Darlington Safeguarding Partnership
Protecting Children and Adults

Durham
Safeguarding Children Partnership

The Child Death Review Process for County Durham and Darlington Annual Report

2024/25

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Foreword

Chair of County Durham & Darlington Child Death Overview Panel

Welcome to annual report of County Durham & Darlington Child Death Overview Panel (CDOP) 2024/25. This report summarises the panel's activity over the last year which aims review all deaths of children normally resident in the County Durham and Darlington area, in order to learn lessons and share any findings for the prevention of future deaths.

The child death process requires agencies to contribute and participate in the review process prior to the case being considered by the Child Death Overview Panel. Thanks must go to all frontline staff and managers involved in this process, without whom we could not fulfil our task.

Meeting virtually is well established and has facilitated professionals' attendance at Joint Agency Response Meetings (JARs) and Child Death Review Meetings (CDRMs) leading to improved information sharing and learning.

The County Durham & Darlington CDOP met four times within the timeframe of this annual report with very good multi-agency attendance. We continue to welcome observers to the Panel from constituent agencies.

CDOP seeks to take action on modifiable risk factors with examples highlighted within the report.

This annual report will assist in ensuring that learning from child deaths reviews is shared with partners and other relevant partnerships including the Health & Wellbeing Board. It is also used to inform the wider Durham Safeguarding Children Partnership and Darlington Safeguarding Partnership annual reports.

I would like to extend a huge thanks to Panel members and Tracy Hetherington as CDOP Co-ordinator for their commitment, support and expertise within the Child Death Review process.

Amanda Healy

Director of Public Health County Durham

Chair of County Durham & Darlington Child Death Overview Panel

Introduction

The death of a child is a devastating loss which profoundly affects all those involved. Since April 2008, all deaths of children up to the age of 18 years, excluding stillbirths and planned terminations, are reviewed by CDOP to comply with the statutory requirement set out in Working Together 2023. In the event of a birth which is not attended by a healthcare professional, child death partners may carry out initial enquiries to determine whether the baby was born alive. If the baby was born alive then the death must be reviewed.

The Children Act 2004 requires Child Death Review (CDR) Partners, (2 Local Authorities from one ICB in our footprint) to ensure arrangements are in place to carry out child death reviews, including the establishment of a CDOP. The reviews are conducted in accordance with Working Together 2023 alongside the Statutory and Operational Guidance (England) 2018. Legislation allows for CDR partners to arrange for review of a death of a child not normally resident there. This process is pragmatic with consideration given to where the most learning can take place.

The statutory task of the multi-agency panel is to scrutinise the circumstances surrounding each child's death and where appropriate, to provide challenge to the agencies involved to enhance learning, as well as to make recommendations to appropriate agencies to improve service delivery and patient experience. The merged panel has been functioning for three years. Meeting virtually is well established and this has facilitated a wider diversity of professionals' attendance at Joint Agency Response meetings (JARs) and Child Death Review Meetings (CDRMs) leading to improved information sharing and learning.

In April 2019 the National Child Mortality Database (NCMD) became operational and is a national repository of data relating to all children’s deaths in England. This will enable more detailed analysis and interpretation of all data arising from the child death review process. County Durham and Darlington CDOP continue to be fully compliant within this process.

The purpose of the panel is to:

- Ascertain why a child has died by a thorough but proportionate review of the facts and circumstances surrounding the death,
- Determine the contributory and modifiable factors,
- Make recommendations to all relevant organisations where actions have been identified which may prevent further deaths or promote the health, safety, and well-being of children,
- Provide detailed data to NCMD which is analysed nationally and regular reports are produced e.g. on the impact of deprivation on child deaths,
- Produce an annual report highlighting local trends and patterns and any actions taken by the panel
- Contribute to the wider learning locally, regionally, and nationally. The CDOP is not commissioned to undertake public health campaigns or deliver interventions arising from the learning from reviews, rather it relies on its' partners in the Health and Well-being Boards and the Safeguarding Children Partnerships to incorporate the lessons learned into policy and develop appropriate interventions.

Child Death Review Process

The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If the Child Death Overview Panel identify action that be taken by a person or organisation, they must inform them.

In addition, the Child Death Review Partners:

- Must prepare and publish reports on:
  - what they have done as a result of the child death review arrangements in their area, *and*
  - how effective the arrangements have been in practice;
- may request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process - the person or organisation must comply with the request, and if they do not, the child death review partners may take legal action to seek enforcement
- may make payments directly towards expenditure incurred in connection with arrangements made for child death reviews or analysis of information about deaths reviewed, or by contributing to a fund out of which payments may be made; and may provide staff, goods, services, accommodation, or other resources to any person for purposes connected with the child death review or analysis process.

Where a case has been subject to an internal or external review/investigation, a copy of the completed action plan that demonstrates that all actions have been addressed is submitted to the CDOP for assurance and recording purposes.

There are three interrelated processes for reviewing child deaths:

1. **Joint Agency Response**

   A co-ordinated multi-agency response (on-call health professional, police investigator, duty social worker), should be triggered if a child's death:

   - is or could be due to external causes;
   - is sudden and there is no immediately apparent cause (including 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; *or*
   - in the case of a stillbirth where no healthcare professional was in attendance.

2. **Child Death Review Meeting (CDRM)**

   This is a multi-agency meeting where all matters relating to an individual's child's death are discussed. The CDRM should be attended by professionals directly involved in the care of that child during life and those involved in the investigation after death. The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved.

   The CDRM could take the form of a final case discussion following a Joint Agency Response, a perinatal mortality review group meeting in the case of a baby who dies in a neonatal unit, or a hospital-based mortality meeting following the death of a child in hospital.

3. **Child Death Overview Panel (CDOP)**

A multi-agency panel set up by CDR partners to review the deaths of all children normally resident in County Durham and Darlington in order to learn lessons and share any findings for the prevention of future deaths.

The CDOP should be informed by a standardised report from the CDRM, and ensures independent multi-agency scrutiny by senior professionals who were not directly involved in the child's care during life.

The Panel has two distinct elements:

- **Case reviews**

  The Panel categorise a likely/cause of death, identify any environmental, extrinsic, medical or personal modifiable factors that may have contributed to the death and consider any agency, strategic, regional and/or national recommendations to prevent future deaths.

- **Business**

  The Panel considers the business arising from case reviews and the other responsibilities and statutory functions of CDOP.

