Shropshire, Telford and Wrekin Child Death Overview Panel Annual Report (1 April 2024 to 31 March 2025)

Contents

Foreword from the Independent Chair of the Child Death Overview Panel

This is my second annual report as the Independent Chair for the Shropshire, Telford and Wrekin Child Death Overview Panel (CDOP), and I am pleased to reflect on the substantial progress made over the past year.

In 2024–25, we have continued to strengthen the child death review process across the system. Key developments include the establishment of a more robust governance framework, with regular business meetings now embedded to provide oversight and accountability. We now have in place a substantive Child Death Review team, comprising a dedicated Child Death Specialist Nurse, administrative support, and a Designated Doctor. This increased capacity and structure bring us closer in alignment with national expectations and enable a more consistent and timely review of cases.

We have also integrated CDOP with the quarterly child mortality workshops, creating valuable opportunities for deep dives into emerging themes and learning across the system. These workshops have facilitated more joined-up reflection and planning between local and regional partners, helping to drive system-wide improvements.

Despite these gains, the CDOP service continues to face significant challenges. The major reorganisation of the NHS has brought a level of disruption and uncertainty, with implications for strategic continuity and operational delivery. Ensuring that the child death review process remains resilient and independent amidst wider system change will be a priority going forward.

As ever, I remain grateful to all professionals involved in this vital work. Their dedication ensures that we continue to learn from each child's life and death, with the ultimate aim of reducing preventable child mortality in our communities.

Mike Leaf
Independent Chair of the Shropshire, Telford and Wrekin CDOP
Summer 2025

Section 1: Executive Summary

There is a legal requirement for statutory partners to make arrangements to carry out child death reviews. These arrangements should result in the establishment of a) a CDOP, or equivalent, to review the deaths (excluding infants live-born following planned, legal terminations of pregnancy, and stillbirths) of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children. The focus of the CDOP should be on identifying any modifiable factors that may help prevent unnecessary future child deaths or harm. The report uses data submitted by CDOP to the National Child Mortality Database.

For Shropshire, Telford and Wrekin, during 2024/25, the responsibility for reviewing child deaths sat with NHS Shropshire, Telford and Wrekin (NHS STW), Shropshire Council and Telford & Wrekin Council.

The purpose of this Annual Report

This report has a number of specific purposes, including to:

- Clarify and outline the processes adopted by the Shropshire, Telford and Wrekin CDOP and service.
- Assure the child death review partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across Shropshire, Telford and Wrekin, which meets national guidance.
- Provide an overview of information on any trends and patterns in child deaths reviewed across Shropshire, Telford and Wrekin during the last reporting year (2024/25).
- Highlight issues and themes arising from the child deaths reviewed.
- Report on achievements and progress from last year's annual report.
- Make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across Shropshire, Telford and Wrekin.

Achievements during 2024/25

Over the period of time covered by this report, the CDOP and service has achieved the following:

- Engaged with other CDOPs, across the West Midlands region and nationally, to share good practice.
- Circulated good practice, learning and resources across Shropshire, Telford and Wrekin, including:
    - Best Practice Guides for completing Reporting Forms for 0-19 Service, Education Settings and GP's
    - Training sessions with the 0-19 service
    - 7-minute briefing regarding reporting form completion
    - 7-minute briefing focusing on safer sleep.
    - Provided support and guidance to local providers on processes.

- Established stronger process between CDOP, service and the quarterly multi-agency child death workshops, with system and regional partners, addressing key themes from child deaths to develop a system action plan.
- Ensured that relevant key public health messages such as safer sleep messages were being promoted in a consistent way across Shropshire, Telford and Wrekin, including:
    - 7-minute briefing regarding safer sleep, Specialist Nurse has proactively shared resources with 0-19 Service and has been to all 0-19 Team Meetings across the region - safer sleep was used as an example of how 0-19 Service can continue to promote this area to reduce risks of deaths
- Contributed data, inquiry and insights to the 4 child mortality workshops held in the system.

Update on 2024/25 Priorities

- Review the current processes with the purpose of identifying areas of improving effectiveness and efficiency.
  Update: a substantive CDR team has been established with a new agenda format established. The meetings now flow more smoothly, with a clarity on what is happening to actions and recommendations
- Maximise the impact of the child death workshops and thematic action plan.
  Update: A close working two-way relationship has been established where issues from CDOP can be escalated for further themed discussion at the workshops. The panel receives feedback from any workshop discussions.
- Improve the quality and frequency of analysis forms from child death review meetings.
  Update: A system has been developed so that all panel members have access to all reports and outputs from any review, and consistent draft analysis forms produced for consideration at each panel. Analysis forms from CDR Meetings are now of a higher quality, with more comprehensive outputs.
- Provide assurance that multi-agency partner strategies are in place to address modifiable factors.
- *Update: Link to safer sleep as above and also the child mortality workshops on the deteriorating child and Road Traffic Collision's*. Development of Nurse led Pre-conception programme to enhance reproductive health -Partnership with LMNS, public health, and LAs
- Develop a risk register so that mitigating action can be progressed.
  Update: A risk register has been established and is being monitored by the Business group
- Implement the key findings of the independent review on child death review processes.
  Update:
    - *Governance structure now completed,*
    - *Designated Dr and Nurse both now in post*
    - *CDR process in place to ensure Specialist Nurse is present for all CDR's and links with SATH to support their CDR process*
    - *Key Worker has been recruited in SATH*
    - *Specialist Nurse meets with bereaved families to obtain feedback and offer support*
    - *CDOP and service now led by STW ICB and the Local Authorities*

