Derby and Derbyshire Child Death Overview Panel Annual Report April 2024 to March 2025

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Introduction

The Child Death Review Team (CDR) and Child Death Overview Panel (CDOP) members have continued to review child deaths within the framework of the statutory guidance. Through the activity of the team and CDOP, learning has been disseminated across the partnership with an aim to drive improvements in service provision and prevent future child deaths.

This reporting year has allowed us to hear the unique stories of 65 children, young people, and their families. Their stories matter and the privilege of hearing from them allows us to look for ways to prevent and reduce the future deaths of children across Derby and Derbyshire. We are grateful to all those families who decided to contact us to share their feedback and concerns and share their child's voice. We will continue to hold the voices of children and their families at the very heart of what we do.

This year's annual report has a focus on palliative care, this follows on from a previous annual report in 2020 where the CDR team and CDOP highlighted concerns around children being able to access 24-hour palliative care services at home. The Child Death Review Team have collated learning from the CDOP reviews this year and written an additional report to draw attention to the fact that there remains a challenge for families in accessing consistent palliative care at home for their children.

The Derby and Derbyshire Child Death Review Team completed an audit of the children that died where group A Streptococcus was the cause of death; the aim was to consider any learning to help prevent future deaths. The team worked with Sheffield Childrens Hospital collaboratively and the work has been shared across the region. The learning has also been submitted to the Royal college of Paediatrics and Child Health and will be presented in e-poster form at their conference in May 2026. This is an excellent example of collaborative learning and combining knowledge across disciplines and hospitals to reduce future child deaths.

This year the CDR Team completed a survey with CDOP members to gain assurance on the functioning of CDOP working with partner agencies and to ensure that there is an effective framework for sharing and disseminating learning.

We remain grateful to those 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. And who, despite often challenging circumstances, work above and beyond to give children the experience that they deserve.

Finally, we would like to thank the members of the Child Death Review Team, the Child Death Review Partners, and members of CDOP for their hard work, support, and commitment to the review of all child deaths in Derby and Derbyshire.

Juanita Murray
Chair of the Derby and Derbyshire Child Death Overview Panel
Dr Nic Medd
Designated Doctor for Child Death for Derby and Derbyshire

Derby and Derbyshire Child Death Notifications

Notifications Key Information:

There were 66 child death notifications in 2024/2025.

There have been more deaths this year. Although there were less children that died aged 1-4, there were more babies that died under the age of 1 (including pre-term).
Only 11 received a Joint Agency Response (JAR) as they were sudden and unexpected deaths.

The largest age group was neonatal deaths (0-27 days) at 50%. This is slightly above the national average (42%). 30% of those were <23 weeks gestation. For all deaths of infants under 1 year old 74% of them had been born prematurely (before 37 weeks).

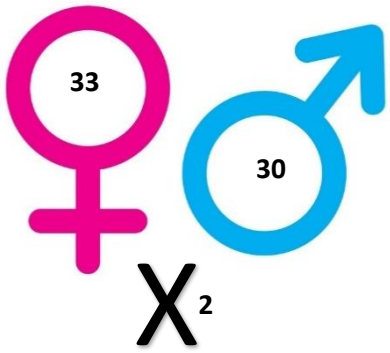
The deaths of children under the age of 1 are slightly higher than the national average. Deaths of children aged 15-17 years are less than the national average.

54 children (82%) died in hospital. 41% (22) of those deaths occurred in our local hospitals. 5 deaths occurred in the child's home and 5 died in a hospice.

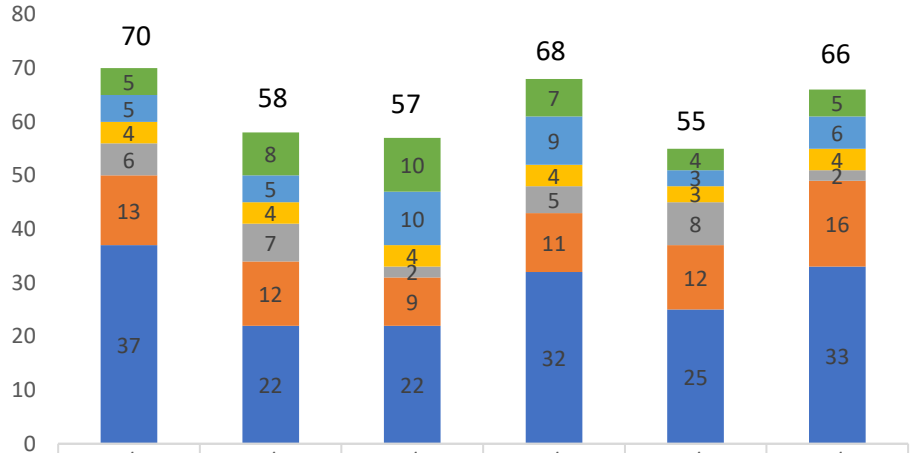
66 notifications received

11 Joint Agency Responses completed

62 average deaths over 6-year period

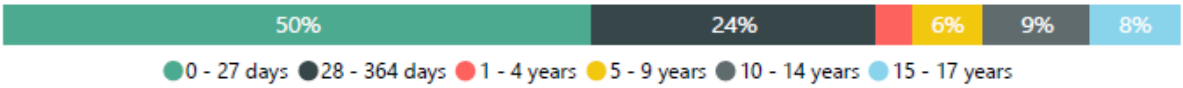


Number of Child Death Notifications 2019-2025

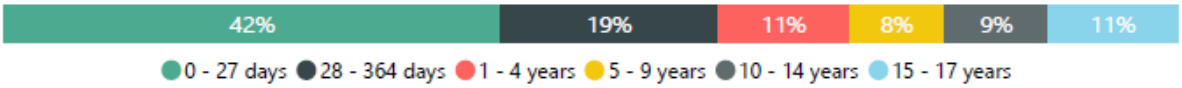


	19/20	20/21	21/22	22/23	23/24	24/25
15-17 years	5	8	10	7	4	5
10-14 years	5	5	10	9	3	6
5-9 years	4	4	4	4	3	4
1-4 years	6	7	2	5	8	2
28-364 days	13	12	9	11	12	16
0-27 days	37	22	22	32	25	33

