Healthcare Improvement Scotland

care inspectorate

National Hub for reviewing and learning from the deaths of children and young people

Data release: Year ending 31 March 2025

June 2026

Published June 2026

www.healthcareimprovementscotland.scot

Contents

Introduction

Background

The National Hub for reviewing and learning from the deaths of children and young people (National Hub) is a joint programme managed by Healthcare Improvement Scotland and the Care Inspectorate. Its aims are to ensure that:

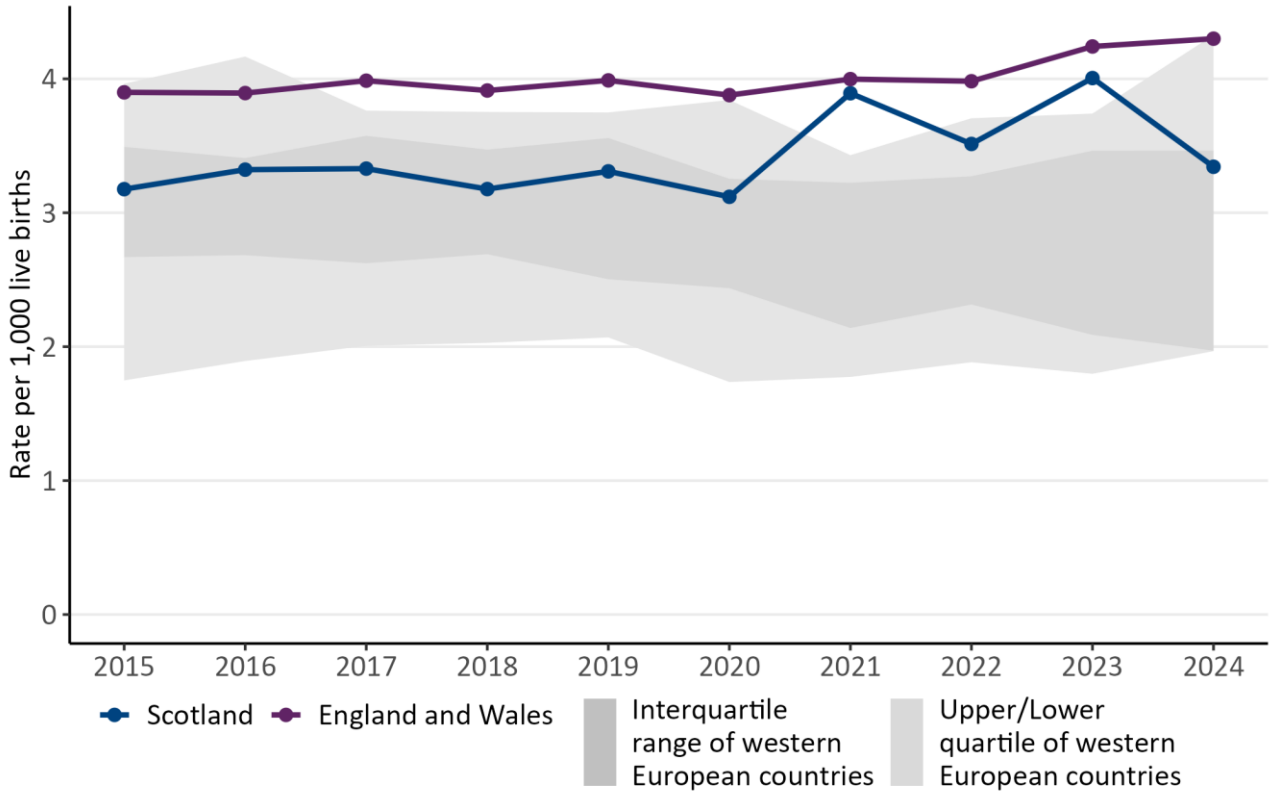
- the death of every child in Scotland is subject to a quality review,
- bereaved families and carers are meaningfully engaged in those review processes and
- learning from reviews is collated, shared and acted upon to help reduce preventable deaths over time.

The National Hub published national guidance for carrying out child death reviews (CDRs) and started collecting CDR data from October 2021. Scotland has one of the highest mortality rates for children under the age of 18 in western Europe (see figures 1.1 and 1.2). In view of this, there is a clear need to collate data and learning on a national basis.

Figures 1.1 and 1.2 show how Scotland and England/Wales compare to 14 western European countries: Finland, Norway, Sweden, Italy, Spain, Ireland, Portugal, Denmark, Greece, Austria, Germany, Netherlands, Belgium, and France. The shaded area shows the spread of mortality in comparator western European countries. For each year the dark band shows the range of mortality in the middle 50% (interquartile range), while the lighter bands either side show the range of mortality in the highest and lowest 25% (upper/lower quartiles).

Before 2021, Scotland had an infant mortality comparable to other countries in western Europe. An increase in mortality in the years following COVID-19 led to Scotland having amongst the highest infant mortality in western Europe in recent years. England and Wales have consistently had some of the highest rates in western Europe since 2015.

Figure 1.1 Mortality rate for under ones in Scotland and England & Wales compared with western European countries[1]

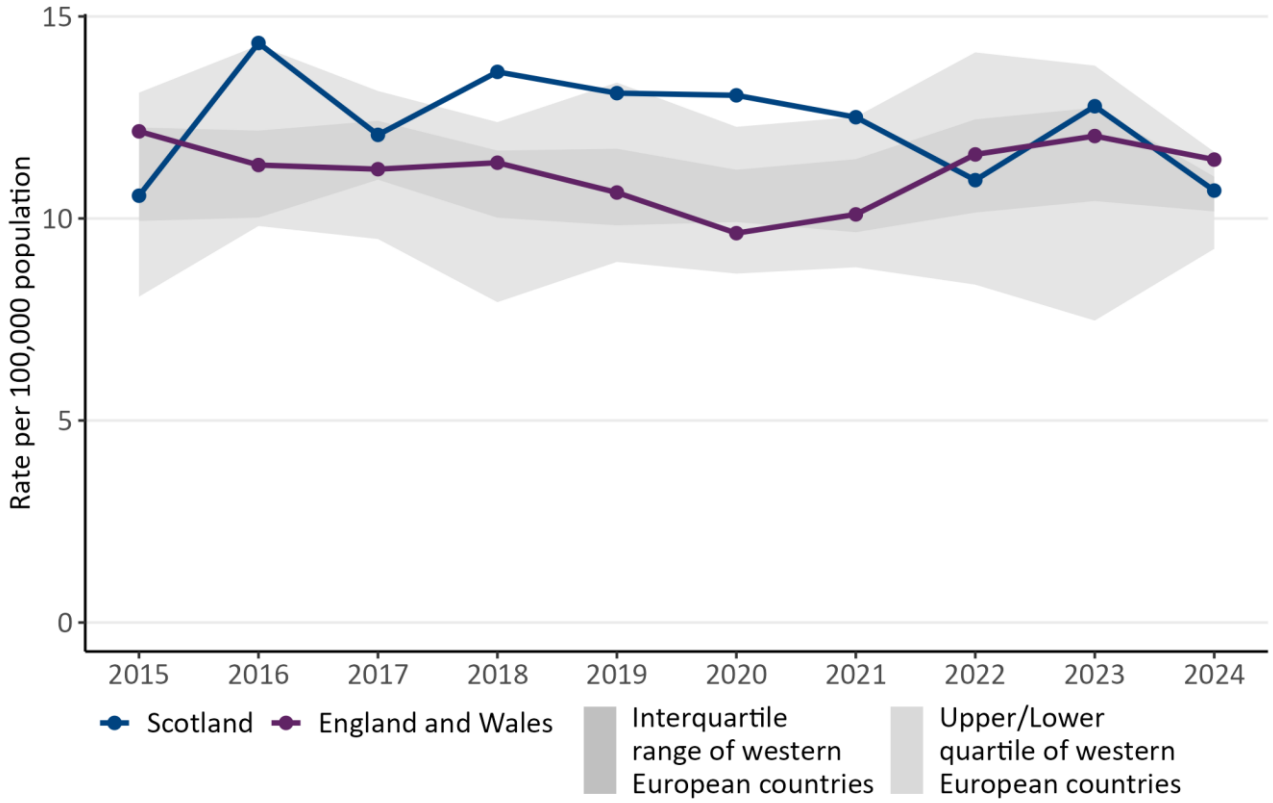


Sources: Human Mortality Database, Office for National Statistics and National Records of Scotland

[1] Rates based on registered deaths and population estimates. Scotland rates based on Human Mortality Database data from 2015 to 2018 and National Records of Scotland data from 2019 to 2024. England and Wales rates are based ONS data. Data availability reduces to 11 countries in 2023 and 6 in 2024.

Scotland had one of the highest mortality rates in western Europe in the years 2016 to 2021 for 1-17-year-olds, but in the years since, Scotland has been more in line with other western European countries. England and Wales mortality rates for 1-17-year-olds have remained similar to other western European countries since 2015.

Figure 1.2 Mortality rate for 1-17-year-olds in Western European countries



Sources: Human Mortality Database, Office for National Statistics and National Records of Scotland

About child death reviews (CDRs)

Reviews should be conducted into the deaths of all live born children between 0-17 years, and young people up to their 26th birthday who are in receipt of continuing care or aftercare services at the time of their death.

The National Hub worked with stakeholders to create national guidance[2] for NHS boards and local authorities/partnerships to use when reviewing the deaths of children and young people in Scotland. The guidance recommends keeping family and carers at the centre of the review process and provides key steps to ensure consistency when reviewing the circumstances surrounding the death.

Information from each review is captured in a core review dataset (CRDS). Each NHS board and local authority/health and social care partnership (HSCP) area across Scotland share completed CRDS via a secure online reporting portal. This process enables the National Hub to collate and analyse review data at a national level.

About this data release

This is the National Hub's second annual data release, which summarises child death data from the National Records of Scotland (NRS) from 1 April 2024 to 31 March 2025 and compares it to historic data by financial year from 1 April 2019. This release also summarises cumulative findings from CDRSs from the start of National Hub data collection on 1 October 2021 to 31 March 2025. In this data release, 'child' can mean a baby, child or young person.

Previous publications, including our first data release can be found on the Data and Guidance[3] page of the National hub website.

[2] National Guidance when a child or young person dies.
https://www.healthcareimprovementscotland.scot/publications/national-guidance-when-a-child-or-young-person-dies/

[3] National Hub data and guidance for NHS boards and local authorities
https://www.healthcareimprovementscotland.scot/inspections-reviews-and-regulation/national-hub-for-reviewing-and-learning-from-the-deaths-of-children-and-young-people/national-hub-data-and-guidance-for-nhs-boards-and-local-authorities/

Summary of deaths in Scottish children and young people

This section provides an overview of child death data received via NRS from 1 April 2024 to 31 March 2025 and compares it to historic data by financial year from 1 April 2019. It encompasses children aged between 0-17 years and young people in receipt of continuing care or aftercare at the time of their death up to the age of 26 years. This reporting period allows for alignment and comparison with the other UK nations.

Data in this section is published with permission of NRS, which registers all deaths in Scotland and publishes official statistics. Data for the period 1 October 2021 to 31 December 2024 is extracted from NRS end of year reports that will be more likely to have a post-mortem examination completed. Data for the period 1 January 2025 to 31 March 2025 is extracted from the weekly notifications that the National Hub receives, and as such the underlying causes of death in these cases may change following completion of a post-mortem examination.

