NCMD

National Child Mortality Database

Knowledge, understanding and learning to improve young lives

Child Death Review Data: Year ending 31 March 2020

November 2020

HQIP

Healthcare Quality Improvement Partnership

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Acknowledgements

The National Child Mortality Database (NCMD) programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices. Its aim is to promote quality improvement in patient outcomes. HQIP holds the contract to commission, manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. NCAPOP is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies (www.hqip.org.uk/national-programmes).

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1. Introduction

Child death review (CDR) processes are mandatory for Child Death Review Partners (CDR Partners) in England. The CDR process has been in place in England since 1 April 2008 and was previously the responsibility of Local Safeguarding Children Boards (LSCBs). CDR Partners are responsible for reviewing the deaths of all children up to the age of 18. This function is carried out through local Child Death Overview Panels (CDOPs). The overall purpose is to understand why children die and to put in place interventions to protect other children and reduce the risk of future deaths.

In 2018, the Department of Health and Social Care (DHSC) published new and revised statutory and operational guidance related to CDR. The new guidance requires all CDR partners to gather information from every agency that has had contact with the child, during their life and after their death, including health and social care services, law enforcement, and education services. This is done using a set of statutory CDR forms.

The National Child Mortality Database (NCMD) launched on 1 April 2019 and collates data collected by CDOPs in England from reviews of all children, who die at any time after birth before their 18th birthday. There is a statutory requirement for CDOPs to collect this data and to provide it to the NCMD.

The data in this report covers the number of reviews of children whose death was reviewed by a CDOP between 1 April 2019 and 31 March 2020. It should be read in conjunction with the following two data tables:

- Reference Tables – “Child Death Reviews Data (year ending 31 March 2020)”
- Table 1 CSV data

These data have been published for a number of years and are used by CDOPs to inform the production of their local annual reports. Data for 2018/19 and 2017/18 was published by NHS Digital and prior to that it was published by Department for Education. The format has been kept consistent with previous publications, however due to a change in data collection processes there are a few changes which are listed in Section 6. Additionally, it reports the number of notifications of children that died between 1 April 2019 and 31 March 2020.

The second NCMD annual report will follow this publication in Spring 2021 to include detailed analysis along with key messages and recommendations informed by the data and in consultation with the NCMD stakeholder professional and public representation groups.

2. Deaths occurring between 1 April 2019 and 31 March 2020

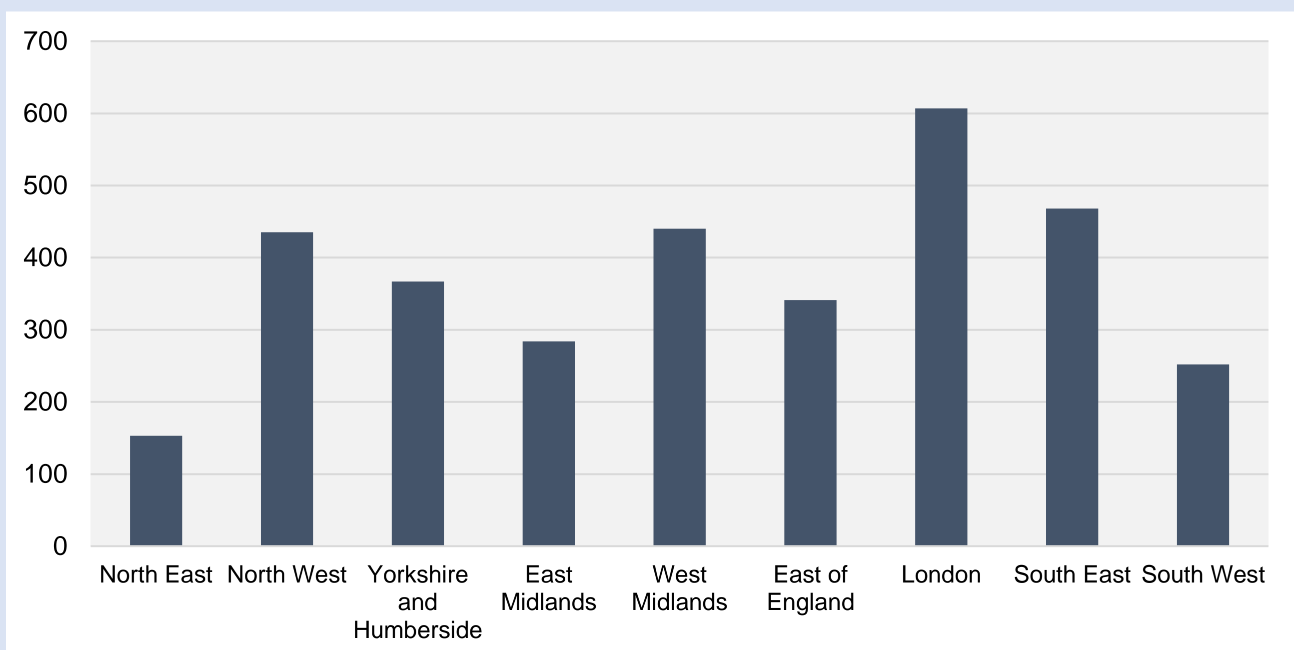
This section of the report focuses on the number of child death notifications received by NCMD where the child died between 1 April 2019 and 31 March 2020.

