



Gloucestershire Child Death Overview Panel Annual Report

2024–25

Gloucestershire Child Death Overview Panel



Contents

Introduction and Context	3
Key Data and Observations	3
Child Death Notifications: A Five-Year Perspective	4
Gender Distribution of Child Deaths	5
Age Distribution of Child Deaths	5
Ethnicity and Representation in Child Deaths	5
Religion and Data Collection Challenges	6
Deprivation and Child Mortality Patterns	6
Neonatal Deaths: A Closer Look	6
CDOP Panel Activity	7
ALTE Reviews	8
Achievements in 2024–25	8
Plans for 2025–26	9
Multi-Agency Challenges	9
National Comparisons and Local Insights	10
Conclusion	10
Data Presentation	
Total Data	11
Expected and Unexpected Deaths Data	20
Neonatal Data	23

Introduction and Context

The death of a child is a rare but deeply tragic event that reverberates through families, communities, and professional networks. In Gloucestershire, the Child Death Overview Panel (CDOP) plays a vital role in ensuring that each child’s death is respectfully reviewed, and that any learning which may help prevent future deaths is identified and acted upon.

This annual report for 2024–25 not only outlines the number and nature of child deaths across the county but also provides a structured analysis of patterns and trends over time. By examining five years of data, the report seeks to reduce the impact of year-on-year variation and uncover longer-term themes. It compares local findings with regional and national benchmarks, offering insights into areas such as neonatal mortality, unexpected deaths, deprivation, ethnicity, and age distribution.

The analysis highlights both expected consistencies—such as the vulnerability of infants and adolescents—and unexpected findings, including a higher proportion of deaths in less deprived areas and a disproportionate representation of ethnic minority children. These observations prompt further reflection on service provision, health equity, and the need for targeted public health interventions.

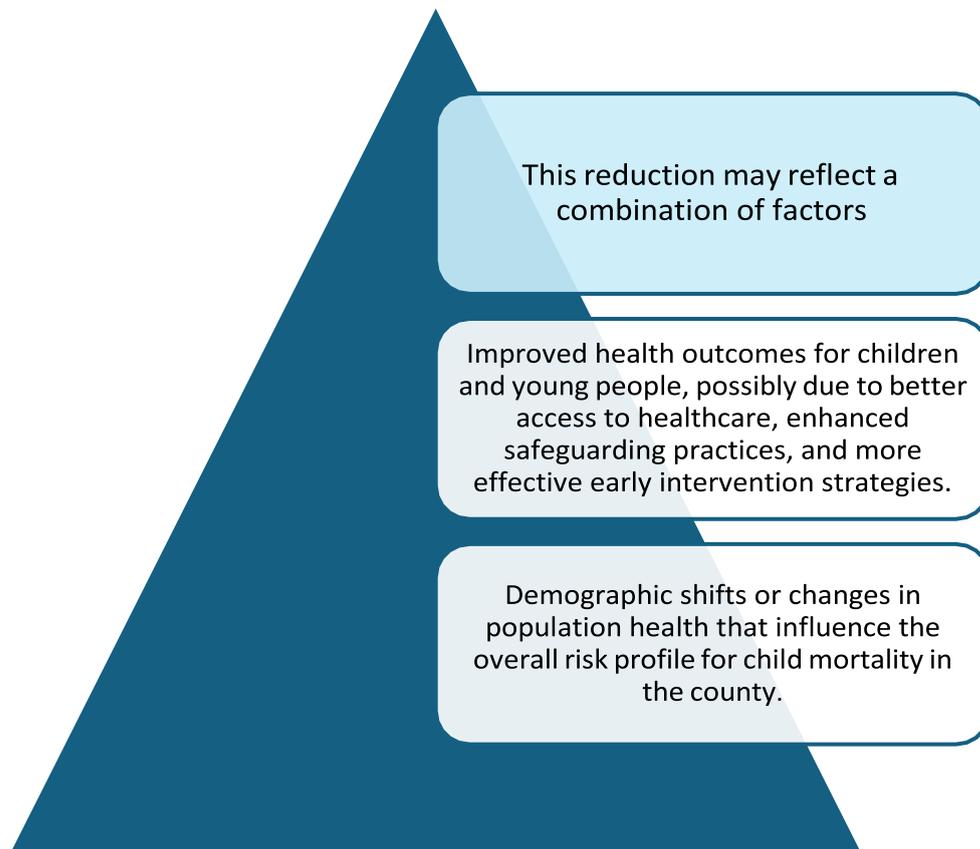
Through this report, Gloucestershire CDOP reaffirms its commitment to learning, collaboration, and continuous improvement in safeguarding the lives of children and young people.



Key Data and Observations

Child Death Notifications: A Five-Year Perspective

Between April 2024 and March 2025, 25 child deaths were notified in Gloucestershire. This figure is identical to the previous year (2023–24), suggesting a degree of stability in annual reporting. However, when viewed in the context of the preceding years, a clear downward trend emerges.



While the numbers are small and subject to natural fluctuation, the five-year data provides a valuable lens through which to assess longer-term patterns. It also reinforces the importance of maintaining consistent review processes and ensuring that all deaths are captured and analysed to inform future prevention efforts.

Gender Distribution of Child Deaths

In the reporting period from April 2024 to March 2025, the gender distribution of child deaths in Gloucestershire was nearly equal, with 12 males and 13 females. This balance marks a shift from previous years, where female deaths had been more prevalent.

This change suggests that, at least for this reporting year, there is no significant gender disparity in child mortality within the county. It should be noted the numbers are small and should be interpreted with caution.

It is important to continue monitoring this data over time to determine whether this balance is sustained or if any emerging trends require further investigation. Gender-based analysis remains a key component of understanding vulnerability and tailoring interventions appropriately.

Age Distribution of Child Deaths

The age profile of child deaths in Gloucestershire during 2024–25 revealed a clear bimodal pattern. The highest number of deaths occurred in two distinct age groups: infants under one year of age and older children aged between 10 and 17 years.

This distribution is consistent with both regional and national data. Infant deaths often reflect vulnerabilities related to neonatal health, congenital conditions, and complications around birth. Meanwhile, deaths among adolescents are more likely to be associated with external factors such as mental health challenges, risk-taking behaviours, trauma, or self-harm.

The presence of these two peaks highlights the importance of targeted interventions at both ends of the age spectrum. For infants, continued focus on maternity care, neonatal services, and early health screening remains essential. For older children and teenagers, multi-agency efforts around mental health support, safeguarding, and education are critical to reducing risk and improving outcomes.

Ethnicity and Representation in Child Deaths

The analysis of ethnicity in child death notifications for Gloucestershire in 2024–25 reveals a concerning disparity. Children from ethnic minority backgrounds were disproportionately represented in the data when compared to their share of the local population.

According to the 2021 Census, only 6.9 percent of Gloucestershire residents identify as belonging to an ethnic minority group (excluding white minorities), which is significantly lower than the national average of 12.3 percent. However, the proportion of child deaths involving ethnic minority children exceeded this local baseline, suggesting that these groups may face heightened vulnerabilities.

This overrepresentation raises important questions about health equity, access to services, and the broader social determinants of health. It may reflect differences in socioeconomic status, cultural barriers to healthcare engagement, or systemic inequalities in service provision. While the numbers are small and must be interpreted with care, the trend is consistent enough to warrant further investigation.

Understanding and addressing these disparities is essential to ensuring that all children, regardless of background, receive equitable care and support. The CDOP's continued focus on ethnicity data will help inform targeted interventions and culturally responsive practices across Gloucestershire's health and safeguarding systems.

Religion and Data Collection Challenges

In the 2024–25 reporting period, religious affiliation was not stated in 14 out of the 25 child death cases reviewed. This represents more than half of the total and highlights an ongoing challenge in capturing accurate data on religion, particularly for infants and younger children who may not yet have expressed personal beliefs.

In many cases, religion may be inferred from parental affiliation, but this is not always recorded or considered reliable. The absence of this information limits the ability to explore potential cultural or faith-based factors that might influence health behaviours, access to services, or bereavement support needs.

