Department for Education

Statistical Release

OSR 11/2011

19 July 2011

Coverage: England

Theme: Health, well-being and Care

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CHILD DEATH REVIEWS: YEAR ENDING 31 MARCH 2011

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 2010 and 31 March 2011.

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, identifying if there were any modifiable factors[1] 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 (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 148[2] LSCBs on behalf of all 94[3] CDOPs. Prior to 01 April 2010 CDOPs were required to provide data on the number of reviews completed and the number of deaths which were assessed to be preventable[4]. Data collected for the year ending 31 March 2011 was the first year in which panels were required to provide additional data about the Child Death Review Process, including details about the age, gender and ethnicity of the children.

COVERAGE

This is the third year of this data collection. Child death reviews completed in the year ending 31 March 2009 and 2010 were published under the title of "Preventable child deaths in England". From 01 April 2010 CDOPs were no longer required to assess if each death was preventable. Therefore the title of the publication has been revised to reflect this change. From 01 April onwards CDOPs were required to determine if there were modifiable factors identified in the death.

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[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 LSCB, depending on the local configuration of services and population served.
[3] Neighbouring LSCBs may decide to share a CDOP, depending on the local configuration of services and population served.
[4] 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.

Reviewing child deaths is an extremely complex responsibility of the LSCB. Please see the section on "Data Quality and Interpretation".

KEY POINTS

Number of reviews completed

- 4,061 child death reviews were completed by Child Death Overview Panels (CDOPs) in the year ending 31 March 2011.
- Of the child death reviews completed in the year ending 31 March 2011, 800 were indentified as having modifiable factors (20%).
- In the year ending 31 March 2011 CDOPs in Yorkshire and the Humber identified modifiable factors in the highest proportion of the child death reviews that they completed (27%) and the South East identified the lowest (10%).
- 39% of child deaths which occurred in the year ending 31 March 2011 and were notified to CDOPs had completed reviews by 31 March 2011. The remaining 61% of reviews were ongoing at 31 March 2011.

Number of child deaths registered

- According to the Office for National Statistics (ONS) 4,476 child deaths which occurred between 01 April 2008 and 31 March 2009 were registered in England. Approximately 13,400 children have died since the statutory responsibility to review child deaths was introduced on 01 April 2008. (The number of registered deaths which occurred in the years ending 31 March 2010 and 31 March 2011 is not yet available, so this total is based on assuming the number of deaths in these two years is the same as those in the year ending 31 March 2009. This has been used as an estimate as in England the number of child deaths do not vary greatly year on year). Approximately 71% of these child death reviews were completed by 31 March 2011.

Characteristics of child deaths where the review was completed

Of the child death reviews completed in the year ending 31 March 2011 where there was sufficient information available for the CDOP to determine if there were modifiable factors in the death:

- 22% of all deaths which were identified as having modifiable factors were due to sudden unexpected, unexplained deaths. A further 19% were due to neonatal/perinatal events and an additional 19% were due to trauma and external factors.
- CDOP are asked to categorise the likely cause of death. They also record the event which caused the death. Death categorised as being due to trauma and external factors had the highest proportion of deaths identified as having modifiable factors (68%). Deaths due to malignancy had the lowest proportion of deaths which were identified as having modifiable factors, only 4%.
- Deaths where the event which led to the death was drowning had the highest proportion of deaths identified as having modifiable factors (72%). 69% of deaths due to road traffic accidents/ collisions were identified as having modifiable factors.
- Deaths of male and female children had similar proportions identified as having modifiable factors, 21% of male deaths and 19% of female deaths.
- Modifiable factors were identified in a higher proportion of deaths of older children (38% of deaths in children aged 15-17 years) compared to younger children (16% of deaths in children ages under 1 year.)

BACKGROUND

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 in England. This is the third year of collection.

LSCBs are responsible for reviewing the deaths of all 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 wellbeing of children and to reduce the number of future child deaths.

From 01 April 2010 onwards CDOPs were asked to identify if there were modifiable factors in the death. Previously CDOPs were asked to assess if the death was preventable or potentially preventable, but CDOPs 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 to categories were grouped and redefined as "modifiable factors".

Data collected in the year ending 31 March 2011 is the first year for which all CDOPs were required to provide additional information about the child death reviews which had been completed by their CDOP, for example details about the child's age, gender, ethnicity and cause of death. Data were collected on a voluntary basis in the year ending 31 March 2010 and was provided on behalf of over 80% of LSCBs

Please note 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.

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 were approximately 4,600 deaths of children registered in 2009 and this number has been falling in recent years. The latest data on registered deaths shows that 4,476 deaths occurred between 01 April 2008 and 31 March 2009.

Legislation

The Children Act 2004 places a statutory duty 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. 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 deaths 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

Not all child deaths which occurred in the year ending 31 March 2011 had completed child death reviews by 31 March 2011. 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 2011, 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. CDOPs 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. A large proportion of the child death reviews completed in the year ending 31 March 2011 were for deaths which happened prior to 01 April 2010 (60%)

We may also find that child deaths which occurred in the years ending 31 March 2009 and 31 March 2010 will not all have a child death review completed because of the difficulties panels experienced in the first two years of reviewing child deaths.

Data collected in the year ending 31 March 2011 included additional information about completed child death reviews for the first time. (Prior to 1 April 2010 CDOPs were only required to provide the number of deaths which had been reviewed and the number of these which were assessed as preventable.) Although additional data were provided by all CDOPs there were a number of questions where the information was unknown within some CDOPs. Some CDOPs reported that this information was not collected in their CDOP, 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 unknown (of the reviews where there was sufficient information available for the CDOP to determine if there were modifiable factors in the death.) For all other data items requested the proportion of cases where the information was unknown represented 1% or less of the completed reviews. The proportion of cases where the information was unknown varied greatly across CDOPs and across regions.

	Proportion of completed reviews where this information was unknown	Ranging from	Ranging to
Asylum seeking status	14%	0% in the South West and East of England	42% in the North West
Ethnicity	9%	2% in Yorkshire and the Humber	16% in the South East
Statutory orders	9%	0% in Yorkshire and the Humber	29% in the North East
Recommendations	8%	0% in three regions	24% in the North West
Child protection plans	7%	0% in Yorkshire and the Humber	29% in the North East
Location at the time of death	4%	0% in most regions	28% in the East of England

KEY FINDINGS

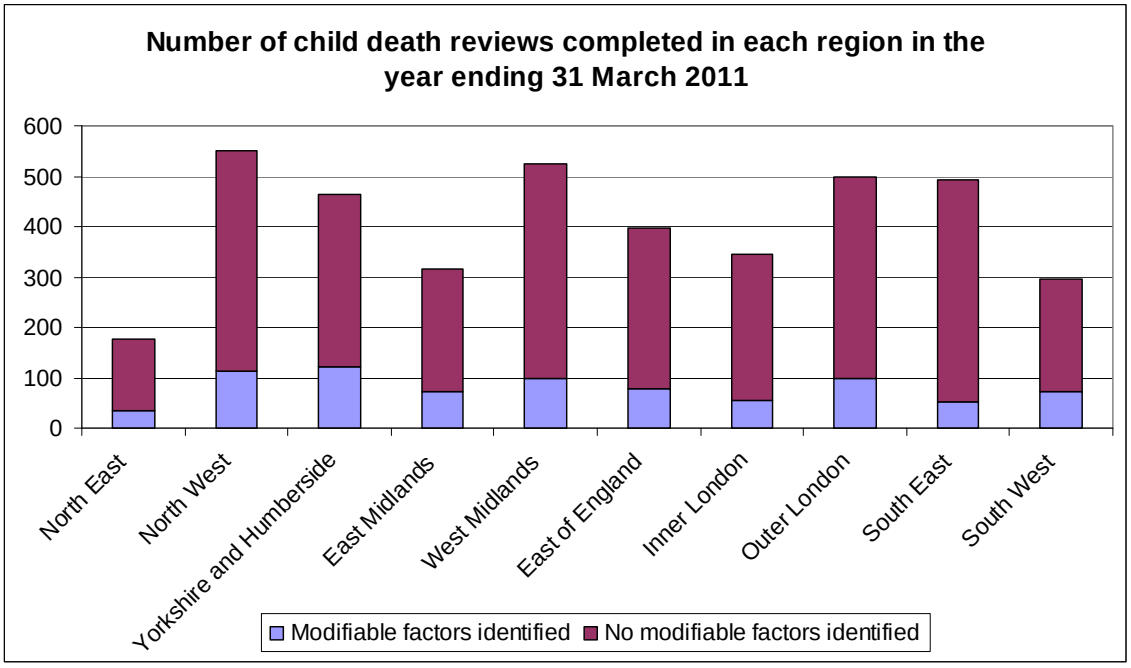
Number of child death reviews completed

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

4,061 child death reviews were completed by CDOPs in the year ending 31 March 2011. 800 of these deaths were indentified as having modifiable factors. There were 43 deaths where there was not sufficient information available for the CDOP to determine if there were modifiable factors in the death.

