NHS
Norfolk and Waveney
Integrated Care Board

Suffolk
Safeguarding
Partnership

NHS
Suffolk and North East Essex
Integrated Care Board (ICB)

Norfolk and Suffolk Child Death Overview Panel

Annual Report 2024-2025

Norfolk Safeguarding
Children Partnership

Suffolk
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Norfolk
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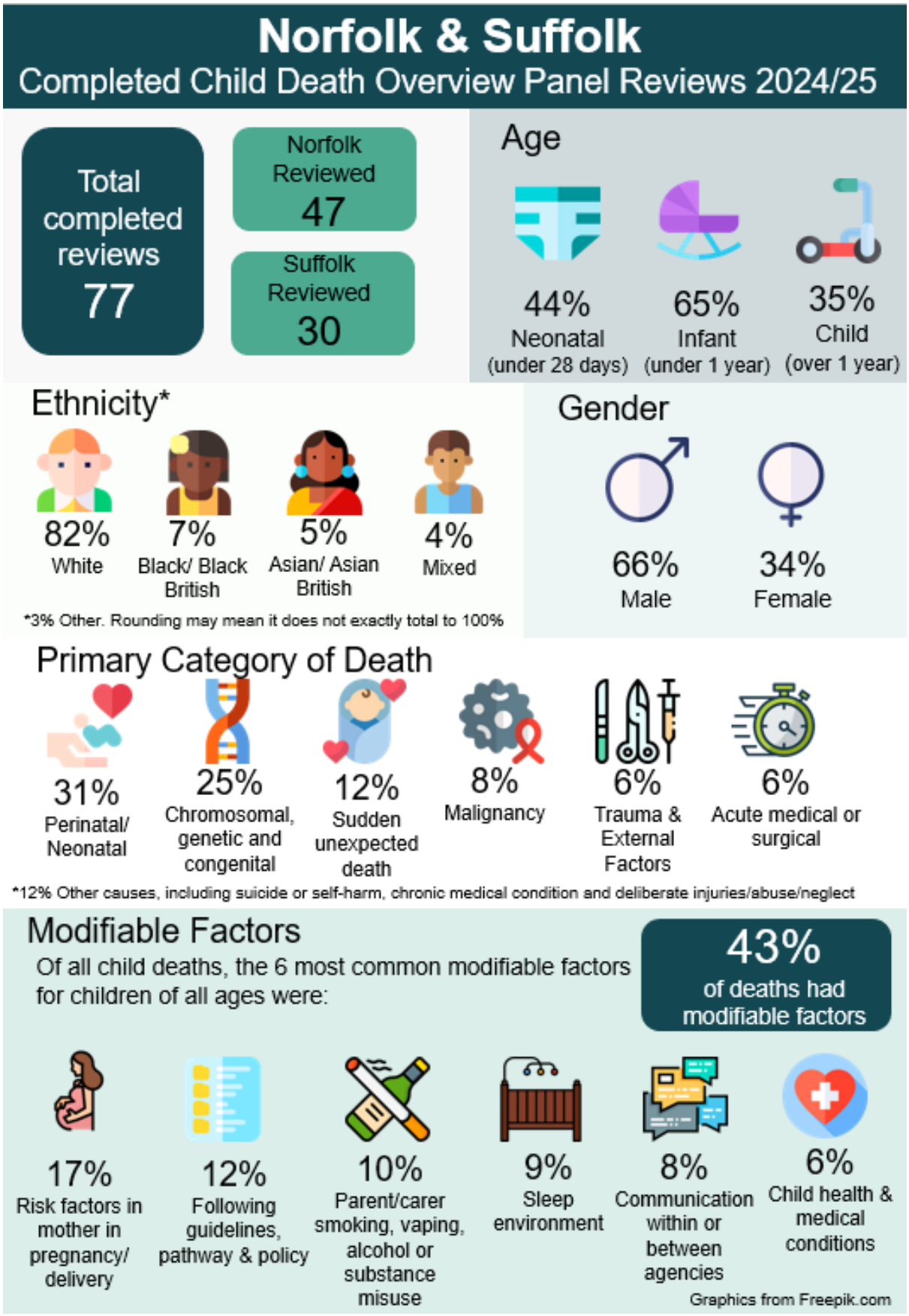
INTRODUCTION

The Norfolk and Suffolk Child Death Overview Panels (CDOP), review the death of every resident child aged under 18 years in Norfolk and Suffolk. They report into the respective Safeguarding Children Partnerships.

The Child Death Overview Panel (CDOP) annual report is a summary of the activity carried out by the panels in line with the national guidance which include child mortality trends, causes of death, modifiable factors, actions taken, and any lessons learnt – all of these are considered by each CDOP for every child death. The aim is to improve outcomes for children across Norfolk and Suffolk. This report summarises the work of both CDOPs and the cases that have been reviewed in the period from April 2024 to the end of March 2025.

Each county has established a specific Child Death Review Team (CDRT), Suffolk since 2019 with Norfolk from April 2021. These have both proved instrumental in improving the quality and effectiveness of practice. The Child Death Review process is important, can be challenging and is rewarding. Thanks are due to all those who have taken part and contributed to this process in Norfolk and Suffolk.



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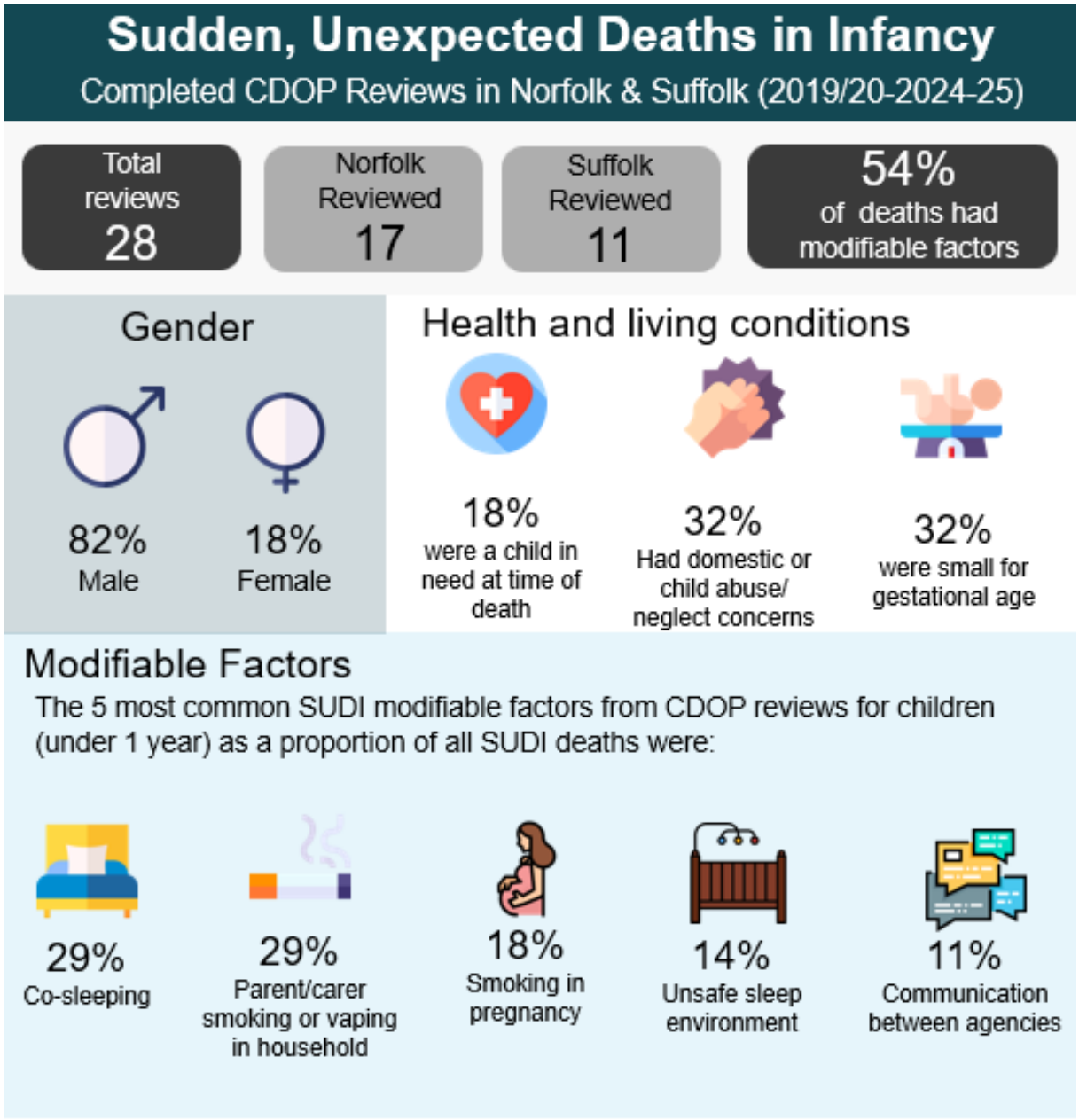

