Merseyside and Isle of Man Child Death Overview Panel

Annual Report 2024 – 2025

Foreword from Merseyside and Isle of Man CDOP Independent Chair:

The death of loved one is something that we all experience, and the death of a child is particularly tragic and difficult to comprehend. We recognise the effect this can have on bereaved parents, families and friends, and on the professionals whose work is with children in the last moments of their lives and in the time soon after death.

The role of the Child Death Overview Panel (CDOP) is to identify learning from the death of any child in Merseyside or the Isle of Man, The panel is formed of professionals and lay people, many of whom are from agencies responsible for key issues such as health, education, social care and policing. Collectively we seek to determine whether a death was preventable and to identify modifiable factors that may have contributed to it, and which if changed or addressed, could potentially reduce the risk of future child deaths. The annual report of the Child Death Overview Panel provides a summary of this learning with recommendations for partners who can implement the learning to prevent similar events occurring in the future.

I must offer thanks to all frontline staff and managers involved in this process, without whom we could not fulfil our task. Frontline staff are the 'human face' of the child death review process, supporting families' at the most difficult time of their lives.

I would also like to express my thanks to all panel members working within Liverpool and Isle of Man CDOP. The panel are a highly committed, professional and dedicated group of people who are passionate about bringing about change to save children's lives.

I also offer huge thanks to the CDOP Business support team who ensure that the Panel and associated processes are discharged effectively.

Lastly, my thoughts and condolences go to all those who have been affected by the death of a child.

Jane Lunt, Independent Chair

Merseyside and Isle of Man CDOP

Useful links:

Previous CDOP Annual Report – *Merseyside and Isle of Man CDOP Annual Report 2023-2024*

Safeguarding Practice Review Process - Child Safeguarding Practice Review Panel Guidance for Safeguarding Partners September 2022

SUDiC Protocol – *Merseyside Joint Agency Protocol - Sudden & Unexpected Deaths in Childhood (SUDiC) December 2024*

Whilst it is imperative that we review all child deaths, it is essential that we do not lose sight of the fact that behind every statistic is a child, a family and a community who have experienced a bereavement. As such, the report can make for difficult reading.

Purpose of CDOP:

The death of a child is a devastating loss which profoundly affects all those involved. Since April 2008, all deaths of children up to the age of 18 years, excluding still births and planned terminations are to be reviewed by a Child Death Overview Panel in line with the national guidance and statutory requirement set out in the Child Death Review Statutory and Operational Guidance published in October 2018. Child Death Overview Panels should "*review the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children.*" Child Death Review Statutory and Operational Guidance published in October 2018.

Responsibility for reviewing child deaths across Merseyside and the Isle of Man sits with the following statutory partners:

- Knowsley Borough Council
- Liverpool City Council
- Sefton Borough Council
- St Helens Borough Council
- Wirral Borough Council
- Isle of Man
- NHS Cheshire & Merseyside ICB (Integrated Care Board)
- Merseyside Police

Purpose of the Report:

The purpose of the Annual Report is to:

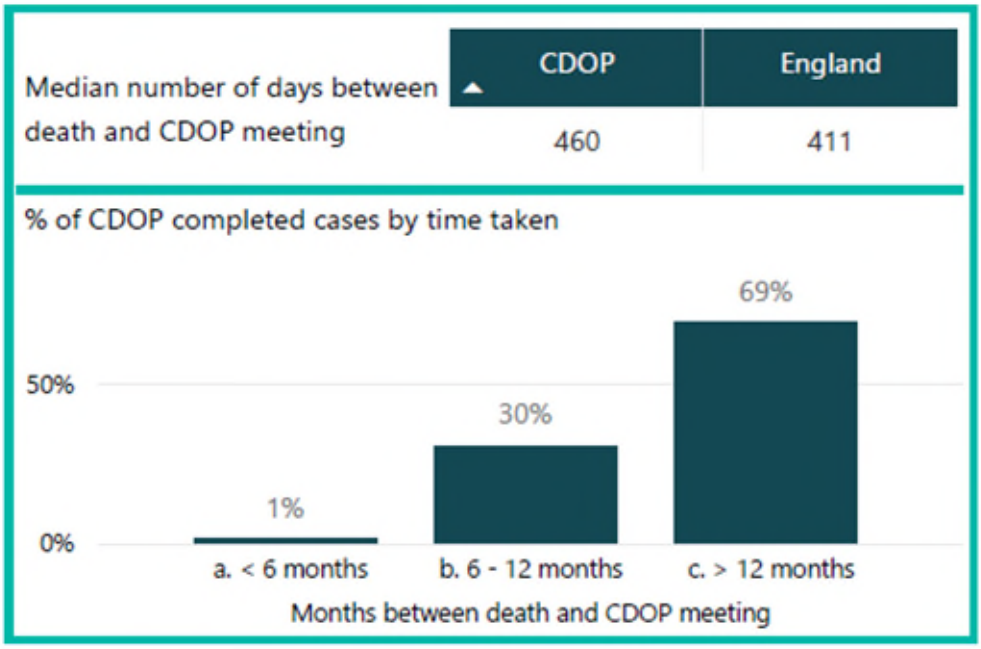
- Outline the processes adopted by Merseyside and Isle of Man CDOP
- Assure the Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across Merseyside and the Isle of Man which is in line with national guidance
- Provide an overview of information on trends and patterns in child deaths reviewed across Merseyside and the Isle of Man during 2024-2025
- Highlight issues arising from those reviewed child deaths – for the region as a whole as well as identifying pertinent issues in each Local Authority area.
- Report on progress from the issues identified in Merseyside and Isle of Man CDOP's last annual report
- Make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across Merseyside and the Isle of Man which may help to positively influence infant and child mortality across the region.

