Department for Education

Statistical First Release

Child Death Reviews – Year ending March 2014

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Issued by	Department for Education, Sanctuary Buildings, Great Smith Street, London SW1P 3BT
Press office	020 7783 8300
Public enquiries	0370 000 2288
Statistician	Andy Brook
Phone	01325 735408
Email	Andrew.Brook@education.gsi.gov.uk
Internet	Statistics: child death reviews

3,658 Reviews completed by Child Death Overview Panels in the year ending 31 March 2014 – a year on year decrease from 4,061 in the year ending 31 March 2011

22% The percentage of child death reviews (823 reviews) identified as having modifiable factors, a slight increase from 20% in the year ending 31 March 2011

72% The percentage of child death reviews completed in the year ending 31 March 2014 that were reviewed within 12 months of death[1] which has shown a year-on-year decrease from 80% in the year ending 31 March 2011

66% The percentage of deaths reviews of children under one year old in the year ending 31 March 2014[1]. This percentage is consistent with the previous three years.

56% The percentage of child deaths reviews for boys (2,015) compared to 44% for girls (1,587)[1]. The majority of reviews have been for boys' deaths for in each of the last four years

67% The percentage of serious case reviews related to a child death where modifiable factors were found[1]

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[1] As a percentage of those where there is sufficient evidence to assess whether there were any modifiable factors. In the year ending 31 March 2014, there were 40 deaths with insufficient evidence.

An Official Statistics publication

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1. Introduction

This Official Statistics Release contains information on child death reviews that were completed in the year ending 31 March 2014 (a reporting year goes from 1 April through to 31 March the following year). Data has been provided by all 148 Local Safeguarding Children Boards on behalf of 86 Child Death Overview Panels. From 1 April 2008, Local Safeguarding Children Boards have had a statutory duty to review deaths of all children from birth (excluding still born babies) up to 18 years old, who are normally resident within their area. This is known as the Child Death Review Process.

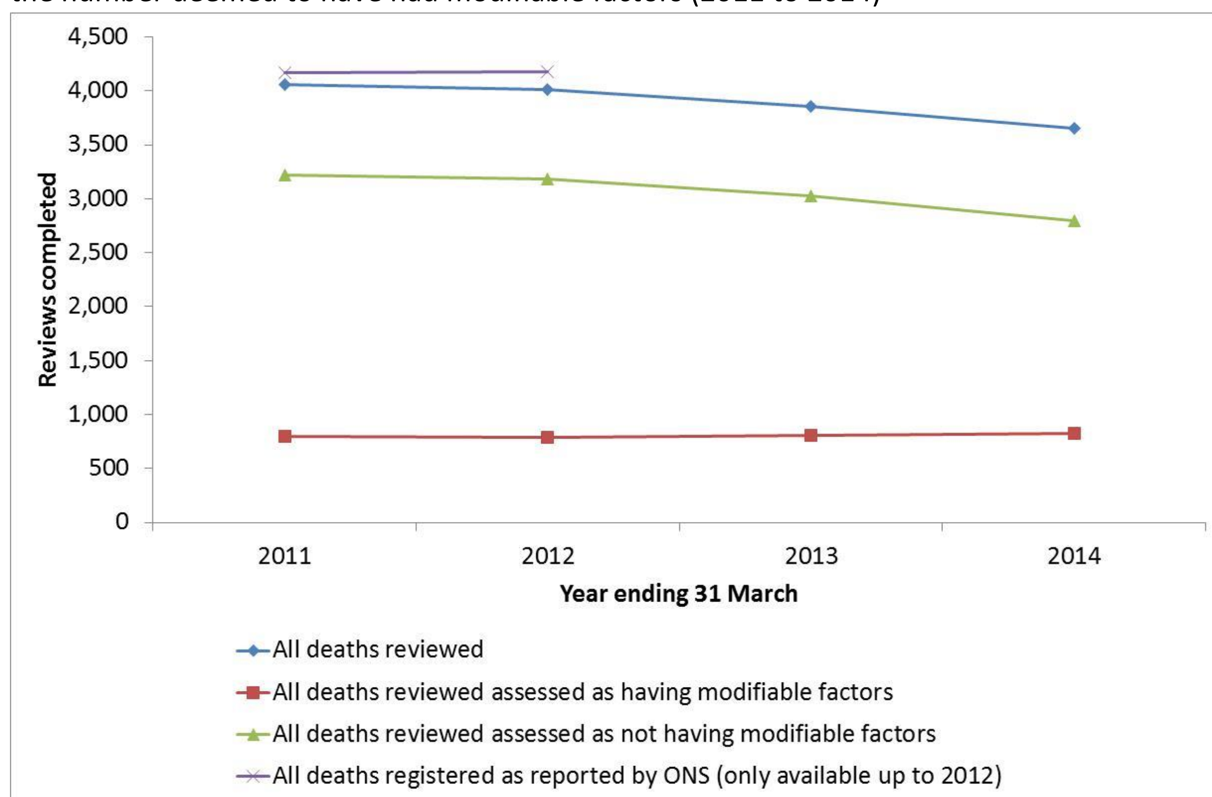
Reviewing deaths involves collating information on the cause, location and other circumstances of the death, including whether there were any modifiable factors in the death and determining if there are lessons which could be learned to reduce future child deaths. A modifiable death is defined as one where there are factors which may have contributed to the death which, by means of nationally or locally achievable interventions, could be modified to reduce the risks of future child deaths. However, the review is not an investigation into why a child has died and it is not a serious case review, although a serious case review may be completed in respect of a death where abuse or neglect is considered to be a factor.

