NCMD

Child Death Reviews Data: year ending 31 March 2020

(previously LSCB1 data collection)

Published: 12th November 2020

Introduction

This analysis focuses on the number of child death reviews completed and the decisions made by Child Death Overview Panels (CDOPs) on behalf of their CDR Partners in England. The tables included show child death reviews completed within the year, including modifiable factors, child characteristics and circumstances of the death. These tables should be read in conjunction with the descriptive report titled "Child Death Reviews Data (year ending 31 March 2020)" which has been published simultaneously on the NCMD website.

Note: Figures prior to year ending March 2018 were published by Department for Education and figures in year ending March 2018 and 2019 were published by NHS Digital.

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Table 1: Number of child death[1] reviews completed by Child Death Overview Panels by region
Years ending 31 March 2016 to 2020
Coverage: England

	Number of child death reviews which were completed in the year ending 31 March[2,3]					Number of child death reviews completed which were assessed as having modifiable factors in the year ending 31 March[2,4]					Proportion of all completed child deaths reviewed which were assessed as having modifiable factors in the year ending 31 March[2,4]					Number of notifications received where the death occurred in the year ending 31 March
	2016	2017	2018	2019	2020	2016	2017	2018	2019	2020	2016	2017	2018	2019	2020	2020
England	3,665	3,575	3,595	3,250	2,738	863	974	1,015	965	862	24%	27%	28%	30%	31%	3,347
Region[5]																
North East	151	157	130	135	110	27	39	45	35	41	18%	25%	33%	25%	37%	153
North West	546	582	565	490	366	161	176	215	200	164	29%	30%	38%	41%	45%	435
Yorkshire and Humberside	407	414	380	315	348	115	126	130	100	128	28%	30%	34%	31%	37%	367
East Midlands	296	280	310	230	214	67	74	95	65	79	23%	26%	31%	27%	37%	284
West Midlands	489	444	595	485	408	96	125	150	140	102	20%	28%	25%	28%	25%	440
East of England	358	303	300	305	234	108	98	85	70	66	30%	32%	29%	22%	28%	341
London	555	600	605	600	484	108	125	125	170	116	19%	21%	21%	28%	24%	607
South East	545	500	455	465	342	91	130	110	115	96	17%	26%	25%	25%	28%	468
South West	318	295	255	225	232	90	81	60	80	70	28%	27%	24%	37%	30%	252

Source: LSCB1, NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. Figures prior to 2018 are shown to the nearest whole number. For 2018, all figures are rounded to nearest 5; therefore, subtotals may not add to totals due to rounding. Percentages are shown rounded to the nearest whole number and have been derived from unsuppressed figures.

3. Please note that not all child deaths which occur each year will have their child death review completed by 31 March. This is mainly because it may take a number of months to gather sufficient information to fully review a child's death.

4. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths. The denominator for the percentage is the number of all deaths reviewed. There were 23 deaths in 2020 where it was not known if there were modifiable factors. In 2019, there were 35 deaths (rounded), in 2018, there were 55 deaths (rounded), in 2017, there were 20 such deaths, in 2016, there were 39, and in 2015 there were 31.

5. Region definitions can be found on the tab: 'LAA to Region mapping'

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Table 2: Number of reviews completed by Child Death Overview Panels by the year in which the child death occurred
Years ending 31 March 2016 to 2020
Coverage: England

	Number[2] of child death reviews completed in the year ending 31 March[3]		
	Where the death occurred prior to the start of the year ending 31 March	**Where the death occurred during the year ending 31 March**	**All child death reviews completed in year ending 31 March**
2016	2,412	1,253	3,665
2017	2,280	1,295	3,575
2018	2,260	1,335	3,595
2019	2,080	1,170	3,250
2020	1,998	740	2,738
The number of which were assessed as having modifiable factors[4]:			
2016	663	200	863
2017	733	241	974
2018	690	320	1,015
2019	705	260	965
2020	707	155	862
Proportion of completed reviews which were assessed as having modifiable factors[2,4]:			
2016	27%	16%	24%
2017	32%	19%	27%
2018	31%	24%	28%
2019	34%	22%	30%
2020	35%	21%	31%