% of death notifications by age group - CDOP



% of death notifications by age group - National (England)



Death notifications by LAA

LAA name	Cases
Derby	33
Derbyshire	33
Total	**66**

Child Population

The child population data for 0–15-year-olds 2024 (16 -17-year-olds data forms part of the adult data set)

Local Authority Area	Child Population 0-15 years
Derby City	54,830
Derbyshire	137,337

These figures account for the child population ONS figures for 2024 for 0–15-year-olds. 16- and 17-year-olds form part of the adult population data set and are not represented in the figures. Derby City account for 28% of the total child population and Derbyshire for 72%. Although there are changes to population size the percentage share has remained similar to 2021. There were 33 deaths of Derby City children this year and 33 of children living in Derbyshire. There is a higher rate of child deaths in Derby City compared to population size at 50% of the total number of deaths. This is not unexpected due to the known links between child death and deprivation as Derby City have more areas of deprivation according to IMD decile.

Derby and Derbyshire CDOP Completed Reviews

65 children reviewed at CDOP

86% with modifiable factors (43% England)

11 CDOP meetings held.

CDOP Review Key Information:

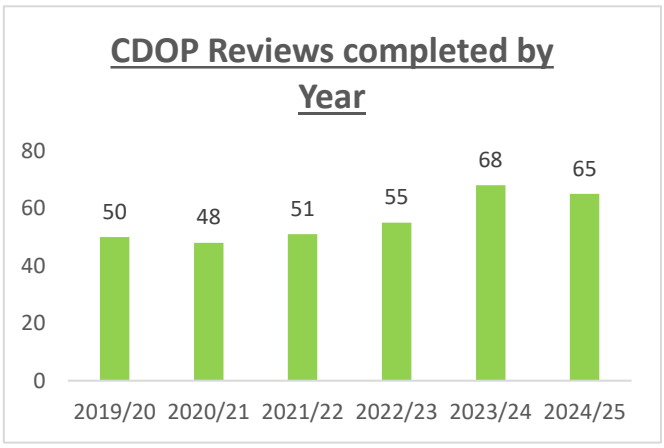
The top 2 recorded categories of death were:

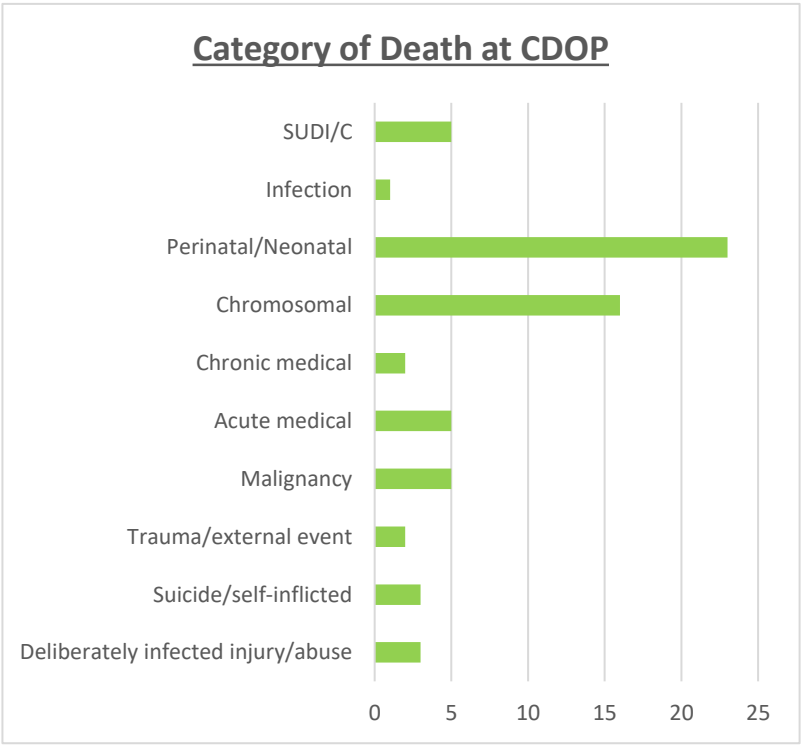
- Deaths due to perinatal/neonatal event (35%)
- Chromosomal, genetic anomalies (25%)

CDOP reviews in 24/25 by year of death

Year of Death	Cases
2019/20	1
2020/21	2
2021/22	4
2022/23	13
2023/24	34
2024/25	11

Cases are only reviewed at panel once all other investigations (including Inquests, Police investigations, Serious Incident Investigations and Child Safeguarding Practice Reviews) are concluded and the reports available to CDOP. This can lead to some delay between the year of death and completion of the review.





Derby and Derbyshire Identified Contributory Factors

Part of the child death review process is for CDOP to identify any contributory factors and consider if the factor is modifiable. Contributory factors are factors that may have contributed to a child's vulnerability, ill-health or death. Contributory factors are recorded in 4 domains, and more than one factor can be identified for each child during the review.

Top 5 Contributory Factors:

Child health history/medical conditions (A)

Risk factors in mother during pregnancy/delivery (A)

Parent/carers health (B)

Smoking/alcohol/substance misuse by parent/carer (B)

Staffing/bed capacity/equipment (D)

The list of contributory factors is similar to last year. Staffing/bed capacity/equipment is placed as the fifth most common which differs from last year where the child's developmental conditions/disabilities was the fifth most common.

