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PREVENTABLE CHILD DEATHS IN ENGLAND: YEAR ENDING 31 MARCH 2010

INTRODUCTION

This Official Statistical Release (OSR) provides figures on child death reviews which have been completed by Local Safeguarding Children Boards (LSCBs) in England between 1 April 2009 and 31 March 2010.

LSCBs 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 LSCBs 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 (CDRP). The duties of the LSCB 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 (CDOP) which reviews child deaths on behalf of the LSCB.

Reviewing child deaths includes collecting information about the circumstances of the fatality, assessing if the death was preventable 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 (SCR), although a SCR may be completed in respect of a death where abuse or neglect were considered to be a factor.

Data has been provided by all 145[1] LSCBs on behalf of all 93[2] CDOPs. 2009-10 was the first year which panels were asked to provide additional voluntary data about the Child Death Review Process and these data were provided on behalf of 123 out of the 145 LSCBs.

NOTE ON INTERPRETATION

This is the second year of this data collection and reviewing child deaths is an extremely complex responsibility of the LSCBs. Therefore these figures should be interpreted with caution. Please see the section on Data Quality and Interpretation.

KEY POINTS

- 3,450 child death reviews were completed by Child Death Overview Panels (CDOPs) in the year ending 31 March 2010.
- Of the child death reviews completed in the year ending 31 March 2010, 150 were assessed as preventable.
- Inner London has the highest proportion of deaths which were assessed as preventable in 2009-10 (6%) and the North West region has the lowest proportion (2%).

[1] Neighbouring Local Authorities may decide to share one LSCB, depending on the local configuration of services and population served

[2] Neighbouring LSCBs may decide to share a CDOP, depending on the local configuration of services and population served

- Each year there are approximately 5,000 child deaths registered in England, so approximately 10,000 children have died since the statutory responsibility to review child deaths was introduced on 01 April 2008. Approximately 57% of these child deaths had their child death review completed by 31 March 2010 (Based on the number of deaths registered in 2008. This has been used as an estimate for the total number of child deaths in 2008-09 and 2009-10 as in England the number of child deaths do not vary greatly year on year).
- Based on voluntary data provided by 122 out of the 145 LSCBs, approximately 75% of child deaths which occurred in 2008-09 had their child death review completed by 31 March 2010. 39% of child deaths which occurred in 2009-10 had their child death review completed by 31 March 2010 (Based on voluntary data provided by 115 LSCBs)
- Voluntary data provided by 119 LSCBs indicates that the majority of deaths which were assessed as preventable in 2009-10 were due to trauma and other external factors (54%).
- 27% of deaths which were assessed as preventable in 2009-10 were due to road traffic accidents, followed by other events (15%) and other non-intentional injury, accidents or trauma (13%). (Based on voluntary data provided by 96 LSCBs).
- 27% of deaths which were assessed as preventable in 2009-10 were for children aged 1-4 years, followed by children aged 15-17 years (26%) and children aged 10-14 years (19%). (Based on voluntary data provided by 116 LSCBs).
- Voluntary data provided by 118 LSCBs indicates that deaths of males and females are equally likely to be assessed as preventable child deaths, with 4% of male and female deaths being assessed as preventable.
- CDOPs assess if a child's deaths was preventable, potentially preventable or not preventable and voluntary data provided by 119 LSCBs indicated that 15% of child deaths were assessed as potentially preventable. This means that there were potentially modifiable factors extrinsic to the child. The most common cause of death which was assessed as potentially preventable was sudden unexplained death in infancy (27%).

BACKGROUND

The Children Act 2004 places a statutory requirement on local authorities in England to set up Local Safeguarding Children Boards (LSCBs). One of the LSCBs' 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 LSCBs had been able to do this since 2006. Chapter 7 in *Working Together to Safeguard Children* (HM Government 2010) sets out the guidance to be followed by LSCBs.

The LSCB data collection was introduced from 1 April 2008 and is designed to collect information on the number of child death reviews which have been completed by Child Death Overview Panels (CDOPs) on behalf of their LSCBs, and the number of these cases which were assessed as being preventable child deaths in England. This is the second year of collection.

