

Derby and Derbyshire Child Death Overview Panel Annual Report April 2025 to March 2026



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Powerful beyond words

Tiny, small & helpless?
Powerless and weak?
How can I try to help you
When I can't hear you speak

A life too short, a tragedy
A potential unfulfilled
But powerless & silent, no!
I hear you if I will

You speak to me so loudly
When I look to help the rest
Whispering gentleness and love
As I try to do my best

Your life though short
Is valued beyond worth
Silent & powerless, no!
You are powerful beyond words

N Medd

Introduction: Babies- dependency, vulnerability and untold potential

Babies are vulnerable and dependent, shaped by factors beyond their control from before their birth. Their outcomes are influenced by maternal health, the quality of maternity and neonatal care, and the ability of parents to provide safe and effective care for them. The systems and processes around delivery are often impacted by issues highlighted in the many maternity reviews. Unlike older children, infants cannot express when something is wrong, making them entirely dependent on those around them.

The Nuffield Trust report that the Infant mortality rate (IMR) in the UK remains higher than in other countries. IMR is a nationally recognised indicator of the health status of a country and the effectiveness of healthcare systems. It highlights societal inequalities and gaps in access to safe, high-quality, family-centred care.

Evidence from a recent NCMD study shows that the first 1,000 days, from conception to age two, are critical, with early ill health impacting outcomes, and mortality, across the whole of childhood.

If we can put effective preventative measures in place so that healthy women have healthy babies who grow up to be healthy adults then the long-term positive impact on our families, society and the NHS is enormous.

This year's CDOP report focuses on babies, highlighting both the factors contributing to infant deaths in Derby and Derbyshire and the actions being taken with our partners to address them.

Keeping babies safe and reducing infant mortality was a key driver for our CDOP chair Juanita Murray who retired in June 2026 following the ICB reconfiguration. This report acknowledges the fantastic work she achieved and supported.

The health of babies will remain a priority for Derby and Derbyshire CDOP and, as we welcome our new chair Iain Little who starts in August 2026, we know that our children's future is in safe hands.

Maria Montessori, Italian physician and educator born in 1870, said that '*a child is both a hope and a promise for mankind*'.

The health of babies is a powerful measure of the quality of our current health systems and our future population health. Investment in them is an investment in a healthier, fairer society for us all.

Finally, we would like to thank CDOP members and partners for their continued commitment and dedication in this vital work to improve outcomes for children, young people and their families.

Dr Nic Medd and Kayleigh McMahon

Derby and Derbyshire Child Death Notifications

Notifications Key Information:

There were 68 child death notifications in 2025/26. This is 2 more than last year. There were also 6 more joint agency responses completed.

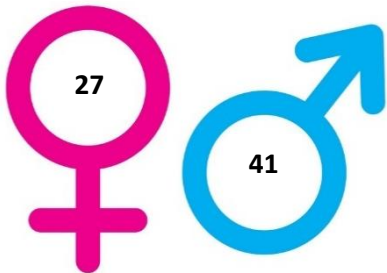
The largest age group was 0-27 days; this is the same as last year and in line with national data.

Of the 55 children that died in hospital, 36 (65%) were in hospitals out of area. 19 deaths (35%) occurred in one of our local hospitals.

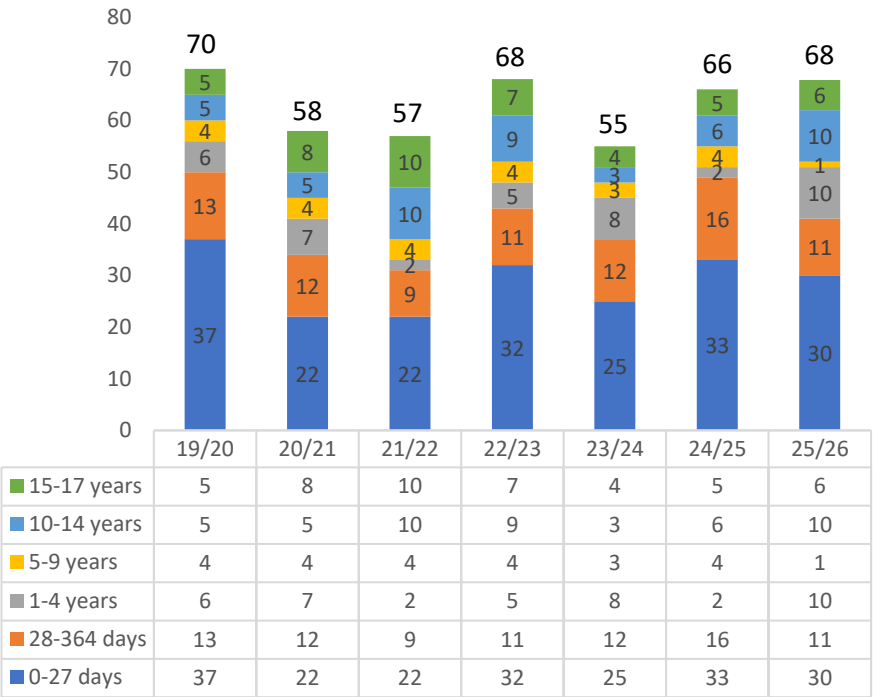
68 notifications received

17 Joint Agency Responses completed

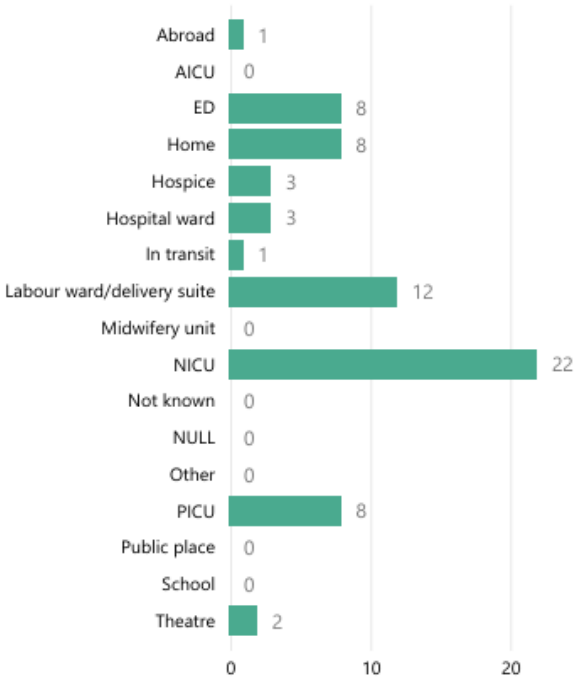
63 average deaths over 7-year period



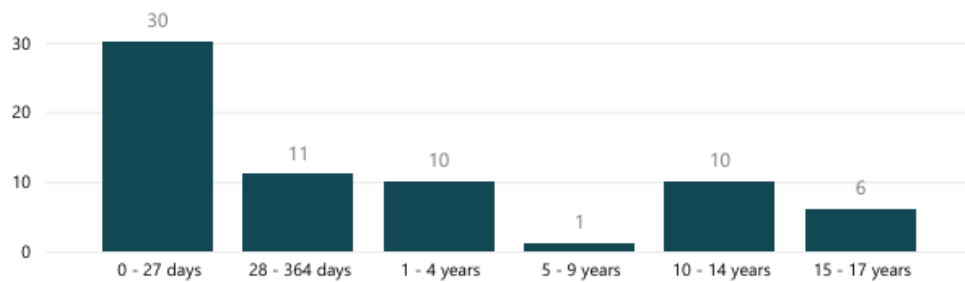
Number of Child Death Notifications 2019-2026



