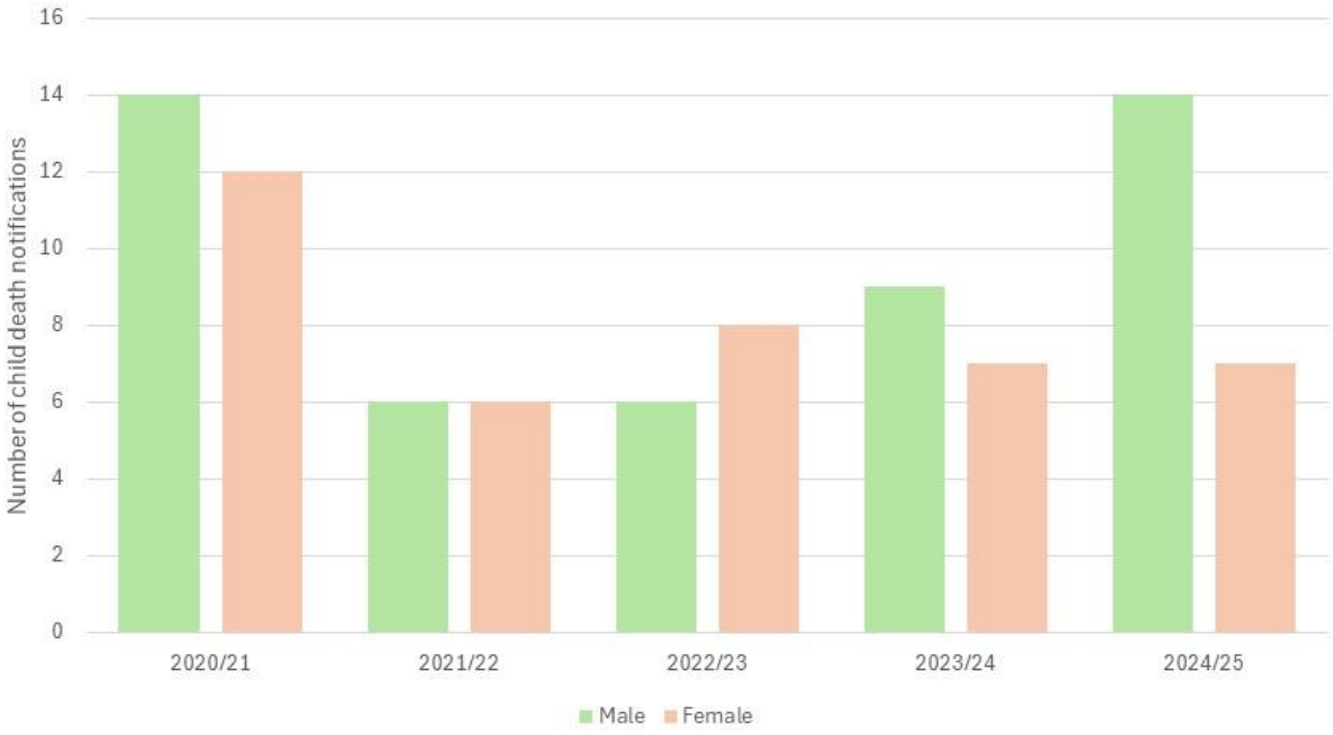


Infant and child deaths by gender

During 2024/25 there were double the number of male child deaths (14) than female (7), compared with the previous year when there was only a slightly higher number of males than females (**Figure 7**). However, there was no statistically significant difference between the proportions of males and females in 2024/25 compared to 2023/24, nor was there any statistically significant difference between 2024/25 and the previous four years combined.

Although Hull had a higher notification rate in 2024/25 among males (male 43.8, female 23.0 mortality rate per 100,000 children), there was no statistically significant difference between males and females due to the small numbers of deaths. The difference in the mortality rates for England between males and females was less marked than Hull (male 33.0, female 25.9 deaths per 100,000 children), but, due to the increased statistical power to detect differences with the larger total number of deaths in England, this difference between males and females was highly statistically significant. Hull's 2024/25 mortality rates were not statistically significantly different from England's 2023/24 mortality rates for either males or females.

Figure 7: Gender of the 89 child death notifications in Hull for 2020/21 to 2024/25



Ethnicity

Of the 21 children whose deaths were notified to Hull CDOP in 2024/25, 13 (62%) were recorded as White British ethnicity and 8 (38%) were from a range of other ethnic backgrounds; a similar proportion to the previous year as illustrated in **Figure 8**. Over the last five years 62% of Hull children who died were White British and 38% were from other ethnic backgrounds (16% White-other, 7% Mixed, 9% Black or Black British, and 7% Asian or Asian British).

Using estimates of the population from the 2021 Census, the mortality rates for Asian or Asian British children were more than twice as high in Hull for 2024/25 than England for 2023/24, and more than three times higher for Black or Black British children. The rates were also higher for Mixed (1.3 times higher) and White (1.2 times higher). Despite these substantial differences, due to the very small number of deaths in Hull, there was no statistically significant difference in the mortality rates per 100,000 children between Hull (in 2024/25) and England (in 2023/24) for Asian or Asian British, Black and Black British, Mixed or White. However, some caution should be used when interpreting the results as there is some evidence that the numbers in the population have increased for some minority ethnic groups since the Census.

However, despite the small numbers, there was a statistically significant difference in the mortality rates among minority ethnic groups in Hull for 2024/25 as illustrated in **Figure 9**.

Figure 8: Minority ethnic group of the 89 child death notifications in Hull for 2020/21 to 2024/25