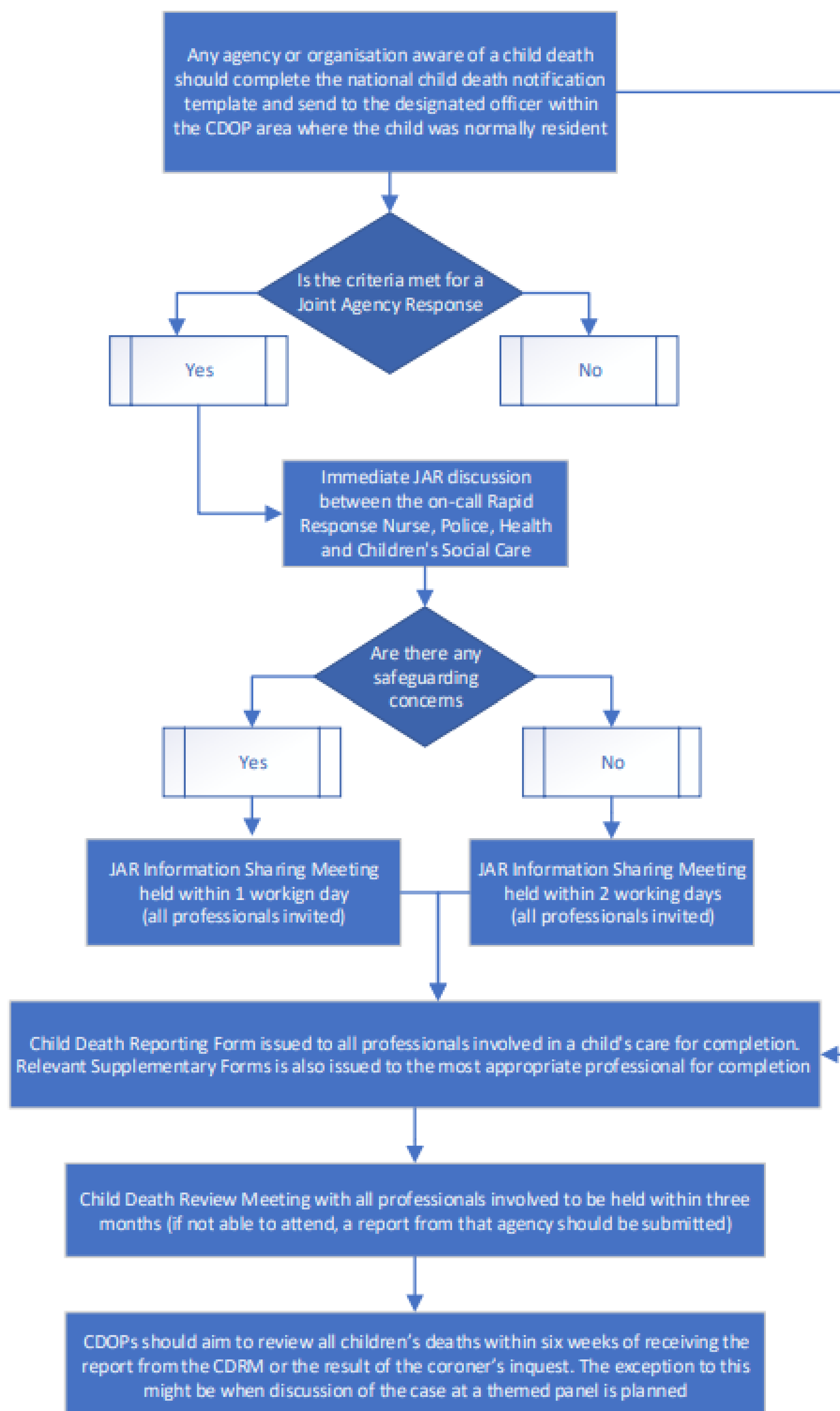
Role of Lead Professionals

The role of the Designated Doctor (child deaths) is carried out by a Consultant Paediatrician and leads in the co-ordinating of responses and health input to the Child Death Review process in County Durham and Darlington.

The Joint Agency Response process is carried out by a team of senior nurses to manage and deliver the process for sudden and unexpected deaths. This ensures their active involvement at the onset of the review process in line with Government guidance. The Joint Agency Response process augments the local review of all unexpected deaths and ensures that parents are engaged and received appropriate support during the process.

CDOP Membership as at 31 March 2025	
Amanda Healy (Chairperson)	Director of Public Health Durham County Council
Paula Mather	Business Manager, Durham Safeguarding Children Partnership
Amanda Hugill	Business Manager, Darlington Safeguarding Partnership
Tracy Hetherington	Child Death Overview Panel Co-ordinator for County Durham & Darlington
Dr Juliet Jude	Designated Doctor for the Child Death Review Process North East & North Cumbria Integrated Children's Board
Catherine Hodgkiss	Rapid Response Manager County Durham & Darlington NHS Foundation Trust
Joanne Stout	Associate Director of Nursing – Family Health County Durham & Darlington NHS Foundation Trust
Dr Nicola Cleghorn	Designated Paediatrician for Safeguarding Children North East & North Cumbria Integrated Children's Board
Detective Superintendent Andy Reynolds	Head of Safeguarding Durham Constabulary
Siobhan Arbon	Strategic Manager – Safeguarding & Professional Practice Durham Children & Young People's Service
Alison Lavender	Head of Service – Early Intervention & First Contact Darlington Children's Services
Nichola Howard	Named Lead Professional for Safeguarding Children North East Ambulance Service NHS Foundation Trust
Amy Cross	Named Nurse Safeguarding Children Tees, Esk & Wear Valleys NHS Foundation Trust
Julie Potts	Named Nurse Child Protection Harrogate & District NHS Foundation Trust

Child Death Review Process Flowchart



Key Achievements for 2024/25

Learning from Child Death Reviews

The aggregated findings from all child deaths informs local strategic planning including the joint strategic needs assessment and assets assessment, on how to best safeguard and promote the welfare of children in the area.

The CDOP is not commissioned to deliver public health interventions but learning from CDOP is shared with partners and integrated into programmes to support the health and wellbeing of children in County Durham and Darlington.

Finalised Child Death Reviews

33 Child Death Reviews were finalised by the Child Death Overview Panel during 2024/25. The aggregated findings from all child deaths informs local strategic planning including the joint strategic needs assessment and assets assessment, on how to best safeguard and promote the welfare of children in the area.

The finalised Child Death Reviews have been uploaded to the National Child Mortality Database which is a repository of data relating to all children's deaths in England. This will enable more detailed analysis and interpretation of all data arising from the child death review process, to ensure that lessons are learned following a child's death that learning is widely shared, and that actions are taken, locally and nationally, to reduce child mortality.

