LONDON BOROUGH OF CAMDEN	WARDS All
REPORT TITLE North Central London Annual Child Death Report	
REPORT OF Director of Public Health	
FOR SUBMISSION TO Camden Health and Wellbeing Board	**DATE** 11th March 2026

SUMMARY OF REPORT

It is 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 to help learn lessons from these deaths and identify ways to prevent future tragedies. Every child death is subject to a child death review (CDR) meeting, regardless of how they died.

The Camden public health team have led on the development of this report for the past two years. It was written on behalf of North Central London (NCL) CDR partners of the NHS Integrated Care Board and the five Local Authorities of NCL (Barnet, Camden, Enfield, Haringey, and Islington).

The 2024/25 NCL annual child death report consists of four main sections:

1) Quantitative findings
2) Case review of child deaths
3) Progress on actions
4) Recommendations

This report provides a summary of key findings from the 2024/25 annual NCL child death report, along with progress against last year's recommendations and recommendations resulting from this year's findings. This report also includes two case studies which illustrate the complex mix of social factors that collectively contributed to a state of vulnerability and ill health in the children. In particular, mental ill health, domestic abuse and serious youth violence are linked to a range of other complex social factors in many child death cases.

This report is intended to provide an overview about child deaths in NCL and highlight the recommendations that need to be taken forward across different parts of our health and care system that might prevent future child deaths. The Health and Wellbeing Board are invited to consider the implications for Camden. The full annual report for 2024/25 is included as an appendix.

Local Government Act 1972 – Access to Information

No documents that require listing have been used in the preparation of this report.

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RECOMMENDATIONS

The Camden Health and Wellbeing Board is requested to note this report.

Signed:

Kirsten Watters
Director of Health & Wellbeing and Statutory Directory of Public Health

Date: 27th February 2026

1. Introduction

1.1 The purpose of this paper is to inform Health and Wellbeing Board (HWB) members about the findings from the 2024/25 North Central London (NCL) annual child death report, including a series of multi-agency recommendations aimed at improving the health and safety of children and young people and preventing future child deaths.

1.2 The Camden public health team have led on the development of this report for the past two years, on behalf of North Central London. This is the fifth annual report written on behalf of NCL Child Death Review (CDR) partners of the NHS Integrated Care Board and the five Local Authorities of NCL (Barnet, Camden, Enfield, Haringey, and Islington).

2. Overview of the Child Death Overview Panel (CDOP) process

2.1 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. Every child death is subject to a child death review (CDR) meeting, regardless of how they died.

2.2 The NCL CDOP reviews the deaths of all children who are resident in the NCL boroughs of Barnet, Camden, Enfield, Haringey and Islington.

2.3 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.

2.4 All deaths are anonymised and discussed individually by the CDOP, 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.

2.5 The CDOP reviews each factor intrinsic to the child, their family, their environment, and the service provision they experienced. These factors are called ‘contributory factors,’ and they are considered by the panel in order to determine whether they contributed to a child’s state of vulnerability and ill health, not just their death.

2.6 Some contributory factors are considered modifiable. Modifiable factors are those which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future deaths.

2.7 NCL CDOP works hard to identify every opportunity to learn and to recommend improvements that might prevent another child death in the future.

