Bristol, North Somerset
and South Gloucestershire
Child Death Overview Panel

Bristol, North Somerset & South Gloucestershire

Child Death Overview Panel Annual Report

April 2024 – March 2025

CONFIDENTIAL

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Acknowledgements

We would like to acknowledge the hard work of all professionals involved in every step of the Child Death Review process, and those who sit on the Child Death Overview Panel (CDOP), who have made the content of this report possible.

This is the first report of Bristol, North Somerset and South Gloucestershire (BNSSG) CDOP as the decision has been made to align Panels to Integrated Care System footprints since 1st April 2024.

We acknowledge the contribution of John Twigger, Principal Public Health Specialist and Magdalena Szapiel, Senior Public Health Specialist, Bristol City Council, who have provided analytical support and background demographics.

Mary Gainsborough, Consultant Community Paediatrician and Designated Doctor for Children's Deaths
and Ann Farr, Child Death Review Team

Foreword

The Bristol, North Somerset and South Gloucester (BNSSG) Child Death Overview Panel is a multi-professional panel that covers the three Unitary Authority areas of Bristol, North Somerset and South Gloucestershire. It is made up of representatives from a range of organisations, including health, social care and the Police. The CDOP also has representation from those with experience of losing a child or of supporting families bereaved through a child's death.

Every death of a child is a tragedy which impacts of family, friends and community. The panel's task is to learn from the circumstances of every death to:

- Identify any changes which can be made that might help prevent further deaths.
- Share the learning regionally and nationally, with other CDOPs and agencies involved in the process.
- Identify trends and target interventions to prevent further deaths
- Identify learning and service improvements that will ensure that families are well supported

The review process is not about allocating blame but is about learning lessons to prevent deaths in the future.

All CDOP Members have a responsibility for sharing learning from panel discussions and as Chair of the Panel and I want to encourage every Member to consider this responsibility carefully in each meeting so that learning is maximised and we take all opportunities to improve the care and support for children and their families and communities and make changes where there may be opportunity to prevent further deaths.

This report presents a summary of data about child deaths notified to and reviewed by BNSSG CDOP in 2024/25. It also summarises actions taken in response to the Panel's learning and reflection. As you read this report, please consider the data and learning in relation to your role, particularly if there are actions you can take in response that might help ensure that children receive excellent care, and families are well supported or prevent further deaths.

I want to commend the hard work and dedication of the Panel members, and the support from Dr Mary Gainsborough, Designated Doctor for Children's Deaths, and the team in the Child Death Enquiry Office whose dedication makes sure that we focus our efforts on making things safer for children and families across our area.

Sally Hogg, Consultant in Public Health, Bristol and Chair of CDOP

Executive Summary

This report provides an overview of all deaths notified to the Child Death office between 1st April 2024 and 31st March 2025 of children who are normally resident in the areas represented by the Bristol, North Somerset and South Gloucestershire CDOP and those cases reviewed by the Child Death Overview Panel over the same period.

Data related to Child Death Notifications

- 42 child deaths were notified to the West of England Child Death Enquiries Office between 1st April 2024 and 31st March 2025. This is a decrease in comparison to the total of 51 deaths reported in 2023-2024, and less than the preceding year (2022-2023, 55).
- Over the 12 month period, 79% died in hospital (NICU, PICU, Emergency Department and Hospital Wards/Delivery Suite/Labour ward), 9% at home or in a relative's home, public place or other location and 12% in a hospice.
- 22 notifications (26%) were received for babies dying in the neonatal period (0-27 days). A further 7 children (8%) died in the first year of life, 5 (6%) were aged 10-14 years old. The numbers of the other deaths age groups were less than 5%, so exact figures are not given.
- Regarding ethnicity, the mortality rate in those who were registered as Black or Black British was the highest, followed by Asian or Asian British and other ethnicity children.
- Over a half of the notified deaths occurred in the 40% of the most deprived areas of BNSSG (quintile 1 – most deprived and 2 – more deprived than average).
- 10 (24%) of cases notified in 2024-2025 triggered a Joint Agency Response.

Data from cases reviewed by the Child Death Overview Panel

- The BNSSG CDOP reviewed 60 cases between 1st April 2024 and 31st March 2025.
- There is an inevitable time-lag between notification of the child's death to CDOP review. The majority of these are ongoing due to Police Investigations, Coroners processes, deaths out of area or abroad. There are 2 cases of children who died during the period of 2019-20 which are still outstanding, 2 cases still to be reviewed from 2020-2021, 1 case from 2021-22, 5 from 2022-23 and 19 cases to be reviewed from 2023-2024. All other children who died before 2019 have been reviewed by CDOP. There are also 34 cases still to be reviewed from 2024-2025 although many of these have already had a Child Death Review meeting.
- The most common Categories of death were perinatal/neonatal at 32% and chromosomal, genetic or congenital anomaly, which occurred in 27% of cases.
- The most common Mode of Death was withholding, withdraw or limitation of life sustaining treatment which occurred in 40% of deaths reviewed.
- Mental health of a parent is mentioned in 26% or reviewed cases and smoking in 22%.
- CDOP identified 'modifiable factors' in (15) 25% of cases. Modifiable factors are defined as 'one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.
- It is known that family bereavement follow-up was documented as offered in 83% of cases and was offered or provided by a range of professionals depending on the type and location of the child's death. 7% of families declined support during 2024-2025 and it is not known if support was offered in 10% of cases.

- Due to the small numbers, there is only weak evidence of any differences in mortality by different ethnic groups, however it does appear that in those cases reviewed there were disproportionally more deaths amongst Black, mixed and Asian ethnicities compared to their respective population, and proportionally fewer deaths amongst white children compared to their population.

Service Improvement

CDOP has taken forward actions arising from individual cases which include contacting local Hospital Trusts, ICBs and Local Authorities. Specific actions relate to learning from immunisation issues, recognition of serious illness and provision of hospital paediatric palliative care out of hours.

Achievements and Future Priorities

These include addressing some national priorities as well as ongoing improvements to local arrangements, such as improved working with regional CDOPs and reviewing the CDOP membership and their responsibilities.

1. Background

1.1 The Child Death Review Process

Since 1st April 2008, Local Safeguarding Children Boards (LSCBs) in England had a statutory responsibility for child death review processes which was continued by the alternative local safeguarding arrangements implemented from 2019. The relevant legislation is enshrined within the Children Act 2004 and applies to all young people under the age of 18 years. The processes to be followed when a child dies are currently outlined within Working Together to Safeguard Children 2023: Chapter 6 Child Death Review Processes[1]. The process focuses on identifying 'modifiable factors' in the child's death. Child Death Review: Statutory and Operational Guidance[2] was published in October 2018. The overall purpose of the child death review process is to understand how and why children die, to put in place interventions to protect other children and to prevent future deaths. It is intended that these processes will:

- Document and accurately establish causation of death in each individual child.
- Identify patterns of death in a community so that preventable factors can be recognised and reduced.
- Contribute to improved multi-professional collection of medical, social and forensic evidence in the small proportion of deaths where there has been maltreatment or neglect.
- Ensure appropriate family and bereavement support is in place.
- Identify learning points for service provision, which relate to care of the child.

Working Together (2023) and the CDR Statutory Guidance (2018) outline two inter-related processes…a **'Joint Agency Response'** where a group of professionals came together for the purpose of evaluating the cause of death in an individual child, where the death of that child was not anticipated and the cause is not fully understood, and a **'Child Death Overview Panel**' (CDOP) that comes together to undertake an overview of *all* child deaths under the age of 18 years in a defined geographical area.

The Bristol, North Somerset and South Gloucester (BNSSG) Child Death Overview Panel is a multi-professional panel that covers the three Unitary Authority areas of Bristol, North Somerset and South Gloucestershire which is also the area covered by BNSSG Integrated Care Board. The membership of the Panel (Appendix A) is arranged to ensure that there is the necessary level of expertise and experience, and that each of the three Unitary Authority areas is appropriately represented. Until Sept 2024, the BNSSG CDOP Chair was taken by the South Gloucestershire Director of Public Health, which then rotated

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[1] Chapter 6: Child death reviews (workingtogetheronline.co.uk)

[2] https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidanceengland

to Bristol DPH (delegated to one of the Consultants in Public Health. The Terms of Reference, Governance Arrangements and Membership are summarised in documents available from the Child Death office at the University of Bristol which administers all functions of the BNSSG CDOP.

The BNSSG CDOP reviews information on every child who has died whose post code of residence is within its geographical boundary. Some of these deaths may occur outside the BNSSG footprint. The BNSSG CDOP additionally reviews the deaths of some non-resident children who may be under the care of a specialist paediatric medical or surgical team in Bristol, but this follows review by their local CDOP and these cases are no longer counted in the total of cases reviewed by BNSSG CDOP.

A child's case is reviewed at the CDOP after it has been discussed at a local Child Death Review meeting. Standard information on each child is collected on national Notification Forms and Reporting Forms during the child death review process. The Notification Form is a basic notification form that has essential identifying information on the child and key professionals. Reporting Forms are completed by all agencies involved in the care of a child and capture clinical and social data on the child and background information relating to the family. An Analysis Form is completed at the local Child Death Review meeting and aims to identify modifiable factors relating to the child's death, as well as highlight learning that arises from each case. All patient information is made anonymous. A detailed compilation of all data on Reporting Forms & Analysis Form on each child is presented to the CDOP as an anonymous case record. At CDOP meetings each case is reviewed, and the Panel deliberates on the decisions reached at the local Child Death Review meeting. The panel will agree any additions or amendments on a final Analysis Form for each child. The CDOP Chair records recurring themes relating to modifiable factors and takes responsibility for any actions arising from the case discussion.

All CDOP Members have a responsibility for sharing learning from panel discussions. Data and learning gathered through the CDR process also feeds into the National Child Mortality Database (NCMD) [3] which records comprehensive data, standardised across a whole country (England), on the circumstances of children's deaths. The purpose of collating information nationally is to ensure that deaths are learned from, that learning is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die.

1.2 Production of annual report (processing and verification of data)

This is the first Annual Report of the Bristol, North Somerset and South Gloucester (BNSSG) CDOP and is a publicly available document. Previous Annual Reports can be found online https://bristolsafeguarding.org/professional-resources/child-death-overview-panel or requested from the Child Death office at University of Bristol.

The Child Death office use the following sources to ensure optimal notification of child deaths:

- Weekly returns from the Local Registrar's Offices
- Regular checks on BadgerNet for missing cases
- Joint Agency Response phone calls and reports
- Close working with the Child Health Information Service

CDOP is required to produce an annual report each year outlining the work of the panel and relevant learning from the cases reviewed to inform the priorities of the CDR Partners. The annual report is produced using data collected by the University of Bristol through the Child Death office. Information collected at the point of notification of death is entered onto the eCDOP case management tool. Information collected from statutory forms, CDRMs and CDOP reviews is populated onto eCDOP as the case progresses through the child death review process. The eventual CDOP multi-agency dataset is extremely comprehensive. eCDOP dataset is submitted to the National Child Mortality Database who

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[3] About the NCMD - National Child Mortality Database

produce data summaries on a quarterly basis and this report is based on the quarter 4 report from 2024/25.