2. Trends

The number of child death reviews has decreased year on year since the year ending 31 March 2011. In that year there were 4,061 child death reviews, compared to 3,658 in the year ending 31 March 2014. Figures from the Office for National Statistics (ONS) show that the number of child deaths remained steady between the years ending 31 March 2011 and 31 March 2012. More recent data are not available so it is not possible to say whether the fall in the number of reviews is related to a fall in the number of deaths. Data for the year ending 31 March 2013 will be available on 16 July 2014. Based on an approximated number of child deaths nationally, we estimate that reviews were carried out and reported for around 82% of deaths.

The number and percentage of reviews which were assessed as having modifiable factors has increased slightly since the year ending 31 March 2011 (20% compared to 22% in the most recent period). A small number of deaths each year (40 of those reviewed in the year ending 31 March 2014) had insufficient information to determine whether there were any modifiable factors in the death. These 40 deaths have been excluded from the analysis in sections 3 to 6 in this release. See technical note 3 for further information.

Chart 1: Number of child deaths and child deaths reviewed in the year ending 31 March and the number deemed to have had modifiable factors (2011 to 2014)



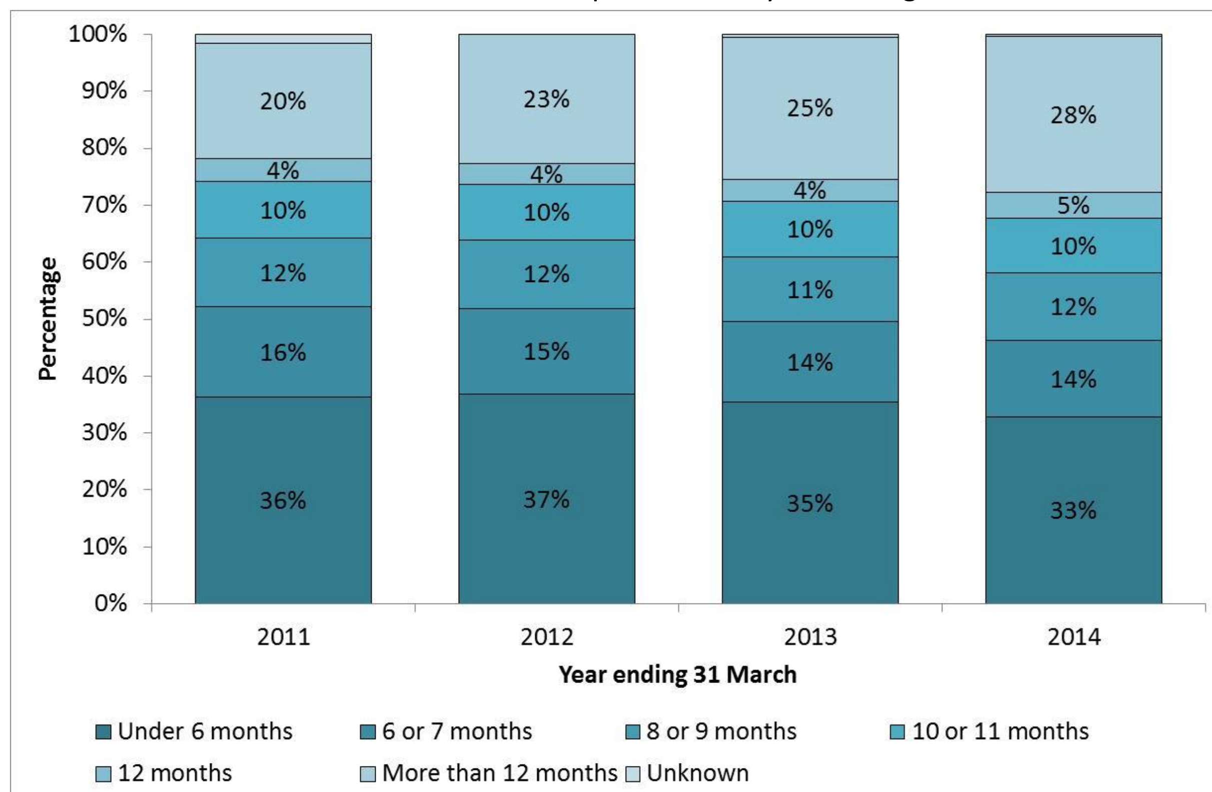
3. Duration of reviews (Table 4)

