Family Factsheets

Factsheet 16

The Child Death Review Process (England)

From 1 April 2008 Child Death Review (CDR) processes were made mandatory for Local Safeguarding Children Boards (LSCBs) in England for all child deaths up to the age of 18 years.

The overall purpose of the child death review process is to understand why children die and put in place interventions to protect other children and prevent future deaths.

Following the death of a child, information about the circumstances of their death is collected and summarised from records held by ambulance services, hospitals, community health services, schools, police, children's services and other agencies.

A Child Death Overview Panel (CDOP) of doctors, other health specialists and child care professionals consider the anonymous information, to 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. It 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.

Another part of this process is the rapid response team who 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. Some children

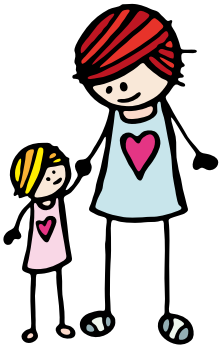
will die unexpectedly, but in the context of their illness, this will not be surprising. The rapid response team will need to consider these deaths, but will not need to investigate the circumstances. Where a death is unexpected, but not surprising, a home visit will usually not be necessary.

All the professionals involved in this process should ensure that children will be cared for with respect and dignity at all times. Key aims of the CDOP and Rapid Response team are to ensure that services for families are provided, families are supported and lessons for the future are learnt.

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 all agencies to be notified in advance so that when the child dies, there is no confusion about the nature of the death.

As a family, you should be made aware of who to contact, so that appropriate support from the CDOP and Rapid Response Team is in place.

If you would like more information about the Child Death Review Process you can call our Together for Families Helpline on **0808 8088 100**.



Together for Families Helpline
7am-Midnight, 7 days a week

0808 8088 100

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