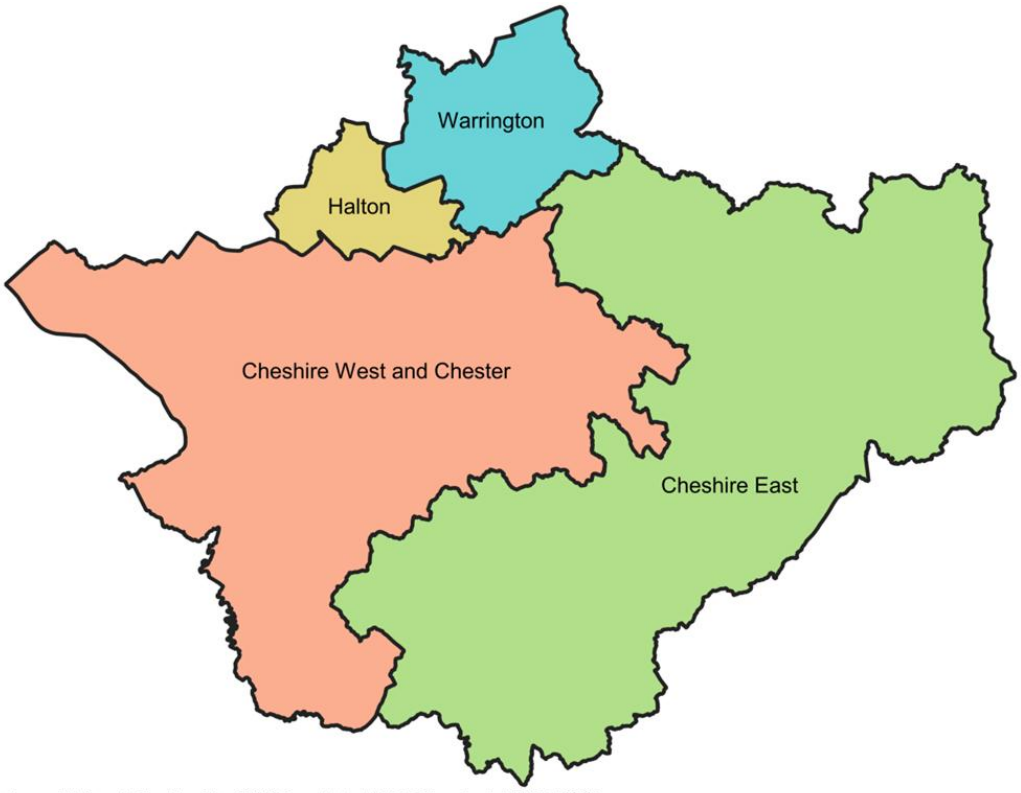
Annual Report of the

Pan Cheshire
Child Death Overview Panel

2024/25



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Foreword

The Pan Cheshire Child Death Overview Panel (CDOP) reviews every death of a child or young person aged up to 18 years of age living in Cheshire East, Cheshire West and Chester, Halton and Warrington. This is the 10th annual report published since the establishment of the combined child death overview process across the Pan Cheshire geographical area.

This current report focuses on children whose deaths were either notified to the Pan Cheshire Child Death Overview Panel during 2024/25, or whose reviews concluded during 2024/25. Panel has met a total of six times during this period and reviewed a total of 70 cases.

During the time of this report the Child Death Overview Panel business administration function moved from Cheshire East Local Authority to Mid Cheshire Hospitals NHS Trust, and an additional administrator was appointed. The relocation and increase in administrative resource have enhanced the efficiency of the Pan Cheshire Child Death Overview function.

I would like to take this opportunity to thank Mike Leaf, the Independent Chair of the Pan Cheshire CDOP until September 2024, for leading the process over the past eight years.

The dedication and commitment of the panel members is apparent in their rigorous and sensitive review of the cases presented at each panel. Effective multiagency partnership is demonstrated in the work of the panel and the additional members of the Child Death Overview Panel business meeting

It is evident that the Pan Cheshire Child Death Overview Panel and Child Death Review partners, through individual practice and professional reporting, strive to identify opportunities for learning and improvement to prevent the future death of children locally, regionally and nationally.

Glenda M Augustine

Independent Chair – Pan Cheshire Child Death Overview Panel

Introduction

Each child death is a tragedy, and there has been a statutory requirement to review the death of all children up to the age of 18 years since April 2008.

"The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. Families experiencing such a tragedy should be met with empathy and compassion. They need clear and sensitive communication. They also need to understand what happened to their child and know that people will learn from what happened. The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths[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. The reviews are conducted in accordance with Working Together to Safeguard Children 2023 alongside Child Death Review Statutory and Operational Guidance, 2018.

Child Death Overview Panels exist to ensure the independent and systematic review of the death of every child, so that lessons can be learned from these tragic events and shared effectively to prevent future deaths, wherever possible. As a panel, we are dedicated to ensuring our families are supported following the death of their child, and that any learning from these heartbreaking losses is fully acknowledged and shared across our Pan Cheshire area and beyond.

It is noted that the final report of the Thirlwall Inquiry is expected to be published in early 2026. However, there may be some communication regarding actions to be taken prior to this date[2] and 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.

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[1] HM Government (2023) Working Together to Safeguard Children 2023. A guide to multi-agency working to help, protect and promote the welfare of children. Available from: Working together to safeguard children 2023: statutory guidance) (Accessed 18 June 2025).
[2] The Thirlwall Inquiry. Available from: Update on Final Report | The Thirlwall Inquiry/ © Crown Copyright 2025 (Accessed 18 June 2025).

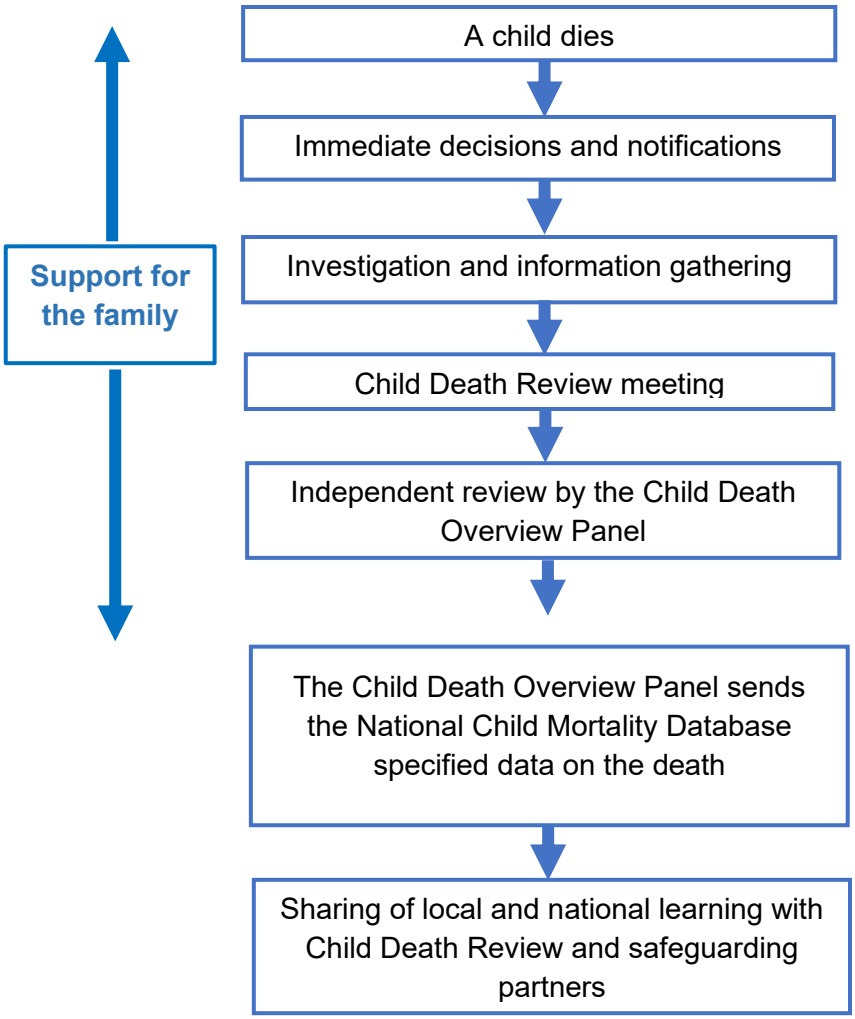
The Pan Cheshire Child Death Overview Panel

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

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.

When a child dies, the process undertaken is illustrated in the figure below.



The Child Death Overview Panel review is intended to be the final, independent review of a child's death by senior professionals from different specialities and organisations with no responsibility for providing care to the child during their life. The Panel consists of varied experts including public health

representatives, the Designated Doctor for Child Deaths for the local area; social services; police, the Designated Doctor or Nurse for Safeguarding; nursing and/or midwifery; and other professionals that Child Death Review partners consider should be involved. Additional professionals may be asked to contribute reports in relation to individual cases.

The review considers the four domains outlined within the Child Death Review Analysis Form as outlined in Table 1 below. The aim is to analyse any relevant factors that may have contributed to the child's death. The information gathered may help identify factors that could be altered to prevent future deaths.

Table 1: Child Death Review Analysis Form Domains

Domain	**Domain Descriptor**
Domain A: **Factors intrinsic to the child**	Factors in the child (and in neonatal deaths, in the pregnancy relating to the child's age, gender and ethnicity; any pre-existing medical conditions, developmental or behavioural issues or disability, and for neonatal deaths, the mother's health and wellbeing
Domain B: **Factors in social environment including family and parenting capacity.**	Factors in family structure and functioning and any wider family health issues; provision of basic care (safety, emotional warmth; stimulation; guidance and boundaries; stability); engagement with health services (including antenatal care where relevant); employment and income; social integration and support; nursery/preschool or school environment.
Domain C: **Factors in the physical environment**	Issues relating to the physical environment the child was in at the time of the event leading to death, and for neonatal deaths, the mother's environment during pregnancy. Include poor quality housing; overcrowding; environmental conditions; home or neighbourhood safety; as well as known hazards contributing to common childhood injuries (e.g. burns, falls, road traffic collisions).
Domain D: **Factors in service provision.**	Issues in relation to service provision or uptake. Include any issues relating to identification of illness, assessment, investigations and diagnosis; treatment or healthcare management; communication or teamwork within or between agencies; and organisational or systemic issues. Consider underlying staff factors, task factors, equipment, and work environment, education and training, and team factors.

Supporting families with child bereavement

At the centre of every child death are families and friends experiencing devastating loss. An important role of the Child Death Overview Panel is to ensure they have the support and importantly, the compassion and sensitivity that is so greatly needed in such distressing circumstances. Child Bereavement UK has produced guidance to support professionals with this important role.

> "Working with families who are grieving can feel daunting…
>
> Nothing we can do or say can take away the pain of bereavement, but families tell us of the importance of sensitive care. Poor care can intensify and prolong a family's distress, whilst care that is sensitive and appropriate can help families in their grief. The effects of this are positive and long-lasting…
>
> Supporting bereaved families includes good communication, responding to their needs in a timely way, and being emotionally self-aware"[3].

The guidance states:

"Listening to others means using all our senses to pick up on what the person is communicating, and it involves much more than just what we are hearing.

