ROTHERHAM

CHILD DEATH OVERVIEW PANEL

Annual Report

1 April 2024 –31 March 2025

Contents

Foreword

This year will be the first time while I have been the Chair that Rotherham Child Death Overview Panel (CDOP) publishes a separate annual report for Rotherham, rather than contributing a Rotherham section to a joint South Yorkshire report. There have been a number of important changes during the last year that set the context for this.

Following a review of oversight arrangements for Rotherham's CDOP last year, the decision was taken to move from the aegis of the Safeguarding Children Partnership to that of the Health and Wellbeing Board. Whilst it remains of paramount importance to the Panel to identify and respond to any safeguarding concerns that arise from case discussions, it is certainly true that the large majority of the learning and actions generated by CDOP cases are largely of a healthcare or public health nature.

As a result of this decision, it was logical to reconfigure the administrative and management arrangements of the Panel, which previously sat within the administration of the Safeguarding Partnership. Since January this year, the Rotherham NHS Foundation Trust has been providing this function, which is now merged with their existing functions to support the child death review processes that take place in the Trust prior to the preparation of documents for review at a CDOP Panel. This provides an opportunity for a more joined up and efficient process, and appears to be working well.

I have to take the opportunity afforded to me in this foreword to pay tribute to Sharon Pagdin, our former Lead Nurse for Child Death Review, who retired from a long career of public service, dedication and care in December last year, and I would also like to thank Jean Summerfield, who has taken on the mantle so readily as Lead Nurse and CDOP Manager, and who is brilliantly supported by Ellie Brown, our CDOP Administrator. I would also like to thank Dr Sundhar Kanagasabapathy, our Designated Paediatrician and all of our panel members, who have dedicated their time to such a worthwhile but obviously emotionally challenging responsibility. Despite all the changes we have seen during the year, we have nevertheless been able to reduce our backlog of cases, which is a great achievement.

The South Yorkshire CDOP took the pragmatic decision in October 2024 to relegate itself to become more of a community of interest, with less frequent meetings. It is fair to say at this point in time that the exact shape and ongoing purpose of the regional group is still being discussed, which will no doubt include a consideration of any remaining value in joint reporting at a South Yorkshire level. Irrespective of how this plays out, Rotherham has already taken the decision that it will produce its own annual reports of CDOP activity and learning (during the twelve months to the end of March), which will be approved for publication by Rotherham's Health and Wellbeing Board each Autumn. This is the first of those reports.

Alex Hawley

Consultant in Public Health

Chair of Rotherham Child Death Overview Panel

July 2025.

Introduction

Since April 2008, all deaths of children up to the age of 18 years are reviewed by a Child Death Overview Panel (CDOP) to comply with the statutory requirement set out in Working Together.

This report outlines the activities and findings of the Rotherham Child Death Overview Panel (CDOP) for the period April 2024 to March 2025.

All deaths of Rotherham children, (from birth up to 18 years) excluding stillbirths and planned terminations, are reviewed by the CDOP within Rotherham, in accordance with the statutory requirement.

National data for 2024/25 is not yet available, so this report will focus on Rotherham CDOP activity, with comparisons made with previous years to illustrate any points where necessary.

In South Yorkshire around 80 to 100 child deaths are expected per year. There is random variation in the data year-to-year, due to the small numbers involved. The total number of child deaths recorded in South Yorkshire during 2023-24 was 97. This is less than 2022-23 when there were 108.

The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity.

CDOP aims to identify patterns, modifiable factors, and opportunities for prevention. Rotherham CDOP operates in collaboration with the South Yorkshire CDOP, which includes Barnsley, Doncaster and Sheffield, to share anonymised data and coordinate regional actions.

South Yorkshire CDOP

Across South Yorkshire, individual Child Death Overview panel (CDOP) review processes continue to cover each local authority area. It is felt that this remains the most efficient and practical way to carry out individual reviews, enabling the best alignment to networks of healthcare, social care, education, and other related agencies.

The South Yorkshire CDOP provides a forum for the four areas to work together. Through this collaboration, Barnsley, Doncaster, Rotherham and Sheffield data is combined to enable improved opportunity to identify themes, trends and shared learning than can be achieved at local authority level.

Rotherham CDOP

The purpose of CDOP panels are to:

- Ascertain why a child has died by a thorough but proportionate review of the facts and circumstances surrounding the death
- Determine the contributory and modifiable factors
- To make recommendations to all relevant organisations where actions have been identified which may prevent further deaths or promote the health, safety and wellbeing of children
- Provide detailed data to NCMD which they analyse nationally and produce regular reports
- Produce an annual report highlighting local trends and patterns and any actions taken
- Contribute to the wider learning locally, regionally and nationally.

Rotherham CDOP meetings are held bi-monthly. There were eight Rotherham CDOP meetings during 2024/2025 period, which included two additional meetings to support reduction of the backlog of cases.
During the reporting period, Rotherham CDOP reviewed 29 child deaths. These included some deaths notified in previous years as Rotherham CDOP.