Note: The UK Office for National Statistics advises that care should be taken regarding publishing small numbers of events in person-related statistics. This is due to the need to preserve confidentiality as there may be a risk that individuals could be identified.

2. Summary Death Notification Data 2024/2025

This section summarises all deaths notified to the Child Death office between 1st April 2024 and 31st March 2025 of children who are normally resident in the areas represented by the BNSSG CDOP.

A proportion of deaths occurring each year in the BNSSG area are of children residing in areas outside the region (Bristol, North Somerset and South Gloucestershire), including children visiting the area from other parts of the UK. This is because Bristol has tertiary referral units for neonates and children and specialist services including cardiology, oncology and neurology. These cases are then notified to their own area CDOPs so do not form part of this dataset.

It should be noted that UHBW produce an Annual Report on child deaths reviewed within the Bristol Royal Hospital for Children (BRHC) which includes children cared for from out of area, and this is available from the Child Death Review Coordinators at BRHC.

Table 1: Notifications by LSCB 2024-25

LSCB name	Cases
Bristol City	21
North Somerset	8
South Gloucestershire	13
Total	**42**

There were 42 notifications in the last 12 month period. This is less than the preceding 2 years (2023-24 51 and 2022-2023 55). Please note that these figures do not include cases from BaNES which were included in the relevant Annual Reports due to inclusion of BaNES in the West of England CDOP arrangements at the time. This data is drawn from the eCDOP Notification database.

Data from the NCMD indicates that nationally, following a significant reduction in child deaths during the first year of the pandemic (2020-21), mortality returned to close to pre-pandemic levels in the following year and subsequent years so it is interesting that this year’s total is again lower, if not quite as low as in pandemic years.

The numbers of notifications are too small to draw any conclusions whether the reduction in numbers of deaths is statistically significant or whether it will continue in the following year.

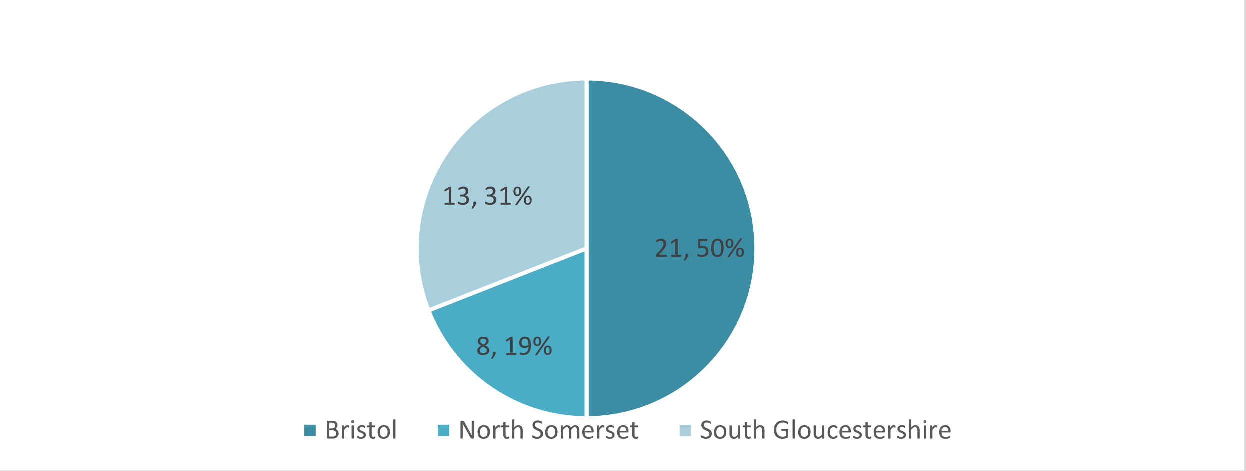
Table 2: BNSSG notifications from 1st April 2020 to 31st March 2025 by month and year

	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
Q1: April, May June	9	9	15	8	12
Q2: July, August, September	12	8	10	11	13
Q3: October, November, December	7	8	16	12	9
Q4: January, February, March	13	14	14	20	8
Totals:	**40**	**39**	**55**	**51**	**42**

CDOP monitor new death notification quarterly, looking for any concerning trends, alongside individual case reviews.

2.1 Analysis of notifications by Area of Residence

Figure 1: Notifications by area of residence 2024-2025



50% of all notifications came from Bristol, 31% from South Gloucestershire and 19% from North Somerset.

Figure 2: Notifications by area of residence (2024/25) – crude mortality rates per 100,000 population (2023), with 95% confidence intervals.

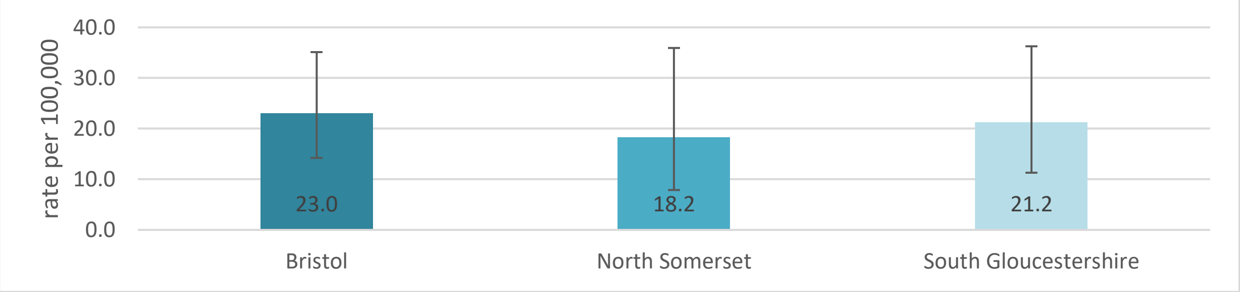


Figure 2. shows that there is no statistically significant difference in mortality rates between Bristol, North Somerset and South Gloucestershire.

The numbers of notifications for any one area of residence are small so that the most likely explanation for any pattern is random year-on-year variation. However, CDOP should always try to exclude contributory factors such as differences in coding practice or an increase in a particular category of death.

2.2 Place of deaths notified

Figure 3: Location of Death - deaths notified to BNSSG CDOP in 2024/25

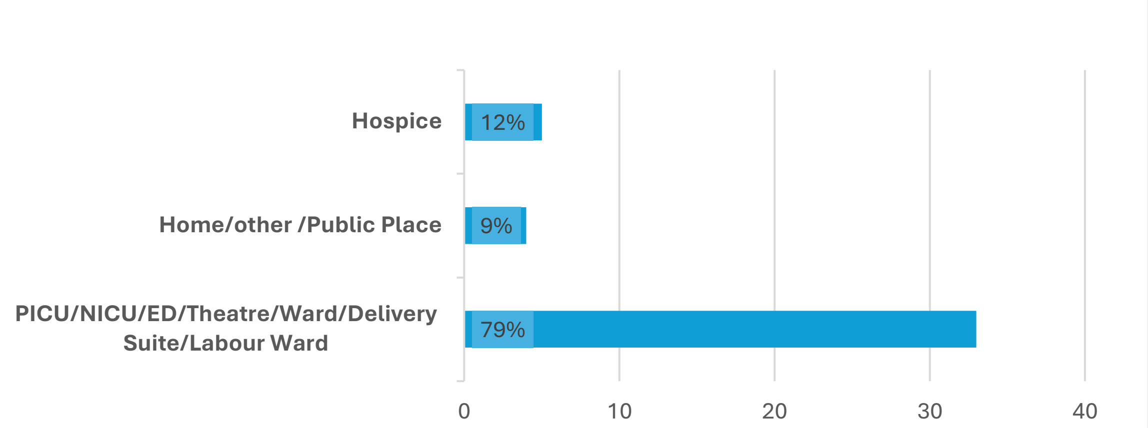


Figure 3. Shows that over the 12 month period, 79% died in hospital (NICU, PICU, Emergency Department and Hospital Wards/Delivery Suite/Labour ward), 9% at home or in a relative's home, public place or other locations and 12% in hospices.

2.3 Age at Death of notifications

Table 3: Notifications of death by age and year (NCMD)

	2022-2021	2021-2022	2022-2023	2023-2024	2024-2025
0-27 days	19	14	23	14	22
28 days - 364 days	9	15	9	<5	7
1 - 4 years	<5	<5	7	7	<5
5 - 9 years	<5	<5	5	5	<5
10 - 14 years	<5	<5	8	<5	5
15 - 17 years	<5	6	<5	10	<5
TOTAL	**40**	**39**	**55**	**51**	**42**

In 2024-25 of the total number of notifications of death received, 52% were received for babies dying in the neonatal period (0-27 days). A further 17% died in the first year of life, 7% deaths were children aged between 1-4 years old, 10% were aged 5-9 years old, 12% were of children between 10-14 years and <5% of deaths were of children aged between 15-17. Death rates were highest in the neonatal period. This is consistent with data from previous years. Rates for other age groups have fluctuated year on year but indicate a lower rate in 15-17 year olds than other age groups.

Table 4: Crude rate of death notifications per 100,000 population by year and age (using ONS population estimates 2020-2023), BNSSG area of residence

Age	2020/21	2021/22	2022/23	2023/24	2024/25
under 1	270.8	284.5	315.9	276.6	297.1
1 - 4	6.9	2.4	16.8	16.8	7.2
5 - 9	5.3	1.8	9.0	9.0	7.2
10 - 14	3.7	3.6	14.1	3.5	8.7
15 - 17	13.4	19.8	9.6	30.8	3.1
All < 18	20.6	20.1	28.2	25.9	21.4

The highest numbers and rates of notifications have been seen in infants (under 1 age group: 69% of all notifications in 2024/25). Due to very small numbers of notifications in the older age groups the rates fluctuate widely from year to year.