Most common contributory factors identified:

Domain A: factors intrinsic to the child:

- Child health history/medical conditions.
- Risk factors in mother during pregnancy/delivery
- Child's developmental conditions/disabilities

Domain B: factors in the social environment including family and parenting capacity:

- Parent/carers health
- Smoking/alcohol/substance misuse by parent/carer.
- Domestic or child abuse/neglect

Domain C: Factors in the physical environment:

- Poverty/deprivation
- Home safety conditions
- Sleep environment

Domain D: Factors in service provision:

- Staffing/bed capacity/equipment
- Initiation of treatment/identification of illness
- Communication within or between agencies

Domain	Identified in:
Domain A – child	65 cases (100%)
Domain B – social environment	53 cases (82%)
Domain C – physical environment	13 cases (20%)
Domain D – service provision	54 cases (83%)

Derby and Derbyshire Identified Modifiable Factors

CDOP is responsible for identifying any modifiable factors in relation to the child's death. Modifiable factors are defined as factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

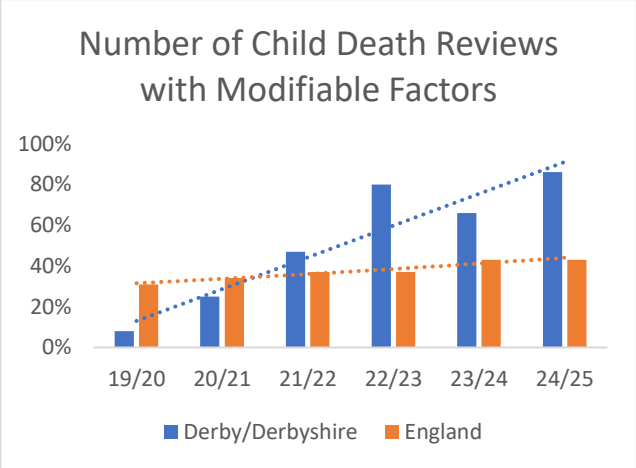
Top 5 Modifiable Factors:

- Smoking by a parent (including in pregnancy) 29%
- Poor communication between agencies 20%
- High Maternal BMI 20%
- Guideline available but not followed 15%
- Issue with treatment, including delays 14%

Modifiable factors key information:

- Modifiable factors were identified in 86% of cases compared to 43% across England.
- The fewest factors identified were in the category of perinatal/neonatal event and chromosomal/genetic anomalies.
- Children aged 10-17 have the highest % of modifiable factors overall. Last year it was age 1-4 years.
- 4 of these modifiable factors are the same as last year. The new one is 'issue with treatment, including delays'
- Unsafe sleep environment is not in the top 5 modifiable factors this year which is positive

Primary category of death (CDOP)	Modifiable factors identified (%)		
	2022/23	2023/24	2024/25
Trauma & external factors	100%	100%	100%
Sudden unexpected, unexplained death	100%	↓83%	↑100%
Suicide/deliberate self-harm	75%	↑100%	100%
Malignancy	50%	↑80%	↑100%
Infection	0%	↑75%	↑100%
Deliberately inflicted injury, abuse or neglect	100%	↓67%	↑100%
Chronic medical condition	25%	↑50%	↑100%
Acute medial/surgical	67%	↑80%	↑100%
Perinatal/neonatal event	85%	↓76%	↑78%
Chromosomal, genetic and congentital anomalies	83%	↓38%	↑75%
Total	80%	↓66%	↑86%



Cases with modifiable factors increased from 66% to 86%. This is much higher than the England average of 43%. The CDR Team is working with CDOP to have a consistent approach to modifiability and are awaiting national guidance which will support our local guidance on decision making for modifiable factors.

Age group	Modifiable factors identified (%)		
	2022/23	2023/24	2024/25
0-27 days	79%	↓69%	↑79%
28–364 days	90%	↓83%	↑94%
1-4 years	100%	↓88%	↓75%
5-9 years	40%	40%	↑83%
10-14 years	89%	↓44%	↑100%
15-17 years	75%	↓64%	↑100%
Total	80%	↓66%	↑86%

Learning Theme – Palliative Care

All child deaths are important to CDOP. We can all learn from individual deaths by sharing positive practice as well as the consideration of improving practice across the partnership. CDOP has a role to look at themes and trends and to focus on any improvements that can be made to prevent future deaths and improve care and services to children.

In 2020, the Derby and Derbyshire Child Death Overview Panel heard the case of a brave young person who wanted to die at home after being diagnosed with an untreatable bone cancer but at the time there was no service available to the child. Alongside their specialist oncology nurse, the young person courageously wrote of their experience and why they felt passionately that there should be provision for young people of any age to be able to die at home if that was what they chose.

Unfortunately, since 2020 and in this year Derby and Derbyshire CDOP frequently hear stories that clearly demonstrate that the children in our area are not receiving consistent palliative care services. It appears that there is a particular challenge in providing children with 24/7 nursing and medical support so that they can die at home if that is what they and their families choose.

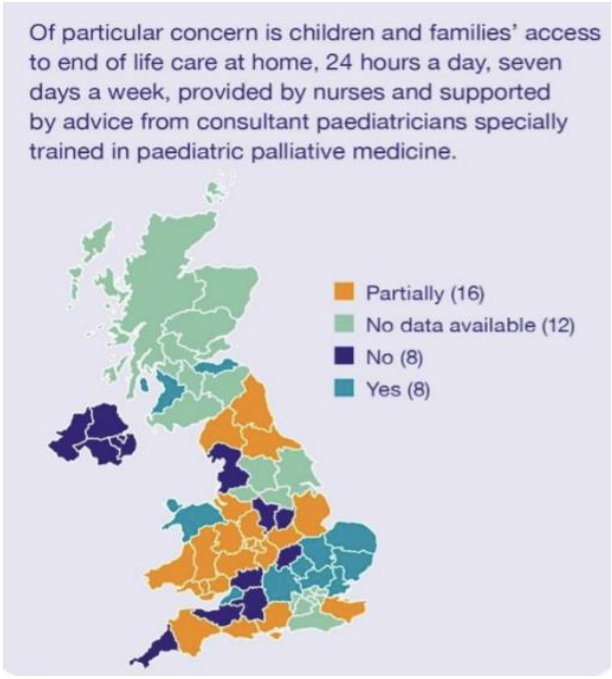
The Child Death Review Team have collated learning from the CDOP reviews and written an additional report to draw attention to the fact that the concerns raised in 2020 remain and with the request there should be further consideration of how the gaps in service provision can be improved for future children and their families.

