Department for Education

Child deaths reviewed in England 2015-16

Statutory guidance for child death overview panels for the completion of the Local Safeguarding Children Board Child Death Data Collection

This version issued January 2016

Contents

Purpose of return

The Local Safeguarding Children Board (LSCB) child death data collection was introduced from 1 April 2008 and is designed to collect information on the number of child deaths which have been reviewed by Child Death Overview Panels (CDOPs) on behalf of their LSCBs, and the number of these cases which were identified as having modifiable factors[1] child deaths in England. This is the eighth year of collection.

Additional optional questions were added to the data collection form for the 2009-10 collection and these data items became mandatory from the 2010-11 collection onwards. If the information requested is not available for all children please complete the questions as fully as possible, providing information about the number of child deaths where the information is unknown.

Deadline

A LSCB1 data return is required from **all** LSCBs in England, even those where no reviews have been completed by their CDOP in the financial year. An LSCB1 form is required from all LSCBs. If possible, LSCBs can also provide child level data through the LSCB_A1 form (one for each child death review which was completed between 1 April 2015 and 31 March 2016).

All LSCB1 data returns should be returned to the Department for Education by **13 May 2016**.

How to return the data

The LSCB return should be completed using Excel and should be transferred securely to the CSAR Programme Office inbox no later than 13 May 2016. Further details of how to securely transfer the data collection form will be emailed to CDOP chairs and coordinators before 31 March 2016.

If you have any difficulties in completing or sending the form or need to update contact details please contact ProgrammeOffice.CSAR@education.gsi.gov.uk.

General background notes

In England, there are currently approximately 4,400 child deaths registered each year. The reviewing of all child deaths by Local Safeguarding Children Boards (LSCBs) became mandatory from 1 April 2008; although LSCBs have been able to do this since 2006. The key purpose of reviewing all child deaths is to learn lessons and reduce child deaths in the future. England is the first country to put in place multi-agency

[1] 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. (*Working Together to Safeguard Children (2010)* Paragraph 7.23)

arrangements that will provide a comprehensive understanding of the cause of all child deaths.

LSCBs have been provided with templates to use to record information on child deaths in Word documents. These templates can be downloaded here.

LSCBs use these templates to record:

- Case specific information and case management information (Form A)
    - Basic identifying details of the child
    - Details of the referrer
    - Details of the death
    - Details of notification
    - Agency contacts (Form A1)
- Information about the deaths of a child provided by an agency (Form B)
    - Identifying and reporting details
    - Summary of case and circumstances leading to the death
    - The child
    - Family environment
    - Parenting capacity
    - Service provision
    - Supplementary forms to gather information about events which led to the death (B2-B12)
- The cause of death and summary (Form C)
    - Categorisation of death
    - Modifiable issues identified, learning points and recommendations
    - Action specific to case
- Information from rapid response (Form D)
    - Basic identifying details of the child
    - Information about laboratory tests, home visits, inquest etc.
- A summary of all deaths within the LSCB (Form E)
    - Number of deaths in LA
    - Number of these reviewed by CDOP
    - Agencies involved in panels

- Causes of deaths

For information on the child death review processes, please visit https://www.gov.uk/childrens-services/safeguarding-children.

Notes on individual numbered items on LSCB1 form

Please note LSCBs have a responsibility to review the deaths of all children up to the age of 18 years who are normally resident in their geographical area (excluding babies who are stillborn and planned terminations of pregnancy carried out within the law[2]). CDOPs must therefore review neonatal deaths (deaths of infants aged less than 28 days) and deaths defined as "expected" deaths as well as "unexpected" deaths. Each death should be discussed by the panel (the time taken and the depth of the discussion may of course vary depending on the nature of the circumstances of the death in question) and a decision about whether there were modifiable factors which may have contributed to the death must be made and agreed by the child death overview panel, and signed off by the chair of the panel.

Please only provide information within the data collection form for child deaths where the decision about whether there were modifiable factors which may have contributed to the death has been agreed by the CDOP and signed off by the chair of the CDOP.

The CDOP is responsible for reviewing the deaths of all children normally resident in their area. Neighbouring LSCBs may decide to share a CDOP. Therefore one CDOP may be responsible for reviewing the deaths of children for a number of LSCBs and a number of Local Authorities.

This data collection form aims to collect information at LSCB level (with a breakdown by the LAs which feed into this LSCB).

We would also like to collect the names of other LSCBs (if any) with which your LSCB shares a CDOP. However, we require the name(s) of the partnering LSCB(s) only, we do not require any data about the deaths for which these LSCBs are leading the reviews, as this will be collected separately.

