BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	24th September 2025
	LEAD OFFICER	Jean Summerfield, Lead Nurse for Child Deaths Alex Hawley, CDOP Chair
	TITLE:	Child Death Overview Panel Annual Report 2024-25

Background

1.1 Child Death Overview Panels (CDOP) are statutory bodies established in every part of England. The child death review partners (i.e. the local authority and the ICB) in every local authority area are required to make arrangements for the review of each death of a child normally resident in the area.

1.2 The purposes of the reviews are to derive learning from each child death that might be helpful to the welfare or public health of children in the area, which might include factors that could be modified in order to prevent future deaths.

1.3 The child death review partners are also required to publish a report to cover how they have carried out these child death review arrangements and how effective this has been.

1.4 Following a review of Rotherham's arrangements, in December 2024 the Health and Wellbeing Board agreed to take on the oversight role for Rotherham's CDOP, inheriting that role from the Rotherham Safeguarding Children's Partnership. Alongside this decision, the responsibility for managing and administering the Panel moved from the Safeguarding Board to the Acute Trust's Safeguarding Team.

1.5 Previously, the reporting arrangements for Rotherham had been solely through an annual report prepared by the South Yorkshire CDOP, with individual place sections contributed by each of the four SY places. In the Autumn of 2024, a decision was taken by all the four CDOPs to relegate South Yorkshire CDOP to a community of interest. In view of this, whilst some joint regional reporting may continue to take place, Rotherham CDOP will in any case now always present a Rotherham annual report to the Health and Wellbeing Board.

1.6 This is the first of those such reports, which has largely been prepared by the new administrative resource at TRFT, and agreed by the whole CDOP panel (at its July meeting).

Key Issues

2.1 The key issues are set out in the annual report.

2.2 Child deaths are rare, and annual numbers of notifications vary considerably, but over the longer period we expect to see of an average of around 17 child deaths per year in Rotherham. However, the number of cases reviewed does not necessarily correspond to the deaths in a given year, as the time taken for all the related information to be collated for a case to come to panel also varies considerably.

2.3	In 2024-25 there were 20 child deaths notified in Rotherham, but the panel reviewed 29 cases, partly because additional panels were held as part of a concerted effort to reduce the backlog of cases awaiting a review.
2.4	The report contains tabulations, charts and other analysis of the cases reviewed, e.g. by category of death and age, as well as summarising the learning from deaths and the identification of child deaths.
2.5	From time to time the panel will ask for work to be done, for example through a task and finish group, to search for additional learning arising from a case discussion, such as through a literature search around a particular topic, or to carry out deeper analysis of the data. Rotherham CDOP has made good use of its GP Registrars on a Public Health placement in this respect. An appendix to the report shows the outcome of one such piece of work carried out during the year to look back at infant and neonatal deaths over recent years, in order to understand a large single-year increase in Rotherham in 2021/22.
Key Actions and Relevant Timelines	
3.1	The report will be presented to the Health and Wellbeing Board in September 2025, seeking approval for its publication.
3.2	The report will then be shared for information with the Safeguarding Partnership.
Implications for Health Inequalities	
4.1	As is set out in the report, the pattern of child deaths we see continues to bear out the general finding (as described by the National Child Mortality Database) that the risk of child death increases with deprivation. CDOP constantly seeks to understand where social conditions may be directly contributory to preventable deaths or have played a more indirect role in the vulnerability of a child who has died, and to take actions to address such concerns. Unfortunately, the conditions that lead to such learning are very often outside the scope of the panel.
Recommendations	
5.1	That the Board approve the annual report for publication.