Department for Education

Statistical Release

OSR 14/2012

24 July 2012

Coverage: England

Theme: Health, well-being and Care

Issued by
Department for Education
Sanctuary Buildings
Great Smith Street
London SW1P 3BT

Telephone:
Press Office
020 7925 6789
Public Enquiries
0370 000 2288

Statistician
Sarah Wolstenholme

Email
info@education.gsi.gov.uk

Internet
http://www.education.gov.uk/

CHILD DEATH REVIEWS: YEAR ENDING 31 MARCH 2012

INTRODUCTION

This Official Statistical Release provides figures on child death reviews which have been completed by Local Safeguarding Children Boards in England between 1 April 2011 and 31 March 2012.

Local Safeguarding Children Boards are responsible for developing policies and procedures for safeguarding and promoting the welfare of children in their Local Authority area. From 1 April 2008, all Local Safeguarding Children Boards have had a statutory responsibility to review the deaths of all children from birth (excluding still born babies) up to 18 years, who are normally resident within their area. This is known as the Child Death Review Process. The duties of the Local Safeguarding Children Boards regarding these processes are set out in Chapter 7 of *Working Together to Safeguard Children* (HM Government 2010). Their responsibilities include setting up a Child Death Overview Panel (panels) which reviews child deaths on behalf of the Local Safeguarding Children Board.

Reviewing child deaths includes collecting information about the circumstances of the fatality, identifying if there were any modifiable factors[1] in the death and determining if there are lessons which could be learned to reduce future child deaths. However this is not an investigation into why a child has died and it is not a serious case review, although a serious case review may be completed in respect of a death where abuse or neglect were considered to be a factor.

COVERAGE

Data has been provided by all 148[2] Local Safeguarding Children Boards on behalf of all 92[3] panels. This is the fourth year of this data collection. Reviewing child deaths is an extremely complex responsibility of the Local Safeguarding Children Boards. Please see the section on “Data Quality and Interpretation”.

KEY POINTS

Number of reviews completed

- 4,012 child death reviews were completed by Child Death Overview Panels in the year ending 31 March 2012. This is slightly lower than the number of review completed in the year ending 31 March 2011 (1% fewer reviews were completed the year ending 31 March 2012).
- Of the child death reviews completed in the year ending 31 March 2012, 784 were identified as having modifiable factors (20%). This is the same proportion as identified in the year ending 31 March 2011.

[1] A modifiable death is defined as where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.
[2] Neighbouring Local Authorities may decide to share one Local Safeguarding Children Board, depending on the local configuration of services and population served.
[3] Neighbouring Local Safeguarding Children Boards s may decide to share a Child Death Overview Panel, depending on the local configuration of services and population served.

- In the year ending 31 March 2012 panels in the South West identified the highest proportion of modifiable factors in the child death reviews that they completed (32%) and the South East identified the lowest (12%).
- The deaths of 3,994 children who dies in the year ending 31 March 2012 were notified to panels. 40% of these deaths had completed reviews by 31 March 2012. The remaining 60% of reviews were ongoing at 31 March 2012.

Number of child deaths registered

- According to the Office for National Statistics (ONS) 4,476 children who died in the year ending 31 March 2009 were registered in England. 4,409 were registered as occurring in the year ending 31 March 2010.
- Data on registrations of deaths which occurred in the year ending 31 March 2011 and 2012 is not yet available. Assuming that the number of deaths in these two years is the same as the number of deaths which were registered as occurring in the year ending 31 March 2010, then approximately 17,700 children have died since the statutory responsibility to review child deaths was introduced on 1 April 2008. Approximately 76% of these child death reviews were completed by 31 March 2012.
- Panels reported that 3,994 deaths were notified to them as having occurred in the year ending 31 March 2012. This is a rate of 36 per 100,000 children in the population aged 0-17 years. (Based on mid 2010 population estimates).This rate varied greatly across regions with the rate in Inner London being the highest at approximately 50 per 100,000 children and the North East being the lowest at approximately 30 per 100,000 children.

Characteristics of child deaths where the review was completed

There were 48 deaths reviewed (1% of all reviews completed) where there was insufficient information available for the panel to determine if there were modifiable factors in a child's death. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information is provided to the panel.

The following findings refer to the child death reviews completed in the year ending 31 March 2012 where there was sufficient information available for the panel to determine if there were modifiable factors in the death (3,964 out of 4,012):

- Modifiable factors were identified in a higher proportion of deaths of older children (with nearly a third of all deaths in children aged 15-17 years having modifiable factors identified) compared to younger children (18% of deaths in children ages under 1 year.) This could reflect the categories of death which occur more frequently in older children (for example suicide and road traffic accidents) which have a higher proportion of deaths with modifiable factors identified.
- Deaths of male and female children were equally likely to have modifiable factors identified.
- Panels are asked to categorise the likely cause of death. They also record the event which caused the death. For example a death due to accidental drowning would have the likely cause of death categorised as "Trauma and other external factors" and the event which caused the death would be recorded as "drowning".
- 24% of all deaths which were identified as having modifiable factors were due to "sudden unexpected, unexplained deaths". A further 23% were due to "neonatal/perinatal events" and an additional 18% were due to "trauma and other external factors".

- The tables below shows deaths categorised as being due to “deliberately inflicted injury, abuse or neglect” had the highest proportion of deaths identified as having modifiable factors. Deaths where the event which led to the death was an “other non-intentional injury/ accident/ trauma” had the highest proportion of deaths identified as having modifiable factors.

Category of death	Percentage of deaths where modifiable factors were identified
Deliberately inflicted injury, abuse or neglect	65%
Sudden unexpected, unexplained death	63%
Trauma and other external factors	62%
Suicide or deliberate self-inflicted harm	48%
Infection	27%
Acute medical or surgical condition	25%
Chronic medical condition	12%
Perinatal/ neonatal event	12%
Chromosomal, genetic and congenital anomalies	8%
Malignancy	2%
Unknown	.

Event which caused the child's death	Percentage of deaths where modifiable factors were identified
Other non-intentional injury/ accident/ trauma	65%
Drowning	58%
Apparent homicide	58%
Sudden unexpected death in infancy	57%
Road traffic accident/collision	50%
Apparent suicide	41%
Other	24%
Neonatal death	12%
Known life limiting condition	7%
Fire and burns	x
Poisoning	x
Substance misuse	x
Unknown	x

BACKGROUND

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. This is the fourth year of collection.

Local Safeguarding Children Boards are responsible for reviewing the deaths of all children who are normally resident in their area, including children who die abroad or in another Local Safeguarding Children Board area. This may involve a number of Local Safeguarding Children Boards working together to address cross boundary issues.

The key objectives of reviewing all child deaths are to learn lessons in order to improve the health, safety and wellbeing of children and to reduce the number of future child deaths.

From 1 April 2010 onwards panels were asked to identify if there were modifiable factors in the death. Previously panels were asked to assess if the death was preventable or potentially preventable, but panels reported difficulties in distinguishing between these two categories, i.e. of factors which did contribute to the death and of factors which may have contributed to the death and ensuring a nationally consistent approach. Therefore these two categories were grouped and redefined as “modifiable factors”.

Please note panels are asked to identify modifiable factors in the child's direct care by any agency, including parents, latent, organisational, systemic or other indirect failure(s) within one or more agency. Therefore a death identified as having modifiable factors may not necessarily be due to a failure of the Local Authority or other agencies to safeguard the child's welfare.

The year ending 31 March 2012 is the second year in which panels were required to provide additional information about the child death reviews which had been completed by their panel, for example details about the child's age, gender, ethnicity and cause of death.

England is the first country to put in place multi-agency arrangements that will provide a comprehensive understanding of the cause of all child deaths.

Legislation

The Children Act 2004 places a statutory duty on local authorities in England to set up Local Safeguarding Children Boards. One of the Local Safeguarding Children Boards' functions, set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006 (SI No 2006/90), is to review the deaths of all children who are normally resident in their area. This function became mandatory in April 2008; although Local Safeguarding Children Boards had been able to do this since 2006. Chapter 7 in *Working Together to Safeguard Children* (HM Government 2010) sets out the guidance to be followed by Local Safeguarding Children Boards. It replaces the previous guidance used in 2006.

The Coroners Rules 1984 as amended by the Coroners (Amendment) Rules 2008 place a duty on coroners to inform the Local Safeguarding Children Board, for the area in which the child died, of the fact of an inquest or post mortem. It also gives coroners powers to share information with Local Safeguarding Children Boards for the purposes of carrying out their functions, which include reviewing child deaths and undertaking Serious Case Reviews.

Registrars of births and deaths are required by the Children and Young Persons Act 2008 to supply Local Safeguarding Children Boards with information on the child's death certificate. In addition, the Registrar General has a duty to provide the Secretary of State with information on all child deaths including those abroad.

DATA QUALITY AND INTERPRETATION

Not all child deaths which occurred in the year ending 31 March 2012 had completed child death reviews by 31 March 2012. This is because it may take a number of months (or years in some cases) to gather sufficient information to be able to fully review a child's death, for example while panels wait for the outcome from criminal proceedings, autopsies, coroners reports and Serious Case Reviews. Please note that although reviews may not have been completed by 31 March 2012, panels have begun to learn lessons from these cases and to take action to resolve the issues.

Panels encountered a number of issues in the first year of reviewing child deaths which reduced the number of reviews completed in the year ending 31 March 2009 and 31 March 2010. Therefore we would not expect the number of reviews completed in the year ending 31 March 2011 and onwards to be similar. Panels completed the reviews for nearly 20% more deaths in the year ending 31 March 2011 compared to the year ending 31 March 2010 and over 100% more than in the year ending 31 March 2009. The number of reviews completed in the year ending 31 March 2012 was very similar to the number reviewed in the previous year, suggesting that panels initial issues have been overcome and the number of reviews which are completed has stabilised (at approximately 4,000).

All panels provided data on the characteristics of the children who died and their panel reviewed the death. However in some panels not all information was known. For some panels this information was not

collected in their panel, while others reported that it was collected, but not for all cases or the information was not readily available.

The table below shows the proportion of completed reviews where the information requested was not known (of the reviews where there was sufficient information available for the panel to determine if there were modifiable factors in the death). For all other data items requested the proportion of cases where the information was not known represented 2% or less of the completed reviews.

The proportion of cases where the information was not known varied greatly across panels and across regions.