If your LSCB shares a CDOP with one or more LSCB please record information for your LSCB only; do not record information about deaths for which other LSCBs sharing your CDOP are leading the reviews.

If your LSCB is responsible for one LA only, please record information about this LA only.

If your LSCB is responsible for more than one LA, please record information for each of these LAs.

[2] Reviews of deaths which follow a planned termination under the law (Abortion Act 1967) should not be carried out by Child Death Overview Panels even in circumstances where a death certificate has been issued. If the LSCB has general concerns about local procedures relating to planned terminations, it should contact the Care Quality Commission. All other deaths (i.e. excluding those deaths which follow a planned termination of pregnancy under the law) which have been registered as live with the General Registrar's Office, should be reviewed by the Child Death Overview Panel.

Please complete all cells within the LSCB1 form which are highlighted in red and where applicable please also complete the cells which are highlighted in orange. If a cell is highlighted in yellow this indicates that there are inconsistencies with data which have been entered into the form. For example if LA1 reports that:

- 5 child death reviews were completed (Item 12).
- No other figures are provided for Items 13-17.
- No child deaths were identified as having modifiable factors (Item 18).
- 4 deaths of male children were identified as having no modifiable factors (Table 8).
- No other cells are completed within Table 8.

This will be identified as an inconsistency as the total values entered in Table 8 should be the same as the total of items 12-17, so there should be 5 child deaths in Table 8. Therefore one child is missing from Table 8 and should be entered in the "no modifiable factors" column or the "insufficient information to assess" column. If this gender is unknown the child should be included within "unknown".

Please provide responses to all items within the LSCB1 form. Additionally, if you wish to provide anonymised child level responses to Tables 1, 2, 5 to 14, and 16, then please provide data through the LSCB1_A1 form (one for each child death review which was completed between 1 April 2015 and 31 March 2016). Please note child level data is optional.

Before returning the LSCB1 form to DfE please ensure that no items or tables are highlighted in yellow.

To identify why a cell has been highlighted in yellow please see the notes above each table and the guidance notes below.

Item 1

Title of the Local Safeguarding Children Board

Provide the name of the Local Safeguarding Children Board to which the data on the LSCB1 form refers.

Items 2-6

Names of Local Authorities which are members of your LSCB:

Local Authority name 1

Local Authority name 2

Local Authority name 3

Local Authority name 4

Local Authority name 5

Each LSCB is responsible for ensuring that all child deaths within at least one LA are reviewed.

Provide the names of all LAs which are members of the LSCB recorded in Item 1. Please note if your LSCB only has one LA member then only this LA name should be recorded.

A full list of LA names can be found in Appendix 1.

Items 7-11

Local Authorities codes which are members of your LSCB:

Local Authority code 1

Local Authority code 2

Local Authority code 3

Local Authority code 4

Local Authority code 5

Provide the LA code for all LAs recorded in items 2-6.

Local authority code 1 should be the code for the local authority recorded against item 2 (Local Authority name 1).

Local authority code 2 should be the code for the local authority recorded against item 3 (Local Authority name 2).

Local authority code 3 should be the code for the local authority recorded against item 4 (Local Authority name 3).

Local authority code 4 should be the code for the local authority recorded against item 5 (Local Authority name 4).

Local authority code 5 should be the code for the local authority recorded against item 6 (Local Authority name 5).

Use the standard 3-digit code which can be found in Appendix 1.

Items 12-17

The number of child deaths where the review of the child's death has been completed by your Child Death Overview Panel for your LSCB between 1 April 2015 and 31 March 2016 for each of the LAs which are members of your LSCB:

(Please include any reviews completed where the child was not normally resident within your LSCB area in item 17)

Local Authority 1

Local Authority 2

Local Authority 3

Local Authority 4

Local Authority 5

Outside of your LSCB area

This is the number of child deaths in your LSCB area where the review of the child's death has been completed by the CDOP between 1 April 2015 and 31 March 2016. Please note for the purposes of this data collection a review is defined as being complete when the CDOP has discussed the child's death (these discussions may vary in the time taken and their depth. This means the review may be completed in a different financial year to that which the child died), agreed a decision about whether there were modifiable factors which may have contributed to the death and this decision has been agreed and signed off by the chair of the CDOP.

This **does not** include cases where the decision may change dependent on outcomes from post mortems, inquests, criminal proceedings, serious case reviews or other investigations.