    - *CDOP Service Policy and Standard Operating Procedure written*
    - *Governance Structure and Terms of Reference complete*
- Establish a business group to oversee CDR processes.
  Update: A Business group has been established and has:
    - *Developed clear terms of reference and CDR Operating Procedures*
    - *Established a risk register for active monitoring*
    - *Overseen the appointment of the substantive CDR Team*
    - *Developed a Business action plan which is regularly monitored to ensure actions and recommendations are implemented*
    - *Established links with the Palliative and End of Life Care Strategy for Children and Young People in Shropshire, Telford and Wrekin*
    - *Considered and circulated numerous child focussed reports including National Child Mortality Database analysis and recommendations*
    - *Provided assurance to partners by ensuring reports and updates are discussed*

Shropshire, Telford and Wrekin overview

The following is an overview of the child deaths in Shropshire, Telford and Wrekin during the period of 2024/25. (Previous year's figures in [brackets]):

- 63% of deaths reviewed were completed within 12 months [53%]
- 37% of deaths reviewed taking over 12 months [47%]
- 11% of deaths reviewed were completed within 6 months [6%]
- 66% of deaths occurring were children under 1 year of age [60%]
- 44% of deaths reviewed had modifiable factors identified [69%].

The modifiable factors identified for Shropshire, Telford and Wrekin, for 2024/25 include:

- high BMI of pregnant mothers
- unsafe sleeping arrangements
- smoking (including mother or both parents)
- use of alcohol
- mental health challenges for mother
- illegal drug use.

Section 2: Overview and Processes

Child Death Overview Panel (CDOP) membership

The Shropshire, Telford and Wrekin CDOP has a core membership of:

- Independent chair
- Detective Inspector, West Mercia Police
- Named Doctor for CDOP and Safeguarding Children, Associate Specialist Community Paediatrician, Shropshire Community Health NHS Trust (SCHT)
- Specialist Nurse for Child Death, NHS Shropshire Telford and Wrekin ICB

- Designated Dr for Child Death, NHS Shropshire Telford and Wrekin ICB
- Consultant Paediatrician, SaTH
- Consultant Neonatologist/Neonatal Paediatrician SaTH
- Matron, Neonatal Services, SaTH
- Matron, Paediatrics, SaTH
- Designated Nurses for Children's Safeguarding
- Divisional Director of Nursing - Women's and Children's, SaTH
- Specialist Midwife – Bereavement, SaTH
- Service Delivery Manager, Children's Social Care, Shropshire Council
- Service Delivery Manager, Children's Social Care, Telford & Wrekin Council
- Neonatal Link Nurse, Hope House Hospice
- Public Health Practitioner, Telford & Wrekin Council
- Healthy Child Programme Coordinator (ages 0 - 19), Public Health, Shropshire Council
- Education
- Head of Service Healthy Population
- CDOP service Administrator and Secretary to Designated and Named Nurses, ICB

Other members can be co-opted as and when necessary.

Agency representation meetings

For the year 2024/25, there has been good agency representation. Membership will be continually reviewed to ensure that there continues to be representation from all professional perspectives and geographies.

The Shropshire, Telford and Wrekin CDOP service also continues to be represented at the West Midlands CDOP Network meetings.

Notification process

The notification process via the e-form on the eCDOP system is working well for all teams when notifying a death.

When Shropshire, Telford and Wrekin child deaths occur out of area, the CDOP service has sometimes been notified by hospitals and the CDOP contacts out of the area, as well as Shropshire, Telford and Wrekin agencies.

This continues to demonstrate good communication between local organisations and the CDOP service within Shropshire, Telford and Wrekin. Many of the deaths notified within a particular year are not reviewed in the same year because of other review processes, including inquests, criminal processes, post-mortems and internal review processes such as Serious Incident Reviews and Perinatal Mortality Reviews.

Links to coroners and registrars

There continues to be an excellent working relationship with the coroners within Shropshire, Telford and Wrekin, as well as good engagement with Shropshire, Telford and Wrekin registrars.

Communicating with parents, families and carers

The Shropshire, Telford and Wrekin CDOP leaflet, 'What we have to do when a child dies', is distributed by the registrars to families, along with a list of support resources to enable them to exercise some choice if they want to pursue bereavement support. Many will already have had contact with bereavement support resources through the hospitals, but the opportunity to access alternative or additional support is enabled through the provision of this information.

'When a child dies – a guide for parents and carers' is a newly produced leaflet and is provided to all bereaved families or carers: https://www.lullabytrust.org.uk/wp-content/uploads/parent-leaflet-child-death-review.pdf. The leaflet provides a detailed explanation of many of the processes associated with a child's death and contains contact details of the CDOP service admin for further support and advice.

