

# **Annual report of the Bury, Oldham, and Rochdale Child Death Overview Panel 2025**

Including data for 2022/23 – 2024/25

**Dr Steven Senior**

Consultant in Public Health

Chair of the Bury, Oldham, and Rochdale Child Death Overview Panel.

## Table of Contents

Executive summary.....	4
Summary of recommendations.....	5
1. Introduction and background .....	6
2. The Child Death Overview Process .....	6
3. Contents of this report .....	7
4. Data protection.....	8
5. Demographics of children and Young People in Bury, Oldham, and Rochdale .....	8
5.1 Population statistics .....	8
5.2 Births .....	9
5.3 Poverty and children in care .....	13
6. Mortality statistics.....	15
7. Notified deaths .....	18
7.1 Notified by local authority area of residence and year of death .....	18
7.2 Notified deaths by gender and year of death .....	20
7.3 Notified deaths by age at death .....	21
7.3 Notified deaths by ethnicity .....	22
7.4 Notified deaths by deprivation .....	23
8. Analysis of deaths reviewed .....	25
8.1 Numbers of deaths reviewed .....	25
8.2 Demographics of deaths reviewed .....	27
8.3 Deaths reviewed by category of death, pre-existing conditions, and learning disability .....	28
8.4 Deaths reviewed by presence of contributing factors .....	30
Specific modifiable factors: maternal over/under weight .....	31
Specific modifiable factors: consanguinity .....	31
Specific modifiable factors: smoking, alcohol, and substance misuse .....	32
Specific modifiable factors: unsafe sleeping arrangements .....	33
9. Previous recommendations and actions .....	33
10. Recommendations .....	34
Appendix A: Child Death Overview Panel Responsibilities.....	35
Appendix B: CDOP categories of death .....	36

## List of tables:

Table 1: Numbers of 0-17 year olds in Bury Oldham and Rochdale by sex (Census 2021) ....	8
Table 2: Numbers of 0-17 year olds in Bury Oldham and Rochdale by ethnic category (Census 2021) .....	8
Table 3: Population projections for 0-19 year olds (ONS, 2018-based) .....	9
Table 4: deaths and death rates reported to CDOP by local authority and year .....	18
Table 5: deaths reported to CDOP by gender and year .....	20
Table 6: Deaths reported by age group .....	21
Table 7: Deaths and approximate rates by broad ethnic background .....	22
Table 8: Deaths and death rates by decile of deprivation .....	24
Table 9: Numbers of deaths reviewed by local authority and year reviewed.....	25
Table 10: Numbers of deaths reviewed by year reviewed and year of death.....	25
Table 11: Numbers of deaths notified to CDOP and reviewed by CDOP by year .....	26
Table 12: Number of deaths reviewed by age and gender .....	27
Table 13: Number of deaths reviewed by ethnicity .....	27
Table 14: Numbers of death by category of death .....	28
Table 15: Deaths reviewed where a pre-existing medical condition was present .....	29
Table 16: Deaths reviewed by whether the child had a diagnosed learning disability .....	29
Table 17: Deaths reviewed by modifiable factors contributing to deaths.....	30
Table 18: Deaths reviewed by age group and modifiable factors present.....	31
Table 19: Deaths reviewed where parents were known to be blood relatives .....	32
Table 20: Deaths where smoking, alcohol, or substance misuse issues were identified .....	33

## Executive summary

- The Bury, Rochdale, and Oldham Child Death Overview Panel (CDOP) reviews all deaths of children normally resident in the three local authority areas.
- This report provides an analysis of deaths reported to CDOP and reviewed by CDOP in 2022/23, 2023/24, and 2024/25. It also includes demographic data on the population of children in Bury, Rochdale, and Oldham, as well as data on important contributors to child mortality, such as rates of premature births, child poverty, and homelessness among families with children.
- Birth rates in Bury, Rochdale, and Oldham have fallen since 2016 but remain above average for England. The Office for National Statistics projects that the numbers of children living in the three local authority areas will be similar in 2030 to 2023.
- Child death rates have tended to be higher than average for England in Oldham and Rochdale while rates in Bury have been similar to the England average. Numbers and rates of death fell in Oldham between 2022/23 and 2024/25 and increased in Bury and Rochdale between 2023/24 and 2024/25. These increases are not statistically significant and are likely to reflect random year-to-year fluctuations.
- Children living in areas of higher deprivation continue to be more likely to die, as are children from Asian ethnic background (potentially because they are more likely than White children to grow up in areas of deprivation). Rates of child poverty and homelessness have increased sharply since 2020/21 in all three areas covered by this report.
- Along with the effects of poverty, CDOP continues to identify known, modifiable risk factors in its reviews of child deaths. Modifiable factors were identified as contributing to 70% of deaths reviewed by CDOP between 2022/23 and 2024/25. The most common category of modifiable factor were factors relating to the social environment and factors relating to service provision (present in 36% and 38% of deaths reviewed respectively).
- The most common modifiable risk factors identified in reviews of child deaths included:
  - **Smoking, alcohol misuse, and substance misuse** during pregnancy and in the household;
  - **High maternal BMI** was identified as a factor in 22 deaths (14% of all deaths reviewed), 14 of which occurred before the baby was 28 days old.
  - **Unsafe sleeping arrangements**, which were linked to one third of deaths categorised as sudden unexplained child deaths. Unsafe sleeping arrangements often co-occurred with alcohol use by one or both parents; and
  - **Consanguinity** (parents closely related) was a factor in 24 deaths reviewed (15% of all deaths). The most common category of death identified for these deaths were 'chromosomal, genetic, and congenital anomalies' (14 of 24 deaths). Consanguinity was a factor in 56% of deaths in this category.

## Summary of recommendations

Based on the analysis of deaths reported to and reviewed by CDOP, as well as of the publicly available data presented above, this report recommends that:

- **Child poverty:** Health and Wellbeing Boards should note the worsening in measures of child poverty and to work with local partners to ensure that local antipoverty plans address increases in childhood poverty.
- **Smoking, alcohol, and substance misuse:** Health and Wellbeing Boards, with partners, should continue to work to reduce smoking, alcohol, and drug misuse in pregnancy by:
  - Ensuring smoking status and alcohol or substance misuse problems are identified early by ensuring that pregnant people are asked about smoking status, alcohol use, and substance use, that this information is recorded, and referrals to appropriate services are made; and
  - Continuing wider work to reduce the prevalence of smoking, alcohol misuse, and substance misuse across the population and ensuring provision of smoking cessation and drug and alcohol treatment services.
- **Safe sleeping arrangements:** Health and Wellbeing Boards, with partners, should continue to promote safe sleeping practices, noting the possible relationship between unsafe sleeping arrangements and overcrowded or otherwise inappropriate housing and with alcohol use by parents. Safeguarding partnerships should ensure for children who have additional vulnerabilities that are captured in child protection or child in need plan.
- **Consanguinity:** Health and Wellbeing Boards should work with partners and community organisations to raise awareness of the increased risk of death and illness faced by children born to parents who are close blood relatives and assure themselves that genetic counselling and testing services are being offered appropriately.
- **Maternal healthy weight and nutrition:** reductions in high maternal body weight is likely best achieved by reducing high body weight in the population as a whole. This should include efforts to improve diet and exercise in childhood as well as adulthood and reduce inequalities. Health and Wellbeing Boards should assure themselves of plans to reduce obesity in the population, as well as that support with nutrition and appropriate exercise is available to pregnant people and to people planning to become pregnant.

## **1. Introduction and background**

The CDOP Annual Report is prepared to inform Child Death Review (CDR) Partners about local patterns and trends in child deaths, any lessons learned, actions taken, and the effectiveness of the broader child death review process. The report highlights relevant and modifiable factors contributing to the infant (under one year of age) and child (age 1-17 years) mortality rate in Bury, Rochdale, and Oldham. It also highlights.

The Bury, Rochdale, and Oldham CDOP is one of four CDOPs that make up the Greater Manchester (GM) CDOP Network:

- Manchester CDOP
- Bury, Rochdale & Oldham CDOP
- Bolton, Salford & Wigan CDOP
- Tameside, Trafford & Stockport CDOP

## **2. The Child Death Overview Process**

The Bury, Rochdale, and Oldham Child Death Overview Panel (CDOP) reviews all deaths of children normally resident in the three local authority areas. This includes only live births and excludes stillbirths and legally terminated pregnancies. The panel may also review deaths of non-resident children who died in the local authority area. The panel operates under the Child Death Review Statutory and Operational Guidance.<sup>1</sup> The chart below, taken from this guidance summarises the child death review process, and where CDOP sits in this process:

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<sup>1</sup> Department for Health and Social Care (2018) [Child Death Review Statutory and Operational Guidance \(England\)](#).

**Figure 1: The child death review process**

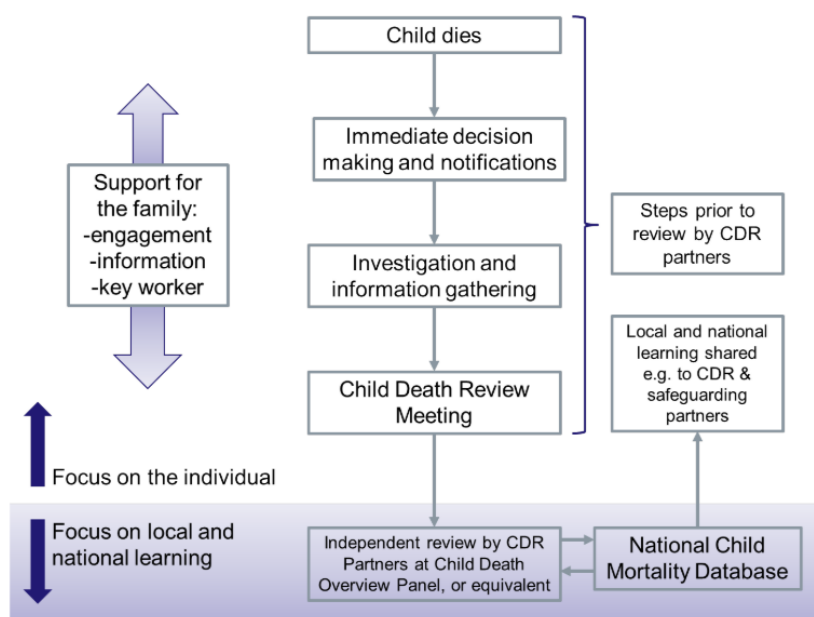


Figure 1 Chart illustrating the full process of a child death review. This includes both the statutory responsibilities of CDR partners to review the deaths of children at an independent multi-agency panel (described here, and throughout, as review at CDOP or equivalent), and the processes that precede or follow this independent review. Further explanation is below.

