



LLR Child Death Overview Panel Annual Report 2024/25

Rob Howard, LLR CDOP Chair, Director of Public Health, Leicester City Council

Dr Suzi Armitage, LLR Designated Doctor for Child Deaths

Helen Reeve, Senior Data Analyst, Leicester City Council

Headline findings



Top **6** contributory
factors that could be
modified
to reduce future
child deaths in our
area



Smoking in pregnancy



Unhealthy weight in pregnancy



Household exposure to cigarette smoke



Poor communication between agencies



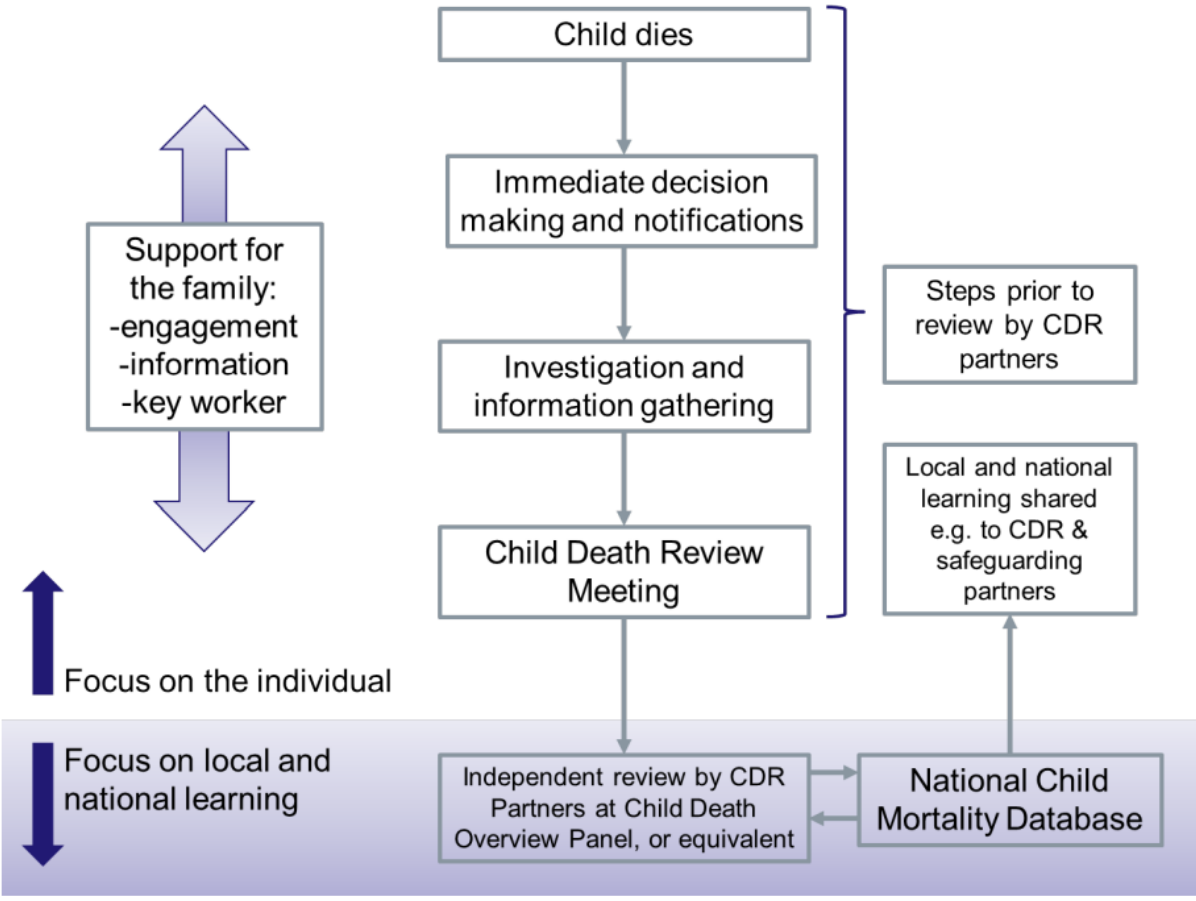
Guidelines or policies not being followed