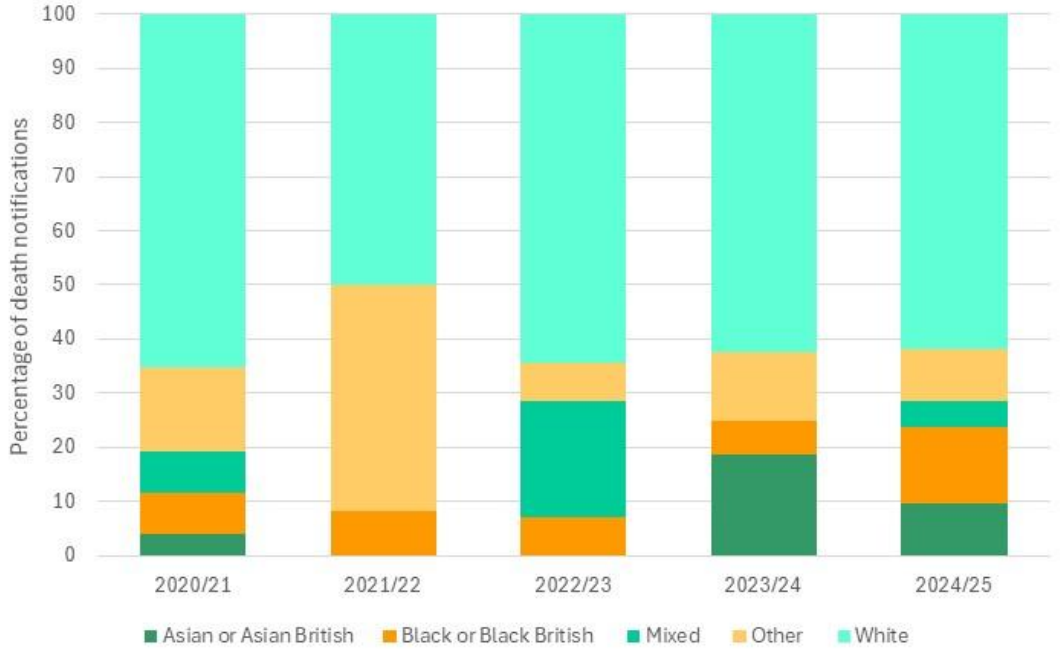
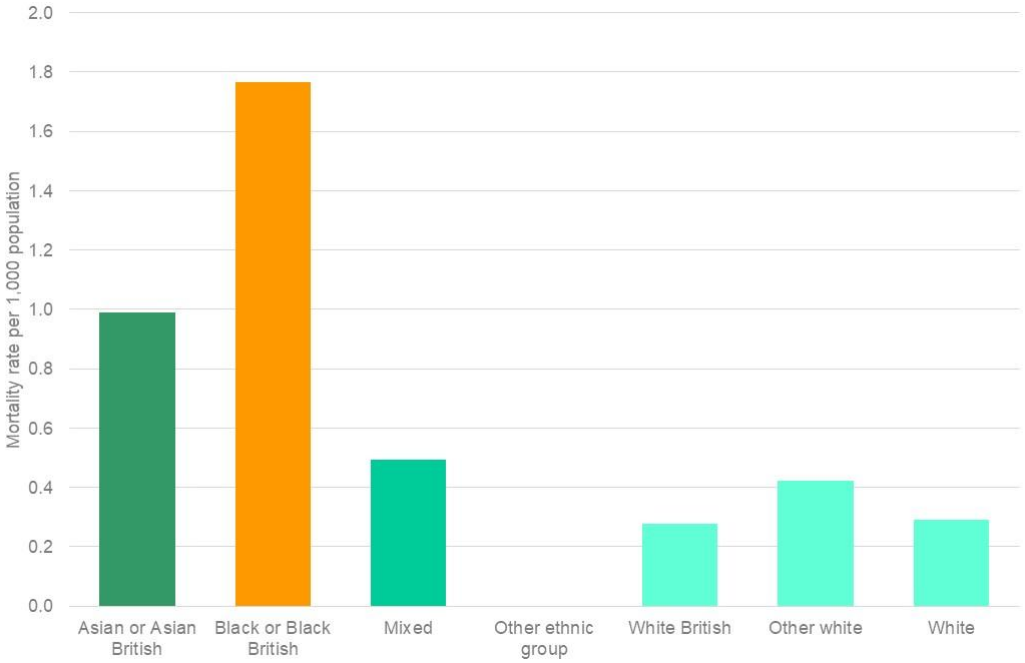


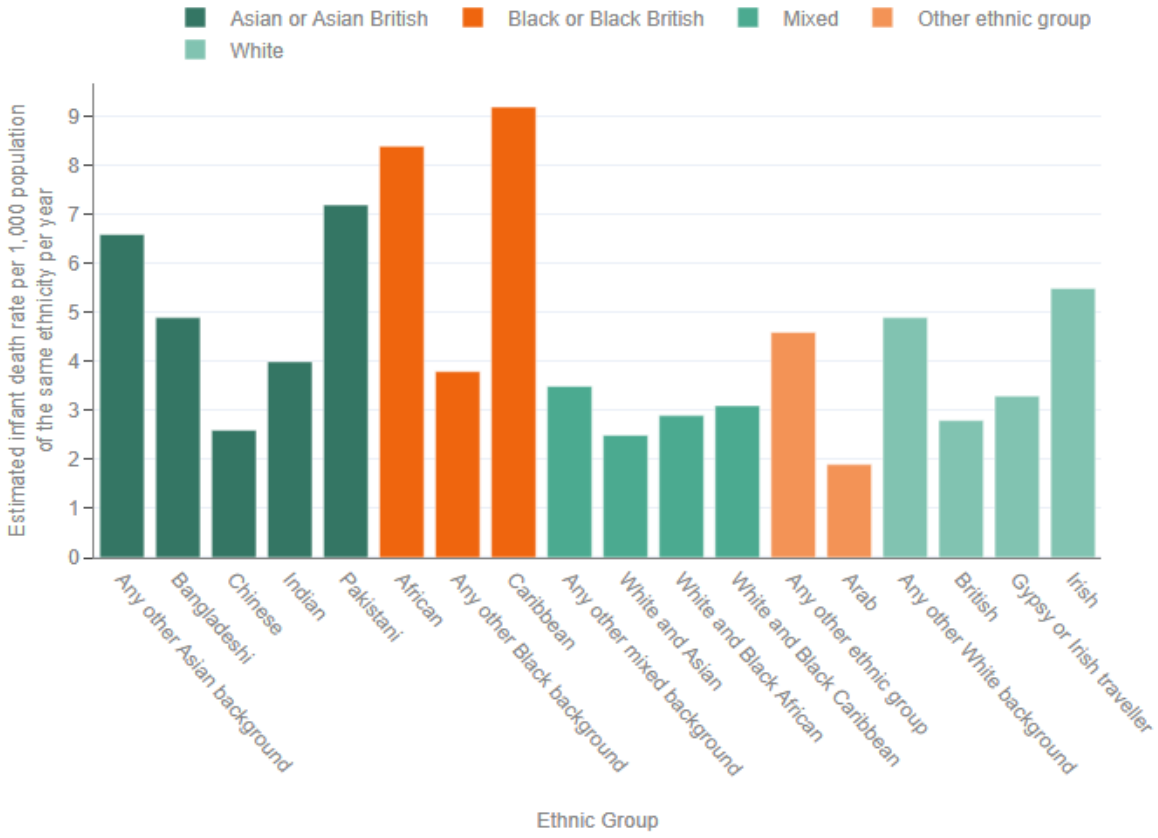
Figure 9: Mortality rates by minority ethnic group of the 89 child death notifications in Hull for 2024/25



For England for 2023/24, the infant mortality rate was highest for Black and Black British infants and Asian and Asian British infants compared to Mixed or White. It is not possible to accurately calculate the infant mortality rate for Hull as the number of live births by separate ethnicity groups is not known. However, using the Census 2021, if births were in proportion to the number of women, infant mortality in Hull would appear much higher for Asian, Black, and Mixed ethnic groups than for White. For Black or Black British infants, the rate looks significantly higher than England, but this result should be treated with caution. It relies on estimated births, and fertility differences or temporary residents (such as students) could affect the figures. If fertility is lower than assumed, the true mortality rate could be even higher.

Nationally, within these ethnicity groupings, over a five-year period, the infant death rate was highest for infants of black Caribbean ethnicity, followed by black African, and Asian – Pakistani as illustrated in **Figure 10**. This was higher than the rate for white British ethnic background.

Figure 10: Estimated mortality rates per 1,000 infant population for England, by ethnicity for 2019/20 to 2023/24



Roma not presented due to small numbers.
Data Source: NCMD, ONS Census (2021)
www.ncmd.info/cdr24/

Children with learning disabilities

In 2024/25 there were no reviews of children with diagnosed learning disabilities.