Death notifications by place of death



Death notifications by age group



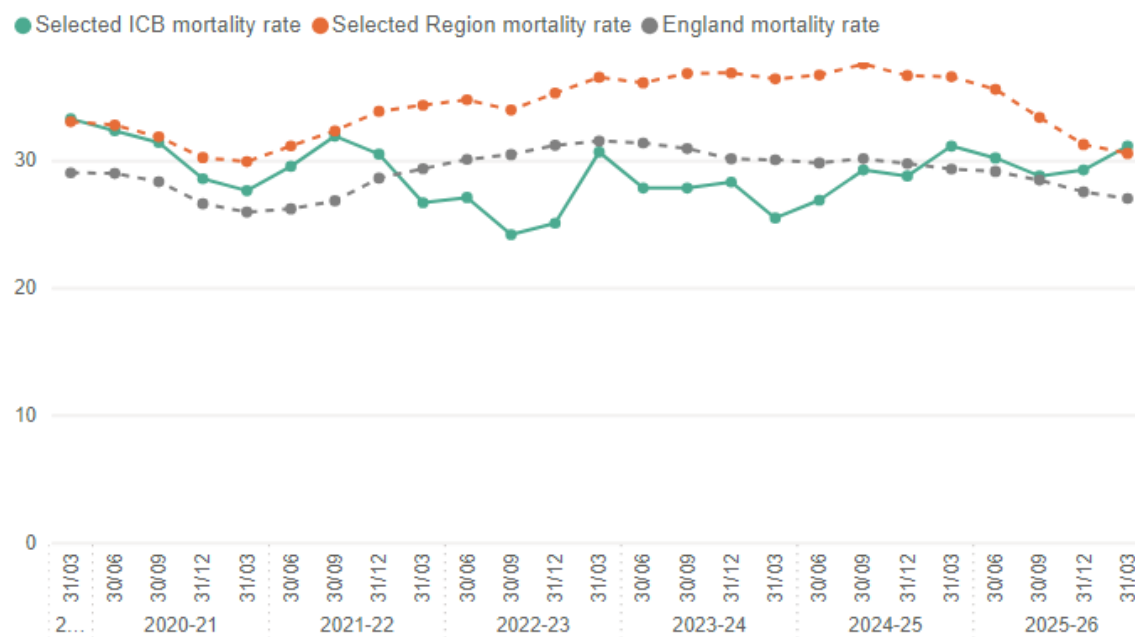
% of death notifications by age group - CDOP



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



Estimated rate of deaths of children aged 0 - 17 years per 100,000 pop...



https://app.powerbi.com/MobileRedirect.html?action=OpenReport&reportObjectId=e0011d85-f75b-460f-9b50-4c5304cf78ef&ctid=b2e47f30-cd7d-4a4e-a5da-b18cf1a4151b&reportPage=aa3827dab84640930f64&pbi_source=copyvisualimage NCMD - Infant and child mortality in England

CDOP will continue to review our mortality rate and consider if there are any trends that will inform future learning and actions. This will be an aim for 2026/27.

Derby and Derbyshire CDOP Completed Reviews

58

CDOP reviews completed

84%

with modifiable factors (48% England)

11

CDOP meetings held.

CDOP reviews in 25/26 by year of death

Year of Death	Cases
2021/22	2
2022/23	3
2023/24	6
2024/25	40
2025/26	7

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 reports available to CDOP. This can lead to some delay between the year of death and completion of the review.

CDOP Review Key Information:

The top 3 categories of death were:

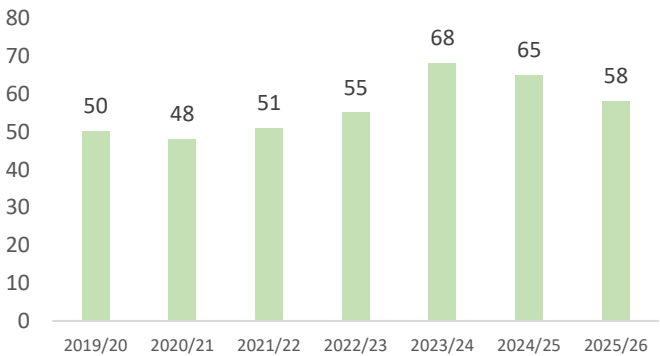
- Perinatal/neonatal event (52%)
- Chromosomal, genetic & congenital anomalies (14%)
- Sudden, unexpected, unexplained death (12%)

4 children had a learning disability.

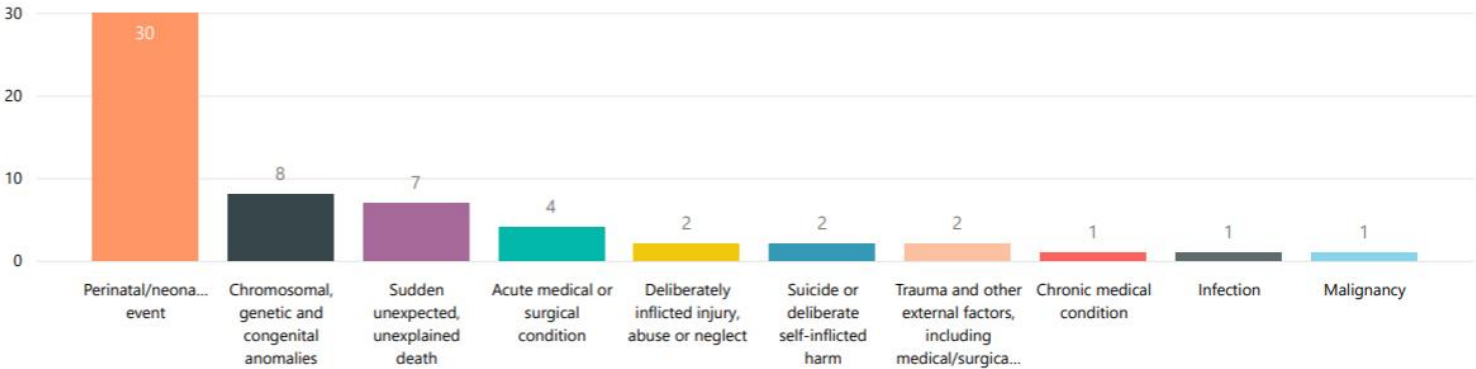
Themed panels held:

- Neonatal x 5
- Self-harm/PREVENT x 1
- SUDI x 1

CDOP Reviews completed by Year



Completed CDOP reviews by primary category of death



Derby and Derbyshire Identified Contributory Factors

The child death review teams & CDOP analyse any relevant factors that may have contributed to the child's death, and which may have been modifiable. The factors are recorded in 4 domains, and more than one factor in each domain can be identified for each child. Contributory factors are nationally standardised and defined. They are factors which may have contributed to the vulnerability, ill-health or death of the child.

- Domain A - factors intrinsic to the child.** Including child's age, gestation, gender, ethnicity, pre-existing medical conditions, developmental/behavioural issues or disability, risks in pregnancy.

Domain B - factors in the social environment including family structure and functioning, health issues, provision of basic care, engagement with services, deprivation, support, school environment.

