



Knowledge, understanding and
learning to improve young lives

Child Death Reviews in 2023: Key Updates

Vicky Sleaf, Deputy Director and Tom Williams, Data Manager

Tuesday 14th November 2023

12.00 noon to 1.00pm

****Presentation will start at 12.05pm to allow participants time to join****

Child Death Reviews in 2023: Key Updates

Vicky Sleaf, Deputy Director
Tom Williams, Data Manager

14 November 2023

NCMD

National Child Mortality Database

**Knowledge, understanding and
learning to improve young lives**

What will this webinar cover?

- CDR Data Release for 2022/2023
- System updates
- Upcoming NCMD thematic reports
- National work relating to alerts
- Ongoing and upcoming work



Child Death Reviews Data: year ending 31 March 2023

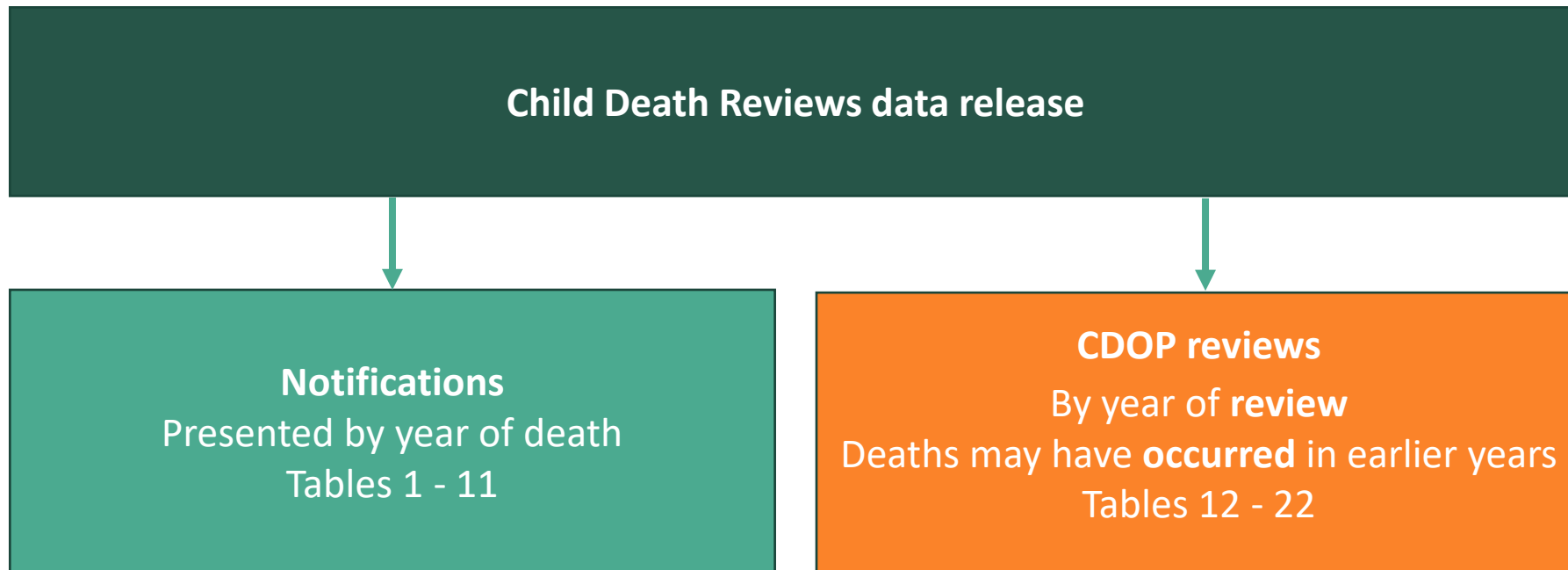
- The data tables and descriptive summary can both be found: www.ncmd.info/cdr23
- Data tables can be downloaded in XLS format.
- The summary is presented in HTML format to make the data more accessible and user friendly to readers, allowing for more interactive content to be displayed.
- A greater level of detail is provided in the data tables than previous years, including:
 - More tables split by age group (neonatal/infant/1-17 years/0 – 17 years), and region
 - Different geographies presented i.e. by NHS Integrated Care Boards.
- Changes were in response to many data requests received throughout the year and to make more data available.

Notifications vs Reviews

The release aims to give a descriptive overview of:

The number of child deaths occurring up to 31 March 2023 (notifications)

The number of reviews of children whose death was reviewed by a CDOP before 31 March 2023 (reviews).



Section 1: The number of child death notifications

- Summarises child deaths (0 - 17 years) up to 31 March 2023
- Deaths that were notified to a Child Death Overview Panel in England
- Excludes stillbirths and legal terminations of pregnancy

Notifications

Presented by year of death

Tables 1 - 11

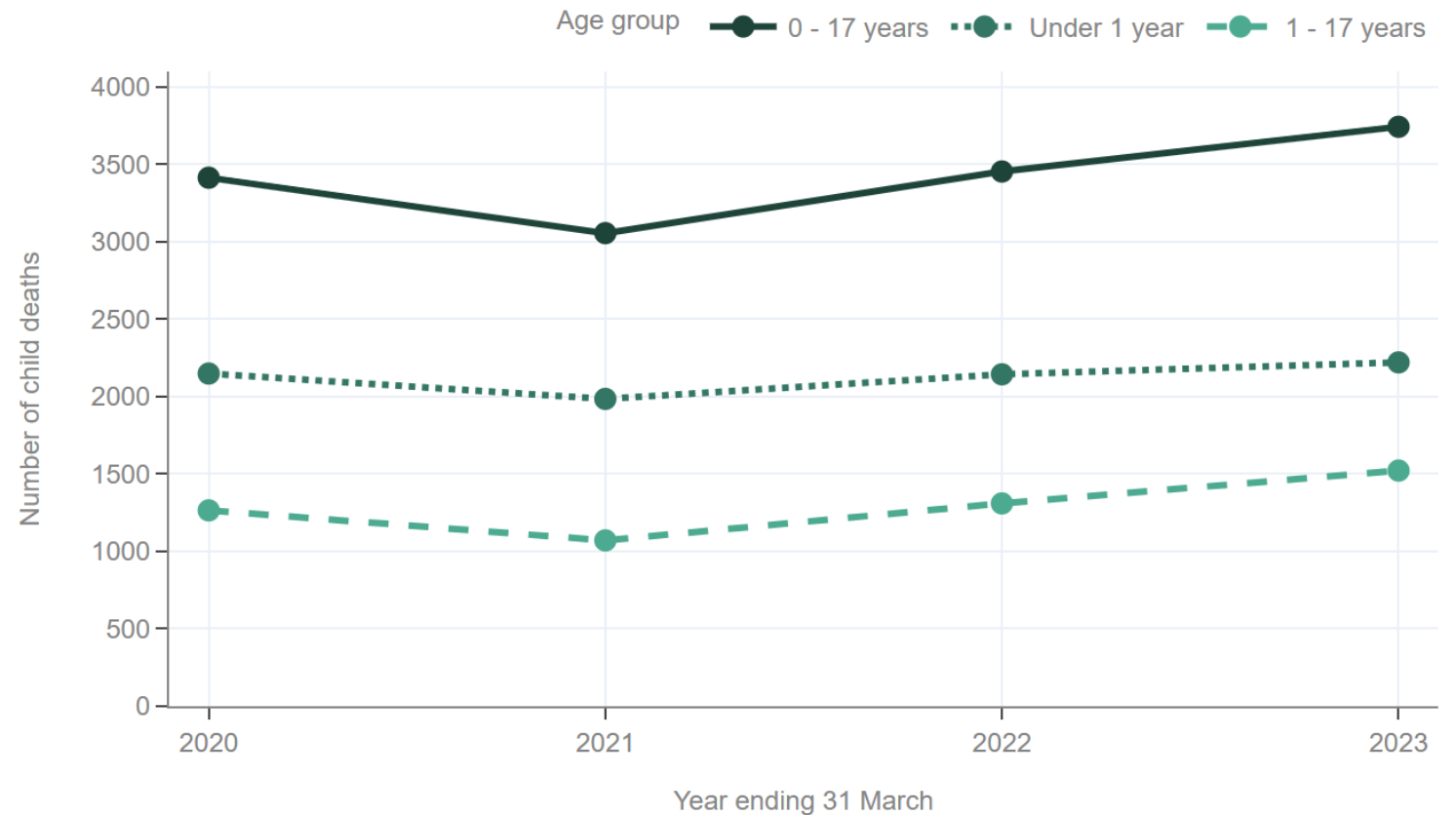
Methodology

- Population data used to calculate rates is mainly ONS mid-year population estimates, along with Census 2021 data for the most recent years. ONS Live births data was used to calculate Neonatal/Infant mortality rate.
- Footnotes under each table/chart will give more information on the population used for the data presented and any limitations of this.
- Unless stated otherwise; Neonatal and infant mortality rates are presented as a rate per 1,000 live births and overall child (0-17) mortality presented per 100,000 population.
- Interpretation should be made in context of actual number of deaths. Sometimes rates presented are based on a relatively low number of deaths.



