Learning from Child Death Reviews

Annual Report of Stockport,

Tameside and Trafford's

Child Death Overview Panel, 2019/2020, 2020/2021

Learning from Child Death Reviews: Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel, 2019/2020, 2020/2021 has been prepared on behalf of Stockport, Tameside and Trafford Child Death Overview Panel and Stockport, Tameside and Trafford Child Death Overview Panel Strategic Group by;

- **Helen Gollins, Acting Director of Public Health, Trafford Council, and STT CDOP Chair**
- **Eleanor Roaf, DPH Trafford, Trafford Council**
- **Shelley Birch, Child Death Overview Panel Manager (Tameside, Trafford and Stockport), Trafford Council.**
- **Eleanor Banister, Public Health Intelligence and Early Intervention and Prevention Lead, Public Health, Stockport Council**
- **Beenish Hanif, Public Health Intelligence Manager, Public Health, Trafford Council.**
- **Jacqui Dorman, Public Health Intelligence Manager, Policy, Performance and Intelligence, Tameside 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 this experience.

Due to the pandemic, we did not produce a report last year, and so this report, *Learning from Child Death Reviews; the Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel, 2019-21*, covers two years, and describes why children who lived in Stockport, Tameside and Trafford died and presents eight recommendations from this learning.

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 2019/2020 and 2020/21

Key points from data analysis:

- The panel received 79 notifications in 2019/21, bringing the 7 year total across STT to 347
- There is no clear trend towards a higher or lower notification rate, although the annual rate has fallen slightly over the last four years. The seven year average is 3.0 notifications per 10,000 population aged under 18.
- Infants aged under 1 year continue to make up the largest proportion of notifications (42 notifications or 53% of total).
- 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 number of cases closed by the panel in 2019/21 (67) was again lower than previous years.
- Two thirds(67.6%) of infants who died had a low birth weight; more than three-quarters of infants who died were premature (78.3)
- After perinatal/neonatal event (26.9%), the two most common categories of death were chromosomal, genetic and congenital anomalies (19.4%) and sudden unexpected and unexplained deaths (17.9%).
- Modifiable factors were identified in 35 (52%) closed cases. Smoking, substance misuse and co-sleeping were the most common factors recorded,
- Two-fifths (27 or 40%) of closed cases were expected deaths.

4. Recommendations

Eight recommendations for Stockport's, Tameside and Trafford's Health and Wellbeing Boards to endorse and sponsor.

I. All CDOP partners to ensure the robust data recording of protected characteristics as required under the Equality Act 2010.

II. The CDOP Strategic Group to progress a CDOP 5 year look back review to identify robust trends and inform strategic decision making.

III. Tameside CDOP to use the data provided by the 5 year review to understand the boroughs expected and unexpected death pattern.

IV. STT CDOP representative to engage with the Greater Manchester CDOP system about the 5 year data review to share methodology and outputs.

V. Health and Wellbeing Boards to reduce the number of pregnant women, partners and household/family members who smoke by;
   a. working with Public Health Directorates and Maternity providers to support the delivery of the Baby Clear programme to all pregnant women ensuring continued support once the baby has been born.
   b. working with Public Health Directorates to support the delivery of smoking cessation interventions at a population level, thereby reducing the risk of smoking to children.

VI. Health and Wellbeing Boards promote improvements in mental health and resilience by;
   a. working with Public Health Directorates to better understand the relationship between self harm and suicide and to ensure services are commissioned that respond to the risks posed from this behaviour.
   b. ensuring there is collaborative working between the CDOP Strategic Group and Greater Manchester Suicide Prevention Programme to ensure Children and Young People are included in the work programme and that this is cascaded to localities.
   c. Ensuring that young people and their parents are supported to reduce their drug or alcohol use
   d. Ensure all women are aware of the support in place to address domestic abuse

VII. Health and Wellbeing Boards to support a reduction in co-sleeping and promote safe sleeping by;
   a. working with Public Health Directorates in partnership with Health Visiting and Maternity services to ensure all families receive appropriate safe sleeping interventions.
   b. working with Public Health in partnership with Health Visiting colleagues to implement a safe sleeping awareness campaign to all front line services that are in contact with families with infants.

VIII. Health and Wellbeing Boards to improve the outcomes for babies by taking actions to reduce the numbers and proportions of children who are born prematurely and / or with low birthweight:
   a. Reducing the number of women who smoke or use alcohol or other drugs in pregnancy (see above)
   b. Ensuring all women are supported to access high quality antenatal care from early in their pregnancies.
   c. Encourage only one embryo to be implanted in IVF procedures, to reduce the risks from multiple births
   d. working with maternity services to 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.
   e. working with Public Health Directorates to support the delivery of healthy weight interventions at a population level, thereby promoting the healthy weight of women of childbearing age. This work should start in childhood, as we know that children who are overweight or obese are more likely to be obese/overweight as adults, and that achieving a healthy weight while still growing is easier than losing weight as an adult.

Content

Learning from Child Death Reviews

Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel, 2019/2020, 2020/2021

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 this experience.

This report, Learning *from Child Death Reviews; the Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel, 2019-21* describes why children who lived in Stockport, Tameside and Trafford died and presents eight recommendations from this learning.

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 normally resident in one of the three boroughs, and, 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 require a total population of 500,000, with an average of 60 child deaths per year. The geographical footprint of STT CDOP includes the network of NHS health providers, Police and social care providers for this cluster.

The pandemic has had an impact on every aspect of life and work. Before the pandemic the panel met quarterly and in person. During Spring and early Summer 2020, the panel was paused due to the significant pressure on services and panel members. Delays in case completion as the hospital had staffing issues and medical staff were moved to Covid wards. There were also delays in coronal processes which impacted on case information.

From January 2021 the panel moved to being virtual and met monthly to ensure that cases were reviewed at an appropriate time. This so far has been highly effective. It has supported attendance and engagement in case discussions.

During the pandemic the notification process was amended to ensure Covid was captured as the cause, or contributing factor a death.

The CDOP is accountable to the 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 been established to ensure that action is taken to address any emerging issues or trends from the CDOP. With membership including Public Health and Safeguarding, this group aims 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. Due to the pandemic this Board has paused, however, it is planned to meet again in the new year.

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 2020, Stockport, Tameside and Trafford had an estimated combined population of 171,485 under 18 year olds. 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.

