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North Central London Child Death Overview Panel (CDOP) Annual Report 2024/25

Camden Public Health

Emma Wells, Public Health Intelligence Analyst

Carla Stanke, Senior Public Health Strategist

Abigail Knight, Public Health Consultant

Foreword

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Welcome to the North Central London Child Death Overview Panel (NCL CDOP) annual report. This is our fifth annual report written by NCL CDOP on behalf of the CDR partners of NHS Integrated Care Board and the five Local Authorities of NCL (Barnet, Camden, Enfield, Haringey, and Islington).

The loss of a child is life changing for the family, friends, and the community. The distress experienced by the parents, siblings, wider family, friends, and community cannot be measured. NCL CDOP works hard to identify every opportunity to learn and to recommend improvements that might prevent another child death in the future. Every child death is subject to a child death review meeting, regardless of how they died, and we review each factor intrinsic to the child, their family, their environment, and the service provision they experienced.

The panel seeks to hear the voice of bereaved parents in all cases ensuing their lived experience is captured to help develop learning and continually improve the quality of life for children. Using their feedback, and that of multi-agency practitioners, we are able to review how services were experienced by them and where necessary seek assurance on changes to practice. There are many examples of positive feedback from families about the excellent care and compassion provided by individuals, teams and services, this work is recognised at panel and service leads are informed to reinforce good practice. Feedback from families emphasise that the care and compassion showed by staff at times of indescribable heartbreak, when their child dies, leaves a lasting memory for families and memories of these experiences are carried with them for their lifetime.

Children, families, friends, and communities will always remain at the heart of what we do. As we continue to ensure each child's legacy is captured, we develop a clearer picture of services in NCL. The recommendations in this year's annual report reflect NCL CDOP's ambition to support services to reach the highest possible standard of care and compassion provided to children and families. Achieving this ambition requires the active involvement of multi-agency services across NCL to implement these recommendations. Together, we must strive to reduce inequalities, improve services and strengthen partnerships.

Bridget Griffin
Independent Chair, NCL CDOP

Executive summary

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- North Central London Child Death Overview Panel (NCL CDOP) received 454 notifications for child deaths occurring between 2020/21– 2024/25, of which 10.1% *(n=46)* were from children usually resident outside of NCL.
- More than half of deaths were for children aged under 1 year (59.3%; *n=269*), of which 61.7% occurred in the first 27 days of life.
- The child death rate was higher in males compared to females (30.5 vs 22.3 per 100,000 population), though this difference was not significant.
- The White Other (41.6 per 100,000), Black or Black British (36.0 per 100,000) and Asian or Asian British (34.0 per 100,000) ethnic groups had the highest child death rates. The rates in these groups were significantly higher than that for children of White British or Irish ethnicity, who had the lowest child death rate (12.7 per 100,000).
- 28.2% *(n=115)* of deaths occurred in children living in areas of NCL amongst the 20% most deprived in England.
- The majority of child deaths occurred in hospital (77.5%), followed by 12.9% at home, 3.3% in a public place and 6.3% elsewhere.
- For deaths occurring between 2020/21 – 2024/25, the most common primary category of child death was Chromosomal, genetic and congenital anomalies, which was recorded in 31.1% of completed child death reviews by NCL CDOP. This was followed by Perinatal/neonatal event (22.3%) and Malignancy (14.9%).
- 23.1% (*n=80)* of reviews for child deaths occurring between 2020/21 – 2024/25 identified modifiable factors.

Key findings

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North Central London Child Death Overview Panel were notified of

454 child deaths

which occurred between 1st April 2020 – 31st March 2025

1 in 3

deaths occurred in the first 27 days of life

28.2%

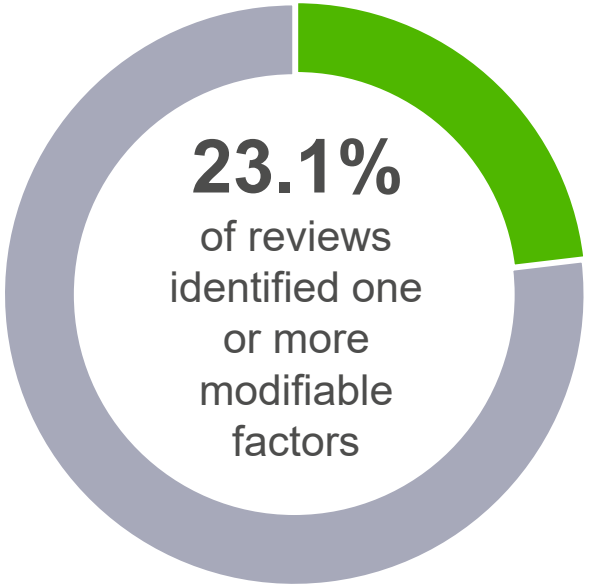
of deaths occurred in children living in areas amongst the **20% most deprived** in England

Males had a higher child death rate than females, though this difference was not significant

Top three causes of child deaths:

1. Chromosomal, genetic and congenital anomalies
2. Perinatal/neonatal event
3. Malignancy

Children from a White Other, Black or Black British and Asian or Asian British ethnic group had a **significantly higher** death rate than those from a White British or Irish ethnic group



Executive summary: key learning arising from case review

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The NCL CDOP met 14 times in 2024/25 and discussed 145 child deaths. The key learning and actions arising from this process relate to the following themes:

Wider determinants of health	Communication	Other issues
• Poverty and deprivation • Housing • Consanguinity • Maternal BMI • Unsafe sleeping • Antenatal screening • Immigration-related issues	• Communication with families • Culturally appropriate communication • Language support • Trust	• Involvement of pharmacies • Out of hours care • Privacy after a child dies • Palliative care • Barriers to engaging with services • Engagement with the child death review process

Within the topics of mental health, domestic abuse and serious youth violence, several inter-related social complexities were noted as contributory factors.

Executive summary: recommendations

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The NCL CDOP review identifies several core themes which remain year on year. We propose a three-year strategic programme of multi-agency work, initiated by themed appreciative enquiry workshops, co-hosted by local government and NHS leads and covering the following topics:

- Structural Racism and Inequality
- Poverty Proofing and Stigma Reduction
- Serious Youth Violence
- Mental Health Support
- Domestic Abuse
- Barriers to Engaging with Services

Additionally, we set out a series of recommendations for completion over the next calendar year for frontline professionals, health and social care leaders to enact over the next 12 months and report back via the 25/26 CDOP annual report. These fall under the oversight of:

- NCL ICS Mortality Group
- NCL Directors of Public Health
- Directors of Children's Services
- Health service provider organisations and frontline staff
- NCL LMNS
- NCL CDOP

Contents

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Quantitative Analysis

- Child death notifications
- Infant deaths
- Neonatal deaths
- Child death reviews completed by NCL CDOP
- Spotlight on learning disability
- Appendix A: Borough-level analysis
  - Barnet
  - Camden
  - Enfield
  - Haringey
  - Islington

Case Review of Child Deaths

- Learning: wider determinants of health
- Learning: communication
- Learning: other issues
- Intersectionality between social needs
- Positive aspects and examples of excellent care

Progress on actions from 2023/24

Recommendations

- For ICB
- For Directors of Public Health
- For Directors of Children Services
- For health service providers and frontline staff
- For maternity staff
- For CDOP

Child Death Overview Panel (CDOP)

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Since 2008, it has been a legal requirement in England for Child Death Overview Panels (CDOPs) to review the deaths of all children up to the age of 18 years (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) to help learn lessons from these deaths and identify ways to prevent future tragedies.

The North Central London CDOP (NCL CDOP) reviews the deaths of all children who are resident in the North Central London boroughs of Barnet, Camden, Enfield, Haringey and Islington.

The panel meets after all information about the death has been gathered by the Child Death Review (CDR) process and is attended by NHS, Public Health, the Police and Social Services.

All deaths are anonymised and discussed individually by the panel, and any lessons learned are shared with practitioners and parents both locally and nationally, with the aim of improving the health and safety of children and young people and preventing future child deaths.

Technical information

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The data in this report summarises information about child deaths occurring in the five-year period between 1st April 2020 and 31st March 2025 that were to notified to North Central London Child Death Overview Panel (NCL CDOP).

A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

Where data is presented as a rate and/or by borough, this is based on children known to be usually resident in NCL. Cases were excluded from these analyses if the child's postcode:

- was unknown or incomplete,
- corresponded to an area outside of NCL, or
- was for a hospital or other healthcare setting (e.g., GOSH).

The estimated neonatal and infant death rates reported have been calculated using Office for National Statistics (ONS) data for live births, and the rate is presented per 1,000 live births. Birth statistics are compiled from information supplied when births are registered - a legal requirement - and represent births that occurred in that calendar year, although they may also include a very small number of late registrations from the previous year.

The estimated child (0-17 and 1-17 years) death rates were calculated using the Greater London Authority (GLA) 2020 based housing led (identified capacity scenario) population projections and are presented per 100,000 children of the same age.

Technical information (2)

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ONS and GLA publish live births and population estimates using calendar years. As the Child Death Review (CDR) data uses financial years, live births and population estimates that correspond to the largest proportion of the financial year were used, for example, 2024 live births and population estimates were used to calculate rates for deaths occurring between 1st April 2024 – 31st March 2025.

Census 2021 data (population aged 0-17 years) was used to calculate rates of child death by ethnic group for all years. It should be noted that changes were made to data collection of ethnicity by NCMD in April 2021, April 2023 and January 2024 so these categories are likely to be underestimated. In April 2021 'Gypsy or Irish Traveller' was added to 'White' and 'Arab' was added to 'Other ethnic group'. In April 2023 'Roma' was added to 'White' and added to the paper forms in January 2024. A breakdown of the broad and detailed ethnic groups is shown in *Appendix 1*.

The totals for subgroup analyses have been calculated and then rounded to the nearest five to avoid disclosing small numbers, meaning that the total of rounded values may differ from the actual total.

In some instances, the number of deaths presented is low, and therefore the confidence intervals will be wider. Therefore, all rates should be interpreted alongside the actual number of deaths. Error bars on bar charts and a shaded area on line graphs represent 95% confidence intervals.

CDOPs are required to assign a category of death to each death reviewed within the Analysis Form, the final output of the child death review process. The classification of categories is hierarchical where the uppermost selected category is recorded as the primary category should more than one category be selected. The definitions for each category are shown in *Appendix B*.

A note on population estimates

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The National Child Mortality Database (NCMD) uses population data from the ONS mid-year population estimates (which are calculated based on the Census results) to calculate rates of child mortality (0-17 and 1-17 years).

Across England, the population aged 0-17 years in Census 2021 was 3% less than the previous ONS mid-2020 estimates. Therefore, the impact of using Census 2021 data at a national level is likely small. However, this difference was much greater in many of the inner London boroughs; for example, the Census 2021 figure for the population aged 0-17 years in Islington was 15% lower than previous estimates.

Therefore, child mortality rates in this report were calculated using the GLA 2020 based housing led (identified capacity scenario) population projections.

As a result, it is not possible to directly compare data in this pack against the England average. However, where possible, text narrative describing the England trend has been included. Unless otherwise specified, data for England has been taken from the National Child Mortality Database (NCMD) Child Death Review Data Release: Year ending 31 March 2025.[1] Where the most recent data was unavailable, figures have been taken from the 2024 NCMD data release.[2]

Abbreviations

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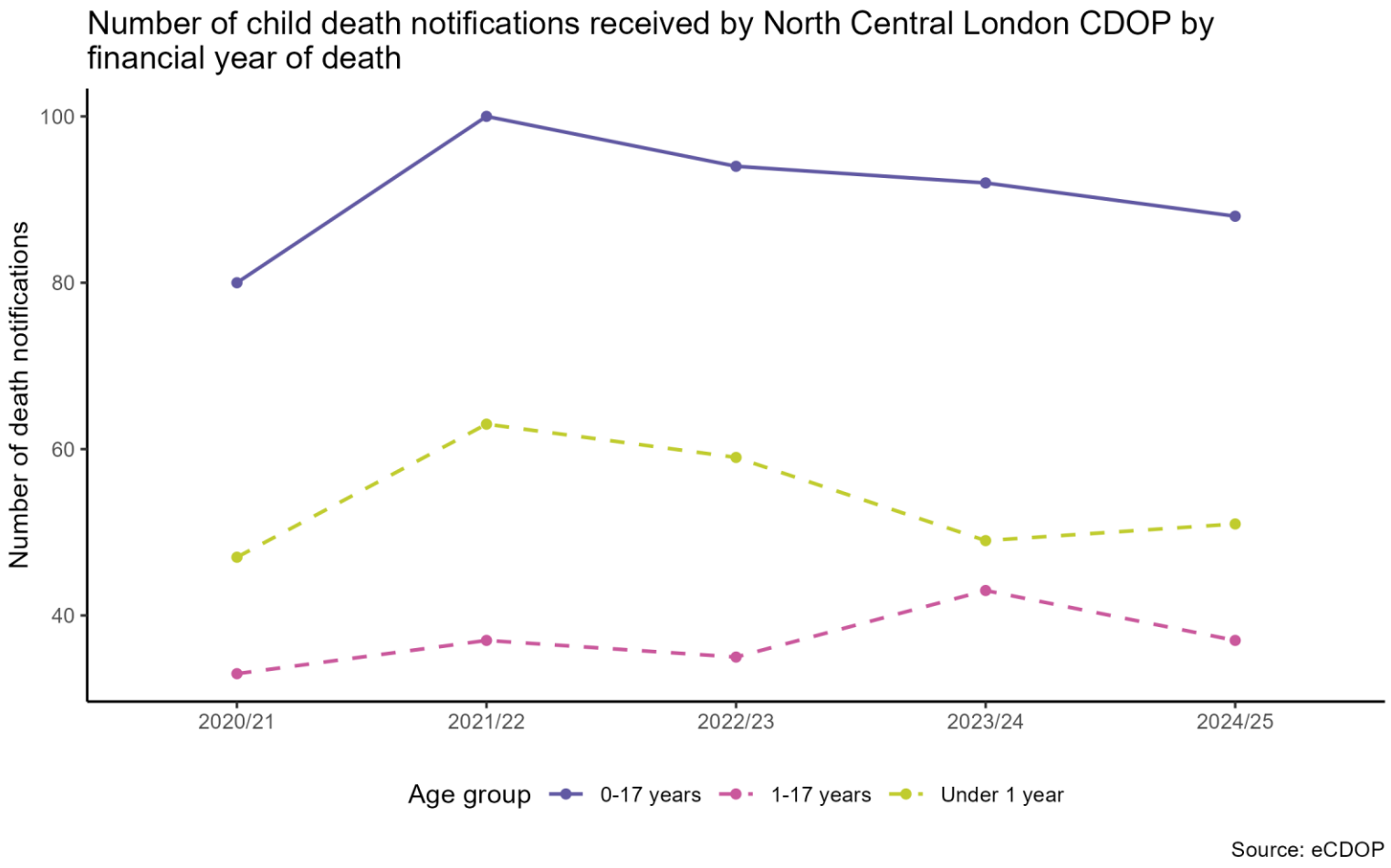
- CDOP – Child Death Overview Panel
- CDR - Child Death Review
- CDRM – Child Death Review Meeting
- IMD - Index of Multiple Deprivation
- GLA – Greater London Authority
- NCL – North Central London
- NCMD – National Child Mortality Dataset
- ONS – Office for National Statistics

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Child death notifications

Child deaths

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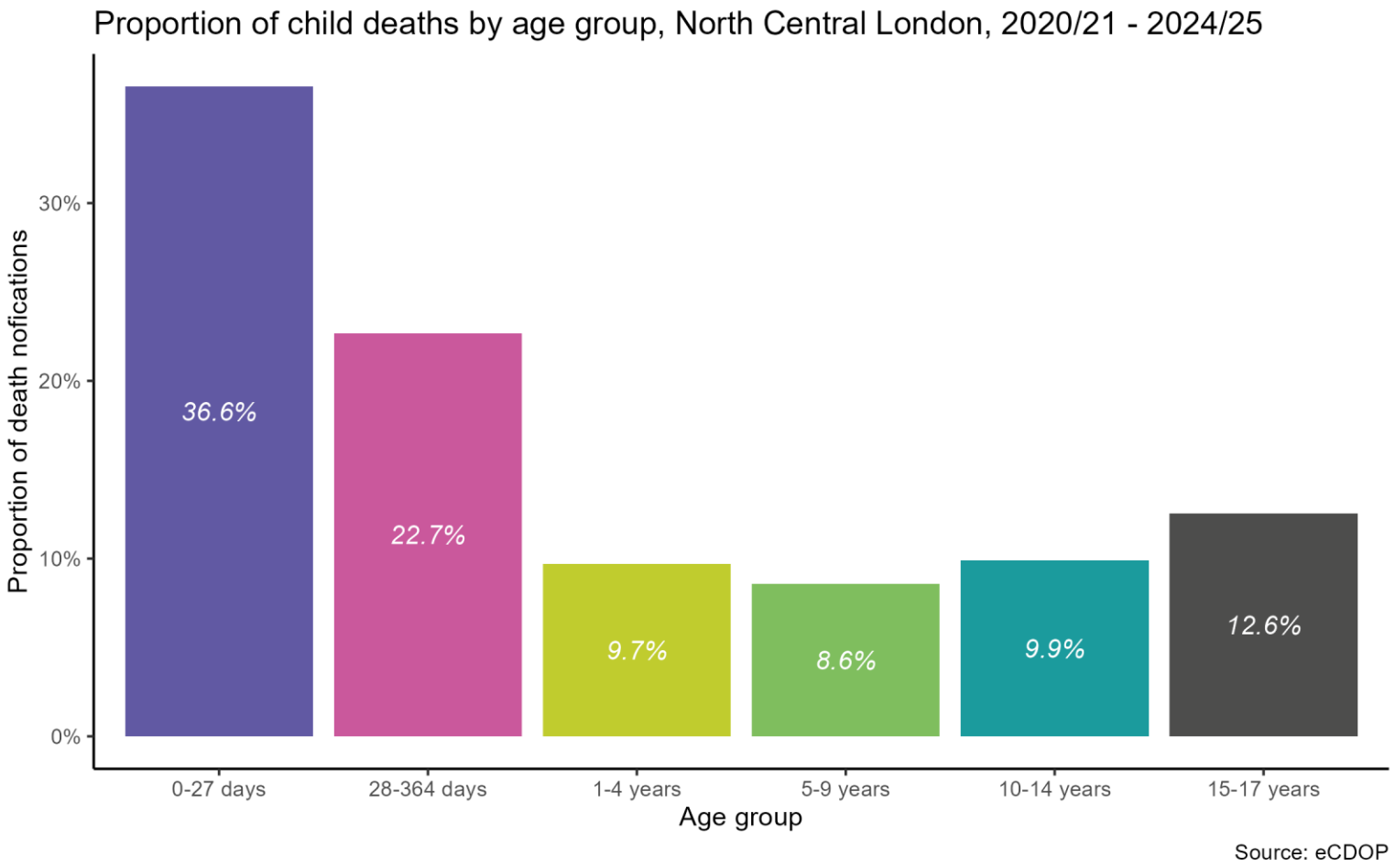


Source: eCDOP

- Between 2020/21 and 2024/25, NCL CDOP received 454 child death notifications.
- 10.1% *(n=46)* of notifications were from children normally resident outside of NCL.
- Compared to 2023/24, there were slightly more infant deaths and slightly fewer deaths in children aged 1-17 years.
- In England, the number of deaths in 2024/25 decreased by 2% on the previous year but remained higher than in 2019/20.

Child deaths by age group

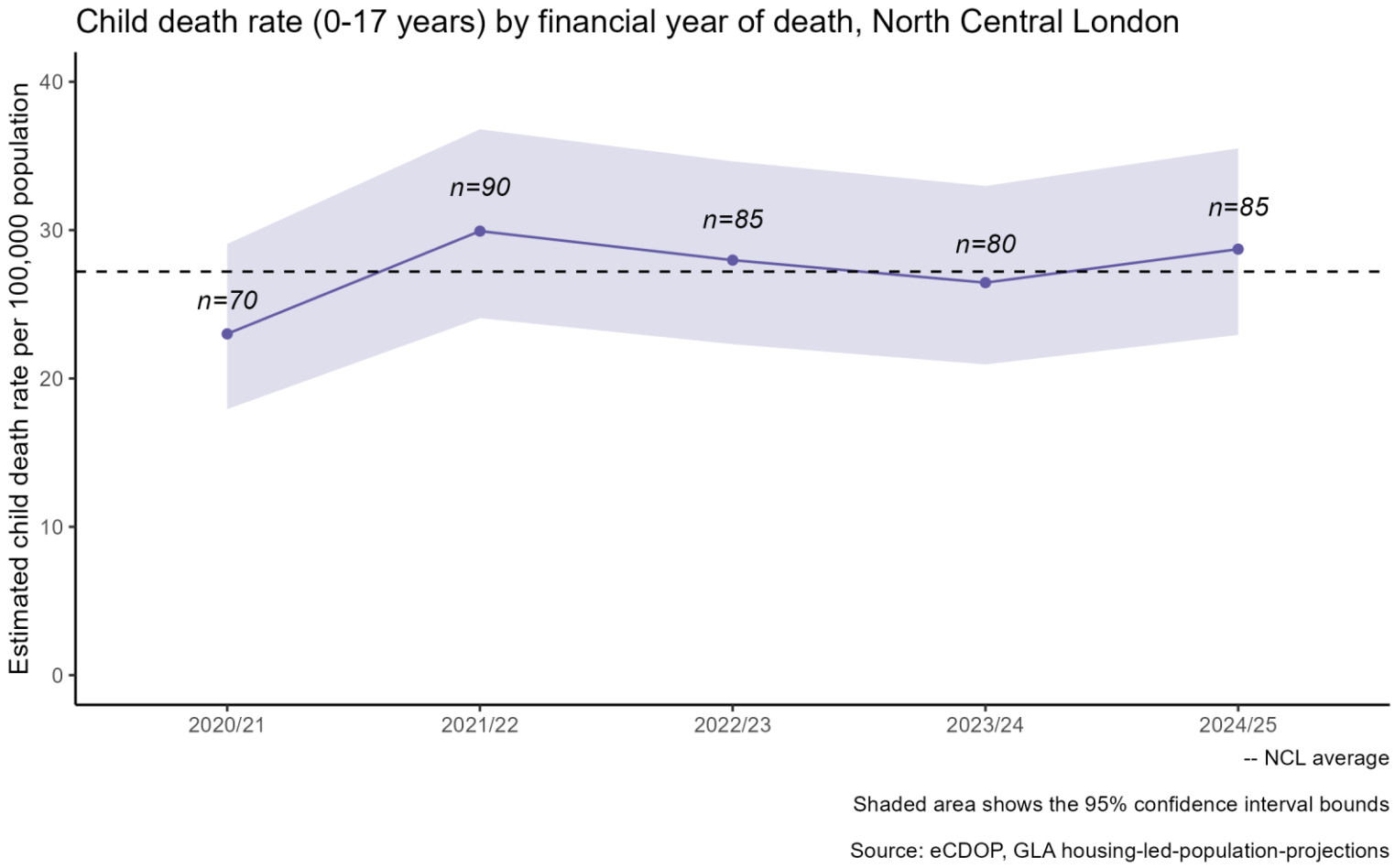
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- Children are at the greatest risk of death within the first year of life.
- Between 2020/1 - 2024/25 59.3% *(n=270)* of child deaths notified to NCL CDOP occurred in children aged under 1 year, of which 61.7% occurred in the first 27 days of life.
- This was followed by deaths in children aged 15-17 (12.6%), 10-14 years (9.9%), 1-4 years (9.7%), and 5-9 years (8.6%).
- This age profile of deaths was similar to that seen nationally.

Child deaths (age 0-17) by year

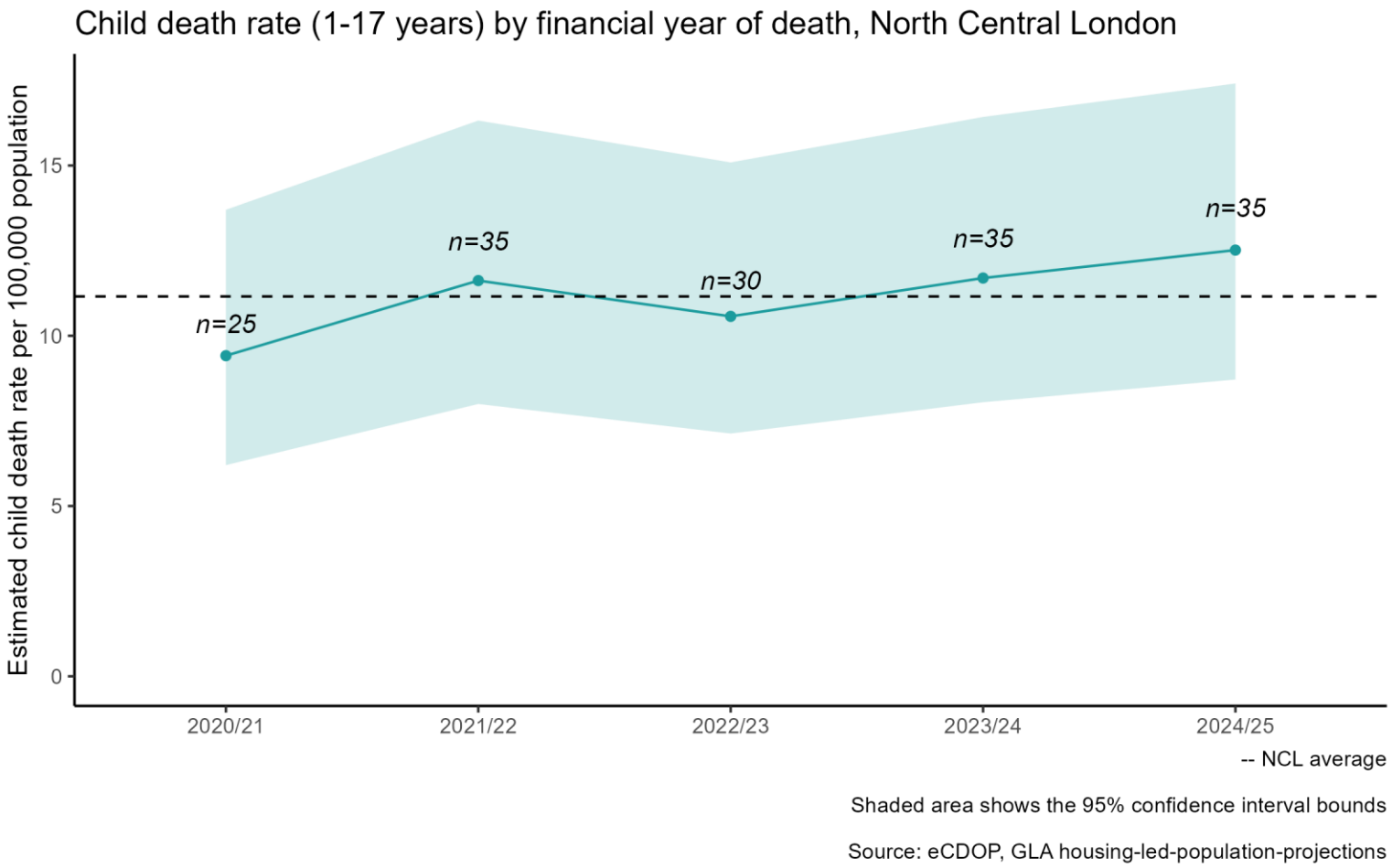
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- Between 2020/21 – 2024/25, NCL CDOP received 408 death notifications of children aged 0-17 years living in NCL; a rate of 27.2 per 100,000 population.
- There has been no significant change in the rate of child deaths in NCL over the past five years.
- In England, there were 3,492 child deaths in 2024/25, an estimated rate of 28.7 deaths per 100,000 children. This was slightly lower than the 2023/24 rate of 29.8 per 100,000 but remains higher than 2019/20.

Child deaths (age 1-17) by year

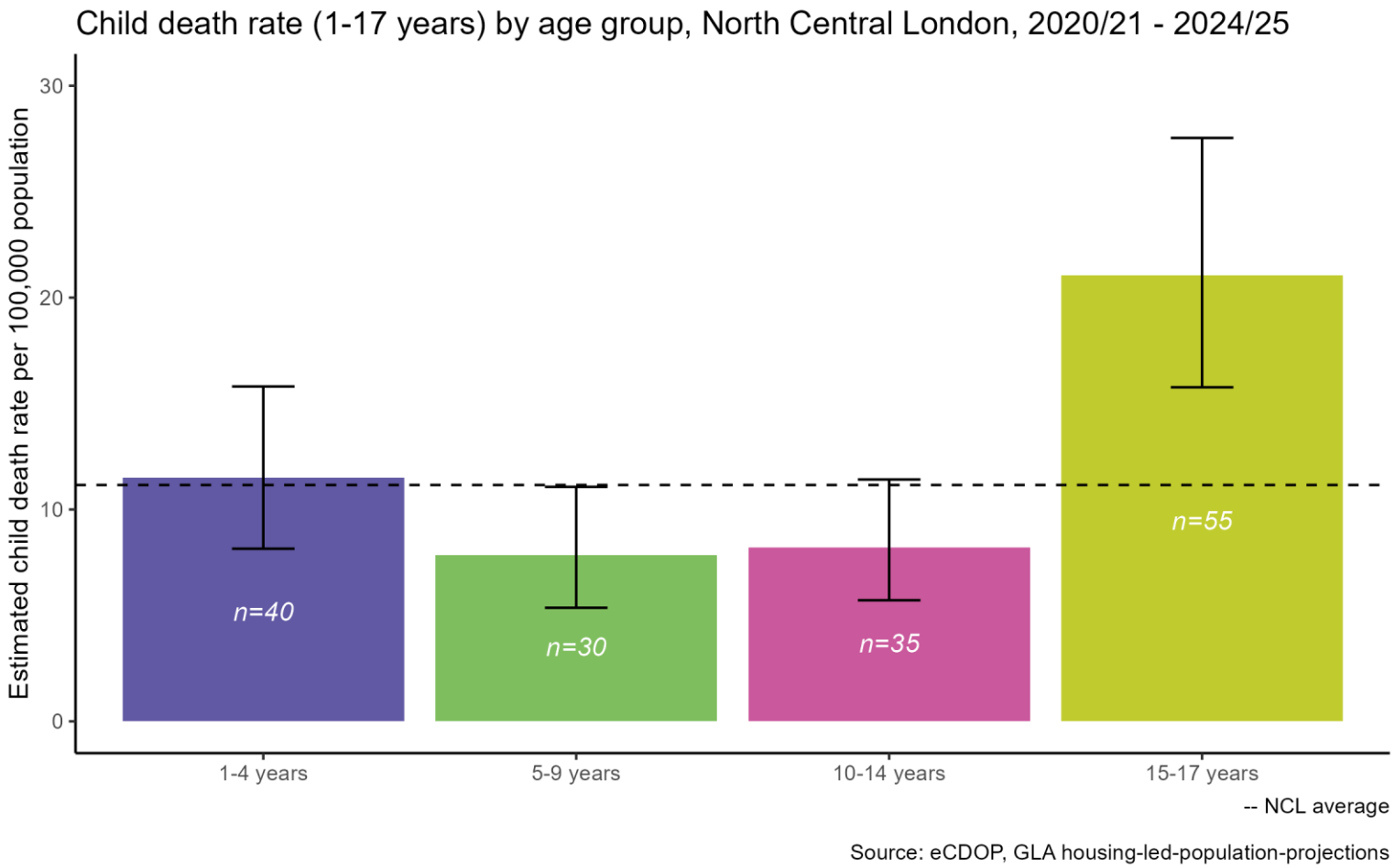
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- Between 2020/21 – 2024/25, NCL CDOP received 158 death notifications of children aged 1-17 years living in NCL; a rate of 11.2 per 100,000 population.
- There has been no significant change in the death rate of children aged 1-17 years in NCL over the past five years.
- In England, deaths of children aged between 1 and 17 years decreased by 4% between 2023/24 and 2024/25.

Child deaths by age group and year

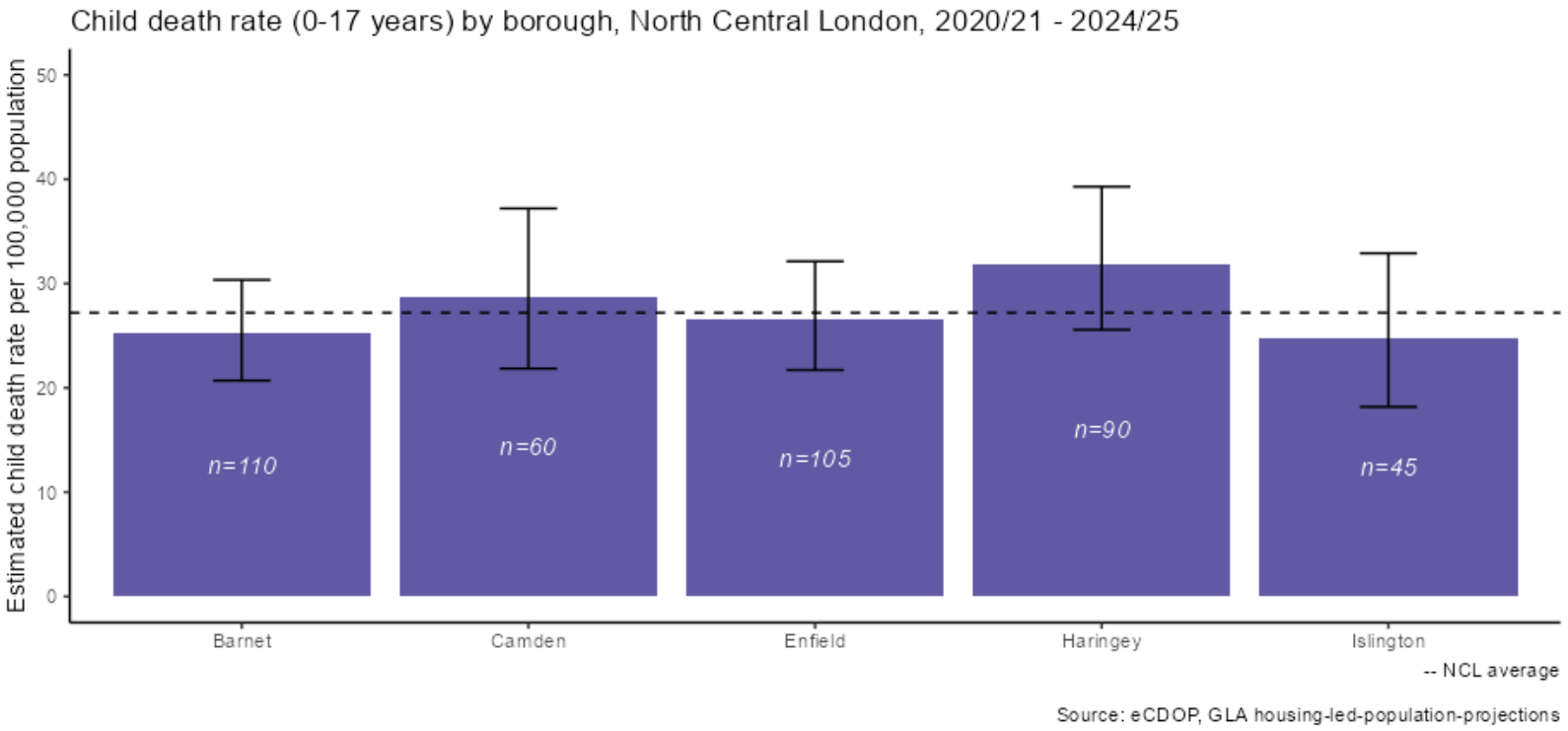
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- In NCL, the rate of child (1-17 years) deaths was significantly higher for children aged 15-17 years (21.1 per 100,000; *n=55*) than those aged 10-14 years (8.2 per 100,000; *n=35*) or 5-9 years (7.8 per 100,000; *n=30*).
- Children aged 1-4 years had a death rate of 11.5 per 100,000 population (*n=40*).
- There has been no significant change in the rate of child deaths by age group in NCL in recent years.
- In England, a similar pattern is seen, with the highest death rate for children aged 15-17 years followed by 1-4 years.

Child deaths (age 0-17) by borough

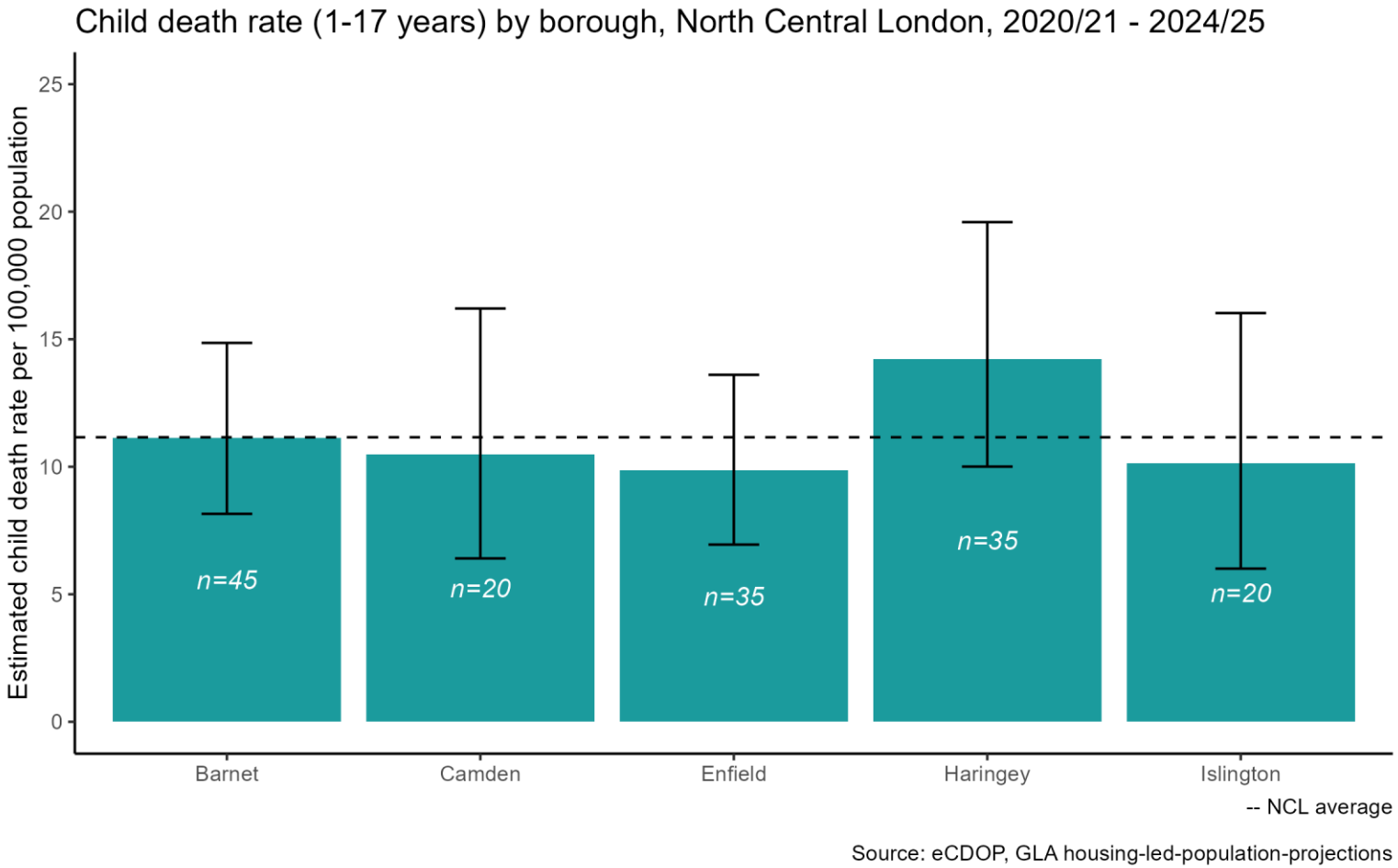
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- There was no significant difference in the child death rate between boroughs in NCL.
- There has been no significant change in the child death rate over the past five years in any of the five boroughs.
- Between 2020/21 – 2024/25, the highest total number of death notifications were from Barnet, Enfield and Haringey, while Camden and Islington had the fewest.

Child deaths (age 1-17) by borough

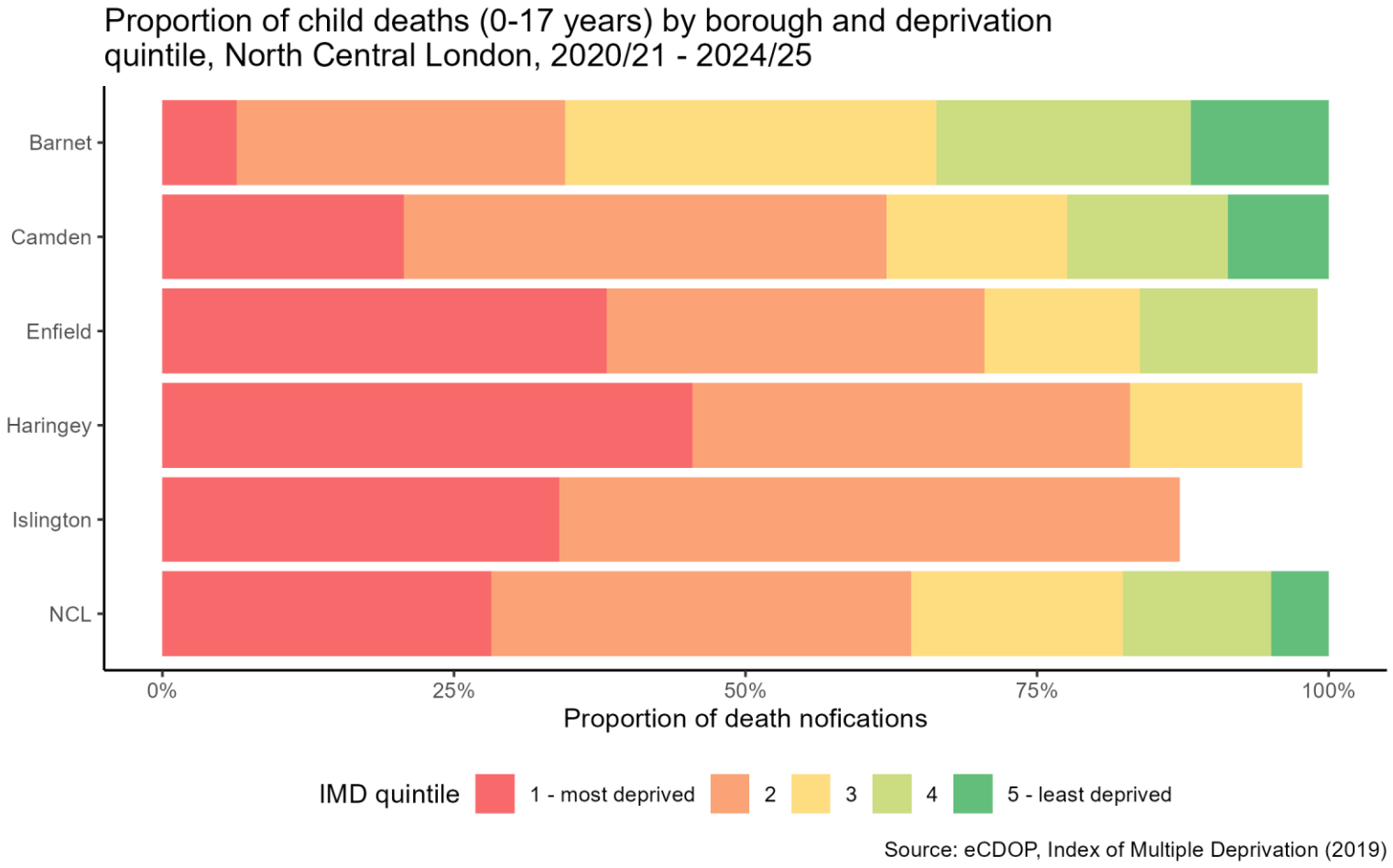
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- There was no significant difference in the death rate of children aged 1-17 years between boroughs in the five-year period between 2020/21 – 2024/25.

Child deaths by borough and deprivation

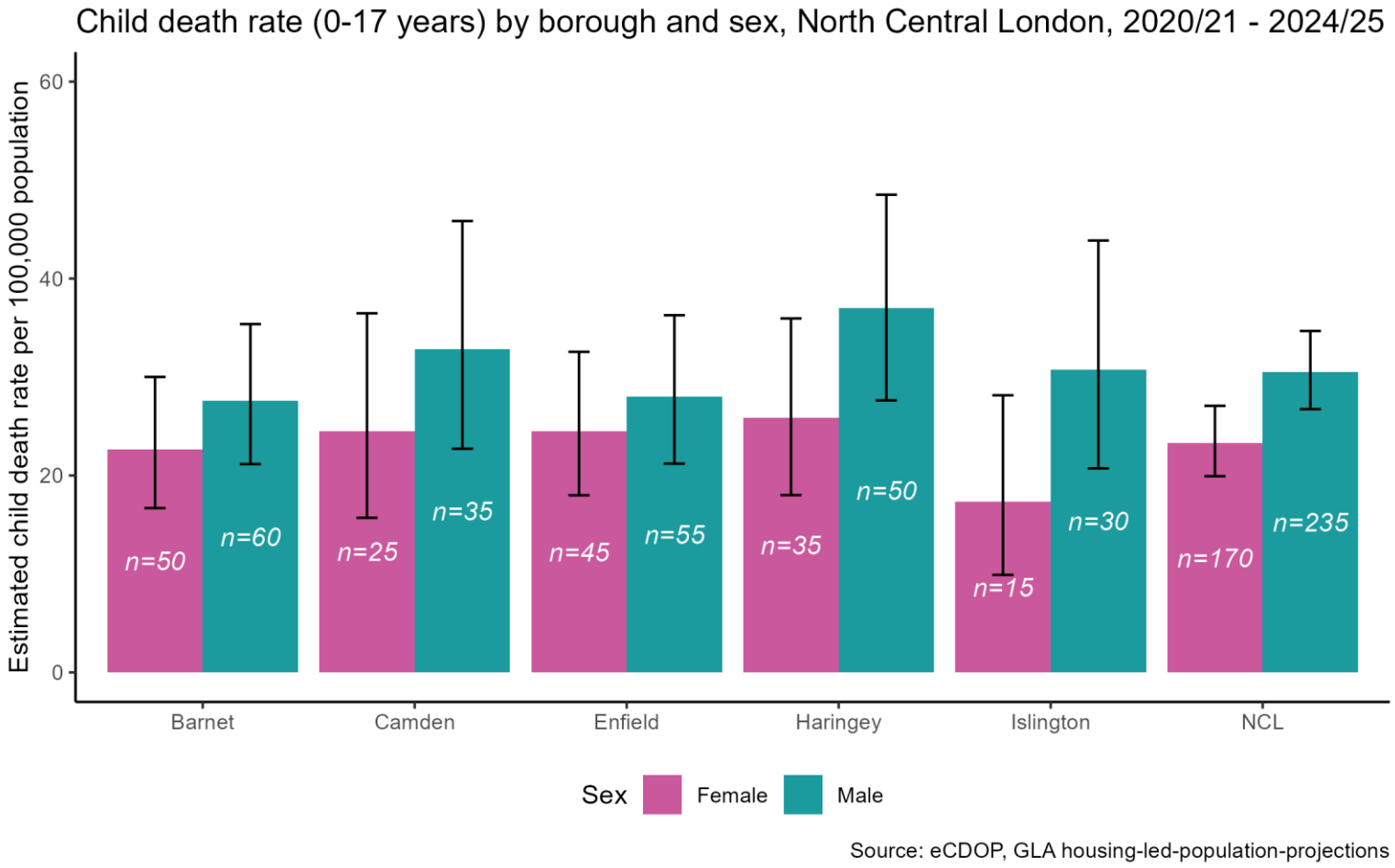
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- Child mortality increases with higher levels of deprivation.
- Nationally, the death rate of children living in the 20% most deprived areas is more than twice that of children living in the 20% least deprived areas.
- In NCL, 28.2% *(n=115)* of deaths occurred in children living in areas amongst the 20% most deprived in England.
- Based on Index of Multiple Deprivation (IMD) 2019 score, Haringey ranks 38th, Islington 41st, Enfield 57th, Camden 90th and Barnet 119th most deprived out of 153 upper tier local authorities in England.