Please note that there are limitations with this data. It cannot be taken as indicative of the events/number of deaths/issues experienced of a particular year. The data contained within covers deaths which have taken place over a number of years and therefore, whilst useful, should not be used to draw firm conclusions for any fixed period of time.

Merseyside and Isle of Man Data:

In 2024/2025 Merseyside and Isle of Man CDOP reviewed 93 children and were notified of 91 deaths occurring. As a result of the various processes (such as Police/Coronial investigations or Safeguarding/Practice Learning Reviews), which take place following the tragic death of a child, many child deaths we are notified of; are not reviewed in the same year the death occurred. The deaths reviewed in any given year are likely to have occurred several months before being discussed at Panel. In 2024/2025 Panel meetings, 1 of the deaths reviewed happened in 2019/2020, 2 deaths reviewed took place in 2020/2021, 21 of the deaths reviewed happened in 2022/2023, 67 of the reviewed deaths took place in 2023/2024 and 2 during 2024/2025.

The National Child Mortality Database compares Merseyside and Isle of Man CDOP's median review period from child's date of death and review against other CDOPs across England:



In 2024-2025, Merseyside and Isle of Man CDOP reviewed deaths 49 days later than the median review time taken from other CDOPs in England. This is an increase on last years' review time; however, it is of note that the CDOP team have implemented a new approach to Panel whereby older cases are prioritised for review. As such, the majority of deaths (69%) were reviewed more than 12 months after the child had died.

This increase in review time is also reflective of the level of complexity of the cases which were reviewed at Panel this year, as several specialist post-mortem tests were required to be completed, the results of which take time to be shared. In addition to this, due to unforeseen circumstances last year (strike action etc.), Panel dates had to be moved/cancelled, which has an impact on the timeliness of reviews which we have worked to catch up on this year. We expect that as the older cases are cleared, these figures will improve over the next reporting period.

Each Local Authority area covered by Merseyside and Isle of Man CDOP had completed child death reviews in 2024-2025:

Local Authority Area	Number of Child Deaths Reviewed
Isle of Man	<5
Knowsley	10
Liverpool	39
Sefton	13
St Helens	11
Wirral	16

There were 62 male children (67%) and 31 female children (33%) reviewed.

As per previous years, the largest number of deaths reviewed were White British children who were 0 – 27 days old, followed jointly by 28 days – 1 year old, 1 – 4 years and 10 - 14 years. For a breakdown of the ages and ethnicity of the children reviewed at CDOP, please see the table below:

Completed CDOP reviews by ethnic group and age group

Ethnic Group	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	Total
White	23	10	10	6	10	8	67
Unknown	0	0	1	0	0	1	2
Other	1	3	2	1	0	0	7
Mixed	2	0	0	1	0	2	5
Black or Black British	2	2	2	0	0	1	7
Asian or Asian British	3	1	0	0	1	0	5
Total	**31**	**16**	**15**	**8**	**11**	**12**	**93**

Panel identified modifiable factors in 41 of the 93 cases reviewed – this equates to 44% of the cases reviewed by Merseyside and Isle of Man CDOP, which is a decrease on the 52% of cases with modifiable factors identified in 2023-24. In comparison, 43% of cases reviewed at other CDOPs across England were found to have modifiable factors, which has remained static when compared to last year.

