Report to:	**HEALTH AND WELLBEING BOARD**
Date:	14 September 2023
Reporting Officer:	Anne Whittington, Consultant in Public Health, Population Health Debbie Watson, Director of Population Health
Subject:	**STOCKPORT TAMESIDE AND TRAFFORD CHILD DEATH OVERVIEW PANEL (STT CDOP) ANNUAL REPORT 2021-22**
Report Summary:	This paper summarises the findings of the annual report of the tripartite Child Death Overview Panel (CDOP) for Stockport, Tameside and Trafford (STT) and resulting recommendations. The report covers the year 2021/22.
Recommendations:	The Health and Wellbeing Board acknowledge the report and accept the recommendations within it.
Links to Health and Wellbeing Strategy:	The report and recommendations within it link to the Health and Wellbeing Strategies focus areas of giving children the best start in life; helping people to stay well across the life course and detect illness earlier; and the overarching objective to reduce inequalities.
Policy Implications:	Should the recommendations within this report be accepted there may be policy implications to ensure that action is taken to integrate the recommendations into local systems for action and monitoring, including holding member organisations accountable for progress.
Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)	There are no direct financial implications arising from this report. The recommendations from this report could have financial implications where policy or service delivery changes are implemented as a result. Any changes, and the associated financial implications, will need to be the subject of separate reports
Legal Implications: (Authorised by the Borough Solicitor)	The Children Act 2004 Part 2 requires: • child death review partners for a local authority area in England must make arrangements for the review of each death of a child normally resident in the area • to consider if appropriate, make arrangements for the review of a death in their area of a child not normally resident there • analysis of information about deaths reviewed
Risk Management:	The purpose of this report is to identify any themes and opportunities for prevention of avoidable child deaths. The recommendations aim to address modifiable factors identified as common themes.
Access to Information:	All papers relating to this report can be obtained by contacting: Anne Whittington, Consultant in Public Health Telephone: 07971117006 e-mail: anne.whittington@tameside.gov.uk

1. INTRODUCTION & OVERVIEW

1.1 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 the child has the best death possible and their family and carers are supported throughout. Child death reviews are a statutory responsibility under the Children Act 2004.

1.2 Each year the Stockport, Tameside and Trafford (STT) Child Death Overview Panel (CDOP) publish a report, to describe why children who lived in STT died, to learn from the circumstances as far as possible and present recommendations for the future.

1.3 This annual report (**Appendix 1**) considers the learning from child death cases that were notified to the STT CDOP and were reviewed and closed by the panel between 1 April 2021 and 31 March 2022. In a simplified explanation of the process: all cases of child death are referred to the panel as a notification. An information gathering process then takes place for each case and when that and all other investigations are complete, the CDOP reviews and closes the case. Therefore, some cases are closed in a different year to the year they are notified.

1.4 In total in 2021/22, 39 cases were notified (20 or 51.3% in Tameside) and 45 cases were closed by the panel (13 or 28.9% in Tameside). Notifications are analysed by their fixed demographic factors whereas closed cases consider the conclusions of the panel, such as modifiable factors and cause of death.

1.5 Two-fifths (38.5%) of notifications across STT were infants (i.e. aged under 1 year). This is slightly lower than in previous years in STT, where a half of child deaths were aged under a year. Age distribution across other age groups (4 year grouping) was fairly even (10-18%).

1.6 Around a quarter (23.1%) of STT notifications belonged to a non-White ethnic group, which is in line with the proportion of the child population in these groups. There was a tendency towards higher children death notification rates in more deprived areas of STT but small numbers mean this trend is not clear.

1.7 For those infants that died in the first year of life, low birthweight and prematurity contributed to a high proportion of deaths and these factors increased risk of dying within the first 28 days.

1.8 The largest proportion of deaths (33%) were due to chromosomal, genetic and congenital anomalies; the second largest proportion (27%) were due to perinatal/neonatal even and the third largest were cancers and trauma/injuries (16% each).

1.9 Modifiable factors were identified in 24% of cases, which is fewer than the proportion (50%) in 2019-20. Factors included parental smoking, domestic abuse, parental mental health and parental alcohol or substance misuse.

1.10 Just over half of deaths were expected, which is higher than previous years and this was more commonly the case for deaths of children under the age of 1 year.

2. RECOMMENDATIONS

2.1 As per the front of this report.

2.2 There are recommendations from the STT CDOP Chair for the Health and Wellbeing Board to endorse and sponsor, which are as follows:

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
    g. Multiple embryo implantation during IVF procedures

ii. 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. 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.

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

iv. 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.

v. The data used to compile the annual report should be stored in a consistent format to enable a rolling 5-year look back review to identify robust trends and provide a firmer basis for specific recommendations to the health and wellbeing board. This should inform the recommendations in annual reports from 2024-25 onwards.

APPENDIX 1

Learning from Child Death Reviews

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

2021/2022

NHS
Greater Manchester
Integrated care

Tameside Metropolitan Borough

TRAFFORD COUNCIL

STOCKPORT METROPOLITAN BOROUGH COUNCIL

Document Control

Date	Version	Forum/Officer	Purpose	Amendments
26.04.23	1	Eleanor Banister	First draft	Yes
22.06.23	1.1	Ben Fryer	Drafting of recommendations, minor changes	Yes
11.07.23	1.2	Ben Fryer	Re-ordering of recommendations, Addition of Tameside profile	Yes
26.07.23	1.3	Ben Fryer	Addition of Trafford profile	Yes
09.08.23	1.4	Ben Fryer	Feedback from Public Health colleagues across STT	Yes
16.08.23	1.5	Eleanor Banister	Corrected chart labels and page numbering	Yes

Learning from Child Death Reviews: Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel 2021/2022 has been prepared on behalf of Stockport, Tameside and Trafford Child Death Overview Panel and Stockport, Tameside and Trafford Child Death Review partners by:

1. **Ben Fryer, Consultant in Public Health, Stockport Council, and STT CDOP Chair**
2. **Eleanor Banister, Public Health Intelligence and Early Intervention and Prevention Lead, Public Health, Stockport Council**
3. **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 the child has the best death possible and 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 2021/22.

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 2021/22

Key points from data analysis:

- The panel received 39 notifications in 2021/22, bringing the 8 year total across STT to 386
- There is no clear trend towards a higher or lower notification rate, although the annual rate has fallen slightly over the last five years compared to the first three years. The four year average is 2.6 notifications per 10,000 population aged under 18.
- Infants aged under 1 year accounted for 15 notifications (39% of total) which is slightly lower than in previous years in STT, where a 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.
- The notification rate is higher than average in children who live in areas of STT ranked in the most deprived 20% in England, but the gradient across deprivation quintiles is less clear.
- The panel closed 45 cases in 2021/22 (67), this is higher than the totals in the previous two (pandemic affected) years. 80% of these cases were from 2019/20 or 2020/21.
- Just over a half (54%) of infants who died had a low birth weight; and 56% of infants who died were premature.
- In 2021/22 chromosomal, genetic and congenital anomalies makes up the largest category of cause of death for closed cases (15 deaths, 33%), perinatal/neonatal event makes up the second largest category (12 deaths, 27%) followed by cancers and trauma / injuries both 6 deaths (16%) each.

- Modifiable factors were identified in 11 (24%) of closed cases. Smoking, domestic violence, perinatal mental health and substance misuse were the most common factors recorded.
- Just over a half (56%) of closed cases were expected deaths.

