FINAL [7.0] Approved: SWL CDOP 03.09.2025

South West London Integrated Care System

South-West London Child Death Overview Panel

Report: 2024 -25

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Foreword

Interim Independent Chair: Tara Kerr-Elliott

The South-West London Child Death Overview Panel (CDOP) reviews every death of a child or young person aged up to 18 years old living in Richmond, Kingston, Wandsworth, Sutton, Merton and Croydon.

I have had the absolute privilege to chair this panel for the last year, and it is an honour to introduce this year's annual report.

Every child represented in this report represents the loss of a unique life, and the enduring grief of their families and communities. I know that all members of the panel are touched by each child's story and ensure that during each review, the child, their family and the wider circumstances that shaped not just their death, but also their life, remain the centre of every discussion.

The purpose of the CDOP is not only to identify modifiable factors that could reduce the risk of future deaths but also to improve our understanding of how services, systems, and communities can better support children and families in life and when death occurs. This year's report reflects the dedication and commitment of all partners involved in the review process, and I thank them for their professionalism, sensitivity, and willingness to engage in open and honest discussion.

Over the past year, we have seen emerging themes that require both local attention and broader systemic attention. The panel has again reviewed a few sudden and unexpected infant deaths, many of which occurred in the context of socioeconomic deprivation. These cases have highlighted the persistent and complex relationship between poverty and unsafe sleep environments. While many families are aware of safer sleep guidance, structural inequalities such as overcrowded housing and limited access to safe sleeping spaces, and insecure work or the need to work overtime can make adherence a challenge. The panel recognizes the importance of promoting safer sleep not only through education, but also through action on poverty and the broader determinants of health. Preventing such deaths requires a coordinated, compassionate approach that understands the realities families face and supports them in making safer choices within those constraints.

We have also heard from families that provide input into the review process, examples of compassionate and innovative practice that have made a real difference to them during the most painful moments of their lives.

I have witnessed the panels committed to influencing service development, policy decisions, and front-line practice and I extend my deepest thanks to all those who have contributed to this year's report, with particular thanks to the Doctors, Nurses, Managers/Coordinators, and Single Point of contacts for SW London CDOP, and above all, I would like to honor the memory of the children whose lives are recorded within it. May our collective learning be a legacy that leads to change.

Tara Kerr-Elliott
Interim Independent Chair, Child Death Overview Panel
24th June 2025

Chapter One:

1. Introduction

Executive Summary

The SWL CDOP serves as an inter-agency forum for Child Death Reviews across the boroughs of Croydon, Merton, Kingston upon Thames, Richmond upon Thames, Sutton, and Wandsworth.

The primary aims of the Child Death Review (CDR) process are to:

- Understand the causes and contributing factors of each child's death.
- Identify modifiable factors that could reduce future deaths.
- Provide actionable recommendations to prevent future deaths and promote the health, safety, and well-being of children.
- Produce an annual report highlighting local patterns and trends in child deaths, lessons learned, actions taken to inform policy, training and service development,
- Support local, regional, and national initiatives to enhance learning from Child Death Reviews.

1.1 Statutory Framework and Governance

The Child Death Review Statutory and Operational Guidance (2018) is part of the regulatory framework of the 'Working Together to Safeguard Children' guidance (2023) on child death reviews. The National Child Mortality Database is responsible for the statistical analysis of child death review data, collating data nationally and supporting continuous learning across London.

Chapter Two

2. Operational Overview

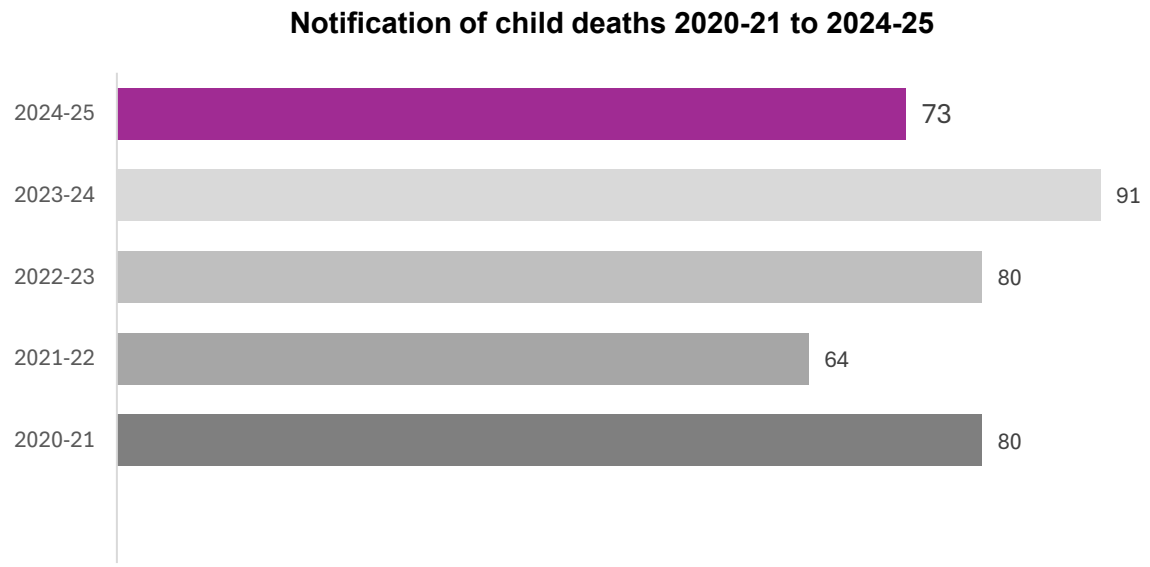
2.1 Panel Membership

The South-West London CDOP includes representatives from:

- Health (including Designated Doctors and Nurses, Midwifery and Maternity)
- Local Authority Children's Services
- Metropolitan Police (Child Abuse Investigation Team)
- Local authority (Public Health) representatives of South West London boroughs of Croydon, Merton, Kingston/Richmond Upon Thames, Sutton, and Wandsworth.
- There continues to be a vacancy in Wandsworth for the Designated Doctor role (vacant for four years).
- All meetings have been quorate due to the use of a rota system where each agency representative commits to attend 3 meetings per year ensuring all agencies are represented, which is working well.

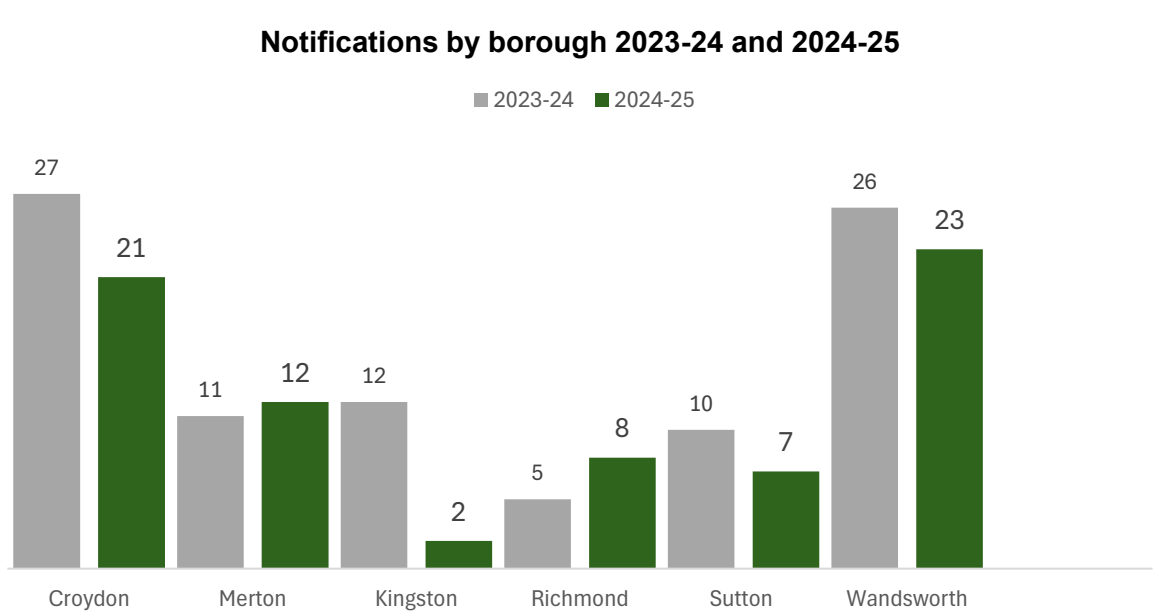
2.2 Notifications of child death

In the reporting year 2024-25, SW London received 73 new notifications of child death.