Nationally, there is a growing trend of individuals identifying as having no religion, especially among younger populations. However, the data remains incomplete and inconsistent, making it difficult to draw firm conclusions or identify patterns. Continued efforts to improve the quality and consistency of data collection in this area will be important for future analysis and service planning.

Deprivation and Child Mortality Patterns

One of the more unexpected findings in the 2024–25 data is the relationship between deprivation and child deaths. Contrary to national patterns, where higher levels of deprivation are typically associated with increased child mortality, Gloucestershire's data shows a greater number of deaths occurring in the less deprived deciles.

This trend has not only emerged in the current year but has also persisted across the past five years, suggesting it is not a statistical anomaly. It raises important questions about the local socioeconomic landscape and the accessibility of services across different communities.

This finding warrants further investigation. Understanding why child deaths are more prevalent in less deprived areas could help refine local public health strategies and ensure that resources are targeted effectively to where they are most needed.

It should be noted that the deciles are taken from the 2019 survey.

Neonatal Deaths: A Closer Look

Neonatal deaths in Gloucestershire continued to decline in 2024–25, with 11 cases reported, most occurring in hospital settings such as Gloucestershire Royal and St Michael's in Bristol. The majority of these deaths involved White–British infants, reflecting local demographics. However, the recurring pattern of higher death rates in less deprived areas remains unusual compared to national trends and suggests a need for further investigation into local health and social dynamics.

11 neonatal deaths in 2024–25, continuing a five-year downward trend

Most occurred in hospital settings, particularly:

- Gloucestershire Royal Hospital
- St Michael’s Hospital, Bristol

Deprivation data showed higher rates in less deprived areas

Majority were White–British, consistent with local demographics.

CDOP Panel Activity

In 2024–25, the Gloucestershire CDOP successfully closed 49 cases, reflecting a significant effort to address both current and historic reviews. The leading cause of death was perinatal and neonatal events, accounting for 20 cases, followed by infection and congenital anomalies. A smaller number of cases involved suicide, self-harm, trauma, and neglect. The panel continues to prioritise older cases affected by previous delays, while maintaining momentum in reviewing new notifications, ensuring that learning is captured and shared across the partnership.

49 cases were closed in 2024–25.

Causes of death included:-



Perinatal/Neonatal events (20 cases)



Infection (5)



Congenital anomalies (5)



Suicide/Self-harm (2)



Trauma and neglect (3 combined)

ALTE Reviews

Over the past five years, Gloucestershire CDOP conducted 21 reviews of Acute Life-Threatening Events (ALTEs), which involve sudden collapses requiring intensive care. In 2024–25, nine referrals were made, with four meeting the criteria for review. These cases included serious incidents such as overdose, drowning, and attempted suicide, highlighting the importance of coordinated multi-agency responses and safeguarding measures to prevent further harm.

Acute Life Threatening Events (ALTE's) are serious collapses requiring intensive care



21 ALTE reviews were conducted over five years



In 2024–25, 9 referrals were made, with 4 meeting review criteria.



These cases included incidents such as overdose, drowning, and attempted suicide.

Achievements in 2024–25

During the year, Gloucestershire CDOP strengthened its partnerships with bereavement charities, including 2wish and Sunflowers, to improve support for families. The team actively promoted the child death review process at regional induction events and worked to update local protocols. These efforts helped enhance inter-agency communication and deepen collaboration with police and health colleagues, contributing to a more coordinated and responsive system.

Achievements in 2024–25



Strengthened partnerships with bereavement charities:
2wish and Sunflowers



Promoted CDOP processes at regional induction events.



Enhanced relationships with police and health colleagues.



Updated protocols and improved inter-agency communication.

Plans for 2025–26

The panel aims to clear the remaining backlog of cases and significantly increase closures, while ensuring learning is shared widely across agencies. A strong focus will be placed on delivering targeted training to professionals including school nurses, suicide charities, GRH staff, and newly qualified social workers. Plans also include improving public health messaging, particularly around seasonal risks, revisiting cases from 2021 to 2023 to identify modifiable factors and refining how cause of death data is analysed and presented to better inform future prevention work.



Multi-Agency Challenges

Despite strong collaboration across agencies, Gloucestershire CDOP continues to face operational challenges that impact the consistency and effectiveness of the child death review process. One key issue is the recommendation for joint home or scene visits by health professionals and police following a child's death. While this practice is supported by national guidance, it is not a statutory requirement and is not currently included in the contractual responsibilities of Designated Doctors in Gloucestershire. As a result, such visits are undertaken voluntarily and unsustainably, raising concerns about long-term feasibility without additional funding and formal role adjustments.

Another recurring challenge involves the timeliness of death notifications, particularly when a child dies on an adult hospital ward. Staff in these settings may be unfamiliar with CDOP protocols, and the urgency required in initiating the review process. This can lead to delays in information sharing and hinder the panel's ability to conduct prompt and thorough reviews. Addressing these gaps will require targeted training, clearer guidance, and improved communication across all healthcare environments where children may be treated.

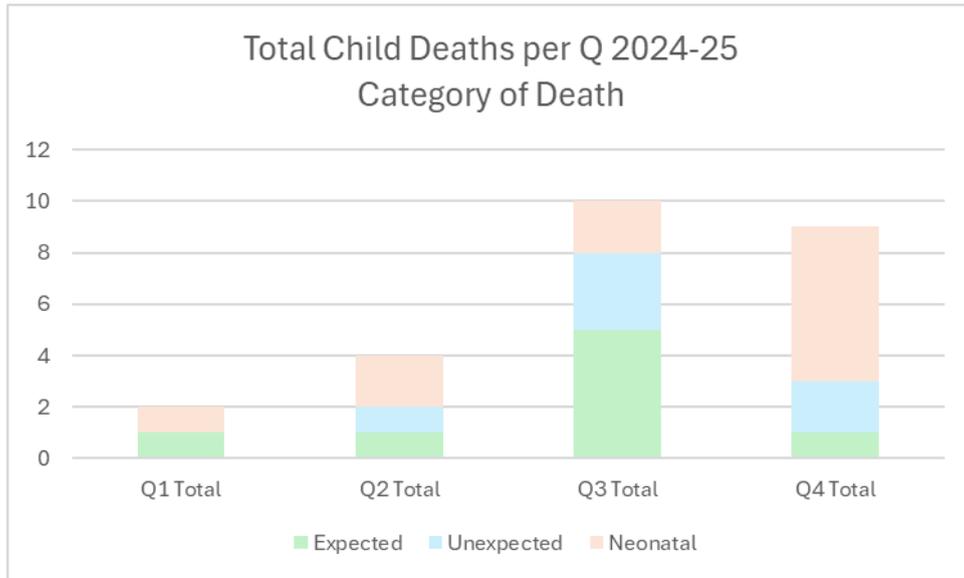
National Comparisons and Local Insights

Gloucestershire's child death data broadly reflects national trends in age distribution and neonatal vulnerability, with similar peaks in infancy and adolescence. However, differences emerge in ethnicity and deprivation. Ethnic minority children are overrepresented in local death notifications compared to their proportion of the population, a pattern that mirrors national data. According to the National Child Mortality Database, the highest child death rates are among Black or Black British children (55.4 per 100,000), followed by Asian or Asian British children (46.8 per 100,000), both significantly higher than rates for White children. In Gloucestershire, ethnic minority residents make up just 6.9 per cent of the population (excluding white minorities), yet their representation in child death data exceeds this, suggesting disparities in health outcomes and access to services. Additionally, Gloucestershire shows a higher number of deaths in less deprived areas, which diverges from national expectations and may reflect differences in service provision or hidden vulnerabilities. These findings highlight the need for further local analysis and culturally responsive approaches to child health and safeguarding.