The number of child death notifications (Reference Table 1)

The NCMD received **3,347** child death notifications from CDOPs in England where the child died between 1 April 2019 and 31 March 2020. CDOPs in the London region submitted the most child death notifications to NCMD (607), where the North East region submitted the least number of notifications (153).

A more detailed breakdown of notification data will be available within the second NCMD Annual Report.

Figure 1: The number of child death notifications received by Child Death Overview Panels by region, Year ending 31 March 2020



3. Deaths reviewed between 1 April 2019 and 31 March 2020

This section of the report presents the number of child death reviews completed by CDOPs between 1 April 2019 and 31 March 2020. It is important to note that the CDOP review of the child death may not be completed in the same year as when the death occurred. Therefore, the population of children reported in Section 2 partially overlap but is distinct from the population of children described in this section of the report.

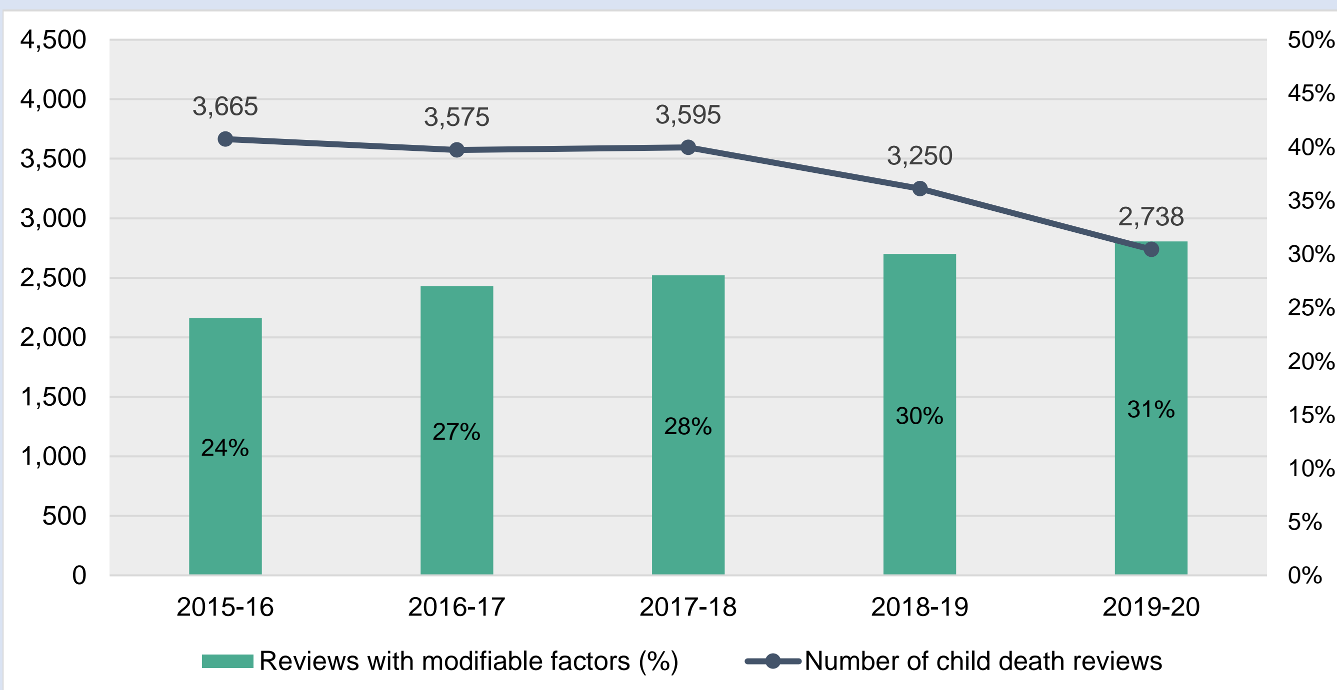
During the child death review the CDOP is responsible for identifying any modifiable factors in relation to the child's death. A modifiable factor is defined as any factor which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