GRAPH 1: NOTIFICATION OF CHILD DEATHS 2020-21 TO 2024-25

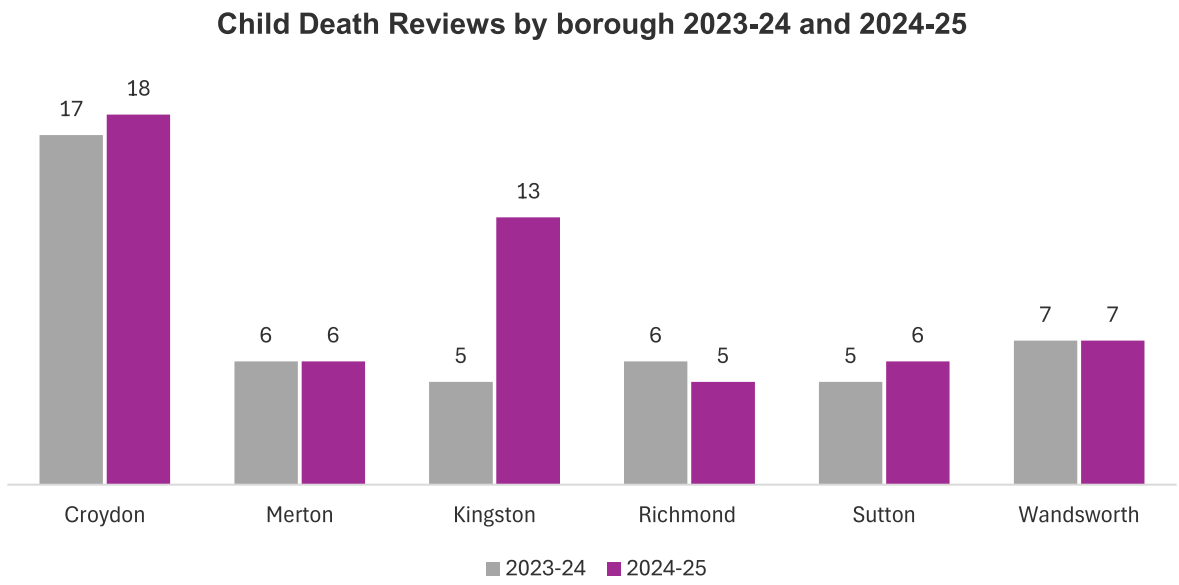
This is further explained in detail by each borough over two years.



GRAPH 2: NOTIFICATIONS BY BOROUGH 2023-24 AND 2024-25

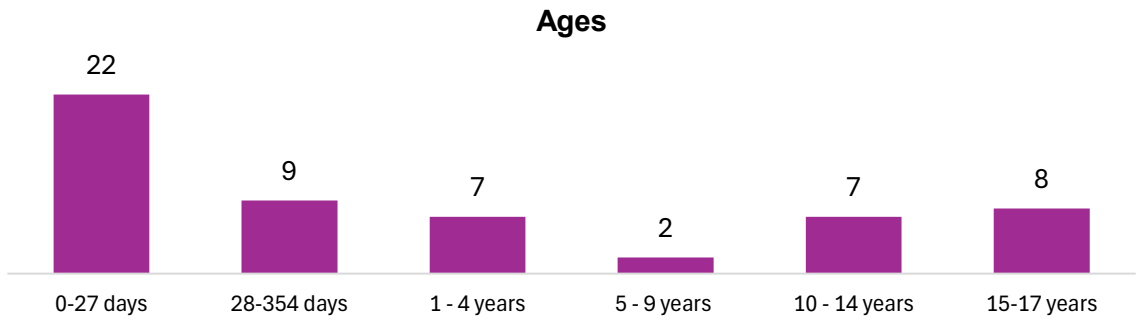
2.3 Summary of Child Death Reviews in 2024-25

There were 55 child death reviews completed in the 2024-25 reporting year at South-West London CDOP (please note these deaths may have occurred within the reporting year, or previous years). This is illustrated by borough. Croydon and Wandsworth are among the top 10 London boroughs with the highest child populations per person.

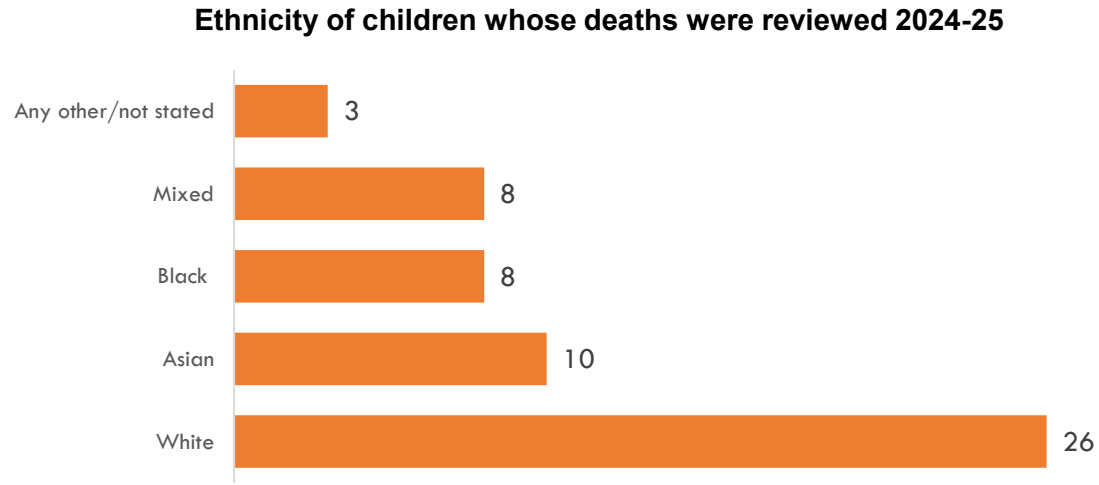


GRAPH 3: CHILD DEATH REVIEWS BY BOROUGH 2023-24 AND 2024-25

- In the 2024-25 period, over half of all child deaths reviewed involved children under one year of age.
- Thirty were male, twenty-six were female, and one was gender neutral.
- Fourteen of the 55 reviewed cases involved children who left surviving siblings.
- Twenty-eight of the children were from ethnic minority backgrounds.