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 (2020)		Number	63,903	50,956	56,626	648,590	12,093,288
			% of Total (all ages)	21.7%	22.4%	23.8%	22.8%	21.4%
2	Proportion of 0-17 year olds belonging to Black & Minority Ethnic Groups (2011)			14.7%	16.3%	25.3%	27.4%	25.5%
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) (2019/20)	Absolute	Number	6,859	8,941	5,051	123,529	1,685,298
			%	12.0%	19.5%	10.0%	21.2%	15.6%
		Relative	Number	8,407	11,064	6,230	151,064	2,065,267
			%	14.7%	24.2%	12.3%	26.0%	19.1%
5	Live births (2019)		Number	3,040	2,796	2,505	34,396	610,505
			Rate (per 1,000 females aged 15-44 years)	58.7	66.7	58.1	60.7	57.7
6	Low birth weight of term babies (2019)		Number	68	75	52	986	16,048
			%	2.5%	3.1%	2.3%	3.2%	2.9%
7	Infant mortality (2018-20)		Number	41	35	13	497	7,111
			Rate (per 1,000 live births)	4.3 (CI 3.1-5.9)	4.3 (CI 3.0-6.0)	1.7 (CI 0.9-3.0)	4.9 (CI 4.4-5.3)	3.9 (CI 3.8-4.0)
8	Child mortality 2018-20)		Number	19	17	14	249	3,627
			Rate (DSR per 100,000 population aged 1-17)	10.8 (CI 6.5-17.0)	12.4 (CI 7.2-19.9)	8.8 (CI 4.8-14.8)	13.7 (CI 12.1-15.6)	10.8 (CI 10.4-11.2)
9	Looked After Children (2020)		Number	370	705	380	5,980	80,080
			Rate (per 10,000 population aged 0-17)	58	139	67	93	67

Source: Maternal and Child Health Profiles (2021)[iii].

6. What we know from CDOP Notifications and Closed Cases, 2019/2020, 2020/2021

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 2019 and 31st March 2021.

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 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 review 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 'notification' 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 2019/20 and 2020/21. 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 2019/20 and 2020/21. In many cases there is more than a year between notification and closure.

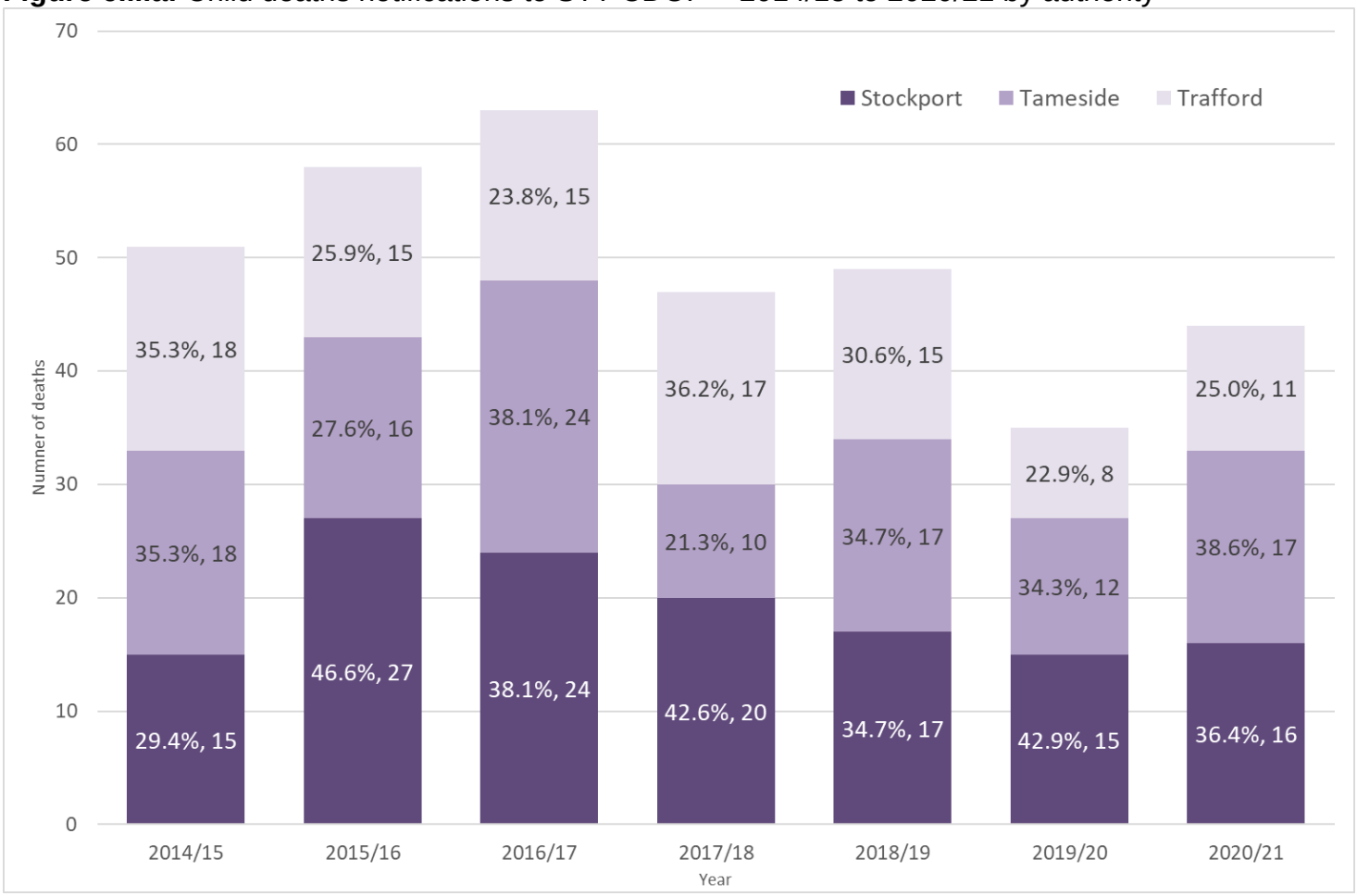
Therefore notifications show epidemiological pattern of deaths for the year under review, whereas closed cases provide intelligence about cases from a range of years.

6.ii. Demographic breakdown of notifications

6.ii.a. Number of notifications

The panel received 35 notifications in 2019/20 and 44 in 2020/21, both years lower then 2018/19 when 49 notifications were received. The split by local authority was 31 (39.2% of total) in Stockport, 29 (36.7%) in Tameside, and 19 (24.1%) in Trafford. The 2019/21 notifications bring the seven year total across STT since 2014/15 to 347. Aggregating the seven years gives a split by local authority of 38.6% (134) in Stockport, 32.9% (114) in Tameside, and 28.5% (99) in Trafford.