The number of child death reviews (Reference Table 1)

2,738 child deaths were reviewed in England between 1 April 2019 and 31 March 2020, which is a decrease of 512 (16%) in comparison to the previous reporting year. The decrease in the number of reviews for 2019-20 is likely because fewer CDOP meetings took place whilst they were working under transitional arrangements. In addition, many CDOP meetings were cancelled in March 2020 due to the response to the COVID-19 pandemic.

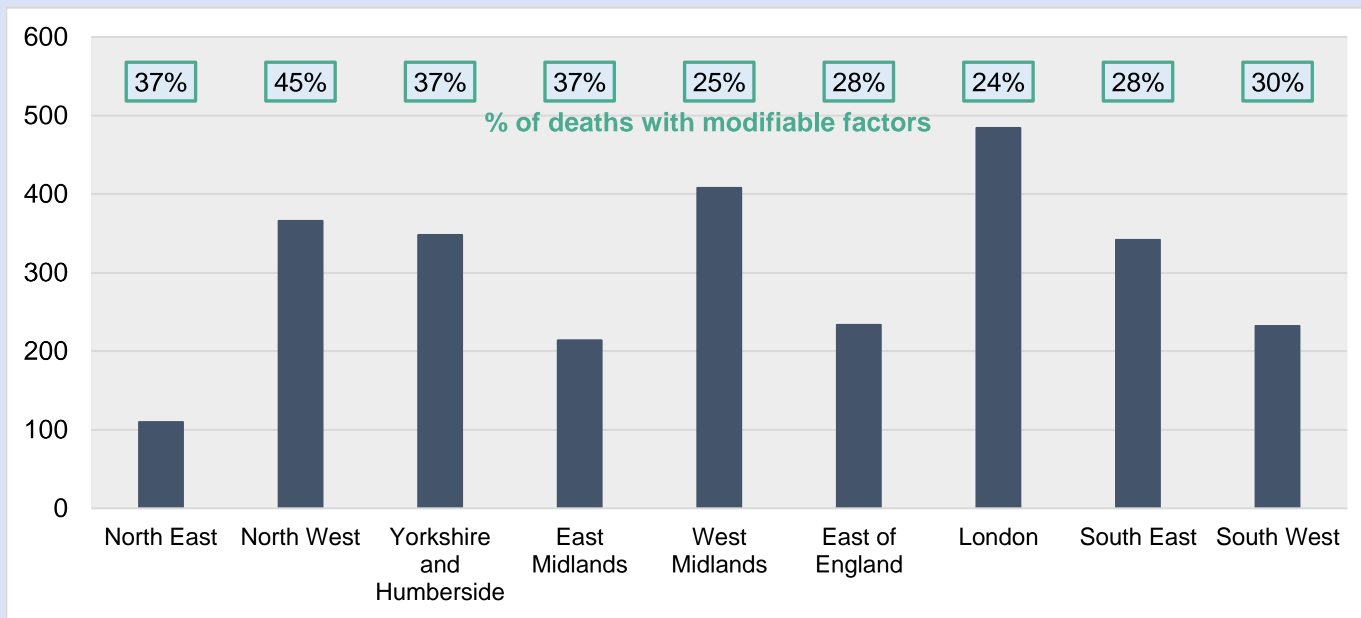
862 (31%) of these reviews identified one or more modifiable factors. This percentage is comparable to the figure reported in 2018-19, but the proportion of cases identified with modifiable factors has increased by 7% since 2015-16.

