Safeguarding Children Partnership STOKE-ON-TRENT

Staffordshire Safeguarding Children Partnership

Stoke-on-Trent and Staffordshire Child Death Overview Panel (CDOP)

Annual Report

Reporting period - 1 April 2024 to 31 March 2025

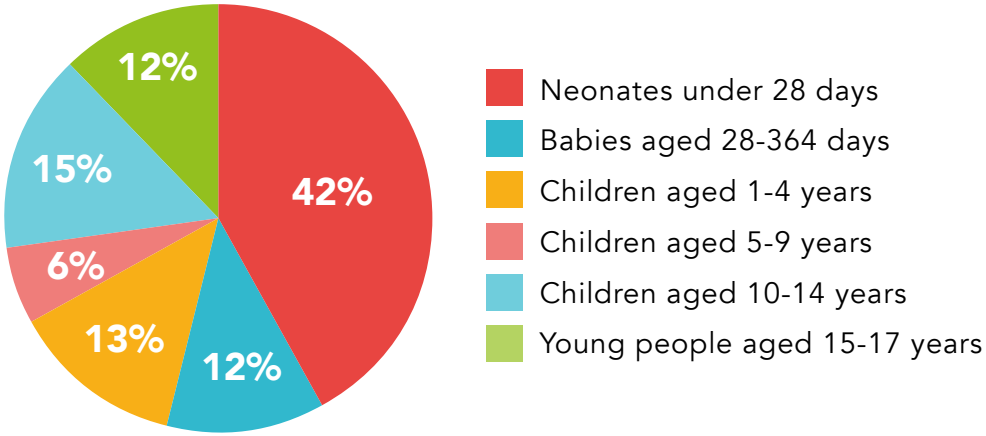
This is the 17th Annual Report of the Stoke-on-Trent and Staffordshire Child Death Overview Panel (CDOP).

Contents

1.Executive Summary

This report presents an overview of child mortality (deaths) across Stoke-On-Trent and Staffordshire; key trends, modifiable factors, learning arising from reviews and progress made against local and national priorities to prevent future deaths.

- Patterns of mortality remain consistent with historical local data and national trends.
- Between April 2024 and March 2025 Staffordshire and Stoke-On-Trent CDOP were notified of **67** deaths of children. This is lower than the 88 notifications in 2023/2024 and the lowest since 2019/20.
- 42% of all deaths were of neonates under 28 days old, reflecting the continued vulnerability of this age group.



- **18 deaths** (27%) were classified as sudden and unexpected, compared with 32 in the previous year.
- Infant mortality continues to reflect wider population disparities. The estimated Staffordshire infant death rate is 5.1 per 1,000 live births, higher than the national average, and consistent with the higher regional rate seen across the West Midlands. There are pockets where the rate is even higher, such as in Stoke-on-Trent where it is **7.3 per 1,000 live births**.
- SSOT CDOP held meetings on **9** occasions during this period. There were 3 general panels, 3 neonatal-themed meetings, 1 suicide thematic review meeting and 2 face to face business meetings.
- During the 2024/25 period the SSOT CDOP reviewed a total of 48 deaths. Only one case triggered a Child Safeguarding Practice Review (CSPR).
- Among **Stoke-on-Trent deaths, 6 of 9 reviewed cases** had modifiable factors; most deaths occurred within the first 28 days of life.
- Across **North and South** Staffordshire, **20** of **39** deaths reviewed had modifiable factors, again with most children dying within the first 28 days of life.

1.1 Key learning from child deaths in 2024/25:

High maternal BMI, which is the most common modifiable factor nationally and locally.

Maternal and household smoking, including missed opportunities for timely stop smoking support.

Service provision issues, including gaps in communication, not using agreed pathways, unclear or incomplete documentation, and missed assessments.

Unsafe sleeping practices continue to contribute to infant deaths despite parents being given safer sleep messages at multiple points during pregnancy and beyond. Two deaths this year had sleeping environment concerns as modifiable factors.

Prematurity related vulnerabilities, often coupled with modifiable antenatal risk factors.

Psychosocial contributors, including living pressures, mental health issues in young people, and household stressors contributed to the increased rates of suspected suicides.

Outcomes continue to be shaped by deprivation, ethnicity, language barriers, and limited access to services. Several cases highlighted issues with interpretation services and the vulnerability of asylum seeking families.

2. Overview of CDOP process

The death of a child is a profound loss, and reviews are conducted with compassion to understand what happened, why, and how future deaths can be prevented.

Child death review partners follow national statutory guidance[1],[2] to review all child deaths in their area, including certain non-resident cases. Sudden or unexplained deaths trigger a Joint Agency Response within 72 hours to coordinate safeguarding and family support. Every case undergoes a Child Death Review meeting, with findings submitted to the multi-agency Child Death Overview Panel (CDOP). In Staffordshire and Stoke-on-Trent, CDOP works with professionals and a lay member representing bereaved families, using anonymised data to identify learning and modifiable factors. Data is shared nationally via the Child Mortality Database, supporting thematic learning and interventions to reduce future child deaths.

2.2 Members of Staffordshire and Stoke-on-Trent CDOP

The following partners are represented at CDOP in Staffordshire:

- Local Authority public health
- Integrated Care Board (ICB)
- Designated doctors and nurses for child death
- Staffordshire and Stoke-on-Trent – Local Authority education representatives
- Local Authority children's social care
- Designated Leads for Safeguarding in primary care
- Staffordshire Police
- Nursing/Midwifery/Obstetrics/Neonatology
- Lay/bereaved parent representation