3. 2024/25 NCL annual child death report: overview

3.1 The 2024/25 NCL annual child death report consists of four main sections:

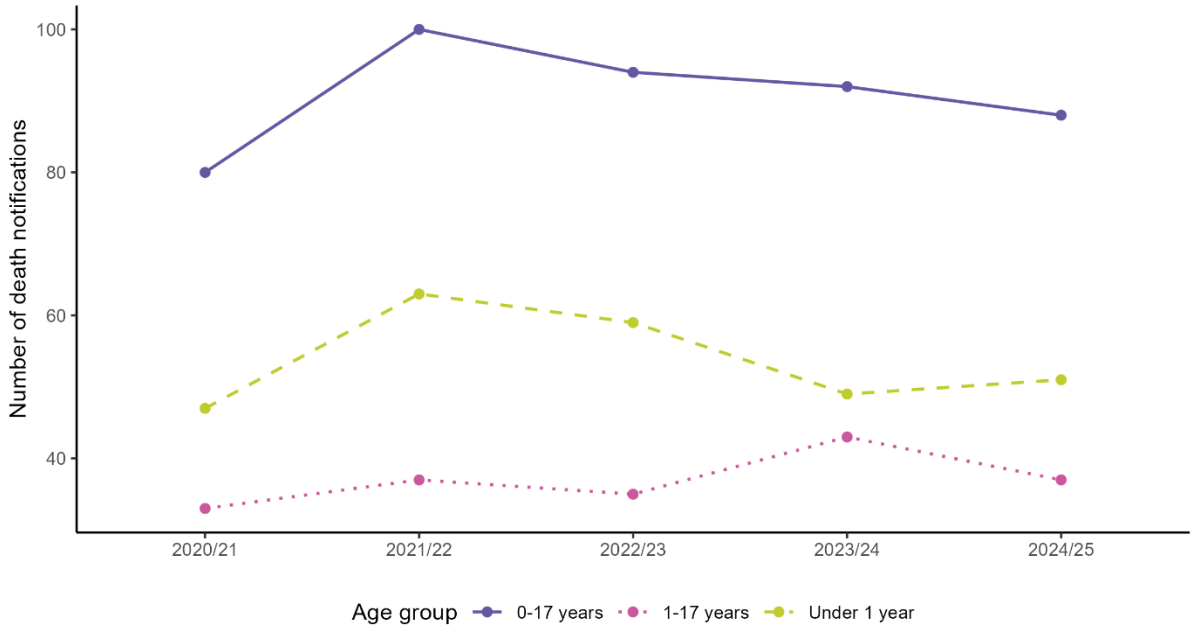
- Quantitative findings
- Case review of child deaths
- Progress on actions
- Recommendations

4. Quantitative findings

Unless otherwise specified, the figures below summarise child deaths for all of NCL across the past five years (2020/21–2024/25). Further analysis is available in the full annual report for 2024/25 on pages 13-64 (see Appendix A).

4.1 In 2024/25, a total of 88 deaths were recorded, representing a small decrease from 92 the previous year. This overall change reflects a slight rise in infant deaths (51 compared with 49 in 2023/24), alongside a decrease in deaths among children aged 1–17 (37 compared with 43).

Number of child death notifications received by North Central London CDOP by financial year of death



Source: eCDOP

4.2 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.

4.3 The greatest risk of death was in the first year of life. 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.

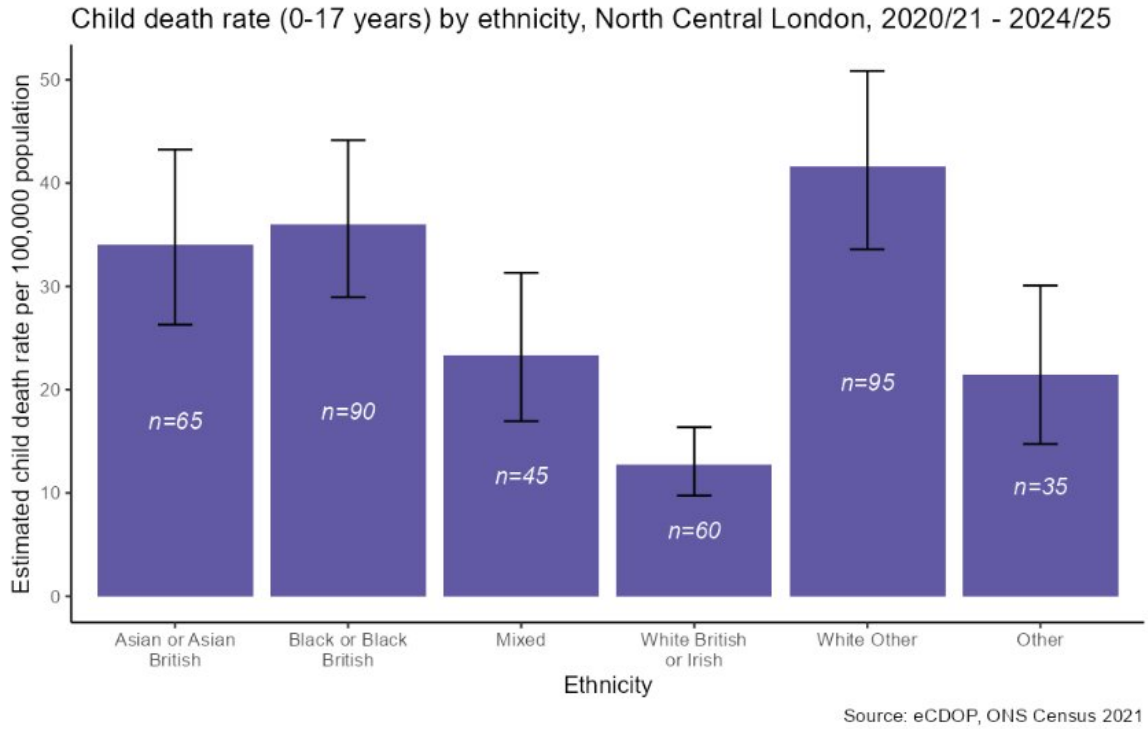
4.4 The most common primary category of death was “chromosomal, genetic and congenital anomalies” (31.1%), followed by “perinatal/neonatal event” (22.3%) and “malignancy” (14.9%).