Figure 2: The number of child death reviews completed by Child Death Overview Panels in England, Year ending 31 March 2020



CDOPs in London reviewed the most child deaths (484), where the North East reviewed the least (110) which is consistent with the number of notifications submitted to NCMD. CDOPs in the North West identified the highest proportion (45%) of modifiable factors in the child death reviews they completed, where London reported the lowest proportion of cases with modifiable factors (24%).

Figure 3: The number of child death reviews completed by Child Death Overview Panels and the proportion of cases with modifiable factors identified by Region, Year ending 31 March 2020



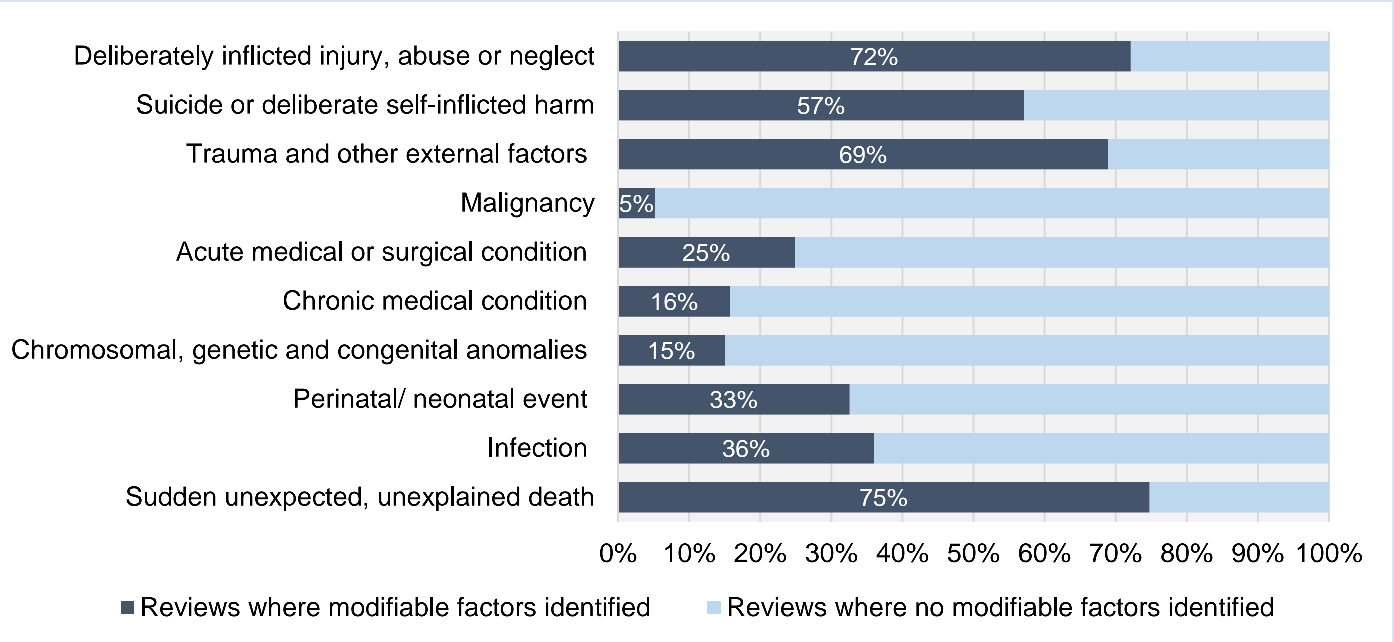
Category of death (Reference Table 4)