2009-10 is the first year in which LSCBs were asked to provide additional optional information about the child deaths which had been reviewed by their CDOP, for example details about the child's age, gender, ethnicity and cause of death. Data collected in 2010-11 will require this breakdown from all LSCBs at aggregate level, although LSCBs will have the option to provide child level forms.

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

The key objectives of reviewing all child deaths are to learn lessons in order to improve the health, safety and well being of children and to reduce future incidence of preventable child deaths.

For the purposes of reviewing child deaths preventable and avoidable factors are defined as: *Events, actions or omissions contributing to the death of a child or to substandard care of a child who died, and which, by means of national or locally achievable interventions, can be modified.*

Please note panels are asked to identify preventable or avoidable 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 preventable death may not necessarily be due to a failure of the Local Authority to safeguard the child's welfare.

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.

In England, there are currently approximately 4,800 deaths of children registered per year.

Legislation

The Children Act 2004 includes a requirement on Local Authorities in England to set up Local Safeguarding Children Boards (LSCBs) by 1 April 2006.

One of the functions of LSCBs 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. The requirement for LSCBs to undertake their functions relating to child deaths did not apply until 1 April 2008. However LSCBs could decide to undertake these functions from 1 April 2006. The statutory guidance *Working Together to Safeguard Children* (2010) sets out how the child death review process should be undertaken. It replaces the previous guidance used in 2006.

The Coroners Rules 1984 as amended by the Coroners (Amendment) Rules 2008 place a duty on coroners to inform the LSCB, 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 LSCBs for the purposes of carrying out their functions, which include reviewing child death and undertaking Serious Case Reviews.

Registrars of Births and Deaths are required by the Children and Young Persons Act 2008 to supply LSCBs 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

LSCBs are required to assess if a child death is preventable, potentially preventable or not preventable. This data collection does not include details of the number of deaths which were assessed as potentially preventable for all LSCBs, although this information is available for LSCBs which provided voluntary data. It also excludes reviews of child deaths which were ongoing at the 31 March 2010 where a decision about preventability had yet to be made.

COVERAGE AND MISSING DATA

Not all child deaths which occurred in 2009-10 had been fully reviewed by 31 March 2010 by their CDOP. 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 2010, panels have begun to learn lessons from these cases and to take action to resolve the issues.

This is the second year that child deaths have been reviewed and data collected from LSCBs. Panels encountered a number of issues in the first year of reviewing child deaths and this may have affected the data collected for this second year and will also affect comparisons between data collected in 2008-09 and 2009-10. This will also affect comparisons made with data collected in the future as we may not expect to see similar trends in the number of child death reviews completed and the number of preventable child deaths in future years.

We may also find that child deaths which occurred in 2008-09 will not all have a child death review completed because of the difficulties panels experienced in the first year of reviewing child deaths.

FINDINGS FROM THE ADDITIONAL OPTIONAL DATA COLLECTED FROM CDOPS

LSCBs were asked to provide additional data items on a voluntary basis. Data was provided on behalf of 123 out of the 145 LSCBs in England to at least one of the 17 additional data items. (This data was provided on behalf of 129 out of the 152 Local Authorities). As not all LSCBs were required to provide data we cannot be sure that these findings accurately reflect national proportions, therefore these data should be treated with caution.

Key findings

Number of child death reviews completed

(This information can be found in tables A, B, D, E and Q)

Changes in the number of child deaths which were assessed as preventable

There has been an increase in the number of child death reviews completed by Child Death Overview Panels (CDOPs), from 2,000, in the year ending 31 March 2009 to 3,450 in the year ending 31 March 2010. The number of child deaths which were assessed as preventable has increased from 110 in the year ending 31 March 2009 to 150 in the year ending 31 March 2010, however as the number of completed child death reviews has increased over the period the proportion of deaths which were assessed as preventable has fallen from 5% to 4%. The change in proportions reflects the issues which panels encountered in assessing preventability (please see the section on data quality below) so these figures should be treated with caution.