Domain C – factors in the physical environment including sleep environment, poor quality housing, overcrowding, home/neighbourhood safety.

Domain D – factors in service provision including service provision/uptake. Issues relating to assessment, diagnosis, treatment, communication and organisation/system issues. It includes staff factors, task factors, equipment, work environment, training etc.

Top 5 Contributory Factors:

- Child health history/medical conditions (A)
- Risk Factors in mother during pregnancy/delivery (A)
- Parent/carers health (B)
- Communication within or between agencies (D)
- Smoking/vaping/alcohol/substance misuse by parent/carer (B)

Domain	Identified in number of cases:
Domain A – child	56 cases (97%)
Domain B – social environment	48 cases (83%)
Domain C – physical environment	21 cases (36%)
Domain D – service provision	49 cases (84%)

Top 3 contributory factors per domain:

- 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/vaping/alcohol/substance misuse by a parent/carer
 - Domestic or child abuse/neglect

Domain C: factors in the physical environment:

 - Sleep environment
 - Poverty and deprivation
 - Home safety/conditions

Domain D: factors in service provision:

 - Communication within or between agencies
 - Access to appropriate services
 - Initiation of treatment/identification of illness

Derby and Derbyshire Identified Modifiable Factors

CDOP is responsible for identifying any modifiable factors in relation to the child’s death. Modifiable factors are factors which **may** have contributed to the death of the child, and which **might** be modified by an action to reduce the risk of future deaths either at a local, regional or national level.

Top 5 Modifiable Factors:

	Poor documentation/record keeping (D)
	Smoking by parent/carer (B)
	Poor communication between agencies (D)
	Guideline available but not followed (D)
	High maternal BMI (A)

Modifiable factors key information:

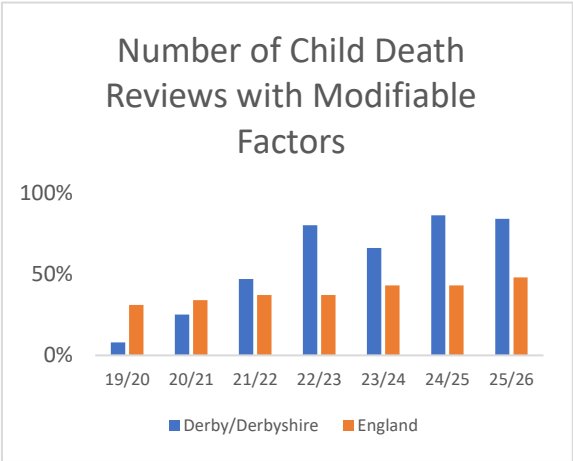
- Modifiable factors were identified in 84% of cases, compared to 48% in England.
- There has been no clear national guidance for identifying modifiable factors. This has led to subjective and variable rates between the CDOPs nationally. Historically, Derby/Derbyshire had a lower than national average rate. Due to this, local learning to improve consistency in identifying modifiable factors led to the rate increasing to above the national average.
- Following the publication of the national guidance in July 2026, the local guidance will be reviewed to ensure it is in line to improve consistency.

Smoking leads to adverse pregnancy outcomes including placental abruption, prematurity and low birth weight. It also increases the risk of SIDS. High maternal BMI is linked to pregnancy complications including increased risk of congenital abnormalities, pre-eclampsia and gestational diabetes. *See page 12 for further details and local actions.*

Poor communication included between NHS services (e.g. referral & handover), between health and social care and between health and education. Poor documentation/record keeping included risk assessments and checklists not being fully completed, information not being recorded sufficiently and limited information on Father's. A lot of the learning and actions had already been identified via internal reviews such as PMRT, CDRM and PSIRF. There is ongoing work to improve electronic systems to support documentation and information sharing.

Factors related to guidelines included differences between local/national guidelines, (e.g. the local fetal monitoring guideline wasn't in line with the saving babies lives care bundle) or guidelines being available but not followed (e.g. management of recurrent bleeds, pre-rapture of membranes and cervical cerclage).

Age group	Modifiable factors identified (%)			
	2022/23	2023/24	2024/25	2025/26
0-27 days	79%	↓69%	↑79%	↑81%
28-364 days	90%	↓83%	↑94%	↓93%
1-4 years	100%	↓88%	↓75%	↑100%
5-9 years	40%	40%	↑83%	-
10-14 years	89%	↓44%	↑100%	↓80%
15-17 years	75%	↓64%	↑100%	↓80%
Total	80%	↓66%	↑86%	↓84%

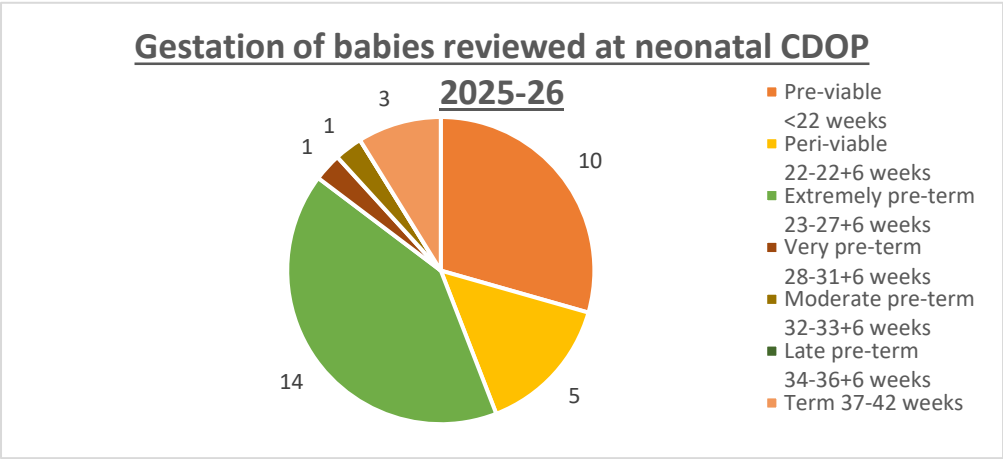


Learning Themes – Neonatal themed panels

All child deaths are important to CDOP. Learning from individual deaths includes sharing positive practice as well as considering how to improve practice across the partnership. CDOP has a role identifying themes, trends and learning to help prevent future deaths and improve care and services to children.

34 neonatal cases were reviewed during the 5 neonatal themed CDOP meetings held this year. This section focuses on newborn health and neonatal mortality in more detail.

Similarly to the NCMD report "[Contribution of Newborn health to Childhood Mortality across England](#)" only 3 (12%) babies were born at term (>37 weeks), highlighting that prematurity is the major factor in neonatal death.



10 babies (29%) reviewed at CDOP were of pre-viable gestation. This shows effective introduction of the statutory requirement that babies showing any signs of life, even at pre-viable gestations, are classified as a live birth and reviewed at CDOP. Previously it was likely that these babies will have been recorded as still-births and not reviewed at CDOP. Their inclusion makes the neonatal death rate seem high, but it is likely accounted for by increased reporting.