	Proportion of completed reviews where this information was not known	Ranging from	Ranging to
Asylum seeking status	10%	1% in Yorkshire and the Humber and East of England	28% in Outer London
Ethnicity	9%	1% in the South West	13% in the South East
Statutory orders	7%	0% Yorkshire and the Humber and East of England	20% in the North East and North West
Child protection plans	5%	0% Yorkshire and the Humber and East of England	20% in the North East

The proportion of cases recorded with not known information has declined since last year's data collection; however the proportion of cases where the ethnicity was not known has remained at the same proportion.

Panels were able to provide data in aggregate form or at child level. A number of panels provided child level information, but as this information was provided for only 18% of all reviews completed it is not possible to identify national trends as this 18% may not be representative. Some trends identified at child level have been provided, but these findings should be treated with caution.

KEY FINDINGS

Number of child death reviews completed

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

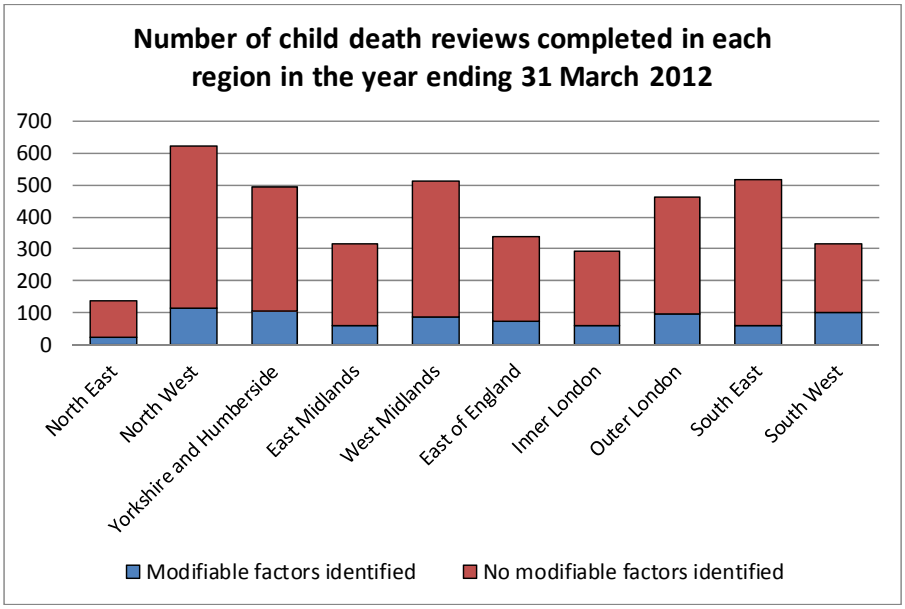
4,012 child death reviews were completed by panels in the year ending 31 March 2012. 784 of these deaths were identified as having modifiable factors. There were 48 deaths where there was not sufficient information available for the panel to determine if there were modifiable factors in the death.

The number of child death reviews which were completed within the year ending 31 March 2012 was very similar to the number reviewed in the previous year. The proportion of deaths identified as having modifiable factors was also the same (20% in both years).

Panels reported that 3,994 deaths were notified to them as having occurred in the year ending 31 March 2012, this is a rate of 36 per 100,000 children in the population aged 0-17 years. (Based on mid 2010 population estimates). This rate varied greatly across regions with the rate in Inner London being the highest at approximately 50 per 100,000 children and the North East being the lowest at approximately 30 per 100,000 children.

Number of deaths which were identified as having modifiable factors in the year ending 31 March 2012

20% of all child death reviews completed in England were identified as having modifiable factors. The South West identified modifiable factors in the highest proportion of deaths (32%) and the South East identified the lowest (12%). This proportion of deaths where modifiable factors were identified in these two regions is statistically significantly different to the national proportion.



Proportion of child deaths where the review is complete

Approximately 76% of child deaths which occurred between the 4 years from 1 April 2008 to 31 March 2012 had had a completed child death review by 31 March 2012. (This calculation assumes that the numbers of child deaths which occurred in the years ending 31 March 2011 and 31 March 2012 are the same as the number of child deaths which occurred in the year ending 31 March 2010, as reported by the Office for National Statistics.)

Please note however that as panels experienced a number of difficulties in the first two years of reviewing child deaths, we may find that not all child deaths which occurred in the years ending 31 March 2009 and 31 March 2010 will have a completed child death review recorded in the data collection. This is because some panels struggled to gather sufficient information to fully review some of the child deaths and also some panels have misinterpreted the guidance to fully review all child deaths. Some child deaths had less in depth reviews or were not reviewed at all and therefore will not appear in the data collection tables.

Time between the child's death and completing the review

The deaths of 3,994 children who died in the year ending 31 March 2012 were notified to panels. 40% of these deaths had completed reviews by 31 March 2012. The remaining 60% of reviews were ongoing at 31 March 2012.

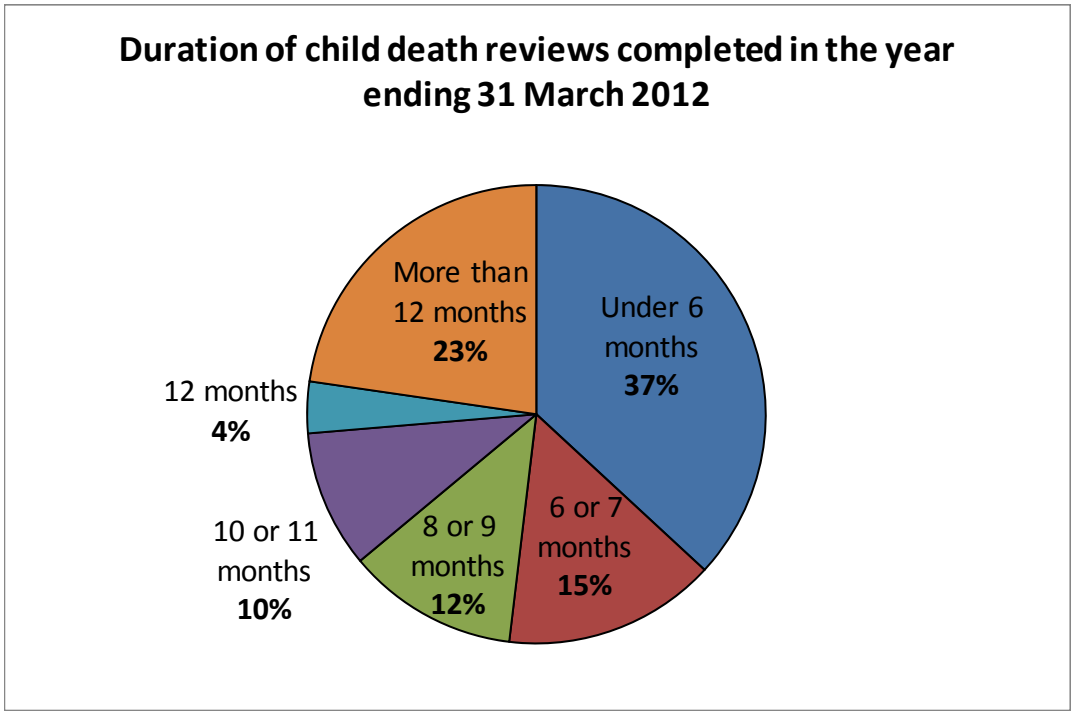
The proportion of reviews which were completed varied greatly across regions. The South East completed the child death reviews for over half of the deaths which occurred in the year ending 31 March 2012 and were being led by a panel within their region. The South West completed reviews for less than a fifth of the deaths which occurred in the year ending 31 March 2012 and were being led by a panel within their region.

The proportion of child death reviews which are completed will greatly depend on the time of year in which the death occurred. For example if a large proportion of the deaths in the year happened towards the end of the year, we would not expect that the reviews for these deaths would be completed by the 31 March. It will also depend on the practice within the panel. For example some panels review deaths by themes to be able to identify trends, so it may be a number of months after a death until another similar death occurs and the deaths are reviewed together.

The following findings refer to child death reviews completed in the year ending 31 March 2012 where there was sufficient information available for the panel to determine if there were modifiable factors in the death:

The data collected suggests that reviews of child deaths are likely to take longer if modifiable factors are identified. This can be seen in Table D where just over a third of deaths which were identified as having modifiable factors took more than 12 months to complete the child death review, compared to 20% of deaths where no modifiable factors were identified. This can also be seen in Table B where 40% of all reviews completed in the year ending 31 March 2012 were for deaths which occurred in the year ending 31 March 2012, whereas 28% of deaths which were identified as having modifiable factors occurred in the year ending 31 March 2012. This is likely to be because more information needs to be gathered to make an accurate assessment of which factors were modifiable and to ensure that lessons are learned. It is also likely that it will take longer for all the information required to review the death to become available, for example corners reports and the outcomes from criminal processing.

37% of child death reviews completed in the year ending 31 March 2012 took less than 6 months to complete and 23% took over one year to complete.



Frequency of Child Death Overview Panel meetings

Panels met 6 times on average in the year ending 31 March 2012 and completed an average of 7 reviews per meeting. The average number of meetings varied greatly across regions, from 5 meetings in Outer London to 9 meetings in the East of England. There is strong relationship between the number of deaths registered as occurring each year and the number of meetings, i.e. in areas where there are a greater number of deaths there are a greater number of meetings.

The average number of reviews completed per meeting also varied, from 5 in Inner London and to 8 in the North West and the West Midlands.

Reviewing deaths which occurred outside of the Local Safeguarding Children Boards area
(This information can be found in Table F)

Each Local Safeguarding Children Board (Board) is required to review the deaths of children aged 0-17 years old who are normally resident within their Board's area. However on occasion another Board may lead on reviewing a child's death or discuss the death within their panel if it is felt that there are lessons to be learned within the Board. For example if a child died on a road within an Board's area other than where the child was normally resident, then the two panels may work together and decide that it would be appropriate for the death to be reviewed by the panel where the child died as the main learning would be likely to be around road safety in that area.

For a small number of child deaths which were reviewed in the year ending 31 March 2012 the panel which completed the review was not the panel within the area where the child was normally resident (only 31 cases out of the 4,061 reviews completed). The main reason why another panel reviewed the death was because the child died in a hospital within the panels area (this is the case for 55% of these deaths).

The South West led on reviews of the highest proportion of deaths where the child was not normally resident within the panels area; these cases represented 4% of all completed child death reviews in this region compared to 0.5% in all other regions.

