



Knowledge, understanding and
learning to improve young lives

Child Death Reviews Data: year ending 31 March 2024

Tom Williams, Data Manager and Brian Hoy, Data Analyst

Thursday 21st November 2024

12.00pm to 1.00pm

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

Child Death Reviews Data: year ending 31 March 2024

Tom Williams, Data Manager

Brian Hoy, Data Analyst

21 November 2024

NCMD

National Child Mortality Database

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

Child Death Reviews Data: year ending 31 March 2024

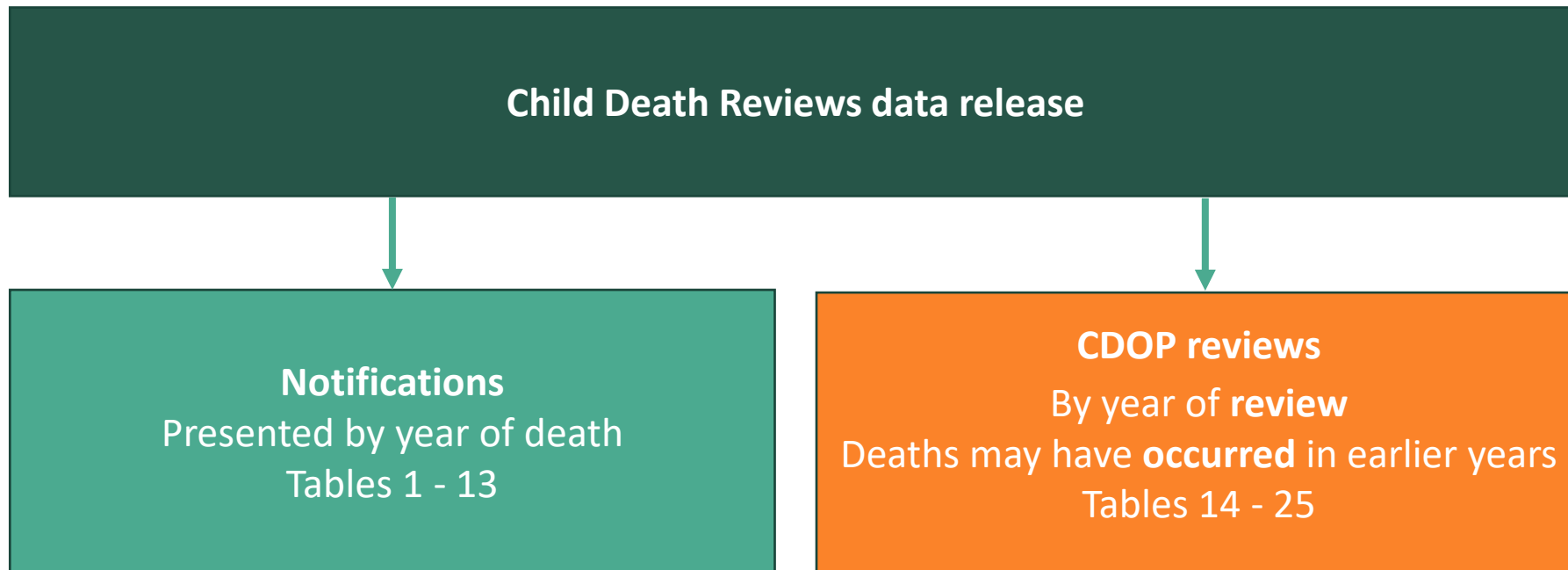
- Published 14th November 2024.
- The data tables and descriptive summary can both be found: www.ncmd.info/cdr24
- Data tables can be downloaded in XLS format.
- The summary is presented in HTML format to make the data more accessible and user friendly to readers, allowing for more interactive content to be displayed.
- A greater level of detail is provided in the data tables than previous years, including:
 - More granular data on ethnicity
 - More detail on contributory and modifiable factors recorded

Notifications vs Reviews

The release aims to give a descriptive overview of:

The number of child deaths occurring up to 31 March 2024 in England (notifications).

The number of reviews of children whose death was reviewed by a CDOP in England before 31 March 2024 (reviews).



Section 1: The number of child death notifications

- Summarises child deaths (0 - 17 years) up to 31 March 2024
- 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 - 13

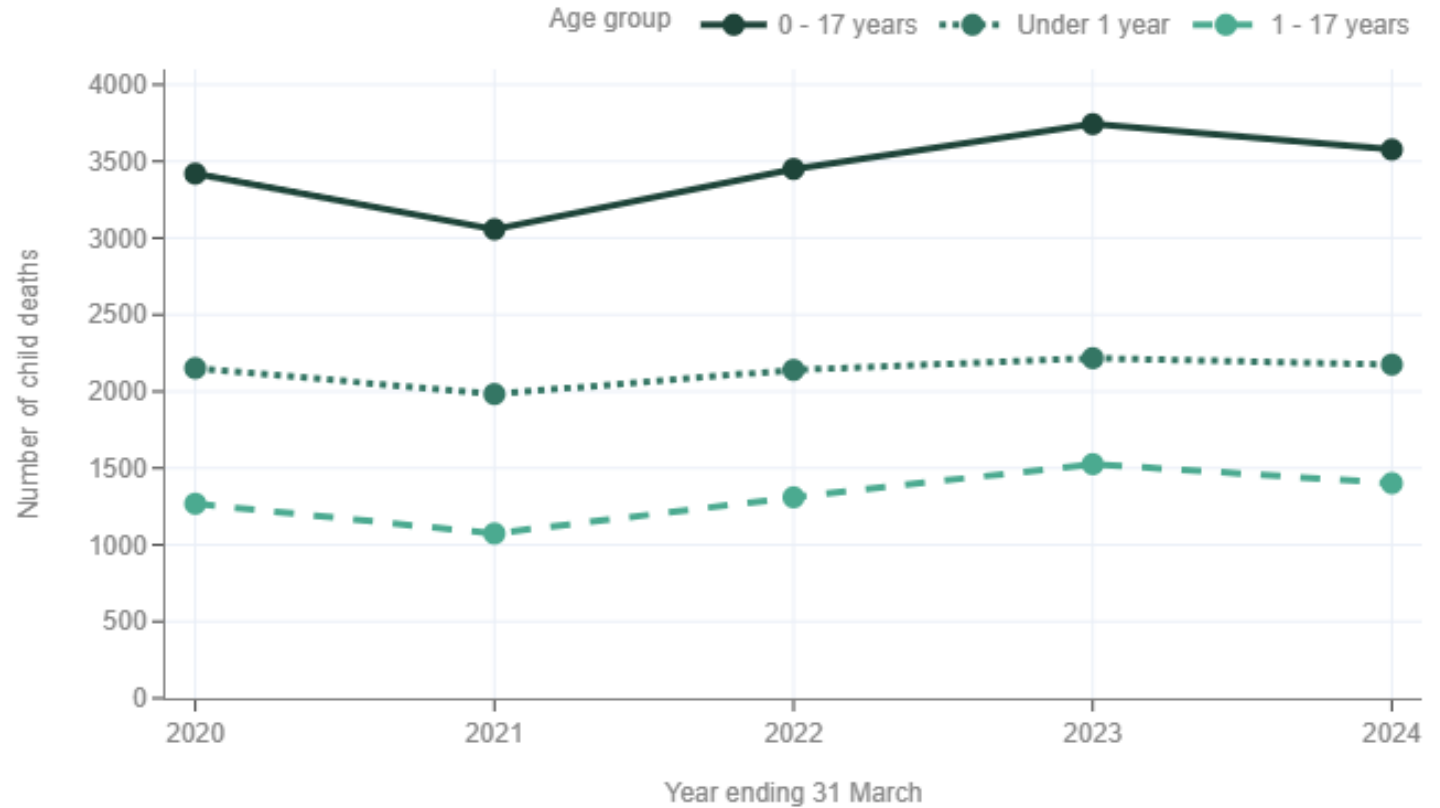
Methodology

- Population data used to calculate rates is mainly ONS mid-year population estimates, Census 2021 data is used for all five years when mid-year population estimates not available.
- ONS Live births data was used to calculate Neonatal/Infant mortality rate. Unless stated otherwise.
- 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.
 - Child (0-17) mortality, or mortality of 1-17 years, 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.
- Methodology and limitations of this data release is outlined in the technical information section.



Trend of child deaths

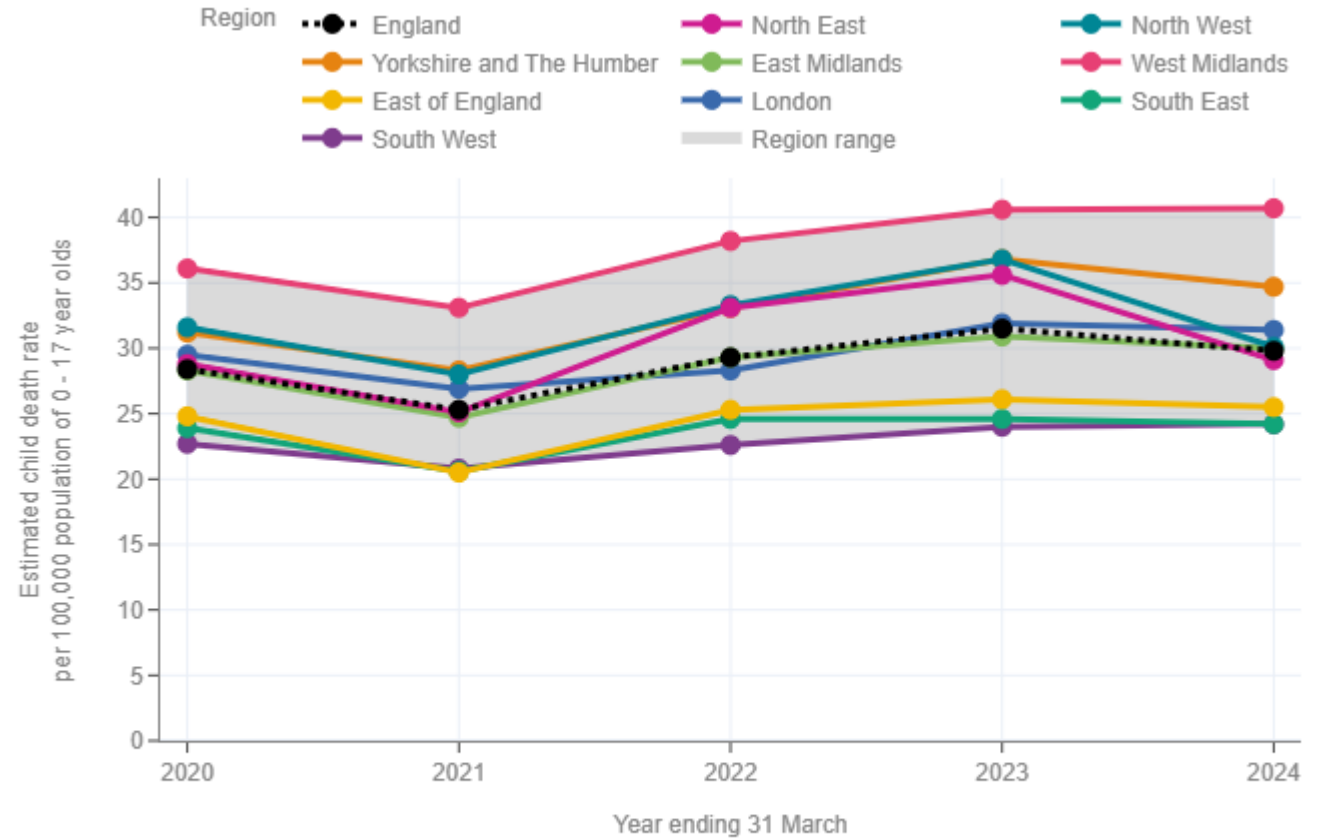
- 3,577 child deaths in England in the latest year.
- Compared to the previous year:
- 0 – 17 years ↓4%
 - Infant deaths ↓2%
 - 1 – 17 years ↓8%
- Number of deaths remained higher in 2023-24 compared to 2019-20 (pre-COVID pandemic).



Data Source: NCMD
www.ncmd.info/cdr24/

Child mortality by region

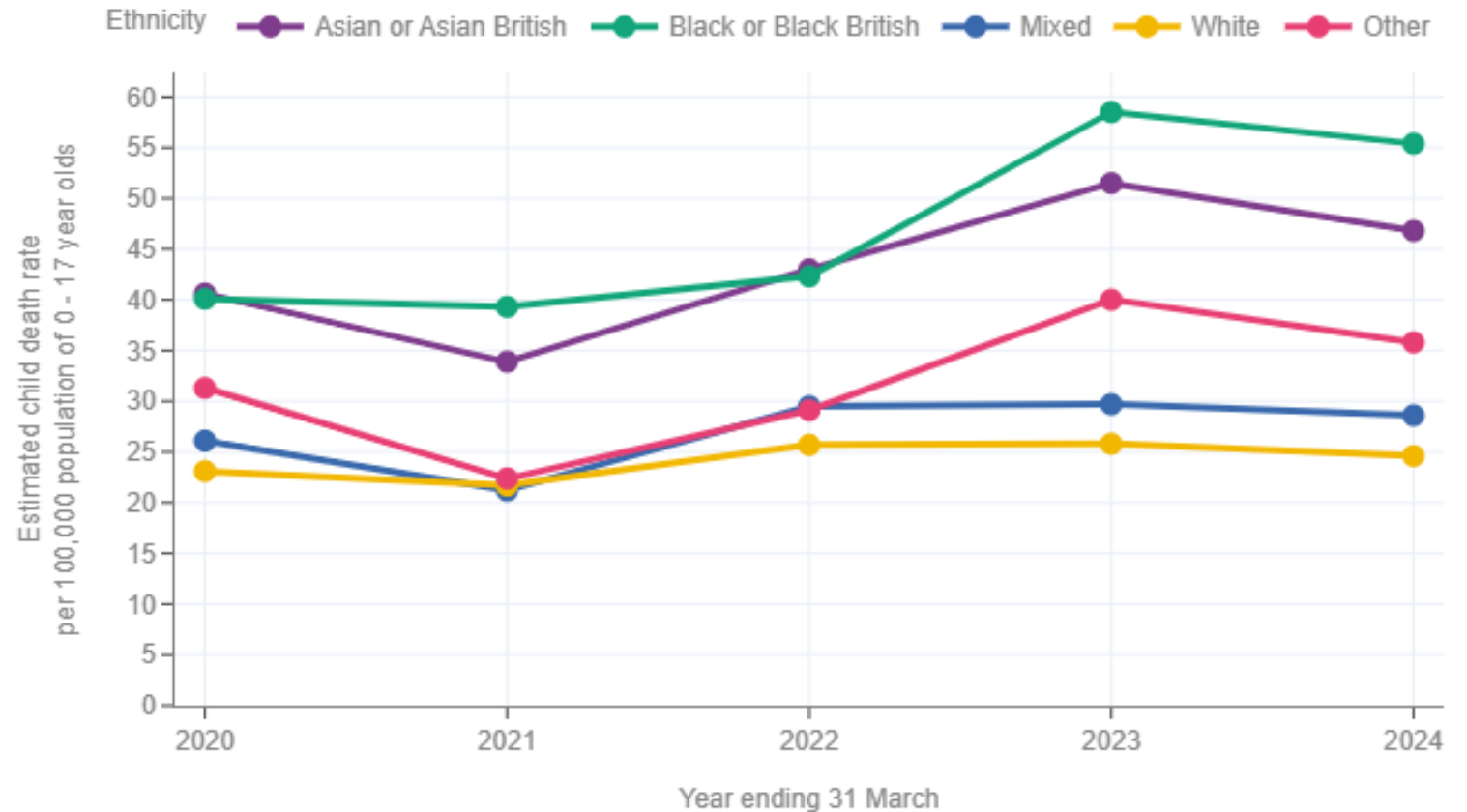
- Estimated child death rate per 100,000 population of 0 – 17 year olds.
- Regional differences remained; the child death rate varied across regions in England, with the rate ranging from 24.2 to 40.7 per 100,000 population.
- Further tables available that present data down by region and age group, deprivation, ethnicity, place of death, and gestational age.



