NHS
Hampshire and Isle of Wight

Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel

Annual Report

1st April 2024 – 31st March 2025

NHS Hampshire and Isle of Wight Integrated Care Board

Foreword

England has 68 Child Death Review Teams. Only 7 deal with more cases than The Hampshire Isle of Wight Portsmouth and Southampton team. The size of our caseload is important, because, although each child death is a devastation for their parents and wider family, it is only through the systematic review of the many issues that surround such sadness, that patterns and repeating concerns can be discovered. Large data sets improve our ability to identify issues that health providers and other partners can work on to prevent future deaths and provide families with better support.

The aim of the Child Death Review process is for a wide range of knowledgeable professionals to review thoroughly each child death and to determine whether there can be found in an individual case or in groups of similar deaths factors which can be researched and improved; all with the aim of reducing such deaths in the future.

I have the privilege of acting as the independent chair of the Hampshire Isle of Wight Portsmouth and Southampton Child Death Overview Panel and I am always amazed at the knowledge, compassion and desire to improve things that is demonstrated by the professionals that attend.

The reduction of child mortality is something that we all want to see. The Child Death Overview Panel activities described in this report demonstrate how we are seeking to contribute to this most worthwhile of objectives.

Chris Miller

Independent Chair

Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel

Executive summary

All the below summary points are explored further within the main body of the report.

- The Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel received 73 child death notifications during 2024/2025

- We have seen variation in the number of deaths that occur each year since 2018/2019 when the Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel data was amalgamated. The 73 deaths reported in 2024/2025 are noted to be the lowest we have recorded, but this may just reflect statistical variance as opposed to be related to any specific health and/or public health intervention

- In 2024/2025 a Joint Agency Response was required for 34 child deaths which equates to 47% (34 out of 73) of all reported deaths which is an increase from 2023/2024 when 37% (36 out of 97) instigated a joint agency response

- 52% of deaths within the Hampshire, Isle of Wight, Portsmouth, and Southampton area occurred within the first year of life

- During the reporting year 2024/2025 there were 13 child deaths within the Hampshire, Isle of Wight, Portsmouth and Southampton area for non-resident children. The team can provide assurance that the appropriate pathways were followed by their local Child Death Overview Panel teams

- 66% of child deaths occurring across the patch between 1st April 2021- 31st March 2025 are Hampshire residents

- During 2024/2025, 13 Child Death Overview Panels were held, and 98 cases were heard and closed. The Child Death Overview Panel team have worked diligently to ensure that historic cases were reviewed at panel. All open cases have been reviewed on a weekly basis to ensure timely review at the Child Death Overview Panel

- Of those cases reviewed during 2024/2025 the highest percentage of modifiable factors were identified in the 15-17 years age group. This is expected due to the bespoke panels which was held during the financial year

- From the cases reviewed during 2024/25 learning has been identified around gender identity/incongruence, unsafe sleep environment, education attendance, early referral to appropriate teams and monitoring of cardiotocographs, and safety netting

- Learning from child deaths has continued to be delivered through bespoke teaching sessions and supervision groups across multi-agency professionals

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Introduction

This is the fifth annual report for the joint Child Death Overview Panel across Hampshire, Isle of Wight, Portsmouth, and Southampton.

Since October 2019, there has been a strategic Child Death Overview Panel covering all of Hampshire, Isle of Wight, Portsmouth and Southampton. This is an equal partnership for the mutual benefit of all children and young people and provides oversight and assurance of the entire child death review process in accordance with legislation and local child death review policies.

Child death review partners who are the Local Authorities and Integrated Care Boards (now known as NHS Hampshire and Isle of Wight Integrated Care Board) for Hampshire, Isle of Wight, Portsmouth and Southampton hold the legal responsibility for reviewing child deaths including the establishment of a Child Death Overview Panel as set out in the Children Act 2004, and amended by the Children and Social Work Act 2017. The reviews are conducted in accordance with Working Together 2023 alongside the Statutory and Operational Guidance.

A child death review must be carried out for all children regardless of the cause of death. This includes the death of any live-born baby where a death certificate has been issued. Those deaths where a termination of pregnancy (of any gestation) carried out within the law has occurred do not require a child death review.

The purpose for reviewing the deaths is grounded in respect for the rights of children and their families with the intention to ascertain why children die and put in place interventions to protect other children and prevent future deaths from occurring. See Appendix 1 for Child Death Overview Panel for statutory duties.

Following a brief exploration of the local population, this report will be considered in two parts - child deaths occurring during the reporting period 2024/2025, and the child deaths which have been heard at panel during this period. Cases are reviewed at panel once full investigations including coronial inquests are completed and therefore will include cases that have sadly died prior 2024/2025.

Population data

This area of the report explores the demographics of the four local authority areas which make up Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel. The population of each local authority differs considerably with a much larger population within Hampshire. Numbers of child deaths cannot therefore be directly compared between authorities.

The total estimated population across the four local authorities is 1,998,300 with children aged 0-17 amounting to 395,537. Around 1 in 6 of Hampshire, Isle of Wight, Portsmouth and Southampton population are therefore children aged 0-17.

This is divided by local authority areas as follows (Office for National Statistics 2021):

Hampshire: **281,088 (71%)**

Isle of Wight: **23,640 (6%)**

Portsmouth: **41,401 (10%)**

Southampton: **49,408 (12%)**

Over 19,000 babies are born on average each year within Hampshire, Isle of Wight, Portsmouth and Southampton.

Part 1 - Child deaths occurring during 2024/2025

Some comparisons made with the National data will be referring to the year 2023/2024, rather than 2024/2025 which the local data is pertaining to. This is due to the National 2024/2025 data not being available, until the 3rd quarter of each year.

Total number of infant and child deaths 2024/2025

The Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel received 73 child death notifications during 2024/2025 relating to 395,537 children aged under 18 years resident in the Hampshire, Isle of Wight, Portsmouth and Southampton area (Office for National Statistics 2021).