The number of completed child death reviews which were assessed as preventable varies greatly across each region, from a high of 6% in Inner London to a low of 2% in the North West. Most regions have seen a decrease in the proportion of deaths which were assessed as preventable between 2008-09 and 2009-10, with the largest decrease being seen in the South West, from 15% to 5%. As the number of child death reviews completed and the number of these assessed as preventable is fairly small in each region these proportions should be treated with caution. A change of only a small number of child deaths being assessed as preventable can result in a large change in the proportion.

Data quality

These proportions may also have been affected by the issues which panels encountered as they began the child death review process. Some CDOPs had difficulties in interpreting the definition of preventability, which meant that they were unable to assess a number of deaths which occurred in 2008-09 by the 31 March 2009, therefore these reviews were completed in 2009-10. This meant that some of the most complex cases, and most likely to be preventable, were assessed in 2009-10 which may have artificially increased the proportion of deaths which were assessed as preventable in 2009-10 for these panels. On the other hand some CDOPs prioritised the order in which they reviewed child deaths to make sure that the most complex deaths, where they needed to learn lessons, and were likely to be assessed as preventable, were fully reviewed by 31 March 2009, which may have meant that the proportion of child deaths assessed as preventable in 2008-09 was artificially high for these panels. So these figures should be treated with caution.

Time between the child's death and completing the review

Of the child death reviews completed in 2009-10 approximately half were for deaths which occurred in 2008-09 and half for deaths which occurred in 2009-10. However when we look at the proportion of deaths which were assessed as preventable, 69% of these deaths occurred in 2008-09 and 27% occurred in 2009-10, suggesting that the reviews of preventable child deaths are likely to take longer than deaths which are not assessed as preventable. (Based on voluntary data provided by 122 LSCBs). This is likely to be because more information needs to be gathered to make an accurate assessment of preventability and to ensure that lessons are learned.

42% of child death reviews are completed within 6 months of the date the child died and 11% of reviews take more than 12 months to complete. (Based on voluntary data provided by 113 LSCBs). However these proportions vary greatly across the regions with 5% of child deaths in the East of England and 19% of deaths in the South West taking more than 12 months to complete.

Proportion of child deaths where the review is complete

Approximately 60% of child deaths which occurred between the 2 years from 01 April 2008 to 31 March 2010 had had a completed child death review by 31 March 2010. (Based on assuming that the number of child deaths which occurred in 2008-09 and 2009-10 is the same as the number of child deaths which were registered in the calendar year 2008 and reported by the Office for National Statistics). Please note however that as panels experienced a number of difficulties in the first year of reviewing child deaths, 2008-09, we may find that not all child deaths which occurred in 2008-09 will have a full 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.

Approximately 75% of all child deaths which occurred in 2008-09 had a completed child death review by 31 March 2010 and 39% of child deaths which occurred in 2009-10 also had a complete child death review by 31 March 2010. (Based on voluntary data provided by 122 and 115 LSCBs respectively and estimates of the number of child deaths in 2008-09 using the ONS death registration data for calendar year 2008)

Notifications of child deaths

(This information can be found in table C)

Most CDOPs reported that they were informed of child deaths very soon after they occurred, with only 2% of the notifications received in 2009-10 being for deaths which occurred in 2008-09. (Based on voluntary data provided by 115 LSCBs).

Reviewing deaths which occurred outside of the LSCB area

(This information can be found in table F)

Each LSCB is required to review the deaths of children aged 0-17 who are normally resident within their LSCB area. However on occasion another LSCB may lead on reviewing the child's deaths or discuss the death within their panel if it is felt that there are lessons to be learned within the LSCB. For example if a child died on a road within an LSCB 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. Most LSCBs who provided voluntary data reported that they did not review any deaths other than those for children who were normally resident in their area (75 out of the 92 LSCBs which provided voluntary data). 60 child deaths were discussed by panels other than that where the child was normally resident, with the main reason for this being that the child died in a hospital within the LSCB area. Approximately half of these cases were in the South West where some panels routinely discuss deaths which occurred in the local hospital, regardless of where the child was normally resident.

