

# Cambridgeshire and Peterborough Child Death Overview Panel (CDOP)



[Annual Report 1 April 2024 – 31 March 2025](#)

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### 1. Introduction

This annual report sets out the work, findings and learning of the Cambridgeshire and Peterborough Child Death Overview Panel (CDOP) for the period 1 April 2024 to 31 March 2025. It is produced in accordance with the Child Death Review Statutory and Operational Guidance (2018) and fulfils statutory responsibilities under Working Together to Safeguard Children (2023).

The aim of the CDOP is to prevent future child deaths by considering ways to improve support for children, young people, and their families.

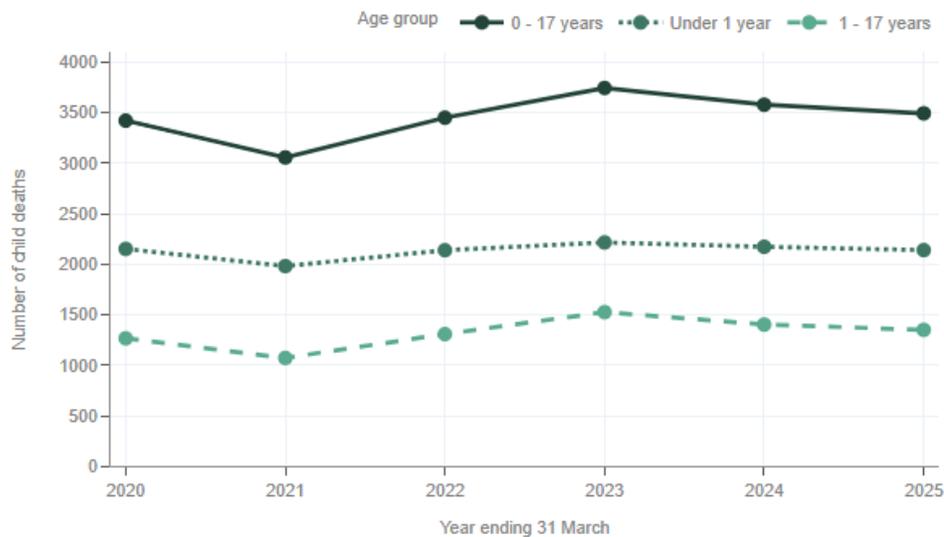
### 2. CDOP Area and Population

The CDOP covers the footprint of Cambridgeshire County Council and Peterborough City Council, serving a diverse urban and rural population. The estimated child population (0–17 years) for Peterborough unitary authority in the Office for National Statistics (ONS) mid-year report estimates a population of 57,600. The estimated child population (0-17 years) for Cambridgeshire, taken from the Children and Young People’s Joint Strategic Needs Assessment (JSNA) report, estimates a total population of 139,191.

There were 3,492 child (0 – 17 years) deaths in England in the year ending 31 March 2025, an estimated rate of 28.7 deaths per 100,000 children. The number of deaths decreased by 2% on

the previous year but remained higher than 2019-20. Infant (children under 1 year) deaths decreased by 2% on the previous year and deaths of children aged between 1 and 17 years decreased by 4% (Figure 1). The estimated rate of infant deaths per 1,000 live births decreased from 3.9 to 3.8 and deaths of 1 – 17-year-olds per 100,000 population (1 – 17 years) decreased from 12.3 to 11.6.

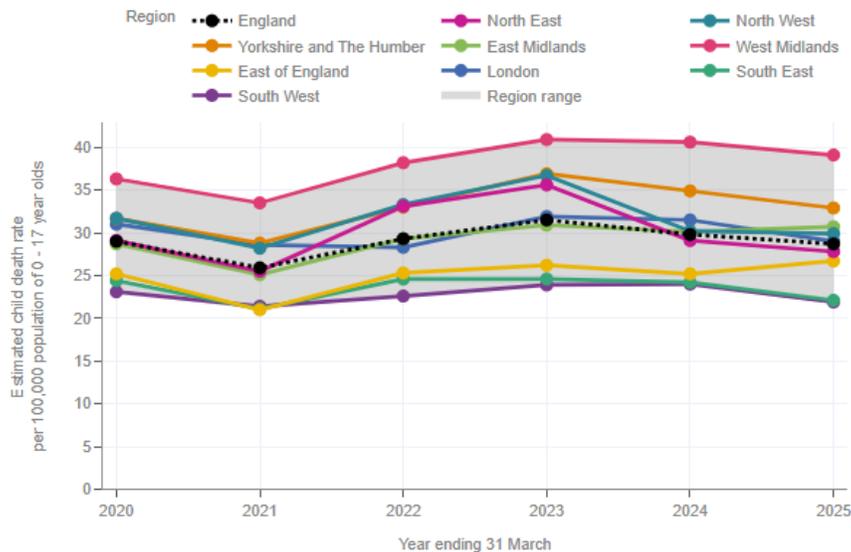
Figure 1. Number of child death notifications, by year ending 31 March



Data Source: NCMD  
[www.ncmd.info/cdr25/](http://www.ncmd.info/cdr25/)

The child death rate varied across regions in England, with the rate ranging from 21.9 to 39.1 per 100,000 population of 0-17-year-olds. The East of England region had a rate of 26.7.

