



SFR 26/2013

18 July 2013

Coverage: England

Theme: Health, well-being and Care

CHILD DEATH REVIEWS: YEAR ENDING 31 MARCH 2013

INTRODUCTION

This Official Statistical Release provides figures on child death reviews which have been completed by Local Safeguarding Children Boards in England between 1 April 2012 and 31 March 2013.

Local Safeguarding Children Boards are responsible for developing policies and procedures for safeguarding and promoting the welfare of children in their Local Authority area. From 1 April 2008, all Local Safeguarding Children Boards have had a statutory responsibility to review the deaths of all children from birth (excluding still born babies) up to 18 years, who are normally resident within their area. This is known as the Child Death Review Process. The duties of the Local Safeguarding Children Boards regarding these processes are set out in Chapter 7 of *Working Together to Safeguard Children* (HM Government 2010). Their responsibilities include setting up a Child Death Overview Panel (panels) which reviews child deaths on behalf of the Local Safeguarding Children Board.

Reviewing child deaths includes collecting information about the circumstances of the fatality, identifying if there were any modifiable factors¹ in the death and determining if there are lessons which could be learned to reduce future child deaths. However this is not an investigation into why a child has died and it is not a serious case review, although a serious case review may be completed in respect of a death where abuse or neglect were considered to be a factor.

The number of child death reviews completed has remained relatively stable over the past 3 years, as has the proportion of deaths where modifiable factors were identified. The main causes of deaths continue to be neonatal or perinatal events and chromosomal, genetic and congenital anomalies. This reflects the fact that nearly two thirds of deaths were children who were aged under 1 year. Factors present in the deaths reviewed have been collected for the first time, showing that issues such as co-sleeping, smoking in the household and poor parenting/supervision contribute to a number of child deaths.

COVERAGE

Data has been provided by all 148² Local Safeguarding Children Boards on behalf of all 92³ panels. This is the fourth year of this data collection. Reviewing child deaths is an extremely complex responsibility of the Local Safeguarding Children Boards. Please see the section on "Data Quality and Interpretation".

Issued by

Department for Education
Sanctuary Buildings
Great Smith Street
London SW1P 3BT

Telephone:
Press Office
020 7925 6789
Public Enquiries
0370 000 2288

Statistician
Sarah Wolstenholme

Email
info@education.gsi.gov.uk
Internet
<http://www.education.gov.uk/>

¹ A modifiable death is defined as where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

² Neighbouring Local Authorities may decide to share one Local Safeguarding Children Board, depending on the local configuration of services and population served.

³ Neighbouring Local Safeguarding Children Boards may decide to share a Child Death Overview Panel, depending on the local configuration of services and population served.

MAIN POINTS

Number of reviews completed

- 3,857 child death reviews were completed by Child Death Overview Panels in the year ending 31 March 2013. This is slightly lower than the number of reviews completed in the year ending 31 March 2012 (4% fewer reviews were completed the year ending 31 March 2013).
- Of the child death reviews completed in the year ending 31 March 2013, 806 were identified as having modifiable factors (21%). This is a slightly higher proportion than in the year ending 31 March 2012 (20%).
- In the year ending 31 March 2013, panels in the South West identified the highest proportion of modifiable factors in the child death reviews that they completed (29%) and the South East identified the lowest (15%).
- The deaths of 3,954 children who died in the year ending 31 March 2013 were notified to panels. 38% of these deaths had completed reviews by 31 March 2013. The remaining 62% of reviews were on-going at 31 March 2013.

Number of child deaths registered

- According to the Office for National Statistics (ONS), the deaths of 4,476 children who died in the year ending 31 March 2009 were registered in England. 4,409 were registered as occurring in the year ending 31 March 2010 and 4,173 in the year ending 31 March 2011.
- Data on registrations of deaths which occurred in the year ending 31 March 2012 and 2013 is not yet available. Assuming that the number of deaths in these two years is the same as the number of deaths which were registered as occurring in the year ending 31 March 2011, then approximately 21,400 children have died since the statutory responsibility to review child deaths was introduced on 1 April 2008. Approximately 81% of these child death reviews were completed by 31 March 2013.
- Panels reported that 3,954 deaths were notified to them as having occurred in the year ending 31 March 2013. This is a rate of 35 per 100,000 children in the population aged 0-17 years. (Based on mid 2011 population estimates).
- This rate varied greatly across regions with the rate in Inner London being the highest at approximately 45 per 100,000 children and the South East being the lowest at approximately 26 per 100,000 children.

Characteristics of child deaths where the review was completed

There were 22 deaths reviewed (0.6% of all reviews completed) where there was insufficient information available for the panel to determine if there were modifiable factors in a child's death. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information is provided to the panel.

The following findings refer to the child death reviews completed in the year ending 31 March 2013 where there was sufficient information available for the panel to determine if there were modifiable factors in the death (3,835 out of 3,857):

- Modifiable factors were identified in a higher proportion of deaths of children aged 28 days-364 days and children aged 15-17 years (with nearly 3 in every 10 deaths having modifiable factors

identified in these age groups) compared to the youngest of babies where only 16% of deaths in children ages under 28 days were identified as having modifiable factors. This could reflect the categories of death which occur more frequently in older children (for example suicide and road traffic accidents) and more frequently in infants (for example sudden unexpected deaths in infancy) which have a higher proportion of deaths with modifiable factors identified.

- Deaths of male children were more likely to have modifiable factors identified. However this is not a statistically significant difference.
- Panels are asked to categorise the likely cause of death. They also record the event which caused the death. For example a death due to accidental drowning would have the likely cause of death categorised as “Trauma and other external factors” and the event which caused the death would be recorded as “drowning”.
- 26% of all deaths which were identified as having modifiable factors were categorised as being due to “perinatal/neonatal events” A further 23% were categorised as being due to “sudden unexpected, unexplained deaths” and an additional 16% were due to “trauma and other external factors”.
- The tables below shows deaths categorised as being due to “deliberately inflicted injury, abuse or neglect” had the highest proportion of deaths identified as having modifiable factors. Deaths where the event which led to the death was “drowning” had the highest proportion of deaths identified as having modifiable factors.

Category of death	Percentage of deaths where modifiable factors were identified
Deliberately inflicted injury, abuse or neglect	65%
Sudden unexpected, unexplained death	63%
Trauma and other external factors	58%
Suicide or deliberate self-inflicted harm	46%
Acute medical or surgical condition	29%
Infection	26%
Chronic medical condition	16%
Perinatal/ neonatal event	15%
Chromosomal, genetic and congenital anomalies	7%
Malignancy	x
Unknown	x

Event which caused the child's death	Percentage of deaths where modifiable factors were identified
Drowning	61%
Apparent homicide	57%
Sudden unexpected death in infancy	57%
Road traffic accident/collision	56%
Apparent suicide	44%
Other non-intentional injury/ accident/ trauma	43%
Other	22%
Neonatal death	14%
Known life limiting condition	7%
Fire and burns	x
Poisoning	x
Substance misuse	x

BACKGROUND

The Local Safeguarding Children Boards data collection was introduced from 1 April 2008 and is designed to collect information on the number of child death reviews completed and the decisions made by Child Death Overview Panels on behalf of their Local Safeguarding Children Boards in England. This is the fifth year of collection.

Local Safeguarding Children Boards are responsible for reviewing the deaths of all children who are normally resident in their area, including children who die abroad or in another Local Safeguarding Children Board area. This may involve a number of Local Safeguarding Children Boards working together to address cross boundary issues.

The main objectives of reviewing all child deaths are to learn lessons in order to improve the health, safety and wellbeing of children and to reduce the number of future child deaths.

From 1 April 2010 onwards panels were asked to identify if there were modifiable factors in the death. Previously panels were asked to assess if the death was preventable or potentially preventable, but panels reported difficulties in distinguishing between these two categories, i.e. of factors which did contribute to the death and of factors which may have contributed to the death and ensuring a nationally consistent approach. Therefore these two categories were grouped and redefined as “modifiable factors”.

