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PREVENTABLE CHILD DEATHS IN ENGLAND: YEAR ENDING 31 MARCH 2009

INTRODUCTION

This Statistical Release (STR) provides figures on child deaths which have been reviewed by Local Safeguarding Children Boards (LSCBs) in England between 1 April 2008 and 31 March 2009.

LSCBs 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 LSCBs 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 (CDRP). The duties of the LSCB regarding these processes are set out in Chapter 7 of *Working Together to Safeguard Children* (HM Government 2006). Their responsibilities included setting up a Child Death Overview Panel (CDOP) which reviews child deaths on behalf of the LSCB.

Reviewing child deaths includes collecting information about the circumstances of the fatality, assessing if the death was preventable (as defined in Public Service Agreement 13 (PSA 13)) and determining if there are lessons which could be learned. However this is not an investigation into why a child has died and it is not a Serious Case Review (SCR), although a SCR may be completed in respect of a death where abuse or neglect were considered to be a factor.

The public sector agreement to “Improve children and young people’s safety” (PSA 13) includes monitoring preventable child deaths as recorded through child death review panel processes (indicator 4). Future data from LSCBs will provide information to monitor the progress being made against this national indicator.

NOTE ON INTERPRETATION

This is the first year of data collection and reviewing child deaths is an extremely complex responsibility of the LSCBs. Therefore these figures should be interpreted with caution. Please see the section on Data Quality and Interpretation.

KEY POINTS

- LSCBs in England reviewed 2,000 deaths between 01 April 2008 and 31 March 2009, of which 110 were considered to have been preventable (5%).
- The South West of England has the highest proportion of deaths which were assessed as preventable child deaths (15%) and the North West of England has the lowest proportion (2%).
- Approximately 41% of all child deaths were reviewed by LSCBs in 2008-09. (Based on the number of deaths registered in 2007. This has been used as an estimate for the total number of child deaths in 2008-09 as in England these numbers do not vary greatly year on year).

- Summary information has been derived from statistical data supplied by the 144[1] LSCBs in England. 92[2] Child Death Overview Panels (CDOPs) review child deaths on behalf of these LSCBS.

BACKGROUND

The implementation of the Child Death Review Processes (CDRP) is a high profile initiative which has firm ministerial endorsement and cross-government agreement. Its introduction was signalled in the Government's response to the Victoria Climbié Inquiry Report and the *Every Child Matters* (ECM) Green Paper. One of the functions of LSCBs set out in Regulation 6 (SI No 2006/90) is to undertake reviews of each child death in their area. Chapter 7 in Working Together (HM Government 2006) sets out the guidance to be followed by LSCBs.

The LSCB data collection was introduced from 1 April 2008 and is designed to collect information on the number of child deaths which have been reviewed by Child Death Overview Panels (CDOPs) on behalf of their LSCBs, and the number of these cases which were assessed as being preventable child deaths in England. This is the first year of collection.

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

The key purpose of reviewing all child deaths is to learn lessons and reduce the incidence of preventable child deaths in the future.

The PSA Delivery Agreement 13: Improve children and young people's safety (April 2008) defines preventable and avoidable factors 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.*

Please note panels are asked to identify preventable or avoidable 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 preventable death may not necessarily be due to a failure of the Local Authority to safeguard the child's welfare.

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.

In England, there are currently approximately 5,000 deaths of children registered per year.

Legislation

The Children Act 2004 includes a requirement on Local Authorities in England to set up Local Safeguarding Children Boards (LSCBs) by 1 April 2006.

One of the functions of LSCBs set out in Regulation 6 (SI No 2006/90) is to undertake the reviewing of all child deaths in their area. The requirement for LSCBs to undertake their functions relating to child deaths

[1] Neighbouring Local Authorities may decide to share one LSCB, depending on the local configuration of services and population served

[2] Neighbouring LSCBs may decide to share a Child Death Overview Panel, depending on the local configuration of services and population served

did not apply until 1 April 2008. However LSCBs could decide to undertake these functions from 1 April 2006. From 1 April 2006, they were encouraged to put in place the procedures set out in Chapter 7 of the statutory guidance *Working Together to Safeguard Children* (2006).

In July 2008, in partnership with the Ministry of Justice (MoJ), the DCSF amended the Coroners Rules 1984 to place a duty on coroners to notify LSCBs of all child deaths over which they have jurisdiction. A power for coroners to provide LSCBs with information relevant to children who die and for whom they have jurisdiction was also introduced.