There were also a small number of cases where a death of a child who was not normally resident in the panels area was discussed, but the panel did not lead on the child death review (15 cases). Again the main reason these deaths were discussed was because the child died in a hospital within the panels area (this is the case for 47% of these deaths).

Actions Local Safeguarding Children Boards have taken following the reviews of child deaths
(This information was provided in free text fields so is not presented within a table)

Panels have made a large number of recommendations in the year ending 31 March 2012, both locally and nationally, following child death reviews. These ranged from continuing to raise awareness of the dangers of smoking during pregnancy to working with families to ensure that child and baby car seats are securely fitted.

There are a number of issues which continue to be key concerns to panels:

- Safe sleeping (including co-sleeping) - This continues to be a national issue and some panels have raised the need for safe sleeping lessons to be embedded into practice rather than short lived awareness campaigns. This is because they have found that when the campaigns ended the number of deaths relating the unsafe sleeping practices returned to previous levels.

- Consanguinity - Panels continue to be concerned that inter-family couples do not have sufficient understanding of the increased risks of having a child with a disability or of having a child die under the age of 5. Some panels are producing leaflets to be distributed in GP surgeries, Mosques, walk in centres, colleges and other settings to address this issue.
- Smoking - A number of panels are working with pregnant women to highlight the risks of maternal smoking and substance misuse during pregnancy, of premature births and complications associated with prematurely born babies.
- Road safety - this continues to be a key learning point for a number of panels. Actions ranged from improving lighting around accident spots and focusing awareness raising of accident prevention on children with learning difficulties and behaviour problems such as ADHD and autism.
- Fire safety - working with local fire stations organising safety sessions.
- Health appointments - a number of panels have highlighted the importance of following up missed appointments.
- Vaccinations - Messages on a number of issues relating to vaccinations have been shared across panels, including:
  - raising awareness of the importance of influenza vaccinations for pregnant women and vulnerable children.
  -sharing information about the meningitis vaccines offered locally and which strains of meningitis are covered.
  - highlighting to GPs the need for invitations and follow up invitations for influenza vaccination.
  - the importance of offering swine flu vaccinations to front line staff and the risks of swine flu to pregnant women.

A number of issues have become of increasing concern to panels within the recent year:

- Suicide - Panels decided that in a number of deaths which related to self-inflicted harm there were modifiable factors, including around risk taking behaviour.
- Falls - A number of panels have identified risks relating to falls and have taken forward actions including raising awareness of falls from balconies while abroad and recommending changes to window and door locks.
- Water safety - a number of panels have taken forward actions following accidental drowning. This ranged from private land owners reinforcing fences around ponds to introducing water safety campaigns to raise awareness of the risks of bathing in canals and rivers, to working closely with schools to ensure that children meet the requirements to be able to swim.
- Diabetes - spreading knowledge of the symptoms and dangers of diabetes.
- Teen pregnancies (including concealed pregnancies).
- Vitamin D deficiency - with some panels introducing offering free vitamins supplements to pregnant mothers.
- Hospital discharge - encouraging hospital staff to offer further advice when children are discharged from hospital covering signs to look for, how to administer medication properly and what to do if parents are concerned.
- Financial difficulties - some panels are increasing the advice and support given to families with financial difficulties, e.g. advice on managing money and how to make funds go further.

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

Panels are asked to categorise the likely cause of death. They also record the event which caused the death. For example a death due to accidental drowning would have the likely cause of death categorised as “Trauma and other external factors” and the event which caused the death would be recorded as “drowning”.

The following findings refer to the child death reviews completed in the year ending 31 March 2012 where there was sufficient information available for the panels to determine if there were modifiable factors in the death:

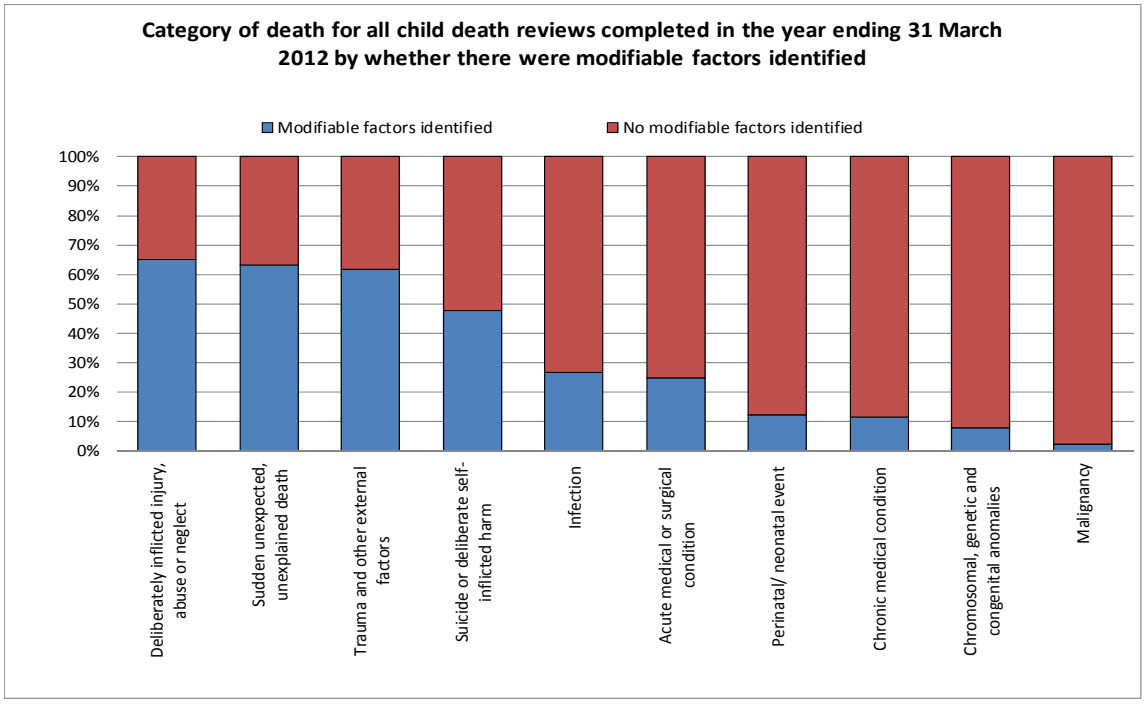
37% of all child death reviews completed involved deaths where the category of death was recorded as a “neonatal or perinatal event”, with a further 24% being due to “chromosomal, genetic and congenital anomalies”. This is to be expected as approximately two thirds of all completed child death reviews were for children aged under 1 year.

24% of all deaths which were identified as having modifiable factors were due to “sudden unexpected, unexplained deaths” (this includes deaths where the pathological diagnosis is either sudden infant death syndrome or unascertained, therefore a number of these reviews are likely to be for deaths of infants). A further 23% were due to “neonatal/perinatal events” and an additional 18% were due to “trauma and other external factors” (this includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors).

The category of death which had the largest proportion of cases identified as having modifiable factors was deaths due to “deliberately inflicted injury, abuse or neglect” (65% of these deaths were assessed as having modifiable factors). Over half of the deaths caused by:

- sudden unexpected, unexplained death and
- trauma and other external factors

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

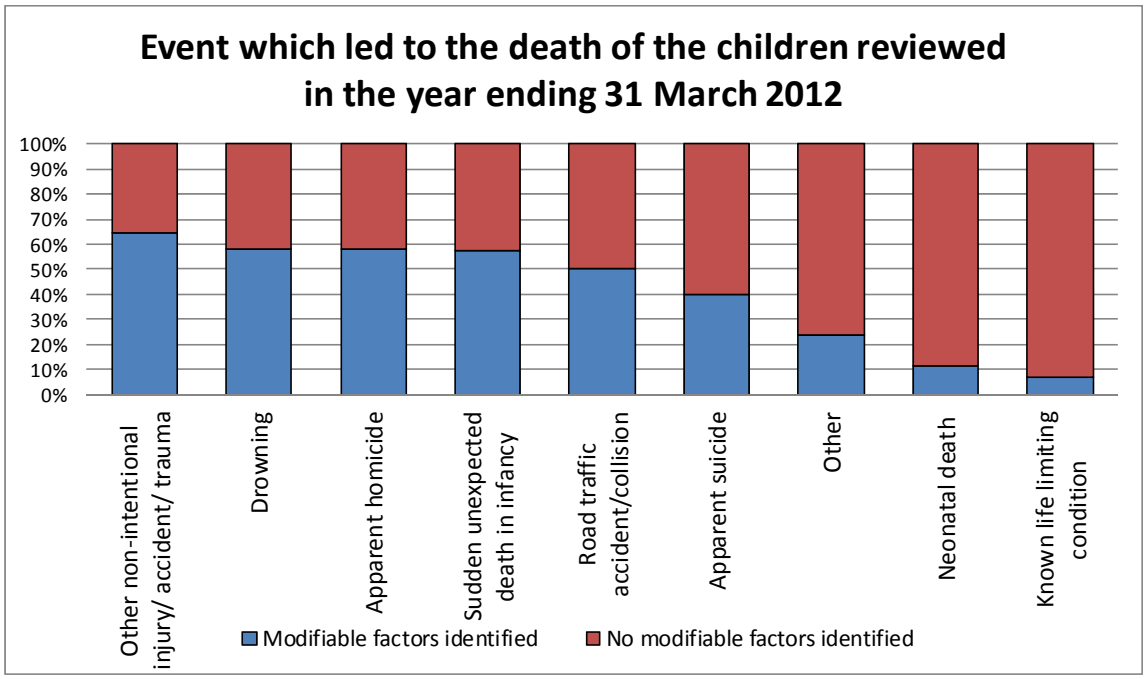


Please note, due to the small number of deaths which were categorised as being due to "deliberately inflicted injury, abuse or neglect" and "suicide or deliberate self-inflicted harm", the proportion of these deaths which were identified as having modifiable factors should be treated with caution. Taking data for the year ending 31 March 2011 and 2012 together shows that across the two years 63% of deaths due to "deliberately inflicted injury, abuse or neglect" were identified as having modifiable factors and 55% of deaths due "suicide or deliberate self-inflicted harm" were identified as having modifiable factors.

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

- other non-intentional injury/ accident/ trauma;
- drowning;
- apparent homicide; and
- sudden unexpected death in infancy;

were identified as having modifiable factors (65%, 58%, 58% and 57% respectively).