Review of the Governance of the Child Death Overview Panel

This work was completed in February 2024 and a decision was made by the Safeguarding Partners to move the governance out of DSCP/DSP arrangements. As a result, a regional working group has been set up to review the CDOP functions and business support arrangements. County Durham and Darlington are represented on this group

Designated Doctor for Child Deaths

A new Designated Doctor for Child Deaths was successfully appointed in 2023 following the retirement of the previous Designated Doctor. This ensures that there is continuation of the role in leading in co-ordinating the responses and health input to the Child Death Review process.

Child Death Overview Panel Escalation Process

This was developed and agreed in early 2024. The aim of the process is to improve the timeliness of submission of child death review paperwork by relevant agencies. The impact of this was to be evaluated during 2023-24, however due to staffing changes this will be evaluated in 2025/2026.

Guidance for Practitioners on how to complete an effective Child Death Reporting Form

This was developed to support practitioners and provide clarification as to what should be considered when completing the child death paperwork. This has been positively received, particularly those practitioners who have not had any experience in completing such paperwork.

Child Death Review Data & Analysis

There is a well-established system for notifying the CDOP of the death of a child in line with the statutory requirements to report all deaths of children up to the age of 18 years within 24 hours (or next working day) after the death.

All of the below data has been collated from the National Child Mortality Database (NCMD).

Table 1: Total number of death notifications, County Durham and Darlington

Local Authority area	2023-24	2024-2025
Durham	30 (79%)	29 (74%)
Darlington	8 (21%)	10 (26%)
County Durham & Darlington Total	**38**	**39**

There were 39 deaths notified to the CDOP in 2024/25, compared to 38 the previous year. The number of cases notified to CDOP differed from the number of cases reviewed by the Panel during a reporting period as the child death review process prior to the CDOP meeting is often delayed due to other parallel processes, such as coronial, police, Child Safeguarding Practice Reviews, needing to be concluded before CDOP.

Table 2: Age of child at time of death

Days/Years	2023/24	2024/25
0-27 days	20 (53%)	18 (46%)
28-364 days	5 (13%)	7 (18%)
1-4 years	3 (8.5%)	5 (13%)
5-9 years	3 (8.5%)	2 (5%)
10-14 years	5 (13%)	5 (13%)
15-17 years	1 (3%)	2 (5%)
County Durham & Darlington Total	**38**	**39**

The majority of the cases reviewed by the CDOP in 2024/25 were in children <1 year old with 18 cases (46%) in the 0-27 days category and 7 cases in the (18%) 28-364 days category.

Table 3: Place of Death of cases

Place of Death	2023-24	2024/25
Hospital	25 (66%)	31 (79%)
Home	11 (29%)	6 (15%)
Public Place	0	1 (3%)
Abroad	1 (2.5%)	0
Other Residency	1 (2.5%)	1 (3%)
County Durham & Darlington Total	**38**	**39**

In the majority of cases 31 (79%) reviewed by the CDOP the death occurred in hospital which is consistent with the pattern from the previous year.

Table 4: Number of deaths by gender

Gender	2023/24	2024/25
Male	18 (47%)	20 (51%)
Female	20 (53%)	19 (49%)
County Durham & Darlington Total	**38**	**39**

The majority 20 (51%) of cases reviewed by the CDOP in 2024/25 were male children.

Table 5: Number of deaths by ethnicity

Ethnicity (Broad)	2023/24	2024/25
White	33 (87.5%)	36 (92%)
Mixed	1 (2.5%)	1 (3%)
Asian	1 (2.5%)	0
Black or Black British - African	2 (5%)	2 (5%)
Other	0	0
Not Stated	1 (2.5%)	0

County Durham & Darlington Total	**38**	**39**

The majority 36 (92%) of cases reviewed and closed by the CDOP in 2024/25 were relating to white children. This is consistent with the distribution seen in the previous year.

Deaths which have been reviewed and finalised at CDOP

County Durham & Darlington CDOP reviewed and finalised 33 cases during this reporting period. The Panel does not review cases until all information is gathered and other processes have been completed such as Serious Incident Reviews, Root Cause Analysis, criminal proceedings and Serious Case Reviews. At each Panel, the Designated Doctor for Child Deaths presents the circumstances of each death to the multi-agency panel. The case is reviewed in detail and recommendations/actions logged for monitoring purposes.

The number of cases notified to CDOP as noted on page 13 differs from the number of cases reviewed and finalised by the Panel during the reporting period as the child death review process prior to the CDOP meeting is often delayed due to other parallel processes, such as coronial, police, Child Safeguarding Practice Reviews, needing to be concluded before the case reaches CDOP.

In 2024/25 there were 33 deaths reviewed and finalised by the panel compared to 43 the previous year, 27 of these (82%) were in Durham and 6 (18%) in Darlington.

Cases Reviewed and Closed by CDOP County Durham and Darlington in 2024/25

The data in the following tables refer to the reviewed and closed cases for County Durham and Darlington.

Table 6: Total number of deaths reviewed and closed

Local Authority area	2023/24	2024/25
Durham	38 (88%)	27 (82%)
Darlington	5 (12%)	6 (18%)
County Durham & Darlington Total	**43**	33

Table 7: Age of Child at time of death in cases reviewed and closed

Age of Child	2023/24	2024/25
0-27 days	24 (56%)	6 (18%)
28-364 days	3 (7%)	7 (22%)
1-4 years	3 (7%)	6 (18%)
5-9 years	2 (4.5%)	3 (9%)
10-14 years	6 (14%)	5 (15%)

15-17 years	5 (11.5%)	6 (18%)
County Durham & Darlington Total	**43**	**33**

In 2024/25 39% (13) of all reviewed/finalised cases were aged less than 1 year. In 2023/24 this was 63% (27 cases).

Table 8: Place of Death of child in cases reviewed and closed

Place of Death	2023/24	2024/25
Hospice	0	0
Abroad	0	1 (3%)
Hospital	34 (79%)	24 (73%)
Home	8 (19%)	5 (15%)
Public Place	1 (2%)	2 (6%)
Other Residence	0	1 (3%)
County Durham & Darlington Total	**43**	**33**

In the majority of cases reviewed by CDOP deaths occurred in hospital 24 (73%). This has been consistent over time.

Table 9: Gender of child cases reviewed and closed

Gender	2023/24	2024/25
Male	22 (50%)	19 (57%)
Female	22 (50%)	14 (43%)
County Durham & Darlington Total	**43**	**33**

The majority 19 (57%) of cases reviewed by the CDOP in 2024/25 were male children.