GRAPH 4: AGES



GRAPH 5: REVIEWS: ETHNICITY OF CHILDREN

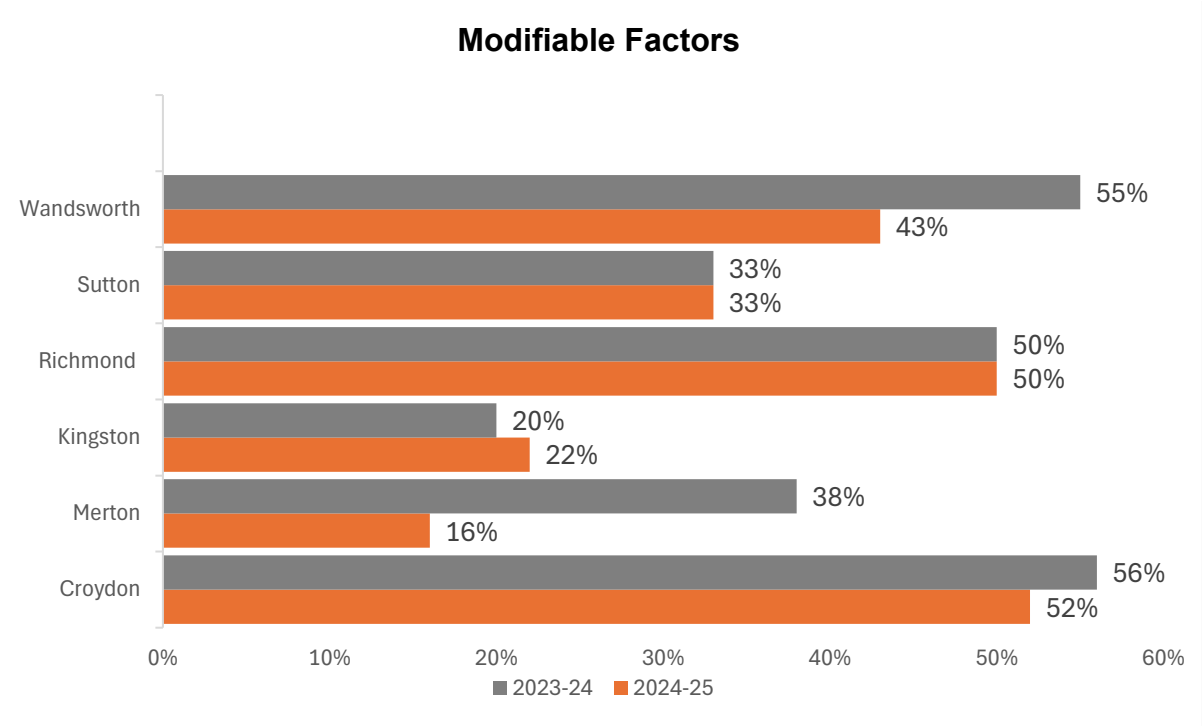
2.4 Local Child Death Reviews

Before a final review at CDOP, a local child death review meeting is held with professionals directly involved in the care of the child. The purpose of the Child Death Review meeting (CDRM) is:

- To review background history, treatment, and outcomes of investigations to confirm as far as possible the probable cause of death.
- To ascertain any contributory or modifiable factors from the death.

- To capture learning points and propose actions
- To review the support provided to the family
- To ensure that the Child Death Overview Panel and, where appropriate the coronial office, are informed of the outcomes of any investigation into the child's death.
- Refer the completed cases to the regional South-West London Overview Panel for final scrutiny of learning and actions taken for further recommendations at a regional or national level.

Between 1st April 2024 and 31st March 2025, 56 local child death reviews were held for children living in SW London. One case was kept open pending actions to be completed which has now been done.



GRAPH 6: Modifiable Factors

The category of "Modifiable Factors" is selected when the CDR or CDOP meeting identifies one or more factors that by means of local or national intervention, the risk of future child deaths may be reduced.

- In 2024-25 30 of 55 or 54% of reviewed cases had modifiable factors.
- This is higher than the 40% (28 of 70) of reviewed cases in 2023-2024.

Common examples of modifiable factors by domain include

Domain A, factors in the child

- Maternal Infection, delivery and obstetric complications
- Acute onset illness
- Chronic conditions
- Service provision issues for children with a Learning /physical disability.

Domain B, Factors in the family

- Involvement with Children's social care
- Parental physical or mental health Domestic violence/neglect.

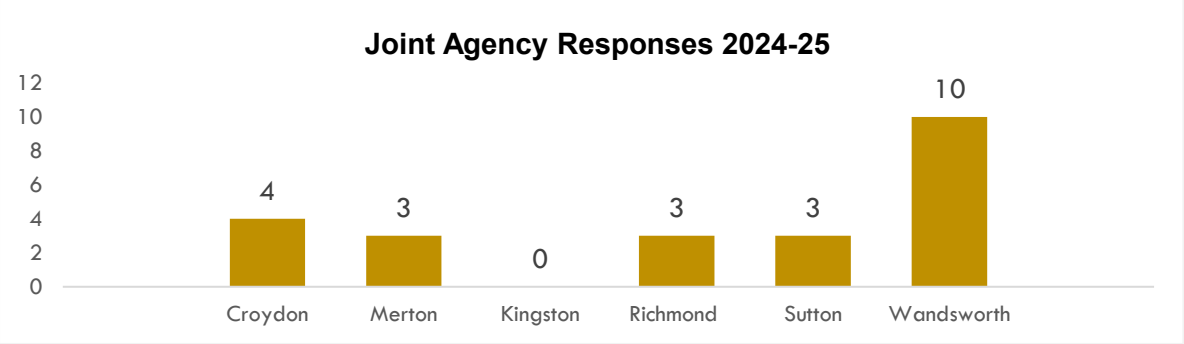
Domain C factors in the home environment

- Unsafe sleep arrangements
- overcrowding, poverty, and deprivation.
- Health and safety concerns including unauthorized access to restricted public spaces.

Domain D, factors in service delivery

- Delays in escalation of treatment
- Guidelines /pathways/policies not followed
- Poor communication between professionals and / or with families

2.5 Joint Agency Response



GRAPH 7: Joint Agency Responses 2024-25

A Joint Agency Response is a coordinated multi-agency review triggered when a child's death meets any of the following specific criteria:

- The death may be due to external causes.
- The death is sudden, and unexplained
- The child was brought to hospital near death and is expected to die.
- The death occurs in custody or when the child was detained under the Mental Health Act.
- Initial circumstances raise suspicions that the death may not have been natural.
- In the case of a stillbirth, where no healthcare professional was present.

For the 73 child death notifications that occurred during 2024-25, 23 Joint Agency Responses were held. This is lower than the 36 Joint Agency Responses held in 2023-24, but proportionately lower, (31% in 2024-25 compared to 33% in 2023-2024). This broadly consistent demand requires sufficient capacity from contributing agencies/professionals, to ensure an effective joint agency response.

2.6 Post-mortem Examinations and Reports

Post-mortems provide more information on the cause of death and can be offered to parents voluntarily or mandated on instruction of the coroner.

In 2024-25, Of the 55 reviewed cases, 22 were subject to postmortem examinations which is 40% of all notifications and most were directed by the coroner. In the remaining 33 cases, the cause of death was agreed upon without the need for a post-mortem examination

In the previous year, of the 70 reviewed cases, 31 cases had a post-mortem completed, of which twenty-five were coroners' post-mortems.

2.7 Coroners

Coroners are independent judicial officers responsible for investigating deaths that are violent, unnatural, or sudden with an unknown cause.

In 2024-25 of the 73 new notifications of child deaths, 22 cases have been referred to the coroners for investigation which is 30% of all new notifications. This is the same proportionately as in 2023-24, when of the 91 new notifications of child deaths, 33 cases (30%) were referred for a coronial investigation.

In 2024-25 of the 55 reviewed cases, nineteen required a coroner's Inquest. For 36 cases, the death certificate was issued following a discussion between the clinical team and a medical examiner and did not require referral to a coroner

Regulation 28 orders (Prevention of future deaths) were issued by the coroner on two cases reviewed; one related to a baby product that fell short of safety regulations, and the other raised concerns about long waiting times for CAMHS referrals.

All coronial offices local to South-West London, continue to experience backlogs in concluding inquests due to the high caseload of both adults and children, and staff turnover. This may also be impacted by limited capacity in paediatric pathology services. This leads to delays concluding child death reviews and sharing learning from inquests. Both the South-West London CDOP and the London CDOP Chairs network have called for separate inquest lists for adults and children, and faster resolution of child cases; however, no response has been received to date.

The SW London ICS Quality Directorate has been informed of the reason for delays in completing child death reviews for cases that await inquests.

Of the 136 cases open in April 2025, eighty-two have coronial involvement (60%).

Public Health representatives on the panel have also agreed to make a separate representation to the Coroner's Service, for consideration of a recommendation that inquest lists for children under 18 be separated from those of adults. This could support faster resolution of child death inquests.