Child deaths (age 0-17) by sex

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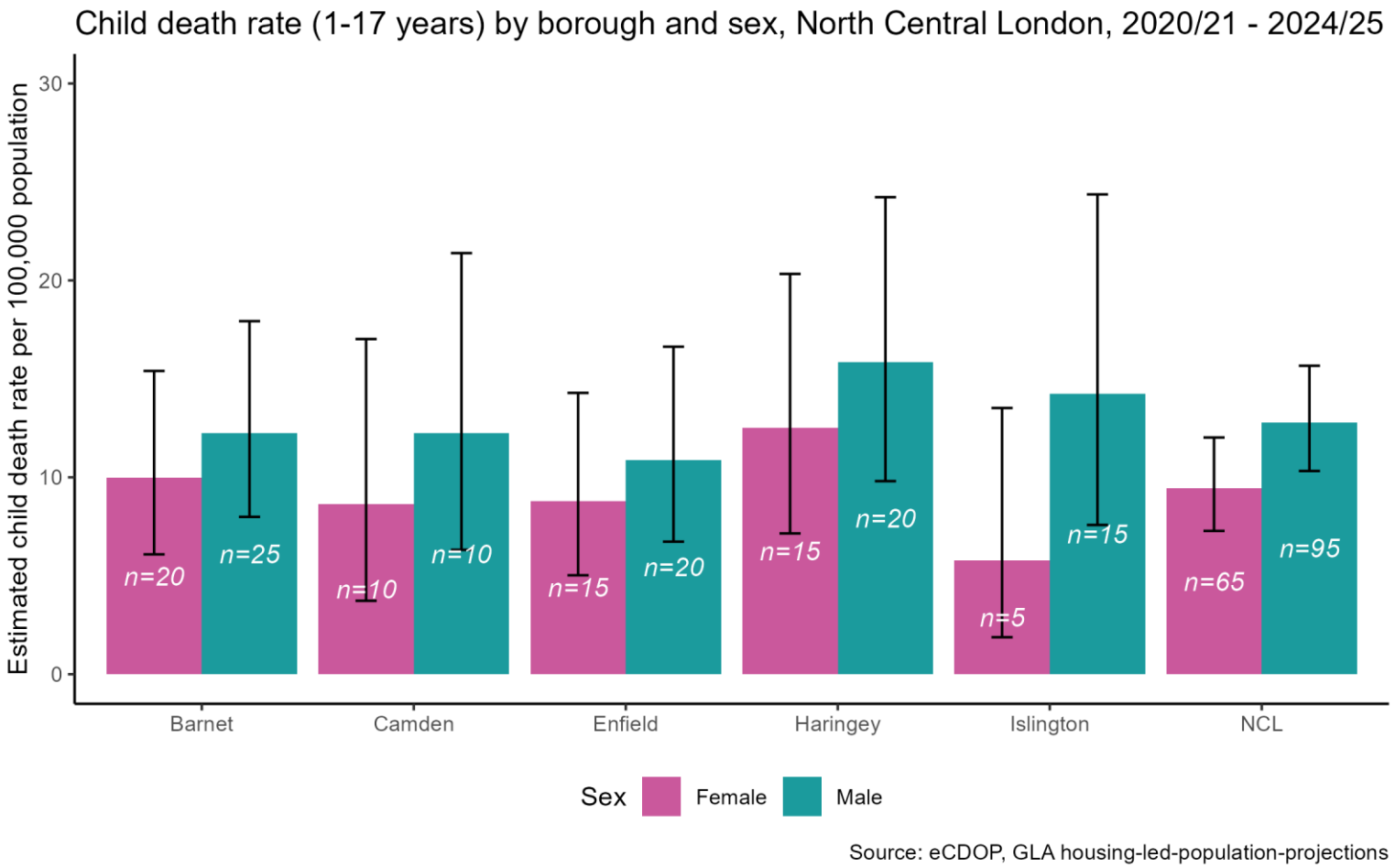


Source: eCDOP, GLA housing-led-population-projections

- Between 2020/21 – 2024/25, the child death rate in NCL was higher in males compared to females (30.5 vs 23.3 per 100,000 population), however this different was not significant.
- This sex difference was seen in each of the five NCL boroughs, although it was not statistically significant.
- In England, in 2024/25, 58.1% of deaths notified were for males compared to 41.1% for females.

Child deaths (age 1-17) by sex

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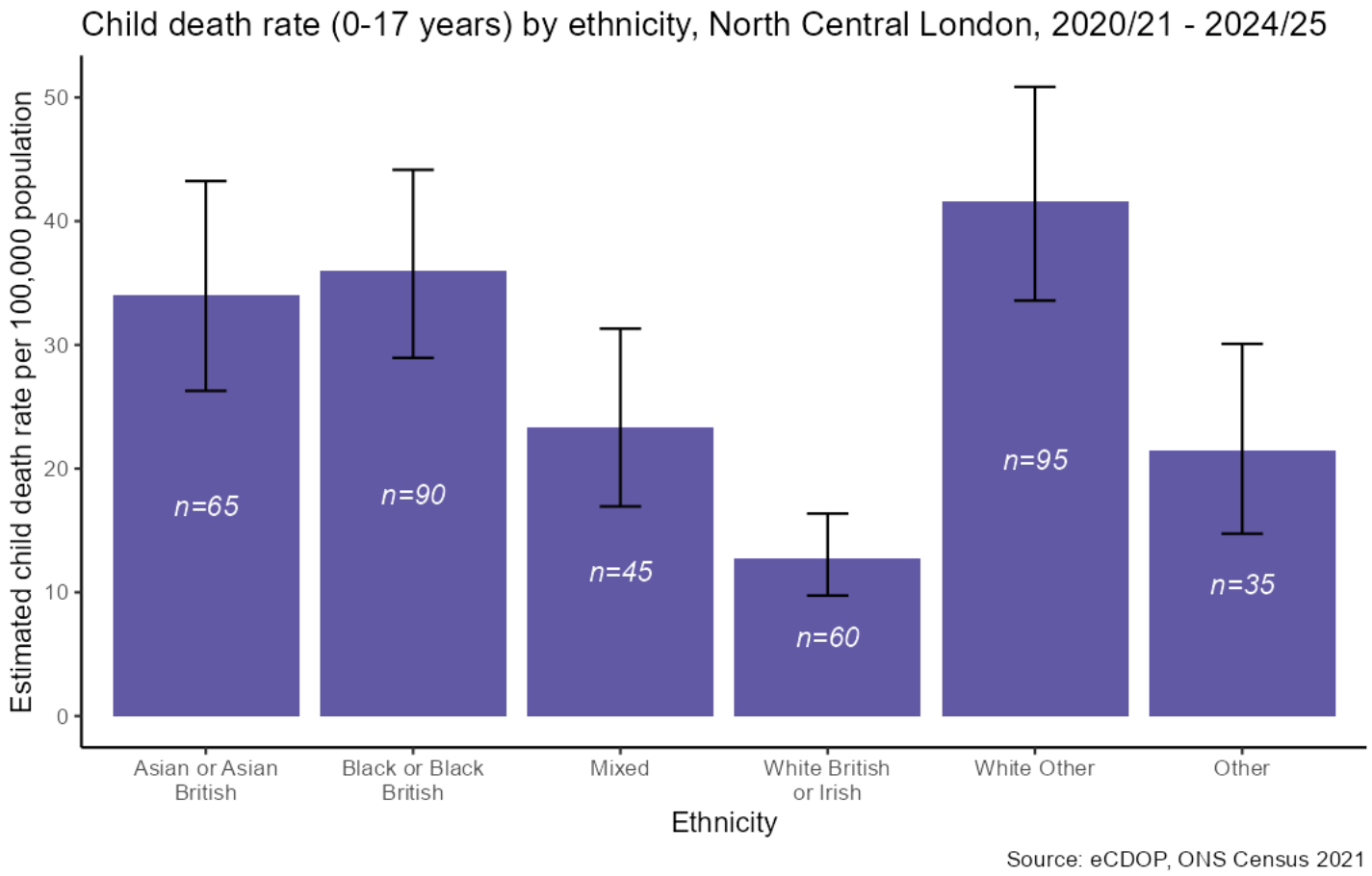


Source: eCDOP, GLA housing-led-population-projections

- There was no statistically significant difference in the death rate by sex of children aged 1-17 years in NCL between 2020/21 – 2024/25.

Child deaths (age 0-17) by ethnic group

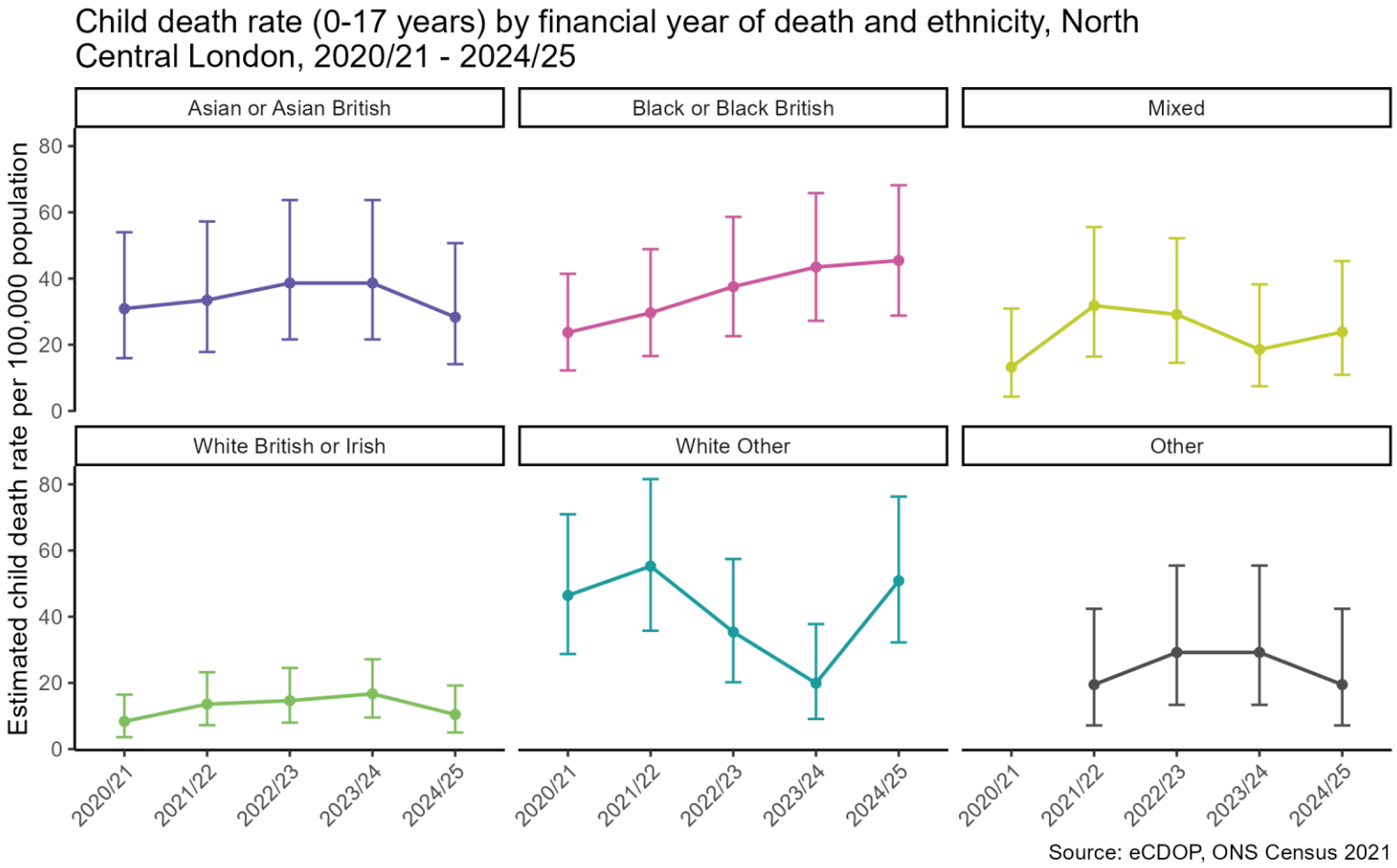
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- The recording of ethnicity status has improved in recent years, rising from 87.1% of NCL cases in 2020/21 to 96.5% in 2024/25.
- Between 2020/21 – 2024/25, the child death rate in NCL was highest for children from a White Other (41.6 per 100,000 population), Black or Black British (36.0 per 100,000) and Asian or Asian British ethnic group (34.0 per 100,000).
- These groups had a statistically significantly higher child death rate compared to children of White British or Irish ethnicity, which had the lowest rate (12.7 per 100,000).
- In England, in 2024/25, the child death rate was highest for children of Black or Black British and Asian or Asian British ethnicity.

Child deaths by ethnic group

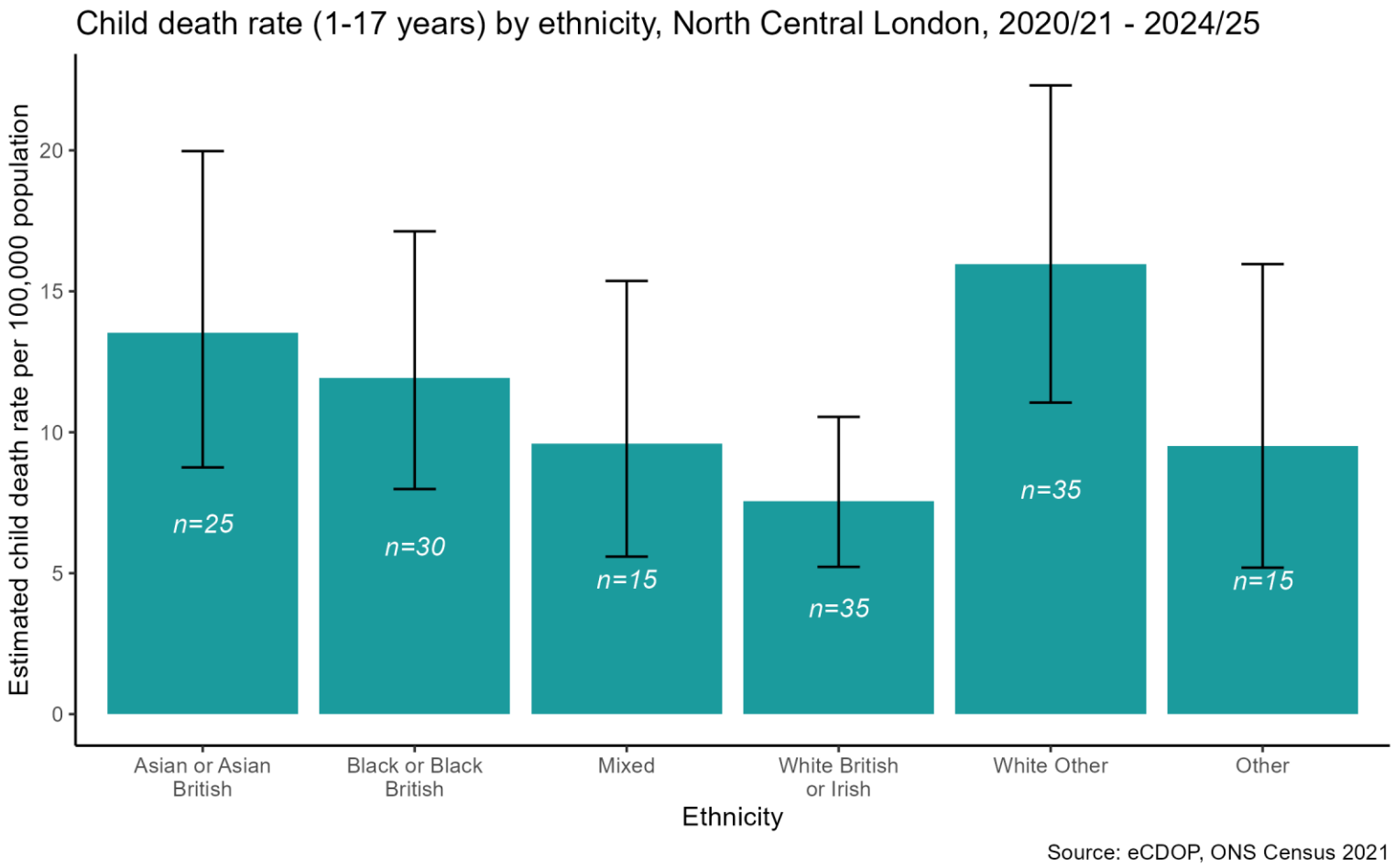
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- There has been no significant change in the rate of child deaths in NCL by ethnicity in recent years.

Child deaths (age 1-17) by ethnic group

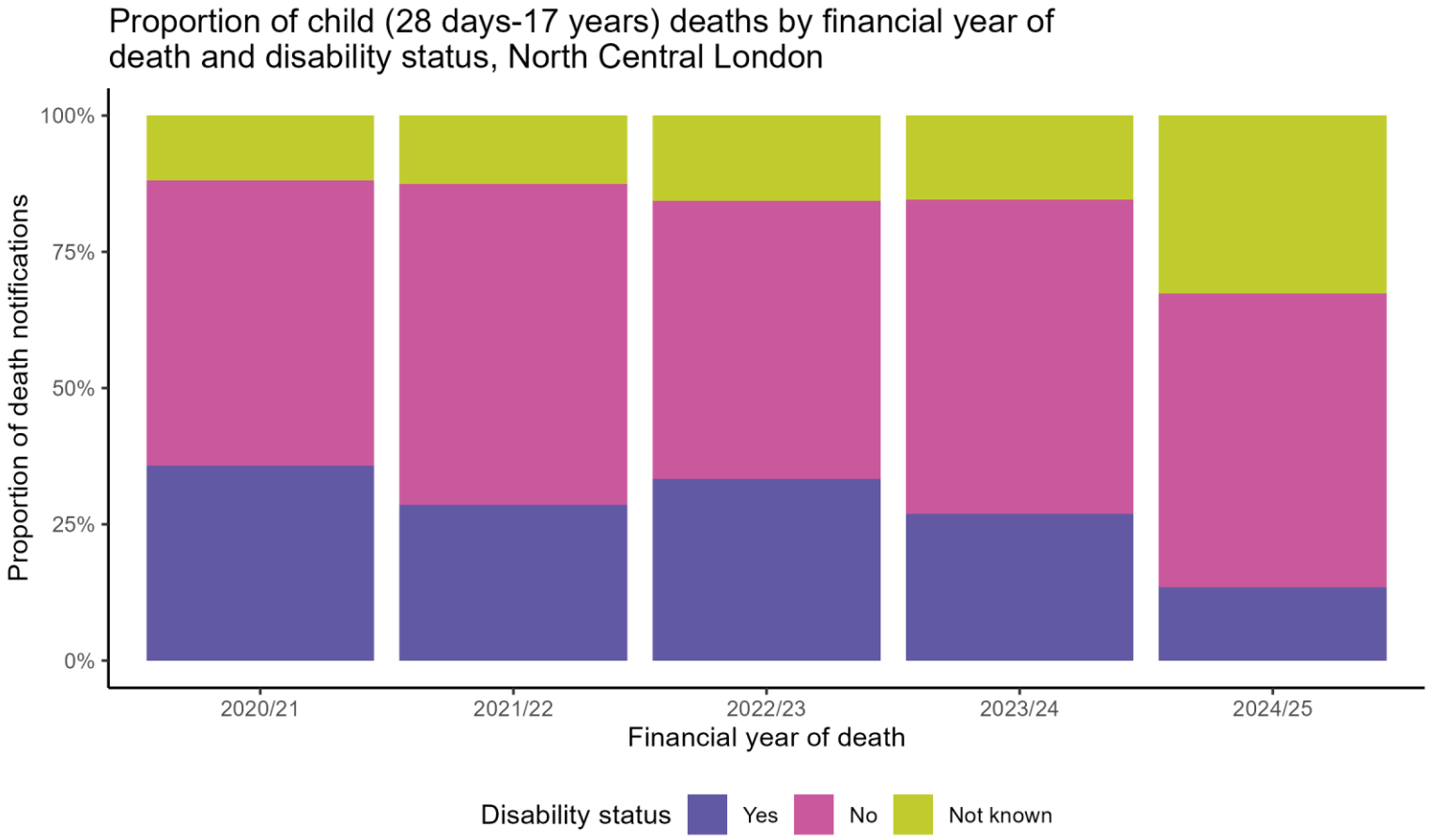
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- A significant difference in the estimated death rate among children aged 1-17 years was observed in the White Other ethnic group, which had a higher rate (16.0 per 100,000) than the White British or Irish group (7.5 per 100,000).
- National death rates for broad ethnic categories for children aged 1-17 years are not yet available. Therefore, comparisons can only be made using narrower ethnic categories, which are less directly comparable to our data.
- In England in 2024/25, the highest child death rates were observed among children from the 'White – Gypsy or Irish Traveller', 'White – Irish', 'Asian or Asian British – Pakistani', and 'Any other Asian background' groups.

Child deaths by disability status

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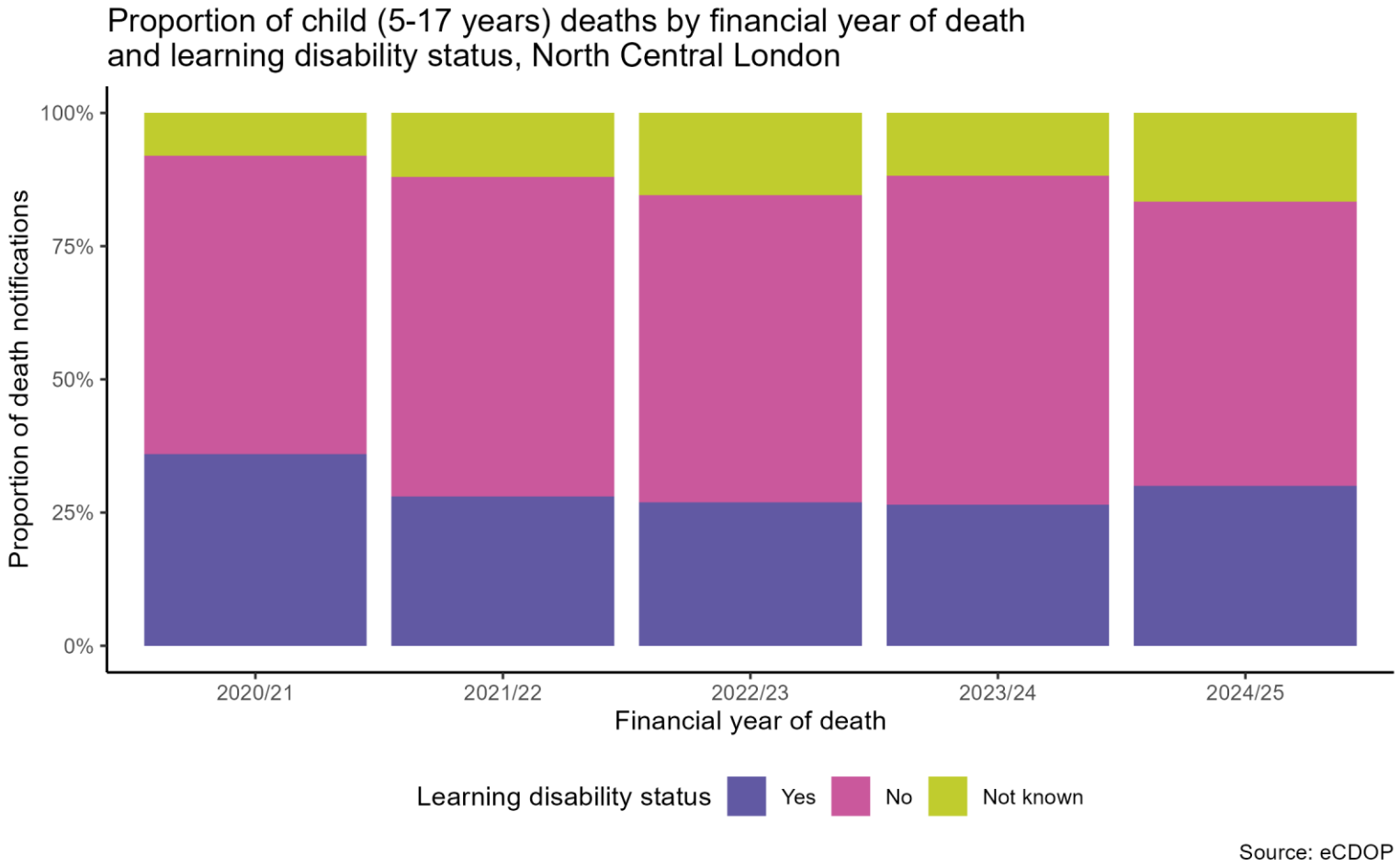
Source: eCDOP

- Between 2020/21 – 2024/25, 27.3% *(n=70)* of child (28 days-17 years) deaths notified to NCL CDOP were for children recorded as having a disability.
- 17.8% *(n=45)* of all death notifications had an unknown disability status. Data recording seems to have declined since 2020/21 with disability status not known for 32.7% (*n=15*) of cases in 2024/25.

Note that cases where the child was aged 0-27 days, or the response was “Not applicable – too young”, were excluded from this analyses.

Child deaths by learning disability status

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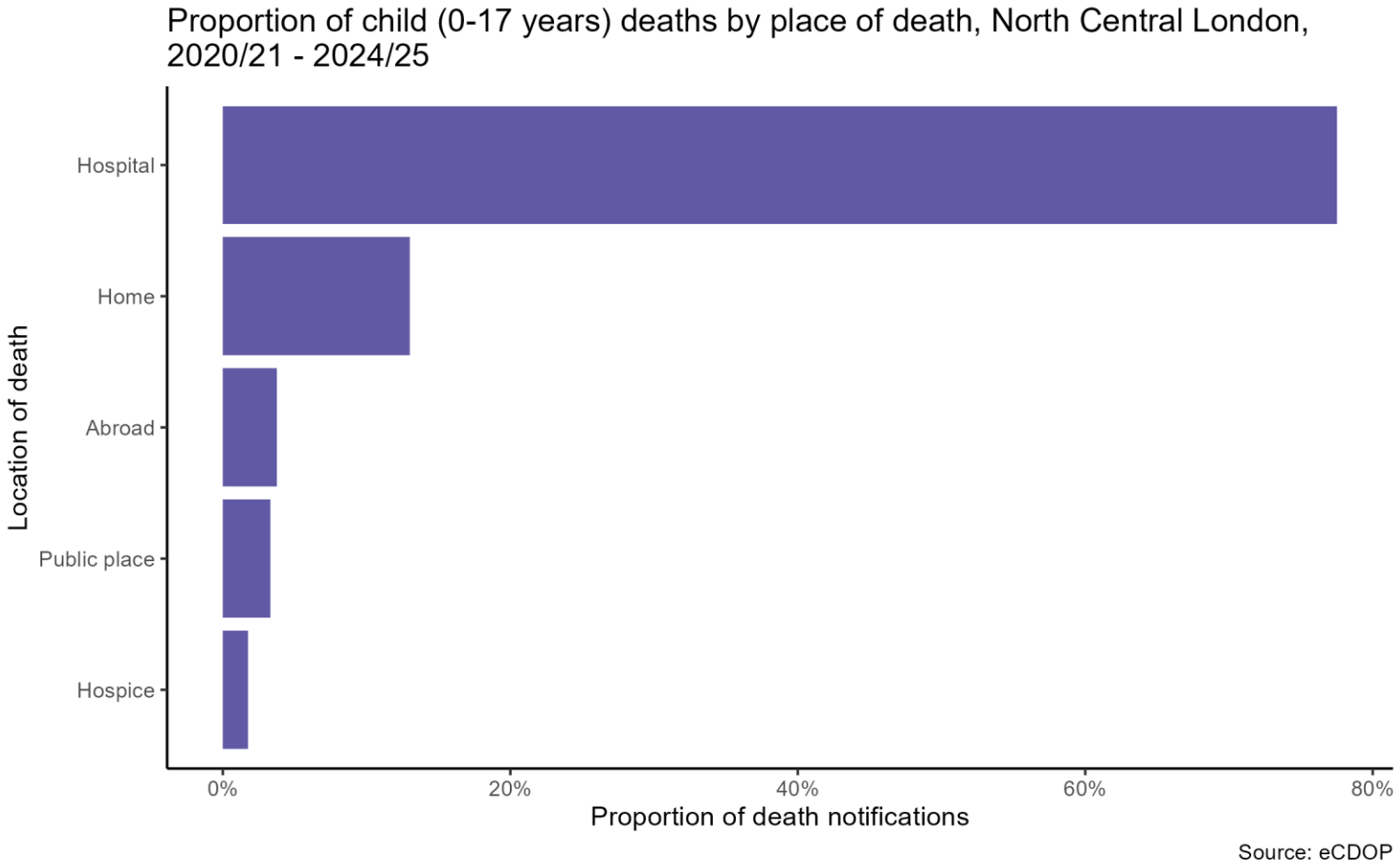
Source: eCDOP

- Between 2020/21 – 2024/25, 29.3% (*n=40*) of child (5-17 years) deaths notified to NCL CDOP were for children with a confirmed learning disability.
- Learning disability status was "Not known" for 12.9% *(n=20)* of cases.
- In England, between 2019/20 – 2021/22, 31% of deaths of children aged 4 –17 years were in children with a learning disability.[2] This proportion was highest for those aged 4-9 years (40%), followed by 10-14 years (34%) and 15-17 years (20%).[2]

Note that deaths of children aged 0-4 years were not included in this analyses due to difficulties in diagnosing a learning disability in younger children.

Place of death

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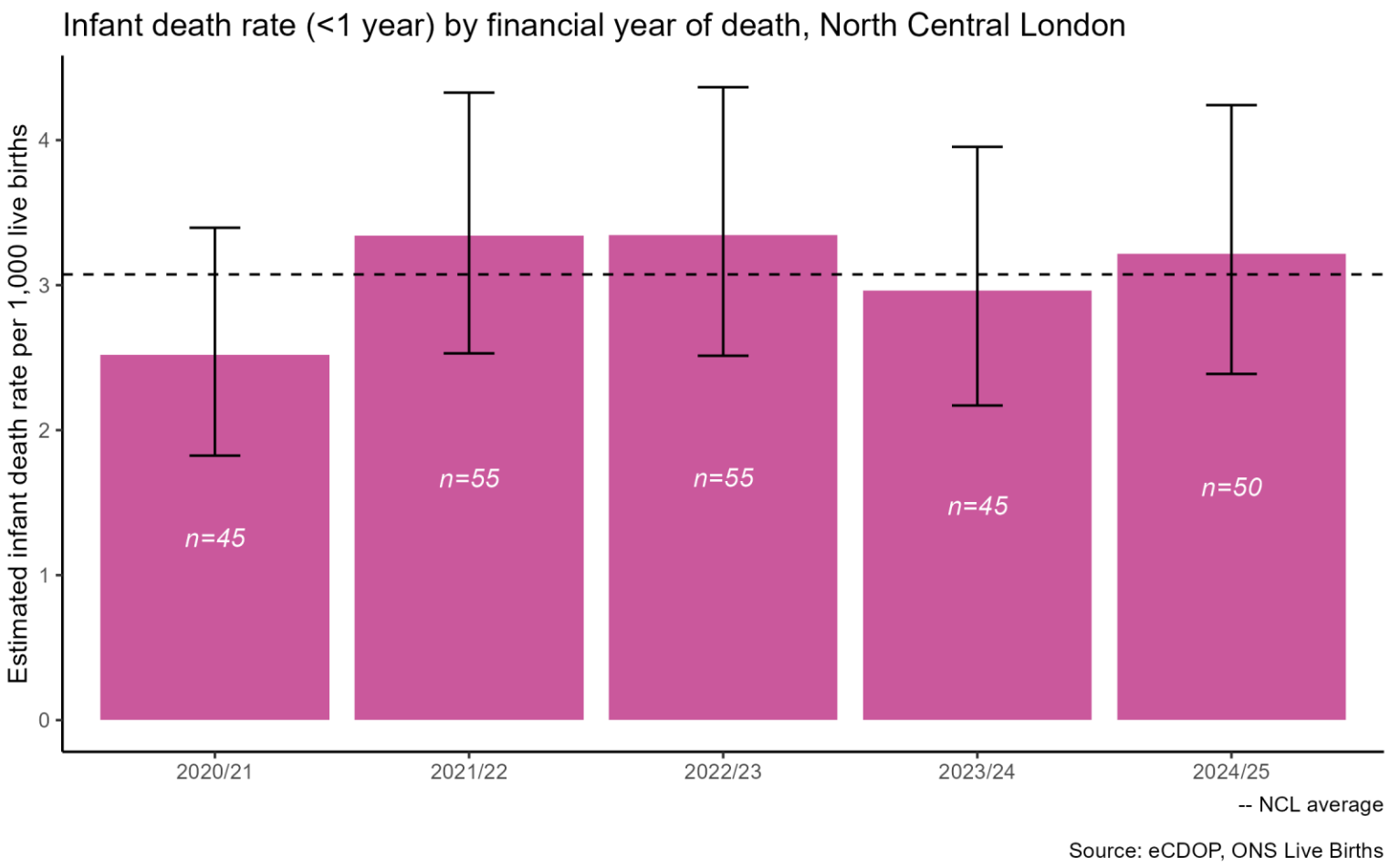


- The majority of child deaths notified to NCL CDOP between 2020/21 – 2024/25 occurred in a hospital setting (77.5%; *n=454*), while 22.5% *(n=102)* occurred in a non-hospital setting.
- In England, in 2024/25, 74.0% of child deaths occurred in a hospital and 26.0% in a non-hospital setting.

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Infant deaths

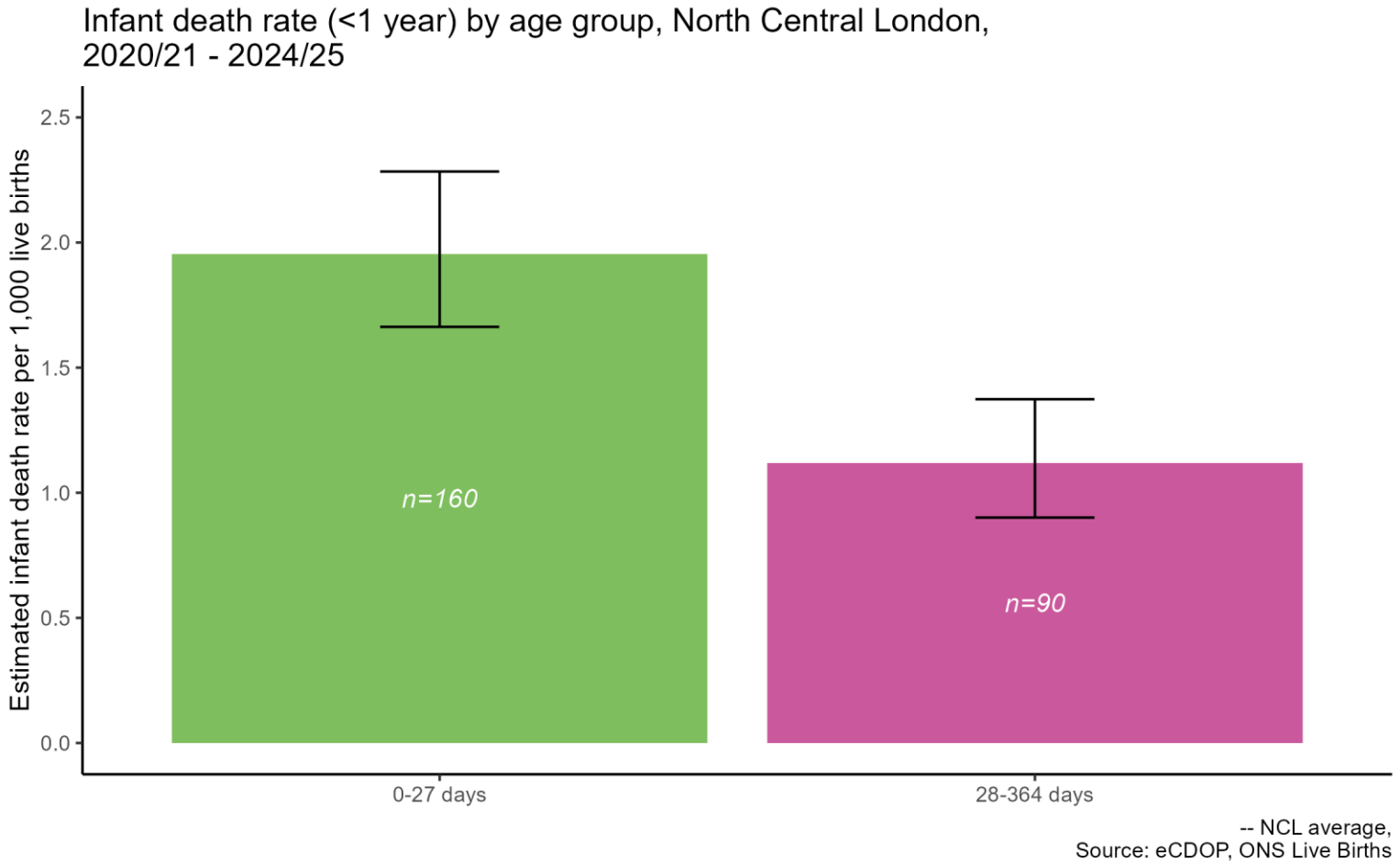
Infant deaths by year



- Between 2020/21 – 2024/25, NCL CDOP received 250 death notifications of children aged under 1 year living in NCL; a rate of 3.1 per 1,000 live births.
- Although there was a lower rate of infant deaths in NCL in 2020/21, there has been no significant change in the rate of infant deaths in the last five years.
- In England, although the number of deaths decreased, the estimated infant death rate decreased from 3.9 to 3.8 per 1,000 live births between 2023/24 and 2024/25, but remained higher than in 2019/20.

Infant deaths by age

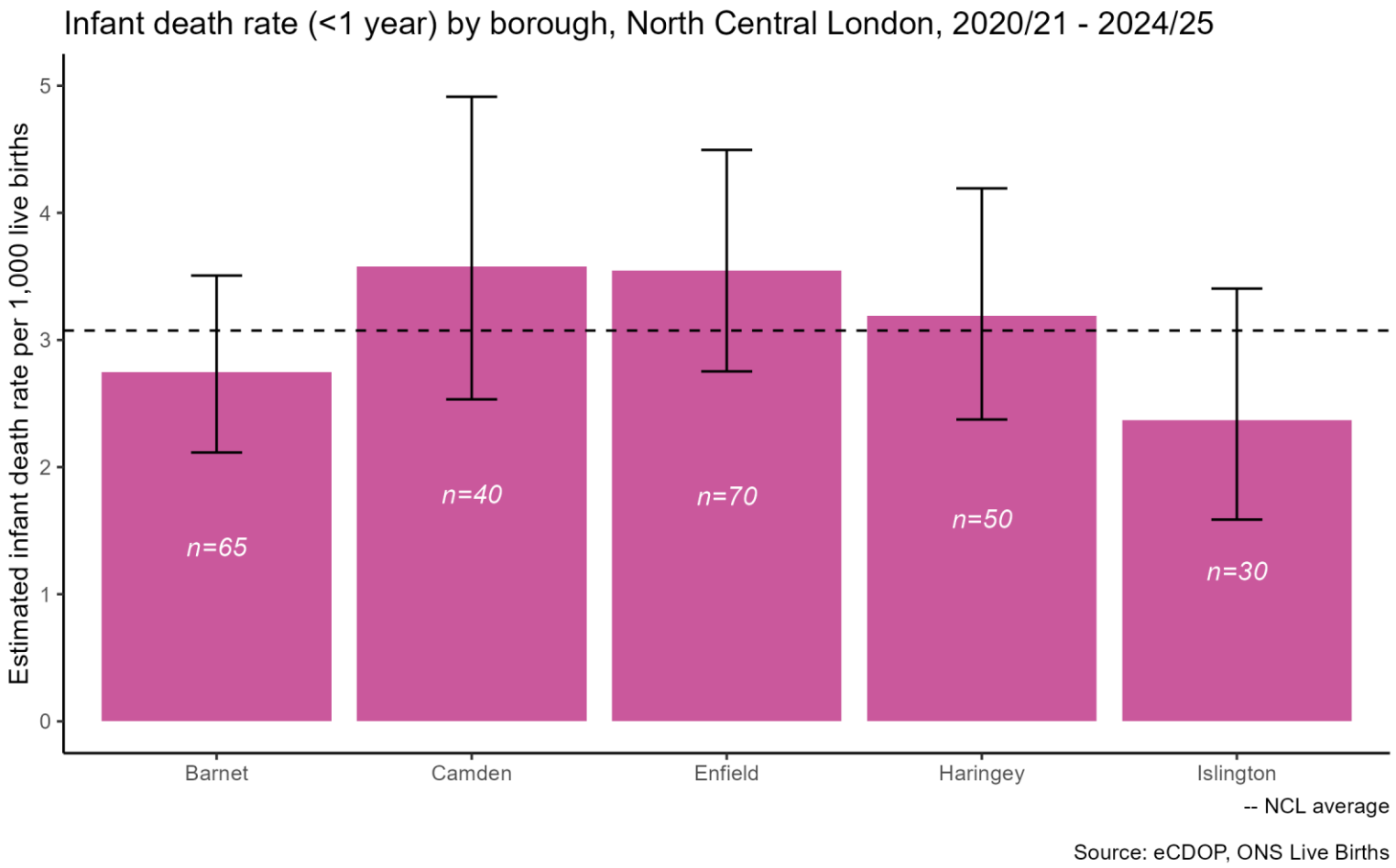
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- Between 2020/21 – 2024/25, NCL CDOP received 160 death notifications of infants aged 0-27 days, and 90 death notifications of infants aged 28-364 days.
- The death rate was significantly higher for infants aged 0-27 days compared to 28-364 days (2.0 vs 1.1 per 1,000 live births).

Infant deaths by borough

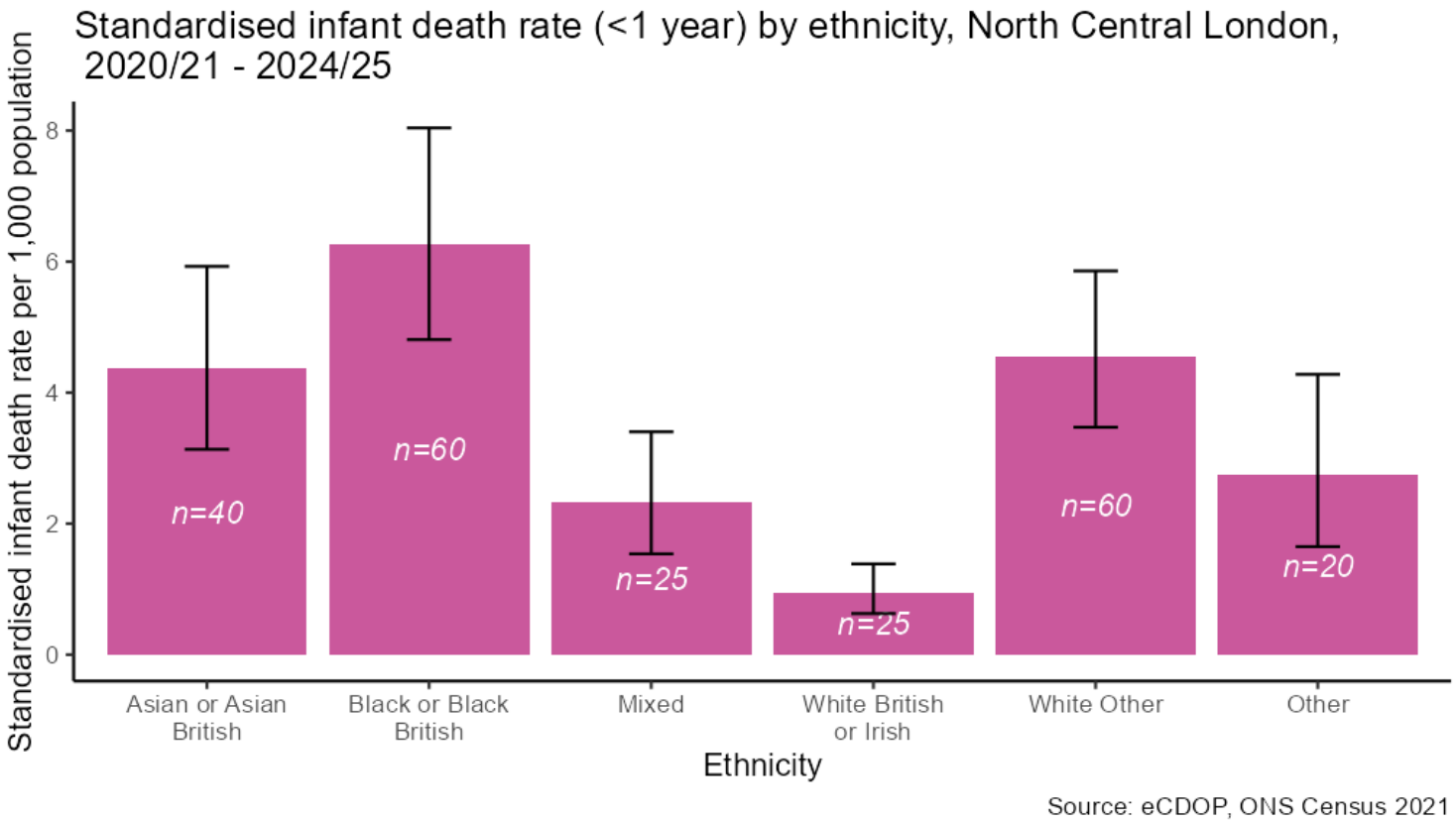
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- Between 2020/21 – 2024/25, there was no statistically significant difference in the rate of infant deaths between boroughs in NCL.

Infant deaths by ethnic group

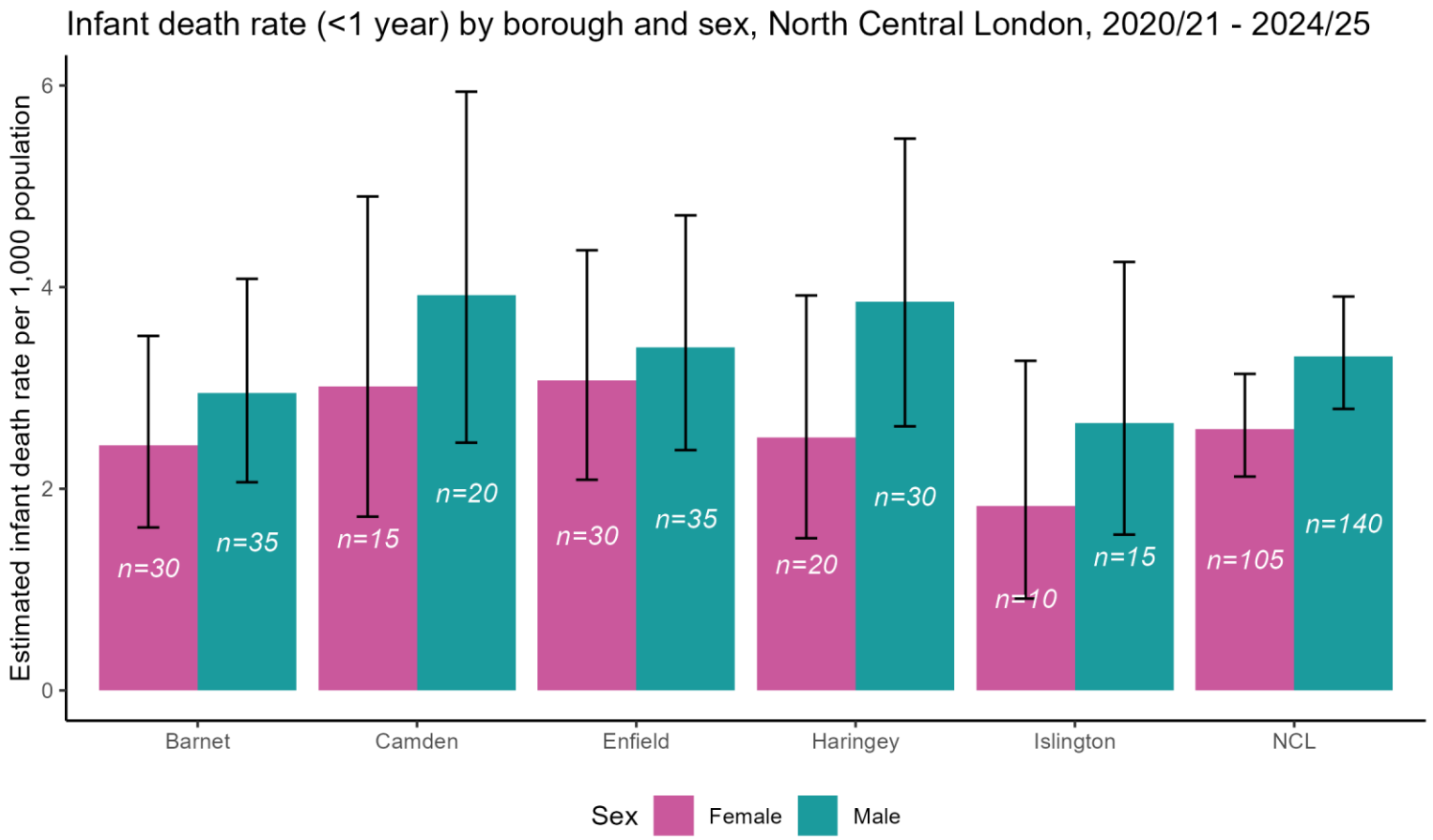
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- Infant death rates varied by ethnicity, with White British or Irish infants having a significantly lower rate (1.0 per 1,000) compared to infants from other ethnic groups.
- The estimated infant death rate in NCL was highest for infants of Black or Black British ethnicity (6.3 per 1,000 population); more than six times higher than the rate of infants of White British or Irish ethnicity.