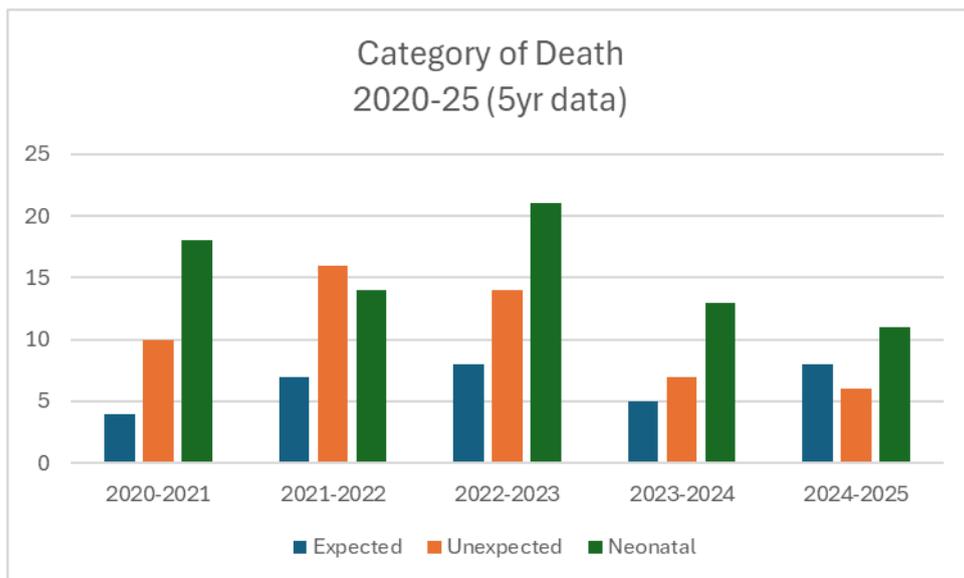
Conclusion

The Gloucestershire CDOP Annual Report 2024–25 presents a comprehensive review of child deaths across the county, identifying key patterns and areas for improvement. While overall numbers remain low and broadly align with national trends in age and neonatal vulnerability, notable local differences in ethnicity and deprivation highlight the need for targeted, culturally sensitive interventions. The panel has made significant progress in closing cases and strengthening multi-agency collaboration, but challenges remain around timely notifications and sustainable home visit practices. Continued focus on learning, equity, and service development will be essential in reducing preventable deaths and improving outcomes for children and families across Gloucestershire.

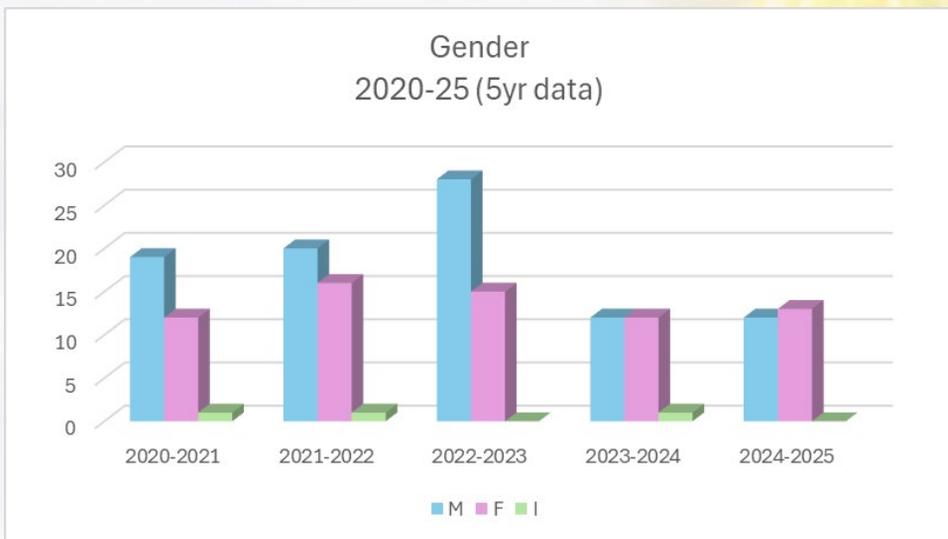
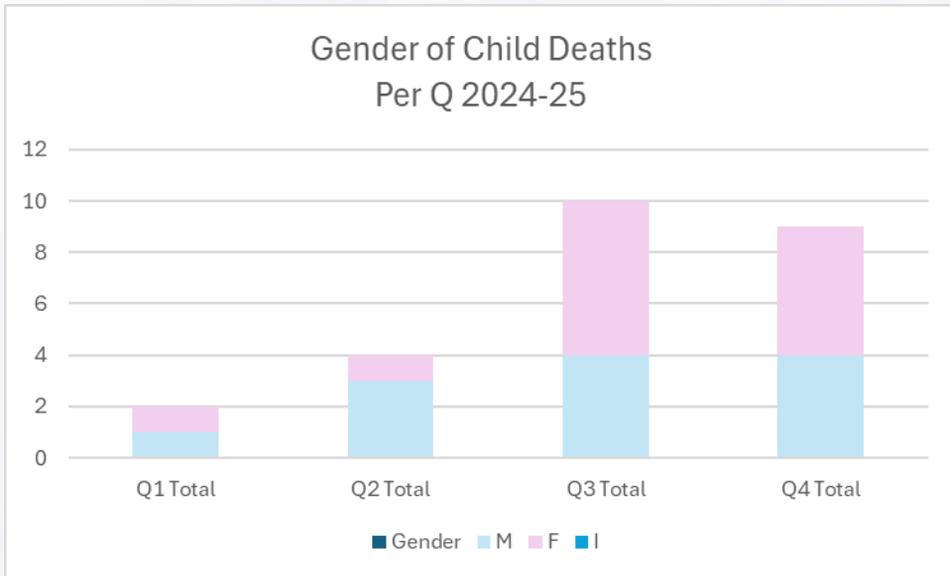
All Deaths for the Year Category of Deaths



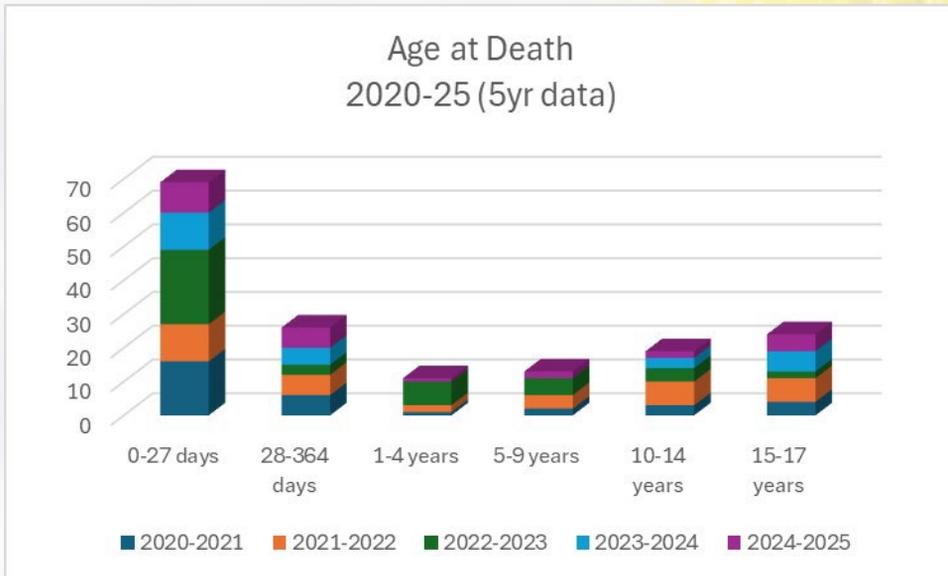
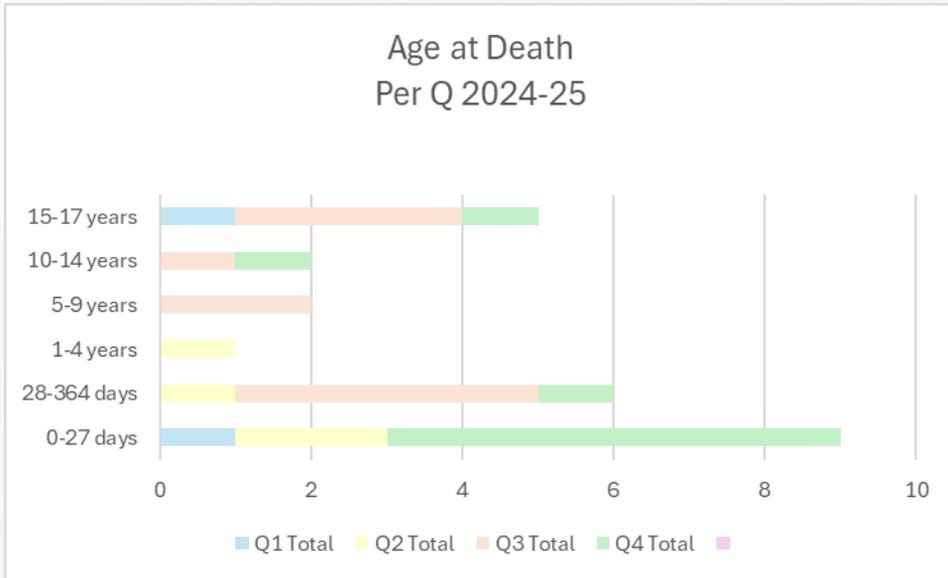
Of the 25 deaths for the year



