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**Child Death Review Process Guidelines for Practitioners**

Every child death is a devastating loss that profoundly affects parents, siblings, grandparents, extended family, and friends, as well as professionals involved in caring for the child during their life. Families want to understand what happened to their child and be assured that any learning arising from their child’s death will help prevent future children’s deaths.

When a child dies, Child Death Review Partners (CCG & Local Authorities) make arrangements to complete a child death review to investigate the reasons for the death. The Child Death Overview Panel (CDOP) meets to review the deaths of all children resident in the local authority area. CDOPs have been set up to review every child death using a standardised approach. CDOP is a panel of senior professionals from various agencies that meet monthly to review anonymised information on all child deaths up to the age of 18 years who are resident in the local area of Shropshire and Telford & Wrekin.

**A child death review must be carried out for all children under 18 years of age regardless of cause of death. This does not include stillbirths, late foetal loss, or terminations of pregnancy (of any gestation) carried out within the law. Cases where a baby initially survives and then subsequently dies after a planned termination of pregnancy (carried out within the law) are not subject to a child death review.**

**The aims and responsibilities of CDOPs are to:**

Request information using standardised reporting and analysis forms to capture the expertise and thoughts of the professionals that cared for the child for the purposes of the Child Death Review Process, to which parties must comply.

Establish, as far as is possible, the cause of the child’s death.

Identify any modifiable contributory factors.

Learn lessons in order to reduce the risk of future child deaths and promote the health, safety and the well being of other children.

Make arrangements for the analysis of information on child deaths in order to identify matters relevant to the welfare of children, to consider whether action should be taken in relation to matters identified and to inform relevant organisations as required.

Publish reports on what they have done as a result of the child death review arrangements and how effective the arrangements have been in practice.

Ensure that all statutory obligations are met.

Many agencies will perform reviews of the care of the deceased child after their death. Examples include Serious Incidents (SUI) review, a Child Death Review meeting (often called an M&M), a Perinatal Mortality Review Tool meeting (PMRT) or a Network Review meeting. There may also be independent reviews by other agencies such as a Serious Case Reviews or HSIB investigations.

It is important that we are aware of what investigations are occurring (including criminal or coronial investigations). We appreciate that these investigations can often take some time to complete. Once completed, we would require the provider to share any significant learning with us.

Once all the information is received then we will present the case at CDOP.

***For further information*:**

**Child Death Review Statutory and Operational Guidance**:

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf>

[Child Death Overview Process (CDOP) Induction Training - YouTube](https://www.youtube.com/watch?v=lGFjqvteLBM&feature=youtu.be)