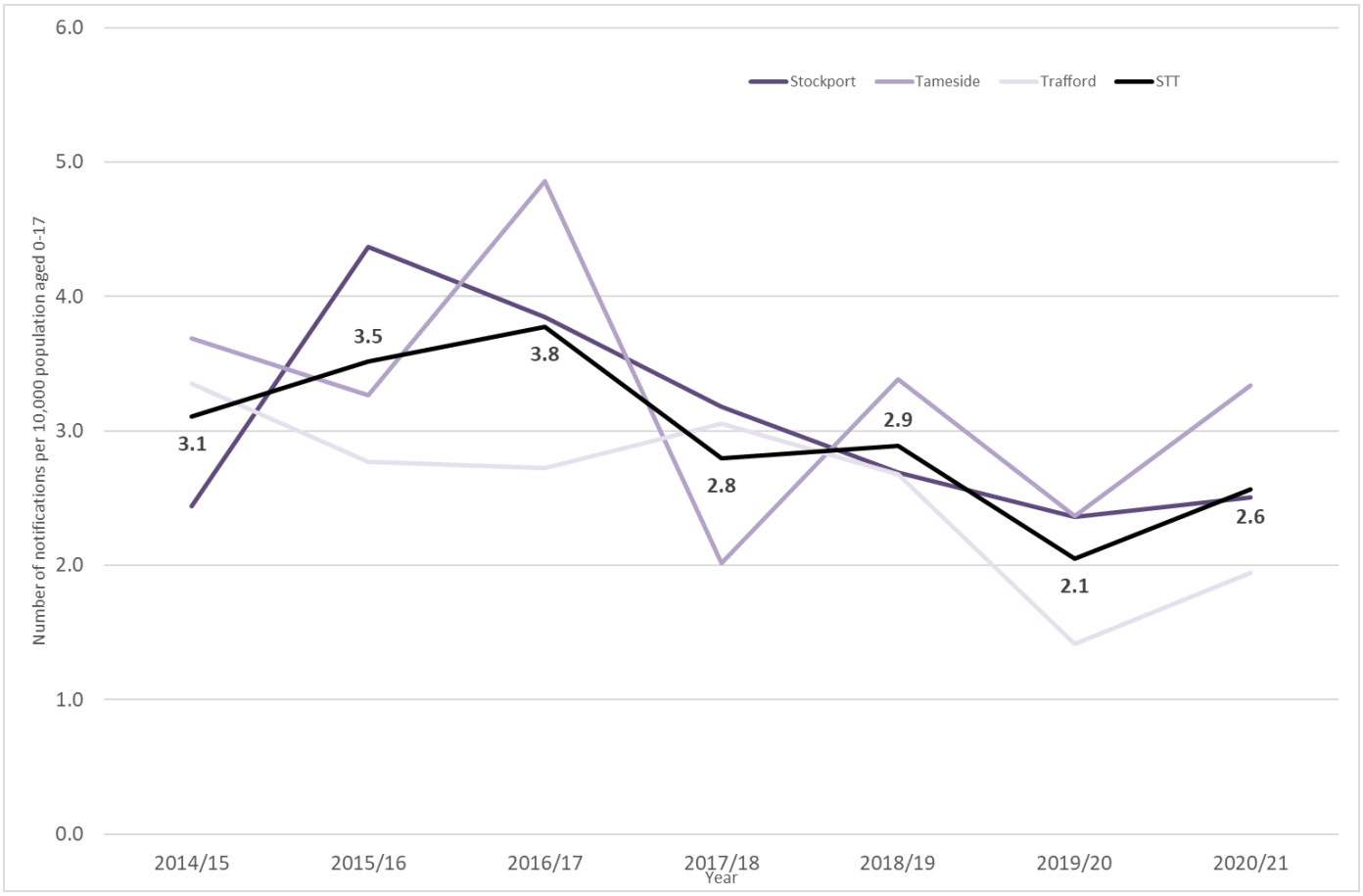
Figure 6.ii.a: Child deaths notifications to STT CDOP – 2014/15 to 2020/21 by authority



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 44 notifications in 2020/21 give a rate of 2.6 per 10,000 population aged under 18, which is very similar to 2017/18 (2.8 per 10,000), but also similar to 2014/15 (3.1 per 10,000), which probably indicates that the notification rate is hovering around the same level. 2019/20 had the lowest level of notification at 2.1 per 10,000, but this is still within tolerance. The seven year aggregated notifications give a rate for STT of 3.0 per 10,000, which is similar in Stockport (3.1 per 10,000) and Tameside (3.3 per 10,000) but slightly lower in Trafford (2.6 per 10,000). It is worth noting that nationally, early indicators suggest that the child death rate dropped in the UK in 2020, especially for the under 10s, as children were at low risk from Covid, and were significantly less likely to die from infectious diseases, or underlying conditions [iv].

Figure 6.ii.b: Trend in child death notification rate (per 10,000 population aged under 18)