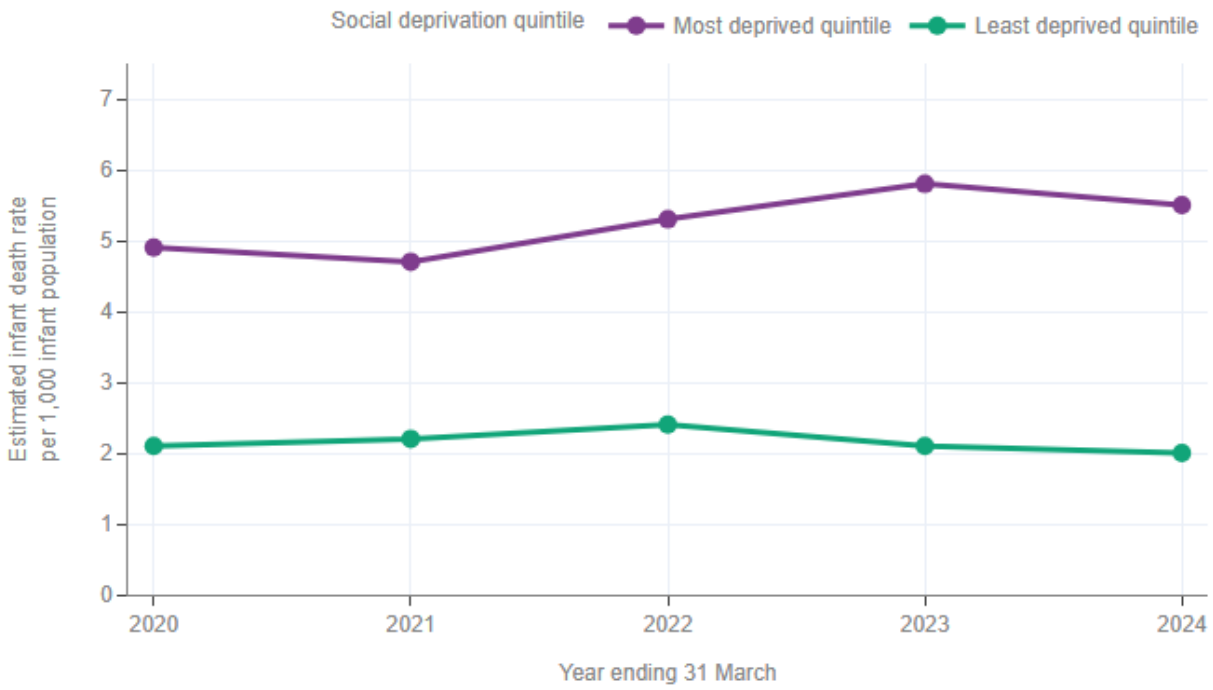
Health inequalities

11 (73%) of the 15 infant deaths in Hull occurred in infants who lived in the most deprived fifths of areas nationally. However, the majority of population of Hull and the majority of live births (62%) are among Hull residents living in the most deprived fifth of areas of England.

Hull's mortality rates across the deprivation fifths are similar to the national pattern. There is no statistically significant difference between the deprivation groups in Hull because the number of deaths of infants and children is too small to be confident in the comparisons. In contrast, England shows a clear and statistically significant trend, with mortality increasing as deprivation increases[8].

In 2023/24 the death rate of infants who were resident in the most deprived neighbourhoods of England (5.5 per 1,000 infant population), remained more than twice that of infants resident in the least deprived neighbourhoods (2.0 per 1,000 infant population) as illustrated in **Figure 11**. Similar to all child deaths, the infant death rates for the most and least deprived areas have decreased compared to the previous year but the difference in rates between these areas remained higher than the prior three years.

Figure 11: Estimated mortality rates per 1,000 infant population for England for children living in the least deprived and most deprived tenth of areas of England for 2019/20 to 2023/24



Data Source: NCMD, ONS mid-year population estimates, Index of Multiple Deprivation (2019)
Please note population for year ending 31 March 2023 is used for year ending 31 March 2024.
www.ncmd.info/cdr24/

[8] https://cpag.org.uk/sites/default/files/2024-11/Child%20mortality%20and%20deprivation%20in%20England.pdf
What is the relationship between deprivation, modifiable factors and childhood deaths: a cohort study using the English National Child MortalityDatabase | BMJ Open

60% of Hull's children and young people live in the most deprived fifth of areas of England so it is not surprising that the majority of the child deaths occur in this group with 16 of the 21 child deaths in Hull in 2024/25 occurring among children living in the most deprived fifth of areas nationally.

Comparison of mortality rates with England and the region

From the Office for Health Improvement & Disparities' Fingertip tool, there is year-on-year variability in the number of deaths and the infant mortality rates in Hull due to the small numbers, although the rate has decreased over the last two decades. Even though the levels of deprivation are much higher in Hull, and there is a strong association between deprivation and infant mortality nationally, the infant mortality rate in Hull has not been statistically significantly different compared to England in the last two decades.

The latest infant mortality rate in Hull is lower than both England and the region as illustrated in **Table 3**. The neonatal and post-neonatal mortality rates in Hull for 2022-24 are both lower than the region, and the neonatal mortality rate in Hull is lower than England. The post neonatal mortality rate in Hull for 2022-24 is only slightly higher than England.

Table 3: Infant mortality rates for 2022-24 in Hull compared to England and the region

Infant mortality measure	Hull			Yorkshire & Humber	England
	Number of deaths	Rate per 1,000 live births	Hull's rank*	Rate per 1,000 live births	Rate per 1,000 live births
Neonatal mortality (<28 days)	26	2.8	10	3.6	3.1
Post-neonatal (28-365 days)	11	1.2	10	1.5	1.1
Infant mortality (<1 year)	37	4.0	8	5.1	4.2

*Rank out of the 15 upper-tier local authorities in the Yorkshire and Humber region (a rank of 1 denotes the highest mortality rate and a rank of 15 denotes the lowest mortality rate)

From the Office for Health Improvement & Disparities' Fingertips tool

Infant mortality rate: There is year-on-year variability in Hull, but the mortality rate has reduced from 5.0 deaths per 1,000 live births to 4.0 deaths per 1,000 live births between 2001-03 and 2022-24.

Nationally, there is a strong association with deprivation, and infants living in the most deprived tenth of areas of England have a mortality rate of 6.4 deaths per 1,000 live births which is more than twice as high as infants living in the least deprived tenth of areas of England (2.8 deaths per 1,000 live births). The infant mortality rates in Hull are lower than expected given Hull's very high levels of deprivation.

Neonatal and post-neonatal deaths: The neonatal mortality rate in Hull has been consistently similar to or lower than England between 2010-12 and 2022-24. Since 2015-17, the post-neonatal mortality rate has been higher in Hull compared to England although only statistically significantly higher for one year (2015-17) due to the small number of post-neonatal deaths. However, the post neonatal mortality rate has been falling from a high of 1.9 post-neonatal deaths per 1,000 live births in 2015-17 to a low of 1.2 post-neonatal deaths per 1,000 live births in 2022-24 (compared to a consistent mortality rate of 1.1 post-neonatal deaths per 1,000 live births for England over the same time period).

Nationally, neonatal and post-neonatal mortality rates were more than twice as high for infants living in the most deprived tenth of areas of England compared to infants living in the least deprived tenth of areas of England. The neonatal mortality rates in Hull are lower than expected given Hull's very high levels of deprivation.

The latest child mortality rate (for ages 1-17 years) per 100,000 population is slightly lower than England for 2022-24 and among the lowest in the region (**Table 4**).