Table 10: Ethnicity of child cases reviewed and closed

Ethnicity (Broad)	2023/24	2024/25
White	40 (94%)	29 (88%)
Mixed	0	1 (3%)

Asian	1 (2%)	0
Black	0	3 (9%)
Other	1 (2%)	0
Not Stated	1 (2%)	0
County Durham & Darlington Total	**43**	**33**

The overwhelming majority of cases referred to and closed by CDOP relate to children of White Ethnicity 29 (88%), this is consistent with the distribution seen in the previous year and also reflects the overall composition of the local population.

Table 11: Duration of Reviews, County Durham and Darlington

Duration of Review	2023/24	2024/25
Under 6 months	1 (2%)	0
6-12 months	14 (32%)	4 (12%)
Over 12 months	29 (66%)	29 (88%)
County Durham & Darlington Total	**44**	**33**

The majority of cases (88%) reviewed by CDOP were finalised over 12 months from the date of death. There are several factors that may contribute to a longer length of time between the death of a child and the final CDOP review including delay in the return of reporting forms, awaiting completion of necessary investigations including post-mortem reports or a criminal investigation, or the undertaking of a Child Safeguarding Practice review or Coroner's inquest. All other investigations and reports must be completed prior to review and case closure by the CDOP.

Modifiable Factors

The review process is required to identify modifiable factors in the cases so agencies can learn lessons, improve practice, and ultimately prevent further deaths. A modifiable factor is defined as something which: "may have contributed to the death of the child and which, by means of locally and nationally achievable interventions, could be modified to reduce the risk of future child deaths". While identified modifiable factors by the CDOP provide significant learning to improve practice and prevent future harm, there are opportunities through the entirety of the child death process (including Joint Agency Response Meetings, Hospital Mortality Meetings and Child Death Review Meetings) to identify learning and opportunities for smaller, micro-changes to practice, e.g., a need for workplace training or amendments to internal policies and procedures.

There is a degree of subjectivity in identifying modifiable risk factors which is decided on a case-by-case basis. Information on factors contributing to the child's death is reliant on the thorough completion of national CDOP reporting forms by clinicians. Completion of the CDOP Analysis Proforma is done after the CDRM where all the relevant professionals who know the family share knowledge of the child's life and the circumstances of the death. Four domains are used to categorise the identified risk factors with a corresponding level of relevance (0-2):

0 - Information not available
1 - No factors identified, or factors identified but are unlikely to have contributed to the death
2 - Factors identified that may have contributed to vulnerability, ill health or death

This information should inform the learning of lessons at a local level:

Domain A: Factors intrinsic to the child.
Domain B: Factors in social environment including family and parenting capacity
Domain C: Factors in the physical environment
Domain D: Factors in service provision

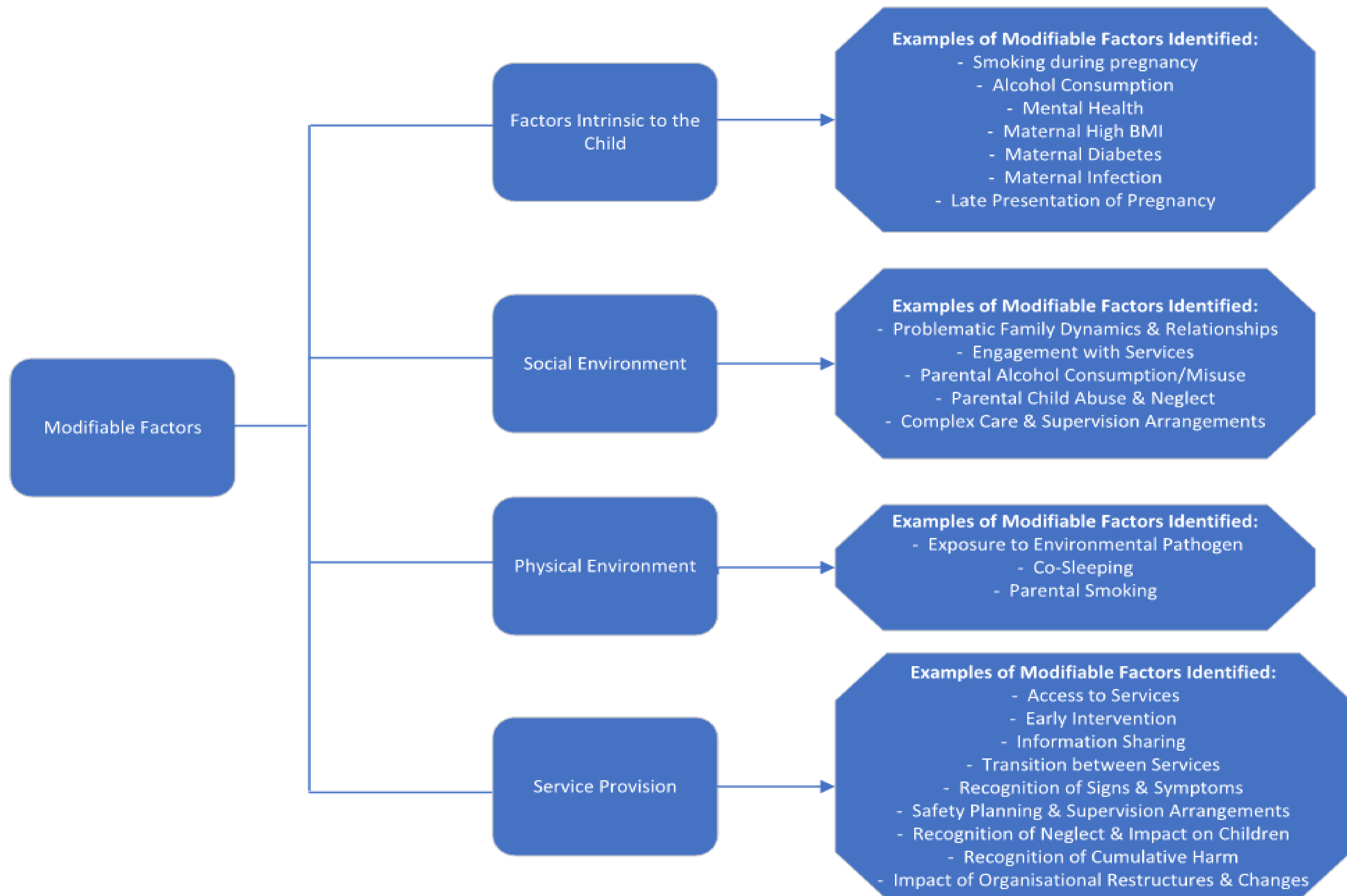
Of the 33 cases reviewed in 2024/25, modifiable factors were identified in 20 (61%).