The TRFT CDR Lead Nurse Sharon Pagdin retired in December 2024. Her hard work and dedication to driving change, developing arrangements when a child dies and improving recognition of the needs of the bereaved has been greatly valued and will be much missed. There was no gap in service as TRFT appointed in a timely way, allowing a significant handover period to ensure a seamless transfer.

Review and analysis of all Rotherham children who have died

In 2024/25 Rotherham recorded twenty child deaths in total, six more than the previous year and slightly above average for Rotherham (17). At 31/03/25, there were twenty-two active cases progressing through the child death review process. Six of these cases date back over a year as Coronial inquests, specialist pathology reports, criminal investigation and capacity within Rotherham Safeguarding Children Partnership administrative arrangements delay the review process. The CDOP

has collaborated with other agencies involved and worked extensively in partnership to address the issues identified. Exceptional CDOPs have taken place during 2024 to reduce the backlog, which will continue to be monitored through Rotherham CDOP

A total of 29 cases were reviewed at CDOP throughout 2024-2025, which worked to significantly reduce the backlog of cases.

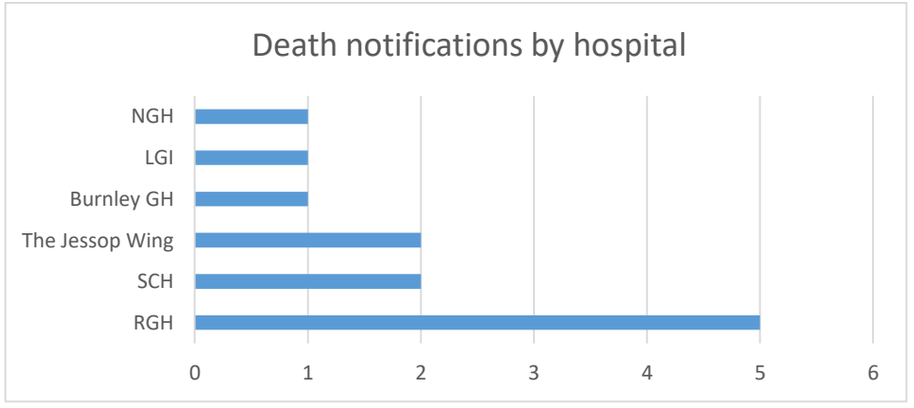
Four deaths were not considered part of the Rotherham CDOP process. Two cases were transferred to Sheffield, one to Doncaster and one case was noted to be a stillbirth, therefore not required to be considered in CDOP.

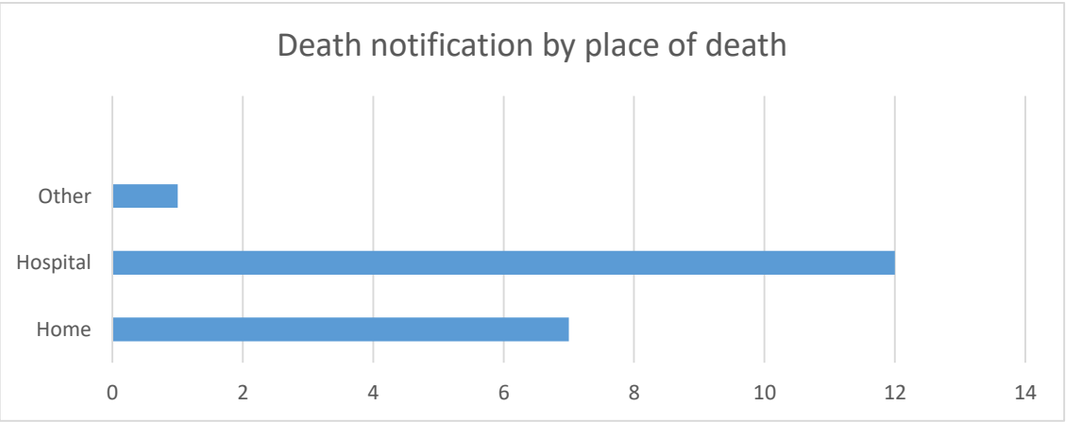
Number of Rotherham child deaths on a financial yearly basis from 2016 onward.

2024/2025	2023/2024	2022/2023	2021/2022	2020/2021	2019/2020	2018/2019	2017/2018	2016/2017
20	**14**	**17**	**23**	**11**	**13**	**22**	**20**	**15**

Notifications of Rotherham Child Deaths 1 April 24 – 31 March 2025

Expected deaths	Q1	Q2	Q3	Q4	Unexpected deaths	Q1	Q2	Q3	Q4
Child resident in Rotherham	**4**	**2**	**4**	**1**	Child Resident in Rotherham	**3**	**3**	**0**	**3**





Annual Comparison

Death notifications by LA and year

LAA name	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Rotherham	13	9	23	17	14	20
Total	**13**	**9**	**23**	**17**	**14**	**20**

Death notifications by age group and year

Age group	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
0 - 27 days	3	2	14	5	8	7
28 - 364 days	5	3	3	1	1	4
1 - 4 years	2		2	3		2
5 - 9 years	1	2	2	4	3	5
10 - 14 years				3	2	1
15 - 17 years	2	2	2	1		1
Total	**13**	**9**	**23**	**17**	**14**	**20**