Learning from Life and Death Reviews (LeDeR) with a Learning Disability and Autism

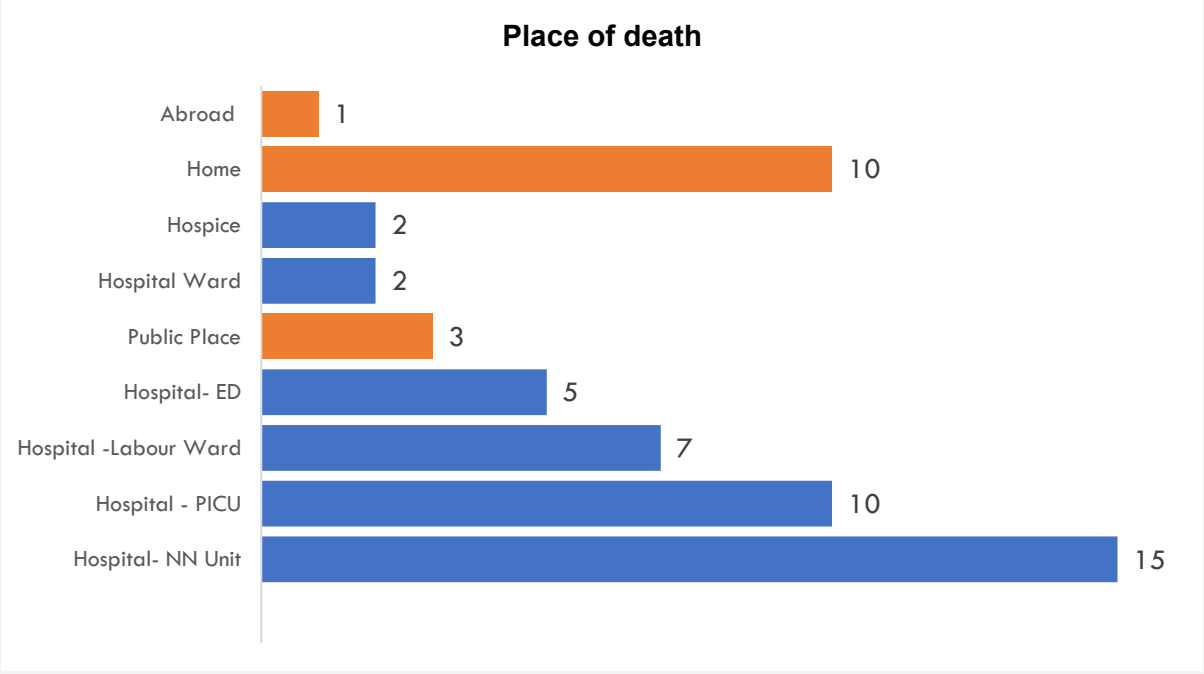
This process applies to children with diagnoses including ADHD /ADD /Autism or neurodiversity between the ages of 4 and 18 years old. In 2024-25, Child death reviews contribute data to the LeDeR process for children in this age category. Five children in this category were reviewed; four had profound physical and learning

difficulties, and one had Autism and died from a trauma-related incident. Learning has been shared from a Local Authority level with reference to this death.

It is hoped that feedback on themes from these reviews will result in decreasing numbers of deaths, greater use of reasonable adjustments in health and care services for children with neurodiversity, and better outcomes for children because of local service improvement projects.

With reference to concerns shared in the previous year on the need for parity of service delivery for children with continuing care packages, across all six boroughs in South-West London an update has been provided by continuing health care on equitable improvements to the continuing health care offer across South-West London which have been implemented since 2025.

2.8 Commentary on deaths reviewed – Place of incident leading to death



GRAPH 8: Place of death

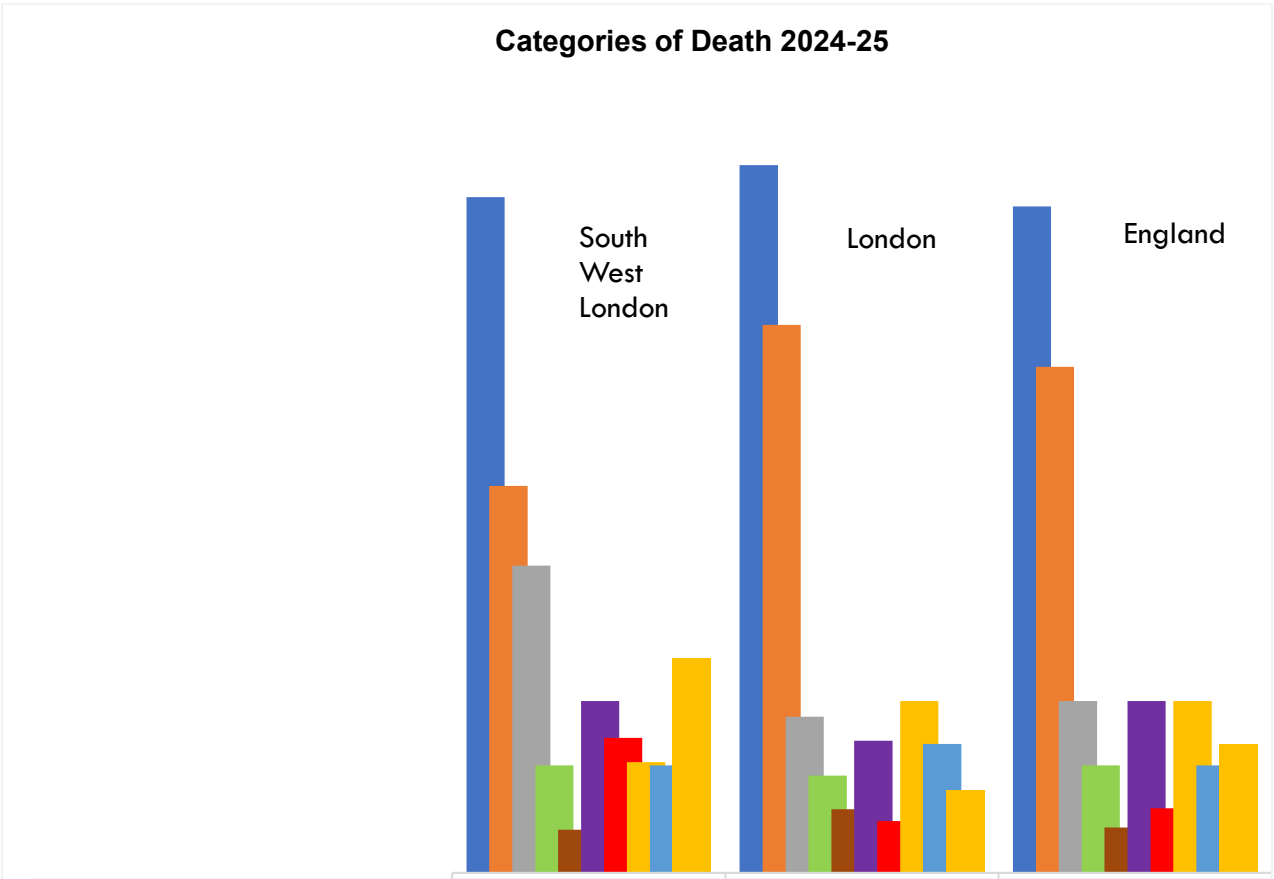
The place of Incident leading to death of death is recorded to ascertain those deaths that occurred in a clinical environment with access to medical care and at home or in a public place.

In 2025-26 87% of child deaths occurred in a clinical setting compared to 79% in 2023-24.