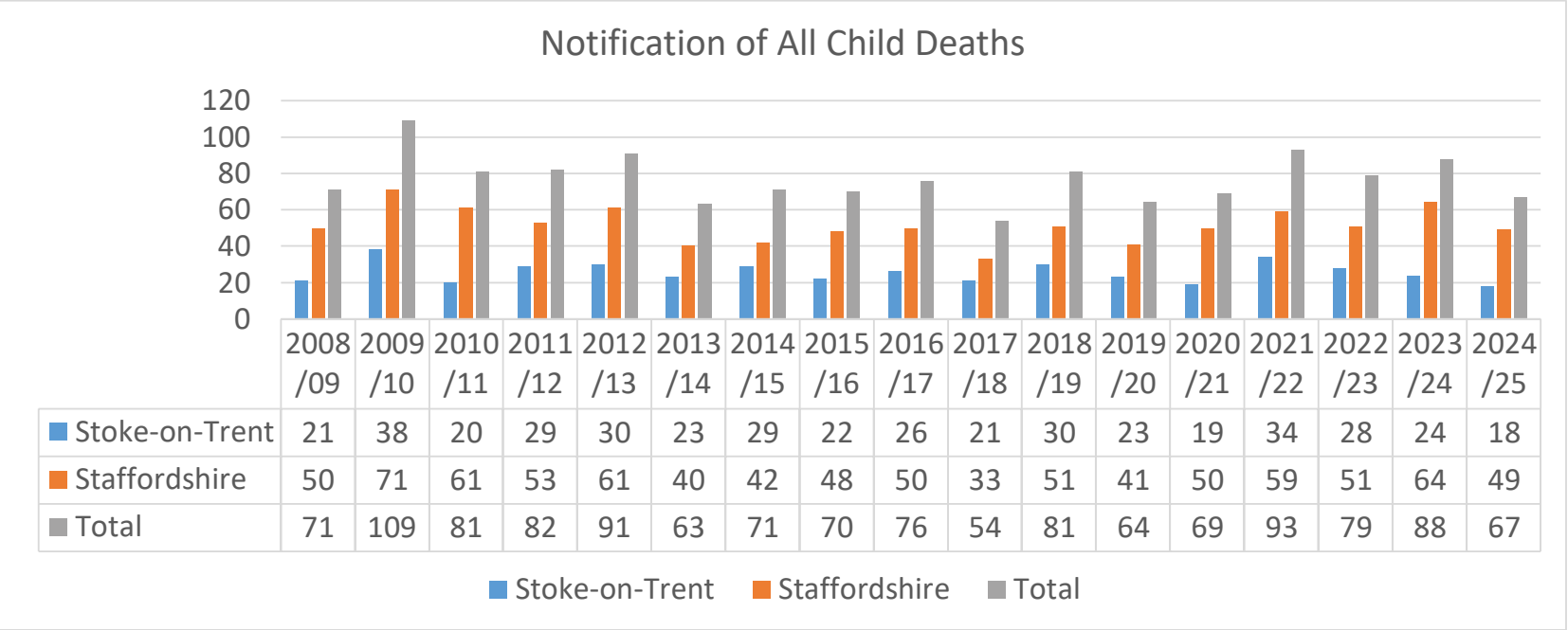
Additional representation may be sought for specific case reviews to provide subject matter or other expertise, as required.

[1] Working together to safeguard children - GOV.UK
[2] Child death review: statutory and operational guidance (England) - GOV.UK

3. Notifications of child deaths

This section summarises all child deaths notified to the Stoke-on-Trent and Staffordshire CDOP between 1 April 2008 and 31 March 2025, covering children normally resident in the area who died locally or elsewhere. Data is drawn from the local eCDOP system, which feeds into the National Child Mortality Database (NCMD).

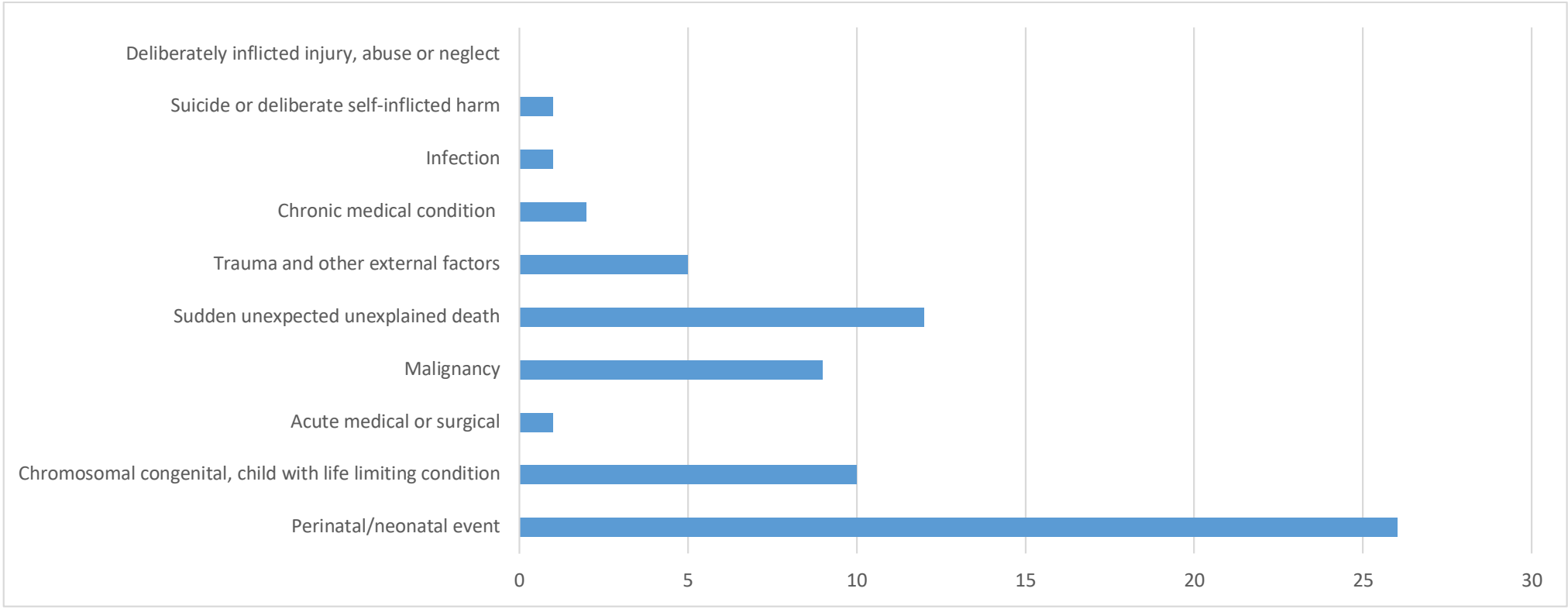
There were **67** child deaths in Staffordshire and Stoke-on-Trent between April 2024 - March 2025. 18 of these were in Stoke -on- Trent and 49 in Staffordshire. These are the lowest rates in 5 years.



