Learning from Child Death Reviews

Report of Stockport, Tameside and Trafford (STT) Child Death Overview Panel

2022/2023 & 2023/2024

Document Control

Date	Version	Forum/Officer	Purpose	Amendments
05/08/2024	1	Eleanor Banister	First draft	Yes
27/09/2024	2	Ben Fryer	Second draft	Yes
11/12/2024	3	Ben Fryer	Third draft	Yes
23/12/2024	3.1	Ben Fryer	Final draft	Yes

Learning from Child Death Reviews: Report of Stockport, Tameside and Trafford's Child Death Overview Panel 2022/2023 & 2023/2024 has been prepared on behalf of Stockport, Tameside and Trafford Child Death Overview Panel and Stockport, Tameside and Trafford Child Death Review partners by:

- **Ben Fryer, Consultant in Public Health, Stockport Council, and STT CDOP Chair**
- **Eleanor Banister, Public Health Intelligence and Early Intervention and Prevention Lead, Public Health, Stockport Council**
- **Shelley Birch, Child Death Overview Panel Manager (Tameside, Trafford and Stockport), Trafford Council.**

Please send all comments to Shelley Birch, Shelley.birch@tameside.gov.uk.

Executive Summary

1. Introduction

The death of any child is a tragedy. It is therefore important that we understand why our children die and what as a system we can do differently to prevent this from happening or, if inevitable, ensure that the child has the best death possible[1] and that their family and carers are supported throughout.

Each year the Stockport, Tameside and Trafford (STT) Child Death Overview Panel publish a report, 'Learning from Child Death Reviews', to describe why children who lived in Stockport, Tameside and Trafford died, to learn from the circumstances as far as possible, and present recommendations for the future. This report summarises findings from 2022/2023 & 2023/2024.

2. Data protection

Losing a child is a distressing time; every care has been taken to ensure the data presented does not lead to the identification of any individual children and their families as we do not wish to add to anyone's grief.

Professionals who require the more detailed data analysis can request a copy of the data by emailing Shelley Birch, shelley.birch@tameside.gov.uk.

3. What we know about the children who died and cases that were closed in 2022/2023 & 2023/2024

Key points from data analysis:

- The panel received 105 notifications in the 24-month period 2022-24, bringing the 10 year total across STT to 491.
- There is no clear trend towards a higher or lower notification rate, although the annual rate has risen over the last two years compared to the previous five years. The ten year average is 29.3 notifications per 100,000 population aged under 18, with the rate for 2022-24 being 30.6 per 100,000.
- Infants aged under 1 year accounted for 58 notifications (55% of total) which is similar to previous years in STT, where around half of child deaths were aged under a year
- The factor of ethnicity is difficult to comment on as the recording of ethnicity in notified cases is not complete, although levels of recording are improving.
- The notification rate is higher than average in children who live in areas of STT ranked in the most deprived 20% in England, and the gradient across deprivation quintiles is clear.
- The panel closed 51 cases in 2022-24, this is lower than the totals in the previous three (pandemic affected) years. 83% of these cases were from 2022/21 or 2020/21.
- Around a half (45%) of infants who died had a low birth weight; and 59% of infants who died were premature.
- In 2022-24 chromosomal, genetic and congenital anomalies makes up the largest category of cause of deaths for closed cases (18 deaths, 35%), perinatal/neonatal event makes up

[1] There is no accepted definition of the best death possible, but a regularly quoted working definition suggests that 'a good death is one that is free from avoidable distress and suffering for patients, families and caregivers; in general accord with patients' and families' wishes; and reasonably consistent with clinical, cultural and ethical standards'. M. Field, C. Cassel (Eds.), When children die: Improving palliative and improving end-of-life care for children and their families, National Academies Press, Washington, DC (2003)

the second largest category (12 deaths, 24%) followed by deaths of people with a chronic medical condition (4 deaths, 7.8%) and deaths involving suicide or deliberate self-harm (4 deaths, 7.8%).

- Modifiable factors were identified in 24 (47%) of closed cases. Smoking, domestic violence, maternal BMI, unsafe sleeping and missed opportunities in medical care were the most common factors recorded.
- More than half (61%) of closed cases were expected deaths.

4. Recommendations

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 continue to 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

Contents

Learning from Child Death Reviews

Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel 2022/2023 & 2023/2024

1. Introduction

The death of any child is a tragedy. It is therefore important that we understand why our children die and what as a system we can do differently to prevent this from happening or, if inevitable, ensure that the child has the best death possible and that their family and carers are supported throughout.

Each year the Stockport, Tameside and Trafford (STT) Child Death Overview Panel publish a report, 'Learning from Child Death Reviews', to describe the mortality trends for children and why children who lived in Stockport, Tameside and Trafford died, to learn from the circumstances as far as possible, and present recommendations for the future. This report summarises findings from across two years, 2022/2023 & 2023/2024.

2. Data protection

Losing a child is a distressing time; every care has been taken to ensure the data presented does not lead to the identification of any individual children and their families.

Professionals who require the more detailed data analysis can request a copy by emailing Shelley Birch, shelley.birch@tameside.gov.uk.

3. The Child Death Overview Process

The Stockport, Tameside and Trafford Child Death Overview Panel (STT CDOP) undertakes a review of all child deaths (excluding those babies who are still born, and planned terminations of pregnancy carried out within the law) up to the age of 18 years who are either normally resident in one of the three boroughs, or, if they consider it appropriate, any non-resident child who has died in their area. The Child Death Review Partners and CDOP adhere to the statutory guidance: Child Death Review Statutory and Operational Guidance (England) 2018[i]. The CDOP reviews each case in a structured and consistent manner in line with Working Together, 2023[ii].

There are four CDOPs across Greater Manchester, including STT CDOP. It is recommended that CDOPs serve a total population of 500,000, with an average of 60 child deaths per year. The geographical footprint of STT CDOP covers an estimated population of 771,700 people (ONS 2023 Mid Year Estimate), receives an average of 40 to 60 notifications per year and includes a network of NHS health, police and social care providers for this cluster.

It is important that deaths are reviewed without undue delay, and that the panel has capacity to review 60 deaths per year to meet need. Over the last 12 months, the CDOP manager, Shelley Birch, has effectively resolved the backlog in preparing cases for the panel, which has moved the 'bottleneck' limiting case progression to the panel meetings themselves. We therefore recommend that the panel moves to meeting for a minimum of 24 hours per year, matching the pre-pandemic capacity. It is for the CDOP chair, in consultation the panel manager and members, to plan meetings for each year to meet this recommendation.

The CDOP is accountable to each locality's Health and Wellbeing Board. Appendix A provides more information about the CDOP process with links to local membership and arrangements.

4. Implementing Local Learning

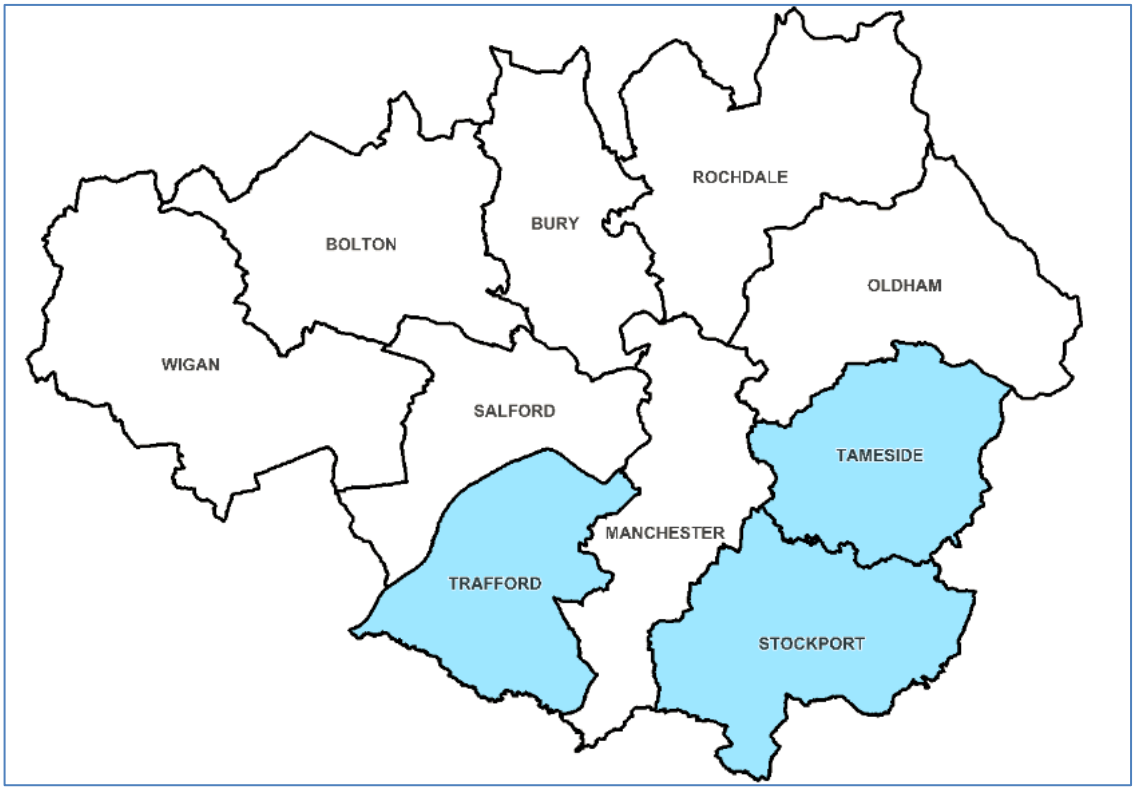
A tripartite group of consultants in public health representing the three districts has been formed to support the CDOP chair in leading the work of CDOP, and implementing learning locally. This group has reviewed and approved this report and supported work to pull together an update on the actions resulting from the previous report. Stockport, Tameside and Trafford Health and Wellbeing Boards are accountable for the work of this group.