Data Source: NCMD, ONS mid-year population estimates
www.ncmd.info/cdr24/

Child mortality by ethnicity

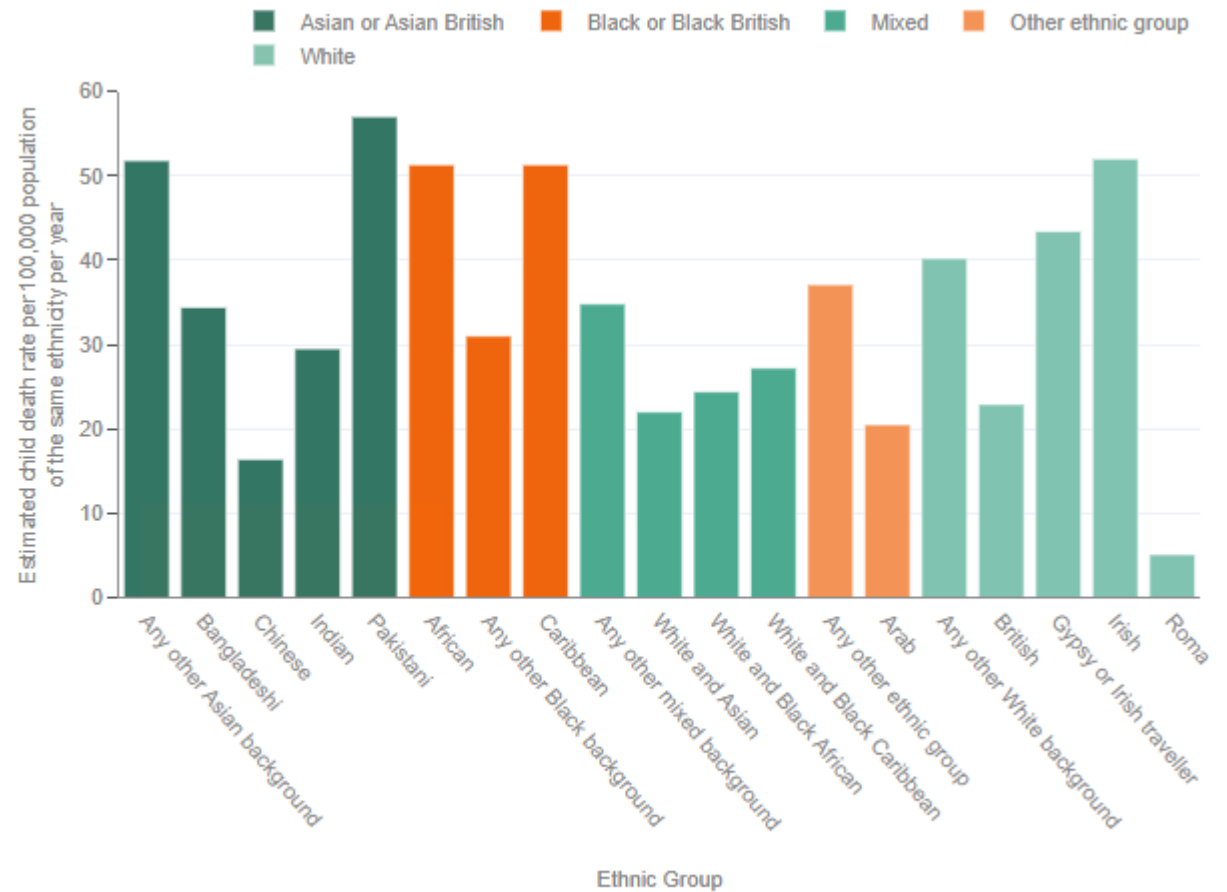
- Ethnic disparities persisted.
- The child death rate remained highest for children of black or black British ethnicity (55.4) and Asian or Asian British ethnicity (46.8).
- The child death rate was lowest for children of white ethnicity (24.6).



Data Source: NCMD, ONS Census (2021)
www.ncmd.info/cdr24/

Child mortality by ethnicity

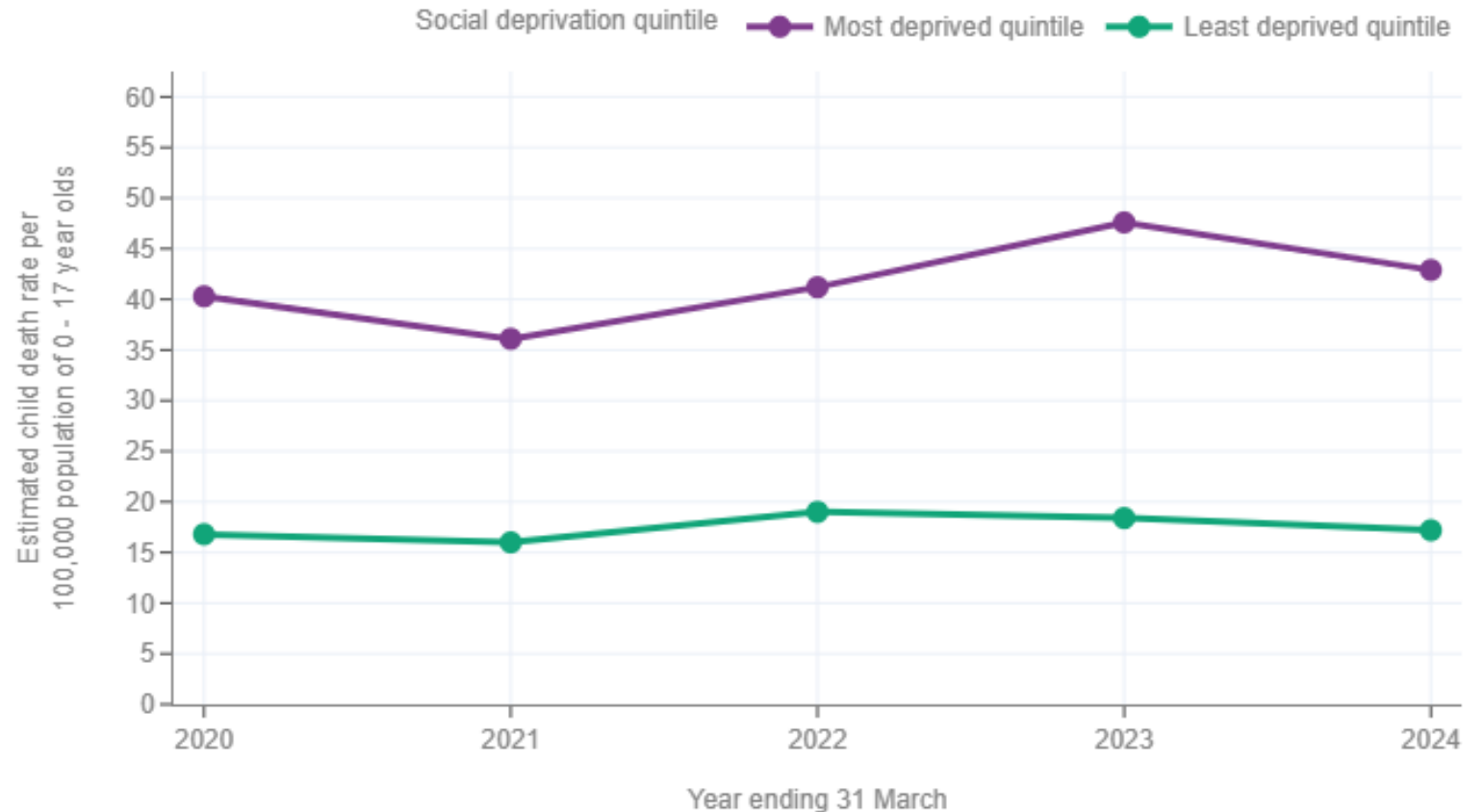
- Over a five-year period (April 2019 – March 2024).
- The child death rate was highest for children of Asian Pakistani ethnicity (57.0), any other Asian background (51.8), black African (51.3) or black Caribbean (51.3).
- The child death rate of children from a white British ethnic background (22.9).



Data Source: NCMD, ONS Census (2021)
www.ncmd.info/cdr24/

Child mortality by deprivation

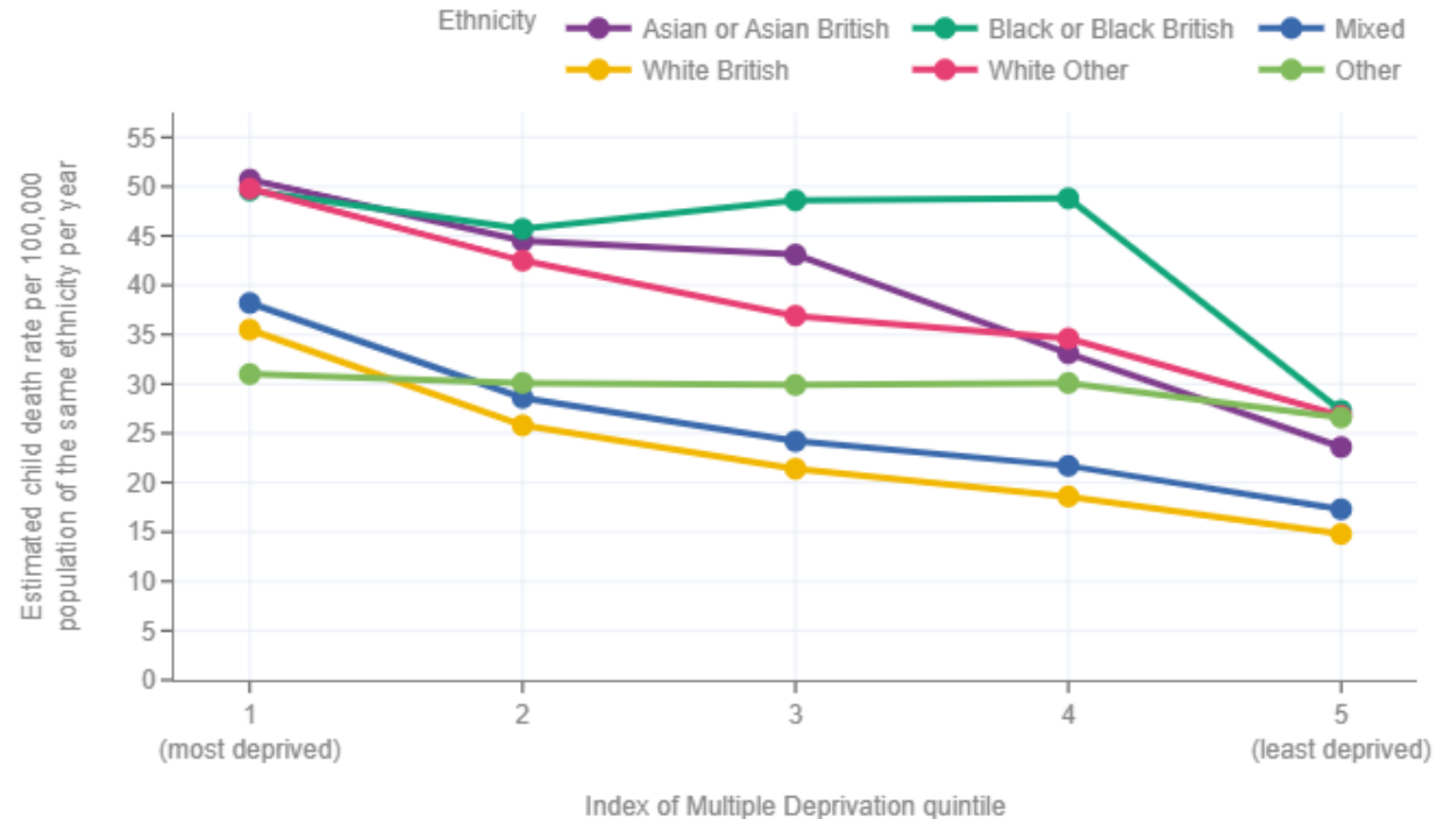
- Child death rate of those living in the most deprived areas remained more than twice that of those living in the least deprived areas.
- Table 4 presents rates by region and deprivation.