Infant deaths by sex

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Source: eCDOP, GLA housing-led-population-projections

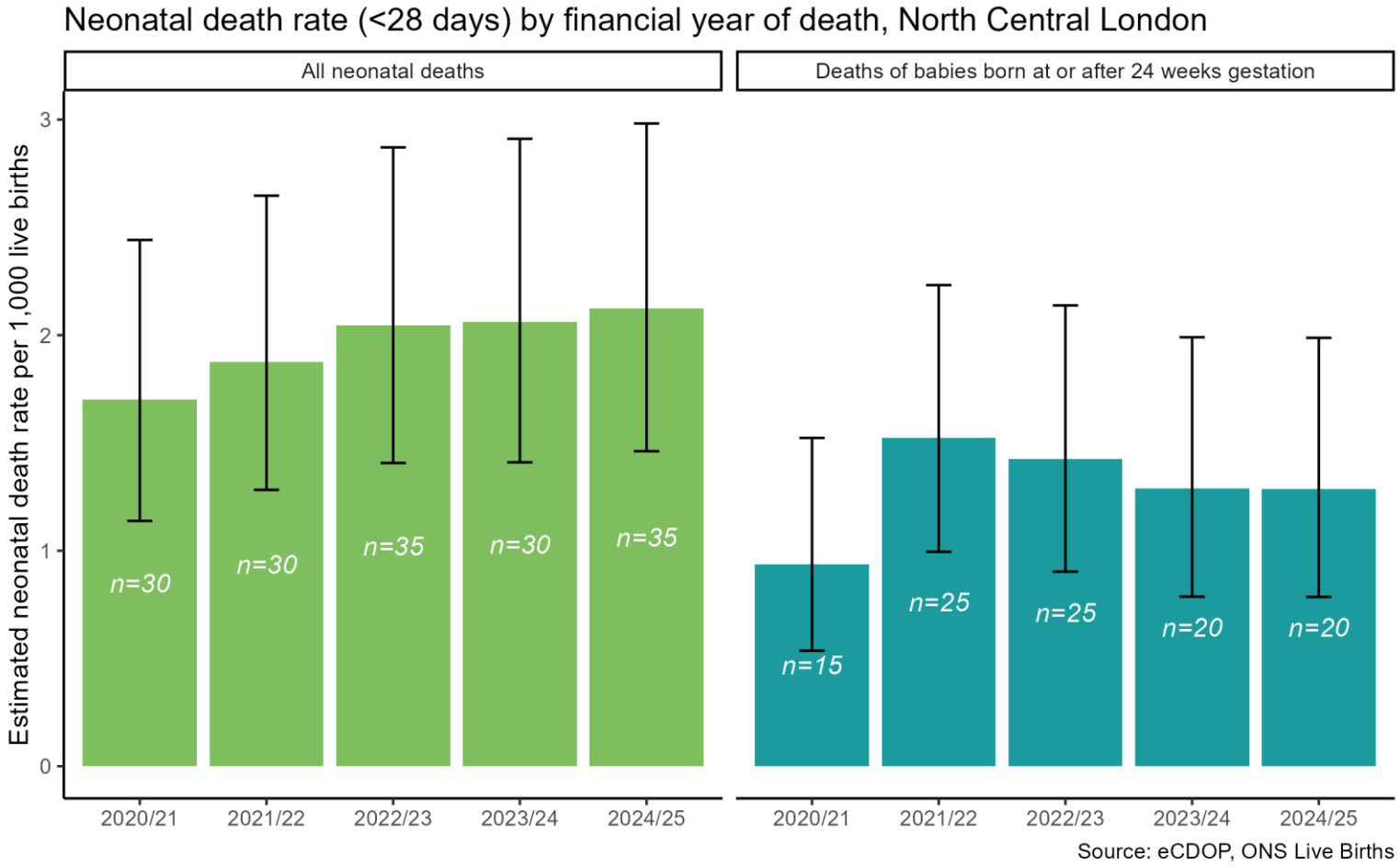
- Between 2020/21 – 2024/25, the infant death rate in NCL was higher in males than females (3.3 vs 2.6 per 1,000 population), although this was not statistically significant.
- This sex difference was also seen in each of the five NCL boroughs, although it was not statistically significant in any area (most likely due to small numbers of deaths).

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Neonatal deaths

Neonatal deaths by year

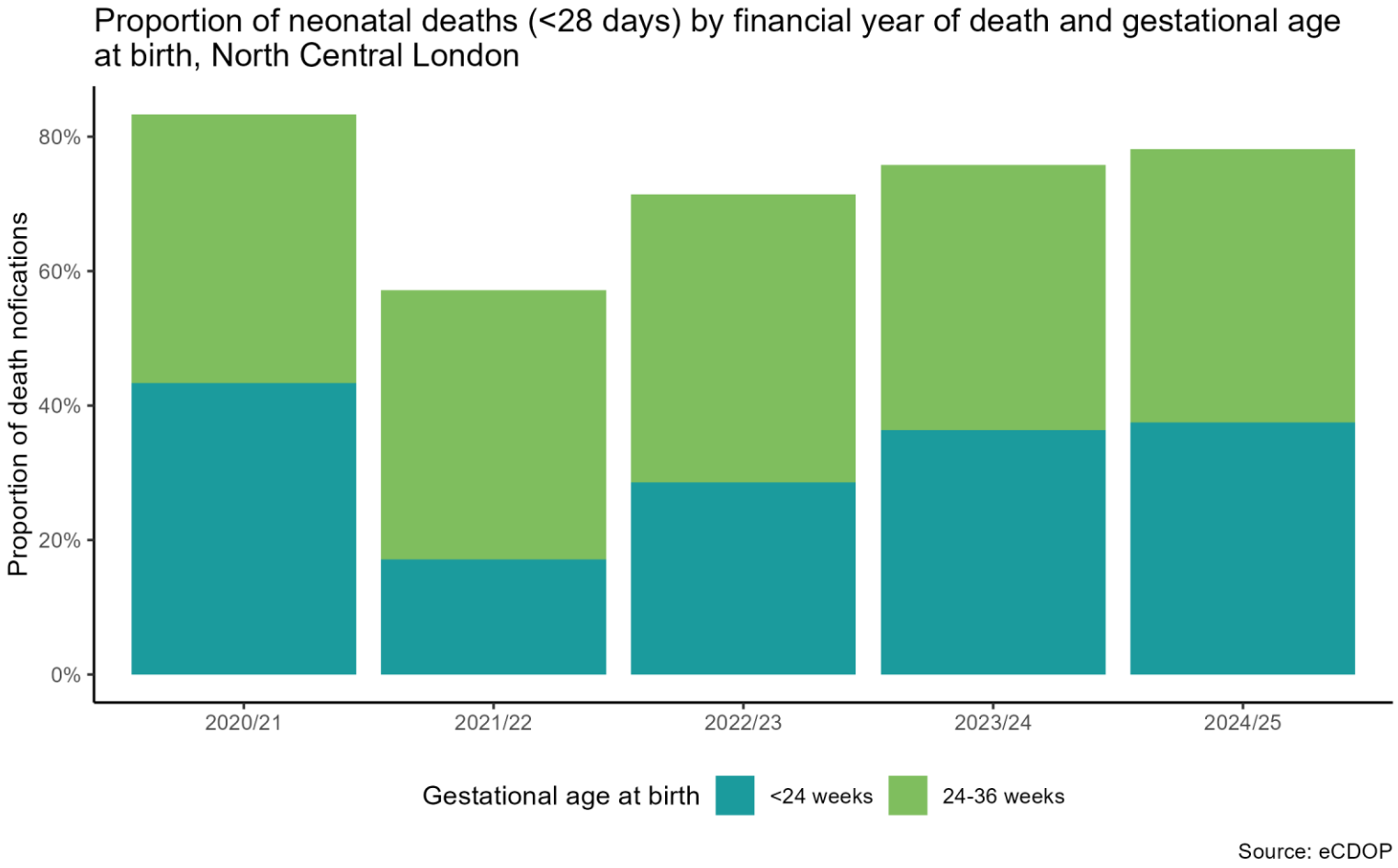
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- Between 2020/21 – 2024/25, the estimated neonatal death rate of children living in NCL was 2.0 per 1,000 live births *(n=160).* This rate has been increasing in recent years, although not statistically significant.
- In NCL, between 2020/21 – 2024/25, the estimated neonatal death rate for babies born at 24 weeks or over was 1.3 per 1,000 live births *(n=105).* There is a national target to reduce the rate of neonatal mortality rate to 1.0 per 1,000 live births born at or over 24 weeks gestation, by 2025.
- In England, the estimated neonatal death rate was 2.6 per 1,000 live births, a decrease from the previous year (2.7 per 1,000), but still higher than in 2019/2020.

Neonatal deaths by gestational age at birth

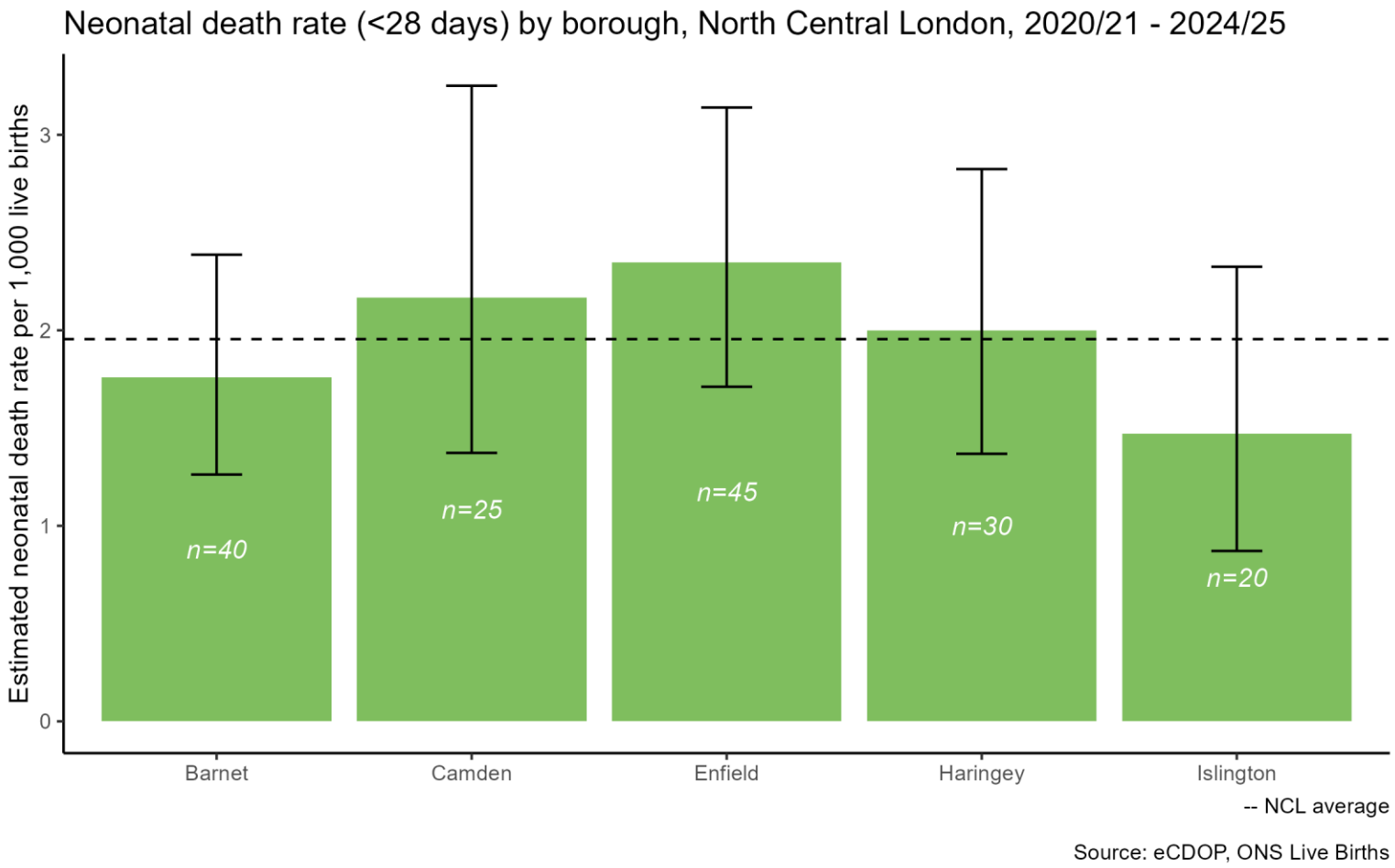
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- 72.7% *(n=120)* of neonatal deaths notified to NCL CDOP between 2020/21 – 2024/25 were of babies born at a premature gestational age (before 37 weeks), while 32.1% *(n=55)* were of babies born under 24 weeks gestation.
- In England, the proportion of neonatal deaths of babies born before 37 weeks was 78.4%, with 42.6% born under 24 weeks. Nationally, deaths of babies under 24 weeks have increased, which may reflect factors such as more consistent recognition of signs of life and better reporting to CDOPs.

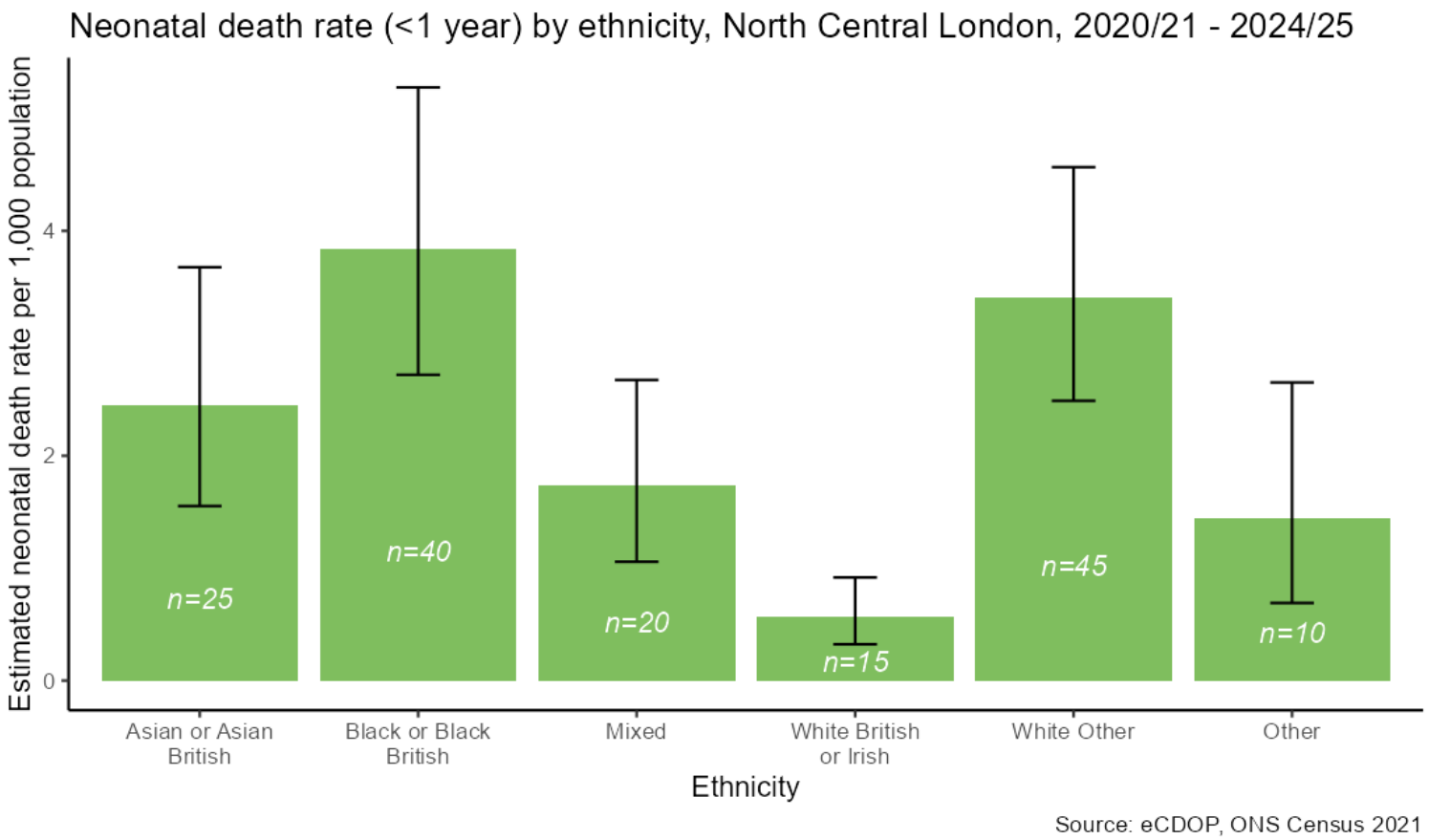
Neonatal deaths by borough

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- There was no significant difference in the rate of neonatal deaths between boroughs.

Neonatal deaths by ethnic group



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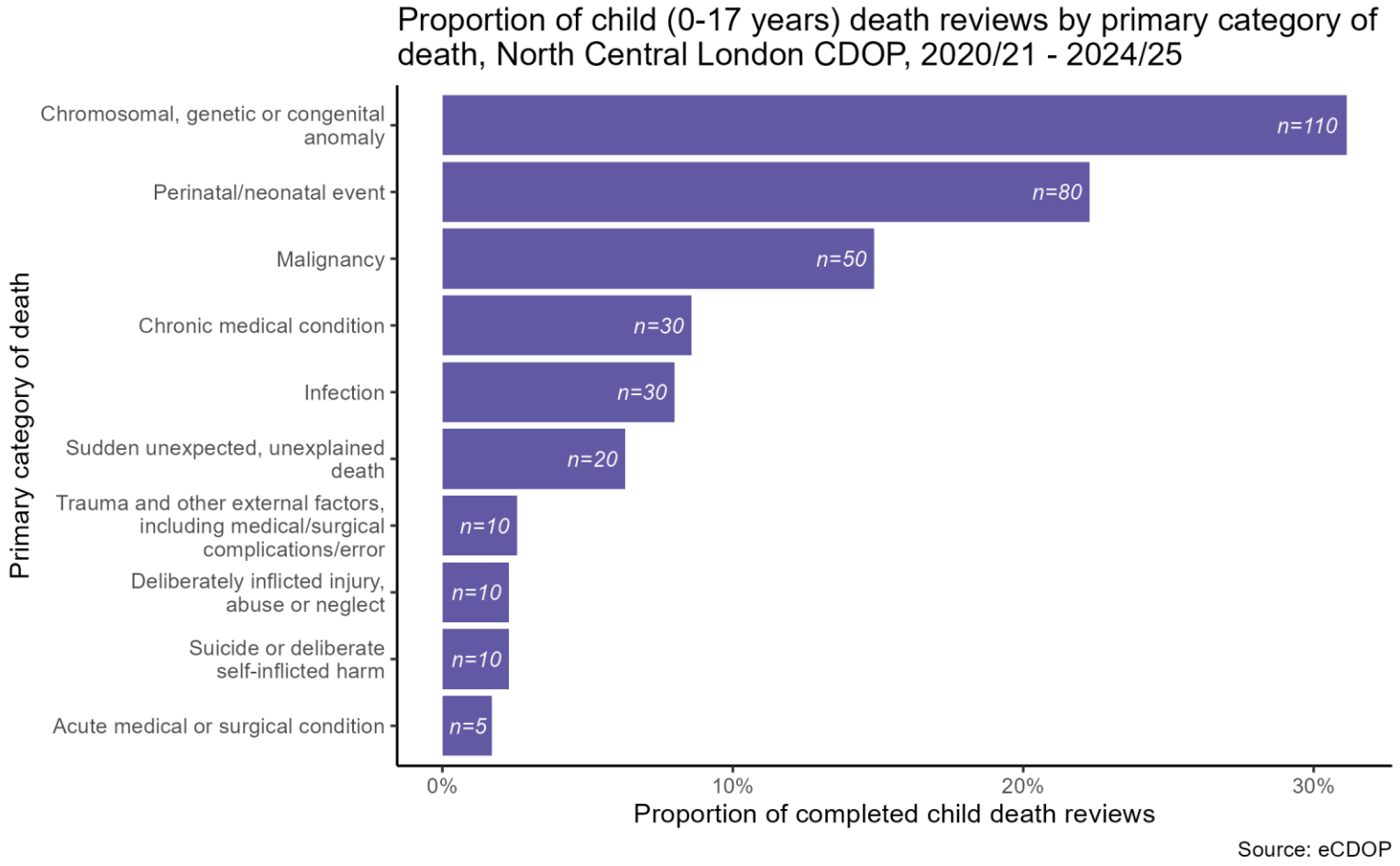
- The estimated neonatal death rate in NCL was highest for the Black or Black British ethnic group (both 3.8 per 1,000 population), followed by the White Other (3.4 per 1,000 population), Asian or Asian British (2.5 per 1,000 population), and Mixed ethnic groups (1.7 per 1,000 population).
- These four groups had a significantly higher death rate compared to neonates from the White British or Irish ethnic group (0.6 per 1,000).
- Neonates from an Other ethnic group (1.4 per 1,000) also had a higher death rate than the White British or Irish ethnic group, although this was not statistically significant.

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Child death reviews completed by NCL CDOP

Primary category of death (NCL, CDOP)

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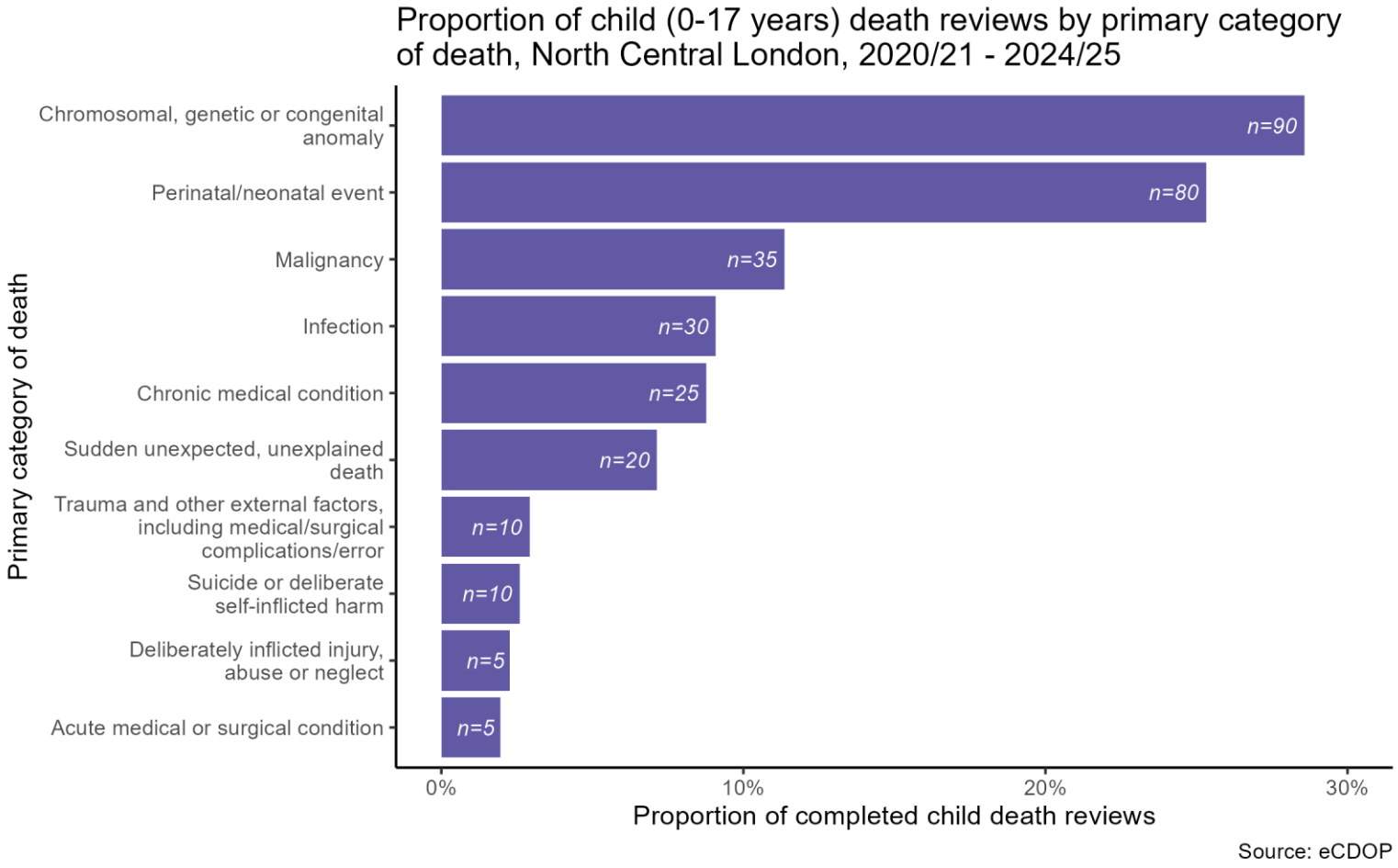


- Due to the time it takes for the majority of deaths that occurred within a particular year to be reviewed by a CDOP (with some causes of death taking longer to review than others), caution should be applied when interpreting this data as figures may change as more reviews, particularly those for deaths occurring in 2023/24 and 2024/25, are completed.
- The most common primary category of death for deaths notified to NCL CDOP between 2020/21 – 2024/25 was Chromosomal, genetic and congenital anomaly, which was recorded in 31.1% *(n=110)* of all completed child death reviews.
- This was followed by Perinatal/neonatal event (22.3%; *n=80*) and Malignancy (14.9%; *n=50*).

This analyses is based on all child deaths reviews by NCL CDOP, including those of children not usually resident in NCL (or whose normal residence was not known).

Primary category of death (NCL)

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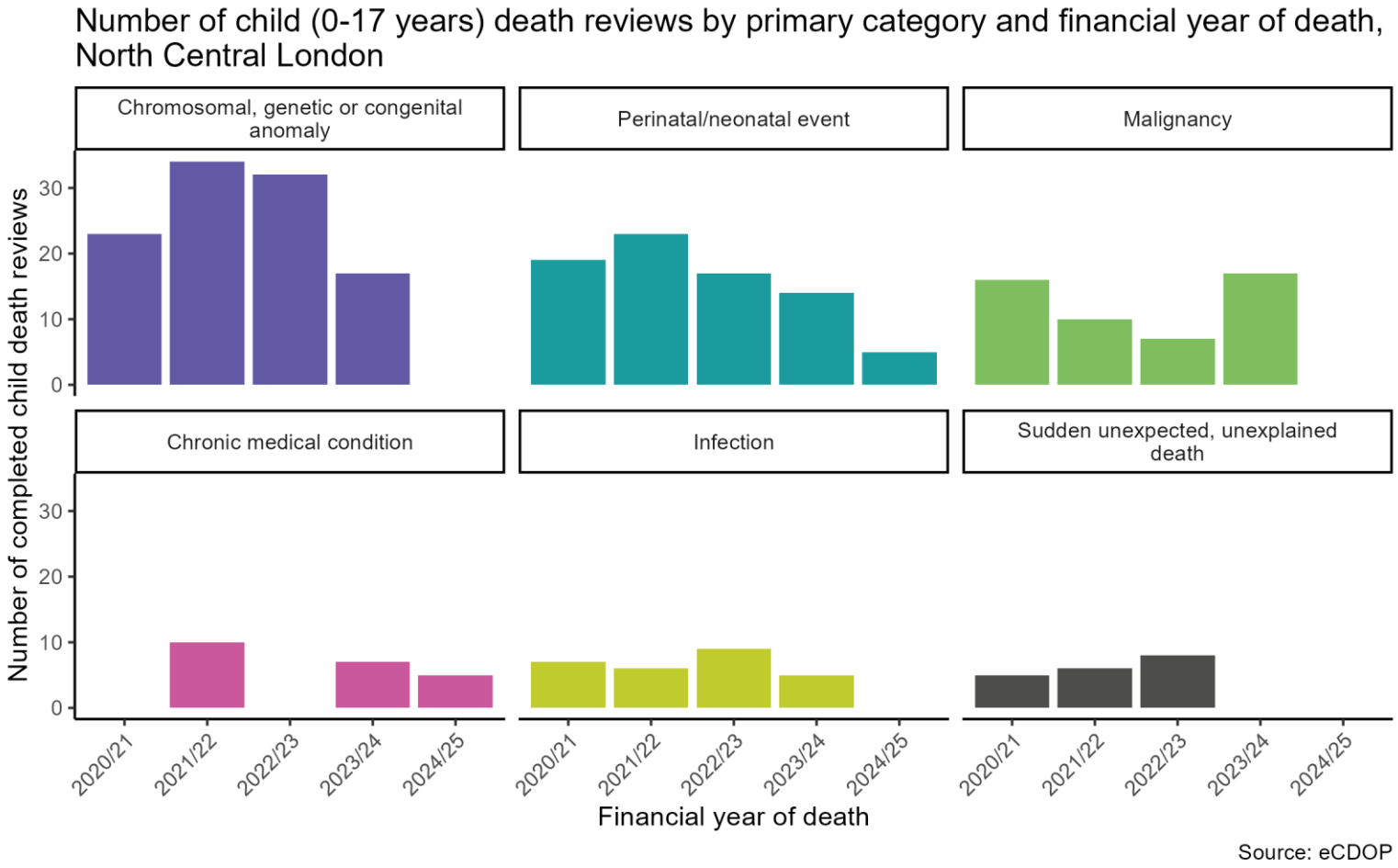


- Due to the time it takes for the majority of deaths that occurred within a particular year to be reviewed by a CDOP (with some causes of death taking longer to review than others), caution should be applied when interpreting this data as figures may change as more reviews, particularly those for deaths occurring in 2023/24 and 2024/25, are completed.
- The majority of deaths of children usually resident in NCL were categorised as Chromosomal, genetic or congenital anomaly (28.6%) or Perinatal/neonatal event (25.3%), followed by Malignancy (11.4%), Infection (9.1%) Chronic medical condition (8.8%) and Sudden unexpected, unexplained death (7.1%).
- In England, a third of deaths occurring in 2024/25 were categorised as Perinatal/neonatal event (33%), followed by Chromosomal, genetic and congenital anomaly (23%), and Acute medical or surgical condition (9%).

This analyses excludes children who either usually resided outside of North Central London (e.g., international patients who travel to NCL for healthcare), or whose area of usual residence was unknown.

Primary category of death by year

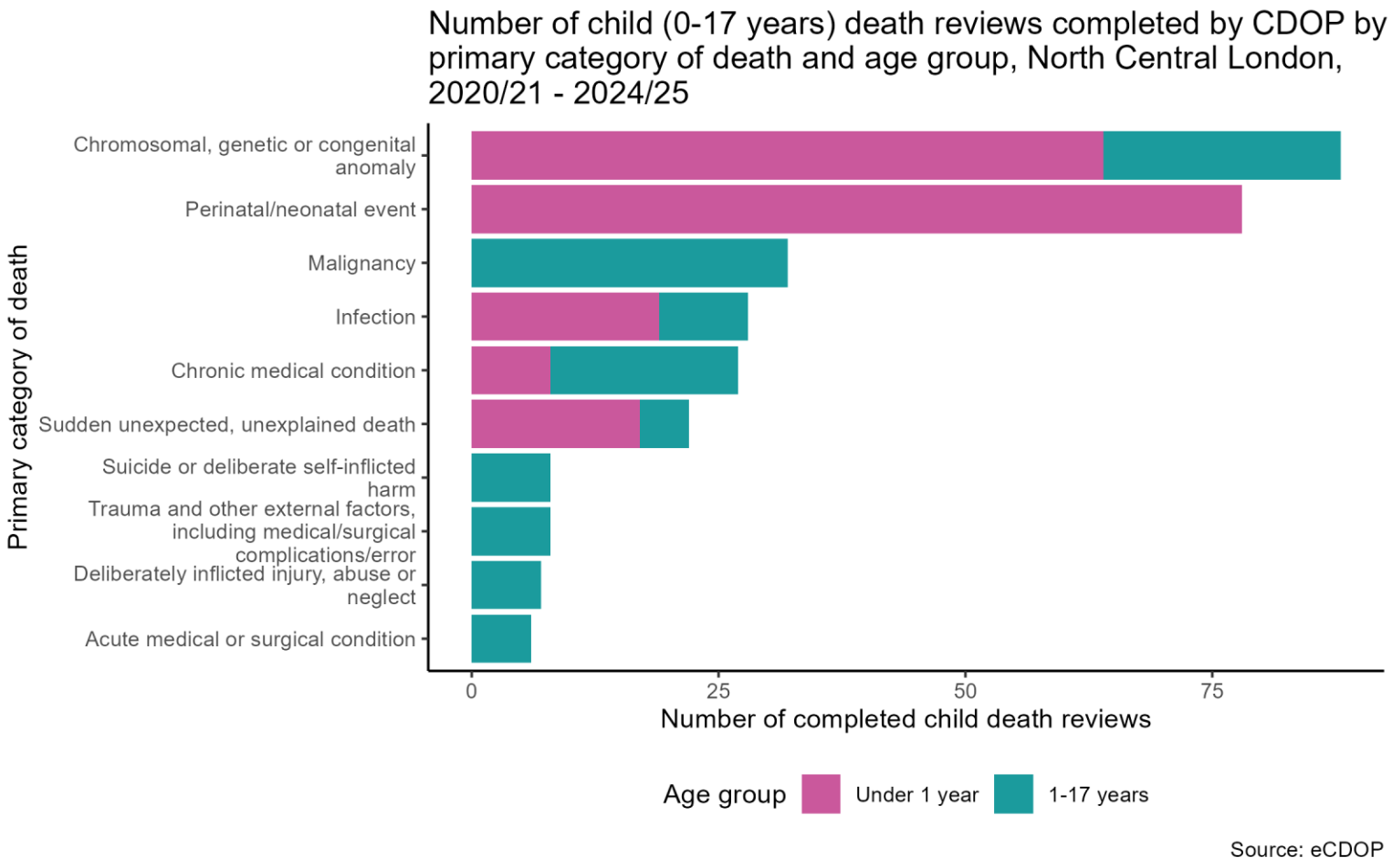
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- Due to the time it takes for the majority of deaths that occurred within a year to be reviewed by a CDOP (with some causes of death taking longer to review than others due to other investigations that need to happen e.g., an inquest), caution should be applied when interpreting this data as figures may change as more reviews, particularly those for deaths occurring in 2023/24 and 2024/25, are completed.

Primary category of death by age group

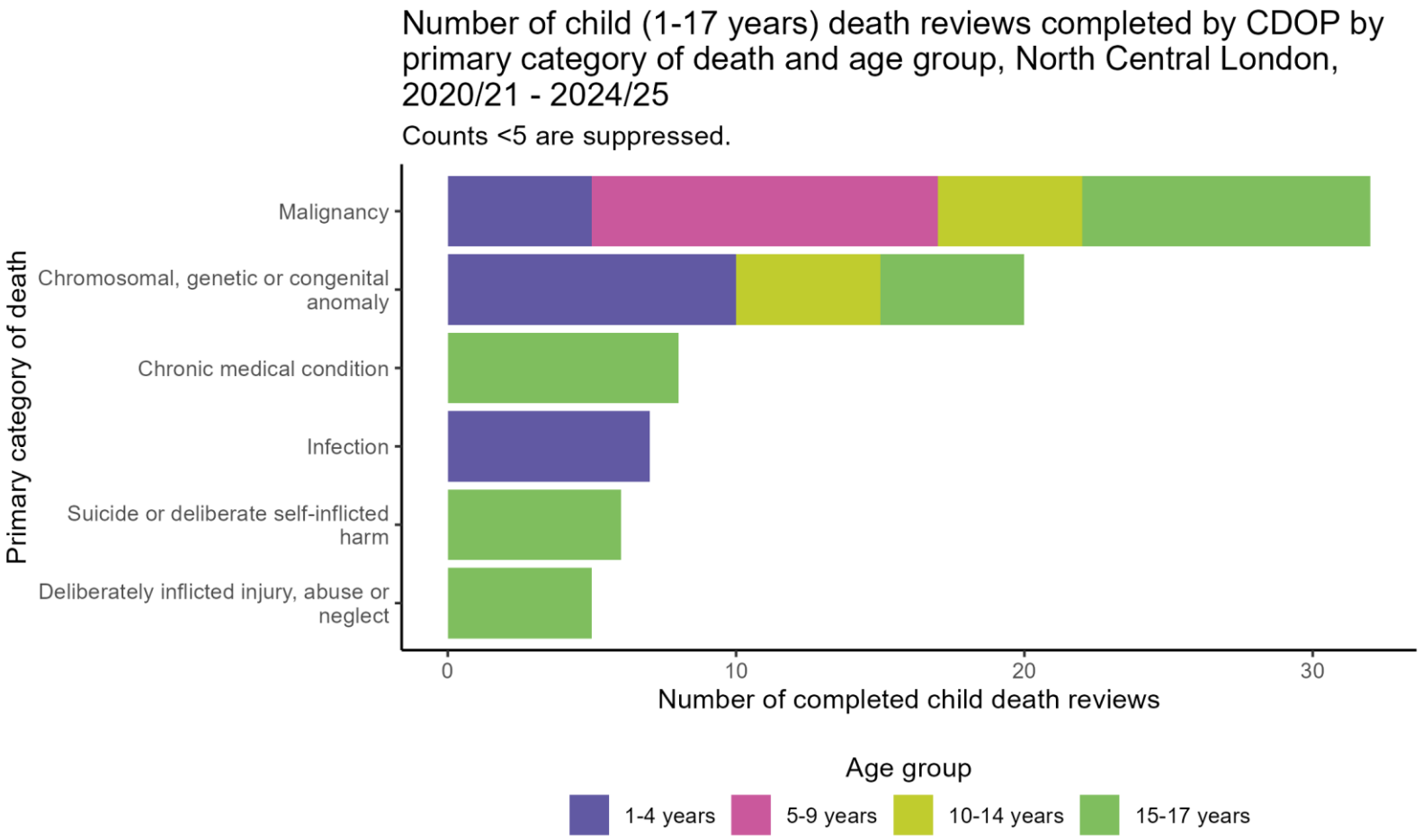
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- Due to the time it takes for the majority of deaths that occurred within a particular year to be reviewed by a CDOP (with some causes of death taking longer to review than others), caution should be applied when interpreting this data as figures may change as more reviews, particularly those for deaths occurring in 2023/24 and 2024/25, are completed.
- Between 2020/21 and 2024/25, the most common primary category of death of children aged under 1 year usually resident in NCL was perinatal/neonatal event and for children aged between 1-17 years it was malignancy.

Primary category of death by age group (1-17)

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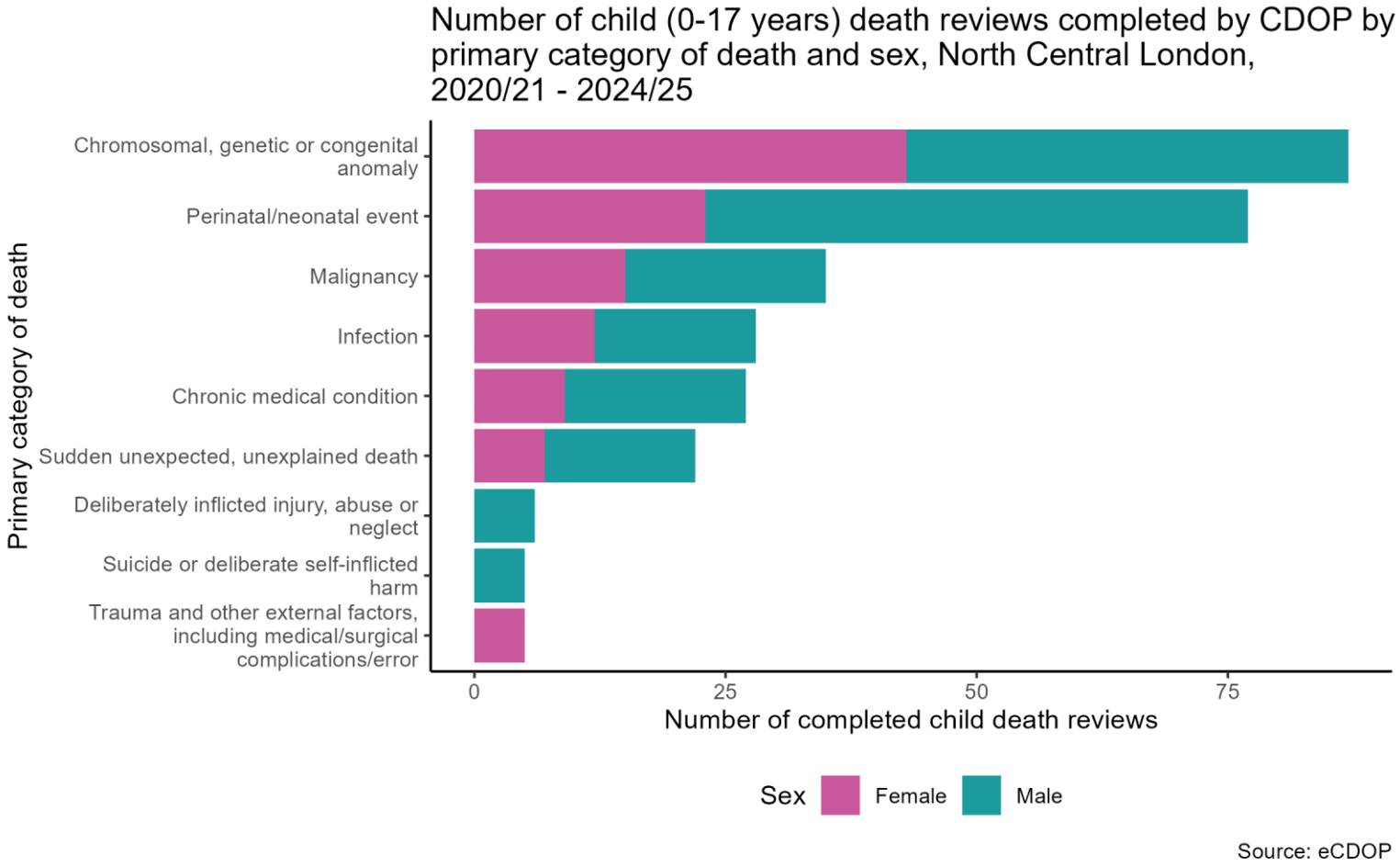


Source: eCDOP

- As counts below 5 are suppressed, approximately 20 death notifications are not shown on this chart. The same caveat from the previous slide regarding incomplete child death reviews also applies here.
- For children over the age of one, the most common cause of death was malignancy (30 reviews), followed by chromosomal, genetic or congenital anomaly (20 reviews) and chronic medical condition (10 reviews).
- Among 15-17 year olds, the leading category of death was malignancy, followed by chronic medical condition, and suicide or deliberate self-infected harm.

Primary category of death by sex

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Source: eCDOP

- Due to the time it takes for the majority of deaths that occurred within a particular year to be reviewed by a CDOP (with some causes of death taking longer to review than others), caution should be applied when interpreting this data as figures may change as more reviews, particularly those for deaths occurring in 2023/24 and 2024/25, are completed.
- Between 2020/21 and 2024/25, the most common primary category of death for females usually resident in NCL was chromosomal, genetic or congenital anomaly and for males it was perinatal/neonatal event.

Modifiable and contributory factors

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As part of the child death review process, CDOPs are responsible for recording any contributory factors identified during the review and deciding which may be modifiable.

- **Modifiable factors** are those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.
- **Contributory factors** are those which may have contributed to vulnerability, ill health or death. Their identification ensures that population trends of drivers of morbidity and mortality in the under 18 population are captured so they can be addressed.

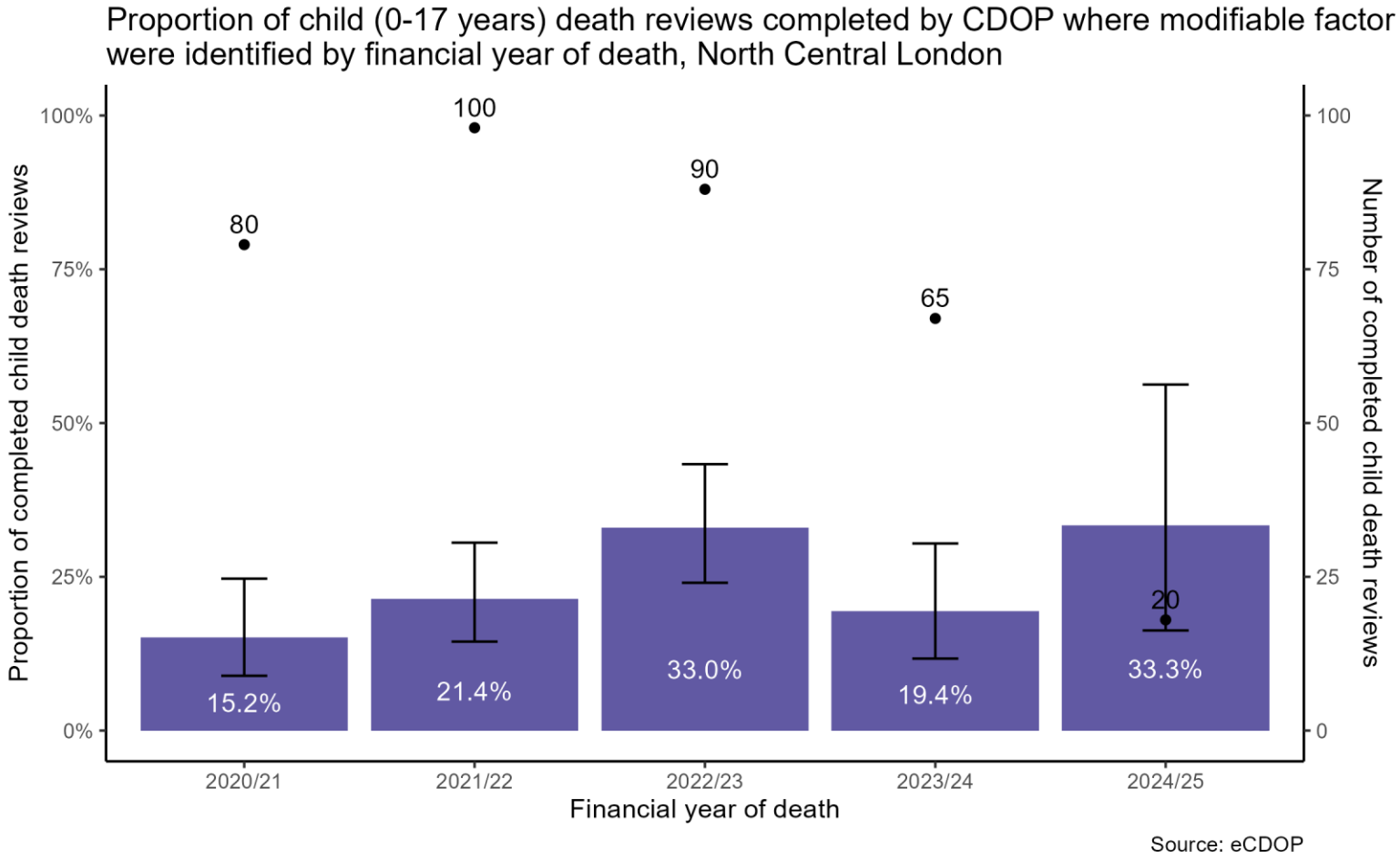
These factors are grouped into four domains: factors intrinsic to the child; factors in the social environment including family and parenting capacity; factors in the physical environment; and factors in service provision.

The following slides relate to modifiable factors determined among deaths which occurred between 2020/21 – 2024/25 and have been reviewed by NCL CDOP.

The recording and scoring of contributory factors was found to be inconsistent and has not therefore been included in this analysis.

Modifiable factors

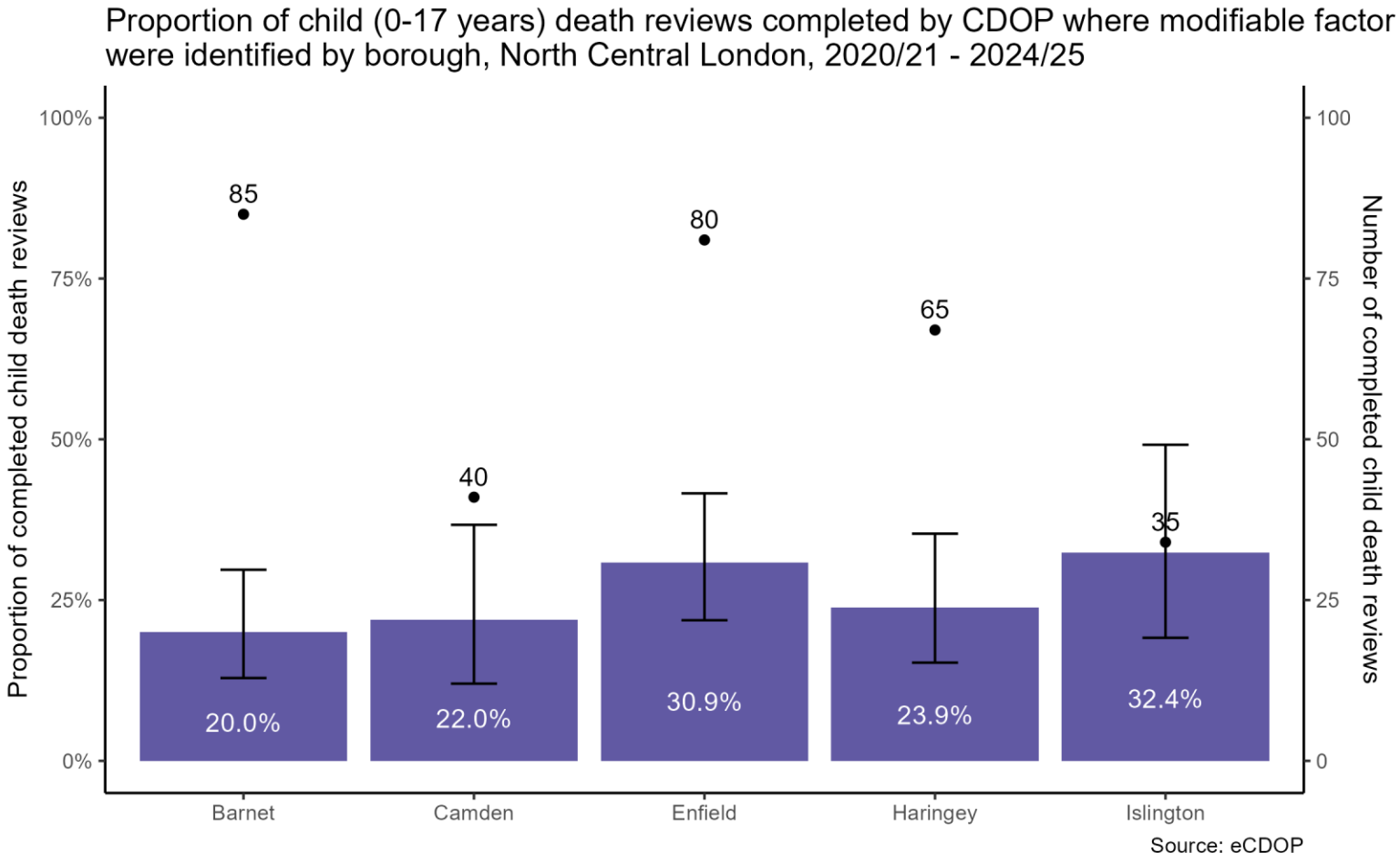
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- 23.1% *(n=80)* of child death reviews, for deaths occurring between 2020/21 – 2024/25, identified modifiable factors. 2.6% *(n=10)* of reviews had inadequate information to identify modifiable factors.
- In England, 48% of child death reviews completed in 2024/25 identified modifiable factors. Nationally, the number of reviews with a modifiable factor was the highest since 2019/20 and has shown a consistent upwards trend over the last 6 years.

