Cumbria Safeguarding Children Partnership

# Child Death Overview Panel Annual Report

1st April 2024 – 31st March 2025

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## Foreword

As the newly appointed Chair of the Cumbria Child Death Overview Panel (CDOP), I have the honour of presenting this annual report. I succeeded Carol Stewart in September 2024, and I want to express my deepest gratitude to Carol for her exceptional leadership and dedication. Her efforts have ensured that the Cumbria CDOP has maintained rigorous oversight of the child death review process for our statutory partners.

Chairing a CDOP is a privilege and challenge. The death of a child is a profoundly tragic and traumatic event that impacts families, friends, and communities. It is an honour to be involved in ensuring that we learn from tragic deaths and aim to prevent deaths in the future.

The CDOP comprises a diverse range of agencies and professionals, including Doctors and safeguarding leads from the integrated care boards and local hospitals, public health, social care and education representatives from the Local Authorities, and police colleagues. Together, panel members meticulously examine the circumstances of each child death and I continue to be humbled by the expertise and compassion that is shared by Panel colleagues. Underpinning all members is a determination to prevent future deaths and ensure that all children and families receive the best care and support available.

This annual report reflects on the child deaths reviewed by the panel in 2024-25, highlighting our achievements, challenges, and priorities for 2025-26. Our multi-agency working group has been established and is collaboratively advancing key areas of learning and development but there is always more to do. This year, we will continue to work collaboratively to raise awareness of the child death review process, exploring options for the footprint of CDOP, whilst working with system partners to respond to the modifiable factors identified in this report.

I am consistently impressed by the dedication of our panel members, who often confront the most tragic and distressing circumstances. I extend my heartfelt thanks to them for ensuring the continued effective and efficient review of child deaths throughout the year. This achievement would not have been possible without the behind-the-scenes work of our CDOP administrator, who ensures the smooth operation of our panels.

It has been a privilege to work with such a committed panel of multi-agency partners, all dedicated to reducing the risk of child deaths.

**Vicky Hepworth-Putt**
**Chair of Child Death Overview Panel**

## Contents

## Introduction

The death of a child is a devastating loss that profoundly affects all those involved. Since April 2008 all deaths of children up to the age of 18 years, excluding still births and planned terminations should be reviewed by a Child Death Overview Panel (CDOP) determine whether there is anything that can be learned that might help prevent future deaths. From 1st April 2019 notifications of still births and planned terminations where a clinician is not present have been notified and reviewed by the CDOP.

The publication of the Child Death Review Statutory and Operational Guidance in 2018 builds on the requirements set out in Chapter 5 of Working Together to Safeguard Children 2018, now updated in Chapter 6 of Working Together to Safeguard Children 2023. This document details how individual professionals and organisations across all sectors involved in the Child Death Review should contribute to guided standardised practice nationally and enable thematic learning to prevent future child deaths.

Child Death Review partners, the Local Authorities and Integrated Care Boards (ICB) for Cumbria now hold responsibility for the delivery of the Child Death Review Process as set out in the Children Act 2004, as amended by the Children and Social Work Act 2017. The CDOP is multiagency with differing areas of professional expertise. This process is undertaken locally for all children who are normally resident in Cumbria.

The collation and sharing of all learning from Child Death Reviews and the CDOP is managed by the National Child Mortality Database (NCMD) which has been operational since 1st April 2019. The NCMD is an NHS funded project, delivered by the University of Bristol, that gathers information on all children who die across England with the aim to learn lessons that could lead to changes to improve and save children's lives in the future.

The purpose of the Child Death Review Process is to try to ascertain why children die and put in place interventions to protect other children and prevent future deaths wherever possible. The process intends to:

- Document, analyse and review information in relation to each child that dies in order to confirm the cause of death, determine any contributing factors and to identify learning arising from the process that may prevent future child deaths
- To make recommendations to all relevant organisations where actions have been identified which may prevent future deaths or promote the health, safety and wellbeing of children
- To produce an annual report on local patterns and trends in child death, any lessons learnt and actions taken, and the effectiveness of the wider Child Death Review Process
- To contribute to local, regional and national initiatives to improve learning from Child Death Reviews

## Child Death Review (CDR) Process

A Joint Agency Response (JAR) will be triggered in full for all child deaths that are sudden or unexpected. An unexpected death is a term used for the death of an infant or child whose death was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death. Within this process the lead agency will be either the Police or the Safeguarding Team at the Trust involved in the care of the child, who will inform the Child Death Review

Officer, who then ensures a meeting takes place within 72 hours of the child's death. The aim of the JAR is to enable the sharing of information, multi-agency discussions and planning to safeguard other individuals if identified.

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 will hold 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.

Following notification being received by Child Death Review Officer, each agency that was involved in the care of the child prior to their death must complete a 'Reporting Form'. This form captures all the relevant information about the child and family to inform the CDOP process when considering modifiable factors. In addition to the reporting form there are a number of supplementary forms that the Child Death Review Officer uses to collect information from the relevant professionals. This information is also shared with the National Child Mortality Database (NCMD) and collated for review by the CDOP.

The process for expected deaths: the death of an infant or child which was anticipated following on from a period of illness that has been identified as terminal differs slightly as they do not usually require a JAR.

Supporting and engaging with a family who have lost a child is of the utmost importance throughout the whole child death review process. Recognising the complexities of the process and the differing emotional responses that bereavement can bring, families are given a single named point of contact, called a 'key worker'. Regardless of the professional background this person should -

- Be a reliable and readily accessible point of contact for the family after the death;
- Help co-ordinate meetings between the family and professionals as required;
- Be able to provide information on the child death review process and the course of any investigations pertaining to the child;
- Liaise as required with the Coroner's Officer and Police Family Liaison Officer;
- Represent the 'voice' of the parents at professional meetings, ensure that their questions are effective addressed and to provide feedback to the family afterwards;
- Signpost to expert bereavement support if required.

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 that child during their life. A CDR meeting can take many forms such as a Local Case Discussion, Perinatal Mortality Meeting, an NHS Serious Incident Investigation or a Hospital Morbidity and Mortality Meeting and typically, this meeting happens three months or more following the death of a child.

The purpose of the CDR Meeting is to discuss and review the background history, treatment and outcomes of investigations to determine, as far as possible, the likely cause of death; to ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment and service delivery; to describe any learning arising from the death and, where appropriate, to identify actions that should be taken by an organisation involved to improve the safety or welfare of children or the child death review process and to review 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. The analysis form is drafted within the meeting which is then presented to the CDOP.

## Child Death Overview Panel

CDR Partners have a legal responsibility to ensure that the deaths of children normally resident in their area are reviewed. This function is carried out by the Child Death Overview Panel (CDOP) to ensure that a review is undertaken for all infant/child deaths age 0-17 years, excluding babies who are stillborn, late foetal loss and planned terminations of pregnancy carried out within the law.