Please note the decision about whether there were modifiable factors which may have contributed to the death should be agreed by the CDOP and signed off by the chair of the CDOP for every child death, including cases which have had a preliminary discussion within a sub panel and where there is no foreseeable contention about the decision made by the sub panel.

Where a child was normally resident within your LSCB area please record the death against the LA were the child was normally resident (items 12-16).

Where a child has died in a LSCB area other than the area where the child was normally resident, more than one LSCB may be involved in reviewing the death. The LSCBs should decide which one of them has the lead responsibility for this process and

therefore which LSCB will be providing data on the child's death for the purposes of this return.

Please note if your panel led on the review of a child who was **not normally resident within your LSCB area**, and this review was completed between 1 April 2015 and 31 March 2016, then this should be recorded in item 17.

Details of completed reviews where the child was not normally resident within your LSCB area should also be included in all other tables within the collection and details of why this death has been reviewed by your CDOP should be provided in the second and third column of Table 4.

If your CDOP is shared by more than one LSCB and your CDOP completed the review at least one child's death where the child was normally resident outside of your CDOP area, then please record information about these outside of area reviews on only one of the LSCB1 forms. This is to avoid double counting of these child death reviews when the forms are collated.

If your CDOP discussed a child's death where the child was not normally resident within your LSCB area, but did not lead on reviewing the child's death because the CDOP where the child was normally resident led the review, then this should also be recorded in column one of Table 4, but should not be included in any other tables or numbered items.

For example, a child may die in a specialist hospital within LSCB A; however the child is normally resident in LSCB B. The two LSCBs will work together to gather information about the child's death. The two LSCBs may agree that LSCB A should lead on the review of the child death; therefore the review of this child's death should be included in the data collection form for LSCB A in item 17 and all additional tables (Tables 1-18) (and item 23 if appropriate). LSCB B should record this death in Table 3 as a notification of a death where another CDOP will lead on the review and should not be included in any other data items or tables.

Child deaths resulting from terminations (see footnote 2) should not be reviewed by your panel therefore please do not include these deaths in the data collection form.

This return includes reviews of child deaths which happened during the financial year, but may also include cases where the child died in the previous financial year, but where the review has been completed in the current financial year. For example, a child could die in February 2015 and the CDOP could make its decision on whether there were modifiable factors which may have contributed to the death in August 2015, and this review should be included within this table. Whereas a case where a child died in August 2015 and a final decision about whether there were modifiable factors was not made by 31 March 2016 should not be included.

Please provide the number of deaths that were reviewed by your CDOP for each of the LAs which are members of your LSCB, as well as any reviews which were completed where the child was not normally resident within your LSCB area.

The number recorded in item 12 should correspond to the number of deaths reviewed on behalf of the LA recorded in item 2 and 7.

The number recorded in item 13 should correspond to the number of deaths reviewed on behalf of the LA recorded in item 3 and 8.

The number recorded in item 14 should correspond to the number of deaths reviewed on behalf of the LA recorded in item 4 and 9.

The number recorded in item 15 should correspond to the number of deaths reviewed on behalf of the LA recorded in item 5 and 10.

The number recorded in item 16 should correspond to the number of deaths reviewed on behalf of the LA recorded in item 6 and 11.

Enter totals in the boxes. Enter 0 if there were no child death reviews. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Items 18-23

Of these deaths where the review is complete, the number the panel identified as having modifiable factors (as recorded through form C) for each of the LAs which are members of your LSCB:

Local Authority 1

Local Authority 2

Local Authority 3

Local Authority 4

Local Authority 5

Outside of your LSCB area

This is the number of child deaths which have been reviewed by the CDOP for your LSCB between 1 April 2015 and 31 March 2016, and where a decision has been made that there were modifiable factors which may have contributed to the death. Please note this decision should be agreed by the CDOP and signed off by the chair of the CDOP for every child's death.

This **does not** include cases where the decision may change dependent on outcomes from post mortems, inquests, criminal proceedings, serious case reviews or other investigations.

Please provide the number of deaths where the panel has decided there were modifiable factors which may have contributed to the death for each of the LAs which are members of your LSCB. Please also provide the number of deaths where there were modifiable factors which may have contributed to the death and the child was not normally resident within your LSCB area in item 17.

The number recorded in item 18 should correspond to the information recorded about the LA detailed in item 2, 7 and 12 and should be less than or equal to the value entered in item 12.

The number recorded in item 19 should correspond to the information recorded about the LA detailed in item 3, 8 and 13 and should be less than or equal to the value entered in item 13.

The number recorded in item 20 should correspond to the information recorded about the LA detailed in item 4, 9 and 14 and should be less than or equal to the value entered in item 14.