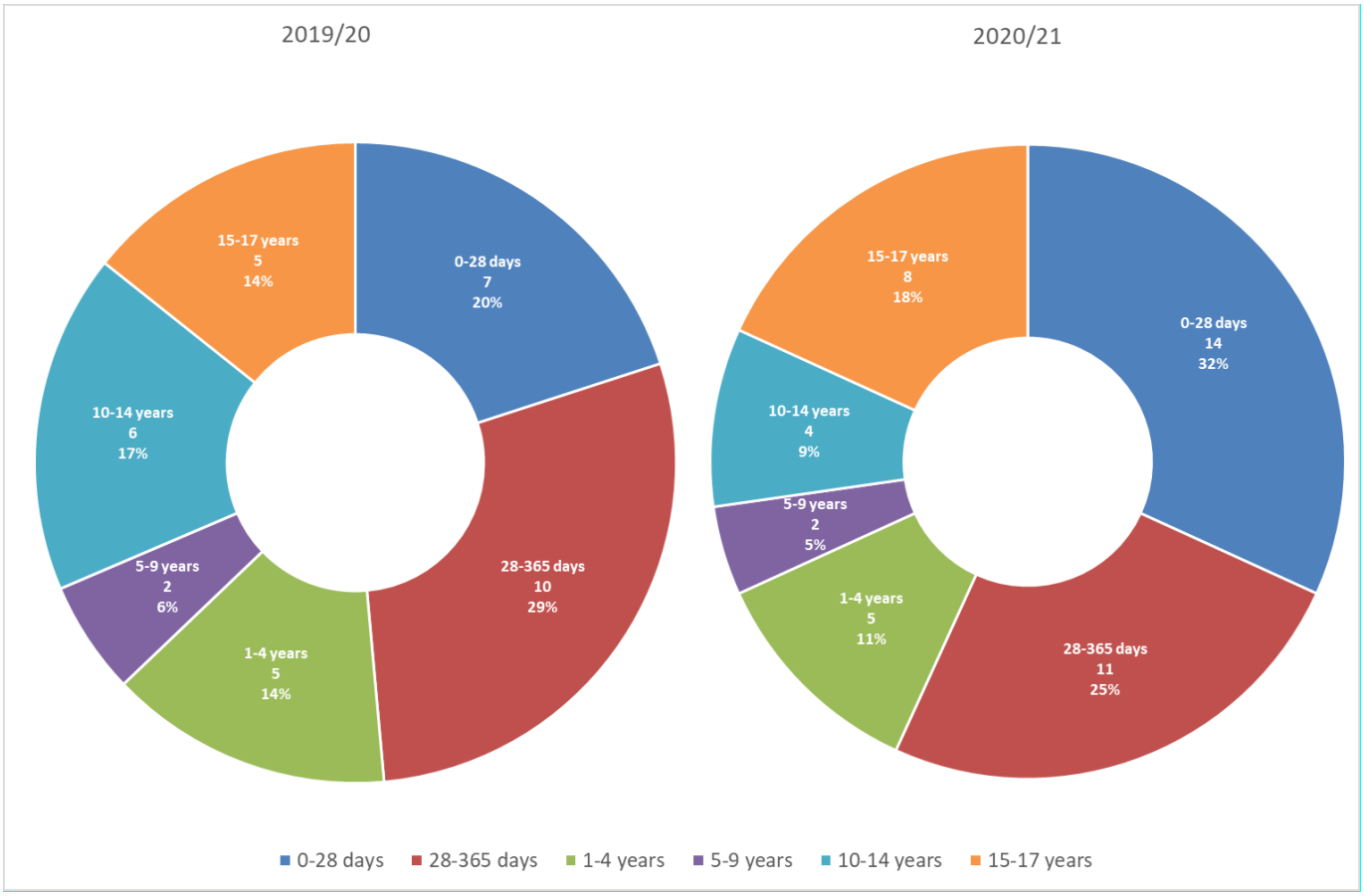


6.ii.c. Age breakdown of notifications

Of the 79 notifications in 2019/21, 21 (26.6%) were neonates (i.e. aged under 28 days) and 21 (26.6%) were aged between 28 days and 1 year. This means that over half (42 or 53.2%) of notifications across STT are infants (i.e. aged under 1 year). This is in line with previous years in STT and Greater Manchester. Again, differences in age patterns between the three authorities within STT can be difficult to detect; however, there does seem to be a consistent pattern that in Stockport a higher proportion of child deaths are of neonates (38.7% compared to 26.6% for STT). This is a topic we will return to in the coming year, in order to establish any underlying causes of this.

Reviewing the 21 notifications of deaths of children aged over 1 year, at STT level the distribution across age groups was fairly even with 10 (12.7%) aged 1 to 4 years, 4 (5.1%) aged 5 to 9 years, 10 (12.7%) aged 10 to 14 years, and 13 (16,5%) aged 15 to 17 years. Any differences between the three authorities in this distribution are difficult to detect due to the small numbers involved.

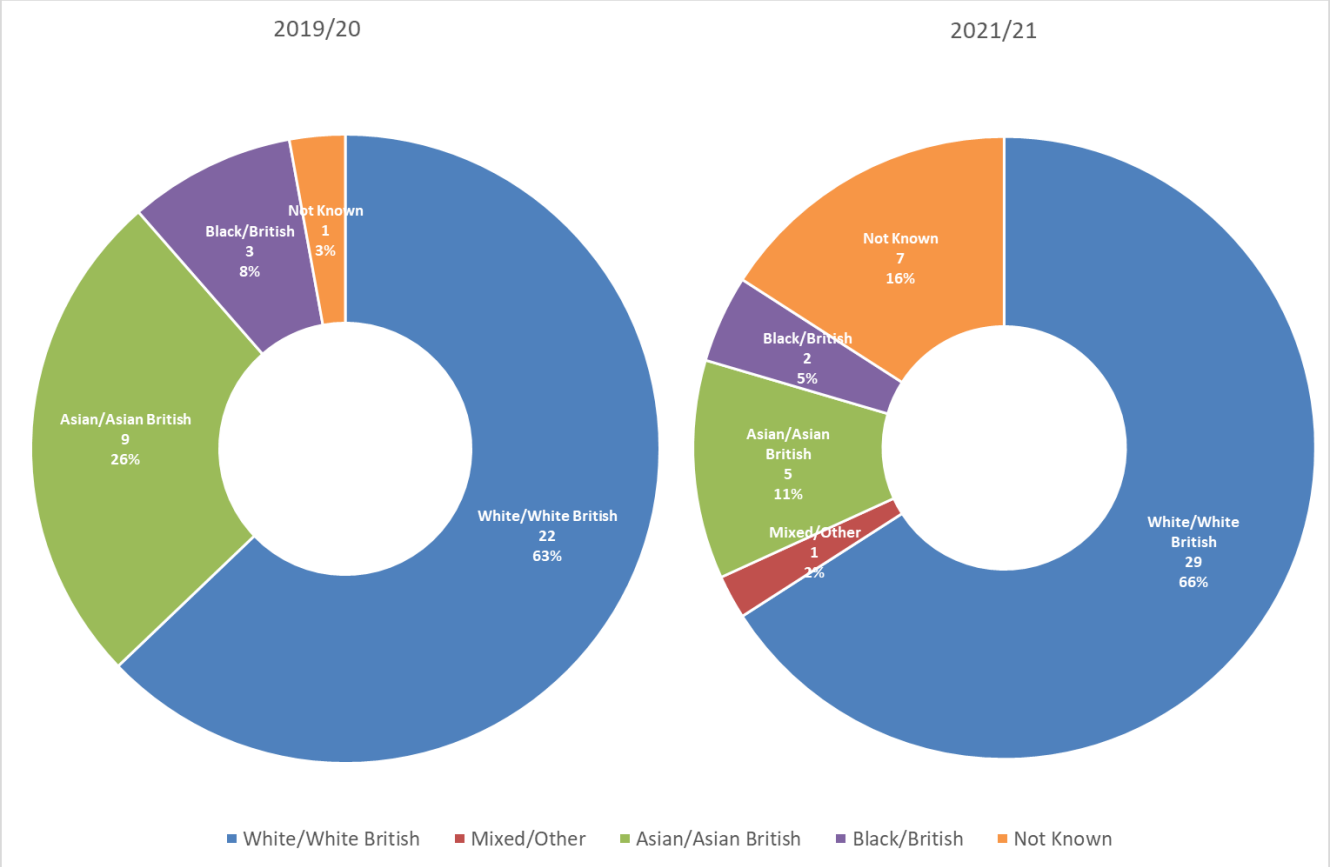
Figure 6.ii.c: Age breakdown of child death notifications



6.ii.d. Ethnicity breakdown of notifications

Of the 79 notifications during 2019/21, 20 (25.3%) belonged to a non-White group. This is in line with the estimated proportion of the STT child population belonging to non-White groups (20%) given the small numbers involved. However, there are 8 notifications (10.1% 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 35.4% which may suggest that these children are overrepresented among children who die. We need to improve our recording of ethnicity in order to better understand what, if any, impact it has on child death rates locally.