In reviewing the death of each child, the CDOP considers relevant factors and modifiable factors in the family environment, parenting capacity and service provision. The CDOP identifies what action could be taken locally, regionally or at a national level with the aim of preventing child deaths and to improve the health and safety of children and young people.

The purpose of the Child Death Overview Panel is to consider any learning or factors that could prevent future deaths of children. A Panel should cover a population such that it typically reviews at least 60 deaths per year. Over the past five years, Cumbria CDOP has reviewed an average of 20 tragic deaths per year. To meet recommendations, it will be necessary for Cumbria CDOP to consider options to alter its footprint, potentially through combining with other panels.

Following the completion of the CDR process and once the cause of the child's death has been determined for both expected and unexpected child deaths, the information relating to the case is anonymised apart from the first name, which is to keep the focus on the child and is taken to the CDOP for discussion and review.

The functions of the CDOP are:

- to collect and collate information about each child death, seeking relevant information from professionals;
- to analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;
- to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and well-being of children;
- to notify the Child Safeguarding Practice Review Panel (CSPR) and Local Safeguarding Partnership (LSP) when it suspects that a child may have been abused or neglected;
- to notify the Medical Examiner and the Doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;
- to provide specified data to the National Child Mortality Database (NCMD); to produce an annual report for child death review partners on local patterns and trends in child deaths, any lessons learnt, and actions taken, and the effectiveness of the wider child death review process; and
- to contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

## The eCDOP system in Cumbria

The eCDOP system is being used across England and feeds into the National Child Mortality database. The eCDOP Database management with Quality Education Systems continues to be used for meaningful data collection, consolidation, and analysis of data from panel reviews.

The eCDOP system provides an online procedural structure for notifications, reporting and meeting protocol for Cumbria and supports coordination of interaction between the two parts of a child death review as required under the new working arrangements for Child Death Overview Panels.

## Membership and Panel Meetings

The Child Death Overview Panel meetings are held on a bi-monthly basis and have had consistent organisational commitment since they were established in 2008. Membership for April 2024-March 2025 can be seen below:-

| Title | Organisation |
|---|---|
| Consultant in Public Health (Chair) | Westmorland & Furness Council |
| Designated Doctor for Safeguarding (Vice-Chair) | North East & North Cumbria ICB |
| Designated Nurse for Safeguarding Children and Looked After Children | Lancashire & South Cumbria ICB |
| Consultant in Public Health | Public Health, Cumberland Council |
| Lead Midwife, Safeguarding | North Cumbria Integrated Care |
| Consultant Paediatrician for Child Death | North East & North Cumbria ICB |
| Consultant Paediatrician | North Cumbria Integrated Care |
| Designated Doctor | Lancashire & South Cumbria ICB |
| Detective Superintendent | Cumbria Constabulary |
| Service Manager, Children's Services | Cumberland Council |
| Senior Manager, Children's Services | Westmorland & Furness Council |
| Safeguarding Practitioner | North West Ambulance Service |
| Named Midwife for Safeguarding | University Hospitals of Morecambe Bay Trust |
| Named Nurse for Safeguarding | University Hospitals of Morecambe Bay Trust |
| Education Representatives | Cumberland Council and Westmorland & Furness Council |
| CSCP Partnership & Improvement Manager | Cumbria Safeguarding Children Partnership |
| CSCP Child Death Review Co-ordinator | Cumbria Safeguarding Children Partnership |

## Data Analysis

This section of the report provides a summary of infant and child mortality in Cumbria based on national and local figures.

### Infant mortality rate in Cumbria.

This data is presented for Cumberland and Westmorland Councils. Infant mortality is defined as deaths under one year of age, with the rate calculated per 1,000 live births during the same year.

Figure 1 shows the crude infant mortality rate (per 1,000) for 2021/23. The chart uses pooled data to provide a more accurate dataset and illustrates that both Cumberland and Westmorland and Furness have a rate that is below the national and regional averages (North East and North West). Cumberland is statistically similar to the England average and Westmorland and Furness is significantly lower.

Chart 1. Infant mortality (crude rate per 1,000) by locality, 2021/23.


The trend in infant mortality has been decreasing both nationally and locally, although there is more variation in the local data due to the smaller number of deaths. Nationally, there has been a downward trend from 2001/03 – 2013/15 and the rate has been stable from 2013/15 – 202/21. There was an in increase in 2021/23 and future years will demonstrate whether the trend is changing.

Figure 2 illustrates the trend for Cumberland compared to the national average. It shows that the infant mortality crude rate for Cumberland has decreased from 4.1 per 1,000 to 3.1 per 1,000 in 2021/23. During this time, the highest mortality rate was 5.0 per 1,000 in 2003/05 and the lowest was 2.7 per 1,000 in 2009/11. This was significantly lower than the national average.

Figure 2. Chart to illustrate the trend in infant mortality (crude per 1,000) for Cumberland compared to England, 2001/03 – 2021/23.

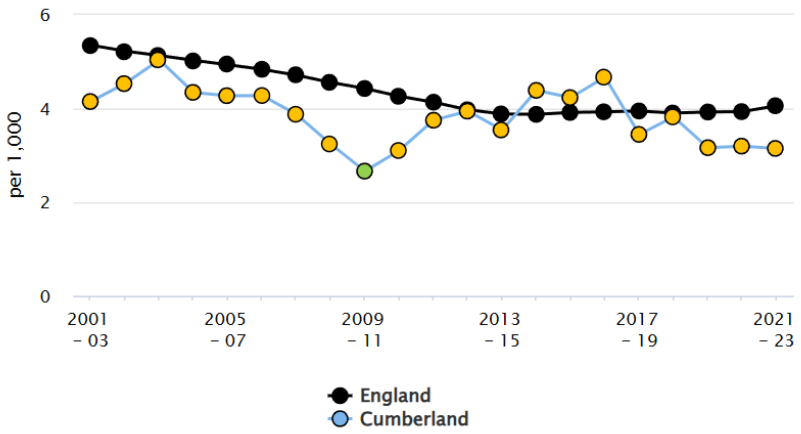



Figure 3 shows the number of deaths and the comparison to the regional average in addition to the rate and comparison to England. The North West infant mortality rate was consistently higher for the time period displayed.