4.5 Most child deaths occurred in hospital (77.5%), followed by 12.9% at home, 3.3% in a public place and 6.3% elsewhere.

4.6 *Equity*

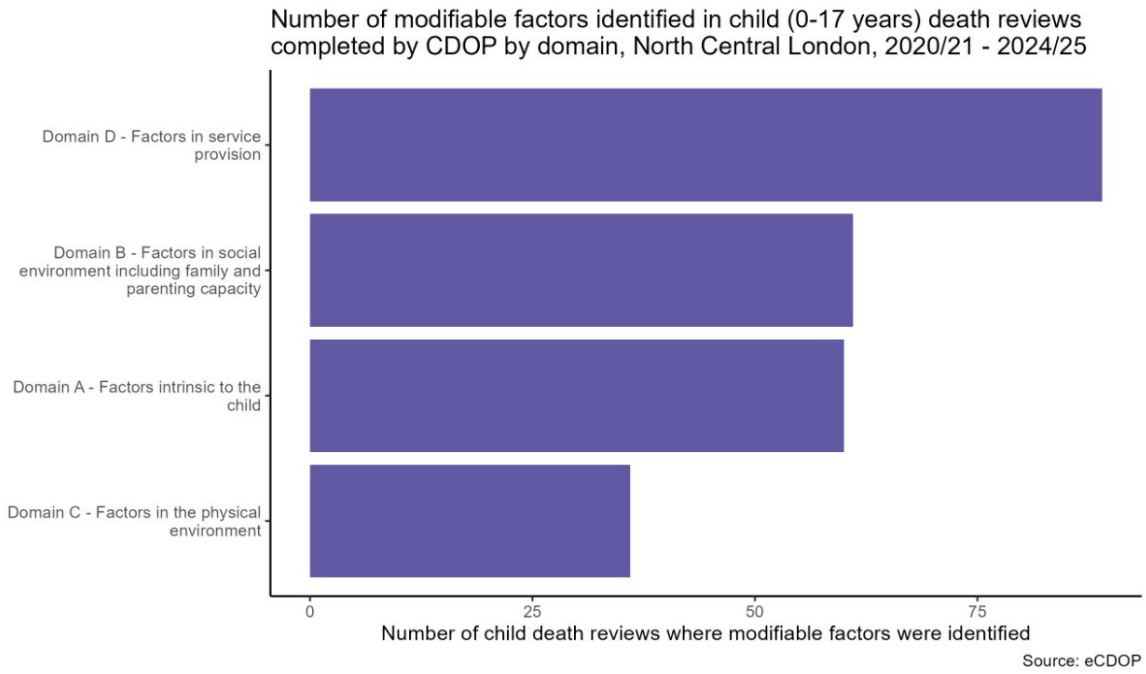
28.2% (n=115) of deaths occurred in children living in areas of NCL amongst the 20% most deprived in England.

