

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 2024–2025.

This briefing references the [Child death data release 2025 | National Child Mortality Database](#) for the year ending 31 March 2025.

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

Number of infant and child deaths from 1st April 2024 to 31st March 2025

- From 1st April 2024 to 31st March 2025, there were 71 child deaths notified in Nottingham City and Nottinghamshire residents, with 22 normally resident in Nottingham City and 49 in Nottinghamshire. This is a small decrease in the 77 deaths in the 23/24 reporting period.

Infant and Child deaths and Ethnicity

- In England for the year ending 31 March 2025, the child mortality rate remained highest among children of Black or Black British ethnicity (58.1 per 100,000 population) and Asian or Asian British ethnicity (52.2 per 100,000 population). The rates for all ethnic groups other than Asian or Asian British ethnicity have decreased in comparison to the previous year.
- However, the count from the overall completed cases for child deaths in Nottinghamshire and Nottingham City was highest in White British children with 43 out of the 74 cases (66.2%). This was followed by the next highest of 10 cases for Black or Black British (13.5%) and then 9 for Asian or Asian British (12.2%)

Infant and Child Deaths and Deprivation

- The child death rate for children living in England's most deprived neighbourhoods was 42.0 per 100,000 population, more than twice that of children resident in the least deprived neighbourhoods (17.4 per 100,000 population).
- The Office for National Statistics (ONS) and NHS Digital (NHSD) on registered births and deaths in Nottingham and Nottinghamshire over a recent 5-year period (2020-2024).. This shows that infant mortality rates are highest in Gedling and Nottingham City (5.4) and lowest in Broxtowe and Rushcliffe (3.1 and 3.6). This indicates that socioeconomic deprivation may be one of the factors associated with infant mortality rates.
- However, due to the relatively small sample sizes, the differences between local authorities do not appear to be statistically significant.

Child death review

Deaths reviewed between 1st April 2024 to 31st March 2025

- CDOPs in England reviewed 3,515 child deaths, some of which may have occurred in earlier years. This figure is a 4% increase on the previous year (3,374) and the highest number since 2019-20 for completed cases.
- In the same period, Nottingham City and Nottinghamshire CDOP met on 12 occasions and completed reviews of 74 child deaths

Likely cause of death in child death review

- The two most common primary categories of death across Nottingham and Nottinghamshire correlated with the national figures, including perinatal/neonatal events, which accounted for 35.4% of reviews and chromosomal, genetic, and congenital anomalies at 28.4%. Sudden unexpected and explained deaths were less common locally compared to nationally. There has been a slight local rise in malignancy from 7.8% to 9.5% this recording year and a fall of acute medical or surgical conditions at 6.8% down from 15.7%.

Timeliness of reviews

- At the national-level, 38% of reviews in the year ending 31 March 2025 were completed by the CDOP within 12 months of the death
- In Nottinghamshire and Nottingham City, 34% of reviews occurred within 12 months⁸. This is a decrease from last year's figure of 51% and slightly lower than the England-level.
- It is of note that the median time to complete reviews in 2024/25 was 404 days which is lower than the 2023/24 figure of 411. This suggests a modest reduction in overall review times, although the majority of reviews continue to exceed the 12-month review time.

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 2024/25, 48% of reviews nationally found modifiable factors. Locally, 61% had modifiable factors
- A look back over the past five years (2019-25) in Nottingham and Nottinghamshire shows the highest proportion of cases with modifiable factors was for sudden unexpected, unexplained deaths (88%), followed closely by deaths caused by trauma and other external factors (73%). This is in keeping with the nature of these deaths.
- It is important to note that perinatal/neonatal deaths (Category 8), has the highest absolute number of deaths (n=155) and had modifiable factors identified in 66% of cases.
- The top three modifiable factors locally in 2024–25 were high maternal BMI, parental smoking, and service provision issues. This broadly mirrors national findings for infant deaths, particularly in relation to maternal health and smoking
- 'Missed opportunity to optimise clinical care' is the most prevalent issue identified and remains from the 2023/24 data. This includes delays in monitoring, treatment and escalation and a failure to follow clinical pathways or procedures. A review of these cases did not identify a consistent reason for delay. There was no, one pathway or service area that was identified as a recurring issue, but it remains unclear if a broader theme related to how we help staff stay up-to-date on guidelines and pathways should be noted.
- 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 evaluating how learning is analyzed and shared to create maximum impact.