Chapter Three

3. Statistical Overview

3.1 ANALYSIS OF CHILD DEATHS FOR 2024-25



	South West London	London	England
Perinatal/neonatal event.	31%	33%	31%
Chromosomal, genetic or congenital anomaly.	18%	25%	24%
Sudden unexpected, unexplained death.	14%	7%	8%
Chronic medical condition.	5%	5%	5%
Deliberately inflicted injury, abuse or neglect.	2%	3%	2%
Acute medical or surgical condition. Perinatal/neonatal event.	8%	6%	8%
Suicide or deliberate self-inflicted harm.	6%	2%	3%
Malignancy.	5%	8%	8%
Infection.	5%	6%	5%
Trauma and other external factors, including medical/surgical complications/error.	10%	4%	6%

Graph 9: Categories of Death 2024-25

55 cases were reviewed by the panel in 2024-25. When interpreting the data, caution is necessary due to the small sample size. The data is pseudonymised and presented in rounded percentages to maintain confidentiality. Comparisons are made with

regional (London) and national (England) data. It is important to note that the data represents cases reviewed by SW London, London, and England CDOP Panels in the 2024-25 reporting year and does not reflect the overall rate of notified child deaths occurring in these categories for the year – Deaths may have occurred in this or previous years, therefore the samples are not necessarily comparable

THEMES FROM COMPLETED REVIEWS

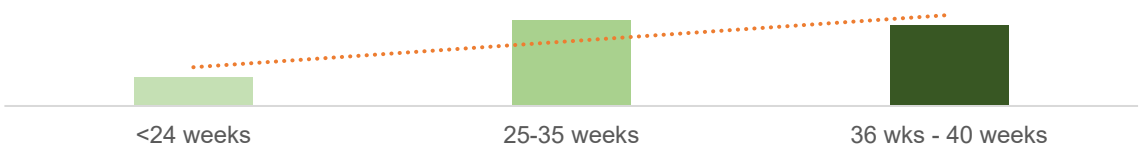
3.1.1 Perinatal/Neonatal Event

- Perinatal deaths occur around birth or within the first week after birth.
- Neonatal deaths occur within the first 28 days of life
- These deaths can be due to a range of factors, including complications during pregnancy, labour, or delivery.

In 2024-25, perinatal/neonatal child deaths continue to be the leading cause of child deaths in South-West London and, at 31%, is similar to London (33%) and England (31%) figures. There were 17 actual deaths.

- 15% of these babies were born at under 23+ weeks gestation, which is less than 20% of the same gestation last year.
- Forty-four percent of these babies were between born at 24 – 35 weeks gestation which is higher than the thirty-eight percent (38%) of cases in this category last year.
- 41% of these deaths involved babies born at term.
- The panel continues to follow up on the difficulties in identifying learning from child death reviews for babies under 23+ weeks gestation from the London CDOP Network to assess whether they should continue to be reviewed.

Gestation: perinatal/neonatal child deaths



GRAPH 10: Gestation: perinatal/neonatal child deaths

1. Among the babies, 47% were male, 49% were female, and 4% were indeterminate in gender.
2. Fifty-two percent of deaths were related to immaturity/prematurity which is less than the 83% of the deaths for this reason last year. Perinatal asphyxia accounted for 17% of these cases which is also down from 27% of cases for this reason last year.
3. Eleven percent (11%) were referred for safety incident reviews down from 19% last year.
4. These reviews highlighted the following areas of concern: -

- Escalation processes for obstetric review.
- The importance of identifying named consultants on duty and contact information for complex foetal medicine unit patients in delivery suites.
- CTG monitoring guidance and practice.
- Training for staff on foetal anaemia.
- Ensuring effective pain management for mothers.
- Updating records and documentation promptly.

3.1.2 Chromosomal, Congenital, And Genetic Conditions

- Chromosomal abnormalities result from changes in the structure or number of chromosomes.
- Congenital anomalies (also known as birth defects) are structural or functional abnormalities present at birth.
- Genetic disorders result from changes or mutations in specific genes.

In the 2024-25 review period, chromosomal, congenital, and genetic anomalies accounted for 18% of child deaths (10 deaths) a slight increase from 16% in the previous year. Comparatively, both London and England reported similar figures, with 25% and 24% respectively, consistent with the previous year. Each case involved specific identifiable chromosomal, congenital, and genetic anomalies, which were associated with prematurity or included heart and respiratory conditions. All affected

families were offered or referred for genetic testing to inform future pregnancy planning.

The increased utilization of genetic testing has provided parents with insights into the nature and diagnosis of the identified anomalies, enabling informed decisions regarding future pregnancies. Feedback from parents has been positive, and consultations with hospital specialists' post-mortem have facilitated a better understanding of how chromosomal and congenital anomalies impact life expectancy.

3.1.3 Sudden Unexpected Death of an Infant/Child (Sudi/C)

Sudden Unexpected Deaths in Infancy and Childhood (SUDI/C) refer to cases where a child dies suddenly and without an immediately identifiable cause. In South-West London, SUDI/C remains the third leading cause of child mortality, with 7 deaths recorded in 2024–25—maintaining a consistent rate of 14% for the second consecutive year of completed reviews. This figure is significantly higher than the average rates of reviewed cases for both London (7%) and England (8%). South-West London has the second highest rate of SUDI/C deaths among London regions, matching the number reported in North-West London. Notably, South-West London also includes two of the largest child populations in London. Croydon ranks 2nd and Wandsworth 8th in terms of child population in these boroughs.

Notably, 66% of these deaths occurred in infants aged between 28 and 364 days, across all ethnic groups. This year there was positive feedback on the quick response time and resuscitation efforts of London Ambulance service despite the outcome.

Despite ongoing communication campaigns aimed at mitigating risk factors for Sudden Unexpected deaths of Infants and children, key concerns persist. These include unsafe sleep environments, and overcrowded living conditions. Educational efforts have been shared for antenatal and postnatal messaging to target and include fathers in the home, as well as others caring for babies for example foster carers, and emphasizing the importance of regular physical checks on sleeping infants rather than sole reliance on monitoring devices.

3.1.4 Trauma

In 2024–25, 6 child deaths (10% of all reviews) in South-West London fell into this category, with the majority involving tragic accidents. Half of these deaths involved public/private transport. One of the incidents occurred abroad. A bereaved parent has

contributed to sharing key learning from their experiences, which has been made available through a YouTube podcast.

3.1.5 Acute Medical Conditions

In the 2024–25 reporting year, 4 child deaths (8% of all child deaths in South-West London) were attributed to acute medical concerns—an increase from 3% (2 deaths) in 2023–24. These deaths followed a sudden onset of illness of short duration. In one case, concerns were raised about the London Ambulance Service's response, prompting the service to conduct a review of its processes.

3.1.6 Suicide, and Self-Inflicted Harm

Suicide and self-harm are serious concerns affecting adolescents in SW London. In 2024–25, South-West London recorded 3 child deaths in this category, representing 6% of all reviewed cases. This rate is significantly higher than the London average of 2% and the national average of 3%. Among the reviewed cases, 66% involved children with known mental health concerns, and 33% were on waiting lists for CAMHS referrals at the time of death.

One third of the reviews highlighted factors such as income, employment, health, and barriers to accessing services, some were on waiting lists for mental health referral, others had not engaged with services. Despite these challenges, the children were performing well academically at school at the time of their deaths.

Learning from these cases were shared with primary care services and pharmacy leadership emphasizing caution with prescribed medication for children known to be under CAMHS care, and compliance with the British National Formulary (BNF) and NICE guidelines.

3.1.7 Malignancy (Cancer)

In 2024–25, cancer accounted for 2 child deaths (5% of all cases reviewed) in South-West London, down from 3 deaths (7%) in the previous year.

Statistical data for London and England stands at 8%, also reflecting a decrease from the previous year. These cases involved children of all age groups and ethnicities. The most common type of cancer in children is leukaemia, which accounts for about a third of all cases of childhood cancer. In terms of service provision, this category of child

death continues to be well-resourced, with comprehensive support. Particular strengths identified include:

- Multidisciplinary support including physiotherapy and occupational therapy, particularly when a child's mobility declines.
- Good communication between teams and families; Timely hospice referrals.
- Families were well-informed and supported in decision making.