Data Source: NCMD, ONS mid-year population estimates, Index of Multiple Deprivation (2019)
 Please note population for year ending 31 March 2023 is used for year ending 31 March 2024.
www.ncmd.info/cdr24/

Child mortality by ethnicity and deprivation

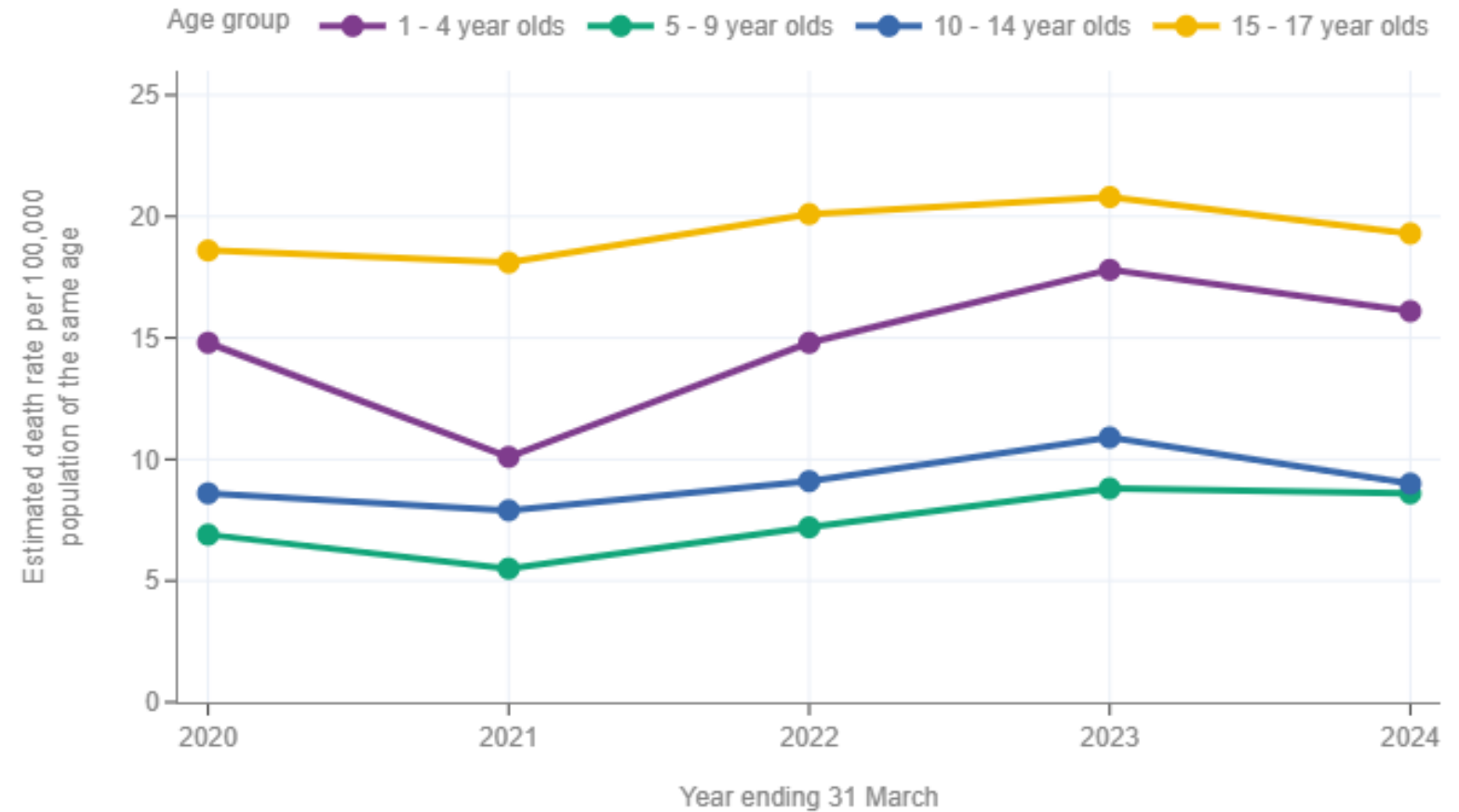
- Over a five-year period (April 2019 – March 2024)
- Child death rates for children of black and Asian ethnicities remained higher than for children of white British ethnicity across all 5 deprivation quintiles



Data Source: NCMD, ONS Census (2021), Index of Multiple Deprivation (2019)
www.ncmd.info/cdr24/

By age group

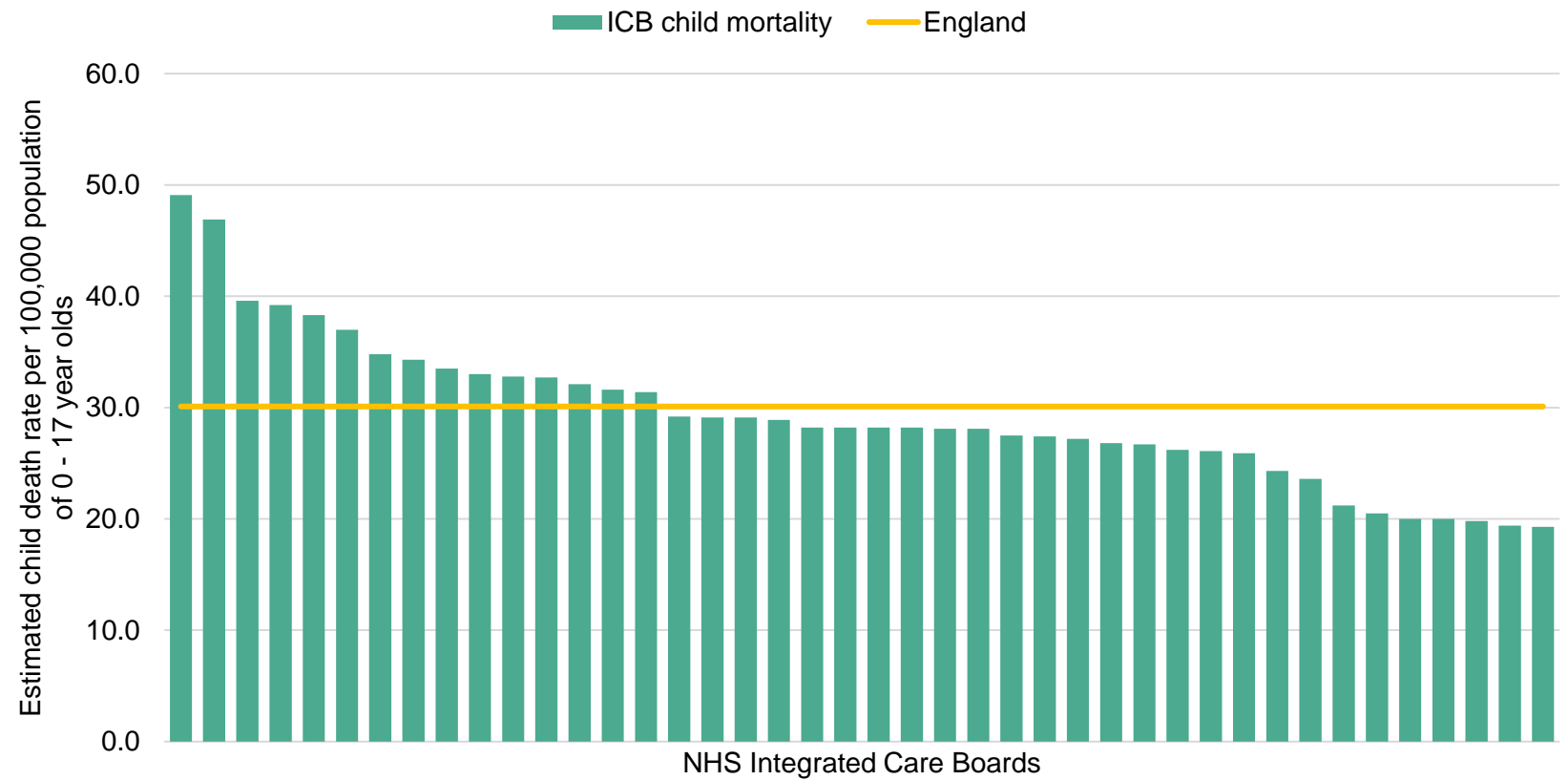
- **1-17 years only**
- The child death rate remained highest for children aged between 15-17 years (19.3) and 1-4 years (16.1)
- Child death rates for all age groups decreased in comparison to the previous year



Data Source: NCMD, ONS mid-year population estimates
www.ncmd.info/cdr24/

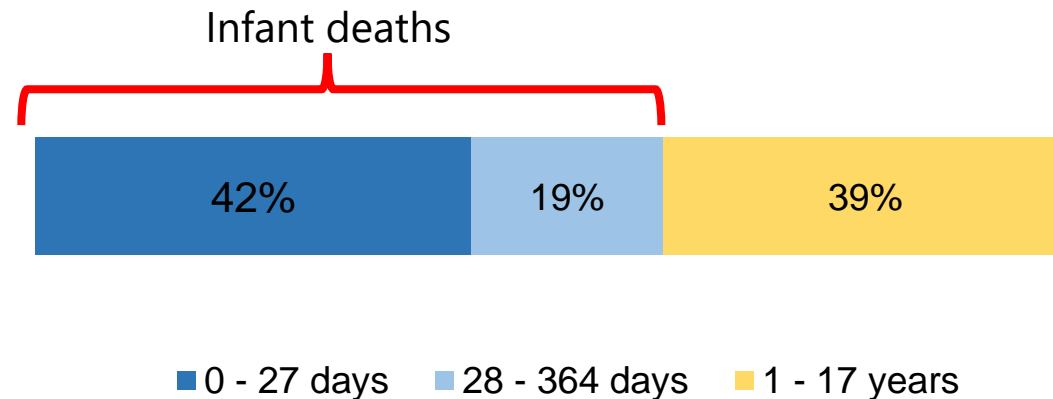
NHS Integrated Care Boards

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



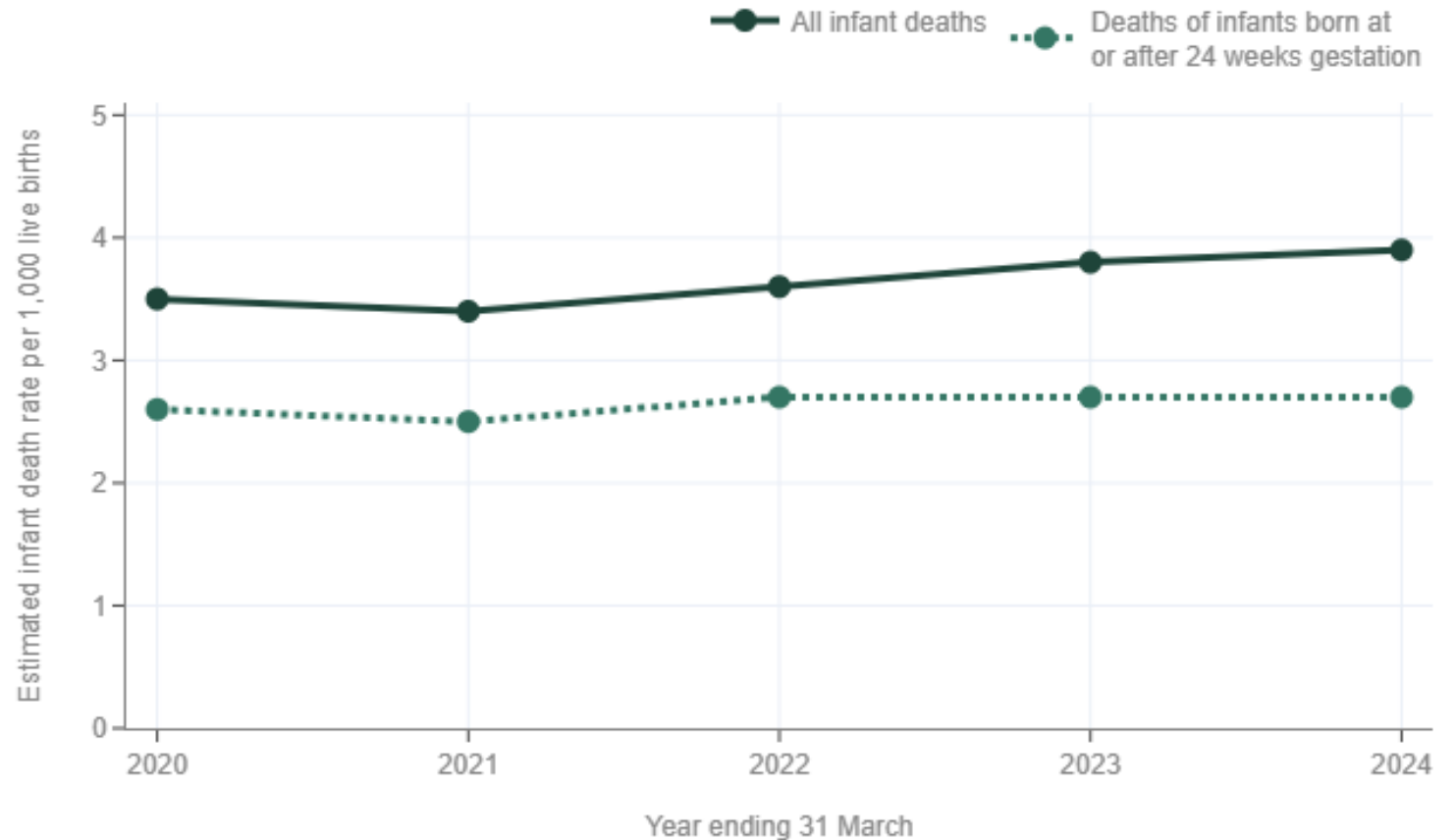
Infant mortality

- Children aged under 1
- Infant mortality is an indicator of the general health of an entire population
- Presented per 1,000 live births
- Infant deaths represent 61% of all child (0-17) deaths