Source: LSCB1, NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.
2. Figures prior to 2018 are shown to the nearest whole numbers. From 2018, all figures are rounded to nearest 5; therefore, subtotals may not add to totals due to rounding. Percentages are shown rounded to the nearest whole numbers and have been derived from unsuppressed figures.
3. Please note that not all child deaths which occur each year will have their child death review completed by 31 March. This is mainly because it may take a number of months to gather sufficient information to fully review a child's death.
4. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

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Table 3: Time between the death of a child and the completion of the CDOP review
Year ending 31 March 2020
Coverage: England

Length of time	All child death reviews completed in the year ending 31 March[2]			Percentage[2] of this length of time with:			Percentage of reviews in each year by duration
	Modifiable factors identified[3]	No modifiable factors identified[3]	Total	Modifiable factors identified[3]	No modifiable factors identified[3]	Total	
Under 6 months	130	646	776	17%	83%	100%	29%
6-12 months	335	695	1,030	33%	67%	100%	38%
More than 12 months	397	512	909	44%	56%	100%	33%
All	862	1,853	2,715	32%	68%	100%	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.
2. Please note that not all child deaths which occur each year will have their child death review completed by 31 March. This is mainly because it may take a number of months to gather sufficient information to fully review a child's death.
3. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

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Table 4: Number of reviews completed by Child Death Overview Panels by category of death
Year ending 31 March 2020
Coverage: England

	Category of death[2]										
	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	All child death reviews completed in year ending 31 March 2020
All child death reviews completed in the year ending 31 March 2020[3]											
Number of which had:											
Modifiable factors identified[3]	43	60	80	11	43	21	101	277	62	164	862
No modifiable factors identified[3]	17	45	36	201	130	112	573	574	110	55	1,853
TOTAL	60	105	116	212	173	133	674	851	172	219	2,715
Percentage of this category of death which had:											
Modifiable factors identified[4]	72%	57%	69%	5%	25%	16%	15%	33%	36%	75%	32%
No modifiable factors identified[4]	28%	43%	31%	95%	75%	84%	85%	67%	64%	25%	68%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of each category of death under this assessment:											
Modifiable factors identified[4]	5%	7%	9%	1%	5%	2%	12%	32%	7%	19%	100%
No modifiable factors identified[4]	1%	2%	2%	11%	7%	6%	31%	31%	6%	3%	100%
Of all deaths	2%	4%	4%	8%	6%	5%	25%	31%	6%	8%	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. Category of death and event are recorded at different times in the review process and there may be deaths where it was not possible to determine the intent and so classifications may differ. The number of deaths recorded as "suicide or deliberate self-inflicted harm" may be different to the number of deaths recorded as "apparent suicide" in Table 5. Similarly, the number of deaths recorded as "perinatal/neonatal event" may be different to the number recorded as "neonatal death" in Table 5.

3. In the year ending 31 March 2020, there were 23 deaths where panels had insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. 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. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.

4. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

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Table 5: Number of reviews completed by Child Death Overview Panels by event which caused the child's death
Year ending 31 March 2020
Coverage: England