Trend of child deaths

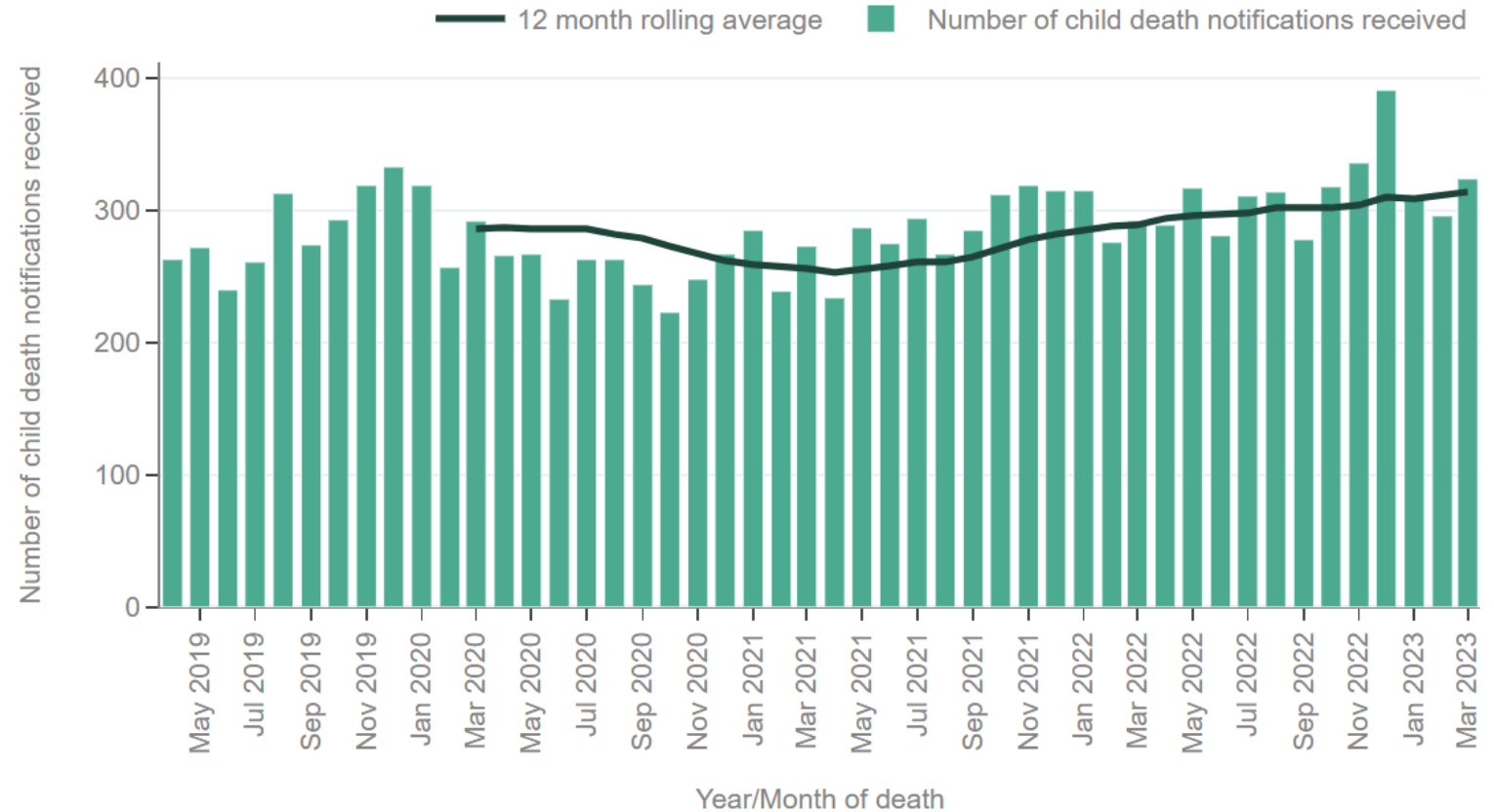
- 3,743 child deaths in England in the latest year.
- Compared to the previous year:
- 0 – 17 years ↑ 8%
 - Infant deaths ↑ 4%
 - 1 – 17 years ↑ 16%



Data Source: NCMD
www.ncmd.info/cdr23/

Trend of child deaths

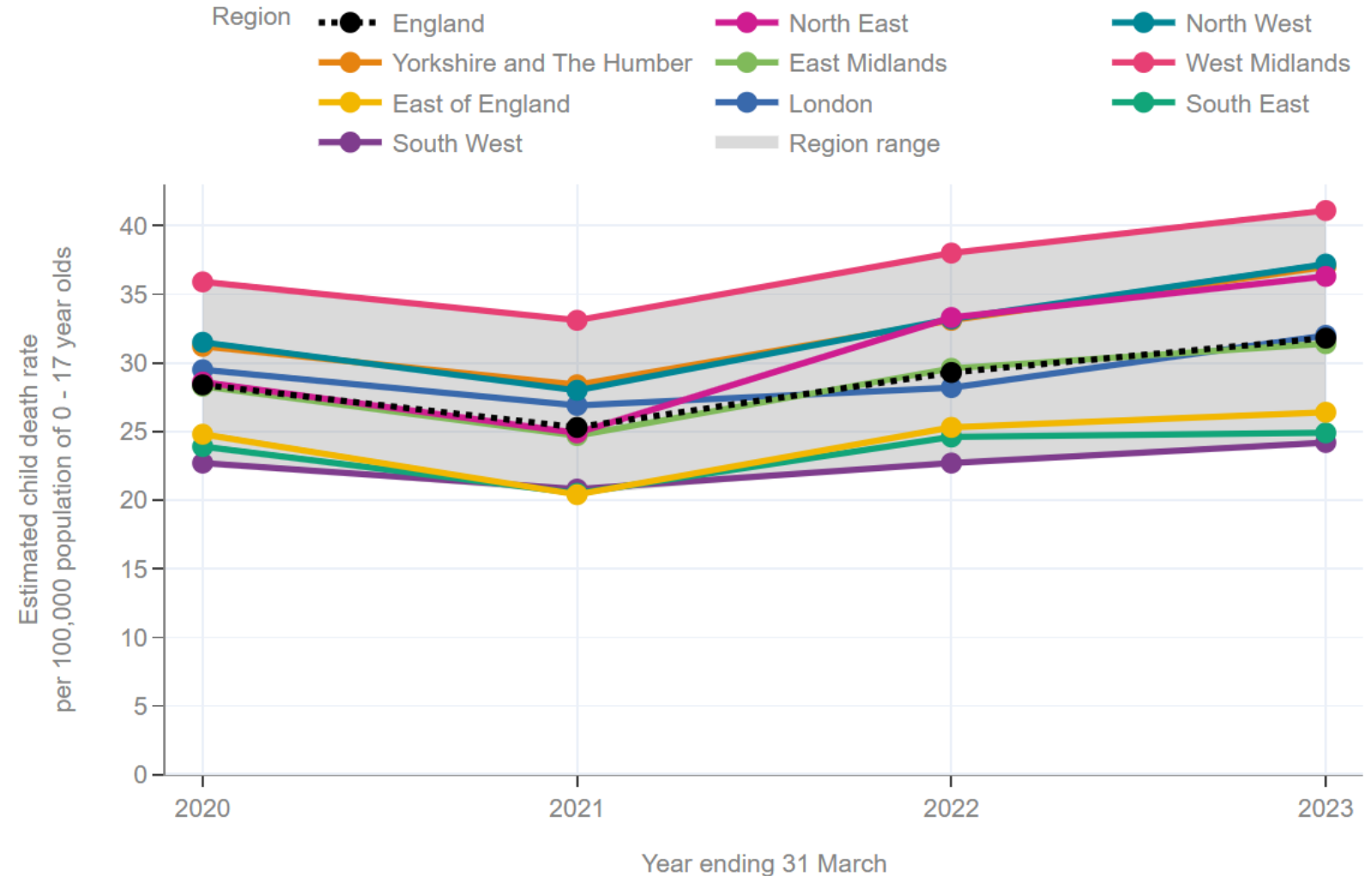
- 391 deaths during December 2022, the highest in any single month since 2019



Data Source: NCMD
www.ncmd.info/cdr23/

Child mortality by region

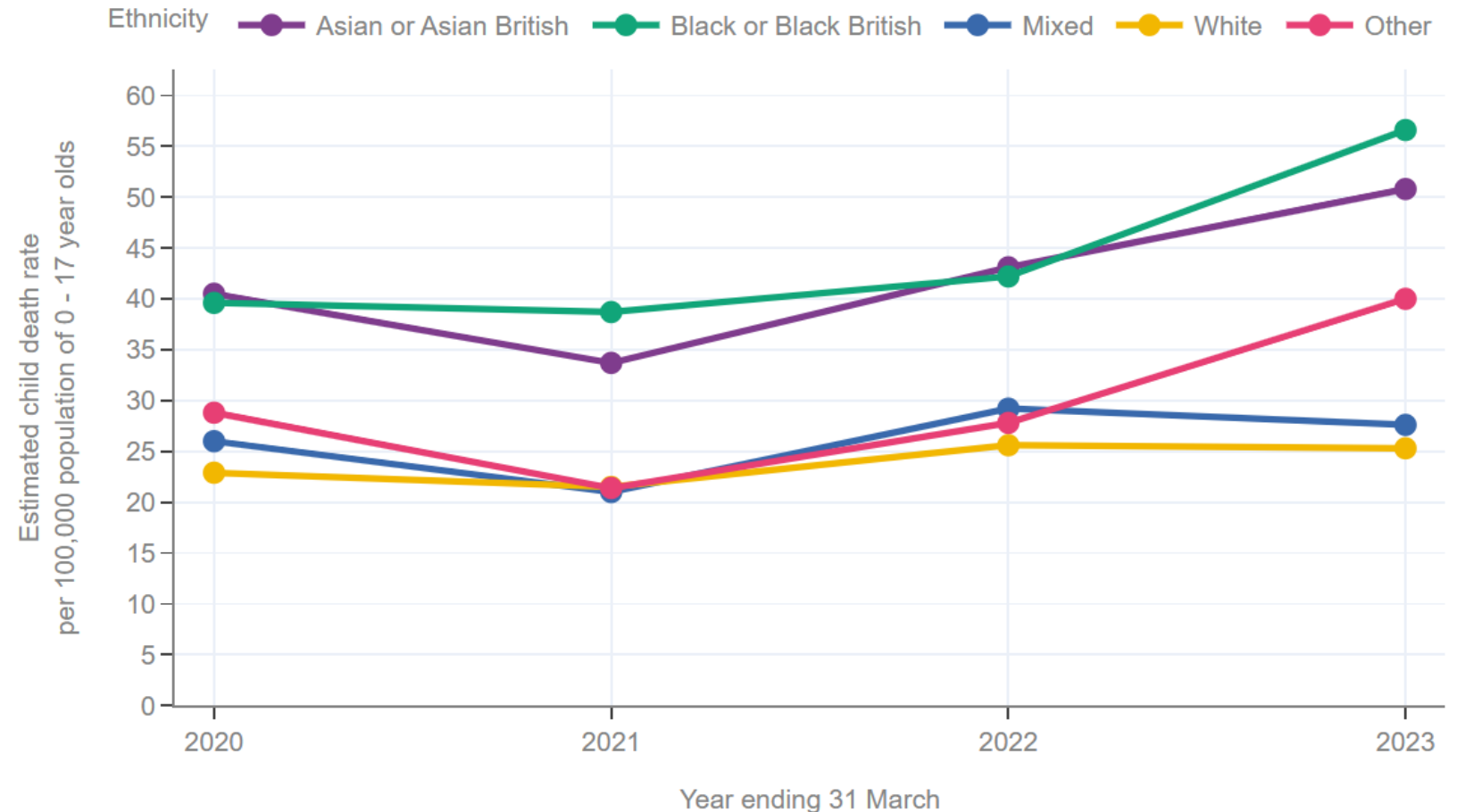
- Estimated child death rate per 100,000 population of 0 – 17 year olds.
- Child mortality rate for most regions increased in the latest year.
- Further tables available that present data down by region.