	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Stoke-on-Trent	21	38	20	29	30	23	29	22	26	21	30	23	19	34	28	24	18
Staffordshire	50	71	61	53	61	40	42	48	50	33	51	41	50	59	51	64	49
Total	71	109	81	82	91	63	71	70	76	54	81	64	69	93	79	88	67

3.1 Local Notifications: initial categorisation

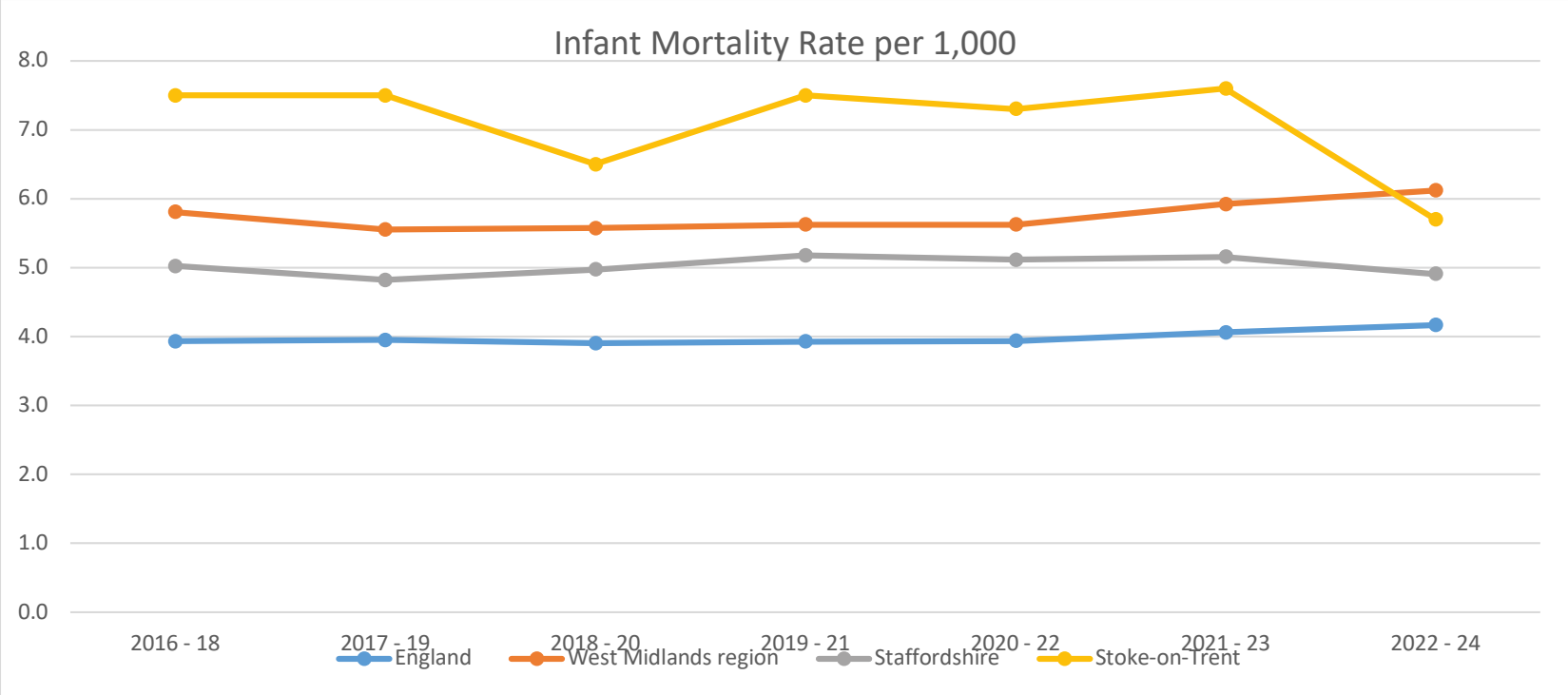
This table illustrates the initial categories of death for all 67 notifications during this reporting period, ahead of case review. Some of these deaths have not been to CDOP review and so remain in initial assigned category, which may change following review.



The most common primary category of death for reviews in 2024-25 for Stoke-On-Trent and Staffordshire was Perinatal/ neonatal event, which was recorded for **39%** of all child death reviews, which follows the national picture of 33%.

3.2 Notification of deaths: infants (under one year of age)

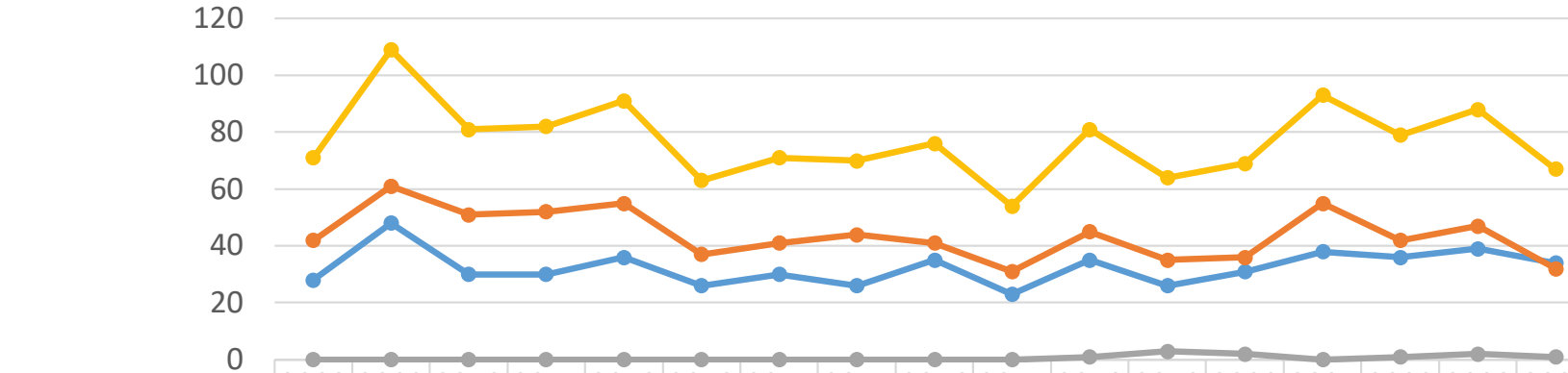
The following chart shows the infant mortality rate for Stoke-on-Trent and Staffordshire (separately) compared to the West Midlands and England averages. Infant mortality rates in Stoke-on-Trent have been consistently higher than Staffordshire, the West Midlands and England. The most recent data point shows a significant drop for Stoke-on-Trent (and a small drop for Staffordshire), but we have to interpret this data with caution: it may be that this is a real reduction, but as the absolute numbers are quite small, the reliability of single data points is limited. There is a possibility that this is a sign of a positive trend, but we need to wait until future data is published to be certain**.



