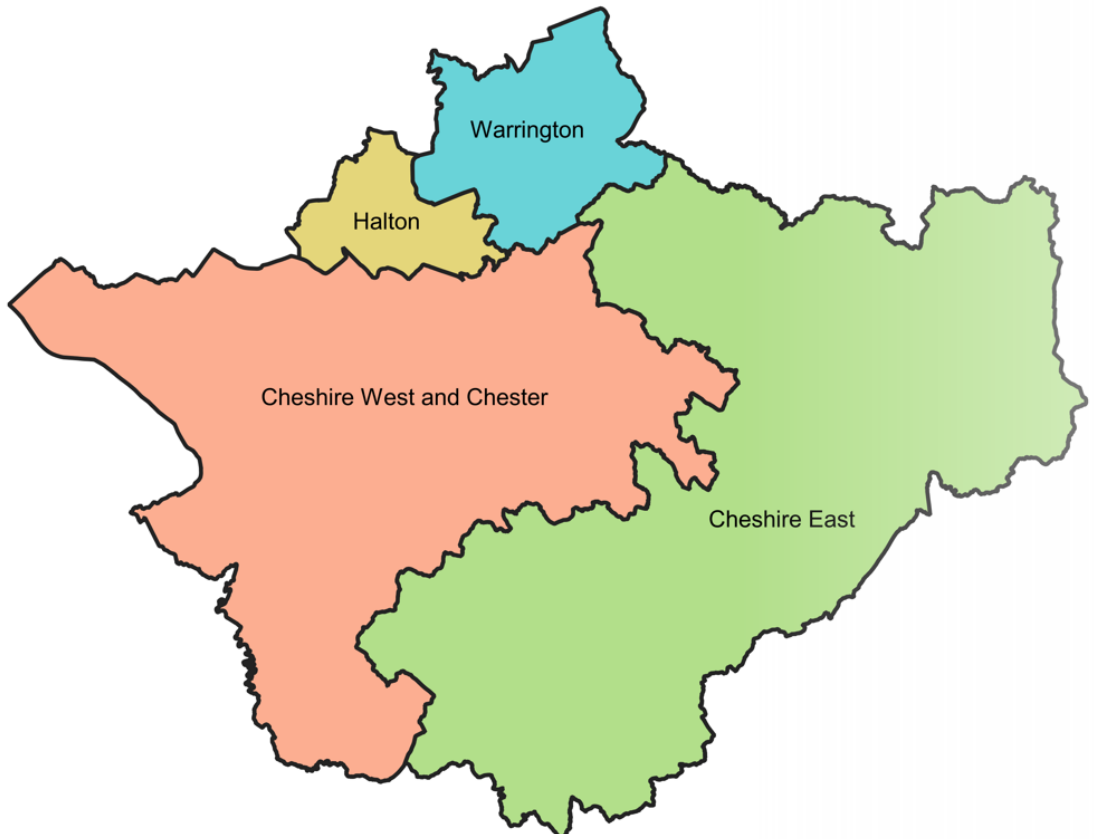

Annual Report of the

Pan Cheshire Child Death Overview Panel

2024/25

Source: ONS Counties and Unitary Authorities (May 2023) Boundaries UK BFE (downloaded 28/11/2023)
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1. Introduction

Each child death is a tragedy.

"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].

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.