% of cases where modifiable factors were identified by age group

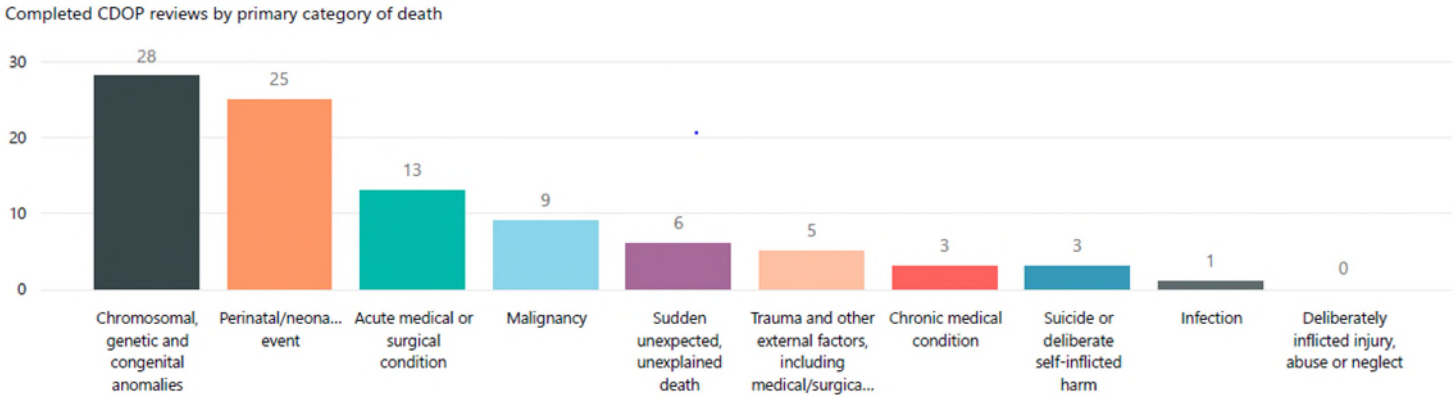
Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	31	18	58%
28 - 364 days	16	8	50%
1 - 4 years	15	4	27%
5 - 9 years	8	1	13%
10 - 14 years	11	3	27%
15 - 17 years	12	7	58%
Total	**93**	**41**	**44%**

For the Local Authorities covered by Merseyside and Isle of Man CDOP, in relation to the primary category of death, a similar distribution pattern was observed last year.

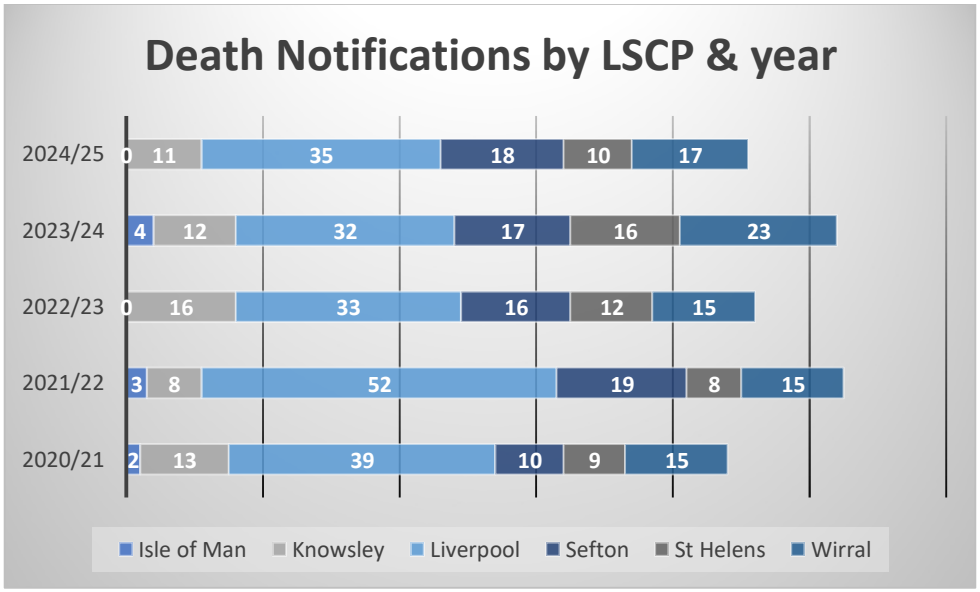
This year the highest proportion of deaths fell under 'chromosomal, genetic, and congenital anomalies', which was the second highest category last year. Deaths attributed to 'perinatal or neonatal events' was the highest category of death in 2023-2024, whereas this category of death moved into the second category in 2024-2025.

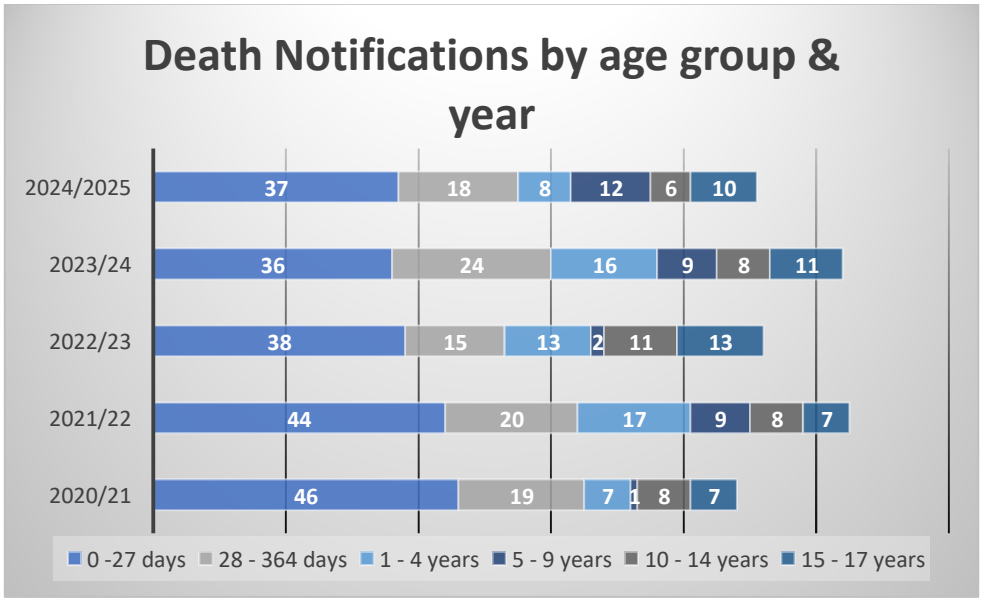
It should be noted that there were an increased number of non-neonatal Panel meetings in 2024-2025 than would occur normally, which may have influenced these figures. The decision to hold more non-neonatal Panel meetings was due to the number of non-neonatal children who required review and for whom the ongoing processes had concluded, as such this was prioritised to ensure that some historic cases were reviewed in as timely a way as possible.