The number recorded in item 21 should correspond to the information recorded about the LA detailed in item 5, 10 and 15 and should be less than or equal to the value entered in item 15.

The number recorded in item 22 should correspond to the information recorded about the LA detailed in item 6, 11 and 16 and should be less than or equal to the value entered in item 16.

The number entered in item 23 should be less than or equal to the value entered in item 17.

Enter totals in the boxes. Enter 0 if there were no child death reviews. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Items 24-28

Is the Child Death Overview Panel which reviews the child deaths within your LSCB responsible for reviewing the deaths of children from any other LSCB area(s)? (If so please list the name(s) of the LSCBs below):

LSCB 1

LSCB 2

LSCB 3

LSCB 4

LSCB 5

Provide the name of all LSCBs which share a CDOP with your LSCB. As CDOPs may be responsible for reviewing the deaths of children within more than one LSCB we wish to collect information about which LSCBs feed into the same CDOP. With this information we will be able to derive the number of child deaths which have been reviewed by each CDOP. However, please note that the details recorded in items 2-23 should refer to your LSCB only and not any other LSCBs which feed into your CDOP. The information from partner LSCBs is not required as this will be collected through a separate form sent to the relevant LSCB.

If your CDOP is not shared with any other LSCBs please leave this section blank.

Table 1

Of the child deaths where the review of the child's death has been completed by your CDOP on behalf of your LSCB between 1 April 2015 and 31 March 2016, when did the death of these children occur:

Please supply a breakdown of the number of child death reviews that were completed by your CDOP between 1 April 2015 and 31 March 2016 (as entered in items 12-17) by the date when the death occurred.

If the dates of any child deaths are unknown please provide information about the number of child deaths where the date of death is unknown within table 18.

Please note for the purposes of this data collection a “review” is defined as being complete when the CDOP has discussed the child’s death (these discussions may vary in depth and time taken), agreed a decision about whether there were modifiable factors which may have contributed to the death and this decision has been agreed and signed off by the chair of the CDOP.

Please note the decision about whether there were modifiable factors which may have contributed to the death should be agreed by the CDOP and signed off by the chair of the CDOP for every child death, including cases which have had a preliminary discussion within a sub panel and where there is no foreseeable contention in the decision made by the sub panel.

Enter totals in the boxes. Enter 0 if there were no child death reviews completed. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Table 2

Of the child death reviews which were identified as having modifiable factors (As recorded through form C) by your CDOP on behalf of your LSCB between 1 April 2015 and 31 March 2016, when did the death of these children occur:

Please supply a breakdown of the number of child death reviews that were completed by your CDOP between 1 April 2015 and 31 March 2016 where the panel decided that there were modifiable factors which may have contributed to the death (as entered in items 18-23) by the date when the death occurred.

If the dates of any child deaths are unknown please provide information about the number of child deaths where the date of death is unknown within table 18.

Enter totals in the boxes. Enter 0 if there were no child death reviews completed where the panel decided that there were modifiable factors which may have contributed to the death. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Table 3

How many child death reviews, where your CDOP was leading the review, were ongoing (i.e. not completed) at 31 March 2016, for each of the LAs which are members of your LSCB:

Please provide the total number of child death reviews which were in the process of being reviewed by your CDOP. Only record reviews which your CDOP is leading and do not record any reviews which were completed by 31 March 2016. This includes deaths which have been discussed by the CDOP but a final decision about modifiable factors has not yet been made and it also includes deaths which have been notified to your CDOP, but your CDOP has not yet discussed.

Please provide a breakdown of these ongoing reviews by the year in which the child died.

Enter totals in the boxes. Enter 0 if there were no ongoing (i.e. not completed) child death reviews at 31 March 2016. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Table 4

The number of child deaths which have been discussed by your CDOP on behalf of your LSCB between 1 April 2015 and 31 March 2016, where the child was not normally resident within your LSCB area. E.g. where the death occurred in a hospital within your LSCB area, but the child was normally resident outside of your LSCB area:

Please provide the number of child deaths that occurred outside your LSCB area, which your panel have either discussed or fully reviewed. If your panel discussed the death but another CDOP led on the child death review please record this death in the first column only. (Please include deaths where the CDOP leading the review was yet to complete the review at 31 March as well as those where the review was completed. If a death was discussed more than once please only record this once). If your panel discussed the death and led on the child death review and completed the child death review between 1 April 2015 and 31 March 2016 then please record this in the third column only. (Please note if your panel is in the process of leading the review of a child death where the child was not normally resident within your LSCB area, but the review was not complete by 31 March 2016 then this death should not be recorded within this table).