The NICE Guideline - End of life care for infants, children and young people with life-limiting conditions: planning and management (2016, updated 2019) has a section on what children and families should expect of end-of-life care at home. Alongside the guideline are the NICE Quality Standards (QS160, 2017)

Services should have agreed strategies and processes to support children and young people who are approaching the end of life and are being cared for at home. These services should be based on managed clinical networks and should collaborate on care planning and service delivery (Section 1.5.10).

There is an expectation that:

- Palliative care services are commissioned to provide 24-hour paediatric palliative care at home for children and young people approaching the end of life, which include 24-hour access to children's nursing care and advice from a consultant in paediatric palliative care.
- That systems are in place for infants, children and young people approaching the end of life and being cared for at home to have 24-hour access to children's nursing care and advice from a consultant in paediatric palliative care and that families have contact details for children's nursing care and advice from a consultant in paediatric palliative care, available 24 hours a day when families need it.



Reports main findings

- The standard for access to 24 hour a day palliative 24 hours 7 days a week care is met in a third (30%) of local ICB's in England, with nearly a half (47%) partially meeting it and almost one quarter (23%) not meeting it at all.
- In England, only 6 ICBs (14%) are commissioning and delivering services to provide 24-hour access to both children's nursing care and advice from a specialist consultant in paediatric palliative care.
- Two in five (41%) of ICBs do not commission this at all.

Recommendations:

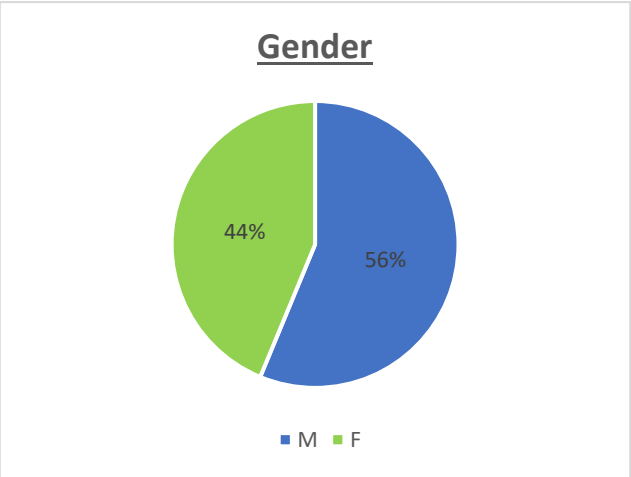
- The UK's governments should hold local NHS bodies and councils to greater account for implementing the existing policy frameworks relating to children's palliative care.
- Time is short for children and young people with life-limiting or life-threatening conditions. If these actions are not taken now, more children with life-limiting conditions and their families will be denied choice and control over their palliative care, particularly at end of life, wasting vital NHS and local government resources.

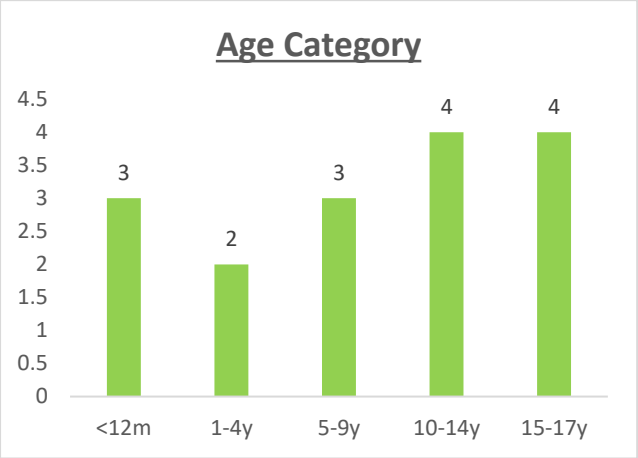
What is the impact in Derby and Derbyshire

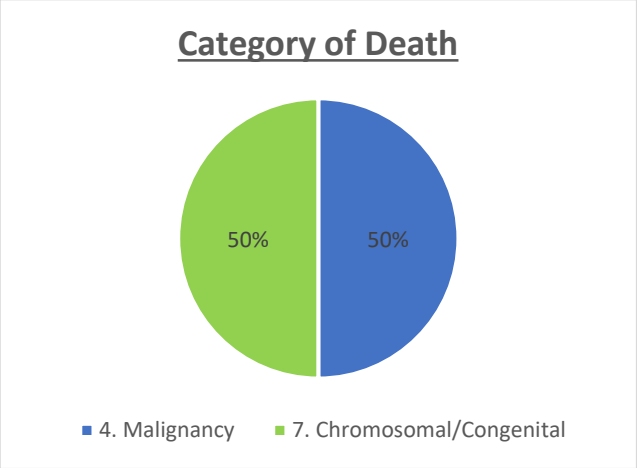
The Child Death Review Team completed an audit collecting data and learning from the last 4 years.