4. Recommendations

The CDOP Chair has identified five 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
    g. Multiple embryo implantation during IVF procedures.

II. 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. 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.

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

IV. 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.

V. The data used to compile the annual report should be stored in a consistent format to enable a rolling 5-year look back review to identify robust trends and provide a firmer basis for specific recommendations to the health and wellbeing board. This should inform the recommendations in annual reports from 2024-25 onwards

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Learning from Child Death Reviews

Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel 2021/22

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 the child has the best death possible and 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 2021/22.

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.

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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, 2018[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 762,000 people (ONS 2021 Mid Year Estimate), receives an average of 40 to 50 notifications per year and includes a network of NHS health, police and social care providers for this cluster.

From January 2021 the panel moved to being virtual and monthly to ensure that cases were reviewed in a timely manner, this was from a previous pre-pandemic structure of quarterly

face to face meetings. The change so far has been highly effective; it has supported attendance and engagement in case discussions.

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

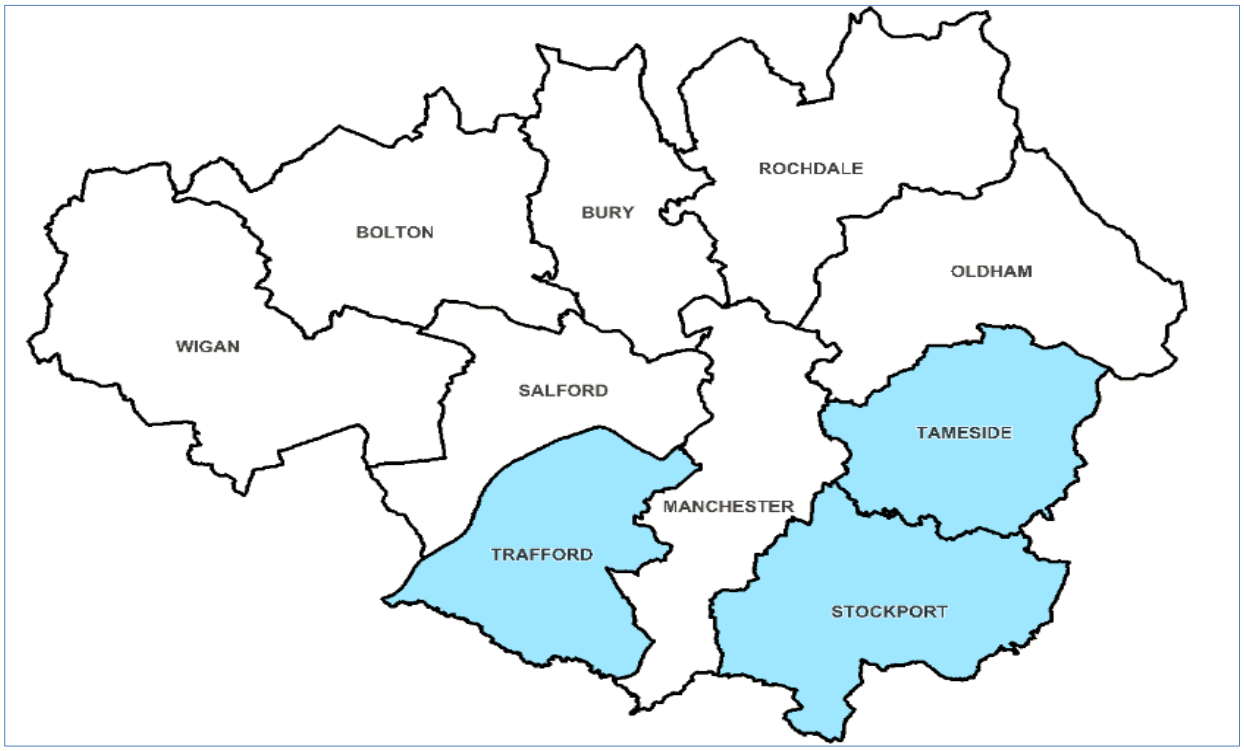
A Strategic Child Death Group has previously been established to ensure that action is taken to address any emerging issues or trends from CDOP. This group will be re-activated in 2023 to ensure system ownership and change as a result of CDOP learning. Stockport, Tameside and Trafford Health and Wellbeing 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 2021, Stockport, Tameside and Trafford had an estimated combined population of 168,400 under 18 year olds (ONS 2021 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.

Indicator				Stockport	Tameside	Trafford	GM	England
1	Population aged 0 to 17 years (2021)		Number	62,515	51,134	54,751	653,244	11,761,656
			% of Total (all ages)	21.2%	22.1%	23.2%	22.8%	20.8%
2	Proportion of 0-24 year olds belonging to Black, Asian & Minority Ethnic Groups (2021)			18.3%	21.6%	32.1%	34.0%	26.7%
3	Projected growth in 0 to 17 population (2020-2030)		Number	2,702	-279	1,082	9,622	144,517
			%	4.2%	-0.6%	1.9%	1.5%	1.2%
4	Children in Low Income Families (under 16s) (2020/21)	Absolute	Number	6,352	8,073	4,644	115,051	1,641,209
			%	11.1%	17.6 %	9.2%	19.7%	15.1%
		Relative	Number	8,138	10,234	5,767	144,770	2,003,734
			%	14.2%	22.3 %	11.4%	24.8%	18.5%
5	Live births (2021)		Number	3,227	2,525	2,413	33,445	595,948
			Rate (per 1,000 females aged 15-44 years)	60.0	57.0	54.6	56.5	54.3
6	Low birth weight (2021)	of term babies	Number	48	46	42	815	14,986
			%	1.7%	2.1%	1.9%	2.7%	2.8%
		of all babies	Number	216	140	148	2,336	39,826
			%	6.8%	6.0%	6.3%	7.2%	6.8%
7	Infant mortality (2019-21)		Number	41	34	13	523	7,036
			Rate (per 1,000 live births)	4.4 (CI 3.1-5.9)	4.4 (CI 3.0-6.1)	1.8 (CI 1.0-3.1)	5.2 (CI 4.8-5.7)	3.9 (CI 3.8-4.0)
8	Child mortality (2018-20)		Number	16	19	17	220	3,471
			Rate (DSR per 100,000 population aged 1-17)	8.9 (CI 5.1-14.5)	13.8 (CI 8.3-21.6)	10.8 (CI 6.3-17.3)	n/a	10.3 (CI 9.9-10.6)
9	Looked After Children (2022)		Number	447	666	359	6,027	82,170
			Rate (per 10,000 population aged 0-17)	72	130	66	92	70

Source: ONS Population and Census Data[iii]; OHID Maternal and Child Health Profiles (as at 26-04-2023)[iv]

6. What we know from CDOP Notifications and Closed Cases 2021/2022

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 2021 and 31st March 2022.

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 2021/22. 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 2021/22. 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.