Positive feedback was received from all parents regarding the support provided by services, third-sector charities, hospices, and schools, which conducted celebration of life events. Each year, this category of child death continues to receive the most praise in terms of service provision. Some parents also identified suggestions for improvements for agencies which were passed on for action.

3.1.8 Infection

Infections can be caused by both bacteria and viruses and these deaths accounted for 5% of child deaths in 2024-25. This rate aligns with the national average for England. The most commonly identified cause of death relating to infections were septicaemia and meningoencephalitis. It is important to note that a number of perinatal/neonatal child deaths had an infection element but were recorded in that category due to prematurity.

A post-action review was conducted for one case, providing valuable insights and recommendations. These included the importance of adhering to standardized sepsis guidelines, conducting thorough risk assessments, and implementing the national Paediatric Early Warning Systems (PEWS) to address the rapid deterioration of children with infection-related conditions. It also highlighted the need for simpler safety netting advice for parents and the application of paediatric-specific guidelines for London Ambulance Service personnel which has recently been implemented in their operational procedures.

3.1.9 Chronic Medical Conditions

In 2024–25, 3 child deaths (5% of all reviews) in South-West London were due to complications arising from complex medical conditions—unchanged from the previous year. This rate aligns with the averages reported across both London and England.

All affected children received comprehensive care packages. One child's death was attributed to asthma and consequently, learning was shared about the importance of annual medication reviews, identifying signs of emergency medication overuse, and enhancing strategies to help young people better understand and become better advocates for their own health condition.

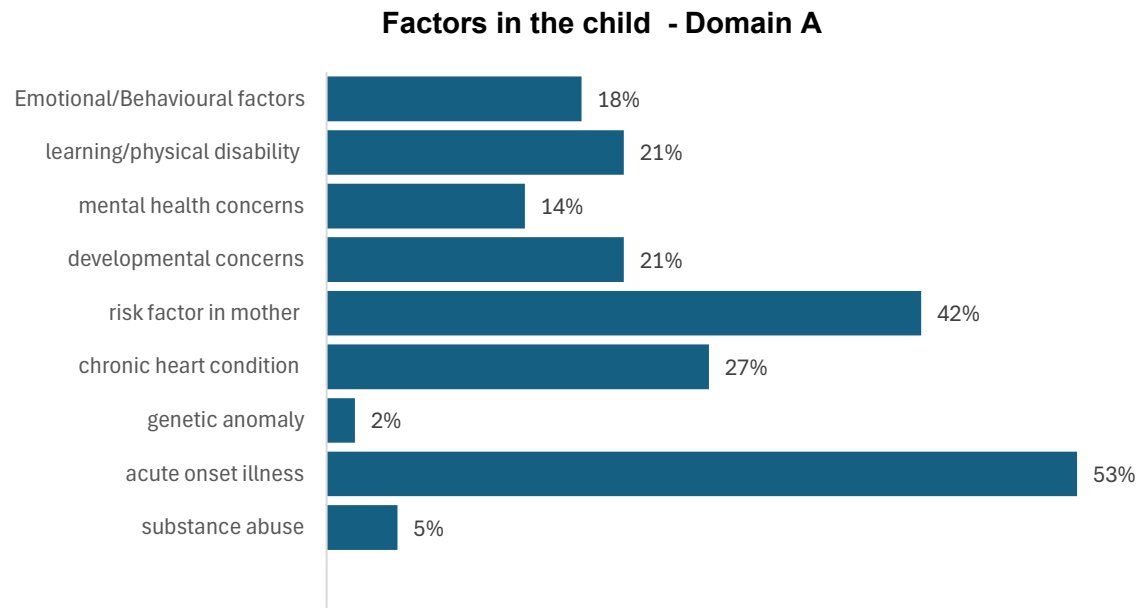
3.1.10 Deliberately Inflicted Deaths

Deliberately inflicted child deaths involve intentional harm through abuse, neglect, or violence. Two per cent (2%) child deaths were in this category.

3.2 Child Death Domains

The domains are thematic areas used to categorise and analyse information about a child death. They help to identify modifiable factors, or issues that are present or could be changed, to reduce the risk of future deaths. The information from these domains is captured in the data collected by the National child mortality database (NCMD) from child data nationally and contribute to national reports. These include (a) factors in the Child, (b) factors in the parents, family and social environment, (c) Factors in the physical environment and (d) Factors in service provision.

3.2.1 Factors in the Child (Domain A)



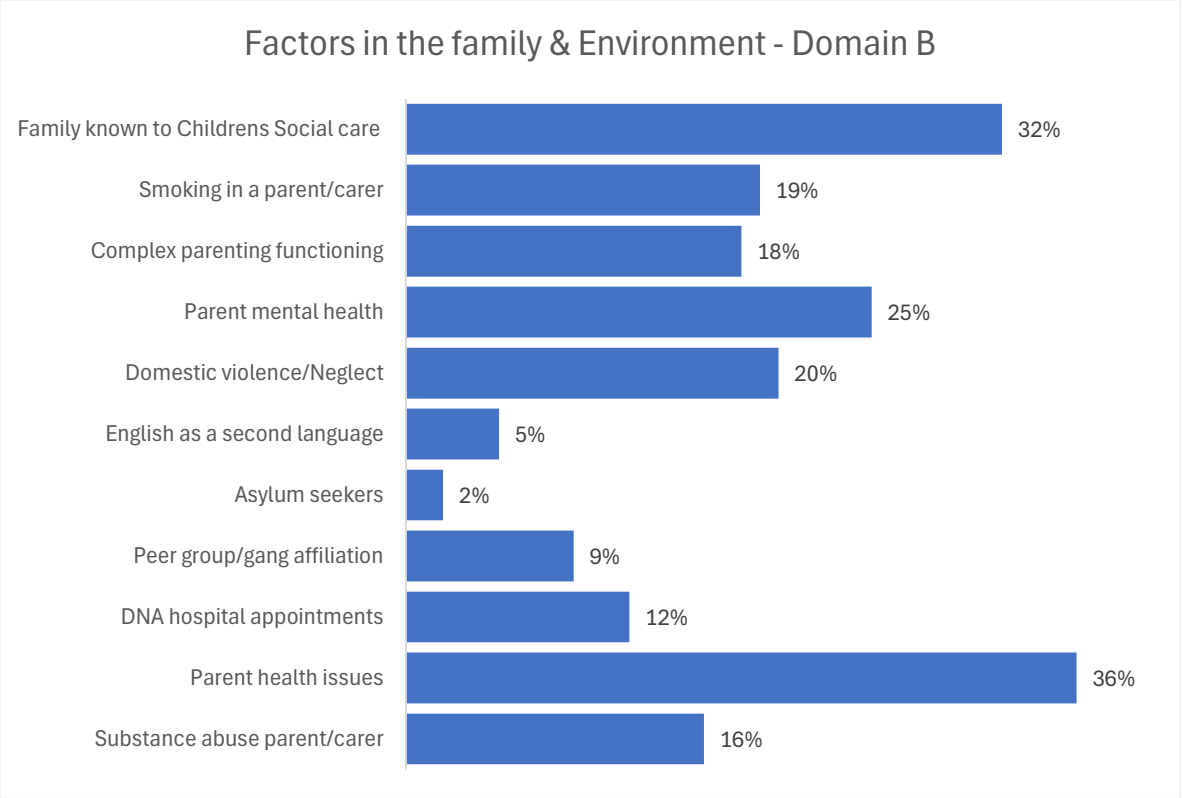
GRAPH 11: Factors in the child - Domain A

In 2024-25, 85% of reviewed cases had a factor in the child noted which is higher than the previous year of 50%. In a number of cases more than one subcategory was used.

In this reporting year, the most common factors identified were:

- Acute illness onset (53%)
  - Rapid deterioration in mother or baby
- Maternal risk factors (42%)
  - Obstetric complications, infections,
  - Parental smoking, substance misuse
- Chronic conditions / genetic anomalies (27%)
- Emotional/behavioural factors (18%)
  - Suicidal ideation, bullying, bereavement, high-risk behaviours
  - Growing concerns over social media and internet use

3.2.2 Factors in the Parents, Family, and Social Environment (Domain B)



GRAPH 12: Factors in the family & Environment

Factors in the family were identified in 42% of all reviewed cases and in some cases, more than one issue in this category were noted.

