Child Death Review meeting

Agenda

1. **Introductions and purpose of meeting**

2. **Family details**

3. **Summary and chronology of circumstances leading to death:**
   - Ambulance Service
   - Receiving hospital
   - Police

4. **Background information and family history**
   - Hospital
   - Health
   - Children's Services
   - Police
   - School / Nursery
   - Coroner

5. **Actions taken so far:**
   - Rapid Response home visit

6. **Information sharing and analysis**
   - Analysis of information to assist in the identification of cause of death
   - Identify any factors that may have contributed to death
   - Factors intrinsic to child
   - Factors in relation to service provision
   - Factors in parenting capacity
   - Factors in the environment
   - Information to inform the inquest

7. **Actions needed**
   - Parent's & carer's needs and future care
   - Sibling's needs
   - Any missing information?
   - Control of information
   - Potential media interest
   - Staff Debrief

8. **Learning points**

9. **Modifiable Factors/Recommendations**

NB: There should be an explicit discussion of the potential of abuse or neglect either causing or contributing to the death. This should be documented as part of the meeting. Where there are concerns relating to abuse or neglect refer to Surrey Case Review Panel for consideration of a Child Safeguarding Practice Review.