Table 12: Number and Percentage of reviews completed with identified Modifiable Factors, County Durham and Darlington

Local Authority Area								
	Total Number of Cases		No Modifiable factors		Modifiable Factors		% with modifiable Factors	
	23/24	24/25	23/24	24/25	23/24	24/25	23/24	24/25
Durham	38	27	22	10	17	17	39%	63%
Darlington	5	6	2	3	3	3	7%	50%

County Durham & Darlington Total	**43**	**33**	**24**	**13**	**20**	**20**	**45%**	**61%**

Diagram 1: Examples of modifiable factors identified by CDOP



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Maternal Obesity in Pregnancy

A modifiable and relevant factor highlighted by County Durham & Darlington CDOP is the mother's body mass index (BMI) during pregnancy. For most adults, an ideal BMI is in the 18.5 to 24.9 range (healthy weight range).

The standard BMI ranges for adults in the UK are:

Category	**BMI Range (kg/m²)**
Underweight	< 18.5
Healthy weight	18.5 – 24.9
Overweight	25 – 29.9
Obese	30 – 39.9
Severe obesity	≥ 40

Note: For people from Asian, Chinese, Middle Eastern, Black African or African-Caribbean backgrounds, health risks occur at lower BMI thresholds (Overweight: 23–27.4, Obesity: ≥ 27.5).
Note: People first language in sharing of information verbally would recognise 'those living with obesity/categorised with obesity'.

Relevant NICE guidelines:
Overweight and obesity management (NG246): https://www.nice.org.uk/guidance/ng246
Quality standard on BMI and waist-to-height ratio (QS212):
https://www.nice.org.uk/guidance/qs212
Maternal and child nutrition (NG247): https://www.nice.org.uk/guidance/ng247

Pregnancy recommendations
BMI ranges for pregnancy are the same as for adults and associated with higher risks (gestational diabetes, pre-eclampsia, etc.). NICE advises not to focus on weight loss during pregnancy but to focus on healthy eating and physical activity.

Additional recommendation: Higher folic acid dose (5 mg daily) for BMI ≥ 30 in early pregnancy.
NHS advice on overweight and pregnancy: https://www.nhs.uk/pregnancy/keeping-well/overweight/

Being overweight or obese increases the risk of complications for pregnant women and their babies including gestational diabetes, pre-eclampsia, high blood pressure, shoulder dystocia, premature delivery and risk of stillbirth and birth defects. The higher a woman's BMI, the higher the chance of these complications.

Maternal Diabetes

Maternal diabetes can have significant effects on neonatal outcomes. Babies born to mothers with diabetes are at risk of various complications including:

- Perinatal mortality including stillbirths and neonatal deaths;
- Pre-term births (before 37 completed weeks' gestational age);
- Congenital malformations;
- Increased birthweight;
- Neonatal hypoglycaemia;
- Respiratory distress;
- Pre-eclampsia

Smoking

Smoking continues to have a negative impact on the general health of children and remains a key modifiable factor for child deaths in the North East. The CDOP collates information regarding the smoking status including maternal smoking in pregnancy and smoking in the household during the child's life.

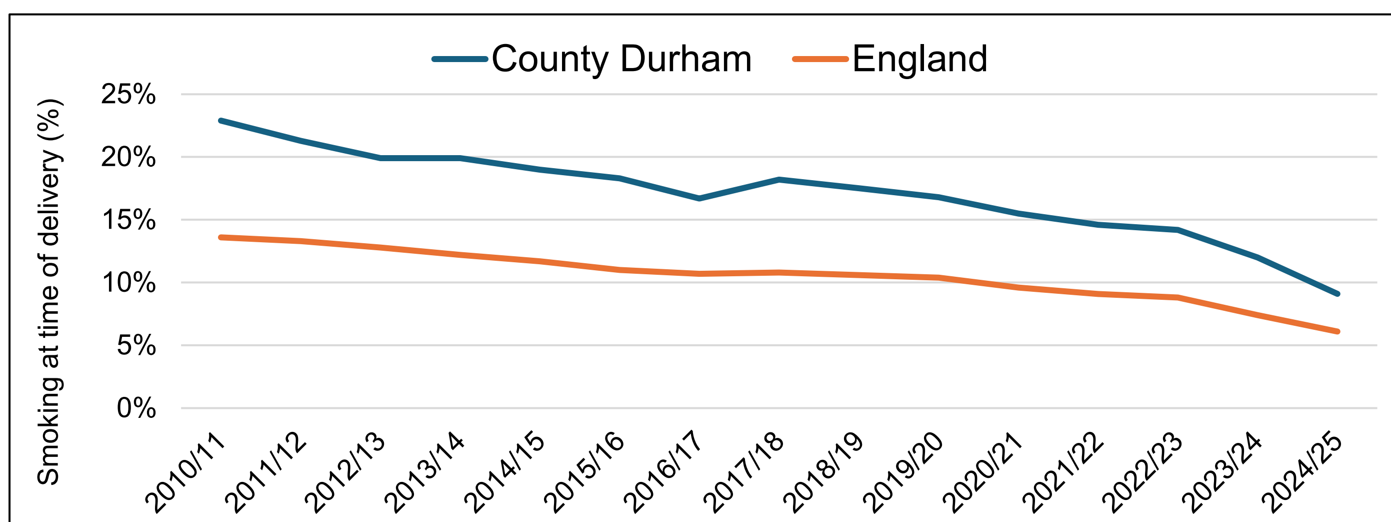
Maternal smoking in pregnancy and/or parental household smoking was the most common occurring modifiable factor which the CDOP deemed a significant relevant factor in relation to the cause of death. A smoke-free home is the best way of protecting babies and children. The update below outlines some of the data and progress made in this area in 24/25.

Tobacco Dependency in Pregnancy (TDiP)

Smoking in pregnancy remains one of the leading preventable causes of poor birth outcomes, infant mortality and long-term health issues. It is strongly linked to poorer maternal and child health outcomes and contributes to widening inequalities for children and families. Tobacco smoke contains harmful substances such as carcinogens and carbon monoxide which can cross the placenta and affect foetal growth and development. Babies born to mothers who smoke are more likely to be born prematurely, have low birthweight and experience respiratory problems, all of which increase the risk of infant death. Smoking in pregnancy is also a recognised risk factor for sudden unexpected death in infancy (SUDI), and exposure to second-hand smoke after birth further heightens this risk.