As illustrated in figure 1, the focus of CDOP is on local and national learning. This involves looking for patterns between deaths and common ‘modifiable factors’ - things that could be changed to prevent future deaths. The purpose of CDOP is not to assure the preceding steps in the child death review process or to check that actions identified in reviews of specific cases have been taken. CDOP is accountable to the Health and Wellbeing Boards of the three local authority areas. Reports are also shared with local safeguarding partnerships. A full list of CDOP responsibilities is presented in Appendix A.

### 3. Contents of this report

This report contains:

- An overview of the demographics of children in Bury, Oldham, and Rochdale, including numbers of live births, fertility rates, and factors relating to child health such as rates of premature births, low birth weight, and poverty indicators.
- A summary of publicly available child mortality statistics.
- A description of numbers of deaths *notified* to CDOP between 1<sup>st</sup> April 2022 and 31<sup>st</sup> March 2023 and 1<sup>st</sup> April 2024 and 31<sup>st</sup> March 2025.
- Analysis of deaths *reviewed* by the CDOP between 1<sup>st</sup> April 2022 and 31<sup>st</sup> March 2023 and 1<sup>st</sup> April 2024 and 31<sup>st</sup> March 2025.
- Recommendations for Health and Wellbeing Boards in Bury, Rochdale, and Oldham.

It is important to note that due to the length of the child death review process, deaths reviewed each year may not have happened or been notified to the panel in that year.

This report contains analysis of three financial years' CDOP data, 2022-23, 2023-24 and 2024-25.

#### 4. Data protection

Data about children who die and the circumstances of their death is shared anonymously with the CDOP members. The panel is a confidential environment and panel members are aware of their obligation to treat information shared in meetings in confidence. Panel members and observers are required to sign confidentiality agreement. Every care has been taken in this report to make sure that no child can be identified from the data presented. Due to the personal nature of the underlying data it cannot be shared more widely.

#### 5. Demographics of children and Young People in Bury, Oldham, and Rochdale

##### 5.1 Population statistics

Table 1 provides the overall number of children aged 0-17 in Bury, Oldham, and Rochdale in the 2021 census. Children make up a higher proportion of the overall population in Oldham (25.6% of the population) than in Rochdale (24.3%) or Bury (22.6%). However, this can vary within local authorities.

**Table 1: Numbers of 0-17 year olds in Bury Oldham and Rochdale by sex (Census 2021)**

Sex	Bury		Oldham		Rochdale	
	No.	%	No.	%	No.	%
Female	20,156	10.4%	29,196	12.1%	25,063	11.2%
Male	21,597	11.1%	29,789	12.3%	26,774	12.0%
Total	43,852	22.6%	61,953	25.6%	54,361	24.3%

Table 2 shows a breakdown of the ethnicities of children in each local authority area. Oldham has the highest proportion of children belonging to Black and ethnic minority backgrounds (47.87% of children), followed by Rochdale (38.82%) and Bury (16.93%). Across all three areas the largest ethnic minority category was 'Asian, Asian British, or Asian Welsh' although within this there was variation in what proportion identified as Pakistani, Bangladeshi, and other Asian backgrounds. Note: the total numbers of children in table 1 and 2 do not match. This is due to demographic data missing in the census data for a small number of children.

**Table 2: Numbers of 0-17 year olds in Bury Oldham and Rochdale by ethnic category (Census 2021)**

Ethnic category	Bury		Oldham		Rochdale	
	No.	%	No.	%	No.	%



Asian, Asian British or Asian Welsh	6,782	15.45%	21,700	35.02%	13,840	25.33%
Black, Black British, Black Welsh, Caribbean or African	1,164	2.65%	3,410	5.50%	3,164	5.79%
Mixed or Multiple ethnic groups	2,688	6.12%	3,321	5.36%	2,914	5.33%
Other ethnic group	1,186	2.70%	1,235	1.99%	1,289	2.36%
White	32,067	73.07%	32,300	52.13%	33,424	61.18%
<b>Grand Total</b>	<b>43,887</b>	<b>100.00%</b>	<b>61,966</b>	<b>100.00%</b>	<b>54,631</b>	<b>100.00%</b>

Population projections from the Office for National Statistics (ONS) suggest that the 0–17-year-old population is expected to be broadly stable up to 2030, with forecast increases of between 1% and 3%. However, these projections are based on 2018 population estimates, and projections depend on accurately predicting birth rates, which may change.

**Table 3: Population projections for 0-19 year olds (ONS, 2018-based)**

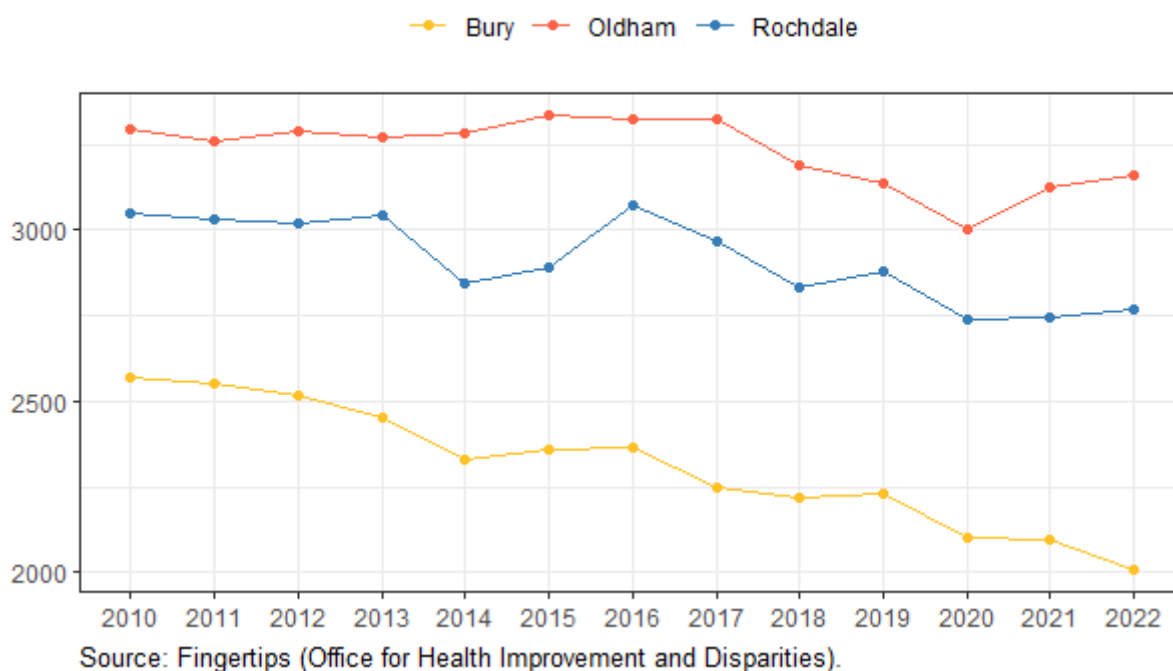
<b>Area</b>	<b>Bury</b>	<b>Oldham</b>	<b>Rochdale</b>
2023	35,490	48,641	43,977
2030	35,875	49,219	45,203
% Growth	1.1%	1.2%	2.8%

## 5.2 Births

Figure 2 shows the number of live births in Bury, Oldham, and Rochdale by year from 2010 to 2022. Numbers of births fell in all three areas over the 12-year period. The biggest fall was in Bury, where the number of live births fell from 2,571 to just over 2,008 (a 22% reduction in live births). The smallest fall was in Oldham, where the number of births fell from around 3,300 to 3,158 (around a 4% decrease).

**Figure 2: Live births**

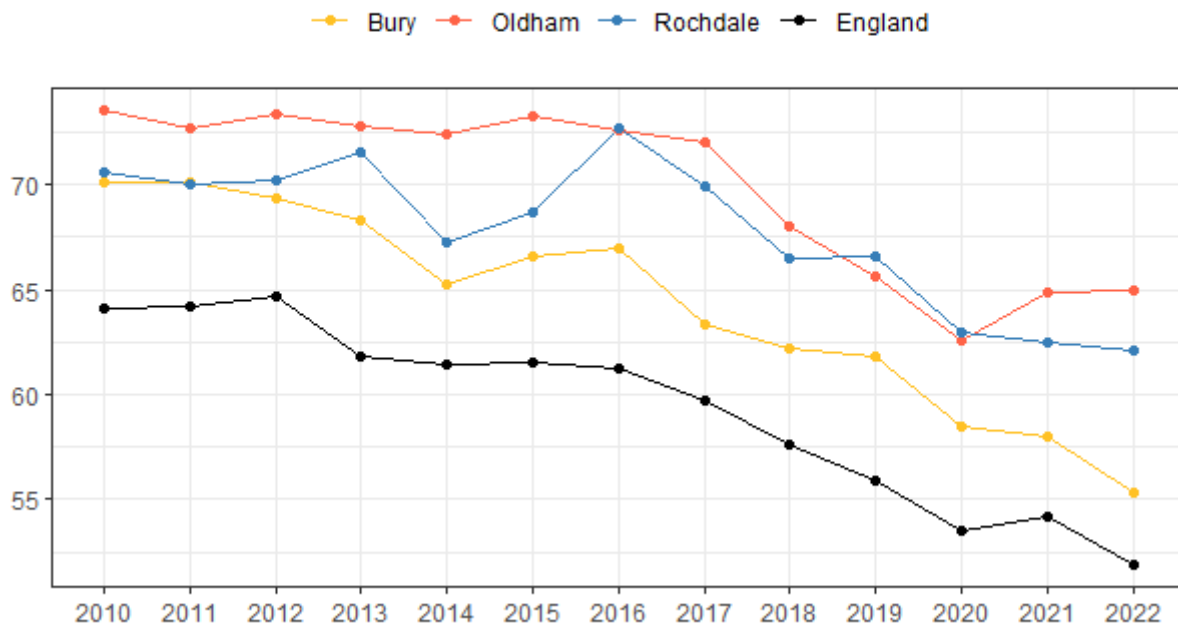
Live births 2010 to 2022



The general fertility rate gives a measure of the number of births relative to the number of females aged 15 to 44 (as very few births are to females aged under 15 or over 45). Figure 3 shows the general fertility rate for Bury, Rochdale, Oldham, and England for the same 12-year period. The national fertility rate fell from around 64 per 1,000 women per year in 2010 to 52 in 2022 (a 19% decrease). General fertility rates were higher in Bury, Rochdale, and Oldham than England over the whole period. However, fertility rates fell more sharply in Bury, reducing the gap in general fertility rates from 6 births per 1,000 females aged 15-44 to 3.4 births per 1,000 females aged 15-44. General fertility rates only fell by 12% in Rochdale and Oldham, with Oldham's general fertility rate increasing slightly from 2020.