Figure 2. Estimated child death rate per 100,000 population, by region

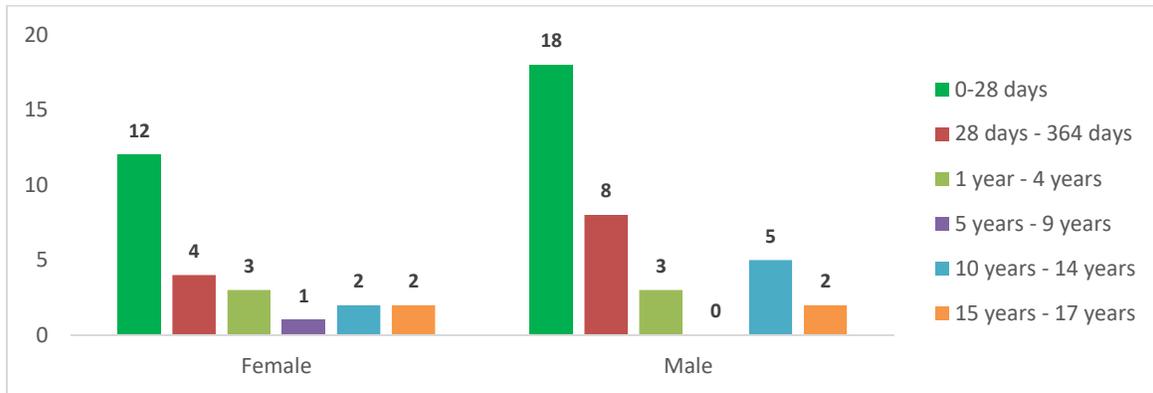


Data Source: NCMD, ONS mid-year population estimates  
[www.ncmd.info/cdr25/](http://www.ncmd.info/cdr25/)

### 3. Summary of Child Deaths

Between 1 April 2024 and 31 March 2025, 60 child deaths were notified to the CDOP, and 40 cases were fully reviewed during the reporting period.

#### Age and sex at death



In Cambridgeshire and Peterborough there continued to be a higher rate of mortality in the neonatal period (0-28 days), accounting for 50% of all deaths in 2024/25. There was also an increase in the deaths of babies born under 24-week gestation, with 47% of all deaths in the neonatal period being below 24-weeks' gestation. There continues to be a higher number of male child deaths in comparison to females, particularly in the first year of life.

In England, 78% of neonatal deaths were of babies born at a premature gestational age (before 37 weeks), which was a decrease from last year (79%). The proportion of neonatal deaths notified to CDOPs of babies born under 24 weeks gestation also continued to increase (42% vs 32% in the year ending March 2020).

This increase in deaths of babies under 24 weeks is difficult to interpret but may be impacted by multiple factors, such as more consistent recognition of signs of life by clinical teams, babies receiving survival focused care, appropriate completion of MCCDs (medical certificate of cause of death), and better reporting to CDOPs.

Figure 15. Proportion of neonatal deaths by gestational age at birth

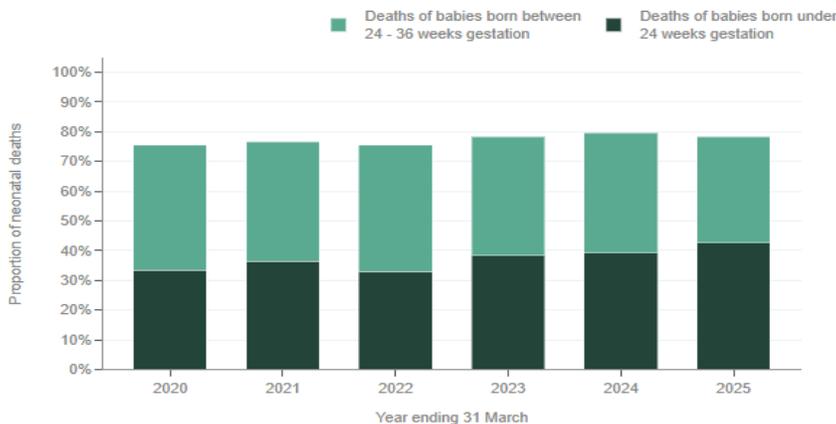
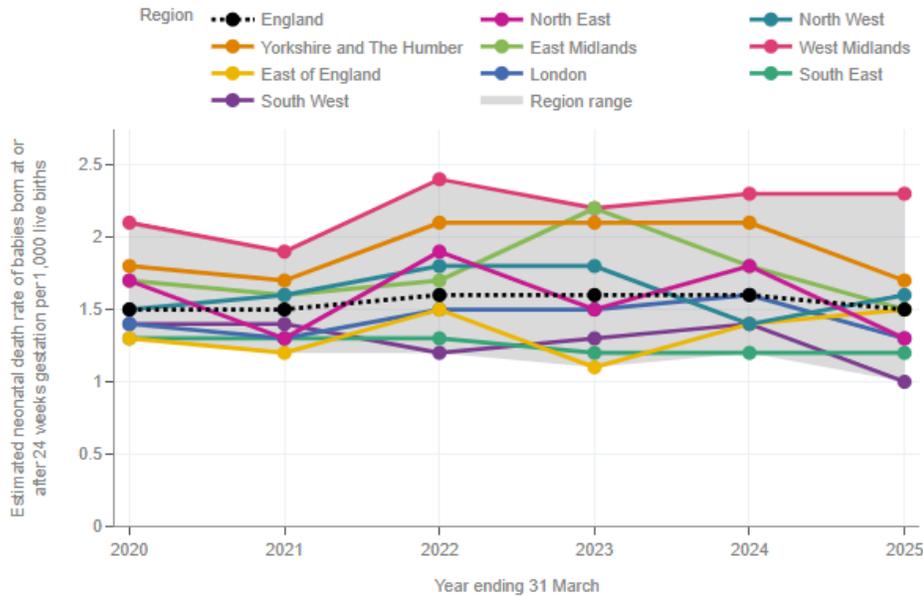