Figure 3. Table to compare Cumberland to England and the North West, number and crude rate per 1,000, 2001/03 – 2021/23.

| | Cumberland | | | | | | |
|---|---|---|---|---|---|---|---|
| Period | | Count | Value | 95% Lower CI | 95% Upper CI | North West | England |
| 2001 - 03 | | 32 | 4.1 | 2.8 | 5.9 | 5.7 | 5.4 |
| 2002 - 04 | | 36 | 4.5 | 3.2 | 6.3 | 5.6 | 5.2 |
| 2003 - 05 | | 41 | 5.0 | 3.6 | 6.8 | 5.7 | 5.1 |
| 2004 - 06 | | 36 | 4.3 | 3.0 | 6.0 | 5.6 | 5.0 |
| 2005 - 07 | | 36 | 4.3 | 3.0 | 5.9 | 5.5 | 4.9 |
| 2006 - 08 | | 37 | 4.3 | 3.0 | 5.9 | 5.3 | 4.8 |
| 2007 - 09 | | 34 | 3.9 | 2.7 | 5.4 | 5.0 | 4.7 |
| 2008 - 10 | | 29 | 3.2 | 2.2 | 4.7 | 4.9 | 4.6 |
| 2009 - 11 | | 24 | 2.7 | 1.7 | 4.0 | 4.7 | 4.4 |
| 2010 - 12 | | 28 | 3.1 | 2.1 | 4.5 | 4.6 | 4.3 |
| 2011 - 13 | | 33 | 3.8 | 2.6 | 5.3 | 4.4 | 4.1 |
| 2012 - 14 | | 34 | 3.9 | 2.7 | 5.5 | 4.3 | 4.0 |
| 2013 - 15 | | 30 | 3.5 | 2.4 | 5.1 | 4.2 | 3.9 |
| 2014 - 16 | | 37 | 4.4 | 3.1 | 6.0 | 4.5 | 3.9 |
| 2015 - 17 | | 35 | 4.2 | 2.9 | 5.9 | 4.6 | 3.9 |
| 2016 - 18 | | 37 | 4.7 | 3.3 | 6.4 | 4.6 | 3.9 |
| 2017 - 19 | | 26 | 3.4 | 2.3 | 5.1 | 4.5 | 3.9 |
| 2018 - 20 | | 28 | 3.8 | 2.5 | 5.5 | 4.3 | 3.9 |
| 2019 - 21 | | 23 | 3.2 | 2.0 | 4.7 | 4.4 | 3.9 |
| 2020 - 22 | | 23 | 3.2 | 2.0 | 4.8 | 4.4 | 3.9 |
| 2021 - 23 | | 22 | 3.1 | 2.0 | 4.8 | 4.6 | 4.1 |

Figure 4 below illustrates the trend in infant mortality for Westmorland and Furness. This shows that the infant mortality rate for Westmorland and Furness has decreased from 4.1 per 1,000 in 2001/03 to 2.2 per 1,000 in 2021/23. During this time, the highest mortality rate was 5.2 per 1,000 on 2006/08 and the lowest was 1.9 per 1,000 in 2015/17. In 2015/17 and 2021/23, the rate was significantly lower than the national average. As is explained below, some of these rates need to be treated with caution due to the small number of deaths.

Figure 4. Chart to illustrate the trend in infant mortality (crude per 1,000) for Westmorland and Furness compared to England, 2001/03 – 2021/23.

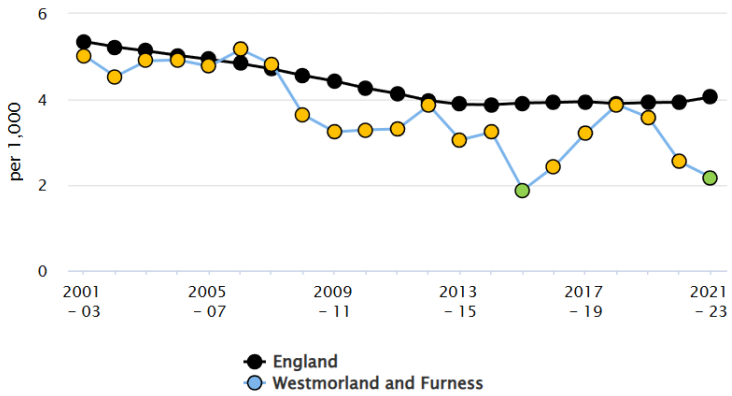



Figure 5 shows the number of deaths in Westmorland and Furness, and the comparison to the regional average in addition to the rate and comparison to England. The North West infant mortality rate was consistently higher for the time period displayed. The * in the table highlight data that should be treated with caution, as rates calculated from between 3 and 19 deaths are less reliable due to the small number of deaths.

Figure 5. Table to compare Cumberland to England and the North West, number and crude rate per 1,000, 2001/03 – 2021/23.

| Period | | Westmorland and Furness | | | | North West | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | 95% Lower CI | 95% Upper CI | | |
| 2001 - 03 | | 31 | 5.0 | 3.4 | 7.1 | 5.7 | 5.4 |
| 2002 - 04 | | 28 | 4.5 | 3.0 | 6.6 | 5.6 | 5.2 |
| 2003 - 05 | | 31 | 4.9 | 3.3 | 7.0 | 5.7 | 5.1 |
| 2004 - 06 | | 31 | 4.9 | 3.3 | 7.0 | 5.6 | 5.0 |
| 2005 - 07 | | 30 | 4.8 | 3.2 | 6.8 | 5.5 | 4.9 |
| 2006 - 08 | | 33 | 5.2 | 3.6 | 7.3 | 5.3 | 4.8 |
| 2007 - 09 | | 31 | 4.8 | 3.3 | 6.8 | 5.0 | 4.7 |
| 2008 - 10 | | 23 | 3.6 | 2.3 | 5.5 | 4.9 | 4.6 |
| 2009 - 11 | | 20 | 3.2 | 2.0 | 5.0 | 4.7 | 4.4 |
| 2010 - 12 | | 20 | 3.3 | 2.0 | 5.1 | 4.6 | 4.3 |
| 2011 - 13 | | 20 | 3.3 | 2.0 | 5.1 | 4.4 | 4.1 |
| 2012 - 14 | | 23 | 3.9 | 2.4 | 5.8 | 4.3 | 4.0 |
| 2013 - 15 | | 18 | 3.1* | 1.8 | 4.8 | 4.2 | 3.9 |
| 2014 - 16 | | 19 | 3.2* | 1.9 | 5.1 | 4.5 | 3.9 |
| 2015 - 17 | | 11 | 1.9* | 0.9 | 3.4 | 4.6 | 3.9 |
| 2016 - 18 | | 14 | 2.4* | 1.3 | 4.1 | 4.6 | 3.9 |
| 2017 - 19 | | 18 | 3.2* | 1.9 | 5.1 | 4.5 | 3.9 |
| 2018 - 20 | | 21 | 3.9 | 2.4 | 5.9 | 4.3 | 3.9 |
| 2019 - 21 | | 19 | 3.6* | 2.2 | 5.6 | 4.4 | 3.9 |
| 2020 - 22 | | 13 | 2.5* | 1.4 | 4.3 | 4.4 | 3.9 |
| 2021 - 23 | | 11 | 2.2* | 1.1 | 3.9 | 4.6 | 4.1 |

## Child Mortality Rate in Cumbria.

This data is presented for Cumberland and Westmorland and Furness Councils. The data presented is the directly age-standardised rate of death in persons aged 1 to 17 years. Nationally, injuries are the commonest cause of death after the age of one and many of these injury related deaths are avoidable.