Missed signs of deterioration



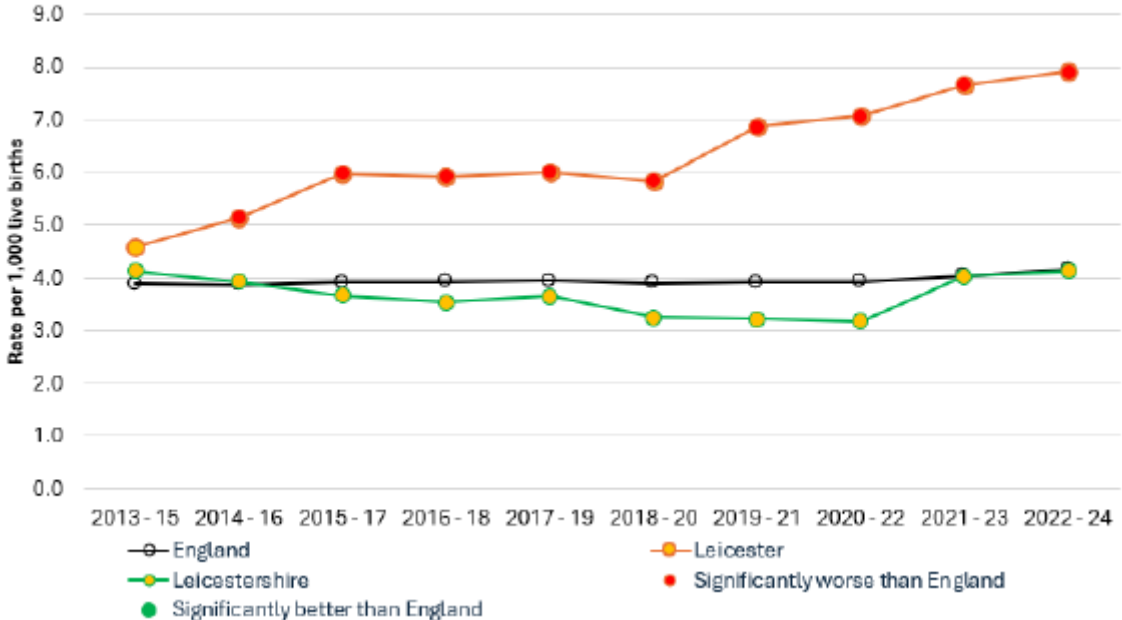
Child Death Review Process



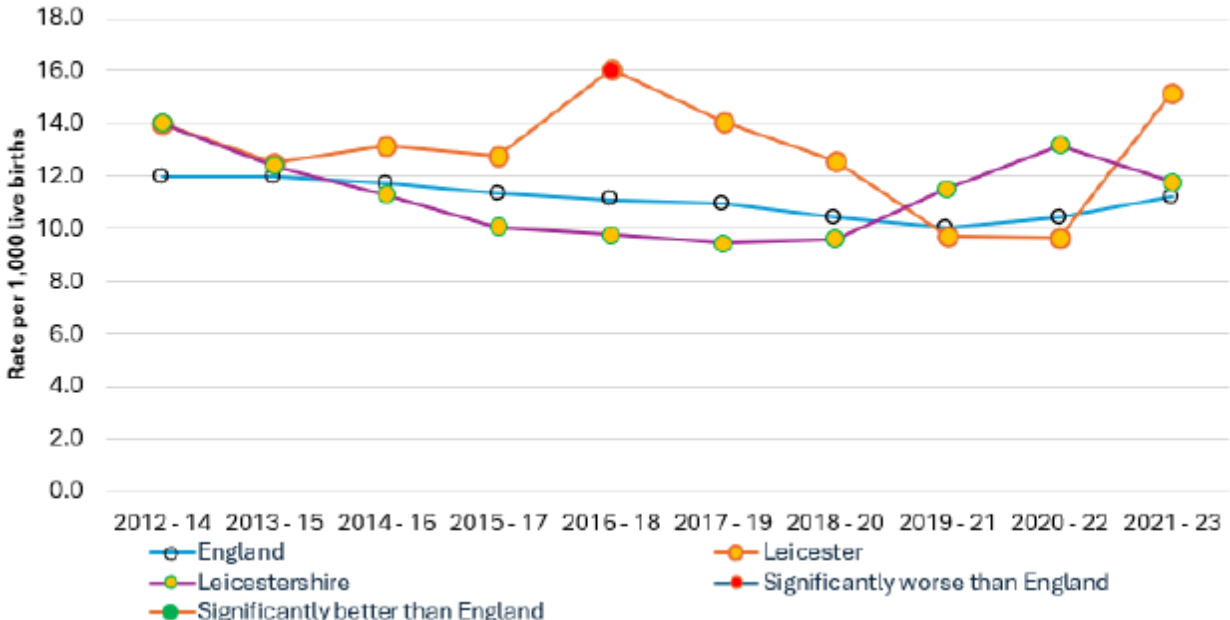


Summary Statistics

Infant mortality rate



Child mortality rate (1 to 17 years)