Deaths involving reviews and investigations

Child deaths are considered at panel once all relevant investigations and reports have been completed. These include deaths that have been the subject of a child safeguarding practice review (previously a serious case review (SCR), critical incident review or any learning review.

This approach is consistent with that undertaken across the West Midlands and much of England. This may, on occasion, result in a delay between notification and completion that exceeds the specified six-month timescale. The CDOP service will continue to monitor this process.

National Child Mortality Database

Data collected by the National Child Mortality Database (NCMD) is collated and released on a quarterly basis, with the annual set of data already released for 2024/25 included in this Shropshire, Telford and Wrekin CDOP annual report. The NCMD produces a regional comparative document usually published in Autumn.

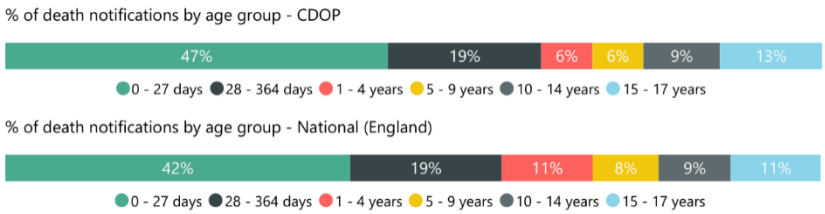
The NCMD has developed some quality standards for notifications, reporting and analysis. Within the Q4 report for this year, all criteria were met.

Section 3: Data and Analysis

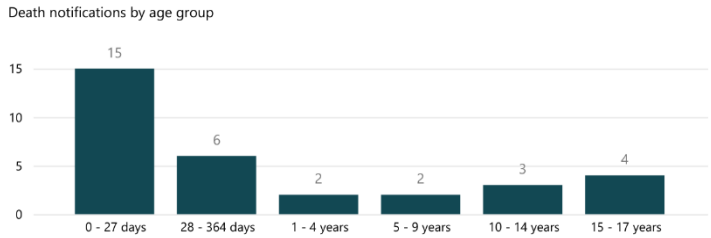
It should be noted that it is often difficult to make clear conclusions analysing data from a relatively small number of cases reviewed each year. The learning from each individual case is noted at each CDOP meeting, with the appropriate action taken at that time. It should be noted that the majority of deaths occurring in any one year, are not reviewed by the CDOP within the same year, due to additional processes, including inquests, criminal processes, post-mortems, and internal reviews such as Serious Incident Reviews, many of which are outside the control of CDOP.

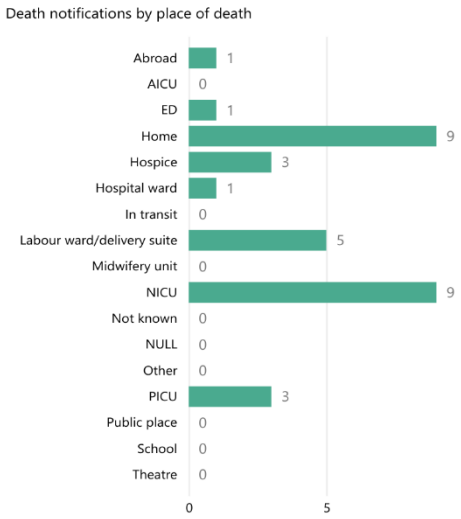
Notifications Overview

A total of 32 deaths were notified in 2024/25: 17 from Shropshire and 15 from Telford & Wrekin. Nearly half (47%) occurred in the first 27 days of life, consistent with national patterns. Most deaths occurred at home or in hospital.



The majority (66%) of deaths occurring were children under 1 year of age compared to 60% in the previous year. This also compared to the national percentage of 61%. There was a slightly higher percentage of neonatal deaths in our area, compared to the national average.





It can be seen that the majority of deaths within hospital occur in the Neonatal Intensive Care Unit and labour/ delivery suite. This reflects the significant proportion of deaths (47%) occuring in the neonatal period, with the majority (66%) occurring within the first year of life.

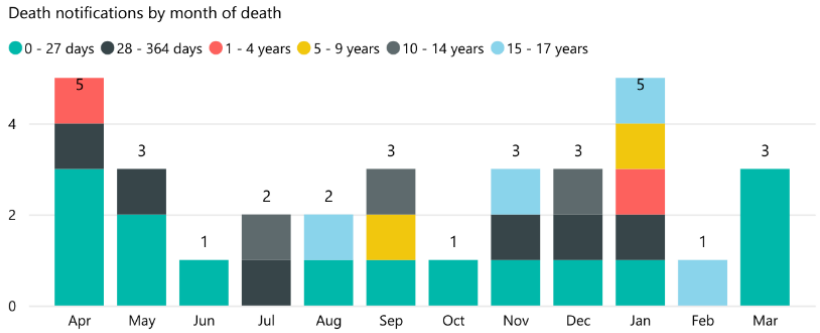
Death notifications by hospital

PlaceOfDeathHospital	Cases
The Princess Royal Hospital, The Shrewsbury and Telford Hospital NHS Trust	6
Birmingham Children's Hospital, Birmingham Women's and Children's NHS Foundation Trust	3
New Cross Hospital, The Royal Wolverhampton Hospitals NHS Trust	3
Birmingham Women's Hospital, Birmingham Women's and Children's NHS Foundation Trust	2
Royal Stoke University Hospital, University Hospitals of North Midlands NHS Trust	2
John Radcliffe Hospital, Oxford University Hospitals NHS Trust	1
Royal Shrewsbury Hospital, The Shrewsbury and Telford Hospital NHS Trust	1
Ysbyty Gwynedd, Betsi Cadwaladr University Health Board	1
Total	**19**