Data Source: NCMD, ONS mid-year population estimates, ONS Census (2021)
www.ncmd.info/cdr23/

Child mortality by ethnicity

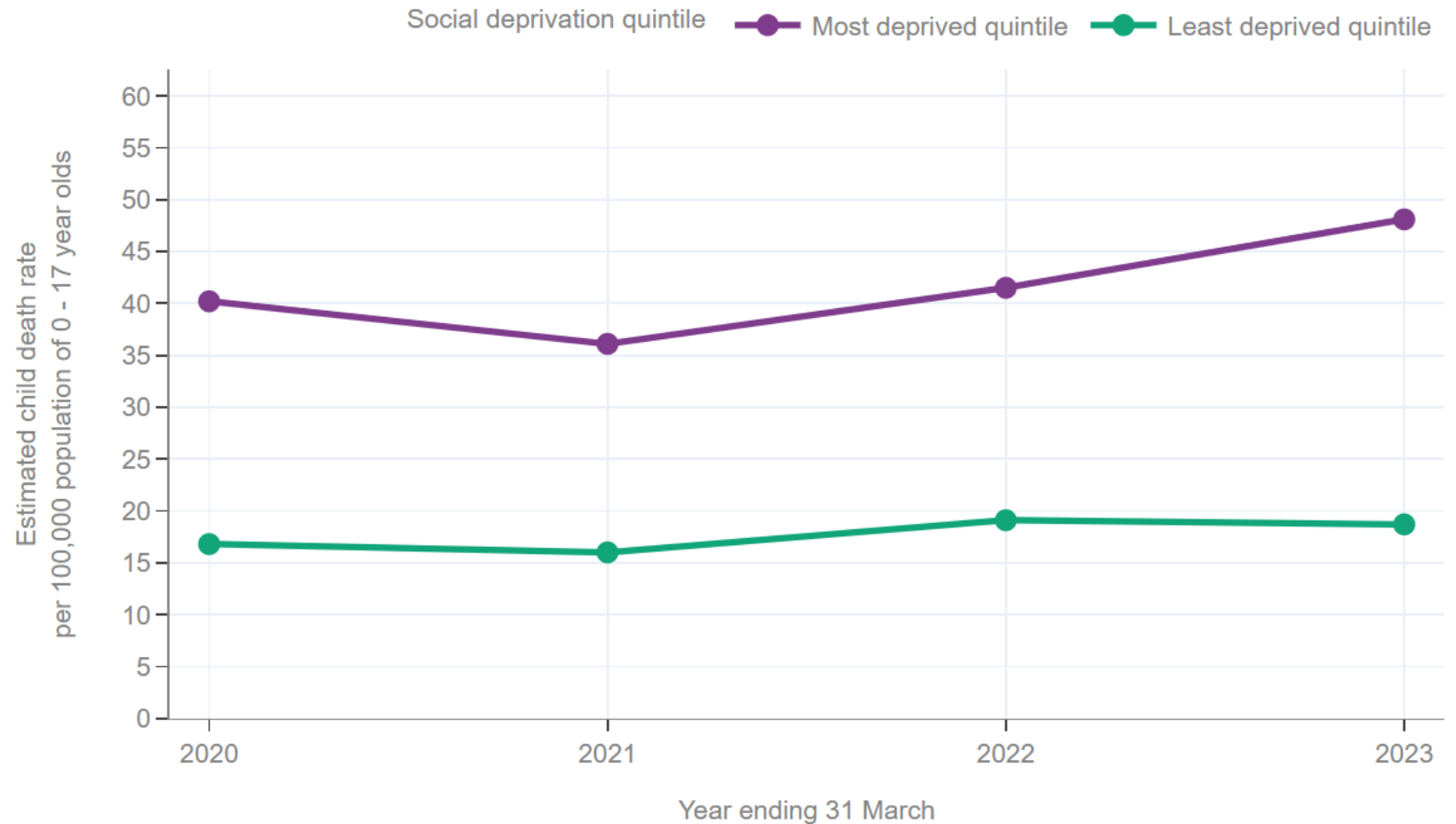
- Ethnic groupings based on those used in the Census: <https://www.ethnicity-facts-figures.service.gov.uk/style-guide/ethnic-groups>
- Child mortality rates of children from black or Asian ethnic groups approximately double that of children of white ethnicity.
- Table 6 presents rates by region and ethnicity.



Data Source: NCMD, ONS Census (2021)
www.ncmd.info/cdr23/

Child mortality by deprivation

- Child death rate of those living in the most deprived areas more than twice that of those living in the least deprived areas.
- The death rate in the least deprived areas decreased slightly from the previous year, however, the death rate for the most deprived areas increased.
- Table 4 presents rates by region and deprivation

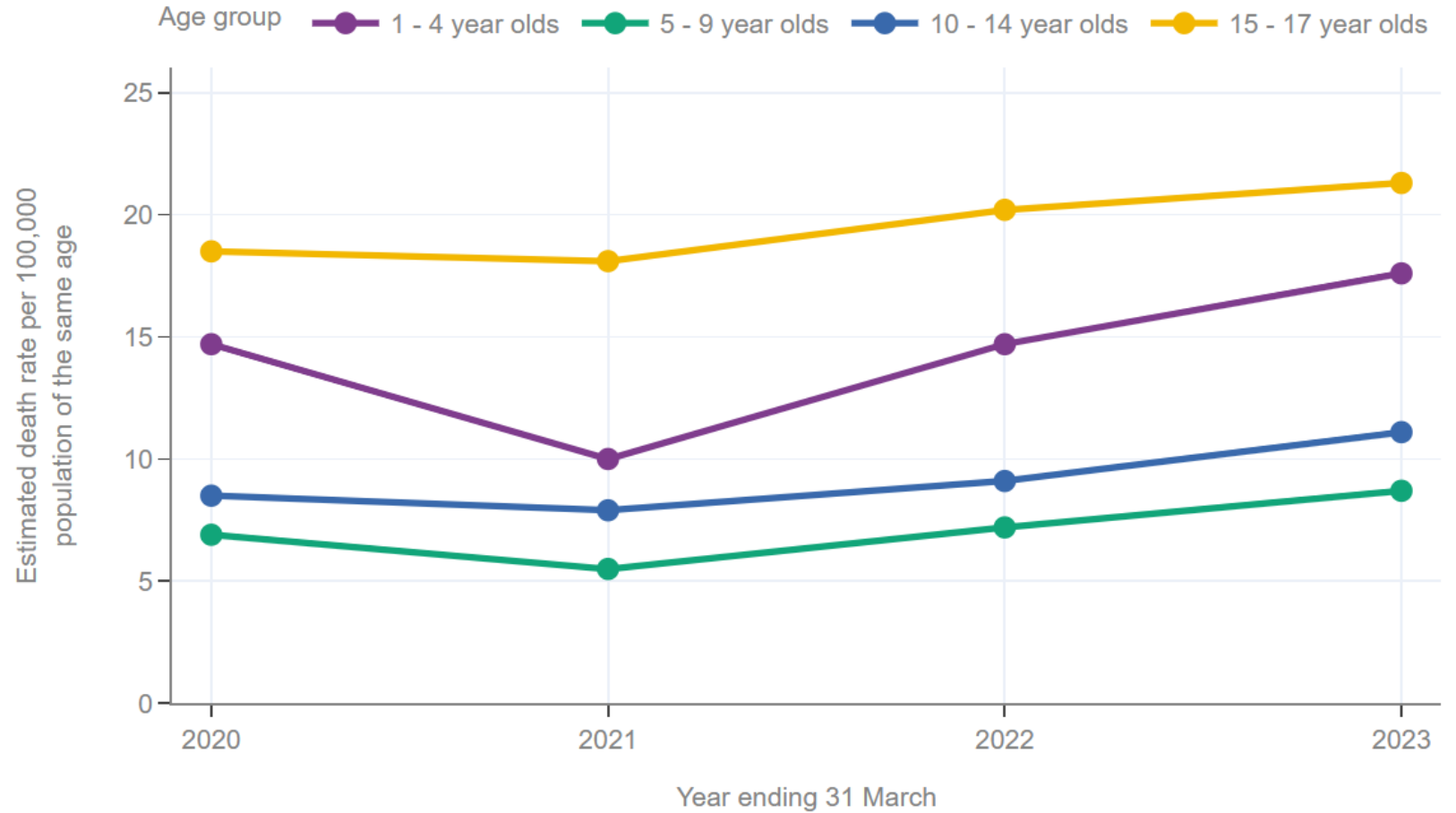


Data Source: NCMD, Index of Multiple Deprivation (2019)

www.ncmd.info/cdr23/

By age group

- **1-17 years only**



Data Source: NCMD, ONS mid-year population estimates, ONS Census (2021)