Figure 4: BNSSG notifications by age, 2024/25

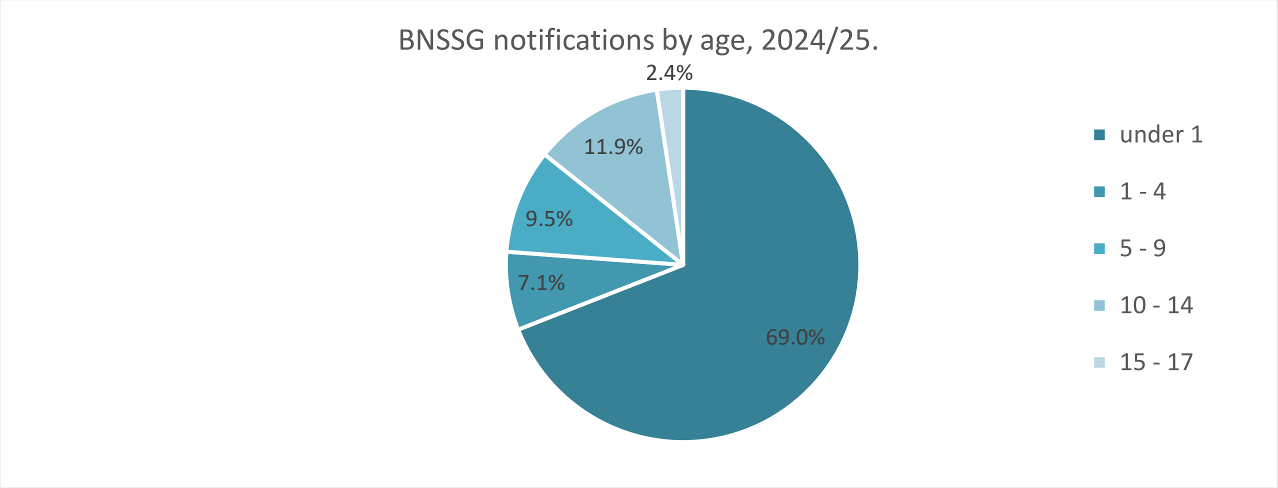


Figure 4. Shows that in 2024/25 the majority of notifications came from the youngest (under 1) age group, followed by 10 to 14s and 5 to 9s.

Figure 5: Crude rate of child death notifications 2020/21 to 2024/25. Crude rates per 100,000 population aged under 18. 95% Confidence Intervals. (using ONS population estimates 2020-2023), BNSSG area of residence.

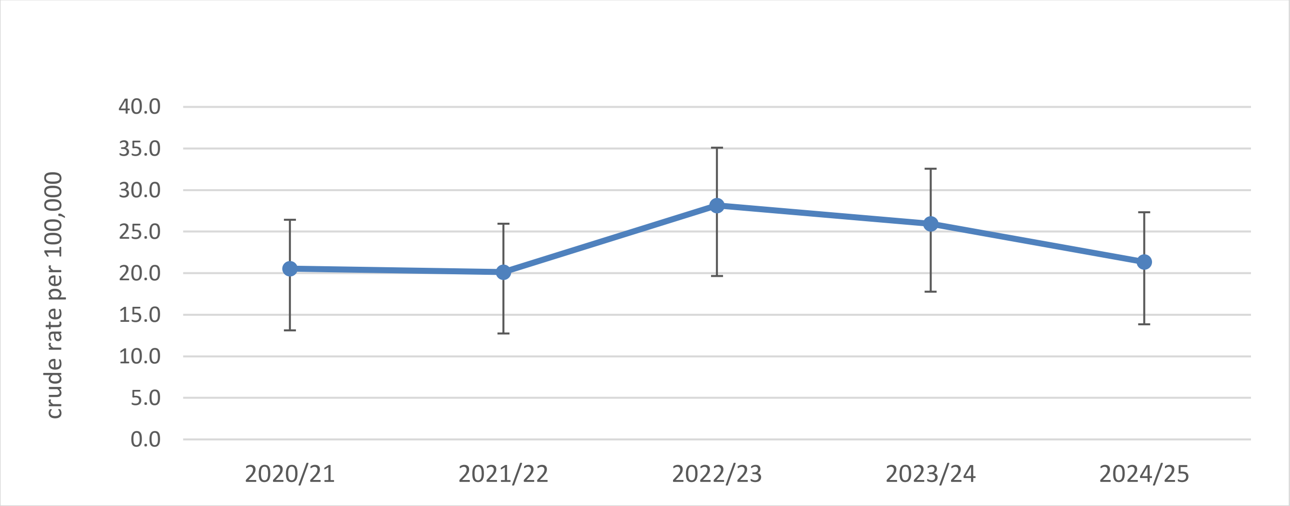


Figure 5. Shows crude rates of death notifications per 100,000 population by the year of notification. Since 2022/23 the rates have been falling. As the numbers of notifications constitute between 0.02% to 0.03% of the population of the under 18s, the rates are prone to random year-on-year variation. Overlapping confidence intervals suggest that there is no statistically significant difference between annual rates.

Figure 6: BNSSG Child Death Notifications 2020/21 to 2024/25. Crude rates per 100,000 population by year and age group (aged 1 to 17); using ONS population estimates 2020-2023; BNSSG area of residence

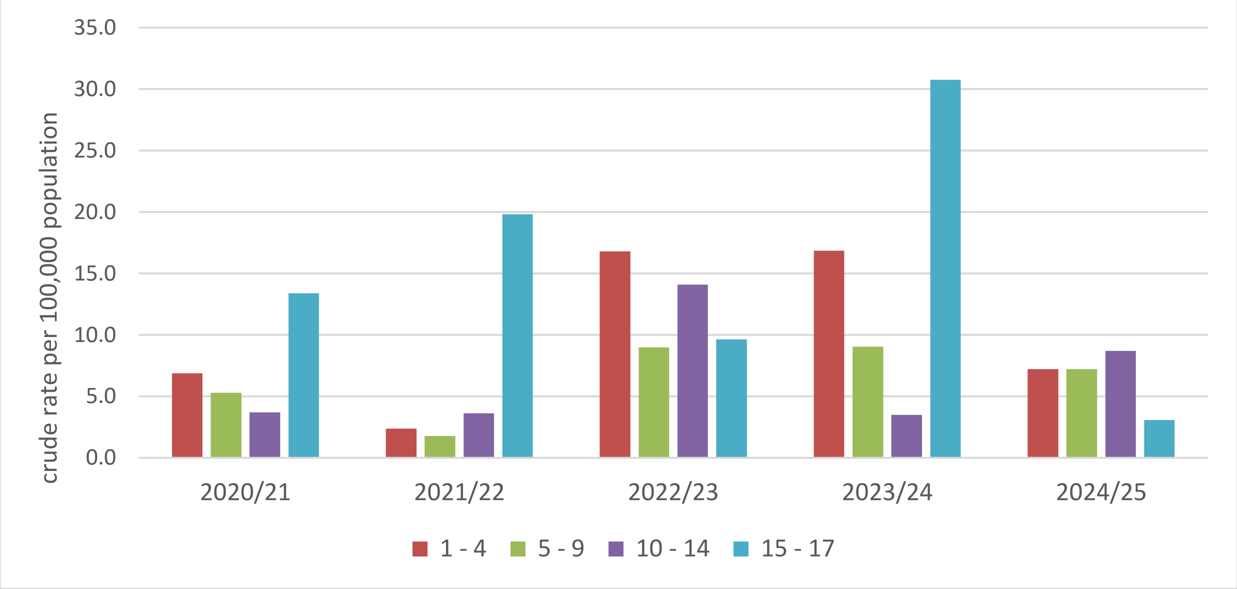


Figure 6. Shows that crude rates of death notifications in children aged 1 to 17 vary across the years and age groups. The years 2021/22 and 2023/24 saw a high rate in children aged 15 to 17 (19.8 and 30.8 per 100,000 respectively), while in 2024/25 the same rate has dropped to 3.1. Such variation may be caused by the relatively small numbers of notifications, where a small year-on-year change in numbers can result in a large change in rates. In 2024/25 the rates decreased in the 1-4, 5-9 and 15-17 age groups compared to the previous year, but the difference is not statistically significant due to the small numbers of notifications involved

Figure 7: BNSSG Children aged under 1 death notifications, 2020/21 to 2024/25. Crude rate of death notifications per 100,000 population aged under 1; using ONS population estimates 2020-2023; BNSSG area of residence

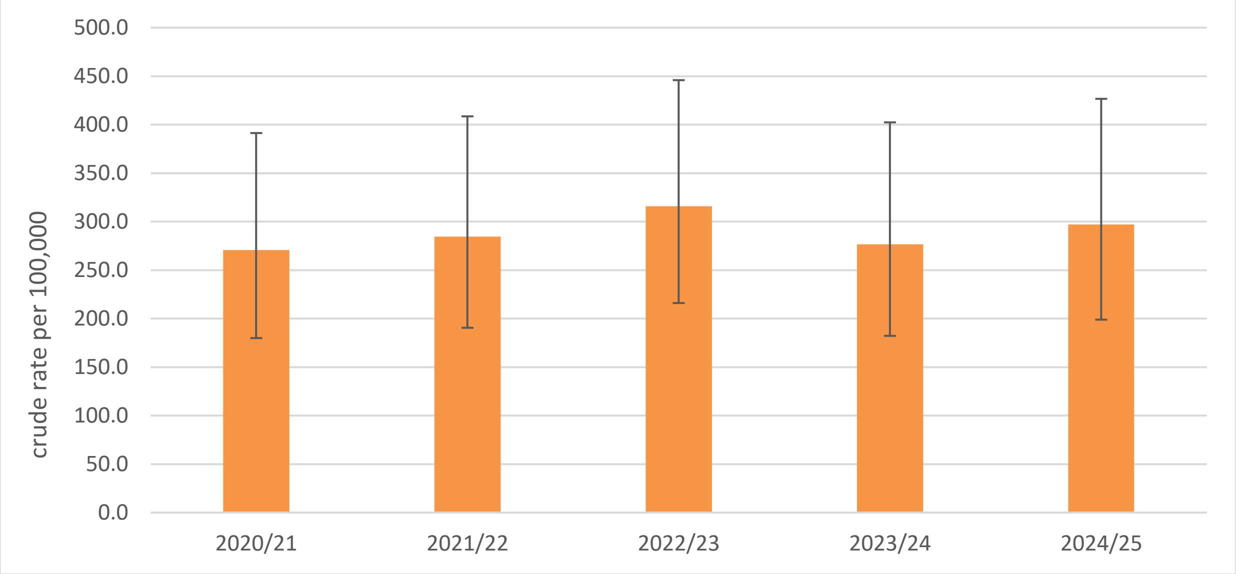


Figure 7. Shows that the annual rates of death notifications in children under 1 are not statistically significantly different, ranging from 270.8 per 100,000 in 2020/21 to 315.9 per 100,000 in 2022/23.

2.4 Gender of deaths notified

In the last 12 months, 52% of notifications of deaths were of boys and 48% of girls. This indicates no change regarding the gender split in recent years, with more deaths in boys than girls.

