Child Death Overview Process
Leicester, Leicestershire & Rutland

7 Minute Briefing

1. Background

All Local Authorities and ICBs in England have a joint statutory responsibility to review the deaths of all children under 18 years, who are usually resident in their area. They are the 'Child Death Review Partners' in each area. The legal basis for this is set out in the Childrens Act & Working Together to Safeguard Children 2018. The three LLR Local Authorities and ICB jointly commission the LLR Child Death Review Service. Nationally work is ongoing to integrate & streamline Child Death Reviews with MBRRACE and local Perinatal Mortality Review processes.

2. Why it matters

The Child Death Review (CDR) process includes the Joint Agency Response to unexpected child deaths (including medically unattended stillbirths), and the process for joint working and coordination to support families for all deaths. Deaths are reviewed to identify the factors that contributed, and whether any factors are 'modifiable', to reduce child mortality. Learning is shared, and actions are undertaken to reduce risk.

3. The role of the MW - initially

Notification: Professionals from all agencies have a duty to notify the CDR team of the death of any child (liveborn of any gestation, up to 17 years 364 days). Locally this is done via the eCDOP portal: https://www.ecdop.co.uk/LLR/Live/Public
No log-in is required. The form has several mandatory fields, including details about the child, parents, & circumstances of death. This comes directly to the local CDR team, and to the National Child Mortality Database (NCMD) who use the information for real-time surveillance and national data collection.

Child Death Initial Meeting: if you are involved in a Joint Agency Response case (typically an unattended stillbirth, or sudden unexpected death), you may be invited to a multiagency Child Death Initial Meeting, along with Police, Social Care and others from health. Information about circumstances of death is shared, support for family discussed, and any initial learning and actions identified.

4. The role of the MW – reporting & review

Reporting Form: Reporting Forms are requested via eCDOP. This is to gather data for the National Child Mortality Database and to inform the local review.

Child Death Review Meeting: For babies who die in hospital before discharge home, this will usually be the Perinatal Mortality Review Meeting. In all other cases, a multiagency meeting is held once all information is gathered. Information is reviewed, contributory & modifiable factors analysed, and support for the family discussed. This information goes to the Child Death Overview Panel (CDOP).

5. Child Death Overview Panel

The Child Death Overview Panel (CDOP) for each area is a multiagency panel that reviews deaths of all children usually resident in that area. The CDOP will consider factors in the family and social environment and physical environment, as well as in service provision, that may have contributed to the death in each case. Frequent modifiable factors found in neonatal cases include maternal obesity, and parental smoking. Learning is shared and actions taken to address these.

6. Support resources

Child Death Review Statutory & Operational Guidance (England)

LLR Child Death Overview Panel website
(including links to Annual Report & learning)

Any queries: Contact the team via CDR Admin
melvinna.west@nhs.net

7. Questions to consider/discuss

Do I know the circumstances for when a Joint Agency Response is required?

Do I know how to access the relevant guidance in the event of a Joint Agency Response?

How can I share information about the CDR Process with colleagues in my team?