Gender of Deaths

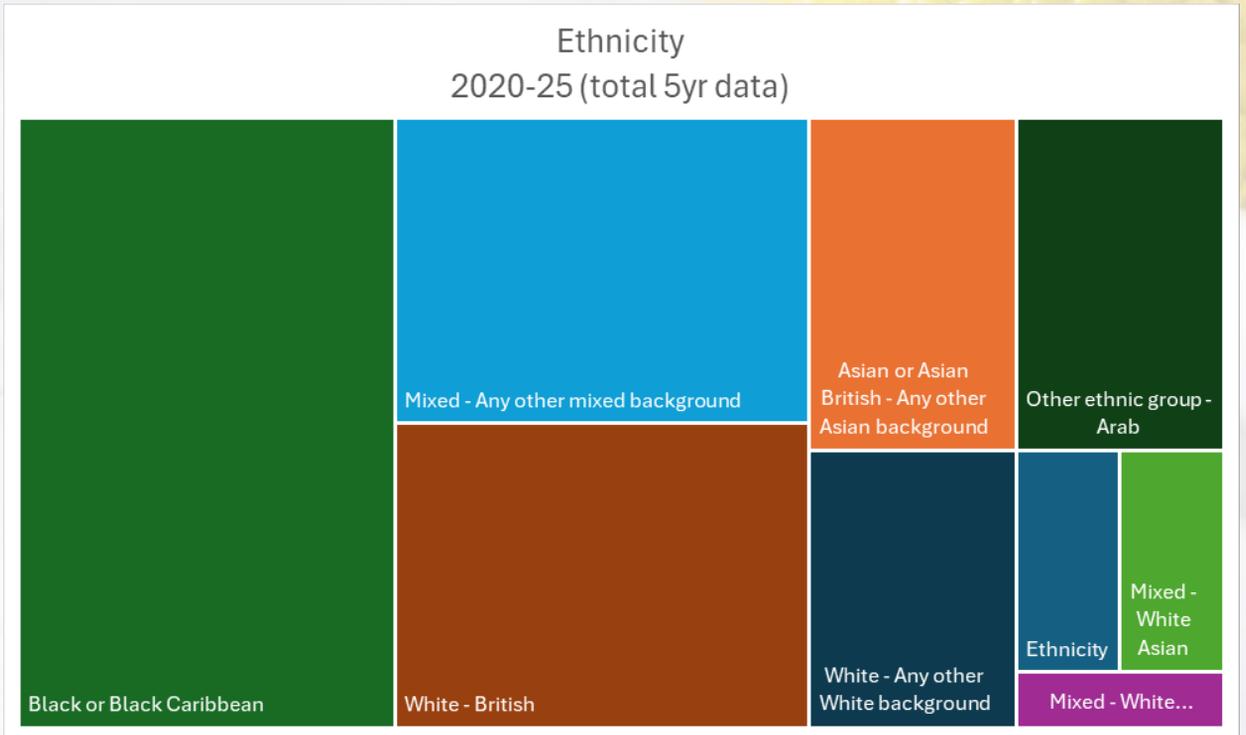
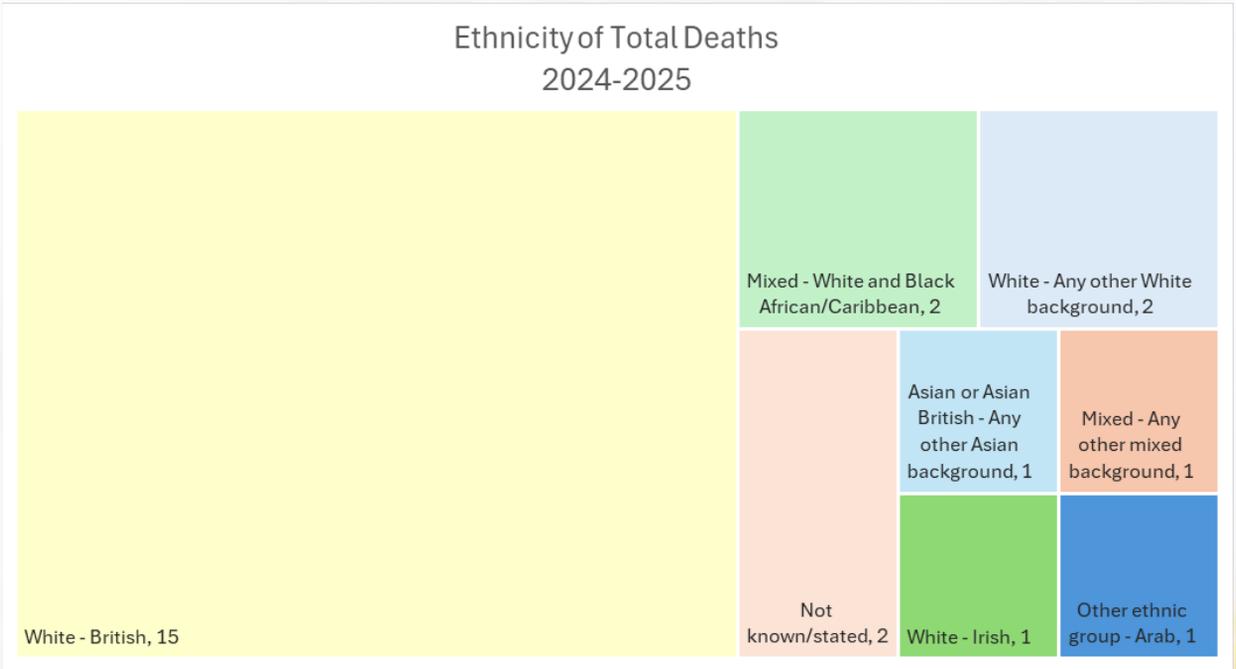