2.5 Ethnicity of deaths notified

Figure 8: Death notifications by ethnic group, BNSSG 2024/25

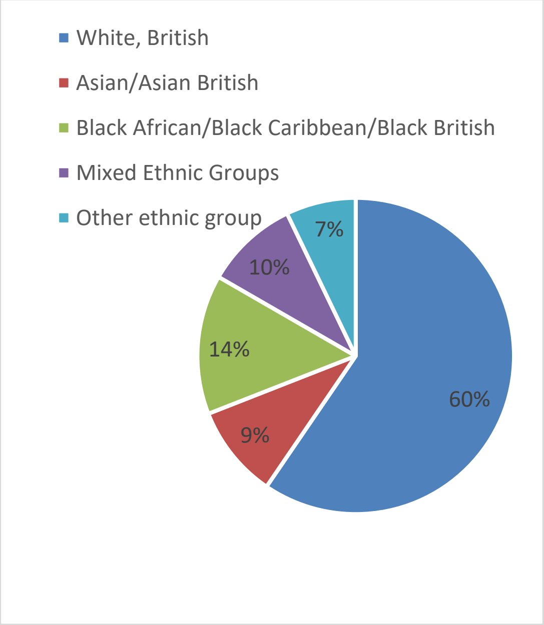
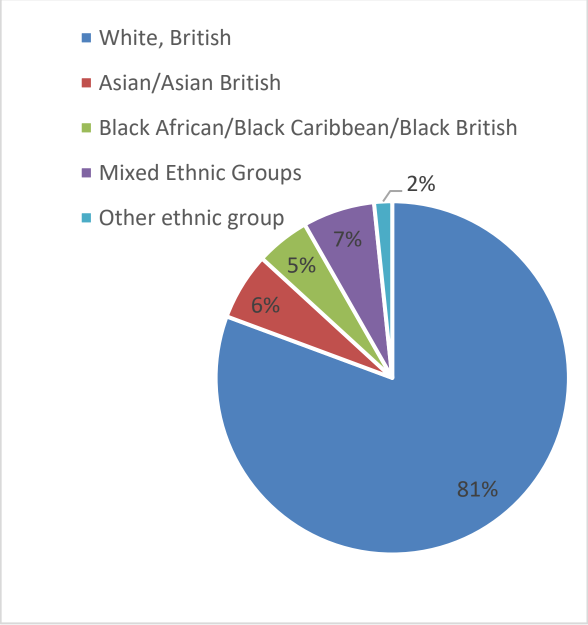


Figure 9: 2021 Census estimated proportion of population under 25 by ethnicity, BNSSG

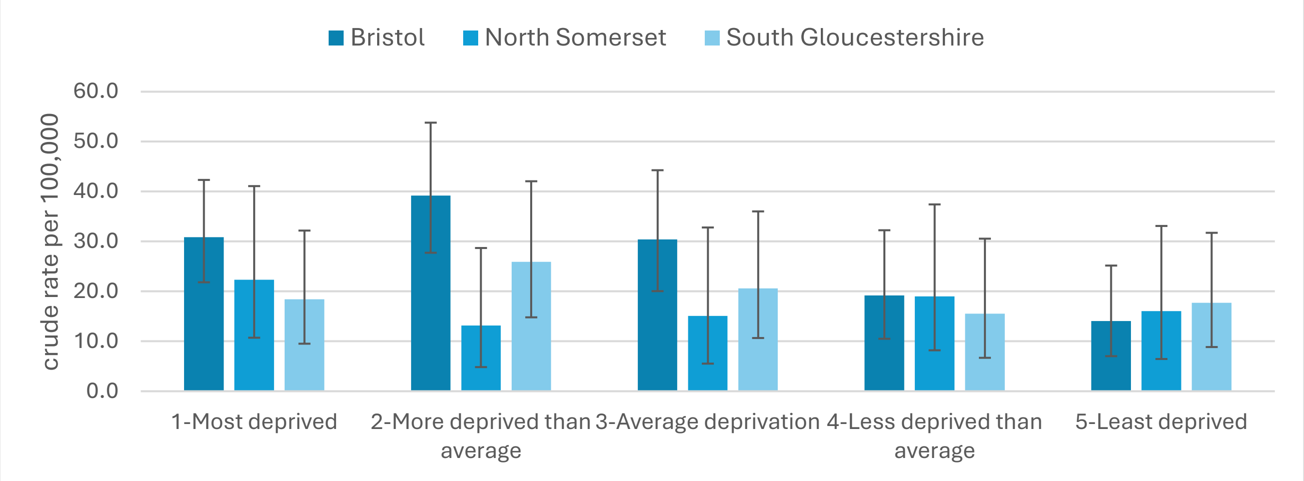


The National Child Mortality Database has analysed ethnicity in the death notification data for the 5 years 2019-2024 in infants (under 1 year-olds) and children aged 1 to 17. The data shows that infant mortality rate was the highest in the Other ethnic group (9.0 per 1,000 infants) and in the Black and Black British ethnic group (6.6 per 1,000 infants). Among children aged 1 to 17 the highest mortality rate has been observed in the Black and Black British ethnic group (29.3 per 100,000 population), followed by Other (19.8) and Asian and Asian British (15.9). The death notification rates among White infants (2.4 per 1,000) and children aged 1 to 17 (6.9 per 100,000) were significantly lower.

The data from the 2024/25 notifications seem to follow that trend, with the disproportionate more death notifications among Black and Black British and Asian and Asian British ethnic groups compared to their respective populations.

2.6 Area Deprivation (Indices of Multiple Deprivation) of notifications

Figure 10: Notifications Mortality rate by local area relative deprivation, quintile. 2020/21 to 2024/25 95% Confidence Intervals. ONS population estimates of children 0-17, with 95% confidence intervals. Bristol, North Somerset and South Gloucestershire



Using each areas local quintiles based in IMD 2019 scores, the 2020-2025 notification data show that 53.6% of deaths occurred in more deprived areas of each locality. The mortality rates were the highest in Bristol deprived areas.

When proportion of deaths are looked at, there is evidence of a higher rate amongst the most deprived areas compared to the least deprived – this is driven by both the slightly larger child population, and the higher death rate among those children.

2.7 Postmortem examinations in Deaths notified

Postmortem examinations make an important contribution to explaining how a child dies and may be ordered by the coroner or offered by the attending clinician when the circumstances surrounding the death remain unclear. A postmortem occurred in 12 deaths notified during 2024-2025 (29%). 30 (71%) cases did not have a postmortem at the point of notification of the death.

2.8 Deaths notified requiring a Joint Agency Response (JAR)

Since the inception of the child death review process there has been a requirement to perform further investigations for children who die where the cause is unknown. This was previously called a Rapid Response, but the terminology was changed following the publication of the Child Death Review Statutory and Operational Guidance in 2018 and it is now referred to as a Joint Agency Response (see Section 4 above). The full guidance for conducting a JAR can be found in the Kennedy guidelines 2016[4].

A Joint Agency Response should be triggered if a child's death[5]:

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[4] Sudden-unexpected-death-in-infancy-and-childhood-2e.pdf (rcpath.org)

[5] Child Death Review Statutory and Operational Guidance (England) (publishing.service.gov.uk)

- is or could be due to external causes
- is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy/childhood (SUDI/C))
- occurs in custody, or where the child was detained under the Mental Health Act
- where the initial circumstances raise any suspicions that the death may not have been natural
- in the case of a stillbirth where no healthcare professional was in attendance

A JAR is also required when a child collapses unexpectedly, is resuscitated and admitted to hospital but expected to die shortly.

For the Notifications received during 2024-2025, there were 10 (24%) cases which required a Joint Agency Response, 32 (76%) did not have a Joint Agency Response. From CDOP reviews, there were no case which should have triggered a JAR that did not have one.

3. Child Death Overview Panel Review Data 2024-2025

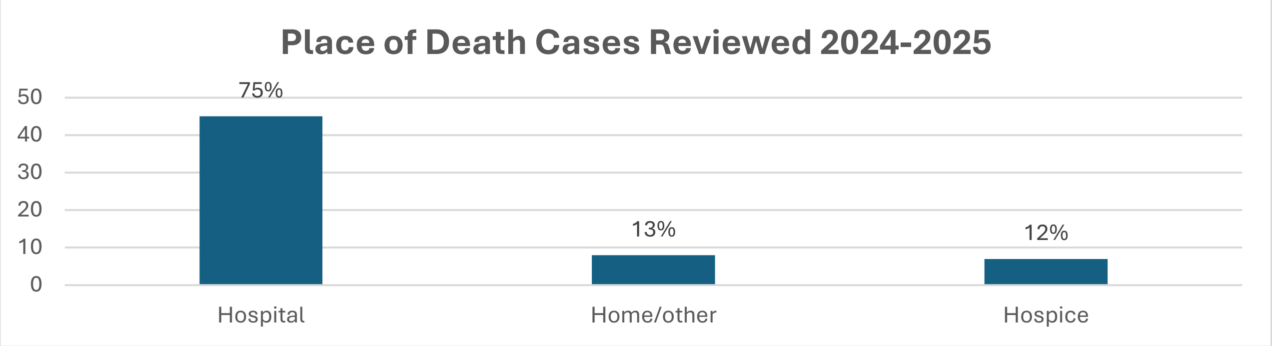
This section summarises characteristics of the children reviewed at CDOP 2024-25. The BNSSG CDOP reviewed 60 cases between 1st April 2024 and 31st March 2025. There is an inevitable time-lag (6-12 months) between notification of a child's death and discussion at CDOP**.** There are various factors that contribute to this: the return of Reporting Forms from professionals, the completion of the final postmortem report by the pathologist and receipt of the final report from the local child death review meeting. When the outcome of a Coroner's inquest is awaited, there may be a delay of over a year before a case might be brought before CDOP. The undertaking of a criminal investigation or a Child Safeguarding Practice Review will also affect when a case is discussed at Panel.

Table 5: The number of Completed CDOP reviews each year by year of death

	2019/2020	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**	**2024/2025**
Final number of notifications	40	41	39	55	51	42
Years of Review	**Number reviewed**	**Number reviewed**	**Number reviewed**	**Number reviewed**	**Number Reviewed**	**Number Reviewed**
2016/17	6	0	0	0	0	0
2017/18	12	6	2	0	0	0
2018/19	22	9	2	0	0	0
2019/20	1	22	15	3	0	0
2020/21	0	2	21	10	5	0
2021/22	0	0	2	21	12	3
2022/23	0	0	0	3	30	17
2023/24	0	0	0	0	0	32
2024/25	0	0	0	0	0	8
Total	**41**	**39**	**42**	**37**	**47**	**60**

There is an inevitable time-lag between notification of the child's death to CDOP review. The majority of these are ongoing due to Police Investigations, Coronial Processes, deaths out of area or abroad. There are 2 cases of children who died during the period of 2019-20 which are still outstanding. All other children who died before 2019-20 have been reviewed by CDOP. 2 cases are still to be reviewed from 2020-2021, 1 case from 2021-22, 5 from 2022-23 and 19 cases to be reviewed from 2023-2024, and 34 cases to be reviewed from 2024-2025 although many of these have already had a Child Death Review meeting.

Figure 11: Place of Death - deaths reviewed by BNSSG CDOP in 2024/25



From the cases reviewed during 2024-2025, 75% died in Hospitals, (NICU, PICU, Emergency Department and Hospital Wards/Delivery Suite/Labour ward), 13% at home or in a relative's home, public place or other locations and 12% in hospices.