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

Taking data for the year ending 31 March 2011 and 2012 together shows that across the two years:

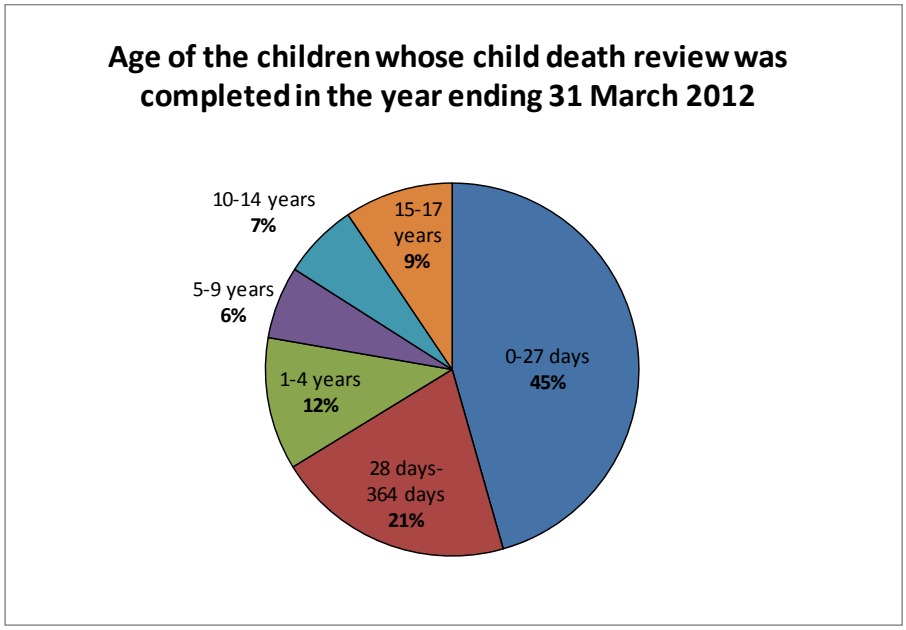
- 64% of deaths due to "drowning";
- 58% of deaths due to "other non-intentional injury/ accident/ trauma";
- 52% of deaths due to "apparent suicide"; and
- 52% of deaths due to "apparent homicide"

were identified as having modifiable factors

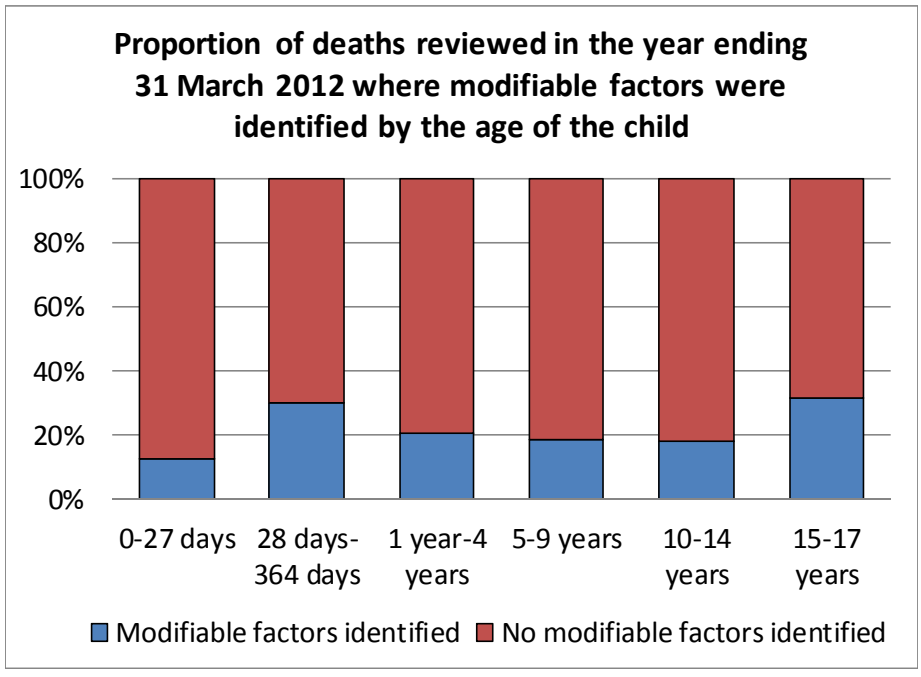
Age of the child
(This information can be found in Table I)

The following findings refer to the child death reviews completed in the year ending 31 March 2012 where there was sufficient information available for the panel to determine if there were modifiable factors in the death:

The majority of child death reviews completed in the year ending 31 March 2012 were for children aged under 1 year (66%).



Older children who died aged 15-17 years were more likely to have modifiable factors identified in their deaths, with 32% of this age group having modifiable factors identified, compared to 18% of children aged under 1 year.



For 19 of the 118 children aged 15-17 years old at the time of the death, where modifiable factors were identified, child level information was provided. This child level information showed that the most frequent category of death for these children was “trauma and other external factors” (approximately 1/3 of these deaths) followed by “suicide or deliberate self-inflicted harm” and “acute medical or surgical condition” (approximately 1/5 of these deaths fell in each of these categories). As child level data were available for only 16% of these children these findings should be treated with caution.

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

There were slightly more reviews of male children completed (58% of the child death reviews completed in the year ending 31 March 2012 where there was sufficient information available for the panel to determine if there were modifiable factors in the death). The latest data available (for 2010, as reported by the Office for National Statistics) show a slightly higher proportion of deaths registered in England were for male children, so we would expect that a slightly higher proportion of child death reviews were for male children.

Deaths of male and female children had the same proportion identified as having modifiable factors, (20% of the child death reviews completed in the year ending 31 March 2021 where there was sufficient information available for the panel to determine if there were modifiable factors in the death).

Ethnicity
(This information can be found in Table K)

Please note that ethnicity was unknown in 9% of the reviews which were completed. This may be because this information was not collected or because it was not readily available in the required format.

The following findings refer to the child death reviews completed in the year ending 31 March 2012 where there was sufficient information available for the panel to determine if there were modifiable factors in the death:

The majority of child death reviews were for white children (61%). A similar proportion of deaths across white, black/black British and other ethnic group children were identified as having modifiable factors (21% of deaths where the child was white, 20% where the child was black/black British and 21% where the child was of other ethnic group). When the child was identified as having an “unknown” ethnicity the proportion of deaths which were identified as having modifiable factors was significantly lower (12%). The proportion of deaths of Asian children where modifiable factors were identified was also significantly lower (15%). Children of mixed ethnicity were more likely to have modifiable factors in their death (28%).

Data for the year ending 31 March 2011 found that the proportion of deaths where modifiable factors were identified was similar across all ethnicities, so these differences across ethnicities represent a new trend.

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

The following findings refer to the child death reviews completed in the year ending 31 March 2012 where there was sufficient information available for the panel to determine if there were modifiable factors in the death:

Panels reported that most children were in hospital at the time of the event which led to their death (72%). In 43% of the deaths where the child was in hospital the child was in a neonatal unit at the time of the event which led to their death. This reflects the high proportion of child deaths which are neonatal deaths and are likely to be children who have not left hospital since birth. If the child was in a hospital then there were a lower proportion of deaths identified as having modifiable factors (15%) compared to other known locations, such as a public place (50%), other private residence (46%), abroad (45%) and the home of normal residence (34%).

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

The number of children who were abroad or in another private residence at the time of the event or condition which led to their death is still very small when taking data for the year ending 31 March 2011 and 2012 together (less than 100 children). Therefore findings broken down by modifiable factors should still be treated with caution. But the data for these children show that the deaths of children who were in these locations are more likely to have modifiable factors identified (47% and 51% respectively were identified as having modifiable factors).

Children who were in a public place at the time of the event which led to their deaths had the highest proportion of deaths which were assessed as having modifiable factors (50%). This could reflect the high proportion of deaths due to road traffic accidents and drowning which were identified as having modifiable factors and which are likely to happen in a public place.

Asylum seekers
(This information can be found in Table M)

Please note the asylum seeking status of the child was unknown in 10% of the reviews which were completed. This may be because this information was not collected or because it was not readily available in the required format or the information that the panel gathered could not conclusively determine if the child was or was not an asylum seeker.

The following findings refer to the child death reviews completed in the year ending 31 March 2012 where there was sufficient information available for the panel to determine if there were modifiable factors in the death:

The majority of child death reviews completed were for children who were known not to be asylum seekers (90%). Less than 1% were for children who were seeking asylum. Due to the small number of children identified as being asylum seekers at the time of their death, the proportion of deaths where modifiable factors were identified has not been published within the tables to ensure individual children cannot be identified.

The number of asylum seeking children is still very small when taking data for the year ending 31 March 2011 and 2012 together (approximately 40 children) so findings broken down by modifiable factors should still be treated with caution, but the data for these children show that the deaths of

asylum seeking children are less likely to have modifiable factors identified (16% compared to 20% where it was known that the child was not an asylum seeker).

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

Please note for 7% of the reviews completed it was not known if the child was the subject of a statutory order. For 5% of the reviews completed it was not known if the child was the subject of a child protection plan (CPP). This may be because this information was not collected, or because it was not readily available in the required format, or the panel could not conclusively determine if a CPP or a statutory order was in place from the information available.

The following findings refer to the child death reviews completed in the year ending 31 March 2012 where there was sufficient information available for the panel to determine if there were modifiable factors in the death:

1% of children were the subject of a statutory order at the time of their deaths, with a further small number of deaths (less than 0.5%) where the child had previously been subject to a statutory order, but not at the time of death. When the child was subject to a statutory order at the time of the death, a higher proportion of cases were identified as having modifiable factors compared to children who were not subject to a statutory order (49%). Due to the small number of deaths where there was a statutory order in place at the time of death, the proportion of deaths which were identified as having modifiable factors should be treated with caution.

Taking data for the year ending 31 March 2011 and 2012 together shows that across the two years, 49% of deaths where the child was the subject of a statutory order at the time of their deaths were identified as having modifiable factors. However these findings are still based on small numbers (less than 100 children) and therefore they should be treated with caution.

1% of child death reviews completed were for children who were the subject of a CPP at the time of their death, with a further 2% having been the subject of a CPP previously, but not at the time of death. When the child was the subject of a CPP at the time of the death or prior to the death a higher proportion of cases were identified as having modifiable factors compared to children who were not the subject of a CPP (49% and 33% compared to 20%). Due to the small number of deaths where there was a CPP in place at the time of death, or prior to the death, the proportion of deaths which were identified as having modifiable factors should be treated with caution.