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SUMMARY

Efficiency

- The Norfolk and Suffolk CDOPs met on 12 different occasions. (6 for Norfolk and 6 for Suffolk)
- The review process remains efficient, with most cases reviewed in under 12 months, far surpassing the national average. The median review time was 263 days in Norfolk and Suffolk, compared to a national average of 411 days.

CDOP Notifications

- Between April 2024 and March 2025, the Norfolk and Suffolk Child Death Overview Panels (CDOP) were informed of 80 child deaths: 50 in Norfolk and 30 in Suffolk.
    - Out of these, 18 met the criteria for a joint agency response.
- National data for 2023/24 (latest data available) allows us to compare the number of deaths in our area to nationally. Child deaths (aged 1-17 years) are significantly lower in Norfolk and Waveney ICB at 6.6 per 100,000 population to what we see nationally, 12.4 per 100,000 in England. Suffolk and North-East Essex ICB are statistically similar.
- The majority of deaths, 37 cases, occurred during the neonatal period (0–27 days).
- The highest death rate for children aged 1 and over, continues to be for those aged between 15-17 years-old (15.3 per 100,00 population), followed by 1–4-year-olds (10.1 per 100,000, mirroring what we see nationally

CDOP Completions

- Between April 2024 and March 2025, Norfolk and Suffolk CDOPs reviewed 77 child deaths (47 in Norfolk and 30 in Suffolk)
- In Norfolk and Suffolk in 2024/25, 66% of the deaths reviewed were male and 34% female.
- The most common category of death was Perinatal/Neonatal events, with 24 deaths, followed by Chromosomal, Genetic, and Congenital Anomalies, which had 19 deaths.

Modifiable factors

- Modifiable factors, which are risk factors that could be changed to lower future child deaths, were found in 43% of reviewed cases. This is an increase from the previous year's 33% and matches national trends. The most frequently mentioned modifiable areas were:
    - Pregnancy-related risks (39%), including maternal smoking and high BMI
    - Issues with guidelines/pathway/ policy (27%)
    - Smoking, vaping, alcohol or substance misuse by parent or carer (24%)
    - Sleep environment (21%)
    - Communication within and between agencies (18%)

- In 2024/25, 25 children died who were known to social care either at the time of their death or at some point in their history. Of these, 60% (N=15) were identified as having modifiable factors. This is higher, but not significantly so, compared to children not known to social care in which 35% of deaths had modifiable factors (17 out of 49 deaths).

Sudden Infant Deaths

- All Sudden Unexpected Death in Infancy (SUDI) in 2024/25, had modifiable risk factors (N = 9).
- These included unsafe sleep environments and parental smoking or substance use. SUDI cases made up a large portion of deaths with modifiable factors in infants aged 28–364 days.

EFFICIENCY

The child death review process in Norfolk and Suffolk continues to be efficient and 70% of deaths are brought to review at CDOP in less than 12 months, with 19% of deaths being reviewed in under 6 months (Figure 1).

- The Norfolk and Suffolk CDOPs met on 12 different occasions. (6 for Norfolk and 6 for Suffolk). Norfolk and Suffolk took a median of 263 days between the child's death and the CDOP meeting. This is higher compared to last year's average across both counties (228 days in 2023/24) but still substantially better than the national picture (411 days between death and meeting) (Figure 2). Between April 2024 and March 2025, Norfolk and Suffolk CDOPs reviewed 77 child deaths (47 in Norfolk and 30 in Suffolk)

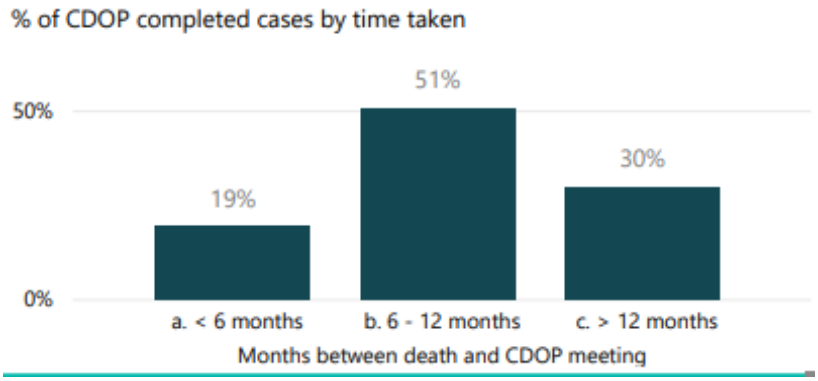


Figure 1: % of CDOP completed cases by time taken.

	CDOP	England
Median number of days between death and CDOP meeting	263	411

Figure 2: Median number of days between death and CDOP meeting for Norfolk and Suffolk CDOP compared to England.

While the reasons for variations in time taken to review child-deaths are not always clear, cases involving criminal investigations tend to take the longest, followed by inquests. In addition, there are 6 cases which have been open from 2019-2023, contributing to extended time to panel.

In Norfolk and Waveney, the presence of a paediatric pathologist significantly reduces the time needed to receive post-mortem reports, resulting in shorter review timelines

compared to Suffolk[1]. In contrast, forensic post-mortem cases conducted outside the region often experience delays in receiving reports that can extend to over a year.

CHILD DEATH OVERVIEW PANEL NOTIFICATIONS 2024/25

ANNUAL COMPARISON

Between the 1st of April 2024 and 31st March 2025, the Norfolk and Suffolk CDOP panels were notified of 80 deaths, with 50 of these in Norfolk and 30 in Suffolk (Figure 3).