Number of deaths which were identified as having modifiable factors in the year ending 31 March 2011

20% of all child death reviews completed in the England were identified as having modifiable factors. Yorkshire and the Humber identified modifiable factors in the highest proportion of deaths (27%) and the South East identified the lowest (10%). This proportion of deaths where modifiable deaths were identified in these two regions is statistically significantly different to the national proportion.



Proportion of child deaths where the review is complete

Approximately 71% of child deaths which occurred between the 3 years from 01 April 2008 to 31 March 2011 had a completed child death review by 31 March 2011. (Based on assuming that the number of child deaths which occurred in the years ending 31 March 2010 and 31 March 2011 are the same as the number of child deaths which were occurred in the year ending 31 March 2009, 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.

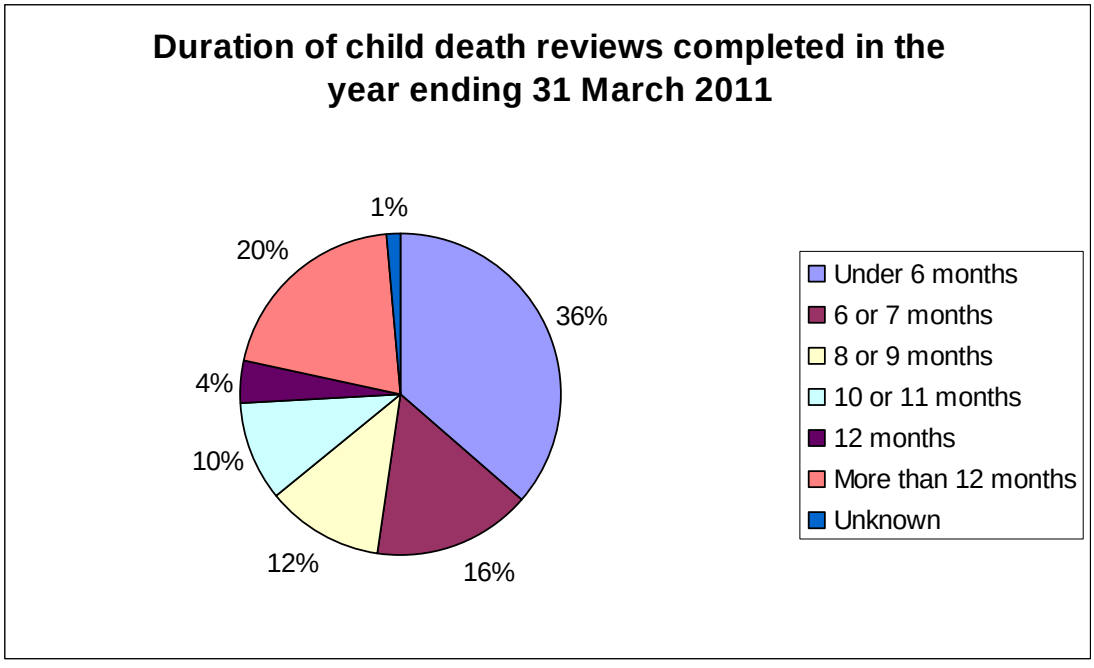
Time between the child's death and completing the review

39% of the 4,164 child deaths which were notified to CDOPs where the death happened in the year ending 31 March 2011 had their child death review completed by 31 March 2011. The remaining 61% of reviews were ongoing at 31 March 2011. The proportion of reviews which were completed varied greatly across regions with the West Midlands completing the child death reviews for over half of the deaths which occurred in the year ending 31 March 2011 and were being led by a CDOP within their region and the South West completing reviews for less than a fifth of the death which occurred in the year ending 31 March 2011 and were being led by a CDOP within their region. The proportion of deaths which are reviewed 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 CDOP, 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.

Of the child death reviews completed in the year ending 31 March 2011 where there was sufficient information available for the CDOP 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 approximately 1/3 of deaths which were identified as having modifiable factors took more than 12 months to complete the child death review, compared to 17% of deaths where no modifiable factors were identified. This can also be seen in Table B where 40% of all reviews completed in the year ending 31 March 2011 were for deaths which occurred in the year ending 31 March 2011, whereas only 26% of deaths where modifiable factors were identified occurred in the year ending 31 March 2011. 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.

Over a third of child death reviews completed in the year ending 31 March 2011 took less than 6 months to complete and 20% took over one year to complete.



Frequency of Child Death Overview Panel meetings

CDOPs met 7 times on average in the year ending 31 March 2011 and completed an average of 6 reviews per meeting. The average number of meetings varied greatly across regions, from 5 meetings in Outer London and the North West to 11 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 5 in Inner London and Yorkshire and the Humber to 8 in the North East and South West.

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 years old who are normally resident within their LSCB area. However on occasion another LSCB 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 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.

For a small number of child deaths which were reviewed in the year ending 31 March 2011 the CDOP which completed the review was not the CDOP within the area where the child was normally resident (only 33 cases). The main reason why another CDOP reviewed the death was because the child died in a hospital within the CDOP area (this is the case for 64% of these deaths).

The South West led on reviews of the highest proportion of deaths where the child was not normally resident within the CDOP area; these cases represented 7% of all completed child death reviews in this area compared to 0.3% in all other regions.

There were also a small number of cases where a death of a child who was not normally resident in the CDOP area was discussed, but the CDOP did not lead on the child death review (21 cases). Again the main reason these deaths were discussed was because the child died in a hospital within the CDOP area (this is the case for 62% of these deaths).

Actions LSCBs have taken following the reviews of child deaths
(This information can be found in Table G)

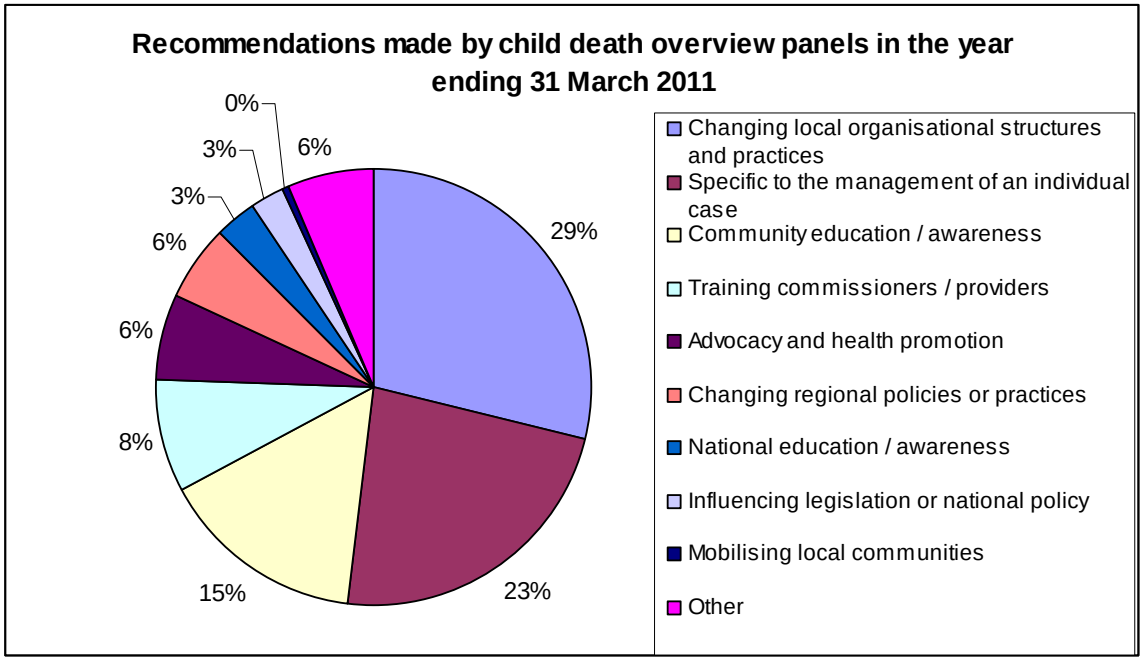
LSCBs have made a large number of recommendations in the year ending 31 March 2011 both locally and nationally following child death reviews. These ranged from continuing to raise awareness of the dangers of co-sleeping to promoting the excellent services provided by hospices and Macmillan nurses.

