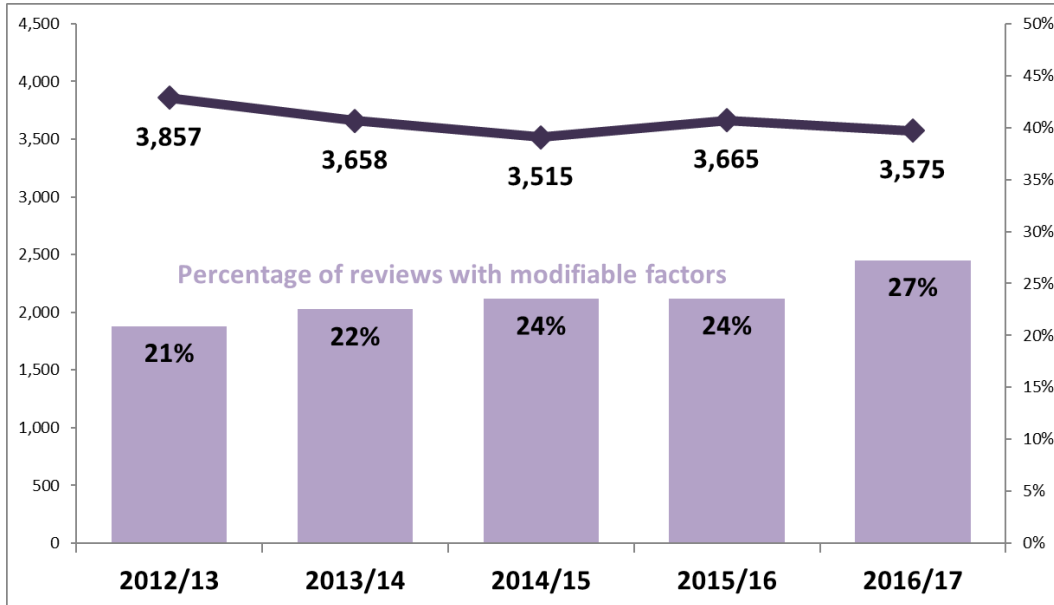




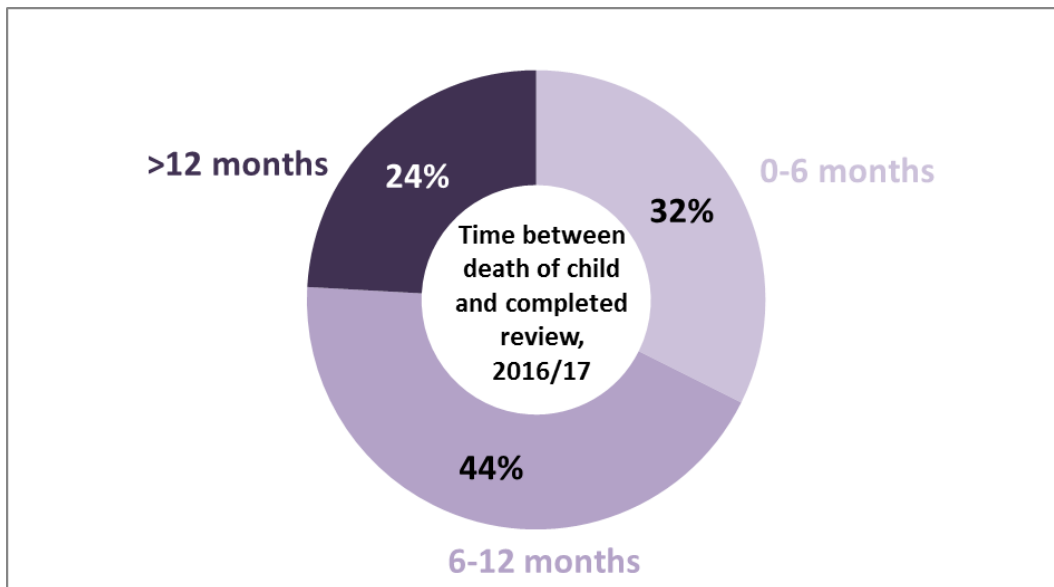
Number of child death reviews have fallen slightly in the latest year



The number of reviews of child deaths completed by Child Death Overview Panels in England has fallen slightly from 3,665 in the year ending 31 March 2016 to 3,575 in the year ending 31 March 2017.