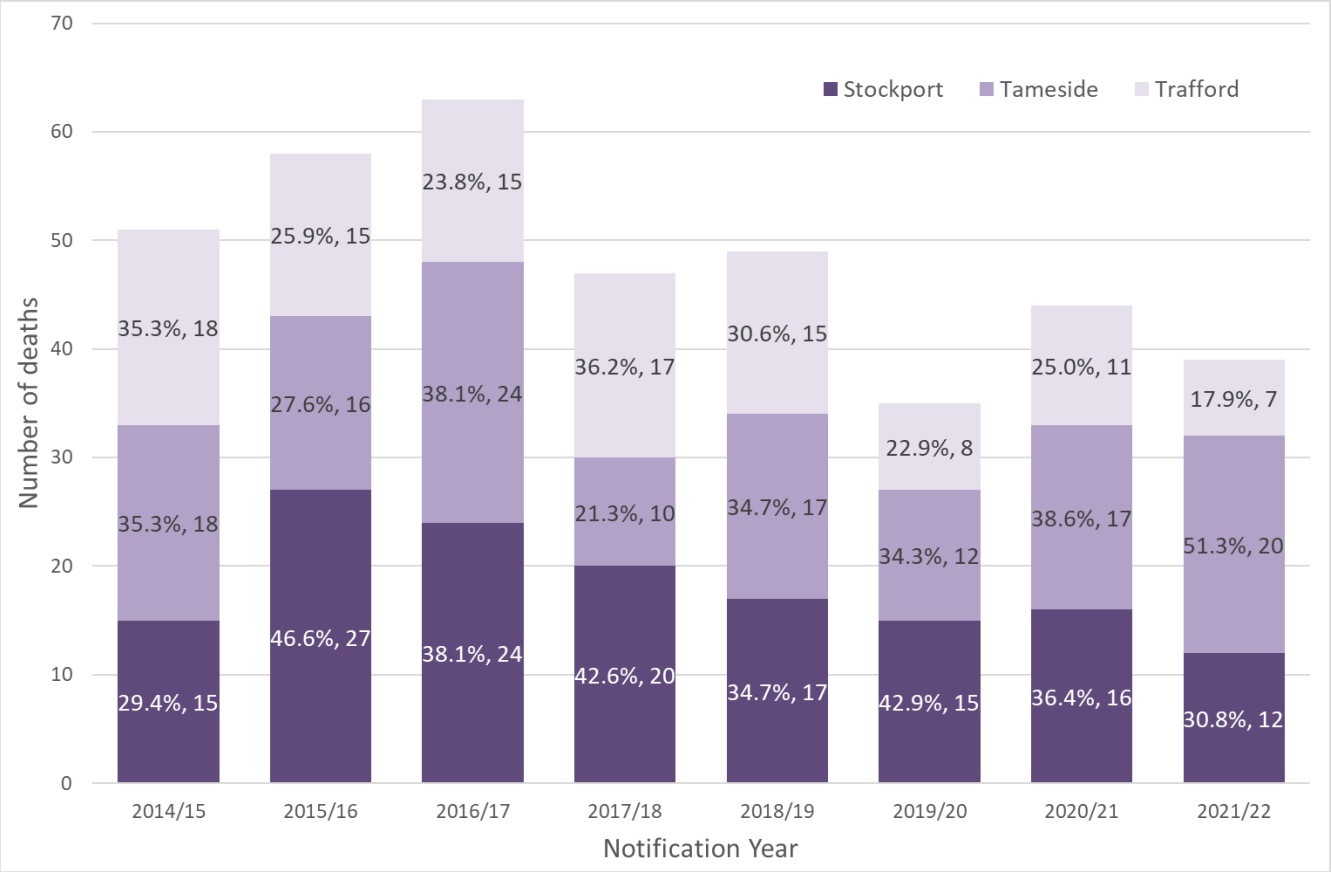
6.ii. Demographic breakdown of notifications

6.ii.a. Number of notifications

The panel received 39 notifications in 2021/22, a level similar to the average of the previous four years. The 2021/22 notifications bring the eight year total notifications across STT since 2014/15 to 386.

The split by local authority in 2021/22 was 12 (30.8% of total) in Stockport, 20 (51.3%) in Tameside, and 7 (17.9%) in Trafford; due to small number variation this is not a statistically significant difference for the one year period. Aggregating the eight year total gives a split by local authority of 37.8% (146) in Stockport, 34.7% (134) in Tameside, and 27.5% (106) in Trafford; with Stockport's proportion being similar to the borough's 0-17 population share (37.3%), Tameside slightly higher (29.7%) and Trafford slightly lower (32.9%).

Figure 6.ii.a: Child deaths notifications to STT CDOP – 2014/15 to 2021/22 by authority

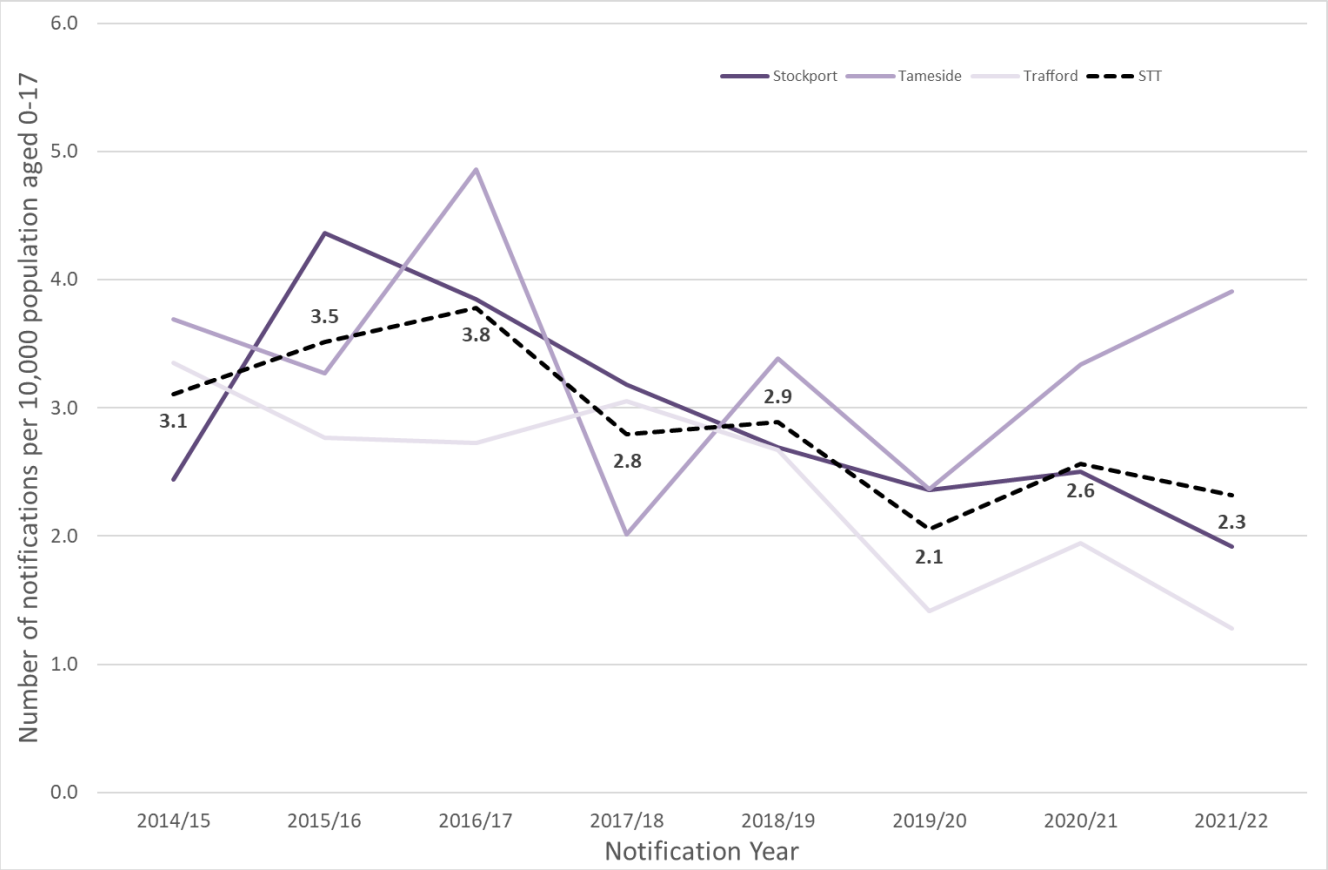


6.ii.b. Notification rate

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 39 notifications in 2021/22 give a rate of 2.3 per 10,000 population aged under 18, which is very similar to the average over the last four years (2.6 per 10,000 2017/18-2020/21), which probably indicates that the notification rate is around the same level.