Eighteen of these deaths met the criteria for a joint agency response, which occurs when a death occurs in one of the following circumstances:

- death due to external causes
- occurring in suspicious circumstances
- death that is sudden, unexpected and unexplained
- the death of a child under the Mental Health Act (MHA)

LAA name	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Norfolk	42	33	45	45	49	50
Suffolk	37	27	39	43	29	30
Total	**79**	**60**	**84**	**88**	**78**	**80**

Figure 3: Death notifications by Local Authority and Year

Data released annually allows us to compare the number of death notifications in Norfolk and Waveney, and Suffolk and North-East Essex ICB's up to the 2023/24 financial year, to see if notifications were in line with what we would expect based on our births and population.

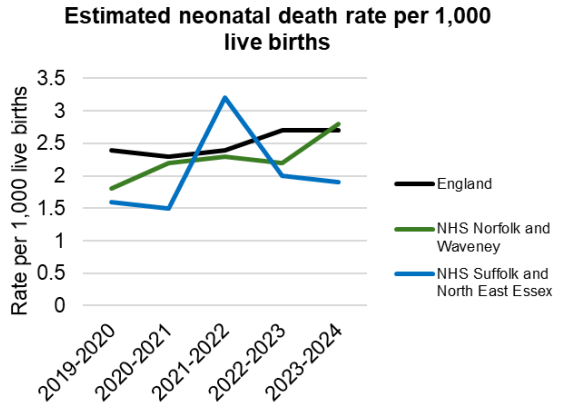
Neonatal, infant and child death rates in Norfolk and Waveney and Suffolk and North-East Essex fluctuated between 2019-20 and 2023-24 (Figure 4). In 2023/24 (latest year available for national data) deaths rates were as follows:

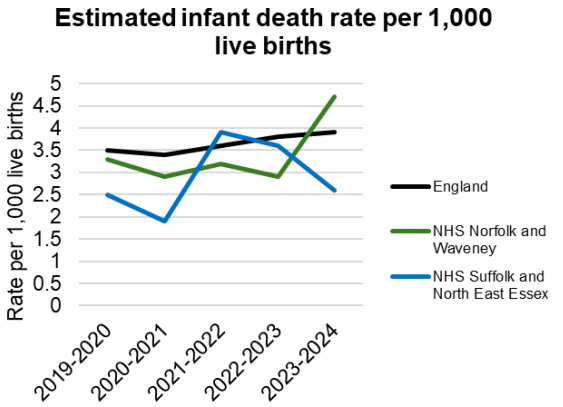
- **Neonatal deaths:** 2.8 per 1,000 live births in Norfolk and Waveney and 1.9 per 1,000 live births in Suffolk and North-East Essex. These are not significantly different to what we see nationally (2.7 per 1,000 live births). In England, the neonatal mortality rate ambition is 1.0 death per 1,000 live births of infants born at 24 weeks or over.
- **Infant deaths:** 4.7 per 1,000 live births in Norfolk and Waveney and 2.6 per 1,000 live births in Suffolk and North-East Essex. These are not significantly different to what we see nationally (3.9 per 1,000 live births).

[1] Note that the Paediatric Pathologist in Norfolk is due to retire in March 2026 and as yet there is no clear succession strategy.

- **Child deaths (aged 1-17 years):** 6.6 per 100,000 population in Norfolk and Waveney and 8.6 per 100,000 population in Suffolk and North-East Essex. Norfolk and Waveney ICB are significantly lower to what we see nationally (12.4 per 100,000 population), whilst Suffolk and North-East Essex ICB is statistically similar.

For year 2023/24	Norfolk & Waveney	Suffolk & North East Essex	England	Compared to England
Estimated neonatal death rate per 1,000 live births	2.8	1.9	2.7	Better
Estimated infant death rate per 1,000 live births	4.7	2.6	3.9	No different
Estimated death rate per 100,000 population of children aged 1 - 17 years in the same ICB	6.6	8.6	12.4	Worse





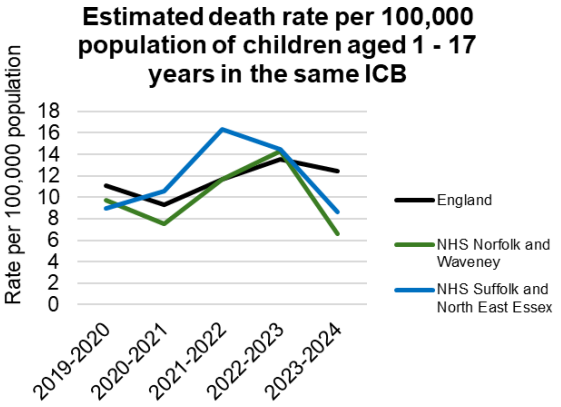


Figure 4: Comparison of Estimated Death Rate Notifications between England, Norfolk & Waveney and Suffolk and North-East Essex ICB in 2019/20-2023/24

AGE

In 2024/25, 37 deaths notifications out of 80 were for neonatal children aged 0-27 days (Figure 5). Deaths in Norfolk and Suffolk are significantly higher for neonates when compared to than any other age group. Nationally, we know that neonatal mortality is

higher among infants born prematurely, as this increases the risk of serious health complications.