**Figure 3: General fertility rate**

Birth rate per 1,000 females aged 15 to 44 years 2010 to 2022



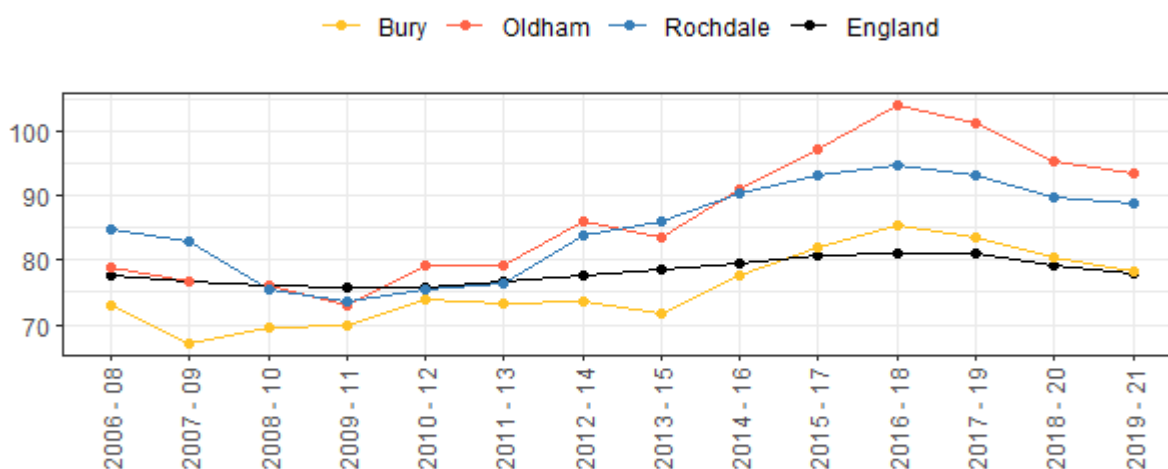
Source: Fingertips (Office for Health Improvement and Disparities).

Babies born prematurely (before 37 weeks of gestation) often experience a range of poor health and other outcomes including higher risk of death. As well as being a cause of poor health in children, premature births are associated with poor maternal health, particularly smoking in pregnancy.

Rates of premature births are higher in Oldham and Rochdale than Bury and England. And while premature birth rates have remained roughly the same in Bury and England, rates of premature birth have increased in Oldham and Rochdale, starting from the 2010-12 period.

**Figure 4: Babies born prematurely (before 37 weeks gestation)**

Crude rate per 1,000 births 2018/19 to 2022/23



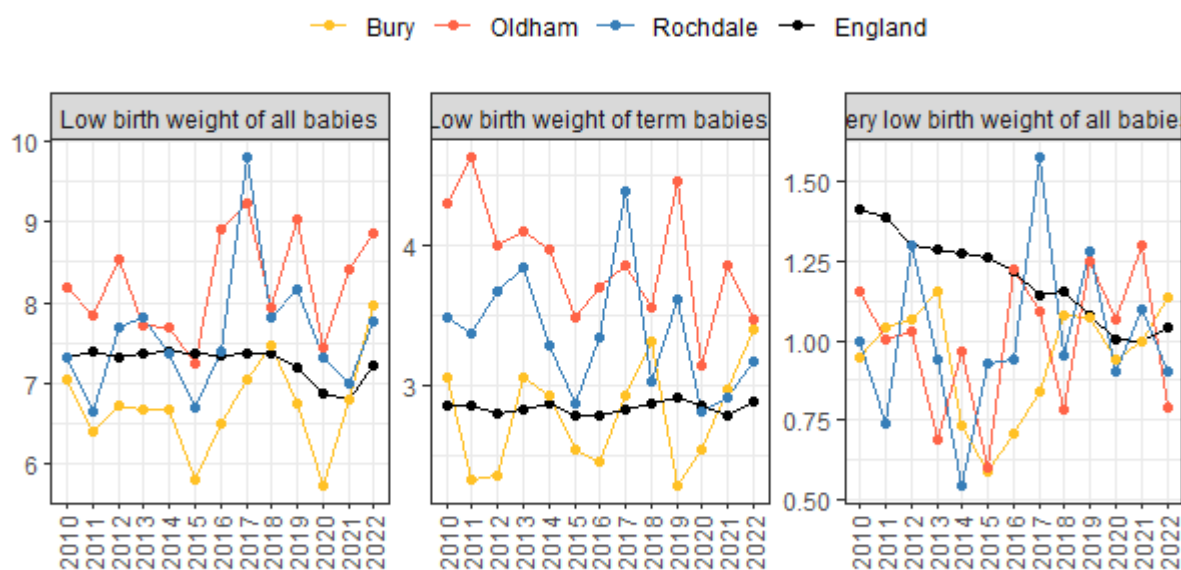
Source: Fingertips (Office for Health Improvement and Disparities). Crude rate of premature live births (gestational age between 24-36 weeks) and all stillbirths per 1,000 live births and stillbirths.

Children born at low birth weights (less than 2.5 kg) are also at higher risk of dying and poor health. Premature birth is one cause of low birth weights so separate indicators are available for babies born after 37 weeks of gestation as well as for all babies. Figure 5 shows babies born at less than 2.5kg as a percentage of all live births (left panel) and of all births of babies born after at least 37 weeks gestation (middle panel). The right panel shows the percentage of all babies born at very low birth weight (less than 1.5kg).

The numbers involved for Bury, Rochdale, and Oldham are small in each year and the data are noisy as a result. Rochdale and Oldham have tended to have a higher proportion of babies born at low birth weights, whereas Bury has tended to be similar to the national average, although the proportion of babies born at low birth weight increased in Bury for at least the three most recent years' data (2020 – 2022). While England saw a decrease in the proportion of babies born at very low birth weight, no such trend exists for Bury, Rochdale, or Oldham.

**Figure 5: Low birth weight babies**

Percent of all births, 2014/15 to 2022/23



Source: Fingertips (Office for Health Improvement and Disparities). Babies are considered low birth weight if they weigh less than 2,500g at birth and very low birth weight if they weigh less than 1,500g. Babies are considered born at term if they are born after 37 weeks of gestation.

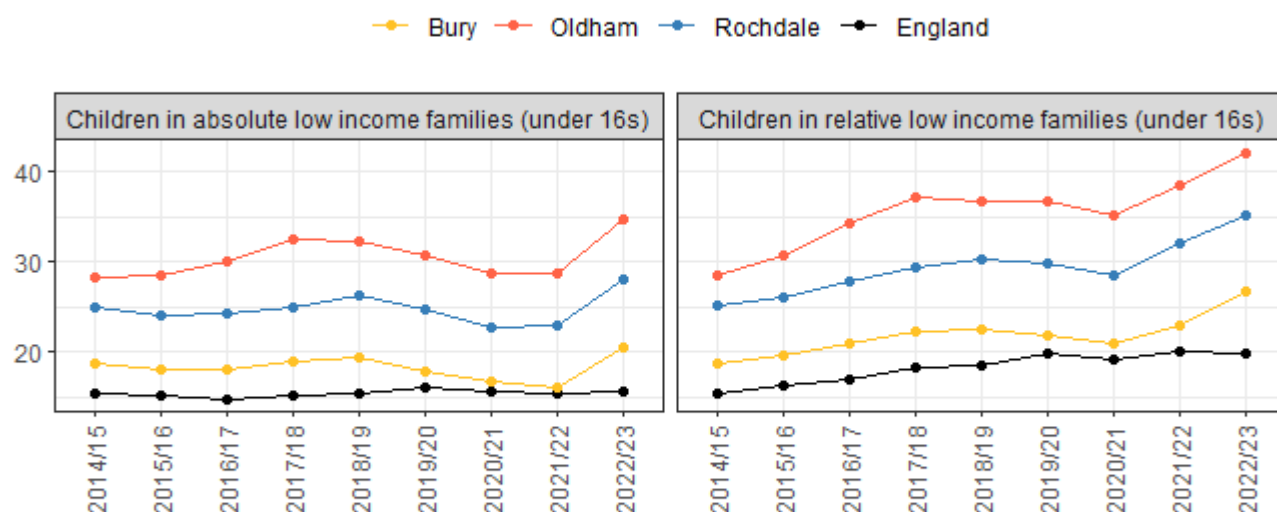
### 5.3 Poverty and children in care

Poverty is a major cause of child deaths and poor health. Families living in poverty often lack access to the basic building blocks of health, such as good quality housing, good diets, safe outdoor environments in which to plan and be physically active. Poverty also causes stress and mental illness, increasing the risk of childhood neglect or abuse or domestic violence. Families on low incomes are also more likely to be exposed to environmental hazards such as air pollution. And access to healthcare also tends to be worse for people living in poverty.

Figure 6 shows the proportion of children living in low-income families. Low income can be defined in absolute or relative terms. A household is in relative low income if household receives less than 60% of the median household income. A household in absolute low income is one which receives less than 60% of the median household income in 2010/11, updated to match inflation. This is designed to assess how low-income households are faring with reference to inflation. Figure 7 shows the number of households with children who are registered homeless per 1,000 households with children. Both child poverty and homelessness indicators have worsened markedly since 2020/21. Figure 8 shows the numbers of children in care per 10,000 children. All three local authorities covered in this report have a greater proportion of children in care than the national average, particularly Rochdale. Bury and Oldham saw increases between 2018/19 and 2021/22 which reflect a national trend. In the most recent data (2023/24) Rochdale and Bury's rates of children in care remain stable or decline slightly, while Oldham's rate increased markedly.