Cause of death

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

38% of child death reviews completed in 2009-10 were for deaths where the category of death was recorded as a neonatal or perinatal event, with a further 21% being due to chromosomal, genetic and congenital anomalies. (Based on data provided by 119 LSCBs.) This is to be expected as nearly two thirds of all completed child death reviews were for children aged under 1 year.

The majority of deaths which were assessed as preventable in 2009-10 were due to trauma and other external factors (54%), which included drowning, road traffic accidents and deaths due to fires. A further 15% were due to deliberately inflicted injury, abuse or neglect. (Based on data provided by 119 LSCBs)

27% of potentially preventable child deaths were due to sudden unexpected, unexplained deaths, with a further 19% due to trauma and other external factors and 18% due to neonatal or perinatal events.

CDOPs were also asked to provide a breakdown of these child deaths by the event which caused the death. 27% of preventable child deaths were due to road traffic accidents, there were also a number of preventable child deaths due to other events (15%), other non-intentional injury/ accident/ trauma (13%) and drowning (11%). (Based on data provided by 96 LSCBs)

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

(This information can be found in table I)

LSCBs reported that most children were in hospital at the time of the event which led to their death (72%). This may reflect the high proportion of child deaths which are neonatal deaths and are likely to be children who have not left hospital since birth, but some LSCBs may have misinterpreted this question and provided the place where the child died in error (rather than place where the event which led to the death occurred). (Based on data provided by 107 LSCBs.)

Age of the child

(This information can be found in table J)

The majority of child death reviews completed in 2009-10 were for children aged under 1 year (65%).

27% of child deaths which were assessed as preventable were for children aged 1-4 years at the time of their deaths, followed by 26% being aged 15-17 years and 19% being aged 10-14 years.

Children aged 0-27 days have the lowest proportion of child deaths being assessed as preventable (1% of all children this age). Children aged 10-14 years have the highest proportion of deaths being assessed as preventable (12% of all children in this age group).

Children aged 15-17 years have the highest proportion of deaths being assessed as potentially preventable (30% of all children in this age group) and children aged 0-27 days have the lowest proportion (8%). (Based on data provided by 116 LSCBs)

Gender of the child

(This information can be found in table K)

The majority of child deaths reviews completed in 2009-10 were for male children (56%). Male and female children are equally likely to be assessed as preventable (4% of all deaths reviewed were assessed as preventable for both males and females).

Males seem to be slightly more likely to have their death assessed as potentially preventable, with 17% of male deaths being assessed as potentially preventable, compared to 13% of female deaths. (Based on data provided by 118 LSCBs).

Ethnicity

(This information can be found in table L)

The majority of child deaths reviews completed in 2009-10 were for white children (60%). (Based on data provided by 108 LSCBs). A breakdown by preventability was not requested due to changes in the ethnicity categories used by CDOPs which were introduced in 2009-10.

Asylum seekers

(This information can be found in table M)

The majority of child death reviews completed in 2009-10 were for children who were known not to be asylum seekers (82%) however there were a number of children where it was unknown if the child was an asylum seeker (17%). This may mean that the information that the panel gathered could not conclusively determine if the child was or was not an asylum seeker, or it may be that the panel decided that they would not investigate the asylum seeking status of the child as this would not affect the outcome of the review. (Based on data provided by 105 LSCBs).

Serious case reviews

(This information can be found in table N)

The majority of child death reviews completed in 2009-10 were for children where there was not a Serious Case Review (SCR) associated with their death as this was not appropriate (98%). For the majority of deaths where a SCR was instigated it was a body other than the CDOP who recommended the SCR (85%). There were a small proportion of child deaths where the CDOP recommended a SCR but this was not taken forward. However LSCBs reported that for these cases the SCR was not taken forward as the LSCB determined that a SCR was not appropriate following further information becoming available about the death. (Based on data provided by 97 LSCBs.)

Child Protection Plans and Statutory Orders

(This information can be found in table O)

1% of child death reviews completed in 2009-10 were for children who were the subject of a Child Protection Plan (CPP) at the time of their death, with a further 11% of deaths where it was unknown if the child was the subject of a CPP. (Based on data provided by 90 LSCBs.)