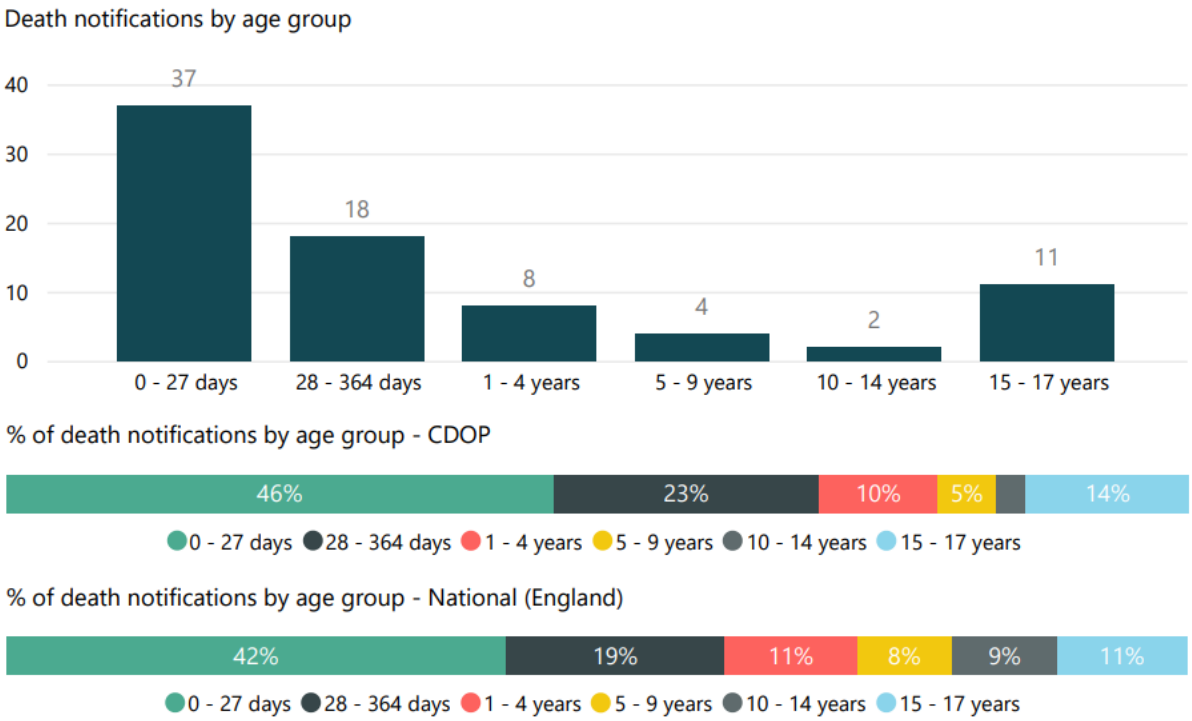


Figure 5: Death Notifications by Age Group, compared to nationally

The highest death rate for children aged 1 and over, continues to be for those aged between 15-17 years-old (15.3 per 100,00 population), followed by 1–4-year-olds (10.1 per 100,000)(Figure 6). This mirrors what we see nationally[2]. The latest data shows that death rates for all age groups, except the 15–17-year-olds, declined in comparison to the previous rolling two-year period.

[2] https://www.ncmd.info/publications/child-death-data-2023/

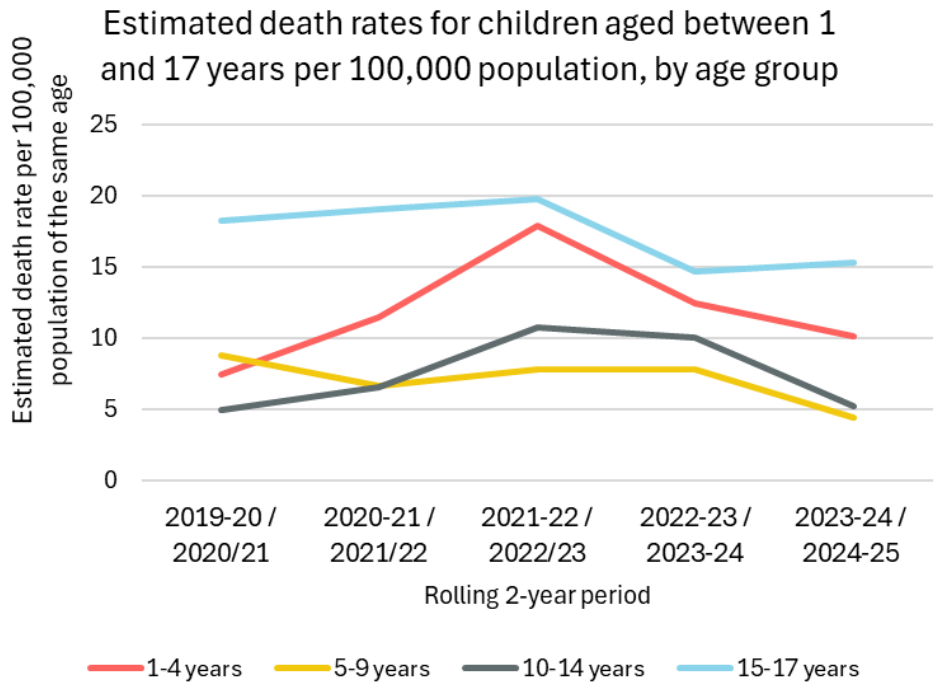


Figure 6. Estimated death rate notifications for children aged between 1 and 17 years (per 100,000) population), by age group

DEPRIVATION

The death rate for children aged 0-17 years in Norfolk and Suffolk varies annually with no clear trends based on levels of deprivation in the neighbourhoods in which their family lives. For the six-year period between 2019/20 and 2024/25, there were no significant differences in child death rates based on levels of deprivation for children aged 0-17 years (Figure 7)[3]. This is different to what we see nationally, where the child death rate is highest for those living in the most deprived neighbourhoods, at 42.9 per 100,000 population (aged 0-17 years) for the year ending 31st March 2024. This is more than twice that of children living in the least deprived neighbourhoods (17.2 per 100,000)[4].

[3] Note this is only calculated for postcodes which could be converted to IMD decile

[4] Child death data release 2024 | National Child Mortality Database

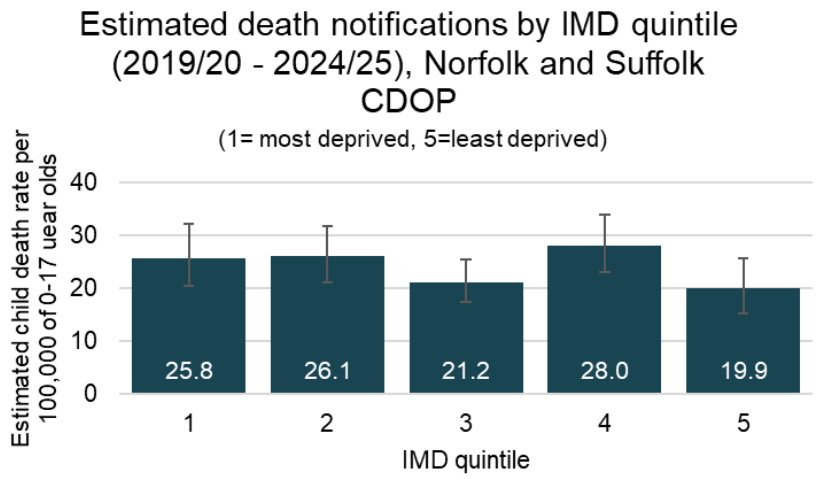


Figure 7. Estimated child death notifications (0-17 years) by indices of multiple deprivation quintile for the period between 2019-20 and 2024-25 in Norfolk and Suffolk CDOPs. Quintile 1 is the most deprived area while quintile 5 is the least deprived.

Infant deaths in the most deprived neighbourhoods were significantly higher (4.4 per 1,000) compared to the least deprived neighbourhoods (2.3 per 1,000) (Figure 8)[5]. This is in line with what we see nationally, where the death rate of infants in the most deprived neighbourhoods of England (5.5 per 1,000), is twice that of infants in the least deprived neighbourhoods (2.0 per 1,000).

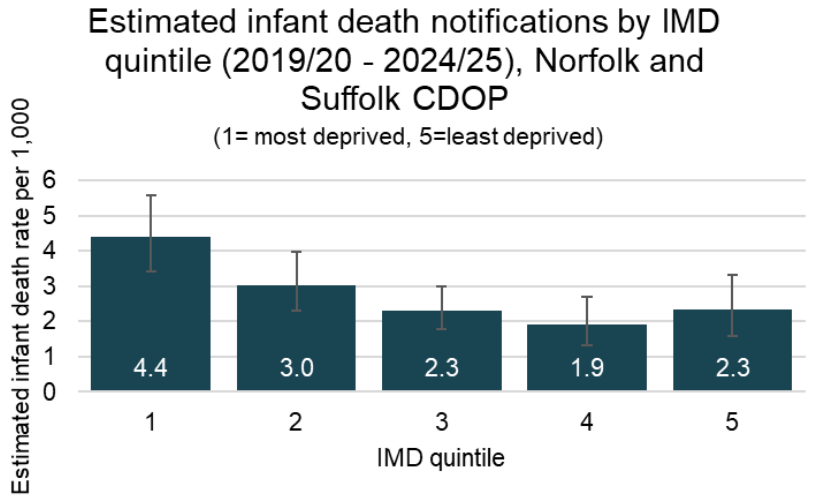


Figure 8. Estimated infant death notifications by indices of multiple deprivation quintile for the period between 2019-20 and 2024-25 in Norfolk and Suffolk CDOPs. Quintile 1 is the most deprived area while quintile 5 is the least deprived.

