



## Department for Education

### About this release

This Statistical First Release contains information on child death reviews that were completed in the year 1 April 2015 to 31 March 2016. 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. Data has been provided by all 148 Local Safeguarding Children Boards on behalf of 86 Child Death Overview Panels.

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### Feedback

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7925 6789.

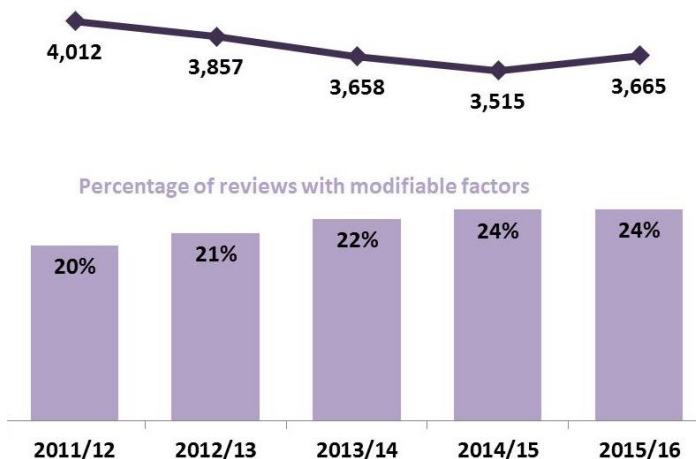
If non-media:

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## Child Death Reviews – Year ending 31 March 2016

### Numbers of child death reviews have risen in the latest year

The number of child death reviews that were completed has shown a rise in the most recent year after decreasing steadily over previous years. There were 3,665 reviews completed by Child Death Overview Panels in the year ending 31 March 2016, compared to 3,515 in the year ending 31 March 2015.



### Deaths with modifiable factors unchanged

The proportion of deaths which were assessed as having modifiable factors has remained unchanged at 24 per cent in the most recent year, following a gradual year-on-year increase since the year ending 31 March 2012. For further details on the definition of modifiable factors, see the Background section of this release.

## 1. Trends

**Table 1**

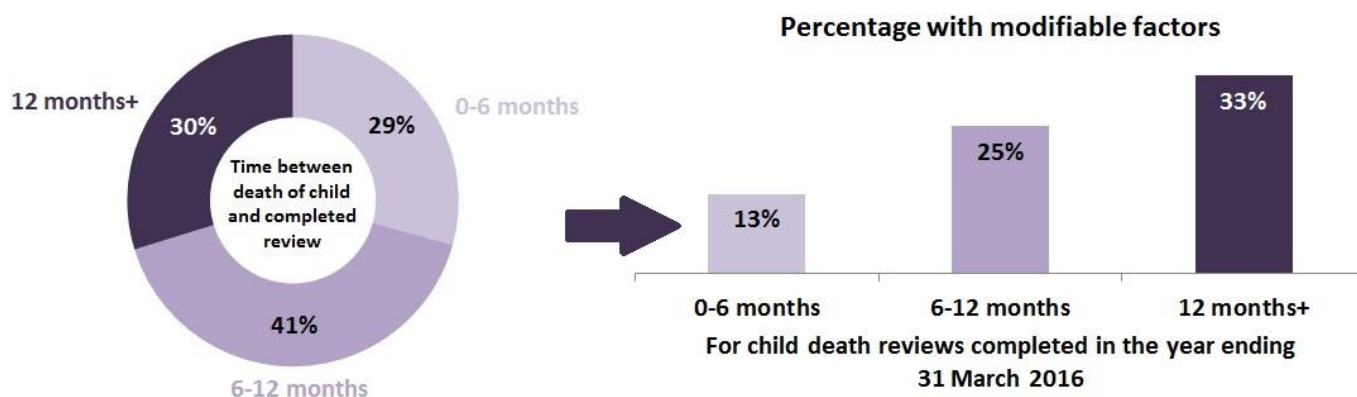
The number of child death reviews has risen slightly in the most recent year after an annual decrease since the year ending 31 March 2012. The percentage of reviews which were assessed as having modifiable factors increased between 2012 and 2015 but has remained unchanged in the most recent year.

The overall decrease in the number of child death reviews prior to the most recent year is consistent with a decrease in the number of registered child deaths. The most recent data from the Office for National Statistics show that the number of child deaths decreased between the years ending 31 March 2012 and 31 March 2014 ([here](#)).

## 2. Duration of reviews

**Table 3**

70% of child deaths reviews completed during the year were finalised within 12 months of the child’s death, the same proportion as last year. Reviews generally take longer if modifiable factors are identified in the death and in the year ending 31 March 2016, 13% of reviews which were completed in less than six months had identified modifiable factors, compared to 33% of reviews which took longer than a year to complete.