Of child deaths reviewed in the year ending 31 March 2014, 72% were completed within 12 months of the child's death, a year on year decrease from 78% in the year ending 31 March 2011.

Reviews take longer if modifiable factors are identified in the death. In the year ending 31 March 2014, 1,185 reviews were completed in less than six months of which 12% had identified modifiable factors. This compares to 995 reviews which took longer than a year of which 33% had modifiable factors. This means that reviews completed in the same reporting year as the death of the child have a consistently lower proportion of modifiable factors than those where the death occurred in a previous reporting year (these proportions have been stable at 14% for deaths during the same year and around 25% for deaths in previous years for the last three reporting years). See Table 3 for the figures underpinning these percentages.

The breakdown of the timescales of the reviews is shown in Chart 2 on the following page.

Chart 2: Duration of child death reviews completed in the year ending 31 March 2011 to 2014



4. Cause and location of death (Tables 5-7)

Panels record the likely cause of death, event which caused the death and location of the death. In the year ending 31 March 2014 and where there was sufficient evidence to make an assessment, 68% of the deaths reviewed occurred in an acute hospital and 3% in a hospice. This is consistent with over 80% of deaths reviewed that had a likely cause in the child's health problems[2] and with 70% of reviews where the event which caused the death was a known life limiting condition or it was a neonatal death. However, deaths in an acute hospital had a lower percentage of modifiable factors (17%) than all deaths combined, and lower than those for deaths that occurred at home (35%). The number and percentage of modifiable deaths in a hospice is suppressed due to small numbers.

By contrast, the number of deaths in public spaces is relatively small (4% of deaths where there was enough evidence to make an assessment) but child death reviews identified modifiable factors in over half the cases (53%). This is consistent with a high proportion of modifiable factors when the event that caused the death was either a road traffic accident/collision or drowning (with respectively, 65% and 63% of reviews completed in the year ending 31 March 2014 identifying modifiable factors).

These results are consistent with the previous three years.

[2] This covers perinatal/neonatal event; chromosomal, genetic and congenital anomalies; infection; malignancy, acute medical or surgical condition and chronic medical condition.

Table A: Category of death (year ending 31 March 2014)

Category of death	Percentage with modifiable factors
Sudden unexpected, unexplained death	68%
Trauma and other external factors	59%
Deliberately inflicted injury, abuse or neglect	56%
Suicide or deliberate self-inflicted harm	39%
Acute medical or surgical condition	29%
Infection	22%
Perinatal/neonatal event	18%
Chronic medical condition	15%
Chromosomal, genetic and congenital anomalies	9%
Malignancy	4%

Excludes three reviews where the category of death was unknown.

Table B: Events which caused the child's death (year ending 31 March 2014)

Event which caused the child's death	Percentage with modifiable factors[1]
Road traffic accident/collision	65%
Drowning	63%
Sudden unexpected death in infancy	61%
Apparent homicide	54%
Apparent suicide	35%
Other non-intentional injury/accident/trauma	32%
Neonatal death	17%
Known life limiting condition	8%
Fire and burns	x%
Poisoning	x%
Substance misuse	x%
Other	25%

[1] Percentages based on a numerator of five or fewer or a denominator of ten or fewer have been suppressed and replaced by a cross (x).