The registered child deaths for 2024/2025 in each area Hampshire, Isle of Wight, Portsmouth and Southampton are as follows:

• 48 in Hampshire

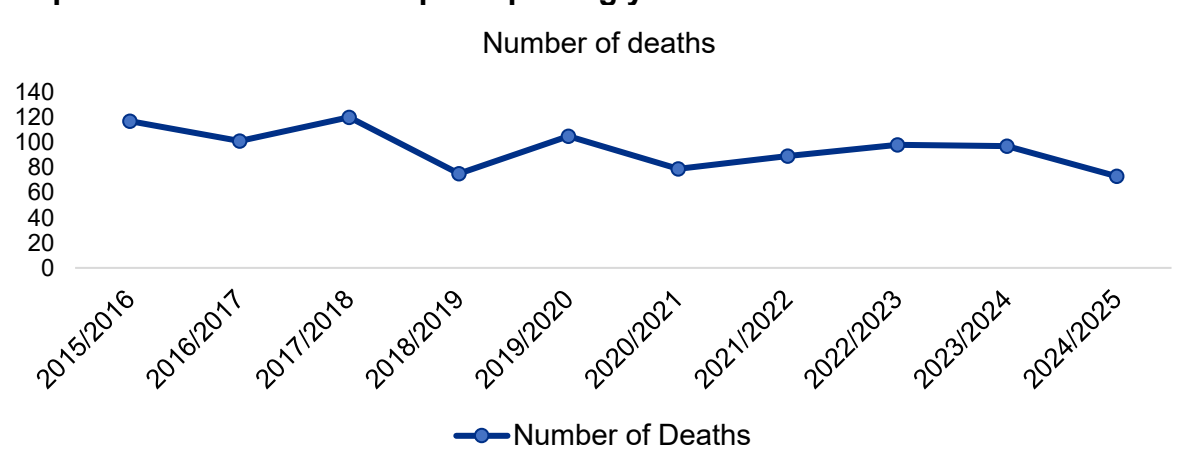
• <5 on the Isle of Wight

• 10 in Portsmouth

• 12 in Southampton

There has been a noticeable fall in numbers of child deaths in the reporting year 2024/2025 (73), compared to 2023/2024 when there were 97 deaths and 2022/2023 when there were 98. The 73 deaths in 2024/2025 are the lowest recorded since 2018/2019.

Graph 1: Number of deaths per reporting year



Looking at the 10-year picture the overall number of child deaths has reduced. This reduction may be in part due to natural variants and/or the number of children living with life limiting and life threatening conditions increasing, as highlighted in the recent National Child Mortality Database report NCMD Life Limiting Conditions.

Unexpected child deaths

When a child death is unexpected, A Joint Agency Response is triggered, see Appendix 2 for additional information regarding this process.

In 2024/2025 a Joint Agency Response was required for 34 child deaths which equates to 47% (34 out of 73) of all reported deaths. This appears to be an increase from 2023/2024 when 37% (36 out of 97) instigated a Joint Agency Response. The team is confident having followed all due processes and governance that no concerns regarding this have been identified.

Gender

During the reporting year 2024/2025, 34% of the child deaths were female and 64% were male.1% of the infant deaths were classed as Indeterminate (due to underlying genetic conditions).

The gender distribution of deaths across Hampshire, Isle of Wight, Portsmouth and Southampton follows the national trend where a higher number of deaths are seen amongst males (57% in 2023/2024). This has continued to be the case across Hampshire, Isle of Wight, Portsmouth and Southampton in the previous reporting years.

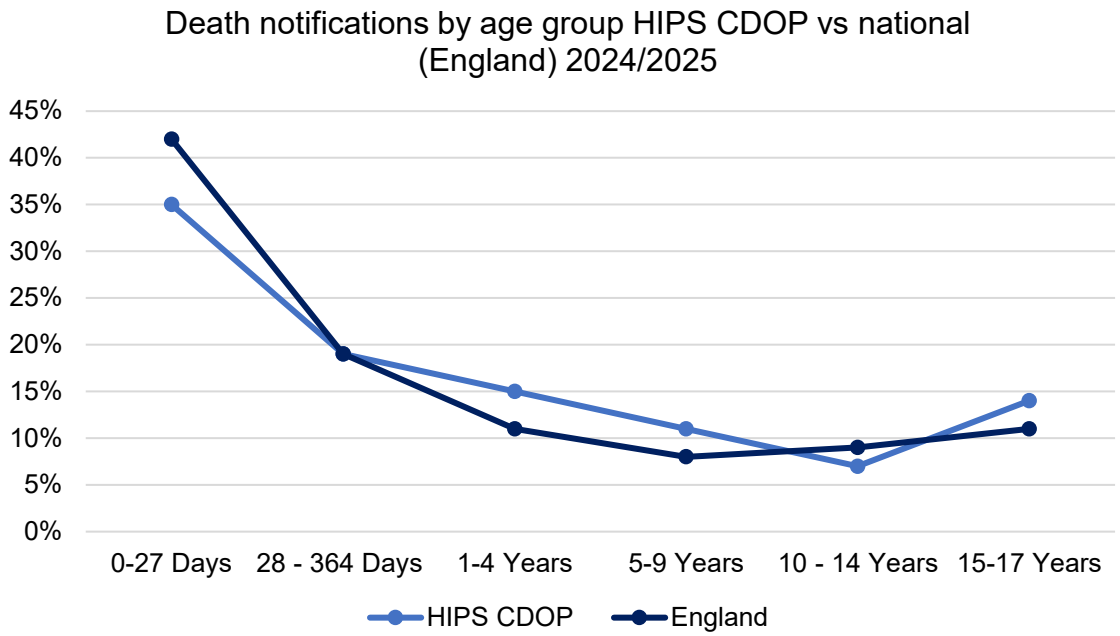
Age at time of death

National Child Mortality Database data 2023/2024 indicated that there were 3,577 child (0 – 17 years) deaths in England in the year ending 31 March 2024, an estimated overall rate of 29.8 deaths per 100,000 children.

The child death rate varied across regions in England, with the rate ranging from 24.2 to 40.7 per 100,000 population of 0–17-year-olds. The Southeast had the lowest death rate per 100,000 children alongside the Southwest, both being 24.2%. It is difficult to extrapolate the reasons why this may be the case when specific data is not available for our localities, however it is likely due to the affluent areas within the region. The national and local data shows that there is an increased risk of death with worsening deprivation, and this is felt to be one of the significant factors resulting in the variation within regions.

The chart below shows the percentage of child deaths by age group for Hampshire, Isle of Wight, Portsmouth and Southampton compared to the national picture during the reporting year 2024/2025. The chart evidences that most child deaths across Hampshire, Isle of Wight, Portsmouth and Southampton occur during the first year of life, particularly the first month of life. This is largely due to perinatal causes, some of which can be prevented through lifestyle factors before and during pregnancy. The chart below reflects that the local picture aligns with the national picture and deaths within the first month of life have remained the highest category across Hampshire, Isle of Wight, Portsmouth and Southampton under one month has remained the highest in previous reporting years.

Graph 2: Death notifications by age group 2024/2025



It has been suggested nationally that the higher number of infant deaths compared to other age groups may be partially due to national data classification issues. Increases in deaths around the first day of life have a large impact on infant mortality; as stillbirths are reducing, there is a suggestion that nationally rises in infant mortality may partly be explained by deaths of babies particularly at the extremes of viability now being classified as neonatal deaths when formerly they were classified as stillbirths RCPCH Infant mortality.

Across England, the infant mortality rate was 3.9 per 1,000 live births, an increase from the previous year (3.8), and remained higher than 2019-20. For infants born at 24 weeks or over, the estimated mortality rate nationally was 2.7 deaths per 1,000 live births, the same rate as the previous two years.