3.1 Mode of death

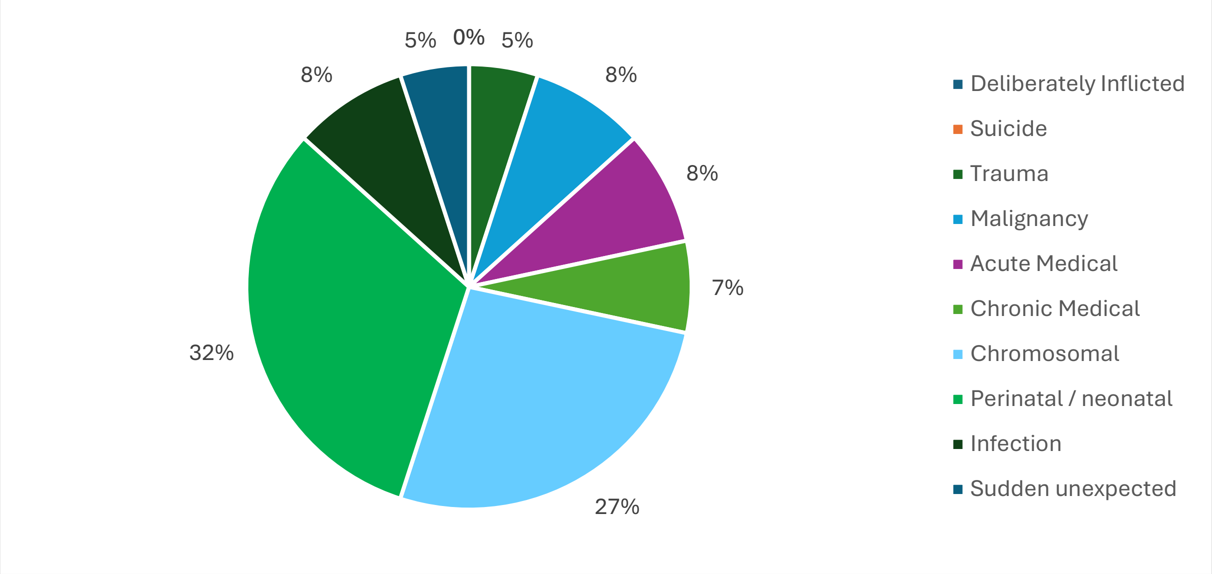
Table 6: Mode of death of cases reviewed by CDOP between 1st April 2024 and 31st March 2025

MODE OF DEATH 2024-2025	Totals
Withholding, withdraw or limitation of life-sustaining treatment	24
Witnessed Event	<5
Planned Palliative Care	20
Found Dead	<5
Brainstem Death	<5
Failed cardiopulmonary resuscitation	13

The most common way children died was following active withholding, withdrawal or limitation of life sustaining treatment, most commonly in an intensive care situation (this decision is always made following careful consideration with the parents and carers). This occurred in 40% of the deaths reviewed by CDOP. In 33% of cases the child died following planned palliative care and 22% after failed cardio-pulmonary resuscitation attempts, although the child may have been critically ill on NICU or PICU prior to the final event. In 5% of cases the child had died from other causes.

3.2 Category of Death

Figure 12: Category of Death Cases Reviewed 2024/25



In 2024/25 the most frequent category of death in cases reviewed was Perinatal and Neonatal deaths (32%) Chromosomal, Genetic and Congenital Anomalies (27%). 8% of deaths were due to malignancy, 5% Trauma and other external factors, 8% were because of an acute medical condition. 8% were due to Infection, 5% were due to Sudden or unexplained deaths and less than 5% Chronic Medical Conditions. There were no cases due to Suicide or Self Inflicted harm.

3.3 Ethnicity of cases reviewed

Figures 13: Ethnicity of Reviewed Cases 2024/25

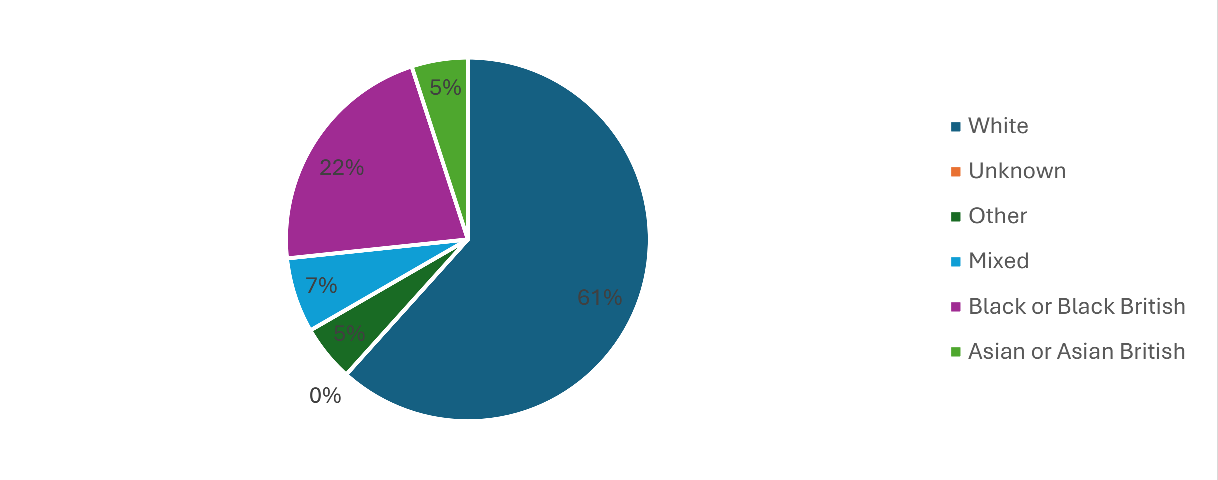
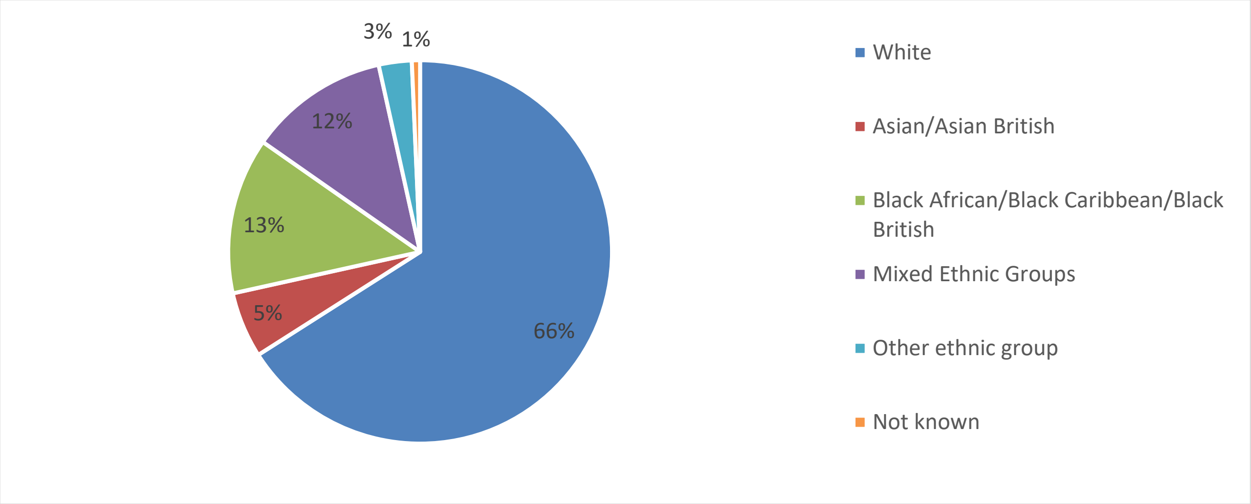


Figure 13. Shows that 61% of cases reviewed by CDOP between 2024/25 were children of White Ethnicity and 5% of Other origin. The proportion of reviews for children whose ethnicity was recorded as Black or Black British was 22%, recorded as Mixed was 7% and those of Asian/Asian British - 5%. There were no cases for other ethnicities and there were no cases where ethnicity was not recorded.

The proportion of deaths in the White ethnic group seems lower than the proportion of White population in BNSSG (approximately 81% of young people in BNSSG are White according to 2021 Census).

As the numbers of deaths recorded in certain ethic group are very small, the proportions may be prone to change dramatically from one year to another. However, the proportion of deaths reviewed in the Black ethnic group (22%) seems to be higher than the percentage of Black young people in the BNSSG population (5%).

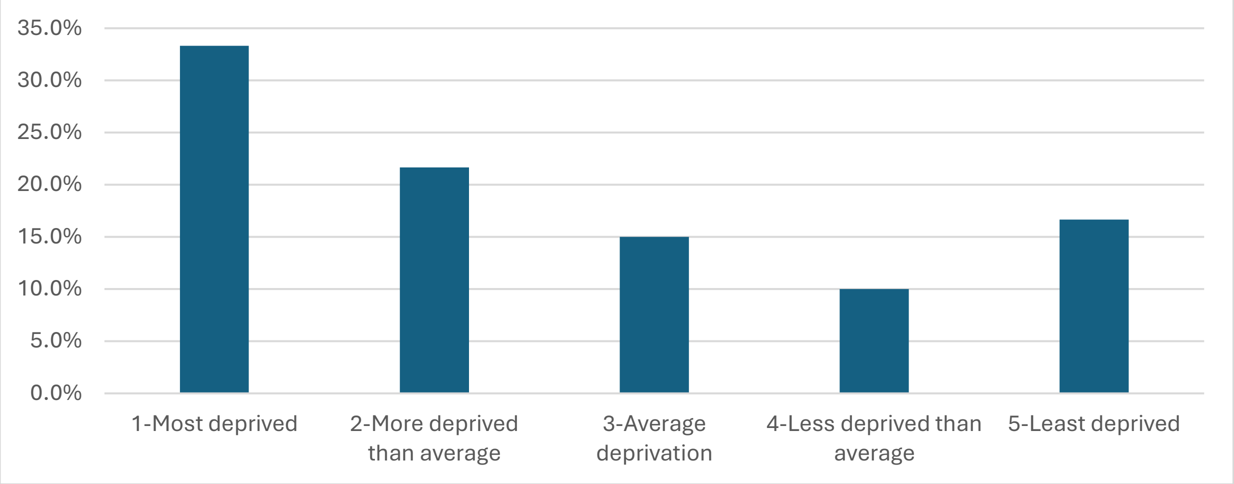
Figure 14: Deaths Reviewed by Ethnicity, 3 year pooled rates, 2022/23-2024/25



The 3 years (2022/23-2024/25) of data show a similar picture, with a smaller proportion of deaths in the White ethnic group compared to the 2021 Census population estimates and the higher proportions of Black, Asian and Mixed ethic groups.