Table 4: Child (aged 1-17 years) mortality rates for 2022-24 in Hull compared to England and the region

Measure	Hull			Yorkshire & Humber	England
	Number of deaths	**Rate per 100,000 population**	**Hull's rank***	**Rate per 100,000 population**	**Rate per 100,000 population**
Child mortality rate (1-17 years)	20	11.5	12*	14.3	11.6

*Rank out of the 14 upper-tier local authorities in the Yorkshire and Humber region with data as the numbers in York are too low (a rank of 1 denotes the highest mortality rate and a rank of 14 denotes the lowest mortality rate). The rank in Hull is equal 12th highest as East Riding of Yorkshire also has a mortality rate of 11.5 deaths per 100,000 population.

Child Mortality rate: For the majority of years in the last two decades, the child mortality rate (deaths among those aged 1-17 years) has been comparable to England with only five years being statistically higher than England (the latest year it was statistically significantly higher was 2014-16). There have been just over 11 deaths per 100,000 population for the last five years in Hull compared to just over 10 deaths per 100,000 population for England for 2018-20 to 2020-22 and over 11 per 100,000 population for England for 2021-23 and 2022-24.

Nationally, there is a strong association with deprivation, and children living in the most deprived tenth of areas of England have a mortality rate of 15.0 deaths per 100,000 population which is more than 60% higher than the mortality rate for children living in the least deprived tenth of areas of England (9.2 deaths per 100,000 population). The child mortality rates in Hull are lower than expected given Hull's very high levels of deprivation.

CHILD DEATH REVIEWS

Total reviews

Between April 2024 and March 2025 Hull Child Death Overview Panel reviewed 16 child deaths, compared to 23 in the previous year. This is slightly fewer reviews for the size of our population than other CDOPs nationally.

The total number of reviews each year has varied since the statutory process commenced in 2008, ranging from 10 to 32. A total of 90 reviews were completed over the last five years. 93% of Hull child deaths notified have been reviewed by Hull CDOP.

Ages

There were 13 reviews of infant deaths (eight neonates/aged under 28 days and five aged 28 - 364 days), two children aged 1-4 years and one review in the 15-17 year age group.

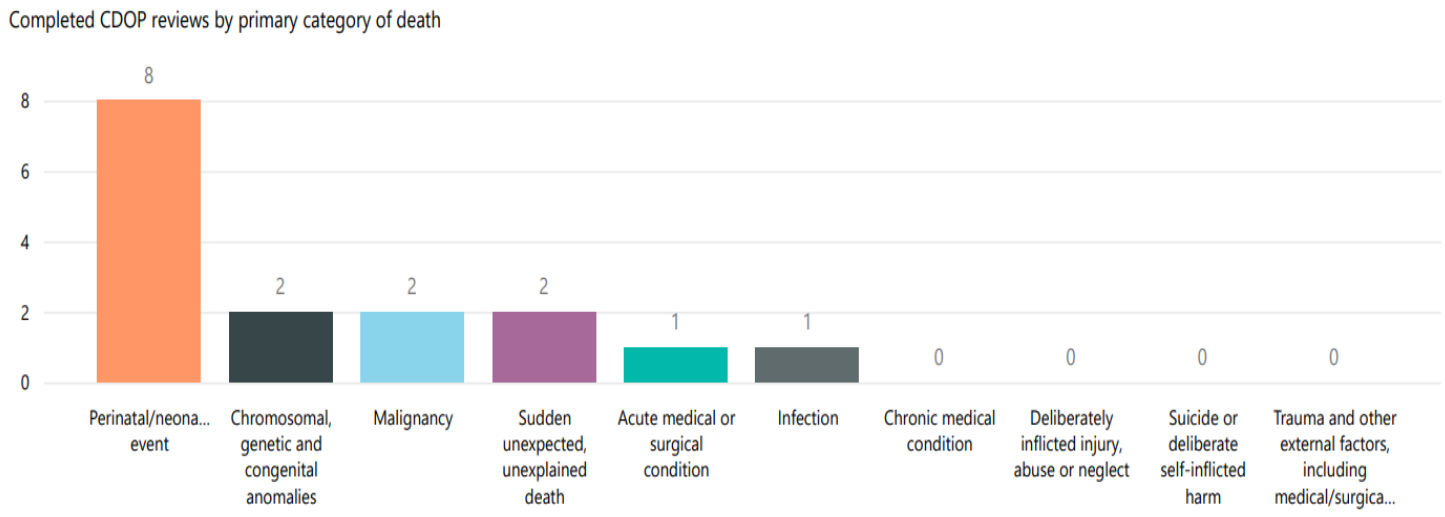
Gender

Ten of the reviews were for males and six of the reviews were for females.

Primary category of death

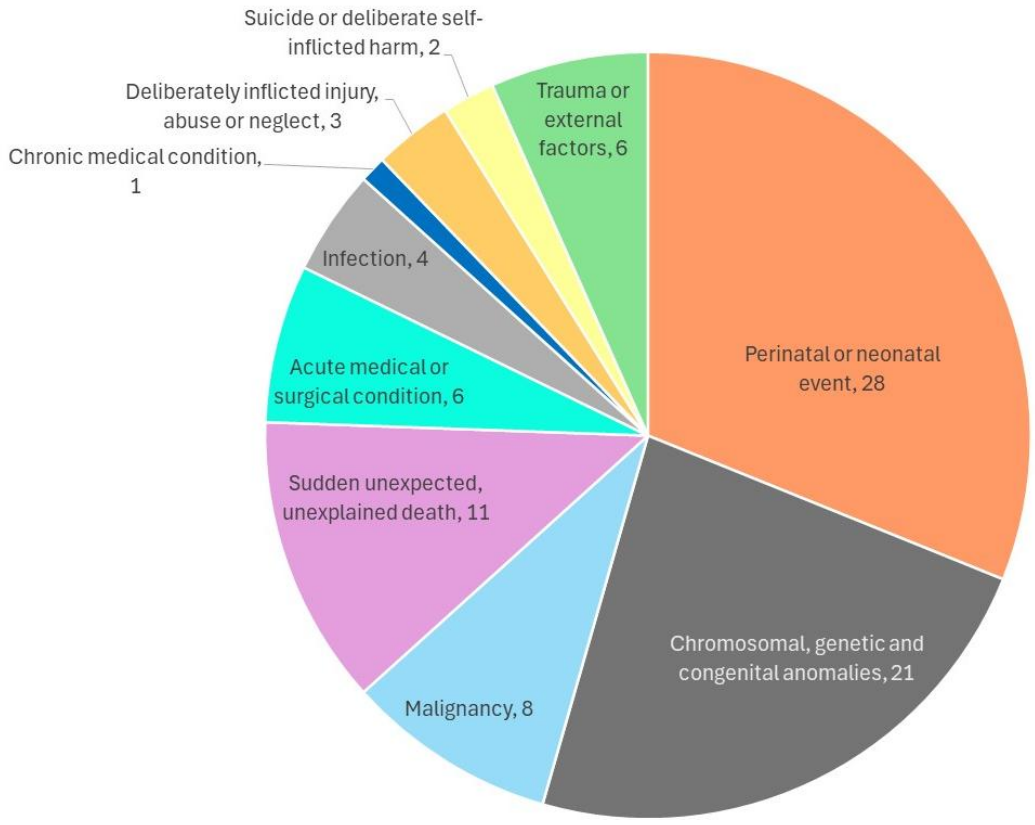
The review of deaths during the CDOP meeting require members to categorise each child death using a pre-determined list, which are recorded locally and reported to the National Child Mortality Database for national analysis. The numbers of deaths falling into each category vary year on year, and there is no clear pattern except that the numbers are highest for perinatal or neonatal events as a cause of death. Among Hull deaths that were reviewed during 2024/25, eight of the 13 reviews had this as a cause of death representing 56% of all reviews as illustrated in **Figure 12**.