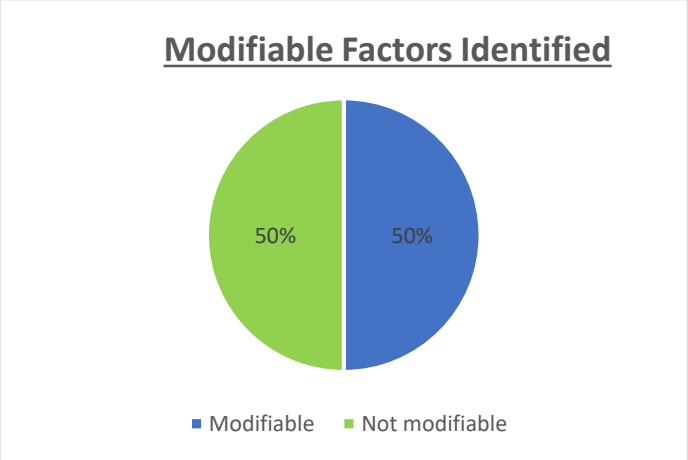
296 deaths reviewed by CDOP panel over the 4-year review period.
60 of the cases reviewed have been recorded as having a life-limiting condition.

The two main categories of life limiting conditions that may be appropriate for end-of-life care are oncological conditions and those children with a complex neurodisability.
The audit only includes cases that had been heard at CDOP In the 4-year period 16 cases where identified where there were concerns with end-of-life service provision.









The chromosomal/congenital category includes children with a neurodisability, those with neurodegenerative conditions and genetically inherited metabolic conditions.

The voices of children's families and the challenges they faced were a feature in the CDOP review this enhanced the learning.

Challenges for families:

- Challenges for families being able to get expert help and advice for their children especially out of hours or at weekends.
- Being able to source 24/7 nursing support for families in place so that their child can die at home.
- Medical review by appropriately trained doctors especially out of hours and at weekends.
- Different IT systems being used by different health care providers which can lead to challenges.
- A specific lack of resource/service for 16- 17-year-olds who can sometimes fall between paediatric and adult services.
- There can be challenges for families in getting death appropriately verified out of hours which can be extremely distressing.
- There are still challenges for some families in being able to access the anticipatory medications that their child.

In the absence of commissioned services, CDOP identified that so often staff go out of their way to help these children and families.

Learning and identified gaps in service provision:

- Lack of a consistent 24/7 specialist palliative nursing support at home.
- Lack of access to specialist paediatric palliative care clinicians 24/7. Often adult service providers are asked to fill the gaps. This can lead to issues in training, medication administration and familiarisation with paediatric services.
- There have been situations where the administration of pain and symptom relieving medications has been delayed due to lack of available trained people to advise, prescribe or administer the medication.
- There can be issues after death with death verification leading to distress and unnecessary intrusion for the family.
- Difficulty in communication when different providers are brought together to provide a patchwork service and use different IT systems.

For our children and families, we urgently need resilient provision of end-of-life care for children dying at home so that there is:

- Access to appropriately trained and skilled medical and nursing professionals 24/7.
- Access to required medications any time of day or night 7 days a week.

The audit findings and report were presented to the Derby and Derbyshire Children and Young People's Delivery Board. A family kindly gave permission for their experience to be shared which was a powerful illustration to those listening. The report has been shared with the East Midlands Paediatric Palliative Care Network, and the West Midlands Children's Network Group.

Learning Theme – Invasive Group A Streptococcal Disease

Group A Streptococcus, also called Streptococcus Pyogenes, is a very important organism and is thought to rank as one of the top 10 causes of death from infectious diseases worldwide with more than 570 000 deaths being attributed to this organism annually worldwide.

Many of us will carry group A streptococcus in our throats and on our skin and it doesn't usually result in illness. Group A streptococcus usually causes a mild illness, and most infections are not serious and can be treated with antibiotics.

Rarely, group A streptococcus can cause more serious infections when the organism gets into parts of the body where it is not normally found such as the bloodstream and lungs. This is called invasive group A streptococcal disease (iGAS). Invasive group A streptococcal disease can be fatal.

Following the low incidence of group A Streptococcal infection during the COVID 19 pandemic, late 2022 and early 2023 saw a surge in cases of invasive group A streptococcus with an increased number occurring in children.

This increase in cases and sadly deaths of children was seen in Derby and Derbyshire.

The Derby and Derbyshire Child Death Review Team completed an audit of the children that died where group A Streptococcus was the cause of death; the aim was to consider any learning to help prevent future deaths.

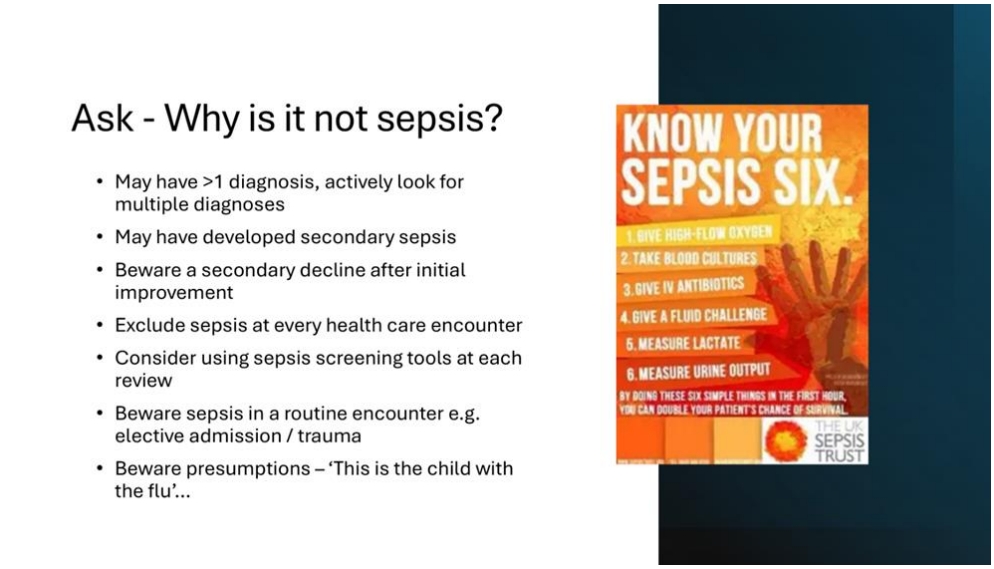
Learning Themes from the audit:

- Importance of full examination initially and including re-examinations and observations prior to discharge or after interventions.
- Consideration by health professionals of more than 1 concurrent diagnosis.
- Active exclusion of sepsis at each healthcare encounter.
- Understanding and awareness that children can rapidly deteriorate.
- Consideration of the timing of medical procedures that can destabalise children who are critically unwell.
- Antibiotics to be given within an hour of the diagnosis being made.
- Consideration of the availability of ultrasound, intensive care and transport teams when not in a specialist tertiary centre.
- Importance of prompt reviewing all test and investigations.
- Some children had prior contact with health professionals before their illness deteriorated, they were clinically stable with no sign of severe illness. To recognise it can be challenging for health care professionals to identify those children with the potential to deteriorate particularly in the winter months when viruses are common.
- The importance of listening to parents and ensuring parents know when and how to access urgent help if they are concerned.
- These children became unwell often several days into their illnesses. The importance of considering a more serious infection in a child who deteriorates after an initial improvement.

As Derby and Derbyshire CDOP see only a small proportion of cases affected with group A Streptococcus the Designated Doctor for Child Death worked with a team of experts at Sheffield Children's Hospital regional paediatric infectious diseases unit. The team in Sheffield had audited 50 cases of children suffering with invasive group A streptococcus infection over the same period. The learning was combined and a learning event was held with senior professionals from medicine, paediatrics, nursing and the child death review team to understand the factors that were important in those that had a poor outcome and to try and identify learning which would help health professionals in the management of group A Streptococcus in the future.

Learning from combined learning event:

The following key messages are for health care professionals involved in seeing children with potential septicaemia and would be applicable to septicaemia caused by other organisms.

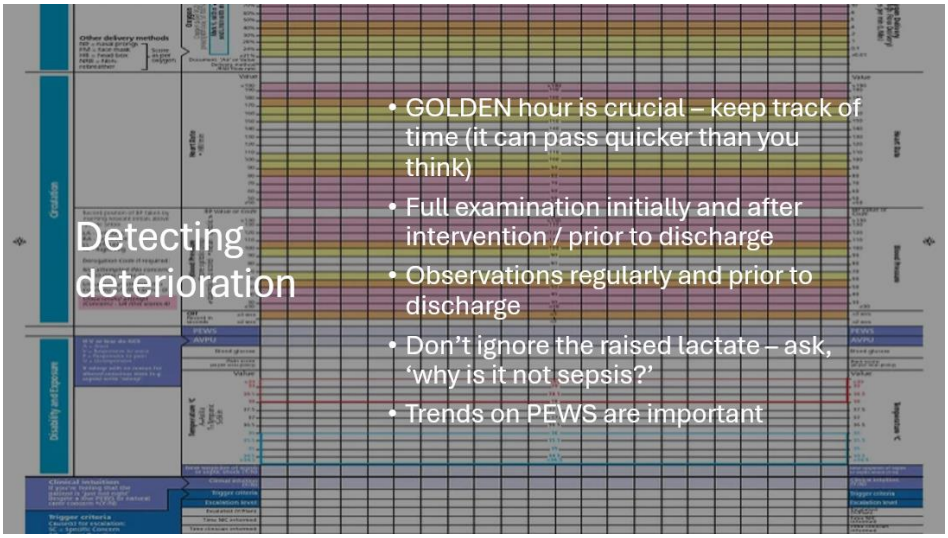


Antibiotics

- Start BROAD then FOCUS
- Aim for administration within 1 hour of decision
- If concerns iGAS – add Clindamycin
- Current iGAS resistance is increasing
- Role of IVIG – probably will be given on PICU as likely unwell

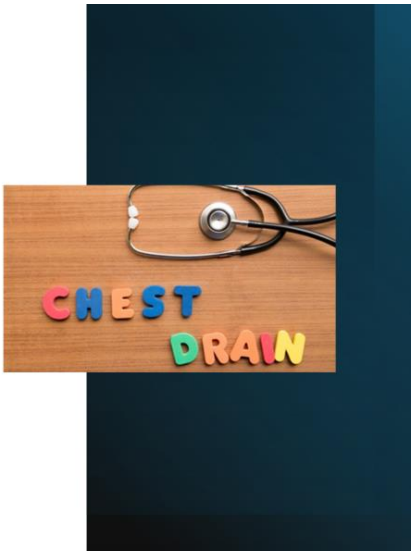
Detecting deterioration

- GOLDEN hour is crucial – keep track of time (it can pass quicker than you think)
- Full examination initially and after intervention / prior to discharge
- Observations regularly and prior to discharge
- Don't ignore the raised lactate – ask, 'why is it not sepsis?'
- Trends on PEWS are important



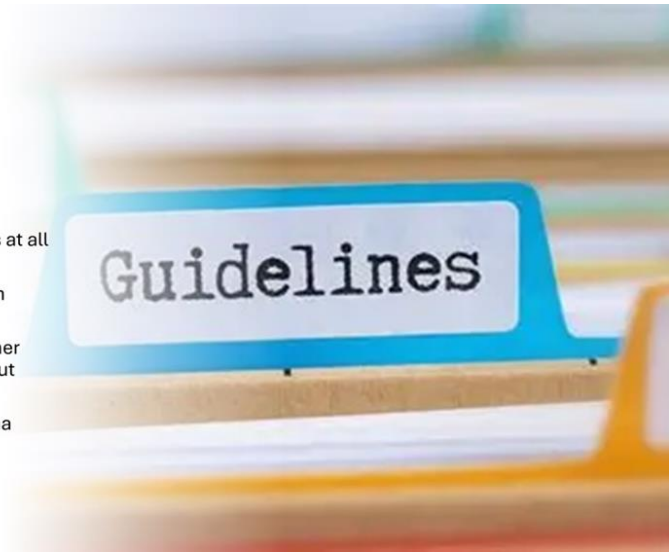
When to drain an empyema?