Figure 14. Estimated neonatal death rate of babies born at or over 24 weeks gestation per 1,000 live births, by region



Data source: NCMD, ONS Live births  
[www.ncmd.info/cdr25/](http://www.ncmd.info/cdr25/)

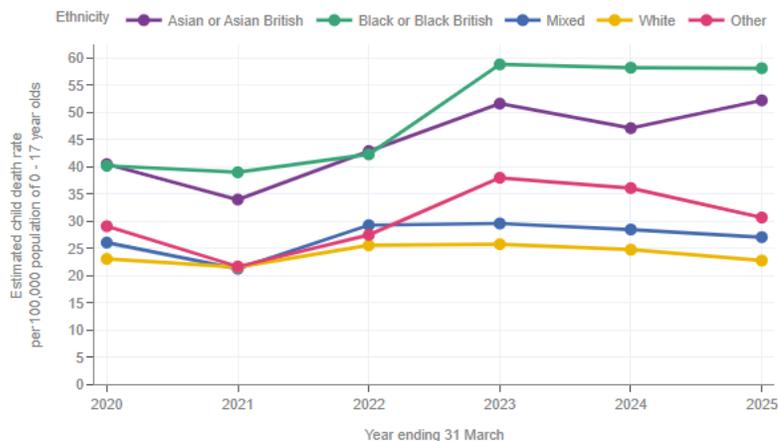
In the East of England there was a neonatal death rate of 1.5 per 1,000 live births.

### Deaths by ethnicity

Across Cambridgeshire and Peterborough there were 12 deaths of children who were Asian or Asian British, 4 Black or Black British, 5 of Mixed Ethnicity, 8 White – any other background, and 29 White British. Two families did not wish to state their ethnicity.

In England, the child death rate in the year ending 31 March 2025 remained highest for children of black or black British ethnicity (58.1 per 100,000 population) and Asian or Asian British ethnicity (52.2 per 100,000 population) (Figure 3). The rates for all ethnic groups other than Asian or Asian British ethnicity have decreased in comparison to the previous year.

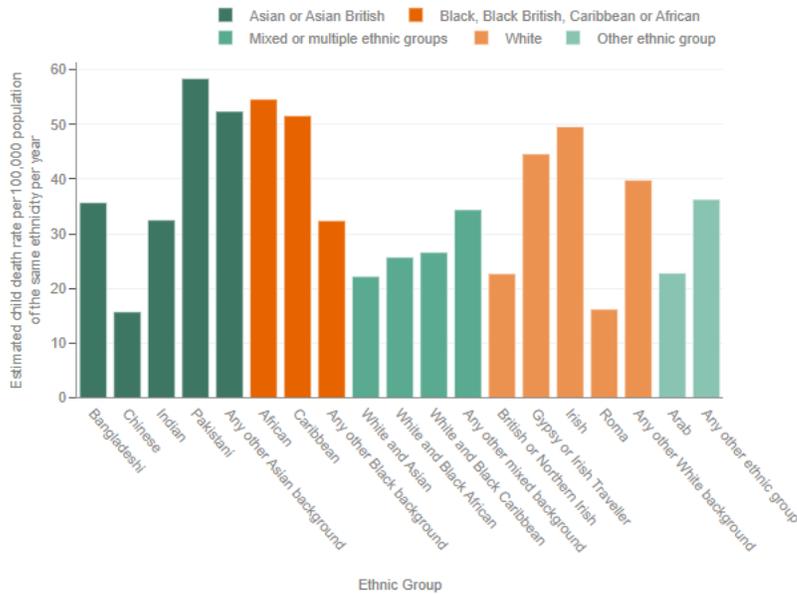
Figure 3. Estimated child death rate per 100,000 population, by ethnicity



Data Source: NCMD, ONS Census (2021)  
[www.ncmd.info/cdr25/](http://www.ncmd.info/cdr25/)

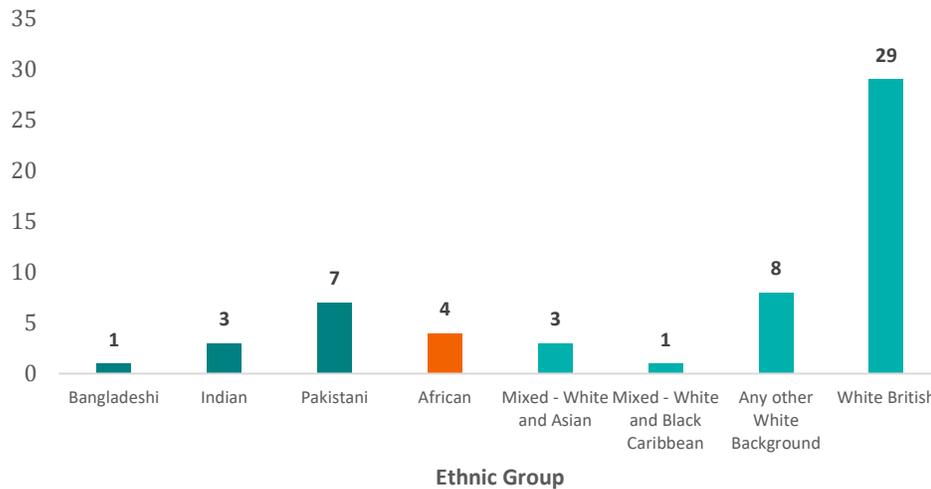
Within these ethnicity groupings, over a six-year period, the child death rate was highest for children of Asian Pakistani ethnicity (58.4 per 100,000 population), followed by black African (54.6 per 100,000 population), any other Asian background (52.4 per 100,000 population) or black Caribbean (51.6 per 100,000 population). This was more than double the rate of children from a white British ethnic background (22.7 per 100,000 population). The child death rate was lowest for those of Chinese ethnicity (15.7 per 100,000 population).