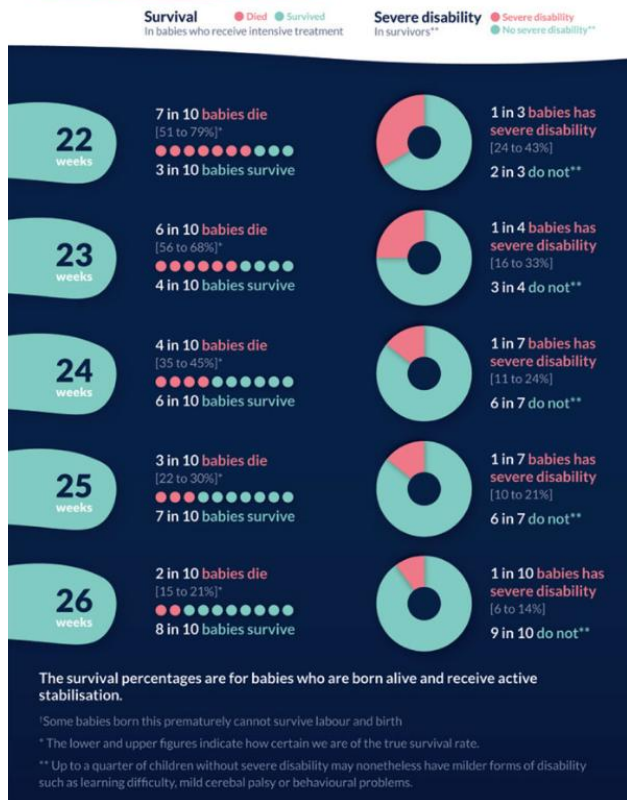
Babies can be born early for 2 main categories of reason:

1. Spontaneous preterm labour – the mother goes into labour early.
2. Delivery of the baby for fetal or maternal wellbeing – this is when continuing with the pregnancy might endanger the life of the mother (e.g. from preeclampsia) or baby (e.g. from declining placental function). In these cases, the risk benefit of early delivery is weighed up and made by the obstetric team in conjunction with the mother.

Prematurity remains the leading cause of death in babies and preventing preterm birth remains a challenge. What causes spontaneous preterm labour is not fully understood. Overall, it is thought to be due to multiple mechanisms and factors. Infection and inflammation are thought to potentially play a role. Maternal risk factors such as ethnicity, previous preterm births, multiple pregnancies, obstetric disease, bleeding, smoking, obesity and domestic abuse increase the risk of preterm delivery.

In 2023, a local themed CDOP report 'How big problems start small: the effect of maternal and neonatal health on childhood mortality' looked at 4 important factors – exposure to cigarette smoke, domestic abuse, maternal obesity and preterm delivery. The neonatal CDOP reviews in 2025/26 identified similar themes.

Outcome for babies born alive between 22 & 26 weeks' gestation†



Most recent survival data from the British Association of Perinatal Medicine (BAPM) published in 2026:

Survival to neonatal discharge rates are higher for babies born at a greater gestation.

22 weeks - survival to neonatal unit discharge is around **8%** of babies alive at the onset of labour, **10%** of live births, **20%** of babies who received survival focused care, and **30%** of babies admitted to neonatal units

23 weeks - As a proportion of neonatal admissions, survival to neonatal discharge is around **50%** for babies born at 23 weeks,

24 -26 weeks – Survival from neonatal admission to discharge is **70%** at 24 weeks, **80%** at 25 weeks and **85%** at 26 weeks.

The infographic is produced by BAPM for use with parents for counselling. The outcomes on latest 2026 data are slightly different to the infographic.

Neonatal Theme – Transfer of babies

As a result of the increased mortality at lower gestations, the highest risk babies (less than 27 weeks and less than 800g) should be born and cared for in a level 3 NICU and the best chance of survival is to complete an in-utero transfer (IUT) – before the baby is born. There is evidence that ex-utero transfer after birth adversely affects babies' health and mortality rates. Within Derby/Derbyshire there are 2 NHS hospital trusts that have level 2 neonatal units. Royal Derby Hospital is within the East Midlands neonatal operational delivery network, and the nearest level 3 unit is Nottingham University Hospitals. Chesterfield Royal Hospital is within the Yorkshire & Humber neonatal operational delivery network, and the nearest level 3 unit is The Jessop Wing, Sheffield Teaching Hospitals.

There are several reasons why an in-utero transfer may not be possible.

1. Precipitate labour – it may be unsafe to transfer Mother due to the high risk of delivery on route.
2. Unwell Mother – Mother's condition may mean she is too unstable to transfer.
3. Cot availability – There may not be a level 3 cot available within an appropriate distance.

58% of the neonatal cases reviewed in 2025/26 were either born in the 'wrong' place (not in a level 3 unit when they should have been) or were transferred out of the clinical network for a level 3 cot. Transfers out of clinical network provides appropriate medical care for the baby but is challenging for families who are a long way from their homes, families and supportive networks.

Babies who develop abdominal issues such as necrotising enterocolitis also may require more than one transfer, firstly to a level 3 bed and then to a surgical bed. Whilst at present there is no easy answer to this, CDOP acknowledges the trauma for families and the challenges for babies in having to move around the country to receive the care they need.

Whilst maternal condition or precipitant delivery cannot be modified, cot capacity/availability within the network are potentially modifiable factors. This issue has been raised locally and within the regional neonatal networks.

Local Trusts have completed some work to identify the need to facilitate in utero transfer at the earliest opportunity.

Neonatal Theme – domestic abuse and routine enquiry

The reported incidence of domestic abuse has also reduced this year. It was only identified in 3 cases. Substance/alcohol misuse were only seen in 2 cases.

Neonatal Theme – Exposure to smoke

Smoking rates remain high, however smoking cessation was almost always offered and household members are now included. 10 (29%) of the babies reviewed had been exposed to maternal, paternal or household smoking.

It is unclear why smoking services offers are being declined. There needs to be consideration regarding the quality of the offer for smoking cessation services, particularly for those that initially decline. The barriers for people accessing cessation services need to be carefully considered to identify ways to overcome them (e.g. clinic location).

Neonatal Theme – Maternal obesity

Maternal obesity continues to be a theme in neonatal cases, although it was only present in 5 cases (14%) which has reduced from 42% previously. Maternal BMI is now considered as part of the PMRT review. Increased awareness of services available for women is required to increase referrals and to access to the service, ultimately reducing risk factors linked to high maternal BMI.

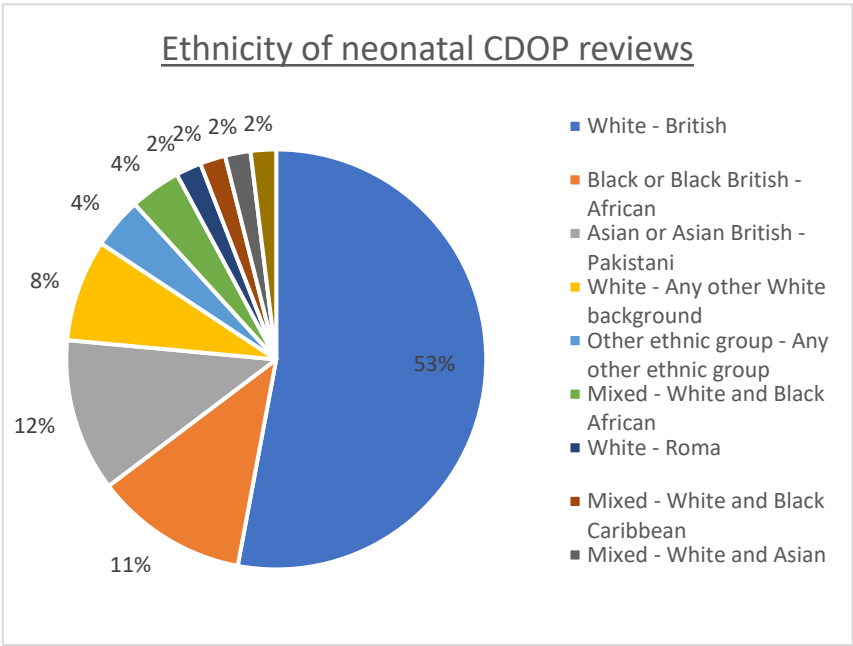
[The Healthy Beginnings campaign](#) across Derbyshire and Derby City promotes the importance of preconception and pregnancy health, encouraging prospective parents to consider their physical and emotional wellbeing before and during pregnancy. The campaign provides evidence-based information on healthy lifestyles, including nutrition, physical activity, smoking cessation, alcohol avoidance, and mental wellbeing, alongside support for managing existing health conditions and accessing local services.