Modifiable factors by borough

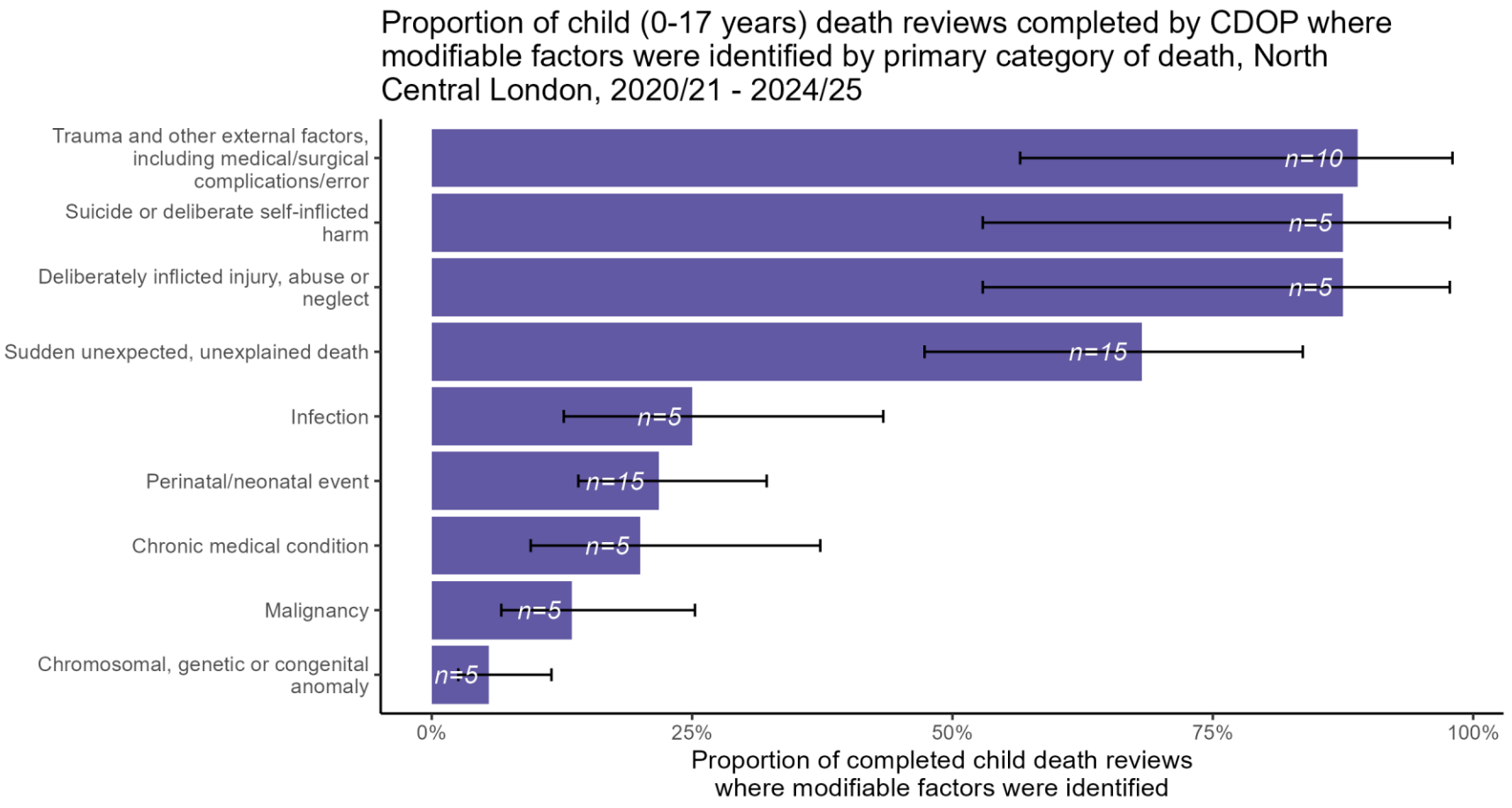
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- For deaths occurring between 2020/21 – 2024/25, Islington (32.4%), Enfield (30.9%) and Haringey (23.9%) had the highest proportion of completed child death reviews in NCL which identified one or more modifiable factors.

Modifiable factors by cause of death

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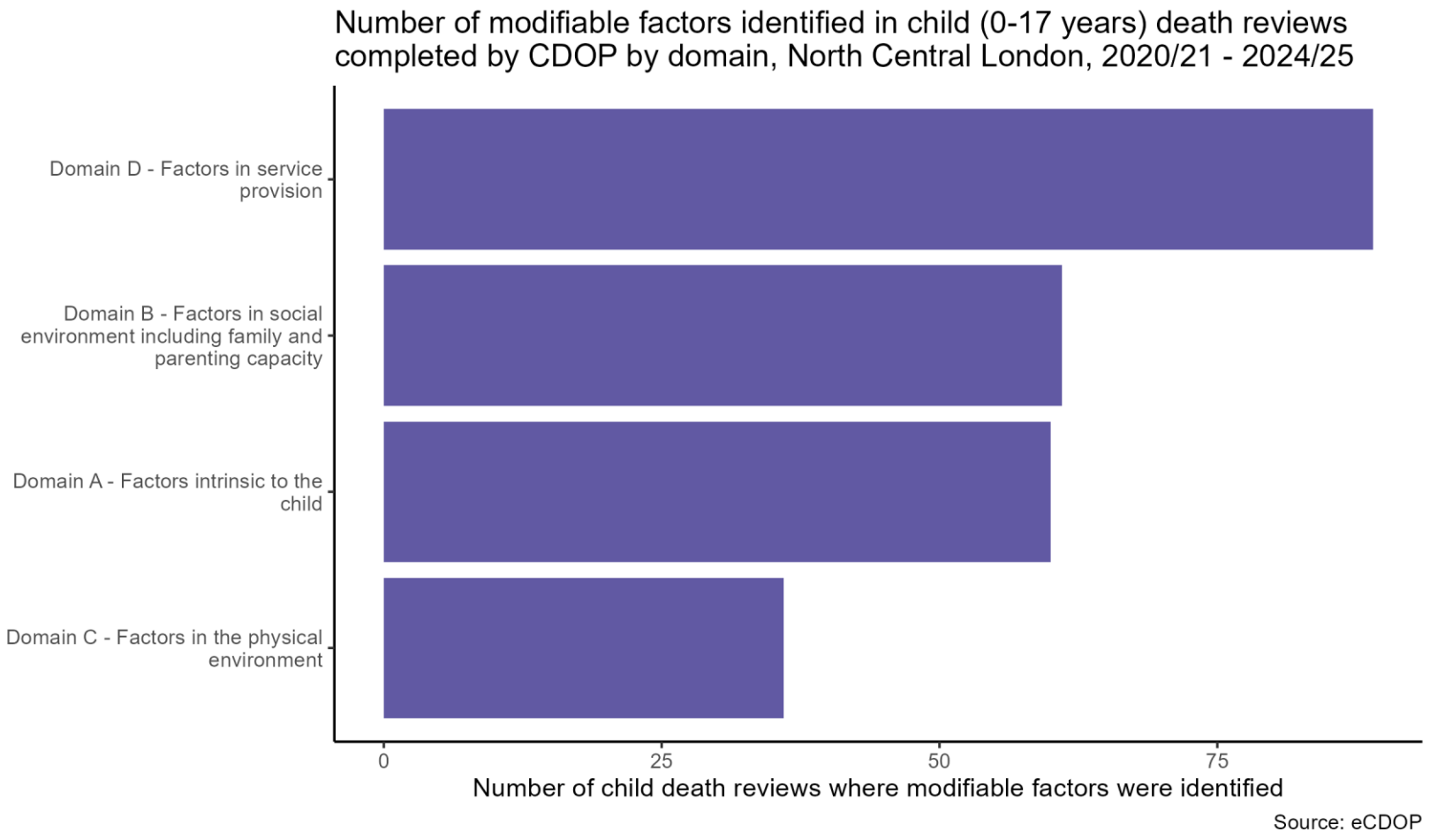


Source: eCDOP

- Deaths categorised as Trauma or other external factors had the highest proportion of reviews with modifiable factors (88.9%), followed by Deliberately inflicted injury, abuse or neglect, and Suicide or deliberate self-inflicted harm (both 87.5%).
- The highest number of modifiable factors were recorded in deaths categorised as a perinatal/neonatal event (*n=15).*
- In England, in 2024/25, 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%).

Modifiable factors by domain

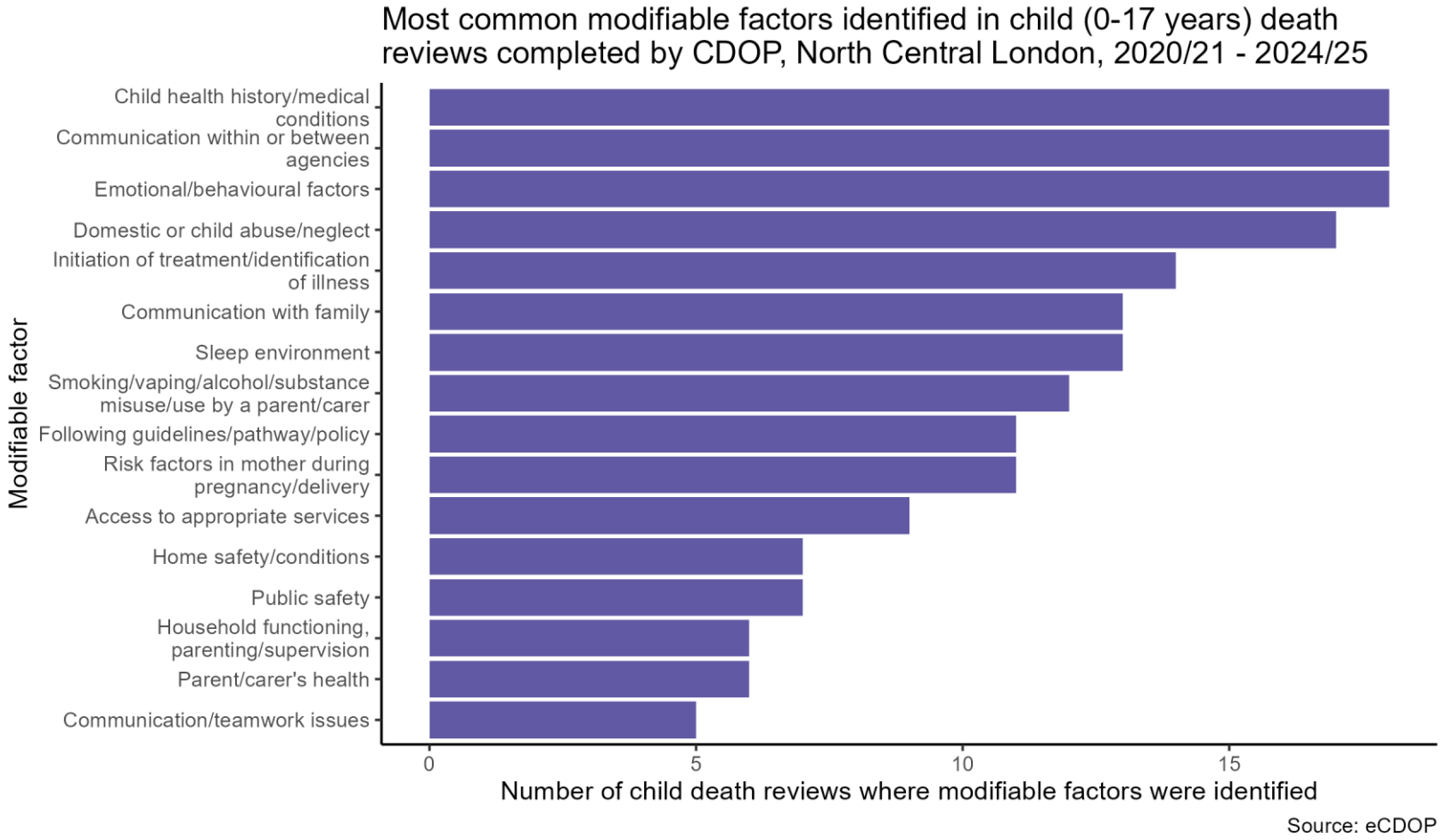
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- The largest number of modifiable factors identified by NCL CDOP were related to service provision (including delays in identification or initiating treatment or communication issues) (36.2%; *n=90)*, followed by factors in the social environment (including family and parenting capacity) and those intrinsic to the child (both 24.8%; *n=60*), then factors intrinsic to the child (24.4%; *n=60*).
- Note that more than one modifiable factor can be identified in each child death review.

Most common modifiable factors

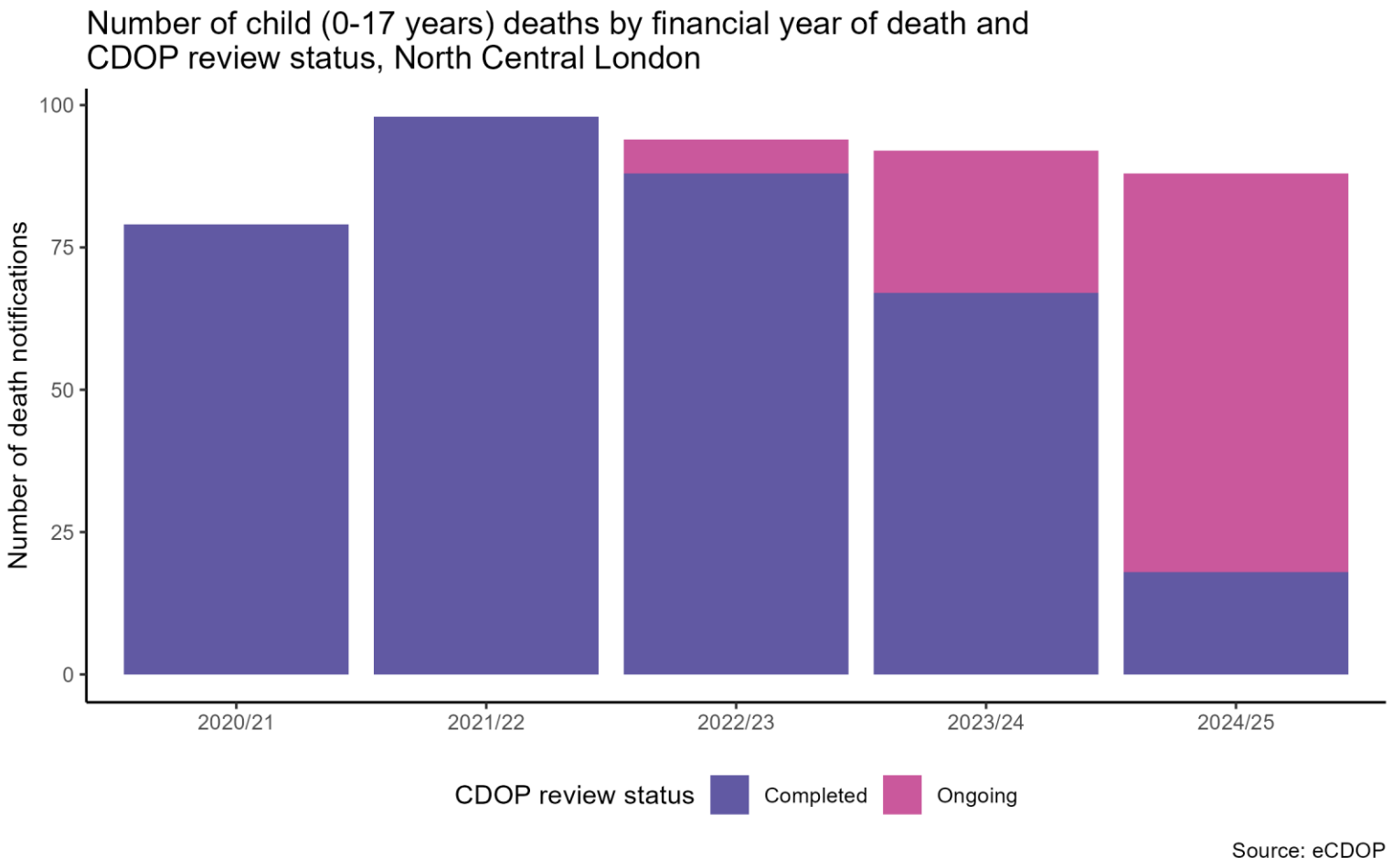
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- The most common recorded modifiable factors by NCL CDOP during reviews of deaths of children aged 0-17 years between 2020/21 – 2024/25 were child health history/medical conditions, communication within or between agencies, and emotional/behavioural factors (e.g., mental health condition, risky behaviour etc).
- More than one modifiable factor can be identified in each child death review.

Ongoing/completed reviews

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Source: eCDOP

- There is a time delay between a death being notified to the CDOP and the case being discussed and closed at panel.
- As of October 2025, 104 (22.9%) child deaths notified to NCL CDOP between 2020/21 – 2024/25 remain open to the panel.
- Nationally, the median time taken to complete reviews in 2024/25 was 435 days (around 14 months). 38% of reviews were completed by CDOP within 12 months of the death, a continuing fall from 2019/2020 when 67% were completed within 12 months.

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Spotlight on learning disability

“Learning Disability” in CDOP data

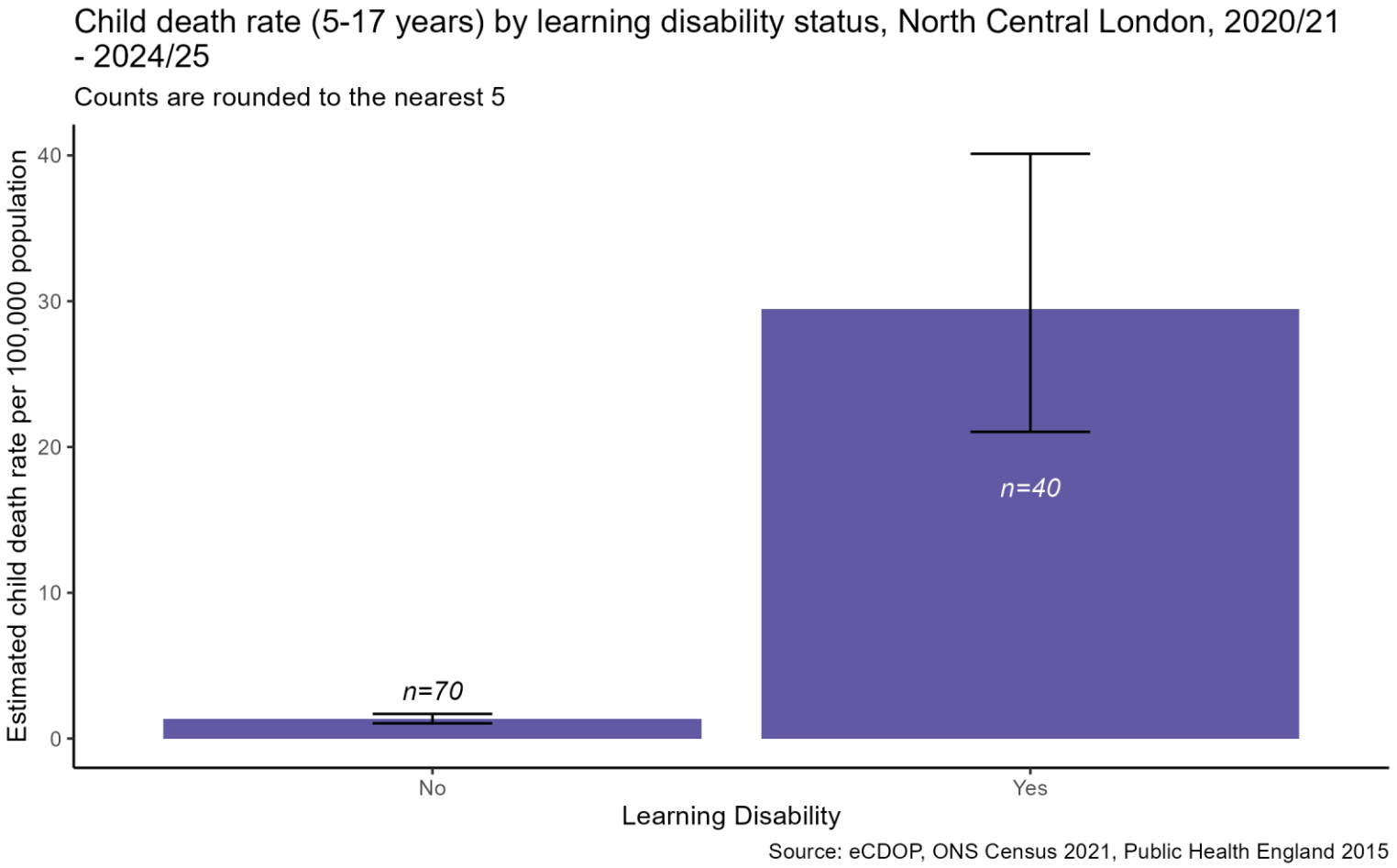
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- In 2023/24, 0.54% of registered patients in England were on the learning disability register.[4]
- There are no national data available on the prevalence of learning disability in children.[3] In 2015, Public Health England estimated that 2.5% of children in England have a learning disability (PHE).[5]
- The following analysis only looks at children aged 5 – 17 as learning disabilities are rarely diagnosed before this age.

- A learning disability involves lower intellectual ability and significant impairment of social or adaptive functioning. It is different from other conditions such as autism, dyslexia or ADHD, which are not classified as learning disabilities.[6]
- Despite this distinction, in roughly one fifth of child death notifications where a learning disability was recorded in NCL, the details section listed only one or more of these other conditions, most commonly autism.
- The most common condition cited in NCL child deaths where a learning disability was identified were developmental or global delay. These terms are used when a child takes longer to reach certain development milestones than other children their age.[7] Overtime, these delays may be reclassified as a long-term learning difficulty or disability, or as an intellectual disability, and these terms are sometimes used interchangeably.[8]

Child deaths (age 5-17) by Learning Disability Status

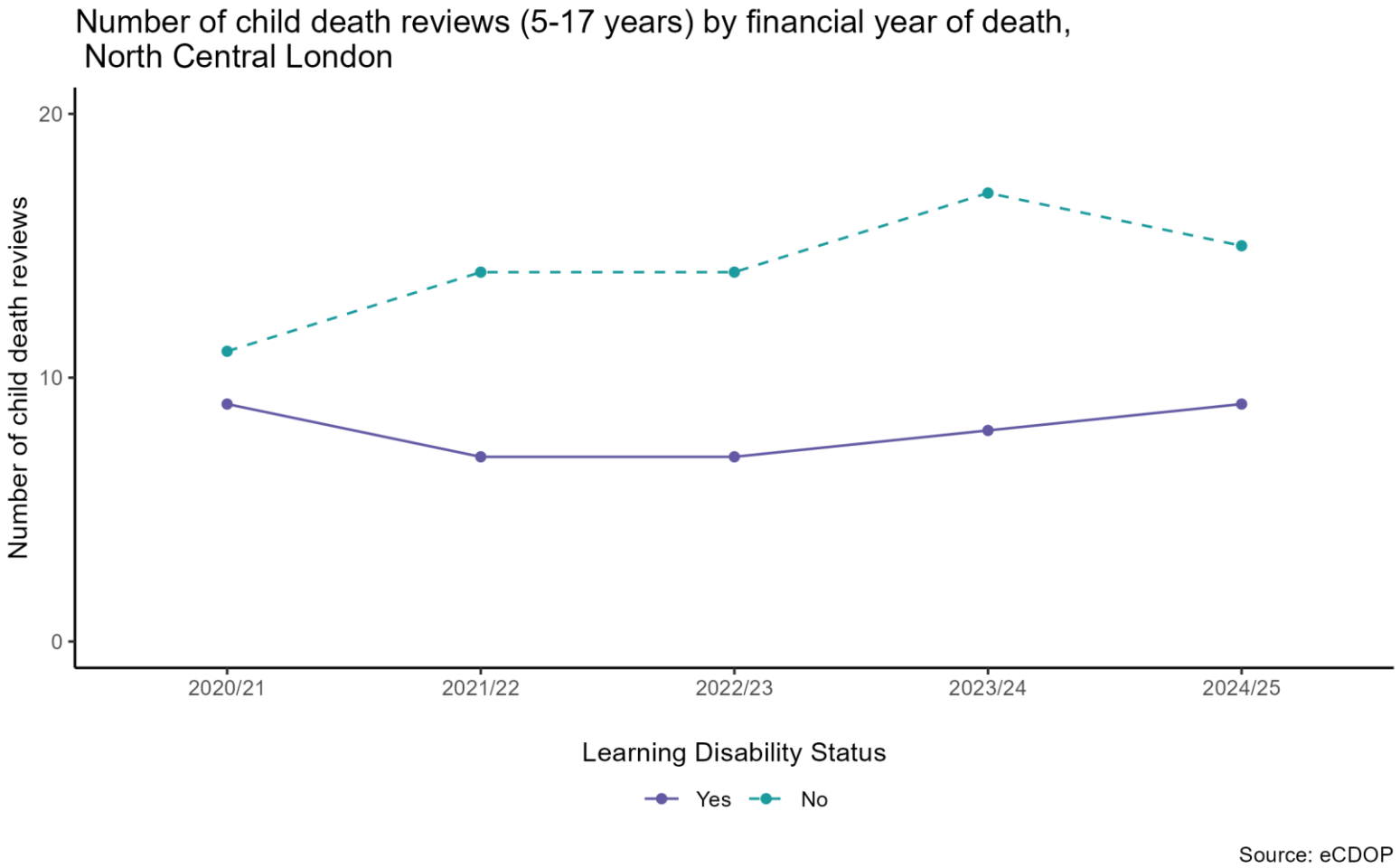
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- Children with learning disabilities are at a greater risk of child death than their peers (29.5 deaths per 100,000 compared to 1.3 per 100,000), a significant difference.
- This is roughly similar to the national picture, where 31% of deaths of children aged 4-17 years had a diagnosed learning disability (compared to 36% of children aged 5-17 years in NCL).
- The population estimate used to estimate the death rate on this slide is based on the 2.5% learning disability prevalence figure used in the 2024 national CDOP report on the topic[3], which references a Public Health England estimate from 2015[5].

Child deaths (age 5-17) by Financial Year and Learning Disability Status

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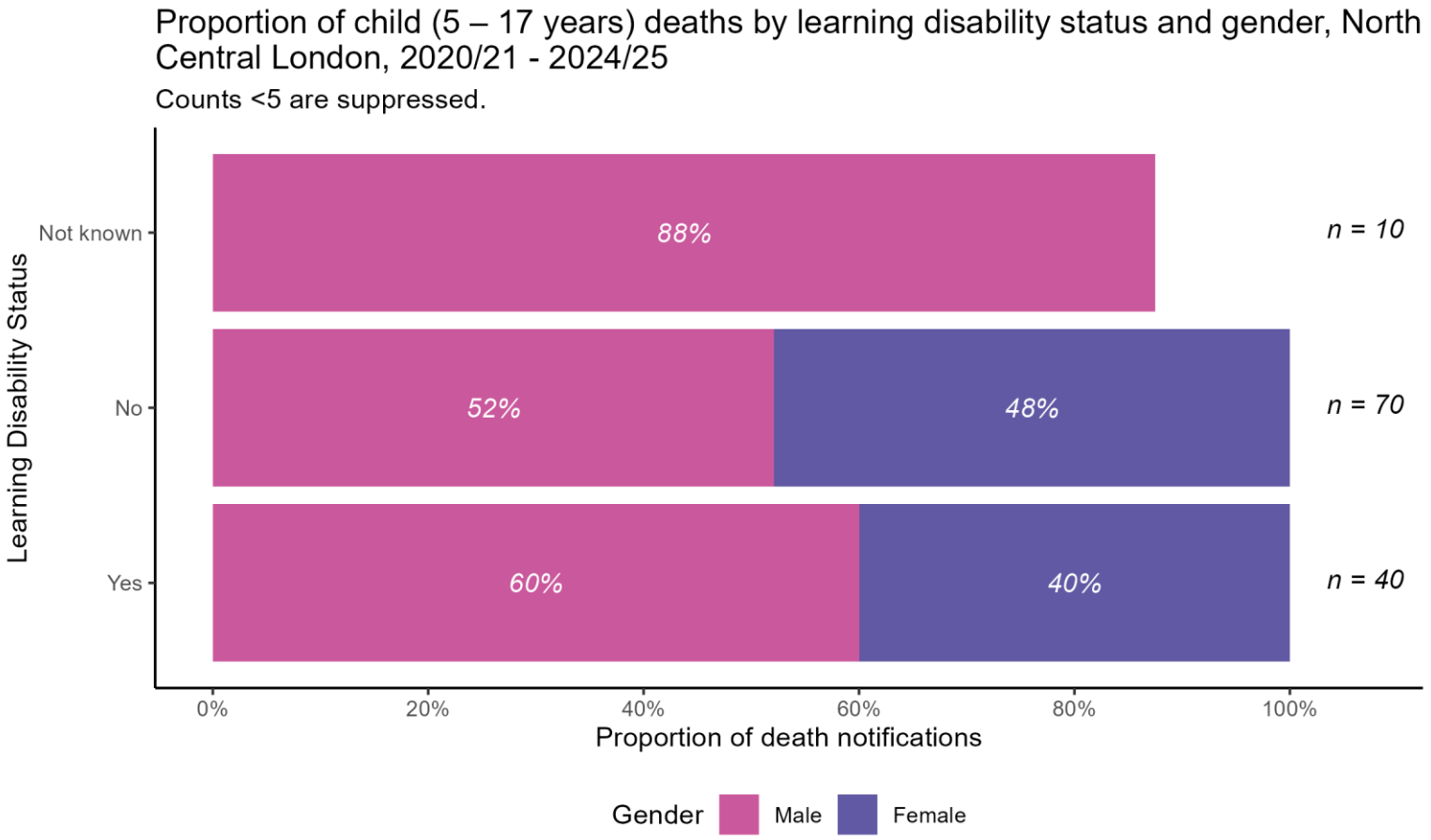


Source: eCDOP

- The number of deaths where the child had a learning disability has stayed fairly consistent over the last five years.
- The number of child deaths with a negative learning disability status (i.e. They reported 'no' to the question 'Is the child known to have Learning Disabilities?') has increased slightly since 2020/21.

Child deaths (age 5-17) by Sex and Learning Disability Status

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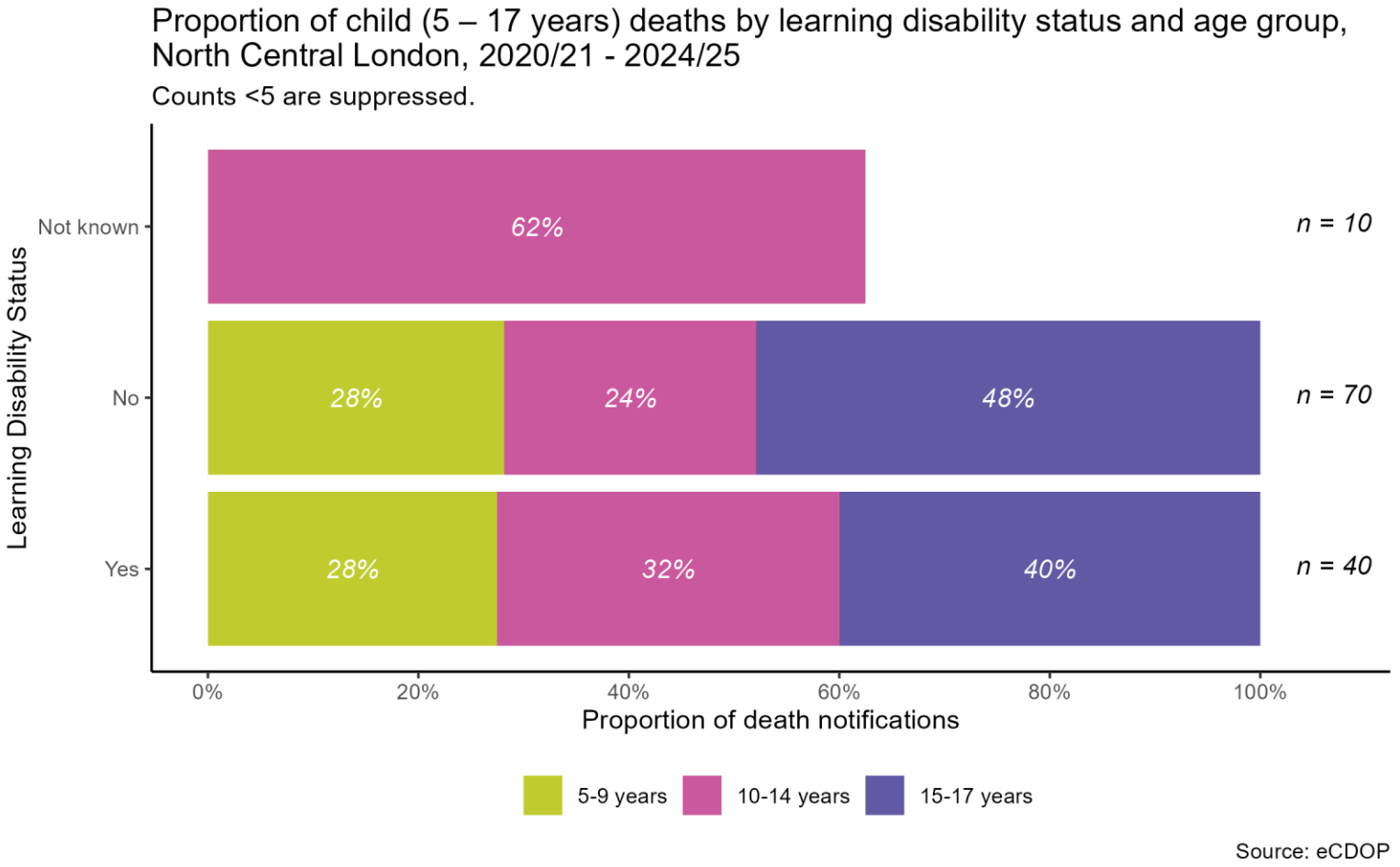


Source: eCDOP

- The sex distribution among child deaths with a recorded learning disability was broadly similar to those without (60% male compared with 52% male).
- Deaths where learning disability status was unknown were predominantly male.

Child deaths (age 5-17) by Age and Learning Disability Status

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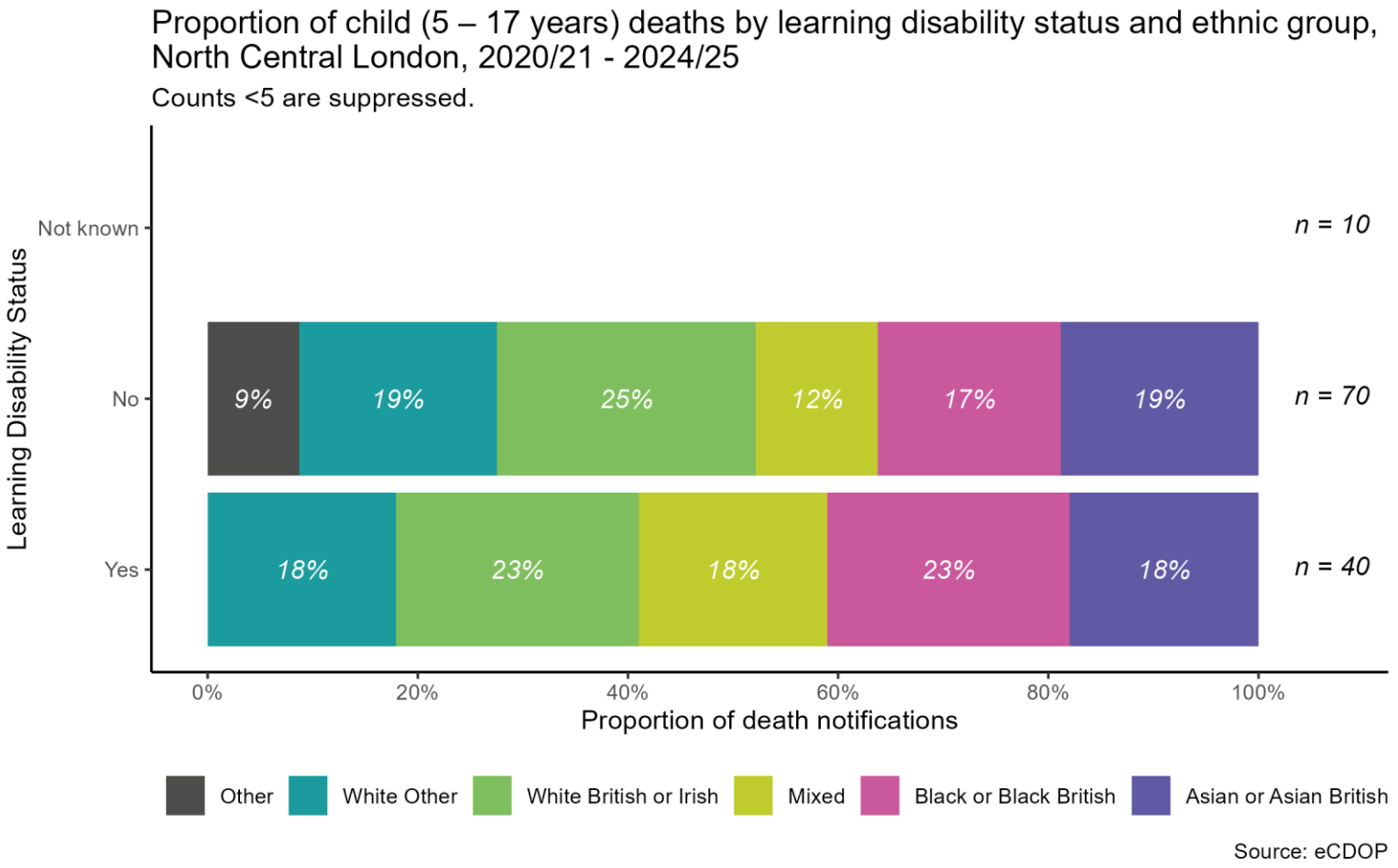


Source: eCDOP

- This analysis includes only children aged 5 and above, as there is a higher diagnostic rate in this age group.
- The age distribution for children with and without learning disabilities is statistically similar.
- Most deaths where learning disability status was unknown occurred in the 10–14 age group.

Child deaths (age 5-17) by Ethnicity and Learning Disability Status

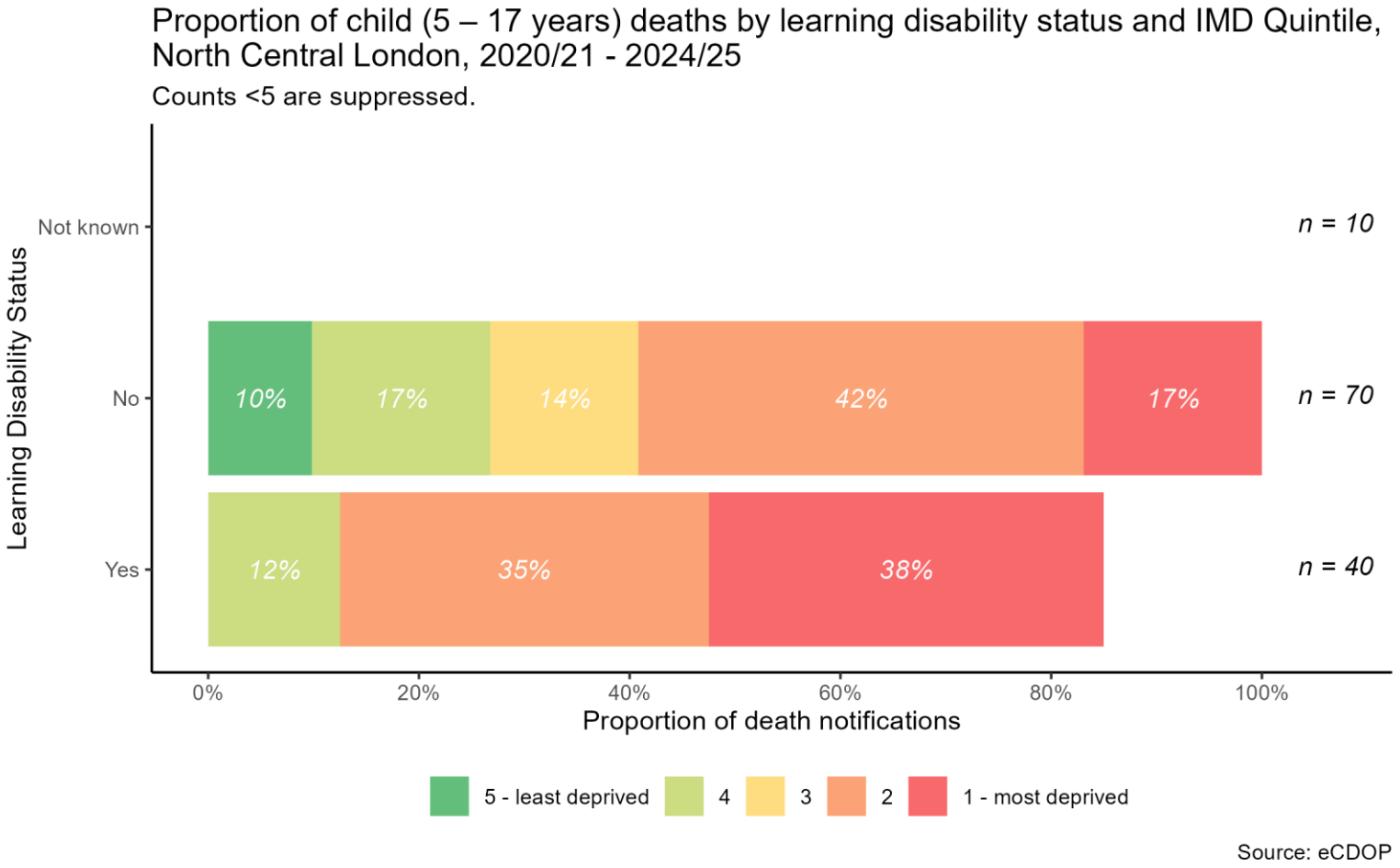
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- Between 2020/21 – 2024/25, a higher proportion of child deaths in the Black or Black British and Mixed ethnic groups occurred among those with a recorded learning disability compared to those without.
- Over the same period, there were no deaths of children in the “Other” ethnic group with a recorded learning disability.
- Deaths with unknown learning disability status were too few to analyse by ethnic group.

Child deaths (age 5-17) by Index of Multiple Deprivation and Learning Disability Status

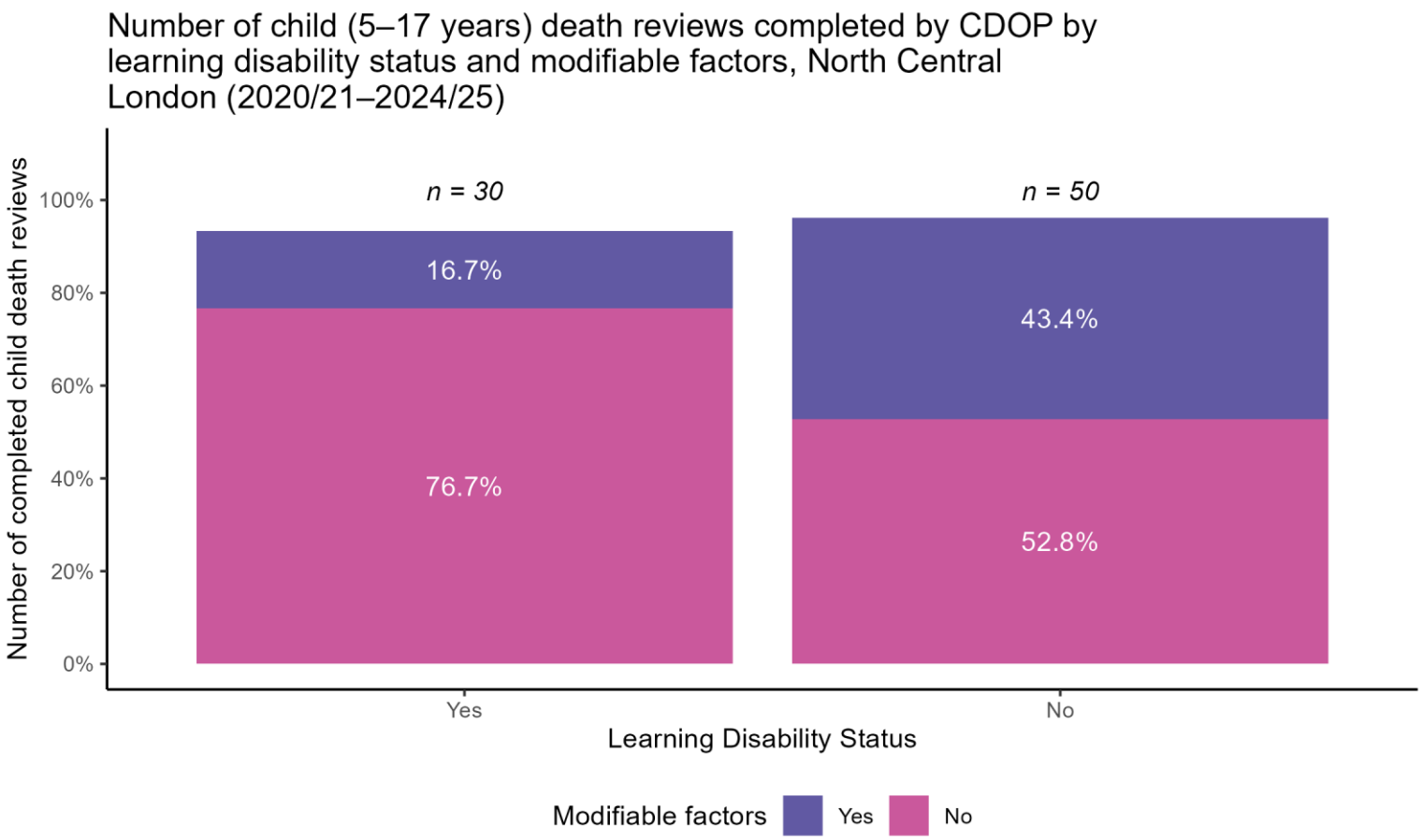
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- A greater proportion of deaths among children with a learning disability occurred in the most deprived quintile (38%) compared with deaths among children without a learning disability (17%).

Proportion of completed reviews where modifiable factors were involved

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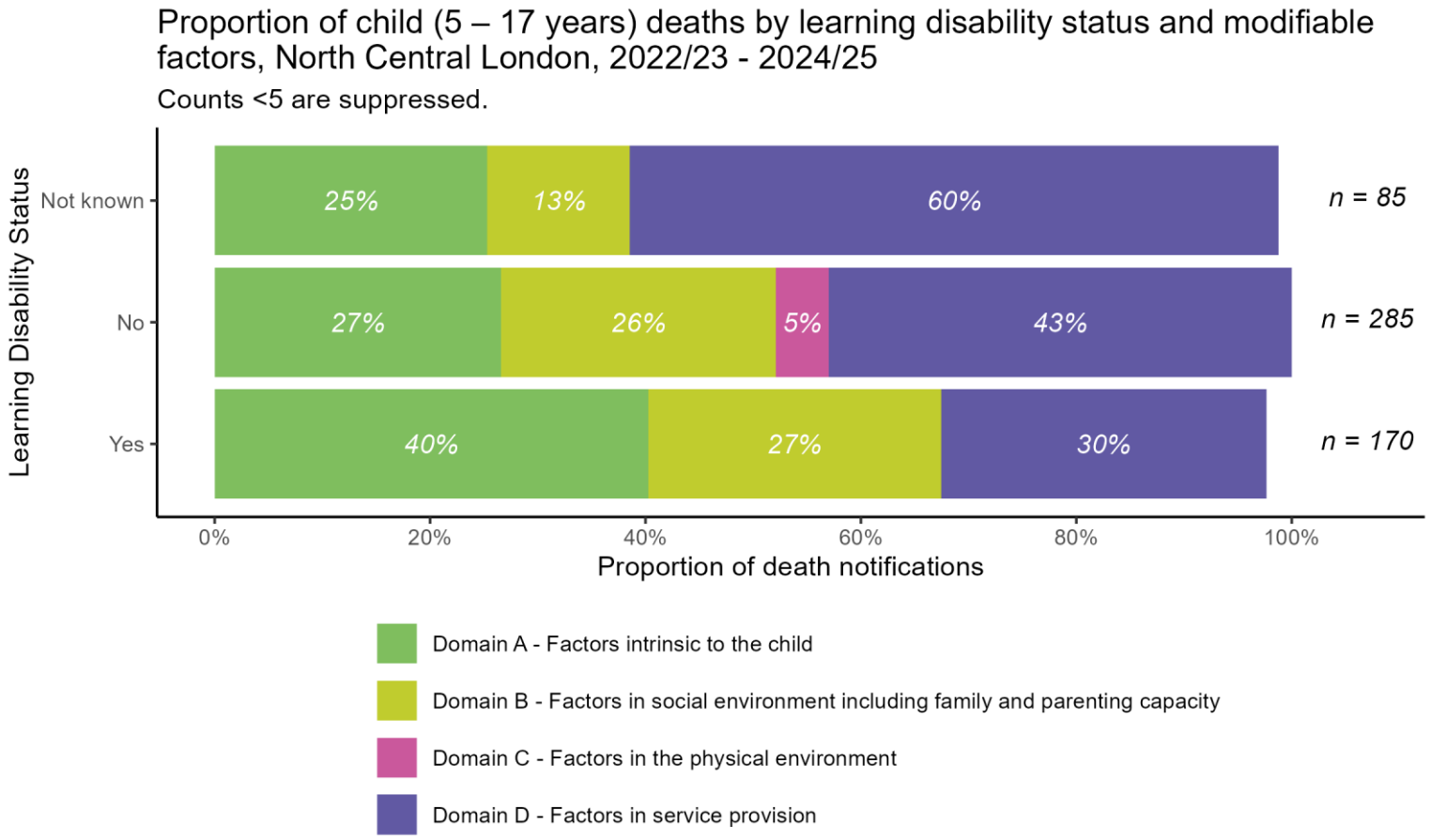


Source: eCDOP

- Children with learning disabilities were less likely to have modifiable factors identified in their deaths (16.7%) compared to those without (43.4%), although this difference was not statistically significant.
- This pattern may reflect the complexity of care needs in this group. Nationally, between 2019/20 and 2023/24 in England, 92% of children with a learning disability who died had five or more chronic conditions. Where data on underlying conditions was available, 89% had a life-limiting neurodisability.
- In England, a lower proportion of deaths involving children with a learning disability had modifiable factors (21%) compared to those without (33%).