The Princess Royal Hospital (providing childrens, maternity and obstetric care in the system) had the highest number of deaths as a single Trust, although the highest total number of deaths occurred in tertiary centres outside the area. This is not unexpected, as children/ babies attending these facilities are likely to be the most seriously ill. *(Please note data in the table on the right only includes deaths*

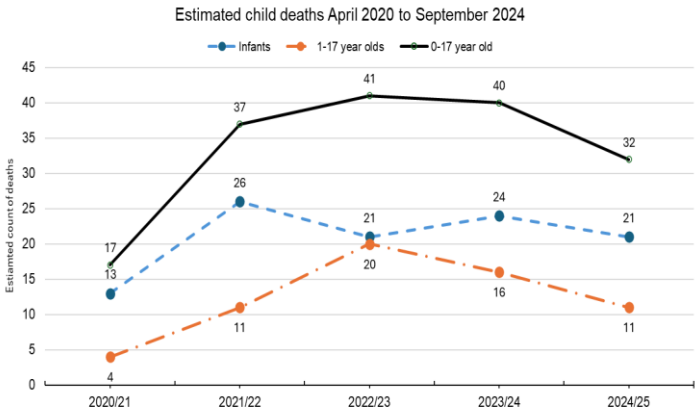
that CDOP were going to review or had reviewed by 31/3/25. It does not include the total number of deaths in each hospital and excludes any death where another CDOP is conducting the review.)

For the year in question it can be seen that January and April had the highest number of deaths. Having reviewed the data from previous years, there appear to be no seasonal patterns in terms of notified deaths.



Annual Comparisons

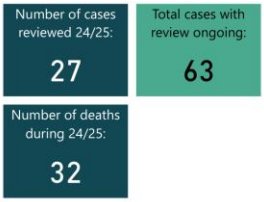
Figures for the 2024/25 period show that there were 32 child deaths over this period, representing a reduction of 8 compared to the previous financial year and the lowest total recorded since 2020/21.. The proportion of neonatal deaths remains high each year, and remains above the England average.

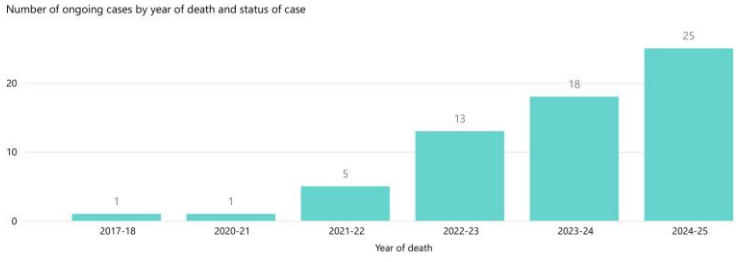


Infant deaths continue to account for the majority of deaths in persons aged under 18 accounting for 66% of deaths in 2024/25.

Ongoing Cases and Reviews

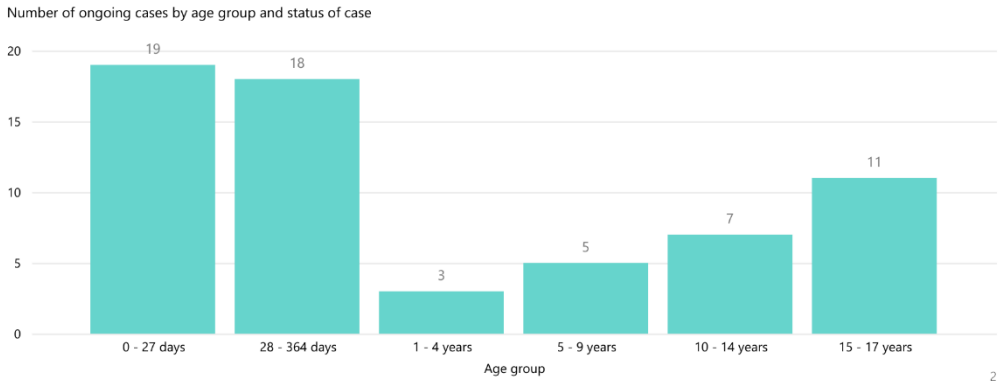
At the end of 2024/25, 63 cases remained ongoing in the CDOP – 33 from Shropshire and 30 from Telford & Wrekin. The majority of these cases relate to deaths in 2023/24 and 2024/25, indicating expected delays between death and review.





Ongoing cases were most frequent in the neonatal and post-neonatal age groups. The Child Death Review Business Group monitors ongoing cases at each of its meetings throughout the year, including reasons for any delays. As CDOP is the final stage of the child death review process, cases are not brought to panel until all other reviews have been concluded e.g. coroners inquests, perinatal mortality reviews, criminal investigations etc. One national issue affecting the local picture is the lack of paediatric pathologists, leading to delays when post mortems are required.