Common issues identified included:

- Domestic violence (20%)
- Parental mental health concerns (25%)
  - Depression, anxiety, learning disability
- Parental physical health issues (36%)
- Complex family environments (18%)
  - Poverty, truancy, disguised compliance, service avoidance
- Language barriers (5%)
  - English as a second language
- Substance misuse (16%)

This is an increase from 7% last year.

- Missed appointments (12%)
  - This is an increase from 3% last year

3.2.3 Factors in the Home and Environment (Domain C)

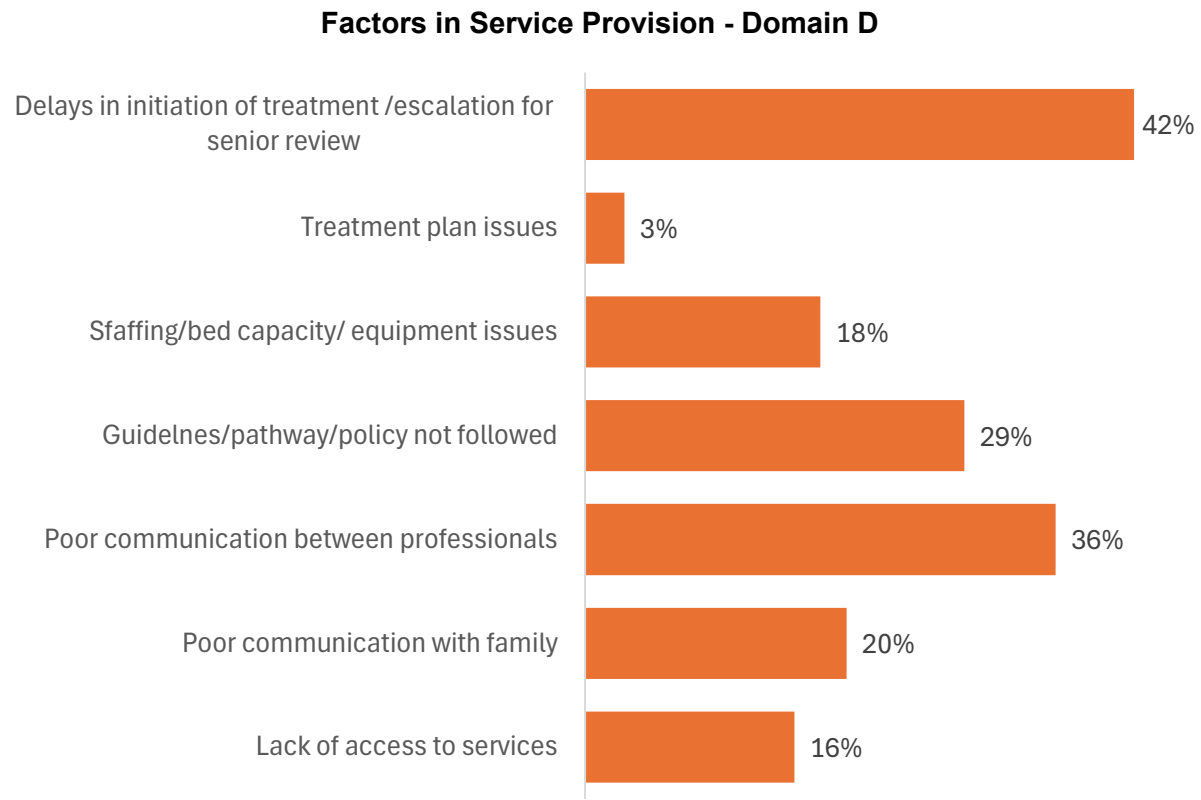
GRAPH 13: Factors in the home and Environment

Factors in the home and environment were noted in 18 cases and are a growing category of concern in child death reviews with common issues.

- Overcrowded and unsuitable home conditions were noted in ten cases.

- Public safety risks including high-risk behaviour accessing prohibited pedestrian areas (construction sites, prohibited areas of railway tracks,) motor vehicle collisions and drowning were noted in four cases.
- In particular, co-sleeping and unsafe sleeping arrangements were noted in four SUDI-related child deaths.

3.2.4 Factors in Service Provision (Domain D)



GRAPH 14: Factors in Service Provision - Domain D

In 2024-25, 40 cases or 72% of case reviews had concerns about service provision issues which is slightly less than the 80% recorded in this category last year. Some had more than one sub- category. These cases had the following issues noted.

- Delays in initiation of treatment, delays in recognition of a deteriorating child, and delays in escalation of care were noted in 36% of cases, an increase in comparison to 31% for last year.
- Cases where there is a guideline or policy in place which was not followed, featured in 29% an increase over 22% reported last year.

- Insufficient staffing levels at times of high activity, a shortage of specialist bed capacity, or defective or unavailable equipment were noted in 18% of cases.
- Poor communication between professionals, particularly in cases involving more than one service was identified in 36% of cases, which is an improvement on the previous year's statistic of 48%.
- The vulnerability of children absent or not in education was noted. There may be scope to improve processes for how concerns around children whose attendance is reduced due to reported health conditions, is explored with a child's wider network, particularly where evidence of engagement with relevant health services is not forthcoming upon request from their parents.
- Twenty percent of cases noted poor communication with parents by professionals to assist with understanding care management and parent expectations, parents' complaints regarding confusing advice, and two instances of inadequate access to interpreting services.
- In 2024–25, delays in diagnosis and escalation for senior clinical review were the most frequently noted concerns within health services. For social care, the highest category of concern for that agency related to delays in accessing services particularly children's continuing healthcare—highlighting gaps in timely service provision totalling 42% across both sectors.

3.3 Serious Incident/Patient Safety Investigations

In 2024-25, ten of the 55 reviewed child deaths (18%) were subject to Patient Safety investigations. The issues arising have been covered in the Factors in Service Provision.

Hospitals involved were:

- Croydon Hospital x 2
- Kingston Hospital x 2
- Chelsea and Westminster x 1
- Epsom and St Helier x1
- St Georges x 3, plus one Healthcare Safety Investigation Branch (HSIB) report

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents. Its purpose is to learn from incidents and improve patient safety.

As of May 2024, Martha's Law is being piloted across 143 NHS sites in England, including paediatric critical care networks. Martha's Law, also known as Martha's Rule, is a patient safety initiative introduced by NHS England in response to the death of 13-year-old Martha Mills in 2021. Martha died from sepsis after her parents' concerns about her deteriorating condition were not acted upon. A coroner later concluded that she likely would have survived had she been moved to intensive care earlier. Martha's Law provides patients, families, and carers with a formal mechanism to request an urgent second clinical opinion if they feel their concerns about a patient's condition are not being adequately addressed. It aims to improve the identification and management of clinical deterioration by patients, families and carers can request a second opinion, and any staff member can request a review from a different clinical team if they are concerned about a patient's condition.[1]

The panel has been reporting on feedback activity to the SW London Patient Safety Surveillance group on shared learning from Child Death Overview Panel meetings as part of the CDOP's contribution to the organizational response to child deaths by the integrated care system (ICS). The panel has concerns that there needs to be improved communication of the learning from the factors in service provision and patient safety to services with a joint aim of operational service improvement.

There have been suggestions that the learning currently being collected separately by the eCDOP/National Child Mortality Database process could be further analysed to get a true picture of the landscape of service delivery and its effect on patient safety, as valuable data is being collected from the CDOP process by the NCMD. The panel has sent the recommendations from local case reviews on a six-monthly basis to local hospitals for assurance that improvements from the Serious incident investigations and panel reviews have been considered and implemented.