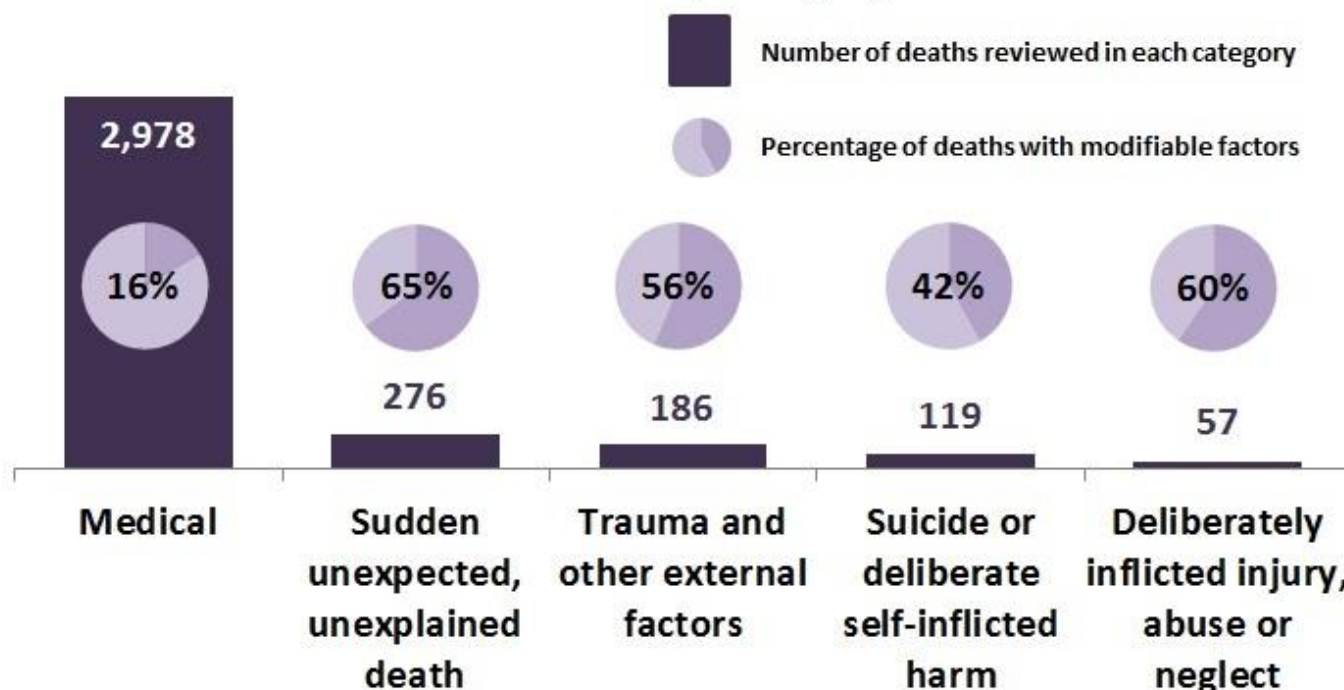
## 3. Circumstances

**Tables 4 to 6**

Around a third of all child death reviews were due to a perinatal/neonatal event; the percentage of these deaths with modifiable factors has steadily increased to 23% in 2016 from 10% in 2011. This compares to sudden, unexpected, unexplained deaths which represented 8% of all child death reviews, but where 65% of cases had modifiable factors.

The following chart shows the numbers of reviews for category of death together with the proportion of that category which had modifiable factors.

## Number of deaths reviewed and percentage with modifiable factors by category of death



In the year ending 31 March 2016, 2,458 of the deaths reviewed occurred in an acute hospital and 128 in a hospice. This is broadly consistent with 2,978 deaths reviewed that had a likely cause of the child's health problems<sup>1</sup> and with 2,464 of reviews where the event which caused the death was a known life limiting condition or it was a neonatal death. Deaths in an acute hospital had a lower percentage of modifiable factors (19%) than deaths in most other locations.

By contrast, the number of deaths in public spaces is relatively small (143 deaths) but child death reviews identified modifiable factors in 48% of the cases. This is consistent with a high proportion of modifiable factors when the event that caused the death was a road traffic accident/collision (43%).

## 4. Legal

### Tables 7 to 9

Due to small numbers, information in this section should be treated with caution.