Areas where actions are currently ongoing include:

- Co sleeping – This continues to be a key concern in a number of CDOP areas. A number of CDOPs have organised awareness raising campaigns around the dangers of co-sleeping, especially if drinking alcohol, taking drugs or smoking. Promotional blankets, dummies and thermometers have been distributed in some CDOP areas, as well as placing posters in hospitals, GPs and supermarkets. Some recommendations also address the dangers of sleeping with babies on planes.

- Blind cords – Deaths caused by accidental strangulation by blind cords have occurred in a number of different areas, so CDOPs have shared this information with health care professionals so that they are able to advise and warn parents of the dangers.
- Consanguinity – This continues to be a key factor in a number of child deaths so awareness campaigns in schools have been run to highlight the health risks and information has been provided to pregnant inter-family couples to prepare them for potential health problems.
- In vitro fertilisation (IVF) – A number of CDOPs have suggested that the guidelines on number of embryos used at any one time in IVF treatment be revised as there are a number of deaths where this has been a factor.
- Road safety – Awareness campaigns have been run in a number of CDOP areas to target school age children, including providing information about cycling safety.
- Smoking – A number of CDOPs are working with health visitors and other health professionals to highlight the risk to children of passive smoking and smoking during pregnancy.
- Vaccinations – A number of CDOPs are publicising the importance of children being vaccinated before travelling abroad. They are also publicising the importance of vulnerable children being vaccinated against 'flu.
- Bereavement support – much work has been done within CDOPs to improve the support and counselling offered to families, especially where there are other children in the family. Work is also being done to ensure that parents understand the child death reviewing processes and are provided with information and feedback.
- Breast feeding – the health benefits of breastfeeding are being promoted within some CDOP areas.
- Transition from paediatric to adult care - Pathways for young people moving from paediatric care to adult care are being reviewed and improved in some CDOP areas.
- Language barriers – Some CDOP areas are looking for ways to remove language barriers, especially when contacting emergency services.
- Missed appointments – practice is being changed in some CDOP areas to follow up missed appointments.
- Fire safety – A number of CDOPs are raising awareness of fire safety and investigating the possibility of providing equipment (for example, CO2 monitors and smoke detectors) to families with vulnerable children.
- Sharing good practice – CDOPs are sharing good practices identified, for example promoting the excellent services offered in hospices and by Macmillan nurses.

Please note in 8% of deaths the specific recommendations made regarding the death were unknown. This may be because this information was not collected or because it was not readily available in the required format. Many of the recommendations made were described as "changing local organisational structures and practices" (29%), "recommendations specific to the management of an individual case" (23%) and "community education / awareness" (15%).



Cause of death
(This information can be found in Tables H and I)

CDOP 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”.

Of the child death reviews completed in the year ending 31 March 2011 where there was sufficient information available for the CDOP to determine if there were modifiable factors in the death:

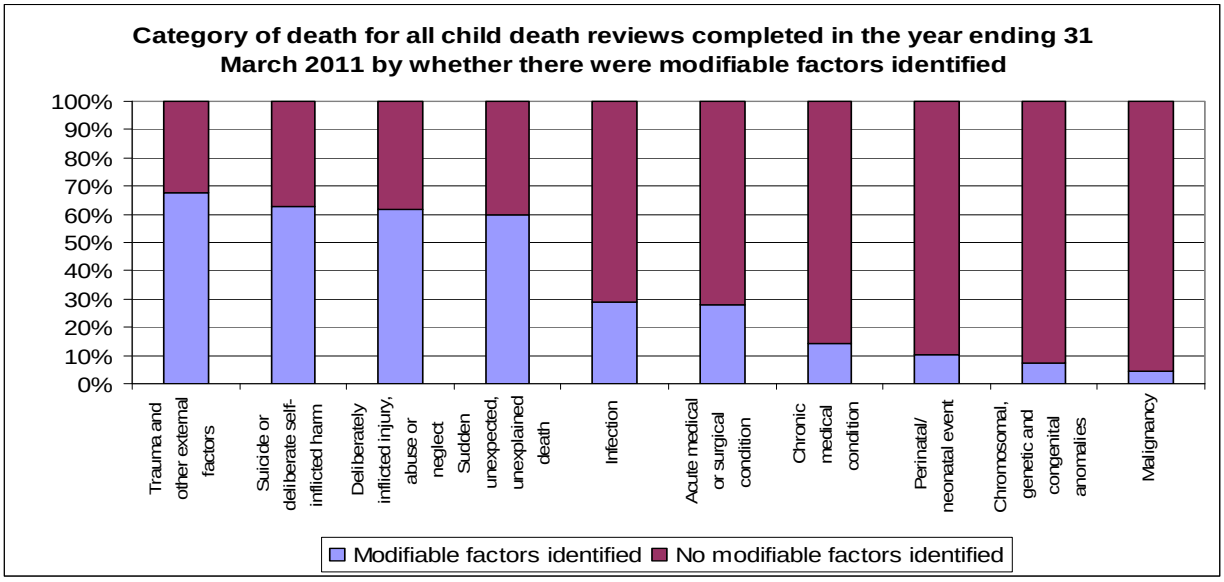
36% of child death reviews completed involved deaths where the category of death was recorded as a neonatal or perinatal event, with a further 24% being due to chromosomal, genetic and congenital anomalies. This is to be expected as approximately two thirds of all completed child death reviews were for children aged under 1 year.

22% of all deaths which were identified as having modifiable factors 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). A further 19% were due to neonatal/perinatal events and an additional 19% were due to trauma and external factors.

The category of death which had the largest proportion of cases identified as having modifiable factors was deaths due to trauma and external factors (68% of these deaths were assessed as having modifiable factors). Over half of the deaths caused by:

- suicide or deliberate self-inflicted harm;
- deliberately inflicted injury, abuse or neglect; and
- sudden unexpected, unexplained death

were identified as having modifiable factors (63%, 62% and 60% respectively.)

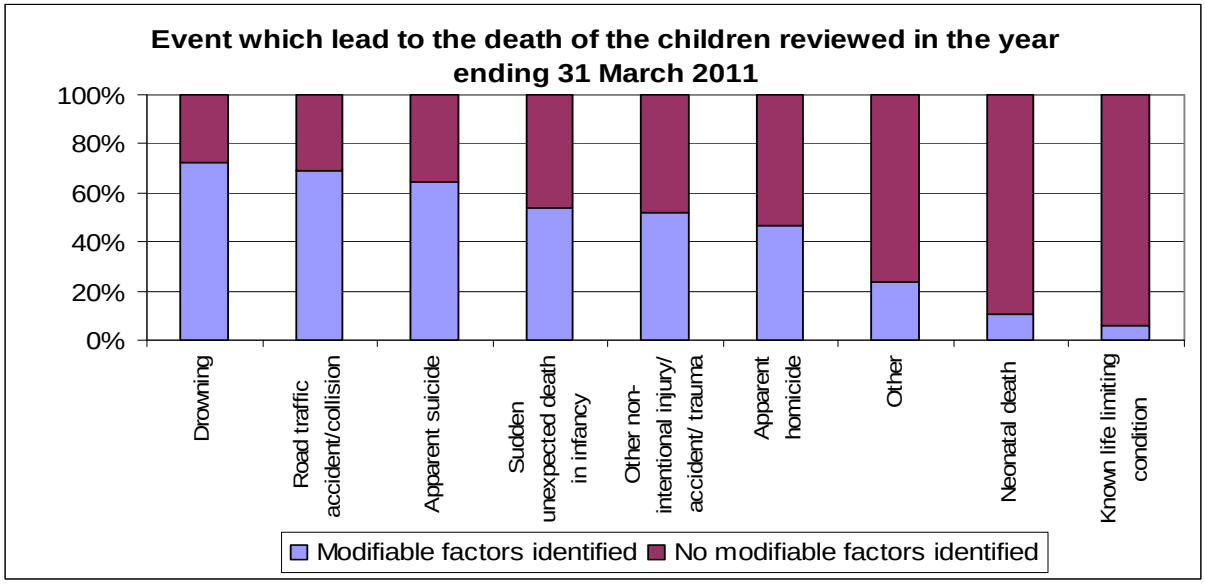


Please note, due to the small number of deaths which were categorised as being due to "deliberately inflicted injury, abuse or neglect" or "suicide or deliberate self-inflicted harm", the proportion of deaths which were identified as having modifiable factors should be treated with caution.