The emerging NHS Greater Manchester ICS provides opportunities to strengthen and formalise existing links between the CDOP system and the NHS Integrated Care System, with CDOP findings contributing to quality improvement activities in the NHS. The Strategic Child Death Group and GM CDOP chairs will continue working with NHS colleagues to develop a clear plan for this.

5. What we know about children who live Stockport, Tameside and Trafford

Understanding our population across STT is important for us to contextualise the circumstances in which our children and young people die.

Figure 5.i: Stockport, Tameside and Trafford within Greater Manchester.



Source: Trafford Public Health, 2019.

In 2023, Stockport, Tameside and Trafford had an estimated combined population of 172,150 under 18 year olds (ONS 2023 Mid Year Estimate). Table 5.ii, provides an overview of the characteristics of the children and young people who live in each of the three boroughs.

It is important to understand the similarities and differences between the boroughs when reviewing the number of notifications and the conclusions from the closed cases; with Tameside having higher levels of poverty and looked after children and Trafford having a more ethnically diverse young population.

Local profiles for each borough can be found in Appendix B.

Table 5.ii: Overview of the characteristics of the children and young people who live Stockport, Tameside and Trafford.
Source: ONS Population and Census Data[iii]; OHID Maternal and Child Health Profiles (as at 06-08-2024)[iv].

Indicator				Stockport	Tameside	Trafford	GM	England
1	Population aged 0 to 17 years (2023)		Number	64,102	52,031	56,015	671,017	11,998,646
			% of Total (all ages)	21.4%	22.2%	23.6%	22.8%	20.8%
2	% age 0-24 Black, Asian & Minority Ethnic Groups (2021)			18.3%	21.6%	32.1%	34.0%	26.7%
3	Projected growth in 0 to 17 population (2023-2033)		Number	-843	-1,121	+64	-32,891	-261,287
			%	-1.3%	-2.2%	+0.1%	-4.9%	-2.2%
4	Children in Low Income Families (under 16s) (2022/23)	Absolute	Number	7.496	9,882	5,144	140,448	1,645,057
			%	13.2%	21.4%	10.4%	23.8%	15.6%
		Relative	Number	9,973	13,000	6,651	179,814	2,091,929
			%	17.6%	28.2%	13.5%	30.4%	19.8%
5	Live births (2022)		Number	2,931	2,488	2,170	33,035	577,046
			Rate per 1,000 female 15-44	54.3	55.6	49.2	54.5	51.9
6	Low birth weight	of term babies (2022)	Number	54	70	51	879	14,982
			%	2.1%	3.3%	2.7%	3.0%	2.9%
		of all babies (2021)	Number	216	140	148	2,336	39,826
			%	6.8%	6.0%	6.3%	7.2%	6.8%
7	Stillbirth rate (2020-22)		Number	39	34	24	458	6,958
			Rate per 1,000 births	4.2 (CI 3.0-5.7)	4.5 (CI 3.1-6.3)	3.5 (CI 2.2-5.2)	4.6 (CI 4.1-5.0)	3.9 (CI 3.8-4.0)
8	Infant mortality (2020-22) <1 year		Number	27	34	20	491	6,918
			Rate per 1,000 live births	2.9 (CI 1.9-4.2)	4.5 (CI 3.1-6.3)	2.9 (CI 1.8-4.5)	4.9 (CI 4.5-5.4)	3.9 (CI 3.8-4.0)
8a	Neonatal mortality (2020-22) <28 days		Number	22	16	15	339	5,037
			Rate per 1,000 live births	2.4 (CI 1.5-3.5)	2.1 (CI 1.2-3.5)	2.2 (CI 1.2-3.6)	3.4 (CI 3.1-3.8)	2.9 (CI 2.8-2.9)
8b	Post-neonatal mortality (2020-22) - 28 days-1 year		Number	5	18	5	152	1,881
			Rate per 1,000 live births	0.5 (CI 0.2-1.3)	2.4 (CI 1.3-3.8)	0.7 (CI 0.2-1.7)	1.5 (CI 1.3-1.8)	1.1 (CI 1.0-1.1)
9	Child mortality (2020-22) Age 1-17		Number	13	29	14	235	3,496
			Rate (DSR) per 100,000 aged 1-17	7.4 (CI 3.9-12.6)	20.2 (CI 13.5-29.0)	9.1 (CI 5.0-15.3)	n/a	10.4 (CI 10.1-10.8)
10	Children in care (2022/23)		Number	481	656	350	6,105	83,840
			Rate per 10,000 aged 0-17	76	127	63	92	71

6. What we know from CDOP Notifications and Closed Cases 2022/2023 & 2023/2024

This annual report considers the learning from child death cases that were notified to the STT CDOP and were reviewed and closed by the panel between 1st April 2022 and 31st March 2024.

6.i. Data analysis

When a child dies, any or all of the agencies involved with the child inform CDOP. This is referred to as a 'notification'. The administrator then begins the process of gathering information from all official sources who may know the child and/or family in order to build a picture of the circumstances leading up to the death of the child. Once this process is complete and all other investigations involving the Coroner, Police or Children's Services have been concluded, the CDOP reviews each case. Having assessed all the available information the panel, made up of professionals from a number of agencies, discuss the relevant points and reach a conclusion regarding the category of death and any modifiable factors or issues specific to that case. At this point the 'case' is considered by the CDOP to be 'closed'.

In this section the analysis of factors that are "fixed" (i.e. age and sex, ethnicity, and deprivation of area of mother's residence) is of ***notifications*** to the panel during 2022/2023 & 2023/2024. This is a reasonable proxy of deaths that have occurred within this period because the period between death and notification is usually only a matter of days, and this gives a better unit of analysis for considering epidemiological patterns in child deaths across the STT CDOP area. Birthweight and gestation is also "fixed" in this sense and would ideally be analysed at notification level, but this information is often not available until later in the review process.

Factors such as category of death, whether the death was expected or not, and whether any modifiable factors were present are not determined until the case is closed by CDOP and so analysis of these factors relates to cases ***closed*** during 2022/2023 & 2023/2024. In many cases there is more than a year between notification and closure.

Therefore notifications show epidemiological pattern of deaths for the year under review, whereas closed cases provide intelligence about cases from a range of years but where the investigations are complete.

6.ii. Demographic breakdown of notifications

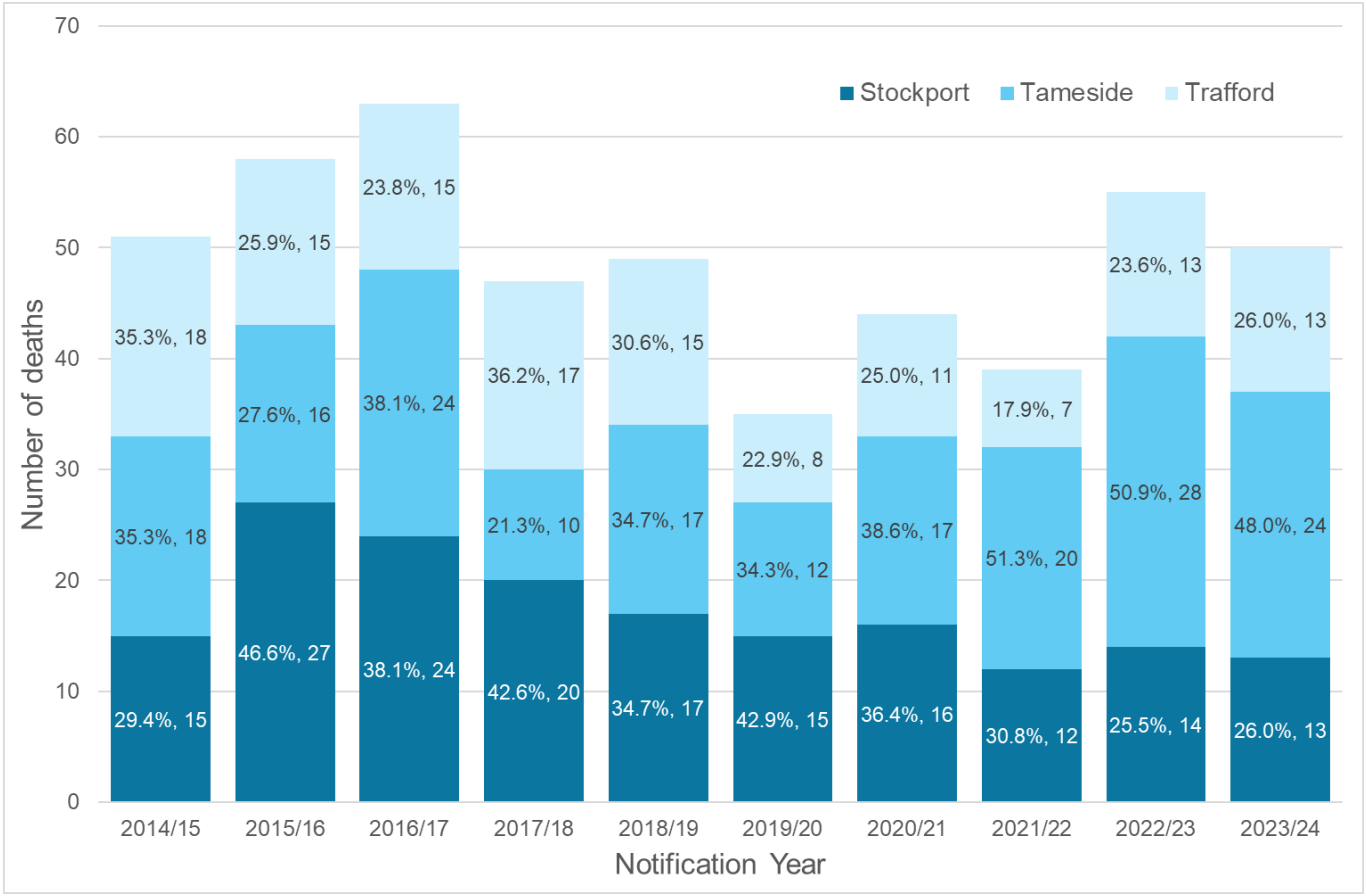
6.ii.a. Number of notifications

The panel received 55 notifications in 2022/23 and 50 notifications in 2023/24, a level around 20% higher than the average of the previous five years (average 43 2017/8-2021/22). The 2022-24 notifications bring the ten year total notifications across STT since 2014/15 to 491.

