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. 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', to reduce child mortality. Learning is shared, and actions are undertaken to reduce risk.

3. The role of Education/school - Initially

Child Death Initial Meeting: as the Head Teacher (or other teacher/Designated Safeguarding Lead from the school) 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. It is helpful for schools to share information about the child, their achievements, attendance, mental and physical health, friendship groups and where appropriate any safeguarding or other concerns.
Information around circumstances of the death is shared by all professionals, support for family is discussed, and any initial learning and actions identified. Support for the school will also be discussed.

Reporting Form: Reporting Forms are requested from Education settings (by email via the child death review team) to gather data about the child. Information to share may include:

- Child's personality/likes and dislikes.
- Areas of strength/ support needed.
- Relationships (peers and staff).
- Physical/ emotional or mental health concerns.
- Safeguarding concerns

4. The role of Education/School – in the Review

Child Death Review Meeting: when all the information is gathered & all other processes have concluded (this may be some time after the death), a multiagency review meeting is held. Information is discussed, contributory and modifiable factors are analysed, and support for the family discussed. This information goes to the Child Death Overview Panel (CDOP) for their final scrutiny. Part of the role of the Panel is to identify and share learning, including through 7-minute briefings (previous examples include, epilepsy safety, private fostering. Community Defibrillators). Finally, all data is submitted to the National Child Mortality Database who use this information for real-time surveillance and national data collection with the aim of preventing children's deaths in the future by making recommendations for service providers and policy makers.

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 2018 (Chapter 5)
- Child Death Review Statutory & Operational Guidance (England) 2018

6. Support resources

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

psychology@leics.gov.uk or psychology@leicester.gov.uk
Members of the team will be invited to attend the initial meeting to look at support options

Queries Send to CDR Admin melvinna.west@nhs.net

7. Questions to consider

Would I know where to go for resources to support colleagues and students?

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