Infant mortality rates in Stoke-On-Trent have been consistently higher than Staffordshire, the West Midlands and England.

3.3 Notifications of death - by gender

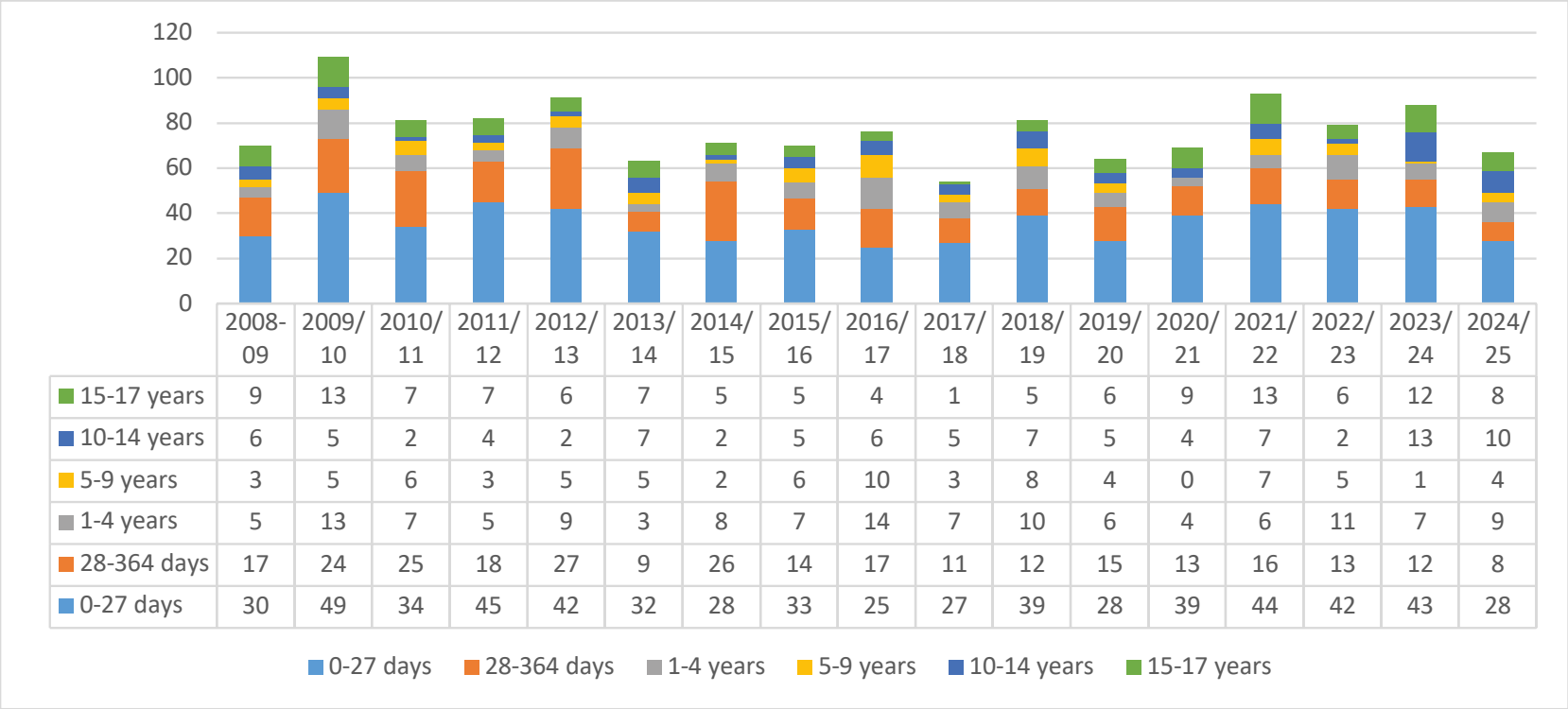
Since the introduction of CDOP in April 2008 deaths of males have consistently accounted for over half of all notifications nationally. The reporting period from April 2024 to March 2025 demonstrated a local position in keeping with this national picture. Notifications that fall into 'indeterminate' are for babies of extremely low gestation.



	2008 /09	2009 /10	2010 /11	2011 /12	2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22	2022 /23	2023 /24	2024 /25
Female	28	48	30	30	36	26	30	26	35	23	35	26	31	38	36	39	34
Male	42	61	51	52	55	37	41	44	41	31	45	35	36	55	42	47	32
Indeterminate											1	3	2		1	2	1
Total	71	109	81	82	91	63	71	70	76	54	81	64	69	93	79	88	67

3.4 Notifications of death – by age

In 2024/25, babies under 1 year accounted for 53.7% of child deaths in Stoke-on-Trent and Staffordshire, with the first 28 days being the highest-risk period. Nationally, 61% of child deaths were in this age group. For children aged 1–17 years, the highest national death rate was among 15–17-year-olds (19.0 per 100,000), followed by 1–4-year-olds (13.5 per 100,000). Locally, the highest number of deaths occurred in 10–14-year-olds, then 1–4-year-olds.



	2008-09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
15-17 years	9	13	7	7	6	7	5	5	4	1	5	6	9	13	6	12	8
10-14 years	6	5	2	4	2	7	2	5	6	5	7	5	4	7	2	13	10
5-9 years	3	5	6	3	5	5	2	6	10	3	8	4	0	7	5	1	4
1-4 years	5	13	7	5	9	3	8	7	14	7	10	6	4	6	11	7	9
28-364 days	17	24	25	18	27	9	26	14	17	11	12	15	13	16	13	12	8
0-27 days	30	49	34	45	42	32	28	33	25	27	39	28	39	44	42	43	28

Neonatal deaths (babies under 28 days of age) accounted for 42% of all deaths in Stoke-On-Trent and Staffordshire.

3.5 Notifications of infant deaths – prematurity

Nationally 78% of neonatal deaths(babies who died under 28 days of age) were of babies born at a premature gestational age (before 37 weeks). Locally, for Staffordshire and Stoke on Trent the percentage is 71% for 24/25 (23/24 was 79%, 22/23 was 86%).