The split by local authority in 2022-24 was 27 (25.7% of total) in Stockport, 52 (49.5%) in Tameside, and 26 (24.8%) in Trafford. While more Tameside children died in both this two year period and the previous year (2021/22) than Stockport or Trafford children, due to small number variation this is not a statistically significant difference. It is, however, a cause for increasing concern and further investigations are underway to understand this better.

Aggregating the ten year total gives a split by local authority of 35.2 % (173) in Stockport, 37.9% (186) in Tameside, and 26.9% (132) in Trafford; with Stockport's proportion of notifications being similar to the boroughs share of the 0-17 population (37.1%), Tameside slightly higher (30.2%) and Trafford slightly lower (32.7%).

Figure 6.ii.a: Child deaths notifications to STT CDOP – 2014/15 to 2023/24 by authority

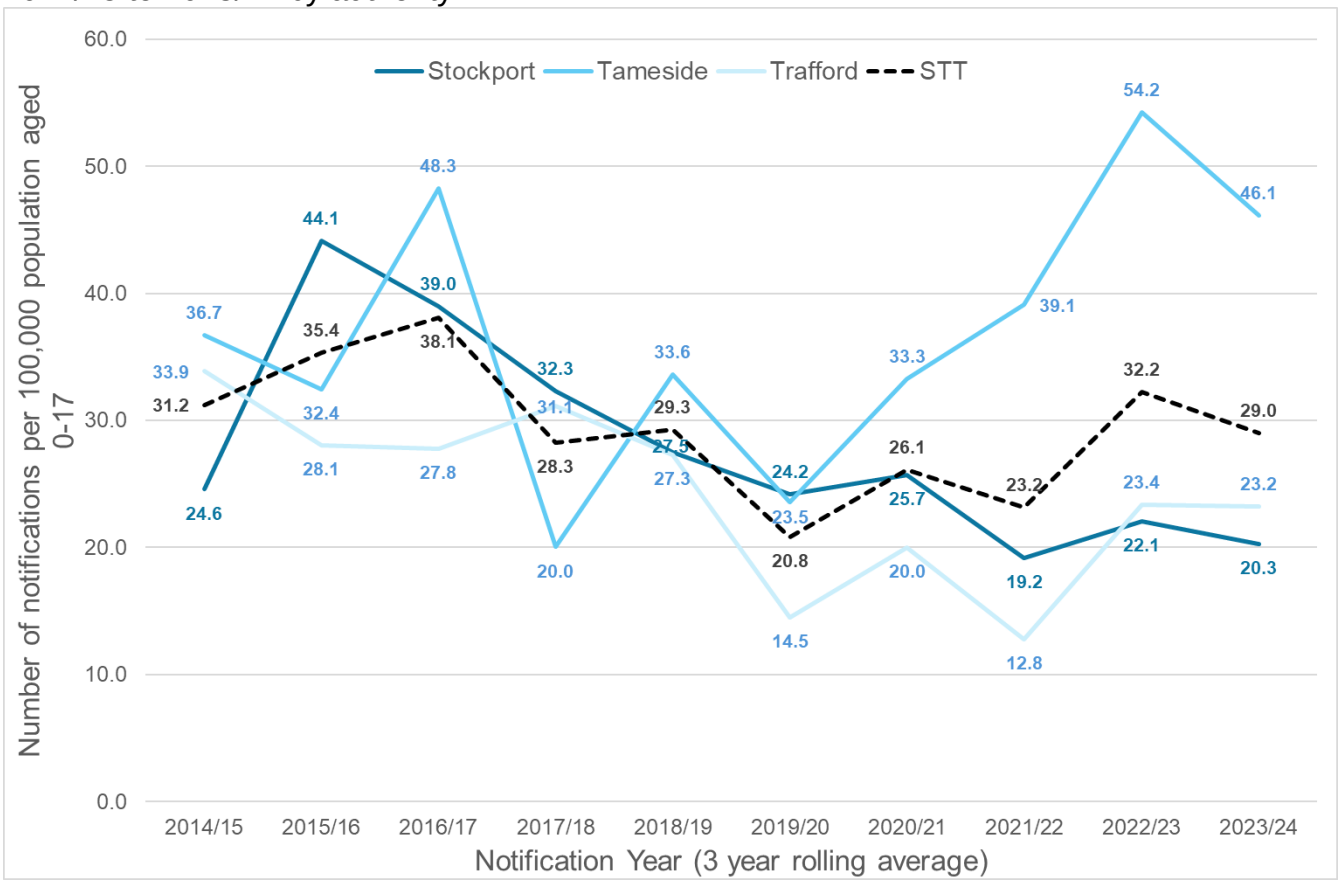


6.ii.b. Notification rate

At local authority level the notification rate tends to fluctuate year on year due to the relatively small numbers, and so it is difficult to detect underlying trends. Aggregating the notifications for STT smooths out some of this fluctuation: the 105 notifications in 2022/23 & 2023/24 combined give a rate of 30.6 per 100,000 population aged under 18, which is higher than the average over the last five years (25.5 per 100,000 2017/18-2021/22), the rise in 2022-24 is due to the higher numbers of deaths in Tameside in this period (50.2 per 100,000 in 2022-24, which is statistically significantly higher than STT average in this period) compared to 21.2 per 100,000 in Stockport and 23.3 per 100,000 in Trafford.

The ten year aggregated notifications give a rate for STT of 29.3 per 100,000, which is similar in Stockport (27.8 per 100,000), higher, but not statistically significantly so, in Tameside (36.8 per 100,000) and slightly lower, but again not statistically significantly so, in Trafford (24.1 per 100,000).

Figure 6.ii.b: Trend in child death notification rate (per 100,000 population aged under 18) – 2014/15 to 2023/24 by authority



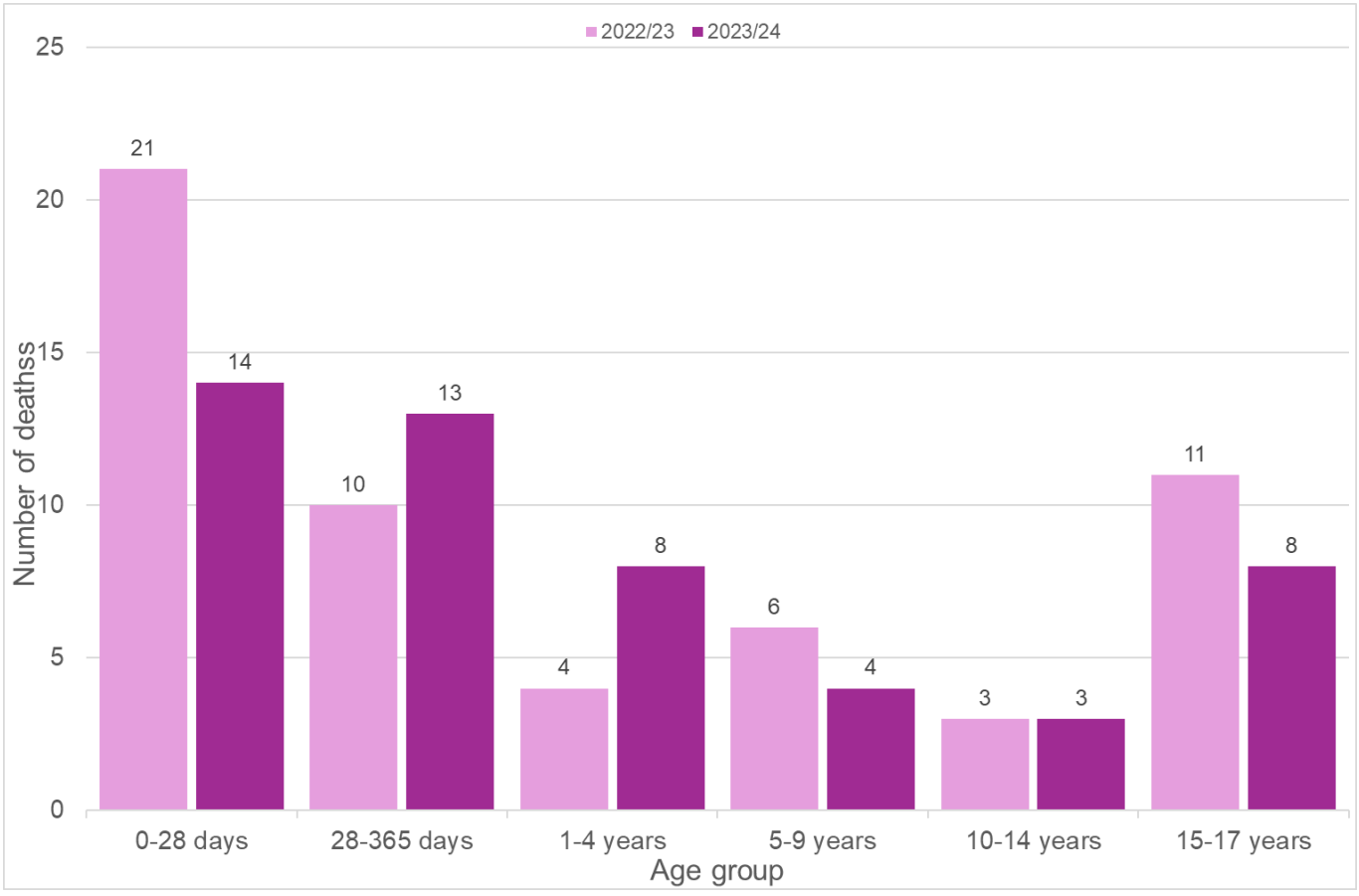
Between 2019/20 and 2022/23, the child death notification rate in Tameside has seen a steady increase from a baseline of being more closely comparable with Stockport and Trafford. Direct comparison between 2019/20 and 2022/23 rates illustrates the notification rate has more than doubled in this time. The rate for 2023/24 appears to have declined slightly, although still indicates a considerable rise from the 2019/20 rate. As discussed earlier in this report, the numbers contributing to this rate are small and therefore this trend should be treated with caution. However, given the sustained increasing trend, further investigation is warranted to better understand what could be contributing to this and if any actions need to be taken. A broader mortality review is underway in Tameside and this will include child deaths. Relevant findings of this review and any subsequent recommendations will be shared with the Child Death Review Partners for Stockport, Tameside and Trafford.