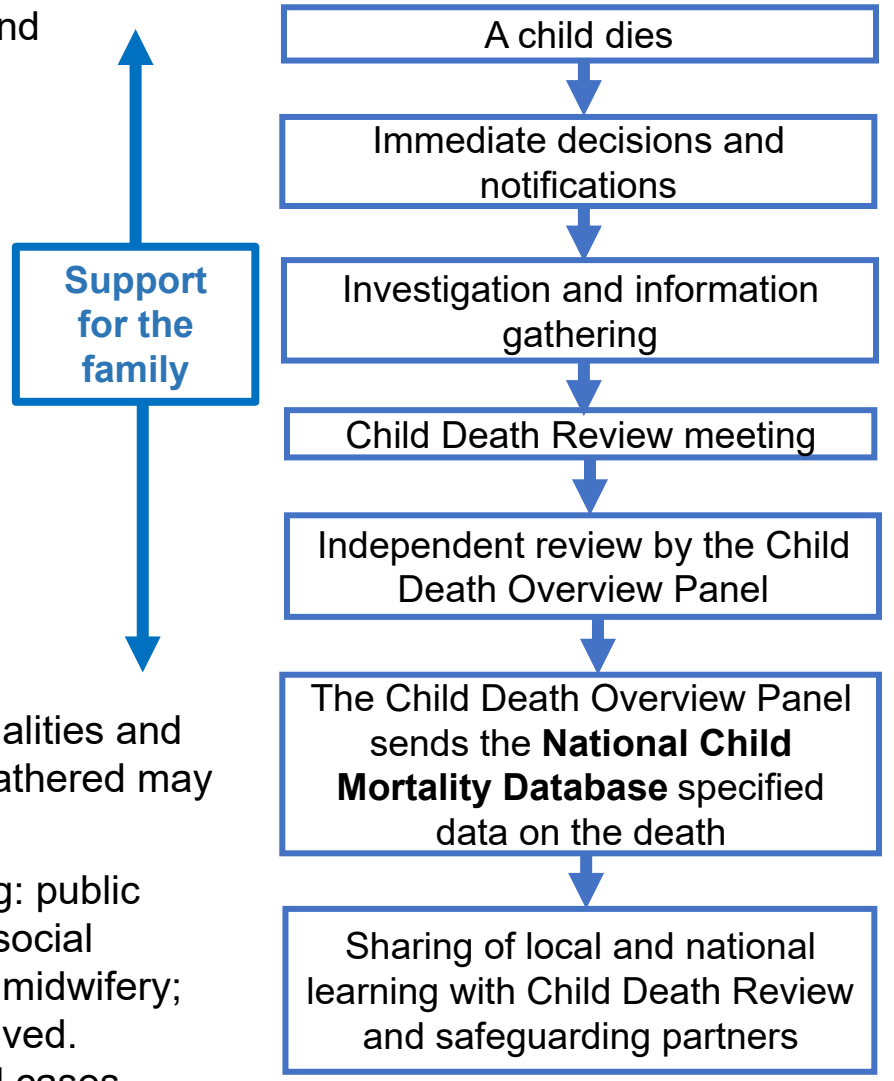
This current report focuses on children **whose deaths were either notified to the Pan Cheshire Child Death Overview Panel during 2024/25**, or whose reviews concluded during 2024/25.

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 the 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 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

2. The Pan Cheshire Child Death Overview Panel footprint and process

- Child Death Review partners include the local authorities and the NHS Cheshire and Merseyside Integrated Care Board.
- The Cheshire 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 described in the figure to the right is undertaken. More detail is provided in the statutory guidance.
- The review by the Child Death Overview Panel 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 the child during their life. The information gathered may help identify factors that could be altered to prevent future deaths.
- The Pan Cheshire Child Death Overview 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.



3. 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 families have the support and importantly, 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"[1]

4. Purpose of the Child Death Overview Panel Annual Report

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

- To clarify and outline some of the CDOP 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 Cheshire.
- To provide an overview of information on trends and patterns in child deaths reviewed across Cheshire during the last reporting year (2024/25) and highlight issues arising from the child deaths reviewed.
    - This could include deaths of children who were resident in the Cheshire CDOP footprint, or who died in the Cheshire CDOP footprint
- To report on achievements and progress.
- To make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across Cheshire.