With the enactment of the Children and Young Persons Act 2008, from 1 April 2009 registrars have a duty to provide LSCBs with the 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

LSCBs are required to assess if a child death is preventable, potentially preventable or not preventable. This data collection does not include details of the number of deaths which were assessed as potentially preventable or not preventable. It also excludes reviews of child deaths which were ongoing at the 31 March 2009 where a decision about preventability had yet to be made.

A national data collection system is being developed to collect more comprehensive information about child deaths. This will allow more detailed analysis of the data held by LSCBs, including analysis by age, gender and cause.

COVERAGE AND MISSING DATA

As this is the first year that child deaths have been reviewed and recorded these figures should be interpreted with caution. Not all deaths in 2008-09 had been fully reviewed on 31 March 2009 by their CDOP due to the time lag between the death and the assessment of the available information about the child death. Panels have also encountered a number of process issues which have further reduced the number of deaths they were able to review.

Panels have reported that many of these process issues have now been resolved, that the process of reviewing child deaths is improving and from 1 April 2009 onwards, all deaths should be reviewed once all the relevant information becomes available. However the issues which panels encountered during 2008-09 will affect the reported number of deaths which were reviewed and the number of these which were assessed as preventable up to 31 March 2009. The completeness of the data provided will have been compromised in the following ways:

- Not all LSCBs had been informed of every child death within their area and therefore they had not been able to review these.
- Where incomplete information about the child had been provided to panels, they were not able to identify the child, and therefore could not gather information to assess the death.
- Where panels experienced delays while waiting for post mortem results, coroners' reports, criminal investigation outcomes and Serious Case Reviews outcomes they were unable to fully review some child deaths by the 31 March 2009, therefore some of the most complex cases will now be reviewed in 2009-10. Please note that although a decision about preventability may not have been made by 31 March 2009, panels have begun to learn lessons from these cases and to take action to resolve the issues.

- Some LSCBs have prioritised the order in which deaths are reviewed, due to the limited number of times the panels were able to meet before 31 March 2009. Some panels ensured that deaths where lessons needed to be learned were addressed first. This has resulted in a number of expected and probably unpreventable deaths yet to be reviewed on 31 March 2009. These cases will now be reviewed in 2009-10.
- LSCBs have reported difficulties in understanding and interpreting the definition of preventable child deaths. This has resulted in a number of panels failing to reach a decision on preventability for some of the most complex deaths by the 31 March 2009. As a result these deaths will now have their reviews finalised in 2009-10.
- In this first year of the review process, there have been inconsistencies in how panels have interpreted the guidance around the reviewing of all child deaths, with some panels reporting that they have not reviewed neo-natal deaths or only reviewed unexpected deaths. Other panels felt that they were unable to review the deaths which occurred before the panels were set up and chairs and co-ordinators were recruited. In some LSCBs this has resulted in deaths for only a quarter of the year being considered by the panel.

TABLES

Table 1 Number of child deaths reviewed by CDOPs between 01 April 2008 and 31 March 2009, nationally and regionally. Including
- the number of deaths which were assessed as preventable
- an estimate of the proportion of all child deaths which have been reviewed. (Based on the number of deaths registered in 2007).

NOTES TO EDITORS

1. This is the first year that LSCBS have been required to review all child deaths. This is a complex and challenging area. It will take time and considerable dedication from LSCBs to implement Child Death Overview Panels (CDOPs) and ensure that all child deaths in England are reviewed.

2. Reviewing child deaths requires a great deal of judgement from the panel and a common understanding of the definition of preventable. This means it may take a number of years to build a consistent national approach to the review process. Therefore it may be sometime before the data collection provides an accurate representation of preventable child deaths in England.

3. Reviews of similar deaths in subsequent years may result in different assessments of preventability. Decisions may change as the process evolves and as panels build a consistent approach to understanding preventability. In addition, local trends may begin to emerge which would suggest that similar deaths should be assessed as preventable.

4. Not all child deaths lead to a Serious Case Review (SCR). Child death reviews, in relation to the deaths of any children normally resident in the LSCB area, include:

   (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 instigated 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 SCR might apply, the Chair of the LSCB should be contacted and the SCR procedures followed.

5. Not all deaths which resulted in a SCR will be assessed as preventable, some may be assessed as having limited factors which were preventable and therefore they may be categorised as potentially preventable.