The eight year aggregated notifications give a rate for STT of 2.9 per 10,000, which is similar in Stockport (2.9 per 10,000), slightly higher in Tameside (3.4 per 10,000) and slightly lower in Trafford (2.4 per 10,000).

Figure 6.ii.b: Trend in child death notification rate (per 10,000 population aged under 18) – 2014/15 to 2021/22 by authority



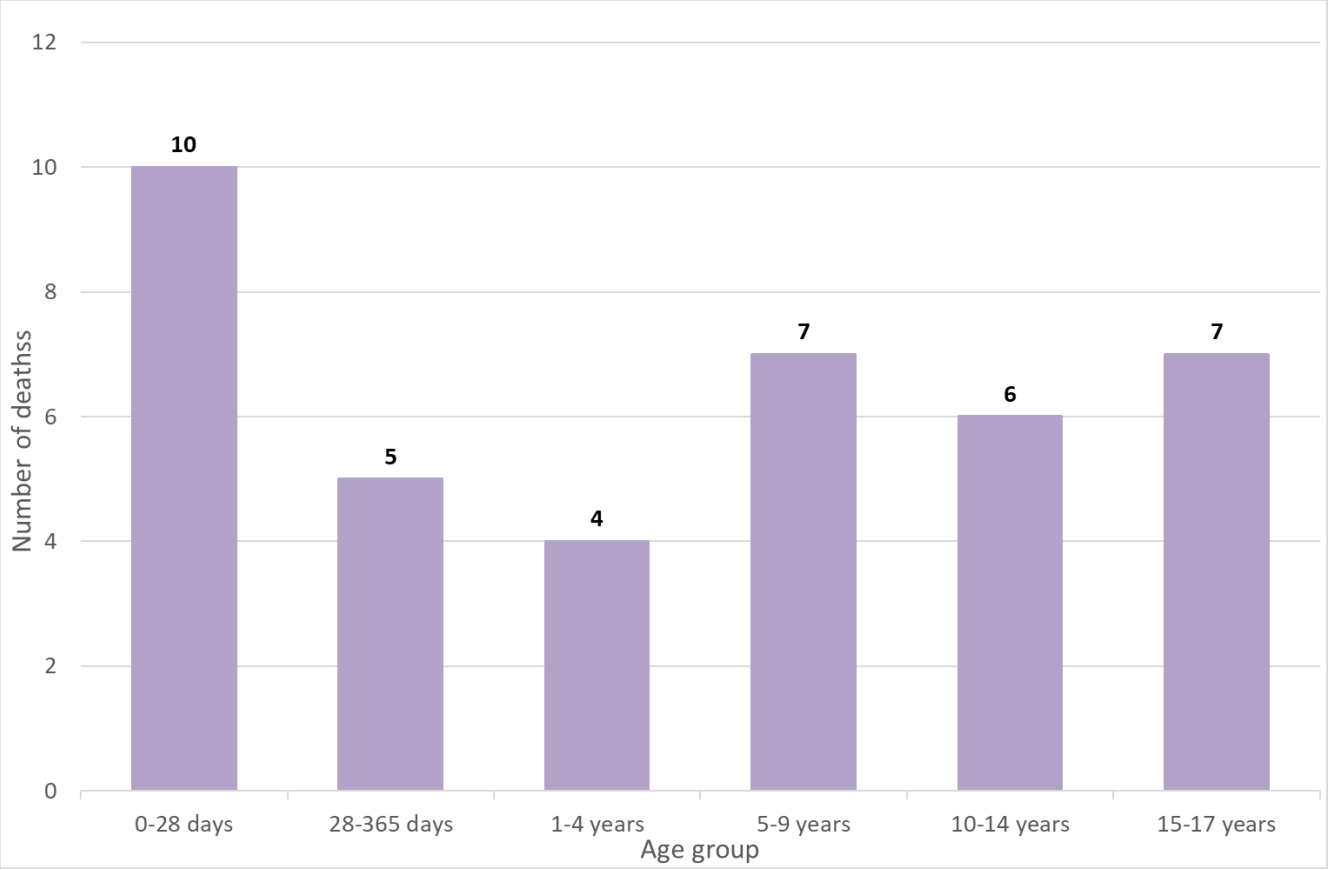
6.ii.c. Age breakdown of notifications

Of the 39 notifications in 2021/22, 10 (25.6%) were neonates (i.e. aged under 28 days) and 5 (12.8%) were aged between 28 days and 1 year. This means that around two-fifths (15 or 38.5%) of notifications across STT are infants (i.e. aged under 1 year). This is slightly lower than in previous years in STT, where a half of child deaths were aged under a year.

Differences in age patterns between the three authorities within STT can be difficult to detect due to the small numbers; however, as with previous years there does seem to be a consistent pattern that in Stockport a higher proportion of child deaths are of neonates (50.0% compared to 38.5% for 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 4 (10.3%) aged 1 to 4 years, 7 (17.9%) aged 5 to 9 years, 6 (15.4%) aged 10 to 14 years, and 7 (17,9%) aged 15 to 17 years. Any differences between the three authorities in this distribution are difficult to detect due to the small numbers involved.