Infant mortality rate

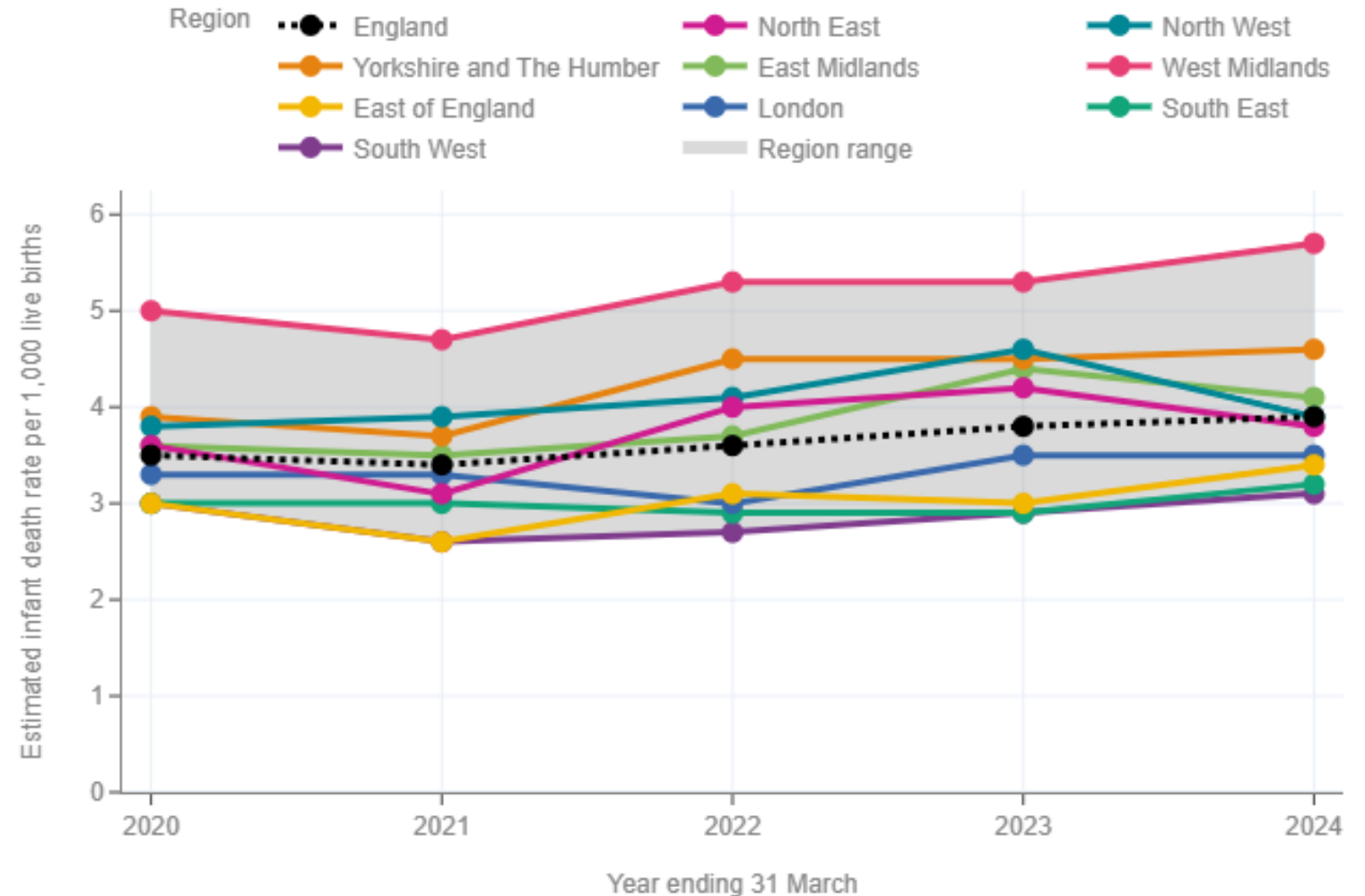
- The estimated infant mortality rate was 3.9 per 1,000 live births, an increase from 3.8 in the previous year, and remained higher than 2019-20.
- For infants born at 24 weeks or over, the estimated rate was 2.7 deaths per 1,000 live births of the same gestational age; the same rate as the previous two years.



Data source: NCMD, ONS Live births
www.ncmd.info/cdr24/

Infant mortality rate by region

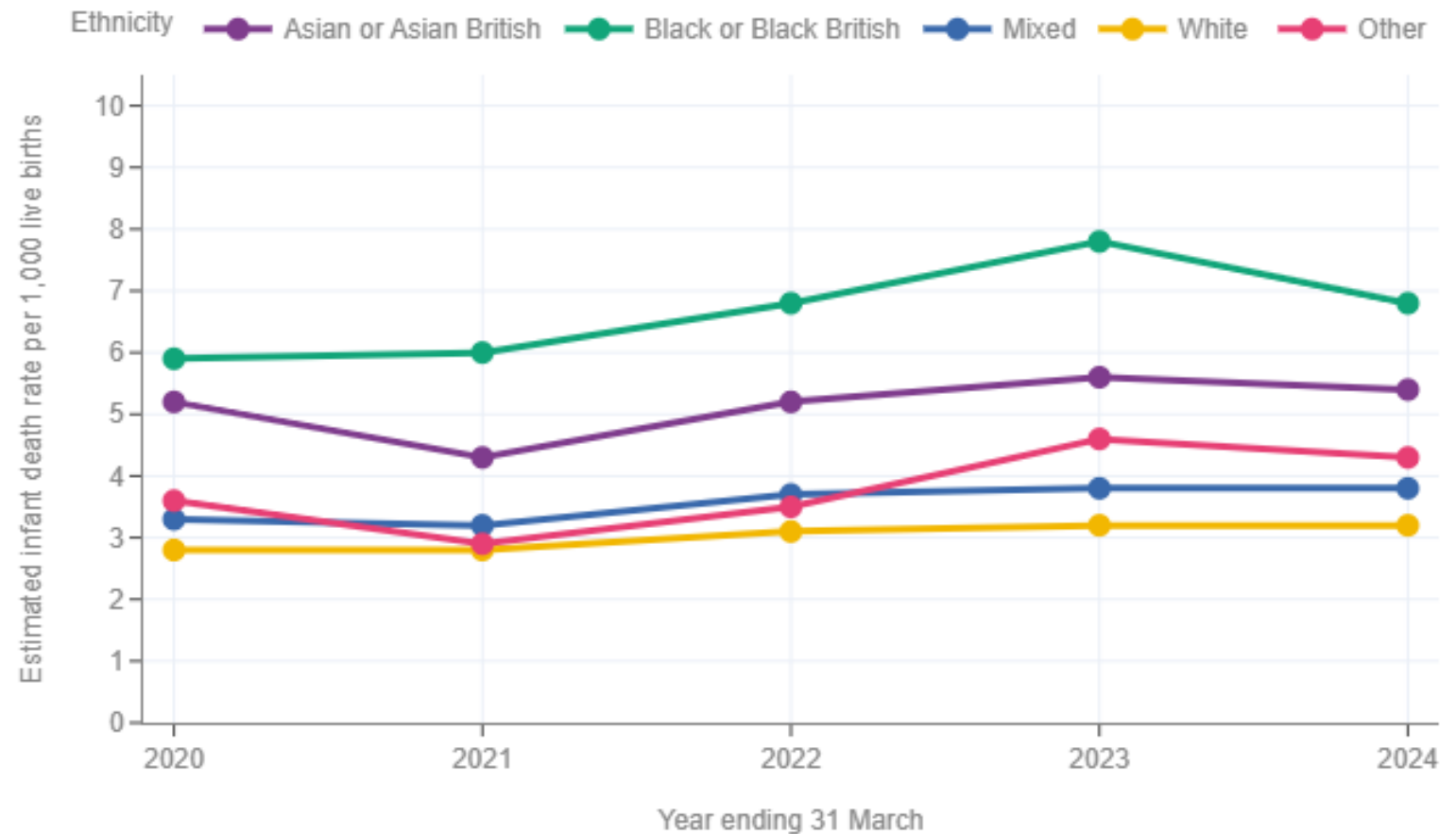
- Patterns of infant deaths were similar to those reported for all child deaths.
- The infant death rate in each region of England ranged from 3.1 to 5.7 per 1,000 live births



Data source: NCMD, ONS Live births
www.ncmd.info/cdr24/

Infant mortality rate by ethnicity

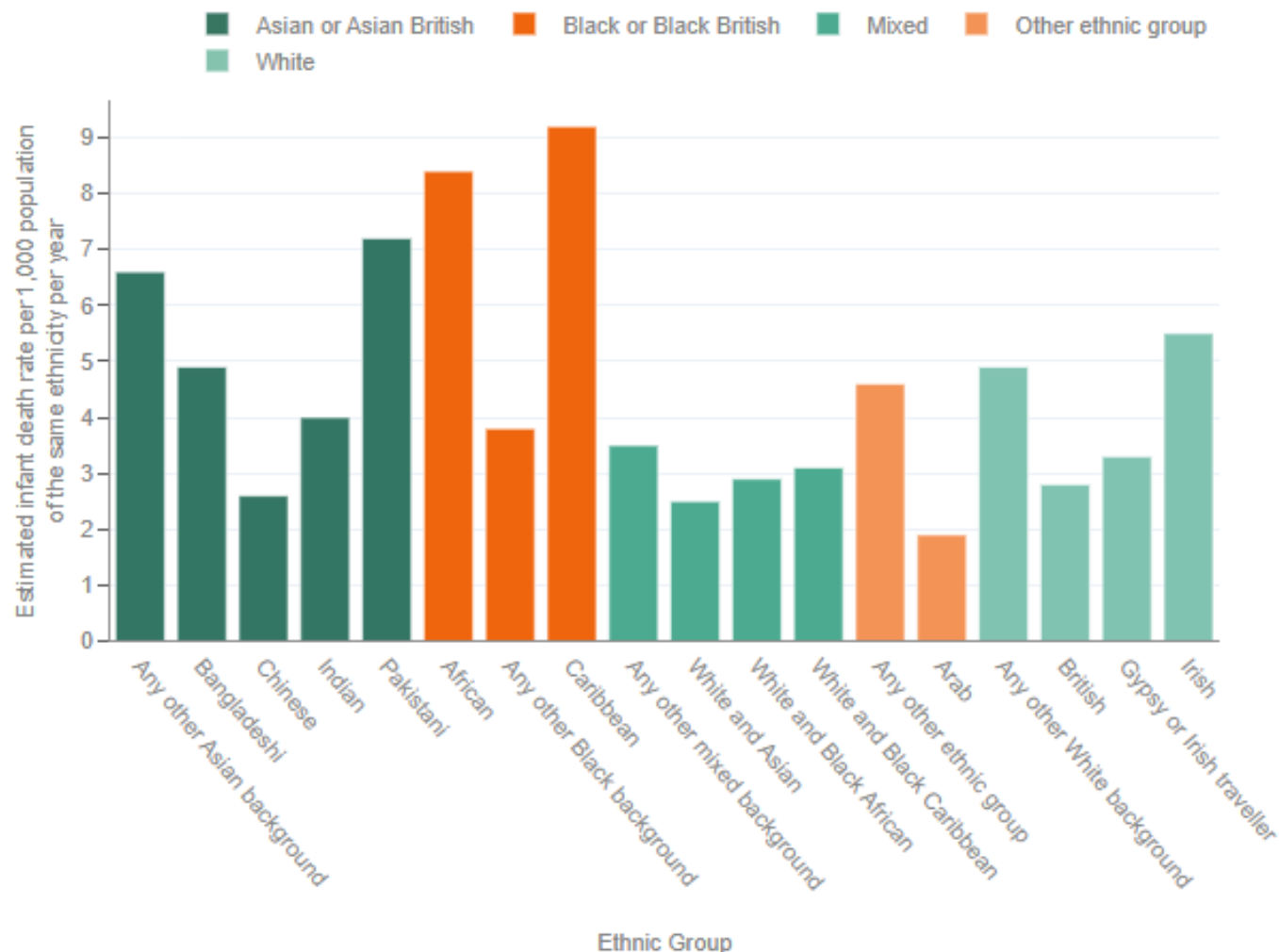
- The infant mortality continued to be highest for infants of black or black British ethnicity (6.8), more than double the rate of infants of white ethnicity (3.2).
- Death rate of infants of Asian or Asian British (5.4) also continued to be higher than infants of white ethnicity.
- Table 6 presents rates by region and ethnicity.