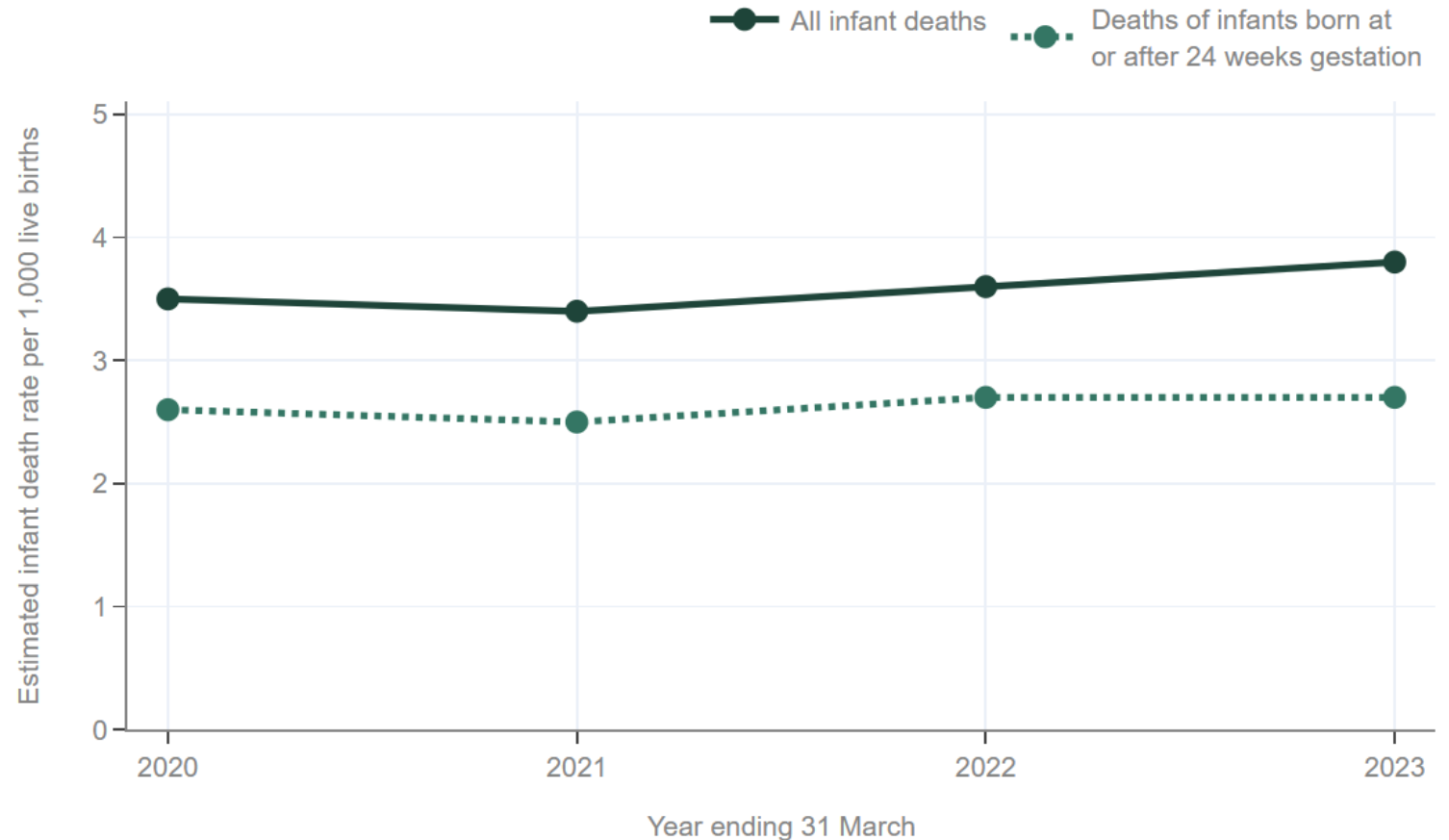
www.ncmd.info/cdr23/

Infant mortality

- Children aged under 1
- Infant mortality is an indicator of the general health of an entire population
- Presented per 1,000 live births
- 59% of all child deaths

Infant mortality rate

- The infant mortality rate was 3.8 per 1,000 live births, an increase from 3.6 in the previous year.



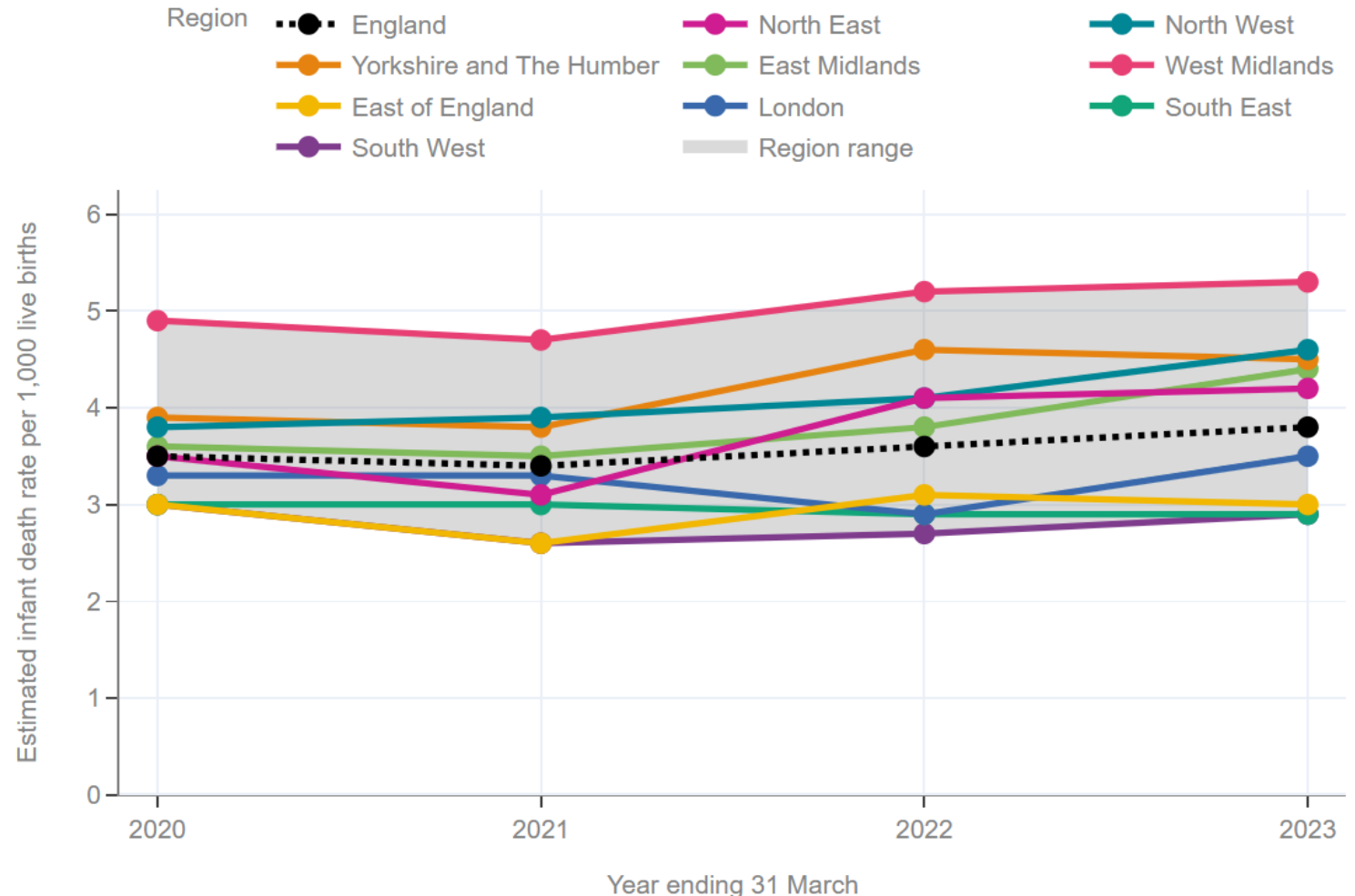
Data source: NCMD, ONS Live births

Please note the proportion of infants born at or after 24 weeks gestation for year ending 31 March 2023 was assumed to be the same as previous years, and this estimate was used to calculate the infant death rate in the latest year.