Wider context



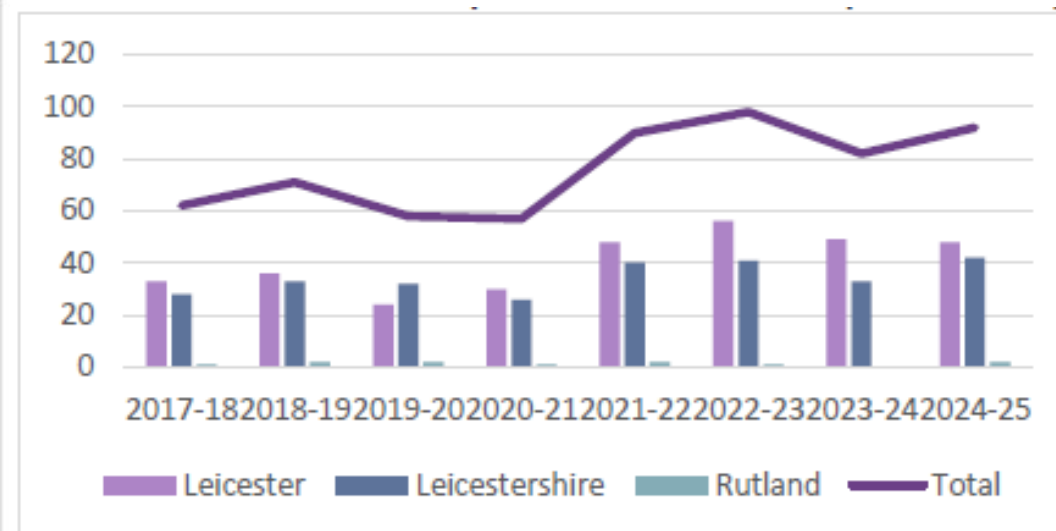
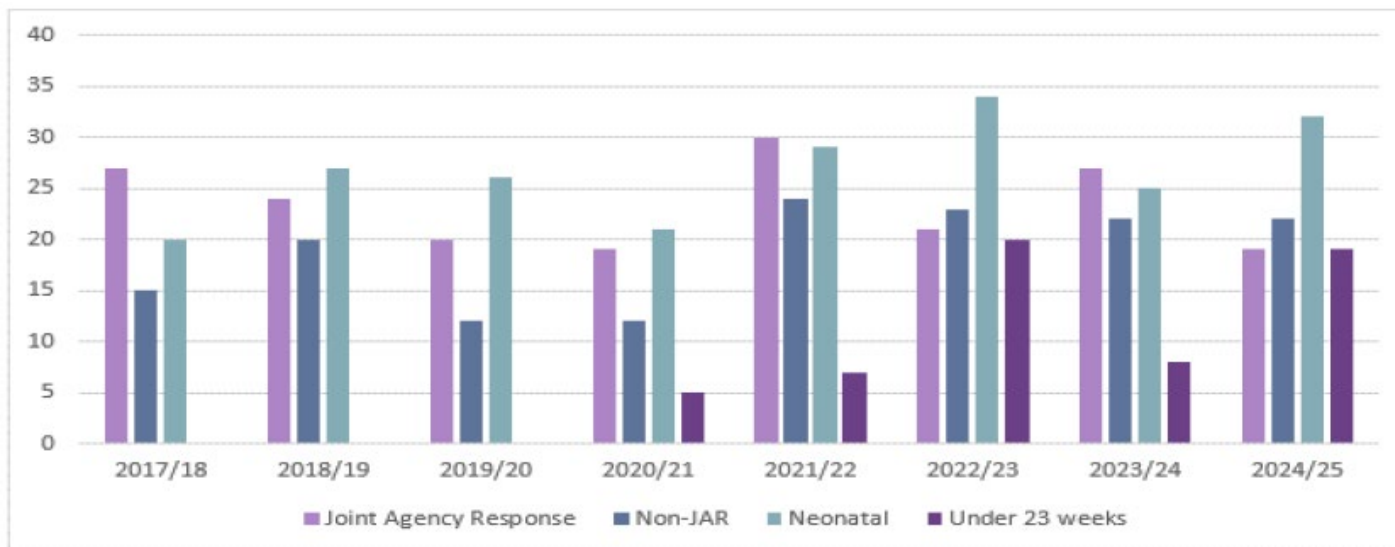
ICB: NHS Leicester, Leicestershire and Rutland Data source: NCMD, ONS mid-year population estimates

	Your ICB		England
	Infant deaths	Rate per 1,000 infants	Rate per 1,000 infants
1 (Most deprived)	126	7.7	5.3
2	48	4.1	3.8
3	45	3.9	3.0
4	51	3.2	2.6
5 (Least deprived)	40	3.1	2.2

ICB: NHS Leicester, Leicestershire and Rutland Data source: NCMD, ONS mid-year population estimates

	Your ICB		England
	Deaths of 1 - 17 year olds	Rate per 100,000 population	Rate per 100,000 population
1 (Most deprived)	41	13.0	15.4
2	36	17.4	12.4
3	33	14.5	11.5
4	36	10.9	10.0
5 (Least deprived)	23	8.3	8.3

Notifications 2024/25



Location of death:

- 77% In hospital
 - 56% on delivery suite or neonatal unit
 - 9% in Paediatric Intensive Care
- 20% Child's home
- 1% Hospice
- 1% Abroad

- 92 notifications in total.
- 29% of cases – Joint Agency Response
- 55% of cases – babies who died after birth on delivery suite or NNU
 - 37% of these born at <23/40 gestation.