Age at Time of Death



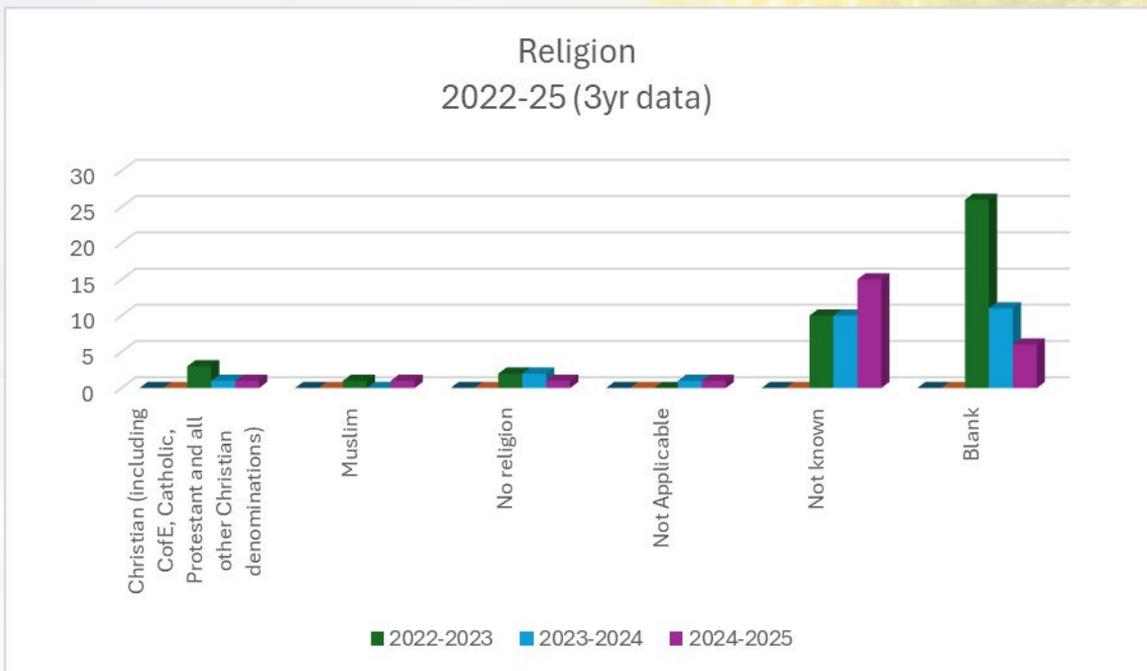
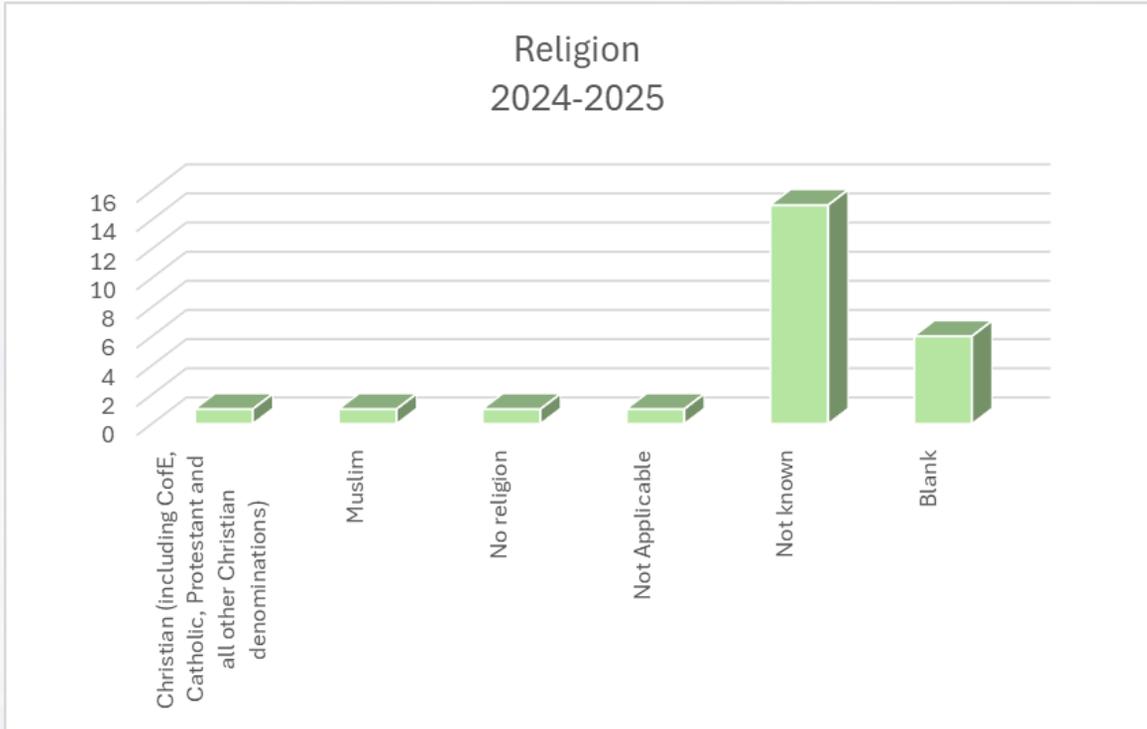
Ethnicity

Full data was not collected at the start of this date range.

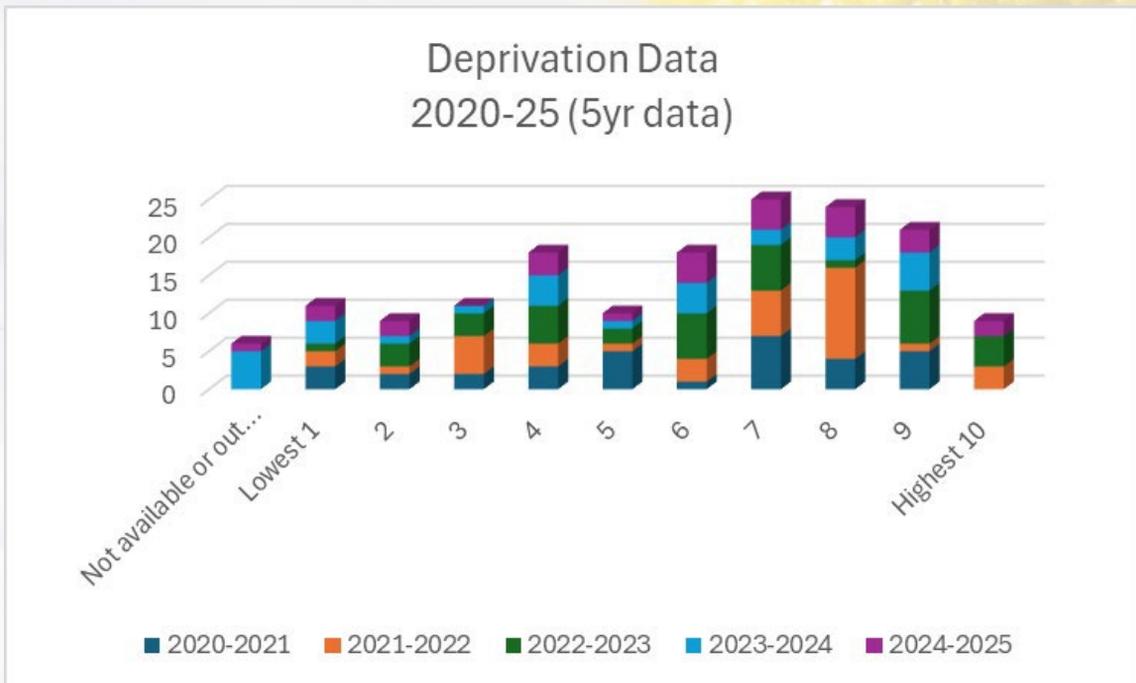
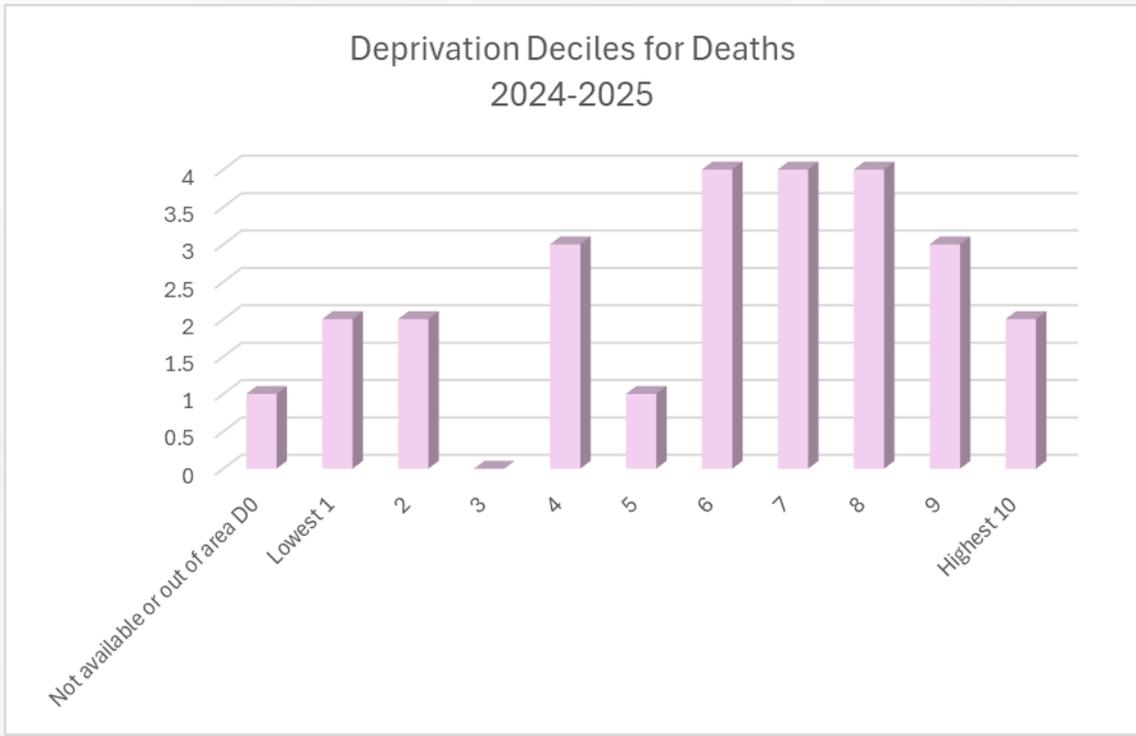


Religion

The requirement for gathering this data was inconsistent and only a solid three years of data is available for reporting purposes.