5. Serious case reviews, child protection plans and statutory orders (Tables 8-10)

A serious case review was carried out for 2% of all deaths reviewed which is the same percentage in the year ending 31 March 2013 and one percentage point higher than in the years ending 31 March 2011 and 31 March 2012. As numbers of serious case reviews are very small care must be taken when interpreting the data and considering trends. For deaths reviewed in 2013-14 that were subject to a serious case review, 67% were deemed to have modifiable factors, compared to 22% of those not subject to a serious case review.

Around 1% of children (51 children out of 3,618) whose death was reviewed during the year ending 31 March 2014 were the subject of a child protection plan at the time of their death. This percentage has remained unchanged since the year ending 31 March 2011. Due to small numbers of children in this group, care must be taken when interpreting these figures.

Almost half of children (47%) who died while the subject of a child protection plan had modifiable factors identified compared to 23% for children who had never been the subject of a plan.

The number and proportion of children who were subject to any statutory order[3] at the time of their death has risen for reviews in the year ending 31 March 2014. 62 children out of 3,618 (2% of all reviews) were subject to a statutory order, an increase of one percentage point from the year ending 31 March 2013. The numbers involved are small, however and so care should be taken when interpreting numbers and trends. 23% of reviews of children who had never been subject to statutory orders had modifiable factors in their death compared to 39% who were subject to statutory orders at the time of the death and 50% who had previously been subject to statutory orders.

6. Characteristics (Table 11)

Over the last four reporting years (i.e. since the year ending 31 March 2011), consistently, two out of three child deaths reviewed were for children aged under 1 year. Over the same period, the age groups where child death reviews identified the highest proportion as having modifiable factors were children aged 28 to 364 days and those aged 15 to 17 years (both 31%, in the year ending 31 March 2014). In the year ending 31 March 2014, the age group with the lowest proportion identified as having modifiable factors was children aged 5 to 9 years where 14% were identifiable as modifiable. However, in the three previous years, reviews of neonatal deaths identified the least modifiable factors.

Boys' deaths have consistently accounted for over half of deaths reviewed since the year ending 31 March 2011 and in the last two reporting years, the panels were slightly more likely to identify modifiable factors in reviews of boys' deaths than in girls' deaths (24% and 21% respectively in the year ending 31 March 2014).

Reviews of deaths of children from a White background accounted for the around three out of five of reviews completed in the current and the three previous reporting years (63% in the year ending 31 March 2014). Reviews of deaths of children from the Asian ethnic background consistently had the lowest percentage identified of modifiable factors across all ethnic groups in each of the last four reporting years: 16% in the year ending 31 March 2014, compared to 25%, 22% and 24% for reviews of deaths of children from White, Black and mixed ethnic backgrounds respectively.

Due to low numbers of children recorded as asylum seekers (around 10 deaths each year), this information has been removed from the statistical first release. There are no indications that the proportion of deaths of asylum seekers with modifiable factors is different from that of other children.

[3] Subject to any pre court disposals, Referral Orders, Youth Rehabilitation Orders and Detention and Training Orders

7. List of tables

The following tables are available in excel format on the department's statistics website: Statistics: child death reviews.

Reviews and timeliness

1 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards.
Years ending 31 March 2009 to 2014

2 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by region and the year in which the child death occurred.
Year ending 31 March 2014

3 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by the year in which the child death occurred.
Years ending 31 March 2011 to 2014

4 Time between the death of a child and the completion of the child death review.
Years ending 31 March 2011 to 2014

Cause and events

5 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by category of death.
Year ending 31 March 2014

6 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by event which caused the child's death.
Year ending 31 March 2014

7 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by location at time of the event or condition which led to the death.
Year ending 31 March 2014

Serious case reviews, child protection plans and statutory orders

8 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by Serious Case Review status.
Years ending 31 March 2011 to 2014

9 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by Child Protection Plan status.
Years ending 31 March 2011 to 2014

10 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by Statutory Order status.
Years ending 31 March 2011 to 2014

Characteristics

11 Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by age of the child at the time of death, gender and ethnicity.
Year ending 31 March 2014

Child Death Overview Panel meetings

12 Number of child deaths discussed by Child Death Overview Panels where the child was not normally resident within the Local Safeguarding Children Board area.
Years ending 31 March 2011 to 2014