Improving preconception health is a key component of prevention and early intervention. The health and lifestyle choices of both parents before conception can significantly influence fertility, pregnancy outcomes, and the lifelong health of their child. Supporting individuals to optimise their health before pregnancy can reduce the risk of complications and contribute to healthier pregnancies and improved outcomes for babies.

The Healthy Beginnings [Preconception Toolkit](#) supports professionals to incorporate preconception health messages into routine contacts through the Making Every Contact Count (MECC) approach. This is particularly important given that around 45% of pregnancies in the UK are unplanned, limiting opportunities for prospective parents to prepare for pregnancy in advance.

From a child death review perspective, promoting preconception health contributes to wider efforts to reduce avoidable risks associated with poor pregnancy outcomes, prematurity, low birth weight and infant mortality. Encouraging early engagement with health services and healthier lifestyle behaviours supports the ambition to give every child the best possible start in life and helps address factors that may contribute to preventable child deaths.

Neonatal Theme – Ethnicity



National data has similar findings and an NCMD study stated that 12% of infant deaths in England could be avoided if all infants had the same risk of death as White infants.

Work is being done at a national level to understand the factors that may have an impact on this disparity in mortality rate.

Neonatal Theme – parental age

A maternal age of greater than 40 was seen in 6 deaths (18%).

Increasing paternal age was also seen and CDOP considered whether it was a risk factor for neonatal mortality. Public health colleagues completed a research review and found limited and inconsistent evidence that paternal age is an independent risk factor for premature birth / neonatal death.

Neonatal Theme – parental voices

Similarly to the findings of the Ockenden review, there was a theme of parents not feeling listened to. Failure to listen to families is a recognised contributory factor. The final Ockenden maternity review is due to be published in June 2026. CDOP will ensure that family voices are captured through the CDR process, including through PMRT/CDRM. Parental concerns will be considered potential modifiable factors, including whether their concerns were escalated appropriately and responded to adequately. CDOP will review the Ockenden & Amos reviews and the implications for CDOP and partners.

Neonatal Theme – donor breast milk

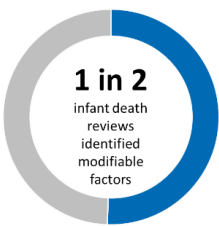
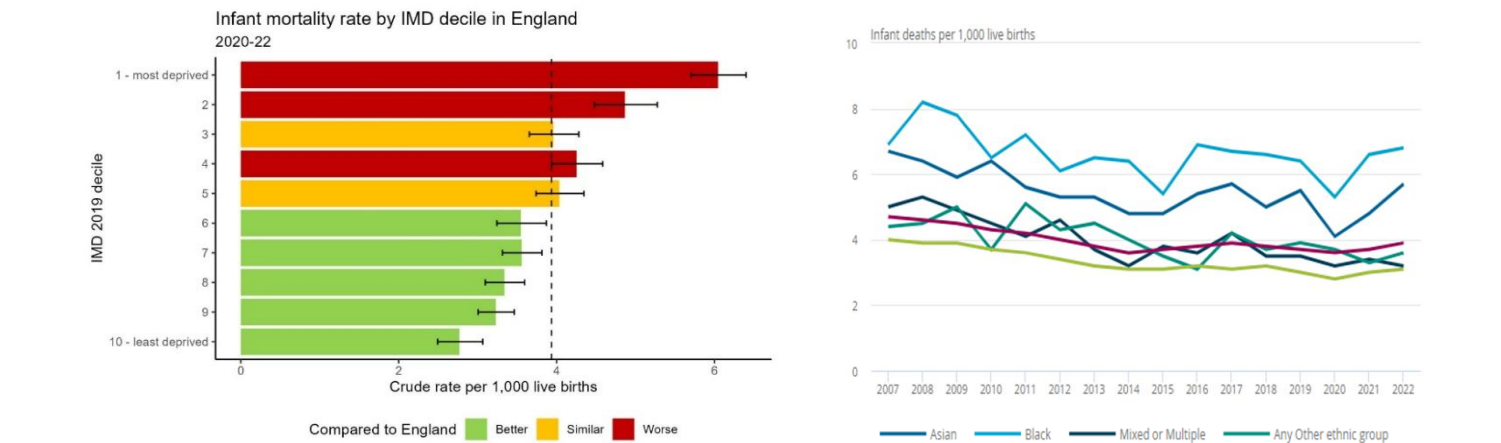
There are now processes and resources in place to support Mothers who wish to donate breast milk following the death of their baby. Both neonatal units will discuss the option with the mother and provide information. Local milk banks facilitate donation and provide emotional support to the family following the death of their baby. There are now facilities and procedures in place on both neonatal units to offer babies donated breast milk.

Learning Themes – Public Health infant mortality deep dive

Infant mortality is an important measure of the health of a population and is a useful indicator of other social, economic and environmental factors that affect overall health outcomes. The infant mortality rate in England has decreased considerably over the past 40 years, mainly because of improvements in public health and medicine. This improvement has stalled in the last 20 years though, and progress has fallen behind other European countries. The first 28 days of life represent the most vulnerable time for a child's survival, and most infant deaths occur in this neonatal period. It has also been shown that up to 70% of deaths in children under 10 years have a contributory neonatal illness. Addressing the causes of infant mortality can therefore lead to wide ranging improvements in the health of neonates and infants, and therefore older children too. The infant mortality rate varies by personal and population characteristics. These include deprivation, geography and ethnicity.

The NCMD produced their data in a JAMA paper in 2022 stating that, 12% of infant deaths in England could be avoided if all infants in England had the same risk of death as White infants, a new study from the NCMD shows. Such a change, which equates to more than 200 deaths per year, would bring England – which currently has one of the highest infant mortality rates in Europe – in line with other EU nations.

Our data shows the same, that non white babies have a disproportionately high mortality rate. We need to understand the reason for this more if we are effectively to bring equality of outcome to all racial groups.



CDOP completed 181 reviews between April 2019 – August 2024. Half of the reviews identified modifiable risk factors. The interaction of multiple factors can increase the impact and vulnerability to death (compared to those with only one factor present). Few risk factors for infant mortality exist in isolation. For example:

- The risk of **low birthweight** increases with prematurity, maternal smoking, maternal substance and alcohol misuse, poor maternal nutrition, young age of mother and pregnancy complications.
- **Smoking** is associated with not only low birthweight, but also congenital abnormalities, placental abruption, preterm birth, miscarriage, still birth, neonatal death and SUDI.