NCMD
National Child Mortality Database

	Event which caused the child's death[7]																		
	Neonatal death[8]	Known life limiting condition[6]	Sudden unexpected death in infancy	Vehicle collision	Drowning	Fire, burns or electrocution	Poisoning	Other non-intentional injury/ accident/ trauma	Apparent violent related death[2]	Apparent suicide[3] or self harm	Acute epilepsy	Acute asthma or anaphylaxis	Acute metabolic diabetic ketoacidosis	Cardiac congenital or acquired	Other chromosomal, genetic, or congenital anomaly	Infection	Oncology condition	Other	Unknown	All child death reviews completed in year ending 31 March 2020
All child death reviews completed in the year ending 31 March 2020[4]																			
Number of which had:																			
Modifiable factors identified[5]	290	18	151	35	7	6	*	21	42	61	5	11	*	33	90	54	11	10	11	862
No modifiable factors identified[5]	589	52	48	20	6	*	*	8	23	47	28	5	*	243	439	91	211	31	10	1,853
Total	879	70	199	55	13	6	*	29	65	108	33	16	5	276	529	145	222	41	21	2,715
Percentage of this event which had:																			
Modifiable factors identified[5]	33%	26%	76%	64%	54%	100%	100%	72%	65%	56%	15%	69%	60%	12%	17%	37%	5%	24%	52%	32%
No modifiable factors identified[5]	67%	74%	24%	36%	46%	0%	0%	28%	35%	44%	85%	31%	40%	88%	83%	63%	95%	76%	48%	68%
Total	100%	100%	100%	100%	100%	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]	34%	2%	18%	4%	1%	1%	*	2%	5%	7%	1%	1%	*	4%	10%	6%	1%	1%	1%	100%
No modifiable factors identified[5]	32%	3%	3%	1%	*	*	*	*	1%	3%	2%	*	*	13%	24%	5%	11%	2%	1%	100%
Of all deaths	32%	3%	7%	2%	*	*	*	1%	2%	4%	1%	1%	*	10%	19%	5%	8%	2%	1%	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. A violent related death 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.

3. Category of death and event are recorded at different times in the review process and there may be deaths where it was not possible to determine the intent and so classifications may differ. The number of deaths recorded as "apparent suicide" may be different to the number of deaths recorded as "suicide or deliberate self-inflicted harm" in Table 4. Similarly, the number of deaths recorded as "neonatal death" may be different to the number recorded as "perinatal/neonatal event" in Table 4.

4. In the year ending 31 March 2020, there were 23 deaths where panels had insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. 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. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.

5. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

6. Due to a change in data collection and more granular categories reported in the year ending 31 March 2020, Known life limiting condition presents less data than in previous years.

7. Due to a change in data collection, NCMD validated this data to improve data quality.

8. A neonatal death is related to neonatal or perinatal events.

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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
Year ending 31 March 2020
Coverage: England

	Location at time of the event or illness							All child death reviews completed in year ending 31 March 2020
	Hospital	Home or other private residence	Public place	School	Hospice	Abroad	Other/ Not Known	
All child death reviews completed in the year ending 31 March 2020[2]								
Number of which had:								
Modifiable factors identified[3]	550	222	63	*	18	6	*	862
No modifiable factors identified[3]	1,342	310	53	*	123	14	9	1,853
Total	1,892	532	116	*	141	20	11	2,715
Percentage of deaths in this location which had:								
Modifiable factors identified[3]	29%	42%	54%	33%	13%	30%	18%	32%
No modifiable factors identified[3]	71%	58%	46%	67%	87%	70%	82%	68%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of each location under this assessment:								
Modifiable factors identified[3]	64%	26%	7%	*	2%	1%	*	100%
No modifiable factors identified[3]	72%	17%	3%	*	7%	1%	*	100%
Of all deaths	70%	20%	4%	*	5%	1%	*	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. In the year ending 31 March 2020, there were 23 deaths where panels has insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. 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. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.

3. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

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Table 7: Number of reviews completed by Child Death Overview Panels by Child Safeguarding Practice Review (previously Serious Case Review) status[2,3,4]

Years ending 31 March 2016 to 2020

Coverage: England

Child Safeguarding Practice Review status		All child death reviews completed in the year ending 31 March			Percentage of this Child Safeguarding Practice Review status with:			*Percentage of reviews in each year by Serious Case Review status*
		Modifiable factors identified[5]	No modifiable factors identified[5]	Total	Modifiable factors identified[5]	No modifiable factors identified[6]	Total	
A Child Safeguarding Practice Review did not take place	2016	784	2,677	3,461	23%	77%	100%	95%
	2017	914	2,545	3,459	26%	74%	100%	97%
	2018	865	2,345	3,215	27%	73%	100%	91%
	2019	870	2,115	2,980	29%	71%	100%	93%
	2020	776	1,648	2,424	32%	68%	100%	89%
A Child Safeguarding Practice Review took place	2016	62	54	116	53%	47%	100%	3%
	2017	59	35	94	63%	37%	100%	3%
	2018	65	25	90	74%	26%	100%	3%
	2019	60	10	75	85%	15%	100%	2%
	2020	38	10	48	79%	21%	100%	2%
Unknown[6,7]	2016	17	32	49	35%	65%	100%	1%
	2017	1	1	2	50%	50%	100%	-
	2018	80	155	235	34%	66%	100%	7%
	2019	35	125	160	22%	78%	100%	5%
	2020	48	195	243	20%	80%	100%	9%
All	2016	863	2,763	3,626	24%	76%	100%	100%
	2017	974	2,581	3,555	27%	73%	100%	100%
	2018	1,015	2,525	3,540	29%	71%	100%	100%
	2019	965	2,250	3,215	30%	70%	100%	100%
	2020	862	1,853	2,715	32%	68%	100%	100%

Source: LSCB1, NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. Figures prior to 2018 are shown to the nearest whole numbers. For 2018, all figures are rounded to nearest 5; therefore, subtotals may not add to totals due to rounding. Percentages are shown rounded to the nearest whole numbers and have been derived from unsuppressed figures.

3. "-" represents percentages less than 0.5% but greater than 0%.

4. In the year ending 31 March 2020, there were 23 deaths where panels had insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. 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. In 2019, there were 35 deaths (rounded); In 2018, there were 55 such deaths (rounded); In 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.

5. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

6. It was unknown if the death resulted in serious case review. This may because this information is not collected by the panel or the information collected is not in the required format.

7. Due to submission issues in 2018 and 2019, there were more 'Unknowns' for SCR status

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Table 8: Number of reviews completed by Child Death Overview Panels by Social Care status[2,4]
Year ending 31 March 2020
Coverage: England

Known to Social Care		All child death reviews completed in the year ending 31 March			Percentage of this status with			*Percentage of reviews in each year by status*
		Modifiable factors identified[3]	No modifiable factors identified[3]	Total	Modifiable factors identified[3]	No modifiable factors identified[3]	Total	
Yes		**104**	**149**	**253**	**41%**	**59%**	**100%**	**9%**
	Child protection plan[5]	32	9	41	78%	22%	100%	-
	Looked after child[5]	12	13	25	48%	52%	100%	-
	Child in need[5]	31	74	105	30%	70%	100%	-
	Other[5]	47	70	117	40%	60%	100%	-
Previously, but not at time of death		**78**	**96**	**174**	**45%**	**55%**	**100%**	**6%**
Not at all		**407**	**1,022**	**1,429**	**28%**	**72%**	**100%**	**53%**
Unknown[6]		**273**	**586**	**859**	**32%**	**68%**	**100%**	**32%**
All		**862**	**1,853**	**2,715**	**32%**	**68%**	**100%**	**100%**

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. In the year ending 31 March 2020, there were 23 deaths where panels had insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. 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. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.

3. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

4. Due to a change in the way in which this question is answered following a change in CDR processes in the year ending 31 March 2020, it is not possible to compare this table to previous years. The deaths reviewed in the year ending 31 March 2020 will have used both the old and new data collection process, depending on when the child died. For children who died before 1 April 2019, CDOPs collected 'Was the child on a child protection plan?' with the following options: At the time of death; Previously, but not at time of death; Not at all; Unknown. From 1 April 2019, the question changed to 'Was the child known to children's social care prior to their death/the event leading to their death?' with the following options where more than one could be selected: Yes on a child protection plan; Yes, as a looked after child; Yes, as a child in need; Yes, as an asylum seeker; Yes, other; Previously known, but not an open case; No; Unknown

5. Each child death review included under 'Yes' can be known to social care in multiple ways and therefore these totals will not sum to the total of child death reviews reported under 'Yes'.

6. Due to a change in data collection and CDR processes in the year ending 31 March 2020, there were more 'Unknowns' for social care status.

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Table 9: Number of reviews completed by Child Death Overview Panels by age of the child at the time of death, gender and ethnicity
Year ending 31 March 2020
Coverage: England

	Age of the child at the time of death						Gender			Ethnicity						All child death reviews completed in year ending 31 March 2020
	0 days-27 days	28 days-364 days	1 year-4 years	5 years-9 years	10 years-14 years	15 years-17 years	Male	Female	Unknown/ Indeterminate	White	Mixed	Asian	Black	Other	Unknown/ not stated	
All child death reviews completed in the year ending 31 March 2020[2]																
Number of which had:																
Modifiable factors identified[3]	328	247	74	43	72	98	482	379	*	562	47	97	43	21	92	862
No modifiable factors identified[3]	778	344	247	168	157	159	1,039	797	17	1,008	89	336	148	66	206	1,853
Total	1,106	591	321	211	229	257	1,521	1,176	18	1,570	136	433	191	87	298	2,715
Percentage of this age group/gender/ethnicity which had:																
Modifiable factors identified[3]	30%	42%	23%	20%	31%	38%	32%	32%	6%	36%	35%	22%	23%	24%	31%	32%
No modifiable factors identified[3]	70%	58%	77%	80%	69%	62%	68%	68%	94%	64%	65%	78%	77%	76%	69%	68%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of each age group/gender/ethnicity under this assessment:																
Modifiable factors identified[3]	38%	29%	9%	5%	8%	11%	56%	44%	*	65%	5%	11%	5%	2%	11%	100%
No modifiable factors identified[3]	42%	19%	13%	9%	8%	9%	56%	43%	1%	54%	5%	18%	8%	4%	11%	100%
Of all deaths	41%	22%	12%	8%	8%	9%	56%	43%	1%	58%	5%	16%	7%	3%	11%	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.
2. In the year ending 31 March 2020, there were 23 deaths where panels had insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. 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. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.
3. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

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Local Authority Area to Region mapping

Region	Child Death Overview Panel	Local Authority Area
East Midlands	Derby and Derbyshire	Derby
		Derbyshire
	Leicester, Leicestershire and Rutland	Leicester
		Leicestershire
		Rutland
	Lincolnshire	Lincolnshire
	Northamptonshire	Northamptonshire
	Nottinghamshire and Nottingham City	Nottingham
		Nottinghamshire
East of England	Bedfordshire	Bedford Borough
		Central Bedfordshire
		Luton
	Cambridge and Peterborough	Cambridgeshire
		Peterborough
	Hertfordshire	Hertfordshire
	Norfolk	Norfolk
	Southend, Essex and Thurrock	Essex
		Southend
		Thurrock
	Suffolk	Suffolk
London	North Central London	Barnet
		Camden
		Enfield
		Haringey
		Islington
	North East London	Barking and Dagenham
		Havering
		Redbridge
	North East London (WELC)	Hackney and City
		Newham
		Tower Hamlets
		Waltham Forest
	North West London	Brent
		Ealing
		Hammersmith and Fulham
		Harrow