Good communication involves:

- Having the right environment, preferably where you will not be disturbed.
- Being compassionately clear about the time the person or family can have with you to talk. This creates a safe environment where they know what they can expect, and it avoids the interaction ending abruptly.
- Listening to the words, the tone of voice and the feelings being conveyed.
- Observing body language and facial expressions and noticing what is not being said as well as what is said.
- Showing your interest and empathy through good eye contact, your tone of voice and body language.

Checking with the person that you have both heard and understood the key messages."[3]

[3] Child Bereavement UK. Supporting bereaved families. Available from: Supporting bereaved families | Child Bereavement UK (Accessed 18 June 2025)

Purpose of the Child Death Overview Panel Annual Report

As outlined in the statutory guidance, the purpose of the Annual Report is:

- To clarify and outline some of the Child Death Overview Panel processes directed by national guidance.
- To assure the Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across the Pan Cheshire Child Death Overview Panel footprint.
- To provide an overview of information on trends and patterns in child deaths reviewed across the Pan Cheshire Child Death Overview Panel footprint during the last reporting year (2024/25).
- To highlight issues arising from the child deaths reviewed. (This could include deaths of children who were resident in the Pan Cheshire Child Death Overview Panel footprint, or who died in the footprint).
- To report on achievements and progress of the Child Death Overview Panel.
- To make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across the Pan Cheshire Child Death Overview Panel footprint.

Key trends in child death notifications

As described in the statutory guidance, when a child dies, a number of notifications should also be made, including: to the child's GP and other professionals; to the Child Health Information System; the relevant Child Death Review partners and the Child Death Overview Panel. This helps to guide how to support the family. It also helps to identify whether Joint Agency Reviews, NHS serious investigations, or referrals to the coroner are required. Across the Pan Cheshire footprint:

- Rates of child notifications were reasonably stable over the last three 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[4].
- The rate of notifications across England was 2.98/10,000 during 2023/24[5].

[4] Based on ONS 2023 mid-year population estimates. ONS (2024) Population estimates for the UK, England, Wales, Scotland, and Northern Ireland: mid-2023. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest (Accessed 25 June 2025)
[5] NCMD (2024) Child Death Review Data Release: Year ending 31 March 2024. Published November 2024. Available from: Child death data release 2024 | National Child Mortality Database (ncmd.info): Table 1 (Accessed 25 June 2025).

- The majority of notifications were in children under the age of 1 year (54%), this was a similar to the age distribution across England as a whole (61%).

A pattern of seasonal variation in child deaths is difficult to ascertain due to the very small numbers involved.

Key findings in child death reviews completed during 2024/25

The Child Death Overview Panel only review child deaths after all other review processes have been undertaken. Therefore, a child death may be notified during one year but be reviewed during another.

The length of time between notification and the final review can vary considerably depending on circumstances and other review processes. The reasons for delays can include awaiting post-mortems and inquests, criminal investigations and out of area mortality reviews.

The deaths of 70 children were reviewed by Pan Cheshire Child Death Overview Panel during 2024/25, the majority, 96%, of which died during 2022/23 (18%), 2023/24 (60%) and 2024/25 (17%)[6].

The key findings were:

- The most child death reviews were completed in Cheshire East (24/70) followed by Cheshire West and Chester (18/70)
- 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)

As of 31 March 2025, final reviews for 52 children were ongoing (compared to 63 as of 31 March 2024) and therefore, could not be completed by the Child Death Overview Panel at this time.

[6] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP Report created on: 15/05/2025. Quarter 4 2024/25: Page 5

Key trends in modifiable factors during 2024/25

Each child death is reviewed to understand if there were any ways children, young people or their families could be supported differently which may prevent future deaths. These are known as modifiable factors.

Modifiable factors are defined as "one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths"[7]

Between 1 April 2024 and 31 March 2025, the leading modifiable (or vulnerability) factors associated with reviews 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[8] (Body mass index ≥30) in 24% (17/70) of all completed reviews
- Mental health concerns of the child[9] 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

It was noted that there is an increase in the proportion of modifiable factors recorded as issues in service provision in 2024/25, 44% compared to the 7% (7/57) recorded in 2023/24. The issues with service provision recorded include:

- Communications issues
    - When a child dies out of area
    - When a child is transferred to a tertiary centre
    - Between tertiary centre and local unit for infants and older children when most of the care is provided by the tertiary centre
- Transitional care for 16 – 18 year olds
- Lack of gender identity services

A deep dive will be undertaken into the issues in service provision identified in the completed reviews to provide further clarity regarding available services or gaps in service, and to determine lessons learned and changes to practice required to improve service delivery.

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[7] GOV.UK (2023) Working together to safeguard children 2023: statutory guidance. Accessed 27 June 2025

[8] Primarily associated with perinatal and neonatal deaths reviewed

[9] Attention Deficit Hyperactivity Disorder (ADHD); Autism; Neurodivergence; note there could also be a link to Adverse Childhood Experiences of the parent in relation to mental health issues – see page 26

Certain causes of death are more frequently associated with modifiable factors that if addressed may prevent further deaths in the future.

- During 2024/25, 41 out of 70 competed reviews were linked to modifiable risk factors, this represents 59% of all deaths reviewed and is higher than the percentage across England as a whole (43%)[10]
- During 2024/25, all completed reviews with a primary cause of death of deliberate or self-inflicted harm and deliberately inflicted injury, abuse or neglect involved modifiable risk factors.
- Modifiable factors were also linked to the majority of completed reviews with the following primary categories of death:
    - Sudden unexpected, unexplained death (86%)
    - Perinatal or neonatal events (70%).
    - Infection (67%).

The picture in Pan Cheshire during 2024/25 was fairly similar to the most commonly identified factors across England during 2023/24[11], in terms of categories, except for trauma and external factors where no modifiable factors were recorded for Pan Cheshire.

[10] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP Report created on: 15/05/2025. Quarter 4 2024/25: Page 3

[11] NCMD (2024) Child Death Review Data Release: Year ending 31 March 2024. Published November 2024. Available from: Child death data release 2024 | National Child Mortality Database (ncmd.info) Table 15: (Accessed 27 June 2025).

Progress during 2024/25 and achievements

Significant progress has been made against the recommendations in the 2023/24 Child Death Overview Panel Annual Report (see Progress against 2023/24 annual report recommendations during 2024/25 for further details.

There has been a number of learning and educational achievements over the past year including 10 'Lunch and Learn' sessions with over 700 attendees in total, an Infant Vulnerability conference with 100 attendees and the development of five posters.

Key achievements include:

- *Awareness raising regarding*:
    - Specialist perinatal and maternal mental health
    - Infant Vulnerability Conference
    - ICON Out of Routine and Infant Safe sleep
    - ICON Infant crying is normal
    - Out of routine and situational risk
    - Prevention of drowning
    - Winter water safety
    - Winter infant safe sleep
    - Road Safety 'THINK'
    - Raising awareness of bereavement support

- *Pan Cheshire Child Bereavement Directory 2024-25*
  A directory providing bereavement Information for professionals, parents, carers, grandparents, siblings, peers and all those affected by the death of an infant or child. The directory includes local and national services to help professionals to support families and signpost to appropriate agencies.

- *7 Minute briefings*
    - Death overseas of children normally resident in Cheshire: Responsibility and Timely notification
    - Joint Agency Response: Process, expectations and information sharing
- *Pan Cheshire CDOP Newsletter resumed and circulated*
  Issues highlighted include: Water Safety; Child safety in the dark, ICON week, Illicit drug warning – 'pink cocaine'; button battery safety; Christmas safety
- *ICON – Infant Crying is Normal (ICON) Progress Report ratified*
  Following a Cheshire East & West ICON steering group report, ICON is now under the continued surveillance of the safeguarding partnership.

Priorities and Recommendations for 2025/26

1. The priorities for **Pan Cheshire Child Death Overview Panel** 2025/26:

a. Foster a cycle of continuous improvement in the child death review process to reflect national guidelines and local learning.
b. Child Death Overview Panel reviews to promote greater reflection on, and scrutiny of, services provided by partner agencies and follow up on actions taken after learning has been identified through partner agency reviews.
c. To promote the findings from the Child Death Overview Panel Annual Report 2024/25 to wider partners.
d. Deep dive into issues of service provision to determine services available, gaps in services, lessons learned and any resulting changes in practice
e. To await the recommendations from the Thirlwall Inquiry, implement changes required and champion them amongst stakeholders.

A Child Death Overview Panel business plan has been developed for 2025/26 with SMART objectives (specific, measurable, achievable, realistic and timely) to facilitate progress against these priorities.

2. The recommendations for **System Leaders/Partners** for 2025/26 are:

    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.

Appendix One: Data Analysis

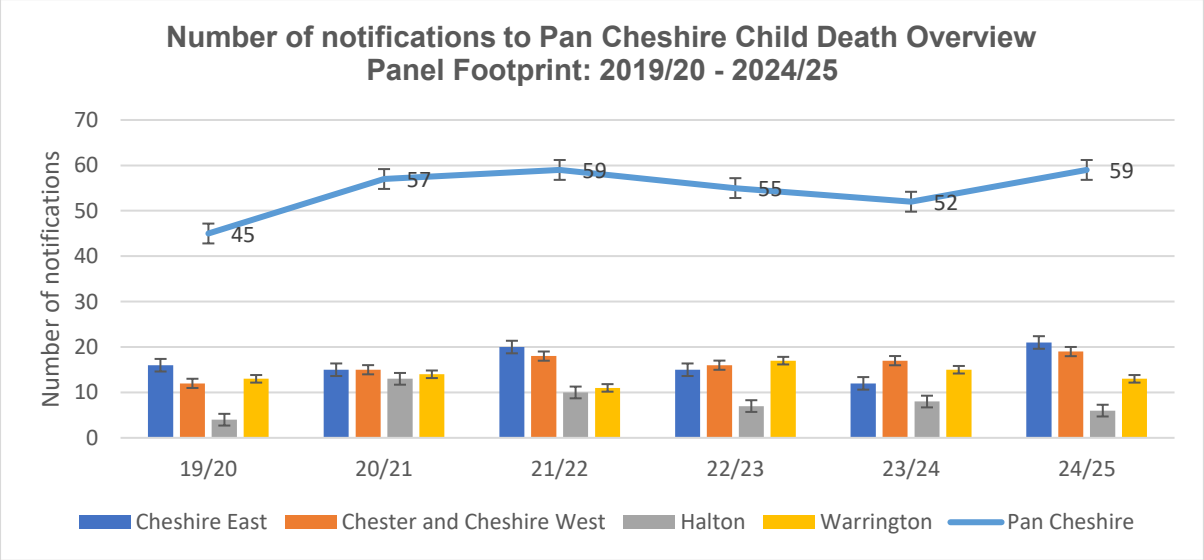
Cautionary Note:

The data analysed within this report is based on small numbers and, therefore, should be interpreted with caution. Small random changes in the absolute number of events between reporting periods may have a large apparent effect on the data presented as rates and percentages without demonstrating a statistically significant difference.