Several interventions are known to reduce the risk of infant mortality:

- Folic acid supplementation, vaccination programmes, breastfeeding, safe sleeping advice, smoking cessation support, screening for gestational diabetes, early recognition and treatment of illness.

Rates of infant mortality are significantly higher in Derby than the rest of England, with rates in both Derby and Derbyshire being high amongst those living in deprived areas and from ethnic minority groups.

The risk factors contributing to infant mortality are manifold and intercommunicated. Reducing the exposure of infants and parents to these will not only reduce rates of infant mortality, but will also reduce stillbirth, child morbidity and improve people's health and wellbeing into adulthood.

Learning Themes – SIDS Themed panel

A themed review of babies who died from SIDS or unascertained causes identified key learning to strengthen safer sleep practice and reduce future risk. SIDS stands for sudden infant death syndrome.

SIDS Theme – sling safety

Safer sleep advice should routinely include sling safety, particularly the risks associated with hands-free breastfeeding and sling use at festivals and events. In response, a poster was developed to promote safer sleep at local festivals. Public Health worked with local festivals to ensure the poster was shared on the festival websites and displayed at the festivals.

Learning has been shared with the NCMD to raise nationally. Sling safety has also been incorporated into the Keeping Babies Safer (KBS) strategy to support practitioners to advise on sling safety when working with families.

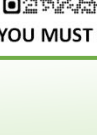
BABY SAFETY AT FESTIVALS



Safer Sleep:
(A) Always sleep baby...
(B) on their back...
(C) In a clear cot or sleep space—
Follow the ABC's!
And Always Plan Ahead!



Co-Sleeping with Baby:
Co-sleeping is NOT recommended if any adult smokes, drinks alcohol, takes drowsy medication or if baby was premature/had a low birth weight.



Hands Free Feeding:
Always take your baby out of the sling/carrier to feed— this helps prevent choking or suffocation, especially in young (<4) or vulnerable babies.
All advice from Lullaby Trust.

The T.I.C.K.S. Rule for Safe Babywearing

Keep your baby close and keep your baby safe.
When you're wearing a sling or carrier, don't forget the T.I.C.K.S.



- ✓ TIGHT
- ✓ IN VIEW AT ALL TIMES
- ✓ CLOSE ENOUGH TO KISS
- ✓ KEEP CHIN OFF THE CHEST
- ✓ SUPPORTED BACK

Joined Up Care Derbyshire



Cots, Moses Baskets, and Travel Cots are SAFE for Baby
Pods, Bouncers, Swings, Armchairs/Sofas, and Car Seats are NOT RECOMMENDED

YOU MUST SEEK IMMEDIATE MEDICAL ATTENTION IF YOU/BABY NEED IT.

SIDS Theme – Early Help Assessment

The panel highlighted the importance of Early Help Assessments for vulnerable families. The Families First Partnership will support earlier identification of need and more coordinated family support.

SIDS Theme – Baby movement/apnoea monitors

Families may use movement or apnoea monitors for reassurance; however, these do not prevent SIDS and may provide false reassurance. Parents with a previous SIDS loss are often very anxious and should be offered CONI (care of the next infant) support, delivered by Health Visitors, in subsequent pregnancies and after birth.

SIDS Theme – Parental / carer alcohol use

Alcohol use by either parent when co-sleeping with a baby is dangerous due to the lack of arousal of the carer. It is a known risk factor for SIDS. It is often reported by parents to health care professionals as 'only' being low level alcohol use and is quite normalised in societal behaviour. Parents often under report and downplay their alcohol use.

SIDS Theme – Safer sleep for babies that have spent time on NICU

Parents may inadvertently replicate NICU sleep practices, such as sleeping prone or with positioners in place, at home without recognising that these occur under continuous monitoring in hospital and for specific medical indications. Previously babies would spend time in the nursery on the ward prior to discharge, which enabled the nurses to advise and demonstrate safer sleep practices. However, babies are going home much quicker now and may not spend any time in the nursery. Work is underway through the KBS steering group to strengthen discharge messaging and promote consistent safer sleep advice on NICUs & paediatric wards, supported by resources from the [Baby Sleep Project](#).

24 cases reviewed at CDOP found to have a cause of death as either **sudden infant death syndrome (SIDS)** or **unascertained** in this time.

Cases where a cause of death was identified have been excluded.

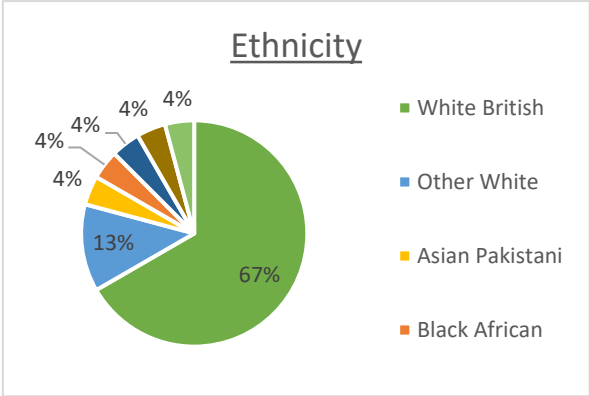
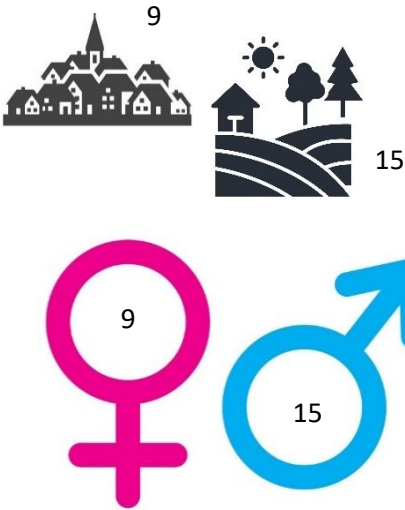
Age	Number of cases
0-1 month	12
2 – 6 months	10
7-12 months	2

100% of the cases had **modifiable factors** identified. Including:

- Maternal BMI
- Smoking (household/in pregnancy)
- Parental alcohol misuse or on the night of child's death
- Parental substance misuse
- Missed appointments
- Deprivation
- Information sharing
- In relation to sleep environment:
 - Items in the cot (cuddly toys, sleep positioners, loose blankets)
 - Prone sleeping
 - Unsafe co-sleeping (including with alcohol/substances/on sofa)
 - Out of routine circumstances
 - Temperature (room or baby overdressed)

These were the top **contributory factors** identified:

- Parental alcohol (including on night of death)
- Parental smoking (household/in pregnancy)
- Deprivation
- Items in the cot
- Parental mental health
- Acute infection in the infant
- Unsafe co-sleeping (with risk factors present)



The Lullaby Trust report that there is an increased risk of SIDS in **boys** (51% of unexplained infant deaths in 2023).

Nationally, 87% of SIDS happen in the **first 6 months** of life. Our data mirrors this (88%).

10 of the babies were born **preterm** (before 37 weeks). Pre-term babies are at a higher risk of SIDS, although it is not fully understood why. An [NCMD report](#) has identified that being unwell in the neonatal period increases the risk of SIDS.