CDOPs are required to assign a category of death to each death reviewed within the Analysis Form, the final output of the child death review process. The classification of categories is hierarchical where the uppermost selected category is recorded as the primary category should more than one category be selected.

851 reviews (31%) recorded a primary category of “Perinatal/neonatal event”, and a further 674 reviews (25%) recorded a primary category of “Chromosomal, genetic and congenital anomalies”. These two categories combined represent over half (56%) of reviews completed.

Deaths with a primary category of “Sudden unexpected and unexplained” had the highest proportion (75%) of deaths identified as having modifiable factors, closely followed by deaths with a primary category of “Deliberately inflicted injury, abuse or neglect” (72%). Deaths with a primary category of “Malignancy” had the lowest proportion (5%) of deaths identified as having modifiable factors. This is consistent with previous years’ data.

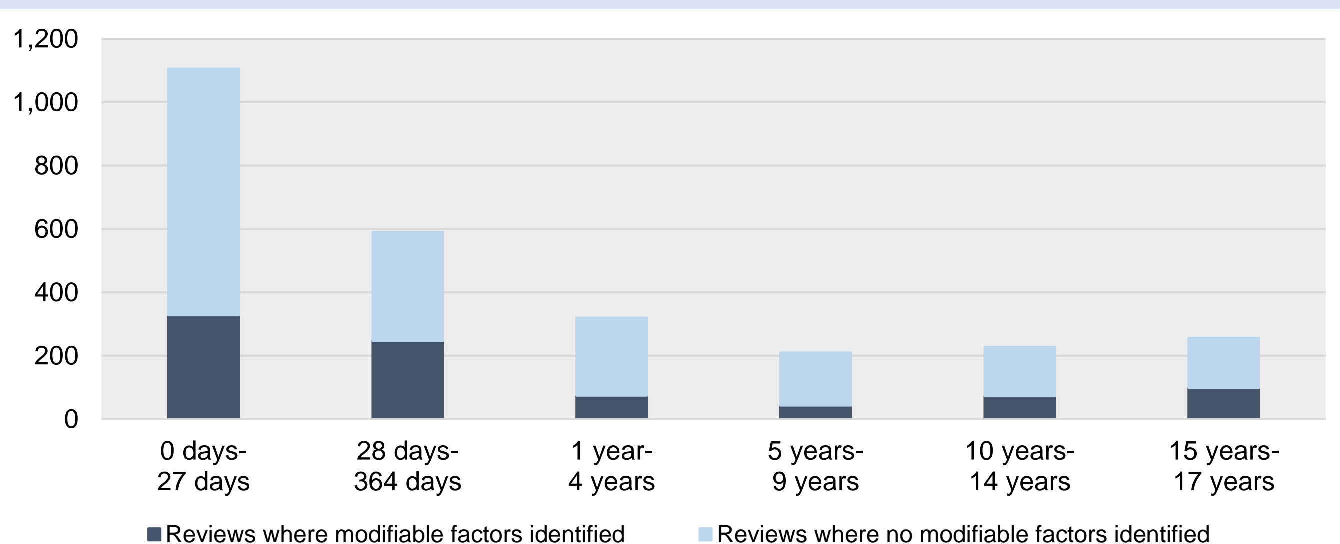
Figure 4: The proportion of child death reviews completed by Child Death Overview Panels with modifiable factors identified by primary category of death, Year ending 31 March 2020



Demographics (Reference Table 9)

Deaths occurring in the neonatal period (0–27 days) represented the largest proportion of deaths reviewed (n=1106, 41%) and a further 591 (22%) deaths were within the 28-364 days age group. Together, deaths where the child was aged under 1 represented 63% of child deaths reviewed during 2019-20. The largest proportion of cases with modifiable factors identified was the 28-364 days age group (42%), where the lowest proportion was in the 5-9 years age group (20%).