Hampshire Isle of Wight, Portsmouth and Southampton sits within the Southeast region where the infant mortality rate is 3.2 per 1,000 live births – lower than across England. This is most likely linked to deprivation factors which is further explored in the report.

Ethnicity

Nationally, the child death rate in the year ending 31 March 2024 across England was highest for children of Black or Black British ethnicity (55.4 per 100,000 population) and Asian or Asian British ethnicity (46.8 per 100,000 population).

The rates for all ethnic groups have decreased in comparison to the previous year. Recent research from the National Child Mortality Database (2024) and the Office for National Statistics (2024), reveals persistent ethnic disparities in neonatal and child mortality across England and Wales. Preterm birth is a major contributor to infant mortality and disproportionately affects Black and Asian families. Pakistani mothers experience the highest rates of neonatal and child deaths, even after adjusting for socioeconomic and gestational factors. Elevated risks are also observed among Black African and Bangladeshi groups. Socioeconomic disadvantage, such as long-term unemployment, is strongly associated with higher mortality, yet ethnic disparities remain even after controlling for income, location, and maternal age. This suggests that additional factors—such as access to healthcare, cultural barriers, and systemic inequalities—play a significant role in these outcomes.

Nationally, the child death rate for White ethnicity was 24.6 per 100,000 in 2023/2024 (National Child Mortality Database 2024).

Within these ethnicity groupings, over a five-year period, the child death rate was highest for children of Asian Pakistani ethnicity (57.0 per 100,000 population), followed by any other Asian background (51.8 per 100,000 population), black African (51.3 per 100,000 population) or black Caribbean (51.3 per 100,000 population). This was more than double the rate of children from a white British ethnic background (22.9 per 100,000 population). The child death rate was lowest for those of Chinese ethnicity (16.4 per 100,000 population).

Across Hampshire, Isle of Wight, Portsmouth and Southampton, during 2024/2025, 80% of the child deaths were white British with the remaining 20% from ethnic minority groups. This figure has not been explored further within this report due to the small numbers and the need to ensure data is not identifiable.

This is in keeping with the demographics of Hampshire and the Isle of Wight, where 81% of the population are white British. There are variations in the percentage of population with ethnic minority backgrounds seen within the Hampshire and the Isle of Wight population accounting for 12.1% in Hampshire, 6.2% in the Isle of Wight, 22.3% in Portsmouth and 31.9% in Southampton (Office for National Statistics 2021).

Place of death

During 2024/2025, 68% of child deaths occurred in hospital and 19% at home. Of the 19% who died at home, 71% were unexpected. Place of death is detailed in table 1 below:

Table 1: Place of death

Place of death	HIPS 2024/25	HIPS 2023/24	NCMD 2023/24
Hospital	68%	65%	74%
Home	19%	18%	15%
Hospice	10%	9%	4%
Public Place	3%	5%	4%

These figures reflect that locally and nationally most child deaths occur within a hospital, home or hospice environment. No concerning themes have been identified during this reporting year. This will continue to be closely monitored by the Child Death Overview Panel team.

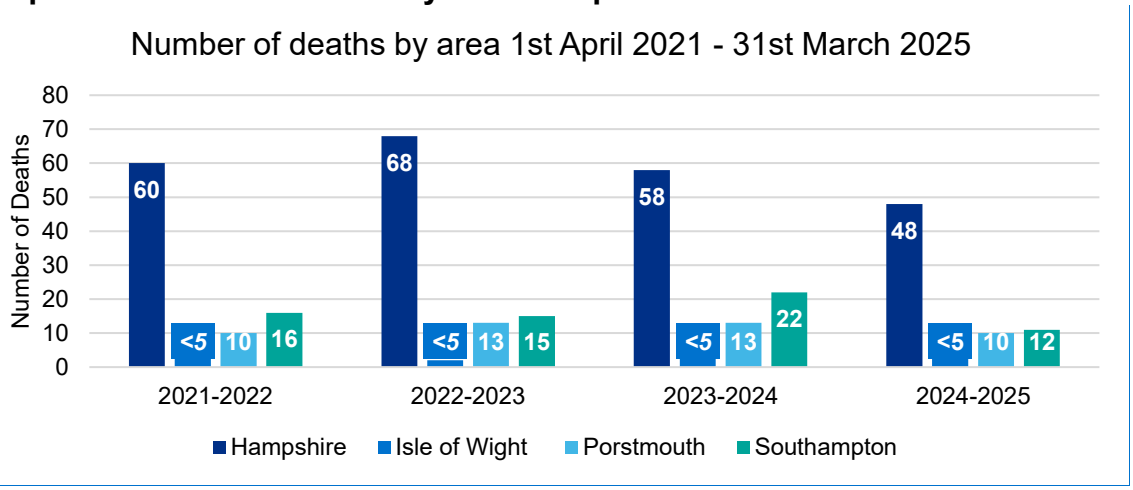
The specific location where the death has occurred is now recorded and monitored by the Child Death Overview Panel team to look for evidence of unusual variance that may require more formal review. Hampshire, Isle of Wight, Portsmouth, and Southampton Child Death Overview Panel can provide assurance that any unusual variance will be highlighted to both the Integrated Care Board and specific trusts.

This will be revisited when the final Thirlwall inquiry is published in 2026, and any additional recommendations and learning will be actioned.

Death by area

The below graph demonstrates that 66% of child deaths occurring across the patch between 2021-2025 are Hampshire residents. This is what would be expected as 71.6% of the under 18 population reside in Hampshire, with Isle of Wight (5.98%), Portsmouth, (12.5%) and Southampton, (14%). Numbers of child deaths can therefore not be directly compared between Local Authorities.

Graph 3: Number of deaths by area 1st April 2021 – 31st March 2025



For reasons of confidentiality, figures <5 have been suppressed.

A small proportion of deaths occurring each year within Hampshire, Isle of Wight, Portsmouth and Southampton are of children who reside in other areas across the United Kingdom. University Hospitals Southampton is a tertiary referral unit for neonates and children and houses specialist services including paediatric intensive care, cardiology, oncology and neurology. Most deaths that occur out of area are children who are under the care of University Hospitals Southampton. These out of area cases are then notified to their own area Child Death Overview Panels, and following discussions a joint decision is made as to where the child death review should take place. This process is reflected in the Child Death Overview Panel standard operating procedure, and the team can provide assurance that no issues or concerns have been raised.