Learning

There was good evidence that safe sleep advice is now being given to families after birth. However, families are not always following that advice. The main risk groups include families where their routine suddenly changes, families who have had a preterm baby and families who have consumed alcohol. Those from more deprived backgrounds remain at higher risk. For health professionals it is important that we continue to target these vulnerable groups to reduce deaths. The parental voices audit helps to understand why parents may not always follow safe sleep messaging.

Keeping Babies Safe Steering Group



KBS Training summary

The KBS training programme continued to have a positive impact on practitioners' knowledge, confidence and safeguarding practice.

- 57 practitioners completed the KBS e-learning module. The course was rated highly, with 86% scoring it above average (average rating 4.3/5) and a learning gain of 0.73, exceeding the global average for e-learning. 96% of delegates reported improved knowledge and skills, with increased confidence, curiosity and proactive practice.
- 148 practitioners attended Level 3 KBS training, representing a 10% increase on the previous year. Feedback was overwhelmingly positive, with most delegates rating the training 5/5, all confirming that learning outcomes were met and almost all stating that the content was relevant to their role.

Delegates reported greater confidence in professional curiosity, particularly when exploring concerns around substance use. The training strengthened understanding of key safeguarding issues, including bruising in non-mobile babies, household risk factors and safer sleep.

Practitioners identified tangible changes to their practice, including improved conversations with parents about safer sleep and co-sleeping, enhanced parenting assessments and interventions, better signposting to support services, and stronger safeguarding decision-making across screening, triage, discharge planning and management oversight.

Keeping Babies Safe Champions continue to have a key role in KBS, ensuring key safety messages are shared amongst practitioners. They have been inventive in how they are shared with parents and families. We thank them for their hard work and commitment.

KBS focus for 26/27:

- Antenatal contacts should be used more effectively to introduce conversations about safer sleep, safe handling, and managing crying.
- The 6–8-week contact presents a key opportunity to reinforce messages, as peak crying occurs around 8 weeks and the highest risk period for SIDS is between 2-4 months.
- Practitioners to be reminded of the risk of smoking in families and encourage and refer to smoking cessation services.
- Update and relaunch co-sleeping assessment following the audit outcome.
- Update and relaunch "every baby matters" tool following the audit outcome.
- Work with the neonatal units to review safer sleep messages on the ward and at discharge home.
- An evaluation of Giving HOPE project is due to be published in June 2026.



Hearing the voices of parents/carers is important to assess the effectiveness and impact of the keeping babies' safe initiatives and messages.

Objectives of the audit:

- To hear the voices of parents and families
- To assess and test the effectiveness and impact of the KBS messages
- To understand the experiences of parents and consider how practice adapts to meet the objectives of the KBS Strategy



Method:

An anonymous survey was sent by 0-19 services, by text message, to parents with babies under 6 months old.

Conclusions:

- It is important that multi-agency practitioners are delivering clear and consistent safer sleep messages to support families to understand how to avoid any risks to their baby
- By having a consistent approach it is hoped the number of babies dying from SIDS would be reduced
- Messages need to be bespoke and delivered at every contact

Co-sleeping/bed-sharing:

Research and feedback from parents suggests that:

- Practitioners should have open and honest conversations about the risks to some babies when co-sleeping
- Practitioners should be confident to advise parents to plan for safer sleep taking into consideration their babies needs and the environment
- 'Out of Routine' sleep episodes should be discussed with parents and a sleep plan created
- Saying to all parents 'do not bedshare' leaves parents without the information to make safe choices

Learning:

- Multi-agency practitioners should deliver clear and consistent messages, every contact counts
- The antenatal contact is important to start the conversations
- Considering the research on SIDS, timing of the messages is important - the 6-8-week check
- Parents are reporting to practitioners they do not plan to bedshare but 34% do so often in unplanned circumstances
- Open and honest conversations about the risks for individual babies should take place with all families to ensure parents understand any risks for their baby to bedsharing
- The vulnerabilities of certain babies and some family situations should be considered - this is described within the Derby and Derbyshire co-sleeping and bedsharing tool which should be used with all families

The voices of children and their families – Florence's story

Florence died at 12 years and 7 months from a life limiting condition. Her parents wrote a tribute for her which was shared with her treating team and CDOP. Florence's parents have kindly given their permission for this to be shared here within the annual report.

They generously and honestly share what it is like to look after a child who is moving towards the end of their life. Their experiences, alongside the many other families we hear from, are crucial in helping health care staff continue to compassionately care for our children and families.

Florence's story

I thought it might be useful for you to have a record of how we (parents) have negotiated the last few weeks of our child's life.

I think every parent will have found the journey different and we all have very different experiences with our children. I don't suppose it's likely that you get written feedback that might help you to help others navigate this difficult time. When we got her diagnoses, we felt sad for her and for a time wondered if we would lose her imminently. As time went on, we learnt to take a day at a time and although thinking about her future was distressing, we were able to see progress and her character, strength and resilience became more obvious.

We didn't see her as a very fragile child that needed wrapping in cotton wool but as a child that needed experiences that would make her small world a bit bigger. We celebrated each birthday and saw the smiles and enjoyment she was able to get out of life despite the obvious discomfort she sometimes felt. I think one thing that really helped in those last few weeks was having encouragement and support to keep doing normal things with her. I think being hopeful and positive and keeping things as normal as possible also helped, but at the same time I found the final trip to the hospice very hard to come to terms with. As she was being transferred from the trolley to her bed, I just felt overwhelmed that she was so poorly that we couldn't make her better. I think I had spent the last few weeks trying to be a nurse – or a doctor, working out what blood results meant and monitoring every little change in her condition. This was extremely stressful, and I just couldn't really let go and let the doctors do their job. So, when I was finally in a place mentally and physically, where I could just let go of that responsibility I found it was a massive burden removed. I think I said to someone it was nice just to be a mum after that.

I was able to give her a bath and take her outside in the sunshine (and rain) in her bed. I enjoyed reading stories to her in the garden. It was also good to have people who knew her well having looked after her through many visits. One nurse looked after her on our first visit and was there when she died. I liked the nurses who were able to laugh and joke with us – keeping the mood light even though she was very poorly.

Going back to the months before she died. That's when we got to know the palliative care team although I know we had been introduced before. I didn't feel it was very necessary at that stage, but it was. In hospital it is hard to get a complete understanding of where we were in the journey, but the palliative team helped us to come to terms with the stage we were at.

Our community nurse was also good at talking things through and being straight with us. We will always be grateful to her and for many years (and probably into the future too).

One area of difficulty was ambulance transport (as was hospital admission previously), but thankfully we were not particularly aware of the long phone calls and discussions about which ambulance service was responsible for transportation in this case. Thank you (CCN) for shielding us from all this and just getting on with it.

Once in the hospice, our visitors were always welcomed through the day. They were a comfort to us, as were the days when we were able to say 'no visitors today. We want to be on our own'.

I think she had a good death. We had 4 whole days with her without the tubes, masks, injections and monitors. Occasionally she would open her eyes but without any distress. When she became restless the pain relief and sedation was given promptly. We were grateful that on the morning she died we could see a change in her and had time for others to come and be with us. We were all there together as she took her last breath and that felt fitting. All her favourite people in the room together.

Because of our faith we believe she is in a better place. I used to talk about it to her even though she wouldn't have understood what I was saying. I would tell her one day we would be together, and she would be able to see and hear and dance and play. I still believe that strongly.