In County Durham, encouraging progress has been made in reducing rates of smoking at time of delivery (SATOD). Over the last 5 years, the number of babies born to mothers who smoke has fallen by -31.5% (Chart 1)[1]. However, in 2023/24, the proportion of mothers who were SATOD was 12% – a rate significantly worse than England (7.4%) and the North East (10.2%)[2].

Chart 1: Chart 1: Percentage of mothers smoking at time of delivery (SATOD), 2010/11 to 2024/25, County Durham and England.

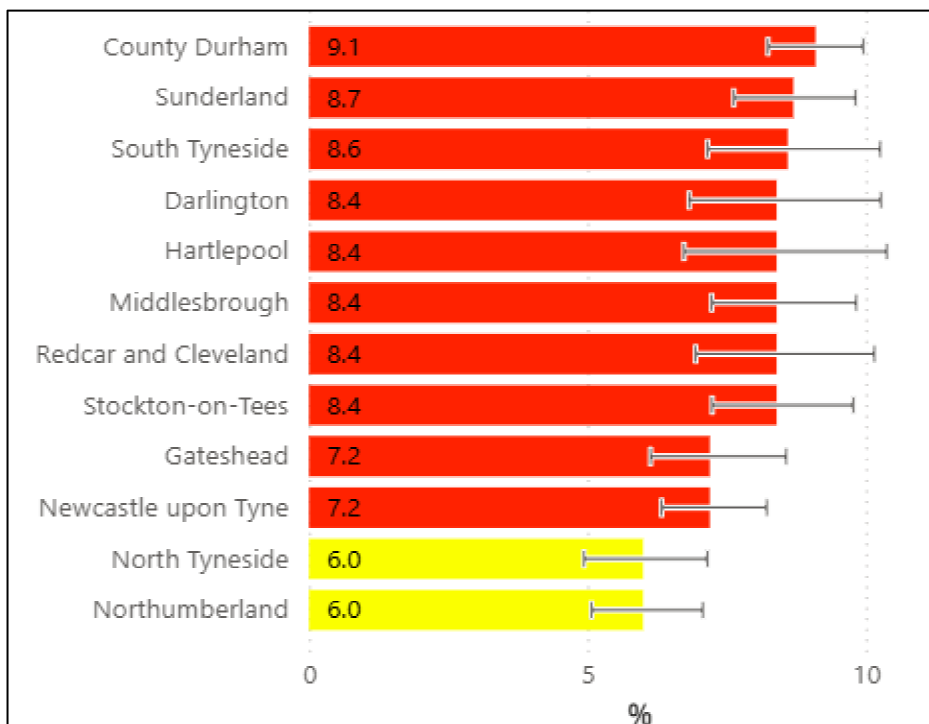


However, despite this reduction the percentage of mothers smoking at delivery in County Durham for 2024/25 (9.1%), remains statistically significantly higher than England (6.1%) and the North East (7.9%) and is the highest of all North East Local Authorities[3]. Locally this proportion equates to almost 400 mothers smoking at time of delivery.

[1] Data analysis and charts sourced from: Durham Insight
[2] Data source, OHID: Child and Maternal Health - Data | Fingertips | Department of Health and Social Care
[3] Data source, OHID: Child and Maternal Health - Data | Fingertips | Department of Health and Social Care

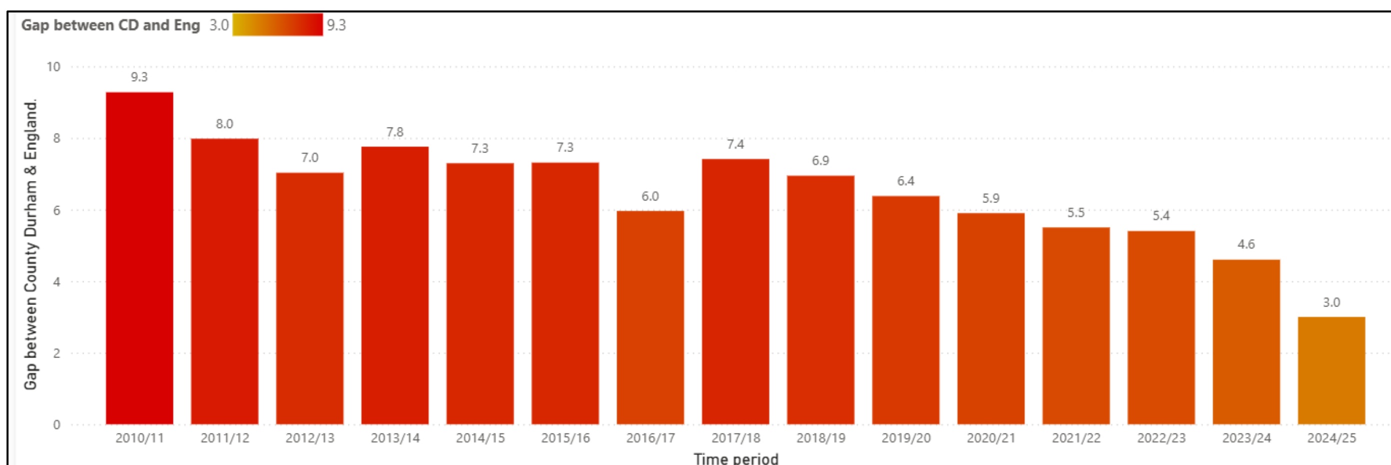
For the year 2024/25 County Durham had the highest proportion of mothers smoking at time of delivery across all North East Local Authorities (Chart 2)) and nationally was ranked 9 out of 153 amongst all local authorities in England. The North East region (10.2%) displays the highest overall SATOD rate of all English regions.

Chart 2: Percentage of mothers smoking at time of delivery (SATOD), North East Local Authorities, 2024/25.