Panels are asked to identify modifiable factors in the child’s direct care by any agency, including parents, latent, organisational, systemic or other indirect failure(s) within one or more agency. Therefore a death identified as having modifiable factors may not necessarily be due to a failure of the Local Authority or other agencies to safeguard the child’s welfare.

The year ending 31 March 2013 is the third year in which panels were required to provide additional information about the child death reviews which had been completed by their panel, for example details about the child’s age, gender, ethnicity and cause of death.

England is the first country to put in place multi-agency arrangements that will provide a comprehensive understanding of the cause of all child deaths.

Legislation

The Children Act 2004 places a statutory duty on local authorities in England to set up Local Safeguarding Children Boards. One of the Local Safeguarding Children Boards’ functions, set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006 (SI No 2006/90), is to review the deaths of all children who are normally resident in their area. This function became mandatory in April 2008; although Local Safeguarding Children Boards had been able to do this since 2006. Chapter 5 in *Working Together to Safeguard Children* (HM Government 2013) sets out the guidance to be followed by Local Safeguarding Children Boards. It replaces the previous guidance published in 2006 and 2010.

The Coroners Rules 1984 as amended by the Coroners (Amendment) Rules 2008 place a duty on coroners to inform the Local Safeguarding Children Board, for the area in which the child died, of the fact of an inquest or post mortem. It also gives coroners powers to share information with Local Safeguarding Children Boards for the purposes of carrying out their functions, which include reviewing child deaths and undertaking Serious Case Reviews.

Registrars of births and deaths are required by the Children and Young Persons Act 2008 to supply Local Safeguarding Children Boards with information on the child’s death certificate. In addition, the Registrar General has a duty to provide the Secretary of State with information on all child deaths including those abroad.

DATA QUALITY AND INTERPRETATION

Not all child deaths which occurred in the year ending 31 March 2013 had completed child death reviews by 31 March 2013. This is because it may take a number of months (or years in some cases) to gather sufficient information to be able to fully review a child’s death, for example while panels wait for the

outcome from criminal proceedings, autopsies, coroners reports and Serious Case Reviews. Please note that although reviews may not have been completed by 31 March 2013, panels have begun to learn lessons from these cases and to take action to resolve the issues.

Panels encountered a number of issues in the first year of reviewing child deaths which reduced the number of reviews completed in the year ending 31 March 2009 and 31 March 2010. Therefore we would not expect the number of reviews completed in the year ending 31 March 2011 and onwards to be similar. Panels completed the reviews for nearly 20% more deaths in the year ending 31 March 2011 compared to the year ending 31 March 2010 and over 100% more than in the year ending 31 March 2009. The number of reviews completed in the year ending 31 March 2013 was very similar to the number reviewed in the previous year, suggesting that panels initial issues have been overcome and the number of reviews which are completed has stabilised (at approximately 4,000). The number of child death reviews completed in the year ending 31 March 2013 is lower than the previous year, however this does not necessarily mean that the number of deaths has fallen. Data published by the ONS suggests that the number of deaths of children aged 0-17 which are registered in England has fallen in recent years, but is only available up to the year ending 31 March 2011.

All panels provided data on the characteristics of the children who died and their panel reviewed the death. However in some panels not all information was known. For some panels this information was not collected in their panel, while others reported that it was collected, but not for all cases or the information was not readily available.

The table below shows the proportion of completed reviews where the information requested was not known (of the reviews where there was sufficient information available for the panel to determine if there were modifiable factors in the death). For all other data items requested the proportion of cases where the information was not known represented 1% or less of the completed reviews.

The proportion of cases where the information was not known varied greatly across panels and across regions.

	Proportion of completed reviews where this information was not known	Ranging from	Ranging to
Asylum seeking status	8%	0% in the South West	22% in Inner London
Ethnicity	7%	1% in the South West	11% in the East Midlands, East of England and South East
Statutory orders	5%	0% Yorkshire and the Humber	16% in Inner London
Child protection plans	4%	0% Yorkshire and the Humber	15% in Inner London

The proportion of cases recorded with information which is not known has declined since last year's data collection; however the proportion of cases where the child protection plan status was not known has remained at the same proportion.

Panels were able to provide data in aggregate form or at child level. A number of panels provided child level information, but as this information was provided for only 15% of all reviews completed it is not possible to identify national trends as this 15% may not be representative.

MAIN FINDINGS

Number of child death reviews completed

(This information can be found in Tables A-E)

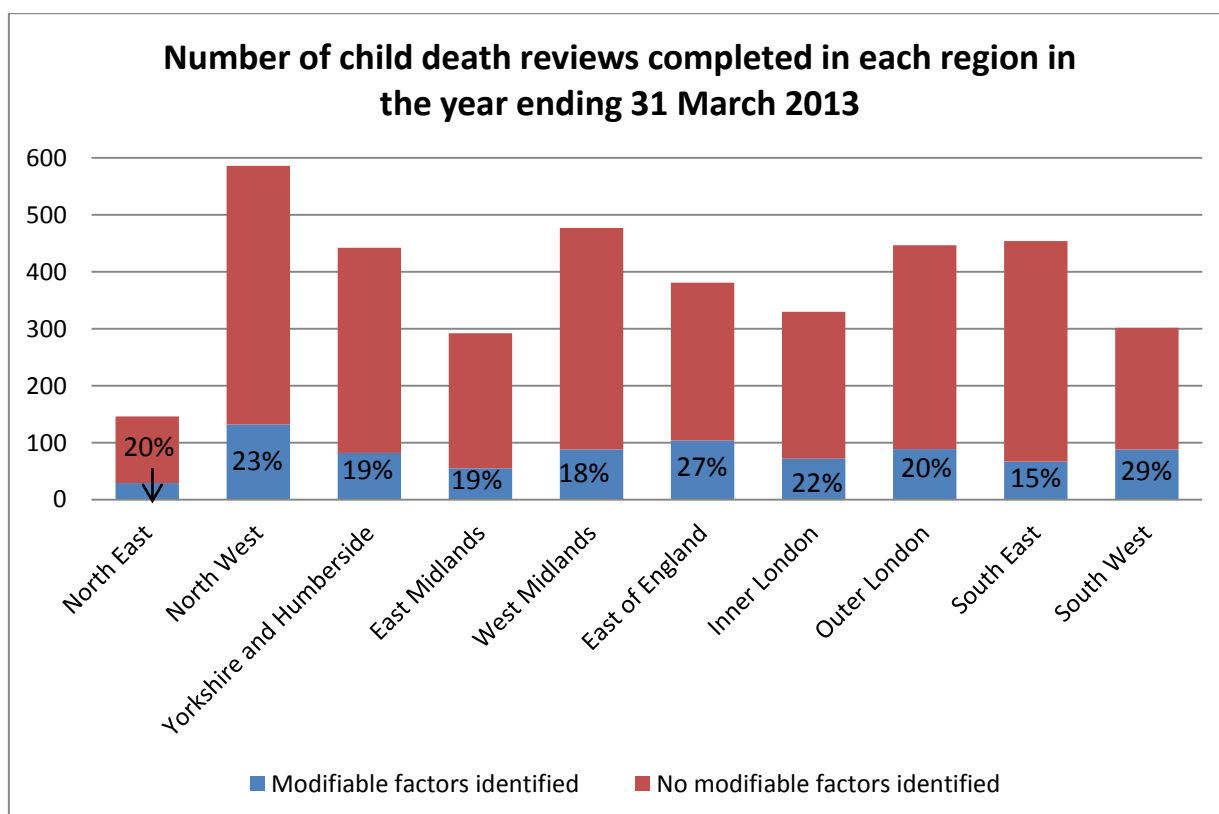
3,857 child death reviews were completed by panels in the year ending 31 March 2013. 806 of these deaths were identified as having modifiable factors. There were 22 deaths where there was not sufficient information available for the panel to determine if there were modifiable factors in the death.

The number of child death reviews which were completed within the year ending 31 March 2013 was slightly lower than the number reviewed in the previous year (4,012). The proportion of deaths identified as having modifiable factors was also the similar (21% in the year ending 31 March 2013 and 20% in the year ending 31 March 2012).

