**Child Death Review Guidance 2018**

Overview:

Immediate decision making & notifications

(within 1-2 hours if possible)

CDRM

Investigation & information gathering

CDOP

Child Dies

 Perinatal Mortality Review

 JAR Coroner/PM

Child Death Review Meeting:

Discussion of the child’s death by professionals from all agencies directly involved with the child’s life and death.

The key worker presents parents queries and views and reports back to them.

Aims are:

* Review history, investigations, treatment, cause of death
* Ascertain any contributory or modifiable factors in the child, the environment or service delivery
* Describe learning and identify actions to improve child safety and welfare
* Review support for family and staff
* Inform the coroner and CDOP

The meeting will complete as far as possible the draft analysis form to go to CDOP and should be chaired by lead professional for child death process within the Trust, generally in the location where the death occurred.

 Joint Agency Response? MCCD?

 Coroner?

Inform:

GP

Other professionals (midwives; health visitor; school nurse; etc)

CHIS

CDR Partners

MBRRACE

LeDer

 Serious Incident?

**Support for the family:**

* **Engagement – with the review and investigation process**
* **Information – from and to all relevant agencies**
* **Key worker – named, single point of contact. It is the responsibility of the organisation where the child was certified dead to identify a key worker for the family.**