Please break this figure down by the reason why your panel reviewed this child death:

- The child died in a hospital within the CDOP area
- The child had been treated in a hospital within the CDOP area prior to the death
- The child was involved in a road traffic accident within the CDOP area
- Other (please state)

If this is due to an "other" reason than those listed please supply information about this reason (line 123).

Enter totals in the boxes. Enter 0 if there were no child death reviews. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Cells within this table will remain yellow until values or "0" are entered. Therefore if no deaths outside of your LSCB are were discussed please enter 0 in every cell.

Table 5

Of the child death reviews completed by your CDOP on behalf of your LSCB between 1 April 2015 and 31 March 2016, what was the category of deaths, as recorded in Form C, for these children:

Please supply a breakdown of the total number of child death reviews that were completed by your CDOP between 1 April 2015 and 31 March 2016 (as entered in items 12-17) by the category of death and broken down by the CDOP's decision on whether there were modifiable factors which may have contributed to the death.

Please only include child deaths where the death has been discussed by the CDOP and the decision on whether there were modifiable factors which may have contributed to the death has been agreed by the CDOP and signed off by the chair of the CDOP.

If this information is not available please provide figures for the number of unknown category. If the figures supplied in this table are still not consistent with those supplied in items 12-17 please provide details in table 18.

Enter totals in the boxes. Enter 0 if there were no child death reviews. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Table 6

How many of the child death reviews completed by your CDOP on behalf of your LSCB between 1 April 2015 and 31 March 2016, were caused by the events below:

Please record one event for each child. If more than one event occurred please record the event which is most likely to have caused the death.

Please supply a breakdown of the total number of child death reviews that were completed by your CDOP between 1 April 2015 and 31 March 2016 (as entered in items 12-17) by the event which led to the death and broken down by the CDOP's decision on whether there were modifiable factors which may have contributed to the death.

Please only include child deaths where the death has been discussed by the CDOP and the decision on whether there were modifiable factors which may have contributed to the death has been agreed by the CDOP and signed off by the chair of the CDOP.

If this information is not available please provide figures for the number of unknown events.

If the figures supplied in this table are still not consistent with those supplied in items 12-17 please provide details in table 18.

Cells will remain yellow if the total number of deaths defined as having modifiable factors, no modifiable factors and deaths where there was insufficient information to assess is not the same as those entered in Table 5 (line 142).

Enter totals in the boxes. Enter 0 if there were no child death reviews. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Table 7

Of the child death reviews completed by your CDOP on behalf of your LSCB between 1 April 2015 and 31 March 2016, how many children were in each of the following age groups:

Please supply a breakdown of the total number of child death reviews that were completed by your CDOP between 1 April 2015 and 31 March 2016 (as entered in items 12-17) by the age of the child at the time of death and broken down by the CDOP's decision on whether there were modifiable factors which may have contributed to the death.

Please only include child deaths where the death has been discussed by the CDOP and the decision on whether there were modifiable factors which may have contributed to the death has been agreed by the CDOP and signed off by the chair of the CDOP.

If this information is not available please provide figures for the number of unknown ages.

If the figures supplied in this table are still not consistent with those supplied in items 12-17 please provide details in table 18.

Cells will remain yellow if the total number of deaths defined as having modifiable factors, no modifiable factors and deaths where there was insufficient information to assess is not the same as those entered in Table 5 (line 142).

Enter totals in the boxes. Enter 0 if there were no child death reviews. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Table 8

Of the child death reviews completed by your CDOP on behalf of your LSCB between 1 April 2015 and 31 March 2016, how many children were of each of the following genders:

Please supply a breakdown of the total number of child death reviews that were completed by your CDOP between 1 April 2015 and 31 March 2016 (as entered in items 12-17) by the gender of the child and broken down by the CDOP's decision on whether there were modifiable factors which may have contributed to the death.

Please only include child deaths where the death has been discussed by the CDOP and the decision on whether there were modifiable factors which may have contributed to the death has been agreed by the CDOP and signed off by the chair of the CDOP.

If this information is not available please provide figures for the number of unknown genders.

If the figures supplied in this table are still not consistent with those supplied in items 12-17 please provide details in table 18.

Cells will remain yellow if the total number of deaths defined as having modifiable factors, no modifiable factors and deaths where there was insufficient information to assess is not the same as those entered in Table 5 (line 142).