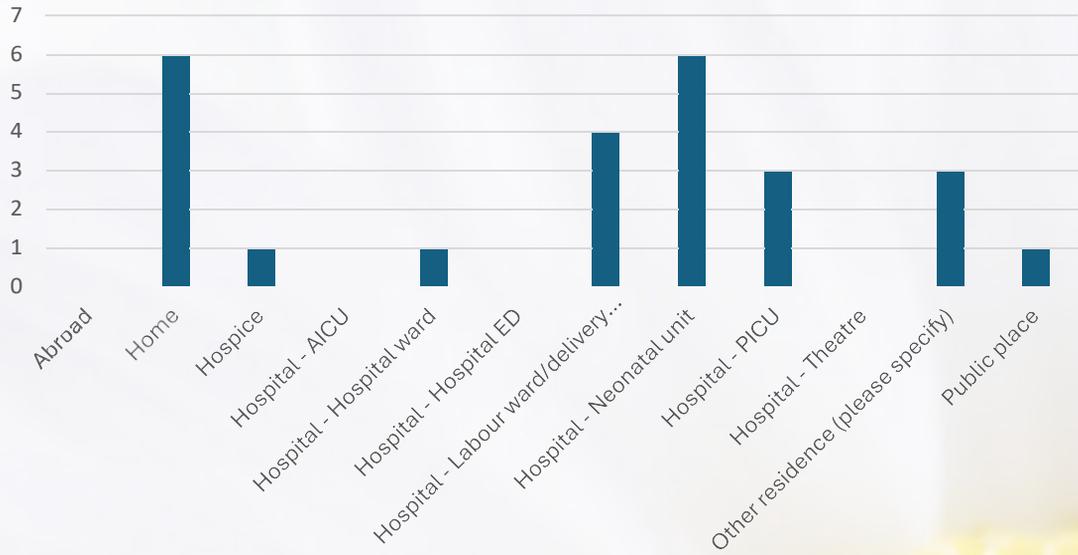


Deprivation Deciles

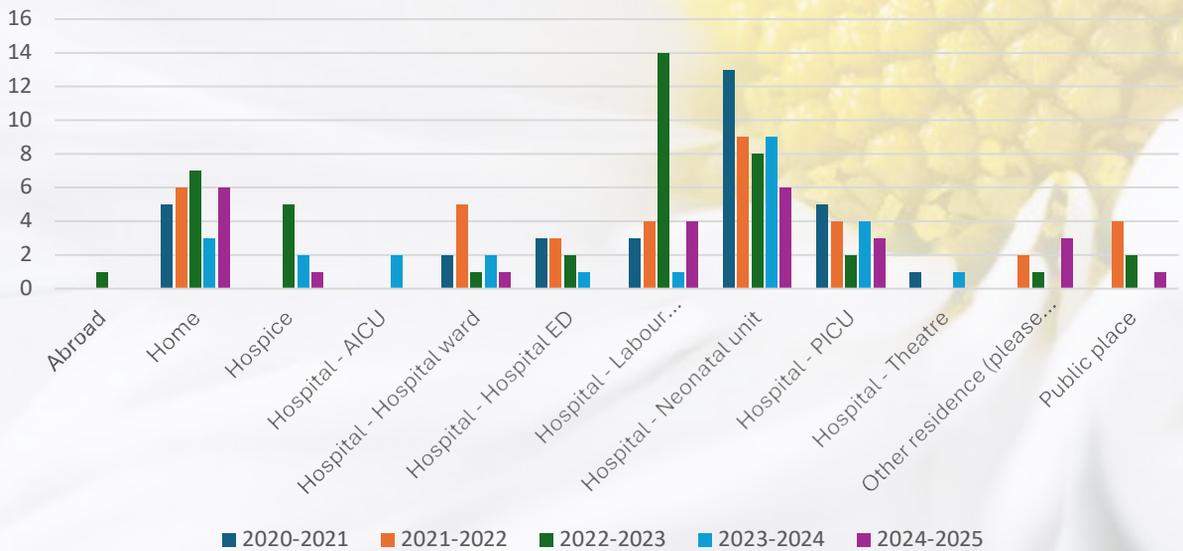


Location of Death

Location of Death
2024-2025



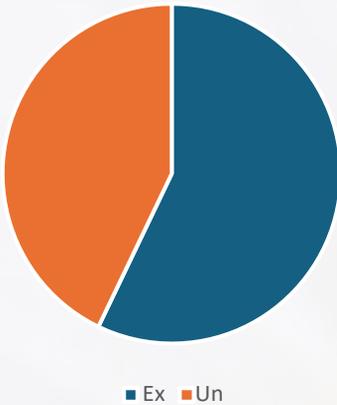
Location of Death
2020-25 (5yr data)



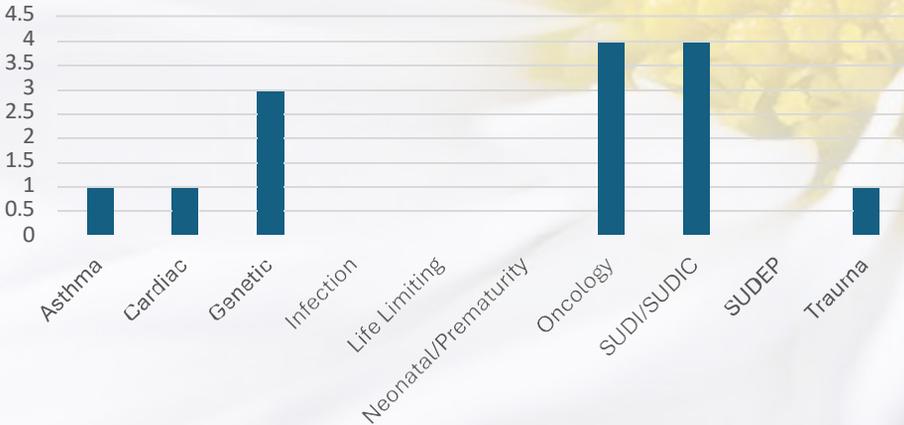
Expected and Unexpected Deaths Only

It should be noted that the majority of the cases populating this section of data are still current and final information may alter these figures for next years report.