Figure 6 illustrates the trend in child deaths for Cumberland, compared to the national average. Nationally, there has been a declining trend in the rate of child deaths. In 2001/03 the rate was 18.0 per 100,000 and it has declined to the lowest rate of 10.0 per 100,000 in 2019/21. Since 2019/21, the rate has been increasing to 11.2 per 100,000 in 2021/23.

In 2001/03, the child mortality rate in Cumberland was 16.8 per 100,000 and this has decreased to 13.7 per 100,000. This is not a statistically significant difference. The lowest child mortality rate was 8.6 per 100,000 in 2007/08. This was significantly lower than the national average. The highest child mortality rate was 18.8 per 100,000 in 2010/12, which was significantly higher than the national average. The number of child deaths during this time ranged from 14 in 2007/09 to 29 in 2010/12. This relatively rapid change in the rate is visible in figure 6 below. It is notable that the rate in Cumberland has increased since 2019/21, but this is not statistically significant.

Figure 6. Chart to illustrate the trend in child mortality (rate per 100,000) for Cumberland compared to England, 2001/03 – 2021/23.

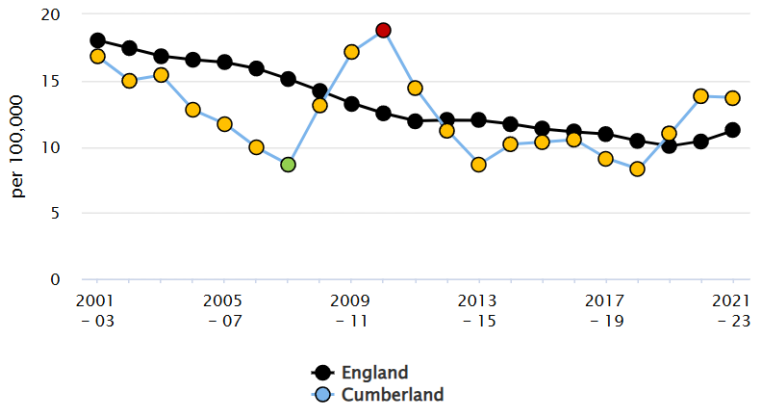
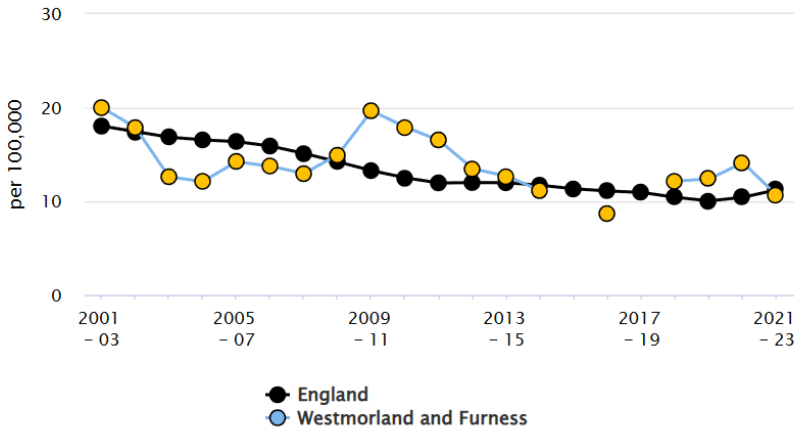



Figure 7 illustrates the trend in child deaths for Westmorland and Furness, compared to the national average. The highest rate of child mortality was 20.0 per 100,000 in 2001/03. There were 27 child deaths in 2001/03. There were fewer than 10 deaths in 2015/17 and 2017/19 and therefore the rates have been suppressed due to data quality.

Figure 7. Chart to illustrate the trend in child mortality (rate per 100,000) for Westmorland and Furness compared to England, 2001/03 – 2021/23.

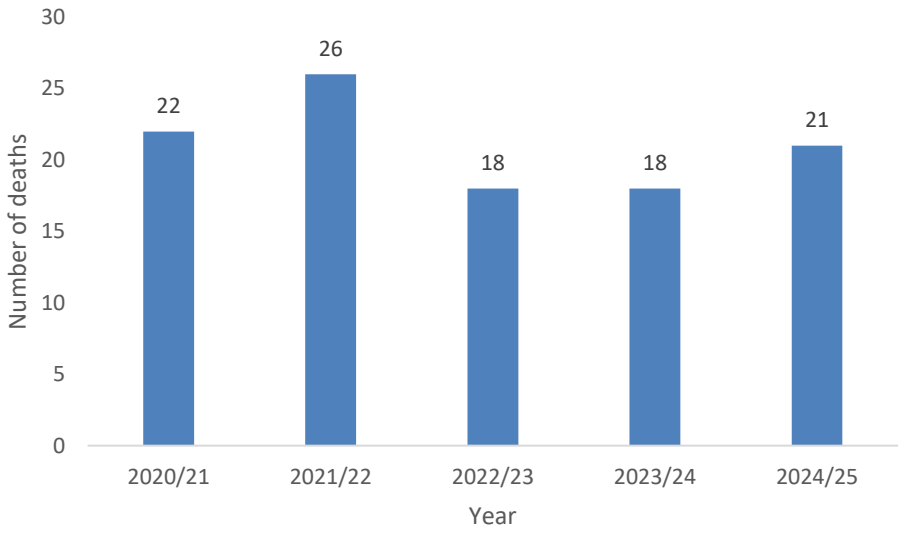



## Total Number of Infant and Child Deaths

The following data is based on local CDOP collected datasets. A total of 21 infants and children who reside in Cumbria have been reported as died in 2024/25.

Figure 8 shows the number of child deaths in Cumbria between 2020/21 and 2024/25. During this period, the number of child deaths has fluctuated between 18 and 26, with the highest number of deaths (26) in 2021/22 and the lowest number (18) in 2022/23- 2024/25.

Figure 8 – Number of child deaths annually in Cumbria 202/21 – 2024/2025




## Age of Infant and Child Deaths for 2024/25

The data detailed in table 4 summarises the age of the Cumbria children at death over the past 5 years.

Table 4 The age of infants and children at time of death in Cumbria (2020/21 – 2024/25)

| Age Range | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|---|---|
| 0-27 days | 8 | 6 | 6 | 7 | 9 | 36 |
| 28-364 days | 5 | 5 | 5 | 6 | <5 | 25 |
| 1 – 4 years | <5 | <5 | <5 | <5 | <5 | 12 |
| 5 – 9 years | <5 | <5 | <5 | <5 | <5 | 11 |
| 10 – 14 years | <5 | <5 | <5 | <5 | <5 | 15 |
| 15 – 17 years | <5 | 8 | <5 | <5 | <5 | 14 |

Source – Cumbria CDOP data

It should be noted NCMD data shows that a child is most at risk of death when under the age of 1 and particularly within the first 27 days of life. In 2024-25 the highest number of deaths notified in Cumbria were for 0-27 days, followed by 28-364 days.