www.ncmd.info/cdr23/

Infant mortality rate by region

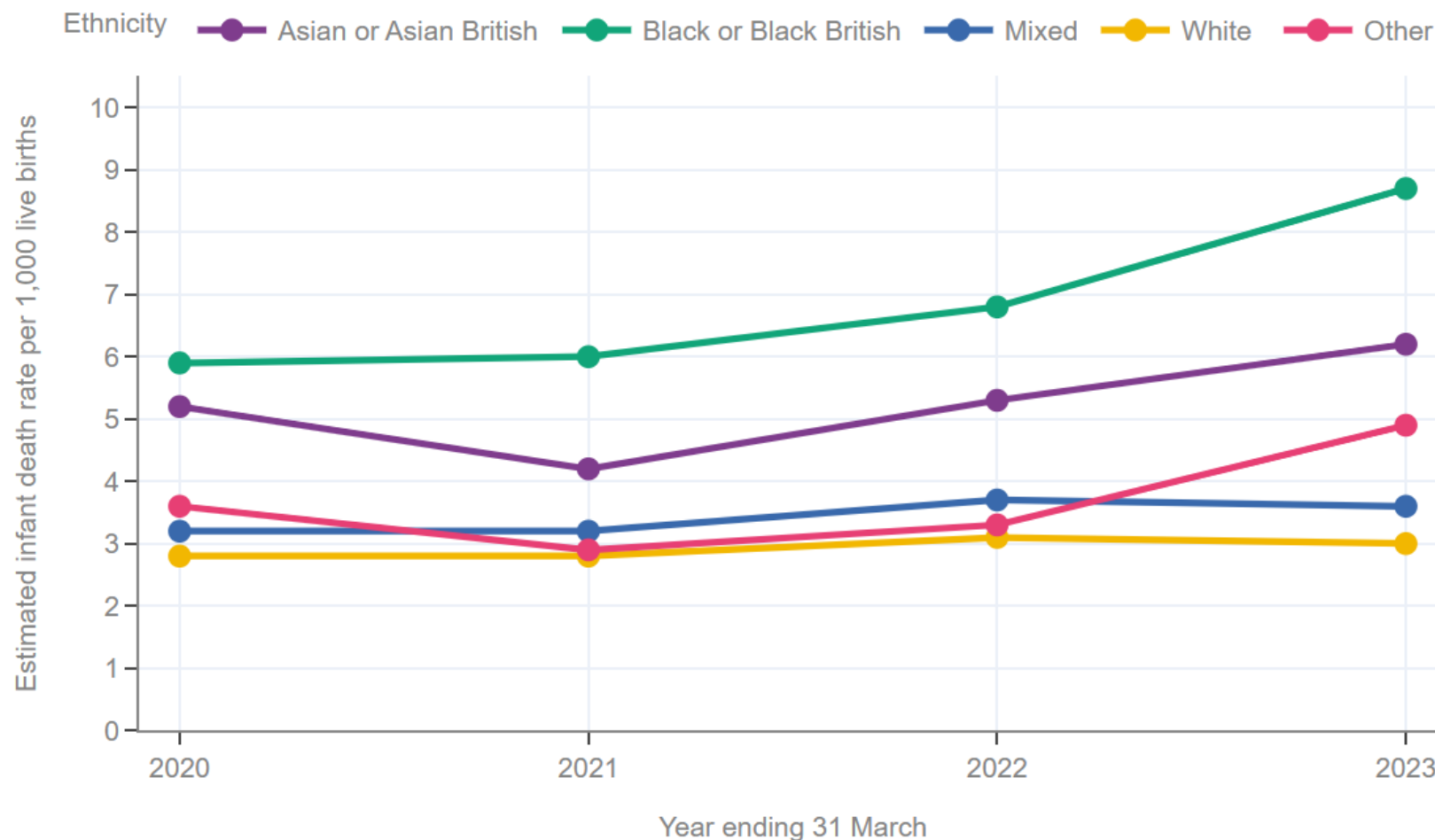
- Patterns of infant deaths were similar to those reported for all child deaths.
- The infant death rate in each region of England ranged from 2.9 to 5.3 per 1,000 live births



Data source: NCMD, ONS Live births
www.ncmd.info/cdr23/

Infant mortality rate by ethnicity

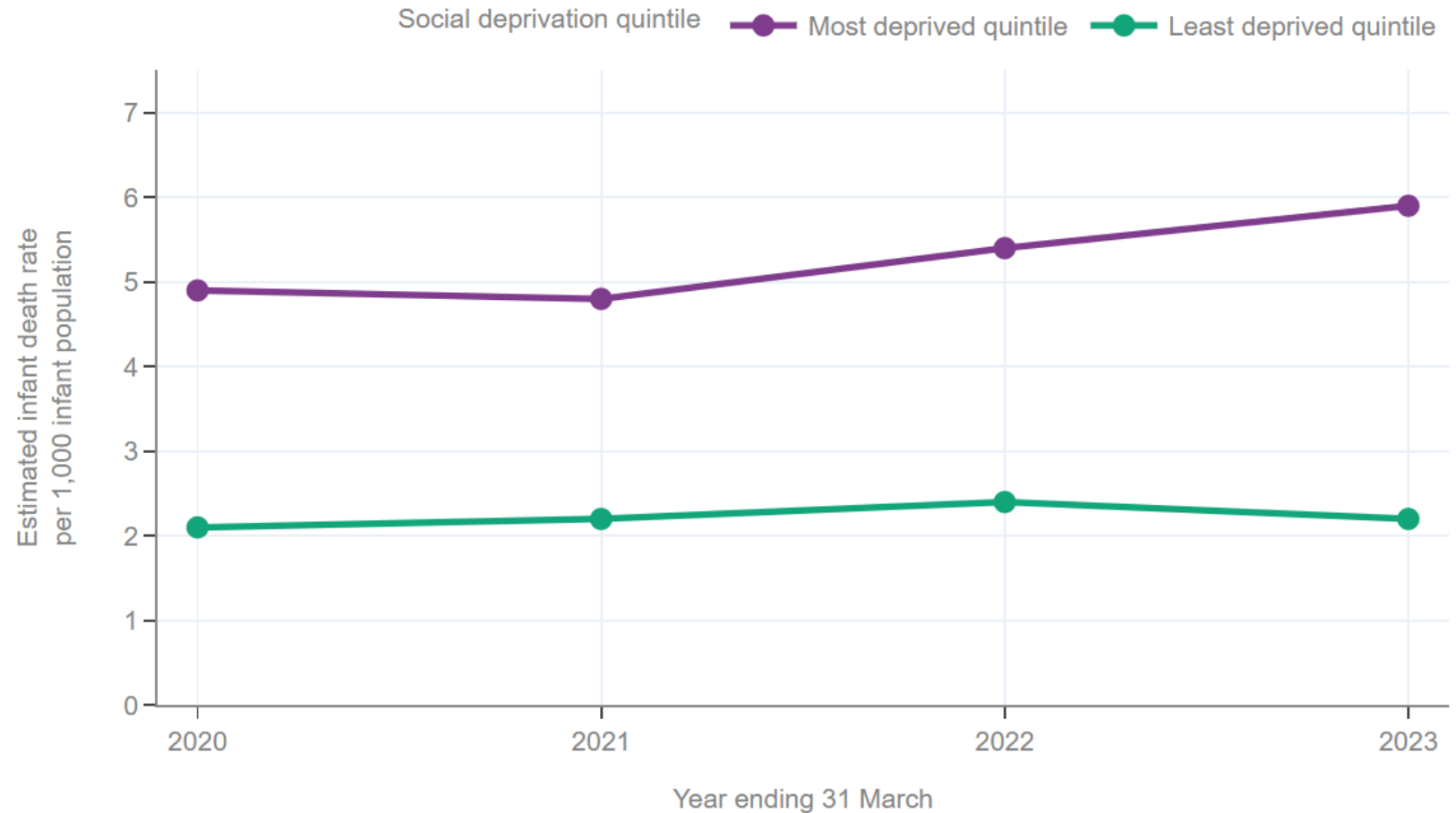
- The infant mortality continued to be highest for infants of black or black British ethnicity, approximately three times the rate of infants of white ethnicity.
- Death rate of infants of Asian or Asian British also continued to be higher than infants of white ethnicity.
- Table 6 presents rates by region and ethnicity.



Data source: NCMD, ONS Live births
www.ncmd.info/cdr23/

Infant mortality rate by deprivation

- Infant mortality rate of those resident in the most deprived areas was more than twice that of infants resident in the least deprived areas.
- Table 4 presents rates by region and deprivation