Data source: NCMD, ONS Live births
www.ncmd.info/cdr24/

Infant mortality rate by ethnicity

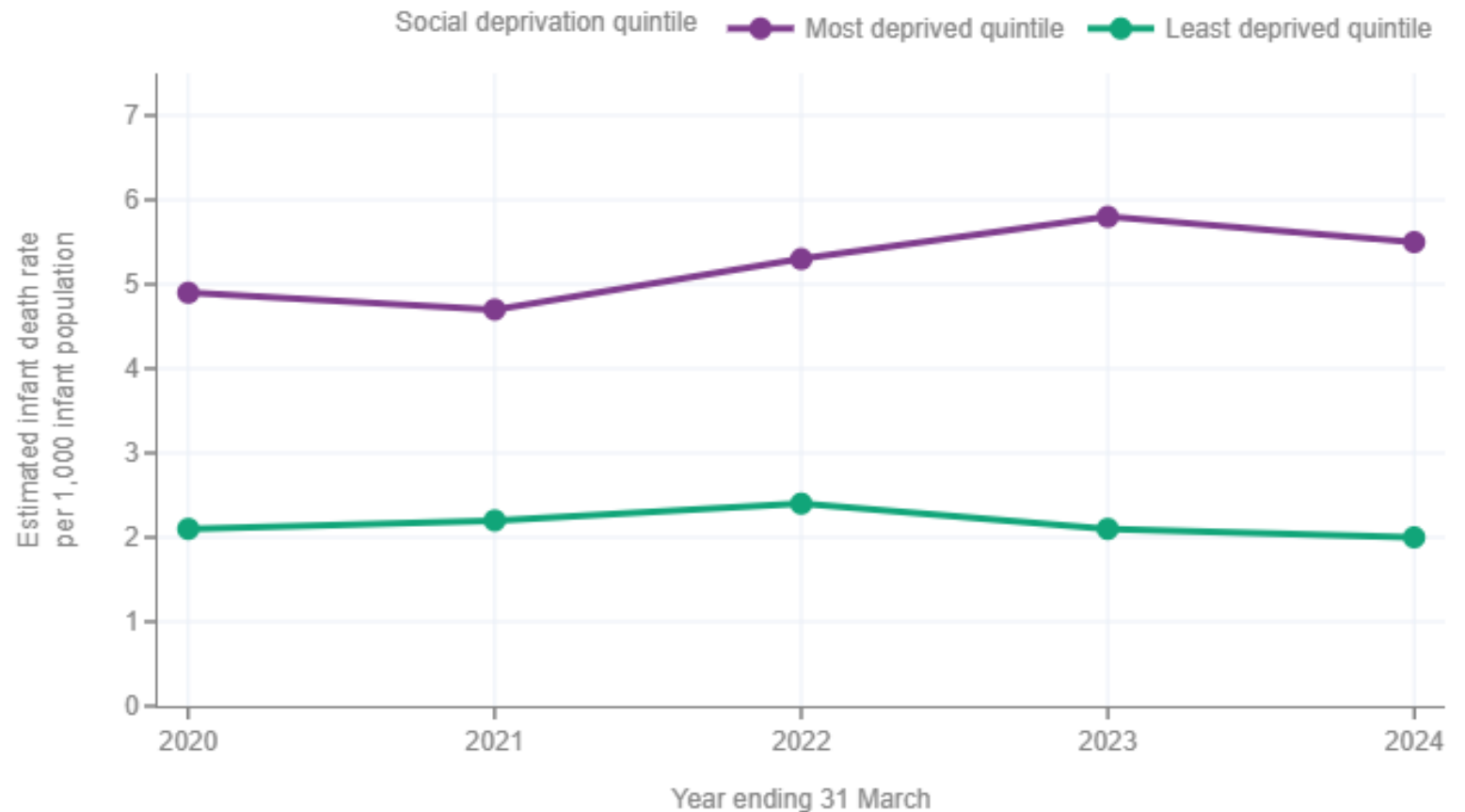
- Over a five-year period (April 2019 – March 2024)
- The infant mortality rate was highest for infants of black Caribbean (9.2), black African (8.4) or Asian Pakistani ethnicity (7.2)
- The infant mortality rate of infants from a white British ethnic background (2.8).
- The infant mortality rate was lowest for those of Chinese ethnicity (2.6) and Arab ethnicity (1.9).



Roma not presented due to small numbers.
 Data Source: NCMD, ONS Census (2021)
www.ncmd.info/cdr24/

Infant mortality rate by deprivation

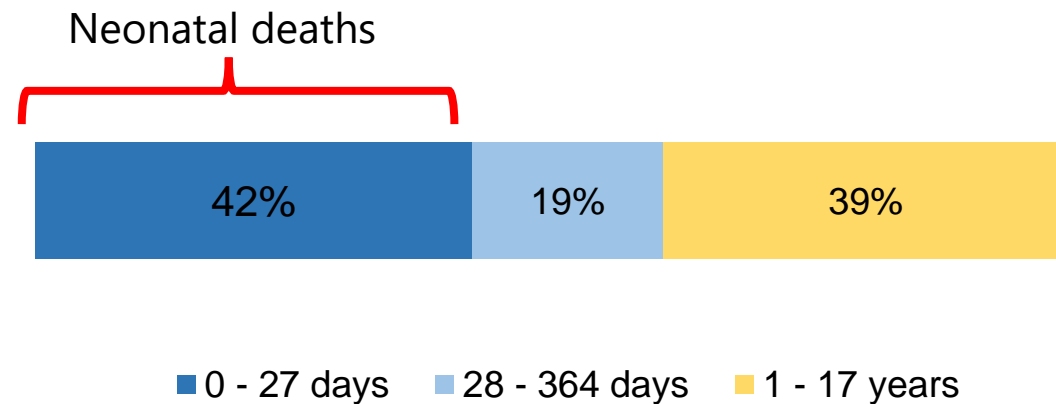
- Socioeconomic disparities persisted; infant mortality for the most deprived neighbourhoods of England (5.5), remained more than twice that of infants resident in the least deprived neighbourhoods (2.0).
- Table 4 presents rates by region and deprivation



Data Source: NCMD, ONS mid-year population estimates, Index of Multiple Deprivation (2019)
 Please note population for year ending 31 March 2023 is used for year ending 31 March 2024.
www.ncmd.info/cdr24/

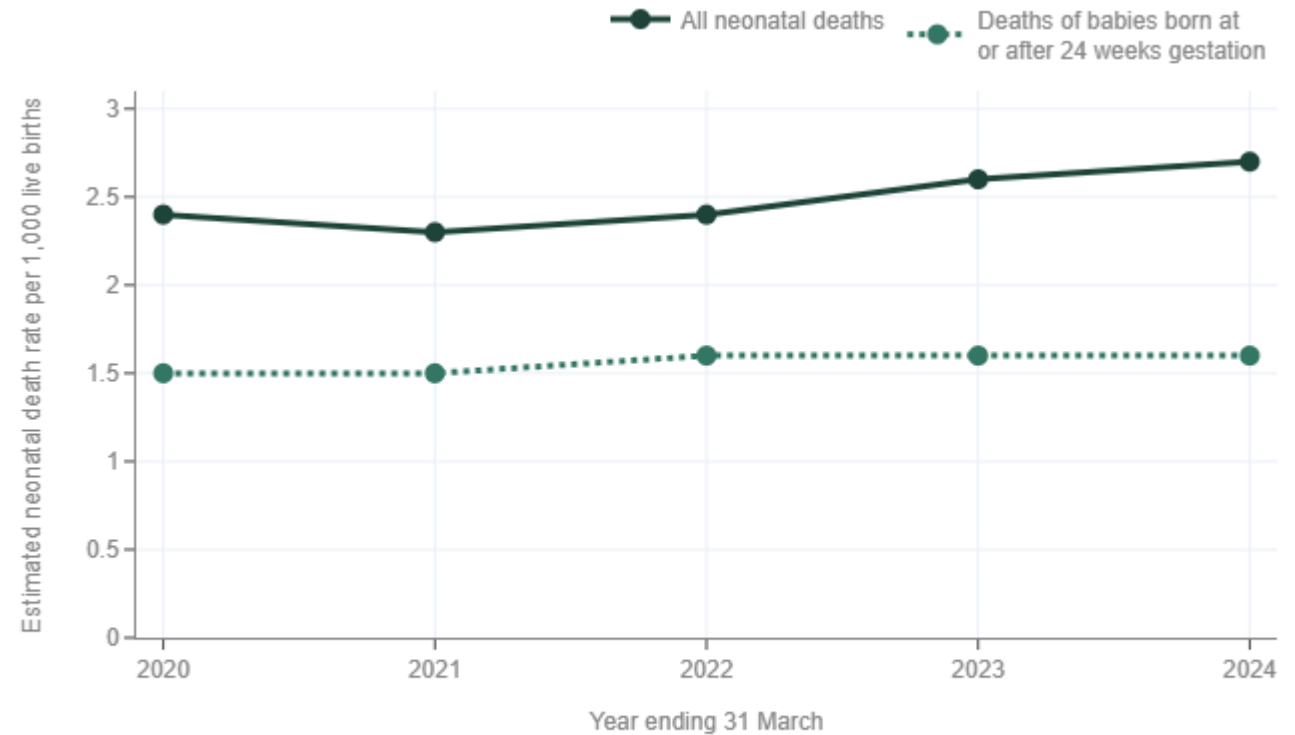
Neonatal mortality

- Deaths of babies aged under 28 days
- Presented per 1,000 live births
- 42% of all child deaths



Neonatal mortality

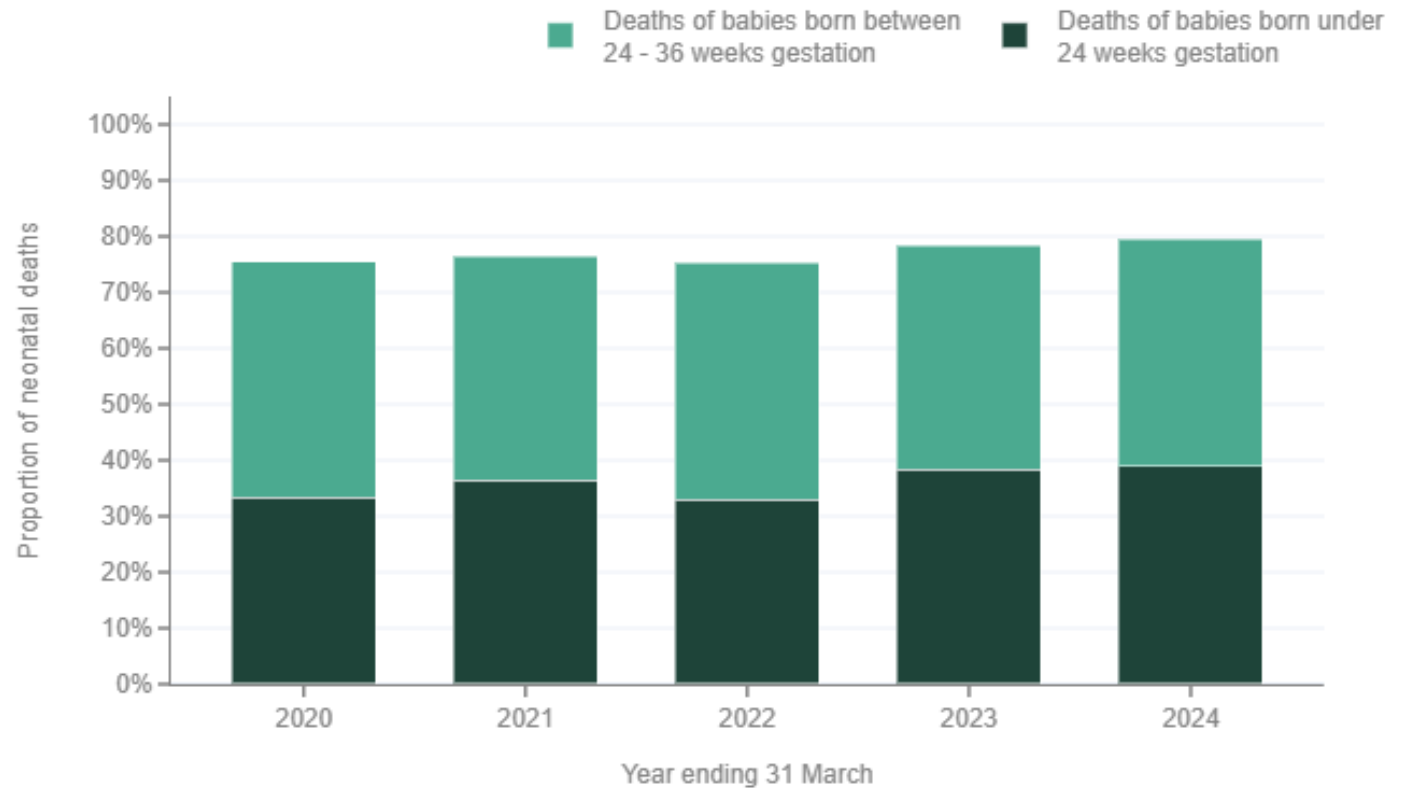
- The estimated neonatal death rate increased from 2.6 to 2.7 per 1,000 live births.
- For babies born at 24 weeks or over the rate remained at 1.6 per 1,000 live births.



Data source: NCMD, ONS Live births
www.ncmd.info/cdr24/

Neonatal mortality

- 80% of neonatal deaths were of babies born prematurely (before 37 weeks), an increase in comparison to previous years.
- Increase in the proportion of deaths notified to CDOPs of babies born under 24 weeks gestation (39% vs 33% in the year ending 31 March 2020).



Data Source: NCMD
www.ncmd.info/cdr24/

Section 2: The number of child death reviews by CDOPs

CDOP reviews

By year of review

Deaths may have **occurred** in earlier years

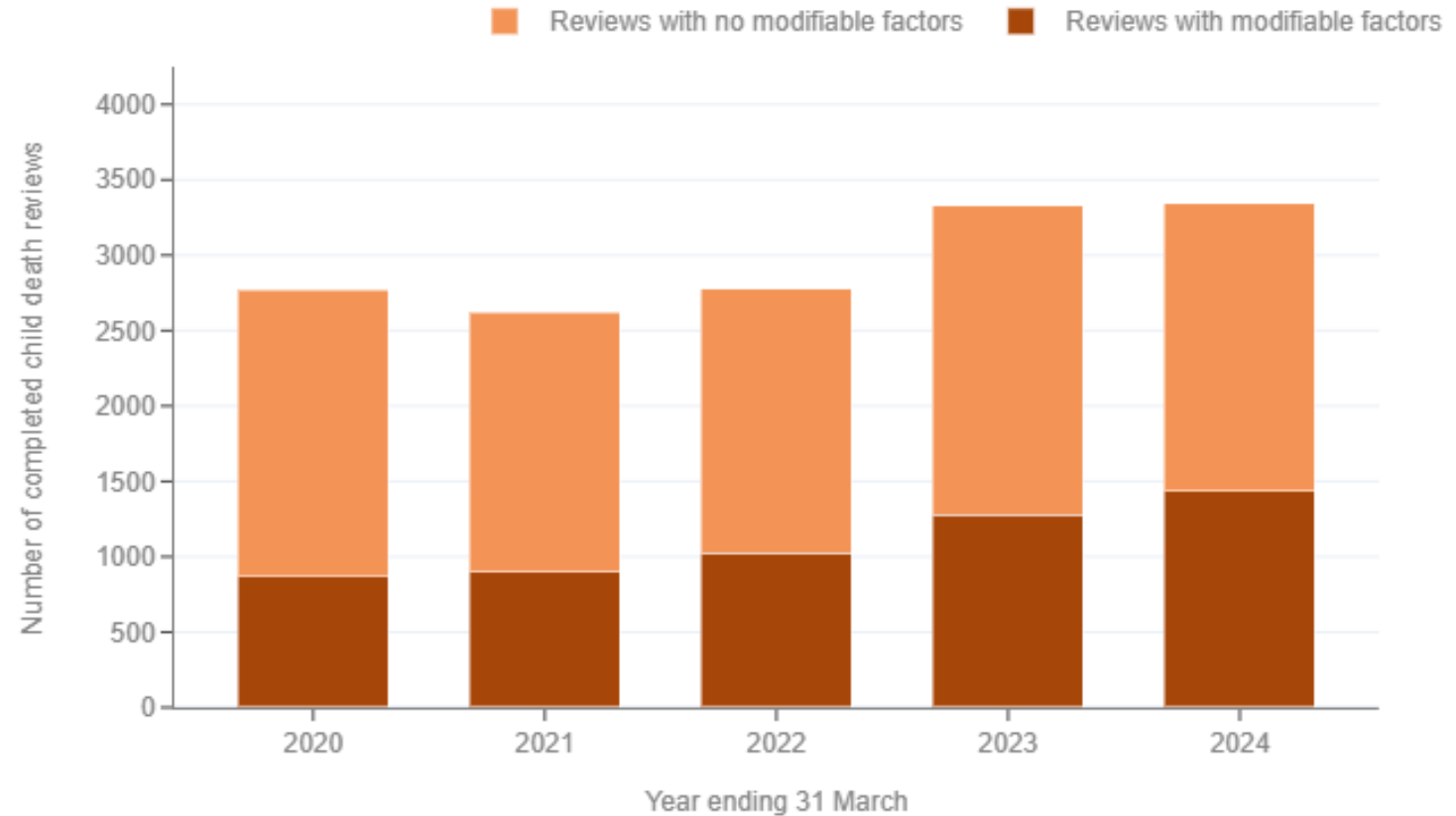
Tables 14 - 25

14% of reviews were of deaths that occurred in the same year.