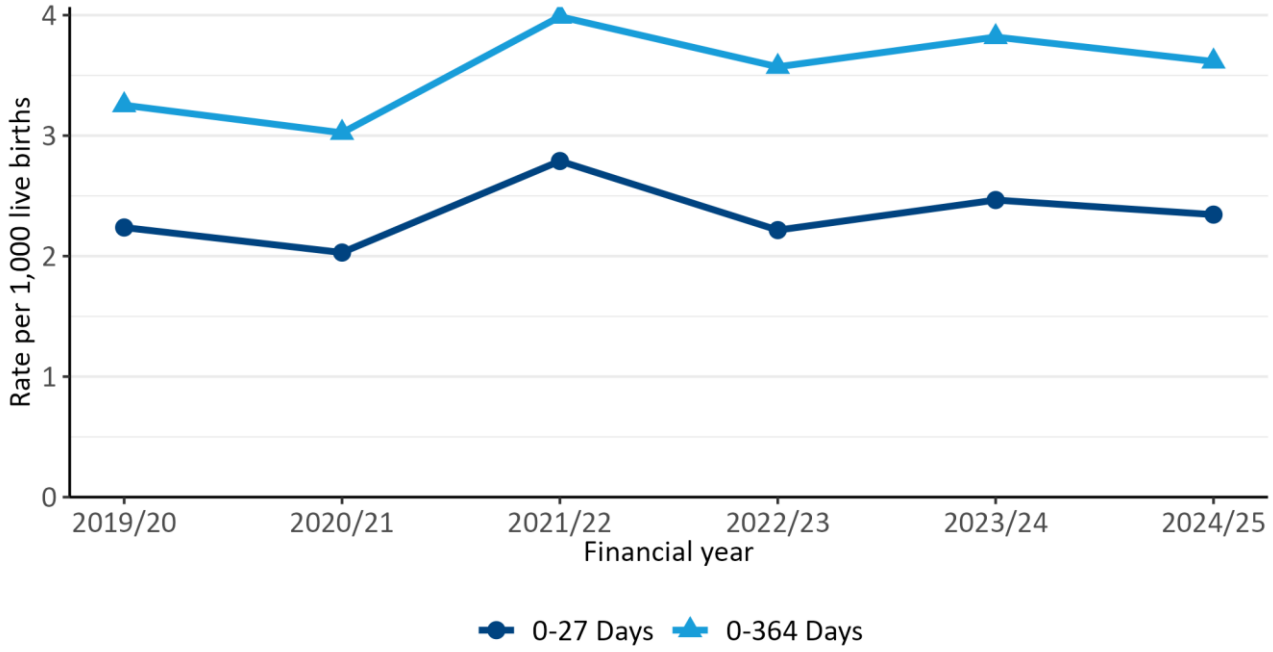
Deaths of children under 18 years

There were 270 deaths of children aged between 0-17 years in Scotland between April 2024 and March 2025. Based on the latest mid-year population estimate for 2024, this is a rate of 26.5 deaths per 100,000 children.

Age

Infant and neonatal death rates for 2024/25 remain below the rates observed in 2021/22 but higher than those observed previously (Figure 2.1).

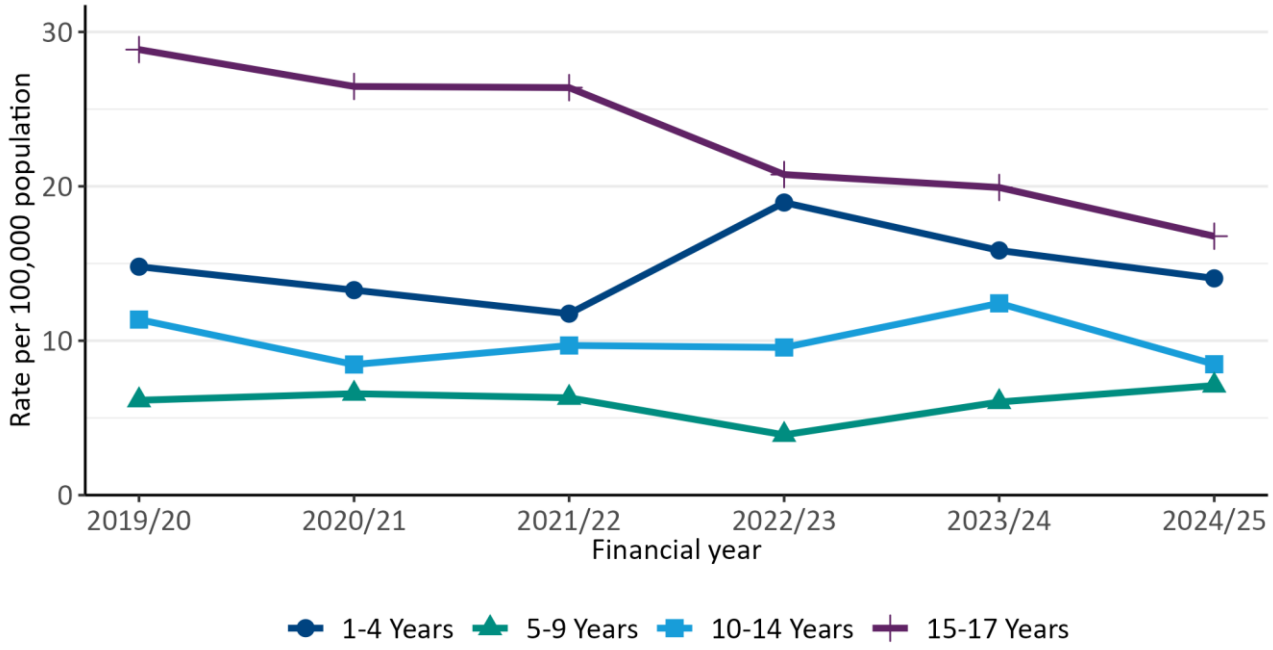
Figure 2.1: Rate of neonatal and infant deaths by financial year



Source: National Records of Scotland vital events

For children aged between 1-17 years the highest death rates continue to be seen for older children aged between 15-17 years (17 per 100,000 population), though this rate has been steadily falling over five years. The death rate in children aged between 1-4 years fell again in 2024/25 after increasing in 2022/23. Death rates for both 5-9 years and 10-14 years have remained relatively consistent over five years (Figure 2.2).

Figure 2.2: Rate of child deaths by age group and financial year

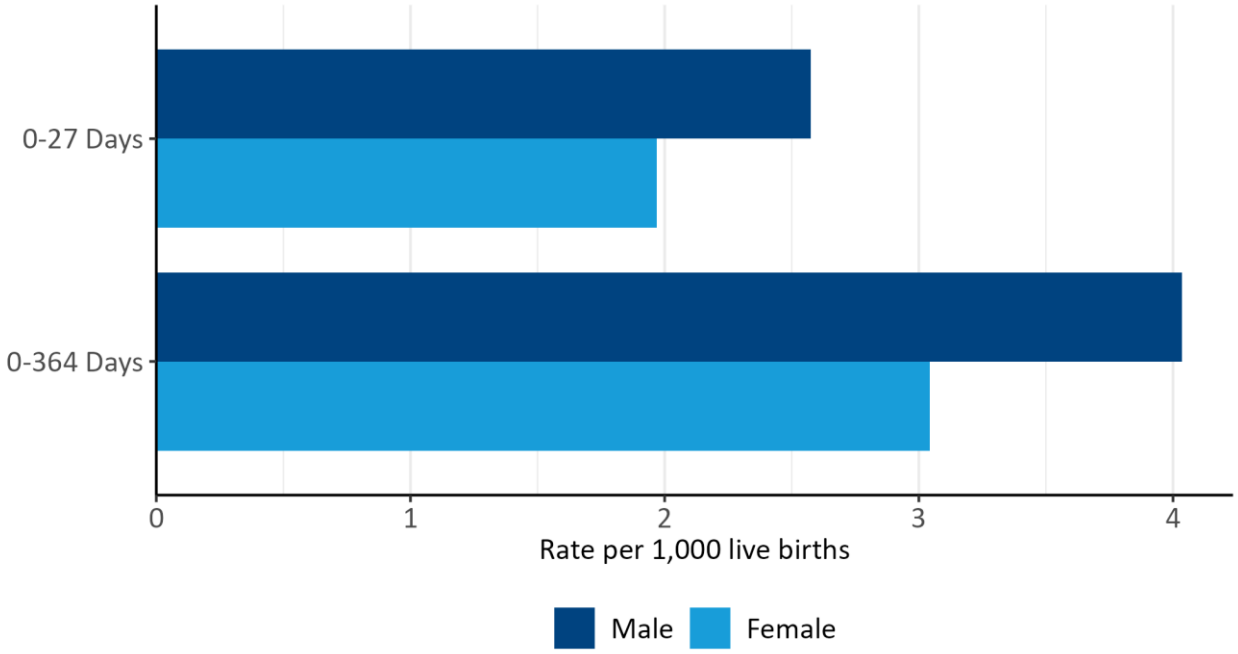


Source: National Records of Scotland vital events and mid-year population estimates

Age and sex

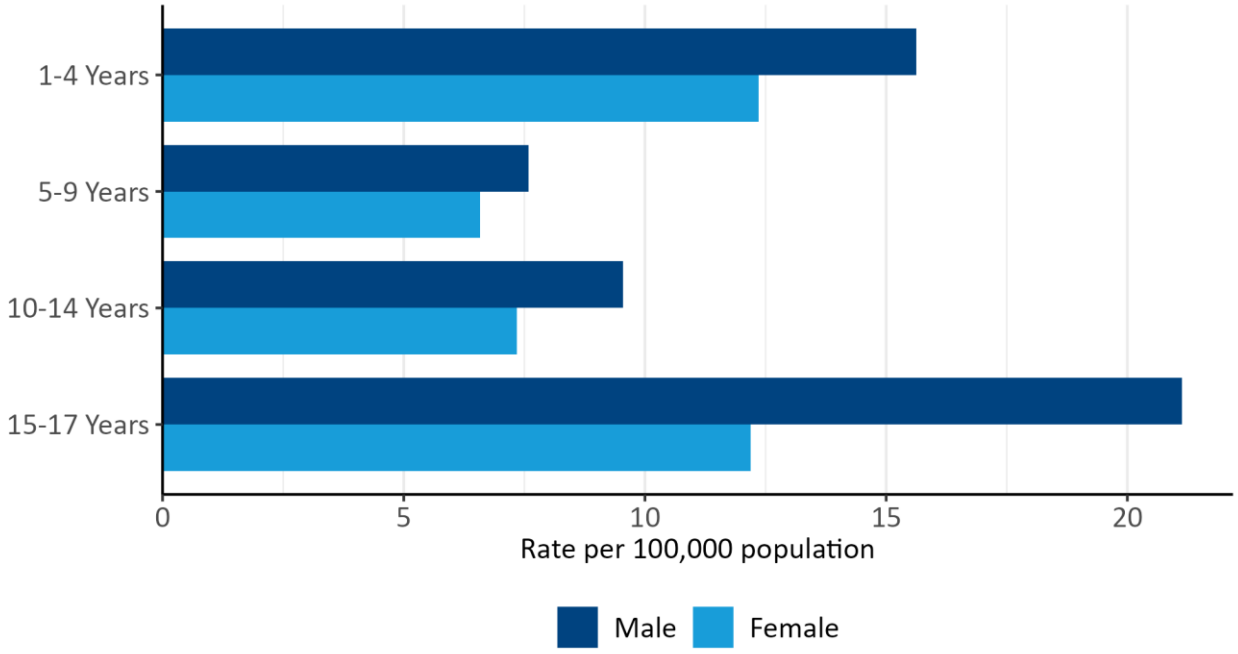
Rates varied between males and females within age groups. In 2024/25, males had a higher rate of death in all age groups. The biggest difference being between males and females in the 15-17 years age group where the male rate is nearly twice that for females (Figures 2.3 and 2.4). However, this difference in gender rates has decreased from last year where rates of deaths in males were more than five times higher than the rate of female deaths for this age group.