Figure 4. Estimated death rates for children aged between 0 and 17 years per 100,000 population, by ethnicity (years ending 2020-2025)



Data Source: NCMD, ONS Census (2021)  
[www.ncmd.info/cdr25/](http://www.ncmd.info/cdr25/)

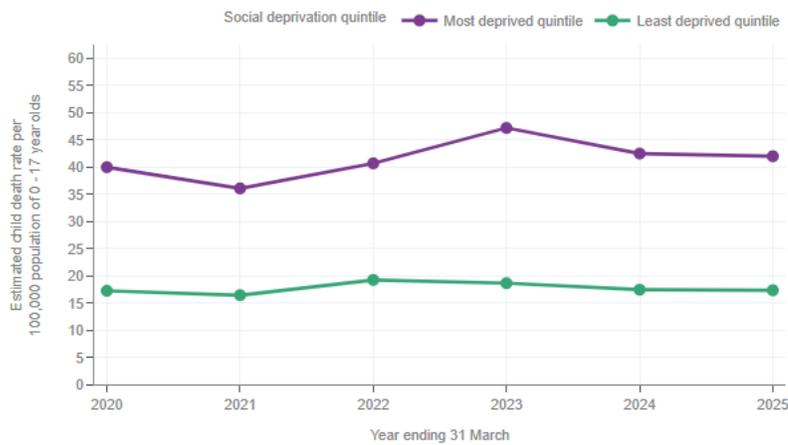
**Cambridgeshire and Peterborough death rate by ethnicity  
2024-25**



### Child deaths by deprivation

The child death rate for children resident in the most deprived neighbourhoods of England was 42.0 per 100,000 population, more than twice that of children resident in the least deprived neighbourhoods (17.4 per 100,000 population). The child death rates decreased from the previous year for both quintiles, although the difference in rates between these areas is still higher than any year recorded before 2023.

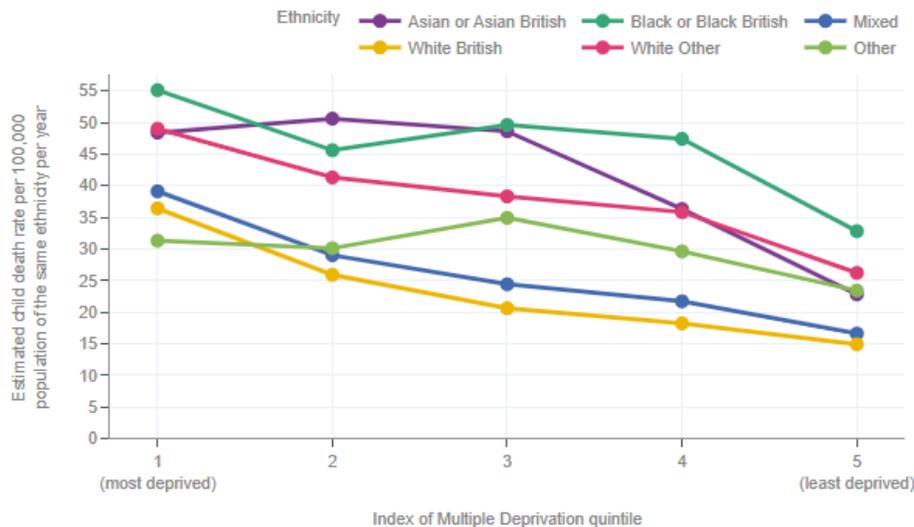
Figure 5. Estimated child death rate per 100,000 population, by most/least deprived quintiles



Data Source: NCMD, ONS mid-year population estimates, Index of Multiple Deprivation (2025)  
Please note population for year ending 31 March 2023 is used for years ending 31 March 2024 and 2025.  
[www.ncmd.info/cdr25/](http://www.ncmd.info/cdr25/)