In 2021/22 there was an increase in the number of deaths in the 15–17-year age group. Six of the deaths were unexpected and two were expected, none of the deaths were linked.

## Expected and Unexpected Child Deaths

There are two categories for child deaths.

- A child death is an “expected” death where the death of an infant or child was anticipated due to a life limiting condition.
- 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.

During 2024/25 there have been 9 expected deaths and 12 unexpected deaths notified to the Cumbria CDOP. Over a 5-year average there have been 56 expected deaths and 49 unexpected deaths notified to CDOP, as illustrated in figure 9.

Figure 9. Numbers of expected or unexpected child deaths in Cumbria (2020/21 – 2024/25)


## Location of Death

Table 5 shows the location of child deaths between 2020/21 – 2024/25 in Cumbria. Hospital was the main location of death, and over the last four years, the home was the second.

Table 5 Location of deaths (number) in Cumbria 2019/20 - 2024/25

| Location | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|---|---|
| Hospital | 15 | 14 | 11 | 13 | 13 | 66 |
| Home | <5 | 8 | <5 | <5 | 7 | 26 |
| Public Place | <5 | <5 | <5 | <5 | <5 | 10 |
| Hospice | <5 | <5 | <5 | <5 | <5 | 3 |

Source – Cumbria CDOP data

It should be noted that the figures for 2024/25, ten deaths occurred in hospitals which were outside of Cumbria.

It is worth noting that in most instances the location of the child death is recorded as in hospital. This is often because the child is usually transferred from the community for emergency treatment/assessment before pronounced deceased. It may also be because:

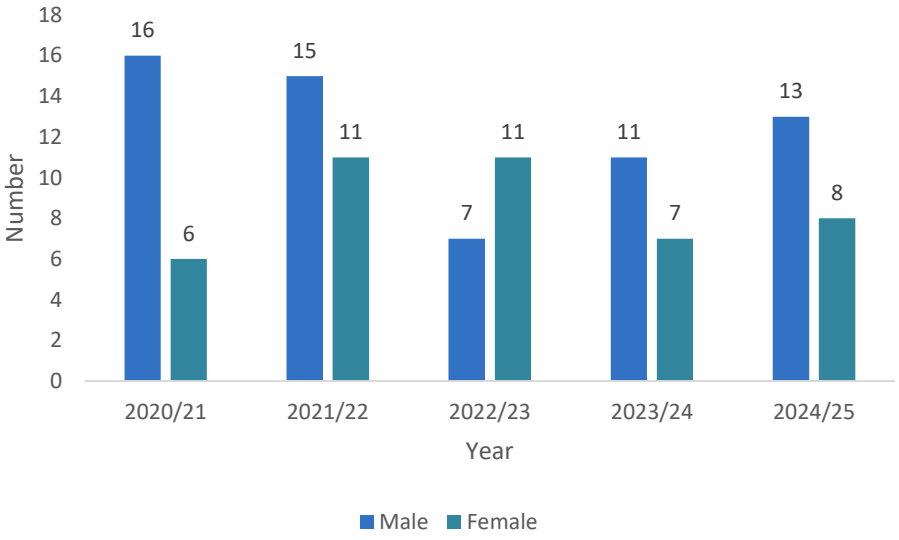
- Neonatal death where the child is already in the hospital setting.

- Children with malignancy or chronic condition who are being cared for in hospital.
- The child or parent's choice of where the child receives end of life care.

### Infant and Child Deaths by Gender

Figure 10 shows the number of deaths by the gender from 2020/21 – 2024/25. 59% (62) of the child deaths have been male and 41% (43) have been female between 202/21 – 2024/25.

Figure 10 – Infant and child death by gender (number) 2020/21 – 2024/25




Nationally, the rate of child mortality (children aged between 1 and 17 years of age) in males is 12.8 per 100,000, and in females is 9.6 per 100,000 in years 2021-2023. The rate of infant mortality was 4.5 per 1,000 for males and 3.6 per 1,000 for females in 2021-2023.

### Deprivation

Infant and child mortality risk varies by socio-economic background. The social deprivation and the increased risk of child death has been highlighted at a national level following the publication of the NCMD Child Mortality and Social Deprivation Report 15. The report analyses data for children who died during 2019/20 in England and identifies a clear association between the risk of child death and the level of deprivation (for all categories of death except cancer) for the place of residence. More specifically, the report states that over a fifth of all child deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived – which translates to over 700 fewer children dying per year in England.

NCMD data (2024) shows the child death rate for children resident in the most deprived neighbourhoods of England was 42.9 per 100,000 population, more than twice that of children resident in the least deprived neighbourhoods (17.2 per 100,000 population). Whilst the death rate in both the least and most deprived neighbourhoods decreased slightly from the previous year, the difference in the rates between the areas of most and least deprivation is higher than any year recorded before 2023.

The death rate of infants who were resident in the most deprived neighbourhoods of England was 5.5 per 1,000 infant population, more than twice that of infant's resident in the least deprived neighbourhoods (2.0 per 1,000 infant population). Similar to child deaths, inequalities in infant deaths widened, with the infant death rate for the most and least deprived having decreased but the difference between the rates remaining higher than previous three years.

Figures 11 and 12 show the rate of infant and child mortality in deprivation deciles based on lower super output areas (2020-2022). This is very granular data that enables an understanding of inequalities in deprivation between and within local authority areas. Both figures illustrate that the rate of mortality is significantly higher in the most deprived areas in England.

Figure 11 Inequalities in infant mortality (rate per 1,000) by deprivation (LSOA21 deprivation deciles within area) in England 2021-2023