The other categories of death have relatively small numbers in comparison, please see the table below for details:



In terms of trends with our notification data, the table below shows the number of notifications of child death by the Local Authority (LSCP – Local Safeguarding Children's Partnership) in which the child was usually resident and the child's age when they died:

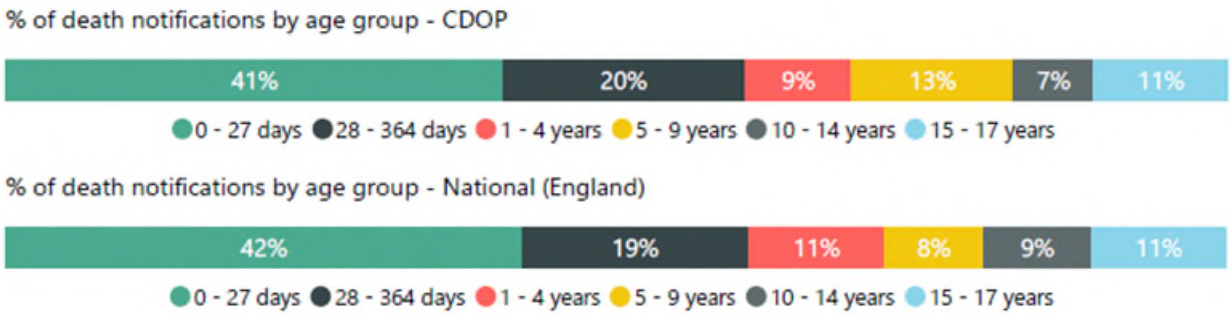




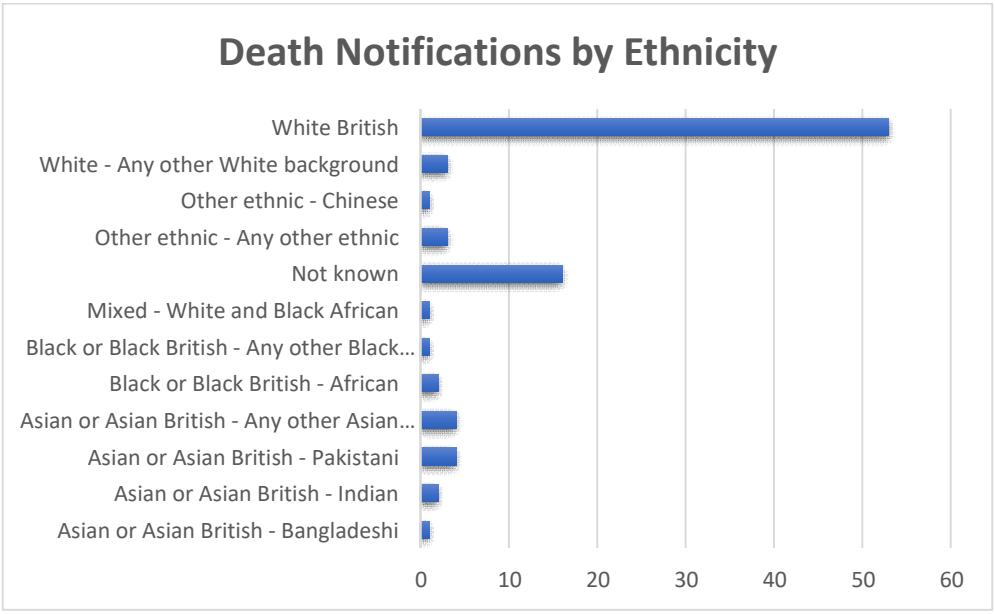
This illustrates that as would be expected, with the largest population, Liverpool consistently has the highest number of child deaths of all the areas covered by our CDOP. Our CDOP's highest number of deaths continues to fall into the neonatal (0 - 27 days) period of a child's life, with 37 notified deaths (41% of the total deaths) in 2024/25 falling into this category.

Looking at our CDOP data against a national comparison, our notification data per age group appears to be generally in line with what other CDOPs are reporting. The main concern in this data being that our 5 – 9-year-old deaths are higher than the national average by 5%.