The pattern of ongoing cases in the figure below reflects the overall pattern of deaths by age group, and broadly follows the pattern at a national level.



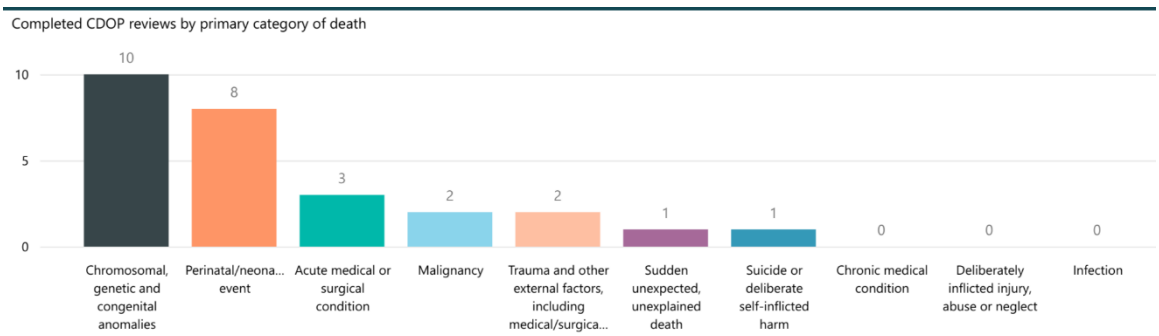
Ongoing cases comprise of those deaths that have been notified to the CDOP service and have not yet been scheduled for a panel. In most cases, CDOP administration is awaiting for the conclusion of various processes and information including:

- Perinatal Mortality Reviews
- Child Death Review Meetings
- Police investigations
- Post mortems
- Inquests
- Children's Safeguarding Practice Reviews

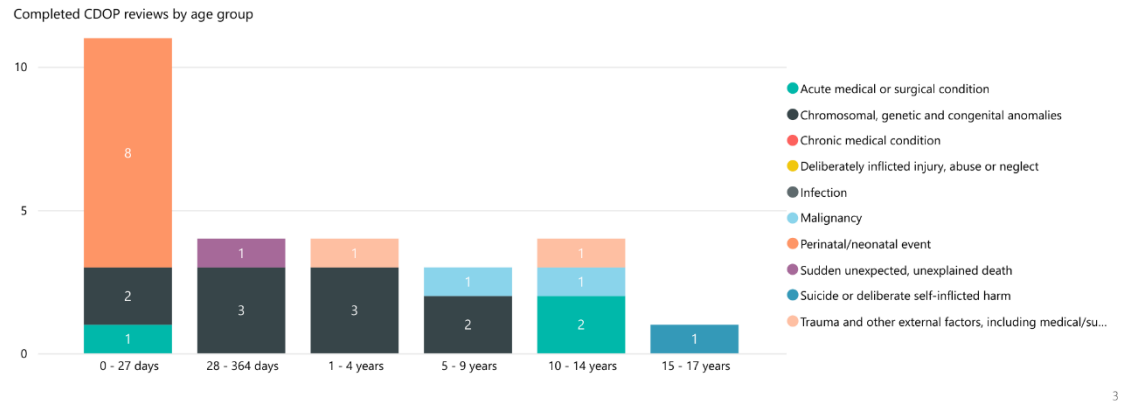
This is why relatively few deaths in any one year get reviewed at CDOP in the same year.

Completed Reviews Overview

A total of 27 reviews were completed in 2024/25. The most common categories of death were chromosomal, genetic and congenital anomalies (10 cases) and perinatal/neonatal events (8 cases).



The largest number of reviews completed were in the 0–27 day-old group, which is the group with the largest number of deaths, and which follows the national picture. Reviews were spread fairly evenly across age groups,.



Local Authority and Year of Death

Of the 27 completed reviews, 17 were for Telford & Wrekin and 10 for Shropshire. Most reviews were for deaths occurring in 2023/24 (15), with 7 relating to deaths in 2024/25, reflecting the typical delay between death and review.

Number of cases reviewed 24/25:

27

Completed CDOP Reviews by LAA

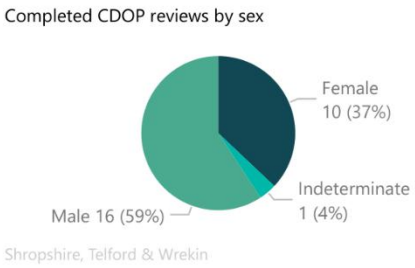
LAA name	Cases
Shropshire	10
Telford & Wrekin	17
Total	**27**

Completed CDOP Reviews by year of death

Year of death	Cases
2022-23	5
2023-24	15
2024-25	7
Total	**27**

26% of reviews were undertaken from the same year that the deaths occurred.

Gender



This chart shows that more male child deaths were reviewed than female, continuing a consistent pattern observed in previous years and aligning with national trends. This gender imbalance is particularly noticeable in neonatal and infant deaths.