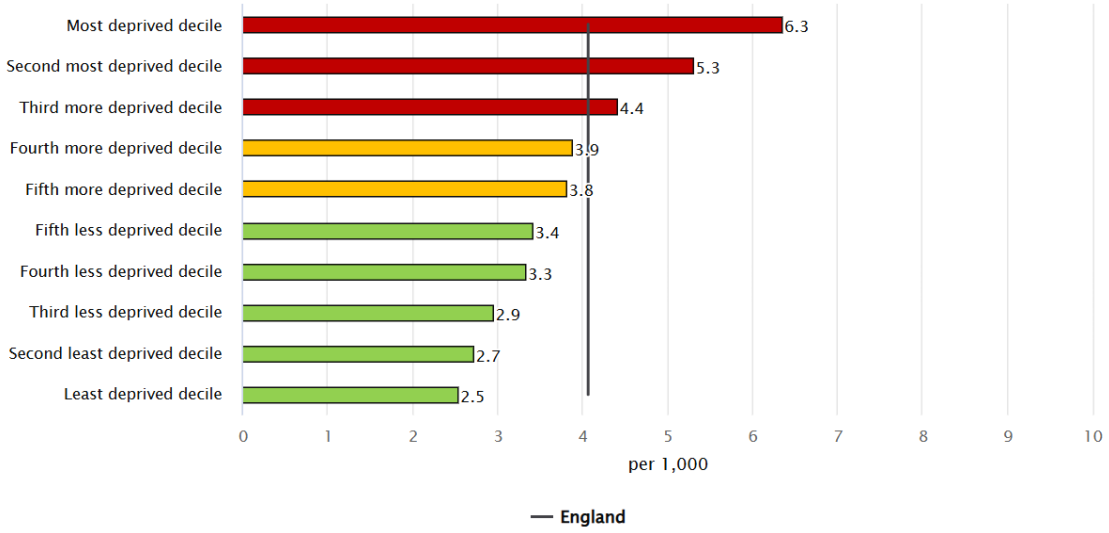


Figure 12 Inequalities in child mortality (rate per 100,000) by deprivation (LSOA21 deprivation deciles within area) in 2020-2022.

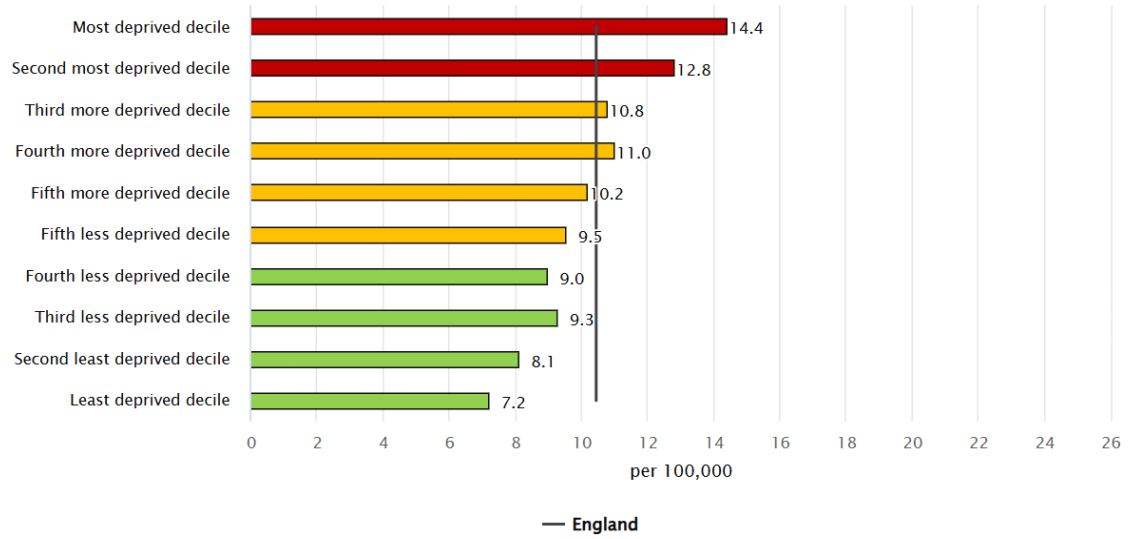



Table 6 illustrates the number of infant and child deaths by deprivation decile. This table clearly illustrates the difference in the count of infant and child mortality by deprivation. The number of infants dying in the most deprived areas was over four times higher than the least deprived, and the number of children dying was more than twice as high in the most deprived compared to least deprived.

Table 6 Number of infant and child deaths in England by deprivation decile (LSOA21 deprivation deciles) 2020-2022.

| | Infant mortality | Child mortality |
|---|---|---|
| | Count | |
| England | 7,050 | 3,496 |
| Most deprived decile | 1,459 | 610 |
| Second most deprived decile | 1,101 | 489 |
| Third most deprived decile | 869 | 381 |
| Fourth most deprived decile | 714 | 360 |
| Fifth most deprived decile | 658 | 322 |
| Fifth less deprived decile | 564 | 295 |
| Fourth less deprived decile | 518 | 570 |
| Third less deprived decile | 444 | 285 |
| Second less deprived decile | 393 | 252 |
| Least deprived decile | 303 | 232 |

## Ethnicity

In 2024/25, out of the 21 deaths notified, there were 18 infants/children who were of white/British ethnicity, 2 were black or black/British African and 1 Asian/British. It is not possible to draw conclusions from this data.

The NCMD Child Death review Data Release for year ending 31 March 2024 illustrated that estimated child mortality rate was highest for children from black or black British ethnicity (55.4 per 100,000) followed by Asian or Asian British (46.8 per 100,000). Over a five year period (2020-2024) the child death rate was highest for children of Asian Pakistani ethnicity (57.0 per 100,000) followed by any other Asian background (51.8 per 100,000), black African (51.3 per 100,000) or black Caribbean (51.3 per 100,000). These rates are more than double the rate from a white British ethnic background (22.9 per 100,000).

## Disabled Children

Of those deaths notified in 2024/25, less than five children were known to have a disability. The LeDeR programme strives to ensure that reviews of deaths lead to learning which will result in improved health and social care services for people with learning disabilities. It is not an investigation nor is it aimed at holding any individual or organisation to account.

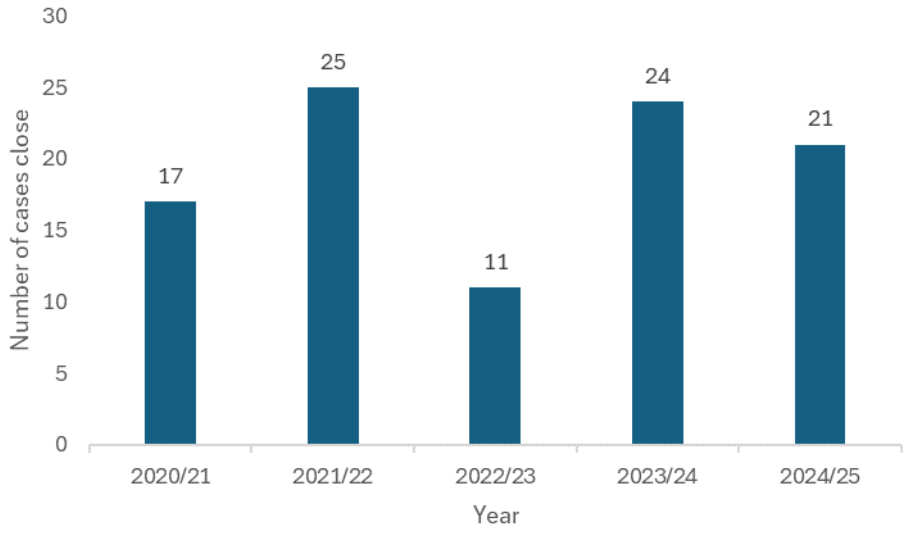
## Child Deaths Reviewed and Closed by the CDOP

Once the CDRM has taken place, all investigations have concluded and sufficient information has been collated, the CDOP holds the final multi-disciplinary review. An examination of the data of all the cases discussed and closed at panel provides an opportunity to identify trends and areas for learning.