6.ii.c. Age breakdown of notifications

Of the 105 notifications in 2022-24, 35 (33.3%) were neonates (i.e. aged under 28 days) and 23 (21.9%) were aged between 28 days and 1 year. This means that around a half (58 or 55.2%) of notifications across STT are infants (i.e. aged under 1 year). This is similar to previous years in STT.

Reviewing the 24 notifications of deaths of children aged over 1 year, at STT level the distribution across age groups was fairly even with 12 (11.4%) aged 1 to 4 years, 10 (9.5%) aged 5 to 9 years, 6 (5.7%) aged 10 to 14 years. Greater numbers of deaths are recorded for children undergoing their transition to adulthood from age 15 to 17 years, with 19 deaths (18.1%) in this 3-year age group.

Figure 6.ii.c.i: Age breakdown of child death notifications 2022/2023 & 2023/2024



Any differences between the three authorities in this distribution are difficult to detect due to the small numbers although for all areas the proportion of deaths <1 years was 48% or more.

Table 6.ii.c.ii: Age breakdown of child death notifications 2022/2023 & 2023/2024 by locality

Age	Stockport	Tameside	Trafford
0-28 days	9	14	12
28-365 days	4	13	6
1-4 years	3	6	3
5-9 years	3	5	2
10-14 years	2	3	1
15-17 years	6	11	2
TOTAL	**27**	**52**	**26**

6.ii.d. Ethnicity breakdown of notifications

Of the 105 notifications during 2022/23 and 2023/24, 25 (23.8%) belonged to ethnic minority groups (excluding white minorities). This is in line with the estimated proportion of the STT child population belonging to ethnic minority groups (23.7% aged 0-24 at the 2021 Census). However, there are 2 notifications (1.9% of total) where ethnic group is not known (these are cases which are still open to CDOP pending further information).

Figure 6.ii.d.i: Ethnic group breakdown of notifications 2022/2023 & 2023/2024

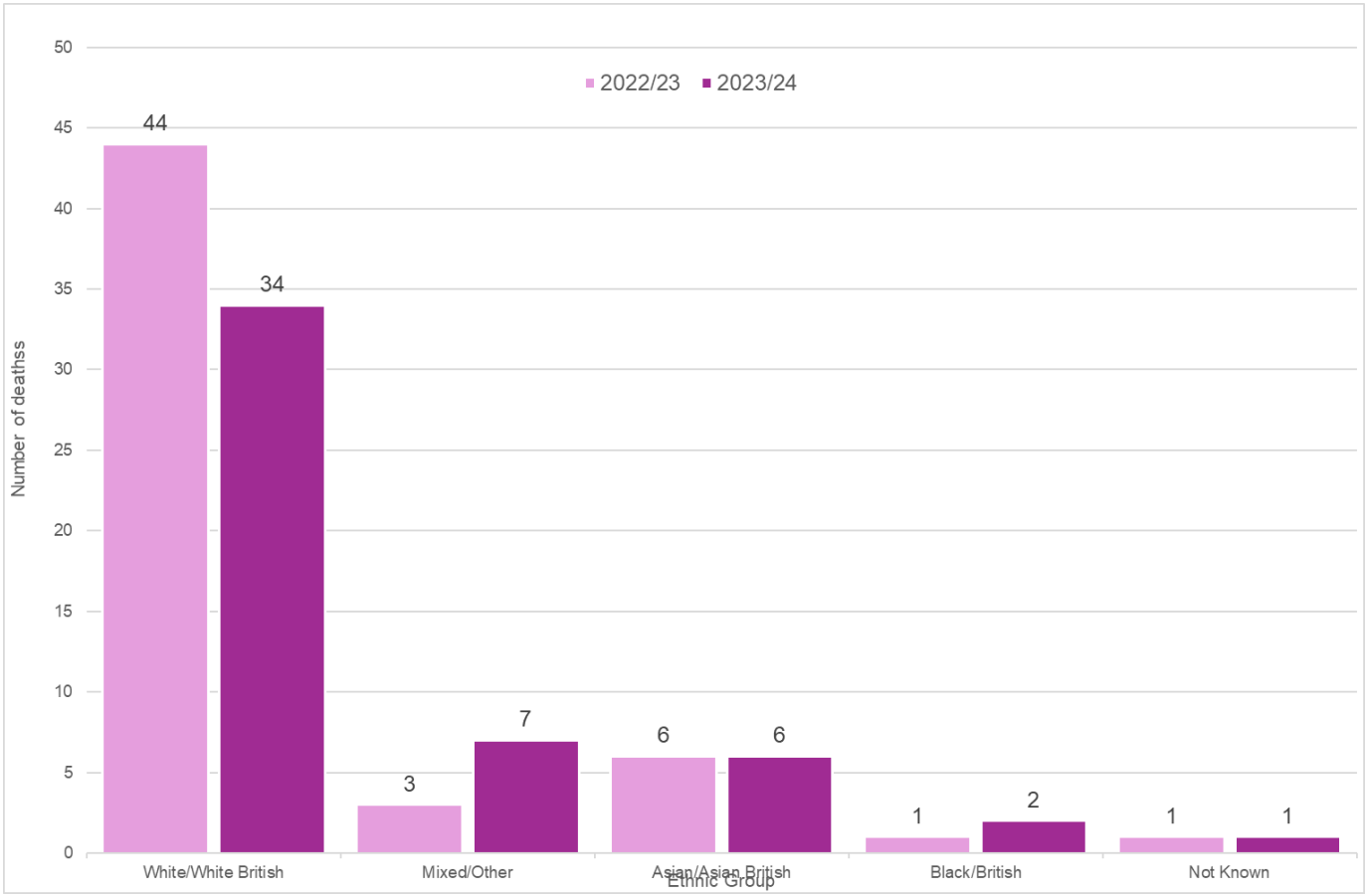


Table 6.ii.d.ii: Ethnic group breakdown of notifications 2022/2023 & 2023/2024 by locality

Ethnic group	Stockport	Tameside	Trafford
White/White British	22	38	18
Mixed/Other	1	5	4
Asian/Asian British	3	5	4
Black/British	0	3	0
Not Known/Not Input	1	1	0
TOTAL	**27**	**52**	**26**

6.ii.e. Deprivation breakdown of notifications

Trafford is the least deprived district in Greater Manchester. Based on the 2019 Index of Multiple Deprivation it ranks 191st of 317 districts in England (where a rank of 1 is the most deprived district) and only 8.7% of Trafford small areas (LSOAs) rank in the 20% most deprived in England. Stockport is also one of the less deprived districts in Greater Manchester, ranking 130th in England on IMD 2019 and with 16.3% of LSOAs ranked in the 20% most deprived. Tameside is much more deprived with an IMD 2019 rank of 28th most deprived in England and 42.6% of LSOAs ranked in the 20% most deprived in England.

Of the 105 notifications across STT, 45 (42.9%) were of children who lived in small areas which rank in the 20% most deprived in England, a crude rate over the last two years of 50.3 per year per 100,000 aged 0-17. There is tendency towards higher child death notification rates in more deprived areas of STT; and the two year period shows a clear variation between the quintiles which is evident, although less clearly over the five year period.

Nationally the mortality rate for infants living in the 10% most deprived areas in England was almost three times higher than for infants living in the 10% least deprived areas; a wider difference than seen during any of the previous 12 years[2].

This apparent strengthening of the relationship between deprivation and child death suggests that poverty (and particularly child poverty), which underlies many of the modifiable factors is a key underlying determinant of child deaths.

Figure 6.ii.e.ii: Notification rate (crude child mortality rate) according to national deprivation quintile of mother's area of residence 2019/2024 & 2022/2024.