Figure 2.3: Rate of neonatal and infant deaths by age group and sex in 2024/25



Source: National Records of Scotland vital events

Figure 2.4: Rate of child deaths by age group and sex in 2024/25

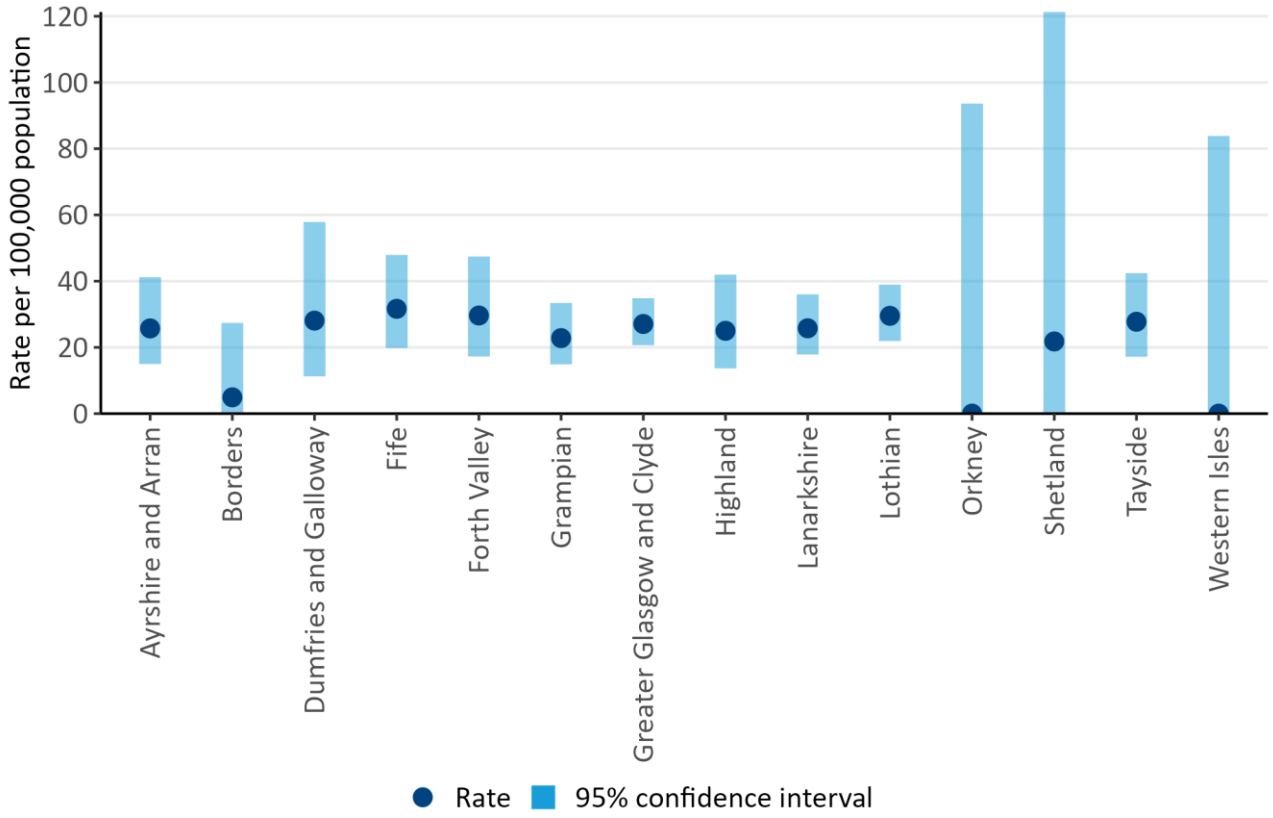


Source: National Records of Scotland vital events and mid-year population estimates

Area of residence

In 2024/25, the rate of child deaths by NHS board of residence ranged from 0-32 per 100,000 population aged between 0-17 years (Figure 2.5). Confidence intervals show the range in which rates could have occurred by chance and must be considered when comparing rates for different areas, particularly areas with smaller populations. The variation in rates could also be partially due to areas having different populations. For example, some areas have higher levels of deprivation which is linked to higher child mortality.

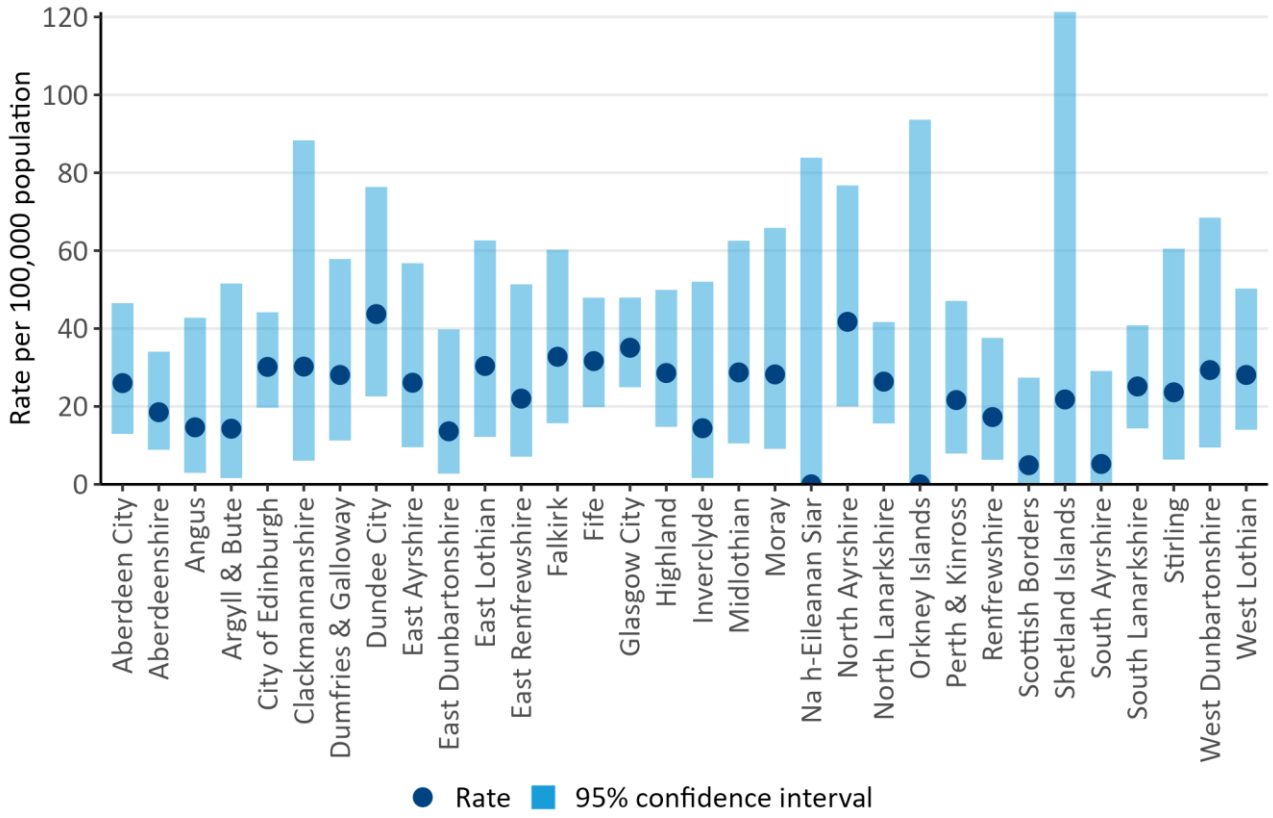
Figure 2.5: Rate of child deaths per 100,000 population by NHS board of residence for 2024/25, with 95% confidence intervals



Source: National Records of Scotland vital events and mid-year population estimates

The child death rate by local authority of residence ranged from 0-44 per 100,000 population aged between 0-17 years (Figure 2.6).

Figure 2.6: Rate of child deaths per 100,000 population by local authority of residence for 2024/25, with 95% confidence intervals

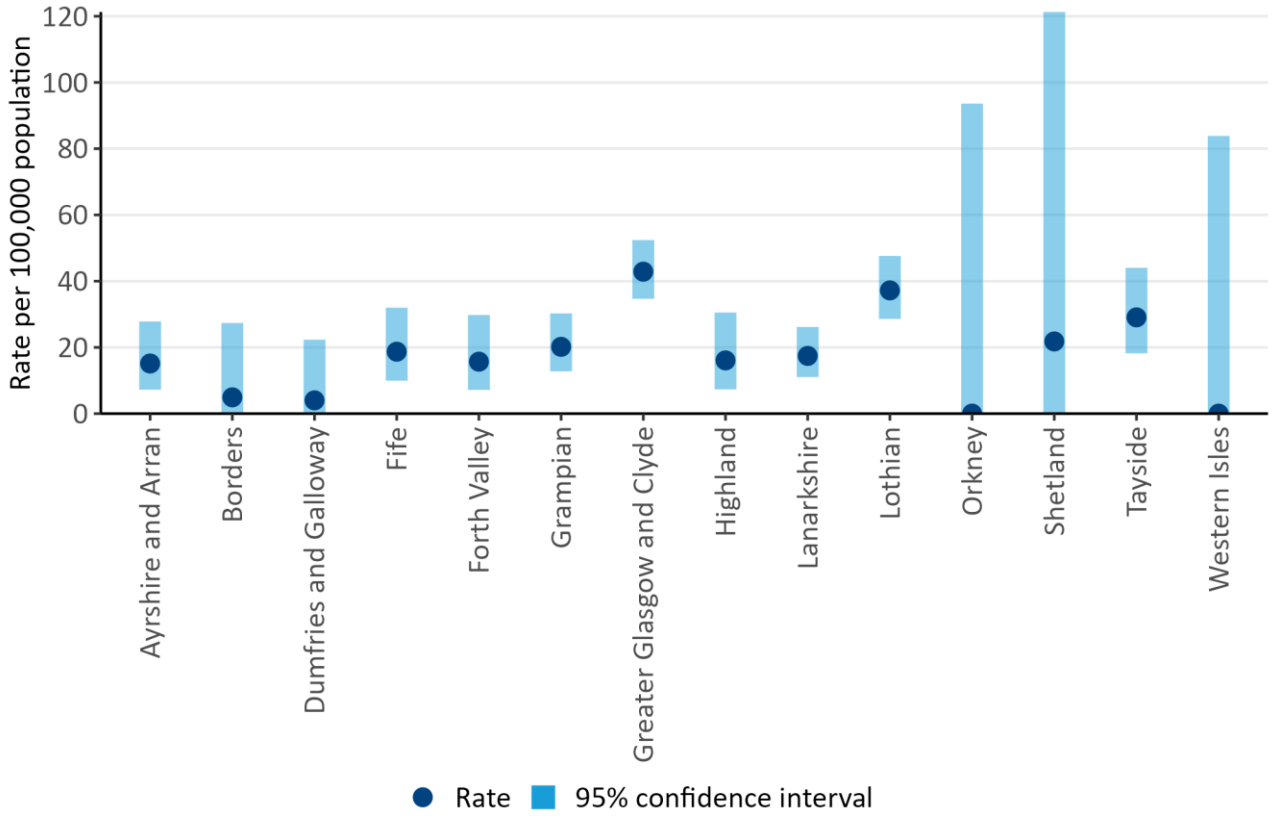


Source: National Records of Scotland vital events and mid-year population estimates

Area of death

When based on location of death, the child death rate varied from 0-43 per 100,000 population for NHS boards (Figure 2.7). NHS boards with large specialist hospitals have some of the highest child death rates when based on the area where the death occurred. Similarly, there is an increase in occurrence in regions where children's hospices are located. These results are expected as areas with specialist care facilities receive more critically unwell children from across Scotland.

Figure 2.7: Rate of child deaths per 100,000 population by NHS board of death for 2024/25, with 95% confidence intervals



Source: National Records of Scotland vital events and mid-year population estimates

Cause of death

NRS codes each death for underlying cause using the *International Classification of Diseases 10th revision (ICD-10)* from information available on the death certificate. Deaths that require further investigation as to the cause of death are often initially coded as 'sudden unexpected, unexplained death' then later updated with a confirmed cause of death. Data from 1 January to 31 March 2025 used in this report have not yet been updated with confirmed cause of death.

Deaths in children aged between 0-17 years were most commonly due to a 'perinatal or neonatal event' (n=99; 37%), due to the largest proportion of deaths occurring in the neonatal period. The

second highest number of deaths were due to 'Sudden unexpected, unexplained death' (n=43; 16%) (Figure 2.8). This is comparable to data reporting for the year 2023/24 (32% and 20% respectively).

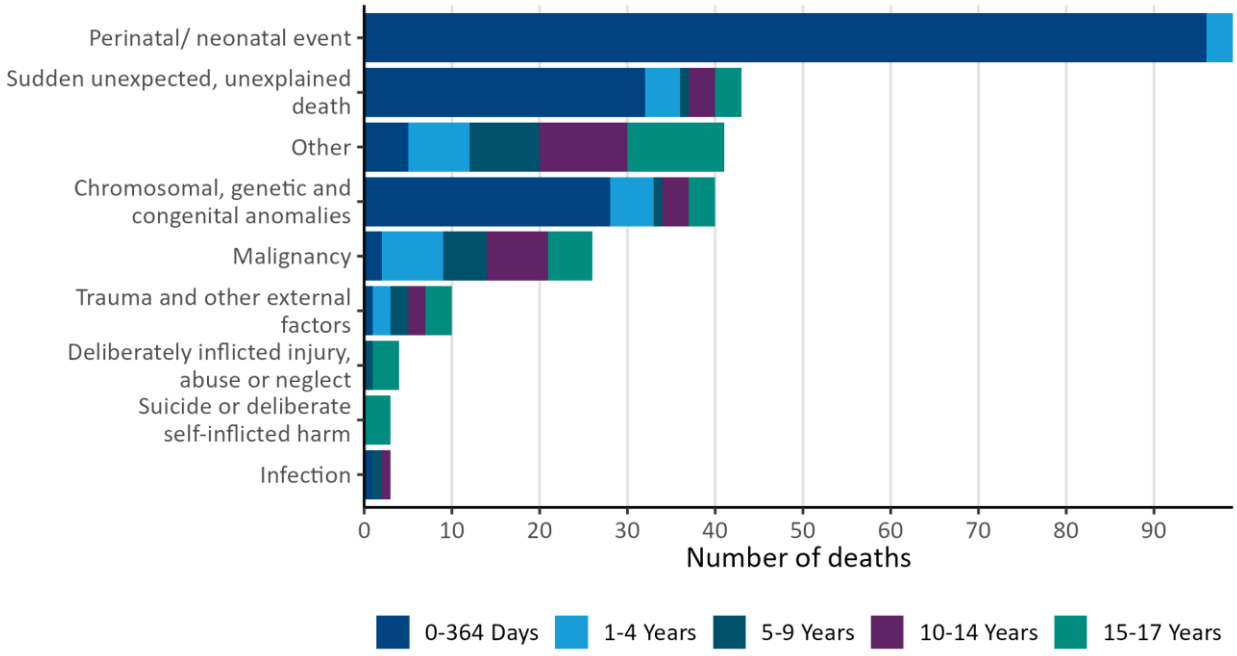
The most common causes of death for each age group were:

- 'Perinatal/neonatal event' - for children aged under 1.
- 'Malignancy' and 'Other'* - for children aged between 1-4 years.
- 'Other'* - for children aged between 5-9 years.
- 'Other'* - for children aged between 10-14 years, and
- 'Other' - for children aged between 15-17 years.

