Factsheet 16

The Child Death Review

The overall purpose of the child death review (CDR) process is to understand why children die and put in place interventions to protect other children and prevent future deaths. It is important that every child death is reviewed, whether it was expected or unexpected.

The review is designed to support you and other members of your family in understanding why your child died. It will also try to prevent other children dying from the same cause. At the time of your child's death the process should be clearly explained to you and support offered throughout. Links to further guidance for how the process works in the four UK nations are available below.

Some child deaths are anticipated and not preventable. Families caring for a child with a life-limiting or life-threatening condition may have been supported to develop an end of life care plan for their child and have discussed who will need to be notified at the time of their child's death with a trusted professional.

Some children will die unexpectedly but, in the context of their illness, this will not be surprising. When it is anticipated that a child might die, for example a child discharged from hospital to home or children's hospice for end of life care, it can be helpful for your care team to inform the relevant agencies e.g. your child's GP, so that when your child dies, there is no confusion about the nature of the death.

The child death review process may vary depending on the particular circumstances surrounding the child's death and is different across the four UK nations.

In all areas, information about your child's death will be anonymised and a panel formed to consider this information.

The panel may consist of doctors and other health specialists and childcare professionals. They will try to ascertain what caused the death, what support and treatment was offered to the child and their family up until the death, and what support was offered to the family after the child died. It is required to consider whether there were any preventable factors that contributed to the death.

The panel decides whether there are any recommendations and actions needed to help prevent similar child deaths in the future. These recommendations are shared with local health trusts, public health departments, children's services and the police, as well as specialist agencies such as the fire service or traffic authorities in order to influence and improve services and life chances for children and families.

In some areas, a response team may be called upon to support families after a sudden unexpected death. For some families this may involve a home visit by a police officer and health professional, with the aim of gathering information to help understand the cause of death, and to ensure the family are provided with support.

All sudden, unexpected deaths of children must by law be reported to the coroner, who liaises with the police, health care professionals and social care teams in order to assess the situation and decide if a thorough investigation is necessary.

Where death is expected, this rapid response will not occur. The response team will need to consider these deaths but will not need to investigate the circumstances. Where a death is unexpected, but not surprising, a home visit will usually not be necessary. All the professionals involved in this process should ensure that children will be cared for with respect and dignity at all times.

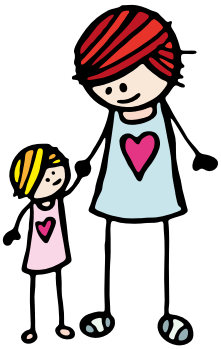
Useful guidance has been developed to inform people of the Child Death Review:

Leaflet for families: The Child Death Review in England

Webpage: Child Death Review Programme Wales

Webpage: National guidance when a child or young person dies in Scotland

Webpage: Information on the role of the Child Death Overview Panel in Northern Ireland



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