Figure 5: The number of child death reviews completed by Child Death Overview Panels by age group, Year ending 31 March 2020



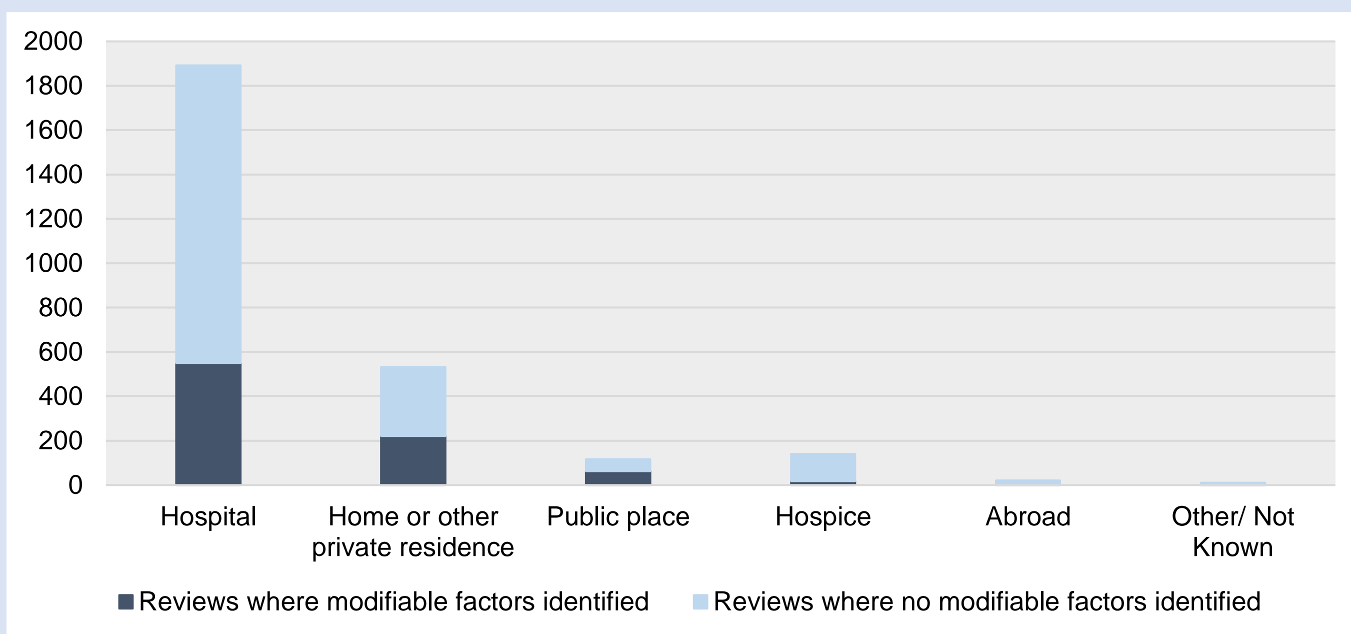
Males represented just over half of child death reviews (56%) and had the same proportion of deaths identified as having modifiable factors to females (32%).

1,570 reviews were completed of deaths of children from a White background, accounting for 65% of reviews completed where the child's ethnicity was recorded. By contrast, 760 (31%) of the deaths reviewed were for children from a Black, Mixed or Asian ethnic background.