** 'Other' currently includes acute medical or surgical conditions, and chronic medical conditions including but not exclusively; asthma, diabetic ketoacidosis, intracranial haemorrhage, appendicitis, liver disease and immune deficiencies.*

Further information on the ICD-10 codes used for these causes of death groupings can be found in the accompanying data tables.

Figure 2.8: Number of child deaths by cause and age group 2024/25

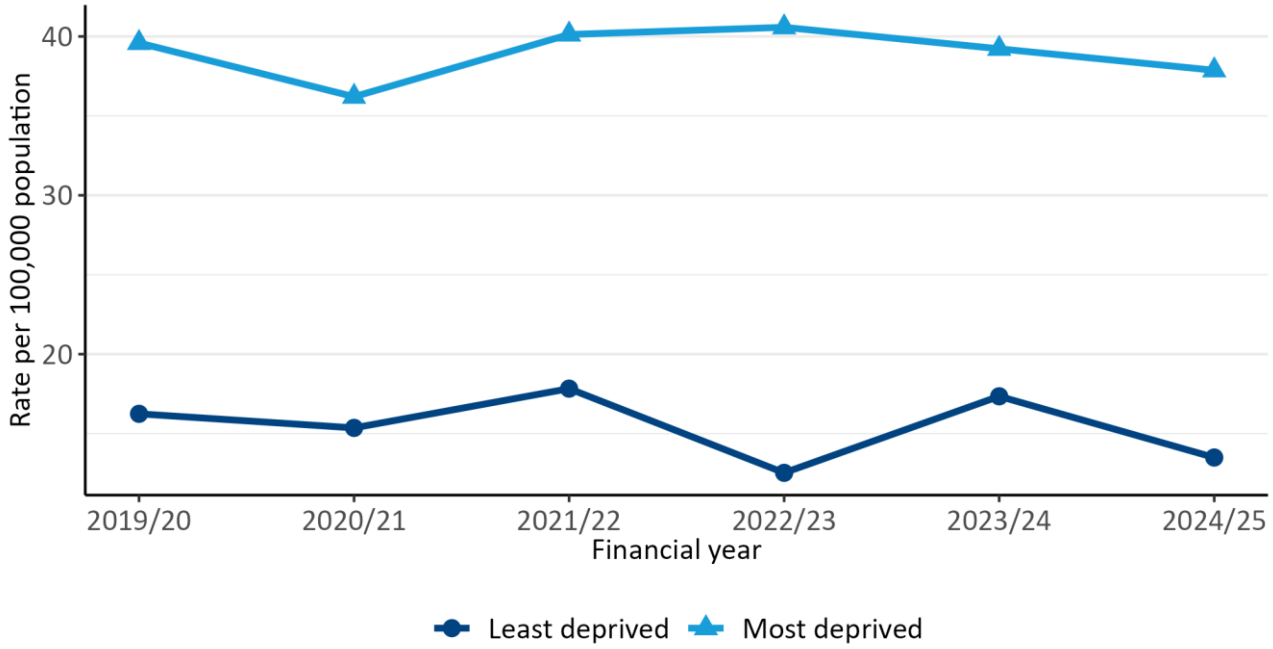


Source: National Records of Scotland vital events

Deprivation

The rate of deaths has remained highest for children living in the most deprived areas of Scotland. In 2024/25, the gap between least and most deprived remains similar to previous years (Figure 2.9).

Figure 2.9: Rate of deaths for the most and least deprived areas by financial years



Source: National Records of Scotland vital events and mid-year population estimates

Ethnicity

The recording of ethnicity information in data about deaths of children aged between 0-17 years was around 76% in 2024/25, with the remaining not provided. This is a small improvement on the previous year (70% in 2023/24) but not yet sufficient to make analysis of child deaths by ethnicity reliable, especially for less common ethnic groups. Recording of ethnicity is not consistent across all age groups, with information reported for under ones being considerably lower than older age groups.

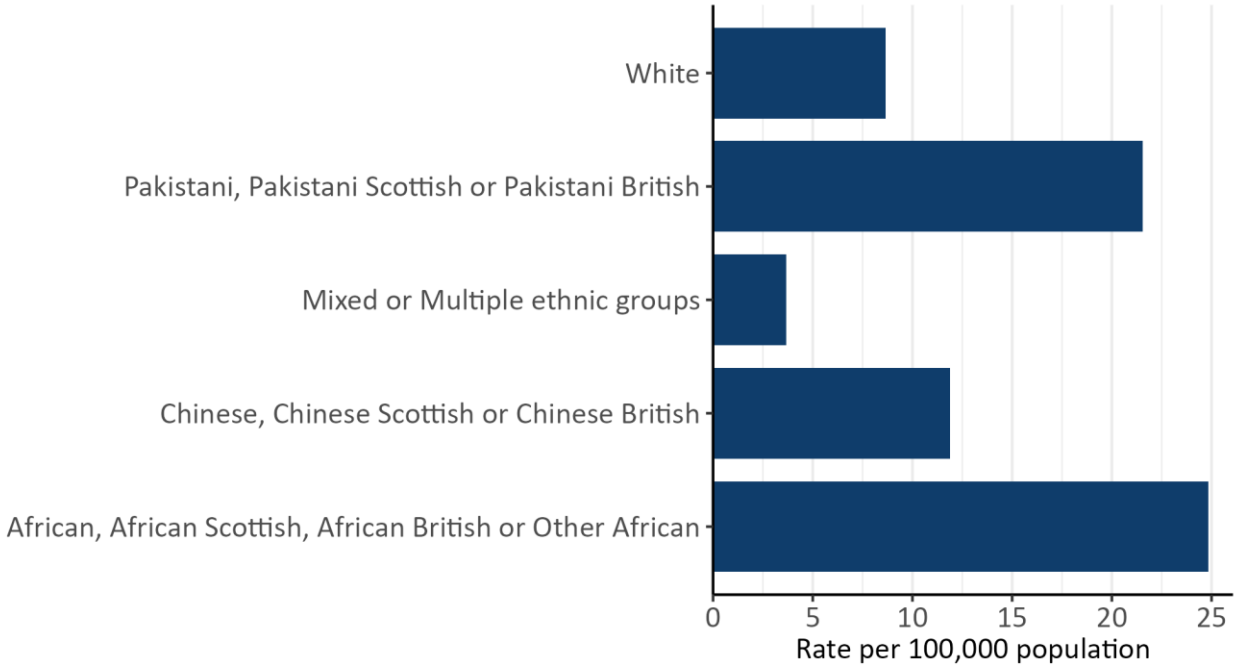
Recording of ethnicity was more notably improved in children aged 1-17 years, with ethnic group recording up from 76% in 2023/24 to 85% in 2024/25. Scotland's child deaths rates in 2024/25 were highest for children born to African, African Scottish, African British or African Other (25 per 100,000 population) and Pakistani, Pakistani Scottish or Pakistani British (22 per 100,000 population) mothers (Figure 2.10).

Due to this being the first time that the National Hub has published data relating to ethnicity, there is no previous publication that allows for a Scottish data comparison.

The National Child Mortality Database (NCMD[4]) publishes a data release relating to child deaths in England and has recently reported deaths by ethnicity at a similar rate to Scotland for white children (11.2 per 100,000 in 2024, 10.7 per 100,000 in 2025).

The Office of National Statistics (ONS), which provides data on ethnicity to NCMD, groups ethnic minorities differently from the National Records of Scotland (NRS). The NCMD reports the rate of deaths in *Asian or Asian British* populations, while NRS reports *Pakistani, Pakistani Scottish or Pakistani British* and *Chinese, Chinese Scottish* or *Chinese British* separately. This makes drawing comparisons between the two datasets less reliable. Similarly, the NCMD reports rates for *Black, Black British, Caribbean* or *African* populations compared to the categories *African, African Scottish, African British* or *African Other* populations reported by NRS.

Figure 2.10: Rate of death by ethnic group in children aged 1-17 years 2024/25



Source: National Records of Scotland vital events and 2022 census population estimates

[4] https://www.ncmd.info/

Child death reviews for children under 18 years

Between 1 October 2021 and 31 March 2025, NRS notified the National Hub of 1,007 children under the age of 18 who died in Scotland. The National Hub also received notification of an additional 21 deaths of Scottish children who died outside of Scotland.

Of the 1,028 child death notifications, 51 were removed as they did not meet the National Hub criteria for a child death review, for example babies born with signs of life of less than 22 weeks' gestation, stillbirths, late foetal loss, or terminations of pregnancy carried out within the law.

Over this 3.5-year period, the National Hub has shared a total of 977 NRS child death notifications with designated child death review (CDR) leads in NHS boards and local authorities. Local area leads are responsible for carrying out, or with partners, commissioning, reviews into the circumstances surrounding the child's death and submitting the outcomes in the form of a core review dataset (CRDS) to the National Hub.

Whilst the previous section of this release considers NRS data between April 2019 and March 2025, this section summarises initial findings from core review datasets for children and young people who died between 1 October 2021 and 31 March 2025. It provides cumulative information over this period and begins to offer some insight into the lives and deaths of children and young people as revealed by their individual reviews.

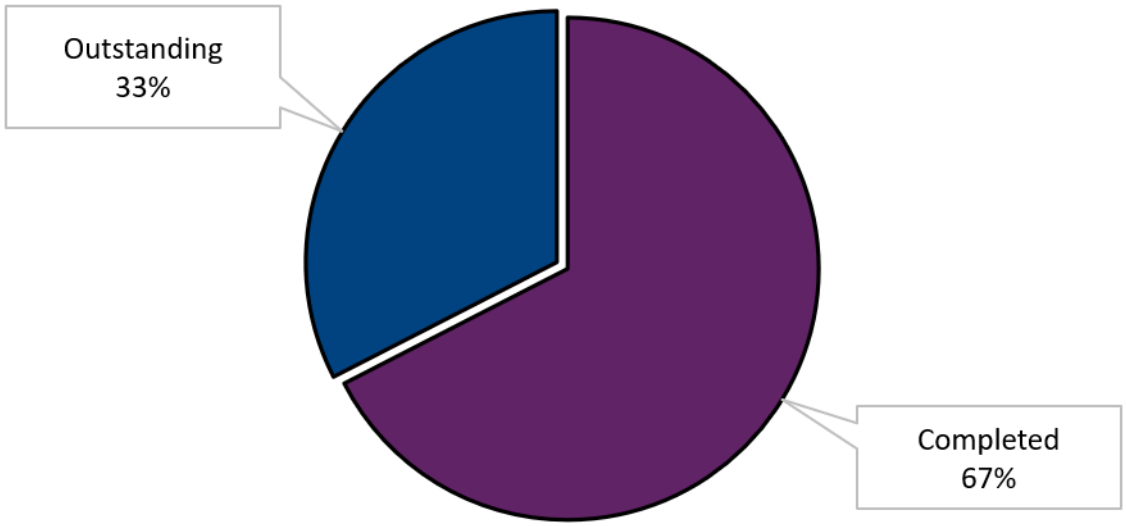
Core review datasets (CRDS)

As part of the child death review process, outcomes of child death reviews are submitted to the National Hub in a standardised core review dataset[5] or CRDS. As of 1 April 2025, CRDS have been completed and uploaded to the National Hub's online reporting portal for 659 (67%) of the 977 deaths of children aged under 18 that met the child death review criteria (Figure 3.1). The figures in this section are based on those completed reviews.