6. Data on the actions LSCBs have taken following the reviews of child deaths are not collected centrally, however this information is held by each LSCB.

7. The proportion of all deaths which have been reviewed by each region has been calculated using the number of death registrations in 2007 for children aged 0-17. The number of child deaths has remained stable for the past 5 years at approximately 5,000 deaths a year, with year on year figures varying very little. (Decreasing only 3% over the 5 year period).

8. The figures provided are based on data provided by all 144 LSCBS. 8 of these LSCBs reported that they had not reviewed any child deaths during the year. There were also other LSCBs which appear to have reviewed a lower percentage of deaths. The key reasons for this include:

    - Some LSCBs are responsible for reviewing the deaths of very few children, therefore if there were delays in notifications these few deaths may not have been reviewed by 31 March 2009.
    - Some panels had very few meetings scheduled in 2008-09 and the meetings which took place focused on agreeing procedures rather than beginning to review child deaths.
    - 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.
    - Reviews have been delayed as panels wait for outcomes from SCRs, criminal investigations and post mortems.

9. Figures presented in the tables have been rounded to the nearest 10. Numbers from 1 to 5 inclusive have been suppressed, being replaced in the published tables by a cross (x). Where any number is shown as zero (0), the original figure submitted was zero. Data has been presented at national and regional level; however due to small numbers it is not possible to provide data at LSCB or CDOP level.

10. For information and guidance on the child death review processes please visit: **http://www.everychildmatters.gov.uk/socialcare/safeguarding/childdeathreview**

Chapter 7 – Child death review processes
Taken from Working Together to Safeguard Children 2006
http://www.everychildmatters.gov.uk/resources-and-practice/IG00060/

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

    - Mortality Statistics Deaths registered in 2007
      http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=15096&Pos=1&ColRank=2&Rank=352
    - Mortality Statistics: Childhood, infant and perinatal:
      http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=6305&Pos=&ColRank=1&Rank=192
    - Infant mortality
      http://www.nchod.nhs.uk/
      Click on the 'compendium of indicators' of the left hand side and then 'indicator specifications'. Scroll through an alphabetical list of indicators available at various geographical levels for England. Go to 'M' for morality from various causes.
    - Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-07
      http://www.dcsf.gov.uk/research/programmeofresearch/projectinformation.cfm?projectId=15743&type=5&resultspage=11
    - Why Children Die: A pilot study (2006) (May 2008)
      http://www.cemach.org.uk/getdoc/cc3d51cc-5043-4132-99b7-af5219276dce/Child-Death-Review.aspx

Table 1: Number of child deaths[1] reviewed by Child Death Overview Panels (CDOPs) on behalf of Local Safeguarding Children Boards (LSCBs)[2]
Year ending 31 March 2009
Coverage: England

	Number of child deaths which have been reviewed on behalf of LSCBs	Number of child deaths reviewed on behalf the LSCB which were assessed as preventable[3]	Proportion of all deaths reviewed which were assessed as preventable[3]	Number of deaths which occurred in 2007 for children aged 0-17[4]	Number of child deaths reviewed as an approximated proportion of all child deaths[5]
England	**2,000**	**110**	**5%**	**4,850**	**41%**
Region					
North East	50	10	12%	250	20%
North West	390	10	2%	680	58%
Yorkshire and Humberside	230	10	4%	560	41%
East Midlands	160	10	5%	420	38%
West Midlands	350	20	4%	620	55%
East of England	200	x	x	480	42%
London	360	20	5%	830	43%
Inner London	150	20	10%	370	40%
Outer London	210	x	x	460	45%
South East	220	30	14%	650	33%
South West	50	10	15%	360	13%

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).
3. Please note that as this is the first year which LSCBs were required to review all child deaths a number of panels have been unable to review all child deaths by 31 March 2009. Some panels have ensured that the most complex and most likely preventable child deaths were fully reviewed by 31 March 2009, whereas in other cases panels have only been able to fully review the least complex cases and most likely unpreventable child deaths by 31 March 2009.
4. Figures represent the number of deaths which were registered in the calendar year 2007 for children aged 0 to 17 in England.
5. Please note that a number of panels were not able to fully review all child deaths within their areas by the 31 March 2009. This is mainly because 2008-09 was the first year which LSCBs were required to review all child deaths and this is an extremely complex area which requires time to ensure that all process are in place and information flows quickly between relevant parties.

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ENQUIRIES

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