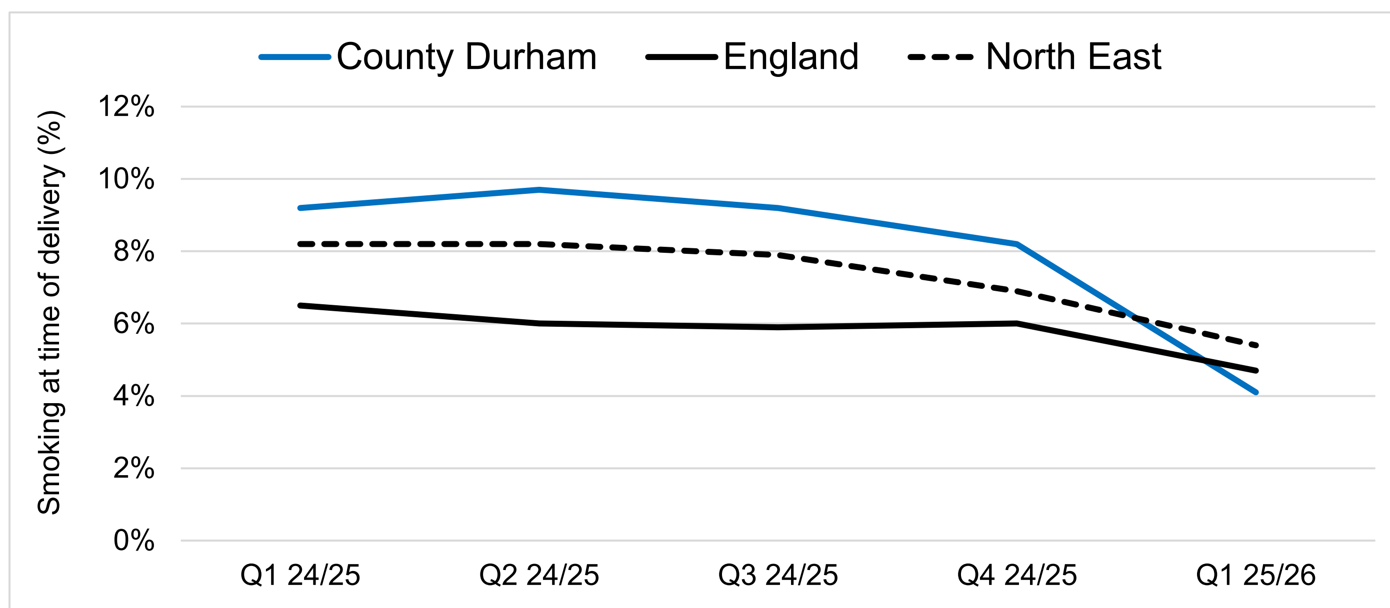
The absolute gap between County Durham and England has been narrowing since 2017/18 years and now stands at 3% (Chart 3).

Chart 3: Absolute gap between County Durham and England



Recent SATOD data from NHS England also shows improvement. The annual SATOD rate for County Durham (at Sub-ICB level) in 2024/25 was 9.1%, down from 12% the previous year (compared to 7.8% across the North East and North Cumbria ICB and 6.1% for England as a whole). The latest quarterly data (Q1 2025/26) shows a further reduction to 4.1%, lower than both the regional (5.4%) and national (4.7%) figures (Chart 4). The gap with England has narrowed from 5.9 to 3.0 percentage points since 2020/21.

Chart 4: Proportion of mothers smoing at time of delivery, quarterly, Q1 2024/25 to Q1 2025/26, County Durham, North East region and England.



While we have made progress, local data still shows a wide gap in outcomes across the county – with SATOD rates ranging from 1.6% to 33.9% depending on where people live. An equity analysis carried out by County Durham's Public Health Intelligence team confirmed that the highest smoking rates are concentrated in the most deprived communities. Babies born to mothers who smoke are disproportionately from these areas, where the inequality gap in SATOD rates has increased to over 150%. The findings have helped to identify where the impact of smoking-related risks to infant health is greatest.

To address this, the Tobacco Dependency in Pregnancy (TDIP) Steering Group has taken a structured approach to driving change. As well as the equity analysis to guide targeted action, this has included an Action SWOT review and a large multi-agency workshop in May 2025. Over 70 professionals took part, identifying practical steps to make support more accessible, reduce stigma, strengthen pathways between maternity, early years and children's services, and embed prevention earlier. These insights have directly shaped a new TDIP Action Plan, which sets out system priorities and a local ambition to reduce SATOD to 0% by 2029/30 – going beyond the national target of 5%.

Reducing smoking in pregnancy and promoting smoke-free families is central to improving outcomes for children in County Durham. For CDOP, this work is particularly relevant given the strong association between maternal smoking, health inequalities, SUDI, and other causes/determinants of infant death. Continued system-wide focus on prevention and equity in relation to smoking in pregnancy and childhood exposure to second-hand smoke will help to reduce avoidable infant deaths and give more children the best start in life.

While we have made progress, local data still shows a wide gap in outcomes across the county – with SATOD rates ranging from 1.6% to 33.9% depending on where people live. An equity analysis carried out by County Durham's Public Health Intelligence team confirmed that the highest smoking rates are concentrated in the most deprived communities. Babies born to mothers who smoke are disproportionately from these areas, where the inequality gap in SATOD rates has increased to over 150%. The findings have helped to identify where the impact of smoking-related risks to infant health is greatest.

To address this, the Tobacco Dependency in Pregnancy (TDIP) Steering Group has taken a structured approach to driving change. As well as the equity analysis to guide targeted action, this has included an Action SWOT review and a large multi-agency workshop in May 2025. Over 70 professionals took part, identifying practical steps to make support more accessible, reduce stigma, strengthen pathways between maternity, early years and children's services, and embed prevention earlier. These insights have directly shaped a new TDIP Action Plan, which sets out system priorities and a local ambition to reduce SATOD to 0% by 2029/30 – going beyond the national target of 5%.

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Modifiable factors associated with Sudden and Unexpected Death in Infancy/Childhood (SUDI/C)

In deaths categorised as sudden unexpected or unexplained, the CDOP highlighted several modifiable factors identified including:

- Unsafe sleeping arrangements such as co-sleeping.
- Alcohol consumption by the young person.
- Children and Young People's Mental Health

The update below outlines the work in this area during 24/25.

Eyes on the Baby Project

This project was initiated following an initial brief from CDOP that identified SUDI as a theme and key stakeholders were asked to consider what action was needed to reduce the number of sudden infant deaths in the area. They Eyes on the Baby project was a collaborative piece of work conducted by key stakeholders. A training and implementation package to promote safer sleeping and prevent sudden infant deaths was launched in 2023 and is available via the Durham Safeguarding Partnership platform.

A regional steering group meets regularly to coordinate the regional response to this important area of work. The group also organised a successful regional Eyes on the Baby Sharing Event in May 2025 which was attended by partners from a range of organisations across the region. The regional approach to his work is being coordinated via the Regional Children and Young People's leads group.