London	North West London	Hillingdon
		Hounslow
		Kensington and Chelsea
		Westminster
	South East London BGL	Bexley
		Greenwich
		Lewisham
	South East London	Bromley
		Lambeth
		Southwark
	South West London	Croydon
		Kingston upon Thames
		Merton
		Richmond upon Thames
		Sutton
		Wandsworth
North East	Durham and Darlington	Darlington
		Durham
	North and South of Tyne	Gateshead
		Newcastle upon Tyne
		North Tyneside
		Northumberland
		South Tyneside
		Sunderland
	Tees	Hartlepool
		Middlesbrough
		Redcar and Cleveland
		Stockton on Tees
North West	Blackpool, Blackburn and Lancashire	Blackburn with Darwen
		Blackpool
		Lancashire
	Bolton, Salford and Wigan	Bolton
		Salford
		Wigan
	Bury, Rochdale and Oldham	Bury
		Oldham
		Rochdale
	Cumbria	Cumbria
	Manchester	Manchester
	Merseyside	Knowsley
		Liverpool
		Sefton
		St Helens
		Wirral
		Isle Of Man
	Pan Cheshire	Cheshire East
		Chester and Cheshire West

	Pan Cheshire	Halton
		Warrington
	Stockport, Tameside and Trafford	Stockport
		Tameside
		Trafford
South East	Hampshire and Isle of Wight	Hampshire
		Isle of Wight
		Portsmouth
		Southampton
	Kent and Medway	Kent
		Medway Towns
	Milton Keynes	Milton Keynes
	Oxfordshire and Buckinghamshire	Buckinghamshire
		Oxfordshire
	Pan Berkshire	Bracknell Forest
		Reading
		Slough
		West Berkshire
		Windsor and Maidenhead
		Wokingham
	Pan Sussex	Brighton and Hove
		East Sussex
		West Sussex
	Surrey	Surrey
South West	Gloucestershire	Gloucestershire
	Pan Dorset and Somerset	Bournemouth, Christchurch and Poole
		Dorset
		Somerset
	South West Peninsula	Cornwall
		Devon
		Isles of Scilly
		Plymouth
		Torbay
	Swindon and Wiltshire	Swindon
		Wiltshire
	West of England	Bath and North East Somerset
		City of Bristol
		North Somerset
		South Gloucestershire
West Midlands	Birmingham	Birmingham
	Black Country	Dudley
		Sandwell
		Walsall
		Wolverhampton
	Coventry, Warwickshire and Solihull	Coventry
		Solihull
		Warwickshire

	Herefordshire and Worcestershire	Herefordshire
		Worcestershire
	Shropshire, Telford and Wrekin	Shropshire
		Telford and Wrekin
	Stoke on Trent and Staffordshire	Staffordshire
		Stoke on Trent
Yorkshire and Humberside	Barnsley	Barnsley
	Bradford	Bradford
	Doncaster	Doncaster
	East Riding of Yorkshire	East Riding of Yorkshire
	Kingston upon Hull	Kingston upon Hull
	Leeds	Leeds
	Northern Lincolnshire	North East Lincolnshire
		North Lincolnshire
	Rotherham	Rotherham
	Sheffield	Sheffield
	Wakefield, Calderdale and Kirklees	Calderdale
		Kirklees
		Wakefield
	York City and North Yorkshire	North Yorkshire
		York City

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Disclosure control:

In order to minimise the disclosure risk associated with small numbers, we have applied the following controls to these tables:

- "*" denotes that a figure has been suppressed due to small numbers (less than 5, including zero)
- "-" denotes less than 0.5% but greater than 0%

Methodology

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.

Figures reported are following data being checked by the NCMD team. 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 30th 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 to be 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 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.

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Data descriptions

The table below contains information and field definitions about the accompanying CSV file.

CSV data file column name	Description of field
Period	The reporting period
Geog_level	Geographical level breakdown (National, regional or local authority)
Geog_name	Geographical name breakdown
Review_total	Total number of child death reviews completed in the year ending 31 March 2020
Mod_total	Total number of child death reviews completed in the year ending 31 March 2020 where modifiable factors were identified in the review