A serious case review was carried out for 3% of all deaths reviewed in the year, which is slightly higher than in previous years. Of the deaths reviewed in 2015-16 that were subject to a serious case review, 53% were deemed to have modifiable factors, compared to 79% in 2014-15, although this is still much higher than the figure for those not subject to a serious case review, where only 23% were deemed to have modifiable factors in 2015-16.

<sup>1</sup> The "Medical" category includes perinatal/neonatal event; chromosomal, genetic and congenital abnormalities; infection; malignancy; acute medical or surgical condition; and chronic medical condition.

53 children out of 3,626 (1.5%) whose death was reviewed during the year were the subject of a child protection plan at the time of their death. Of these 53 children, 53% had modifiable factors identified compared to 23% for children who had never been the subject of a plan.

49 children were subject to a statutory order<sup>2</sup> at the time of their death. This is just 1% of all reviews, which is unchanged from the year ending 31 March 2015. 24% of children who had never been subject to statutory orders had modifiable factors identified, compared to 35% who were subject to statutory orders at the time of the death and 30% who had previously been subject to statutory orders.

## 5. Characteristics

### Table 10

Consistent with previous years, approximately two thirds of reviews completed were of children who died under the age of one; with 43% for children aged 0-27 days; and a further 21% for children aged between 28 and 364 days at the time of death. The age group where child death reviews identified the highest proportion as having modifiable factors were children aged 28 to 364 days (34%) and the lowest were those aged 5 to 9 years (17%).

Boys' deaths have consistently accounted for over half of deaths reviewed. The panels in the year ending 31 March 2016 were more likely to identify modifiable factors in reviews of boys' deaths (26%) than in girls' deaths (21%).

Reviews of deaths of children from a White background have consistently accounted for around two thirds of reviews completed where the child's ethnicity was recorded. By contrast, 17% of the deaths reviewed were for children from an Asian background.

The Department collects information on reviews of deaths of asylum seeking children but this has not been included in the statistical first release due to small numbers in the groups.

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<sup>2</sup> Subject to any pre court disposals, Referral Orders, Youth Rehabilitation Orders, and Detention and Training Orders.

## 6. Tables

The following tables are available in Excel format on the DfE statistics website: [Statistics: child death reviews](#).

### Reviews and timeliness

1. Number of child death reviews completed by Child Death Overview Panels by region.  
Years ending 31 March 2012 to 2016
2. Number of child death reviews completed by Child Death Overview Panels by the year in which the child death occurred.  
Years ending 31 March 2012 to 2016
3. Time between the death of a child and the completion of the child death review.  
Years ending 31 March 2012 to 2016

### Cause and events

4. Number of child death reviews completed by Child Death Overview Panels by category of death.  
Year ending 31 March 2016
5. Number of child death reviews completed by Child Death Overview Panels by event which caused the child's death.  
Year ending 31 March 2016
6. Number of child death reviews completed by Child Death Overview Panels by location at time of the event or condition which led to the death.  
Year ending 31 March 2016

### Serious case reviews, child protection plans and statutory orders

7. Number of child death reviews completed by Child Death Overview Panels by Serious Case Review status.  
Years ending 31 March 2012 to 2016
8. Number of child death reviews completed by Child Death Overview Panels by Child Protection Plan status.  
Years ending 31 March 2012 to 2016
9. Number of child death reviews completed by Child Death Overview Panels by Statutory Order status.  
Years ending 31 March 2012 to 2016

### Characteristics

10. Number of child death reviews completed by Child Death Overview Panels by age of the child at the time of death gender and ethnicity.  
Year ending 31 March 2016

### Child Death Overview Panel meetings

11. 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 2012 to 2016
12. Number of times which the Child Death Overview Panel met.  
Years ending 31 March 2012 to 2016

## 7. Background

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. Factors may be judged modifiable if they could use nationally or locally achievable interventions to reduce the risks of future child deaths. Reviewing deaths involves collating information on the cause, location and other circumstances of the death, but 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. 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.
4. 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
    - 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.
5. 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.
6. 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>.



## 8. Technical

1. The number of deaths registered as occurring during the year for children aged 0-17 years old is reported by the Office for National Statistics and latest data has been included in Table 1.
2. In a small number of cases (39 reviews in the year ending 31 March 2016) 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, 2 and 12 but excluded from subsequent analysis in tables 3 to 11.
3. In order to protect individual data, numbers from 1 to 5 inclusive have been suppressed and are shown as crosses (x). To ensure the suppressed number cannot be identified by simple arithmetic, secondary suppression may be required. This usually means that the next smallest number is also suppressed. 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%.
4. 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.
5. 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>.
6. 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.

## 9. Feedback

If you have any feedback or questions, please contact:

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Department  
for Education

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