Data Source: NCMD, Index of Multiple Deprivation (2019)
www.ncmd.info/cdr23/

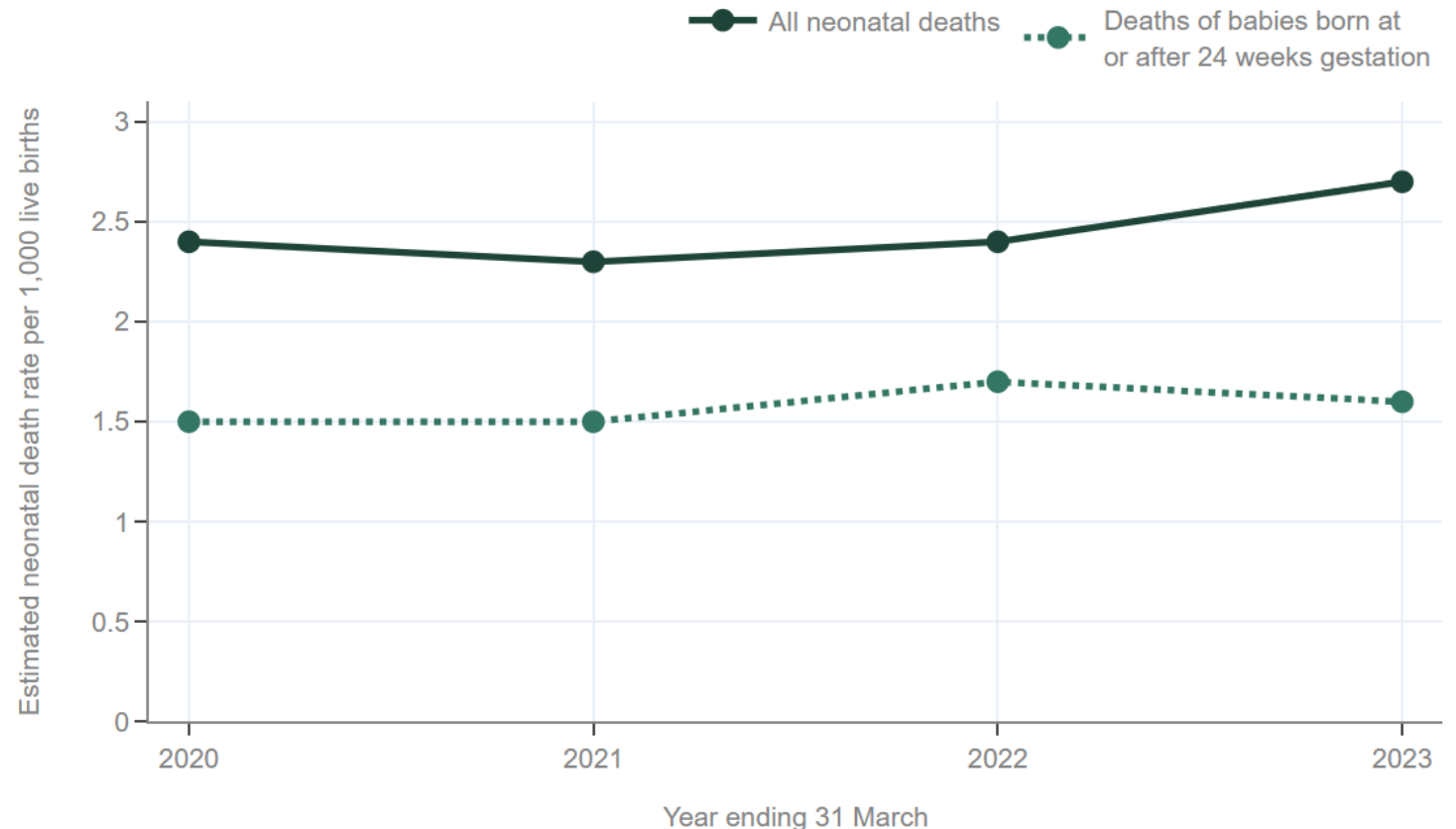
Neonatal mortality

- Deaths of babies aged under 28 days
- Presented per 1,000 live births
- 41% of all child deaths



Neonatal mortality

- The estimated neonatal death rate increased from 2.4 to 2.7 per 1,000 live births.
- For babies born at 24 weeks or over the rate decreased from 1.7 to 1.6 per 1,000 live births
- Neonatal mortality rate ambition by 2025 is 1.0 per 1,000 live births for ≥ 24 weeks.
- 79% of neonatal deaths were of babies born at a prematurely (before 37 weeks), up from 75% in the previous year. Increased proportion of deaths notified to CDOPs of babies born under 24 weeks gestation (39% vs 33% in the previous year).



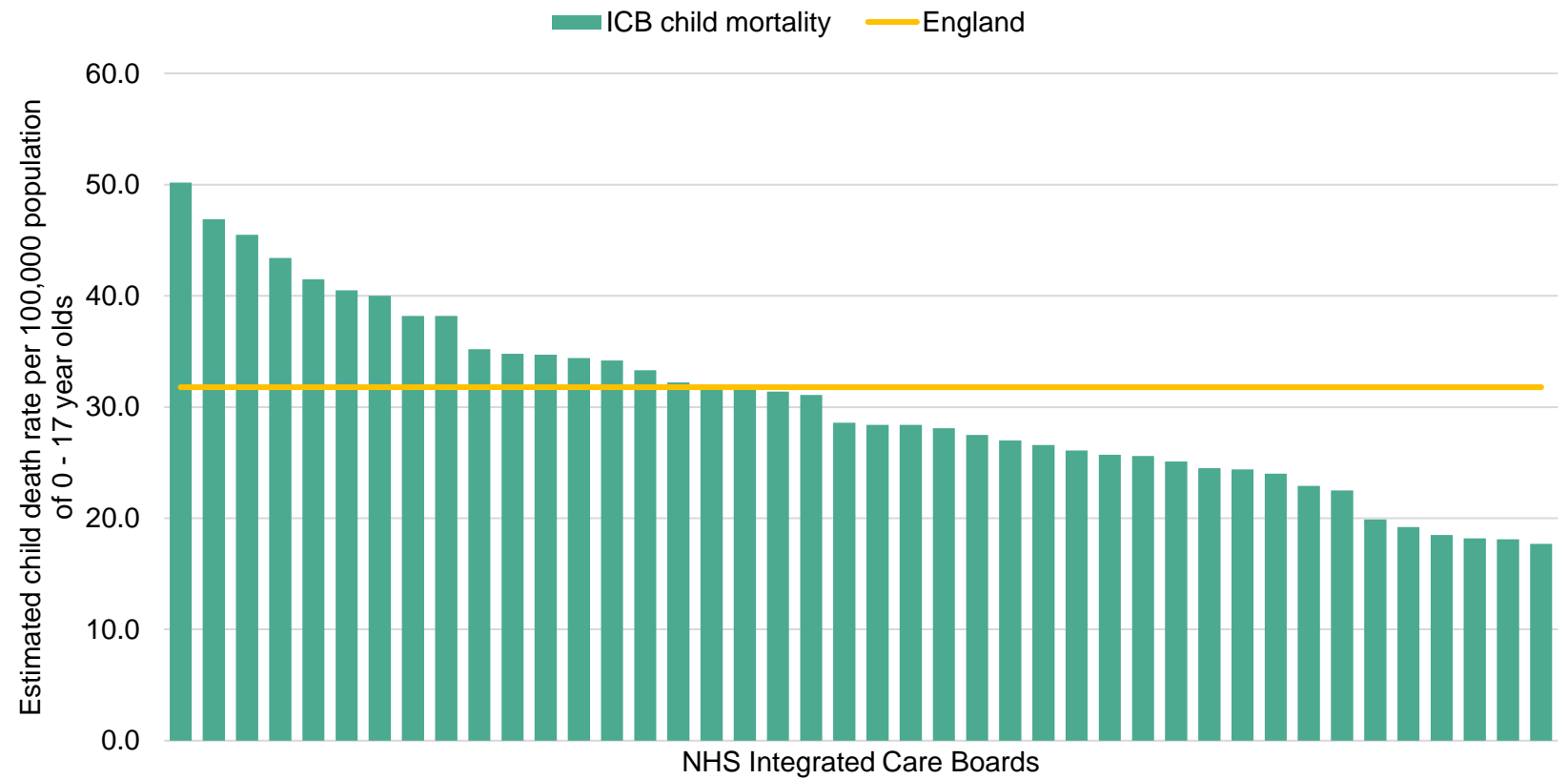
Data source: NCMD, ONS Live births

Please note the proportion of babies born at or after 24 weeks gestation for year ending 31 March 2023 was assumed to be the same as previous years, and this estimate was used to calculate the neonatal death rate in the latest year.

www.ncmd.info/cdr23/

NHS Integrated Care Boards

- Table 11
- By ICB and age group (Neonatal, infant, 1-17 years, 0-17 years)



Section 2: The number of child death reviews by CDOPs

CDOP reviews

By year of review

Deaths may have **occurred** in earlier years

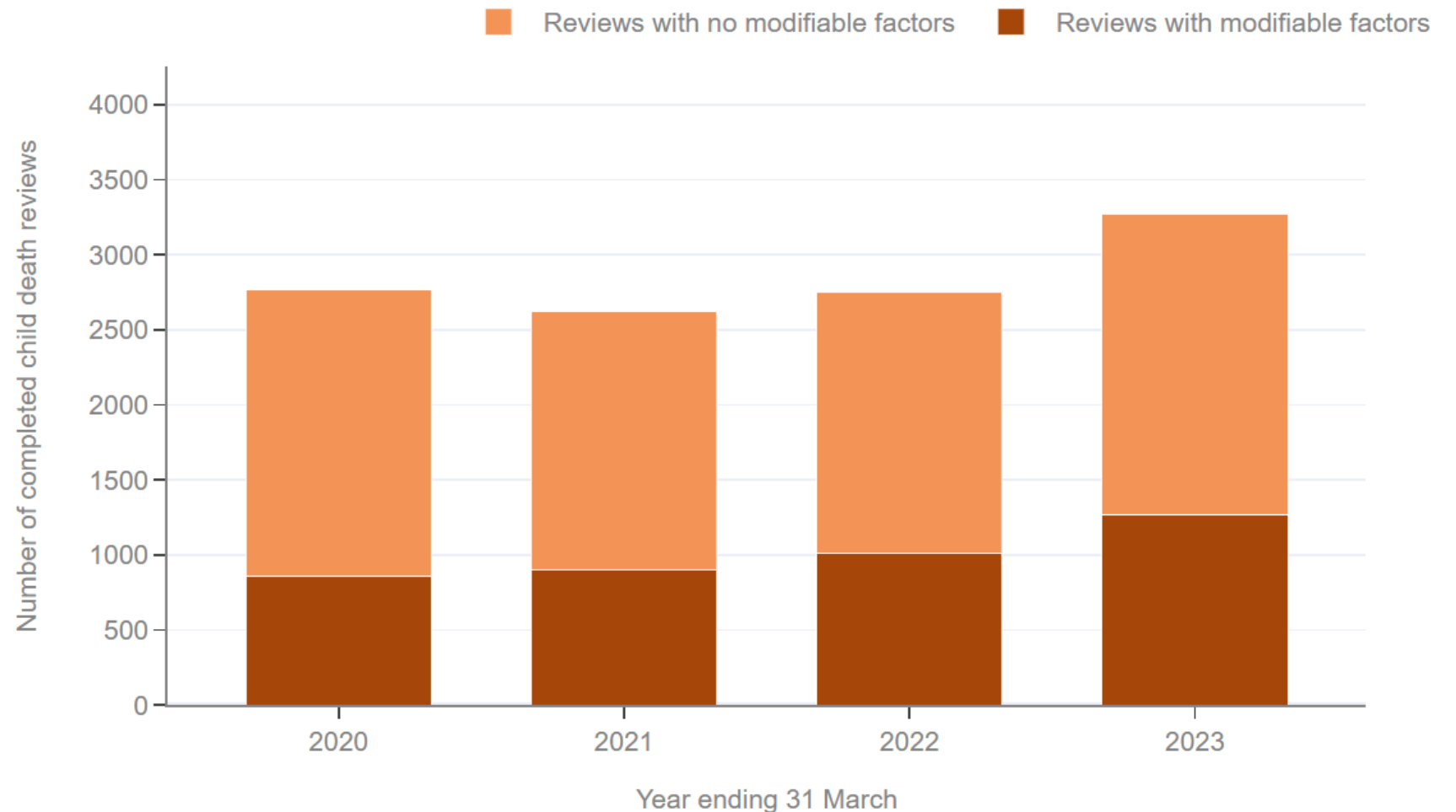
Tables 12 - 22

16% of reviews were of deaths that occurred in the same year.

