

BRIEFING	TO:	Health and Wellbeing Board
	DATE:	29/03/2023
	LEAD OFFICER	Alex Hawley
	TITLE:	South Yorkshire CDOP Annual Report 2021-22

Background

1.1 Rotherham's Child Death Overview Panel (CDOP) has been in existence across England since 2008.

1.2 The [2018 Working together to safeguard children](#) guidance introduced changes to the child death review processes set out in new guidance: [Child death review: statutory and operational guidance \(England\) - GOV.UK \(www.gov.uk\)](#). A key change was to place the responsibility for constituting CDOPs with the local 'Child Death Review Partners' – the CCG (now ICB Place) and the local authority. Whilst no longer officially falling within the Safeguarding remit therefore, Rotherham chose to continue with the Safeguarding Children Partnership as the body providing its governing oversight.

1.3 CDOPs are statutory multi-agency entities, whose purpose is to review the death of every child resident in their area who dies before their eighteenth birthday. The only exceptions are stillbirths and planned legal terminations. The aim of the review is to identify "modifiable factors" – i.e. factors that may have contributed to the child's death that could have followed a different course. The overall purpose is to share learning in order to prevent child deaths.

1.4 Rotherham's CDOP is a member of the South Yorkshire CDOP (SYCDOP), which exists to conduct thematic reviews as described in the guidance above across a wider footprint. Whilst all individual case reviews are conducted at the place level, the annual reporting is produced at South Yorkshire level.

1.5 The host authority for chairing and administering SYCDOP rotates between the four localities on an annual basis. Rotherham was the host authority when the annual report for 2021-22 was produced.

1.6 The annual report has been taken to Rotherham Children's Safeguarding Partnership for approval (and through each of the other local area's governance arrangements) prior to publication here: <https://www.rscp.org.uk/downloads/file/155/south-yorkshire-child-death-overview-panel-annual-report-2021-2022>. The full report is provided to the Health and Wellbeing Board for information.

Key Issues

2.1 The report has the following structure:

Introduction: providing an overview of work done at South Yorkshire level, topics discussed, and plans in the pipeline

Thematic review: a report of a thematic review of cases where maternal obesity was a factor, including a series of recommendations

Local area updates: work done in each place CDOP, based on what worked well, areas for improvement, and future plans

Summary data analysis: covering child death notifications during the year, and reviews carried out during the period, analysed by local place and other key attributes.

2.2	<p>Deaths occurring during this year showed a significant uplift from 2020-21. This needs to be considered alongside the extreme social distancing measures taken during that year, when the number of child deaths was unusually low. This effect is evident across the whole country, where the numbers of child deaths were below normal expectations, very probably due in large part to the protection of children from infections as a result of lockdowns and other restrictions of social mixing.</p>
Key Actions and Relevant Timelines	
3.1	<p>The key actions of Rotherham CDOP and SYCDOP are set out in the report.</p>
Implications for Health Inequalities	
4.1	<p>A clear association between deprivation and risk of child mortality has been established by the National Child Mortality Database (to which all CDOPs contribute), showing a 10% increase in risk of death between each decile of increasing deprivation.</p>
4.2	<p>SYCDOP chose to look at maternal obesity for its thematic review because of the parallel association between obesity and deprivation.</p>
Recommendations	
5.1	<p>The report is provided to the Health and Wellbeing Board for information. The Board is asked to note the contents of the report, with particular regard to the local update report for Rotherham, representing a considerable multi-agency effort to learn and help to prevent child deaths.</p>
5.2	<p>The Board is also asked to note the recommendations from the South Yorkshire thematic review of cases with a focus on maternal obesity.</p>