**Figure 6: Proportion of children in low income families**

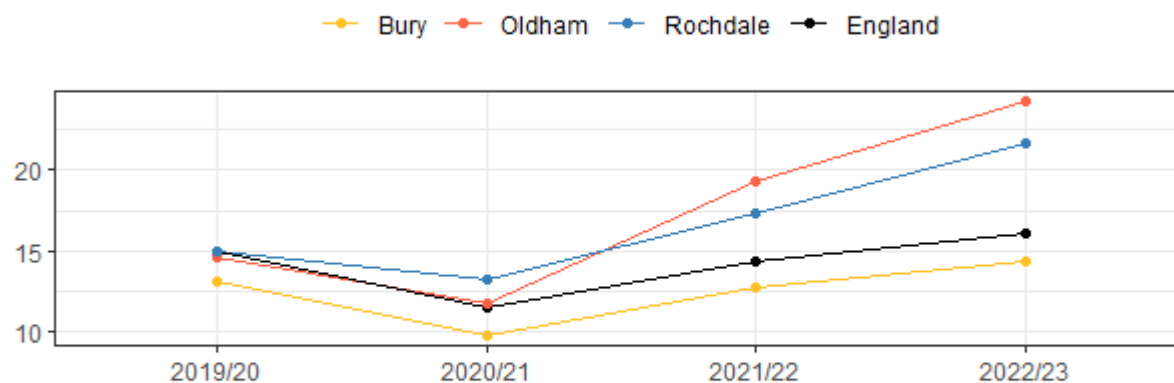
Percent, 2014/15 to 2022/23



Source: Fingertips (Office for Health Improvement and Disparities). Percentage of children (under 16 years) in a local area. Absolute low income is defined as a family in low income Before Housing Costs (BHC) in the reference year in comparison with incomes in 2010 to 2011. A family must have claimed one or more of Universal Credit, Tax Credits or Housing Benefit at any point in the year to be classed as low income.

**Figure 7: Homeless households with children**

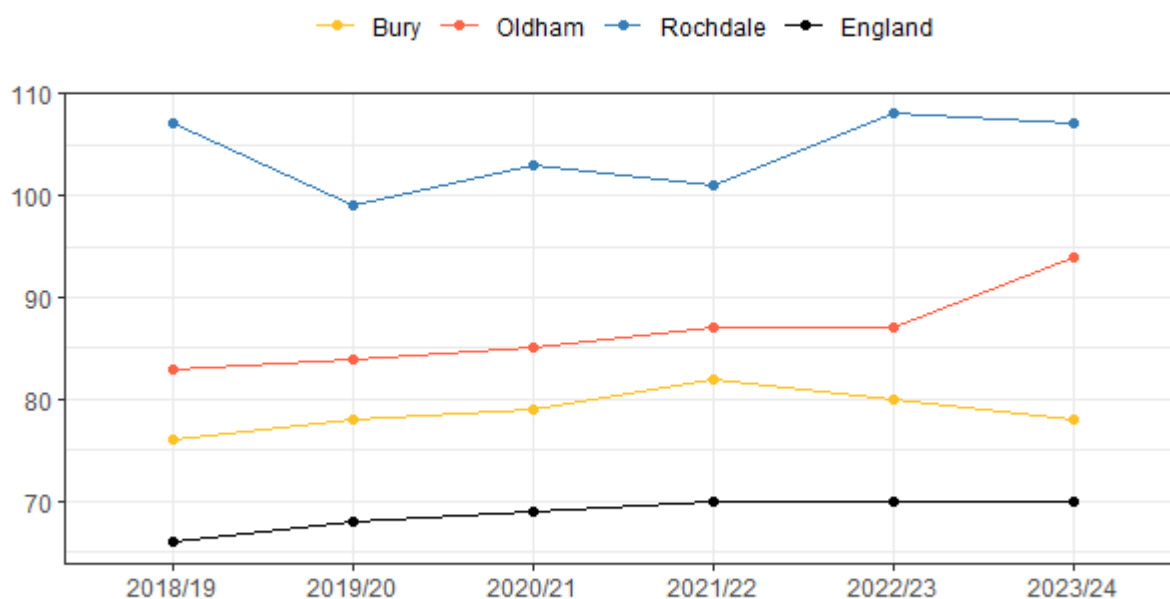
Rate per 1,000 households with children 2019/20 to 2022/23



Source: Fingertips (Office for Health Improvement and Disparities). Households including one or more dependent children owed a prevention or relief duty under the Homelessness Reduction Act, crude rate per 1,000 estimated households that include at least one dependent child. Children are dependent if they're under 18 and living at home. An 18 year old can also count as dependent if they're in full time education or can't support themselves for other reasons, and they live at home.

**Figure 8: Children in care**

Rate per 10,000 children 2018/19 to 2022/23



Source: Fingertips (Office for Health Improvement and Disparities). Children looked after at 31 March on the given year as a rate per 10,000 population aged under 18 years.

## 6. Mortality statistics

Figure 9 shows mortality rates for children aged 1 to 17 years, the infant mortality rate which reflects deaths in those aged 0 to 1 year old, the neonatal mortality rate which covers deaths in babies aged 0 to 28 days old and the post-neonatal mortality rate which covers deaths of babies aged 29 days to 1 year old. Due to the small numbers of deaths covered, trends are harder to discern.

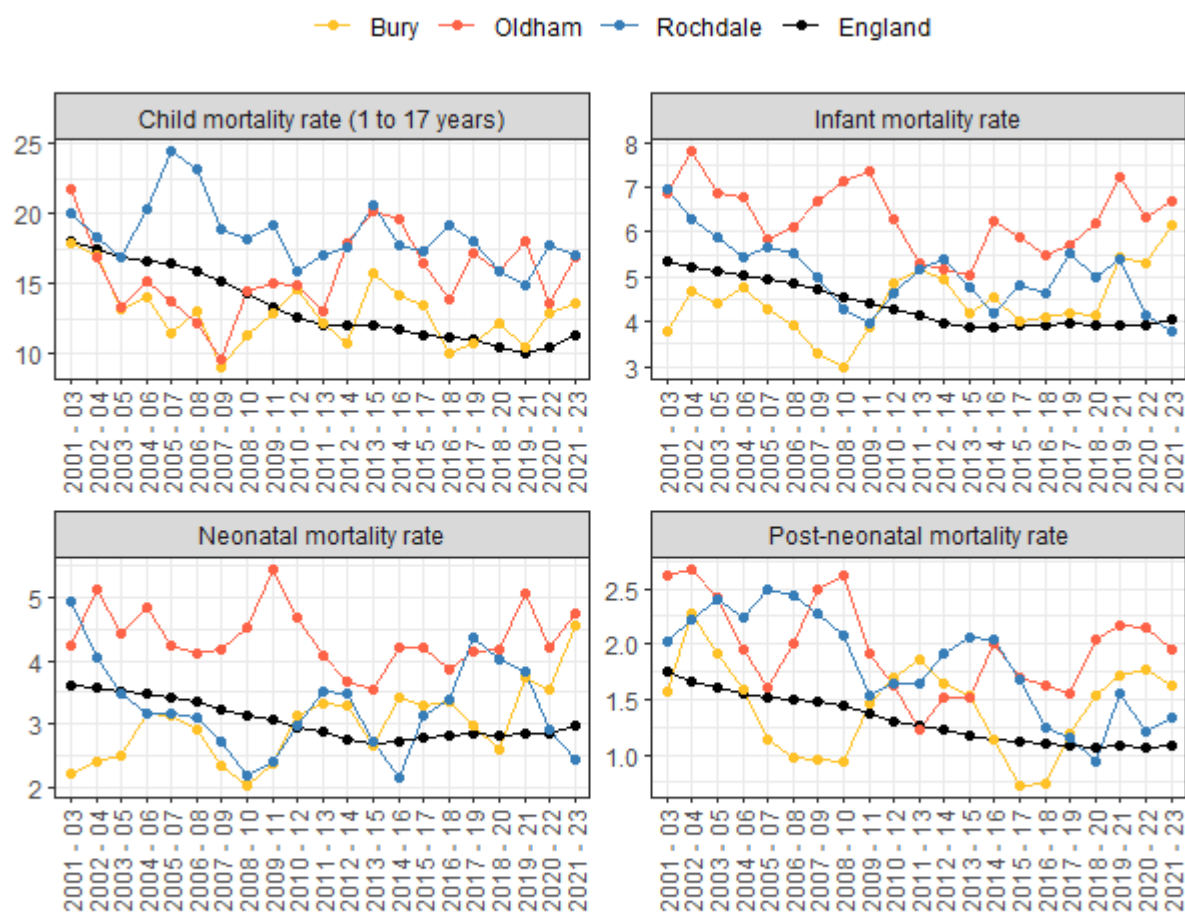
Oldham and Rochdale's child mortality rates have been higher than the national average in every period whereas child mortality in Bury has been closer to the national average, although the 2020-22 and 2021-23 periods saw increases in Bury's child mortality rate.

Infant mortality rates in Oldham have been consistently higher than the national average, and both neonatal and post-neonatal mortality has contributed to this. Infant mortality in Rochdale appears to fall between 2001-03 and 2009-11 before levelling off and then falling again in 2020-22 and 2021-23. Infant mortality in Bury was below or similar to the England average between 2001-03 and 2009-11 after which it has roughly followed the national trend until 2019-21 when infant mortality rates start to increase.

Figure 10 shows the rate of deaths and serious injuries among children aged 0 to 15 years in road traffic accidents. These appear to have decreased slightly up to 2012-14 after which they have remained stable across all three areas.

**Figure 9: Child, infant, neonatal, and post-neonatal mortality rates**

Rate per 1,000

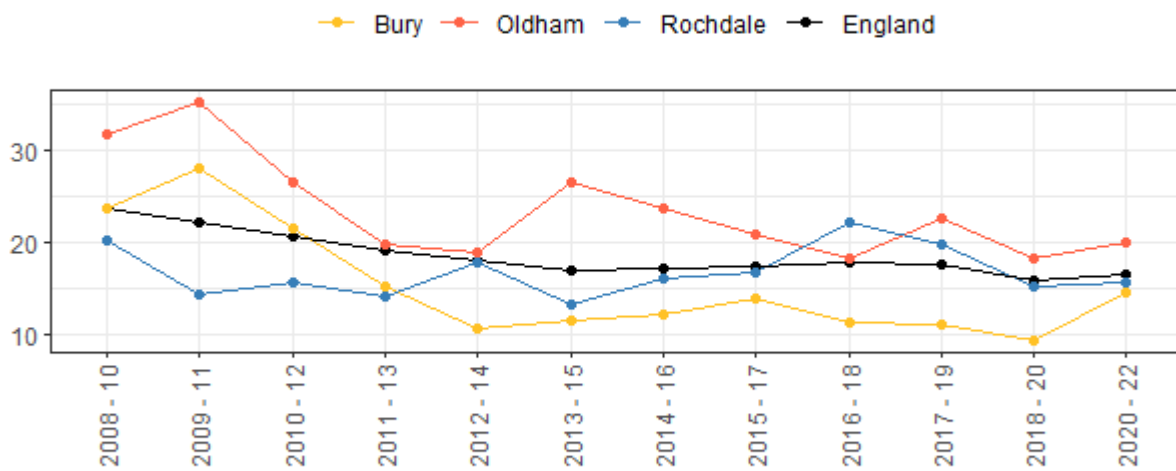


Source: Fingertips (Office for Health Improvement and Disparities). Child mortality rate: number of deaths in children aged 1 to 17 years per 1,000 population aged 1-17. Infant mortality rate: number of deaths in babies aged under 1 year per 1,000 live births in the same year. Neonatal mortality rate: the number of deaths in the first 28 days of life per 1,000 live births. Post-neonatal mortality rate: the number of deaths in babies aged 29 days to 1 year per 1,000 live births.



