Nottinghamshire and Nottingham City Child Death Overview Panel (CDOP) Annual Report Briefing 2023/24

Background

Whenever a child or young person under the age of 18 dies, their death must be looked into through a process called the Child Death Review (CDR). This involves meetings where professionals who were involved in the child's care come together to discuss what happened before and around the time of the child's death. The information from these meetings is then passed on to a group called the Child Death Overview Panel (CDOP). This panel is made up of experts from different services, and they carry out an independent review. Their aim is to identify anything that might have been done differently to help prevent similar deaths in the future. Each year, CDOP produces a full report for the Safeguarding Children Partnership, which highlights key findings and lessons learned. This bulletin provides a summary of CDOP's work and learning during the year 2023–2024.

This briefing references the Child death data release 2024 | National Child Mortality Database for the year ending 31 March 2024.

CDOP function and membership

The Nottinghamshire and Nottingham City CDOP is co-chaired by a Public Health Consultant from and Nottingham City or Nottinghamshire County Council, with leadership rotating every two years. Members of the panel include representatives from:

- Public Health teams (City and County Councils)
- Designated Doctors for Child Deaths (Nottingham University Hospital Trust, Sherwood Forest Hospital Trust and Doncaster and Bassetlaw Hospital Trust)
- Lead Nurses for Child Deaths (from same local hospital trusts as above)
- Children's Social Care (City and County Councils)
- Nottinghamshire Police
- Designated Nurse Safeguarding Children (Nottingham and Nottinghamshire Integrated Care Board)
- Midwifery (from same local hospital trusts as above)
- Nottinghamshire Safeguarding Children Partnership

The coordination and administration of CDOP is delivered on behalf of Nottinghamshire and Nottingham City by a single Child Death Administrator and a Development Manager from Nottinghamshire County Council.

Child death data

Infant and child deaths

- Infant deaths (under 1) in Nottingham City fell to 5.2 per 1,000 live births (2021–23), down from 6.1 in previous years, and no longer significantly worse than the England average (4.1). Nottinghamshire matched the national average at 4.1 per 1,000 live births, down from 4.6.
- Child deaths (ages 1–17) in Nottingham City were 13.9 per 100,000 population (2020–22), down from previous years and no longer significantly above the national average (10.4). Nottinghamshire's rate was 7.4 per 100,000 population, now lower than the national average.

Number of infant and child deaths from 1st April 2023 to 31st March 2024

- 77 deaths were recorded locally, 11 in Nottingham City and 66 in Nottinghamshire. This is a slight rise from 72 deaths in the previous year.

Infant and Child deaths and Ethnicity

- Nationally, Black and Asian children had the highest child death rates, over twice that of White British children. However, death rates across all ethnic groups have decreased compared to the previous year.
- Most local child deaths were among White British children (53%), but no concerning patterns were found when looking at different ethnic groups.

Infant and Child Deaths and Deprivation

- Children in England's most deprived areas are over twice as likely to die as those in the least deprived.
- Locally, infant death rates were highest in Nottingham City (5.6 per 1,000 live births), with the lowest in Broxtowe (3.3) and Rushcliffe (3.7), suggesting a link to deprivation. However, the differences were not statistically significant due to the small number of cases.

Child death review

Deaths reviewed between 1st April 2023 to 31st March 2024

- In 2023/24, 3,345 child deaths were reviewed across England, some of which may have occurred in earlier years. This is the highest number since 2019/20.
- In the same period, Nottinghamshire and Nottingham City CDOP met 12 times and completed 51 child death reviews.

Likely cause of death in child death review

- The most common causes of death locally were perinatal or neonatal events (45.1%) and genetic or congenital conditions (17.6%), which reflects national trends (31% and 24% respectively). Sudden unexpected deaths, which was the third most frequent nationally (8%) was less common locally (2%).
- Acute medical or surgical conditions (15.7%) was the third most frequent cause of death locally, followed by cancer (7.8%), and trauma or external factors (5.9%).

Timeliness of reviews

- 51% of local reviews were completed within 12 months, which is better than the national average of 42%, but down from 62% the previous year.
- The median time to complete a review was 357 days locally and 411 days nationally. This is longer than in 2022/23, when it took 265 days locally and 335 days nationally, showing that reviews are now taking more time to complete.

Modifiable factors

- A key aim of the CDR process is to identify modifiable factors, i.e. things that may have contributed to a child's death or made them more vulnerable, which could be changed by national or local intervention to help prevent future deaths.
- In 2023/24, 43% of reviews nationally found modifiable factors. Locally, 32 out of 51 cases (63%) had modifiable factors – the highest in five years for Nottinghamshire and Nottingham City.
- The highest rates of modifiable factors were found in sudden unexpected deaths (86%) and deaths from trauma or external causes (83%), which is expected given their nature.
- The most common modifiable factors locally were parental smoking, issues with service provision and high maternal body mass index (BMI).
- Service-related issues remains at a similar level to recent years but are higher than in 2020/21, possibly reflecting early learning, and experience with, the Ockenden Maternity review team.
- The most common service-related issue was related to missed opportunities to optimise clinical care. These were not specific to one organisation and in many cases where service issues were found, improvements had already been identified and acted on before the CDOP review took place.
- Local initiatives and working groups across Nottinghamshire and Nottingham City continue to support parents with quitting smoking, weight reduction, safe sleep for babies, and substance use.

Conclusion

- The Nottinghamshire and Nottingham City CDOP continues to meet national requirements by carrying out timely child death reviews and bringing together professionals from different agencies.
- The Annual Report includes recommendations to enhance the local operation of the CDOP and strengthen collaboration with partners across the CDR process. For example, it recommends auditing the learning identified in CDOP cases to provide assurance to members that learning is being implemented and evaluated by service providers.