Annual Comparison

All death notification from 01/04/19 by month and year

Month of death	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Apr	1	0	0	1	1	2
May	1	1	2	1	0	0
Jun	1	0	2	2	1	5
Jul	1	1	1	0	1	3
Aug	3	1	3	3	3	1
Sep	0	1	2	2	2	1
Oct	2	0	3	2	1	1
Nov	2	1	2	4	1	0
Dec	2	1	1	0	1	3
Jan	0	1	1	1	0	1
Feb	0	1	3	0	1	1
Mar	0	1	3	1	2	2
Total	**13**	**9**	**23**	**17**	**14**	**20**

Overview

Data on this page relates to deaths after 1st April 2019 or where CDOP review was outstanding at 1st April 2019, up to and including 31st March 2025

NCMD National Child Mortality Database

Number of cases reviewed 24/25:	Total cases with review ongoing:
29	22

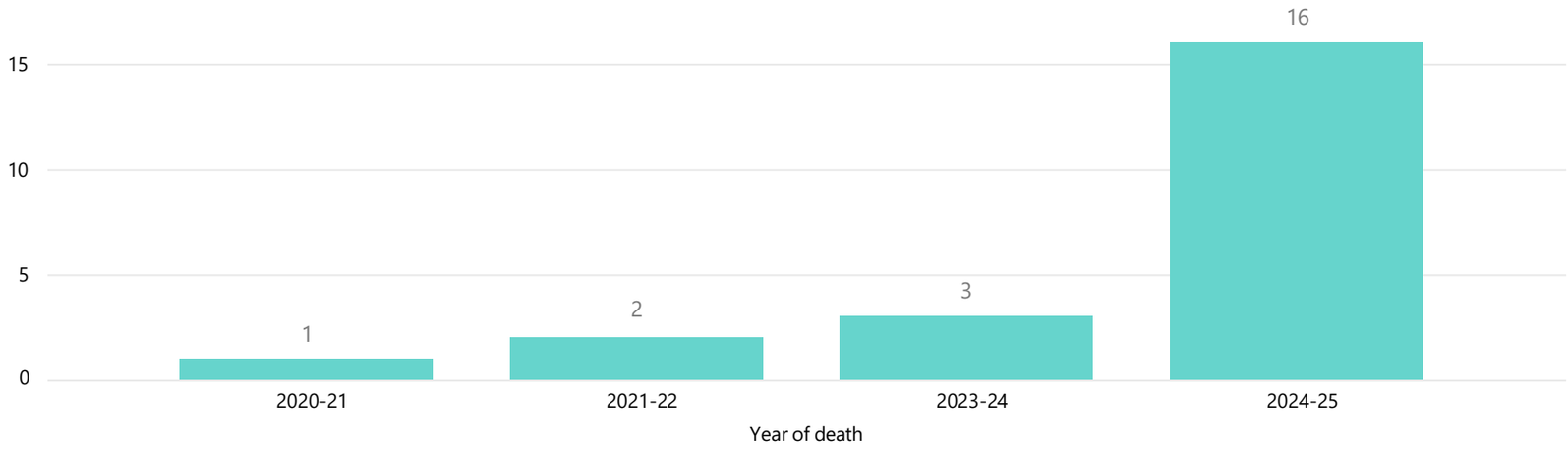
Number of deaths during 24/25:

20

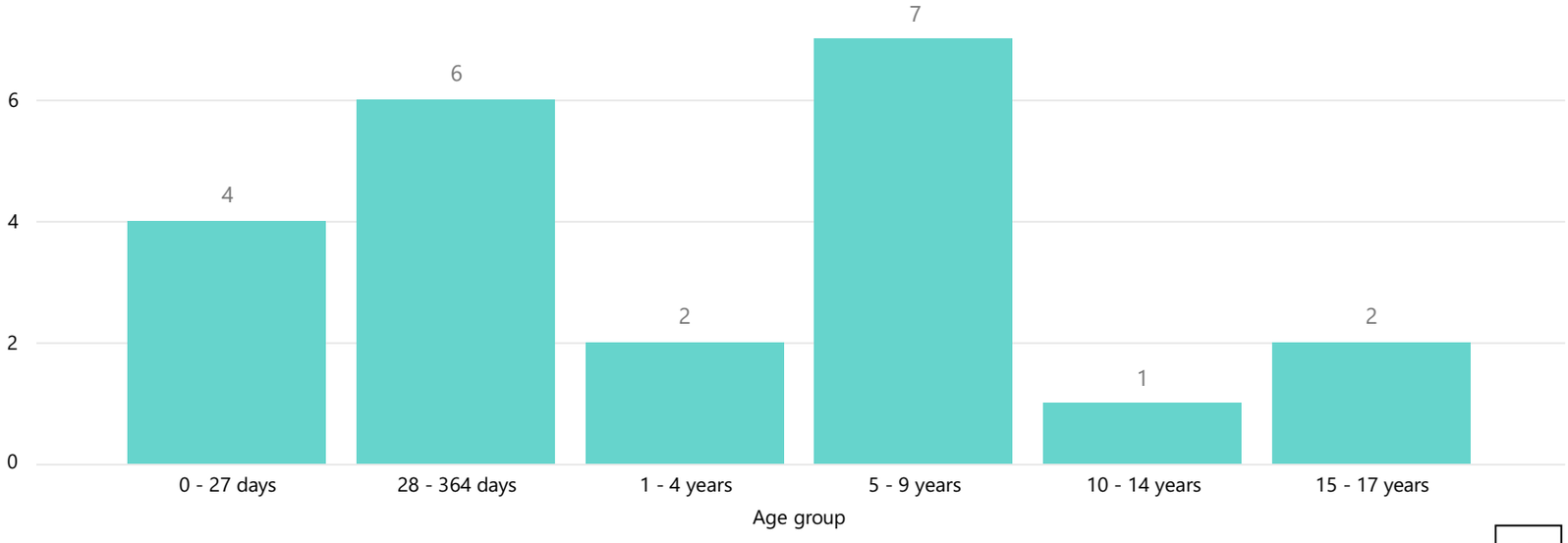
Number of ongoing cases entered by LAA

LAA name	Cases
Rotherham	22
Total	**22**

Number of ongoing cases by year of death and status of case



Number of ongoing cases by age group and status of case



Completed Reviews - Overview 1

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2024 and 31st March 2025

NCMD National Child Mortality Database

Number of cases reviewed 24/25:

29

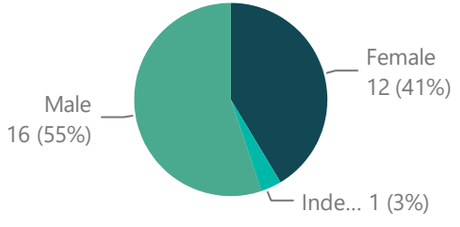
Completed CDOP Reviews by LAA

LAA name	Cases
Rotherham	29
Total	**29**

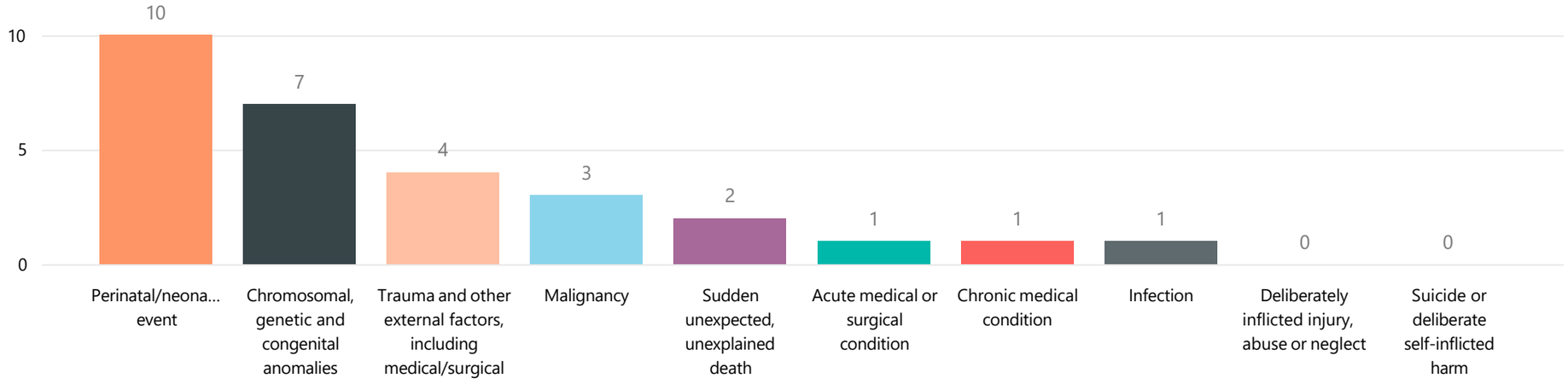
Completed CDOP Reviews by year of death

Year of death	Cases
2021-22	3
2022-23	11
2023-24	11
2024-25	4
Total	**29**

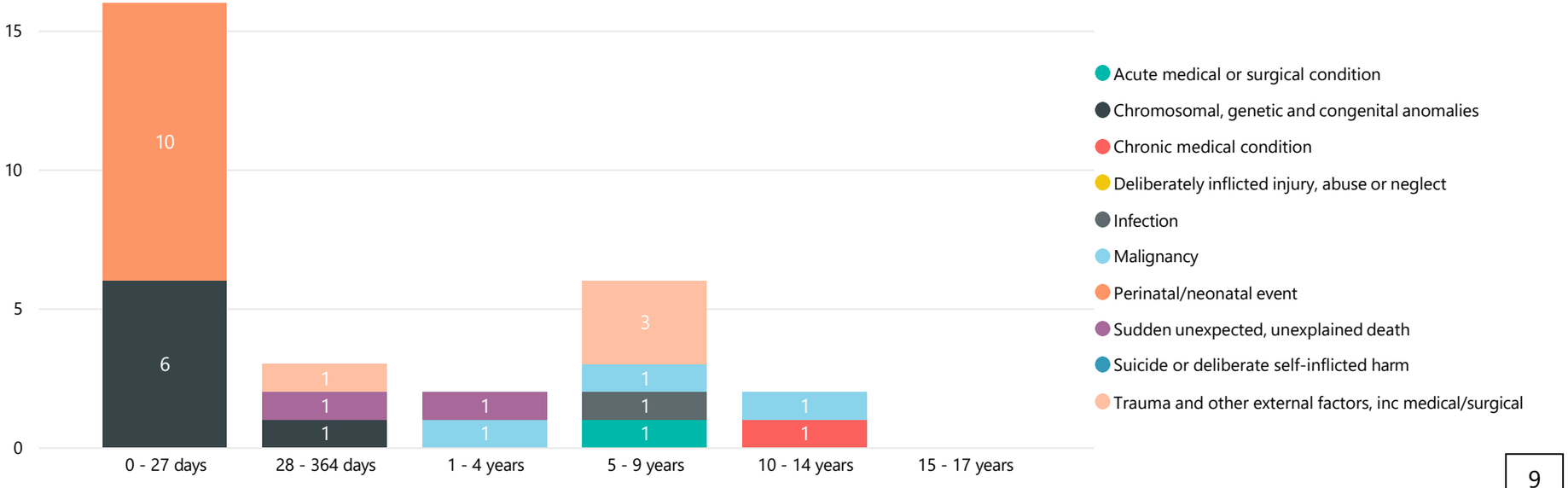
Completed CDOP reviews by sex



Completed CDOP reviews by primary category of death



Completed CDOP reviews by age group



Completed Reviews - Overview 2

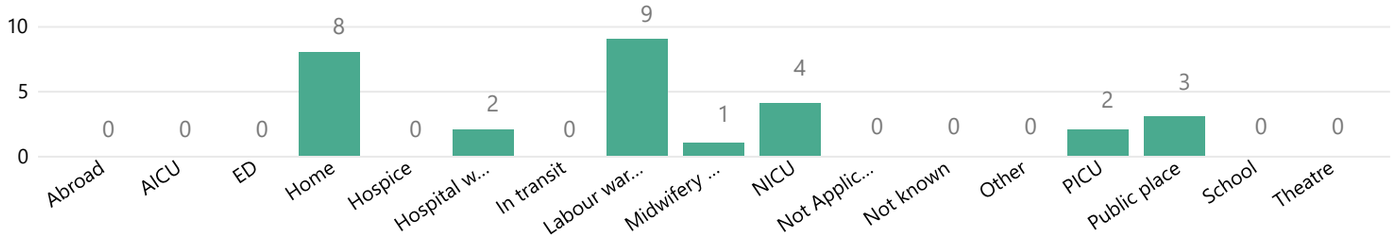
Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2024 and 31st March 2025

NCMD National Child Mortality Database

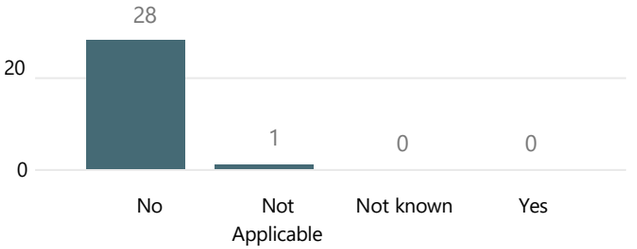
Number of cases reviewed 24/25:

29

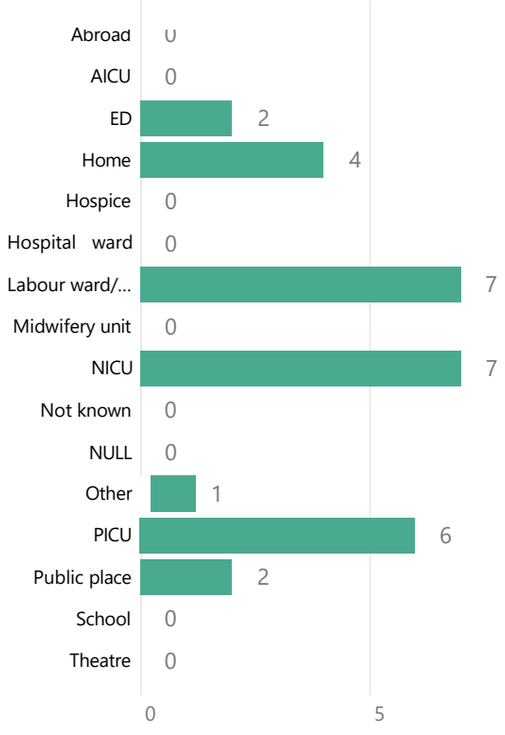
Completed CDOP reviews by place of onset of illness/incident



Completed CDOP reviews by abuse/neglect concerns



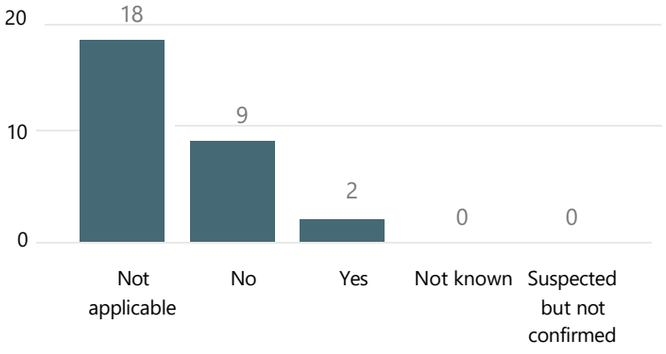
Completed CDOP reviews by place of death