1. Number of notifications to the Pan Cheshire Child Death Overview Panel

Natural variation in the number of deaths notified to Child Death Overview Panels is to be expected from year to year. Between 2019 and 2025, the number of child death notifications across the Pan Cheshire footprint has varied from 45 to 59. There were 7 more notifications during 2024/25 across Pan Cheshire footprint, 59, compared to 52 notifications received during 2023/24. The highest numbers of death notifications in 2024/25 were seen in Cheshire East and then Cheshire West and Chester.

Figure 1: Notifications of death across Pan Cheshire Footprint

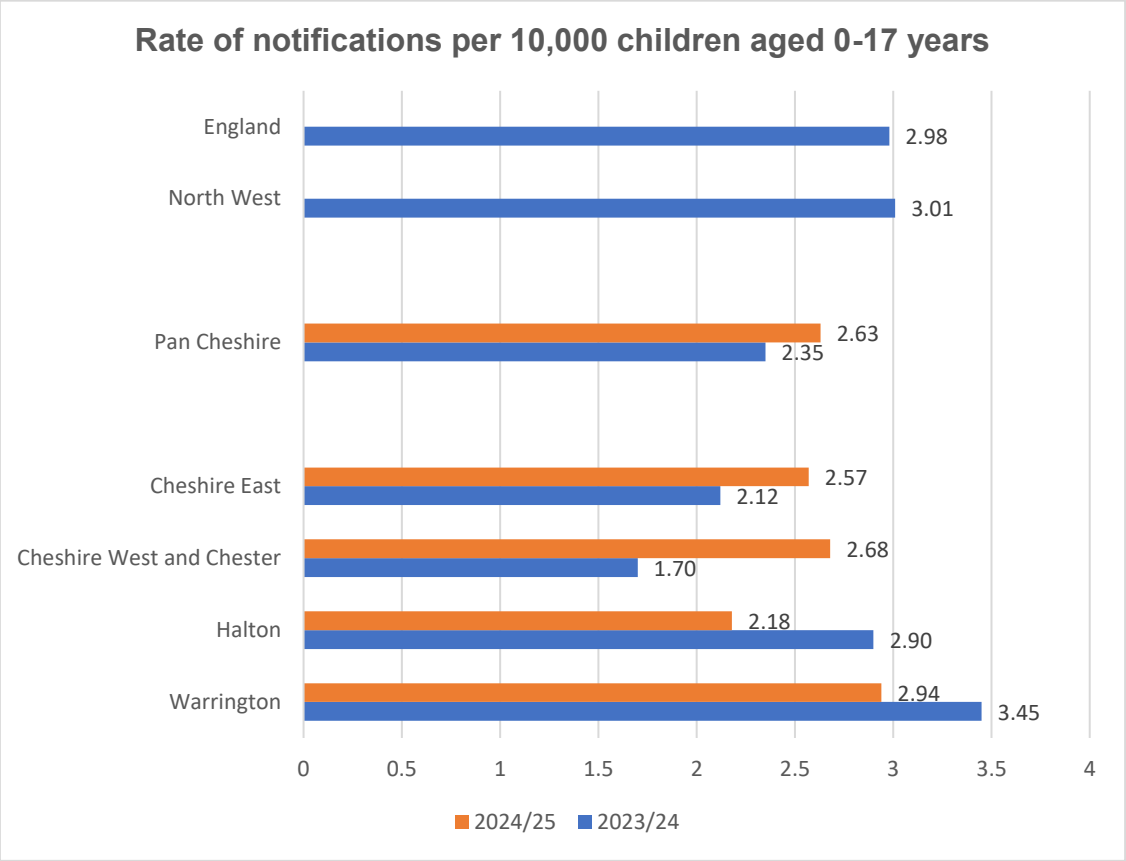


2. Rate of notifications per 10,000 children aged 0-17years

During 2024/25, the rate of notifications to the Pan Cheshire Child Death Overview Panel was 2.63/10,000 children aged 0-17 years. At time of writing this report, the national death notification rate for 2024/25 was not published. However, the death notification rate across England for 2023/24 was 2.98/10,000 children aged 0-17 years. This was higher than the Pan Cheshire rate for 2023/24 (2.35/10,000)[4] (although the statistical significance of this difference has not been determined).

The regional notification rates for 2023/24 ranged from 2.42/10,000 in the South East and South West to 4.07/10,000 in the West Midlands. The rate across the North West was 3.01/10,000[5].

Figure 2: Comparison of rate of notification: national and regional



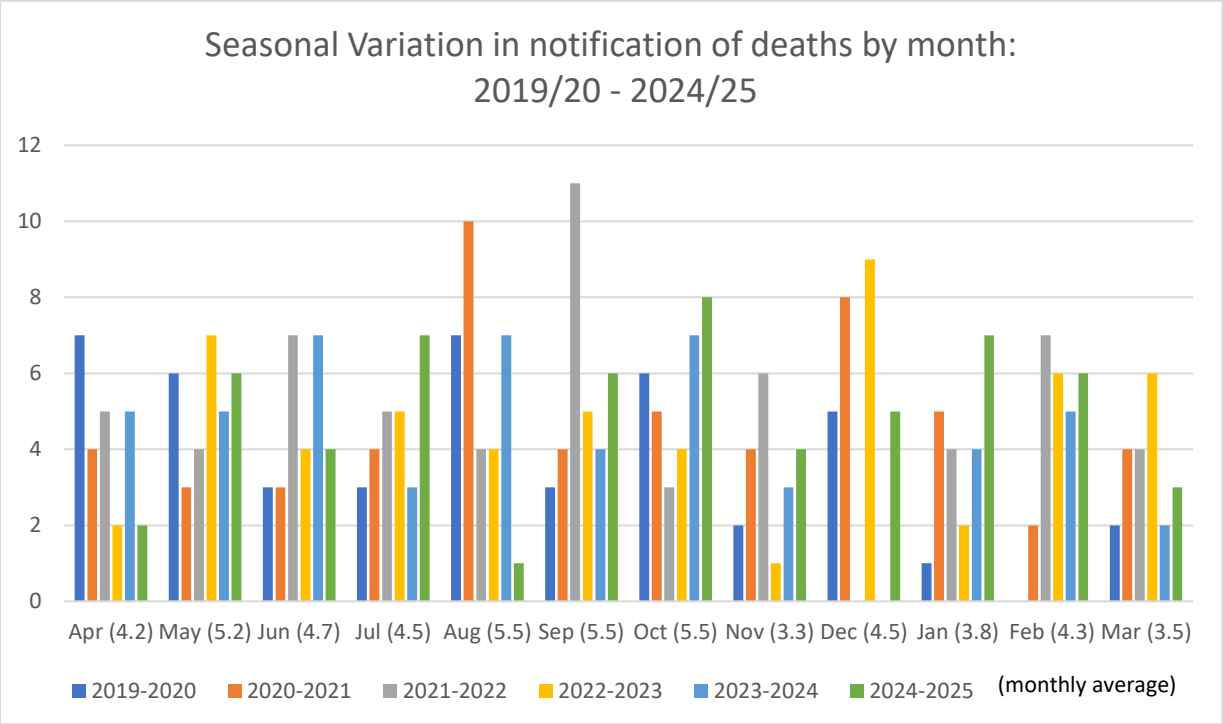
During 2024/25, the highest notification rate was seen in Warrington where there were 2.94 notifications/10,000 children aged 0-17 years. Warrington also had the highest rate during 2023/24 (3.45 notifications per 10,000). However, whilst this year's rate is lower than the rate recorded for 2023/24 statistical significance for 2024/25 is undetermined.

It may appear that there was a higher rate of notifications in Cheshire West and Cheshire in 2024/25 (2.68/10,000) compared to 2023/24 (1.70/10,000). This is due to the random variation associated with small numbers. A case log and performance report is produced for each Child Death Overview Panel Business meeting allowing scrutiny and review of notifications by area and timely review of all cases to identify any patterns or trends.

3. Notifications by month (2019/20 – 2024/25)

Seasonal variation in notifications to the Pan Cheshire Child Death Overview Panel are provided in Figure 3. Monthly numbers of notifications varied from 1 in December to 8 in October. It is difficult to discern a pattern in terms of seasonal variation as the numbers for each given month vary from year to year. However, the months with the highest average rate of notifications over the last six years were August, September and October (equally), followed by May[12].

Figure 3: Seasonal variation in notifications by month: 2019/20 – 2024/25

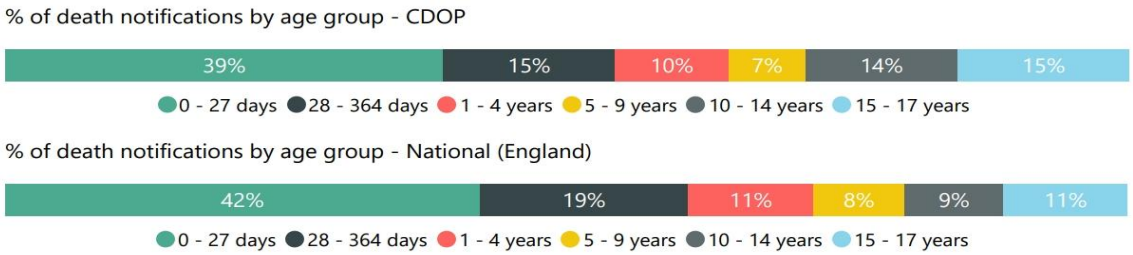


4. Notifications by age during 2024/25

The age distribution of notifications to Pan Cheshire Child Death Overview Panel was very similar to the England average (61%), with the majority being deaths in the first year of life (54%) as shown in Figure 4[12].

[12] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP Report created on: 15/05/2025. Quarter 4 2024/25: Page 6

Figure 4: Age distribution of notifications compared to England



5. Number of child death reviews completed 2024/25

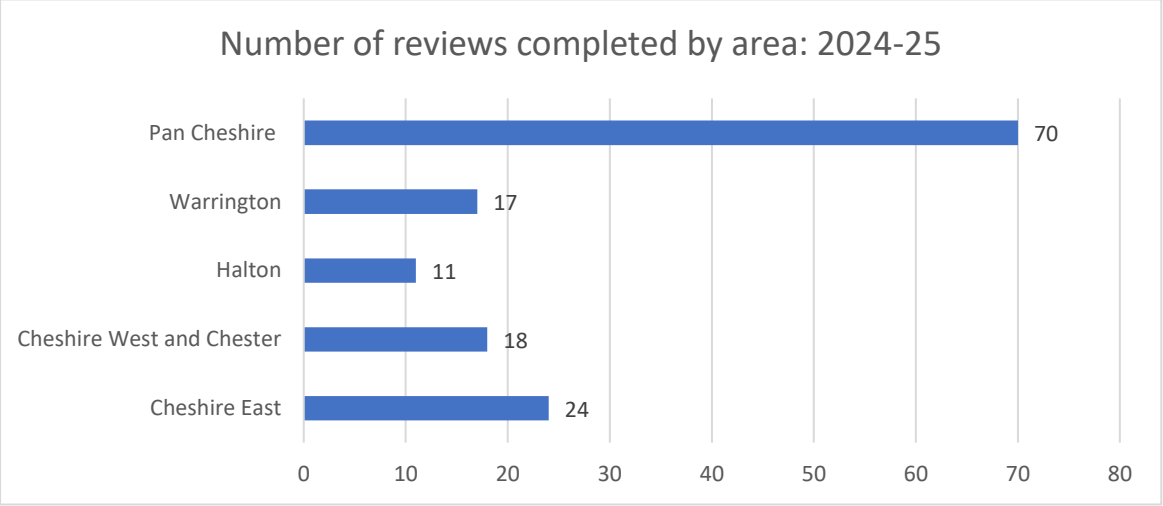
Child deaths are reviewed by the Child Death Overview Panel only when all information has been provided, and once all other review processes are completed. This is to ensure a final independent review by senior professionals to make sure all learning is identified and to ensure this learning will then be shared with wider relevant professionals to try and prevent future deaths, where possible.