The median time taken for CDOP reviews was to complete 411 days.

Number of child death reviews

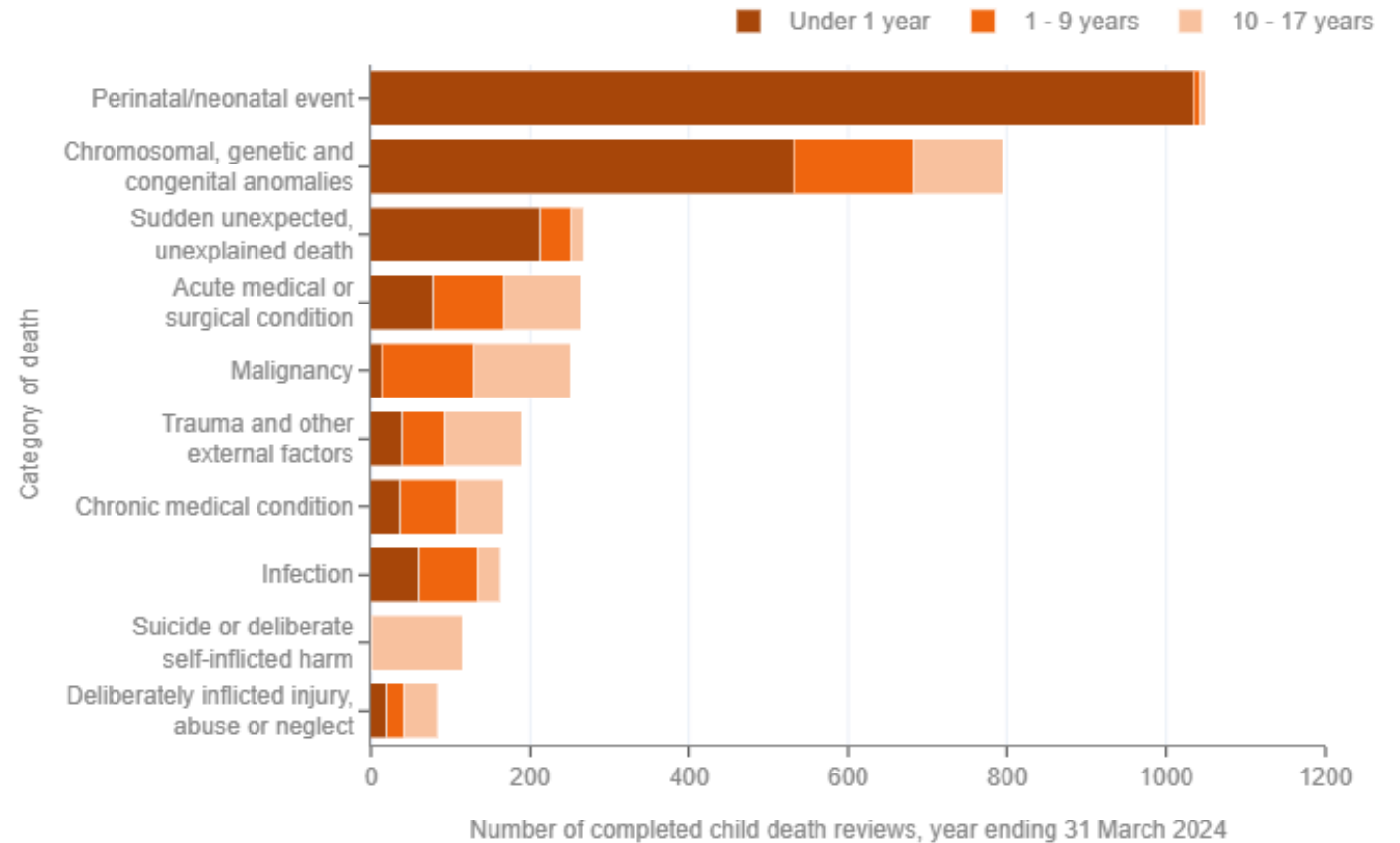
- 3,345 completed reviews
- 43% of deaths reviewed in the latest year ending 31 March 2024 identified modifiable factors.
- The proportion of reviews that identified modifiable factors continued to rise (up from 38% in the previous year).
- The proportion of reviews with modifiable factors varied per region from 34% to 57%.



Data Source: NCMD
www.ncmd.info/cdr24/

Category of death

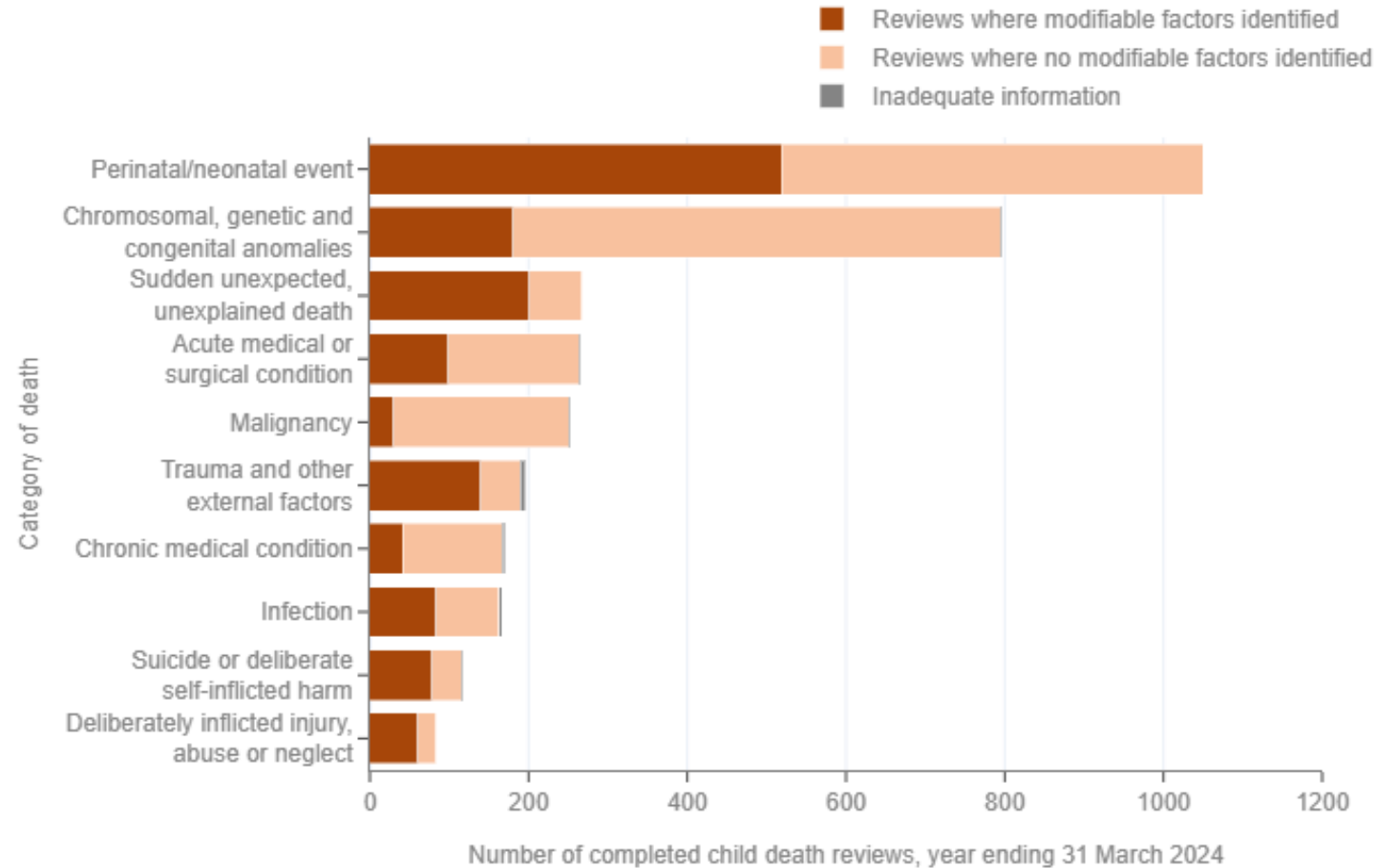
- The 3 most common primary category of death was Perinatal/neonatal event (31%), Chromosomal, genetic and congenital anomalies (24%) and Sudden unexpected and unexplained deaths (8%).
- Under 1s → Perinatal/neonatal event
- 1-9 years → Chromosomal, genetic and congenital anomalies
- 10 – 17 years → Malignancy



Data Source: NCMD
www.ncmd.info/cdr24/

Proportion of modifiable factors identified

- Deaths categorised as Perinatal/neonatal event have the highest number of deaths with modifiable factors identified.
- Deaths categorised as Trauma or other external factors had the highest proportion of reviews with modifiable factors (76%), followed by Sudden unexpected and unexplained death (75%), Deliberately inflicted injury, abuse or neglect (73%), and Suicide or deliberate self-inflicted harm (68%).



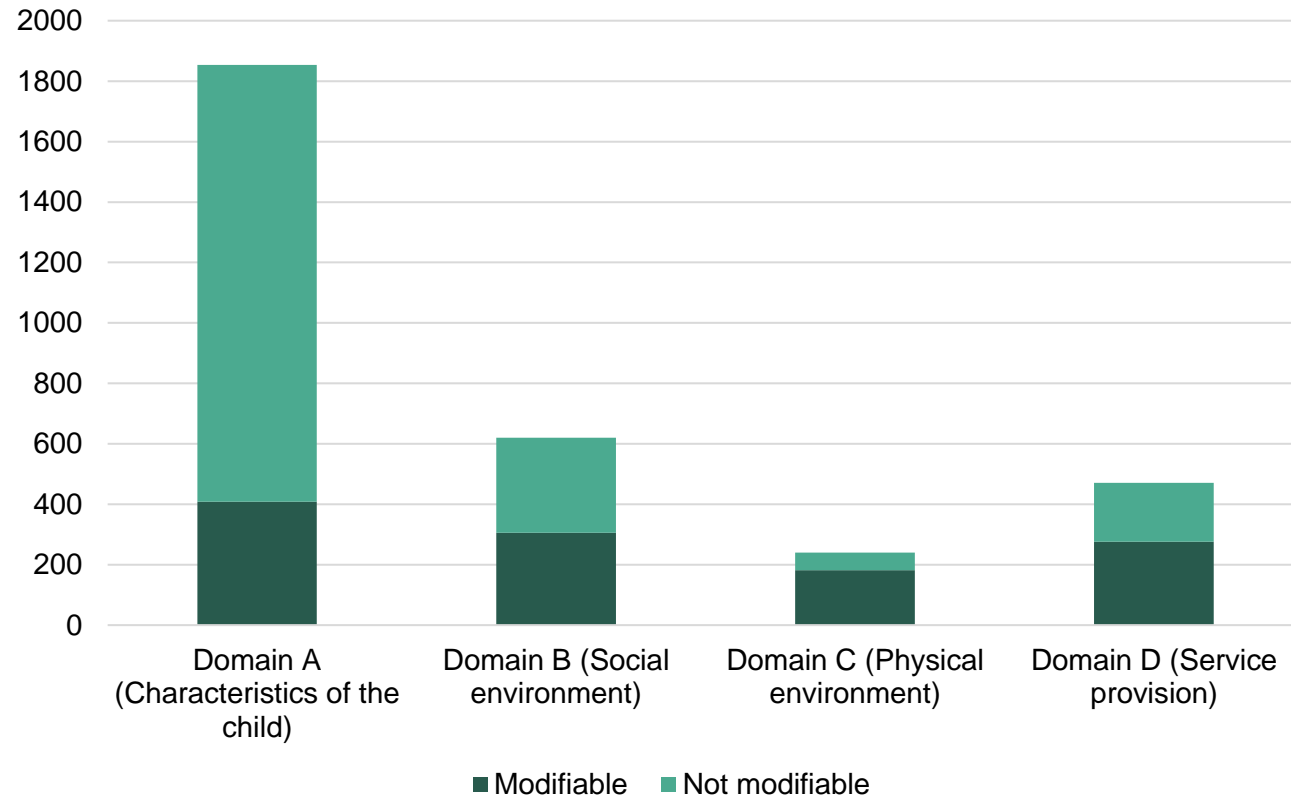
Data Source: NCMD
www.ncmd.info/cdr24/

Contributory and modifiable factors

- Table 25
- A contributory factor is defined as a factor that may have contributed to vulnerability, ill health or death.
- Modifiable factors are those which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future deaths.
- Of the 3,345 child death reviews completed in the year ending 31 March 2024, 3,176 (95%) identified contributory factors and 1,120 identified modifiable factors where a group and sub-group were assigned to the factor.
- More than one modifiable factor was identified by the CDOPs in many of the reviews. The interaction of multiple factors can increase the impact of these factors and vulnerability to death compared with what the impact might have been if there was only one factor present.
- We have separated the analysis for under 1s and 1-17 years, because of the differences between the two groups.