1% of children were the subject of a statutory order at the time of their deaths, with a further 12% of deaths where it was unknown if a statutory order was in place. (Based on data provided by 87 LSCBs.)

Where it was unknown if the child was the subject of a CPP or a Statutory Order this may mean that the information that the panel gathered could not conclusively determine if a CPP or Statutory Order was in place, or it may be that the panel decided that they would not investigate these areas as this would not affect the outcome of the review.

Frequency of Child Death Overview Panel meetings

(This information can be found in table P)

CDOPs met on average 9 times in 2009-10 and completed 4 reviews per meeting. The average number of meetings varied greatly across regions, from 6 meetings in the North West to 14 meetings in the North East. The average number of reviews completed per meeting also varied greatly from 2 in Inner London to 6 in the West Midlands. (Based on data provided by 118 LSCBs.)

Actions LSCBs have taken following the reviews of child deaths

LSCBs have made a large number of recommendations both locally and nationally following child death reviews, they range from improvements to local roads, to improving inter-agency working, to contacting national agencies to improve awareness of key issues.

Actions taken already include:

- Awareness campaigns around safe sleeping to reduce the number of sudden infant deaths and deaths related to sleeping in parents beds or on the sofa with parents. For example: http://www.communitycare.co.uk/Articles/2010/06/23/114744/Targeting-parents-at-risk-of-sudden-infant-deaths.htm
- Making improvements to local roads, including traffic calming measures, cycle lanes and barriers, parking restrictions, warning signs and reducing foliage, as well as introducing additional road safety training for school children, to reduce the number of deaths due to traffic accidents.
- Running community road shows to share a range of findings from child death reviews.
- Making sure leaflets are available in more languages, especially around safe sleeping for babies.
- Reviewing how children who present at A&E departments because of apparent self harm are assessed and monitored.
- Reviewing procedures following non-attendance at health appointments, including vaccinations.
- Raising awareness of the dangers of leaving children unattended in the bath whether in a bath seat or not.
- Reviewing services available to children, ranging from advice on pregnancy and sexual health to accessibility of services for re-housed families with disabled children or children with life limiting illnesses.
- Contacting GPs to ensure that databases are up to date so that end of life plans are accurate and can be shared with other services, such as ambulance services.
- Reviewing the bereavement support offered to families.
- Offering feedback to services including recognising good practice and sharing with others.
- Awareness raising campaigns around securing disabled children's wheelchairs in vehicles.
- Reviewing psychological support for children with chronic conditions, namely Epilepsy and Diabetes.
- Obtain information on research and work being conducted around the UK where children from consanguineous parents die.
- Producing leaflets warning of the dangers of air weapons and displaying these in hospitals, police stations and schools.

TABLES

Table A: Number of child death reviews completed by CDOPs in the years ending 31 March 2009 and 31 March 2010, nationally and regionally. Including

- the number of deaths which were assessed as preventable
- an estimate of the proportion of all child deaths which have been reviewed. (Based on the number of deaths registered in 2008).

Further release of information

Tables (Excel file) will be added alongside this publication on the DfE Research and Statistics Gateway. These will repeat the table contained within this publication and will also provide further breakdowns by:

- The number of child death reviews completed
- The number of notifications of child deaths
- The number of child deaths discussed for children who are not normally resident within the LSCB area
- Characteristics of child death reviews completed
- The number of meetings to discuss child deaths and the timing of reviews

Tables showing the underlying data provided by all LSCBs, at Local Authority level for the statutory data provided and regional and national level for the voluntary data provided, will also be published alongside this publication on the DfE Research and Statistics Gateway. 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. This is the second year that LSCBS have been required to review all child deaths. This is a complex and challenging area. It will take time and considerable dedication from LSCBs to implement Child Death Overview Panels (CDOPs) and ensure that all child deaths in England are reviewed.

2. Reviewing child deaths requires a great deal of judgement from the panel and a common understanding of the definition of preventable. This means it may take a number of years to build a consistent national approach to the review process. Therefore it may be sometime before the data collection provides an accurate representation of preventable child deaths in England.