70 reviews of child deaths were completed by the Child Death Overview Panel during 2024/25 (compared to 52 during 2023/24). The year of death of the cases reviewed ranged from 2018/19 to 2024/25:

- 4% had died between 2018/19 and 2021/22
- 19% had died during 2022/23
- 60% had died during 2023/24
- 17% had died during 2024/25

Of the reviews of child deaths completed, the highest numbers related to children resident in Cheshire East and Cheshire West and Chester as shown in Figure 5[13].

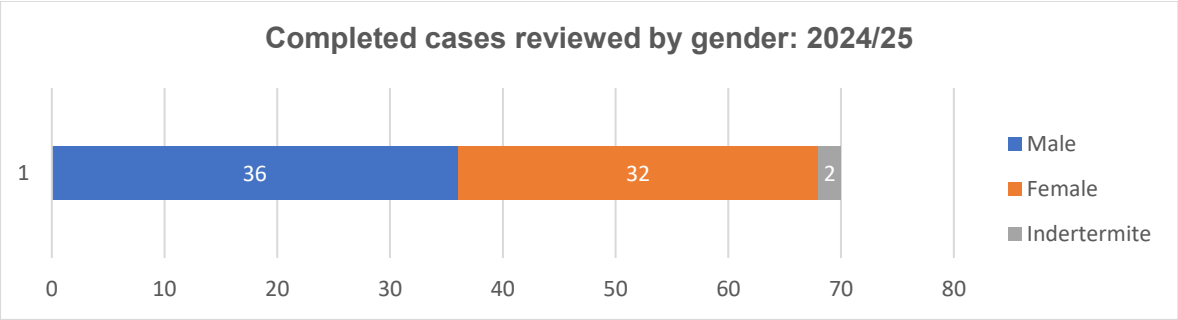
Figure 5: Number of reviews completed by area in 2024/25



[13] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP Report created on: 15/05/2025. Quarter 4 2024/25: Page 3

There were slightly more male children reviewed than female as shown in Figure 6[13].

Figure 6: Number of reviews completed by gender in 2024/25



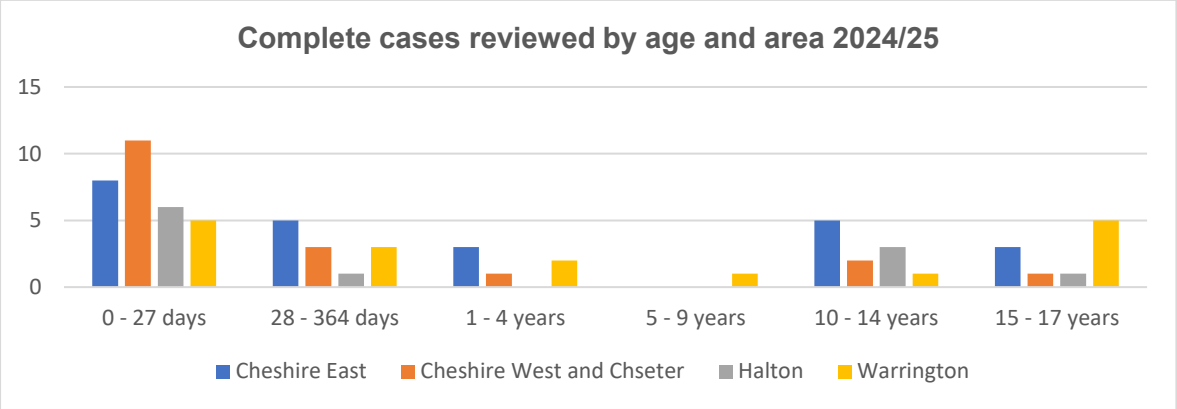
As of 31 March 2025, there were 52 cases with reviews ongoing (compared to 63 on 31 March 2024), which therefore, could not be reviewed by the Child Death Overview Panel. Cheshire East has 19 ongoing cases, Cheshire West and Chester 15, Warrington 13, and Halton 5[14].

The length of time between notification and the final review can vary considerably depending on circumstances and other review processes. The reasons for delays can include awaiting post-mortems and inquests and updates from out of area mortality reviews.

6. Child death reviews completed by age and area (2024/25)

The highest numbers of child deaths reviewed related to death during the neonatal period (40/70,57%). 60% (42/70) of the child deaths reviewed related to death within the first year. The next highest proportions of reviews related to 10–14-year-olds (16% - 11/70) and 15–17-year-olds (14% - 10/70) as shown in Figure 7[14].

Figure 7: Completed cases reviewed by age and area



[14] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP Report created on: 15/05/2025. Quarter 4 2024/25: Page 2

7. Expected and Unexpected Deaths

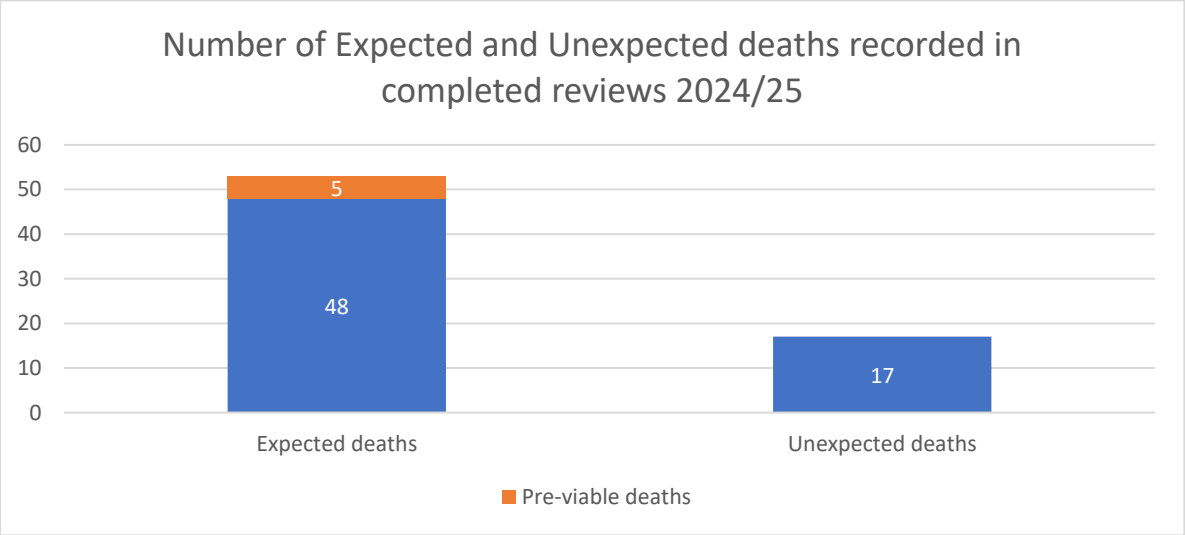
Child deaths fall under one of two categories:

• *Expected Death*: A child death is an "expected" death when the death of an infant or child was anticipated, such as for children born with life-limiting conditions

• *Unexpected Death*: An unexpected death is defined as a death that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death.

The category of death was used to define whether the child deaths reviewed were expected or unexpected. There were 76% (53/70) completed reviews that were the death was expected and 24% (17/70) where an unexpected death was reported as shown in Figure 8.

Figure 8: Number of expected and unexpected deaths 2024/25



Extreme Prematurity and Pre-Viable Deaths 2024/25

Extreme prematurity is defined as birth occurring before 28 weeks gestation[15] and there is an increasing risk of mortality with decreasing gestational age. At 26 weeks gestation up to 21% of babies may die and this increases to 79% of babies born at 22 weeks gestation. A framework for practice in the management of extremely premature delivery before 27 weeks gestation states[16]:

[15] World Health Organisation Factsheet (2023) Preterm birth. www.who.int/news-room/fact-sheets/detail/preterm-birth (Accessed 16 July 2025)

[16] Mactier H, Bates SE, Johnston T BAPM Working Group, *et al* Perinatal management of extreme preterm birth before 27 weeks of gestation: a framework for practice *Archives of Disease in Childhood - Fetal and Neonatal Edition* 2020;**105:**232-23: F233-4

‘Neonatal stabilisation may be considered for babies born from 22+0 weeks of gestation following assessment of risk and multiprofessional discussion with parents. It is not appropriate to attempt to resuscitate babies born before 22+0 weeks of gestation’.

There was a total of six child death reviews (9% - 6/70) categorised as extremely premature. However, a large majority of these reviews were for babies born before 22 weeks gestation and could be classified as pre-viable.

Pre-viable deaths

A total of five child death reviews were undertaken where the gestation ranged between 17+4 weeks and 22+0 weeks. These pre-viable deaths represent 7% (5/70) of the cases reviewed in 2024/25, and account for 83% of the cases reviewed with a category of death due to extreme prematurity (5/6).

There has been undocumented discussion that publication of guidance to help interpret ‘signs of life’ in babies born at these extremes of gestation may have contributed to an increasing number of pre-viable babies being registered as live births. As these babies subsequently die shortly after birth, they are included in the child death review process and contribute to the total of expected deaths (see Figure 8).

8. Categories of death for completed child deaths reviews 2024/25

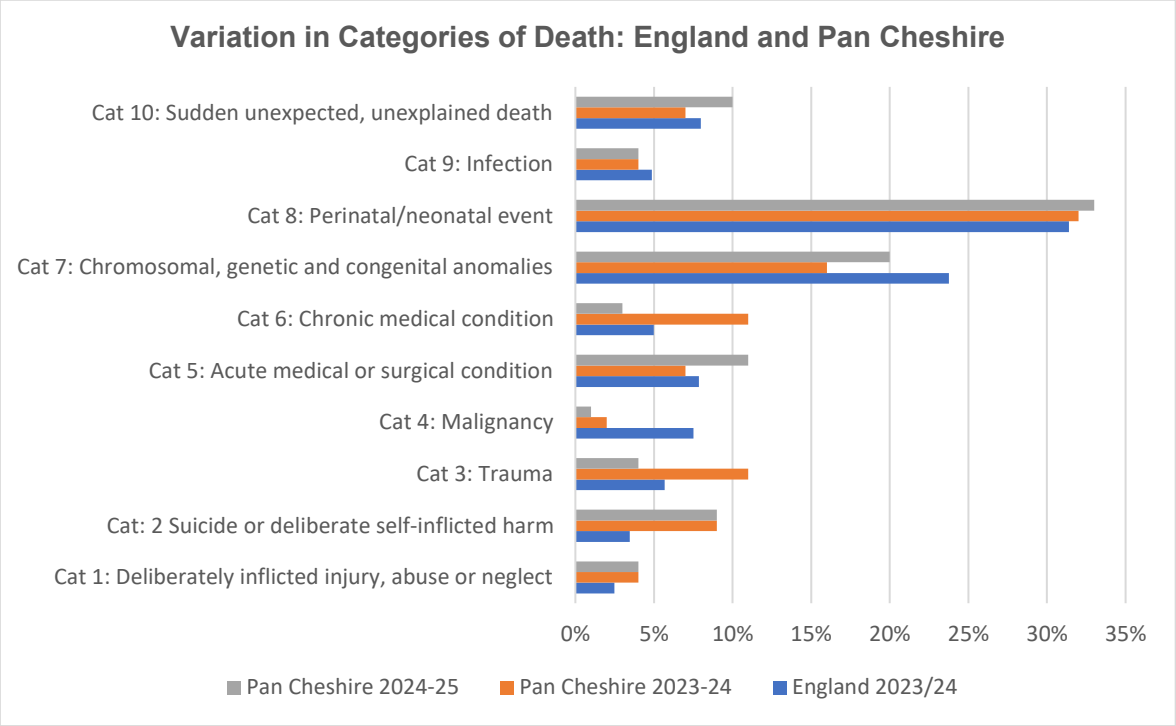
There are ten categories of death (with some subcategories) listed on the Child Death Analysis Form and the most frequent causes of death amongst completed reviews in 2024/25 were:

- Category 1: Perinatal/neonatal events (33% - 22/70)
- Category 7: Chromosomal, genetic and congenital anomalies (20% - 14/70),
- Category 5: Acute medical or surgical condition 11% (8/70)
- Category 10: Sudden unexpected, unexplained death 10% (7/70).