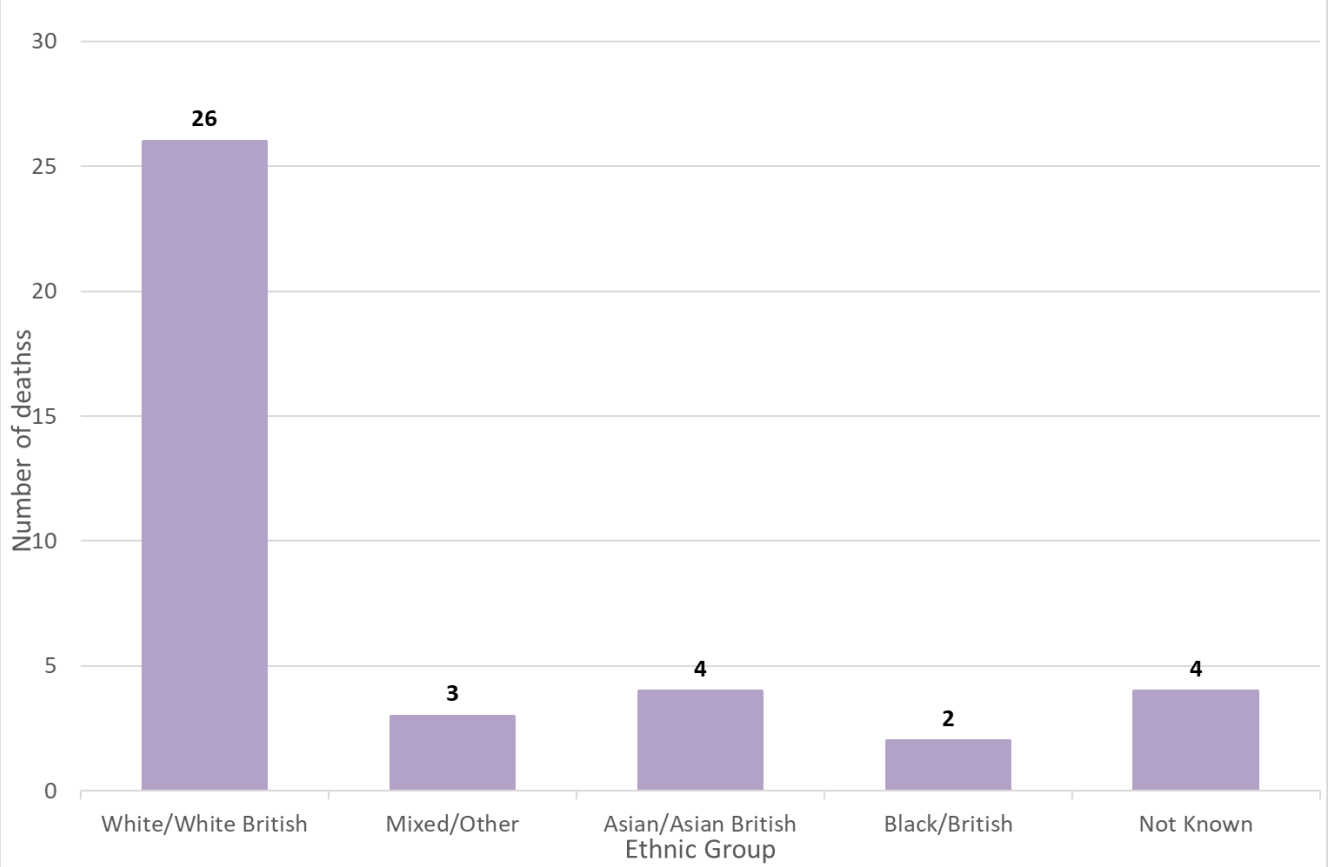
Figure 6.ii.c: Age breakdown of child death notifications 2021/22



6.ii.d. Ethnicity breakdown of notifications

Of the 39 notifications during 2021/22, 9 (23.1%) belonged to a non-White group. This is in line with the estimated proportion of the STT child population belonging to non-White groups (23.7% aged 0-24 at the 2021 Census). However, there are 4 notifications (10.3% of total) where ethnic group is not known (these are cases which are still open to CDOP pending further information). If, for instance, all these unknown cases were of non-White children then this would bring the proportion of deaths which were of non-White children to 33.4% which may suggest that these children are overrepresented among children who die.

Figure 6.ii.d: Ethnic group breakdown of notifications 2021/22

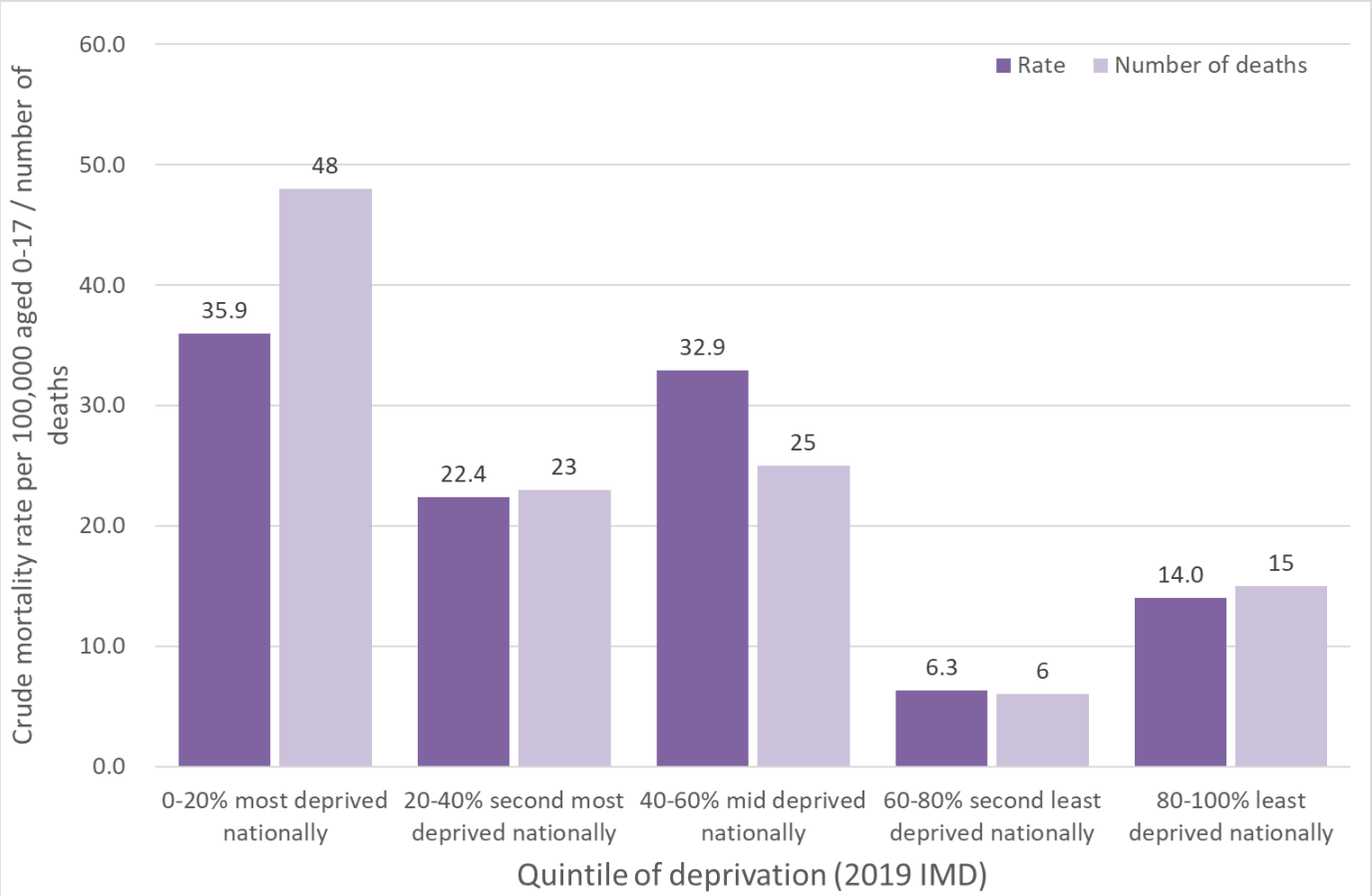


6.ii.e. Deprivation breakdown of notifications

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 39 notifications across STT, 15 (38.5%) were of children who lived in small areas which rank in the 20% most deprived in England, a crude rate over the last three years of 35.9 per 100,000 aged 0-17. There is tendency towards higher child death notification rates in more deprived areas of STT; but because of the relatively small number of deaths involved the trend is perhaps not as clear as it could be with variation between the quintiles with the mid deprived quintile having a rate not much lower than that of the most deprived.