Taking data for the year ending 31 March 2011 and 2012 together shows that across the two years 47% of deaths where the child was the subject of a CPP at the time of their death and 39% of deaths where the child was the subject of a CPP previously were identified as having modifiable factors. However these findings are still based on a fairly small number of children so should be treated with caution.

Please note that where a CPP or a statutory order was in place at the time of the death and modifiable factors were identified in the death this does not necessarily mean that the modifiable factors identified were related to the child being the subject of a CPP or a statutory order.

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

The following findings refer to the child death reviews completed in the year ending 31 March 2012 where there was sufficient information available for the panel to determine if there were modifiable factors in the death:

A serious case review was carried out for 1% of all deaths. The majority of these serious case reviews were instigated by a body other than the panel, but approximately one fifth were recommended by the panel.

There were a small number of child deaths where the panel recommended a serious case review but this was not taken forward. However some panels reported that internal management reviews took place instead or it was decided that a serious case review was not appropriate following further information becoming available about the death.

The deaths which were the subject of serious case reviews had a higher proportion which were identified as having modifiable factors, compared to deaths where a serious case review was not appropriate (77% compared to 19%). However due to the small number of cases where a serious case review was carried out these findings should be treated with caution.

Taking data for the year ending 31 March 2011 and 2012 together shows that across the two years 73% of deaths which were the subject of serious case reviews had modifiable factors identified. However these findings are still based on a fairly small number of children (less than 100) and therefore should be treated with caution.

A serious case review is carried out when abuse or neglect is known or suspected to be a factor in the death. We would expect therefore that modifiable factors would be identified in a higher proportion of deaths where there was a serious case review, as deaths due to “deliberately inflicted injury, abuse or neglect” have a higher proportion of deaths identified as having modifiable factors compared to other causes of death.

TABLES

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

Table B: 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

Table C: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards in the same year in which the death occurred

Table D: Time between the death of a child and the completion of the child death review

Table E: Number of times which the Child Death Overview Panel met

Table F: Number of child deaths discussed by Child Death Overview Panels where the child was not normally resident within the Local Safeguarding Children Board area

Table G: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by category of death

Table H: 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

Table I: 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

Table J: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by gender

Table K: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by ethnicity

Table L: 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

Table M: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by asylum seeking status

Table N: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by Statutory Order status

Table O: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by Child Protection Plan status

Table P: Number of child death reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by Serious Case Review status

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

Tables showing the underlying data provided by all Local Safeguarding Children Boards will also be published alongside this publication on the DfE Research and Statistics Gateway.
http://www.education.gov.uk/rsgateway/DB/STR/d001079/index.shtml

These tables will include the data provided in the additional tables in a format which may be more helpful to users who would like to complete further analysis.

TECHNICAL NOTES

Background

1. As stated earlier in the year ending 31 March 2010 panels were required to identify if the death was preventable or potentially preventable. Voluntary data from panels provided in the year ending 31 March 2010 suggested that approximately 15% of deaths were assessed as potentially preventable and a further 4% were assessed as preventable.

2. Reviews of similar deaths in subsequent years may result in different assessments of whether there were modifiable factors. Decisions may change as the process evolves and as panels build a consistent approach to understanding “modifiable factors”. In addition, local trends may begin to emerge which would suggest that similar deaths should be assessed as having had “modifiable factors”.

3. Most child deaths do not lead to a serious case review. A child death review is completed for every child that dies in England and includes:
   (a) collecting and analysing information about each death with a view to identifying—

(i) any matters of concern affecting the safety and welfare of children in the area of the authority including any case giving rise to the need for a review mentioned in regulation 5(1)(e); and

(ii) any general public health or safety concerns arising from deaths of such children;

(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

A Serious Case Review is initiated where:

(a) abuse or neglect of a child is known or suspected; and

(b) either—

(i) the child has died, or

(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child's welfare.

If it is thought, at any time, that the criteria for a serious case review might apply, the Chair of the Local Safeguarding Children Boards 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 and guidance on the child death review processes please visit:
http://www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/childdeathreview

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

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

At the time of publication this guidance was under consultation.

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

- Munro review of Child Protection:
http://www.education.gov.uk/childrenandyoungpeople/strategy/laupdates/a0077242/munro-review-final-report
- Scoping review to draw together data on child injury and safeguarding and to compare the position of England with that in other countries:
https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-RR083
- Mortality Statistics Deaths registered in 2010:
http://www.ons.gov.uk/ons/rel/vsob1/mortality-statistics--deaths-registered-in-england-and-wales--series-dr-/2010/stb-deaths-by-cause-2010.html
- Mortality Statistics: Childhood, infant and perinatal:
http://www.ons.gov.uk/ons/rel/vsob1/child-mortality-statistics--childhood--infant-and-perinatal/2010/stb-cms-2010.html

Infant mortality
http://www.nchod.nhs.uk/
Click on the 'compendium of indicators' across the top of the screen and then 'indicator specifications'. Then click on “alphabetically” and go to 'M' for morality from various causes.

- Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2007-09
http://www.education.gov.uk/publications/standard/publicationdetail/page1/DFE-RR040
- Why Children Die: A pilot study (2006) (May 2008)
http://www.injuryobservatory.net/why_children_die.html

Tables

6. The proportion of all deaths which have been reviewed by each region in Table A has been estimated using the number of deaths registered as occurring between 1 April 2009 and 31 March 2010 for children aged 0-17 years old as reported by the Office for National Statistics (ONS). The number of child deaths registered has fallen in recent years, but does not vary by a large number year on year. (Decreasing by a maximum of 5% in a single year over the 5 year period). Deaths are not always registered in the year in which they occur, so the number of deaths registered over a period of time is not always the same as the number of deaths which occurred over the same period of time.

7. The figures in Table A are based on data provided by all 148 Local Safeguarding Children Boards. None of these Local Safeguarding Children Boards reported that they had not reviewed any child deaths during the year, but there were some Local Safeguarding Children Boards which appear to have reviewed a lower proportion of deaths. The key reasons for this include:

    - some Local Safeguarding Children Boards are responsible for reviewing the deaths of very few children, therefore if there were delays in notifications or the death occurred toward the end of the year then a high proportion of these deaths may not have been reviewed by 31 March 2012;
    - some panels experienced difficulties in gathering sufficient information to review child deaths, for example from the health services (especially where incomplete information was known about the child) or where the child had died outside the country, which caused delays in the review;
    - reviews have been delayed as panels wait for outcomes from for example, serious case reviews, criminal investigations and post mortems.

8. Some panels were unable to determine if there were modifiable factors in a child’s death as there was insufficient information available. In some cases this was because it was not possible to gather further information. For example if the coroner was unable to conclusively determine the cause of death. In other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel.

Confidentiality

9. In order to protect individual data, numbers from 1 to 5 inclusive have been suppressed and are shown as crosses (x). Where any number is shown as zero (0), the original figure submitted was zero. Percentages are shown rounded to whole numbers but where the numerator was five or less or the denominator was 10 or less, they have been suppressed and replaced by a cross. Where a percentage is zero because the number from which that percentage has been

calculated is a zero, the percentage is shown as zero. (.) represents values which are not applicable. (-) represents percentages less than 0.5% but greater than 0%.

10. It has been necessary to suppress other figures whenever it would be possible to calculate the value of a suppressed number by means of simple arithmetic. The rule applied in these circumstances has been to suppress the next smallest data item provided its value is strictly less than 20.

11. In some cases it would still be possible to identify individual data when figures are suppressed, therefore in these cases values have been rounded to the nearest 10.

12. For some national tables where information is categorised as “unknown”, providing numbers from 1 to 5 is sufficient and practical. This avoids unnecessary destruction to the data which would result from having to apply secondary suppression.

13. All tables are presented at national and regional level due to small numbers at local level. Providing these data at local authority, Local Safeguarding Children Board or panel level could risk individual children being identified.

14. As part of a Government drive for data transparency in official publications supporting data for this publication has been made available. Within the underlying data provided by all Local Safeguarding Children Boards the number of child death reviews completed and the number of these completed reviews which were identified as having modifiable factors has been provided at local authority level.

Revisions

15. There are no planned revisions to this Statistical Release, however, if at a later date we need to make a revision this will comply with the Departmental revisions policy which is published at: http://www.education.gov.uk/rsgateway/nat-stats.shtml

An Official Statistics publication

16. This is an Official Statistics publication. Official Statistics are produced to high professional standards set out in the National Statistics Code of Practice. They undergo regular quality assurance reviews to ensure that they meet customer needs. They are produced free from any political interference.

17. Please contact Sarah Wolstenholme at Sarah.Wolstenholme@education.gsi.gov.uk if you have comments on the content or presentation of this release so that we can take account of your needs in future editions.