Enter totals in the boxes. Enter 0 if there were no child death reviews. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Table 9

Of the child death review completed by your CDOP on behalf of your LSCB between 1 April 2015 and 31 March 2016, how many children were the subject of a child protection plan:

Please supply a breakdown of the total number of child death reviews that were completed by your CDOP between 1 April 2015 and 31 March 2016 (as entered in items 12-17) by the child protection plan status of the child (i.e. the child was the subject to a child protection plan at the time of the death or the child had previously been the subject of a child protection plan or the child was not known to have ever been the subject of a child protection plan or unknown) and broken down by the CDOP's decision on whether there were modifiable factors which may have contributed to the death.

If this information is not available please provide figures for the number of children where this information is unknown.

If the figures supplied in this table are still not consistent with those supplied in items 12-17 please provide details in table 18.

Cells will remain yellow if the total number of deaths defined as having modifiable factors, no modifiable factors and deaths where there was insufficient information to assess is not the same as those entered in Table 5 (line 142).

Enter totals in the boxes. Enter 0 if there were no child death reviews. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Table 10

Of the child death review completed by your CDOP on behalf of your LSCB between 1 April 2015 and 31 March 2016, how many children were subject to any statutory orders:

Please supply a breakdown of the total number of child death reviews that were completed by your CDOP between 1 April 2015 and 31 March 2016 (as entered in items 12-17) by the child's statutory order status (i.e. the child was subject to a statutory order at the time of the death, the child had previously been subject to a statutory order, the child was not known to have ever been subject to a statutory order or unknown) and broken down by the CDOP's decision on whether there were modifiable factors which may have contributed to the death.

If this information is not available please provide figures for the number of children where this information is unknown.

If the figures supplied in this table are still not consistent with those supplied in items 12-17 please provide details in table 18.

Cells will remain yellow if the total number of deaths defined as having modifiable factors, no modifiable factors and deaths where there was insufficient information to assess is not the same as those entered in Table 5 (line 142).

Enter totals in the boxes. Enter 0 if there were no child death reviews. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Table 11

DfE are aware that reviewing child deaths is an extremely complex task and it may take a number of months to gather all the relevant information to be able to fully review the death. We would therefore like to make an assessment of the average length of time between a child's death and the completion of the review. ***Please note this information will not be used as a performance measure.***

Of the child death reviews completed by your CDOP on behalf of your LSCB between 1 April 2015 and 31 March 2016, how long after the death of the child was the review completed:

Please supply a breakdown of the total number of child death reviews that were completed by your CDOP between 1 April 2015 and 31 March 2016 (as entered in items 12-17) by the amount of time between the child's death and the completion of the child death review and broken down by the CDOP's decision on whether there were modifiable factors which may have contributed to the death.

Please note for these purposes a child death review is complete when the child's death has been discussed by the CDOP and a decision about whether there were modifiable factors which may have contributed to the death has been agreed by the panel and signed off by the CDOP chair.

Data collected has revealed that there were number of reasons why there may be lengthy delays between the death of a child and the completing on the child death review, these have included:

- Waiting for results from post mortems
- Waiting for outcomes from the SCRs
- Waiting for the outcome from criminal proceedings

- Delays in receiving information from other agencies
- Delays related to the setting up of a CDOP

The data collected through this data item will allow DfE to understand if the amount of time between a child's death and the completion of the review reduces over time as the child death review process evolves or whether there will always be complex child deaths which require a number of months to gather sufficient information to fully review the child's death.

If this information is not available please provide figures for the number of unknowns.

If the figures supplied in this table are still not consistent with those supplied in items 12-17 please provide details in table 18.

Cells will remain yellow if the total number of deaths defined as having modifiable factors, no modifiable factors and deaths where there was insufficient information to assess is not the same as those entered in Table 5 (line 142).

Enter totals in the boxes. Enter 0 if there were no child death reviews. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Table 12

Of the child death reviews completed by your CDOP on behalf of your LSCB between 1 April 2015 and 31 March 2016, how many children were of the following ethnicities:

Please supply a breakdown of the total number of child death reviews that were completed by your CDOP between 1 April 2015 and 31 March 2016 (as entered in items 12-17) by the ethnicity of the child and broken down by the CDOP's decision on whether there were modifiable factors which may have contributed to the death.

Please note for these purposes a child death review is complete when the child's death has been discussed by the CDOP and a decision about whether there were modifiable factors which may have contributed to the death has been agreed by the panel and signed off by the CDOP chair.

If this information is not available please provide figures for the number of unknown/not stated ethnicities.

If the figures supplied in this table are still not consistent with those supplied in items 12-17 please provide details in table 18.