Over the same period, the percentage of reviews with modifiable factors has increased from 24% to 27%.

A larger percentage of reviews were completed within 12 months of the child's death



Of the child death reviews completed during in the year ending 31 March 2017, 76% were finalised within 12 months of the child's death. This is an increase from 70% in the year ending 31 March 2016.

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About this release

This Statistical First Release contains information on child death reviews that were completed in the year 1 April 2016 to 31 March 2017 in England.

From 1 April 2008, Local Safeguarding Children Boards (LSCBs) have had a statutory duty to review deaths of all children from birth (excluding stillbirths and and planned terminations of pregnancy carried out within the law) 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 90 Child Death Overview Panels.

In this publication

The following tables are included in the SFR:

- SFR36_2017_Tables (Excel .xls)
- Underlying data (open format .csv and metadata .txt)

Feedback

We are changing how our releases look and welcome feedback on any aspect of this document at

CLA.STATS@education.gov.uk.

1. Introduction

The Local Safeguarding Children Board's (LSCBs) 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 LSCBs in England. LSCBs are required to review the death of every child normally resident in their area and ensure the child death review process is in place so that bereaved families are supported in their grief, that other siblings and the wider public are protected from similar circumstances, and that reasons for the death are investigated. A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening. 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, LSCBs 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 actions (at a national or local level) could be taken 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 specifically a SCR.

A child death review is completed for every child that dies who is usually resident in England (excluding stillbirths and planned terminations of pregnancy carried out within the law) 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 (SCR). A SCR 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.

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 result in a SCR will be assessed as having modifiable factors.

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.

For information on the child death review processes, see Chapter 5 of the 'Working Together to Safeguard Children' document at the [safeguarding children website](#). The data collection forms used to gather information for this publication and the related guidance can be found at [here](#).

2. Number of reviews (Table 1)

The number of child death reviews has fallen slightly in the most recent year after an increase in the previous year, however, the longer term trend is a gradually decreasing number of reviews.

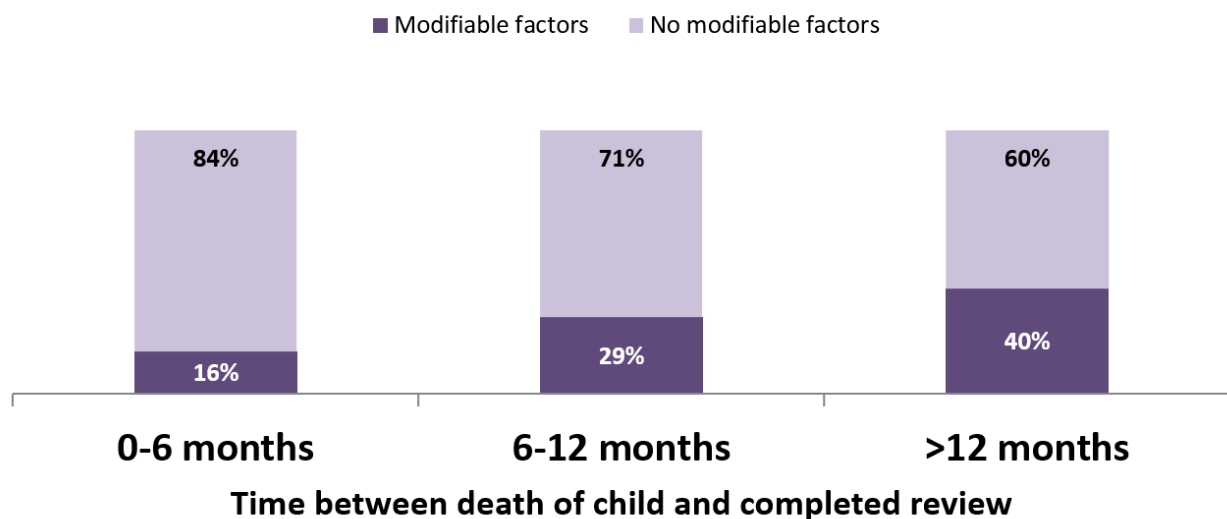
The percentage of reviews which were assessed as having modifiable factors has increased in the most recent year from 24% to 27%. There has been a longer term increasing trend in the percentage of modifiable factors, which may be for a number of reasons some of which are detailed in the [Introduction](#) above.