Figure 6.ii.d: Ethnic group breakdown of notifications

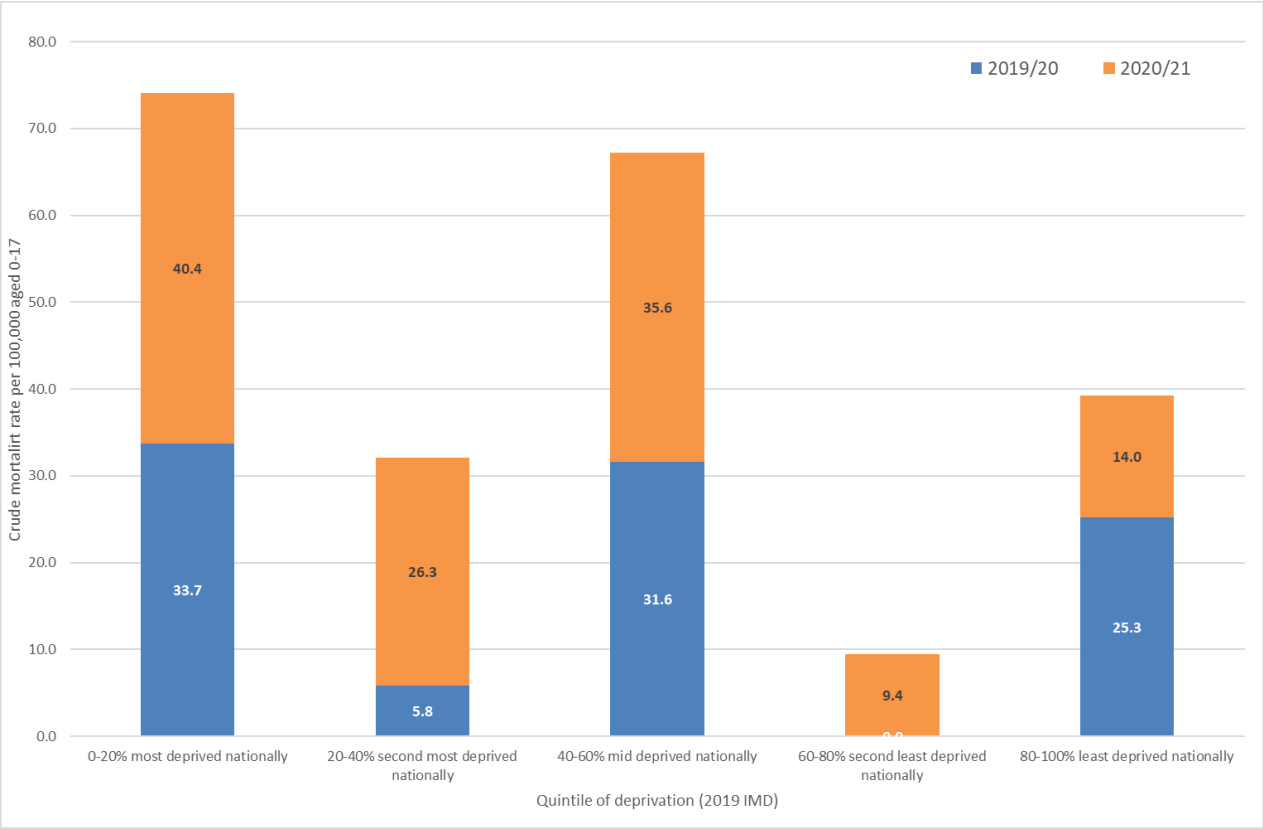


6.ii.e. Deprivation breakdown of notifications

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 79 notifications across STT, 33 (41.8%) were of children who lived in small areas which rank in the 20% most deprived in England, a crude rate over the two years of 74.,1 per 100,000 aged 0-17. Whether there is tendency towards higher child death notification rates in more deprived areas of STT in 2019/21 is unclear, partly because of the relatively small number of deaths involved. However, the crude rate in areas ranked in the 20% most deprived areas in England (74.1 per 100,000) is twice as high as in the least deprived 20% (39.3 per 10,000), but there is significant variation between the quintiles with the mid deprived quintile having a rate not much below that of the most deprived.

Figure 6.ii.e: Notification rate according to national deprivation quintile of mother's area of residence



6.iii. Analysis of cases closed during 2019/20 and 2020/21

6.iii.a. Number of closed cases

In 2019/21, 67 cases were closed by the panel:

- 38 were closed in 2019/20 and 29 and 2020/21
- This is lower than previous years, and substantially lower than a peak of 64 cases closed by the panel in 2010/11.
- The breakdown by authority was 27 (40.3%) in Stockport, 25 (37.3%) in Tameside and 15 (22.4%) in Trafford.
- Only 22 (14.9%) were notified to CDOP within the same financial year as they were closed.
- The average (mean) number of days from notification to close was 422.13, but varied by authority from 354.7 for Trafford cases, 389.9 for Stockport cases to 497.4 for Tameside cases,
- Deaths of children aged over 1 year tend to take longer to close, probably reflecting the circumstances and causes of death.

6.iii.b Birthweight and gestation and multiple births

In 2019/20 24 (63.2%) of cases closed by the panel in were infants (age <1 year), in 2020/21 13 (44.8%) of cases closed by the panel in were infants (age <1 year), 37 in total .Among these:

- 16 (43.2%) had very low birthweight (<1,500g), and a further 9 (24.3%) had a low birthweight (1,500-2,499g); bringing the proportion with low birthweight to two-thirds (25 out of 37 or 67.6%). 11 had a birthweight above 2499g, 1 was unknown.
- In comparison in 2019,485 live births across STT were of low birthweight, which is 5.8% of the total live births. These figures are not directly comparable, but if we assume approximately 970 low birthweight births across two years in STT, 25 deaths gives a crude mortality rate of 2.5% for low weight births, and with an approximate 15,700 non-low weight births across two years in STT, 13 deaths gives a crude mortality rate of 0.1% for non-low weight births. While this analysis should be treated with caution due to the small numbers and the lack of definitional consistency, it is clear that having a low birthweight greatly increases the risk of a baby dying in their first year of life.

Of the babies who died within 12 months of their birth:

- 13 of the 16 babies (81.3%) with very low birthweight died within 28 days of their birth
- 2 of the 9 babies (22.2%) with low birthweight died within 28 days of their birth
- 4 of the 11 babies (36.3%) with birthweight >2499g died within 28 days of their birth
- All 16 babies with very low birthweight were premature (<37 weeks), with 14 being extremely premature (<30 weeks).
- 5 of the 9 babies with low birthweight were premature, none were extremely premature.
- 14 (37.8%) were extremely premature (<30 week), and a further 15 (40.5%) were premature (30-36 weeks); bringing the proportion who were premature to more than three-quarters (29 out of 37 or 78.3%). 8 (21.6%) were full term.
- In comparison in 2019 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 91.6% live births were over 37 weeks gestation. Prematurity therefore adds greatly to the risk of a baby dying in its first year of life.

- 12 of the 14 babies (85.7%) who were extremely premature died within 28 days of their birth
- 5 of the 15 babies (33.3%) who were premature died within 28 days of their birth
- 4 of the 11 babies (25.0%) who were full term died within 28 days of their birth
- 10 (27.0%) were multiple births (1 triplet, 9 twins – 2 from the same pregnancy and 7 single twins).
- In comparison across England and Wales, 3.0% of maternities resulting in a live birth were twins and 0.1% of maternities resulting in a live birth were triplets or higher multiples.
- 8 (80%) of the multiple births died within 28 days of their birth, and all these 8 were extremely premature and had a very low birthweight
- Of the other 2 multiple births, one was premature with a low birthweight and one was full terms with a birthweight >2499g, both of these deaths were a sudden infant death,

Overall, therefore, prematurity, low birthweight, and being one of a multiple birth all increase the risks of a baby dying in its first year of life. These factors are clearly not independent of each other but any steps that can be taken to reduce the risk of any of these three factors being present will help reduce our infant mortality rate and the impact of a baby's death on families in our boroughs.