ENQUIRIES

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

Safeguarding and Vulnerable Children's Analysis Team
Department for Education
Ground floor, Sanctuary Buildings
Great Smith Street
LONDON, SW1P 3BT

Telephone Number: 0207 3408479

Email: Sarah.Wolstenholme@education.gsi.gov.uk

Press enquiries should be made to the Department's Press Office at:

Press Office Newsdesk,
Department for Education
Sanctuary Buildings
Great Smith Street
LONDON
SW1P 3BT

Telephone Number: 0207 9256789

Table A: Number of child death[1] reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards[2]
Years ending 31 March 2009, 2010, 2011 and 2012
Coverage: England

	Number of child death reviews which have been completed on behalf of Local Safeguarding Children Boards in the year ending 31 March [3,4,5]					Number of child death reviews completed on behalf the Local Safeguarding Children Board which were assessed as preventable[8] in the year ending 31 March[9,10]		Proportion of all completed child deaths reviewed which were assessed as preventable[8] in the year ending 31 March[9,10]		Number of child death reviews completed on behalf the Local Safeguarding Children Board which were assessed as having modifiable factors in the year ending 31 March[10]		Proportion of all completed child deaths reviewed which were assessed as having modifiable factors in the year ending 31 March[10]		Number of deaths of children aged 0-17 which occurred in the year ending 31 March 2010[11]		Approximate total number of deaths in year ending 2009-2012[12]	Number of child death reviews completed in 2009-2012 as an approximated proportion of all child deaths[13,14]
	2009 [6]	2010	2011 [7]	2012	Total 2009-2012	2009	2010	2009	2010	2011	2012	2011	2012	2009	2010		
England	1,998	3,446	4,061	4,012	13,517	108	148	5%	4%	800	784	20%	20%	4,476	4,409	17,703	76%
Region																	
North East	50	163	176	135	524	6	9	12%	6%	35	25	20%	19%	195	181	738	71%
North West	392	494	552	623	2,061	9	12	2%	2%	113	114	20%	18%	666	624	2,538	81%
Yorkshire and Humberside	229	384	463	492	1,568	9	11	4%	3%	123	106	27%	22%	528	500	2,028	77%
East Midlands	160	332	316	317	1,125	8	18	5%	5%	73	60	23%	19%	380	350	1,430	79%
West Midlands	345	520	524	513	1,902	15	26	4%	5%	100	89	19%	17%	572	588	2,336	81%
East of England	203	337	397	339	1,276	x	19	x	6%	78	75	20%	22%	426	436	1,734	74%
London	356	512	843	759	2,470	19	24	5%	5%	155	154	18%	20%	783	815	3,228	77%
Inner London	148	176	345	295	964	15	10	10%	6%	56	58	16%	20%	342	320	1,302	74%
Outer London	208	336	498	464	1,506	x	14	x	4%	99	96	20%	21%	441	495	1,926	78%
South East	215	508	493	519	1,735	30	19	14%	4%	51	61	10%	12%	621	575	2,346	74%
South West	48	196	297	315	856	7	10	15%	5%	72	100	24%	32%	305	340	1,325	65%

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding still births.
2. Numbers from 1 to 5 inclusive have been suppressed, being replaced by a cross (x). Percentages are shown rounded to whole numbers but where the numerator was five or less or the denominator was 10 or less, they have been suppressed and replaced by a cross (x).
3. The child death review process was introduced in April 2008, so data collected in the year ending 31 March 2009 and 2010 represent the first two years of this data collection. Please note that the number of reviews which were completed in these two years may have been influenced by the issues which panels encountered as they introduced the process of reviewing child deaths. There may also be deaths which occurred in the year ending 31 March 2009 or early in the year ending 31 March 2010 which panels have either reviewed in less depth or felt unable to review as little data were available, which are not included in the tables above.
4. Please note that not all child deaths which occur each year will have their child death review completed by the 31 March. This is mainly because it may take a number of months to gather sufficient information to fully review a child's death.
5. Figures for 2009 and 2010 exclude deaths which were completed by a Child death Overview Panels (Panles) other than the Panel where the child was normally resident. Figures for 2011 and 2012 include reviews of child deaths which were completed where the child was not normally resident in the Panels area. Table F (Column E) shows the number of child deaths which were reviewed by a panel other than the Panel where the child was normally resident.
6. Please note that one Panel in the North West included child death reviews which had been completed in April 2009 in the data provided for the year ending 31 March 2009, therefore there are a small number of children included in both column D and column E in the table above.
7. Please note that one Panel in the East of England was unable to provide data which were consistent with the requirements of the data collection. However they estimate that the number of reviews reported above as being completed by 31 March 2011 is approximately correct.
8. A preventable child death is defined as "events, actions or omissions contributing to the death of a child or to substandard care of a child who died, and which, by means of national or locally achievable interventions, can be modified".
9. Please note that a number of panels encountered issues in the first year of reviewing child deaths which meant that the proportion of deaths assessed as preventable was artificially high, or artificially low. For example some panels prioritised the order in which deaths were reviewed to ensure that by 31 March 2009 the deaths with they felt had the greatest learning points were reviewed fully. This resulted in a high proportion of preventable child deaths in the first year of reviewing deaths. Other panels had experienced problems interpreting the definition of preventability, therefore by 31 March 2009 they felt unable to fully review many of the child deaths which were the most complex and more likely to be preventable. This resulted in a low proportion of preventable child deaths in the first year of reviewing deaths.
10. From 1 April 2008 to 31 March 2010 Panels were required to assess if a death was preventable. 2010-11 was the first year which Panels were asked to assess if there were modifiable factors in the child's death. A modifiable death is defined where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.
11. Figures represent occurrences of deaths of children aged 0 to 17 who were resident in England, as recorded by the Office for National Statistics. There are a small number of deaths which occurred in 2008-09 or 2009-10 but had not been registered by the time these data were extracted. Deaths are only included if they were registered by the following August. For example, the 2009-10 data includes deaths that occurred from April to December 2009, and were registered by August 2010; and deaths that occurred in January to March 2010, and were registered by August 2011.
12. Data on the number of occurrences of deaths in the year ending 31 March 2011 and 31 March 2012 are not yet available, so the number of deaths in these years is assumed to be the same as those in the year ending 31 March 2010. So this figure is the number of deaths which occurred in 2008-09 (column X) plus three times the number of occurrences of deaths in the year ending 31 March 2010 (column Y).
13. As child deaths do not necessarily occur in the same year in which the child death review is completed, it is not possible to provide a breakdown by the individual year, however tables C provides the proportion of deaths which occurred in the year ending 31 March 2012 which were also fully reviewed in the year ending 31 March 2012.
14. This proportion is calculated by dividing the total number of child death reviews completed in the year ending 31 March 2009, 2010, 2011 and 2012 (column H) by the approximate number of deaths in the year ending 31 March 2009, 2010, 2011 and 2011 (Column AA).

Table B: Number of child deaths[1,2] reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by the year in which the child death occurred
Year ending 31 March 2012
Coverage: England

	Number of child deaths reviews completed in the year ending 31 March 2012			Percentage of child death reviews completed in the year ending 31 March 2012	
	Where the death occurred prior to 01 April 2011	Where the death occurred between 01 April 2011 and 31 March 2012	All child death reviews completed in year ending 31 March 2012	Where the death occurred prior to 01 April 2011	Where the death occurred between 01 April 2011 and 31 March 2012
England	2,401	1,611	4,012	60%	40%
Region					
North East	90	45	135	67%	33%
North West	379	244	623	61%	39%
Yorkshire and Humberside	332	160	492	67%	33%
East Midlands	166	151	317	52%	48%
West Midlands	248	265	513	48%	52%
East of England	175	164	339	52%	48%
London	501	258	759	66%	34%
Inner London	193	102	295	65%	35%
Outer London	308	156	464	66%	34%
South East	247	272	519	48%	52%
South West	263	52	315	83%	17%
The number of which were assessed as having modifiable factors [3]:					
England	565	219	784	72%	28%
Region					
North East	17	8	25	68%	32%
North West	80	34	114	70%	30%
Yorkshire and Humberside	75	31	106	71%	29%
East Midlands	40	20	60	67%	33%
West Midlands	60	29	89	67%	33%
East of England	55	20	75	73%	27%
London	115	39	154	75%	25%
Inner London	44	14	58	76%	24%
Outer London	71	25	96	74%	26%
South East	42	19	61	69%	31%
South West	81	19	100	81%	19%
Proportion of completed reviews which were assessed as having modifiable factors:					
England	24%	14%	20%	.	.
Region					
North East	19%	18%	19%	.	.
North West	21%	14%	18%	.	.
Yorkshire and Humberside	23%	19%	22%	.	.
East Midlands	24%	13%	19%	.	.
West Midlands	24%	11%	17%	.	.
East of England	31%	12%	22%	.	.
London	23%	15%	20%	.	.
Inner London	23%	14%	20%	.	.
Outer London	23%	16%	21%	.	.
South East	17%	7%	12%	.	.
South West	31%	37%	32%	.	.

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. Percentages are shown rounded to whole numbers. (.) represents values which are not applicable.
3. A modifiable death is defined where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Table C: Number of child deaths[1] reviews completed in the same year in which they occurred by Child Death Overview Panels on behalf of Local Safeguarding Children Boards

Child deaths which occurred in year ending 31 March 2012

Coverage: England

	Number of deaths notified to Child Death Overview Panels which occurred in the year ending 31 March 2012[2,3]	Number of deaths which occurred in the year ending 31 March 2012 where the child death review was completed by 31 March 2012[4]	Percentage of deaths which occurred in the year ending 31 March 2012 and the review was completed by 31 March 2012[4,5]
England	3,994	1,611	40%
Region			
North East	149	45	30%
North West	560	244	44%
Yorkshire and Humberside	448	160	36%
East Midlands	309	151	49%
West Midlands	554	265	48%
East of England	389	164	42%
London	715	258	36%
Inner London	305	102	33%
Outer London	410	156	38%
South East	534	272	51%
South West	336	52	15%

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding still births.
2. Notifications are only included in the table above if the panel led on the review of the child's death. If a panel was notified of deaths, but another panel was also notified of the death and this second panel led the review, then the notification would be included only once in the table for the panel which led the review.
3. Please note that there may be further deaths which occurred in the year ending 31 March 2012 which have not yet been notified to panels. Therefore there maybe further deaths which occurred in the year ending 31 March 2012 which are not recorded in the table above.
4. Please note that it is not always possible to fully review all child deaths within the same year which they occurred. This is mainly because it may take a number of months to gather sufficient information to fully review a child's death.
5. Percentages are shown rounded to whole numbers.