Child deaths (age 5-17) by Modifiable Factors and Learning Disability Status

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Source: eCDOP

- More than one modifiable factor can be identified in each child death review.
- Where modifiable factors were identified, a higher proportion of deaths involving a learning disability had factors intrinsic to the child (40% vs. 27%).
- A lower proportion of deaths were related to factors in service provision compared to deaths without a learning disability (30% vs. 43%).

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Case review of child deaths: 2024/25

Overview: learning from case review of child deaths 2024/25

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This section relates to cases that were reviewed by CDOP over the course of 2024/25, which differs from the number of deaths occurring in 2024/25. The purpose of this review was to identify key themes emerging from case notes, and system changes required in response.

The CDOP panel met 14 times in 2024/25 and discussed 145 child deaths.

2024/25 CDOP meetings	Number of cases discussed
CDOP x 8	84
Perinatal panel x 5	61
Strategic x 1	0
Total cases reviewed	**145**

Case review: key themes

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The key learning and actions resulting from case review of 145 child deaths discussed by CDOP relate to three themes:

1. Wider determinants of health
2. Communication
3. Other issues

Learning: wider determinants of health

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Poverty and deprivation

There were several cases where poverty and deprivation were noted as contributory factors. Examples include:

- overcrowded housing and co-sleeping as a result
- family with No Recourse to Public Funds status
- material deprivation: family unable to afford funeral; family needed support with school uniform, books, toys
- parents forced to quit working due to child's care needs, with knock-on effects on family's financial stability
- pregnant woman sleeping in her car antenatally

Housing

Different housing issues were noted in several cases, including:

- overcrowding and small/cramped accommodation
- homelessness/requiring emergency housing
- pregnant woman sleeping in her car antenatally
- poor housing conditions and issues requiring repair, e.g., moving to a hotel because of sewage problems in normal residence
- eviction notice and subsequent stress on family
- housing not suitable for the needs of the child, e.g., child unable to access the bathroom because of mobility issues
- no room for cot in bedroom which meant baby slept in buggy

Learning: wider determinants of health

North Central London Health and Care
Integrated Care System

Immigration-related issues

A few instances of immigration-related issues were noted during case review:

- child asylum seeker had no details of diagnosis with them, plus family history of complex social problems including non-English speaking mother and homelessness
- delays in accessing treatment believed to be linked to conflict in home country
- asylum seeking mother was un-booked for maternity care in the UK as she didn't realise she could receive care before her immigration documents were processed

Consanguinity

Several instances of consanguinity were recorded. Referrals for genetic counselling are usually not recorded, and there are a few instances where notes indicate that the family was not referred for genetic counselling.

Maternal BMI

High maternal BMI was noted as a contributory factor in several cases, often coded as modifiable and often linked to premature births.

Learning: wider determinants of health

North Central London Health and Care
Integrated Care System

Unsafe sleeping

Several cases included unsafe sleeping as a contributory (and modifiable) factor. Different factors were noted in cases involving unsafe sleeping, including:

- poor housing/small flat
- staying somewhere other than family home because of environmental issues
- domestic violence in the home
- smoking in the home
- overheated bedroom
- adult duvet covering baby
- baby placed on stomach with blankets rolled up to stop child from rolling
- items stored in cot which prevented baby from sleeping there
- co-sleeping with previous babies who were born healthy, which is different to co-sleeping with a baby who has health problems

Antenatal screening

<u>Smoking</u>
Smoking in the home by mother or father was noted in several cases

<u>Domestic abuse</u>
Current and/or previous domestic abuse was noted as a contributory factor in several cases

<u>Gestational diabetes</u>
A couple of instances were recorded where women eligible for gestational diabetes screening during pregnancy were not offered it

Learning: communication

North Central London Health and Care
Integrated Care System

Communication with families

There were many instances where careful, sensitive communication was done well and the family felt listened to, like they were treated respectfully and that the information conveyed was appropriate. Issues that highlight where this could be improved include:

- to help manage a family's expectation about treatment outcomes
- to avoid families feeling like they are suspects in their child's death
- to avoid families feeling judged for opting to decline treatment in cases of terminal diagnoses
- to help families when they feel powerless

One family noted the importance of using sensitive, thoughtful wording in reports, and highlighted that reading phases such as 'it may not have changed the outcome' was particularly distressing.

Culturally appropriate communication

More culturally sensitive and appropriate communication would have enhanced the relationship with families in a few cases. This communication relates to supporting a family to honour religious customs related to the timing of burials, as well as helping families to plan the timing of repatriation (for international private patients). This also relates to cultural sensitivity when delivering bad news on Fridays (Muslim holy days).

Learning: communication

North Central London Health and Care
Integrated Care System

Language support

Case review revealed situations where interpreters were used appropriately/at every appointment. However, several examples were noted where families with English as an additional language or low/no spoken English had communication problems related to their care. Examples include:

- interpreters were not used for all discussions
- arrangements other than an interpreter were used including using members of staff to translate during birth and using family members to translate during antenatal appointments
- interpreter available but had difficulty understanding the dialect, therefore defaulted to speaking English – which resulted in poor information sharing
- language barriers linked with income deprivation, child asylum seeker, lack of social support
- difficulty finding face to face interpreters in A & E for emergency situations
- child accompanied for emergency care by family member who did not speak English, which made it difficult for medical team to ascertain whether child's presentation was typical or not

This is also relevant for international private patients.

Trust

A few instances were noted where families struggled to trust services. The reasons for this are personal and complex; some examples that illustrate this include:

- One parent did not seek medical attention or treatment for a child's health condition because of mistrust in clinical services, and chose not to have their child receive routine immunisations
- One family said they lost trust in service providers because of culturally insensitive communication and avoidable delays

Learning: other issues

North Central London Health and Care
Integrated Care System

Privacy after a child dies

Examples were noted where the availability of a private, sound-proof space was not available for parents following the death of their child.

Out of hours care

Case review revealed instances where out of hours care was provided seamlessly (e.g., by an overnight Noah's Ark on-call nurse) and also where the lack of advocates out of hours was challenging (e.g., when changes were made to treatment and the family needed support).

Pharmacies

Some instances were noted where closer working with pharmacies would have beneficial in relation to the care of the child. Some examples include:

- to avoid delays in dispensing medication with the frequency required of the medical condition
- where an earlier multidisciplinary meeting with the pharmacy would have been useful in managing the care of a child with multiple medical complexities

Learning: other issues

North Central London Health and Care
Integrated Care System

Palliative care

Early involvement of palliative care is often welcomed by families, and parents frequently say how grateful they are for the opportunity for early parallel planning. There were cases that highlighted challenges related to palliative care involvement; examples include:

- where language barriers were a barrier to developing end of life care plans
- when including palliative care earlier in multidisciplinary meetings would have been useful for uncertain diagnoses
- when early palliative care involvement would have helped in exploring treatment options, including not to treat

There is value in considering whether families fully understand what palliative care means and how the process works, and whether communication about this could be improved.

Barriers to engaging with services

Different barriers to engaging with services were noted. Often these barriers were linked with social complexities, including:

- difficulty filling in forms linked with income deprivation
- missed health appointments linked to income deprivation, English as an additional language, unsafe sleeping, overcrowded housing
- not engaging with health checks linked to domestic violence, alcohol consumption around time of death, parental smoking
- asylum seeking pregnant women not booked for pregnancy care in UK as she did not realise that antenatal care was available before her documents were processed

Learning: other issues

North Central London Health and Care
Integrated Care System

Engagement with child death review process

There were many cases where the family engaged with the child death review process. When families engaged they:

- sometimes expressed gratitude for the care their child received
- sometimes had no comments or questions
- sometimes had questions about the care their child received or feedback, both positive and negative, about communication with care providers

There were also many cases where it was noted that families did not engage with the process or were not asked to engage with the process, and sometimes this field was left blank entirely—so it's not known whether families were invited to engage or not.

For one family who declined to participate, it was noted that they were too angry about their child's death to participate in the child death review process.

Intersectionality between social needs

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Integrated Care System

Under the topics of mental health, domestic abuse and serious youth violence, several inter-related issues were noted as contributory factors:

Mental health

For cases where mental health was noted as a contributory factor in a child's death, the following factors were also recorded:

- discomfort caused by medical condition linked to suicidal ideation or self-harm
- sexual orientation or gender identity issues
- alcohol and drug consumption
- sexual abuse
- bullying at school via social media
- learning disability
- refusal to engage with services
- gang affiliation
- loss of key relationships
- racism by family member
- parental use of alcohol, drugs or smoking; parental mental health issues
- family income deprivation
- perceived lack of safety where child lived
- lack of adherence to medication
- domestic violence in the home
- possession of knives
- denied access to community schemes as child grew older
- previous social care involvement, where older siblings were removed from the family home

Domestic abuse

Many instances where domestic abuse was noted were linked to additional social complexities, for example:

- parental smoking, substance use and drug use
- gang activity in family
- income deprivation
- mental health issues in mother
- unsafe sleeping
- English as an additional language

Serious youth violence

For cases related to serious youth violence, the following contributory factors were also present:

- physical abuse by a family member
- possession of weapons
- domestic violence in the home
- family history of gang involvement

Positive aspects and examples of excellent care

North Central London Health and Care
Integrated Care System

Positive feedback from families and examples of excellent care fell into four categories:

Support services

- Numerous examples of parents expressing gratitude for the care their child received
- Commendations for care received from keyworkers, Noah's Ark and Life Force
- Acknowledging the value and importance of early palliative care involvement
- Examples of care providers going above and beyond their ordinary duties to provide exemplary care
- Appropriate use of interpreting services during care and after discharge, to keep family updated and informed

Communication

- Thoughtful, detailed replies from healthcare providers in response to queries from parents
- Good handover of care records between local authorities
- Many examples of excellent multidisciplinary working across agencies, teams and Trusts
- Sensitive communication from trusted care providers helped families prepare for seeing their child's body after death
- What's App group chats between parents and services reduced barriers to communication with families

Parent-centred

- Appropriate referrals for testing and counselling
- Being given time to spend grieving with a child before a post-mortem was important and invaluable
- Acknowledgement of engaged parents and the importance of this in advocating for their child, effectively managing their care and meeting their needs
- Importance of parents feeling like they are in control of options
- Outpatient care enabled a family to spend the remaining time with their child on memory making activities

Holistic support

- Family living in a poor quality, small flat was successfully re-homed following their child's death
- Acknowledgement of the importance of wider support from family members and faith leaders
- Importance of supporting families to hold a child before they die and with memory making activities, like making hand or footprints
- Acknowledgement of skilful care that allows a child to die peacefully with their family
- Importance of schools in supporting students as well as siblings
- Support in facilitating an early burial, according to a family's spiritual needs

North Central London
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Integrated Care System

Progress on actions from 2023/24

CDOP process

North Central London Health and Care
Integrated Care System

Last year, we asked CDOP to review its governance, reporting and surveillance processes.

We made progress on…	Further progress could be made on…	Local authority example
Since then, CDOP has improved its documentation and reporting practice. It reports into the NCL Mortality Group and the Population Health Management group on a quarterly basis. Improved surveillance practice is evident in the improved quality of analysis available in this year's annual report.	Disseminated leadership and accountability for CDOP recommendations across NCL could be further strengthened – particularly within the ICB and among Directors of Children's Services. Continued efforts to improve the recording of domains B and C will support our understanding of social circumstance and contributory factors, quality of care for people with learning disabilities and learning difficulties, and in how we address barriers to accessing care and support.	Barnet: working to ensure that a member of the public health team with knowledge of the CDOP process attends CDRMs for child deaths where suicide, RTAs, or SUDIs are a potential causes Islington: worked closely with the CDOP leads to ensure Public Health are included in the CDRMs for child deaths by suicide and developed the follow-up actions identified at the CDRM.

Safeguarding in context: health effects of child poverty and structural racism

North Central London Health and Care
Integrated Care System

	Recommendation	Context	Progress
4	Strengthen systemwide understanding of the health impacts of child poverty and structural racism	To better promote upstream intervention and effective integration of support between NHS and local authority services	Camden: the Raise Camden programme is currently working with partners to consider how our Family and Youth Hubs networks can work to address this problem Islington: Tackling racism is a high priority for Islington's Safeguarding Children Partnership and the Maternity and Early Childhood Partnership Board. Islington's Tackling Poverty Steering Group leads and coordinates work across the Council and with partners to reduce longer-term poverty. A key approach is using data from the Low Income Family Tracker (LIFT) dashboard to identify and target support.
5	Population Health Management Board needs to ensure resource allocation on the basis of multiple measures of need rather than population numbers.	Families experiencing poverty often face complex circumstances	Evidence from the CDOP annual report has been fed into the NCL Mental Health JSNA
6	Equitable practice in service delivery	To support a more outcomes-driven approach and rebuild trust among the most underserved communities	Camden: Camden's Equitable Services Programme adopts a QI methodology to systematically assess and address disproportionality across service pathways: access, uptake, completion, experience and outcome. This is being piloted with CYP Health and Wellbeing services in the first instance. Islington: completed a Health Equity Audit of access to breastfeeding support.

Safeguarding in context: continued, focused attention on families with social complexities

North Central London Health and Care
Integrated Care System

	Recommendation	Context	Progress
7	All services need consistent and routine provision of language support services	Rolled over from last year	Camden, Haringey, Barnet, Islington: consistent approaches have been developed for translation and interpretation
8	Resource and training needs to be passed through to community organisations to support families' needs more fully being met	Lack of engagement with services was a consistent theme in this report	Camden: Camden's participation and VCSE teams support sector-wide engagement. The council is piloting a grassroots framework approach to better engage smaller organisations with relational practice within our neighbourhood systems. Islington: has a consistent and systematic approach to ensuring training and resources are offered to local community and faith organisations with good reach into different ethnic and minoritised communities.
9	Continued support to meet families' healthcare needs in the community, rather than A & E	Families living in deprivation are more likely to access A&E over GP services	• With UCLH, Camden and Islington are piloting paediatric led clinics in family hubs to follow up children with high frequency, low acuity attendance at A&E, and link families into community services • The ABC programme delivered by North Middlesex Hospital in the community across Enfield and Haringey is accessible to all communities and offered in community languages • Islington have developed a red/amber/green insert for child red books explaining the appropriate use of different healthcare organisations from pharmacy to A&E.
10	MECC programmes should be in operation across paediatric programmes	These should take social circumstance into account and cover immunisations, smoking in the household, healthy weight, etc.	Camden, Haringey, Barnet, Islington: MECC programmes are established across councils, with varying offers for children and families Islington: offers MECC and Coaching for Health training to frontline workers. Topic specific toolkits/ resources have been developed to support frontline workers with having difficult conversations, identifying issues and signposting to support, such parental substance use, healthy weight and mental health and childhood vaccinations.
11	Domestic violence needs to be routinely considered and safe space made available for parental engagement.	Routine screening for domestic violence does not always happen	Islington's specialist VAWG workforce development team delivers Domestic Abuse training across the children and families workforce including to the police, and have a post co-located at the Whittington Hospital to encourage routine enquiry.
12	Boroughs should work with health systems to develop means of assessing and addressing housing factors which are having a significant impact on child health	Quality of housing, repairs and accessibility factors were of concern	Camden: is scoping its Health and Housing dataview to allow a systematic approach to this work. Islington: developed a system whereby patients can raise issues with their housing (ie. dampness) and indoor air pollution as well as clinicians being able to identify the most seriously affected patients and escalate in accordance with Council Housing teams

Perinatal pathways

North Central London Health and Care
Integrated Care System

	Recommendation	Context	Progress
13	Closer engagement between LMNS and local authority in the pre-conception and perinatal pathway would ensure an integrated approach and contextual support	*Equity and Equality in maternity services* This report finds significant ethnic disparities in neonatal and infant deaths	Camden: some midwife clinics are delivered in Family Hubs; a series of listening events were held for Bangladeshi women and birthing people about their maternity experiences; regularly liaise with maternity colleagues to explore support of their programmes Islington: antenatal maternity clinics run in all Family Hubs and some children's centres. Midwifery continuity teams also have clinics in 2 of 3 family hubs.
14	• Review practice in Redbridge around pre-conception genetic screening and counselling campaigns and approaches • Ensure genetic counselling is routinely offered to families following a pregnancy where genetic anomalies from consanguinity were identified	*Pre-conception pathways* Pre-conception genetic counselling for consanguineous relationships can support decision making within a family planning journey	Camden: undertaking a review of preconception genetic counselling on behalf of NCL, with the team at GOSH
15	• Maternal weight management should be sensitively discussed in birth planning and community antenatal support sessions. • Birthing people should be provided with weight management support within GP and health visiting follow up at the appropriate time. GPs should also ensure this is raised as part of contraception reviews	*Pre-conception pathways* Maternal BMI is a modifiable factor if it can be identified and acted upon at a sufficiently early stage	• Camden: included maternal weight management in its Healthy Weight Accelerator Plan, and a programme of work related to maternal nutrition is being developed. • Haringey: commissioned health visiting service includes this in their assessments and contacts • Barnet: HV team has healthy llifestyle advice within their protocols; breastfeeding mothers can join Tier 2 weight management programme • Islington: included maternal weight in the Healthy Weight Action plan. A 'cooking programme during pregnancy' pilot is being established within a Family Hub
16	Awareness campaigns should be delivered to support family planning	*Pre-conception pathways*	

Systems support: safer sleeping

North Central London Health and Care
Integrated Care System

	Recommendation	Context	Progress
17	• An NCL-wide source of guidance • Specific guidance for overcrowded circumstances needs to be developed • Professionals need to be able to support families who have a preference for co-sleeping, to ensure they are enabled to co-sleep as safely as possible	*Safe sleeping practices* Safe sleeping factors are a common modifiable factor in child death reviews	**Camden**: working with Little Village to support safe sleeping for families in temporary accommodation; refers to Family Hubs and Safeguarding websites; Raise Camden Taskforce considering how Lullaby Trust guidance can be enabled within TA and overcrowded housing **Haringey**: commissioned health visiting service provides information and has conversations with families on a regular basis; information is available in Family Hubs; refers to Lullaby Trust guidance **Barnet**: As part of a wider safer sleeping workstream, Barnet Safeguarding Children Partnership is working with Health Visitors, the Police, Midwives, Housing and Public Health to promote safe sleeping, including in emergency situations, in line with the Lullaby Trust Guidance; recently developed safer sleeping materials, in alignment with NICE guidelines and Lullaby Trust guidance – these are shared on the Royal Free website; health visitors deliver safe sleeping information. **Islington**: promote safer sleeping advice at all new birth visits and 6-8 week checks. It is also discussed in child health clinics and new parents groups. An item on safer sleep was placed in the Bright Start Bright Ideas newsletter to parents of age 0-5.

Systems support

North Central London Health and Care
Integrated Care System

	Recommendation	Context	Progress
18	Within the CAMHS system, prioritisation needs to be given to children living in the most complex social circumstances	*Mental Health support* Children and young people's mental health was identified as a contributory factor in a number of avoidable deaths	Evidence from the CDOP annual report has been fed into the NCL Mental Health JSNA Islington: completed a comprehensive mental health JSNA in January 2025 which is informing ongoing service improvement and practice development. Detailed Health Needs Assessments on vulnerable children and young people (Children Looked After, Autistic children and young carers) are also being produced. A deep-dive report on CYP mental health is being presented to the Health and Wellbeing Board to highlight key complex challenges that require system wide thinking and senior leadership.
19	• School staff and wider support services, such as Family Hubs, transport, after club activities, need to be training in First Aid and Basic Life Support, and the necessary equipment should be made available. • Sufficient emotional support should be made available to staff within a school following a child death	*Schools*	• **Camden**: producing resources to be shared across NCL for wider use and application. This will be disseminated via the Camden Children's Safeguarding Partnership • **Barnet**: training for school staff on first aid is organised by each school (e.g through St. John's Ambulance); all SEN Transport drivers and Passenger Assistants have First Aid training; all schools now have a defibrillator on site; schools have a multiagency response to support the entire school community, including staff, in response to the death of a child by suicide; Barnet Integrated Clinical Services and Barnet Education and Learning offer also coordinated support to schools for any critical incident; school staff always have access to free confidential support via Qwell • **Haringey**: schools offer support to staff • **Islington**: have a clear protocol for critical incident support to schools and the school community following suicides and other traumatic deaths in schools; audited the spare supply of Adrenaline Auto-Injector pens in schools and are developing a rationale for investing in stock for secondary schools as a lever for engaging on the Asthma Friendly Schools programme.
20	Clinical staff need to ensure they are specifically trained in the deterioration and management of children with learning disabilities and non-verbal children.	*Children with Learning Disabilities*	

Communication

North Central London Health and Care
Integrated Care System

	Recommendation	Context	Progress
21	• There is a clear and consistent link between the London Ambulance Services and DNR plans • Thresholds of viability for neonatal births • Ensure information is shared with community services following a death • Police need prompt notification of children with a life-limiting illness who die at home, to prevent unnecessary and distressing investigation • Where timings for repatriation may conflict with religious burial customs	*Care Pathways Policy and Practice* SOPs are available on the communication of neonatal and child deaths	
22	Care planning meetings should be held with parents at an early stage.	*Parental involvement in Care Planning* Early care planning allows palliative care involvement	
23	• The development of post-mortem resources for families • Where complex circumstances are noted for surviving siblings, a clear process needs to be in place to ensure these are acted on	*Family support following a child death*	
24	Consistent recording of parent involvement in the child death review process	*Parent involvement in the child death review* This enables learning to be shared with all organisations involved in child death reviews, with the aim of supporting parents to make sense of their loss.	

North Central London Health and Care
Integrated Care System

Recommendations

Recommendations for a multi-agency approach to emergent trends

North Central London Health and Care
Integrated Care System

The NCL CDOP Review identifies several core themes which remain year on year. We propose a **three-year strategic programme of multi-agency work**, initiated by themed appreciative enquiry workshops, co-hosted by local government and NHS leads. Work of individual organisations will continue as a priority across all of these areas, but this sets out our proposed schedule for collective action. We seek to update against these themes in each forthcoming CDOP annual report with updates to Children's Safeguarding Partnerships.

2026 priorities:

- Poverty Proofing and Stigma Reduction (Directors of Public Health to lead)
- Domestic Abuse (Directors of Children's Services to lead)

2027 priorities:

- Structural Racism and Inequality (Directors of Public Health to lead)
- Mental Health Support (ICB Directors to lead)

2028 priorities:

- Barriers to Engagement with Services (ICB Directors to lead)
- Serious Youth Violence (Directors of Children's Services to lead)

Recommendations for NCL ICS Mortality Group

North Central London Health and Care
Integrated Care System

1. ICB Leaders should take responsibility and accountability for oversight of the recommendations of this report, and provide clear direction for the governance and implementation under the new ICB structures.

2. Our data continues to show marked differences in outcomes on the basis of ethnicity. We require urgent and sustained action on the part of provider organisations. We recommend anti-racist policies, action plans with annual review against outcomes. The ICB holds an important role in coordinating this across provider organisations.

3. The ICB needs to lead on providing CONI training for all health visitors and coordinating practice among borough-level professionals in Health Visting and Family Hubs to ensure consistency of approach. This is currently available in 1 of 5 NCL boroughs but is not routinely applied due to the postcode lottery.

4. The ICB must improve pathways with pharmacies so that earlier engagement can support greater continuity of care of unwell children.

5. The ICB must assess the sufficiency of out-of-hours, weekend and holiday support to ensure continuity of care for palliative care paediatric services.

Recommendations for NCL Directors of Public Health

North Central London Health and Care
Integrated Care System

1. Take responsibility for dissemination and action within respective local authorities.

2. There is increasing evidence of child deaths resulting from poverty. We need to tackle the root causes of poverty through multi-agency partnership work, and local authorities will be required to develop Child Poverty plans in response to the forthcoming national Child Poverty review.

3. Nominate a DPH to take a lead role in coordinating a multi-agency appreciative enquiry exercise into poverty proofing and stigma reduction with recommendations and ongoing action plan.

4. Our data continues to show marked differences in outcomes on the basis of ethnicity. We require urgent and sustained action on the part of provider organisations. We recommend anti-racist policies, action plans with annual review against outcomes.

5. Housing has also increasingly been linked to child deaths. We recommend Directors of Public Health take forward the evidence linking child death and housing conditions to Housing Committees for their consideration in housing allocation and repairs prioritisation.

6. Housing conditions have also meant that safe sleeping guidelines cannot be routinely followed in overcrowded conditions. We recommend a priority campaign for safe sleeping in overcrowded circumstances and, where possible, provision of safe sleeping material goods.

7. Maternal BMI remains a modifiable factor and is often linked to premature births. Programmes to support maternal nutrition and follow up support for women postnatally should be made available.

8. Strengthen the MECC approach to safe sleeping guidance by midwives, health visitors, Family Hub staff, housing staff and police – any frontline staff who may come into contact with young babies, with a particular focus on families who speak English as an additional language. Ensure fathers/partners also understand safe sleeping messages.

Recommendations for Directors of Children's Services

North Central London Health and Care
Integrated Care System

1. Our data continues to show marked differences in outcomes on the basis of ethnicity. We require urgent and sustained action on the part of provider organisations. We recommend anti-racist policies, action plans with annual review against outcomes.

2. Given the range of complexities associated with asylum seekers and people fleeing areas of conflict, we need to ensure a specific package of support and protocol is put in place to best meet their medical and holistic needs, with points of liaison to specialist centres.

3. Nominate a DCS to take a lead role in coordinating a multi-agency appreciative enquiry exercise into domestic abuse with recommendations and ongoing action plan.

4. Ensure recommendations for other leads in this report are embedded in Family Hub and wider Family Support Services within the borough:
   - MECC approaches to safer sleeping, smoking cessation, domestic abuse
   - Provide maternal and postnatal nutritional support
   - CONI programme
   - Ensure links and access to the NCL ICB website resources on key safety messages including first aid, water safety, safer sleeping in overcrowded accommodation, etc.

Recommendations for health service provider organisations and frontline staff

North Central London Health and Care
Integrated Care System

1. Continue to deliver the excellent practice highlighted in the findings of this report.

2. Our data continues to show marked differences in outcomes on the basis of ethnicity. We require urgent and sustained action on the part of provider organisations. We recommend anti-racist policies, action plans with annual review against outcomes.

3. Given the range of complexities associated with asylum seekers and people fleeing areas of conflict, we need to ensure a specific package of support and protocol is put in place to best meet their medical and holistic needs, with points of liaison to specialist centres.

4. Interpreting should be considered a right. Practice should follow from this, with particular attention to emergency and maternity settings, recognising that family members acting as interpreters is not always appropriate.

5. Mandatory training for communicating with sensitivity covering the communication themes highlighted in this report should be put in place and regularly refreshed for all professionals working with families in healthcare settings. This must include understanding of palliative care and expectations around timing of funerals.

6. Mandatory training on learning disability, neurodiversity and associated intersectionality to improve the quality of person-centred care for children and families with diverse needs.

7. Referral for genetic counselling following child death resulting from consanguinity needs to be standardised to avoid omissions. We will need to take forward any recommendations resulting from the current consanguinity review by NCL CDOP.

Recommendations for NCL LMNS

North Central London Health and Care
Integrated Care System

1. Continue to deliver the excellent practice highlighted in the findings of this report.

2. Our data continues to show marked differences in outcomes on the basis of ethnicity. We require urgent and sustained action on the part of provider organisations. We recommend anti-racist policies, action plans with annual review against outcomes.

3. Audit and improve consistency in referrals for smoking cessation programmes and adherence to guidelines for CO screening during pregnancy.

4. Audit and improve adherence to guidelines for domestic abuse screening during pregnancy.

5. Standardise Gestational Diabetes screening for women when they meet eligibility criteria and undertake clinical audit to examine its application on the basis of ethnicity.

6. Maternal BMI remains an important modifiable factor, often linked to premature births. Programmes to support maternal nutrition should be made available.

7. A MECC approach to delivering safe sleeping messages, in line with NICE guidelines -- with a particular focus on families who speak English as an additional language. Ensure fathers/partners also understand safe sleeping messages.

8. Adopt an ICB-coordinated systemwide approach to CONI.

9. Mandatory training for communicating with sensitivity covering the communication themes highlighted in this report should be in place and regularly refreshed for all professionals working with families in healthcare settings.

10. Interpreting should be considered a right. Practice should follow from this, with particular attention to emergency and maternity settings, recognising that family members acting as interpreters is not always appropriate.

Recommendations for NCL CDOP

North Central London Health and Care
Integrated Care System

1. CDOP needs to maintain its good practice in coordinating progress against recommendations from each of the named groups. CDOP needs to report this into the Population Health Management Board, Director of Children's Services Group and Mortality Group on a quarterly basis, escalating barriers in delivery to the named accountable officer within the ICB.

2. CDOP should ensure this report is published on the NCL ICB website. CDOP should delegate responsibility for local dissemination and action within local authorities to Directors of Public Health.

3. CDOP should ensure that recommendations from NCMD reports are similarly circulated for action through these networks.

4. CDOP needs to ensure evidence from reviews and annual report findings are appropriately shared with and inform each Appreciative Enquiry exercise: poverty proofing, stigma reduction and domestic abuse.

5. Oversee the completion of the ongoing consanguinity review and oversee dissemination of recommendations across the system.

6. Training in accurate coding and greater awareness of underlying support requirements for patients – and their parents/carers - with learning disabilities, neurodivergence and other learning difficulties needs to be made available to all colleagues leading on CDRMs.

7. Review how we can evidence impact on outcomes from the work of CDOP, building this into existing surveillance and reporting processes.

Acknowledgements



North Central London
Health and Care
Integrated Care System

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- Christina Keating, NCL CDOP Designated Lead Nurse
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North Central London Health and Care
Integrated Care System

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6. **National Institute for Health and Care Excellence (NICE) (2025)**. *Learning disabilities: Definition*. *Clinical Knowledge Summaries.* Available at: https://cks.nice.org.uk/topics/learning-disabilities/background-information/definition/ [Accessed: 19/11/25]

7. **Mencap (n.d.)**. *Global developmental delay*. Available at: https://www.mencap.org.uk/learning-disability-explained/learning-disability-and-conditions/global-developmental-delay [Accessed: 19/11/25]

8. **Cambridgeshire and Peterborough Children's Health (n.d.).** *Learning disability*. Available at: https://cambspborochildrenshealth.nhs.uk/services/cambridgeshire-community-paediatrics/developmental-delay/learning-disability/ [Accessed: 19/11/25]

Additional reading

North Central London Health and Care
Integrated Care System

NCMD data release for 2025, which covers child deaths notified and reviewed up until 31 March 2025

Available from NCL CDOP Administrator:

- NCL oncology themed panel briefing
- NCL serious youth violence panel briefing
- NCL SUDI briefing
- 5 key messages about asthma

North Central London Health and Care
Integrated Care System

Appendix A: Borough-level Analysis

North Central London
Health and Care
Integrated Care System

Barnet

Borough-level analysis

Executive summary – child deaths in Barnet

North Central London Health and Care
Integrated Care System

Barnet received approximately 110 notifications of child deaths between 2020/21– 2024/25, where the child was usually resident in NCL.

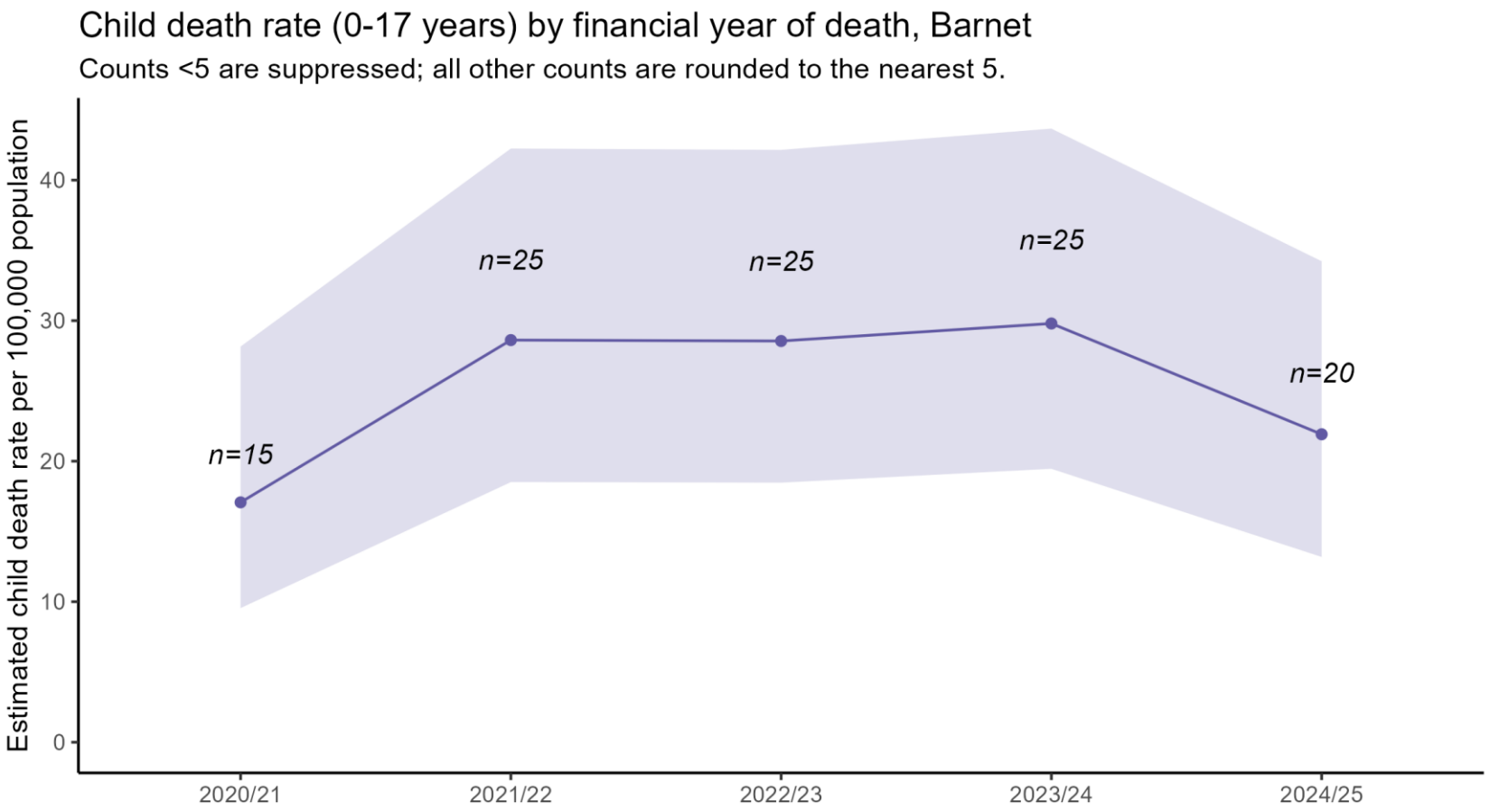
- More than half of these deaths were among children aged under one year (58%). Of these infant deaths, 64% occurred in the first 27 days of life.
- The child death rate was higher in male than female children (27.6 vs 22.6 per 100,000 population), although this difference was not statistically significant.
- The highest child death rates were observed in the Black or Black British (44.1 per 100,000), Asian or Asian British (40.5 per 100,000), and White Other (33.7 per 100,000) ethnic groups. The rates in these groups were significantly higher than that for children of White British or Irish ethnicity (12.8 per 100,000).
- 6% of deaths occurred in children living in areas amongst the 20% most deprived in England.
- 20% of completed reviews identified at least one modifiable factor. The most common modifiable factor domain was "factors in service provision" (45%).

Data note:

- Numbers in this analysis are very small. Differences between many groups were not statistically significant, even where NCL-level data shows significant variation. This limits the ability to draw firm conclusions about underlying patterns or trends from the quantitative data alone.
- In most charts, some groups are excluded because there were fewer than five deaths in that category. For data protection purposes, these categories are suppressed, so the lowest rate or proportion may not always be shown.
- This borough-level analysis only includes deaths where the child was usually resident in NCL.
- All counts are rounded to the nearest 5 for data protection.

Child deaths (age 0-17) by financial year

North Central London Health and Care
Integrated Care System



Shaded area shows the 95% confidence interval bounds

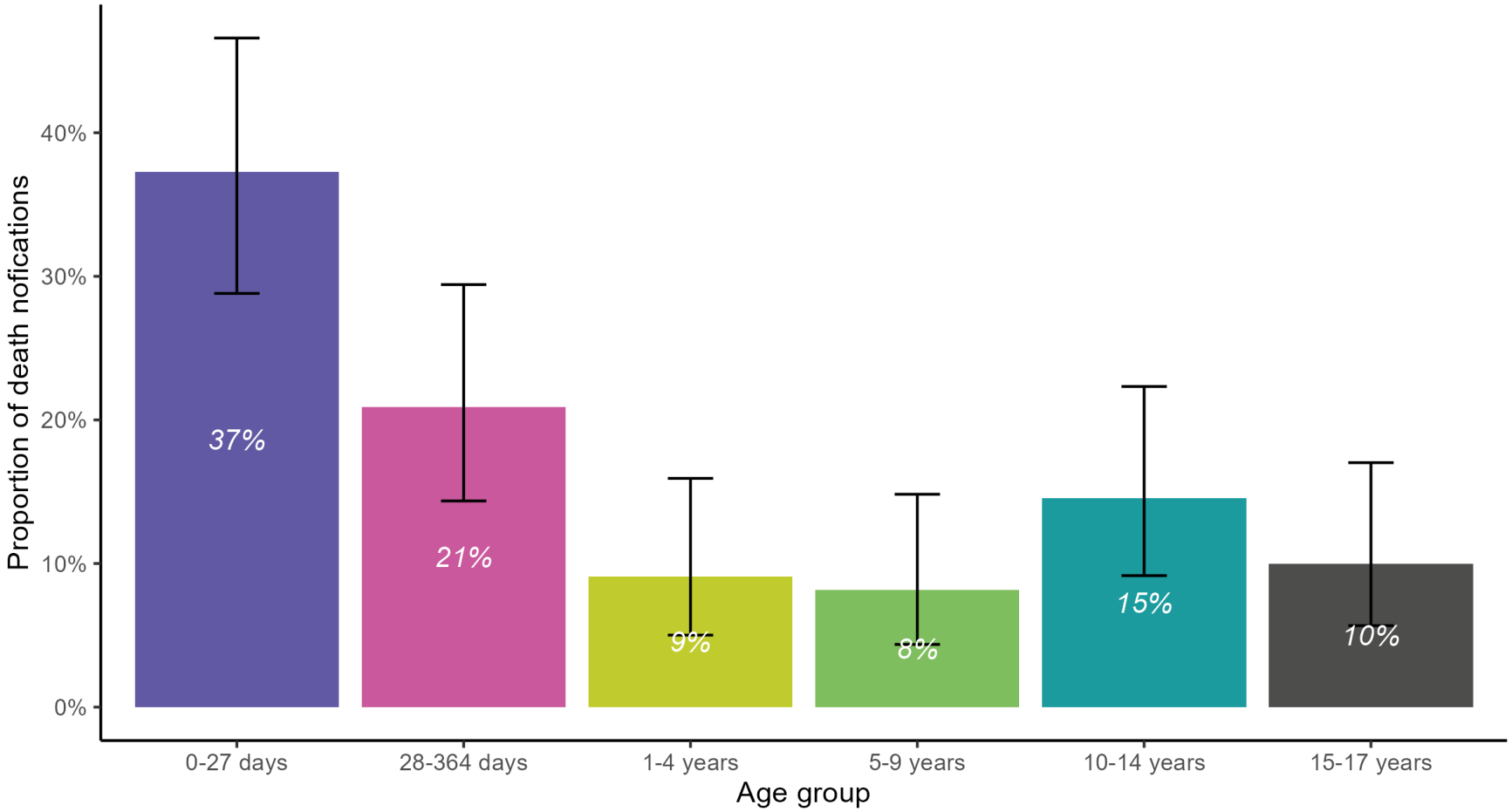
Source: eCDOP, GLA housing-led-population-projections

Child deaths by age group

North Central London Health and Care
Integrated Care System

Proportion of child deaths by age group, Barnet, 2020/21 - 2024/25

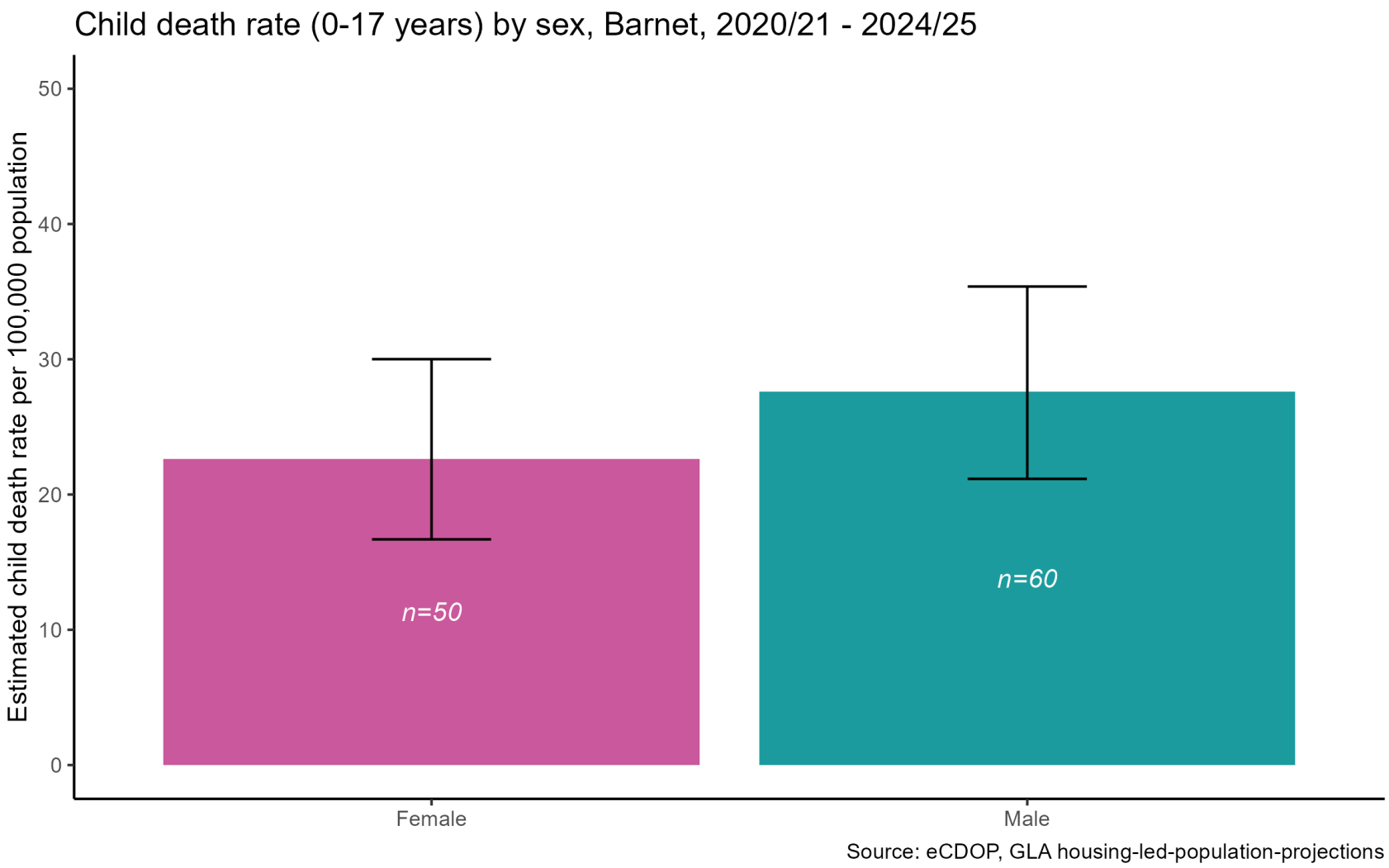
Counts <5 are suppressed.