Figure 12: Primary category of death for reviews in 2024/25



Over a five year period, the primary causes of death will be more representative of the causes compared to a single year, so the proportions of child deaths by primary cause of death are presented in **Figure 13** for the last five years.

Figure 13: Primary category of death for 90 reviews conducted over the five year period 2020/21 to 2024/25



Of the 90 child deaths that have been reviewed by the Hull Child Death Overview Panel over the past five years, the main categories are:

Perinatal/neonatal event = 31%

Sudden unexpected or unexplained death = 12%

Chromosomal, genetic and congenital abnormalities = 23%

The mortality rates were considerably higher among children from minority ethnic groups particularly for Asian or Asian British and for Black and Black British; despite the small numbers, there is a statistically significant difference.

Health inequalities

Over half of Hull's population live in the most deprived fifth of areas of England. So, it is not surprising that the majority of the reviews in Hull occurred among children living in the most deprived fifth of areas of England.

National comparison

In the last five years, the number of reviews has varied from 12 to 24 in Hull, with a particularly high number of reviews in 2021/22 and in 2023/24. In the 2023/24, this was in part due to catching up with reviews that had been delayed due to capacity challenges. Over the entire five-year period, there have been 90 reviews undertaken which is a little higher than other CDOPs nationally for the size of our population.

There was no statistically significant difference in the review rate per 100,000 population between Hull (2020/21 to 2024/25) and England (2023/24) for any of the ten primary causes of death.

Over the five-year period 2020/21 to 2024/25, the two categories of deaths with the highest percentage of reviews were similar for Hull and England with perinatal and neonatal events accounting for the highest percentage of deaths (31% for both Hull and England), chromosomal and genetic conditions accounting for the second highest percentages (23% for Hull and 24% for England). Sudden unexpected unexplained deaths accounted for the third highest percentages (12% for Hull and 8% for England).

Modifiable factors

Statutory guidance describes modifiable factors as factors in the child, the family, the environment, or in service provision that may have contributed to the child's death and that could be changed through actions (locally and/or nationally) which would reduce the risk of future deaths.

During the review of each death, contributory and modifiable factors are identified and analysed to enable learning and preventative action at a population level. These are based on the information available to us from the child death review(s) – and we are more likely to hear about factors that are routinely recorded in medical notes (such as a mum's smoking status during pregnancy) than we are about less-well documented challenges such as difficulty accessing services. It is important to be clear that when the CDOP identifies a modifiable factor during a review, it does not necessarily mean it was a causal factor in that particular child's death – it may be something that could be altered to help prevent future deaths .

CDOP ensures that any issues, learning points, and recommendations are shared with the appropriate agencies or professionals so they can take action as required. In most cases, this will have already occurred earlier in the child death review process.

Actions identified and recorded by CDOP are tracked through an action log until the panel is satisfied that they have been completed or that suitable governance and monitoring arrangements are in place within the responsible agency.

Of the 16 deaths reviewed in Hull during 2024/25, 14 (88%) identified one or more modifiable factor; this compares with 43% of reviews for England for 2023/24; eleven reviews identified two or more factors. There is some variability among CDOPs around determining modifiable factors, so the Association of Child Death Review Professionals is working with CDOPs on clarifying the guidance to ensure greater consistency in future.

In child death reviews, the analysis typically considers a range of factors grouped into key domains to understand what contributed to the child's death and identify learning for prevention.

13 of the 14 reviews identified with modifiable factors were for infant deaths under the age of one year, which included eight neonatal deaths (under the age of 28 days). Just over half had service or organisational issues that were modifiable, almost one-third had high maternal body mass index as a modifiable factor and almost one-fifth had smoking in pregnancy as a modifiable factor.

Nationally in 2023/24, the most common recorded modifiable factors by CDOPs during reviews of infant deaths were smoking by a parent/carer (27%), high maternal body mass index (BMI) (23%), and smoking in pregnancy (22%). The most common recorded modifiable factors by CDOPs during reviews of deaths of children aged 1 – 17 years were poor communication between agencies (12%), issues with treatment (e.g., delay in starting treatment, side effects or complications developed as a result of treatment, or medical or surgical error) (9%) and lack of appropriate supervision (e.g., young child unsupervised in a bath) (9%).

During the five-year period 2020/21 – 2024/25, of the 90 deaths reviewed in Hull, 62 (69%) had one or more modifiable factors. As a high percentage of child death reviews were completed among infants particularly, those aged under 28 days, a relatively high percentage of modifiable factors were maternal factors relating to pregnancy or household circumstances such as household smoking and unsafe sleeping that were risk factors with a higher impact on infants.

7. CDOP LEARNING AND ACTIONS FROM CHILD DEATHS REVIEWED IN 2024/25

Learning is one of the most critical components of the child death review process. Hull's arrangements ensure that any learning identified is shared locally through multi-agency representatives and regionally and nationally via the eCDOP system to the National Child Mortality Database at every stage of the process. This approach ensures that insights inform both immediate practice improvements and broader system-level change.

The Child Death Overview Panel , as the final stage of the review process, plays a pivotal role in analysing learning from all child deaths to identify common themes, patterns, and strategies that can reduce future risks and drive continuous quality improvement in practice and supporting families. CDOP does not work in isolation; it operates within a network of interconnected multi-agency review processes designed to promote shared learning wherever a child dies. These include the Perinatal Mortality Review Tool (PMRT), Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR), the Patient Safety Incident Response Framework (PSIRF), Child Safeguarding Practice Reviews (CSPR), and Maternity and Newborn Safety Investigations (MNSI) reviews, among others. While each process has its own methodology, they share a common goal: improving systems and care to ensure every family receives the best possible support in the future.

This chapter summarises the key learning identified by Hull CDOP during 2024/25.

Good Practice

Hull CDOP often hears examples of excellent practice and strong multi-agency support provided to children and their families before and after a child's death. We are deeply grateful to bereaved families and professionals who share their experiences with us, helping us understand what worked well and where improvements can be made. Their voices are central to shaping better care for others in the future.

Whenever possible, we ensure that positive feedback is passed on to the teams and individuals involved, recognising their commitment and the difference their care has made during the most difficult of times.

General reflections on learning

The reviews undertaken during 2024/25 reinforce the importance of effective communication, continuity of care, and family-centred support as fundamental components of safe and compassionate practice.

Across several cases, gaps in communication between hospital teams, primary care and families were identified as significant issues, often leading to delays and increased distress for bereaved families.

Feedback from parents highlighted the need for a single point of contact to guide them through complex processes, timely updates, and culturally sensitive bereavement care.

Professionals also acknowledged that mandatory training should better incorporate child death review processes to clarify roles and responsibilities.

Reviews revealed barriers for non-English-speaking families, those with insecure immigration status and communities with limited engagement with health services. Challenges such as the absence of translated materials, reliance on written English and digital-only resources often left families without essential information.

Clinical learning emphasised the need for early recognition of severe infection, robust consent processes for high-risk procedures, and proactive risk management, even when incidents are rare but catastrophic.

Collectively, these insights call for a stronger focus on inclusion; proactive, clear and accessible public health messaging and multi-agency collaboration, alongside improvements in clinical governance and workforce training.