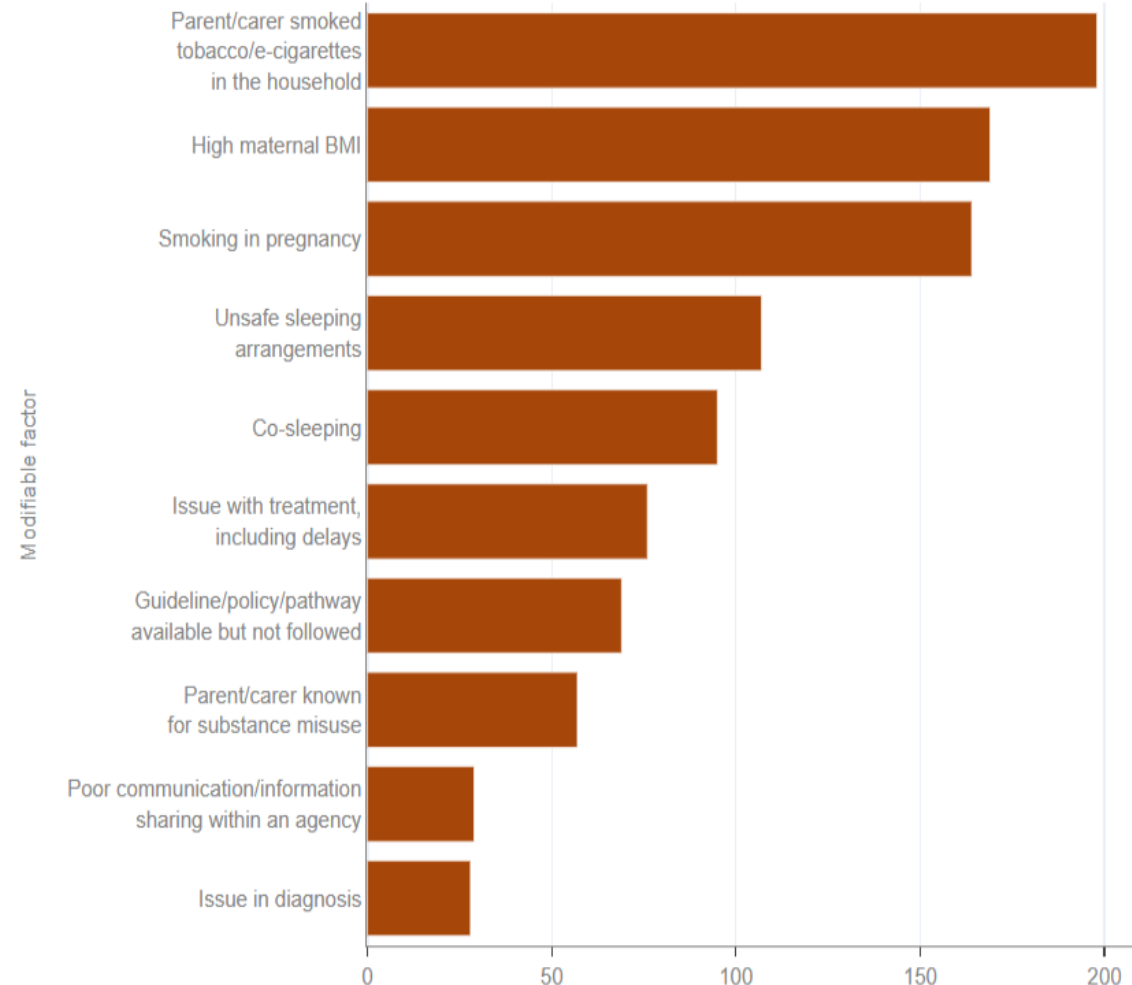
Modifiable factors – deaths of children aged under 1

- Infants (children aged under 1).
- In total, 47% of infant death reviews identified modifiable factors.



Modifiable factors – deaths of children aged under 1

- Completed CDOP reviews in the year ending 31 March 2024.
- Modifiable factors identified during the CDOP review.



Parent/carer smokes tobacco / e-cigarettes in the household

- This does not include smoking in pregnancy which is captured under a separate group
- Frequently comes up in the under 1 age group in association with deaths due to SIDS and deaths due to prematurity (pre 37 weeks' gestation)
- Challenges here include access to smoking cessation services and take-up of those services by smokers
- NCMD reviewed and revised the questions on smoking and vaping to better support good quality data collection in this area
- New questions were implemented into the system in October 2024 and relate to smoking and vaping by the child and by family members

High maternal BMI

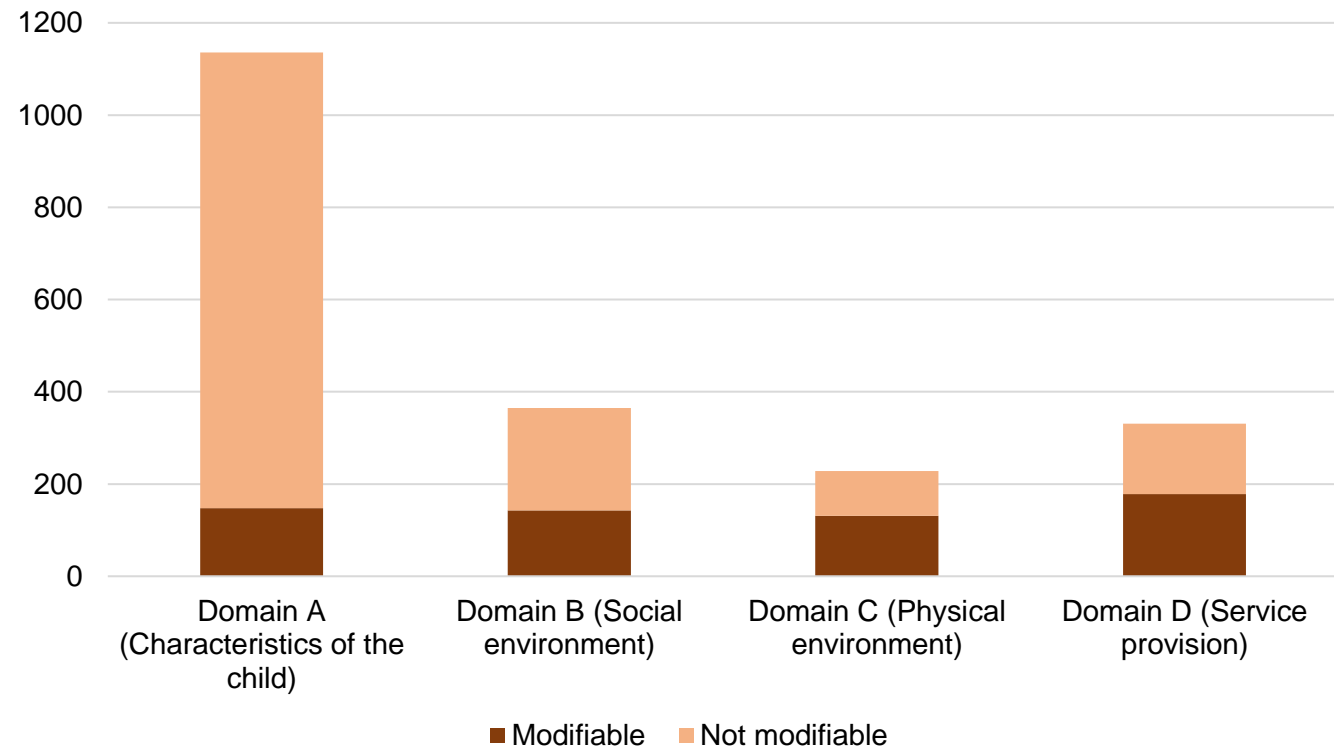
- This factor was recorded as modifiable in relation to deaths due to complications of extremely premature delivery and some deaths due to chromosomal, genetic or congenital anomalies
- Risks associated with a raised BMI include gestational diabetes, pre-eclampsia, postpartum haemorrhage, prolonged labour, birth defects and fetal macrosomia
- Women who enter pregnancy with a Body Mass Index above 30 kg/m² face an increased risk of complications during pregnancy and birth ([Reference](#))
- [NICE guidance](#) defines obesity differently for different ethnicities. It is currently being updated.

Unsafe sleeping arrangements

- Unsafe sleeping arrangements includes factors such as sleeping position, toys/cushions/items in the cot, high room temperature, inappropriate sleeping surface e.g. sofa
- [Sudden Unexplained Deaths in Infancy & Childhood Thematic Report](#) showed that unsafe sleeping arrangements were recorded as a modifiable factor in 72% of deaths of infants under 1 whose deaths remained unexplained after investigation.
- Recommendations were around ensuring personalised safer sleep advice is given to families and use of safer sleep assessment tools to identify families at higher risk
- [Promoting safer sleep for babies in high-risk groups in England](#) was published last year and has some useful findings and suggestions on implications for practice

Modifiable factors – deaths of children aged 1 – 17 years

- In total, 38% of reviews of 1 – 17 year olds identified modifiable factors.



Poor communication / information sharing between agencies

- This has been reported as a modifiable factor in every thematic report we have published
- Most recently in the [Learning Disability and Autism Thematic Report](#) this included failures to involve families in care planning, poor monitoring of prescribed medication, lack of allocation of a care co-ordinator, and silo working
- It is a particular issue for children who have moved between areas or been placed out of their local area e.g. temporary accommodation / looked after child placements
- **Recommendation 18** in [Deaths due to Traumatic Incidents Thematic Report](#) tasked local integrated care boards to review and improve information sharing and communication processes, including information sharing between schools especially for managed moves of children in care to ensure there is sufficient information available to inform the induction process and support strategies and interventions in the new areas

Issues with treatment, including delays

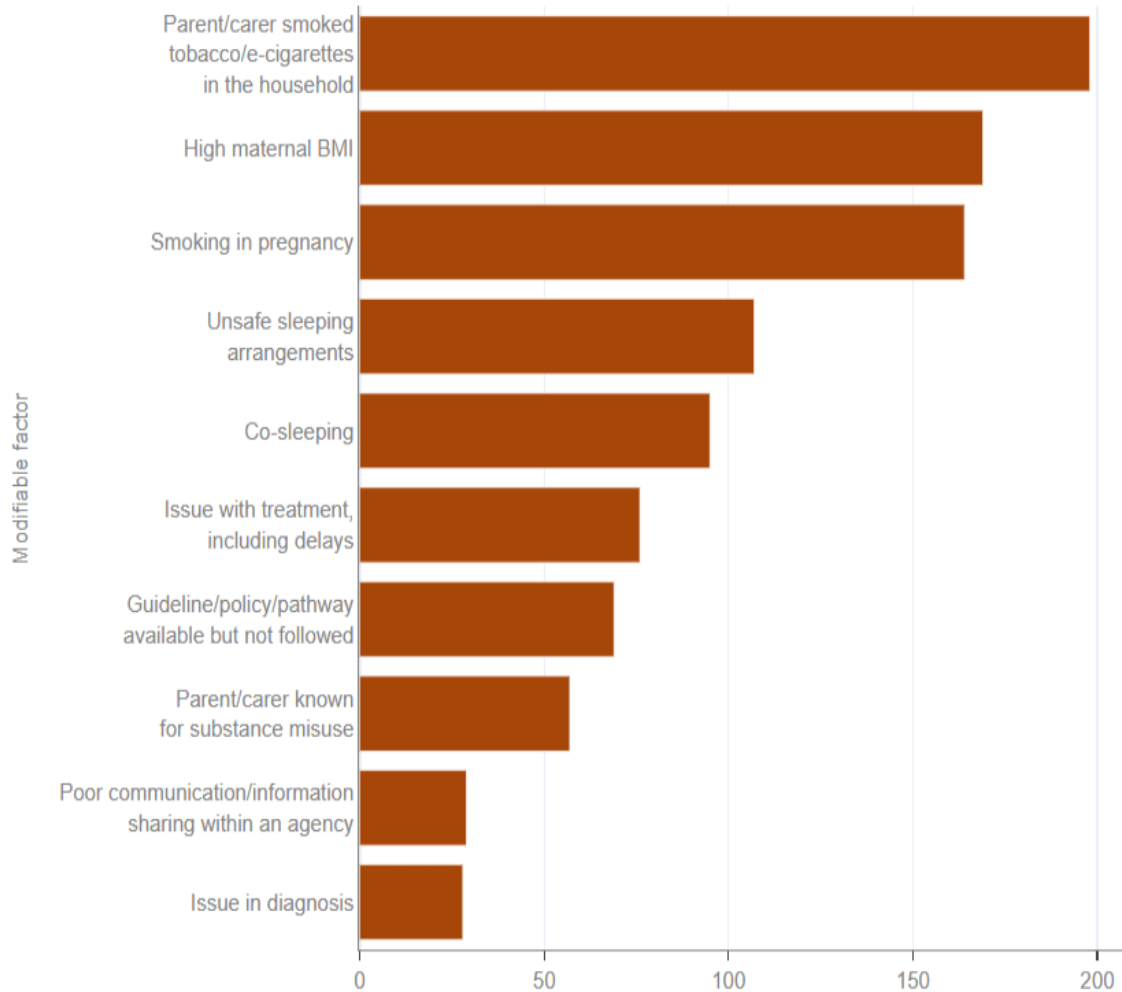
- This includes issues relating to the treatment the child received for their condition e.g., delay in starting treatment, side effects or complications developed as a result of treatment, or medical or surgical error.
- Timely recognition of sepsis was identified in the [Infection Related Deaths Thematic Report](#) as an area of particular challenge