Cells will remain yellow if the total number of deaths defined as having modifiable factors, no modifiable factors and deaths where there was insufficient information to assess is not the same as those entered in Table 5 (line 142).

Enter totals in the boxes. Enter 0 if there were no child death reviews. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Table 13

Were any of the child death reviews completed by your CDOP on behalf of your LSCB between 1 April 2015 and 31 March 2016 on a child who was seeking asylum (either as an unaccompanied child or with their family):

Please provide the number of completed child death reviews between 1 April 2015 and 31 March 2016 by whether it was:

- Known that the child was an asylum seeker (either as an unaccompanied child or with their family)
- Unknown whether the child was an asylum seeker
- Known that the child was not an asylum seeker

Please also provide a breakdown by the CDOP's decision on whether there were modifiable factors which may have contributed to the death.

Please only include child deaths where the death has been discussed by the CDOP and the decision on whether there were modifiable factors which may have contributed to the death has been agreed by the CDOP and signed off by the chair of the CDOP.

If this information is not available please provide figures for the number of unknowns.

If the figures supplied in this table are still not consistent with those supplied in items 12-17 please provide details in table 18.

Cells will remain yellow if the total number of deaths defined as having modifiable factors, no modifiable factors and deaths where there was insufficient information to assess is not the same as those entered in Table 5 (line 142).

Enter totals in the boxes. Enter 0 if there were no child death reviews. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Table 14

Of the child death reviews completed by your CDOP on behalf of your LSCB between 1 April 2015 and 31 March 2016, where was the child at the time of the event or condition which led to the death?

Please supply a breakdown of the total number of child death reviews that were completed by your CDOP between 1 April 2015 and 31 March 2016 (as entered in items 12-17) by where the child was at the time of the event or condition which led to the death and broken down by the CDOP's decision on whether there were modifiable factors which may have contributed to the death.

Please provide the location of the event or condition which led to the child's death. **Do not record the place where the death was confirmed**. For example if a child was involved in a road traffic accident and was taken to hospital where they later died because of their injuries, then the location of the event which led to the death should be recorded as the place of the accident, i.e. a public place, not the hospital.

Please note if the event which led to the death occurred on a road or a railway, please record this under "public place". If the event which led to the death occurred in the delivery suite or operating theatre then please record this under "Acute hospital- other".

Please only include child deaths where the death has been discussed by the CDOP and the decision on whether there were modifiable factors which may have contributed to the death has been agreed by the CDOP and signed off by the chair of the CDOP.

If this information is not available please provide figures for the number of unknowns.

If the figures supplied in this table are still not consistent with those supplied in items 12-17 please provide details in table 18.

Cells will remain yellow if the total number of deaths defined as having modifiable factors, no modifiable factors and deaths where there was insufficient information to assess is not the same as those entered in Table 5 (line 142).

Enter totals in the boxes. Enter 0 if there were no child death reviews. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Table 15

Between 1 April 2015 and 31 March 2016 how many times did your CDOP meet in order to discuss child deaths on behalf of your LSCB.

This information will allow the DfE to gain further information about the resources and time involved in reviewing child deaths. **Please note this information will not be used as a performance measure.**

Please provide the number of times that your CDOP met to review child deaths between 1 April 2015 and 31 March 2016 inclusive.

Please do not include the number of rapid response meetings or any other sub-panel meetings.

Enter totals in the box. Enter 0 if there were no child death reviews. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

Table 16

Please give details of the number of Serious Case Reviews associated with the child death reviews completed by your CDOP on behalf of your LSCB between 1 April 2015 and 31 March 2016.

Please supply a breakdown of the total number of child death reviews that were completed by your CDOP between 1 April 2015 and 31 March 2016 (as entered in items 12-17) by whether:

- A SCR was not appropriate, so was not recommended by the CDOP or any other body
- A SCR was recommended by a body other than the CDOP
- A SCR was recommended by the CDOP and taken forward
- A SCR was recommended by the CDOP and not taken forward. (Please include cases where a SCR was recommended but a decision was made at a later date that a SCR was not appropriate.)

Cells will remain yellow if the total number of deaths defined as having modifiable factors, no modifiable factors and deaths where there was insufficient information to assess is not the same as those entered in Table 5 (line 142).

Enter totals in the box. Enter 0 if there were no child death reviews. Boxes must not contain letters or symbols, such as hyphens or asterisks. If the data are unavailable, do not insert a zero – leave the relevant box blank.

This information will allow the DfE to understand if CDOPs instigate SCRs or whether this process is already ongoing when the panel begins to review the child death.