[2] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2022

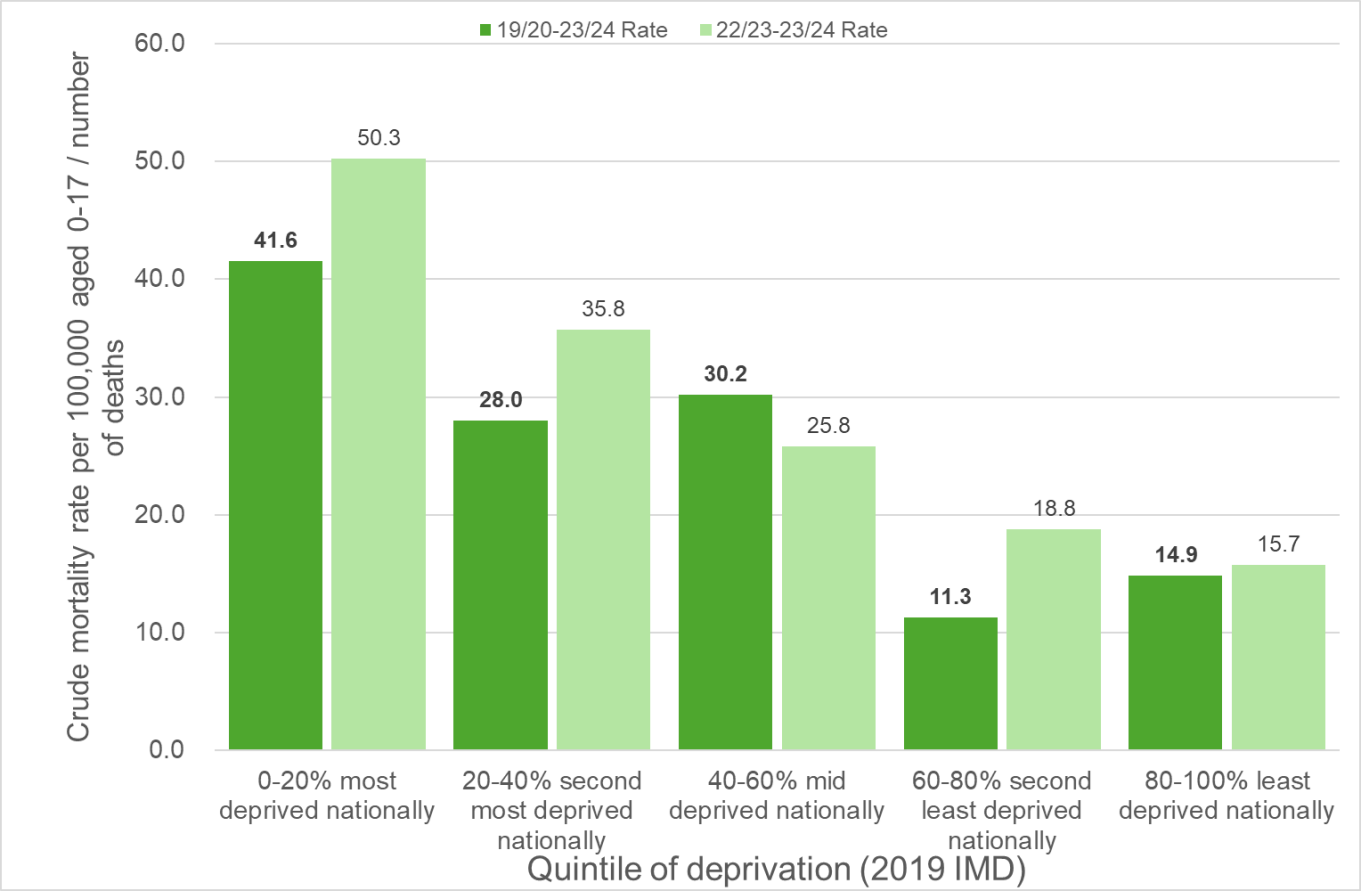


Table 6.ii.e.ii: National deprivation quintile of mother's area of residence 2022/2024 by locality

2019 Deprivation	Stockport	Tameside	Trafford
0-20% most deprived nationally	8	32	5
20-40% second most deprived nationally	6	9	9
40-60% mid deprived nationally	5	6	2
60-80% second least deprived nationally	2	5	5
80-100% least deprived nationally	6	0	5
TOTAL	**27**	**52**	**26**

6.iii. Analysis of cases closed during 2022-24

6.iii.a. Number of closed cases

In 2022/23 22 cases were closed by the panel, and 2023/24 29 cases were closed:

- This is lower than the totals in the previous years (38 closed in 2019/20, 29 in 2020/21 and 45 in 2021/22) and is substantially lower than a peak of 64 cases closed by the panel in 2010/11. This is likely to reflect a combination of greater complexity in the cases being presented to panel, and the panel meeting for fewer hours than prior to the pandemic. The impact of the introduction of the new eCDOP computer system may also be a relevant factor.

- The breakdown of closed cases in the two-year period 2022-24 by authority was 16 (31.4%) in Stockport, 21 (41.2%) in Tameside and 14 (27.5%) in Trafford.

- Only 6 of these closed cases (11.8%) were notified to CDOP in 2022/23, 27 (52.9%) were notified in 2021/22, 16 (31.4%) were notified in 2020/21 and 2 (3.9%) in 2018/19.

- For cases closed in the two year period, the average (mean) number of days from notification to close was 748 (over 2 years), but varied by authority from 689 days for Stockport cases, 740 days for Tameside cases to 826 days for Trafford cases. The average time has increased since 2021/22 (666 days).

- Deaths of children aged over 1 year tend to take longer to close (754 days comparted to 739 days), probably reflecting the circumstances and causes of death.

- The rate limit on closing cases is typically determined by the process of gathering the information required by the panel. This work is time consuming and can't be completed until all other processes (including coroner's inquests) have been completed. The panel process does not regularly contribute significantly to the duration from notification to closure, but there is now an increasing number of cases that are prepared and awaiting panel discussion. We will therefore make a recommendation in relation to the capacity of the panel.

6.iii.b Birthweight and gestation and multiple births for deaths < 1 year

In 2022-24, 22 (43.1%) of cases closed by the panel were infants (died within 12 months of their birth).

Babies who are born extremely prematurely (before 28 weeks) have a very low chance of survival. They generally have a very low birthweight, under-developed organs (particularly lungs) and are very vulnerable to infections. Low birthweight and prematurity independently predict a higher risk of neonatal mortality, but are confounders for each other.

Among these 22 cases:

- 9 (40.9%) had very low birthweight (<1,500g), and a further 1 (4.5%) had a low birthweight (1,500-2,499g); bringing the proportion with low birthweight to half (10 out of 22 or 45.5%). 7 had a birthweight above 2499g (31.8%), 5 had unknown birth weight (22.7%).
- 9 of the 10 babies (90%) with low birthweight died within 28 days of their birth.
- 4 of the 7 babies (57.1%) with birthweight >2499g died within 28 days of their birth.

- All 9 babies with very low birthweight were extremely premature (<30 weeks).
- 11 of the total 22 infant deaths (50.0%) were extremely premature (<30 weeks), and a further 2 (9.1%) were premature (30-36 weeks); bringing the proportion who were premature to more than a half (13 out of 22 or 59.1%). 9 (40.9%) were full term.
- 11 of the 11 babies (100%) who were extremely premature died within 28 days of their birth
- 0 of the 2 babies (0%) who were premature died within 28 days of their birth
- 4 of the 9 babies (44.4%) who were full term died within 28 days of their birth
- None of the infant deaths closed were linked to multiple births, which may suggest that work done to reduce multiple implantation of embryos during IVF has been effective, but might reflect small number variation. We need to be cautious in drawing conclusions and be vigilant about changes in this indicator.

6.iii.c Place of death of closed cases

The place of birth is not included in the dataset, however the place of death is included as shown in the table below, along with the associated hospital where known. For deaths that occurred at home or elsewhere there is often a transfer to hospital.

Table 6.iii.c.i: Place of death for deaths & associated hospitals < 1 year in 2022/2023 & 2023/2024

Place of death	Stockport	Tameside	Trafford	TOTAL
St Mary's or Royal Manchester Childrens Hospital	2 = NICU	2 = NICU	1 = delivery suite 1 = neonatal unit 1 = NICU	7
Stepping Hill Hospital	2 = delivery suite 1 = NICU 1 = PICU			4
Tameside Hospital		1 = NICU		1
Wythenshawe Hospital			1 = delivery suite 1 = neonatal unit	2
Home	1 = home 1 = unstated ED 1 = St Mary's ED	1 = unstated NICU 1 = unstated ED 1 = Tameside ED	1 = home	7
Not stated			1 = unstated PICU	1
Total	**9**	**6**	**7**	**22**

Table 6.iii.c.ii: Place of death for deaths & associated hospitals with >1 year in 2022/2023 & 2023/2024