Lack of appropriate supervision

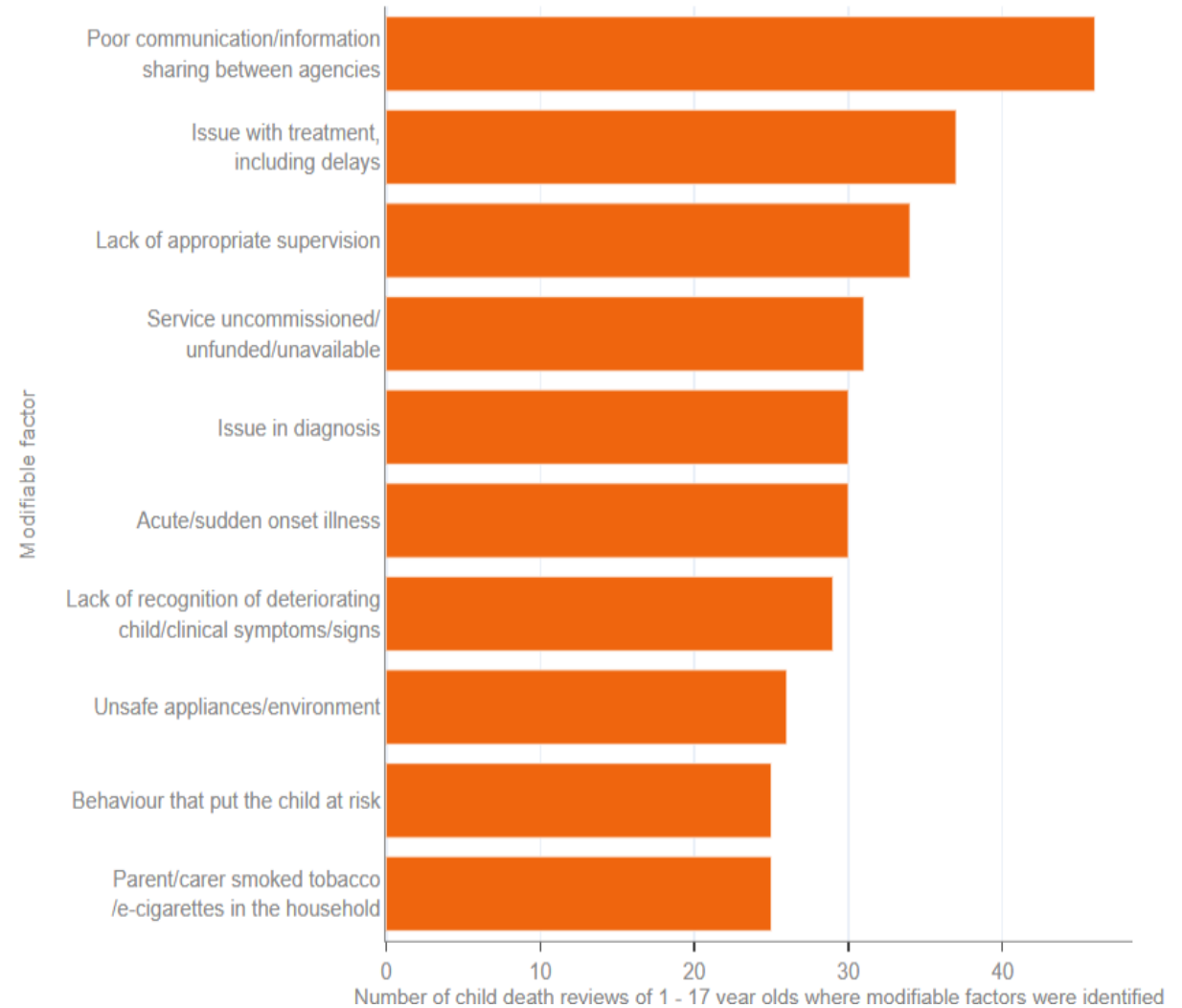
- This describes instances where there was not appropriate supervision of the child at the time of the event leading to death e.g., young child unsupervised in a bath.
- [Deaths due to Traumatic Incidents Thematic Report](#) highlighted this issue in relation to drowning. Recommendation 6 was around keeping young children within arm's reach during bathtime.
- In our recent [Drowning Update](#), we showed that in the most recent year, 90% of drowning deaths occurred when the child was unsupervised
- RLSS [Splash Safety at Your Pad](#) campaign was launched in response to this with advice for families on staying safe at bath time.

Modifiable factors

Under 1s

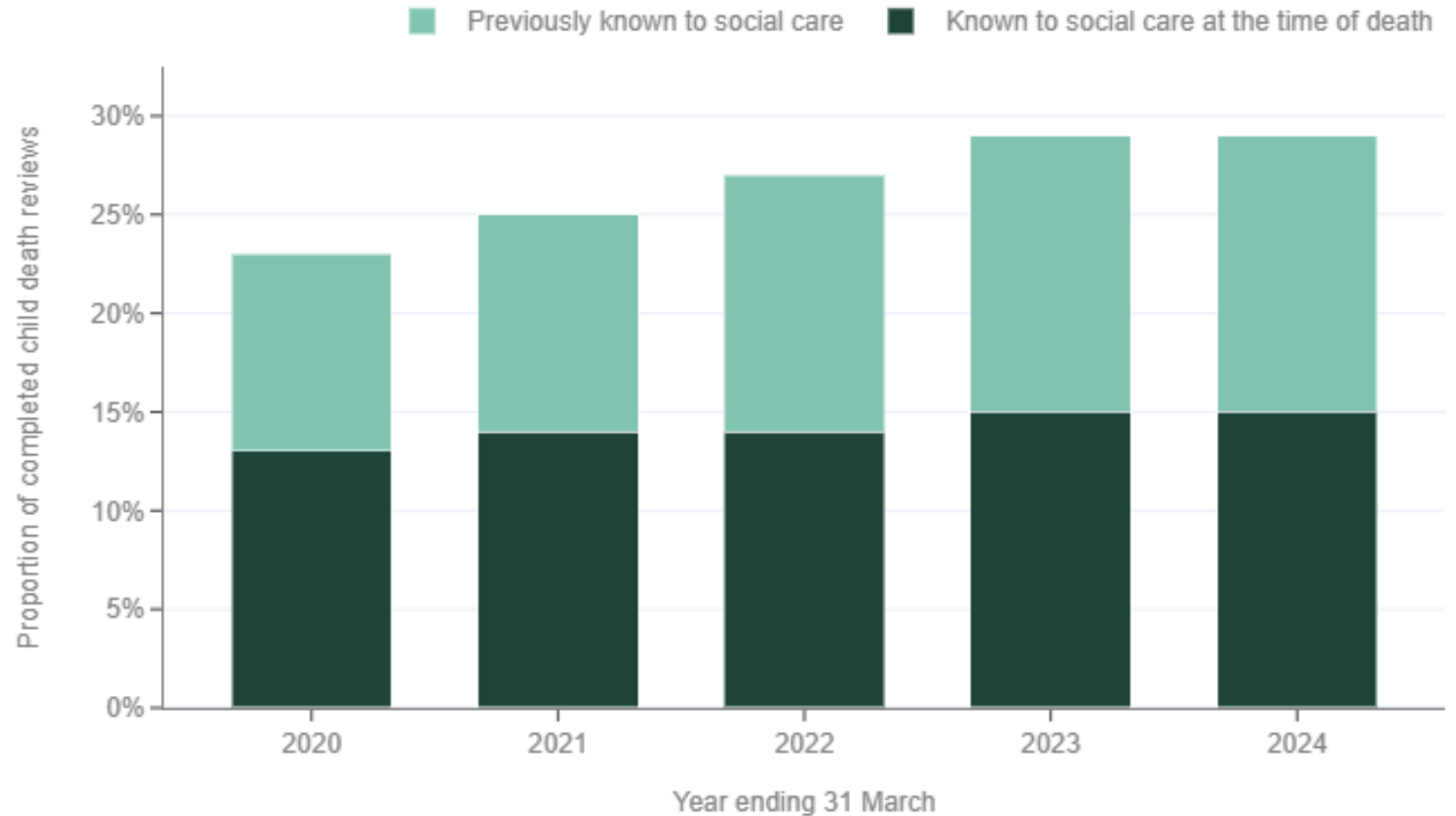


1 – 17 year olds



Social care

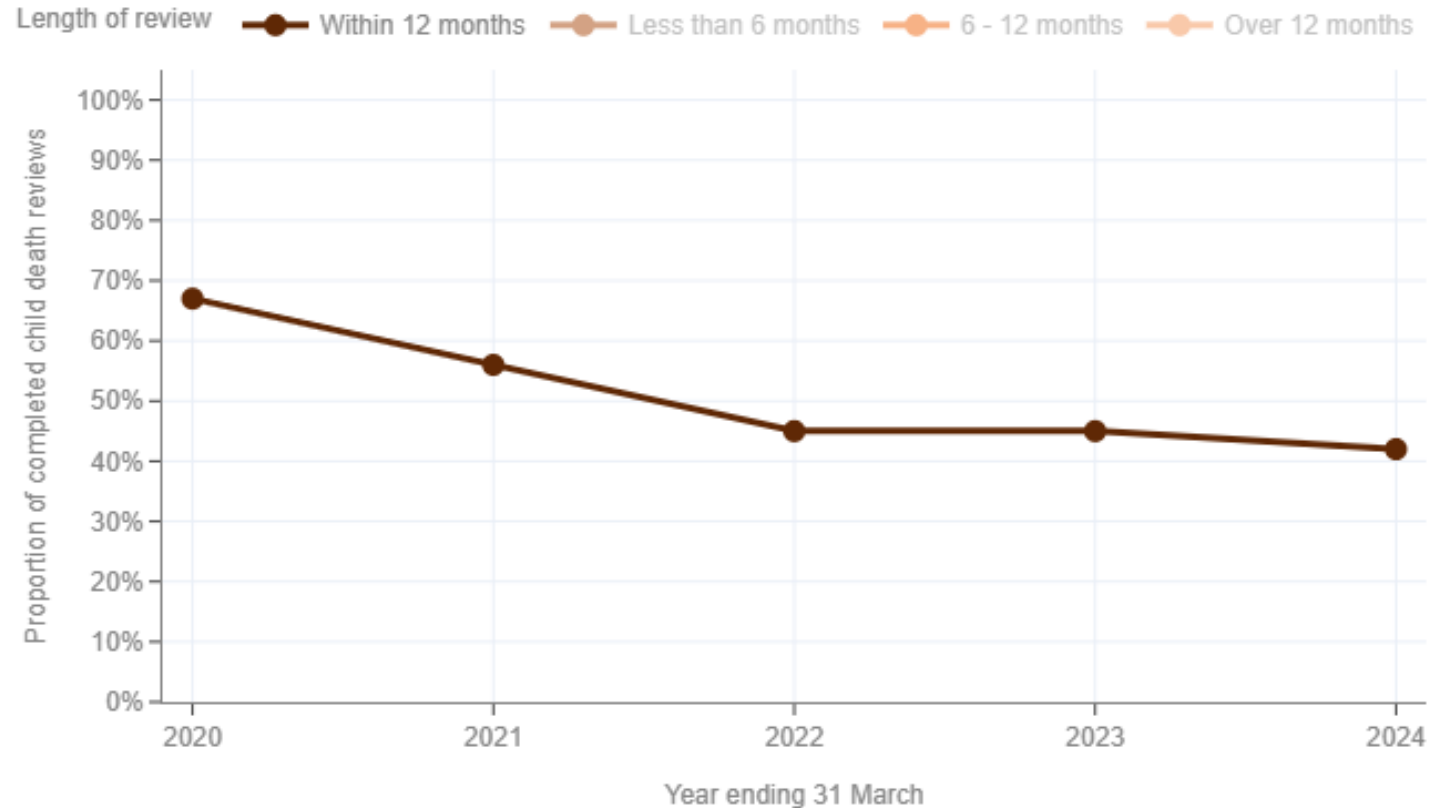
- 15% of children were known to social care at the time of their death; a similar proportion to previous years (14%)
- 46% identified modifiable factors.
- A further 14% of reviews were of children who were reported as previously known to social care, which has increased each year from 10% in the year ending 31 March 2020.



Data Source: NCMD
www.ncmd.info/cdr24/

Duration of CDOP reviews

- 42% of reviews were completed by the CDOP within 12 months.



Data Source: NCMD
www.ncmd.info/cdr24/

Summary & Next steps

- The number of child deaths that occurred in 2023-24 decreased by 4% on the previous year but remained higher than 2019-20.
- Although the number of infant deaths decreased, the estimated infant death rate increased from 3.8 to 3.9 per 1,000 live births.
- The estimated neonatal death rate increased from 2.6 to 2.7 per 1,000 live births. For babies born at 24 weeks or over, the rate remained at 1.6 deaths per 1,000 live births; the same as the previous two years.
- Ethnic, regional, socio-economic disparities persist.
- Of 3,345 completed CDOP reviews, 43% identified modifiable factors, an increase on previous years.
- Many modifiable factors were identified, but the most common modifiable factors recorded during CDOP reviews were:
 - **Infants:**
 - Parental smoking/smoking in pregnancy
 - High maternal BMI
 - Unsafe sleeping arrangements
 - **1 – 17 years:**
 - Poor communication and information sharing between agencies
 - Issues with treatment
 - Lack of appropriate supervision
- Engage, share and promote the use of these data with those who can implement action.
- NCMD surveillance continues including escalation of alerts and thematic reports.

NCMD Thematic Reports for 2024/25

- Deaths due to asthma and anaphylaxis report is currently due to be published on 12 December 2024.
- Sign up to our [Mailing list](#) to receive a free copy when it is published
- 2025 - Deaths of children with life-limiting conditions, and palliative care
- 2025 – Consanguinity



Acknowledgements

- All Child Death Overview Panels (CDOPs) and Child Death Review Professionals who continue to submit data for this release and for their continued support with information to NCMD for the national analysis and learning from child deaths in England.
- Every child who dies is a precious individual and their deaths represent a devastating loss for family and friends. With all child deaths there is a strong need to understand what happened, and why. We must ensure that anything that can be learned to prevent future deaths from happening is identified and acted upon.

Keep in touch

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Look at	Our web pages for professionals here

More data and information on the CDR data release 2024 available at: www.ncmd.info/cdr24

Next webinar:
Preventing Future Child Deaths Through Shared Learnings – Tuesday 26th November at 11.30

www.ncmd.info/events



Questions