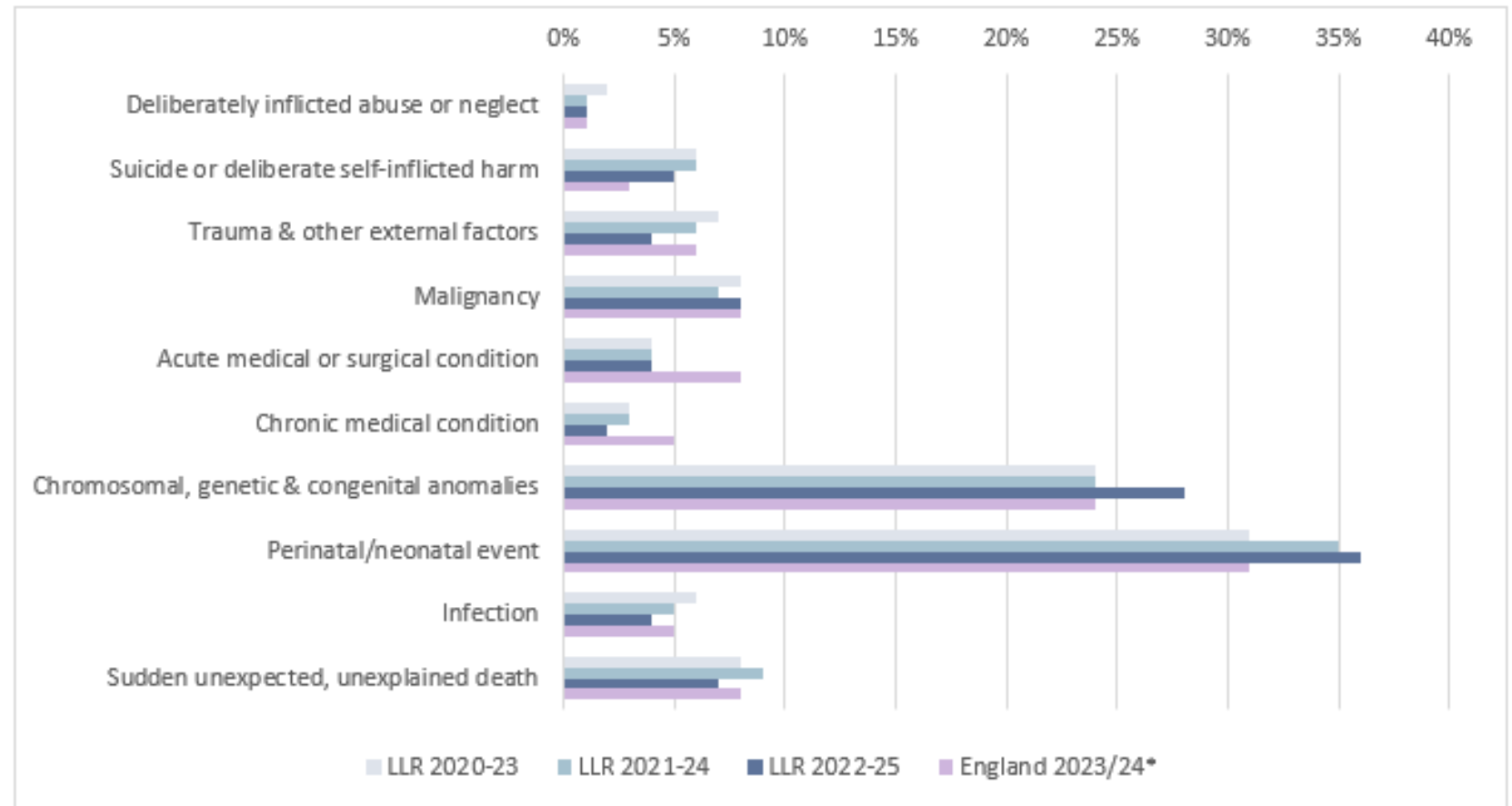
Completed Reviews 2024/25

Completed reviews by year of death 2024/25

Year of death	Cases
2017-18	1
2021-22	4
2022-23	24
2023-24	47
2024-25	5
Total	81

Category of death for completed reviews – 3 year merged data 2020 – 2025

*Data from NCMD Data Release Child Death Reviews Data: year ending 31 March 2024, published November 2024



Analysing the death of a child

- Health history/medical conditions
- Risk factors in mother during pregnancy
- Developmental conditions/disability
- Emotional/behavioural factors
- Smoking/substance misuse by child
- Other

- Initiation of treatment/identification of illness
- Following guidelines/pathway/policy
- Access to appropriate services
- Staffing/bed capacity/equipment
- Communication within or between agencies
- Communication with family
- Other

Child Factors



Family & Social Environment

Service Provision

Physical Environment

- Smoking/alcohol/substance misuse by parent/carer
 - Challenges with access to services
 - Domestic or child abuse/neglect
 - Household functioning
 - Poverty & Deprivation
 - Social Care
 - Cultural factors
 - Parent/Carer's health
 - School/peer groups
 - Other
- Sleep environment
 - Home safety/conditions
 - Vehicle Collision
 - Public Safety
 - Other

Definitions

Contributory Factor = Factor present & contributed to the death or vulnerability of the child.