[5] Note this is only calculated for postcodes which could be converted to IMD decile

GENDER

Nationally, mortality rates are higher for males than females, due to differences in biological, social and environmental factors. Males are more likely to be born prematurely and suffer from respiratory conditions, with females more likely to have a greater immune response and resistance to infection[6]. In England, for child death reviews completed in 2023/24, 57% of the deaths were male. This is statistically similar to the proportion observed in Norfolk and Suffolk in 2024/25, where 66% of the deaths reviewed were male and 34% female **(**Figure 9**)**.

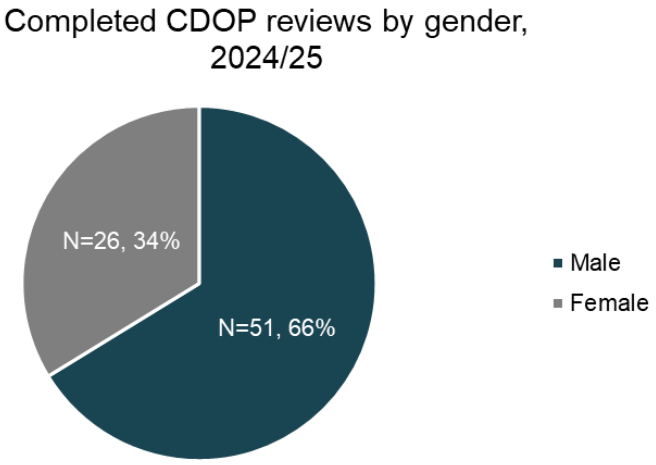


Figure 9: Completed CDOP Reviews by Gender

ETHNIC GROUP

Nationally we know that child death rates are highest for children that are of black or black British ethnicity (55.4 per 100,000) and Asian and Asian British ethnicity (46.8 per 100,000), which is much higher compared to children of white ethnicity (24.6 per 100,000)[7].

Norfolk and Suffolk have a less diverse population compared to England as a whole, with 94% of its population known to be white during the Census in 2021 compared to 82% nationally. In 2024/2025, ethnicity data was recorded in all completed child death reviews (Figure 10). Of the completed reviews, 82% (63/77) were for children that were of white ethnicity.

[6] https://www.pnas.org/doi/10.1073/pnas.0800221105

[7] Child death data release 2024 | National Child Mortality Database

Ethnic Group	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	Total
White	26	12	5	3	9	8	63
Unknown	0	0	0	0	0	0	0
Other	2	0	0	0	0	0	2
Mixed	2	0	0	0	0	1	3
Black or Black British	2	3	0	0	0	0	5
Asian or Asian British	2	1	0	0	1	0	4
Total	**34**	**16**	**5**	**3**	**10**	**9**	**77**

Figure 10: Completed CDOP reviews by ethnic group and age group

CATEGORY OF DEATH

The most common primary category of death in Norfolk and Suffolk CDOP is Perinatal/neonatal events, accounting for 24 deaths, followed by Chromosomal, genetic and congenital anomalies with 19 deaths (Figure 11). These are also the two most common categories of death nationally[8].

[8] Child death data release 2024 | National Child Mortality Database

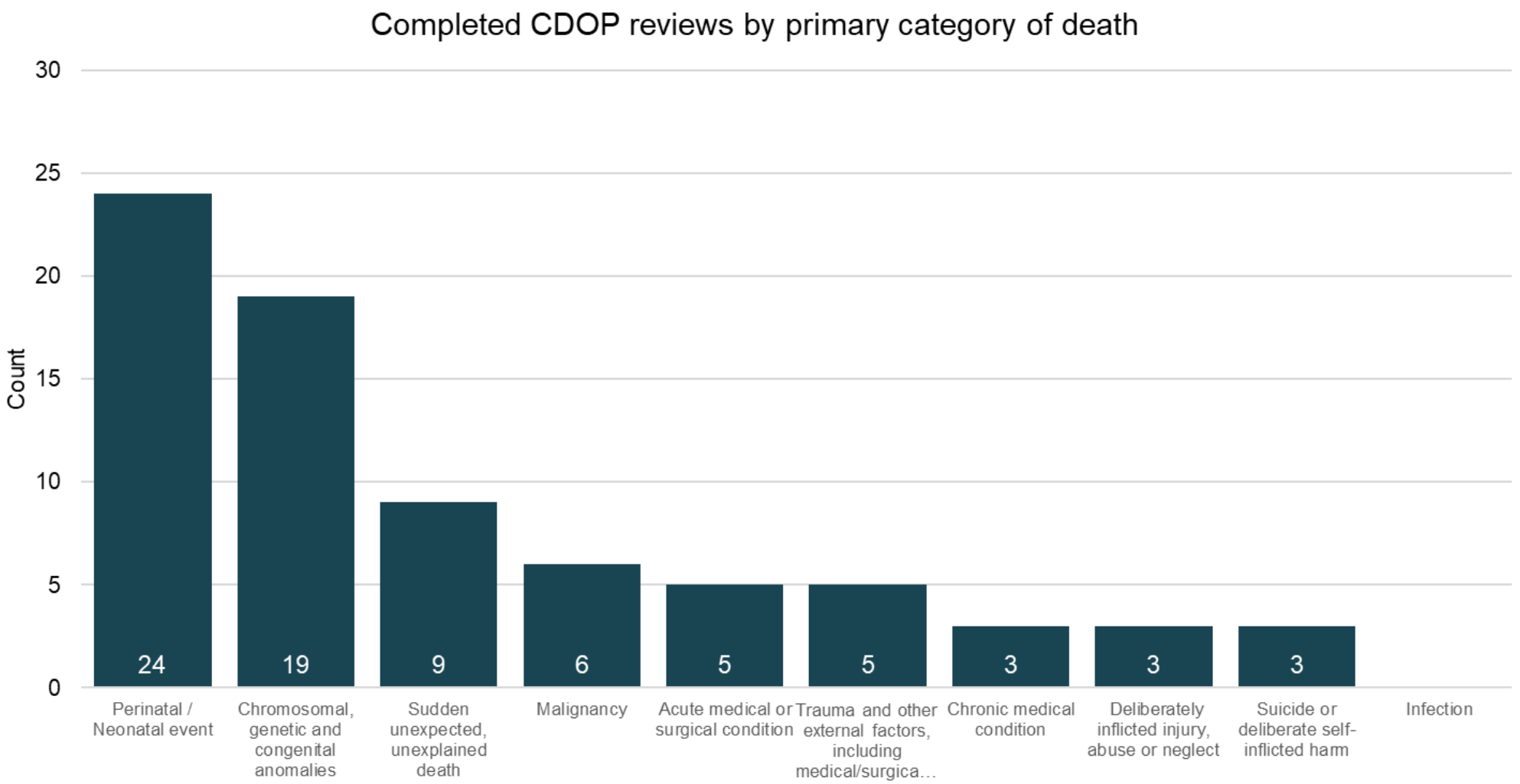


Figure 11: Completed CDOP Reviews by Primary Category of Death, 2024/25

LEARNING FROM CASES

Learning in the child death review process encompasses the full journey leading up to the death as well as the events that follow. All learning from the CDOP Panel is carefully documented, with special attention paid to identifying and agreeing modifiable factors that may have contributed to a child death. This well-structured process emphasises learning from each case, considering the factors that could prevent the future deaths of children. Modifiable factors are defined as 'those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced'.

