7 Minute Briefing - The Child Death Review Process

North West London Child Death Review Team
Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea,Westminster

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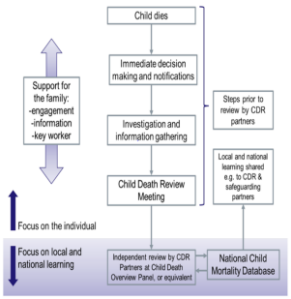
North West London Integrated Care System

Who we are

The North West London Child Death Review Team (NWL CDR) comprises of 3 Specialist Nurses, 1 Specialist Midwife and 1 Administrator.
The CDR process was instigated because of a need for further evaluation of trends and themes after the wrongful conviction of 3 women for the deaths of their babies. The process started in 2018, and aims to improve learning as well as the experience of bereaved parents. The team works closely with the Local Authorities and the MET Police as well as healthcare professionals, schools and 0-19 services. NWL CDR Team cover the 8 North West London boroughs as shown below. All deaths in babies and children under 18 normally resident in these boroughs, should be reported regardless of place of death. ***It is everyone's responsibility to report a child death!*** The NWL CDR Team currently work Monday - Friday, 9am - 5pm. Please email nhsnwl.cdr@nhs.net or call 0203 350 4806 to contact us.

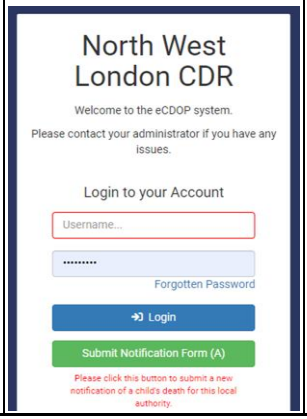
NWL Picture

- NW London is a diverse area with 2.4m people from more than 200 ethnicities
- ONS data suggests 477,394 of the population in NWL were 0-17 years in 2021.
- The National Child Mortality Database (NCMD) data suggests the NWL CDR team has the highest incidence in England of child deaths, receiving 142 notifications in 2021/22.
- Most childhood deaths occur in the perinatal or neonatal period, and the majority of children who die are male.
- In 2021/2022 the team were able to complete 117 cases:
  o Further information on these cases will be provided in a seperate briefing.



Form A's

All deaths in children born with signs of life and normally resident in the 8 NWL Boroughs, **must** be reported to the NWL CDR Team as a statutory requirement. This includes the death of any live-born baby, regardless of gestation at birth, where a death certificate has been issued. *However, this does not include babies who are stillborn, or born with signs of life after a legal termination of pregnancy.*
A login is not required to complete a notification form, and can be accessed via the following link...**https://www.ecdop.co.uk/NWLondon/Live/Public.**
The CDR Team triage each notification and make a decision as to whether the death is expected or unexpected - this then triggers the pathway the case will follow.



JAR's

A Joint Agency Response (JAR) meeting is triggered by the CDR Team for those deaths which are considered:
- Is or could be due to external causes;
- Is sudden and there is no immediately apparent cause (incl. SUDI/C);
- Occurs in custody, or where the child was detained under the Mental Health Act;
- Where the initial circumstances raise any suspicions that the death may not have been natural;
- Or in the case of a stillbirth where no healthcare professional was in attendance.

The aim is to hold these meetings within 48 hours of the child dying and should involve all professionals involved in the child's life and sad death.
The NWL CDR team ensure these meetings are as holistic as possible, and paint a picture of what the child was like during their life as well as the circumstances surrounding their death. The JAR meeting also offers professionals the opportunity to debrief.
This is a statutory requirement, so all invited professionals are expected to attend.

Keyworking

The NWL CDR Team have recently recommenced their keyworking service for the families of those children who die unexpectedly. We will be doing this role within our Monday – Friday, 9am – 5pm working hours and aims to:
- Act as a single point of contact for the bereaved family, who they can turn to for information on the child death review process, and who can signpost them to sources of support.
- Be a reliable and readily accessible point of contact for the family after the death
- Help co-ordinate meetings between the family and professionals as required
- Be able to provide information on the child death review process and the course of any investigations pertaining to the child
- Liaise as required with the Coroner's Officer and Police Family Liaison Officer
- Represent the 'voice' of the parents at professional meetings, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards
- Signpost to expert bereavement support if required.

CDRM's

A Child Death Review Meeting (CDRM) is held for every child who dies, and aims to:
- Determine, as far as possible, the likely cause of death
- Ascertain contributory and modifiable factors
- Describe any learning arising from the death and identify any action that should be taken
- Review support provided to the family and to ensure that the family are provided with the outcomes of any investigation into their child's death
- To review the support provided to staff involved
- Complete a draft analysis form of each individual case to inform the independent review at a CDOP meeting

This meeting should be held at 3 months after the child's death, however this is dependent on the receipt of other investigations such a post-mortems or police matters. The CDRM involves professionals directly involved in the life or death of a child.
The CDRM meeting may be replaced by a PMRT meeting where appropriate.

CDOP Panels

The NWL CDR Team currently run 3 Child Death Overview Panels which aim to finalise the learning and outcomes from the death of each child. Each child is reviewed at panel a year after their death, however this timeline is dependent on other investigations. These meetings are attended by representatives of each professional to ensure objectivity, public health and charities.
- Flute Panel - H&F, K&C, Westminster, Harrow, Brent
- Triangle Panel – Hillingdon, Hounslow, Ealing
- Neonatal Panel – Neonates from all boroughs where there are no safeguarding concerns.

In the future, the team aims to create further specialist panels such as trauma, SUDI and suicide as well as a specialist Grenfell panel.
After these panels, learning is disseminated through our partners and regular publications which are sent via email.
National themes are generated by NCMD – they produce information reports which are available on their website.
If you wish to observe one of our panels, please do drop us an email.