Panels reported that 3,954 deaths were notified to them as having occurred in the year ending 31 March 2013, this is a rate of 35 per 100,000 children in the population aged 0-17 years. (Based on mid 2011 population estimates). This rate varied greatly across regions with the rate in Inner London being the highest at approximately 45 per 100,000 children and the South East being the lowest at approximately 26 per 100,000 children.

Number of deaths which were identified as having modifiable factors in the year ending 31 March 2013

21% of all child death reviews completed in England were identified as having modifiable factors. The South West identified modifiable factors in the highest proportion of deaths (29%) and the South East identified the lowest (15%). This proportion of deaths where modifiable factors were identified in these two regions is statistically significantly different to the national proportion.



Proportion of child deaths where the review is complete

Approximately 81% of child deaths which occurred between the 5 years from 1 April 2008 to 31 March 2013 had had a completed child death review by 31 March 2013. (This calculation assumes that the numbers of child deaths which occurred in the years ending 31 March 2012 and 31 March 2013 are the same as the number of child deaths which occurred in the year ending 31 March 2011, as reported by the Office for National Statistics.)

Please note however that as panels experienced a number of difficulties in the first two years of reviewing child deaths, we may find that not all child deaths which occurred in the years ending 31 March 2009 and 31 March 2010 will have a completed child death review recorded in the data collection. This is because some panels struggled to gather sufficient information to fully review some of the child deaths and also some panels have misinterpreted the guidance to fully review all child deaths. Some child deaths had less in depth reviews or were not reviewed at all and therefore will not appear in the data collection tables.

Time between the child's death and completing the review

The deaths of 3,954 children who died in the year ending 31 March 2013 were notified to panels. 38% of these deaths had completed reviews by 31 March 2013. The remaining 62% of reviews were on-going at 31 March 2013.

The proportion of reviews which were completed varied greatly across regions. The North West completed the child death reviews for nearly half of the deaths which occurred in the year ending 31 March 2013 and were being led by a panel within their region. The South West completed reviews for less than an eighth of the deaths which occurred in the year ending 31 March 2013 and were being led by a panel within their region.

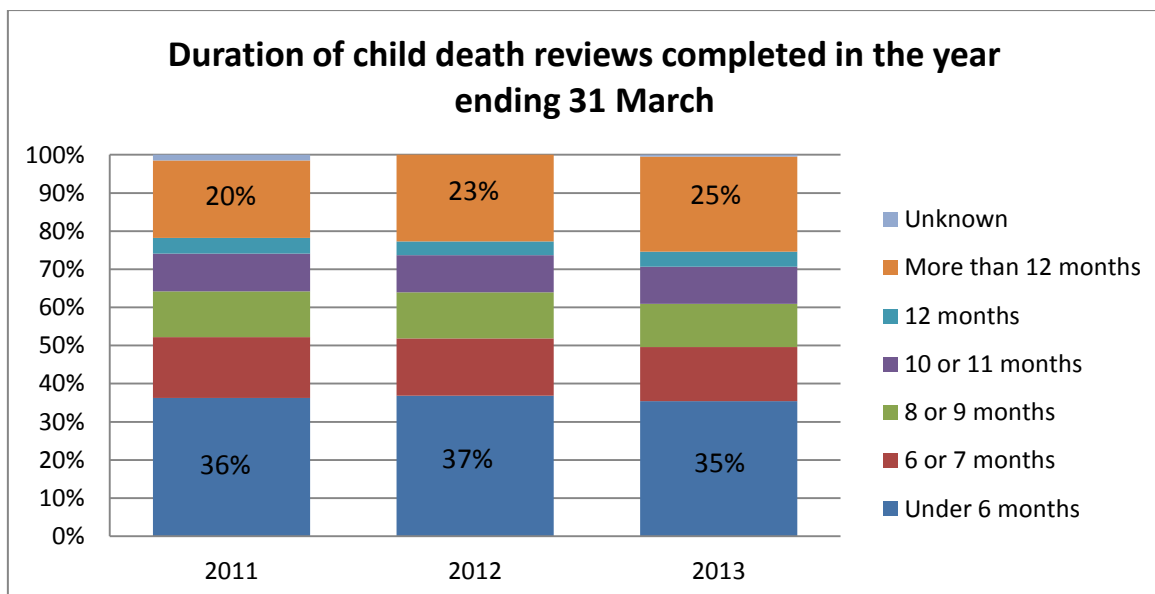
The proportion of child death reviews which are completed will greatly depend on the time of year in which the death occurred. For example if a large proportion of the deaths in the year happened towards the end of the year, we would not expect that the reviews for these deaths would be completed by the 31 March. It will also depend on the practice within the panel. For example some panels review deaths by themes to be able to identify trends, so it may be a number of months after a death until another similar death occurs and the deaths are reviewed together.

The following findings refer to child death reviews completed in the year ending 31 March 2013 where there was sufficient information available for the panel to determine if there were modifiable factors in the death:

The data collected suggests that reviews of child deaths are likely to take longer if modifiable factors are identified. This can be seen in Table D where nearly 40% of deaths which were identified as having modifiable factors took more than 12 months to complete the child death review, compared to 21% of deaths where no modifiable factors were identified. This can also be seen in Table B where 39% of all reviews completed in the year ending 31 March 2013 were for deaths which occurred in the year ending 31 March 2013, whereas 26% of deaths which were identified as having modifiable factors occurred in the year ending 31 March 2013. This is likely to be because more information needs to be gathered to make an accurate assessment of which factors were modifiable and to ensure that lessons are learned. It is also likely that it will take longer for all the information required to review the death to become available, for example coroners reports and the outcomes from criminal processing.

35% of child death reviews completed in the year ending 31 March 2013 took less than 6 months to complete and 25% took over one year to complete. The proportion of reviews which have taken

more than 1 year to complete has increased in recent years from 20% in the year ending 31 March 2011 as can be seen in the chart below.



Note: the durations in the chart above are for deaths where there was sufficient information to assess modifiable factors only.

Frequency of Child Death Overview Panel meetings

Panels met 6 times on average in the year ending 31 March 2013 and completed an average of 7 reviews per meeting. The average number of meetings varied greatly across regions, from 4 meetings in Outer London to 10 meetings in the East of England. There is strong relationship between the number of deaths registered as occurring each year and the number of meetings, i.e. in areas where there are a greater number of deaths there are a greater number of meetings.

The average number of reviews completed per meeting also varied, from 6 in Inner London, the North East, Yorkshire and the Humber and the East Midlands to 9 in the North West.

Reviewing deaths which occurred outside of the Local Safeguarding Children Boards area

(This information can be found in Table F)

Each Local Safeguarding Children Board (Board) is required to review the deaths of children aged 0-17 years old who are normally resident within their Board's area. However on occasion another Board may lead on reviewing a child's death or discuss the death within their panel if it is felt that there are lessons to be learned within the Board. For example if a child died on a road within an Board's area other than where the child was normally resident, then the two panels may work together and decide that it would be appropriate for the death to be reviewed by the panel where the child died as the main learning would be likely to be around road safety in that area.

For a small number of child deaths which were reviewed in the year ending 31 March 2013 the panel which completed the review was not the panel within the area where the child was normally resident (only 25 cases out of the 3,857 reviews completed). The main reason why another panel reviewed the death was because the child died in a hospital within the panel's area (this is the case for 72% of these deaths).

The South West led on reviews of the highest proportion of deaths where the child was not normally resident within the panels area; these cases represented 6% of all completed child death reviews in this region compared to 0.2% across the rest of England.

There were also a small number of cases where a death of a child who was not normally resident in the panels area was discussed, but the panel did not lead on the child death review (15 cases). Again the main reason these deaths were discussed was because of an "other reason" (this is the case for 53% of these deaths).

Actions Local Safeguarding Children Boards have taken following the reviews of child deaths

(This information was provided in free text fields so is not presented within a table, further information on the factors identified in the death reviewed can be found in table Q)

Panels have made a large number of recommendations in the year ending 31 March 2013, both locally and nationally, following child death reviews. These ranged from continuing to raise awareness of the dangers of smoking during pregnancy to working with families to ensure that child and baby car seats are securely fitted.