Whilst some modifiable factors, such as the absence of safety features in the home or unsafe sleeping practices, such as co-sleeping after consuming alcohol or drugs may seem straightforward, they rely heavily on human behaviour.

More complex factors are those which revolve around broader social issues and health systems such as poverty. Although, in Norfolk and Suffolk we have not found a significant difference based on levels of poverty, national data has shown that there is a clear association with deprivation and the risk of child death for all categories of death, except cancer[9]. These complex challenges are harder to address and continue to be a subject of discussion.

Family involvement with the recognition of good practice remains a key role in the review process. This acknowledgement of good practice often enables families to manage their grief in a more supported and constructive way.

MODIFIABLE DEATHS

Modifiable factors are those, where if actions could be taken through national or local interventions, the risk of future child deaths could be reduced[10].

Between April 2024 and March 2025, Norfolk and Suffolk CDOPs reviewed **77 child deaths** (47 in Norfolk and 30 in Suffolk). Norfolk and Suffolk identified modifiable factors in **43% of its deaths**, which is in line with what we see nationally. This is higher than in Norfolk and Suffolk in 2023/24 in which **33% of deaths** had modifiable factors (Figure 12).

[9] Child Mortality and Social Deprivation | National Child Mortality Database

[10] https://bmjopen.bmj.com/content/12/12/e066214

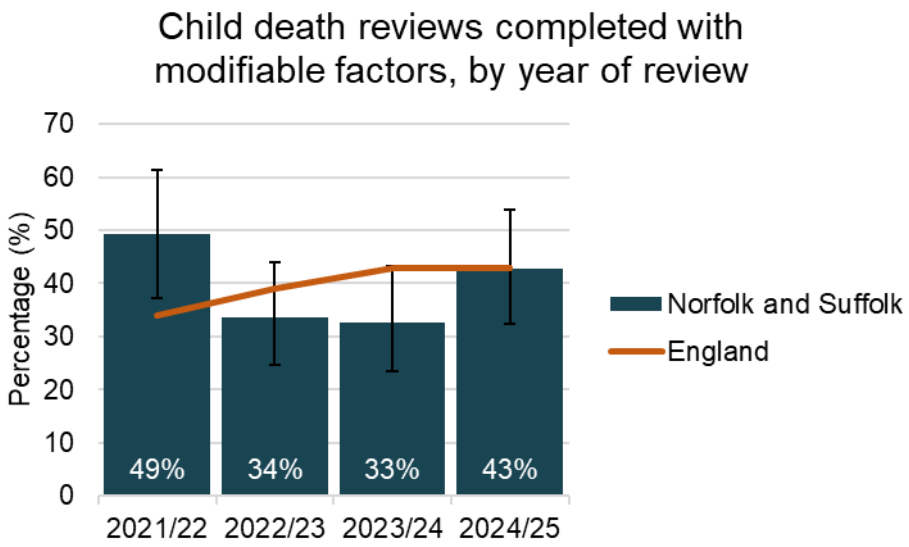


Figure 12. Child death reviews completed with modifiable factors, by year of review

AGE

The highest proportion of deaths identified with modifiable factors were for children aged 28 to 364 days-old (63%; 10 of 16 deaths) (Figure 13). Of these, 8 were attributed to sudden, unexpected death in infancy (SUDI).

% 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	34	13	38%
28 - 364 days	16	10	63%
1 - 4 years	5	3	60%
5 - 9 years	3	0	0%
10 - 14 years	10	6	60%
15 - 17 years	9	1	11%
Total	**77**	**33**	**43%**

Figure 13. Percentage of cases where modifiable factors were identified by age group

CATEGORY OF DEATH

Modifiable factors were identified in all deaths recorded as SUDI and in those resulting from deliberately inflicted injury, abuse or neglect (Figure 14). SUDI deaths are those unexplained following a postmortem examination, also known as sudden infant death

syndrome (SIDS). For those who died from deliberately inflicted injury, abuse or neglect, 2 out of 3 of the deaths, had communications within or between agencies as a modifiable factor.

% 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	5	2	40%
Suicide or deliberate self-inflicted harm	3	1	33%
Sudden unexpected, unexplained death	9	9	100%
Perinatal/neonatal event	24	13	54%
Malignancy	6	1	17%
Infection	0	0	0%
Deliberately inflicted injury, abuse or neglect	3	3	100%
Chronic medical condition	3	1	33%
Chromosomal, genetic and congenital anomalies	19	1	5%
Acute medical or surgical condition	5	2	40%
Total	**77**	**33**	**43%**

Figure 14. Percentage of cases where modifiable factors were identified by category of death

SOCIAL CARE STATUS

In 2024/25, 25 children died who were known to social care either at the time of their death or at some point in their history. Of these, 60% (N=15) were identified as having modifiable factors (Figure 15). This is higher, but not significantly so, compared to children not known to social care in which 35% of deaths had modifiable factors (17 out of 49 deaths). It is also higher than in previous years, for example in both 2022/23 and 2023/24, 38% (N=8) of children known to social care at some point in their history had modifiable factors associated with their death. Future monitoring will be required to see if this is an upward trend or due to chance in Norfolk and Suffolk. Nationally, we know that children known to social care at the time of death are more likely to report modifiable factors, with 46% of deaths for those known to social care compared to 40% of children who were never known to social care[11]. However, children who had previously been known to social care (but were not at time of death) are not reported on nationally.

Children known to social care at some point includes those with a child protection plan, looked after children, child in need, asylum seekers known to social care and those listed under ‘social care other’.