- If septicaemic – TREAT the sepsis first, but consider early drainage for **SOURCE CONTROL (likely will need PICU referral/management)**
- If respiratory compromise or mediastinal shift – think early drainage for **MECHANICAL EFFECT (likely will need PICU referral/management)**
- If clinically stable and not septicaemic – Trial of antibiotics for **24-48 hrs** and drain if **NO IMPROVEMENT and,**
- Consider performing USS – depth of empyema (>1-2cm), presence of septae and no improvement after 24-48 hrs of antibiotics may require drainage **(discussion with respiratory team)**



Guidelines

- Do you have a sepsis guideline?
- Do you screen for sepsis at all healthcare encounters?
- Do you have a section on iGAS?
- In your guidelines for other conditions do you rule out sepsis?
- Do you have an empyema guideline?



Communication with families at discharge

- What should they be concerned about?
- **When** should they access help?
- Are they aware that their child could develop a secondary problem?
- **How** should they access help?
- Do they know the signs of sepsis?
- Just because we have seen him / her now does not mean if things change....
- Written information to follow up on verbal information given?
- Documentation of the advice you've given

Communication between professionals

- Use SBAR
- Clear communication in the ASK – Why are you phoning? For advice? For transfer/care uplift? For both?
- At the end
  - What have we agreed?
  - If not transferred now
    - What are the triggers for reescalation?
    - What would the specialist be concerned and want to know about?

The findings and learning were shared at the Learning from Incidents and Excellence Session led by the Yorkshire and Humber critical care network. A learning briefing has been disseminated to practitioners across the region. The learning has also been submitted to the Royal college of Paediatrics and Child health annual conference and will be presented in e-poster form at their conference in May 2026.

This is an excellent example of collaborative learning and combining knowledge across disciplines and hospitals to reduce future child deaths.

Keeping Babies Safe in Derby & Derbyshire

The Keeping Babies Safe Strategy – the Three Steps for Baby Safety was published in 2021 and reviewed and updated in 2024. The strategy underpins the work this year of the Keeping Babies Safe Steering Group and the priority of Derby and Derbyshire Safeguarding Partnership – The Safety of Babies.

A full evaluation of the practice and outcomes of the KBS initiatives was completed by the strategic lead for KBS on behalf of the DDSCP. Evaluation and Impact Report on Three Steps for Baby Safety sets out progress that has been made locally. This including gaining the views of families, frontline practitioners, and leaders. The report is published on the DDSCP website.

The KBS Champions have had a key role in developing the KBS resources, ensuring that the key safety messages are shared amongst practitioners and have been inventive in how they are shared with parents and families.

There are approximately 100 KBS Champions across Derby and Derbyshire. A network event Is delivered to champions twice a year. These meetings provide an opportunity to update champions on KBS work across the system and allow practitioners to share their experiences.

Keeping Babies Safe Audit and Voices of Families

The audit was in two parts – record keeping audit of 197 Health Visitor and Midwifery records and an anonymous online questionnaire to families where 460 responses were received. The audit considered the practice around safer sleep and delivery of the Parent Education Programme 'Never Ever Shake Your Baby'.

A high level of assurance was received that the key safer sleep messages are embedded into practice and remembered by parents. The Never Ever Shake Your Baby animation is being shown to parents with advice on safe handling and the management of crying.

The importance of contact with families in the antenatal period was evident from the audit and the importance of utilising the 6-8 week contact as an opportunity to deliver the messages.

Consideration needs to be given at all contacts to promote and utilise the co-sleeping and bedsharing tool and the development of quality conversations around safer sleep and bedsharing with families.

The KBS Roadshows for Early Years Practitioners

Leads from the KBS Steering Group and the Derby and Derbyshire Safeguarding Childrens Partnership (DDSCP) developed and delivered with partners two KBS interactive roadshows for Early Years Practitioners which included nursery workers, childminders and foster carers. The three interactive stations were in line with the KBS strategy: Safer Sleep, Safe Space and Safe Handling.

80 delegates attended the roadshows which were positively evaluated.

The Voices of Parents and the Child

When a child dies it is a tragedy for any family no matter what the circumstances are. Families and individuals manage the death of a child in their own way. Some will want to have an understanding about the child death review process and want to contribute their thoughts and feelings about their child's care and share personal information about their child, others want to grieve in their own way and do not wish to contribute to the processes following the death.

It is important to the Derby and Derbyshire Child Death Review Team that we contact every family following the death of their child and encourage a dialogue and the sharing of information if that is what a family wish to do. This is very much in the hands of the family. The team respect the wishes of families and their decisions.

The CDOP meeting will always consider the voice of the child and if the family have shared any views or information or would like any feedback following CDOP meeting.

The Lead Nurse for Child Death Review is a link for the families regarding the child death review processes. This includes liaising with the Coroner around care concerns, signposting families to support and bereavement services and answering any questions regarding the CDOP processes and meetings.

Any family requesting feedback will receive a letter from the Chair of CDOP thanking them for their contribution and with any learning that has been gained from hearing their child's story.

The team and CDOP believe it is important to get the balance between an independent review of a child's death and remembering the importance of the child's life and voice and how this can enrich any learning for CDOP and our wider partnership.

One family kindly gave permission to share their experience of their son who died at home from a life limiting condition. His story was moving and powerful and helped to illustrate the challenges that can face children and their families at the end of their lives. A consultant in palliative care medicine who looked after this child stated:

- As we say in Palliative care *"we only have one chance to get it right" we don't always manage to achieve this in adult palliative care but we need to always strive to make this difference, paediatric palliative care should be no different.*
- Dad's words regarding his son - *'He died peacefully at home on his sofa in his lounge right where he wanted to be, surrounded by his family. The last thing he'll remember is being in his mother's arms telling him how much we all love him'.*

Ensuring our children and young people are enabled to die peacefully in a way that we would want for our own loved ones is something that Derby and Derbyshire CDOP are passionate about and something we continue to petition and strive for.