Whilst there is significant variation from year to year (due to the small numbers involved) and statistical significance has not been determined, the distribution of the causes of death are fairly similar in the Pan Cheshire Child Death Overview Panel footprint to the England average[17] as shown in Figure 9..

[17] NCMD (2024) Child Death Review Data Release: Year ending 31 March 2024. Published November 2024. Available from: Child death data release 2024 | National Child Mortality Database (ncmd.info): Table 16 (Accessed 26 June 2025).

Figure 9: Variation in categories of death: National and Pan Cheshire



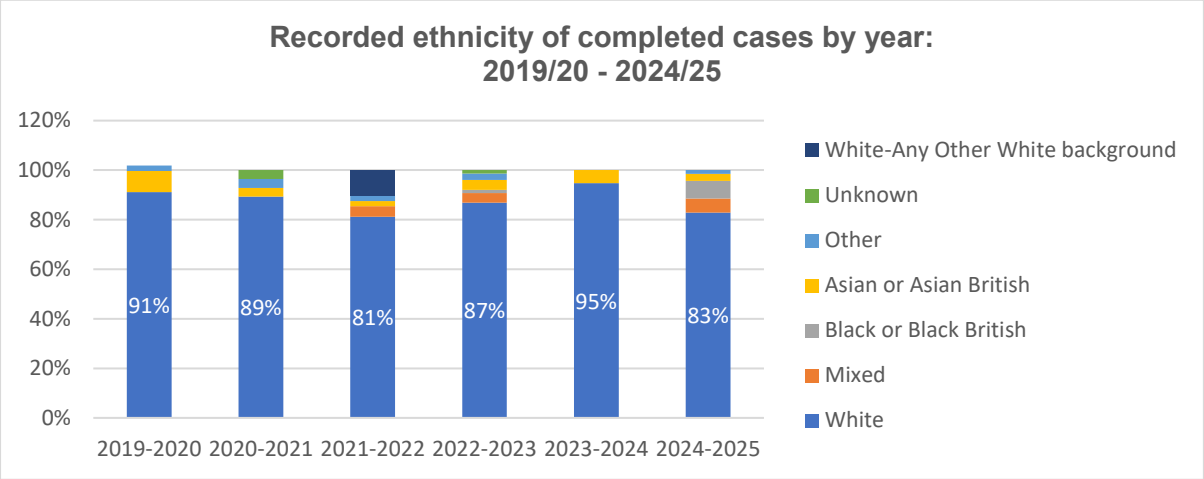
9. Completed child death reviews by ethnicity 2024/25

The majority of completed case reviews in 2024/25 had a recorded ethnicity of "white" (58/70, 83%). This has been a consistent finding since 2019/20, with the exception of 2023/24 when the proportion of 'white' ethnicity was 95% (see Figure 10).

The School Census indicates that 83.5% of children and young people are recorded as "White British" across the Pan Cheshire area. The numbers of closed cases are comparatively very small compared to the entire population. However, children from ethnicities other than White British do not appear to be significantly overrepresented (Black ethnicity 6.38%; Mixed ethnicity 4.15%; Asian ethnicity 4.04%)[18].

[18] GOV.UK(2025) Academic year 2024/25. Schools, pupils and their characteristics. Available from: https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics (Accessed 27 June 2025).

Figure 10: Recorded ethnicity of completed cases by year: 2019/20 – 2024/25

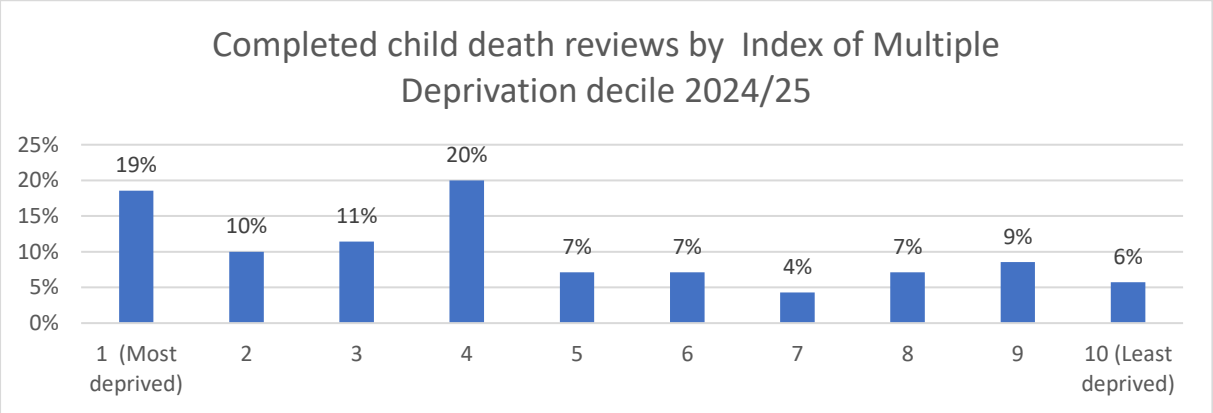


10. Completed child death reviews by deprivation deciles 2024/25

Deprivation is a key factor that is associated with poorer outcomes for child health and wellbeing. Deprivation is also associated with the risk of death in childhood and a report from the National Child Mortality Database[19] demonstrated a clear association between the risk of death and the level of deprivation for children who died in England at the time of the report.

A review of deprivation in the completed child death reviews across Pan Cheshire in 2024/25 indicates a higher proportion of deaths in the most deprived decile (19%), compared to the least deprived (6%), with the highest proportion of deaths occurring in the 4th decile (20%) – see Figure 11. There will need to be some consideration given to current policies and strategies in place within and across partner agencies to address issues associated with deprivation and the impact on health outcomes.

Figure 11: Competed child death reviews by Index of Multiple Deprivation decile



[19] NCDM (2021) Child Mortality and Social Deprivation: National Child Mortality Database Programme Thematic Report April 2019 – March 2020 NCMD-Child-Mortality-and-Social-Deprivation-report_20210513.pdf (Accessed 16 July 2025)

11. Modifiable factors in child death reviews completed during 2024-25

Modifiable factors are factors across the domains specific to the child, the social environment, the physical environment, and service delivery that could be altered to prevent future deaths[20]. During 2024-25, the leading associated modifiable (or vulnerability) factors across the Cheshire Child Death Overview Panel area 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[21] 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

There is a noted increase in the proportion of modifiable factors recorded as issues in service provision in 2024/25, 44% compared to the 7% (7/57) recorded in 2023/24. The issues with service provision recorded include:

- Communications issues
    - When a child dies out of area
    - When a child is transferred to a tertiary centre
    - Between tertiary centre and local unit for infants and older children when most of the care from birth is provided by the tertiary centre
- Transitional care for 16 – 18 year olds
- Lack of gender identity services

A deep dive will be undertaken into the issues in service provision identified in the completed reviews to provide further clarity regarding available services or gaps in service, and to determine lessons learned and changes to practice required to improve service delivery.

Maternal obesity and smoking appear to be consistent modifiable factors, accounting for 20% and 16%, respectively, of all completed reviews completed in 2023/24.

Maternal Obesity

Maternal obesity is not only linked to many adverse outcomes for both mother and baby during pregnancy and birth, but there is also evidence that an obese intrauterine environment is associated with long-term obesity risk for the child[22]. There was a new indicator for 2024 on obesity in early pregnancy, derived from Maternity Services Data Set version 2.0. This is a statistic in development so may

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[20] GOV.UK (2023) Working together to safeguard children 2023: statutory guidance (Accessed 27 June 2025).
[21] Attention Deficit Hyperactivity Disorder (ADHD); Autism; Neurodivergence
[22] Dearden L and Ozanne S.E (2023) Early life impacts of maternal obesity: a window of opportunity to improve the health of two generations *Phil. Trans. R. Soc. B***378** 20220222. **https://doi.org/10.1098/rstb.2022.0222**. (Accessed 24 July 2025).

initially be subject to issues with data completeness[23]. The data indicates that in England during 2023/24 over 1:4 (26.2%) women booking in pregnancy are recorded as obese within the first 14 weeks of pregnancy.

The data available for Pan Cheshire indicates that the proportion of obesity in early pregnancy is similar to the England average in Warrington (25.7%). However, more than 1:3 women in Halton (35.9%) are recorded as being obese in early pregnancy, statistically significantly greater than the England average. Unfortunately, the data was incomplete for Cheshire East and Cheshire West and Chester at the time of data publication (see Table 2).

A multi-agency approach is needed to address the challenges of the obesogenic environment. Pre-conception support and advice can have an impact on the proportion of women recorded as obese at booking. Further consideration is also needed on the feasibility of interventions that can safely support healthy eating during pregnancy to improve maternal health and long-term outcomes for the child.

Table 1: Obesity in early pregnancy, local, regional and national: 2023-24

	2023/24
Cheshire East	Data incomplete
Cheshire West and Chester	Data incomplete
Halton	35.9%
Warrington	25.7%
North West	28.4%
England	26.2%

Smoking during pregnancy

The latest data on smoking at the time of delivery across the four local authorities in Pan Cheshire for 2024/25[24] indicate that the proportion of women smoking in Cheshire East (4.8%), Cheshire West and Chester (5.1%) and Warrington is statistically similar to the England average, with Halton being statistically higher than the England average.