[11] https://www.ncmd.info/publications/child-death-review-data-release-2024/

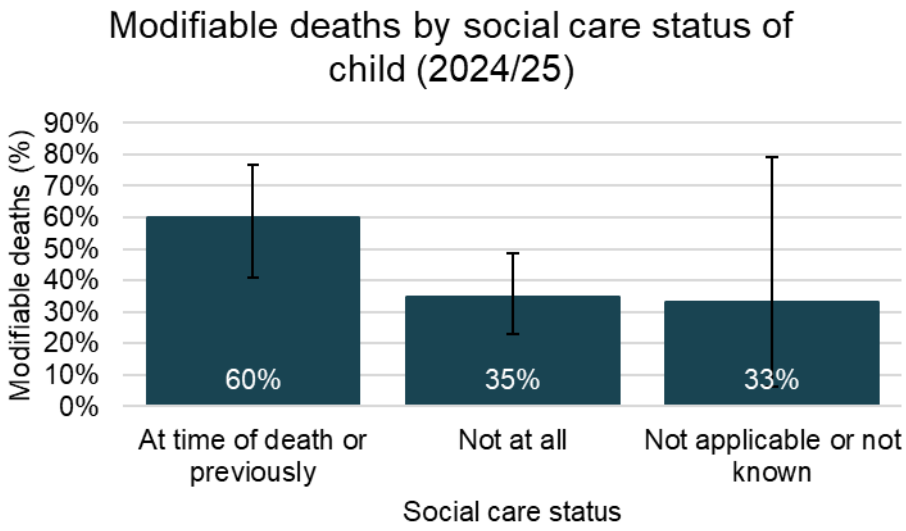


Figure 15. Deaths with modifiable factors by social care status of child

MODIFIABLE DOMAINS

For each death, contributory factors are recorded, and it is then decided whether these were modifiable or not. These are categorised in accordance with the NCMD Contributory Factors Guidance, as follows:

A. Factors intrinsic to the child
B. Factors in the social environment including family and parenting capacity
C. Factors in the physical environment
D. Factors in service provision.

The most frequently listed modifiable factors in Norfolk and Suffolk were those with factors intrinsic to the child (52% of deaths with modifiable factors), or with associated service provision (45% of deaths with modifiable factors).

Risk factors in mothers during pregnancy; including high maternal BMI and smoking during pregnancy were the most common modifiable factors identified following child death, noted in 39% of all deaths with identified modifiable factors (Figure 16). This was followed by issues relating to following guidelines/pathway/policy, identified in 27% of deaths with modifiable factors, which covers issues with service provision including when guidance is available but not adequately used by the practitioner. Also smoking, vaping, alcohol or substance misuse by parent or carer (24%), sleep environment (21%), and communication issues within and between agencies (18%) of deaths with modifiable factors.

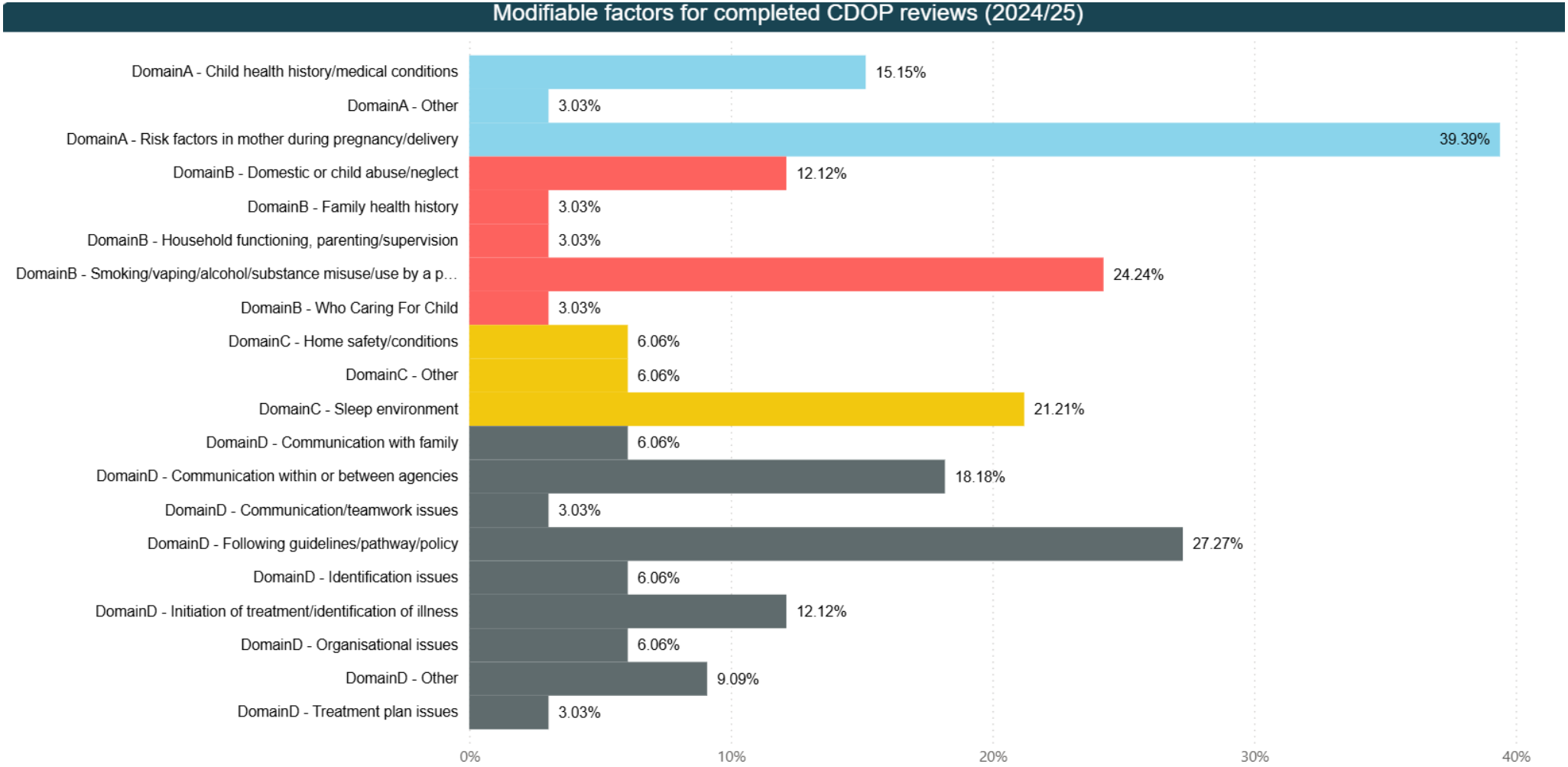


Figure 16. Modifiable factors for completed CDOP reviews. *Domain A – Factors intrinsic to child (blue), Domain B – Factors in social environment (red), Domain C – Factors in physical environment (yellow), Domain D – Factors in service provision (grey)*

When breaking this down by age, 37% (10/27) deaths in children over the age of 1 had modifiable factors identified at CDOP, of which 70% had factors related to service provision including:

- Issues in diagnosis (modifiable factor in 3 deaths)
- Guideline/policy/pathway being available but not followed (modifiable factor in 2 deaths)
- Lack of recognition of deteriorating child clinical symptoms (modifiable factor in 2 deaths)
- Issues with availability of information (modifiable factor in 2 deaths)

FOCUS SPECIAL: SUDDEN UNEXPECTED DEATH IN INFANTS

Sudden Unexpected Death in Infancy (SUDI) continues to be one of the most avoidable causes of child death reviewed by CDOP. In 2024/25, all SUDI related deaths reviewed were found to have modifiable factors.

Modifiable factors identified through CDOP reviews included those which were antenatal and postnatal. Between 2021/22-2024/25, 59% of all modifiable SUDI deaths across Norfolk and Suffolk consisted of hazardous sleep environments, and 59% with parental smoking, vaping, alcohol or drug misuse (Figure 17). These findings are consistent with national evidence of associations between deprivation and infant mortality including SUDI.