Completed CDOP reviews by ethnic group and age group

Ethnic Group	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	Total
White	9	1	1	5	2	0	**18**
Unknown	1	0	0	0	0	0	**1**
Other	2	0	0	0	0	0	**2**
Mixed	0	1	0	0	0	0	**1**
Black or Black British	2	0	0	0	0	0	**2**
Asian or Asian British	2	1	1	1	0	0	**5**
Total	**16**	**3**	**2**	**6**	**2**	**0**	**29**

Completed CDOP reviews where had a learning disability



Completed CDOP reviews by ethnic group and primary category of death

Ethnic Group	Acute medical or surgical condition	Chromosomal, genetic and congenital anomalies	Chronic medical condition	Deliberately inflicted injury, abuse or neglect	Infection	Malignancy	Perinatal/neonatal event	Sudden unexpected, unexplained death	Suicide or deliberate self-inflicted harm	Trauma and other external factors, including medical/surgical complications/error	Total
White	0	4	1	0	1	2	6	1	0	3	**18**
Unknown	0	0		0	0	0	1	0	0	0	**1**
Other	0	1	0	0	0	0	1	0	0	0	**2**
Mixed	0	0	0	0	0	0	0	1	0	0	**1**
Black or Black British	0	1	0	0	0	0	1	0	0	0	**2**
Asian or Asian British	1	1	0	0	0	1	1	0	0	1	**5**
Total	**1**	**7**	**1**	**0**	**1**	**3**	**10**	**2**	**0**	**4**	**29**

Modifiable Factors

The CDOP review process requires panels to identify if there are any modifiable factors in relation to each death. The purpose of this is to enable agencies to learn lessons, improve practice and ultimately prevent further deaths. A modifiable factor is defined as something which: “may have contributed to the death of the child and which, by means of locally and nationally achievable interventions, could be modified to reduce the risk of future child deaths”.

Identifying modifiable factors is crucial for preventing future child deaths. Nationally, 43% of child deaths reviewed in the year ending March 2024 had modifiable factors. The proportion of reviews identifying such factors varied by region, ranging from 34% to 57%. The national and regional figures for 2024/25 are not yet available; however, modifiable factors were identified in four Rotherham CDOP reviews.

These identified issues related to the use of seatbelts in modified vehicles, the management of tracheostomies in babies and the importance of good communication between professionals.

While specific child mortality data for Rotherham is not detailed in the NCMD 2023–2024 report, regional and national trends suggest that factors such as socioeconomic deprivation and ethnic disparities likely influence child health outcomes in the area. Efforts by local health services to monitor and address these issues are crucial in improving child health and reducing mortality rates.

Common Modifiable Factors Identified nationally (using 2023-24 data):

- **Infant Deaths (Under 1 year):**
  - Parental smoking: Identified in 27% of reviews.
  - High maternal Body Mass Index (BMI): 23%.
  - Smoking during pregnancy: 22%.
- **Children Aged 1–17 Years:**
  - Poor inter-agency communication: 12%.
  - Issues with treatment (e.g., delays, complications): 9%.
  - Lack of appropriate supervision:

Additionally, 15% of the children reviewed were known to social care at the time of their death, with 46% of these cases identifying modifiable factors.

National Child Mortality Database

The analysis of modifiable factors in child deaths highlights critical areas for intervention both nationally and within South Yorkshire, including Rotherham. Efforts to reduce parental smoking, manage maternal health and improve interagency communication are essential steps toward decreasing preventable child mortality.

The child death process also creates an opportunity at the meetings for services to identify other changes to practice, e.g. a need for workplace training or amendments to policies and procedures.

CDOPs themselves do not undertake public health campaigns or deliver interventions arising from the learning from reviews. Instead, through Health and Wellbeing Boards and Safeguarding Children Partnerships, lessons learned are incorporated into policy and appropriate interventions are developed. Rotherham CDOP continues to monitor trends and causes of death to inform prevention strategies.

It is recognised nationally that there have been inconsistencies in data recording and interpretation of modifiable factors over previous years. There is a degree of subjectivity when modifiable factors are decided on a case-by-case basis and is reliant on the thorough completion of national CDOP reporting forms by clinicians which takes place after the Child Death Review Meeting (CDRM) where all the relevant professionals who know the family share knowledge of the child's life and circumstances of the death. Across South Yorkshire, there is some variation in the agreement of modifiable factors, particularly around parental smoking status.

Four domains are used to categorise the information with a corresponding level of relevance (0-2):

Domain A: Factors intrinsic to the child

Domain B: Factors in social environment including family and parenting capacity

Domain C: Factors in the physical environment

Domain D: Factors in service provision.