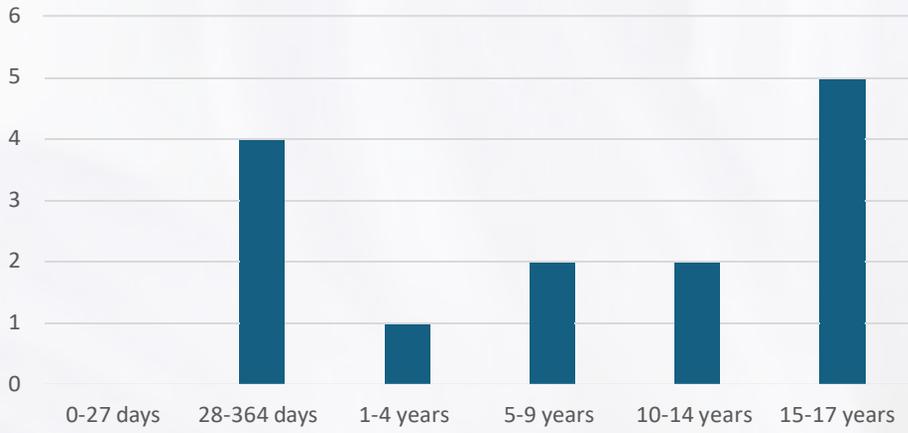
Category
2024-25



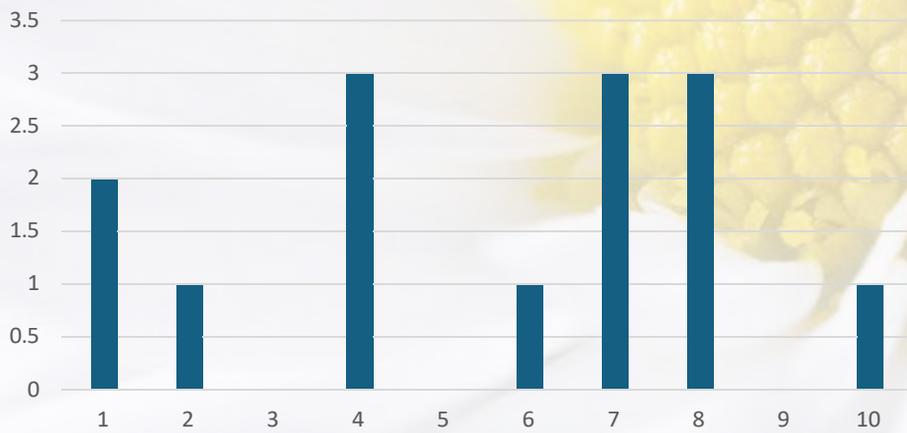
Category of Death
2024-25



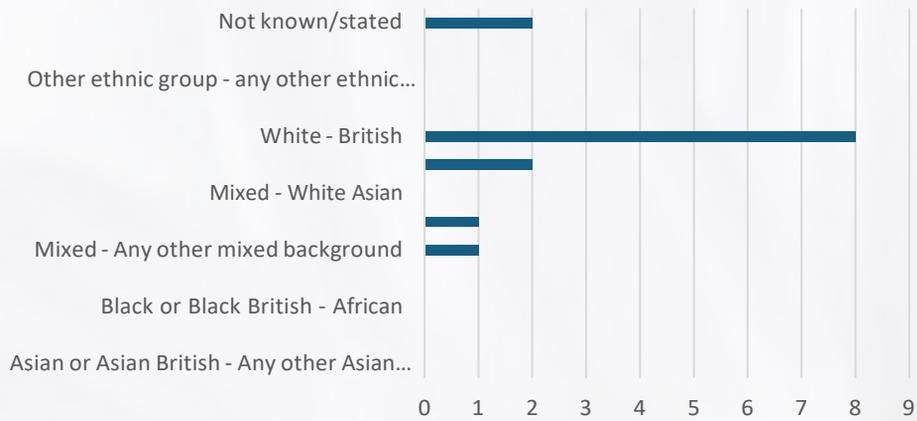
Age at Death 2024-25



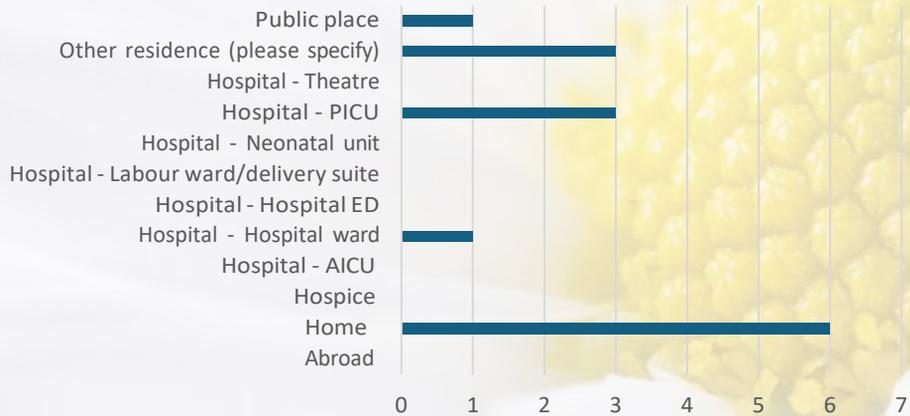
Deprivation Deciles 2024-25



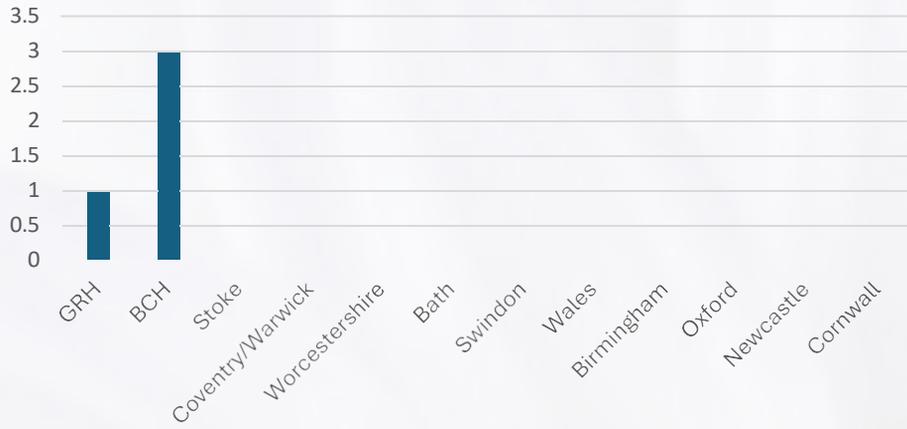
Ethnicity 2024-25



Place of Death 2024-25

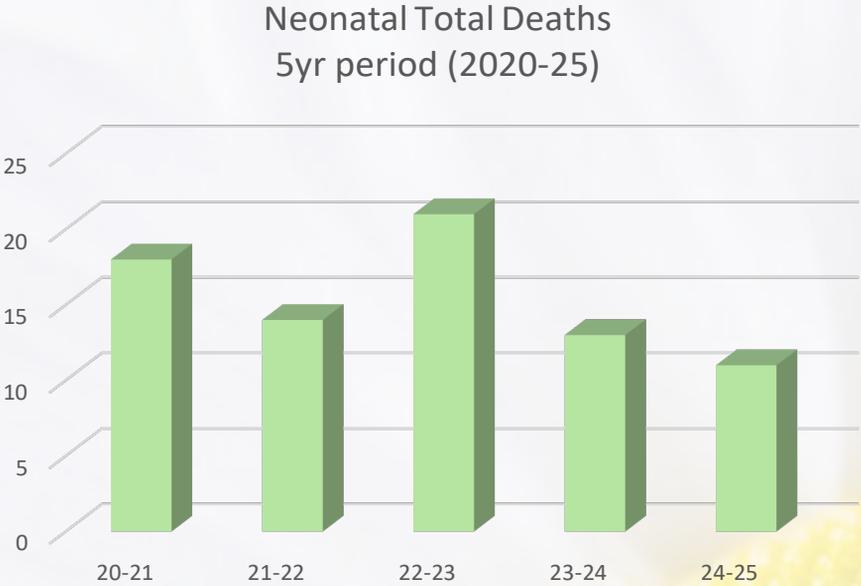


Hospital of Death 2024-25

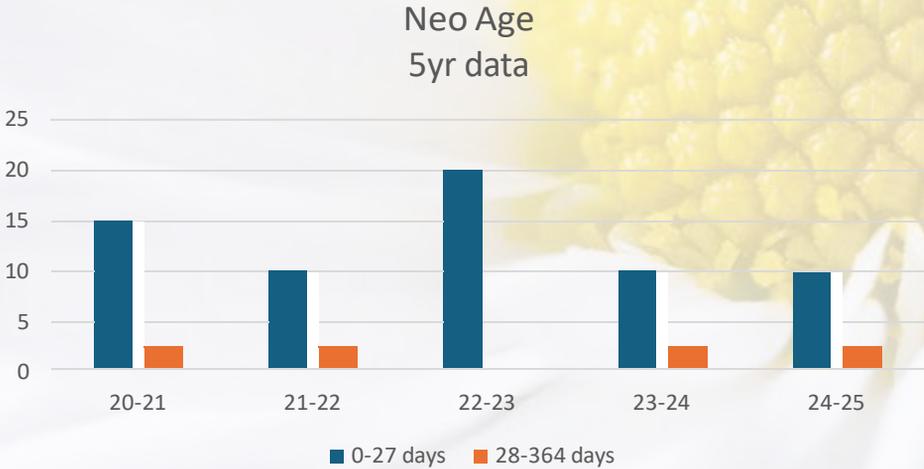


Neonatal Data Reports

The following section shows a reduction over five years for Neonatal deaths.