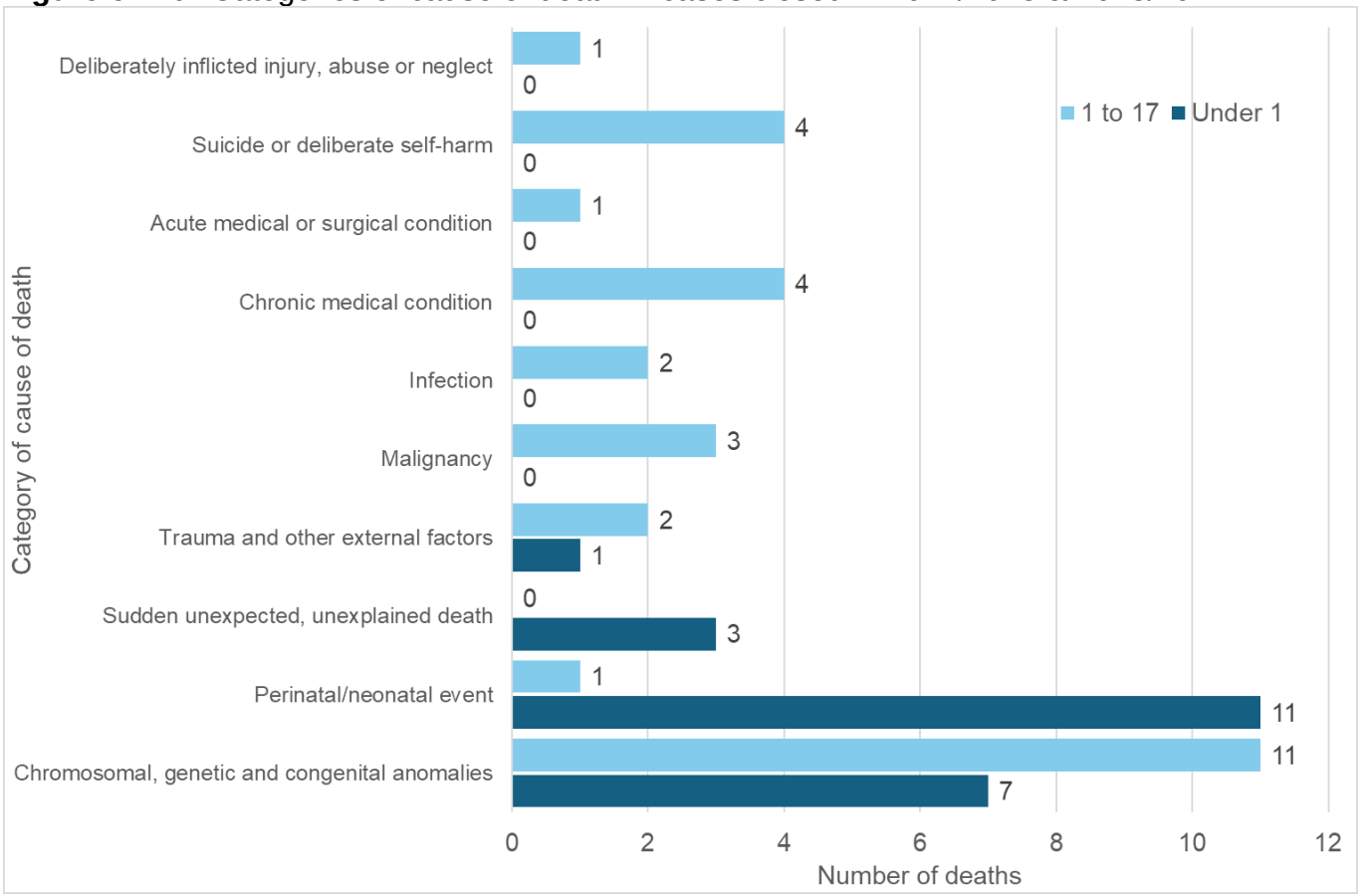
Place of death	Stockport	Tameside	Trafford	
Royal Oldam		1 = PICU		1
Tameside Hospital	1 = PICU	1 = Tameside other unit		2
Wythenshawe Hospital	1 = other unit			1
Home	2 = Stepping Hill ED 1 = unstated ED	1 = St Mary's ED 1 = Oldham ED 1= Tameside PICU 2 = Tameside other 1 = unstated	1 = home 1 = Wythenshawe unstated	11
Hospice		1 = Tameside other 2 = unstated	1 = Wythenshawe unstated	4
Public Place	1 = Stepping Hill other unit	1 = St Mary's ED 1 = unstated		3
Other	1 = unstated ED	1 = unstated paediatric ward 1 = Tameside unstated	1 = unstated ED 2 = unstated acute hospital 1 = unstated PICU	7
Total	**7**	**15**	**7**	**29**

6.iii.d. Categories of cause of death

In 2022/2023 & 2023/2024 chromosomal, genetic and congenital anomalies made up the largest category of cause of death for closed cases (18 deaths, 35.3%). Perinatal/neonatal events formed the second largest category (12 deaths, 23.5%) followed by chronic medical conditions (4 deaths, 7.8%) and suicide or deliberate self-harm (4 deaths, 7.8%).

The 17 closed cases of children aged over 1 year were spread across a range of categories, the majority of deaths aged under a year were due to chromosomal, genetic and congenital anomalies or perinatal/neonatal event .

Figure 6.iii.d: Categories of cause of death in cases closed in 2022/2023 & 2023/2024



6.iii.e. Modifiable factors

When identifying how a death came about, the CDOP panel identifies a number of risk factors. Some of these risk factors are not things we as a society currently know how to change, such as the presence of a spontaneous congenital abnormality. Some, such as smoking by parents, can be changed, and are thus categorised as 'modifiable factors'.

It is important to note that some factors are generally viewed as non-modifiable, but can – in particular circumstances – be viewed as modifiable.

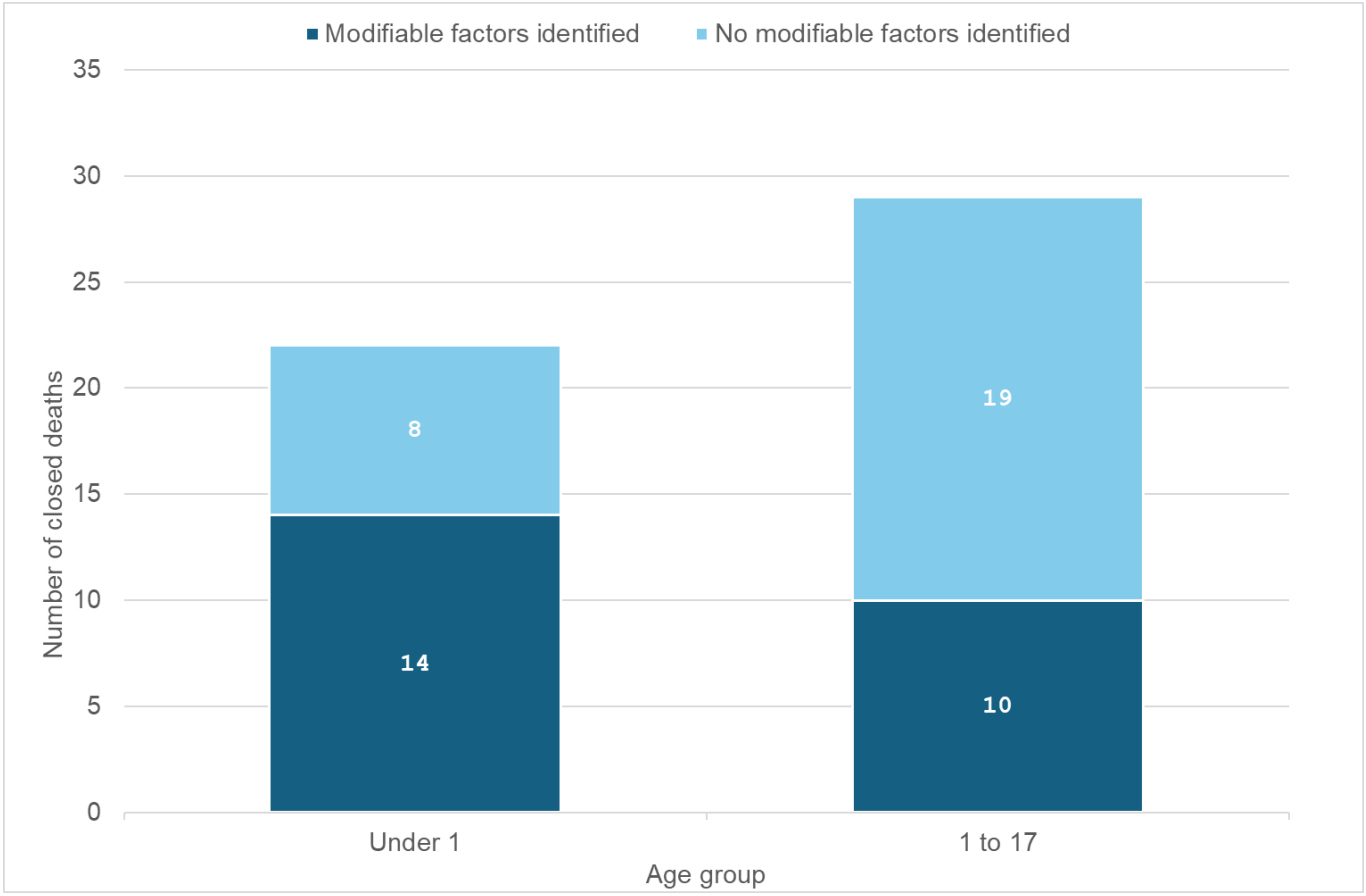
Children born to close cousins (consanguinity) are more likely to suffer genetic abnormalities than children born to unrelated parents, but in line with guidance, we do not generally consider this to be a modifiable factor. However, where a given couple have already given birth to a child with a confirmed genetic abnormality, and should have received genetic counselling, any subsequent child born with a genetic abnormality would be considered modifiable, as parents are then able to make an informed choice about further attempts to conceive[v].