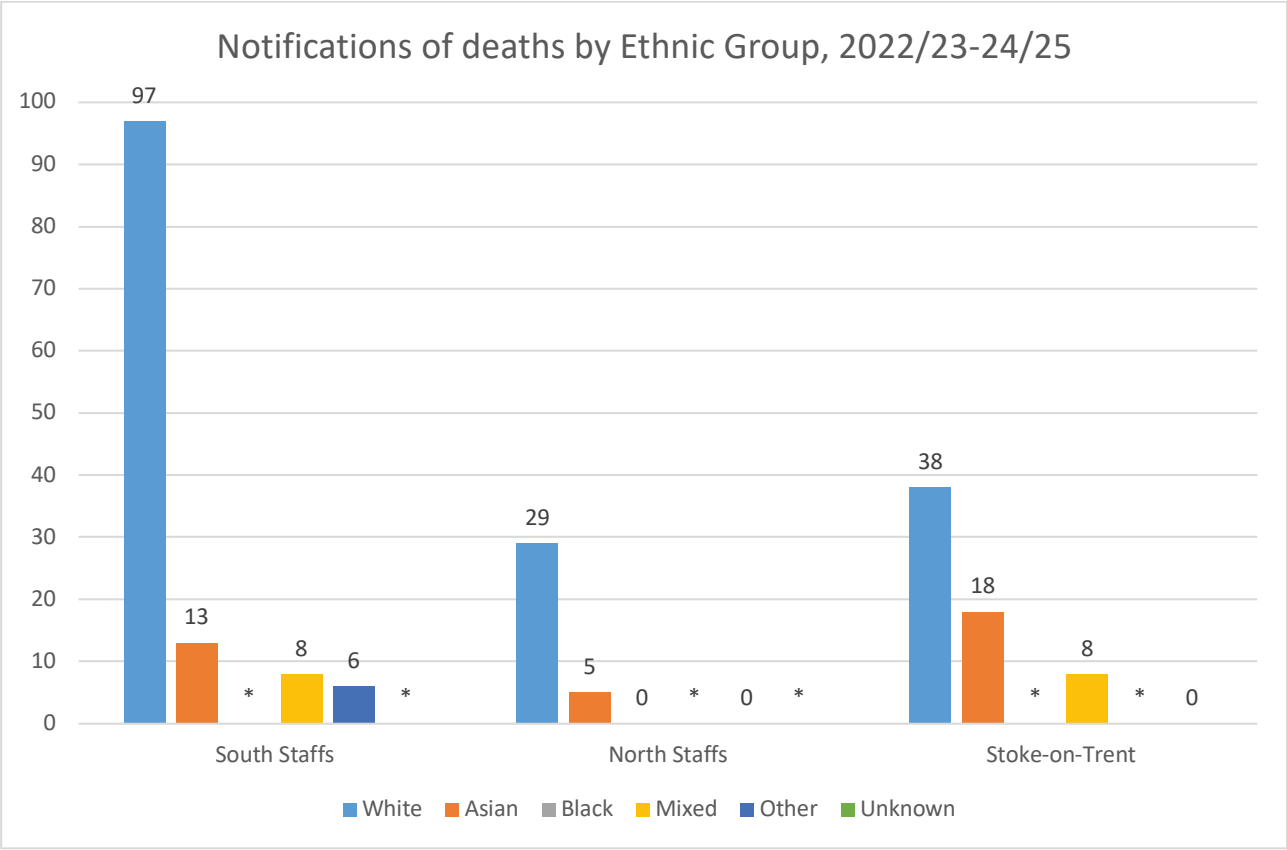
The National Child Mortality Database has highlighted the significant impact of prematurity on child mortality rates.

The potentially modifiable factors that contribute to these deaths are smoking during pregnancy, lack of involvement with appropriate services, and maternal obesity, which have all been identified locally, highlighting the need for targeted intervention to reduce the risk of prematurity and improve outcomes for children born prematurely.

71% of babies that died in the neonatal period had a gestion of under 37 weeks, nationally this figure was 78%.

3.6 Notifications of deaths - by ethnic group

There is an over-representation of deaths of children from non-White backgrounds in Staffordshire. This trend is in line with national research, which highlights the magnitude of the inequality around child deaths.