[23] DHSC (2024) Child and Maternal Health - Data | Fingertips | Department of Health and Social Care (Accessed 24 July 2025)
[24] NHS Digital (2025) Statistics on Women's Smoking Status at Time of Delivery: England, Quarter 4, 2024-25 Statistics on Women's Smoking Status at Time of Delivery: Data tables - NHS England DigitalStatistics on Women's Smoking Status at Time of Delivery: Data tables - NHS England Digital Table 5 (Accessed 23 July 2025)

However, Halton had the highest proportion of complete data submitted, with the smoking status known for 97% of all maternities, with only 2.9% (30) deliveries where the status was unknown. The lowest proportion of known smoking status was reported in Cheshire West and Chester with 82.6% known smoking status and 17.3% (450) deliveries) unknown see Table 2. Completeness of data may have a negative impact on the proportion of women known to be smoking at the time of delivery in areas with a high proportion of women with an unknown status recorded.

Whilst nationally there has been a steady decline in the number of women smoking during pregnancy over the past 10 years (11.7% 2014/15 – 5.6% 2024/25) this rate of decline in smoking is not reflected within the general adult population (25.3% 2006 – 15.8% 2024)[25] so smoking cessation advice and support services is still required for pregnant women and families where children exposed to environmental tobacco smoke.

Table 2: Women's Smoking Status at the Time of Delivery: Local, Regional and National 2024/25

	Percentage known smokers (CI)	Percentage known smoking status (smokers and non smokers)	Percentage unknown smoking status (number)
Cheshire East	4.8% (4.0-5.6)	87.5%	12.5% (400)
Cheshire West and Chester	5.1% (4.2-6.0)	82.6%	17.3% (450)
Halton	9.5% (7.7-11.3)	97.0%	2.9% (30)
Warrington	6.5% (5.3-7.7)	93.4%	6.6% (115)
North West	6.2% (6.0-6.4)	92.9%	7.1% (4835)
England	5.6% (5.6-5.7)	92.2%	7.8% (39,590)

(CI = Confidence Intervals)

It was noted that mental health concerns of the child or late booking/hidden pregnancy were identified as modifiable factors in 2023/24 completed reviews. The National Child Mortality Database produced a thematic report that may provide some insight to addressing some mental health concerns[26], and there is a 2025/26 Pan Cheshire recommendation to strengthen relations with the Local Maternal and Neonatal Services networks to share learning.

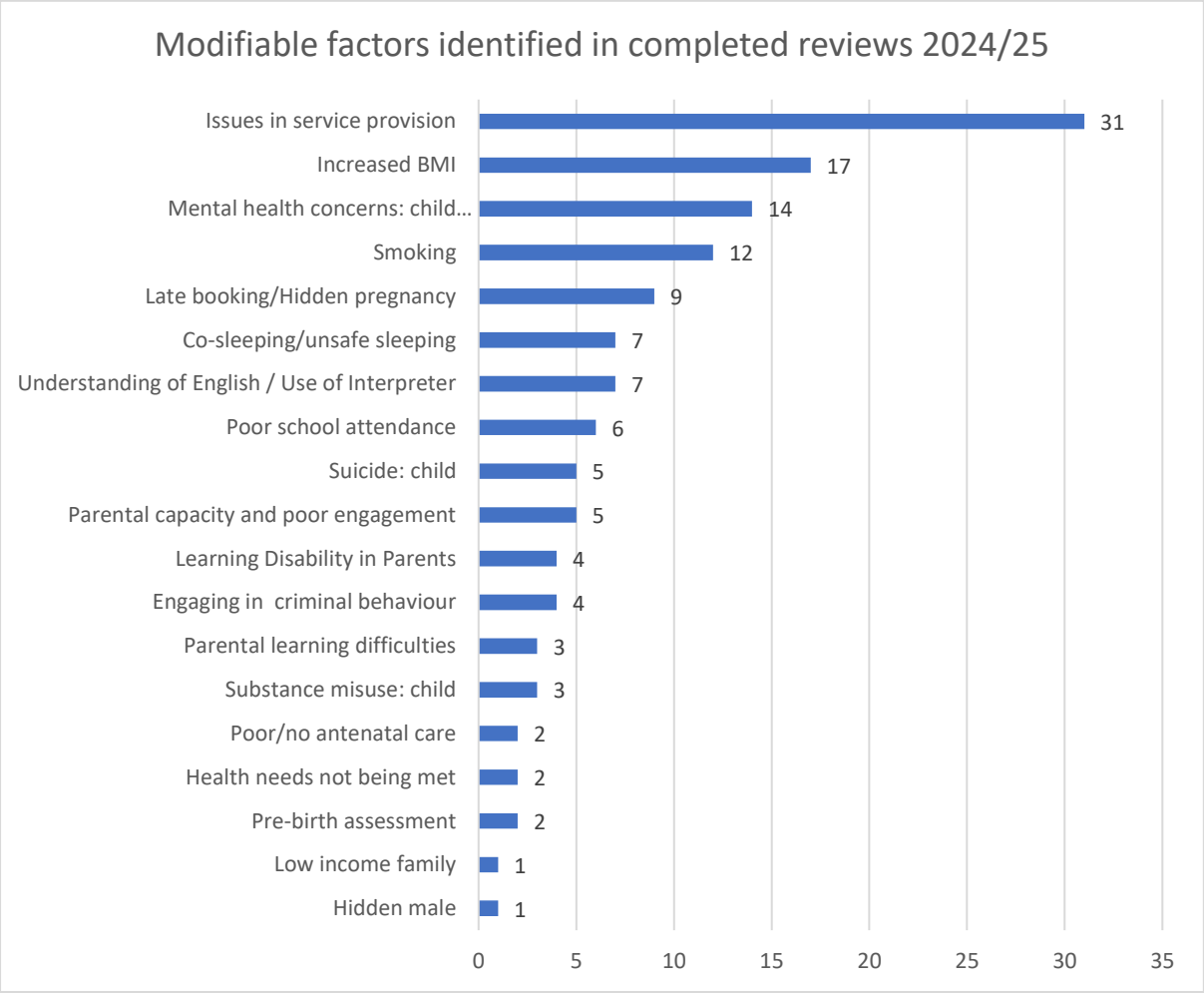
[25] Jackson SE, Cox S, Buss V, Tattan-Birch H, Brown J. Trends in smoking prevalence and socio-economic inequalities across regions in England: A population study, 2006 to 2024. Addiction [Internet]. [cited 2025 Mar 26] https://onlinelibrary.wiley.com/doi/abs/10.1111/add.70032 (Accessed 23 July 2025)

[26] NCMD (2024) Learning from deaths: Children with a learning disability and autistic children aged 4-17 years. National Child Mortality Database Programme Thematic report – Data from April 2019 to March 2022. NCMD-Learning-disability-and-autism-report_FINAL.pdf (Accessed 14 July 2025)

There were no modifiable factors identified for the following areas:

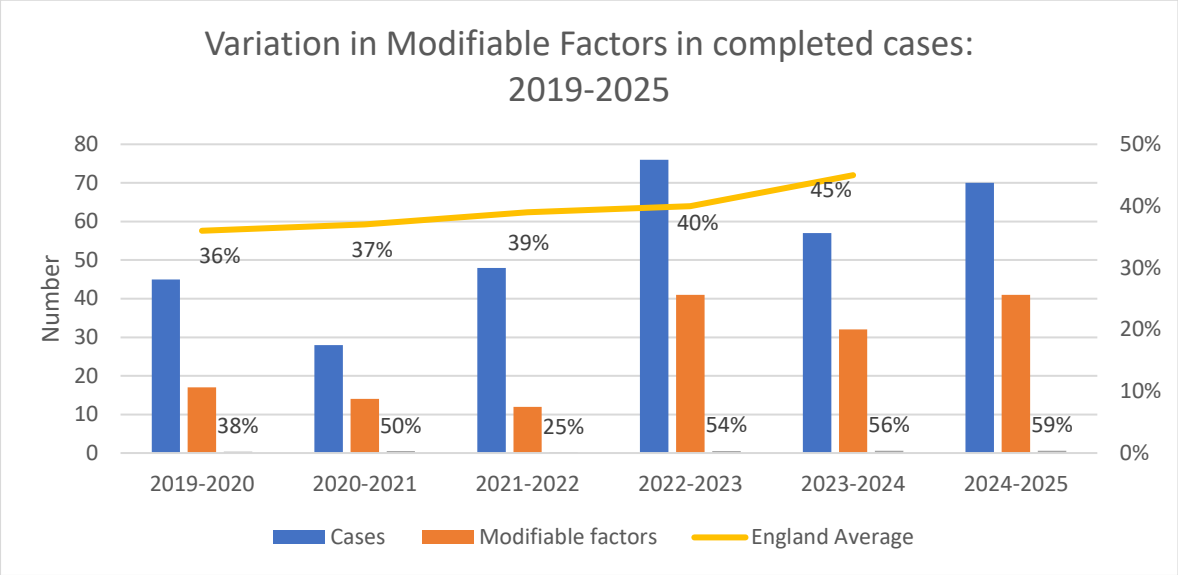
- Identification/involvement in gangs
- Step Up/Step Down
- Misuse of alcohol: child
- Suicide: key adult

Figure 12: Modifiable factors identified in completed reviews 2024/25



The recording of modifiable factors across Pan Cheshire has shown little variation since 2022/23. The percentage of modifiable factors recorded for Pan Cheshire has been consistently higher than the England average over the past 6 years (2019/20 – 2024/25) with the exception of 2021/22 (See Figure 13 – note 2024/25 data for England not yet available).

Figure 13: Variation in modifiable factors 2019/20 – 2024/25.



There is currently no national guidance to support decision-making regarding modifiable factors, and, as a result, there is variable reporting of modifiable factors across the 58 Child Death Overview Panels across England. Therefore, the data currently collected regarding modifiable factors may not be directly comparable nationally. There is work underway by the National Child Mortality Database to review and redefine recording of modifiable factors to ensure consistency of reporting in the future.

12. Modifiable risk factors by cause of death

During 2024/25, 41 out of 70 completed reviews were linked to modifiable risk factors. This represents 59% of all completed reviews and is higher than the percentage across England as a whole (45%). All completed reviews during this period with a primary category of suicide or deliberate self-inflicted harm and deliberately inflicted injury, abuse or neglect, had modifiable risk factors.

Modifiable factors were also linked to the majority of closed cases with the following primary categories of death:

- Sudden unexpected, unexplained death.
- Perinatal or neonatal events.
- Infection.
- Acute medical or surgical condition.
- Chromosomal, genetic and congenital anomalies.

The category of deaths with the highest numbers of cases with modifiable factors identified was for perinatal/neonatal events (see Table 3). These findings are dis-

similar to the national picture presented for child deaths during 2023-24, the national analysis for 2024-25 is not yet available[27].