Table D: Time between the death of a child and the completion of the child death review[1,2,3,4]
Child death reviews completed in year ending 31 March 2012
Coverage: England

	Time between the death of the child and the completion of the child death review for reviews completed in the year ending 31 March 2012							All child death reviews completed in year ending 31 March 2012 with an assessment of modifiable factors[5,6]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[5,6]	All child death reviews completed in year ending 31 March 2012
	Under 6 months	6 or 7 months	8 or 9 months	10 or 11 months	12 months	More than 12 months	Unknown			
All child death reviews completed in the year ending 31 March 2012										
of which:										
Modifiable factors identified[5]	160	122	95	89	44	274	0	784	.	784
No modifiable factors identified[5]	1,302	473	383	296	100	626	0	3,180	.	3,180
Total	1,462	595	478	385	144	900	0	3,964	48	4,012
Percentage of this duration:										
Modifiable factors identified[5]	11%	21%	20%	23%	31%	30%	.	20%	.	.
No modifiable factors identified[5]	89%	79%	80%	77%	69%	70%	.	80%	.	.
Total	100%	100%	100%	100%	100%	100%	.	100%	.	.
Percentage of each duration under this assessment:										
Modifiable factors identified[5]	20%	16%	12%	11%	6%	35%	0%	100%	.	.
No modifiable factors identified[5]	41%	15%	12%	9%	3%	20%	0%	100%	.	.
Total	37%	15%	12%	10%	4%	23%	0%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding still births.
2. Please note that when reviewing a child's death it may take a number of months to gather sufficient information to allow the panel to full review the child's death.
3. Percentages are shown rounded to nearest whole number.
4. (.) represents values which are not applicable.
5. Some panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel.
6. A modifiable death is defined where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

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

Year ending 31 March 2012

Coverage: England

	Number of child death reviews completed in the year ending 31 March 2012	Number of Child Death Overview Panels	Number of Child Death Overview Panel meetings in year ending 31 March 2012	Average number of meetings per Child Death Overview Panel in year ending 31 March 2012[2,3]	Average number of child death reviews completed per meeting in year ending 31 March 2012[3,5]
England	4,012	92	584	6	7
Region					
North East	135	4	22	6	6
North West	623	13	77	6	8
Yorkshire and Humberside	492	13	74	6	7
East Midlands	317	6	48	8	7
West Midlands	513	10	65	7	8
East of England	339	6	52	9	7
London	759	25	127	5	6
Inner London	295	10	57	6	5
Outer London	464	15	70	5	7
South East	519	9	73	8	7
South West	315	6	46	8	7

Source: LSCB1

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

2. Figures are rounded to the nearest whole number.

3. This number is calculated by dividing the number of meetings (column F) by the number of Child Death Overview Panels (column E).

4. This value is calculated by diving the number of completed child death reviews (column D) by the total number of times the panel met (column F).

Table F: Number of child deaths discussed by Child Death Overview Panels where the child was not normally resident within the Local Safeguarding Children Board area
Year ending 31 March 2012
Coverage: England

	Number of child deaths discussed in the year ending 31 March 2012 where the child was not normally resident within the LLocal Safeguarding Children Board area	
	Discussed only and did not lead on the review	**Led the review and this was completed by 31 March 2012**
England	15	31
Region		
North East	x	x
North West	0	x
Yorkshire and Humberside	0	6
East Midlands	0	x
West Midlands	x	0
East of England	x	x
London	8	x
Inner London	x	x
Outer London	x	x
South East	0	x
South West	0	14

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding still births.
2. Numbers from 1 to 5 inclusive have been suppressed, being replaced by a cross (x).

Table G: Number of child death[1] reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by category of death
Year ending 31 March 2012
Coverage: England

	Category of death[2]											All child death reviews completed in year ending 31 March 2012 with an assessment of modifiable factors[4,5]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[4,5]	All child death reviews completed in year ending 31 March 2012
	Deliberately inflicted injury, abuse or neglect	Suicide or deliberate self-inflicted harm	Trauma and other external factors	Malignancy	Acute medical or surgical condition	Chronic medical condition	Chromosomal, genetic and congenital anomalies	Perinatal/ neonatal event	Infection	Sudden unexpected, unexplained death	Unknown[3]			
All child death reviews completed in the year ending 31 March 2012														
Number of which had:														
Modifiable factors identified[5]	28	34	145	7	48	23	73	178	63	185	0	784	.	784
No modifiable factors identified[5]	15	37	88	278	144	176	876	1,282	174	110	0	3,180	.	3,180
TOTAL	43	71	231	285	192	199	949	1,460	237	295	0	3,964	48	4,012
Percentage of this category of death which had:														
Modifiable factors identified[4]	65%	48%	62%	2%	25%	12%	8%	12%	27%	63%	.	20%	.	20%
No modifiable factors identified[4]	35%	52%	38%	98%	75%	88%	92%	88%	73%	37%	.	80%	.	79%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	100%	.	100%
Percentage of each category of death under this assessment:														
Modifiable factors identified[4]	4%	4%	18%	1%	6%	3%	9%	23%	8%	24%	0%	100%	.	.
No modifiable factors identified[4]	-	1%	3%	9%	5%	6%	28%	40%	5%	3%	0%	100%	.	.
Of all deaths	1%	2%	6%	7%	5%	5%	24%	37%	6%	7%	0%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding still births.
2. Percentages are shown rounded to whole numbers but where the denominator was 10 or less, they have been suppressed and replaced by a cross (x). (.) represents values which are not applicable. (-) represents percentages less than 0.5% but greater than 0%.
3. Some categories of death may be unknown because this information is not available in the format requested. There may also be cases where data were provided to the panel by a sub-panel (for example a specialist panel to review neonatal deaths) and information about the cause of death has not been provided. There may also be other cases where the cause of death was inconclusive or difficult to determine.
4. Some panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information is provided to the panel.
5. A modifiable death is defined where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Table H: Number of child death[1] 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 2012

Coverage: England

	Event which caused the child's death[2]													All child death reviews completed in year ending 31 March 2012 with an assessment of modifiable factors[6,7]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[6,7]	All child death reviews completed in year ending 31 March 2012
	Neonatal death	Known life limiting condition	Sudden unexpected death in infancy	Road traffic accident/collision	Drowning	Fire and burns	Poisoning	Other non-intentional injury/ accident/ trauma	Substance misuse	Apparent homicide[3]	Apparent suicide[4]	Other	Unknown[5]			
All child death reviews completed in the year ending 31 March 2012																
Number of which had:																
Modifiable factors identified[5]	199	69	187	54	22	x	x	55	x	15	28	133	x	784	.	784
No modifiable factors identified[5]	1514	933	140	53	16	x	0	30	x	11	40	430	x	3,180	.	3,180
Total	1713	1002	327	107	38	15	x	85	x	26	69	562	11	3,964	48	4,012
Percentage of this event which had:																
Modifiable factors identified[5]	12%	7%	57%	50%	58%	x	x	65%	x	58%	41%	24%	x	20%	.	20%
No modifiable factors identified[5]	88%	93%	43%	50%	42%	x	0%	35%	x	42%	59%	76%	x	80%	.	79%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	.	100%
Percentage of each event under this assessment:																
Modifiable factors identified[5]	25%	9%	24%	7%	3%	2%	x	7%	1%	2%	4%	17%	x	100%	.	.
No modifiable factors identified[5]	48%	29%	4%	2%	1%	x	0%	1%	x	-	1%	14%	-	100%	.	.
Of all deaths	43%	25%	8%	3%	1%	-	x	2%	-	1%	2%	14%	-	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding still births.
2. Numbers from 1 to 5 inclusive have been suppressed, being replaced by a cross (x). Percentages are shown rounded to whole numbers but where the numerator was five or less or the denominator was 10 or less, they have been suppressed and replaced by a cross (x). It has been necessary to suppress other figures whenever it would be possible to calculate the value of a suppressed number by means of simple arithmetic. The rule applied in these circumstances has been to suppress the next smallest data item provided its value is strictly less than 20. (.) represents values which are not applicable. (-) represents percentages less than 0.5% but greater than 0%.
3. A homicide may be assessed as having no modifiable factors if the panel determines that the homicide was unforeseen, for example a random act where there were no previous concerns about the suspect.
4. The number of deaths recorded as being due to "apparent suicide" may be different to the number of deaths recorded as "suicide or deliberate self-inflicted harm" in Table G. There may be deaths where it was not possible to determine the intent, so they were recorded as "suicide or deliberate self-inflicted harm" in Table G, but they were not be recorded as "suicide" in the table above. The data above is collected by panels at the start of the review process and the data in Table G is collected at the end of the review process, so there may be deaths which were thought to be suicide at the start of the review process, but were later reclassified.
5. All deaths were the event was unknown were within the same panel who experienced difficulties in extracting accurate data from their database to answer this question.
6. Some panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information is provided to the panel.
7. A modifiable death is defined where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Table I: Number of child death[1] reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards[2] by age of the child at the time of death

Year ending 31 March 2012

Coverage: England

	Age of the child at the time of death[2]							All child death reviews completed in year ending 31 March 2012 with an assessment of modifiable factors[3,4]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[3,4]	All child death reviews completed in year ending 31 March 2012
	0-27 days	28 days- 364 days	1 year-4 years	5-9 years	10-14 years	15-17 years	Unknown			
All child death reviews completed in the year ending 31 March 2012										
Number of which had:										
Modifiable factors identified[4]	231	248	94	46	47	118	0	784	.	784
No modifiable factors identified[4]	1576	571	362	203	213	255	0	3,180	.	3,180
Total	1807	819	456	249	260	373	0	3,964	48	4,012
Percentage of this age group which had:										
Modifiable factors identified[4]	13%	30%	21%	18%	18%	32%	.	20%	.	20%
No modifiable factors identified[4]	87%	70%	79%	82%	82%	68%	.	80%	.	79%
Total	100%	100%	100%	100%	100%	100%	.	100%	100%	100%
Percentage of each age group under this assessment:										
Modifiable factors identified[4]	29%	32%	12%	6%	6%	15%	0%	100%	.	.
No modifiable factors identified[4]	50%	18%	11%	6%	7%	8%	0%	100%	.	.
Of all deaths	46%	21%	12%	6%	7%	9%	0%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding still births.
2. Percentages are shown rounded to whole numbers but where the denominator was 10 or less, they have been suppressed and replaced by a cross (x) (.) represents values which are not applicable.
3. Some panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information is provided to the panel.
4. A modifiable death is defined where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Table J: Number of child death[1] reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by gender
Year ending 31 March 2012
Coverage: England

	Gender[2]			All child death reviews completed in year ending 31 March 2012 with an assessment of modifiable factors[3,4]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[3,4]	All child death reviews completed in year ending 31 March 2012
	Male	Female	Unknown/ Not stated			
All child death reviews completed in the year ending 31 March 2012						
Number of which had:						
Modifiable factors identified[4]	455	329	0	784		784
No modifiable factors identified[4]	1,843	1,324	13	3,180		3,180
Total	2,298	1,653	13	3,964	48	4,012
Percentage of this gender which had:						
Modifiable factors identified[4]	20%	20%	0%	20%	.	.
No modifiable factors identified[4]	80%	80%	100%	80%	.	.
Total	100%	100%	100%	100%	.	.
Percentage of each gender under this assessment:						
Modifiable factors identified[4]	58%	42%	0%	100%	.	.
No modifiable factors identified[4]	58%	42%	-	100%	.	.
Of all deaths	58%	42%	-	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding still births.
2. Percentages are shown rounded to whole numbers. (.) represents values which are not applicable. (-) represents percentages less than 0.5% but greater than 0%.
3. Some panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information is provided to the panel.
4. A modifiable death is defined where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Table K: Number of child death[1] reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by ethnicity
Year ending 31 March 2012
Coverage: England