The median time taken for CDOP reviews was to complete 392 days.

Number of child death reviews

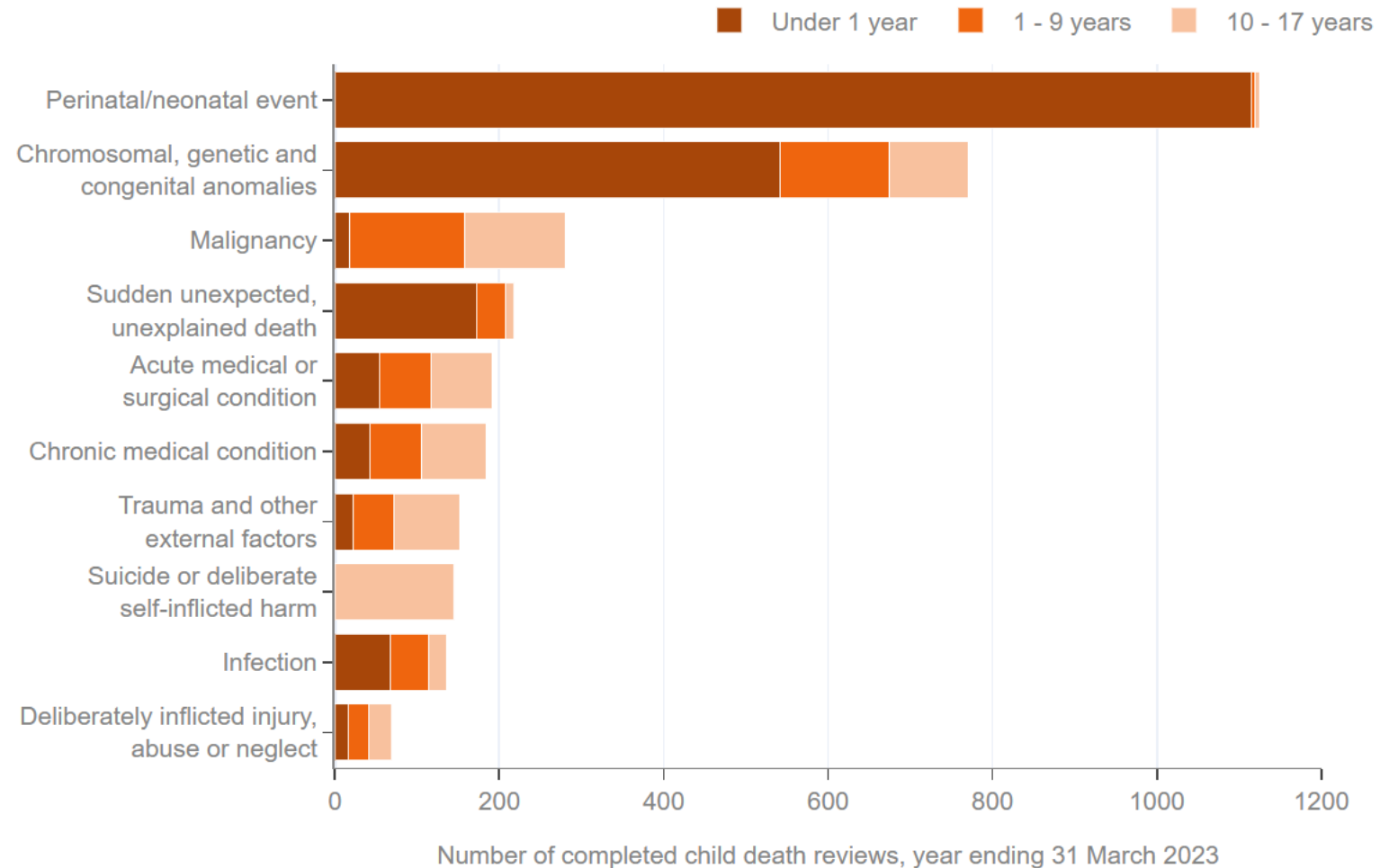
- 3,271 completed reviews
- 39% of deaths reviewed in the latest year ending 31 March 2023 identified modifiable factors.
- The proportion of reviews that identified modifiable factors continued to rise (up from 37% in the previous year)



Data Source: NCMD
www.ncmd.info/cdr23/

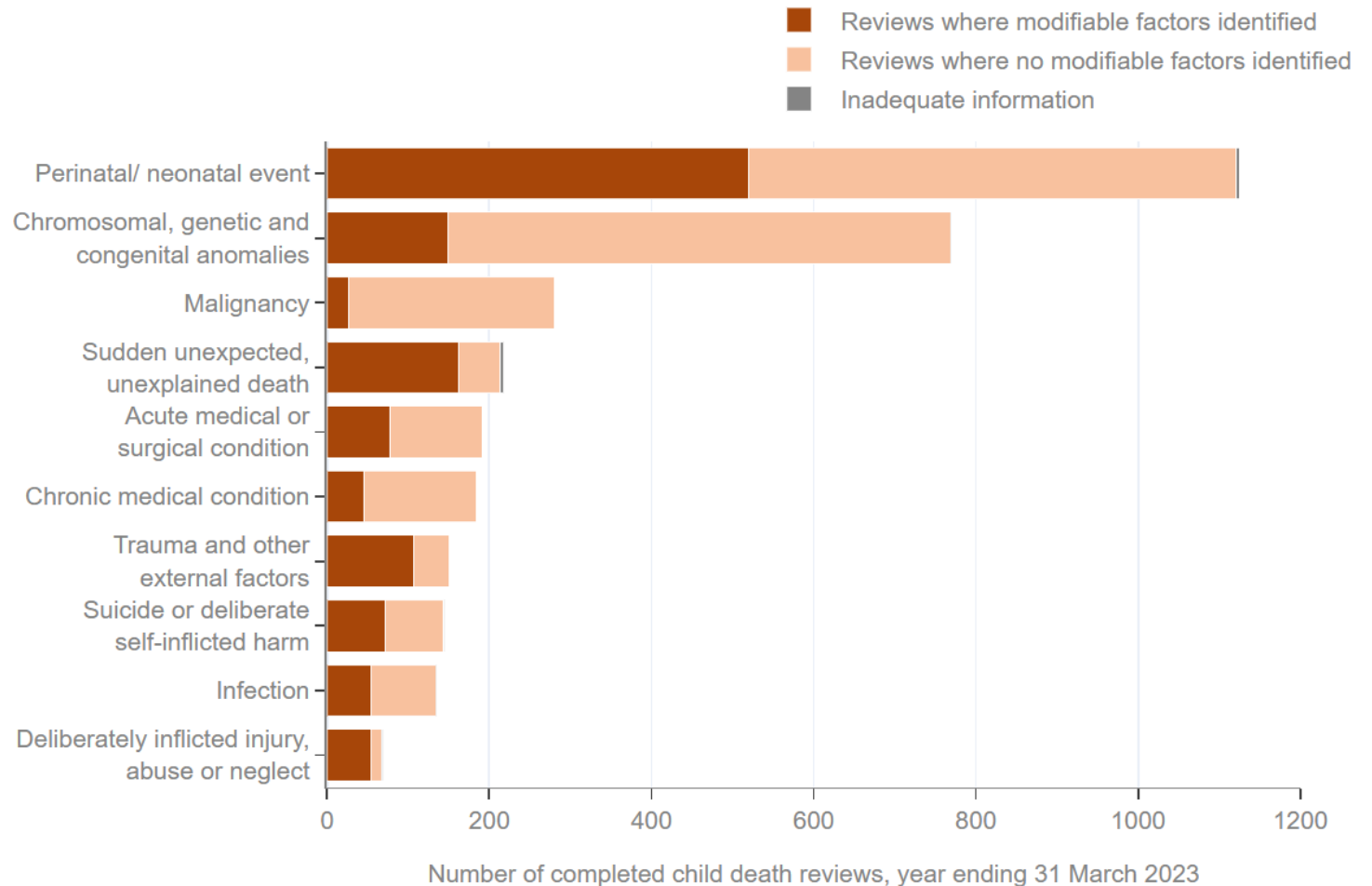
Category of death

- The 3 most common primary category of death was Perinatal/neonatal event (36%), Chromosomal, genetic and congenital anomalies (24%) and Malignancy (9%).
- These patterns were similar to previous years.
- Under 1s → Perinatal/neonatal event
- 1-9 years → Malignancy
- 10 – 17 years → Suicide or deliberate self-inflicted harm