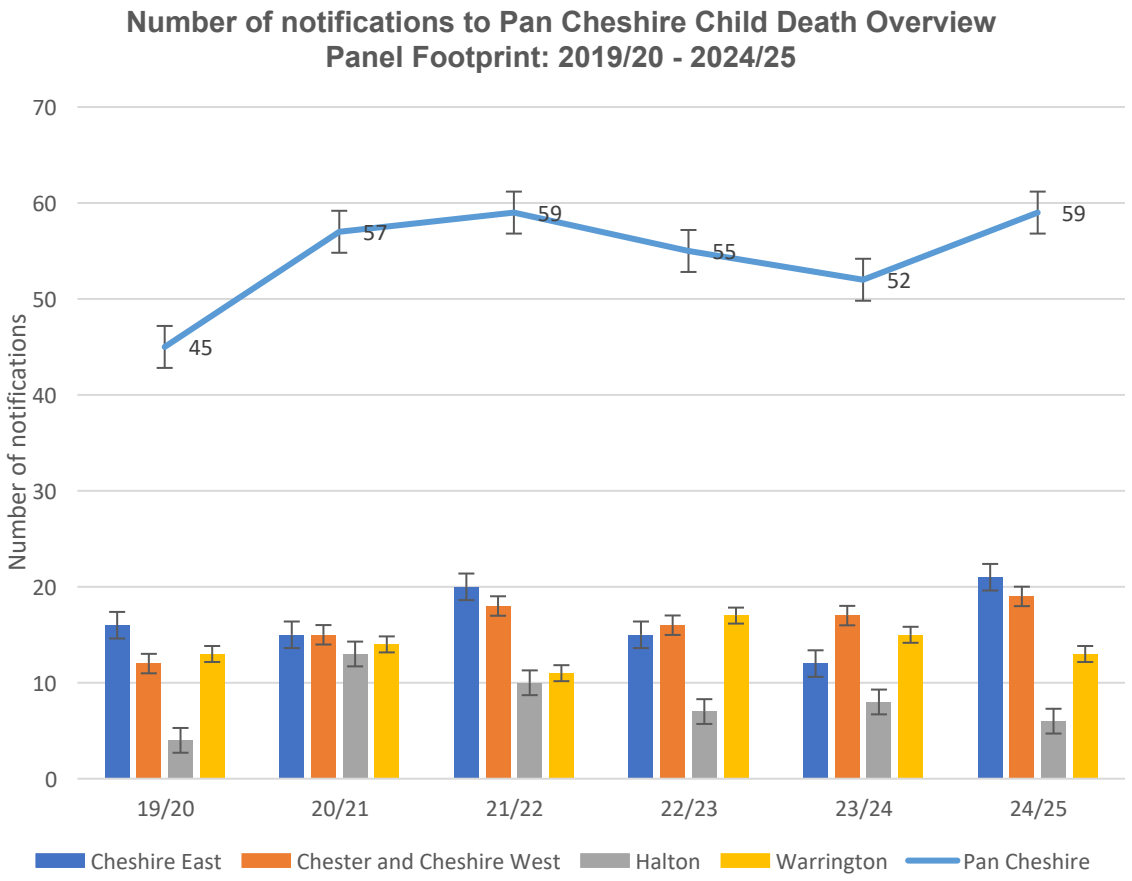
5. Key trends in child death notifications