Source: eCDOP

Child deaths (age 0-17) by sex

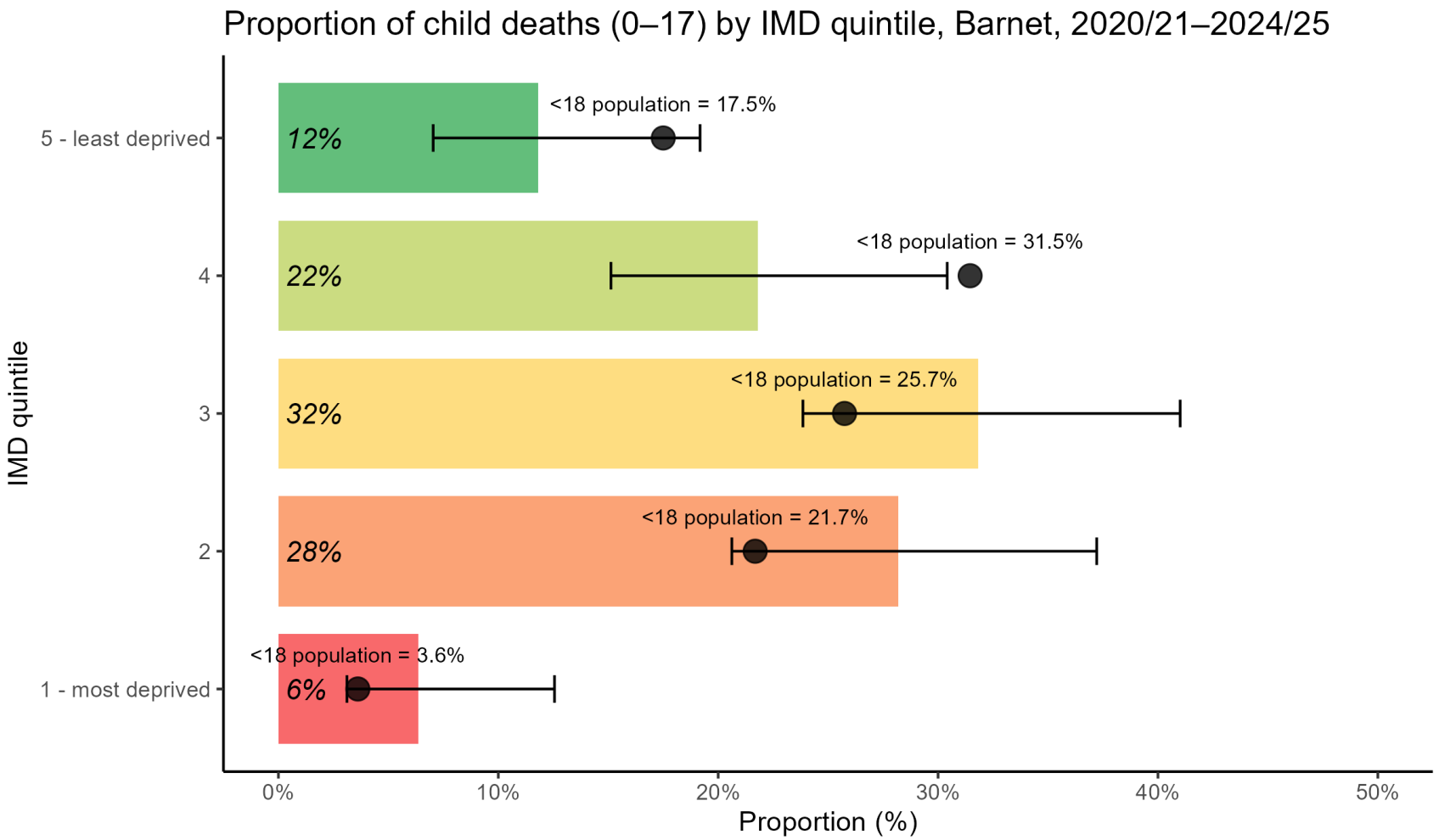
North Central London Health and Care
Integrated Care System



Source: eCDOP, GLA housing-led-population-projections

Child deaths (age 0-17) by deprivation

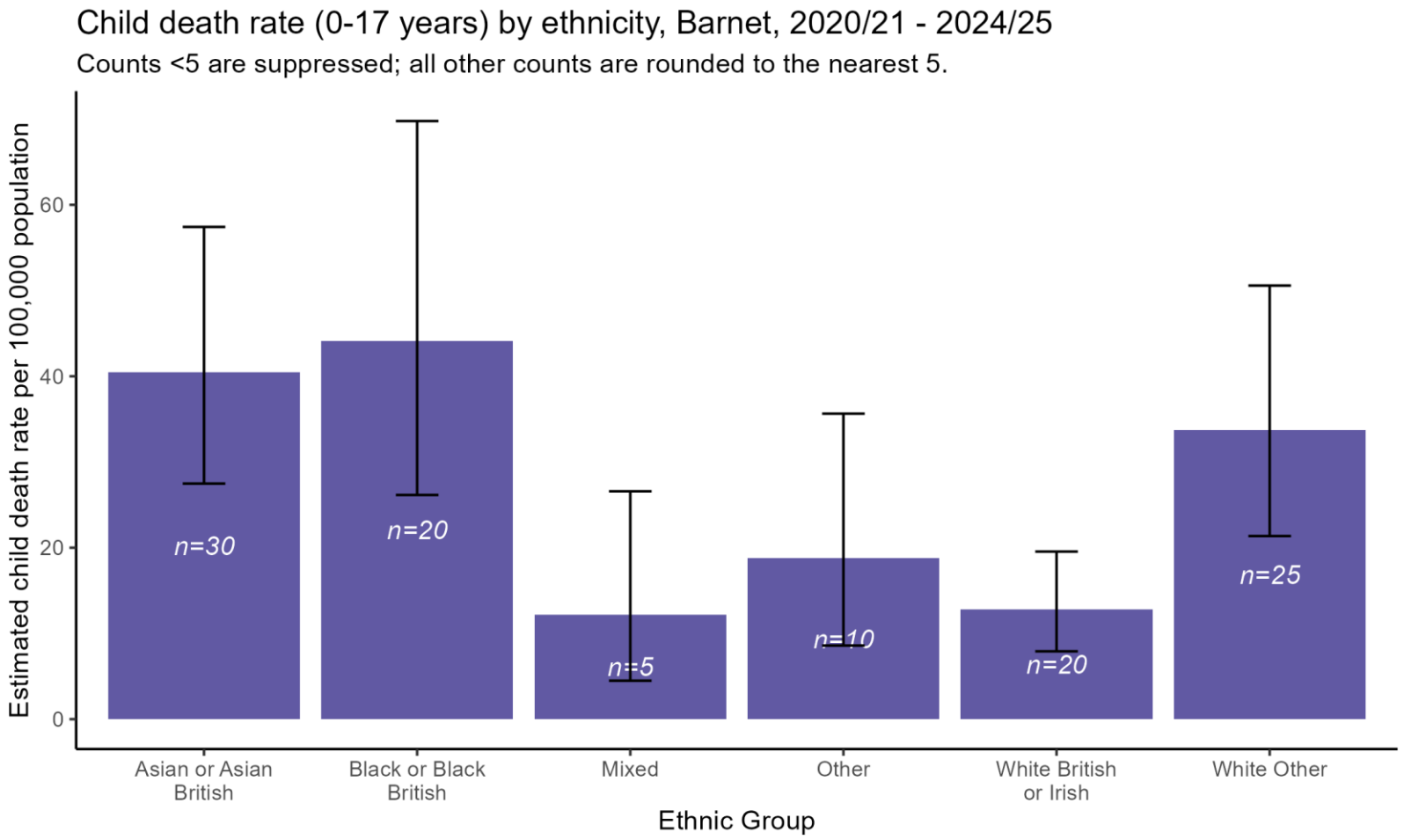
North Central London Health and Care
Integrated Care System



Source: eCDOP, ONS Census 2021, Index of Multiple Deprivation (2019)
Black circles represent the proportion of the Borough's under 18 population resident in each quintile.

Child deaths (age 0-17) by ethnic group

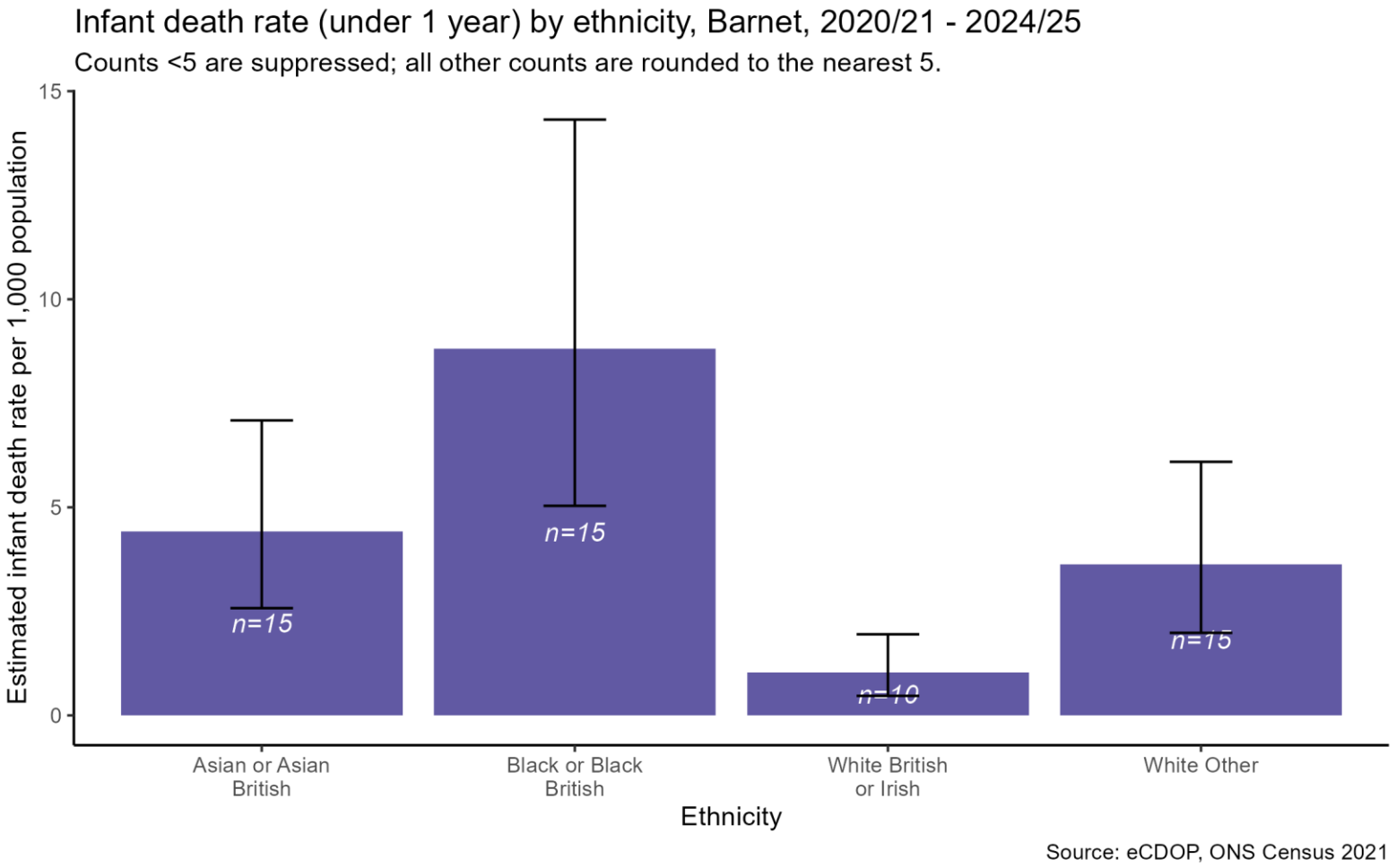
North Central London Health and Care
Integrated Care System



Source: eCDOP, ONS Census 2021

Infant deaths by ethnic group

North Central London Health and Care
Integrated Care System



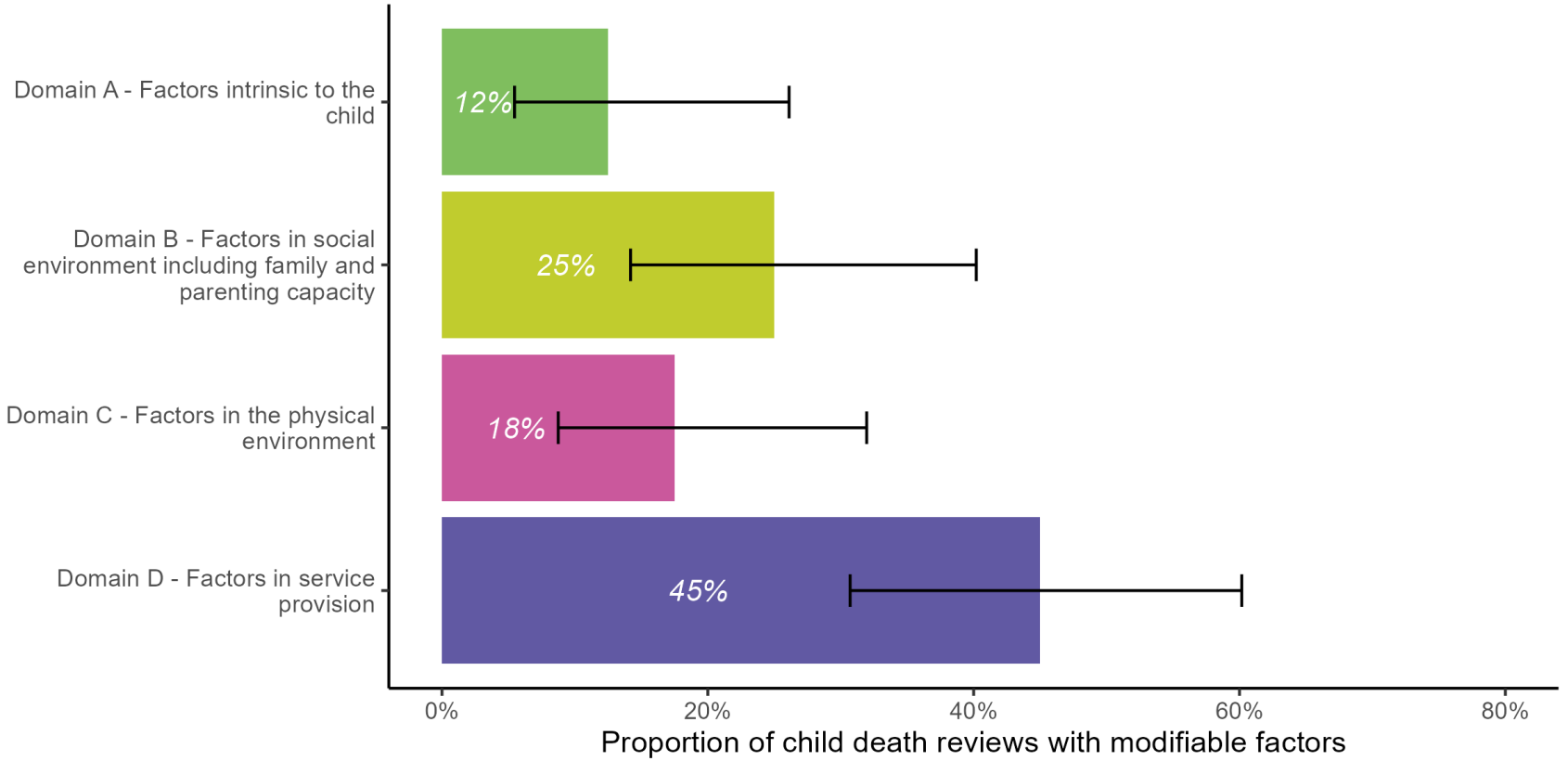
Source: eCDOP, ONS Census 2021

Modifiable factors by domain

North Central London Health and Care
Integrated Care System

Proportion of modifiable factor domains identified in child (0–17 years) death reviews completed by CDOP by domain, Barnet, 2022/23 – 2024/25

Counts <5 are suppressed.



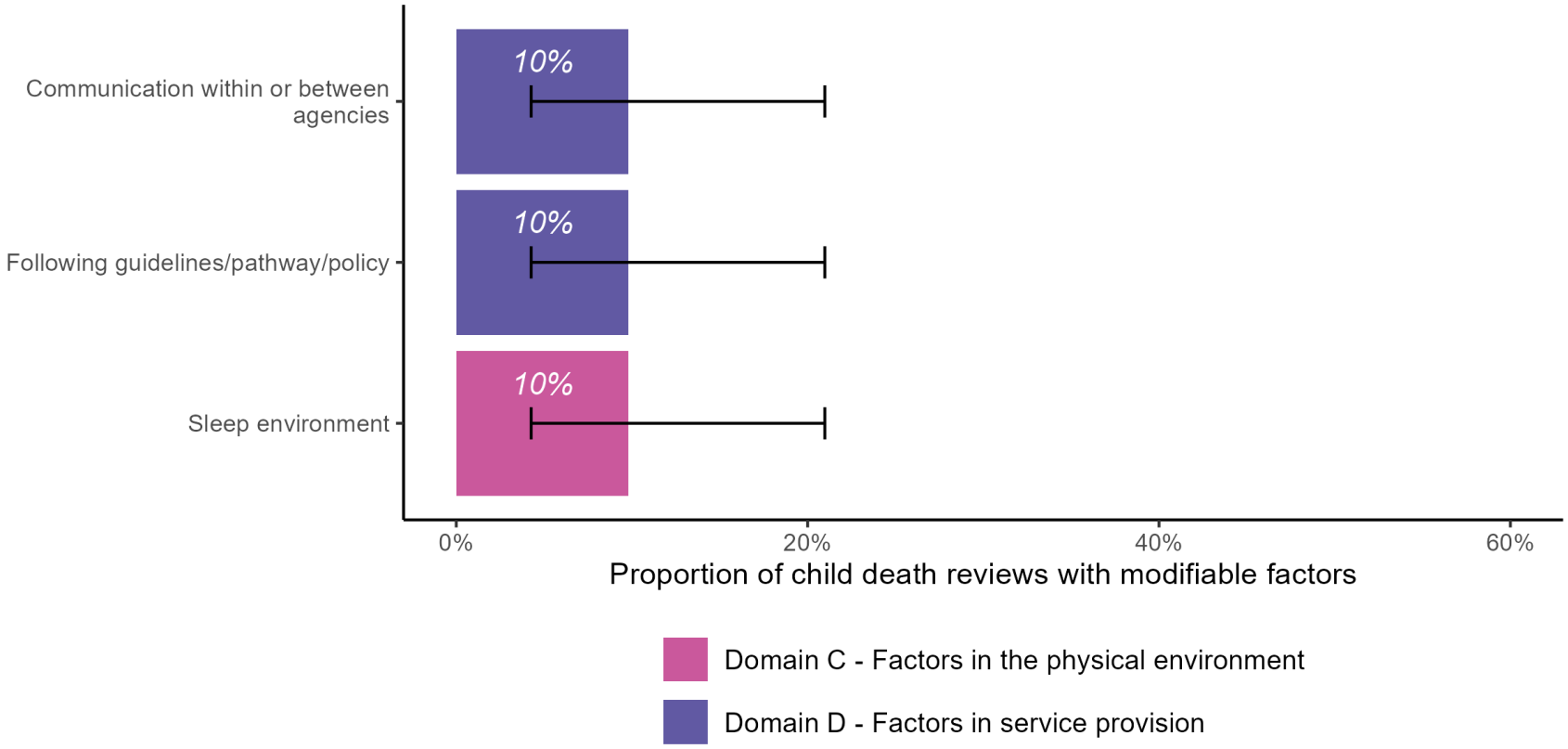
Source: eCDOP

Modifiable factors by sub-domain

North Central London Health and Care
Integrated Care System

Proportion of modifiable factors identified in child (0–17 years) death reviews completed by CDOP by sub-domain, Barnet, 2020/21 – 2024/25

Counts <5 are suppressed.



Source: eCDOP

North Central London
Health and Care
Integrated Care System

Camden

Borough-Level Analysis

Executive summary – child deaths in Camden

North Central London Health and Care
Integrated Care System

Camden received approximately 60 notifications of child deaths between 2020/21– 2024/25, where the child was usually resident in NCL.

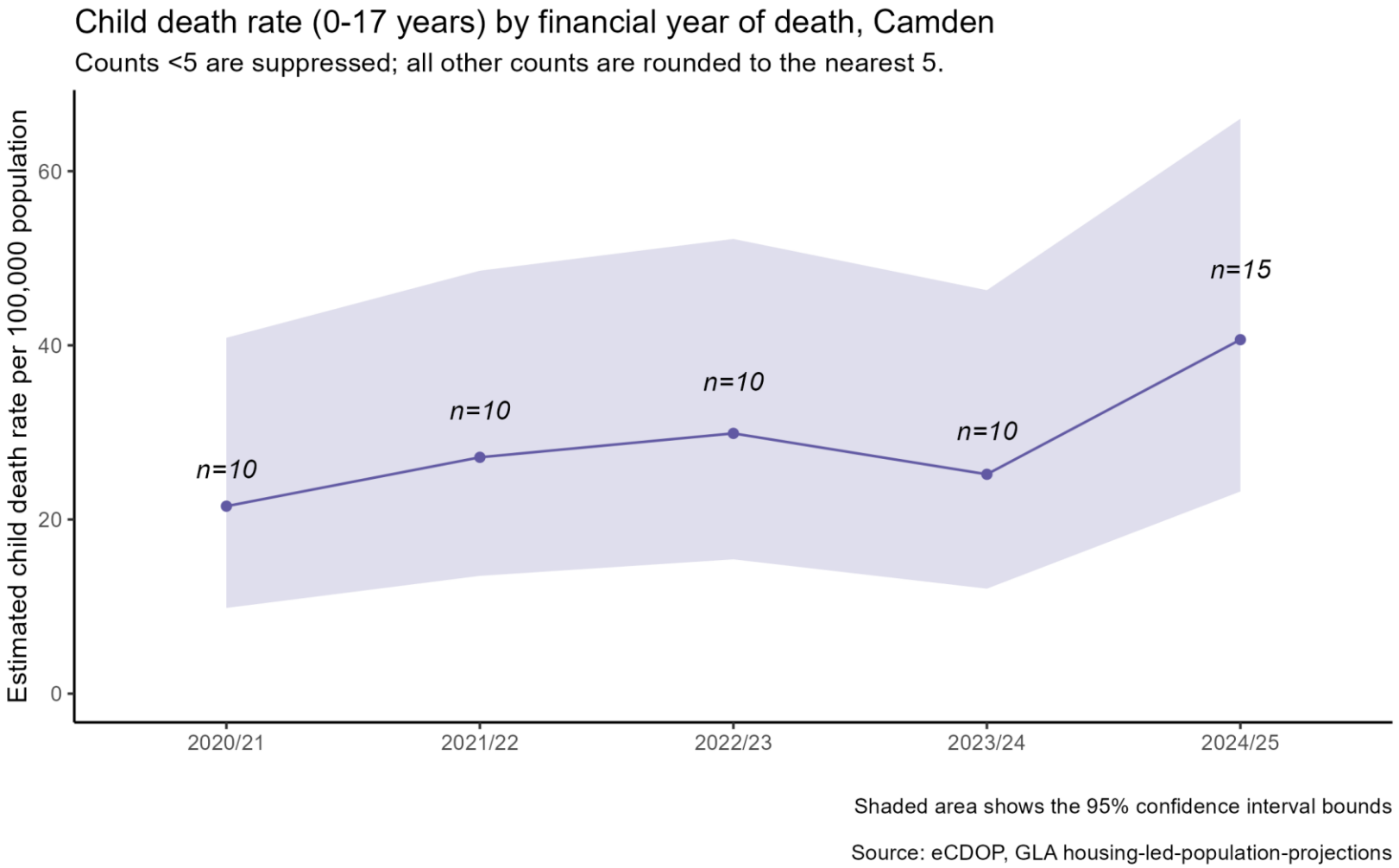
- More than half of these deaths were among children aged under one year (66%). Of these infant deaths, 61% occurred in the first 27 days of life.
- The child death rate was higher in male than female children (32.8 vs 24.5 per 100,000 population), although this difference was not statistically significant.
- The highest child death rates were observed in the Other (60.4 per 100,000) and Black or Black British (50.5 per 100,000) ethnic groups. All ethnic groups, except White Other, had rates that were statistically significantly higher than those for children of White British or Irish ethnicity.
- 21% of deaths occurred in children living in areas amongst the 20% most deprived in England.
- 22% of completed reviews identified at least one modifiable factor. The most common modifiable factor domain was "factors in service provision" (53%).

Data note:

- Numbers in this analysis are very small. Differences between many groups were not statistically significant, even where NCL-level data shows significant variation. This limits the ability to draw firm conclusions about underlying patterns or trends from the quantitative data alone.
- In most charts, some groups are excluded because there were fewer than five deaths in that category. For data protection purposes, these categories are suppressed, so the lowest rate or proportion may not always be shown.
- This borough-level analysis only includes deaths where the child was usually resident in NCL.
- All counts are rounded to the nearest 5 for data protection.

Child deaths (age 0-17) by financial year

North Central London Health and Care
Integrated Care System

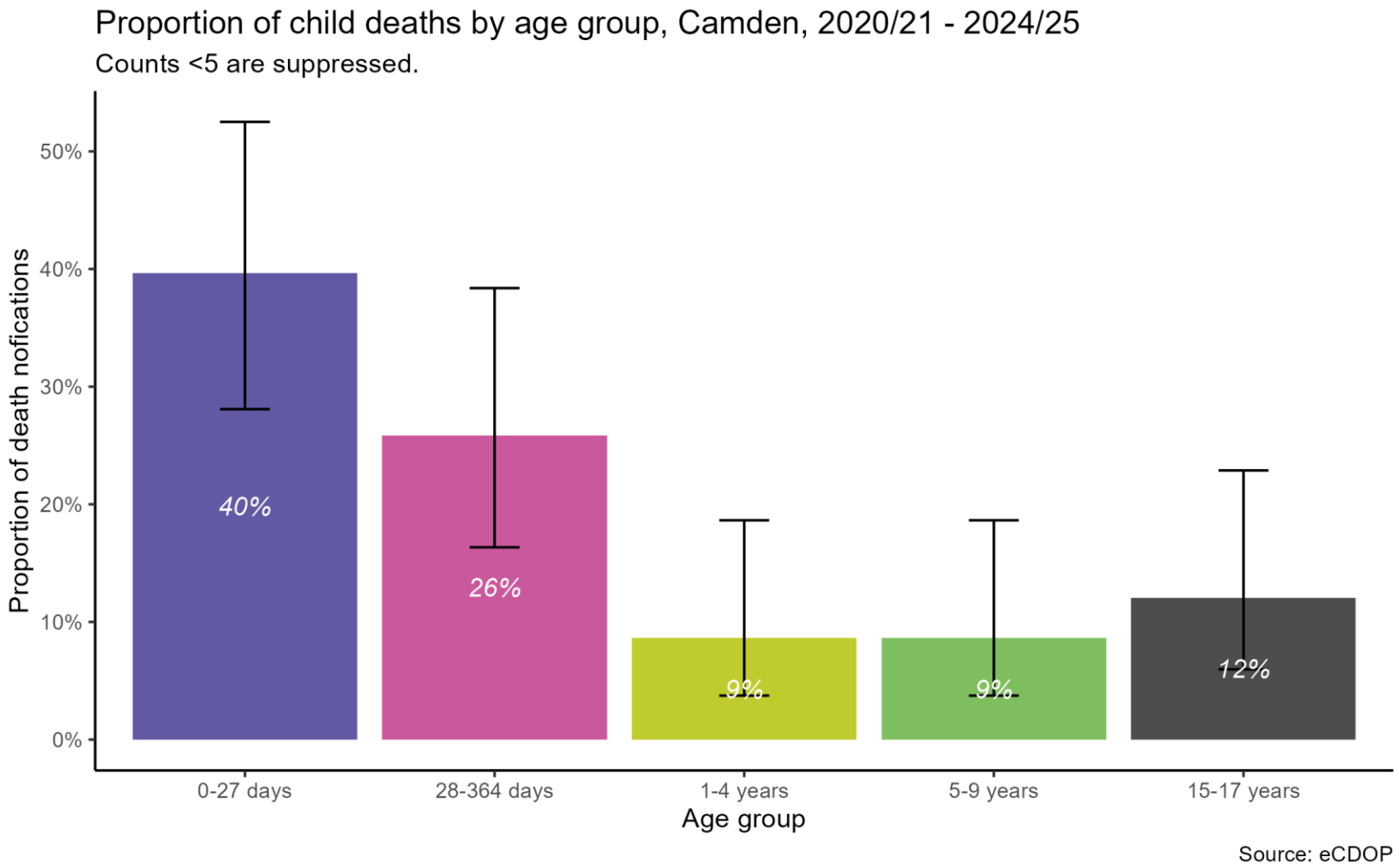


Shaded area shows the 95% confidence interval bounds

Source: eCDOP, GLA housing-led-population-projections

Child deaths by age group

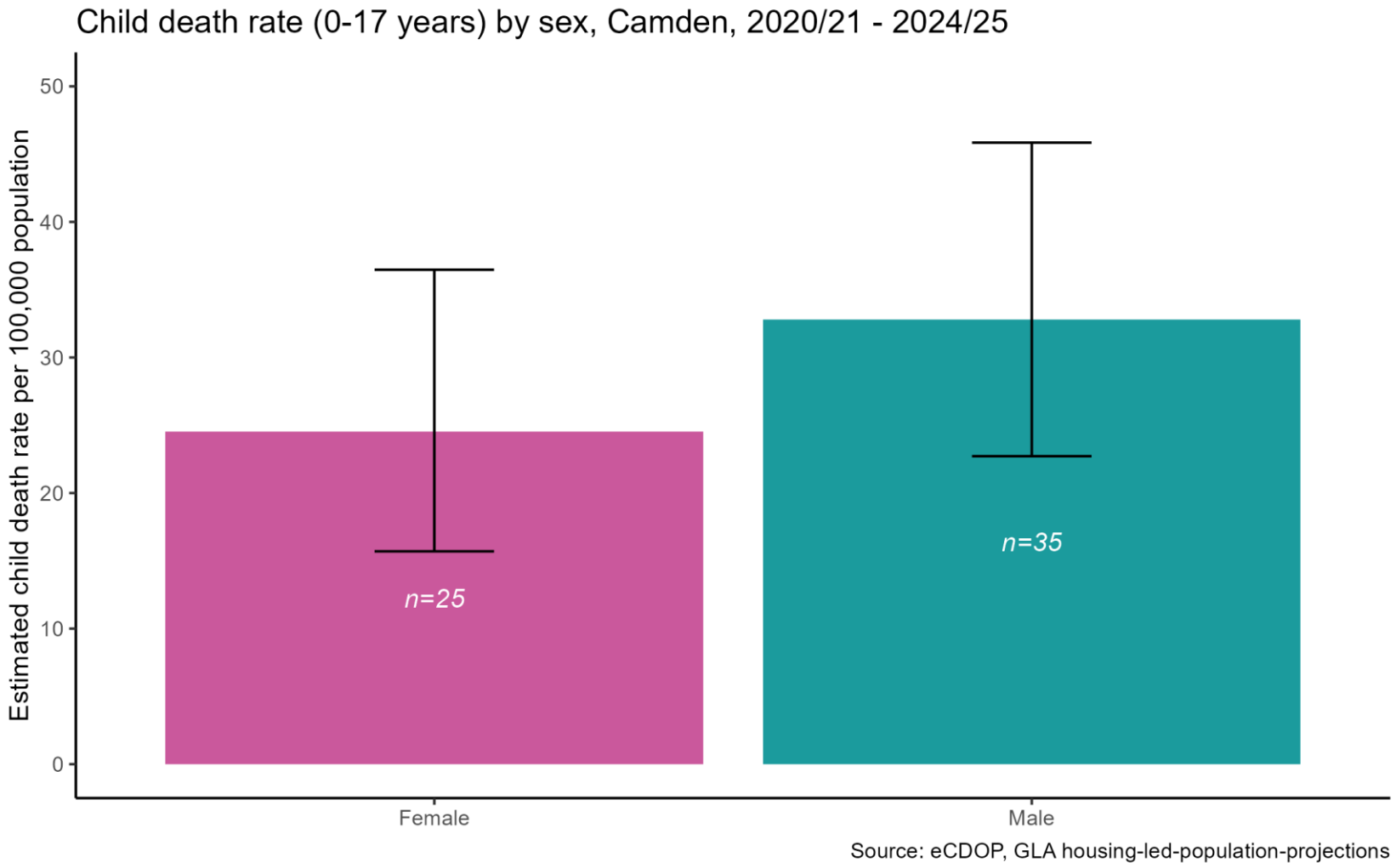
North Central London Health and Care
Integrated Care System



Source: eCDOP

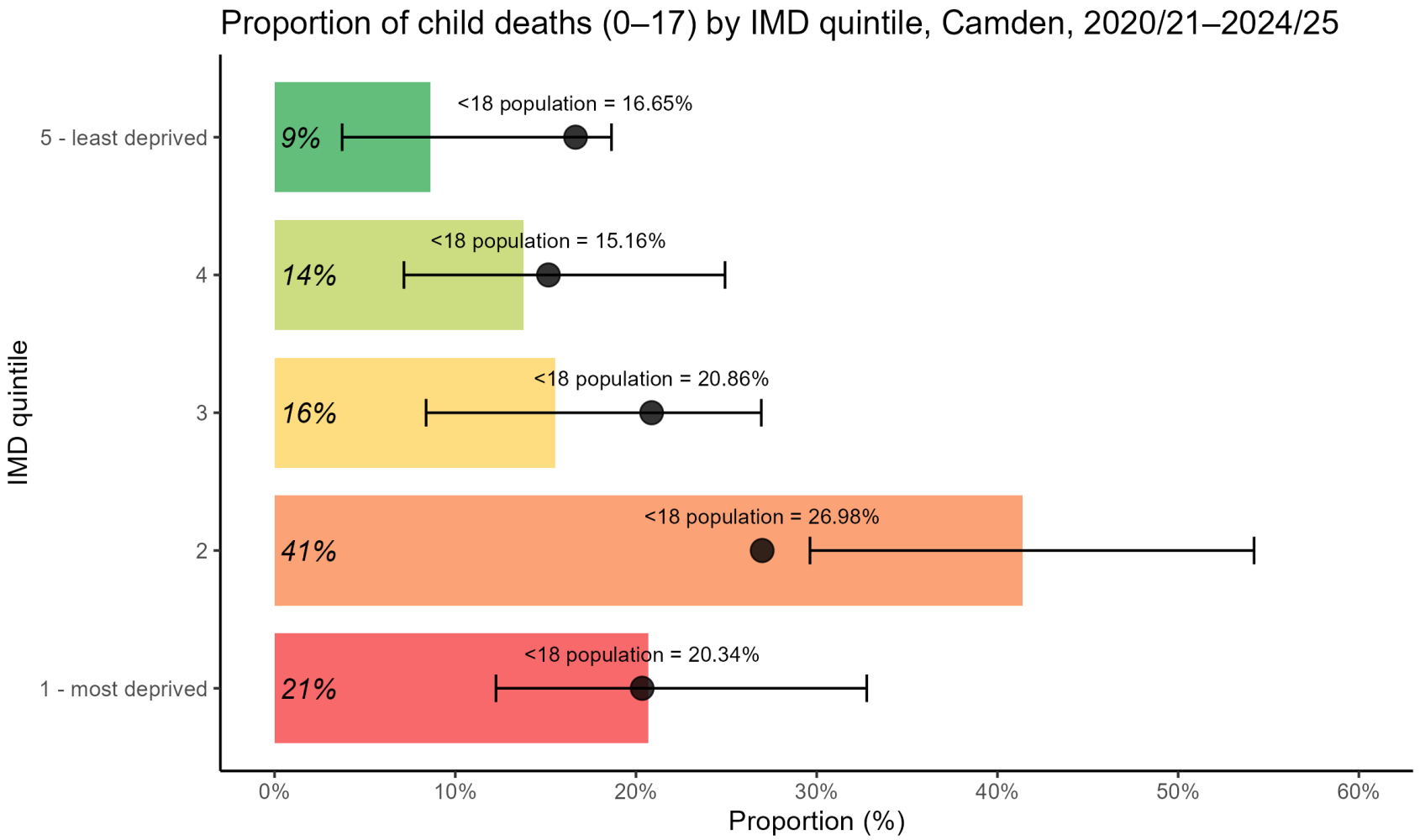
Child deaths (age 0-17) by sex

North Central London Health and Care
Integrated Care System



Child deaths (age 0-17) by deprivation

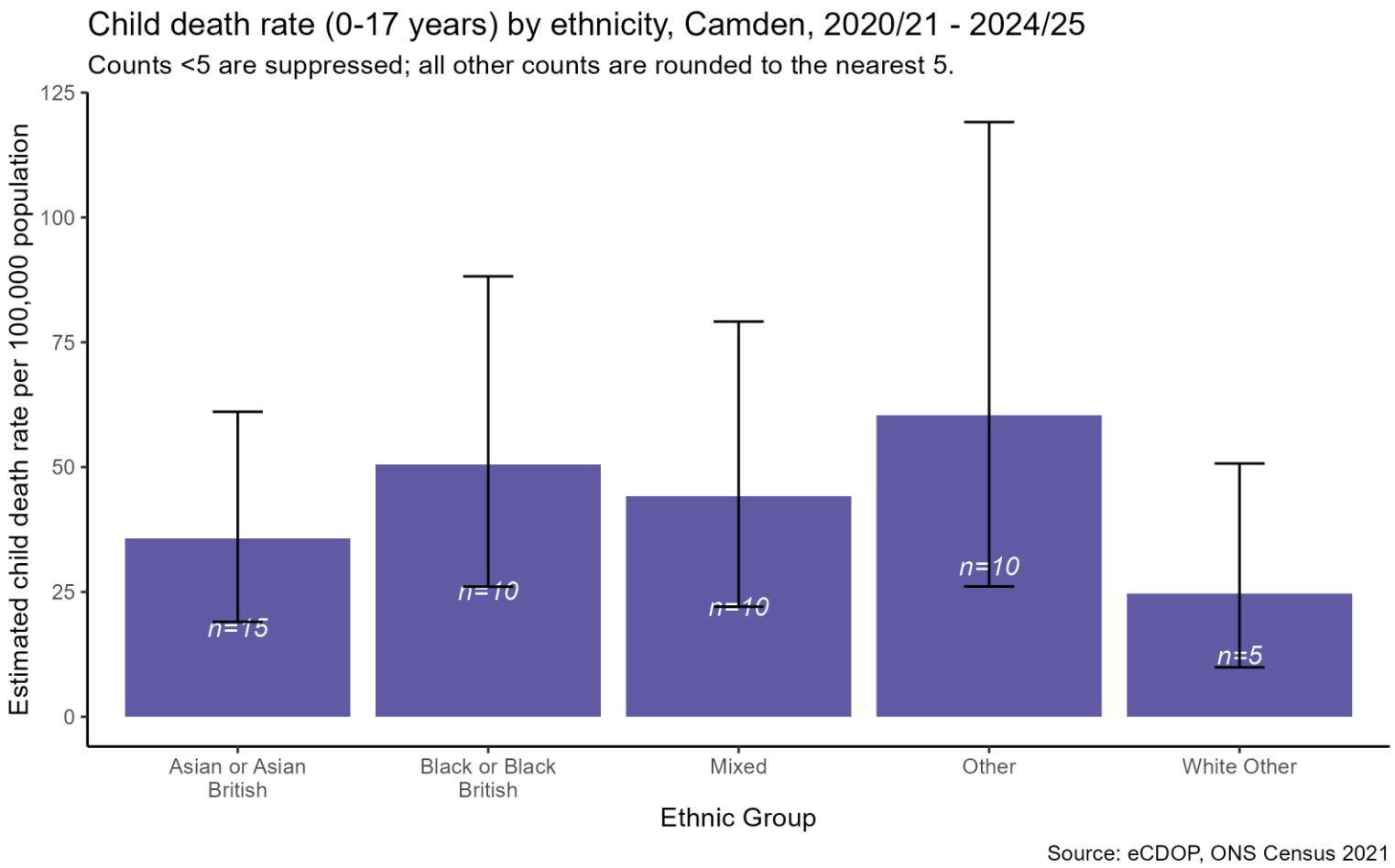
North Central London Health and Care
Integrated Care System



Source: eCDOP, ONS Census 2021, Index of Multiple Deprivation (2019)
Black circles represent the proportion of the Borough's under 18 population resident in each quintile.

Child deaths (age 0-17) by ethnic group

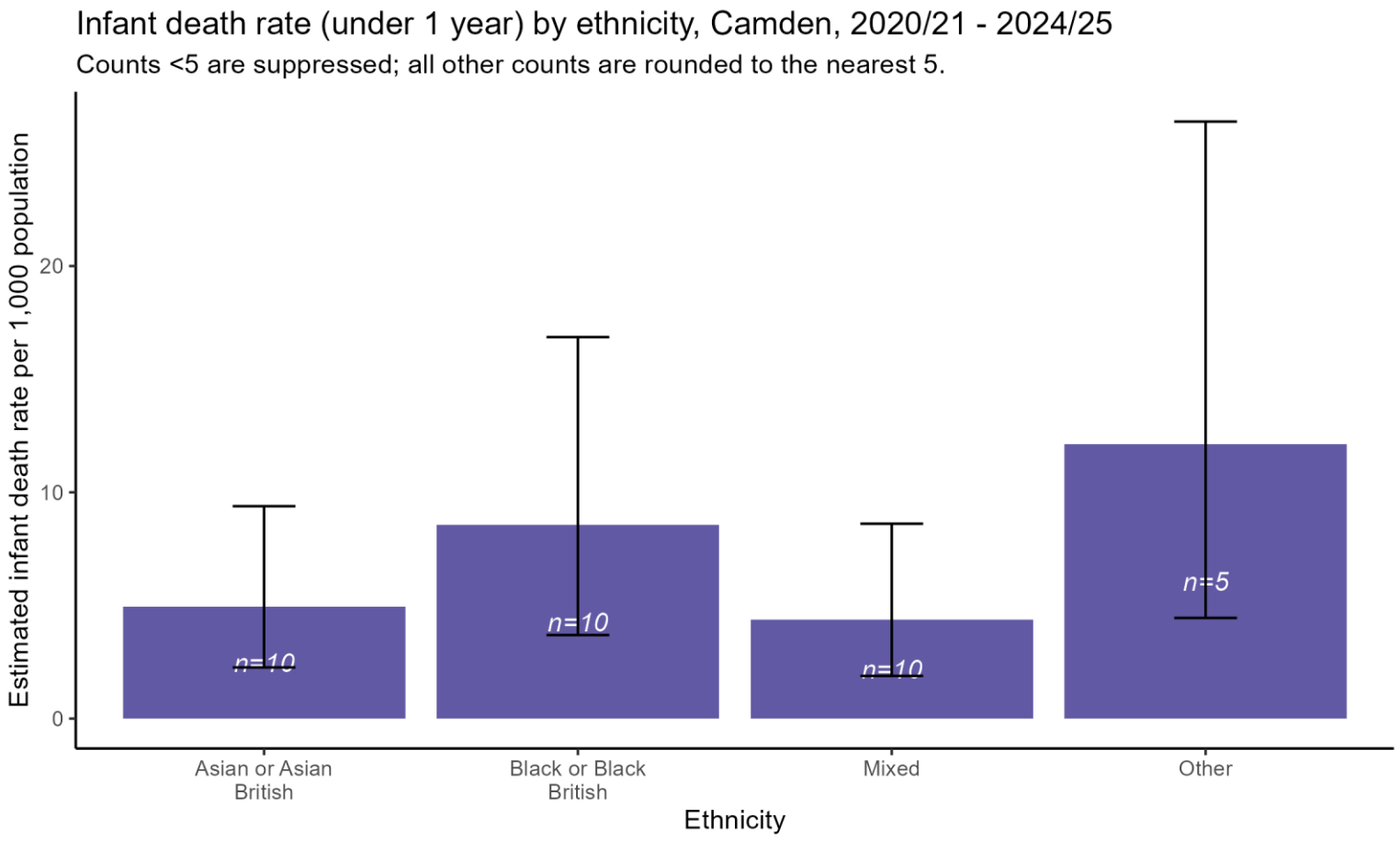
North Central London Health and Care
Integrated Care System



Source: eCDOP, ONS Census 2021

Infant deaths by ethnic group

North Central London Health and Care
Integrated Care System



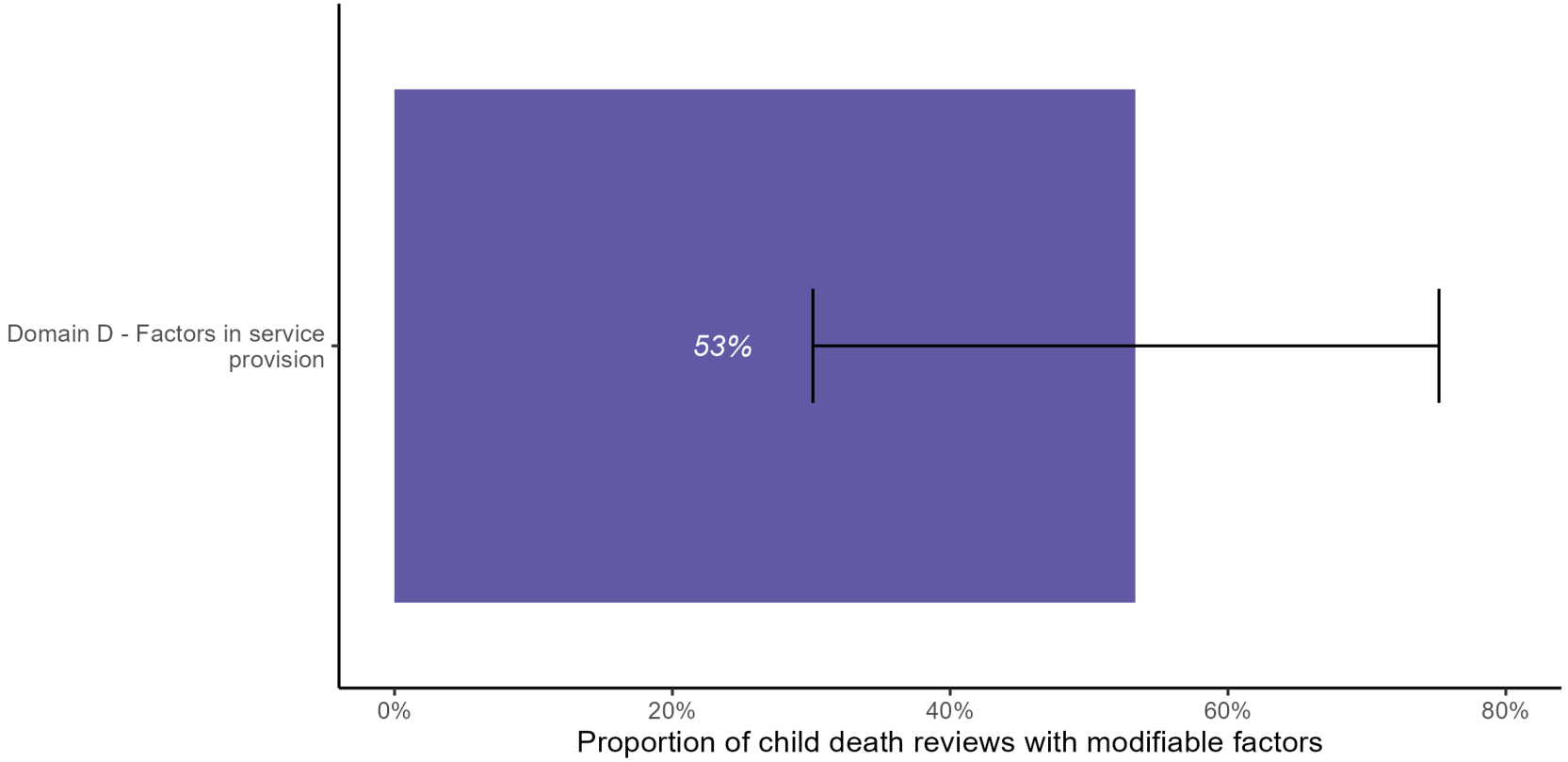
Source: eCDOP, ONS Census 2021

Modifiable factors by domain

North Central London Health and Care
Integrated Care System

Proportion of modifiable factor domains identified in child (0–17 years) death reviews completed by CDOP by domain, Camden, 2022/23 – 2024/25

Counts <5 are suppressed.



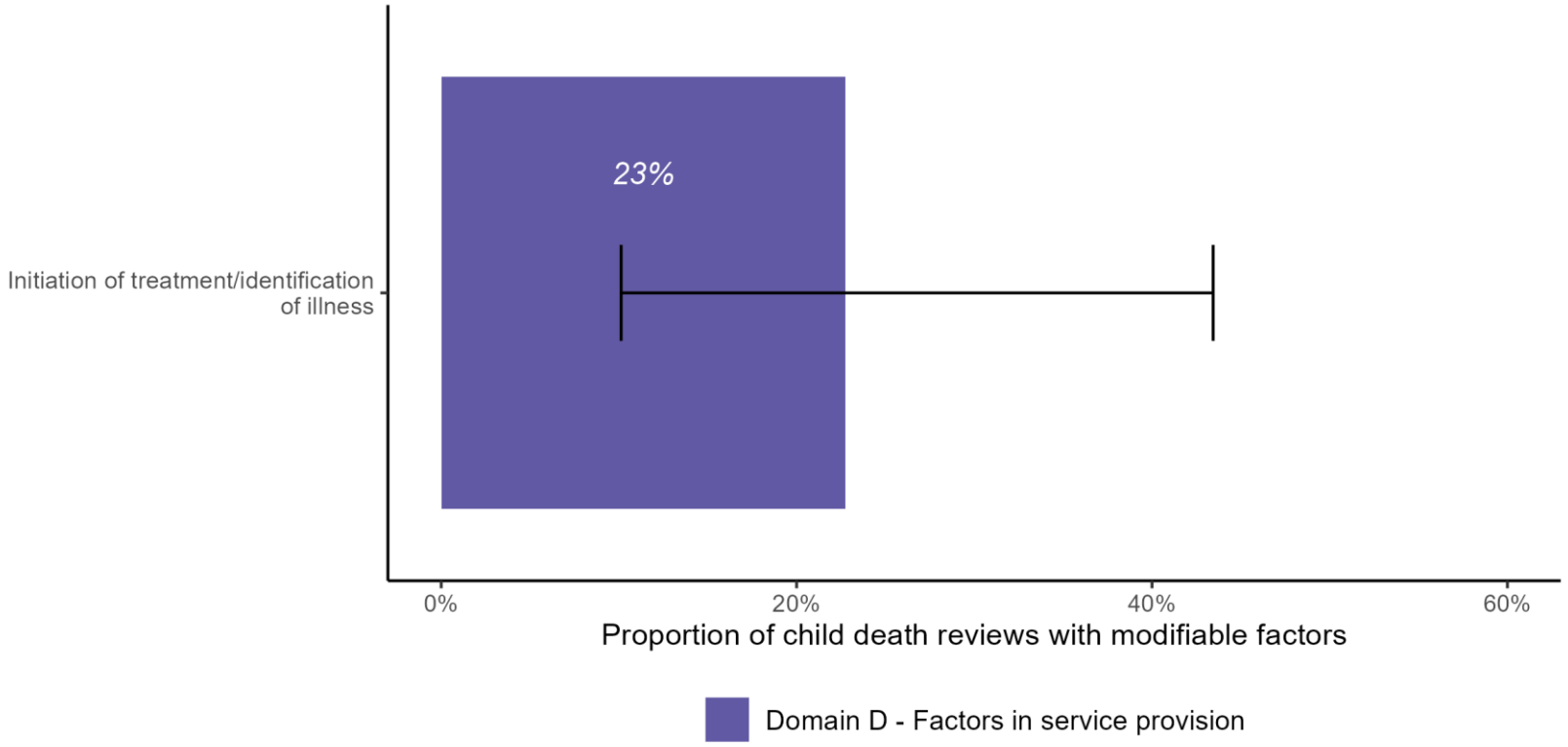
Source: eCDOP

Modifiable factors by sub-domain

North Central London Health and Care
Integrated Care System

Proportion of modifiable factors identified in child (0–17 years) death reviews completed by CDOP by sub-domain, Camden, 2020/21 – 2024/25

Counts <5 are suppressed.



Source: eCDOP

North Central London
Health and Care
Integrated Care System

Enfield

Borough-Level Analysis

Executive summary – child deaths in Enfield

North Central London Health and Care
Integrated Care System

Enfield received approximately 105 notifications of child deaths between 2020/21– 2024/25, where the child was usually resident in NCL.