3. Reviews of similar deaths in subsequent years may result in different assessments of preventability. Decisions may change as the process evolves and as panels build a consistent approach to understanding preventability. In addition, local trends may begin to emerge which would suggest that similar deaths should be assessed as preventable.

4. Not all child deaths lead to a Serious Case Review (SCR). 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 instigated 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 SCR might apply, the Chair of the LSCB should be contacted and the SCR procedures followed.

5. Not all deaths which resulted in a SCR will be assessed as preventable, some may be assessed as having limited factors which were preventable and therefore they may be categorised as potentially preventable.

6. For information and guidance on the child death review processes please visit:
http://www.everychildmatters.gov.uk/socialcare/safeguarding/childdeathreview

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

Chapter 7 – Child death review processes
Taken from Working Together to Safeguard Children 2010
http://www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/workingtogether/workingtogethertosafeguardchildren/

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

- Mortality Statistics Deaths registered in 2008:
http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=15096&Pos=1&ColRank=2&Rank=352
- Mortality Statistics: Childhood, infant and perinatal:
http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=6305&Pos=&ColRank=1&Rank=192
- Infant mortality
http://www.nchod.nhs.uk/
Click on the 'compendium of indicators' of the left hand side and then 'indicator specifications'. Scroll through an alphabetical list of indicators available at various geographical levels for England. Go to 'M' for morality from various causes.
- Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-07
http://www.dcsf.gov.uk/research/programmeofresearch/projectinformation.cfm?projectId=15743&type=5&resultspage=11
- Why Children Die: A pilot study (2006) (May 2008)
http://www.cemach.org.uk/getdoc/cc3d51cc-5043-4132-99b7-af5219276dce/Child-Death-Review.aspx

Tables

8. The proportion of all deaths which have been reviewed by each region in Table A has been calculated using the number of death registrations in 2008 for children aged 0-17. The number of child deaths has remained stable for the past 5 years at approximately 5,000 deaths a year, with year on year figures varying very little. (Decreasing only 1% over the 5 year period).

9. The figures in Table A are based on data provided by all 145 LSCBs. 1 of these LSCBs reported that they had not reviewed any child deaths during the year. There were also other LSCBs which appear to have reviewed a lower percentage of deaths. The key reasons for this include:

    - Some LSCBs are responsible for reviewing the deaths of very few children, therefore if there were delays in notifications these few deaths may not have been reviewed by 31 March 2010.
    - 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.
    - Reviews have been delayed as panels wait for outcomes from SCRs, criminal investigations, post mortems, etc.
    - Many panels were unable to review all child deaths which occurred in 2008-09 in the same year, therefore these deaths needed to be reviewed in 2009-10 meaning that a number of panels had a greater than expected number of cases to review in 2009-10.

10. Some panels were unable to determine if deaths were preventable 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 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.

Confidentiality

11. In order to protect individual data, all figures have been rounded to the nearest 10. Numbers from 1 to 5 inclusive (before rounding) 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.

12. Voluntary data has been presented in the tables at national and regional level as due to small numbers it is not possible to provide data at LSCB or CDOP level. Providing the voluntary data provided at LSCB or CDOP level could risk individual children being identified.

13. As part of a Government drive for data transparency in official publications supporting data for this publication has been made available. This supporting data includes the number of child death reviews completed and the number of these completed reviews which were assessed as preventable on behalf of each local authority.

Revisions

14. There are no planned revisions to this Statistical First 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: http://www.dcsf.gov.uk/rsgateway/nat-stats.shtml

    Tables A and D within the additional tables were amended in September 2010.

An Official Statistics publication

15. 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.