There are a number of issues which continue to be a concern to panels:

- Safe sleeping (including co-sleeping) - This continues to be a national issue and some panels have raised the need for safe sleeping messages to be shared with the wider family and anyone who may look after the child. In 3% of the deaths reviewed co-sleeping may have contributed to vulnerability, ill-health or death and in a further 1% co-sleeping provided a completed and sufficient explanation for the death (Please note that in 16% of the deaths reviewed this information was not available)
- Language barriers- access to health services especially emergency services.
- Consanguinity - Panels continue to be concerned that inter-family couples do not have sufficient understanding of the increased risks of having a child with a disability or of having a child die under the age of 5. In 2% of the deaths reviewed consanguinity may have contributed to vulnerability, ill-health or death and in a further 1% consanguinity provided a completed and sufficient explanation for the death (Please note that in 19% of the deaths reviewed this information was not available)
- Bereavement support-including the support offered to children following the death of a parent, carer or sibling.
- Smoking - A number of panels are working with pregnant women to highlight the risks of maternal smoking. They also continue to raise awareness of the risks of smoking in the home. In 7% of the deaths reviewed smoking by the parent/carers in a household may have contributed to vulnerability, ill-health or death and in 5% smoking by the mother during pregnancy may have contributed to vulnerability, ill-health or death (Please note that in 18% and 23% respectively of the deaths reviewed this information was not available)
- Road safety - this continues to be a main learning point for a number of panels. Actions ranged from improving links with the road safety teams to raising awareness of the importance of cycling helmets.

A number of issues have become of increasing concern to panels within the recent year:

- Safe bathing- A number of panels raised concerns about unsafe bathing practices.
- Suicide- The number of deaths due to suicide continues to be a concern to panels and they are taking actions in a number of areas, including working with the Samaritans and schools to

offer support.

- Domestic violence- In 3% of the deaths reviewed domestic violence may have contributed to vulnerability, ill-health or death. (Please note that in 16% of the deaths reviewed this information was not available.)
- Early recognition of sick children- a number of panels reported that they are working closely with health professions to improve the early recognition of illnesses.
- Ambulance procedures- a number of panels are reviewing procedures.
- Parental supervision- A number of panels reported that parental supervisions was a factors in accident related deaths and actions were being taken to address this. In 4% of the deaths reviewed poor parenting/supervision may have contributed to vulnerability, ill-health or death and in a further 1% poor parenting/supervision provided a completed and sufficient explanation for the death (Please note that in 14% of the deaths reviewed this information was not available)

Cause of death

(This information can be found in Tables G and H)

Panels are asked to categorise the likely cause of death. They also record the event which caused the death. For example a death due to accidental drowning would have the likely cause of death categorised as “Trauma and other external factors” and the event which caused the death would be recorded as “drowning”.

The following findings refer to the child death reviews completed in the year ending 31 March 2013 where there was sufficient information available for the panels to determine if there were modifiable factors in the death:

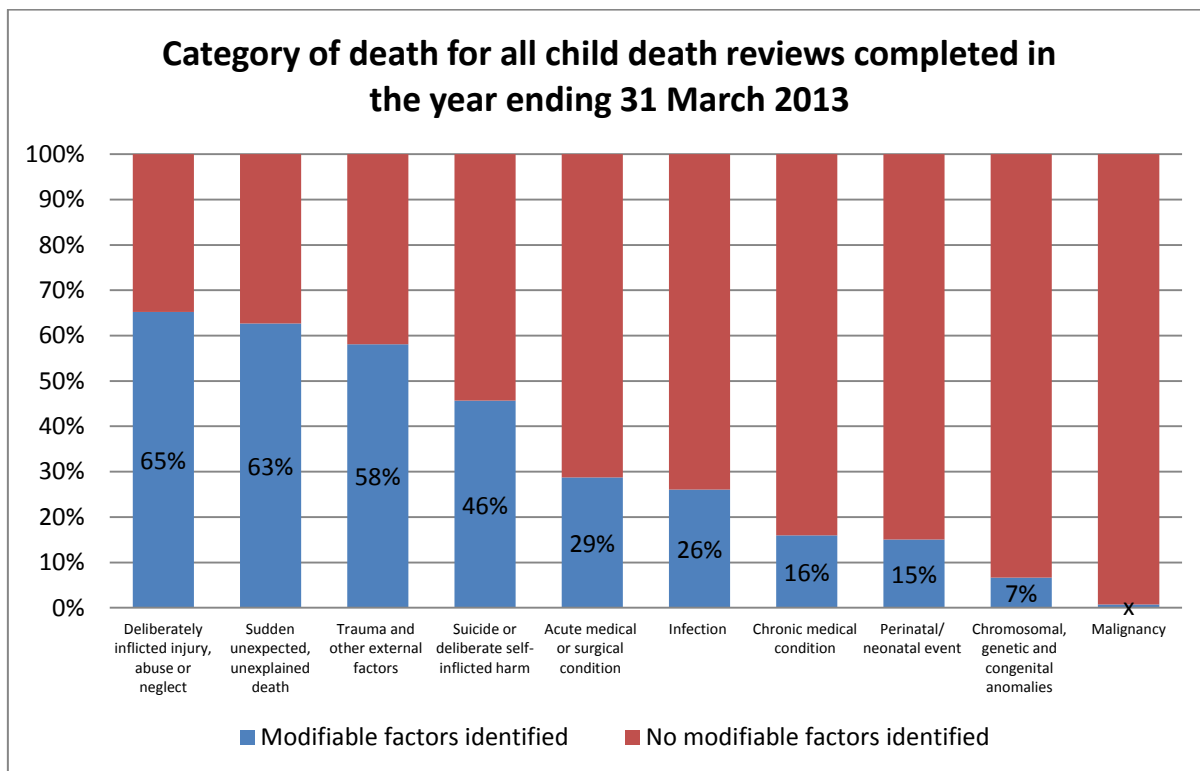
36% of all child death reviews completed involved deaths where the category of death was recorded as a “perinatal/neonatal event”, with a further 23% being due to “chromosomal, genetic and congenital anomalies”. This is to be expected as approximately two thirds of all completed child death reviews were for children aged under 1 year.

26% of all deaths which were identified as having modifiable factors were due to “perinatal/neonatal events”. A further 23% were due to “sudden unexpected, unexplained deaths” (this includes deaths where the pathological diagnosis is either sudden infant death syndrome or unascertained, therefore a number of these reviews are likely to be for deaths of infants) and an additional 16% were due to “trauma and other external factors” (this includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis and other extrinsic factors).

The category of death which had the largest proportion of cases identified as having modifiable factors was deaths due to “deliberately inflicted injury, abuse or neglect” (65% of these deaths were assessed as having modifiable factors). Over half of the deaths caused by:

- sudden unexpected, unexplained death and
- trauma and other external factors

were identified as having modifiable factors (63% and 58% respectively.)



Note: the categories in the chart above are for deaths where there was sufficient information to assess modifiable factors only and exclude deaths categorised as “unknown” due to small numbers.