The longer term decreasing trend in the number of child death reviews is consistent with a longer term decreasing trend in the number of registered child deaths. However, the most recent data from the Office for National Statistics (ONS) show that the number of child deaths registered increased between the years ending 31 March 2014 and 31 March 2015 (see Figure 2 [here](#)) – this may account for some of the increase in the number of reviews completed in the year ending 31 March 2016.

3. Duration of reviews (Table 3)

Of the child deaths reviews completed during the most recent year, 76% were finalised within 12 months of the child's death, this is an increase from 70% last year. Reviews taking more than 12 months to complete are more likely to have modifiable factors than those reviews which take less than 12 months to finalise. In the year ending 31 March 2017, 16% of reviews which were completed in less than six months had identified modifiable factors, compared to 40% of reviews which took longer than a year to complete.

Percentage of reviews completed in 2016/17 with modifiable factors by time taken

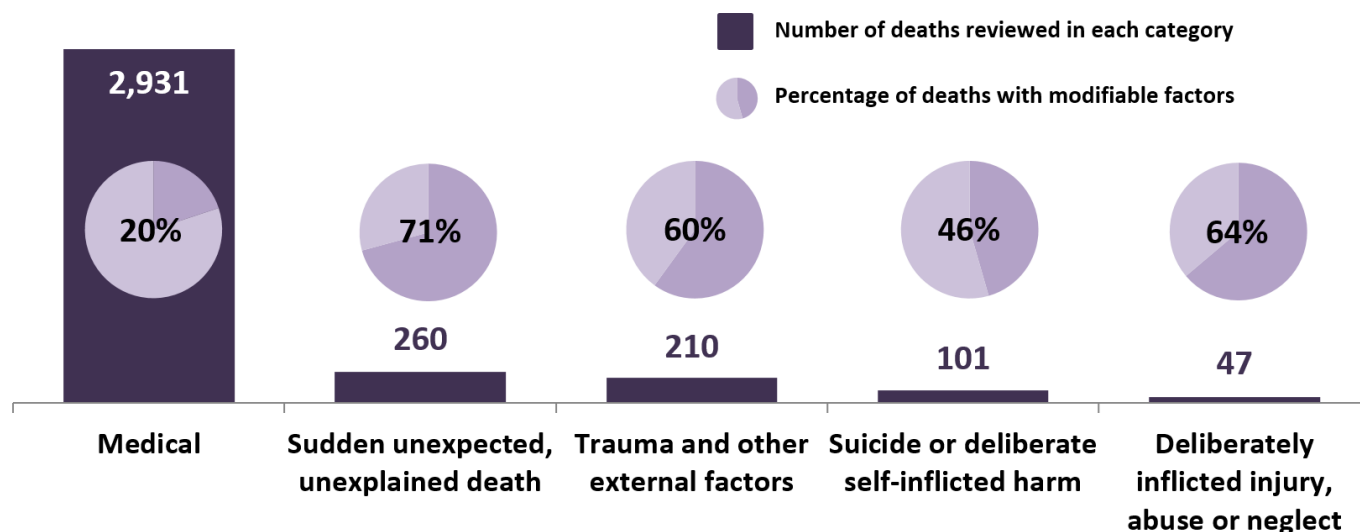


4. Circumstances (Table 4, Table 5 & Table 6)

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 28% in the year ending 31 March 2017 from 15% in the year ending 31 March 2013. This compares to sudden, unexpected, unexplained deaths which represented 7% of all child death reviews but where 71% of cases had modifiable factors.

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

Number of deaths reviewed in 2016/17 and percentage with modifiable factors by category of death



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

In the year ending 31 March 2017, 2,444 of the deaths reviewed occurred in an acute hospital and 153 in a hospice. This is broadly consistent with 2,931 deaths reviewed that were medical¹ and with 2,351 of reviews where the event which caused the death was a known life limiting condition or it was a neonatal death. Deaths in a hospice and an acute hospital had lower percentages of modifiable factors (5% and 24% respectively) than deaths in other locations.