Ethnicity and Primary Cause and Age

The majority of reviewed deaths (21) were in White children. Asian or Asian British children accounted for 4 deaths. There were small numbers for other ethnicities. Across all ethnicities, chromosomal anomalies and perinatal events were most common.

Completed CDOP reviews by ethnic group and age group

Ethnic Group	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	Total
White	9	3	2	3	3	1	21
Unknown	1	0	0	0	0	0	1
Other	0	0	0	0	0	0	0
Mixed	0	0	0	0	0	0	0
Black or Black British	0	0	0	0	1	0	1
Asian or Asian British	1	1	2	0	0	0	4
Total	**11**	**4**	**4**	**3**	**4**	**1**	**27**

Completed CDOP reviews by ethnic group and primary category of death

Ethnic Group	Acute medical or surgical condition	Chromosomal, genetic and congenital anomalies	Chronic medical condition	Deliberately inflicted injury, abuse or neglect	Infection	Malignancy	Perinatal/neonatal event	Sudden unexpected, unexplained death	Suicide or deliberate self-inflicted harm	Trauma and other external factors, including medical/surgical complications/error	Total
White	1	8	0	0	0	2	7	1	1	1	21
Unknown	0	0		0	0	0	1	0	0	0	1
Other	0	0	0	0	0	0	0	0	0	0	0
Mixed	0	0	0	0	0	0	0	0	0	0	0
Black or Black British	1	0	0	0	0	0	0	0	0	0	1
Asian or Asian British	1	2	0	0	0	0	0	0	0	1	4
Total	**3**	**10**	**0**	**0**	**0**	**2**	**8**	**1**	**1**	**2**	**27**

Crude trend analysis by ethnicity can be challenging for areas such as Shropshire Telford and Wrekin where one ethnicity is estimated to account to 7-8 of every 10 people. However, published research and national priorities point towards a need to provide support to mothers from minority ethnic groups particularly those from an Asian or Black backgrounds, analysis at this level is still important to understand how different population groups are impacted by child mortality. It is equally important to not overlook persons from a “White Other” ethnicity as this grouping can also include persons who face language and cultural barriers, as well as transient populations.

Locally the table below shows us that the White British ethnic grouping is the only group to have recorded an average of more than 2 deaths per financial year over the past five reporting periods. However, at times the Asian and British Asian, Black and Black British, and Mixed ethnic groups have recorded higher crude mortality rate than the White British ethnicity and combined they do account for around a fifth of all child deaths each financial period.

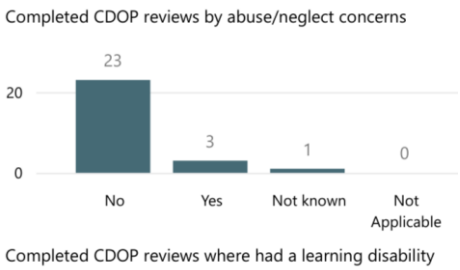
0-17 Population estimates

Ethnic grouping	Census 2021	Registered patient population April 2025
White British	85.1%	73.8%
Mixed	4.5%	3.8%
Asian or Asian British	3.9%	4.8%
White other	3.6%	7.7%
Black or Black British	2.2%	3.1%
Other ethnic groups	0.7%	1.7%

Crude rate per 1,000 population estimate						
Ethnic group	2020/21	2021/22	2022/23	2023/24	2024/25	Average deaths per year (April 2020-March 2025)
Asian and British Asian		0.52	0.77	0.81	0.61	**2**
Black and Black British	0.46		1.36	0.62	0.62	**2**
Mixed		0.22	0.88		0.52	**2**
Other			1.34	1.13		**1**
White - British	0.17	0.38	0.32	0.40	0.32	**26**
White other		0.56	0.55	0.13	0.13	**1**

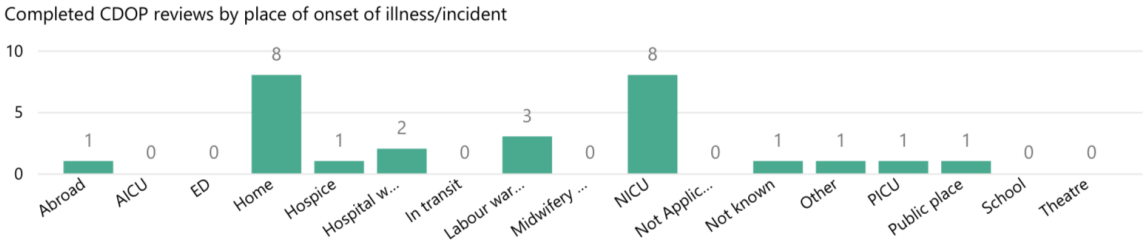
Abuse or Neglect Concerns

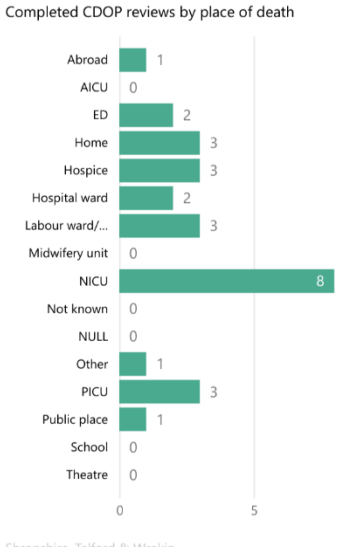
Of those cases reviewed in the year 2024/25, 3 (11%) of the deaths raised concerns of potential neglect or abuse. Where any additional learning is identified at CDOP, this is forwarded to the relevant agencies.