The remainder of this report focuses on data relating to the 21 cases discussed and closed by the CDOP from 1 April 2024 to 31 March 2025. Of the 21 cases closed during 2024/25, all except for 1 case were historical cases where the death occurred prior to 1 April 2024. Year on year, there has been variations in the number of cases closed by the Cumbria CDOP, with an average of 21 cases closed per year.

Cases can take six months and longer to be brought to Panel for review. This may be because the CDOP is awaiting information from agencies, for example post-mortem reports or if there is an on-going Police investigation, in which case the discussions may be deferred pending the result of the enquiry. It should be noted that the child's death cannot be discussed at Panel until all information is received.

Figure 13 Number of deaths reviewed and closed by CDOP each year (2020/21 – 2024/25)




Source – Cumbria CDOP data - please note that not all cases signed off will have died in that year.

Delays in 2024/25 were due to challenges in accessing adequate information and other statutory processes. The circumstances leading to the death and the nature of the death also impact upon the number of deaths closed by the CDOP. Deaths where the cause appears to be unnatural, sudden, and unexpected can be subject to multiple investigations that can remain ongoing for a significant time, which impacts on the timeliness of the CDOP review. In addition, there have been some situations where deaths have been reviewed multiple times prior to closure due to complexities. CDOP has as a standing item on the agenda to discuss numbers of historical deaths and what actions can be taken to move them forward.

NCMD data shows that 3,345 child deaths were reviewed by CDOPs in England between 1 April 2023 and 31 March 2024 (some of these deaths may have occurred in earlier years). This is a similar number to the previous year and the highest number since 2019/20.

## Categories of Child Deaths

During the CDOP meetings, members categorise all child deaths which are then recorded on the eCDOP system. Categories of child death are identified nationally and are provided by the Department for Education. Detailed in the table below are the categories of child deaths that have been agreed for those deaths signed off during 2024/25. Numbers are suppressed for categories where there are less than five deaths.

Table 6 – Categories of Child Death

| Category | 2019/ 2020 | 2020/ 2021 | 2021/ 2022 | 2022/ 2023 | 2023/ 2024 | 2024/ 2025 | Total |
|---|---|---|---|---|---|---|---|
| 1. **Deliberately inflicted injury, abuse or neglect** – this includes numerous physical injuries, which may be related to homicide as well as deaths from war, terrorism or other mass violence. It also includes severe neglect leading to death | <5 | <5 | <5 | <5 | <5 | <5 | <5 |
| 2. **Suicide or deliberate self-inflicted harm** – this includes any action intentionally to cause | <5 | <5 | <5 | <5 | <5 | <5 | <5 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | one's own death. It will usually apply to adolescents rather than younger children. | | | | | | | |
| 3. | **Trauma and other external factors** – this relates to unintentional physical injuries caused by external factors. It does not include any deliberately inflicted injury, abuse or neglect. | <5 | <5 | <5 | <5 | <5 | <5 | 12 |
| 4. | **Malignancy** – this includes cancer and cancer like conditions such as solid tumours, leukaemia and lymphomas and other malignant proliferative conditions, even if the final event leading to death was infection haemorrhage, etc. | <5 | <5 | <5 | <5 | <5 | <5 | 9 |
| 5. | **Acute medical or surgical condition** – a brief sudden onset of illness which resulted in the death of a child. | <5 | <5 | <5 | <5 | 5 | <5 | 12 |
| 6. | **Chronic medical condition** – a medical condition which has lasted a long time or was recurrent and resulted in the death of child. | <5 | <5 | <5 | <5 | <5 | <5 | 7 |
| 7. | **Chromosomal, genetic and congenital anomalies** – medical conditions resulting from anomalies in genes or chromosomes as well as a defect that is present at birth. | 8 | <5 | <5 | <5 | <5 | 6 | 23 |
| 8. | **Perinatal/neonatal event** – the of a child as a result of extreme prematurity, adverse outcomes of the birthing process, intrauterine procedures or within the first four weeks of life. | 7 | 6 | <5 | <5 | 7 | 7 | 30 |
| 9. | **Infection** – this can be any primary infection, ie not a complication of one of the above categories, arising after the first postnatal week, 0or after discharge of a preterm baby. | <5 | <5 | <5 | <5 | <5 | <5 | <5 |
| 10. | **Sudden unexpected or unexplained death** – this is where pathological diagnosis 6is either Sudden infant Death Syndrome (SIDS) or 'unascertained' at any age. | <5 | <5 | <5 | <5 | <5 | <5 | 7 |

Source – Cumbria CDOP data. To note: the figures in the below tables from 2018/19 – 2019/20 were for deaths reviewed and signed off. The figures for 2020/21 and 2021/22 are for child deaths notified to CDOP in that year and signed off in that year. Figures for 2022/23 are for those deaths reviewed and signed off and were for deaths from the year 2021/22. One of the deaths reviewed and signed off, was from 2022/23. For the deaths reviewed and signed off in 2024/25, 1 was for 2024/25 and the rest were from 2021/22-2023/24.

Of the 109 deaths that have been reviewed over the past six years –

- 28% were due to a perinatal/neonatal events,
- 21% were due to chromosomal, genetic and congenital anomalies,
- 11% were due to trauma and other external factors,
- 11% were due to acute medical or surgical condition
- 8% were due to malignancy

The NCMD report for 2023-24 shows that the most common primary category of death in England was perinatal/neonatal event, which was recorded in 31% of all child death reviews. 24% were categorised as chromosomal, genetic and congenital anomalies, 8% as sudden unexpected and unexplained death, or acute medical or surgical condition, or malignancy. The most common primary category of death for children under 1 was perinatal event; for children aged between 1 and 9 years it was chromosomal, genetic and congenital anomalies; and for children aged between 10 and 17 years it was malignancy. This pattern is similar to previous years.

### 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 identify and agree any modifiable factors that may have prevented the death. This information forms part of the reporting to NCMD who reviews all the information provided by each local CDOP to provide a national overview.

Where modifiable factors are identified, the Panel addresses these and utilises the CDOP action tracker. It is not usually within the remit of CDOP to take action directly, but any issues identified, learning points and recommendations are given to relevant agencies to enable them to take action as appropriate. When this is felt necessary, it is placed on an action log until CDOP are assured that the necessary action has been taken.

Out of the 21 deaths that were reviewed and signed off in 2024/25, there were 16 deaths where modifiable factors were identified by the Panel. The modifiable factors that were noted on several occasions include:

- High maternal BMI
- Parental smoking
- Lack of communication between healthcare services
- Water safety and low or no swimming ability
- Commissioning of community services
- Lack of translation services

Please note that these modifiable factors may not have been a factor in the cause of death of the child, but may have in some way contributed, or may be a risk factor for other children.