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

- drowning;
- road traffic accident/collision;
- apparent suicide;
- sudden unexpected death in infancy; and
- other non-intentional injury/ accident/ trauma

were identified as having modifiable factors (72%, 69%, 65%, 54% and 52% respectively).



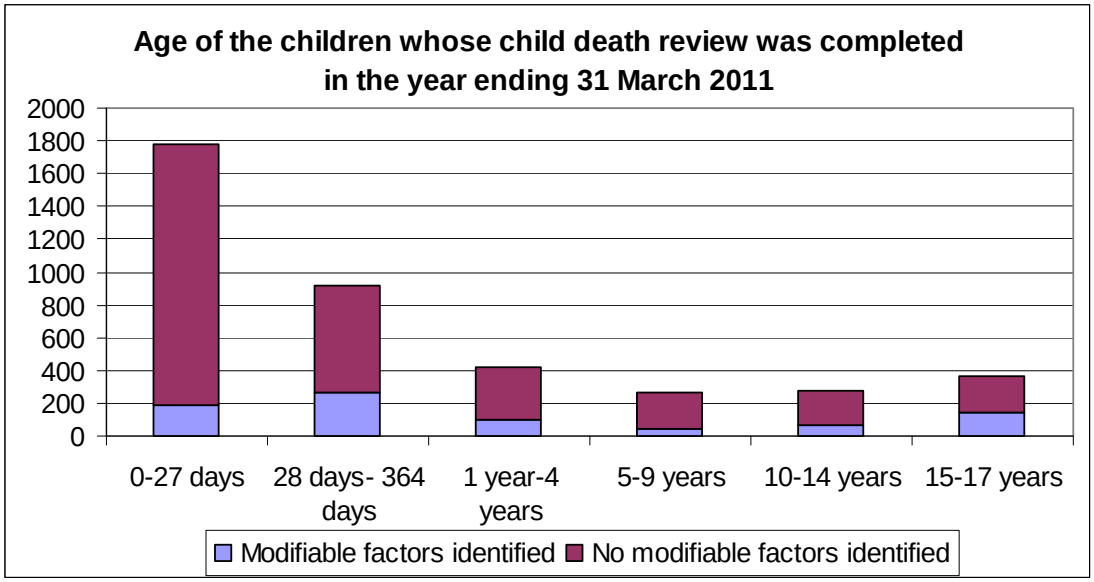
Please note, due to the small number of deaths which were due to "drowning", "other non-intentional injury/ accident/ trauma", "apparent suicide" and "apparent homicide" the proportion of deaths which were identified as having modifiable factors should be treated with caution.

Age of the child
(This information can be found in Table J)

Of the child death reviews completed in the year ending 31 March 2011 where there was sufficient information available for the CDOP to determine if there were modifiable factors in the death:

The majority of child death reviews completed in the year ending 31 March 2011 were for children aged under 1 year (67%).

Older children who died aged 15-17 years, were more likely to have modifiable factors identified in their deaths, with 38% of this age group having modifiable factors identified, compared to 16% of children aged under 1 year.



Gender of the child
(This information can be found in Table K)

There were slightly more reviews of male children completed (54% of the child death reviews completed in the year ending 31 March 2011 where there was sufficient information available for the CDOP to determine if there were modifiable factors in the death). The latest data available (for 2009 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 review were for male children.

Deaths of male and female children had similar proportions identified as having modifiable factors, 21% of male deaths and 19% of female deaths (of the child death reviews completed in the year ending 31 March 2011 where there was sufficient information available for the CDOP to determine if there were modifiable factors in the death).

Ethnicity
(This information can be found in Table L)

Please note that ethnicity was unknown in 9% 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.

Of the child death reviews completed in the year ending 31 March 2011 where there was sufficient information available for the CDOP to determine if there were modifiable factors in the death:

The majority of child death reviews were for white children (60%). A similar proportion of deaths across each ethnic group were identified as having modifiable factors (22% of deaths where the child was white, 20% were the child was mixed/multiple ethnic groups, 20% where the child was black/black British and 17% where the child was Asian/ Asian British). When the child was identified as having an “unknown” ethnicity the proportion of deaths which were identified as having modifiable factors was significantly lower (14%).

Place of the event which led to the child’s death
(This information can be found in Table M)

Of the child death reviews completed in the year ending 31 March 2011 where there was sufficient information available for the CDOP to determine if there were modifiable factors in the death:

CDOPs reported that most children were in hospital at the time of the event which led to their death (70%). In nearly half 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 was a lower proportion of deaths identified as having modifiable factors (15%) compared to other known locations, such as a public place (57%), other private residence (54%), abroad (47%) and the home of normal residence (35%).

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

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 (57%). 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 N)

Please note the asylum seeking status of the child was unknown in 14% 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.

Of the child death reviews completed in the year ending 31 March 2011 where there was sufficient information available for the CDOP 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 (86%). 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 as not been published within the tables to ensure individual children cannot be identified.

Statutory Orders and Child Protection Plans
(This information can be found in Table O and Table P)

Please note for 9% of the reviews completed it was unknown if the child was the subject of a statutory order. For 7% of the reviews completed it was unknown if the child was the subject of a child protection plan (CPP). 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 CPP or a statutory order was in place from the information available.

Of the child death reviews completed in the year ending 31 March 2011 where there was sufficient information available for the CDOP to determine if there were modifiable factors in the death:

1% of children were the subject of a statutory order at the time of their deaths, with a further 0.4% of deaths 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 prior to the death a higher proportion of cases were identified as having modifiable factors compared to children who were not subject to a statutory order (49% and 50% compared to 20%). Due to the small number of deaths where there was a statutory order in place at the time of death or prior, the proportion of deaths which were identified as having modifiable factors should be treated with caution.

1% of child death reviews completed were for children who were the subject of a CPP at the time of their death, with a further 1% having been the subject of a CPP previously, but not at the time of death. When the child was the subject of a CPP 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 CPP (45% and 45% compared to 20%). Due to the small number of deaths where there was a CPP 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.

Please note that where a CPP 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 CPP or a statutory order.

Serious case reviews
(This information can be found in Table Q)

Of the child death reviews completed in the year ending 31 March 2011 where there was sufficient information available for the CDOP to determine if there were modifiable factors in the death there were also serious case reviews (SCRs) carried out for 1% of all deaths. Approximately 1/3 of the SCRs were recommended by the CDOP, with the remainder being instigated by other bodies.

There were a small number of child deaths where the CDOP recommended a SCR but this was not taken forward. However some CDOPs reported that internal management reviews (IMRs) took place instead or it was decided that an SCR was not appropriate following further information becoming available about the death.

The deaths which were the subject of SCRs had a higher proportion which were identified as having modifiable factors, compared to deaths where a SCR was not appropriate (70% compared to 19%). However due to the small number of cases where a SCR was carried out these findings should be treated with caution.

A SCR 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 SCR, 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.

TABLES

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

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

Table C: Number of child death reviews completed in by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs) 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 (CDOP) met

Table F: Number of child deaths discussed by Child Death Overview Panels (CDOPs) where the child was not normally resident within the LSCB area

Table G: Recommendations made by the Child Death Overview Panel (CDOP) following the completion of child death reviews

Table H: Number of child death reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs) by category of death

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

Table J: Number of child death reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs) by age of the child at the time of death

Table K: Number of child death reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs) by gender

Table L: Number of child death reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs) by ethnicity

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

Table N: Number of child death reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs) by asylum seeking status

Table O: Number of child death reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs) by Statutory Order status

Table P: Number of child death reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs) by Child Protection Plan status

Table Q: Number of child death reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs) by Serious Case Review (SCR) status

Tables (Excel file) will be added alongside this publication on the DfE Research and Statistics Gateway. These will repeat the tables contained within this publication.

Tables showing the underlying data provided by all LSCBs will also be published alongside this publication on the DfE Research and Statistics Gateway. These tables will include the data provide 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 third year that LSCBs have been required to review all child deaths. From 01 April 2010 onwards CDOPs were required to identify if there were modifiable factors in the death of each child. Previously CDOPs were required to identify if the death was preventable or potentially preventable, but CDOPs reported difficulties in distinguishing between the two categories, i.e. of factors which did contribute to the death and 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". Voluntary data from CDOPs 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. 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 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 SCR might apply, the Chair of the LSCB should be contacted and the SCR procedures followed.