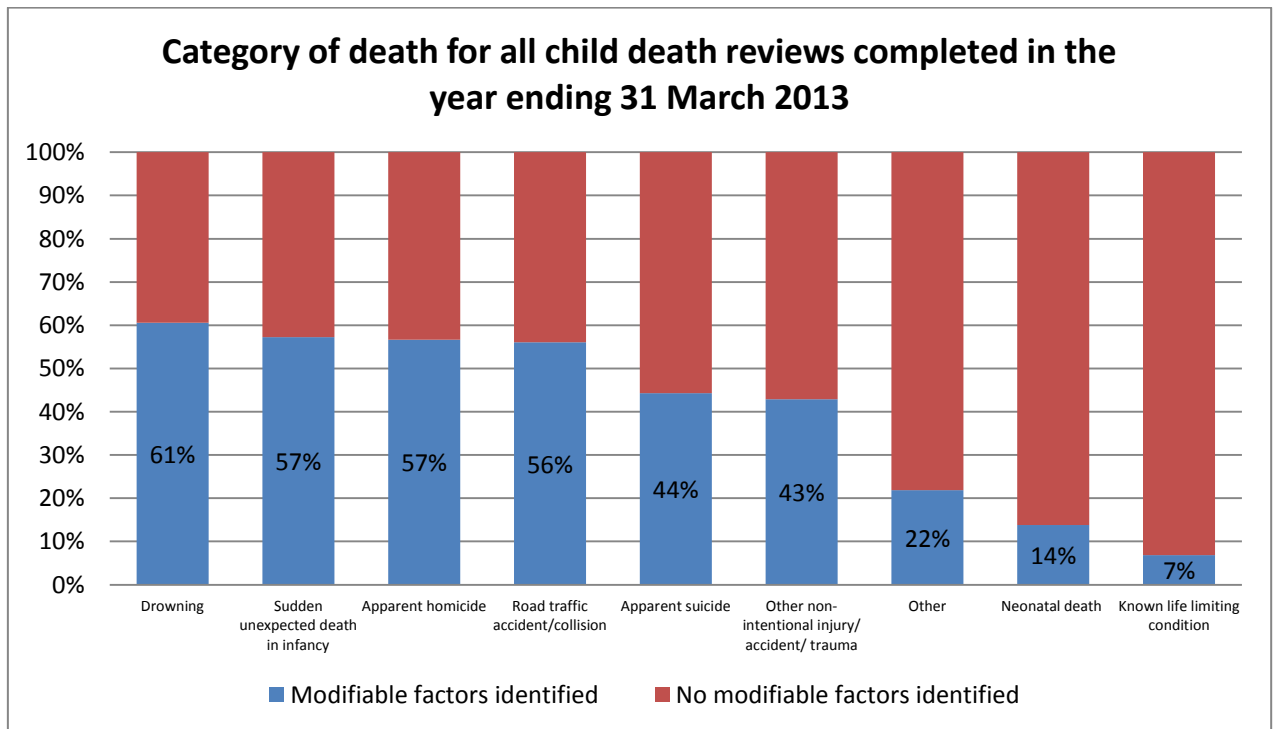
Please note, due to the small number of deaths (less than 100) which were categorised as being due to “deliberately inflicted injury, abuse or neglect” and “suicide or deliberate self-inflicted harm”, the proportion of these deaths which were identified as having modifiable factors should be treated with caution. Taking data for the year ending 31 March 2011, 2012 and 2013 together shows that across the three years 64% of deaths due to “deliberately inflicted injury, abuse or neglect” were identified as having modifiable factors and 52% of deaths due “suicide or deliberate self-inflicted harm” were identified as having modifiable factors.

The number of reviews completed where the death was categorised as “suicide or deliberate self-inflicted harm” was higher in the year ending 31 March 2013 compared to 2012 (30% increase) as was deaths categorised as “acute medical or surgical condition” (11% increase). The number of deaths under all other categories has remained stable or decreased.

Panels were also required to provide details of the event which caused the death. Over 50% of the deaths which were due to:

- drowning;
- apparent homicide;
- sudden unexpected death in infancy; and
- road traffic accident/collision

were identified as having modifiable factors (61%, 57%, 57% and 56% respectively).



Note: the events in the chart above are for deaths where there was sufficient information to assess modifiable factors only and exclude deaths due to “fire and burns”, “poisoning” and “substance misuse” due to small numbers.

Please note, due to the small number of deaths (less than 100) which were due to “drowning”, “apparent homicide”, “other non-intentional injury/ accident/ trauma”, “road traffic accident/collision”, and “apparent suicide” the proportion of these deaths which were identified as having modifiable factors should be treated with caution.

Taking data for three year ending 31 March 2011, 2012 and 2013 together shows that across this time period the following proportions of deaths were identified as having modifiable factors:

- 63% of deaths due to “drowning”;
- 53% of deaths due to “apparent homicide”
- 53% of deaths due to “other non-intentional injury/ accident/ trauma”;
- 59% of deaths due to “road traffic accident/collision; and
- 49% of deaths due to “apparent suicide”

The proportion of deaths due to “fire and burns”, “poisoning” and “substance misuse” which had modifiable factors identified have not been presented due to small numbers, even when looking across the three years ending 31 March 2011, 2012 and 2013 the figures are still very small (under 60) and under 10 for poisoning, however the proportions for the other two events have been presented below for information, but should be treated with caution:

- 87% of deaths due to “fire and burns” and
- 64% of deaths due to “substance misuse”;

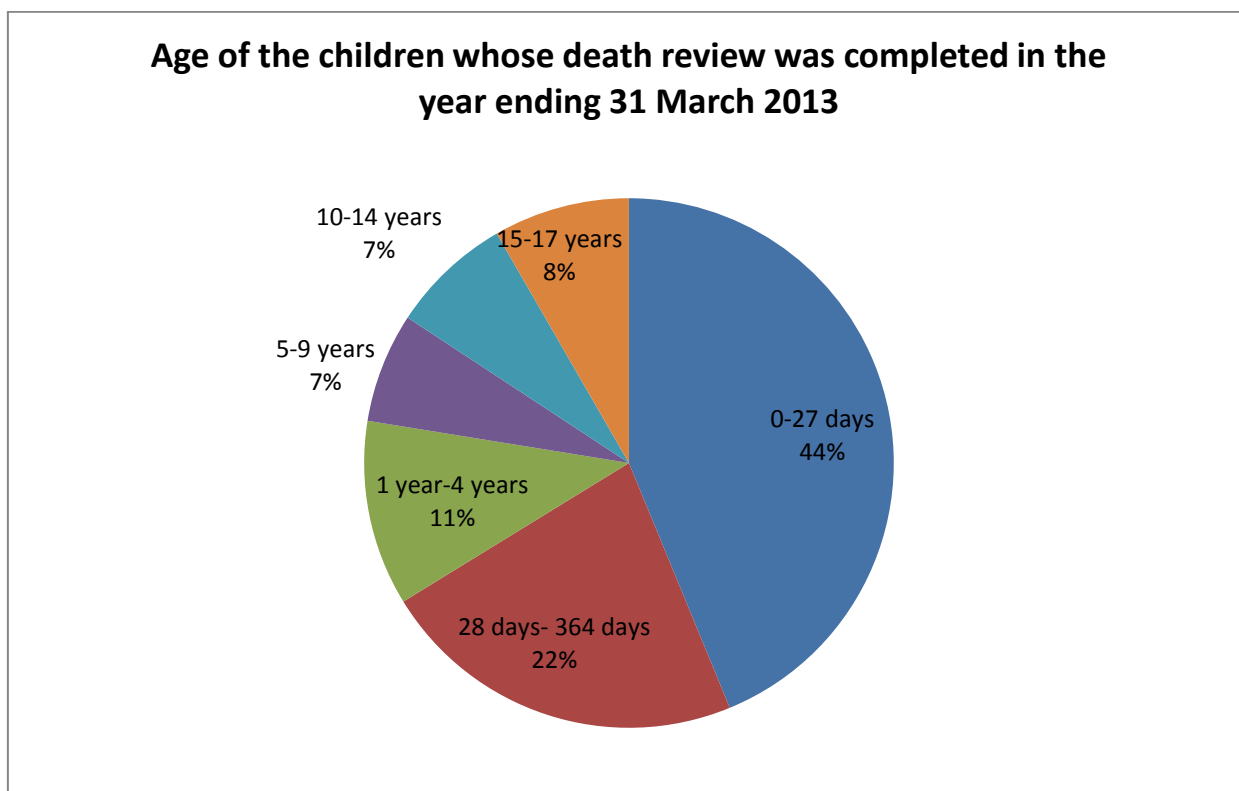
were identified as having modifiable factors.