Place of Illness Onset and Death

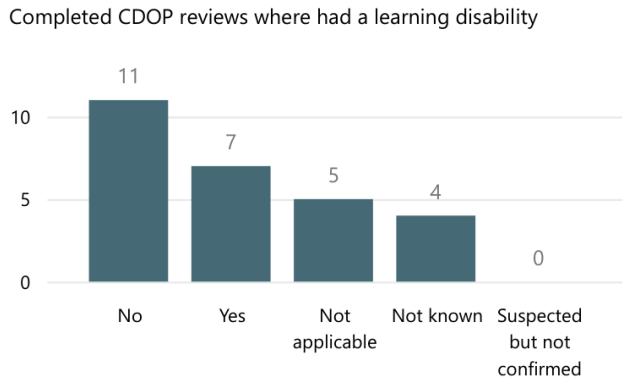
The most frequent onset of illness occurred at home and in neonatal intensive care units (NICU). Similarly, places of death were most commonly the NICU and hospital wards, each accounting for 8 cases reviewed. This reinforces the vulnerability of neonates and infants with serious medical conditions, where hospitals can provide the most appropriate care.





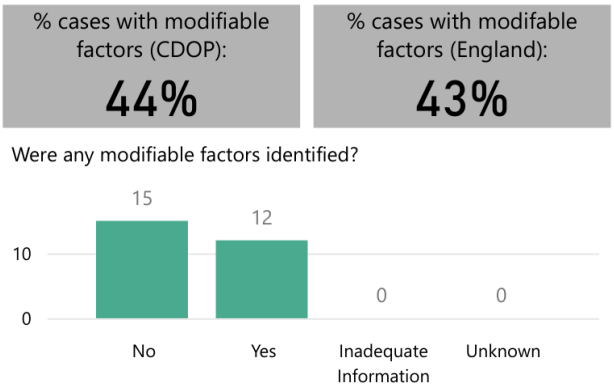
It is unsurprising that the majority of deaths occur in hospital, as this is where treatment is provided for those with prematurity, life-threatening events or conditions.

Learning Disability



This chart shows that 26% of the deaths reviewed had a diagnosed learning disability. Within these cases where learning disabilities were present, these often coexisted with other complex health conditions. The local areas contact for Learning from the lives and deaths of people with learning disabilities and autism (LeDeR) attends CDOPs where such cases are discussed for input of their expertise triangulation of learning.

Modifiable Factors



A modifiable factor is a factor which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths. Modifiable factors were identified in 12 of 27 cases (44%), broadly in line with the national average. These were most prevalent in deaths due to trauma, suicide, unexplained death, and perinatal causes. Older children (10–17 years) and neonates had the highest proportions of modifiable factors. Because of the low numbers in certain categories, for example the age group 15 – 17 years, and Black or Black British, percentages and the colour shading in the tables below need to be treated with caution.

% of cases where modifiable factors were identified by age group

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	11	6	55%
28 - 364 days	4	1	25%
1 - 4 years	4	1	25%
5 - 9 years	3	0	0%
10 - 14 years	4	3	75%
15 - 17 years	1	1	100%
Total	**27**	**12**	**44%**

% of cases where modifiable factors were identified by ethnic group

Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
White	21	9	43%
Unknown	1	1	100%
Other	0	0	0%
Mixed	0	0	0%
Black or Black British	1	1	100%
Asian or Asian British	4	1	25%
Total	**27**	**12**	**44%**

Whilst ***Perinatal / neonatal events*** and ***Chromosomal, genetic and congenital anomalies*** categories of death account for the highest proportion of deaths on an annual basis, arguably it is in the perinatal/ neonatal group that offers an opportunity to impact on overall deaths, because this category also offers a high percentage of modifiable factors.

In general these include:

- high BMI of pregnant mothers
- unsafe sleeping arrangements
- smoking (including mother or both parents)
- use of alcohol
- mental health challenges for mother
- illegal drug use.