13 Number of times which the Child Death Overview Panel met.
Years ending 31 March 2011 to 2014

8. Background information

1 The Local Safeguarding Children Boards data collection was introduced from 1 April 2008 and is designed to collect information on the number of child death reviews completed and the decisions made by Child Death Overview Panels on behalf of their Local Safeguarding Children Boards in England. Until 31 March 2010, panels were asked to assess whether a death was preventable or potentially preventable but due to difficulties distinguishing between these two categories, they were grouped and redefined as "modifiable factors". Since 1 April 2010, Local Safeguarding Children Boards have therefore been required to determine whether there were modifiable factors in the death of a child when reviewing the death.

2 Reviews of similar deaths in subsequent years may have resulted in different assessments of whether there were modifiable factors. Decisions may have changed as the process evolved and as panels built a consistent approach to understanding 'modifiable factors'. In addition, local trends may have begun to emerge which would suggest that deaths should be assessed as having had 'modifiable factors' when previously this would not have been the case.

3 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
  - 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.

Most child deaths do not lead to a serious case review. A serious case review is initiated where:

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

If it is thought, at any time, that the criteria for a serious case review might apply, the Chair of the Local Safeguarding Children Board should be contacted and the serious case review procedures followed. Not all deaths which result in a serious case review will be assessed as having modifiable factors.

4 For information on the child death review processes, please visit https://www.gov.uk/childrens-services/safeguarding-children. The data collection forms used to gather information for this publication and the related guidance can be found at https://www.gov.uk/child-death-data-collection.

9. Technical notes

1 The proportion of all deaths which have been reviewed by each region in Table 1 has been estimated using the number of deaths registered as occurring in the year ending 31 March 2012 for children aged 0-17 years old as reported by the Office for National Statistics. Deaths are not always registered in the year in which they occur and reviews are often not completed until several months after the death 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 and is not the same as the number of deaths reviewed in the same period.

2 The figures in the tables are based on data provided by 86 Child Deaths Overview Panels on behalf of 148 Local Safeguarding Children Boards in the year ending 31 March 2014. A full return has been received from all Local Safeguarding Children Boards in each year of the collection.

3 In a small number of cases (40 reviews in the year ending 31 March 2014) panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death. In other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel. These cases have been included in the number of reviews completed in tables 1 to 3 and 13 but excluded from subsequent analysis in tables 4 to 12.

4 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 fewer or the denominator was 10 or fewer, they have been suppressed and replaced by a cross. Where a percentage is zero because the number from which that percentage has been calculated is a zero, the percentage is shown as zero. (.) represents values which are not applicable. (-) represents percentages less than 0.5% but greater than 0%.

5 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. 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.

6 No tables are presented at a level smaller than regional level due to small numbers at a local level. Providing this data at a local level could risk individual children being identified. Regional data has not been included in Tables 12 and 13 this year due to small numbers and little variation for each region.

7 As part of a Government drive for data transparency in official publications supporting data for this publication have been made available. Within the supporting data 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.

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

9 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.

10. Related publications

Earlier releases of Department for Education: Child death reviews are available here.

The information page for the Child Death Review Programme for NHS Wales, including the 2013 Annual Report can be found here.

Home Office data on homicides of children under 16 years old can be found here as part of a wider release: *Crime Statistics, Focus on Violent Crime and Sexual Offences, 2012/13*.

The Statistical Bulletin *Deaths Registered in England and Wales, 2012* is produced by the Office for National Statistics and provides detailed data on infant mortality including perinatal and neonatal deaths. This release can be found here. Note that the next edition of this release will be published on 16 July 2014.

The Department for Education publish a two-year report *New Learning from Serious Case Reviews.* The latest release can be found here.

The Ofsted release *Serious Incident Notifications* can be found here and provide the first information on notifications of serious incidents involving children that were notified to Ofsted by local authorities.

11. Got a query? Like to give feedback?

If from the media	Press Office News Desk, Department for Education, Sanctuary Buildings, Great Smith Street, London SW1P 3BT. 020 7925 6789
If non-media	Andy Brook, Children's Social Care, Department for Education, 1F Area G, Mowden Hall, Staindrop Road, Darlington, DL3 9BG. 01325 735408. Andrew.Brook@education.gsi.gov.uk

Department for Education

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