Age of the child

(This information can be found in Table I)

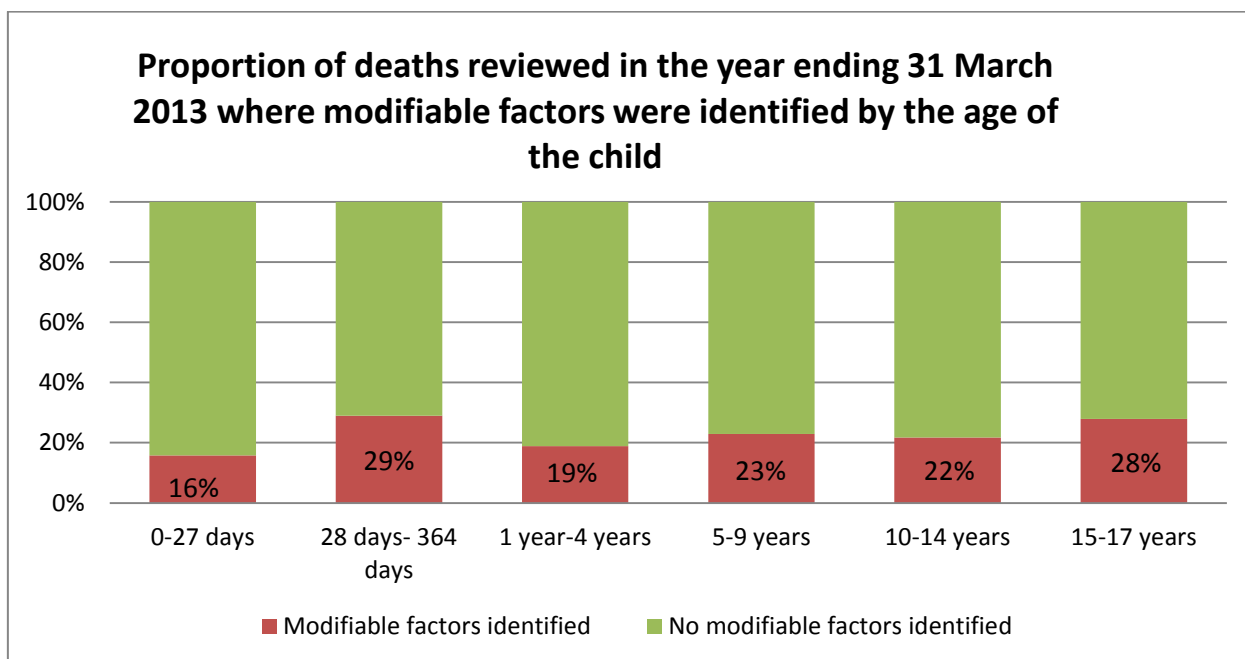
The following findings refer to the child death reviews completed in the year ending 31 March 2013 where there was sufficient information available for the panel to determine if there were modifiable factors in the death:

The majority of child death reviews completed in the year ending 31 March 2013 were for children aged under 1 year (66%).



Note: the ages in the chart above are for deaths where there was sufficient information to assess modifiable factors only.

Modifiable factors were identified in a higher proportion of deaths of children aged 28 days-364 days and children aged 15-17 years (with nearly 3 in every 10 deaths having modifiable factors identified in these age groups) compared to the youngest of babies where only 16% of deaths in children ages under 28 days were identified as having modifiable factors. This could reflect the categories of death which occur more frequently in older children (for example suicide and road traffic accidents) and more frequently in infants (for example sudden unexpected deaths in infancy) which have a higher proportion of deaths with modifiable factors identified.



Note: the ages in the chart above are for deaths where there was sufficient information to assess modifiable factors only.

Gender of the child

(This information can be found in Table J)

There were more reviews of male children's deaths completed in the year ending 31 March 2013 compared to female deaths. (57% of the child death reviews completed in the year ending 31 March 2013 where there was sufficient information available for the panel to determine if there were modifiable factors in the death). The latest data available (for 2011, as reported by the Office for National Statistics) show a slightly higher proportion of deaths registered in England were for male children, so we would expect that a slightly higher proportion of child death reviews were for male children.

Deaths of male and female children had similar proportion identified as having modifiable factors, (22% and 19% respectively of the child death reviews completed in the year ending 31 March 2013 where there was sufficient information available for the panel to determine if there were modifiable factors in the death). This difference is not statically significant.

Ethnicity

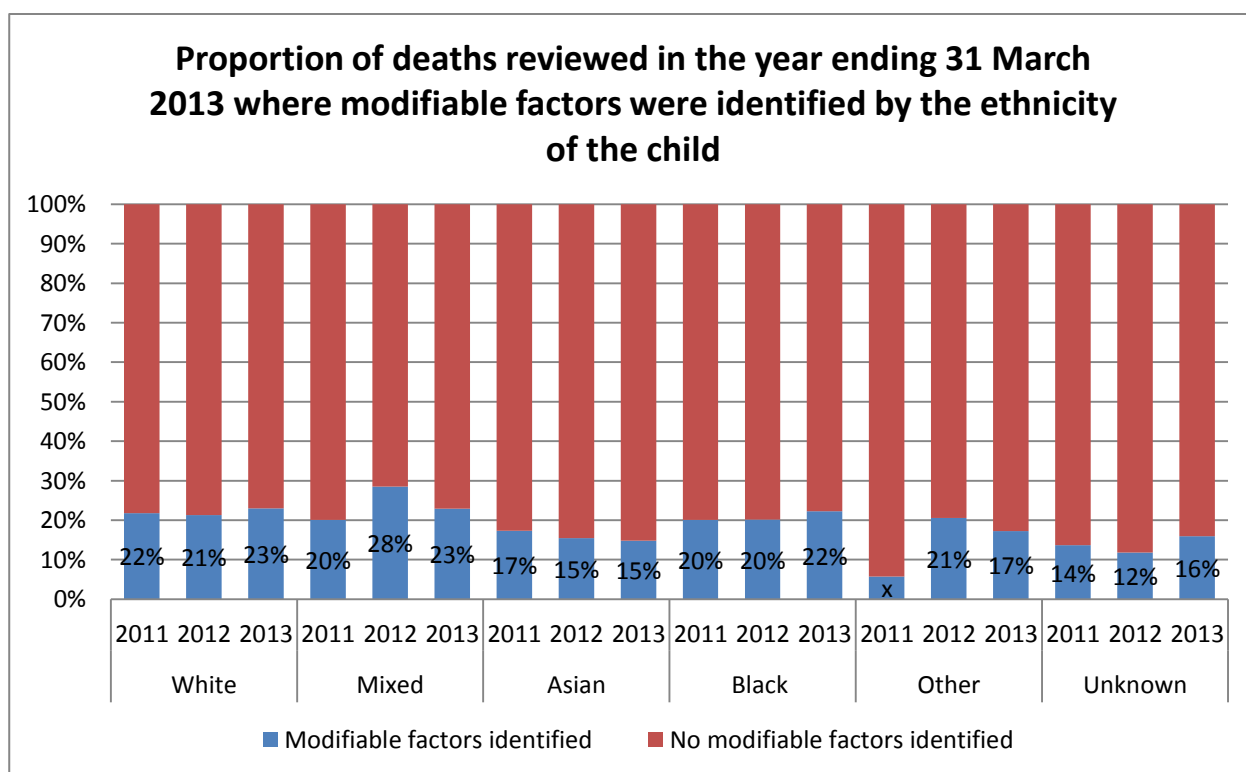
(This information can be found in Table K)

Please note that ethnicity was unknown in 7% of the reviews which were completed in the year ending 31 March 2013. This may be because this information was not collected or because it was not readily available in the required format. This is an improvement compared to last year where 9% of ethnicities were unknown.

The following findings refer to the child death reviews completed in the year ending 31 March 2013 where there was sufficient information available for the panel to determine if there were modifiable factors in the death:

The majority of child death reviews were for white children (62%). A similar proportion of deaths across white, mixed and black/black British children were identified as having modifiable factors (23% of deaths where the child was white or mixed and 22% where the child was black/black British). When the child was identified as being “Asian”, “unknown” or “other” ethnicity the proportion of deaths which were identified as having modifiable factors was significantly lower (15%, 16% and 17% respectively).

Data for the year ending 31 March 2012 found that the proportion of deaths where modifiable factors were identified was higher in mixed ethnicity children (28%). Data for the year ending 31 March 2011 found the proportion of modifiable deaths was similar across all ethnicities, so data for 2013 suggests a return to the trends seen in the year ending 31 March 2011.