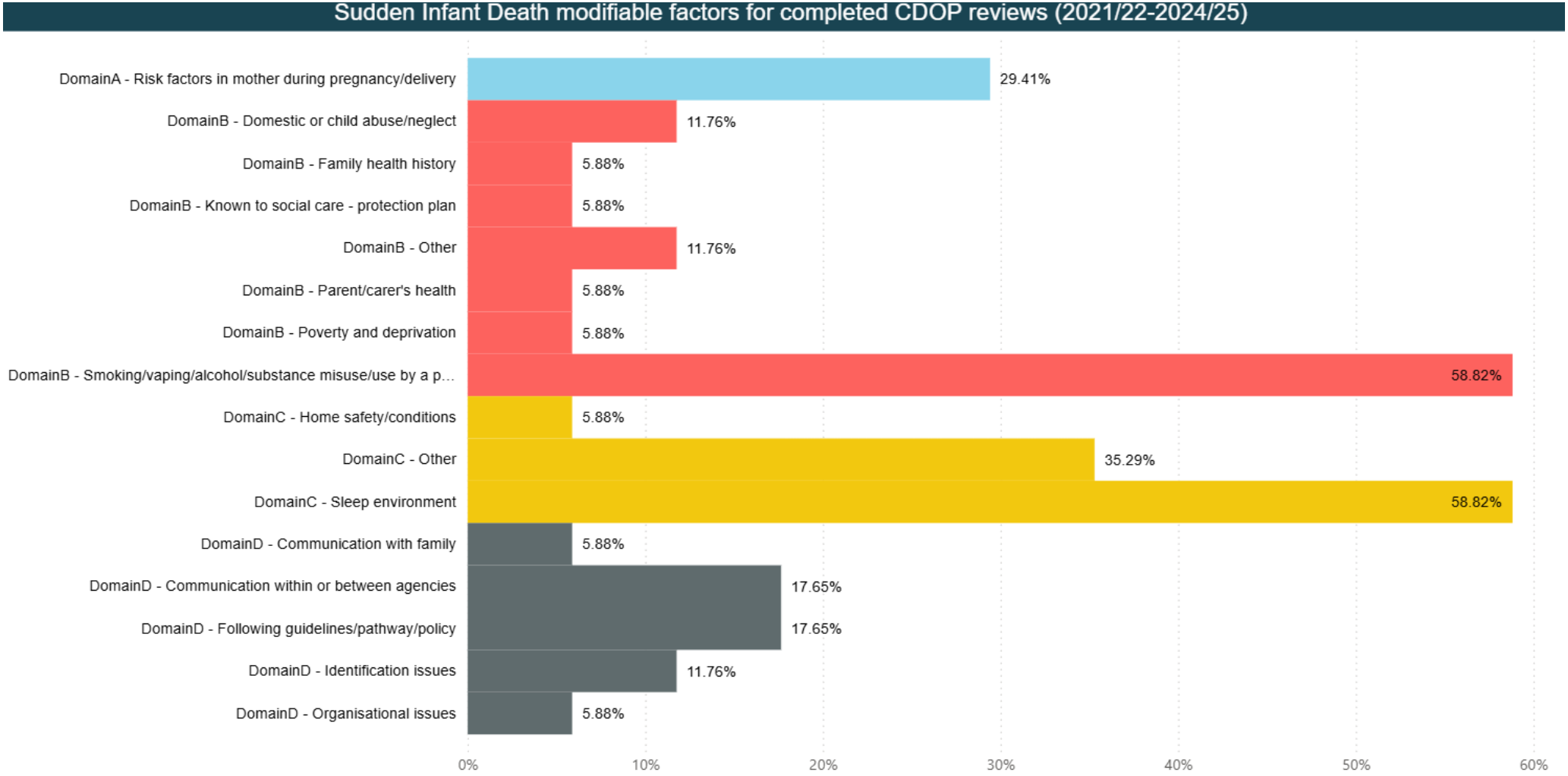


Figure 17. Modifiable factors associated with SUDI (2021/22 - 2024/25). *Domain A – Factors intrinsic to child (blue), Domain B – Factors in social environment (red), Domain C – Factors in physical environment (yellow), Domain D – Factors in service provision (grey)*

RISK REDUCTION AND PREVENTION

SUDI avoidance must be an interagency intervention, including ongoing safe sleep messaging coupled with targeted intervention for families with extremely entrenched difficulties. The following principles, taken from guidance on Just One Norfolk and national campaigns such as The Lullaby Trust, are essential for reducing SUDI risk:

• **Back to Sleep, Feet to Foot**: The safest sleep position for babies is on their back, with feet at the foot of the cot.

• **Clear Sleep Environment**: Only a firm, flat, waterproof mattress and lightweight bedding should be in the cot whilst baby is sleeping. Other non-essentials such as soft pillows, toys, and blankets should be removed as these can obstruct their breathing if they cover babies face.

• **No Smoking**: Parents and carers should be encouraged to quit smoking before, during, and after pregnancy. Smoking significantly raises the risk of SUDI, especially in conjunction with bed-sharing. Cars and homes should be smoke-free.

• **Avoid Overheating**: Room temperatures kept at 16–20°C and babies should not be overdressed. Baby sleeping bags with tog ratings offer the appropriate amount of warmth without blankets.

• **Sharing the Room**: Room sharing with a parent or carer for at least the first six months for sleep during day and night is the safest.

• **Prevention of Co-sleeping in Dangers**: Co-sleeping should never be on an armchair or a sofa and should never happen if the adult has consumed alcohol, taken drugs or medication, is a smoker, or is extremely exhausted.

PUBLIC HEALTH COMMUNICATION AND COMMUNITY SUPPORT

There should be a clear message across health visiting, midwife services, early help, children's centres, and general practice. Vulnerable families, most notably those with a history of substance abuse, domestic violence, mental health issues, or homelessness should be offered support specifically to meet their needs.

The Just One Norfolk Safe Sleep Campaign provides simple, accessible, evidence-based guidance to parents and carers and has a vital role in the enforcement of best practice. It optimises coordinated, county-wide messaging so that families are provided with clear, consistent and non-judgmental guidance.

A safe sleep webinar was held at the end of 2023 through the Suffolk Safeguarding Partnership (SSP) which was attended by over 350 professionals. In January 2024 the Safer Sleep for Babies Thinking Tool was launched, these were rolled out across

primary care at the end of 2024. SSP have a range of materials available for use by professionals in all agencies on their website.

Multi-agency work remains essential. CDOP training needs to be shared across maternity, health visiting, primary care and safeguarding teams to facilitate earlier risk identification and response within the child's life. All agencies working with families need to ensure that:

- Safe sleep advice is provided in trauma-informed and culturally sensitive ways.
- Parental understanding is assessed and documented, especially where there are known prior risk factors.
- Housing and home conditions are considered when assessing the acceptability of the sleeping environment.

Every contact with a family presents a possibility for promoting safe sleeping. Workers should feel able to confidently discuss the risks of SUDI and challenge harmful familial habits in a supportive, non-critical manner. The use of leaflets, demonstration beds, and hands-on equipment (e.g. baby boxes or sleeping bags) can be invaluable in reinforcing learning.

Where groups are faced with barriers to following safe sleep advice such as over-crowded housing, inappropriate or no furniture for a baby, or poor mental health, practitioners must raise concerns and call upon appropriate support from wider services.