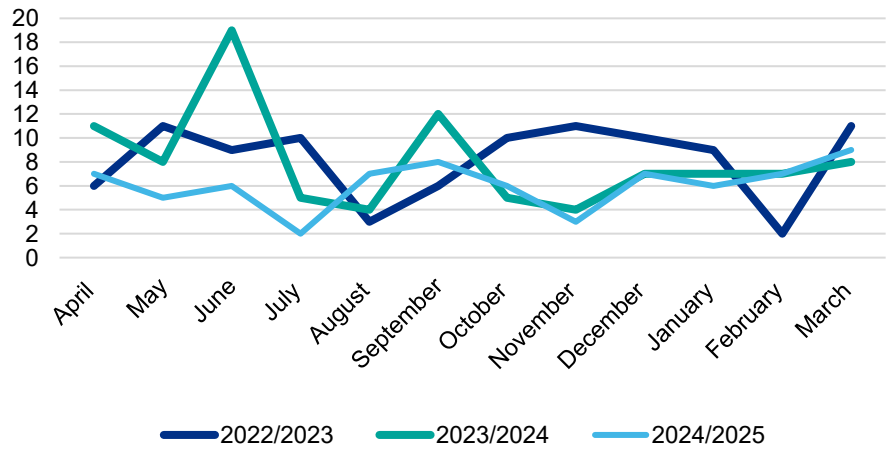
During the reporting year 2024/2025 there were 13 child deaths within the Hampshire, Isle of Wight, Portsmouth and Southampton area notified to the team for non-resident children. These included children who sadly died at acute Hospital Trusts and in Hospice environments within the Hampshire, Isle of Wight, Portsmouth and Southampton footprint. These deaths are in addition to the 73 deaths which are referred to within this report as they will be reviewed within their own area Child Death Overview Panels. Assurance can be given that all due processes have been followed regarding these deaths.

Deaths by month

In the previous annual report for 2023/2024, it was recognised that there was a significant increase in child deaths during the month of June 2023. When the data was analysed, there was no evidence to suggest an increase in deaths in an area of the Integrated Care Board or modifiable theme. A number of these cases were related to end of life care in life limiting conditions that resulted in the increase in the total cases reported. The total number of deaths for 2023/2024 was not significantly higher than the preceding year and this demonstrates the statistical variation that can be seen.

This has been further reviewed for deaths within 2024/2025 to provide assurance regarding themes and trends. The team are confident that no patterns are emerging that require further scrutiny. The last 3 years data is presented in graph 4 below:

Graph 4: HIPS death notifications by month 1st April 2022 – 31st March 2025



Deprivation

The National Child Mortality Database data release for 2023/2024 reflects the child death rate for children resident in the most deprived neighbourhoods of England is 42.9% per 100,000 population, more than twice that of children resident in the least deprived neighbourhoods (17.2 per 100,000 population). This is reflected within the Southeast area where the child death rate for children resident in the most deprived neighbourhoods was 40.6% per 100,000 population and 14.2% per 100,000 population in the least deprived neighbourhoods. The figures for specific local authorities within the Southeast are not yet available.

There is a clear link between the risk of death and level of deprivation (National Child Mortality Database 2021). It has been identified that there is a relative 10% increase in the risk of death between each decile of increasing deprivation. Over a fifth of child deaths within England may have been avoided if those children living in deprived areas had the same risks as those living in the least deprived areas.

Deprivation is made up of many factors. In England deprivation is often described using the Index of Multiple Deprivation, a composite measure of the following domains:

- Living Environment
- Employment
- Crime
- Education
- Health
- Income
- Barriers to housing

The Index of Multiple Deprivation (IMD) datasets are small area measures of relative deprivation across each of the constituent nations of the United Kingdom.

There are 44 areas across the Hampshire, Isle of Wight, Portsmouth and Southampton footprint which are ranked in the 10% most deprived: 7 in Hampshire, 15 in Portsmouth and 19 in Southampton. The indices of deprivation are relative measures of deprivation. This means it can tell you if one area is more deprived than another, but not by how much (Fingertips Deprivation Score IMD 2019).

The Designated Doctor for child deaths has been leading a strategic initiative aimed at deepening our understanding of the patterns and causes of child mortality across the Hampshire, Isle of Wight, Portsmouth, and Southampton area. This work involves a close collaboration between the Child Death Overview Panel Team and Public Health colleagues, with a shared goal of identifying how child deaths correlate with wider social determinants - particularly inequalities and deprivation. By mapping these deaths against geographic and socioeconomic data, the team have been working to pinpoint specific population areas where children and families may be at greater risk. The information obtained from this collaborative approach will hopefully be able to be used to support how we analyse and learn from each child death.

Ultimately, this supports the wider multi-agency effort to improve outcomes for vulnerable families and communities, in line with the NHS 10-year plan.

Further work will be continuing in 2025/2026 with plans to review individual cases, as well as completing a thematic analysis to identify recurring patterns and contributing factors. This will involve the Child Death Overview Panel Team and Public Health jointly interrogating five years' worth of child death data collected through the Child Death Overview Panel process. The focus will be regarding refining the data to ensure it captures not just medical causes of death, but also contextual factors such as housing conditions, access to healthcare, parental support, and environmental risks. By layering this data with public health intelligence, the team aims to build a more holistic picture of where and why child deaths are occurring.

The anticipated outcome of this work is to influence both local and national practice. Locally, within the Hampshire, Isle of Wight, Portsmouth and Southampton area, the findings can then be presented to help shape service delivery, and guide frontline professionals in identifying and supporting families at risk.

Nationally, the insights will be shared with the National Child Mortality Database to contribute to broader policy development and ensure that learning from Hampshire, Isle of Wight, Portsmouth and Southampton is reflected in national strategies to reduce preventable child deaths. This work represents a step forward in using data-driven approaches to safeguard children and promote equity in health outcomes. This work will be further reported on within the 2025/2026 Annual report.

Part 2 - Child Death Overview Panel cases reviewed

The majority of the 73 child deaths that occurred during the reporting year have not been heard at panel due to processes not yet being fully completed, e.g. awaiting coroner's record of inquest, ongoing investigations etc. This report recognises that the unreviewed cases means that the report may be unrepresentative of local patterns and trends in child deaths, lessons learned, and actions taken, and these outstanding child death reviews will be reported on in the following years. This is usual practice.

During 2024/2025, 13 Child Death Overview Panels have taken place, and a total of 98 cases were heard and closed. The panel aims to review and close 6 to 8 cases per meeting. Those cases where the panel request additional information or there are uncertainties around specific aspects of the case, remain open, are added to the action tracker and reviewed at the next panel meeting.

The Child Death Overview Panels are themed, under the title, Neonatal, Joint Agency Response, Life Limiting/Medical or Suicide. In addition to these a pre-viable meeting is held monthly for those born with signs of life under 22 weeks gestation who sadly die. By holding themed panels assurance can be provided that clinical experts in the appropriate field are present to contribute to reviews. This ensures both clinical expertise and a high degree of scrutiny with independent experts.

