ONESTOCKPORT
Health and Care Board

Child Death Overview Panel Report 2022-24

Report To (Meeting):	ONE Stockport Health and Care Board		
Report From (Board Lead)	Jilla Burgess-Allen, Director of Public Health, Stockport MBC		
Report From (Author):	Ben Fryer, Consultant in Public Health, Stockport MBC		
Date:	26/03/2025	**Agenda Item No:**	13
Previously Considered by:	Stockport Health and Wellbeing Board		

Purpose of the report:

The Child Death Overview Panel (CDOP) for Stockport, Tameside and Trafford (STT) reviews all child deaths that occur in our three districts so that we can learn why our children die and what as a system we can do differently to prevent this happening, or if that death is inevitable, ensure that the child has the best death possible and that their family and carers are supported throughout.

This report covers the years 2022/23 and 2023/24 and includes information at the notification stage from 105 death notifications, and at the conclusion of the investigation (case closure) stage from 51 children's deaths.

Key points (Executive Summary):

The findings of the report are best summarised by the Infographic which forms one of the papers for this action.

The CDOP Chair has identified eight recommendations for Stockport's, Tameside and Trafford's Health and Wellbeing Boards to endorse and sponsor. These recommendations have been approved by the Child Death Review Partners in Stockport, Tameside and Trafford.

I. Health and Wellbeing Boards should continue their work to address the longstanding causes of increased risk of child deaths. These are recurring modifiable factors in recent CDOP cases, and their contribution to child deaths is supported by a broad evidence base. They include:
    a. Obesity; particularly in children and women of childbearing age
    b. Smoking by pregnant women, partners, and household members / visitors
    c. Parental drug and alcohol abuse
    d. Domestic abuse
    e. Mental ill health
    f. Co-sleeping, and other unsafe sleeping practices

II. Health and Wellbeing boards should develop and implement a strategic approach to reducing poverty (particularly child poverty) and the impact of poverty on the prevalence of the modifiable factors that increase the risk of child death. This poverty is an underlying cause of the modifiable factors listed above, and is associated with a wide range of other poor child outcomes.

III. In line with the recommendations of previous CDOP annual reports, Maternity services should
   a. Ensure that all women are supported to access high quality antenatal care from early in their pregnancies.
   b. Ensure the consistent application of RCOG good practice for triaging and reaching clinical judgements about contacts made by women during labour, to reduce the risk of poor birth outcomes.
   c. Deliver safe, evidence based healthy weight interventions, so that when a women books with the service and she is recorded as not being a healthy weight she is supported to maintain or, if safe to do so, reduce her BMI.
   d. Ensure that all women, partners and members of their household who smoke at the time of their booking appointment are encouraged and supported to stop smoking

IV. The CDOP review partners should review the panel membership and quoracy in line with the 2023 version of Working Together to learn from child deaths. Fair representation should be provided across the three areas.

V. All CDOP partners should continue working to ensure the robust data recording of protected characteristics as required under the Equality Act 2010.

VI. The CDOP chair should work with CDOP panel members and the STT Child Death Review Partners on an ongoing basis. This should include (as a minimum):
   a. Reviewing the draft annual report and agree its recommendations
   b. Providing an update on the actions taken in response to the recommendations in the previous annual report.
   c. Maintaining an awareness of the cases awaiting panel discussion and responding to any challenges and changes within the management of the CDOP process. This year, we specifically recommend that CDOP panel duration should increase to 24 hours per year in order to provide adequate capacity.

VII. The Community Safety Partnerships (and children's safeguarding partnership, as appropriate) in each borough should review the instances of deaths and other serious incidents that are linked to unsafe riding/driving of motor vehicles by children and young people and consider creating a comprehensive strategy to reduce such occurrences.

VIII. Tameside CDOP partners are asked to review the concerning indications that child deaths in the borough have increased over time. While these changes have not yet reached statistical significance, they are sufficient to justify cautious further inquiry

In relation to recommendation II above, it should be noted that Stockport already has a wide ranging approach to poverty. This approach is led through the Anti-Poverty Board

and Steering Group and is framed through our Equality Objectives. These objectives were agreed at Cabinet in March 2024 and are available at Anti Poverty Objectives 2024-27. A progress report on Child Poverty was presented to Children's and Families Scrutiny on 22 January and can be found at Agenda for Children & Families Scrutiny Committee on Wednesday, 22nd January, 2025, 6.00 pm - Stockport Council
Recommendation:
The Board are asked to: • Note the report, and • Ask all board members to support the delivery of actions relevant to their organisation.

Decision		**Discuss/Direction**	**X**	**Information/Assurance**	**X**

Aims (please indicate x)		
Which integrated care aim(s) is / are supported by this report:	People are happier and healthier and inequalities are reduced	**X**
	There are safe, high-quality services which make best use of the Stockport pound	**X**
	Everyone takes responsibility for their health with the right support	**X**
	We support local social and economic development together	**X**

Conflicts of Interests	
Potential Conflicts of Interest:	Nil

Risk and Assurance:	
List all strategic and high level risks relevant to this paper	This report fulfils a duty under Working Together to Safeguard Children 2023. It describes the way in which children living in the three boroughs lived and died, and the modifiable factors that could have reduced the likelihood of the deaths that occurred. Please see main report for detail on these modifiable factors.

Consultation and Engagement:	
Local People / Patient Engagement:	Nil
Workforce Engagement:	This report has been reviewed by the CDOP panel and stakeholder reference group.

• **Potential Implications:** The report suggests that the number of deaths reviewed over a two year period is below the number of children who have died. This may suggest a resourcing gap, but in the interim; a recommendation is made to increase the amount of panel time available, which has no direct cost implication.

Financial Impact: Please note - All reports with a financial implication require detail of the level of funding, funding stream and comments from Finance.	Non-Recurrent Expenditure	£
	Recurrent Expenditure (please state annual cost)	£

	Funding stream	Yes	No
	Included in the s75 Pooled Budget		
	GM ICB (Stockport) delegated budget		
	Other, please specify:		
Finance Comments:	N/A		
Performance Impact:	The Child Death Overview Panel reports through the health and wellbeing board. A summary of actions taken as a result of the previous report brought to health and wellbeing board is included within the papers for this item.		
Workforce Impact:	There are no direct impacts on the workforce as a result of this report, but the report may help frame our understanding of the learning and development needs of colleagues who work with children.		
Quality and Safety Impact:	This report highlights that 12 of the 51 deaths that were presented to panel within this two year period occurred as a result of a perinatal or neonatal event. Medical care was identified as a modifiable factor in 4 of those 51 cases. Recommendations are given that seek to improve quality and safety in this regard.		
Compliance and/or Legal Impact:	This report fulfils a duty under Working Together to Safeguard Children 2023		
Equality and Diversity: Has an equality impact assessment been completed?	This is a routine report, and does not relate to a significant decision. An impact assessment has not been undertaken Child deaths are more likely in our more deprived neighbourhoods and (at least at a national level) occur more frequently in minority ethnic groups. Action to reduce child death would be expected to reduce the inequality in child health outcomes and have a positive impact on health equity		
	If Not Applicable please explain why	Yes		No		N/A	X
Environmental Impact: Has an environmental impact assessment been completed?	General Statement: This is a routine report, and does not relate to a significant decision. An impact assessment has not been undertaken		
	If Not Applicable please explain why	Yes		No		N/A	X