Modifiable Factor = Factor could be modified by means of a locally or nationally achievable intervention to reduce risk of future deaths.



Local learning: contributory factors (1)

Domain A: Factors intrinsic to the child 2024/25

Noted in 80 cases (99%).

Factor by group	No of cases	% of cases
Child health history/medical condition	77	95
Risk factor in mother during pregnancy	32	40
Child's developmental condition/disability	11	14
Emotional/behavioural factors	3	4
Other	2	2
Smoking/alcohol/substance use/misuse by child	2	2

Domain B: Factors in the family/social environment

2024/25

Noted in 31 cases (39%).

Factor by group	No of cases	% of cases
Parent/carer's health	12	15
Cultural factors	10	12
Smoking/alcohol/substance misuse/use by parent/carer	10	12
Challenges for parents with access to services	9	11
Household functioning, parenting/supervision	8	10
Domestic or child abuse/neglect	7	9
Social Care	3	4
Poverty & deprivation	2	2
Other	1	1
School/peer groups	1	1

Local learning: contributory factors (2)



Domain C: Factors in the physical environment 2024/25

Noted in 5 cases (6%).

Factor by group	No of cases	% of cases
Sleep environment	4	5
Home safety/conditions	1	1
Public Safety	1	1
Vehicle collision	0	0

Domain D: Factors in service provision 2023/24

Noted in 24 cases (30%).

Factor by group	No of cases	% of cases
Following guidelines/pathway/policy	13	16
Initiation of treatment/identification of illness	8	10
Communication within or between agencies	6	7
Access to appropriate services	5	6
Communication with family	5	6
Staffing/bed capacity/equipment	5	6
Other	1	1