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



6.iii. Analysis of cases closed during 2021/22

6.iii.a. Number of closed cases

In 2021/22, 45 cases were closed by the panel:

- This is higher than the totals in the previous two (pandemic affected) years (38 closed in 2019/20, 29 in 2020/21) but is substantially lower than a peak of 64 cases closed by the panel in 2010/11.
- The breakdown by authority was 19 (42.2%) in Stockport, 13 (28.9%) in Tameside and 13 (28.9%) in Trafford.
- Only 2 (4.4%) were notified to CDOP in 2021/22, 20 (44.4%) were notified in 2020/21 and 16 (35.6%) in 2019/20; 7 cases (15.6%) were notified in either 2018/19 or 2017/18.
- The average (mean) number of days from notification to close was 666 (almost 2 years), but varied by authority from 598 days for Stockport cases, 667 days for Tameside cases to 765 days for Trafford cases,
- Deaths of children aged over 1 year tend to take longer to close (763 days comparted to 581 days), probably reflecting the circumstances and causes of death.
- The rate limit on closing cases is 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 itself does not contribute significantly to the duration from notification to closure.

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

In 2021/22 24 (53.3%) of cases closed by the panel were infants (died within 12 months of their birth). Among these:

- 6 (25.0%) had very low birthweight (<1,500g), and a further 7 (29.2%) had a low birthweight (1,500-2,499g); bringing the proportion with low birthweight to half (13 out of 25 or 54.2%). 9 had a birthweight above 2499g (37.5%) , 2 were unknown (8.3%).
- In comparison in 2021 504 live births across STT were of low birthweight, 6.4% of the total live births with a birthweight recorded. These figures are not directly comparable, but if we assume approximately 500 low birthweight births in 2021/22 in STT, 16 deaths gives a crude mortality rate of 3.2% for lowweight births, and with an approximate 7,300 non-low weight births across STT, 7 deaths gives a crude mortality rate of 0.1% for non-lowweight births. This analysis should be treated with caution due to the small numbers and the lack of definitional consistency; **however it is clear that having a low birthweight increases the risk of a baby dying in their first year of life.**
- 3 of the 6 babies (50.0%) with very low birthweight died within 28 days of their birth

- 2 of the 7 babies (28.6%) with low birthweight died within 28 days of their birth
- 3 of the 9 babies (33.3%) with birthweight >2499g died within 28 days of their birth
- All 6 babies with very low birthweight were premature (<37 weeks), with 4 being extremely premature (<30 weeks).
- 5 of the 7 babies with low birthweight were premature, with 1 being extremely premature. One birth was full term and one had an unknown gestation.
- 6 of the total 25 infant deaths (24.0%) were extremely premature (<30 week), and a further 8 (32.0%) were premature (30-36 weeks); bringing the proportion who were premature to more than a half (14 out of 25 or 56.0%). 9 (37.5%) were full term and 1 (4.2%) had an unknown gestation.
- In comparison in 2021 across the North West (figures are not available at local authority level routinely), 1.3% of live births were before 32 weeks gestation, 6.8% live births were between 32 and 36 weeks gestation and 91.7% live births were over 37 weeks gestation.
  Prematurity therefore adds greatly to the risk of a baby dying in its first year of life.
- 4 of the 6 babies (66.7%) who were extremely premature died within 28 days of their birth
- 1 of the 8 babies (12.5%) 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
- 1 (4.0%) was a multiple birth (a single twin).
- In comparison across England and Wales in 2021, 2.7% of maternities resulting in a live birth were twins and 0.1% of maternities resulting in a live birth were triplets or higher multiples.
- In previous STT CDOP report the level of multiple births has been much higher, and we may be seeing a small number variation impact for this lower number in 2021/22.

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, and shows a reasonably even split across the main providers in the area.

Table 6.iii.c.i: Place of death for deaths < 1 year in 2021/22

	Area of Residence			All STT
Hospital of death	**Stockport**	**Tameside**	**Trafford**	
St Marys Hospital	6	3	2	11
Tameside Hospital		5		5
Stepping Hill Hospital	3			3
Wythenshawe Hospital	1			1
Other hospital (1 each)	1	3		4
Total	**11**	**11**	**2**	**24**

Table 6.iii.c.ii: Place of death for deaths >1 year in 2021/22

	Area of Residence			All STT
Hospital of death	**Stockport**	**Tameside**	**Trafford**	
St Marys Hospital	1		4	5
Tameside Hospital		1		1
Stepping Hill Hospital	5			5
Wythenshawe Hospital	2		2	4
Other hospital (1 each)			2	2
Elsewhere (non hospital)		1	3	4
Total	**8**	**2**	**11**	**21**

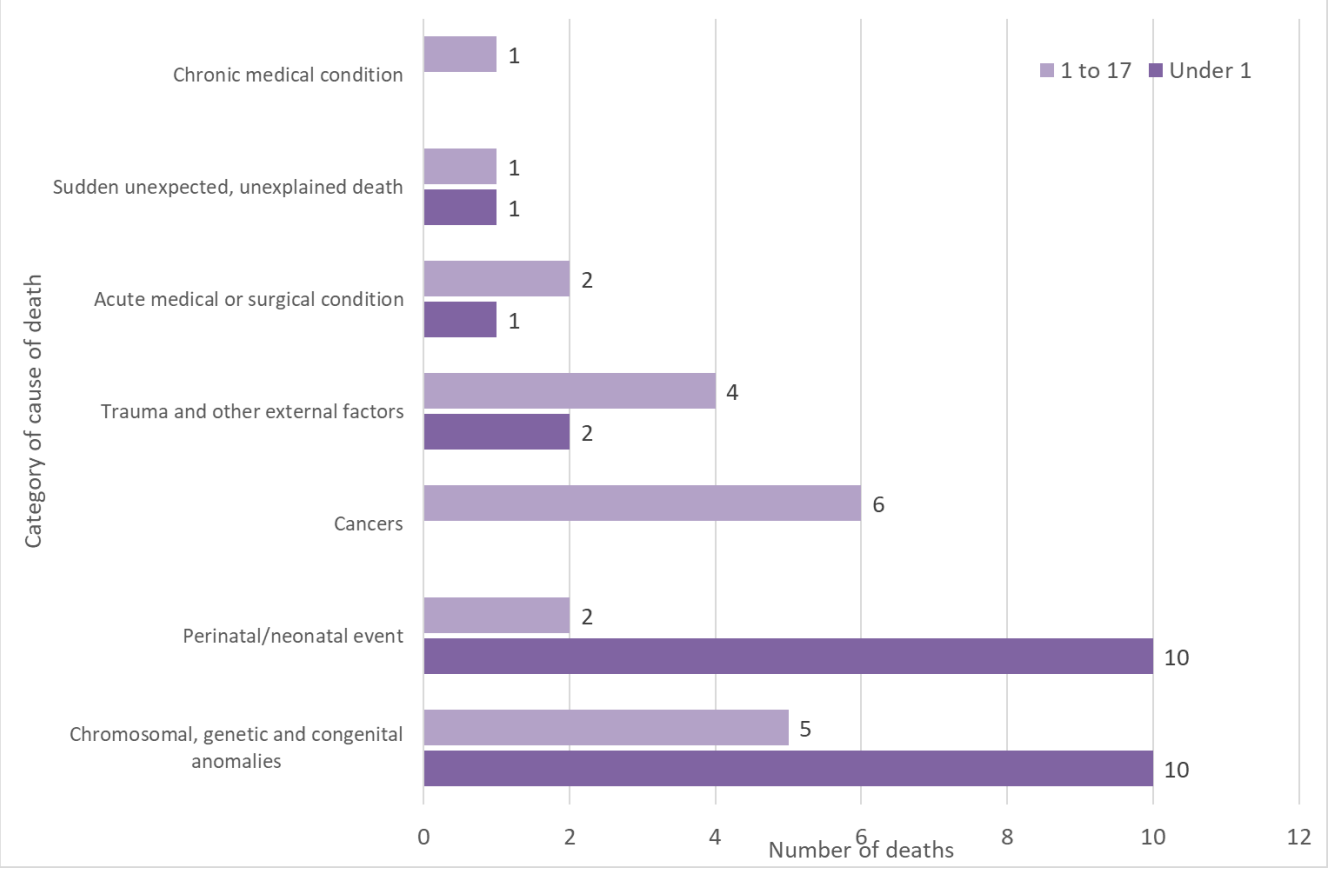
6.iii.d. Categories of cause of death

In 2021/22 chromosomal, genetic and congenital anomalies makes up the largest category of cause of death for closed cases (15 deaths, 33%), perinatal/neonatal event makes up the second largest category (12 deaths, 27%) followed by cancers and trauma / injuries both 6 deaths (16%) each.