Modifiable factors were identified in 24 (47.1%) of cases in 2022/2023 & 2023/2024:

The modifiable factors that were present included:

- Parental smoking (mentioned in 7 cases)
- Domestic violence (mentioned in 4 cases)
- Maternal BMI (mentioned in 4 cases)
- Unsafe sleeping (mentioned in 3 cases)
- Issues with medical care / missed opportunity (mentioned in 3 cases)
- Parental mental health (mentioned in 2 cases)
- Unsafe storage of medication at home (mentioned in 2 cases)
- Unsafe driving (speed, lack of seat belt, pursuit) (mentioned in 2 cases)
- Alcohol consumption on night before death by carers of babies (mentioned in 2 cases)
- Parenting capacity (mentioned in 2 cases)
- Other factors with one mention each:
    - Self-neglect by mother
    - Overcrowding
    - Cannabis use
    - Working hours of nurses / staffing
    - Butane exposure
    - Obesity of child
    - Bullying
    - EHCP review not completed for 7 yrs
    - Lack of social care input
    - Adult supervision
    - Chaotic lifestyle
    - Family criminality

Figure 6.iii.e: Proportion of closed cases with a modifiable factor 2022/2023 & 2023/2024

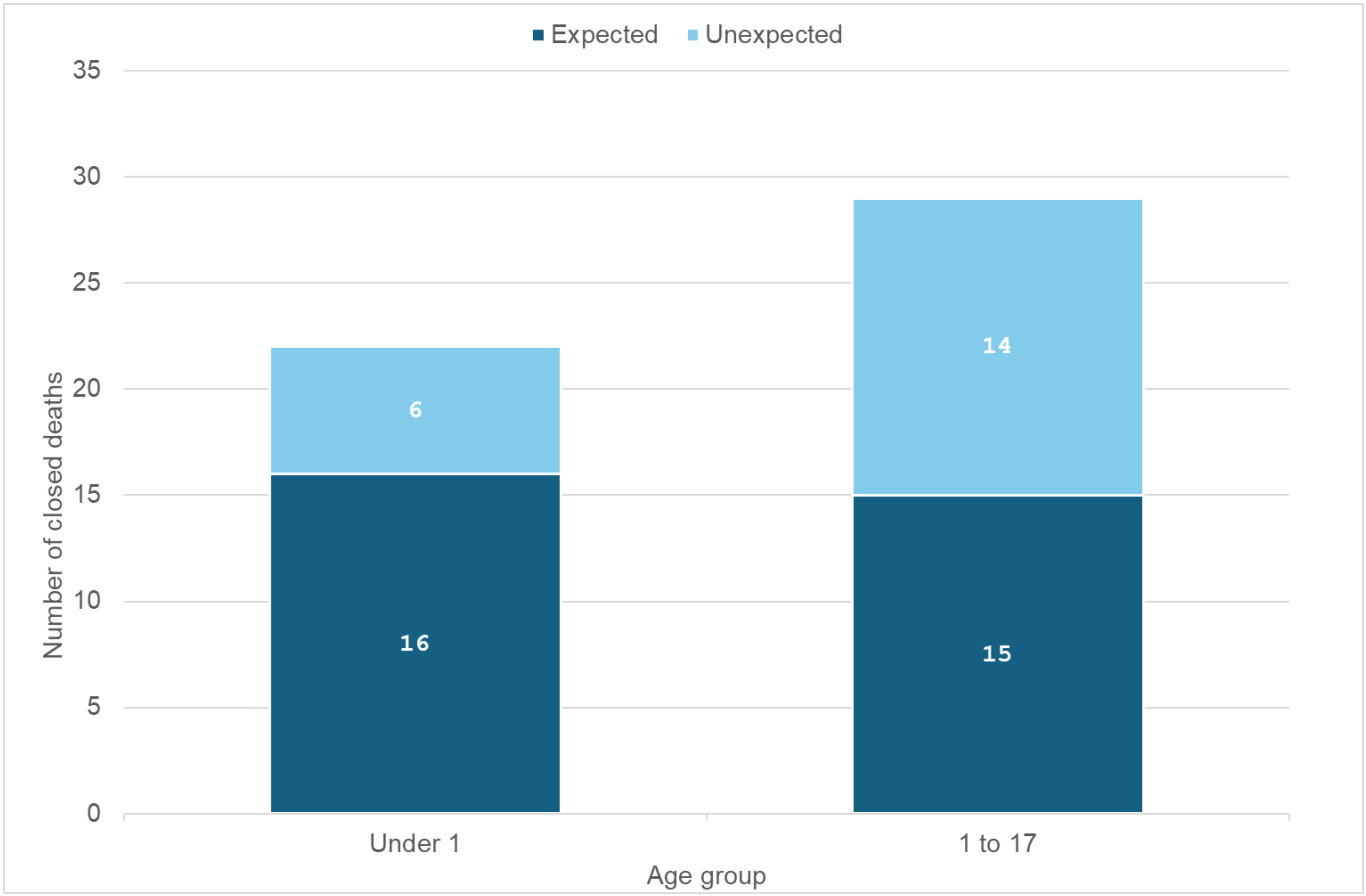


6.iii.f. Expected deaths

Around a half (31 or 60.8%% in 2022-24) of closed cases across STT were deaths which were expected. This is slightly higher than in recent years. The proportion expected was higher for infant deaths (72.7%) when compared to deaths for those aged 1-17 years (51.7%).

At local authority level, the proportion expected was similar across all areas: Stockport (56.3%), Tameside (59.1%) and Trafford (64.3%).

Figure 6.iii.f: Proportion and numbers of deaths as expected and unexpected



Row Labels	2019/20	2020/21	2021/22	2022/23	2023/24
Expected	16	11	25	15	16
Unexpected	21	17	20	7	13
Not known	1	1	0	0	0

7. Recommendations

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 continue to 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

8. How will we know we have made a difference?

Each borough will integrate the recommendations into the appropriate local systems for action and monitoring. The three public health departments will be asked to report on actions taken against the previous year's recommendations each year. Each HWB will need to ensure that its respective member organisations are accountable for progress.

9. Summary

When a child dies it is so important that the parents, carers and professionals, who were part of this experience understand the circumstances of the death. NHS, LA organisations and other partners have a responsibility to review each case, identify good practice and poor practice.

Learning must affect practice so as a system we can prevent avoidable deaths from happening or, if inevitable, ensure the child has the best death possible and their family and carers are supported throughout this experience.

Appendix A: CDOP Responsibilities and Operational Arrangements

Ai: Child Death Overview Panel Responsibilities

CDOP responsibilities are:

- to collect and collate information about a child's death, seeking relevant information from professionals and where appropriate family members.
- to analyse the information obtained, to confirm or clarify the cause of death, to determine any contributing factors, and to identify any learning arising from the child death review process that may prevent future death.
- to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths and will promote the health safety and well-being of children.
- to notify the relevant locality's Child Safeguarding Practice Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected.
- to notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it is identified there are any errors or deficiencies in an individual child's registered cause of death.
- to provide specific data to NHS digital through the National Child Mortality Database.
- to produce an annual report for Child Death Review Partners on local patterns and trends in child deaths, and any lessons learned, and actions taken and the effectiveness of the wider child death review process.
- to contribute to local, regional and national initiatives to improve learning from child death reviews including where appropriate approved research carried out within the requirements of data protection.

Aii: Child Death Overview Panel Operational Arrangements

CDOP will;

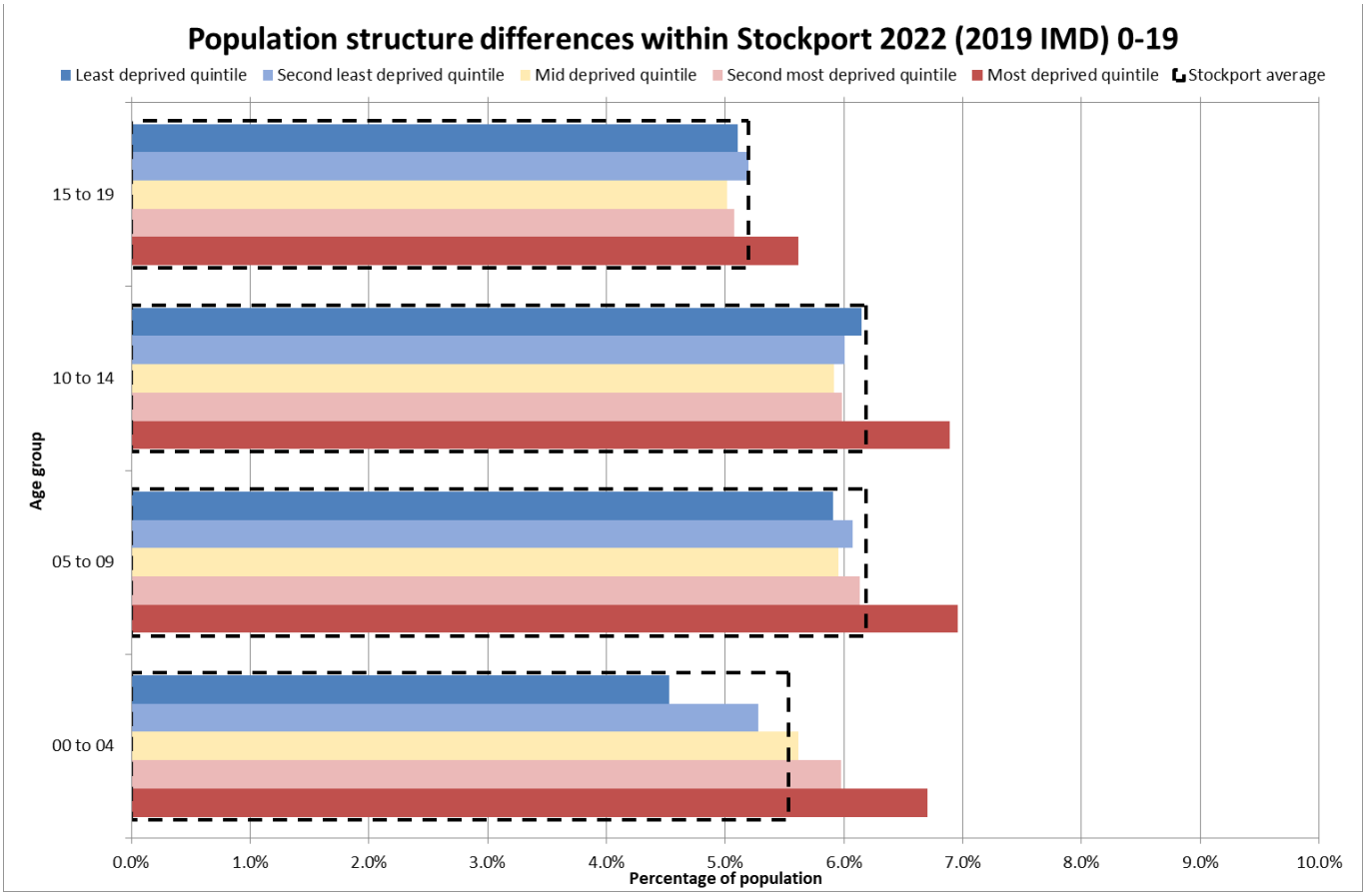
- meet quarterly to enable the deaths of children to be discussed in a timely manner and within the statutory timeframe of six months. Exceptions are where there is a current criminal or coronial investigation.
- ensure that effective rapid response arrangements for sudden deaths are in place, to enable key professionals to come together to undertake enquiries into and evaluate and make an analysis of each unexpected death of a child.
- review the appropriateness of agency responses to each death of a child.
- review relevant environmental, social, health and cultural aspects of each death to ensure a thorough consideration of how such deaths may be prevented in the future.
- determine whether each death had any potentially modifiable factors.
- make appropriate recommendations to Stockport, Tameside and Trafford Safeguarding Partnership's where there are concerns of abuse and neglect in order that prompt action can be taken to learn from and prevent future deaths where possible.
- report and inform the LeDeR process of any deaths of children over 4 years who have a Learning Disability.