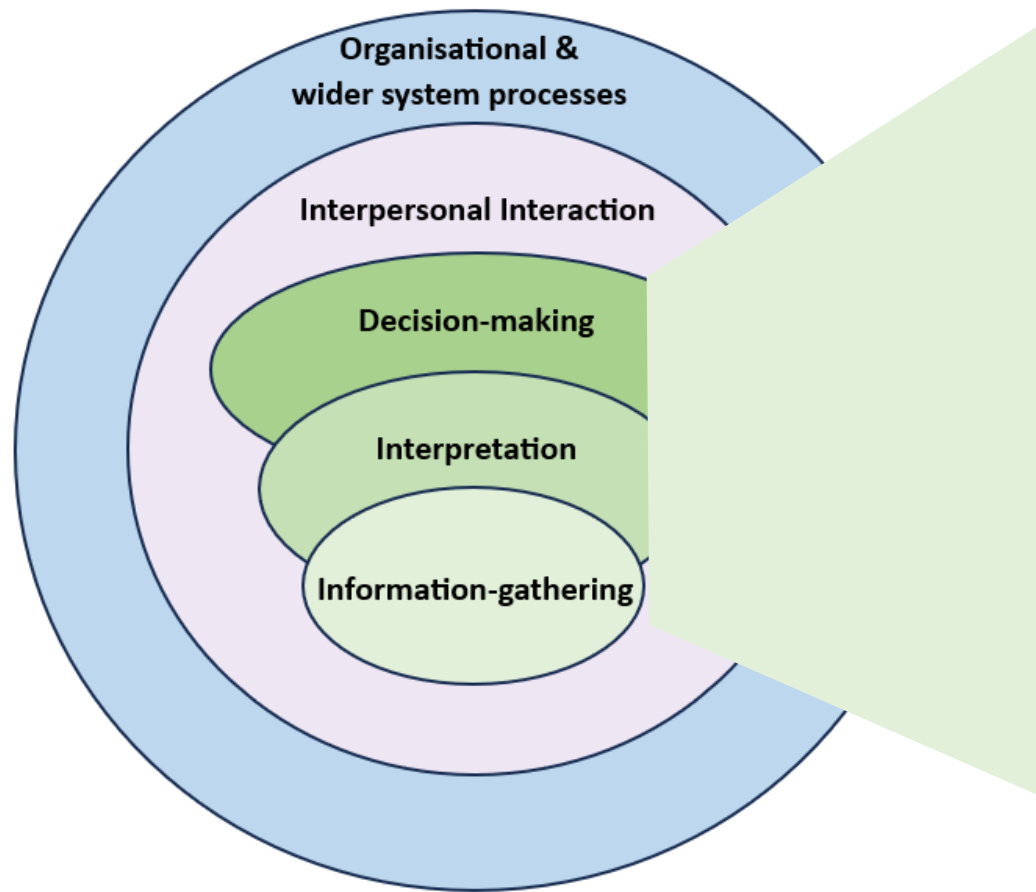
Local learning: modifiable factors

- Modifiable factors in 46% of LLR cases (43% England)
- 49% of these cases were children who died <28 days of age
- Most deprived quintile – MF in 60% of cases, least deprived quintile MF in 25%
- Most frequent by domain sub-group:
 - Smoking in pregnancy
 - High maternal BMI
 - Household smoking by parent/carer
 - Poor communication/information-sharing between agencies
 - Guidelines/policy/pathways not being followed.



Local learning: Service provision

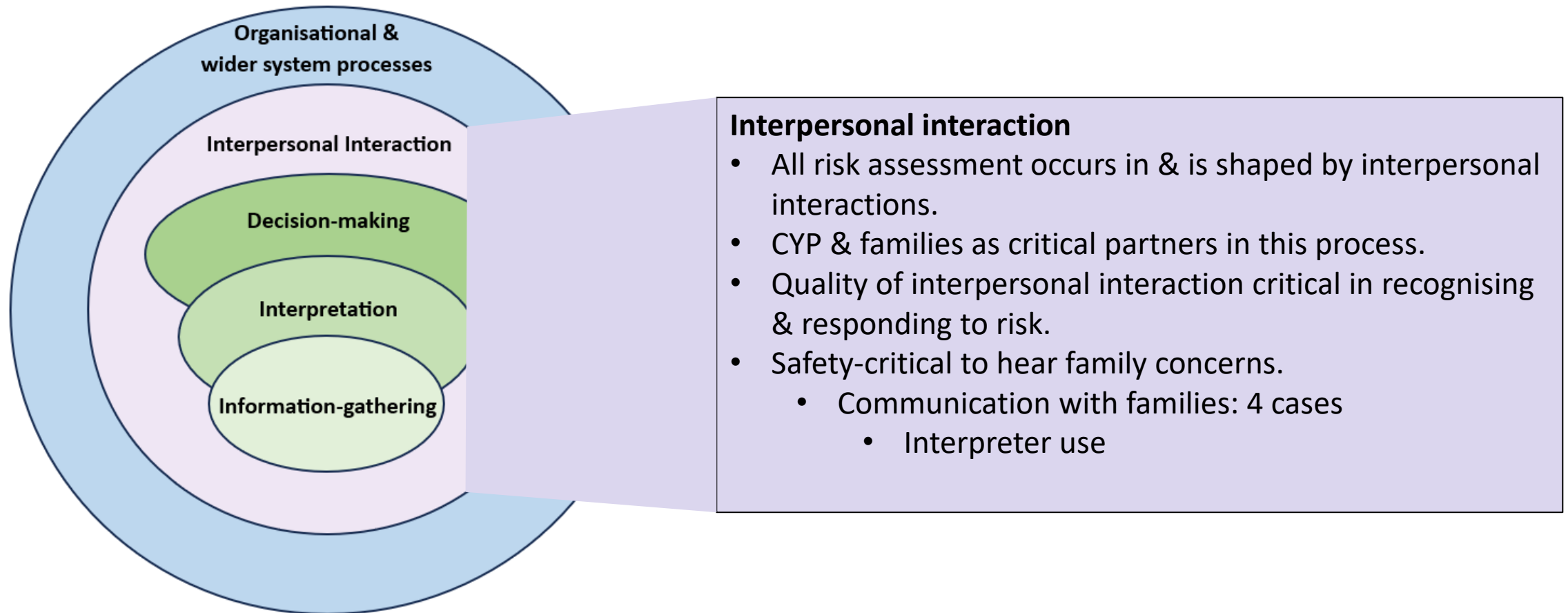
- 25% of completed reviews had modifiable factors relating to service provision.
 - 80% - learning already identified
 - 20% - learning identified at CDR Meeting (15%) or CDOP (5%).
- Low frequency, high-harm events
- Risk identification & mitigation
- Interagency working – different systems interacting