Categories of child death

Nationally, the most common primary category of death for reviews in England 2023-24 was perinatal/neonatal event, which was recorded for 31% of all child death reviews. This was followed by chromosomal, genetic and congenital anomalies (24%), sudden unexpected and unexplained death (8%), acute medical or surgical condition (8%) and malignancy (8%). These patterns were similar to previous years.

The highest primary category of death identified locally at panel was also perinatal/neonatal event which amounted to 39% (38 out of 98 cases heard). This was followed by chromosomal, genetic and congenital anomalies at 21%. The lowest category of death was identified as chronic medical condition and suicide or deliberate self-inflicted harm at 6%.

It is important to remember that the number of deaths recorded within each category is determined by the themed panels. Therefore, we are unable to draw conclusions from this data as trends identified do not reflect a specific time frame.

Modifiability

In all child death reviews, four key domains are examined to understand the circumstances surrounding the child's death. These domains help identify factors that may have contributed to the death, and potential areas for prevention in the future. The main domains include factors intrinsic to the child, factors in social environment including family and parenting capacity, factors in the physical environment and factors in service provision.

One of the key functions of the Child Death Overview Panels is to decide whether any of the factors identified under the four domains are modifiable.

The Panel works to the national definition as shown below:

"A death should be categorised as modifiable if the panel have identified factors that could be changed to reduce the risk of future deaths by means of locally or nationally achievable interventions" (National Child Mortality Database 2023).

Determining modifiability is not about determining whether the death being reviewed was preventable but whether there was a reasonable probability that if the factor in question was modified, by achievable methods, the risk of future child deaths would be reduced.

Modifiable factors are discussed within the local child death review meetings prior to panel, and it is expected that these will be identified and actioned immediately as necessary. The panel has the benefit of having the oversight of all child deaths across Hampshire, Isle of Wight, Portsmouth and Southampton where themes and trends can be quickly identified.

The National Child Mortality Database recognises that there continues to be variability in whether Child Death Overview Panels decide certain factors are modifiable or not. Some variability is to be expected given that the same factor may be modifiable in one case and not in another. For example, parental smoking might be modifiable in the case of a child that died of asthma but is unlikely to be modifiable for a child that dies in a road traffic collision. A set of guiding principles designed to reduce variability between Child Death Overview Panels are currently being developed by the Natonal Child Mortality Database to ensure consistency within Child Death Overview Panels across England.

During the process of reviewing a child death at panel if any matters of concern are identified which may affect the safety and welfare of children in the area, or a wider public health or safety concern arising from a particular death or from a pattern of deaths within the area, immediate action is taken and recommendations are made, despite identifying whether it was modifiable or not.

Nationally, the most recorded modifiable factors during reviews of infant deaths during 2023/2024 were smoking by a parent/carer, high maternal body mass index, and smoking in pregnancy**.** These are all known risks for premature delivery.

Nationally, the most common recorded modifiable factors during reviews of deaths of children aged 1 – 17 years were poor communication between agencies, issues with treatment (e.g., delay in starting treatment, side effects or complications developed because of treatment, or medical or surgical error) and lack of appropriate supervision.

Following review of the 98 cases heard at the Child Death Overview Panel in 2024/2025, 62 cases had modifiable factors identified which equates to 63% of the reviewed cases. The percentage of modifiable factors across England in 2024/2025 was 43%. This highlights the current ongoing work required to streamline the variability of determining modifiable factors.

The most common modifiable factors identified are listed in table 2 below, under each of the four domains below.

Table 2: Common modifiable factors

Domain A Factors intrinsic to the child	**Domain B** Factors in social environment	**Domain C** Factors in the Physical Environment	**Domain D** Factors in Service Provision
Maternal raised body mass index Smoking in pregnancy Child smoking/alcohol Gender identity issues	Parental smoking Parental drug misuse/alcohol Lack of school/college attendance Domestic violence/abuse Income deprivation Neglect	Unsafe sleep environment Historic social care involvement	Earlier referral to appropriate teams Cardiotocography (CTG) monitoring Safety netting

In the annual report 2023/2024 the following modifiable factors were discussed and will therefore not be revisited in this year's report.

- Smoking
- Domestic abuse
- Raised maternal BMI
- Delayed diagnosis
- Housing Issues

It is recognised that behavioural risk factors may have an impact on the number and type of modifiable factors being identified. Professionals can advise parents and carers regarding safe and healthy practices however, for a variety of reasons parents/carers may not implement this advice. There is no evidence to suggest this is due to culture or language barriers however, further work is being completed by the Designated Doctor and Public Health to review 5 years of data which may provide further narrative.

The following modifiable factors will be addressed during this annual report and the learning/actions taken discussed:

- Gender identity issues
- Unsafe sleep environment
- Lack of school/college attendance
- Earlier referral to appropriate teams
- Cardiotocography monitoring
- Safety netting

Key learning and recommendations from child death reviews 2024/2025

Gender identity/incongruence

The NHS referral pathway for Children and Young People's Gender Services defines gender incongruence as a 'marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children'. This includes a strong desire to be a different gender than the assigned sex, a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender.

Gender identity issues were identified in several cases reviewed where death was classified as suicide. The Cass Report (2024) did not identify that gender questioning significantly increases suicide risk; however, it can add additional risk to other comorbidities. The report further highlights a significant shift in treatment away from medical intervention towards a more holistic approach to care is required, with a gap of specialist support services having been identified.

We are aware that work is currently underway between Hampshire and the Isle of Wight Integrated Care Board Children's and Young People commissioning team and local providers regarding a secondary care level of service for this group of young people with complex needs.

Unsafe sleep environment

During this reporting period the Child Death Overview Panel have sadly reviewed several cases where an unsafe sleep environment has been a contributory factor in the child's death. An unsafe sleep environment for a child under the age of 1 year can include pillows or duvets, cot bumpers, soft toys or comforters, bulky bedding, pods or nests and bed sharing especially when under the influence of alcohol and or drugs.

To ensure consistent safe sleep messages are being delivered to families and carers, the Child Death Overview Panel team have been working closely with the local safeguarding children's partnership and public health. Following this work, the Child Death Overview Panel have gained assurance that professionals are aware that safe sleep advice is to be discussed at every midwifery and health visiting contact. In all cases which were reviewed at panel during 2024/25, it had been documented that safe sleep messages had been given.

The Child Death Overview Panel now meet with the local partnerships each quarter when required, to review deaths of children where the unsafe sleep environment may have been a factor in their death. This allows the Child Death Overview Panel team to recognise themes, trends or actions that require an immediate response.

The local safeguarding children's partnership delivers safe sleep training 3 times a year. This training is available for all professionals across the system. As of March 2025, the training can now be accessed at any time via e-learning. The learning from child deaths portfolio group have planned the annual learning conference for professionals, with the local safeguarding children's partnership attending to discuss safe sleep.