Location (Reference Table 6)

1,892 (70%) of the deaths reviewed occurred in a Hospital Trust and 532 (20%) of deaths reviewed had occurred at Home or another private residence. The highest proportion of deaths with modifiable factors could be seen in deaths that occurred in a public place (54%). The lowest proportion of deaths with modifiable factors was seen in deaths that occurred in a Hospice (13%).

Figure 6: The number of child death reviews completed by Child Death Overview Panels by location at the time of event or illness, Year ending 31 March 2020



School not presented in the figure due to low numbers

Child Safeguarding Practice Review (Reference Table 7)

A Child Safeguarding Practice Review (previously Serious Case Review) is conducted when a child is seriously harmed, or dies, as a result of abuse or neglect. The review identifies how local professionals and organisations can improve the way they work together. Out of the number of child death reviews completed throughout the year, the NCMD received information that a Child Safeguarding Practice Review was carried out for at least 48 child deaths. Of these, 79% identified modifiable factors in the review.

Social care (Reference Table 8)

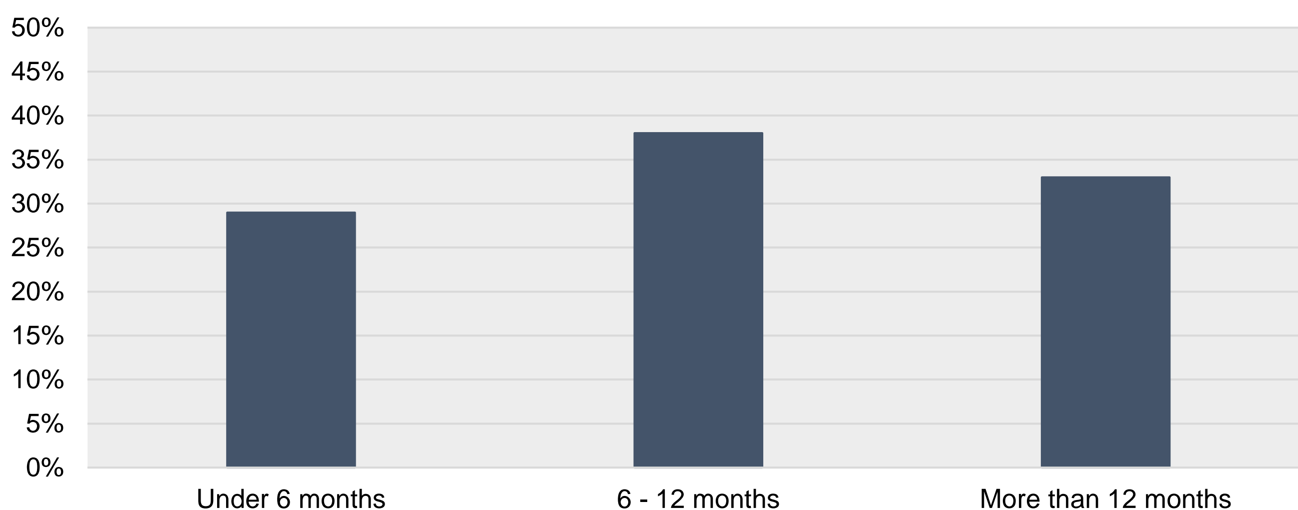
The NCMD received information on 253 children whose death was reviewed during the year were known to social care at the time of their death. Of these, 41% had modifiable factors identified in the review. See Table 8 for a detailed breakdown of how these children were known to social care.

Duration of reviews (Reference Table 2 & Reference Table 3)

740 (27%) reviews completed by CDOPs were of children who died between 1 April 2019 and 31 March 2020, while 1,998 (73%) reviews were of children who died during previous years.

776 (29%) reviews were finalised within 6 months of the child's death, while 1,806 (67%) of the reviews were finalised within 12 months of the child's death. The 909 (33%) reviews that took over 12 months to complete presented the highest proportion of reviews where modifiable factors were identified (44%), compared to 17% for reviews taking under 6 months. There are a number of factors that may contribute to a longer length of time between the death of a child and CDOP review, for example; the return of reporting forms, the receipt of the final post mortem report, undertaking of a criminal investigation or a Child Safeguarding Practice Review, and receipt of the final report from the local child death review meeting. In addition, on occasion when the outcome of a Coroner's inquest is awaited, there may be a longer delay before a case can be reviewed by the CDOP.