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: Place of death for deaths < 1 year in 2019/20 and 2020/21

Hospital of death	All STT
St Marys Hospital	10
Tameside Hospital	10
Stepping Hill Hospital	7
Wythenshawe Hospital	5
Other (1 each)	3
Unknown	2
Total	**37**

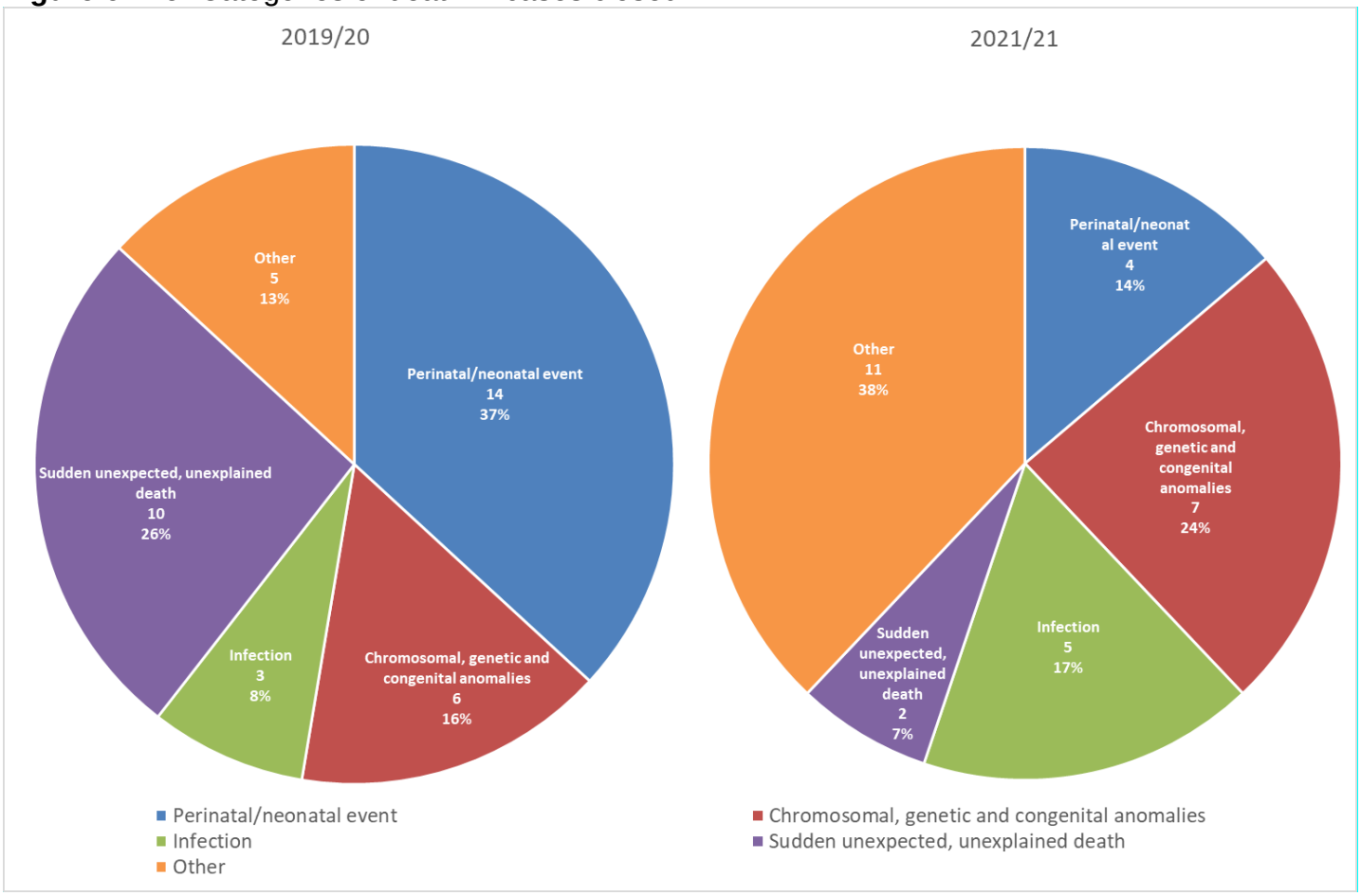
6.iii.c. Categories of death

In line with previous years, in 2019/20 the category of perinatal/neonatal event makes up the largest category of death with 14/38 (37%) closed cases, followed by 10 (26%) sudden unexpected and unexplained deaths at and 6 (16%) of children who died had chromosomal, genetic and congenital anomalies.

The 17 closed cases of children aged over 1 year were spread across a range of categories, the majority (9 or 90%) of the sudden unexpected and unexplained deaths were aged under a year.

In 2020/21 the other category was the most common cause (11/29 or 38%) covering a range of chronic medical conditions, acute medical condition and external causes of injury. Chromosomal, genetic and congenital anomalies accounted for 7 (24%) of cases, followed by infections (5 or 17%). No records mentioned COVID-19 coronavirus as a contributory factor.