To increase the knowledge and expertise of the Police when attending a home visit for an unexpected child death, frontline officers have been offered safe sleep training. The Lullaby Trust safe sleep week was also publicised internally through the force.

Lack of school/college attendance

During the reporting year a theme was identified at panel that linked young people who sadly died by suspected suicide with having either sporadic attendance at an education provision in the months leading up to their death or attendance had ceased altogether.

A national briefing from the Children's Commissioner (2024) found that in the 2022/2023 academic year, 22.3% of all pupils were persistently absent from school. In 2018/2019, that figure was 10.9%, meaning that rates of persistent absence have more than doubled since the coronavirus pandemic. The Children's Commissioner's Attendance Audit found that many education provisions felt like the social contact between parents and schools had been broken.

This finding was highlighted in panel in some cases where communication about a young person's attendance from the educational settings to home could be strengthened, with parents not always being aware their children were not attending.

From the start of the 2024/2025 academic year, it became mandatory for schools to share attendance data with the Department for Education.

During the panel, the Education representative was asked to consider how safety netting for young people who miss school/college is put in place. The Child Death Overview Panel will track the frequency of this theme to see if it is noted in future cases. If a concern is identified, further work with education settings will be explored.

Earlier referral to appropriate teams - early intervention from palliative care teams

It is widely recognised that children with complex chronic medical conditions benefit from early introduction of palliative care services and advanced care planning for symptom management and to support quality of life and medical decision making. This is included within the National Institute for Health and Care Excellence Guideline NG61 (2019).

The Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel identified several cases where an earlier referral to palliative care teams could have been considered. Whilst this referral would not have sadly changed the predicted outcome, it would potentially have resulted in more opportunity for the family to be supported.

It is acknowledged that at the time of writing this report the National Child Mortality Database have released their report focusing on the learning from child death reviews on palliative and end of life care pathways (2025) where appropriate parallel planning and timely engagement with palliative care was found to be a theme in the cases reviewed nationally from April 2019 to March 2022. The recommendations within this report are being reviewed and actioned accordingly.

The reviews have found evidence to show that palliative care services are being utilised earlier in a larger number of cases as the service develops. This includes reaching out to the local paediatric services regarding the importance of ensuring their services are utilised at the appropriate stage of a child's journey and to promote parallel planning concepts. Whilst this is encouraging progress, the Child Death Overview Panel team recognise that this needs ongoing support and engagement. We plan to connect with palliative care specialists and children's continuing care team to support this further.

(CTG) monitoring

Cardiotocography (CTG) is an electronic means of recording the unborn baby's heart rate pattern, to assess their well-being.

There were several cases heard at panel where interpretation of cardiotocograph recordings were highlighted as modifiable factors in the care.

From these cases, two themes were identified within these case discussions. The first was around the importance of recognising abnormalities within the appropriate timeframe and the second around the importance of key management decisions not being based on cardiotocograph interpretations alone, but alongside the clinical picture, history, stage and progress of labour, any risk factors, and the mother's preferences.

The Child Death Overview Panel Team can provide assurance that the recommendations and learning have been shared and disseminated across the footprint. A quality improvement project aimed at understanding barriers and identifying any training or resource needs to facilitate holistic review has been undertaken by a local trust. Care of women in labour guideline has also undergone a routine review.

The team will continue to track the frequency of this being an identified factor within an infant's care to ensure learning and actions have been embedded.

Safety netting

Safety-netting is information given to a patient or their carer during a primary care consultation, or following attendance at Hospital, about actions to take if their condition fails to improve, changes or if they have further concerns about their health in the future.

During panel reviews a theme was identified where safety netting advice had not been effective and could potentially have changed the outcome for the child. It was felt that where these elements had not worked as intended, it led to gaps in understanding or accessing the necessary care. The importance of not relying on a one size fits all response to safety netting information was highlighted and it was felt that when parents are being given safety netting advice it should be offered in several different formats to ensure the advice is heard and fully understood. The importance of embedding safety netting throughout the clinical encounter, rather than limiting it to discharge advice is recognised. Clinicians need to consider any barriers to understanding the information being shared, such as the clients reading ability, and ensuring the information is accessible and culturally sensitive.

As a direct result of these discussions, an amendment has been made on the Healthier Together website around safety netting, highlighting the need for professionals to send resources to families, in addition to explaining and showing families this information. The caption 'Send it, Show it, Say it' has been used to reiterate this message.

In addition to this to ensure learning is disseminated the Designated Doctor will be delivering a set of lunch and learn sessions around safety netting highlighting the critical importance of clear communication, follow-up plans, contingency planning, and access to care in preventing adverse outcomes.

Suicide prevention

Every child or young person who dies by suspected suicide is a precious individual and their deaths represent a devastating loss. As with all deaths of children and young people, there is a strong need to understand what happened, and why, in every case. We must also ensure that anything that can be learned to prevent future child suicide or young suicide is identified and acted upon (NCMD Report 2021).

In the reporting year 2024/2025 the Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel team held a thematic suicide panel. A previous suicide panel in 2020/2021 identified themes in relation to deaths by suspected suicide. A thematic review of the data covering suspected suicides was therefore repeated in September 2024, to ascertain if the trends and themes that emerged previously continue to be a factor. The aim of the thematic review was to ensure that the findings would help ensure that health inequalities are given the scrutiny needed to reduce the risk of child deaths across the region, working closely with our Public Health colleagues.

During the panel, cases where children and young people aged 15-17 years died by suspected suicide were reviewed. Multiple risk factors were identified, some of these included losses of key relationships, mental health needs of the child, risk taking behaviours, problems experienced within the school environment, school attendance, gender identity and social media/internet use. During the thematic review the charity Amparo presented to the panel members regarding the bereavement support for local children and families as well as support offered for educational settings following a child death by suspected suicide.

Several recommendations and actions were outlined following the thematic review. These included the implementation of a suspected suicide checklist for the joint agency response, developed by the National Child Mortality Database, this provides a list of prompts for Joint Agency Response practitioners when responding to a suspected suicide. Changes have been made to the National Child Mortality Database reporting form and supplementary suicide or self-harm form to better identify children and young people with gender distress and those waiting/open to NHS/private provider for treatment. This is a statutory data collection. Public Health are invited to the initial Joint Agency Response following a suspected suicide, to ensure consideration of the risk of clustering and contagion.

The Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel team have continued to work with the Public Health and the multiagency Hampshire and Isle of Wight Real Time Surveillance (RTS) Working Group to ensure joint working, quality improvement and links to appropriate services, including suicide bereavement support services around child deaths where suspected suicide is a key factor.

Educational initiatives/teaching and learning

The Designated Doctor has played a central role in delivering targeted teaching across multiple professional groups. Senior paediatric resident doctors participated in immersive simulation training designed to replicate the clinical and emotional realities of responding to a child death. These sessions included a simulated Joint Agency Response, followed by structured debriefing and teaching on Child Death Overview Panel processes, thematic learning, and the importance of compassionate communication with bereaved families. Paediatric Emergency Medicine trainees also received bespoke training focused on early recognition of deterioration, escalation protocols, and the wider safeguarding context surrounding unexpected child deaths.