Appendix B: Borough Child Profiles

i: Stockport

There are 64,102 children and young people aged 0-17 living in Stockport (ONS Mid-Year Estimate 2023), a population that is currently increasing – up 3.6% in the five years since 2018. Due to fluctuations in birth rates there are more children per year aged 6-15 years (around 3,600 per year) than aged 0-5 (3,300 per year) and 16-17 years (3,500). Births reached their lowest level in 2001-2003, at less than 3,000 per year, and then rose to a high in 2012 (3,500), since when numbers have started to fall again, reaching 2,900 again by 2022, following the well-known cyclical trend.

Fertility rates are generally highest in the most deprived areas of Stockport and were especially high in these areas between 2009 and 2014 (at over 80 per 1000 females aged 15-44), 60-70% higher than in the most affluent areas), meaning that younger population is much more likely to be deprived than the Stockport average. Data from 2021 shows that fertility rates in the most deprived quintile fell to the Stockport average for the first time, it is not known yet whether this is a short-term pandemic impact or a change in the long term trend.



Stockport's population is not particularly ethnically diverse, when compared to other areas of Greater Manchester, however ethnic diversity is increasing, especially for younger populations. Data from the 2021 Census for Stockport suggests that 82% of the 0-24 population describe their ethnicity as White, 9% as Asian, and 6% as mixed and 3% as black or other. Stockport's non-white population is not evenly distributed, and is largest in Heald Green, Gatley and Heaton Mersey, where less than 60% of the 0-24 year population describe themselves as white.

Health inequalities in Stockport are stark, the borough includes the most deprived GP population in Greater Manchester (Brinnington) and the least (Bramhall); life expectancy is more than 10 years lower in the former than the later. For children and young people this manifests itself in the deprived areas in higher levels of smoking in pregnancy, childhood obesity and children with SEND (special educational needs or disability) and lower levels of breastfeeding, mental wellbeing and educational attainment.

Overall Stockport performs well for childhood vaccinations, maintaining uptake levels through the pandemic, smoking in pregnancy and child obesity (although levels are increasing). Stockport does however have high levels of hospital admissions for injuries, self-harm and asthma and lower levels of school readiness than expected.

Borough Priorities

- Stockport Council Plan: https://www.stockport.gov.uk/council-plan
- One Stockport Borough Plan https://www.onestockport.co.uk/the-stockport-borough-plan/
- Stockport JSNA: https://www.stockport.gov.uk/health-and-wellbeing-board/joint-strategic-needs-assessment
- Stockport Family: https://www.stockport.gov.uk/topic/stockport-family
- CDOP https://www.stockport.gov.uk/health-and-wellbeing-board/stockport-child-death-overview-panel-statutory-responsibilities

ii: Tameside

More people now live in Tameside than at any time in the past, with population projections estimating that this will continue to increase over the next 10 years.

The ethnic composition of the Tameside population is also changing, with the last Census (2021) showing that 17.6% of the local population are from an ethnic minority group; this is an increase from the last Census (2011) of 15.8%.

Across Tameside in 2023 there were 52,031 children and young people under the age of 18 years. This is 22% of the total population.

Around 21% of children under 16 in Tameside live in absolute poverty and 28% in relative.

In 2023 there were 2,424 babies born in Tameside; 29% of babies were born in the most deprived decile. 7.4% of babies were born with a low birth weight under 2500 grams, with 1% being of very low birth weight (<1500 grams). The highest proportion of births were born to mothers aged 30-34 years (34%). 3% of babies were born to women under 19 years and 20% to women over the age of 35 years. Focused work has contributed to a sustained fall in rates of smoking at time of delivery, which is good news.

Health, wellbeing and social outcomes are generally worse in Tameside than the England average. With low levels of breastfeeding initiation and breastfeeding at 6 to 8 weeks. Additionally, healthy life expectancy at birth is well below the England average for both males and females. We also have higher levels of child dental decay, higher rates of teenage conceptions and children requiring emergency admission to hospital for asthma.

Population vaccination coverage for 2-year-olds across all vaccines has fallen again, with most below national target levels. Additionally, MMR for one dose at 2 years old is below target levels at 88.4% coverage but there is still a higher rate for DTaP/IPV/Hib at 2 years old (94.2% coverage).

A&E attendances for all young people in Tameside are significantly higher than the England average. In older children, hospital admissions for self-harm are similar to the England average, but hospital admissions for asthma are the highest in England.

School readiness is improving for our 5-year-olds but is still significantly worse than the England average, currently 60.9% of children in Tameside are school ready.

Tameside has significantly higher numbers of children in care, with health and social care outcomes being significantly worse than in the general population.

Please find more information here: Child and Maternal Health - Data | Fingertips | Department of Health and Social Care (phe.org.uk)

Relevant local strategies and links can be found below:

- Joint Strategic Needs Assessment – including SEND JSNA and Children and Young People JSNA
- Healthy Places Strategic Framework 2024-2029
- Building Back Fairer Stronger Together - Tameside Joint Health and Wellbeing Strategy and Locality Plan 23-28
- Grow in Tameside - support for early years
- Tameside Family Hubs

iii: Trafford

An estimated 60,720 children and young people aged 0-19 live in Trafford which makes up about 1 in 4 (25.6%) of the total population (ONS, Mid-2023 estimates).

In 2023 there were 2,161 live births to mothers resident in Trafford. Trafford's total fertility rate of 1.44 is the same as the rate for England (ONS, 2023). Between the years 2011 and 2021, the Census indicated that the number of children aged under 15 in Trafford decreased from 14,870 to 13,466, a drop of 9.4%. The same sources indicate an increase in the population aged 5 to 19 from 41,634 to 45,650, a rise of 9.6%. (Census Data, Trafford Data Lab). Between the years 2022 and 2037, the 0-19 population in Trafford is projected to decrease by 2.3% (a drop of 1,420 children and young people). (ONS, 2020).

Around a third of children in Trafford (33.1%) belong to an ethnically diverse group, predominantly Asian or Asian British (17.2%), mixed or multiple ethnic groups (8.6%) and Black, Black British, Caribbean or African (3.9%) (Census 2021).

Trafford is the least deprived authority in Greater Manchester, however, there is variation in deprivation within Trafford (Index of Multiple Deprivation). Seven small areas within Trafford ('LSOAs') rank among the lowest 10% in England for deprivation. The Income Deprivation Affecting Children domain of the 2019 Indices suggests that in one area 44% of children are living in income-deprived families.

The rate of children in care (63 per 10,000 population under 18 years of age) in Trafford is lower than the England average (71 per 10,000 population under 18 years of age) (Child and Maternal Health Profile).

Trafford Joint Strategic Needs Assessment's section on children and young people can be accessed at http://www.traffordjsna.org.uk/Life-course/Start-well.aspx .

10. References

[i] HM Government, (2018), *Child Death Review Statutory and Operational Guidance*.
[ii] HM Government, (2023), *Working Together to Safeguard Children 2023; A guide to multi-agency working to help, protect and promote the welfare of children.*
[iii] Office of National Statistics https://www.ons.gov.uk/peoplepopulationandcommunity
[iv] OHID (Office for Health improvement and Disparities) Maternal and Child Health Profiles, *https://fingertips.phe.org.uk/profile/child-health-profiles.*
[v] NCMD-Guidance-on-Consanguinity.pdf