Completed Reviews - Modifiable Factors

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2024 and 31st March 2025

NCMD National Child Mortality Database

Number of cases reviewed 24/25:

29

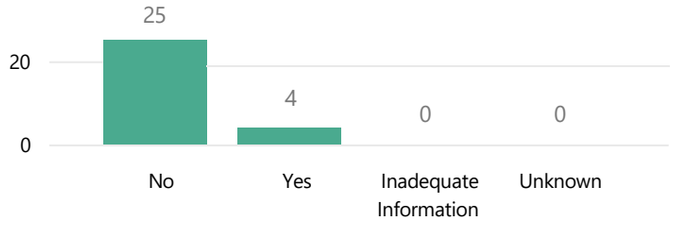
% cases with modifiable factors (CDOP):

14%

% cases with modifiable factors (England):

43%

Were any modifiable factors identified?



% of cases where modifiable factors were identified by category of death

Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Trauma and other external factors, including medical/surgical complications/error	4	2	50%
Suicide or deliberate self-inflicted harm	0	0	0%
Sudden unexpected, unexplained death	2	0	0%
Perinatal/neonatal event	10	1	10%
Malignancy	3	0	0%
Infection	1	0	0%
Deliberately inflicted injury, abuse or neglect	0	0	0%
Chronic medical condition	1	0	0%
Chromosomal, genetic and congenital anomalies	7	1	14%
Acute medical or surgical condition	1	0	0%
Total	**29**	**4**	**14%**

% of cases where modifiable factors were identified by age group

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	16	2	13%
28 - 364 days	3	1	33%
1 - 4 years	2	0	0%
5 - 9 years	6	1	17%
10 - 14 years	2	0	0%
15 - 17 years	0	0	0%
Total	**29**	**4**	**14%**

Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
White	18	3	17%
Unknown	1	0	0%
Other	2	0	0%
Mixed	1	0	0%
Black or Black British	2	0	0%
Asian or Asian British	5	1	20%
Total	**29**	**4**	**14%**

eCDOP

eCDOP provides a shared IT system for each of the areas that make up South Yorkshire CDOP to enable notification of child death and rapidly allows wraparound support for families and schools. The four local authorities jointly procure a licence on an annual rolling basis with Barnsley acting as the contractual lead authority.

In April 2019, the National Child Mortality Database (NCMD) became operational and pulls from the relevant data within eCDOP. The NCMD system is used to generate the data contained within this report.

Learning from Child Deaths

During the process of reviewing a child death, if the CDOP panel identifies a theme or matter of concern that could affect the safety or welfare of children in Rotherham, or any wider public health concerns arising from a death or from a pattern of deaths in the area, action will be taken and specific recommendations made. Learning is also routinely shared with professionals through South Yorkshire CDOP meetings and wider Safeguarding children groups and networks.

During 2024/25 Rotherham CDOP commissioned a Task and Complete Group to consider a disproportionally high number of infant and neonatal deaths across South Yorkshire in 2021/22, demonstrated by data released by the NCMD.

The group, led by V Raven, looked at the death of every child under one year and collated age, cause of death (as per medical certificate of death), category of death and learning points. Review of this data showed that there were fourteen neonatal deaths and three infant deaths. Two of these deaths may have survived should alternative action have been taken by staff at Jessops. However, the large majority were immaturity/prematurity related deaths with no significant learning points identified.

Data released by NCMD spanned from 1 April 2019 to 31 March 2024 and across South Yorkshire:-

- Most infant, neonatal and child deaths occurred within the highest level of social deprivation, and the least deaths were seen within the lowest levels of social deprivation.
- Most childhood deaths were seen in children aged one to four, and deaths across South Yorkshire in those aged five to nine and ten to fourteen years followed national trends.

- Hospital was consistently the most common place of all child deaths.
- South Yorkshire was close to the national average of population-adjusted child deaths in 2019/20 and 2020/21, but then consistently above average from 2021/22 onwards.
- Every region in South Yorkshire had the greatest proportion of deaths occurring in neonates, and the second greatest proportion in infants.
- Across South Yorkshire regions, the highest proportion of deaths were seen in the categories of: *Chromosomal, genetic and congenital anomalies* and *Perinatal/neonatal events.*
- Rotherham saw a high number of child deaths in 2022/23. This was seen in Barnsley and Doncaster, but not Sheffield.

There was further breakdown of child deaths in Rotherham in 2022/23, as above, cause of death (as per medical certificate of death), category of death and learning points were evaluated. There were ten deaths in total; the most common causes of death were infection on a background of a chronic medical condition. There were two cases where death may have been avoided with learning points identifying areas of failure across primary and secondary care.

Overall, the Task and Finish group did not identify any significant concerns from the data reviewed from 1 April 2019 to 31 March 2024. Across South Yorkshire:

- Most infant, neonatal and child deaths occurred within the highest level of social deprivation, and the least deaths were seen within the lowest levels of social deprivation.
- Most childhood deaths were seen in children aged one to four, and deaths across South Yorkshire in those aged five to nine and ten to fourteen years followed national trends.
- Hospital was consistently the most common place of all child deaths.
- South Yorkshire was close to the national average of population-adjusted child deaths in 2019/20 and 2020/21, but then consistently above average from 2021/22 onwards.