In addition, regional General Practitioner safeguarding leads were engaged through dedicated teaching sessions that provided practical guidance on the Joint Agency Response and Child Death Overview Panel frameworks. Emphasis was placed on the completion of Form A and B, with the aim of improving the quality and consistency of General Practitioner contributions to the child death review process. These sessions were well received and have already led to improved engagement and more comprehensive information sharing from primary care.

The Designated Doctor also continues to provide structured supervision sessions for Joint Agency Response health leads, who act as chairs during multi-agency investigations into child deaths. These sessions offer a valuable forum for reflective practice, peer support, and shared learning across professional boundaries. They enable Joint Agency Response chairs to discuss complex cases, explore emerging themes, and refine their approach to sensitive conversations with families and colleagues. Looking ahead, future projects will include bespoke teaching modules focused on specific medical conditions—such as epilepsy, asthma, and metabolic disorders—that may require tailored questioning during the Joint Agency Response process. These sessions aim to equip professionals with the tools to build a more complete picture of the child's life, health trajectory, and interactions with services, ultimately enhancing the quality and depth of the child death review.

Learning from child deaths portfolio group

The Learning from Child Deaths Portfolio Group has continued to meet quarterly during the reporting year. The Senior Designated Nurse for Safeguarding Children Hampshire has continued to support the Child Death Overview Panel team and has led the learning from child deaths portfolio group.

The group membership currently consists of health providers and police. Consideration is currently being given as to whether this should also include children's social care.

The purpose of the group is to provide individual and shared strategic oversight of all elements of child death work across the system, ensuring alignment with national priorities, promoting best practice, and supporting system-wide learning and improvement.

During the reporting year 2024/2025 the portfolio group have undertaken several actions. These have included the development of lunch and learns, with the first session delivered by the Child Death Overview Panel team. The session included, an overview of the Child Death Overview Panel process, modifiable factors, National Child Mortality Database, Child Death Reviews, Joint Agency Response, Data and an overview of eCDOP. Over 120 professionals attended with an overall positive response. These sessions are to continue during 2025/2026.

As part of the ongoing quality improvement work the learning from child deaths portfolio group have developed and undertaken several audits. These have included audits of the A Notifications, B Reporting forms and the Joint Agency Response. The aims and objectives of the audits were to understand if the correct processes are being undertaken and identify areas where improvements are required. All audits reflected good areas of practice as well as areas for quality improvement. Action plans have been implemented and will continue to be reviewed by the portfolio group.

At the end of June 2024, the Child Death Portfolio group developed a training day to support and enhance the learning and development of those working within the child death process. Over 50 professionals were in attendance from multi agency partners. Various speakers attended which included a powerful presentation bringing the parents voice to the forefront, by a bereaved mother who talked about her own experience and her efforts to raise awareness of SUDC (sudden unexplained death in childhood).

The portfolio group also developed a key worker survey to understand the experience of key workers, appointed through the Joint Agency Response for unexpected child deaths between 1st February 2024 – 31st January 2025. The survey obtained responses from 15 professionals. One third of responders felt they could have benefitted from more information around the role, including how to support families, and expectations of their involvement. Most key workers reported finding the role to be challenging but rewarding with identified challenges around time required, support, information about the role and manager understanding. Most responses demonstrated that families valued them as their key worker.

Achievements and challenges in 2024/2025

- This year has seen a significant expansion in professional education and system-level collaboration across the Hampshire, Isle of Wight, Portsmouth, and Southampton footprint. A key focus has been on strengthening clinical understanding, improving multi-agency communication, and enhancing the quality of care provided to children and families—particularly in the context of child death review and prevention

- Four quarterly reports have been written to provide assurance to the Executive team that the Child Death Overview Panel combines best practice with the requirements which must be followed within the Statutory and Operational Guidance

- At the end of June, the child death portfolio group of which Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel are part of were involved in supporting a Child Death professionals learning and development event. Over 50 professionals were in attendance from Police, Primary Care, acute and community trusts and Childrens Services

- Continued development of the Joint Agency Response process and collaboration across the Child Death Review and Child Death Overview Panel reviews

- A Standard Operating Procedure has been written. This Procedure will help to ensure that staff are knowledgeable and competent regarding the Child Death Overview Panel process. This includes policies, processes and standards required to ensure all staff are working within the statutory and operational guidance and promote best practice. This will be reviewed annually

- The Child Death Overview Panel team have presented at the Primary Care Supervision session, The Independent Hospital Forum and the Education Forum to highlight the process to be undertaken when a child sadly dies, the role of the panel and the importance of providing information when requested to ensure a robust and comprehensive review takes place

- The Child Death Overview Panel team have continued to work closely with QES – the Software provider of the eCDOP system and now have access to a test case for the electronic system to support with training needs

- An experienced independent Chair has been recruited, prior to this the Senior Designated Nurse for Safeguarding children continued to chair the Child Death Overview panel to ensure the statutory requirements were met

- The number of Reporting forms (Form B) used to collate information regarding children who have sadly died, being distributed has substantially increased from 343 in 2023/24 to 509 in 2024/25. This reflects the Child Death Overview Panel teams' commitment to support professionals in completing the B Reporting Forms, offering 1:1 phone and video calls as well as the recent lunch and learn sessions

- The Child Death Overview Panel team have been working with the Learning from Child Deaths Portfolio group to undertake several Audits including the A Notification and B Reporting form

- The Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel can now be found on both Stay Connected and the Integrated Care Board website

- Challenges have continued with some provider services not fully understanding the child death review process, including the need to complete statutory forms when requested and arranging timely child death review meetings to enable cases to progress to panel. Work has continued around this and providing support where required

- Some challenges remain around identifying who will lead on chid death review meetings particularly in complex cases and those outside of the Joint Agency Response process. The Designated Doctor is providing direction as required

- Work continues with the Coroners service around sharing of postmortem and Inquest results. While work continues to maintain consistent communication, notable progress has been achieved through direct engagement with coroners' officers. This engagement has facilitated the development of a more robust system for identifying when post-mortem reports are received, enabling paediatricians to be involved earlier in the process and to provide timely support to families during the review of findings

- The Hampshire and Isle of Wight Healthcare NHS Foundation Trust safeguarding support team has collaborated with the Trust Family Liaison Officers to provide additional training on the initial, intermediate and final Joint Agency Response processes. The Family Liaison Officers are currently supporting several families where it has been appropriate to do so as key workers, assisting those who have experienced the unexpected death of a child. We are optimistic that families are receiving better support than in the past, and initial verbal feedback has been positive. Given the professional backgrounds and experience of the trust Family Liaison Officers, we hope they can offer the best possible support to parents during these challenging times