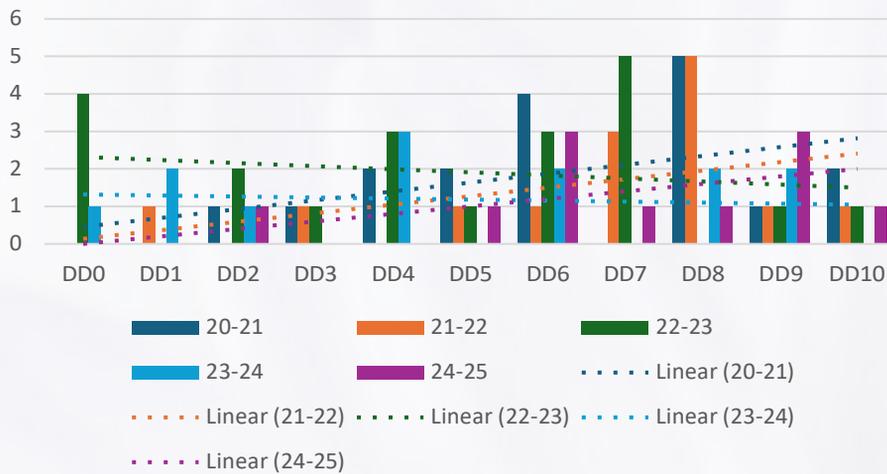


Comment



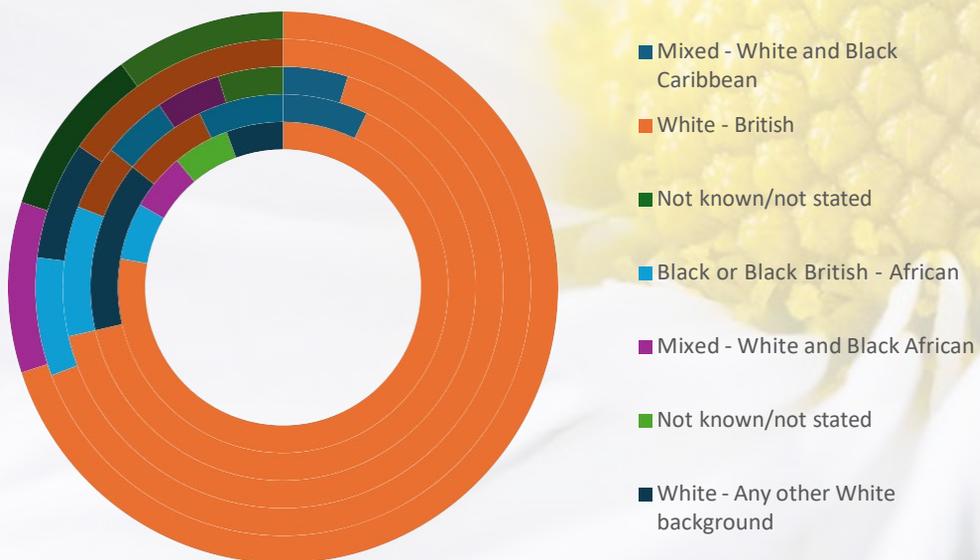
Comment

Neo Deprivation Decile per Year 5yr data

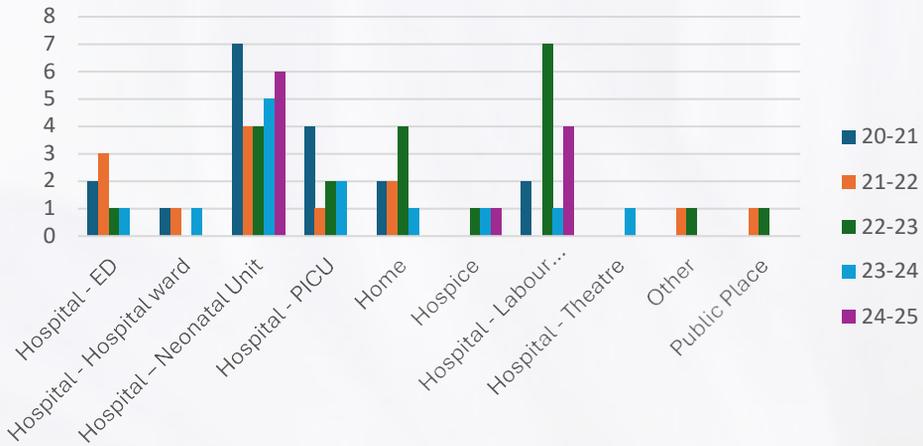


The neo data continues to contradict the national picture with rates of neonatal deaths increasing with deciles reflective of low deprivation. This trend has been seen throughout the last five years.

Neo Ethnicity 5yr data

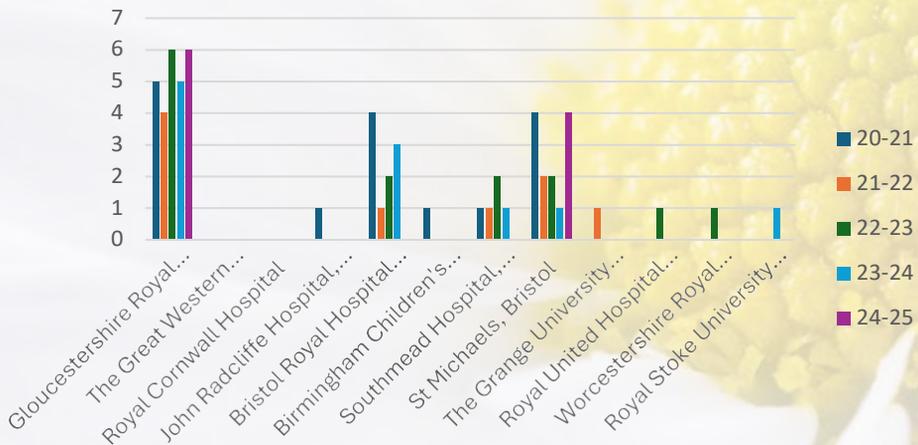


Neo Location of Death 5 yrs



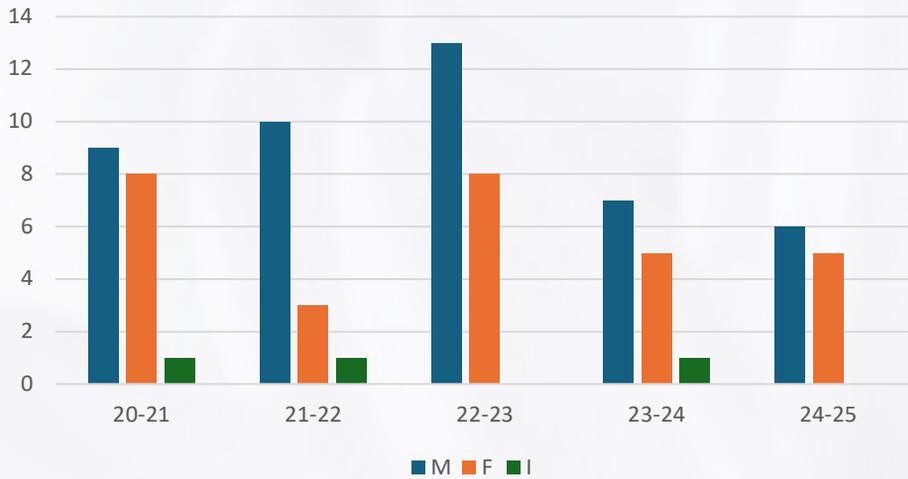
Comment

Neo Hospital of Death 5yr data



As with previous years the majority of neonatal deaths are within the hospital setting, and the range of these hospitals reflects our large geographical area and the location of our usual intensive care units.

Neo Gender 5yr data



The highest total cases of neonatal deaths in 24-25 were predominantly from the White – British ethnic group. This reflects a consistent trend for this age group over the last 5 years.