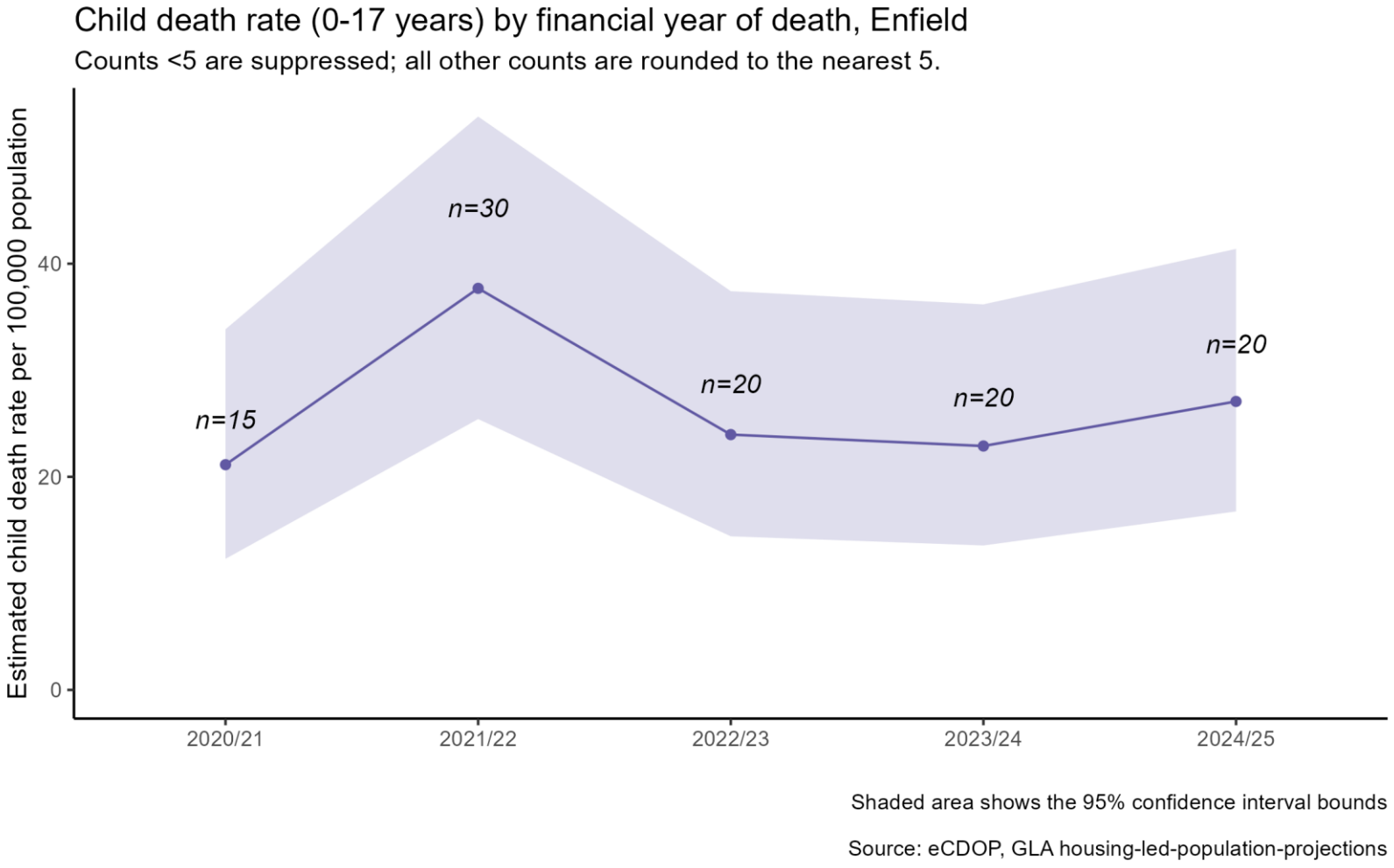
- More than half of these deaths were among children aged under one year (65%). Of these infant deaths, 66% occurred in the first 27 days of life.
- The child death rate was higher in male than female children (28.0 vs 24.5 per 100,000 population), although this difference was not statistically significant.
- The highest child death rates were observed in the White Other (46.8 per 100,000) and Asian or Asian British (30.0 per 100,000) ethnic groups. The rate for White Other children was significantly higher than that for children of White British or Irish ethnicity (13.1 per 100,000).
- 38% of deaths occurred in children living in areas amongst the 20% most deprived in England.
- 31% of completed reviews identified at least one modifiable factor. The most common modifiable factor domain was "factors in social environment" (38%).

Data note:

- Numbers in this analysis are very small. Differences between many groups were not statistically significant, even where NCL-level data shows significant variation. This limits the ability to draw firm conclusions about underlying patterns or trends from the quantitative data alone.
- In most charts, some groups are excluded because there were fewer than five deaths in that category. For data protection purposes, these categories are suppressed, so the lowest rate or proportion may not always be shown.
- This borough-level analysis only includes deaths where the child was usually resident in NCL.
- All counts are rounded to the nearest 5 for data protection.

Child deaths (age 0-17) by financial year

North Central London Health and Care
Integrated Care System

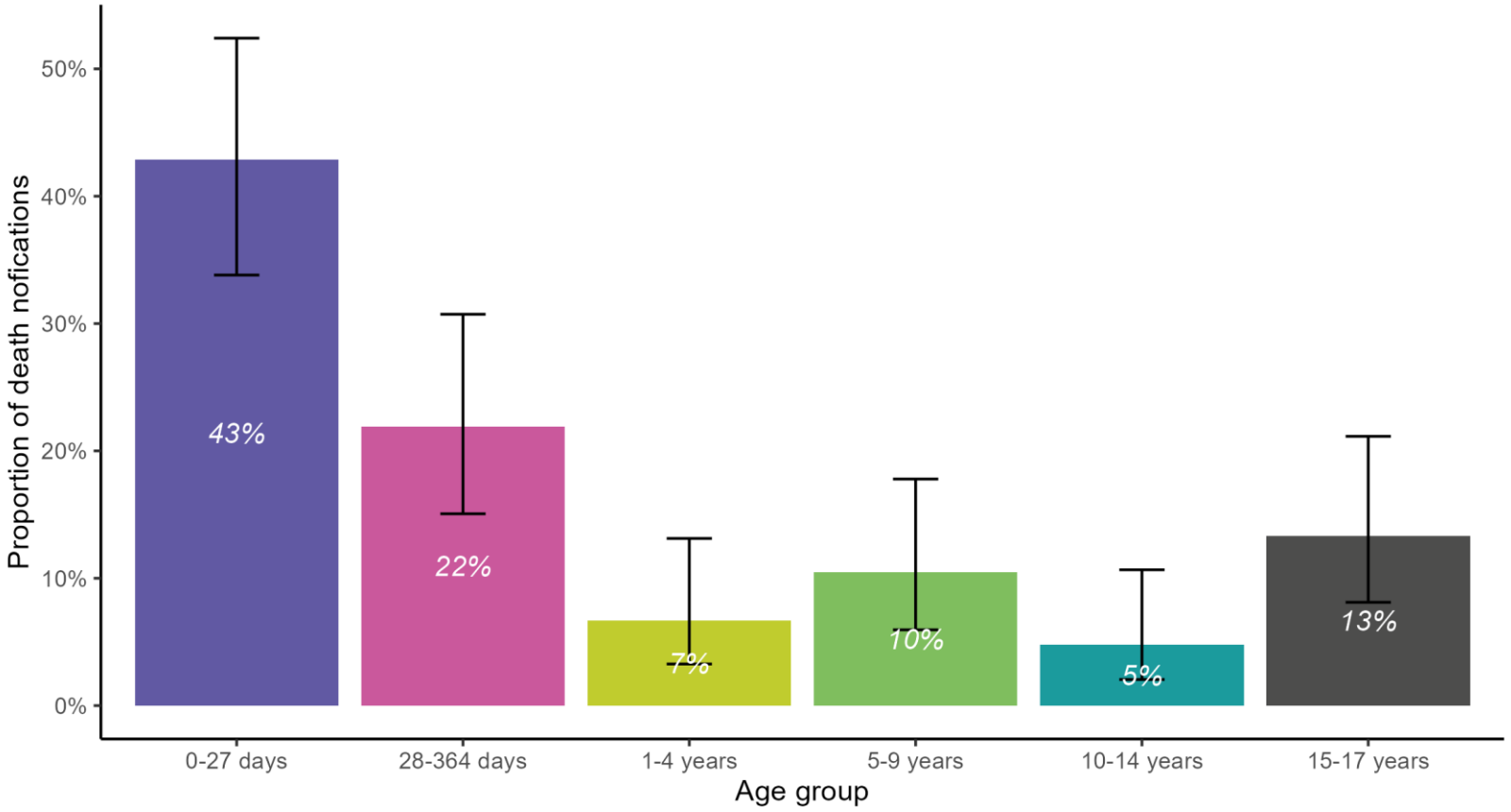


Child deaths by age group

North Central London Health and Care
Integrated Care System

Proportion of child deaths by age group, Enfield, 2020/21 - 2024/25

Counts <5 are suppressed.

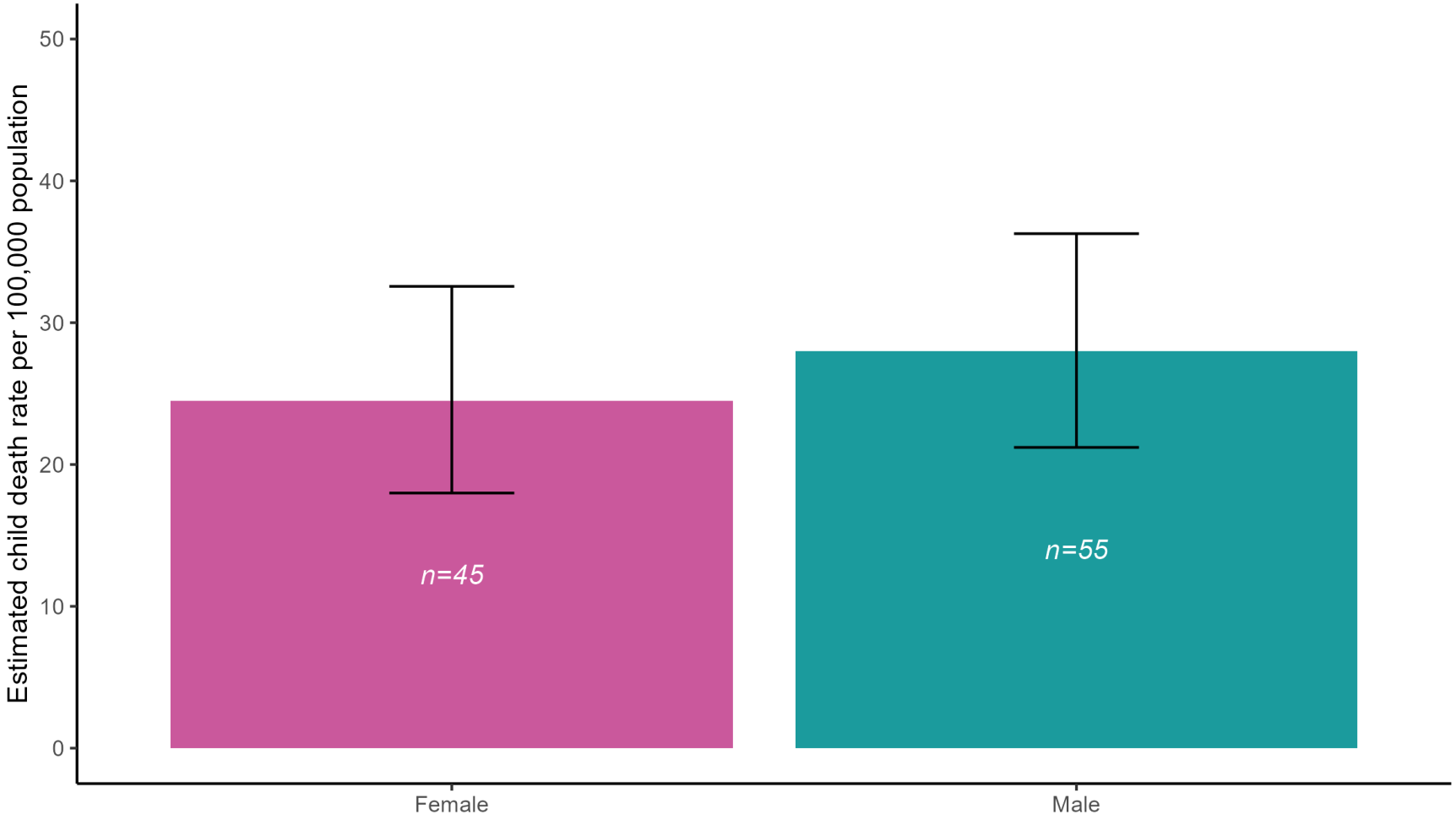


Source: eCDOP

Child deaths (age 0-17) by sex

North Central London Health and Care
Integrated Care System

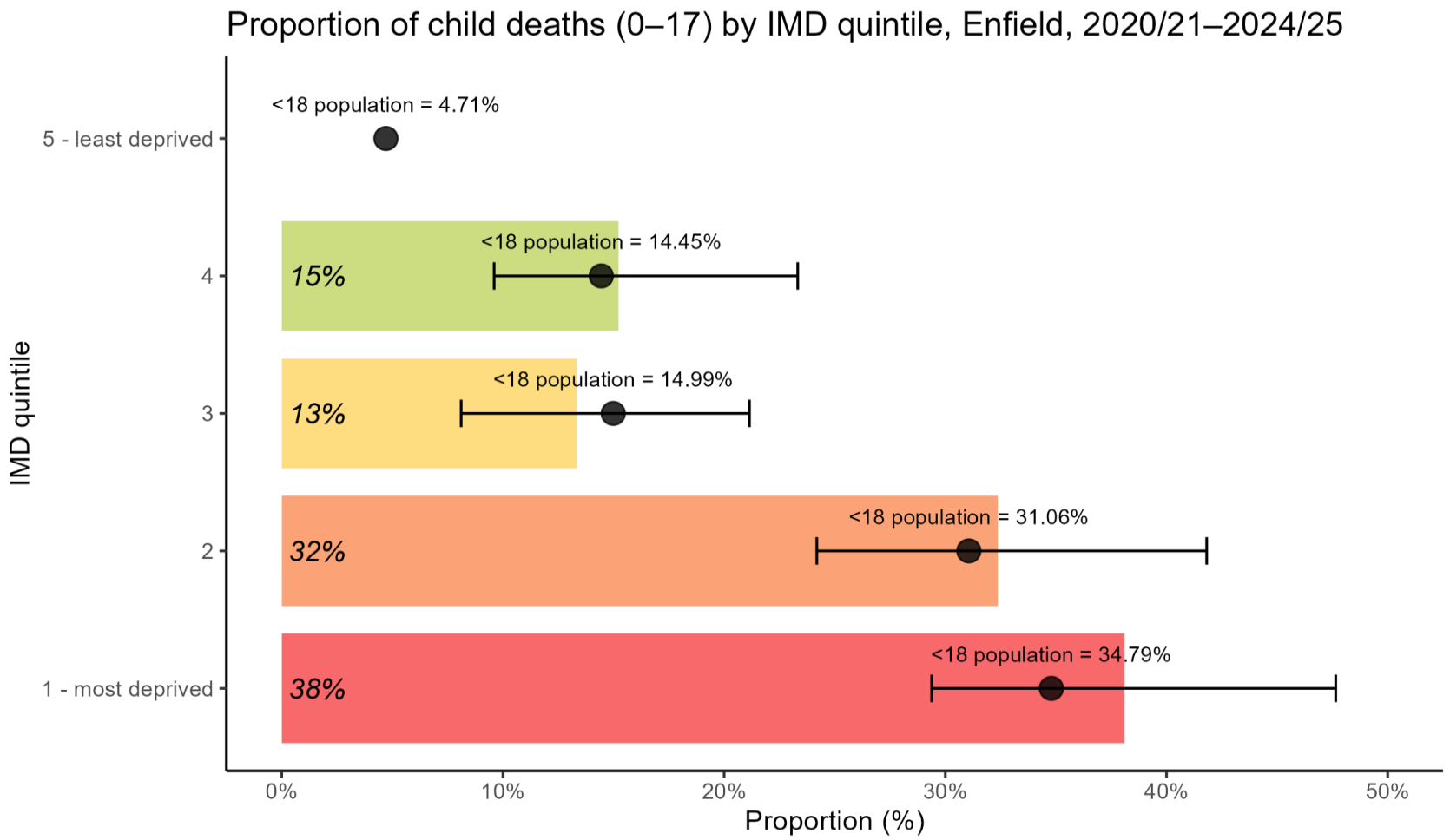
Child death rate (0-17 years) by sex, Enfield, 2020/21 - 2024/25



Source: eCDOP, GLA housing-led-population-projections

Child deaths (age 0-17) by deprivation

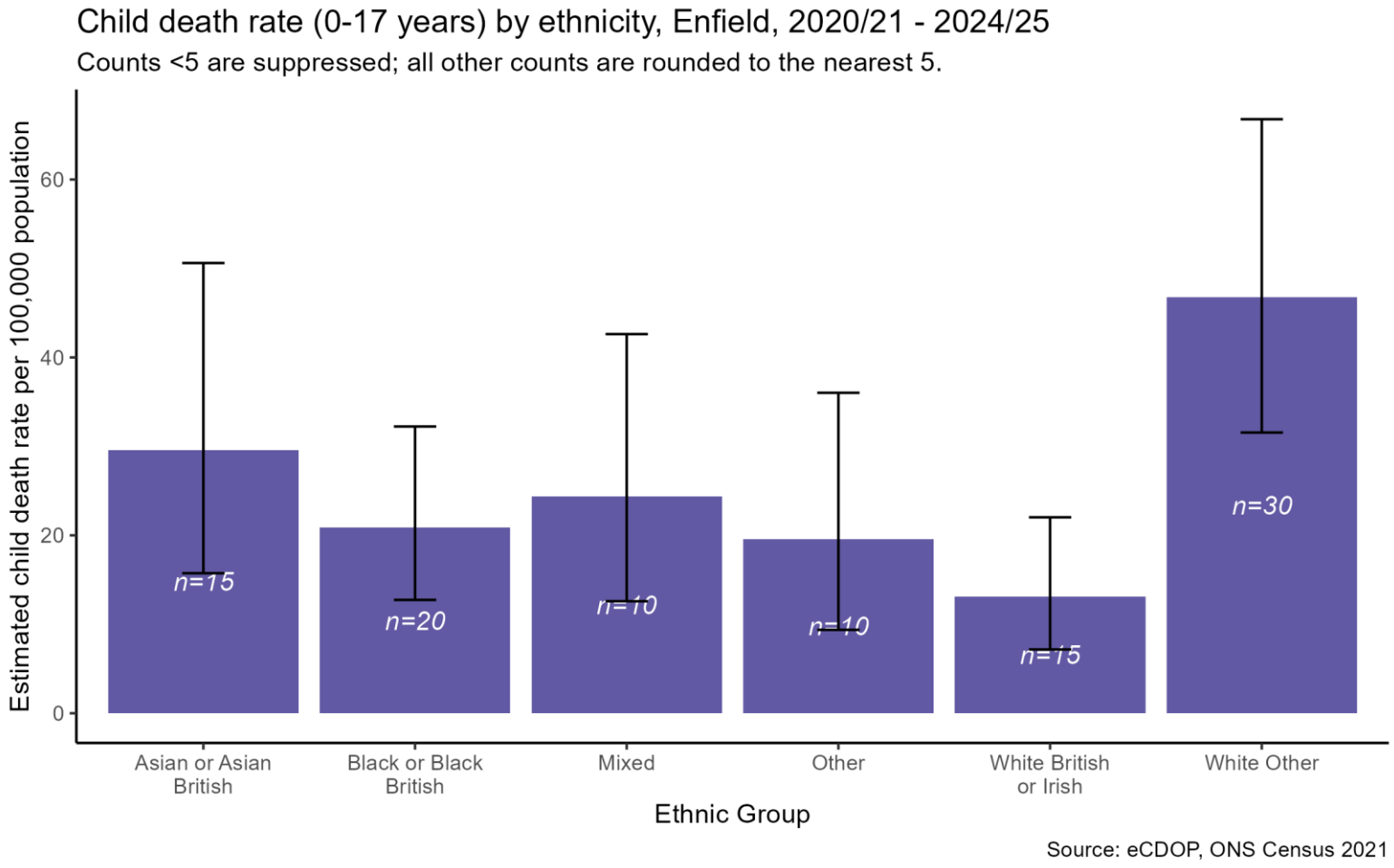
North Central London Health and Care
Integrated Care System



Source: eCDOP, ONS Census 2021, Index of Multiple Deprivation (2019)
Black circles represent the proportion of the Borough's under 18 population resident in each quintile.

Child deaths (age 0-17) by ethnic group

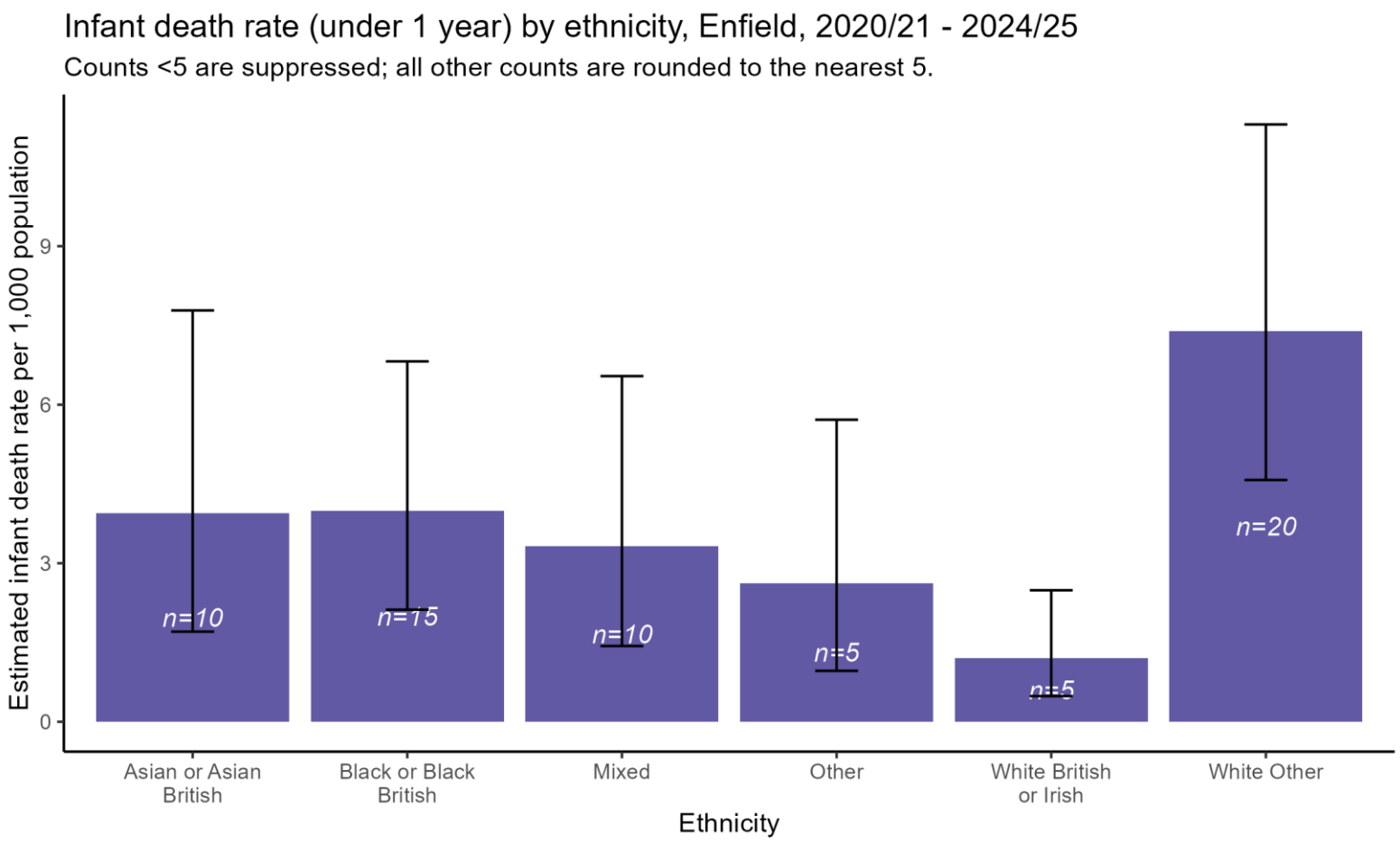
North Central London Health and Care
Integrated Care System



Source: eCDOP, ONS Census 2021

Infant deaths by ethnic group

North Central London Health and Care
Integrated Care System

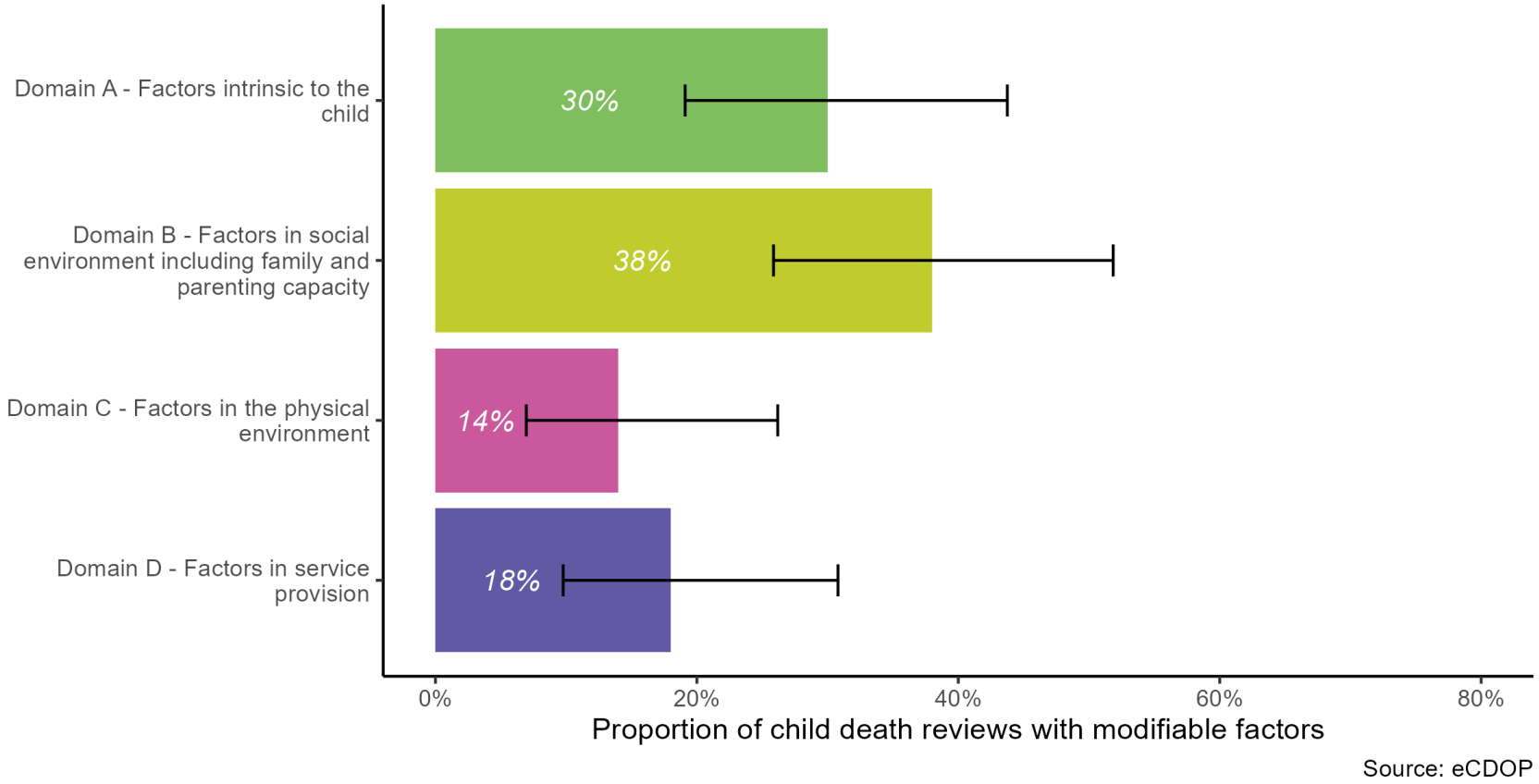


Modifiable factors by domain

North Central London Health and Care
Integrated Care System

Proportion of modifiable factor domains identified in child (0–17 years) death reviews completed by CDOP by domain, Enfield, 2022/23 – 2024/25

Counts <5 are suppressed.



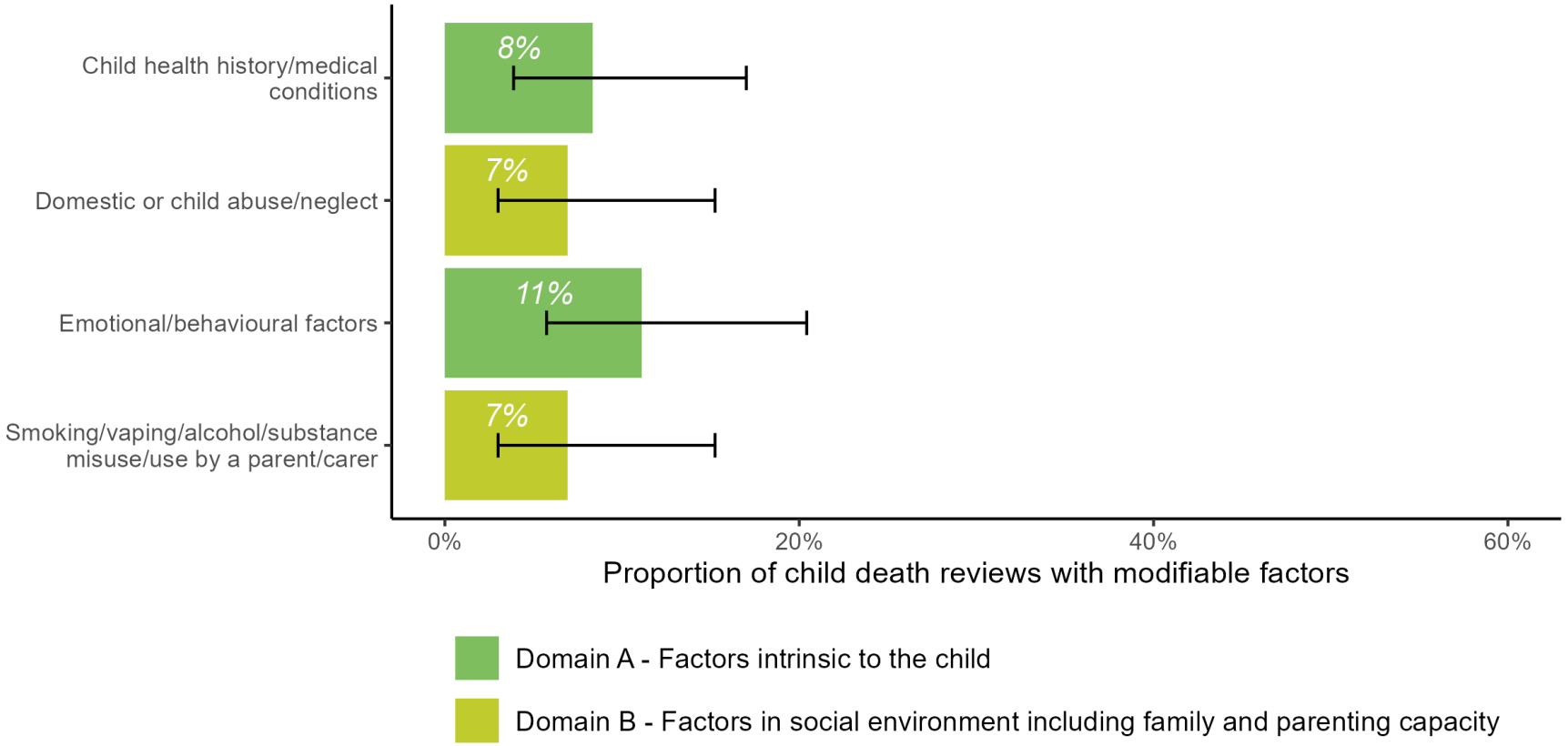
Source: eCDOP

Modifiable factors by sub-domain

North Central London Health and Care
Integrated Care System

Proportion of modifiable factors identified in child (0–17 years) death reviews completed by CDOP by sub-domain, Enfield, 2020/21 – 2024/25

Counts <5 are suppressed.



Source: eCDOP

North Central London
Health and Care
Integrated Care System

Haringey

Borough-Level Analysis

Executive summary – Child deaths in Haringey

North Central London Health and Care
Integrated Care System

Haringey received approximately 90 notifications of child deaths between 2020/21– 2024/25, where the child was usually resident in NCL.

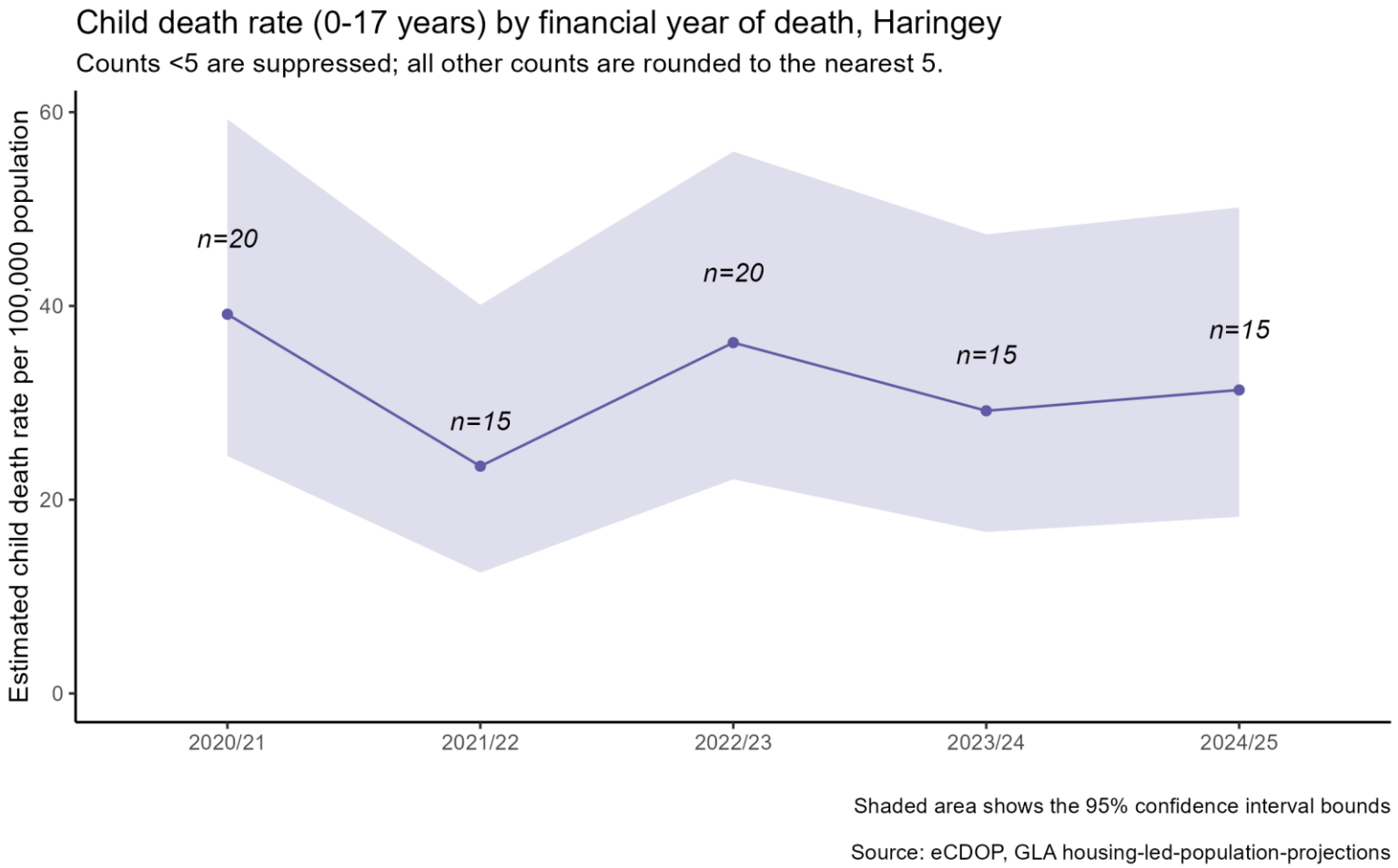
- More than half of these deaths were among children aged under one year (58%). Of these infant deaths, 63% occurred in the first 27 days of life.
- The child death rate was higher in male than female children (37.0 vs 25.9 per 100,000 population), although this difference was not statistically significant.
- The highest child death rates were observed in the White Other (56.2 per 100,000) and Black or Black British (47.7 per 100,000) ethnic groups. The rates in these groups were significantly higher than that for children of White British or Irish ethnicity (13.6 per 100,000).
- 45% of deaths occurred in children living in areas amongst the 20% most deprived in England.
- 24% of completed reviews identified at least one modifiable factor. The most common modifiable factor domain was "factors in service provision" (39%).

Data note:

- Numbers in this analysis are very small. Differences between many groups were not statistically significant, even where NCL-level data shows significant variation. This limits the ability to draw firm conclusions about underlying patterns or trends from the quantitative data alone.
- In most charts, some groups are excluded because there were fewer than five deaths in that category. For data protection purposes, these categories are suppressed, so the lowest rate or proportion may not always be shown.
- This borough-level analysis only includes deaths where the child was usually resident in NCL.
- All counts are rounded to the nearest 5 for data protection.

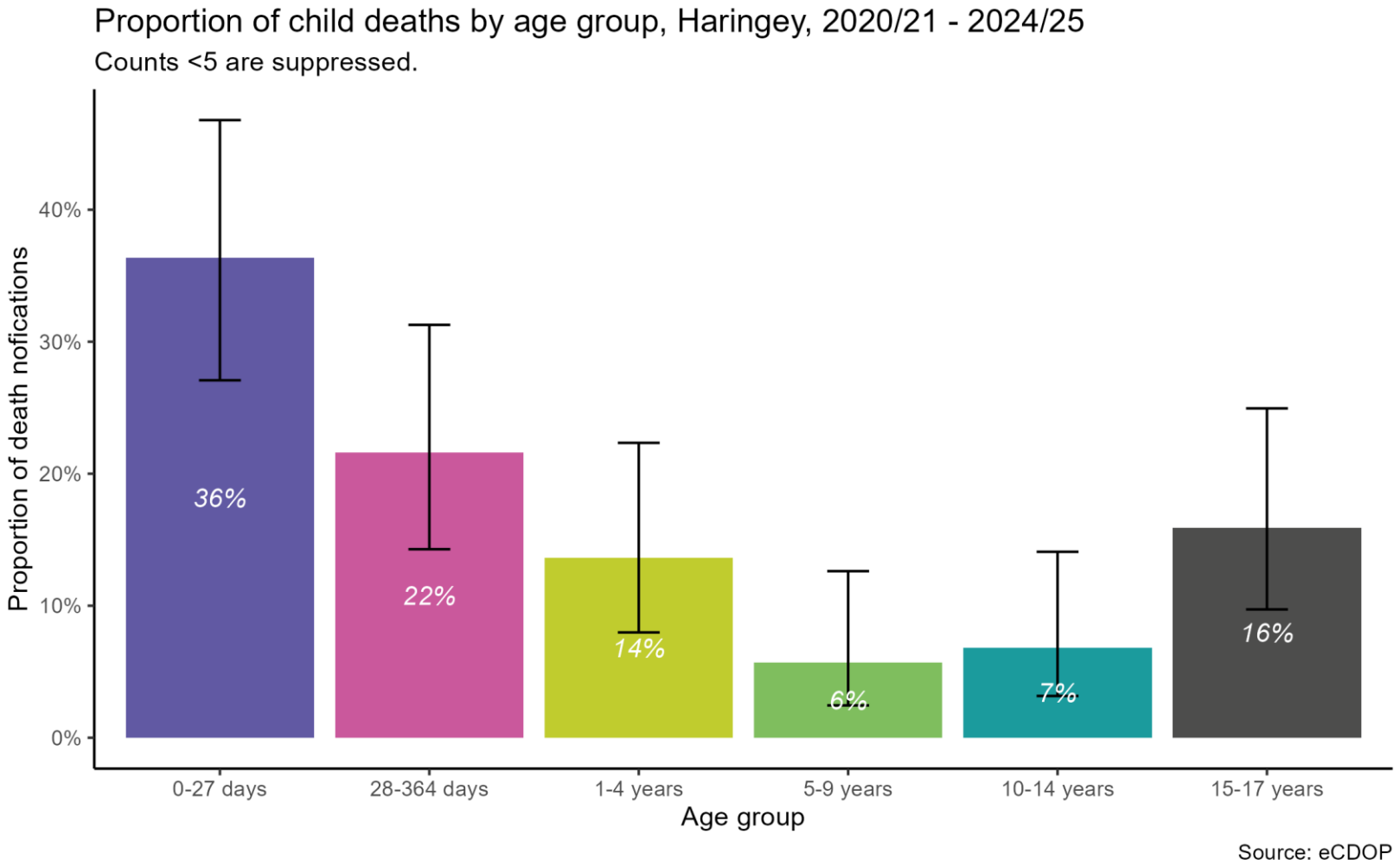
Child deaths (age 0-17) by financial year

North Central London Health and Care
Integrated Care System



Child deaths by age group

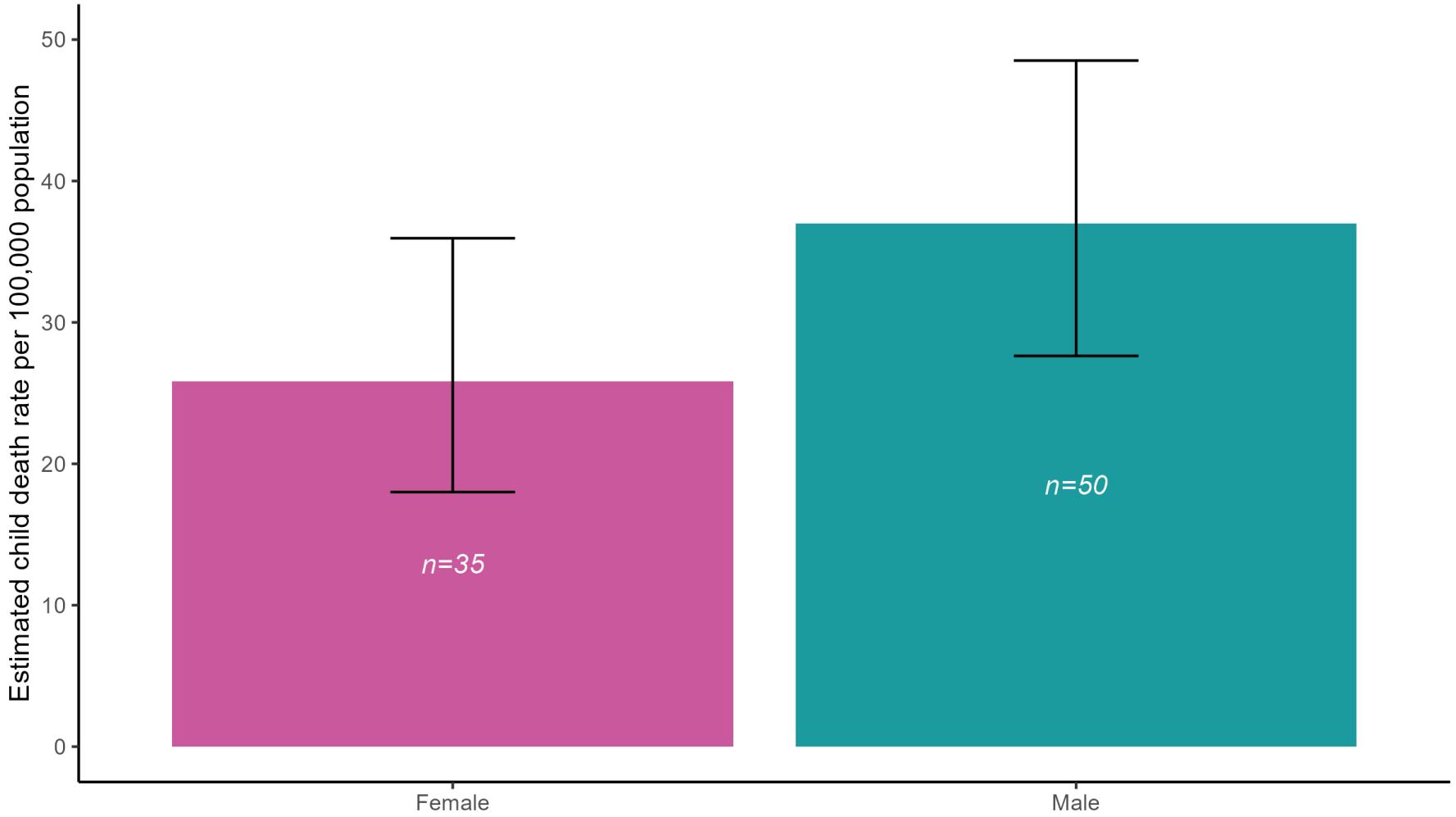
North Central London Health and Care
Integrated Care System



Child deaths (age 0-17) by sex

North Central London Health and Care
Integrated Care System

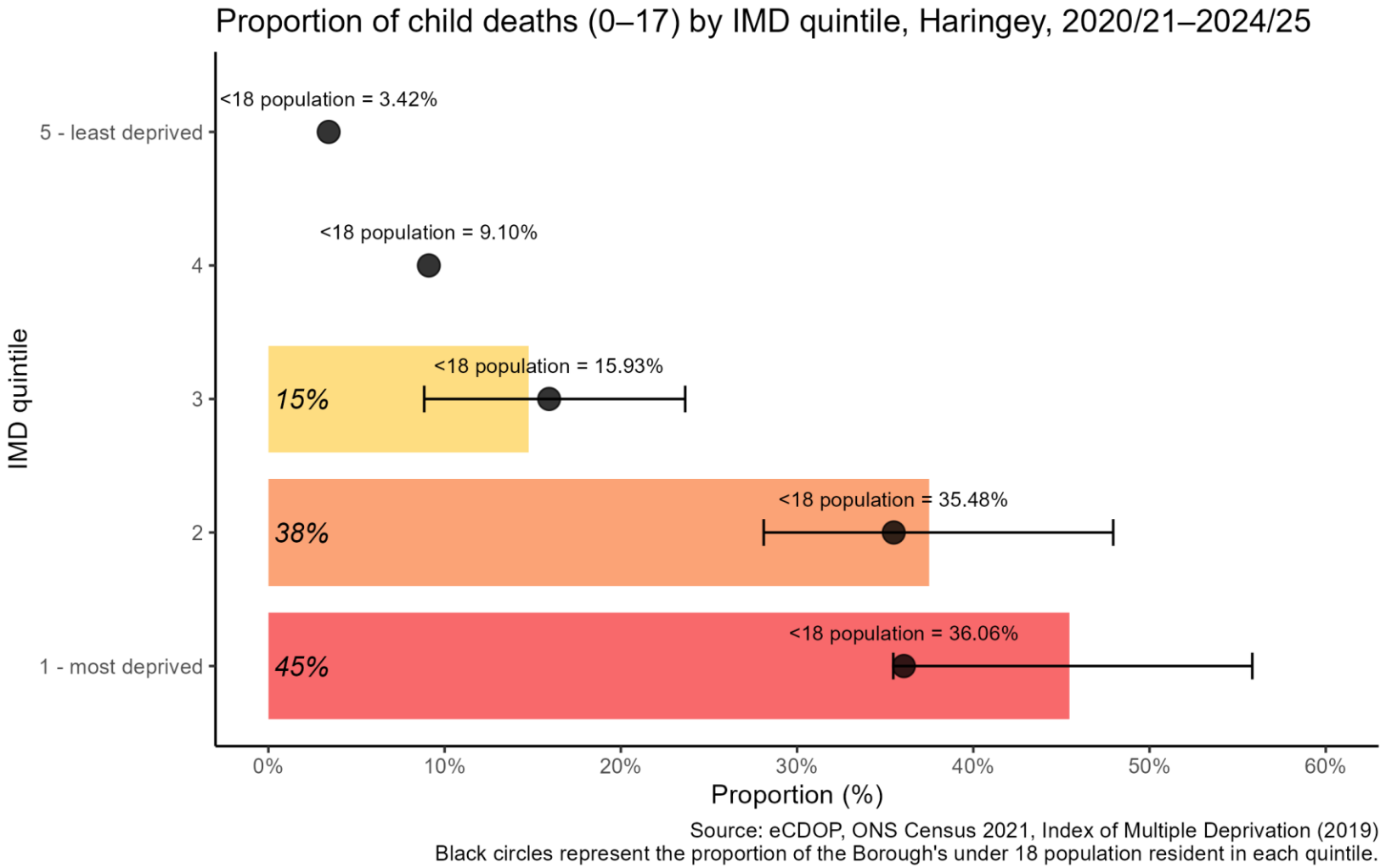
Child death rate (0-17 years) by sex, Haringey, 2020/21 - 2024/25



Source: eCDOP, GLA housing-led-population-projections

Child deaths (age 0-17) by deprivation

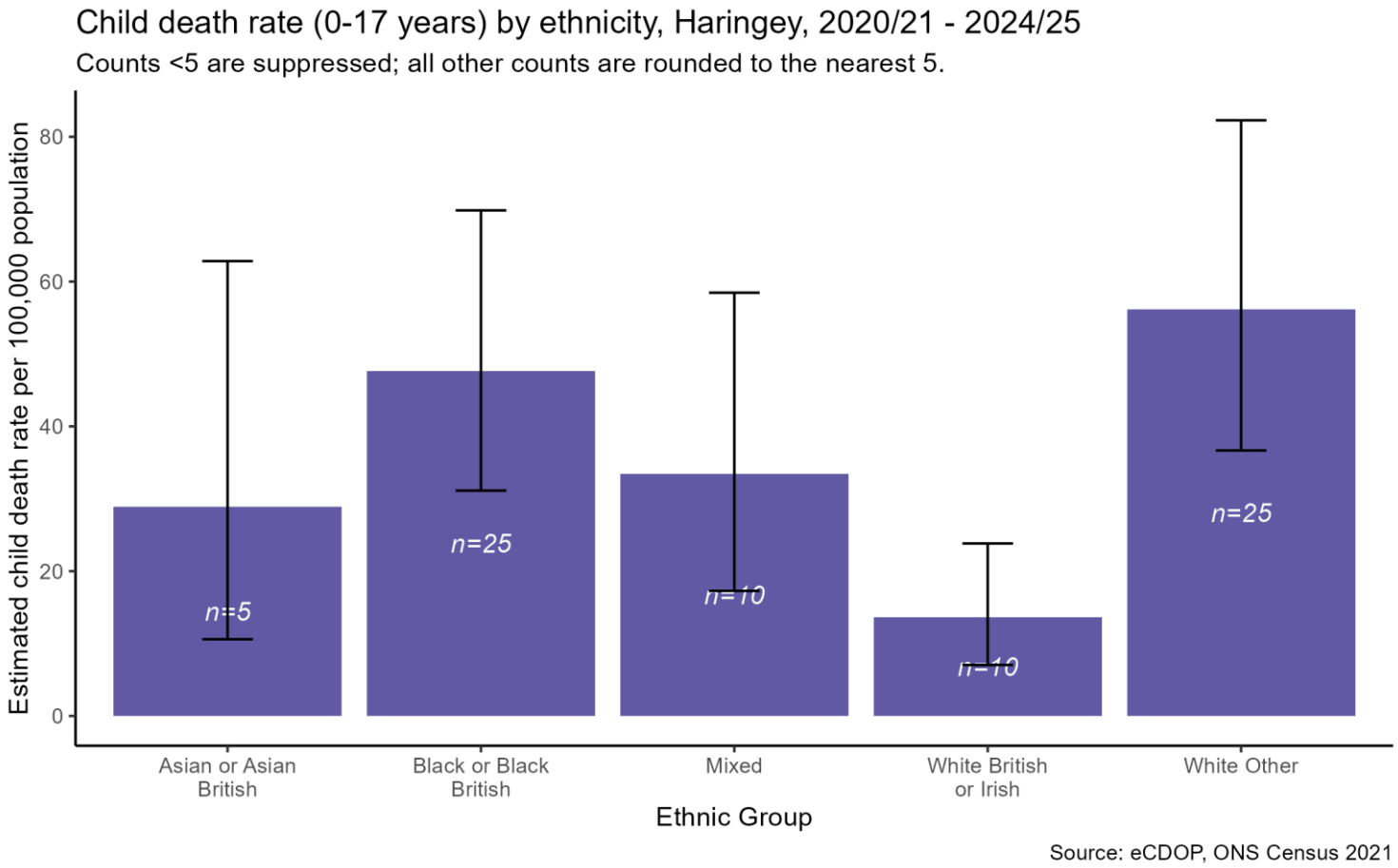
North Central London Health and Care
Integrated Care System



Source: eCDOP, ONS Census 2021, Index of Multiple Deprivation (2019)
Black circles represent the proportion of the Borough's under 18 population resident in each quintile.