- Every region in South Yorkshire had the greatest proportion of deaths occurring in neonates, and the second greatest proportion in infants.
- Across South Yorkshire regions, the highest proportion of deaths were seen in the categories of: *Chromosomal, genetic and congenital anomalies* and *Perinatal/neonatal events.*
- Rotherham saw a high number of child deaths in 2022/23. This was seen in Barnsley and Doncaster, but not Sheffield.

There was further breakdown of child deaths in Rotherham in 2022/23, as above, cause of death (as per medical certificate of death), category of death and learning points were evaluated. There were ten deaths in total; the most common causes of death were infection on a background of a chronic medical condition. There were two cases where death may have been avoided with learning points identifying areas of failure across primary and secondary care.

Overall, the Task and Finish group did not identify any significant concerns from the data review. *Further detail can be seen in Appendix 1*

National Child Mortality trends

Analysis of the NCMD data for 2023/24 highlighted the following:

Total Child Deaths: 3,577 deaths among children aged 0–17 in England, a 4% decrease from the previous year.

Infant Mortality: Accounted for 61% of child deaths, with a rate of 3.9 per 1,000 live births, slightly up from 3.8 the previous year.

Neonatal Deaths: Represented 42% of child deaths, with a rate of 2.7 per 1,000 live births, an increase from 2.6 the prior year.

Ethnic Disparities:

- Black or Black British children: 55.4 deaths per 100,000 population.
- Asian or Asian British children: 46.8 deaths per 100,000.
- White children: 25.5 deaths per 100,000.

Deprivation Impact: Children in the most deprived areas had death rates more than twice those in the least deprived areas.

Rotherham, being part of the Yorkshire and the Humber region, aligns with the regional trends observed in the NCMD data. The region's child death rate ranged from 24.2 to 40.7 per 100,000 population of 0–17-year-olds.

The Rotherham CDOP's proactive approach in reviewing various categories of deaths and planning for future reviews indicates a commitment to understanding and addressing mortality factors within its service area.

Membership and attendance

The Rotherham CDOP Terms of Reference sets out a list of roles that are required to form the core membership. This comprises of:

Nursing and/or Midwifery (TRFT)	Bluebell Wood Children's Hospice
Designated Doctor for Child Death	South Yorkshire Police
Child Death Review Lead Nurse	Primary care (GP or 0-19 Practitioner)
Children Social Care Services	

Agency	**%**
Public Health	100%
Designated Doctor, TRFT	100%
Lead Nurse CDR, TRFT	100%
Nursing rep, TRFT	100%
Midwifery rep, TRFT	62.5%
RSCP Business Unit	25%
RDaSH	100%
C&YP Services, RMBC	37.5%
SYICB	75%
Bluebell Wood Children's Hospice	87.5%
* South Yorkshire Police (Attendance where appropriate agreed)	87.5%

Next Steps

Building on the progress of the past year, the Rotherham CDOP work programme for the coming year will continue to prioritise the reduction of preventable child deaths through targeted action, learning, and system improvement. A key focus will be the enhancement of our Safe Sleep campaign. We will strengthen partnerships with maternity, health visiting, and early-years services to promote consistent safe sleep messaging and increase community engagement. Targeted interventions will be developed for high-risk groups, informed by local and national data in partnership with SYCDOP partners.

Work to reduce the backlog will continue, however, we are mindful that many of the remaining cases are delayed for reasons beyond the control of CDOP, such as Police investigations, awaiting inquests and specialist reports. This will be closely monitored going forward with a position statement provided to each CDOP meeting, and appropriate escalation agreed if required.

In addition, we will undertake a comprehensive review of modifiability factors identified through Child Death Overview Panel (CDOP) case reviews. This will involve thematic analysis to better understand recurring issues and opportunities for early intervention. The findings will guide recommendations to improve service delivery, inform training, and influence policy across agencies.

Through these priorities, we aim to drive meaningful change, reduce inequalities, and promote safer environments for children and families.

Conclusion

While national child mortality rates have seen a slight decrease, disparities persist, particularly in regions like Yorkshire and the Humber. Rotherham, along with neighbouring towns and cities, faces challenges related to socioeconomic deprivation that impact child health outcomes. Addressing these issues requires targeted interventions and policy changes focused on health equity and socioeconomic improvements.

This year’s report reflects the strong performance of the CDOP in delivering its statutory responsibilities with rigour, compassion, and consistency. Despite the challenging context in which many partner agencies continue to operate, the Panel maintained a timely and thorough review process, ensuring that all child deaths were examined in detail. This report highlights the continued commitment of Rotherham CDOP to understanding the factors contributing to child deaths and identifying opportunities for

prevention. While every child death is a profound tragedy, each review offers a vital chance to learn and improve services. Themes emerging from our analyses, such as modifiable risk factors, the importance of early intervention, and the value of coordinated multi-agency responses already inform practice changes across agencies and will continue to guide our recommendations for local practice and policy. Collaboration across health, social care, education, and the voluntary sector remains central to our work.

Looking forward, we will strengthen our focus on addressing inequalities, listening to families, and ensuring that the voice of the child remains at the heart of everything we do. Through collaborative and reflective practice with our partners and communities, we remain committed to reducing preventable child deaths and improving outcomes for all children and families across Rotherham.

Appendix 1

National Child
Mortality Database Su