Category of death

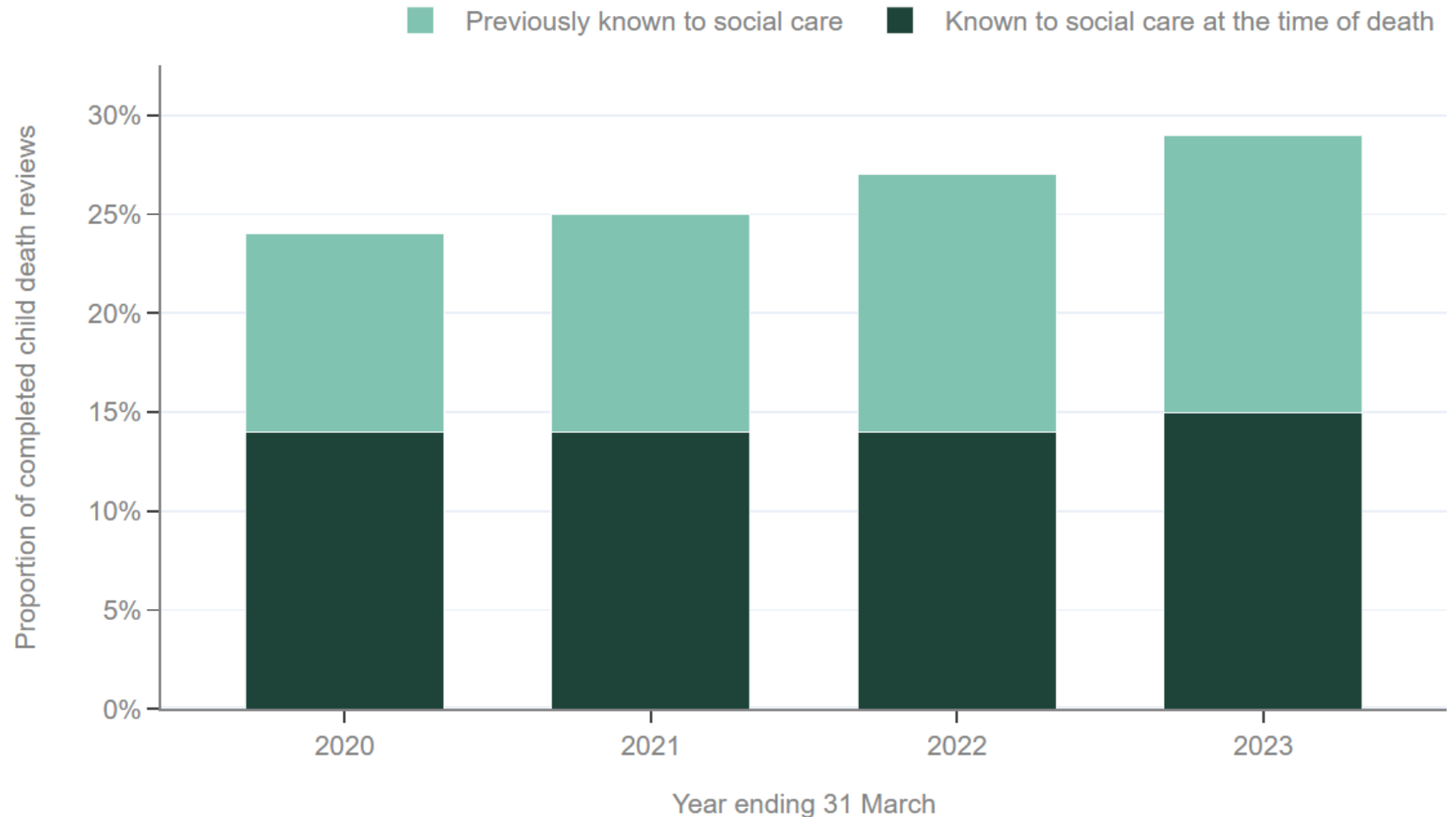
- Modifiable factors are defined as factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.
- Deliberately inflicted injury, abuse or neglect had the highest proportion of reviews with modifiable factors (81%), followed by Sudden unexpected and unexplained death (76%), Trauma or other external factors (76%), Trauma or other external factors (71%) and Suicide or deliberate self-inflicted harm (50%).



Data Source: NCMD
www.ncmd.info/cdr23/

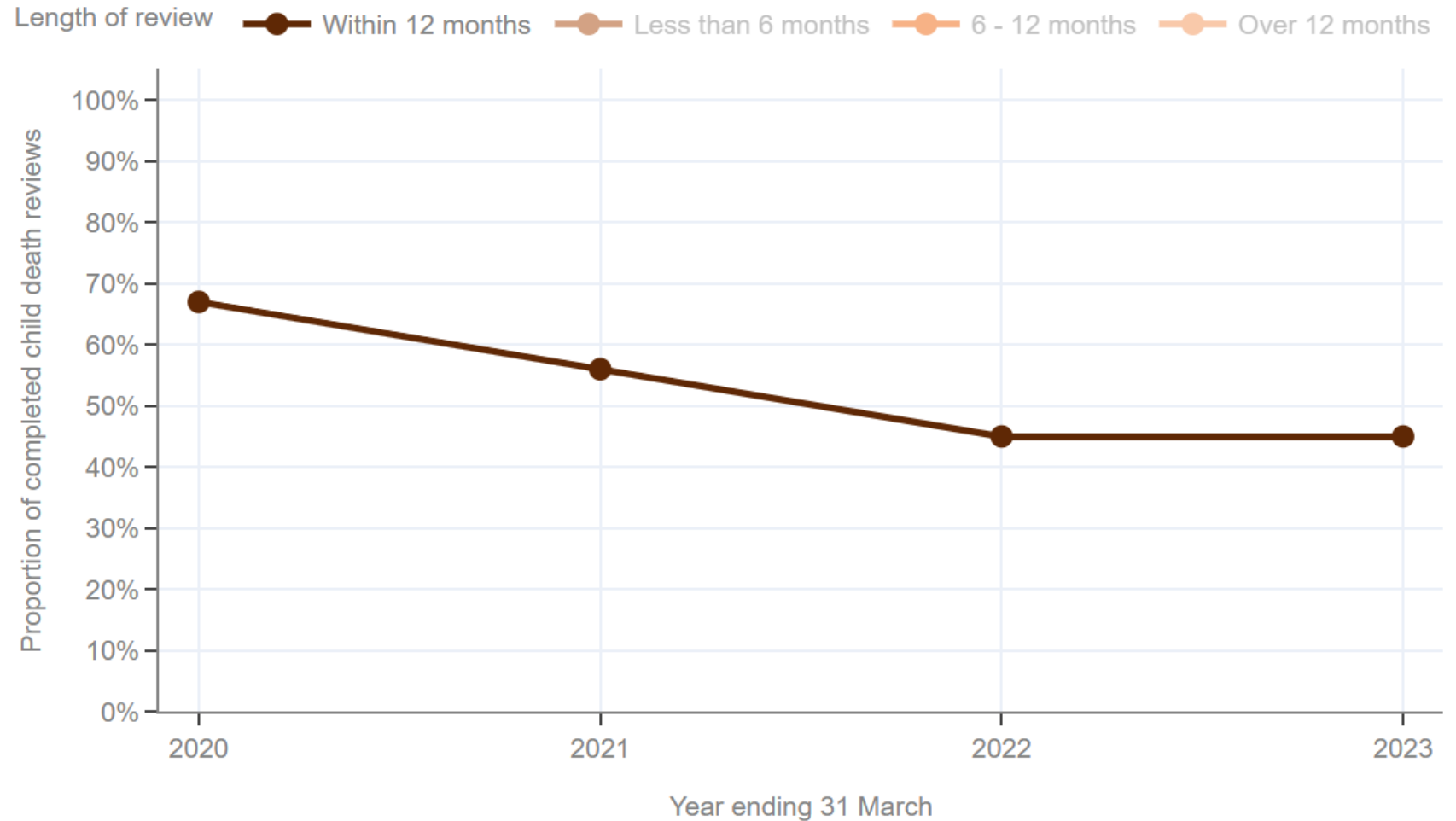
Social care

- 15% of children were known to social care at the time of their death, a similar proportion to previous years. 42% identified modifiable factors.
- A further 14% of reviews were of children who were reported as previously known to social care, which has increased each year from 10% in the year ending 31 March 2020.



Duration of CDOP reviews

- 45% of reviews were completed by the CDOP within 12 months.



Next steps

- Engage, share and promote the use of these data with those who can implement action.
- NCMD surveillance continues and thematic reports, including escalation of alerts.
- Further investigative analysis.

NCMD Thematic Reports for 2023/2024

- Infections report is currently due to be published on 14 December 2023.
- Sign up to our [Mailing list](#) to receive a free copy when it is published
- 2024 - Deaths of children with a learning disability or autism
- 2024 – Deaths due to asthma or anaphylaxis





Updates to Statutory Forms

- The data collection forms, eCDOP and NCMD portal were updated in October 2023
- These updates were to collect new information such as details on Temporary Accommodation, whether the parents of the child were care leavers and changes to the chromosomal form following the national Task & Finish Group on consanguinity.

National work relating to alerts

- Deductions of patients from GP surgeries (Pan Sussex CDOP)
- Critical central venous line complications in neonates (North West London CDOP)
- Baby bath seats (various CDOPs)



Ongoing and upcoming work

- ICB-level reports have been distributed to CDOPs which details characteristics of deaths of children resident within their area and benchmark comparisons.
- SUDIC JAR checklist is now available for joint agency response professionals
- Following the parliamentary debate on SUDC deaths, we have agreed some changes to the supplementary reporting form on SUDIC deaths
- The team continues to accept invitations to speak at regional CDOP events and other conferences. Unfortunately, we cannot accept all the invitations we receive due to capacity, but we try to attend whenever we can. Recently we have run or contributed to events in Leeds, Berkshire, Surrey, Sussex, Manchester, Bristol, London, Preston and Birmingham
- One of our charity partners, Sands has recently published the [Bereaved Parents Experience of Care Survey Report](#)



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Questions