Figure 6.iii.c: Categories of death in cases closed



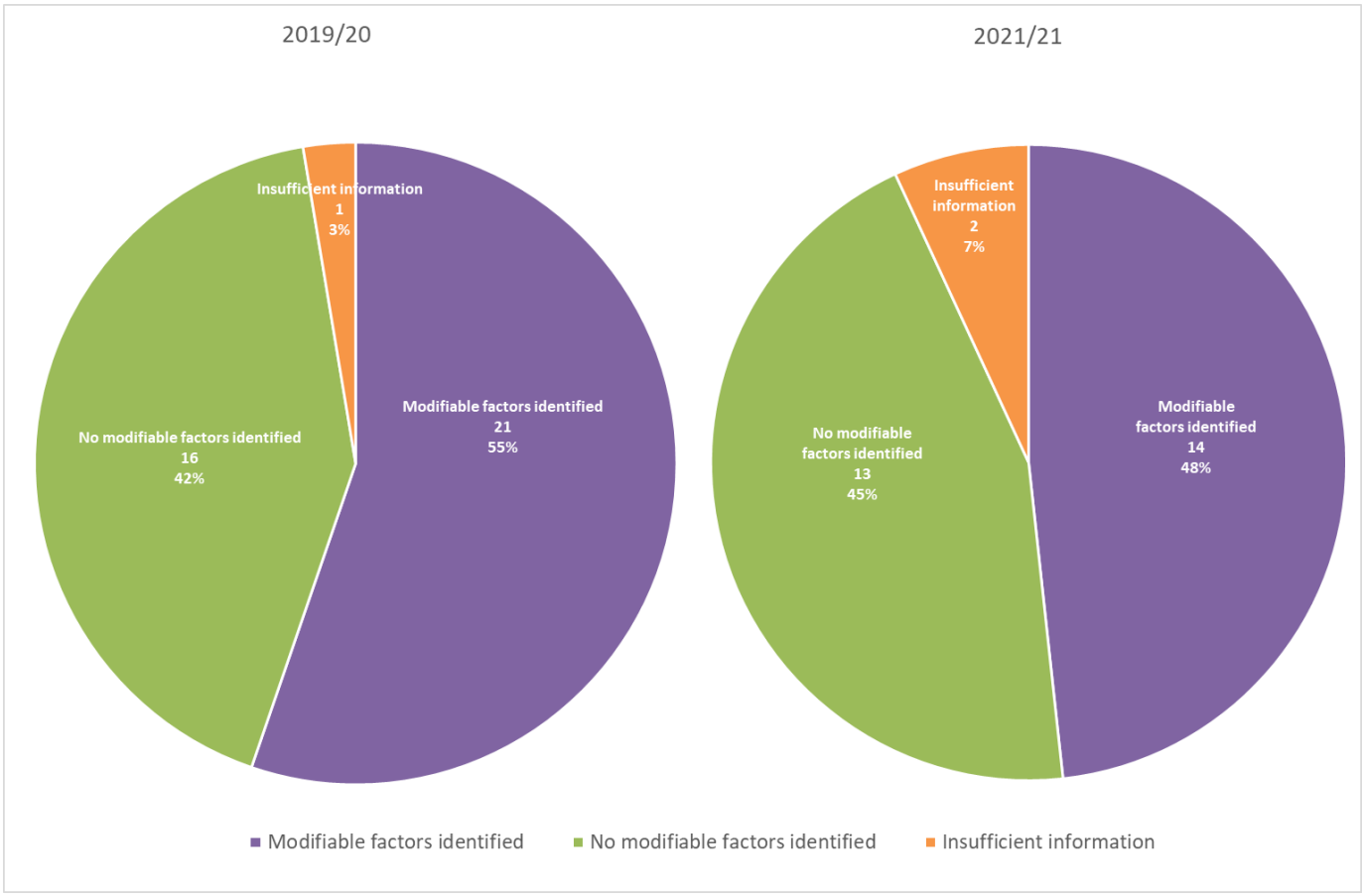
6.iii.d. Modifiable factors

Modifiable factors were identified in 21(55%) of closed cases in 2019/20 and 14 (48%) of cases in 2020/21.

Present modifiable factors included:

- Parental smoking (mentioned in 14 cases)
- Substance misuse (mentioned in 10 cases)
- Co-sleeping (mentioned in 6 cases)
- Domestic violence (mentioned in 5 cases)
- High maternal BMI (mentioned in 4 cases)
- Maternal mental health (mentioned in 3 cases)
- Neglect (mentioned in 2 cases)
- Missing / not attending appointments (mentioned in 2 cases)
- Monitoring of IVF / assisted pregnancy (mentioned in 23 cade)
- Other factors with one mention each:
    - Lack of safety device on blind
    - Being a young carer
    - Presence of play equipment
    - Overheating
    - Gang culture.

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



6.iii.e. Expected deaths

Around two fifths (16 or 42% in 2019/20 and 11 or 38% in 2020.21) of closed cases across STT were deaths which were expected. At local authority level, the proportion expected was higher in Trafford (53%), average in Stockport (44%) and lower in Tameside (28%), but again the number at local authority level is too small to show any significant difference at this level.

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

7. Recommendations

Eight recommendations for Stockport's, Tameside and Trafford's Health and Wellbeing Boards to endorse and sponsor.

I. All CDOP partners to ensure the robust data recording of protected characteristics as required under the Equality Act 2010.

II. The CDOP Strategic Group to progress a CDOP 5 year look back review to identify robust trends and inform strategic decision making.

III. Tameside CDOP to use the data provided by the 5 year review to understand the boroughs expected and unexpected death pattern.

IV. STT CDOP representative to engage with the Greater Manchester CDOP system about the 5 year data review to share methodology and outputs.

V. Health and Wellbeing Boards to reduce the number of pregnant women, partners and household/family members who smoke by;
   a. working with Public Health Directorates and Maternity providers to support the delivery of the Baby Clear programme to all pregnant women ensuring continued support once the baby has been born.
   b. working with Public Health Directorates to support the delivery of smoking cessation interventions at a population level, thereby reducing the risk of smoking to children.

VI. Health and Wellbeing Boards promote improvements in mental health and resilience by;
   a. working with Public Health Directorates to better understand the relationship between self harm and suicide and to ensure services are commissioned that respond to the risks posed from this behaviour.
   b. ensuring there is collaborative working between the CDOP Strategic Group and Greater Manchester Suicide Prevention Programme to ensure Children and Young People are included in the work programme and that this is cascaded to localities.
   c. Ensuring that young people and their parents are supported to reduce their drug or alcohol use
   d. Ensure all women are aware of the support in place to address domestic abuse

VII. Health and Wellbeing Boards to support a reduction in co-sleeping and promote safe sleeping by;
   a. working with Public Health Directorates in partnership with Health Visiting and Maternity services to ensure all families receive appropriate safe sleeping interventions.
   b. working with Public Health in partnership with Health Visiting colleagues to implement a safe sleeping awareness campaign to all front line services that are in contact with families with infants.

VIII. Health and Wellbeing Boards to improve the outcomes for babies by taking actions to reduce the numbers and proportions of children who are born prematurely and / or with low birthweight:
   a. Reducing the number of women who smoke or use alcohol or other drugs in pregnancy (see above)
   b. Ensuring all women are supported to access high quality antenatal care from early in their pregnancies.
   c. Encourage only one embryo to be implanted in IVF procedures, to reduce the risks from multiple births
   d. working with maternity services to 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.
   e. working with Public Health Directorates to support the delivery of healthy weight interventions at a population level, thereby promoting the healthy weight of women of childbearing age. This work should start in childhood, as we know that children who are overweight or obese are more likely to be obese/overweight as adults, and that achieving a healthy weight while still growing is easier than losing weight as an adult.

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 STT CDOP Strategic Group will oversee the progress of these recommendations. The HWB will be accountable for the progress of these recommendations. The recommendations will be reported as part of the 2021/22 Annual Report cycle.

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[v]

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 learnt 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.

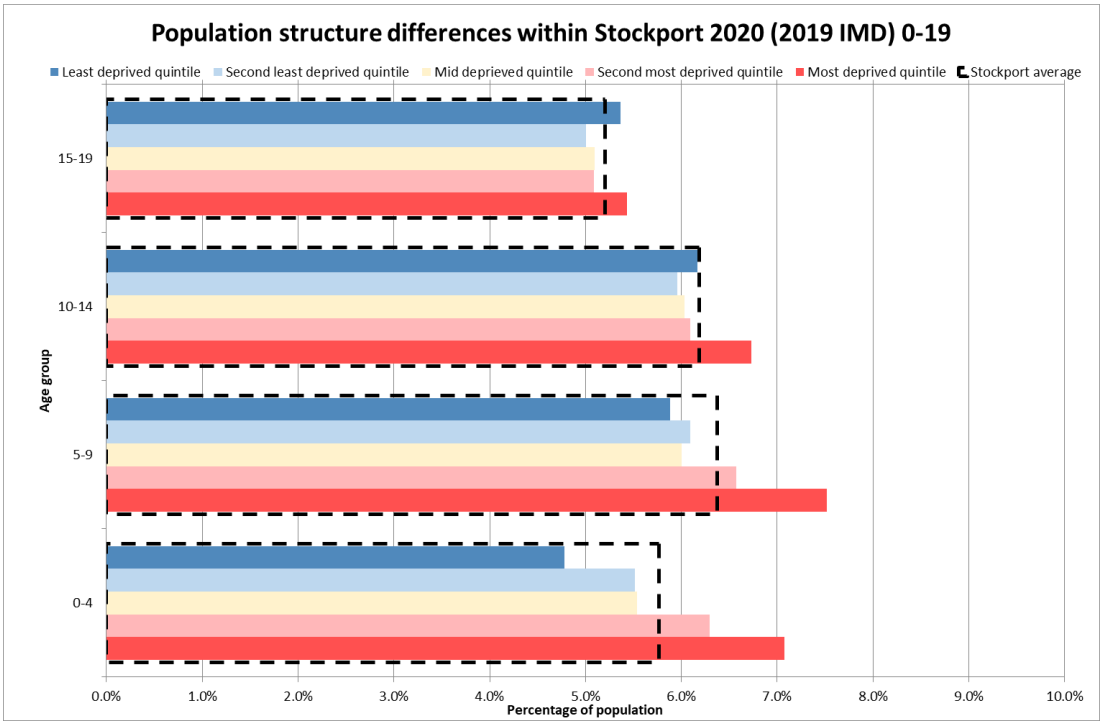
The full description of local CDOP arrangements for Stockport, Tameside and Trafford can be found here:
www.traffordccg.nhs.uk/docs/Publications/STT-CDOP-implementation-plan-June-2019.pdf