As part of the work on SUDI Prevention in County Durham the County Durham Start for Life Fund (SFLF) was set up. The fund compliments wider Injury Prevention work and provides safety resources, such as safe sleeping equipment, for families on the referral of a professional reducing rates of Sudden Unexpected Death in Infancy and child hospital admissions resulting from accidents. The SFLF was launched in September 2023, and during its first year of operation (to end August 2024) 679 families with a total of 988 children were supported.

Deprivation

Deprivation is a key factor that is associated with poorer outcomes for child health and wellbeing. Higher levels of deprivation continued to be associated with higher infant mortality rates. The ONS reports that nationally infant mortality in the most deprived 10% is more than double that in the least deprived 10% of areas[4]. However, this is not the case in County Durham and Darlington (chart 5).

The Indices of Deprivation (IoD2025) measure multiple dimensions of neighbourhood deprivation in 33,755 small areas or neighbourhoods, called Lower-layer Super Output Areas (LSOAs), in England. The IoD25 suite of resources comprises of 7 standalone domains which are combined and weighted together to form the Index of Multiple Deprivation 2025 (IMD25), the official measure of deprivation in England.

The seven domains used to create the Indices of Multiple Deprivation (IMD) are:

Income (22.5% of the IMD): The proportion of the population in an area experiencing deprivation relating to low income.

Employment (22.5% of the IMD): The proportion of the working-age (18-66) population who are involuntarily excluded from the labour market e.g. by unemployment, sickness or disability, or caring responsibilities.

[4] Child and infant mortality in England and Wales: Office for National Statistics, 2023

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Education, skills and training (13.5% of the IMD): Looks at barriers to learning and skills development across all ages in the local population.

Health and disability (13.5% of the IMD): Reflects the risk of premature death and the impairment of quality of life through poor physical or mental health.

Crime (9.3% of the IMD): Measures the risk of personal and material victimisation at a local level.

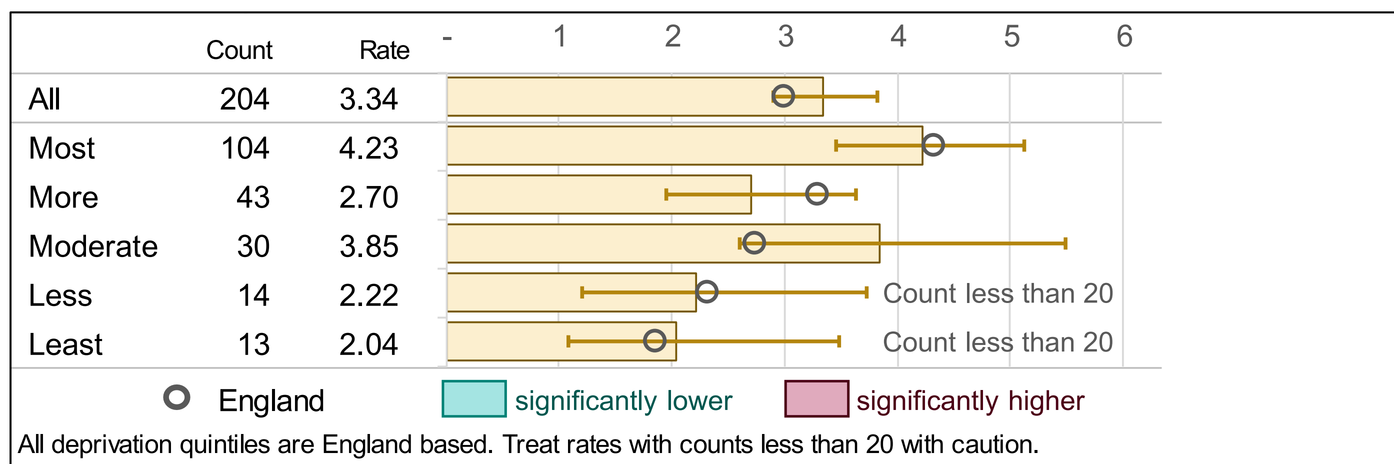
Barriers to housing and services (9.3% of the IMD): The physical and financial accessibility of housing and local services.

Living environment (9.3% of the IMD): The quality of the local environment

By creating a weighted average of the combined ranks for the LSOAs in larger areas an IMD ranking can be derived. In this way, local authorities can be ranked in terms of their deprivation; a range of 1 is the most deprived and 317 is the least deprived.

- Overall, County Durham is the 40th most deprived Local Authority in England, more deprived than 84% of local authority districts in England.
- Overall, Darlington is the 55th most deprived Local Authority in England, and is more deprived than 65% of local authority districts in England.

Chart 5: County Durham and Darlington crude mortality rate per 10,000 population with 95% confidence intervals, compared to England, aged 0-17 years, by deprivation quintile (Indices of Deprivation 2025), 2020-2024 pooled.
Source: ONS based registered deaths 2020-2024, LKIS North East & Yorkshire



- Age group specific mortality rates (aged 0-17 years) by deprivation quintile in County Durham and Darlington are similar to those in England (Chart 5). This indicates that the observed differences are not statistically significant. Additionally, caution is advised for quintiles with fewer than 20 cases (Less and Least deprived), as small numbers reduce reliability. Overall, the data does not demonstrate a significant association between deprivation quintile and child death rates in County Durham and Darlington for the period 2020-2024.

Table 14: Category of child deaths

The categories below are determined by the DfE and every CDOP nationally follows them.

Category		2023/24	2024/25
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	0	2 (6%)
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	3 (7%)	1 (3%)
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, 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)	5 (12%)	4 (12%)
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.	1 (2%)	2 (6%)
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	2 (5%)	8 (24%)
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	2 (5%)	0
7	**Chromosomal, genetic or congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac	10 (24%)	4 (12%)
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)	15 (35%)	9 (27%)
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.	2 (5%)	0
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)	3 (7%)	3 (9%)

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Recommendations and Learning from CDOP 2024/25

e-CDOP Implementation

Currently in County Durham and Darlington the system for notifying the CDOP of the death of a child is via e-mail using a report template provide by the NCMD; there is a real risk of duplication and/or notifications not being received immediately following the death of a child which is a statutory requirement. The Public Health Programme Manager has been working closely with procurement and legal services to acquire the e-CDOP system which is the national electronic system and all agencies will receive full training prior to the implementation. Agency data is then transferred to NCMD, reducing duplication.

Dissemination of learning from reviews

Panel members are tasked with taking the learning from individual cases and share this widely within their organisations and networks so staff in all partner agencies are aware of modifiable factors when supporting and advising parents/carers and children/young people.

This report will be shared with all lead agencies and will be available on the websites of Durham County Council, Public Health.