More specific learning

Across the child death review system:

- Continued to address gaps in end-of-life care/palliative care resource and engage with the Humber and North Yorkshire ICB End-of-Life strategy. Work continues to develop sustainable pathways for local palliative care resources and compassionate extubation outside of hospital.
- Focused efforts on improving multi-agency collaboration and communication with Yorkshire Ambulance Service to review attendance policies and explore alternative ways to capture first-on-scene learning.
- NICU processes were strengthened through the introduction of complex-case communication sheets and actions to ensure timely uploading of discharge summaries to electronic records.

- Recurring themes highlighted barriers for migrant and non-English-speaking families. Actions included securing dedicated interpreter access, providing translated bereavement resources, using learning from cases to highlight impact of health inequalities within our local community to all professionals working with children and families.

- Parents influenced key improvements in bereavement support, including safer discharge practices, memory box redesign and integration of lived experience into staff training. Bereavement checklists were updated, and parent feedback now informs child death review training, ensuring compassionate and responsive care.

- Hospital protocols have been updated, including, within antenatal, embedding paired blood sampling in Sudden Unexpected Death in Children (SUDIC) cases, and sepsis pathways have been amended to include broader-spectrum antibiotic considerations.

- Additional measures included reinforcing consistent tailored safer sleep messaging, refining Medical Examiner and Coroner processes for writing death certificates for live births/deaths at home, and re-emphasising the need to use interpreters in complex discussions with families, who first language is not English.

- Public health messaging has been strengthened through collaborating with partners of the local Unintentional Injuries and Safer Sleep Service to share learning from reviews and reinforce key safer sleep and child safety messages. CDOP will continue to reinforce safer sleep and accident prevention key messages and risk factors with partners, using insights from local and national reviews, safety alerts and NCMD thematic reports.

- Enhanced emergency response awareness by continued promotion of the use of the What3Words app during child death review meetings and training sessions to support accurate location reporting in emergencies.

- Improved information pathways through work with multi-agency partners to ensure robust, timely, and efficient information-sharing processes are in place for ensuring timely child notifications are submitted.

Collaborative learning and joint working

Throughout 2024/25, Hull CDOP strengthened multi-agency collaboration to improve the child death review process and deliver system-wide learning:

- Local Maternity and Neonatal System (LMNS) representation was invited to relevant CDOP meetings to strengthen neonatal review processes and align care pathways.
- The Panel are exploring introducing lay members through Maternity and Neonatal Voices Partnerships (MNVP) to ensure family perspectives inform reviews.
- Work began on joint learning events with CDOPs in the ICB area.
- Proposals for a joint annual report across the Humber and North Yorkshire ICB footprint discussed to improve consistency and shared learning.
- Preventive initiatives such as safer sleep, accident prevention and water safety education were delivered through joint working between CDOP, public health teams and safeguarding partnerships.
- NCMD thematic reports and webinars (e.g., asthma, anaphylaxis, infection-related deaths) were cascaded to enable agencies to apply nationally evidenced recommendations, ensuring consistent practice, informed decision-making, and co-ordinated preventive action to reduce avoidable child deaths

8. PARENT & CARER INVOLVEMENT IN CHILD DEATH REVIEWS

CDOP members are deeply grateful to parents and carers who share their experiences with us. Their courage and openness help us learn and make changes that can save children's lives and improve support for families in the future.

While parents and carers do not attend review meetings, their knowledge of their child's life, illness and experiences of care is precious. We offer families information about the review process and invite them to meet face-to-face with the Designated Paediatrician and CDOP Co-ordinator. This meeting is a safe space to ask questions about their child's death and the review process, and to share their experiences—whether positive or negative—of the care and support they received.

By listening with compassion and acting as advocates for parents and carers, we honour their journey through unimaginable loss. Every story shared helps us reflect and improve. Families are offered the opportunity to receive feedback on how CDOP will use this learning as a lasting legacy to their beloved child, ensuring their voice makes a difference for others.

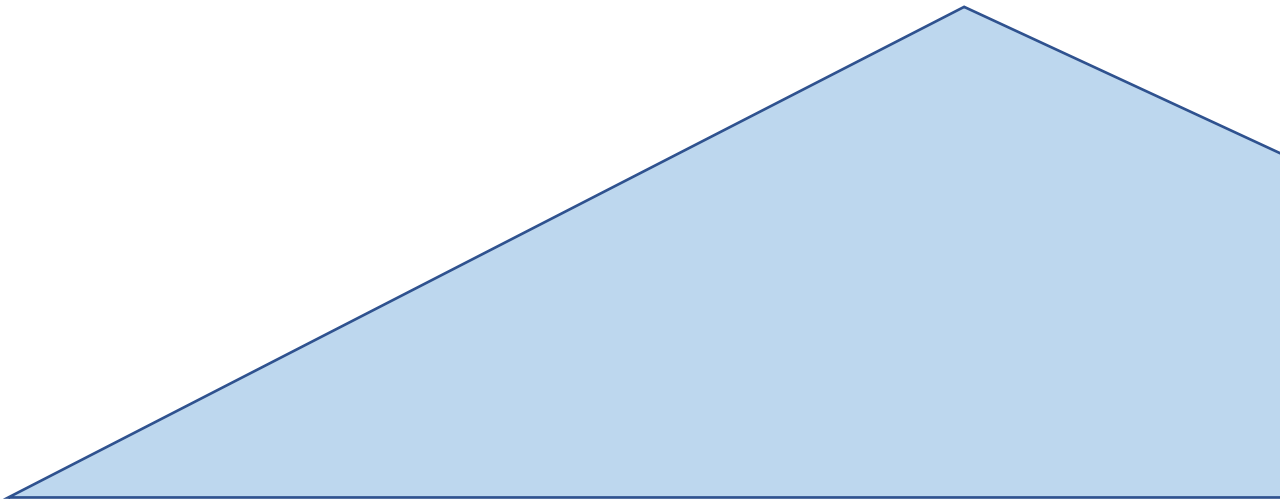
During 2024/25, Hull CDOP actively incorporated parental feedback into service improvements and strategic planning. Parents influenced changes to bereavement care, including the creation of a dedicated room for families at Hull Royal Infirmary, redesign of memory boxes with separate provision of information and improved support for families leaving the hospital environment. Their input reinforced the need for a keyworker role, an expected element of best practice within the statutory guidance to support families through the child death review process, provide regular updates and signpost to appropriate support services.

Parents also highlighted the importance of tailored information for fathers and advocated for a more personalised, trauma-informed approach to communication. These contributions have shaped local training, informed procedural changes and strengthened the commitment to family-centred care across agencies.

9. TRAINING

During 2024/25, three in-person Joint Agency Response training courses for professionals were delivered, with a further four planned for 2025/26. The Designated Paediatrician for Child Death has also provided single-agency training sessions to police officers and hospital doctors.

By 31 March 2025, nearly 800 professionals across the Hull and East Riding area—predominantly from health, police and children's social care—had received training on responding to the unexpected death of a child. This training helps to ensure that each unexpected child death is investigated thoroughly and systematically, in a way that is sensitive to and supportive of parents, carers and professionals.



10. PROGRESS AGAINST LAST YEAR'S RECOMMENDATIONS

In the 2023/24 CDOP annual report we made the following recommendations for action this year:

- A primary focus for CDOP should remain reducing the number of cases waiting for review, whilst seeking to ensure that a quality discussion continues to take place for every child.
    - Unfortunately, there has not been a reduction in the number of cases awaiting a child death review; at the end of last year there were 22 reviews pending and this year there are 27 awaiting a final review. This has been due to a number of factors relating to capacity of the CDOP Co-ordinator to arrange meetings and prepare cases for review, capacity of key professionals to attend Child Death Review Meetings, the increase in notifications during the year and cancellation of two CDOP meetings to review cases. In 2024/25 there were 21 notifications, 18 Child Death Review Meetings and 16 reviews were finalised at CDOP.