Assurance and the Dissemination of Learning

To ensure that CDOP is meeting the statutory guidance (2018) it is important to give assurance to the Child Death Review Partners (CDR) that CDOP is functioning well and is sharing and disseminating the learning across the partnership. This is achieved by quarterly reporting by the Chair of CDOP to the CDR partners and by sharing any areas of developments as well as any risks or concerns. Assurance is also given through the Derby and Derbyshire ICB Safeguarding Committee and through the sharing of the Annual Report to the CDR Partners and the Derby and Derbyshire Safeguarding Children's Partnership. The report is then published on the DDSCP website.

The dissemination and sharing of learning are fundamental to the work of the Child Death Review Team and CDOP. The team disseminate leaning through other groups such as JUCD Childrens Delivery Board, the Derbyshire Self-harm and Suicide Prevention Partnership and the Derby and Derbyshire Safeguarding Childrens Partnership. The team share learning regionally with the East Midlands Regional CDOP group and nationally with NHSE and the NCMD.

This year the CDR Team completed a survey with CDOP members to gain assurance on the functioning of CDOP working with partner agencies and to ensure that there is a framework for sharing and disseminating learning.

Assurance from CDOP members:

The team completed a survey of CDOP members to sense check that members have a good understanding of the processes, feel able to contribute and have a system of sharing learning across their own organisations. We also asked members if they could articulate how CDOP made a difference and what the impact has been.

The key themes of the survey:

- There is a good understanding of the CDR processes and the role of CDOP members.
- CDOP members felt supported by the CDR Team.
- All CDOP members felt they can contribute during the meeting
- The majority have a good understanding of how modifiable factors are considered
- Only half of CDOP members felt they always had the time to read the information and prepare prior to the meeting.

CDOP members told us:

How do members share and disseminate learning:

- Through a wide range of safeguarding forums.
- To GP practices through the GP newsletter.
- Consultant and clinical meetings.
- Childrens Social Care manager and team meetings.
- Themes are shared to improve the team's knowledge around child deaths and to identify any training needs.
- Specific learning regarding safe sleeping is shared in the neonatal units and post-natal wards.
- Leaders and professionals' meetings.
- Within the Best Start teams in Public Health for information and onward sharing. There is a greater role for Public Health to have, for example greater incorporation within our own work and work with partners and commissioned services.
- Email.
- Newsletters.

The CDR Team produce CDOP newsletters looking at themes and practice and any new information or reports received regionally or nationally including incorporating findings from NCMD themed reports.

The CDR Team also produce learning briefings following Themed CDOP meetings to ensure that the themes and learning from the panels are brought together to inform practice.

Last words from our CDOP members

I just want to say thank you for making me feel so welcome to CDOP. It's such a lovely friendly group, and despite the context of the discussions/cases everyone supports each other and brings their expertise to the room. It's great to see how we can improve our service

Despite the nature of the discussions, I've enjoy being a panel member, and will continue to support the development of the panel with understanding and actioning behavioural and wider determinants factors that are identified as themes in contributing to child deaths.

Big thank you to the team for all the work that you do in enabling the CDOP process to run as smoothly and effectively as it does - great job

Achievements of the Child Death Review Team and CDOP

- Produced a second report on the challenges of 24/7 palliative care for children which was shared with the Derby and Derbyshire Children's Delivery Group and other networks.
- Completed an audit on children who have died of Streptococcus A Disease, learning produced and combined learning event delivered with Sheffield Children's Hospital. Learning shared across networks.
- Delivered training to GP's which included key learning from themed reviews and awareness raising of child death review and CDOP processes.
- Delivered combined training for consultant paediatricians at UHDB led by the Designated Doctor Child Death and senior Police representatives on deaths from inflicted injury and the joint agency response process.
- Delivered training for named and designated safeguarding professionals on CDOP and the learning from thematic reviews.
- Feedback questionnaire shared with CDOP members and assurance gained that CDOP processes are working well and learning is shared appropriately
- Following an options report being written funding for psychological support for the CDR team has been agreed by the Derby and Derbyshire ICB.
- Following a recommendation from a Child Safeguarding Child Practice Review the CDR Team met with colleagues in Nottinghamshire to strengthen the Joint Agency Response when there is cross border working.
- CDOP Briefings were produced on water safety and the safety of babies whilst being bathed.
- The KBS Strategy – The Three Steps for Baby Safety was reviewed and updated.
- A KBS audit was completed of Midwifery and Health Visitor records on the practice around safer sleep and the parent education programme 'Never Ever Shake Your Baby'.
- An online KBS questionnaire was developed for families with 460 responses this formed part of the KBS audit.
- Two KBS Early Years Practitioners Roadshows were delivered.
- Funding was secured to deliver The Giving HOPE project in Derby and Derbyshire to be launched next year.

Key Priorities for 2025-2026

- To commence psychological support for the CDR team.
- Review and update the guidelines for the Joint Agency Response (JAR).
- Plan a webinar to launch the new JAR guidelines and work with partners to raise awareness about new JAR processes.
- Plan further JAR training.
- Development of a formal governance structure with the Child Death Review Partners.
- Plan a Themed CDOP meeting for children who died by self-inflicted means.
- Continued development of the work on deprivation and the association with child death.
- Develop and launch the Giving HOPE Project across Derby and Derbyshire.
- Review and re launch the Co sleeping/bedsharing tool and guidance.
- Review the KBS Every Baby Matters tool.

References

Department of Health and Social Care & Department for Education (2018) **Child death review: statutory and operational guidance (England)**

NICE Guidance NG61 (2019) **End of life care for infants, children and young people with life-limiting conditions: planning and management.**

NICE Quality Standard QS160 (2017) **End of life care for infants, children and young people**