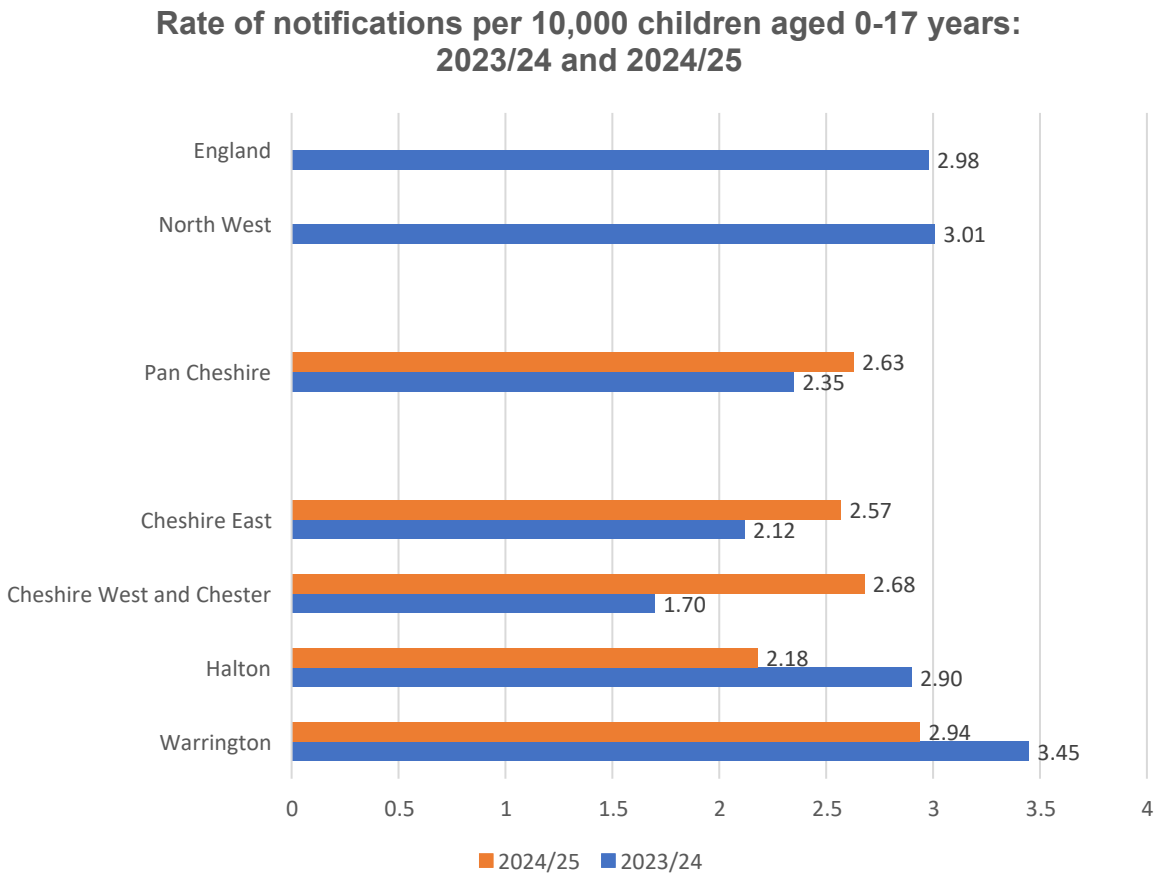
As described in the statutory guidance, when a child dies, a number of notifications should also be made, including: to the child's GP and other professionals; to the Child Health Information System; the relevant Child Death Review partners and the Child Death Overview Panel. This helps to guide how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

- **Rates of child notifications 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*.
    - The rate of notifications across England as a whole was 2.98/10,000 during 2023/23[1].
- **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%).
- It is difficult to discern a pattern of seasonal variation due to the very small numbers involved.

*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)

5a. Number and rate of child death notifications





6. Key trends in reviews of child deaths completed by the Child Death Overview Panel during 2024/25

Child deaths are reviewed by the Child Death Overview Panel only after all other review processes are undertaken. Therefore, a child death may be notified during one year and reviewed in another.

- The length of time between notification and review can vary considerably depending on circumstances and other review processes.
- The reasons for delays can include awaiting further investigation through neonatal reviews, post-mortems and inquests.

There were **70 child deaths reviewed by Pan Cheshire CDOP during 2024/25**, the majority of which died during 2022/23, 2023/24 or 2024/25 (96%).

As of 31 March 2025, reviews of 52 children were ongoing (compared to 63 on 31 March 2024) and therefore could not be reviewed by the Child Death Overview Panel.

