

Parent Information - Dorset Child Death Reviews

The Government requires a case review to be held for every child who dies from birth to eighteen years, regardless of the cause of death. The review is attended by all the agencies who usually have routine contact with or provide services to families and those who were involved in giving care to the child and family around the time of death (e.g. health, education, social services). The aim of the review is:

- To ensure that children and families receive the service and support they need
- To ensure that every death is investigated, and potential causes or preventable factors and learning points are identified. This helps us understand what happened and will help us to try to reduce the number of child deaths in the future
- To improve our local response to child deaths and improve the service for other families

This is achieved by sharing information in a confidential manner and completing a child death information collection form that is based on the national child death study.

How are parents and carers involved?

Whilst parents and carers are not invited to attend, we do encourage parents and carers to feedback any messages, good or bad regarding the services and support they received. This can be done in a number of ways:

- Through any professional (e.g. midwife, health visitor, GP, community nurse or hospital)
- Through the nurse or doctor responsible for child death reviews (see contact details below)

Many parents and carers find it helpful to meet with the consultant who cared for their child at the time of their death to ask questions and talk about any concerns or worries they may have. We can arrange this for all families and there is no time limit on when the meeting takes place. Parents can decide where the meeting is held – home, hospital or somewhere else, e.g. GP surgery.

What happens next?

The child death review co-ordinators (a nurse and doctor) write a summary of the child's information. This summary does not contain any information (names, addresses etc) that could identify a child.

The summary is reviewed by the Child Death Overview Panel of the Local Safeguarding Children's Board. This group has a responsibility to ensure any preventable factors, trends and risks are addressed at senior level. It also ensures local information contributes to national studies into child deaths to try to reduce the number of children that die. It is sadly acknowledged however that some deaths are not preventable.

How can I get more information?

If you wish to find out more information please contact the nurse or doctor responsible for child death reviews who are:

East Dorset Tel: **01202 448037** Dr Janet Kelsall or Karen Fernley (Nurse)
West Dorset Tel: **01305 254748** Dr Wendy D'Arrigo or Allison Ryder (Nurse)