There has been a relative increase from 50% completed CRDS (n=361/724) from results published in the National Hub 2025 data release.

[5] https://www.healthcareimprovementscotland.scot/publications/core-review-data-set-forms-and-guidance/

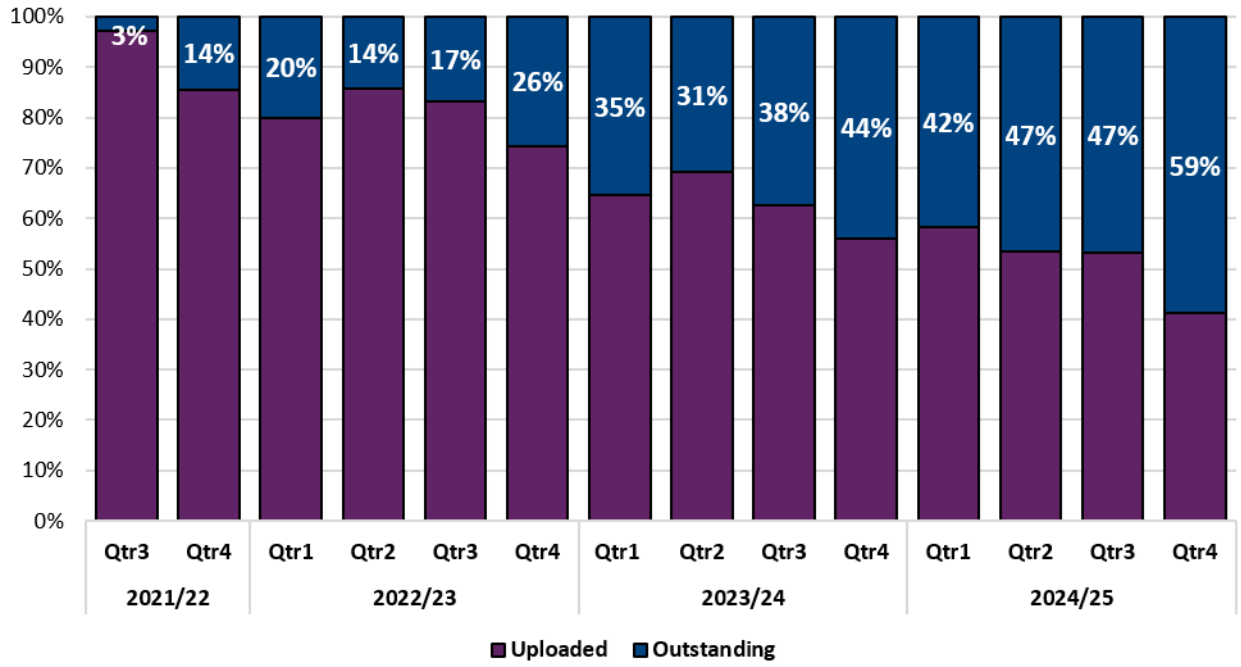
Figure 3.1: Proportion of completed vs outstanding CRDSs uploaded to the online reporting portal



From the 140 child deaths recorded in the partial data collection period October 2021 to March 2022, CRDS have been completed for 128 (91%). This completion percentage decreases to 80% (n=218) in 2022/23 and 63% (n=180) in 2023/24 and 51% (n=133) for deaths in 2024/25 (Figure 3.2).

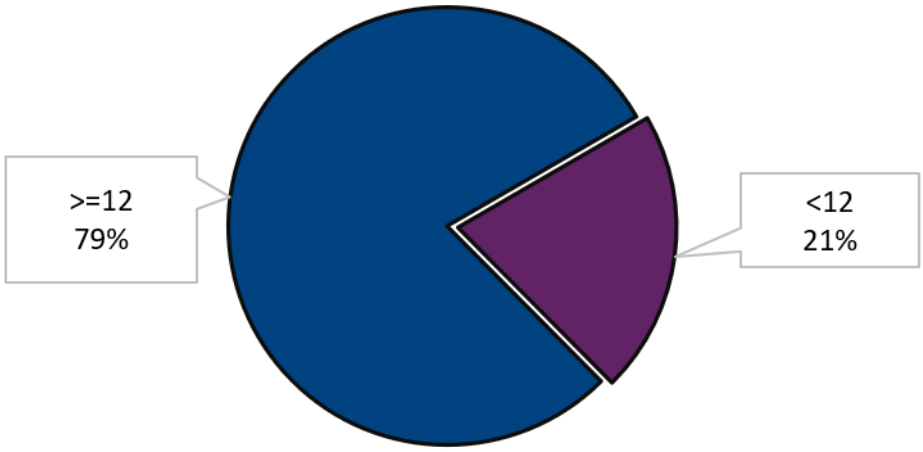
The lower numbers of total child deaths recorded for the data collection period 2021/22 is reflective of the National Hub being launched on 1 October 2021. Therefore, data was collected from only the last two quarters of that financial year.

Figure 3.2: Proportion of completed CRDSs by financial year and quarter



Of the 659 completed CRDS, 21% (n=137) were uploaded to the portal within 12 months of the death occurring (Figure 3.3). This result is similar to that published in the 2025 data release (23% uploaded within 12 months).

Figure 3.3: Proportion of CRDS completed within 12 months

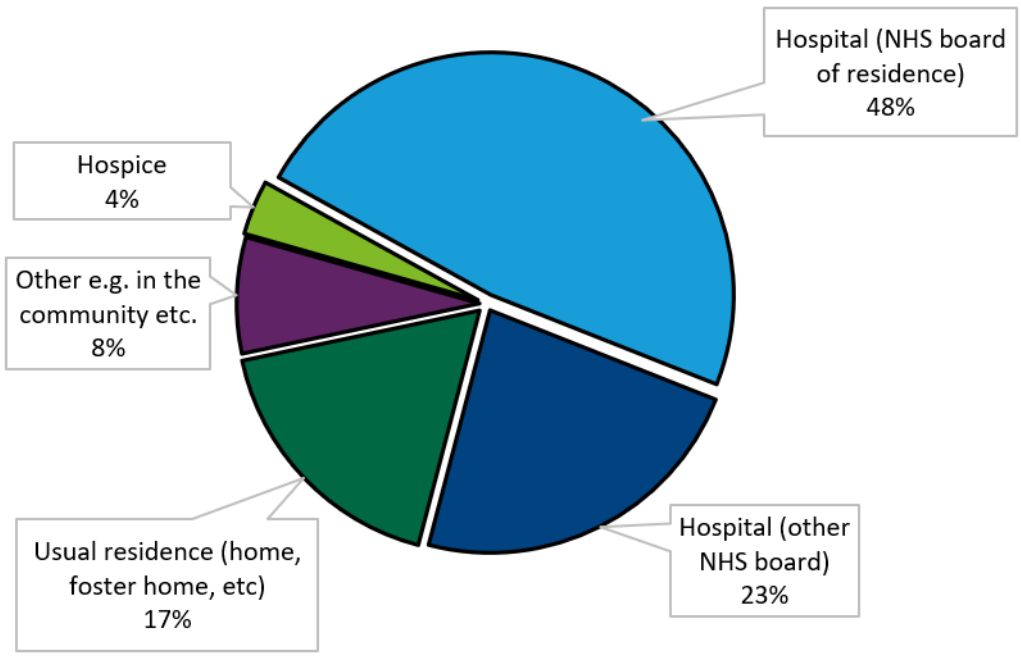


Location of death

Just under half of the CRDS completed were for individuals who died at a hospital in their board of residence (48%, n=316). Almost a quarter (23%, n=152) were for deaths that happened in a hospital in another health board, 17% (n=116) were within their usual residence, 8% (n=51) in "other" locations that include the community, in transit or outside of Scotland, and 4% (n=24) in a hospice (Figure 3.4).

These figures are in keeping with those reported in the National Hub 2025 data release.

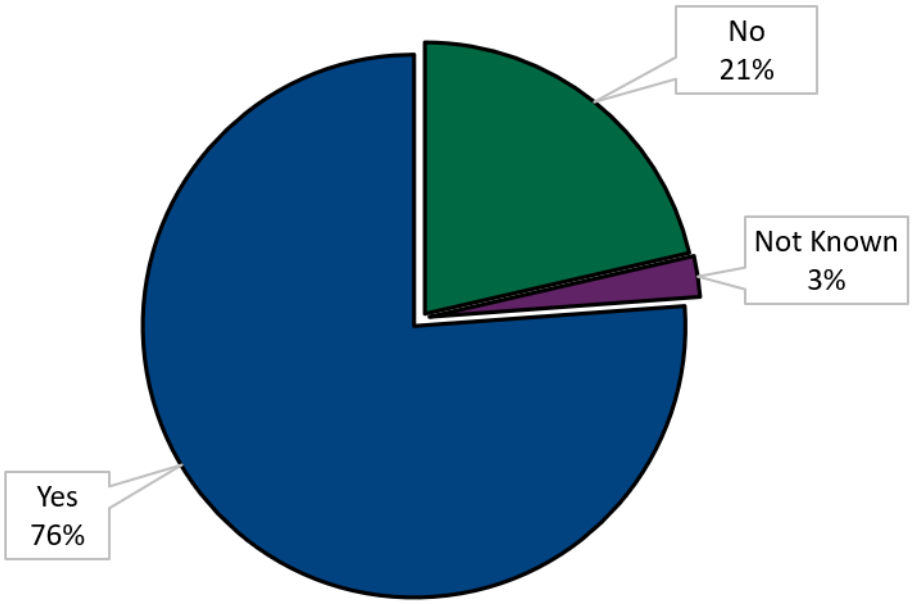
Figure 3.4: Location of child or young person when they died



Informing families and carers

Families and carers were notified about the intention to complete a review in 76% of instances (n=502). In 16 cases (3%) it was not recorded whether family had been notified or not (Figure 3.5). These results have not changed from those published in the National Hub data release 2025.

Figure 3.5: Proportion of families and carers informed of their child's review

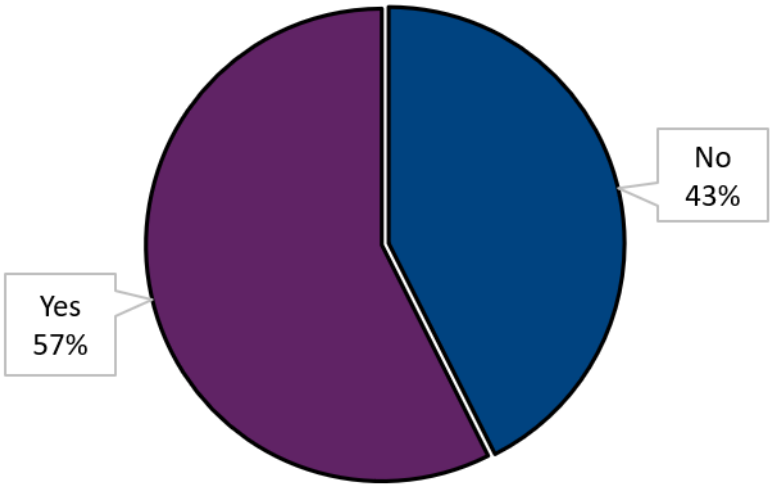


Expected and unexpected deaths

From the 659 completed CRDS, the death was expected in 57% (n=378) of cases (Figure 3.6).

These results have not changed from those published in the National Hub data release 2025.