   Not all deaths which resulted in a SCR 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/safeguarding/safeguardingchildren/childdeathreview

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

   Chapter 7 – Child death review processes
   Taken from Working Together to Safeguard Children 2010
   http://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010

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

   - Munro review: http://www.education.gov.uk/childrenandyoungpeople/strategy/laupdates/a0077242/munro-review-final-report
   - 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.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-RR083
   - Mortality Statistics Deaths registered in 2009: 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' across the top of the screen and then 'indicator specifications'. Then click on “alphabetically” and go to 'M' for morality from various causes.
   - Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2007-09
     http://www.education.gov.uk/publications/standard/publicationdetail/page1/DFE-RR040
   - 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

6. The proportion of all deaths which have been reviewed by each region in Table A has been estimated using the number of death registered as occurring between 01 April 2008 and 31 March 2009 for children aged 0-17 years old as report by the Office for National Statistics (ONS). The number of child deaths registered remained relatively stable for the previous 5 years with an average of approximately 4,800 deaths registered each calendar year, with year on year figures varying very little. (Decreasing by 3% over the 5 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 LSCBs. None of these LSCBs reported that they had not reviewed any child deaths during the year, but there were some LSCBs which appear to have reviewed a lower proportion 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 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 2011;
    - 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, SCRs, criminal investigations and post mortems;
    - Some panels were unable to review all child deaths which occurred in the year ending March 2009 and March 2010 in the same year in which the death occurred. This meant that some panels completed these review in the year ending 31 March 2011, whereas other CDOPs decided to close any incomplete reviews.

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, and 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.

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. It has been identified that 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, LSCB or CDOP 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 LSCBs 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: http://www.education.gov.uk/rsgateway/nat-stats.shtml

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.

ENQUIRIES

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

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Press Office Newsdesk,
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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, 2010 and 2011
Coverage: England

	Number of child death reviews which have been completed on behalf of LSCBs in the year ending 31 March [3,4]				Number of child death reviews completed on behalf of the LSCB which were assessed as preventable[9] in the year ending 31 March[10,11]		Proportion of all completed child deaths reviewed which were assessed as preventable[9] in the year ending 31 March[10,11]		Number of child death reviews completed on behalf of the LSCB which were assessed as having modifiable factors in the year ending 31 March[8,12]	Proportion of all completed child deaths reviewed which were assessed as having modifiable factors in the year ending 31 March[12]	Number of deaths of children aged 0-17 which occurred in the year ending 31 March 2009[13]	Estimated total number of deaths in year ending 2009, 2010 and 2011[14]	Number of child death reviews completed in 2009, 2010 and 2011 as an estimated proportion of all child deaths[15,16]
	2009[5,6]	2010[5,6]	2011[7,8]	Total 2009, 2010 and 2011	2009	2010	2009	2010	2011	2011			
England	1,998	3,446	4,061	9,505	108	148	5%	4%	800	20%	4,476	13,428	71%
Region													
North East	50	163	176	389	6	9	12%	6%	35	20%	195	585	66%
North West	392	494	552	1,438	9	12	2%	2%	113	20%	666	1,998	72%
Yorkshire and Humberside	229	384	463	1,076	9	11	4%	3%	123	27%	528	1,584	68%
East Midlands	160	332	316	808	8	18	5%	5%	73	23%	380	1,140	71%
West Midlands	345	520	524	1,389	15	26	4%	5%	100	19%	572	1,716	81%
East of England	203	337	397	937	x	19	x	6%	78	20%	426	1,278	73%
London	356	512	843	1,711	19	24	5%	5%	155	18%	783	2,349	73%
Inner London	148	176	345	669	15	10	10%	6%	56	16%	342	1,026	65%
Outer London	208	336	498	1,042	x	14	x	4%	99	20%	441	1,323	79%
South East	215	508	493	1,216	30	19	14%	4%	51	10%	621	1,863	65%
South West	48	196	297	541	7	10	15%	5%	72	24%	305	915	59%

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. 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 the year ending 31 March 2009 or early in the year ending 31 March 2010 which panels have either reviewed in less depth or felt unable to review as little data were available, which are not included in the tables above.
4. Please note that not all child deaths which occur each year will have their child death review completed by the 31 March. 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 these figures.
6. Please note that one LSCB in the North West 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.
7. These figures includes reviews of child deaths which were completed where the child was not normally resident in the CDOP area. Table F (Column E) shows the number of child deaths which were reviewed by a panel other than the CDOP where the child was normally resident.
8. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.
9. 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".
10. 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.
11. From 01 April 2008 to 31 March 2010 CDOPs were required to assess if a death was preventable.
12. 2010-11 was the first year which CDOPs were asked to assess if there were modifiable factors in the child's death. A modifiable death is defined where there are factors which may have contributed to the death. These factors are are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.
13. Figures represent occurrences of deaths of children aged 0 to 17 in England as recorded by the Office for National Statistics. There may be a small number of deaths which occurred in 2008-09 but they had not been registered by the. time these data were extracted.
14. Data on the number of occurrences of deaths in the year ending 31 March 2010 and 31 March 2011 are not yet available, so the number of deaths in these years is assumed to be the same as those in the year ending 31 March 2009. So this figure is three times the number of occurrences of deaths in the year ending 31 March 2009 (column U).
15. 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 provides the proportion of deaths which occurred in the year ending 31 March 2011 which were also fully reviewed in the year ending 31 March 2011.
16. This proportion is calculated by dividing the total number of child death reviews completed in the year ending 31 March 2009, 2010 and 2011 (column G) by the approximate number of deaths in the year ending 31 March 2009, 2010 and 2011 (Column V).

Table B: Number of child death[1,2] reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs) by the year in which the child death occurred
Year ending 31 March 2011
Coverage: England

	Number of child deaths reviews completed in the year ending 31 March 2011			Percentage of child death reviews completed in the year ending 31 March 2011	
	Where the death occurred prior to 01 April 2010	Where the death occurred between 01 April 2010 and 31 March 2011	All child death reviews completed in year ending 31 March 2011[3]	Where the death occurred prior to 01 April 2010	Where the death occurred between 01 April 2010 and 31 March 2011
England	2,423	1,638	4,061	60%	40%
Region					
North East	111	65	176	63%	37%
North West	352	200	552	64%	36%
Yorkshire and Humberside	314	149	463	68%	32%
East Midlands	163	153	316	52%	48%
West Midlands	252	272	524	48%	52%
East of England	199	198	397	50%	50%
London	537	306	843	64%	36%
Inner London	229	116	345	66%	34%
Outer London	308	190	498	62%	38%
South East	247	246	493	50%	50%
South West	248	49	297	84%	16%
The number of which were assessed as having modifiable factors[4]:					
England	589	211	800	74%	26%
Region					
North East	24	11	35	69%	31%
North West	83	30	113	73%	27%
Yorkshire and Humberside	97	26	123	79%	21%
East Midlands	53	20	73	73%	27%
West Midlands	78	22	100	78%	22%
East of England	40	38	78	51%	49%
London	115	40	155	74%	26%
Inner London	44	12	56	79%	21%
Outer London	71	28	99	72%	28%
South East	37	14	51	73%	27%
South West	62	10	72	86%	14%
Proportion of completed reviews which were assessed as having modifiable factors:					
England	24%	13%	20%	.	.
Region					
North East	22%	17%	20%	.	.
North West	24%	15%	20%	.	.
Yorkshire and Humberside	31%	17%	27%	.	.
East Midlands	33%	13%	23%	.	.
West Midlands	31%	8%	19%	.	.
East of England	20%	19%	20%	.	.
London	21%	13%	18%	.	.
Inner London	19%	10%	16%	.	.
Outer London	23%	15%	20%	.	.
South East	15%	6%	10%	.	.
South West	25%	20%	24%	.	.

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. Percentages are shown rounded to whole numbers. (.) represents values which are not applicable.
3. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.
4. A modifiable death is defined 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.