Note: the chart above is based on deaths where there was sufficient information to assess modifiable factors only.

Place of the event which led to the child’s death

(This information can be found in Table L)

The following findings refer to the child death reviews completed in the year ending 31 March 2013 where there was sufficient information available for the panel to determine if there were modifiable factors in the death:

Panels reported that most children were in hospital at the time of the event which led to their death (68%). In 45% of the deaths where the child was in hospital the child was in a neonatal unit at the time of the event which led to their death. This reflects the high proportion of child deaths which are neonatal deaths and are likely to be children who have not left hospital since birth. If the child was in a hospital then there were a lower proportion of deaths identified as having modifiable factors (15%) compared to other known locations, such as a public place (52%), other private residence (47%), abroad (39%) and the home of normal residence (35%).

Please note, due to the small number of deaths (less than 100) where the child was abroad or at another private residence at the time of the event which led to their deaths the proportion of these deaths which were identified as having modifiable factors should be treated with caution.

Taking data for the year ending 31 March 2011, 2012 and 2013 together shows that across this time period 49% of deaths where the child was at an “other residence” at the time of the event which led to their death had modifiable factors identified and 44% where the child was abroad.

Children who were in a public place at the time of the event which led to their deaths had the highest proportion of deaths which were assessed as having modifiable factors (52%). This could reflect the high proportion of deaths due to road traffic accidents and drowning which were identified as having modifiable factors and which are likely to happen in a public place.

Asylum seekers

(This information can be found in Table M)

Please note the asylum seeking status of the child was unknown in 8% of the reviews which were completed. This may be because this information was not collected or because it was not readily available in the required format or the information that the panel gathered could not conclusively determine if the child was or was not an asylum seeker. This is an improvement compared to last year where 10% of asylum seeking status's were unknown.

The following findings refer to the child death reviews completed in the year ending 31 March 2013 where there was sufficient information available for the panel to determine if there were modifiable factors in the death:

The majority of child death reviews completed were for children who were known not to be asylum seekers (91%). Less than 1% were for children who were seeking asylum. Due to the small number of children identified as being asylum seekers at the time of their death, the proportion of deaths where modifiable factors were identified has not been published within the tables to ensure individual children cannot be identified.

The number of asylum seeking children is still very small when taking data for the year ending 31 March 2011, 2012 and 2013 together (approximately 50 children) so findings broken down by modifiable factors should still be treated with caution, but the data for these children show that the deaths of asylum seeking children are equally likely to have modifiable factors identified (21% in both groups).

Child Protection Plans and Statutory Orders

(This information can be found in Table N and Table O)

For 4% of the reviews completed it was not known if the child was the subject of a child protection plan. For 5% of the reviews completed it was not known if the child was the subject of a statutory order. This may be because this information was not collected, or because it was not readily available in the required format, or the panel could not conclusively determine if a child protection plan or a statutory order was in place from the information available.

The following findings refer to the child death reviews completed in the year ending 31 March 2013 where there was sufficient information available for the panel to determine if there were modifiable factors in the death:

1% of child death reviews completed were for children who were the subject of a child protection plan at the time of their death, with a further 2% having been the subject of a child protection plan previously, but not at the time of death. When the child was the subject of a child protection plan at the time of the death or prior to the death a higher proportion of cases were identified as having modifiable factors compared to children who were not the subject of a child protection plan (61% and 41% compared to 20%). Due to the small number of deaths where there was a child protection plan in place at the time of death, or prior to the death, the proportion of deaths which were identified as having modifiable factors should be treated with caution.

Taking data for the year ending 31 March 2011, 2012 and 2013 together shows that across the three years 52% of deaths where the child was the subject of a child protection plan at the time of their death and 39% of deaths where the child was the subject of a child protection plan previously were identified as having modifiable factors, compared to 20% where the child was never the subject of a child protection plan. However these findings are still based on a fairly small number of children so should be treated with caution.

1% of children were the subject of a statutory order at the time of their deaths, with a further 1% where the child had previously been subject to a statutory order, but not at the time of death. When the child was subject to a statutory order at the time of the death or previously, a higher proportion of cases were identified as having modifiable factors compared to children who were not subject to a statutory order (35% and 36% respectively compared to 21%). Due to the small number of deaths where there was a statutory order in place at the time of death or previously, the proportion of deaths which were identified as having modifiable factors should be treated with caution.

Taking data for the year ending 31 March 2011, 2012 and 2013 together shows that across the three years, 45% of deaths where the child was the subject of a statutory order at the time of their deaths and 34% where the child was the subject of a statutory order prior to their deaths were identified as having modifiable factors, compared to 20% where the child was never the subject of a statutory order. However these findings are still based on fairly small number of children so should be treated with caution.

Please note that where a child protection plan or a statutory order was in place at the time of the death and modifiable factors were identified in the death this does not necessarily mean that the modifiable factors identified were related to the child being the subject of a child protection plan or a statutory order.

Serious case reviews

(This information can be found in Table P)

The following findings refer to the child death reviews completed in the year ending 31 March 2013 where there was sufficient information available for the panel to determine if there were modifiable factors in the death:

A serious case review was carried out for 2% of all deaths. The majority of these serious case reviews were instigated by a body other than the panel, but approximately one fifth were recommended by the panel.

There were a small number of child deaths where the panel recommended a serious case review but this was not taken forward. However some panels reported that internal management reviews took place instead or it was decided that a serious case review was not appropriate following further information becoming available about the death.

The deaths which were the subject of serious case reviews had a higher proportion which were identified as having modifiable factors, compared to deaths where a serious case review was not appropriate (80% compared to 20%). However due to the small number of cases where a serious case review was carried out these findings should be treated with caution.

Taking data for the year ending 31 March 2011, 2012 and 2013 together shows that across the three years 76% of deaths which were the subject of serious case reviews had modifiable factors identified compared to 19% where there was no serious care review.

The number of child death reviews completed where a serious case review was also carried out was higher in the year ending 31 March 2013 compared to previous years (79 compared to 39 in 2012 and 39 in 2011). This does not necessarily mean that more serious case reviews were carried out during the year as the reviews of child deaths are not always completed in the year in which the child died or a serious case review is instigated.

A serious case review is carried out when abuse or neglect is known or suspected to be a factor in the death. We would expect therefore that modifiable factors would be identified in a higher proportion of deaths where there was a serious case review, as deaths due to “deliberately inflicted injury, abuse or neglect” have a higher proportion of deaths identified as having modifiable factors compared to other causes of death.

Factors identified in the reviews completed

(This information can be found in Table Q)

Please note that the data provided in the year ending 31 March 2013 was the first year that this information was requested, therefore these findings should be treated with caution. A small number of panels reported that this information was not available for any of the deaths reviewed (less than 10 panels) and further panels reported that this information was only available for deaths where modifiable factors were identified, this was due to issues with the data collection forms (less than 20 panels). For between 12% and 23% of the reviews completed there is not sufficient information available to determine if the factors requested were present. Panels were asked to record every factor present therefore children may be recorded against multiple factors.

In the reviews completed in the year ending 31 March 2013 the following factors provided a complete and sufficient explanation for more than 1% of all deaths:

- “Acute/Sudden onset illness” (31%)
- “Other chronic illness” (13%)
- “Other disability or impairment in the child” (2%)
- “Other factors” (3%) – including prematurity and mothers BMI

In the reviews completed in the year ending 31 March 2013 the following factors may have contributed to vulnerability, ill-health or death for 5% or more of all deaths:

- “Acute/Sudden onset illness” (5%)
- “Other chronic illness” (7%)
- “Smoking by the parent/carer in a household” (7%)
- “Smoking by the mother during pregnancy” (5%)

TABLES

Table A: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards

Table B: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by the year in which the child death occurred

Table C: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards in the same year in which the death occurred

Table D: Time between the death of a child and the completion of the child death review

Table E: Number of times which the Child Death Overview Panel met

Table F: Number of child deaths discussed by Child Death Overview Panels where the child was not normally resident within the Local Safeguarding Children Board area

Table G: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by category of death

Table H: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by event which caused the child's death

Table I: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by age of the child at the time of death

Table J: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by gender

Table K: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by ethnicity

Table L: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by location at time of the event or condition which led to the death

Table M: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by asylum seeking status

Table N: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by Statutory Order status

Table O: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by Child Protection Plan status

Table P: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by Serious Case Review status

Table Q: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by factors identified in the death

Tables (Excel file) will be added alongside this publication on the GOV.UK website. These will repeat the tables contained within this publication.