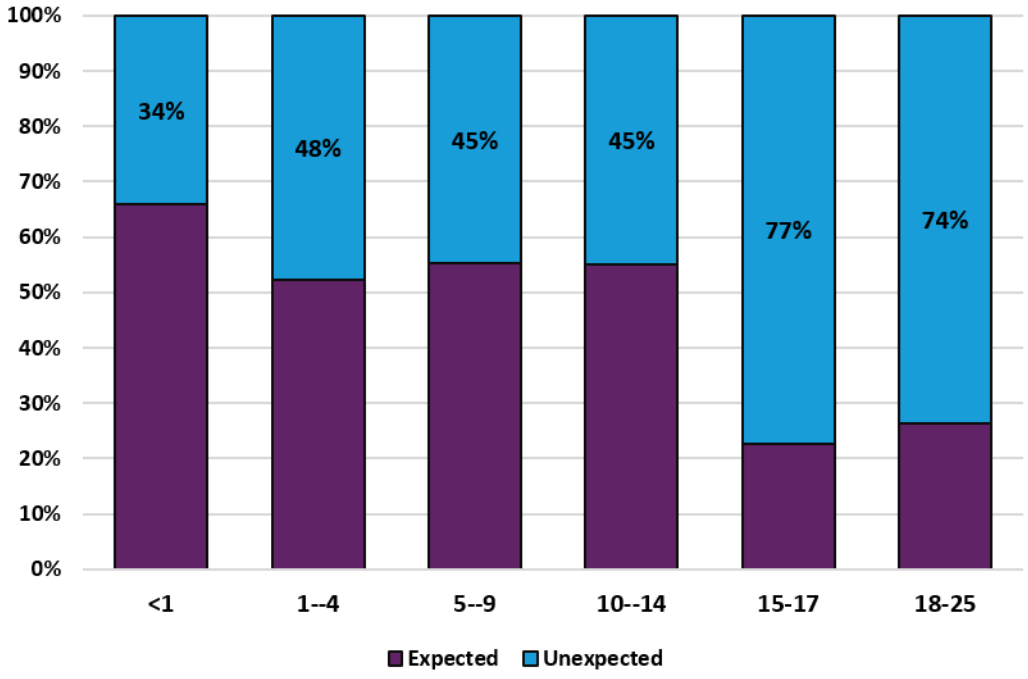
Figure 3.6: Proportion of CRDS that indicated whether the death was expected at the time



The proportion of unexpected deaths increased as age increases, from 34% of deaths for under 1-year olds being unexpected, 45-48% of those aged 1-4, 5-9 and 10-14, 77% of 15-17-year-olds and 74% of 18-25-year-olds (Figure 3.7).

There have been small increases in the proportion of unexpected deaths in most age groups in comparison to data published last year with the exception of the 15-17 and 18-25 years age groups which reduced from 81% to 77% and 89% to 74% respectively.

Figure 3.7: Proportion of expected and unexpected deaths, by age group



Category of death

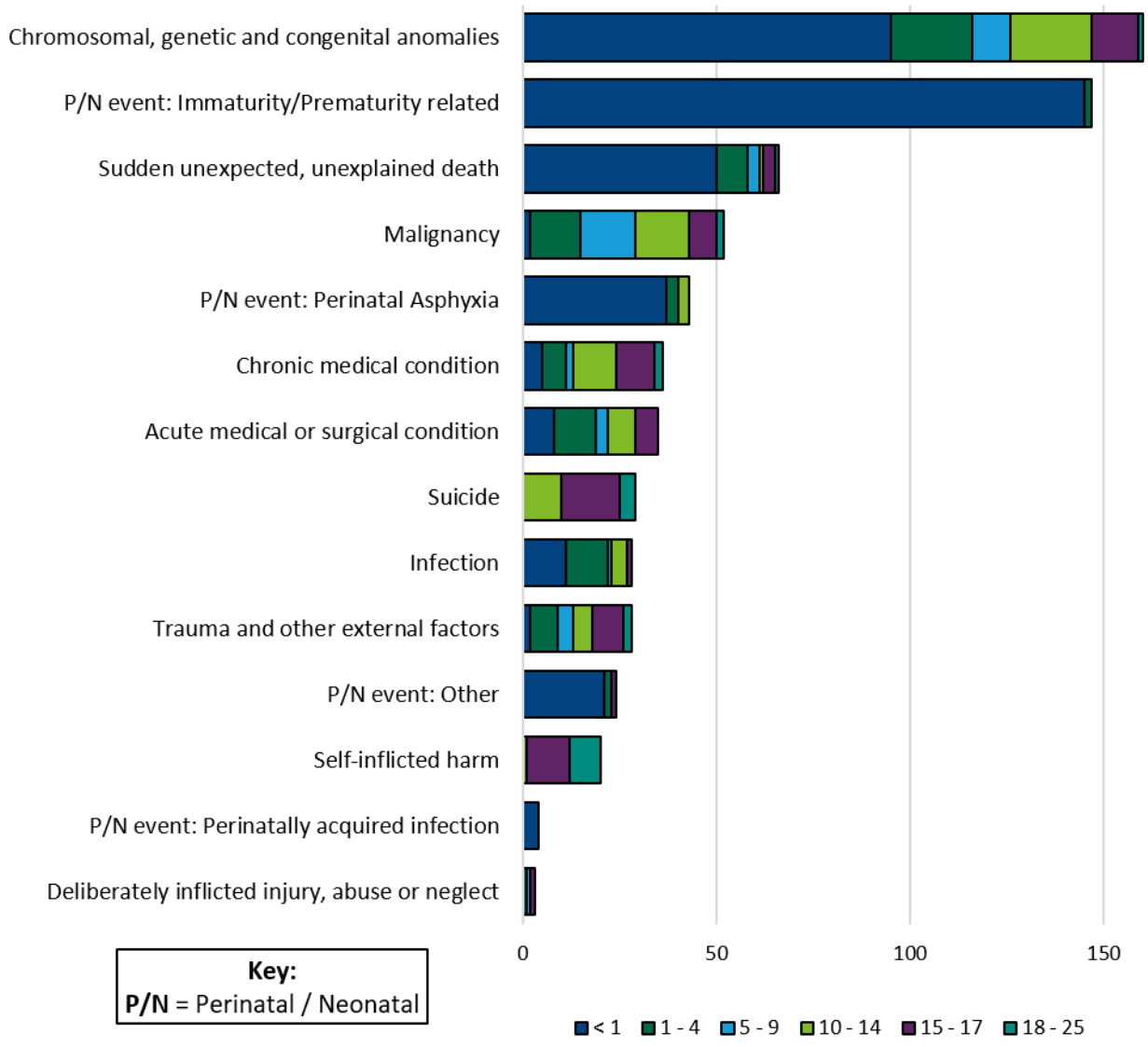
As part of the review process, the review team categorises why the child died. These categories are based on the National Child Mortality Database (NCMD) *Category of Death: Clarification* [6](2021) to allow future national comparisons.

The most common category of death between October 2021, and March 2025 based on returned CRDS was *Chromosomal, genetic and congenital anomalies* (24%, n=160*).* This was followed by *Perinatal/Neonatal Event: Immaturity/Prematurity related,* which accounted for 38% of all deaths for children under 1 year old, and 22% (n=147) of total deaths. This was followed by *Sudden unexpected, unexplained death* (10%, n=67) and *Malignancy* (8%, n=52) (Figure 3.8).

[6] NCMD Category of death: Clarifications https://www.ncmd.info/guidance/categoryofdeath/

In the National Hub data release 2025, *Perinatal/Neonatal events: Prematurity/immaturity related* was the largest category. In this report this has been exceeded *by Chromosomal, genetic and congenital anomaly* deaths.

Figure 3.8: Categories of death, by age group

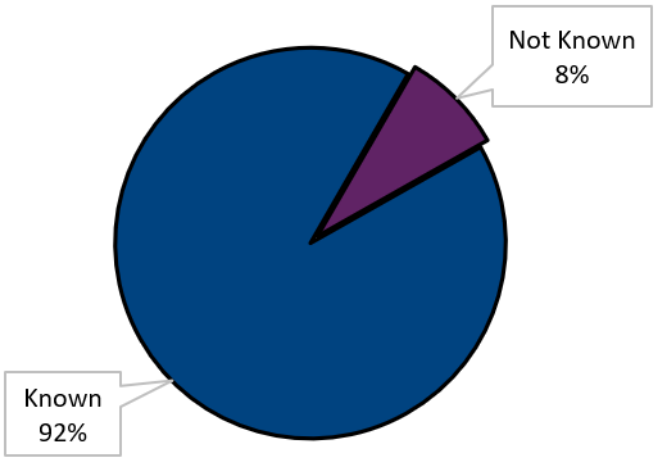


Ethnicity

From the 659 completed CRDS, 92% (n=603) reported the ethnicity of the child or young person. The highest population within this number was *White Scottish* (68%, n=448) and 8% (n=56) of completed CRDS reported ethnicity as *Not known* (Figure 3.9).

The percentage of CRDS that contain information relating to ethnicity has increased from 89% in the 2025 Data release to 91% in this report.

Figure 3.9: Proportion of CRDS that reported ethnicity



Review outcomes: contributory and modifiable factors

Contributory factors

The CRDS asks review teams to consider a list of intrinsic, familial, social, environmental, and service provision factors that may have contributed to the vulnerability, ill-health or death of the child or young person. For each of these contributing factors, review teams must grade the level of influence that these factors have had on the individual's death. The list of contributory factors can be found in sections 5-9 of the CRDS.

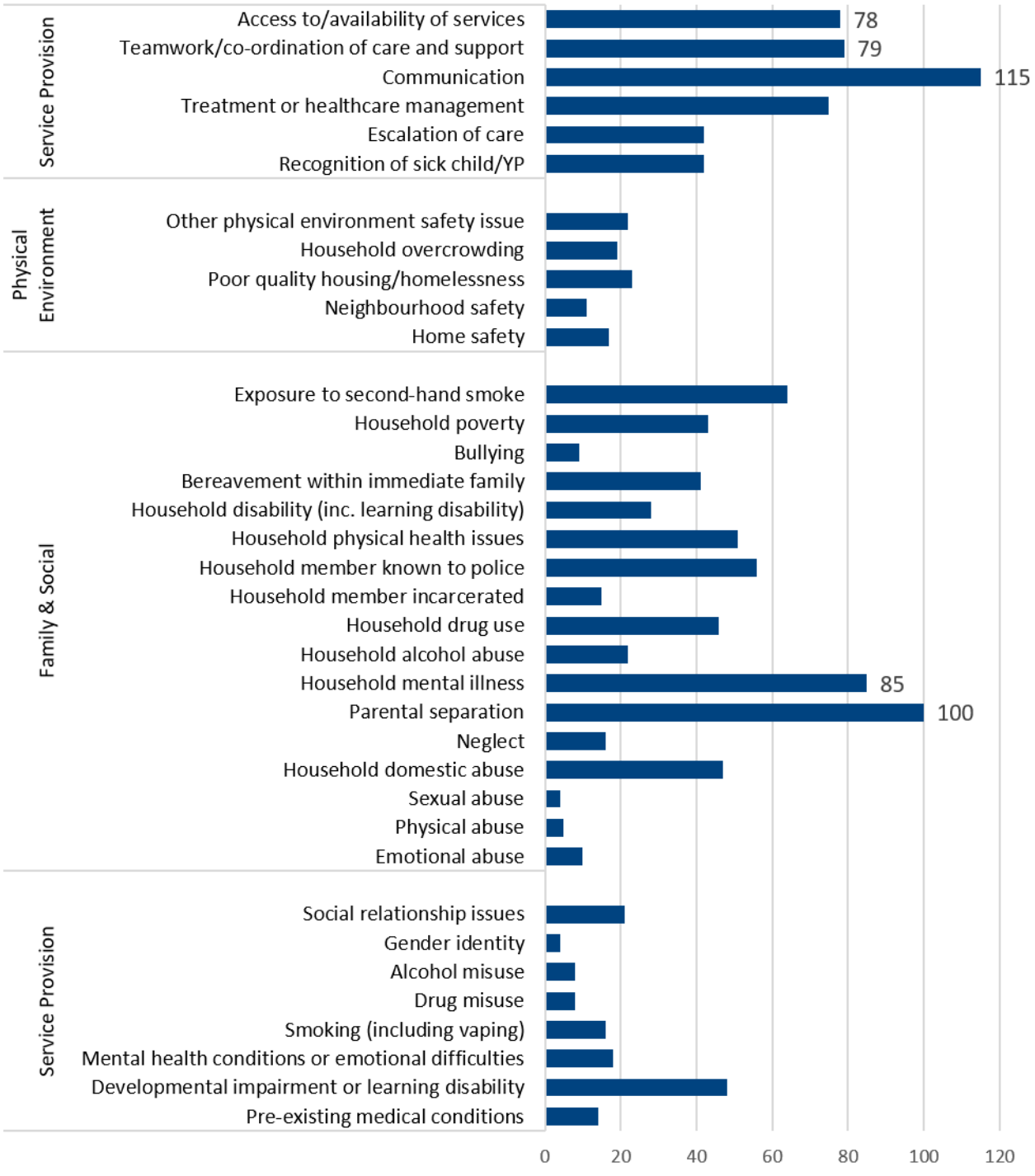
The level of influence is graded on a 4-point scale:

- 0 - information not available
- 1 - factor not identified
- 2 - factor identified but unlikely to have contributed to vulnerability, ill-health or death; or
- 3 - factor identified that may have contributed to vulnerability, ill-health or death.

Level 2 contributory factors

Level 2 factors were identified a total of 1302 times across the 659 completed CRDS. *Communication* was the most identified (n=115), followed by *parental separation* (n=100) and *household mental Illness* (n=85), *coordination of care* (n=79) and *access or availability of services* (n=78) (Figure 3.10). These results mirror those reported in our previous data release.