Table C: Number of child death[1,2,3] reviews completed in by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs) in the same year in which the death occurred
Child deaths which occurred in year ending 31 March 2011
Coverage: England

	Number of deaths notified to CDOPs which occurred in the year ending 31 March 2011 and the CDOP were leading the review	Number of deaths which occurred in the year ending 31 March 2011 where the child death review was completed by 31 March 2011[4]	Percentage of deaths which occurred in the year ending 31 March 2011 and the review was completed by 31 March 2011[4]
England	4,164	1638	39%
Region			
North East	169	65	38%
North West	566	200	35%
Yorkshire and Humberside	491	149	30%
East Midlands	323	153	47%
West Midlands	531	272	51%
East of England[4]	395	198	50%
London	827	306	37%
Inner London	349	116	33%
Outer London	478	190	40%
South East	539	246	46%
South West	323	49	15%

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. Percentages are shown rounded to whole numbers. (.)
3. Notifications are only included in the table above if the CDOP led on the review of the child's death. If a panel was notified of deaths, but another CDOP was also notified of the death and this second CDOP led the review, then the notification would be included only once in the table for the CDOP which led the review.
4. Please note that it is not always possible to fully review all child deaths within the same year which they occurred. This is mainly because it may take a number of months to gather sufficient information to fully review a child's death.
5. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.

Table D: Time between the death of a child and the completion of the child death review [1,2,3]

Child death reviews completed in year ending 31 March 2011

Coverage: England

	Time between the death of the child and the completion of the child death review for reviews completed in the year ending 31 March 2011[4]							All child death reviews completed in year ending 31 March 2011 with an assessment of modifiable factors[6,7,8]	Insufficient available to assess if there were modifiable factors in the death modifiable[7]	All child death reviews completed in year ending 31 March 2011[8]
	Under 6 months	6 or 7 months	8 or 9 months	10 or 11 months	12 months	More than 12 months	Unknown[5]			
All child death reviews completed in the year ending 31 March 2011										
of which:										
Modifiable factors identified [7]	151	118	110	110	35	271	5	800	.	800
No modifiable factors identified [7]	1,307	520	372	290	131	544	54	3,218	.	3,218
Total	1,458	638	482	400	166	815	59	4,018	43	4,061
Percentage of this duration:										
Modifiable factors identified [7]	10%	18%	23%	28%	21%	33%	8%	20%	.	.
No modifiable factors identified [7]	90%	82%	77%	73%	79%	67%	92%	80%	.	.
Total	100%	100%	100%	100%	100%	100%	100%	100%	.	.
Percentage of each duration under this assessment:										
Modifiable factors identified [7]	19%	15%	14%	14%	4%	34%	1%	100%	.	.
No modifiable factors identified [7]	41%	16%	12%	9%	4%	17%	2%	100%	.	.
Total	36%	16%	12%	10%	4%	20%	1%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. (.) represents values which are not applicable.
3. Please note that when reviewing a child's death it may take a number of months to gather sufficient information to allow the panel to full review the child's death.
4. Percentages are shown rounded to nearest whole number.
5. The time between the death of the child and the completion of the child death review was unknown in a number of cases because the data in some CDOP areas was not collected in the required format.
6. 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 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.
7. A modifiable death is defined 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.
8. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.

Table E: Number of times which the Child Death Overview Panel (CDOP) met[1]

Year ending 31 March 2011

Coverage: England

	Number of child death reviews completed in the year ending 31 March 2011[2]	Number of CDOPs	Number of CDOP meetings in year ending 31 March 2011	Average number of meetings per CDOP in year ending 31 March 2011[3,4]	Average number of child death reviews completed per meeting in year ending 31 March 2011[3,5]
England	4,061	94	627	7	6
Region					
North East	176	4	22	6	8
North West	552	16	76	5	7
Yorkshire and Humberside	463	14	86	6	5
East Midlands	316	6	50	8	6
West Midlands	524	8	73	9	7
East of England	397	6	67	11	6
London	843	25	143	6	6
Inner London	345	10	63	6	5
Outer London	498	15	80	5	6
South East	493	9	71	8	7
South West	297	6	39	7	8

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.
3. Figures are rounded to the nearest whole number.
4. This number is calculated by dividing the number of meetings (column F) by the number of CDOPs (column E).
5. This value is calculated by diving the number of completed child death reviews (column D) by the total number of times the panel met (column F).

Table F: Number of child deaths discussed by Child Death Overview Panels (CDOPs) where the child was not normally resident within the LSCB area

Year ending 31 March 2011

Coverage: England

	Number of child deaths discussed in the year ending 31 March 2011 where the child was not normally resident within the LSCB area	
	Discussed only and did not lead on the review	Led the review and this was completed by 31 March 2011
England	21	33
Region		
North East	0	x
North West	12	x
Yorkshire and Humberside	x	0
East Midlands	0	x
West Midlands	x	x
East of England	x	x
London	x	x
Inner London	x	0
Outer London	x	x
South East	x	x
South West	x	21

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.

2. Numbers from 1 to 5 inclusive have been suppressed, being replaced by a cross (x).

Table G: Recommendations made by the Child Death Overview Panel (CDOP) following the completion of child death reviews[1,2,3]
Child death reviews completed in year ending 31 March 2011
Coverage: England

	Recommendation made following a completed child death review in the year ending 31 March 2011										All recommendations made in year ending 31 March 2011[4]	All child death reviews completed in year ending 31 March 2011[5]			
	Changing local organisational structures and practices	Specific to the management of an individual case	Community education / awareness	Training commissioners / providers	Advocacy and health promotion	Changing regional policies or practices	National education/ awareness	Influencing legislation or national policy	Mobilising local communities	Other		Recommendations made	Recommendations unknown/ unavailable in format requested[3]	No recommendations[4]	Total
England	346	277	184	101	75	69	35	32	5	77	1201	1058	335	2668	4,061
North East	34	17	8	6	5	5	1	1	0	9	86	86	3	87	176
North West	16	17	24	6	18	2	4	2	0	2	91	77	131	344	552
Yorkshire and Humberside	42	39	32	12	3	10	1	3	2	23	167	150	0	313	463
East Midlands	44	14	13	14	2	6	2	6	0	4	105	67	0	249	316
West Midlands	38	61	27	9	14	9	8	5	0	0	171	158	7	359	524
East of England	21	14	38	2	5	1	2	2	0	3	88	87	59	251	397
London	48	67	30	22	14	11	9	5	1	25	232	224	54	565	843
Inner London	30	28	7	7	4	6	1	2	0	18	103	102	4	239	345
Outer London	18	39	23	15	10	5	8	3	1	7	129	122	50	326	498
South East	48	21	6	4	3	6	5	0	2	3	98	95	81	317	493
South West	55	27	6	26	11	19	3	8	0	8	163	114	0	183	297
Proportion of each recommendation made in each region															
England	29%	23%	15%	8%	6%	6%	3%	3%	0%	6%	100%	.	.	.	.
North East	40%	20%	9%	7%	6%	6%	1%	1%	0%	10%	100%	.	.	.	.
North West	18%	19%	26%	7%	20%	2%	4%	2%	0%	2%	100%	.	.	.	.
Yorkshire and Humberside	25%	23%	19%	7%	2%	6%	1%	2%	1%	14%	100%	.	.	.	.
East Midlands	42%	13%	12%	13%	2%	6%	2%	6%	0%	4%	100%	.	.	.	.
West Midlands	22%	36%	16%	5%	8%	5%	5%	3%	0%	0%	100%	.	.	.	.
East of England	24%	16%	43%	2%	6%	1%	2%	2%	0%	3%	100%	.	.	.	.
London	21%	29%	13%	9%	6%	5%	4%	2%	0%	11%	100%	.	.	.	.
Inner London	29%	27%	7%	7%	4%	6%	1%	2%	0%	17%	100%	.	.	.	.
Outer London	14%	30%	18%	12%	8%	4%	6%	2%	1%	5%	100%	.	.	.	.
South East	49%	21%	6%	4%	3%	6%	5%	0%	2%	3%	100%	.	.	.	.
South West	34%	17%	4%	16%	7%	12%	2%	5%	0%	5%	100%	.	.	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. Percentages are shown rounded to nearest whole number. (.) represents values which are not applicable.
3. A number of panels do not record the recommendations made in the format requested, so in some areas there are a high number of unknowns/unavailable in format requested.
4. Please note that CDOPs may not identify actions or recommendations following the death of every child. Therefore there will be a number of cases where no recommendations are made. There may also be some cases where more than one recommendation is made following the death of a child, therefore the total number of recommendations is not the same as the total number of reviews where recommendations were made. (I.e. column M is not necessarily the same as column N)
5. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.

