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 2023. The three LLR Local Authorities and ICB jointly commission the LLR Child Death Review Service. The LLR Child Death Overview Panel (CDOP) is a multiagency panel, analysing all child deaths in LLR, as the final part of the review process.

2. Why it matters

The Child Death Review process incorporates the Joint Agency Response to unexpected child deaths, 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’, in order to reduce child mortality. Learning is shared, and actions are undertaken to reduce risk.

3. The role of the GP - initially

Notification: Any professional who is first to become aware of the death of a child has a statutory responsibility to notify the CDR Partners. This is done via the eCDOP portal. No log-in is required. The form has several mandatory fields, including details about the child, parents, & circumstances of death. This goes directly to the LLR Child Death Review team, and to the National Child Mortality Database (NCMD) who use the information for real-time surveillance and national data collection.

https://www.ecdop.co.uk/LLR/Live/Login
Click ‘Submit Notification Form (A)’

Child Death Initial Meeting: as the GP of a child who has died, you may be invited to a multiagency Child Death Initial Meeting, along with Police, Social Care and others from health. Information around circumstances of death is shared, support for family discussed, and any initial learning and actions identified.

4. The role of the GP – 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: a multiagency meeting held once all information is gathered & all other processes concluded (this may be some time after the death). Information is reviewed, contributory & modifiable factors are analysed, and support for the family discussed. This information goes to the Child Death Overview Panel (CDOP) for their final scrutiny before all data is submitted to the National Child Mortality Database.

5. Information-sharing

The legal basis for sharing relevant information (without requirement for consent) with LLR Child Death Review process, including via eCDOP, and with the National Child Mortality Database is set out in:

- The Children Act 2004
- Working Together to Safeguard Children 2023 (Chapter 6)
- Child Death Review Statutory & Operational Guidance (England) 2018

6. Support resources

NCMD Advice for GPs after the death of a child

Child Death Review Statutory & Operational Guidance (England)

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

Queries? Send in via Mel West, CDR Admin

7. Questions to consider/discuss

Would I know where to go for resources to support a bereaved family?

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

Am I aware of the impact of secondary trauma, and where can I go for support if needed?