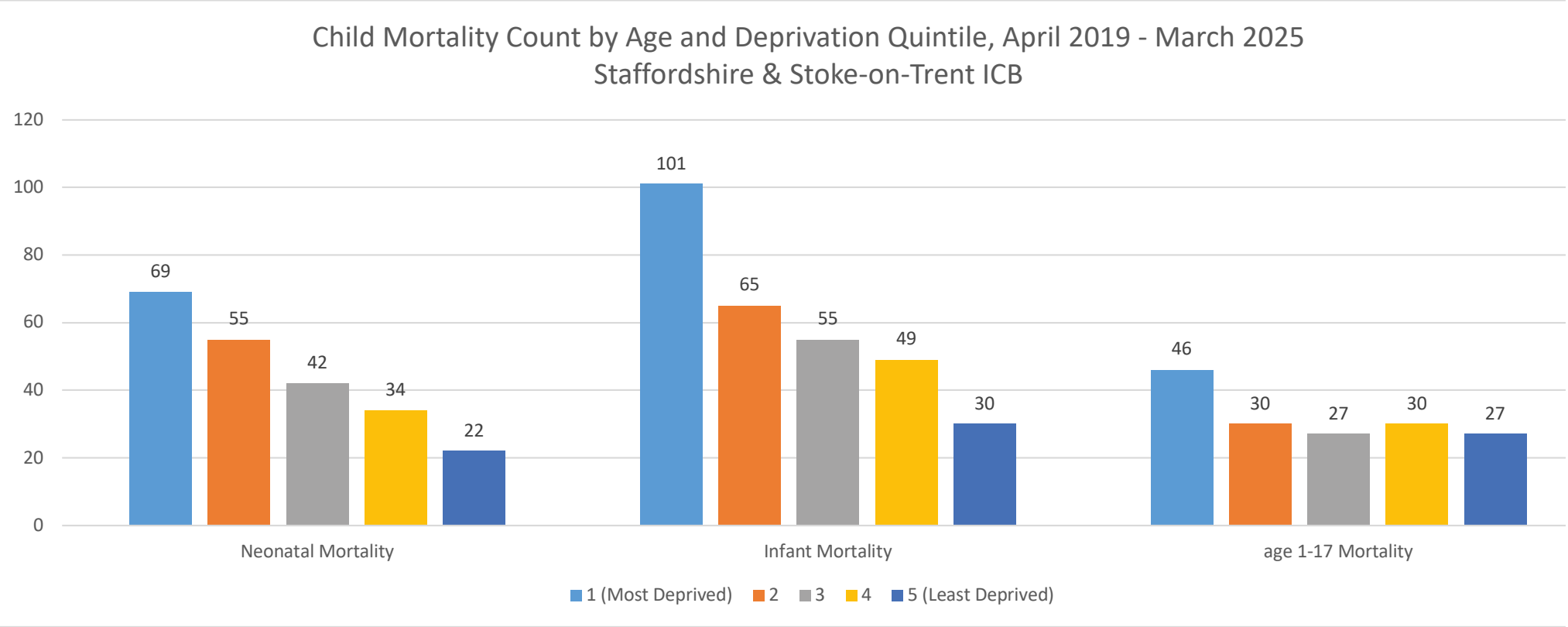


In Staffordshire, an estimated **10.7%** of births during 2022-2025 were to women from ethnic minority groups. Children of Asian, Black, Mixed or Other ethnicities accounted for **22.2%** of infant deaths.

In Stoke-on-Trent, an estimated **29.5%** of births were to women from ethnic minority groups. Children of Asian, Black, Mixed or Other ethnicities accounted for **45.7%** of infant deaths*.

3.6 Notification of deaths – by deprivation

Deprivation is a known risk factor for child deaths[3]. This correlation is replicated in Staffordshire, with deaths of children living in the most deprived areas of Staffordshire 2-3 times more likely than for those living in the most affluent areas.



Children from more deprived areas are more likely to die than children from wealthier areas

[3] Child Mortality and Social Deprivation | National Child Mortality Database

3.7 Notifications of death - unexpected[4]

Of 67 notifications in 2024/25, 18 were classed as 'unexpected', though some involved children with known life-limiting conditions. These deaths typically require a Joint Agency Response (JAR). Several sudden infant deaths had parallel investigations still ongoing. Local hospitals also managed unexpected deaths of children from outside the county needing specialist care. These cases are reviewed locally through Mortality and Morbidity meetings, the Perinatal Mortality Review Tool (for babies 22 weeks and over), and Child Death Review Meetings (CDRMs). Relevant CDOP representatives may attend, and any learning, actions, or modifiable factors are shared through the CDOP network.

Category	Name & description of category	No. within this category
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	Suppressed - fewer than 5
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.	Suppressed – fewer than 5
3	**Trauma/other external factors, including medical/surgical complications/error**. Includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death. **Excludes** deliberately inflicted injury, abuse or neglect (category 1).	5
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.	Suppressed – fewer than 5
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.	Suppressed – fewer than 5
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	7

Of the 67 child deaths during this period, **18** were categorised as '**sudden and unexpected**' (27%). Last year there were 88 deaths and 32 of these were sudden and unexpected (36%).

[3] Death was not expected within a 24 hour period ahead of death

3.8 Road Traffic Collisions

Over the last 10 years **22** children have died due to road traffic collisions, including drivers, passengers or pedestrians. The number of child deaths due to road traffic collisions has remained similar over the last few years, apart from a notable spike within Staffordshire in the 2023-35 reporting period..

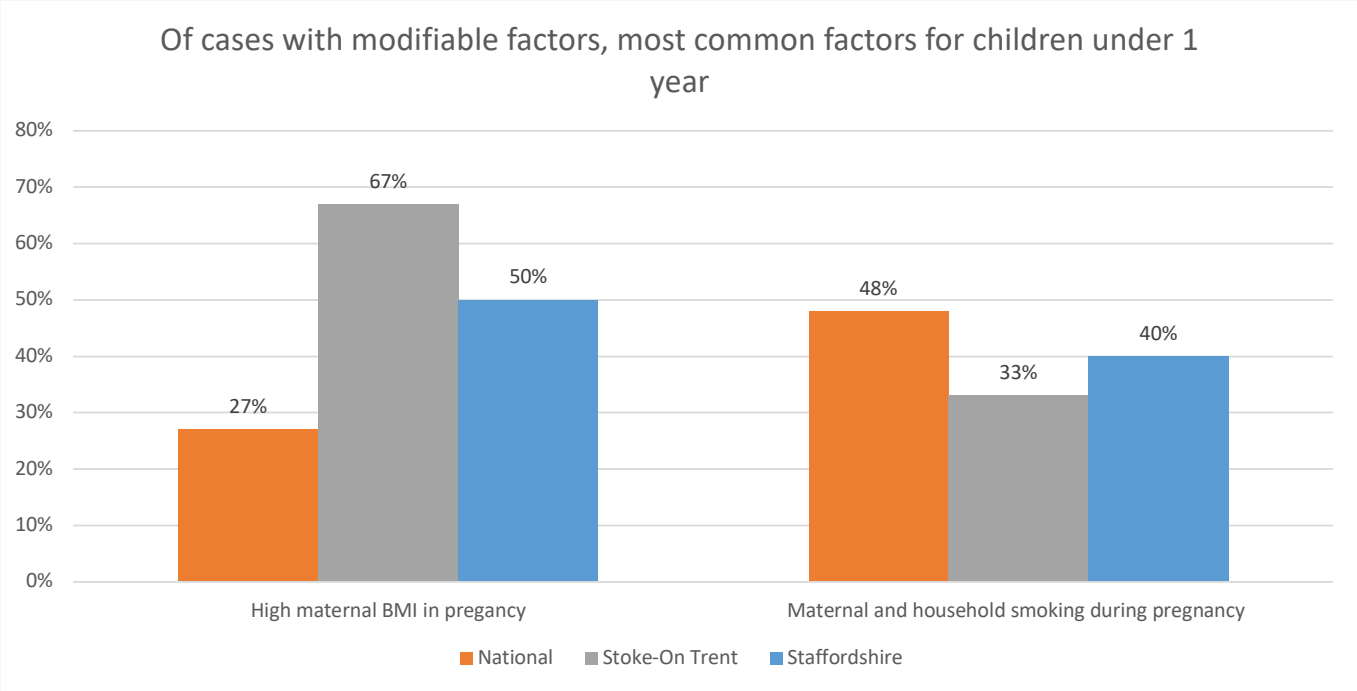
There are no key patterns or significant themes identified through the learning reviews of these deaths as every review has identified unique circumstances. However, one theme that has been highlighted locally, nationally and regionally is the increase in road traffic collisions involving new or inexperienced young drivers with multiple passengers within the vehicle.