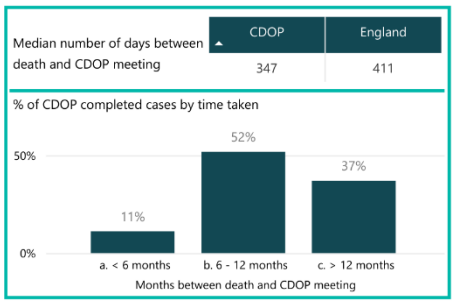
% of cases where modifiable factors were identified by category of death

Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Trauma and other external factors, including medical/surgical complications/error	2	2	100%
Suicide or deliberate self-inflicted harm	1	1	100%
Sudden unexpected, unexplained death	1	1	100%
Perinatal/neonatal event	8	5	63%
Malignancy	2	0	0%
Infection	0	0	0%
Deliberately inflicted injury, abuse or neglect	0	0	0%
Chronic medical condition	0	0	0%
Chromosomal, genetic and congenital anomalies	10	1	10%
Acute medical or surgical condition	3	2	67%
Total	**27**	**12**	**44%**

Within Shropshire, Telford and Wrekin, modifiable factors identified include:

- Parental smoking
- parental drug misuse
- maternal BMI
- unsafe sleeping environment
- recognition of the deteriorating child and escalation

Timeliness and Data Quality



There has been an improvement in the percentage of cases being completed with 63% of deaths reviewed being completed within 12 months, up from 53% in the previous year. Also a reduction in the percentage of cases taking over a year, down from 47% in 2023/24 to 37%. In addition, there has been a marked improvement in the percentage of cases completed within 6 months, up from 6% in 2023/24 to 11%.

Data completeness remains strong, with nearly all key fields completed for both notifications and reviews.

90 - 100% Good level of data completeness
< 90% Data completeness requires improvement

Notification fields - % completion of fields (2024/25 notifications)

CDOP Name	Cases	NHS No	DoD	Sex	Postcode	Suspected CoD	Place of Death	Hospital specified^	Notification Details	Ethnicity	Gestational Age (Under 1s)
Shropshire, Telford & Wrekin	32	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Notification fields - % completion of fields

CDOP Name	Cases	NHS No	DoD	Sex	Postcode	Suspected CoD	Place of Death	Hospital specified^	Notification Details	Ethnicity	Gestational Age (Under 1s)	Investigated by Coroner	Post Mortem
Shropshire, Telford & Wrekin	27	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%

Reporting fields - % completion of fields

CDOP Name	Cases	Events occurred selection	Circumstances of Death	Where at onset of illness	Known to social care	Subject to SCR	Mode of Death	Death subject to JAR
Shropshire, Telford & Wrekin	27	100%	100%	96%	100%	93%	96%	100%

Analysis fields - % completion of fields

CDOP Name	Cases	CDOP category of death	CDOP meeting date	Cause of death	Domain factors recorded (at least 1)	Modifiable factors selection	Learning points text	Actions text
Shropshire, Telford & Wrekin	27	100%	100%	100%	100%	100%	100%	100%

Summary of Actions Taken by CDOP following panel

The following provides a summary of actions undertaken by CDOP throughout the year:

- Followed up with the ambulance service re actions taken by them regarding staff re-training
- Ensured a child's siblings had been supported – the death was some time ago
- Asked for assurance from SATH re communication between midwifery and HV
- Liaised with tertiary centres and other hospitals re ensuring we have invites to CDRM's and the correct information included in reporting forms

Section 4: Priorities, Recommendations and Acknowledgements

Priorities for 2025/26

We have identified the following priorities for 2025/26:

- Maximise the impact of the child death workshops and thematic action plan.
- Provide assurance that multi-agency partner strategies are in place to address modifiable factors.
- Develop a self-assessment framework to provide oversight of areas for improvement within the CDR processes across the system.
- Manage risks and any transitional implications associated with the NHS reorganisations.

Recommendations for strategic partners

Local safeguarding and health and wellbeing partners are asked to:

1. Note the contents of this annual report, and note that Shropshire, Telford and Wrekin has robust processes for oversight and undertaking child death reviews.
2. Continue to assure themselves that through the various strategic partnerships there is an adequate coordinated approach to:
    - The importance of timely and completion of childrens asthma reviews
    - Establishing a children's asthma diagnosis service.
    - Recognition of the deteriorating child, including in the community in older children,
    - Continuing to reduce smoking at time of delivery
    - Preconception care driven by the Local Maternity and Neonatal System (LMNS)
    - Mental health waiting support and triage

Acknowledgements

As noted in the foreword, much of the business of the CDOP and service is dependent on the continued support of panel members and the administrative support. Thank you to the panel members for their continued support and to the senior leadership support at NHS STW and both local authorities.

Appendix I: Category of Death

In light of your consideration of the case, categorise the likely cause of death using the following schema.

This classification is hierarchical. **All relevant categories should be ticked if more than one category could reasonably be applied.** The uppermost ticked category will be recorded as the primary category and others as secondary categories.

Category	Name & description of category
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children. **Please choose from the sub-categories below:**
2 (i)	**Suicide (where the panel feels the intention of the child was to take their own life)**
2 (ii)	**Self-inflicted harm leading to death (where it is unclear if the child's intention was to take their own life)**
2 (iii)	**Death as the result of substance misuse (excluding deaths as a result of a deliberate overdose)**
3	**Trauma and other external factors, including medical/surgical complications/error** This includes isolated head injury, other or multiple traumas, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death. **Excludes** deliberately inflicted injury, abuse or neglect (category 1).
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.

7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week). **Please choose from the sub-categories below:**
8 (i)	**Immaturity/Prematurity related**
8 (ii)	**Perinatal Asphyxia (HIE and/or multi-organ failure)**
8 (iii)	**Perinatally acquired infection**
8 (iv)	**Other (please specify)**
9	**Infection** Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).