Appendix B: Borough Child Profiles

i: Stockport

There are 63,900 children and young people aged 0-17 living in Stockport (ONS Mid-Year Estimate 2020), a population that is growing slightly – up 3.3% since 2015. Due to fluctuations in birth rates there are more children per year aged 4-11 years (around 3,700) than aged 0-1 (3,200) 2-3 and 15-17 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 2020, following the well-known cyclical trend.

Fertility rates are highest in the most deprived areas of Stockport, currently 39% higher than in the least deprived areas, 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 the under 10 population in particular is much more likely to be deprived than the Stockport average.



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. Sample data from Stockport GP Practices in 2019 suggests that 82% of the 0-17 population describe their ethnicity as White, 8% as Asian, and 5 % as other. Stockport's BAME population is not evenly distributed, and is largest in Heald Green, Gatley and Heaton Mersey.

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.

Stockport JSNA

- Overall summary (all ages): http://www.stockportjsna.org.uk/wp-content/uploads/2016/04/2015-16-JSNA-Key-Summary.pdf

- Key issues for children: http://www.stockportjsna.org.uk/wp-content/uploads/2016/04/2015-16-JSNA-Implications-for-Children-and-Young-Peoples-Services.pdf

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 Health and Wellbeing Strategy: https://www.stockport.gov.uk/health-and-wellbeing-board/joint-health-and-wellbeing-strategy, contains hyperlinks to other key strategies too. This is under review and a new One Stockport Health and Care Plan will be published soon.
- 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

The resident mid-year population estimate (2020) was 227,117 residents. 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 (2011) showing that 15.8% of the local population are from an ethnic minority group; this is an increase from the last Census (2001) of 7.4%.

Deprivation is higher in Tameside with approximately 11,064 (24.2%) children under 16 years living in relative poverty, and 8,941 (19.5%) children living in absolute poverty which is based on whether households have less than 60% of the current median household income to live on after housing costs. (2019/20)

In 2020/21 there were 2,765 babies born in Tameside; 27% of babies were born in the most deprived decile. 5% of babies were born with a low birth weight under 2500 grams, with less than 0.5% being of very low birth weight (<1500 grams). The highest proportion of births were born to mothers aged 25-34 years (55%). 1% of babies were born to women under 18 years and 17% to women over the age of 35 years.

Health, wellbeing and social outcomes are generally worse in Tameside than the England average. However levels of smoking in pregnancy have reduced significantly in recent years to 10.2% (2021) of pregnant women still smoking at time of delivery, similar to the England average. Levels of breast feeding initiation and at 6 to 8 weeks is still significantly lower than the England average.

Population vaccination coverage for 2 year olds across all vaccines has reduced in the last few years and we are now similar to the England average for MMR vaccination rates (94% coverage) but have a higher rate for Dtap/IPV/Hib (96% coverage).

A&E attendances for 0-4 year olds in Tameside are significantly higher than the England average. Hospital admissions for asthma in children and young people under 19 years is currently the highest in England at 405/100,000

Prevalence of obesity in reception (12%) and year 6 children (21%) is significantly higher than the England average and 33% of five year olds experience visually obvious tooth decay

School readiness is improving for our 5 year olds but is still significantly worse than the England average, currently 66% 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 the general population.

More information can be found here: Child & Maternal health profiles

iii: Trafford

An estimated 59,378 under 18s live in Trafford i.e. about 1 in 4 (24%) of the total population (proportionally slightly higher than England at 22%) *(ONS, Mid-2020 estimates).*

Between 2010 and 2020, Trafford's under-18 population grew by almost 5,350 or 10%, which is substantially more than the growth seen in this age group across Tameside, Stockport and England as a whole *(ONS, Mid-year estimates for 2010 and 2020).* Over the next 10 years, however, growth in this age group is projected to slow to 219 or 0.4% between 2020 and 2030; this is driven by strong growth in the 15-18 year age group, against a decline in those aged under 14 *(ONS, 2020-based subnational population projections).*

In 2020 there were 2,326 live births to mother's resident in Trafford. This is 7% lower than in 2013 when there were 2,817 live births. Trafford's fertility rate (54 live births per 1,000 females aged 15 to 44) is slightly lower than, England (55.3 per 1000) *(ONS, 2020)*and fertility rates tend to be higher in areas of Trafford with higher Black and Minority Ethnic (BME) population.

The proportion of Trafford under-18s belonging to BME group is growing: in the 2001 Census, 15.5% (or 7,500) under 18s were from a BME group. By the 2011 Census this had grown to 25.3% (or 13,100). More recent data from the 2019 School Census indicate that approaching a third of Trafford school children now belongs to a BME group.

Trafford is the least deprived authority in Greater Manchester – only 5.7% of small areas in Trafford rank in the 10% most deprived in England; however, children who live in these areas tend to fare worst on a range of indicators of health and wellbeing. The Income Deprivation Affecting Children domain of the 2019 Indices suggests that 11.7% of Trafford 0-15 year olds are living in poverty, but this rises to 44% in one small area.

Children and young people in care are among those who can be particularly vulnerable to poor health and social outcomes. Trafford's rate of children in care has been rising over time and is high relative to other similar authorities.

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. The Health and Wellbeing Board has three life course sub-boards including "Start Well and Ready for Life" which has three priorities to:

- improve school readiness, particular in children eligible for Free School Meals
- improve mental wellbeing and resilience, in particular by tackling Adverse Childhood Experiences (ACEs); and,
- increase the proportion of children who have a healthy weight.

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] Public Health England, (2021) Maternal and Child Health Profiles, *https://fingertips.phe.org.uk/profile/child-health-profiles.*
[iv] Odd D et al (2021) *Child Mortality in England During the First Year of the COVID-19 Pandemic* ,doi: https://doi.org/10.1101/2021.08.23.21262114
[v] HM Government, (2018), *Child Death Review Statutory and Operational Guidance*.