Over the last 10 years 21 children have died as a result of a road traffic collision.

4. Modifiable Factors

During April 2024 and March 2025 the panel reviewed a total of 48 child deaths[1].From the reviews completed in this period only 1 was subject to a Child Safeguarding Practice Review (CSPR).

CDOPs record contributory factors and identify which are 'modifiable'—those where local or national action could reduce future child deaths. Panels also note learning points and good practice, assigning actions to relevant agencies and monitoring them until completion. Common modifiable factors nationally and locally include high maternal BMI and maternal or household smoking. Reviews found modifiable factors for 48% of child deaths nationally, 51% in Staffordshire, but 67% in Stoke-On-Trent. Of these cases with modifiable factors the below chart shows the incidence of high maternal BMI and smoking.



4.1 Modifiable factors for child deaths in Stoke-on-Trent:

Of the **9** child deaths reviewed by the panel in 2024/2025 of children from Stoke on Trent , there were 6 cases where modifiable factors were identified. Most of these deaths had multiple factors, and most died under a year of age. 8 deaths were from the age range 0-27 days.

Modifiable factors

High maternal BMI was found in 4 deaths

Maternal and household smoking found in 2 deaths

Services: Delay in administering maternal antibiotics was present in 1 death

Significant stress, caused by trying to meet high expectations around school performance and behaviour found in 1 young person's death by suicide

Services: Delay in accessing care due to language barrier and lack of knowledge of services found in 1 death

4.2 Modifiable factors for child deaths in North and South Staffordshire:

Out of the 39 child deaths reviewed by the panel in 2024/2025 of children from North Staffordshire (7), and South Staffordshire (32), there were **20 cases** where modifiable factors were identified, and most of these deaths had multiple factors, and most died before their first birthday.

Modifiable factors

Maternal and household smoking found in 8 deaths

High maternal BMI was found in 10 deaths

Unsafe sleeping environment was found in 1 death

Maternal substance misuse present in 3 deaths

Services: Poor communication between agencies was present in deaths

Maternal alcohol use present in 2 deaths

Services: Learning around protocol present in 3 deaths

5. Activities and whole system approaches to learning

5.2 Death by Suicide

The following highlights the most common factors identified nationally in deaths by suicide:

Risk-taking behaviour

Conflict within key relationships

Problems with service provision

Abuse and neglect

Loss of key relationships

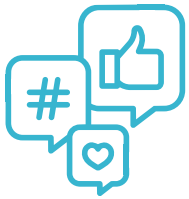
Problems at school

Bullying

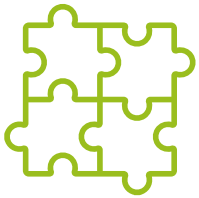
Medical condition in the child

Drug or alcohol misuse by the child

Mental health needs of the child



Social media and internet use



Neurodevelopmental conditions

Sexual orientation/ identity and gender identity

Problems with the law

Household functioning

A local review has identified the following as likely risk factors in child deaths by suicide in Staffordshire:

Household functioning: 78% of children and young people (CYP) whose deaths were reviewed experienced at least one factor in the household functioning category in their household circumstances. Included divorced parents, separation, pressured environment, parents with neurodiversity.

Loss of key relationship: 78% had lost a significant loss in their life prior to their death (e.g. bereavement, school change, location move, disengagement).

Mental health needs of a child: 44% CYP either had a confirmed mental health condition, currently or previously, and 36% had made an attempt to take their life more than twice previously. 55% CYP were unknown to services, suggesting that mental health needs or risks were not identified prior to the child or young person's death.

Risk Taking Behaviour: 36% CYP had 'missing' episodes, 44 % of CYP misused alcohol and/or cannabis.

Conflict with key relationships: 55% CYP had experienced conflict in their relationships with family, friends, or boyfriends/girlfriends.

Problems with service provision: Communication and information sharing, waiting lists for assessments, cross border issues, lack of transitional arrangements in education.

Abuse or neglect: physical, sexual or emotional. 44% of children locally had experience at least one form of abuse or neglect.

Bullying: 33% of CYP had raised bullying as an issue, current and/or historic.

Problems at school: attendance – 44 % had sporadic and slipping attendance, inadequate transitioning arrangements between schools that were not robust enough to ensure continuity of learning and support. Particularly for those children with neurodiversity (confirmed or suspected) in 33 % of CYP. Nationally and regionally, close attention is being paid to the number of suspected suicides via real-time surveillance trend analysis.

Deprivation and circumstance has less of an impact on suicide than other child deaths.

Child suicide is not limited to certain groups; rates of suspected suicide were similar across all areas, and regions in England, including urban and rural environments, and across deprived and affluent neighbourhoods.

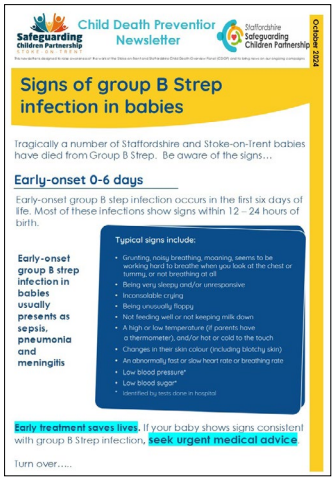
Additional learning from the NCMD thematic review includes:

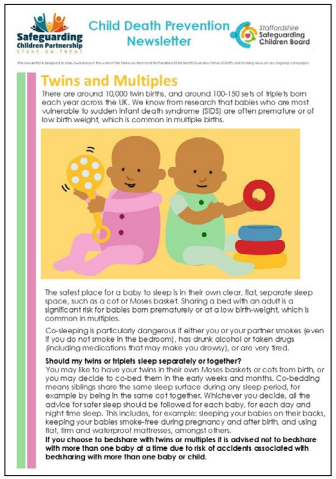
- Poor joint working and poor information sharing (between agencies/professionals)
- Lack of confidence amongst professionals to talk about suicide with children and young people
- The importance of safe and accessible spaces for children and young people
- The importance of recognising the impact of background social factors on the mental health and well-being of children and young people
- The importance of accessibility to mental health services
- Lack of clear policies on bullying and cyber bullying in schools and colleges
- The importance of recognition of challenges for children and young people related to their protected characteristics.

