Rotherham Child Death Overview Panel Annual Report

1 April 2024 – 31 March 2025

Presented by:

Alex Hawley, CDOP Chair &

Jean Summerfield, Lead Nurse Child Death Review

Foreword & Context

- First standalone Rotherham CDOP report
- Transitioned oversight from Safeguarding Children Partnership to Health and Wellbeing Board
- Administrative support now provided by Rotherham NHS Foundation Trust
- Tribute to Sharon Pagdin; welcome to Jean Summerfield
- SY CDOP having less frequent meetings.
- Backlog of cases reduced despite organisational changes

CDOP Purpose & Structure

- The panel includes RMBC – public health and social care; TRFT – safeguarding, paediatrics, midwifery; SYP; RDaSD; ICB; Children's hospice
- Statutory function – to review deaths of children (under 18 years) excluding stillbirths and planned terminations
- To categorise cause of death
- To consider the importance/relevance of factors present within four key domains - factors intrinsic to the child; factors in social environment including family and parenting capacity; factors in the physical environment; factors in service provision
- To identify modifiable factors, and prevention opportunities
- To update the National Child Mortality Database
- To share learning and take whatever improvement actions are identified within the system to prevent future deaths or reduce vulnerabilities

South Yorkshire CDOP network

- Covers Barnsley, Doncaster, Rotherham & Sheffield
- Enables identification of regional themes & trends
- Pragmatic shift in 2024 – now a community of interest with less frequent meetings
- Still valuable for shared learning & data comparison

Rotherham CDOP 2024–25

- 8 meetings held (2 additional to reduce backlog)
- 29 cases reviewed (20 deaths in 2024/25)
- 22 active cases ongoing (delays due to inquests, reports, investigations)
- Age Distribution: Highest in neonates (0–27 days)
- Place of Death: Mostly hospital-based
- Ethnicity: Majority White; some Asian, Black, Mixed
- Collaboration with agencies to improve timeliness

Modifiable Factors

4 cases (14%) had modifiable factors

National average: 43% of cases had modifiable factors

Issues included:

- Seatbelt use in modified vehicles
- Tracheostomy management in babies
- Inter-professional communication

National common factors:

Parental smoking, high maternal BMI, supervision issues, poor inter-agency communication

Learning & Actions

Themes/actions identified at CDOP inform local practice.

- Safe Sleep campaign enhancement planned
- Task & Finish group reviewed neonatal deaths (2021/22)
- Most deaths linked to deprivation and chronic conditions
- Learning shared with professionals and networks

  Example: Swimming lessons partnership for children with learning disabilities

Task & Finish group reviewed infant/neonatal deaths

Findings:

- Most deaths due to prematurity/immaturity
- Some avoidable deaths due to care delays
- No evidence of a single factor explaining increase in numbers

National Trends

- 3,577 child deaths in England 23/24 (↓ 4% vs previous year)
- Child deaths at 29.8 per 100k children

  Significant disparities:
  - Black children: 55.4 deaths/100k
  - Asian children: 46.8 deaths/100k
  - White children: 25.5 deaths/100k
- Children in most deprived areas >2x death rate of least deprived. Deprivation strongly linked to mortality.
- Infant deaths (within 1st year of life) = 61% of total child deaths
- Neonatal deaths (within 28 days of birth) = 42% of total child deaths
- Infant mortality rate (under 1 year): 3.9 per 1,000 live births – a slight increase from the previous year

Next Steps

- Thematic review of modifiable factors
- Strengthen multi-agency collaboration
- Focus on health equity and early intervention
- Continue to work to improve the Safe Sleep offer
- Targeted interventions for high-risk groups
- Continue backlog reduction & monitoring delays
- Thematic review of modifiability factors
- Influence training, service delivery & policy
- Aim: Reduce inequalities & prevent child deaths

Conclusion

- CDOP delivered statutory responsibilities effectively
- CDOP maintained rigorous review standards
- Continued to strive towards timely & thorough reviews
- Identified modifiable factors & learning points
- Continued commitment to learning, prevention and family support
- Focus on reducing inequalities and improving child outcomes
- Persistent challenges: deprivation & inequalities
- Commitment to prevention, partnership & family voice
- Ongoing work to improve outcomes for children & families in Rotherham