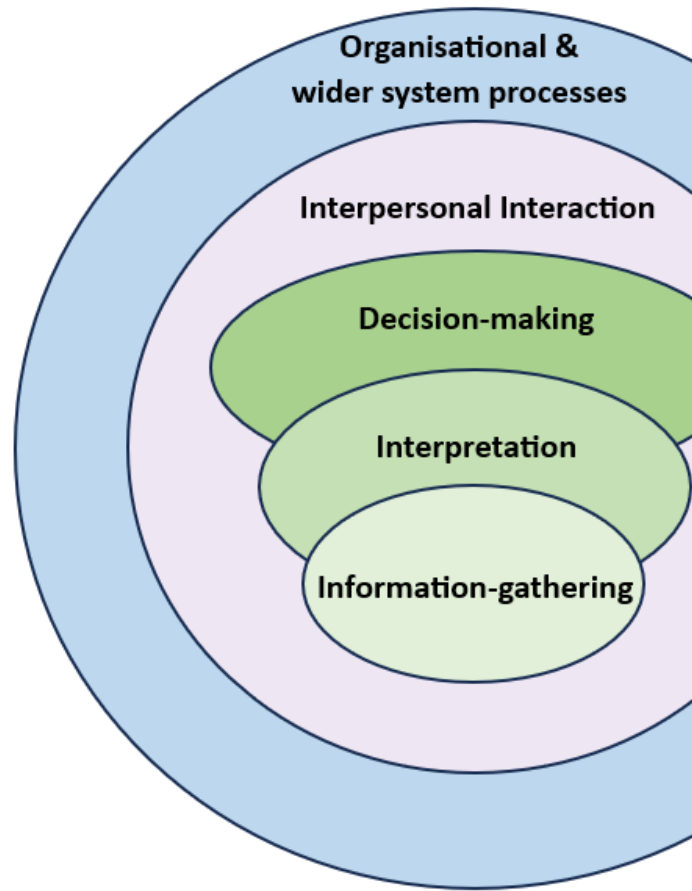
Recognising Risks – info gathering, interpretation & decision-making

- Subject matter expertise
 - Issues in identifying illness or initiating treatment: 7 cases
 - Issues impacting on quality of referral, assessment or review: 5 cases
- Clear, evidence-based policy & guidance
 - Issues with guidance, pathways or policy: 9 cases
- Information-sharing to recognise emerging pictures of risk
 - Issues in communication within or between agencies: 6 cases

Risk assessment framework for reducing high-harm low-frequency events, adapted from Nathan et al⁷. Available under CC BY License.



Risk assessment framework for reducing high-harm low-frequency events, adapted from Nathan et al⁷. Available under CC BY License.



Risk assessment framework for reducing high-harm, low-frequency events, adapted from Nathan et al⁷. Available under CC BY License.

Organisational & wider system processes







- Risk assessment & interpersonal interaction occurs within broader organisational & system processes & pressures
- To mitigate risks, need available & effective resources:
 - Provision of MHST
 - Organisational level processes which support care planning & risk assessment
 - Organisational level support to meet training needs
 - Clear & frictionless referral pathways
- Issues with access to appropriate services: 2 cases
- Issues with staffing capacity/skill mix: 3 cases

Addressing inequalities

- **Consider how diversity & difference may alter how risk factors present, interact & impact on CYP & families**
 - EAAL
 - Neurodiversity/Sensory impairments
 - LD
 - Black & minority ethnic groups
 - Trauma-experienced
 - Deprivation