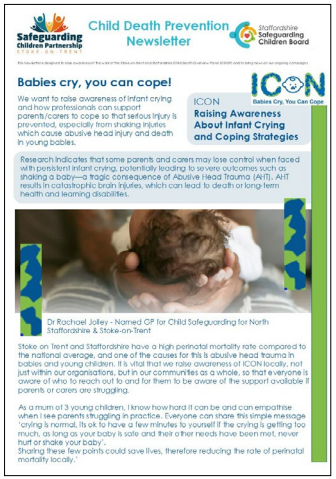
5.3 Sharing information

Learning from Child Death Reviews is collated nationally by the NCMD to inform actions that reduce child mortality. Locally, CDOP reviews capture learning, address safeguarding concerns, and feed into parallel processes. Panel members share insights within their agencies and cascade emerging trends and good practice through briefings, newsletters, and assurance groups.

The below are images of the Child Death Prevention newsletters circulated during this period







5.4 Training

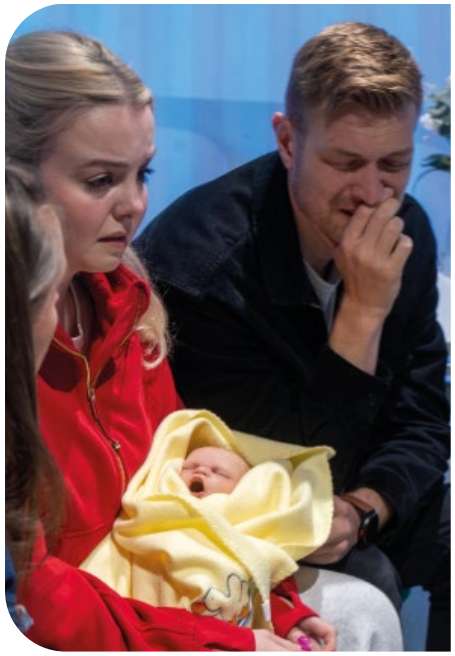
In 2024/25, multiagency training was informed by local evidence and data, with CDOP members delivering sessions to frontline staff on safer sleep and insights from local child deaths. Additional training was provided by the Detective Chief Inspector and Coordinator to Staffordshire Police's child protection team on Sudden Unexpected Death in Infants (SUDI), joint agency response, and learning from first responders.

5.5 Supporting Safer Sleep

Promoting safer sleep remains a priority in Staffordshire and Stoke-on-Trent. In the past year, there were sudden deaths linked to unsafe sleep, including a child on an adult bed and two co-sleeping on sofas. Despite parents receiving safer sleep advice, risks persist. Professionals continue to share guidance and co-sleeping information via the Protect Your Little Bundle booklet, and new resources like a card thermometer to check room temperature have been introduced.

5.6 Multiagency Child Death Simulation Day 2024

The partnership delivered its first child death simulation training for Staffordshire and Stoke-on-Trent. Held at Staffordshire University's Centre for Innovation, the full-day event guided professionals through the multiagency response following a child's death—from the 999 call, to Emergency department care, cause-of-death investigation, bereavement support, and joint agency processes.



5.7 Child Death Operations Group

Staffordshire Police established a bi-monthly Child Death Operations Group, led by D/Supt Victoria Lee, to share learning, address challenges, and support investigations. The group feeds into the child death review process.

5.8 Learning from local modifiable factors for the under 1's

Training sessions highlighted local findings on safer sleep and Sudden Infant Death Syndrome (SIDS), stressing consistent advice to families. Positive evaluations secured funding to continue these sessions.

5.9 Infant Mortality local system action

A pan-Staffordshire and Stoke-on-Trent Infant Mortality review process is providing a co-ordinated, whole-system approach to improve the survival of babies and young children to reduce infant mortality.

5.10 University Hospital of North Midlands (UHNM) staff training

Bereavement study days for UHNM and hospice staff improved understanding of CDOP, SUDI processes, and eCDOP notifications. From September 2025, community nurses will also attend.

5.11 Focus on Safer Sleep

Safer sleep education is embedded in UHNM training, with resources like Lullaby Trust leaflets and Protect Your Little Bundle booklet provided to families. ICON ("Babies cry, you can cope") is promoted during discharge.

5.12 Education - Student Nurses and health visitors

Child death nurses support placements for student nurses and health visitors, offering insight into CDOP and end-of-life care, including attendance at PMRTs, CDRMs, JAR meetings, and SUDIC simulation training.

6 Future priorities

- Strengthening prevention work around pre conception and maternal health, especially obesity and smoking.
- Ensure there are no gaps within smoking cessation processes and service across the county for household members who do not attend booking or appointments.
- Further multi agency child death simulation days are arranged for 2025.
- Ensuring consistent use of interpretation services.
- Continuing multi agency work to reduce unsafe sleeping practices.
- Delivering the Suspected Suicide Multi Agency Action Plan.
- Enhancing systematic learning from modifiable factors across all under 1 deaths.
- Enhance CDOP panel member induction process.

7 Appendix and References

1. All local death data is taken from: Staffordshire and Stoke on Trent eCDOP

2. National data is taken from the National Child Mortality Database (NCMD) Child Death Review Data Release: Year ending 31 March 2025 Child death data release 2025 | National Child Mortality Database

3. *Notifications of death by ethnic group - A caveat to the data included in this highlight box is that, in the absence of an alternative - more suitable – methodology/data source, we have used mother's ethnicity for the denominator and child's ethnicity for the numerator. If all the children of Mixed ethnicity were born to White mothers, the comparison for Staffs would be **17.3%** of mortality against 10.7% of births, and for Stoke **34.3%** of mortality against 29.5% of births.

4. ** Note there are wide confidence intervals around even the three-year data for Stoke (last year 5.9-9.6) due to smaller numbers: this year's 5.7 is only a 'statistically significant' change. The Stoke-on-Trent data is also more volatile than Staffordshire and West Midlands region as a result of small numbers. Staffordshire has moved from significantly worse than England to no statistically significant difference in the most recent year, while Stoke-on-Trent remains (just) significantly worse.

   The CDOP data is by financial year (this chart is calendar year) but shows a similar drop in the most recent single-year (24/25) for Staffs (from 64 to 49, -23.5%) and Stoke-on-Trent (from 24 to 18, -25%).