**Figure 10: Children aged 0-15 killed or seriously injured in road traffic accidents**

Rate per 100,000 children 2008-10 to 2020-22



Source: Fingertips (Office for Health Improvement and Disparities). The number of children aged 0-15 years that were killed or seriously injured in road traffic collisions per 100,000 population aged 0-15 years. Rolling three year averages.

## 7. Notified deaths

### 7.1 Notified by local authority area of residence and year of death

Table 4 shows the numbers of deaths reported to the Bury, Rochdale, and Oldham CDOP by local authority of residence and financial year in which the child died. As the number of deaths is related to the size of the population, the table also provides the population aged 0-17<sup>2</sup>, the child mortality rate per 100,000 children, and 95% confidence intervals for the rate. Death numbers and rates are shown graphically in figures 11 and 12.

**Table 4: deaths and death rates reported to CDOP by local authority and year**

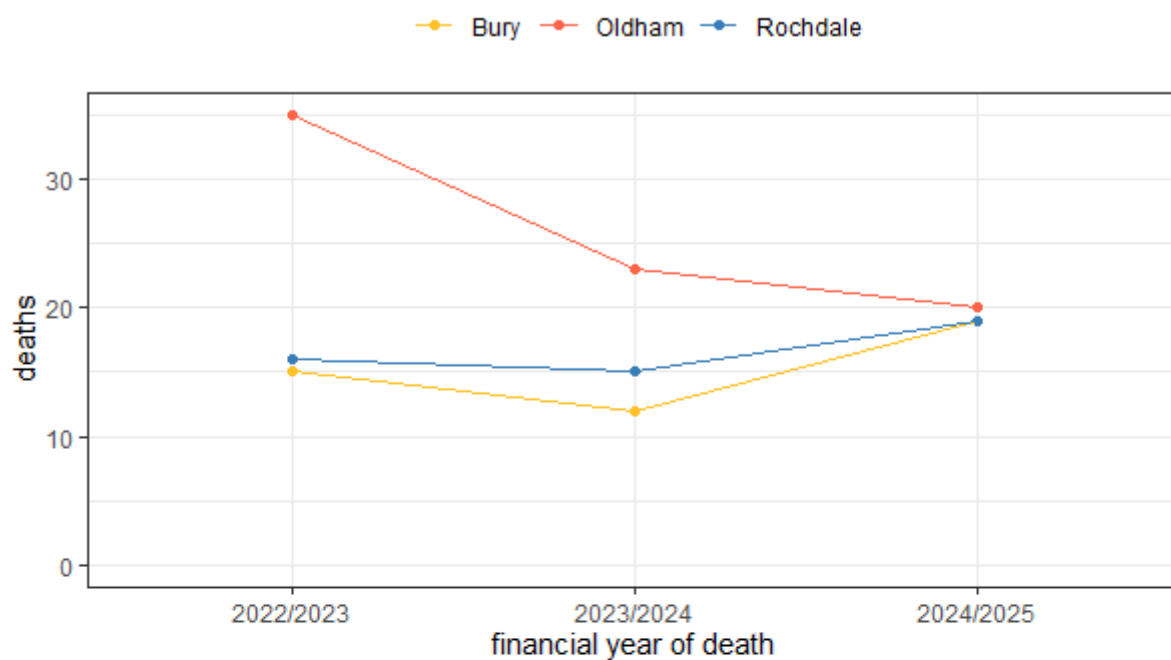
Financial year	Local authority	deaths	population	rate per 100k	95% confidence interval	
2022/2023	Bury	15	43,841	34.2	19.1	56.4
2023/2024	Bury	12	43,965	27.3	14.1	47.6
2024/2025	Bury	19	44,039	43.1	26	67.3
2022/2023	Oldham	35	62,401	56.1	39.1	78
2023/2024	Oldham	23	62,995	36.5	23.1	54.8
2024/2025	Oldham	20	63,667	31.4	19.2	48.5
2022/2023	Rochdale	16	55,556	28.8	16.5	46.7
2023/2024	Rochdale	15	56,376	26.6	14.9	43.8
2024/2025	Rochdale	19	57,289	33.2	20	51.8

Due to the small numbers of deaths, differences between local authority areas and between different years are not statistically significant and could be due to chance variation. That important caveat aside, numbers and rates of deaths fell in Oldham between 2022/23 and 2024/24. Numbers and rates of deaths increased in Bury and Rochdale between 2023/24 and 2024/25.

<sup>2</sup> Population data were derived from the ONS mid-year population estimates tool. Population estimates were not available for 2024/25 so populations were estimated by extrapolating population growth from 2021/22 to 2023/24 in each area to the following year.

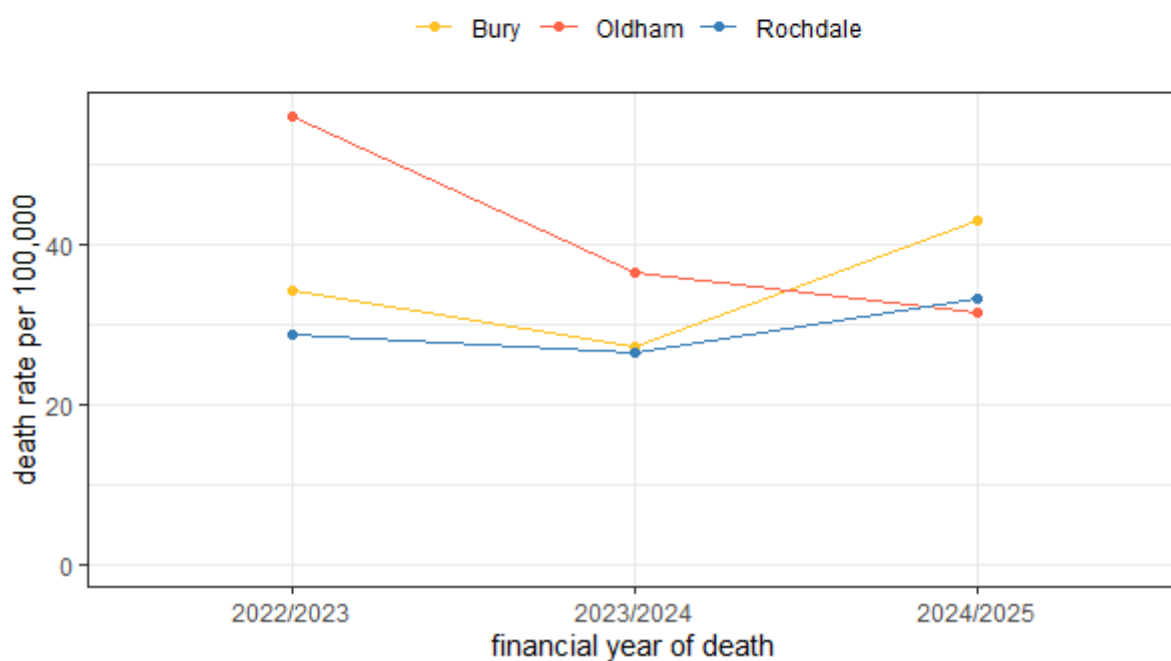
**Figure 11: deaths reported by financial year of death**

Bury, Oldham, and Rochdale. 2022/23 - 2024/25



**Figure 12: deaths rates per 100k by financial year of death**

Bury, Oldham, and Rochdale. 2022/23 - 2024/25



## 7.2 Notified deaths by gender and year of death

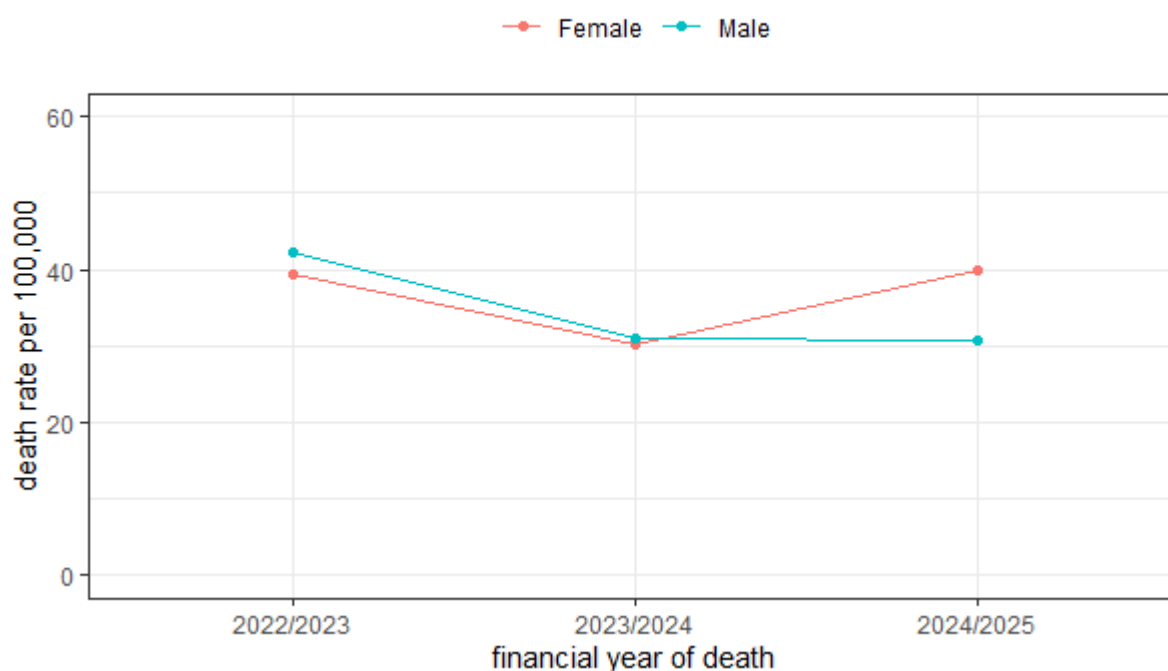
Table 5 shows deaths and death rates per 100,000 children by year and gender, combined across Bury, Rochdale, and Oldham. Numbers of deaths and death rates were similar between male and female children. A slight decrease in the number of deaths reported between 2022/23 and 2023/24 was seen in both male and female children, followed by a slight increase in Female deaths in 2024/25. However, this decrease may still be due to chance variation, rather than a meaningful reduction in child mortality rates. Figure 13 presents death rates by gender and financial year in which the child died.