This has been examined by the CDOP team and at this time there is no apparent link or theme emerging between the notifications or circumstances of deaths of children in this age range at this time. This is something that CDOP will continue to monitor for any indication that there may be a factor which is particularly impacting on this age group. However, we remain mindful that on a local CDOP level, our numbers are smaller and therefore can result in more dramatic changes in % rates.



In terms of notifications by ethnicity, our highest number of deaths (58%) were classified as White British at the point the notification was received. We also have a high number of cases reported where ethnicity is either not known or not stated (18%). This is an area of data which we are working with partners to improve on notification forms and is often a category which we can update during the processing period once information becomes available. Whilst acknowledging that we have a high number of cases reported where ethnicity is either not known or not stated, given that the % of White British people in the Merseyside population currently stands at almost 92% overall (95% in Isle of Man), the % of deaths to those of non-white British ethnicity appears disproportionately higher. Again, this is something we are actively working to gather more data on to enhance our understanding of the issues affecting the local population.



Modifiable Factors:

Modifiable factors are defined as one or more factors across any domain which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future child deaths. We have examined the most frequently occurring modifiable factors in 2024-2025 for all Local Authority areas, where there was more than one case:

Modifiable Factor	2024 - 2025	2023 - 2024	2022 - 2023
Smoking in household	41%	17%	10%
Service Issues	31%	21%	26%
Smoking during pregnancy/at time of delivery	31%	20%	13%
Domestic abuse	23%	2%	4%
High maternal BMI	21%	10%	11%
Substance use (parent)	18%	13%	8%
Engagement with health services/non-attendance at health appointments	13%	10%	4%
Unsafe sleep	10%	11%	5%
Alcohol use (parent)	10%	7%	4%
Parental substance/alcohol use on the day/around the time of child's death	8%	5%	Not previously included in report
Lack of adherence to health advice	8%	2%	2%
Mum's health/wellbeing	8%	1%	2%
Low maternal BMI	8%	Not previously included in report	Not previously included in report
Speeding vehicle/reckless driving	8%	Not previously included in report	Not previously included in report
Substance use in pregnancy	8%	Not previously included in report	Not previously included in report
Child not born in appropriate setting	8%	Not previously included in report	Not previously included in report
Delay in seeking medical attention	8%	Not previously included in report	Not previously included in report

Home conditions	5%	5%	Not previously included in report
Alcohol use in pregnancy	5%	Not previously included in report	Not previously included in report
Emotional abuse	5%	Not previously included in report	Not previously included in report
Public safety issues	5%	Not previously included in report	Not previously included in report

Across both age groups we have seen a significant increase in the number of cases reviewed where there was smoking in the household, to the extent that this has replaced Service Issues – which is an umbrella term for various features, from non-colocation of services to equipment not being available – as the leading modifiable factor in the deaths reviewed in 2024-2025. Although, the top three modifiable factors – smoking in the household, service issues and smoking during pregnancy/at the time of delivery have remained the same as last year. It is concerning that messaging shared with the public around the dangers of smoking in general, but particularly in pregnancy/around children, does not appear to be having the desired impact in terms of the numbers of cases reviewed at Panel reducing. However, as a Panel we recognize that we are often dealing with complex families; which can result in one review generating a number of modifiable factors. It could be that for families who are harder-to-reach or have multiple issues to address, smoking cessation is not a priority for them. The increase in the use of vapes could also be impacting on this factor.

There has also been a noted increase in cases where medical advice was not followed or where health appointments were missed. Work has already been completed in cases where this was noted, to address any potential administrative issues which may have contributed to a missed appointment, including when there have been an issues with interpreter availability, but we need to better understand, in cases where administrative errors have not been an issue, as to why people would choose not to follow medical advice or attend a required appointment. Linked with this, the increase in Mum's health/wellbeing is a concern and may also be connected with the increase in cases where maternal BMI features as a modifiable factor; high maternal BMI has doubled in the cases reviewed this year compared to 2023-2024 and low maternal BMI is a new addition to the table. When considering the data presented in this report, we need to be mindful of the bigger picture in terms of austerity, poverty, food availability and health inequalities in the region and their impact on maternal and childhood health.

As was noted in the previous annual report, there has been an effort to differentiate between parental alcohol and substance misuse to make it easier to identify where there may be issues and where we may need to consider introduction of services which can assist those wanting cessation support. Looking at the data for the deaths reviewed in 2024-2025, there has been a further increase in both parental substance and alcohol use. More concerningly, is that both alcohol use and substance use in pregnancy feature in the modifiable factors in this year's reviewed deaths – neither of which had been in high enough numbers to feature in the report before. Many professional services are aware of the increase in recreational drug use in recent years and this is now showing in terms of the data reviewed at CDOP.

We have also seen more new items added to the modifiable factors most frequently captured by Panel – such as public safety issues and speeding vehicles/reckless driving. It is of note that this may be entirely due to the cases which were discussed this year generating reportable figures, rather than an emerging local trend. This is something that CDOP will continue to monitor over the coming months and years to highlight if these modifiable factors are indeed more concerning than they may first appear.