3.4 Local area deprivation of cases reviewed

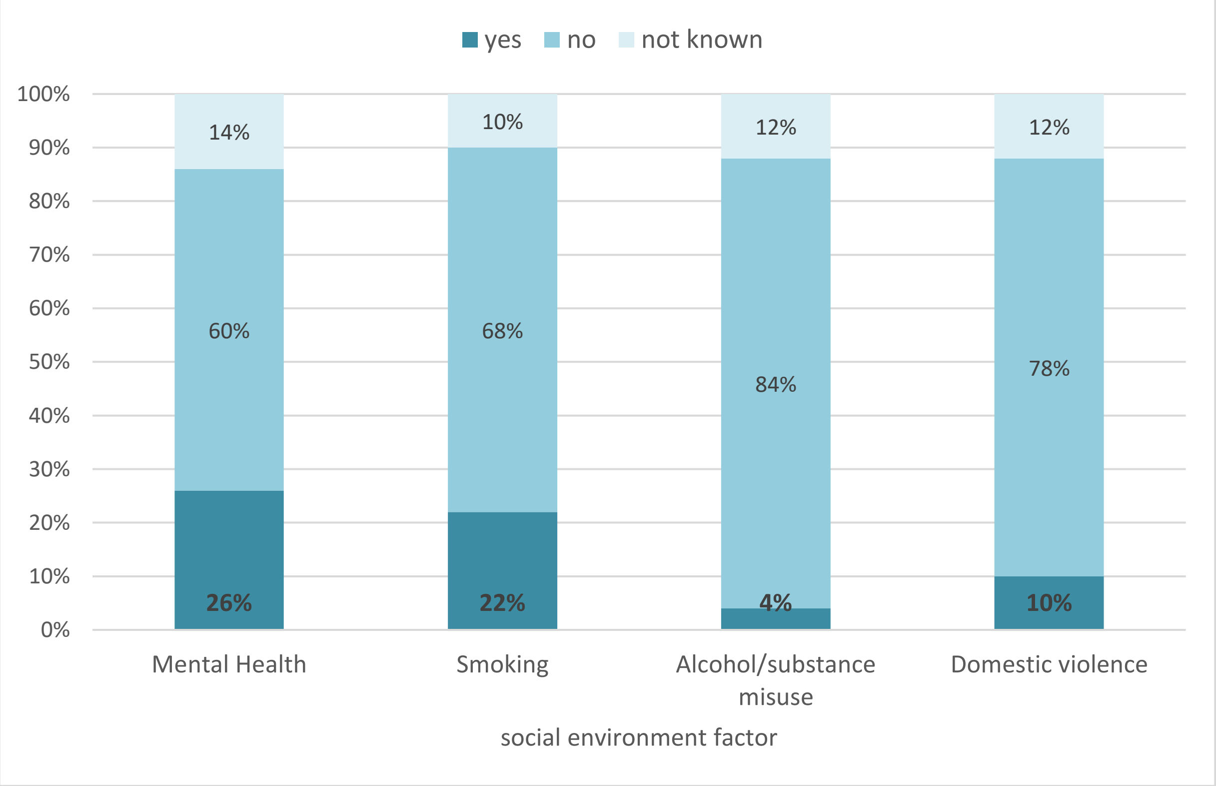
Figure 15: Percentage of cases reviewed in 2024/25 in BNSSG, by deprivation quintile



The data for 2024/25 show that over a half of all cases (55%) relates to children deaths from areas more deprived than average (33% in the most deprived quintile and 22% in the more deprived quintile). That association is visible especially in case reviews from Bristol, while the numbers or reviews from North Somerset and South Gloucestershire are too small to show any meaningful pattern.

3.5 Social Factors in cases reviewed

Figure 16: Factors in the social environment (including parenting capacity recorded in cases reviewed by CDOP between 1st April 2024 and 31st March 2025) - proportion of cases where the factor was present (yes), not present (no) or not known



A mental health condition in a parent or carer is mentioned in 26% of all reviews.

Regionally, the estimate prevalence of common mental health disorder in the population 16 and over is 16.2%[6].

It is estimated the around 25% of mothers in the BNSSG region will experience a perinatal mental health condition[7]. There are no estimates for the mental health of fathers.

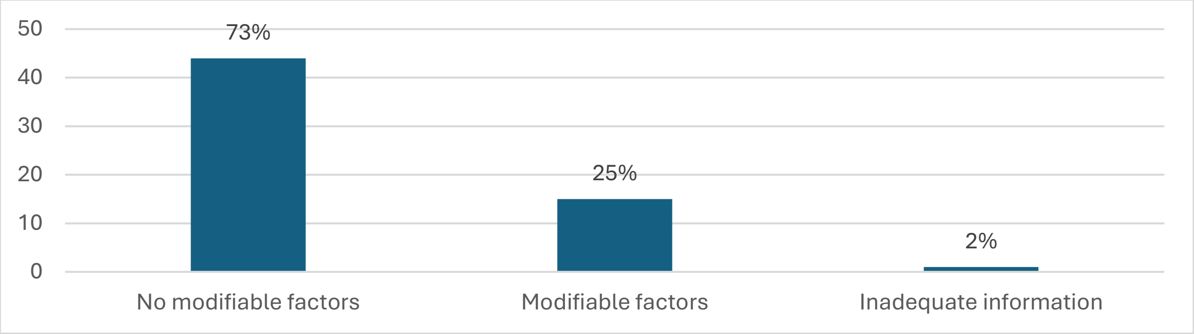
Smoking by a parent is mentioned in 22% of reviews. For context, the BNSSG rate of mothers smoking at time of delivery was around 7% in 2023/24, while the smoking rate in early pregnancy – 9.9%. There is no equivalent figure for father or partner smoking or smoking in a child's home more generally, but the smoking prevalence in adults in the BNSSG is 10.6% (males: 11% and females: 10%), so smoking prevalence in the reviews data does appear to be disproportionally high[8].

Alcohol or substance misuse by a parent or carer is mentioned in 4% of reviews. It is estimated that regionally 3.5% of women drank alcohol in early pregnancy in 2023/24 and 5.8% of adults were high risk drinkers in 2022 (above 50 units a week for men, above 35 units for women)[9].

Domestic violence is mentioned in 10% of reviews. Regionally, the rate of domestic abuse per 1,000 population aged 16 and over was 24.5 (or 2.4%)[10] in 2023/24, which makes the prevalence in the reviews appear 4 times higher.

3.6 Modifiability of category of death

Figure 17: Modifiability of cases reviewed by CDOP between 1st April 2024 and 31st March 2025



Modifiable factors are defined as one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths. An example of a modifiable factor might be a death resulting from a vaccine preventable infection where the vaccine had not been given to the child.

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[6] Mental health and wellbeing JSNA | Fingertips | Department of Health and Social Care

[7] Perinatal mental health | Fingertips | Department of Health and Social Care

[8] Smoking Profile - Data | Fingertips | Department of Health and Social Care

[9] Alcohol Profile - Data | Fingertips | Department of Health and Social Care

[10] Perinatal mental health | Fingertips | Department of Health and Social Care

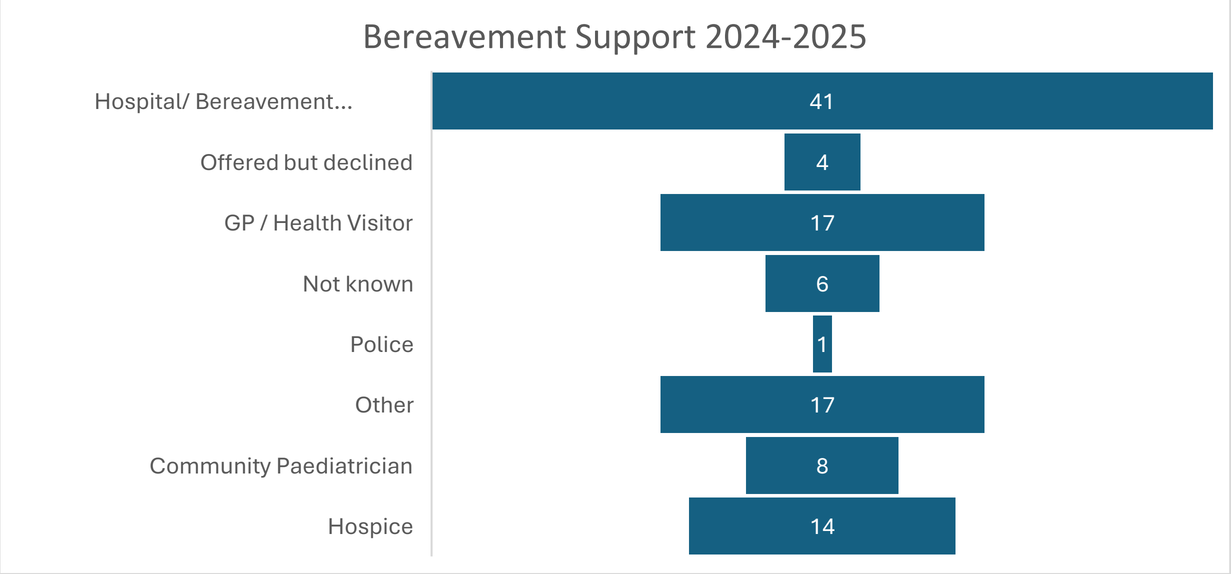
Table 6: Reviewed Cases Modifiability by Category of Death 2024-2025 (NCMD Data)

Primary Category of Death	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Trauma and other external factors, including medical/surgical complications/error	3	0	0%
Suicide or deliberate self-inflicted harm	0	0	0%
Sudden unexpected, unexplained death	2	1	50%
Perinatal/neonatal event	19	5	26%
Malignancy	5	0	0%
Infection	6	4	67%
Deliberately inflicted injury, abuse or neglect	0	0	0%
Chronic medical condition	4	1	25
Chromosomal, genetic and congenital anomalies	16	2	13%
Acute medical or surgical condition	5	2	40%
Totals:	**60**	**15**	**25%**

Of cases reviewed by the BNSSG CDOP in this twelve-month period 2024-25 modifiable factors were identified in 25% of cases. Nationally 43% of child deaths were assessed as having modifiable factors in the same time period.

3.7 Family follow up

Figure 18: Main Agency providing follow up to families in cases reviewed by CDOP between 1st April 2024 and 31st March 2025



Active engagement with bereaved parents underpins the entire child death review process. Parental input into the child death review meeting should occur as a matter of course. Parents are invited to submit questions to the local child death review meeting, and feedback by the lead health professional on all aspects of this meeting is then given at a follow-up appointment with the family.

The main Agency providing bereavement support to families was the Hospital and other various Agencies which include Hospices and Community Services. A small number of families declined support. (4) In some cases, support was accepted from more than one source.