Table H: Number of child death[1] reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs) by category of death
Year ending 31 March 2011
Coverage: England

	Category of death[2]											All child death reviews completed in year ending 31 March 2011 with an assessment of modifiable factors[4,5,6]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[4,5]	All child death reviews completed in year ending 31 March 2011[6]
	Deliberately inflicted injury, abuse or neglect	Suicide or deliberate self-inflicted harm	Trauma and other external factors	Malignancy	Acute medical or surgical condition	Chronic medical condition	Chromosomal, genetic and congenital anomalies	Perinatal/ neonatal event	Infection	Sudden unexpected, unexplained death	Unknown[3]			
All child death reviews completed in the year ending 31 March 2011														
Number of which had:														
Modifiable factors identified[5]	29	44	152	11	61	34	70	148	72	179	0	800	.	800
No modifiable factors identified[5]	18	26	73	240	157	203	898	1,301	179	120	3	3,218	.	3,218
TOTAL	47	70	225	251	218	237	968	1,449	251	299	3	4,018	43	4,061
Percentage of this category of death which had:														
Modifiable factors identified[4]	62%	63%	68%	4%	28%	14%	7%	10%	29%	60%	x #	20%	.	.
No modifiable factors identified[4]	38%	37%	32%	96%	72%	86%	93%	90%	71%	40%	x #	80%	.	.
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100% #	100%	.	.
Percentage of each category of death under this assessment:														
Modifiable factors identified[4]	4%	6%	19%	1%	8%	4%	9%	19%	9%	22%	0% #	100%	.	.
No modifiable factors identified[4]	1%	1%	2%	7%	5%	6%	28%	40%	6%	4%	0% #	100%	.	.
Of all deaths	1%	2%	6%	6%	5%	6%	24%	36%	6%	7%	0% #	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. Percentages are shown rounded to whole numbers but where the denominator was 10 or less, they have been suppressed and replaced by a cross (x). (.) represents values which are not applicable.
3. Some categories of death may be unknown because this information is not available in the format requested. There may also be cases where data were provided to the CDOP by a sub-panel (for example a specialist panel to review neonatal deaths) and information about the cause of death has not been provided. There may also be other cases where the cause of death was inconclusive or difficult to determine.
4. 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 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.
5. A modifiable death is defined 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.
6. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.

Table I: Number of child death[1] reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs)[2,3] by event which caused the child's death

Year ending 31 March 2011

Coverage: England

	Event which caused the child's death												All child death reviews completed in year ending 31 March 2011 with an assessment of modifiable factors[5,6,7]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[5,6]	All child death reviews completed in year ending 31 March 2011[7]
	Neonatal death	Known life limiting condition	Sudden unexpected death in infancy	Road traffic accident/collision	Drowning	Fire and burns	Poisoning	Other non-intentional injury/ accident/ trauma	Substance misuse	Apparent homicide[3]	Apparent suicide[4]	Other			
All child death reviews completed in the year ending 31 March 2011															
Number of which had:															
Modifiable factors identified[6]	172	54	191	74	21	x	x	46	x	15	40	168	800	.	800
No modifiable factors identified[6]	1495	882	162	33	8	x	0	43	x	17	22	550	3218	.	3218
Total	1667	936	353	107	29	17	x	89	x	32	62	718	4,018	43	4,061
Percentage of this event which had:															
Modifiable factors identified[6]	10%	6%	54%	69%	72%	x	x	52%	x	47%	65%	23%	20%		.
No modifiable factors identified[6]	90%	94%	46%	31%	28%	x	0%	48%	x	53%	35%	77%	80%		.
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		.
Percentage of each event under this assessment:															
Modifiable factors identified[6]	22%	7%	24%	9%	3%	x	x	6%	x	2%	5%	21%	100%	.	.
No modifiable factors identified[6]	46%	27%	5%	1%	0%	x	0%	1%	x	1%	1%	17%	100%	.	.
Of all deaths	41%	23%	9%	3%	1%	0%	x	2%	x	1%	2%	18%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. 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). 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. (.) represents values which are not applicable.
3. A homicide may be assessed as being not preventable if the panel determines that the homicide was unforeseen, for example a random act where there were no previous concerns about the suspect.
4. The number of deaths recorded as being due to "apparent suicide" may be different to the number of deaths recorded as "suicide or deliberate self-inflicted harm" in Table H. There may be deaths where it was not possible to determine the intent, so they were recorded as "suicide or deliberate self-inflicted harm" in Table H, but they were not be recorded as "suicide" in the table above. The data above is collected by CDOPs at the start of the review process and the data in Table H is collected at the end of the review process, so there may be deaths which were thought to be suicide at the start of the review process, but were later reclassified.
5. 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 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.
6. A modifiable death is defined 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.
7. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.

Table J: Number of child death[1] reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs)[2] by age of the child at the time of death
Year ending 31 March 2011
Coverage: England

	Age of the child at the time of death[2]							All child death reviews completed in year ending 31 March 2011 with an assessment of modifiable factors[4,5,6]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[5]	All child death reviews completed in year ending 31 March 2011[6]
	0-27 days	28 days- 364 days	1 year-4 years	5-9 years	10-14 years	15-17 years	Unknown[3]			
All child death reviews completed in the year ending 31 March 2011										
Number of which had:										
Modifiable factors identified[5]	183	261	103	45	68	139	1	800	.	800
No modifiable factors identified[5]	1595	661	316	216	203	224	3	3,218	.	3,218
Total	1778	922	419	261	271	363	4	4,018	43	4,061
Percentage of this age group which had:										
Modifiable factors identified[5]	10%	28%	25%	17%	25%	38%	x	20%	.	.
No modifiable factors identified[5]	90%	72%	75%	83%	75%	62%	x	80%	.	.
Total	100%	100%	100%	100%	100%	100%	100%	100%	.	.
Percentage of each age group under this assessment:										
Modifiable factors identified[5]	23%	33%	13%	6%	9%	17%	0%	100%	.	.
No modifiable factors identified[5]	50%	21%	10%	7%	6%	7%	0%	100%	.	.
Of all deaths	44%	23%	10%	6%	7%	9%	0%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. Percentages are shown rounded to whole numbers but where the denominator was 10 or less, they have been suppressed and replaced by a cross (x) (.) represents values which are not applicable.
3. There may be cases where the age of the child at the time of the death is unknown, this could be because this information was not provided to the CDOP by a sub-panel or this information may have been difficult . to collect, for example if the child died abroad
4. 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 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.
5. A modifiable death is defined 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.
6. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.

Table K: Number of child death[1] reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs)[2] by gender

Year ending 31 March 2011

Coverage: England

	Gender			All child death reviews completed in year ending 31 March 2011 with an assessment of modifiable factors[3,4,5]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[4]	All child death reviews completed in year ending 31 March 2011[5]
	Male	Female	Unknown/ Not stated			
All child death reviews completed in the year ending 31 March 2011						
Number of which had:						
Modifiable factors identified[4]	457	342	1	800	.	800
No modifiable factors identified[4]	1,731	1,478	9	3,218	.	3,218
Total	2,188	1,820	10	4,018	43	4,061
Percentage of this gender which had:						
Modifiable factors identified[4]	21%	19%	x	20%	.	.
No modifiable factors identified[4]	79%	81%	x	80%	.	.
Total	100%	100%	100%	100%	.	.
Percentage of each gender under this assessment:						
Modifiable factors identified[4]	57%	43%	0%	100%	.	.
No modifiable factors identified[4]	54%	46%	0%	100%	.	.
Of all deaths	54%	45%	0%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. Percentages are shown rounded to whole numbers but where the denominator was 10 or less, they have been suppressed and replaced by a cross (x) (.) represents values which are not applicable.
3. 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 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.
4. A modifiable death is defined 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.
5. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.

Table L: Number of child death[1] reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs) by ethnicity
Year ending 31 March 2011
Coverage: England

	Ethnicity[2]						All child death reviews completed in year ending 31 March 2011 with an assessment of modifiable factors[4,5,6]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[4,5]	All child death reviews completed in year ending 31 March 2011[6]
	White	Mixed/ Multiple ethnic groups	Asian/ Asian British	Black/ African/ Caribbean/ Black British	Other ethnic group	Unknown[3]			
All child death reviews completed in the year ending 31 March 2011									
Number of which had:									
Modifiable factors identified[5]	530	40	120	70	x	50	800	.	800
No modifiable factors identified[5]	1,900	140	550	270	50	320	3,218	.	3,218
Total	2,450	180	680	340	50	370	4,018	43	4,061
Percentage of this ethnicity which had:									
Modifiable factors identified[5]	22%	20%	17%	20%	x	14%	20%	.	.
No modifiable factors identified[5]	78%	80%	83%	80%	x	86%	80%	.	.
Total	100%	100%	100%	100%	100%	100%	100%	.	.
Percentage of each ethnicity under this assessment:									
Modifiable factors identified[5]	66%	4%	14%	8%	x	6%	100%	.	.
No modifiable factors identified[5]	59%	4%	17%	8%	2%	10%	100%	.	.
Of all deaths	60%	4%	17%	8%	1%	9%	100%	.	.