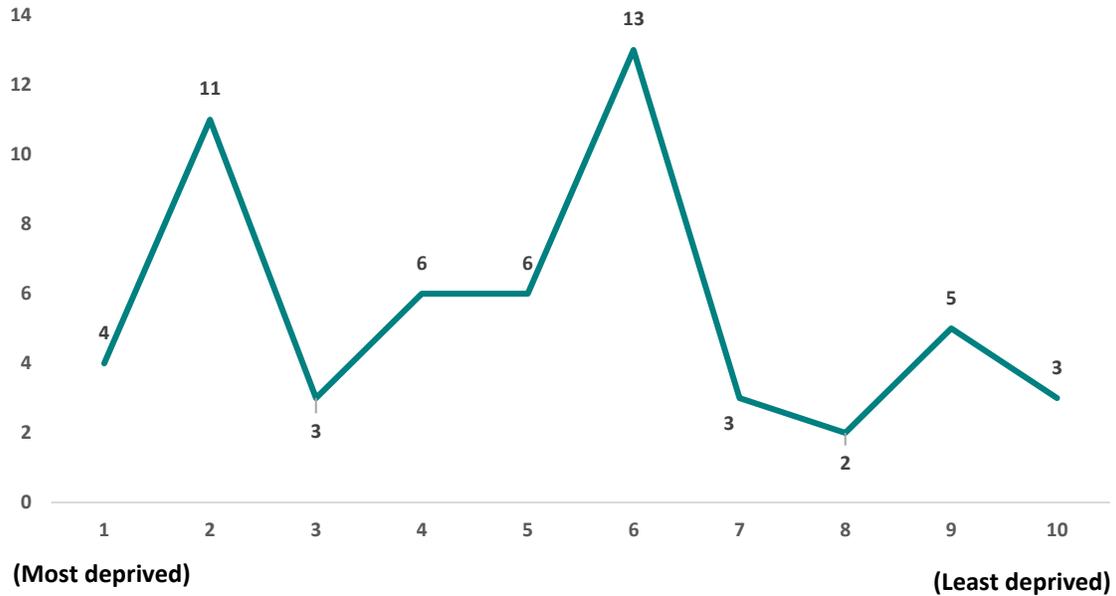
Over the six-year period, death rates for children of black and Asian ethnicities remained higher than for children of white British ethnicity across all five deprivation quintiles.

### Estimated death rates for children aged between 0 and 17 years per 100,000 population, by IMD quintile and ethnicity (years ending 2020-2025)

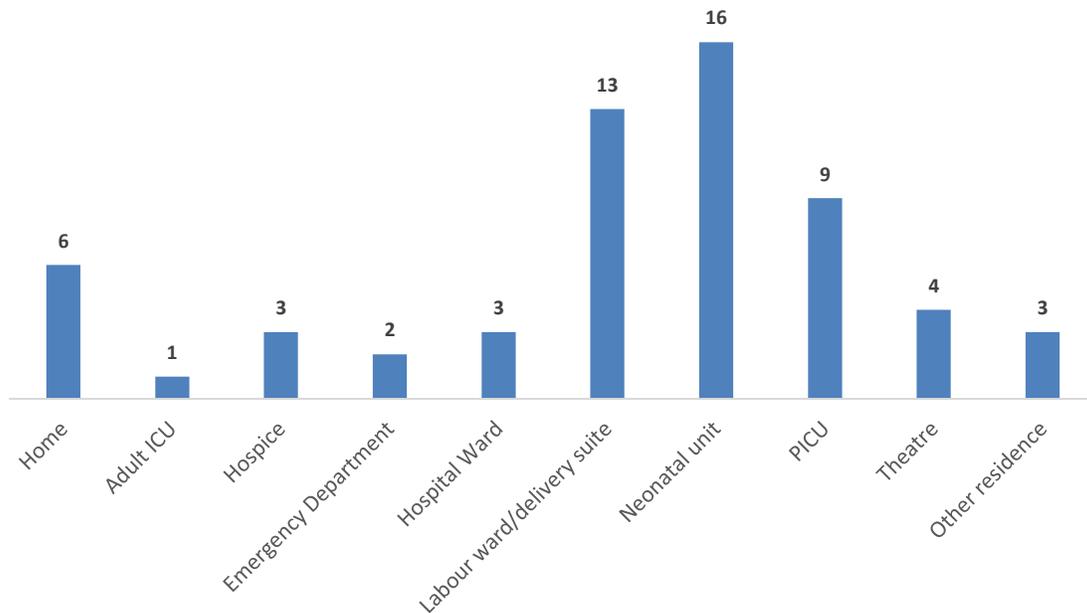


Data Source: NCMD, ONS Census (2021), Index of Multiple Deprivation (2025)  
[www.ncmd.info/cdr25/](http://www.ncmd.info/cdr25/)

Cambridgeshire and Peterborough child deaths by index of multiple deprivation decile



Place of death

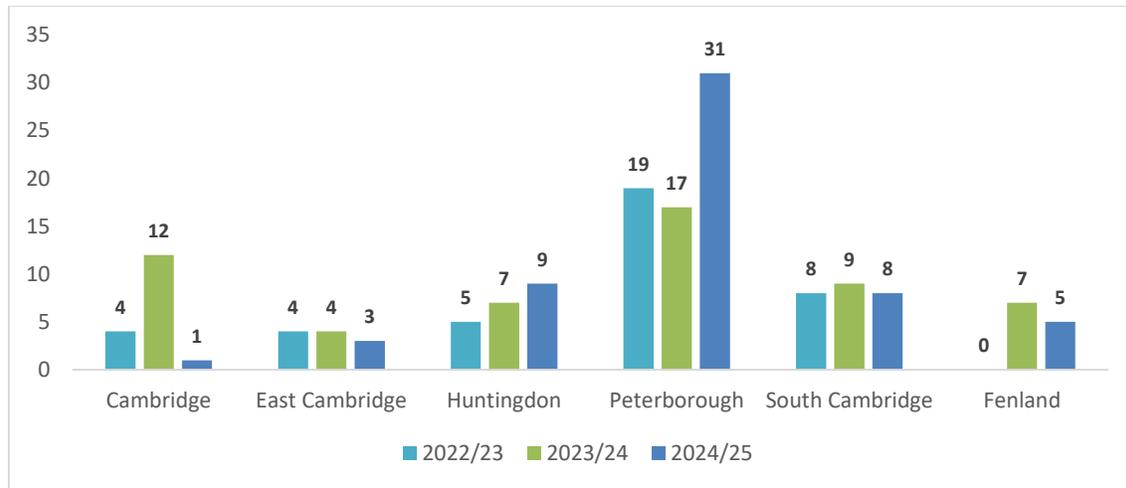


The most common place of death in Cambridgeshire and Peterborough was the neonatal unit (16), closely followed by the labour ward/deliver suite (13), this is in keeping with most deaths being in the neonatal period.