Table 3: Category of Death for Completed Pan Cheshire Cases by Modifiable Factors 2024/25

Category of Death	Completed Reviews	Modifiable Factors	% Where Modifiable Factors Identified
Trauma and other external factors, including medical/surgical complications/error	3	0	**0%**
Suicide or deliberate self-inflicted harm	6	6	**100%**
Sudden unexpected, unexplained death	7	6	**86%**
Perinatal/neonatal event	23	16	**70%**
Malignancy	3	0	**0%**
Infection	3	2	**67%**
Deliberately inflicted injury, abuse or neglect	1	1	**100%**
Chronic medical condition	2	0	**0%**
Chromosomal, genetic and congenital anomalies	14	6	**43%**
Acute medical or surgical condition	8	4	**50%**
Total	**70**	**41**	**59%**

13. Modifiable risk factors by categories of death: England average 2024-25

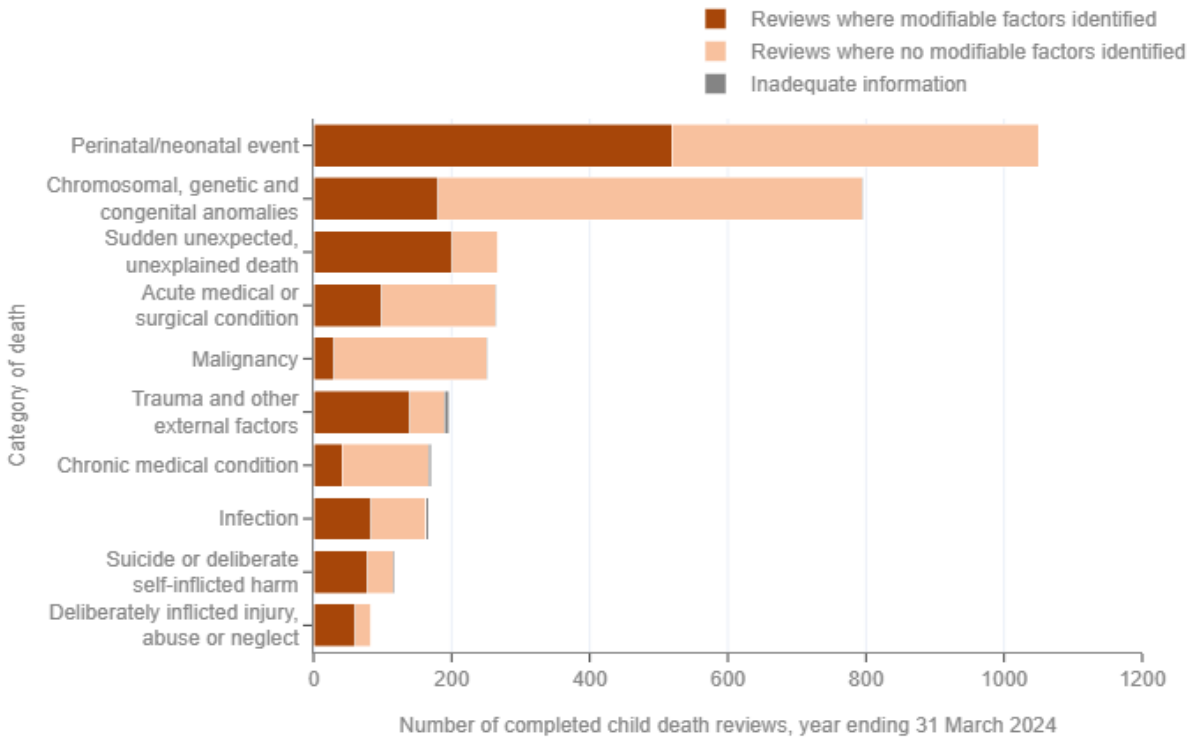
The picture in Pan Cheshire during 2024/25 was fairly similar to the England picture during 2023/24, in terms of primary categories, except for trauma and external factors where no modifiable factors were recorded for Pan Cheshire[28].

Categories of death where modifiable factors were most frequently identified in child deaths across England included:

- Trauma or other external factors (76%).
- Sudden unexpected and unexplained death (75%).
- Deliberately inflicted injury, abuse or neglect (73%).
- Suicide or deliberate self-inflicted harm (68%).

[27] NCMD (2024) Child Death Review Data Release: Year ending 31 March 2024. Published November 2024. Available from: Child death data release 2024 | National Child Mortality Database (ncmd.info) Table 15: (Accessed 27 June 2025).
[28] NCMD (2024) Child Death Review Data Release: Year ending 31 March 2024. Published November 2024 – Figure 17. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 27 June 2025).

Figure 14: Number of reviews completed by England Child Death Overview Panels by primary category of death and whether modifiable factors were identified, year ending 31 March 2024



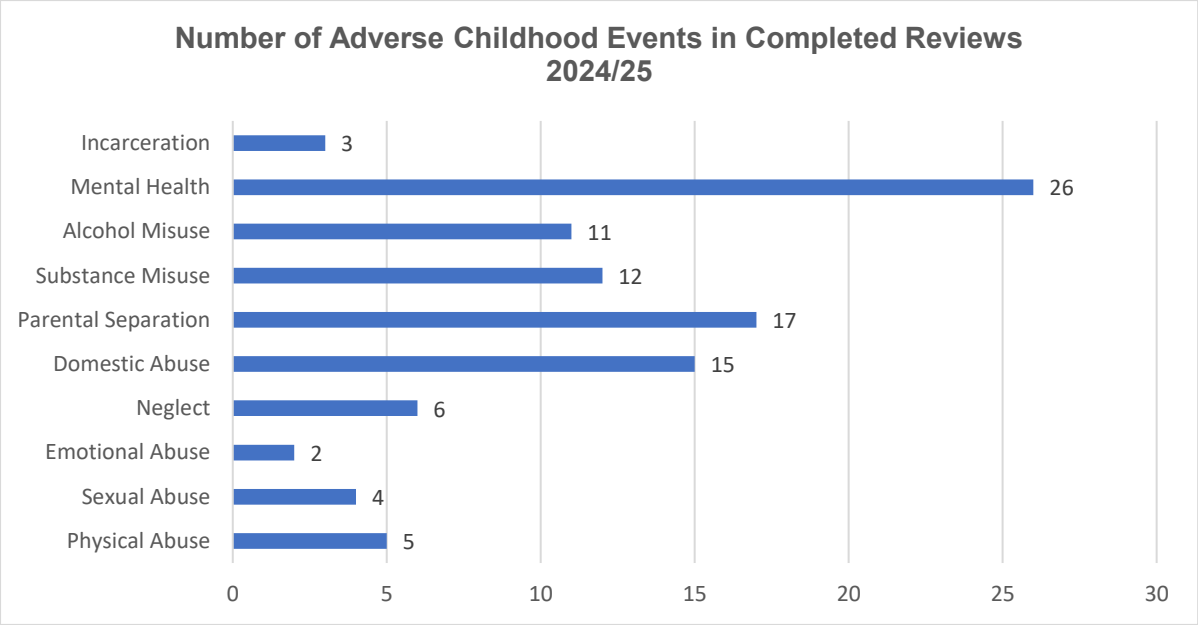
Data Source: NCMD
www.ncmd.info/cdr24/

14. Adverse childhood experiences in cases of child death

Adverse Childhood Experiences (ACEs) are a set of adverse events or environmental factors occurring in a person's life under the age of 18. It has been shown that ACEs can negatively affect people's health and opportunities throughout their life, however in many cases ACEs are preventable[29].

There was a total of 101 ACEs recorded for the completed cases reviewed in 2024/25, with the most common event being mental health issues of parent/care giver[30] (26), followed by parental separation (17) and domestic abuse (15) as shown in Figure 15.

Figure 15: Number of Adverse Childhood Events Recorded 2024/25

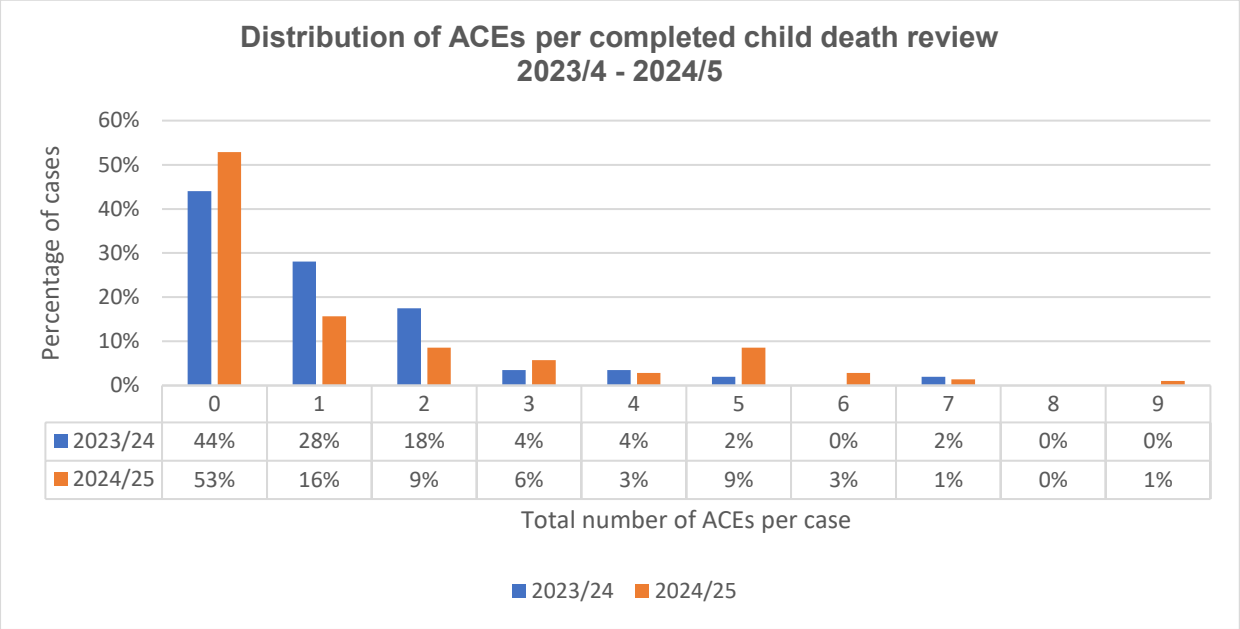


The number of ACEs recorded per case reviewed in 2024/25 ranged from zero to nine, compared to zero to seven in 2023/24, see Figure 14. Over half of the cases reviewed (53% - 37/70) had zero associated ACEs, and 17% (12/70) had four or more ACEs identified. There appear to be more cases reviewed with zero associated ACEs in 2024/25 compared to 44% (25/57) in 2023/24. However, there were also a higher proportion of cases with four or more ACEs identified in 2024/25 compared to 7% (4/57) cases identified in 2023/24 as shown in Figure 16.

[29] CDC (2024) Adverse Childhood Experiences. Available from: https://www.cdc.gov/aces/about/index.html?CDC_AAref_Val=https://www.cdc.gov/violenceprevention/aces/preventingace-datatoaction.html (Accessed 13 September 2024).