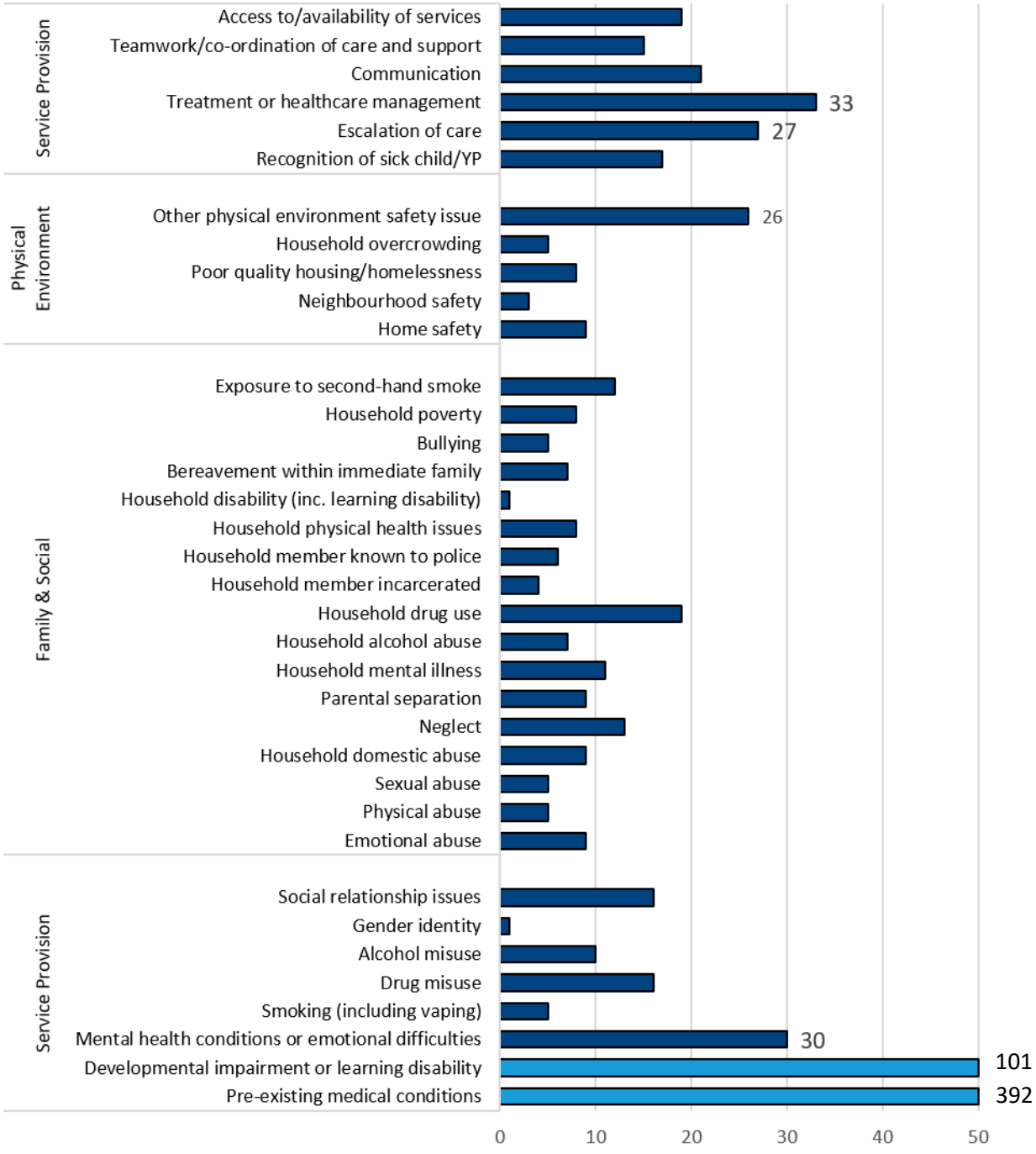
Figure 3.10: Frequency of Level 2 contributory factors in CRDS



Level 3 contributory factors

Level 3 factors were identified a total of 891 times across the 659 completed CRDS. *Pre-existing medical conditions* appeared most frequently (n=392) and followed by *developmental impairment or learning disability* (n=101). Both figures have been cropped in the graph below for readability. *Treatment and healthcare management* was identified in 33 CRDS, followed by *mental health conditions or emotional disability* (n=30) and *appropriate escalation of care* (n=27) (Figure 3.11). These results are in keeping with those reported in our previous data release.

Figure 3.11: Frequency of Level 3 contributory factors in CRDS

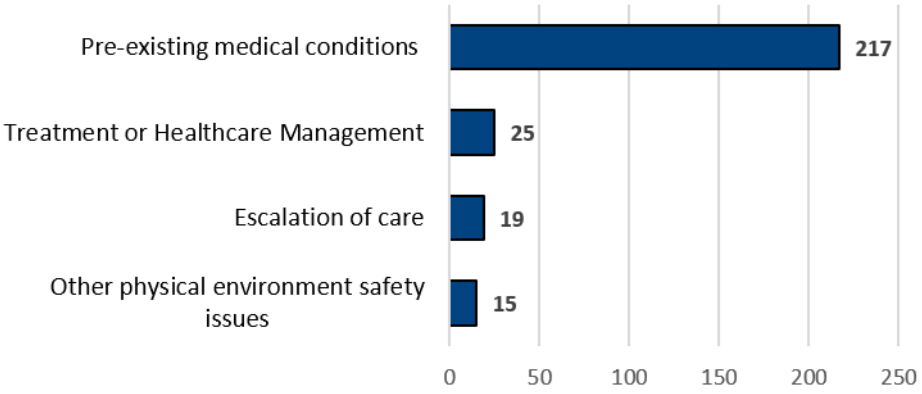


Common contributory factors

The most common recorded level 3 contributory factors of deaths in infants under one year old were *pre-existing medical conditions* (n=217), followed by *treatment or healthcare management (*n=25*) appropriate escalation of care* (n=19), and other *physical environment safety* (n=15) (Figure 3.12). The total number of deaths of under ones was 382.

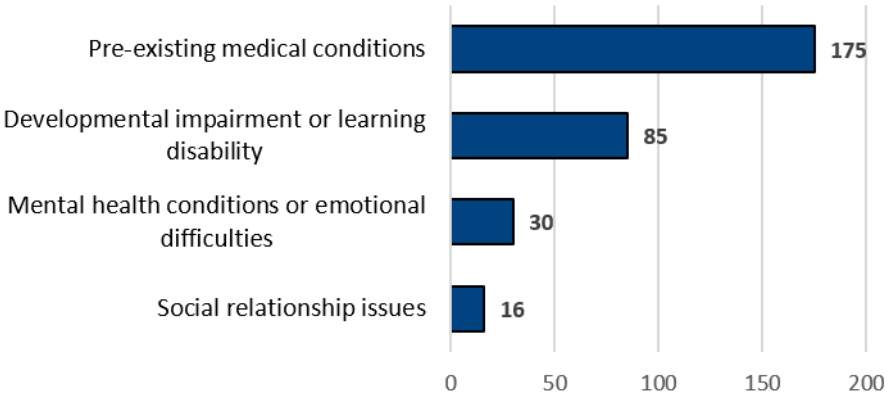
These findings are largely in keeping with those reported last year, apart from the reduction in the proportion of cases that reported *developmental impairment or learning disability*, and the increase in reporting of *other physical environmental safety.*

Figure 3.12: Most common level 3 contributory factors in under ones



The most common recorded level 3 contributory factors of children and young people aged 1-17 years was *pre-existing medical conditions* (n=175), *developmental impairment or learning disability* (n=85), *mental health or emotional difficulties* (n=30) and *social relationship issues* (n=16) (Figure 2.13). The total number of deaths of children aged 1-17 was 148.

Figure 3.13: Most common level 3 contributory factors in ages 1-17



Modifiable factors

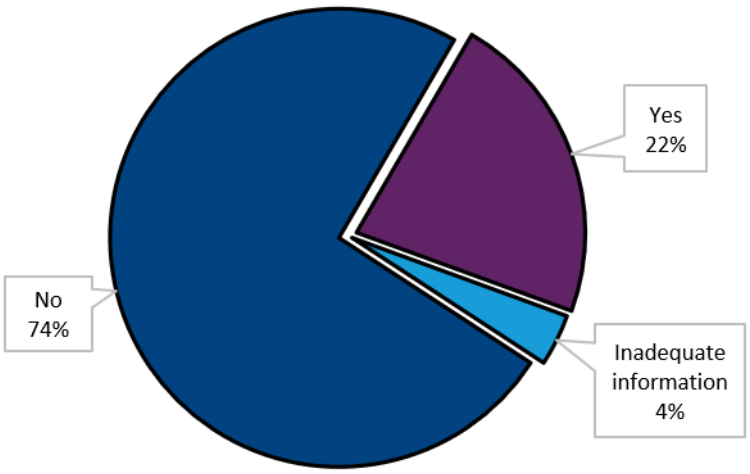
Review teams make a judgement as to whether factors have been identified which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future death of a child or young person in similar circumstances.

The presence of these modifiable factors is answered as either yes, no, or inadequate information upon which to make a judgement.

Modifiable factors were identified in 22% (n=146) of completed CRDS, the highest proportion of these being in children aged 1 and over. There was inadequate information upon which to make a judgement in 4% (n=24) of cases (Figure 3.14).

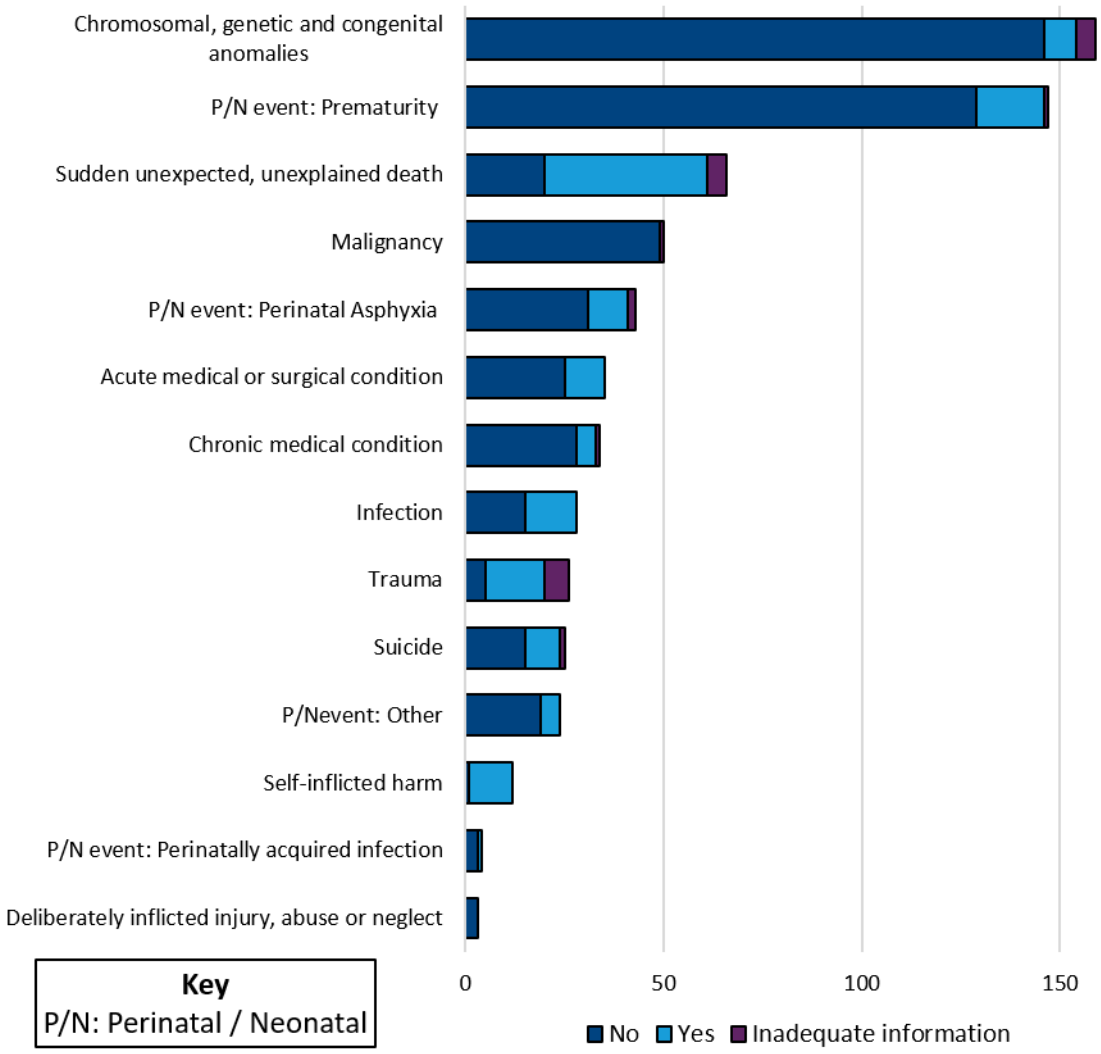
The results are in keeping with those reported in previous data releases.