Of the 60 total deaths, eight children died in hospitals outside of the locality, either because they were receiving specialist care, or because the hospital was in a closer proximity to their home address.

Furthermore, the Cambridgeshire and Peterborough CDOP were notified of 12 deaths which were shared with out of area CDOP teams as it was agreed that the learning from each child’s death sat within their locality, rather than in Cambridgeshire and Peterborough.

### Deaths by local area



Locally, there has been a significant decrease in child deaths in Cambridge city, with a slight decline also seen in East Cambridge, South Cambridge and Fenland in comparison to 2023/24. Huntingdon has seen a slight increase, whereas Peterborough city has seen the highest number of deaths recorded by year, with an increase of 82% from 2023/24.

### Peterborough child deaths

	Score/ rank	Income score	Employment score	Health & disability rank	Barriers to housing & services rank	Living environment rank	Income deprivation affecting children rank
1 – most deprived 10 - least deprived	1	2	2	6	10	4	1
	2	9	7	9	5	1	3
	3	4	3	4	7	7	3
	4	5	4	7	7	9	1
	5	6	9	4	2	4	3
	6	5	3	0	0	4	5
	7	0	4	1	0	1	3
	8	0	0	0	0	1	6
	9	0	0	0	0	0	6
	10	0	0	0	0	0	0

There are links between income, health and disability, and barriers to housing and services deprivation and the number of child deaths in the Peterborough local authority area. However, when looking specifically at income deprivation that affects children, a measure used to assess the proportion of children under 16 living in low-income households, most deaths were in the least deprived postcode areas.

64% of children resident in Peterborough that died in 2024-25 were non-White British. With 35% of the total number of child deaths in Peterborough being from Asian or Asian British ethnic backgrounds. As highlighted on page five, the NCMD have highlighted that children from Asian or Asian British ethnic backgrounds, have the highest child mortality rate in England per 100,000 population of children from the same ethnic background.

### Categories of death

Whilst the CDOP does not determine the cause of a child’s death, a category is selected as part of the review based on the information provided by either the coroner, or on the medical certificate of cause of death.

Category of death	Date of death							
	2017/ 18	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/ 23	2023/ 24	2024/ 25
Acute medical or surgical condition	0	2	6	5	6	4	5	11
Suicide or deliberate self-inflicted harm	1	3	1	4	2	1	1	1
Chromosomal, genetic and congenital anomalies	1	7	16	9	14	10	2	16
Malignancy	1	1	1	4	1	3	1	2
Infection	0	4	5	2	4	3	1	8
Sudden unexpected, unexplained death	1	5	2	2	3	0	1	0
Trauma and other external factors, including medical/surgical complications/error	0	3	2	3	4	3	3	2
Deliberately inflicted injury, abuse or neglect	1	1	1	0	0	0	0	0
Chronic medical condition	2	1	3	0	7	4	4	11
Perinatal/neonatal event	0	2	15	9	6	5	10	20
<b>Total:</b>	<b>7</b>	<b>27</b>	<b>52</b>	<b>38</b>	<b>47</b>	<b>33</b>	<b>28</b>	<b>77</b>

\*figures only include closed cases reviewed by the CDOP, note some children and young people have more than one category of death.

There has been a noticeable increase in deaths categorized as acute medical or surgical conditions, infection, and chronic medical conditions. The most common cause of death categorized as an acute medical or surgical condition was acute respiratory failure. For deaths

categorized as infection it was pneumonia or sepsis, and for chronic medical conditions the majority of children had an underlying genetic disorder which contributed to a chronic condition.

In England, the most common primary category (i.e., the likely cause) of death for reviews in 2024-25 was *Perinatal/neonatal event*, which was recorded for 33% of all child death reviews, followed by *Chromosomal, genetic and congenital anomalies* (23%) and *Acute medical or surgical condition* (9%). These patterns were similar to previous years.

The most common primary category of death for children under 1 was *Perinatal/neonatal event*; for children aged between 1 and 9 years it was *Chromosomal, genetic and congenital anomalies*; and for children aged between 10 and 17 years it was *Acute medical or surgical condition*.

Of the deaths reported to the CDOP team, eight of the children were known to have a learning disability. Where it is identified that a child/young person has a learning disability, a discussion will take place between the CDOP team and the Learning Disabilities Mortality Review Programme (LeDeR) locally to ensure their expertise is utilised during the review process, and so that any learning and sharing of this can be captured effectively by both teams. The Cambridgeshire and Peterborough CDOP have also welcomed a children's learning disability Nurse onto the panel as a substantive member.