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

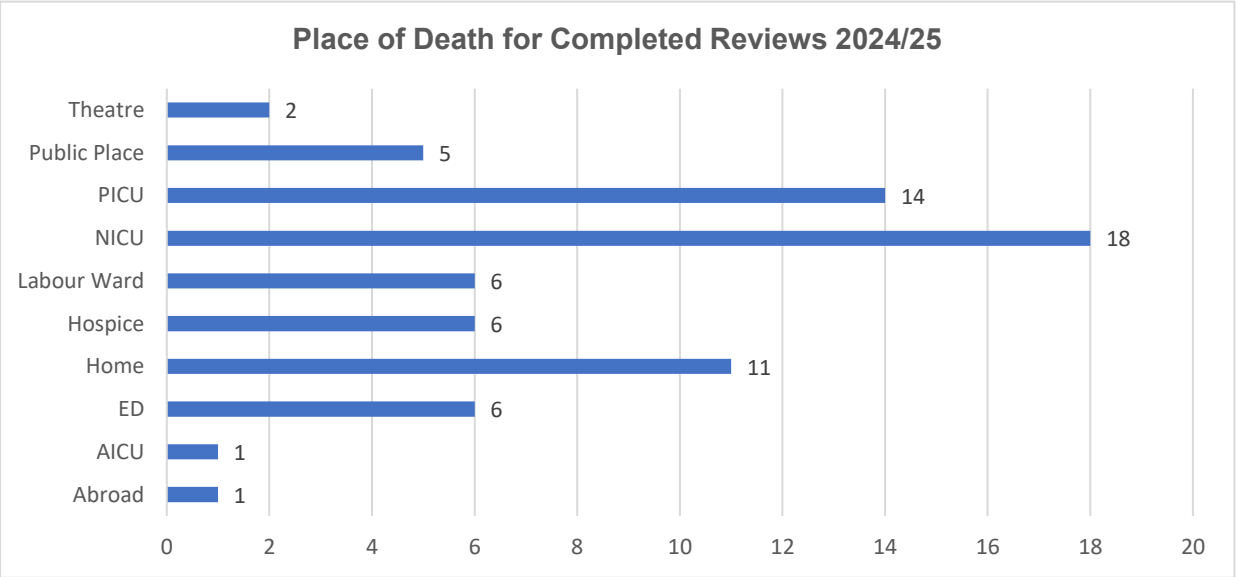
Figure 16: ACE Distribution per case 2023/4 – 2024/5



15. Place of death for reviews completed 2024/25)

The majority of deaths reviewed in 2024/25 occurred in hospital either in the neonatal intensive care unit (26% - 18/70) or paediatric intensive care unit (20% - 14/70), followed by deaths at home (16% - 11/70) as shown in Figure 17.

Figure 17: Place of death for completed reviews 2024/25



Appendix Two: Training and Development during 2024/25

Mental Health – lunch and learn

A significant number of cases that are reviewed by the Pan Cheshire Child Death Overview Panel identifies many of the mothers have past or current mental health issues. The specialist mental health services provided a multi professional lunch and learn presentation for Cheshire & Merseyside. The aim was to update professionals, particularly in health and social care, on perinatal/maternal mental health and infant relationships. The presentation highlighted what the Maternal mental Health services have to offer; when professionals should refer/seek support; how to get this support and the referral processes. The feedback from the event indicated that it was a very informative well received session. 226 professionals attended this event.

SILVER BIRCH HUBS
Cheshire and Merseyside Maternity Wellbeing Support

Cheshire and Mersey Specialist Perinatal Service
Mental healthcare for women and families

ICON, Out of Routine and Infant Safe Sleep – lunch and learn to Cheshire East drug and alcohol team and Cheshire West Early Years Managers (TEAMS)

A learning session to Cheshire East Drug and alcohol teams on unsafe sleep, ICON, sudden and unexpected deaths and situational and out of routine risks. This included how a co-ordinated multi-professional response with key professionals supporting families can help particularly if approaches such as motivational interviewing are used and consideration is given to each family's personal circumstances and thresholds and assumptions are not lowered based on deprived backgrounds. 36 staff attended the Cheshire East lunch and learn delivered by the Specialist CDR (child death review) Nurse and by the founder of ICON Dr Suzanne Smith.

Infant Vulnerability conference –

Situational and out of routine risks, SUDIC, Unsafe sleep and Cold rooms were the focus of this multiagency conference, using Pan-Cheshire local and national statistics. Presenters included the specialist Child Death Review nurse, the Designated Doctor for Child Deaths, and safeguarding midwives from two of our NHS trusts. The event was fully booked with 100 attendees

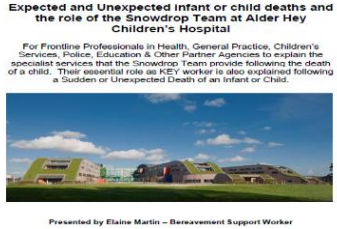
Support of ICON and Infant Safe Sleep Week Events –

We continue to support National events to raise public awareness regarding Infant safe sleep and the ICON which is a UK-based initiative designed to support parents and caregivers in understanding and managing infant crying. It aims to prevent Abusive Head Trauma (AHT) by providing information and coping strategies for dealing with persistent infant crying.

Resources, toolkits, newsletters and information on webinars were shared to all agencies in Cheshire via the communication teams.
Safe sleep, out of routine and situational risk and cold rooms lunch and learn event was delivered by the Specialist CDR Nurse and the Safeguarding Midwife for Cheshire East to support Infant safe sleep week and raise awareness of safe sleep across Pan Cheshire, 53 professionals attended.

The Winter tips booklet for keeping your baby safe was re shared with multi-agencies across Pan Cheshire in the weeks leading up to the Christmas festive period when families maybe more likely to be out of routine and exposing their infants to situational risks associated with unsafe sleep.

Bereavement
'Raising awareness of bereavement support' by the planning and facilitation of a suite of lunch and learn events by key organisations, the Alder Centre, the Child Death Helpline. the Snow Drop Team, Claire House Hospice and the Chester Milk bank. The latter of which seems to be a relatively unknown service, so this was a good opportunity to raise awareness and give women the choice to donate their breast milk following the loss of a baby if they so wish. Extensive bereavement support is also provided to these parents.
These events provided detailed information to professionals on the outstanding bereavement services that are available and the referral pathways. A total of 235 professionals attended these sessions from both Pan Cheshire and Merseyside.



Accident Prevention: Water Safety

Cheshire has an extensive network of rivers and there have been incidents of children drowning in Cheshire. These incidents highlight the dangers of water and the importance of water safety education, particularly during summer months and school holidays when children are more likely to take risks.

Royal Life Saving Society Prevention of Drowning Lunch and Learn: Royal Life Saving Society (RLSS) facilitated a lunch and learn session to raise awareness of drowning. The session was attended by health, care and education professionals and the voluntary sector from both Cheshire and Merseyside as the extensive waterways in Cheshire also border Merseyside. There were 52 attendees to this event and feedback was excellent

RLSS drowning Prevention week: A poster was developed with links to resources for professionals to educate parents/carers and children - shared throughout Cheshire & Merseyside

World Drowning Prevention Week: Links to resources for professionals to educate parents/carers and children were shared across Cheshire & Merseyside

Winter Water Safety Poster designed and circulated to multi agencies in Cheshire in November. This was also re-released following poor weather and icy conditions following the Christmas holiday period. This was in response to an incident during the previous year in the Midlands of several children who had died whilst playing on an icy river

Water Safety Poster designed in response to a local drowning and awareness of an out of area incident resulting in a critically ill child. Poster and message regarding water safety circulated prior to the school holidays to multi-professionals across Pan Cheshire & Merseyside.

NMCD Drowning Deaths in England Report 2022-2023.

Shared to raise awareness of National figures and concerns regarding a rise in deaths of children from drowning. This was shared across Cheshire & Merseyside.

Accident Prevention: **Road Safety**

'THINK!' is a road safety campaign supporting children as they move to secondary school. A poster was designed and circulated to multi-agencies in response to a Road Traffic Collision which resulted in a child death in Cheshire. The THINK 'safe Adventures', aims to help parents across the country prepare their children for independent travel when they move to secondary school.

Cheshire Fire & Rescue Service advice – The Fire and Rescue Service information for parents and carers on teaching children how to cross the road safely with a key message TO STOP, LOOK, LISTEN and THINK. The Poster and information from both 'THINK' and the Cheshire fire & rescue service was disseminated throughout Cheshire.

Appendix Three: Progress against 2023/24 annual report recommendations during 2024/25

Recommendation	Progress during 2024/25	Next steps
1. Identify mechanisms for professional development.	Integrated Care Board (ICB) lunch and learn sessions have been planned with a standard slide set produced for consistency.	To develop a calendar of learning events across Cheshire and Merseyside, promoted by the ICB and accessible to local trusts and partner agencies.
2. To review more cases than notifications received within the reporting year	The outstanding number of cases reduced from 59 to 52 and 70 cases were reviewed within the reporting year.	To maintain 2 monthly meetings and expedite information required to review cases where possible.
3. Develop stronger relationships with the Coroner's office, particularly in relation to information sharing, post-mortem reports and child death review meetings.	Annual meetings with the coroner are an established part of routine Child Death Overview Panel business and there is an agreed memorandum of understanding (MOU).	To maintain annual meetings with Coroner's Office and amend MOU as required.
4. Strengthen the Child Death Overview Panel business support functions through additional investment and funding arrangements.	A second part-time administrator is in post providing effective business support. There is agreement between the Pan Cheshire and Merseyside business administrators to provide cross-cover to maintain business continuity.	To maintain business continuity.
5. Maintain Pan Cheshire Child Death Overview Panel compliance with the National Child Mortality Database Report Key Performance indicators.	Compliance with key performance indicators has been demonstrated in the quarter four 2024/25 National Child Mortality Database report which highlighted 100% completeness for all indicators.	To maintain this good standard of data completeness.

6. Use business meetings to consider impact of trends on overall child health and mechanisms to awareness raise/train. To consider ways to link with near-miss reports.	The revised tracker provides summary of notifications and, with further analysis, may be able to identify trends for future learning. Minutes from ALTE meetings have been requested for review at each meeting to consider near-misses.	To ensure information provided by the tracker and ALTE reports are reviewed at each Business meeting.
7. To identify an analytical lead to explore the analytical capacity within eCDOP to report back regularly to the business meetings.	Analytical support has been agreed with the Public Health team in Cheshire East, to commence in September 2025.	To provide more detailed analysis of data available in eCDOP and include findings in the recently produced CDOP performance report ans.
8. Analyse trends and themes that will inform awareness raising/ training sessions as required.	Longer-term comparative analysis of modifiable factors has been included in the 2024/25 annual report along with an in-depth review of adverse childhood experiences associated with child deaths. .	Circulate National Child Mortality Database quarterly reports; monitor themes emerging from panels and national reports, and provide recommendations; develop 7-minute briefings
9. Raise the profile of Child Death Overview Panel and the Child Death Review processes, and highlight impacts, with Health and Wellbeing Boards, and children's safeguarding partners.	The circulation of the annual report will be mapped to ensure that all partner agencies have received the report and are aware of the key findings and learning.	The annual report to be presented at all Health and Wellbeing Boards and Children's Safeguarding Partnerships.
10. Develop a system for identifying and monitoring impact of all learning from the CDR processes	Learning pathways requested from each agency to support dissemination of learning and monitoring impact.	To map the pathway of learning for Child Death Review partners.

Contributors to the report

This report was produced through a collaborative multi-agency team including:

- Glenda Augustine, Independent Chair Pan Cheshire Child Death Overview Panel, Cheshire East Council
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- Sue Pilkington, Designated Nurse Safeguarding Children and Children in Care, Cheshire West Place, NHS Cheshire and Merseyside Integrated Care Board
- Dr Rajiv Mittal, Designated doctor for Safeguarding and Child deaths, Countess of Chester Hospital
- Anne Barber, Senior Administrator, Pan Cheshire Child Death Overview Panel, Mid Cheshire Hospitals NHS Foundation Trust
- The wider Pan Cheshire Child Death Overview Panel and Business Meeting members