Tables showing the underlying data provided by all Local Safeguarding Children Boards will also be published alongside this publication on the DfE the GOV.UK website.

These tables will include the data provided in the additional tables in a format which may be more helpful to users who would like to complete further analysis.

TECHNICAL NOTES

Background

1. As stated earlier in the year ending 31 March 2010 panels were required to identify if the death was preventable or potentially preventable. Voluntary data from panels provided in the year ending 31 March 2010 suggested that approximately 15% of deaths were assessed as potentially preventable and a further 4% were assessed as preventable.
2. Reviews of similar deaths in subsequent years may result in different assessments of whether there were modifiable factors. Decisions may change as the process evolves and as panels build a consistent approach to understanding “modifiable factors”. In addition, local trends may begin to emerge which would suggest that similar deaths should be assessed as having had “modifiable factors”.
3. Most child deaths do not lead to a serious case review. A child death review is completed for every child that dies in England and includes:
 - (a) collecting and analysing information about each death with a view to identifying—
 - (i) any matters of concern affecting the safety and welfare of children in the area of the authority including any case giving rise to the need for a review mentioned in regulation 5(1)(e); and
 - (ii) any general public health or safety concerns arising from deaths of such children;
 - (b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

A Serious Case Review is initiated where:

- (a) abuse or neglect of a child is known or suspected; and
- (b) either—
 - (i) the child has died, or
 - (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child’s welfare.

If it is thought, at any time, that the criteria for a serious case review might apply, the Chair of the Local Safeguarding Children Boards should be contacted and the serious case review procedures followed.

Not all deaths which result in a serious case review will be assessed as having modifiable factors.

4. For information and guidance on the child death review processes please visit:
<http://www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/childdeathreview>

The data collection forms used to gather information for this publication can also be found at the link above.

Chapter 5 – Child death reviews

Taken from Working Together to Safeguard Children 2013

<http://www.education.gov.uk/aboutdfe/statutory/q00213160/working-together-to-safeguard-children>

Chapter 7 – Child death review processes

Taken from Working Together to Safeguard Children 2010

<http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eOrderingDownload/00305-2010DOM-EN.pdf>

5. Other data and research with may be of interest can be found below:

- Munro review of Child Protection:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf
- Scoping review to draw together data on child injury and safeguarding and to compare the position of England with that in other countries:
<https://www.gov.uk/government/publications/scoping-review-to-draw-together-data-on-child-injury-and-safeguarding-and-to-compare-the-position-of-england-with-that-in-other-countries>
- Mortality Statistics Deaths registered in 2011:
<http://www.ons.gov.uk/ons/rel/vsob1/mortality-statistics--deaths-registered-in-england-and-wales--series-dr-/2011/stb-deaths-registered-in-england-and-wales-in-2011-by-cause.html>
- Mortality Statistics: Childhood, infant and perinatal:
<http://www.ons.gov.uk/ons/rel/vsob1/child-mortality-statistics--childhood--infant-and-perinatal/2011/stb-cms-2011.html>
- New learning from serious case reviews: a two year report for 2009-2011
Chapter 2: Setting serious case review data in context with other data on violent 12 and maltreatment-related deaths in 2009-10
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/184053/DFE-RR226_Report.pdf
- Infant mortality
<http://www.nchod.nhs.uk/>
Click on the 'compendium of indicators' across the top of the screen and then 'indicator specifications'. Then click on "alphabetically" and go to 'M' for morality from various causes.
- Why Children Die: A pilot study (2006) (May 2008)
<http://www.publichealth.hscni.net/publications/why-children-die-pilot-study-2006>

Tables

6. The proportion of all deaths which have been reviewed by each region in Table A has been estimated using the number of deaths registered as occurring between 1 April 2010 and 31 March 2011 for children aged 0-17 years old as reported by the Office for National Statistics (ONS). The number of child deaths registered has fallen in recent years, but does not vary by a large number year on year. (Decreasing by a maximum of 5% in a single year over the 3 year period). Deaths are not always registered in the year in which they occur, so the number of deaths registered over a period of time is not always the same as the number of deaths which occurred over the same period of time.
7. The figures in Table A are based on data provided by all 148 Local Safeguarding Children Boards. One of these Local Safeguarding Children Boards reported that they had not reviewed any child

deaths during the year, and other Local Safeguarding Children Boards have reviewed a small number of deaths. The reasons for this include:

- some Local Safeguarding Children Boards are responsible for reviewing the deaths of very few children, therefore if there were delays in notifications or the death occurred toward the end of the year then a high proportion of these deaths may not have been reviewed by 31 March 2013;
 - some panels experienced difficulties in gathering sufficient information to review child deaths, for example from the health services (especially where incomplete information was known about the child) or where the child had died outside the country, which caused delays in the review;
 - reviews have been delayed as panels wait for outcomes from for example, serious case reviews, criminal investigations and post mortems.
8. Some panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. In some cases this was because it was not possible to gather further information. For example if the coroner was unable to conclusively determine the cause of death. In other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel.

Confidentiality

9. In order to protect individual data, numbers from 1 to 5 inclusive have been suppressed and are shown as crosses (x). Where any number is shown as zero (0), the original figure submitted was zero. Percentages are shown rounded to whole numbers but where the numerator was five or less or the denominator was 10 or less, they have been suppressed and replaced by a cross. Where a percentage is zero because the number from which that percentage has been calculated is a zero, the percentage is shown as zero. (.) represents values which are not applicable. (-) represents percentages less than 0.5% but greater than 0%.
10. It has been necessary to suppress other figures whenever it would be possible to calculate the value of a suppressed number by means of simple arithmetic. The rule applied in these circumstances has been to suppress the next smallest data item provided its value is strictly less than 20.
11. In some cases it would still be possible to identify individual data when figures are suppressed, therefore in these cases values have been rounded to the nearest 10.
12. For some national tables where information is categorised as "unknown", providing numbers from 1 to 5 is sufficient and practical. This avoids unnecessary destruction to the data which would result from having to apply secondary suppression.
13. All tables are presented at national and regional level due to small numbers at local level. Providing these data at local authority, Local Safeguarding Children Board or panel level could risk individual children being identified.
14. As part of a Government drive for data transparency in official publications supporting data for this publication has been made available. Within the underlying data provided by all Local Safeguarding Children Boards the number of child death reviews completed and the number of these completed reviews which were identified as having modifiable factors has been provided at local authority level.

Revisions

15. There are no planned revisions to this Statistical Release, however, if at a later date we need to make a revision this will comply with the Departmental revisions policy which is published at: <https://www.gov.uk/government/organisations/department-for-education/about/statistics#announcements-and-information>

An Official Statistics publication

16. This is an Official Statistics publication. Official Statistics are produced to high professional standards set out in the National Statistics Code of Practice. They undergo regular quality assurance reviews to ensure that they meet customer needs. They are produced free from any political interference.
17. Please contact Sarah Wolstenholme at Sarah.Wolstenholme@education.gsi.gov.uk if you have comments on the content or presentation of this release so that we can take account of your needs in future editions.

ENQUIRIES

Enquiries about the figures contained in this press release should be addressed to:

Safeguarding and Vulnerable Children's Analysis Team
Department for Education
Ground floor, Sanctuary Buildings
Great Smith Street
LONDON, SW1P 3BT
Telephone Number: 01325 735408
Email: Andy.Brook@education.gsi.gov.uk

Press enquiries should be made to the Department's Press Office at:

Press Office Newsdesk,
Department for Education
Sanctuary Buildings
Great Smith Street
LONDON
SW1P 3BT
Telephone Number: 0207 9256789