The 21 closed cases of children aged over 1 year were spread across a range of categories, the majority of deaths aged under a year were dure to chromosomal, genetic and congenital anomalies or perinatal/neonatal event .

One record mentioned COVID-19 coronavirus as a contributory factor, in terms of the mental health and wellbeing of the child. This is understood to be the impact of lockdown and other restrictions, rather than the impact of the infection itself.

Figure 6.iii.d: Categories of cause of death in cases closed



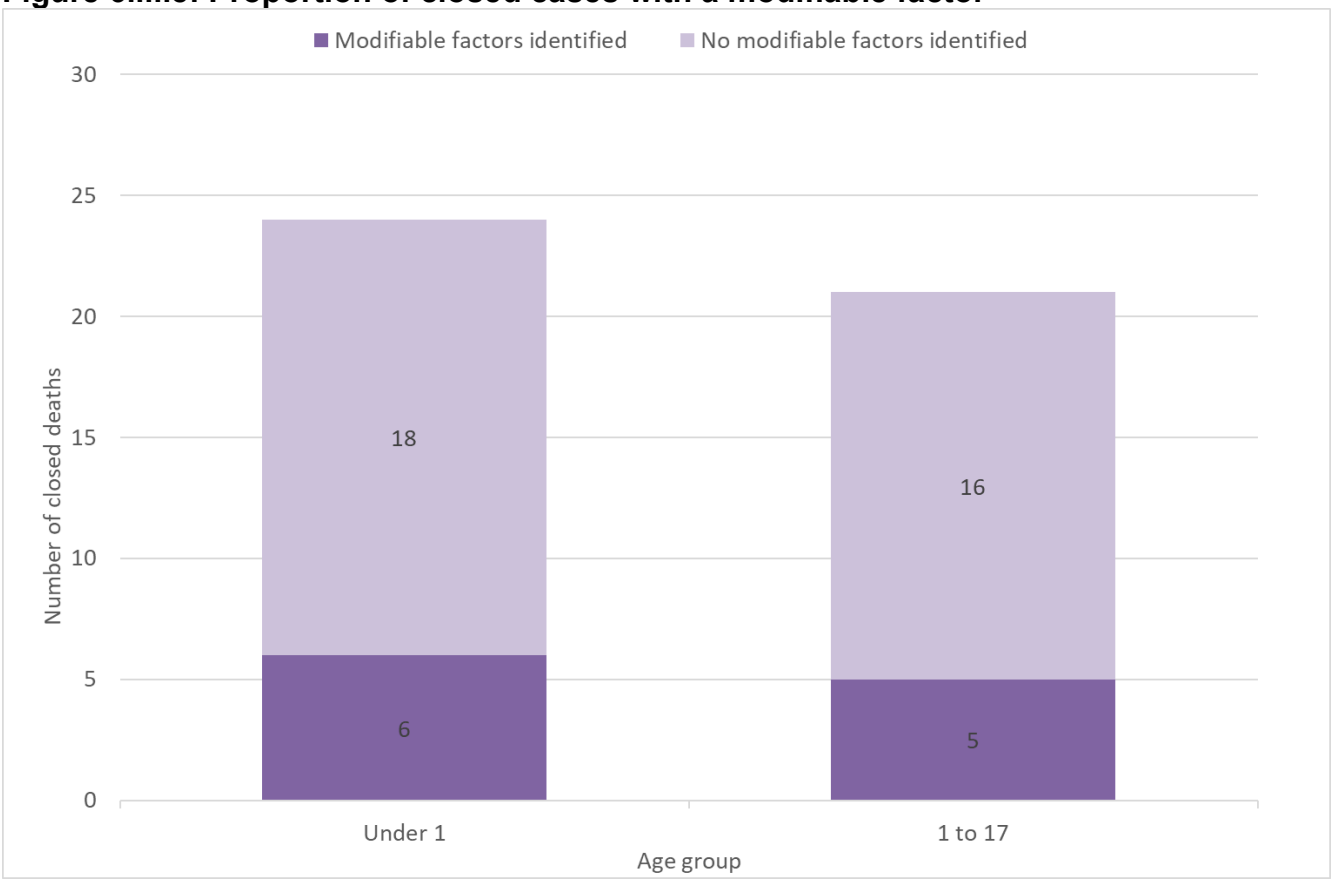
6.iii.e. Modifiable factors

Modifiable factors were identified in 11 (24%) of cases in 2021/222. This is noticeably lower than the roughly 50% of cases that had modifiable factors identified in 2019-2021.

Present modifiable factors included:

- Parental smoking (mentioned in 7 cases)
- Domestic violence (mentioned in 5 cases)
- Parental mental health (mentioned in 5 cases)
- Parental Substance misuse (mentioned in 3 cases)
- Parental alcohol misuse (mentioned in 2 cases)
- Leaving unattended (mentioned in 2 cases – by water and at height)
- Other factors with one mention each:
    - Child's substance misuse
    - Risk taking behaviours of child
    - Missed opportunities to support parents
    - Information sharing between agencies
    - Injuries inflicted on child
    - Reckless driving
    - Mothers BMI
    - Co-sleeping
    - COVID-19 impact on child