7. Key trends in modifiable factors during 2024/25

Each child death case is reviewed to understand if there were any ways children, young people or their families could be supported differently that may prevent future deaths. These are known as modifiable factors. Due to the small numbers of child deaths seen each year, it can be helpful to take a longer term view to understand common modifiable or vulnerability factors.

Between 1 April 2024 and 31 March 2025, the leading modifiable factors associated with reviews completed by the Pan-Cheshire Child Death Overview Panel area have included:

- **Issues in service provision**
- **Obesity** (body mass index ≥30)
- **Mental health concerns of the child**
- **Smoking**
- **Late booking/hidden pregnancy**

More information on modifiable factors is provided on the next slide.

8. Causes of death associated with modifiable factors during 2024/25

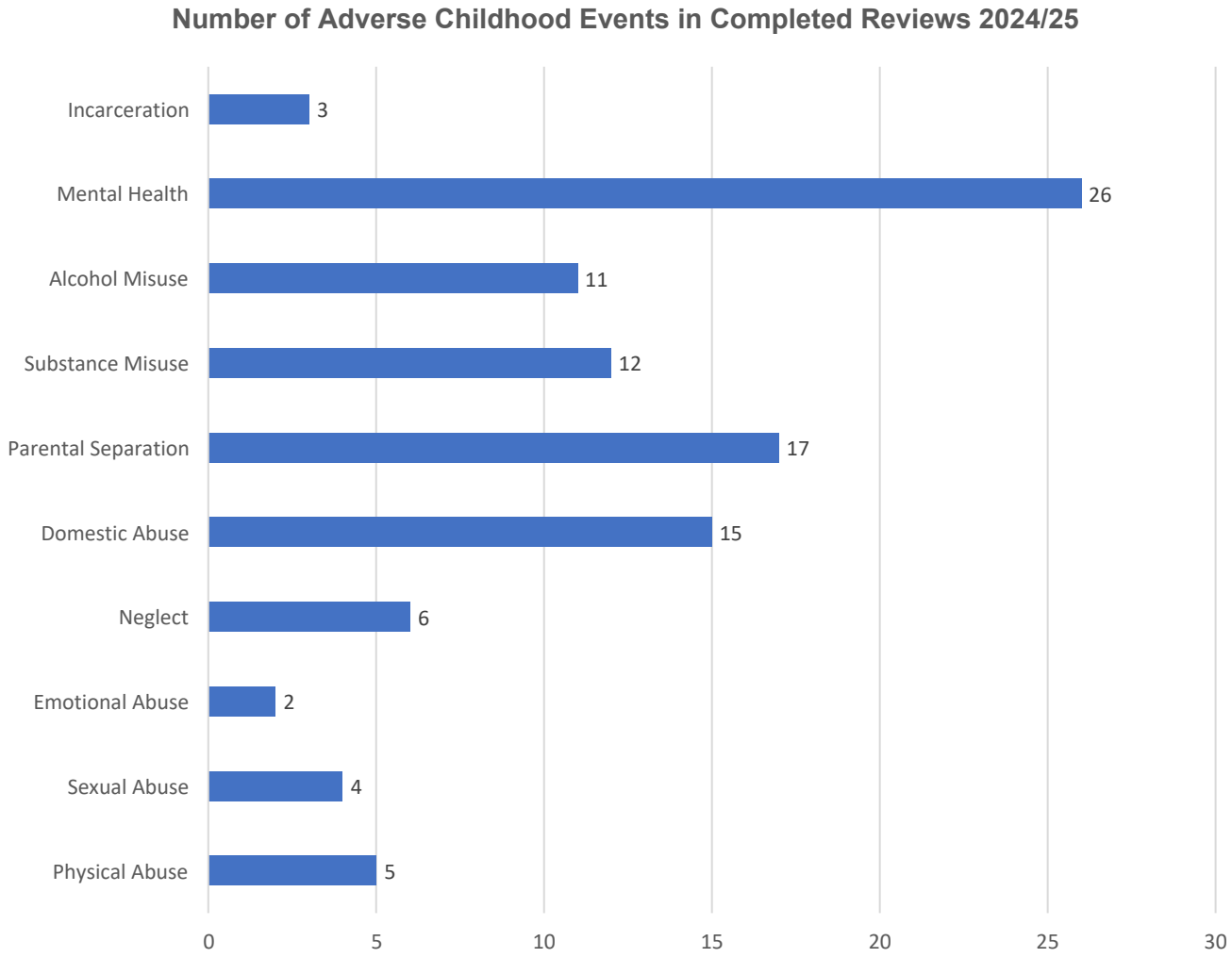
Certain causes of death are more frequently associated with modifiable factors that if addressed may prevent further deaths in the future.