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).



4.7 *Modifiable Factors*

23.1% (n=80) of reviews for child deaths occurring between 2020/21 – 2024/25 identified at least one modifiable factor. The largest number of modifiable factors were related to service provision, including delays in identification or initiating treatment or communication issues.

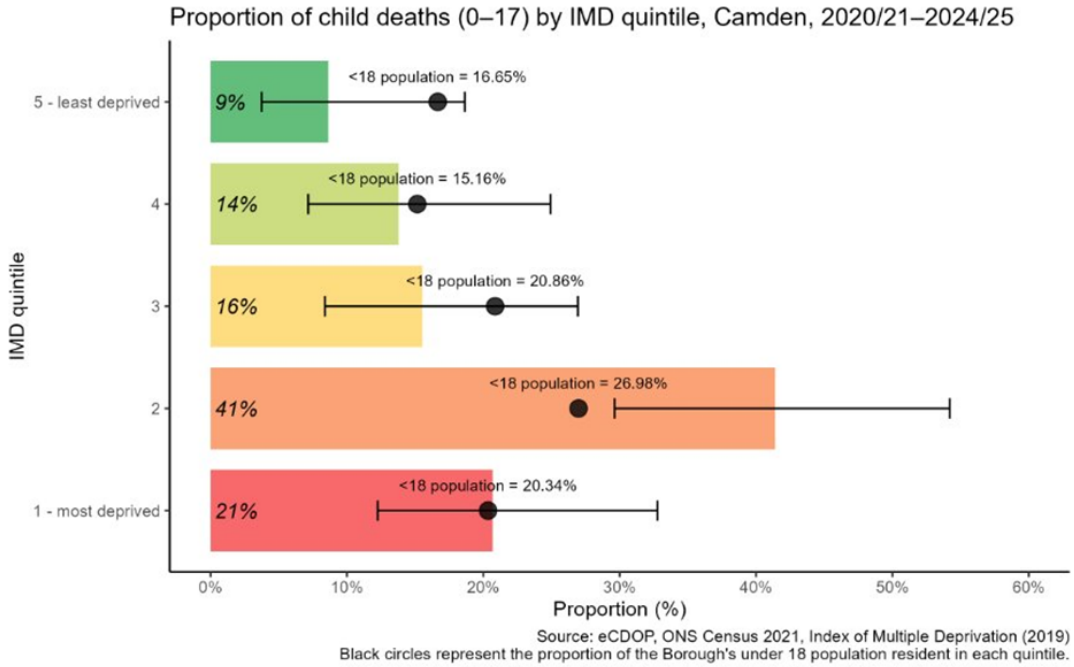


4.8 *Camden-specific findings*
Due to small numbers, findings for Camden should be interpreted as descriptive insight rather than statistically reliable evidence of trends or patterns. Trends and patterns are more accurately understood from the larger NCL-level dataset described above. For a descriptive analysis of child death notifications for each of the five NCL boroughs, please refer to pages 98–148 of the final report (attached as an Appendix).

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

4.8.2 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.

4.8.3 21% of deaths occurred in children living in areas amongst the 20% most deprived in England.



4.8.4 22% of completed reviews identified at least one modifiable factor. The most common modifiable factor domain was "factors in service provision" (53%).

5. Case review findings

5.1 The purpose of the case review process was to identify key themes emerging from the case notes from each child's death that was reviewed by CDOP, and system changes required in response.

5.2 The NCL CDOP met 14 times in 2024/25 and reviewed 145 child deaths. Because of the steps involved from the time a child dies to when their case is reviewed by CDOP, the number of individual cases reviewed by CDOP over the course of 2024/25 differs from the actual number of deaths occurring in 2024/25.