Figure 18. Shows which was the main agency that offered follow-up for cases reviewed by CDOP between 1st April 2024 and 31st March 2025. Families may have been offered follow-up by more than one agency following their child's death. The offer of follow-up remains open to families; however, some families may choose not to take-up this offer for months or sometimes years depending on their specific need.

In addition, families are routinely given national and local information on charities offering bereavement support & counselling.

A bereavement pathway has been developed within University Hospitals Bristol and Weston NHS Foundation Trust and the team have offered support to all families of children who have been seen at the Bristol Children's Hospital since the team was set up, and now extend this offer to the families of children and young people even when death is confirmed outside the hospital. There are also Bereavement teams in NICU at Southmead and St Michaels. Case reviews undertaken by CDOP in 2024-25 have provided evidence that families are consistently offered this support and it is welcomed by many.

4. Child Death Overview Panel Activity

4.1 Actions arising from CDR/CDOP review of individual cases

The key purpose of a robust child death review process is to enable effective learning from individual deaths and trends and thematic reviews.

All CDOP Members have a responsibility for sharing learning from panel discussions.

Effective governance procedures within organisations should ensure that significant factors are identified and managed through the local child death review meeting. The CDOP also reviewed many cases where good practice had been identified.

To ensure that issues identified at CDOP were rapidly disseminated through their constituent agencies, the Safeguarding Partners within the BNSSG area have CDOP matters as a standing agenda item at their meetings.

In certain cases, the CDOP sought assurance that a particular action arising from a child's death had been addressed.

4.2. Themes emerging from reviewed cases at CDOP during the year April 2024–March 2025

In 2024/25 there were 3 Neonatal themed meetings. There were no other specific themed CDOP meetings.

The following learning points have arisen this year from one or more CDOP case reviews:

Paediatric Palliative Care

The Starling Service pilot was launched in July 2023 providing End of Life care at home when this was the preferred option for families. The first three cases were reviewed by CDOP with many positive aspects.

A further child was able to be accepted & transferred from hospital to the hospice at a weekend and this was only possible due to the Starling on-call rota meaning there was medical cover 24/7.

A number of case reviews have highlighted the lack of out of hours Paediatric Palliative Care (PPC) specialist input for children who are in hospital. CDOP raised this with the ICB who highlight that this provision sits with NHS England specialist commissioning and there is no funding forthcoming. The PPC medical cover is currently for 4 weekdays only.

Lack of PPC out of hours has meant some careful plans & decisions (e.g. about managing seizures) made during the day were changed when general teams managed the child overnight and some symptoms may have been less well-managed.

Vaccine preventable infections

A case of pneumococcal pneumonia (invasive pneumococcal disease IPD) was found to be due to a serotype not in the current vaccine (PC13) given to infants.

CDOP to write to UKHSA to flag the increased incidence of invasive Pneumococcal disease and enquire about any plans in the future for development of a vaccination that covers a higher number of serotypes.

There are at least 100 different pneumococcal serotypes that can cause serious disease in children and adults. Given the success of the PCV immunisation programme, most of the current IPD cases are now due to non-PCV13 serotypes, but the number of children developing IPD is much lower than the pre-vaccine years.

Recently, two higher valent vaccines (PCV15 and PCV20) have been licensed for children and adults in Europe and other parts of the world. There are several other PCVs which include even more serotypes (PCV21, PCV24, PCV30+) which are currently under investigation in clinical trials. The UK Joint Committee for Vaccination and Immunisation (JCVI) regularly reviews the evidence on pneumococcal vaccines and advises the Secretary of State related to their implementation into the childhood and adult immunisation programmes.

In the context of these vaccine preventable infections, there was some consideration of vaccine reluctance. One case arose during lockdown when shielding deterred parents from engaging with routine immunisations. Another followed lack of engagement with vaccination when contacted by the GP surgery. All professionals across settings need to take responsibility when they become aware of vaccine reluctance. There was discussion about opportunistic promotion such as when attending ED, if noted a child is unvaccinated there can be a prompt ('is this something you want to talk about').

There is a Vaccine clinic at the Children's Hospital which GPs can refer to, and CDOP investigated how this is promoted to GPs via Remedy. Referral criteria include unimmunised with vaccine hesitancy, previous allergies & needle phobia.

The ICB Vaccine delivery group work to advertise the importance of immunisations uptake via various social media sources, face/face meeting. Links to the Oxford Vaccine Group resources were suggested Home | Vaccine Knowledge Project as well as the Muslim Council of Britain Operation Vaccination Campaign | Muslim Council of Britain. There could be further improvements in collating these resources and identifying a place to collect these resources for ease of access by health professionals & families. ICB Vaccine Delivery Group has an ongoing a role here.

Recognition of serious illness

There were a small number of deaths where recognition of the severity of a child's illness by parents or by professionals may have played a role.

One family attended an adult tertiary hospital which had a children's minor injury unit but no paediatric Emergency Department.

The ICB shared data that was assuring that the majority of children do attend Bristol Children's Hospital. The data did not suggest a general issue with parents taking children to adult Emergency Departments. However, it was agreed a system communication would be helpful at the start of the new school year to remind parents and practitioners of where to take a child.

All services need to be direct to BRHC (and raise awareness about this for parents & professionals).
In relation to parental judgement of the severity of illness, which came up in another case, 111 usually directs to hospital for many more cases than would be needed. But in this case parents called their GP and were asked 'is this an emergency' and didn't know what to say.
Brisdoc shared with GPs a 'Tips and Tripwires in Urgent Paediatric Primary Care' briefing via their Bulletin.

NCMD reported on the theme of infection-related deaths in 2023.

Care of the Next Infant
There is still no formal CONI Programme in BNSSG to support parents who have lost a previous baby with SUDI. But there is now the Family Nurse Partnership for first child of young mothers and Maternal Early Childhood Sustained Home-visiting which may pick up similar issues https://www.earlychildhoodconnect.edu.au/home-visiting-programs/mecsh-public/about-mecsh. CDOP will continue to liaise about this in the coming year.

Poor housing conditions
Damp and mould were identified in Local Authority Social Housing during the Joint Agency Response home visit following death of a baby from an infectious cause.

CDOP ascertained Local Authority responses to the new obligation on Social Housing providers to act on damp and mould where young children are living, referring to the updated Social Housing Regulation Bill legislation for all social housing providers.

Safety around vehicles
There is a Safe Play initiative which CDOP has checked includes separation of cars from homes in design of traveler's sites and involves co-production with travelers.

Inquests
Clinicians questioned at an inquest found this a difficult and challenging experience and CDOP acknowledged the vulnerability that clinicians may face when attending inquests, as there is no routine training for this, although there is now a course run by the MAPLE (Multidisciplinary Approach to Paediatric End of Life Education) team in Bristol on the Coroner's process and Inquests.

Medically complex and difficult decision-making
A number of cases have raised issues around this area of health care for children with the most complex conditions.
Challenges with medical leadership and case co-ordination led CDOP to contact the Hospital Trust to support the business case for funding for a named complex disability doctor within the hospital to support complex patients. Although this post was planned a couple of years ago, there remains no funding available in the current budgetary constraints, but the Women's and Children's Division remain aware and committed to improving this in the longer term.

Another young person who had a neuromuscular disorder required input from multiple speciality teams within the hospital. As they approached End of Life, this was particularly important. CDOP became aware there is currently no co-ordinated joint clinic meaning any arrangements for joint working were ad hoc, time-consuming and poorly co-ordinated. CDOP were informed by the Neuromuscular service that they are making efforts to try and set up a one-stop shop for children affected by neuromuscular conditions where they would also receive their annual cardiac assessment at the same time as the neuromuscular clinic assessment. This has not yet come to fruition. Involvement of the Palliative Care team would also be important. There is joint clinic working between the Neuromuscular clinic and both Respiratory and Endocrine which is a recently funded development. CDOP understand there is no funding for joint clinic working between Neurology and Cardiology. Also, since 2007, the neuromuscular consultants worked jointly with Spinal surgeons when children have a scoliosis, however that was stopped in 2020 due to lack of funding.

Those working in the neuromuscular field recognise the importance of joint working and integration of the services. This is important for co-ordinated discussions about palliative care and advance planning and has also become particularly relevant now that new disease modifying treatments are available (such as treatments for spinal muscular atrophy with gene therapy). All neuromuscular patients who are deemed to have a life-limiting condition are, within the 1st year of diagnosis, referred to palliative care services.

Verification of Death

SWAST have reviewed and implemented a change in practice (to allow 5min between Recognition of Life extinct and Confirmation of death) and measures to ensure senior review if there is any concern through the CUSS assertiveness approach (where professionals use a graded assertiveness approach to communicating moving through Concern, Uncertainty, Safety to STOP) and the Major Trauma and Resus Advice helpline.

Vaping & co-sleeping

Risk factors associated with SUDI are always recorded by CDOP, noting that these are not causal as such. The long-term risks of vaping and co-sleeping are not currently known but the Lullaby Trust advise that parents should not co-sleep with their babies if they vape.

The Health Visiting leads informed CDOP that their teams confidently talk about smoking and bedsharing with families using the information on the Lullaby Trust website, but they were not clear about the discussions taking place around vaping. They agreed to take this to the Health Visiting teams and look at resources they could use. In future they will be making sure staff feel confident in having conversations about vaping and vaping with co-sleeping.

CDOP chair also contacted the Tobacco leads in Bristol CC to promote this issue, and as HVs work across BNSSG, any educational benefits would potentially be seen across the BNSSG area.

Transition to adult services

There were cases which raised the question of healthcare arrangements for young people around the time of transfer to adult services. CDOP enquired about transitional care pathways when planning ICU admission for 16- and 17-year-olds with complex needs.

For adolescents aged 16 or 17 years with complex needs who present acutely in Bristol, critical care is provided in the most appropriate and feasible location at UHBW. This means that in practice if the Paediatric Intensive Care Unit (PICU) has capacity (beds and staffing) and the patient has not yet

transitioned to adult services then they should be admitted to PICU. If PICU is near/at capacity then there is a pragmatic discussion with the General Intensive Care Unit (GICU) team to discuss the possibility of mutual aid, including discussing the pressures across both services to reach a decision which considers patient safety together with service pressures. This includes patient complexity, support requirements and patient size (to ensure GICU have appropriate kit/expertise etc) amongst other factors.
For those patients who are admitted to GICU, the PICU team provide outreach support with daily visits or phone calls as needed. This includes consultant paediatric intensivist support alongside paediatric physiotherapy, dietetic and pharmacy involvement as necessary, as well as attending MDTs/discharge planning meetings. There is a Standard operating Procedure (SOP) describing transition arrangements of critically ill children between PICU and Adult ICU in UHBW.

For adolescents aged 16 or 17 years with complex needs, the transition process is variable between specialties at Bristol Royal Hospital for Children (BRHC), but this predominantly involves having been seen in 2 adult/joint clinics before they have been deemed to have transitioned to adult services. There is ongoing work in UHBW and within the paediatric critical care Operational Delivery Network reviewing the process of transition, particularly to ensure clear routes of communication and mutual aid agreements.