#### 4. Modifiable Factors

The CDOP is responsible for identifying any modifiable factors in relation to the child's death. Modifiable factors are defined as factors which, by means of national or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Modifiable factors were identified in 21 cases. Below are the themes from cases where modifiable factors were identified by the Cambridgeshire and Peterborough CDOP –

##### 1. Child's Daily Life and Lived Experience

- Failure to understand the child or young person's ethnic, cultural, religious and social identity.
- Overlooking the impact of exclusion from education, social marginalisation, and gang association.
- Neurodiversity and mental health concerns are not fully explored.
- Young people are not seen, heard, or spoken to directly.

##### 2. Parenting Capacity and Family Functioning

- Parental substance misuse, smoking, and health risks during pregnancy.
- Limited support for parents with language barriers, health needs, or caring responsibilities
- Lack of a Think Family / whole-family approach.
- Co-sleeping and unsafe home environments.

##### 3. Professional Practice, Curiosity and Decision-Making

- Early assumptions that risk had reduced, particularly following moves into the locality.
  - Identified risks (child criminal exploitation, harm to others, health deterioration) were not revisited dynamically.
  - Over-reliance on partial information or third-party accounts.
4. Information Sharing, Recording and Multi-Agency Working
- Incomplete or unclear information shared between agencies and across Local Authority boundaries.
  - Poor documentation of clinical decisions and family conversations (e.g. organ donation, Respect forms).
5. Access to and Quality of Health Care
- Antenatal risk factors (high BMI, smoking, drug use, diabetes risk) identified but inconsistently acted upon.
  - Missed clinical opportunities.
  - Poor communication between clinical teams.
6. Responding to Critical Incidents and Deaths
- Delays in emergency response, escalation and senior decision-making.
  - Resuscitation decisions made without access to key documentation.
  - Inconsistent application and notification of deaths to Police impacted consistency and response as part of JAR procedures.
  - Delayed or absent bereavement support.
7. Equality, Diversity and Inclusion
- Cultural identity is not embedded in assessment or planning.
  - Language needs are not met appropriately.
8. Prevention and Early Help
- Missed opportunities for early help referrals.
  - Education disengagement is not addressed as a safeguarding risk.

In England, deaths categorised as Deliberately inflicted injury, abuse or neglect had the highest proportion of reviews with modifiable factors (84%), followed by Sudden unexpected and unexplained death (78%), and Trauma and other external factors (71%).

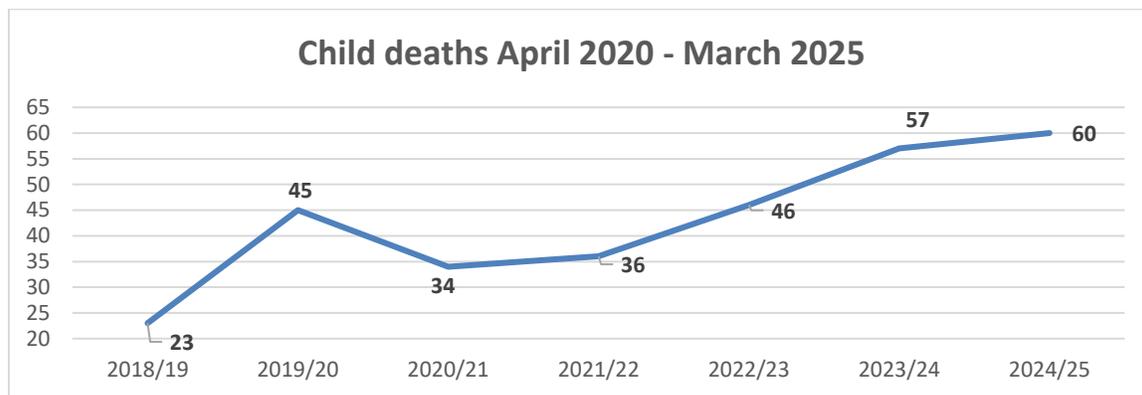
The most common recorded modifiable factors by CDOPs in England during reviews of infant deaths were high maternal BMI (Body Mass Index) (442), Parent/carer smoked tobacco/e-cigarettes in the household (426) and smoking/e-cigarette use (including vaping devices) in pregnancy (365).

The most common recorded modifiable factors by CDOPs in England during reviews of deaths of children aged 1 – 17 years were poor communication/information sharing between agencies

(102), service uncommissioned/unfunded/unavailable (77) for example, a lack of routine 24-hour access to community nursing services for palliative care or issues with access to mental health services. Other modifiable factors included issues with treatment, including delays (e.g., delay in starting treatment, side effects or complications developed as a result of treatment, or medical or surgical error) (73).

## 5. Key Themes and Learning

There has been a 5% increase in the number of child deaths locally in comparison to 2023/24, a steady increase that has been happening annually since 2021/22. The highest reporting months for notifications were September 2024 and November 2024, with eight deaths having been reported into CDOP during both months. November continues to be the most common month in Cambridgeshire and Peterborough for child mortality rates.



The Cambridgeshire and Peterborough CDOP identified 68 learning points from 26 of the 40 cases reviewed in 2024/25, with some learning points being derived from patient safety incident investigations (PSII's), Trust level child death review meetings (CDRM's), perinatal mortality review toolkit (PMRT) meetings, and one case being subject to a Domestic Abuse Related Death Review (DARDR), all of which feed into the final CDOP review. Themes of these learning points were –

### 1. Person-centered Care, Consent and Equality

- Interpreters must be routinely offered, with consent discussions (risks, benefits, alternatives and outcomes) clearly documented and coded.
- Improved culturally appropriate public health messaging, including contraception, termination services and genetic testing for consanguineous families.
- Young people must be seen, heard and involved in decisions about their health and mental health care.