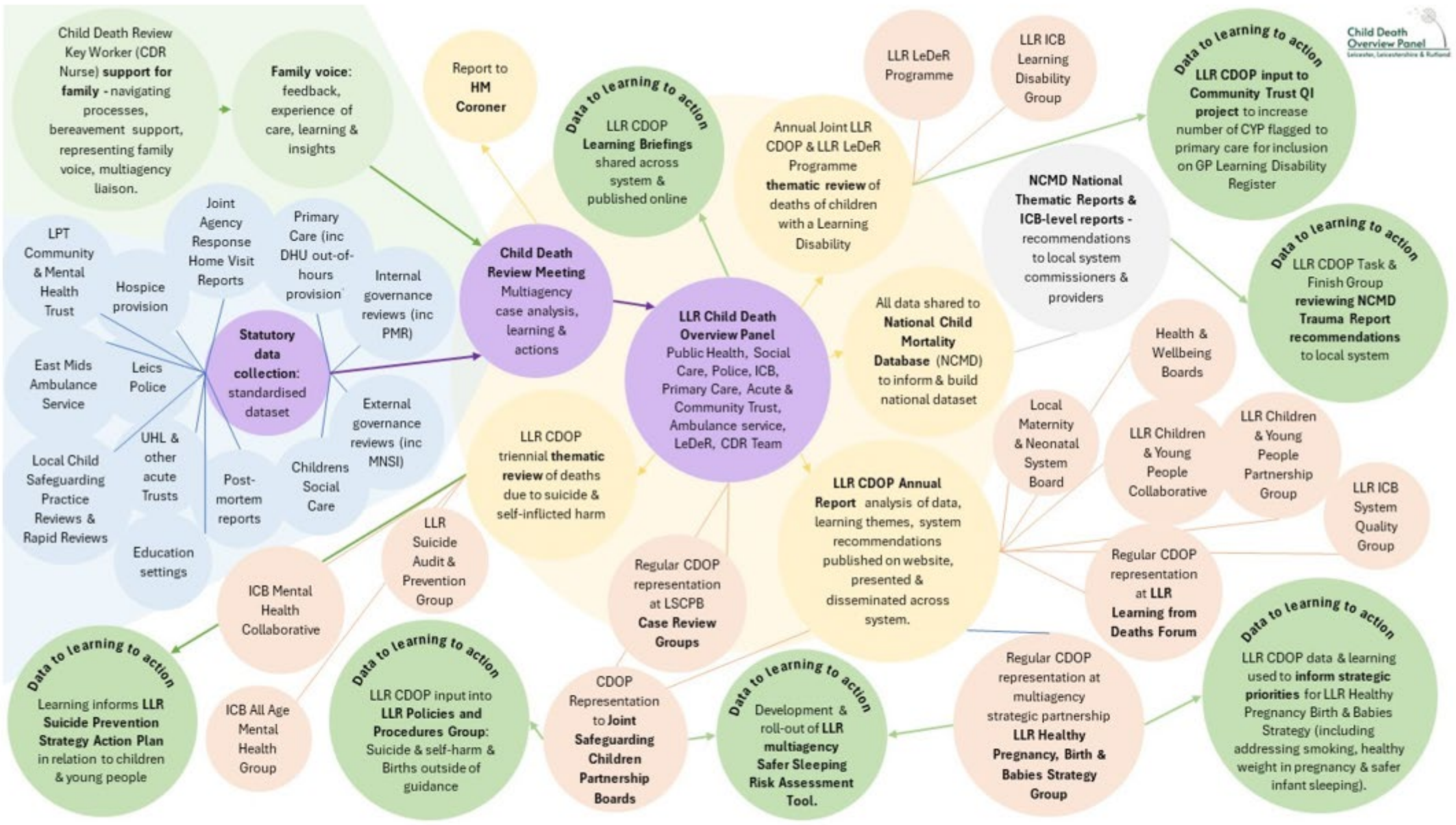
Thematic learning – Learning Disability

	Care Passports to support information-sharing & accessible care for all
	Inclusion of CYP with LD on the GP LD Register & participation in good quality annual health checks.
	CYP with LD are vulnerable to impact of environmental smoke exposure when household members smoke.
	Identification & management for those at risk of aspiration pneumonia
	Timely & clear advanced care planning with choice about location for end-of-life care and information about pre & post bereavement care.
	Importance of an allocated medical lead for every child & young person with complex health needs.



National learning: NCMD Reports

- Available online: www.ncmd.info
- Learning from deaths: Children with LDA aged 4-17yrs
 - Provision of reasonable adjustments – digital flags
 - Awareness of risk of infection
 - Named healthcare professionals
 - Timely access to support for those on NDC assessment waiting lists
- Child deaths due to Asthma / Anaphylaxis
 - Asthma as important & significant public health issue
 - Adoption of asthma friendly homes
 - 87% of deaths – 3+ reliever inhalers prescribed in 12 months before death
 - 50% of deaths – 12+ reliever inhalers prescribed in 12 months before death



Key:

- Data source: professionals
- Data source: families
- Child death review process.
- Regular CDOP data & learning outputs.
- System-level groups and multiagency partnerships.
- Example of translating CDR data into learning, & then into action.



CDOP Recommendations

1. Infant Mortality

- Promote & protect breastfeeding for all
- Safer Sleeping Risk Assessment Tool
- Reduce rates of smoking in pregnancy, increase number of smoke-free homes
- Promotion of healthy weight before & in pregnancy

2. Service provision

- Curiosity in governance reviews – barriers & drivers to following guidance/policy
- Support staff to be able to recognise & respond to risk & empower to escalate concerns
- Restorative culture of openness & learning, welcome the voice of CYP & front-line professionals & fully consider wider system context.

3. Learning from excellence

- Sharing of best practice so all can see what good care, communication & advanced care planning looks like
- UHL & LPT to ensure appropriate training for medical staff around communication, advanced care planning & supporting families with post-bereavement care & processes.



CDOP Recommendations (2)

4. CYP with Learning Disability

- Develop, promote & embed Care Passports
- Ensure all CYP with a Learning Disability are on the GP Practice LD Register
- Allocated lead medical consultant for all CYP with LD & medical complexity

5. Healthy lungs for babies, children, young people & families

- Promote smoke-free homes across LLR
- Accessible smoking cessation services for households as part of antenatal care
- Public health work to address poor outdoor air quality across LLR
- Smoking cessation in-reach services via Paediatric Respiratory Clinics
- Consider adopting 'Asthma-friendly homes' initiative



Further information

- LLR CDOP information & resources including supporting bereaved families, Annual Reports, 7 Minute Briefings & STAR Briefings:

<https://lrsb.org.uk/child-death-overview-panel-cdop>

- National Child Mortality Database: www.ncmd.info

- Child Death Reviews: Statutory & Operational Guidance

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1120062/child-death-review-statutory-and-operational-guidance-england.pdf