Figure 7: The percentage of reviews completed by Child Death Overview Panels by the number of months between the date of death and the date of the Child Death Overview Panel meeting, Year ending 31 March 2020



4. List of Reference Tables

Table 1	Number of child death reviews completed by Child Death Overview Panels by region
Table 2	Number of child death reviews completed by Child Death Overview Panels by the year in which the child death occurred
Table 3	Time between the death of a child and the completion of the CDOP review
Table 4	Number of reviews completed by Child Death Overview Panels by category of death
Table 5	Number of reviews completed by Child Death Overview Panels by event which caused the child's death
Table 6	Number of reviews completed by Child Death Overview Panels by location at time of the event or illness which led to the death
Table 7	Number of reviews completed by Child Death Overview Panels by Child Safeguarding Practice Review (previously Serious Case Review) status
Table 8	Number of reviews completed by Child Death Overview Panels by Social Care status
Table 9	Number of reviews completed by Child Death Overview Panels by age of the child at the time of death, gender and ethnicity
LAA to region mapping	Mapping of local authority areas to regions
Disclosure and methodology	Description of the methodology used in the CSV and Data tables
Data descriptions	Contains information and field definitions about the accompanying CSV file

All Reference Tables can be found here.

5. Further information

Child death reviews: Year ending 31 March	Previous versions of this publication can be found at the following websites: 2018 and 2019: https://digital.nhs.uk/data-and-information/publications/statistical/child-death-reviews/2019 2017 and earlier: https://www.gov.uk/government/collections/statistics-child-death-reviews
Child death review forms	The data collection forms used to gather information on child deaths can be found here: https://www.gov.uk/government/publications/child-death-reviews-forms-for-reporting-child-deaths
Child death review statutory and operational guidance	The child death review statutory and operational guidance can be found here: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england
Child death review process	For information on the child death review processes, see Chapter 5 of the 'Working Together to Safeguard Children' document which can be found here: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

6. Technical information

Data in this report represents data that was submitted to the NCMD. As a newly established continuing data collection and with some transitional arrangements still ongoing, more data may be submitted retrospectively, and the figures represented here may change.

All data was checked by the NCMD team prior to data analysis. This includes exclusion of cases that did not meet the criteria for CDOP review and removal of any duplicates.

From May - July 2020 the NCMD team contacted CDOPs to confirm that the data held was correct:

- 52 CDOPs confirmed that the data held was correct
- 3 CDOPs were unable to submit so partial data (i.e. only data which they had submitted) were included for analysis
- For a further 3 CDOPs, the NCMD team was unable to confirm whether the data submitted was correct. These data have been included but are unconfirmed.

Data was downloaded on 30 September 2020.

In a small number of cases (23 reviews in the year ending 31 March 2020), panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. These cases have been included in the number of reviews completed in Tables 1 and 2 but excluded from Tables 3 to 9. This methodology was kept consistent with previous years' publications.

Changes to previous publications

Data on children subject to a statutory order has been withdrawn from the data collection process, and therefore this table is no longer published.

The number of times which CDOPs met and the number of child deaths where the child was not normally resident within the Local Safeguarding Children Board area and are not reported within this publication.

Table 1 now presents data on notifications submitted to the NCMD, rather than death registration data from ONS.

Table 3 has been grouped into smaller timeframes to improve presentation of this data.

Table 5 and 6 now present slightly different categories to represent changes in data collection.

Table 8 has been changed due to a change in the structure of how this question is now asked within the data collection forms.

Table 9 was previously presented as Table 10 in previous publications.

For further information on NCMD data processing please see our Privacy Notice.

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