I want to say thank you to everyone who looked after her through her life. Also, the wonderful staff at Bluebell Wood who let us do things our way. We are a team, but a much wider team took care of her too, especially her carers at home. The last 4 days was special and not horrible. We were by then a unit of 3 and we loved being altogether despite the sadness. Now we are down to 2 at home and we are having to just get on with it and manage.

I hope this account helps to give some perspective on what it's like to be in that situation. Her funeral will be about hope and gratitude, and we will just have to manage a day at a time now as we have done successfully for the last 12 years.

Wider work / Partner learning

The **NCMD** have produced recent national reports on:

- [Understanding consanguinity-related child deaths](#)
- [NCMD-HSV-Briefing.pdf](#)
- [NCMD-falls-from-windows-and-balconies-briefing.pdf](#)
- [NCMD Life Limiting Conditions Report.pdf](#)

The CDR team have continued to promote and disseminate these excellent systematic reviews. The NCMD have also produced an updated 'when a child dies' leaflet in the 10 commonest languages spoken in the UK.

Health partners have produced excellent learning which the CDR team have been able to share across the footprint. Examples include medical learning posters on neonatal and paediatric health topics.

The NHS Trusts have continued to provide high quality and compassionate bereavement care to families.

The **East Midlands child death network** has continued to meet quarterly and share learning and themes from the 4 different CDOP's as well as improve cross border working. Occasional themes have been looked at with one example being access to community-based defibrillators.

Both **Neonatal ODN's** continue to review neonatal deaths and produce learning posters for sharing across the footprint.

National guidance [BAPM Neonatal Mortality Governance FEB 26.pdf](#)

Police colleagues have continued to implement Joint Agency Response training.

Charities continue to play a significant role. One example in March 2026 was when SUDC-UK succeeded in a 2nd Westminster parliamentary debate into sudden and unexplained death in childhood urging the government to look at what more can be done at a national level to reduce these deaths.



Achievements of the Child Death Review Team and CDOP

Psychological support is now in place for the CDR team, and it is going well.

The palliative care report has been shared at the children's and young people's delivery board and is due to be shared at the scrutiny panels for Derby and Derbyshire later in 2026.

CDOP member feedback survey was completed which demonstrated strong engagement and good understanding of the CDR process and their roles with CDOP. Members felt able to contribute to CDOP and most understood contributory/modifiable factors, although suggested that additional guidance would be beneficial. Members describe CDOP as welcoming, inclusive, professional, supportive and respectful and they valued the opportunity to bring together multidisciplinary expertise to learn from child deaths and improve services. Themed panels were highly valued, with members reporting that they enable deeper exploration of specific themes, identification of service gaps, sharing of good practice and involvement of specialist expertise. The survey identified opportunities to strengthen member support, improve dissemination of learning, enhance training opportunities and further develop guidance and resources for panel members.

A themed panel of deaths of children who had suffered a self-inflicted death where radicalisation, prevent and online harm was held with expert visitors present and learning disseminated to partners.

The CDR team considered how best to support CDOP members to disseminate key learning across the system. An NHS futures page has been developed for CDOP members and will be a central point for sharing information on processes and learning.

The CDR Team and Police representatives were keynote speakers at the National ACDRP conference in November 2025 in Birmingham. The team highlighted the role of the joint agency response in deaths from trauma and the challenges of working across boundaries.

The JAR guidance has been re-written. This included the introduction of new pathways (skin biopsy and whole genomic sequencing) and the new "early child death information sharing meeting". It involved a lot of joint strategic work across all key partners (health/CSC/Police/coroners/pathology). A webinar was held to launch the updated guidance. The early information sharing meeting is working well to provide improved information sharing and an early co-ordinated approach following sudden & unexpected deaths. The updated JAR paperwork is enhancing practice and improving information sharing amongst professionals involved in the response.

The NCMD monitoring report confirms high level of compliance and data completeness, providing assurance to the CDR partners.

There is now an Obstetrician representative who attends the neonatal CDOP panels. This will be useful to provide expert interpretation of maternal health factors, such as obesity, hypertension, smoking etc. and will help understand the circumstances around preterm birth and delivery complications. This will also strengthen links between CDOP learning, PMRT and local maternity systems.

The lead nurse and designated doctor continue to have an active role nationally with both being on the ACDRP national executive board as nursing and medical representatives.

The lead nurse, CDOP coordinator and CDOP chair continue to lead regionally coordinating the proactive East Midlands child death review group bringing together learning and resources from CDOP's across the region.

Teaching from the child death team and multiagency partners has continued with training for hospital and community paediatricians.

It has been a challenging year for the child death review team and CDOP. There are significant risks to the child death team and processes associated with the national ICB reforms.

Whilst the national ICB reforms are being completed it is currently unclear where the strategic responsibility for CDR/CDOP will sit going forward.

The CDOP Co-ordinator is on a secondment through DHcFT. At the time of writing this report, it is confirmed the role is permanent and appointed to.

Notably we have lost some of our key members, we give special thanks for all their hard work and many years of service:

- Juanita Murray – Chair of CDOP, strategic lead for KBS and Designated Nurse for Safeguarding Children.
- Michelina Racioppi – CDOP safeguarding representation and Assistant Director for Safeguarding Children.
- Colin Barker – CDOP Lay member

Iain Little, Consultant in Public Health, will be chairing CDOP going forward. The Lead Nurse will continue the KBS work as interim strategic lead, with support from the DDSCP business unit.

There continues to be many cases under coronial investigation. The CDR Team have regular contact with the coroner's officers and are kept up to date with progress.

There is a national shortage of Paediatric Pathologists. This means there is often a delay in postmortems being completed and the reports can take many months to be shared. This creates a delay in the coroner's investigation but also causes upset and uncertainty for families. The ACDRP (National forum) are in direct communication with the RCPCH and RCPATH to escalate this national concern.

There continues to be delays in receiving CDRM/PMRT reports/minutes from tertiary centres outside of Derby/Derbyshire. The CDR team are in regular contact with the external trusts and make appropriate escalations.

The lack of 24/7 palliative care to enable children to die at home is still a concern following an audit completed by the CDR team. This has been escalated and to the CDR partners. The Directors of Public Health will be sharing the issue at scrutiny committees and recommend a system wide response.

Key Priorities for 2026-2027

Despite the local and national uncertainty of CDR/CDOP in the ICB/NHS England reforms, the team have ensured that the statutory responsibilities for CDR/CDOP are still met to a high standard. With the loss of key individuals, this will be more challenging, but the team will endeavour to ensure this continues.

Due to the uncertainty of the ICB reforms, it has been difficult to plan training/development sessions, and the team have had to cancel the ones planned for 2026. The team are hopeful these can be planned for later in 2026/ early 2027.

The ICB clustering will enable the cluster teams to work more closely together and will provide an opportunity to develop CDR/CDOP further.

The KBS parental feedback audit poster and Group A Strep audit poster will be presented at the national RCPCH national conference in May 2026.

There will be an evaluation into the implementation and monitoring of the effectiveness of the updated JAR guidance.

Recruit a safeguarding representative and lay member for CDOP.

Development of a key worker pathway.

When the NCMD publish the modifiable factors guidance, the Lead Nurse will review and update the local guidance to improve consistency in identifying modifiable factors.

Review our mortality rates and consider if there are any trends that will inform future learning and actions.

CDOP will review the Ockenden & Amos reviews and the implications for CDOP and partners.

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