REPORT TO:	Health & Wellbeing Board
DATE:	14th January 2026
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Pan Cheshire Child Death Review Panel Annual Report 2024/2025
WARD(S)	All Wards

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to share the findings and recommendations from the child death reviews undertaken by the Pan Cheshire Child Death Overview Panel during 2024/2025

2.0 RECOMMENDATION: That

1) **the report be noted; and**

2) **the Board approves the Pan Cheshire Child Death Overview Panel recommendations for system leaders/partners in 2025/26:**

   a) **The Directors of Public Health across the Pan Cheshire footprint to ensure that women and families have good access to health advice and services to promote a healthy weight, mental wellbeing, and smoking cessation.**

   b) **The Pan Cheshire maternity services are aware of, and refer mothers to, services that support maintaining a healthy weight during, and after, pregnancy and smoking cessation.**

   c) **All Pan Cheshire Multi-Agency Safeguarding Children Partnerships to ensure that therapeutic interventions are in place to reduce the harmful effects of adverse childhood experiences identified.**

   d) **Cheshire and Merseyside Health and Care Partnership to assess the feasibility of delivering a comprehensive service for pre-conceptual care and advice for first and**

subsequent pregnancies.

3.0 SUPPORTING INFORMATION

3.1 The Children Act 2004, as amended by the Children and Social Work Act 2017, requires Child Death Partners, to ensure arrangements are in place to carry out child death reviews, including the establishment of a Child Death Overview Panel.

3.2 The Pan Cheshire Child Death Review partners include the local authorities and the NHS Cheshire and Merseyside Integrated Care Board. The Child Death Overview Panel includes representatives from across:

- Cheshire East
- Cheshire West and Chester
- Halton
- Warrington

3.3 The child death review process is outlined in statutory guidance, Working Together to Safeguard Children 2023 and Child Death Review Statutory and Operational Guidance (England) 2018.

3.4 The Pan Cheshire Child Death Overview Panel has a statutory requirement to produce an Annual Report each year which includes making recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across the Pan Cheshire footprint. The presentation of the Annual Report to the Halton Wellbeing Board fulfils this statutory responsibility.

3.5 Every child death is a tragedy with huge impacts for the family, friends and professionals that surround and care for that child during their lives. Child Death Overview Panels exist to ensure that each child death is systematically reviewed, so that any learning from these tragic events can be identified and widely shared with the goal of preventing future deaths, wherever possible.

3.6 The report highlights that across the Pan Cheshire footprint:

- Rates of child notifications were reasonably stable over the last five years.
- There were 59 child death notifications during 2024/25 compared to 52 during 2023/24.
- The rate of notifications across Pan Cheshire during 2024/25 was 2.63/10,000 0–17-year-olds and 2.35/10,000 during 2023/24, compared to the rate of notifications across England, which was 2.98/10,000 during 2023/24.
- The majority of notifications were in children under the age of 1 year (54% - 38/70), this was a similar to the age distribution across England as a whole (61%).
- The most child death reviews were completed in Cheshire East (24/70 - 34%)) followed by Cheshire West and Chester (18/70 - 26%).

- 60 % (42/70) child death reviews related to death within the first year of life, 57% (40/70) of which occurred within the neonatal period.
- Perinatal/neonatal events accounted for 33% (22/70) of all completed cases reviewed, with 20% (14/70) completed cases categorised as chromosomal, genetic and congenital anomalies.
- A higher proportion of child death reviews occur in the most deprived decile (19%,13/70), compared to the least deprived (6%, 4/70)

3.7 Between 1 April 2024 and 31 March 2025, the leading modifiable (or vulnerability) factors associated with reviews of death completed by the Pan Cheshire Child Death Overview Panel have included:

- Issues in service provision in 44% (31/70) of all completed reviews
- Maternal obesity (Body mass index ≥30) in 24% (17/70) of all completed reviews
- Mental health concerns of the child 20% (14/70) of all completed reviews
- Smoking in 17% (12/70) of all completed reviews
- Late booking/hidden pregnancy in 12% (12/70) of all completed reviews.

3.8 It was noted that there is an increase in the proportion of modifiable factors recorded as issues in service provision in 2024/25, 44% (31/70) compared to 7% (7/57) in 2023/2024. A review of these issues will be a priority for the Child Death Overview Panel for 2025/2026.

3.9 There were 101 adverse childhood events recorded in the cases reviewed in 2024/25, the most common event being mental health issues of parent/care giver[1] (26), followed by parental separation (17) and domestic abuse (15).

3.8 The report also highlights progress made over the past year by the panel, in terms of ways of working, awareness raising for the public and health and social care professionals, and educational events.

3.9 In addition, it is noted that the final report of the Thirlwall Inquiry is expected to be published in early 2026. The Pan Cheshire Child Death Overview Panel will work with partners to ensure that actions and recommendations are implemented as required to support children, their parents, guardians and carers.

4.0 POLICY IMPLICATIONS

4.1 This report may highlight health and social care needs that may

[1] Living with a parent or caregiver or other family member who is depressed, has other mental health problems, or who has ever attempted suicide

have implications for the Health and Wellbeing Strategy, policies related to children's safeguarding and commissioning plans and services.

5.0 FINANCIAL IMPLICATIONS

5.1 There are potential financial implications for Halton Borough Council, system leaders and partners to address the recommendations in this report in respect of:

- Services to promote healthy lifestyle choices for women and families
- Commissioning therapeutic interventions to address adverse childhood experiences
- Assessing the feasibility of pre-conceptual care and advice services.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

The issues outlined within this report and the recommendations are directly related to improving health and promoting will being, therefore, may have implications for this priority.

6.2 Building a Strong, Sustainable Local Economy

There are no explicitly identified implications for this priority within this report.

6.3 Supporting Children, Young People and Families

The issues in this report are specifically related to children, young people and their families and therefore will have implications for this priority.

6.4 Tackling Inequality and Helping Those Who Are Most In Need

The issues within this report highlight inequalities and will have implications for this priority.

6.5 Working Towards a Greener Future

There are no explicitly identified implications for this priority within this report. However, there may be a subsequent impact resulting from implementation of the recommendations that may require increased travel associated with health and wellbeing consultations.

6.6 **Valuing and Appreciating Halton and Our Community**

There are no explicitly identified implications for this priority within this report.

6.7 **Resilient and Reliable Organisation**

The issues outlined within this report and the recommendations may have implications for this priority in terms of commissioned services to meet the needs of the population.

7.0 **RISK ANALYSIS**

7.1 The Pan Cheshire Child Death Overview Panel Annual Report does not present a direct risk to the organisation. The management of risks associated with the final review of child death is performed by the bi-monthly meeting of Pan Cheshire Child Death Overview Panel business group via an up to date risks and issues log.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 The Child Death Overview Annual Report highlights the health needs of populations with protected characteristics as defined in the Equality Act 2010. Whilst this report did not specifically identify equality and diversity issues, the deep dive into the increased issues with service provision may indicate areas for service improvement.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 There are no explicitly identified implications for this priority within this report. However, there may be a subsequent impact resulting from implementation of the recommendations that may require increased travel associated with health and wellbeing consultations.

10.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

None under the meaning of the Act.