NCMD data shows that nationally deaths categorised as *Trauma or other external factors* had the highest proportion of reviews with modifiable factors (76%), followed by *Sudden unexpected and unexplained death (75%)*, *Deliberately inflicted injury, abuse, neglect* (73%) and *Suicide or deliberate self-inflicted harm (*68%).

## Learning from Child Deaths

The Cumbria CDOP has identified learning points from all deaths and engaged in multi-agency groups to take forward key areas of learning to safeguard and promote the welfare of children in the area. Some of these learning points were –

- Raising awareness of water safety in schools (raised in previous year)
- Raising awareness of using appropriate safety equipment (raised in previous year)
- Improvements to multi agency data sharing (raised in previous year)
- Vitamin K guideline reviewed
- Guidelines for neonatal sepsis reviewed
- Pathways and processes for children approaching end of life care
- Department for Education asked to review adoption guidance

## Training

Members of the Child Death Overview Panel engage in relevant learning, training and conferences about child death at a regional and national level. This includes NCMD webinars, which are designed to provide detailed updates on the NCMD, discuss emerging issues and provide information around the latest events in the child death review sector.

Information from these events is shared as part of a standing agenda item at the Cumbria CDOP, with reflection as to where the learning and recommendations can be implemented.

In addition, this year has seen multi-agency training and learning across the Child Death Review Partners to continuously improve the response to a child's death. The UHMBT Emergency Department team, alongside their bereavement, chaplaincy, paediatric and safeguarding teams have come together with Cumbria Police and NWAS to develop a multi-agency simulation training, which focuses on the sudden and unexpected collapse of a child, the resuscitation attempt and subsequent child death processes.

Since the introduction of the simulation, the scenarios have grown in complexity, with the aim of going some way to replicating the complex, multi-faceted nature of a child death. The most recent event started in a location away from the hospital and allowed police and NWAS to practice their initial response protocols and was able to incorporate some learning around the Suicide Cluster Prevention protocol.

The simulations include police processes that run in parallel to the resuscitation attempts by health teams; realistic multi-agency collaboration during a resuscitation; paediatrician & police joint working following the child death; bereavement support for the family and an overview of child death processes that take place following any sad death of a child.

This training allows colleagues from partner agencies to not only develop knowledge of their own roles, responsibilities and processes, but crucially it enables colleagues to develop a respectful understanding of other agency responsibilities and challenges. In working collaboratively during simulations, colleagues are developing and refining the skills and relationships needed to collaboratively care for children and their families during what is undoubtably one of the worst experiences any parent and family could go through.

## Update on the 2024/25 CDOP priorities

The table below provides an update on the progress made against the recommendations from the annual report 2023/2024. The table shows that good progress has been made across multiple recommendations, with several being completed. The initiation of the CDOP Action sub-group has been influential in driving some of these actions forward.

The CDOP Action sub-group was formed during 2024 and has membership across the organisations represented at CDOP. The sub-group's primary purpose is to ensure that the recommendations from CDOP are translated into practical actions. This may be through the group itself, or through liaising with key stakeholders and local partnerships to ensure action and alignment. The sub-group has an action plan and regularly feeds back to CDOP.

The table below outlines progress against the recommendations in the 2024/2025 Annual Report.

Table 7. Progress against recommendations from Annual Report 2024/25.

| Outcome | Action | When to be completed | Who | Update | RAG |
|---|---|---|---|---|---|
| Increased ability to identify themes and learning from the child death review process | Work closely with neighbouring CDOPs for effective learning including participating in regional networks, national webinars and conferences for wider education and understanding of child deaths. Themed Panel Meetings with geographical neighbours. | March 2025 | CDOP Chair | Relationships have been developed with the chairs of Lancashire and North East CDOPs. Cumbria CDOP Chair attended the Lancashire CDOP Development Day. Chair also attends a national group for CDOP Chairs. | |
| Education colleagues are aware of child death review processes and are able to respond and contribute as required. | Strengthen child death processes within education, including awareness raising and training | March 2025 | CDOP Panel | Education representatives attend the Panel and have been involved in the development of the Cluster Prevention Protocol. Joint working will continue to launch the protocol. | |
| All CDOP members receive an induction prior to undertaking their role | Develop CDOP induction training package. | March 2025 | CDOP Sub-Group | The Induction package has been completed and training is being developed. | |
| The local system is able to respond in a timely, sensitive and appropriate manner to a suspected suicide in a child. | Complete the review of the Suicide Contagion Protocol and circulate the updated Protocol. | March 2025 | CDOP Sub-Group | Complete. | |
| The Child Death Review process is of high quality | Continuous embedding of the child death review process by working in partnership to ensure timely response and review of deaths prior to CDOP. The panel will continue to oversee the effectiveness of the arrangements. | March 2025 | CDOP | Complete. Delays are constantly reviewed and queried. Delays are often a result of the time required to complete key parts of the Child Death Review process, including investigations, and is a national issue. The Panel | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | continues to review this at each meeting. | |
| The Child Death Review process is of high quality | Continue the work to identify if there are any local issues delaying the CDOP process, in order to reduce the number of child deaths that are outstanding to be reviewed. | March 2025 | CDOP | Complete. Delays are constantly reviewed and queried. Delays are often a result of the time required to complete key parts of the Child Death Review process, including investigations, and is a national issue. The Panel continues to review this at each meeting. | |
| Schools are able to support children, families and staff in the event of a child death. | Encourage schools to develop bereavement policies. | March 2025 | CDOP Sub-group | Each local authority is establishing a task and finish group to progress this recommendation | |
| CDOP is able to provide leadership for cross system action in relation to modifiable factors. | Implement CDOP operational group to implement actions aimed at reducing risks identified in modifiable factors. | March 2025 | CDOP | The Sub-group has been established and meets on a bi-monthly basis. The group has an action plan and is providing updates to CDOP at each meeting. | |
| Deaths are reduced through system wide awareness and understanding of safer sleep and effective communication with parents | Operational group to work with partners to ensure the Audit of use of safe sleep assessment is completed. | March 2025 | CDOP Sub-group | A work plan in relation to Safer Sleep has been agreed by CDOP, which includes the development of a strategy, provision of resources and an audit. | |

## CDOP Priorities for 2025/26

Two recommendations from the annual report in 24/25 will need to be continued in 25/26:

- Encourage schools to develop bereavement policies.
- Operational group to work with partners to ensure the Audit of safe sleep assessment is completed.

The following priorities have been identified for CDOP in 2025/26.

- Explore options to extend the geographical footprint for Cumbria CDOP to strengthen the learning process.
- Provide leadership for action in responding to identified modifiable factors.
- Increase ownership and awareness of Cluster Prevention Protocol across the local system.
- Develop training for CDOP members and the wider CDR partners.

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