Surrey Child Death Review Partnership

NHS

Surrey Wide CCG Safeguarding Children Team

Surrey Child Death Review Team

Multi Agency Child Death Review Meeting (CDRM) 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. **Actions taken so far:**
    - Joint Agency Home Visit
5. **Background information and family history**
    - Hospital
    - Health
    - Children's Services
    - Police
    - School / Nursery
    - Coroner
6. **Information sharing, analysis and summary**
    - 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 (MH, ACE's, Alcohol, Smoking, Drug use, Criminal behaviour, friendship, bullying)
    - Factors in relation to service provision
    - Factors in parenting capacity (Poverty, housing, debt, alcohol, drug use, IVF, BMI, Maternal age, Smoking, DA, MH, Criminal behaviour, Transient lifestyle, Social isolation, Multiple partners, other adults at the address)
    - 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**

All minutes from this meeting remain the property of the Child Death Review Partnership. Do not upload minutes to any patient record. No professional identifiable information will be recorded on the minutes, all references to discussions will be noted by agency not individual practitioner. All minutes will be shared with the Coroner for the purposes of the Inquest.