### 2. Assessment, Monitoring and Clinical Decision-Making

- Inconsistent and ineffective assessment and monitoring, including:

- Neonatal observations, Apgar scoring and documentation
- PEWS calculation, sepsis screening and escalation
- Fluid challenges and oxygen saturation monitoring
- Delays or omissions in care escalation and deviation from national guidance.
- Insufficient MDT involvement in complex antenatal, neonatal and paediatric decision-making.
- Failure to identify antenatal risks (e.g. infection, diabetes, late booking).

### 3. Emergency and Acute Care Response

- Incomplete or absent patient records, including failure to record times, observations and neonatal status.
- Equipment and safety issues during neonatal transfer (thermoregulation, securing infants).
- Lack of timely senior oversight, staff debriefing and welfare support following critical incidents.

### 4. Documentation, Information Sharing and Governance

- Poor, delayed or fragmented documentation across systems, also hindering timely information sharing.
- Lack of clear ownership for follow-up when children are known to multiple services.
- Delays and confusion in post-death processes, including police notification, sampling and organ donation documentation.

### 5. End-of-Life Care, Bereavement and Family Support

- Missed or delayed referrals to hospice and palliative care services.
- Limited access to palliative medical input for 16–18-year-olds.
- Lack of local policies to support parental choices following death (e.g. taking baby home).

### 6. Safeguarding, Mental Health and Family Context

- Parental mental health and its impact on caregiving was not consistently addressed.
- Over-reliance on one parent for information; both parents should be engaged where possible.
- Children must not be discharged from mental health services without being seen.
- Stronger monitoring required for elective home education and safeguarding during transitions.

### 7. Continuity of Care, Commissioning and System Gaps

- Inconsistent continuity of care for children with complex needs.
- Service gaps across ICB boundaries.
- Inaccurate information shared with families regarding eligibility for services highlighted the need for staff training.

The CDOP team continues to produce a quarterly newsletter which is shared with all panel members and key agencies across the locality. The newsletter highlights key learning and modifiable factors from reviews, during 2024 – 25, the following topics were included and disseminated –

- Smoking in pregnancy and secondhand smoking
- Baby sling safety
- Maternal mental health support for Black mother's experiencing bereavement
- Water safety
- Hoarding and clutter
- Shortages of salbutamol nebulizer liquids
- Child mortality themes for children with a learning disability and/or autism
- Involving parents in child death reviews
- Wellbeing support for staff involved in a child's death
- Temporary accommodation
- Eligibility for Hospice support
- How to cope when your baby is crying – 'I can't cope (ICON)'

## 6. Family Engagement and Support

Following the death of a child the CDOP team write to all families, offering them the opportunity to be a part of the review, as well as sharing several resources with them to access bereavement support. In the reporting period 2024/25 all parents/carers were written to by the team. Whilst the purpose of the CDOP review is to identify learning to prevent future child deaths, in the reporting period 2024/25, families expressed several positive comments about the care/support they and their child had received.

*"Thank you to the PICU Consultant for your care of my son, and for visiting us at the hospice"*

*"Thank you to the professionals for the care provided to our daughter"*

*"After the birth of our baby, we were cared for wonderfully by our midwife, and the bereavement midwife in the weeks leading up to his funeral"*

*"The care home was very thoughtful; they looked after him and gave me lots of information"*

*"The transport team that took our child to the hospice were excellent"*

*"I would like to thank the bereavement team for everything they did for us. I'll always be grateful"*

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All families are entitled to an identified professional who can support them following the death of their child, this person is often known as the 'key worker'. When a death is classed as unexplained and/or unexpected a lead professional/key worker may be identified during the joint agency response (JAR) process, they should be in regular contact with families as required and may also be the healthcare professional that will discuss the findings of the post mortem report if appropriate.

## 7. Achievements

In June 2024 the CDOP team hosted a training session open to all GP safeguarding leads to discuss the child death review process, how GPs can engage in this, and how they can support bereaved families.

The CDOP team organised and chaired all Child Death Review Meetings (CDRM's) for children who died out of hospital, and for babies that died below 22 weeks gestation throughout 2024-25. Ensuring that professionals who cared for these children and their families were present at the meeting to identify learning, modifiable factors, and positive elements of care. Following this period, and a review of local processes, the team have since supported Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) to develop a CDRM process which will support the Trust in leading CDRMs for deaths where the child has died at home and has a community paediatrician.

In November 2024 the CDOP team hosted a local conference at Cambridgeshire Constabulary headquarters. The conference was open to professionals from all agencies who work with bereaved families, within mortality teams and who have a specialist interest, such as CDOP panel members. Topics covered during the day were the role of the Medical Examiner, how to access Hospice support, how the key worker can support bereaved families and staff, unexpected deaths and the joint agency response from a Policing perspective, and support available for schools following the death of a student.

In February 2025 work commenced to roll out a local whole genome sequencing pathway across the locality. This will support families whose child's death has been classed as unascertained to access genetic testing which may give them answers as to why their child died unexpectedly, as well as supporting testing of siblings, or for any future pregnancies.

The Cambridgeshire and Peterborough Designated Doctor for Child Death Review contributed to the NCMD's thematic report around deaths of children from asthma and anaphylaxis as a subject matter expert. The report was published on the NCMD's website in February 2025.