5.3 The key learning and actions resulting from the case review process fell under three broad headings:

1) *Wider determinants of health*. Under this heading, several learning points emerged related to:
    - Poverty and deprivation
    - Housing
    - Immigration-related issues
    - Maternal BMI
    - Unsafe sleeping
    - Consanguinity
    - Antenatal issues
2) *Communication*. Under this heading, learning emerged related to:

- General communication with families and care providers
- Culturally appropriate communication
- Language support
- Trust

3) *Other*. Under this broad heading, several learning points emerged related to:
    - Privacy after a child dies
    - Out of hours care
    - Pharmacies
    - Palliative care
    - Barriers to engaging with services
    - Engagement with the child death review process

5.4 Several examples for each of the above learning points can be found in the annual report on pages 65-76.

5.5 There were many examples of positive feedback from families about the excellent care and compassion provided by individuals, teams and services. Positive feedback from families and examples of excellent care fell into four categories:

- Support services
- Communication
- Parent-centred care
- Holistic support

5.6 Examples about positive feedback and excellent care can be found in the annual report on page 78.

5.7 Several cases revealed a complex mix of social factors that collectively contributed to a child's state of vulnerability and ill health. Preventative action in any of these areas could have made a difference to the family and prevented problems from getting worse. Two case studies, summarising these risk factors, are shown in the box below.

Case study 1: younger child's death	**Case study 2: older child's death**
• Incomplete immunisation status • Learning disability (non-verbal child) • Drug and alcohol use around the child • Family income deprivation • Overcrowded living conditions • English as an additional language • Lack of social support network in the UK • Parental mental health issues	• Involvement in gangs, and family history of gang involvement • Arrest and conviction for possession of a weapon • Exposure to domestic abuse in the home from a young age • Physical abuse by family member • Maternal mental health problems, domestic abuse, isolation and lack of support

	• Missed appointments with youth offending service • Family known to social services

6. Progress on actions

6.1 Last year, we asked CDOP to review its governance, reporting and surveillance processes. Since then, CDOP has improved its documentation and reporting practice and 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.

6.2 Other recommendations were made in last year's report in relation to:

- Safeguarding in context: health effects of child poverty and structural racism
- Safeguarding in context: continued, focused attention on families with social complexities
- Perinatal pathways
- Systems support – safer sleeping
- Systems support overall
- Communication

6.3 Examples of progress against these recommendations can be found in the annual report on pages 79-86.

6.4 This year we have recommended an approach to disseminated responsibility for action against these recommendations to better reflect their whole-systems nature.

7. Recommendations

7.1 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.

7.2 2026 priorities:

- Poverty Proofing and Stigma Reduction (Directors of Public Health to lead – Camden DPH has volunteered to lead this session)
- Domestic Abuse (Directors of Children's Services to lead)

7.3 2027 priorities:

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

7.4 2028 priorities:

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

7.5 Individual organisations have been identified to lead on different recommendations; these are listed below. Details are provided for those that require local action and Health and Wellbeing Board determination around how to ensure ownership and accountability.

- *For NCL ICS Mortality Group*
- *For NCL Directors of Public Health*
    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.
- *For Directors of Children's Services*

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.

- *For health service provider organisations and frontline staff*
    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.

- *For NCL Local Maternity and Neonatal System (LMNS)*
    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.

- *For NCL CDOP*

7.6 Complete details about each of these recommendations can be found in the annual report on pages 87-94

8. Finance Comments of the Director of Finance

The Director of Finance has been consulted on the contents of the report and has no comments to add to the report.

9. Legal Comments of the Borough Solicitor

The Children Act 2004 section 16M requires the child death review partners to make arrangements for the review of each death of a child normally resident in the area. The child death review partners must make arrangements for the analysis of information about death reviews which includes:

a) Identifying any matters relating to the deaths that are relevant to the welfare of children in the area or to public health and safety
b) To consider whether it should be appropriate for anyone to to take action in relation to any matters identified.

The child death review partners must, at intervals they consider appropriate, prepare and publish a report on what they have done under the arrangements to review deaths and how effective the arrangements have been.

10. Environmental Implications

There are no environmental implications to the contents of this report.

11. Appendices

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

REPORT ENDS