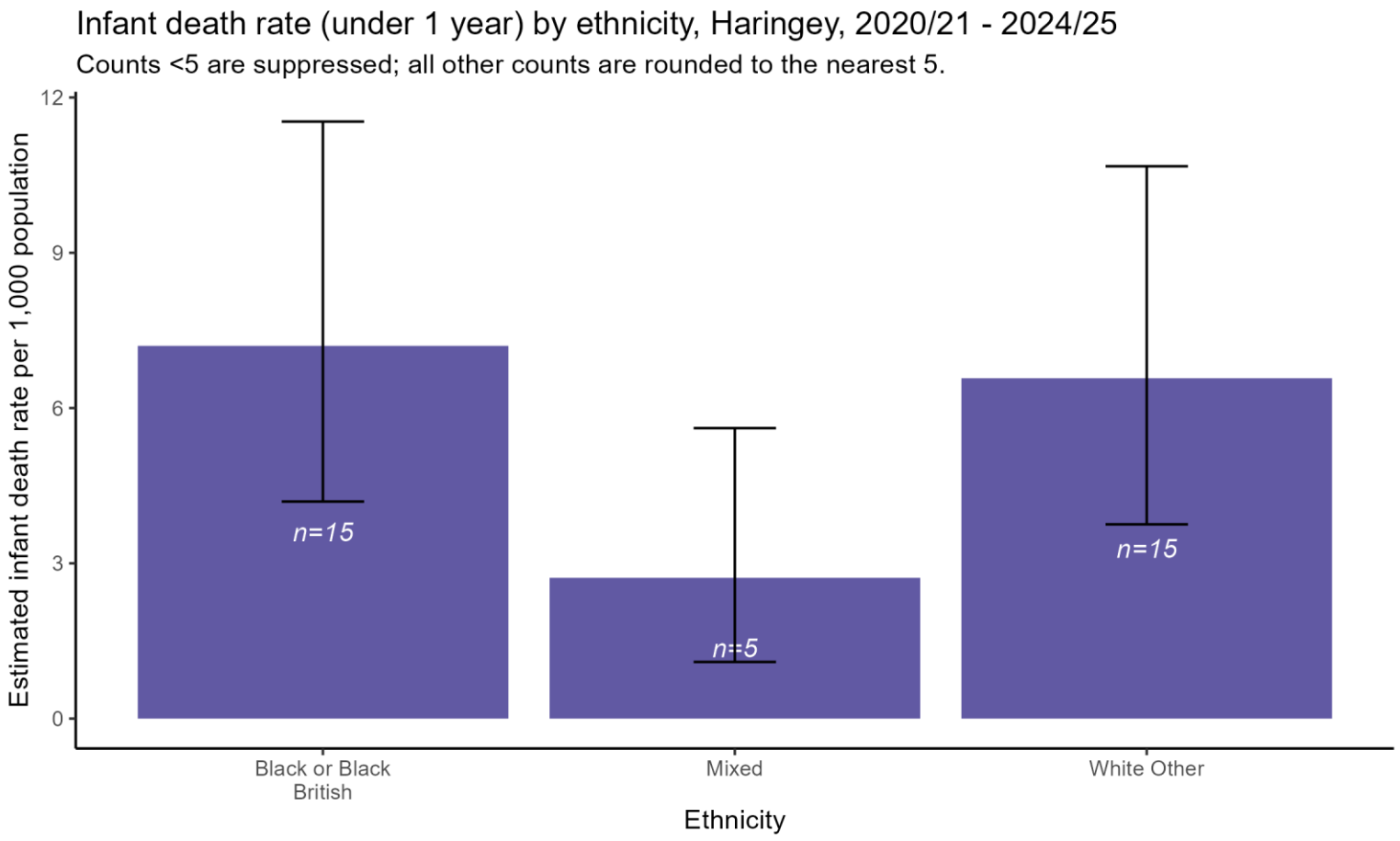
Child deaths (age 0-17) by ethnic group

North Central London Health and Care
Integrated Care System



Infant deaths by ethnic group

North Central London Health and Care
Integrated Care System



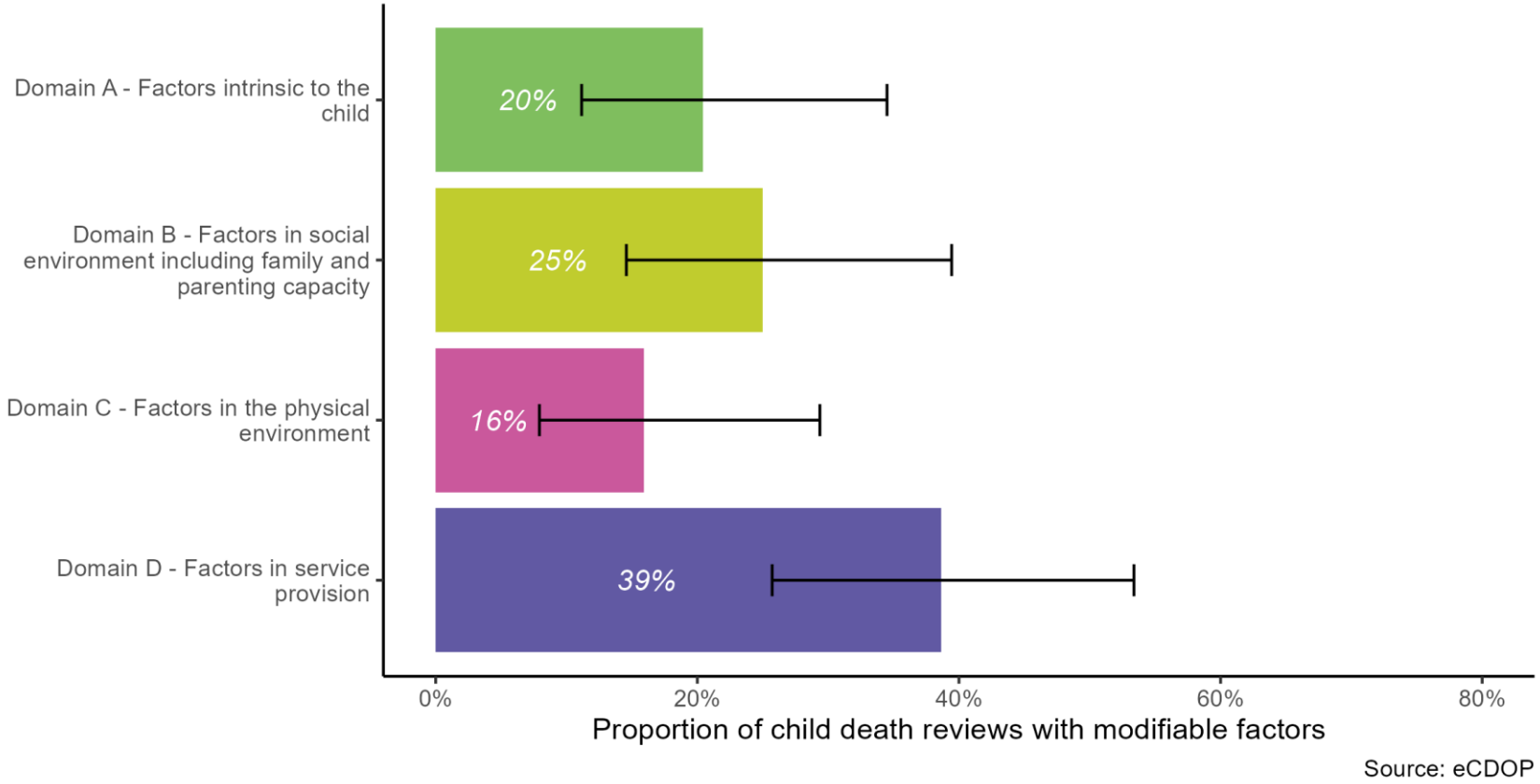
Source: eCDOP, ONS Census 2021

Modifiable factors by domain

North Central London Health and Care
Integrated Care System

Proportion of modifiable factor domains identified in child (0–17 years) death reviews completed by CDOP by domain, Haringey, 2022/23 - 2024/25

Counts <5 are suppressed.



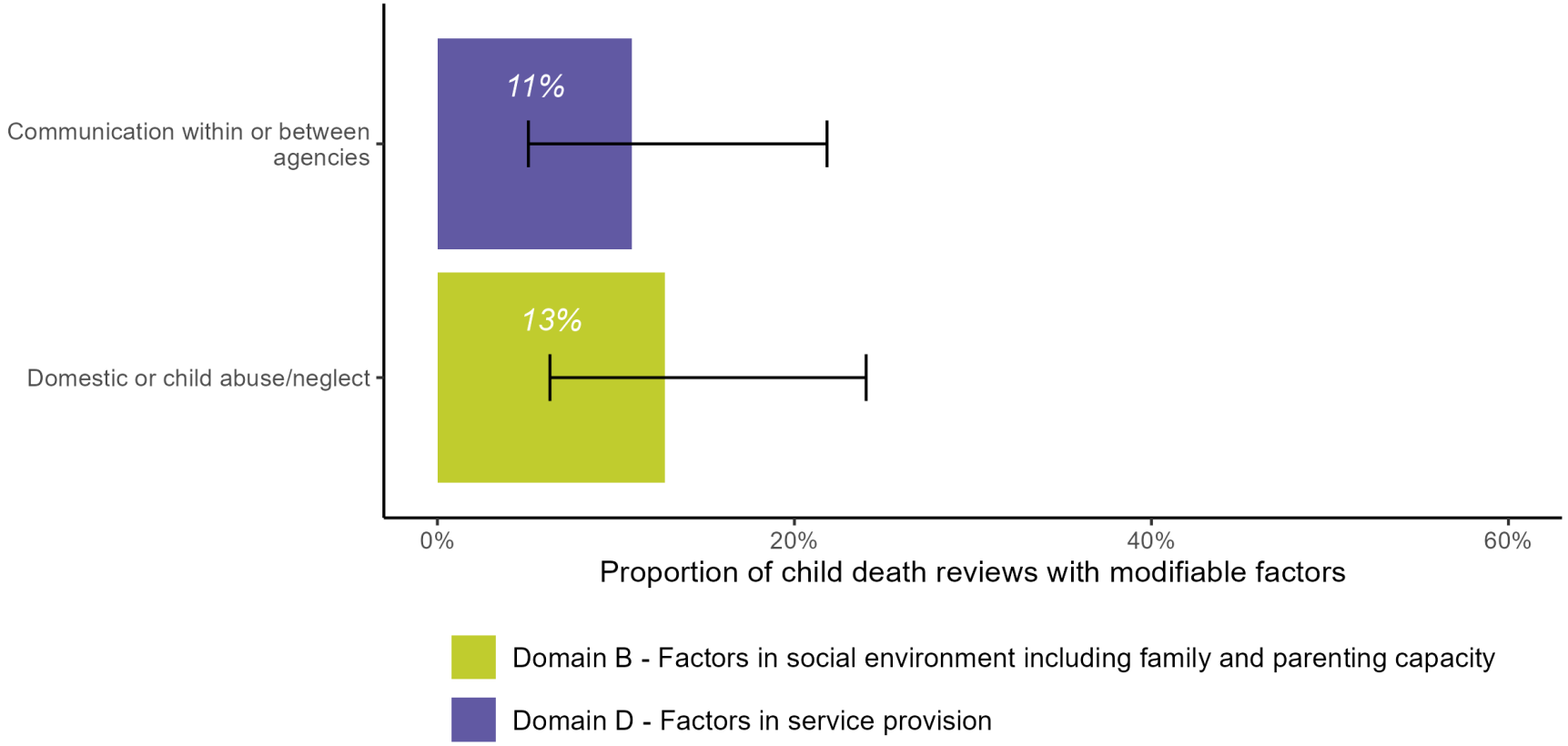
Source: eCDOP

Modifiable factors by sub-domain

North Central London Health and Care
Integrated Care System

Proportion of modifiable factors identified in child (0–17 years) death reviews completed by CDOP by sub-domain, Haringey, 2020/21 – 2024/25

Counts <5 are suppressed.



Source: eCDOP

North Central London
Health and Care
Integrated Care System

Islington

Borough-Level Analysis

Executive summary – child deaths in Islington

North Central London Health and Care
Integrated Care System

Islington received approximately 45 notifications of child deaths between 2020/21– 2024/25, where the child was usually resident in NCL.

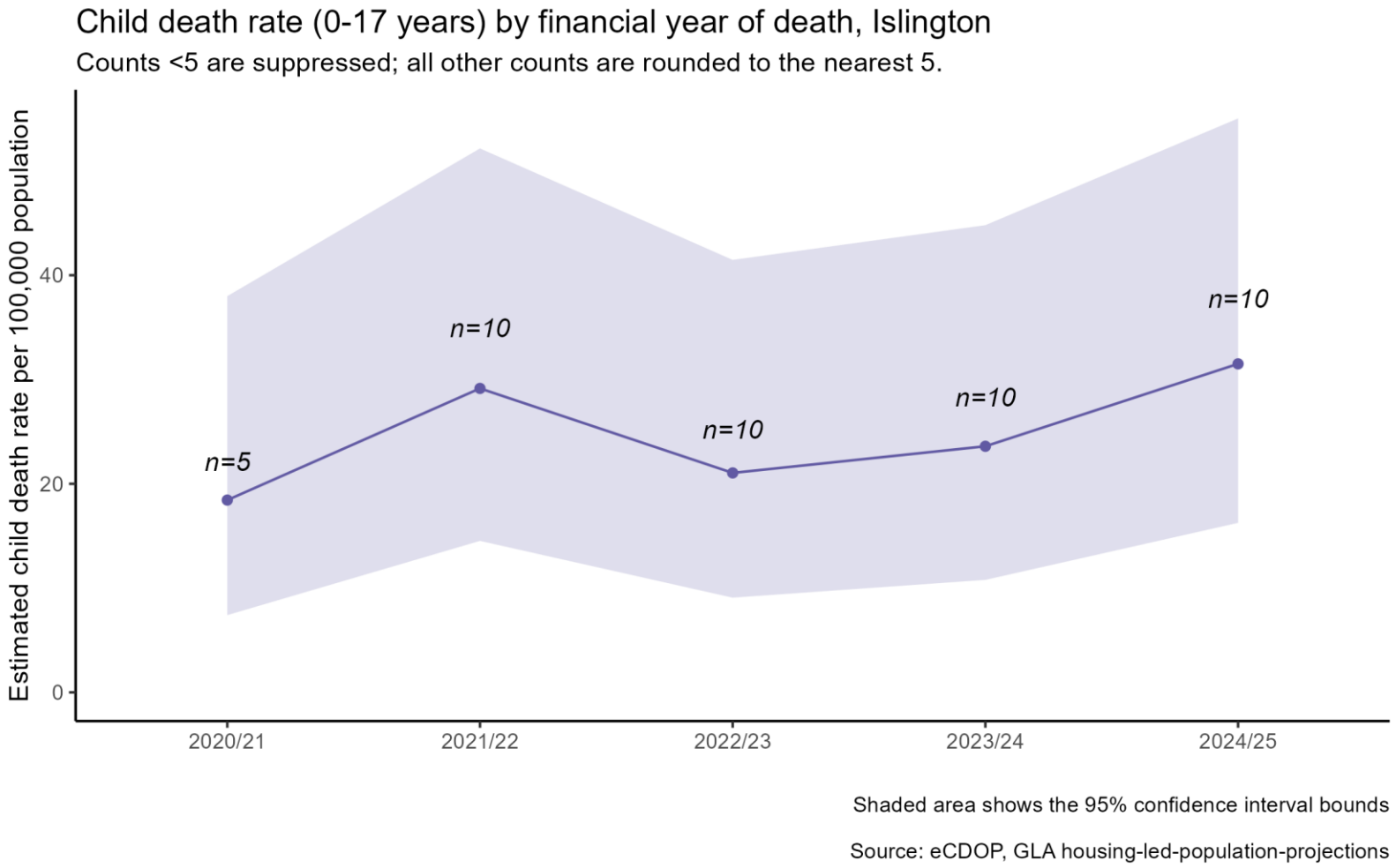
- More than half of these deaths were among children aged under one year (62%). Of these infant deaths, 62% occurred in the first 27 days of life.
- The child death rate was higher in male than female children (30.7 vs 17.3 per 100,000 population), although this difference was not statistically significant.
- The highest child death rates were observed in the White Other (41.9 per 100,000) and Black or Black British (39.3 per 100,000) ethnic groups. Neither rate was significantly higher than that for children of White British or Irish ethnicity (17.1 per 100,000).
- 34% of deaths occurred in children living in areas amongst the 20% most deprived in England.
- 32% of completed reviews identified at least one modifiable factor. The most common modifiable factor domain was “factors in service provision” (37%).

Data note:

- Numbers in this analysis are very small. Differences between many groups were not statistically significant, even where NCL-level data shows significant variation. This limits the ability to draw firm conclusions about underlying patterns or trends from the quantitative data alone.
- In most charts, some groups are excluded because there were fewer than five deaths in that category. For data protection purposes, these categories are suppressed, so the lowest rate or proportion may not always be shown.
- This borough-level analysis only includes deaths where the child was usually resident in NCL.
- All counts are rounded to the nearest 5 for data protection.

Child deaths (age 0-17) by financial year

North Central London Health and Care
Integrated Care System

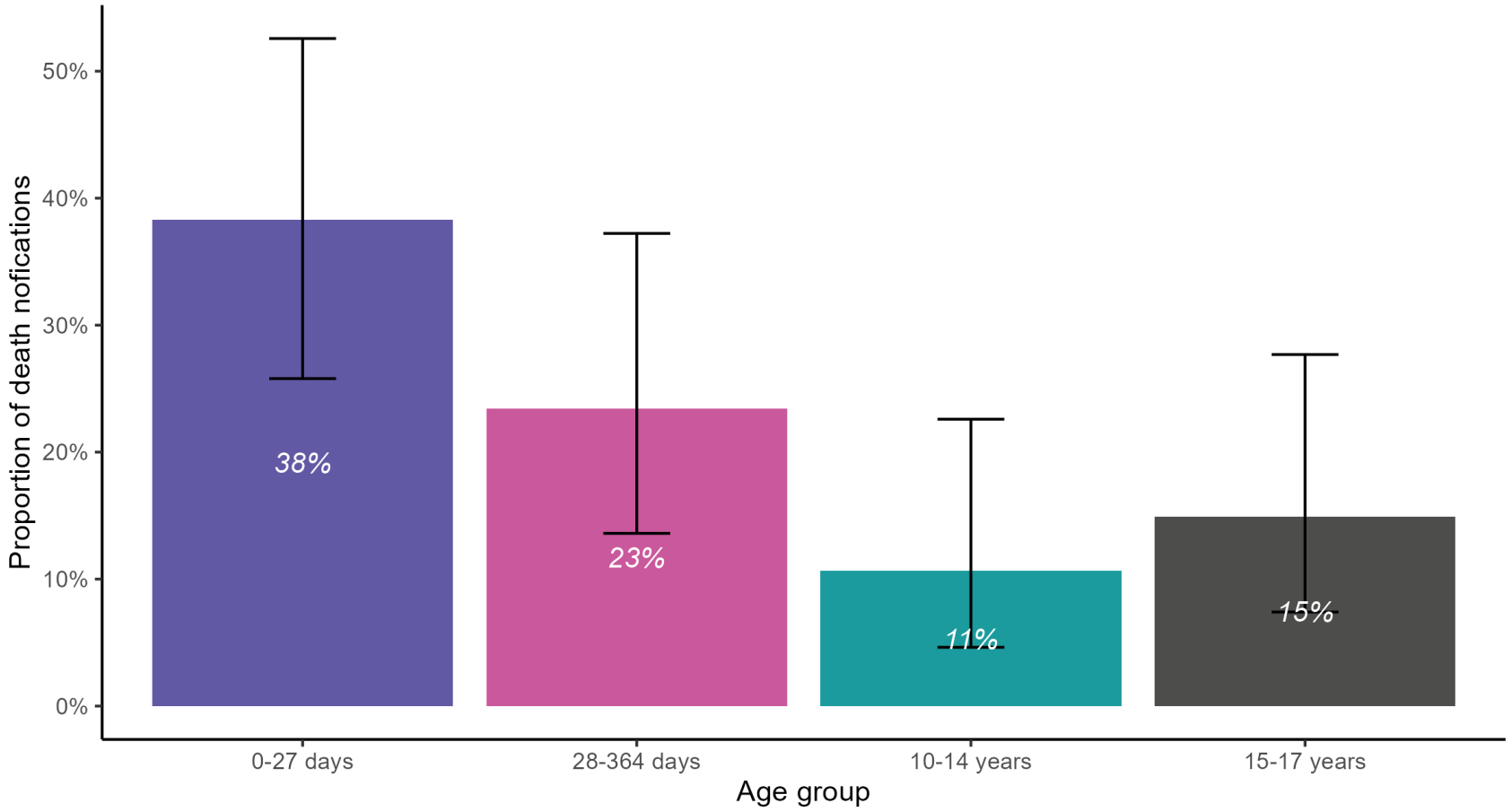


Child deaths by age group

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Proportion of child deaths by age group, Islington, 2020/21 - 2024/25

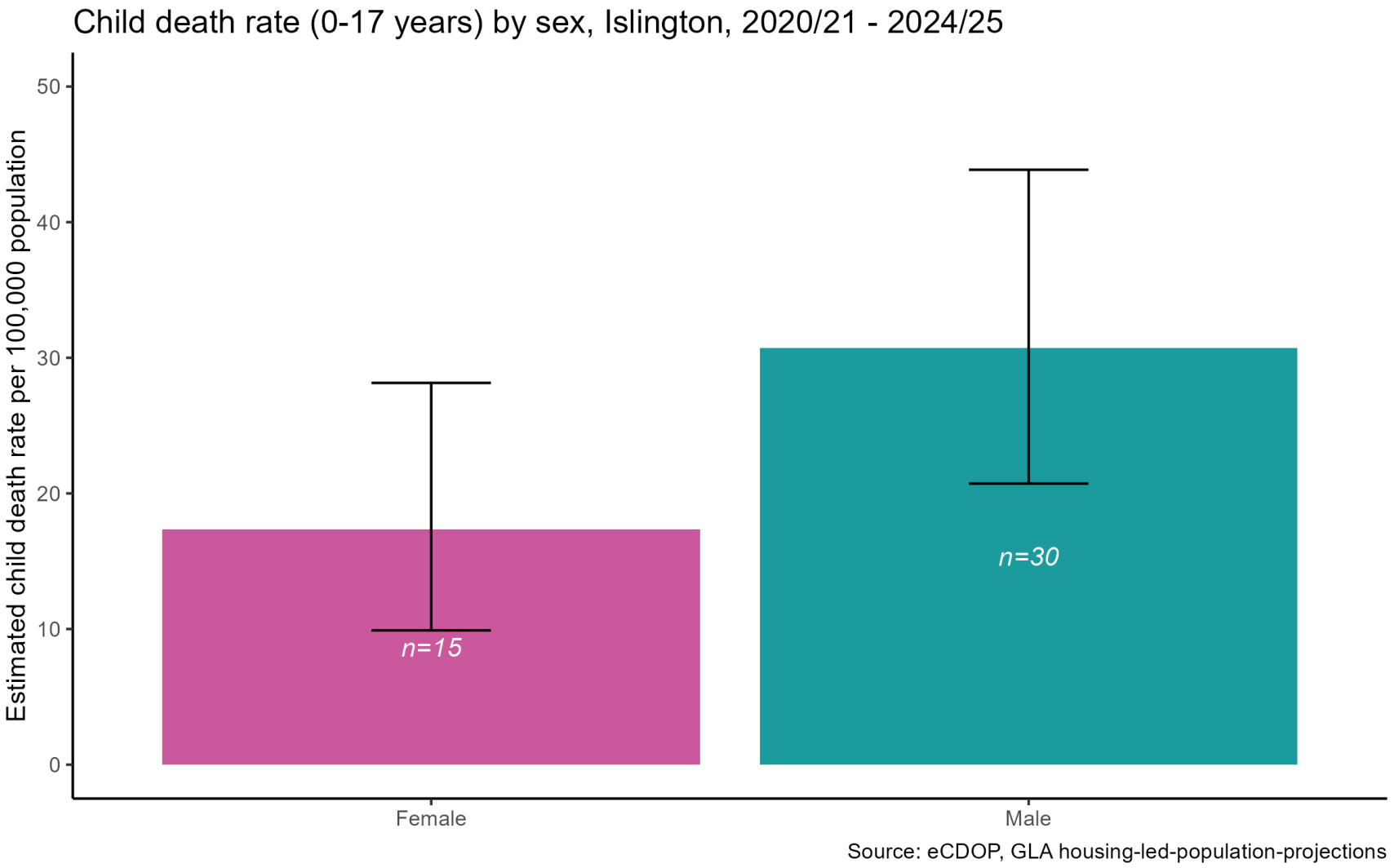
Counts <5 are suppressed.



Source: eCDOP

Child deaths (age 0-17) by sex

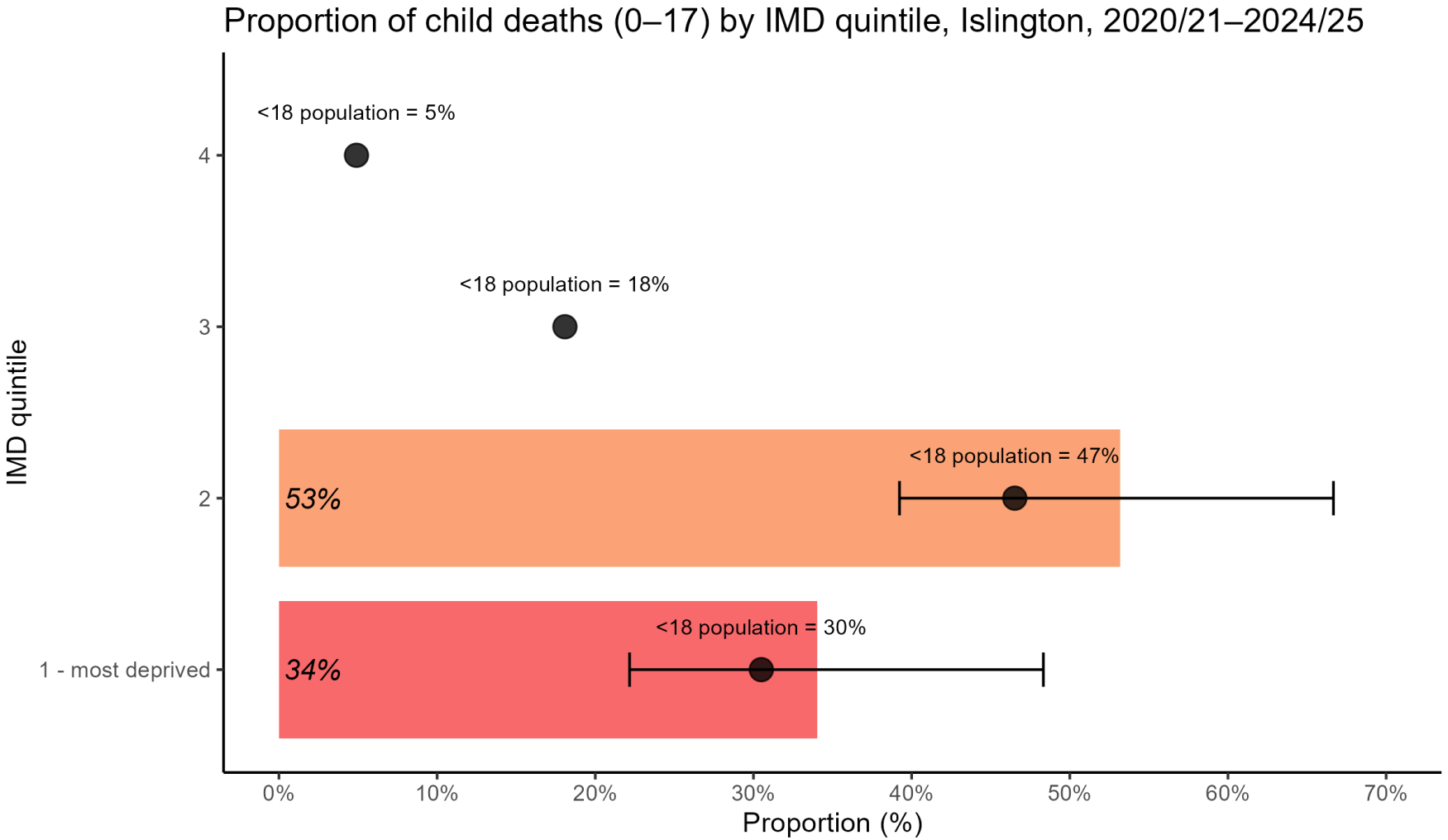
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Source: eCDOP, GLA housing-led-population-projections

Child deaths (age 0-17) by deprivation

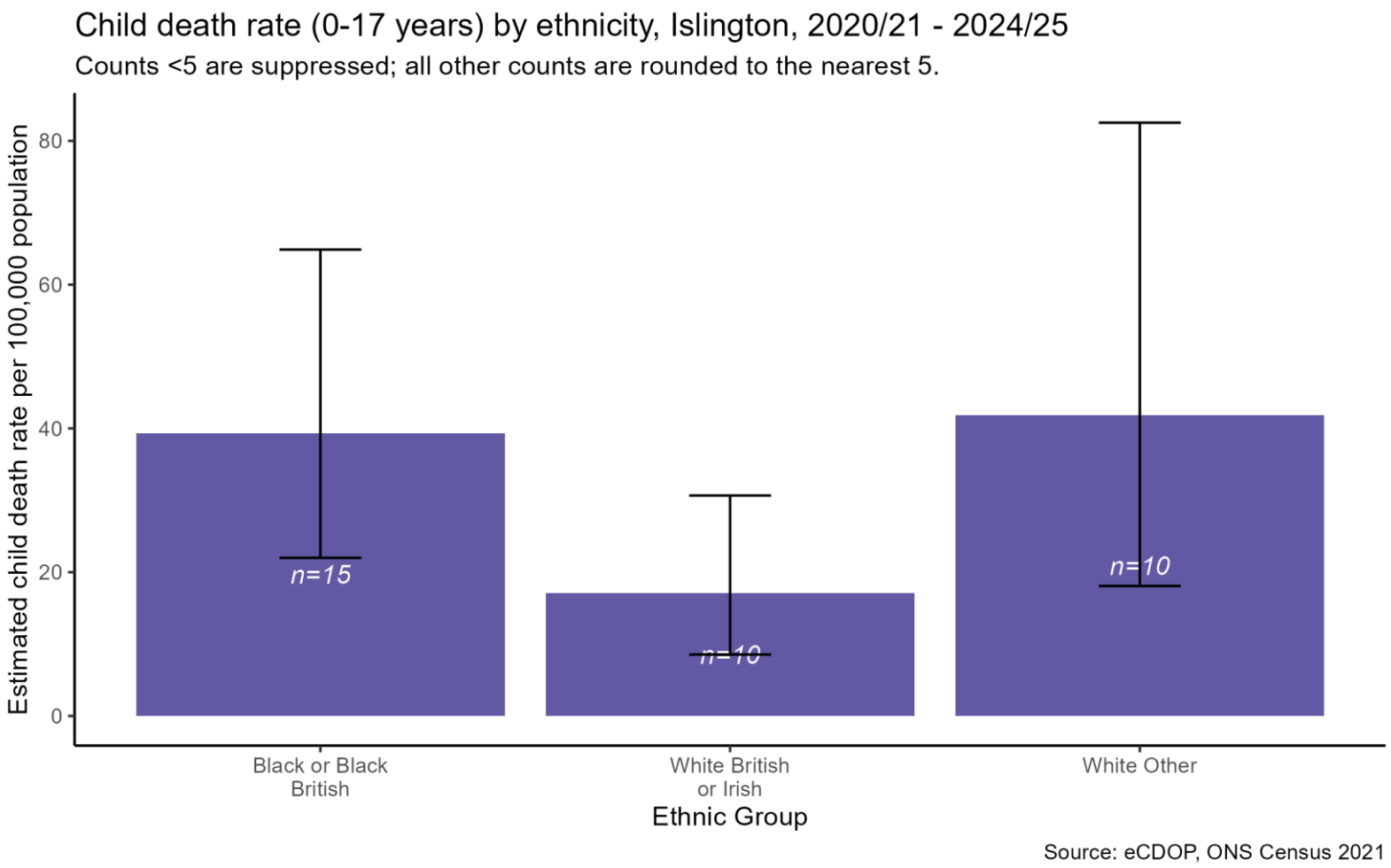
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Source: eCDOP, ONS Census 2021, Index of Multiple Deprivation (2019)
Black circles represent the proportion of the Borough's under 18 population resident in each quintile.

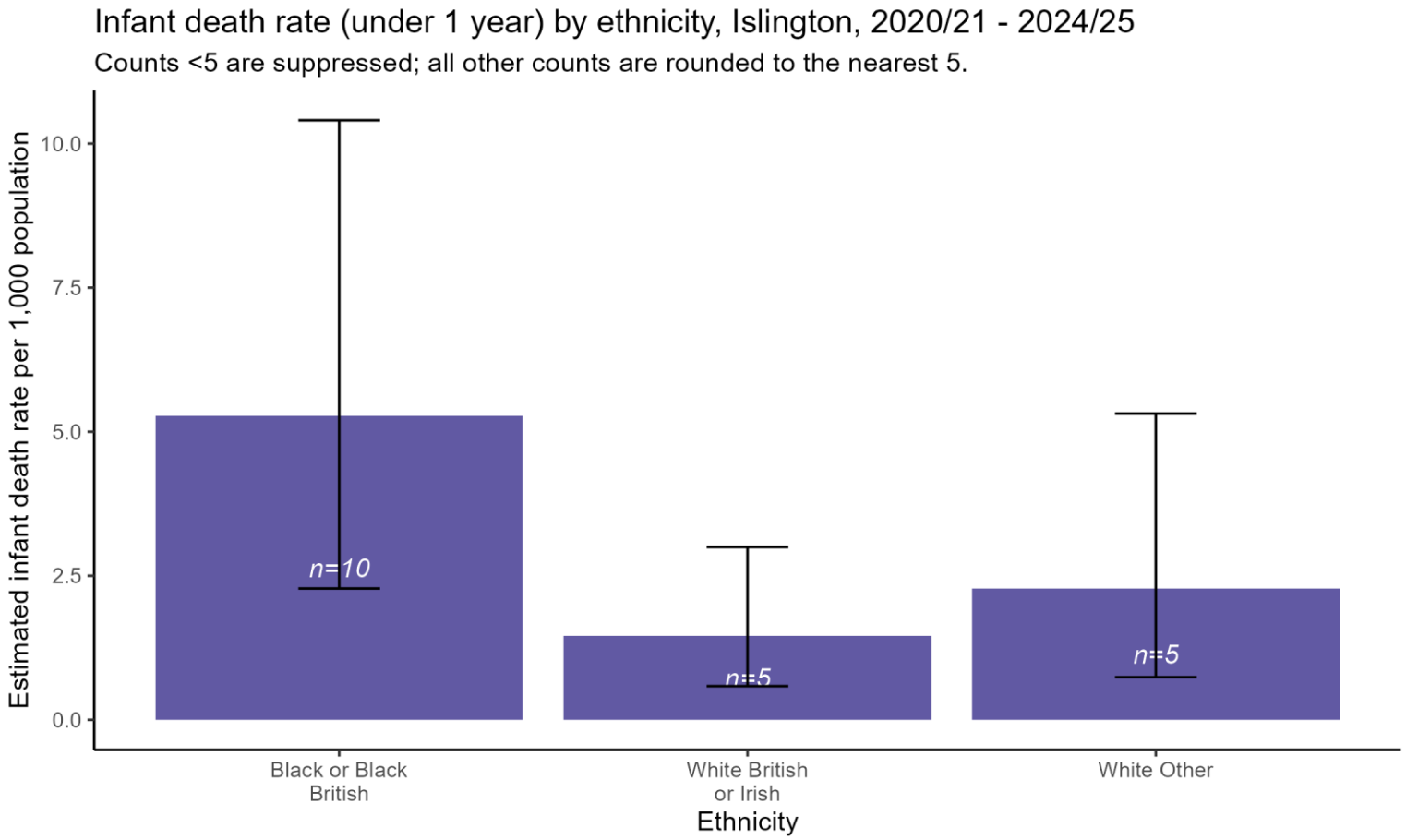
Child deaths (age 0-17) by ethnic group

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Infant deaths by ethnic group

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Integrated Care System



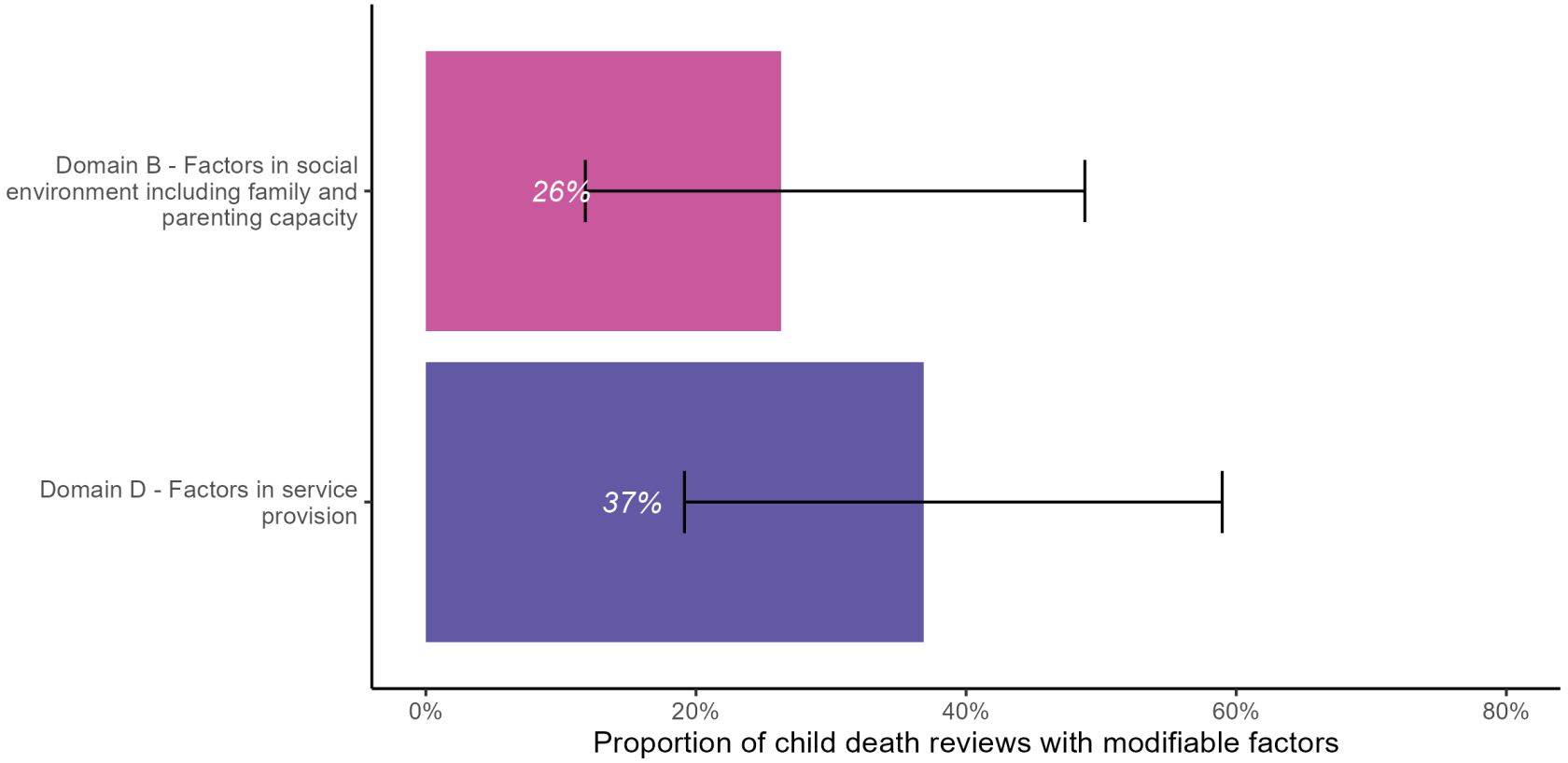
Source: eCDOP, ONS Census 2021

Modifiable factors by domain

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Proportion of modifiable factor domains identified in child (0–17 years) death reviews completed by CDOP by domain, Islington, 2022/23 – 2024/25

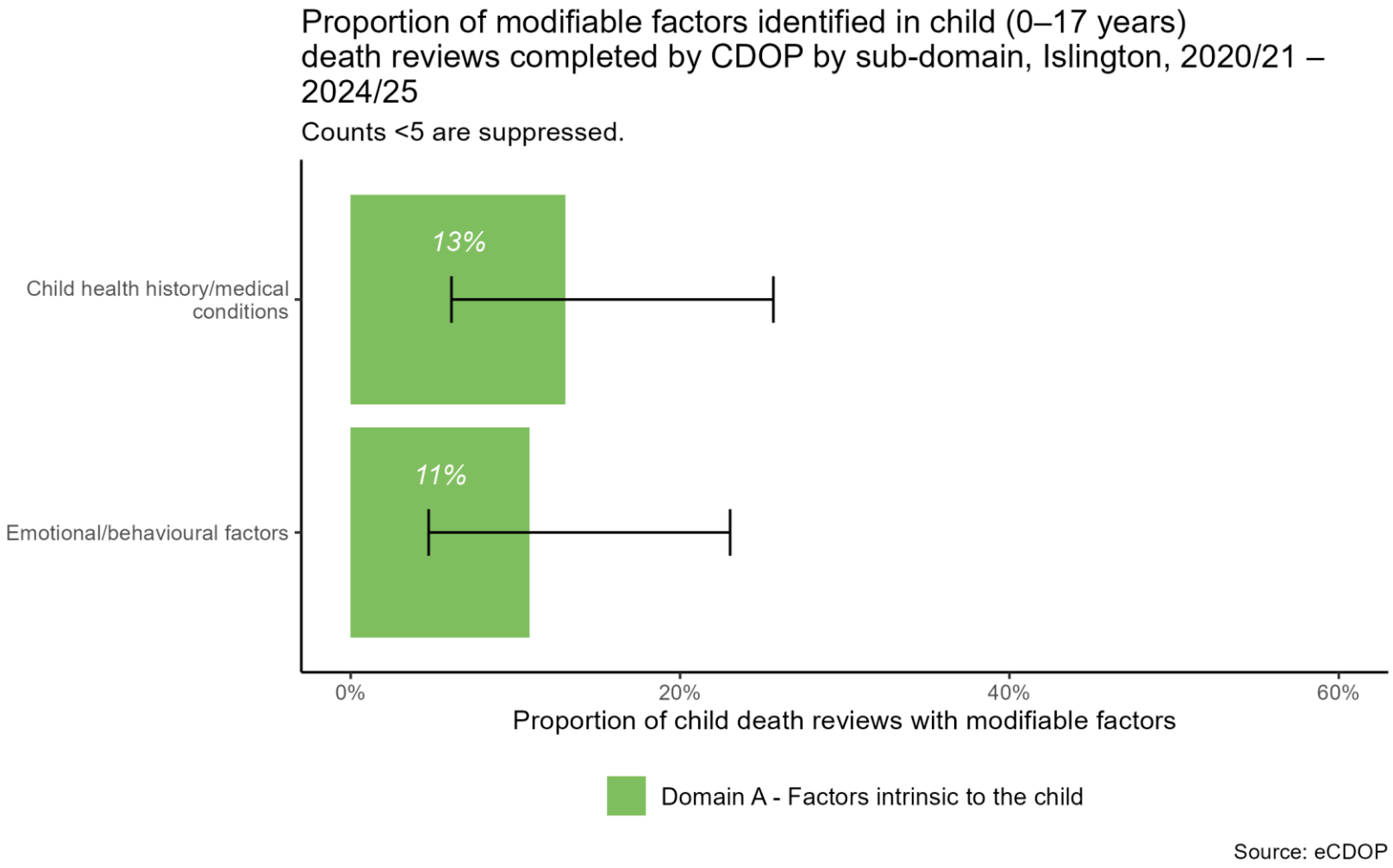
Counts <5 are suppressed.



Source: eCDOP

Modifiable factors by sub-domain

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Integrated Care System



Source: eCDOP

- Due to suppression of counts below 5, the sub-domains shown here may not correspond to the domains shown on the previous slide. In some cases, the most common sub-domains belong to domains that were not among the most common overall.

North Central London Health and Care
Integrated Care System

Appendix B: Data descriptions

Appendix Bi: Broad and detailed ethnic groups

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Integrated Care System

Broad ethnic group	Detailed ethnic group
Asian or Asian British	Any other Asian background
	Bangladeshi
	Chinese
	Indian
	Pakistani
Black or Black British	African
	Any other Black background
	Caribbean
Mixed	Any other mixed background
	White and Asian
	White and Black African
	White and Black Caribbean
White British/Irish	British
	Irish
White Other	Any other White background
	Gypsy or Irish Traveller
Other	Any other ethnic group
	Arab
Not known/stated	Not known/not stated

- Changes were made to data collection of ethnicity by NCMD in April 2021, April 2023 and January 2024 so these categories are likely to be underestimated.
- In April 2021 ‘Gypsy or Irish Traveller’ was added to ‘White’ and ‘Arab’ was added to ‘Other ethnic group’. In April 2023 ‘Roma’ was added to ‘White’ and added to the paper forms in January 2024.

GOV.UK. List of ethnic groups: 2021 Census. Available from: https://www.ethnicity-facts-figures.service.gov.uk/style-guide/ethnic-groups/ [accessed 03/02/25]

Appendix Bii: Analysis form categories of death and descriptions

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Category	Description of category
1. Deliberately inflicted injury, abuse or neglect	This includes suffocation, shaking injury, knifing, shooting, poisoning and other means of probable or definite homicide; also, deaths from war, terrorism or other mass violence; includes severe neglect leading to death.
2. Suicide or deliberate self-inflicted harm	This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.
3. Trauma and other external factors, including medical/surgical complications/error	This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis and other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death. Excludes deliberately inflicted injury, abuse or neglect (category 1).
4. Malignancy	Solid tumours, leukaemia's and lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
5. Acute medical or surgical condition	For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.
6. Chronic medical condition	For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Includes cerebral palsy with clear post-perinatal cause.
7. Chromosomal, genetic and congenital anomalies	Trisomy's, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.
8. Perinatal/neonatal event	Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral palsy without evidence of cause and includes congenital or early-onset bacterial infection (onset in the first postnatal week).
9. Infection	Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.
10. Sudden unexpected, unexplained death	Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5).