Figure 3.14: Modifiable factors recorded on CRDS



Deaths categorised as *self-inflicted harm* (92%, n=11/12) had the highest number of modifiable factors followed by *sudden unexpected, unexplained deaths* (62%, n=41/66), *trauma and other external factors* (58%, n=15/26) and *infection* (n=13/28 46%) (Figure 3.15). These results mirror those reported in our previous data release.

Figure 3.15: Modifiable factors by category of death



Deaths of 'looked after' children and young people receiving continuing care or aftercare services

The National Hub is committed to ensuring the learning from all child deaths contributes to Scotland's aim of implementing the promise [7] by 2030.

Many children have experiences which result in the need for extra care, support or protection from statutory agencies and third sector organisations. 'Looked after' children are defined as those in the care of their local authority. They may be 'looked after at home' (living with a parent in their own home), or 'looked after away from home' (living with kinship carers, foster carers, or in residential or secure care).

In Scotland, all children living with foster carers, kinship carers or in residential care on or after their 16th birthday are entitled to remain in the same place with their same carers up until their 21st birthday (continuing care), or they can request advice, guidance and assistance, or aftercare support from their local authority, up to the age of 26 years.

The most recent published statistics [8] indicate that on 31 July 2025;

- 11,824 children were 'looked after', compared to 11,780 on 31 July 2024, and down 23% since 2014/15 (n=15,400). The rate of children 'looked after' per 1,000 children slightly increased to 11.8 in 2025 from 11.6 per 1,000 children in 2024. This represents a marginal rise since the previous year, up to which there had been a steady decline since a peak in 2011.
- 1,155 young people were in continuing care, 23% of those who were eligible for continuing care at the time of ceasing to be looked after (n=4,927). This is a similar proportion to the previous year when 22% of those eligible were in continuing care (n=1,115).
- An estimated 9,386 young people were eligible for aftercare services with 4,545 (48%) receiving them. This compares to a revised estimate of 51% for the previous year.

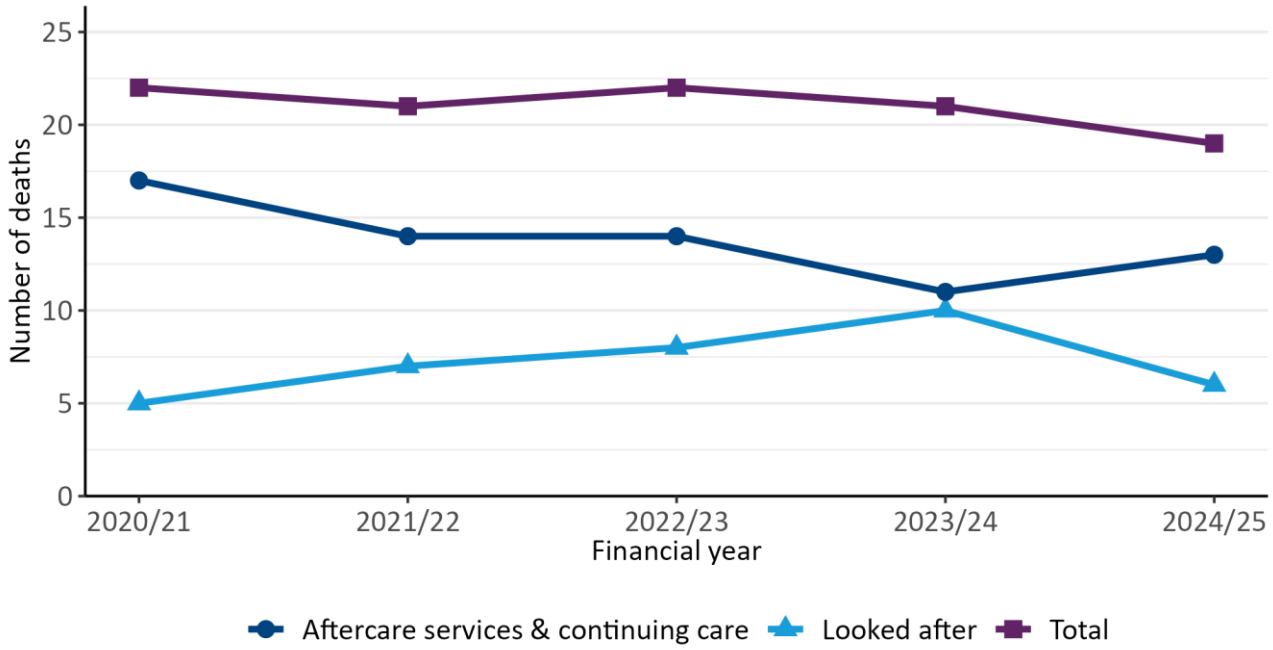
There is a statutory requirement for local authorities to notify the Care Inspectorate and Scottish Government of the death of a looked after child or young person in receipt of continuing care or aftercare services. Care Inspectorate notification data has been used to inform this section of the data release.

[7] https://thepromise.scot/

[8] Children's social Work Statistics: Looked After Children 2024-25. https://www.gov.scot/publications/childrens-social-work-statistics-looked-after-children-2024-25/

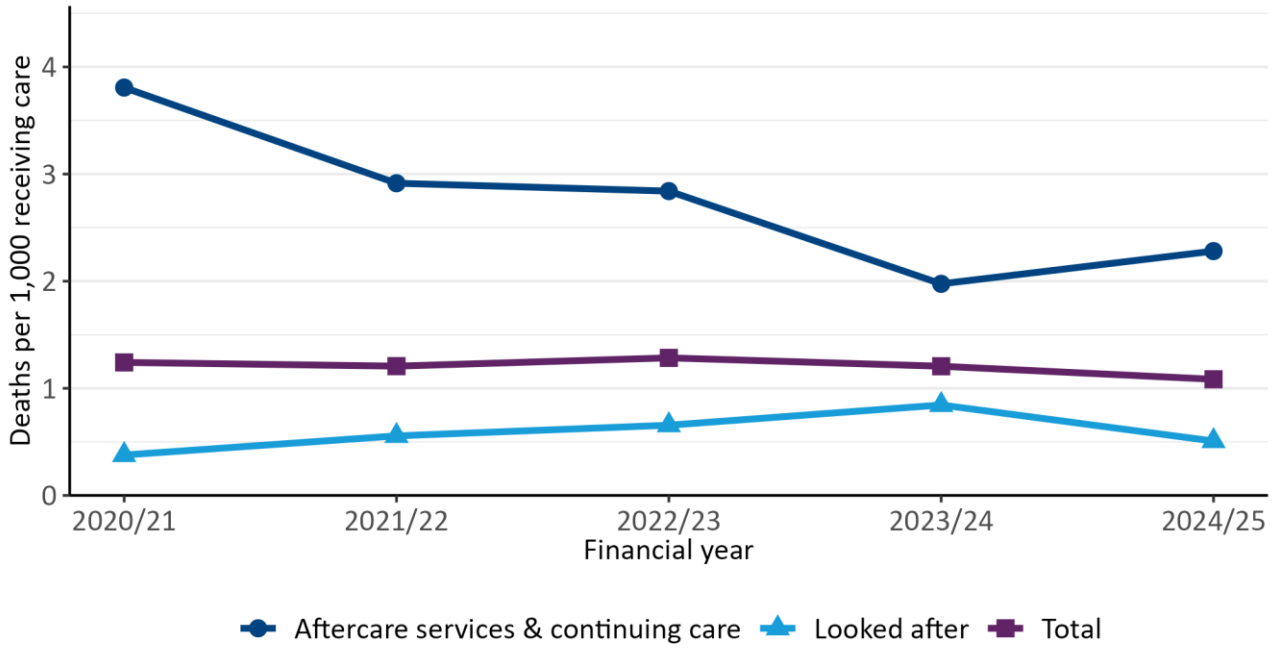
Throughout the five-year period from April 2020 to March 2025, the total number of deaths across all care groups has remained consistent, with some very minor fluctuations in the data (Figure 4.1). During this period, the Care Inspectorate received notifications of the deaths of 36 'looked after' children and 69 young people who were receiving a continuing care placement or aftercare services. This equates to a rate of 0.58 per 1,000 looked after children and 2.71 per 1,000 young people in receipt of continuing care or aftercare services (Figure 4.2).

Figure 4.1: Number of deaths of looked after children and young people in receipt of continuing care and aftercare services, 2020/21 to 2024/25



Source: Care Inspectorate notification of child deaths data

Figure 4.2: Rate of deaths of looked after children and young people in receipt of continuing care and aftercare services, 2020/21 to 2024/25



Source: Care Inspectorate notification data and Scottish Government Children's Social Work Statistics

During the one-year period April 2024 to March 2025, there were six deaths of 'looked after' children. Half of these deaths were reported to be due to health-related concerns such as underlying, life-limiting or complex health conditions, with the remainder unascertained or trauma-related.

The number of deaths of young people who were in receipt of continuing care or aftercare services at the time of their death remained similar to previous years, with the deaths of 13 young people during the reporting year. As with previous years, almost all (n=12) were male, with ages ranging from 17-25 years. Half of these deaths (n=7) were reported as suspected suicide or suspected drug related causes. For the remaining young people, the cause of death was reported to be due to health-related conditions or were unknown unascertained pending post-mortem examination results.

Additional information about the deaths of looked after children and young people in receipt of continuing care or aftercare provision can be found in the Care Inspectorate report Learning Reviews for children and adults in Scotland Summary Report 2025.[9]

[9] https://www.careinspectorate.scot/resources-data/publications-and-statistics/library/learning-reviews-summary-report-2025

Reviews for ‘looked after’ children and young people in receipt of continuing care or aftercare services

The National Hub examines the learning from reviews carried out following the deaths of looked after children and young people in receipt of continuing care or aftercare support.

The National Hub received core review dataset information relating to 13 (48%) of the 27 looked after children and 24 (56%) of the 43 young people aged 16-25 years in receipt of continuing care or aftercare support, who died between October 2021 and March 2025.

Full statistical analysis of dataset information was therefore not considered to be sufficiently robust at this time due to the small number of core review datasets completed for both groups of children and young people.

Next steps

The National Hub will continue to produce an annual data release, with associated data tables published on the Healthcare Improvement Scotland website. We will report on emerging themes over time, as we build richer data. These reports will focus on factors identified as having the greatest potential to influence change, as we work to meet our objectives:

- Ensure the death of every child in Scotland is subject to a quality review.
- Keep bereaved families and carers at the heart of those review processes.
- Collate, share and act upon learning from reviews to help reduce preventable deaths over time.

Having full and robust data, submitted timeously is vital to identifying themes and learning to meet these aims. The National Hub would like to acknowledge the work undertaken by NHS boards, local authorities and partnerships to deliver quality child death reviews as well as their efforts to share learning from reviews. We would also like to thank them for their respective data contributions to enable this release. We will continue to engage with all our stakeholders to encourage and support timely submission of child death review data to support the objectives of the National Hub.

Find out more about the National Hub's work [10] on the Healthcare Improvement Scotland website. You can download resources for professionals involved in reviews as well as information about reviews for bereaved families and carers.

We welcome queries or feedback on this release, or any aspect of our work.

Email HIS.CDRNationalHub@nhs.scot

[10] https://www.healthcareimprovementscotland.scot/inspections-reviews-and-regulation/national-hub-for-reviewing-and-learning-from-the-deaths-of-children-and-young-people/

Resources

1. Vital Events Reference Tables 2024 - National Records of Scotland (NRS)
2. National Hub for reviewing and learning from the deaths of children and young people
3. National Hub's National guidance when a child or young person dies (October 2021)
4. National Hub's Core review data set guidance (April 2026)
5. Supporting documents - Children's Social Work Statistics: Looked After Children
6. Children (Scotland) Act 1995
7. Children and Young People (Scotland) Act 2014
8. Category of death: Clarifications - National Child Mortality Database

Published June 2026

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