- **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%)*
- **During 2024/25, all completed reviews with a primary category 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**
  - **Perinatal or neonatal events**
  - **Infection**
- **These factors were similar to the modifiable factors across England** as reported in the most recent data release (relating to 2023/24 child deaths)[1].

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

9. Adverse Childhood Experiences (ACEs) 2024/25

- **A total of 101 ACEs were identified for cases reviewed**
- **53% - (37/70) had zero ACEs** compared to 44% (25/57) in 2023/24
- **17% (12/70) had four or ACEs more** compared to 7% (4/57) in 2023/24
- **The most common ACE identified was mental health issues of parent/caregiver**
- Other common ACES identified were parental separation, domestic abuse, substance misuse and alcohol misuse



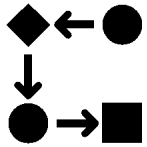
10. Progress during 2024/25 and achievements

Significant progress has been made against the recommendations in the 2023/24 CDOP annual report (see Progress during 2024/25 and achievements) for further details. Key achievements include:

- Awareness raising regarding
  - **Infant Vulnerability**
  - **The ICON programme** provides information about infant crying including how to support parents/carers cope, reduce stress and prevent injuries
  - **Prevention of drowning**
  - **Safe sleep, including winter safe sleep**
  - **Road Safety 'THINK'**
  - **Winter water safety**
  - **Specialist perinatal and maternal mental health**
- Improved efficiency of the business administrator function through increased resource

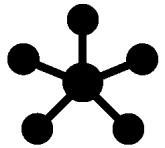
11. Child Death Overview Panel priorities for 2025/26

The priorities for 2025/26 are to:



- Foster a cycle of continuous improvement in the child death review process to reflect national guidelines and local learning.
- 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.

- Deep dive into issues of service provision to determine services available, gaps in services, lessons learned and any resulting changes in practice.



- To promote the findings from the Child Death Overview Panel annual report 2024/25 to wider partners.
- To await the recommendations from the Thirlwall Inquiry, implement changes required and champion the same amongst stakeholders.

A CDOP business plan has been developed to facilitate progress against these priorities.

12. Recommendations for System Leaders/Partners 2025/26

The 2025/26 recommendations for System Leaders/Partners are:

- The **Directors of Public Health across the Pan Cheshire footprint** to ensure that women and families have good access to health and advice services to promote a healthy weight, mental well being and smoking cessation.
- The **Pan Cheshire Maternity Services** are aware of, and refer mothers to, service that support maintaining a healthy weight during, and after pregnancy and smoking cessation.
- **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.
- **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.

Contributors to the report

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

- Glenda Augustine, Independent Chair Pan Cheshire CDOP, Cheshire East Council
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- Dr Rajiv Mittal, Designated doctor for Safeguarding and Child deaths, Countess of Chester Hospital
- Anne Barber, Senior Administrator, Pan Cheshire CDOP, Mid Cheshire Hospitals NHS Foundation Trust
- Members of the CDOP business group