**Table 5: deaths reported to CDOP by gender and year**  
**Bury, Rochdale, and Oldham 2022/23 – 2024/25**

Financial year	Gender	Deaths	Population	Rate per 100k	95% confidence interval	
2022/2023	Female	31	78,854	39.3	26.7	55.8
2023/2024	Female	24	79,524	30.2	19.3	44.9
2024/2025	Female	32	80,316	39.8	27.2	56.2
2022/2023	Male	35	82,944	42.2	29.4	58.7
2023/2024	Male	26	83,812	31	20.3	45.4
2024/2025	Male	26	84,679	30.7	20.1	45

**Figure 13: deaths rates per 100k by gender and financial year of death**

Bury, Oldham, and Rochdale. 2022/23 - 2024/25



### 7.3 Notified deaths by age at death

Table 6 shows numbers of deaths reported in Bury, Rochdale, and Oldham between 2021/22 and 2023/24. Because numbers of deaths are small, the data are presented for all three years and all three areas combined. These data are presented graphically in figure 14<sup>3</sup>.

Numbers and rates of deaths were significantly higher in children aged under 1 year, consistent with national data that this is the time when the risk to a child's life is highest. Death rates were significantly higher among children aged 15-17 than among children aged 5-9 or 10-14.

**Table 6: Deaths reported by age group**  
**Bury, Rochdale, and Oldham, 2021/22 to 2023/24**

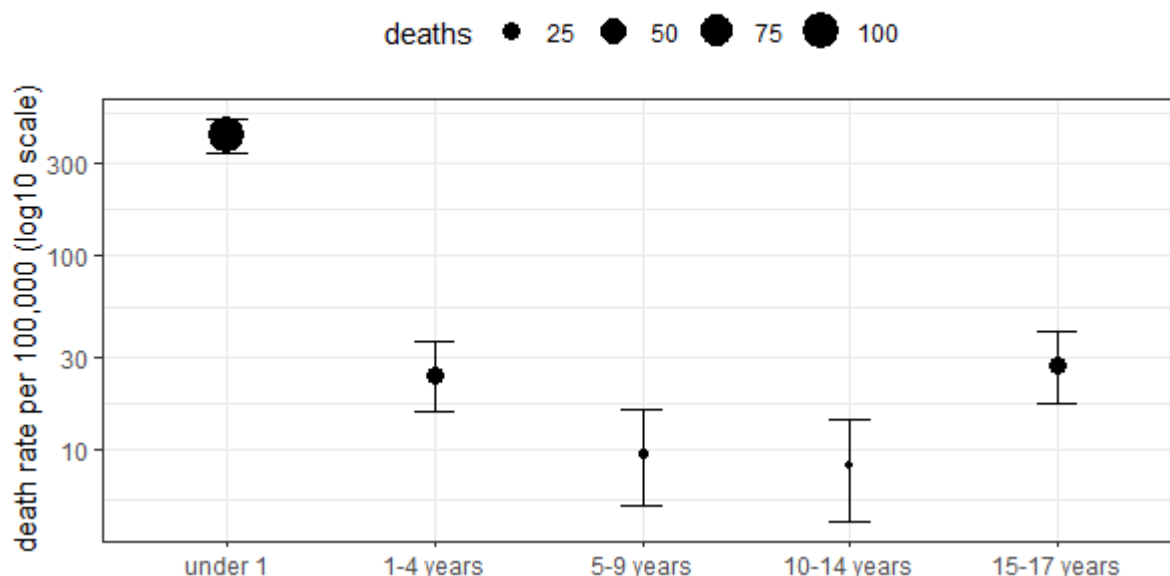
Age group	Deaths	Population	Rate per 100k	95% confidence interval	
under 1	101	23,929	422.1	343.8	512.8
1-4 years	25	102319	24.4	15.8	36.1
5-9 years	13	136,543	9.5	5.1	16.3
10-14 years	12	144,386	8.3	4.3	14.5
15-17 years	23	84,709	27.2	17.2	40.7

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<sup>3</sup> Due to the much higher mortality rate in children under 1, this graph uses a logarithmic scale for death rates. This makes variation in death rates in older children easier to see.

**Figure 14: deaths rates per 100k by age at death**

Bury, Oldham, and Rochdale. 2022/23 - 2024/25



### 7.3 Notified deaths by ethnicity

Table 7 shows death numbers and approximate rates<sup>4</sup> by ethnic category for Bury, Oldham, and Rochdale from 2021/22 to 2023/24. Death rates are presented graphically in figure 15.

Although there were more deaths among White British children, death rates were higher for most other ethnic groups. Small numbers mean that in most cases the apparent higher cases may be due to chance variation, except for children of Asian and 'other' ethnic backgrounds where death rates appear to be significantly higher than for their White British counterparts.

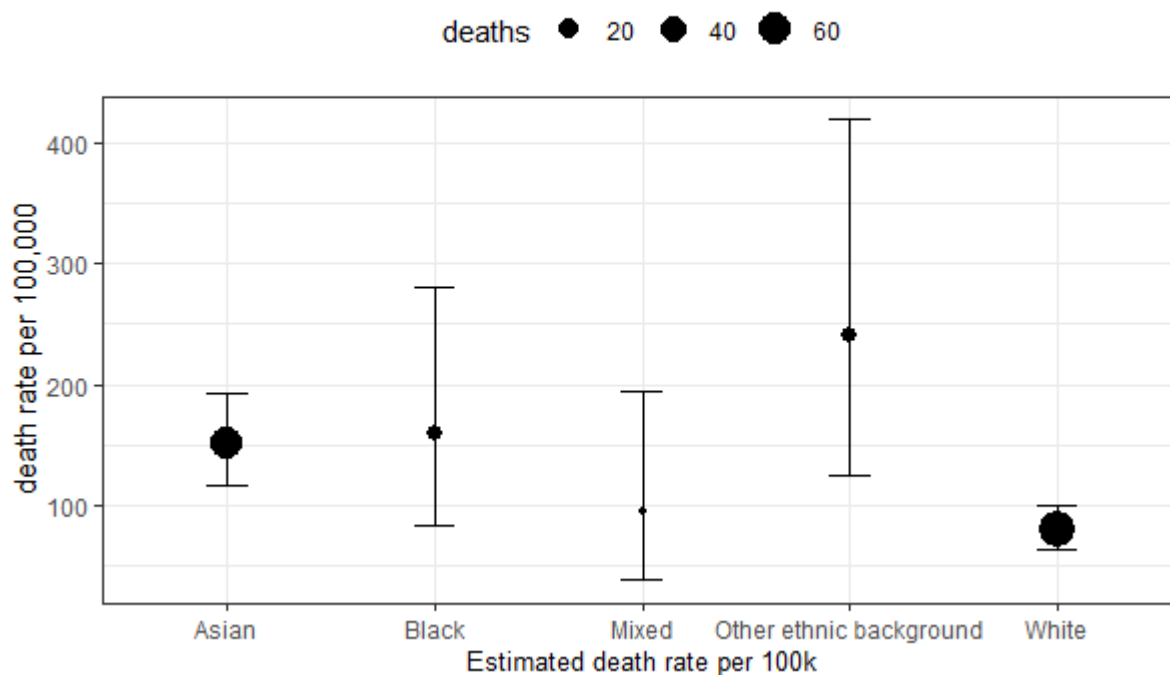
**Table 7: Deaths and approximate rates by broad ethnic background**  
Bury, Rochdale, and Oldham, 2022/23 – 2024/25

Ethnic category	Deaths	Population	Rate per 100k	95% confidence interval	
White	78	97,087	80.3	63.5	100.3
Asian	63	41,672	151.2	116.2	193.4
Black	12	7,484	160.3	82.8	279.6
Other ethnic background	12	4,993	240.3	124	419.1
Mixed	7	7,398	94.6	37.9	194

<sup>4</sup> Mid-year population estimates are not available by ethnicity and age. The nearest data that are available are from the 2021 census which gives an age and ethnicity breakdown of the census population. The rates have been calculated by dividing the number of deaths in each ethnic category over the three years 2021/22 to 2023/24 by three times the combined 0-17 populations for Bury, Rochdale, and Oldham.

**Figure 15: deaths rates per 100k by age at death**

Bury, Oldham, and Rochdale. 2022/23 - 2024/25



#### 7.4 Notified deaths by deprivation

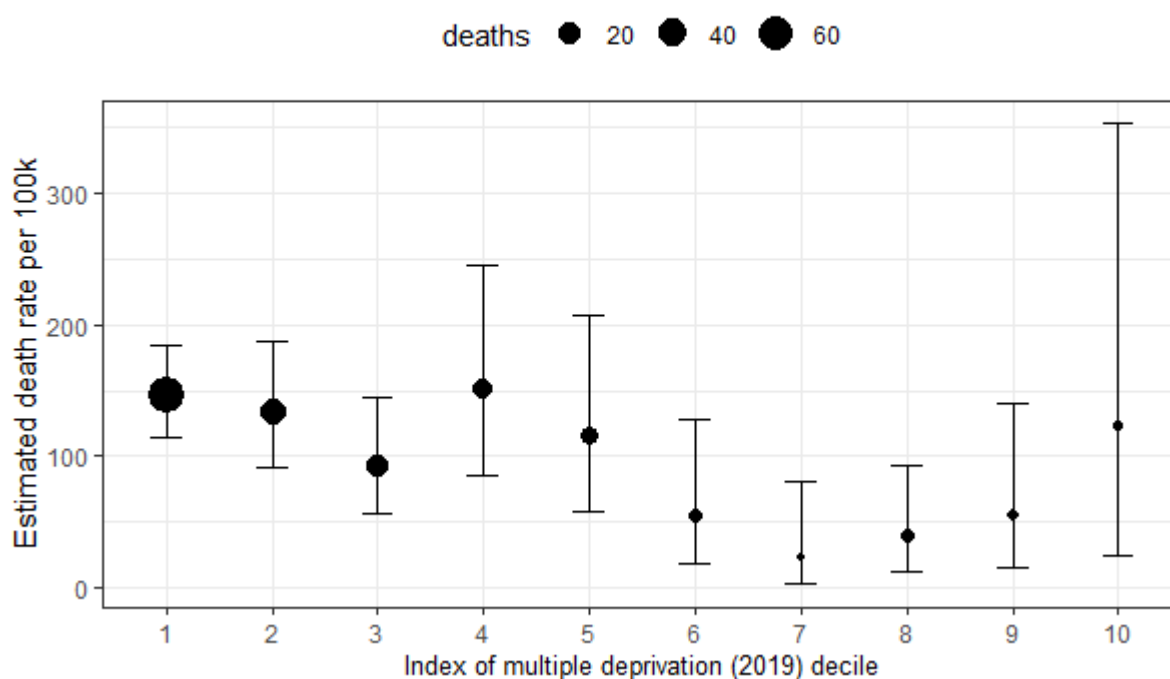
The Index of Multiple Deprivation gives a measure of the deprivation experienced by populations living in small areas (lower super output areas, with populations of around 1,500). Table 8 shows the number of notified deaths by decile of deprivation. More children died in areas of higher deprivation than in less deprived areas. However, the combined population of Bury, Rochdale, and Oldham is more deprived than England as a whole. This is reflected in greater numbers of children living in deciles 1, 2, and 3. Nevertheless, death rates were higher in the more deprived areas than in less deprived areas. This reflects the effects of poverty and higher rates of low birth weight, homelessness, and other risks described in section 5 above in these areas. These data are presented graphically in figure 16.