One case was subject to a Mental Health Investigation. A regulation 28 Order was issued by the coroner raising concern that the waiting times for Mental Health

[1] https://www.england.nhs.uk/patient-safety/marthas-rule/

assessments were unacceptably long. This is a national concern, and it was acknowledged this is due to a lack of resources that has not kept pace with significantly increasing demand.

Key learning included:

- Training for CAMHS staff to better understand the needs of young people and the risk assessment forms that can support that.
- Improvements in waiting list management, including caseload governance improvements in prioritising needs of clients and escalating risk
- Improvements in documentations of risk assessments with audit to ensure these are of a high standard to enable complex discussions and decision making.

3.4 Child Safeguarding Practice Reviews

In 2024-25 two reviewed cases were subject to Child Safeguarding Practice Reviews (CSPRs).

A CSPR was conducted concerning medical neglect issues involving a child with a rare life-limiting condition, who was previously subject to a child protection plan, but was under a child in need plan at the time of death. The situation was further exacerbated by missed clinic appointments and the restrictions on face-to-face visits during the COVID-19 pandemic.

Key learning included:

- Better multi-agency coordination of healthcare for children with complex health conditions who are particularly vulnerable, such as those under child protection plans where there are emerging concerns about possible medical neglect.
- Best practices in parental education regarding health problems, including how to recognize and seek help when they are struggling to meet their child's healthcare needs, encouraging practitioners to explore reasons for missed appointments, and directing parents to appropriate support services.
- Peer support from other parents with similar experiences.

- The importance of ensuring clinical oversight of children during national crises such as pandemic conditions.

The other case involved the sudden unexpected death of a baby while in foster care.

Key learnings included:

- To seek assurance that the Individual Management Reviews are being implemented by each agency. A campaign to raise awareness of safe sleeping arrangements for children to include 'what if' questions.
- To seek assurance that independent fostering agencies comply with standard 10 of the National Minimum Standards: Providing a suitable physical environment for the foster child, whereby the foster home needs to be able to comfortably accommodate all who live there.
- To seek assurance that new-born babies and infants are placed with foster carers who have completed safer sleeping and paediatric first aid training.
- To seek assurance that managers and supervisors are aware of the importance of following up in supervision that safer sleeping arrangements have been checked by social workers and health professionals when they have made home visits to new-born babies and infants.

Learning was shared with agencies to identify concerns raised at reviews and for assurance that service improvements have been made.

3.5 Bereavement Support

In the past year, 87% of families were offered bereavement support, a slight decrease from the previous year's 100% although records were unclear or unrecorded in 10% of cases. 3% are recorded as not being offered the service, possibly due to the family having supportive religious/familial networks.

Families who declined initial offers of support were informed that they could access services up to a year later if needed. Most accepted support came from third-sector charities, health visiting, and hospital bereavement services, with GPs providing significant support for out-of-hospital deaths. Some offers of bereavement support, like these from GPs and health visitors, are often under-reported. The SW London Child Death Overview Panel expresses gratitude as always to key workers, bereavement

nurses, and family liaison nurses in hospitals for their essential roles in the bereavement process. They ensure families are informed, represent parents' voices at professional meetings, and provide feedback to concerns raised by parents.

SW London Hospitals have established bereavement procedures across Midwifery, Neonatology, Primary Care, and Paediatrics, ensuring cross-agency coordination to offer appropriate support or signposting to third-sector charities. Hospices continue to provide enhanced support accessible up to three years after a child's death.

3.6 Parents and Carers' Feedback to the Child Death Overview Panel

In most cases, parents want to understand why their child died and are offered a meeting to discuss any questions they may have. Thirty-Eight of the 55 families provided feedback during the CDR process with common themes including:

- Questions regarding the training of carers.
- Lack of regular visits by social workers, and how this was addressed by children's social care management.
- Missed opportunities for early safer sleep advice by health visitors
- Poor communication regarding children's wellbeing to their birth parents, coupled with challenges in managing expectations when children are looked after.
- A perception by parents there was an inadequate skill mix of staff in maternity services.
- Poor information sharing between hospitals.
- Difficulties contacting CAMHS due to a lack of a designated single point of contact and inconsistent communication from the service.
- Limited engagement regarding the return of personal items by the Police after Sudden unexpected child death.
- Frustration with coroners on delays in processing of inquests.
- Delays with cold cot provision, mortuary access, and post-mortem samples after a child dies.

- Concerns about prevention or early detection of infection and concerns about infection in placental histology.
- Questions about earlier scanning of cervix for competency as a preventative measure, if signs of incompetence are detected.
- Inquiry about delay of pre-term labour and scanning issues for antenatal identification of anomalies.
- A request for easier to understand guidelines for parents on when to seek urgent care.
- Simpler safety netting information on seeking medical advice for children with an elevated temperature for extended periods.

  Despite the challenges, several parents expressed gratitude for exceptional care.

3.7 Learning/Training Activities of SW London CDOP 2024-25

South-West London CDOP Perinatal/Neonatal Training event

SW London CDOP hosted a training event with a focus on improving services, support, and engagement within an organization or trust. This included the following themes: -

- Collaborative working with Medical Examiners and bereaved families
- Support from the Lullaby Trust and other training resources
- Promoting safe sleep practices, especially in temporary accommodation
- Learning from previous cases to inform service improvements
- Updates on Care of Next Infant (CONI) programme

The event was attended by panel members and had representation from health and social care and was well received, with participants saying they found the speakers informative and interesting, and the learning would help their everyday skills and knowledge.

YouTube Podcast on Sling Safety

The inquest into a case involving the death of a baby in a sling, determined that there is insufficient information available from any source to inform parents of safe positioning of young babies in carriers and, in particular, in relation to breastfeeding, and issued a Regulation 28 Order for services to promote learning and to raise awareness on this issue.

The father of this baby participated in a YouTube presentation in collaboration with the Local Authority on safe positioning of babies in slings to share learning and promote their safer use.

Chapter Four

4. Conclusion and Priorities for 2025-26

4.1 Goals for next Reporting year 2025-26

The Panel aims are as follows:

I. To continuously monitor and identify trends in child deaths within the South-West London area, to ensure that there are more timely updates and reporting to ensure the earlier implementation and dissemination of learning, by quarterly reporting.

II. To collaborate with the SW London Patient Safety Surveillance group, facilitating shared learning from CDOP meetings as part of the panel's contribution to the organizational response to child deaths as part of the South-West London Integrated Care System (ICS).

III. There is an ongoing discussion about the need to provide psychological support and/or restorative supervision for panel members due to the distressing nature of case review content, with the panel hoping for implementation in the 2025-26 reporting year.

IV. To disseminate learning and recommendations from child death reviews, promoting best practices across all services to have a positive effect in reducing child deaths.

SUMMARY

The recommendations and insights derived from 55 child death reviews and the South-West London Child Death Overview Panel (CDOP) in 2024-25 have significantly contributed to enhancing organizational practices, and the education, training, and communication within local partner agencies.

Through structured reviews, parent feedback, and regional learning events, the panel continues to support efforts to reduce preventable deaths and improve outcomes for children and families across South-West London.

Appendix 1: Statutory and Regulatory Legislation

Child Death Review Statutory and Operational Guidance (England) (October 2018)
These documents provide statutory guidance for reviewing child deaths in England.

https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england-

Chapter 6: Working Together to Safeguard Children 2023 – Child Death Reviews

https://assets.publishing.service.gov.uk/media/65cb4349a7ded0000c79e4e1/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf

The Child Death Review partners are local authorities and clinical commissioning groups for the local area as set out in section 16Q of the Children Act 2004 (the Act), as amended by the Children and Social Work Act 2017.

Child death data release 2024 | National Child Mortality Database

https://www.gov.uk/government/statistics/2024-child-health-profiles/child-health-profiles-2024-statisitcal-commentary

Appendix 2: NCMD Monitoring Reports 2024-25 (not attached to this document)

Croydon

Kingston Upon Thames

Richmond Upon Thames

Merton

Sutton

Wandsworth