In addition to the general picture for modifiable factors across the region, CDOP has also separated out the modifiable factors identified at the Neonatal and Non-Neonatal Panels for 2024-2025 in an effort to make the modifiable factors clearer for each age group. As with the table above, these are the most frequently occurring modifiable factors in for all Local Authority areas, where there was more than one case in which the factor was reported:

Neonatal

Modifiable Factor	2024-2025
Smoking in household	67%
Smoking in pregnancy/time of delivery	48%
Domestic abuse	43%
Service issues	38%
High maternal BMI	38%
Parental substance use	24%
Child not born in appropriate setting	19%
Low maternal BMI	14%
Parental alcohol use	14%
Engagement with health services/non-attendance at health appointments	10%
Lack of adherence to health advice	10%
Mum's health/wellbeing	10%
Alcohol use in pregnancy	10%
Substance use in pregnancy	10%
Unsafe sleep	10%

Non-neonatal

Modifiable Factor	2024-2025
Service issues	44%
Speeding vehicle/recklessness	17%
Neglect	17%
Engagement with health services/non-attendance at health appointments	17%
Delay in seeking medical attention	11%
Emotional abuse	11%
Smoking in pregnancy	11%
Parental substance use	11%
Smoking in the household	11%
Unsafe sleep	11%
Public safety issues	11%

When separated into the different age ranges covered, it is clear that whilst issues which would be linked with maternal health and premature birth – such as smoking in the household and during pregnancy are higher for the neonatal age group, service issues remains the most prevalent modifiable factor for the non-neonatal age group.

When we look at the modifiable factors for all ages, there has been a significant increase in families experiencing domestic abuse from 2% last year to 23% in the cases reviewed this year. Whilst it should also be noted that whilst domestic abuse is more likely to be considered a modifiable factor at the neonatal panel meeting – due to the fact that increased stress within the household will put a mother at increased risk of a premature birth, or a physical assault could directly cause injury to the mother and baby; for all of the cases reviewed, domestic abuse was recorded in 38, and was not known in 2 cases – meaning that of all of the children reviewed at CDOP in 2024-2025, 41% were living in households where domestic abuse was a feature.

When we examine our data collection methods – whereas forms have changed and been modified for easier identification and collation of information around modifiable factors, which could explain a new entry on the table or an increase in numbers as time goes on, this is not the case for domestic abuse. This is a modifiable factor and an ACE which we have collected responses on for a number of years. Hence, we need to consider if there has been an increase in identification of domestic abuse relationships given the legal inclusion of coercive control as a feature and as such, we have an increase in our reportable numbers, or if there is a societal influence(s) which is making domestic abuse more likely to occur. CDOP have always reviewed children who have lived in families with a number of complexities, at times those living in challenging circumstances; and as such some reviews will have a number of modifiable factors recorded for one child – and others will have no modifiable factors identified at all.

In addition, CDOP have started to collate information relating to poverty and deprivation – as these are closely linked with health inequalities. From information shared in our agency returns, it was indicated that 12% of the children reviewed at CDOP lived in poverty – with 14% not known. We expect this number to increase as the data collection form specifically asking the question around poverty has now been in circulation for some time, therefore the number of children reviewed in future Panels will have this as mandatory data point. That doesn't necessarily mean that the number of children and families living in poverty will have increased, just that we are actively capturing data relating to it, which will help to deepen our understanding of the societal issues potentially impacting our modifying factors and mortality rates. Whilst home conditions featured for the first time as a modifiable factor in 2023-2024, it has remained static, impacting 5% of cases reviewed this year – again given the on-going cost of living crisis and the levels of poverty in the area, it is unsurprising that people would understandably struggle to maintain or heat their home. Environmental factors are becoming more recognized in terms of their impact on the longer-term health outcomes for children and families and certainly can be linked with health for those people with respiratory issues.

Of all of the children reviewed at CDOP in 2024-2025, 29% were open to Children's Social Care at the time of their death and 27% had been previously known to Children's Social Care in some way. This could have been as a Looked After young person, on a Child in Need or Child Protection Plan or open to Early Help/Family Hubs. When we consider these additional factors on top of the modifiable factors – it is clear that there is work which can be completed to help reduce childhood mortality across the region, as statistically, many of the families who go on to experience the death of a child are already known to services prior to their bereavement. Therefore, working closely with these families around the modifiable factors which may increase the risk of infant mortality again (such as a parent who smokes or uses drugs/alcohol) would be a step in the right direction of more robust preventative work for all local areas and agencies.