**Table 8: Deaths and death rates by decile of deprivation, Bury, Rochdale, and Oldham, 2021/22-2023/24**

IMD (2019) decile	Population aged 0-17	Deaths	Rate per 100k	95% Confidence interval	
1 (most deprived)	49,084	72	146.7	114.8	184.7
2	24,689	33	133.7	92	187.7
3	20,425	19	93	56	145.2
4	10,606	16	150.9	86.2	244.7
5	9,488	11	115.9	57.8	207
6	9,066	5	55.2	17.8	127.6
7	8,558	2	23.4	2.6	80.9
8	12,474	5	40.1	12.9	92.7
9	7,202	4	55.5	14.9	140.3
10 (least deprived)	2,431	3	123.4	24.8	352.9

**Figure 16: deaths rates per 100k by age at death**

Bury, Oldham, and Rochdale. 2022/23 - 2024/25





## 8. Analysis of deaths reviewed

### 8.1 Numbers of deaths reviewed

This section describes the activity of the Bury, Rochdale, and Oldham CDOP for the financial years 2021/22, 2022/23, and 2023/24 in terms of numbers of child deaths reviewed.

Because the deaths reviewed in these years happened between 2017/18 and 2022/23 and the population denominators changed over that time, it is not appropriate to express numbers of deaths as rates. For this reason this section only counts of deaths reviewed are presented.

Table 9 gives the number of deaths reviewed by the local authority area in which the child was living at the time they died and the financial year in which the death was reviewed.

**Table 9: Numbers of deaths reviewed by local authority and year reviewed**

Year reviewed	Bury	Oldham	Rochdale	Total
<b>2022/23</b>	8	19	8	35
<b>2023/24</b>	15	18	17	50
<b>2024/25</b>	21	34	17	72
<b>Total</b>	44	71	42	157

Due to the variable length of the child death review process, many CDOP reviews do not happen in the year in which the child died. Table 10 shows the numbers of deaths reviewed by year the child died and the year the CDOP review was completed.

**Table 10: Numbers of deaths reviewed by year reviewed and year of death**

	Year reported						
Year reviewed	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	Total
<b>2022/23</b>	1	9	14	11	0	0	35
<b>2023/24</b>	2	1	15	15	17	0	50
<b>2024/25</b>	0	0	2	3	45	22	72
<b>Total</b>	3	10	31	29	62	22	157

Table 11 shows the number of child deaths notified to CDOP and the number of child deaths reviewed each year for 2022/23 to 2024/25.

**Table 11: Numbers of deaths notified to CDOP and reviewed by CDOP by year**

<b>Year</b>	<b>Deaths notified</b>	<b>Deaths reviewed</b>
<b>2022/2023</b>	66	35
<b>2023/2024</b>	50	50
<b>2024/2025</b>	58	72

The number of child deaths notified to CDOP exceeded the number of deaths reviewed in 2022/23 and in previous years. This was a result of both limited CDOP officer capacity, limited panel time, impacts of COVID-19 on child death review processes in 2020 and 2021, and delays in receiving key information from partners. This led to a backlog of unreviewed cases has built up.

In response CDOP panel meetings for Bury, Rochdale, and Oldham have been extended from half days to full days. This has increased the numbers of cases reviewed per panel to 25 in March 2025. This contributed to the increase in cases reviewed in 2023/24 and in 2024/25 when 14 more cases were closed than were notified. If continued, this provides capacity to review up to 100 cases per year.

As of the 31<sup>st</sup> of March 2024, the backlog stood at 156 cases. This was a decrease of 12 from the same date in 2024. Assuming the panel can continue to close 25 cases per panel, the backlog should decrease by around 40 cases per year. It is worth noting that the 'backlog' will never reach zero as it includes cases for which the panel is awaiting information from partners, including where inquests are ongoing.

## 8.2 Demographics of deaths reviewed

Table 12 presents the numbers of child deaths reviewed by the Bury, Rochdale, and Oldham CDOP. Table 13 presents the numbers of child deaths reviewed by the Bury, Rochdale, and Oldham CDOP by ethnic category.

**Table 12: Number of deaths reviewed by age and gender  
Bury, Rochdale, and Oldham, 2021/22 – 2022/23**

Age Group	Female deaths	Male deaths	Total
0-27 days	25	21	46
28-364 days	15	28	43
1-4 years	8	9	17
5-9 years	6	6	12
10-14 years	7	12	19
15-17 years	7	13	20
<b>Total</b>	25	21	46

**Table 13: Number of deaths reviewed by ethnicity  
Bury, Rochdale, and Oldham, 2021/22 - 2022/23**

Ethnic category	Deaths reviewed
White	80
Asian	52
Black	10
Mixed	8
Other ethnic background	4
Ethnicity not known	3
<b>Total</b>	157

### 8.3 Deaths reviewed by category of death, pre-existing conditions, and learning disability

All CDOP panels use a standard set of categories of death to describe the broad cause of death based on the information available to them. A list of the standard categories of death is provided in Appendix B. The most common category of death was ‘chromosomal, genetic, and congenital anomalies’. This category includes deaths due to extra copies of chromosomes, single gene disorders, cystic fibrosis, congenital heart anomalies, and neurodegenerative conditions. Although this was the most common cause when deaths across the three areas were combined and for Oldham and Rochdale, the most common category of death for Bury was ‘perinatal and neonatal event’. This was the second most common category of death for Oldham and Rochdale. This category includes deaths due to extreme prematurity and its consequences, such as lung or intestinal diseases.

**Table 14: Numbers of death by category of death, Bury, Rochdale, and Oldham, 2021/22 - 2023/24**

Category of death	Bury		Rochdale		Oldham		Total
	n	%	n	%	n	%	
Chromosomal, genetic and congenital anomalies	6	13.6	12	28.6	25	35.2	43
Perinatal/neonatal event	9	20.5	5	11.9	19	26.8	33
Sudden unexpected, unexplained death	7	15.9	4	9.5	4	5.6	15
Trauma and other external factors, including medical/surgical complications/error	5	11.4	3	7.1	7	9.9	15
Acute medical or surgical condition	6	13.6	4	9.5	3	4.2	13
Malignancy	3	6.8	4	9.5	3	4.2	10
Infection	1	2.3	4	9.5	3	4.2	8
Chronic medical condition	1	2.3	2	4.8	4	5.6	7
Deliberately inflicted injury, abuse or neglect	2	4.5	4	9.5	1	1.4	7
Suicide or deliberate self-inflicted harm	4	9.1	0	0	2	2.8	6
<b>Total</b>	<b>44</b>	<b>100</b>	<b>42</b>	<b>99.9</b>	<b>71</b>	<b>99.9</b>	<b>157</b>

As shown in table 15 of the 157 deaths reviewed over the three years from April 2022 to March 2025, 79 were of children with pre-existing medical conditions. This represents 50.3% of all deaths. This does not mean that the pre-existing medical condition was the cause of death, though this is likely to be the case for those deaths categorised as due to chronic medical conditions or chromosomal, genetic and congenital anomalies.

**Table 15: Deaths reviewed where a pre-existing medical condition was present**  
**Bury, Rochdale, and Oldham, 2022/23 - 2024/25**

Pre-existing medical condition	Deaths	Percent
Yes	79	50.3%
No	36	22.9%
Not known	23	14.6%
Not Applicable	19	12.1%

Table 16 shows the numbers and percentage of deaths by whether the child had a diagnosed learning disability. In many cases (over 40%) this category was not applicable, in most cases because the child was too young for a learning disability to be diagnosed: of the 65 child deaths where learning disability status was 'not applicable', 30 were neonates aged under 28 days, 31 were aged under 1 year, and 4 were aged 1-4 years old.

**Table 16: Deaths reviewed by whether the child had a diagnosed learning disability**  
**Bury, Rochdale, and Oldham, 2022/23 – 2024/25**

Learning disability	Deaths	Percent
Yes	22	14%
No	40	25.5%
Not known	30	19.1%
Not applicable	65	41.4%

## 8.4 Deaths reviewed by presence of contributing factors

The main purpose of CDOP is to identify factors that contributed to the deaths of children reviewed with a focus on common modifiable factors that could be changed to prevent other children from dying in future.

Potentially modifiable factors contributing to deaths are grouped into four 'domains':

- **Domain A:** factors intrinsic to the child, such as low birth weight, genetic or chromosomal abnormalities, or poor maternal health.
- **Domain B:** factors in social environment including family and parenting capacity. This includes smoking, drug use, and domestic violence in the household as well as wider social risks, such as issues with peer groups or at school.
- **Domain C:** factors in the physical environment, such as inadequate or absent safety equipment or access to open water.
- **Domain D:** factors in service provision, such as when a service fails to follow its procedures and guidance, or when two or more services fail to communicate or work together appropriately.

However, the presence of these factors does not necessarily mean that factor could have been modified in that case. CDOP makes a judgement on whether each factor was modifiable or not. Table 17 presents numbers and percentages of deaths where modifiable factors were identified by CDOP.