Figure 6.iii.e: Proportion of closed cases with a modifiable factor

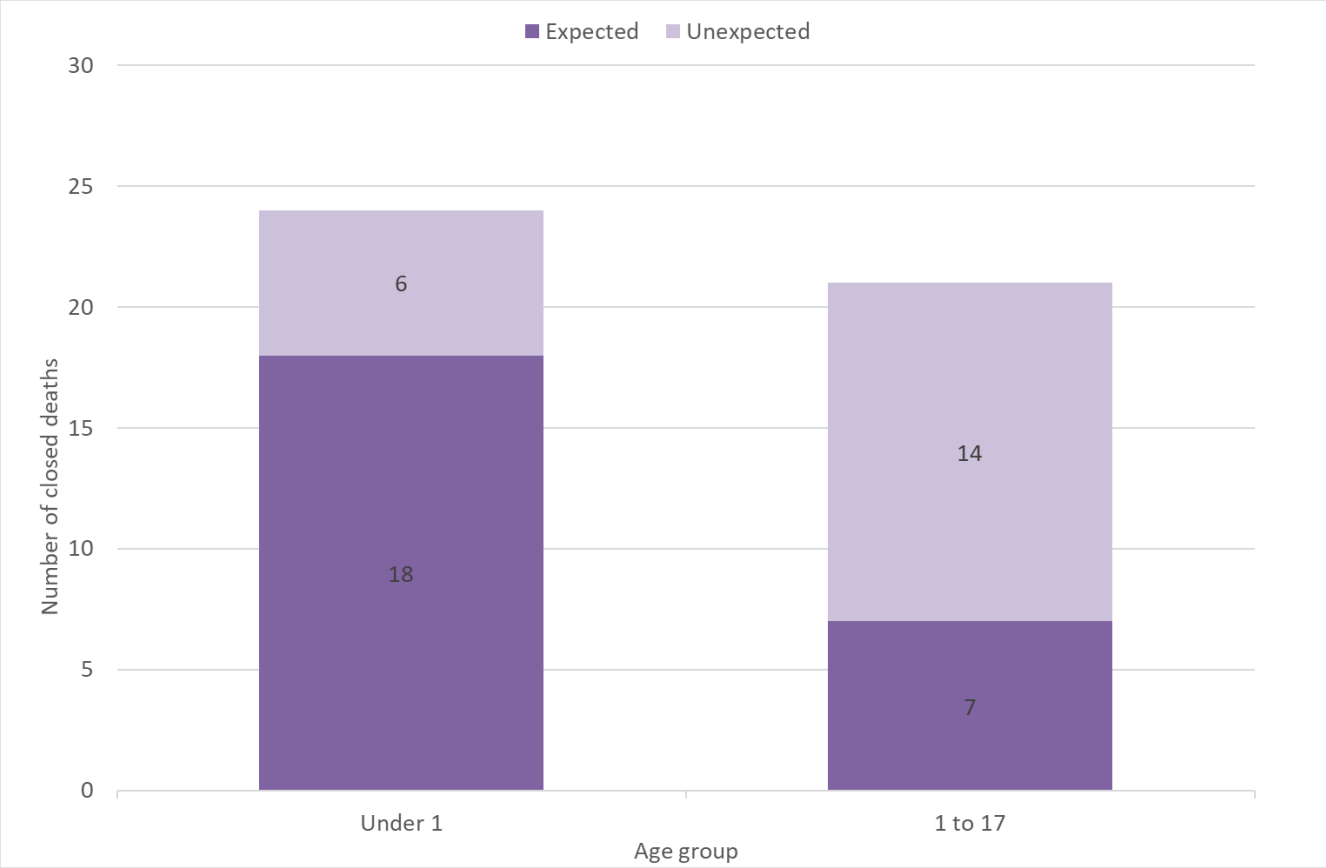


6.iii.f. Expected deaths

Around a half (25 or 55.6%% in 2021/22) 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 (75.0%) when compared to deaths for those aged 1-17 years (33.3%).

At local authority level, the proportion expected was higher in Stockport (73.7%) average in Tameside (53.8%) and lower in Trafford (3087%), although due to small numbers this wis not a significant difference at this level.

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



7. Recommendations

The CDOP Chair has identified five 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.

vi. 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
g. Multiple embryo implantation during IVF procedures

vii. 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. 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.

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

ix. 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.

x. The data used to compile the annual report should be stored in a consistent format to enable a rolling 5-year look back review to identify robust trends and provide a firmer basis for specific recommendations to the health and wellbeing board. This should inform the recommendations in annual reports from 2024-25 onwards.

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.

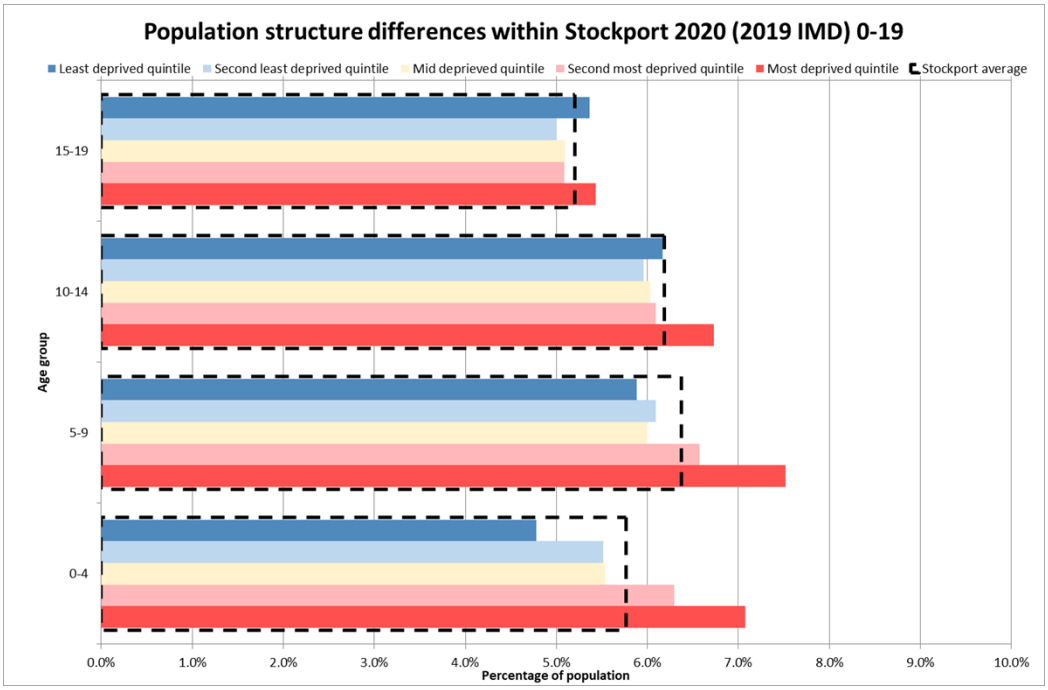
- determine whether each death had any potentially modifiable factors.
- make appropriate recommendations to Stockport, Tameside and Trafford Safeguarding Partnership's where there are concerns of abuse and neglect in order that prompt action can be taken to learn from and prevent future deaths where 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 62,500 children and young people aged 0-17 living in Stockport (ONS Mid-Year Estimate 2021), a population that is currently stable – up 0.2% in the five years since 2016. Due to fluctuations in birth rates there are more children per year aged 5-13 years (around 3,600 per year) than aged 0-4 (3,300 per year) and 14-17 years (3,400). 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 3,100 by 2021, 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. First 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 update 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 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 2021 there were 51,210 children and young people under the age of 18 years. This is 22% of the total population. Around 17% of children under 16 in Tameside live in poverty and this rises to 25% after housing costs.

In 2022 there were 2,420 babies born in Tameside; 28% of babies were born in the most deprived decile. 6% of babies were born with a low birth weight under 2500 grams, with less than 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 19% to women over the age of 35 years.

Health, wellbeing and social outcomes are generally worse in Tameside than the England average. With significantly higher levels of smoking in pregnancy than the England average, low levels of breast feeding initiation and at 6 to 8 weeks.

Population vaccination coverage for 2 year olds across all vaccines has increased in particular for MMR vaccination rates (90% coverage) but there is a significantly higher rate for Dtap/IPV/Hib (95% 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 60.1% of children in Tameside are school ready.

Tameside has significantly high 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 - OHID (phe.org.uk)

iii: Trafford

An estimated 59,467 children and young people aged 0-19 live in Trafford which makes up about 1 in 4 (25.2%) of the total population (ONS, Mid-2021 estimates).

In 2021 there were 2,413 live births to mothers resident in Trafford. Trafford's total fertility rate of 1.58 is slightly higher than the rate of 1.55 for England (ONS, 2022). 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 (66 per 10,000 population under 18 years of age) in Trafford is similar to the England average 70 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, (2018), *A guide to inter-agency working to safeguard children. A guide to inter-agency working to Safeguarding and Protecting 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.*