Last year's priorities, (some which were rolled over from previous year) with update in italics:

- Work to support the recruitment of a Designated Doctor for Child Death – *This work has continued and was entered on to the Risk Register for both CDOP and the ICB as a priority. Agreement was given in January 2025 to start the recruitment process for the post.*
- Continue to work to improve the quality and frequency of analysis forms from CDRM to Panel and better embed the CDRM process – *This work remains on-going. The CDRM forum has been set up by CDOP Team and offers professionals involved in the CDRM process with an opportunity to meet and discuss best practice, how we can move plans forward, any issues with applying the process as well as offer some peer support and raise issues with the CDOP Team who can escalate/seek advice on these on a regional/national basis.*
- Develop themed panels to assist with increasing our understanding of the issues across Merseyside and the Isle of Man as well as potential emerging issues and future planning for CDOP (increased recreational ketamine use and passive ingestion of cocaine have been identified as potential areas of interest) – *This will roll over to our priorities for this year. It has been a priority for Panel to focus on reviewing cases due to some Panel meetings having to be cancelled in 2023-2024. Once the CDRM process is better embedded, themed Panels will be more easily achieved.*
- Provide assurance that multi-agency partner strategies are in place to address modifiable factors and assist in the plans to tackle these where feasible – *CDOP has continued to work alongside all multi-agency partners in the Merseyside and Isle of Man regions to highlight modifiable factors and to seek feedback as to the steps being taken to address these. This will continue as a priority into 2025-2026.*
- To recruit a new Independent Chair to oversee both the Neonatal and Non-neonatal Panel meetings (current Chair has given notice of resignation, thus creating a vacancy) – *This work was completed and our New Independent Chair for CDOP, Jane Lunt, started in post in October 2024.*
- Explore the possibility with one of our local universities completing some analysis work on a completed data set from CDOP to assist in our understanding of the factors affecting infant mortality across Merseyside and the Isle of Man – *This work is on-going. Public Health colleagues have been assisting in approaching the local universities to explore this further.*
- To establish a new working group with strategic oversight of how effective our Safer Sleep messages are across Merseyside and facilitating changes where these are needed – *There is now a new forum specifically for Professionals involved in Safer Sleep. The representation at the forum is less health dominated, allowing for more agencies to become actively involved in supporting messages around safer sleep reaching families.*
- To ensure that the recommendations from the Independent Review and resulting Action Plan are implemented – *The recommendations from the Independent Review have now been included in the CDOP risk register and work is underway to complete any outstanding actions.*
- Ensure that all data is extracted from the previous data system (Sentinel) by 30th September 2024 – *This work was completed by end of June 2024.*

Priorities for 2025-2026:

- Continue to support the ICB in the recruitment for a Designated Doctor for Child Death
- Continue to work to support Trusts and Hospices to embed consistent CDRM process, which will improve the quality and frequency of analysis forms from CDRM to Panel
- Develop themed panels to assist with increasing our understanding of the issues across Merseyside and the Isle of Man as well as potential emerging issues and future planning for CDOP for example, issues highlighted relating to ethnicity and learning from the National Safeguarding Panel '"It's Silent": Race, racism and safeguarding children.' March 2025.
- Seek assurance from Public Health and multi-agency partners that strategies are in place to address modifiable factors which impact their specific area and assist in the plans to tackle these where feasible.
- Explore the possibility with one of our local universities completing some analysis work on a completed data set from CDOP to assist in our understanding of the factors affecting infant mortality across Merseyside and the Isle of Man.
- To host events for professionals around any emerging issues from our notification data as well as issues arising at Panel.
- To complete the revision of the Acute Life-Threatening Event (ALTE) Protocol, ensure this is signed off and circulated to all professionals and agencies.
- To revise the CDOP Protocol
- To work more closely with Pan-Cheshire CDOP on hosting events for frontline staff and potentially to consider joint thematic Panel meetings
- To ensure that CDR and CDOP processes and avenues for feedback are successfully embedded into the revised model of ICB functioning

As a group of partner agencies, we strive to take every opportunity to learn from the reviews with a view to improving outcomes for children, families and communities.

Positive steps taken by/as a result of CDOP data:

Merseyside and Isle of Man CDOP regularly share the data we are collecting and collating across multi-agency forums with all of the involved Local Authorities. This is done via Health and Wellbeing Boards, Local Safeguarding Children Partnerships, Safer Sleep Group meetings as well as the CDOP Business meeting and individual forums as and when the information is relevant.

As a result of the information gathered and shared by CDOP the following actions have taken place:

- A Neonatal Intensive Care Unit (NICU) is being built on site at Alder Hey Children's Hospital – sometimes very unwell babies need to be transferred to Alder Hey for specialist surgical intervention and then back to access NICU care at the hospital they came from. As such, a case was made to ensure the number of transfers between hospitals are minimized.