**Table 17: Deaths reviewed by modifiable factors contributing to deaths**  
**Bury, Rochdale, and Oldham, 2022/23 – 2024/25**

Factors present	Any factors	Domain A	Domain B	Domain C	Domain D
Absent	47 (30%)	107 (68%)	100 (64%)	127 (81%)	97 (62%)
Present	110 (70%)	50 (32%)	57 (36%)	30 (19%)	60 (38%)

Potentially modifiable factors contributing to deaths were identified in 110 (70%) of 129 deaths reviewed by the Bury, Rochdale, and Oldham CDOP between April 2022 and March 2025. Factors in domain B (relating to the social environment) and domain D (relating to service provision) were most common, identified in 36% and 38% of deaths respectively.

Table 18 shows the proportion of deaths reviewed where potentially modifiable factors were identified broken down by age group. This shows some variation in which domains potentially modifiable factors identified fell into by age group, however the small numbers of deaths in each age group over the three years means that any variations need to be treated with caution. The relative scarcity of factors relating to the physical and social environments in neonatal deaths is plausible as many of these children never leave hospital following birth. Factors intrinsic to the child, such as prematurity, congenital or genetic disease, or poor maternal health (smoking, high BMI) are more common in this age group, identified in 50% of cases reviewed. Factors relating to the social environment (such as smoking, alcohol

misuse, drug use, or domestic violence) were more common in children who died between 28 days and 9 years, identified in 75% of deaths in children aged between 5 and 9. Factors relating to the physical environment, such as lack of appropriate safety features were also most commonly identified in deaths of children aged 5 to 9 years, found in 41.7% of cases reviewed. Factors relating to service provision were identified in a similar proportion of all deaths. These typically relate to delays in care, failure to follow appropriate protocols, and poor communication between agencies.

**Table 18: Deaths reviewed by age group and modifiable factors present**  
**Bury, Rochdale, and Oldham, 2022/23 – 2024/25**

Age Group	deaths	Domain A factors present		Domain B factors present		Domain C factors present		Domain D factors present	
		n	%	n	%	n	%	n	%
0-27 days	46	23	50	9	19.6	4	8.7	19	41.3
28-364 days	43	14	32.6	23	53.5	11	25.6	12	27.9
1-4 years	17	3	17.6	7	41.2	3	17.6	9	52.9
5-9 years	12	3	25	9	75	5	41.7	4	33.3
10-14 years	19	3	15.8	5	26.3	4	21.1	6	31.6
15-17 years	20	4	20	4	20	3	15	10	50

### *Specific modifiable factors: maternal over/under weight*

Both high and low maternal bodyweight is associated with increased risk of child death. Mechanisms involved include higher risk of birth asphyxia in children of mothers with BMIs greater than 30 and at higher levels of obesity increased risk of congenital anomaly.<sup>5</sup>

High maternal BMI was identified as a factor in 22 deaths (14% of all deaths reviewed), 14 of which occurred before the baby was 28 days old and a further 6 occurred before the child's first birthday. 10 of 22 deaths where high maternal BMI was recorded were categorised as 'chromosomal, genetic, and congenital anomalies' and 7 of 22 were categorised as 'perinatal or neonatal events'.

### *Specific modifiable factors: consanguinity*

Genetic relatedness (consanguinity) between parents increases the risk of congenital abnormalities and early child death. This is in part due to the higher risk of severe autosomal

<sup>5</sup> Thornton et al (2023) [Non-linear associations of maternal pre-pregnancy body mass index with risk of stillbirth, infant, and neonatal mortality in over 28 million births in the USA: a retrospective cohort study](#); Johannsen et al (2014) [Maternal overweight and obesity in early pregnancy and risk of infant mortality: a population based cohort study in Sweden](#).

recessive diseases (where two copies of the disease-causing gene are needed for the disease to occur)<sup>6</sup>.

Table 19 shows deaths reviewed broken down by whether the parents of the child were known to be blood relatives. Of the 157 deaths reviewed by CDOP over the three years from 2022/23 to 2024/25, 24 (15%) were of children born to parents who were known to be blood relatives. Parental relatedness was not known for a further 33 deaths (21% of deaths reviewed). Deaths of children whose parents were related involved children who died at all ages. The most common category of death identified for these deaths were 'chromosomal, genetic, and congenital anomalies' (14 of 24 deaths). Of 43 deaths reviewed that were categorised as due to this cause, 24 (56%) were in children whose parents were known to be close relatives.

**Table 19: Deaths reviewed where parents were known to be blood relatives**  
**Bury, Rochdale, and Oldham, 2022/23 - 2024/25**

<b>Are parents blood relatives</b>	<b>n</b>	<b>%</b>
No	100	64
Not known / not applicable	30	19
Yes	24	15

### *Specific modifiable factors: smoking, alcohol, and substance misuse*

Smoking, alcohol misuse, and substance misuse are risk factors for poor child and adult health. All three continue to be identified in reviews of child deaths across Bury, Rochdale, and Oldham.

Table 20 provides numbers of deaths where parental smoking, alcohol misuse, or substance misuse were identified. Data on these factors is not always recorded, so the numbers below should be taken as a minimum and are probably an underestimate. Smoking by the children who died is not reliably recorded but data are available on children who had known drug or alcohol misuse issues.

Smoking during pregnancy was identified by CDOP in 7 deaths (5% of those reviewed by the panel) between 2022/23 to 2024/25. All these deaths involved children aged under 6 months old. Smoking in the household (not necessarily during pregnancy) was identified in 23 deaths. Maternal smoking was identified in 21 deaths, paternal smoking in 11 deaths, and both parents smoking in 12 deaths. Alcohol and substance misuse in parents were less common and were identified in 8 and 13 deaths.

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<sup>6</sup> Olubunmi et al (2019) [A review of the reproductive consequences of consanguinity](#).



**Table 20: Deaths where smoking, alcohol, or substance misuse issues were identified**  
**Bury Oldham and Rochdale, 2022/23 – 2024/25**

<b>Modifiable factor</b>	<b>n</b>	<b>%</b>
Mother smoked during pregnancy	10	6.4
Mother smoked	29	18.5
Father smoked	17	10.8
Both parents smoked	14	8.9
Mother had an alcohol misuse issue	12	7.6
Father had an alcohol misuse issue	12	7.6
Both parents had an alcohol misuse issue	6	3.8
Mother had a substance misuse issue	8	5.1
Father had a substance misuse issue	16	10.2
Both parents had a substance misuse issue	4	2.5
Child had drug or alcohol issue	4	2.5

*Specific modifiable factors: unsafe sleeping arrangements*

There were 6 deaths where unsafe sleeping practices were identified. Five of these deaths were categorised as ‘sudden unexpected, unexplained death’ by CDOP, and made up 33.3% of 15 deaths in this category. The remaining death was categorised as due to a chromosomal, genetic, or congenital anomaly.

All 6 deaths were in babies aged 28-364 days old. In 4 of the 6 deaths where unsafe sleeping arrangements were noted there was also smoking in the household. In 5 of 6 deaths one or both parents were believed to be misusing alcohol.

The tendency of these risk factors to co-occur suggests that a combined strategy for tackling them may be appropriate.

## 9. Recommendations

Based on the analysis of deaths reported to and reviewed by CDOP, as well as of the publicly available data presented above, this report recommends that:

- **Child poverty:** Health and Wellbeing Boards should note the worsening in measures of child poverty and to work with local partners to ensure that local antipoverty plans address increases in childhood poverty.
- **Smoking, alcohol, and substance misuse:** Health and Wellbeing Boards, with partners, should continue to work to reduce smoking, alcohol, and drug misuse in pregnancy by:
  - Ensuring smoking status and alcohol or substance misuse problems are identified early by ensuring that pregnant people are asked about smoking status, alcohol use, and substance use, that this information is recorded, and referrals to appropriate services are made; and
  - Continuing wider work to reduce the prevalence of smoking, alcohol misuse, and substance misuse across the population and ensuring provision of smoking cessation and drug and alcohol treatment services.
- **Safe sleeping arrangements:** Health and Wellbeing Boards, with partners, should continue to promote safe sleeping practices, noting the possible relationship between unsafe sleeping arrangements and overcrowded or otherwise inappropriate housing and with alcohol use by parents. Safeguarding partnerships should ensure for children who have additional vulnerabilities that are captured in child protection or child in need plan.
- **Consanguinity:** Health and Wellbeing Boards should work with partners and community organisations to raise awareness of the increased risk of death and illness faced by children born to parents who are close blood relatives and assure themselves that genetic counselling and testing services are being offered appropriately.
- **Maternal healthy weight and nutrition:** reductions in high maternal body weight is likely best achieved by reducing high body weight in the population as a whole. This should include efforts to improve diet and exercise in childhood as well as adulthood and reduce inequalities. Health and Wellbeing Boards should assure themselves of plans to reduce obesity in the population, as well as that support with nutrition and appropriate exercise is available to pregnant people and to people planning to become pregnant.

## **Appendix A: 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.

## Appendix B: CDOP categories of death

Category	Name & description of category
1	<b>Deliberately inflicted injury, abuse, or neglect</b> This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.
2	<b>Suicide or deliberate self-inflicted harm</b> This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.
2 (i)	<b>Suicide (where the panel feels the intention of the child was to take their own life)</b>
2 (ii)	<b>Self-inflicted harm leading to death (where it is unclear if the child's intention was to take their own life)</b>
2 (iii)	<b>Death as the result of substance misuse (excluding deaths as a result of a deliberate overdose)</b>
3	<b>Trauma and other external factors, including medical/surgical complications/error</b> This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death. <b>Excludes</b> Deliberately inflicted injury, abuse, or neglect (category 1).
4	<b>Malignancy</b> Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
5	<b>Acute medical or surgical condition</b> For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.
6	<b>Chronic medical condition</b> For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. <b>Includes</b> cerebral palsy with clear post-perinatal cause.
7	<b>Chromosomal, genetic and congenital anomalies</b> Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.
8	<b>Perinatal/neonatal event</b> Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, post-haemorrhagic hydrocephalus, irrespective of age at death. It <b>includes</b> cerebral palsy without evidence of cause, and <b>includes</b> congenital or early-onset bacterial infection (onset in the first postnatal week).
8 (i)	<b>Immaturity/Prematurity related</b>
8 (ii)	<b>Perinatal Asphyxia (HIE and/or multi-organ failure)</b>
8 (iii)	<b>Perinatally acquired infection</b>
8 (iv)	<b>Other (please specify)</b>
9	<b>Infection</b> Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.
10	<b>Sudden unexpected, unexplained death</b> Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. <b>Excludes</b> Sudden Unexpected Death in Epilepsy (category 5).