ENQUIRIES

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

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Table A: Number of child death[1] reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs)[2]
Years ending 31 March 2009 and 2010
Coverage: England

	Number of child death reviews which have been completed on behalf of LSCBs in the year ending 31 March [3,4,5]			Number of child death reviews completed on behalf the LSCB which were assessed as preventable[6] in the year ending 31 March			Proportion of all completed child deaths reviewed which were assessed as preventable[7] in the year ending 31 March			Number of deaths of children aged 0-17 registered in 2008[8]	Approximate total number of deaths in year ending 2009 and 2010[9]	Number of child death reviews completed in 2009 and 2010 as an approximated proportion of all child deaths[10,11]
	2009	2010	Total 2009 and 2010	2009	2010	Total 2009 and 2010	2009	2010	Total 2009 and 2010			
England	2,000	3,450	5,440	110	150	260	5%	4%	5%	4,790	9,590	57%
Region												
North East	50	160	210	10	10	20	12%	6%	7%	200	410	52%
North West[12]	390	490	890	10	10	20	2%	2%	2%	690	1,370	65%
Yorkshire and Humberside	230	380	610	10	10	20	4%	3%	3%	560	1,120	55%
East Midlands	160	330	490	10	20	30	5%	5%	5%	390	790	62%
West Midlands	350	520	870	20	30	40	4%	5%	5%	660	1,310	66%
East of England	200	340	540	x	20	20	x	6%	4%	490	980	55%
London	360	510	870	20	20	40	5%	5%	5%	810	1,610	54%
Inner London	150	180	320	20	10	30	10%	6%	8%	350	690	47%
Outer London	210	340	540	x	10	20	x	4%	3%	460	920	59%
South East	220	510	720	30	20	50	14%	4%	7%	650	1,290	56%
South West	50	200	240	10	10	20	15%	5%	7%	360	710	34%

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. Figures are rounded to the nearest 10. Figures may not add up due to rounding. Numbers from 1 to 5 inclusive have been suppressed, being replaced by a cross (x). 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 (x).
3. The child death review process was introduced in April 2008, so data collected in the year ending 31 March 2009 and 2010 represent the first two years of this data collection. Please note that the number of reviews which were completed in these two years may have been influenced by the issues which panels encountered as they introduced the process of reviewing child deaths. There may also be deaths which occurred in 2008-09 or early 2009-10 which panels have either reviewed in less depth or felt unable to review as little data was available, which are not included in the tables above.
4. Please note that a number of panels were not able to fully review all child deaths within their areas by the 31 March 2010. This is mainly because it may take a number of months to gather sufficient information to fully review a child's death.

5. There may be additional deaths which were fully reviewed by a CDOP other than the CDOP where the child was normally resident which are not included in the table above. Table F includes the number of child deaths which were reviewed by panel other than the CDOP where the child was normally resident. Please note however that this table also includes deaths which were discussed by panel other than that in which the child was normally resident, but this panel did not lead on the review, therefore they may be double counting if the totals of these two tables are added.
6. A preventable child death is defined as "events, actions or omissions contributing to the death of a child or to substandard care of a child who died, and which, by means of national or locally achievable interventions, can be modified".
7. Please note that a number of panels encountered issues in the first year of reviewing child deaths which meant that the proportion of deaths assessed as preventable was artificially high, or artificially low. For example some panels prioritised the order in which deaths were reviewed to ensure that by 31 March 2009 the deaths with they felt had the greatest learning points were reviewed fully. This resulted in a high proportion of preventable child deaths in the first year of reviewing deaths. Other panels had experienced problems interpreting the definition of preventability, therefore by 31 March 2009 they felt unable to fully review many of the child deaths which were the most complex and more likely to be preventable. This resulted in a low proportion of preventable child deaths in the first year of reviewing deaths.
8. Figures represent the number of deaths which were registered in the calendar year 2008 for children aged 0 to 17 in England.
9. This is the approximate number of deaths in the year ending 31 March 2009 and 2010, which is calculated using twice the number of deaths registered in 2008 (column P).
10. As child deaths do not necessarily occur in the same year in which the child death review is completed, it is not possible to provide a breakdown by the individual year, however tables D and E break this down by year for the LSCBs which provided voluntary data which makes this breakdown possible.
11. This proportion is calculated by dividing the sum of number of child death reviews completed in the year ending 31 March 2009 and 31 March 2010 (column F) by the approximate number of deaths in the year ending 31 March 2009 and 31 March 2010 (Column Q).
12. Please note that one LSCB included child death reviews which had been completed in April 2009 in the data provided for the year ending 31 March 2009, therefore there are a small number of children included in both column D and column E in the table above.