For adolescents in the Southwest who live outside of Bristol, for emergency care pre transition, a similar discussion occurs with the local Adult Intensive Care Unit (AICU) and the Wales and West Acute Transport for Children (WATCh) team to decide upon the most suitable critical care location to care for the patient (depending on various factors- complexity, potential need for sub-specialist involvement, size, trajectory etc). Paediatric District General Hospital (DGH) teams are encouraged to identify a link consultant to liaise with their local AICU such that patients nearing transition are flagged to them so potential admissions can be anticipated and planned for.

The Paediatric Critical Care Society and the (adult) Intensive Care Society have issued national guidance regarding paediatric to adult critical care transition. One of their recommendations is that there should be a medical and nursing Adult Critical Care Transition Lead within each Trust to coordinate the transition process. This has not yet been enacted across the Southwest, but this would be a valuable step in facilitating a smooth transition to adult services.

Informing primary care about a child's admission to PICU and subsequent death
CDOP saw comments from GPs who had not known about a child patient of theirs being admitted to PICU or having died, in a timely way and before the family make contact with the surgery themselves. The aim is for primary care to be able to support parents proactively.

Informing GPs of PICU admission was discussed, with barriers being the large numbers (many of whom are elective post-operative admissionns), identifying the correct GP contact details & getting through etc. There is a PIC Integrated Care meeting with chaplaincy, charities etc. and this was suggested as a suitable forum to raise and action this.
The UHBW checklist following the death of a child includes informing the GP, but as this may not be until the next working day, unfortunately the GP may not always be notified before finding out through another route or being contacted by the family.

Regional working
CDOP review of a child from BNSSG but who died elsewhere raised concern about a delay involving the Joint Agency Response team from our area.

Conversely, cases where a child resided elsewhere but died in BNSSG do not routinely come to BNSSG CDOP for review, but it is important that learning is shared across both areas, and arrangements for this are now being put in place.

SWAST access to Advance Care Plans

Paramedics were not aware of a child's significant and complex needs until arriving at the scene and this made it challenging to administer medication due to the patient size and weight.

There is ongoing work on this issue which has proved over the years more complex than expected. In the meantime, families are always advised to keep a paper copy of the Advance Care Plan with the child at all times.

Organ Donation (Good practice)

CDOP reviewed cases where organ donation was facilitated with the generous support of a child's family. This included organ donation from a Muslim family, and CDOP acknowledged the exceptional circumstances in which organ donation was made possible by HM Coroner, who consented to organ donation and rapid burial. CDOP further recognised that this has opened a welcome discussion about different faith and ethnic groups considering organ donation.

Location of Rainbow room

CDOP raised the issue of poor access to the current location of the Bereavement suite within the Children's hospital with bereaved families having to walk through Children's out-patients, and funeral directors having to collect a child from the back entrance next to the bin store. The Trust acknowledge this issue but do not have funds to address this within current estate but will be aware when future redevelopment is being planned.

Delay in receiving the post-mortem reports

This is an ongoing theme affecting many families who wait to know why their child died and also affects completion of other reviews and learning opportunities being as timely as they should. The distress caused should not be underestimated. There is a large shortage in the numbers of Paediatric Pathologists nationally which CDOP have raised with the Royal College of Pathologists previously. Local teams continue to support bereaved families to be as informed as possible about what timelines to expect realistically, and when reports are released, there is a clear pathway for the Paediatrician to share the results with parents alongside the Coroner.

5. Achievements

National agenda

Thirlwall enquiry

Reflecting on events at the Countess of Chester hospital, BNSSG CDOP needed to reflect how any concerns would be noticed in our area. CDOP regularly review the numbers and characteristics of child death notifications to spot any unusual peaks by age, place of death, category of death etc. The annual review data provides another opportunity to do this.

NCMD asthma and allergy themed report 2024

While BNSSG CDOP have not had any asthma or allergy deaths in this 12 month period, there is no room for complacency and there have been cases in previous years. The learning from this report highlights the importance of asthma plans and communication between secondary and primary care, as well as engagement with families and young people themselves.

Deaths of Child in Need - Children's Commissioner for England report Jan 25

Deaths of children in need | Children's Commissioner for England includes deaths of Children in Care, and among others highlights the risks of home schooling when children may be 'invisible' to services.

Association of Child Death Review Professionals

The Designated Doctor continues to be the South-West rep and Palliative Care rep at the quarterly Executive meetings. BNSSG CDOP had a presence at the Association of Child Death Review Professionals annual conference delivering 2 multi-agency workshops on the JAR in NICUs and CDRMs in a hospital setting.

Other examples of learning from CDOP reviews

NCMD coordinated an event to illustrate how some CDOPs have ensured learning from cases. One CDOP ccollaborated with the Lullaby Trust to produce a graphic to support safety when 'Staying Away from Home' with a poster & toolkit for providers of accommodation and tourist and emergency accommodation providers, including safe sleeping and how to access emergency medical support. Another CDOP worked with their local council team including the Emergency Planning officer and commissioned a water safety 'Be Water Wise' video and campaign which was distributed through schools.

Introduction of statutory Medical Examiner service in Sept 2024

The Designated Doctor has worked alongside the Medical Examiner leads in setting up the processes across settings, including NICUs, PICU, other hospital wards, hospice and community, trying to ensure an integrated process that doesn't duplicate aspects of the established Child Death Review process, but gives families an early opportunity to raise any concerns. Any significant learning or governance issues will feed through to the later CDR and CDOP meetings.

CDOP has started to review the first cases with statutory Medical Examiner involvement. There was discussion about the timing of 'deceased' notification to the NHS spine so that access to records is still permitted but that other professionals are notified as soon as possible.

Improvements to local CDOP and CDR process

CDR Key Worker - the Child Death office & Children's hospital child death team have been asked to record who the key worker for CDR is in every case & prompt the chair about family questions for the CDRM.

Streamlining Safeguarding Rapid Review and CDR processes - there has been work on this at Council and ICB level so that when there is a Joint Agency Response, there can be better co-ordination. This followed some of the high-profile cases in early 2024 when many agencies needed to respond quickly.

Regional working – sharing CDOP cases where learning is relevant across CDOP areas, for example when a child from another area has then died in the tertiary hospital. The Designated Doctor organized a meeting with counterparts, and the CDOP Chairs continue to have a regional group.

CDOP Strategic Meeting has continued to meet quarterly to review commissioning arrangements and contracting, monitor KPIs, and this year has also updated the Terms of Reference and Induction pack for CDOP members. There has also been a chance to review CDOP rotations to ensure appropriate representation across the three areas of BNSSG, and quoracy achieved for each meeting.

A Health Visiting representative has been re-established on CDOP, as well as the **Coroners Officer**. In some cases, it is possible to group case discussions to match a particular professional's availability, but with such a range of cases it is not possible to do this for each panel member. But CDOP greatly appreciates the commitment and time that each Panel member brings and has worked to make their contribution as effective as possible.

Sharing learning is always a consideration, and this year CDOP has linked with the Local Authority newsletters and One Care bulletin for GPs so as to include content for those audiences with relevant learning points in a timely way.

The CD team has met with the **ICB Designated Nurses** to review the notification process to ICB and what actions they should take.

The Designated Doctor has delivered **training** to a number of departments about the JAR and CDR processes, as well as to the MAPLE (Improving Paediatric End of Life care) course run in Bristol for a national audience.

Genetics

The Designated Doctor has developed a process to offer Whole Genome Sequencing (R441) genetic testing panel to families following SUDI/C when the investigations and postmortem have not been able to find a cause for their child's death.

Separately, the Generation Study launched in July 2024 offering Whole Genome testing to all newborns to identify a large number of inherited conditions where early diagnosis can make a difference to outcome. Inevitably a small number of babies in this study have later died, usually from unrelated causes, but the Designated Doctor has worked with the Generation Study team locally and nationally to consider how to feedback results from the study in an appropriate way.

Support for professionals

This is always an important focus, to consider the impact of this difficult area of work on staff well-being. This year there was chance to review the support for the Paediatricians who work on-call in the JAR team, looking at Psychology support and debriefs, and this is continuing to be developed, with funding issues once again being a constraint.

There were also good examples of teams where TRIM (a trauma focused peer support system) is in place, such as police and ambulance staff.

6. Future Priorities

Many of the above projects are work in progress and will continue in the next year.

Working towards having a CDOP manager (as previously) may help be able to increase local learning from cases and more training sessions to partner agencies.

CDR nurses have also been considered but without any funding streams in BNSSG.

Keeping all settings updated about Joint Agency Response criteria and CDR processes remains a challenge for a small team, especially where child deaths occur infrequently such as adult settings, wards and community locations.

7. Appendix A - CDOP membership April 2024 to March 2025

Role	Core member	Organisation
Nominated Chair	Sarah Weld from August 2022 Sally Hogg from Sept 2024	Director of Public Health, South Gloucestershire Consultant in Public Health, Bristol
Designated Doctor for Children's Deaths	Dr Mary Gainsborough	Sirona Care & Health on behalf of BNSSG ICB
Consultant Neonatologist	Dr Ziju Elanjikal / Dr Claire Rose	University Hospitals Bristol and Weston NHS Trust/North Bristol NHS Trust
Coroner's Officer	Linda Brown	Avon Coroner's Office
Children's Social Care	Emma Collings From September 2024 Jo Ratcliffe	Strategic Safeguarding Service Manager, South Gloucestershire Council Head of Service, Quality Assurance and Safeguarding, North Somerset Council
Designated Nurse Safeguarding Children Deputy Designated Nurse for All Age Safeguarding	Toyah Carty-Moore Louise Field to April 2025	BNSSG BSW ICB Deputy Designated Nurse for All Age Safeguarding BNSSG
Midwifery Ward Manager	Sara Arnold	University Hospitals Bristol and Weston NHS Trust
Consultant Obstetrician	Dr Rachna Bahl	University Hospitals Bristol and Weston NHS Trust
General Practitioner	Dr Patrick Nearney and Dr Elaine Lunts	Bristol
Police	Detective Inspector Andrew Branch from April 2024	Avon & Somerset Constabulary
Consultant Paediatric Intensivist	Dr Alvin Schadenberg	University Hospitals Bristol and Weston NHS Trust
Consultant, Paediatric Emergency Medicine	Dr Nick Sargant and Bianca Cuellar	University Hospitals Bristol and Weston NHS Trust
Safeguarding Specialist and Lead for Child Deaths	Chris Rogers to September 2024 then Ali Mann Safeguarding Specialist	South Western Ambulance Service NHS Foundation Trust
Lay Representative	Julie Kembrey	Bereaved Parent and Ambassador for Jessie May Trust with an interest in Bereavement Services.