Priorities

Last year's priorities 2024 - 2025

Below are the priorities from last year Child Death Overview Panel 2023/2024 report, with update in italics:

• Suicide (awareness and prevention) - to support the work of national and local agencies in tackling deaths of young people where suicide and self-harm has been identified. ***A bespoke suicide panel was held in September 2024 and a thematic report produced***

• Out of routine and dangerous sleeping arrangements – to highlight the increased risk to infants when unsafe sleeping practices are undertaken Themed panel to be convened in this reporting year around safe sleep. ***This work continues and has been further explained on*** ***page 19***

• Smoking – the impacts of and cessation support - to continue to highlight the dangers of smoking for infants, children and unborn babies ***This work continues***

• Key Worker role – to further strengthen this so every family is offered a Key Worker during this difficult time. Currently there is a plan to discuss with local hospice for this provision in unexpected deaths. ***Significant progress has been made to ensure families are offered a key worker. The community safeguarding teams Family Liaison Officers have taken on the key worker role for many families following an unexpected child death***

• To continue to develop and deliver the yearly Learning from Child Death Multiagency event for the Hampshire, Isle of Wight, Portsmouth and Southampton professionals ***This has been achieved, and planning is in progress for 2025***

• Audit of the form A's and form B's that are submitted by multiagency partners to eCDOP to help improve standards and highlight where improvements can be made ***This has been completed***

• Audit of the Joint Agency Response that have taken place between April 2023/2024 to be developed and undertaken. This will help to highlight any key learnings which will help to strengthen the Joint Agency Response Data ***This has been completed***

• To continue with the monthly themed panels ***This has been completed during the reporting period***

• Future discussions for Child Death Overview Panel for 2024/2025 regarding independent chair and recruitment to the role ***This has been completed***

• Linking with the Southeast Child Death Overview Panel Regional Network to share learning and aim towards a more standardised process and reporting for Child Death

Overview Panels across the region incorporating national good practice ***The team continue to attend the 8 weekly Southeast network meetings. Learning has been shared across each individual child death overview panel including themes and trends. Work streams and local projects are also shared within the network***

• To improve communications with the coroners and increase their understanding of the role of the Child Death Overview Panel. Clear and robust pathways regarding Post-Mortems are required ***This work continues and has been further explained in the report***

• Develop the use of the briefings for wider dissemination of learning about the themes and trends ***This has been achieved through thematic reporting and the delivery of lunch and learn sessions***

Priorities for 2025 - 2026

- Undertake a thematic Child Death Overview Panel to review cases where unsafe sleeping arrangements may have been a contributory factor in the child's death

- Develop a Data Protection Impact Assessment to ensure best practice through reviewing security and ensuring any risks with the processing of sensitive information are assessed

- Undertake a thematic Child Death Overview Panel to review cases where the child/young person died by suicide

- Continue to work with the learning from child deaths portfolio group to deliver lunch and learn sessions for multi professionals and to help identify ongoing quality improvement work

- Formulate a framework to be used when a child dies for primary care. This guidance is for general practitioners and staff, with the aim to support professionals following a child death. The document will provide practical guidance, support bereaved parents as well as support each other and sign posting

- As part of the ongoing quality assurance work and feedback from the panel members survey, create a one-minute guide for panel members to include, panel members responsibilities, panel preparation and modifiable factors. Training links and resources to be included within this

- To continue with the monthly themed panels

- Continue to collaborate with Public Health to deepen our understanding of the patterns and causes of child mortality across the footprint. with a shared goal of identifying how child deaths correlate with wider social determinants - particularly inequalities and deprivation

Conclusion

In overall conclusion, the 2024-2025 Hampshire, Isle of Wight, Southampton and Portsmouth Child Death Overview Panel Annual Report reflects a year of continued commitment to improving the child death review process through quality improvement, multi-agency collaboration and professional education. The report highlights the work undertaken by the Child Death Overview Panel Team and the wider Learning from Child Deaths Portfolio Group in respect to its commitment and responsibilities in strengthening pathways and processes following a child death.

As a team, comprehensive work has been undertaken at both a local and national level and the team have established and embedded communication pathways with the National Child Mortality Database. This provides ongoing assurance that a robust child death review process is in place and that the statutory responsibilities required are being fulfilled.

Thematic panels, targeted audits, and bespoke training sessions have further strengthened the review process and enhanced the system's ability to identify modifiable factors and implement learning. Notably, the team has made significant progress in embedding safe sleep messaging and supporting earlier referrals to palliative care services. Panel members will continue to be tasked with taking the learning from the reviews and sharing it widely within their organisations and networks.

The report highlights the importance of understanding the wider social determinants of health, particularly deprivation and inequality, in shaping child mortality outcomes. The strategic partnership between the Child Death Overview Panel and Public Health colleagues is a promising development, with plans to undertake a detailed thematic analysis of five years' worth of child death data. This work will help inform targeted interventions, ensuring that learning from each child death leads to meaningful change.

Looking ahead, we face a rapidly changing healthcare landscape, with new challenges and opportunities. The priorities for 2025-2026 reflect a continued focus on thematic reviews, data protection, professional development, and system-wide learning. The Child Death Overview Panel team remains committed to fulfilling its statutory responsibilities while driving innovation and improvement in the child death review process.

Incorporating the NHS core values, through maintaining a culture of transparency, compassion, and continuous learning, the Hampshire, Isle of Wight, Portsmouth and Southampton Child Death Overview Panel continues to play a vital role in safeguarding children and supporting families through some of the most difficult experiences imaginable. The insights and actions outlined in this report will help shape a safer, more responsive system for children and young people across the region.

Appendix 1 Child Death Overview Panel statutory duties

On behalf of the child death review partners, the Child Death Overview Panel will conduct the statutory review and provide the final independent multi agency scrutiny for the deaths of all children who are normally resident in Hampshire, Isle of Wight, Portsmouth and Southampton.

The review will occur once all other child death processes i.e. coronial inquest or Child Safeguarding Practice Review (CSPR) have been completed. The statutory task of the multi-agency panel lies in its ability to scrutinise the circumstances surrounding each child's death and where appropriate, to provide challenge to the agencies involved to further enhance the learning, as well as make recommendations to the appropriate agencies to improve service delivery and patient experience.

The Hampshire and Isle of Wight, Portsmouth and Southampton Child Death Overview Panel also holds the single statutory duty to report every child death under the age of 18 to the National Child Mortality Database (NCMD) immediately after death, and regardless of cause.

Appendix 2 Joint Agency Response

A Joint Agency Response (JAR) is a coordinated multi-agency response for investigating and reviewing all sudden and unexpected child deaths. This should be triggered if a death or a collapse that will likely lead to death is 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

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