- Work with other local CDOPs to develop joint analysis of data, wider sharing of learning, and processes for sharing review outcomes where a child has died outside of their home area.
    - Hull CDOP has taken several steps to work with other local CDOPs on joint analysis, wider learning, and processes for sharing review outcomes when a child dies outside their home area.
        - Hull CDOP to initiate some work on formal agreements and terms of reference with East Riding CDOP to enable joint reviews and oversight of out-of-area deaths.
        - Proposals were discussed for a shared annual report across the Humber and North Yorkshire ICB footprint, aiming to improve consistency and accelerate identification of trends, but, due to capacity, some areas were unable to commit to a formal report but provided some data for comparison analysis.
        - Plans were made to share case learning with East Riding and explore joint thematic reviews to address recurring risks such as safer sleep and antenatal care gaps.
        - Work continues to clarify accountability for cross-area reviews.

- Develop a process for 'real time' CDOP consideration of child death notifications to ensure timely identification of changes to patterns or new and emerging concerns.
    - Exploration of models across the region - work is underway to create one for Hull CDOP members

- Use the forthcoming Association of Child Death Review Professionals quality standards for Child Death Review, including CDOP, to undertake a self assessment across the child death review system, and identify areas for quality improvement.
    - The CDOP section of the self-assessment tool was completed, and gaps and opportunities raised with the Child Death Review Executive group. Wider governance discussions have also taken place.

11. PRIORITIES FOR 2025/26 ONWARDS

At the time of writing this report, NHS England was introducing major reforms to the structure and role of Integrated Care Boards (ICBs) which will influence how they fulfil their statutory duties as Child Death Review partners. While CDOPs retain their legal responsibility to review all child deaths and identify learning, ICBs are required to reduce running costs and transition to a leaner, more strategic commissioning model. As ICB functions are reorganised, this may affect how operational support is provided to Hull CDOP and could impact the ability to progress quality improvements, even though ICB involvement remains mandatory and the local Executive Group continues to be chaired by an ICB colleague.

- Proactively understand the impact of ICB reforms and use its specialist expertise to shape local implementation in Hull, ensuring statutory responsibilities are protected while maximising opportunities and minimising any potential harm.

- Recommend strengthening shared accountability and governance across Child Death Review partners to ensure timely delivery of recommendations arising from child death review learning. This includes promoting and embedding best practice in the keyworker function within local CDR arrangements, ensuring consistent, supportive, and family-centred co-ordination throughout the review process.

- Explore opportunities for CDOP to complete a greater number of reviews, enabling timely learning while upholding high-quality, compassionate scrutiny.

- Create and use a real-time tracker that highlights early themes, trends and learning from notifications and reviews, linked with relevant insight from partners locally, regionally and nationally. This will help CDOP spot issues sooner and act proactively.

- Develop a protocol to strengthen cross-boundary learning by ensuring CDOP captures and applies lessons from reviews of children who die outside the area, as well as those who live outside the area but die in a local hospital.

- Whole Genome Sequencing for unexplained infant and child deaths is now approved as an additional investigation after post-mortem for cases such as SUDI, SUDC and SIDS, helping to improve understanding of why some infants and children die unexpectedly. CDOP will work with the ICB to support sustainable funding so it is available for all local children whose death remains unexplained, by providing local evidence, highlighting inequity and system risk, escalating cases where WGS access is inadequate.

The Child Death Review Executive Group will oversee and provide assurance for the outcomes and priorities set out in the CDOP annual report.

Contact details:
Cathy Eccersley, Child Death Review Co-ordinator
Hull CDOP correspondence address: Anlaby Suite, Hull Royal Infirmary, Anlaby Road, Hull HU2 3JZ
Email: cdop@hullcc.gov.uk

APPENDIX 1

Child death review professionals' meetings

Below is a brief description of the professionals' meetings required within the child death review process:

- **Joint Agency Response meetings (JARs)** are a co-ordinated multi-agency response which is triggered if a child's death:
- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (incl. Sudden and unexpected Death in Infancy/Childhood (SUDI/C);
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural; or
- in the case of a stillbirth where no healthcare professional was in attendance

A JAR should also be triggered if children are brought to hospital near death, are successfully resuscitated, but are expected to die in the following days.

The "Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation (2016)" gives comprehensive advice and expectations of all agencies involved in a Joint Agency Response.

A JAR meeting is held within 72 hours of a child's death; it is an initial information-sharing and planning meeting to consider outstanding investigations, notification of agencies, arrangements for the post mortem examination, plans for a visit to the home or scene of collapse and consider if abuse or neglect is known or suspected (in which case, it may meet the criteria for a child safeguarding practice review). JAR meetings will be attended by professionals involved with the child prior to, at the time of death, and with the family immediately after the death.

Child Death Review Meeting (CDRM) - For every child death, agencies / professionals known to the child/family will be asked to complete Agency Reporting Forms to record their involvement, including medical information and support to the family and contribute to a multi-agency meeting of professionals, where all matters relating to an individual child are discussed by the professionals directly involved in the care of that child during life and those involved in reviewing the death and supporting the bereaved family.

The CDRM focuses on local learning with the aim of:

- reviewing the background history, treatment, and outcomes of investigations, to determine, as far as is possible, the likely cause of death;
- ascertaining contributory and modifiable factors across domains specific to the child, the social and physical environment, and service delivery;
- describing any learning arising from the death and, where appropriate, to identify any actions that should be taken by any of the organisations involved to improve the safety or welfare of children or the child death review process;

- reviewing the support provided to the family and to ensure that the family are provided with:
  - the outcomes of any investigation into their child's death;
  - a plain English explanation of why their child died (accepting that sometimes this is not possible even after investigations have been undertaken) and any learning from the review meeting;
- ensuring that CDOP and, where appropriate, the coroner is informed of the outcomes of any investigation into the child's death; and
- reviewing the support provided to staff involved in the care of the child.

National guidance states that this should take place within three months following the death or receipt of post mortem report /conclusion of police and other investigations, but prior to an Inquest (if applicable). Locally, our timescales have exceeded three months due to a back log in cases created during the pandemic, the capacity of clinicians to contribute to review reports and meetings and administrative support to organise multi-agency reviews for all deaths. Grouping some cases of similar causes has alleviated some resource issues and has brought about rich learning.

All child death notifications and reports are recorded and reported on via a secure web-based software called e-CDOP, which allows the local child death review process to be managed efficiently, with confidential sharing of multi-agency information. e-CDOP is fully compliant to the data processing GDPR standards outlined by the ICO and with Working Together guidance. E-CDOP feeds into the National Child Mortality Database.

APPENDIX 2

NCMD reports, publications and webinars

- NCMD Guidance for CDR Professionals and CDOPs on consanguinity

  The aims are to ensure consistent and culturally competent handling of consanguinity in child death reviews. This includes standardising how factors related to consanguinity are recorded and classified as modifiable or contributory, reducing variation in practice, and improving professionals' awareness of sensitive discussion and documentation. It also seeks to strengthen engagement with diverse communities in a supportive manner and guarantee equitable access to culturally competent genetic services for families at increased genetic risk, enabling informed decision-making.