Table 17

For all child death reviews completed by your CDOP between 1 April 2015 and 31 March 2016 please record the factors identified which contributed to the child's death. Please record all factors which were relevant to the death, for example if co-sleeping and smoking by the parent/carer in a household or during pregnancy were both identified as factors then please record both for that death. Factors should be identified for all deaths whether they are deemed as having modifiable factors or not.

For all child death reviews completed between 1 April 2015 and 31 March 2016 please record details of the factors (as detailed in Form C) which may have or did contribute to the death.

Please only include child deaths where the death has been discussed by the CDOP and the decision on whether there were modifiable factors which may have contributed to the death has been agreed by the CDOP and signed off by the chair of the CDOP.

If information is not available on whether a specific factor may have contributed to the death, count the child in the "information not available" column for that row. Cells will remain yellow if the total number of deaths in **each row of the table** is not the same as the total provided in items 12-17.

Table 18

Please use the box below to provide any further narrative information which you wish to share with DfE, e.g. information about the actions and recommendations which your panel had made:

Please provide any other information in this section that:

- Has not already been collected within the form, but which your panel feels would be of interest to DfE.
- Gives details of any issues that may impact on the data supplied.
- Provides information about the completeness of the data provided.
- Identifies local trends that may require national intervention

Appendix A – Local Authority codes

201	City of London
202	Camden
203	Greenwich
204	Hackney
205	Hammersmith and Fulham
206	Islington
207	Kensington and Chelsea
208	Lambeth
209	Lewisham
210	Southwark
211	Tower Hamlets
212	Wandsworth
213	Westminster
301	Barking and Dagenham
302	Barnet
303	Bexley
304	Brent
305	Bromley
306	Croydon
307	Ealing
308	Enfield
309	Haringey
310	Harrow
311	Havering
312	Hillingdon
313	Hounslow
314	Kingston upon Thames
315	Merton
316	Newham
317	Redbridge
318	Richmond upon Thames
319	Sutton
320	Waltham Forest
330	Birmingham
331	Coventry
332	Dudley
333	Sandwell
334	Solihull
335	Walsall
336	Wolverhampton
340	Knowsley
341	Liverpool
342	St Helens
343	Sefton
344	Wirral
350	Bolton
351	Bury
352	Manchester
353	Oldham
354	Rochdale
355	Salford
356	Stockport
357	Tameside
358	Trafford
359	Wigan
370	Barnsley
371	Doncaster
372	Rotherham
373	Sheffield
380	Bradford
381	Calderdale
382	Kirklees
383	Leeds
384	Wakefield
390	Gateshead
391	Newcastle upon Tyne
392	North Tyneside
393	South Tyneside
394	Sunderland
420	Isles of Scilly
800	Bath and North East Somerset
801	Bristol, City of
802	North Somerset
803	South Gloucestershire
805	Hartlepool
806	Middlesbrough
807	Redcar and Cleveland
808	Stockton-on-Tees
810	Kingston Upon Hull, City of
811	East Riding of Yorkshire
812	North East Lincolnshire
813	North Lincolnshire
815	North Yorkshire
816	York
821	Luton
822	Bedford Borough
823	Central Bedfordshire
825	Buckinghamshire
826	Milton Keynes
830	Derbyshire
831	Derby
835	Dorset
836	Poole
837	Bournemouth
840	Durham
841	Darlington
845	East Sussex
846	Brighton and Hove
850	Hampshire
851	Portsmouth
852	Southampton
855	Leicestershire
856	Leicester
857	Rutland
860	Staffordshire
861	Stoke-on-Trent
865	Wiltshire
866	Swindon
867	Bracknell Forest
868	Windsor and Maidenhead
869	West Berkshire
870	Reading
871	Slough
872	Wokingham
873	Cambridgeshire
874	Peterborough
876	Halton
877	Warrington
878	Devon
879	Plymouth
880	Torbay
881	Essex
882	Southend-on-Sea
883	Thurrock
884	Herefordshire
885	Worcestershire
886	Kent
887	Medway
888	Lancashire
889	Blackburn with Darwen
890	Blackpool
891	Nottinghamshire
892	Nottingham
893	Shropshire
894	Telford and Wrekin
895	Cheshire East
896	Cheshire West and Chester
908	Cornwall
909	Cumbria
916	Gloucestershire
919	Hertfordshire
921	Isle of Wight
925	Lincolnshire
926	Norfolk
928	Northamptonshire
929	Northumberland
931	Oxfordshire
933	Somerset
935	Suffolk
936	Surrey
937	Warwickshire
938	West Sussex

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