- Launched the SUDiC Protocol following a six-month trial and review period. The final Protocol was reviewed and circulated in January 2025.
- Launched the initial ALTE Protocol (with revision planned for April/May 2025 following consultation with Designated Doctors).
- Agreed to fund the review and update for SERIOUS training for frontline professionals (this training equips professionals to discuss suicidal ideation with children).
- Completed the data transfer from Sentinel to eCDOP.
- Developed and delivered training on SUDiC Processes in a live session to over 80 Police officers across Merseyside which was filmed allowing for Police colleagues who were unable to attend to continue to access the training.
- Developed and delivered training on SUDiC Processes to several Hospital Trusts – including health colleagues based in the Safeguarding Teams, A&E Departments and Maternity Units with a specific session for the Consultants and midwives based at Liverpool Women's Hospital and wards in Alder Hey Children's Hospital.
- Developed and delivered training on SUDiC and CDOP processes to colleagues across the local authorities.
- Continued to deliver training sessions on eCDOP for new staff/refresher sessions.
- Recruited successfully to the Independent Chair post.
- Started the planning process for a Primary Care workforce event around asthma hygiene and best practice around inhaler prescribing.
- Supported the ICB in recruitment processes for the Designated Doctor for Child Death post.
- Sought support from Pan-Mersey Multi-Agency Safeguarding Arrangements board as a body who could offer oversight and governance to CDOP.
- Continued to work to raise profile of CDOP.
- Visited The Milk Bank at Countess of Chester Hospital and signposted to the support they can offer bereaved families in the revised SUDiC Protocol.
- CDOP Team have continued to work alongside supporting the NCMD in identifying national and regional trends in data which can help NCMD make appropriate recommendations to shape services now and in the future.

Local Area Information

Isle of Man:

There were less than 5 deaths reviewed, and no notifications received by Merseyside and Isle of Man CDOP for the Isle of Man in 2024 - 2025, as such there is limited scope in completing any further analysis as there is little data to support this.

In terms of modifiable factors identified, these were (listed in prevalence order):

- Smoking in pregnancy/time of delivery
- Smoking in the household
- Service Issues
- Low maternal BMI

Knowsley:

There were 10 deaths reviewed, and 11 notifications processed by Merseyside and Isle of Man CDOP for Knowsley in 2024 – 2025.

Of the 11 notified deaths, 73% (8) were considered to be expected.

7 of the 11 notifications (64%) were of children who were under 1 year of age.

In terms of modifiable factors identified for the 10 Knowsley children who were reviewed at Panel were (listed in prevalence order):

- High maternal BMI
- Smoking in the household
- Service Issues
- Domestic abuse

Liverpool:

There were 39 deaths reviewed, and 35 notifications processed by Merseyside and Isle of Man CDOP for Liverpool in 2024 – 2025.

Of the 35 notified deaths, 69% (24) were considered to be expected.

24 of the 35 notifications (69%) were of children who were under 1 year of age.

In terms of modifiable factors identified for the 39 Liverpool children, which were reviewed at Panel were (listed in prevalence order):

- Service issues
- Smoking in household
- Smoking in pregnancy/time of delivery
- Parental substance use
- High maternal BMI
- Domestic abuse
- Child not born in appropriate setting
- Engagement with health services/non-attendance at health appointments
- Parental alcohol use
- Speeding vehicle/recklessness
- Neglect
- Substance use in pregnancy
- Not following medical advice
- Low maternal BMI
- Alcohol use in pregnancy
- Emotional abuse
- Parent consumed alcohol/substances around the time/on the day of the child's death
- Unsafe sleep

Sefton:

There were 13 deaths reviewed, and 18 notifications processed by Merseyside and Isle of Man CDOP for Sefton in 2024 – 2025.

Of the 18 notified deaths, 56% (10) were considered to be expected.

9 of the 18 notified deaths (50%) were of children who were under 1 year of age.

In terms of modifiable factors identified for the 13 Sefton children, which were reviewed at Panel were (listed in prevalence order):

- Service issues
- Smoking during pregnancy/time of delivery
- Smoking in the household
- Domestic abuse
- Engagement with health services/non-attendance at health appointments
- Not following medical advice
- Public safety issues
- Parental substance use

St Helens:

There were 11 deaths reviewed, and 10 notifications processed by Merseyside and Isle of Man CDOP for St Helens in 2024 – 2025.

Of the 10 notified deaths, 60% (6) were considered to be expected.

6 of the 10 notified deaths (60%) were of children who were under 1 year of age.

In terms of modifiable factors identified for the 11 St Helens children, who were reviewed at Panel were (listed in prevalence order):

- Smoking in household
- Smoking in pregnancy
- Service issues
- Substance use in pregnancy
- Domestic abuse
- Parental substance use
- Child not born in appropriate setting
- Public safety issues
- Unsafe sleep
- Engagement with health services/non-attendance at health appointments

Wirral:

There were 16 deaths reviewed, and 17 notifications processed by Merseyside and Isle of Man CDOP for Wirral in 2024 – 2025.

Of the 16 notified deaths, 69% (11) were considered to be expected.

9 of the 16 notified deaths (56%) were of children who were under 1 year of age.

In terms of modifiable factors identified for the 16 Wirral children who were reviewed at Panel were (listed in prevalence order):

- Smoking in the household
- Smoking during pregnancy/time of delivery
- Parental substance use
- Unsafe sleep
- Neglect
- Parental alcohol use
- Home conditions
- High maternal BMI
- Parental alcohol/substance use on the day/around the time of child's death
- Child not born in appropriate setting
- Speeding vehicle/recklessness