By contrast, the number of deaths in public spaces is relatively small (148 deaths) but child death reviews identified modifiable factors in 51% 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 (69%).

5. Legal (Table 7, Table 8 & Table 9)

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

Child Protection Plans

68 children out of 3,555 (2%) whose death was reviewed during the year were the subject of a child protection plan at the time of their death. Of these 68 children, 59% had modifiable factors identified compared to 26% for children who had never been the subject of a plan.

Statutory Orders

64 children were subject to a statutory order² at the time of their death, this is 2% of the 3,555 reviews during the year. 27% of children who had never been subject to statutory orders had modifiable factors identified, compared to 45% who were subject to statutory orders at the time of the death.

Serious Case Reviews (SCRs)

A SCR was carried out for 3% of the 3,555 reviews during the year, which is the same as in the previous year. Of the deaths reviewed in 2016/17 that were subject to a SCR, 63% were deemed to have modifiable

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

² Subject to any pre-court disposals, Referral Orders, Youth Rehabilitation Orders, and Detention and Training Orders.

factors, this is much higher than the figure for those not subject to a SCR, where only 26% were deemed to have modifiable factors.

6. 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 (37%) and the lowest were those aged 5 to 9 years (20%).

Boys' deaths account for over half of the deaths reviewed (56%). The panels in the year ending 31 March 2017 were only slightly more likely to identify modifiable factors in reviews of boys' deaths (28%) than in girls' deaths (27%).

Reviews of deaths of children from a White background account for around two thirds of reviews completed where the child's ethnicity was recorded. By contrast, 16% of the deaths reviewed, where the child's ethnicity was recorded, were for children from an Asian background. This is in contrast to the child population as a whole, where 79% of children are from a White background and 10% are from an Asian background³.

³ Figures for the child population are taken from the 2011 national census and may not reflect the current population. [2011 Census](#)
[Nomis Official Labour Market Statistics](#)

7. Accompanying 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 2013 to 2017
- 2 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 2013 to 2017
- 3 Time between the death of a child and the completion of the child death review, Years ending 31 March 2013 to 2017

Cause and events

- 4 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 2017
- 5 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 2017
- 6 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 2017

Serious case reviews, child protection plans and statutory orders

- 7 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 2013 to 2017
- 8 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 2013 to 2017
- 9 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 2013 to 2017

Characteristics

- 10 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 2017

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 2013 to 2017
- 12 Number of times which the Child Death Overview Panel met, Years ending 31 March 2013 to 2017

When reviewing the tables, please note that:

Rounding conventions

The Code of Practice for Official Statistics requires that reasonable steps should be taken to ensure that all published or disseminated statistics produced by the Department for Education protect confidentiality.

Further information on the rounding conventions used in this SFR are included in the footnotes of the tables.

8. Further information is available

Child death reviews: year ending 31 March, previous publications	Previous versions of this publication can be found at the following website: Statistics: child death reviews .
Child death reviews: year ending 31 March, data collection	The data collection forms used to gather information for this publication and the related guidance can be found at here .
ONS data	The latest Office for National Statistics (ONS) data on deaths registered in England and Wales can be found here .
Child death reviews process	For information on the child death review processes, see Chapter 5 of the 'Working Together to Safeguard Children' document at the safeguarding children website .

9. Official Statistics

The United Kingdom Statistics Authority has designated these statistics as Official Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics.

Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods, and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as Official Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

The Department has a set of [statistical policies](#) in line with the Code of Practice for Official Statistics.

10. Technical information

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.

In a small number of cases (20 reviews in the year ending 31 March 2017), panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. These cases have been included in the number of reviews completed in Tables 1, 2 and 12 but excluded from Tables 3 to 11.

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

As part of a Government drive for data transparency in official publications underlying data for this publication have been made available. Within the underlying 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. Child Death Overview Panels may cover more than one local authority. Where figures for individual local authorities have been reported in combination with a neighbouring authority, this has been noted in the data.

11. Get in touch

Media enquiries

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Other enquiries/feedback

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Department for Education

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