	Ethnicity[2]						All child death reviews completed in year ending 31 March 2012 with an assessment of modifiable factors[4,5]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[4,5]	All child death reviews completed in year ending 31 March 2012
	White	Mixed	Asian	Black	Other	Unknown[3]			
All child death reviews completed in the year ending 31 March 2012									
Number of which had:									
Modifiable factors identified[5]	516	51	99	62	15	41	784	.	784
No modifiable factors identified[5]	1,903	128	540	246	58	305	3,180	.	3,180
Total	2,419	179	639	308	73	346	3,964	48	4,012
Percentage of this ethnicity which had:									
Modifiable factors identified[5]	21%	28%	15%	20%	21%	12%	20%	.	.
No modifiable factors identified[5]	79%	72%	85%	80%	79%	88%	80%	.	.
Total	100%	100%	100%	100%	100%	100%	100%	.	.
Percentage of each ethnicity under this assessment:									
Modifiable factors identified[5]	66%	7%	13%	8%	2%	5%	100%	.	.
No modifiable factors identified[5]	60%	4%	17%	8%	2%	10%	100%	.	.
Of all deaths	61%	5%	16%	8%	2%	9%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding still births.
2. Percentages are shown rounded to whole number
3. The ethnicity of the children was unknown in 9% of the reviews completed, this may because this information is not collected by the panel or the information collected is not in the required format.
4. Some panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information is provided to the panel.
5. A modifiable death is defined where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Table L: Number of child death[1] 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 2012

Coverage: England

	Location at time of the event or condition[2]											All child death reviews completed in year ending 31 March 2012 with an assessment of modifiable factors[3,4]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[3,4]	All child death reviews completed in year ending 31 March 2012
	Acute Hospital	Home of normal residence	Other private residence	Foster home	Residential care	Public place	School	Hospice	Mental health inpatient unit	Abroad	Other	Not known			
All child death reviews completed in the year ending 31 March 2012															
Number of which had:															
Modifiable factors identified[4]	410	250	20	0	0	70	x	x	0	20	x	x	784	.	784
No modifiable factors identified[4]	2430	490	20	x	x	70	x	110	0	20	10	20	3,180	.	3,180
Total	2840	740	40	x	x	140	x	120	0	40	10	20	3,964	48	4,012
Percentage of deaths in this location which had:															
Modifiable factors identified[4]	15%	34%	46%	0%	0%	50%	x	x	.	45%	x	x	20%	.	.
No modifiable factors identified[4]	85%	66%	54%	x	x	50%	x	96%	.	55%	75%	83%	80%	.	.
Total	100%	100%	100%	x	x	100%	x	100%	.	100%	100%	100%	100%	.	.
Percentage of each location under this assessment:															
Modifiable factors identified[4]	53%	32%	2%	0%	0%	9%	x	x	0%	2%	x	x	100%	.	.
No modifiable factors identified[4]	76%	15%	1%	x	x	2%	x	4%	0%	1%	-	1%	100%	.	.
Of all deaths	72%	19%	1%	x	x	4%	x	3%	0%	1%	-	1%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding still births.
2. Figures are rounded to the nearest 10. Figures may not add up due to rounding. Numbers from 1 to 5 inclusive have been suppressed, being replaced by a cross (x). Percentages are shown rounded to whole numbers but where the numerator was five or less or the denominator was 10 or less, they have been suppressed and replaced by a cross (x). (.) represents values which are not applicable. (-) represents percentages less than 0.5% but greater than 0%.
3. Some panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information is provided to the panel.
4. A modifiable death is defined where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Table M: Number of child death[1] reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by asylum seeking status
Year ending 31 March 2012
Coverage: England

	Number of child death reviews completed in year ending 31 March 2012 [2]			All child death reviews completed in year ending 31 March 2012 with an assessment of modifiable factors[4,5]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[4,5]	All child death reviews completed in year ending 31 March 2012
	Where the child was known to be an asylum seeker	Where it was known that the child was not an asylum seeker	Where it was unknown if the child was an asylum seeker[3]			
All child death reviews completed in the year ending 31 March 2012						
of which:						
Modifiable factors identified[5]	x	730	50	784	.	784
No modifiable factors identified[5]	20	2,830	330	3,180	.	3,180
Total	20	3,560	380	3,964	48	4,012
Percentage of this asylum seeking status:						
Modifiable factors identified[5]	x	20%	13%	20%	.	.
No modifiable factors identified[5]	79%	80%	87%	80%	.	.
Total	100%	100%	100%	100%	.	.
Percentage of each asylum seeking status under this assessment:						
Modifiable factors identified[5]	x	93%	6%	100%	.	.
No modifiable factors identified[5]	1%	89%	10%	100%	.	.
Total	1%	90%	10%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to 18 years, excluding still births.
2. Figures are rounded to the nearest 10. Figures may not add up due to rounding. Numbers from 1 to 5 inclusive have been suppressed, being replaced by a cross (x). Percentages are shown rounded to whole numbers but where the numerator was five or less or the denominator was 10 or less, they have been suppressed and replaced by a cross (x). (.) represents values which are not applicable.
3. The asylum seeking status of the child was unknown in 10% of the reviews completed, this may be cause this information is not collected by the panel or the information collected is not in the required format
4. Some panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information is provided to the panel.
5. A modifiable death is defined where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Table N: Number of child death[1] reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by Child Protection Plan status

Year ending 31 March 2012

Coverage: England

	Child protection plan[2]				All child death reviews completed in year ending 31 March 2012 with an assessment of modifiable factors[4,5]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[4,5]	All child death reviews completed in year ending 31 March 2012
	At the time of death	Previously, but not at time of death	Not at all	Unknown[3]			
All child death reviews completed in the year ending 31 March 2012							
of which:							
Modifiable factors identified[4]	22	20	715	27	784		784
No modifiable factors identified[4]	23	40	2,949	168	3,180		3,180
Total	45	60	3,664	195	3,964	48	4,012
Percentage of this child protection plan status:							
Modifiable factors identified[4]	49%	33%	20%	14%	20%	.	.
No modifiable factors identified[4]	51%	67%	80%	86%	80%	.	.
Total	100%	100%	100%	100%	100%	.	.
Percentage of each child protection plan status under this assessment:							
Modifiable factors identified[4]	3%	3%	91%	3%	100%	.	.
No modifiable factors identified[4]	1%	1%	93%	5%	100%	.	.
Total	1%	2%	92%	5%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding still births.
2. Percentages are shown rounded to whole numbers. (.) represents values which are not applicable.
3. It was unknown if 5% of the children reviewed were the subject of a child protection plan at the time of their death or previously. This may because this information is not collected by the panel or the information collected is not in the required format.
4. Some panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information is provided to the panel.
5. A modifiable death is defined where there are factors which<u>may</u> have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

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

Year ending 31 March 2012

Coverage: England

	Statutory orders				All child death reviews completed in year ending 31 March 2012 with an assessment of modifiable factors[4,5]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[4,5]	All child death reviews completed in year ending 31 March 2012
	At the time of death	Previously, but not at time of death	Not at all	Unknown[3]			
All child death reviews completed in the year ending 31 March 2012							
of which:							
Modifiable factors identified[5]	20	x	710	40	784	.	784
No modifiable factors identified[5]	30	10	2,900	240	3,180	.	3,180
Total	50	20	3,610	290	3,964	48	4,012
Percentage of this statutory order status:							
Modifiable factors identified[5]	49%	x	20%	15%	20%	.	.
No modifiable factors identified[5]	51%	82%	80%	85%	80%	.	.
Total	100%	100%	100%	100%	100%	.	.
Percentage of each statutory order status under this assessment:							
Modifiable factors identified[5]	3%	x	91%	6%	100%	.	.
No modifiable factors identified[5]	1%	-	91%	8%	100%	.	.
Total	1%	-	91%	7%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding still births.
2. Figures are rounded to the nearest 10. Figures may not add up due to rounding. Numbers from 1 to 5 inclusive have been suppressed, being replaced by a cross (x). Percentages are shown rounded to whole numbers but where the numerator was five or less or the denominator was 10 or less, they have been suppressed and replaced by a cross (x). (.) represents values which are not applicable. (-) represents percentages less than 0.5% but greater than 0%.
3. It was unknown if 7% of the children reviewed were subject to a statutory order at the time of their death or previously. This may be because this information is not collected by the panel or the information collected is not in the required format.
4. Some panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information is provided to the panel.
5. A modifiable death is defined where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Table P: Number of child death[1] reviews completed by Child Death Overview Panels on behalf of Local Safeguarding Children Boards by Serious Case Review status

Year ending 31 March 2012

Coverage: England

	Child death reviews completed in year ending 31 March 2012[2]			All child death reviews completed in year ending 31 March 2012 with an assessment of modifiable factors[4,5]	All child death reviews where there was insufficient information available to assess if there were modifiable factors in the death[4,5]	All child death reviews completed in year ending 31 March 2012
	A SCR did not take place	A SCR did take place	Unknown[3]			
All child death reviews completed in the year ending 31 March 2012						
of which:						
Modifiable factors identified[4]	742	30	12	784	.	784
No modifiable factors identified[4]	3,101	9	70	3,180	.	3,180
Total	3,843	39	82	3,964	48	4,012
Percentage of this SCR status:						
Modifiable factors identified[4]	19%	77%	15%	20%	.	.
No modifiable factors identified[4]	81%	23%	85%	80%	.	.
Total	100%	100%	100%	100%	.	.
Percentage of each SCR status under this assessment:						
Modifiable factors identified[4]	95%	4%	2%	100%	.	.
No modifiable factors identified[4]	98%	-	2%	100%	.	.
Total	97%	1%	2%	100%	.	.

Source: LSCB1

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding still births.
2. Percentages are shown rounded to whole numbers. (.) represents values which are not applicable. (-) represents percentages less than 0.5% but greater than 0%.
3. All deaths were it was unknown if a serious case review took place were within the same panel who experienced difficulties in extracting accurate data from their database to answer this question.
4. Some panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information is provided to the panel.
5. A modifiable death is defined where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.