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). (.) represents values which are not applicable.
3. The ethnicity of the children was unknown in 9% of the reviews completed, this may be cause this information is not collected by the CDOP or the information collected is not in the required format.
4. 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 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.
5. A modifiable death is defined 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.
6. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.

Table M: Number of child death[1] reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs) by location at time of the event or condition which led to the death
Year ending 31 March 2011
Coverage: England

	Location at time of the event or condition[2]											All child death reviews completed in year ending 31 March 2011 with an assessment of modifiable factors[4,5,6]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[4,5]	All child death reviews completed in year ending 31 March 2011[6]
	Acute Hospital	Home of normal residence	Other private residence	Foster home	Residential care	Public place	School	Hospice	Mental health inpatient unit	Abroad	Other	Not known[3]			
All child death reviews completed in the year ending 31 March 2011														
Number of which had:														
Modifiable factors identified[5]	410	240	30	0	x	80	x	x	0	20	x	20	800	.	800
No modifiable factors identified[5]	2390	450	20	x	x	60	10	130	0	20	x	130	3,218	.	3,218
Total	2800	690	50	x	x	140	10	130	0	30	x	150	4018	43	4,061
Percentage of this location which had:														
Modifiable factors identified[5]	15%	35%	54%	x	x	57%	x	x	.	47%	x	12%	20%	.	.
No modifiable factors identified[5]	85%	65%	46%	x	x	43%	64%	97%	.	53%	x	88%	80%	.	.
Total	100%	100%	100%	x	x	100%	100%	100%	.	100%	x	100%	100%	.	.
Percentage of each location under this assessment:														
Modifiable factors identified[5]	51%	30%	3%	0%	x	10%	x	x	0%	2%	x	2%	100%	.	.
No modifiable factors identified[5]	74%	14%	1%	x	x	2%	0%	4%	0%	1%	x	4%	100%	.	.
Of all deaths	70%	17%	1%	x	x	4%	0%	3%	0%	1%	x	4%	100%	.	.

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). (.) represents values which are not applicable.
3. The location at the time of the event or condition which led to the death of the child was unknown in 4% of the reviews completed, this may be cause this information is not collected by the CDOP or the information collected is not in the required format.
4. 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 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.
5. A modifiable death is defined 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.
6. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.

Table N: Number of child death[1] reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs)2,3 by asylum seeking status
Year ending 31 March 2011
Coverage: England

	Number of child death reviews completed in year ending 31 March 2011[2]			All child death reviews completed in year ending 31 March 2011 with an assessment of modifiable factors[4,5,6]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[5]	All child death reviews completed in year ending 31 March 2011[6]
	Where the child was known to be an asylum seeker	Where it was known that the child was not an asylum seeker	Where it was unknown if the child was an asylum seeker[3]			
All child death reviews completed in the year ending 31 March 2011						
of which:						
Modifiable factors identified[5]	x	710	90	800	.	800
No modifiable factors identified[5]	10	2,750	460	3,218	.	3,218
Total	10	3,460	550	4,018	43	4,061
Percentage of this asylum seeking status:						
Modifiable factors identified[5]	x	21%	16%	20%	.	.
No modifiable factors identified[5]	x	79%	84%	80%	.	.
Total	100%	100%	100%	100%	.	.
Percentage of each asylum seeking status under this assessment:						
Modifiable factors identified[5]	x	89%	11%	100%	.	.
No modifiable factors identified[5]	0%	85%	14%	100%	.	.
Total	0%	86%	14%	100%	.	.

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). (.) represents values which are not applicable.
3. The asylum seekign status of the child was unknown in 14% of the reviews completed, this may be cause this information is not collected by the CDOP or the information collected is not in the required format
4. 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 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.
5. A modifiable death is defined 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.
6. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.

Table O: Number of child death[1] reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs)[2] by Statutory Order status

Year ending 31 March 2011

Coverage: England

	Statutory orders				All child death reviews completed in year ending 31 March 2011 with an assessment of modifiable factors[4,5,6]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[4,5]	All child death reviews completed in year ending 31 March 2011[6]
	At the time of death	Previously, but not at time of death	Not at all	Unknown[3]			
All child death reviews completed in the year ending 31 March 2011							
of which:							
Modifiable factors identified[5]	19	8	718	55	800	.	800
No modifiable factors identified[5]	20	8	2893	297	3,218	.	3,218
Total	39	16	3,611	352	4,018	43	4,061
Percentage of this statutory order status:							
Modifiable factors identified[5]	49%	50%	20%	16%	20%	.	.
No modifiable factors identified[5]	51%	50%	80%	84%	80%	.	.
Total	100%	100%	100%	100%	100%	.	.
Percentage of each statutory order status under this assessment:							
Modifiable factors identified[5]	2%	1%	90%	7%	100%	.	.
No modifiable factors identified[5]	1%	0%	90%	9%	100%	.	.
Total	1%	0%	90%	9%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. Percentages are shown rounded to whole numbers. (.) represents values which are not applicable.
3. It was unknown if 9% of the children reviewed were subject to a statutory order at the time of their death or previously. This may be because this information is not collected by the CDOP or the information collected is not in the required format.
4. 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 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.
5. A modifiable death is defined 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.
6. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.

Table P: Number of child death[1] reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs)[2] by Child Protection Plan status
Year ending 31 March 2011
Coverage: England

	Child protection plan				All child death reviews completed in year ending 31 March 2011 with an assessment of modifiable factors[4,5,6]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[4,5]	All child death reviews completed in year ending 31 March 2011[6]
	At the time of death	Previously, but not at time of death	Not at all	Unknown[3]			
All child death reviews completed in the year ending 31 March 2011							
of which:							
Modifiable factors identified[5]	18	22	718	42	800		800
No modifiable factors identified[5]	22	27	2,924	245	3,218		3,218
Total	40	49	3642	287	4018	43	4061
Percentage of this child protection plan status:							
Modifiable factors identified[4]	45%	45%	20%	15%	20%	.	.
No modifiable factors identified[4]	55%	55%	80%	85%	80%	.	.
Total	100%	100%	100%	100%	100%	.	.
Percentage of each child protection plan status under this assessment:							
Modifiable factors identified[4]	2%	3%	90%	5%	100%	.	.
No modifiable factors identified[4]	1%	1%	91%	8%	100%	.	.
Total	1%	1%	91%	7%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. Percentages are shown rounded to whole numbers. (.) represents values which are not applicable.
3. It was unknown if 7% of the children reviewed were the subject of a child protection plan at the time of their death or previously. This may be cause this information is not collected by the CDOP or the information collected is not in the required format.
4. 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 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.
5. A modifiable death is defined 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.
6. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.

Table Q: Number of child death[1] reviews completed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs) by Serious Case Review (SCR) status
Year ending 31 March 2011
Coverage: England

	Child death reviews completed in year ending 31 March 2011[2]			All child death reviews completed in year ending 31 March 2011 with an assessment of modifiable factors[3,4,5]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[4]	All child death reviews completed in year ending 31 March 2011[5]
	A SCR did not take place	A SCR did take place	Unknown			
All child death reviews completed in the year ending 31 March 2011						
of which:						
Modifiable factors identified[4]	759	38	3	800	.	800
No modifiable factors identified[4]	3,202	16	0	3,218	.	3,218
Total	3,961	54	3	4,018	43	4,061
Percentage of this asylum seeking status:						
Modifiable factors identified[4]	19%	70%	x	20%	.	.
No modifiable factors identified[4]	81%	30%	x	80%	.	.
Total	100%	100%	100%	100%	.	.
Percentage of each asylum seeking status under this assessment:						
Modifiable factors identified[4]	95%	5%	0%	100%	.	.
No modifiable factors identified[4]	100%	0%	0%	100%	.	.
Total	99%	1%	0%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. Percentages are shown rounded to whole numbers but where the denominator was 10 or less, they have been suppressed and replaced by a cross (x) (.) represents values which are not applicable.
3. 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 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.
4. A modifiable death is defined 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.
5. Please note that one CDOP in the East of England was unable to provide data which were consistent with the requirements of the data collection. Therefore there are approximately 30 deaths in the East of England which have been recorded as being completed by 31 March 2011, but the reviews had not yet been completed.