- NCMD Webinar to introduce the Child Death Review Toolkit

  A resource designed to help families understand and engage with the Child Death Review process. It was co-developed by researchers, bereaved parents, and professionals to ensure sensitive, consistent communication and support.

- NCMD thematic report on "Learning from deaths of children with a learning disability and autistic children aged 4 – 17 :

  An analysis of 818 deaths of children aged 4–17 with learning disabilities and/or autism in England (April 2019–March 2022) revealed stark health inequalities and systemic challenges. These children accounted for 31% of all deaths in this age group, with most having multiple chronic conditions—78% had congenital anomalies and 71% epilepsy—and 92% had five or more comorbidities. Deaths were more common among boys, those from deprived areas, and Asian or Asian British children, with hospital being the most frequent place of death (56%). CDOP reviews identified chromosomal anomalies, chronic medical conditions, and infections as leading causes, while only 21% of deaths had modifiable factors such as missed appointments or delayed interventions. The report calls for improved anticipatory care, reasonable adjustments under the Equality Act, better recognition of diagnostic overshadowing, and enhanced multi-agency collaboration, alongside staff training and digital flags, to reduce preventable deaths and ensure equitable healthcare for this vulnerable population.

- NCMD webinar updating CDOPs on national work relating to suicides among children and young people

  The webinar highlighted the transformation of Children and Young People's Gender Services following the Cass Review, showcasing how CDOP work contributes to safeguarding and system learning. NHS England is moving from a single provider to regional services to deliver holistic care, with two new services launched in April 2024 and more planned over three years. Despite progress, over 6,000 children and young people remain on the waiting list, many with complex mental health and social needs, increasing risks such as self-harm and suicide.

To address this, children and young people's mental health providers are assessing and supporting these young people locally, and a new referral pathway introduced in September 2024 ensures comprehensive secondary care assessments before specialist services. The session also emphasized improvements in NCMD reporting, suicide alert systems, and data-sharing protocols, aiming to strengthen care coordination, reduce preventable deaths, and demonstrate the impact of CDOP reviews in driving safer, more equitable services.

- Webinar: Talking About Lactation – The Importance of Shared Decision Making in Antenatal Anticipatory Care Planning

  The webinar highlighted the growing need for compassionate, informed, and shared decision-making for families facing life-limiting foetal diagnoses, as advances in diagnostic technology increase antenatal identification. Speakers discussed how anticipatory care planning and palliative birth plans can empower families to maintain control and create meaningful memories, while addressing complex choices such as lactation management. Through initiatives like the Memory Milk Gift, professional engagement, clear pathways, resources, and cultural sensitivity, healthcare teams can support parents in navigating grief and parallel planning with a person-centred approach that respects their wishes and values.

- Webinar-Preventing Future Child Deaths Through Shared Learnings

  Practical knowledge from real-world projects that help support families and safeguard children's lives: 'Away from Home' safer sleep project presented by Victoria Newcombe from the Southwest Peninsula CDOP and Water Safety Initiative from the Wakefield CDOP team

- Child death reviews in 2024: Autumn update

  The 2024 child death data for England reported 3,577 deaths, a 4% decrease from the previous year but still above pre-pandemic levels, with infants accounting for 61% of cases and an infant mortality rate of 3.9 per 1,000 live births. Neonatal mortality rose to 2.7 per 1,000, and 80% of neonatal deaths involved premature babies. Persistent inequalities were evident, with higher mortality among children from Black and Asian ethnic backgrounds and deprived areas, alongside regional variations. Of 3,345 CDOP reviews, 43% identified modifiable factors—such as parental smoking, high maternal BMI, and unsafe sleep for infants, and poor inter-agency communication, treatment delays, and lack of supervision for older children.

  The report emphasizes using these insights to inform prevention strategies and improve care, with upcoming thematic reports on asthma, anaphylaxis, life-limiting conditions, and consanguinity reinforcing NCMD's commitment to reducing preventable deaths.

- Thematic report on Child deaths due to Asthma or Anaphylaxis

The NCMD thematic report on child deaths due to asthma and anaphylaxis (April 2019–March 2023) found that most of these deaths were preventable and highlighted significant health inequalities. There were 54 asthma-related deaths, mainly among boys and older children (15–17 years), with rates four times higher in the most deprived areas and elevated among minority ethnic groups. Many children had repeated emergency attendances, poor asthma control, and exposure to air pollution above WHO limits. For anaphylaxis, deaths were often linked to food allergies, delayed recognition, and inadequate emergency response. Common systemic issues included lack of personalised care plans, poor inter-agency communication, and missed opportunities for timely intervention. The report draws out learning and recommendations for service providers and policymakers including calls for urgent improvements in anticipatory care, consistent implementation of allergy and asthma guidelines, better staff training, and multi-agency collaboration to reduce preventable deaths and address persistent inequalities.

- Training Webinar: Completing An Asthma Review

The Clinical Lead for children and young people's Asthma Transformation shared key information on completing Asthma reviews. The National Child Mortality Database looked at child deaths caused by asthma and anaphylaxis. Over four years, 54 children died from asthma – about one child every month. Most collapsed suddenly in the community, leading to an emergency response. The review explored many factors, like hospital visits, prescriptions, smoking or vaping history, and whether children were followed up by their GP after hospital care.

Child Death Overview Panels (CDOPs) face problems collecting the right information. Forms were often incomplete because it was hard to find the right person to answer questions, and older cases did nothave the right forms in the system. Important details, like ambulance and emergency call records, were often missing. This makes it difficult to understand what happened before the child reached hospital.

Advice for an effective review included: (1) Gather Complete Information - Start by collecting all relevant details about the child's care and circumstances. This includes hospital visits, prescriptions, smoking or vaping history, and whether the child had GP follow-up after hospital discharge. Try to get pre-hospital data like 999 call logs and ambulance notes, as these show what happened before the child reached hospital. Use the asthma and anaphylaxis supplementary form, but check if extra questions are needed for a full picture. (2) Work Together and Fill Gaps - Identify the right professionals who can provide accurate answers and make it easy for them to share information. If forms are incomplete or missing, follow up quickly. For older cases, check if the form was visible in the system and add missing details. Aim for a clear timeline of events and contributing factors. This helps CDOPs understand what went wrong and what can prevent future deaths.

- NCMD Webinar 6/2/25 – Safer Sleep Update

  Dr Anna Pease, a research fellow working on the Baby Sleep Project being piloted, shared the latest insights and best practices for promoting safer infant sleep and advised of a professionals' toolkit due to be published at the end of the year.

  Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Death in Infancy (SUDI) are rare but serious risks for babies. Research shows that most deaths happen in the first two months and are linked to things like low birth weight, smoking, and unsafe sleep environments. Key advice to keep babies safe include: always put your baby on their back to sleep, keep their sleep space clear, use a firm flat mattress, avoid smoking, and keep the baby in your room for the first six months. Never sleep with your baby on a sofa or armchair, and avoid bed-sharing if you smoke, drink, or your baby was premature.

  Families often report being aware of best practice or advice given, but that other factors can sometimes impact their ability to implement the advice consistently, e.g. tiredness, routines, or wanting to comfort their tired and/or poorly baby. The Baby Sleep Project focuses on practical support and honest conversations. Start by acknowledging what parents are doing well, explain risks clearly, and offer simple steps to make sleep safer. Plans should fit each family's routine and include reassurance. New resources and training for health professionals aim to make safer sleep advice easier to follow and more effective.